



South Mississippi County Regional Medical Center

Osceola, 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 South Mississippi County Regional Medical Center (SMCRMC), we have spent more than 60 years providing high-quality compassionate healthcare to the greater Osceola community. The “2016 Community Health Needs Assessment” identifies local health and medical needs and provides a plan of how SMCRMC 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

South Mississippi County Regional Medical Center ("SMCRMC" 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 South Mississippi Regional Medical Center area of Mississippi County are:

1. Physicians
2. Cancer
3. Diabetes
4. Accessibility/Affordability
5. Stroke
6. Heart Disease

The Hospital has developed implementation strategies for all six of the needs 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 South Mississippi County Regional 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 South Mississippi County Regional 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

South Mississippi County Regional 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 Advisor⁶ 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.

Data sources include:⁷

Website or Data Source	Data Element	Date Accessed	Data Date
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⁵ Federal Register Op. cit. P 78967

⁶ “Local Expert” is an advisory group of at least 15 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

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



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.CHNA.org	To identify potential needs from a variety of resources and health need metrics	October 25, 2016	2015
www.datawarehouse.hrsa.gov	To identify applicable manpower shortage designations	October 25, 2016	2015
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 27 Local Expert Advisors. Survey responses started October 10, 2016, and ended with the last response on October 25, 2016.
- 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
 - Focus on access to care through transportation for low income residents and those in rural areas, and offer alternative payment options and free screenings and clinics to low income residents and older adults
 - Provide education on diabetes, nutrition, prenatal care, and preventive care

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 15 Local Experts occurred again via an internet-based survey (explained below) beginning December 7, 2016, and ending May 8, 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 SMCRMC 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.

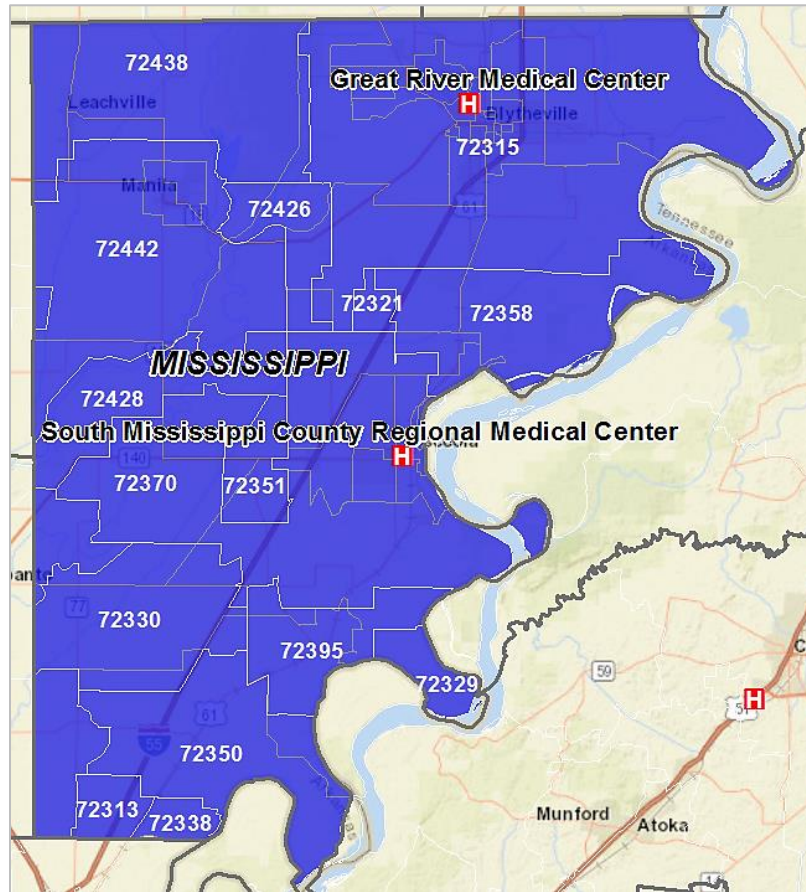
We divided the prioritized needs into two groups: “Significant” and “Other Identified Needs.” Our criteria for identifying and prioritizing Significant Needs was based on a descending frequency rank order of the needs based on total points cast by the Local Experts, further ranked by a descending frequency 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 SMCRMC executive team where a reasonable break point in rank order occurred.



COMMUNITY CHARACTERISTICS



Definition of Area Served by the Hospital



SMCRMC, 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 90% 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 Expert 2.7										
2016 Demographic Snapshot										
Area: Mississippi County										
Level of Geography: ZIP Code										
DEMOGRAPHIC CHARACTERISTICS										
			Selected Area	USA				2016	2021	% Change
2010 Total Population			46,202	308,745,538	Total Male Population			21,026	20,323	-3.3%
2016 Total Population			43,131	322,431,073	Total Female Population			22,105	21,209	-4.1%
2021 Total Population			41,532	334,341,965	Females, Child Bearing Age (15-44)			8,458	8,092	-4.3%
% Change 2016 - 2021			-3.7%	3.7%						
Average Household Income			\$52,158	\$77,135						
POPULATION DISTRIBUTION										
Age Distribution						HOUSEHOLD INCOME DISTRIBUTION				
						Income Distribution				
Age Group	2016	% of Total	2021	% of Total	USA 2016 % of Total	2016 Household Income	HH Count	% of Total	USA % of Total	
0-14	9,460	21.9%	8,770	21.1%	19.0%	<\$15K	3,811	23.0%	12.3%	
15-17	1,969	4.6%	1,893	4.6%	4.0%	\$15-25K	2,003	12.1%	10.4%	
18-24	4,243	9.8%	4,194	10.1%	9.8%	\$25-50K	4,612	27.8%	23.4%	
25-34	5,523	12.8%	5,431	13.1%	13.3%	\$50-75K	2,347	14.1%	17.6%	
35-54	10,513	24.4%	9,499	22.9%	26.0%	\$75-100K	1,768	10.7%	12.0%	
55-64	5,384	12.5%	5,096	12.3%	12.8%	Over \$100K	2,047	12.3%	24.3%	
65+	6,039	14.0%	6,649	16.0%	15.1%					
Total	43,131	100.0%	41,532	100.0%	100.0%	Total	16,588	100.0%	100.0%	
EDUCATION LEVEL										
Education Level Distribution						RACE/ETHNICITY				
						Race/Ethnicity Distribution				
2016 Adult Education Level	Pop Age 25+	% of Total	USA % of Total	Race/Ethnicity			2016 Pop	% of Total	USA % of Total	
Less than High School	2,330	8.5%	5.8%	White Non-Hispanic			25,392	58.9%	61.3%	
Some High School	3,639	13.3%	7.8%	Black Non-Hispanic			14,870	34.5%	12.3%	
High School Degree	9,778	35.6%	27.9%	Hispanic			1,791	4.2%	17.8%	
Some College/Assoc. Degree	8,156	29.7%	29.2%	Asian & Pacific Is. Non-Hispanic			256	0.6%	5.4%	
Bachelor's Degree or Greater	3,556	13.0%	29.4%	All Others			822	1.9%	3.1%	
Total	27,459	100.0%	100.0%	Total			43,131	100.0%	100.0%	
© 2016 The Nielsen Company, © 2016 Truven Health Analytics Inc.										



