Great River Medical Center

Blytheville, Arkansas

MISSISSIPPI COUNTY
Hospital System

Community Health Needs Assessment
and Implementation Strategy

Adopted by Board Resolution March 26, 2018

MISSISSIPPI COUNTY
Hospital System

Dear Community Member:

At Great River Medical Center (GRMC), we have spent more than 60 years providing high-quality compassionate healthcare to the greater Blytheville community. This Community Health Needs Assessment identifies local health and medical needs and provides a plan of how GRMC will respond to such needs. This document illustrates one way we are meeting our obligations to efficiently deliver medical services.

The hospital will conduct this effort at least once every three years. The report produced three years ago is also available for your review and comment. As you review this plan, please see if, in your opinion, we have identified the primary needs of the community and if you think our intended response will lead to 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, along with other area organizations and agencies, can collaborate to bring the best each has to offer to support change and to address the most pressing identified needs.

I invite your response to this report. As you read, please think about how to help us improve health and medical services in our area. We all live in, work in, and enjoy this wonderful community, and together, we can make our community healthier for every one of us.

Thank You,

Chris Raymer
Chief Executive Officer
Mississippi County Hospital System

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EXECUTIVE SUMMARY

EXECUTIVE SUMMARY

Great River Medical Center ("GRMC" or the "Hospital") has performed a Community Health Needs Assessment to determine the health needs of the local community, and to develop an implementation plan to outline and organize how to meet those needs.

Data was gathered from multiple well-respected secondary sources to build an accurate picture of the current community and its health needs. A survey of a select group of Local Experts was performed to review the prior CHNA and provide feedback, and to ascertain whether the previously identified needs are still a priority. A second survey was distributed to the same group that reviewed the data gathered from the secondary sources and determined the Significant Health Needs for the community.

The Significant Health Needs for the Great River Medical Center area of Mississippi County are:

1. Physicians
2. Cancer
3. Diabetes
4. Accessibility/Affordability
5. Mental Health

The Hospital has developed implementation strategies for four of the five needs (Physicians, Cancer, Diabetes, and Accessibility/Affordability) including activities to continue/pursue, community partners to work alongside, and leading and lagging indicators to track.

APPROACH

APPROACH

A Community Health Needs Assessment (CHNA) is part of the required hospital documentation of "Community Benefit" under the Affordable Care Act (ACA), required of all not-for-profit hospitals as a condition of retaining tax-exempt status. ***While Great River Medical Center is not a 501(c)(3), this study is designed to comply with standards required of a not-for-profit hospital and helps assure Great River Medical Center identifies and responds to the primary health needs of its residents.***

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.

Project Objectives

Great River Medical Center partnered with Quorum Health Resources (Quorum) to:[1]

- Complete a CHNA report, compliant with Treasury – IRS
- Produce the information necessary for the Hospital to issue an assessment of community health needs and document its intended response

Overview of Community Health Needs Assessment

Typically, non-profit 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 those who did not have 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:

- An Emergency Room open to all, regardless of ability to pay
- Surplus funds used to improve patient care, expand facilities, train, etc.
- A board controlled by independent civic leaders
- All available and qualified physicians granted hospital privileges

Specifically, the IRS requires:

- Effective on tax years beginning after March 23, 2012, each 501(c)(3) hospital facility must conduct a CHNA at least once every three taxable years, and adopt an implementation strategy to meet the community needs identified through the assessment.
- The assessment may be based on current information collected by a public health agency or non-profit organization, and may be conducted together with one or more other organizations, including related

[1] Part 3 Treasury/IRS – 2011 – 52 Section 3.03 (2) third party disclosure notice

organizations.

- The 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 downloadable from the hospital website.
- Failure to complete a CHNA in any applicable three-year period results in an excise tax to the organization of $50,000. For example, if a facility does not complete a CHNA in taxable years one, two, or three, it is subject to the penalty in year three. If it then fails to complete a CHNA 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).
- An organization that fails to disclose how it is meeting needs identified in the assessment is subject to existing incomplete return penalties.[2]

Community Health Needs Assessment Subsequent to Initial Assessment

The Final Regulations establish a required step for a CHNA developed after the initial report. This requirement calls for considering written comments received on the prior CHNA and Implementation Strategy as a component of the development of the next CHNA and Implementation Strategy. The specific requirement is:

> *"The 2013 proposed regulations provided that, in assessing the health needs of its community, a hospital facility must take into account input received from, at a minimum, the following three sources:*
>
> *(1) At least one state, local, tribal, or regional governmental public health department (or equivalent department or agency) with knowledge, information, or expertise relevant to the health needs of the community;*
>
> *(2) members of medically underserved, low-income, and minority populations in the community, or individuals or organizations serving or representing the interests of such populations; and*
>
> *(3) written comments received on the hospital facility's most recently conducted CHNA and most recently adopted implementation strategy.[3]*
>
> *…the final regulations retain the three categories of persons representing the broad interests of the community specified in the 2013 proposed regulations but clarify that a hospital facility must*

[2] Section 6652
[3] Federal Register Vol. 79 No. 250, Wednesday December 31, 2014. Part II Department of the Treasury Internal Revenue Service 26 CFR Parts 1, 53, and 602 P. 78963 and 78964

''solicit'' input from these categories and take into account the input ''received.'' The Treasury Department and the IRS expect, however, that a hospital facility claiming that it solicited, but could not obtain, input from one of the required categories of persons will be able to document that it made reasonable efforts to obtain such input, and the final regulations require the CHNA report to describe any such efforts."

Representatives of the various diverse constituencies outlined by regulation to be active participants in this process were actively solicited to obtain their written opinion. Opinions obtained formed the introductory step in this Assessment.

To complete a CHNA:

"… the final regulations provide that a hospital facility must document its CHNA in a CHNA report that is adopted by an authorized body of the hospital facility and includes:

(1) A definition of the community served by the hospital facility and a description of how the community was determined;

(2) a description of the process and methods used to conduct the CHNA;

(3) a description of how the hospital facility solicited and took into account input received from persons who represent the broad interests of the community it serves;

(4) a prioritized description of the significant health needs of the community identified through the CHNA, along with a description of the process and criteria used in identifying certain health needs as significant and prioritizing those significant health needs; and

(5) a description of resources potentially available to address the significant health needs identified through the CHNA.

… final regulations provide that a CHNA report will be considered to describe the process and methods used to conduct the CHNA if the CHNA report describes the data and other information used in the assessment, as well as the methods of collecting and analyzing this data and information, and identifies any parties with whom the hospital facility collaborated, or with whom it contracted for assistance, in conducting the CHNA."[4]

Additionally, a CHNA developed subsequent to the initial Assessment must consider written commentary received regarding the prior Assessment and Implementation Strategy efforts. We followed the Federal requirements in the solicitation of written comments by securing characteristics of individuals providing written comment but did not maintain identification data.

"…the final regulations provide that a CHNA report does not need to name or otherwise identify any specific individual providing input on the CHNA, which would include input provided by individuals in the

[4] Federal Register Op. cit. P 78966 As previously noted the Hospital collaborated and obtained assistance in conducting this CHNA from Quorum Health Resources

form of written comments."[5]

Quorum takes a comprehensive approach to the solicitation of written comments. As previously cited, we obtained input from the required three minimum sources and expanded input to include other representative groups. We asked all participating in the written comment solicitation process to self-identify themselves into any of the following representative classifications, which is detailed in an Appendix to this report. Written comment participants self-identified into the following classifications:

(1) Public Health – Persons with special knowledge of or expertise in public health

(2) Departments and Agencies – Federal, tribal, regional, State, or local health or other departments or agencies, with current data or other information relevant to the health needs of the community served by the hospital facility

(3) Priority Populations – Leaders, representatives, or members of medically underserved, low income, and minority populations, and populations with chronic disease needs in the community served by the hospital facility. Also, in other federal regulations the term Priority Populations, which include rural residents and LGBT interests, is employed and for consistency is included in this definition

(4) Chronic Disease Groups – Representative of or member of Chronic Disease Group or Organization, including mental and oral health

(5) Broad Interest of the Community – Individuals, volunteers, civic leaders, medical personnel, and others to fulfill the spirit of broad input required by the federal regulations

Other (please specify)

Quorum also takes a comprehensive approach to assess community health needs. We perform several independent data analyses based on secondary source data, augment this with Local Expert Advisor[6] opinions, and resolve any data inconsistency or discrepancies by reviewing 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 expert area residents to note if they perceived the problems or needs identified by secondary sources existed in their portion of the county.

Most data used in the analysis is available from public Internet sources and Quorum proprietary data from Truven. Any critical data needed to address specific regulations or developed by the Local Expert Advisor individuals cooperating with us in this study are displayed in the CHNA report appendix.

[5] Federal Register Op. cit. P 78967

[6] "Local Expert" is an advisory group of local residents, inclusive of at least one member self-identifying with each of the five Quorum written comment solicitation classifications, with whom the Hospital solicited to participate in the Quorum/Hospital CHNA process

Data sources include:[7]

Website or Data Source	Data Element	Date Accessed	Data Date
www.countyhealthrankings.org	Assessment of health needs of Mississippi County compared to all State counties	October 25, 2016	2012
www.cdc.gov/communityhealth	Assessment of health needs of Mississippi County compared to its national set of "peer counties"	October 25, 2016	2011
Truven (formerly known as Thompson) 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 proportion of each group in the entire area; and, to access population size, trends and socio-economic characteristics	October 25, 2016	2016
http://svi.cdc.gov	To identify the Social Vulnerability Index value	October 25, 2016	2010
www.worldlifeexpectancy.com/usa-health-rankings	To determine relative importance among 15 top causes of death	October 25, 2016	2015

Federal regulations surrounding CHNA require local input from representatives of particular demographic sectors. For this reason, Quorum developed a standard 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 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 and the Hospital's desire to represent the region's geographically and ethnically diverse population. We received community input from 16 Local Expert Advisors. Survey responses started October 10, 2016 and ended with the last response on November 21, 2016.

[7] The final regulations clarify that a hospital facility may rely on (and the CHNA report may describe) data collected or created by others in conducting its CHNA and, in such cases, may simply cite the data sources rather than describe the ''methods of collecting'' the data. Federal Register Op. cit. P 78967

- Information analysis augmented by local opinions showed how Mississippi County relates to its peers in terms of primary and chronic needs and other issues of uninsured persons, low-income persons, and minority groups. Respondents commented on whether they believe certain population groups ("Priority Populations") need help to improve their condition, and if so, who needs to do what to improve the conditions of these groups.
- Local opinions of the needs of Priority Populations, while presented in its entirety in the Appendix, was abstracted in the following "take-away" bulleted comments:
    - Yes, all of these groups exist and have unique needs to be addressed
    - Transportation is an issue and translation services are needed
    - Low income and older adults are particularly at risk

When the analysis was complete, we put the information and summary conclusions before our Local Expert Advisors who were asked to agree or disagree with the summary conclusions. They were free to augment potential conclusions with additional comments of need, and new needs did emerge from this exchange. Consultation with 14 Local Experts occurred again via an internet-based survey (explained below) beginning December 2016 and ending June 2017.

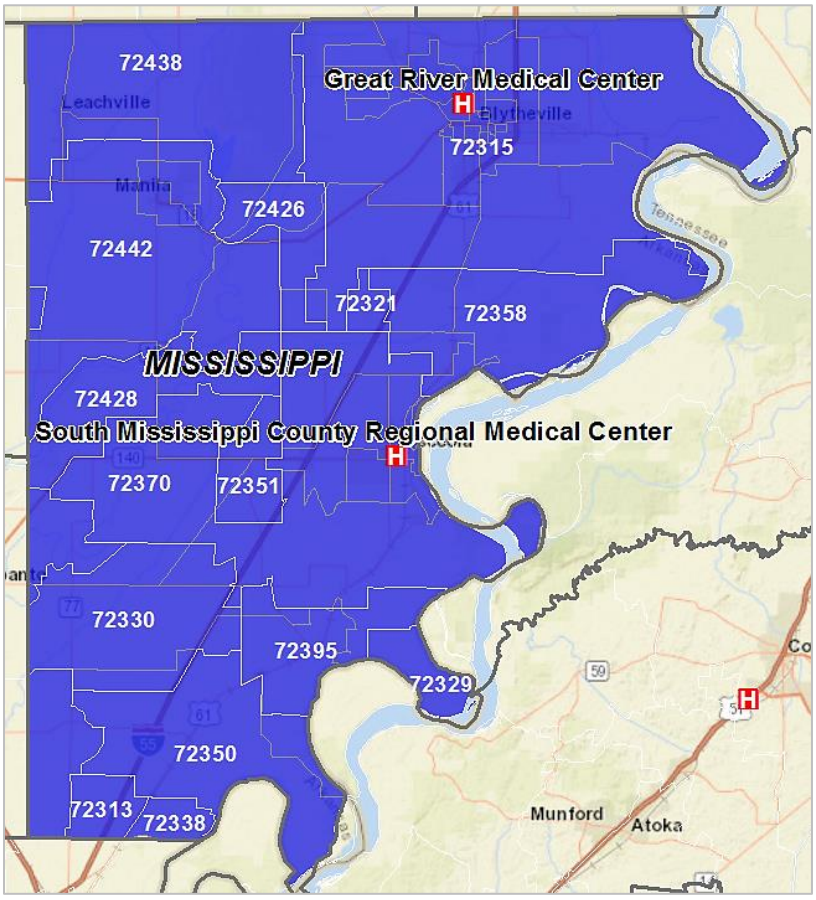
Having taken steps to identify potential community needs, the Local Experts then participated in a structured communication technique called a "Wisdom of Crowds" method. The premise of this approach relies on a panel of experts with the assumption that the collective wisdom of participants is superior to the opinion of any one individual, regardless of their professional credentials.

In the GRMC process, each Local Expert had the opportunity to introduce needs previously unidentified and to challenge conclusions developed from the data analysis. While there were a few opinions of the data conclusions not being completely accurate, the vast majority of comments agreed with our findings. We developed a summary of all needs identified by any of the analyzed data sets. The Local Experts then allocated 100 points among the potential significant need candidates, including the opportunity to again present additional needs that were not identified from the data. A rank order of priorities emerged, with some needs receiving none or virtually no support, and other needs receiving identical point allocations.

