

Community Health Needs Assessment

December 2013

Baptist Health

all our best

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Baptist Health Mission, Vision, and Values

Mission

Baptist Health exists to provide quality patient-centered services, promote and protect the voluntary not-for-profit health-care system, provide quality health education, and respond to the changing needs of the residents of Arkansas with Christian compassion and personal concern consistent with our charitable purpose.

Vision

Baptist Health will improve the health of Arkansans by changing the way healthcare is delivered.

Values

In fulfilling our mission, we place special emphasis on the values of:

- Service
- Honesty
- Respect
- Stewardship
- Performance



Introduction to Community Health Needs Assessment

As a result of the Patient Protection and Affordable Care Act (PPACA), all tax-exempt hospitals are required to assess the health needs of their community through a Community Health Needs Assessment (CHNA). A CHNA, which is conducted every three years, is a written document developed for a hospital that includes a description of the community served by the hospital; the process used to conduct the assessment including how the hospital took into account input from community members including those with special knowledge of or expertise in public health; identification of any persons with whom the hospital has worked on the assessment; and the health needs identified through the assessment process. The CHNA written report must include descriptions of the following:

- The community served and how the community was determined
- The process and methods used to conduct the assessment including sources and dates of the data and other information as well as the analytical methods applied to identify community health needs
- How the organization took into account input from persons representing the broad interests of the community served by the hospital, including a description of when and how the hospital consulted with these persons or the organizations they represent
- The prioritized community health needs identified through the CHNA as well as a description of the process and criteria used in prioritizing the identified needs
- The existing healthcare facilities and other resources within the community and available to meet community health needs

The CHNA requirement also includes that hospitals must adopt an implementation strategy to meet the community health needs identified through the assessment. An implementation strategy is a written plan that addresses each of the community health needs identified through a CHNA. The plan must include the following:

- List of the prioritized needs the hospital plans to address and the rationale for not addressing the others
- Actions the hospital intends to take to address the chosen health needs
- The anticipated impact of these actions and the plan to evaluate such impact (e.g. identify the data sources you will use to track the plan's impact)
- Identify the programs and resources the hospital plans to commit to address the health need
- Describe any planned collaboration between the hospital and other facilities or organizations in addressing the health need.

A CHNA is considered conducted in the taxable year that the written report of its findings, as described above, is approved by the hospital governing body and made widely available to the public. The implementation plan is considered implemented on the date it is approved by the governing body. Conducting the CHNA and approval of the implementation strategy must occur in the same fiscal year. CHNA compliance is reported on IRS Form 990, Schedule H.

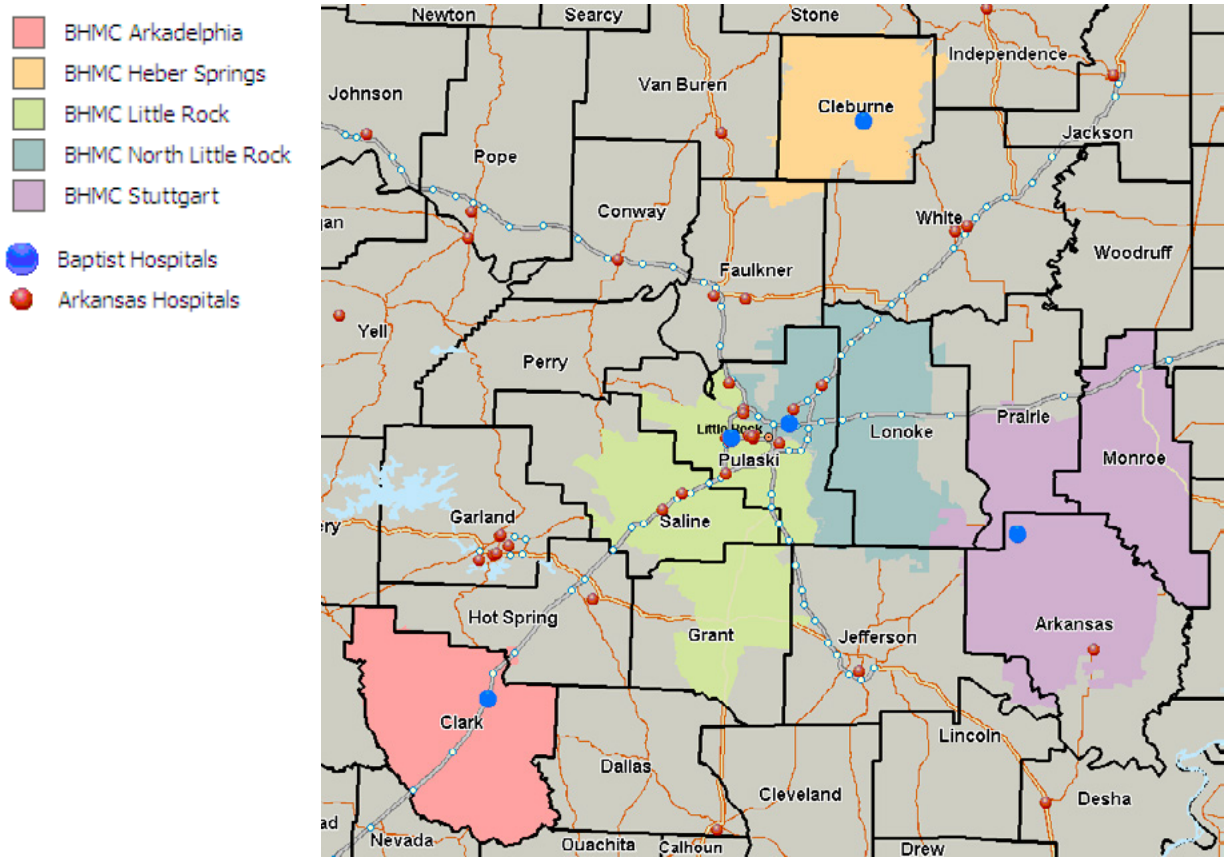
Executive Summary

The Community Health Needs Assessment (CHNA) is a requirement of all tax-exempt (501(c)(3)) hospitals beginning with fiscal year 2013. As part of the IRS Form 990, Schedule H, individually licensed not-for-profit hospitals are required to assess the health needs of their community, prioritize the health needs, and develop implementation plans for the prioritized health needs they've chosen to address.

In April 2012 Baptist Health began the CHNA process for each of their seven hospitals: BHMC–Little Rock, BHMC–North Little Rock, Baptist Health Extended Care Hospital, Baptist Health Rehabilitation Institute, BHMC–Stuttgart, BHMC–Arkadelphia, and BHMC–Heber Springs. Baptist Health engaged Truven Health Analytics (formerly the Healthcare Business of Thomson Reuters) for assistance in completing a CHNA for each of the seven hospitals.

Baptist Health used inpatient and outpatient data as well as market-share data to define the community served for each facility. The community served for the three acute-care, non-critical access hospitals was defined using the ZIP codes that represent greater than or equal to 2 percent of the hospital's combined inpatient discharges/outpatient visits AND in which the hospital's inpatient market share is greater than or equal to 20 percent. ZIP codes that did not meet that criteria but were either contiguous to or surrounded by ZIP codes that were a part of the community served definition were included. The community served for the two critical access hospitals was defined as the county in which the hospital is located.

The communities served for the Extended Care Hospital and Rehabilitation Institute were defined by the disease/injury state of patients in the communities served by the five acute-care Baptist Health hospitals.



To facilitate the qualitative and quantitative data collection, Baptist Health formed a CHNA advisory group consisting of representatives from each facility. Members of the CHNA advisory group were asked to represent their respective hospitals and work in an advisory capacity during the assessment process. Additionally, members of the CHNA advisory group participated in the community health needs prioritization process and will be integral in the implementation planning to address health needs.

In September 2012, interviews (both one-on-one and small groups) and focus groups were conducted to take into account input from persons who represent the broad interests of the community served by the hospital (a CHNA requirement). As a part of this process, 93 interviews and six focus groups (one for each acute-care facility and one wellness center client focus group) were conducted. Individuals interviewed included representatives from public health departments, such as Dr. Joe Thompson, Arkansas surgeon general, and Gary Wheeler of the Arkansas Department of Health; representatives of local organizations; such as Marilyn Clark of the American Heart Association/American Stroke Association; physicians and other health care providers; such as Dr. Meenakshi Budhraja; and employees of Baptist Health familiar with community needs. Focus group participants included representatives of medically underserved, low-income, and minority populations such as Susana O'Daniel of Arkansas Advocates for Children & Families, Hayes Miller of the Family Service Agency, and Cheryl Vines of the Arkansas Spinal Cord Commission. Additional input was gathered from low-income and minority populations via a focus group conducted with Baptist Health wellness center clients.

The interviews revealed that the majority of individuals feel that the health status of the community they represent is good to fair. Much of this is attributed to chronic diseases as well as lifestyle choices and lack of preventive health efforts. The need for more health-care providers and services as well as improved access to health care was identified as the top needs across all those interviewed. Not surprisingly, barriers to good health include socioeconomic factors as well as access issues. The elderly and minority populations were identified as those being most at risk.

In December 2012, the findings of the community health needs assessment were presented and Truven Health assisted in facilitating the prioritization of health needs with representatives from Baptist Health. Baptist Health participants included:

<table>
<tr>
<td>BHMC–Little Rock
• Greg Crain – VP/ Administrator
• Ann McQueen – Director of Patient and Community Services
• Brenda Goodhart – Director of Women's and Children's Program Line</td>
<td>BHMC–North Little Rock
• Harrison Dean – Senior VP/ Administrator
• Steven Webb – Vice President
• Don Garner – Director of Pharmacy
• Jodie Wagner – Director of Clinical Information</td>
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• Keith Moore – Assistant VP of Patient Services
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• Terry Amstutz – VP/ Administrator
• Susan Williams – Chief Nursing Officer
• Whitney Daniel – Director of Pharmacy</td>
<td colspan="2">Baptist Health Corporate
• Doug Weeks – Senior Vice President of Hospital Operations
• Bob Roberts – Senior Vice President of Financial Services
• Brent Beaulieu – Vice President of Financial Services
• Will Rusher – CEO of Arkansas Health Group/ Vice President of Practice Plus
• Mark Lowman – Vice President of Strategic Development
• Robert Buchanan – Manager of Research and Development
• Teresa Conner – Manager of Community Outreach
• Michael Shepherd – Research and Data Analyst</td>
</tr>
</table>

As a part of the health-needs assessment, Truven Health evaluated the demographics of each of the facility service areas. Some key demographic findings include:

- Little Rock and North Little Rock are the fastest growing communities followed by Heber Springs
- Heber Springs has largest proportion of the population ages 65 plus
- Stuttgart has the largest proportion of population on Medicaid or uninsured
- Little Rock has the highest median income as well as the largest non-white proportion of the population

Health needs were defined in seven distinct categories —cause of death, health outcomes, chronic conditions, health behaviors, prevention, access to care, and socioeconomic and environmental factors. For all communities served, Baptist Health had the following shared health needs:

Cause of Death • Stroke • Chronic Lower Respiratory Disease **Health Outcomes** • Low Birth Weight • Poor or Fair Health Status • Poor Physical Health & Mental Health Days	**Chronic Conditions** • Hypertension • Asthma • Diabetes • Coronary Heart Disease • Arthritis **Health Behaviors** • Smoking • Obesity • Sexually Transmitted Infections	**Prevention** • Colorectal Screening • Mammography **Access** • Lack of PCPs **Socioeconomic & Environment** • Children in Single-Parent HHs • Access to Recreational Facilities • Percentage of Fast Food Restaurants

The prioritization work group selected criteria to help prioritize the health needs. The criteria selected included feasibility (is the problem amenable to interventions?), hospital capacity (does the hospital have the capacity to act on the issue?), and hospital strength (extent to which initiatives that address the health issues can build on hospital's existing strengths and resources). Working in small groups that represented each hospital, each health need was rated using the criteria selected to determine a score for each health need.

The table below indicates the health needs identified for each facility. The highlighted boxes are the five health needs that scored the highest in the prioritization process. Even though the highlighted health needs had the highest scores, the needs that will actually be addressed for the purposes of the CHNA are at the discretion of each Baptist Health hospital.

HEALTH NEED	BHMC Little Rock	BHMC North Little Rock	BHMC Stuttgart	BHMC Heber Springs	BHMC Arkadelphia	BHRI	BHECH
Cause of Death							
▪ Cancer	X	X	X				
▪ Stroke	X	X	X		X	X	X
▪ Chronic Lower Respiratory Disease	X	X	X	X		X	X
▪ Diabetes	X	X			X		
▪ Heart Disease			X	X			
▪ Injury-related Deaths			X				
Health Outcomes							
▪ Premature Death	X	X	X				
▪ Low Birth Weight	X	X	X	X			
▪ Infant Mortality	X	X					
▪ Poor or Fair Health Status	X	X	X	X		X	X
▪ Poor Physical Health & Mental Health Days	X	X	X	X	X	X	X
Chronic Conditions							
▪ Hypertension	X	X	X		X	X	X
▪ Asthma	X	X	X	X	X	X	X
▪ Diabetes	X	X	X	X	X	X	X
▪ Coronary Heart Disease	X	X	X	X		X	X
▪ Arthritis	X	X	X	X	X		
▪ High Cholesterol			X	X			
Health Behaviors							
▪ Smoking	X	X	X	X		X	X
▪ Obesity	X	X	X		X	X	X
▪ Excessive Drinking	X	X	X	X			
▪ Sexually Transmitted Infections	X	X	X		X		
▪ Physical Inactivity			X	X			
▪ Teen Birth Rate			X				
▪ Lack of Healthy Eating			X				
Prevention							
▪ Pap Test	X	X	X				
▪ Diabetic Screening	X	X	X				
▪ Preventable Hospital Stays	X	X	X				
▪ Colorectal Screening			X	X	X	X	X
▪ Mammography			X	X	X	X	X
▪ Flu Shot			X	X			
▪ Prostate Screening				X			
▪ HIV Test			X				
Access							
▪ Lack of PCPs	X	X	X	X	X		
▪ No Personal Doctor			X	X			
▪ Uninsured			X		X		

HEALTH NEED	BHMC Little Rock	BHMC North Little Rock	BHMC Stuttgart	BHMC Heber Springs	BHMC Arkadelphia	BHRI	BHECH
Socioeconomic & Environment							
▪ Children in Single-Parent HHs	X	X	X		X		
▪ Violent Crime	X	X					
▪ Access to Recreational Facilities	X	X	X	X		X	X
▪ Access to Healthy Food	X	X					
▪ Percentage of Fast Food Restaurants	X	X	X		X	X	X
▪ Inadequate Social Support			X				
Spinal Cord Injury							
▪ Injury Hospitalizations due to Motor Vehicle Accidents/Falls						X	X

After selecting the community health needs that will be addressed, an implementation plan will be developed for each health need for each facility. Additionally, the CHNA process requires an organization to provide rationalization for those health needs that are not addressed. Baptist Health corporate staff will be working with each hospital to complete this process. The implementation plans will then need to be approved by the Baptist Health governing body and attached to the IRS Form 990, Schedule H, for the 2013 filing.

Community Health Needs Assessment Overview and Methodologies

The Community Health Needs Assessment (CHNA) is a requirement of all tax-exempt (501(c)(3)) hospitals beginning with fiscal year 2013. As part of the IRS Form 990, Schedule H, individually licensed not-for-profit hospitals are required to assess the health needs of their community, prioritize the health needs, and develop implementation plans for the prioritized health needs they've chosen to address.

Baptist Health partnered with Truven Health Analytics (formerly the Healthcare Business of Thomson Reuters) to complete a Community Health Needs Assessment (CHNA) for each of the following Baptist Health facilities:

- Baptist Health Medical Center–Little Rock
- Baptist Health Medical Center–North Little Rock
- Baptist Health Medical Center–Arkadelphia
- Baptist Health Medical Center–Heber Springs
- Baptist Health Medical Center–Stuttgart
- Baptist Health Extended Care Hospital
- Baptist Health Rehabilitation Institute

Consultant Qualifications & Collaboration

Truven Health Analytics and its legacy companies have been delivering analytic tools, benchmarks, and strategic consulting services to the health-care industry for more than 50 years. Truven Health combines rich data analytics in demographics (including the Community Needs Index; developed with Dignity Health), planning, and disease prevalence estimates with experienced strategic consultants to deliver comprehensive and actionable Community Health Needs Assessments. Baptist Health did not collaborate with any other local organization in completing this assessment.

Defining the Community Served

Each Baptist Health hospital has a unique definition of the community served based on inpatient discharges/outpatient visits data, market-share data, and other considerations.

Baptist Health used inpatient and outpatient data as well as market-share data from the Arkansas Department of Health to define the community served for each facility. The community served for the three acute-care, non-critical access hospitals was defined using the ZIP codes that represent greater than or equal to 2 percent of the hospital's combined inpatient discharges/outpatient visits AND in which the hospital's inpatient market share is greater than or equal to 20 percent. ZIP codes that did not meet that criteria but were either contiguous to or surrounded by ZIP codes that were a part of the community served definition were included. The community served for the two critical access hospitals was defined as the county in which the hospital is located.

The communities served for the Extended Care Hospital and Rehabilitation Institute were defined by the disease/injury state of patients in the communities served by the five Baptist Health acute-care hospitals.

Assessment of Health Needs – Methodology and Data Sources

To assess health needs of the Baptist Health communities, a quantitative and qualitative approach was used. In addition to collecting data from a number of public and Truven Health proprietary sources, interviews (both in-person and telephone) and

focus groups were conducted with individuals representing community leaders/groups, public organizations, patients, providers, and Baptist Health representatives from the hospital and corporate levels.

Quantitative data sources include:

- Health Indicators Warehouse
    - National Vital Statistics System – Mortality (CDC, NCHS), 2007-2009
    - Linked Birth/Infant Death Data Set (CDC, NCHS), 1998-2008
- Arkansas Department of Health
    - Health Statistics Branch (ADH, HSBCS), 2005-2007, 2010
    - Arkansas Department of Health BRFSS, 2009, 2010, 2004-2010
- County Health Rankings
    - County Health Rankings (NCHS), 2002-2008, 2006-2008
    - County Health Rankings (BRFSS), 2004-2010, 2010
    - County Health Rankings (NCHHSTP), 2009
    - County Health Rankings (Medicare/Dartmouth Institute), 2009
    - County Health Rankings (Health Resources & Services Administration), 2010
    - County Health Rankings (American Community Survey), 2006-2010
    - County Health Rankings (FBI), 2007-2009
    - County Health Rankings (USDA), 2006
    - County Health Rankings (Census County Business Patterns), 2009
- Truven Health Analytics
    - Community Need Index, 2012
    - Emergency Department Estimates, 2012
    - Heart Disease Estimates, 2011
    - Cancer Estimates, 2011
    - Demographics (Nielsen), 2000, 2012, and 2017 ZIP Code estimates
    - Insurance Coverage Estimates, 2012

Qualitative Assessment of Health Needs

To take into account the input of persons representing the broad interests of the community, Truven Health conducted interviews (both one-on-one and small groups) as well as focus groups in September 2012. The interview questionnaire was designed to understand how participants feel about the general health status of the community and the various drivers contributing to health issues. Ninety-three interviews were completed for the CHNA process for Baptist Health. Individuals were grouped into the following categories to ensure broad participation: community leaders/groups, public health and other health-care organizations, other providers (including physicians), and Baptist Health representatives (corporate and hospital).

Six focus groups were also conducted to solicit feedback from community members. Focus groups were designed to familiarize community members with the CHNA process and gain a better understanding of the community's perspective of priority health needs. Focus groups were formatted for individual as well as small-group feedback and also helped identify other community organizations already addressing health needs in the community. A focus group was conducted for each acute-care facility, and one focus group was hosted with Baptist Health wellness center clients.

Quantitative Assessment of Health Needs

In addition to the qualitative feedback, quantitative health indicators were collected and analyzed to assess community health needs. Forty-six indicators were evaluated for each of the counties or ZIP codes (depending on level of data available) in the Baptist Health service area. The categories and indicators included the following:

Arkansas Top Cause of Death • 2007-2009 Heart Disease Death Rate • 2007-2009 Overall Cancer Death Rate • 2007-2009 Stroke Death Rate • 2005-2007 Chronic Lower Respiratory Disease-Related Death Rate • 2005-2007 Diabetes-Related Death Rate • 2007-2009 Injury Death Rate	**Health Outcomes** • 2006-2008 Premature Death Rate • 2002-2008 Low Birth Weight • 1999-2008 Infant Death per 1000 Live Births • % Fair/Poor Health • Physically Unhealthy Days • Mentally Unhealthy Days	**Chronic Conditions** • 2009 % Have Hypertension • 2009 % Have High Cholesterol • 2010 % Currently Have Doctor Diagnosed Asthma • 2010 % Have Diabetes • 2010 % Have Angina or Coronary Heart Disease • 2009 % Have Arthritis
Socioeconomic • 2006-2010 % No Social-Emotional Support • 2006-2010 % Single-Parent Households	**Environment** • 2007-2009 Violent Crime Rate • 2009 Recreational Facility Rate • 2006 % Limited Access to Healthy Foods • 2009 % Fast Food Restaurants	**Top Causes of Spinal Cord Injury** • 2010 % of Injury Hospitalizations due to Motor Vehicle Accidents • 2010 % of Injury Hospitalizations due to Falls • 2010 % of Injury Hospitalizations due to Violence
Health Behaviors • 2004-2010 % Adult Smoking • 2010 % Are Obese • 2010 % No Exercise • 2004-2010 % Binge Drinking • 2009 Sexually Transmitted Infections • 2002-2008 Teen Birth Rate • 2009 % Consume Less Than 5 Fruits & Vegetables Per Day	**Prevention** • 2010 % Age 50 + Never had a Sigmoidoscopy or Colonoscopy • 2010 % Age 40+ No Mammogram in Past 2 Years • 2010 % Women (Age 18+) No Pap Test in Past 3 Years • 2010 % Men (Age 40+) No PSA test in 2 years • 2010 % Age 65 + No Flu Shot In Past Year • 2010 % Adults Ages 18 - 64 No HIV Test • 2009 Diabetic Screening	**Access** • 2009 Preventable Hospital Stays Rate • 2010 % No Personal Doctor • Ratio of Primary Care Physicians to Population • 2012 Uninsured

For each health indicator, a comparison was made between the community's county-level data and the data for the United States and Arkansas. For Baptist Health, the State of Arkansas health indicator scores were used as the comparative benchmark. Health needs were identified where the service area county indicator did not meet the state-level benchmark.

Information Gaps

The community served definition for each facility varies depending on a number of factors including market share and surrounding geography. With the exception of the Baptist Health critical access hospitals, the community served is defined at the ZIP code level. The Baptist Health critical access hospitals' community served is defined as the county in which the hospital is located.

The most geographically detailed health indicators are only available at the county level. This presents a number of challenges as health indicators were evaluated across several counties for Baptist Health Medical Center–Little Rock, Baptist Health Medical Center–North Little Rock, and Baptist Health Medical Center–Stuttgart. In evaluating data for entire counties versus ZIP code level data, it is difficult to understand the health needs for specific population pockets within a county. It is also a challenge to tailor programs to address community health needs as placement and access to those programs in one part of the county may or may not actually impact the population who truly need the service.

Prioritizing Community Health Needs

Using the qualitative feedback from the interviews and focus groups and the health indicators data, a list of community health needs were identified for Baptist Health. To prioritize the identified health needs, Truven Health facilitated a prioritization session with Baptist Health representatives. Participants included:

<table>
<tr>
<td>BHMC–Little Rock
Greg Crain – VP/ Administrator
Ann McQueen – Director of Patient and Community Services
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Mark Lowman – Vice President of Strategic Development
Robert Buchanan – Manager of Research and Development
Teresa Conner – Manager of Community Outreach
Michael Shepherd – Research and Data Analyst</td>
</tr>
</table>

Utilizing a modified version of a method developed by Hanlon and his colleagues (see Hanlon & Pickett, 1990), Baptist Health representatives selected criteria in order to prioritize the health needs. The original list included nine criteria including magnitude of the health need, consequences as a result of the health need, feasibility that the problem is amenable to interventions, impact of the health need on vulnerable populations, whether the health need is a root cause for other issues, hospital capacity to address the issue, whether the issue can be addressed using the hospital's existing strengths and resources, the availability of local expertise to address the issue, and the probability of quick success. Participants were asked to select the top three to five prioritization criteria.

Using a multi-voting process, the criteria selected included **feasibility** (is the problem amenable to interventions?), **hospital capacity** (does the hospital have the capacity to act on the issue?), and **hospital strength** (extent to which initiatives that address the health issues can build on hospital's existing strengths and resources). After choosing the criteria, Baptist Health representatives worked in small groups that represented each facility, and each community-specific health need was rated using the criteria selected to determine a score for each health need. Health needs that scored the highest against the selected criteria served as the starting point for the health needs to be addressed. Each Baptist Health facility then worked with Baptist Health corporate staff to determine which of the top health needs their facility would address.

Summary

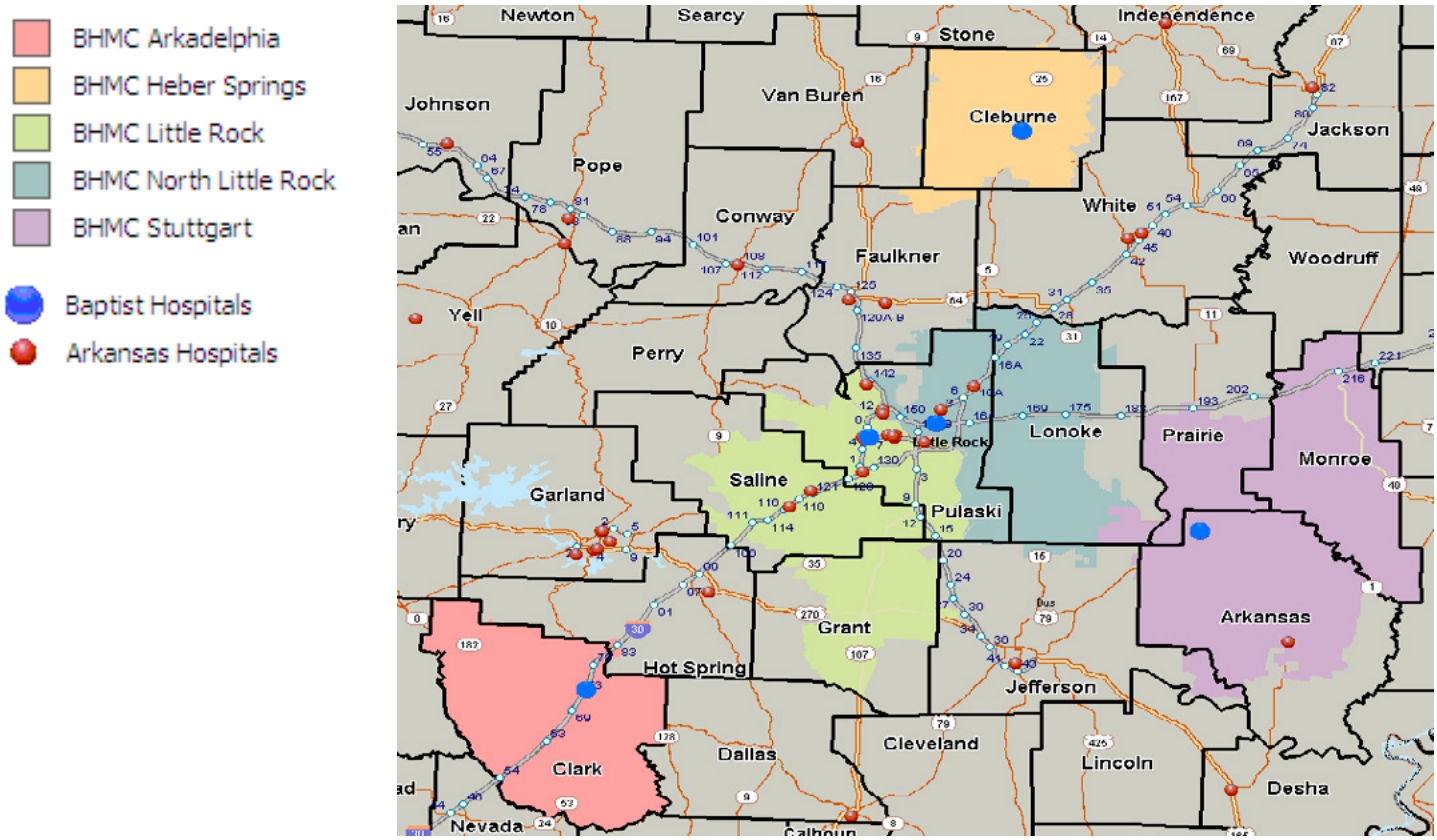
Baptist Health conducted a Community Health Needs Assessment beginning April 2012 to identify and begin to address the health needs of the communities that they serve. Using both qualitative community feedback as well as publically available and proprietary health indicators, Baptist Health was able to identify and prioritize community health needs for each of their hospital facilities. The remainder of this report will provide a summary of findings for the Baptist Health system as well as a detailed assessment for each of the seven Baptist Health hospitals.

Baptist Health Community Served

The community served by the acute-care hospitals was defined using the ZIP codes that represent greater than or equal to 2 percent of the hospital's combined inpatient discharges/outpatient visits AND in which the hospital's inpatient market share is greater than or equal to 20 percent. ZIP codes that did not meet that criteria but were either contiguous to or surrounded by ZIP codes that were a part of the community served definition were included.

The community served by the critical access hospitals was defined as the county in which the hospital is located.

The communities served by the Extended Care Hospital and Rehabilitation Institute were defined by the disease/injury state of patients in the communities served for all the Baptist Health hospitals.



Baptist Health Community Served Demographics

- Little Rock and North Little Rock are the fastest growing communities followed by Heber Springs
- Heber Springs has the largest proportion of the population age 65 plus
- Stuttgart has the largest proportion of population on Medicaid or uninsured
- Little Rock has the highest median income as well as the largest non-white proportion of the population

Benchmarks / Baptist Health Community	Total Current Population	5 Year Population Change	% of Population 0-17	% of Population 65+	% Women of Child Bearing Age (15-44)	% of Non-White Population	Insurance Coverage		Median HH Income
							Medicaid	Uninsured	
United States	**313,095,504**	**3.9%**	**24%**	**13%**	**20%**	**37%**	**15%**	**16%**	**$50,054**
Arkansas	**2,965,859**	**4.6%**	**25%**	**14%**	**20%**	**26%**	**17%**	**18%**	**$33,015**
Baptist Health Overall	647,146	4.7%	25%	13%	21%	34%	15%	16%	$40,965
Little Rock	356,152	5.4%	25%	12%	21%	37%	15%	15%	$48,756
North Little Rock	210,923	5.2%	26%	12%	21%	31%	16%	15%	$41,559
Stuttgart	30,014	-4.0%	24%	17%	18%	33%	20%	22%	$35,796
Arkadelphia	24,342	-0.2%	22%	14%	23%	29%	15%	26%	$32,835
Heber Springs	25,715	4.3%	20%	23%	16%	4%	13%	16%	$35,891



Key Findings

This Community Health Needs Assessment revealed similar themes for the individual communities served by each of the Baptist Health facilities. For the larger urban hospitals of BHMC–Little Rock and BHMC–North Little Rock, preventable hospitalization was identified as a priority health need. Given the long-term effects and implications, smoking and obesity were also seen as priority health needs across several of the Baptist Health organizations. In general, preventive health screenings — for diabetes, colorectal cancer, prostate cancer, and breast cancer (mammograms) — were also identified as a priority.

The interviews and focus groups revealed that the majority of individuals feel that the health status of the community they represent is good to fair. Much of this is attributed to chronic disease, lifestyle choices, and lack of preventive health efforts. The need for more health-care providers and services as well as improved access to health care was identified as the top needs across all those interviewed. Not surprisingly, barriers to good health include socioeconomic factors and access issues. The elderly and minority populations were identified as those being most at risk.

Taking into account the quantitative health indicators along with the community feedback, the top five prioritized health needs for each of the Baptist Health hospitals include:

BHMC-LR	BHMC-NLR	BHMC-S	BHMC-HS	BHMC-A	BHRI	BHECH
Preventable Hospital Stays	Diabetic Screening	Smoking	Flu Shots	Colorectal Screening	Stroke (cause of death)	Stroke (cause of death)
Diabetic Screening	Low Birth Weight	Obesity	Mammograms	Mammograms	Injuries due to motor vehicle accidents/ falls	Diabetes (prevalence)
Diabetes (cause of death)	Infant Mortality	Physical Inactivity	Prostate Screening	Stroke (cause of death)	Obesity	Injuries due to motor vehicle accidents/ falls
Lack of PCPs	Preventable Hospital Stays	Diabetes (prevalence)	Colorectal Screening	Lack of PCPs	Smoking	Hypertension
Infant Mortality	Diabetes (cause of death)	Hypertension	Lack of PCPs	Hypertension	Chronic Lower Respiratory Disease (cause of death)	Asthma



Community Needs Assessment

Baptist Health Medical Center–Little Rock

December 2013

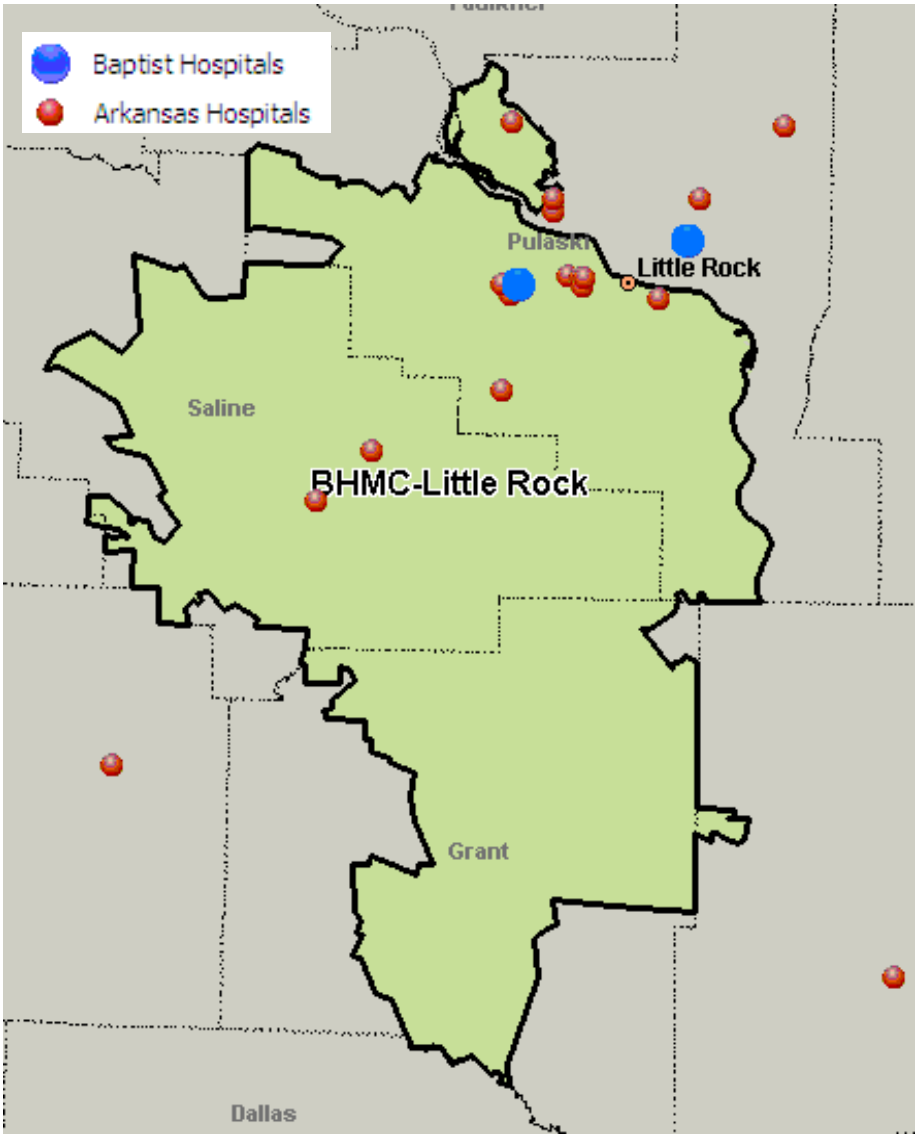
Baptist Health Medical Center–Little Rock

Baptist Health Medical Center–Little Rock is a 732-bed facility that provides comprehensive healthcare services to residents throughout the state. The BHMC–Little Rock campus is home to the Baptist Health Bariatrics Center, Heart Institute, Orthopedic Center, Transplant Institute, and Women's Center. BHMC–Little Rock has more than 32,000 inpatient discharges a year and sees almost 59,000 patients in the Emergency Department each year, making it one of the busiest Emergency Departments in the state.

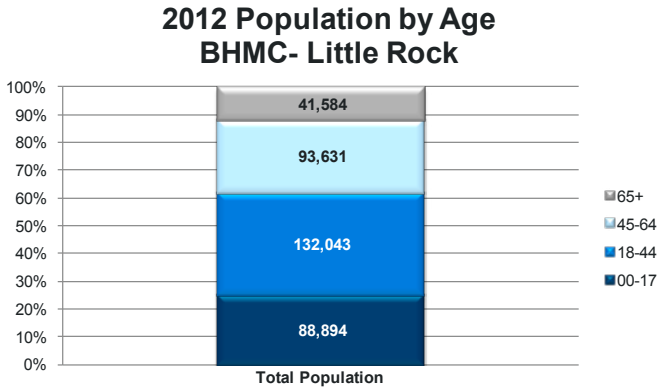
Community Served and Demographics

The community served for BHMC–Little Rock was determined using the ZIP codes that represent greater than or equal to 2 percent of the hospital's combined inpatient discharges/outpatient visits AND in which the hospital's inpatient market share is greater than or equal to 20 percent. ZIP codes that did not meet those criteria but that are either contiguous or surrounded by ZIP codes in the community served were also included.

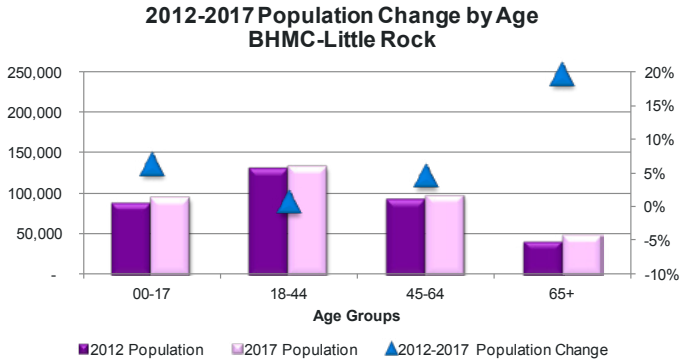
Thirty-eight ZIP codes constitute the community served for BHMC–Little Rock. A detailed list of the ZIP codes can be found in the **Baptist Health Medical Center-Little Rock Appendix.** Below is a map that illustrates the BHMC–Little Rock community served (light green).



The BHMC–Little Rock community served population is approximately 356,152. By 2017, this population is projected to grow 5.4 percent — the fastest-growing community among the Baptist Health hospitals. While the largest portion of the population is made up of white non-Hispanics (222,836), in the next five years the largest percentages of growth will be in the Hispanic (+31 percent, +6,538 individuals) and Asian (+22 percent, +1,612 individuals) populations. The largest growth in population will take place among black non-Hispanics (+7,108 individuals) between 2012 and 2017.



The 18-44 age group constitutes the largest portion of the BHMC–Little Rock community served, followed by the 45-64 age group.



By 2017, the age 65 plus population will have the largest percentage of growth.

The median household income for the BHMC–Little Rock community served is $48,756. More than 57 percent of individuals have private insurance — either employer-sponsored insurance (51 percent) or individually purchased (6 percent). Another 15 percent are covered by Medicaid, 15 percent are uninsured, and 13 percent are covered by Medicare or are Medicare dual eligible.

Interviews & Focus Groups

Interviewees and focus group participants were categorized into representative groups. In the chart below, an "I" indicates an interview and "FG" indicates participation in a focus group. For individuals outside Baptist Health, representative organizations have been listed.

Community Leaders/ Groups		Public and Other Organizations	Other Providers	Baptist Health		Baptist Health - Corporate	
Simpson, Ed (BHMC Board Member/ Pastor, I)	Miller, Virgil (BHMC Board Member / Metropolitan National Bank, I)	Phelps, Beth (UA Cooperative Ext., I)	Budhraja, M.D, Meenakshi (BHMC, I)	Cook, D'borai (BHMC, I)	Bennett, Anthony (BHMC, I)	Harrington, Russ (BHMC, I)	Weeks, Doug (BHMC, I)
Stodola, Mark (City of Little Rock, I)	Coulson, Mike (BHMC Board Member / Gasoline Distribution, I)	Bushmiar, Margo (AR School Nursing Association, FG)	Wheeler, Gary (Arkansas Department of Health, I)	Goodhart, Brenda (BHMC, I)	Wilson, Stan (BHMC, I)	Wells, Troy (BHMC, I)	Roberts, Bob (BHMC, I)
Thompson, M.D., Joe (AR Surgeon General/ AR Ctr for Health Improvement, I)	Ortega, Cesar (Mosaic Church, FG)	Thomas, Stuart (Little Rock Police Department, FG)	Dillaha, M.D., Jennifer (Arkansas Department of Health, I)	Crain, Greg (BHMC, I)	Williams, Jean (BHMC, I)	Gardner, M.D., Guy (BHMC, I)	Lowman, Mark (BHMC, I)
Blackshear, M.D., Jack (BHMC Board Member/Retired, I)	Brown, Pat (Mosaic Church, FG)	Purifoy, Vivian (Grant County Health Department, I)		Shaw, Brad (BHMC, I)	Nix, Julie (BHMC, I)	Alston, Leila (BHMC, I)	Lusby, Glenn (BHMC, I)
Jones, Jim (BHMC Board Member/ Crews & Associates, I)	O'Daniel, Susana (Arkansas Advocates for Children & Families, FG)	Halverson, Paul (Arkansas Department of Health, I)		Pahls, M.D., Wendell (BHMC, I)	Guthrie, Sandy (BHMC, I)	Bailey, Letitia (BHMC, I)	McQueen, Ann (BHMC, I)
	Jackson, Keith (P.A.R.K., FG)	Talbot, Lauren (Arkansas Prostate Cancer Foundation, I)		Pryor, Sandy (BHMC, I)	Massiet, Jill (BHMC, I)		
		Clark, Marilyn (American Heart Assoc/ American Stroke Assoc, I)		Stanfield, Jenny (BHMC Community Outreach, I)			

The individuals highlighted in purple indicate Health Department representatives (local, regional, or state), as well as individuals representing or serving medically underserved, low-income, or minority populations.

In the interview process, the majority of individuals said the current health status of the community is either "fair" or "poor." The major issues contributing to this health status include lifestyle choices, lack of preventative care, lack of access to health-care, obesity, and other chronic diseases.

For the BHMC–Little Rock community, the top five health needs identified in the interview process include:

1. Access to healthcare
2. Obesity
3. Prevention/lifestyle modification
4. Affordable care
5. Health-care providers/services

Barriers to good health care in this community include socioeconomic factors, access to healthcare, and affordable healthcare. The elderly and minority populations were identified as vulnerable groups that will need special attention when addressing health needs.

Focus group participants were asked to grade the health of the community based on an A-F scale, provide feedback in terms of that grade, and work in small groups to determine the top three health needs of the community. For the BHMC–Little Rock group, the average grade for the health of the community was a C. Much of this was attributed to the prevalence of chronic diseases/ conditions, overconsumption of fast food, nicotine use/smoking, and alcohol consumption. While there have been improvements to dental care for children and walking/biking trail systems for the community, there are still opportunities to raise the level of awareness of services available and create affordable access to health-care for minority populations.

The focus group split into two smaller groups to determine the top three health needs of the community. Group 1 selected access to a dental-care clinic (free or affordable), substance abuse, and obesity. Group 2 selected health education, more health-care clinics (free or affordable), and access to care to connect people to the health resources already in place.

In the same small groups, focus group participants were asked to identify community resources that could help address the health issues in the community. Some of the resources identified include:

• Churches • Mosaic • P.A.R.K and other after school programs • Boys and Girls Club • Colleges	• City/state government • Friendly Chapel • Watershed • Goodwill • Our House	• Police department • Homeless shelters • Trail systems • Library • Hospitals

The **Baptist Health Medical Center-Little Rock Appendix** includes a more comprehensive list of existing community resources available to address the health needs of the community.

Additionally, a focus group was conducted of Baptist Health wellness center clients. Fourteen clients participated with ages ranging from 19 to 68. A majority of the participants were from minority groups and covered by Medicaid. The major barriers to health care that were identified were lack of transportation and availability of timely appointments at the free/reduced fee clinics. Participants also identified public safety as a barrier to exercise —specifically lack of sidewalks, streetlights, and safe parks. The group expressed a desire for more health-education fairs that reduce barriers for attending by providing transportation and holding such events in a "neutral" location (many are held in churches and people have a perception they are not open to non-church members). Other programs in which the group expressed interest were cooking classes, self-defense, parent-child interaction, substance abuse, and activity centers for adolescents.

Health Indicators

While the community served was defined at the ZIP code level, the most geographically detailed health indicators were only available at the county level. For that reason, health indicators for BHMC–Little Rock were evaluated for Grant County, Saline County, and Pulaski County. These counties represent the ZIP codes within the community served.

Health needs for those counties that did not meet the state benchmark include:

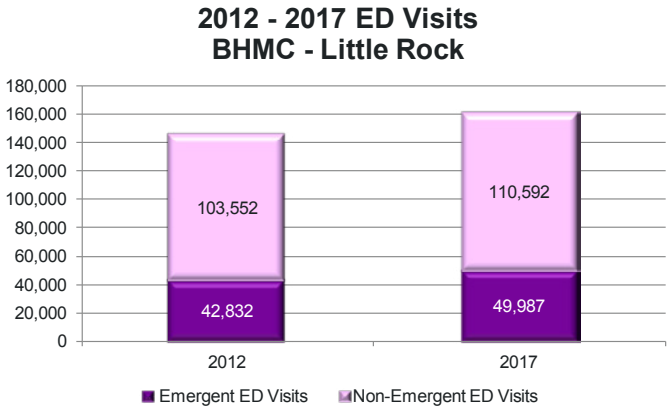
Cause of Death • Cancer • Stroke • Chronic Lower Respiratory Disease • Diabetes	**Chronic Conditions** • Hypertension • Asthma • Diabetes • Coronary Heart Disease • Arthritis	**Prevention** • Pap Test • Diabetic Screening • Preventable Hospital Stays **Access** • Lack of PCPs
Health Outcomes • Premature Death • Low Birth Weight • Infant Mortality • Poor or Fair Health Status • Poor Physical Health & Mental Health Days	**Health Behaviors** • Smoking • Obesity • Excessive Drinking • Sexually Transmitted Infections	**Socioeconomic & Environment** • Children in Single-Parent Households • Violent Crime • Access to Recreational Facilities • Access to Healthy Food • Percentage of Fast Food Restaurants

Truven Health Analytics supplemented the publically available data with estimates of disease prevalence for heart disease and cancer, emergency department visit estimates, and the community need index.

Heart disease estimates indicate a prevalence of 115,293 cases for the BHMC–Little Rock community served. The majority (70 percent) of the 2011 estimates of heart-disease prevalence indicate hypertension as the primary diagnosis. Other diagnoses include arrhythmias (13 percent), ischemic heart disease (12 percent), and congestive heart failure (5 percent).

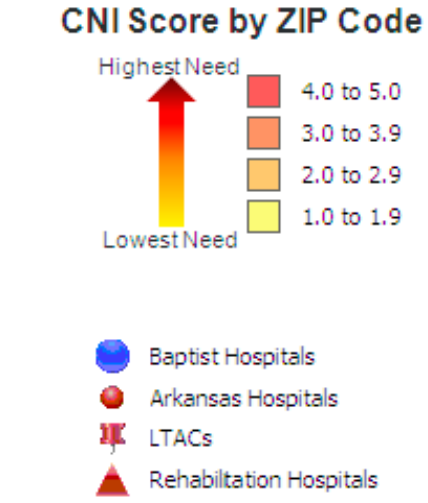
The 2011 cancer incidence estimates reveal at least 300 new cases of each of the following types of cancer: prostate, breast, and lung. For the community served, it is estimated that there will be 2,103 new cancer cases.

Emergency department visits are slated to grow by approximately 14,000 visits between 2012 and 2017.



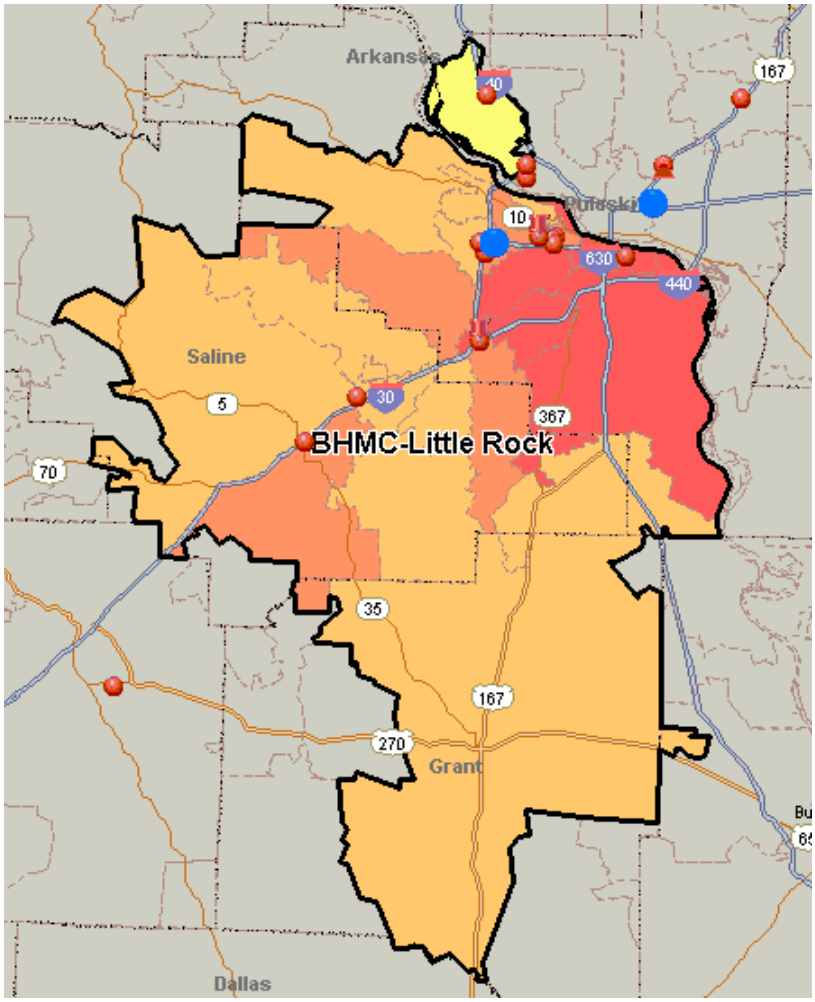
The Truven Health Community Need Index (CNI) is a statistical approach to identifying health needs in a community. The CNI takes into account vital socio-economic factors (income, cultural, education, insurance, and housing) about a community to generate a CNI score for every populated ZIP code in the United States. The CNI is strongly linked to variations in community healthcare needs and is a strong indicator of a community's demand for various healthcare services.

The BHMC–Little Rock community served had a CNI of 3.3 on a scale of 1.0 (lowest needs) to 5.0 (highest needs). Compared to the other Baptist Health communities, BHMC–Little Rock has the second-lowest CNI score.



Community Overall CNI Score

BHMC–Little Rock 3.3
BHMC–North Little Rock 3.4
BHMC–Stuttgart 4.5
BHMC–Heber Springs 3.2
BHMC–Arkadelphia 4.4



Prioritized Health Needs

From BHMC–Little Rock, Greg Crain, vice president/administrator, Ann McQueen, director of Patient and Community Services; and Brenda Goodhart, director of Women's and Children's program line; participated in the prioritization meeting.

Using the criteria selected by the larger group, the five health needs that scored the highest in the prioritization process for BHMC–Little Rock were:

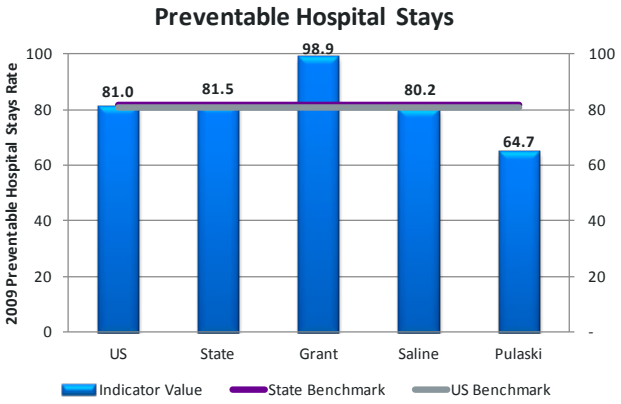
1. Preventable hospital stays
2. Diabetic screening
3. Diabetes (cause of death)
4. Lack of primary care physicians
5. Infant mortality

HEALTH NEED	BHMC-Little Rock
Cause of Death	
▪ Cancer	X
▪ Stroke	X
▪ Chronic Lower Respiratory Disease	X
▪ Diabetes	X
Health Outcomes	
▪ Premature Death	X
▪ Low Birth Weight	X
▪ Infant Mortality	X
▪ Poor or Fair Health Status	X
▪ Poor Physical Health & Mental Health Days	X
Chronic Conditions	
▪ Hypertension	X
▪ Asthma	X
▪ Diabetes	X
▪ Coronary Heart Disease	X
▪ Arthritis	X
Health Behaviors	
▪ Smoking	X
▪ Obesity	X
▪ Excessive Drinking	X
▪ Sexually Transmitted Infections	X
Prevention	
▪ Pap Test	X
▪ Diabetic Screening	X
▪ Preventable Hospital Stays	X
Access	
▪ Lack of PCPs	X
Socioeconomic & Environment	
▪ Children in Single-Parent HHs	X
▪ Violent Crime	X
▪ Access to Recreational Facilities	X
▪ Access to Healthy Food	X
▪ Percentage of Fast Food Restaurants	X

The table to the left indicates the health needs identified for the BHMC-Little Rock community. The highlighted boxes are the five health needs that scored the highest in the prioritization process.

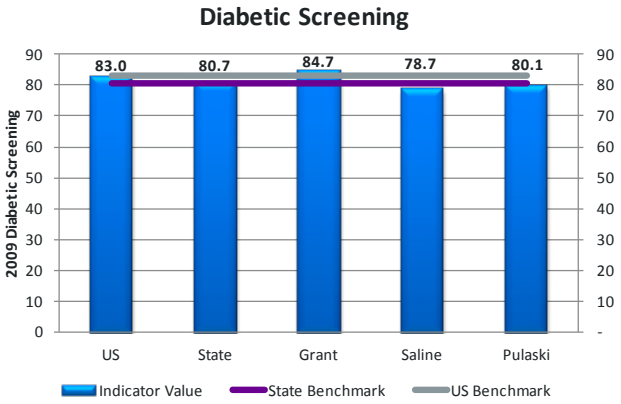
Even though the highlighted health needs had the highest scores, the needs that will actually be addressed for the purposes of the CHNA are at the discretion of BHMC-Little Rock.

For each of the prioritized health needs, the comparative benchmark graph has been provided to illustrate gaps between county indicators for the community served and the state benchmark (purple). While the graphs below provide metrics at the county level, BHMC-Little Rock will focus on the portions of each county within the definition of their community served.



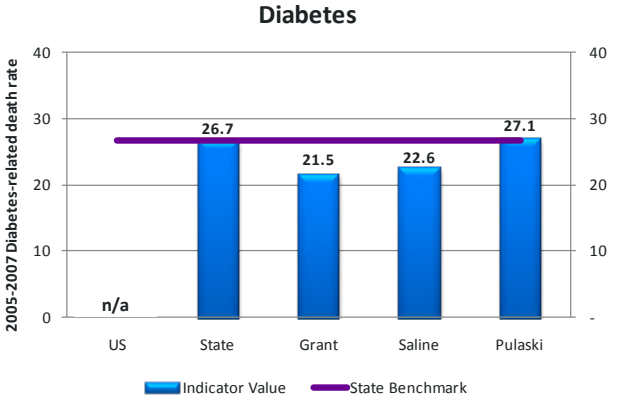
Source: County Health Rankings (Medicare/Dartmouth Institute)

Notes: Hospitalization rate for ambulatory-care sensitive conditions per 1,000 Medicare enrollees



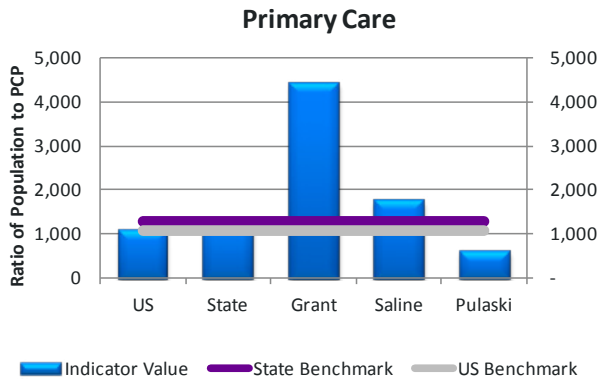
Source: County Health Rankings (Medicare/Dartmouth Institute)

Notes: Percent of diabetic Medicare enrollees that receive HbA1C screening



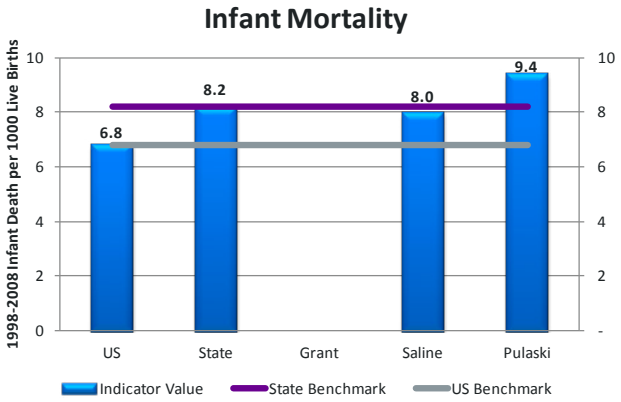
Source: Health Statistics Branch, ADH

Notes: 2005-2007 Diabetes-related deaths (per 100,000)



Source: County Health Rankings (Health Resources & Services Administration)

Notes: Ratio of population to primary care physicians



Source: Linked Birth/Infant Death Data Set (CDC-NCHS)

Notes: Rate of all infant deaths (within 1 year), per 1,000 live births

Summary

The community health needs assessment for the BHMC–Little Rock community served revealed a number of health issues related to disease management, lifestyle choices, and socioeconomic or environmental factors. By weighing the qualitative feedback and the quantitative data, along with the prioritization criteria, the top health needs identified include preventable hospital stays, diabetic screening, diabetes (cause of death), lack of primary-care physicians, and infant mortality.

BHMC–Little Rock will be working with internal stakeholders to determine the community health needs to be addressed. With the goal of improving the health of the community, implementation plans with specific tactics and time frames will be developed to address these health needs.

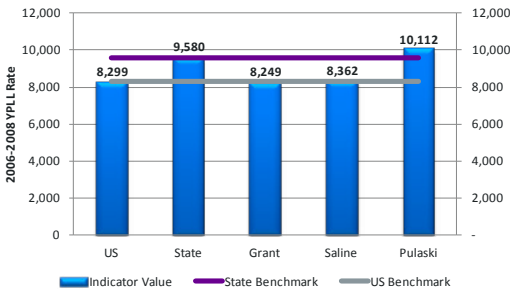
Baptist Health Medical Center–Little Rock Appendix

BHMC-Little Rock Community Served Definition ZIP Code Table

BAPTIST HEALTH COMMUNITY	ZIP	PONAME	COUNTY NAME	CBSANAME
BHMC-Little Rock	72002	Alexander	Saline, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72011	Bauxite	Saline, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72015	Benton	Saline, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72018	Benton	Saline, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72019	Benton	Saline, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72022	Bryant	Saline, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72053	Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72065	Hensley	Saline, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72089	Bryant	Saline, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72103	Mabelvale	Saline, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72113	Maumelle	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72150	Sheridan	Grant, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72158	Benton	Saline, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72164	Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72180	Hensley	Saline, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72183	Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72201	Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72202	Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72203	Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72204	Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72205	Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72206	Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72207	Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72209	Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72210	Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72211	Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72212	Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72214	Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72215	Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72216	Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72217	Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72219	Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72221	Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72222	Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72223	Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72225	Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72227	Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72260	Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72295	Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro

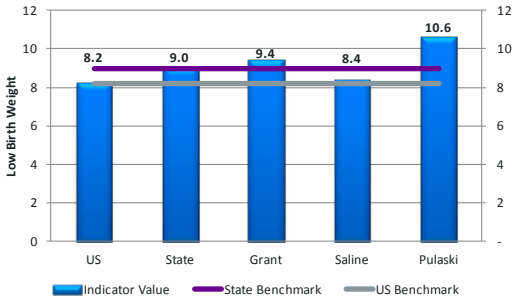
BHMC LITTLE ROCK: HEALTH OUTCOMES

Premature Deaths



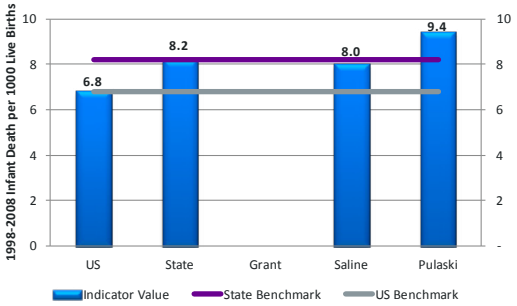
Source: County Health Rankings (NCHS)
Notes: Years of potential life lost before the age of 75 per 100,000 population

Low Birth Weight



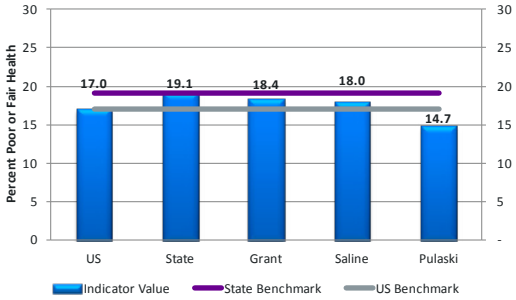
Source: County Health Rankings (NCHS)
Notes: Percent of live births with low birth weight (< 2500 grams)

Infant Mortality



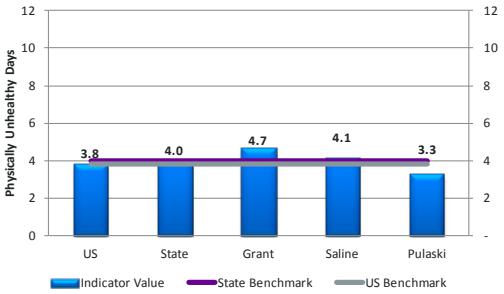
Source: Linked Birth/Infant Death Data Set (CDC-NCHS)
Notes: Rate of all infant deaths (within 1 year), per 1,000 live births

Poor or Fair Health



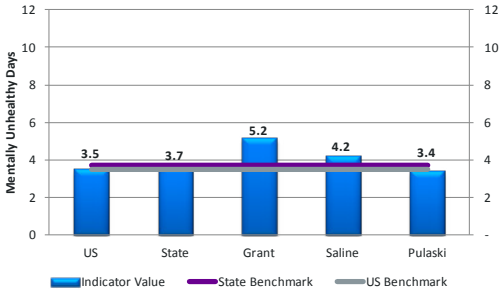
Source: County Health Rankings (BRFSS)
Notes: Percent of adults reporting fair or poor health (age-adjusted)

Poor Physical Health Days



Source: County Health Rankings (BRFSS)
Notes: Average number of physically unhealthy days reported in past 30 days (age-adjusted)

Poor Mental Health Days

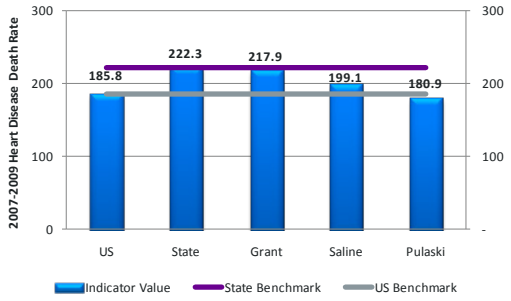


Source: County Health Rankings (BRFSS)
Notes: Average number of mentally unhealthy days reported in past 30 days (age-adjusted)

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

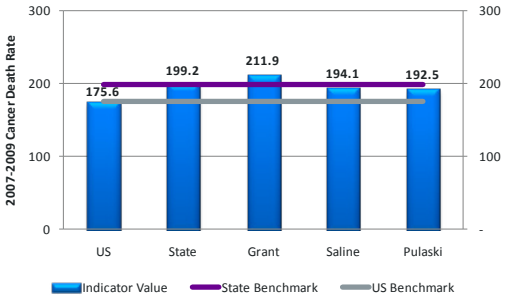
BHMC LITTLE ROCK:CAUSE OF DEATH

Heart Disease



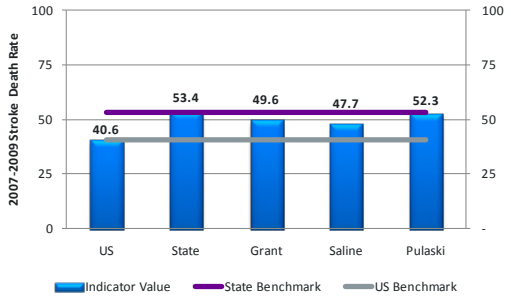
Source: National Vital Statistics System-Mortality (CDC, NCHS)
Notes: 2007-2009 Heart disease deaths (per 100,000)

Cancer



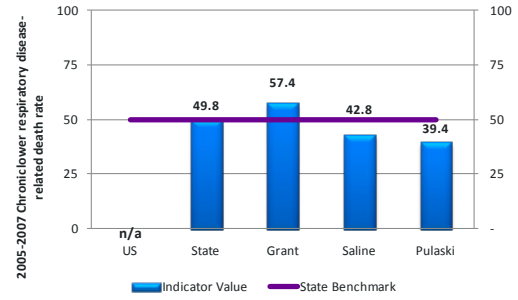
Source: National Vital Statistics System-Mortality (CDC, NCHS)
Notes: 2007-2009 Overall cancer death rate (per 100,000)

Stroke



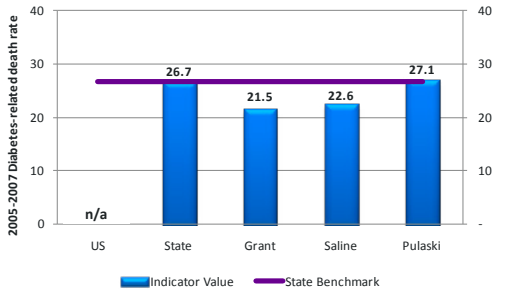
Source: National Vital Statistics System-Mortality (CDC, NCHS)
Notes: 2007-2009 Stroke death rate (per 100,000)

Respiratory Disease



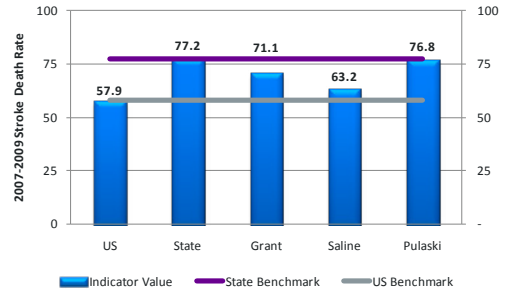
Source: Health Statistics Branch, ADH
Notes: 2005-2007 Chronic lower respiratory disease-related deaths (per 100,000)

Diabetes



Source: Health Statistics Branch, ADH
Notes: 2005-2007 Diabetes-related deaths (per 100,000)

Injury

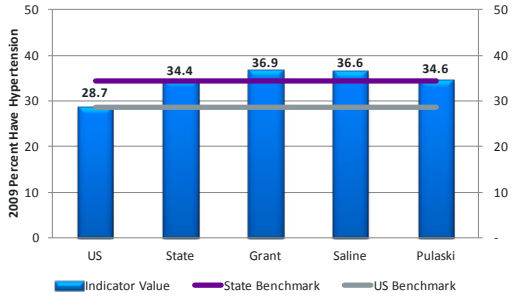


Source: National Vital Statistics System-Mortality (CDC, NCHS)
Notes: 2007-2009 Injury death rate (per 100,000)

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BHMC LITTLE ROCK: CHRONIC CONDITIONS

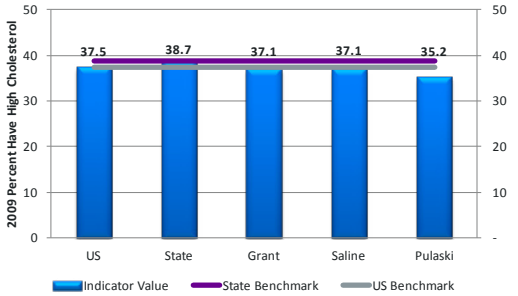
Hypertension



Source: Arkansas Department of Health BRFSS

Notes: Percent of adults that report having been diagnosed with high blood pressure

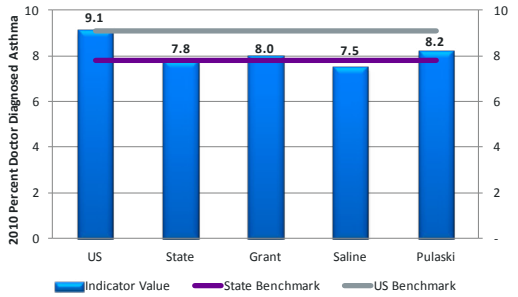
High Cholesterol



Source: Arkansas Department of Health BRFSS

Notes: Percent of adults that report having been diagnosed with high blood cholesterol

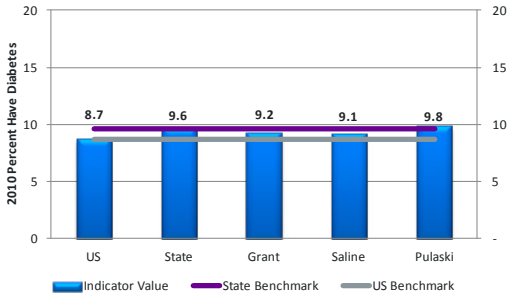
Asthma



Source: Arkansas Department of Health BRFSS

Notes: Percent of adults that report having been diagnosed with asthma

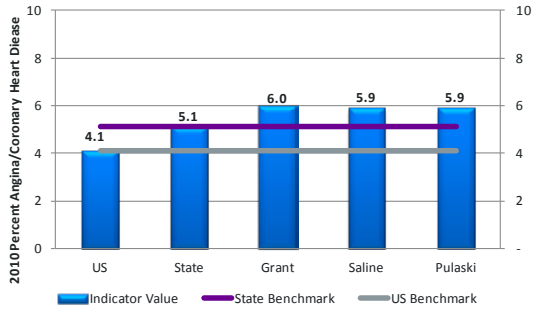
Diabetes



Source: Arkansas Department of Health BRFSS

Notes: Percent of adults that report having been diagnosed as having diabetes

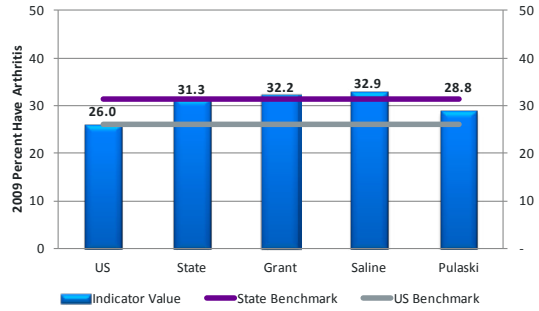
Coronary Heart Disease



Source: Arkansas Department of Health BRFSS

Notes: Percent of adults that report having been diagnosed as having Coronary Heart Disease

Arthritis



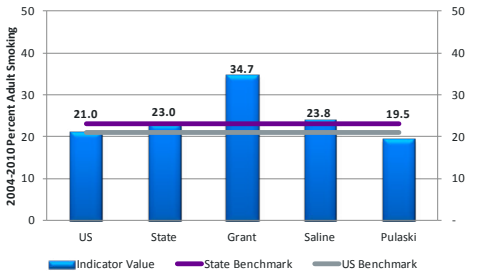
Source: Arkansas Department of Health BRFSS

Notes: Percent of adults that report having been diagnosed as having Arthritis

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

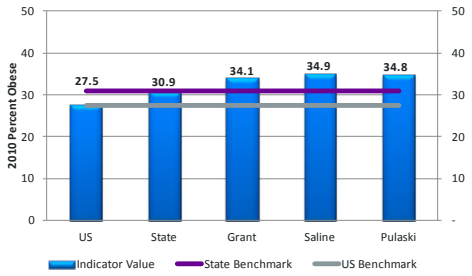
BHMC LITTLE ROCK: HEALTH BEHAVIORS

Adult Smoking



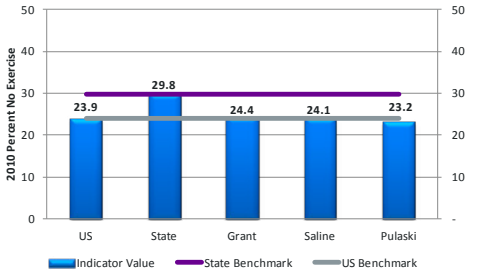
Source: County Health Rankings (BRFSS), Arkansas Department of Health BRFSS
Notes: Percent of adults 18 years+ that report currently smoking cigarettes

Adult Obesity



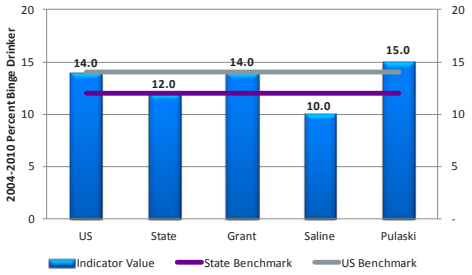
Source: Arkansas Department of Health BRFSS
Notes: Percent of adults 18 years and over that report BMI >= 30 (per self-reported weight/height)

Physical Inactivity



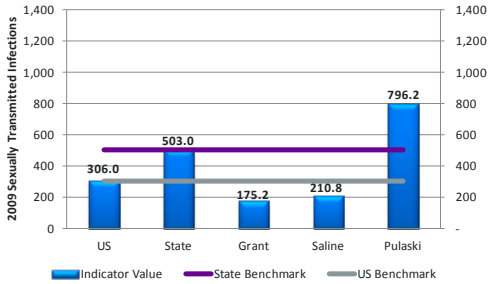
Source: Arkansas Department of Health BRFSS
Notes: Percent of Adults that report no leisure-time exercise in past month

Excessive Drinking



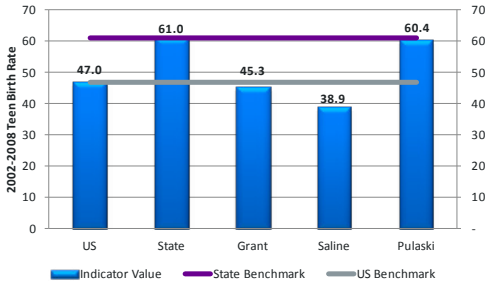
Source: County Health Rankings (BRFSS), Arkansas Department of Health BRFSS
Notes: Percent of adults 18 years and over that report binge drinking

Sexually Transmitted Infections



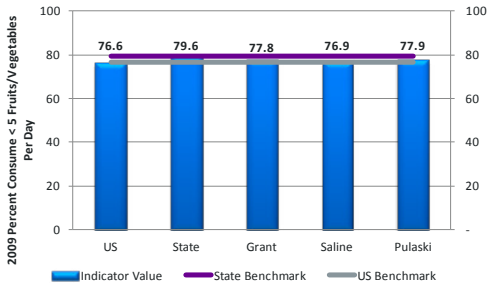
Source: County Health Rankings (BRFSS)
Notes: Chlamydia rate per 100,000 population

Teen Birth Rate



Source: County Health Rankings (BRFSS)
Notes: Percent of all live births to mothers less than 18 years of age

Lack of Healthy Eating

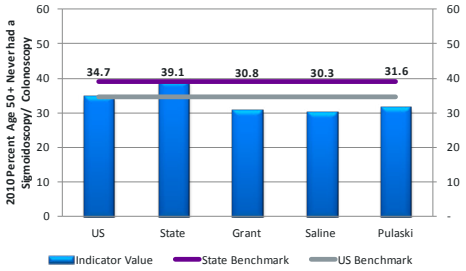


Source: Arkansas Department of Health BRFSS
Notes: Percent of Adults that report fewer than 5 servings of fruits/vegetables per day

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BHMC LITTLE ROCK: PREVENTION

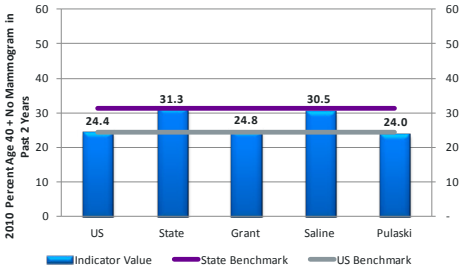
No Colorectal Screening



Source: Arkansas Department of Health BRFSS

Notes: Percent of adults age 50+ that report never having had a sigmoidoscopy or colonoscopy

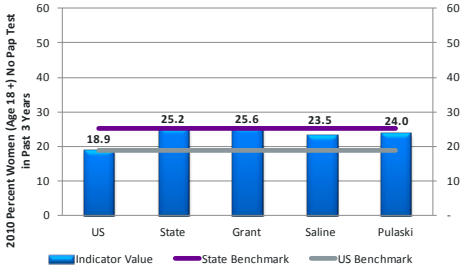
No Mammography



Source: Arkansas Department of Health BRFSS

Notes: Percent of women age 50+ that report no mammogram in the past 2 years

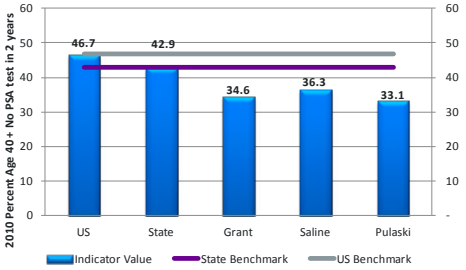
No Pap Test



Source: Arkansas Department of Health BRFSS

Notes: Percent of women age 18+ that report no Pap test in the last 3 years

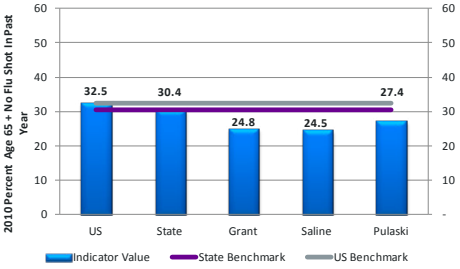
No Prostate Screening



Source: Arkansas Department of Health BRFSS

Notes: Percent of men age 40+ that report no PSA test in the last 2 years

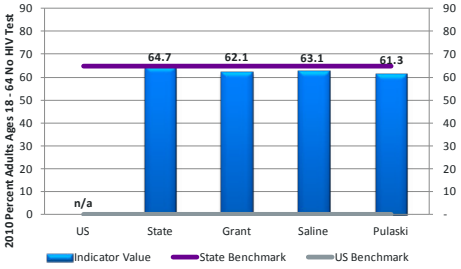
No Flu Shot



Source: Arkansas Department of Health BRFSS

Notes: Percent of adults age 65+ that report having no Influenza vaccine in past 12 months

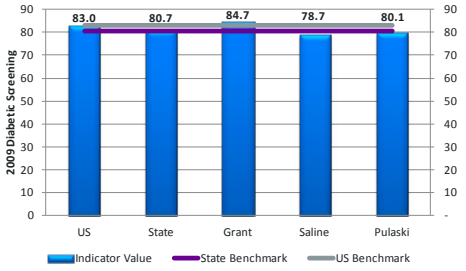
No HIV Test



Source: Arkansas Department of Health BRFSS

Notes: Percent of adults age 18-64 that report having never having an HIV test

Diabetic Screening



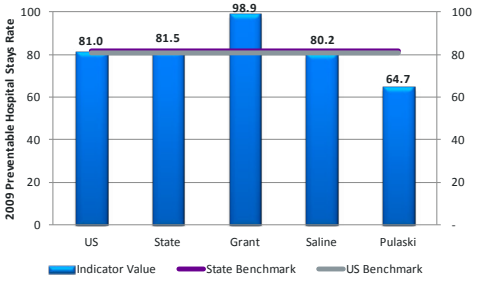
Source: County Health Rankings (Medicare/Dartmouth Institute)

Notes: Percent of diabetic Medicare enrollees that receive HbA1c screening

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

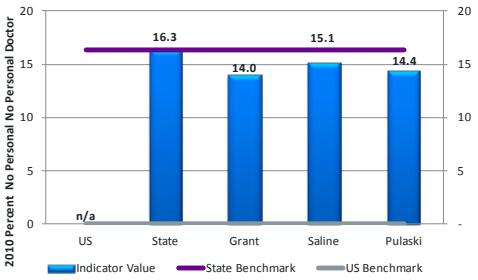
BHMC LITTLE ROCK: ACCESS

Preventable Hospital Stays



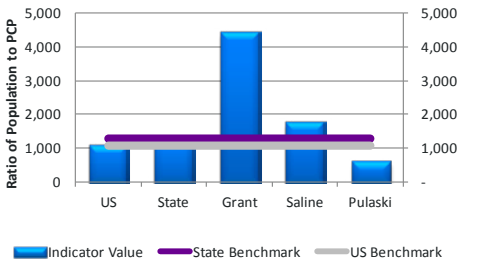
Source: County Health Rankings (Medicare/Dartmouth Institute)
Notes: Hospitalization rate for ambulatory-care sensitive conditions per 1,000 Medicare enrollees

Personal Doctor



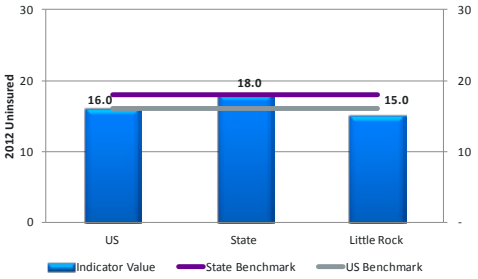
Source: Arkansas Department of Health BRFSS
Notes: Percent of adults age 18+ that report having no personal doctors

Primary Care



Source: County Health Rankings (Health Resources & Services Administration)
Notes: Ratio of population to primary care physicians

Uninsured

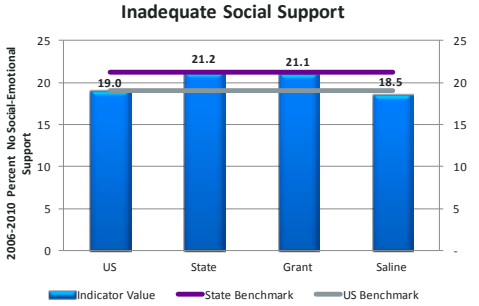


Source: Truven Health (Insurance Coverage Estimates)
Notes: Percent uninsured

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

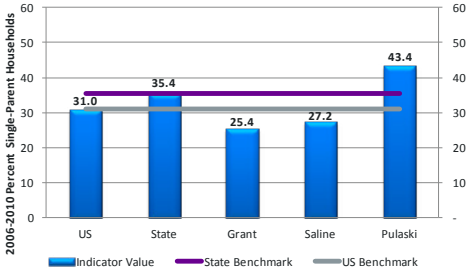
BHMC LITTLE ROCK: SOCIOECONOMIC

Inadequate Social Support



Source: County Health Rankings (BRFSS)
Notes: Percent of adults without social/emotional support

Children in Single Parent Households

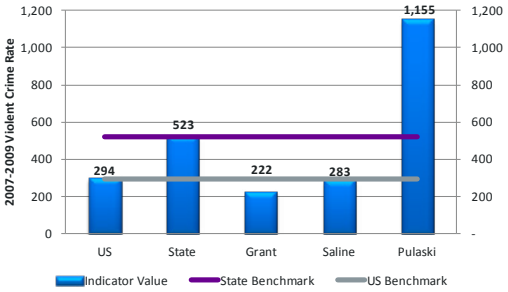


Source: County Health Rankings (BRFSS)
Notes: Percent of children that live in household headed by single parent

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

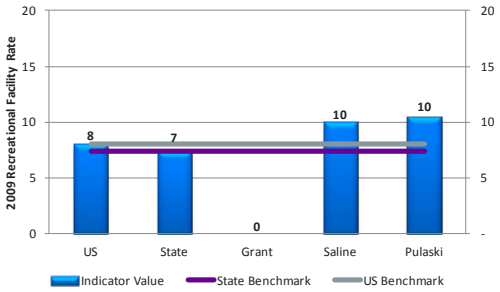
BHMC LITTLE ROCK: ENVIRONMENT

Violent Crime



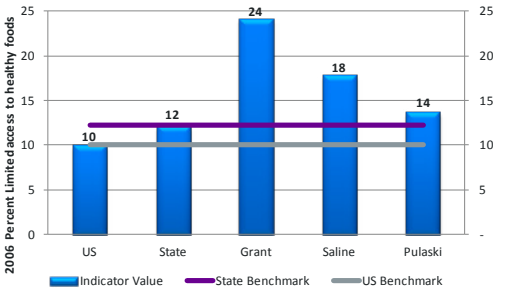
Source: County Health Rankings (BRFSS)
Notes: Violent crime rate per 100,000 population

Recreational Facilities



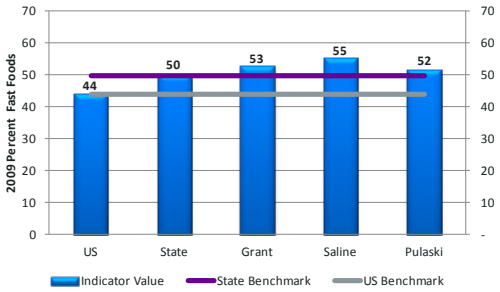
Source: County Health Rankings (Census County Business Patterns)
Notes: Rate of recreational facilities per 100,000 population

Access to Healthy Foods



Source: CHR (USDA)
Notes: Percent of population who are low-income and do not live close to a grocery store

Fast Food Restaurants



Source: CHR (USDA)
Notes: Percent of all restaurants that are fast-food establishments

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

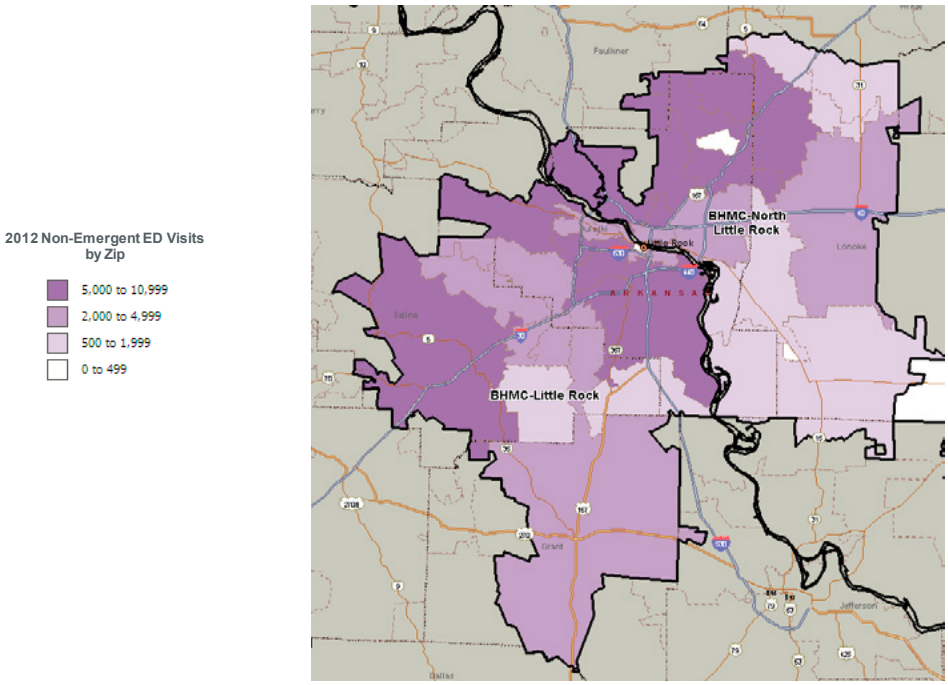
BHMC – LITTLE ROCK
CNI BARRIER SCORE BY ZIP CODE

Baptist Health Community	Zip	2011 Population	Overall CNI Score	Income Rank	Education Rank	Culture Rank	Insurance Rank	Housing Rank
BHMC Little Rock	72204	33,910	5	4	4	5	5	5
	72206	24,819	5	4	4	5	5	5
	72202	10,992	5	5	4	5	5	5
	72201	842	5	4	4	5	5	5
	72209	31,911	4	4	3	5	5	5
	72015	28,918	4	4	3	3	3	5
	72205	23,824	3	2	1	5	4	5
	72211	21,414	3	1	1	4	2	5
	72210	13,432	3	3	2	4	3	4
	72103	12,751	3	3	3	4	3	4
	72150	12,585	3	4	3	2	2	3
	72002	12,289	3	2	3	3	2	3
	72227	11,848	3	3	1	4	3	5
	72207	11,394	3	2	1	3	2	5
	72011	3,922	3	3	3	2	2	3
	72019	22,349	2	2	1	3	2	4
	72113	21,622	2	1	1	3	1	3
	72223	18,422	2	2	1	4	1	4
	72022	12,673	2	2	2	3	2	3
	72212	12,558	2	2	1	4	1	4
	72065	4,609	2	2	3	3	2	1

The CNI score is an average of five different barrier scores that measure various socio-economic indicators of each community. The CNI is strongly linked to variations in community healthcare needs and is a strong indicator of a community's demand for various healthcare services.