Customer Segmentation¹²

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 Death¹³

Cause of Death			Rank among all counties in AR (#1 rank = worst in state)	Rate of Death per 100,000 age adjusted		Observation
AR Rank	Mississippi Rank	Condition		AR	Mississippi	
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 Populations¹⁴

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
- Focus on access to care through transportation for low income residents and those in rural areas, and offer alternative payment options and free screenings and clinics to low income residents and older adults
- Provide education on diabetes, nutrition, prenatal care, and preventive care

¹⁴ <http://www.ahrq.gov/research/findings/nhqdr/nhqdr14/index.html>

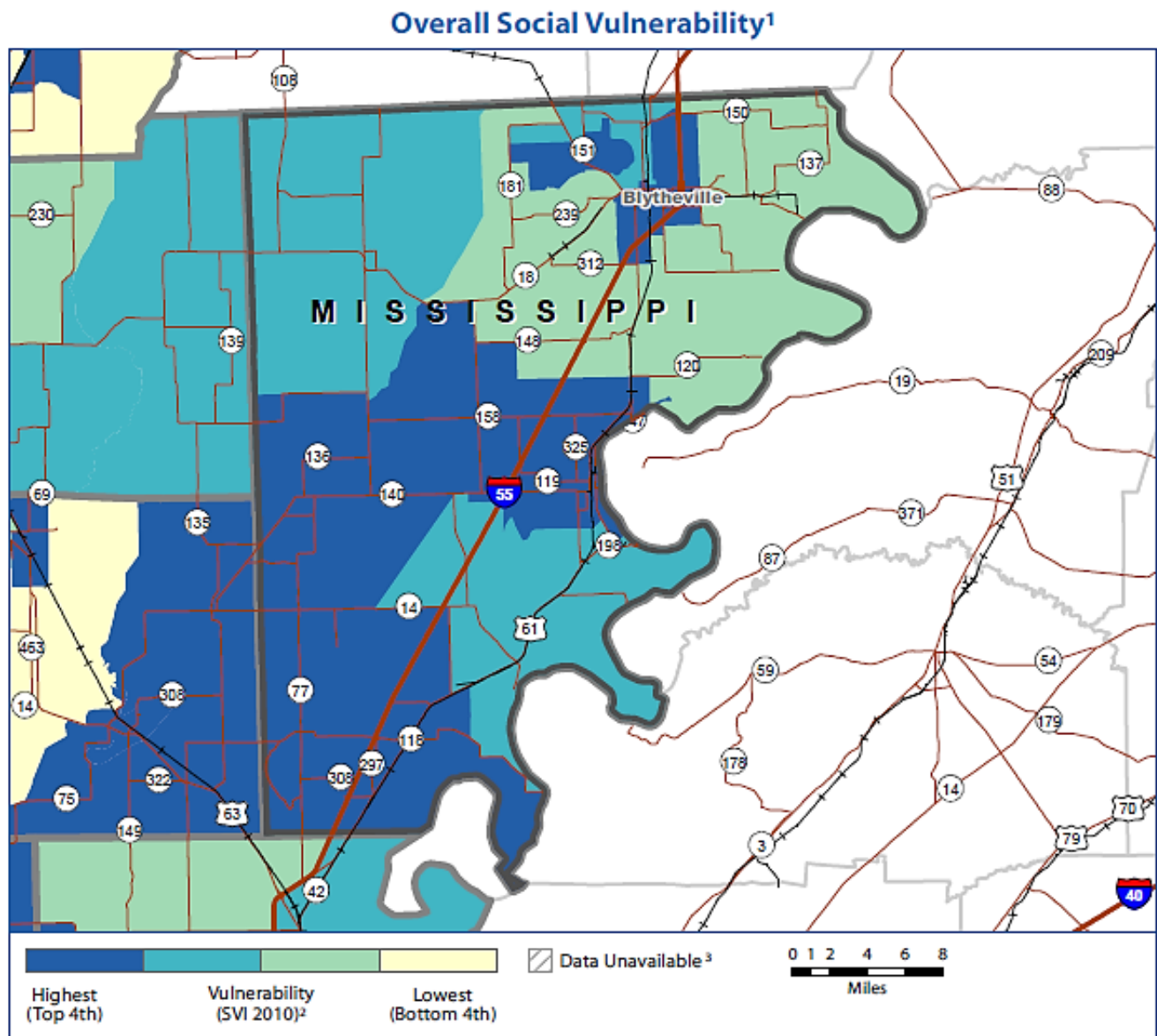
¹⁵ All comments and the analytical framework behind developing this summary appear in Appendix A



Social Vulnerability¹⁶

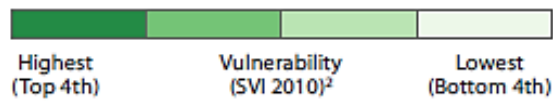
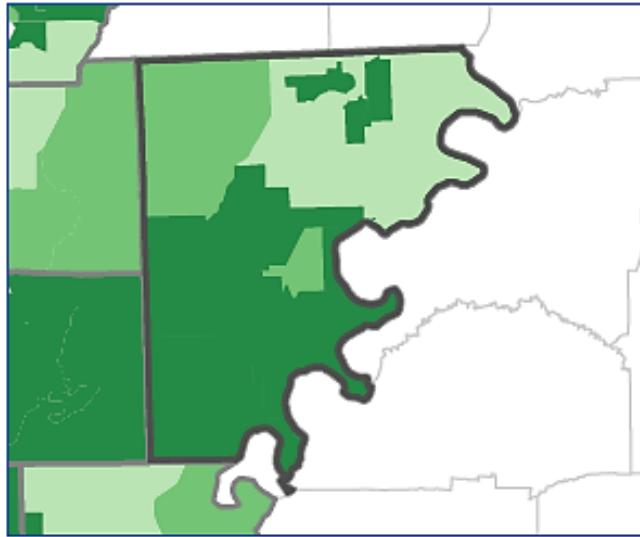
Social vulnerability refers to the resilience of communities when confronted by external stresses on human health, stresses such as natural or human-caused disasters, or disease outbreaks.

Mississippi County falls into the top three quartiles of social vulnerability. The area around SMCRM is in the highest two quartiles.