We divided the prioritized needs into two groups: "Significant" and "Other Identified Needs." Our criteria for identifying and prioritizing Significant Needs was based on a descending frequency rank order of the needs based on total points cast by the Local Experts, further ranked by a descending frequency count of the number of local experts casting any points for the need. By our definition, a Significant Need had to include all rank ordered needs until at least fifty percent (50%) of all points were included and to the extent possible, represented points allocated by a majority of voting local experts. The determination of the break point — "Significant" as opposed to "Other" — was a qualitative interpretation by Quorum and the GRMC executive team where a reasonable break point in rank order occurred.

COMMUNITY CHARACTERISTICS

Definition of Area Served by the Hospital



GRMC, in conjunction with Quorum, defines its service area as Mississippi County in Arkansas, which includes the following ZIP codes:[8]

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

In 2015, the Hospital received 87.9% of its Medicare inpatients from this area.[9]

[8] The map above amalgamates zip code areas and does not necessarily display all county zip codes represented below
[9] Truven MEDPAR patient origin data for the hospital

Demographics of the Community[10]

	Mississippi County	Arkansas	U.S.
2016 Population[11]	43,131	2,980,525	322,431,073
% Increase/Decline	(3.7%)	1.9%	3.7%
Estimated Population in 2021	41,532	3,037,958	334,341,965
% White, non-Hispanic	58.9%	72.8%	61.3%
% Black, non-Hispanic	34.5%	15.3%	12.3%
Median Age	35.8	38.0	38.0
Median Household Income	$37,323	$42,989	$55,072
Unemployment Rate (Aug 2016)	7.1%	3.9%	5.0%
% Population >65	14.0%	16.2%	15.1%
% Women of Childbearing Age	19.6%	19.2%	19.6%

2016 Benchmarks
Area: Mississippi County
Level of Geography: ZIP Code

Area	2016-2021 % Population Change	Median Age	Population 65+ % of Total Population	Population 65+ % Change 2016-2021	Females 15-44 % of Total Population	Females 15-44 % Change 2016-2021	Median Household Income	Median Household Wealth	Median Home Value
USA	3.7%	38.0	15.1%	17.6%	19.6%	1.5%	$55,072	$54,224	$192,364
Arkansas	1.9%	38.0	16.2%	13.3%	19.2%	0.7%	$42,989	$44,358	$116,253
Selected Area	-3.7%	35.8	14.0%	10.1%	19.6%	-4.3%	$37,323	$27,148	$78,017

Demographics Expert 2.7
DEMO0003.SQP
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[10] The tables below were created by Truven Market Planner, a national marketing company
[11] All population information, unless otherwise cited, sourced from Truven (formally Thomson) Market Planner

Demographics Expert 2.7
2016 Demographic Snapshot
Area: Mississippi County
Level of Geography: ZIP Code

DEMOGRAPHIC CHARACTERISTICS

	Selected Area	USA
2010 Total Population	46,202	308,745,538
2016 Total Population	43,131	322,431,073
2021 Total Population	41,532	334,341,965
% Change 2016 - 2021	-3.7%	3.7%
Average Household Income	$52,158	$77,135

	2016	2021	% Change
Total Male Population	21,026	20,323	-3.3%
Total Female Population	22,105	21,209	-4.1%
Females, Child Bearing Age (15-44)	8,458	8,092	-4.3%

POPULATION DISTRIBUTION

	Age Distribution				
Age Group	2016	% of Total	2021	% of Total	USA 2016 % of Total
0-14	9,460	21.9%	8,770	21.1%	19.0%
15-17	1,969	4.6%	1,893	4.6%	4.0%
18-24	4,243	9.8%	4,194	10.1%	9.8%
25-34	5,523	12.8%	5,431	13.1%	13.3%
35-54	10,513	24.4%	9,499	22.9%	26.0%
55-64	5,384	12.5%	5,096	12.3%	12.8%
65+	6,039	14.0%	6,649	16.0%	15.1%
Total	43,131	100.0%	41,532	100.0%	100.0%

HOUSEHOLD INCOME DISTRIBUTION

	Income Distribution		
2016 Household Income	HH Count	% of Total	USA % of Total
<$15K	3,811	23.0%	12.3%
$15-25K	2,003	12.1%	10.4%
$25-50K	4,612	27.8%	23.4%
$50-75K	2,347	14.1%	17.6%
$75-100K	1,768	10.7%	12.0%
Over $100K	2,047	12.3%	24.3%
Total	16,588	100.0%	100.0%

EDUCATION LEVEL

	Education Level Distribution		
2016 Adult Education Level	Pop Age 25+	% of Total	USA % of Total
Less than High School	2,330	8.5%	5.8%
Some High School	3,639	13.3%	7.8%
High School Degree	9,778	35.6%	27.9%
Some College/Assoc. Degree	8,156	29.7%	29.2%
Bachelor's Degree or Greater	3,556	13.0%	29.4%
Total	27,459	100.0%	100.0%

RACE/ETHNICITY

	Race/Ethnicity Distribution		
Race/Ethnicity	2016 Pop	% of Total	USA % of Total
White Non-Hispanic	25,392	58.9%	61.3%
Black Non-Hispanic	14,870	34.5%	12.3%
Hispanic	1,791	4.2%	17.8%
Asian & Pacific Is. Non-Hispanic	256	0.6%	5.4%
All Others	822	1.9%	3.1%
Total	43,131	100.0%	100.0%

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Customer Segmentation[12]

Claritas Prizm uses Census data, sources of demographic and consumer information, and 30 years of annual consumer surveys to classify all U.S. households into 66 demographically and behaviorally distinct groups. These segments represent clusters of at least 250 households that have comparable characteristics and exhibit similar behaviors. The top segments in Mississippi County are:

Claritas Prizm Segments	Characteristics	
Segment #1 (28%)	• Urbanicity: Town/Rural • Income: Low Income • Income Producing Assets: Low • Age Ranges: 25-44 • Presence of Kids: w/ Kids	• Homeownership: Mostly Renters • Employment Levels: Service Mix • Education Levels: High School • Ethnic Diversity: White, Black, Hispanic, Mix
Segment #2 (17%)	• Urbanicity: Town/Rural • Income: Low Income • Income Producing Assets: Low • Age Ranges: 45-64 • Presence of Kids: w/o Kids	• Homeownership: Homeowners • Employment Levels: Mix • Education Levels: High School • Ethnic Diversity: White, Black, Mix
Segment #3 (12%)	• Urbanicity: Town/Rural • Income: Lower Mid(Scale) • Income Producing Assets: Low • Age Ranges: <55 • Presence of Kids: w/o Kids	• Homeownership: Renters • Employment Levels: Service Mix • Education Levels: High School • Ethnic Diversity: White, Black, Hispanic, Mix
Segment #4 (12%)	• Urbanicity: Rural • Income: Lower Mid(Scale) • Income Producing Assets: Below Avg • Age Ranges: 25-44 • Presence of Kids: w/ Kids	• Homeownership: Mix • Employment Levels: Blue Collar Mix • Education Levels: High School • Ethnic Diversity: White, Black, Hispanic, Mix
Segment #5 (11%)	• Urbanicity: Town • Income: Lower Mid(Scale) • Income Producing Assets: Moderate • Age Ranges: 45-64 • Presence of Kids: w/o Kids	• Homeownership: Homeowners • Employment Levels: Service Mix • Education Levels: College Graduate • Ethnic Diversity: White, Asian, Mix

[12] Truven Health Analytics Household Targeter

Each of the 66 Claritas Prizm segments exhibits prevalence toward specific health behaviors. In the second column of the chart below, the national average is 100%, so the 'Demand as % of National' shows a community's likelihood of exhibiting a certain health behavior more or less than the national average. The next column shows the percentage of the population that is likely to exhibit those behaviors.

Where Mississippi County varies more than 5% above or below the national average (that is, less than 95% or greater than 105%), it is considered significant. Items in the table with **red text** are viewed as statistically significant **adverse** findings. Items with **blue text** are viewed as statistically significant **beneficial** findings. Items with black text are neither a favorable nor unfavorable finding.

Health Service Topic	Demand as % of National	% of Population Affected	Health Service Topic	Demand as % of National	% of Population Affected
Weight / Lifestyle			**Cancer**		
BMI: Morbid/Obese	115.8%	34.6%	Mammography in Past Yr	88.9%	40.5%
Vigorous Exercise	96.8%	54.5%	Cancer Screen: Colorectal 2 yr	90.0%	22.9%
Chronic Diabetes	135.8%	16.5%	Cancer Screen: Pap/Cerv Test 2 yr	87.5%	52.5%
Healthy Eating Habits	85.0%	25.2%	Routine Screen: Prostate 2 yr	97.1%	31.1%
Ate Breakfast Yesterday	105.8%	64.0%	**Orthopedic**		
Slept Less Than 6 Hours	122.4%	20.2%	Chronic Lower Back Pain	136.2%	31.9%
Consumed Alcohol in the Past 30 Days	79.8%	43.8%	Chronic Osteoporosis	111.5%	11.0%
Consumed 3+ Drinks Per Session	108.1%	29.0%	**Routine Services**		
Behavior			FP/GP: 1+ Visit	103.0%	90.9%
I Will Travel to Obtain Medical Care	94.6%	22.5%	Used Midlevel in last 6 Months	101.9%	42.2%
I am Responsible for My Health	92.4%	60.4%	OB/Gyn 1+ Visit	87.3%	40.4%
I Follow Treatment Recommendations	91.8%	47.6%	Medication: Received Prescription	95.5%	51.1%
Pulmonary			**Internet Usage**		
Chronic COPD	119.4%	4.7%	Use Internet to Talk to MD	76.1%	9.6%
Tobacco Use: Cigarettes	121.5%	31.0%	Facebook Opinions	86.9%	8.9%
Heart			Looked for Provider Rating	89.4%	12.8%
Chronic High Cholesterol	123.7%	27.2%	**Emergency Services**		
Routine Cholesterol Screening	88.1%	44.7%	Emergency Room Use	110.4%	37.4%
Chronic Heart Failure	130.6%	6.1%	Urgent Care Use	95.5%	22.3%

Leading Causes of Death[13]

Cause of Death			Rank among all counties in AR	Rate of Death per 100,000 age adjusted		Observation (Compared to U.S.)
AR Rank	Mississippi County Rank	Condition	(#1 rank = worst in state)	AR	Mississippi County	
1	**1**	Heart Disease	2 of 75	217.5	355.4	Higher than expected
2	**2**	Cancer	13 of 75	183.1	229.9	Higher than expected
3	**3**	Lung	6 of 75	58.9	72.3	Higher than expected
4	**4**	Stroke	34 of 75	45.5	64.3	Higher than expected
7	**5**	Diabetes	2 of 75	24.0	57.0	Higher than expected
5	**6**	Accidents	47 of 75	47.4	54.7	As expected
8	**7**	Flu - Pneumonia	14 of 75	20.8	33.4	Higher than expected
10	**8**	Blood Poisoning	6 of 75	15.8	26.0	Higher than expected
6	**9**	Alzheimer's	31 of 75	34.8	24.3	As expected
9	**10**	Kidney	30 of 75	19.2	22.4	Higher than expected
14	**11**	Homicide	8 of 75	7.7	14.4	Higher than expected
11	**12**	Suicide	57 of 75	17.3	12.9	As expected
12	**13**	Liver	32 of 75	10.4	8.7	As expected
13	**14**	Hypertension	45 of 75	7.8	5.7	As expected
15	**15**	Parkinson's	52 of 75	6.2	3.6	Lower than expected

[13] www.worldlifeexpectancy.com/usa-health-rankings

Priority Populations[14]

Information about Priority Populations in the service area of the Hospital is difficult to encounter if it exists. Our approach is to understand the general trends of issues impacting Priority Populations and to interact with our Local Experts to discern if local conditions exhibit any similar or contrary trends. The following discussion examines findings about Priority Populations from a national perspective.

We begin by analyzing the National Healthcare Quality and Disparities Reports (QDR), which are annual reports to Congress mandated in the Healthcare Research and Quality Act of 1999 (P.L. 106-129). These reports provide a comprehensive overview of the quality of healthcare received by the general U.S. population and disparities in care experienced by different racial, ethnic, and socioeconomic groups. The purpose of the reports is to assess the performance of our health system and to identify areas of strengths and weaknesses in the healthcare system along three main axes: **access to healthcare**, **quality of healthcare**, and **priorities of the National Quality Strategy** (NQS). The complete report is provided in Appendix C.