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BHMC – LITTLE ROCK & NORTH LITTLE ROCK NON-EMERGENT ED VISITS BY ZIP

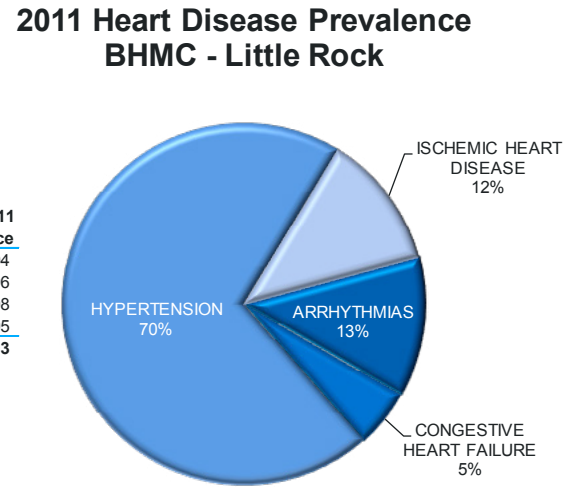


Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

Little Rock

Zip Code	2012 Total ED Visits	2012 Non-Emergent ED Visits	2012 % Non-Emergent	2017 Total ED Visits	2017 Non-Emergent ED Visits	2017 % Non-Emergent	2012 - 2017 % Chg Non-Emergent
72002	5,868	4,599	78%	6,614	5,052	76%	10%
72011	1,865	1,486	80%	2,142	1,672	78%	13%
72015	11,850	9,252	78%	13,338	10,201	76%	10%
72019	10,274	7,983	78%	11,646	8,855	76%	11%
72022	6,101	4,809	79%	7,006	5,407	77%	12%
72065	2,128	1,673	79%	2,359	1,814	77%	8%
72103	5,380	4,240	79%	5,764	4,431	77%	5%
72113	8,635	5,867	68%	10,301	6,844	66%	17%
72150	5,126	3,554	69%	5,591	3,764	67%	6%
72201	463	300	65%	543	329	61%	10%
72202	4,462	2,974	67%	4,726	2,976	63%	0%
72204	13,558	9,388	69%	14,446	9,619	67%	2%
72205	9,585	6,177	64%	9,888	6,160	62%	0%
72206	10,834	7,244	67%	11,439	7,381	65%	2%
72207	4,479	2,854	64%	4,602	2,865	62%	0%
72209	13,429	9,596	71%	14,343	9,854	69%	3%
72210	6,220	4,203	68%	7,164	4,700	66%	12%
72211	8,377	5,757	69%	9,082	6,076	67%	6%
72212	4,972	3,235	65%	5,344	3,435	64%	6%
72223	7,889	5,302	67%	9,212	6,092	66%	15%
72227	4,889	3,059	63%	5,029	3,065	61%	0%
Total	**146,384**	**103,552**	**71%**	**160,579**	**110,592**	**69%**	**7%**

BHMC – LITTLE ROCK
2011 ESTIMATED HEART DISEASE PREVALENCE



BHMC - Little Rock

Heart Disease Type	2011 Prevalence
ARRHYTHMIAS	14,394
CONGESTIVE HEART FAILURE	5,996
HYPERTENSION	80,908
ISCHEMIC HEART DISEASE	13,995
Grand Total	**115,293**

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

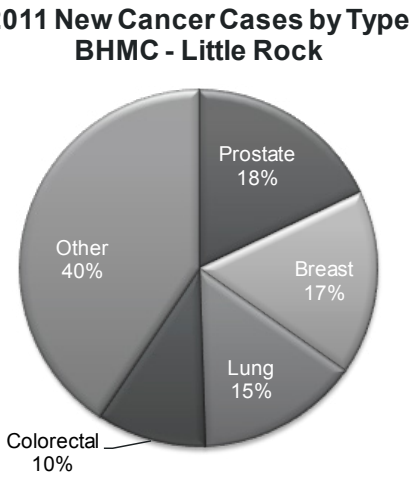
Little Rock

Zip Code	ARRHYTHMIAS 2011 Prevalence	CONGESTIVE HEART FAILURE 2011 Prevalence	HYPERTENSION 2011 Prevalence	ISCHEMIC HEART DISEASE 2011 Prevalence	TOTAL HEART DISEASE 2011 Prevalence
72002	480	189	2,554	447	3,670
72011	135	52	739	121	1,047
72015	1,225	476	6,004	1,122	8,827
72019	965	381	4,869	911	7,126
72022	506	197	2,591	463	3,757
72065	177	69	943	165	1,354
72103	484	188	2,547	444	3,663
72113	817	352	5,178	812	7,159
72150	576	258	3,184	672	4,690
72201	39	17	234	40	330
72202	518	221	2,826	511	4,076
72204	1,282	535	7,688	1,207	10,712
72205	1,209	518	6,469	1,192	9,388
72206	1,119	478	6,262	1,118	8,977
72207	563	242	3,072	562	4,439
72209	1,033	420	6,418	944	8,815
72210	544	233	3,277	544	4,598
72211	771	323	4,821	729	6,644
72212	593	259	3,380	610	4,842
72223	724	314	4,485	735	6,258
72227	634	274	3,367	646	4,921
Total	**14,394**	**5,996**	**80,908**	**13,995**	**115,293**

BHMC – LITTLE ROCK
2011 ESTIMATED CANCER INCIDENCE

BHMC - Little Rock

Cancer Type	2011 Incidence (new Cancer cases)
PROSTATE	378
BREAST	354
LUNG	309
OTHER	221
COLORECTAL	208
NH LYMPHOMA	82
KIDNEY	70
MELANOMA	67
BLADDER	62
LEUKEMIA	62
PANCREAS	57
ORAL CAVITY	51
UTERINE	46
STOMACH	34
OVARIAN	34
BRAIN	29
THYROID	29
CERVICAL	10
Grand Total	**2,103**

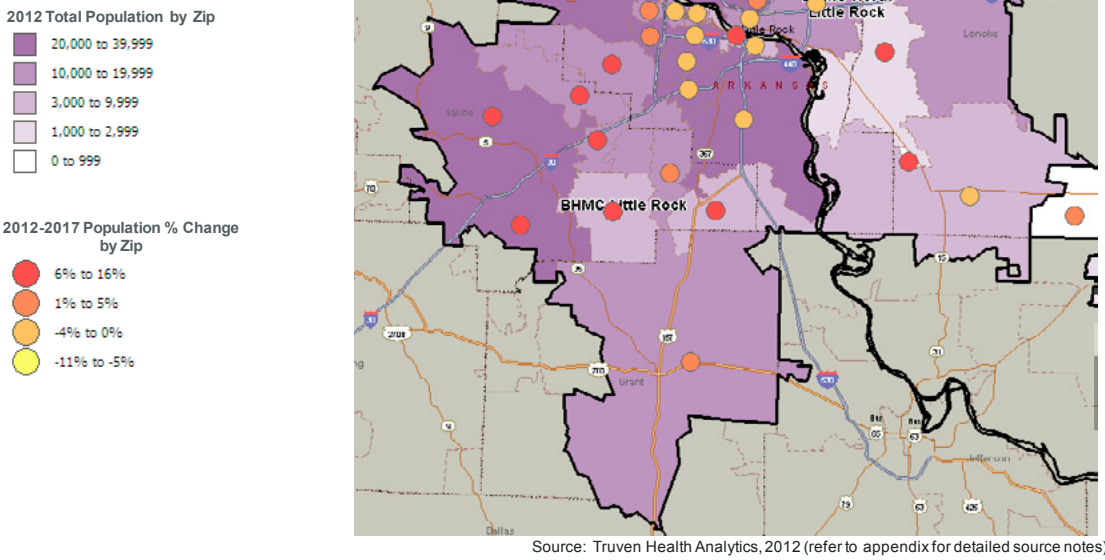


Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

Little Rock

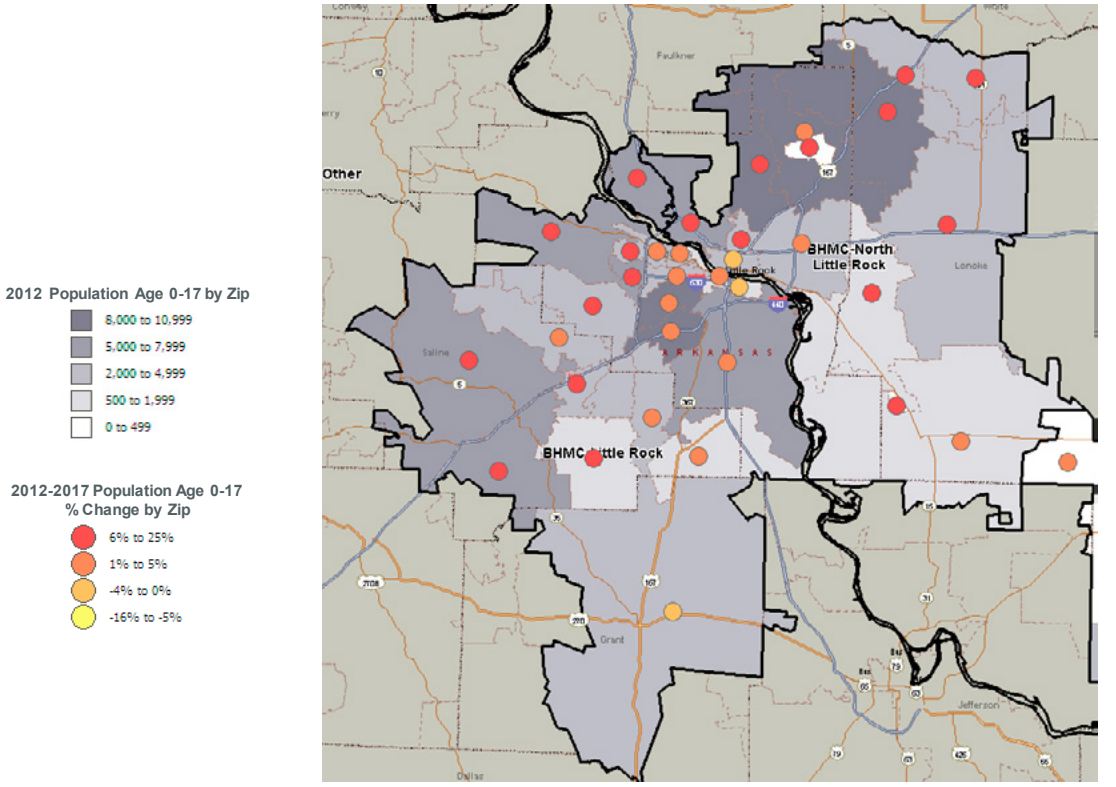
Zip Code	BREAST 2011 Incidence	COLORECTAL 2011 Incidence	LUNG 2011 Incidence	PROSTATE 2011 Incidence	OTHER 2011 Incidence
72002	12	7	10	13	30
72011	3	2	3	4	9
72015	29	18	25	30	73
72019	23	14	20	25	60
72022	12	7	10	13	31
72065	4	3	4	5	11
72103	12	7	10	13	30
72113	22	11	17	22	52
72150	13	9	13	15	35
72201	1	1	1	1	2
72202	12	8	12	15	28
72204	32	19	29	37	72
72205	30	17	26	28	68
72206	26	17	26	34	63
72207	14	8	12	13	33
72209	26	15	22	27	59
72210	14	8	12	15	33
72211	20	10	16	18	46
72212	15	8	13	16	36
72223	18	10	16	20	46
72227	15	9	14	15	37
Total	**354**	**208**	**309**	**378**	**855**

BHMC – LITTLE ROCK & NORTH LITTLE ROCK
2012 – 2017 TOTAL POPULATION



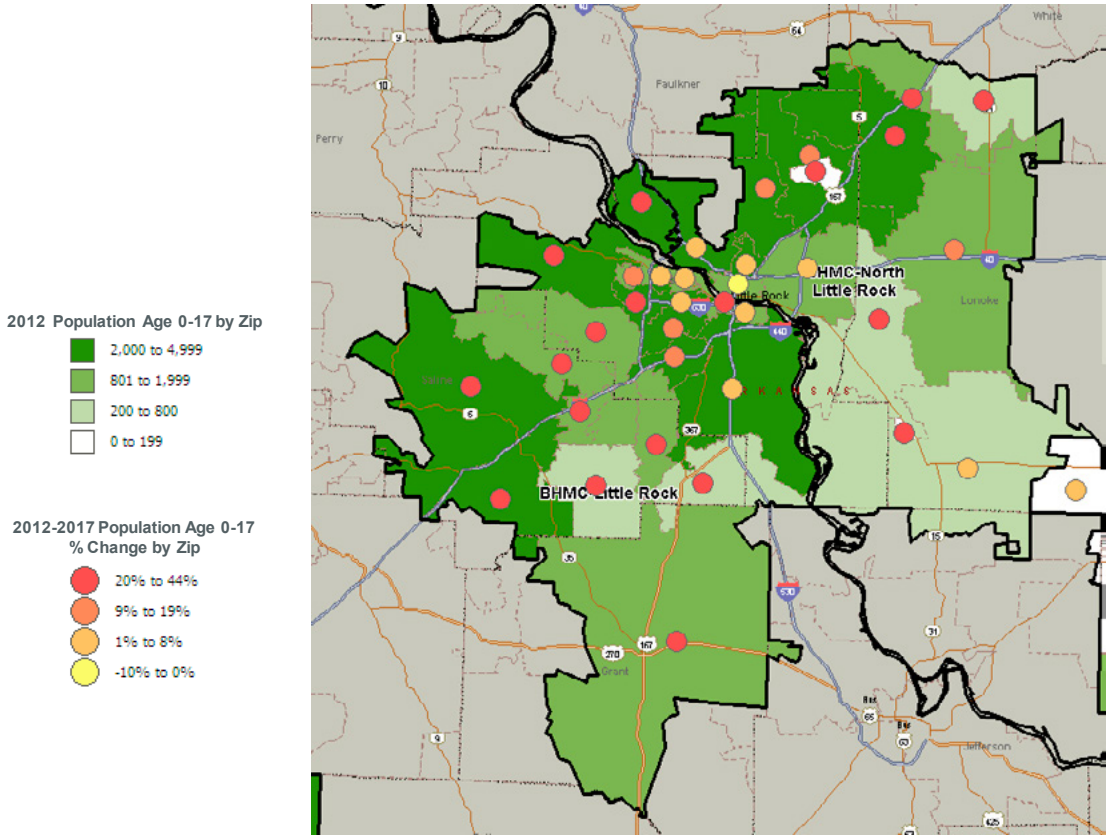
Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BHMC – LITTLE ROCK & NORTH LITTLE ROCK
2012 – 2017 POPULATION CHILDREN AGE 0-17



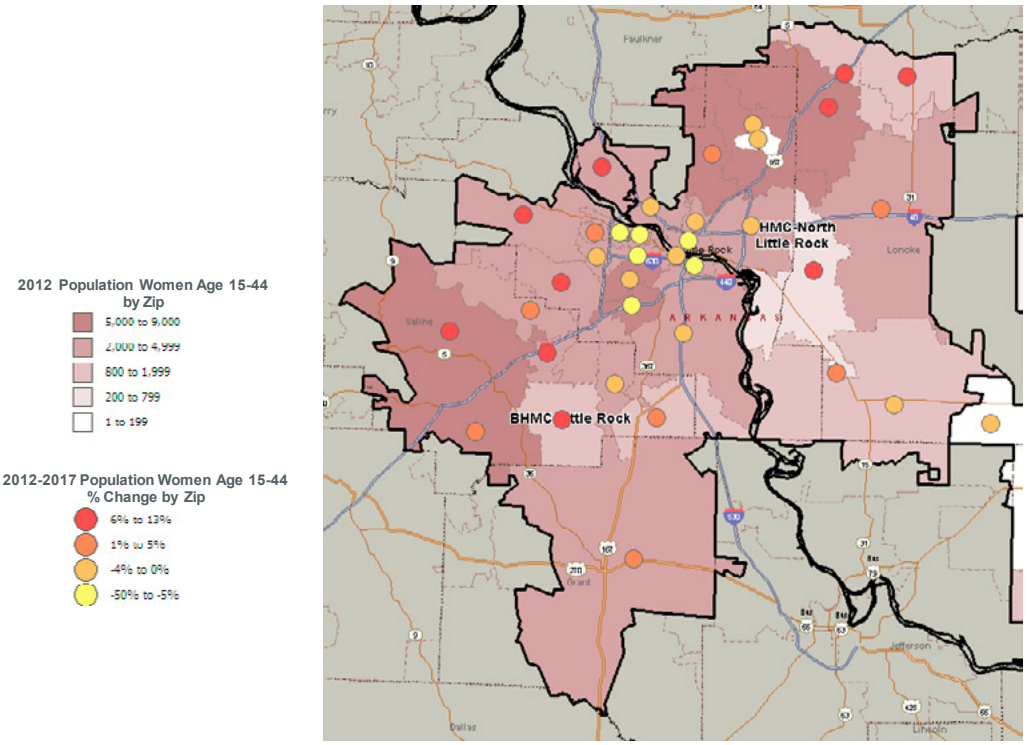
Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BHMC – LITTLE ROCK & NORTH LITTLE ROCK
2012 – 2017 POPULATION AGE 65+



Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BHMC – LITTLE ROCK & NORTH LITTLE ROCK
2012 – 2017 POPULATION WOMEN CHILDBEARING AGE



Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BHMC –LITTLE ROCK
2012 – 2017 POPULATION BY AGE GROUP BY ZIP

LITTLE ROCK

Zip Code	Age Group	2000 Population	2012 Population	2017 Population	2012-2017 Change
72002	00-17	2,849	3,503	3,658	4%
72002	18-44	4,304	5,382	5,651	5%
72002	45-64	2,659	4,048	4,491	11%
72002	65+	894	1,383	1,912	38%
72011	00-17	946	1,197	1,284	7%
72011	18-44	1,361	1,817	1,944	7%
72011	45-64	645	1,132	1,351	19%
72011	65+	227	357	497	39%
72015	00-17	5,451	7,286	7,799	7%
72015	18-44	8,579	10,714	11,127	4%
72015	45-64	4,677	6,809	7,747	14%
72015	65+	3,022	3,338	4,009	20%
72019	00-17	4,853	5,945	6,385	7%
72019	18-44	7,003	9,272	9,987	8%
72019	45-64	4,691	7,112	7,700	8%
72019	65+	2,169	2,784	3,738	34%
72022	00-17	2,772	3,901	4,240	9%
72022	18-44	3,841	5,527	5,966	8%
72022	45-64	2,259	3,865	4,432	15%
72022	65+	1,040	1,407	1,886	34%
72065	00-17	1,022	1,211	1,259	4%
72065	18-44	1,705	2,142	2,201	3%
72065	45-64	1,008	1,426	1,539	8%
72065	65+	319	473	657	39%
72103	00-17	3,284	3,384	3,421	1%
72103	18-44	4,822	4,934	4,884	-1%
72103	45-64	2,861	3,383	3,520	4%
72103	65+	973	1,239	1,615	30%

LITTLE ROCK

Zip Code	Age Group	2000 Population	2012 Population	2017 Population	2012-2017 Change
72113	00-17	3,429	5,977	7,033	18%
72113	18-44	5,235	7,442	8,081	9%
72113	45-64	3,309	6,899	7,708	12%
72113	65+	880	2,202	3,099	41%
72150	00-17	2,966	3,011	2,954	-2%
72150	18-44	4,318	4,361	4,453	2%
72150	45-64	2,765	3,528	3,696	5%
72150	65+	1,392	1,689	2,061	22%
72201	00-17	60	101	105	4%
72201	18-44	424	433	431	0%
72201	45-64	187	302	341	13%
72201	65+	80	142	174	23%
72202	00-17	2,381	1,864	1,857	0%
72202	18-44	4,782	3,995	3,705	-7%
72202	45-64	2,564	2,352	2,319	-1%
72202	65+	1,569	1,412	1,475	4%
72204	00-17	8,717	8,249	8,499	3%
72204	18-44	14,035	13,066	12,682	-3%
72204	45-64	6,657	7,328	7,118	-3%
72204	65+	3,449	3,489	3,819	9%
72205	00-17	4,327	4,477	4,573	2%
72205	18-44	10,435	8,681	8,000	-8%
72205	45-64	5,064	5,939	5,978	1%
72205	65+	3,915	3,646	3,935	8%
72206	00-17	6,926	6,094	6,242	2%
72206	18-44	10,389	9,461	9,299	-2%
72206	45-64	6,688	6,545	6,181	-6%
72206	65+	3,572	3,526	3,768	7%

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

LITTLE ROCK

Zip Code	Age Group	2000 Population	2012 Population	2017 Population	2012-2017 Change
72207	00-17	2,140	2,426	2,518	4%
72207	18-44	4,549	3,770	3,465	-8%
72207	45-64	2,693	3,087	3,145	2%
72207	65+	1,777	1,765	1,899	8%
72209	00-17	10,299	10,088	10,195	1%
72209	18-44	13,156	12,830	12,467	-3%
72209	45-64	5,671	6,689	6,754	1%
72209	65+	2,575	2,787	3,093	11%
72210	00-17	2,600	3,915	4,519	15%
72210	18-44	4,433	5,583	5,913	6%
72210	45-64	2,868	4,397	4,642	6%
72210	65+	932	1,752	2,282	30%
72211	00-17	3,963	5,441	5,977	10%
72211	18-44	8,996	8,414	8,047	-4%
72211	45-64	3,737	5,458	6,006	10%
72211	65+	1,612	2,024	2,506	24%
72212	00-17	2,679	2,997	3,314	11%
72212	18-44	3,636	3,919	4,077	4%
72212	45-64	3,365	3,808	3,588	-6%
72212	65+	1,329	1,769	2,063	17%
72223	00-17	3,490	5,589	6,445	15%
72223	18-44	4,917	6,325	6,946	10%
72223	45-64	3,376	6,238	6,640	6%
72223	65+	992	2,257	2,966	31%
72227	00-17	2,381	2,238	2,345	5%
72227	18-44	4,315	3,975	3,804	-4%
72227	45-64	3,207	3,286	3,111	-5%
72227	65+	1,939	2,143	2,314	8%

BHMC – LITTLE ROCK
2012 – 2017 WOMEN CHILDBEARING AGE BY ZIP

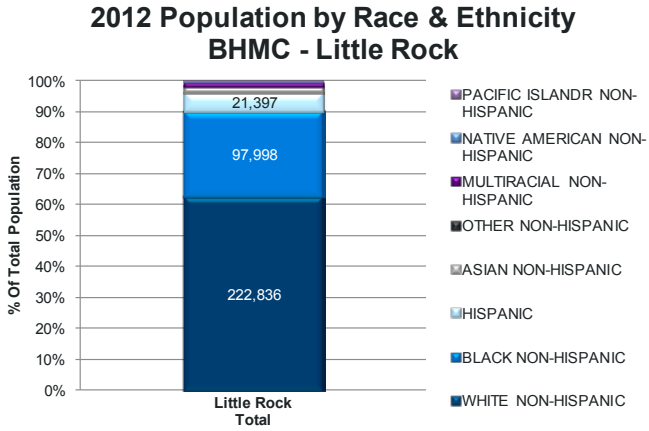
BHMC-LITTLE ROCK

Zip Code	2012 Population	2017 Population	2012-2017 Change
72002	2,972	3,104	4%
72011	1,015	1,087	7%
72015	5,778	6,112	5%
72019	5,081	5,502	8%
72022	3,192	3,465	8%
72065	1,043	1,075	3%
72103	2,756	2,719	-1%
72113	4,268	4,613	7%
72150	2,462	2,493	1%
72201	196	196	0%
72202	2,170	2,007	-8%
72204	7,146	6,874	-4%
72205	4,747	4,410	-8%
72206	4,975	4,800	-4%
72207	2,205	2,061	-7%
72209	7,748	7,422	-4%
72210	3,226	3,442	6%
72211	4,796	4,659	-3%
72212	2,345	2,402	2%
72223	3,792	4,079	7%
72227	2,281	2,189	-4%
TOTAL	**74,194**	**74,711**	**0.7%**

Note: women childbearing age = females age 15-44

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BHMC –LITTLE ROCK
2012-2017 POPULATION BY RACE & ETHNICITY



BHMC-Little Rock

Race/Ethnicity	2012 Population	2017 Population	2012-2017 Population Change	2012-2017 Population % Chg
WHITE NON-HISPANIC	222,836	225,977	3,141	1%
BLACK NON-HISPANIC	97,998	105,106	7,108	7%
HISPANIC	21,397	27,935	6,538	31%
ASIAN NON-HISPANIC	7,215	8,827	1,612	22%
OTHER NON-HISPANIC	462	586	124	27%
MULTIRACIAL NON-HISPANIC	4,917	5,701	784	16%
NATIVE AMERICAN NON-HISPANIC	1,241	1,296	55	4%
PACIFIC ISLANDR NON-HISPANIC	86	99	13	15%
Grand Total	**356,152**	**375,527**	**19,375**	**5%**

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BHMC –LITTLE ROCK
RACE & ETHNICITY BY ZIP

BHMC-Little Rock

Zip Code	Ethnicity	2000 Population	2012 Population	2017 Population	2012-2017 Change
72002	ASIAN NON-HISPANIC	54	94	111	18%
72002	BLACK NON-HISPANIC	308	1,364	1,867	37%
72002	HISPANIC	138	965	1,388	44%
72002	MULTIRACIAL NON-HISPANIC	103	213	266	25%
72002	NATIVE AMERICAN NON-HISPANIC	72	76	76	0%
72002	OTHER NON-HISPANIC	2	13	17	31%
72002	PACIFIC ISLANDR NON-HISPANIC	1	1	1	0%
72002	WHITE NON-HISPANIC	10,028	11,590	11,986	3%
72011	ASIAN NON-HISPANIC	5	12	15	25%
72011	BLACK NON-HISPANIC	19	99	141	42%
72011	HISPANIC	36	170	242	42%
72011	MULTIRACIAL NON-HISPANIC	14	44	61	39%
72011	NATIVE AMERICAN NON-HISPANIC	19	18	16	-11%
72011	OTHER NON-HISPANIC	3	1	2	100%
72011	PACIFIC ISLANDR NON-HISPANIC	1	-	-	0%
72011	WHITE NON-HISPANIC	3,082	4,159	4,599	11%
72015	ASIAN NON-HISPANIC	75	183	239	31%
72015	BLACK NON-HISPANIC	1,036	1,635	1,991	22%
72015	HISPANIC	425	1,313	1,734	32%
72015	MULTIRACIAL NON-HISPANIC	229	372	444	19%
72015	NATIVE AMERICAN NON-HISPANIC	96	164	193	18%
72015	OTHER NON-HISPANIC	5	28	40	43%
72015	PACIFIC ISLANDR NON-HISPANIC	6	6	4	-33%
72015	WHITE NON-HISPANIC	19,857	24,446	26,037	7%
72019	ASIAN NON-HISPANIC	85	183	236	29%
72019	BLACK NON-HISPANIC	157	699	975	39%
72019	HISPANIC	198	750	1,068	42%
72019	MULTIRACIAL NON-HISPANIC	131	243	294	21%
72019	NATIVE AMERICAN NON-HISPANIC	73	72	77	7%
72019	OTHER NON-HISPANIC	3	6	8	33%
72019	PACIFIC ISLANDR NON-HISPANIC	14	1	1	0%
72019	WHITE NON-HISPANIC	18,055	23,159	25,151	9%

BHMC-Little Rock

Zip Code	Ethnicity	2000 Population	2012 Population	2017 Population	2012-2017 Change
72022	ASIAN NON-HISPANIC	98	265	352	33%
72022	BLACK NON-HISPANIC	236	1,262	1,798	42%
72022	HISPANIC	105	871	1,289	48%
72022	MULTIRACIAL NON-HISPANIC	75	200	256	28%
72022	NATIVE AMERICAN NON-HISPANIC	42	71	80	13%
72022	OTHER NON-HISPANIC	2	26	36	38%
72022	PACIFIC ISLANDR NON-HISPANIC	-	1	-	-100%
72022	WHITE NON-HISPANIC	9,354	12,004	12,713	6%
72065	ASIAN NON-HISPANIC	40	99	125	26%
72065	BLACK NON-HISPANIC	321	493	527	7%
72065	HISPANIC	36	147	198	35%
72065	MULTIRACIAL NON-HISPANIC	60	62	62	0%
72065	NATIVE AMERICAN NON-HISPANIC	20	22	21	-5%
72065	OTHER NON-HISPANIC	-	6	8	33%
72065	PACIFIC ISLANDR NON-HISPANIC	-	-	1	0%
72065	WHITE NON-HISPANIC	3,577	4,423	4,714	7%
72103	ASIAN NON-HISPANIC	99	140	156	11%
72103	BLACK NON-HISPANIC	1,786	2,624	2,862	9%
72103	HISPANIC	211	1,096	1,443	32%
72103	MULTIRACIAL NON-HISPANIC	152	196	220	12%
72103	NATIVE AMERICAN NON-HISPANIC	59	66	72	9%
72103	OTHER NON-HISPANIC	4	13	15	15%
72103	PACIFIC ISLANDR NON-HISPANIC	1	5	5	0%
72103	WHITE NON-HISPANIC	9,628	8,800	8,667	-2%
72113	ASIAN NON-HISPANIC	96	517	729	41%
72113	BLACK NON-HISPANIC	1,026	3,543	4,888	38%
72113	HISPANIC	230	803	1,125	40%
72113	MULTIRACIAL NON-HISPANIC	127	334	437	31%
72113	NATIVE AMERICAN NON-HISPANIC	64	78	75	-4%
72113	OTHER NON-HISPANIC	3	47	68	45%
72113	PACIFIC ISLANDR NON-HISPANIC	-	12	17	42%
72113	WHITE NON-HISPANIC	11,307	17,186	18,582	8%

BHMC-Little Rock

Zip Code	Ethnicity	2000 Population	2012 Population	2017 Population	2012-2017 Change
72150	ASIAN NON-HISPANIC	18	44	57	30%
72150	BLACK NON-HISPANIC	123	171	190	11%
72150	HISPANIC	75	221	289	31%
72150	MULTIRACIAL NON-HISPANIC	67	126	149	18%
72150	NATIVE AMERICAN NON-HISPANIC	43	51	55	8%
72150	OTHER NON-HISPANIC	2	2	2	0%
72150	PACIFIC ISLANDR NON-HISPANIC	3	-	-	0%
72150	WHITE NON-HISPANIC	11,110	11,974	12,422	4%
72201	ASIAN NON-HISPANIC	4	14	18	29%
72201	BLACK NON-HISPANIC	395	287	241	-16%
72201	HISPANIC	14	31	42	35%
72201	MULTIRACIAL NON-HISPANIC	8	16	20	25%
72201	NATIVE AMERICAN NON-HISPANIC	4	5	4	-20%
72201	OTHER NON-HISPANIC	1	1	1	0%
72201	PACIFIC ISLANDR NON-HISPANIC	-	-	-	0%
72201	WHITE NON-HISPANIC	325	624	725	16%
72202	ASIAN NON-HISPANIC	73	186	218	17%
72202	BLACK NON-HISPANIC	7,024	5,264	4,898	-7%
72202	HISPANIC	164	264	312	18%
72202	MULTIRACIAL NON-HISPANIC	104	150	170	13%
72202	NATIVE AMERICAN NON-HISPANIC	34	31	28	-10%
72202	OTHER NON-HISPANIC	10	10	12	20%
72202	PACIFIC ISLANDR NON-HISPANIC	2	6	7	17%
72202	WHITE NON-HISPANIC	3,885	3,712	3,711	0%
72204	ASIAN NON-HISPANIC	351	391	409	5%
72204	BLACK NON-HISPANIC	22,198	22,184	22,340	1%
72204	HISPANIC	993	2,479	3,166	28%
72204	MULTIRACIAL NON-HISPANIC	361	520	582	12%
72204	NATIVE AMERICAN NON-HISPANIC	76	88	89	1%
72204	OTHER NON-HISPANIC	27	67	80	19%
72204	PACIFIC ISLANDR NON-HISPANIC	11	2	3	50%
72204	WHITE NON-HISPANIC	8,841	6,401	5,449	-15%

BHMC-Little Rock

Zip Code	Ethnicity	2000 Population	2012 Population	2017 Population	2012-2017 Change
72205	ASIAN NON-HISPANIC	355	552	606	10%
72205	BLACK NON-HISPANIC	5,614	6,420	6,758	5%
72205	HISPANIC	431	797	971	22%
72205	MULTIRACIAL NON-HISPANIC	269	362	398	10%
72205	NATIVE AMERICAN NON-HISPANIC	63	85	93	9%
72205	OTHER NON-HISPANIC	21	37	43	16%
72205	PACIFIC ISLANDR NON-HISPANIC	6	8	9	13%
72205	WHITE NON-HISPANIC	16,982	14,482	13,608	-6%
72206	ASIAN NON-HISPANIC	108	185	216	17%
72206	BLACK NON-HISPANIC	14,717	12,563	12,234	-3%
72206	HISPANIC	357	1,097	1,436	31%
72206	MULTIRACIAL NON-HISPANIC	286	434	492	13%
72206	NATIVE AMERICAN NON-HISPANIC	84	84	88	5%
72206	OTHER NON-HISPANIC	12	15	18	20%
72206	PACIFIC ISLANDR NON-HISPANIC	4	13	14	8%
72206	WHITE NON-HISPANIC	12,007	11,235	10,992	-2%
72207	ASIAN NON-HISPANIC	136	127	121	-5%
72207	BLACK NON-HISPANIC	754	1,405	1,637	17%
72207	HISPANIC	114	243	301	24%
72207	MULTIRACIAL NON-HISPANIC	87	141	164	16%
72207	NATIVE AMERICAN NON-HISPANIC	21	30	35	17%
72207	OTHER NON-HISPANIC	9	6	8	33%
72207	PACIFIC ISLANDR NON-HISPANIC	3	2	3	50%
72207	WHITE NON-HISPANIC	10,035	9,094	8,758	-4%
72209	ASIAN NON-HISPANIC	231	126	106	-16%
72209	BLACK NON-HISPANIC	19,372	21,177	20,936	-1%
72209	HISPANIC	1,810	6,565	8,104	23%
72209	MULTIRACIAL NON-HISPANIC	445	391	359	-8%
72209	NATIVE AMERICAN NON-HISPANIC	76	65	55	-15%
72209	OTHER NON-HISPANIC	29	55	62	13%
72209	PACIFIC ISLANDR NON-HISPANIC	8	5	6	20%
72209	WHITE NON-HISPANIC	9,730	4,010	2,881	-28%

BHMC-Little Rock

Zip Code	Ethnicity	2000 Population	2012 Population	2017 Population	2012-2017 Change
72210	ASIAN NON-HISPANIC	90	475	642	35%
72210	BLACK NON-HISPANIC	1,416	5,547	7,404	33%
72210	HISPANIC	167	1,131	1,629	44%
72210	MULTIRACIAL NON-HISPANIC	98	237	297	25%
72210	NATIVE AMERICAN NON-HISPANIC	60	51	44	-14%
72210	OTHER NON-HISPANIC	5	26	33	27%
72210	PACIFIC ISLANDR NON-HISPANIC	-	1	2	100%
72210	WHITE NON-HISPANIC	8,997	8,179	7,305	-11%
72211	ASIAN NON-HISPANIC	712	1,713	2,131	24%
72211	BLACK NON-HISPANIC	2,513	4,771	5,654	19%
72211	HISPANIC	437	1,124	1,468	31%
72211	MULTIRACIAL NON-HISPANIC	214	325	388	19%
72211	NATIVE AMERICAN NON-HISPANIC	49	53	53	0%
72211	OTHER NON-HISPANIC	17	47	59	26%
72211	PACIFIC ISLANDR NON-HISPANIC	5	13	15	15%
72211	WHITE NON-HISPANIC	14,361	13,291	12,768	-4%
72212	ASIAN NON-HISPANIC	401	597	680	14%
72212	BLACK NON-HISPANIC	896	1,698	2,015	19%
72212	HISPANIC	131	282	368	30%
72212	MULTIRACIAL NON-HISPANIC	102	162	189	17%
72212	NATIVE AMERICAN NON-HISPANIC	21	28	29	4%
72212	OTHER NON-HISPANIC	4	10	12	20%
72212	PACIFIC ISLANDR NON-HISPANIC	1	3	4	33%
72212	WHITE NON-HISPANIC	9,453	9,713	9,745	0%

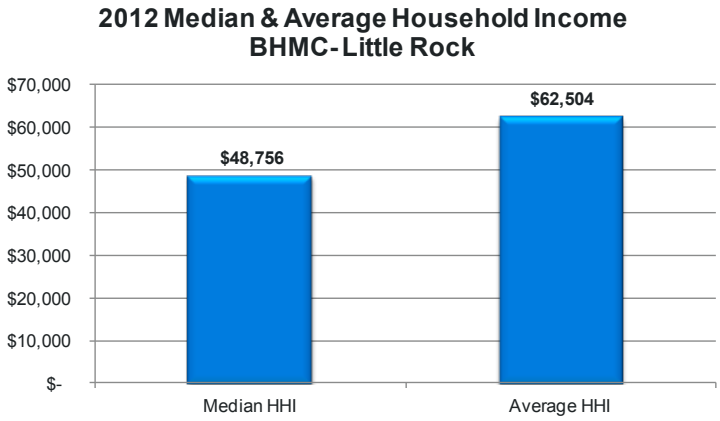
BHMC-Little Rock

Zip Code	Ethnicity	2000 Population	2012 Population	2017 Population	2012-2017 Change
72223	ASIAN NON-HISPANIC	344	1,129	1,504	33%
72223	BLACK NON-HISPANIC	860	2,159	2,755	28%
72223	HISPANIC	172	469	651	39%
72223	MULTIRACIAL NON-HISPANIC	130	239	293	23%
72223	NATIVE AMERICAN NON-HISPANIC	41	74	84	14%
72223	OTHER NON-HISPANIC	13	38	54	42%
72223	PACIFIC ISLANDR NON-HISPANIC	1	6	6	0%
72223	WHITE NON-HISPANIC	11,214	16,295	17,650	8%
72227	ASIAN NON-HISPANIC	270	183	156	-15%
72227	BLACK NON-HISPANIC	1,597	2,633	2,995	14%
72227	HISPANIC	282	579	711	23%
72227	MULTIRACIAL NON-HISPANIC	116	150	160	7%
72227	NATIVE AMERICAN NON-HISPANIC	25	29	29	0%
72227	OTHER NON-HISPANIC	12	8	8	0%
72227	PACIFIC ISLANDR NON-HISPANIC	1	1	1	0%
72227	WHITE NON-HISPANIC	9,539	8,059	7,514	-7%

BHMC – LITTLE ROCK
HOUSEHOLD INCOME

BHMC-LITTLE ROCK

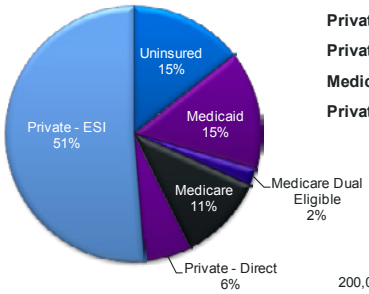
Zip Code	2012 Total Households	2012 Average Household Income	2012 Median Household Income
72002	5,355	$54,340	$46,974
72011	1,626	$53,327	$47,931
72015	10,583	$51,882	$43,648
72019	9,639	$65,603	$52,846
72022	5,919	$62,862	$54,434
72065	1,830	$61,807	$56,670
72103	4,836	$48,600	$41,816
72113	9,451	$85,085	$69,096
72150	4,960	$55,778	$45,146
72201	611	$36,477	$24,928
72202	5,143	$42,521	$24,299
72204	12,033	$39,864	$31,844
72205	11,071	$54,534	$41,054
72206	10,176	$44,143	$34,522
72207	5,471	$86,968	$57,507
72209	11,674	$39,117	$31,672
72210	6,483	$64,564	$51,125
72211	9,932	$71,734	$56,961
72212	5,229	$103,138	$76,206
72223	7,976	$115,345	$85,828
72227	5,420	$74,891	$49,362



Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BHMC – LITTLE ROCK
INSURANCE COVERAGE

2012 Insurance Coverage by Insurance Type
BHMC - Little Rock



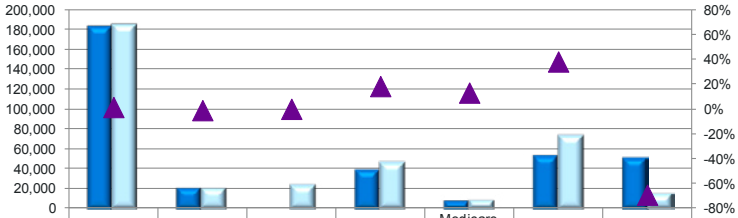
Private ESI (Employer Sponsored Insurance) = Plans offered through an employer

Private Exchanges = Plans purchased via an insurance exchange or insurance market place

Medicare Dual Eligible = Medicare enrollees receiving additional benefits via Medicaid

Private Direct = Individuals who purchase insurance directly from an insurance provider

2012 - 2017 Insurance Coverage
BHMC - Little Rock



	Private ESI	Private Direct	Private Exchange	Medicare	Medicare Dual Eligible	Medicaid	Uninsured
2012 Covered Lives	182,585	21,483	0	39,353	8,130	53,227	51,375
2017 Covered Lives	185,224	21,254	23,944	46,566	9,195	73,538	15,810
% Chg	1%	-1%	0%	18%	13%	38%	-69%

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BHMC – LITTLE ROCK
INSURANCE COVERAGE BY ZIP

BHMC-Little Rock

Zip Code	Insurance Type	2012 Covered Lives	2017 Covered Lives	% Chg
72002	Private - ESI	8,829	9,195	4%
72002	Private - Direct	1,033	1,051	2%
72002	Private - Exchange	0	930	N/A
72002	Medicare	1,077	1,481	38%
72002	Medicare Dual Eligible	139	185	33%
72002	Medicaid	1,746	2,348	34%
72002	Uninsured	1,492	522	-65%
72011	Private - ESI	3,052	3,268	7%
72011	Private - Direct	358	377	5%
72011	Private - Exchange	0	294	N/A
72011	Medicare	277	385	39%
72011	Medicare Dual Eligible	37	51	38%
72011	Medicaid	421	578	37%
72011	Uninsured	359	123	-66%
72015	Private - ESI	15,276	16,027	5%
72015	Private - Direct	1,796	1,819	1%
72015	Private - Exchange	0	1,988	N/A
72015	Medicare	2,609	3,135	20%
72015	Medicare Dual Eligible	325	389	20%
72015	Medicaid	4,388	6,042	38%
72015	Uninsured	3,752	1,283	-66%
72019	Private - ESI	16,261	17,053	5%
72019	Private - Direct	1,907	1,970	3%
72019	Private - Exchange	0	1,485	N/A
72019	Medicare	2,175	2,906	34%
72019	Medicare Dual Eligible	274	357	30%
72019	Medicaid	2,424	3,303	36%
72019	Uninsured	2,072	736	-64%

BHMC-Little Rock

Zip Code	Insurance Type	2012 Covered Lives	2017 Covered Lives	% Chg
72022	Private - ESI	9,294	9,979	7%
72022	Private - Direct	1,089	1,153	6%
72022	Private - Exchange	0	937	N/A
72022	Medicare	1,096	1,464	34%
72022	Medicare Dual Eligible	143	185	29%
72022	Medicaid	1,661	2,285	38%
72022	Uninsured	1,420	521	-63%
72065	Private - ESI	3,429	3,493	2%
72065	Private - Direct	404	406	0%
72065	Private - Exchange	0	332	N/A
72065	Medicare	368	507	38%
72065	Medicare Dual Eligible	48	64	33%
72065	Medicaid	541	699	29%
72065	Uninsured	463	156	-66%
72103	Private - ESI	7,762	7,635	-2%
72103	Private - Direct	911	868	-5%
72103	Private - Exchange	0	824	N/A
72103	Medicare	965	1,250	30%
72103	Medicare Dual Eligible	124	156	26%
72103	Medicaid	1,712	2,241	31%
72103	Uninsured	1,463	468	-68%
72113	Private - ESI	14,506	15,711	8%
72113	Private - Direct	1,702	1,846	8%
72113	Private - Exchange	0	1,339	N/A
72113	Medicare	2,218	3,057	38%
72113	Medicare Dual Eligible	514	654	27%
72113	Medicaid	1,784	2,628	47%
72113	Uninsured	1,794	687	-62%

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BHMC-Little Rock

Zip Code	Insurance Type	2012 Covered Lives	2017 Covered Lives	% Chg
72150	Private - ESI	6,855	6,765	-1%
72150	Private - Direct	806	774	-4%
72150	Private - Exchange	0	760	N/A
72150	Medicare	1,617	1,953	21%
72150	Medicare Dual Eligible	331	388	17%
72150	Medicaid	1,587	2,081	31%
72150	Uninsured	1,392	444	-68%
72201	Private - ESI	115	124	8%
72201	Private - Direct	14	13	-7%
72201	Private - Exchange	0	88	N/A
72201	Medicare	143	177	24%
72201	Medicare Dual Eligible	34	39	15%
72201	Medicaid	336	507	51%
72201	Uninsured	338	103	-70%
72202	Private - ESI	1,170	1,142	-2%
72202	Private - Direct	138	119	-14%
72202	Private - Exchange	0	788	N/A
72202	Medicare	1,431	1,503	5%
72202	Medicare Dual Eligible	322	336	4%
72202	Medicaid	3,272	4,579	40%
72202	Uninsured	3,290	891	-73%
72204	Private - ESI	10,891	10,507	-4%
72204	Private - Direct	1,289	1,166	-10%
72204	Private - Exchange	0	2,733	N/A
72204	Medicare	3,506	3,835	9%
72204	Medicare Dual Eligible	823	879	7%
72204	Medicaid	7,790	10,846	39%
72204	Uninsured	7,834	2,154	-73%

BHMC-Little Rock

Zip Code	Insurance Type	2012 Covered Lives	2017 Covered Lives	% Chg
72205	Private - ESI	9,740	9,167	-6%
72205	Private - Direct	1,148	1,036	-10%
72205	Private - Exchange	0	1,504	N/A
72205	Medicare	3,671	3,965	8%
72205	Medicare Dual Eligible	853	900	6%
72205	Medicaid	3,656	4,876	33%
72205	Uninsured	3,675	1,038	-72%
72206	Private - ESI	8,485	8,130	-4%
72206	Private - Direct	1,003	907	-10%
72206	Private - Exchange	0	2,051	N/A
72206	Medicare	3,577	3,818	7%
72206	Medicare Dual Eligible	798	836	5%
72206	Medicaid	5,865	8,054	37%
72206	Uninsured	5,898	1,692	-71%
72207	Private - ESI	5,983	5,672	-5%
72207	Private - Direct	705	657	-7%
72207	Private - Exchange	0	572	N/A
72207	Medicare	1,782	1,919	8%
72207	Medicare Dual Eligible	409	432	6%
72207	Medicaid	1,083	1,429	32%
72207	Uninsured	1,089	346	-68%
72209	Private - ESI	12,653	12,243	-3%
72209	Private - Direct	1,492	1,353	-9%
72209	Private - Exchange	0	2,690	N/A
72209	Medicare	2,793	3,095	11%
72209	Medicare Dual Eligible	665	721	8%
72209	Medicaid	7,376	10,325	40%
72209	Uninsured	7,416	2,080	-72%

BHMC-Little Rock

Zip Code	Insurance Type	2012 Covered Lives	2017 Covered Lives	% Chg
72210	Private - ESI	8,480	8,901	5%
72210	Private - Direct	999	1,028	3%
72210	Private - Exchange	0	1,061	N/A
72210	Medicare	1,771	2,269	28%
72210	Medicare Dual Eligible	404	488	21%
72210	Medicaid	1,990	2,921	47%
72210	Uninsured	2,001	689	-66%
72211	Private - ESI	13,260	13,259	0%
72211	Private - Direct	1,564	1,539	-2%
72211	Private - Exchange	0	1,262	N/A
72211	Medicare	2,022	2,482	23%
72211	Medicare Dual Eligible	489	567	16%
72211	Medicaid	1,995	2,778	39%
72211	Uninsured	2,007	647	-68%
72212	Private - ESI	7,870	7,750	-2%
72212	Private - Direct	928	919	-1%
72212	Private - Exchange	0	579	N/A
72212	Medicare	1,795	2,069	15%
72212	Medicare Dual Eligible	399	437	10%
72212	Medicaid	748	1,029	38%
72212	Uninsured	752	257	-66%

BHMC-Little Rock

Zip Code	Insurance Type	2012 Covered Lives	2017 Covered Lives	% Chg
72223	Private - ESI	13,288	14,131	6%
72223	Private - Direct	1,561	1,668	7%
72223	Private - Exchange	0	1,063	N/A
72223	Medicare	2,284	2,959	30%
72223	Medicare Dual Eligible	516	624	21%
72223	Medicaid	1,375	2,025	47%
72223	Uninsured	1,383	527	-62%
72227	Private - ESI	5,386	5,072	-6%
72227	Private - Direct	636	585	-8%
72227	Private - Exchange	0	664	N/A
72227	Medicare	2,176	2,337	7%
72227	Medicare Dual Eligible	483	507	5%
72227	Medicaid	1,477	1,964	33%
72227	Uninsured	1,485	446	-70%
BHMC-Little Rock Total		**356,153**	**375,531**	**5%**

Interview & Focus Group Analysis

INTERVIEW ANALYSIS APPROACH

- Coded participants and consolidated interview responses
- Participant responses were parsed by question/topic and categorized
    - Participants gave multiple responses per question – each response recorded individually
    - Therefore, response count can be greater than number of participants
- Density analysis conducted on responses by category

Interview questions were designed to approach some subjects in a multitude of ways and give the interviewer flexibility in conducting the interview. Therefore not every question is represented with a response table as some question responses were collapsed while others eliminated due to time constraints. Additionally some questions were not designed for response consolidation but used to inform other sections of the analysis.

BHMC LITTLE ROCK INTERVIEW SUMMARY

Questions 1 and 2 were background/ice-breaker questions regarding the community or organization each person represented.

03. What would you say is the current health status of the community?

Response Category	Response Count	Percent of Responses
Fair	17	46%
Poor	10	27%
Good	5	14%
Good-Fair	3	8%
Fair-Poor	1	3%
Other	1	3%
Grand Total	**37**	**100%**

03a. Reasoning?

Response Category	Response Count	Percent of Responses
Prevention/Lifestyle	5	17%
Lack of Access to Healthcare	4	13%
Obesity	4	13%
Chronic/Other Diseases	3	10%
Smoking	2	7%
Other	2	7%
Unhealthy Population	2	7%
Health Disparities	2	7%
Alcohol/Drug Abuse	1	3%
Good Access to Healthcare	1	3%
Un/UnderInsured	1	3%
Lower Socioeconomic Status	1	3%
Higher Socioeconomic Status	1	3%
Mental Health	1	3%
Grand Total	**30**	**100%**

04. Top health needs of the community?

Response Category	Response Count	Percent of Responses
Access	19	11%
Obesity	17	10%
Prevention/Lifestyle Modification	16	9%
Affordable Care	14	8%
Healthcare Providers/Services	13	7%
Food/Nutrition	11	6%
Cardiovascular	11	6%
Diabetes	11	6%
Primary Care/PCPs	6	3%
Care Coordination	6	3%
Trauma/Injury	6	3%
Mental Health	5	3%
Dental	5	3%
Stroke	5	3%
Chronic Diseases	4	2%
Prenatal	3	2%
Sexual Health	3	2%
Health Education	3	2%
Alcohol/Drug Abuse	3	2%
Socioeconomic	3	2%
Smoking	3	2%
Cancer	2	1%
Medications	2	1%
Elderly	1	1%
Transportation	1	1%
Other	1	1%
Communication Barriers	1	1%
Medical Compliance	1	1%
Grand Total	**176**	**100%**

4b. What healthcare services are missing?

Response Category	Response Count	Percent of Responses
Primary Care/PCPs	2	50%
Home Care	1	25%
Mental Health	1	25%
Grand Total	**4**	**100%**

4c. What is the number one barrier to good health care?

Response Category	Response Count	Percent of Responses
Socioeconomic	9	29%
Access	5	16%
Affordable Care	4	13%
Food/Nutrition	2	6%
Care Coordination	2	6%
Prevention/Lifestyle Modification	2	6%
Insurance	2	6%
Culture	1	3%
Medical Compliance	1	3%
Communication Barriers	1	3%
Transportation	1	3%
Health Education	1	3%
Grand Total	**31**	**100%**

4d. What concerns you the most about the health of the community?

Response Category	Response Count	Percent of Responses
Socioeconomic	3	15%
Obesity	3	15%
Prevention/Lifestyle Modification	2	10%
Healthcare Providers/Services	2	10%
Care Coordination	2	10%
Elderly	1	5%
Primary Care	1	5%
Chronic/Other Diseases	1	5%
Violence/Crime	1	5%
Chronic Diseases	1	5%
Affordable Care	1	5%
Mental Health	1	5%
Lack of services	1	5%
Grand Total	**20**	**100%**

05. Leading social determinants of health?

Response Category	Response Count	Percent of Responses
Socioeconomic	42	43%
Food/Nutrition	9	9%
Environment	7	7%
Alcohol/Drug Abuse	7	7%
Prevention/Lifestyle Modification	7	7%
Violence/Crime	6	6%
Culture	5	5%
Health Education	5	5%
Transportation	4	4%
Smoking	2	2%
Insurance	1	1%
Access	1	1%
Trauma/Injury	1	1%
Other	1	1%
Grand Total	**98**	**100%**

06. primary health indicators?

Response Category	Response Count	Percent of Responses
Condition/Disease Rates	45	35%
Obesity	18	14%
Smoking	10	8%
Preventative Care Rates	9	7%
Hospital/Public Health Measures	8	6%
Socioeconomic	7	5%
Teen Pregnancy	5	4%
Other	5	4%
Alcohol/Drug Abuse Rates	5	4%
Mortality/Life Expectancy Rates	4	3%
Infant Mortality/Low Birthweight	3	2%
Insurance Coverage	3	2%
Lifestyle Measures	3	2%
ER Visits	2	2%
Injury/Disability Rates	1	1%
HP2020	1	1%
Mental Health	1	1%
Grand Total	**130**	**100%**

07. vulnerable groups/populations?

Response Category	Response Count	Percent of Responses
Elderly	20	26%
Minorities	18	23%
Un/UnderInsured	10	13%
Children/Teens	9	12%
Poor	5	6%
Other	5	6%
Homeless	2	3%
Disabled	2	3%
Women	2	3%
Mental Health	2	3%
Young Adults	1	1%
LTAC	1	1%
Chronic Diseases	1	1%
Grand Total	**78**	**100%**

09. In terms of specific actions/programs, what do you think could be done to address the health needs we've discussed?

Response Category	Response Count	Percent of Responses
Access/Affordable Care	13	22%
Community Outreach/Education	11	18%
Public Health/Health Outcomes	6	10%
Care Coordination	6	10%
Community Collaboration	4	7%
Recreation	3	5%
Elderly	3	5%
Prevention/Screenings	3	5%
Other	3	5%
Policy	2	3%
Social Resources	2	3%
Crime/Violence	1	2%
Food/Nutrition	1	2%
Specialty Providers/Services	1	2%
Lifestyle	1	2%
Grand Total	**60**	**100%**

10. What are some ways Baptist Health or other organizations can engage the community in addressing health needs?

Response Category	Response Count	Percent of Responses
Community Outreach/Education	17	33%
Community Collaboration	11	22%
Access/Affordable Care	8	16%
Care Coordination	4	8%
Prevention/Screenings	4	8%
Environment/Socioeconomic	4	8%
Technology	2	4%
Other	1	2%
Grand Total	**51**	**100%**

11. What do you consider Baptist Health's role to be in the community?

Response Category	Response Count	Percent of Responses
Leadership	3	43%
Provide Care for Underserved	2	29%
Coordination	1	14%
Outreach	1	14%
Grand Total	**7**	**100%**

12. How is Baptist Health currently meeting the health needs of the community?

Response Category	Response Count	Percent of Responses
Education/Outreach	8	57%
Prevention/Screenings	3	21%
Other	2	14%
Charitable Care	1	7%
Grand Total	**14**	**100%**

13. Are there specific health issues in the community in which Baptist should take a lead in addressing?

Response Category	Response Count	Percent of Responses
Chronic/Other Diseases	6	50%
Food/Nutrition	2	17%
Obesity	2	17%
Rural Healthcare	1	8%
Other	1	8%
Grand Total	**12**	**100%**

13a. Are there any specific organizations in the community that would be a good fit for Baptist Health to partner with to address health needs?

Response Category	Response Count	Percent of Responses
UAMS, public school system	1	25%
State Government (Collaborate to prevent overlap of services)	1	25%
Public School System	1	25%
Nursing Homes (Coordination)	1	25%
Grand Total	**4**	**100%**

BHMC-Little Rock Focus Group Summary

LOCATION: BHMC-LITTLE ROCK DATE: 9/10/12

DISCUSSION 1:

- What grade do you give the health of this community (A-F)?
- Write the Grade down on sticky note and place on flipchart/white board
- Discuss as a group the grade chosen
    - What factors did you consider when you chose a grade?
    - What do you think of when you think of health?

RESPONSES:

When asked to grade the health of the community served by BHMC-Little Rock, focus group participants provided three C's, one C-, one D, and one B+. Contributing factors to the lower grades include poor physical health, chronic health conditions such as diabetes, high blood pressure, high rates of stroke, and obesity. Among children, there has been an increase in the rates of Type 1 and Type 2 diabetes.

While Pulaski County ranks well in terms of health compared to other counties in the state, lifestyle choices such as consumption of fast food, use of nicotine/smoking, and alcohol contribute to poor health. Where healthy foods are expensive and possibly difficult to access, fast food outlets provide several cheap options.

Other barriers to good health include transportation and access to affordable care. The Latino community is especially challenged because they do not have insurance, experience long wait times for appointments at the free clinic and usually end up utilizing the emergency department for basic health services. After hours clinics are also not utilized effectively as focus group participants felt there was a low level of awareness of these services, especially among female teenagers. In general, there is a feeling that more clinics are needed in the city to serve the vulnerable populations.

Culturally, a good portion of the community does not have high rates of health literacy and do not understand the value and importance of preventive and screening services. Churches are working to better understand the needs of the community and in general feel the needs of the underserved community are overwhelming.

Engaging the younger population in their healthcare is one way to begin improvement efforts. Access to dental care for children has improved and the trail systems also support a healthier lifestyle. Improved advertising of the after-hours clinic may also help improve access to those who need healthcare services.

DISCUSSION 2:

- Break into 2-3 smaller groups
- As a group identify the top 3 health needs of the community
    - Agree upon the top 3 needs and why
    - Write each need on sticky note and place on flipchart/white board
    - One person from the group share with the larger group why those needs were chosen

RESPONSES:

GROUP 1:

1. Access to a dental care clinic
    a. There is only one free dental clinic.
    b. Dental care is important because it can lead to more serious health problems.
2. Substance abuse
    a. Severe shortage of substance abuse programs.
3. Obesity
    a. Cause of many other health problems
    b. Occurring more frequently in children and resulting in adolescent diabetes. A child in the school system died last week because he had undiagnosed diabetes. It is important to get the parents to understand health problems in their children.
    c. Presence of food deserts

GROUP 2:

1. Education
    a. Need more community outreach to churches, schools, and the police department.
    b. Diabetes and obesity is a huge problem that needs to be addressed.
    c. Mental health and stress is also an important problem. There needs to be more activity around these topics.
    d. Services for disabled children who are not able to exercise
2. More health clinics
    a. When there is no access to trails/parks or other recreational activities, people turn to drugs and alcohol when they are stressed.
3. Improve access to care by connecting people to the resources that are already in place
    a. There is a lack of finances to get the appropriate care.

DISCUSSION 3:

- Stay the same smaller groups
- As a group identify up to 10 community resources (health/community organizations)
    - Work together to identify resources and list on flipchart paper
    - Discuss ways these resources could work together to address the health needs discussed
    - One person from the group share with larger group 2-3 ideas from discussion

RESPONSES:

In general, there is a need for resources to collaborate to get the information and knowledge out to the community. Churches are good instruments for communicating information as they have the attention of large congregations. Disseminating healthcare information should be like communication during a natural disaster – information and help must be readily available. Getting the media (local television stations) involved would help the relay the message of available health services.

GROUP 1:

- Friendly Chapel (soup kitchen)
- Mosaic/Churches
- P.A.R.K. and after school programs
- Boys and Girls Club
- River City Ministry
- Watershed
- Food banks
- Schools
- Goodwill
- Our House
- Hospitals/free clinics
- Homeless shelters
- Trail systems
- Police department
- Colleges

GROUP 2:

- Library
- Community Centers
- Schools
- Churches
- Public services (police department)
- Port authority
- Hospitals
- City/state government
- Police department
- Homeless shelters
- TV/Media

DISCUSSION 4:

- Stay the same smaller groups
- As a group, choose one of the health needs your group identified earlier
- Identify two goals you'd like to accomplish related to the need
    - Goals should be SMART (Specific, Measurable, Attainable, Realistic, Time-sensitive)
- For each goal identify 2-3 action steps that would help achieve the goal

RESPONSES:

Unfortunately, there was no time for this exercise during this focus group session.

Health Resources Available to Meet Identified Needs

BHMC-Little Rock

Other Hospital Facilities

Hospital Name	Address	City	Owner Type	Type of Service
St. Vincent Doctors Hospital	3101 Saint Vincent Cir.	Little Rock	Not-for-Profit	General Medical & Surgical
JL McClellan Memorial VA Hospital	4300 W. 7th St.	Little Rock	Veteran's Administration	General Medical & Surgical
St. Vincent Infirmary Medical Center	2 Saint Vincent Cir.	Little Rock	Not-for-Profit	General Medical & Surgical
Saline Memorial Hospital	1 Medical Park Dr.	Benton	Not-for-Profit	General Medical & Surgical
UAMS Medical Center	4301 W. Markham St.	Little Rock	Local Government	General Medical & Surgical
Arkansas Children's Hospital	1 Children's Way	Little Rock	Nonprofit	Children's General
Rivendell Behavioral Health Services	100 Rivendell Dr.	Benton	For Profit	Children's Psychiatric
Select Specialty Hospital- Little Rock	2 Saint Vincent Cir.	Little Rock	For Profit	Long Term Acute Care
Pinnacle Pointe Behavioral Health	11501 Financial Centre Pkwy.	Little Rock	For Profit	Psychiatric
The BridgeWay Hospital	21 Bridgeway Rd.	North Little Rock	For Profit	Psychiatric
United Methodist Behavioral Hospital	1601 Murphy Dr.	Maumelle	For Profit	Psychiatric
Arkansas State Hospital	305 S. Palm St.	Little Rock	Local Government	Psychiatric
Arkansas Heart Hospital	1701 S. Shackleford Rd.	Little Rock	For Profit	Heart Specialty

Cause of Death: Stroke

Chronic Conditions: Coronary Heart Disease (Pulaski, Grant, Saline)

Program Name	Description	Website	Phone Number	State	County
Arkansas Department of Health Heart Disease and Stroke Prevention			501-661-2942	x	
Arkansas Wellness Coalition (AWC)	Includes members of the health care and employer community whose goal is to improve the health and well-being of all Arkansans through the use of nationally recognized, peer reviewed, clinical guidelines for physician, consumer, and employer education. Develop materials referring to nationally recognized standards such as those put forth by Healthy People 2010, the National Committee of Quality Assurance, and other disease-specific organizations such as the American Diabetes Association and the American Heart Association.		501-661-2942	x	
Southern Ain't Fried Sundays - Arkansas Minority Health Commission	Faith Based Outreach Program SAFS is designed to educate African American churches and organizations about healthier alternatives to preparing and cooking southern-style foods. It is also a mechanism for partnering with these groups in an effort to educate their members about the signs and symptoms of stroke, diabetes, and heart attacks. The program is being revamped to expand its reach to the Hispanic communities and individual participants.	http://www.arminorityhealth.com/programs_saf.html	877-264-2826	X	
UAMS Center for Distance Health AR SAVES Program (Stroke Assistance through Virtual Emergency Support)	A stroke management system specifically targeting patients at rural hospitals to by increasing access to subspecialty expertise through telemedicine technology, thereby engineering a coordinated assessment and care-based plan for Arkansas' stroke patients. Ensuring timely administration of clot-busting drugs to improve the chances of recovery while reducing permanent, stroke-related disability and, quite possibly, mortality.		501-686-8514	X	

Program Name	Description	Website	Phone Number	State	County
Arkansas Chronic Illness Collaborative (ACIC)	The ACIC is a group of health care and public health professionals dedicated to improving the management of chronic diseases. The ACIC is a way for health care clinic teams to use the National Health Disparities Collaborative Chronic Care Model to share ideas and knowledge, learn and apply new techniques, and match medical practices with clinical guidelines based on scientific evidence about what works best (diabetes, cancer and cardiovascular diseases)	http://www.healthy.arkansas.gov/programsServices/chronicDisease/Initiatives/Pages/Acic.aspx		X	

Cause of Death: Cancer (Grant)

Program Name	Description	Website	Phone Number	State	County
Arkansas Cancer Coalition	The Arkansas Cancer Coalition exists to provide a favorable environment for cancer control partners to work to reduce, and ultimately eliminate, the burden of cancer for every person in the state. The Coalition is a partnership of individuals and organizations working together to: Provide an overview of the current status of cancer control in Arkansas Reduce the overall burden of cancer by providing and maintaining a plan of goals and strategies Improve the quality of life for those personally affected by cancer by strengthening and sustaining the cancer control partnership support network	http://www.arcancercoalition.org/resources/reduce-your-risk		X	
Arkansas Chronic Illness Collaborative (ACIC)	The ACIC is a group of health care and public health professionals dedicated to improving the management of chronic diseases. The ACIC is a way for health care clinic teams to use the National Health Disparities Collaborative Chronic Care Model to share ideas and knowledge, learn and apply new techniques, and match medical practices with clinical guidelines based on scientific evidence about what works best (diabetes, cancer and cardiovascular diseases)	http://www.healthy.arkansas.gov/programsServices/chronicDisease/Initiatives/Pages/Acic.aspx		X	

Cause of Death: Chronic Lower Respiratory Disease (Grant)

Program Name	Description	Website	Phone Number	State	County
Arkansas Wellness Coalition (AWC)	Includes members of the health care and employer community whose goal is to improve the health and well-being of all Arkansans through the use of nationally recognized, peer reviewed, clinical guidelines for physician, consumer, and employer education. Develop materials referring to nationally recognized standards such as those put forth by Healthy People 2010, the National Committee of Quality Assurance, and other disease-specific organizations such as the American Diabetes Association and the American Heart Association.		501-661-2942	X	
Arkansas Chronic Illness Collaborative (ACIC)	The ACIC is a group of health care and public health professionals dedicated to improving the management of chronic diseases. The ACIC is a way for health care clinic teams to use the National Health Disparities Collaborative Chronic Care Model to share ideas and knowledge, learn and apply new techniques, and match medical practices with clinical guidelines based on scientific evidence about what works best (diabetes, cancer and cardiovascular diseases)	http://www.healthy.arkansas.gov/programsServices/chronicDisease/Initiatives/Pages/Acic.aspx		X	

Health Outcomes: Low Birth Weight (Grant, Pulaski)

Health Outcomes: Infant Mortality (Pulaski)

Program Name	Description	Website	Phone Number	State	County
Arkansas Department of Health	ADH provides prenatal care to an average of 5,000 women annually at many of the Local Health Units.		1-800-462-0599	X	
Arkansas Department of Health Nurse-Family Partnership	Nurse-Family Partnership is a free, voluntary program that partners first-time moms with registered nurses. NFP is available to any first-time mom who is under her 28th week of pregnancy, and who is below 200% of the Federal poverty level.	http://www.adhhomecare.org/nurse-family-arkansas.htm		X	

Health Outcomes: Poor Physical Health and Mental Health Days (Grant, Saline)

Program Name	Description	Website	Phone Number	State	County
Arkansas Department of Health – Hometown Health Improvement	HHI initiatives currently exist in every county around the state. HHI coalitions do powerful and unique work to improve the health of those in their communities. Once the coalition is established, many communities are choosing to conduct health behavior surveys to gain important information specific to their communities. Many coalitions are now implementing activities to affect the health of the community. Examples of some activities include: tobacco cessation programs for adolescents, household hazardous waste round-up, parenting support groups, local industry wellness programs, health fairs, and health resource guides.				X (All counties)
Chronic Disease Self Management Program – Be Well Live Well	Developed by the Stanford Patient Education Research Center, the evidence based program teaches participants the skills needed to live well with chronic diseases. It also shows participants how to organize their lives, make and achieve goals, eat properly, exercise and communicate effectively with physicians and others. National outcome studies reveal that CDSMP participants experience a marked decrease in the number of hospital stays and doctor visits.	http://www.agec.org/2012/10/cdsmp-branded-for-arkansas-be-well-live-well/		X	

Chronic Conditions: Hypertension (Grant, Saline, Pulaski)

Program Name	Description	Website	Phone Number	State	County
Southern Ain't Fried Sundays - Arkansas Minority Health Commission	Faith Based Outreach Program SAFS is designed to educate African American churches and organizations about healthier alternatives to preparing and cooking southern-style foods. It is also a mechanism for partnering with these groups in an effort to educate their members about the signs and symptoms of stroke, diabetes, and heart attacks. The program is being revamped to expand its reach to the Hispanic communities and individual participants.	http://www.arminorityhealth.com/programs_saf.html	877-264-2826		

Chronic Conditions: Asthma (Grant, Pulaski)

Program Name	Description	Website	Phone Number	State	County
The Delta Area Health Education Center (AHEC)	Utilizing the American Lung Association's curriculums, asthma education is provided to children, parents, caregivers and teachers.		870-572-2727		X Located in Pine Bluff (Jefferson County) Serving Grant County
Arkansas Respiratory Health Association	Services offered: Conduct asthma, COPD and tobacco/cessation educational programs for patients, the general public and schools. Coordinate support groups for COPD patients. Provide continuing educational opportunities for school and healthcare professionals.	http://www.arkresp.org	800-880-5864 ext. 100	X	

Chronic Conditions: Arthritis (Grant, Saline)

Program Name	Description	Website	Phone Number	State	County
Arkansas Arthritis Foundation	Various educational programs	http://www.arthritis.org/arkansas/		X	

Chronic Conditions: Diabetes (Pulaski)

Prevention: Diabetic Screening (Saline, Pulaski)

Program Name	Description	Website	Phone Number	State	County
American Diabetes Association	Educational Resources; Advocacy		(501) 221-7444		X (all counties)
Arkansas Health Care Access Foundation	Locates doctors to donate office visits; prescription assistance; free to those who qualify	http://ahcaf.org/			X (all counties)

Program Name	Description	Website	Phone Number	State	County
Arkansas Wellness Coalition	Includes members of the health care and employer community whose goal is to improve the health and well-being of all Arkansans through the use of nationally recognized, peer reviewed, clinical guidelines for physician, consumer, and employer education. Develop materials referring to nationally recognized standards such as those put forth by Healthy People 2010, the National Committee of Quality Assurance, and other disease-specific organizations such as the American Diabetes Association and the American Heart Association.		501-661-2942	X	

Program Name	Description	Website	Phone Number	State	County
Arkansas Chronic Illness Collaborative (ACIC)	The ACIC is a group of health care and public health professionals dedicated to improving the management of chronic diseases. The ACIC is a way for health care clinic teams to use the National Health Disparities Collaborative Chronic Care Model to share ideas and knowledge, learn and apply new techniques, and match medical practices with clinical guidelines based on scientific evidence about what works best (diabetes, cancer and cardiovascular diseases)	http://www.healthy.arkansas.gov/programsServices/chronicDisease/Initiatives/Pages/Acic.aspx		X	
Diabetes Education Program Sites – Pulaski County	Baptist Health Diabetes Self Mgmt Program – Little Rock The Arkansas Diabetes Self Mgmt Education Program – Little Rock		501-202-1877 501-296-1220 501-552-4763 501-202-3701		X
Center for Healing Hearts and Spirits – Little Rock	Offers health education for diabetes.	http://www.hhscenter.org	501-372-3800		(Little Rock)

Health Behaviors: Obesity (Pulaski, Grant, Saline)

Socioeconomic & Environment: Access to Healthy Food (Pulaski, Grant, Saline)

Socioeconomic & Environment: Percentage of Fast Food Restaurants (Pulaski, Grant, Saline)

Program Name	Description	Website	Phone Number	State	County
Arkansas Department of Health Lifestage Health Branch	Mission is the prevention and reduction of obesity through the adoption of healthy eating practices and increased physical activity. Provides technical assistance, managing and supporting evidence-based programs, disseminating materials and resources, and skills-building within the Agency, in schools, at worksites, among partners and with the general public.		501-661-2099	X	
Arkansas Coalition for Obesity Prevention (ArCOP)	A coalition whose goal is to increase the percentage of Arkansans of all ages who have access to healthy and affordable food and who engage in regular physical activity. Coalition is structured around six working teams: Access to Healthy Foods; Built Environment; Early Childhood and Schools; Healthcare; Worksite Wellness; and Social Marketing	http://www.arkansasobesity.org/		X	
Southern Ain't Fried Sundays - Arkansas Minority Health Commission	Faith Based Outreach Program SAFS is designed to educate African American churches and organizations about healthier alternatives to preparing and cooking southern-style foods. It is also a mechanism for partnering with these groups in an effort to educate their members about the signs and symptoms of stroke, diabetes, and heart attacks. The program is being revamped to expand its reach to the Hispanic communities and individual participants.	http://www.arminorityhealth.com/programs_saf.html	877-264-2826	X	

Program Name	Description	Website	Phone Number	State	County
Arkansas Rice Depot	Arkansas Rice Depot's mission is to find sensible solutions to hunger in Arkansas. • Food For Families: Our statewide free food bank serves 300 church and community hunger organizations • Food For Kids: Backpacks of food and supplies are sent home with children having problems in school due to hunger at home, currently operating in more than 600 schools, serving over 35,000 students and siblings • Food For Seniors: Home-delivered food boxes given each month to seniors	http://ricedepot.org/		X	
Arkansas Department of Health - PEPPI	Peer Exercise Program Promotes Independence is a physical activity program specifically designed for older adults to increase and maintain their level of fitness and independence. The physical activity program includes strength training using resistance bands and walking. PEPPI program provides older Arkansans with the opportunity to learn how to exercise correctly (i.e. using correct techniques) in a safe environment, both physically (at the senior centers, churches, or other community groups), and mentally (among people of similar age and health conditions), and to increase their level of physical activity.	http://www.healthy.arkansas.gov/programsServices/chronicDisease/PhysicalActivity/Pages/default.aspx		X	
Arkansas Department of Health - WIC FMNP	The purposes of the WIC FMNP are to provide fresh, nutritious, unprepared fruits and vegetables from farmers' market to women and children who are nutritionally at risk and to expand the awareness and use of farmers' markets, as well as increase sales at such markets. During the farming season, WIC FMNP provides clients in the WIC Program with checks to purchase locally grown fresh fruits and vegetables sold by authorized farmers at authorized farmers' markets.	http://www.healthy.arkansas.gov/programsServices/WIC/Pages/FMNP.aspx		X	

Program Name	Description	Website	Phone Number	State	County
Arkansas Department of Health Pick a Better Snack Program	The Arkansas 5 A Day Coalition, a partnership of organizations whose mission is to increase Arkansans' consumption of fruits and vegetables, coordinated the implementation of this program in two elementary schools during the 2006-07 and 2007-08 school years. Using Food Stamp Nutrition Education funds, as well as private contributions, the Pick a Better Snack Program has been implemented in more than twenty schools throughout the State. The program has been well received by both teachers and students.	http://www.healthy.arkansas.gov/programsServices/chronicDisease/Nutrition/Pages/Programs.aspx		X	
Arkansas Department of Health Healthy Restaurant Award	The Healthy Arkansas Restaurant Award is a voluntary program that provides public recognition to restaurants that meet certain health criteria. Restaurants self-apply and self-report through a questionnaire-type application. Criteria considered include smoke-free status of facility, labeling of food items, and number and types of healthy nutrition choices that are offered. Applications must be completed by a designee of the restaurant. Menus, inserts or photo of menu board with nutrient information must be submitted with the application to confirm the information.	http://www.healthy.arkansas.gov/programsServices/chronicDisease/Nutrition/Pages/Programs.aspx		X	
Bess Chisum Stephens Community Center	Offers a variety of low-cost exercise classes to the community including aquatic classes	http://centersforyouthandfamilies.org/programs/bess-chisum-stephens-community-center/			X (Little Rock, Pulaski County)

Health Behaviors: Excessive Drinking (Grant, Pulaski)

Program Name	Description	Website	Phone Number	State	County
Arkansas Center for Addictions Research, Education, and Services (AR-CARES)	This comprehensive family treatment program called the Arkansas Center for Addictions Research, Education and Services (Arkansas CARES) focuses on breaking the cycle of maternal addiction.	http://methodistfamily.org/programs/arkansas-CARES.html			X (Little Rock, Pulaski County)

Health Behaviors: Sexually Transmitted Infections (Pulaski)

Program Name	Description	Website	Phone Number	State	County
Arkansas Department of Health STD Testing Center	Future Builders, Inc. 16117 Highway 365 Little Rock, Arkansas 72206 Thursday 10:30 am to 2:30 pm After hours by appointment only		501-897-5566		X
Pulaski County Health Unit Sites – STD Testing	Pulaski County Jacksonville 3000 N 1st Street Jacksonville 501-982-7477 Pulaski County College Station 4206 Frazier Pike College Station 501-490-1602 Pulaski County NLR Health Unit 2800 N Willow North Little Rock 501-791-8551 Pulaski Central Health Unit 3915 W 8th Street Little Rock 501-280-3100		501-982-7477 501-490-1602 501-791-8551 501-280-3100		X

Health Behaviors: Smoking (Grant, Saline)

Program Name	Description	Website	Phone Number	State	County
Stamp Out Smoking	Arkansas Tobacco Quitline: A 24-hour direct line to professionally trained Quit Coaches® waiting to help you fight the good fight, plus a 24-hour online community of support from others who've gone through exactly what you're facing … and you can even get a supply of the latest nicotine replacement therapy medications at no cost.	http://www.stampoutsmoking.com/get-help-to-quit/	1-800-QUIT NOW	x	

Program Name	Description	Website	Phone Number	State	County
Arkansas Department of Health Tobacco Prevention and Cessation Program – STOP Program	The Systems Training Outreach Program (STOP) currently uses Outreach to provide education and support to providers. Increasing the capacity and efficiency of care systems by asking, documenting tobacco use and advising patients to stop, the Outreach Specialists educate healthcare providers to be aware of available and accessible cessation treatment interventions. In particular, the specialists will help providers systematically identify patients who are tobacco users, provide guidance to quit and connect them to available resources to successfully quit.	http://www.healthy.arkansas.gov/programsServices/chronicDisease/coalition/Pages/tobacco.aspx		x	

Access: Lack of PCPs (Grant, Saline)

Program Name	Description	Website	Phone Number	State	County
Arkansas Department of Health Office of Rural Health and Primary Care	Promotes the development of community-based health care services and systems throughout Arkansas to ensure that well managed, quality health services are available to all citizens		501-280-4560	X	
Area Health Education Centers (AHEC)	Programs provide access to medical services for rural residents and education for healthcare students and professionals.	http://ruralhealth.uams.edu/AHEC-Programs			X Located in Pine Bluff (Jefferson County) Serving Grant County
American Academy of Family Physicians	The Arkansas Academy of Family Physicians Foundation and TransforMED, a wholly owned subsidiary of the American Academy of Family Physicians, announced that three family medicine practices have been selected to receive facilitative and financial support as they implement a new model of health care known as the patient-centered medical home.	http://www.transformed.com/news-eventsdetailpage.cfm?listingID=102		X	
University of Arkansas Foundation	Education and Promotion of Physician Assistants in Arkansas	http://www.uamshealth.com/News/UAMSPhysicianAssistantNorthwestArkansasResidencyProgramsReceiveGrantsfromBlueYouFoundation?id=5349&showBack=true&PageIndex=0&cid=4		X	

Program Name	Description	Website	Phone Number	State	County
ADH ConnectCare	ConnectCare works to connect Medicaid and ARKids recipients to a primary care physician and a medical home. Telephone Helpline Specialists who staff a toll-free telephone call center respond to Medicaid and ARKids recipient questions and concerns, give information and offer guidance on accessing resources, and assist clients in locating and assigning a primary care physician.	http://www.healthy.arkansas.gov/programsServices/familyHealth/HealthConnections/Pages/ConnectCare.aspx		X	
Christian Community Care Clinic	Since 1999, our clinic has been providing a variety of health care services to Saline County residents in need.	http://www.bentoncareclinic.com/	501-776-1703		X
Harmony Health Clinic Open Hands College Station Center Shepherd's Hope Neighborhood Health Center Westside	Pulaski County clinics for low income and uninsured individuals in need	http://www.harmonyclinicar.org/ http://jcssi.org http://jcssi.org http://shepherdshopelr.org/ http://www.dolr.org/offices/catholiccharities/westside.php			X

Socioeconomic & Environment: Single-Parent Households (Pulaski)

Program Name	Description	Website	Phone Number	State	County
Arkansas Voices	To advocate for children left behind by incarceration or loss of a parent for any reason and to provide mentoring, services and supports for the children, their caregivers, and incarcerated parents, with the goal of strengthening and empowering the family unit.	http://www.arkansasvoices.org/		X	
Arkansas Single Parent Scholarship Fund	Single Parent Scholarships (SPSF) are given to low-income single parents who are pursuing post-secondary education in preparation for skilled employment. We organize affiliated scholarship funds that serve every county of Arkansas	http://www.aspsf.org/index.html		X	

Socioeconomic & Environment: Violent Crime (Pulaski)

Program Name	Description	Website	Phone Number	State	County
Black on Black Crime Coalition	Driven by its mission to increase public awareness and reduce black on black crime in Pulaski County, the Coalition has developed a plan of action that includes: an education/awareness campaign program initiatives with its partners collaborations with existing organizations that serve citizens and institutions directly and indirectly affected by black on black crime	http://www.hhscenter.org/bonbcrim.html			X
City of Little Rock – Neighborhood Alert Centers	The aim of the Neighborhood Alert Centers is to meet 6 tactical objectives. • Build trust in City Services and Staff • Broadcast a sense of unified neighborhood intolerance for drug and criminal activity • Deny drug dealers and customers access to open space in the neighborhood • Remove the sense of impunity street market dealers feel • Clean up the neighborhoods • Create a climate of achievement and reclaim neighborhood power Alert Center team members have assisted residents to create neighborhood groups such as crime watches and neighborhood associations, as well as neighborhood business organizations and religious organization alliances. They have organized and participated in neighborhood clean-ups. Neighborhood facilitators approached City Hall with the idea of creating a tool lending library through the alert centers so residents would have access to yard tools and lawn mowers to promote neighborhood beautification. Frequent neighborhood functions, alert center open houses and block parties are held to boost neighbor-to-neighbor and neighbor-to-City Staff relations.	http://www.littlerock.org/citydepartments/housing_programs/alertcenters/goals.aspx			
Pulaski County Youth Services	Take a holistic approach to curb the problems of gangs, violence, crime and substance abuse while enhancing the well-being of the community, children, youth and families by getting parents and community members involved in the lives of children and youth.	http://co.pulaski.ar.us/youthservices.shtml	501-340-8250		X

Community Needs Assessment

Baptist Health Medical Center–North Little Rock

December 2013



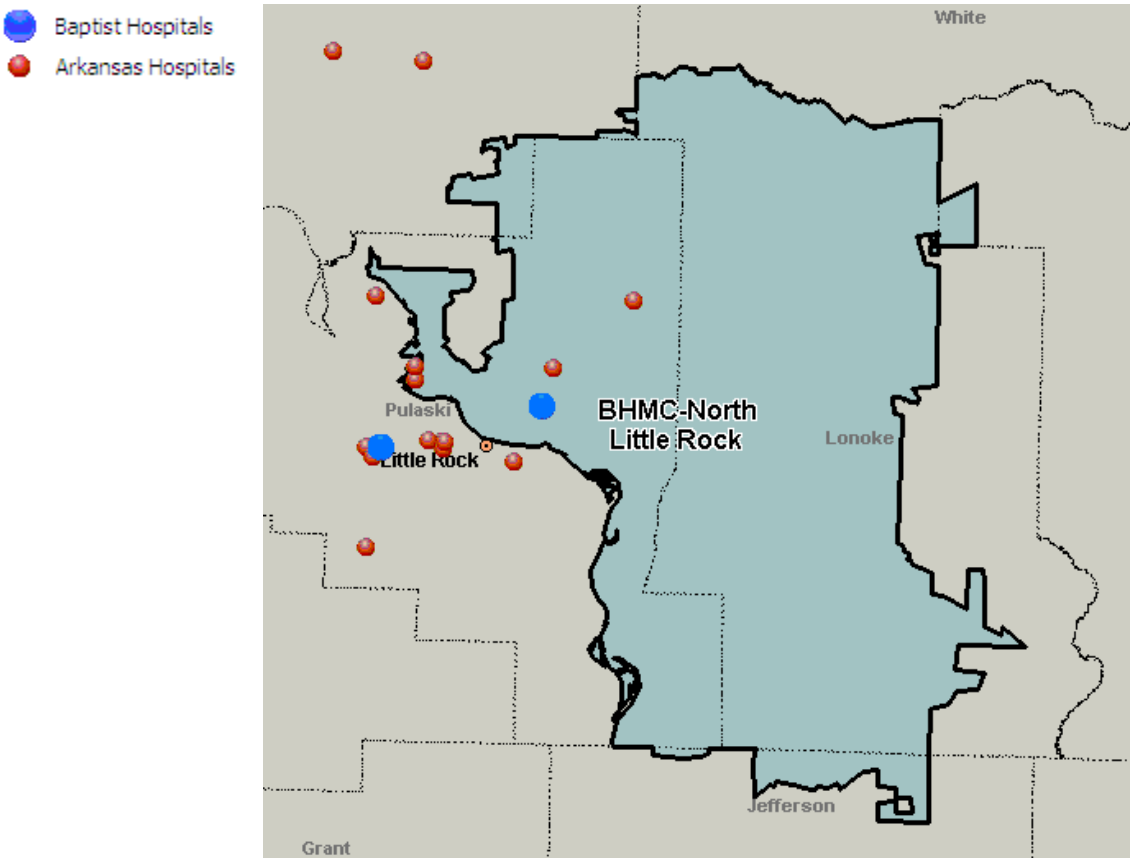
Baptist Health Medical Center–North Little Rock

Baptist Health Medical Center–North Little Rock is a 248-bed facility that provides comprehensive healthcare services to residents throughout the state. The BHMC–North Little Rock campus is home to the Baptist Health Breast Center, Cardiac Rehab, MRI, PET/CT Imaging Center, Rehab Center, Sleep Center, and Wound and Hyperbaric Center. The BHMC-North Little Rock Emergency Department sees almost 50,000 patients per year. A medical office building is located on the campus directly across from the hospital, allowing doctors and patients convenient access to the hospital.

Community Served and Demographics

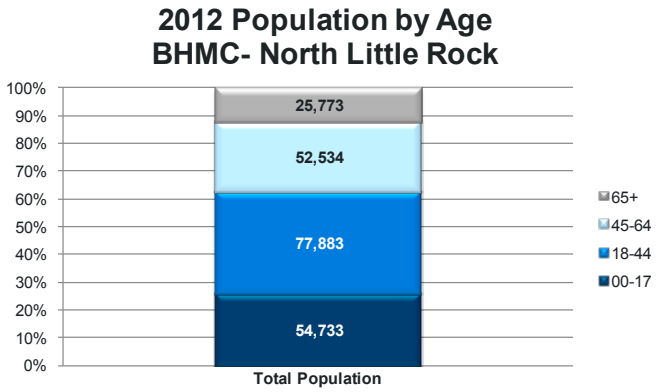
The community served for BHMC–North Little Rock was determined using the ZIP codes that represent greater than or equal to 2 percent of the hospital's combined inpatient discharges/outpatient visits AND in which the hospital's inpatient market share is greater than or equal to 20 percent. ZIP codes that did not meet those criteria but that are either contiguous or surrounded by ZIP codes in the community served were also included.

Twenty-one ZIP codes constitute the community served for BHMC–North Little Rock. A detailed list of the ZIP codes can be found in the **Baptist Health Medical Center-North Little Rock Appendix.** Below is a map that illustrates the BHMC–North Little Rock community served (blue).

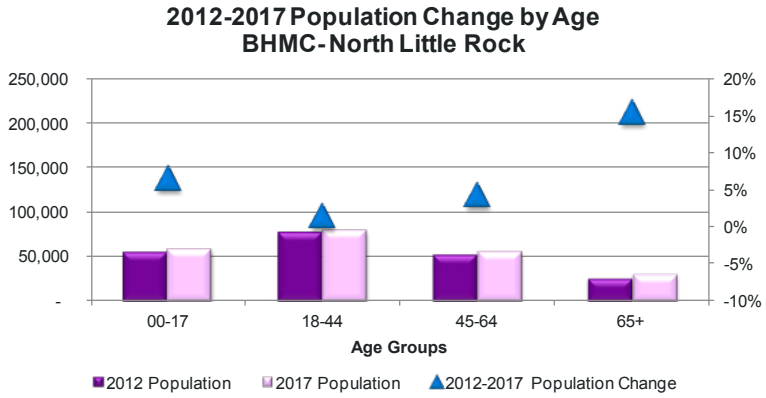


The BHMC–North Little Rock community served population is approximately 210,923. By 2017, this population is projected to grow 5.2 percent— the second fastest growing community among the Baptist Health facilities. While the largest portion of the population is made up of white non-Hispanics (144,752), in the next five years; the largest percentages of growth will be in the Hispanic (+28 percent, +2,910 individuals) and multicultural non-Hispanic (+20 percent, +827 individuals) populations. The largest growth in population will take place among Black non-Hispanics (+4,830 individuals) between 2012 and 2017.

The 18-44 age group constitutes the largest portion of the BHMC–North Little Rock community served, followed by the 00-17 age group.



By 2017, the age 65 plus population will have the largest percentage of growth.



The median household income for the BHMC–North Little Rock community served is $41,559. More than 54 percent of individuals have private insurance — either employer-sponsored insurance (48 percent) or individually purchased (6 percent). Another 16 percent are covered by Medicaid, 15 percent are uninsured, and 15 percent are covered by Medicare or are Medicare dual eligible.

Interviews & Focus Groups

Interviewees and focus group participants were categorized into representative groups. In the chart below, an "I" indicates an interview and "FG" indicates participation in a focus group. For individuals outside Baptist Health, representative organizations have been listed.

Community Leaders/ Groups	Public and Other Organizations	Other Providers	Baptist Health	
Baxter, Charley (Patrick Henry Hayes Senior Center, I)	Hartwick, Terry (Chamber of Commerce, I)	Burks, M.D. , Karen (Family Practice Physician, FG)	Harrison, Dean (BHMC-NLR, I)	Hardin, Kay (BHMC-NLR, I)
Jones, Jim (BHMC Board Member/ Crews & Associates, I)	Kirspel, Kenneth (NLR School District, I)	Miller, Hayes "Q" (Family Service Agency, FG)	Meimann, Ricki (BHMC-NLR, I)	Henry, Cleta (BHMC-NLR, I)
Shaddox, Ken (Park Hill Baptist Church, FG)	Ballard, Jamsetta (NLR School District, I)	Wheeler, Gary (Arkansas Department of Health, I)	Wallis, Naomi (BHMC-NLR, I)	Martin, Kathy (BHMC-NLR, I)
Thompson, M.D., Joe (AR Surgeon General/ AR Ctr for Health Improvement, I)	Rhodes, Bernadette (City of NLR, FG)	Clark, Marilyn (American Heart Assoc/ American Stroke Assoc, I)	Wagner, Jody (BHMC-NLR, I)	Webb, Steven (BHMC-NLR, I & FG)
	Woods, Carey (NLR Health Department, FG)	Halverson, Paul (Arkansas Department of Health, I)		
	Norman, Tommy (NLR Police Department, FG)			

The individuals highlighted in purple indicate Health Department representatives (local, regional, or state), as well as individuals representing or serving medically underserved, low-income, or minority populations.

In the interview process, the majority of individuals said the current health status of the community is either "good" or "poor." The major issues contributing to this health status include lifestyle choices, lack of access to health-care, and an aging population.

For the BHMC–North Little Rock community, the top five health needs identified in the interview process include:

1. Obesity
2. Diabetes
3. Chronic Diseases
4. Food/Nutrition
5. Cardiovascular

Barriers to good health care in this community include socioeconomic factors, access to healthcare, and affordable healthcare. The elderly, children/teens, minority populations, uninsured/under-insured, and poor were identified as vulnerable groups that will need special attention when addressing health needs.

Focus group participants were asked to "grade" the health of the community based on an A-F scale, provide feedback in terms of that grade, and work in small groups to determine the top three health needs of the community. For the BHMC – North Little Rock group, the average grade for the health of the community was a C. Much of this was attributed to the prevalence of chronic diseases/conditions, lack of healthy food options, and access issues due to transportation. Participants also felt that there was a paradigm between opportunities in the city versus more rural areas.

The focus group split into two smaller groups to determine the top three health needs of the community. Group 1 selected childhood obesity, tobacco use, and access to care. Group 2 selected cancer (more screenings and prevention), affordability of care, and mental health.

In the same small groups, focus group participants were asked to identify community resources that could help address the health issues in the community. Some of the resources identified include:

• Churches	• Senior Centers	• Police department
• Community Centers	• Baptist Health	• United Way
• Local Health Departments	• Boys & Girls Club	• Trail systems
• Women can run	• Family Service Agency	• Library
• Food Banks	• School District	• Head Start

Baptist Health Medical Center-North Little Rock Appendix includes a more comprehensive list of existing community resources available to address the health needs of the community.

Health Indicators

While the community served was defined at the ZIP code level, the most geographically detailed health indicators were only available at the county level. For that reason, health indicators for BHMC–North Little Rock were evaluated for Pulaski County and Lonoke County. These counties represent the ZIP codes within the community served.

Health needs for those counties that did not meet the state benchmark include:

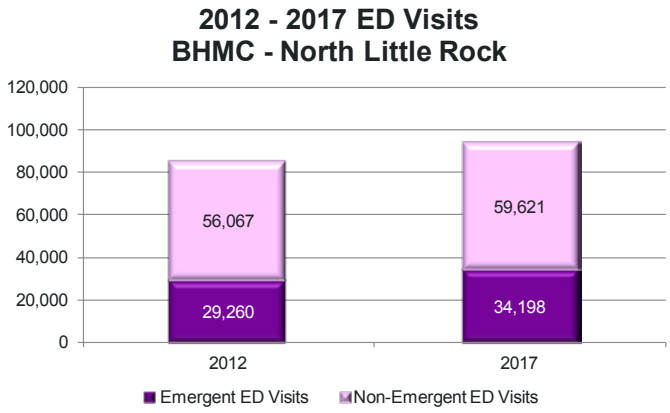
Cause of Death • Cancer • Stroke • Chronic Lower Respiratory Disease • Diabetes	**Chronic Conditions** • Hypertension • Asthma • Diabetes • Coronary Heart Disease • Arthritis	**Prevention** • Pap Test • Diabetic Screening • Preventable Hospital Stays **Access** • Lack of PCPs
Health Outcomes • Premature Death • Low Birth Weight • Infant Mortality • Poor or Fair Health Status • Poor Physical Health & Mental Health Days	**Health Behaviors** • Smoking • Obesity • Excessive Drinking • Sexually Transmitted Infections	**Socioeconomic & Environment** • Children in Single-Parent HHs • Violent Crime • Access to Recreational Facilities • Access to Healthy Food • Percentage of Fast Food Restaurants

Truven Health Analytics supplemented the publically available data with estimates of disease prevalence for heart disease and cancer, emergency department visit estimates, and the community need index.

Heart disease estimates indicate a prevalence of 62,263 cases for the BHMC–North Little Rock community served. The majority (70 percent) of the 2011 estimates of heart disease prevalence indicate hypertension as the primary diagnosis. Other diagnoses include arrhythmias (12 percent), ischemic heart disease (13 percent), and congestive heart failure (5 percent).

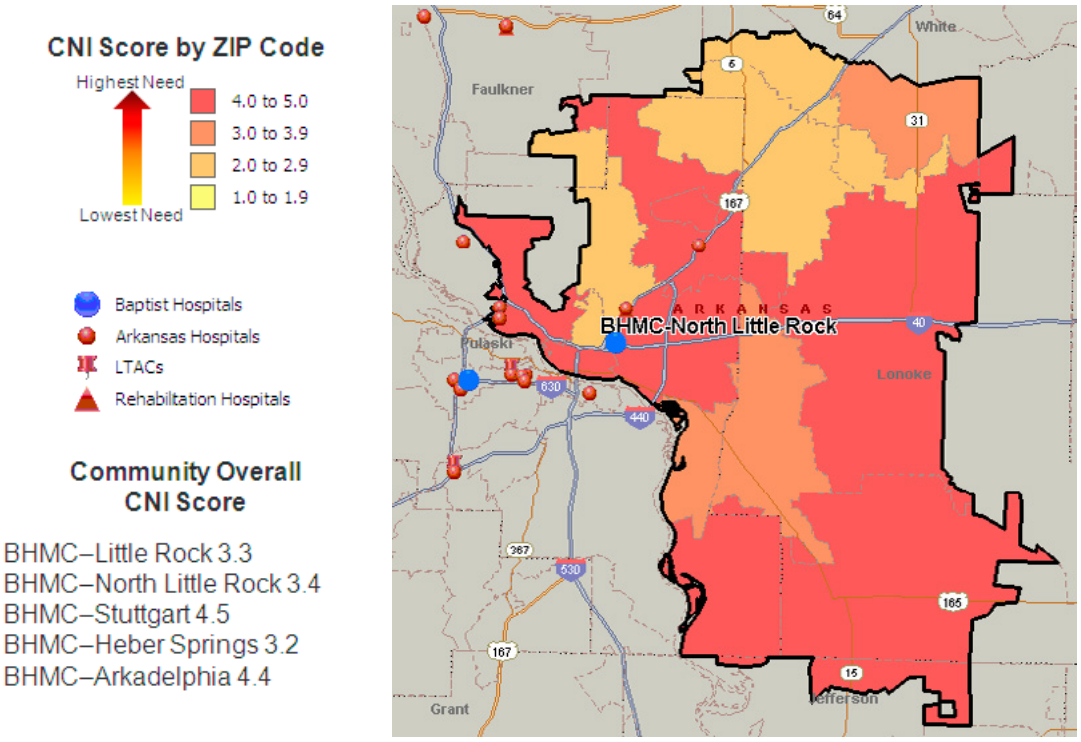
The 2011 cancer incidence estimates reveal at least 200 new cases of each of the following types of cancer: prostate and breast. For the community served, it is estimated that there will be 1,253 new cancer cases.

Emergency department visits are slated to grow by approximately 8,500 visits between 2012 and 2017.



The Truven Health Community Need Index (CNI) is a statistical approach to identifying health needs in a community. The CNI takes into account vital socio-economic factors (income, cultural, education, insurance, and housing) about a community to generate a CNI score for every populated ZIP code in the United States. The CNI is strongly linked to variations in community healthcare needs and is a strong indicator of a community's demand for various healthcare services.

The BHMC–North Little Rock community served had a CNI of 3.4 on a scale of 1.0 (lowest needs) to 5.0 (highest needs). Compared to the other Baptist Health communities, BHMC–North Little Rock falls in the middle.



Prioritized Health Needs

From the BHMC–North Little Rock campus, Harrison Dean, senior vice president/administrator; Steven Webb, vice president; Don Garner, director of Pharmacy; and Jodie Wagner, director of Clinical Information, participated in the prioritization meeting.

Using the criteria selected by the larger group, the five health needs that scored the highest in the prioritization process for BHMC–North Little Rock were:

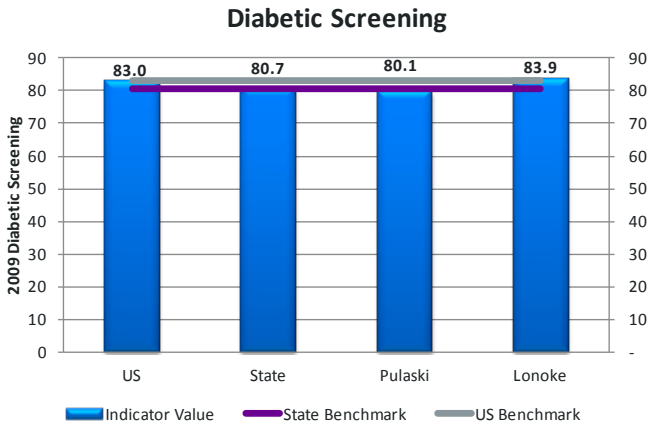
1. Diabetic screening
2. Low Birth Weight
3. Infant Mortality
4. Preventable hospital stays
5. Diabetes (cause of death)

HEALTH NEED	BHMC North Little Rock
Cause of Death	
▪ Cancer	X
▪ Stroke	X
▪ Chronic Lower Respiratory Disease	X
▪ Diabetes	X
Health Outcomes	
▪ Premature Death	X
▪ Low Birth Weight	X
▪ Infant Mortality	X
▪ Poor or Fair Health Status	X
▪ Poor Physical Health & Mental Health Days	X
Chronic Conditions	
▪ Hypertension	X
▪ Asthma	X
▪ Diabetes	X
▪ Coronary Heart Disease	X
▪ Arthritis	X
Health Behaviors	
▪ Smoking	X
▪ Obesity	X
▪ Excessive Drinking	X
▪ Sexually Transmitted Infections	X
Prevention	
▪ Pap Test	X
▪ Diabetic Screening	X
▪ Preventable Hospital Stays	X
Access	
▪ Lack of PCPs	X
Socioeconomic & Environment	
▪ Children in Single-Parent HHs	X
▪ Violent Crime	X
▪ Access to Recreational Facilities	X
▪ Access to Healthy Food	X
▪ Percentage of Fast Food Restaurants	X

The table to the left indicates the health needs identified for the BHMC-North Little Rock community. The highlighted boxes are the five health needs that scored the highest in the prioritization process.

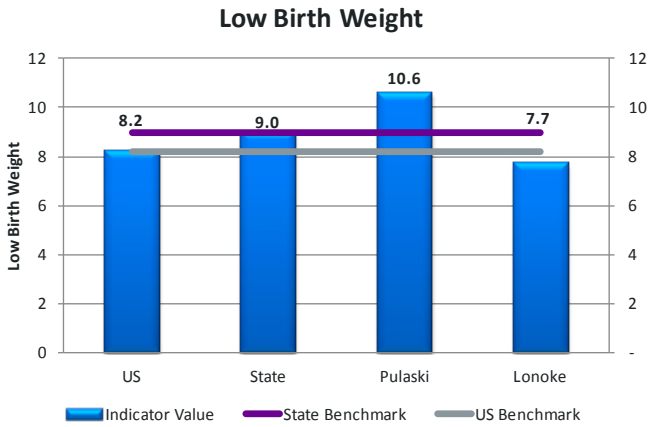
Even though the highlighted health needs had the highest scores, the needs that will actually be addressed for the purposes of the CHNA are at the discretion of BHMC-North Little Rock.

For each of the prioritized health needs, the comparative benchmark graph has been provided to illustrate gaps between county indicators for the community served and the state benchmark (purple). While the graphs below provide metrics at the county level, BHMC-North Little Rock will focus on the portions of each county within the definition of their community served.



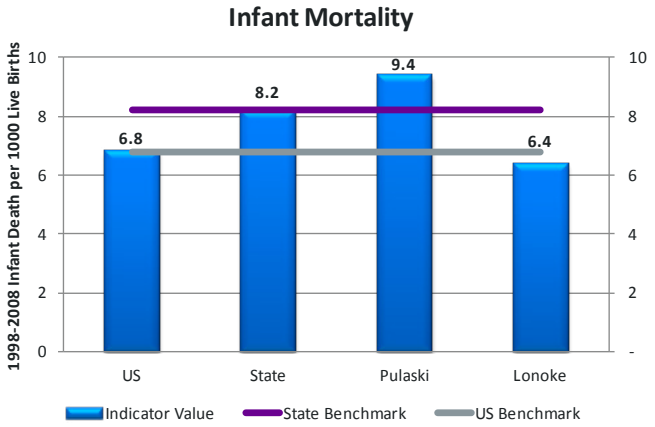
Source: County Health Rankings (Medicare/Dartmouth Institute)

Notes: Percent of diabetic Medicare enrollees that receive HbA1C screening



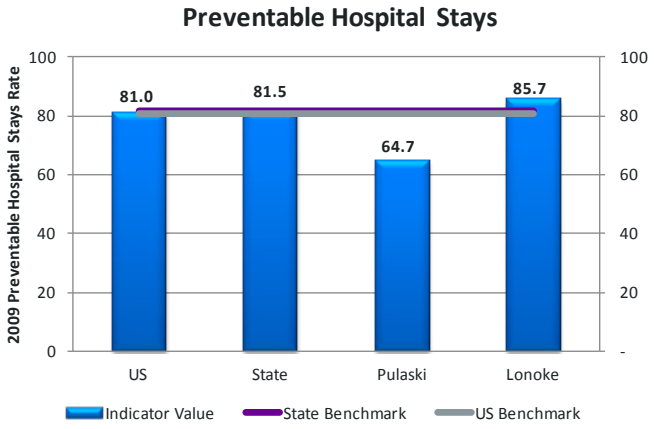
Source: County Health Rankings (NCHS)

Notes: Percent of live births with low birth weight (<2,500 grams)



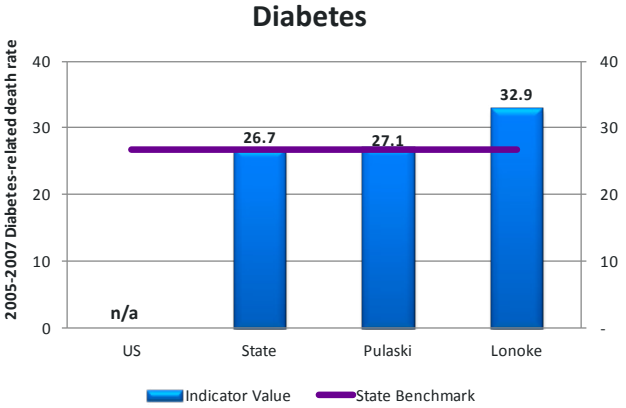
Source: Linked Birth/Infant Death Data Set (CDC-NCHS)

Notes: Rate of all infant deaths (within 1 year), per 1,000 live births



Source: County Health Rankings (Medicare/Dartmouth Institute)

Notes: Hospitalization rate for ambulatory-care sensitive conditions per 1,000 Medicare enrollees



Source: Health Statistics Branch, ADH

Notes: 2005-2007 Diabetes-related deaths (per 100,000)

Summary

The community health needs assessment for the BHMC–North Little Rock community served revealed a number of health issues related to disease management, lifestyle choices, and socioeconomic or environmental factors. By weighing the qualitative feedback and the quantitative data, along with the prioritization criteria, the top health needs identified include diabetic screening, low birth weight, infant mortality, and preventable hospital stays.

BHMC–North Little Rock will be working with internal stakeholders to determine the community health needs to be addressed. With the goal of improving the health of the community, implementation plans with specific tactics and time frames will be developed to address these health needs.