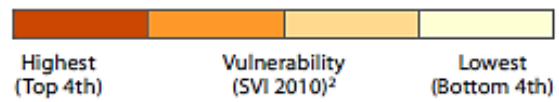
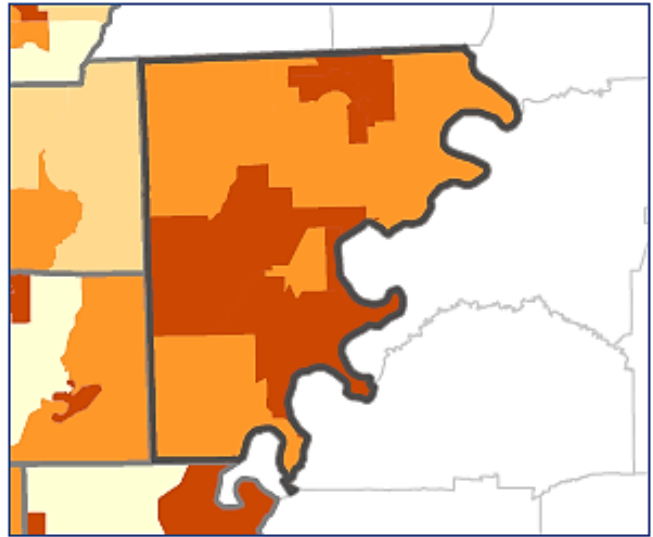


¹⁶ <http://svi.cdc.gov>

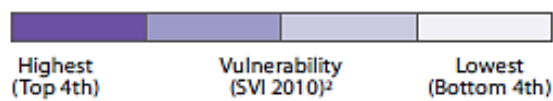
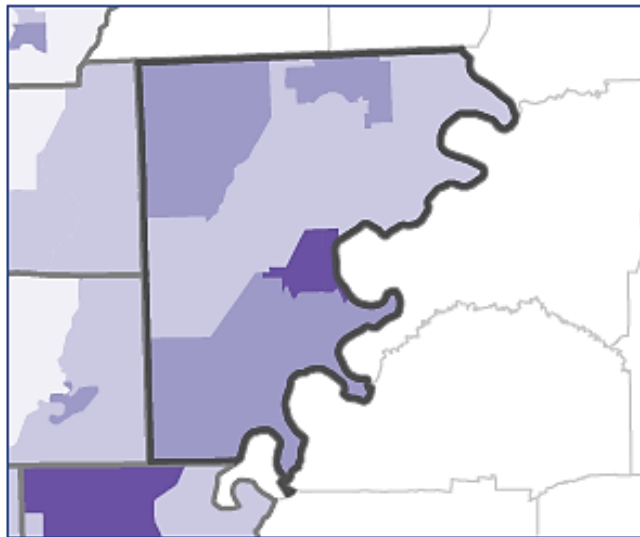
Socioeconomic Status⁵



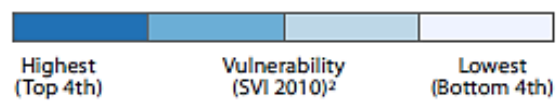
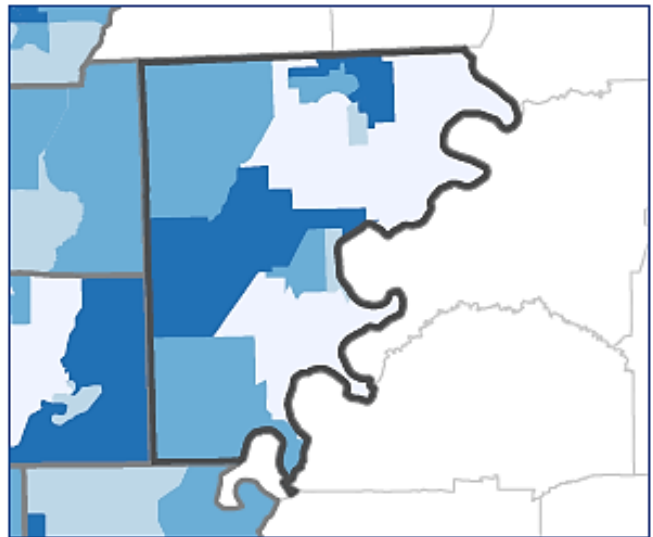
Household Composition⁶



Race/Ethnicity/Language⁷



Housing/Transportation⁸





Summary of Survey Results on Prior CHNA

In the Round 1 survey, a group of 27 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	3	15	18
2) Departments and Agencies with relevant data/information regarding health needs of the community served by the hospital	3	15	18
3) Priority Populations	3	15	18
4) Representative/Member of Chronic Disease Group or Organization	1	17	18
5) Represents the Broad Interest of the Community	19	6	25
Other			6
Answered Question			25
Skipped Question			2

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

SMCRMC 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	20	3	4
Cancer	19	4	4
Diabetes	20	3	4
Dental	17	6	4
Accessibility/Affordability	21	2	4
Compliance Behavior/Predisposing Conditions	17	5	4
Homicide	11	12	4
Lung Disease	19	4	4
Stroke	20	3	4



SMCRMC 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	23	0	4
Diabetes	22	1	4
Accessibility/Affordability	22	1	4
Compliance Behavior/Predisposing Conditions	20	2	5
Lung Disease	21	2	4
Stroke	22	1	4



Comparison to Other State Counties¹⁷

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 (<i>best being #1</i>)	71/75		
Premature Death (deaths prior to age 75)*	12,700	9,100	5,200
Health Behaviors			
Overall Rank (<i>best being #1</i>)	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 (<i>per 1,000 females age 15-19</i>)	77	53	19
Access to Exercise Opportunities	23%	61%	91%
Clinical Care			
Overall Rank (<i>best being #1</i>)	63/75		
Preventable Hospital Stays (<i>per 1,000 Medicare enrollees</i>)	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 (<i>best being #1</i>)	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 (<i>best being #1</i>)	73/75		
Air Pollution	13.2 µg/m ³	11.8 µg/m ³	9.5 µg/m ³

*Per 100,000



Comparison to Peer Counties¹⁸

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 (<i>per 1,000 Medicare enrollees</i>)	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 (<i>per 1,000 females age 15-19 years</i>)	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 Data¹⁹

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 COUNTY measures that are WORSE than the U.S. average and had an UNFAVORABLE change				
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 COUNTY measures that are WORSE than the U.S. average and had an FAVORABLE change				
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 COUNTY measures that are BETTER than the US average and had an UNFAVORABLE change				
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 COUNTY measures that are BETTER than the US average and had an FAVORABLE change				
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 SMCRMC. 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 SMCRMC current efforts responding to the need including any written comments received regarding prior SMCRMC implementation actions
- Establishes the Implementation Strategy programs and resources SMCRMC will devote to attempt to achieve improvements
- Documents the Leading Indicators SMCRMC will use to measure progress
- Presents the Lagging Indicators SMCRMC believes the Leading Indicators will influence in a positive fashion, and
- Presents the locally available resources noted during the development of this report as believed to be currently available to respond to this need.