We asked a specific question to our Local Expert Advisors about unique needs of Priority Populations. We reviewed their responses to identify if any of the report trends were obvious in the service area. Accordingly, we place great reliance on the commentary received from our Local Expert Advisors to identify unique population needs to which we should respond. Specific opinions from the Local Expert Advisors are summarized below:[15]

- Yes, all of these groups exist and have unique needs to be addressed
- Transportation is an issue and translation services are needed
- Low income and older adults are particularly at risk

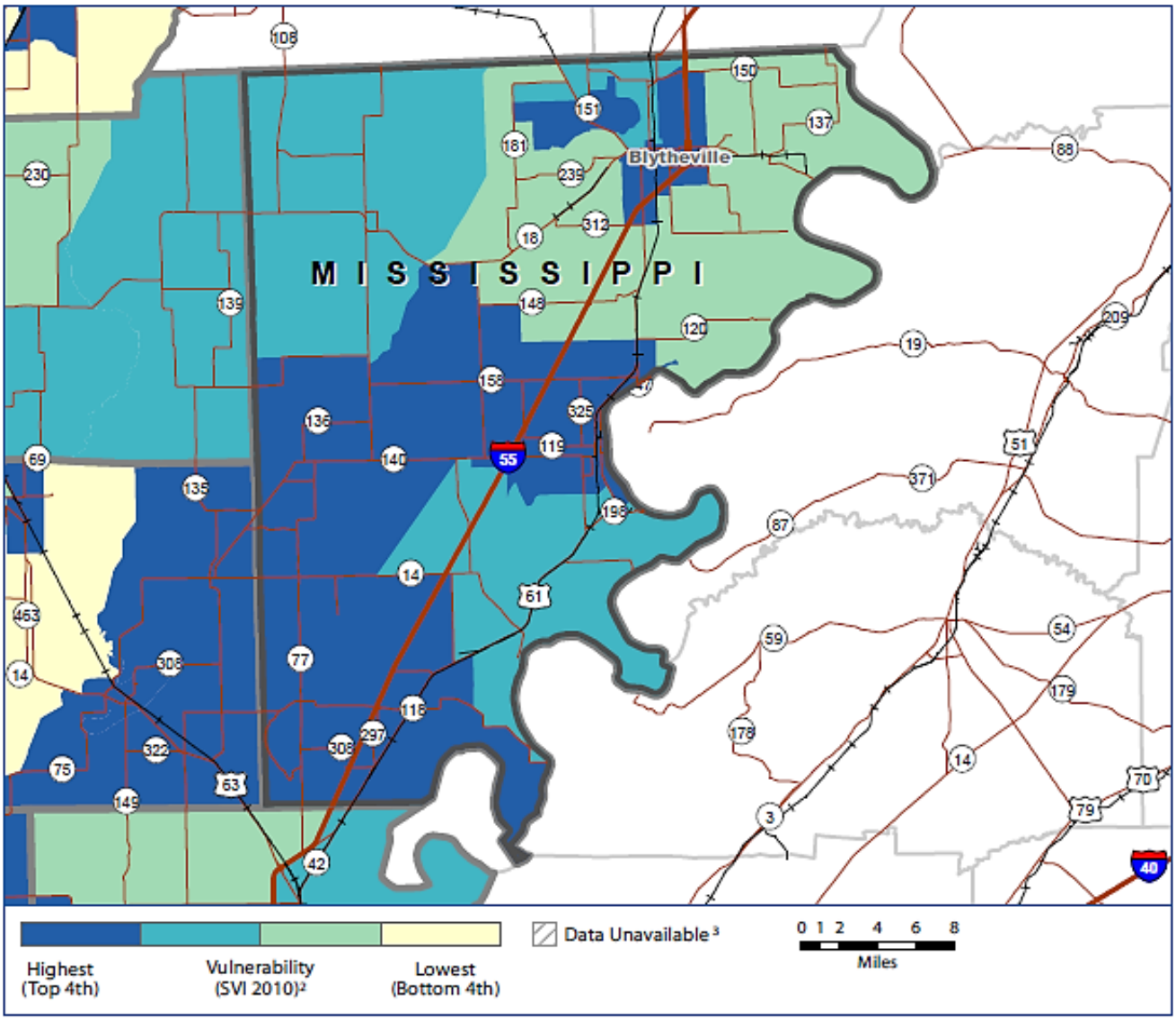
[14] http://www.ahrq.gov/research/findings/nhqrdr/nhqdr14/index.html
[15] All comments and the analytical framework behind developing this summary appear in Appendix A

Social Vulnerability[16]

Social vulnerability refers to the resilience of communities when confronted by external stresses on human health, stresses such as natural or human-caused disasters, or disease outbreaks.

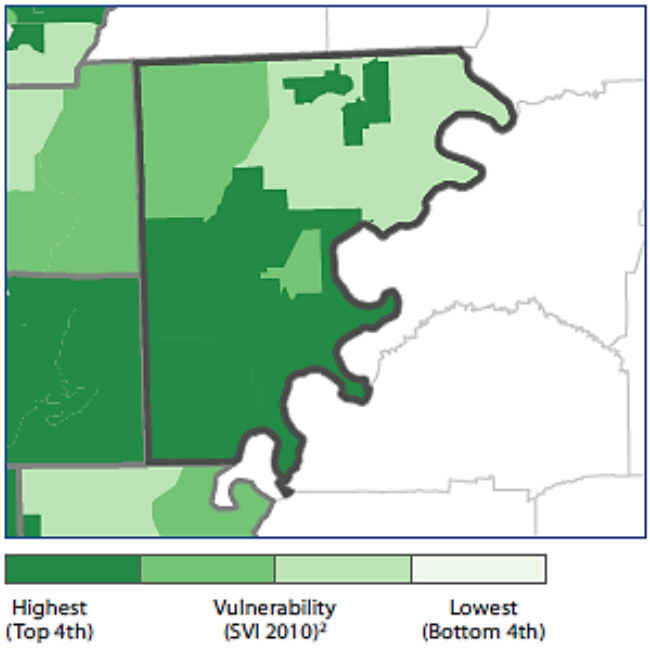
Mississippi County falls into the top three quartiles of social vulnerability. The area closest GRMC is in the highest two quartiles, and a larger surrounding area is in the second lowest quartile.

Overall Social Vulnerability[1]



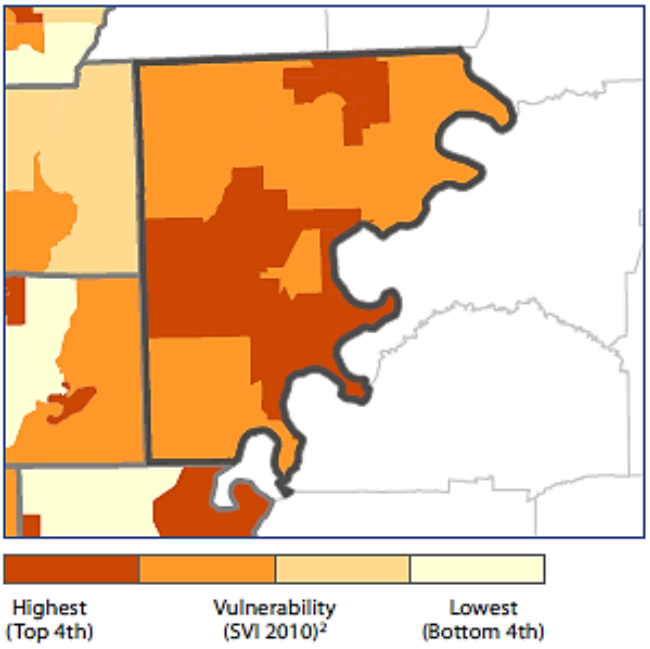
[16] http://svi.cdc.gov

Socioeconomic Status[5]



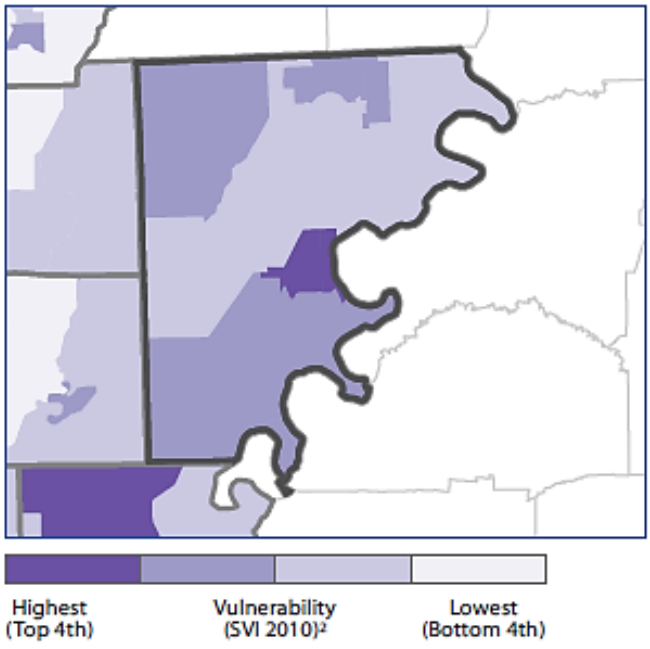
Highest (Top 4th) — Vulnerability (SVI 2010)[2] — Lowest (Bottom 4th)

Household Composition[6]



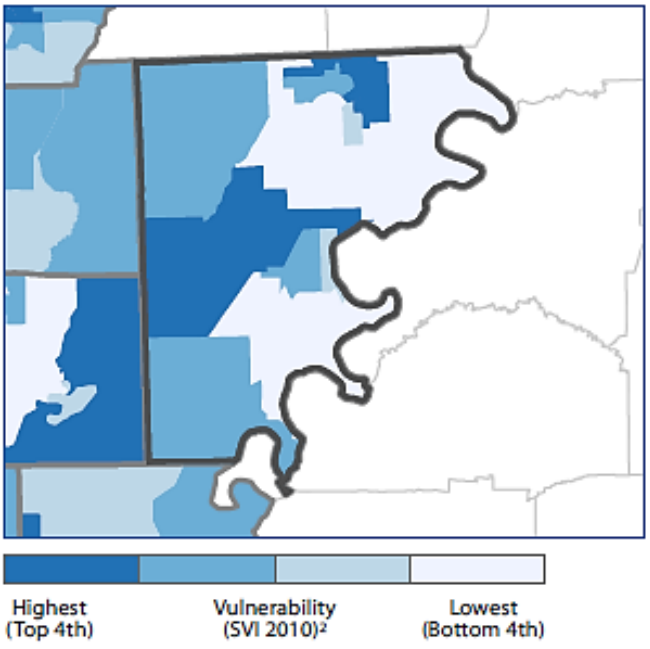
Highest (Top 4th) — Vulnerability (SVI 2010)[2] — Lowest (Bottom 4th)

Race/Ethnicity/Language[7]



Highest (Top 4th) — Vulnerability (SVI 2010)[2] — Lowest (Bottom 4th)

Housing/Transportation[8]



Highest (Top 4th) — Vulnerability (SVI 2010)[2] — Lowest (Bottom 4th)

Summary of Survey Results on Prior CHNA

In the Round 1 survey, a group of 16 individuals provided feedback on the 2013 CHNA. Complete results, including *verbatim* written comments, can be found in Appendix A.

Commenter characteristics:

	Yes (Applies to Me)	No (Does Not Apply to Me)	Response Count
1) **Public Health Expertise**	4	8	12
2) **Departments and Agencies** with relevant data/information regarding health needs of the community served by the hospital	4	9	13
3) **Priority Populations**	7	4	11
4) Representative/Member of **Chronic Disease Group** or Organization	1	9	10
5) Represents the **Broad Interest of the Community**	15	0	15
Other			1
Answered Question			16
Skipped Question			0

Priorities from the last assessment where the Hospital intended to seek improvement:

- Physicians
- Cancer
- Diabetes
- Dental
- Accessibility/Affordability
- Compliance Behavior/Predisposing Conditions
- Homicide
- Lung Disease
- Stroke

GRMC received the following responses to the question: **"Should the hospital continue to consider the needs identified as most important in the 2013 CHNA as the most important set of health needs currently confronting residents in the county?**

	Yes	No	No Opinion
Physicians	9	0	0
Cancer	9	0	0
Diabetes	9	0	0
Dental	8	1	0
Accessibility/Affordability	8	1	0
Compliance Behavior/Predisposing Conditions	7	2	0
Homicide	5	3	1
Lung Disease	8	0	1
Stroke	8	0	1

Comments:

- *Collaboration with all agencies and volunteer effort to improve access to and use of health supporting efforts.*
- *Do not think it should be their priority as there are other programs resources available but they should continue to monitor to see how they might be able to help.*

GRMC received the following responses to the question: **"Should the Hospital continue to allocate resources to help improve the needs identified in the 2013 CHNA?"**

	Yes	No	No Opinion
Physicians	9	0	0
Cancer	9	0	0
Diabetes	8	0	1
Accessibility/Affordability	8	1	0
Compliance Behavior/Predisposing Conditions	6	2	1
Lung Disease	7	1	1
Stroke	8	0	1

Comments:

- *Invest in building collaborative efforts with all agencies and volunteer effort to improve access to and use of health supporting efforts.*

Comparison to Other State Counties[17]

To better understand the community, Mississippi County has been compared to all 75 counties in the state of Arkansas across five areas: Health Outcomes, Health Behaviors, Clinical Care, Social & Economic Factors, and Physical Environment. The last four areas are all Health Factors that ultimately affect the Health Outcomes of Length (Mortality) and Quality of Life (Morbidity).

In the chart below, the county's rank compared to all counties is listed along with any measures in each area that are ***worse than*** the state average and U.S. Best (90th percentile).

	Mississippi County	Arkansas	U.S. Best
Health Outcomes			
Overall Rank *(best being #1)*	71/75		
Premature Death (deaths prior to age 75)*	12,700	9,100	5,200
Health Behaviors			
Overall Rank *(best being #1)*	70/75		
Adult Smoking	26%	25%	14%
Adult Obesity	38%	33%	25%
Physical Inactivity	40%	32%	20%
Alcohol-impaired Driving Deaths	40%	30%	14%
Sexually Transmitted Infections*	1,084.2	523.8	134.1
Teen Births *(per 1,000 females age 15-19)*	77	53	19
Access to Exercise Opportunities	23%	61%	91%
Clinical Care			
Overall Rank *(best being #1)*	63/75		
Preventable Hospital Stays *(per 1,000 Medicare enrollees)*	99	66	38
Diabetic Monitoring	78%	83%	90%
Mammography Screening	44%	58%	71%
Population to Primary Care Physician	2,630:1	1,540:1	1,040:1
Population to Mental Health Provider	1,130:1	520:1	370:1
Population to Dentist	3,400:1	2,300:1	1,340:1

[17] www.countyhealthrankings.org

	Mississippi County	Arkansas	U.S. Best
Social & Economic Factors			
Overall Rank *(best being #1)*	70/75		
Unemployment	9.3%	6.1%	3.5%
Children in Poverty	37%	26%	13%
Children in Single-parent Households	51%	37%	21%
Violent Crime*	792	484	59
Injury Deaths*	89	77	51
Social Associations	11.8	12.0	22.1
Some College Attendance	51%	55%	72%
Physical Environment			
Overall Rank *(best being #1)*	73/75		
Air Pollution	13.2 $\mu g/m^3$	11.8 $\mu g/m^3$	9.5 $\mu g/m^3$

**Per 100,000*

Comparison to Peer Counties[18]

The Federal Government administers a process to allocate all 3,143 U.S. counties into "Peer" groups. County "Peer" groups have similar social, economic, and demographic characteristics. The counties are ranked across six health and wellness categories and divided into quartiles: Better (top quartile), Moderate (middle two quartiles), and Worse (bottom quartile).