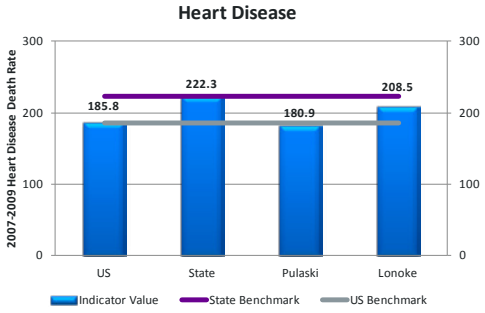
Baptist Health Medical Center–North Little Rock Appendix

BHMC-North Little Rock Community Served Definition ZIP Code Table

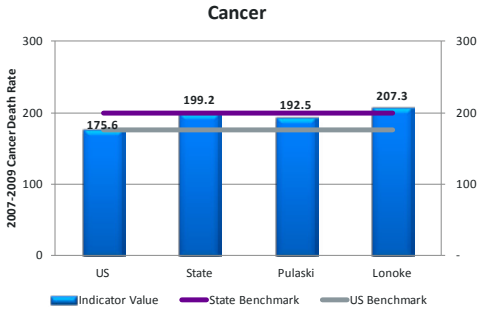
BAPTIST HEALTH COMMUNITY	ZIP	PONAME	COUNTY NAME	CBSANAME
BHMC-North Little Rock	72007	Austin	Lonoke, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-North Little Rock	72023	Cabot	Lonoke, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-North Little Rock	72037	England	Lonoke, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-North Little Rock	72046	England	Lonoke, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-North Little Rock	72076	Jacksonville	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-North Little Rock	72078	Jacksonville	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-North Little Rock	72083	Keo	Lonoke, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-North Little Rock	72086	Lonoke	Lonoke, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-North Little Rock	72099	Little Rock Air Force Bas	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-North Little Rock	72114	North Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-North Little Rock	72115	North Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-North Little Rock	72116	North Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-North Little Rock	72117	North Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-North Little Rock	72118	North Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-North Little Rock	72119	North Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-North Little Rock	72120	Sherwood	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-North Little Rock	72124	Sherwood	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-North Little Rock	72142	Scott	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-North Little Rock	72176	Ward	Lonoke, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-North Little Rock	72190	North Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-North Little Rock	72231	North Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro

Health Indicator Analysis

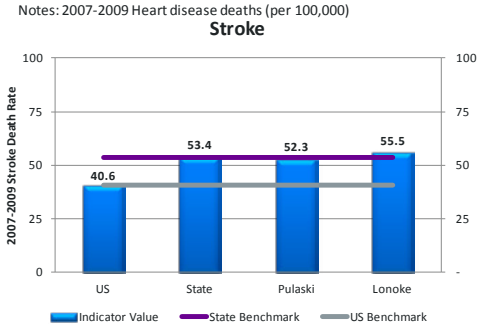
BHMC NORTH LITTLE ROCK:CAUSE OF DEATH



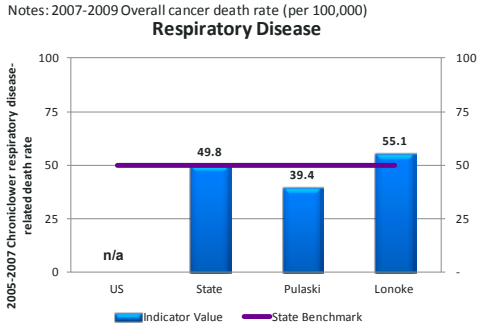
Source: National Vital Statistics System-Mortality (CDC, NCHS)
Notes: 2007-2009 Heart disease deaths (per 100,000)



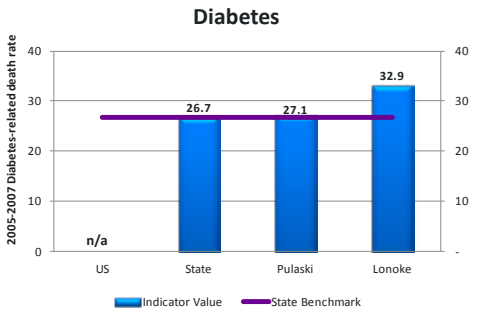
Source: National Vital Statistics System-Mortality (CDC, NCHS)
Notes: 2007-2009 Overall cancer death rate (per 100,000)



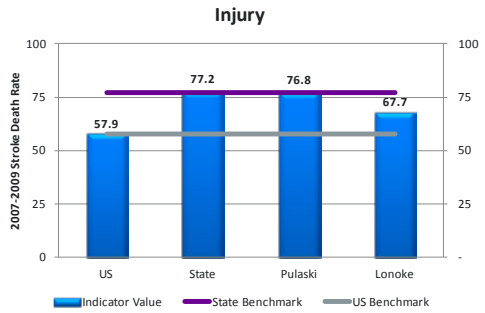
Source: National Vital Statistics System-Mortality (CDC, NCHS)
Notes: 2007-2009 Stroke death rate (per 100,000)



Source: Health Statistics Branch, ADH
Notes: 2005-2007 Chronic lower respiratory disease-related deaths (per 100,000)



Source: Health Statistics Branch, ADH
Notes: 2005-2007 Diabetes-related deaths (per 100,000)

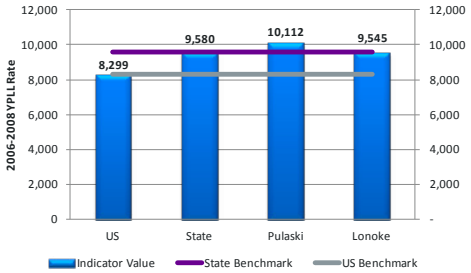


Source: National Vital Statistics System-Mortality (CDC, NCHS)
Notes: 2007-2009 Injury death rate (per 100,000)

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

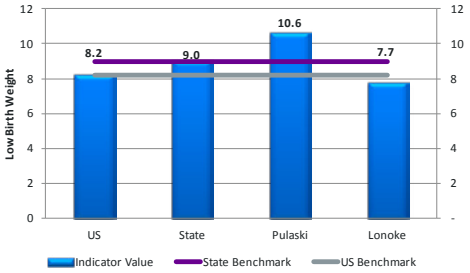
BHMC NORTH LITTLE ROCK: HEALTH OUTCOMES

Premature Deaths



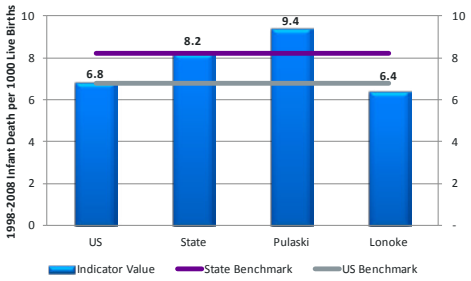
Source: County Health Rankings (NCHS)
Notes: Years of potential life lost before the age of 75 per 100,000 population

Low Birth Weight



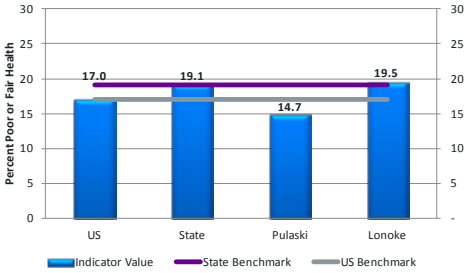
Source: County Health Rankings (NCHS)
Notes: Percent of live births with low birth weight (< 2500 grams)

Infant Mortality



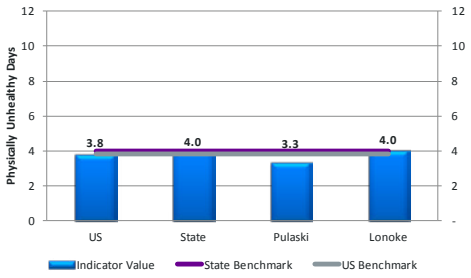
Source: Linked Birth/Infant Death Data Set (CDC-NCHS)
Notes: Rate of all infant deaths (within 1 year), per 1,000 live births

Poor or Fair Health



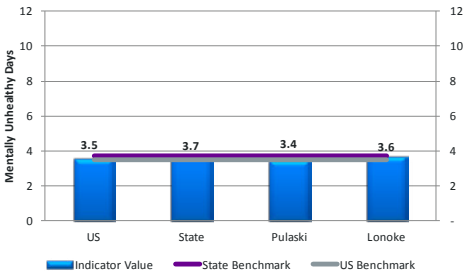
Source: County Health Rankings (BRFSS)
Notes: Percent of adults reporting fair or poor health (age-adjusted)

Poor Physical Health Days



Source: County Health Rankings (BRFSS)
Notes: Average number of physically unhealthy days reported in past 30 days (age-adjusted)

Poor Mental Health Days

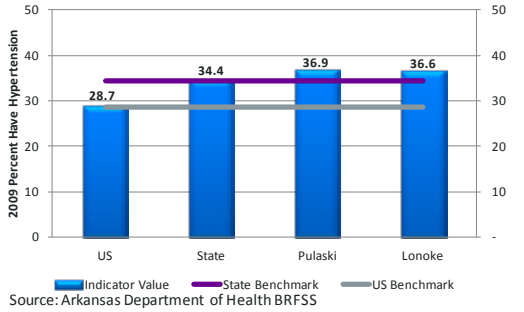


Source: County Health Rankings (BRFSS)
Notes: Average number of mentally unhealthy days reported in past 30 days (age-adjusted)

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BHMC NORTH LITTLE ROCK: CHRONIC CONDITIONS

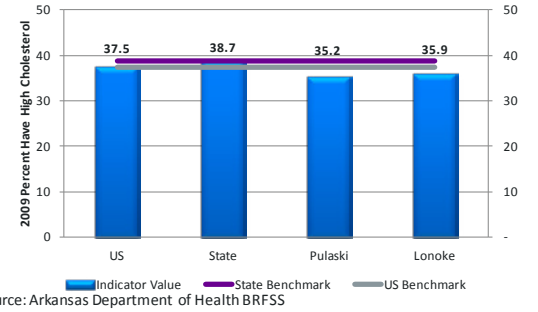
Hypertension



Source: Arkansas Department of Health BRFSS

Notes: Percent of adults that report having been diagnosed with high blood pressure

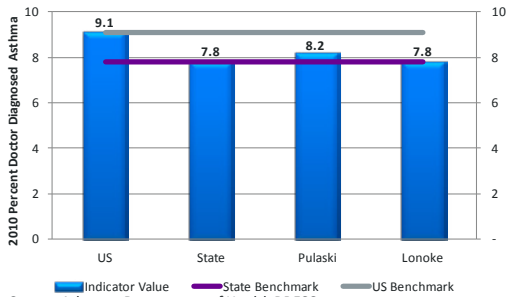
High Cholesterol



Source: Arkansas Department of Health BRFSS

Notes: Percent of adults that report having been diagnosed with high blood cholesterol

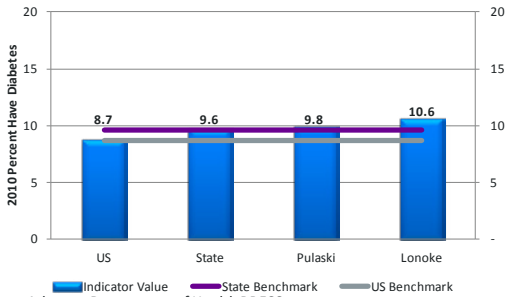
Asthma



Source: Arkansas Department of Health BRFSS

Notes: Percent of adults that report having been diagnosed with asthma

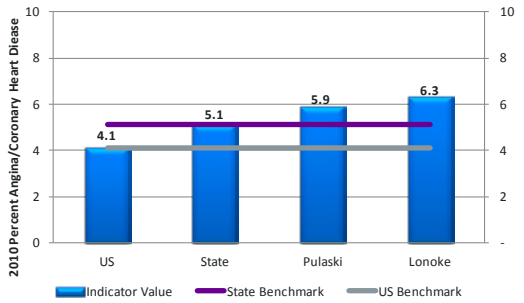
Diabetes



Source: Arkansas Department of Health BRFSS

Notes: Percent of adults that report having been diagnosed as having diabetes

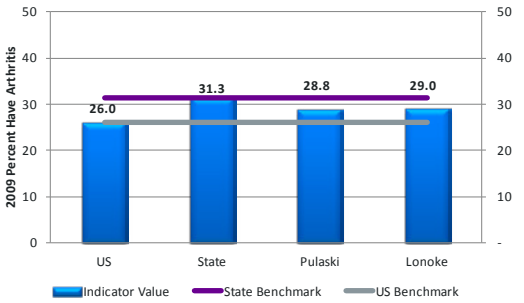
Coronary Heart Disease



Source: Arkansas Department of Health BRFSS

Notes: Percent of adults that report having been diagnosed as having Coronary Heart Disease

Arthritis



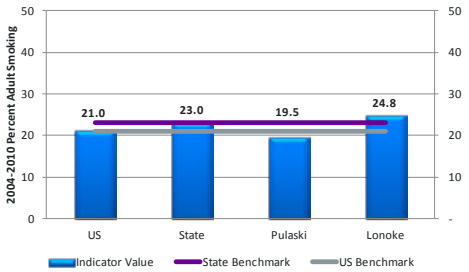
Source: Arkansas Department of Health BRFSS

Notes: Percent of adults that report having been diagnosed as having Arthritis

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

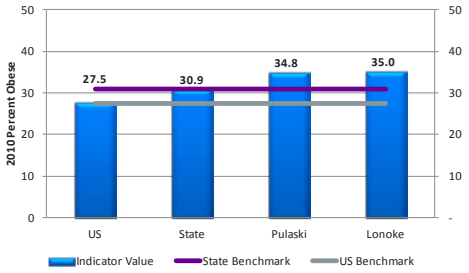
BHMC NORTH LITTLE ROCK: HEALTH BEHAVIORS

Adult Smoking



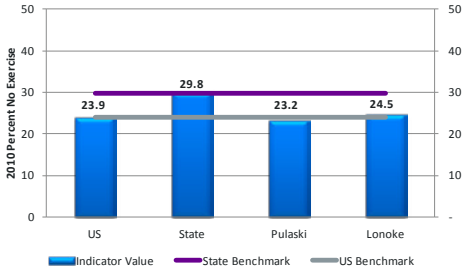
Source: County Health Rankings (BRFSS), Arkansas Department of Health BRFSS
Notes: Percent of adults 18 years+ that report currently smoking cigarettes

Adult Obesity



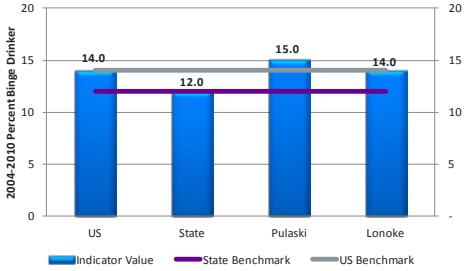
Source: Arkansas Department of Health BRFSS
Notes: Percent of adults 18 years and over that report BMI >= 30 (per self-reported weight/height)

Physical Inactivity



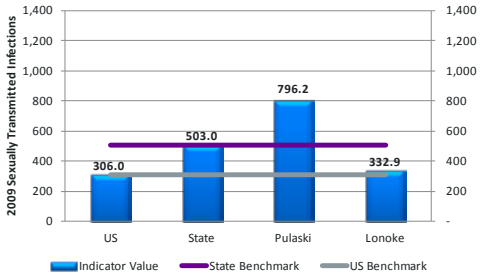
Source: Arkansas Department of Health BRFSS
Notes: Percent of Adults that report no leisure-time exercise in past month

Excessive Drinking



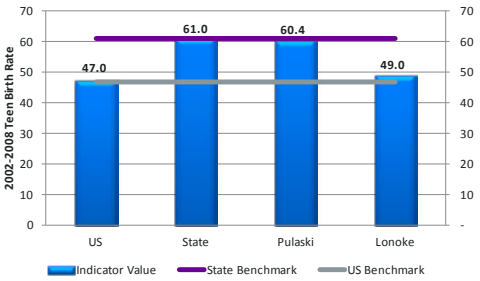
Source: County Health Rankings (BRFSS), Arkansas Department of Health BRFSS
Notes: Percent of adults 18 years and over that report binge drinking

Sexually Transmitted Infections



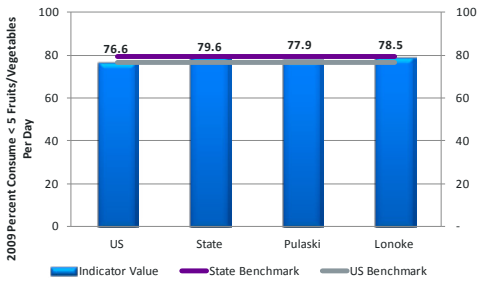
Source: County Health Rankings (BRFSS)
Notes: Chlamydia rate per 100,000 population

Teen Birth Rate



Source: County Health Rankings (BRFSS)
Notes: Percent of all live births to mothers less than 18 years of age

Lack of Healthy Eating

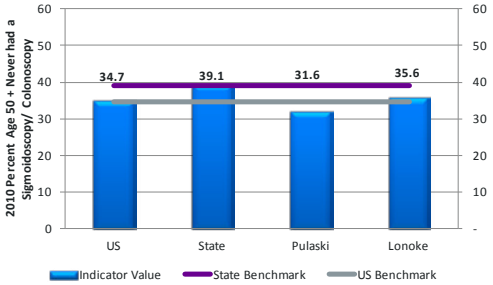


Source: Arkansas Department of Health BRFSS
Notes: Percent of Adults that report fewer than 5 servings of fruits/vegetables per day

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BHMC NORTH LITTLE ROCK: PREVENTION

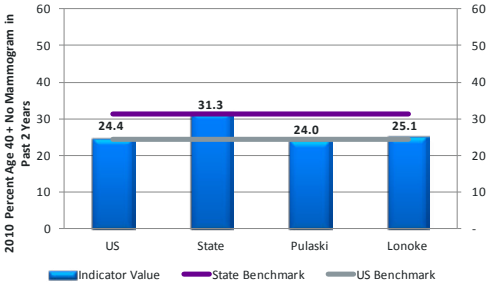
No Colorectal Screening



Source: Arkansas Department of Health BRFSS

Notes: Percent of adults age 50+ that report never having had a sigmoidoscopy or colonoscopy

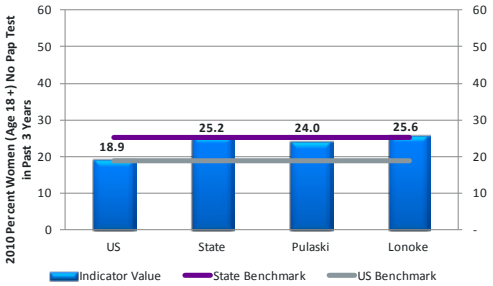
No Mammography



Source: Arkansas Department of Health BRFSS

Notes: Percent of women age 50+ that report no mammogram in the past 2 years

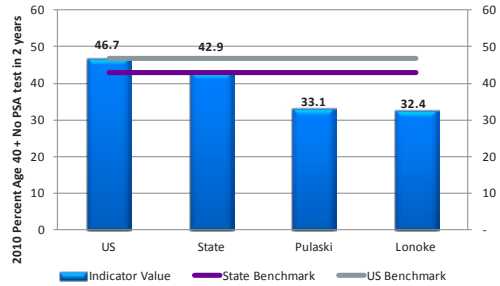
No Pap Test



Source: Arkansas Department of Health BRFSS

Notes: Percent of women age 18+ that report no Pap test in the last 3 years

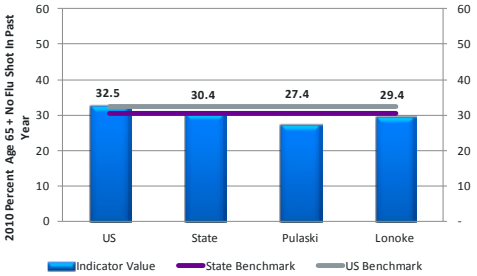
No Prostate Screening



Source: Arkansas Department of Health BRFSS

Notes: Percent of men age 40+ that report no PSA test in the last 2 years

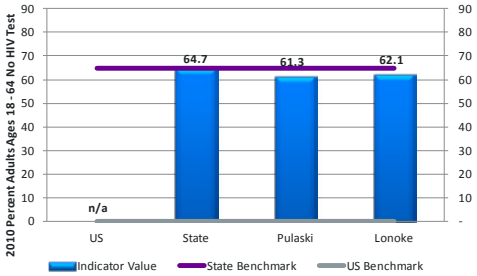
No Flu Shot



Source: Arkansas Department of Health BRFSS

Notes: Percent of adults age 65+ that report having no Influenza vaccine in past 12 months

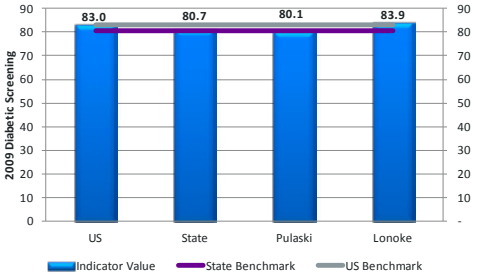
No HIV Test



Source: Arkansas Department of Health BRFSS

Notes: Percent of adults age 18-64 that report having never having an HIV test

Diabetic Screening



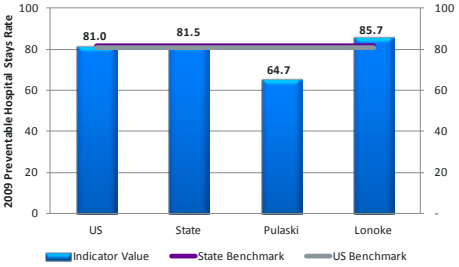
Source: County Health Rankings (Medicare/Dartmouth Institute)

Notes: Percent of diabetic Medicare enrollees that receive HbA1c screening

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

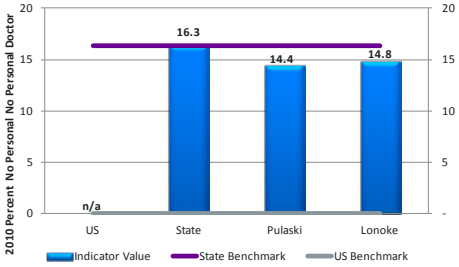
BHMC NORTH LITTLE ROCK: ACCESS

Preventable Hospital Stays



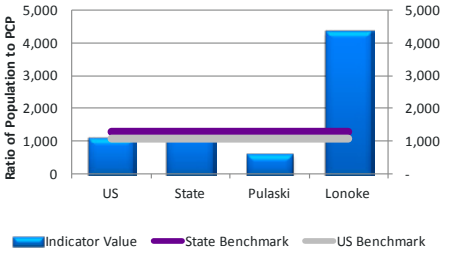
Source: County Health Rankings (Medicare/Dartmouth Institute)
Notes: Hospitalization rate for ambulatory-care sensitive conditions per 1,000 Medicare enrollees

Personal Doctor



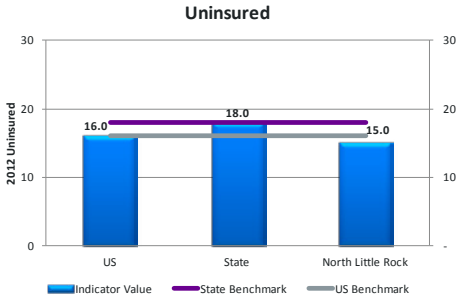
Source: Arkansas Department of Health BRFSS
Notes: Percent of adults age 18+ that report having no personal doctors

Primary Care



Source: County Health Rankings (Health Resources & Services Administration)
Notes: Ratio of population to primary care physicians

Uninsured

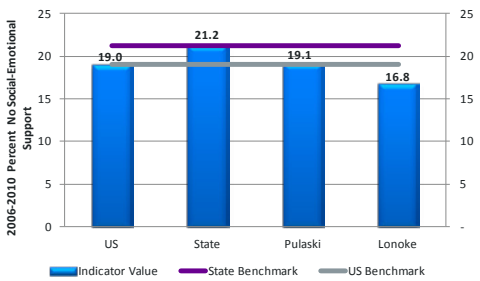


Source: Truven Health (Insurance Coverage Estimates)
Notes: Percent uninsured

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

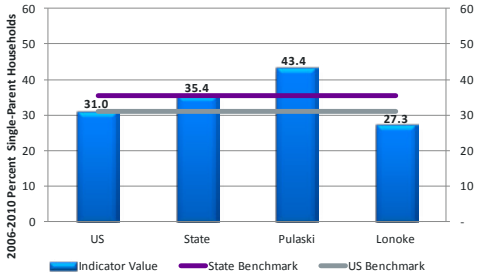
BHMC NORTH LITTLE ROCK: SOCIOECONOMIC

Inadequate Social Support



Source: County Health Rankings (BRFSS)
Notes: Percent of adults without social/emotional support

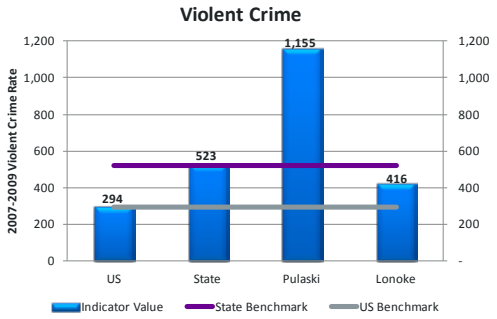
Children in Single Parent Households



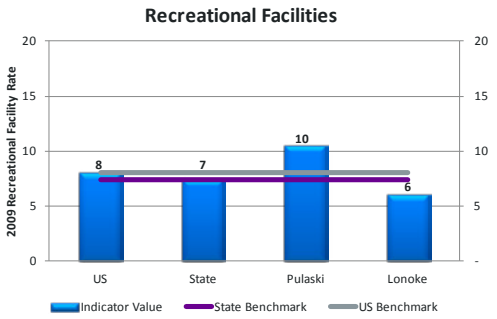
Source: County Health Rankings (BRFSS)
Notes: Percent of children that live in household headed by single parent

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

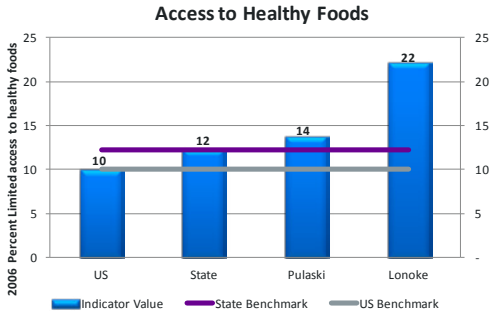
BHMC NORTH LITTLE ROCK: ENVIRONMENT



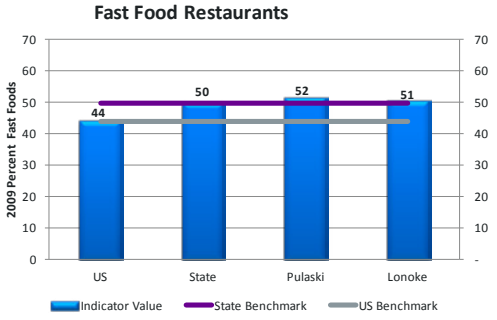
Source: County Health Rankings (BRFSS)
Notes: Violent crime rate per 100,000 population



Source: County Health Rankings (Census County Business Patterns)
Notes: Rate of recreational facilities per 100,000 population



Source: CHR (USDA)
Notes: Percent of population who are low-income and do not live close to a grocery store



Source: CHR (USDA)
Notes: Percent of all restaurants that are fast-food establishments

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

Community Need Index (CNI)

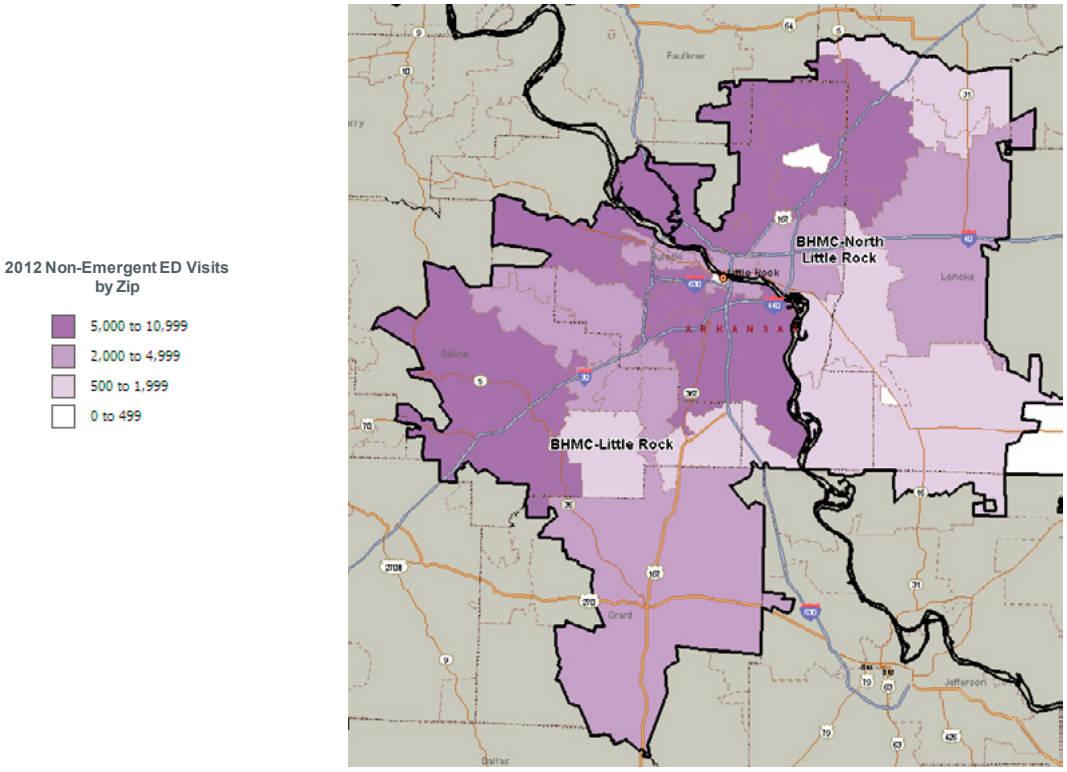
BHMC – NORTH LITTLE ROCK
CNI BARRIER SCORE BY ZIP CODE

Baptist Health Community	Zip	2011 Population	Overall CNI Score	Income Rank	Education Rank	Culture Rank	Insurance Rank	Housing Rank
BHMC North Little Rock	72114	13,255	5	5	5	5	5	5
	72117	12,228	5	4	5	5	5	5
	72046	4,653	5	4	5	5	4	5
	72076	40,524	4	4	3	5	4	5
	72118	21,826	4	3	3	5	4	5
	72086	10,111	4	4	4	4	4	4
	72142	2,266	4	3	5	4	3	4
	72099	1,630	4	4	3	4	4	5
	72083	222	4	5	3	4	4	4
	72120	31,253	3	2	1	4	2	4
	72116	21,356	3	1	1	4	2	5
	72176	7,459	3	3	3	2	3	4
	72023	36,790	2	3	2	2	2	3
	72007	6,787	2	2	3	2	2	2

The CNI score is an average of five different barrier scores that measure various socio-economic indicators of each community. The CNI is strongly linked to variations in community healthcare needs and is a strong indicator of a community's demand for various healthcare services.

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BHMC – LITTLE ROCK & NORTH LITTLE ROCK NON-EMERGENT ED VISITS BY ZIP

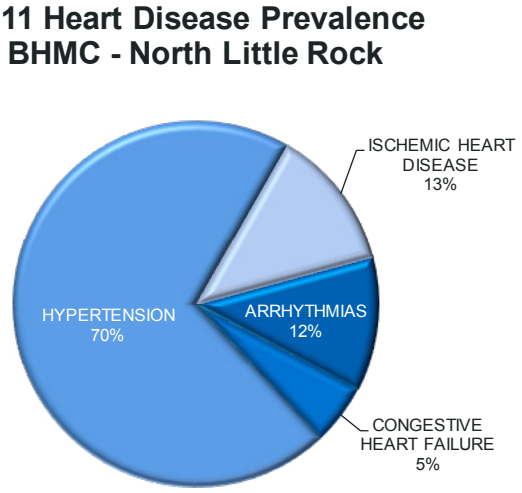


Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

North Little Rock

Zip Code	2012 Total ED Visits	2012 Non-Emergent ED Visits	2012 % Non-Emergent	2017 Total ED Visits	2017 Non-Emergent ED Visits	2017 % Non-Emergent	2012 - 2017 % Chg Non-Emergent
72007	3,115	1,920	62%	3,732	2,219	59%	16%
72023	13,478	8,428	63%	15,730	9,520	61%	13%
72046	1,871	1,125	60%	2,007	1,156	58%	3%
72076	15,767	10,878	69%	16,839	11,246	67%	3%
72083	108	66	61%	125	73	58%	11%
72086	4,214	2,548	60%	4,743	2,769	58%	9%
72099	289	218	75%	298	221	74%	1%
72114	5,824	4,102	70%	6,299	4,160	66%	1%
72116	8,815	5,478	62%	9,191	5,596	61%	2%
72117	5,405	3,655	68%	5,812	3,787	65%	4%
72118	9,349	6,285	67%	9,989	6,529	65%	4%
72120	12,900	8,668	67%	14,066	9,243	66%	7%
72142	1,065	701	66%	1,208	771	64%	10%
72176	3,127	1,995	64%	3,780	2,331	62%	17%
Total	**85,327**	**56,067**	**66%**	**93,819**	**59,621**	**64%**	**6%**

BHMC – NORTH LITTLE ROCK
2011 ESTIMATED HEART DISEASE PREVALENCE



BHMC - North Little Rock

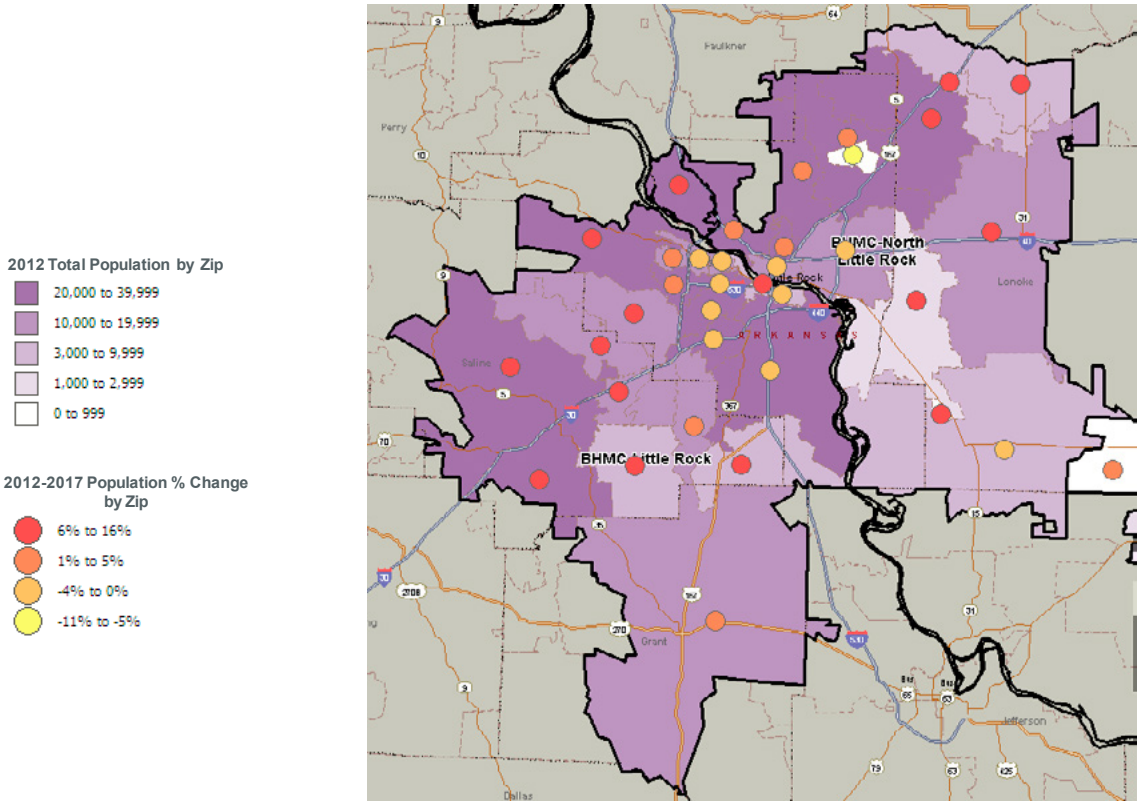
Heart Disease Type	2011 Prevalence
ARRHYTHMIAS	8,212
CONGESTIVE HEART FAILURE	3,729
HYPERTENSION	48,647
ISCHEMIC HEART DISEASE	8,675
Grand Total	**69,263**

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

North Little Rock

Zip Code	ARRHYTHMIAS 2011 Prevalence	CONGESTIVE HEART FAILURE 2011 Prevalence	HYPERTENSION 2011 Prevalence	ISCHEMIC HEART DISEASE 2011 Prevalence	TOTAL HEART DISEASE 2011 Prevalence
72007	221	121	1,473	282	2,097
72023	1,113	603	7,568	1,389	10,673
72046	183	101	1,079	237	1,600
72076	1,478	614	8,850	1,420	12,362
72083	9	5	52	12	78
72086	372	204	2,273	477	3,326
72099	29	8	261	16	314
72114	512	213	2,869	487	4,081
72116	1,174	510	6,175	1,202	9,061
72117	532	225	2,961	526	4,244
72118	960	408	5,384	952	7,704
72120	1,313	559	7,673	1,307	10,852
72142	104	45	602	108	859
72176	212	113	1,427	260	2,012
Total	**8,212**	**3,729**	**48,647**	**8,675**	**69,263**

BHMC – LITTLE ROCK & NORTH LITTLE ROCK
2012 – 2017 TOTAL POPULATION

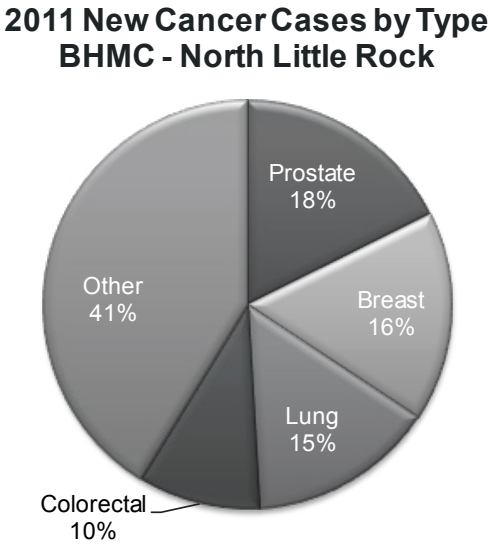


Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BHMC – NORTH LITTLE ROCK
2011 ESTIMATED CANCER INCIDENCE

BHMC - North Little Rock

Cancer Type	2011 Incidence (new Cancer cases)
PROSTATE	221
BREAST	208
LUNG	186
OTHER	128
COLORECTAL	121
NH LYMPHOMA	52
KIDNEY	42
MELANOMA	42
BLADDER	39
LEUKEMIA	38
PANCREAS	34
ORAL CAVITY	30
UTERINE	29
STOMACH	20
OVARIAN	20
BRAIN	18
THYROID	18
CERVICAL	6
Grand Total	**1,253**

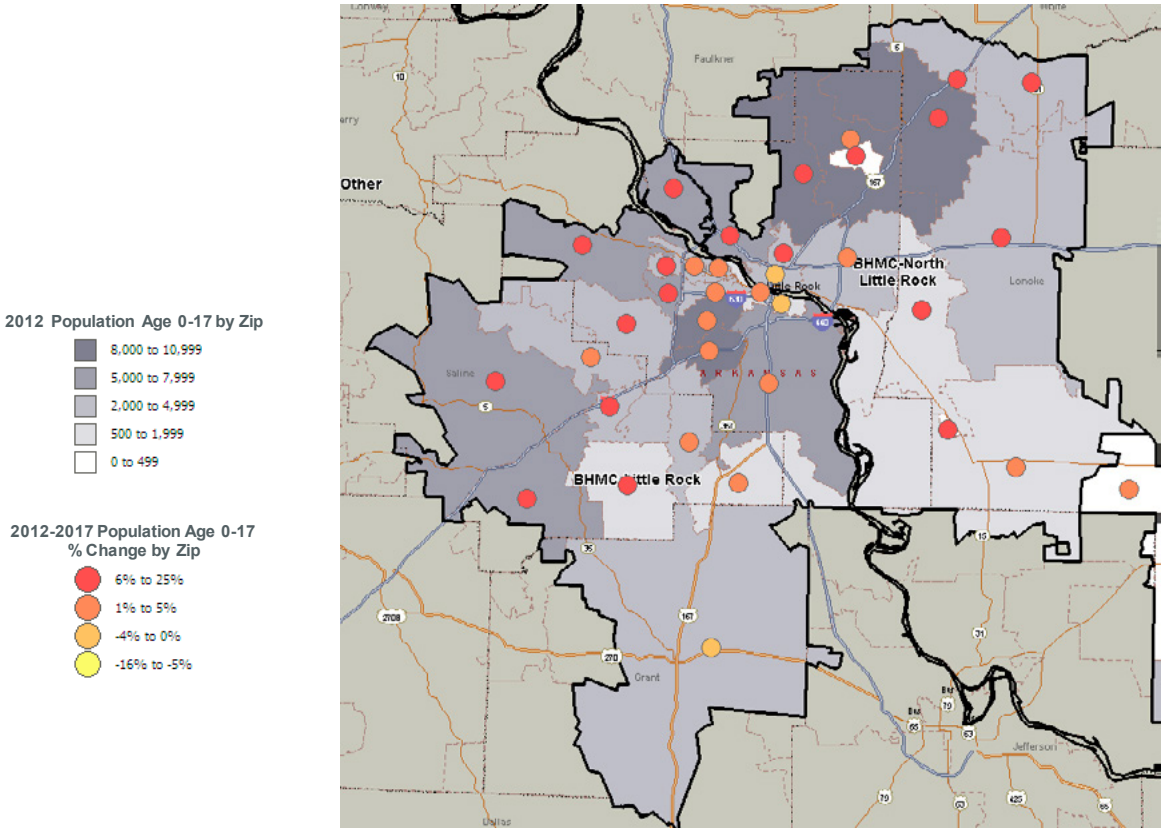


Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

North Little Rock

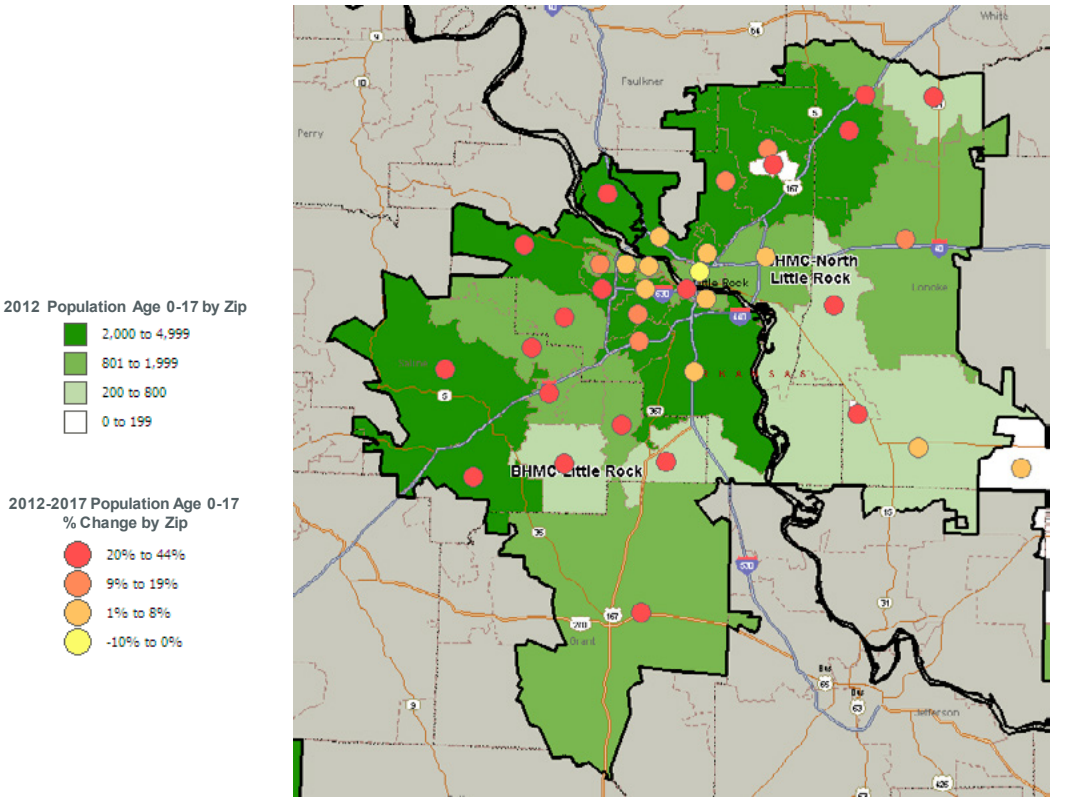
Zip Code	BREAST 2011 Incidence	COLORECTAL 2011 Incidence	LUNG 2011 Incidence	PROSTATE 2011 Incidence	OTHER 2011 Incidence
72007	6	4	6	7	17
72023	33	19	28	33	86
72046	5	3	5	6	13
72076	36	20	30	38	88
72083	0	0	0	0	1
72086	10	6	10	11	27
72099	0	0	0	0	2
72114	12	8	11	14	28
72116	28	16	26	28	69
72117	12	8	12	15	30
72118	23	13	21	24	56
72120	32	18	28	33	80
72142	2	2	2	3	6
72176	6	3	5	6	16
Total	**208**	**121**	**186**	**221**	**517**

BHMC – LITTLE ROCK & NORTH LITTLE ROCK
2012 – 2017 POPULATION CHILDREN AGE 0-17



Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BHMC – LITTLE ROCK & NORTH LITTLE ROCK
2012 – 2017 POPULATION AGE 65+



Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BHMC – NORTH LITTLE ROCK
2012 – 2017 POPULATION BY AGE GROUP BY ZIP

NORTH LITTLE ROCK

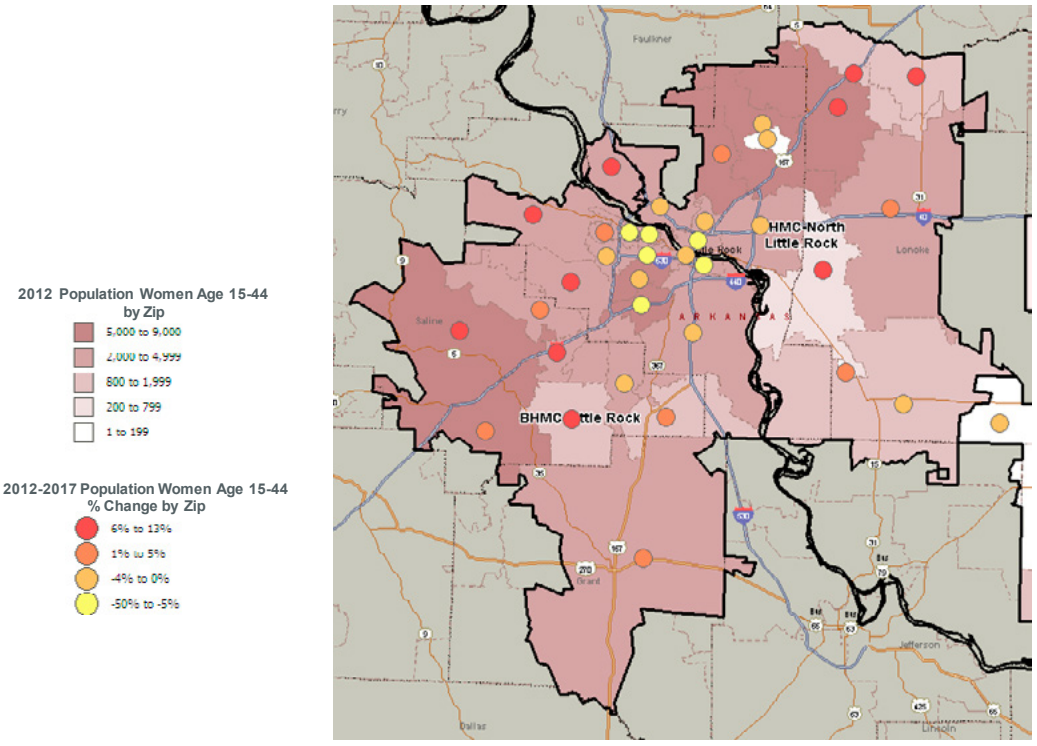
Zip Code	Age Group	2000 Population	2012 Population	2017 Population	2012-2017 Change
72007	00-17	1,405	2,067	2,232	8%
72007	18-44	1,955	3,100	3,431	11%
72007	45-64	1,094	2,217	2,649	19%
72007	65+	419	859	1,179	37%
72023	00-17	7,409	9,840	10,678	9%
72023	18-44	10,001	13,379	14,339	7%
72023	45-64	5,331	9,044	10,477	16%
72023	65+	1,981	3,492	4,655	33%
72046	00-17	1,243	1,190	1,204	1%
72046	18-44	1,684	1,584	1,573	-1%
72046	45-64	1,100	1,055	1,038	-2%
72046	65+	759	674	713	6%
72076	00-17	11,463	10,533	11,013	5%
72076	18-44	16,987	14,642	14,315	-2%
72076	45-64	7,802	9,096	9,104	0%
72076	65+	3,178	4,195	4,750	13%
72083	00-17	59	73	81	11%
72083	18-44	79	94	95	1%
72083	45-64	53	74	82	11%
72083	65+	30	33	42	27%
72086	00-17	2,496	2,846	3,033	7%
72086	18-44	3,455	3,837	3,982	4%
72086	45-64	2,202	2,544	2,708	6%
72086	65+	1,219	1,432	1,688	18%
72099	00-17	90	33	36	9%
72099	18-44	1,224	648	605	-7%
72099	45-64	69	33	37	12%
72099	65+	16	13	18	38%

NORTH LITTLE ROCK

Zip Code	Age Group	2000 Population	2012 Population	2017 Population	2012-2017 Change
72114	00-17	4,756	3,913	3,820	-2%
72114	18-44	5,323	4,720	4,629	-2%
72114	45-64	2,614	2,562	2,438	-5%
72114	65+	1,951	1,514	1,504	-1%
72116	00-17	4,098	4,178	4,466	7%
72116	18-44	7,432	7,112	6,985	-2%
72116	45-64	5,481	6,037	5,917	-2%
72116	65+	3,612	3,969	4,302	8%
72117	00-17	3,499	3,160	3,307	5%
72117	18-44	4,510	4,659	4,644	0%
72117	45-64	2,774	2,900	2,778	-4%
72117	65+	1,563	1,714	1,778	4%
72118	00-17	5,470	5,707	6,136	8%
72118	18-44	8,748	8,242	8,061	-2%
72118	45-64	4,802	5,694	5,709	0%
72118	65+	2,835	2,931	3,158	8%
72120	00-17	6,834	8,100	8,889	10%
72120	18-44	10,861	11,781	11,899	1%
72120	45-64	6,918	8,713	8,839	1%
72120	65+	2,756	3,831	4,584	20%
72142	00-17	497	599	657	10%
72142	18-44	768	906	967	7%
72142	45-64	577	782	814	4%
72142	65+	253	359	438	22%
72176	00-17	1,632	2,494	2,810	13%
72176	18-44	2,189	3,179	3,468	9%
72176	45-64	1,031	1,783	2,238	26%
72176	65+	407	757	978	29%

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BHMC – LITTLE ROCK & NORTH LITTLE ROCK
2012–2017 POPULATION WOMEN CHILDBEARING AGE



Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BHMC – NORTH LITTLE ROCK
2012 – 2017 WOMEN CHILDBEARING AGE BY ZIP

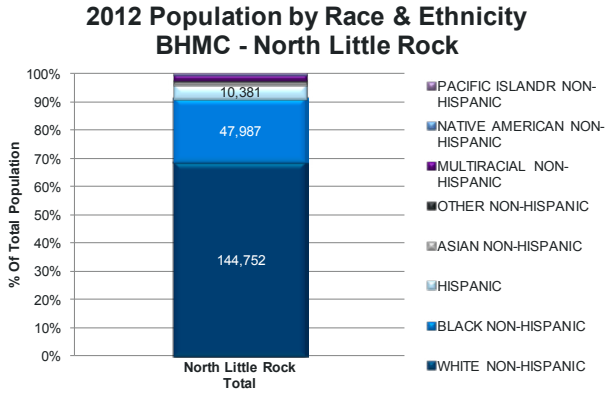
BHMC-NORTH LITTLE ROCK

Zip Code	2012 Population	2017 Population	2012-2017 Change
72007	1,802	1,950	8%
72023	7,586	8,129	7%
72046	920	927	1%
72076	8,256	8,091	-2%
72083	53	56	5%
72086	2,079	2,190	5%
72099	118	116	-2%
72114	2,871	2,740	-5%
72116	3,970	3,901	-2%
72117	2,651	2,575	-3%
72118	4,653	4,566	-2%
72120	6,576	6,647	1%
72142	480	523	8%
72176	1,797	1,985	9%
TOTAL	**43,812**	**44,396**	**1.3%**

Note: women childbearing age = females age 15-44

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BHMC – NORTH LITTLE ROCK
2012-2017 POPULATION BY RACE & ETHNICITY



BHMC-North Little Rock

Race/Ethnicity	2012 Population	2017 Population	2012-2017 Population Change	2012-2017 Population % Chg
WHITE NON-HISPANIC	144,752	146,754	2,002	1%
BLACK NON-HISPANIC	47,987	52,817	4,830	10%
HISPANIC	10,381	13,291	2,910	28%
ASIAN NON-HISPANIC	2,352	2,743	391	17%
OTHER NON-HISPANIC	235	276	41	17%
MULTIRACIAL NON-HISPANIC	4,206	5,033	827	20%
NATIVE AMERICAN NON-HISPANIC	902	935	33	4%
PACIFIC ISLANDR NON-HISPANIC	108	121	13	12%
Grand Total	**210,923**	**221,970**	**11,047**	**5%**

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BHMC –NORTH LITTLE ROCK
RACE & ETHNICITY BY ZIP

BHMC-North Little Rock

Zip Code	Ethnicity	2000 Population	2012 Population	2017 Population	2012-2017 Change
72007	ASIAN NON-HISPANIC	15	65	90	38%
72007	BLACK NON-HISPANIC	9	91	128	41%
72007	HISPANIC	85	224	291	30%
72007	MULTIRACIAL NON-HISPANIC	46	135	184	36%
72007	NATIVE AMERICAN NON-HISPANIC	26	44	50	14%
72007	OTHER NON-HISPANIC	1	3	4	33%
72007	PACIFIC ISLANDR NON-HISPANIC	2	4	7	75%
72007	WHITE NON-HISPANIC	4,689	7,677	8,737	14%
72023	ASIAN NON-HISPANIC	165	434	577	33%
72023	BLACK NON-HISPANIC	92	546	747	37%
72023	HISPANIC	424	1,379	1,889	37%
72023	MULTIRACIAL NON-HISPANIC	266	579	738	27%
72023	NATIVE AMERICAN NON-HISPANIC	112	171	196	15%
72023	OTHER NON-HISPANIC	10	26	33	27%
72023	PACIFIC ISLANDR NON-HISPANIC	9	17	21	24%
72023	WHITE NON-HISPANIC	23,644	32,603	35,948	10%
72046	ASIAN NON-HISPANIC	3	5	7	40%
72046	BLACK NON-HISPANIC	1,377	1,240	1,192	-4%
72046	HISPANIC	61	127	151	19%
72046	MULTIRACIAL NON-HISPANIC	31	72	90	25%
72046	NATIVE AMERICAN NON-HISPANIC	16	9	9	0%
72046	OTHER NON-HISPANIC	1	7	10	43%
72046	PACIFIC ISLANDR NON-HISPANIC	1	-	-	0%
72046	WHITE NON-HISPANIC	3,296	3,043	3,069	1%
72076	ASIAN NON-HISPANIC	630	652	666	2%
72076	BLACK NON-HISPANIC	7,808	10,712	11,981	12%
72076	HISPANIC	1,199	2,332	2,911	25%
72076	MULTIRACIAL NON-HISPANIC	799	1,201	1,385	15%
72076	NATIVE AMERICAN NON-HISPANIC	200	182	185	2%
72076	OTHER NON-HISPANIC	56	51	56	10%
72076	PACIFIC ISLANDR NON-HISPANIC	33	26	26	0%
72076	WHITE NON-HISPANIC	28,705	23,310	21,972	-6%

BHMC-North Little Rock

Zip Code	Ethnicity	2000 Population	2012 Population	2017 Population	2012-2017 Change
72083	ASIAN NON-HISPANIC	1	-	-	0%
72083	BLACK NON-HISPANIC	29	30	30	0%
72083	HISPANIC	4	11	11	0%
72083	MULTIRACIAL NON-HISPANIC	1	4	6	50%
72083	NATIVE AMERICAN NON-HISPANIC	1	1	-	-100%
72083	OTHER NON-HISPANIC	-	-	-	0%
72083	PACIFIC ISLANDR NON-HISPANIC	-	-	-	0%
72083	WHITE NON-HISPANIC	185	228	253	11%
72086	ASIAN NON-HISPANIC	26	57	75	32%
72086	BLACK NON-HISPANIC	1,187	1,388	1,439	4%
72086	HISPANIC	199	406	515	27%
72086	MULTIRACIAL NON-HISPANIC	80	140	172	23%
72086	NATIVE AMERICAN NON-HISPANIC	53	35	33	-6%
72086	OTHER NON-HISPANIC	2	5	7	40%
72086	PACIFIC ISLANDR NON-HISPANIC	1	2	1	-50%
72086	WHITE NON-HISPANIC	7,824	8,626	9,169	6%
72099	ASIAN NON-HISPANIC	16	7	5	-29%
72099	BLACK NON-HISPANIC	297	55	44	-20%
72099	HISPANIC	37	64	76	19%
72099	MULTIRACIAL NON-HISPANIC	19	15	16	7%
72099	NATIVE AMERICAN NON-HISPANIC	12	2	-	-100%
72099	OTHER NON-HISPANIC	1	2	3	50%
72099	PACIFIC ISLANDR NON-HISPANIC	2	-	-	0%
72099	WHITE NON-HISPANIC	1,015	582	552	-5%
72114	ASIAN NON-HISPANIC	44	45	48	7%
72114	BLACK NON-HISPANIC	10,536	9,040	8,736	-3%
72114	HISPANIC	300	614	744	21%
72114	MULTIRACIAL NON-HISPANIC	184	243	266	9%
72114	NATIVE AMERICAN NON-HISPANIC	50	36	35	-3%
72114	OTHER NON-HISPANIC	11	7	5	-29%
72114	PACIFIC ISLANDR NON-HISPANIC	5	26	31	19%
72114	WHITE NON-HISPANIC	3,514	2,698	2,526	-6%

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BHMC-North Little Rock

Zip Code	Ethnicity	2000 Population	2012 Population	2017 Population	2012-2017 Change
72116	ASIAN NON-HISPANIC	195	359	410	14%
72116	BLACK NON-HISPANIC	1,767	3,131	3,659	17%
72116	HISPANIC	337	818	1,054	29%
72116	MULTIRACIAL NON-HISPANIC	194	364	433	19%
72116	NATIVE AMERICAN NON-HISPANIC	82	78	77	-1%
72116	OTHER NON-HISPANIC	7	25	32	28%
72116	PACIFIC ISLANDR NON-HISPANIC	6	10	10	0%
72116	WHITE NON-HISPANIC	18,035	16,511	15,995	-3%
72117	ASIAN NON-HISPANIC	26	48	54	13%
72117	BLACK NON-HISPANIC	6,498	7,918	8,458	7%
72117	HISPANIC	177	558	717	28%
72117	MULTIRACIAL NON-HISPANIC	171	204	215	5%
72117	NATIVE AMERICAN NON-HISPANIC	54	44	44	0%
72117	OTHER NON-HISPANIC	12	20	22	10%
72117	PACIFIC ISLANDR NON-HISPANIC	3	-	-	0%
72117	WHITE NON-HISPANIC	5,405	3,641	2,997	-18%
72118	ASIAN NON-HISPANIC	92	163	191	17%
72118	BLACK NON-HISPANIC	4,529	7,468	8,590	15%
72118	HISPANIC	785	2,279	2,914	28%
72118	MULTIRACIAL NON-HISPANIC	246	414	485	17%
72118	NATIVE AMERICAN NON-HISPANIC	104	80	70	-13%
72118	OTHER NON-HISPANIC	17	34	41	21%
72118	PACIFIC ISLANDR NON-HISPANIC	7	1	2	100%
72118	WHITE NON-HISPANIC	16,075	12,135	10,771	-11%
72120	ASIAN NON-HISPANIC	238	470	560	19%
72120	BLACK NON-HISPANIC	2,522	5,557	6,853	23%
72120	HISPANIC	570	1,269	1,627	28%
72120	MULTIRACIAL NON-HISPANIC	318	635	775	22%
72120	NATIVE AMERICAN NON-HISPANIC	136	145	149	3%
72120	OTHER NON-HISPANIC	33	40	40	0%
72120	PACIFIC ISLANDR NON-HISPANIC	14	21	22	5%
72120	WHITE NON-HISPANIC	23,538	24,288	24,185	0%

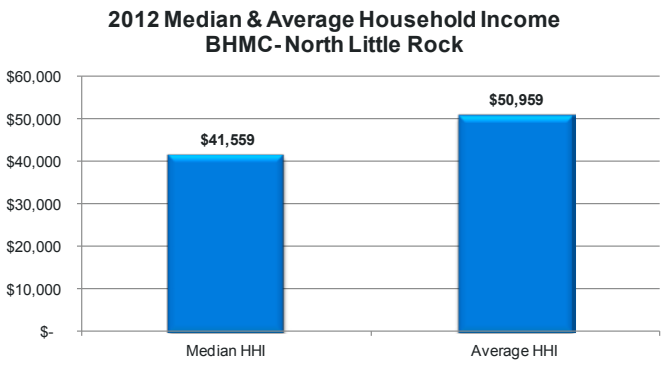
BHMC-North Little Rock

Zip Code	Ethnicity	2000 Population	2012 Population	2017 Population	2012-2017 Change
72142	ASIAN NON-HISPANIC	1	10	13	30%
72142	BLACK NON-HISPANIC	444	725	840	16%
72142	HISPANIC	62	66	74	12%
72142	MULTIRACIAL NON-HISPANIC	18	50	66	32%
72142	NATIVE AMERICAN NON-HISPANIC	8	5	5	0%
72142	OTHER NON-HISPANIC	1	2	2	0%
72142	PACIFIC ISLANDR NON-HISPANIC	2	-	-	0%
72142	WHITE NON-HISPANIC	1,559	1,788	1,876	5%
72176	ASIAN NON-HISPANIC	14	37	47	27%
72176	BLACK NON-HISPANIC	9	86	120	40%
72176	HISPANIC	81	234	317	35%
72176	MULTIRACIAL NON-HISPANIC	55	150	202	35%
72176	NATIVE AMERICAN NON-HISPANIC	37	70	82	17%
72176	OTHER NON-HISPANIC	-	13	21	62%
72176	PACIFIC ISLANDR NON-HISPANIC	-	1	1	0%
72176	WHITE NON-HISPANIC	5,063	7,622	8,704	14%

BHMC – NORTH LITTLE ROCK
HOUSEHOLD INCOME

BHMC-NORTH LITTLE ROCK

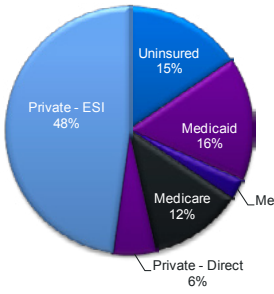
Zip Code	2012 Total Households	2012 Average Household Income	2012 Median Household Income
72007	2,947	$61,874	$53,044
72023	13,193	$62,726	$54,931
72046	1,856	$41,709	$31,957
72076	15,332	$46,206	$38,735
72083	105	$50,143	$38,088
72086	4,023	$51,021	$42,933
72099	55	$44,545	$37,500
72114	5,415	$28,230	$19,902
72116	9,725	$67,764	$54,453
72117	4,755	$37,346	$29,879
72118	9,272	$47,468	$39,136
72120	13,205	$60,146	$50,550
72142	1,046	$62,980	$47,857
72176	3,021	$51,267	$42,858



Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BHMC – NORTH LITTLE ROCK
INSURANCE COVERAGE

2012 Insurance Coverage by Insurance Type
BHMC - North Little Rock

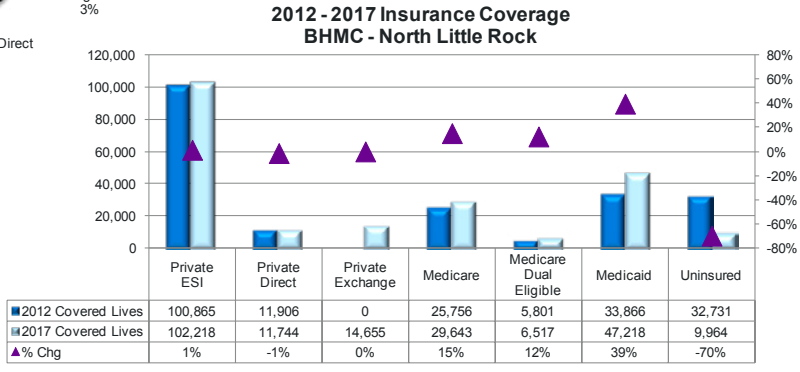


Private ESI (Employer Sponsored Insurance) = Plans offered through an employer

Private Exchanges = Plans purchased via an insurance exchange or insurance market place

Medicare Dual Eligible = Medicare enrollees receiving additional benefits via Medicaid

Private Direct = Individuals who purchase insurance directly from an insurance provider



	Private ESI	Private Direct	Private Exchange	Medicare	Medicare Dual Eligible	Medicaid	Uninsured
2012 Covered Lives	100,865	11,906	0	25,756	5,801	33,866	32,731
2017 Covered Lives	102,218	11,744	14,655	29,643	6,517	47,218	9,964
% Chg	1%	-1%	0%	15%	12%	39%	-70%

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BHMC – NORTH LITTLE ROCK
INSURANCE COVERAGE BY ZIP

BHMC-North Little Rock

Zip Code	Insurance Type	2012 Covered Lives	2017 Covered Lives	% Chg
72007	Private - ESI	5,125	5,576	9%
72007	Private - Direct	602	646	7%
72007	Private - Exchange	0	523	N/A
72007	Medicare	834	1,132	36%
72007	Medicare Dual Eligible	182	240	32%
72007	Medicaid	809	1,129	40%
72007	Uninsured	691	244	-65%
72023	Private - ESI	22,100	23,503	6%
72023	Private - Direct	2,606	2,733	5%
72023	Private - Exchange	0	2,277	N/A
72023	Medicare	3,381	4,455	32%
72023	Medicare Dual Eligible	748	953	27%
72023	Medicaid	3,731	5,116	37%
72023	Uninsured	3,189	1,111	-65%
72046	Private - ESI	1,425	1,388	-3%
72046	Private - Direct	167	152	-9%
72046	Private - Exchange	0	325	N/A
72046	Medicare	658	697	6%
72046	Medicare Dual Eligible	140	147	5%
72046	Medicaid	1,140	1,531	34%
72046	Uninsured	974	286	-71%
72076	Private - ESI	17,416	16,982	-2%
72076	Private - Direct	2,058	1,922	-7%
72076	Private - Exchange	0	2,914	N/A
72076	Medicare	4,227	4,769	13%
72076	Medicare Dual Eligible	978	1,072	10%
72076	Medicaid	6,874	9,495	38%
72076	Uninsured	6,912	2,025	-71%

BHMC-North Little Rock

Zip Code	Insurance Type	2012 Covered Lives	2017 Covered Lives	% Chg
72083	Private - ESI	121	124	2%
72083	Private - Direct	14	13	-7%
72083	Private - Exchange	0	18	N/A
72083	Medicare	33	41	24%
72083	Medicare Dual Eligible	7	8	14%
72083	Medicaid	54	78	44%
72083	Uninsured	46	15	-67%
72086	Private - ESI	4,917	5,038	2%
72086	Private - Direct	581	575	-1%
72086	Private - Exchange	0	764	N/A
72086	Medicare	1,391	1,634	17%
72086	Medicare Dual Eligible	302	349	16%
72086	Medicaid	1,871	2,541	36%
72086	Uninsured	1,599	510	-68%
72099	Private - ESI	371	339	-9%
72099	Private - Direct	47	41	-13%
72099	Private - Exchange	0	86	N/A
72099	Medicare	12	17	42%
72099	Medicare Dual Eligible	3	5	67%
72099	Medicaid	145	180	24%
72099	Uninsured	147	28	-81%
72114	Private - ESI	583	605	4%
72114	Private - Direct	68	58	-15%
72114	Private - Exchange	0	1,057	N/A
72114	Medicare	1,533	1,545	1%
72114	Medicare Dual Eligible	345	352	2%
72114	Medicaid	5,076	7,334	44%
72114	Uninsured	5,104	1,441	-72%

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BHMC-North Little Rock

Zip Code	Insurance Type	2012 Covered Lives	2017 Covered Lives	% Chg
72116	Private - ESI	11,097	10,704	-4%
72116	Private - Direct	1,310	1,252	-4%
72116	Private - Exchange	0	1,135	N/A
72116	Medicare	4,023	4,365	9%
72116	Medicare Dual Eligible	902	958	6%
72116	Medicaid	1,977	2,630	33%
72116	Uninsured	1,988	626	-69%
72117	Private - ESI	3,264	3,200	-2%
72117	Private - Direct	384	351	-9%
72117	Private - Exchange	0	1,080	N/A
72117	Medicare	1,739	1,817	4%
72117	Medicare Dual Eligible	387	404	4%
72117	Medicaid	3,319	4,717	42%
72117	Uninsured	3,337	938	-72%
72118	Private - ESI	9,715	9,535	-2%
72118	Private - Direct	1,145	1,079	-6%
72118	Private - Exchange	0	1,685	N/A
72118	Medicare	2,960	3,204	8%
72118	Medicare Dual Eligible	678	723	7%
72118	Medicaid	4,027	5,628	40%
72118	Uninsured	4,050	1,210	-70%
72120	Private - ESI	18,863	18,826	0%
72120	Private - Direct	2,230	2,193	-2%
72120	Private - Exchange	0	2,004	N/A
72120	Medicare	3,866	4,578	18%
72120	Medicare Dual Eligible	886	1,004	13%
72120	Medicaid	3,280	4,551	39%
72120	Uninsured	3,298	1,054	-68%

BHMC-North Little Rock

Zip Code	Insurance Type	2012 Covered Lives	2017 Covered Lives	% Chg
72142	Private - ESI	1,260	1,303	3%
72142	Private - Direct	150	150	0%
72142	Private - Exchange	0	190	N/A
72142	Medicare	367	443	21%
72142	Medicare Dual Eligible	80	93	16%
72142	Medicaid	395	563	43%
72142	Uninsured	397	133	-66%
72176	Private - ESI	4,608	5,095	11%
72176	Private - Direct	544	579	6%
72176	Private - Exchange	0	597	N/A
72176	Medicare	732	946	29%
72176	Medicare Dual Eligible	163	209	28%
72176	Medicaid	1,168	1,725	48%
72176	Uninsured	999	343	-66%
BHMC-North Little Rock Total		**210,925**	**221,959**	**5%**

Interview & Focus Group Analysis

INTERVIEW ANALYSIS APPROACH

- Coded participants and consolidated interview responses
- Participant responses were parsed by question/topic and categorized
    - Participants gave multiple responses per question – each response recorded individually
    - Therefore, response count can be greater than number of participants
- Density analysis conducted on responses by category

Interview questions were designed to approach some subjects in a multitude of ways and give the interviewer flexibility in conducting the interview. Therefore not every question is represented with a response table as some question responses were collapsed while others eliminated due to time constraints. Additionally some questions were not designed for response consolidation but used to inform other sections of the analysis.

BHMC NORTH LITTLE ROCK INTERVIEW SUMMARY

Questions 1 and 2 were background/ice-breaker questions regarding the community or organization each person represented.

03. What would you say is the current health status of the community?

Response Category	Response Count	Percent of Responses
Good	7	44%
Poor	4	25%
Good-Fair	3	19%
Fair	2	13%
Grand Total	**16**	**100%**

03a. Reasoning?

Response Category	Response Count	Percent of Responses
Prevention/Lifestyle	6	29%
Good Access to Healthcare	3	14%
Good Environment	3	14%
Aging Population	2	10%
Health Disparities	1	5%
Other	1	5%
Obesity	1	5%
Unhealthy Population	1	5%
Higher Socioeconomic Status	1	5%
Lower Socioeconomic Status	1	5%
Lack of Access to Healthcare	1	5%
Grand Total	**21**	**100%**

04. Top health needs of the community?

Response Category	Response Count	Percent of Responses
Obesity	7	13%
Diabetes	6	12%
Chronic Diseases	5	10%
Food/Nutrition	4	8%
Cardiovascular	4	8%
Prevention/Lifestyle Modification	3	6%
Primary Care/PCPs	3	6%
Healthcare Providers/Services	3	6%
No Needs	3	6%
Affordable Care	3	6%
Dental	2	4%
Access	1	2%
Sexual Health	1	2%
Health Education	1	2%
Care Coordination	1	2%
Socioeconomic	1	2%
Smoking	1	2%
Medications	1	2%
Transportation	1	2%
Medical Compliance	1	2%
Grand Total	**52**	**100%**

4c. What is the number one barrier to good health care?

Response Category	Response Count	Percent of Responses
Socioeconomic	3	30%
Access	2	20%
Affordable Care	1	10%
Care Coordination	1	10%
Prevention/Lifestyle Modification	1	10%
Health Education	1	10%
Culture	1	10%
Grand Total	**10**	**100%**

4d. What concerns you the most about the health of the community?

Response Category	Response Count	Percent of Responses
Obesity	2	40%
Uninsured	1	20%
Chronic/Other Diseases	1	20%
Elderly	1	20%
Grand Total	**5**	**100%**

05. Leading social determinants of health?

Response Category	Response Count	Percent of Responses
Socioeconomic	13	32%
Prevention/Lifestyle Modification	5	12%
Food/Nutrition	4	10%
Affordable Care	4	10%
Health Education	4	10%
Access	2	5%
Culture	2	5%
Primary Care	1	2%
Transportation	1	2%
Alcohol/Drug Abuse	1	2%
Environment	1	2%
Violence/Crime	1	2%
Healthcare Providers/Services	1	2%
Care Coordination	1	2%
Grand Total	**41**	**100%**

06. primary health indicators?

Response Category	Response Count	Percent of Responses
Condition/Disease Rates	22	37%
Obesity	8	14%
Infant Mortality/Low Birthweight	6	10%
Socioeconomic	6	10%
Smoking	4	7%
Environmental Measures	3	5%
Hospital/Public Health Measures	3	5%
Lifestyle Measures	2	3%
Other	2	3%
Mortality/Life Expectancy Rates	2	3%
Preventative Care Rates	1	2%
Grand Total	**59**	**100%**

07. vulnerable groups/populations?

Response Category	Response Count	Percent of Responses
Elderly	7	23%
Children/Teens	4	13%
Minorities	4	13%
Un/UnderInsured	4	13%
Poor	4	13%
Disabled	2	7%
Other	2	7%
Young Adults	1	3%
Mental Health	1	3%
Women	1	3%
Grand Total	**30**	**100%**

09. In terms of specific actions/programs, what do you think could be done to address the health needs we've discussed?

Response Category	Response Count	Percent of Responses
Access/Affordable Care	7	25%
Care Coordination	5	18%
Public Health/Health Outcomes	4	14%
Community Outreach/Education	3	11%
Recreation	2	7%
Community Collaboration	2	7%
Social Resources	2	7%
Chronic Disease Care	1	4%
Transportation	1	4%
Policy	1	4%
Grand Total	**28**	**100%**

10. What are some ways Baptist Health or other organizations can engage the community in addressing health needs?

Response Category	Response Count	Percent of Responses
Community Collaboration	7	39%
Access/Affordable Care	5	28%
Other	2	11%
Community Outreach/Education	1	6%
Care Coordination	1	6%
Transportation	1	6%
Environment/Socioeconomic	1	6%
Grand Total	**18**	**100%**

11. What do you consider Baptist Health's role to be in the community?

Response Category	Response Count	Percent of Responses
Leadership	1	100%
Grand Total	**1**	**100%**

13a. Are there any specific organizations in the community that would be a good fit for Baptist Health to partner with to address health needs?

Response Category	Response Count	Percent of Responses
Care Link	1	50%
Senior Center	1	50%
Grand Total	**2**	**100%**

BHMC-North Little Rock Focus Group Summary

LOCATION: BHMC-NORTH LITTLE ROCK DATE: 9/11/12

DISCUSSION 1:

- What grade do you give the health of this community (A-F)?
  - Write the Grade down on sticky note and place on flipchart/white board
- Discuss as a group the grade chosen
  - What factors did you consider when you chose a grade?
  - What do you think of when you think of health?

RESPONSES:

When asked to grade the health of the BHMC-North Little Rock community served, most participants provided a C and one B. While some of the health status was attributed to socioeconomic factors – low income/areas with high levels of poverty, others cite a lack of access to healthy food as an issue. In addition to low health literacy and poor lifestyle choices such as fast food consumption that leads to obesity, the general culture does not emphasize good health. There is a feeling that this has led to children with low health literacy and do not have good examples to follow in terms of healthy living. Transportation is also an issue to accessing healthcare services.

DISCUSSION 2:

- Break into 2-3 smaller groups
- As a group identify the top 3 health needs of the community
  - Agree upon the top 3 needs and why
  - Write each need on sticky note and place on flipchart/white board
  - One person from the group share with the larger group why those needs were chosen

RESPONSES:

GROUP 1:

1. Childhood obesity
   a. More focus on prevention
2. Tobacco use
   a. Need to decrease the amount of tobacco use.
   b. There is also a potential problem with alcohol abuse.
3. Access to care
   a. Seems to be related to access to education.
   b. Needs to be more preventive services.
   c. There is a lack of culture of health.

GROUP 2:

1. Cancer
   a. Needs to be more screenings for prevention.
   b. Cancer is more common among an older population.

2. Affordability of healthcare services is a barrier to care
    a. A lot of people cannot afford the care that they need.
    b. Increased demand to healthcare because of the aging population.
    c. Medicare acceptance is also a problem in this age group.
3. Mental Health

DISCUSSION 3:

- Stay the same smaller groups
- As a group identify up to 10 community resources (health/community organizations)
    - Work together to identify resources and list on flipchart paper
    - Discuss ways these resources could work together to address the health needs discussed
    - One person from the group share with larger group 2-3 ideas from discussion

RESPONSES:

GROUP 1:

- FIT2LIVE
- Community Wellness Centers
- Local Health Departments
- Church support groups
- School wellness
- Women Can Run program
- Food banks
- Parks/trails
- Senior center

GROUP 2:

- Health Department (WIC)
- Baptist Health
- Parks & Recreations
- Boys and Girls Club
- Police Athletic League
- Family Service Agency
- School district
- Local churches
- City of North Little Rock
- United Way
- Homeless coalition
- Head Start

DISCUSSION 4:

- Stay the same smaller groups
- As a group, choose one of the health needs your group identified earlier
- Identify two goals you'd like to accomplish related to the need
    - Goals should be SMART (Specific, Measurable, Attainable, Realistic, Time-sensitive)
- For each goal identify 2-3 action steps that would help achieve the goal

RESPONSES:

GROUP 1:

Community Health Need: Obesity

- Goal 1: 20 churches offering at least 1 class/week
    - Identify and recruit churches and ask to sponsor
    - Schedule and promote classes
- Goal 2: Increase nutritional eating habits by 25%
    - Healthier potlucks, changing where church groups go to eat; what they serve at church so more people try healthier options & it is acknowledged that this is important.

GROUP 2:

Community Health Need: Obesity

- Goal 1: Improve attitudes & actions with exercise
    - Improve group exercise
    - Make it cool and safe
- Goal 2: Improve nutrition
    - Improve awareness of farmer's market- WIC, SNAP, TEA advertising, church and schools
    - Educational cooking classes

Health Resources Available to Meet Identified Needs

BHMC-North Little Rock

Other Hospital Facilities

Hospital Name	Address	City	Owner Type	Type of Service
Central Arkansas Veteran's Healthcare Towbin Healthcare Center	2200 Fort Roots Dr.	North Little Rock	Veteran's Administration	General Medical & Surgical
St. Vincent Medical Center North	2215 Wildwood Ave.	Sherwood	Not-for-profit	General Medical & Surgical
North Metro Medical Center	1400 Braden St.	Jacksonville	Local Government	General Medical & Surgical
Arkansas Surgical Hospital	5201 N. Shore Dr.	North Little Rock	For Profit	Surgical
Allegiance Behavioral Health Hospital of Jacksonville	1400 W. Braden St.	Jacksonville	For Profit	Long Term Acute Care
St. Vincent North Rehabilitation Hospital (in partnership with Healthsouth)	2201 Wildwood Ave.	Sherwood	For Profit	Rehabilitation

Cause of Death: Stroke (Lonoke)

Chronic Conditions: Coronary Heart Disease (Pulaski, Lonoke)

Program Name	Description	Website	Phone Number	State	County
Arkansas Department of Health Heart Disease and Stroke Prevention			501-661-2942	x	
Arkansas Wellness Coalition (AWC)	Includes members of the health care and employer community whose goal is to improve the health and well-being of all Arkansans through the use of nationally recognized, peer reviewed, clinical guidelines for physician, consumer, and employer education. Develop materials referring to nationally recognized standards such as those put forth by Healthy People 2010, the National Committee of Quality Assurance, and other disease-specific organizations such as the American Diabetes Association and the American Heart Association.		501-661-2942	x	

Program Name	Description	Website	Phone Number	State	County
Southern Ain't Fried Sundays - Arkansas Minority Health Commission	Faith Based Outreach Program SAFS is designed to educate African American churches and organizations about healthier alternatives to preparing and cooking southern-style foods. It is also a mechanism for partnering with these groups in an effort to educate their members about the signs and symptoms of stroke, diabetes, and heart attacks. The program is being revamped to expand its reach to the Hispanic communities and individual participants.	http://www.arminorityhealth.com/programs_saf.html	877-264-2826	X	
ARCare	ARcare offers specialized treatment for a variety of cardiovascular conditions including coronary artery disease, heart attack, high blood pressure, high cholesterol, angina, and all other conditions related to the heart and its blood vessel system. Board-Certified Physicians will screen you for heart problems and educate you about healthy lifestyles, regardless of your ability to pay. At ARcare's Health Care, we offer state-of-the-art cardiology care for people with insurance, those without insurance, and those that are underinsured.	http://www.arcare.net/OurServices/OurServicesContinuedpart2/tabid/14185/Default.aspx#cardiology			X (Lonoke County)
UAMS Center for Distance Health AR SAVES Program (Stroke Assistance through Virtual Emergency Support	A stroke management system specifically targeting patients at rural hospitals to by increasing access to subspecialty expertise through telemedicine technology, thereby engineering a coordinated assessment and care-based plan for Arkansas' stroke patients. Ensuring timely administration of clot-busting drugs to improve the chances of recovery while reducing permanent, stroke-related disability and, quite possibly, mortality.		501-686-8514	X	

Program Name	Description	Website	Phone Number	State	County
Arkansas Chronic Illness Collaborative (ACIC)	The ACIC is a group of health care and public health professionals dedicated to improving the management of chronic diseases. The ACIC is a way for health care clinic teams to use the National Health Disparities Collaborative Chronic Care Model to share ideas and knowledge, learn and apply new techniques, and match medical practices with clinical guidelines based on scientific evidence about what works best (diabetes, cancer and cardiovascular diseases)	http://www.healthy.arkansas.gov/programsServices/chronicDisease/Initiatives/Pages/Acic.aspx		X	

Cause of Death: Cancer (Lonoke)

Program Name	Description	Website	Phone Number	State	County
Arkansas Cancer Coalition	The Arkansas Cancer Coalition exists to provide a favorable environment for cancer control partners to work to reduce, and ultimately eliminate, the burden of cancer for every person in the state. The Coalition is a partnership of individuals and organizations working together to: • Provide an overview of the current status of cancer control in Arkansas • Reduce the overall burden of cancer by providing and maintaining a plan of goals and strategies • Improve the quality of life for those personally affected by cancer by strengthening and sustaining the cancer control partnership support network	http://www.arcancercoalition.org/resources/reduce-your-risk		X	
Arkansas Chronic Illness Collaborative (ACIC)	The ACIC is a group of health care and public health professionals dedicated to improving the management of chronic diseases. The ACIC is a way for health care clinic teams to use the National Health Disparities Collaborative Chronic Care Model to share ideas and knowledge, learn and apply new techniques, and match medical practices with clinical guidelines based on scientific evidence about what works best (diabetes, cancer and cardiovascular diseases)	http://www.healthy.arkansas.gov/programsServices/chronicDisease/Initiatives/Pages/Acic.aspx		X	

Cause of Death: Chronic Lower Respiratory Disease (Lonoke)

Program Name	Description	Website	Phone Number	State	County
Arkansas Wellness Coalition (AWC)	Includes members of the health care and employer community whose goal is to improve the health and well-being of all Arkansans through the use of nationally recognized, peer reviewed, clinical guidelines for physician, consumer, and employer education. Develop materials referring to nationally recognized standards such as those put forth by Healthy People 2010, the National Committee of Quality Assurance, and other disease-specific organizations such as the American Diabetes Association and the American Heart Association.		501-661-2942	x	
Arkansas Chronic Illness Collaborative (ACIC)	The ACIC is a group of health care and public health professionals dedicated to improving the management of chronic diseases. The ACIC is a way for health care clinic teams to use the National Health Disparities Collaborative Chronic Care Model to share ideas and knowledge, learn and apply new techniques, and match medical practices with clinical guidelines based on scientific evidence about what works best (diabetes, cancer and cardiovascular diseases)	http://www.healthy.arkansas.gov/programsServices/chronicDisease/Initiatives/Pages/Acic.aspx		x	

Health Outcomes: Low Birth Weight (Pulaski)

Health Outcomes: Infant Mortality (Pulaski)

Program Name	Description	Website	Phone Number	State	County
Arkansas Department of Health	ADH provides prenatal care to an average of 5,000 women annually at many of the Local Health Units.		1-800-462-0599	X	
Arkansas Department of Health Nurse-Family Partnership	Nurse-Family Partnership is a free, voluntary program that partners first-time moms with registered nurses. NFP is available to any first-time mom who is under her 28th week of pregnancy, and who is below 200% of the Federal poverty level.	http://www.adhhomecare.org/nurse-family-arkansas.htm		X	

Health Outcomes: Poor or Fair Health Status (Lonoke)

Program Name	Description	Website	Phone Number	State	County
ADH – Hometown Health Improvement	Hometown Health Improvement initiatives currently exist in every county around the state. HHI coalitions do powerful and unique work to improve the health of those in their communities. Once the coalition is established, many communities are choosing to conduct health behavior surveys to gain important information specific to their communities. Many coalitions are now implementing activities to affect the health of the community. Examples of some activities include: tobacco cessation programs for adolescents, household hazardous waste round-up, parenting support groups, local industry wellness programs, health fairs, and health resource guides.				X (All counties)
Chronic Disease Self Management Program – Be Well Live Well	Developed by the Stanford Patient Education Research Center, the evidence based program teaches participants the skills needed to live well with chronic diseases. It also shows participants how to organize their lives, make and achieve goals, eat properly, exercise and communicate effectively with physicians and others. National outcome studies reveal that CDSMP participants experience a marked decrease in the number of hospital stays and doctor visits.	http://www.agec.org/2012/10/cdsmp-branded-for-arkansas-be-well-live-well/		X	

Chronic Conditions: Hypertension (Pulaski)

Program Name	Description	Website	Phone Number	State	County
Southern Ain't Fried Sundays - Arkansas Minority Health Commission	Faith Based Outreach Program SAFS is designed to educate African American churches and organizations about healthier alternatives to preparing and cooking southern-style foods. It is also a mechanism for partnering with these groups in an effort to educate their members about the signs and symptoms of stroke, diabetes, and heart attacks. The program is being revamped to expand its reach to the Hispanic communities and individual participants.	http://www.arminorityhealth.com/programs_saf.html	877-264-2826		

Chronic Conditions: Asthma (Pulaski)

Program Name	Description	Website	Phone Number	State	County
Arkansas Respiratory Health Association	Services offered: Conduct asthma, COPD and tobacco/cessation educational programs for patients, the general public and schools. Coordinate support groups for COPD patients. Provide continuing educational opportunities for school and healthcare professionals.	http://www.arkresp.org	800-880-5864 ext. 100	X	

Chronic Conditions: Diabetes (Pulaski, Lonoke)

Prevention: Diabetic Screening (Pulaski)

Program Name	Description	Website	Phone Number	State	County
American Diabetes Association	Educational Resources; Advocacy		(501) 221-7444		X (all counties)
Arkansas Health Care Access Foundation	Locates doctors to donate office visits; prescription assistance; free to those who qualify	http://ahcaf.org/			X (all counties)
Arkansas Wellness Coalition	Includes members of the health care and employer community whose goal is to improve the health and well-being of all Arkansans through the use of nationally recognized, peer reviewed, clinical guidelines for physician, consumer, and employer education. Develop materials referring to nationally recognized standards such as those put forth by Healthy People 2010, the National Committee of Quality Assurance, and other disease-specific organizations such as the American Diabetes Association and the American Heart Association.		501-661-2942	X	
Arkansas Chronic Illness Collaborative (ACIC)	The ACIC is a group of health care and public health professionals dedicated to improving the management of chronic diseases. The ACIC is a way for health care clinic teams to use the National Health Disparities Collaborative Chronic Care Model to share ideas and knowledge, learn and apply new techniques, and match medical practices with clinical guidelines based on scientific evidence about what works best (diabetes, cancer and cardiovascular diseases)	http://www.healthy.arkansas.gov/programsServices/chronicDisease/Initiatives/Pages/Acic.aspx		X	

Program Name	Description	Website	Phone Number	State	County
Diabetes Education Program Sites – Pulaski County	Baptist Health Diabetes Self Mgmt Program – Little Rock The Arkansas Diabetes Self Mgmt Education Program – Little Rock Baptist Health Diabetes Health Management Center–North Little Rock		501-202-1877 501-296-1220 501-202-3701		X
ARCare	The ARcare Diabetes Self-Management Program is an AADE recognized education program.	http://www.arcare.net/OurServices/OurServices Continued/tabid/13586/Default.aspx	870-347-2534		x (Lonoke County)
Arkansas Human Development Corporation - Lonoke	Assist the Hispanic and Latin American populations of Arkansas along with other individuals who are economically disadvantaged to learn skills that promote healthy lifestyles. Services: Diabetes, Sexuality/Reproductive Health Education, Health Fairs, Hypertension, Poison Safety Education, Sexually Transmitted Disease, Smoking Education/Prevention.	http://www.arhdc.org	501-676-2721		X

Health Behaviors: Obesity (Pulaski, Lonoke)

Socioeconomic & Environment: Access to Healthy Food (Pulaski, Lonoke)

Socioeconomic & Environment: Percentage of Fast Food Restaurants (Pulaski, Lonoke)

Program Name	Description	Website	Phone Number	State	County
Arkansas Department of Health Lifestage Health Branch	Mission is the prevention and reduction of obesity through the adoption of healthy eating practices and increased physical activity. Provides technical assistance, managing and supporting evidence-based programs, disseminating materials and resources, and skills-building within the Agency, in schools, at worksites, among partners and with the general public.		501-661-2099	X	
Arkansas Coalition for Obesity Prevention (ArCOP)	A coalition whose goal is to increase the percentage of Arkansans of all ages who have access to healthy and affordable food and who engage in regular physical activity. Coalition is structured around six working teams: Access to Healthy Foods; Built Environment; Early Childhood and Schools; Healthcare; Worksite Wellness; and Social Marketing	http://www.arkansasobesity.org/		X	

Program Name	Description	Website	Phone Number	State	County
Southern Ain't Fried Sundays - Arkansas Minority Health Commission	Faith Based Outreach Program SAFS is designed to educate African American churches and organizations about healthier alternatives to preparing and cooking southern-style foods. It is also a mechanism for partnering with these groups in an effort to educate their members about the signs and symptoms of stroke, diabetes, and heart attacks. The program is being revamped to expand its reach to the Hispanic communities and individual participants.	http://www.arminorityhealth.com/programs_saf.html	877-264-2826	X	
Arkansas Rice Depot	Arkansas Rice Depot's mission is to find sensible solutions to hunger in Arkansas. • Food For Families: Our statewide free food bank serves 300 church and community hunger organizations • Food For Kids: Backpacks of food and supplies are sent home with children having problems in school due to hunger at home, currently operating in more than 600 schools, serving over 35,000 students and siblings • Food For Seniors: Home-delivered food boxes given each month to seniors	http://ricedepot.org/		X	
ADH - PEPPI	Peer Exercise Program Promotes Independence is a physical activity program specifically designed for older adults to increase and maintain their level of fitness and independence. The physical activity program includes strength training using resistance bands and walking. PEPPI program provides older Arkansans with the opportunity to learn how to exercise correctly (i.e. using correct techniques) in a safe environment, both physically (at the senior centers, churches, or other community groups), and mentally (among people of similar age and health conditions), and to increase their level of physical activity.	http://www.healthy.arkansas.gov/programsServices/chronicDisease/PhysicalActivity/Pages/default.aspx		X	

Program Name	Description	Website	Phone Number	State	County
ADH - WIC FMNP	The purposes of the WIC FMNP are to provide fresh, nutritious, unprepared fruits and vegetables from farmers' market to women and children who are nutritionally at risk and to expand the awareness and use of farmers' markets, as well as increase sales at such markets. During the farming season, WIC FMNP provides clients in the WIC Program with checks to purchase locally grown fresh fruits and vegetables sold by authorized farmers at authorized farmers' markets.	http://www.healthy.arkansas.gov/programsServices/WIC/Pages/FMNP.aspx		X	
ADH Pick a Better Snack Program	The Arkansas 5 A Day Coalition, a partnership of organizations whose mission is to increase Arkansans' consumption of fruits and vegetables, coordinated the implementation of this program in two elementary schools during the 2006-07 and 2007-08 school years. Using Food Stamp Nutrition Education funds, as well as private contributions, the Pick a Better Snack Program has been implemented in more than twenty schools throughout the State. The program has been well received by both teachers and students.	http://www.healthy.arkansas.gov/programsServices/chronicDisease/Nutrition/Pages/Programs.aspx		X	
ADH Healthy Restaurant Award	The Healthy Arkansas Restaurant Award is a voluntary program that provides public recognition to restaurants that meet certain health criteria. Restaurants self-apply and self-report through a questionnaire-type application. Criteria considered include smoke-free status of facility, labeling of food items, and number and types of healthy nutrition choices that are offered. Applications must be completed by a designee of the restaurant. Menus, inserts or photo of menu board with nutrient information must be submitted with the application to confirm the information.	http://www.healthy.arkansas.gov/programsServices/chronicDisease/Nutrition/Pages/Programs.aspx		X	
ARCare – SilverSneakers Program	SilverSneakers offers an innovative blend of physical activity, healthy lifestyle, and socially oriented programming that allows older adults to take greater control of their health.	http://www.arcare.net/OurServices/OurServicesContinuedpart3/tabid/14186/Default.aspx#wellness	870-347-1137		X (Lonoke County)
Bess Chisum Stephens Community Center	Offers a variety of low-cost exercise classes to the community including aquatic classes	http://centersforyouthandfamilies.org/programs/bess-chisum-stephens-community-center/			X (Pulaski County)

Health Behaviors: Excessive Drinking (Pulaski, Lonoke)

Program Name	Description	Website	Phone Number	State	County
Arkansas Center for Addictions Research, Education, and Services (AR-CARES)	This comprehensive family treatment program called the Arkansas Center for Addictions Research, Education and Services (Arkansas CARES) focuses on breaking the cycle of maternal addiction.	http://methodistfamily.org/programs/arkansas-CARES.html			X (Pulaski County)

Health Behaviors: Sexually Transmitted Infections (Pulaski)

Program Name	Description	Website	Phone Number	State	County
Arkansas Department of Health STD Testing Center	Future Builders, Inc. 16117 Highway 365 Little Rock, Arkansas 72206 Thursday 10:30 am to 2:30 pm After hours by appointment only		501-897-5566		X
Pulaski County Health Unit Sites – STD Testing	Pulaski County Jacksonville 3000 N 1st Street Jacksonville 501-982-7477 Pulaski County College Station 4206 Frazier Pike College Station 501-490-1602 Pulaski County NLR Health Unit 2800 N Willow North Little Rock 501-791-8551 Pulaski Central Health Unit 3915 W 8th Street Little Rock 501-280-3100		501-982-7477 501-490-1602 501-791-8551 501-280-3100		X

Health Behaviors: Smoking (Grant)

Program Name	Description	Website	Phone Number	State	County
Stamp Out Smoking	Arkansas Tobacco Quitline: A 24-hour direct line to professionally trained Quit Coaches® waiting to help you fight the good fight, plus a 24-hour online community of support from others who've gone through exactly what you're facing … and you can even get a supply of the latest nicotine replacement therapy medications at no cost.	http://www.stampoutsmoking.com/get-help-to-quit/	1-800-QUIT NOW	X	

Program Name	Description	Website	Phone Number	State	County
Arkansas Department of Health Tobacco Prevention and Cessation Program – STOP Program	The Systems Training Outreach Program (STOP) currently uses Outreach to provide education and support to providers. Increasing the capacity and efficiency of care systems by asking, documenting tobacco use and advising patients to stop, the Outreach Specialists educate healthcare providers to be aware of available and accessible cessation treatment interventions. In particular, the specialists will help providers systematically identify patients who are tobacco users, provide guidance to quit and connect them to available resources to successfully quit.	http://www.healthy.arkansas.gov/programsServices/chronicDisease/coalition/Pages/tobacco.aspx		X	

Access: Lack of PCPs (Lonoke)

Program Name	Description	Website	Phone Number	State	County
Arkansas Department of Health Office of Rural Health and Primary Care	Promotes the development of community-based health care services and systems throughout Arkansas to ensure that well managed, quality health services are available to all citizens		501-280-4560	X	
Area Health Education Centers (AHEC)	Programs provide access to medical services for rural residents and education for healthcare students and professionals.	http://ruralhealth.uams.edu/AHEC-Programs			X Located in Pine Bluff (Jefferson County) Serving Lonoke County
American Academy of Family Physicians	The Arkansas Academy of Family Physicians Foundation and TransforMED, a wholly owned subsidiary of the American Academy of Family Physicians, announced that three family medicine practices have been selected to receive facilitative and financial support as they implement a new model of health care known as the patient-centered medical home.	http://www.transformed.com/news-eventsdetailpage.cfm?listingID=102		X	
University of Arkansas Foundation	Education and Promotion of Physician Assistants in Arkansas	http://www.uamshealth.com/News/UAMSPhysicianAssistantNorthwestArkansasResidencyProgramsReceiveGrantsfromBlueYouFoundation?id=5349&showBack=true&PageIndex=0&cid=4		X	

Program Name	Description	Website	Phone Number	State	County
ADH ConnectCare	ConnectCare works to connect Medicaid and ARKids recipients to a primary care physician and a medical home. Telephone Helpline Specialists who staff a toll-free telephone call center respond to Medicaid and ARKids recipient questions and concerns, give information and offer guidance on accessing resources, and assist clients in locating and assigning a primary care physician.	http://www.healthy.arkansas.gov/programsServices/familyHealth/HealthConnections/Pages/ConnectCare.aspx		X	
River City Ministry – North Little Rock	River City Ministry is a faith-based, nonprofit focused on "Opening Doors to God by Serving the Poor". River City Ministry seeks to: FEED the hungry by serving a hot lunch and operating a food pantry, CLOTHE those in need with our clothing bus, SHELTER the homeless with a safe, welcoming environment and through HUD housing programs, CARE for the sick through our pharmacy, medical, vision and dental clinics, and LOVE the unloved and underserved to show God's love!	http://www.rivercityministry.org/	501-376-6694		(North Little Rock)
Gardner Memorial Free Community Medical Clinic	To improve the health (mind, body, spirit) of the people of central Arkansas by assuring access to quality, culturally-sensitive care and health education along the continuum, working in collaboration with local communities and resources.	http://www.gardnermemorialumc.org/health_clinic.html	501-374-8852		Central AR
AR Care – Lonoke County	Carlisle Medical Clinic (870) 552-7303 England Medical Clinic (501) 842-3131 Cabot Medical Clinic (501) 941-3522	http://www.arcare.net/OutLocations.aspx	See under description		X

Socioeconomic & Environment: Single-Parent Households (Pulaski)

Program Name	Description	Website	Phone Number	State	County
Arkansas Voices	To advocate for children left behind by incarceration or loss of a parent for any reason and to provide mentoring, services and supports for the children, their caregivers, and incarcerated parents, with the goal of strengthening and empowering the family unit.	http://www.arkansasvoices.org/		X	
Arkansas Single Parent Scholarship Fund	Single Parent Scholarships (SPSF) are given to low-income single parents who are pursuing post-secondary education in preparation for skilled employment. We organize affiliated scholarship funds that serve every county of Arkansas	http://www.aspsf.org/index.html		X	

Socioeconomic & Environment: Violent Crime (Pulaski)

Program Name	Description	Website	Phone Number	State	County
Black on Black Crime Coalition	Driven by its mission to increase public awareness and reduce black on black crime in Pulaski County, the Coalition has developed a plan of action that includes: • an education/awareness campaign • program initiatives with its partners • collaborations with existing organizations that serve citizens and institutions directly and indirectly affected by black on black crime	http://www.hhscenter.org/bonbcrim.html			X
Pulaski County Youth Services	Take a holistic approach to curb the problems of gangs, violence, crime and substance abuse while enhancing the well-being of the community, children, youth and families by getting parents and community members involved in the lives of children and youth.	http://co.pulaski.ar.us/youthservices.shtml	501-340-8250		X
Mayor's Office of Youth Services – North Little Rock	The Mayor's Office of Youth Services provides an integral function in the reduction of juvenile crime by providing intervention and prevention programming support and consultation to the city's public, private and faith-based youth services agencies.	http://www.northlittlerock.ar.gov/programs-resources/Youth-Services/	501-340-5309		(North Little Rock)



Community Needs Assessment

Baptist Health Medical Center–Stuttgart

December 2013



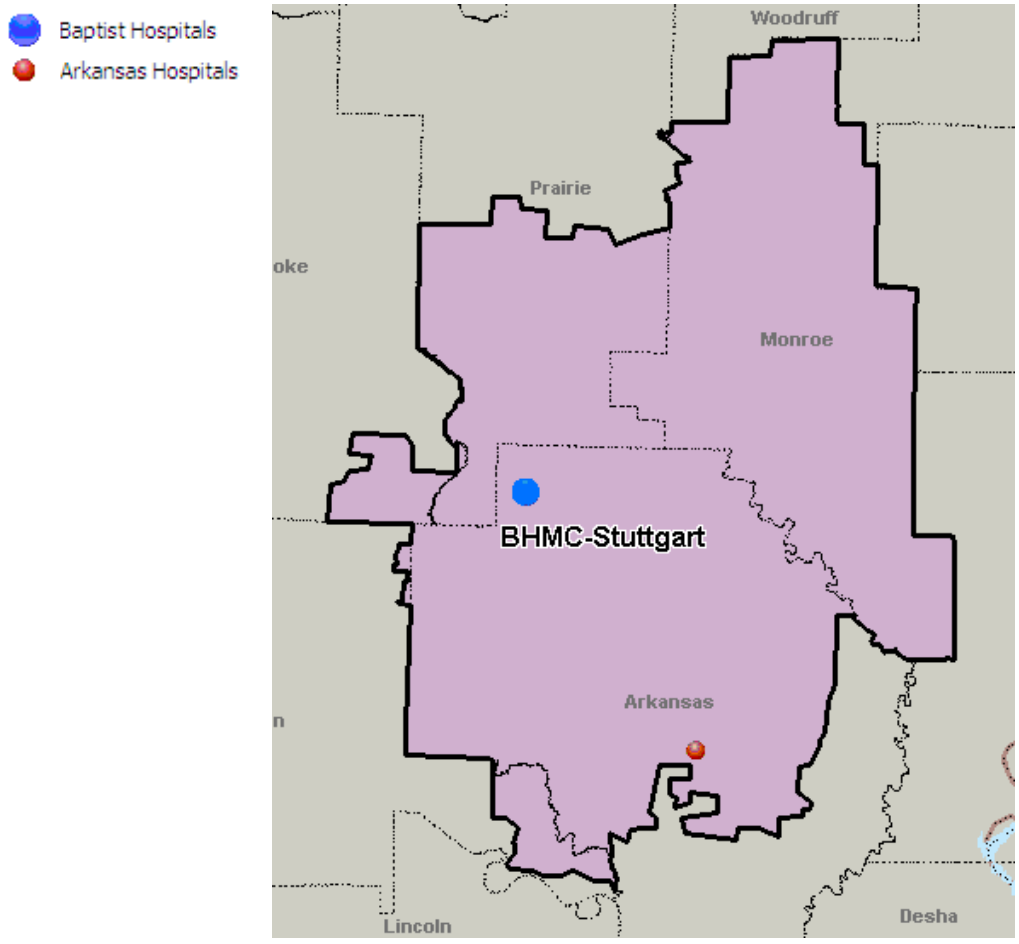
Baptist Health Medical Center–Stuttgart

Baptist Health Medical Center–Stuttgart is a 49-bed facility that provides acute-care services to residents throughout the state. The BHMC–Stuttgart campus is also home to the Baptist Health Sleep Center, Baptist Health Therapy Center, and Home Health.

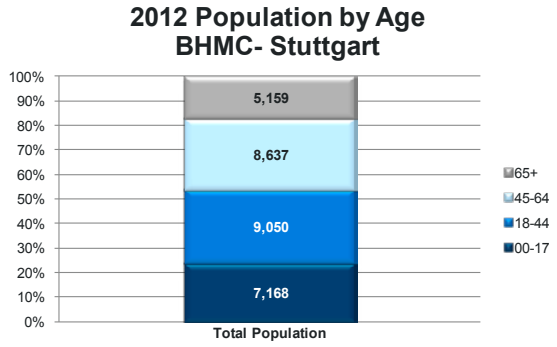
Community Served and Demographics

The community served for BHMC–Stuttgart was determined using the ZIP codes that represent greater than or equal to 2 percent of the hospital's combined inpatient discharges/outpatient visits AND in which the hospital's inpatient market share is greater than or equal to 20 percent. ZIP codes that did not meet those criteria but that are either contiguous or surrounded by ZIP codes in the community served were also included.

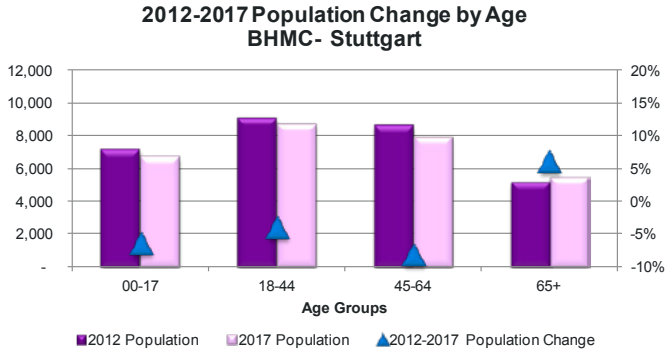
Fifteen ZIP codes constitute the community served for BHMC – Stuttgart. A detailed list of the ZIP codes can be found in the **Baptist Health Medical Center-Stuttgart Appendix.** Below is a map that illustrates the BHMC–Stuttgart community served (purple).



The BHMC–Stuttgart community served population is approximately 30,014. By 2017, this population is projected to decrease by 4.0 percent — the slowest growing community among the Baptist Health hospitals. While the largest portion of the population is made up of white non-Hispanics (20,078), in the next 5 years the largest percentages of growth will be in the Hispanic (+20 percent, +148 individuals) and Asian non-Hispanic (+11 percent, +15 individuals) populations. The largest change in population will take place among white non-Hispanics (-1,125 individuals) between 2012 and 2017.



The 18-44 age group constitutes the largest portion of the BHMC–Stuttgart community served, followed by the 45-64 age group.



By 2017, the 65 plus population will have the largest percentage of growth.

The median household income for the BHMC–Stuttgart community served is $35,796. More than 37 percent of individuals have private insurance — either employer-sponsored insurance (33 percent) or individually purchased (4 percent). Another 20 percent are covered by Medicaid, 22 percent are uninsured and 21 percent are covered by Medicare or are Medicare dual eligible.

Interviews & Focus Groups

Interviewees and focus group participants were categorized into representative groups. In the chart below, an "I" indicates an interview and "FG" indicates participation in a focus group. For individuals outside Baptist Health, representative organizations have been listed.

Community Leaders/ Groups	Public and Other Organizations		Baptist Health
Maynard, Marianne (City of Stuttgart Mayor, I)	Bryant, Melvin (Stuttgart School District, I)	Evans, Jessica (DHS, FG)	Amstutz, Terry (BHMC-S, I)
Criner, Calvin (Holman Heritage Community Center, FG)	Bell, Stephen (Chamber of Commerce, FG)	Vester, Wanda (DHS, FG)	Williams, Susan (BHMC-S, I)
Rogers, Tiffany (State Representative, FG)	Luebke, Susan (PCCUA, FG)	Young, Brenda (DHS, FG)	Blankenship, RuthAnn (BHMC-S, I)
Thompson, M.D., Joe (AR Surgeon General/ AR Ctr for Health Improvement, I)	Holstead, Amanda (PCCUA, FG)	Wheeler, Gary (Arkansas Department of Health, I)	Morgan, M.D., Chris (BHMC-S, I)
Lockwood, Kent (BHMC Board Member/ Producers Inc., I)	Halverson, Paul (Arkansas Department of Health, I)	Clark, Marilyn (American Heart Assoc/ American Stroke Assoc, I)	

The individuals highlighted in purple indicate Health Department representatives (local, regional, or state), as well as individuals representing or serving medically underserved, low-income, or minority populations.

In the interview process, the majority of individuals said the current health status of the community is "poor." The major issues contributing to this health status include chronic/other diseases.

For the BHMC–Stuttgart community, the top five health needs identified in the interview process include:

1. Chronic Diseases
2. Health Providers/Services
3. Cardiovascular
4. Obesity
5. Dental

Barriers to good health care in this community include health education, socioeconomic factors, culture, lifestyle, and insurance coverage. The minority populations, elderly, and children/teens were identified as vulnerable groups that will need special attention when addressing health needs.

Focus group participants were asked to grade the health of the community based on an A-F scale, provide feedback in terms of that grade, and work in small groups to determine the top three health needs of the community. For the BHMC–Stuttgart group, the average grade for the health of the community was a C. Much of this was attributed to increasing need/sicker population, lack of preventive care/health education, lack of healthy foods, culture, transportation issues, and insurance coverage.

The focus group split into two smaller groups to determine the top three health needs of the community. Group 1 selected education, transportation, and activity center. Group 2 selected education, transportation, and access to care.

In the same small groups, focus group participants were asked to identify community resources that could help address the health issues in the community. Some of the resources identified include:

• Churches	• Senior Centers	• Agriculture
• Industries in area	• Baptist Health	• Tourism
• Local Health Departments	• Grand Prairie Center	• Research Centers
• PCCUA	• Dual Service Centers (DHS, ADH)	• Medical Providers
• Good Infrastructure	• Education System	• Civic Clubs

Baptist Health Medical Center-Stuttgart Appendix includes a more comprehensive list of existing community resources available to address the health needs of the community.