In general, SMCRMC is the major hospital in the service area. SMCRMC is a 25-bed critical access hospital located in Osceola, Arkansas. The next closest facilities include:

- Great River Medical Center, Blytheville, AR, 18.1 miles (26 minutes)
- Twin Rivers Regional Medical Center, Kennett, MO, 44.6 miles (57 minutes)
- Pemiscot County Memorial Hospital, Hayti, MO, 45 miles (45 minutes)
- Arkansas Methodist Medical Center, Paragould, AR, 52.2 miles (65 minutes)
- NEA Baptist Memorial Hospital, Jonesboro, AR, 53 miles (67 minutes)
- St. Bernards Medical Center, Jonesboro, AR, 54.1 miles (70 minutes)
- Regional One Health Medical Center, Memphis, TN, 55.4 miles (57 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 SMCRMC 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:

- *I am not aware of the actions that the hospital has taken to address Physicians.*
- *They seem to try to keep a good staff...*
- *Don't know any at this time*
- *???*
- *Do not know*
- *I know efforts have been made to attract physicians to the hospitals but they have had limited success.*
- *Don't know any!*
- *Not aware of any actions*

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

- Worked with county to implement sales tax to assist with recruiting new providers
- ENT available one day a month for surgeries
- Many specialty services provided at Great River Medical Center only 17 miles away
- 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, SMCRMC plans to take the following steps to address this need:

- Begin recruitment process for internal medicine to replace physician planning to retire
- Looking at providing residency placement for DO program at Arkansas State in Jonesboro



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

- Recruited an APN
- Added bone density screenings

Anticipated results from SMCRMC 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 SMCRMC 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 = 2,630:1²⁰

²⁰ www.countyhealthrankings.com



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

Organization	Contact Name	Contact Information
St. Bernards Medical Center		www.stbernards.info 225 E Jackson Ave, Jonesboro, AR 72401 (870) 207-4100
NEA Baptist Memorial Hospital		https://www.baptistonline.org/locations/nea 4800 East Johnson Ave, Jonesboro, AR 72401 (870) 936-1000
Arkansas Children's		http://www.archildrens.org/ 1 Children's Way, Little Rock, AR 72202 (501) 364-1100
UAMS Medical Center		https://uamshealth.com/ 4301 W Markham St, Little Rock, AR 72205 (501) 686-7000
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
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:

An implementation plan was not developed for this need in 2013, so no comments were solicited.

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

- 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 at Great River Medical Center, if needed
- 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

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

- Continue above activities

SMCRMC 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 SMCRM 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 SMCRM 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 100,000²¹

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

Organization	Contact Name	Contact Information
West Cancer Clinic		www.westcancercenter.org 271 West Polk Ave, West Memphis, AR 72301 (870) 733-1800

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



Organization	Contact Name	Contact Information
Susan G. Komen		https://komenarkansas.org/ 904 Autumn Road, Suite 500, Little Rock, AR, 72211 (501) 202-4399
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:

- *I am not aware of actions that the Hospital has taken regarding Diabetes*
- *I am not familiar with any education opportunities the hospital provides.*
- *Provide information about nutrition and increased exercise to the community. Provide diabetes management classes if possible.*
- *I am not sure.*
- *They do address diabetes with information and treatment!*
- *Not aware of any*

SMCRMC 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
- Provide reminders and counseling to diabetic patients to receive annual eye exam, foot exams, and A1C at Great River
- GRMC operates a fitness center available to the community, that is free to SMCRMC employees and available at a reduced rate for families
 - Contract with personal trainer to provide additional services and education at fitness center
- 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, SMCRMC plans to take the following steps to address this need:

- Continue above activities

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

- Wound care clinic works with diabetic patients and provides care and education at Great River Medical Center
- Added pain clinic at GRMC that treats diabetic neuropathy



Anticipated results from SMCRMC 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 SMCRMC 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 100,000²²

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

Organization	Contact Name	Contact Information
Great River Charitable Clinic	Connie Ash, APN	www.greatriverclinic.org 33 Arkansas St, Blytheville, AR 72315 (870) 762-5459

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



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:

- *The Hospital system should be more transparent about its funding.*
- *Those that use the ER as a doctor's office, often don't pay and are written off, where the rest of us never get a bill after 30 days and are turned over to collection. Send a bill and file insurance before you turn people over to collection.*
- *Not aware of any*

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

- 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 at GRMC
- 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
- GRMC operates a fitness center available to the community, that is free to SMCRMC 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, SMCRMC plans to take the following steps to address this need:

- Extended weekend hours for urgent care/fast track

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

- Recruited an APN
- 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 SMCRMC 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 SMCRMCM 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 persons²³

SMCRMCM 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
UAMS Medical Center		https://uamshealth.com/ 4301 W Markham St, Little Rock, AR 72205 (501) 686-7000

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		https://www.facebook.com/theMissCoMission/ 400 East Walnut, Blytheville, AR 72315 (870) 763-8380



5. **STROKE – 2013 SIGNIFICANT NEED; #4 Leading Cause of Death; Stroke Deaths 46th worst of 56 peers**

6. **HEART DISEASE – #1 Leading Cause of Death; Coronary Heart Disease Deaths 57th worst of 57 peers; Cholesterol Screening 11.9% below avg**

Due to the similar services, programs, and resources required to respond to Stroke and Heart Disease, the two needs have been combined into one implementation plan.

Public comments received on previously adopted implementation strategy for STROKE:

- *I have heard speakers representing the hospital speak about the actions implemented into the Hospital and coordination done with the regional hospitals in Memphis. I believe that is excellent work by our Hospital*
- *The team continues its training to be fast responders in this area.*
- *Don't know at this time!*
- *do not know - but hopefully educate community on symptoms of possible stroke.*
- *The hospital system participates in providing Stroke education to the public through public service announcements.*
- *Information*
- *Not aware of any*
- *Continued participation in the state wide internet treatment program is needed.*

Public comments received on previously adopted implementation strategy for HEART DISEASE:

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

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

- Received grant to help provide stroke education at civic group meetings, football games, community events, etc.
- STEMI, tele-stroke (telemedicine) programs available to patients
- Participate in programs like Strike Out Stroke and Arkansas SAVES
- Stroke education provided at local businesses/industries and at health fairs
- GRMC operates a fitness center available to the community, that is free to SMCRMC employees and available at a reduced rate for families
- Hospital volunteers read books to elementary school students and educate on signs and symptoms of stroke

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

- Continue above activities



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

- Provided training to local police department for CPR, first aid, and signs/symptoms of stroke

Anticipated results from SMCRMC 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 SMCRMC intended actions is to monitor change in the following Leading Indicator:

- Door to balloon time
- Number of tele-stroke consults provided

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

- Stroke deaths = 66.8 per 100,000 population²⁴
- Coronary Heart Disease Deaths = 287.1 per 100,000 population²⁵