In the below chart, Mississippi County is compared to its peer counties and the U.S. average, but only areas where the county is Better or Worse are listed. (The list and number of peer counties used in each ranking may differ.)

	Mississippi County	Peer Ranking	U.S. Median
Mortality			
Better			
None	--	--	--
Worse			
Chronic Lower Respiratory Disease Deaths*	80.7	55/56	49.6
Coronary Heart Disease Deaths*	287.1	57/57	126.7
Diabetes Deaths*	66.7	54/56	24.7
Female Life Expectancy	73.9 years	57/57	79.8 years
Male Life Expectancy	68.0 years	56/57	75.0 years
Stroke Deaths*	66.8	46/56	46.0
Morbidity			
Better			
Cancer*	424.8	12/55	457.6
Syphilis*	0.0	2/57	0.0
Worse			
Adult Obesity	44%	51/54	30.4%
Gonorrhea*	352.4	55/57	30.5
Healthcare Access & Quality			
Better			
None	--	--	--
Worse			

[18] https://wwwn.cdc.gov/communityhealth

	Mississippi County	Peer Ranking	U.S. Median
Older Adult Preventable Hospitalizations *(per 1,000 Medicare enrollees)*	112.1	47/56	71.3
Health Behaviors			
Better			
None	--	--	--
Worse			
Adult Female Routine Pap Tests	68%	48/48	77.3%
Adult Physical Inactivity	41.6%	51/54	25.9%
Adult Smoking	30.6%	47/50	21.7%
Teen Births *(per 1,000 females age 15-19 years)*	81.0	50/57	42.1
Social Factors			
Better			
High Housing Costs	27.8%	13/57	27.3%
Worse			
Violent Crime*	790.8	52/56	199.2
Physical Environment			
Better			
Access to Parks	25.0%	7/57	14.0%
Housing Stress	28.3%	9/57	28.1%
Worse			
Air Pollution (annual average PM2.5 concentration)	12.1 µg/m^3	45/57	10.7 µg/m^3

Conclusions from Demographic Analysis Compared to National Averages

The following areas were identified from a comparison of the county to national averages. **Adverse** metrics impacting more than 30% of the population and statistically significantly different from the national average include:

- BMI: Morbid/Obese = 15.8% above average, impacting 34.6%
- I Am Responsible for My Health = 7.6% below average, impacting 60.4%
- I Follow Treatment Recommendations = 8.2% below average, impacting 47.6%
- Tobacco Use (Cigarettes) = 21.5% above average, impacting 31.0%
- Cholesterol Screening = 11.9% below average, impacting 44.7%
- Mammography Screening = 11.1% below average, impacting 40.5%
- Cervical Cancer Screening = 12.5% below average, impacting 52.5%
- Chronic Lower Back Pain = 36.2% above average, impacting 31.9%
- Annual OB/Gyn Visit = 12.7% below average, impacting 40.4%
- Emergency Room Use = 10.4% above average, impacting 37.4%

Beneficial metrics impacting more than 30% of the population and statistically significantly different from the national average include:

- Ate Breakfast Yesterday = 5.8% above average, impacting 64.0%
- Consumed Alcohol in the Past 30 Days = 20.2% below average, impacting 43.8%

Conclusions from Other Statistical Data[19]

The Institute for Health Metrics and Evaluation at the University of Washington analyzed all 3,143 U.S. counties or equivalents applying small area estimation techniques to the most recent county information. The below chart compares Mississippi County statistics to the U.S. average, and lists the change since the last date of measurement.

	Current Date of Data	Statistic	Percent Change	Last Date of Data
UNFAVORABLE measures that are **WORSE** than the U.S. average and got **WORSE**				
Female Life Expectancy	2013	75 years	-0.4 years	1985
Female Obesity	2011	48.3%	8.2% pts	2001
Male Obesity	2011	41.2%	7.9% pts	2001
Male Physical Activity	2011	42.8%	-0.8% pts	2001
UNFAVORABLE measures that are **WORSE** than the U.S. average and **IMPROVED**				
Male Life Expectancy	2013	68.6 years	1.5 years	1985
Female Smoking	2012	25.5%	-3.9% pts	1996
Male Smoking	2012	33.5%	-1.2% pts	1996
Female Physical Activity	2011	36.8%	4.2% pts	2001
DESIRABLE measures that are **BETTER** than the US average but got **WORSE**				
Female Heavy Drinking	2012	3.8%	1.6% pts	2005
Male Heavy Drinking	2012	8.7%	1.6% pts	2005
Female Binge Drinking	2012	7.1%	1.4% pts	2002
DESIRABLE measures that are **BETTER** than the US average and **IMPROVED**				
Male Binge Drinking	2012	18.2%	-1.0% pts	2002

[19] http://www.healthdata.org/us-county-profiles

Community Benefit

"Community health improvement services" means activities or programs, subsidized by the health care organization, carried out or supported for the express purpose of improving community health. Such services do not generate inpatient or outpatient revenue, although there may be a nominal patient fee or sliding scale fee for these services.

"Community benefit operations" means:

- *activities associated with community health needs assessments, administration, and*
- *the organization's activities associated with fundraising or grant-writing for community benefit programs.*

Activities or programs cannot be reported if they are provided primarily for marketing purposes or if they are more beneficial to the organization than to the community. For example, the activity or program may not be reported if it is designed primarily to increase referrals of patients with third-party coverage, required for licensure or accreditation, or restricted to individuals affiliated with the organization (employees and physicians of the organization).

To be reported, community need for the activity or program must be established. Community need can be demonstrated through the following:

- A CHNA conducted or accessed by the organization.
- Documentation that demonstrated community need or a request from a public health agency or community group was the basis for initiating or continuing the activity or program.
- The involvement of unrelated, collaborative tax-exempt or government organizations as partners in the activity or program carried out for the express purpose of improving community health.

Community benefit activities or programs also seek to achieve a community benefit objective, including improving access to health services, enhancing public health, advancing increased general knowledge, and relief of a government burden to improve health. This includes activities or programs that do the following:

- Are available broadly to the public and serve low-income consumers.
- Reduce geographic, financial, or cultural barriers to accessing health services, and if they ceased would result in access problems (for example, longer wait times or increased travel distances).
- Address federal, state, or local public health priorities such as eliminating disparities in access to healthcare services or disparities in health status among different populations.
- Leverage or enhance public health department activities such as childhood immunization efforts.
- Otherwise would become the responsibility of government or another tax-exempt organization.
- Advance increased general knowledge through education or research that benefits the public.

IMPLEMENTATION STRATEGY

Significant Health Needs

We used the priority ranking of area health needs by the Local Expert Advisors to organize the search for locally available resources as well as the response to the needs by GRMC. The following list:

- 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 GRMC current efforts responding to the need including any written comments received regarding prior GRMC implementation actions
- Establishes the Implementation Strategy programs and resources GRMC will devote to attempt to achieve improvements
- Documents the Leading Indicators GRMC will use to measure progress
- Presents the Lagging Indicators GRMC 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, GRMC is the major hospital in the service area. GRMC is a 99-bed, acute care sole-community provider located in Blytheville, Arkansas. The next closest facilities are outside the service area and include:

- South Mississippi County Regional Medical Center, Osceola, AR, 18.1 miles (26 minutes)
- Pemiscot County Memorial Hospital, Hayti, MO, 25.7 miles (28 minutes)
- Twin Rivers Regional Medical Center, 28 miles (35 minutes)
- NEA Baptist Memorial Hospital, Jonesboro, AR, 52.2 miles (61 minutes)
- St. Bernard's Medical Center, Jonesboro, AR, 53.3 miles (65 minutes)

All data items analyzed to determine significant needs are "Lagging Indicators," measures presenting results after a period of time, characterizing historical performance. Lagging Indicators tell you nothing about how the outcomes were achieved. In contrast, the GRMC Implementation Strategy uses "Leading Indicators." Leading Indicators anticipate change in the Lagging Indicator. Leading Indicators focus on short-term performance, and if accurately selected, anticipate the broader achievement of desired change in the Lagging Indicator. In the QHR application, Leading Indicators also must be within the ability of the hospital to influence and measure.

1. **PHYSICIANS – 2013 SIGNIFICANT NEED; Population to Primary Care Physician ratio worse than AR and US**

Public comments received on previously adopted implementation strategy:

- *Believe the hospital attempts to recruit physicians and/or specialists-however, due to low economic status of the community, high crime rate, and bad name for schools, it is very difficult to recruit physicians.*
- *Unkown*
- *I am aware GRMS has an active recruitment program.*
- *Recruit ones that are from area and will stay here*

GRMC services, programs, and resources available to respond to this need include:

- Worked with county to implement sales tax to assist with recruiting new providers
- Added Wound Care service line
- Developed stipend to support General Surgery call coverage
- Specialties available on site include GI, cardiology, ENT, medical oncology (part time), and orthopedics and surgery (full time)
- Arranged for call coverage in nursery
- Mental health screenings available through telehealth in partnership with Mid-South Health Systems
- Telemedicine for neonatology and stroke in partnership with UAMS
- Telemedicine for burn in partnership with Arkansas Children's; consults for emergency pediatric patients
- Tele-trauma available through Arkansas Health Network
- Preparing to go live with Pulsara program (STEMI protocol) in January with Arkansas Department of Health
- Hospital volunteers raise money for scholarships to help support local aspiring physicians and nurses
- Participate in state of Arkansas loan forgiveness program to help bring in physicians
- Local high school students can participate in job shadowing and MASH program to learn about careers in healthcare
- Provide residency placement for Arkansas State University (radiology, respiratory, PT) and Arkansas Northeastern College (EMT/EMTP, RN/LPN, phlebotomy)

Additionally, GRMC plans to take the following steps to address this need:

- Recruiting for pediatrics
- Reviewing addition of a surgeon and APN(s)
- Researching addition of urgent care/convenient care to facilitate access

- Looking to work with new DO school in Jonesboro for residency

GRMC evaluation of impact of actions taken since the immediately preceding CHNA:

- Recruited family practice physician, two APNs, pain management specialist, and OB/GYN
- Extended mammography hours until 9:00pm on first and third Thursdays

Anticipated results from GRMC Implementation Strategy

Community Benefit Attribute Element	Yes, Implementation Strategy Addresses	Implementation Strategy Does Not Address
1. Available to public and serves low income consumers	X	
2. Reduces barriers to access services (or, if ceased, would result in access problems)	X	
3. Addresses disparities in health status among different populations		X
4. Enhances public health activities	X	
5. Improves ability to withstand public health emergency	X	
6. Otherwise would become responsibility of government or another tax-exempt organization	X	
7. Increases knowledge; then benefits the public		X

The strategy to evaluate GRMC intended actions is to monitor change in the following Leading Indicator:

- Number of providers recruited in 2017 = 0

The change in the Leading Indicator anticipates appropriate change in the following Lagging Indicator:

- Population to primary care physicians = 2,630:1[20]

[20] www.countyhealthrankings.com

GRMC anticipates collaborating with the following other facilities and organizations to address this Significant Need:

Organization	Contact Name	Contact Information
Healthy Partners & Affiliate (FQHC)	Valencia Andrews-Pirtle, MD	http://www.eafhc.org/MeetTheProviders/HealthyPartners.aspx 4102 Memorial Dr, Blytheville, AR 72315 (870) 532-6047
Wagner Medical Clinic	Katie Gurley, APN	1001 N 6th St, Blytheville, AR 72315 (870) 281-2530
Great River Charitable Clinic	Connie Ash, APN	www.greatriverclinic.org 33 Arkansas St, Blytheville, AR 72315 (870) 762-5459
Mid-South Health Systems, Inc.	Vickie Winte	209 S Lockard St, Blytheville, AR 72315 (870) 763-2139
UAMS Medical Center		https://uamshealth.com/ 4301 W Markham St, Little Rock, AR 72205 (501) 686-7000
Arkansas Children's		http://www.archildrens.org/ 1 Children's Way, Little Rock, AR 72202 (501) 364-1100
Arkansas Health Network		www.arkansashealthnetwork.com 2 St Vincent Cir, Little Rock, AR 72205 (501) 552-3914
Arkansas Department of Health		www.healthy.arkansas.gov 4815 W. Markham, Little Rock, AR 72205 (800) 462-0599
Arkansas State University		https://www.astate.edu 2105 Aggie Rd, Jonesboro, AR 72401 (870) 972-2100
Arkansas Northeastern College	James Shemwell, PHD	www.anc.edu 2501 South Division Street, Blytheville, AR 72315 (870) 762-1020

Organization	Contact Name	Contact Information
Methodist University Hospital		http://www.methodisthealth.org/locations/methodist-university-hospital 1265 Union Ave, Memphis, TN 38104 (901) 516-7000

2. **CANCER – 2013 SIGNIFICANT NEED; #2 Leading Cause of Death; Mammography Screening below AR avg and US best**

Public comments received on previously adopted implementation strategy:

- *Closed the Radiology Oncology section of cancer care-Not sure why this was not successful*
- *Unknown*
- *I am not aware of any GRMC programs.*

GRMC services, programs, and resources available to respond to this need include:

- Medical oncologist has practice here (Methodist West Clinic)
- Perform PSA (prostate-specific antigen) tests for local cancer group to screen for prostate cancer
- Added resources in clinics to better track and schedule preventive screenings, including sending reminders to patients due for a screening
- IV and infusion therapy services available on site
- Participate in annual health fairs and provide screenings including PSAs, colorectal screenings, education on self-breast exams, etc.
- Provide education of the month in hallways, on website, and in newspaper on cancer prevention including breast cancer awareness month, etc.
- Participate in Susan G. Komen race and raise money to support cancer screening awareness and research for a cure; hospital team has won awards for participation
- Participating in state program to promote and encourage smoking cessation through screenings and smoking cessation training
- Offer contracted rates for mammography screenings to Department of Health to increase availability to low income and uninsured populations
- Shifted employee health insurance plan to incentivize better health choices including smoking cessation
- Provide meeting space for Look Good Feel Better program, a cancer support group for women