Health Indicators

While the community served was defined at the ZIP code level, the most geographically detailed health indicators were only available at the county level. For that reason, health indicators for BHMC–Stuttgart were evaluated for Arkansas, Monroe, and Prairie counties. These counties represent the ZIP codes within the community served.

Health needs for those counties that did not meet the state benchmark include:

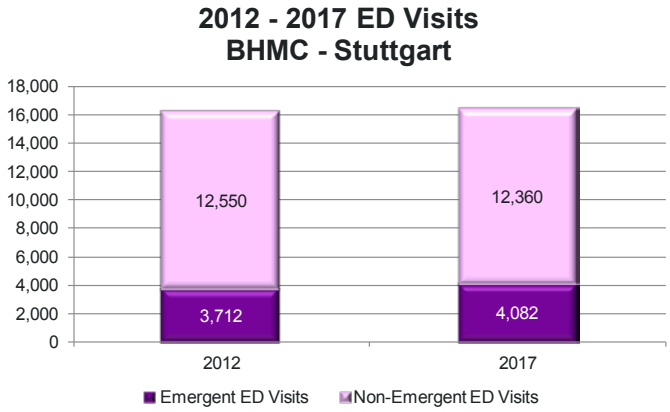
Cause of Death • Heart Disease • Cancer • Stroke • Chronic Lower Respiratory Disease • Injury-Related Deaths	**Chronic Conditions** • Hypertension • High Cholesterol • Asthma • Diabetes • Coronary Heart Disease • Arthritis	**Access** • No Personal Doctor • Lack of PCPs • Uninsured
Health Outcomes • Premature Death • Low Birth Weight • Poor or Fair Health Status • Poor Physical Health & Mental Health Days **Prevention** • Colorectal Screening • Mammography • Pap Test • Flu Shot • Diabetic Screening • HIV Test • Preventable Hospital Stays	**Health Behaviors** • Smoking • Obesity • Physical Inactivity • Excessive Drinking • Sexually Transmitted Infections • Teen Birth Rate • Lack of Healthy Eating	**Socioeconomic & Environment** • Inadequate Social Support • Children in Single Parent-HHs • Lack of Recreational Facilities • Percentage of Fast Food Restaurants

Truven Health Analytics supplemented the publically available data with estimates of disease prevalence for heart disease and cancer, emergency department visit estimates, and the community need index.

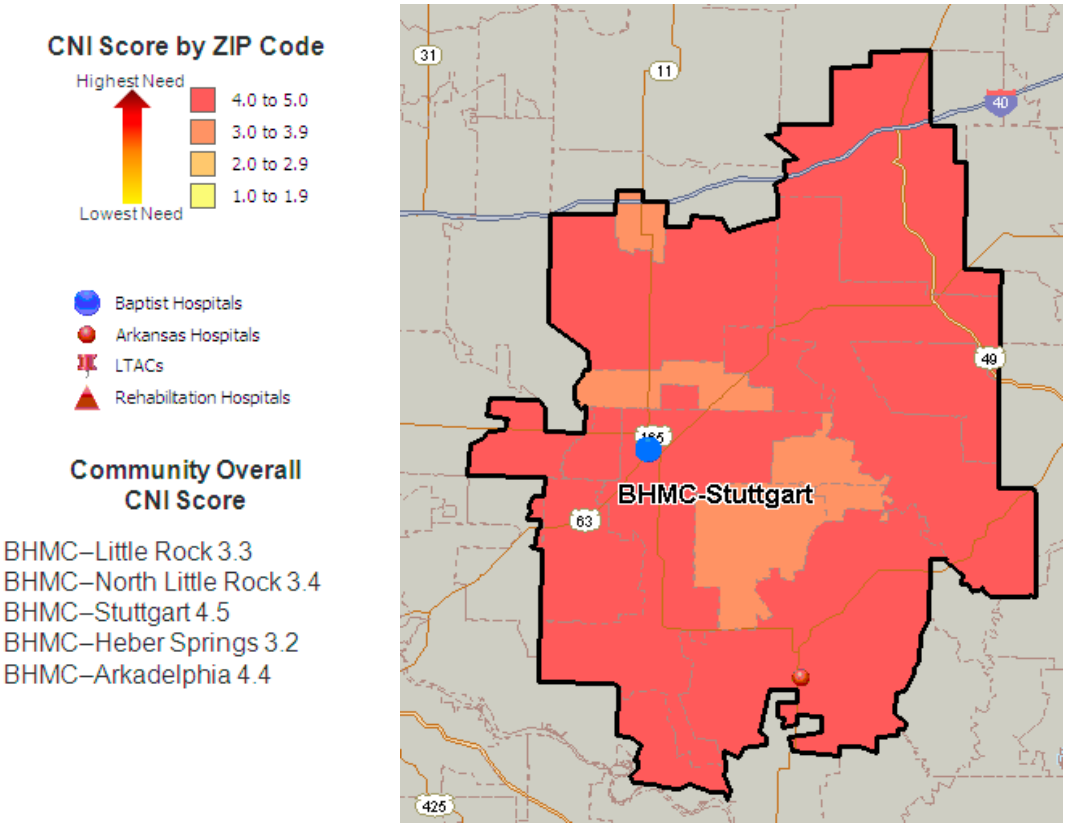
Heart disease estimates indicate a prevalence of 9,875 cases for the BHMC–Stuttgart community served. The majority (62 percent) of the 2011 estimates of heart disease prevalence indicate hypertension as the primary diagnosis. Other diagnoses include arrhythmias (14 percent), ischemic heart disease (16 percent), and congestive heart failure (8 percent).

The 2011 cancer incidence estimates reveal an estimated 232 new cancer cases.

Emergency department visits are slated to grow by approximately 180 visits between 2012 and 2017.



The Truven Health Community Need Index (CNI) is a statistical approach to identifying health needs in a community. The CNI takes into account vital socio-economic factors (income, cultural, education, insurance, and housing) about a community to generate a CNI score for every populated ZIP code in the United States. The CNI is strongly linked to variations in community healthcare needs and is a strong indicator of a community's demand for various healthcare services.



The BHMC–Stuttgart community served had a CNI of 4.5 on a scale of 1.0 (lowest needs) to 5.0 (highest needs). Compared to the other Baptist Health ommunities, BHMC–Stuttgart has the highest need.

Prioritized Health Needs

From the BHMC–Stuttgart campus, Terry Amstutz, vice president/administrator, and Susan Williams, chief nursing officer participated in the prioritization meeting.

Using the criteria selected by the larger group, the five health needs that scored the highest in the prioritization process for BHMC–Stuttgart were:

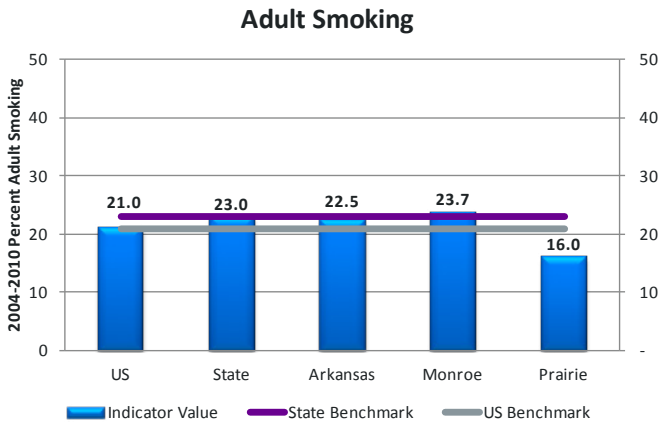
1. Smoking
2. Obesity
3. Physical Inactivity
4. Diabetes
5. Hypertension

HEALTH NEED	BHMC Stuttgart
Cause of Death	
▪ Cancer	X
▪ Stroke	X
▪ Chronic Lower Respiratory Disease	X
▪ Heart Disease	X
▪ Injury-related Deaths	X
Health Outcomes	
▪ Premature Death	X
▪ Low Birth Weight	X
▪ Poor or Fair Health Status	X
▪ Poor Physical Health & Mental Health Days	X
Chronic Conditions	
▪ Hypertension	X
▪ Asthma	X
▪ Diabetes	X
▪ Coronary Heart Disease	X
▪ Arthritis	X
▪ High Cholesterol	X
Health Behaviors	
▪ Smoking	X
▪ Obesity	X
▪ Excessive Drinking	X
▪ Sexually Transmitted Infections	X
▪ Physical Inactivity	X
▪ Teen Birth Rate	X
▪ Lack of Healthy Eating	X
Prevention	
▪ Pap Test	X
▪ Diabetic Screening	X
▪ Preventable Hospital Stays	X
▪ Colorectal Screening	X
▪ Mammography	X
▪ Flu Shot	X
▪ HIV Test	X
Access	
▪ Lack of PCPs	X
▪ No Personal Doctor	X
▪ Uninsured	X
Socioeconomic & Environment	
▪ Children in Single-Parent HHs	X
▪ Access to Recreational Facilities	X
▪ Percentage of Fast Food Restaurants	X
▪ Inadequate Social Support	X

The table to the left indicates the health needs identified for the BHMC-Stuttgart community. The highlighted boxes are the five health needs that scored the highest in the prioritization process.

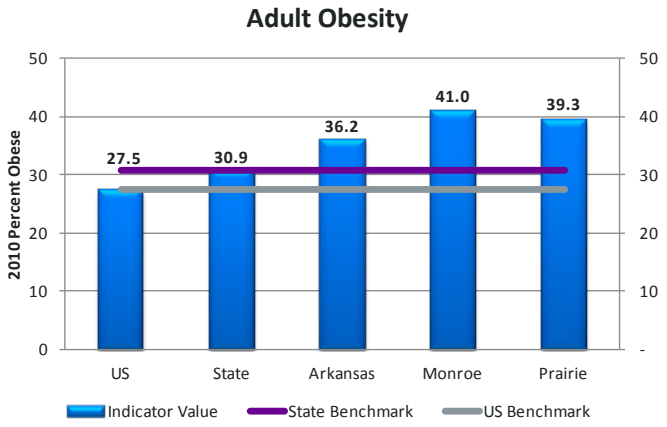
Even though the highlighted health needs had the highest scores, the needs that will actually be addressed for the purposes of the CHNA are at the discretion of BHMC-Stuttgart.

For each of the prioritized health needs, the comparative benchmark graph has been provided to illustrate gaps between county indicators for the community served and the state benchmark (purple).



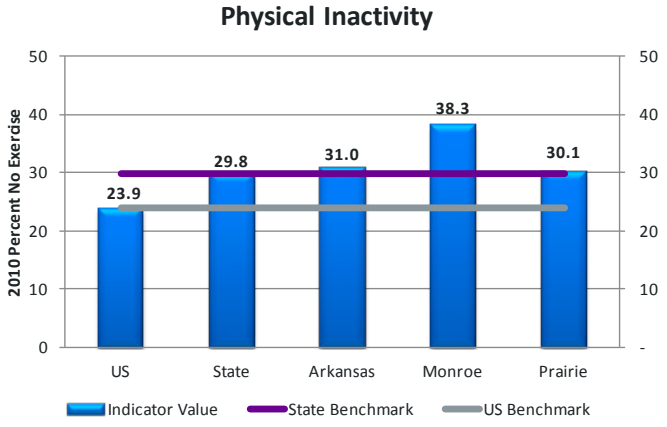
Source: County Health Rankings (BRFSS), Arkansas Department of Health BRFSS

Notes: Percent of adults 18 years + that report currently smoking cigarettes



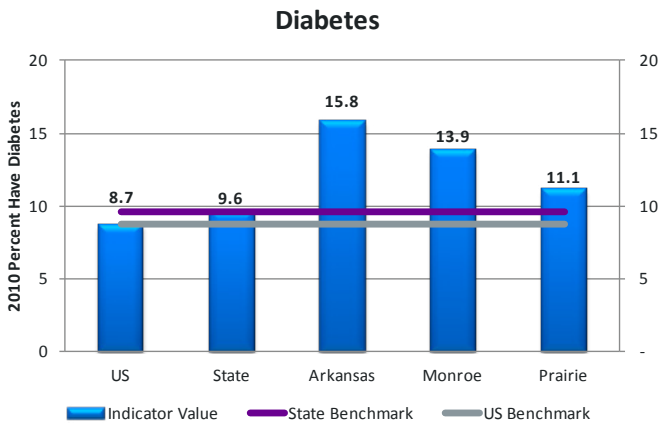
Source: Arkansas Department of Health BRFSS

Notes: Percent of adults 18 years and over that report BMI>=30 (Per self-reported weight/height)



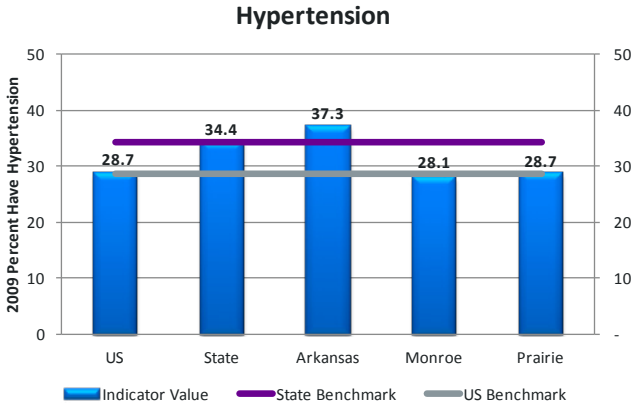
Source: Arkansas Department of Health BRFSS

Notes: Percent of Adults that report no leisure-time exercise in past month



Source: Arkansas Department of Health BRFSS

Notes: Percent of adults that report having been diagnosed as having diabetes



Source: Arkansas Department of Health BRFSS

Notes: Percent of adults that report having been diagnosed with high blood pressure

Summary

The community health needs assessment for the BHMC–Stuttgart community served revealed a number of health issues related to disease management, lifestyle choices, and socioeconomic or environmental factors. By weighing the qualitative feedback and the quantitative data, along with the prioritization criteria, the top health needs identified include smoking, obesity, physical inactivity, diabetes, and hypertension

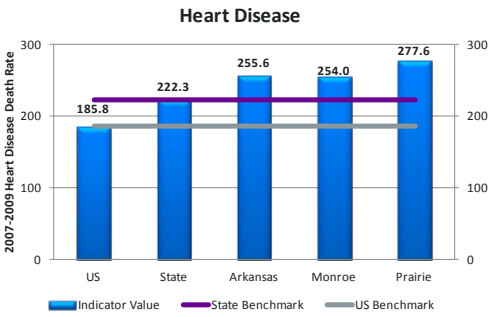
BHMC–Stuttgart will be working with internal stakeholders to determine the community health needs to be addressed. With the goal of improving the health of the community, implementation plans with specific tactics and time frames will be developed to address these health needs.

Baptist Health Medical Center-Stuttgart Appendix

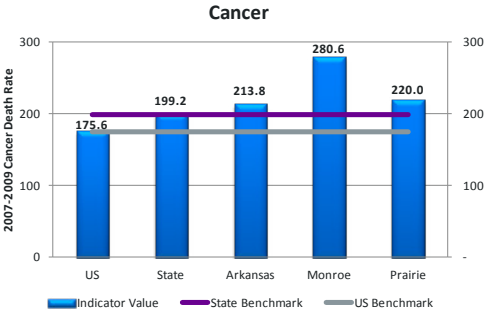
BHMC-Stuttgart Community Served Definition ZIP Code Table

BAPTIST HEALTH COMMUNITY	ZIP	PONAME	COUNTY NAME	CBSANAME
BHMC-Stuttgart	72003	Almyra	Arkansas, AR	Unassigned Area in Arkansas
BHMC-Stuttgart	72021	Brinkley	Monroe, AR	Unassigned Area in Arkansas
BHMC-Stuttgart	72026	Casscoe	Arkansas, AR	Unassigned Area in Arkansas
BHMC-Stuttgart	72029	Clarendon	Monroe, AR	Unassigned Area in Arkansas
BHMC-Stuttgart	72038	Crocketts Bluff	Arkansas, AR	Unassigned Area in Arkansas
BHMC-Stuttgart	72041	De Valls Bluff	Prairie, AR	Unassigned Area in Arkansas
BHMC-Stuttgart	72042	De Witt	Arkansas, AR	Unassigned Area in Arkansas
BHMC-Stuttgart	72064	Hazen	Prairie, AR	Unassigned Area in Arkansas
BHMC-Stuttgart	72069	Holly Grove	Monroe, AR	Unassigned Area in Arkansas
BHMC-Stuttgart	72072	Humnoke	Lonoke, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Stuttgart	72073	Humphrey	Arkansas, AR	Unassigned Area in Arkansas
BHMC-Stuttgart	72108	Brinkley	Monroe, AR	Unassigned Area in Arkansas
BHMC-Stuttgart	72134	Roe	Monroe, AR	Unassigned Area in Arkansas
BHMC-Stuttgart	72160	Stuttgart	Arkansas, AR	Unassigned Area in Arkansas
BHMC-Stuttgart	72170	Ulm	Prairie, AR	Unassigned Area in Arkansas

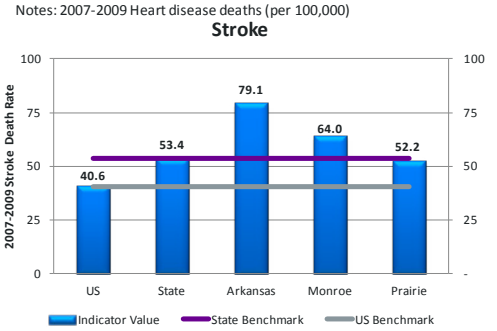
BHMC STUTTGART:CAUSE OF DEATH



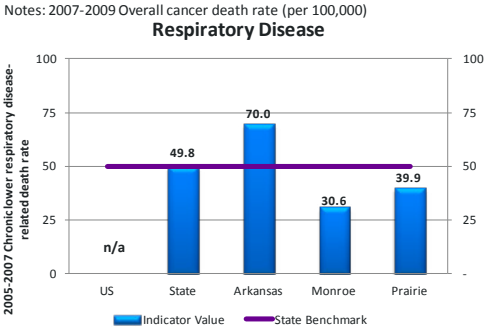
Source: National Vital Statistics System-Mortality (CDC, NCHS)
Notes: 2007-2009 Heart disease deaths (per 100,000)



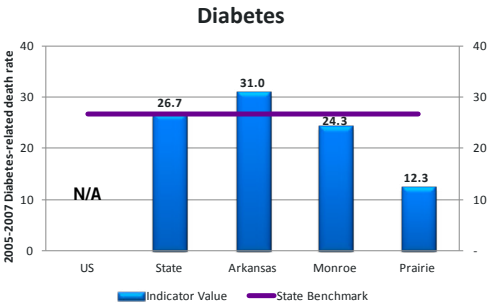
Source: National Vital Statistics System-Mortality (CDC, NCHS)
Notes: 2007-2009 Overall cancer death rate (per 100,000)



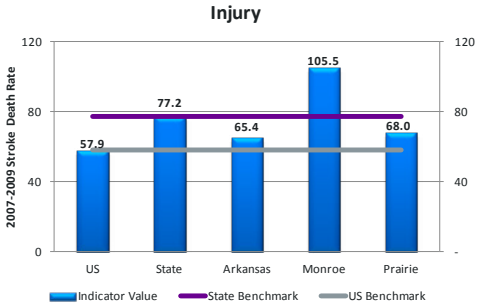
Source: National Vital Statistics System-Mortality (CDC, NCHS)
Notes: 2007-2009 Stroke death rate (per 100,000)



Source: Health Statistics Branch, ADH
Notes: 2005-2007 Chronic lower respiratory disease-related deaths (per 100,000)



Source: Health Statistics Branch, ADH
Notes: 2005-2007 Diabetes-related deaths (per 100,000)

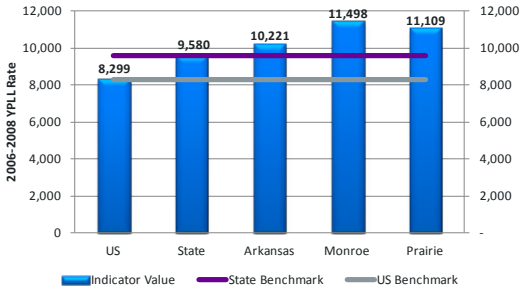


Source: National Vital Statistics System-Mortality (CDC, NCHS)
Notes: 2007-2009 Injury death rate (per 100,000)

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

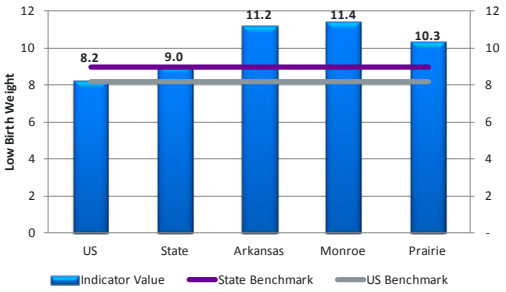
BHMC STUTTGART: HEALTH OUTCOMES

Premature Deaths



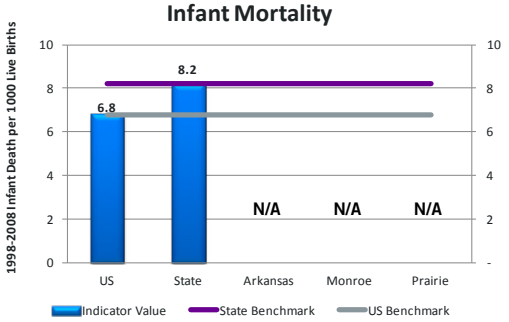
Source: County Health Rankings (NCHS)
Notes: Years of potential life lost before the age of 75 per 100,000 population

Low Birth Weight



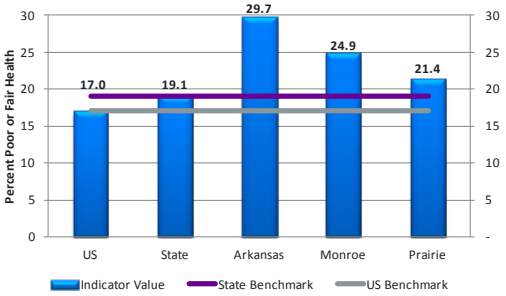
Source: County Health Rankings (NCHS)
Notes: Percent of live births with low birth weight (< 2500 grams)

Infant Mortality



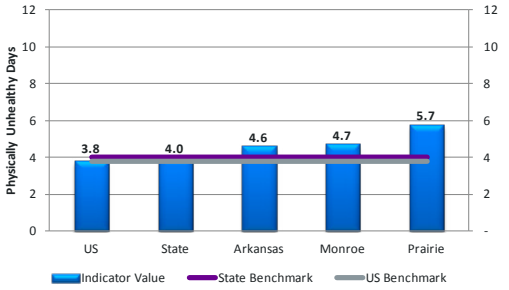
Source: Linked Birth/Infant Death Data Set (CDC-NCHS)
Notes: Rate of all infant deaths (within 1 year), per 1,000 live births

Poor or Fair Health



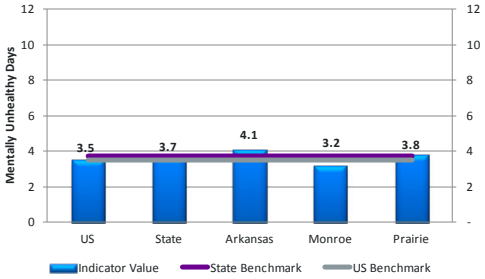
Source: County Health Rankings (BRFSS)
Notes: Percent of adults reporting fair or poor health (age-adjusted)

Poor Physical Health Days



Source: County Health Rankings (BRFSS)
Notes: Average number of physically unhealthy days reported in past 30 days (age-adjusted)

Poor Mental Health Days

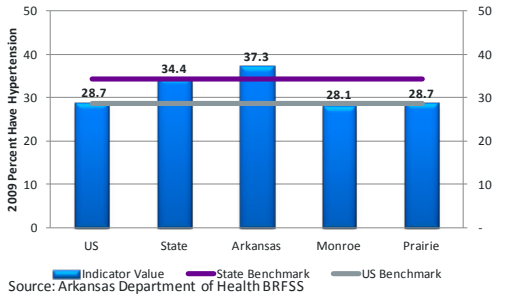


Source: County Health Rankings (BRFSS)
Notes: Average number of mentally unhealthy days reported in past 30 days (age-adjusted)

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BHMC STUTTGART: CHRONIC CONDITIONS

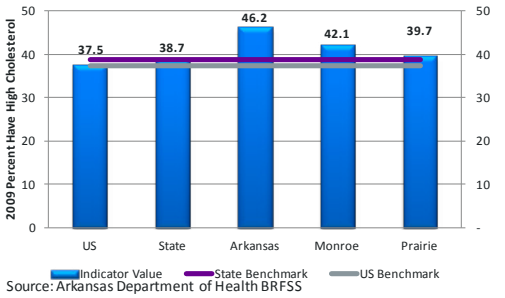
Hypertension



Source: Arkansas Department of Health BRFSS

Notes: Percent of adults that report having been diagnosed with high blood pressure

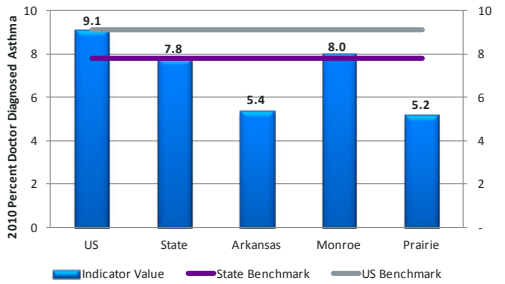
High Cholesterol



Source: Arkansas Department of Health BRFSS

Notes: Percent of adults that report having been diagnosed with high blood cholesterol

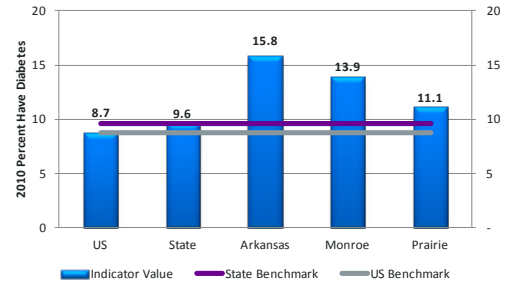
Asthma



Source: Arkansas Department of Health BRFSS

Notes: Percent of adults that report having been diagnosed with asthma

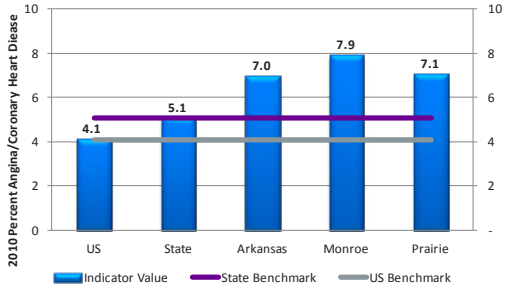
Diabetes



Source: Arkansas Department of Health BRFSS

Notes: Percent of adults that report having been diagnosed as having diabetes

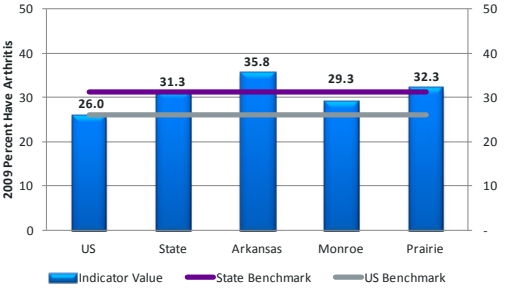
Coronary Heart Disease



Source: Arkansas Department of Health BRFSS

Notes: Percent of adults that report having been diagnosed as having Coronary Heart Disease

Arthritis



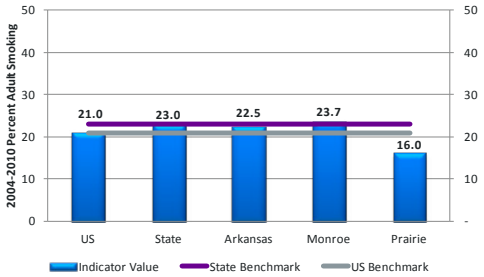
Source: Arkansas Department of Health BRFSS

Notes: Percent of adults that report having been diagnosed as having Arthritis

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

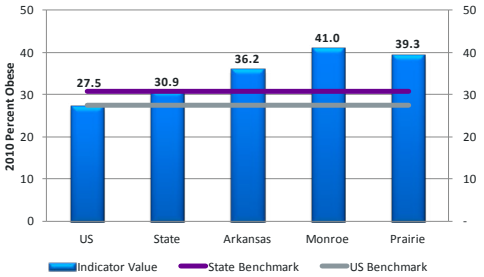
BHMC STUTTGART: HEALTH BEHAVIORS

Adult Smoking



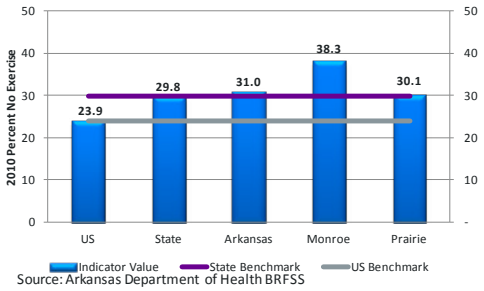
Source: County Health Rankings (BRFSS), Arkansas Department of Health BRFSS
Notes: Percent of adults 18 years+ that report currently smoking cigarettes

Adult Obesity



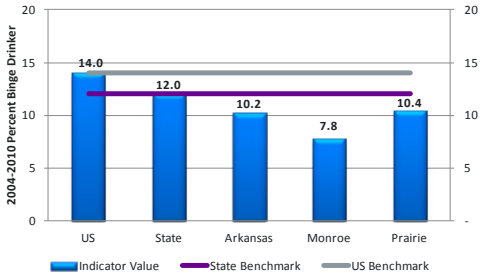
Source: Arkansas Department of Health BRFSS
Notes: Percent of adults 18 years and over that report BMI >= 30 (per self-reported weight/height)

Physical Inactivity



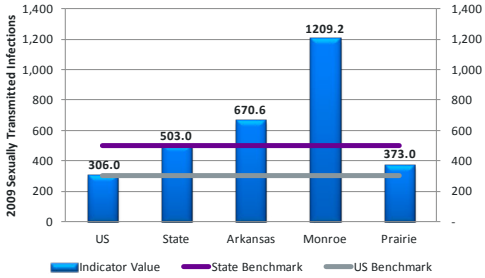
Source: Arkansas Department of Health BRFSS
Notes: Percent of Adults that report no leisure-time exercise in past month

Excessive Drinking



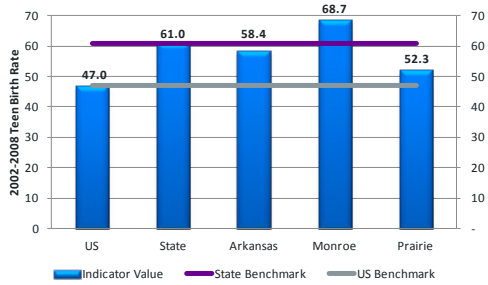
Source: County Health Rankings (BRFSS), Arkansas Department of Health BRFSS
Notes: Percent of adults 18 years and over that report binge drinking

Sexually Transmitted Infections



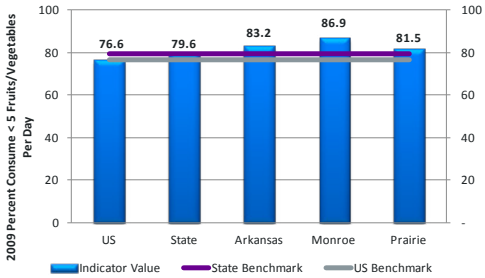
Source: County Health Rankings (BRFSS)
Notes: Chlamydia rate per 100,000 population

Teen Birth Rate



Source: County Health Rankings (BRFSS)
Notes: Percent of all live births to mothers less than 18 years of age

Lack of Healthy Eating

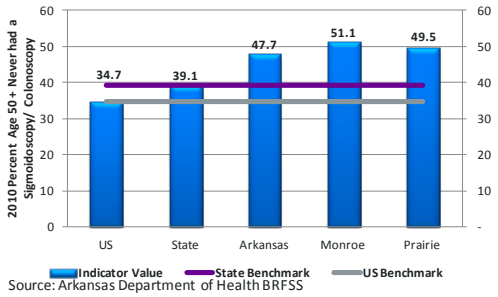


Source: Arkansas Department of Health BRFSS
Notes: Percent of Adults that report fewer than 5 servings of fruits/vegetables per day

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BHMC STUTTGART: PREVENTION

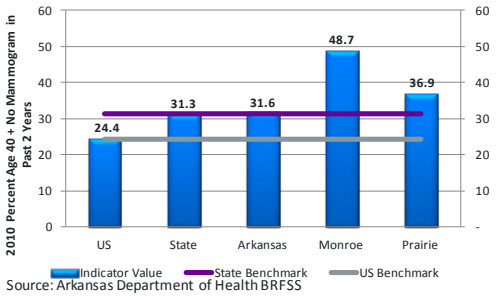
No Colorectal Screening



Source: Arkansas Department of Health BRFSS

Notes: Percent of adults age 50+ that report never having had a sigmoidoscopy or colonoscopy

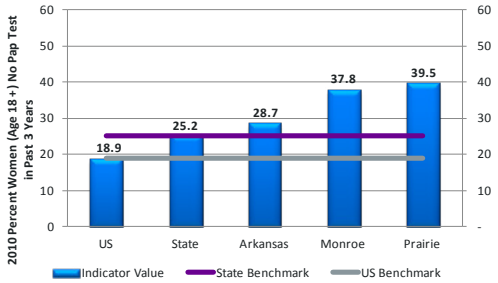
No Mammography



Source: Arkansas Department of Health BRFSS

Notes: Percent of women age 50+ that report no mammogram in the past 2 years

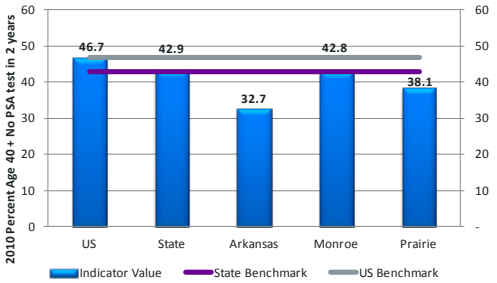
No Pap Test



Source: Arkansas Department of Health BRFSS

Notes: Percent of women age 18+ that report no Pap test in the last 3 years

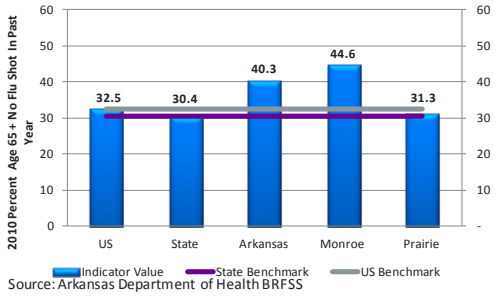
No Prostate Screening



Source: Arkansas Department of Health BRFSS

Notes: Percent of men age 40+ that report no PSA test in the last 2 years

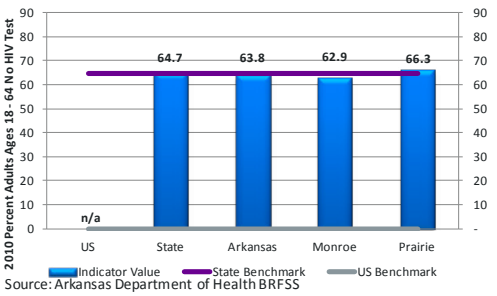
No Flu Shot



Source: Arkansas Department of Health BRFSS

Notes: Percent of adults age 65+ that report having no Influenza vaccine in past 12 months

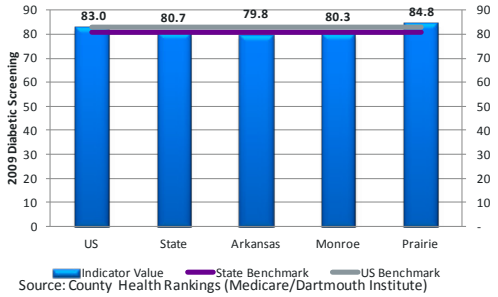
No HIV Test



Source: Arkansas Department of Health BRFSS

Notes: Percent of adults age 18-64 that report having never having an HIV test

Diabetic Screening



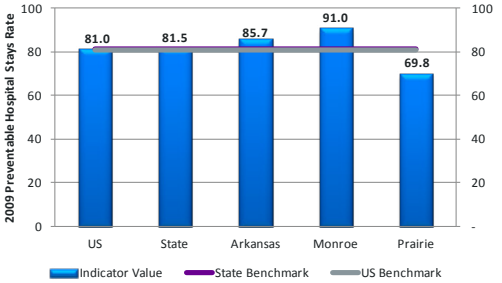
Source: County Health Rankings (Medicare/Dartmouth Institute)

Notes: Percent of diabetic Medicare enrollees that receive HbA1c screening

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

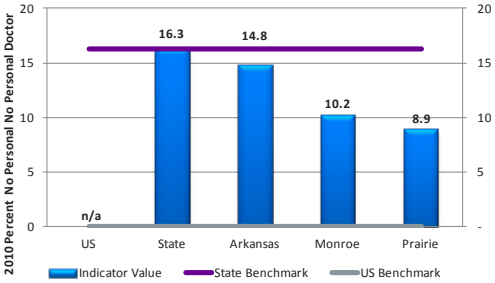
BHMC STUTTGART: ACCESS

Preventable Hospital Stays



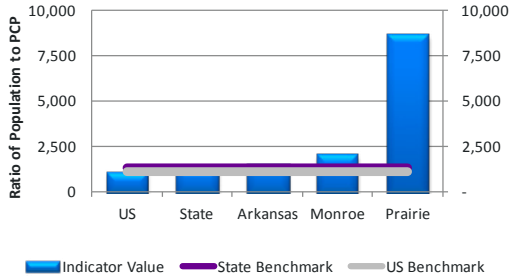
Source: County Health Rankings (Medicare/Dartmouth Institute)
Notes: Hospitalization rate for ambulatory-care sensitive conditions per 1,000 Medicare enrollees

Personal Doctor



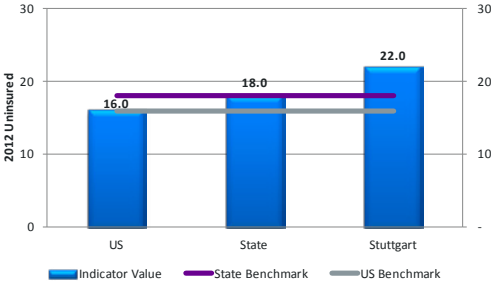
Source: Arkansas Department of Health BRFSS
Notes: Percent of adults age 18+ that report having no personal doctors

Primary Care



Source: County Health Rankings (Health Resources & Services Administration)
Notes: Ratio of population to primary care physicians

Uninsured

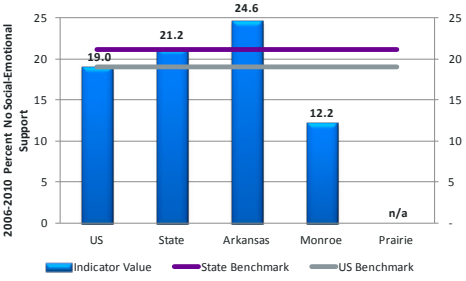


Source: Truven Health (Insurance Coverage Estimates)
Notes: Percent uninsured

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

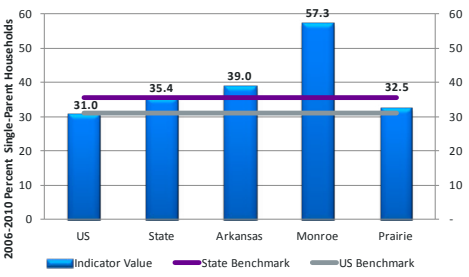
BHMC STUTTGART: SOCIOECONOMIC

Inadequate Social Support



Source: County Health Rankings (BRFSS)
Notes: Percent of adults without social/emotional support

Children in Single Parent Households

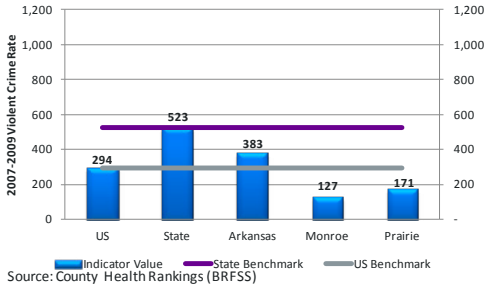


Source: County Health Rankings (BRFSS)
Notes: Percent of children that live in household headed by single parent

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BHMC STUTTGART: ENVIRONMENT

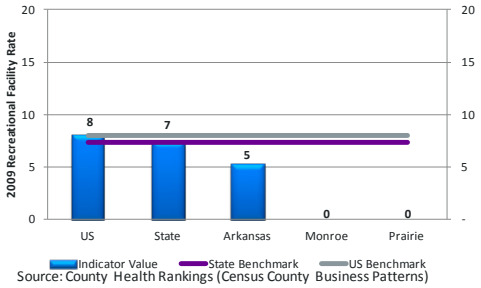
Violent Crime



Source: County Health Rankings (BRFSS)

Notes: Violent crime rate per 100,000 population

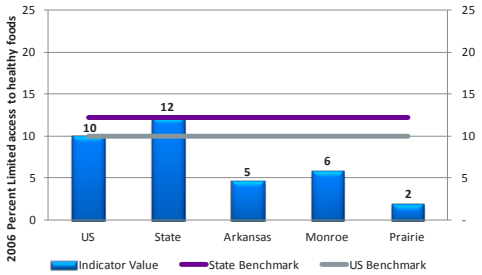
Recreational Facilities



Source: County Health Rankings (Census County Business Patterns)

Notes: Rate of recreational facilities per 100,000 population

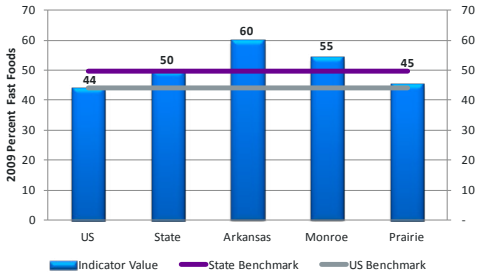
Access to Healthy Foods



Source: CHR (USDA)

Notes: Percent of population who are low-income and do not live close to a grocery store

Fast Food Restaurants



Source: CHR (USDA)

Notes: Percent of all restaurants that are fast-food establishments

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

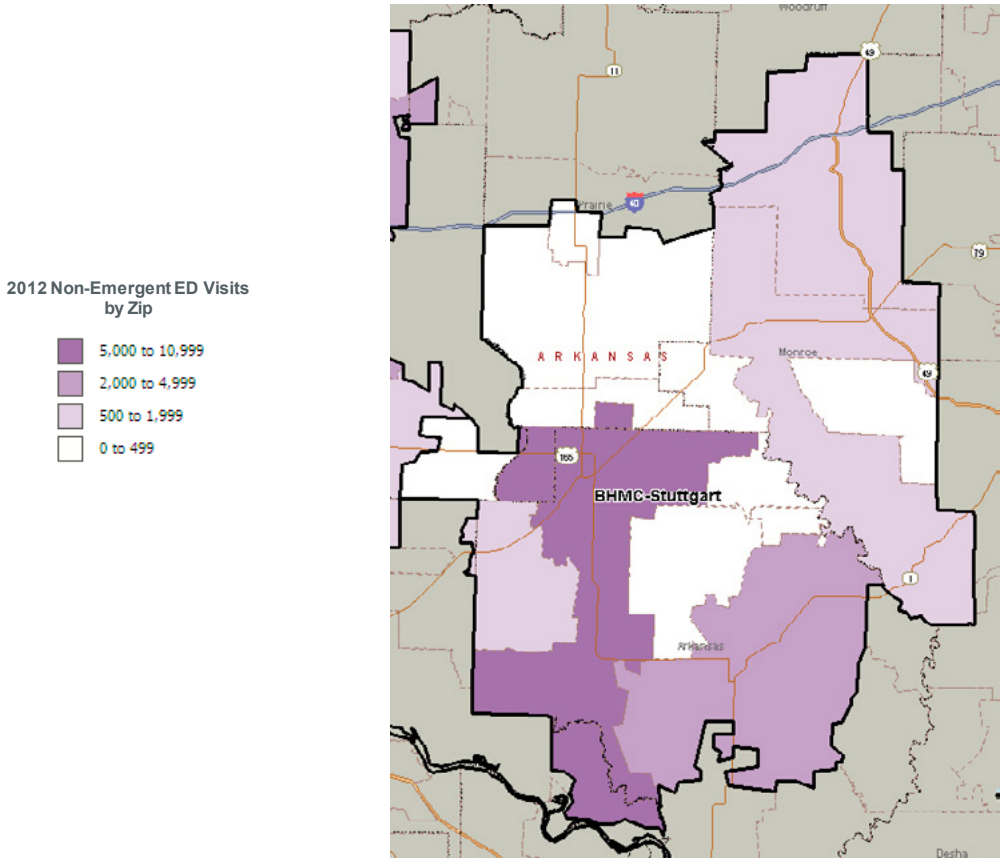
BHMC – STUTTGART
CNI BARRIER SCORE BY ZIP CODE

Baptist Health Community	Zip	2011 Population	Overall CNI Score	Income Rank	Education Rank	Culture Rank	Insurance Rank	Housing Rank
BHMC-Stuttgart	72021	4,158	5	5	5	5	5	5
	72069	1,148	5	5	5	5	5	5
	72042	5,275	5	5	5	4	5	5
	72029	2,233	5	5	5	4	5	5
	72073	1,189	5	5	5	5	5	4
	72134	281	5	5	5	4	4	5
	72160	10,128	4	4	4	5	4	5
	72072	396	4	4	5	4	5	4
	72041	1,559	4	4	5	4	4	4
	72064	1,929	4	4	4	3	4	4
	72003	741	3	2	4	3	3	4
	72026	365	3	4	3	4	2	3
	72170	262	3	1	5	3	3	4
	72038	58	3	4	3	4	2	3

The CNI score is an average of five different barrier scores that measure various socio-economic indicators of each community. The CNI is strongly linked to variations in community healthcare needs and is a strong indicator of a community's demand for various healthcare services.

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BHMC – STUTTGART
NON-EMERGENT ED VISITS BY ZIP



Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

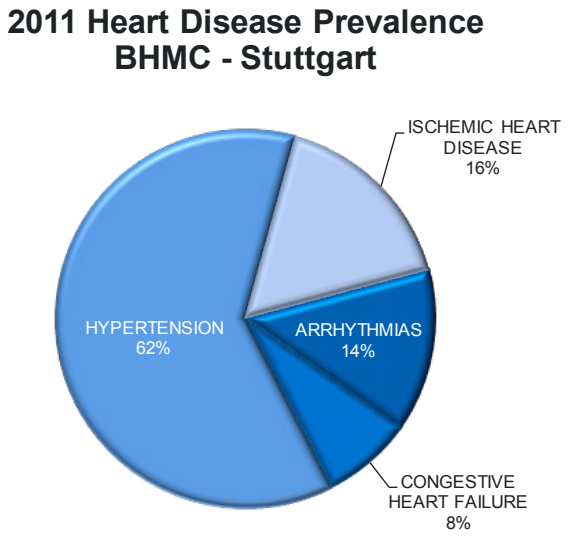
Stuttgart

Zip Code	2012 Total ED Visits	2012 Non-Emergent ED Visits	2012 % Non-Emergent	2017 Total ED Visits	2017 Non-Emergent ED Visits	2017 % Non-Emergent	2012 - 2017 % Chg Non-Emergent
72003	415	345	83%	416	340	82%	-1%
72021	2,160	1,490	69%	2,092	1,380	66%	-7%
72026	175	143	82%	176	142	81%	-1%
72029	1,024	690	67%	1,019	656	64%	-5%
72038	29	24	83%	29	23	79%	-4%
72041	629	396	63%	636	381	60%	-4%
72042	3,137	2,598	83%	3,193	2,589	81%	0%
72064	789	482	61%	820	483	59%	0%
72069	558	374	67%	541	340	63%	-9%
72072	231	140	61%	257	149	58%	6%
72073	618	515	83%	598	489	82%	-5%
72134	140	93	66%	144	93	65%	0%
72160	6,249	5,193	83%	6,410	5,229	82%	1%
72170	108	67	62%	111	66	59%	-1%
Total	**16,262**	**12,550**	**77%**	**16,442**	**12,360**	**75%**	**-2%**

BHMC – STUTTGART
2011 ESTIMATED HEART DISEASE PREVALENCE

BHMC -Stuttgart

Heart Disease Type	2011 Prevalence
ARRHYTHMIAS	1,378
CONGESTIVE HEART FAILURE	764
HYPERTENSION	6,096
ISCHEMIC HEART DISEASE	1,637
Grand Total	**9,875**



Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

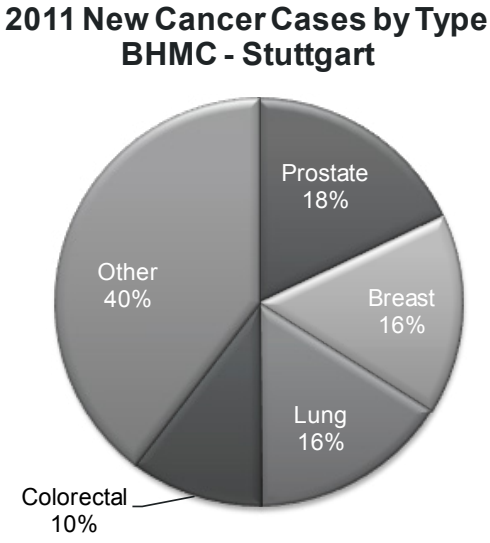
Stuttgart

Zip Code	ARRHYTHMIAS 2011 Prevalence	CONGESTIVE HEART FAILURE 2011 Prevalence	HYPERTENSION 2011 Prevalence	ISCHEMIC HEART DISEASE 2011 Prevalence	TOTAL HEART DISEASE 2011 Prevalence
72003	32	17	136	39	224
72021	184	110	914	213	1,421
72026	16	9	71	20	116
72029	101	61	514	118	794
72038	3	1	11	3	18
72041	82	42	385	97	606
72042	251	137	1,007	303	1,698
72064	112	58	500	134	804
72069	57	34	276	66	433
72072	14	8	90	19	131
72073	50	27	214	60	351
72134	11	7	61	13	92
72160	451	246	1,850	536	3,083
72170	14	7	67	16	104
Total	**1,378**	**764**	**6,096**	**1,637**	**9,875**

BHMC – STUTTGART
2011 ESTIMATED CANCER INCIDENCE

BHMC - Stuttgart

Cancer Type	2011 Incidence (new Cancer cases)
PROSTATE	42
BREAST	37
LUNG	37
COLORECTAL	24
OTHER	21
NH LYMPHOMA	10
BLADDER	9
KIDNEY	8
LEUKEMIA	7
PANCREAS	7
MELANOMA	6
UTERINE	5
ORAL CAVITY	5
STOMACH	4
OVARIAN	4
BRAIN	3
THYROID	3
CERVICAL	1
Grand Total	**232**



Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

Stuttgart

Zip Code	BREAST 2011 Incidence	COLORECTAL 2011 Incidence	LUNG 2011 Incidence	PROSTATE 2011 Incidence	OTHER 2011 Incidence
72003	1	1	1	1	2
72021	5	4	6	6	14
72026	0	0	0	1	1
72029	3	2	3	3	8
72038	0	0	0	0	0
72041	2	1	2	3	5
72042	7	4	6	7	16
72064	3	2	3	3	7
72069	2	1	2	2	4
72072	0	0	0	0	1
72073	1	1	1	2	3
72134	0	0	0	0	1
72160	12	8	12	14	29
72170	0	0	0	0	1
Total	**37**	**24**	**37**	**42**	**92**

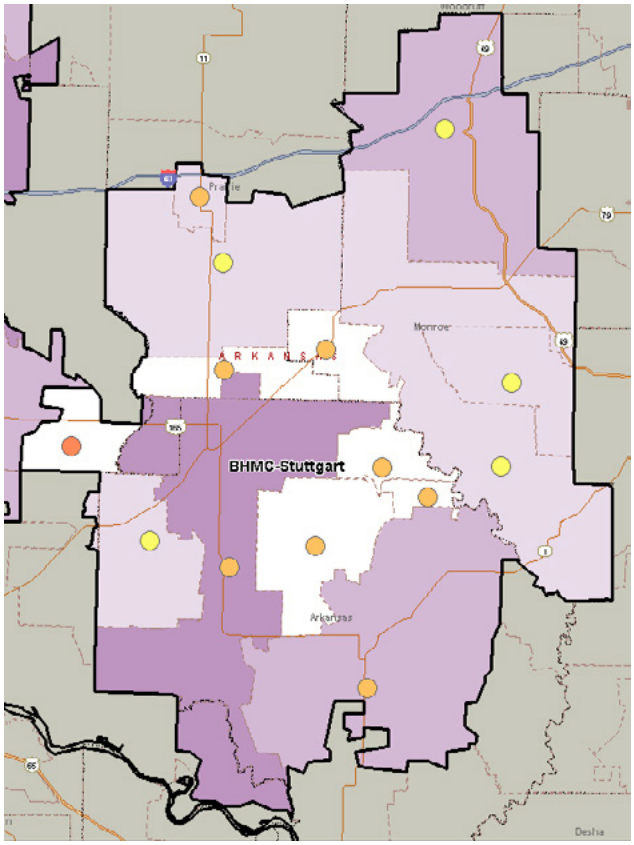
BHMC – STUTTGART
2012 – 2017 TOTAL POPULATION

2012 Total Population by Zip

- 20,000 to 39,999
- 10,000 to 19,999
- 3,000 to 9,999
- 1,000 to 2,999
- 0 to 999

2012-2017 Population % Change by Zip

- 6% to 16%
- 1% to 5%
- -4% to 0%
- -11% to -5%



Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

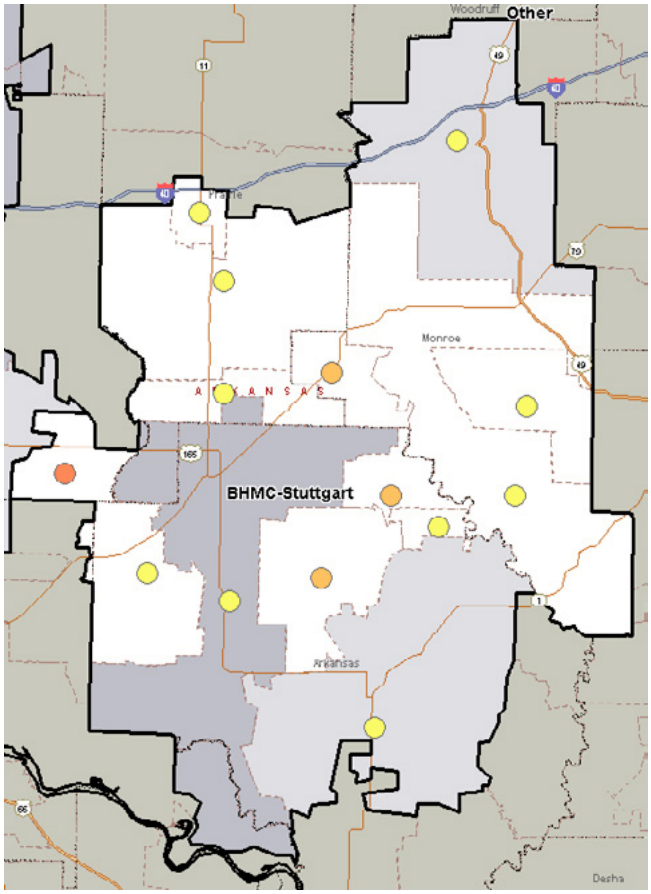
BHMC – STUTTGART
2012 – 2017 POPULATION CHILDREN AGE 0-17

2012 Population Age 0-17 by Zip

- 8,000 to 10,999
- 5,000 to 7,999
- 2,000 to 4,999
- 500 to 1,999
- 0 to 499

2012-2017 Population Age 0-17 % Change by Zip

- 6% to 25%
- 1% to 5%
- -4% to 0%
- -16% to -5%



Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

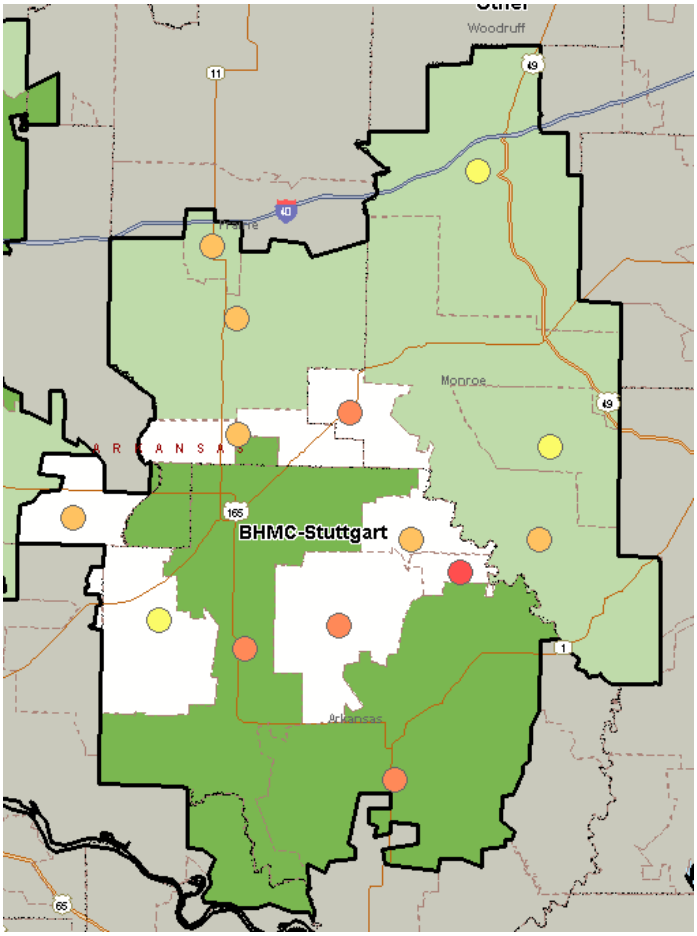
BHMC – STUTTGART
2012 – 2017 POPULATION AGE 65+

2012 Population Age 0-17 by Zip

- 2,000 to 4,999
- 801 to 1,999
- 200 to 800
- 0 to 199

2012-2017 Population Age 0-17 % Change by Zip

- 20% to 44%
- 9% to 19%
- 1% to 8%
- -10% to 0%



Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

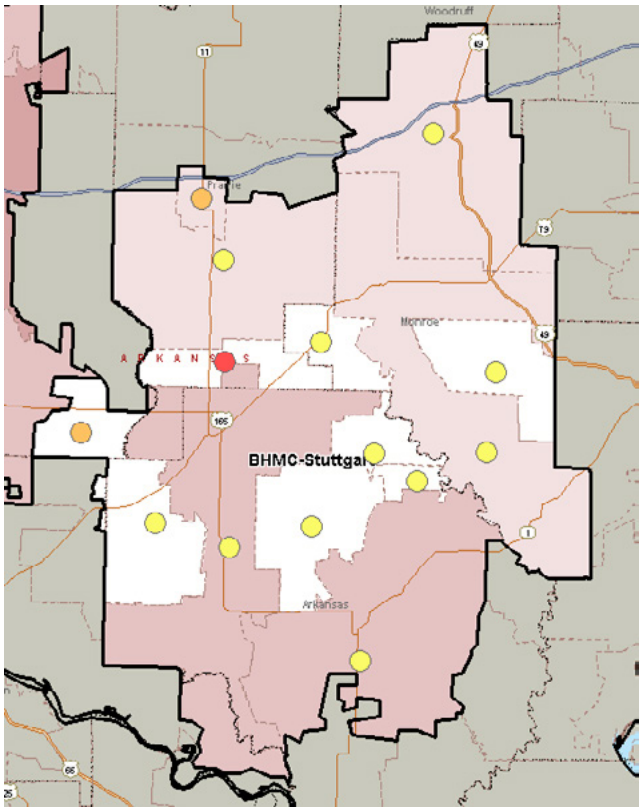
BHMC – STUTTGART
2012–2017 POPULATION WOMEN CHILDBEARING AGE

2012 Population Women Age 15-44 by Zip

- 5,000 to 9,000
- 2,000 to 4,999
- 800 to 1,999
- 200 to 799
- 1 to 199

2012-2017 Population Women Age 15-44 % Change by Zip

- 6% to 13%
- 1% to 5%
- -4% to 0%
- -50% to -5%



Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BHMC – STUTTGART
2012 – 2017 POPULATION BY AGE GROUP BY ZIP

STUTTGART

Zip Code	Age Group	2000 Population	2012 Population	2017 Population	2012-2017 Change
72003	00-17	189	173	167	-3%
72003	18-44	307	228	215	-6%
72003	45-64	225	227	219	-4%
72003	65+	115	105	115	10%
72021	00-17	1,641	1,127	1,005	-11%
72021	18-44	1,714	1,181	1,088	-8%
72021	45-64	1,271	1,258	1,059	-16%
72021	65+	919	793	769	-3%
72026	00-17	83	70	69	-1%
72026	18-44	129	87	82	-6%
72026	45-64	108	112	110	-2%
72026	65+	57	52	55	6%
72029	00-17	701	444	404	-9%
72029	18-44	894	599	537	-10%
72029	45-64	685	664	602	-9%
72029	65+	468	398	415	4%
72038	00-17	12	13	11	-15%
72038	18-44	20	14	13	-7%
72038	45-64	18	19	18	-5%
72038	65+	12	7	10	43%
72041	00-17	429	317	293	-8%
72041	18-44	576	476	442	-7%
72041	45-64	456	466	431	-8%
72041	65+	298	292	311	7%
72042	00-17	1,379	1,253	1,194	-5%
72042	18-44	2,004	1,604	1,552	-3%
72042	45-64	1,419	1,498	1,389	-7%
72042	65+	1,019	866	947	9%

STUTTGART

Zip Code	Age Group	2000 Population	2012 Population	2017 Population	2012-2017 Change
72064	00-17	505	403	378	-6%
72064	18-44	703	573	564	-2%
72064	45-64	536	570	548	-4%
72064	65+	430	421	444	5%
72069	00-17	409	215	182	-15%
72069	18-44	466	290	259	-11%
72069	45-64	331	319	277	-13%
72069	65+	311	226	221	-2%
72072	00-17	146	135	142	5%
72072	18-44	215	214	218	2%
72072	45-64	127	123	129	5%
72072	65+	79	77	81	5%
72073	00-17	361	242	215	-11%
72073	18-44	462	325	304	-6%
72073	45-64	334	300	269	-10%
72073	65+	199	155	150	-3%
72134	00-17	82	61	61	0%
72134	18-44	114	83	79	-5%
72134	45-64	90	100	91	-9%
72134	65+	52	55	61	11%
72160	00-17	2,902	2,660	2,534	-5%
72160	18-44	3,880	3,298	3,256	-1%
72160	45-64	2,636	2,890	2,711	-6%
72160	65+	1,758	1,660	1,840	11%
72170	00-17	67	55	49	-11%
72170	18-44	97	78	80	3%
72170	45-64	80	91	84	-8%
72170	65+	44	52	56	8%

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BHMC – STUTTGART
2012 – 2017 WOMEN CHILDBEARING AGE BY ZIP

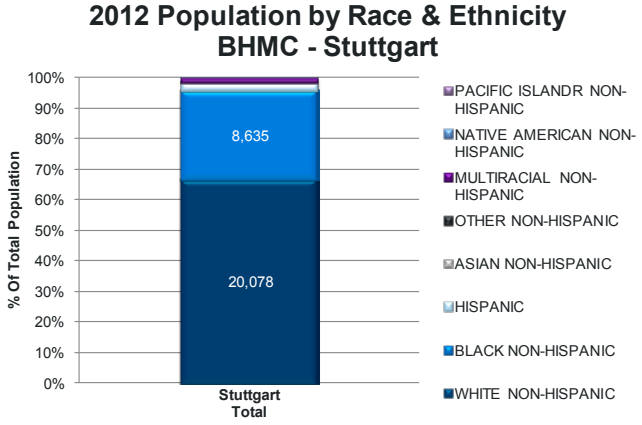
BHMC-STUTTGART

Zip Code	2012 Population	2017 Population	2012-2017 Change
72003	125	119	-5%
72021	728	653	-10%
72026	47	45	-4%
72029	323	288	-11%
72038	9	6	-33%
72041	280	259	-8%
72042	920	880	-4%
72064	322	311	-3%
72069	170	148	-13%
72072	119	120	1%
72073	191	172	-10%
72134	43	41	-5%
72160	1,969	1,878	-5%
72170	40	46	15%
TOTAL	**5,286**	**4,966**	**-6.1%**

Note: women childbearing age = females age 15-44

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BHMC – STUTTGART
2012 POPULATION BY RACE & ETHNICITY



BHMC-Stuttgart

Race/Ethnicity	2012 Population	2017 Population	2012-2017 Population Change	2012-2017 Population % Chg
WHITE NON-HISPANIC	20,078	18,953	(1,125)	-6%
BLACK NON-HISPANIC	8,635	8,356	(279)	-3%
HISPANIC	731	879	148	20%
ASIAN NON-HISPANIC	134	149	15	11%
OTHER NON-HISPANIC	18	18	-	0%
MULTIRACIAL NON-HISPANIC	351	384	33	9%
NATIVE AMERICAN NON-HISPANIC	65	63	(2)	-3%
PACIFIC ISLANDR NON-HISPANIC	2	3	1	50%
Grand Total	**30,014**	**28,805**	**(1,209)**	**-4%**

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BHMC –STUTTGART
RACE & ETHNICITY BY ZIP

BHCM-Stuttgart

Zip Code	Ethnicity	2000 Population	2012 Population	2017 Population	2012-2017 Change
72003	ASIAN NON-HISPANIC	-	1	1	0%
72003	BLACK NON-HISPANIC	68	50	47	-6%
72003	HISPANIC	2	4	5	25%
72003	MULTIRACIAL NON-HISPANIC	4	4	3	-25%
72003	NATIVE AMERICAN NON-HISPANIC	2	-	-	0%
72003	OTHER NON-HISPANIC	-	-	-	0%
72003	PACIFIC ISLANDR NON-HISPANIC	-	-	-	0%
72003	WHITE NON-HISPANIC	760	674	660	-2%
72021	ASIAN NON-HISPANIC	7	35	43	23%
72021	BLACK NON-HISPANIC	2,293	1,896	1,745	-8%
72021	HISPANIC	66	57	51	-11%
72021	MULTIRACIAL NON-HISPANIC	64	42	35	-17%
72021	NATIVE AMERICAN NON-HISPANIC	12	12	14	17%
72021	OTHER NON-HISPANIC	9	5	3	-40%
72021	PACIFIC ISLANDR NON-HISPANIC	2	-	-	0%
72021	WHITE NON-HISPANIC	3,092	2,312	2,030	-12%
72026	ASIAN NON-HISPANIC	-	-	-	0%
72026	BLACK NON-HISPANIC	92	52	41	-21%
72026	HISPANIC	-	2	3	50%
72026	MULTIRACIAL NON-HISPANIC	4	3	3	0%
72026	NATIVE AMERICAN NON-HISPANIC	1	-	-	0%
72026	OTHER NON-HISPANIC	1	1	-	-100%
72026	PACIFIC ISLANDR NON-HISPANIC	-	-	-	0%
72026	WHITE NON-HISPANIC	279	263	269	2%
72029	ASIAN NON-HISPANIC	3	2	2	0%
72029	BLACK NON-HISPANIC	732	602	581	-3%
72029	HISPANIC	53	58	59	2%
72029	MULTIRACIAL NON-HISPANIC	30	26	26	0%
72029	NATIVE AMERICAN NON-HISPANIC	11	13	14	8%
72029	OTHER NON-HISPANIC	-	-	-	0%
72029	PACIFIC ISLANDR NON-HISPANIC	-	-	-	0%
72029	WHITE NON-HISPANIC	1,919	1,404	1,276	-9%

BHCM-Stuttgart

Zip Code	Ethnicity	2000 Population	2012 Population	2017 Population	2012-2017 Change
72038	ASIAN NON-HISPANIC	-	-	-	0%
72038	BLACK NON-HISPANIC	15	8	7	-13%
72038	HISPANIC	-	1	-	-100%
72038	MULTIRACIAL NON-HISPANIC	1	1	1	0%
72038	NATIVE AMERICAN NON-HISPANIC	-	-	-	0%
72038	OTHER NON-HISPANIC	-	-	-	0%
72038	PACIFIC ISLANDR NON-HISPANIC	-	-	-	0%
72038	WHITE NON-HISPANIC	46	43	44	2%
72041	ASIAN NON-HISPANIC	1	1	-	-100%
72041	BLACK NON-HISPANIC	318	242	217	-10%
72041	HISPANIC	7	13	15	15%
72041	MULTIRACIAL NON-HISPANIC	10	5	4	-20%
72041	NATIVE AMERICAN NON-HISPANIC	2	1	-	-100%
72041	OTHER NON-HISPANIC	1	-	-	0%
72041	PACIFIC ISLANDR NON-HISPANIC	-	-	-	0%
72041	WHITE NON-HISPANIC	1,420	1,289	1,241	-4%
72042	ASIAN NON-HISPANIC	9	18	20	11%
72042	BLACK NON-HISPANIC	813	740	724	-2%
72042	HISPANIC	37	163	204	25%
72042	MULTIRACIAL NON-HISPANIC	39	54	61	13%
72042	NATIVE AMERICAN NON-HISPANIC	8	5	4	-20%
72042	OTHER NON-HISPANIC	-	2	3	50%
72042	PACIFIC ISLANDR NON-HISPANIC	-	-	-	0%
72042	WHITE NON-HISPANIC	4,915	4,239	4,066	-4%
72064	ASIAN NON-HISPANIC	-	2	2	0%
72064	BLACK NON-HISPANIC	305	319	325	2%
72064	HISPANIC	15	18	18	0%
72064	MULTIRACIAL NON-HISPANIC	10	20	24	20%
72064	NATIVE AMERICAN NON-HISPANIC	14	6	5	-17%
72064	OTHER NON-HISPANIC	-	-	-	0%
72064	PACIFIC ISLANDR NON-HISPANIC	-	-	-	0%
72064	WHITE NON-HISPANIC	1,830	1,602	1,560	-3%

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BHMC –STUTTGART
RACE & ETHNICITY BY ZIP

BHCM-Stuttgart

Zip Code	Ethnicity	2000 Population	2012 Population	2017 Population	2012-2017 Change
72069	ASIAN NON-HISPANIC	1	1	-	-100%
72069	BLACK NON-HISPANIC	856	652	594	-9%
72069	HISPANIC	8	10	12	20%
72069	MULTIRACIAL NON-HISPANIC	6	9	9	0%
72069	NATIVE AMERICAN NON-HISPANIC	1	2	1	-50%
72069	OTHER NON-HISPANIC	-	-	-	0%
72069	PACIFIC ISLANDR NON-HISPANIC	-	-	-	0%
72069	WHITE NON-HISPANIC	645	376	323	-14%
72072	ASIAN NON-HISPANIC	-	-	-	0%
72072	BLACK NON-HISPANIC	160	146	140	-4%
72072	HISPANIC	8	6	7	17%
72072	MULTIRACIAL NON-HISPANIC	4	12	16	33%
72072	NATIVE AMERICAN NON-HISPANIC	4	-	1	0%
72072	OTHER NON-HISPANIC	-	-	-	0%
72072	PACIFIC ISLANDR NON-HISPANIC	-	-	-	0%
72072	WHITE NON-HISPANIC	391	385	406	5%
72073	ASIAN NON-HISPANIC	2	1	1	0%
72073	BLACK NON-HISPANIC	479	282	235	-17%
72073	HISPANIC	15	10	12	20%
72073	MULTIRACIAL NON-HISPANIC	25	7	6	-14%
72073	NATIVE AMERICAN NON-HISPANIC	2	4	4	0%
72073	OTHER NON-HISPANIC	-	-	-	0%
72073	PACIFIC ISLANDR NON-HISPANIC	-	-	-	0%
72073	WHITE NON-HISPANIC	833	718	680	-5%
72134	ASIAN NON-HISPANIC	1	-	-	0%
72134	BLACK NON-HISPANIC	52	59	63	7%
72134	HISPANIC	2	7	8	14%
72134	MULTIRACIAL NON-HISPANIC	7	4	3	-25%
72134	NATIVE AMERICAN NON-HISPANIC	1	2	2	0%
72134	OTHER NON-HISPANIC	-	-	-	0%
72134	PACIFIC ISLANDR NON-HISPANIC	-	-	-	0%
72134	WHITE NON-HISPANIC	275	227	216	-5%

BHCM-Stuttgart

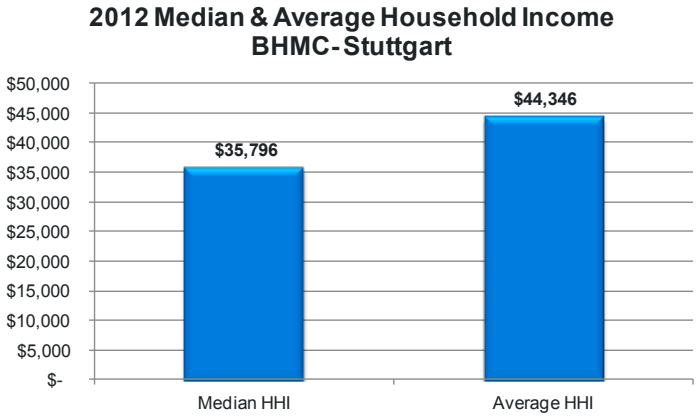
Zip Code	Ethnicity	2000 Population	2012 Population	2017 Population	2012-2017 Change
72160	ASIAN NON-HISPANIC	63	73	80	10%
72160	BLACK NON-HISPANIC	3,504	3,562	3,612	1%
72160	HISPANIC	93	380	483	27%
72160	MULTIRACIAL NON-HISPANIC	64	163	192	18%
72160	NATIVE AMERICAN NON-HISPANIC	25	20	18	-10%
72160	OTHER NON-HISPANIC	2	10	12	20%
72160	PACIFIC ISLANDR NON-HISPANIC	1	2	3	50%
72160	WHITE NON-HISPANIC	7,424	6,298	5,941	-6%
72170	ASIAN NON-HISPANIC	-	-	-	0%
72170	BLACK NON-HISPANIC	23	25	25	0%
72170	HISPANIC	1	2	2	0%
72170	MULTIRACIAL NON-HISPANIC	2	1	1	0%
72170	NATIVE AMERICAN NON-HISPANIC	-	-	-	0%
72170	OTHER NON-HISPANIC	-	-	-	0%
72170	PACIFIC ISLANDR NON-HISPANIC	-	-	-	0%
72170	WHITE NON-HISPANIC	262	248	241	-3%

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BHMC – STUTTGART
HOUSEHOLD INCOME

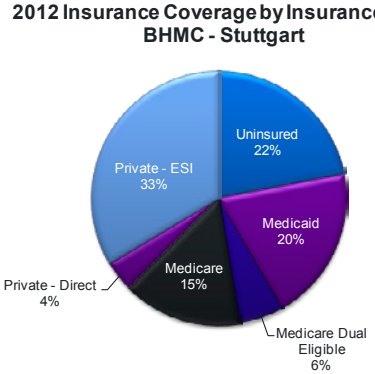
BHMC-STUTTGART

Zip Code	2012 Total Households	2012 Average Household Income	2012 Median Household Income
72003	321	$60,717	$50,469
72021	1,849	$37,353	$25,247
72026	150	$56,517	$54,245
72029	950	$41,695	$30,329
72038	25	$50,800	$51,389
72041	705	$39,521	$31,919
72042	2,202	$42,523	$31,789
72064	829	$43,305	$34,038
72069	457	$31,018	$21,037
72072	223	$38,935	$28,621
72073	457	$40,700	$31,146
72134	134	$49,160	$38,158
72160	4,389	$47,159	$36,364
72170	121	$41,446	$36,389



Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BHMC – STUTTGART
INSURANCE COVERAGE

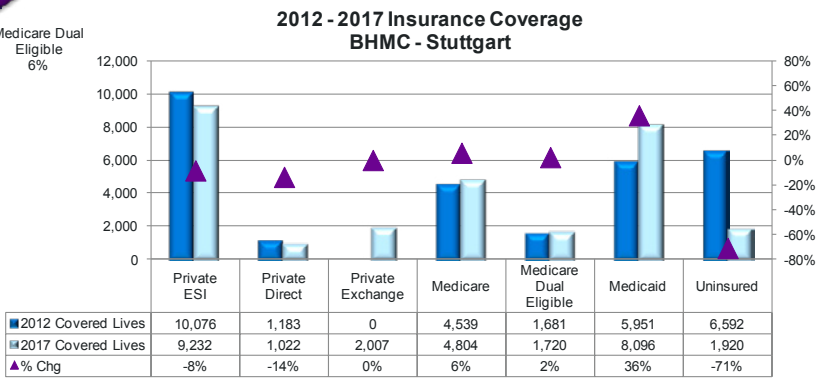


Private ESI (Employer Sponsored Insurance) = Plans offered through an employer

Private Exchanges = Plans purchased via an insurance exchange or insurance market place

Medicare Dual Eligible = Medicare enrollees receiving additional benefits via Medicaid

Private Direct = Individuals who purchase insurance directly from an insurance provider



	Private ESI	Private Direct	Private Exchange	Medicare	Medicare Dual Eligible	Medicaid	Uninsured
2012 Covered Lives	10,076	1,183	0	4,539	1,681	5,951	6,592
2017 Covered Lives	9,232	1,022	2,007	4,804	1,720	8,096	1,920
% Chg	-8%	-14%	0%	6%	2%	36%	-71%

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BHMC – STUTTGART
INSURANCE COVERAGE BY ZIP

BHMC-Stuttgart

Zip Code	Insurance Type	2012 Covered Lives	2017 Covered Lives	% Chg
72003	Private - ESI	377	348	-8%
72003	Private - Direct	44	40	-9%
72003	Private - Exchange	0	43	N/A
72003	Medicare	99	109	10%
72003	Medicare Dual Eligible	29	32	10%
72003	Medicaid	89	115	29%
72003	Uninsured	94	30	-68%
72021	Private - ESI	956	816	-15%
72021	Private - Direct	112	88	-21%
72021	Private - Exchange	0	295	N/A
72021	Medicare	632	612	-3%
72021	Medicare Dual Eligible	340	323	-5%
72021	Medicaid	1,038	1,431	38%
72021	Uninsured	1,282	356	-72%
72026	Private - ESI	171	160	-6%
72026	Private - Direct	21	18	-14%
72026	Private - Exchange	0	18	N/A
72026	Medicare	49	52	6%
72026	Medicare Dual Eligible	15	15	0%
72026	Medicaid	32	41	28%
72026	Uninsured	34	11	-68%
72029	Private - ESI	554	486	-12%
72029	Private - Direct	65	53	-18%
72029	Private - Exchange	0	146	N/A
72029	Medicare	318	330	4%
72029	Medicare Dual Eligible	170	172	1%
72029	Medicaid	447	613	37%
72029	Uninsured	551	158	-71%

BHMC-Stuttgart

Zip Code	Insurance Type	2012 Covered Lives	2017 Covered Lives	% Chg
72038	Private - ESI	29	26	-10%
72038	Private - Direct	4	3	-25%
72038	Private - Exchange	0	3	N/A
72038	Medicare	6	9	50%
72038	Medicare Dual Eligible	2	3	50%
72038	Medicaid	6	7	17%
72038	Uninsured	6	2	-67%
72041	Private - ESI	543	490	-10%
72041	Private - Direct	63	54	-14%
72041	Private - Exchange	0	97	N/A
72041	Medicare	246	261	6%
72041	Medicare Dual Eligible	80	83	4%
72041	Medicaid	298	398	34%
72041	Uninsured	324	94	-71%
72042	Private - ESI	1,721	1,585	-8%
72042	Private - Direct	201	175	-13%
72042	Private - Exchange	0	361	N/A
72042	Medicare	807	874	8%
72042	Medicare Dual Eligible	249	261	5%
72042	Medicaid	1,091	1,483	36%
72042	Uninsured	1,150	339	-71%
72064	Private - ESI	792	740	-7%
72064	Private - Direct	93	82	-12%
72064	Private - Exchange	0	116	N/A
72064	Medicare	352	373	6%
72064	Medicare Dual Eligible	116	121	4%
72064	Medicaid	294	406	38%
72064	Uninsured	320	97	-70%

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BHMC – STUTTGART
INSURANCE COVERAGE BY ZIP

BHMC-Stuttgart

Zip Code	Insurance Type	2012 Covered Lives	2017 Covered Lives	% Chg
72069	Private - ESI	97	85	-12%
72069	Private - Direct	12	9	-25%
72069	Private - Exchange	0	68	N/A
72069	Medicare	180	176	-2%
72069	Medicare Dual Eligible	98	94	-4%
72069	Medicaid	298	409	37%
72069	Uninsured	367	98	-73%
72072	Private - ESI	156	158	1%
72072	Private - Direct	18	17	-6%
72072	Private - Exchange	0	42	N/A
72072	Medicare	75	80	7%
72072	Medicare Dual Eligible	17	18	6%
72072	Medicaid	154	217	41%
72072	Uninsured	131	38	-71%
72073	Private - ESI	324	286	-12%
72073	Private - Direct	37	32	-14%
72073	Private - Exchange	0	70	N/A
72073	Medicare	145	140	-3%
72073	Medicare Dual Eligible	44	43	-2%
72073	Medicaid	230	298	30%
72073	Uninsured	242	68	-72%
72134	Private - ESI	110	100	-9%
72134	Private - Direct	13	11	-15%
72134	Private - Exchange	0	21	N/A
72134	Medicare	43	48	12%
72134	Medicare Dual Eligible	24	25	4%
72134	Medicaid	49	68	39%
72134	Uninsured	60	18	-70%

BHMC-Stuttgart

Zip Code	Insurance Type	2012 Covered Lives	2017 Covered Lives	% Chg
72160	Private - ESI	4,126	3,840	-7%
72160	Private - Direct	485	428	-12%
72160	Private - Exchange	0	710	N/A
72160	Medicare	1,543	1,692	10%
72160	Medicare Dual Eligible	482	514	7%
72160	Medicaid	1,885	2,558	36%
72160	Uninsured	1,988	599	-70%
72170	Private - ESI	120	112	-7%
72170	Private - Direct	15	12	-20%
72170	Private - Exchange	0	17	N/A
72170	Medicare	44	48	9%
72170	Medicare Dual Eligible	15	16	7%
72170	Medicaid	40	52	30%
72170	Uninsured	43	12	-72%
BHMC-Stuttgart Total		**30,022**	**28,801**	**-4%**

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

Interview & Focus Group Analysis

INTERVIEW ANALYSIS APPROACH

- Coded participants and consolidated interview responses
- Participant responses were parsed by question/topic and categorized
    - Participants gave multiple responses per question – each response recorded individually
    - Therefore, response count can be greater than number of participants
- Density analysis conducted on responses by category

Interview questions were designed to approach some subjects in a multitude of ways and give the interviewer flexibility in conducting the interview. Therefore not every question is represented with a response table as some question responses were collapsed while others eliminated due to time constraints. Additionally some questions were not designed for response consolidation but used to inform other sections of the analysis.

BHMC STUTTGART INTERVIEW SUMMARY

Questions 1 and 2 were background/ice-breaker questions regarding the community or organization each person represented.

03. What would you say is the current health status of the community?

Response Category	Response Count	Percent of Responses
Poor	4	36%
Fair	3	27%
Good-Fair	3	27%
Very Good	1	9%
Grand Total	**11**	**100%**

03a. Reasoning?

Response Category	Response Count	Percent of Responses
Chronic/Other Diseases	7	47%
Unhealthy Population	1	7%
Alcohol/Drug Abuse	1	7%
Smoking	1	7%
Health Disparities	1	7%
Obesity	1	7%
Aging Population	1	7%
Lower Socioeconomic Status	1	7%
Higher Socioeconomic Status	1	7%
Grand Total	**15**	**100%**

04. Top health needs of the community?

Response Category	Response Count	Percent of Responses
Chronic Diseases	4	11%
Healthcare Providers/Services	4	11%
Cardiovascular	3	9%
Obesity	3	9%
Dental	3	9%
Affordable Care	2	6%
Access	2	6%
Prevention/Lifestyle Modification	2	6%
Care Coordination	2	6%
Food/Nutrition	2	6%
Elderly	1	3%
Cancer	1	3%
Sexual Health	1	3%
Mental Health	1	3%
Transportation	1	3%
Medications	1	3%
Diabetes	1	3%
Medical Compliance	1	3%
Grand Total	**35**	**100%**

4b. What healthcare services are missing?

Response Category	Response Count	Percent of Responses
Surgery	1	33%
Education	1	33%
Dental	1	33%
Grand Total	**3**	**100%**

4c. What is the number one barrier to good health care?

Response Category	Response Count	Percent of Responses
Health Education	2	29%
Socioeconomic	2	29%
Culture	1	14%
Prevention/Lifestyle Modification	1	14%
Insurance	1	14%
Grand Total	**7**	**100%**

4d. What concerns you the most about the health of the community?

Response Category	Response Count	Percent of Responses
Socioeconomic	2	50%
Chronic/Other Diseases	1	25%
Obesity	1	25%
Grand Total	**4**	**100%**

05. Leading social determinants of health?

Response Category	Response Count	Percent of Responses
Socioeconomic	12	52%
Culture	2	9%
Food/Nutrition	2	9%
Prevention/Lifestyle Modification	2	9%
Transportation	2	9%
Health Education	1	4%
Alcohol/Drug Abuse	1	4%
Insurance	1	4%
Grand Total	**23**	**100%**

06. primary health indicators?

Response Category	Response Count	Percent of Responses
Condition/Disease Rates	7	22%
Alcohol/Drug Abuse Rates	4	13%
Smoking	4	13%
Obesity	4	13%
Hospital/Public Health Measures	3	9%
Socioeconomic	3	9%
Preventative Care Rates	2	6%
Teen Pregnancy	1	3%
ER Visits	1	3%
Mental Health	1	3%
Other	1	3%
Lifestyle Measures	1	3%
Grand Total	**32**	**100%**

07. vulnerable groups/populations?

Response Category	Response Count	Percent of Responses
Minorities	6	35%
Elderly	5	29%
Children/Teens	3	18%
Poor	2	12%
Chronic Diseases	1	6%
Grand Total	**17**	**100%**

09. In terms of specific actions/programs, what do you think could be done to address the health needs we've discussed?

Response Category	Response Count	Percent of Responses
Public Health/Health Outcomes	5	26%
Community Outreach/Education	4	21%
Social Resources	2	11%
Recreation	2	11%
Care Coordination	2	11%
Prevention/Screenings	2	11%
Access/Affordable Care	1	5%
Policy	1	5%
Grand Total	**19**	**100%**

10. What are some ways Baptist Health or other organizations can engage the community in addressing health needs?

Response Category	Response Count	Percent of Responses
Community Outreach/Education	9	53%
Community Collaboration	4	24%
Access/Affordable Care	1	6%
Care Coordination	1	6%
Other	1	6%
Environment/Socioeconomic	1	6%
Grand Total	**17**	**100%**

BHMC-Stuttgart Focus Group Summary

LOCATION: BHMC-STUTTGART DATE: 9/11/12

DISCUSSION 1:

- What grade do you give the health of this community (A-F)?
    - Write the Grade down on sticky note and place on flipchart/white board
- Discuss as a group the grade chosen
    - What factors did you consider when you chose a grade?
    - What do you think of when you think of health?

RESPONSES:

When asked to grade the health of the community served by BHMC-Stuttgart, six focus group participants provided C's, one C-, and one B-. A lack of preventive healthcare services and chronic conditions contribute to the average grade. Heart conditions and kidney issues that require dialysis are common and even the student population at Phillips Community College miss classes due to health issues such as cancer, allergy based problems, and pneumonia. Lack of insurance and a high Medicaid population are also characteristics of the community.

While quality healthcare is available, low health literacy and access to healthcare services is seen as a major driver of the poor health status. Smoking, drug use, and accidents are also common in the community. Delaying care also seems embedded in the culture and that leads to accessing the healthcare system when individuals are very ill and end up staying in the hospital for an extended period. Individuals do not know how to access health information to get answers to their health questions so it becomes the responsibility of health organizations to meet the community where they are for their health needs.

More affluent people may take advantage of physical fitness facilities but there is a need to have these options available for the middle/lower class. Additionally, education on healthy living and introducing community members to farmer's markets would provide people with healthier options. Cooking classes, specifically targeting the younger population, would also provide healthy life skills.

DISCUSSION 2:

- Break into 2-3 smaller groups
- As a group identify the top 3 health needs of the community
    - Agree upon the top 3 needs and why
    - Write each need on sticky note and place on flipchart/white board
    - One person from the group share with the larger group why those needs were chosen

RESPONSES:

1. Activity Center
    a. Need to give people a free, active outlet
2. Health education
3. Connecting/motivating/transporting people to the resources already available.

GROUP 1: Education, Transportation, Activity Center

GROUP 2: Education, Transportation, Access

DISCUSSION 3:

- Stay the same smaller groups
- As a group identify up to 10 community resources (health/community organizations)
    - Work together to identify resources and list on flipchart paper
    - Discuss ways these resources could work together to address the health needs discussed
    - One person from the group share with larger group 2-3 ideas from discussion

RESPONSES:

In general, participants feel churches are the hub of the community as they have congregations of all socioeconomic levels and are trusted by the African American community. One opportunity may be to coordinate transportation services with a church and provide a free service or service based on voluntary donations. Expanding programs that are already in place will also start to improve the health status of the community.

GROUP 1:

- Medical Center
- County Health Clinic
- Industries that offer insurance
- Young doctors
- Research centers
- PCCUA
- Volunteers
- Civic Clubs
- Hunting/tourism

GROUP 2:

- Medical providers
- College
- Volunteers/civic groups
- Industry
- Agriculture
- Tourism
- Grand Prairie Center
- School systems
- Faith based organizations
- Dual Service Centers (Court house, DHS, ADH, etc.)

DISCUSSION 4:

- Stay the same smaller groups
- As a group, choose one of the health needs your group identified earlier
- Identify two goals you'd like to accomplish related to the need
    - Goals should be SMART (Specific, Measurable, Attainable, Realistic, Time-sensitive)
- For each goal identify 2-3 action steps that would help achieve the goal

RESPONSES:

GROUP1:

Community Health Need: Transportation

- Goal 1: Build sidewalk to hospital
    - Seek government funds for sidewalk; need grant writer.
    - Raise awareness about the need and organize a community lobbying effort.
- Goal 2: Insurance for vans
    - Check with insurance companies of what policies are available for the need.
    - Strategize to provide service of a reasonable cost.

GROUP 2:

Community Health Need: Education

- Goal 1: Increase the number participating in current programs
    - Involve area churches in planning and implementation of current programs.
    - Use hospital resources for current programs led by hospital employees and associates.
- Goal 2: Extend the reach of education programs to the underserved areas of the community.
    - Partner with churches and other established groups in underserved areas to bring information and education to the area.
    - Recruit volunteer minority leaders to promote inclusion of all groups in the dissemination of information.