²⁴ <https://wwwn.cdc.gov/communityhealth>

²⁵ <https://wwwn.cdc.gov/communityhealth>



SMCRMC 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
Methodist University Hospital		http://www.methodisthealth.org/locations/methodist-university-hospital 1265 Union Ave, Memphis, TN 38104 (901) 516-7000
St. Bernards Medical Center		www.stbernards.info 225 E Jackson Ave, Jonesboro, AR 72401 (870) 207-4100
NEA Baptist Memorial Hospital		https://www.baptistonline.org/locations/nea 4800 East Johnson Ave, Jonesboro, AR 72401 (870) 936-1000
Dr. S. Karri (cardiologist)		1520 N Division St, Blytheville, AR 72315-1448 (901) 725-2222
Arkansas Stroke Registry		http://www.healthy.arkansas.gov/programs-services/topics/arkansas-stroke-registry
American Heart Association		www.heart.org

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

Organization	Contact Name	Contact Information
Pafford EMS (ambulance service)		www.paffordems.com 105 Plantation Dr., Osceola, AR 72730 (870) 563-0911



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
Hospital Wing		www.hospitalwing.com 1080 Eastmoreland Ave, Memphis, TN 38104 (901) 522-5321
Survival Flight Inc.		survivalflightinc.com 4824 E Baseline Rd #101, Mesa, AZ 85206 (480) 275-4900



Other Needs Identified During CHNA Process

7. MATERNAL/INFANT MEASURES
8. HOMICIDE – 2013 SIGNIFICANT NEED
9. LUNG DISEASE – 2013 SIGNIFICANT NEED
10. OBESITY
11. DENTAL – 2013 SIGNIFICANT NEED
12. ACCIDENTS
13. SMOKING/TOBACCO USE
14. ALZHEIMER'S
15. ALCOHOL
16. MENTAL HEALTH
17. COMPLIANCE BEHAVIOR/PREDISPOSING CONDITIONS – 2013 SIGNIFICANT NEED
18. KIDNEY DISEASE
19. ORTHOPEDICS
20. BLOOD POISONING
21. BUILDING COMMUNITY RELATIONSHIPS
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
5. Stroke
6. Heart Disease

Significant needs where hospital did not develop implementation strategy

None

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. 27 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	3	15	18
2) Departments and Agencies with relevant data/information regarding health needs of the community served by the hospital	3	15	18
3) Priority Populations	3	15	18
4) Representative/Member of Chronic Disease Group or Organization	1	17	18
5) Represents the Broad Interest of the Community	19	6	25
Other			6
Answered Question			25
Skipped Question			2

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?

- *All of these populations exist in our community and all have health needs that need addressing*
- *All of these groups exist and have needs that should be addressed. Also, we need a Specialist in neonatal.*
- *low cost or free transportation to clinics (other than the Medicaid van)
free health clinics (bp, blood sugar, cholesterol) in the Wilson area
clinic in the town of Wilson
diabetic and nutritional education for both diabetics and pregnant women*
- *Yes. Don't know the need other than good health care and good operating facility in this hospital!*



- *Yes....all need education, medical care and substance abuse treatment*
- *Racial and ethnic minority groups: low-income groups; minority groups; women, children, the elderly; individuals with special healthcare needs, including individuals with disabilities.*
- *yes, most do exist in our community and their needs should be addressed*
- *Yes. We must plan and deliver the most effective care to those in greatest need; apply the principles of equity and social justice in practice; ensure that scarce resources are allocated where they can give maximum health benefit.*
- *I think we should take into consideration different ways to pay due to the older population and low income people.*
- *They absolutely exist all throughout Mississippi County. I believe the need of STI prevention and education should be addressed as a matter of public safety.*
- *Handicapped, Federal funding*
- *Yes- most of the significant needs (9) addressed in 2013 CHNA*
- *All of those populations exist in my community. One of the most pressing needs, due to the obesity problem, is education about proper nutrition and programs geared to promote that.*
- *All of them exist.*
- *I do not agree with these priorities. Yes some but not all.*
- *All of these populations exist in our community. Other than the low income population not having a primary care physician and using our local ER as their PCP I can not think of any unique needs.*
- *Yes/*
- *Yes*
- *Yes, we have minority and low-income groups in this area. This is also a rural area and some people have trouble getting to the doctor.*
- *Older Adults, I feel that it is important for them to be adequate care within a timely manner for our elderly.*
- *Yes we have them in our community. Access to competent medical professionals (i.e., primary care doctors and specialists) within the community instead of driving 1+ hours for medical care is a significant need. Also, ability to pay for medical services (including early medical intervention for diseases) prevents many from getting quality and timely medical care.*
- *Yes, low income groups. Needs, basic health care and preventive care.*
- *Yes*



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	20	3	4
Cancer	19	4	4
Diabetes	20	3	4
Dental	17	6	4
Accessibility/Affordability	21	2	4
Compliance Behavior/Predisposing Conditions	17	5	4
Homicide	11	12	4
Lung Disease	19	4	4
Stroke	20	3	4

Comments:

- *I feel that an effort to reduce childhood obesity should be considered in the plan.*
- *Neonatal specialist*
- *Yes*
- *Yes*
- *Access for preventive care, Drug Rehab*
- *As far as the no answers go I believe treatment would be better in Memphis or Jonesboro. Stroke is yes because of the immediate need for treatment.*



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

	Yes	No	No Opinion
Physicians	23	0	4
Diabetes	22	1	4
Accessibility/Affordability	22	1	4
Compliance Behavior/Predisposing Conditions	20	2	5
Lung Disease	21	2	4
Stroke	22	1	4

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.

- *Perhaps consider adding a focus on childhood obesity and prevention.*
- *Provide a bus like the mammography bus for more different types of screenings which could travel to different rural communities two to three times a year. in addition to mammography, you might have bp, cholesterol, blood sugar, prostate and maybe something with peripheral vascular disease.*
- *Mental health, asthma sinus needs!*
- *Children...parents need education on how to care for their children.....to be compliant with check ups, doctor visits, eye exams, dental exams.....we have a huge problem with neglect!!*
- *Yes. Poverty can be absolute (i.e. inadequate to sustain health) or relative (i.e. how poor one person is compared to another). In health terms, it is not only the level of poverty that counts but also the gap between richest and poorest. A large gap results in a big difference in health and life expectancy between rich and poor. It is one of the most significant factors affecting health across the world and therefore action on this issue will be essential.*
- *Drug Rehab*
- *Obesity -Helah conditions linked to obesity include some of the leading causes of preventable death- heart disease, stroke, type 2 diabetes and certain types of cancer. Supoort an employee wellness program featuring health insurance discount for employess who participate- Have an employee wellness committee. Provide information about nutrition and fitness at health fairs.*
- *No*

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

- *I agree that recruiting physicians and retaining physicians this should remain a focus.*
- *You need to maintain a good staff er physicians, otherwise people, if able, are just going to drive on to Jonesboro.*
- *We need to have the best physicians, so the community will not have to travel to receive good care.*
- *a shortage of physicians in this area is a concern...also the OB/GYN visits are a concern....women using drugs and*



alcohol while pregnant is a major problem....children being born to parents who are drug users and women using while pregnant which result in the children having learning disabilities, mental and behavior problems to where it is difficult for them to function in school...more education!