Additionally, GRMC plans to take the following steps to address this need:

- Continue above activities

GRMC evaluation of impact of actions taken since the immediately preceding CHNA:

- Extended mammography hours until 9:00pm on first and third Thursdays to increase access after typical working hours

- Added digital mammography

Anticipated results from GRMC Implementation Strategy

Community Benefit Attribute Element	Yes, Implementation Strategy Addresses	Implementation Strategy Does Not Address
1. Available to public and serves low income consumers	X	
2. Reduces barriers to access services (or, if ceased, would result in access problems)	X	
3. Addresses disparities in health status among different populations	X	
4. Enhances public health activities	X	
5. Improves ability to withstand public health emergency		X
6. Otherwise would become responsibility of government or another tax-exempt organization	X	
7. Increases knowledge; then benefits the public	X	

The strategy to evaluate GRMC intended actions is to monitor change in the following Leading Indicator:

- Number of mammograms provided in 2017 = 1,570
- Number of colonoscopies provided in 2017 = 501

The change in the Leading Indicator anticipates appropriate change in the following Lagging Indicator:

- Cancer death rate = 229.9 per 100,000[21]

[21] www.worldlifeexpectancy.com/usa-health-rankings

GRMC anticipates collaborating with the following other facilities and organizations to address this Significant Need:

Organization	Contact Name	Contact Information
Susan G. Komen		https://komenarkansas.org/ 904 Autumn Road, Suite 500, Little Rock, AR, 72211 (501) 202-4399
West Cancer Clinic		www.westcancercenter.org 271 West Polk Ave, West Memphis, AR 72301 (870) 733-1800
Arkansas State Department of Health (SOS)		http://www.stampoutsmoking.com/ Arkansas Department of Health Tobacco Prevention and Cessation Program 4815 W. Markham St., Slot 3, Little Rock, AR 72205 (501) 661-2953
Mississippi County Health Department		1299 N 10th St, Blytheville, AR 72315 (870) 763-7064
American Cancer Society		www.cancer.org/about-us/local/arkansas 901 N University Ave, Little Rock, AR 72207 (501) 664-3480

3. **DIABETES – 2013 SIGNIFICANT NEED; #5 Leading Cause of Death; Diabetic Monitoring below AR avg and US best; Diabetes Deaths 54th worst of 56 peers**

Public comments received on previously adopted implementation strategy:

- *Need more cross-functional projects in which Nursing Homes, Home Health, etc. are involved*
- *Unknown*
- *No interdisciplinary team approach with other entities outside the hospitals.*

GRMC services, programs, and resources available to respond to this need include:

- Registered dietician on staff to counsel inpatients as well as available to community
- Provide diabetes education at annual health fairs, on website, and in newspaper
- Reminders and counseling provided to diabetic patients to encourage receiving annual eye exam, foot exam, and A1C tests
- Hospital operates a fitness center available to the community, that is free to hospital employees and available at a reduced rate for families
    - Contract with personal trainer to provide additional services and education at fitness center
- Provide meeting space for local Weight Watchers group
- Hospital staff volunteer at local Charity Clinic; clinic has added a diabetic education program
- Implementing chronic care management program for diabetes, heart disease, etc., which includes face-to-face education and counseling

Additionally, GRMC plans to take the following steps to address this need:

- Continue above activities

GRMC evaluation of impact of actions taken since the immediately preceding CHNA:

- Added pain clinic that treats diabetic neuropathy
- Wound Care clinic works with diabetic patients and provides care and education

Anticipated results from GRMC Implementation Strategy

Community Benefit Attribute Element	Yes, Implementation Strategy Addresses	Implementation Strategy Does Not Address
1. Available to public and serves low income consumers	X	
2. Reduces barriers to access services (or, if ceased, would result in access problems)	X	
3. Addresses disparities in health status among different populations	X	
4. Enhances public health activities	X	
5. Improves ability to withstand public health emergency		X
6. Otherwise would become responsibility of government or another tax-exempt organization	X	
7. Increases knowledge; then benefits the public	X	

The strategy to evaluate GRMC intended actions is to monitor change in the following Leading Indicator:

- Percentage of patients receiving diabetic care (foot exam, A1C) in 2017 = 2,383

The change in the Leading Indicator anticipates appropriate change in the following Lagging Indicator:

- Diabetes death rate = 57.0 per 100,000[22]

GRMC anticipates collaborating with the following other facilities and organizations to address this Significant Need:

Organization	Contact Name	Contact Information
Great River Charitable Clinic		www.greatriverclinic.org 33 Arkansas St, Blytheville, AR 72315 (870) 762-5459
Local Weight Watchers group		https://www.mystore411.com/store/view/24540217/Weight-Watchers-Blytheville

[22] www.worldlifeexpectancy.com/usa-health-rankings

Organization	Contact Name	Contact Information
Healogics	Joanne Sullivan, RN – Campus Manager	http://www.healogics.com/ 5220 Belfort Rd, Jacksonville, FL 32256 (904) 446-3400

Other local resources identified during the CHNA process that are believed available to respond to this need:

Organization	Contact Name	Contact Information
Mississippi County Health Department		1299 N 10th St, Blytheville, AR 72315 (870) 763-7064

4. **ACCESSIBILITY/AFFORDABILITY – 2013 SIGNIFICANT NEED; Preventable Hospital Stays above AR avg and US best; Population to Primary Care Physician ratio worse than AR avg and US best; Unemployment above AR avg and US best; Emergency Room Use 10.4% above avg**

Public comments received on previously adopted implementation strategy:

- *Very poor socio-economic community. Limited practitioners that will provide care to patients that have no insurance. Emergency Department has become the walk-in clinic for the indigent*
- *unknown*
- *The Private Option and The Health Insurance Market Place are having a positive effect on people's use of available services. More needs to be done to health people make the most of the opportunity they now have.*
- *Need more work for emergency preparedness*

GRMC services, programs, and resources available to respond to this need include:

- Specialties available on site include GI, cardiology, ENT, medical oncology (part time), and orthopedics and surgery (full time)
- Extended mammography hours until 9:00pm on first and third Thursdays to increase access after working hours
- Mental health screenings available through telehealth in partnership with Mid-South Health Systems
- Telemedicine for neonatology and stroke in partnership with UAMS
- Telemedicine for burn in partnership with Arkansas Children's; consults for emergency pediatric patients
- Tele-trauma available through Arkansas Health Network
- Perform PSA (prostate-specific antigen) tests for local cancer group to screen for prostate cancer
- IV and infusion therapy services available
- Participate in annual health fairs and provide screenings including PSAs, colorectal screenings, education on self-breast exams, cholesterol, lipids, BMI, glucose, etc.
- Provide education of the month in hallways, on website, in newspaper on various health topics including cancer, diabetes, wellness, etc.
- Participating in state program to promote and encourage smoking cessation through screenings and smoking cessation training
- Registered dietician on staff to counsel inpatients as well as available to community
- Provide diabetes education information at annual health fairs, on website, and in newspaper
- Hospital operates a fitness center available to the community, that is free to hospital employees and available at a reduced rate for families
- Implementing chronic care management program for diabetes, heart disease, etc., which includes face-to-face

education and counseling

- Contract with air ambulance service (Air Evac) to quickly transport critical patients
- Charity care policy available to help cover costs
- Added financial assistance coordinator to help people sign up for Medicaid and apply for financial assistance
- Pre-authorize patients from Charity Care clinic and the Mission to fall under Charity Care policy at hospital and receive services
- Added primary care clinic on Friday afternoons to increase access
- Provide free sports physicals to all local schools
- Work with local industries for drug screens, workmen's comp services, on-site health fairs, etc.

Additionally, GRMC plans to take the following steps to address this need:

- Looking into extended hours/weekend hours/urgent care options to increase access

GRMC evaluation of impact of actions taken since the immediately preceding CHNA:

- Recruited family practice physician, two APNs, pain management specialist, OB/GYN
- Added Wound Care service line
- Added digital mammography
- Added resources in clinics to better track and schedule preventive screenings, including sending reminders to patients due for a screening

Anticipated results from GRMC Implementation Strategy

Community Benefit Attribute Element	Yes, Implementation Strategy Addresses	Implementation Strategy Does Not Address
1. Available to public and serves low income consumers	X	
2. Reduces barriers to access services (or, if ceased, would result in access problems)	X	
3. Addresses disparities in health status among different populations	X	
4. Enhances public health activities	X	
5. Improves ability to withstand public health emergency	X	

Community Benefit Attribute Element	Yes, Implementation Strategy Addresses	Implementation Strategy Does Not Address
6. Otherwise would become responsibility of government or another tax-exempt organization	X	
7. Increases knowledge; then benefits the public	X	

The strategy to evaluate GRMC intended actions is to monitor change in the following Leading Indicator:

- Amount of financial assistance provided in 2017 = $433,000 – Bad debt $7,917,000
- Number of financial assistance applications processed and enrolled in 2017 = 1,804

The change in the Leading Indicator anticipates appropriate change in the following Lagging Indicator:

- ER Utilization compared to National Average = 54.9 ER visits/100 persons vs. national average 45.1 ER visits per 100 persons[23]

GRMC anticipates collaborating with the following other facilities and organizations to address this Significant Need:

Organization	Contact Name	Contact Information
UAMS Medical Center		https://uamshealth.com/ 4301 W Markham St, Little Rock, AR 72205 (501) 686-7000
Arkansas Children's		http://www.archildrens.org/ 1 Children's Way, Little Rock, AR 72202 (501) 364-1100
Arkansas Health Network		www.arkansashealthnetwork.com 2 St Vincent Cir, Little Rock, AR 72205 (501) 552-3914
Arkansas Department of Health		www.healthy.arkansas.gov 4815 W. Markham, Little Rock, AR 72205 (800) 462-0599
Mid-South Health Systems, Inc.	Vickie Winte	209 S Lockard St, Blytheville, AR 72315 (870) 763-2139

[23] https://www.cdc.gov/nchs/fastats/emergency-department.htm

Organization	Contact Name	Contact Information
Air Evac	Francis Lewis	https://lifeteam.net 1001 Boardwalk Springs Place, Suite 250 O'Fallon, Missouri 63368 (636) 695-5400
Healthy Partners & Affiliate (FQHC)	Valencia Andrews-Pirtle, MD	http://www.eafhc.org/MeetTheProviders/HealthyPartners.aspx 4102 Memorial Dr, Blytheville, AR 72315 (870) 532-6047
Great River Charitable Clinic	Connie Ash, APN	www.greatriverclinic.org 33 Arkansas St, Blytheville, AR 72315 (870) 762-5459
Local school districts		
Mississippi County Union Rescue Mission	Shari King	https://www.facebook.com/theMissCoMission/ 400 East Walnut, Blytheville, AR 72315 (870) 763-8380

5. MENTAL HEALTH – Local expert concern; Population to Mental Health Provider ratio worse than AR and US

Public comments received on previously adopted implementation strategy:

This was not a 2013 Significant Health Need, so no comments were solicited.

GRMC services, programs, and resources available to respond to this need include:

- Telepsychiatry services available through Mid-South Health Systems

GRMC does not intend to develop an implementation strategy for this Significant Need

Due to resource constraints, a relative lack of available practitioners, and the availability of other organizations to address this need, we are choosing not to develop an implementation strategy at this time. We feel we can have a greater impact by putting attention and resources toward other significant needs for which we are better qualified to serve.

Federal classification of reasons why a hospital may cite for not developing an Implementation Strategy for a defined Significant Need	
1. Resource Constraints	**X**
2. Relative lack of expertise or competency to effectively address the need	**X**
3. A relatively low priority assigned to the need	
4. A lack of identified effective interventions to address the need	
5. Need is addressed by other facilities or organizations in the community	**X**

GRMC anticipates collaborating with the following other facilities and organizations to address this Significant Need:

Organization	Contact Name	Contact Information
Mid-South Health Systems, Inc.	Vickie Winte	209 S Lockard St, Blytheville, AR 72315 (870) 763-2139

Other local resources identified during the CHNA process that are believed available to respond to this need:

Organization	Contact Name	Contact Information
Twin Rivers Regional Medical Center Behavioral Health (First Step Inpatient Unit)		www.twinriversregional.com 1301 1st St, Kennett, MO 63857 (573) 888-8454
Pemiscot Memorial Health Systems (Resolutions Behavioral Health)		www.pemiscot.org 946 E Reed St, Hayti, MO 63851 (573) 359-1372
St. Bernards Behavioral Health		https://www.stbernards.info/clinics/clinic/st.-bernards-behavioral-health 2712 E Johnson Ave, Jonesboro, AR 72401 (870) 932-2800
Forrest City Medical Center (Geropsychiatric Services)		http://www.forrestcitymedicalcenter.com/forrest-city-medical-center/seniorcarelanding.aspx 1601 Newcastle Road, Forrest City, AR 72335 (870) 261-0319
Family Counseling Center (FCC) Behavioral Health – Stapleton Center		http://www.fccinc.org/ 500 Highway 61 J N, Hayti, MO 63851 (573) 359-2600
Families, Inc. – Outpatient Mental Health Counseling Services		www.familiesinc.net 3201 W. Keiser St., Osceola, AR 72370 (870) 622-0592
StoneBridge of Blytheville (Alzheimer's care)		https://stonebridgeseniorliving.com/blytheville/ 1401 E Moultrie Dr., Blytheville, AR 72315 (870)838-0033
Heritage Square Nursing & Rehabilitation Center (Alzheimer's care)		710 N Ruddle Rd, Blytheville, AR 72315 (870) 763-3654

Other Needs Identified During CHNA Process

6. **COMPLIANCE BEHAVIOR/PREDISPOSING CONDITIONS - 2013 SIGNIFICANT NEED**
7. **HEART DISEASE**
8. **OBESITY**
9. **MATERNAL/INFANT MEASURES**
10. **STROKE - 2013 SIGNIFICANT NEED**
11. **DENTAL - 2013 SIGNIFICANT NEED**
12. **HOMICIDE - 2013 SIGNIFICANT NEED**
13. **ALZHEIMER'S**
14. **ALCOHOL**
15. **ACCIDENTS**
16. **LUNG DISEASE - 2013 SIGNIFICANT NEED**
17. **SMOKING/TOBACCO USE**
18. **KIDNEY DISEASE**
19. **BLOOD POISONING**
20. **ORTHOPEDICS**
21. **COMMUNITY COLLABORATION**
22. **HEALTH LITERACY**

Overall Community Need Statement and Priority Ranking Score

Significant needs where hospital has implementation responsibility

1. Physicians
2. Cancer
3. Diabetes
4. Accessibility/Affordability

Significant needs where hospital did not develop implementation strategy

5. Mental Health

Other needs where hospital developed implementation strategy

None

Other needs where hospital did not develop implementation strategy

None

APPENDIX

Appendix A – Written Commentary on Prior CHNA (Round 1)

Hospital solicited written comments about its 2013 CHNA. 16 individuals responded to the request for comments. The following presents the information received in response to the solicitation efforts by the hospital. No unsolicited comments have been received.