Health Resources Available to Meet Identified Needs

BHMC – Stuttgart

Other Hospital Facilities

Hospital Name	Address	City	Owner Type	Type of Service
Dewitt City Hospital	1641 Whitehead Dr.	DeWitt	Local Government	General Medical & Surgical

Cause of Death: Heart Disease (Arkansas, Monroe, Prairie)

Cause of Death: Stroke (Arkansas, Monroe)

Chronic Conditions: Coronary Heart Disease (Arkansas, Monroe, Prairie)

Program Name	Description	Website	Phone Number	State	County
Arkansas Department of Health Heart Disease and Stroke Prevention			501-661-2942	X	
Arkansas Wellness Coalition (AWC)	Includes members of the health care and employer community whose goal is to improve the health and well-being of all Arkansans through the use of nationally recognized, peer reviewed, clinical guidelines for physician, consumer, and employer education. Develop materials referring to nationally recognized standards such as those put forth by Healthy People 2010, the National Committee of Quality Assurance, and other disease-specific organizations such as the American Diabetes Association and the American Heart Association.		501-661-2942	X	
ARCare	ARcare offers specialized treatment for a variety of cardiovascular conditions including coronary artery disease, heart attack, high blood pressure, high cholesterol, angina, and all other conditions related to the heart and its blood vessel system.	http://www.arcare.net/OurServices/OurServices Continuedpart2/tabid/14185/Default.aspx#cardiology			X (Monroe, Prairie Counties)

Program Name	Description	Website	Phone Number	State	County
Southern Ain't Fried Sundays - Arkansas Minority Health Commission	Faith Based Outreach Program SAFS is designed to educate African American churches and organizations about healthier alternatives to preparing and cooking southern-style foods. It is also a mechanism for partnering with these groups in an effort to educate their members about the signs and symptoms of stroke, diabetes, and heart attacks. The program is being revamped to expand its reach to the Hispanic communities and individual participants.	http://www.arminorityhealth.com/programs_saf.html	877-264-2826	X	
UAMS Center for Distance Health AR SAVES Program (Stroke Assistance through Virtual Emergency Support	A stroke management system specifically targeting patients at rural hospitals to by increasing access to subspecialty expertise through telemedicine technology, thereby engineering a coordinated assessment and care-based plan for Arkansas' stroke patients. Ensuring timely administration of clot-busting drugs to improve the chances of recovery while reducing permanent, stroke-related disability and, quite possibly, mortality.		501-686-8514	X	
Arkansas Chronic Illness Collaborative (ACIC)	The ACIC is a group of health care and public health professionals dedicated to improving the management of chronic diseases. The ACIC is a way for health care clinic teams to use the National Health Disparities Collaborative Chronic Care Model to share ideas and knowledge, learn and apply new techniques, and match medical practices with clinical guidelines based on scientific evidence about what works best (diabetes, cancer and cardiovascular diseases)	http://www.healthy.arkansas.gov/programsServices/chronicDisease/Initiatives/Pages/Acic.aspx programsServices/chronicDisease/Initiatives/Pages/Acic.aspx		X	

Program Name	Description	Website	Phone Number	State	County
Arkansas Chronic Illness Collaborative (ACIC)	The ACIC is a group of health care and public health professionals dedicated to improving the management of chronic diseases. The ACIC is a way for health care clinic teams to use the National Health Disparities Collaborative Chronic Care Model to share ideas and knowledge, learn and apply new techniques, and match medical practices with clinical guidelines based on scientific evidence about what works best (diabetes, cancer and cardiovascular diseases)	http://www.healthy.arkansas.gov/programsServices/chronicDisease/Initiatives/Pages/Acic.aspx		X	

Cause of Death: Chronic Lower Respiratory Disease (Arkansas)

Program Name	Description	Website	Phone Number	State	County
Arkansas Wellness Coalition (AWC)	Includes members of the health care and employer community whose goal is to improve the health and well-being of all Arkansans through the use of nationally recognized, peer reviewed, clinical guidelines for physician, consumer, and employer education. Develop materials referring to nationally recognized standards such as those put forth by Healthy People 2010, the National Committee of Quality Assurance, and other disease-specific organizations such as the American Diabetes Association and the American Heart Association.		501-661-2942	X	
Arkansas Chronic Illness Collaborative (ACIC)	The ACIC is a group of health care and public health professionals dedicated to improving the management of chronic diseases. The ACIC is a way for health care clinic teams to use the National Health Disparities Collaborative Chronic Care Model to share ideas and knowledge, learn and apply new techniques, and match medical practices with clinical guidelines based on scientific evidence about what works best (diabetes, cancer and cardiovascular diseases)	http://www.healthy.arkansas.gov/programsServices/chronicDisease/Initiatives/Pages/Acic.aspx		X	

Cause of Death: Injury Related Deaths (Monroe)

Program Name	Description	Website	Phone Number	State	County
Arkansas Department of Health – Statewide Injury Prevention Program	The mission of the SIPP is to reduce the burden of injury mortality and morbidity in Arkansas through primary prevention of injuries. SIPP provides technical assistance and serves as a resource center for designated trauma centers, EMS providers, Hometown Health Improvement Coalitions, and Educational Service Cooperatives. SIPP also offers professional education opportunities through live presentations, webinars, and teleconferencing that provide tools to obtain grant funding, and tools to effectively identify, implement, and evaluate injury prevention initiatives at regional and local levels.	http://www.healthy.arkansas.gov/programsServices/injuryPreventionControl/injuryPrevention/SIPP/Pages/default.aspx		X	

Health Outcomes: Low Birth Weight (Arkansas, Monroe, Prairie)

Program Name	Description	Website	Phone Number	State	County
Arkansas Department of Health	ADH provides prenatal care to an average of 5,000 women annually at many of the Local Health Units.		1-800-462-0599	X	
Arkansas Department of Health Nurse-Family Partnership	Nurse-Family Partnership is a free, voluntary program that partners first-time moms with registered nurses. NFP is available to any first-time mom who is under her 28th week of pregnancy, and who is below 200% of the Federal poverty level.	http://www.adhhomecare.org/nurse-family-arkansas.htm		X	

Health Outcomes: Poor or Fair Health Status (Arkansas, Monroe, Prairie)

Program Name	Description	Website	Phone Number	State	County
ADH – Hometown Health Improvement	Hometown Health Improvement initiatives currently exist in every county around the state. HHI coalitions do powerful and unique work to improve the health of those in their communities. Once the coalition is established, many communities are choosing to conduct health behavior surveys to gain important information specific to their communities. Many coalitions are now implementing activities to affect the health of the community. Examples of some activities include: tobacco cessation programs for adolescents, household hazardous waste round-up, parenting support groups, local industry wellness programs, health fairs, and health resource guides.				X (All counties)
Chronic Disease Self Management Program – Be Well Live Well	Developed by the Stanford Patient Education Research Center, the evidence based program teaches participants the skills needed to live well with chronic diseases. It also shows participants how to organize their lives, make and achieve goals, eat properly, exercise and communicate effectively with physicians and others. National outcome studies reveal that CDSMP participants experience a marked decrease in the number of hospital stays and doctor visits.	http://www.agec.org/2012/10/cdsmp-branded-for-arkansas-be-well-live-well/		X	

Health Outcomes: Poor Physical Health and Mental Health Days (Arkansas, Monroe, Prairie)

Program Name	Description	Website	Phone Number	State	County
Chronic Disease Self Management Program – Be Well Live Well	Developed by the Stanford Patient Education Research Center, the evidence based program teaches participants the skills needed to live well with chronic diseases. It also shows participants how to organize their lives, make and achieve goals, eat properly, exercise and communicate effectively with physicians and others. National outcome studies reveal that CDSMP participants experience a marked decrease in the number of hospital stays and doctor visits.	http://www.agec.org/2012/10/cdsmp-branded-for-arkansas-be-well-live-well/		X	

Chronic Conditions: Hypertension (Arkansas)

Program Name	Description	Website	Phone Number	State	County
Southern Ain't Fried Sundays - Arkansas Minority Health Commission	Faith Based Outreach Program SAFS is designed to educate African American churches and organizations about healthier alternatives to preparing and cooking southern-style foods. It is also a mechanism for partnering with these groups in an effort to educate their members about the signs and symptoms of stroke, diabetes, and heart attacks. The program is being revamped to expand its reach to the Hispanic communities and individual participants.	http://www.arminorityhealth.com/programs_saf.html	877-264-2826		
Greater Delta Alliance for Health Mobile Health Screening Unit	GDAH has a fully equipped mobile unit that is utilized to offer free health screenings including breast exams, blood pressure, blood sugar, weight and BMI, HIV screening as well as specialized screenings through community health partners.	http://gdaharkansas.org/services			X (Arkansas County)
Area Health Education Centers (AHEC)	Health Education: Provides health education to adults on a variety of topics including diabetes, heart health, nutrition and healthy eating. Health Screening: Provides health screenings for area organizations and industry in conjunction with health fairs. Also provides information on how to deal with high blood pressure, cholesterol and glucose. Patients with abnormal readings are referred to health care providers		870-572-2727		X Located in Pine Bluff (Jefferson County) Serving Arkansas County

Chronic Conditions: High Cholesterol (Arkansas, Monroe, Prairie)

Program Name	Description	Website	Phone Number	State	County
Southern Ain't Fried Sundays - Arkansas Minority Health Commission	Faith Based Outreach Program SAFS is designed to educate African American churches and organizations about healthier alternatives to preparing and cooking southern-style foods. It is also a mechanism for partnering with these groups in an effort to educate their members about the signs and symptoms of stroke, diabetes, and heart attacks. The program is being revamped to expand its reach to the Hispanic communities and individual participants.	http://www.arminorityhealth.com/programs_saf.html	877-264-2826		

Program Name	Description	Website	Phone Number	State	County
Greater Delta Alliance for Health Mobile Health Screening Unit	GDAH has a fully equipped mobile unit that is utilized to offer free health screenings including breast exams, blood pressure, blood sugar, weight and BMI, HIV screening as well as specialized screenings through community health partners.	http://gdaharkansas.org/services			X (Arkansas County)
Area Health Education Centers (AHEC)	Health Education: Provides health education to adults on a variety of topics including diabetes, heart health, nutrition and healthy eating. Health Screening: Provides health screenings for area organizations and industry in conjunction with health fairs. Also provides information on how to deal with high blood pressure, cholesterol and glucose. Patients with abnormal readings are referred to health care providers		870-572-2727		X Located in Pine Bluff (Jefferson County) Serving Arkansas and Prairie Counties Located in Helena (Phillips County) Serving Monroe County

Chronic Conditions: Asthma (Monroe)

Program Name	Description	Website	Phone Number	State	County
The Delta Area Health Education Center (AHEC)	Utilizing the American Lung Association's curriculums, asthma education is provided to children, parents, caregivers and teachers.		870-572-2727		X (Monroe County)
Arkansas Respiratory Health Association	Services offered: Conduct asthma, COPD and tobacco/cessation educational programs for patients, the general public and schools. Coordinate support groups for COPD patients. Provide continuing educational opportunities for school and healthcare professionals.	http://www.arkresp.org	800-880-5864 ext. 100	X	

Chronic Conditions: Arthritis (Arkansas, Prairie)

Program Name	Description	Website	Phone Number	State	County
Arkansas Arthritis Foundation	Various educational programs	http://www.arthritis.org/arkansas/		X	

Chronic Conditions: Diabetes (Arkansas, Monroe, Prairie)

Program Name	Description	Website	Phone Number	State	County
American Diabetes Association	Educational Resources; Advocacy		(501) 221-7444		X (all counties)

Program Name	Description	Website	Phone Number	State	County
Arkansas Health Care Access Foundation	Locates doctors to donate office visits; prescription assistance; free to those who qualify	http://ahcaf.org/			X (all counties)
Arkansas Wellness Coalition	Includes members of the health care and employer community whose goal is to improve the health and well-being of all Arkansans through the use of nationally recognized, peer reviewed, clinical guidelines for physician, consumer, and employer education. Develop materials referring to nationally recognized standards such as those put forth by Healthy People 2010, the National Committee of Quality Assurance, and other disease-specific organizations such as the American Diabetes Association and the American Heart Association.		501-661-2942	X	
Arkansas Chronic Illness Collaborative (ACIC)	The ACIC is a group of health care and public health professionals dedicated to improving the management of chronic diseases. The ACIC is a way for health care clinic teams to use the National Health Disparities Collaborative Chronic Care Model to share ideas and knowledge, learn and apply new techniques, and match medical practices with clinical guidelines based on scientific evidence about what works best (diabetes, cancer and cardiovascular diseases)	http://www.healthy.arkansas.gov/programs Services/chronic Disease/Initiatives/Pages/Acic.aspx		X	
ARCare	The ARcare Diabetes Self-Management Program is an AADE recognized education program. Our Diabetes Self-Management Program offers individualized assessments and nutrition planning with a registered dietician. Our program also includes one-on-one education, classroom education, support group meetings, cooking classes, and exercise classes at two nursing homes.	http://www.arcare.net/OurServices/OurServices Continued/tabid/13586/Default.aspx	870-347-2534		X (Monroe, Prairie Counties)
Greater Delta Alliance for Health Diabetes Initiative	This project provides support to local diabetics by providing Diabetes Self-Management Education Program, free A1C screenings as well as diabetes awareness events and screenings throughout the six county service areas.	http://gdaharkansas.org/services			X (Arkansas County)
Des Arc Health Center	Diabetes education		870-256-4178		X (Des Arc, Prairie Counties)

Program Name	Description	Website	Phone Number	State	County
Devalls Bluff Health Center			870-998-2511		X (Prairie County)
Area Health Education Centers (AHEC)	Diabetes (1 on 1 and Group) –Provides diabetes education to individuals and groups. Diabetes Support Group - Offers a monthly support group to individuals with diabetes and their friends and families. Health Education: Provides health education to adults on a variety of topics including diabetes, heart health, nutrition and healthy eating. Health Screening: Provides health screenings for area organizations and industry in conjunction with health fairs. Also provides information on how to deal with high blood pressure, cholesterol and glucose. Patients with abnormal readings are referred to health care providers How Healthy is Your Church? -- Provides free health screenings, information and counseling to area churches.		870-572-2727		X Located in Pine Bluff (Jefferson County) Serving Arkansas and Prairie Counties Located in Helena (Phillips County) Serving Monroe County

Health Behaviors: Obesity (Arkansas, Monroe, Prairie)

Health Behaviors: Physical Inactivity (Arkansas, Monroe, Prairie)

Health Behaviors: Lack of Healthy Eating (Arkansas, Monroe, Prairie)

Socioeconomic & Environment: Percentage of Fast Food Restaurants (Arkansas, Monroe)

Program Name	Description	Website	Phone Number	State	County
Arkansas Department of Health Lifestage Health Branch	Mission is the prevention and reduction of obesity through the adoption of healthy eating practices and increased physical activity. Provides technical assistance, managing and supporting evidence-based programs, disseminating materials and resources, and skills-building within the Agency, in schools, at worksites, among partners and with the general public.		501-661-2099	X	
Arkansas Coalition for Obesity Prevention (ArCOP)	A coalition whose goal is to increase the percentage of Arkansans of all ages who have access to healthy and affordable food and who engage in regular physical activity. Coalition is structured around six working teams: Access to Healthy Foods; Built Environment; Early Childhood and Schools; Healthcare; Worksite Wellness; and Social Marketing	http://www.arkansasobesity.org/		X	

Program Name	Description	Website	Phone Number	State	County
Southern Ain't Fried Sundays - Arkansas Minority Health Commission	Faith Based Outreach Program SAFS is designed to educate African American churches and organizations about healthier alternatives to preparing and cooking southern-style foods. It is also a mechanism for partnering with these groups in an effort to educate their members about the signs and symptoms of stroke, diabetes, and heart attacks. The program is being revamped to expand its reach to the Hispanic communities and individual participants.	http://www.arminorityhealth.com/programs_saf.html	877-264-2826	X	
ARCare – SilverSneakers Program	SilverSneakers offers an innovative blend of physical activity, healthy lifestyle, and socially oriented programming that allows older adults to take greater control of their health.	http://www.arcare.net/OurServices/OurServicesContinuedpart3/tabid/14186/Default.aspx#wellness	870-347-1137		X (Monroe, Prairie)
The Monroe County Hometown Health Community Garden	Provides a community garden to the citizens of Monroe County to grow fruits and vegetables				X Brinkley (Monroe County)
Greater Delta Alliance for Health Mobile Health Screening Unit	GDAH has a fully equipped mobile unit that is utilized to offer free health screenings including breast exams, blood pressure, blood sugar, weight and BMI, HIV screening as well as specialized screenings through community health partners.	http://gdaharkansas.org/services			X (Arkansas County)
Area Health Education Centers (AHEC)	Health Education: Provides health education to adults on a variety of topics including diabetes, heart health, nutrition and healthy eating. Health Screening: Provides health screenings for area organizations and industry in conjunction with health fairs. Also provides information on how to deal with high blood pressure, cholesterol and glucose. Patients with abnormal readings are referred to health care providers How Healthy is Your Church? -- Provides free health screenings, information and counseling to area churches.		870-572-2727		X Located in Pine Bluff (Jefferson County) Serving Arkansas and Prairie Counties Located in Helena (Phillips County) Serving Monroe County

Health Behaviors: Sexually Transmitted Infections (Arkansas, Monroe)

Program Name	Description	Website	Phone Number	State	County
Arkansas County Health Unit – STD Testing	Arkansas County Dewitt Health 1616 South Madison De Witt 870-946-2934 Arkansas County Stuttgart 1602 N Buerkle Road Stuttgart 870-673-6601		870-946-2934 870-673-6601		X (Arkansas County)
Monroe County Health Unit – STD testing	306 W Kings Drive Brinkley, AR		870-734-1461		X (Monroe County)

Health Behaviors: Teen Birth Rate (Monroe)

Program Name	Description	Website	Phone Number	State	County
Area Health Education Centers (AHEC)	Teen Pregnancy Prevention Program: Provides prevention education in area schools. The curriculum focuses on refusal skills and making safe choices.		870-572-2727		X Located in Pine Bluff (Jefferson County) Serving Arkansas and Prairie Counties Located in Helena (Phillips County) Serving Monroe County
Arkansas Department of Health	Family Planning Services are provided to teens, women, men and couples, making it possible for them to choose the number and spacing of their children and to prevent unwanted pregnancies	http://www.healthy.arkansas.gov/programsServices/familyHealth/HealthConnections/Pages/ConnectCare.aspx			

Prevention: Colorectal Screening (Arkansas, Monroe, Prairie)

Program Name	Description	Website	Phone Number	State	County
The Colorectal Cancer Screening Program (CCSP)	The Colorectal Cancer Screening Program (CCSP) is committed to prevention, early detection and treatment of colorectal cancer. The program is designed to provide equitable access to colorectal cancer screenings throughout the state. CCSP targets its services to minorities and people from disadvantaged socioeconomic backgrounds or underserved communities. Participants in need of follow-up are referred to the appropriate services.	http://cancer.uams.edu/?id=11145&sid=2	877-749-4085 or 501-526-7045	X	

Prevention: Mammography (Arkansas, Monroe, Prairie)

Program Name	Description	Website	Phone Number	State	County
ARCare	The ARcare Comprehensive Breast Program is a service administered by ARcare to meet the needs of uninsured and underinsured women under age 59 who are in need of breast care education, screening, diagnostic, and treatment services. This program provides free clinical breast exams, breast care education, mammograms, and surgical consultation to women who have no coverage for these services	http://www.arcare.net/OurServices/OurServices Continued/tabid/13586/Default.aspx	870-347-2534		X (Monroe, Prairie)
Arkansas' BreastCare Program	BreastCare's mission is to increase the rate of early detection of breast and cervical cancer and reduce the morbidity and mortality rates among women in Arkansas by lowering barriers to screening that result from lack of information, financial means, or access to quality services.	http://www.healthy.arkansas.gov/programs services/chronicdisease /arbreastcare/pages/default.aspx		X	
Greater Delta Alliance for Health Mobile Health Screening Unit	GDAH has a fully equipped mobile unit that is utilized to offer free health screenings including breast exams, blood pressure, blood sugar, weight and BMI, HIV screening as well as specialized screenings through community health partners.	http://gdaharkansas.org/services			X (Arkansas County)
Greater Delta Alliance for Health Access Project Pink	Access Project Pink-Southeast Arkansas is a collaborative effort to provide free mammograms, ultrasounds, and free breast exams to the rural, underserved population of women in fifteen counties in Southeast Arkansas.	http://gdaharkansas.org/services			X (Arkansas County)

Prevention: Flu Shots (Arkansas, Monroe, Prairie)

Program Name	Description	Website	Phone Number	State	County
Arkansas, Monroe and Prairie County Health Units	Mass Flu Clinic: A Mass Flu Clinic is a day-long event during which the community comes together to immunize as many people as possible. Arkansas Department of Health (ADH) staff, health professionals and volunteers work as a team to provide vaccine. Some clinics offer "drive-thrus" – you don't even leave your car.	http://www.healthy.arkansas.gov/programsServices/infectiousDisease/Immunizations/SeasonalFlu/Pages/MassFluClinics.aspx	501-362-7581		X

Prevention: Diabetic Screening (Arkansas, Monroe)

Program Name	Description	Website	Phone Number	State	County
Greater Delta Alliance for Health Diabetes Initiative	This project provides support to local diabetics by providing Diabetes Self-Management Education Program, free A1C screenings as well as diabetes awareness events and screenings throughout the six county service area.	http://gdaharkansas.org/services			X (Arkansas County)

Access: Lack of PCPs (Monroe, Prairie)

Program Name	Description	Website	Phone Number	State	County
ADH Office of Rural Health and Primary Care	Promotes the development of community-based health care services and systems throughout Arkansas to ensure that well managed, quality health services are available to all citizens		501-280-4560	X	
Area Health Education Centers (AHEC)	Programs provide access to medical services for rural residents and education for healthcare students and professionals.	http://ruralhealth.uams.edu/AHEC-Programs			

Access: Uninsured (Arkansas, Monroe, Prairie)

Program Name	Description	Website	Phone Number	State	County
Arkansas Health Care Access Foundation	Serves all qualified applicants who are low-income, uninsured citizens throughout Arkansas. Arkansas Health Care Access Foundation (AHCAF) is a statewide volunteer health care program to help low-income, medically uninsured gain access to non-emergency medical care	http://ahcaf.org/			X (all counties)

Program Name	Description	Website	Phone Number	State	County
Brinkley Health Center and Pharmacy (ARcare)	Offering Pharmacy, Pediatrics, Cardiology, Oral Health & Dentistry, Family Practice, Women's Health, Diabetes Self-Management, HIV/AIDS Care Program, Prescription Medication Assistance Program	http://www.arcare.net	870-734-1150		Brinkley (Monroe County)
Holly Grove Health Center	Offering Dental Care Services, Enabling Services, Primary Medical Care		870-462-3393		Holly Grove (Monroe County)
Mid-Delta Health Systems, Inc	Offering comprehensive primary healthcare services to the entire family. Services include primary medical, dental, mental health and preventive health services.		870-747-3381		Clarendon (Monroe County)
Des Arc Health Center (ARcare)	Offering Pharmacy, Pediatrics, Cardiology, Oral Health & Dentistry, Family Practice, Women's Health, Diabetes Self-Management, HIV/AIDS Care Program, Prescription Medication Assistance Program	http://www.arcare.net	870-256-4178		Des Arc (Prairie County)
Hazen Medical Clinic (ARcare)	Offering Pharmacy, Pediatrics, Cardiology, Oral Health & Dentistry, Family Practice, Women's Health, HIV/AIDS Care Program, Prescription Medication Assistance Program	http://www.arcare.net	870-255-3696		Prairie County
Greater Delta Alliance for Health Medicine Assistance Program	The Delta Medicine Assistance Program (DMAP) is designed to assist persons who have difficulty obtaining prescription medication due to fixed incomes, lack of insurance, or other circumstances that limit their ability to fully comply with their physician's protocol to treat chronic health conditions	http://gdaharkansas.org/services			X (Arkansas County)



Community Needs Assessment

Baptist Health Medical Center–Heber Springs

December 2013

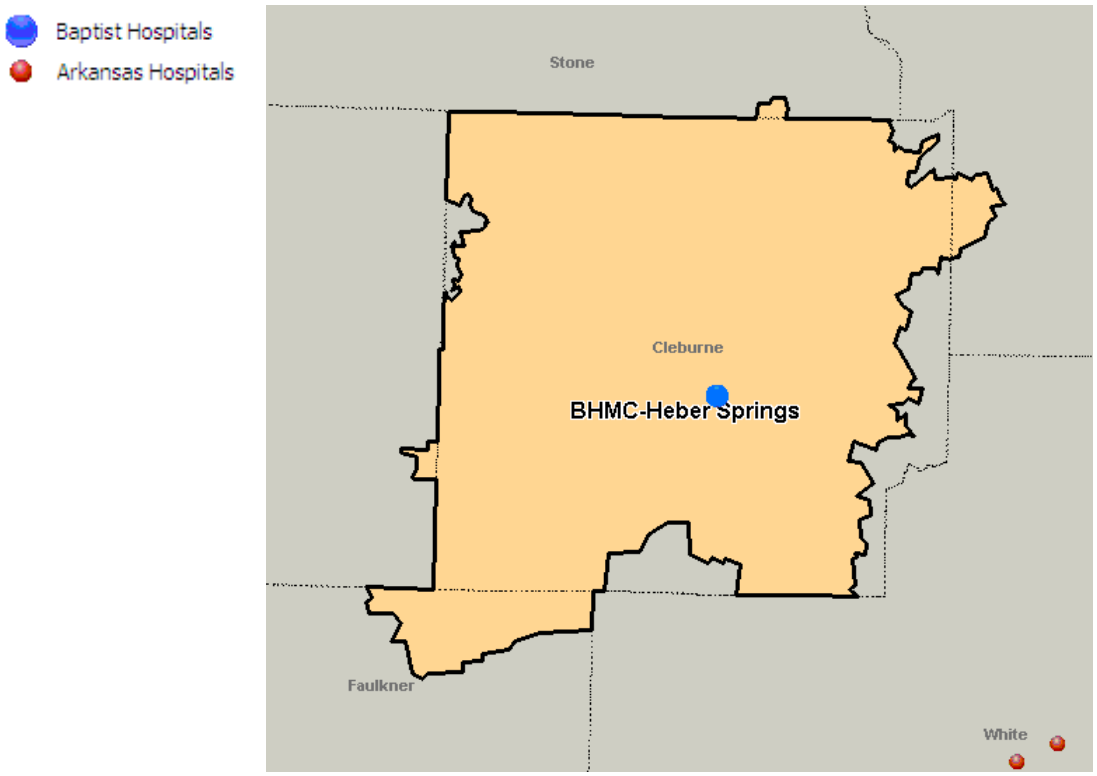
Baptist Health Medical Center–Heber Springs

Baptist Health Medical Center–Heber Springs is a critical access hospital that offers services to residents primarily in Cleburne County. The BHMC–Heber Springs campus is home to the Baptist Health Sleep Center, Chest Pain Center, and Cardiac Rehab. The new facility opened in 2006 and includes an expanded Emergency Department, an expanded operating suite, a centralized outpatient clinic, and in-house MRI services as well as updated inpatient rooms.

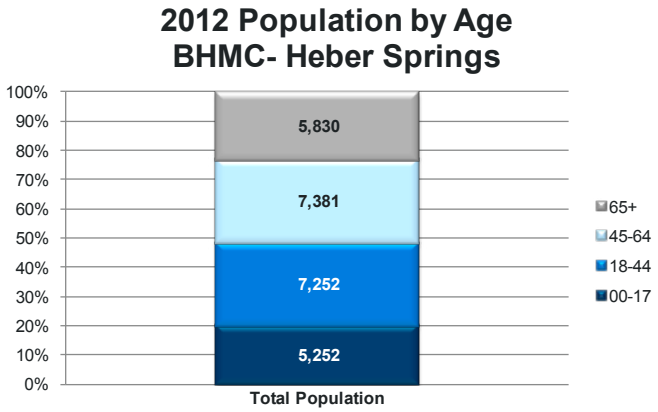
Community Served and Demographics

Given that BHMC–Heber Springs is a critical-access hospital, the community served is defined as Cleburne County.

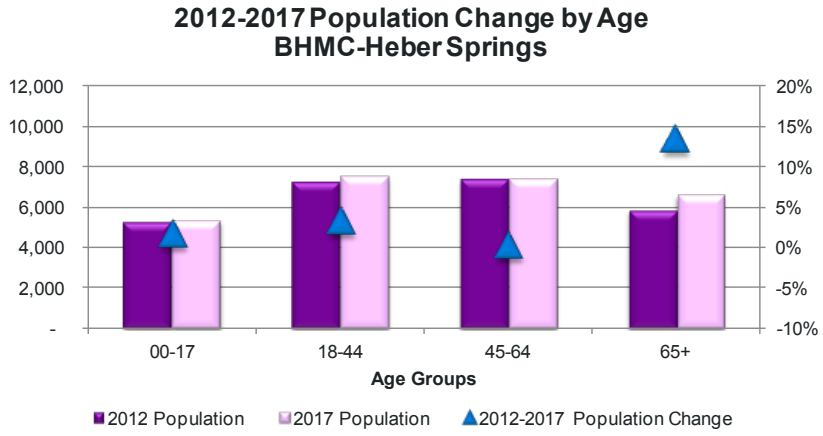
Eleven ZIP codes constitute the community served for BHMC–Heber Springs. A detailed list of the ZIP codes can be found in the **Baptist Health Medical Center-Heber Springs Appendix.** Below is a map that illustrates the BHMC–Heber Springs community served (orange).



The BHMC–Heber Springs community served population is approximately 25,715. By 2017, this population is projected to grow by 4.3 percent. While the largest portion of the population is made up of white non-Hispanics (24,567), in the next five years, the largest percentages of growth will be in the black non-Hispanic (+24 percent, +18 individuals) and Hispanic (+23 percent, +125 individuals) populations. The largest growth in population will take place among white non-Hispanics (+886 individuals) between 2012 and 2017.



The 45-64 age group constitutes the largest portion of the BHMC–Heber Springs community served, followed by the 18-44 age group.



By 2017, the 65 plus population will have the largest percentage of growth.

The median household income for the BHMC–Heber Springs community served is $35,891. More than 46 percent of individuals have private insurance — either employer-sponsored insurance (41 percent) or individually purchased (5 percent). Another 13 percent are covered by Medicaid, 16 percent are uninsured and 25 percent are covered by Medicare or are Medicare dual eligible.

Interviews & Focus Groups

Interviewees and focus group participants were categorized into representative groups. In the chart below, an "I" indicates an interview and "FG" indicates participation in a focus group. For individuals outside Baptist Health, representative organizations have been listed.

Community Leaders/ Groups	Public and Other Organizations		Other Providers	Baptist Health
Debusk, J.R. (First Baptist Church, FG)	Boyette, Chris (Arkansas State University, I)	Clark, Marilyn (American Heart Assoc/ American Stroke Assoc, I)	Cowherd,M.D., Kristy (Family Practice Physician, I)	Wright, Tamara (BHMC-HS, I)
Lynch, Bill (Eagle Bank, I)	Walker, Bobby (HS Police Department, FG)	Halverson, Paul (Arkansas Department of Health, I)	Newman, Gina (Seven Springs Health & Rehab, FG)	Langster, Holly (BHMC-HS, I & FG)
Thompson, M.D., Joe (AR Surgeon General/ AR Ctr for Health Improvement, I)	Hill, Brenda (Cleburne County Community Foundation, FG)	Crawford, R.N., Pam (AK Department of Health, FG)	Walker, P.J. (Southridge Village Assisted Living, FG)	Hyslip, Ruth Anne (BHMC-HS, I)
Lee, Louis (BHMC Board Member/ State Farm, I)	Wheeler, Gary (Arkansas Department of Health, I)	Thompson, Hazel (Cleburne County Health Department, FG)	Wilson,D.D.S, Robert (Private Practice Dentist, FG)	Lacy, Ed (BHMC-HS, I)
			Herring,M.D., John (BHMC-HS, I)	

The individuals highlighted in purple indicate Health Department representatives (local, regional, or state), as well as individuals representing or serving medically underserved, low-income, or minority populations.

In the interview process, the majority of individuals said the current health status of the community is "good." The major issues contributing to this health status include chronic/other diseases.

For the BHMC–Heber Springs community, the top health needs identified in the interview process include:

1. Health Providers/Services
2. Chronic Diseases
3. Access
4. Prevention/Lifestyle Modification
5. Diabetes
6. Obesity
7. Food/Nutrition

Barriers to good health care in this community include socioeconomic factors, culture, affordability of care, lifestyle, and health education. The minority populations, elderly, and children/teens were identified as top vulnerable groups that will need special attention when addressing health needs.

Focus group participants were asked to grade the health of the community based on an A-F scale, provide feedback in terms of that grade, and work in small groups to determine the top three health needs of the community. For the BHMC–Heber Springs group, the average grade for the health of the community was a C. Much of this was attributed to drug abuse, chronic diseases, insurance coverage, lifestyle choices, children in poverty, aging population, and a lack of access to care.

The focus group split into two smaller groups to determine the top three health needs of the community. Group 1 selected prenatal care, geriatrics, and chronic diseases. Group 2 selected substance abuse, obesity, and mental health.

In the same small groups, focus group participants were asked to identify community resources that could help address the health issues in the community. Some of the resources identified include:

• Churches	• Home Health	• Agriculture
• Corporate park/lake	• Baptist Health	• Quality of Life
• Local Health Departments	• Organized sports leagues	• Library
• ASU	• Trail Systems	• Medical Providers
• Community Coalitions	• Education System	• Industry

The Baptist Health Medical Center-Heber Springs Appendix includes a more comprehensive list of existing community resources available to address the health needs of the community.

Health Indicators

While the community served was defined at the ZIP code level, the most geographically detailed health indicators were only available at the county level. For that reason, health indicators for BHMC–Heber Springs were evaluated for Cleburne County. This county represents the ZIP codes within the community served.

Health needs for the county that did not meet the state benchmark include:

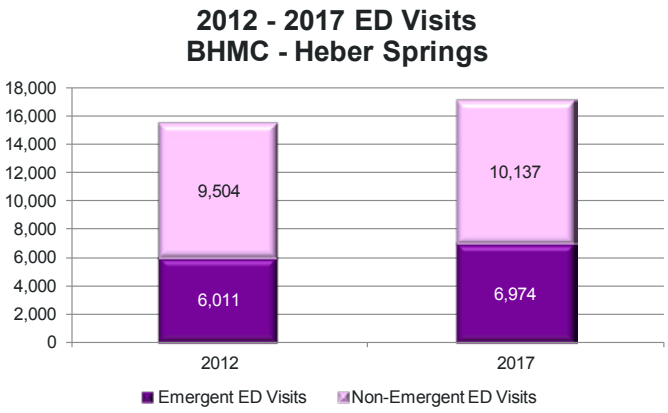
Cause of Death • Heart Disease • Chronic Lower Respiratory Disease	**Chronic Conditions** • High Cholesterol • Asthma • Diabetes • Coronary Heart Disease • Arthritis	**Access** • No Personal Doctor • Lack of PCPs **Socioeconomic & Environment** • Lack of Recreational Facilities
Health Outcomes • Low Birth Weight • Poor or Fair Health Status • Poor Physical Health & Mental Health Days	**Health Behaviors** • Smoking • Physical Inactivity • Excessive Drinking	**Prevention** • Colorectal Screening • Mammography • Prostate Screening • Flu Shot

Truven Health Analytics supplemented the publically available data with estimates of disease prevalence for heart disease and cancer, emergency department visit estimates, and the community need index.

Heart disease estimates indicate a prevalence of 10,715 cases for the BHMC–Heber Springs community served. The majority (62 percent) of the 2011 estimates of heart disease prevalence indicate hypertension as the primary diagnosis. Other diagnoses include arrhythmias (14 percent), ischemic heart disease (17 percent), and congestive heart failure (7 percent).

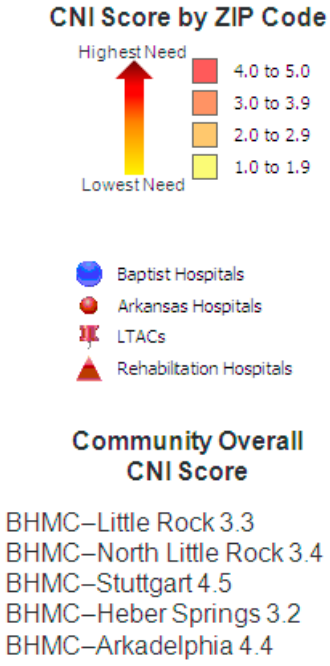
The 2011 cancer incidence estimates reveal an estimated 229 new cancer cases — the highest incidence being prostate cancer.

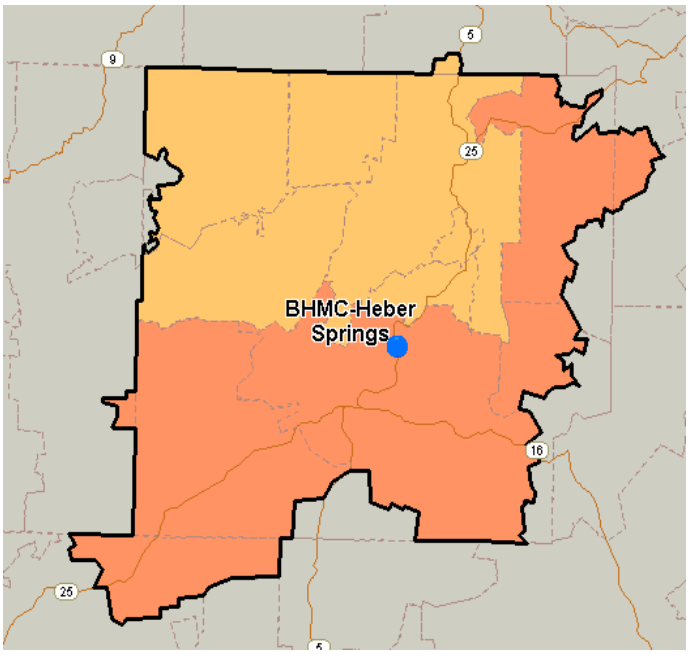
Emergency department visits are slated to grow by approximately 1,500 visits between 2012 and 2017.



The Truven Health Community Need Index (CNI) is a statistical approach to identifying health needs in a community. The CNI takes into account vital socio-economic factors (income, cultural, education, insurance, and housing) about a community to generate a CNI score for every populated ZIP code in the United States. The CNI is strongly linked to variations in community health-care needs and is a strong indicator of a community's demand for various health-care services.

The BHMC–Heber Springs community served had a CNI of 3.2 on a scale of 1.0 (lowest needs) to 5.0 (highest needs). Compared to the other Baptist Health communities, BHMC–Heber Springs has the lowest need.





Prioritized Health Needs

From the BHMC–Heber Springs campus, Ed Lacy, vice president/administrator; Holly Langster, director of Nursing; and Gale Strafaci, administrative assistant, participated in the prioritization meeting.

Using the criteria selected by the larger group, the five health needs that scored the highest in the prioritization process for BHMC–Heber Springs were:

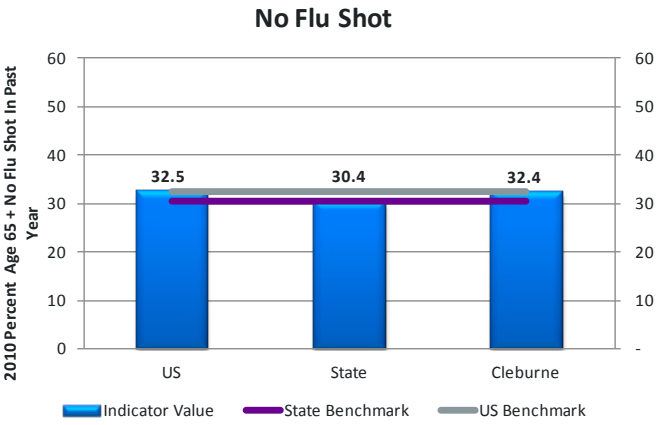
1. Flu shots
2. Mammograms
3. Prostate Screenings
4. Colorectal Screenings
5. Lack of Primary Care Physicians

HEALTH NEED	BHMC Heber Springs
Cause of Death	
▪ Chronic Lower Respiratory Disease	X
▪ Heart Disease	X
▪ Low Birth Weight	X
▪ Poor or Fair Health Status	X
▪ Poor Physical Health & Mental Health Days	X
Chronic Conditions	
▪ Asthma	X
▪ Diabetes	X
▪ Coronary Heart Disease	X
▪ Arthritis	X
▪ High Cholesterol	X
Health Behaviors	
▪ Smoking	X
▪ Excessive Drinking	X
▪ Physical Inactivity	X
Prevention	
▪ Colorectal Screening	X
▪ Mammography	X
▪ Flu Shot	X
▪ Prostate Screening	X
Access	
▪ Lack of PCPs	X
▪ No Personal Doctor	X
Socioeconomic & Environment	
▪ Access to Recreational Facilities	X

The table to the left indicates the health needs identified for the BHMC-Heber Springs community. The highlighted boxes are the five health needs that scored the highest in the prioritization process.

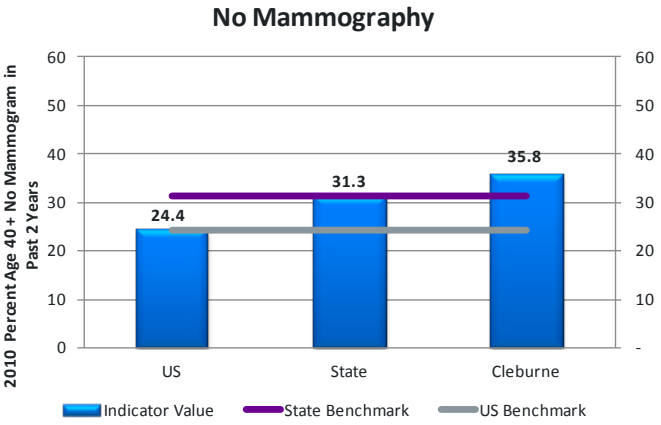
Even though the highlighted health needs had the highest scores, the needs that will actually be addressed for the purposes of the CHNA are at the discretion of BHMC-Heber Springs.

For each of the prioritized health needs, the comparative benchmark graph has been provided to illustrate gaps between county indicators for the community served and the state benchmark (purple).



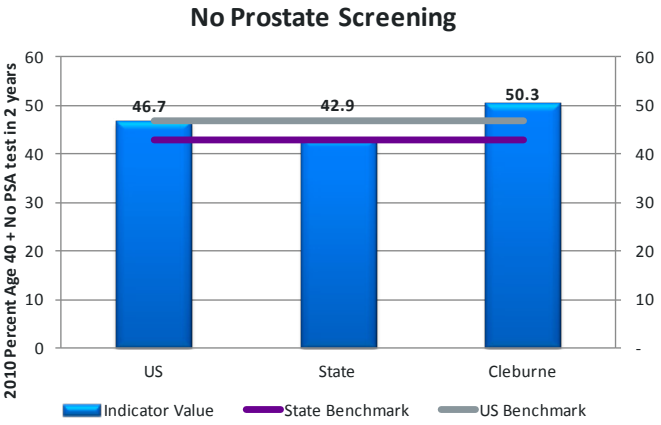
Source: Arkansas Department of Health BRFSS

Notes: Percent of adults age 65 plus that report having no Influenza Vaccine in past 12 months



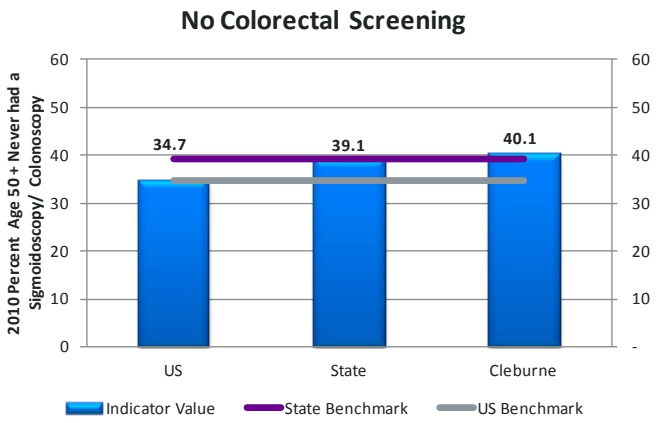
Source: Arkansas Department of Health BRFSS

Notes: Percent of adults age 50+ that report no mammogram in the past 2 years



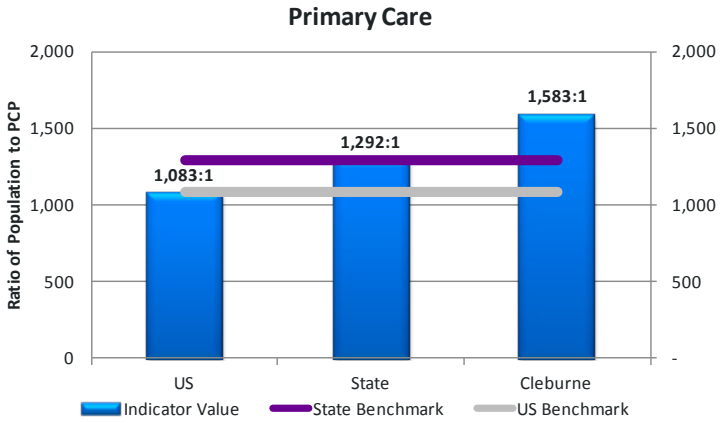
Source: Arkansas Department of Health BRFSS

Notes: Percent of men age 40+ that report no PSA test in last 2 years



Source: Arkansas Department of Health BRFSS

Notes: Percent of adults age 50+ that report never having had a Sigmoidoscopy or colonoscopy



Source: County Health Rankings (Health Resources & Services Administration)

Notes: Ratio of population to primary care physicians

Summary

The community health needs assessment for the BHMC–Heber Springs community served revealed a number of health issues related to disease management, preventive care, access issues, and socioeconomic or environmental factors. By weighing the qualitative feedback and the quantitative data, along with the prioritization criteria, the top health needs identified include flu shots, mammograms, prostate screenings, colorectal screenings, and lack of primary care physicians.

BHMC–Heber Springs will be working with internal stakeholders to determine the community health needs to be addressed. With the goal of improving the health of the community, implementation plans with specific tactics and time frames will be developed to address these health needs.

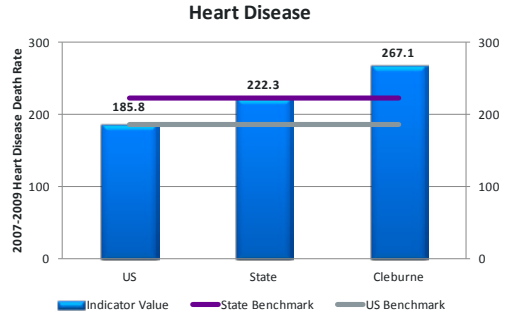
Baptist Health Medical Center–Heber Springs Appendix

BHMC-Heber Springs Community Served Definition ZIP Code Table

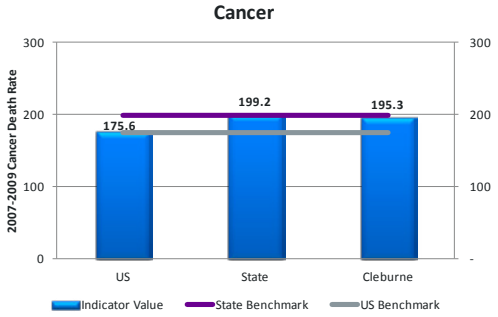
BAPTIST HEALTH COMMUNITY	ZIP	PONAME	COUNTY NAME	CBSANAME
BHMC-Heber Springs	72044	Edgemont	Cleburne, AR	Unassigned Area in Arkansas
BHMC-Heber Springs	72067	Higden	Cleburne, AR	Unassigned Area in Arkansas
BHMC-Heber Springs	72130	Prim	Cleburne, AR	Unassigned Area in Arkansas
BHMC-Heber Springs	72131	Quitman	Cleburne, AR	Unassigned Area in Arkansas
BHMC-Heber Springs	72179	Wilburn	Cleburne, AR	Unassigned Area in Arkansas
BHMC-Heber Springs	72523	Concord	Cleburne, AR	Unassigned Area in Arkansas
BHMC-Heber Springs	72530	Drasco	Cleburne, AR	Unassigned Area in Arkansas
BHMC-Heber Springs	72543	Heber Springs	Cleburne, AR	Unassigned Area in Arkansas
BHMC-Heber Springs	72545	Heber Springs	Cleburne, AR	Unassigned Area in Arkansas
BHMC-Heber Springs	72546	Ida	Cleburne, AR	Unassigned Area in Arkansas
BHMC-Heber Springs	72581	Tumbling Shoals	Cleburne, AR	Unassigned Area in Arkansas

Health Indicator Analysis

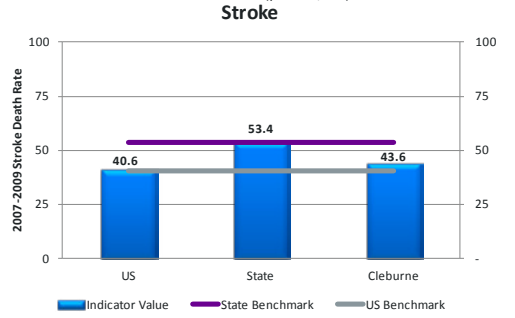
BHMC HEBER SPRINGS:CAUSE OF DEATH



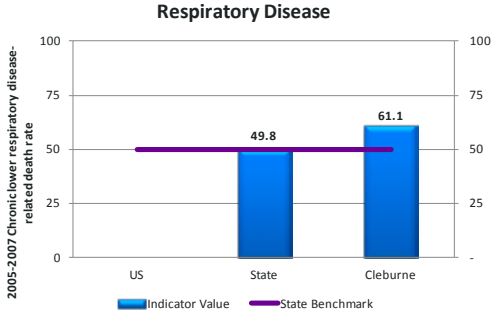
Source: National Vital Statistics System-Mortality (CDC, NCHS)
Notes: 2007-2009 Heart disease deaths (per 100,000)



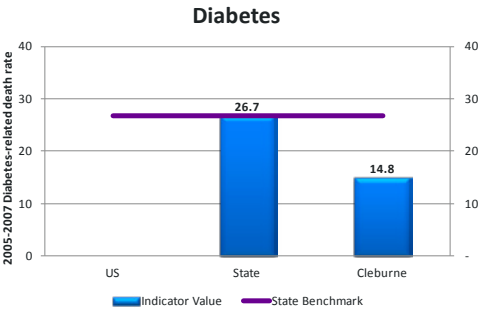
Source: National Vital Statistics System-Mortality (CDC, NCHS)
Notes: 2007-2009 Overall cancer death rate (per 100,000)



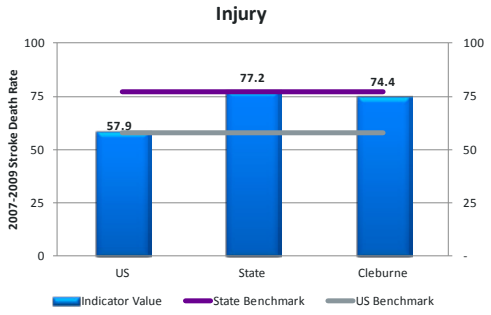
Source: National Vital Statistics System-Mortality (CDC, NCHS)
Notes: 2007-2009 Stroke death rate (per 100,000)



Source: Health Statistics Branch, ADH
Notes: 2005-2007 Chronic lower respiratory disease-related deaths (per 100,000)



Source: Health Statistics Branch, ADH
Notes: 2005-2007 Diabetes-related deaths (per 100,000)

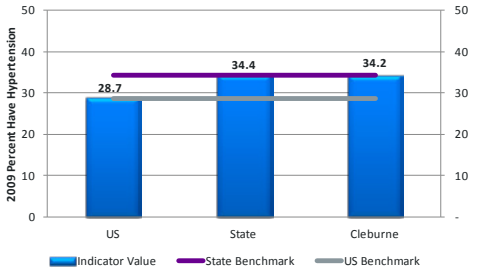


Source: National Vital Statistics System-Mortality (CDC, NCHS)
Notes: 2007-2009 Injury death rate (per 100,000)

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

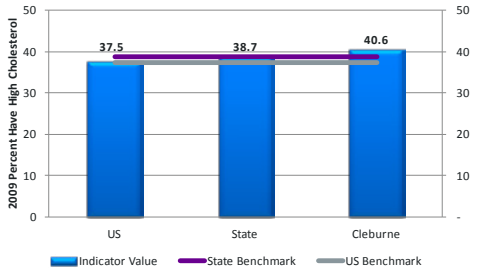
BHMC HEBER SPRINGS: CHRONIC CONDITIONS

Hypertension



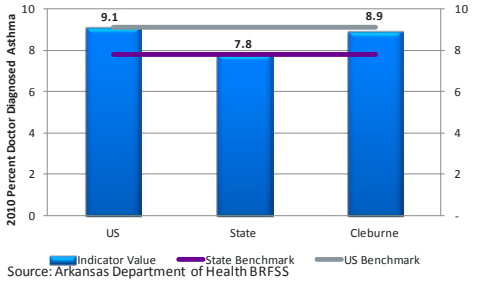
Source: Arkansas Department of Health BRFSS
Notes: Percent of adults that report having been diagnosed with high blood pressure

High Cholesterol



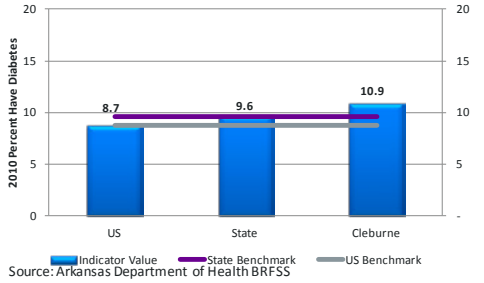
Source: Arkansas Department of Health BRFSS
Notes: Percent of adults that report having been diagnosed with high blood cholesterol

Asthma



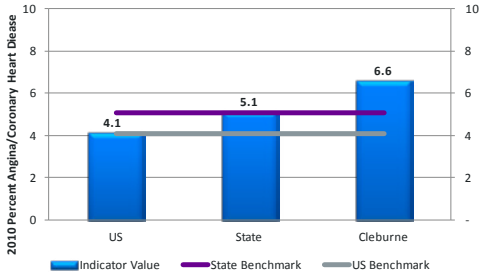
Source: Arkansas Department of Health BRFSS
Notes: Percent of adults that report having been diagnosed with asthma

Diabetes



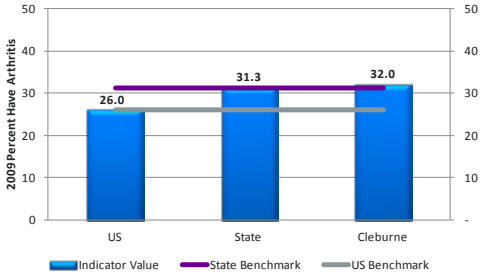
Source: Arkansas Department of Health BRFSS
Notes: Percent of adults that report having been diagnosed as having diabetes

Coronary Heart Disease



Source: Arkansas Department of Health BRFSS
Notes: Percent of adults that report having been diagnosed as having Coronary Heart Disease

Arthritis

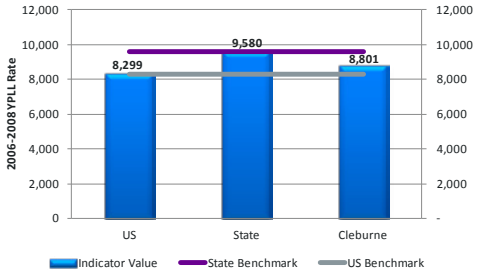


Source: Arkansas Department of Health BRFSS
Notes: Percent of adults that report having been diagnosed as having Arthritis

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

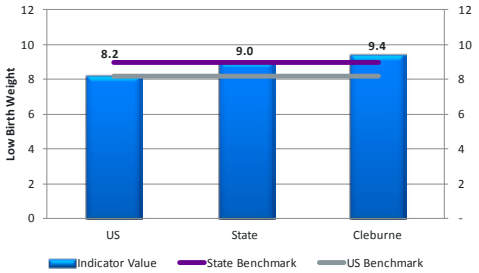
BHMC HEBER SPRINGS: HEALTH OUTCOMES

Premature Deaths



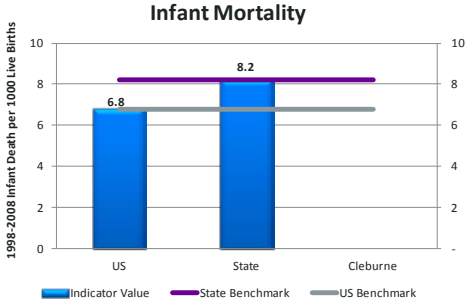
Source: County Health Rankings (NCHS)
Notes: Years of potential life lost before the age of 75 per 100,000 population

Low Birth Weight



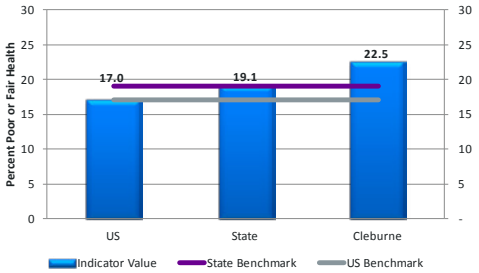
Source: County Health Rankings (NCHS)
Notes: Percent of live births with low birth weight (< 2500 grams)

Infant Mortality



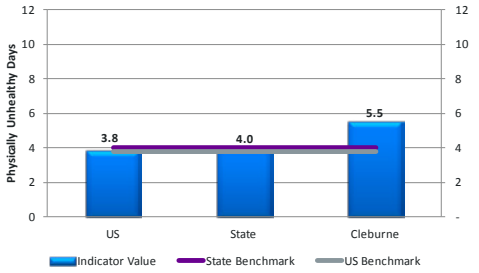
Source: Linked Birth/Infant Death Data Set (CDC-NCHS)
Notes: Rate of all infant deaths (within 1 year), per 1,000 live births

Poor or Fair Health



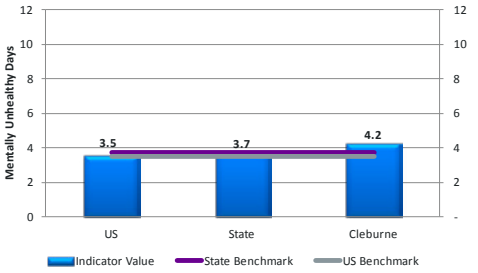
Source: County Health Rankings (BRFSS)
Notes: Percent of adults reporting fair or poor health (age-adjusted)

Poor Physical Health Days



Source: County Health Rankings (BRFSS)
Notes: Average number of physically unhealthy days reported in past 30 days (age-adjusted)

Poor Mental Health Days

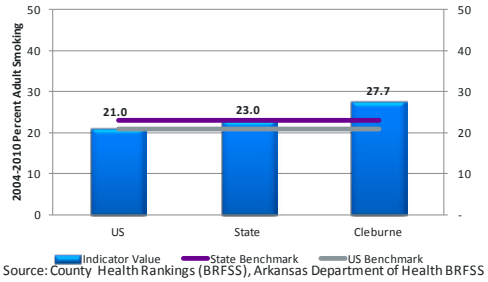


Source: County Health Rankings (BRFSS)
Notes: Average number of mentally unhealthy days reported in past 30 days (age-adjusted)

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

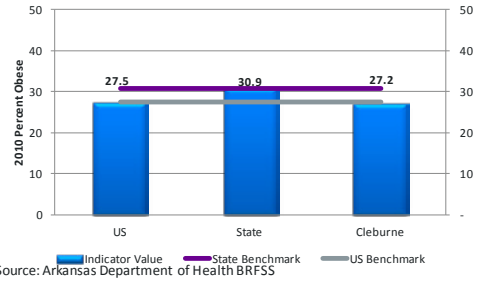
BHMC HEBER SPRINGS: HEALTH BEHAVIORS

Adult Smoking



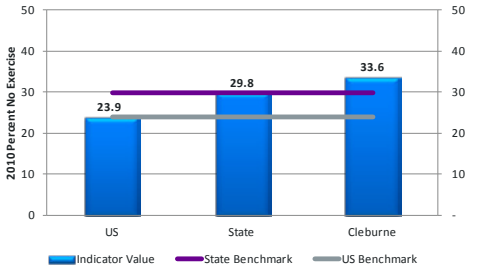
Source: County Health Rankings (BRFSS), Arkansas Department of Health BRFSS
Notes: Percent of adults 18 years+ that report currently smoking cigarettes

Adult Obesity



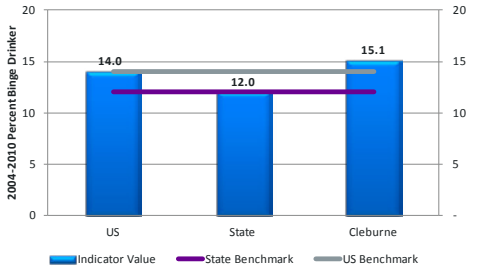
Source: Arkansas Department of Health BRFSS
Notes: Percent of adults 18 years and over that report BMI >= 30 (per self-reported weight/height)

Physical Inactivity



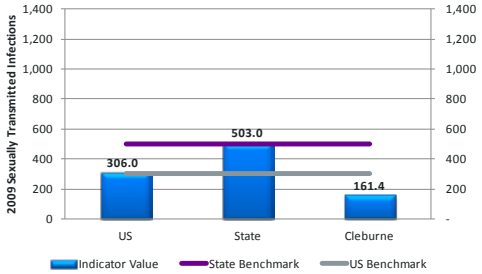
Source: Arkansas Department of Health BRFSS
Notes: Percent of Adults that report no leisure-time exercise in past month

Excessive Drinking



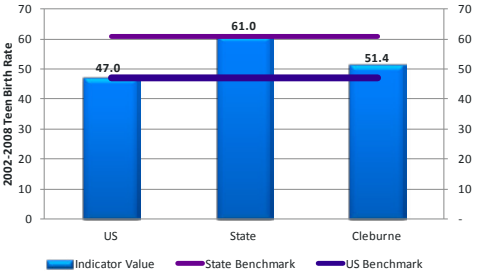
Source: County Health Rankings (BRFSS), Arkansas Department of Health BRFSS
Notes: Percent of adults 18 years and over that report binge drinking

Sexually Transmitted Infections



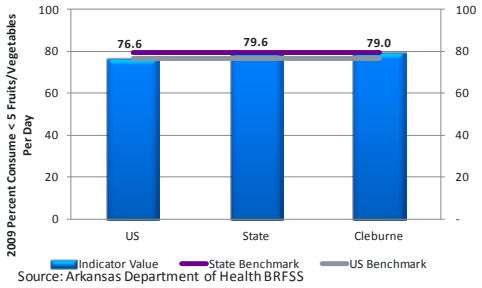
Source: County Health Rankings (BRFSS)
Notes: Chlamydia rate per 100,000 population

Teen Birth Rate



Source: County Health Rankings (BRFSS)
Notes: Percent of all live births to mothers less than 18 years of age

Lack of Healthy Eating

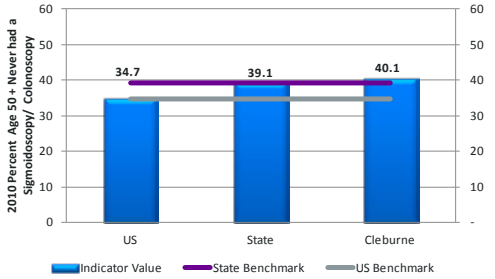


Source: Arkansas Department of Health BRFSS
Notes: Percent of Adults that report fewer than 5 servings of fruits/vegetables per day

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BHMC HEBER SPRINGS: PREVENTION

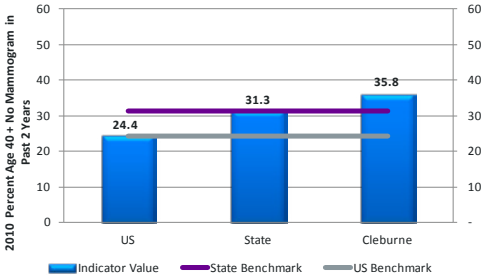
No Colorectal Screening



Source: Arkansas Department of Health BRFSS

Notes: Percent of adults age 50+ that report never having had a sigmoidoscopy or colonoscopy

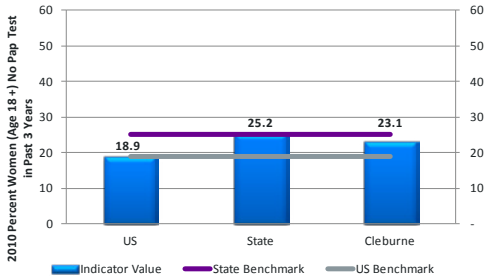
No Mammography



Source: Arkansas Department of Health BRFSS

Notes: Percent of women age 50+ that report no mammogram in the past 2 years

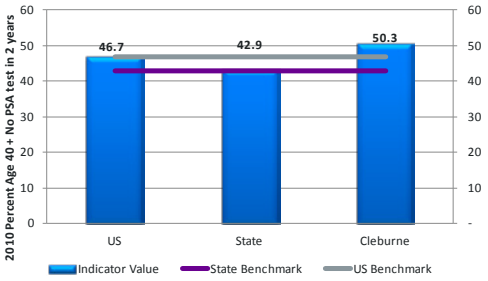
No Pap Test



Source: Arkansas Department of Health BRFSS

Notes: Percent of women age 18+ that report no Pap test in the last 3 years

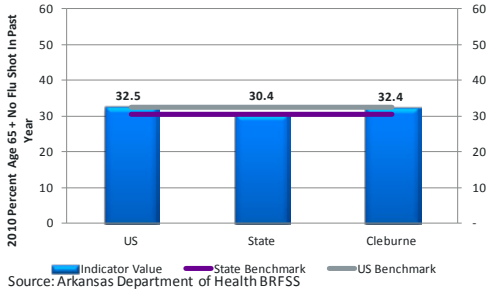
No Prostate Screening



Source: Arkansas Department of Health BRFSS

Notes: Percent of men age 40+ that report no PSA test in the last 2 years

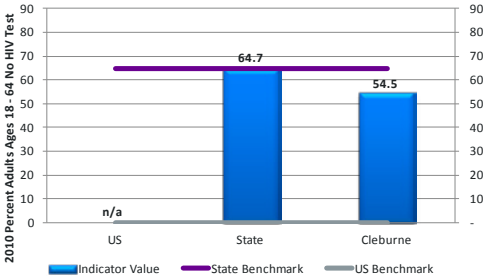
No Flu Shot



Source: Arkansas Department of Health BRFSS

Notes: Percent of adults age 65+ that report having no Influenza vaccine in past 12 months

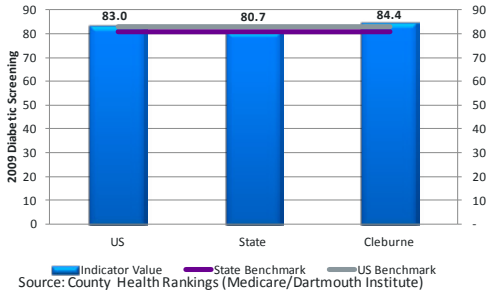
No HIV Test



Source: Arkansas Department of Health BRFSS

Notes: Percent of adults age 18-64 that report having never having an HIV test

Diabetic Screening



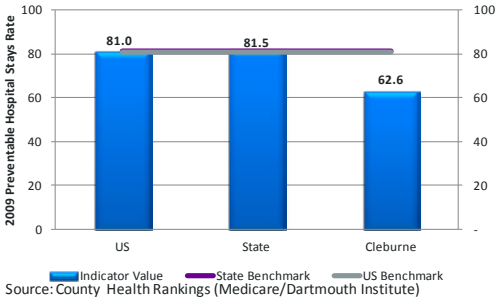
Source: County Health Rankings (Medicare/Dartmouth Institute)

Notes: Percent of diabetic Medicare enrollees that receive HbA1c screening

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

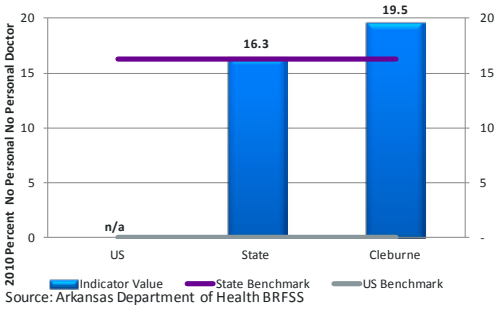
BHMC HEBER SPRINGS: ACCESS

Preventable Hospital Stays



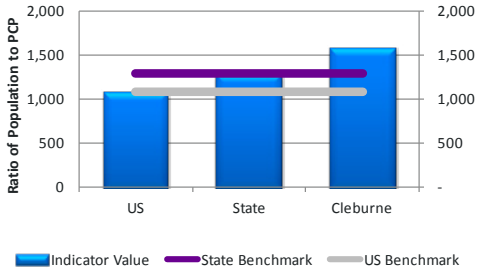
Source: County Health Rankings (Medicare/Dartmouth Institute)
Notes: Hospitalization rate for ambulatory-care sensitive conditions per 1,000 Medicare enrollees

Personal Doctor



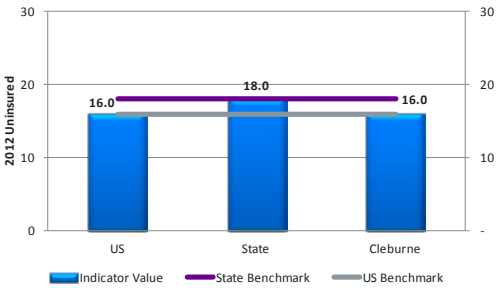
Source: Arkansas Department of Health BRFSS
Notes: Percent of adults age 18+ that report having no personal doctors

Primary Care



Source: County Health Rankings (Health Resources & Services Administration)
Notes: Ratio of population to primary care physicians

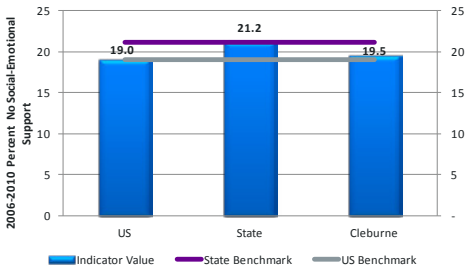
Uninsured



Source: Truven Health (Insurance Coverage Estimates)
Notes: Percent uninsured

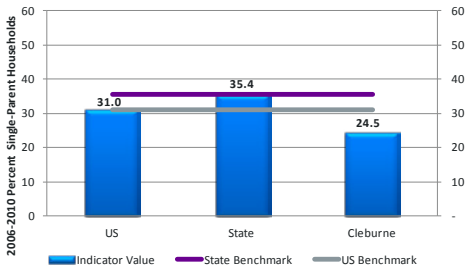
BHMC HEBER SPRINGS: SOCIOECONOMIC

Inadequate Social Support



Source: County Health Rankings (BRFSS)
Notes: Percent of adults without social/emotional support

Children in Single Parent Households

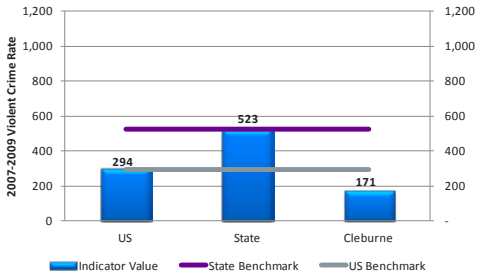


Source: County Health Rankings (BRFSS)
Notes: Percent of children that live in household headed by single parent

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

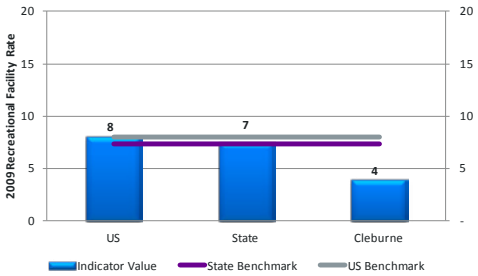
BHMC HEBER SPRINGS: ENVIRONMENT

Violent Crime



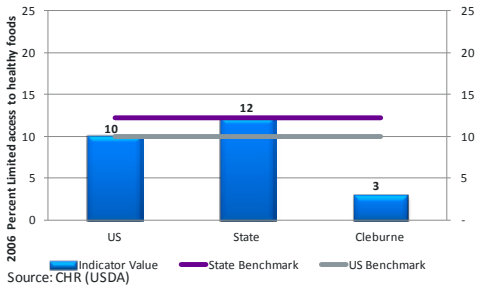
Source: County Health Rankings (BRFSS)
Notes: Violent crime rate per 100,000 population

Recreational Facilities



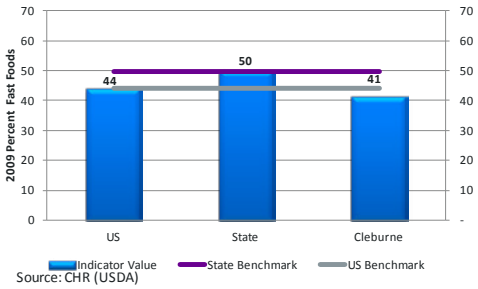
Source: County Health Rankings (Census County Business Patterns)
Notes: Rate of recreational facilities per 100,000 population

Access to Healthy Foods



Source: CHR (USDA)
Notes: Percent of population who are low-income and do not live close to a grocery store

Fast Food Restaurants



Source: CHR (USDA)
Notes: Percent of all restaurants that are fast-food establishments

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

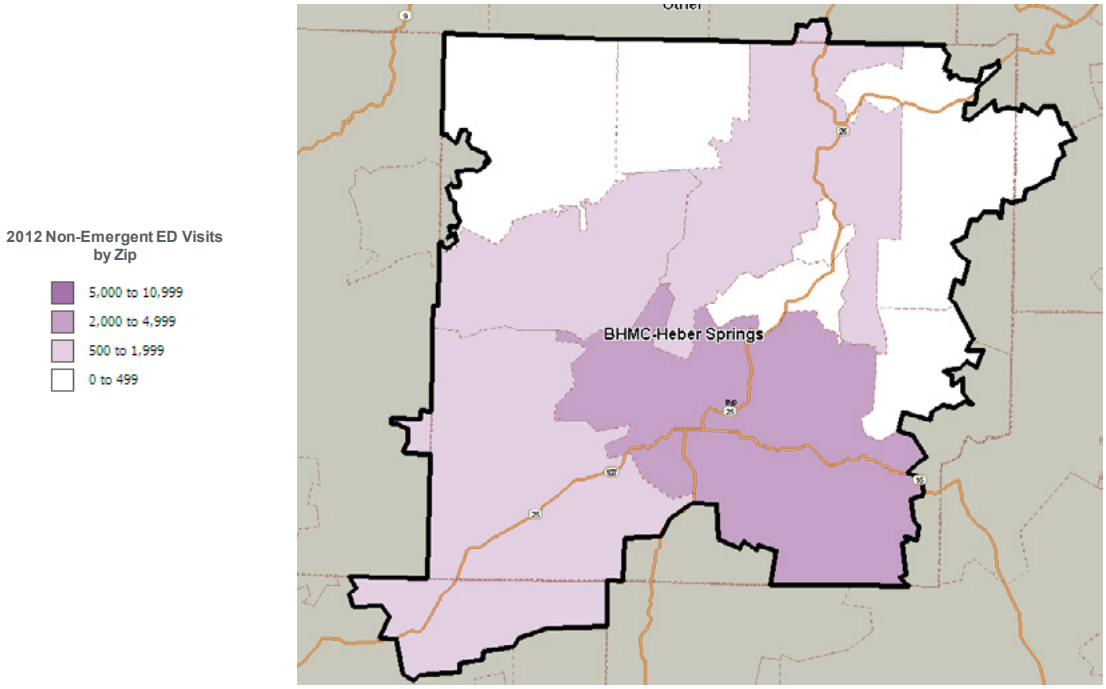
BHMC – HEBER SPRINGS
CNI BARRIER SCORE BY ZIP CODE

Baptist Health Community	Zip	2011 Population	Overall CNI Score	Income Rank	Education Rank	Culture Rank	Insurance Rank	Housing Rank
BHMC Heber Springs	72543	12,503	4	4	4	2	4	4
	72523	1,086	3	5	5	1	4	1
	72131	4,112	3	3	4	2	3	3
	72179	518	3	5	4	1	4	1
	72067	2,759	3	3	4	2	4	1
	72530	1,988	3	4	4	1	3	2
	72581	1,047	3	4	4	1	3	2
	72044	795	3	4	4	1	4	1
	72130	397	3	4	5	1	3	1
	72546	118	2	1	4	1	3	2

The CNI score is an average of five different barrier scores that measure various socio-economic indicators of each community. The CNI is strongly linked to variations in community healthcare needs and is a strong indicator of a community's demand for various healthcare services.

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BHMC – HEBER SPRINGS
NON-EMERGENT ED VISITS BY ZIP

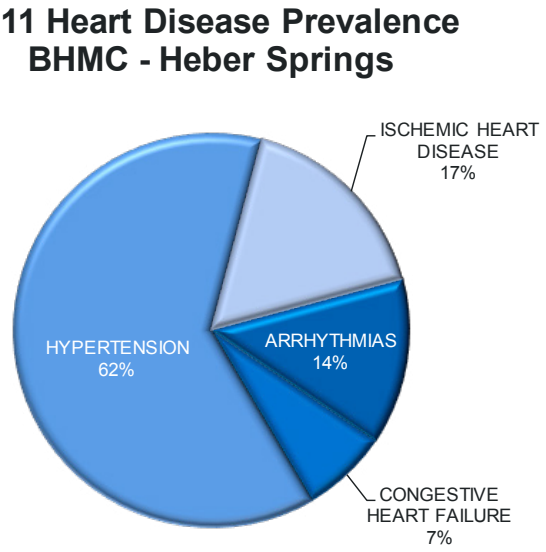


Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

Heber Springs

Zip Code	2012 Total ED Visits	2012 Non-Emergent ED Visits	2012 % Non-Emergent	2017 Total ED Visits	2017 Non-Emergent ED Visits	2017 % Non-Emergent	2012 - 2017 % Chg Non-Emergent
72044	548	312	57%	597	329	55%	5%
72067	1,579	931	59%	1,722	982	57%	5%
72130	251	158	63%	283	173	61%	9%
72131	2,586	1,653	64%	2,855	1,781	62%	8%
72179	311	199	64%	349	212	61%	7%
72523	614	399	65%	658	411	62%	3%
72530	1,165	737	63%	1,290	792	61%	7%
72543	7,782	4,700	60%	8,611	5,019	58%	7%
72546	67	43	64%	73	44	60%	2%
72581	612	372	61%	673	394	59%	6%
Total	**15,515**	**9,504**	**61%**	**17,111**	**10,137**	**59%**	**7%**

BHMC – HEBER SPRINGS
2011 ESTIMATED HEART DISEASE PREVALENCE



BHMC - Heber Springs

Heart Disease Type	2011 Prevalence
ARRHYTHMIAS	1,461
CONGESTIVE HEART FAILURE	758
HYPERTENSION	6,706
ISCHEMIC HEART DISEASE	1,790
Grand Total	**10,715**

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

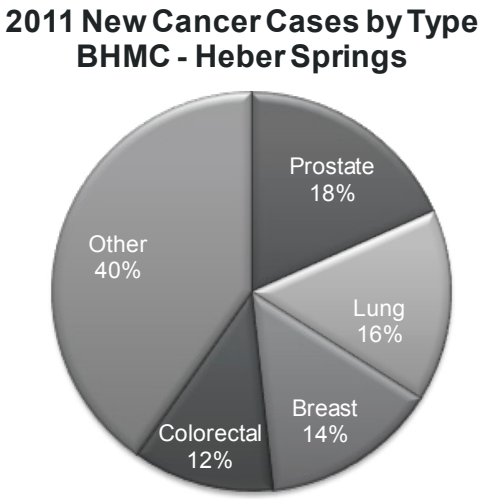
Heber Springs

Zip Code	ARRHYTHMIAS 2011 Prevalence	CONGESTIVE HEART FAILURE 2011 Prevalence	HYPERTENSION 2011 Prevalence	ISCHEMIC HEART DISEASE 2011 Prevalence	TOTAL HEART DISEASE 2011 Prevalence
72044	57	30	242	72	401
72067	176	92	792	223	1,283
72130	21	11	99	25	156
72131	210	108	997	255	1,570
72179	26	13	129	31	199
72523	51	26	254	61	392
72530	100	52	495	122	769
72543	755	392	3,385	920	5,452
72546	6	3	30	8	47
72581	59	31	283	73	446
Total	**1,461**	**758**	**6,706**	**1,790**	**10,715**

BHMC – HEBER SPRINGS
2011 ESTIMATED CANCER INCIDENCE

BHMC - Heber Springs

Cancer Type	2011 Incidence (new Cancer cases)
PROSTATE	42
LUNG	36
BREAST	33
COLORECTAL	26
OTHER	22
NH LYMPHOMA	11
BLADDER	8
MELANOMA	8
LEUKEMIA	7
KIDNEY	7
PANCREAS	6
ORAL CAVITY	5
UTERINE	5
OVARIAN	3
STOMACH	3
BRAIN	3
THYROID	3
CERVICAL	1
Grand Total	**229**

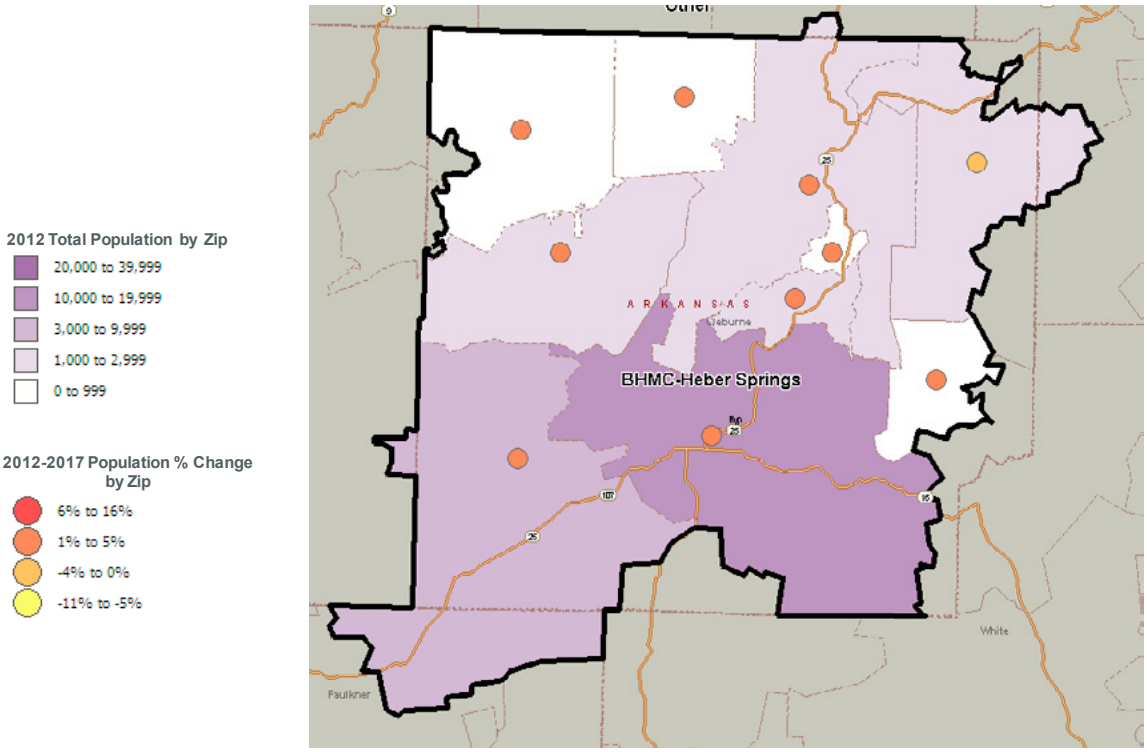


Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

Heber Springs

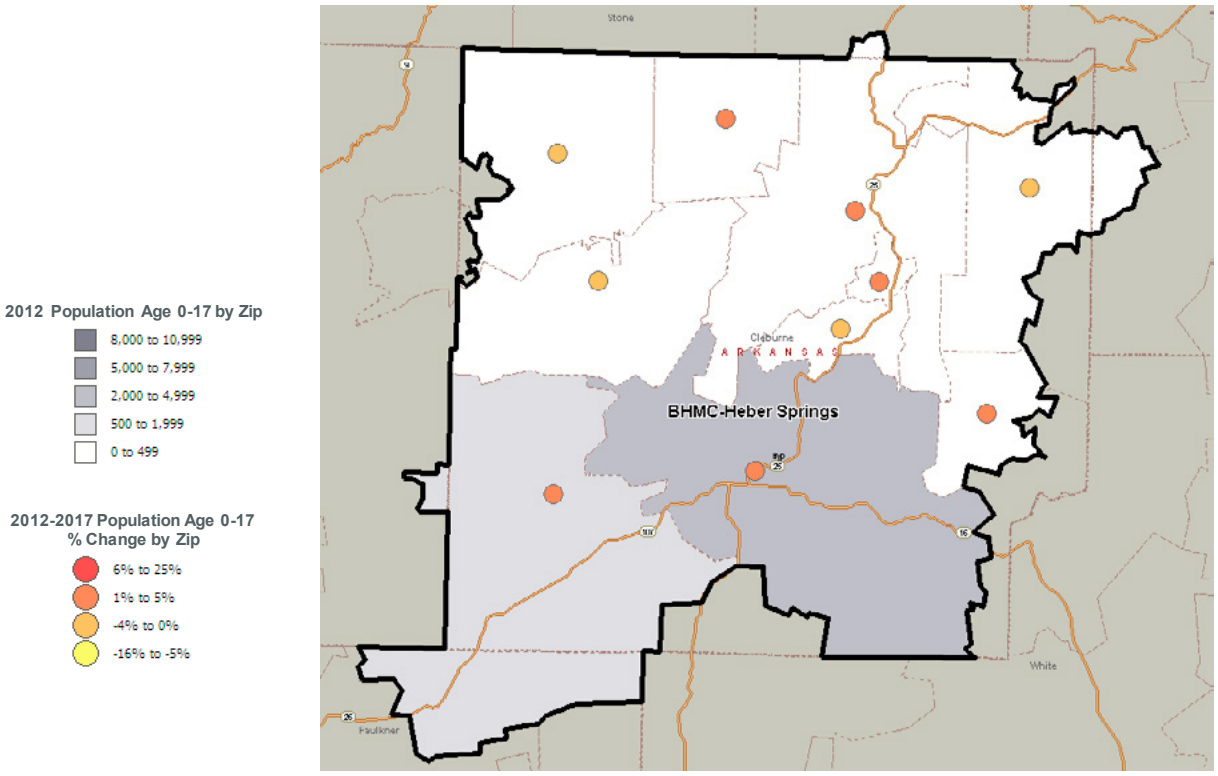
Zip Code	BREAST 2011 Incidence	COLORECTAL 2011 Incidence	LUNG 2011 Incidence	PROSTATE 2011 Incidence	OTHER 2011 Incidence
72044	1	1	1	2	4
72067	4	3	4	6	11
72130	0	0	1	1	1
72131	5	4	5	6	13
72179	1	0	1	1	2
72523	1	1	1	1	3
72530	2	2	2	3	7
72543	17	14	18	21	47
72546	0	0	0	0	0
72581	1	1	1	2	4
Total	**33**	**26**	**36**	**42**	**92**

BHMC – HEBER SPRINGS
2012 – 2017 TOTAL POPULATION



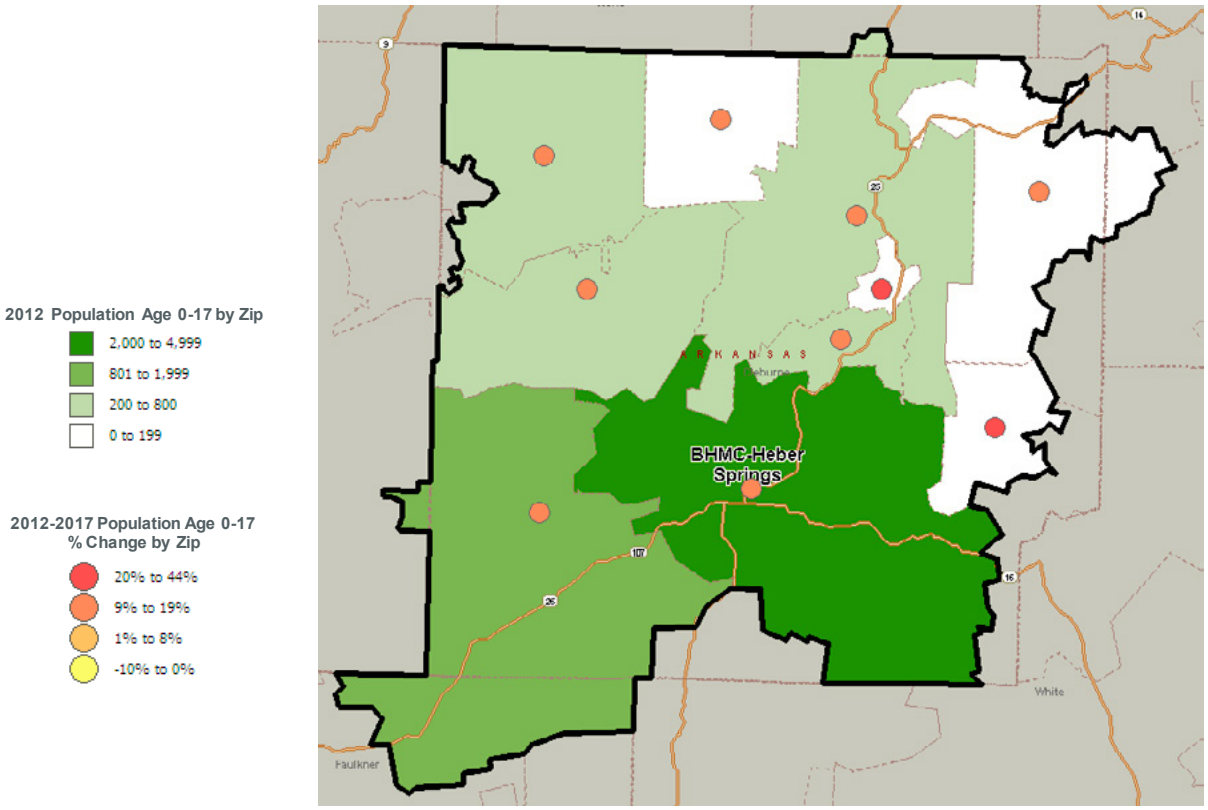
Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BHMC – HEBER SPRINGS
2012 – 2017 POPULATION CHILDREN AGE 0-17



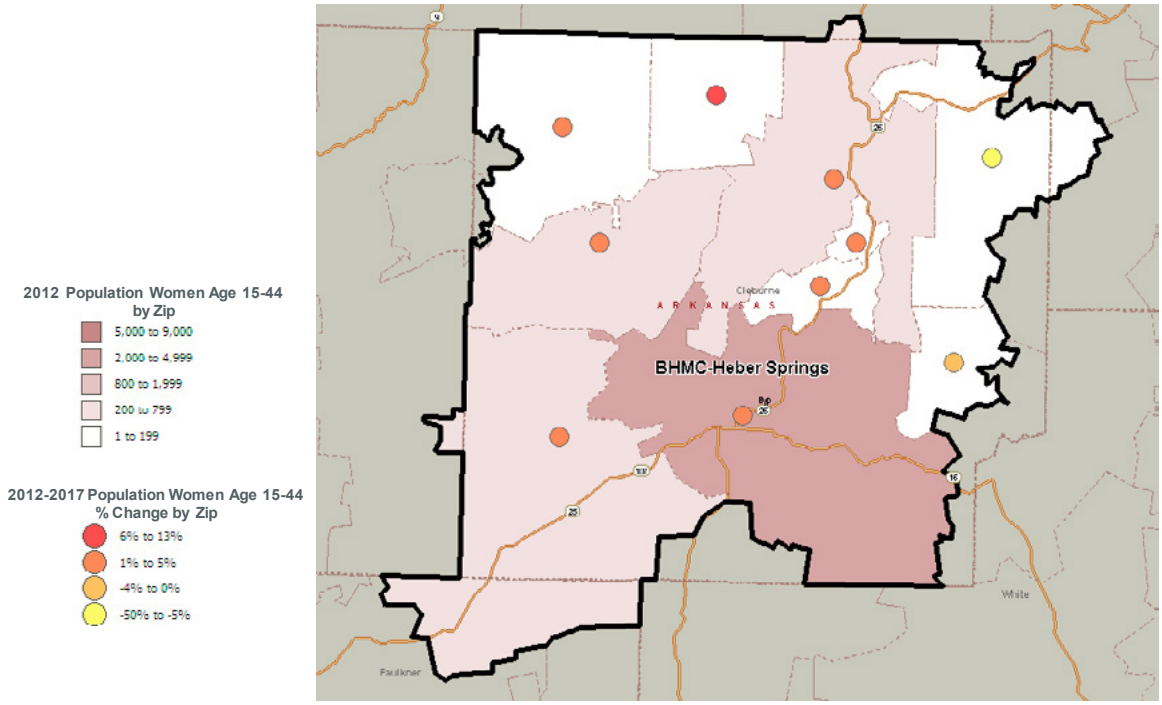
Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BHMC – HEBER SPRINGS
2012 – 2017 POPULATION AGE 65+



Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BHMC – HEBER SPRINGS
2012–2017 POPULATION WOMEN CHILDBEARING AGE



Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BHMC – HEBER SPRINGS
2012 – 2017 POPULATION BY AGE GROUP BY ZIP

HEBER SPRINGS

Zip Code	Age Group	2000 Population	2012 Population	2017 Population	2012-2017 Change
72044	00-17	149	156	155	-1%
72044	18-44	188	202	217	7%
72044	45-64	268	259	246	-5%
72044	65+	229	268	296	10%
72067	00-17	502	480	479	0%
72067	18-44	681	637	675	6%
72067	45-64	799	858	817	-5%
72067	65+	605	668	762	14%
72130	00-17	89	96	97	1%
72130	18-44	126	124	134	8%
72130	45-64	104	123	125	2%
72130	65+	68	84	96	14%
72131	00-17	907	1,070	1,117	4%
72131	18-44	1,257	1,310	1,360	4%
72131	45-64	970	1,173	1,185	1%
72131	65+	740	821	911	11%
72179	00-17	104	112	116	4%
72179	18-44	158	156	157	1%
72179	45-64	137	171	167	-2%
72179	65+	71	91	120	32%

HEBER SPRINGS

Zip Code	Age Group	2000 Population	2012 Population	2017 Population	2012-2017 Change
72523	00-17	268	231	222	-4%
72523	18-44	366	347	332	-4%
72523	45-64	265	290	303	4%
72523	65+	157	172	191	11%
72530	00-17	396	434	442	2%
72530	18-44	618	584	616	5%
72530	45-64	513	613	632	3%
72530	65+	308	367	412	12%
72543	00-17	2,380	2,464	2,497	1%
72543	18-44	3,420	3,571	3,665	3%
72543	45-64	2,844	3,515	3,545	1%
72543	65+	2,541	3,117	3,542	14%
72546	00-17	22	25	26	4%
72546	18-44	35	35	33	-6%
72546	45-64	32	36	36	0%
72546	65+	19	19	25	32%
72581	00-17	177	184	184	0%
72581	18-44	310	286	297	4%
72581	45-64	300	343	339	-1%
72581	65+	191	223	260	17%

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

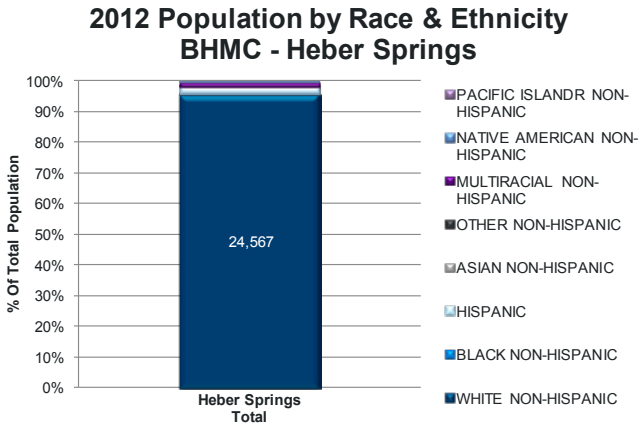
BHMC – HEBER SPRINGS
2012 – 2017 WOMEN CHILDBEARING AGE BY ZIP

BHMC-HEBER SPRINGS

Zip Code	2012 Population	2017 Population	2012-2017 Change
72044	119	121	2%
72067	356	363	2%
72130	68	75	10%
72131	751	767	2%
72179	93	93	0%
72523	185	175	-5%
72530	324	339	5%
72543	2,017	2,048	2%
72546	19	20	5%
72581	162	167	3%
TOTAL	**4,094**	**4,168**	**1.8%**

Note: women childbearing age = females age 15-44

BHMC – HEBER SPRINGS
2012-2017 POPULATION BY RACE & ETHNICITY



BHMC-Heber Springs

Race/Ethnicity	2012 Population	2017 Population	2012-2017 Population Change	2012-2017 Population % Chg
WHITE NON-HISPANIC	24,567	25,453	886	4%
BLACK NON-HISPANIC	75	93	18	24%
HISPANIC	555	680	125	23%
ASIAN NON-HISPANIC	56	61	5	9%
OTHER NON-HISPANIC	2	3	1	50%
MULTIRACIAL NON-HISPANIC	325	389	64	20%
NATIVE AMERICAN NON-HISPANIC	128	144	16	13%
PACIFIC ISLANDR NON-HISPANIC	7	8	1	14%
Grand Total	**25,715**	**26,831**	**1,116**	**4%**

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BHMC –HEBER SPRINGS
RACE & ETHNICITY BY ZIP

BHMC - Heber Springs

Zip Code	Ethnicity	2000 Population	2012 Population	2017 Population	2012-2017 Change
72044	ASIAN NON-HISPANIC	1	2	2	0%
72044	BLACK NON-HISPANIC	-	2	3	50%
72044	HISPANIC	3	10	15	50%
72044	MULTIRACIAL NON-HISPANIC	10	7	6	-14%
72044	NATIVE AMERICAN NON-HISPANIC	3	3	4	33%
72044	OTHER NON-HISPANIC	-	-	-	0%
72044	PACIFIC ISLANDR NON-HISPANIC	1	-	-	0%
72044	WHITE NON-HISPANIC	816	861	884	3%
72067	ASIAN NON-HISPANIC	3	5	6	20%
72067	BLACK NON-HISPANIC	2	4	3	-25%
72067	HISPANIC	28	39	46	18%
72067	MULTIRACIAL NON-HISPANIC	36	29	31	7%
72067	NATIVE AMERICAN NON-HISPANIC	12	16	17	6%
72067	OTHER NON-HISPANIC	-	-	1	0%
72067	PACIFIC ISLANDR NON-HISPANIC	1	-	1	0%
72067	WHITE NON-HISPANIC	2,505	2,550	2,628	3%
72130	ASIAN NON-HISPANIC	-	1	1	0%
72130	BLACK NON-HISPANIC	-	1	-	-100%
72130	HISPANIC	1	5	6	20%
72130	MULTIRACIAL NON-HISPANIC	2	5	6	20%
72130	NATIVE AMERICAN NON-HISPANIC	3	3	5	67%
72130	OTHER NON-HISPANIC	-	-	-	0%
72130	PACIFIC ISLANDR NON-HISPANIC	-	-	-	0%
72130	WHITE NON-HISPANIC	381	412	434	5%
72131	ASIAN NON-HISPANIC	1	7	7	0%
72131	BLACK NON-HISPANIC	2	15	21	40%
72131	HISPANIC	63	78	93	19%
72131	MULTIRACIAL NON-HISPANIC	31	81	104	28%
72131	NATIVE AMERICAN NON-HISPANIC	16	20	21	5%
72131	OTHER NON-HISPANIC	-	-	-	0%
72131	PACIFIC ISLANDR NON-HISPANIC	-	2	2	0%
72131	WHITE NON-HISPANIC	3,761	4,171	4,325	4%
72179	ASIAN NON-HISPANIC	-	1	2	100%
72179	BLACK NON-HISPANIC	1	-	-	0%
72179	HISPANIC	2	8	10	25%
72179	MULTIRACIAL NON-HISPANIC	5	6	6	0%
72179	NATIVE AMERICAN NON-HISPANIC	1	2	3	50%
72179	OTHER NON-HISPANIC	-	-	-	0%
72179	PACIFIC ISLANDR NON-HISPANIC	-	-	-	0%
72179	WHITE NON-HISPANIC	461	513	539	5%

BHMC - Heber Springs

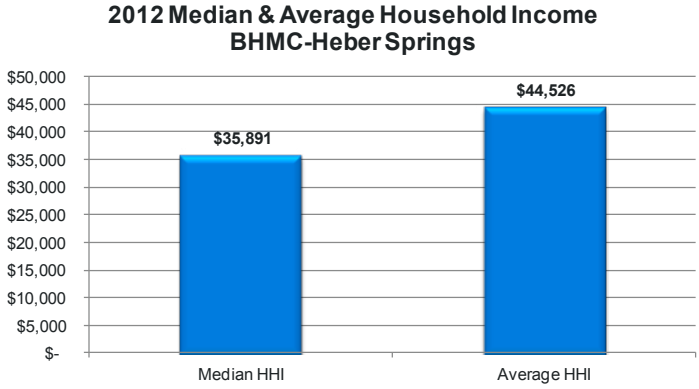
Zip Code	Ethnicity	2000 Population	2012 Population	2017 Population	2012-2017 Change
72523	ASIAN NON-HISPANIC	1	2	1	-50%
72523	BLACK NON-HISPANIC	-	-	-	0%
72523	HISPANIC	11	15	18	20%
72523	MULTIRACIAL NON-HISPANIC	14	6	5	-17%
72523	NATIVE AMERICAN NON-HISPANIC	3	3	3	0%
72523	OTHER NON-HISPANIC	-	-	-	0%
72523	PACIFIC ISLANDR NON-HISPANIC	-	-	-	0%
72523	WHITE NON-HISPANIC	1,027	1,014	1,021	1%
72530	ASIAN NON-HISPANIC	1	7	8	14%
72530	BLACK NON-HISPANIC	1	2	3	50%
72530	HISPANIC	11	18	23	28%
72530	MULTIRACIAL NON-HISPANIC	14	18	19	6%
72530	NATIVE AMERICAN NON-HISPANIC	9	12	14	17%
72530	OTHER NON-HISPANIC	-	-	-	0%
72530	PACIFIC ISLANDR NON-HISPANIC	-	1	1	0%
72530	WHITE NON-HISPANIC	1,799	1,940	2,034	5%
72543	ASIAN NON-HISPANIC	28	26	29	12%
72543	BLACK NON-HISPANIC	22	48	58	21%
72543	HISPANIC	161	367	451	23%
72543	MULTIRACIAL NON-HISPANIC	71	168	208	24%
72543	NATIVE AMERICAN NON-HISPANIC	47	64	71	11%
72543	OTHER NON-HISPANIC	2	2	2	0%
72543	PACIFIC ISLANDR NON-HISPANIC	4	3	3	0%
72543	WHITE NON-HISPANIC	10,850	11,989	12,427	4%
72546	ASIAN NON-HISPANIC	-	1	1	0%
72546	BLACK NON-HISPANIC	-	-	-	0%
72546	HISPANIC	1	2	1	-50%
72546	MULTIRACIAL NON-HISPANIC	1	-	1	0%
72546	NATIVE AMERICAN NON-HISPANIC	-	-	-	0%
72546	OTHER NON-HISPANIC	-	-	-	0%
72546	PACIFIC ISLANDR NON-HISPANIC	-	-	-	0%
72546	WHITE NON-HISPANIC	106	112	117	4%
72581	ASIAN NON-HISPANIC	-	4	4	0%
72581	BLACK NON-HISPANIC	-	3	5	67%
72581	HISPANIC	5	13	17	31%
72581	MULTIRACIAL NON-HISPANIC	7	5	3	-40%
72581	NATIVE AMERICAN NON-HISPANIC	3	5	6	20%
72581	OTHER NON-HISPANIC	-	-	-	0%
72581	PACIFIC ISLANDR NON-HISPANIC	-	1	1	0%
72581	WHITE NON-HISPANIC	963	1,005	1,044	4%

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BHMC – HEBER SPRINGS HOUSEHOLD INCOME

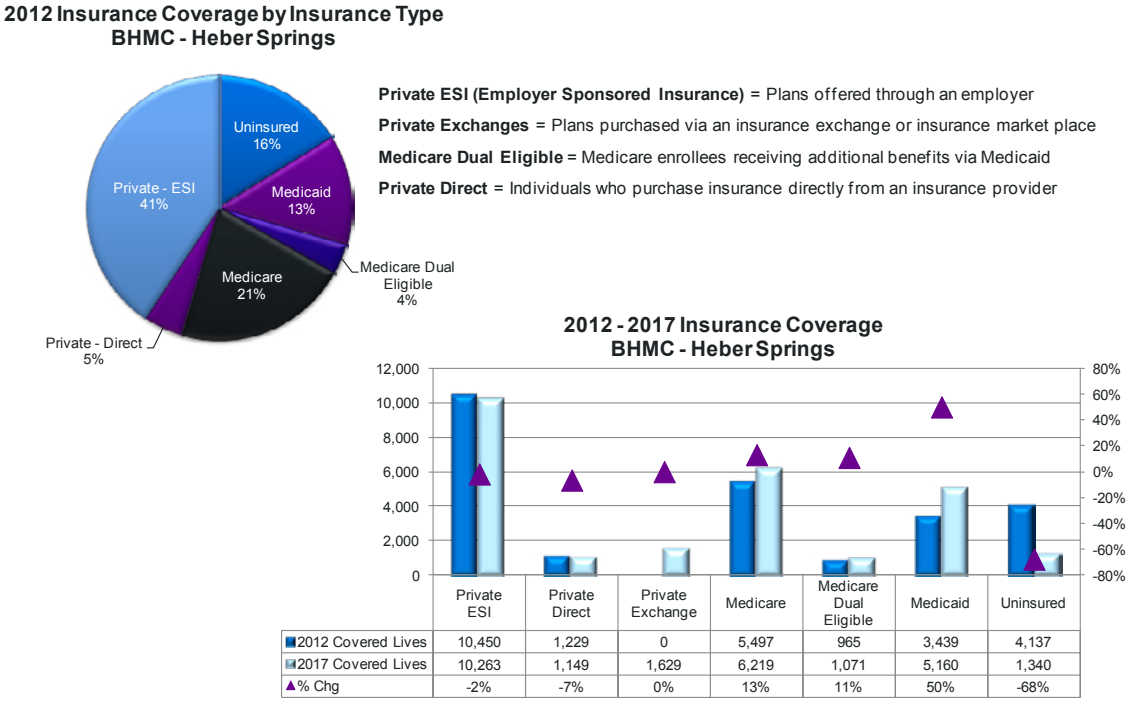
BHMC-HEBER SPRINGS

Zip Code	2012 Total Households	2012 Average Household Income	2012 Median Household Income
72044	414	$39,185	$31,957
72067	1,236	$49,284	$38,391
72130	181	$39,848	$33,030
72131	1,827	$43,058	$35,602
72179	228	$45,340	$35,714
72523	417	$40,588	$33,309
72530	852	$42,884	$36,250
72543	5,329	$48,741	$35,479
72546	50	$49,900	$38,000
72581	465	$46,435	$41,181



Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BHMC – HEBER SPRINGS INSURANCE COVERAGE



Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BHMC – HEBER SPRINGS
INSURANCE COVERAGE BY ZIP

BHMC-Heber Springs

Zip Code	Insurance Type	2012 Covered Lives	2017 Covered Lives	% Chg
72044	Private - ESI	298	287	-4%
72044	Private - Direct	36	32	-11%
72044	Private - Exchange	0	49	N/A
72044	Medicare	255	280	10%
72044	Medicare Dual Eligible	42	46	10%
72044	Medicaid	116	176	52%
72044	Uninsured	139	47	-66%
72067	Private - ESI	1,058	1,019	-4%
72067	Private - Direct	124	117	-6%
72067	Private - Exchange	0	155	N/A
72067	Medicare	635	720	13%
72067	Medicare Dual Eligible	105	116	10%
72067	Medicaid	327	474	45%
72067	Uninsured	393	134	-66%
72130	Private - ESI	195	193	-1%
72130	Private - Direct	23	21	-9%
72130	Private - Exchange	0	27	N/A
72130	Medicare	80	91	14%
72130	Medicare Dual Eligible	15	16	7%
72130	Medicaid	53	82	55%
72130	Uninsured	65	21	-68%
72131	Private - ESI	2,017	1,996	-1%
72131	Private - Direct	237	223	-6%
72131	Private - Exchange	0	290	N/A
72131	Medicare	772	856	11%
72131	Medicare Dual Eligible	138	151	9%
72131	Medicaid	549	844	54%
72131	Uninsured	661	213	-68%
72179	Private - ESI	247	241	-2%
72179	Private - Direct	28	27	-4%
72179	Private - Exchange	0	33	N/A
72179	Medicare	86	112	30%
72179	Medicare Dual Eligible	16	19	19%
72179	Medicaid	68	102	50%
72179	Uninsured	84	27	-68%

BHMC-Heber Springs

Zip Code	Insurance Type	2012 Covered Lives	2017 Covered Lives	% Chg
72523	Private - ESI	450	430	-4%
72523	Private - Direct	53	48	-9%
72523	Private - Exchange	0	72	N/A
72523	Medicare	161	179	11%
72523	Medicare Dual Eligible	30	33	10%
72523	Medicaid	157	228	45%
72523	Uninsured	189	57	-70%
72530	Private - ESI	929	930	0%
72530	Private - Direct	109	104	-5%
72530	Private - Exchange	0	131	N/A
72530	Medicare	345	390	13%
72530	Medicare Dual Eligible	62	68	10%
72530	Medicaid	251	378	51%
72530	Uninsured	302	101	-67%
72543	Private - ESI	4,749	4,671	-2%
72543	Private - Direct	558	521	-7%
72543	Private - Exchange	0	804	N/A
72543	Medicare	2,935	3,324	13%
72543	Medicare Dual Eligible	518	577	11%
72543	Medicaid	1,774	2,669	50%
72543	Uninsured	2,132	683	-68%
72546	Private - ESI	56	54	-4%
72546	Private - Direct	7	6	-14%
72546	Private - Exchange	0	6	N/A
72546	Medicare	17	23	35%
72546	Medicare Dual Eligible	3	4	33%
72546	Medicaid	14	20	43%
72546	Uninsured	17	5	-71%
72581	Private - ESI	451	442	-2%
72581	Private - Direct	54	50	-7%
72581	Private - Exchange	0	62	N/A
72581	Medicare	211	244	16%
72581	Medicare Dual Eligible	36	41	14%
72581	Medicaid	130	187	44%
72581	Uninsured	155	52	-66%
BHMC-Heber Springs Total		**25,717**	**26,831**	**4%**

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

Interview & Focus Group Analysis

INTERVIEW ANALYSIS APPROACH

- Coded participants and consolidated interview responses
- Participant responses were parsed by question/topic and categorized
    - Participants gave multiple responses per question – each response recorded individually
    - Therefore, response count can be greater than number of participants
- Density analysis conducted on responses by category

Interview questions were designed to approach some subjects in a multitude of ways and give the interviewer flexibility in conducting the interview. Therefore not every question is represented with a response table as some question responses were collapsed while others eliminated due to time constraints. Additionally some questions were not designed for response consolidation but used to inform other sections of the analysis.

BHMC HEBER SPRINGS INTERVIEW SUMMARY

Questions 1 and 2 were background/ice-breaker questions regarding the community or organization each person represented.

03. What would you say is the current health status of the community?

Response Category	Response Count	Percent of Responses
Good	4	33%
Fair	3	25%
Poor	3	25%
Good-Fair	1	8%
Very Good-Good	1	8%
Grand Total	**12**	**100%**

03a. Reasoning?

Response Category	Response Count	Percent of Responses
Chronic/Other Diseases	3	20%
Healthy Population	2	13%
Smoking	2	13%
Unhealthy Population	1	7%
Higher Socioeconomic Status	1	7%
Prevention/Lifestyle	1	7%
Health Disparities	1	7%
Obesity	1	7%
Alcohol/Drug Abuse	1	7%
Mental Health	1	7%
Lack of Physicians	1	7%
Grand Total	**15**	**100%**

04. Top health needs of the community?

Response Category	Response Count	Percent of Responses
Healthcare Providers/Services	14	29%
Chronic Diseases	4	8%
Access	3	6%
Prevention/Lifestyle Modification	3	6%
Diabetes	3	6%
Other	3	6%
Obesity	3	6%
Food/Nutrition	3	6%
Cardiovascular	2	4%
Alcohol/Drug Abuse	2	4%
Sexual Health	2	4%
Dental	1	2%
Primary Care/PCPs	1	2%
Affordable Care	1	2%
Care Coordination	1	2%
Mental Health	1	2%
Elderly	1	2%
Grand Total	**48**	**100%**

4b. What healthcare services are missing?

Response Category	Response Count	Percent of Responses
Primary Care/PCPs	2	100%
Grand Total	**2**	**100%**

4c. What is the number one barrier to good health care?

Response Category	Response Count	Percent of Responses
Socioeconomic	3	43%
Culture	1	14%
Affordable Care	1	14%
Prevention/Lifestyle Modification	1	14%
Health Education	1	14%
Grand Total	**7**	**100%**

4d. What concerns you the most about the health of the community?

Response Category	Response Count	Percent of Responses
Chronic/Other Diseases	1	25%
Elderly	1	25%
Obesity	1	25%
Healthcare Policy/Regulation	1	25%
Grand Total	**4**	**100%**

05. Leading social determinants of health?

Response Category	Response Count	Percent of Responses
Socioeconomic	12	33%
Alcohol/Drug Abuse	6	17%
Prevention/Lifestyle Modification	6	17%
Food/Nutrition	3	8%
Trauma/Injury	2	6%
Environment	1	3%
Transportation	1	3%
Culture	1	3%
Health Education	1	3%
Access	1	3%
Smoking	1	3%
Insurance	1	3%
Grand Total	**36**	**100%**

06. primary health indicators?

Response Category	Response Count	Percent of Responses
Condition/Disease Rates	9	24%
Obesity	7	19%
Smoking	4	11%
Hospital/Public Health Measures	3	8%
Mental Health	3	8%
Other	2	5%
Socioeconomic	2	5%
Preventative Care Rates	2	5%
Lifestyle Measures	2	5%
Teen Pregnancy	1	3%
Infant Mortality/Low Birthweight	1	3%
Insurance Coverage	1	3%
Grand Total	**37**	**100%**

07. vulnerable groups/populations?