- *Discount on electrical rates and housing*
- *Very important that we find the best physicians to help take care of our patients.*
- *Access to Doctors is essential for our area the industry is getting bigger and we want them to move in this area*
- *Lack of primary physicians may create over use of hospital emergency rooms*
- *There are very few PCP in the city of Osceola, there are even fewer specialist. All patients that need a specialist have to travel at least 50 miles to a city that offers specialist care. The low PCP's available to the population requires the people to continue to use the ER as a PCP.*
- *Keeping good physicians is a must, it makes the hospital better and the citizens don't have to travel far!*
- *I feel the physicians are our key. They should be knowledgable and want to take the time with their patients.*
- *Lack of quality, modern facilities is a detriment to attract and retain physicians. Turnover of physicians/medical professionals diminishes the quality of health care to residents due to constant development of the physician-patient relationship.*
- *Keeping physicians is critical to keeping the hospital.*

7. Please share comments or observations about the implementation actions the Hospital has taken to address PHYSICIANS.

- *I am not aware of the actions that the hospital has taken to address Physicians.*
- *They seem to try to keep a good staff...*
- *Don't know any at this time*
- *???*
- *Do not know*
- *I know efforts have been made to attract physicians to the hospitals but they have had limited success.*
- *Don't know any!*
- *Not aware of any actions*

8. Please share comments or observations about keeping CANCER among the most significant needs for the Hospital to address.

- *Being the #2 leading cause of death, I agree that preventing and/or treating Cancer should remain a focus.*
- *I don't see that the hospital is on the forefront on this subject, but they do provide good radiology dept.*



- *Cancer center is great in Blytheville!*
- *Yes, agree*
- *Would like to see the big part of our resources used for cancer.*
- *Leading killer in our area we need it*
- *Work with the community on addressing warning signs and symptoms of possible cancer- support health fairs and community organizations. Check out Susan B. Komen grant programs that may help with some procedures. Check with health department on some of their programs - Breast Care.*
- *We have a large population that have cancer.*
- *Many people here are suffering with cancer and have to travel a hour for treatment which is very hard and time consuming !!*
- *Cancer is the devil. I feel most of our resources should be in this area to find a cure or something better to fight it.*
- *Need a board certified oncologist available in the hospital system and the ability to provide treatment locally instead of patients driving to Jonesboro, Memphis, etc.*

9. Please share comments or observations about keeping DIABETES among the most significant needs for the Hospital to address.

- *The hospital should continue to address the issue of diabetes and more importantly, its prevention.*
- *Does the hospital provide nutritional or diabetic education?*
- *Many of our community suffer with this. Great information on this at the hospitals!*
- *Yes, agree*
- *I feel there is not enough information given to the public on diabetes. Maybe informational meeting would help.*
- *Leading killer in our area we need it*
- *Areas with aging population will see a greater prevalence of diabetes since the risk increases with age. Persons over the age of 45 have a greater risk to develop diabetes.*
- *We have a large population of people that have diabetes and a large amount of obese people that have or will have diabetes. Diabetes education should be a priority.*
- *It is a most because of the Number of people that suffer with diabetes!*
- *Diabetes have come a long way but feel the need is still there.*
- *Education and assistance for the population on how to create a healthy lifestyle. Includes education on dietary needs, exercise, etc.*



10. Please share comments or observations about the implementation actions the Hospital has taken to address DIABETES.

- *I am not aware of actions that the Hospital has taken regarding Diabetes*
- *I am not familiar with any education opportunities the hospital provides.*
- *Provide information about nutrition and increased exercise to the community. Provide diabetes management classes if possible.*
- *I am not sure.*
- *They do address diabetes with information and treatment!*
- *Not aware of any*

11. Please share comments or observations about keeping DENTAL among the most significant needs for the Hospital to address.

- *I see where the Hospital did not develop an implementation plan to address dental in 2013. I believe that the Hospital should work closely area dentist and add this to future plans.*
- *There is a strong need for dental care in this county, especially due to the wide spread drug use. I don't know that the hospital has any educational opportunities or dental screenings for this topic. The free clinic in Blytheville does this, I think.*
- *Don't know at this time*
- *Yes, agree*
- *I feel it is not as important as the others.*
- *with the meth problem we have dental is very important*
- *Work with area dentist to have a health fair to assist those with no insurance for cleaning and exams. Educate the community and brushing and flossing and the need for fluoride treatments. Starting early in childhood is the optimal promotion. Check to see if the Walmart foundation will implement a mobile dental clinic to provide free dental care services to all ages*
- *Very important to the low income!*
- *I feel we can take dental off of the most significant.*
- *Don't this this should be hospital's priority*

12. Please share comments or observations about keeping AFFORDABILITY/ACCESSIBILITY among the most significant needs for the Hospital to address.

- *Paying for health needs is always an issue, especially in the Delta areas.*
- *Maybe the hospital is too accessible when it comes to not turning people away that are not really emergencies.*



- *Yes, agree*
- *New industry is here. This will draw people to stay*
- *Low income and the working poor need this!*
- *We should always find ways to help those without insurance or less fortunate*
- *Work with local leaders, state legislators, US Congressional representatives/senators to provide an alternative to the ACA that doesn't lead to the massive cost shifting to the patient*

13. Please share comments or observations about the implementation actions the Hospital has taken to address AFFORDABILITY/ACCESSIBILITY.

- *The Hospital system should be more transparent about its funding.*
- *Those that use the ER as a doctor's office, often don't pay and are written off, where the rest of us never get a bill after 30 days and are turned over to collection. Send a bill and file insurance before you turn people over to collection.*
- *Not aware of any*

14. Please share comments or observations about keeping COMPLIANCE BEHAVIOR/PREDISPOSING CONDITIONS among the most significant needs for the Hospital to address.

- *Particularly in the Delta area, with lower education levels, this need should be addressed.*
- *I don't know anything about this.*
- *Yes, agree*
- *Don't think this is a health care issue. It is administrative.*

15. Please share comments or observations about the implementation actions the Hospital has taken to address COMPLIANCE BEHAVIOR/PREDISPOSING CONDITIONS.

- *I am not aware of these actions by the Hospital.*
- *Ditto*
- *Yes, agree*
- *N/A*

16. Please share comments or observations about keeping HOMICIDE among the most significant needs for the Hospital to address.