1. **Please indicate which (if any) of the following characteristics apply to you. If none of the following choices apply to you, please give a description of your role in the community.**

	Yes (Applies to Me)	No (Does Not Apply to Me)	Response Count
1) **Public Health Expertise**	4	8	12
2) **Departments and Agencies** with relevant data/information regarding health needs of the community served by the hospital	4	9	13
3) **Priority Populations**	7	4	11
4) Representative/Member of **Chronic Disease Group** or Organization	1	9	10
5) Represents the **Broad Interest of the Community**	15	0	15
Other			1
Answered Question			16
Skipped Question			0

Congress defines "Priority Populations" to include:

- **Racial and ethnic minority groups**
- **Low-income groups**
- **Women**
- **Children**
- **Older Adults**
- **Residents of rural areas**
- **Individuals with special needs including those with disabilities, in need of chronic care, or in need of end-of-life care**
- **Lesbian Gay Bisexual Transsexual (LGBT)**
- **People with major comorbidity and complications**

2. **Do any of these populations exist in your community, and if so, do they have any unique needs that should be addressed?**

- *Low-Income-Hard to get healthcare services*
  Older Adults-Do not have funds to obtain most of their healthcare needs
- *Yes and yes*
- *All of the above priority populations are applicable to the student population of Blytheville Schools.*
- *They all exist and I am sure they have many needs.*
- *Yes; need more preventive care for these types of groups.*
- *yes they exist*

- *All of these populations are present in Mississippi county. Transportation is a potential need, there are less than 2 cars per family in the count. Delta Bridge is investigating how to provide transportation. Co-morbidities is a concern, We Care We Deliver has formed to address these concerns; helping them reach the 11,000 people will be a challenge. There is no after hours care except the emergency room, which is typically more expensive than other options. The recognition of social drivers of health,understanding the role and importance of community healthy, and the coordination of services that impact social drivers of health are needs.*
- *Yes-Probably all of them. Need more assistance in prep for long-term care.*
- *Yes they are exist and unique needs would probably be parenting safe sex practices, management of chronic illnesses with limited financial abilities.*
- *Yes*
- *Transportation to specialist for Medicare patients, translation phone or equivalent.*

3. **In the 2013 CHNA, there were 9 health needs identified as "significant" or most important:**
    1. **Physicians**
    2. **Cancer**
    3. **Diabetes**
    4. **Dental**
    5. **Accessibility/Affordability**
    6. **Compliance Behavior/Predisposing Conditions**
    7. **Homicide**
    8. **Lung Disease**
    9. **Stroke**

Should the hospital continue to consider the needs identified as most important in the 2013 CHNA as the most important set of health needs currently confronting residents in the county?

	Yes	No	No Opinion
Physicians	9	0	0
Cancer	9	0	0
Diabetes	9	0	0
Dental	8	1	0
Accessibility/Affordability	8	1	0
Compliance Behavior/Predisposing Conditions	7	2	0
Homicide	5	3	1
Lung Disease	8	0	1
Stroke	8	0	1

Comments:

- *Collaboration with all agencies and volunteer effort to improve access to and use of health supporting efforts.*

- *Do not think it should be their priority as there are other programs resources available but they should continue to monitor to see how they might be able to help.*

4. Should the Hospital continue to allocate resources to help improve the needs identified in the 2013 CHNA?

	Yes	No	No Opinion
Physicians	9	0	0
Cancer	9	0	0
Diabetes	8	0	1
Accessibility/Affordability	8	1	0
Compliance Behavior/Predisposing Conditions	6	2	1
Lung Disease	7	1	1
Stroke	8	0	1

Comments:

- *Invest in building collaborative efforts with all agencies and volunteer effort to improve access to and use of health supporting efforts.*

5. Are there any new or additional health needs the Hospital should address? Are there any new or additional implementation efforts the Hospital should take? Please describe.

- *air quality ozone, substandard housing, recreational facilities, generally access to providers medical, dental and mental health, generally health behaviors continue to be a concern to address, asthma, colon and rectum cancer, depression, diabetes, high blood pressure, high cholesterol (medicare population) infant mortality, low birth rate, cancer mortality, heart disease mortality, homicide, lung disease mortality, stroke mortality, obesity, overall health, STDs are all health concerns (data Community Commons CHNA) The County Health Rankings health outcomes Mississippi County ranks 71 of 75. A sign of hope is the rate of uninsured is less than the AR rate.*
- *None that I can currently think of*
- *Free screenings for cancer, high blood pressure, diabetes*

6. Please share comments or observations about keeping <u>PHYSICIANS</u> among the most significant needs for the Hospital to address.

- *Very few local physicians in the community. Many of the physicians are getting older and are ready for retirement. Few physicians that are willing to admit to nursing homes*
- *Without physicians, our students do not have access to appropriate healthcare. The local hospital should have active recruitment procedures for bringing in physicians and increasing retention rates of physicians.*
- *A lack of primary care physicians remains important, but it is also important to have quality physicians and nurse practitioners. Many primary care MDs are shuffling patients through without attending to actual quality care.*
- *Quality care physicians that patients can rely on and believe in!!*

- *Primary care and pediatric providers continue to be needed. The perception of the quality of doctors needs to be improved.*
- *Need to attempt to recruit physicians. Needs of Nursing Homes need to be considered.*
- *As I have only been with hospital for 1 1/2 years and am primarily at the local college working I am not aware of their specific actions regarding any of these issues.*
- *We need more physicians, especially OBGYN. Currently, there is one option and not a decent option at that. Most complaints I hear are doctors not wanting to work with the local hospital.*
- *Need more physicians of different specialties do the ones here are not over worked and needs of patients*

7. **Please share comments or observations about the implementation actions the Hospital has taken to address PHYSICIANS.**
   - *Believe the hospital attempts to recruit physicians and/or specialists-however, due to low economic status of the community, high crime rate, and bad name for schools, it is very difficult to recruit physicians.*
   - *Unkown*
   - *I am aware GRMS has an active recruitment program.*
   - *Recruit ones that are from area and will stay here*

8. **Please share comments or observations about keeping CANCER among the most significant needs for the Hospital to address.**
   - *Due to high exposure to farm chemicals, cancer is rising. Need improved cancer coverage for Mississippi County*
   - *We have a high cancer rate in our community and access to local treatment is beneficial to the families of our students who are affected by cancer.*
   - *Cancer treatments accessible.*
   - *should be a major focus, increased emphasis on early detection encouraging use of newly available insurance.*
   - *Cancer is huge all over right now. Blytheville needs to keep it's cancer center so patients don't have to drive to other towns.*

9. **Please share comments or observations about the implementation actions the Hospital has taken to address CANCER.**
   - *Closed the Radiology Oncology section of cancer care-Not sure why this was not successful*
   - *Unknown*
   - *I am not aware of any GRMC programs.*

10. **Please share comments or observations about keeping <u>DIABETES</u> among the most significant needs for the Hospital to address.**

- *Access to pediatric diabetes management at LeBonheur in Memphis, TN or AR Children's Hospital in Little Rock, AR is difficult for our students to attain and often have difficulty maintaining appointments due to difficulities associated with travel. The hospital should address the community need for this access locally and consider physician recruitment in this speciality area.*
- *Diabetes continues to be a major health problem.*
- *More education programs locally on weight control*
- *Diabetes is a silent killer. A specialist in that area would be a good idea to have here in town.*

11. **Please share comments or observations about the implementation actions the Hospital has taken to address <u>DIABETES</u>.**

- *Need more cross-functional projects in which Nursing Homes, Home Health, etc are involved*
- *Unknown*
- *GRMC support of We Care We Deliver is the program I am aware GRMC offers.*
- *No interdisciplinary team approach with other entities outside the hospitals.*

12. **Please share comments or observations about keeping <u>DENTAL</u> among the most significant needs for the Hospital to address.**

- *No dental care for the poor and needy.*
- *I am unaware of any dental services provided by the local facility.*
- *Dental clinic days as seen in some of the bigger areas.*
- *Access to dentist continues to be very low, perhaps the lowest. I am unaware of any GRMC program to address shortage of dentist.*
- *Need more access for low-income and/or for people having Medicaid*

13. **Please share comments or observations about keeping <u>AFFORDABILITY/ACCESSIBILITY</u> among the most significant needs for the Hospital to address.**

- *Very poor socio-economic community. Limited practitioners that will provide care to patients that have no insurance. Emergency Department has become the walk-in clinic for the indigent*
- *unknown*
- *The Private Option and The Health Insurance Market Place are having a positive effect on people's use of available services. More needs to be done to health people make the most of the opportunity they now have.*

- *Need more work for emergency preparedness*

14. **Please share comments or observations about the implementation actions the Hospital has taken to address <u>AFFORDABILITY/ACCESSIBILITY</u>.**
    - *unknown*
    - *Aa far as I know, the hospital continues to provide services to those without insurance. The write off / down amount has decreased significantly.*
    - *Emergency Prepardness*

15. **Please share comments or observations about keeping <u>COMPLIANCE BEHAVIOR/PREDISPOSING CONDITIONS</u> among the most significant needs for the Hospital to address.**
    - *unknown*
    - *Continued high rates of health issues related to behavior decision indicates that more needs to be done to help people make healthier choices and follow medical instructions.*

16. **Please share comments or observations about the implementation actions the Hospital has taken to address <u>COMPLIANCE BEHAVIOR/PREDISPOSING CONDITIONS</u>.**
    - *unknown*
    - *I am unaware of any GRMC program regarding Compliance Behavior/Predisposing Conditions*

17. **Please share comments or observations about keeping <u>HOMICIDE</u> among the most significant needs for the Hospital to address.**
    - *The local community has a high violence and homicide rate in comparison to other cities with similar demographics in the state.*
    - *Hospital get involved with the community supporting law enforcement and local charities while educating the under served, bringing them forward by encouraging better health through better living programs.*
    - *The need is high. The hospital could consider the police and sheriff's departments implement epidemiological tools to lower homicide rate.*

18. **Please share comments or observations about keeping <u>LUNG DISEASE</u> among the most significant needs for the Hospital to address.**
    - *High rates of asthma/allergies, COPD and the impact of local agriculture makes lung disease an issue within our local area. Services in these specific area are needed.*

- *Mississippi county has a high rate of poor air quality / high ozone days.*

19. Please share comments or observations about the implementation actions the Hospital has taken to address <u>LUNG DISEASE</u>.

- *unknown*
- *I am unaware of any GRMC programs related to lung disease. Education and alerts for high ozone days may be helpful.*

20. Please share comments or observations about keeping <u>STROKE</u> among the most significant needs for the Hospital to address.

- *unknown*
- *Stroke mortality continues to be high.*

21. Please share comments or observations about the implementation actions the Hospital has taken to address <u>STROKE</u>.

- *unknown*
- *I am unaware of any GRMC program. Perhaps education and about stroke and encouragement to make use of newly acquired health insurance would be beneficial.*

22. Finally, after thinking about our questions and the information we seek, is there anything else you think is important as we review and revise our thinking about significant health needs in the county?