Response Category	Response Count	Percent of Responses
Children/Teens	5	23%
Elderly	5	23%
Middle Aged	2	9%
Women	2	9%
Rural	2	9%
Minorities	2	9%
Un/UnderInsured	1	5%
Chronic Diseases	1	5%
Mental Health	1	5%
Young Adults	1	5%
Grand Total	**22**	**100%**

09. In terms of specific actions/programs, what do you think could be done to address the health needs we've discussed?

Response Category	Response Count	Percent of Responses
Community Outreach/Education	5	19%
Public Health/Health Outcomes	5	19%
Care Coordination	4	15%
Recreation	3	12%
Specialty Providers/Services	3	12%
Socioeconomic	1	4%
Social Resources	1	4%
Access/Affordable Care	1	4%
Other	1	4%
Food/Nutrition	1	4%
Policy	1	4%
Grand Total	**26**	**100%**

10. What are some ways Baptist Health or other organizations can engage the community in addressing health needs?

Response Category	Response Count	Percent of Responses
Community Collaboration	8	42%
Community Outreach/Education	7	37%
Access/Affordable Care	1	5%
Care Coordination	1	5%
Specialty Providers/Services	1	5%
Environment/Socioeconomic	1	5%
Grand Total	**19**	**100%**

13a. Are there any specific organizations in the community that would be a good fit for Baptist Health to partner with to address health needs?

Response Category	Response Count	Percent of Responses
Chamber of Commerce	1	33%
Community Center	1	33%
Senior Center	1	33%
Grand Total	**3**	**100%**

BHMC-Heber Springs Focus Group Summary

LOCATION: BHMC-HEBER SPRINGS DATE: 9/13/12

DISCUSSION 1:

- What grade do you give the health of this community (A-F)?
    - Write the Grade down on sticky note and place on flipchart/white board
- Discuss as a group the grade chosen
    - What factors did you consider when you chose a grade?
    - What do you think of when you think of health?

RESPONSES:

When asked to grade the health of the community served by BHMC-Heber Springs, five focus group participants gave C's, three said C-, and there was one D. Contributing factors to this poor health status include drug abuse, children living in poverty, obesity, a large uninsured population, poor diets, lack of exercise, and a large elder population who have experienced strokes, heart attacks, and live with diabetes. Drug abuse as a result of underlying mental health issues has also led to STIs, unplanned children and more people on Medicaid.

On a positive note, there is a strong spiritual base in the county and people are becoming more active with the community center. Community members are using the indoor walking trail, playing basketball, golfing, and use the lake. The senior population is also engaging through physical activity.

A shortage of physicians may be an issue as new community members are experiencing challenges with getting timely appointments. Existing providers are not taking new patients and there are no urgent care clinics so the community seeks out care in the emergency department. An after-hours clinic to absorb the non-emergent cases would be helpful and improving dental care should a priority.

DISCUSSION 2:

- Break into 2-3 smaller groups
- As a group identify the top 3 health needs of the community
    - Agree upon the top 3 needs and why
    - Write each need on sticky note and place on flipchart/white board
    - One person from the group share with the larger group why those needs were chosen

RESPONSES:

1. Obstetrics
    a. Currently, there is no maternity care, no labor and delivery. People have to drive further away to receive these services.
    b. Early prenatal care means a better start for babies and can help reduce the number of premature babies.
2. Geriatrics
    a. Aging population rations care because of affordability
    b. Many elderly live alone with no one to take care of them
    c. High rates of diabetes, dementia/Alzheimer's
3. Drug abuse
    a. Opiods, narcotics in the middle-age population
    b. Meth and marijuana in the younger population
    c. The Christian Ministries, Clear View Church lead substance abuse programs. Celebrate Recovery is an addiction program also and there are others that have counseling programs. Some of the programs are too full.
4. Obesity
    a. Stems from inactivity and easy accessibility to fast food.
    b. Many younger people do not know how to cook.
    c. Parents have a perception that bigger babies are healthy. Some mothers that do not have that much money may treat their kids to a cupcake because they can't afford more expensive stuff.
5. Mental health
    a. High rates of depression, schizophrenia, and bipolar disorders
    b. People use the emergency department for these services because there is nowhere else to go

DISCUSSION 3:

- Stay the same smaller groups
- As a group identify up to 10 community resources (health/community organizations)
    - Work together to identify resources and list on flipchart paper
    - Discuss ways these resources could work together to address the health needs discussed
    - One person from the group share with larger group 2-3 ideas from discussion

RESPONSES:

GROUP 1

- Churches
- Christian Health Services
- Corporate park/lake
- Hospital
- Community centers
- Health department
- Senior center
- Library

- Healthcare providers
- Industry
- Colleges

GROUP 2

- Hospital
- Community center
- Sports complex
- Recreation
- Senior Center
- College
- Churches
- Health department
- School system

GROUP 3

- Community center
- Hiking trail
- Organized sports leagues
- Faith system
- Community resources (school, AA, etc.)
- Home health
- Dental care
- Police/court system
- School system
- ASU
- Community coalition
- Hospitals

Other general group comments include:

- The churches all have kitchens that they can use to host cooking classes.
- Create a list of community resources for wide distribution.
- Churches can provide spiritual guidance to those who have problems with drug abuse and mental health challenges.

DISCUSSION 4:

- Stay the same smaller groups
- As a group, choose one of the health needs your group identified earlier
- Identify two goals you'd like to accomplish related to the need
    - Goals should be SMART (Specific, Measurable, Attainable, Realistic, Time-sensitive)
- For each goal identify 2-3 action steps that would help achieve the goal

RESPONSES:

GROUP 1:

Community Health Need: Obesity Rate in the County

- Goal 1- 50% of the county to receive nutritional education
    - Incorporate cooperative extension churches for sponsorship.
    - Teach people how to make better food choices and have classes on how to prepare food.
- Goal 2- Increase physical activity by 50%
    - Establish a community activity program and offer rewards towards activities that are accomplished.
    - Health care community to incorporate nutritional and activity as part of patient care.

GROUP 2:

Community Health Need: Adolescent Pregnancy

- Goal 1-Provide prenatal education
    - School, church, and health department partner to provide education.
    - Develop a catalog of available resources for expectant mothers.
- Goal 2-Provide parenting classes
    - Develop healthy choice education.
    - Enlist volunteer mentors that can model parenting skills.

GROUP 3:

Community Health Need: Substance Abuse programs

- Goal 1- Convince those in denial of problem that there is one
    - They can finance programs for failed drug tests.
    - Host gatherings for those working on goals.
- Goal 2- Convince those who know of the problem that changes can be made
    - Mandatory drug screenings by employees and schools
    - Programs for those that fail drug tests.

Health Resources Available to Meet Identified Needs

BHMC-Heber Springs

Other Hospital Facilities

Hospital Name	Address	City	Owner Type	Type of Service
-	-	-	-	-

Cause of Death: Heart Disease

Chronic Conditions: Coronary Heart Disease

Program Name	Description	Website	Phone Number	State	County
Arkansas Department of Health Heart Disease and Stroke Prevention			501-661-2942	x	
Arkansas Wellness Coalition (AWC)	Includes members of the health care and employer community whose goal is to improve the health and well-being of all Arkansans through the use of nationally recognized, peer reviewed, clinical guidelines for physician, consumer, and employer education. Develop materials referring to nationally recognized standards such as those put forth by Healthy People 2010, the National Committee of Quality Assurance, and other disease-specific organizations such as the American Diabetes Association and the American Heart Association.		501-661-2942	x	
ARCare	ARcare offers specialized treatment for a variety of cardiovascular conditions including coronary artery disease, heart attack, high blood pressure, high cholesterol, angina, and all other conditions related to the heart and its blood vessel system.	http://www.arcare.net/OurServices/OurServices Continuedpart2/tabid/14185/Default.aspx#cardiology			X

Program Name	Description	Website	Phone Number	State	County
Arkansas Chronic Illness Collaborative (ACIC)	The ACIC is a group of health care and public health professionals dedicated to improving the management of chronic diseases. The ACIC is a way for health care clinic teams to use the National Health Disparities Collaborative Chronic Care Model to share ideas and knowledge, learn and apply new techniques, and match medical practices with clinical guidelines based on scientific evidence about what works best (diabetes, cancer and cardiovascular diseases)	http://www.healthy.arkansas.gov/programsServices/chronicDisease/Initiatives/Pages/Acic.aspx		X	

Cause of Death: Chronic Lower Respiratory Disease

Program Name	Description	Website	Phone Number	State	County
Arkansas Wellness Coalition (AWC)	Includes members of the health care and employer community whose goal is to improve the health and well-being of all Arkansans through the use of nationally recognized, peer reviewed, clinical guidelines for physician, consumer, and employer education. Develop materials referring to nationally recognized standards such as those put forth by Healthy People 2010, the National Committee of Quality Assurance, and other disease-specific organizations such as the American Diabetes Association and the American Heart Association.		501-661-2942	x	
Arkansas Chronic Illness Collaborative (ACIC)	The ACIC is a group of health care and public health professionals dedicated to improving the management of chronic diseases. The ACIC is a way for health care clinic teams to use the National Health Disparities Collaborative Chronic Care Model to share ideas and knowledge, learn and apply new techniques, and match medical practices with clinical guidelines based on scientific evidence about what works best (diabetes, cancer and cardiovascular diseases)	http://www.healthy.arkansas.gov/programsServices/chronicDisease/Initiatives/Pages/Acic.aspx		x	

Health Outcomes: Low Birth Weight

Program Name	Description	Website	Phone Number	State	County
Arkansas Department of Health	ADH provides prenatal care to an average of 5,000 women annually at many of the Local Health Units.		1-800-462-0599	X	
Arkansas Department of Health Nurse-Family Partnership	Nurse-Family Partnership is a free, voluntary program that partners first-time moms with registered nurses. NFP is available to any first-time mom who is under her 28th week of pregnancy, and who is below 200% of the Federal poverty level.	http://www.adhhomecare.org/nurse-family-arkansas.htm		X	
Antenatal & Neonatal Guidelines, Education, and Learning System	ANGELS links clinicians and patients across the state with the University of Arkansas for Medical Sciences, with high-risk pregnancy services, maternal–fetal medicine specialists, and prenatal genetic counselors. The program facilitates telehealth consultation between patients, their local physicians, and medical center specialists through a statewide telemedicine network.	http://www.innovations.ahrq.gov/content.aspx?id=1706		X	

Health Outcomes: Poor or Fair Health Status

Program Name	Description	Website	Phone Number	State	County
Chronic Disease Self Management Program – Be Well Live Well	Developed by the Stanford Patient Education Research Center, the evidence based program teaches participants the skills needed to live well with chronic diseases. It also shows participants how to organize their lives, make and achieve goals, eat properly, exercise and communicate effectively with physicians and others. National outcome studies reveal that CDSMP participants experience a marked decrease in the number of hospital stays and doctor visits.	http://www.agec.org/2012/10/cdsmp-branded-for-arkansas-be-well-live-well/		X	

Program Name	Description	Website	Phone Number	State	County
Arkansas Department of Health – Hometown Health Improvement	Hometown Health Improvement initiatives currently exist in every county around the state. HHI coalitions do powerful and unique work to improve the health of those in their communities. Once the coalition is established, many communities are choosing to conduct health behavior surveys to gain important information specific to their communities. Many coalitions are now implementing activities to affect the health of the community. Examples of some activities include: tobacco cessation programs for adolescents, household hazardous waste round-up, parenting support groups, local industry wellness programs, health fairs, and health resource guides.				X (All counties)

Health Outcomes: Poor Physical Health Days

Program Name	Description	Website	Phone Number	State	County
Chronic Disease Self Management Program – Be Well Live Well	Developed by the Stanford Patient Education Research Center, the evidence based program teaches participants the skills needed to live well with chronic diseases. It also shows participants how to organize their lives, make and achieve goals, eat properly, exercise and communicate effectively with physicians and others. National outcome studies reveal that CDSMP participants experience a marked decrease in the number of hospital stays and doctor visits.	http://www.agec.org/2012/10/cdsmp-branded-for-arkansas-be-well-live-well/		X	

Program Name	Description	Website	Phone Number	State	County
Arkansas Department of Health – Hometown Health Improvement	Hometown Health Improvement initiatives currently exist in every county around the state. HHI coalitions do powerful and unique work to improve the health of those in their communities. Once the coalition is established, many communities are choosing to conduct health behavior surveys to gain important information specific to their communities. Many coalitions are now implementing activities to affect the health of the community. Examples of some activities include: tobacco cessation programs for adolescents, household hazardous waste round-up, parenting support groups, local industry wellness programs, health fairs, and health resource guides.				X (All counties)

Chronic Conditions: Arthritis

Program Name	Description	Website	Phone Number	State	County
City of Heber Springs	Arthritis Foundation Exercise Classes - Recreational exercise program that is designed to address specific therapeutic problems, reduce pain and stiffness, restore or maintain muscle strength & range of motion, improve balance & coordination, decrease fatigue and increase endurance and improve an overall quality of life. Each class is held in the warm water Therapy Pool and is conducted by an Arthritis Foundation certified	http://www.hebersprings parksandrec.com/aquatics/exercisetraining.html	501-661-2942		X (Heber Springs)
Arkansas Arthritis Foundation	Various educational programs	http://www.arthritis.org/arkansas/		X	

Chronic Conditions: High Cholesterol

Program Name	Description	Website	Phone Number	State	County
Southern Ain't Fried Sundays - Arkansas Minority Health Commission	Faith Based Outreach Program SAFS is designed to educate African American churches and organizations about healthier alternatives to preparing and cooking southern-style foods. It is also a mechanism for partnering with these groups in an effort to educate their members about the signs and symptoms of stroke, diabetes, and heart attacks. The program is being revamped to expand its reach to the Hispanic communities and individual participants.	http://www.arminorityhealth.com/programs_saf.html	877-264-2826		

Chronic Conditions: Diabetes

Program Name	Description	Website	Phone Number	State	County
American Diabetes Association	Educational Resources; Advocacy		(501) 221-7444		X (all counties)
Arkansas Health Care Access Foundation	Locates doctors to donate office visits; prescription assistance; free to those who qualify	http://ahcaf.org/			X (all counties)
Arkansas Wellness Coalition	Includes members of the health care and employer community whose goal is to improve the health and well-being of all Arkansans through the use of nationally recognized, peer reviewed, clinical guidelines for physician, consumer, and employer education. Develop materials referring to nationally recognized standards such as those put forth by Healthy People 2010, the National Committee of Quality Assurance, and other disease-specific organizations such as the American Diabetes Association and the American Heart Association.		501-661-2942	X	

Program Name	Description	Website	Phone Number	State	County
Arkansas Chronic Illness Collaborative (ACIC)	The ACIC is a group of health care and public health professionals dedicated to improving the management of chronic diseases. The ACIC is a way for health care clinic teams to use the National Health Disparities Collaborative Chronic Care Model to share ideas and knowledge, learn and apply new techniques, and match medical practices with clinical guidelines based on scientific evidence about what works best (diabetes, cancer and cardiovascular diseases)	http://www.healthy.arkansas.gov/programsServices/chronicDisease/Initiatives/Pages/Acic.aspx		X	
ARCare	The ARcare Diabetes Self-Management Program is an AADE recognized education program. Our Diabetes Self-Management Program offers individualized assessments and nutrition planning with a registered dietitian.	http://www.arcare.net/OurServices/OurServicesContinued/tabid/13586/Default.aspx	870-347-2534		X (Cleburne County)

Health Behaviors: Smoking

Program Name	Description	Website	Phone Number	State	County
Stamp Out Smoking	Arkansas Tobacco Quitline: A 24-hour direct line to professionally trained Quit Coaches® waiting to help you fight the good fight, plus a 24-hour online community of support from others who've gone through exactly what you're facing … and you can even get a supply of the latest nicotine replacement therapy medications at no cost.	http://www.stampoutsmoking.com/get-help-to-quit/	1-800-QUIT NOW	X	
Arkansas Department of Health Tobacco Prevention and Cessation Program – STOP Program	The Systems Training Outreach Program (STOP) currently uses Outreach to provide education and support to providers. Increasing the capacity and efficiency of care systems by asking, documenting tobacco use and advising patients to stop, the Outreach Specialists educate healthcare providers to be aware of available and accessible cessation treatment interventions. In particular, the specialists will help providers systematically identify patients who are tobacco users, provide guidance to quit and connect them to available resources to successfully quit.	http://www.healthy.arkansas.gov/programsServices/chronicDisease/coalition/Pages/tobacco.aspx		X	

Health Behaviors: Physical Inactivity

Program Name	Description	Website	Phone Number	State	County
ARCare – SilverSneakers Program	SilverSneakers offers an innovative blend of physical activity, healthy lifestyle, and socially oriented programming that allows older adults to take greater control of their health.	http://www.arcare.net/OurServices/OurServicesContinuedpart3/tabid/14186/Default.aspx#wellness	870-347-1137		X

Health Behaviors: Excessive Drinking

Program Name	Description	Website	Phone Number	State	County
Health Resources of Arkansas	The Region 3 Prevention Resource Center (PRC), housed at Health Resources is one of 13 centers operated throughout the state. The PRC is a link into the community to promote healthy behaviors and lifestyle changes to prevent the use and abuse of substances.	http://www.healthresourcesofarkansas.com/prevention.php			X

Prevention: Colorectal Screening

Program Name	Description	Website	Phone Number	State	County
The Colorectal Cancer Screening Program (CCSP)	The Colorectal Cancer Screening Program (CCSP) is committed to prevention, early detection and treatment of colorectal cancer. The program is designed to provide equitable access to colorectal cancer screenings throughout the state. CCSP targets its services to minorities and people from disadvantaged socioeconomic backgrounds or underserved communities. Participants in need of follow-up are referred to the appropriate services.	http://cancer.uams.edu/?id=11145&sid=2	877-749-4085 or 501-526-7045	X	

Prevention: Mammography

Program Name	Description	Website	Phone Number	State	County
ARCare	The ARcare Comprehensive Breast Program is a service administered by ARcare to meet the needs of uninsured and underinsured women under age 59 who are in need of breast care education, screening, diagnostic, and treatment services. This program provides free clinical breast exams, breast care education, mammograms, and surgical consultation to women who have no coverage for these services. The target population of the program includes low-income women who are uninsured or underinsured and are living in or can travel to the ARcare service area and meet income and insurance coverage guidelines.	http://www.arcare.net/OurServices/OurServices Continued/tabid/13586/Default.aspx	870-347-2534		x (Cleburne County)
Arkansas' BreastCare Program	BreastCare's mission is to increase the rate of early detection of breast and cervical cancer and reduce the morbidity and mortality rates among women in Arkansas by lowering barriers to screening that result from lack of information, financial means, or access to quality services.	http://www.healthy.arkansas.gov/programs services/chronicdisease/arbreastcare/pages/default.aspx		X	

Prevention: Prostate Screening

Program Name	Description	Website	Phone Number	State	County
Arkansas Prostate Cancer Foundation	Free screenings and education sessions provided throughout Arkansas Mobile Van: Mobile screening unit has a private exam room for men to have a digital rectal exam (DRE) draw blood and preserve it until taken to the lab for analysis. This service is provided free to men who do not have a diagnosis of prostate cancer and are between ages 40 and 75. African-American men and men with a family history of the disease are eligible to begin screening at age 35.	http://www.arprostatecancer.org/home/programs/	501-748-1249	X	

Prevention: Flu Shots

Program Name	Description	Website	Phone Number	State	County
Cleburne County Health Unit	Mass Flu Clinic: A Mass Flu Clinic is a day-long event during which the community comes together to immunize as many people as possible. Arkansas Department of Health (ADH) staff, health professionals and volunteers work as a team to provide vaccine. Some clinics offer "drive-thrus" – you don't even leave your car.	http://www.healthy.arkansas.gov/programsServices/infectiousDisease/Immunizations/SeasonalFlu/Pages/MassFluClinics.aspx	501-362-7581		X

Access: Lack of PCPs

Program Name	Description	Website	Phone Number	State	County
ADH Office of Rural Health and Primary Care	Promotes the development of community-based health care services and systems throughout Arkansas to ensure that well managed, quality health services are available to all citizens		501-280-4560	X	
Area Health Education Centers (AHEC)	Programs provide access to medical services for rural residents and education for healthcare students and professionals.	http://ruralhealth.uams.edu/AHEC-Programs		X	X Located in Batesville (Independence County) Serving Cleburne County

Access: No Personal Doctor

Program Name	Description	Website	Phone Number	State	County
Arkansas Department of Health Office of Rural Health and Primary Care	Promotes the development of community-based health care services and systems throughout Arkansas to ensure that well managed, quality health services are available to all citizens		501-280-4560	X	
ARCare – Heber Springs Family Care Clinic	ARcare offers family practice care to people with insurance, those without insurance, and those who are underinsured	http://www.arcare.net/OurServices/OurServices Continued/tabid/13586/Default.aspx	(501) 362-9426		X (Heber Springs)

Heber Springs Family Health Center	This is a health care center funded by the federal government. This health center can cover services such as checkups, treatment, pregnancy, immunizations and child care prescription medicine and mental and substance abuse where applicable		501-362-9426		X (Heber Springs)
Christian Health Center	The Christian Health Center of Heber Springs, Arkansas provides basic primary care services for the uninsured adults living in and around Cleburne County.	http://www.chchebersprings.org/			X (Heber Springs)



Community Needs Assessment

Baptist Health Medical Center–Arkadelphia

December 2013

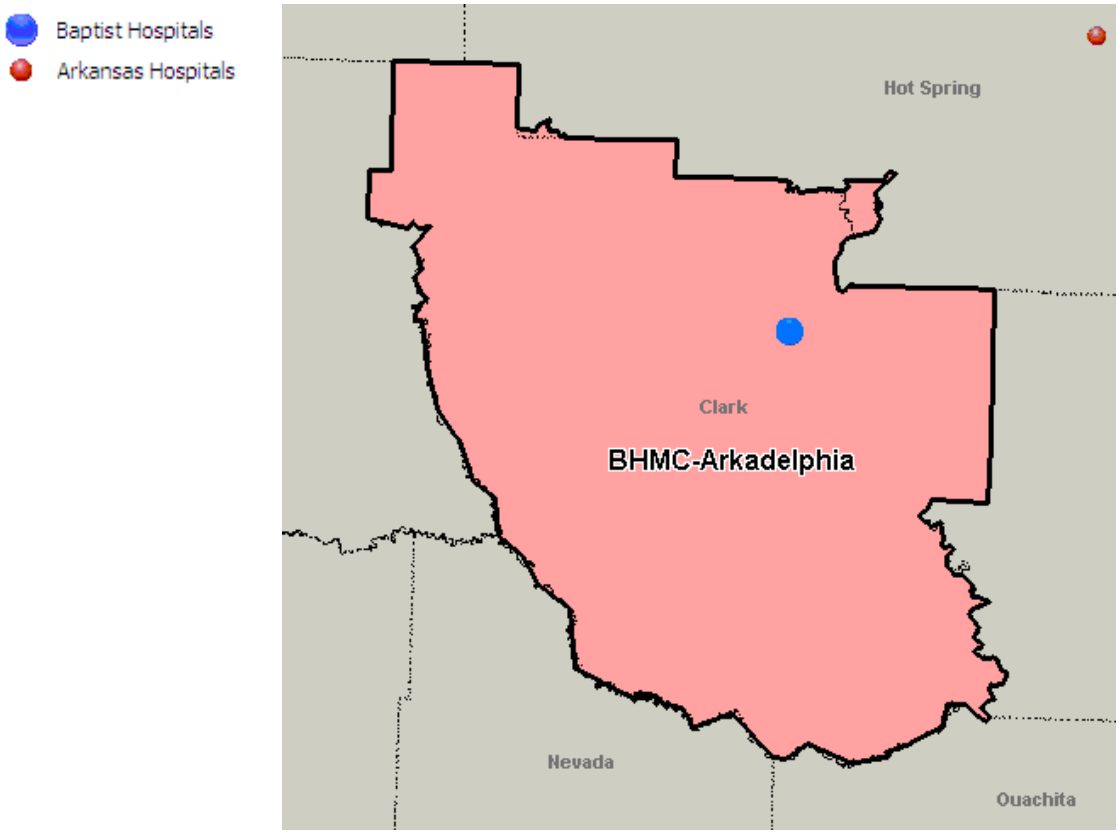
Baptist Health Medical Center–Arkadelphia

Baptist Health Medical Center–Arkadelphia is a critical-access hospital that offers services to residents primarily in Clark County. The BHMC–Arkadelphia campus is home to the Baptist Health Sleep Center, Emergency Department, eICU Care, Surgery, Obstetrics, Cardiology, Orthopedics services, and a Mobile Health Unit.

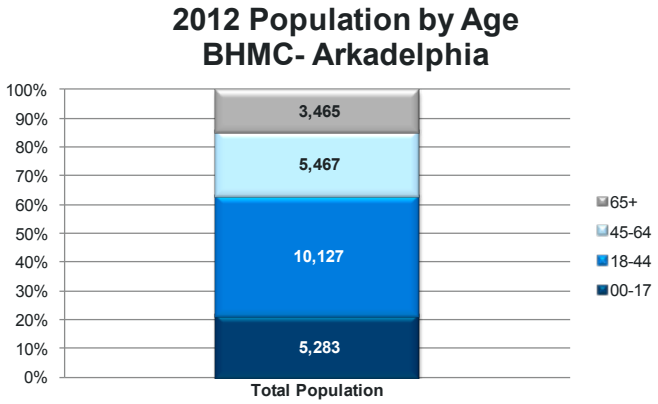
Community Served and Demographics

Given that BHMC–Arkadelphia is a critical-access hospital, the community served is defined as Clark County.

Ten ZIP codes constitute the community served for BHMC–Arkadelphia. A detailed list of the ZIP codes can be found in the **Baptist Health Medical Center-Arkadelphia Appendix.** Below is a map that illustrates the BHMC–Arkadelphia community served (red).

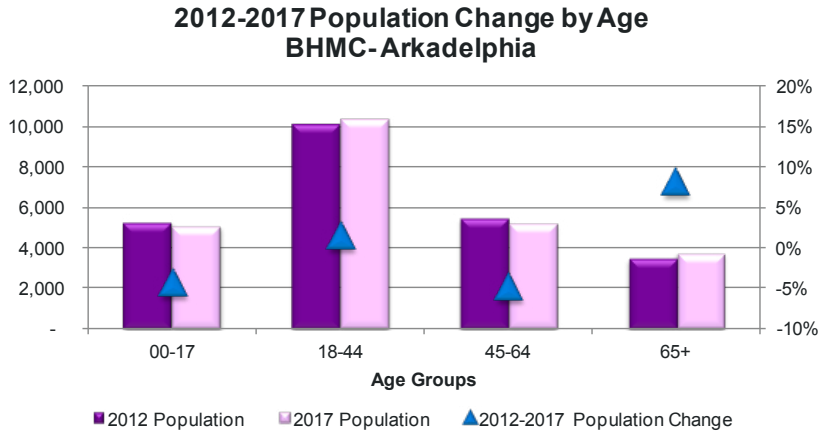


The BHMC–Arkadelphia community served population is approximately 24,342. By 2017, this population is projected to decrease by 0.2 percent. The largest portion of the population is made up of white non-Hispanics (17,297). The largest growth in population will take place among Hispanics (+170 individuals) between 2012 and 2017.



The 18-44 age group constitutes the largest portion of the BHMC–Arkadelphia community served, followed by the 45-64 age group.

By 2017, the 65 plus population will have the largest percentage of growth.



The median household income for the BHMC–Arkadelphia community served is $32,835. More than 42 percent of individuals have private insurance — either employer-sponsored insurance (38 percent) or individually purchased (4 percent). Another 15 percent are covered by Medicaid, 26 percent are uninsured and 17 percent are covered by Medicare or are Medicare dual eligible.

Interviews & Focus Groups

Interviewees and focus group participants were categorized into representative groups. In the chart below, an "I" indicates an interview and "FG" indicates participation in a focus group. For individuals outside Baptist Health, representative organizations have been listed.

Community Leaders/ Groups	Public and Other Organizations			Other Providers	Baptist Health
Dixon, Martha (BHMC-A Advisory Board Member/ Retired, FG)	Bolt, Jimmy (State of Arkansas, I)	Loe, Shelley (Chamber of Commerce, I)	Wheeler, Gary (Arkansas Department of Health, I)	Jackson, Cindy (Clark County Charitable Health Service, I)	Stubblefield, Greg (BHMC-A, I & FG)
Jester, Becky (BHMC-A Advisory Board Member/ Retired, FG)	Wright, Patricia (Arkadelphia School Districts and Community Family Enrichment Center, FG)	Watson, Sandra (Clark County, FG)	Clark, Marilyn (American Heart Assoc/ American Stroke Assoc, I)		Sanford, Mark (BHMC-A, I)
Thompson, M.D., Joe (AR Surgeon General/ AR Ctr for Health Improvement, I)	Winkelmeyer, Cassie (Gurdon School District, FG)	Carrier, Shawnie (Regional Economic Development Alliance, I)	Halverson, Paul (Arkansas Department of Health, I)		Jones, Bobby (BHMC-A, I)
Horne, Rex (BHMC Board Member/ Baptist Church, I)	Watson, Jason (Clark County Sheriff, FG)	Loden, Kathy (Clark County Health Department, I)	Farr, Jack (Department of Human Services, FG)		Hendrix, Sheree (BHMC-A, I)

The individuals highlighted in purple indicate Health Department representatives (local, regional, or state), as well as individuals representing or serving medically underserved, low-income, or minority populations.

In the interview process, the majority of individuals said the current health status of the community is "fair" or "poor." The major issue contributing to this is the lack of physicians.

For the BHMC–Arkadelphia community, the top health needs identified in the interview process include:

1. Obesity
2. Chronic Diseases
3. Dental
4. Affordable Care
5. Food/Nutrition
6. Healthcare Providers/Services

Barriers to good health care in this community include socioeconomic factors, health education, affordability of care, insurance coverage, access, lifestyle choices, and culture. Children/teens, elderly and minority populations were identified as top vulnerable groups that will need special attention when addressing health needs.

Focus group participants were asked to grade the health of the community based on an A-F scale, provide feedback in terms of that grade, and work in small groups to determine the top three health needs of the community. For the BHMC–Arkadelphia group, the average grade for the health of the community was a C. Much of this was attributed to poverty levels, obesity rates, lifestyle choices, access to healthcare, and the environment.

The focus group split into two smaller groups to determine the top three health needs of the community. Group 1 selected economic status, access to healthy foods/affordability, and lifestyle (Southern culture). Group 2 selected finances/affordability, nutrition/obesity, and lifestyle/learned behaviors.

In the same small groups, focus group participants were asked to identify community resources that could help address the health issues in the community. Some of the resources identified include:

• Churches	• CFEC	• United way
• Boys and Girls Club	• Health Departments	• Rainbow
• CADC	• Civic Clubs	• AR Promise
• Head Start	• SCAT	• American Legion
• Henderson State University	• Education System	• Food Pantries

The Baptist Health Medical Center-Arkadelphia Appendix includes a more comprehensive list of existing community resources available to address the health needs of the community.

Health Indicators

While the community served was defined at the ZIP code level, the most geographically detailed health indicators were only available at the county level. For that reason, health indicators for BHMC–Arkadelphia were evaluated for Clark County. This county represents the ZIP codes within the community served.

Health needs for this county that did not meet the state benchmark include:

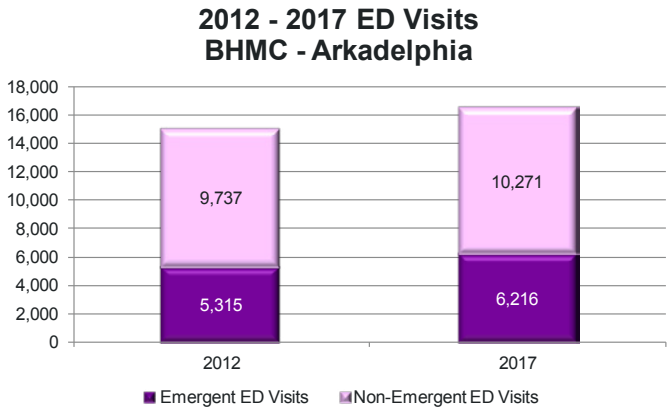
Cause of Death	**Chronic Conditions**	**Access**
• Stroke	• Hypertension	• Uninsured
• Diabetes	• Asthma	• Lack of PCPs
Health Outcomes	• Diabetes	**Prevention**
• Poor Physical Health Days	• Arthritis	• Colorectal Screening
	Health Behaviors	• Mammography
	• Obesity	**Socioeconomic & Environment**
	• Sexually Transmitted Infections	• Single Parent HHs
		• Percentage of Fast Food Restaurants

Truven Health Analytics supplemented the publically available data with estimates of disease prevalence for heart disease and cancer, emergency department visit estimates, and the community need index.

Heart disease estimates indicate a prevalence of 8,488 cases for the BHMC–Arkadelphia community served. The majority (67 percent) of the 2011 estimates of heart disease prevalence indicate hypertension as the primary diagnosis. Other diagnoses include arrhythmias (14 percent), ischemic heart disease (13 percent), and congestive heart failure (6 percent).

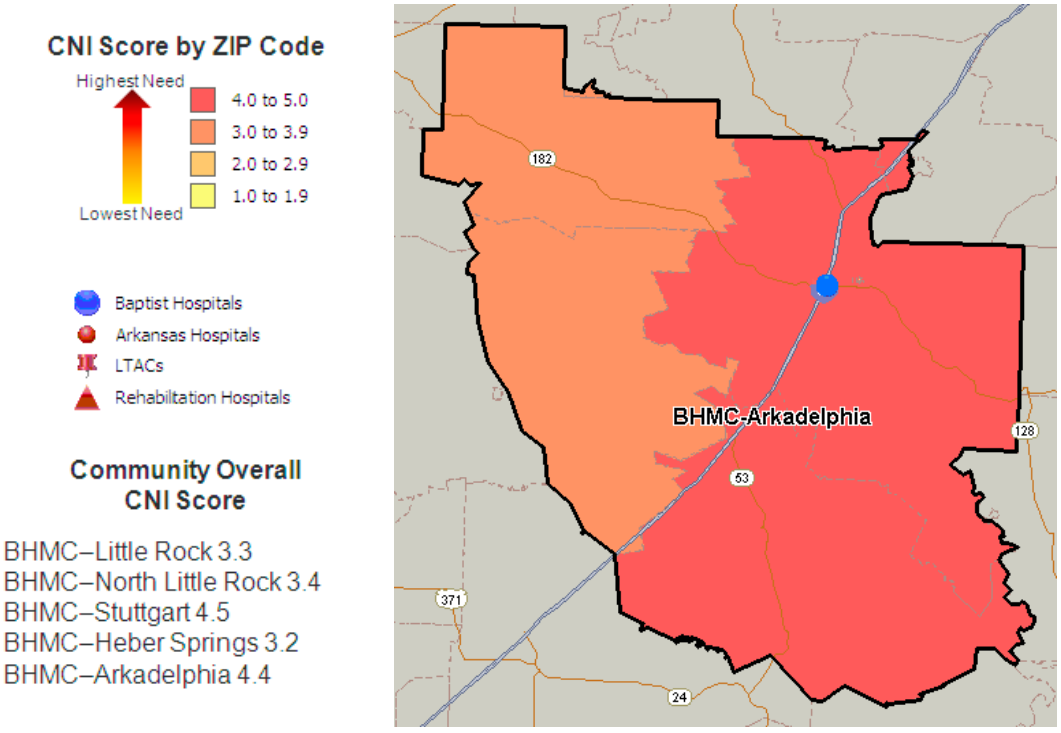
The 2011 cancer incidence estimates reveal an estimated 159 new cancer cases — the highest incidence being prostate cancer.

Emergency department visits are slated to grow by approximately 1,500 visits between 2012 and 2017.



The Truven Health Community Need Index (CNI) is a statistical approach to identifying health needs in a community. The CNI takes into account vital socio-economic factors (income, cultural, education, insurance, and housing) about a community to generate a CNI score for every populated ZIP code in the United States. The CNI is strongly linked to variations in community healthcare needs and is a strong indicator of a community's demand for various healthcare services.

The BHMC-Arkadelphia community served had a CNI of 4.4 on a scale of 1.0 (lowest needs) – 5.0 (highest needs). Compared to the other Baptist Health communities, BHMC–Arkadelphia has the second highest need.



Prioritized Health Needs

From the BHMC–Arkadelphia campus, Greg Stubblefield, vice president/administrator; and Sheree Hendrix, director of Nursing, participated in the prioritization meeting.

Using the criteria selected by the larger group, the five health needs that scored the highest in the prioritization process for BHMC–Arkadelphia were:

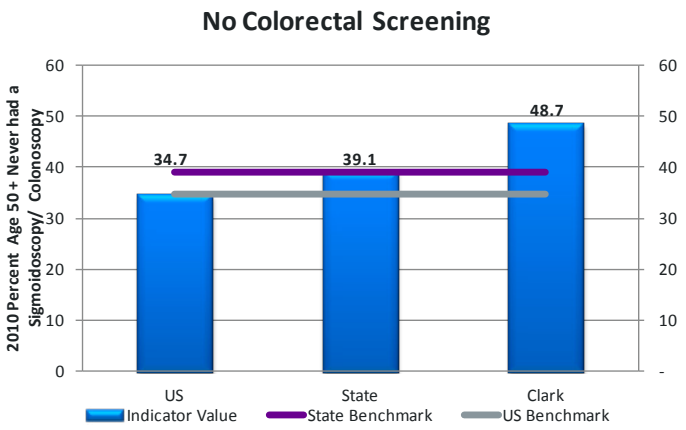
1. Colorectal Screening
2. Mammograms
3. Stroke
4. Lack of Primary Care Physicians
5. Hypertension

HEALTH NEED	BHMC Arkadelphia
Cause of Death	
• Stroke	X
• Diabetes	X
Health Outcomes	
• Poor Physical Health & Mental Health Days	X
Chronic Conditions	
• Hypertension	X
• Asthma	X
• Diabetes	X
• Arthritis	X
Health Behaviors	
• Obesity	X
• Sexually Transmitted Infections	X
Prevention	
• Colorectal Screening	X
• Mammography	X
Access	
• Lack of PCPs	X
• Uninsured	X
Socioeconomic & Environment	
• Children in Single-Parent HHs	X
• Percentage of Fast Food Restaurants	X

The table to the left indicates the health needs identified for the BHMC-Arkadelphia community. The highlighted boxes are the five health needs that scored the highest in the prioritization process.

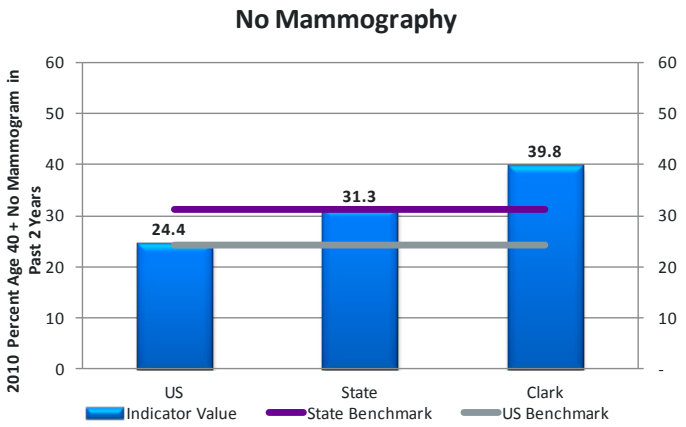
Even though the highlighted health needs had the highest scores, the needs that will actually be addressed for the purposes of the CHNA are at the discretion of BHMC-Arkadelphia.

For each of the prioritized health needs, the comparative benchmark graph has been provided to illustrate gaps between county indicators for the community served and the state benchmark (purple).



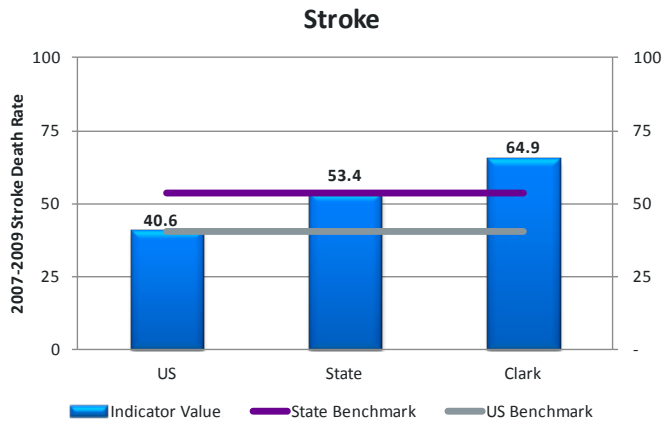
Source: Arkansas Department of Health BRFSS

Notes: Percent of adults age 50+ that report never having had a sigmoidoscopy or colonoscopy



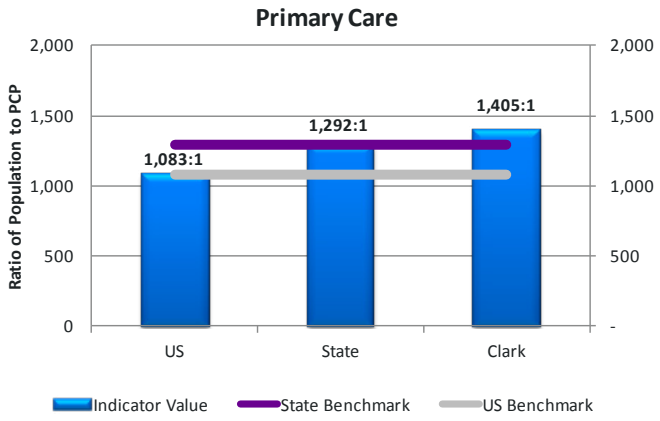
Source: Arkansas Department of Health BRFSS

Notes: Percent of women age 50+ that report no mammogram in The past 2 years



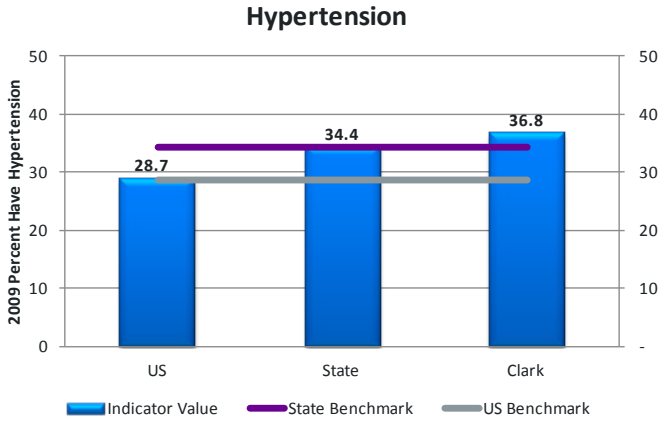
Source: National Vital Statistics System-Mortality (CDC, NCHS)

Notes: 2007-2009 Stroke death rate (per 100,000)



Source: County Health Rankings (Health Resources & Services Administration)

Notes: Ratio of population to primary care physicians



Source: Arkansas Department of Health BRFSS

Notes: Percent of adults that report having been diagnosed with high blood pressure

Summary

The community health needs assessment for the BHMC–Arkadelphia community served revealed a number of health issues related to disease management, preventive care, access issues, and socioeconomic or environmental factors. By weighing the qualitative feedback and the quantitative data, along with the prioritization criteria, the top health needs identified include colorectal screening, mammograms, stroke, lack of primary care physicians, and hypertension.

BHMC–Arkadelphia will be working with internal stakeholders to determine the community health needs to be addressed. With the goal of improving the health of the community, implementation plans with specific tactics and time frames will be developed to address these health needs.

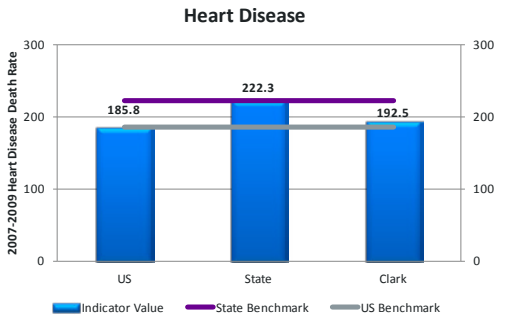
Baptist Health Medical Center–Arkadelphia Appendix

BHMC-Arkadelphia Community Served Definition ZIP Code Table

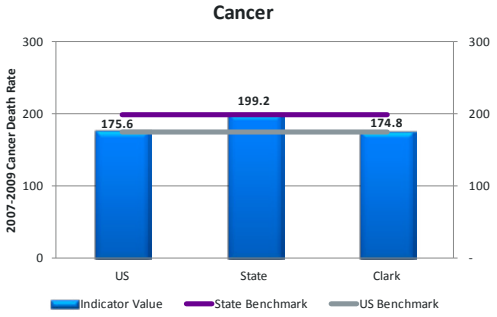
BAPTIST HEALTH COMMUNITY	ZIP	PONAME	COUNTY NAME	CBSANAME
BHMC-Arkadelphia	71721	Gurdon	Clark, AR	Arkadelphia, AR Micro
BHMC-Arkadelphia	71728	Gurdon	Clark, AR	Arkadelphia, AR Micro
BHMC-Arkadelphia	71743	Gurdon	Clark, AR	Arkadelphia, AR Micro
BHMC-Arkadelphia	71772	Gurdon	Clark, AR	Arkadelphia, AR Micro
BHMC-Arkadelphia	71920	Amity	Clark, AR	Arkadelphia, AR Micro
BHMC-Arkadelphia	71921	Amity	Clark, AR	Arkadelphia, AR Micro
BHMC-Arkadelphia	71923	Arkadelphia	Clark, AR	Arkadelphia, AR Micro
BHMC-Arkadelphia	71962	Okolona	Clark, AR	Arkadelphia, AR Micro
BHMC-Arkadelphia	71998	Arkadelphia	Clark, AR	Arkadelphia, AR Micro
BHMC-Arkadelphia	71999	Arkadelphia	Clark, AR	Arkadelphia, AR Micro

Health Indicator Analysis

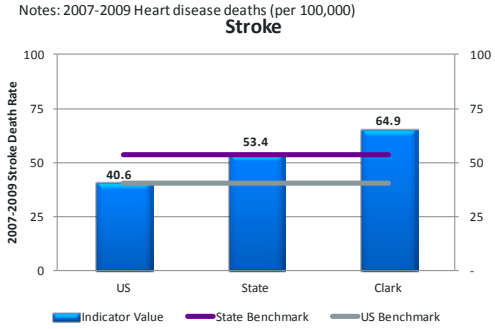
BHMC ARKADELPHIA:CAUSE OF DEATH



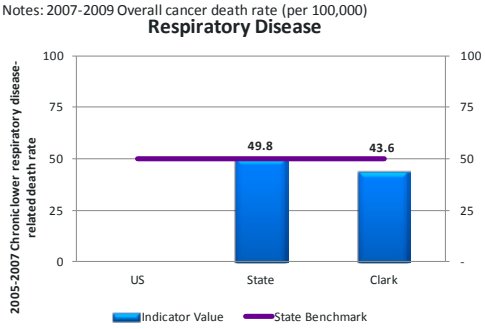
Source: National Vital Statistics System-Mortality (CDC, NCHS)
Notes: 2007-2009 Heart disease deaths (per 100,000)



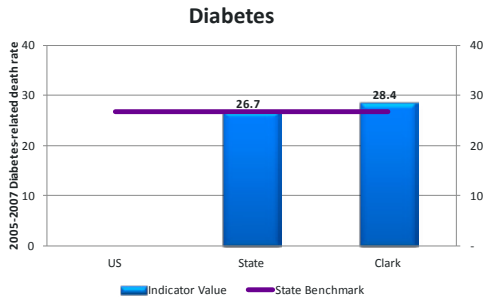
Source: National Vital Statistics System-Mortality (CDC, NCHS)
Notes: 2007-2009 Overall cancer death rate (per 100,000)



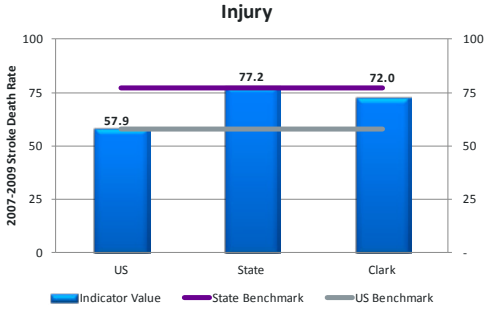
Source: National Vital Statistics System-Mortality (CDC, NCHS)
Notes: 2007-2009 Stroke death rate (per 100,000)



Source: Health Statistics Branch, ADH
Notes: 2005-2007 Chronic lower respiratory disease-related deaths (per 100,000)



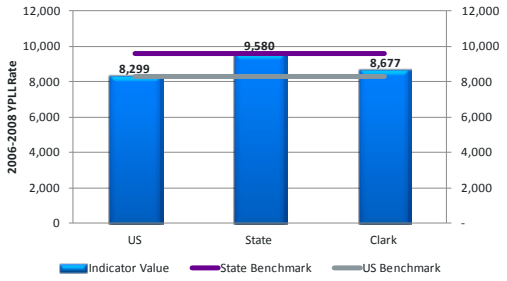
Source: Health Statistics Branch, ADH
Notes: 2005-2007 Diabetes-related deaths (per 100,000)



Source: National Vital Statistics System-Mortality (CDC, NCHS)
Notes: 2007-2009 Injury death rate (per 100,000)

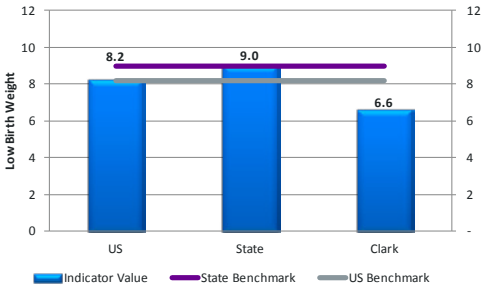
BHMC ARKADELPHIA: HEALTH OUTCOMES

Premature Deaths



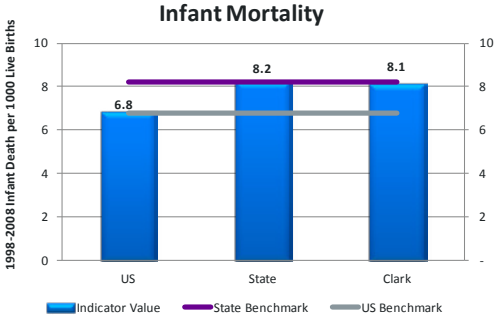
Source: County Health Rankings (NCHS)
Notes: Years of potential life lost before the age of 75 per 100,000 population

Low Birth Weight



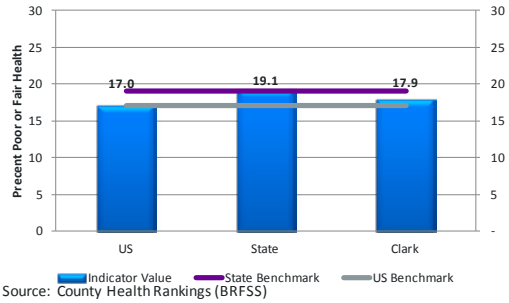
Source: County Health Rankings (NCHS)
Notes: Percent of live births with low birth weight (< 2500 grams)

Infant Mortality



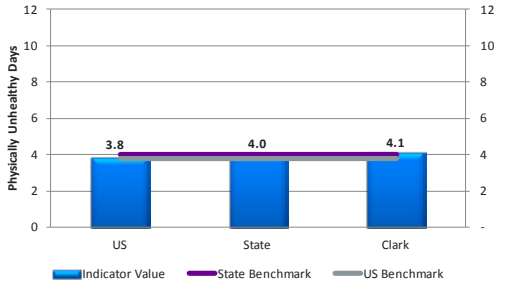
Source: Linked Birth/Infant Death Data Set (CDC-NCHS)
Notes: Rate of all infant deaths (within 1 year), per 1,000 live births

Poor or Fair Health



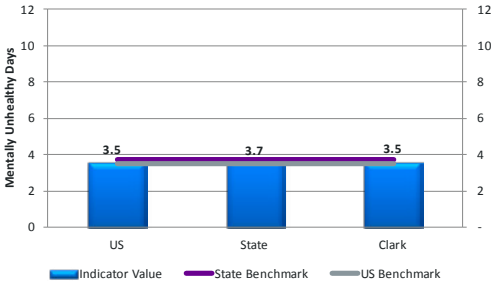
Source: County Health Rankings (BRFSS)
Notes: Percent of adults reporting fair or poor health (age-adjusted)

Poor Physical Health Days



Source: County Health Rankings (BRFSS)
Notes: Average number of physically unhealthy days reported in past 30 days (age-adjusted)

Poor Mental Health Days

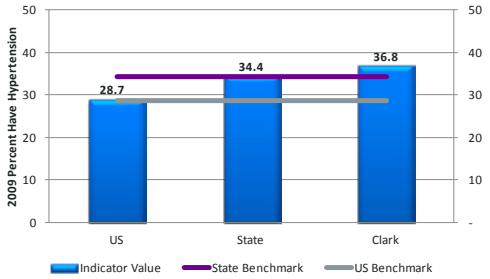


Source: County Health Rankings (BRFSS)
Notes: Average number of mentally unhealthy days reported in past 30 days (age-adjusted)

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

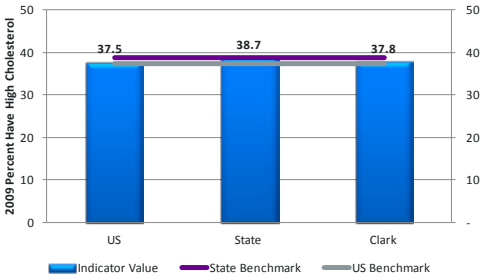
BHMC ARKADELPHIA: CHRONIC CONDITIONS

Hypertension



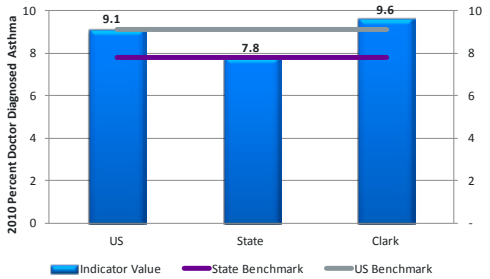
Source: Arkansas Department of Health BRFSS
Notes: Percent of adults that report having been diagnosed with high blood pressure

High Cholesterol



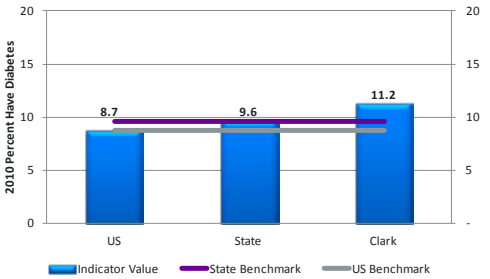
Source: Arkansas Department of Health BRFSS
Notes: Percent of adults that report having been diagnosed with high blood cholesterol

Asthma



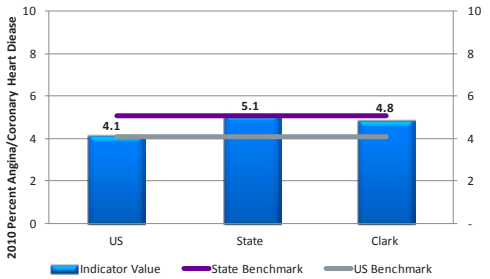
Source: Arkansas Department of Health BRFSS
Notes: Percent of adults that report having been diagnosed with asthma

Diabetes



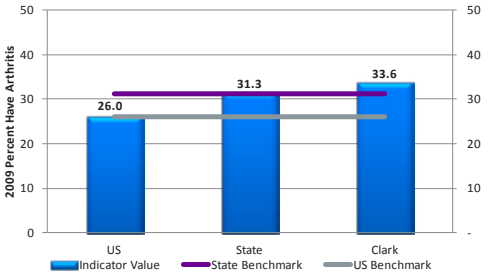
Source: Arkansas Department of Health BRFSS
Notes: Percent of adults that report having been diagnosed as having diabetes

Coronary Heart Disease



Source: Arkansas Department of Health BRFSS
Notes: Percent of adults that report having been diagnosed as having Coronary Heart Disease

Arthritis

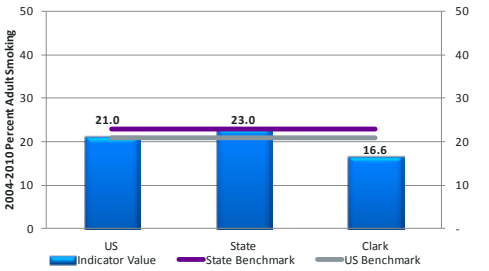


Source: Arkansas Department of Health BRFSS
Notes: Percent of adults that report having been diagnosed as having Arthritis

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

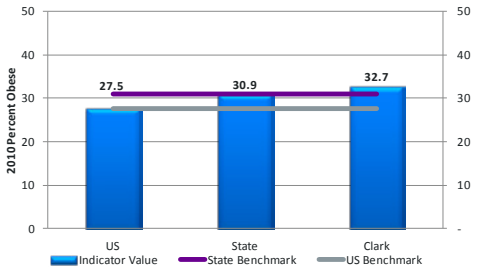
BHMC ARKADELPHIA: HEALTH BEHAVIORS

Adult Smoking



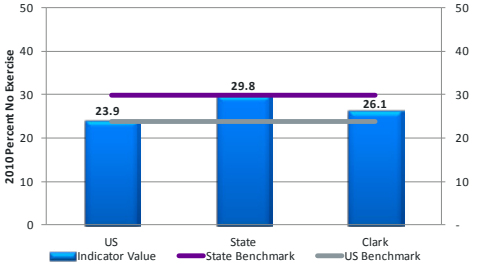
Source: County Health Rankings (BRFSS), Arkansas Department of Health BRFSS
Notes: Percent of adults 18 years+ that report currently smoking cigarettes

Adult Obesity



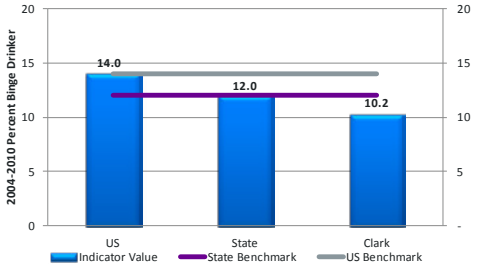
Source: Arkansas Department of Health BRFSS
Notes: Percent of adults 18 years and over that report BMI >= 30 (per self-reported weight/height)

Physical Inactivity



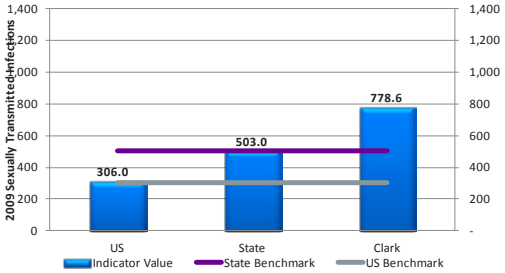
Source: Arkansas Department of Health BRFSS
Notes: Percent of Adults that report no leisure-time exercise in past month

Excessive Drinking



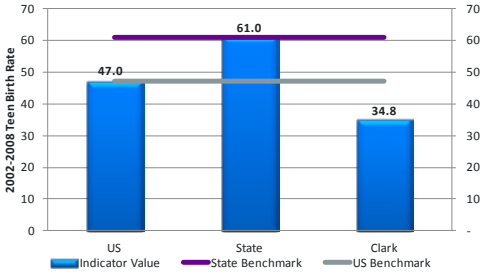
Source: County Health Rankings (BRFSS), Arkansas Department of Health BRFSS
Notes: Percent of adults 18 years and over that report binge drinking

Sexually Transmitted Infections



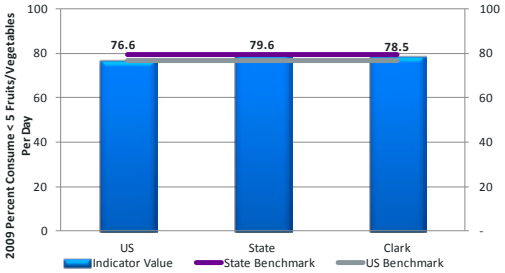
Source: County Health Rankings (BRFSS)
Notes: Chlamydia rate per 100,000 population

Teen Birth Rate



Source: County Health Rankings (BRFSS)
Notes: Percent of all live births to mothers less than 18 years of age

Lack of Healthy Eating

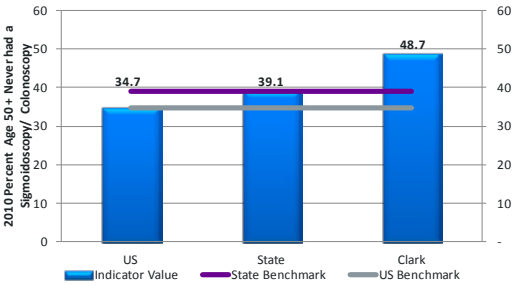


Source: Arkansas Department of Health BRFSS
Notes: Percent of Adults that report fewer than 5 servings of fruits/vegetables per day

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

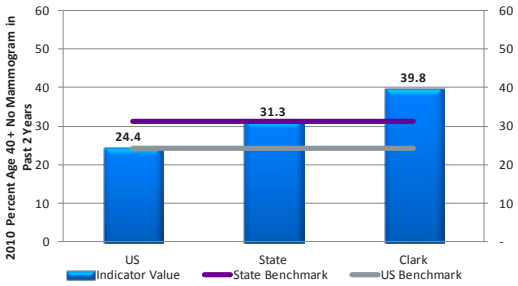
BHMC ARKADELPHIA: PREVENTION

No Colorectal Screening



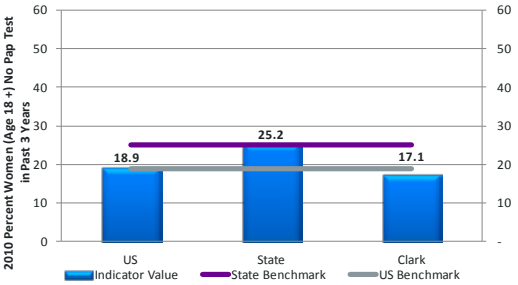
Source: Arkansas Department of Health BRFSS
Notes: Percent of adults age 50+ that report never having had a sigmoidoscopy or colonoscopy

No Mammography



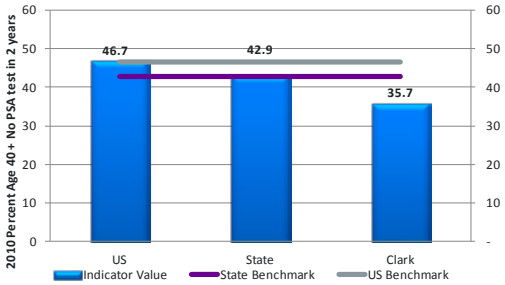
Source: Arkansas Department of Health BRFSS
Notes: Percent of women age 50+ that report no mammogram in the past 2 years

No Pap Test



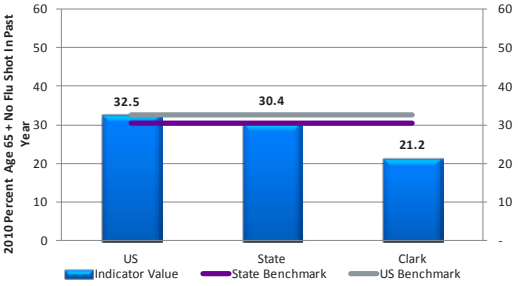
Source: Arkansas Department of Health BRFSS
Notes: Percent of women age 18+ that report no Pap test in the last 3 years

No Prostate Screening



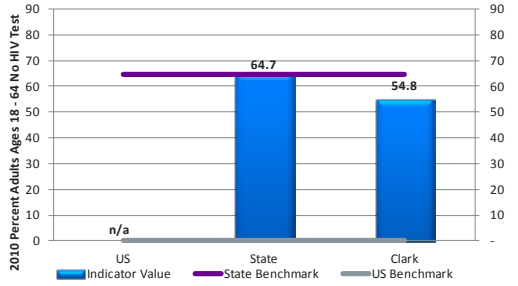
Source: Arkansas Department of Health BRFSS
Notes: Percent of men age 40+ that report no PSA test in the last 2 years

No Flu Shot



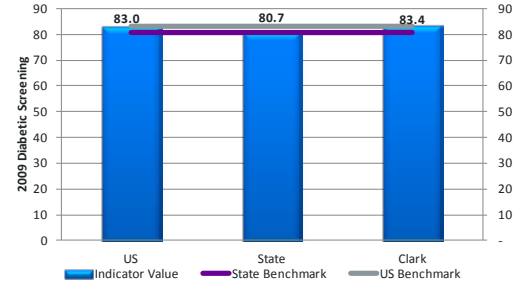
Source: Arkansas Department of Health BRFSS
Notes: Percent of adults age 65+ that report having no Influenza vaccine in past 12 months

No HIV Test



Source: Arkansas Department of Health BRFSS
Notes: Percent of adults age 18-64 that report having never having an HIV test

Diabetic Screening

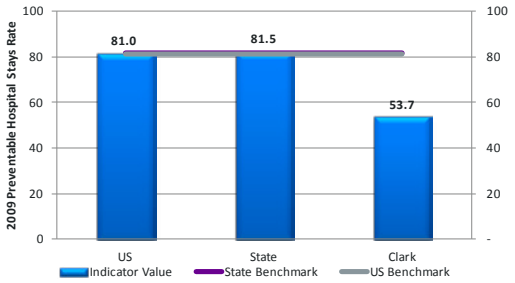


Source: County Health Rankings (Medicare/Dartmouth Institute)
Notes: Percent of diabetic Medicare enrollees that receive HbA1c screening

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

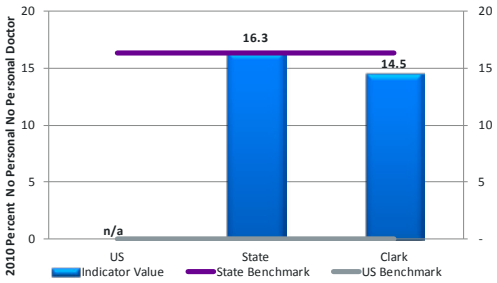
BHMC ARKADELPHIA: ACCESS

Preventable Hospital Stays



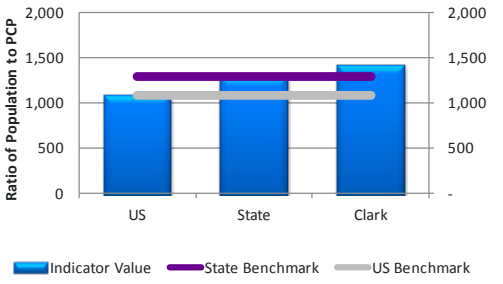
Source: County Health Rankings (Medicare/Dartmouth Institute)
Notes: Hospitalization rate for ambulatory-care sensitive conditions per 1,000 Medicare enrollees

Personal Doctor



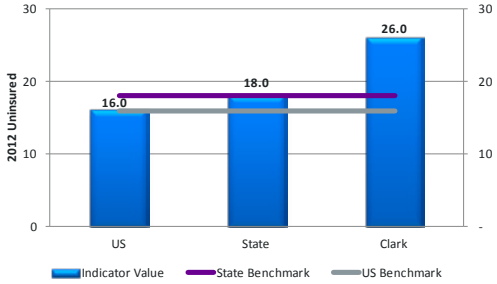
Source: Arkansas Department of Health BRFSS
Notes: Percent of adults age 18+ that report having no personal doctors

Primary Care



Source: County Health Rankings (Health Resources & Services Administration)
Notes: Ratio of population to primary care physicians

Uninsured

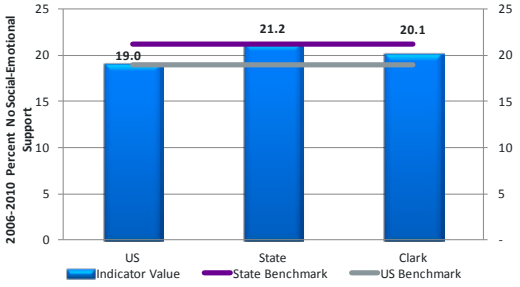


Source: Truven Health (Insurance Coverage Estimates)
Notes: Percent uninsured

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

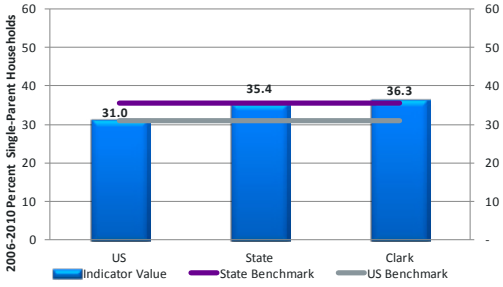
BHMC ARKADELPHIA: SOCIOECONOMIC

Inadequate Social Support



Source: County Health Rankings (BRFSS)
Notes: Percent of adults without social/emotional support

Children in Single Parent Households

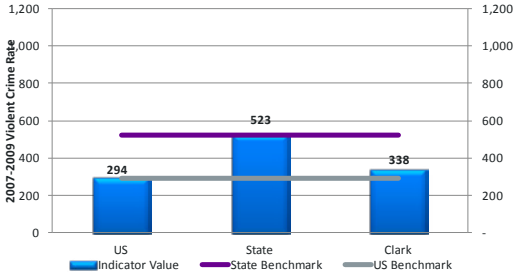


Source: County Health Rankings (BRFSS)
Notes: Percent of children that live in household headed by single parent

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

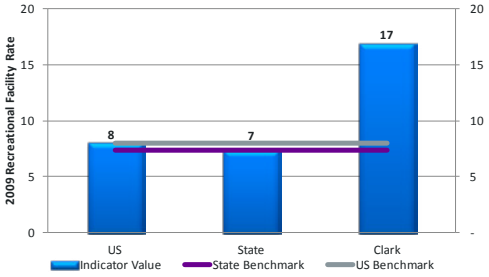
BHMC ARKADELPHIA: ENVIRONMENT

Violent Crime



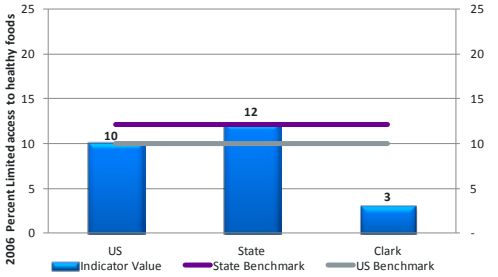
Source: County Health Rankings (BRFSS)
Notes: Violent crime rate per 100,000 population

Recreational Facilities



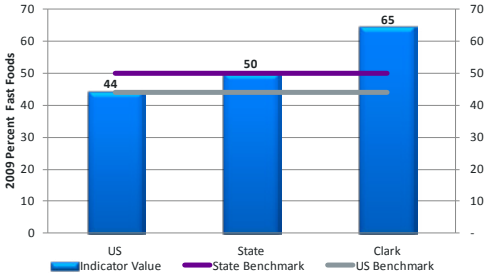
Source: County Health Rankings (Census County Business Patterns)
Notes: Rate of recreational facilities per 100,000 population

Access to Healthy Foods



Source: CHR (USDA)
Notes: Percent of population who are low-income and do not live close to a grocery store

Fast Food Restaurants



Source: CHR (USDA)
Notes: Percent of all restaurants that are fast-food establishments

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

Community Need Index (CNI)

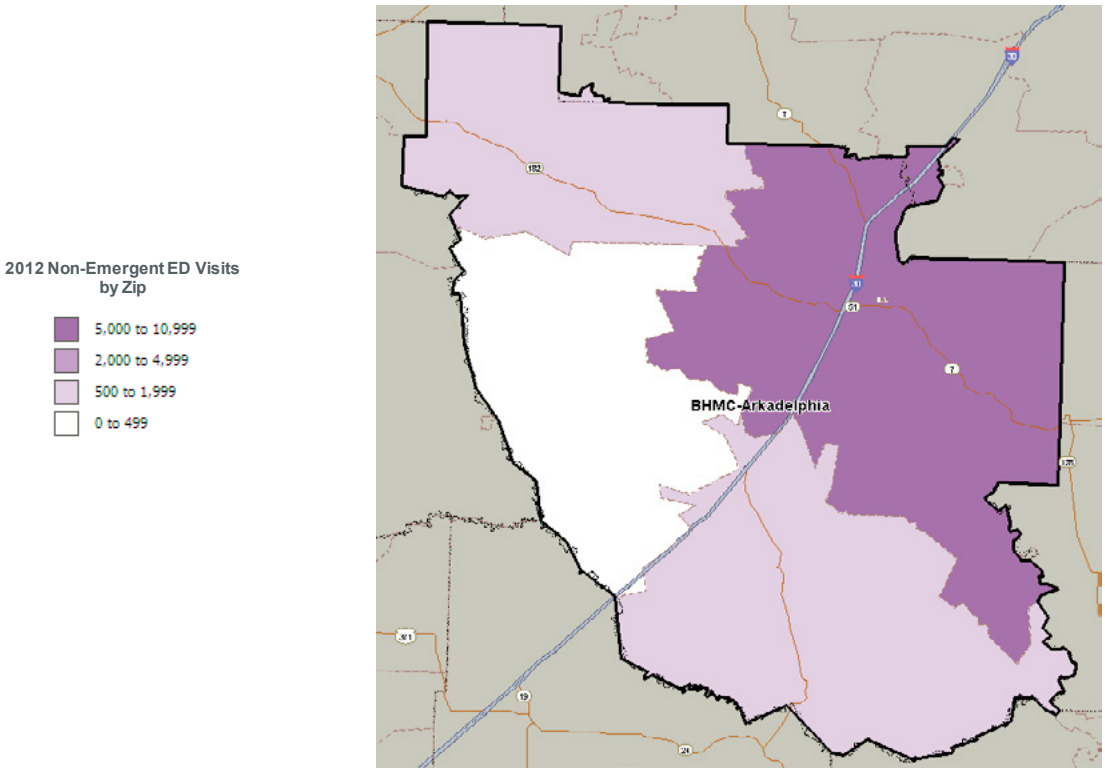
BHMC – ARKADELPHIA
CNI BARRIER SCORE BY ZIP CODE

Baptist Health Community	Zip	2011 Population	Overall CNI Score	Income Rank	Education Rank	Culture Rank	Insurance Rank	Housing Rank
BHMC-Arkadelphia	71923	16,945	5	5	4	4	5	5
	71743	4,120	4	4	5	4	5	4
	71999	17	4	5	1	5	5	5
	71921	2,985	4	4	5	3	5	2
	71962	945	3	2	5	4	5	1
	71998	259	3	1	1	3	4	5

The CNI score is an average of five different barrier scores that measure various socio-economic indicators of each community. The CNI is strongly linked to variations in community healthcare needs and is a strong indicator of a community's demand for various healthcare services.

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BHMC – ARKADELPHIA
NON-EMERGENT ED VISITS BY ZIP

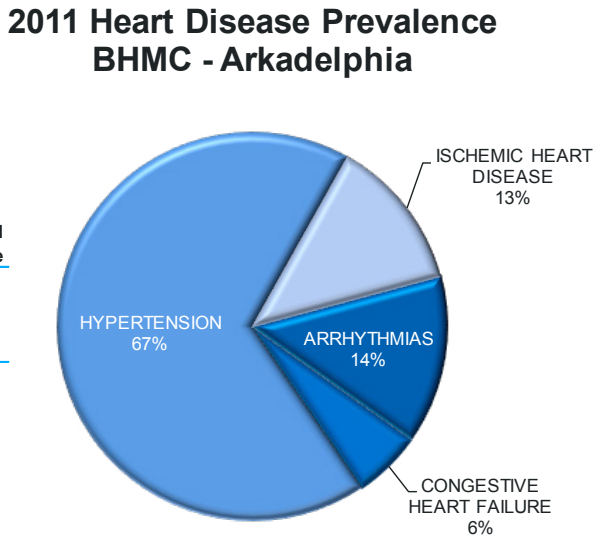


Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

Arkadelphia

Zip Code	2012 Total ED Visits	2012 Non-Emergent ED Visits	2012 % Non-Emergent	2017 Total ED Visits	2017 Non-Emergent ED Visits	2017 % Non-Emergent	2012 - 2017 % Chg Non-Emergent
71743	2,438	1,558	64%	2,620	1,614	62%	4%
71921	1,823	1,137	62%	2,062	1,234	60%	9%
71923	9,758	6,342	65%	10,678	6,684	63%	5%
71962	512	316	62%	561	332	59%	5%
71998	236	177	75%	259	191	74%	8%
71999	285	207	73%	307	216	70%	4%
Total	**15,052**	**9,737**	**65%**	**16,487**	**10,271**	**62%**	**5%**

BHMC – ARKADELPHIA
2011 ESTIMATED HEART DISEASE PREVALENCE



BHMC - Arkadelphia

Heart Disease Type	2011 Prevalence
ARRHYTHMIAS	1,188
CONGESTIVE HEART FAILURE	482
HYPERTENSION	5,740
ISCHEMIC HEART DISEASE	1,078
Grand Total	**8,488**

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

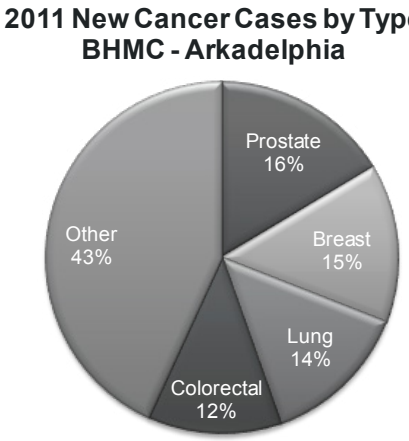
Arkadelphia

Zip Code	ARRHYTHMIAS 2011 Prevalence	CONGESTIVE HEART FAILURE 2011 Prevalence	HYPERTENSION 2011 Prevalence	ISCHEMIC HEART DISEASE 2011 Prevalence	TOTAL HEART DISEASE 2011 Prevalence
71743	202	84	967	189	1,442
71921	157	65	728	150	1,100
71923	773	310	3,765	687	5,535
71962	51	22	241	50	364
71998	5	1	36	2	44
71999	0	0	3	0	3
Total	**1,188**	**482**	**5,740**	**1,078**	**8,488**

BHMC – ARKADELPHIA
2011 ESTIMATED CANCER INCIDENCE

BHMC - Arkadelphia

Cancer Type	2011 Incidence (new Cancer cases)
PROSTATE	26
BREAST	23
LUNG	22
OTHER	20
COLORECTAL	19
NH LYMPHOMA	6
KIDNEY	5
MELANOMA	5
LEUKEMIA	5
BLADDER	5
PANCREAS	4
ORAL CAVITY	4
UTERINE	3
STOMACH	3
OVARIAN	3
BRAIN	2
THYROID	2
CERVICAL	1
Grand Total	**158**



Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

Arkadelphia

Zip Code	BREAST 2011 Incidence	COLORECTAL 2011 Incidence	LUNG 2011 Incidence	PROSTATE 2011 Incidence	OTHER 2011 Incidence
71743	4	3	4	5	12
71921	3	3	3	4	9
71923	15	12	14	16	44
71962	1	1	1	1	3
71998	0	0	0	0	0
71999	0	0	0	0	0
Total	**23**	**19**	**22**	**26**	**68**

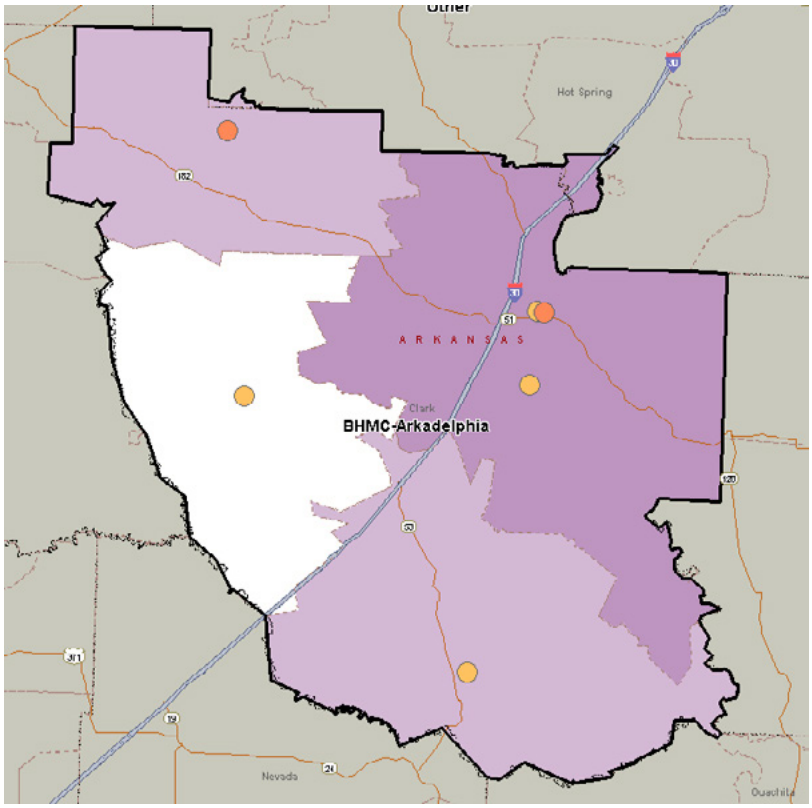
BHMC – ARKADELPHIA
2012 – 2017 TOTAL POPULATION

2012 Total Population by Zip

- 20,000 to 39,999
- 10,000 to 19,999
- 3,000 to 9,999
- 1,000 to 2,999
- 0 to 999

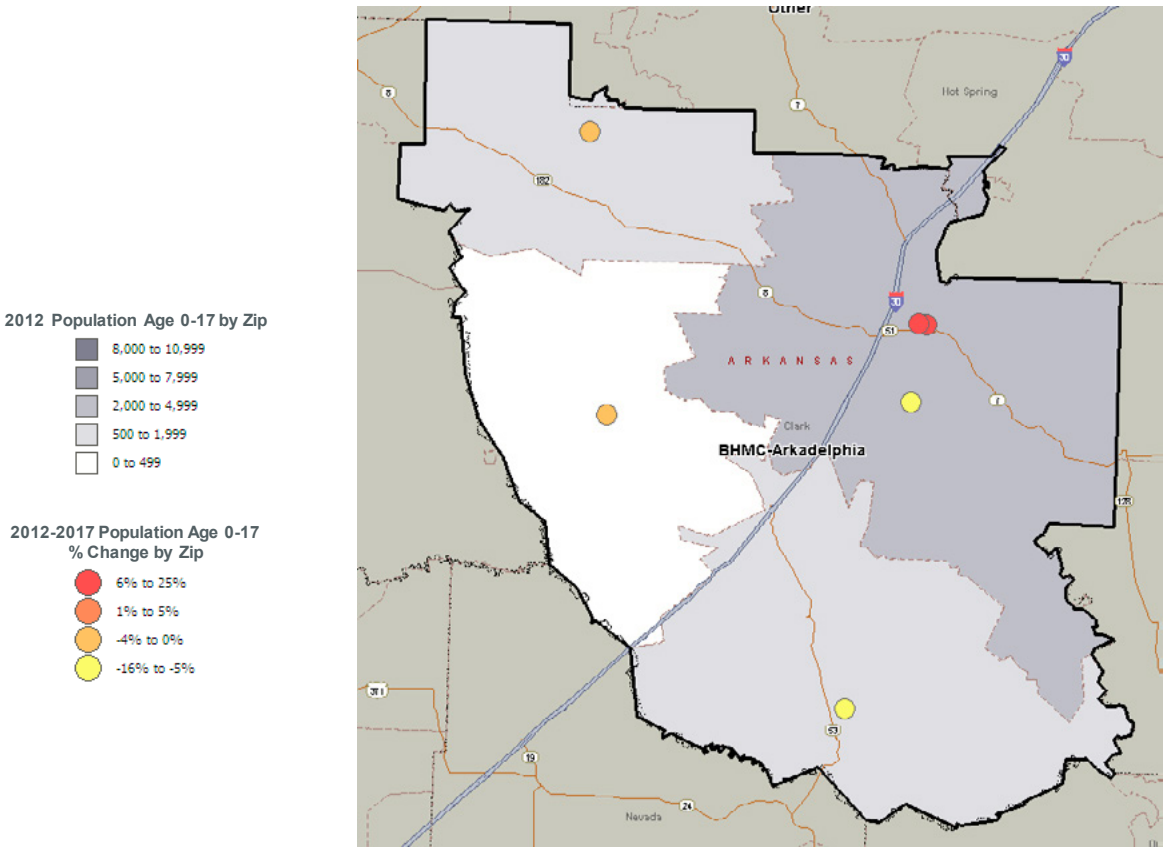
2012-2017 Population % Change by Zip

- 6% to 16%
- 1% to 5%
- -4% to 0%
- -11% to -5%



Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BHMC – ARKADELPHIA
2012 – 2017 POPULATION CHILDREN AGE 0-17

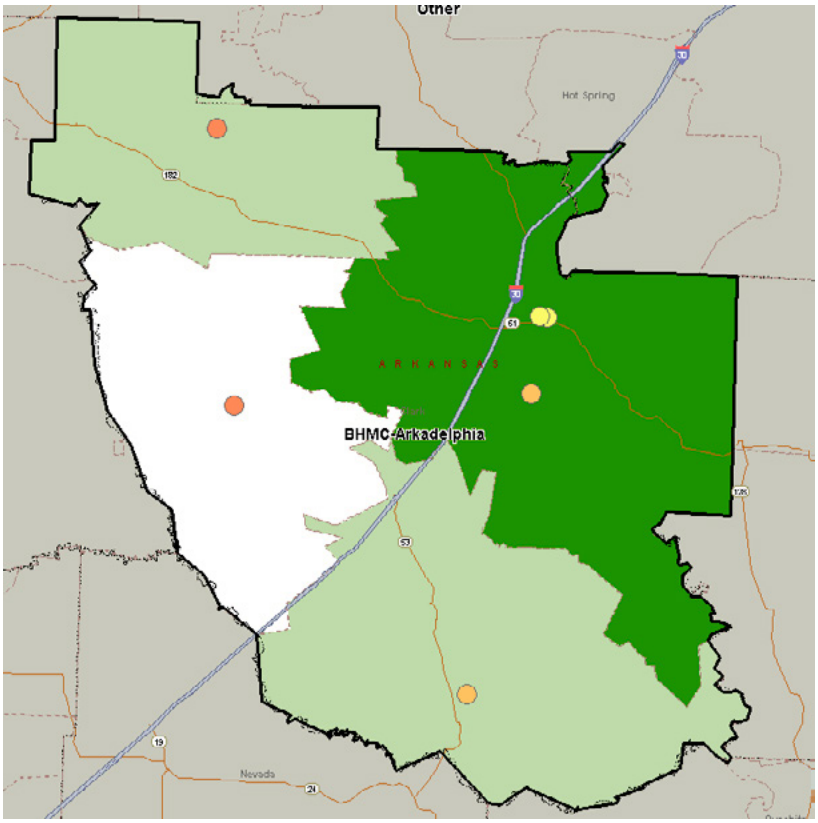


Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BHMC – ARKADELPHIA
2012 – 2017 POPULATION AGE 65+

2012 Population Age 0-17 by Zip
- 2,000 to 4,999
- 801 to 1,999
- 200 to 800
- 0 to 199

2012-2017 Population Age 0-17 % Change by Zip
- 20% to 44%
- 9% to 19%
- 1% to 8%
- -10% to 0%

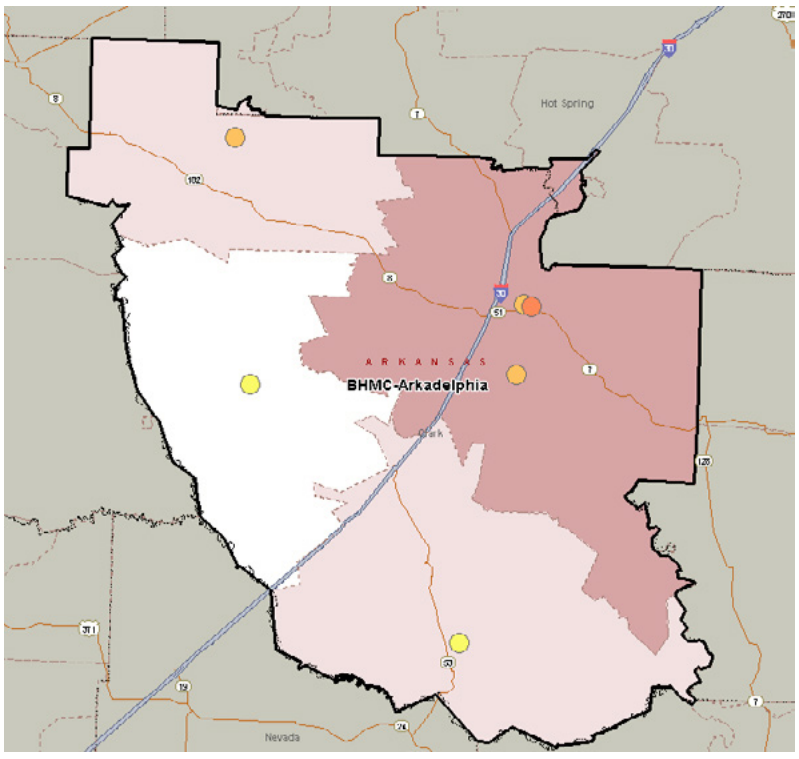


Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BHMC – ARKADELPHIA
2012–2017 POPULATION WOMEN CHILDBEARING AGE

2012 Population Women Age 15-44 by Zip
- 5,000 to 9,000
- 2,000 to 4,999
- 800 to 1,999
- 200 to 799
- 1 to 199

2012-2017 Population Women Age 15-44 % Change by Zip
- 6% to 13%
- 1% to 5%
- -4% to 0%
- -50% to -5%



Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BHMC – ARKADELPHIA
2012 – 2017 POPULATION BY AGE GROUP BY ZIP

ARKADELPHIA

Zip Code	Age Group	2000 Population	2012 Population	2017 Population	2012-2017 Change
71743	00-17	1,184	1,058	1,012	-4%
71743	18-44	1,593	1,345	1,357	1%
71743	45-64	977	1,046	980	-6%
71743	65+	662	596	640	7%
71921	00-17	686	757	744	-2%
71921	18-44	931	966	1,024	6%
71921	45-64	661	792	787	-1%
71921	65+	437	503	574	14%
71923	00-17	3,289	3,225	3,064	-5%
71923	18-44	7,352	6,902	6,993	1%
71923	45-64	3,081	3,344	3,163	-5%
71923	65+	2,346	2,189	2,337	7%
71962	00-17	200	210	202	-4%
71962	18-44	275	243	251	3%
71962	45-64	233	250	235	-6%
71962	65+	136	146	165	13%
71998	00-17	16	8	10	25%
71998	18-44	265	317	318	0%
71998	45-64	16	8	13	63%
71998	65+	13	10	9	-10%
71999	00-17	47	25	27	8%
71999	18-44	353	354	341	-4%
71999	45-64	28	27	22	-19%
71999	65+	28	21	20	-5%

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BHMC – ARKADELPHIA
2012 – 2017 WOMEN CHILDBEARING AGE BY ZIP

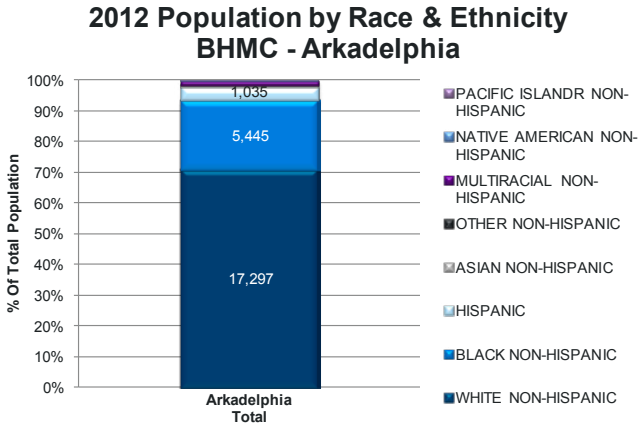
BHMC-ARKADELPHIA

Zip Code	2012 Population	2017 Population	2012-2017 Change
71743	798	763	-4%
71921	546	549	1%
71923	3,817	3754	-2%
71962	140	134	-4%
71998	153	156	2%
71999	176	171	-3%
TOTAL	**5,630**	**5,527**	**-1.8%**

Note: women childbearing age = females age 15-44

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BHMC – ARKADELPHIA
2012 POPULATION BY RACE & ETHNICITY



BHMC-Arkadelphia

Race/Ethnicity	2012 Population	2017 Population	2012-2017 Population Change	2012-2017 Population % Chg
WHITE NON-HISPANIC	17,297	16,937	(360)	-2%
BLACK NON-HISPANIC	5,445	5,562	117	2%
HISPANIC	1,035	1,205	170	16%
ASIAN NON-HISPANIC	127	122	(5)	-4%
OTHER NON-HISPANIC	28	35	7	25%
MULTIRACIAL NON-HISPANIC	317	337	20	6%
NATIVE AMERICAN NON-HISPANIC	89	85	(4)	-4%
PACIFIC ISLANDR NON-HISPANIC	4	5	1	25%
Grand Total	**24,342**	**24,288**	**(54)**	**0%**

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BHMC –ARKADELPHIA
RACE & ETHNICITY BY ZIP

BHMC-Arkadelphia

Zip Code	Ethnicity	2000 Population	2012 Population	2017 Population	2012-2017 Change
71743	ASIAN NON-HISPANIC	2	10	13	30%
71743	BLACK NON-HISPANIC	1,129	1,055	1,056	0%
71743	HISPANIC	144	420	516	23%
71743	MULTIRACIAL NON-HISPANIC	29	51	60	18%
71743	NATIVE AMERICAN NON-HISPANIC	14	10	9	-10%
71743	OTHER NON-HISPANIC	-	2	3	50%
71743	PACIFIC ISLANDR NON-HISPANIC	2	1	1	0%
71743	WHITE NON-HISPANIC	3,096	2,496	2,331	-7%
71921	ASIAN NON-HISPANIC	3	24	29	21%
71921	BLACK NON-HISPANIC	16	16	16	0%
71921	HISPANIC	78	119	141	18%
71921	MULTIRACIAL NON-HISPANIC	19	30	33	10%
71921	NATIVE AMERICAN NON-HISPANIC	17	21	22	5%
71921	OTHER NON-HISPANIC	-	3	4	33%
71921	PACIFIC ISLANDR NON-HISPANIC	-	-	-	0%
71921	WHITE NON-HISPANIC	2,582	2,805	2,884	3%
71923	ASIAN NON-HISPANIC	123	87	74	-15%
71923	BLACK NON-HISPANIC	3,803	4,087	4,199	3%
71923	HISPANIC	344	461	512	11%
71923	MULTIRACIAL NON-HISPANIC	199	214	220	3%
71923	NATIVE AMERICAN NON-HISPANIC	66	50	47	-6%
71923	OTHER NON-HISPANIC	3	20	27	35%
71923	PACIFIC ISLANDR NON-HISPANIC	6	2	3	50%
71923	WHITE NON-HISPANIC	11,524	10,739	10,475	-2%

BHMC-Arkadelphia

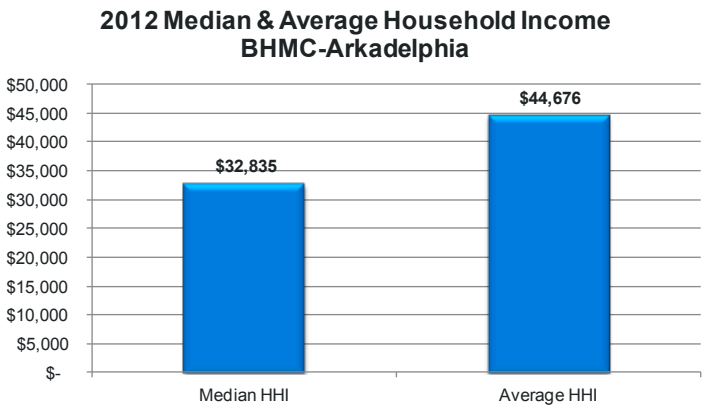
Zip Code	Ethnicity	2000 Population	2012 Population	2017 Population	2012-2017 Change
71962	ASIAN NON-HISPANIC	-	-	2	0%
71962	BLACK NON-HISPANIC	148	129	123	-5%
71962	HISPANIC	7	13	14	8%
71962	MULTIRACIAL NON-HISPANIC	13	14	15	7%
71962	NATIVE AMERICAN NON-HISPANIC	3	1	1	0%
71962	OTHER NON-HISPANIC	-	1	-	-100%
71962	PACIFIC ISLANDR NON-HISPANIC	-	-	-	0%
71962	WHITE NON-HISPANIC	673	691	698	1%
71998	ASIAN NON-HISPANIC	5	1	1	0%
71998	BLACK NON-HISPANIC	17	43	51	19%
71998	HISPANIC	4	5	7	40%
71998	MULTIRACIAL NON-HISPANIC	4	3	4	33%
71998	NATIVE AMERICAN NON-HISPANIC	-	3	2	-33%
71998	OTHER NON-HISPANIC	1	2	1	-50%
71998	PACIFIC ISLANDR NON-HISPANIC	-	-	-	0%
71998	WHITE NON-HISPANIC	279	286	284	-1%
71999	ASIAN NON-HISPANIC	14	5	3	-40%
71999	BLACK NON-HISPANIC	101	115	117	2%
71999	HISPANIC	18	17	15	-12%
71999	MULTIRACIAL NON-HISPANIC	3	5	5	0%
71999	NATIVE AMERICAN NON-HISPANIC	4	4	4	0%
71999	OTHER NON-HISPANIC	1	-	-	0%
71999	PACIFIC ISLANDR NON-HISPANIC	1	1	1	0%
71999	WHITE NON-HISPANIC	314	280	265	-5%

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BHMC – ARKADELPHIA
HOUSEHOLD INCOME

BHMC-ARKADELPHIA

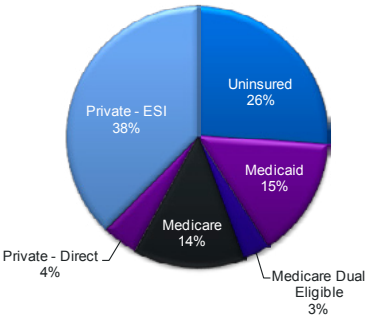
Zip Code	2012 Total Households	2012 Average Household Income	2012 Median Household Income
71743	1,673	$40,655	$32,814
71921	1,193	$42,104	$31,658
71923	5,993	$41,882	$31,363
71962	361	$41,690	$33,673
71998	43	$64,767	$42,500
71999	92	$36,957	$25,000



Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BHMC – ARKADELPHIA
INSURANCE COVERAGE

2012 Insurance Coverage by Insurance Type
BHMC Arkadelphia



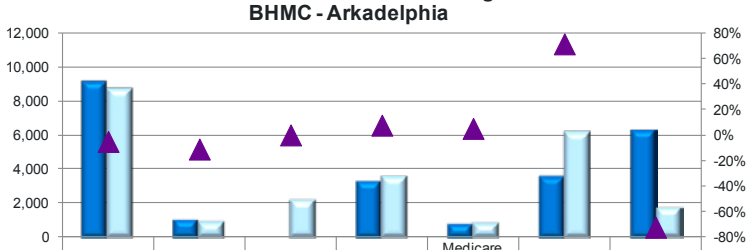
Private ESI (Employer Sponsored Insurance) = Plans offered through an employer

Private Exchanges = Plans purchased via an insurance exchange or insurance market place

Medicare Dual Eligible = Medicare enrollees receiving additional benefits via Medicaid

Private Direct = Individuals who purchase insurance directly from an insurance provider

2012 - 2017 Insurance Coverage
BHMC - Arkadelphia



	Private ESI	Private Direct	Private Exchange	Medicare	Medicare Dual Eligible	Medicaid	Uninsured
2012 Covered Lives	9,153	1,082	0	3,309	838	3,621	6,339
2017 Covered Lives	8,683	962	2,241	3,562	881	6,204	1,755
% Chg	-5%	-11%	0%	8%	5%	71%	-72%

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BHMC – ARKADELPHIA
INSURANCE COVERAGE BY ZIP

BHMC-Arkadelphia

Zip Code	Insurance Type	2012 Covered Lives	2017 Covered Lives	% Chg
71743	Private - ESI	1,666	1,550	-7%
71743	Private - Direct	196	172	-12%
71743	Private - Exchange	0	334	N/A
71743	Medicare	570	610	7%
71743	Medicare Dual Eligible	143	149	4%
71743	Medicaid	534	899	68%
71743	Uninsured	935	275	-71%
71921	Private - ESI	1,156	1,129	-2%
71921	Private - Direct	136	125	-8%
71921	Private - Exchange	0	255	N/A
71921	Medicare	484	548	13%
71921	Medicare Dual Eligible	118	130	10%
71921	Medicaid	409	718	76%
71921	Uninsured	715	226	-68%
71923	Private - ESI	5,634	5,346	-5%
71923	Private - Direct	667	591	-11%
71923	Private - Exchange	0	1,497	N/A
71923	Medicare	2,086	2,219	6%
71923	Medicare Dual Eligible	535	557	4%
71923	Medicaid	2,449	4,197	71%
71923	Uninsured	4,289	1,151	-73%

BHMC-Arkadelphia

Zip Code	Insurance Type	2012 Covered Lives	2017 Covered Lives	% Chg
71962	Private - ESI	328	307	-6%
71962	Private - Direct	38	34	-11%
71962	Private - Exchange	0	68	N/A
71962	Medicare	141	158	12%
71962	Medicare Dual Eligible	33	36	9%
71962	Medicaid	112	188	68%
71962	Uninsured	196	62	-68%
71998	Private - ESI	202	198	-2%
71998	Private - Direct	25	23	-8%
71998	Private - Exchange	0	37	N/A
71998	Medicare	8	9	13%
71998	Medicare Dual Eligible	3	3	0%
71998	Medicaid	38	65	71%
71998	Uninsured	67	13	-81%
71999	Private - ESI	167	153	-8%
71999	Private - Direct	20	17	-15%
71999	Private - Exchange	0	50	N/A
71999	Medicare	20	18	-10%
71999	Medicare Dual Eligible	6	6	0%
71999	Medicaid	79	137	73%
71999	Uninsured	137	28	-80%
BHMC- Arkadelphia Total		**24,342**	**24,288**	**0%**

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

Interview & Focus Group Analysis

INTERVIEW ANALYSIS APPROACH

- Coded participants and consolidated interview responses
- Participant responses were parsed by question/topic and categorized
    - Participants gave multiple responses per question – each response recorded individually
    - Therefore, response count can be greater than number of participants
- Density analysis conducted on responses by category

Interview questions were designed to approach some subjects in a multitude of ways and give the interviewer flexibility in conducting the interview. Therefore not every question is represented with a response table as some question responses were collapsed while others eliminated due to time constraints. Additionally some questions were not designed for response consolidation but used to inform other sections of the analysis.

BHMC ARKADELPHIA INTERVIEW SUMMARY

Questions 1 and 2 were background/ice-breaker questions regarding the community or organization each person represented.

03. What would you say is the current health status of the community?

Response Category	Response Count	Percent of Responses
Fair	4	36%
Poor	3	27%
Good	2	18%
Excellent	1	9%
Very Good	1	9%
Grand Total	**11**	**100%**

03a. Reasoning?