- *At least in south Mississippi County, homicide is not a problem.*



- *I don't understand this question. Blytheville certainly stays busy with homicide victims and Osceola lately also. There is so much violence in this county, it is good there area hospitals there to patch people up or send them to the crime lab.*
- *Yes, agree*
- *As far as the Osceola Hospital goes, we don't see very many homicides at all so we may need to relook at that one.*
- *Not a big issue in our area*
- *Work work with local police and sheriff dept.*
- *We have a very low rate*
- *Not a priority for the hospital. This is a civic/societal issue best left to the community leadership, police departments and social services*
- *not an issue for the hosipital*

17. Please share comments or observations about keeping LUNG DISEASE among the most significant needs for the Hospital to address.

- *This need should be continued to be addressed.*
- *Lung disease and its education is important. There are still many smokers, those with COPD and emphysema and asthma in this area. I do not know what the hospital does with these conditions.*
- *Yes, agree*
- *Lung disease is another important issue facing us today and feel it should be taken seriously.*
- *Leading killer in the area keep it*
- *tobacco free building*
- *This area has a high lung disease rate from smoking, and air Quality doing the fall time many suffer with this!*
- *Education for smoking cessation, etc., needs to be a constant, active campaign for the county residents*

18. Please share comments or observations about the implementation actions the Hospital has taken to address LUNG DISEASE.

- *I am not aware of Hospital implementation actions.*
- *I do not know what they have done.*
- *work with the community to educate on the danger of tobacco use and help the community quit- refer to SOS help line.*
- *Not aware of any*



19. Please share comments or observations about keeping STROKE among the most significant needs for the Hospital to address.

- *With stroke being the #3 cause of death, this issue should continue to be addressed.*
- *I know that the hospital has a heart team that is well trained.*
- *We need to keep this Avery high project*
- *Yes, agree*
- *Stroke is another important issue and I think that many resources should be spent on it.*
- *Keep it*
- *Patients who arrive to the hospital within three hours of their first symptoms have less disability- new advancements in treatment can save lives while effective rehabilitation can help patients recover function lost from a stroke.*
- *The hospital is very active with Stroke education.*
- *A must because the faster someone can get help the less the damage will be from a stroke!*
- *Need to emphasize healthy lifestyles, reduction in hypertension, etc.*
- *Need to continue and expand. A stroke requires quick action.*

20. Please share comments or observations about the implementation actions the Hospital has taken to address STROKE.

- *I have heard speakers representing the hospital speak about the actions implemented into the Hospital and coordination done with the regional hospitals in Memphis. I believe that is excellent work by our Hospital*
- *The team continues its training to be fast responders in this area.*
- *Don't know at this time!*
- *do not know - but hopefully educate community on symptoms of possible stroke.*
- *The hospital system participates in providing Stroke education to the public through public service announcements.*
- *Information*
- *Not aware of any*
- *Continued participation in the state wide internet treatment program is needed*

21. 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?

- *I believe that the Hospital should be more transparent with how it has spent the revenue from the new 5-year*



Hospital tax that began last year. I believe that the Hospital should follow through with the pledge it made to the voters that they would keep it a five year, 1/2 cent tax and not try to change it into a 30-year tax.

- *The hospital needs to serve the needs of the community, whether it is diabetic education, nutrition, health screenings or access to health care. I am not sure how they need to accomplish these goals. Maybe they need to partner with other agencies.*
- *It would be great to build up a great hospital that people do not have to travel out of town to get good health care*
- *Senior health*
Preventive health and wellness
Preventive screenings in community
Children for sure...not sure where to start
- *a lack of programming on your side. If this is not true, make the community aware.*
- *Just keep our Osceola hospital open, it is very important to Osceola and the south end of Mississippi County!!!!*
- *you are on the right track. keep it up*
- *Transportation can be an issue with many in this area.*
- *The whole health care delivery system needs a facelift or update in our community. It is out of date and needs new community awareness.*
- *No*
- *Provide care that would keep people from traveling to the counties!*
- *I feel our local hospital is very important to our community. I feel that we should find ways to better cost effectively run our hospital to make sure that we don't ever lose it.*
- *no*



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	269	14	19.69%	19.69%	Significant Needs
Cancer - 2013 Significant Need	168	13	12.30%	31.99%	
Diabetes - 2013 Significant Need	149	14	10.91%	42.90%	
Accessibility/Affordability - 2013 Significant Need	96	11	7.03%	49.93%	
Stroke - 2013 Significant Need	83	11	6.08%	56.00%	
Heart Disease	61	9	4.47%	60.47%	Other Identified Needs
Maternal/Infant Measures	60	8	4.39%	64.86%	
Homicide - 2013 Significant Need	58	9	4.25%	69.11%	
Lung Disease - 2013 Significant Need	49	9	3.59%	72.69%	
Obesity	49	7	3.59%	76.28%	
Dental - 2013 Significant Need	45	8	3.29%	79.58%	
Accidents	40	7	2.93%	82.50%	
Smoking/Tobacco Use	38	8	2.78%	85.29%	
Alzheimer's	34	7	2.49%	87.77%	
Alcohol	33	6	2.42%	90.19%	
Mental Health	32	7	2.34%	92.53%	
Compliance Behavior/Predisposing Conditions - 2013 Significant Need	30	6	2.20%	94.73%	
Kidney Disease	25	6	1.83%	96.56%	
Orthopedics	19	5	1.39%	97.95%	
Blood Poisoning	18	5	1.32%	99.27%	
Building community relationships	5	1	0.37%	99.63%	
Health Literacy	5	1	0.37%	100.00%	
Total	1,366		100.00%		

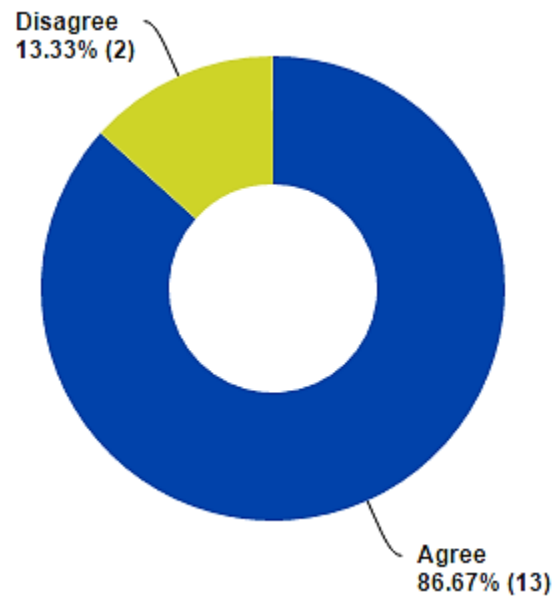
Individuals Participating as Local Expert Advisors