- *Have more cross-functional programs that will involve other healthcare providers.*
- *Meet with local community leaders, their team of health services and discuss actual community needs on a quarterly basis. Implement accountability measures for following through action plans to address the priority needs.*
- *Urgent care facilities*
- *The county needs to come together as a whole. Pulling the resources together would provide a higher level of service. The hospital could step forward and be the bridge of common ground to exhibit a better future for the health of the community.*
- *I believe in GRMC. The staff I interact with are caring and competent. I have had patients tell me how pleased they have been with the care they received. I anticipate the funding stream from the county sales tax will be put to excellent use using information from CHNA, and other data sources to address identified. I hope GRMC will encourage a vision of community health and build collaborative relationships with the many resources in Mississippi County.*

- *I think the hospital does a great job trying to meet the needs of those who seek healthcare at their facilities and I do know that they are starting an effort to reach areas of need in the community with my role in that I will be gradually providing increased education to the community.*

Appendix B – Identification & Prioritization of Community Needs (Round 2)

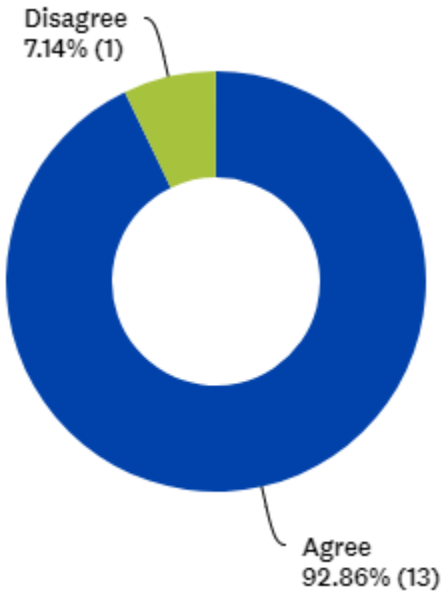
Need Topic	Total Votes	Number of Local Experts Voting for Needs	Percent of Votes	Cumulative Votes	Need Determination
Physicians - 2013 Significant Need	296	13	24.56%	24.56%	Significant Needs
Cancer - 2013 Significant Need	137	10	11.37%	35.93%	
Diabetes - 2013 Significant Need	128	10	10.62%	46.56%	
Accessibility/Affordability - 2013 Significant Need	73	8	6.06%	52.61%	
Mental Health	67	9	5.56%	58.17%	
Compliance Behavior/Predisposing Conditions - 2013 Significant Need	67	6	5.56%	63.73%	Other Identified Needs
Heart Disease	65	7	5.39%	69.13%	
Obesity	53	8	4.40%	73.53%	
Maternal/Infant Measures	45	6	3.73%	77.26%	
Stroke - 2013 Significant Need	39	6	3.24%	80.50%	
Dental - 2013 Significant Need	35	6	2.90%	83.40%	
Homicide - 2013 Significant Need	32	5	2.66%	86.06%	
Alzheimer's	28	7	2.32%	88.38%	
Alcohol	26	5	2.16%	90.54%	
Accidents	23	5	1.91%	92.45%	
Lung Disease - 2013 Significant Need	21	5	1.74%	94.19%	
Smoking/Tobacco Use	19	5	1.58%	95.77%	
Kidney Disease	15	4	1.24%	97.01%	
Blood Poisoning	11	4	0.91%	97.93%	
Orthopedics	10	4	0.83%	98.76%	
Community Collaboration	9	2	0.75%	99.50%	
Health Literacy	6	1	0.50%	100.00%	
Total	1,205		100.00%		

Individuals Participating as Local Expert Advisors

	Yes (Applies to Me)	No (Does Not Apply to Me)	Response Count
1) **Public Health Expertise**	4	10	14
2) **Departments and Agencies** with relevant data/information regarding health needs of the community served by the hospital	2	11	13
3) **Priority Populations**	6	8	14
4) Representative/Member of **Chronic Disease Group** or Organization	3	10	13
5) Represents the **Broad Interest of the Community**	14	0	14
Other			1
Answered Question			14
Skipped Question			0

Advice Received from Local Expert Advisors

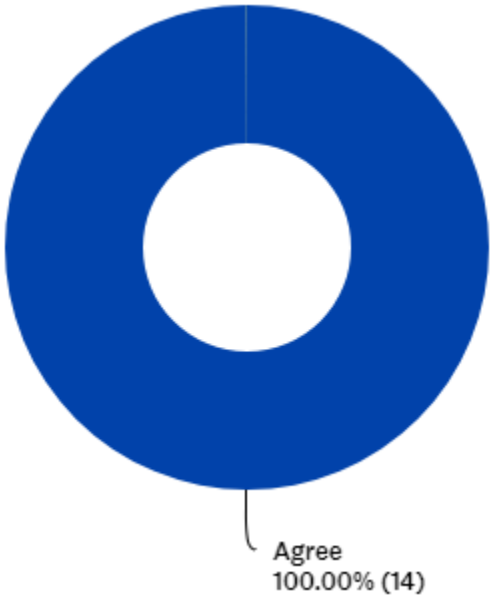
Question: Do you agree with the comparison of Mississippi County to all other Arkansas counties?



Comments:

- *I do not believe that the Air Pollution is above average, but I have no facts to back that up.*
- *I have no way of knowing these specifics; however, most of it sounds reasonable considering my knowledge of the community.*
- *without checking, the data agrees with my learnings from Community Commons and County Rankings data*

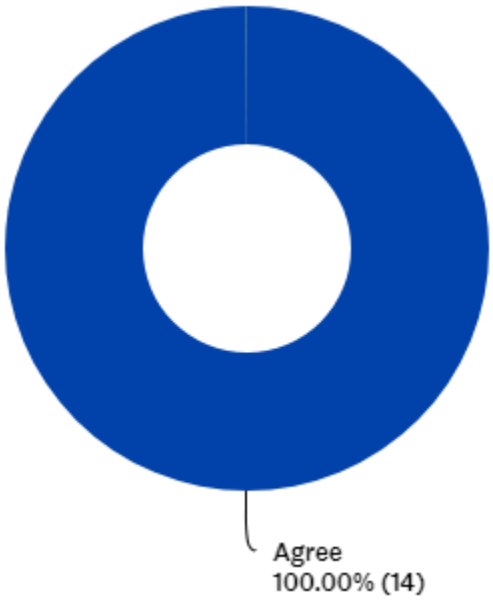
Question: Do you agree with the comparison of Mississippi County to its peer counties?



Comments:

- *It appears that many of these can be addressed from social drivers of health perspective in support of medical driver of health efforts.*

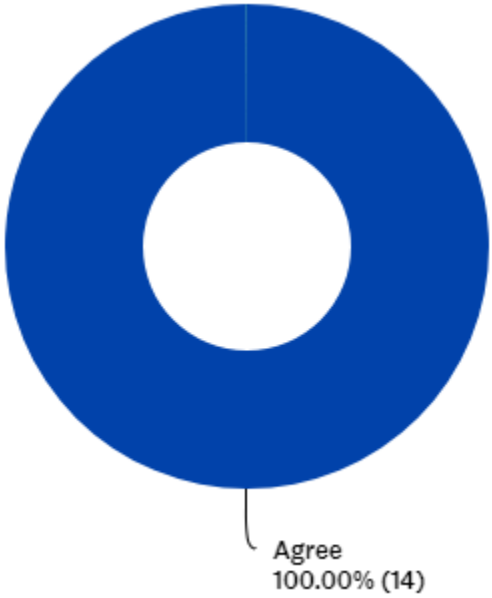
Question: Do you agree with the population characteristics of Mississippi County?



Comments:

- *As with all data so far, I have no means of really measuring its accuracy. It generally does fall within the scope of expectation, given the demographics and socio-economic factors affecting the county.*
- *I am surprised by the racial breakdown, the last data I recall it was closer to (but not) 50% to 50% I wonder if lower back issues are related to the heavy industry? 8 of the 9 variables have an element of choice and are candidates for social drivers of health initiatives*

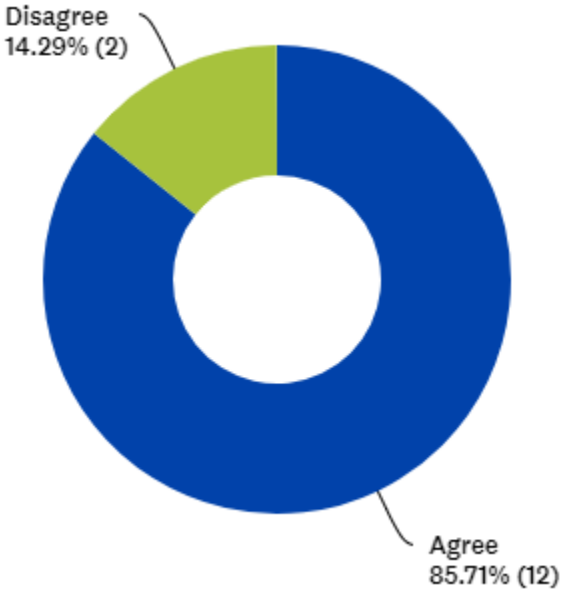
Question: Do you agree with the national rankings and leading causes of death?



Comments:

- *I wonder if lung disease is linked to air pollution ranking? Again many of these are subject initiatives to improve social drivers of health*

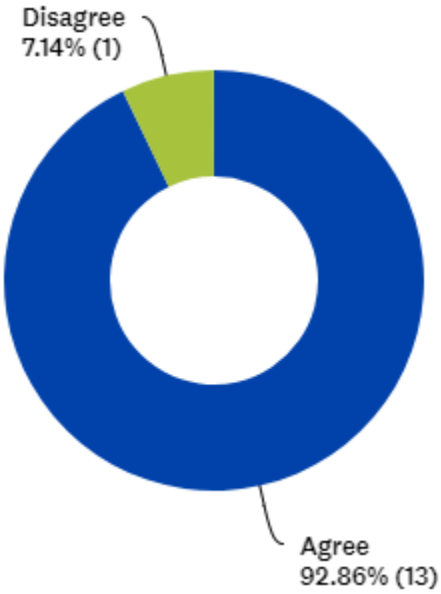
Question: Do you agree with the written comments received on the 2013 CHNA?



Comments:

- *The hospital cannot directly impact some of the items listed, such as substandard housing and homicide. Otherwise, the hospital can engage in the healthcare issues in our community.*
- *I believe many people are either uninformed or do not seek information about such things as health screenings. I also find the first point to be slightly over-reactive.-- substandard housing, for instance, in neither a big issue in the area nor a hospital issue.*
- *I wrote one of them*

Question: Do you agree with the additional written comments received on the 2013 CHNA?



Comments:

- *I believe that as a rural community, while physicians are needed, nurse practitioner practices and urgent care facilities are more sorely needed. Access to immediate primary care for non-life-threatening conditions is important.*

Appendix C – National Healthcare Quality and Disparities Report[24]

The National Healthcare Quality and Disparities Reports (QDR) (annual reports to Congress mandated in the Healthcare Research and Quality Act of 1999 (P.L. 106-129)) are based on more than 250 measures of quality and disparities covering a broad array of healthcare services and settings. Data are generally available through 2012, although rates of un-insurance have been tracked through the first half of 2014. The reports are produced with the help of an Interagency Work Group led by the Agency for Healthcare Research and Quality (AHRQ) and submitted on behalf of the Secretary of Health and Human Services (HHS).

Beginning with this 2014 report, findings on healthcare quality and healthcare disparities are integrated into a single document. This new National Healthcare Quality and Disparities Report (QDR) highlights the importance of examining quality and disparities together to gain a complete picture of healthcare. This document is also shorter and focuses on summarizing information over the many measures that are tracked; information on individual measures will still be available through chartbooks posted on the Web (www.ahrq.gov/research/findings/nhqrdr/2014chartbooks/).

The key findings of the 2014 QDR are organized around three axes: **access to healthcare**, **quality of healthcare**, and **NQS priorities**.

To obtain high-quality care, Americans must first gain entry into the healthcare system. Measures of access to care tracked in the QDR include having health insurance, having a usual source of care, encountering difficulties when seeking care, and receiving care as soon as wanted. Historically, Americans have experienced variable access to care based on race, ethnicity, socioeconomic status, age, sex, disability status, sexual orientation, and residence location.

ACCESS: After years without improvement, the rate of un-insurance among adults ages 18-64 decreased substantially during the first half of 2014.

The Affordable Care Act is the most far-reaching effort to improve access to care since the enactment of Medicare and Medicaid in 1965. Provisions to increase health insurance options for young adults, early retirees, and Americans with pre-existing conditions were implemented in 2010. Open enrollment in health insurance marketplaces began in October 2013 and coverage began in January 2014. Expanded access to Medicaid in many states began in January 2014, although a few had opted to expand Medicaid earlier.

Trends

- From 2000 to 2010, the percentage of adults ages 18-64 who reported they were without health insurance coverage at the time of interview increased from 18.7% to 22.3%.
- From 2010 to 2013, the percentage without health insurance decreased from 22.3% to 20.4%.
- During the first half of 2014, the percentage without health insurance decreased to 15.6%.
- Data from the Gallup-Healthways Well-Being Index indicate that the percentage of adults without health insurance continued to decrease through the end of 2014,[25] consistent with these trends.

[24] http://www.ahrq.gov/research/findings/nhqrdr/nhqdr14/index.html

[25] Levy J. In U.S., Uninsured Rate Sinks to 12.9%. http://www.gallup.com/poll/180425/uninsured-rate-sinks. aspx.

ACCESS: Between 2002 and 2012, access to health care improved for children but was unchanged or significantly worse for adults.

Trends

- From 2002 to 2012, the percentage of people who were able to get care and appointments as soon as wanted improved for children but did not improve for adults ages 18-64.

Disparities

- Children with only Medicaid or CHIP coverage were less likely to get care as soon as wanted compared with children with any private insurance in almost all years.
- Adults ages 18-64 who were uninsured or had only Medicaid coverage were less likely to get care as soon as wanted compared with adults with any private insurance in all years.

Trends

- Through 2012, most access measures improved for children. The median change was 5% per year.
- Few access measures improved substantially among adults. The median change was zero.

ACCESS DISPARITIES: During the first half of 2014, declines in rates of un-insurance were larger among Black and Hispanic adults ages 18-64 than among Whites, but racial differences in rates remained.

Trends

- Historically, Blacks and Hispanics have had higher rates of un-insurance than Whites.[26]

Disparities

- During the first half of 2014, the percentage of adults ages 18-64 without health insurance decreased more quickly among Blacks and Hispanics than Whites, but differences in un-insurance rates between groups remained.
- Data from the Urban Institute's Health Reform Monitoring System indicate that between September 2013 and September 2014, the percentage of Hispanic and non-White non-Hispanic adults ages 18-64 without health insurance decreased to a larger degree in states that expanded Medicaid under the Affordable Care Act than in states that did not expand Medicaid.[27]

ACCESS DISPARITIES: In 2012, disparities were observed across a broad spectrum of access measures. People in poor households experienced the largest number of disparities, followed by Hispanics and Blacks.

Disparities

- In 2012, people in poor households had worse access to care than people in high-income households on all access measures (green).

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[26] In this report, racial groups such as Blacks and Whites are non-Hispanic, and Hispanics include all races.
[27] Long SK, Karpman M, Shartzer A, et al. Taking Stock: Health Insurance Coverage under the ACA as of September 2014. http://hrms.urban.org/briefs/Health-Insurance-Coverage-under-the-ACA-as-of- September-2014.html

- Blacks had worse access to care than Whites for about half of access measures.
- Hispanics had worse access to care than Whites for two-thirds of access measures.
- Asians and American Indians and Alaska Natives had worse access to care than Whites for about one-third of access measures.

ACCESS DISPARITIES: Through 2012, across a broad spectrum of access measures, some disparities were reduced but most did not improve.

Disparity Trends

- Through 2012, most disparities in access to care related to race, ethnicity, or income showed no significant change (blue), neither getting smaller nor larger.
- I n four of the five comparisons shown above, the number of disparities that were improving (black) exceeded the number of disparities that were getting worse (green).