Response Category	Response Count	Percent of Responses
Lack of Physicians	2	29%
Other	2	29%
Unhealthy Population	1	14%
Prevention/Lifestyle	1	14%
Lower Socioeconomic Status	1	14%
Grand Total	**7**	**100%**

04. Top health needs of the community?

Response Category	Response Count	Percent of Responses
Obesity	5	13%
Chronic Diseases	3	8%
Dental	3	8%
Affordable Care	3	8%
Food/Nutrition	3	8%
Healthcare Providers/Services	3	8%
Diabetes	2	5%
Alcohol/Drug Abuse	2	5%
Care Coordination	2	5%
Mental Health	2	5%
Access	2	5%
Smoking	2	5%
Prevention/Lifestyle Modification	2	5%
Medications	1	3%
Sexual Health	1	3%
Other	1	3%
Primary Care/PCPs	1	3%
Prenatal	1	3%
Cardiovascular	1	3%
Grand Total	**40**	**100%**

4b. What healthcare services are missing?

Response Category	Response Count	Percent of Responses
Dental	2	20%
Primary Care/PCPs	2	20%
Eye Exams	1	10%
Breastfeeding Classes	1	10%
Assisted Living/Retirement Homes	1	10%
Preventive Care	1	10%
Substance Abuse Programs	1	10%
Education	1	10%
Grand Total	**10**	**100%**

4c. What is the number one barrier to good health care?

Response Category	Response Count	Percent of Responses
Socioeconomic	4	36%
Health Education	2	18%
Affordable Care	1	9%
Insurance	1	9%
Access	1	9%
Prevention/Lifestyle Modification	1	9%
Culture	1	9%
Grand Total	**11**	**100%**

4d. What concerns you the most about the health of the community?

Response Category	Response Count	Percent of Responses
Obesity	2	33%
Care Coordination	1	17%
Chronic/Other Diseases	1	17%
Prevention/Lifestyle Modification	1	17%
Uninsured	1	17%
Grand Total	**6**	**100%**

05. Leading social determinants of health?

Response Category	Response Count	Percent of Responses
Socioeconomic	14	52%
Food/Nutrition	3	11%
Culture	2	7%
Alcohol/Drug Abuse	2	7%
Prevention/Lifestyle Modification	2	7%
Transportation	1	4%
Violence/Crime	1	4%
Access	1	4%
Health Education	1	4%
Grand Total	**27**	**100%**

06. primary health indicators?

Response Category	Response Count	Percent of Responses
Condition/Disease Rates	11	34%
Obesity	6	19%
Smoking	4	13%
Lifestyle Measures	3	9%
Hospital/Public Health Measures	2	6%
ER Visits	1	3%
Socioeconomic	1	3%
Teen Pregnancy	1	3%
Preventative Care Rates	1	3%
Insurance Coverage	1	3%
HP2020	1	3%
Grand Total	**32**	**100%**

07. vulnerable groups/populations?

Response Category	Response Count	Percent of Responses
Children/Teens	6	43%
Elderly	3	21%
Minorities	3	21%
Young Adults	1	7%
Un/UnderInsured	1	7%
Grand Total	**14**	**100%**

09. In terms of specific actions/programs, what do you think could be done to address the health needs we've discussed?

Response Category	Response Count	Percent of Responses
Public Health/Health Outcomes	4	22%
Community Outreach/Education	4	22%
Prevention/Screenings	2	11%
Social Resources	1	6%
Recreation	1	6%
Food/Nutrition	1	6%
Access/Affordable Care	1	6%
Care Coordination	1	6%
Socioeconomic	1	6%
Other	1	6%
Policy	1	6%
Grand Total	**18**	**100%**

10. What are some ways Baptist Health or other organizations can engage the community in addressing health needs?

Response Category	Response Count	Percent of Responses
Community Outreach/Education	7	47%
Community Collaboration	3	20%
Access/Affordable Care	2	13%
Specialty Providers/Services	1	7%
Technology	1	7%
Environment/Socioeconomic	1	7%
Grand Total	**15**	**100%**

13a. Are there any specific organizations in the community that would be a good fit for Baptist Health to partner with to address health needs?

Response Category	Response Count	Percent of Responses
St. Joe's-Hot springs (Mammograms for employee, Worker Comp. Coverage)	1	100%
Grand Total	**1**	**100%**

BHMC-Arkadelphia Focus Group Summary

LOCATION: BHMC-ARKADELPHIA DATE: 9/13/12

DISCUSSION 1:

- What grade do you give the health of this community (A-F)?
    - Write the Grade down on sticky note and place on flipchart/white board
- Discuss as a group the grade chosen
    - What factors did you consider when you chose a grade?
    - What do you think of when you think of health?

RESPONSES:

When asked to grade the health status of the community served by BHMC-Arkadelphia, six focus group participants gave it a C, there was one C+, and one B. While there has been substantial improvement due to charitable health services, access and afforability are still seen as major drivers to poor health status. Additionally, even as access has improved, community members who most need healthcare services do not take the initiative to use services when needed.

The Gurdon Clinic, staffed by a Nurse Practitioner, tends to serve an older population. In general, the BHMC-Arkadelphia community has issues with poor nutrition, poor dental care, obesity, high levels of povery, and unhealthy lifestyle choices such as smoking. Access to food is a major issue as the need for food has increased to a level where organizations are not able to meet the needs and often runs out of food.

DISCUSSION 2:

- Break into 2-3 smaller groups
- As a group identify the top 3 health needs of the community
    - Agree upon the top 3 needs and why
    - Write each need on sticky note and place on flipchart/white board
    - One person from the group share with the larger group why those needs were chosen

RESPONSES:

Group 1:

- Low economic status
- Healthy food availability/affordability
- Learned behaviors – Southern culture

Group 2:

- Finances/affordability
    - 52% of school kids on reduced/free lunches in school district
- Food/nutrition/obesity
- Learned behaviors/unhealthy habits

DISCUSSION 3:

- Stay the same smaller groups
- As a group identify up to 10 community resources (health/community organizations)
    - Work together to identify resources and list on flipchart paper
    - Discuss ways these resources could work together to address the health needs discussed
    - One person from the group share with larger group 2-3 ideas from discussion

RESPONSES:

Group 1

- Civic clubs – Rotary/Lions/American Legion
- Churches – some have food pantries/ministry
- School district/Boys and Girls Club/Parents & Teachers/College Prep/AR Promise/New Tech
- CADC/Sr. Adult, SCAT/Headstart
- CFEC/Adult education/Rainbow/Group Living/AHDC
- DHS/Health Department
- Foundations – Ross/Olds/Cabe/United Way
- Henderson State University/OBU
- Hospital/Medical community
- Child Care Centers/Courage House

Group 2

- DHS
- CFEC
- CCCHS
- CADC
- Courage House
- Veterans Affairs
- United Way
- Red Cross
- Civic Club
- Churches

DISCUSSION 4:

- Stay the same smaller groups
- As a group, choose one of the health needs your group identified earlier
- Identify two goals you'd like to accomplish related to the need
    - Goals should be SMART (Specific, Measurable, Attainable, Realistic, Time-sensitive)
- For each goal identify 2-3 action steps that would help achieve the goal

RESPONSES:

Both groups focused on obesity and healthy eating.

Goal: Change learned behaviors of unhealthy eating

- Educate children to address childhood obesity in the school system
    - Use baseline measurements done in Clark County
    - Develop community education programs
    - Engage families in eating habits
    - Educate parents on healthy cooking

Goal: Decrease childhood obesity

- Replace food choices/ingredients with health alternatives
- Reward healthy behavior
- Increase physical activity of children
- Work w/ Boys & Girls Club on after school programs

Goal: Increase financial assistance, training and food to families

- Increase the number of families in PTA
- Increase the number of families in WIC
- Increase the number of seniors receiving meals
- Coordinate food providers in the county, reduce duplication of resources
- Increase the number of food pantries and other resource

Health Resources Available to Meet Identified Needs

BHMC–Arkadelphia

Other Hospital Facilities

Hospital Name	Address	City	Owner Type	Type of Service
-	-	-	-	-

Cause of Death: Stroke

Program Name	Description	Website	Phone Number	State	County
Arkansas Department of Health Heart Disease and Stroke Prevention			501-661-2942	x	
Arkansas Wellness Coalition (AWC)	Includes members of the health care and employer community whose goal is to improve the health and well-being of all Arkansans through the use of nationally recognized, peer reviewed, clinical guidelines for physician, consumer, and employer education. Develop materials referring to nationally recognized standards such as those put forth by Healthy People 2010, the National Committee of Quality Assurance, and other disease-specific organizations such as the American Diabetes Association and the American Heart Association.		501-661-2942	x	
UAMS Center for Distance Health AR SAVES Program (Stroke Assistance through Virtual Emergency Support)	A stroke management system specifically targeting patients at rural hospitals to by increasing access to subspecialty expertise through telemedicine technology, thereby engineering a coordinated assessment and care-based plan for Arkansas' stroke patients. Ensuring timely administration of clot-busting drugs to improve the chances of recovery while reducing permanent, stroke-related disability and, quite possibly, mortality.		501-686-8514	X	

Program Name	Description	Website	Phone Number	State	County
Arkansas Chronic Illness Collaborative (ACIC)	The ACIC is a group of health care and public health professionals dedicated to improving the management of chronic diseases. The ACIC is a way for health care clinic teams to use the National Health Disparities Collaborative Chronic Care Model to share ideas and knowledge, learn and apply new techniques, and match medical practices with clinical guidelines based on scientific evidence about what works best (diabetes, cancer and cardiovascular diseases)	http://www.healthy.arkansas.gov/programsServices/chronicDisease/Initiatives/Pages/Acic.aspx		X	

Cause of Death: Diabetes

Chronic Conditions: Diabetes

Program Name	Description	Website	Phone Number	State	County
American Diabetes Association	Educational Resources; Advocacy		(501) 221-7444		X (all counties)
Arkansas Health Care Access Foundation	Locates doctors to donate office visits; prescription assistance; free to those who qualify	http://ahcaf.org/			X (all counties)
AllCare Pharmacy	Diabetes Education and Support Group.		(870) 246-3044		Arkadelphia
Clark County Charitable Health Service	Basic physician visits with lab; Assist with writing patient grants; Patient education following ADA guidelines. Available to uninsured and 185% of poverty line.		(870) 230-1309		X (Clark County)
Amity Community Health Center	Assistance with Medical Services; Diabetes Education. Sliding Scale available		(870) 342-5606		Amity
Arkansas Wellness Coalition	Includes members of the health care and employer community whose goal is to improve the health and well-being of all Arkansans through the use of nationally recognized, peer reviewed, clinical guidelines for physician, consumer, and employer education. Develop materials referring to nationally recognized standards such as those put forth by Healthy People 2010, the National Committee of Quality Assurance, and other disease-specific organizations such as the American Diabetes Association and the American Heart Association.		501-661-2942	X	

Program Name	Description	Website	Phone Number	State	County
Arkansas Chronic Illness Collaborative (ACIC)	The ACIC is a group of health care and public health professionals dedicated to improving the management of chronic diseases. The ACIC is a way for health care clinic teams to use the National Health Disparities Collaborative Chronic Care Model to share ideas and knowledge, learn and apply new techniques, and match medical practices with clinical guidelines based on scientific evidence about what works best (diabetes, cancer and cardiovascular diseases)	http://www.healthy.arkansas.gov/programsServices/chronicDisease/Initiatives/Pages/Acic.aspx		X	

Health Outcomes: Poor Physical Health Days

Program Name	Description	Website	Phone Number	State	County
Arkansas Department of Health – Hometown Health Improvement	HHI initiatives currently exist in every county around the state. HHI coalitions do powerful and unique work to improve the health of those in their communities. Once the coalition is established, many communities are choosing to conduct health behavior surveys to gain important information specific to their communities. Many coalitions are now implementing activities to affect the health of the community. Examples of some activities include: tobacco cessation programs for adolescents, household hazardous waste round-up, parenting support groups, local industry wellness programs, health fairs, and health resource guides.				X (All counties)
Chronic Disease Self Management Program – Be Well Live Well	Developed by the Stanford Patient Education Research Center, the evidence based program teaches participants the skills needed to live well with chronic diseases. It also shows participants how to organize their lives, make and achieve goals, eat properly, exercise and communicate effectively with physicians and others. National outcome studies reveal that CDSMP participants experience a marked decrease in the number of hospital stays and doctor visits.	http://www.agec.org/2012/10/cdsmp-branded-for-arkansas-be-well-live-well/		X	

Chronic Conditions: Hypertension

Program Name	Description	Website	Phone Number	State	County
Arkansas Wellness Coalition	Includes members of the health care and employer community whose goal is to improve the health and well-being of all Arkansans through the use of nationally recognized, peer reviewed, clinical guidelines for physician, consumer, and employer education. Develop materials referring to nationally recognized standards such as those put forth by Healthy People 2010, the National Committee of Quality Assurance, and other disease-specific organizations such as the American Diabetes Association and the American Heart Association.		501-661-2942	X	

Chronic Conditions: Arthritis

Program Name	Description	Website	Phone Number	State	County
Arkansas Arthritis Foundation	Various educational programs	http://www.arthritis.org/arkansas/		X	

Health Behaviors: Obesity

Socioeconomic & Environment: Percentage of Fast Food Restaurants

Program Name	Description	Website	Phone Number	State	County
Arkansas Department of Health Lifestage Health Branch	Mission is the prevention and reduction of obesity through the adoption of healthy eating practices and increased physical activity. Provides technical assistance, managing and supporting evidence-based programs, disseminating materials and resources, and skills-building within the Agency, in schools, at worksites, among partners and with the general public.		501-661-2099	X	

Program Name	Description	Website	Phone Number	State	County
Arkansas Coalition for Obesity Prevention (ArCOP)	• A coalition whose goal is to increase the percentage of Arkansans of all ages who have access to healthy and affordable food and who engage in regular physical activity. Coalition is structured around six working teams: Access to Healthy Foods; Built Environment; Early Childhood and Schools; Healthcare; Worksite Wellness; and Social Marketing	http://www.arkansasobesity.org/		X	
Southern Ain't Fried Sundays - Arkansas Minority Health Commission	Faith Based Outreach Program SAFS is designed to educate African American churches and organizations about healthier alternatives to preparing and cooking southern-style foods. It is also a mechanism for partnering with these groups in an effort to educate their members about the signs and symptoms of stroke, diabetes, and heart attacks. The program is being revamped to expand its reach to the Hispanic communities and individual participants.	http://www.arminorityhealth.com/programs_saf.html	877-264-2826	X	
Arkansas Department of Health - WIC FMNP	The purposes of the WIC FMNP are to provide fresh, nutritious, unprepared fruits and vegetables from farmers' market to women and children who are nutritionally at risk and to expand the awareness and use of farmers' markets, as well as increase sales at such markets. During the farming season, WIC FMNP provides clients in the WIC Program with checks to purchase locally grown fresh fruits and vegetables sold by authorized farmers at authorized farmers' markets.	http://www.healthy.arkansas.gov/programsServices/WIC/Pages/FMNP.aspx		X	

Program Name	Description	Website	Phone Number	State	County
Arkansas Department of Health Healthy Restaurant Award	The Healthy Arkansas Restaurant Award is a voluntary program that provides public recognition to restaurants that meet certain health criteria. Restaurants self-apply and self-report through a questionnaire-type application. Criteria considered include smoke-free status of facility, labeling of food items, and number and types of healthy nutrition choices that are offered. Applications must be completed by a designee of the restaurant. Menus, inserts or photo of menu board with nutrient information must be submitted with the application to confirm the information.	http://www.healthy.arkansas.gov/programsServices/chronicDisease/Nutrition/Pages/Programs.aspx		X	

Health Behaviors: Sexually Transmitted Infections

Program Name	Description	Website	Phone Number	State	County
Clark County Health Unit	HIV/ Sexually Transmitted Diseases Counseling, testing and treatment		870-246-4471		X (Clark County)

Prevention: Colorectal Screening

Program Name	Description	Website	Phone Number	State	County
The Colorectal Cancer Screening Program (CCSP)	The Colorectal Cancer Screening Program (CCSP) is committed to prevention, early detection and treatment of colorectal cancer. The program is designed to provide equitable access to colorectal cancer screenings throughout the state. CCSP targets its services to minorities and people from disadvantaged socioeconomic backgrounds or underserved communities. Participants in need of follow-up are referred to the appropriate services.	http://cancer.uams.edu/?id=11145&sid=2	877-749-4085 or 501-526-7045	X	

Prevention: Mammography

Program Name	Description	Website	Phone Number	State	County
BreastCare - Clark County Health Unit	BreastCare offers FREE screening and diagnostic services for Arkansas women along with public and professional education. Free services for those that qualify: Mammograms, Clinical Breast Exams, Pelvic Exams and Pap Tests, Follow-up Tests, if Needed.		870-246-4471		X (Clark County)
Arkansas' BreastCare Program	BreastCare's mission is to increase the rate of early detection of breast and cervical cancer and reduce the morbidity and mortality rates among women in Arkansas by lowering barriers to screening that result from lack of information, financial means, or access to quality services.	http://www.healthy.arkansas.gov/programsservices/chronicdisease/arbreastcare/pages/default.aspx		X	

Access: Lack of PCPs

Program Name	Description	Website	Phone Number	State	County
ADH Office of Rural Health and Primary Care	Promotes the development of community-based health care services and systems throughout Arkansas to ensure that well managed, quality health services are available to all citizens		501-280-4560	X	

Access: Uninsured

Program Name	Description	Website	Phone Number	State	County
Arkansas Health Care Access Foundation	Serves all qualified applicants who are low-income, uninsured citizens throughout Arkansas. Arkansas Health Care Access Foundation (AHCAF) is a statewide volunteer health care program which was developed to help low-income, medically uninsured Arkansans gain access to non-emergency medical care	http://ahcaf.org/			X (all counties)

Program Name	Description	Website	Phone Number	State	County
The Clark County Charitable Health Service (CCCHS)	The Clark County Charitable Health Service provides basic health care for Clark County residents without any form of insurance, including Medicare and Medicaid. Patients must be approved for eligibility. They must meet income requirements based on the national poverty level. All services provided through the clinic are performed in the private offices of local volunteer health care providers, and the services are provided in Clark County five days a week.		(870) 230-1309		X (Clark County)

Socioeconomic & Environment: Single-Parent Households

Program Name	Description	Website	Phone Number	State	County
Clark County WIC					X (Clark County)

Community Needs Assessment

Baptist Health Rehabilitation Institute

December 2013

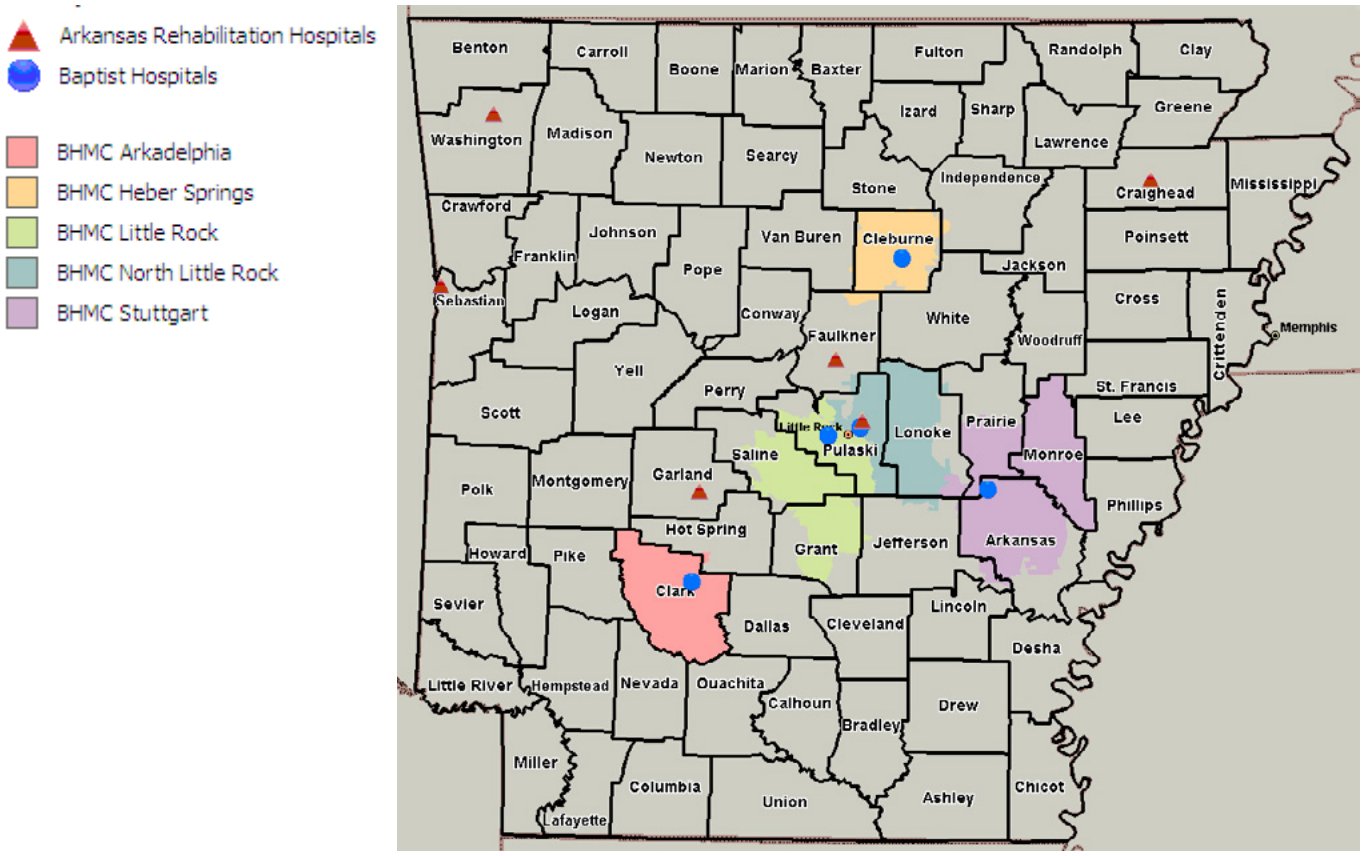


Baptist Health Rehabilitation Institute

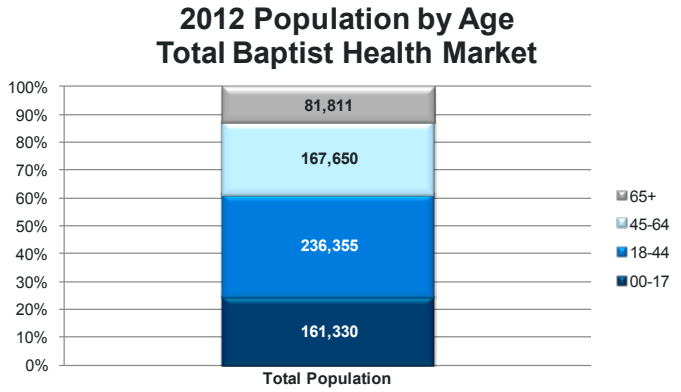
Baptist Health Rehabilitation Institute (BHRI) is the largest and most comprehensive rehabilitation facility in the state and offers a comprehensive inpatient rehabilitation program with specialization in brain and spinal cord injury. Additional services provided include physical therapy, occupational therapy, rehabilitation nursing, psychology, stroke recovery rehabilitation, speech language pathology, therapeutic recreation, and care coordination.

Community Served and Demographics

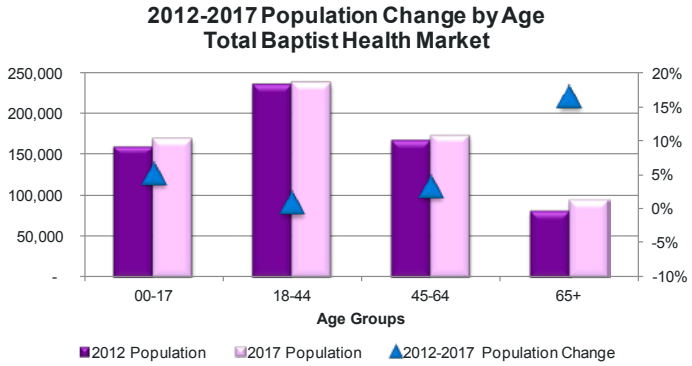
The community served for BHRI is defined as individuals in the communities served by Baptist Health acute-care hospitals who are experiencing functional limitations due to the effects of a variety of disorders and conditions such as brain injury, orthopedic injuries/conditions, spinal cord injuries/conditions, stroke, or Parkinson's disease. Ninety-six ZIP codes constitute the five Baptist Health acute care hospital communities and represent the area served for BHRI. A detailed list of the ZIP codes can be found in the **Baptist Health Rehabilitation Institute Appendix.** Below is a map that illustrates the geography of the BHRI community served, which is comprised of each of the five shaded areas.



The BHRI community served total population is currently estimated at 647,146. By 2017, this population is projected to grow 4.7 percent with the fastest growth in the BHMC-Little Rock (5.4 percent) and BHMC–North Little Rock (5.2 percent) communities. While the largest portion of the population is made up of white non-Hispanics (429,530), in the next five years the largest percentages of growth will be in the Hispanic (+29 percent, +9,891 individuals) and Asian non-Hispanics (+20 percent, +2,018 individuals) populations. The largest growth in population will take place among black non-Hispanics (+11,794 individuals) between 2012 and 2017.



The 18-44 age group constitutes the largest portion of the BHRI community served, followed by the 45-64 age group.



By 2017, the 65 plus population will have the largest percentage of growth.

The median household income for the BHRI community served is $40,965. More than 54 percent of individuals have private insurance — either employer-sponsored insurance (48 percent) or individually purchased (6 percent). Another 15 percent are covered by Medicaid, 16 percent are uninsured and 15 percent are covered by Medicare or are Medicare dual eligible.

Interviews & Focus Groups

Interviewees and focus group participants were categorized into representative groups. In the chart below, an "I" indicates an interview and "FG" indicates participation in a focus group. For individuals outside Baptist Health, representative organizations have been listed.

Community Leaders/ Groups	Public and Other Organizations	Other Providers	Baptist Health
Thompson, M.D., Joe AR Surgeon General/ AR Ctr for Health Improvement	Vines, Cheryl (Spinal Cord Commission, I)	Goss, Kathy (Neuro Restorative Timber Ridge, I)	Bishop, John (BHMC Rehab, I)
		Newman, Gina (Seven Springs Health & Rehab, FG)	Callaway, Ellen (BHMC, I)
			Gentry, Lee (BHMC Rehab, I)
			McLauglin, Scott (BHMC Rehab, I)

The individuals highlighted in purple indicate Health Department representatives (local, regional, or state), as well as individuals representing or serving medically underserved, low-income, or minority populations.

In the interview process, the majority of individuals said the current health status of the community is either "good" or "poor." The major issues contributing to this health status include lifestyle choices, lack of preventative care, lack of access to healthcare, obesity, and other chronic diseases.

For the BHRI community, the top five health needs identified include:

1. Obesity
2. Chronic Diseases
3. Access to care
4. Cardiovascular
5. Food/Nutrition

Barriers to good health care in this community include socioeconomic factors, insurance, and affordable health-care. The elderly, disabled, and minority populations were identified as vulnerable groups that will need special attention when addressing health needs.

The BHMC–Little Rock focus group served as the focus group for the BHRI community given the BHRI physical location on the BHMC–Little Rock campus. Focus group participants were asked to grade the health of the community based on an A-F scale, provide feedback in terms of that grade, and work in small groups to determine the top three health needs of the community. For the BHMC–Little Rock group, the average grade for the health of the community was a C. Much of this was attributed to the prevalence of chronic diseases/conditions, overconsumption of fast food, nicotine use/smoking, and alcohol consumption. While there have been improvements to dental care for children and walking/biking trail systems for the community, there are still opportunities to raise the level of awareness of services available and create affordable access to healthcare for minority populations.

The focus group split into two smaller groups to determine the top three health needs of the community. Group 1 selected access to a dental-care clinic (free or affordable), substance abuse, and obesity. Group 2 selected health education, more health-care clinics (free or affordable), and access to care to connect people to the health resources already in place.

In the same small groups, focus group participants were asked to identify community resources that could help address the health issues in the community. Some of the resources identified include:

• Churches • Mosaic • P.A.R.K and other after school programs • Boys and Girls Club • Colleges	• City/state government • Friendly Chapel • Watershed • Goodwill • Our House	• Police department • Homeless shelters • Trail systems • Library • Hospitals

The Baptist Health Rehabilitation Institute Appendix includes a more comprehensive list of existing community resources available to address the health needs of the community.

Health Indicators

While the community served was defined at the ZIP code level, the most geographically detailed health indicators were only available at the county level. For that reason, health indicators for BHRI were evaluated for Grant County, Saline County, Pulaski County, Lonoke County, Arkansas County, Monroe County, Prairie County, Cleburne County, and Clark County. These counties represent the ZIP codes within the community served.

Health needs were identified for BHRI when a majority of the counties did not meet the state benchmark and the indicator is relevant to rehabilitation:

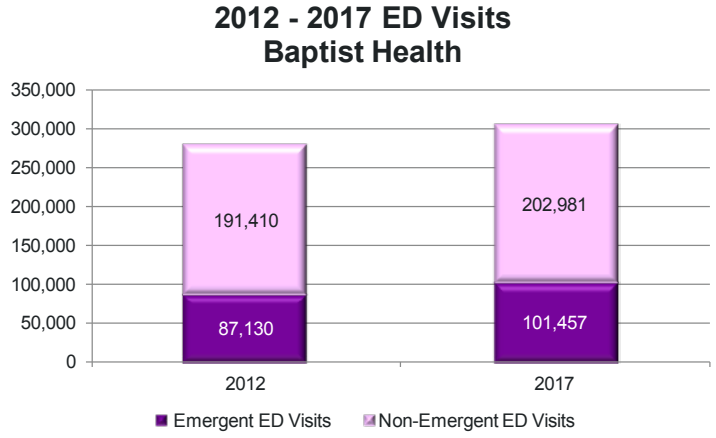
Cause of Death • Stroke • Chronic Lower Respiratory Disease **Health Outcomes** • Poor or Fair Health Status • Poor Physical Health & Mental Health Days	**Chronic Conditions** • Hypertension • Asthma • Diabetes • Coronary Heart Disease • Arthritis **Health Behaviors** • Smoking • Obesity	**Prevention** • Colorectal Screening • Mammography **Spinal Cord Injury** • Injury Hospitalizations due to MVA/Falls **Socioeconomic & Environment** • Access to Recreational Facilities • Percentage of Fast Food Restaurants

Truven Health Analytics supplemented the publically available data with estimates of disease prevalence for heart disease and cancer, emergency department visit estimates, and the community need index.

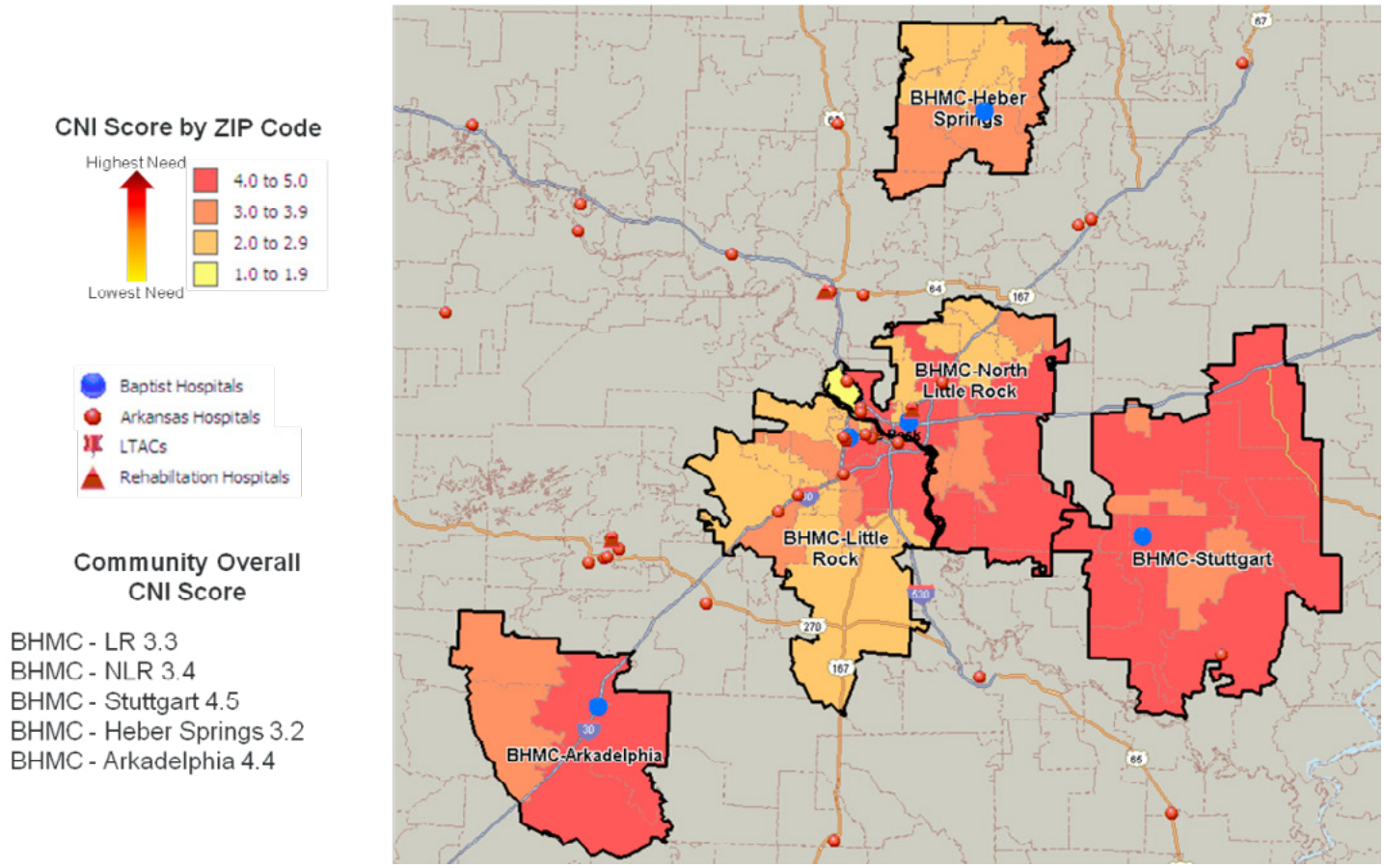
Heart disease estimates indicate a prevalence of 213,634 cases for the BHRI community served. The majority (69 percent) of the 2011 estimates of heart disease prevalence indicate hypertension as the primary diagnosis. Other diagnoses include arrhythmias (12 percent), ischemic heart disease (13 percent), and congestive heart failure (6 percent).

The 2011 cancer incidence estimates reveal at least 500 new cases of each of the following types of cancer: prostate, breast, and lung. For the community served, it is estimated there were 3,976 new cancer cases in 2011.

Emergency department visits are slated to grow by approximately 25,000 visits between 2012 and 2017.



The Truven Health Community Need Index (CNI) is a statistical approach to identifying health needs in a community. The CNI takes into account vital socio-economic factors (income, cultural, education, insurance- and housing) about a community to generate a CNI score for every populated ZIP code in the United States. The CNI is strongly linked to variations in community health-care needs and is a strong indicator of a community's demand for various health-care services.



For the Baptist Health communities served by BHRI, the BHMC–Stuttgart community had the highest CNI of 4.5 on a scale of 1.0 (lowest needs) to 5.0 (highest needs). This is followed closely by BHMC- Arkadelphia with a score of 4.4.

Prioritized Health Needs

For BHRI, Lee Gentry, vice president/administrator; Keith Moore, assistant vice president of Patient Services; and John Bishop, program line manager of IP Rehabilitation, participated in the prioritization meeting.

Using the criteria selected by the larger group, the five health needs that scored the highest in the prioritization process for BHRI were:

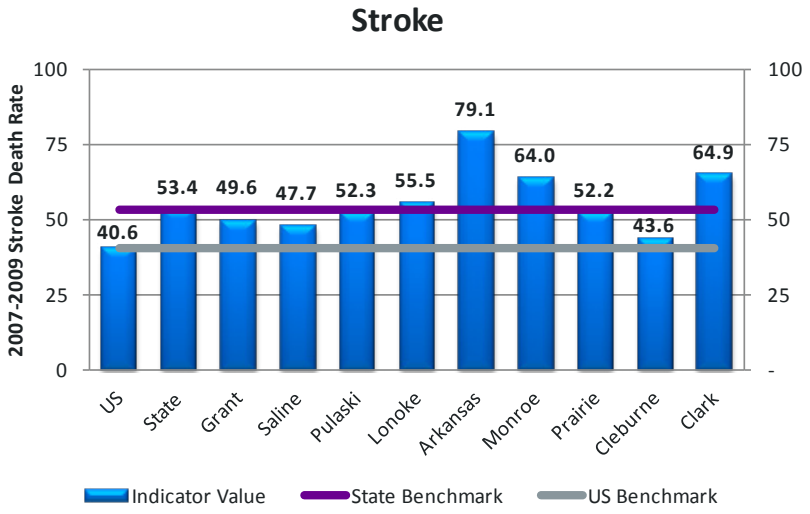
1. Stroke (cause of death)
2. Injuries due to motor vehicle accidents/falls
3. Obesity
4. Smoking
5. Chronic Lower Respiratory Disease (cause of death)

HEALTH NEED	BHRI
Cause of Death	
• Stroke	X
• Chronic Lower Respiratory Disease	X
Health Outcomes	
• Poor or Fair Health Status	X
• Poor Physical Health & Mental Health Days	X
Chronic Conditions	
• Hypertension	X
• Asthma	X
• Diabetes	X
• Coronary Heart Disease	X
Health Behaviors	
• Smoking	X
• Obesity	X
Prevention	
• Colorectal Screening	X
• Mammography	X
Socioeconomic & Environment	
• Access to Recreational Facilities	X
• Percentage of Fast Food Restaurants	X
Spinal Cord Injury	
• Injury Hospitalizations due to Motor Vehicle Accidents/Falls	X

The table to the left indicates the health needs identified for the BHRI community. The highlighted boxes are the five health needs that scored the highest in the prioritization process.

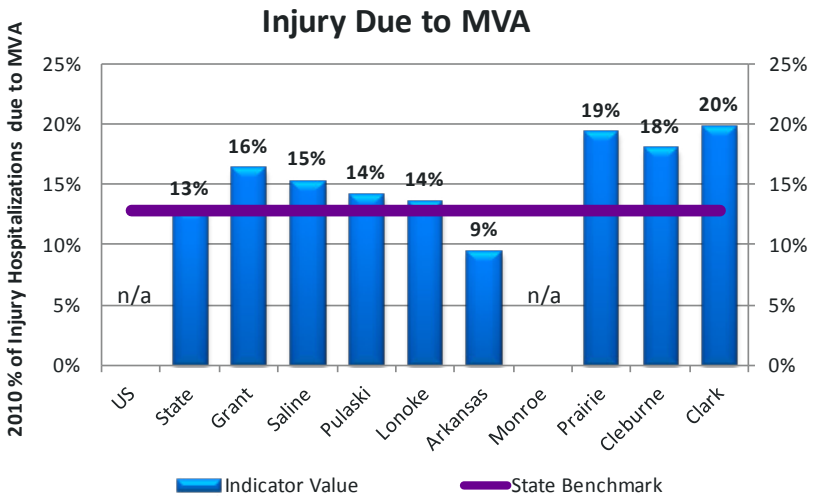
Even though the highlighted health needs had the highest scores, the needs that will actually be addressed for the purposes of the CHNA are at the discretion of BHRI.

For each of the prioritized health needs, the comparative benchmark graph has been provided to illustrate gaps between county indicators for the community served and the state benchmark (purple).



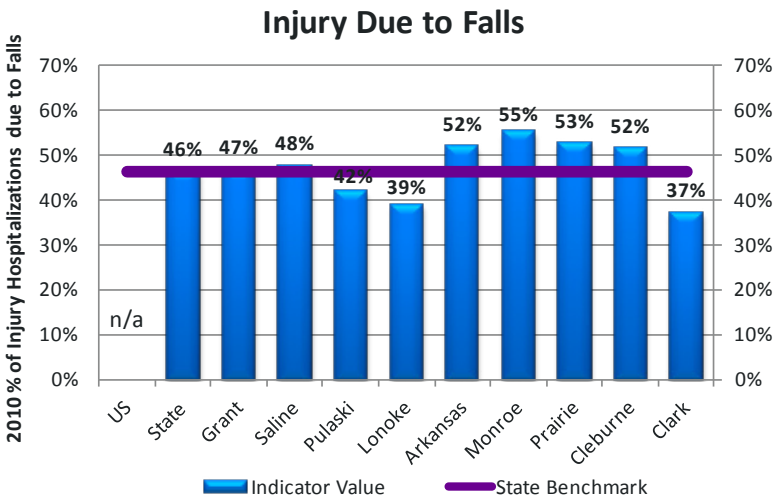
Source: National Vital Statistics System-Mortality (CDC, NCHS)

Notes: 2007-2009 Stroke death rate (per 100,000)



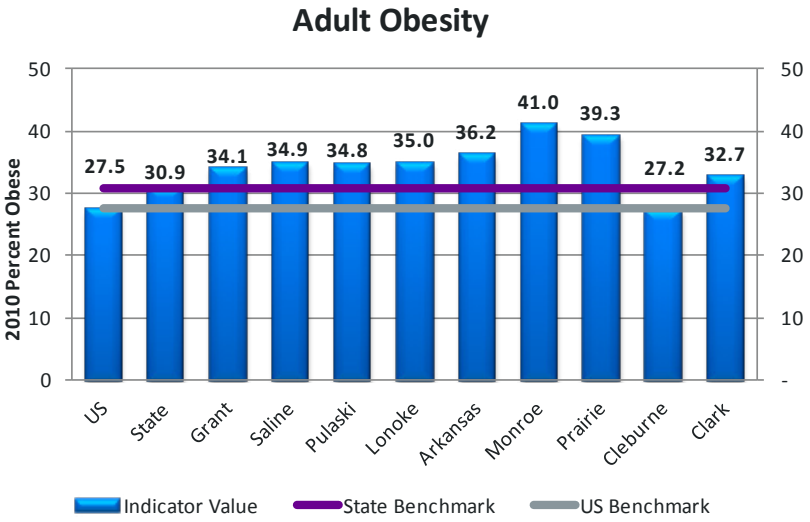
Source: ADH (AR Hospital Discharge Data System)

Notes: Percent of injury discharges with cause due to MVA (not age-adjusted)



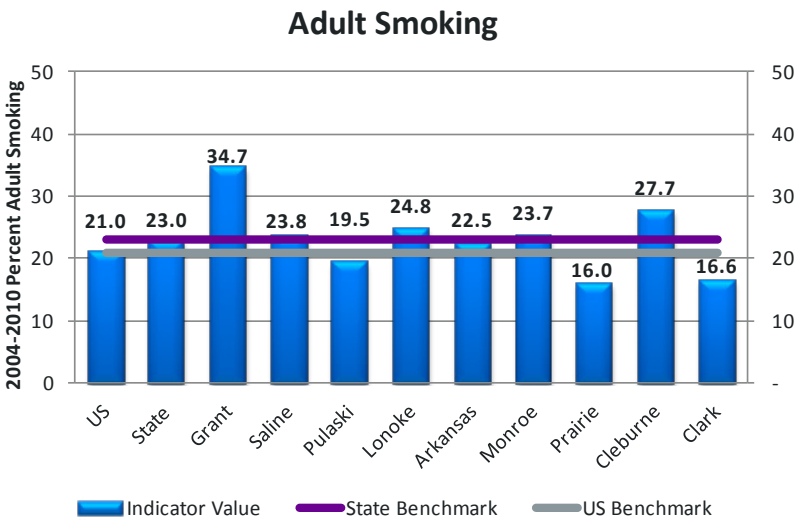
Source: ADH (AR Hospital Discharge Data System)

Notes: Percent of injury discharges with cause due to Falls (not age-adjusted)



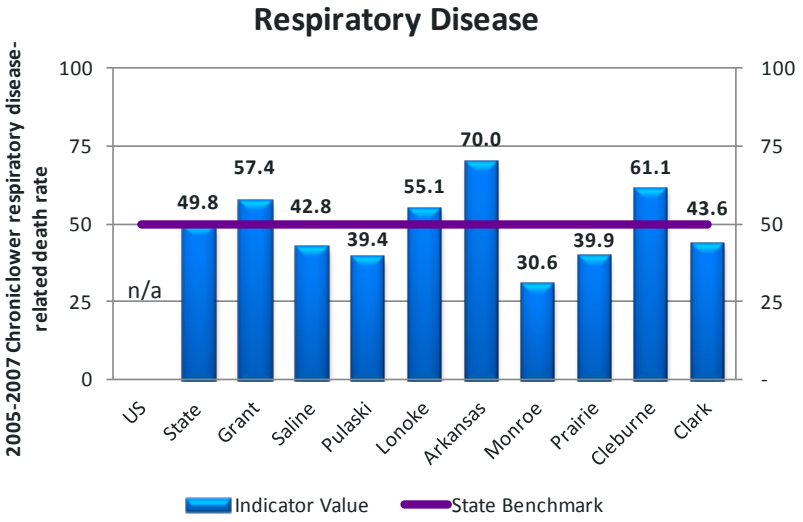
Source: Arkansas Department of Health BRFSS

Notes: Percent of adults 18 years and over that report BMI >= 30 (per self-reported weight/height)



Source: County Health Rankings (BRFSS), Arkansas Department of Health BRFSS

Notes: Percent of adults 18 years+ that report currently smoking cigarettes



Source: Health Statistics Branch, ADH

Notes: 2005-2007 Chronic lower respiratory disease-related deaths (per 100,000)

Summary

The community health needs assessment for the BHRI community served revealed a number of health issues related to disease management, lifestyle choices, and socioeconomic or environmental factors. By weighing the qualitative feedback and the quantitative data, along with the prioritization criteria, the top health needs identified include stroke, injuries due to motor vehicle accidents/falls, obesity, smoking, and chronic lower respiratory disease.

BHRI will be working with internal stakeholders to determine the community health needs to be addressed. With the goal of improving the health of the community, implementation plans with specific tactics and time frames will be developed to address these health needs.

Baptist Health Rehabilitation Institute Appendix

BHRI Community Served Definition ZIP Code Table

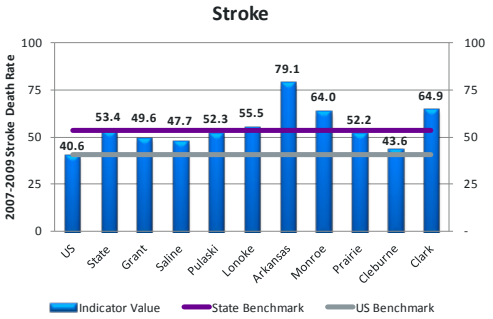
BAPTIST HEALTH COMMUNITY	ZIP	PONAME	COUNTY NAME	CBSANAME
BHMC-Little Rock	72002	Alexander	Saline, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72011	Bauxite	Saline, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72015	Benton	Saline, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72018	Benton	Saline, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72019	Benton	Saline, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72022	Bryant	Saline, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72053	Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72065	Hensley	Saline, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72089	Bryant	Saline, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72103	Mabelvale	Saline, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72113	Maumelle	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72150	Sheridan	Grant, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72158	Benton	Saline, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72164	Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72180	Hensley	Saline, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72183	Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72201	Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72202	Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72203	Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72204	Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72205	Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72206	Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72207	Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72209	Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72210	Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72211	Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72212	Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72214	Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72215	Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72216	Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72217	Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72219	Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72221	Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72222	Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72223	Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72225	Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72227	Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72260	Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72295	Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro

BAPTIST HEALTH COMMUNITY	ZIP	PONAME	COUNTY NAME	CBSANAME
BHMC-North Little Rock	72007	Austin	Lonoke, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-North Little Rock	72023	Cabot	Lonoke, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-North Little Rock	72037	England	Lonoke, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-North Little Rock	72046	England	Lonoke, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-North Little Rock	72076	Jacksonville	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-North Little Rock	72078	Jacksonville	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-North Little Rock	72083	Keo	Lonoke, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-North Little Rock	72086	Lonoke	Lonoke, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-North Little Rock	72099	Little Rock Air Force Bas	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-North Little Rock	72114	North Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-North Little Rock	72115	North Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-North Little Rock	72116	North Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-North Little Rock	72117	North Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-North Little Rock	72118	North Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-North Little Rock	72119	North Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-North Little Rock	72120	Sherwood	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-North Little Rock	72124	Sherwood	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-North Little Rock	72142	Scott	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-North Little Rock	72176	Ward	Lonoke, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-North Little Rock	72190	North Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-North Little Rock	72231	North Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Stuttgart	72003	Almyra	Arkansas, AR	Unassigned Area in Arkansas
BHMC-Stuttgart	72021	Brinkley	Monroe, AR	Unassigned Area in Arkansas
BHMC-Stuttgart	72026	Casscoe	Arkansas, AR	Unassigned Area in Arkansas
BHMC-Stuttgart	72029	Clarendon	Monroe, AR	Unassigned Area in Arkansas
BHMC-Stuttgart	72038	Crocketts Bluff	Arkansas, AR	Unassigned Area in Arkansas
BHMC-Stuttgart	72041	De Valls Bluff	Prairie, AR	Unassigned Area in Arkansas
BHMC-Stuttgart	72042	De Witt	Arkansas, AR	Unassigned Area in Arkansas
BHMC-Stuttgart	72064	Hazen	Prairie, AR	Unassigned Area in Arkansas
BHMC-Stuttgart	72069	Holly Grove	Monroe, AR	Unassigned Area in Arkansas
BHMC-Stuttgart	72072	Humnoke	Lonoke, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Stuttgart	72073	Humphrey	Arkansas, AR	Unassigned Area in Arkansas
BHMC-Stuttgart	72108	Brinkley	Monroe, AR	Unassigned Area in Arkansas
BHMC-Stuttgart	72134	Roe	Monroe, AR	Unassigned Area in Arkansas
BHMC-Stuttgart	72160	Stuttgart	Arkansas, AR	Unassigned Area in Arkansas
BHMC-Stuttgart	72170	Ulm	Prairie, AR	Unassigned Area in Arkansas

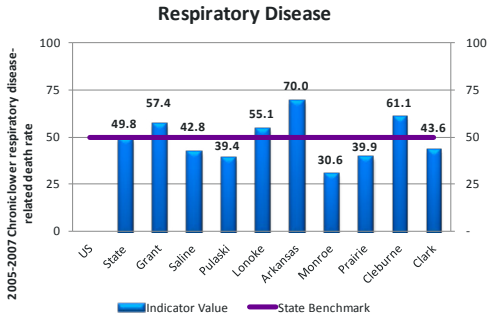
BAPTIST HEALTH COMMUNITY	ZIP	PONAME	COUNTY NAME	CBSANAME
BHMC-Arkadelphia	71721	Gurdon	Clark, AR	Arkadelphia, AR Micro
BHMC-Arkadelphia	71728	Gurdon	Clark, AR	Arkadelphia, AR Micro
BHMC-Arkadelphia	71743	Gurdon	Clark, AR	Arkadelphia, AR Micro
BHMC-Arkadelphia	71772	Gurdon	Clark, AR	Arkadelphia, AR Micro
BHMC-Arkadelphia	71920	Amity	Clark, AR	Arkadelphia, AR Micro
BHMC-Arkadelphia	71921	Amity	Clark, AR	Arkadelphia, AR Micro
BHMC-Arkadelphia	71923	Arkadelphia	Clark, AR	Arkadelphia, AR Micro
BHMC-Arkadelphia	71962	Okolona	Clark, AR	Arkadelphia, AR Micro
BHMC-Arkadelphia	71998	Arkadelphia	Clark, AR	Arkadelphia, AR Micro
BHMC-Arkadelphia	71999	Arkadelphia	Clark, AR	Arkadelphia, AR Micro
BHMC-Heber Springs	72044	Edgemont	Cleburne, AR	Unassigned Area in Arkansas
BHMC-Heber Springs	72067	Higden	Cleburne, AR	Unassigned Area in Arkansas
BHMC-Heber Springs	72130	Prim	Cleburne, AR	Unassigned Area in Arkansas
BHMC-Heber Springs	72131	Quitman	Cleburne, AR	Unassigned Area in Arkansas
BHMC-Heber Springs	72179	Wilburn	Cleburne, AR	Unassigned Area in Arkansas
BHMC-Heber Springs	72523	Concord	Cleburne, AR	Unassigned Area in Arkansas
BHMC-Heber Springs	72530	Drasco	Cleburne, AR	Unassigned Area in Arkansas
BHMC-Heber Springs	72543	Heber Springs	Cleburne, AR	Unassigned Area in Arkansas
BHMC-Heber Springs	72545	Heber Springs	Cleburne, AR	Unassigned Area in Arkansas
BHMC-Heber Springs	72546	Ida	Cleburne, AR	Unassigned Area in Arkansas
BHMC-Heber Springs	72581	Tumbling Shoals	Cleburne, AR	Unassigned Area in Arkansas

Health Indicator Analysis

BHRI: CAUSE OF DEATH



Source: National Vital Statistics System-Mortality (CDC, NCHS)
Notes: 2007-2009 Stroke death rate (per 100,000)

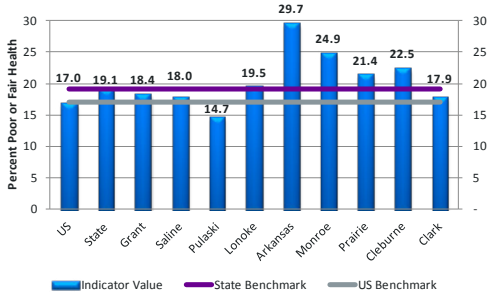


Source: Health Statistics Branch, ADH
Notes: 2005-2007 Chronic lower respiratory disease-related deaths (per 100,000)

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BHRI: HEALTH OUTCOMES

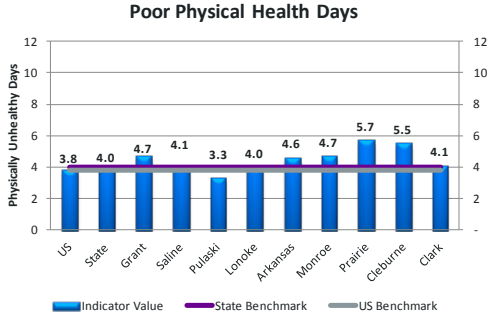
Poor or Fair Health



Source: County Health Rankings (BRFSS)

Notes: Percent of adults reporting fair or poor health (age-adjusted)

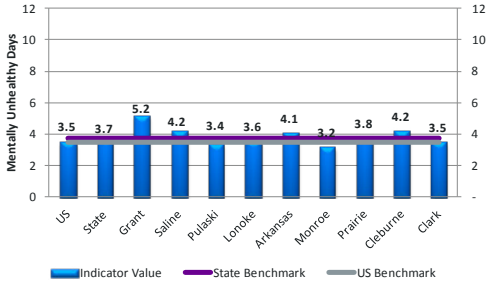
Poor Physical Health Days



Source: County Health Rankings (BRFSS)

Notes: Average number of physically unhealthy days reported in past 30 days (age-adjusted)

Poor Mental Health Days



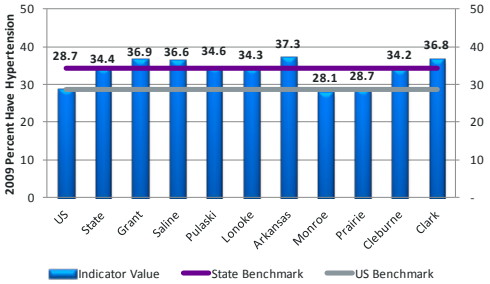
Source: County Health Rankings (BRFSS)

Notes: Average number of mentally unhealthy days reported in past 30 days (age-adjusted)

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BHRI: CHRONIC CONDITIONS

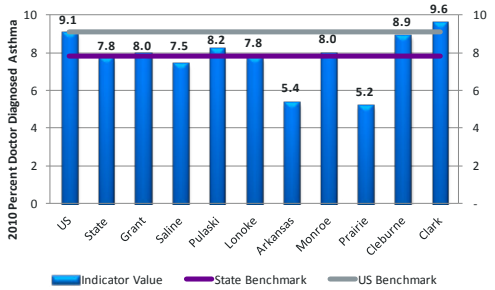
Hypertension



Source: Arkansas Department of Health BRFSS

Notes: Percent of adults that report having been diagnosed with high blood pressure

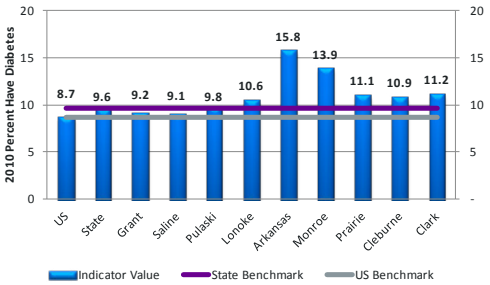
Asthma



Source: Arkansas Department of Health BRFSS

Notes: Percent of adults that report having been diagnosed with asthma

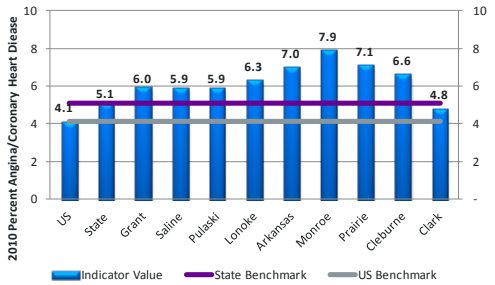
Diabetes



Source: Arkansas Department of Health BRFSS

Notes: Percent of adults that report having been diagnosed as having diabetes

Coronary Heart Disease

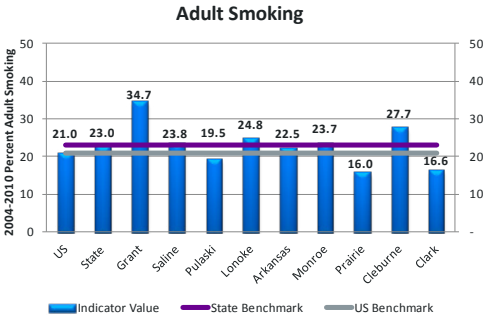


Source: Arkansas Department of Health BRFSS

Notes: Percent of adults that report having been diagnosed as having Coronary Heart Disease

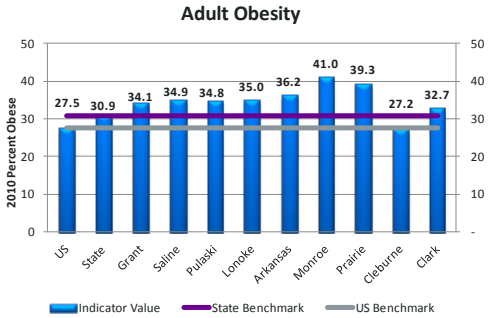
Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BHRI: HEALTH BEHAVIORS



Source: County Health Rankings (BRFSS), Arkansas Department of Health BRFSS

Notes: Percent of adults 18 years+ that report currently smoking cigarettes

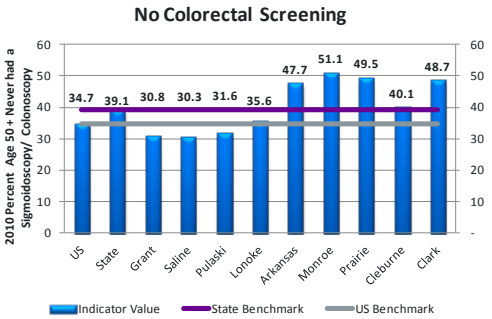


Source: Arkansas Department of Health BRFSS

Notes: Percent of adults 18 years and over that report BMI >= 30 (per self-reported weight/height)

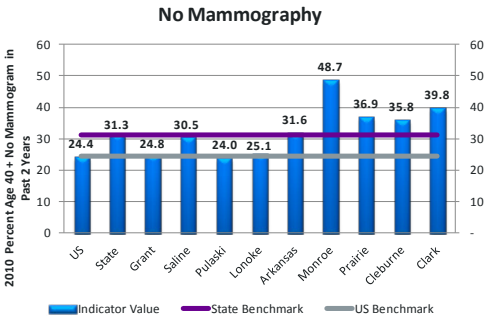
Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BHRI: PREVENTION



Source: Arkansas Department of Health BRFSS

Notes: Percent of adults age 50+ that report never having had a sigmoidoscopy or colonoscopy

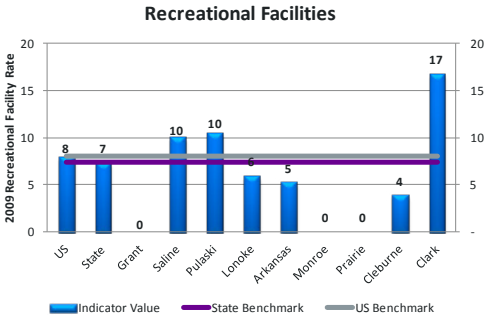


Source: Arkansas Department of Health BRFSS

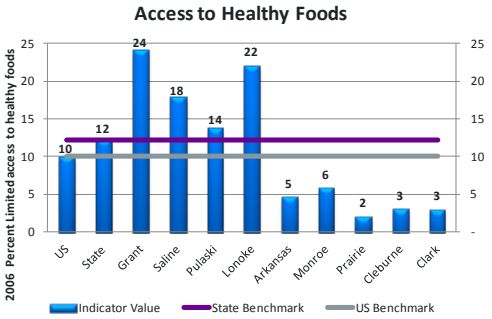
Notes: Percent of women age 50+ that report no mammogram in the past 2 years

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BHRI: ENVIRONMENT



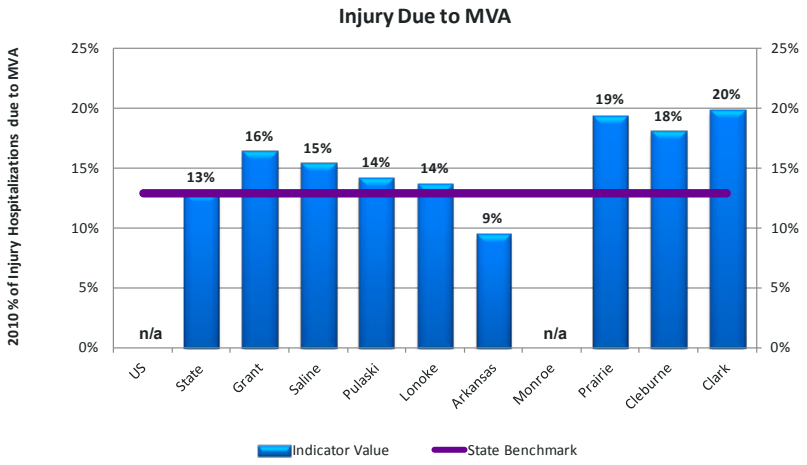
Source: County Health Rankings (Census County Business Patterns)
Notes: Rate of recreational facilities per 100,000 population



Source: CHR (USDA)
Notes: Percent of population who are low-income and do not live close to a grocery store

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

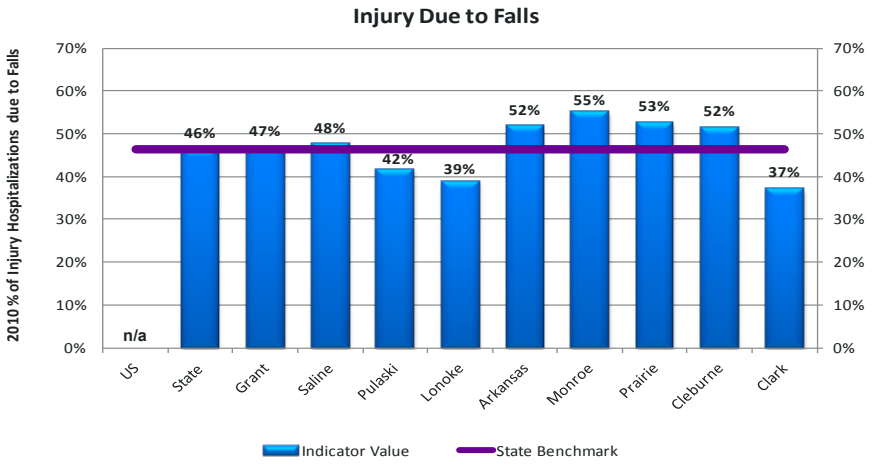
BHRI: SCI- MOTOR VEHICLE ACCIDENTS



Source: ADH (AR Hospital Discharge Data System)
Notes: Percent of injury discharges with cause due to MVA (not age-adjusted)

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

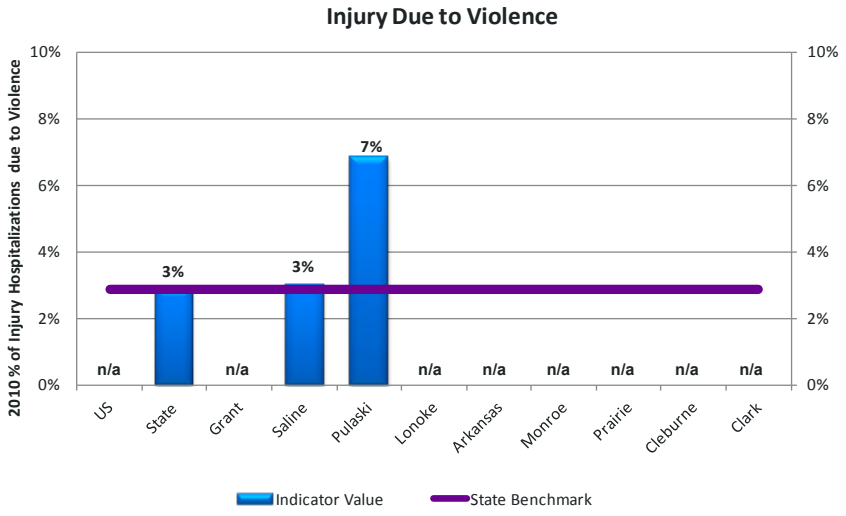
BHRI: SCI- FALLS



Source: ADH (AR Hospital Discharge Data System)
Notes: Percent of injury discharges with cause due to Falls (not age-adjusted)

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BHRI: SCI- VIOLENCE



Source: ADH (AR Hospital Discharge Data System)
Notes: Percent of injury discharges with cause due to Violence (not age-adjusted)

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

Community Needs Index

BAPTIST HEALTH
CNI BARRIER SCORE BY ZIP CODE

Baptist Health Community	Zip	2011 Population	Overall CNI Score	Income Rank	Education Rank	Culture Rank	Insurance Rank	Housing Rank
BHMC Little Rock	72204	33,910	5	4	4	5	5	5
	72206	24,819	5	4	4	5	5	5
	72202	10,992	5	5	4	5	5	5
	72201	842	5	4	4	5	5	5
	72209	31,911	4	4	3	5	5	5
	72015	28,918	4	4	3	3	3	5
	72205	23,824	3	2	1	5	4	5
	72211	21,414	3	1	1	4	2	5
	72210	13,432	3	3	2	4	3	4
	72103	12,751	3	3	3	4	3	4
	72150	12,585	3	4	3	2	2	3
	72002	12,289	3	2	3	3	2	3
	72227	11,848	3	3	1	4	3	5
	72207	11,394	3	2	1	3	2	5
	72011	3,922	3	3	3	2	2	3
	72019	22,349	2	2	1	3	2	4
	72113	21,622	2	1	1	3	1	3
	72223	18,422	2	2	1	4	1	4
	72022	12,673	2	2	2	3	2	3
	72212	12,558	2	2	1	4	1	4
	72065	4,609	2	2	3	3	2	1

The CNI score is an average of five different barrier scores that measure various socio-economic indicators of each community. The CNI is strongly linked to variations in community healthcare needs and is a strong indicator of a community's demand for various healthcare services.

Baptist Health Community	Zip	2011 Population	Overall CNI Score	Income Rank	Education Rank	Culture Rank	Insurance Rank	Housing Rank
BHMC North Little Rock	72114	13,255	5	5	5	5	5	5
	72117	12,228	5	4	5	5	5	5
	72046	4,653	5	4	5	5	4	5
	72076	40,524	4	4	3	5	4	5
	72118	21,826	4	3	3	5	4	5
	72086	10,111	4	4	4	4	4	4
	72142	2,266	4	3	5	4	3	4
	72099	1,630	4	4	3	4	4	5
	72083	222	4	5	3	4	4	4
	72120	31,253	3	2	1	4	2	4
	72116	21,356	3	1	1	4	2	5
	72176	7,459	3	3	3	2	3	4
	72023	36,790	2	3	2	2	2	3
	72007	6,787	2	2	3	2	2	2

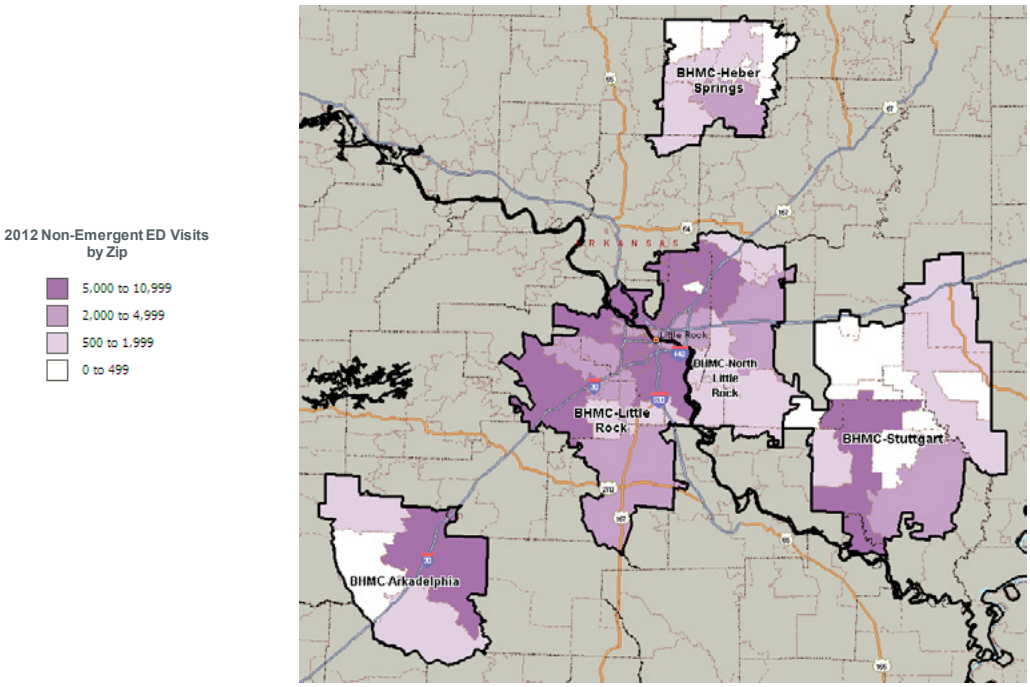
Baptist Health Community	Zip	2011 Population	Overall CNI Score	Income Rank	Education Rank	Culture Rank	Insurance Rank	Housing Rank
BHMC-Stuttgart	72021	4,158	5	5	5	5	5	5
	72069	1,148	5	5	5	5	5	5
	72042	5,275	5	5	5	4	5	5
	72029	2,233	5	5	5	4	5	5
	72073	1,189	5	5	5	5	5	4
	72134	281	5	5	5	4	4	5
	72160	10,128	4	4	4	5	4	5
	72072	396	4	4	5	4	5	4
	72041	1,559	4	4	5	4	4	4
	72064	1,929	4	4	4	3	4	4
	72003	741	3	2	4	3	3	4
	72026	365	3	4	3	4	2	3
	72170	262	3	1	5	3	3	4
	72038	58	3	4	3	4	2	3

Baptist Health Community	Zip	2011 Population	Overall CNI Score	Income Rank	Education Rank	Culture Rank	Insurance Rank	Housing Rank
BHMC Heber Springs	72543	12,503	4	4	4	2	4	4
	72523	1,086	3	5	5	1	4	1
	72131	4,112	3	3	4	2	3	3
	72179	518	3	5	4	1	4	1
	72067	2,759	3	3	4	2	4	1
	72530	1,988	3	4	4	1	3	2
	72581	1,047	3	4	4	1	3	2
	72044	795	3	4	4	1	4	1
	72130	397	3	4	5	1	3	1
	72546	118	2	1	4	1	3	2

Baptist Health Community	Zip	2011 Population	Overall CNI Score	Income Rank	Education Rank	Culture Rank	Insurance Rank	Housing Rank
BHMC-Arkadelphia	71923	16,945	5	5	4	4	5	5
	71743	4,120	4	4	5	4	5	4
	71999	17	4	5	1	5	5	5
	71921	2,985	4	4	5	3	5	2
	71962	945	3	2	5	4	5	1
	71998	259	3	1	1	3	4	5

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BAPTIST HEALTH
NON-EMERGENT ED VISITS BY ZIP



BAPTIST HEALTH
2012 – 2017 ED VISITS BY ZIP

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

Little Rock

Zip Code	2012 Total ED Visits	2012 Non-Emergent ED Visits	2012 % Non-Emergent	2017 Total ED Visits	2017 Non-Emergent ED Visits	2017 % Non-Emergent	2012 - 2017 % Chg Non-Emergent
72002	5,868	4,599	78%	6,614	5,052	76%	10%
72011	1,865	1,486	80%	2,142	1,672	78%	13%
72015	11,850	9,252	78%	13,338	10,201	76%	10%
72019	10,274	7,983	78%	11,646	8,855	76%	11%
72022	6,101	4,809	79%	7,006	5,407	77%	12%
72065	2,128	1,673	79%	2,359	1,814	77%	8%
72103	5,380	4,240	79%	5,764	4,431	77%	5%
72113	8,635	5,867	68%	10,301	6,844	66%	17%
72150	5,126	3,554	69%	5,591	3,764	67%	6%
72201	463	300	65%	543	329	61%	10%
72202	4,462	2,974	67%	4,726	2,976	63%	0%
72204	13,558	9,388	69%	14,446	9,619	67%	2%
72205	9,585	6,177	64%	9,888	6,160	62%	0%
72206	10,834	7,244	67%	11,439	7,381	65%	2%
72207	4,479	2,854	64%	4,602	2,865	62%	0%
72209	13,429	9,596	71%	14,343	9,854	69%	3%
72210	6,220	4,203	68%	7,164	4,700	66%	12%
72211	8,377	5,757	69%	9,082	6,076	67%	6%
72212	4,972	3,235	65%	5,344	3,435	64%	6%
72223	7,889	5,302	67%	9,212	6,092	66%	15%
72227	4,889	3,059	63%	5,029	3,065	61%	0%
Total	**146,384**	**103,552**	**71%**	**160,579**	**110,592**	**69%**	**7%**

North Little Rock

Zip Code	2012 Total ED Visits	2012 Non-Emergent ED Visits	2012 % Non-Emergent	2017 Total ED Visits	2017 Non-Emergent ED Visits	2017 % Non-Emergent	2012 - 2017 % Chg Non-Emergent
72007	3,115	1,920	62%	3,732	2,219	59%	16%
72023	13,478	8,428	63%	15,730	9,520	61%	13%
72046	1,871	1,125	60%	2,007	1,156	58%	3%
72076	15,767	10,878	69%	16,839	11,246	67%	3%
72083	108	66	61%	125	73	58%	11%
72086	4,214	2,548	60%	4,743	2,769	58%	9%
72099	289	218	75%	298	221	74%	1%
72114	5,824	4,102	70%	6,299	4,160	66%	1%
72116	8,815	5,478	62%	9,191	5,596	61%	2%
72117	5,405	3,655	68%	5,812	3,787	65%	4%
72118	9,349	6,285	67%	9,989	6,529	65%	4%
72120	12,900	8,668	67%	14,066	9,243	66%	7%
72142	1,065	701	66%	1,208	771	64%	10%
72176	3,127	1,995	64%	3,780	2,331	62%	17%
Total	**85,327**	**56,067**	**66%**	**93,819**	**59,621**	**64%**	**6%**

Stuttgart

Zip Code	2012 Total ED Visits	2012 Non-Emergent ED Visits	2012 % Non-Emergent	2017 Total ED Visits	2017 Non-Emergent ED Visits	2017 % Non-Emergent	2012 - 2017 % Chg Non-Emergent
72003	415	345	83%	416	340	82%	-1%
72021	2,160	1,490	69%	2,092	1,380	66%	-7%
72026	175	143	82%	176	142	81%	-1%
72029	1,024	690	67%	1,019	656	64%	-5%
72038	29	24	83%	29	23	79%	-4%
72041	629	396	63%	636	381	60%	-4%
72042	3,137	2,598	83%	3,193	2,589	81%	0%
72064	789	482	61%	820	483	59%	0%
72069	558	374	67%	541	340	63%	-9%
72072	231	140	61%	257	149	58%	6%
72073	618	515	83%	598	489	82%	-5%
72134	140	93	66%	144	93	65%	0%
72160	6,249	5,193	83%	6,410	5,229	82%	1%
72170	108	67	62%	111	66	59%	-1%
Total	**16,262**	**12,550**	**77%**	**16,442**	**12,360**	**75%**	**-2%**

Heber Springs

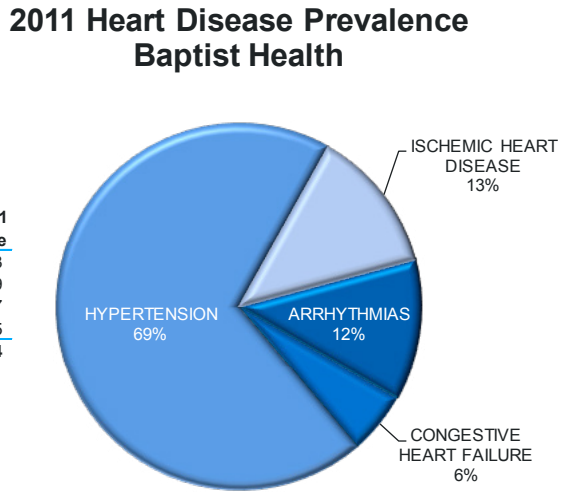
Zip Code	2012 Total ED Visits	2012 Non-Emergent ED Visits	2012 % Non-Emergent	2017 Total ED Visits	2017 Non-Emergent ED Visits	2017 % Non-Emergent	2012 - 2017 % Chg Non-Emergent
72044	548	312	57%	597	329	55%	5%
72067	1,579	931	59%	1,722	982	57%	5%
72130	251	158	63%	283	173	61%	9%
72131	2,586	1,653	64%	2,855	1,781	62%	8%
72179	311	199	64%	349	212	61%	7%
72523	614	399	65%	658	411	62%	3%
72530	1,165	737	63%	1,290	792	61%	7%
72543	7,782	4,700	60%	8,611	5,019	58%	7%
72546	67	43	64%	73	44	60%	2%
72581	612	372	61%	673	394	59%	6%
Total	**15,515**	**9,504**	**61%**	**17,111**	**10,137**	**59%**	**7%**

Arkadelphia

Zip Code	2012 Total ED Visits	2012 Non-Emergent ED Visits	2012 % Non-Emergent	2017 Total ED Visits	2017 Non-Emergent ED Visits	2017 % Non-Emergent	2012 - 2017 % Chg Non-Emergent
71743	2,438	1,558	64%	2,620	1,614	62%	4%
71921	1,823	1,137	62%	2,062	1,234	60%	9%
71923	9,758	6,342	65%	10,678	6,684	63%	5%
71962	512	316	62%	561	332	59%	5%
71998	236	177	75%	259	191	74%	8%
71999	285	207	73%	307	216	70%	4%
Total	**15,052**	**9,737**	**65%**	**16,487**	**10,271**	**62%**	**5%**

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BAPTIST HEALTH
2011 ESTIMATED HEART DISEASE PREVALENCE



Baptist Health

Heart Disease Type	2011 Prevalence
ARRHYTHMIAS	26,633
CONGESTIVE HEART FAILURE	11,729
HYPERTENSION	148,097
ISCHEMIC HEART DISEASE	27,175
Grand Total	**213,634**

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

Little Rock

Zip Code	ARRHYTHMIAS 2011 Prevalence	CONGESTIVE HEART FAILURE 2011 Prevalence	HYPERTENSION 2011 Prevalence	ISCHEMIC HEART DISEASE 2011 Prevalence	TOTAL HEART DISEASE 2011 Prevalence
72002	480	189	2,554	447	3,670
72011	135	52	739	121	1,047
72015	1,225	476	6,004	1,122	8,827
72019	965	381	4,869	911	7,126
72022	506	197	2,591	463	3,757
72065	177	69	943	165	1,354
72103	484	188	2,547	444	3,663
72113	817	352	5,178	812	7,159
72150	576	258	3,184	672	4,690
72201	39	17	234	40	330
72202	518	221	2,826	511	4,076
72204	1,282	535	7,688	1,207	10,712
72205	1,209	518	6,469	1,192	9,388
72206	1,119	478	6,262	1,118	8,977
72207	563	242	3,072	562	4,439
72209	1,033	420	6,418	944	8,815
72210	544	233	3,277	544	4,598
72211	771	323	4,821	729	6,644
72212	593	259	3,380	610	4,842
72223	724	314	4,485	735	6,258
72227	634	274	3,367	646	4,921
Total	**14,394**	**5,996**	**80,908**	**13,995**	**115,293**

North Little Rock

Zip Code	ARRHYTHMIAS 2011 Prevalence	CONGESTIVE HEART FAILURE 2011 Prevalence	HYPERTENSION 2011 Prevalence	ISCHEMIC HEART DISEASE 2011 Prevalence	TOTAL HEART DISEASE 2011 Prevalence
72007	221	121	1,473	282	2,097
72023	1,113	603	7,568	1,389	10,673
72046	183	101	1,079	237	1,600
72076	1,478	614	8,850	1,420	12,362
72083	9	5	52	12	78
72086	372	204	2,273	477	3,326
72099	29	8	261	16	314
72114	512	213	2,869	487	4,081
72116	1,174	510	6,175	1,202	9,061
72117	532	225	2,961	526	4,244
72118	960	408	5,384	952	7,704
72120	1,313	559	7,673	1,307	10,852
72142	104	45	602	108	859
72176	212	113	1,427	260	2,012
Total	**8,212**	**3,729**	**48,647**	**8,675**	**69,263**

Stuttgart

Zip Code	ARRHYTHMIAS 2011 Prevalence	CONGESTIVE HEART FAILURE 2011 Prevalence	HYPERTENSION 2011 Prevalence	ISCHEMIC HEART DISEASE 2011 Prevalence	TOTAL HEART DISEASE 2011 Prevalence
72003	32	17	136	39	224
72021	184	110	914	213	1,421
72026	16	9	71	20	116
72029	101	61	514	118	794
72038	3	1	11	3	18
72041	82	42	385	97	606
72042	251	137	1,007	303	1,698
72064	112	58	500	134	804
72069	57	34	276	66	433
72072	14	8	90	19	131
72073	50	27	214	60	351
72134	11	7	61	13	92
72160	451	246	1,850	536	3,083
72170	14	7	67	16	104
Total	**1,378**	**764**	**6,096**	**1,637**	**9,875**

Arkadelphia

Zip Code	ARRHYTHMIAS 2011 Prevalence	CONGESTIVE HEART FAILURE 2011 Prevalence	HYPERTENSION 2011 Prevalence	ISCHEMIC HEART DISEASE 2011 Prevalence	TOTAL HEART DISEASE 2011 Prevalence
71743	202	84	967	189	1,442
71921	157	65	728	150	1,100
71923	773	310	3,765	687	5,535
71962	51	22	241	50	364
71998	5	1	36	2	44
71999	0	0	3	0	3
Total	**1,188**	**482**	**5,740**	**1,078**	**8,488**

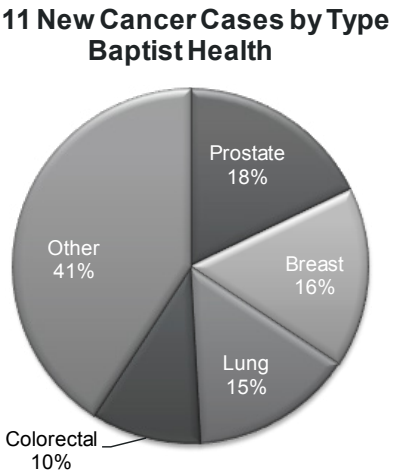
Heber Springs

Zip Code	ARRHYTHMIAS 2011 Prevalence	CONGESTIVE HEART FAILURE 2011 Prevalence	HYPERTENSION 2011 Prevalence	ISCHEMIC HEART DISEASE 2011 Prevalence	TOTAL HEART DISEASE 2011 Prevalence
72044	57	30	242	72	401
72067	176	92	792	223	1,283
72130	21	11	99	25	156
72131	210	108	997	255	1,570
72179	26	13	129	31	199
72523	51	26	254	61	392
72530	100	52	495	122	769
72543	755	392	3,385	920	5,452
72546	6	3	30	8	47
72581	59	31	283	73	446
Total	**1,461**	**758**	**6,706**	**1,790**	**10,715**

BAPTIST HEALTH
2011 ESTIMATED CANCER INCIDENCE

Baptist Health

Cancer Type	2011 Incidence (new Cancer cases)
PROSTATE	709
BREAST	655
LUNG	589
OTHER	412
COLORECTAL	398
NH LYMPHOMA	162
KIDNEY	132
MELANOMA	127
BLADDER	123
LEUKEMIA	119
PANCREAS	108
ORAL CAVITY	96
UTERINE	89
STOMACH	65
OVARIAN	63
BRAIN	55
THYROID	54
CERVICAL	19
Grand Total	**3,976**



Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

Little Rock

Zip Code	BREAST 2011 Incidence	COLORECTAL 2011 Incidence	LUNG 2011 Incidence	PROSTATE 2011 Incidence	OTHER 2011 Incidence
72002	12	7	10	13	30
72011	3	2	3	4	9
72015	29	18	25	30	73
72019	23	14	20	25	60
72022	12	7	10	13	31
72065	4	3	4	5	11
72103	12	7	10	13	30
72113	22	11	17	22	52
72150	13	9	13	15	35
72201	1	1	1	1	2
72202	12	8	12	15	28
72204	32	19	29	37	72
72205	30	17	26	28	68
72206	26	17	26	34	63
72207	14	8	12	13	33
72209	26	15	22	27	59
72210	14	8	12	15	33
72211	20	10	16	18	46
72212	15	8	13	16	36
72223	18	10	16	20	46
72227	15	9	14	15	37
Total	**354**	**208**	**309**	**378**	**855**

North Little Rock

Zip Code	BREAST 2011 Incidence	COLORECTAL 2011 Incidence	LUNG 2011 Incidence	PROSTATE 2011 Incidence	OTHER 2011 Incidence
72007	6	4	6	7	17
72023	33	19	28	33	86
72046	5	3	5	6	13
72076	36	20	30	38	88
72083	0	0	0	0	1
72086	10	6	10	11	27
72099	0	0	0	0	2
72114	12	8	11	14	28
72116	28	16	26	28	69
72117	12	8	12	15	30
72118	23	13	21	24	56
72120	32	18	28	33	80
72142	2	2	2	3	6
72176	6	3	5	6	16
Total	**208**	**121**	**186**	**221**	**517**

Stuttgart

Zip Code	BREAST 2011 Incidence	COLORECTAL 2011 Incidence	LUNG 2011 Incidence	PROSTATE 2011 Incidence	OTHER 2011 Incidence
72003	1	1	1	1	2
72021	5	4	6	6	14
72026	0	0	0	1	1
72029	3	2	3	3	8
72038	0	0	0	0	0
72041	2	1	2	3	5
72042	7	4	6	7	16
72064	3	2	3	3	7
72069	2	1	2	2	4
72072	0	0	0	0	1
72073	1	1	1	2	3
72134	0	0	0	0	1
72160	12	8	12	14	29
72170	0	0	0	0	1
Total	**37**	**24**	**37**	**42**	**92**

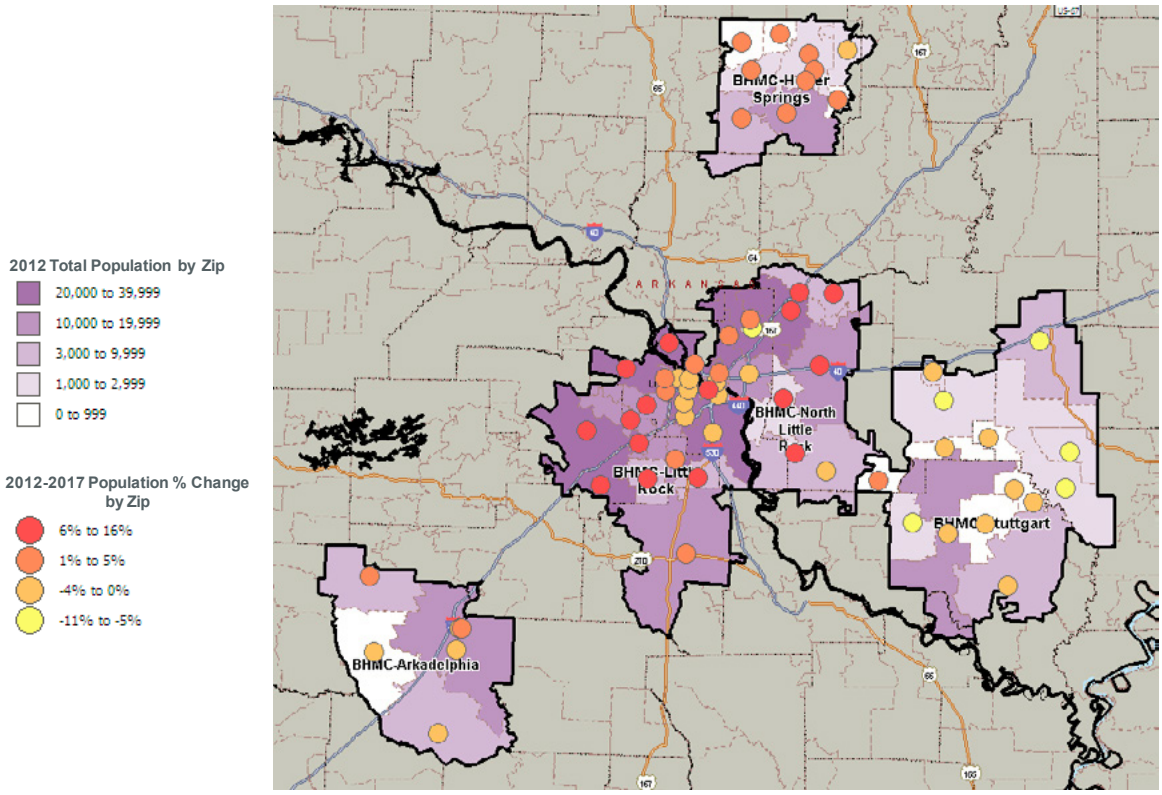
Arkadelphia

Zip Code	BREAST 2011 Incidence	COLORECTAL 2011 Incidence	LUNG 2011 Incidence	PROSTATE 2011 Incidence	OTHER 2011 Incidence
71743	4	3	4	5	12
71921	3	3	3	4	9
71923	15	12	14	16	44
71962	1	1	1	1	3
71998	0	0	0	0	0
71999	0	0	0	0	0
Total	**23**	**19**	**22**	**26**	**68**

Heber Springs

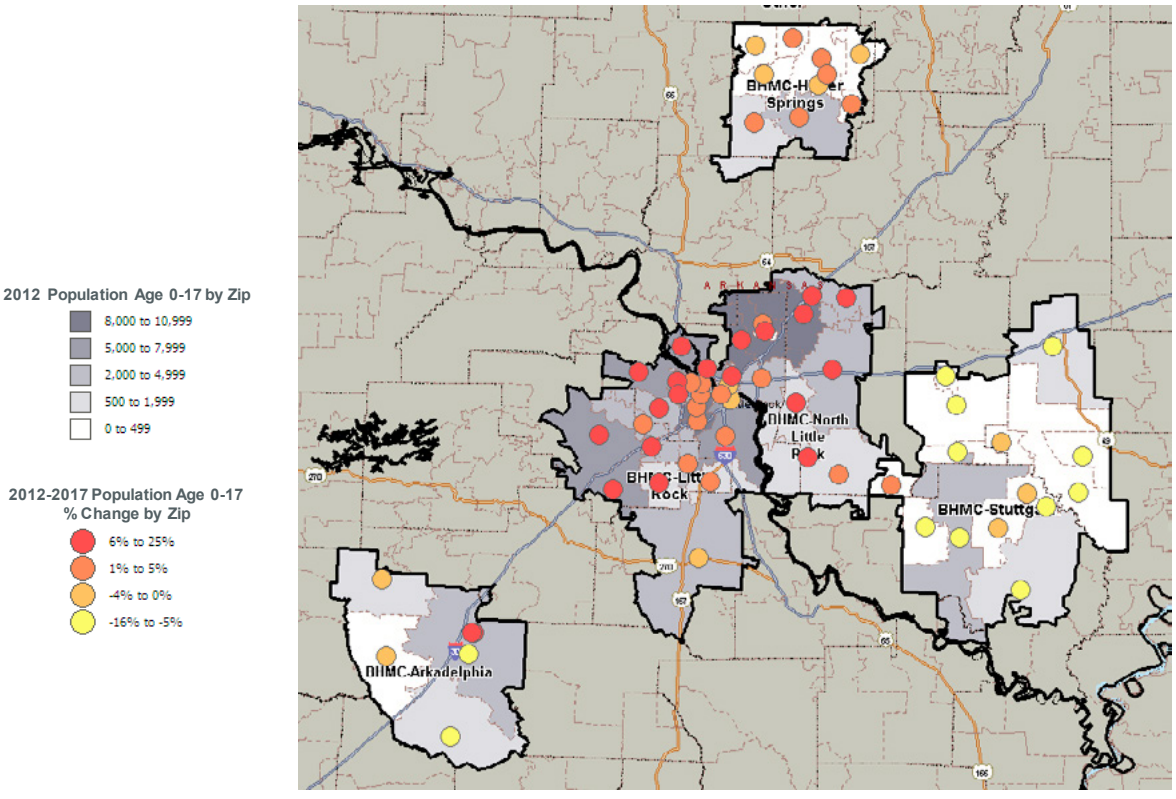
Zip Code	BREAST 2011 Incidence	COLORECTAL 2011 Incidence	LUNG 2011 Incidence	PROSTATE 2011 Incidence	OTHER 2011 Incidence
72044	1	1	1	2	4
72067	4	3	4	6	11
72130	0	0	1	1	1
72131	5	4	5	6	13
72179	1	0	1	1	2
72523	1	1	1	1	3
72530	2	2	2	3	7
72543	17	14	18	21	47
72546	0	0	0	0	0
72581	1	1	1	2	4
Total	**33**	**26**	**36**	**42**	**92**

BAPTIST HEALTH
2012 – 2017 TOTAL POPULATION



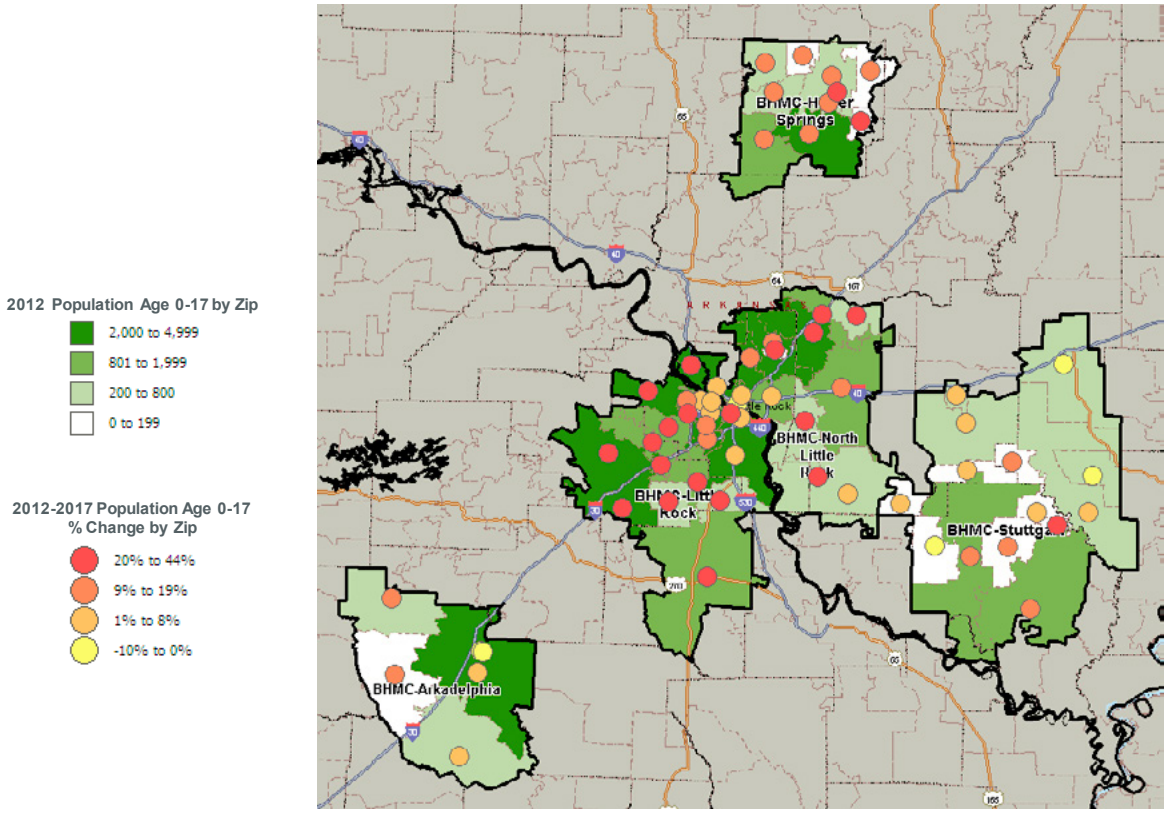
Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BAPTIST HEALTH
2012 – 2017 POPULATION CHILDREN AGE 0-17



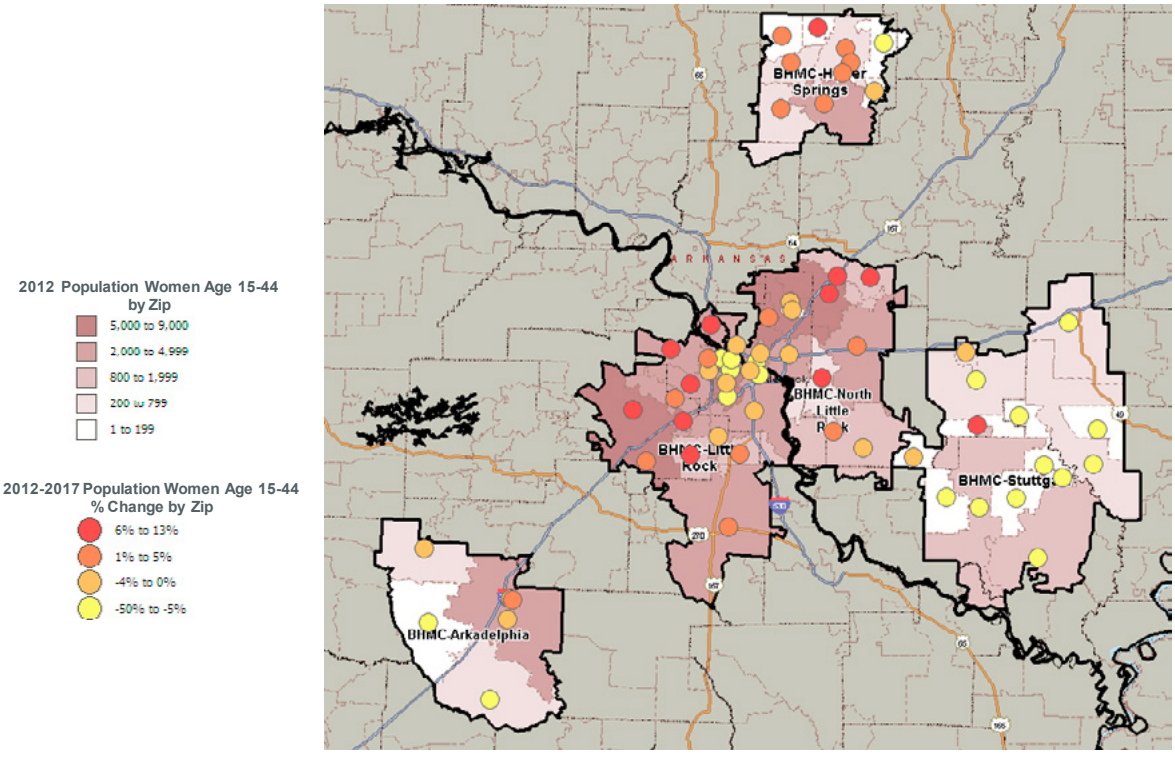
Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BAPTIST HEALTH
2012 – 2017 POPULATION AGE 65+



Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BAPTIST HEALTH
2012–2017 POPULATION WOMEN CHILDBEARING AGE



Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BAPTIST HEALTH
2012 – 2017 POPULATION BY AGE GROUP BY ZIP

LITTLE ROCK

Zip Code	Age Group	2000 Population	2012 Population	2017 Population	2012-2017 Change
72207	00-17	2,140	2,426	2,518	4%
72207	18-44	4,549	3,770	3,465	-8%
72207	45-64	2,693	3,087	3,145	2%
72207	65+	1,777	1,765	1,899	8%
72209	00-17	10,299	10,088	10,195	1%
72209	18-44	13,156	12,830	12,467	-3%
72209	45-64	5,671	6,689	6,754	1%
72209	65+	2,575	2,787	3,093	11%
72210	00-17	2,600	3,915	4,519	15%
72210	18-44	4,433	5,583	5,913	6%
72210	45-64	2,868	4,397	4,642	6%
72210	65+	932	1,752	2,282	30%
72211	00-17	3,963	5,441	5,977	10%
72211	18-44	8,996	8,414	8,047	-4%
72211	45-64	3,737	5,458	6,006	10%
72211	65+	1,612	2,024	2,506	24%
72212	00-17	2,679	2,997	3,314	11%
72212	18-44	3,636	3,919	4,077	4%
72212	45-64	3,365	3,808	3,588	-6%
72212	65+	1,329	1,769	2,063	17%
72223	00-17	3,490	5,589	6,445	15%
72223	18-44	4,917	6,325	6,946	10%
72223	45-64	3,376	6,238	6,640	6%
72223	65+	992	2,257	2,966	31%
72227	00-17	2,381	2,238	2,345	5%
72227	18-44	4,315	3,975	3,804	-4%
72227	45-64	3,207	3,286	3,111	-5%
72227	65+	1,939	2,143	2,314	8%