	Yes (Applies to Me)	No (Does Not Apply to Me)	Response Count
1) Public Health Expertise	14	6	10
2) Departments and Agencies with relevant data/information regarding health needs of the community served by the hospital	2	6	8
3) Priority Populations	2	6	8
4) Representative/Member of Chronic Disease Group or Organization	1	7	8
5) Represents the Broad Interest of the Community	13	1	14
Other			2
Answered Question			15
Skipped Question			0



Advice Received from Local Expert Advisors

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

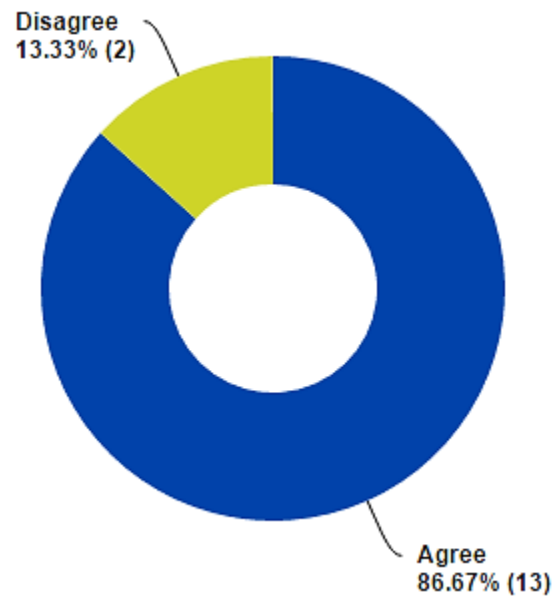


Comments:

- *The community and the people don't communicate this data!*
- *We are subject to farm chemicals. We don't have a lot of job opportunities*



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

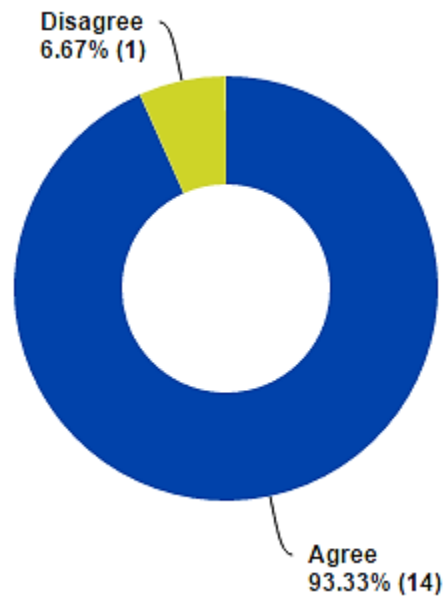


Comments:

- *poverty, lack of jobs*



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

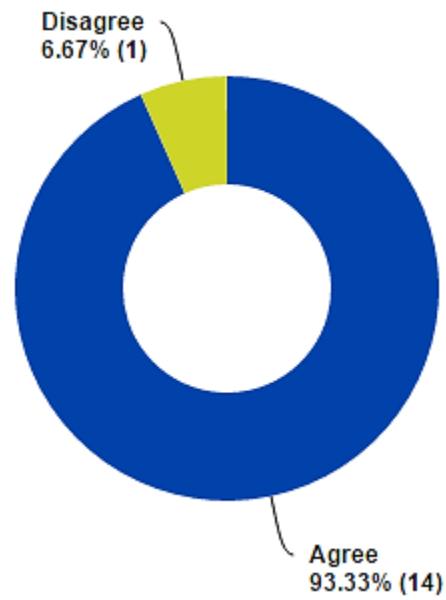


Comments:

- I would think the Emergency Room Use would be significantly higher that 10.4% above average. I would also have thought Ate Breakfast Yesterday would be below average and Consumer Alcohol in the Past 30 Days would be above average.*

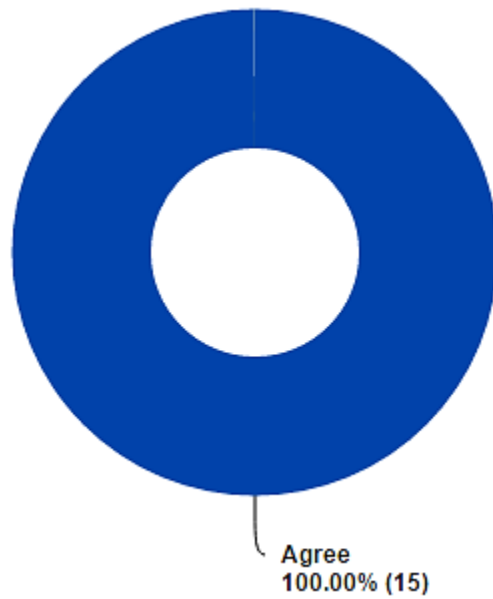


Question: Do you agree with the national rankings and leading causes of death?



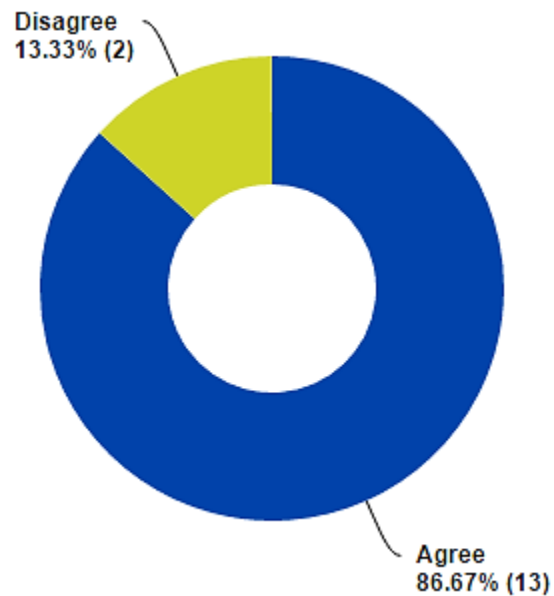


Question: Do you agree with the written comments received on the 2013 CHNA?





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



Comments:

- *Cancer, Diabetes, Lung Disease, and post Stroke care, all should be handled by health centers and specialist in larger cities. Local immediate stroke care is necessary. Homicide is definitely NOT a hospital function, but a law enforcement issue.*
- *I believe Neonatal Specialist would be best utilized in Memphis and Jonesboro due to the fact that we have more diabetes, heart disease, cancer and stroke affect so many more people.*



Appendix C – National Healthcare Quality and Disparities Report²⁶

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/nhqdr/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 2014,²⁷ consistent with these trends.

²⁶ <http://www.ahrq.gov/research/findings/nhqdr/nhqdr14/index.html>

²⁷ 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.²⁸

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.²⁹

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).

²⁸ In this report, racial groups such as Blacks and Whites are non-Hispanic, and Hispanics include all races.

²⁹ Long SK, Karpman M, Shartz 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.
- In 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.³⁰
- 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.

³⁰ 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; tetanusdiphtheria-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.³¹
- 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

³¹ 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.