QUALITY: Quality of health care improved generally through 2012, but the pace of improvement varied by measure.

Trends

- Through 2012, across a broad spectrum of measures of health care quality, 60% showed improvement (black).
- Almost all measures of Person-Centered Care improved.
- About half of measures of Effective Treatment, Healthy Living, and Patient Safety improved.
- There are insufficient numbers of reliable measures of Care Coordination and Care Affordability to summarize in this way.

QUALITY: Through 2012, the pace of improvement varied across NQS priorities.

Trends

- Through 2012, quality of health care improved steadily but the median pace of change varied across NQS priorities:
  - Median change in quality was 3.6% per year among measures of Patient Safety.
  - Median improvement in quality was 2.9% per year among measures of Person-Centered Care.
  - Median improvement in quality was 1.7% per year among measures of Effective Treatment.
  - Median improvement in quality was 1.1% per year among measures of Healthy Living.
  - There were insufficient data to assess Care Coordination and Care Affordability.

QUALITY: Publicly reported CMS measures were much more likely than measures reported by other sources to achieve high levels of performance.

Achieved Success

Eleven quality measures achieved an overall performance level of 95% or better this year. At this level, additional improvement is limited, so these measures are no longer reported in the QDR. Of measures that achieved an overall

performance level of 95% or better this year, seven were publicly reported by CMS on the Hospital Compare website (italic).

- *Hospital patients with heart attack given percutaneous coronary intervention within 90 minutes*
- Adults with HIV and CD4 cell count of 350 or less who received highly active antiretroviral therapy during the year
- *Hospital patients with pneumonia who had blood cultures before antibiotics were administered*
- *Hospital patients age 65+ with pneumonia who received pneumococcal screening or vaccination*
- *Hospital patients age 50+ with pneumonia who received influenza screening or vaccination*
- *Hospital patients with heart failure and left ventricular systolic dysfunction who were prescribed angiotensin-converting enzyme or angiotensin receptor blocker at discharge*
- *Hospital patients with pneumonia who received the initial antibiotic dose consistent with current recommendations*
- *Hospital patients with pneumonia who received the initial antibiotic dose within 6 hours of arrival*
- Adults with HIV and CD4 cell counts of 200 or less who received Pneumocystis pneumonia prophylaxis during the year
- People with a usual source of care for whom health care providers explained and provided all treatment options
- Hospice patients who received the right amount of medicine for pain management

Last year, 14 of 16 quality measures that achieved an overall performance level of 95% or better were publicly reported by CMS. Measures that reach 95% and are no longer reported in the QDR continue to be monitored when data are available to ensure that they do not fall below 95%.

Improving Quickly

Through 2012, a number of measures showed rapid improvement, defined as an average annual rate of change greater than 10% per year. Of these measures that improved quickly, four are adolescent vaccination measures (italic).

- *Adolescents ages 16-17 years who received 1 or more doses of tetanus-diphtheria-acellular pertussis vaccine*
- *Adolescents ages 13-15 years who received 1 or more doses of tetanus-diphtheria-acellular pertussis vaccine*
- Hospital patients with heart failure who were given complete written discharge instructions
- *Adolescents ages 16-17 years who received 1 or more doses of meningococcal conjugate vaccine*
- *Adolescents ages 13-15 years who received 1 or more doses of meningococcal conjugate vaccine*
- Patients with colon cancer who received surgical resection that included 12+ lymph nodes pathologically examined
- Central line-associated bloodstream infection per 1,000 medical and surgical discharges, age 18+ or obstetric admissions
- Women with Stage I-IIb breast cancer who received axillary node dissection or sentinel lymph node biopsy at

time of surgery

Worsening

Through 2012, a number of measures showed worsening quality. Of these measures that showed declines in quality, three track chronic diseases (italic). Note that these declines occurred prior to implementation of most of the health insurance expansions included in the Affordable Care Act.

- Maternal deaths per 100,000 live births
- Children ages 19-35 months who received 3 or more doses of Haemophilus influenzae type b vaccine
- People who indicate a financial or insurance reason for not having a usual source of care
- Suicide deaths per 100,000 population
- Women ages 21-65 who received a Pap smear in the last 3 years
- *Admissions with diabetes with short-term complications per 100,000 population, age 18+*
- *Adults age 40+ with diagnosed diabetes who had their feet checked for sores or irritation in the calendar year*
- Women ages 50-74 who received a mammogram in the last 2 years
- Postoperative physiologic and metabolic derangements per 1,000 elective-surgery admissions, age 18+
- *People with current asthma who are now taking preventive medicine daily or almost daily*
- People unable to get or delayed in getting needed medical care, dental care, or prescription medicines due to financial or insurance reasons

QUALITY DISPARITIES: Disparities remained prevalent across a broad spectrum of quality measures. People in poor households experienced the largest number of disparities, followed by Blacks and Hispanics.

Disparities

- People in poor households received worse care than people in high-income households on more than half of quality measures (green).
- Blacks received worse care than Whites for about one-third of quality measures.
- Hispanics, American Indians and Alaska Natives, and Asians received worse care than Whites for some quality measures and better care for some measures.
- For each group, disparities in quality of care are similar to disparities in access to care, although access problems are more common than quality problems.

QUALITY DISPARITIES: Through 2012, some disparities were getting smaller but most were not improving across a broad spectrum of quality measures.

Disparity Trends

- Through 2012, most disparities in quality of care related to race, ethnicity, or income showed no significant change (blue), neither getting smaller nor larger.

- When changes in disparities occurred, measures of disparities were more likely to show improvement (black) than decline (green). However, for people in poor households, more measures showed worsening disparities than improvement.

QUALITY DISPARITIES: Through 2012, few disparities in quality of care were eliminated while a small number became larger.

Disparities Trends

- Through 2012, several disparities were eliminated.
  - One disparity in vaccination rates was eliminated for Blacks (measles-mumps-rubella), Asians (influenza), American Indians and Alaska Natives (hepatitis B), and people in poor households (human papillomavirus).
  - Four disparities related to hospital adverse events were eliminated for Blacks.
  - Three disparities related to chronic diseases and two disparities related to communication with providers were eliminated for Asians.
  - On the other hand, a few disparities grew larger because improvements in quality for Whites did not extend uniformly to other groups.
  - At least one disparity related to hospice care grew larger for Blacks, American Indians and Alaska Natives, and Hispanics.
  - People in poor households experienced worsening disparities related to chronic diseases.

QUALITY DISPARITIES: Overall quality and racial/ethnic disparities varied widely across states and often not in the same direction.

Geographic Disparities

- There was significant variation in quality among states. There was also significant variation in disparities.
- States in the New England, Middle Atlantic, West North Central, and Mountain census divisions tended to have higher overall quality while states in the South census region tended to have lower quality.
- States in the South Atlantic, West South Central, and Mountain census divisions tended to have fewer racial/ethnic disparities while states in the Middle Atlantic, West North Central, and Pacific census divisions tended to have more disparities.
- The variation in state performance on quality and disparities may point to differential strategies for improvement.

National Quality Strategy: Measures of Patient Safety improved, led by a 17% reduction in hospital-acquired conditions.

Hospital-acquired conditions have been targeted for improvement by the CMS Partnership for Patients initiative, a major public-private partnership working to improve the quality, safety, and affordability of health care for all Americans. As a result of this and other federal efforts, such as Medicare's Quality Improvement Organizations and the HHS National Action Plan to Prevent Health Care-Associated Infections, as well as the dedication of practitioners, the general trend in patient safety is one of improvement.

Trends

- From 2010 to 2013, the overall rate of hospital-acquired conditions declined from 145 to 121 per 1,000 hospital discharges.
- This decline is estimated to correspond to 1.3 million fewer hospital-acquired conditions, 50,000 fewer inpatient deaths, and $12 billion savings in health care costs.[28]
- Large declines were observed in rates of adverse drug events, healthcare-associated infections, and pressure ulcers.
- About half of all Patient Safety measures tracked in the QDR improved.
- One measure, admissions with central line-associated bloodstream infections, improved quickly, at an average annual rate of change above 10% per year.
- One measure, postoperative physiologic and metabolic derangements during elective-surgery admissions, got worse over time.

Disparities Trends

- Black-White differences in four Patient Safety measures were eliminated.
- Asian-White differences in admissions with iatrogenic pneumothorax grew larger.

National Quality Strategy: Measures of Person-Centered Care improved steadily, especially for children.

Trends

- From 2002 to 2012, the percentage of children whose parents reported poor communication significantly decreased overall and among all racial/ethnic and income groups.
- Almost all Person-Centered Care measures tracked in the QDR improved; no measure got worse.

Disparities

In almost all years, the percentage of children whose parents reported poor communication with their health providers was:

- Higher for Hispanics and Blacks compared with Whites.
- Higher for poor, low-income, and middle-income families compared with high-income families.

Disparities Trends

- Asian-White differences in two measures related to communication were eliminated.
- Four Person-Centered Care disparities related to hospice care grew larger.

[28] Agency for Healthcare Research and Quality. Interim Update on 2013 Annual Hospital-Acquired Condition Rate and Estimates of Cost Savings and Deaths Averted From 2010 to 2013. http://www.ahrq.gov/professionals/quality-patient-safety/pfp/interimhacrate2013.html

National Quality Strategy: Measures of Care Coordination improved as providers enhanced discharge processes and adopted health information technologies.

Trends

- From 2005 to 2012, the percentage of hospital patients with heart failure who were given complete written discharge instructions increased overall, for both sexes, and for all racial/ethnic groups.
- There are few measures to assess trends in Care Coordination.

Disparities

- In all years, the percentage of hospital patients with heart failure who were given complete written discharge instructions was lower among American Indians and Alaska Natives compared with Whites.

National Quality Strategy: Many measures of Effective Treatment achieved high levels of performance, led by measures publicly reported by CMS on Hospital Compare.

Trends

- From 2005 to 2012, the percentage of hospital patients with heart attack given percutaneous coronary intervention within 90 minutes of arrival increased overall, for both sexes, and for all racial/ethnic groups.
- In 2012, the overall rate exceeded 95%; the measure will no longer be reported in the QDR.
- Eight other Effective Treatment measures achieved overall performance levels of 95% or better this year, including five measures of pneumonia care and two measures of HIV care.
- About half of all Effective Treatment measures tracked in the QDR improved.
- Two measures, both related to cancer treatment, improved quickly, at an average annual rate of change above 10% per year.
- Three measures related to management of chronic diseases got worse over time.

Disparities

- As rates topped out, absolute differences between groups became smaller. Hence, disparities often disappeared as measures achieved high levels of performance.

Disparities Trends

- Asian-White differences in three chronic disease management measures were eliminated but income-related disparities in two measures related to diabetes and joint symptoms grew larger.

National Quality Strategy: Healthy Living improved in about half of the measures followed, led by selected adolescent vaccines from 2008 to 2012.

Trends

- From 2008 to 2012, the percentage of adolescents ages 16-17 years who received 1 or more doses of meningococcal conjugate vaccine increased overall, for residents of both metropolitan and nonmetropolitan areas, and for all income groups.

- About half of all Healthy Living measures tracked in the QDR improved.
- Four measures, all related to adolescent immunizations, improved quickly, at an average annual rate of change above 10% per year (meningococcal vaccine ages 13-15 and ages 16-17; tetanusdiphteria-acellular pertussis vaccine ages 13-15 and ages 16-17).
- Two measures related to cancer screening got worse over time.

Disparities

- Adolescents ages 16-17 in nonmetropolitan areas were less likely to receive meningococcal conjugate vaccine than adolescents in metropolitan areas in all years.
- Adolescents in poor, low-income, and middle-income households were less likely to receive meningococcal conjugate vaccine than adolescents in high-income households in almost all years.

Disparities Trends

- Four disparities related to child and adult immunizations were eliminated.
- Black-White differences in two Healthy Living measures grew larger.

National Quality Strategy: Measures of Care Affordability worsened from 2002 to 2010 and then leveled off.

From 2002 to 2010, prior to the Affordable Care Act, care affordability was worsening. Since 2010, the Affordable Care Act has made health insurance accessible to many Americans with limited financial resources.

Trends

- From 2002 to 2010, the overall percentage of people unable to get or delayed in getting needed medical care, dental care, or prescription medicines and who indicated a financial or insurance reason rose from 61.2% to 71.4%.
- From 2002 to 2010, the rate worsened among people with any private insurance and among people from high- and middle-income families; changes were not statistically significant among other groups.
- After 2010, the rate leveled off, overall and for most insurance and income groups.
- Data from the Commonwealth Fund Biennial Health Insurance Survey indicate that cost-related problems getting needed care fell from 2012 to 2014 among adults.[29]
- Another Care Affordability measure, people without a usual source of care who indicate a financial or insurance reason for not having a source of care, also worsened from 2002 to 2010 and then leveled off.
- There are few measures to assess trends in Care Affordability.

Disparities

- In all years, the percentage of people unable to get or delayed in getting needed medical care, dental care, or

[29] Collins SR, Rasmussen PW, Doty MM, et al. The Rise in Health Care Coverage and Affordability Since Health Reform Took Effect: Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2014. http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2015/jan/1800_collins_biennial_survey_brief.pdf?la=en

prescription medicines who indicated a financial or insurance reason for the problem was:

- Higher among uninsured people and people with public insurance compared with people with any private insurance.
- Higher among poor, low-income, and middle-income families compared with high-income families.

CONCLUSION

The 2014 Quality and Disparities Reports demonstrate that access to care improved. After years of stagnation, rates of un-insurance among adults decreased in the first half of 2014 as a result of Affordable Care Act insurance expansion. However, disparities in access to care, while diminishing, remained.

Quality of healthcare continued to improve, although wide variation across populations and parts of the country remained. Among the NQS priorities, measures of Person-Centered Care improved broadly. Most measures of Patient Safety, Effective Treatment, and Healthy Living also improved, but some measures of chronic disease management and cancer screening lagged behind and may benefit from additional attention. Data to assess Care Coordination and Affordable Care were limited and measurement of these priorities should be expanded.