LITTLE ROCK

Zip Code	Age Group	2000 Population	2012 Population	2017 Population	2012-2017 Change
72002	00-17	2,849	3,503	3,658	4%
72002	18-44	4,304	5,382	5,651	5%
72002	45-64	2,659	4,048	4,491	11%
72002	65+	894	1,383	1,912	38%
72011	00-17	946	1,197	1,284	7%
72011	18-44	1,361	1,817	1,944	7%
72011	45-64	645	1,132	1,351	19%
72011	65+	227	357	497	39%
72015	00-17	5,451	7,286	7,799	7%
72015	18-44	8,579	10,714	11,127	4%
72015	45-64	4,677	6,809	7,747	14%
72015	65+	3,022	3,338	4,009	20%
72019	00-17	4,853	5,945	6,385	7%
72019	18-44	7,003	9,272	9,987	8%
72019	45-64	4,691	7,112	7,700	8%
72019	65+	2,169	2,784	3,738	34%
72022	00-17	2,772	3,901	4,240	9%
72022	18-44	3,841	5,527	5,966	8%
72022	45-64	2,259	3,865	4,432	15%
72022	65+	1,040	1,407	1,886	34%
72065	00-17	1,022	1,211	1,259	4%
72065	18-44	1,705	2,142	2,201	3%
72065	45-64	1,008	1,426	1,539	8%
72065	65+	319	473	657	39%
72103	00-17	3,284	3,384	3,421	1%
72103	18-44	4,822	4,934	4,884	-1%
72103	45-64	2,861	3,383	3,520	4%
72103	65+	973	1,239	1,615	30%

LITTLE ROCK

Zip Code	Age Group	2000 Population	2012 Population	2017 Population	2012-2017 Change
72113	00-17	3,429	5,977	7,033	18%
72113	18-44	5,235	7,442	8,081	9%
72113	45-64	3,309	6,899	7,708	12%
72113	65+	880	2,202	3,099	41%
72150	00-17	2,966	3,011	2,954	-2%
72150	18-44	4,318	4,361	4,453	2%
72150	45-64	2,765	3,528	3,696	5%
72150	65+	1,392	1,689	2,061	22%
72201	00-17	60	101	105	4%
72201	18-44	424	433	431	0%
72201	45-64	187	302	341	13%
72201	65+	80	142	174	23%
72202	00-17	2,381	1,864	1,857	0%
72202	18-44	4,782	3,995	3,705	-7%
72202	45-64	2,564	2,352	2,319	-1%
72202	65+	1,569	1,412	1,475	4%
72204	00-17	8,717	8,249	8,499	3%
72204	18-44	14,035	13,066	12,682	-3%
72204	45-64	6,657	7,328	7,118	-3%
72204	65+	3,449	3,489	3,819	9%
72205	00-17	4,327	4,477	4,573	2%
72205	18-44	10,435	8,681	8,000	-8%
72205	45-64	5,064	5,939	5,978	1%
72205	65+	3,915	3,646	3,935	8%
72206	00-17	6,926	6,094	6,242	2%
72206	18-44	10,389	9,461	9,299	-2%
72206	45-64	6,688	6,545	6,181	-6%
72206	65+	3,572	3,526	3,768	7%

NORTH LITTLE ROCK

Zip Code	Age Group	2000 Population	2012 Population	2017 Population	2012-2017 Change
72007	00-17	1,405	2,067	2,232	8%
72007	18-44	1,955	3,100	3,431	11%
72007	45-64	1,094	2,217	2,649	19%
72007	65+	419	859	1,179	37%
72023	00-17	7,409	9,840	10,678	9%
72023	18-44	10,001	13,379	14,339	7%
72023	45-64	5,331	9,044	10,477	16%
72023	65+	1,981	3,492	4,655	33%
72046	00-17	1,243	1,190	1,204	1%
72046	18-44	1,684	1,584	1,573	-1%
72046	45-64	1,100	1,055	1,038	-2%
72046	65+	759	674	713	6%
72076	00-17	11,463	10,533	11,013	5%
72076	18-44	16,987	14,642	14,315	-2%
72076	45-64	7,802	9,096	9,104	0%
72076	65+	3,178	4,195	4,750	13%
72083	00-17	59	73	81	11%
72083	18-44	79	94	95	1%
72083	45-64	53	74	82	11%
72083	65+	30	33	42	27%
72086	00-17	2,496	2,846	3,033	7%
72086	18-44	3,455	3,837	3,982	4%
72086	45-64	2,202	2,544	2,708	6%
72086	65+	1,219	1,432	1,688	18%
72099	00-17	90	33	36	9%
72099	18-44	1,224	648	605	-7%
72099	45-64	69	33	37	12%
72099	65+	16	13	18	38%

NORTH LITTLE ROCK

Zip Code	Age Group	2000 Population	2012 Population	2017 Population	2012-2017 Change
72114	00-17	4,756	3,913	3,820	-2%
72114	18-44	5,323	4,720	4,629	-2%
72114	45-64	2,614	2,562	2,438	-5%
72114	65+	1,951	1,514	1,504	-1%
72116	00-17	4,098	4,178	4,466	7%
72116	18-44	7,432	7,112	6,985	-2%
72116	45-64	5,481	6,037	5,917	-2%
72116	65+	3,612	3,969	4,302	8%
72117	00-17	3,499	3,160	3,307	5%
72117	18-44	4,510	4,659	4,644	0%
72117	45-64	2,774	2,900	2,778	-4%
72117	65+	1,563	1,714	1,778	4%
72118	00-17	5,470	5,707	6,136	8%
72118	18-44	8,748	8,242	8,061	-2%
72118	45-64	4,802	5,694	5,709	0%
72118	65+	2,835	2,931	3,158	8%
72120	00-17	6,834	8,100	8,889	10%
72120	18-44	10,861	11,781	11,899	1%
72120	45-64	6,918	8,713	8,839	1%
72120	65+	2,756	3,831	4,584	20%
72142	00-17	497	599	657	10%
72142	18-44	768	906	967	7%
72142	45-64	577	782	814	4%
72142	65+	253	359	438	22%
72176	00-17	1,632	2,494	2,810	13%
72176	18-44	2,189	3,179	3,468	9%
72176	45-64	1,031	1,783	2,238	26%
72176	65+	407	757	978	29%

ARKADELPHIA

Zip Code	Age Group	2000 Population	2012 Population	2017 Population	2012-2017 Change
71743	00-17	1,184	1,058	1,012	-4%
71743	18-44	1,593	1,345	1,357	1%
71743	45-64	977	1,046	980	-6%
71743	65+	662	596	640	7%
71921	00-17	686	757	744	-2%
71921	18-44	931	966	1,024	6%
71921	45-64	661	792	787	-1%
71921	65+	437	503	574	14%
71923	00-17	3,289	3,225	3,064	-5%
71923	18-44	7,352	6,902	6,993	1%
71923	45-64	3,081	3,344	3,163	-5%
71923	65+	2,346	2,189	2,337	7%
71962	00-17	200	210	202	-4%
71962	18-44	275	243	251	3%
71962	45-64	233	250	235	-6%
71962	65+	136	146	165	13%
71998	00-17	16	8	10	25%
71998	18-44	265	317	318	0%
71998	45-64	16	8	13	63%
71998	65+	13	10	9	-10%
71999	00-17	47	25	27	8%
71999	18-44	353	354	341	-4%
71999	45-64	28	27	22	-19%
71999	65+	28	21	20	-5%

HEBER SPRINGS

Zip Code	Age Group	2000 Population	2012 Population	2017 Population	2012-2017 Change
72044	00-17	149	156	155	-1%
72044	18-44	188	202	217	7%
72044	45-64	268	259	246	-5%
72044	65+	229	268	296	10%
72067	00-17	502	480	479	0%
72067	18-44	681	637	675	6%
72067	45-64	799	858	817	-5%
72067	65+	605	668	762	14%
72130	00-17	89	96	97	1%
72130	18-44	126	124	134	8%
72130	45-64	104	123	125	2%
72130	65+	68	84	96	14%
72131	00-17	907	1,070	1,117	4%
72131	18-44	1,257	1,310	1,360	4%
72131	45-64	970	1,173	1,185	1%
72131	65+	740	821	911	11%
72179	00-17	104	112	116	4%
72179	18-44	158	156	157	1%
72179	45-64	137	171	167	-2%
72179	65+	71	91	120	32%

HEBER SPRINGS

Zip Code	Age Group	2000 Population	2012 Population	2017 Population	2012-2017 Change
72523	00-17	268	231	222	-4%
72523	18-44	366	347	332	-4%
72523	45-64	265	290	303	4%
72523	65+	157	172	191	11%
72530	00-17	396	434	442	2%
72530	18-44	618	584	616	5%
72530	45-64	513	613	632	3%
72530	65+	308	367	412	12%
72543	00-17	2,380	2,464	2,497	1%
72543	18-44	3,420	3,571	3,665	3%
72543	45-64	2,844	3,515	3,545	1%
72543	65+	2,541	3,117	3,542	14%
72546	00-17	22	25	26	4%
72546	18-44	35	35	33	-6%
72546	45-64	32	36	36	0%
72546	65+	19	19	25	32%
72581	00-17	177	184	184	0%
72581	18-44	310	286	297	4%
72581	45-64	300	343	339	-1%
72581	65+	191	223	260	17%

STUTTGART

Zip Code	Age Group	2000 Population	2012 Population	2017 Population	2012-2017 Change
72003	00-17	189	173	167	-3%
72003	18-44	307	228	215	-6%
72003	45-64	225	227	219	-4%
72003	65+	115	105	115	10%
72021	00-17	1,641	1,127	1,005	-11%
72021	18-44	1,714	1,181	1,088	-8%
72021	45-64	1,271	1,258	1,059	-16%
72021	65+	919	793	769	-3%
72026	00-17	83	70	69	-1%
72026	18-44	129	87	82	-6%
72026	45-64	108	112	110	-2%
72026	65+	57	52	55	6%
72029	00-17	701	444	404	-9%
72029	18-44	894	599	537	-10%
72029	45-64	685	664	602	-9%
72029	65+	468	398	415	4%
72038	00-17	12	13	11	-15%
72038	18-44	20	14	13	-7%
72038	45-64	18	19	18	-5%
72038	65+	12	7	10	43%
72041	00-17	429	317	293	-8%
72041	18-44	576	476	442	-7%
72041	45-64	456	466	431	-8%
72041	65+	298	292	311	7%
72042	00-17	1,379	1,253	1,194	-5%
72042	18-44	2,004	1,604	1,552	-3%
72042	45-64	1,419	1,498	1,389	-7%
72042	65+	1,019	866	947	9%

STUTTGART

Zip Code	Age Group	2000 Population	2012 Population	2017 Population	2012-2017 Change
72064	00-17	505	403	378	-6%
72064	18-44	703	573	564	-2%
72064	45-64	536	570	548	-4%
72064	65+	430	421	444	5%
72069	00-17	409	215	182	-15%
72069	18-44	466	290	259	-11%
72069	45-64	331	319	277	-13%
72069	65+	311	226	221	-2%
72072	00-17	146	135	142	5%
72072	18-44	215	214	218	2%
72072	45-64	127	123	129	5%
72072	65+	79	77	81	5%
72073	00-17	361	242	215	-11%
72073	18-44	462	325	304	-6%
72073	45-64	334	300	269	-10%
72073	65+	199	155	150	-3%
72134	00-17	82	61	61	0%
72134	18-44	114	83	79	-5%
72134	45-64	90	100	91	-9%
72134	65+	52	55	61	11%
72160	00-17	2,902	2,660	2,534	-5%
72160	18-44	3,880	3,298	3,256	-1%
72160	45-64	2,636	2,890	2,711	-6%
72160	65+	1,758	1,660	1,840	11%
72170	00-17	67	55	49	-11%
72170	18-44	97	78	80	3%
72170	45-64	80	91	84	-8%
72170	65+	44	52	56	8%

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BAPTIST HEALTH
2012 – 2017 WOMEN CHILDBEARING AGE BY ZIP

BHMC-LITTLE ROCK

Zip Code	2012 Population	2017 Population	2012-2017 Change
72002	2,972	3,104	4%
72011	1,015	1,087	7%
72015	5,778	6,112	5%
72019	5,081	5,502	8%
72022	3,192	3,465	8%
72065	1,043	1,075	3%
72103	2,756	2,719	-1%
72113	4,268	4,613	7%
72150	2,462	2,493	1%
72201	196	196	0%
72202	2,170	2,007	-8%
72204	7,146	6,874	-4%
72205	4,747	4,410	-8%
72206	4,975	4,800	-4%
72207	2,205	2,061	-7%
72209	7,748	7,422	-4%
72210	3,226	3,442	6%
72211	4,796	4,659	-3%
72212	2,345	2,402	2%
72223	3,792	4,079	7%
72227	2,281	2,189	-4%
TOTAL	**74,194**	**74,711**	**0.7%**

BHMC-NORTH LITTLE ROCK

Zip Code	2012 Population	2017 Population	2012-2017 Change
72007	1,802	1,950	8%
72023	7,586	8,129	7%
72046	920	927	1%
72076	8,256	8,091	-2%
72083	53	56	5%
72086	2,079	2,190	5%
72099	118	116	-2%
72114	2,871	2,740	-5%
72116	3,970	3,901	-2%
72117	2,651	2,575	-3%
72118	4,653	4,566	-2%
72120	6,576	6,647	1%
72142	480	523	8%
72176	1,797	1,985	9%
TOTAL	**43,812**	**44,396**	**1.3%**

BHMC-ARKADELPHIA

Zip Code	2012 Population	2017 Population	2012-2017 Change
71743	798	763	-4%
71921	546	549	1%
71923	3,817	3754	-2%
71962	140	134	-4%
71998	153	156	2%
71999	176	171	-3%
TOTAL	**5,630**	**5,527**	**-1.8%**

BHMC-HEBER SPRINGS

Zip Code	2012 Population	2017 Population	2012-2017 Change
72044	119	121	2%
72067	356	363	2%
72130	68	75	10%
72131	751	767	2%
72179	93	93	0%
72523	185	175	-5%
72530	324	339	5%
72543	2,017	2,048	2%
72546	19	20	5%
72581	162	167	3%
TOTAL	**4,094**	**4,168**	**1.8%**

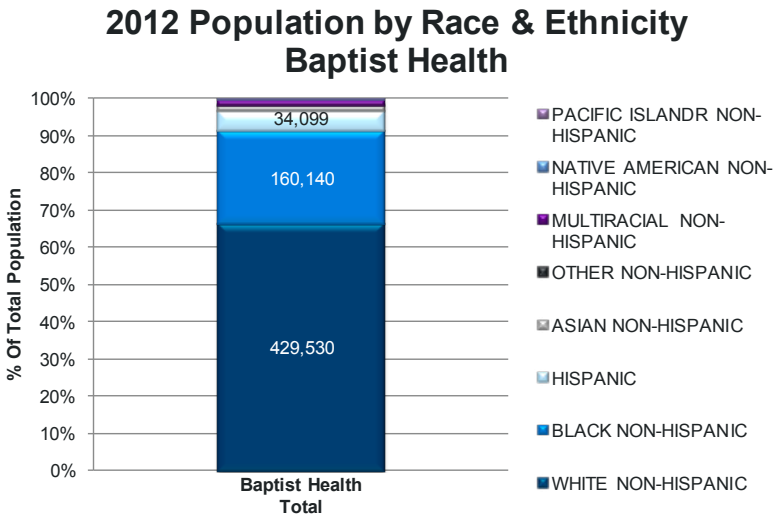
BHMC-STUTTGART

Zip Code	2012 Population	2017 Population	2012-2017 Change
72003	125	119	-5%
72021	728	653	-10%
72026	47	45	-4%
72029	323	288	-11%
72038	9	6	-33%
72041	280	259	-8%
72042	920	880	-4%
72064	322	311	-3%
72069	170	148	-13%
72072	119	120	1%
72073	191	172	-10%
72134	43	41	-5%
72160	1,969	1,878	-5%
72170	40	46	15%
TOTAL	**5,286**	**4,966**	**-6.1%**

Note: women childbearing age = females age 15-44

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BAPTIST HEALTH
2012 POPULATION BY RACE & ETHNICITY



Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BAPTIST HEALTH
2012-2017 POPULATION BY RACE & ETHNICITY

	BHMC-Little Rock				BHMC-North Little Rock			
Race/Ethnicity	2012 Population	2017 Population	2012-2017 Population Chg	2012-2017 Population % Chg	2012 Population	2017 Population	2012-2017 Population Chg	2012-2017 Population % Chg
WHITE NON-HISPANIC	222,836	225,977	3,141	1%	144,752	146,754	2,002	1%
BLACK NON-HISPANIC	97,998	105,106	7,108	7%	47,987	52,817	4,830	10%
HISPANIC	21,397	27,935	6,538	31%	10,381	13,291	2,910	28%
ASIAN NON-HISPANIC	7,215	8,827	1,612	22%	2,352	2,743	391	17%
OTHER NON-HISPANIC	462	586	124	27%	235	276	41	17%
MULTIRACIAL NON-HISPANIC	4,917	5,701	784	16%	4,206	5,033	827	20%
NATIVE AMERICAN NON-HISPANIC	1,241	1,296	55	4%	902	935	33	4%
PACIFIC ISLANDR NON-HISPANIC	86	99	13	15%	108	121	13	12%
Grand Total	**356,152**	**375,527**	**19,375**	**5%**	**210,923**	**221,970**	**11,047**	**5%**

	BHMC-Arkadelphia				BHMC-Heber Springs			
Race/Ethnicity	2012 Population	2017 Population	2012-2017 Population Chg	2012-2017 Population % Chg	2012 Population	2017 Population	2012-2017 Population Chg	2012-2017 Population % Chg
WHITE NON-HISPANIC	17,297	16,937	(360)	-2%	24,567	25,453	886	4%
BLACK NON-HISPANIC	5,445	5,562	117	2%	75	93	18	24%
HISPANIC	1,035	1,205	170	16%	555	680	125	23%
ASIAN NON-HISPANIC	127	122	(5)	-4%	56	61	5	9%
OTHER NON-HISPANIC	28	35	7	25%	2	3	1	50%
MULTIRACIAL NON-HISPANIC	317	337	20	6%	325	389	64	20%
NATIVE AMERICAN NON-HISPANIC	89	85	(4)	-4%	128	144	16	13%
PACIFIC ISLANDR NON-HISPANIC	4	5	1	25%	7	8	1	14%
Grand Total	**24,342**	**24,288**	**(54)**	**0%**	**25,715**	**26,831**	**1,116**	**4%**

	BHMC-Stuttgart			
Race/Ethnicity	2012 Population	2017 Population	2012-2017 Population Chg	2012-2017 Population % Chg
WHITE NON-HISPANIC	20,078	18,953	(1,125)	-6%
BLACK NON-HISPANIC	8,635	8,356	(279)	-3%
HISPANIC	731	879	148	20%
ASIAN NON-HISPANIC	134	149	15	11%
OTHER NON-HISPANIC	18	18	-	0%
MULTIRACIAL NON-HISPANIC	351	384	33	9%
NATIVE AMERICAN NON-HISPANIC	65	63	(2)	-3%
PACIFIC ISLANDR NON-HISPANIC	2	3	1	50%
Grand Total	**30,014**	**28,805**	**(1,209)**	**-4%**

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BAPTIST HEALTH
RACE & ETHNICITY BY ZIP

BHMC-Little Rock

Zip Code	Ethnicity	2000 Population	2012 Population	2017 Population	2012-2017 Change
72002	ASIAN NON-HISPANIC	54	94	111	18%
72002	BLACK NON-HISPANIC	308	1,364	1,867	37%
72002	HISPANIC	138	965	1,388	44%
72002	MULTIRACIAL NON-HISPANIC	103	213	266	25%
72002	NATIVE AMERICAN NON-HISPANIC	72	76	76	0%
72002	OTHER NON-HISPANIC	2	13	17	31%
72002	PACIFIC ISLANDR NON-HISPANIC	1	1	1	0%
72002	WHITE NON-HISPANIC	10,028	11,590	11,986	3%
72011	ASIAN NON-HISPANIC	5	12	15	25%
72011	BLACK NON-HISPANIC	19	99	141	42%
72011	HISPANIC	36	170	242	42%
72011	MULTIRACIAL NON-HISPANIC	14	44	61	39%
72011	NATIVE AMERICAN NON-HISPANIC	19	18	16	-11%
72011	OTHER NON-HISPANIC	3	1	2	100%
72011	PACIFIC ISLANDR NON-HISPANIC	1	-	-	0%
72011	WHITE NON-HISPANIC	3,082	4,159	4,599	11%
72015	ASIAN NON-HISPANIC	75	183	239	31%
72015	BLACK NON-HISPANIC	1,036	1,635	1,991	22%
72015	HISPANIC	425	1,313	1,734	32%
72015	MULTIRACIAL NON-HISPANIC	229	372	444	19%
72015	NATIVE AMERICAN NON-HISPANIC	96	164	193	18%
72015	OTHER NON-HISPANIC	5	28	40	43%
72015	PACIFIC ISLANDR NON-HISPANIC	6	6	4	-33%
72015	WHITE NON-HISPANIC	19,857	24,446	26,037	7%
72019	ASIAN NON-HISPANIC	85	183	236	29%
72019	BLACK NON-HISPANIC	157	699	975	39%
72019	HISPANIC	198	750	1,068	42%
72019	MULTIRACIAL NON-HISPANIC	131	243	294	21%
72019	NATIVE AMERICAN NON-HISPANIC	73	72	77	7%
72019	OTHER NON-HISPANIC	3	6	8	33%
72019	PACIFIC ISLANDR NON-HISPANIC	14	1	1	0%
72019	WHITE NON-HISPANIC	18,055	23,159	25,151	9%

BHMC-Little Rock

Zip Code	Ethnicity	2000 Population	2012 Population	2017 Population	2012-2017 Change
72022	ASIAN NON-HISPANIC	98	265	352	33%
72022	BLACK NON-HISPANIC	236	1,262	1,798	42%
72022	HISPANIC	105	871	1,289	48%
72022	MULTIRACIAL NON-HISPANIC	75	200	256	28%
72022	NATIVE AMERICAN NON-HISPANIC	42	71	80	13%
72022	OTHER NON-HISPANIC	2	26	36	38%
72022	PACIFIC ISLANDR NON-HISPANIC	-	1	-	-100%
72022	WHITE NON-HISPANIC	9,354	12,004	12,713	6%
72065	ASIAN NON-HISPANIC	40	99	125	26%
72065	BLACK NON-HISPANIC	321	493	527	7%
72065	HISPANIC	36	147	198	35%
72065	MULTIRACIAL NON-HISPANIC	60	62	62	0%
72065	NATIVE AMERICAN NON-HISPANIC	20	22	21	-5%
72065	OTHER NON-HISPANIC	-	6	8	33%
72065	PACIFIC ISLANDR NON-HISPANIC	-	-	1	0%
72065	WHITE NON-HISPANIC	3,577	4,423	4,714	7%
72103	ASIAN NON-HISPANIC	99	140	156	11%
72103	BLACK NON-HISPANIC	1,786	2,624	2,862	9%
72103	HISPANIC	211	1,096	1,443	32%
72103	MULTIRACIAL NON-HISPANIC	152	196	220	12%
72103	NATIVE AMERICAN NON-HISPANIC	59	66	72	9%
72103	OTHER NON-HISPANIC	4	13	15	15%
72103	PACIFIC ISLANDR NON-HISPANIC	1	5	5	0%
72103	WHITE NON-HISPANIC	9,628	8,800	8,667	-2%
72113	ASIAN NON-HISPANIC	96	517	729	41%
72113	BLACK NON-HISPANIC	1,026	3,543	4,888	38%
72113	HISPANIC	230	803	1,125	40%
72113	MULTIRACIAL NON-HISPANIC	127	334	437	31%
72113	NATIVE AMERICAN NON-HISPANIC	64	78	75	-4%
72113	OTHER NON-HISPANIC	3	47	68	45%
72113	PACIFIC ISLANDR NON-HISPANIC	-	12	17	42%
72113	WHITE NON-HISPANIC	11,307	17,186	18,582	8%

BHMC-Little Rock

Zip Code	Ethnicity	2000 Population	2012 Population	2017 Population	2012-2017 Change
72150	ASIAN NON-HISPANIC	18	44	57	30%
72150	BLACK NON-HISPANIC	123	171	190	11%
72150	HISPANIC	75	221	289	31%
72150	MULTIRACIAL NON-HISPANIC	67	126	149	18%
72150	NATIVE AMERICAN NON-HISPANIC	43	51	55	8%
72150	OTHER NON-HISPANIC	2	2	2	0%
72150	PACIFIC ISLANDR NON-HISPANIC	3	-	-	0%
72150	WHITE NON-HISPANIC	11,110	11,974	12,422	4%
72201	ASIAN NON-HISPANIC	4	14	18	29%
72201	BLACK NON-HISPANIC	395	287	241	-16%
72201	HISPANIC	14	31	42	35%
72201	MULTIRACIAL NON-HISPANIC	8	16	20	25%
72201	NATIVE AMERICAN NON-HISPANIC	4	5	4	-20%
72201	OTHER NON-HISPANIC	1	1	1	0%
72201	PACIFIC ISLANDR NON-HISPANIC	-	-	-	0%
72201	WHITE NON-HISPANIC	325	624	725	16%
72202	ASIAN NON-HISPANIC	73	186	218	17%
72202	BLACK NON-HISPANIC	7,024	5,264	4,898	-7%
72202	HISPANIC	164	264	312	18%
72202	MULTIRACIAL NON-HISPANIC	104	150	170	13%
72202	NATIVE AMERICAN NON-HISPANIC	34	31	28	-10%
72202	OTHER NON-HISPANIC	10	10	12	20%
72202	PACIFIC ISLANDR NON-HISPANIC	2	6	7	17%
72202	WHITE NON-HISPANIC	3,885	3,712	3,711	0%
72204	ASIAN NON-HISPANIC	351	391	409	5%
72204	BLACK NON-HISPANIC	22,198	22,184	22,340	1%
72204	HISPANIC	993	2,479	3,166	28%
72204	MULTIRACIAL NON-HISPANIC	361	520	582	12%
72204	NATIVE AMERICAN NON-HISPANIC	76	88	89	1%
72204	OTHER NON-HISPANIC	27	67	80	19%
72204	PACIFIC ISLANDR NON-HISPANIC	11	2	3	50%
72204	WHITE NON-HISPANIC	8,841	6,401	5,449	-15%

BHMC-Little Rock

Zip Code	Ethnicity	2000 Population	2012 Population	2017 Population	2012-2017 Change
72205	ASIAN NON-HISPANIC	355	552	606	10%
72205	BLACK NON-HISPANIC	5,614	6,420	6,758	5%
72205	HISPANIC	431	797	971	22%
72205	MULTIRACIAL NON-HISPANIC	269	362	398	10%
72205	NATIVE AMERICAN NON-HISPANIC	63	85	93	9%
72205	OTHER NON-HISPANIC	21	37	43	16%
72205	PACIFIC ISLANDR NON-HISPANIC	6	8	9	13%
72205	WHITE NON-HISPANIC	16,982	14,482	13,608	-6%
72206	ASIAN NON-HISPANIC	108	185	216	17%
72206	BLACK NON-HISPANIC	14,717	12,563	12,234	-3%
72206	HISPANIC	357	1,097	1,436	31%
72206	MULTIRACIAL NON-HISPANIC	286	434	492	13%
72206	NATIVE AMERICAN NON-HISPANIC	84	84	88	5%
72206	OTHER NON-HISPANIC	12	15	18	20%
72206	PACIFIC ISLANDR NON-HISPANIC	4	13	14	8%
72206	WHITE NON-HISPANIC	12,007	11,235	10,992	-2%
72207	ASIAN NON-HISPANIC	136	127	121	-5%
72207	BLACK NON-HISPANIC	754	1,405	1,637	17%
72207	HISPANIC	114	243	301	24%
72207	MULTIRACIAL NON-HISPANIC	87	141	164	16%
72207	NATIVE AMERICAN NON-HISPANIC	21	30	35	17%
72207	OTHER NON-HISPANIC	9	6	8	33%
72207	PACIFIC ISLANDR NON-HISPANIC	3	2	3	50%
72207	WHITE NON-HISPANIC	10,035	9,094	8,758	-4%
72209	ASIAN NON-HISPANIC	231	126	106	-16%
72209	BLACK NON-HISPANIC	19,372	21,177	20,936	-1%
72209	HISPANIC	1,810	6,565	8,104	23%
72209	MULTIRACIAL NON-HISPANIC	445	391	359	-8%
72209	NATIVE AMERICAN NON-HISPANIC	76	65	55	-15%
72209	OTHER NON-HISPANIC	29	55	62	13%
72209	PACIFIC ISLANDR NON-HISPANIC	8	5	6	20%
72209	WHITE NON-HISPANIC	9,730	4,010	2,881	-28%

BHMC-Little Rock

Zip Code	Ethnicity	2000 Population	2012 Population	2017 Population	2012-2017 Change
72210	ASIAN NON-HISPANIC	90	475	642	35%
72210	BLACK NON-HISPANIC	1,416	5,547	7,404	33%
72210	HISPANIC	167	1,131	1,629	44%
72210	MULTIRACIAL NON-HISPANIC	98	237	297	25%
72210	NATIVE AMERICAN NON-HISPANIC	60	51	44	-14%
72210	OTHER NON-HISPANIC	5	26	33	27%
72210	PACIFIC ISLANDR NON-HISPANIC	-	1	2	100%
72210	WHITE NON-HISPANIC	8,997	8,179	7,305	-11%
72211	ASIAN NON-HISPANIC	712	1,713	2,131	24%
72211	BLACK NON-HISPANIC	2,513	4,771	5,654	19%
72211	HISPANIC	437	1,124	1,468	31%
72211	MULTIRACIAL NON-HISPANIC	214	325	388	19%
72211	NATIVE AMERICAN NON-HISPANIC	49	53	53	0%
72211	OTHER NON-HISPANIC	17	47	59	26%
72211	PACIFIC ISLANDR NON-HISPANIC	5	13	15	15%
72211	WHITE NON-HISPANIC	14,361	13,291	12,768	-4%
72212	ASIAN NON-HISPANIC	401	597	680	14%
72212	BLACK NON-HISPANIC	896	1,698	2,015	19%
72212	HISPANIC	131	282	368	30%
72212	MULTIRACIAL NON-HISPANIC	102	162	189	17%
72212	NATIVE AMERICAN NON-HISPANIC	21	28	29	4%
72212	OTHER NON-HISPANIC	4	10	12	20%
72212	PACIFIC ISLANDR NON-HISPANIC	1	3	4	33%
72212	WHITE NON-HISPANIC	9,453	9,713	9,745	0%

BHMC-Little Rock

Zip Code	Ethnicity	2000 Population	2012 Population	2017 Population	2012-2017 Change
72223	ASIAN NON-HISPANIC	344	1,129	1,504	33%
72223	BLACK NON-HISPANIC	860	2,159	2,755	28%
72223	HISPANIC	172	469	651	39%
72223	MULTIRACIAL NON-HISPANIC	130	239	293	23%
72223	NATIVE AMERICAN NON-HISPANIC	41	74	84	14%
72223	OTHER NON-HISPANIC	13	38	54	42%
72223	PACIFIC ISLANDR NON-HISPANIC	1	6	6	0%
72223	WHITE NON-HISPANIC	11,214	16,295	17,650	8%
72227	ASIAN NON-HISPANIC	270	183	156	-15%
72227	BLACK NON-HISPANIC	1,597	2,633	2,995	14%
72227	HISPANIC	282	579	711	23%
72227	MULTIRACIAL NON-HISPANIC	116	150	160	7%
72227	NATIVE AMERICAN NON-HISPANIC	25	29	29	0%
72227	OTHER NON-HISPANIC	12	8	8	0%
72227	PACIFIC ISLANDR NON-HISPANIC	1	1	1	0%
72227	WHITE NON-HISPANIC	9,539	8,059	7,514	-7%

BHMC-North Little Rock

Zip Code	Ethnicity	2000 Population	2012 Population	2017 Population	2012-2017 Change
72007	ASIAN NON-HISPANIC	15	65	90	38%
72007	BLACK NON-HISPANIC	9	91	128	41%
72007	HISPANIC	85	224	291	30%
72007	MULTIRACIAL NON-HISPANIC	46	135	184	36%
72007	NATIVE AMERICAN NON-HISPANIC	26	44	50	14%
72007	OTHER NON-HISPANIC	1	3	4	33%
72007	PACIFIC ISLANDR NON-HISPANIC	2	4	7	75%
72007	WHITE NON-HISPANIC	4,689	7,677	8,737	14%
72023	ASIAN NON-HISPANIC	165	434	577	33%
72023	BLACK NON-HISPANIC	92	546	747	37%
72023	HISPANIC	424	1,379	1,889	37%
72023	MULTIRACIAL NON-HISPANIC	266	579	738	27%
72023	NATIVE AMERICAN NON-HISPANIC	112	171	196	15%
72023	OTHER NON-HISPANIC	10	26	33	27%
72023	PACIFIC ISLANDR NON-HISPANIC	9	17	21	24%
72023	WHITE NON-HISPANIC	23,644	32,603	35,948	10%
72046	ASIAN NON-HISPANIC	3	5	7	40%
72046	BLACK NON-HISPANIC	1,377	1,240	1,192	-4%
72046	HISPANIC	61	127	151	19%
72046	MULTIRACIAL NON-HISPANIC	31	72	90	25%
72046	NATIVE AMERICAN NON-HISPANIC	16	9	9	0%
72046	OTHER NON-HISPANIC	1	7	10	43%
72046	PACIFIC ISLANDR NON-HISPANIC	1	-	-	0%
72046	WHITE NON-HISPANIC	3,296	3,043	3,069	1%
72076	ASIAN NON-HISPANIC	630	652	666	2%
72076	BLACK NON-HISPANIC	7,808	10,712	11,981	12%
72076	HISPANIC	1,199	2,332	2,911	25%
72076	MULTIRACIAL NON-HISPANIC	799	1,201	1,385	15%
72076	NATIVE AMERICAN NON-HISPANIC	200	182	185	2%
72076	OTHER NON-HISPANIC	56	51	56	10%
72076	PACIFIC ISLANDR NON-HISPANIC	33	26	26	0%
72076	WHITE NON-HISPANIC	28,705	23,310	21,972	-6%

BHMC-North Little Rock

Zip Code	Ethnicity	2000 Population	2012 Population	2017 Population	2012-2017 Change
72083	ASIAN NON-HISPANIC	1	-	-	0%
72083	BLACK NON-HISPANIC	29	30	30	0%
72083	HISPANIC	4	11	11	0%
72083	MULTIRACIAL NON-HISPANIC	1	4	6	50%
72083	NATIVE AMERICAN NON-HISPANIC	1	1	-	-100%
72083	OTHER NON-HISPANIC	-	-	-	0%
72083	PACIFIC ISLANDR NON-HISPANIC	-	-	-	0%
72083	WHITE NON-HISPANIC	185	228	253	11%
72086	ASIAN NON-HISPANIC	26	57	75	32%
72086	BLACK NON-HISPANIC	1,187	1,388	1,439	4%
72086	HISPANIC	199	406	515	27%
72086	MULTIRACIAL NON-HISPANIC	80	140	172	23%
72086	NATIVE AMERICAN NON-HISPANIC	53	35	33	-6%
72086	OTHER NON-HISPANIC	2	5	7	40%
72086	PACIFIC ISLANDR NON-HISPANIC	1	2	1	-50%
72086	WHITE NON-HISPANIC	7,824	8,626	9,169	6%
72099	ASIAN NON-HISPANIC	16	7	5	-29%
72099	BLACK NON-HISPANIC	297	55	44	-20%
72099	HISPANIC	37	64	76	19%
72099	MULTIRACIAL NON-HISPANIC	19	15	16	7%
72099	NATIVE AMERICAN NON-HISPANIC	12	2	-	-100%
72099	OTHER NON-HISPANIC	1	2	3	50%
72099	PACIFIC ISLANDR NON-HISPANIC	2	-	-	0%
72099	WHITE NON-HISPANIC	1,015	582	552	-5%
72114	ASIAN NON-HISPANIC	44	45	48	7%
72114	BLACK NON-HISPANIC	10,536	9,040	8,736	-3%
72114	HISPANIC	300	614	744	21%
72114	MULTIRACIAL NON-HISPANIC	184	243	266	9%
72114	NATIVE AMERICAN NON-HISPANIC	50	36	35	-3%
72114	OTHER NON-HISPANIC	11	7	5	-29%
72114	PACIFIC ISLANDR NON-HISPANIC	5	26	31	19%
72114	WHITE NON-HISPANIC	3,514	2,698	2,526	-6%

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Zip Code	Ethnicity	2000 Population	2012 Population	2017 Population	2012-2017 Change
72116	ASIAN NON-HISPANIC	195	359	410	14%
72116	BLACK NON-HISPANIC	1,767	3,131	3,659	17%
72116	HISPANIC	337	818	1,054	29%
72116	MULTIRACIAL NON-HISPANIC	194	364	433	19%
72116	NATIVE AMERICAN NON-HISPANIC	82	78	77	-1%
72116	OTHER NON-HISPANIC	7	25	32	28%
72116	PACIFIC ISLANDR NON-HISPANIC	6	10	10	0%
72116	WHITE NON-HISPANIC	18,035	16,511	15,995	-3%
72117	ASIAN NON-HISPANIC	26	48	54	13%
72117	BLACK NON-HISPANIC	6,498	7,918	8,458	7%
72117	HISPANIC	177	558	717	28%
72117	MULTIRACIAL NON-HISPANIC	171	204	215	5%
72117	NATIVE AMERICAN NON-HISPANIC	54	44	44	0%
72117	OTHER NON-HISPANIC	12	20	22	10%
72117	PACIFIC ISLANDR NON-HISPANIC	3	-	-	0%
72117	WHITE NON-HISPANIC	5,405	3,641	2,997	-18%
72118	ASIAN NON-HISPANIC	92	163	191	17%
72118	BLACK NON-HISPANIC	4,529	7,468	8,590	15%
72118	HISPANIC	785	2,279	2,914	28%
72118	MULTIRACIAL NON-HISPANIC	246	414	485	17%
72118	NATIVE AMERICAN NON-HISPANIC	104	80	70	-13%
72118	OTHER NON-HISPANIC	17	34	41	21%
72118	PACIFIC ISLANDR NON-HISPANIC	7	1	2	100%
72118	WHITE NON-HISPANIC	16,075	12,135	10,771	-11%
72120	ASIAN NON-HISPANIC	238	470	560	19%
72120	BLACK NON-HISPANIC	2,522	5,557	6,853	23%
72120	HISPANIC	570	1,269	1,627	28%
72120	MULTIRACIAL NON-HISPANIC	318	635	775	22%
72120	NATIVE AMERICAN NON-HISPANIC	136	145	149	3%
72120	OTHER NON-HISPANIC	33	40	40	0%
72120	PACIFIC ISLANDR NON-HISPANIC	14	21	22	5%
72120	WHITE NON-HISPANIC	23,538	24,288	24,185	0%

BHMC-North Little Rock

Zip Code	Ethnicity	2000 Population	2012 Population	2017 Population	2012-2017 Change
72142	ASIAN NON-HISPANIC	1	10	13	30%
72142	BLACK NON-HISPANIC	444	725	840	16%
72142	HISPANIC	62	66	74	12%
72142	MULTIRACIAL NON-HISPANIC	18	50	66	32%
72142	NATIVE AMERICAN NON-HISPANIC	8	5	5	0%
72142	OTHER NON-HISPANIC	1	2	2	0%
72142	PACIFIC ISLANDR NON-HISPANIC	2	-	-	0%
72142	WHITE NON-HISPANIC	1,559	1,788	1,876	5%
72176	ASIAN NON-HISPANIC	14	37	47	27%
72176	BLACK NON-HISPANIC	9	86	120	40%
72176	HISPANIC	81	234	317	35%
72176	MULTIRACIAL NON-HISPANIC	55	150	202	35%
72176	NATIVE AMERICAN NON-HISPANIC	37	70	82	17%
72176	OTHER NON-HISPANIC	-	13	21	62%
72176	PACIFIC ISLANDR NON-HISPANIC	-	1	1	0%
72176	WHITE NON-HISPANIC	5,063	7,622	8,704	14%

BHMC-Stuttgart

Zip Code	Ethnicity	2000 Population	2012 Population	2017 Population	2012-2017 Change
72003	ASIAN NON-HISPANIC	-	1	1	0%
72003	BLACK NON-HISPANIC	68	50	47	-6%
72003	HISPANIC	2	4	5	25%
72003	MULTIRACIAL NON-HISPANIC	4	4	3	-25%
72003	NATIVE AMERICAN NON-HISPANIC	2	-	-	0%
72003	OTHER NON-HISPANIC	-	-	-	0%
72003	PACIFIC ISLANDR NON-HISPANIC	-	-	-	0%
72003	WHITE NON-HISPANIC	760	674	660	-2%
72021	ASIAN NON-HISPANIC	7	35	43	23%
72021	BLACK NON-HISPANIC	2,293	1,896	1,745	-8%
72021	HISPANIC	66	57	51	-11%
72021	MULTIRACIAL NON-HISPANIC	64	42	35	-17%
72021	NATIVE AMERICAN NON-HISPANIC	12	12	14	17%
72021	OTHER NON-HISPANIC	9	5	3	-40%
72021	PACIFIC ISLANDR NON-HISPANIC	2	-	-	0%
72021	WHITE NON-HISPANIC	3,092	2,312	2,030	-12%
72026	ASIAN NON-HISPANIC	-	-	-	0%
72026	BLACK NON-HISPANIC	92	52	41	-21%
72026	HISPANIC	-	2	3	50%
72026	MULTIRACIAL NON-HISPANIC	4	3	3	0%
72026	NATIVE AMERICAN NON-HISPANIC	1	-	-	0%
72026	OTHER NON-HISPANIC	1	1	-	-100%
72026	PACIFIC ISLANDR NON-HISPANIC	-	-	-	0%
72026	WHITE NON-HISPANIC	279	263	269	2%
72029	ASIAN NON-HISPANIC	3	2	2	0%
72029	BLACK NON-HISPANIC	732	602	581	-3%
72029	HISPANIC	53	58	59	2%
72029	MULTIRACIAL NON-HISPANIC	30	26	26	0%
72029	NATIVE AMERICAN NON-HISPANIC	11	13	14	8%
72029	OTHER NON-HISPANIC	-	-	-	0%
72029	PACIFIC ISLANDR NON-HISPANIC	-	-	-	0%
72029	WHITE NON-HISPANIC	1,919	1,404	1,276	-9%

BHMC-Stuttgart

Zip Code	Ethnicity	2000 Population	2012 Population	2017 Population	2012-20 Chang
72038	ASIAN NON-HISPANIC	-	-	-	0%
72038	BLACK NON-HISPANIC	15	8	7	-13%
72038	HISPANIC	-	1	-	-100%
72038	MULTIRACIAL NON-HISPANIC	1	1	1	0%
72038	NATIVE AMERICAN NON-HISPANIC	-	-	-	0%
72038	OTHER NON-HISPANIC	-	-	-	0%
72038	PACIFIC ISLANDR NON-HISPANIC	-	-	-	0%
72038	WHITE NON-HISPANIC	46	43	44	2%
72041	ASIAN NON-HISPANIC	1	1	-	-100%
72041	BLACK NON-HISPANIC	318	242	217	-10%
72041	HISPANIC	7	13	15	15%
72041	MULTIRACIAL NON-HISPANIC	10	5	4	-20%
72041	NATIVE AMERICAN NON-HISPANIC	2	1	-	-100%
72041	OTHER NON-HISPANIC	1	-	-	0%
72041	PACIFIC ISLANDR NON-HISPANIC	-	-	-	0%
72041	WHITE NON-HISPANIC	1,420	1,289	1,241	-4%
72042	ASIAN NON-HISPANIC	9	18	20	11%
72042	BLACK NON-HISPANIC	813	740	724	-2%
72042	HISPANIC	37	163	204	25%
72042	MULTIRACIAL NON-HISPANIC	39	54	61	13%
72042	NATIVE AMERICAN NON-HISPANIC	8	5	4	-20%
72042	OTHER NON-HISPANIC	-	2	3	50%
72042	PACIFIC ISLANDR NON-HISPANIC	-	-	-	0%
72042	WHITE NON-HISPANIC	4,915	4,239	4,066	-4%
72064	ASIAN NON-HISPANIC	-	2	2	0%
72064	BLACK NON-HISPANIC	305	319	325	2%
72064	HISPANIC	15	18	18	0%
72064	MULTIRACIAL NON-HISPANIC	10	20	24	20%
72064	NATIVE AMERICAN NON-HISPANIC	14	6	5	-17%
72064	OTHER NON-HISPANIC	-	-	-	0%
72064	PACIFIC ISLANDR NON-HISPANIC	-	-	-	0%
72064	WHITE NON-HISPANIC	1,830	1,602	1,560	-3%

BHMC-Stuttgart

Zip Code	Ethnicity	2000 Population	2012 Population	2017 Population	2012-2017 Change
72069	ASIAN NON-HISPANIC	1	1	-	-100%
72069	BLACK NON-HISPANIC	856	652	594	-9%
72069	HISPANIC	8	10	12	20%
72069	MULTIRACIAL NON-HISPANIC	6	9	9	0%
72069	NATIVE AMERICAN NON-HISPANIC	1	2	1	-50%
72069	OTHER NON-HISPANIC	-	-	-	0%
72069	PACIFIC ISLANDR NON-HISPANIC	-	-	-	0%
72069	WHITE NON-HISPANIC	645	376	323	-14%
72072	ASIAN NON-HISPANIC	-	-	-	0%
72072	BLACK NON-HISPANIC	160	146	140	-4%
72072	HISPANIC	8	6	7	17%
72072	MULTIRACIAL NON-HISPANIC	4	12	16	33%
72072	NATIVE AMERICAN NON-HISPANIC	4	-	1	0%
72072	OTHER NON-HISPANIC	-	-	-	0%
72072	PACIFIC ISLANDR NON-HISPANIC	-	-	-	0%
72072	WHITE NON-HISPANIC	391	385	406	5%
72073	ASIAN NON-HISPANIC	2	1	1	0%
72073	BLACK NON-HISPANIC	479	282	235	-17%
72073	HISPANIC	15	10	12	20%
72073	MULTIRACIAL NON-HISPANIC	25	7	6	-14%
72073	NATIVE AMERICAN NON-HISPANIC	2	4	4	0%
72073	OTHER NON-HISPANIC	-	-	-	0%
72073	PACIFIC ISLANDR NON-HISPANIC	-	-	-	0%
72073	WHITE NON-HISPANIC	833	718	680	-5%
72134	ASIAN NON-HISPANIC	1	-	-	0%
72134	BLACK NON-HISPANIC	52	59	63	7%
72134	HISPANIC	2	7	8	14%
72134	MULTIRACIAL NON-HISPANIC	7	4	3	-25%
72134	NATIVE AMERICAN NON-HISPANIC	1	2	2	0%
72134	OTHER NON-HISPANIC	-	-	-	0%
72134	PACIFIC ISLANDR NON-HISPANIC	-	-	-	0%
72134	WHITE NON-HISPANIC	275	227	216	-5%

BHMC-Stuttgart

Zip Code	Ethnicity	2000 Population	2012 Population	2017 Population	2012-2017 Change
72160	ASIAN NON-HISPANIC	63	73	80	10%
72160	BLACK NON-HISPANIC	3,504	3,562	3,612	1%
72160	HISPANIC	93	380	483	27%
72160	MULTIRACIAL NON-HISPANIC	64	163	192	18%
72160	NATIVE AMERICAN NON-HISPANIC	25	20	18	-10%
72160	OTHER NON-HISPANIC	2	10	12	20%
72160	PACIFIC ISLANDR NON-HISPANIC	1	2	3	50%
72160	WHITE NON-HISPANIC	7,424	6,298	5,941	-6%
72170	ASIAN NON-HISPANIC	-	-	-	0%
72170	BLACK NON-HISPANIC	23	25	25	0%
72170	HISPANIC	1	2	2	0%
72170	MULTIRACIAL NON-HISPANIC	2	1	1	0%
72170	NATIVE AMERICAN NON-HISPANIC	-	-	-	0%
72170	OTHER NON-HISPANIC	-	-	-	0%
72170	PACIFIC ISLANDR NON-HISPANIC	-	-	-	0%
72170	WHITE NON-HISPANIC	262	248	241	-3%

BHMC - Heber Springs

Zip Code	Ethnicity	2000 Population	2012 Population	2017 Population	2012-2017 Change
72044	ASIAN NON-HISPANIC	1	2	2	0%
72044	BLACK NON-HISPANIC	-	2	3	50%
72044	HISPANIC	3	10	15	50%
72044	MULTIRACIAL NON-HISPANIC	10	7	6	-14%
72044	NATIVE AMERICAN NON-HISPANIC	3	3	4	33%
72044	OTHER NON-HISPANIC	-	-	-	0%
72044	PACIFIC ISLANDR NON-HISPANIC	1	-	-	0%
72044	WHITE NON-HISPANIC	816	861	884	3%
72067	ASIAN NON-HISPANIC	3	5	6	20%
72067	BLACK NON-HISPANIC	2	4	3	-25%
72067	HISPANIC	28	39	46	18%
72067	MULTIRACIAL NON-HISPANIC	36	29	31	7%
72067	NATIVE AMERICAN NON-HISPANIC	12	16	17	6%
72067	OTHER NON-HISPANIC	-	-	1	0%
72067	PACIFIC ISLANDR NON-HISPANIC	1	-	1	0%
72067	WHITE NON-HISPANIC	2,505	2,550	2,628	3%
72130	ASIAN NON-HISPANIC	-	1	1	0%
72130	BLACK NON-HISPANIC	-	1	-	-100%
72130	HISPANIC	1	5	6	20%
72130	MULTIRACIAL NON-HISPANIC	2	5	6	20%
72130	NATIVE AMERICAN NON-HISPANIC	3	3	5	67%
72130	OTHER NON-HISPANIC	-	-	-	0%
72130	PACIFIC ISLANDR NON-HISPANIC	-	-	-	0%
72130	WHITE NON-HISPANIC	381	412	434	5%
72131	ASIAN NON-HISPANIC	1	7	7	0%
72131	BLACK NON-HISPANIC	2	15	21	40%
72131	HISPANIC	63	78	93	19%
72131	MULTIRACIAL NON-HISPANIC	31	81	104	28%
72131	NATIVE AMERICAN NON-HISPANIC	16	20	21	5%
72131	OTHER NON-HISPANIC	-	-	-	0%
72131	PACIFIC ISLANDR NON-HISPANIC	-	2	2	0%
72131	WHITE NON-HISPANIC	3,761	4,171	4,325	4%
72179	ASIAN NON-HISPANIC	-	1	2	100%
72179	BLACK NON-HISPANIC	1	-	-	0%
72179	HISPANIC	2	8	10	25%
72179	MULTIRACIAL NON-HISPANIC	5	6	6	0%
72179	NATIVE AMERICAN NON-HISPANIC	1	2	3	50%
72179	OTHER NON-HISPANIC	-	-	-	0%
72179	PACIFIC ISLANDR NON-HISPANIC	-	-	-	0%
72179	WHITE NON-HISPANIC	461	513	539	5%

BHMC - Heber Springs

Zip Code	Ethnicity	2000 Population	2012 Population	2017 Population	2012-2017 Change
72523	ASIAN NON-HISPANIC	1	2	1	-50%
72523	BLACK NON-HISPANIC	-	-	-	0%
72523	HISPANIC	11	15	18	20%
72523	MULTIRACIAL NON-HISPANIC	14	6	5	-17%
72523	NATIVE AMERICAN NON-HISPANIC	3	3	3	0%
72523	OTHER NON-HISPANIC	-	-	-	0%
72523	PACIFIC ISLANDR NON-HISPANIC	-	-	-	0%
72523	WHITE NON-HISPANIC	1,027	1,014	1,021	1%
72530	ASIAN NON-HISPANIC	1	7	8	14%
72530	BLACK NON-HISPANIC	1	2	3	50%
72530	HISPANIC	11	18	23	28%
72530	MULTIRACIAL NON-HISPANIC	14	18	19	6%
72530	NATIVE AMERICAN NON-HISPANIC	9	12	14	17%
72530	OTHER NON-HISPANIC	-	-	-	0%
72530	PACIFIC ISLANDR NON-HISPANIC	-	1	1	0%
72530	WHITE NON-HISPANIC	1,799	1,940	2,034	5%
72543	ASIAN NON-HISPANIC	28	26	29	12%
72543	BLACK NON-HISPANIC	22	48	58	21%
72543	HISPANIC	161	367	451	23%
72543	MULTIRACIAL NON-HISPANIC	71	168	208	24%
72543	NATIVE AMERICAN NON-HISPANIC	47	64	71	11%
72543	OTHER NON-HISPANIC	2	2	2	0%
72543	PACIFIC ISLANDR NON-HISPANIC	4	3	3	0%
72543	WHITE NON-HISPANIC	10,850	11,989	12,427	4%
72546	ASIAN NON-HISPANIC	-	1	1	0%
72546	BLACK NON-HISPANIC	-	-	-	0%
72546	HISPANIC	1	2	1	-50%
72546	MULTIRACIAL NON-HISPANIC	1	-	1	0%
72546	NATIVE AMERICAN NON-HISPANIC	-	-	-	0%
72546	OTHER NON-HISPANIC	-	-	-	0%
72546	PACIFIC ISLANDR NON-HISPANIC	-	-	-	0%
72546	WHITE NON-HISPANIC	106	112	117	4%
72581	ASIAN NON-HISPANIC	-	4	4	0%
72581	BLACK NON-HISPANIC	-	3	5	67%
72581	HISPANIC	5	13	17	31%
72581	MULTIRACIAL NON-HISPANIC	7	5	3	-40%
72581	NATIVE AMERICAN NON-HISPANIC	3	5	6	20%
72581	OTHER NON-HISPANIC	-	-	-	0%
72581	PACIFIC ISLANDR NON-HISPANIC	-	1	1	0%
72581	WHITE NON-HISPANIC	963	1,005	1,044	4%

BHMC-Arkadelphia

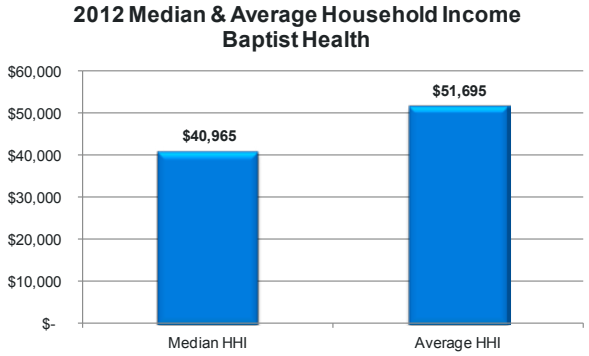
Zip Code	Ethnicity	2000 Population	2012 Population	2017 Population	2012-2017 Change
71743	ASIAN NON-HISPANIC	2	10	13	30%
71743	BLACK NON-HISPANIC	1,129	1,055	1,056	0%
71743	HISPANIC	144	420	516	23%
71743	MULTIRACIAL NON-HISPANIC	29	51	60	18%
71743	NATIVE AMERICAN NON-HISPANIC	14	10	9	-10%
71743	OTHER NON-HISPANIC	-	2	3	50%
71743	PACIFIC ISLANDR NON-HISPANIC	2	1	1	0%
71743	WHITE NON-HISPANIC	3,096	2,496	2,331	-7%
71921	ASIAN NON-HISPANIC	3	24	29	21%
71921	BLACK NON-HISPANIC	16	16	16	0%
71921	HISPANIC	78	119	141	18%
71921	MULTIRACIAL NON-HISPANIC	19	30	33	10%
71921	NATIVE AMERICAN NON-HISPANIC	17	21	22	5%
71921	OTHER NON-HISPANIC	-	3	4	33%
71921	PACIFIC ISLANDR NON-HISPANIC	-	-	-	0%
71921	WHITE NON-HISPANIC	2,582	2,805	2,884	3%
71923	ASIAN NON-HISPANIC	123	87	74	-15%
71923	BLACK NON-HISPANIC	3,803	4,087	4,199	3%
71923	HISPANIC	344	461	512	11%
71923	MULTIRACIAL NON-HISPANIC	199	214	220	3%
71923	NATIVE AMERICAN NON-HISPANIC	66	50	47	-6%
71923	OTHER NON-HISPANIC	3	20	27	35%
71923	PACIFIC ISLANDR NON-HISPANIC	6	2	3	50%
71923	WHITE NON-HISPANIC	11,524	10,739	10,475	-2%

BHMC-Arkadelphia

Zip Code	Ethnicity	2000 Population	2012 Population	2017 Population	2012-2017 Change
71962	ASIAN NON-HISPANIC	-	-	2	0%
71962	BLACK NON-HISPANIC	148	129	123	-5%
71962	HISPANIC	7	13	14	8%
71962	MULTIRACIAL NON-HISPANIC	13	14	15	7%
71962	NATIVE AMERICAN NON-HISPANIC	3	1	1	0%
71962	OTHER NON-HISPANIC	-	1	-	-100%
71962	PACIFIC ISLANDR NON-HISPANIC	-	-	-	0%
71962	WHITE NON-HISPANIC	673	691	698	1%
71998	ASIAN NON-HISPANIC	5	1	1	0%
71998	BLACK NON-HISPANIC	17	43	51	19%
71998	HISPANIC	4	5	7	40%
71998	MULTIRACIAL NON-HISPANIC	4	3	4	33%
71998	NATIVE AMERICAN NON-HISPANIC	-	3	2	-33%
71998	OTHER NON-HISPANIC	1	2	1	-50%
71998	PACIFIC ISLANDR NON-HISPANIC	-	-	-	0%
71998	WHITE NON-HISPANIC	279	286	284	-1%
71999	ASIAN NON-HISPANIC	14	5	3	-40%
71999	BLACK NON-HISPANIC	101	115	117	2%
71999	HISPANIC	18	17	15	-12%
71999	MULTIRACIAL NON-HISPANIC	3	5	5	0%
71999	NATIVE AMERICAN NON-HISPANIC	4	4	4	0%
71999	OTHER NON-HISPANIC	1	-	-	0%
71999	PACIFIC ISLANDR NON-HISPANIC	1	1	1	0%
71999	WHITE NON-HISPANIC	314	280	265	-5%

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BAPTIST HEALTH
HOUSEHOLD INCOME



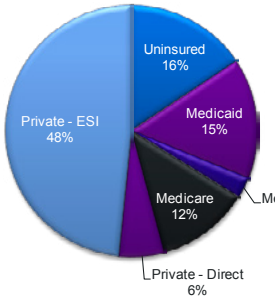
Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BHMC Community	Zip Code	2012 Total Households	2012 Average Household Income	2012 Median Household Income
Arkadelphia	71743	1,673	$40,655	$32,814
Arkadelphia	71921	1,193	$42,104	$31,658
Arkadelphia	71923	5,993	$41,882	$31,363
Arkadelphia	71962	361	$41,690	$33,673
Arkadelphia	71998	43	$64,767	$42,500
Arkadelphia	71999	92	$36,957	$25,000
Heber Springs	72044	414	$39,185	$31,957
Heber Springs	72067	1,236	$49,284	$38,391
Heber Springs	72130	181	$39,848	$33,030
Heber Springs	72131	1,827	$43,058	$35,602
Heber Springs	72179	228	$45,340	$35,714
Heber Springs	72523	417	$40,588	$33,309
Heber Springs	72530	852	$42,884	$36,250
Heber Springs	72543	5,329	$48,741	$35,479
Heber Springs	72546	50	$49,900	$38,000
Heber Springs	72581	465	$46,435	$41,181
Stuttgart	72003	321	$60,717	$50,469
Stuttgart	72021	1,849	$37,353	$25,247
Stuttgart	72026	150	$56,517	$54,245
Stuttgart	72029	950	$41,695	$30,329
Stuttgart	72038	25	$50,800	$51,389
Stuttgart	72041	705	$39,521	$31,919
Stuttgart	72042	2,202	$42,523	$31,789
Stuttgart	72064	829	$43,305	$34,038
Stuttgart	72069	457	$31,018	$21,037
Stuttgart	72072	223	$38,935	$28,621
Stuttgart	72073	457	$40,700	$31,146
Stuttgart	72134	134	$49,160	$38,158
Stuttgart	72160	4,389	$47,159	$36,364
Stuttgart	72170	121	$41,446	$36,389

BHMC Community	Zip Code	2012 Total Households	2012 Average Household Income	2012 Median Household Income
Little Rock	72002	5,355	$54,340	$46,974
Little Rock	72011	1,626	$53,327	$47,931
Little Rock	72015	10,583	$51,882	$43,648
Little Rock	72019	9,639	$65,603	$52,846
Little Rock	72022	5,919	$62,862	$54,434
Little Rock	72065	1,830	$61,807	$56,670
Little Rock	72103	4,836	$48,600	$41,816
Little Rock	72113	9,451	$85,085	$69,096
Little Rock	72150	4,960	$55,778	$45,146
Little Rock	72201	611	$36,477	$24,928
Little Rock	72202	5,143	$42,521	$24,299
Little Rock	72204	12,033	$39,864	$31,844
Little Rock	72205	11,071	$54,534	$41,054
Little Rock	72206	10,176	$44,143	$34,522
Little Rock	72207	5,471	$86,968	$57,507
Little Rock	72209	11,674	$39,117	$31,672
Little Rock	72210	6,483	$64,564	$51,125
Little Rock	72211	9,932	$71,734	$56,961
Little Rock	72212	5,229	$103,138	$76,206
Little Rock	72223	7,976	$115,345	$85,828
Little Rock	72227	5,420	$74,891	$49,362
North Little Rock	72007	2,947	$61,874	$53,044
North Little Rock	72023	13,193	$62,726	$54,931
North Little Rock	72046	1,856	$41,709	$31,957
North Little Rock	72076	15,332	$46,206	$38,735
North Little Rock	72083	105	$50,143	$38,088
North Little Rock	72086	4,023	$51,021	$42,933
North Little Rock	72099	55	$44,545	$37,500
North Little Rock	72114	5,415	$28,230	$19,902
North Little Rock	72116	9,725	$67,764	$54,453
North Little Rock	72117	4,755	$37,346	$29,879
North Little Rock	72118	9,272	$47,468	$39,136
North Little Rock	72120	13,205	$60,146	$50,550
North Little Rock	72142	1,046	$62,980	$47,857
North Little Rock	72176	3,021	$51,267	$42,858

BAPTIST HEALTH
INSURANCE COVERAGE

2012 Insurance Coverage by Insurance Type
Baptist Health



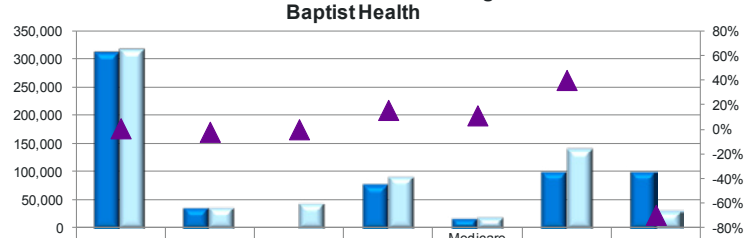
Private ESI (Employer Sponsored Insurance) = Plans offered through an employer

Private Exchanges = Plans purchased via an insurance exchange or insurance market place

Medicare Dual Eligible = Medicare enrollees receiving additional benefits via Medicaid

Private Direct = Individuals who purchase insurance directly from an insurance provider

2012 - 2017 Insurance Coverage
Baptist Health



	Private - ESI	Private - Direct	Private - Exchange	Medicare	Medicare Dual Eligible	Medicaid	Uninsured
2012 Covered Lives	313,129	36,883	0	78,454	17,415	100,104	101,174
2017 Covered Lives	315,620	36,131	44,476	90,794	19,384	140,216	30,789
% Chg	1%	-2%	0%	16%	11%	40%	-70%

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BAPTIST HEALTH
INSURANCE COVERAGE BY ZIP

BHMC-Little Rock

Zip Code	Insurance Type	2012 Covered Lives	2017 Covered Lives	% Chg
72002	Private - ESI	8,829	9,195	4%
72002	Private - Direct	1,033	1,051	2%
72002	Private - Exchange	0	930	N/A
72002	Medicare	1,077	1,481	38%
72002	Medicare Dual Eligible	139	185	33%
72002	Medicaid	1,746	2,348	34%
72002	Uninsured	1,492	522	-65%
72011	Private - ESI	3,052	3,268	7%
72011	Private - Direct	358	377	5%
72011	Private - Exchange	0	294	N/A
72011	Medicare	277	385	39%
72011	Medicare Dual Eligible	37	51	38%
72011	Medicaid	421	578	37%
72011	Uninsured	359	123	-66%
72015	Private - ESI	15,276	16,027	5%
72015	Private - Direct	1,796	1,819	1%
72015	Private - Exchange	0	1,988	N/A
72015	Medicare	2,609	3,135	20%
72015	Medicare Dual Eligible	325	389	20%
72015	Medicaid	4,388	6,042	38%
72015	Uninsured	3,752	1,283	-66%
72019	Private - ESI	16,261	17,053	5%
72019	Private - Direct	1,907	1,970	3%
72019	Private - Exchange	0	1,485	N/A
72019	Medicare	2,175	2,906	34%
72019	Medicare Dual Eligible	274	357	30%
72019	Medicaid	2,424	3,303	36%
72019	Uninsured	2,072	736	-64%

BHMC-Little Rock

Zip Code	Insurance Type	2012 Covered Lives	2017 Covered Lives	% Chg
72022	Private - ESI	9,294	9,979	7%
72022	Private - Direct	1,089	1,153	6%
72022	Private - Exchange	0	937	N/A
72022	Medicare	1,096	1,464	34%
72022	Medicare Dual Eligible	143	185	29%
72022	Medicaid	1,661	2,285	38%
72022	Uninsured	1,420	521	-63%
72065	Private - ESI	3,429	3,493	2%
72065	Private - Direct	404	406	0%
72065	Private - Exchange	0	332	N/A
72065	Medicare	368	507	38%
72065	Medicare Dual Eligible	48	64	33%
72065	Medicaid	541	699	29%
72065	Uninsured	463	156	-66%
72103	Private - ESI	7,762	7,635	-2%
72103	Private - Direct	911	868	-5%
72103	Private - Exchange	0	824	N/A
72103	Medicare	965	1,250	30%
72103	Medicare Dual Eligible	124	156	26%
72103	Medicaid	1,712	2,241	31%
72103	Uninsured	1,463	468	-68%
72113	Private - ESI	14,506	15,711	8%
72113	Private - Direct	1,702	1,846	8%
72113	Private - Exchange	0	1,339	N/A
72113	Medicare	2,218	3,057	38%
72113	Medicare Dual Eligible	514	654	27%
72113	Medicaid	1,784	2,628	47%
72113	Uninsured	1,794	687	-62%

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BHMC-Little Rock

Zip Code	Insurance Type	2012 Covered Lives	2017 Covered Lives	% Chg
72150	Private - ESI	6,855	6,765	-1%
72150	Private - Direct	806	774	-4%
72150	Private - Exchange	0	760	N/A
72150	Medicare	1,617	1,953	21%
72150	Medicare Dual Eligible	331	388	17%
72150	Medicaid	1,587	2,081	31%
72150	Uninsured	1,392	444	-68%
72201	Private - ESI	115	124	8%
72201	Private - Direct	14	13	-7%
72201	Private - Exchange	0	88	N/A
72201	Medicare	143	177	24%
72201	Medicare Dual Eligible	34	39	15%
72201	Medicaid	336	507	51%
72201	Uninsured	338	103	-70%
72202	Private - ESI	1,170	1,142	-2%
72202	Private - Direct	138	119	-14%
72202	Private - Exchange	0	788	N/A
72202	Medicare	1,431	1,503	5%
72202	Medicare Dual Eligible	322	336	4%
72202	Medicaid	3,272	4,579	40%
72202	Uninsured	3,290	891	-73%
72204	Private - ESI	10,891	10,507	-4%
72204	Private - Direct	1,289	1,166	-10%
72204	Private - Exchange	0	2,733	N/A
72204	Medicare	3,506	3,835	9%
72204	Medicare Dual Eligible	823	879	7%
72204	Medicaid	7,790	10,846	39%
72204	Uninsured	7,834	2,154	-73%

BHMC-Little Rock

Zip Code	Insurance Type	2012 Covered Lives	2017 Covered Lives	% Chg
72205	Private - ESI	9,740	9,167	-6%
72205	Private - Direct	1,148	1,036	-10%
72205	Private - Exchange	0	1,504	N/A
72205	Medicare	3,671	3,965	8%
72205	Medicare Dual Eligible	853	900	6%
72205	Medicaid	3,656	4,876	33%
72205	Uninsured	3,675	1,038	-72%
72206	Private - ESI	8,485	8,130	-4%
72206	Private - Direct	1,003	907	-10%
72206	Private - Exchange	0	2,051	N/A
72206	Medicare	3,577	3,818	7%
72206	Medicare Dual Eligible	798	836	5%
72206	Medicaid	5,865	8,054	37%
72206	Uninsured	5,898	1,692	-71%
72207	Private - ESI	5,983	5,672	-5%
72207	Private - Direct	705	657	-7%
72207	Private - Exchange	0	572	N/A
72207	Medicare	1,782	1,919	8%
72207	Medicare Dual Eligible	409	432	6%
72207	Medicaid	1,083	1,429	32%
72207	Uninsured	1,089	346	-68%
72209	Private - ESI	12,653	12,243	-3%
72209	Private - Direct	1,492	1,353	-9%
72209	Private - Exchange	0	2,690	N/A
72209	Medicare	2,793	3,095	11%
72209	Medicare Dual Eligible	665	721	8%
72209	Medicaid	7,376	10,325	40%
72209	Uninsured	7,416	2,080	-72%

BHMC-Little Rock

Zip Code	Insurance Type	2012 Covered Lives	2017 Covered Lives	% Chg
72210	Private - ESI	8,480	8,901	5%
72210	Private - Direct	999	1,028	3%
72210	Private - Exchange	0	1,061	N/A
72210	Medicare	1,771	2,269	28%
72210	Medicare Dual Eligible	404	488	21%
72210	Medicaid	1,990	2,921	47%
72210	Uninsured	2,001	689	-66%
72211	Private - ESI	13,260	13,259	0%
72211	Private - Direct	1,564	1,539	-2%
72211	Private - Exchange	0	1,262	N/A
72211	Medicare	2,022	2,482	23%
72211	Medicare Dual Eligible	489	567	16%
72211	Medicaid	1,995	2,778	39%
72211	Uninsured	2,007	647	-68%
72212	Private - ESI	7,870	7,750	-2%
72212	Private - Direct	928	919	-1%
72212	Private - Exchange	0	579	N/A
72212	Medicare	1,795	2,069	15%
72212	Medicare Dual Eligible	399	437	10%
72212	Medicaid	748	1,029	38%
72212	Uninsured	752	257	-66%

BHMC-Little Rock

Zip Code	Insurance Type	2012 Covered Lives	2017 Covered Lives	% Chg
72223	Private - ESI	13,288	14,131	6%
72223	Private - Direct	1,561	1,668	7%
72223	Private - Exchange	0	1,063	N/A
72223	Medicare	2,284	2,959	30%
72223	Medicare Dual Eligible	516	624	21%
72223	Medicaid	1,375	2,025	47%
72223	Uninsured	1,383	527	-62%
72227	Private - ESI	5,386	5,072	-6%
72227	Private - Direct	636	585	-8%
72227	Private - Exchange	0	664	N/A
72227	Medicare	2,176	2,337	7%
72227	Medicare Dual Eligible	483	507	5%
72227	Medicaid	1,477	1,964	33%
72227	Uninsured	1,485	446	-70%
BHMC-Little Rock Total		**356,153**	**375,531**	**5%**

BHMC-North Little Rock

Zip Code	Insurance Type	2012 Covered Lives	2017 Covered Lives	% Chg
72007	Private - ESI	5,125	5,576	9%
72007	Private - Direct	602	646	7%
72007	Private - Exchange	0	523	N/A
72007	Medicare	834	1,132	36%
72007	Medicare Dual Eligible	182	240	32%
72007	Medicaid	809	1,129	40%
72007	Uninsured	691	244	-65%
72023	Private - ESI	22,100	23,503	6%
72023	Private - Direct	2,606	2,733	5%
72023	Private - Exchange	0	2,277	N/A
72023	Medicare	3,381	4,455	32%
72023	Medicare Dual Eligible	748	953	27%
72023	Medicaid	3,731	5,116	37%
72023	Uninsured	3,189	1,111	-65%
72046	Private - ESI	1,425	1,388	-3%
72046	Private - Direct	167	152	-9%
72046	Private - Exchange	0	325	N/A
72046	Medicare	658	697	6%
72046	Medicare Dual Eligible	140	147	5%
72046	Medicaid	1,140	1,531	34%
72046	Uninsured	974	286	-71%
72076	Private - ESI	17,416	16,982	-2%
72076	Private - Direct	2,058	1,922	-7%
72076	Private - Exchange	0	2,914	N/A
72076	Medicare	4,227	4,769	13%
72076	Medicare Dual Eligible	978	1,072	10%
72076	Medicaid	6,874	9,495	38%
72076	Uninsured	6,912	2,025	-71%

BHMC-North Little Rock

Zip Code	Insurance Type	2012 Covered Lives	2017 Covered Lives	% Chg
72083	Private - ESI	121	124	2%
72083	Private - Direct	14	13	-7%
72083	Private - Exchange	0	18	N/A
72083	Medicare	33	41	24%
72083	Medicare Dual Eligible	7	8	14%
72083	Medicaid	54	78	44%
72083	Uninsured	46	15	-67%
72086	Private - ESI	4,917	5,038	2%
72086	Private - Direct	581	575	-1%
72086	Private - Exchange	0	764	N/A
72086	Medicare	1,391	1,634	17%
72086	Medicare Dual Eligible	302	349	16%
72086	Medicaid	1,871	2,541	36%
72086	Uninsured	1,599	510	-68%
72099	Private - ESI	371	339	-9%
72099	Private - Direct	47	41	-13%
72099	Private - Exchange	0	86	N/A
72099	Medicare	12	17	42%
72099	Medicare Dual Eligible	3	5	67%
72099	Medicaid	145	180	24%
72099	Uninsured	147	28	-81%
72114	Private - ESI	583	605	4%
72114	Private - Direct	68	58	-15%
72114	Private - Exchange	0	1,057	N/A
72114	Medicare	1,533	1,545	1%
72114	Medicare Dual Eligible	345	352	2%
72114	Medicaid	5,076	7,334	44%
72114	Uninsured	5,104	1,441	-72%

BHMC-North Little Rock

Zip Code	Insurance Type	2012 Covered Lives	2017 Covered Lives	% Chg
72116	Private - ESI	11,097	10,704	-4%
72116	Private - Direct	1,310	1,252	-4%
72116	Private - Exchange	0	1,135	N/A
72116	Medicare	4,023	4,365	9%
72116	Medicare Dual Eligible	902	958	6%
72116	Medicaid	1,977	2,630	33%
72116	Uninsured	1,988	626	-69%
72117	Private - ESI	3,264	3,200	-2%
72117	Private - Direct	384	351	-9%
72117	Private - Exchange	0	1,080	N/A
72117	Medicare	1,739	1,817	4%
72117	Medicare Dual Eligible	387	404	4%
72117	Medicaid	3,319	4,717	42%
72117	Uninsured	3,337	938	-72%
72118	Private - ESI	9,715	9,535	-2%
72118	Private - Direct	1,145	1,079	-6%
72118	Private - Exchange	0	1,685	N/A
72118	Medicare	2,960	3,204	8%
72118	Medicare Dual Eligible	678	723	7%
72118	Medicaid	4,027	5,628	40%
72118	Uninsured	4,050	1,210	-70%
72120	Private - ESI	18,863	18,826	0%
72120	Private - Direct	2,230	2,193	-2%
72120	Private - Exchange	0	2,004	N/A
72120	Medicare	3,866	4,578	18%
72120	Medicare Dual Eligible	886	1,004	13%
72120	Medicaid	3,280	4,551	39%
72120	Uninsured	3,298	1,054	-68%

BHMC-North Little Rock

Zip Code	Insurance Type	2012 Covered Lives	2017 Covered Lives	% Chg
72142	Private - ESI	1,260	1,303	3%
72142	Private - Direct	150	150	0%
72142	Private - Exchange	0	190	N/A
72142	Medicare	367	443	21%
72142	Medicare Dual Eligible	80	93	16%
72142	Medicaid	395	563	43%
72142	Uninsured	397	133	-66%
72176	Private - ESI	4,608	5,095	11%
72176	Private - Direct	544	579	6%
72176	Private - Exchange	0	597	N/A
72176	Medicare	732	946	29%
72176	Medicare Dual Eligible	163	209	28%
72176	Medicaid	1,168	1,725	48%
72176	Uninsured	999	343	-66%
BHMC-North Little Rock Total		**210,925**	**221,959**	**5%**

BHMC-Stuttgart

Zip Code	Insurance Type	2012 Covered Lives	2017 Covered Lives	% Chg
72003	Private - ESI	377	348	-8%
72003	Private - Direct	44	40	-9%
72003	Private - Exchange	0	43	N/A
72003	Medicare	99	109	10%
72003	Medicare Dual Eligible	29	32	10%
72003	Medicaid	89	115	29%
72003	Uninsured	94	30	-68%
72021	Private - ESI	956	816	-15%
72021	Private - Direct	112	88	-21%
72021	Private - Exchange	0	295	N/A
72021	Medicare	632	612	-3%
72021	Medicare Dual Eligible	340	323	-5%
72021	Medicaid	1,038	1,431	38%
72021	Uninsured	1,282	356	-72%
72026	Private - ESI	171	160	-6%
72026	Private - Direct	21	18	-14%
72026	Private - Exchange	0	18	N/A
72026	Medicare	49	52	6%
72026	Medicare Dual Eligible	15	15	0%
72026	Medicaid	32	41	28%
72026	Uninsured	34	11	-68%
72029	Private - ESI	554	486	-12%
72029	Private - Direct	65	53	-18%
72029	Private - Exchange	0	146	N/A
72029	Medicare	318	330	4%
72029	Medicare Dual Eligible	170	172	1%
72029	Medicaid	447	613	37%
72029	Uninsured	551	158	-71%

BHMC-Stuttgart

Zip Code	Insurance Type	2012 Covered Lives	2017 Covered Lives	% Chg
72038	Private - ESI	29	26	-10%
72038	Private - Direct	4	3	-25%
72038	Private - Exchange	0	3	N/A
72038	Medicare	6	9	50%
72038	Medicare Dual Eligible	2	3	50%
72038	Medicaid	6	7	17%
72038	Uninsured	6	2	-67%
72041	Private - ESI	543	490	-10%
72041	Private - Direct	63	54	-14%
72041	Private - Exchange	0	97	N/A
72041	Medicare	246	261	6%
72041	Medicare Dual Eligible	80	83	4%
72041	Medicaid	298	398	34%
72041	Uninsured	324	94	-71%
72042	Private - ESI	1,721	1,585	-8%
72042	Private - Direct	201	175	-13%
72042	Private - Exchange	0	361	N/A
72042	Medicare	807	874	8%
72042	Medicare Dual Eligible	249	261	5%
72042	Medicaid	1,091	1,483	36%
72042	Uninsured	1,150	339	-71%
72064	Private - ESI	792	740	-7%
72064	Private - Direct	93	82	-12%
72064	Private - Exchange	0	116	N/A
72064	Medicare	352	373	6%
72064	Medicare Dual Eligible	116	121	4%
72064	Medicaid	294	406	38%
72064	Uninsured	320	97	-70%

BHMC-Stuttgart

Zip Code	Insurance Type	2012 Covered Lives	2017 Covered Lives	% Chg
72069	Private - ESI	97	85	-12%
72069	Private - Direct	12	9	-25%
72069	Private - Exchange	0	68	N/A
72069	Medicare	180	176	-2%
72069	Medicare Dual Eligible	98	94	-4%
72069	Medicaid	298	409	37%
72069	Uninsured	367	98	-73%
72072	Private - ESI	156	158	1%
72072	Private - Direct	18	17	-6%
72072	Private - Exchange	0	42	N/A
72072	Medicare	75	80	7%
72072	Medicare Dual Eligible	17	18	6%
72072	Medicaid	154	217	41%
72072	Uninsured	131	38	-71%
72073	Private - ESI	324	286	-12%
72073	Private - Direct	37	32	-14%
72073	Private - Exchange	0	70	N/A
72073	Medicare	145	140	-3%
72073	Medicare Dual Eligible	44	43	-2%
72073	Medicaid	230	298	30%
72073	Uninsured	242	68	-72%
72134	Private - ESI	110	100	-9%
72134	Private - Direct	13	11	-15%
72134	Private - Exchange	0	21	N/A
72134	Medicare	43	48	12%
72134	Medicare Dual Eligible	24	25	4%
72134	Medicaid	49	68	39%
72134	Uninsured	60	18	-70%

BHMC-Stuttgart

Zip Code	Insurance Type	2012 Covered Lives	2017 Covered Lives	% Chg
72160	Private - ESI	4,126	3,840	-7%
72160	Private - Direct	485	428	-12%
72160	Private - Exchange	0	710	N/A
72160	Medicare	1,543	1,692	10%
72160	Medicare Dual Eligible	482	514	7%
72160	Medicaid	1,885	2,558	36%
72160	Uninsured	1,988	599	-70%
72170	Private - ESI	120	112	-7%
72170	Private - Direct	15	12	-20%
72170	Private - Exchange	0	17	N/A
72170	Medicare	44	48	9%
72170	Medicare Dual Eligible	15	16	7%
72170	Medicaid	40	52	30%
72170	Uninsured	43	12	-72%
BHMC-Stuttgart Total		**30,022**	**28,801**	**-4%**

BHMC-Heber Springs

Zip Code	Insurance Type	2012 Covered Lives	2017 Covered Lives	% Chg
72044	Private - ESI	298	287	-4%
72044	Private - Direct	36	32	-11%
72044	Private - Exchange	0	49	N/A
72044	Medicare	255	280	10%
72044	Medicare Dual Eligible	42	46	10%
72044	Medicaid	116	176	52%
72044	Uninsured	139	47	-66%
72067	Private - ESI	1,058	1,019	-4%
72067	Private - Direct	124	117	-6%
72067	Private - Exchange	0	155	N/A
72067	Medicare	635	720	13%
72067	Medicare Dual Eligible	105	116	10%
72067	Medicaid	327	474	45%
72067	Uninsured	393	134	-66%
72130	Private - ESI	195	193	-1%
72130	Private - Direct	23	21	-9%
72130	Private - Exchange	0	27	N/A
72130	Medicare	80	91	14%
72130	Medicare Dual Eligible	15	16	7%
72130	Medicaid	53	82	55%
72130	Uninsured	65	21	-68%
72131	Private - ESI	2,017	1,996	-1%
72131	Private - Direct	237	223	-6%
72131	Private - Exchange	0	290	N/A
72131	Medicare	772	856	11%
72131	Medicare Dual Eligible	138	151	9%
72131	Medicaid	549	844	54%
72131	Uninsured	661	213	-68%
72179	Private - ESI	247	241	-2%
72179	Private - Direct	28	27	-4%
72179	Private - Exchange	0	33	N/A
72179	Medicare	86	112	30%
72179	Medicare Dual Eligible	16	19	19%
72179	Medicaid	68	102	50%
72179	Uninsured	84	27	-68%

BHMC-Heber Springs

Zip Code	Insurance Type	2012 Covered Lives	2017 Covered Lives	% Chg
72523	Private - ESI	450	430	-4%
72523	Private - Direct	53	48	-9%
72523	Private - Exchange	0	72	N/A
72523	Medicare	161	179	11%
72523	Medicare Dual Eligible	30	33	10%
72523	Medicaid	157	228	45%
72523	Uninsured	189	57	-70%
72530	Private - ESI	929	930	0%
72530	Private - Direct	109	104	-5%
72530	Private - Exchange	0	131	N/A
72530	Medicare	345	390	13%
72530	Medicare Dual Eligible	62	68	10%
72530	Medicaid	251	378	51%
72530	Uninsured	302	101	-67%
72543	Private - ESI	4,749	4,671	-2%
72543	Private - Direct	558	521	-7%
72543	Private - Exchange	0	804	N/A
72543	Medicare	2,935	3,324	13%
72543	Medicare Dual Eligible	518	577	11%
72543	Medicaid	1,774	2,669	50%
72543	Uninsured	2,132	683	-68%
72546	Private - ESI	56	54	-4%
72546	Private - Direct	7	6	-14%
72546	Private - Exchange	0	6	N/A
72546	Medicare	17	23	35%
72546	Medicare Dual Eligible	3	4	33%
72546	Medicaid	14	20	43%
72546	Uninsured	17	5	-71%
72581	Private - ESI	451	442	-2%
72581	Private - Direct	54	50	-7%
72581	Private - Exchange	0	62	N/A
72581	Medicare	211	244	16%
72581	Medicare Dual Eligible	36	41	14%
72581	Medicaid	130	187	44%
72581	Uninsured	155	52	-66%
BHMC-Heber Springs Total		**25,717**	**26,831**	**4%**

BHMC-Arkadelphia

Zip Code	Insurance Type	2012 Covered Lives	2017 Covered Lives	% Chg
71743	Private - ESI	1,666	1,550	-7%
71743	Private - Direct	196	172	-12%
71743	Private - Exchange	0	334	N/A
71743	Medicare	570	610	7%
71743	Medicare Dual Eligible	143	149	4%
71743	Medicaid	534	899	68%
71743	Uninsured	935	275	-71%
71921	Private - ESI	1,156	1,129	-2%
71921	Private - Direct	136	125	-8%
71921	Private - Exchange	0	255	N/A
71921	Medicare	484	548	13%
71921	Medicare Dual Eligible	118	130	10%
71921	Medicaid	409	718	76%
71921	Uninsured	715	226	-68%
71923	Private - ESI	5,634	5,346	-5%
71923	Private - Direct	667	591	-11%
71923	Private - Exchange	0	1,497	N/A
71923	Medicare	2,086	2,219	6%
71923	Medicare Dual Eligible	535	557	4%
71923	Medicaid	2,449	4,197	71%
71923	Uninsured	4,289	1,151	-73%

BHMC-Arkadelphia

Zip Code	Insurance Type	2012 Covered Lives	2017 Covered Lives	% Chg
71962	Private - ESI	328	307	-6%
71962	Private - Direct	38	34	-11%
71962	Private - Exchange	0	68	N/A
71962	Medicare	141	158	12%
71962	Medicare Dual Eligible	33	36	9%
71962	Medicaid	112	188	68%
71962	Uninsured	196	62	-68%
71998	Private - ESI	202	198	-2%
71998	Private - Direct	25	23	-8%
71998	Private - Exchange	0	37	N/A
71998	Medicare	8	9	13%
71998	Medicare Dual Eligible	3	3	0%
71998	Medicaid	38	65	71%
71998	Uninsured	67	13	-81%
71999	Private - ESI	167	153	-8%
71999	Private - Direct	20	17	-15%
71999	Private - Exchange	0	50	N/A
71999	Medicare	20	18	-10%
71999	Medicare Dual Eligible	6	6	0%
71999	Medicaid	79	137	73%
71999	Uninsured	137	28	-80%
BHMC- Arkadelphia Total		**24,342**	**24,288**	**0%**

Interview & Focus Group Analysis

INTERVIEW ANALYSIS APPROACH

- Coded participants and consolidated interview responses
- Participant responses were parsed by question/topic and categorized
    - Participants gave multiple responses per question – each response recorded individually
    - Therefore, response count can be greater than number of participants
- Density analysis conducted on responses by category

Interview questions were designed to approach some subjects in a multitude of ways and give the interviewer flexibility in conducting the interview. Therefore not every question is represented with a response table as some question responses were collapsed while others eliminated due to time constraints. Additionally some questions were not designed for response consolidation but used to inform other sections of the analysis.

BHRI INTERVIEW SUMMARY

Questions 1 and 2 were background/ice-breaker questions regarding the community or organization each person represented.

03. What would you say is the current health status of the community?

Response Category	Response Count	Percent of Responses
Good	3	30%
Poor	3	30%
Fair	2	20%
Good-Fair	1	10%
Fair-Poor	1	10%
Grand Total	**10**	**100%**

03a. Reasoning?

Response Category	Response Count	Percent of Responses
Prevention/Lifestyle	2	25%
Lack of Physicians	1	13%
Un/UnderInsured	1	13%
Lack of Access to Healthcare	1	13%
Good Access to Healthcare	1	13%
Unhealthy Population	1	13%
Other	1	13%
Grand Total	**8**	**100%**

04. Top health needs of the community?

Response Category	Response Count	Percent of Responses
Obesity	4	17%
Chronic Diseases	3	13%
Access	2	8%
Cardiovascular	2	8%
Food/Nutrition	2	8%
Prevention/Lifestyle Modification	1	4%
Diabetes	1	4%
Dental	1	4%
Primary Care/PCPs	1	4%
Sexual Health	1	4%
Care Coordination	1	4%
Mental Health	1	4%
Affordable Care	1	4%
Healthcare Providers/Services	1	4%
Trauma/Injury	1	4%
Health Education	1	4%
Grand Total	**24**	**100%**

4b. What healthcare services are missing?

Response Category	Response Count	Percent of Responses
Long-term Care/Homes	3	100%
Grand Total	**3**	**100%**

4c. What is the number one barrier to good health care?

Response Category	Response Count	Percent of Responses
Socioeconomic	4	31%
Insurance	3	23%
Affordable Care	2	15%
Culture	1	8%
Access	1	8%
Prevention/Lifestyle Modification	1	8%
Health Education	1	8%
Grand Total	**13**	**100%**

4d. What concerns you the most about the health of the community?

Response Category	Response Count	Percent of Responses
Obesity	2	33%
Chronic/Other Diseases	1	17%
Food/Nutrition	1	17%
Other	1	17%
Prevention/Lifestyle Modification	1	17%
Grand Total	**6**	**100%**

05. Leading social determinants of health?

Response Category	Response Count	Percent of Responses
Socioeconomic	12	67%
Transportation	2	11%
Culture	1	6%
Food/Nutrition	1	6%
Health Education	1	6%
Prevention/Lifestyle Modification	1	6%
Grand Total	**18**	**100%**

06. primary health indicators?

Response Category	Response Count	Percent of Responses
Condition/Disease Rates	10	40%
Obesity	4	16%
Socioeconomic	3	12%
Hospital/Public Health Measures	2	8%
Injury/Disability Rates	2	8%
Smoking	2	8%
Preventative Care Rates	1	4%
Lifestyle Measures	1	4%
Grand Total	**25**	**100%**

07. vulnerable groups/populations?

Response Category	Response Count	Percent of Responses
Elderly	4	24%
Disabled	3	18%
Minorities	3	18%
LTAC	2	12%
Chronic Diseases	1	6%
Women	1	6%
Children/Teens	1	6%
Rural	1	6%
Un/UnderInsured	1	6%
Grand Total	**17**	**100%**

09. In terms of specific actions/programs, what do you think could be done to address the health needs we've discussed?

Response Category	Response Count	Percent of Responses
Public Health/Health Outcomes	4	25%
Community Outreach/Education	3	19%
Prevention/Screenings	2	13%
Social Resources	1	6%
Care Coordination	1	6%
Recreation	1	6%
Technology	1	6%
Access/Affordable Care	1	6%
Policy	1	6%
Non-English Speaking Programs	1	6%
Grand Total	**16**	**100%**

10. What are some ways Baptist Health or other organizations can engage the community in addressing health needs?

Response Category	Response Count	Percent of Responses
Community Collaboration	4	36%
Community Outreach/Education	3	27%
Access/Affordable Care	2	18%
Prevention/Screenings	1	9%
Environment/Socioeconomic	1	9%
Grand Total	**11**	**100%**

13. Are there specific health issues in the community in which Baptist should take a lead in addressing?

Response Category	Response Count	Percent of Responses
Rural Healthcare	1	100%
Grand Total	**1**	**100%**

13a. Are there any specific organizations in the community that would be a good fit for Baptist Health to partner with to address health needs?

Response Category	Response Count	Percent of Responses
Telerehab/Satellite Programs	1	100%
Grand Total	**1**	**100%**

BHMC-Little Rock Focus Group Summary

LOCATION: BHMC-LITTLE ROCK DATE: 9/10/12

DISCUSSION 1:

- What grade do you give the health of this community (A-F)?
    - Write the Grade down on sticky note and place on flipchart/white board
- Discuss as a group the grade chosen
    - What factors did you consider when you chose a grade?
    - What do you think of when you think of health?

RESPONSES:

When asked to grade the health of the community served by BHMC-Little Rock, focus group participants provided three C's, one C-, one D, and one B+. Contributing factors to the lower grades include poor physical health, chronic health conditions such as diabetes, high blood pressure, high rates of stroke, and obesity. Among children, there has been an increase in the rates of Type 1 and Type 2 diabetes.

While Pulaski County ranks well in terms of health compared to other counties in the state, lifestyle choices such as consumption of fast food, use of nicotine/smoking, and alcohol contribute to poor health. Where healthy foods are expensive and possibly difficult to access, fast food outlets provide several cheap options.

Other barriers to good health include transportation and access to affordable care. The Latino community is especially challenged because they do not have insurance, experience long wait times for appointments at the free clinic and usually end up utilizing the emergency department for basic health services. After hours clinics are also not utilized effectively as focus group participants felt there was a low level of awareness of these services, especially among female teenagers. In general, there is a feeling that more clinics are needed in the city to serve the vulnerable populations.

Culturally, a good portion of the community does not have high rates of health literacy and do not understand the value and importance of preventive and screening services. Churches are working to better understand the needs of the community and in general feel the needs of the underserved community are overwhelming.

Engaging the younger population in their healthcare is one way to begin improvement efforts. Access to dental care for children has improved and the trail systems also support a healthier lifestyle. Improved advertising of the after-hours clinic may also help improve access to those who need healthcare services.

DISCUSSION 2:

- Break into 2-3 smaller groups
- As a group identify the top 3 health needs of the community
    - Agree upon the top 3 needs and why
    - Write each need on sticky note and place on flipchart/white board
    - One person from the group share with the larger group why those needs were chosen

RESPONSES:

GROUP 1:

1. Access to a dental care clinic
    a. There is only one free dental clinic.
    b. Dental care is important because it can lead to more serious health problems.
2. Substance abuse
    a. Severe shortage of substance abuse programs.
3. Obesity
    a. Cause of many other health problems
    b. Occurring more frequently in children and resulting in adolescent diabetes. A child in the school system died last week because he had undiagnosed diabetes. It is important to get the parents to understand health problems in their children.
    c. Presence of food deserts

GROUP 2:

1. Education
    a. Need more community outreach to churches, schools, and the police department.
    b. Diabetes and obesity is a huge problem that needs to be addressed.
    c. Mental health and stress is also an important problem. There needs to be more activity around these topics.
    d. Services for disabled children who are not able to exercise
2. More health clinics
    a. When there is no access to trails/parks or other recreational activities, people turn to drugs and alcohol when they are stressed.
3. Improve access to care by connecting people to the resources that are already in place
    a. There is a lack of finances to get the appropriate care.

DISCUSSION 3:

- Stay the same smaller groups
- As a group identify up to 10 community resources (health/community organizations)
    - Work together to identify resources and list on flipchart paper
    - Discuss ways these resources could work together to address the health needs discussed
    - One person from the group share with larger group 2-3 ideas from discussion

RESPONSES:

In general, there is a need for resources to collaborate to get the information and knowledge out to the community. Churches are good instruments for communicating information as they have the attention of large congregations. Disseminating healthcare information should be like communication during a natural disaster – information and help must be readily available. Getting the media (local television stations) involved would help the relay the message of available health services.

GROUP 1:

- Friendly Chapel (soup kitchen)
- Mosaic/Churches
- P.A.R.K. and after school programs
- Boys and Girls Club
- River City Ministry
- Watershed
- Food banks
- Schools
- Goodwill
- Our House
- Hospitals/free clinics
- Homeless shelters
- Trail systems
- Police department
- Colleges

GROUP 2:

- Library
- Community Centers
- Schools
- Churches
- Public services (police department)
- Port authority
- Hospitals
- City/state government
- Police department
- Homeless shelters
- TV/Media

DISCUSSION 4:

- Stay the same smaller groups
- As a group, choose one of the health needs your group identified earlier
- Identify two goals you'd like to accomplish related to the need
    - Goals should be SMART (Specific, Measurable, Attainable, Realistic, Time-sensitive)
- For each goal identify 2-3 action steps that would help achieve the goal

RESPONSES:

Unfortunately, there was no time for this exercise during this focus group session.

Health Resources Available to Meet Identified Needs

BHMC-Little Rock

Other Hospital Facilities

Hospital Name	Address	City	Owner Type	Type of Service
St. Vincent Doctors Hospital	3101 Saint Vincent Cir.	Little Rock	Not-for-Profit	General Medical & Surgical
JL McClellan Memorial VA Hospital	4300 W. 7th St.	Little Rock	Veteran's Administration	General Medical & Surgical
St. Vincent Infirmary Medical Center	2 Saint Vincent Cir.	Little Rock	Not-for-Profit	General Medical & Surgical
Saline Memorial Hospital	1 Medical Park Dr.	Benton	Not-for-Profit	General Medical & Surgical
UAMS Medical Center	4301 W. Markham St.	Little Rock	Local Government	General Medical & Surgical
Arkansas Children's Hospital	1 Children's Way	Little Rock	Nonprofit	Children's General
Rivendell Behavioral Health Services	100 Rivendell Dr.	Benton	For Profit	Children's Psychiatric
Select Specialty Hospital- Little Rock	2 Saint Vincent Cir.	Little Rock	For Profit	Long Term Acute Care
Pinnacle Pointe Behavioral Health	11501 Financial Centre Pkwy.	Little Rock	For Profit	Psychiatric
The BridgeWay Hospital	21 Bridgeway Rd.	North Little Rock	For Profit	Psychiatric
United Methodist Behavioral Hospital	1601 Murphy Dr.	Maumelle	For Profit	Psychiatric
Arkansas State Hospital	305 S. Palm St.	Little Rock	Local Government	Psychiatric
Arkansas Heart Hospital	1701 S. Shackleford Rd.	Little Rock	For Profit	Heart Specialty

Cause of Death: Stroke

Chronic Conditions: Coronary Heart Disease (Pulaski, Grant, Saline)

Program Name	Description	Website	Phone Number	State	County
Arkansas Department of Health Heart Disease and Stroke Prevention			501-661-2942	X	

Program Name	Description	Website	Phone Number	State	County
Arkansas Wellness Coalition (AWC)	Includes members of the health care and employer community whose goal is to improve the health and well-being of all Arkansans through the use of nationally recognized, peer reviewed, clinical guidelines for physician, consumer, and employer education. Develop materials referring to nationally recognized standards such as those put forth by Healthy People 2010, the National Committee of Quality Assurance, and other disease-specific organizations such as the American Diabetes Association and the American Heart Association.		501-661-2942	X	
Southern Ain't Fried Sundays - Arkansas Minority Health Commission	Faith Based Outreach Program SAFS is designed to educate African American churches and organizations about healthier alternatives to preparing and cooking southern-style foods. It is also a mechanism for partnering with these groups in an effort to educate their members about the signs and symptoms of stroke, diabetes, and heart attacks. The program is being revamped to expand its reach to the Hispanic communities and individual participants.	http://www.arminorityhealth.com/programs_saf.html	877-264-2826	X	
UAMS Center for Distance Health AR SAVES Program (Stroke Assistance through Virtual Emergency Support)	A stroke management system specifically targeting patients at rural hospitals to by increasing access to subspecialty expertise through telemedicine technology, thereby engineering a coordinated assessment and care-based plan for Arkansas' stroke patients. Ensuring timely administration of clot-busting drugs to improve the chances of recovery while reducing permanent, stroke-related disability and, quite possibly, mortality.		501-686-8514	X	
Arkansas Chronic Illness Collaborative (ACIC)	The ACIC is a group of health care and public health professionals dedicated to improving the management of chronic diseases. The ACIC is a way for health care clinic teams to use the National Health Disparities Collaborative Chronic Care Model to share ideas and knowledge, learn and apply new techniques, and match medical practices with clinical guidelines based on scientific evidence about what works best (diabetes, cancer and cardiovascular diseases)	http://www.healthy.arkansas.gov/programsServices/chronicDisease/Initiatives/Pages/Acic.aspx		X	

Cause of Death: Cancer (Grant)

Program Name	Description	Website	Phone Number	State	County
Arkansas Cancer Coalition	The Arkansas Cancer Coalition exists to provide a favorable environment for cancer control partners to work to reduce, and ultimately eliminate, the burden of cancer for every person in the state. The Coalition is a partnership of individuals and organizations working together to: Provide an overview of the current status of cancer control in Arkansas Reduce the overall burden of cancer by providing and maintaining a plan of goals and strategies Improve the quality of life for those personally affected by cancer by strengthening and sustaining the cancer control partnership support network	http://www.arcancercoalition.org/resources/reduce-your-risk		X	
Arkansas Chronic Illness Collaborative (ACIC)	The ACIC is a group of health care and public health professionals dedicated to improving the management of chronic diseases. The ACIC is a way for health care clinic teams to use the National Health Disparities Collaborative Chronic Care Model to share ideas and knowledge, learn and apply new techniques, and match medical practices with clinical guidelines based on scientific evidence about what works best (diabetes, cancer and cardiovascular diseases)	http://www.healthy.arkansas.gov/programsServices/chronicDisease/Initiatives/Pages/Acic.aspx		X	

Cause of Death: Chronic Lower Respiratory Disease (Grant)

Program Name	Description	Website	Phone Number	State	County
Arkansas Wellness Coalition (AWC)	Includes members of the health care and employer community whose goal is to improve the health and well-being of all Arkansans through the use of nationally recognized, peer reviewed, clinical guidelines for physician, consumer, and employer education. Develop materials referring to nationally recognized standards such as those put forth by Healthy People 2010, the National Committee of Quality Assurance, and other disease-specific organizations such as the American Diabetes Association and the American Heart Association.		501-661-2942	X	

Program Name	Description	Website	Phone Number	State	County
Arkansas Chronic Illness Collaborative (ACIC)	The ACIC is a group of health care and public health professionals dedicated to improving the management of chronic diseases. The ACIC is a way for health care clinic teams to use the National Health Disparities Collaborative Chronic Care Model to share ideas and knowledge, learn and apply new techniques, and match medical practices with clinical guidelines based on scientific evidence about what works best (diabetes, cancer and cardiovascular diseases)	http://www.healthy.arkansas.gov/programsServices/chronicDisease/Initiatives/Pages/Acic.aspx		X	

Health Outcomes: Low Birth Weight (Grant, Pulaski)

Health Outcomes: Infant Mortality (Pulaski)

Program Name	Description	Website	Phone Number	State	County
Arkansas Department of Health	ADH provides prenatal care to an average of 5,000 women annually at many of the Local Health Units.		1-800-462-0599	X	
Arkansas Department of Health Nurse-Family Partnership	Nurse-Family Partnership is a free, voluntary program that partners first-time moms with registered nurses. NFP is available to any first-time mom who is under her 28th week of pregnancy, and who is below 200% of the Federal poverty level.	http://www.adhhomecare.org/nurse-family-arkansas.htm		X	

Health Outcomes: Poor Physical Health and Mental Health Days (Grant, Saline)

Program Name	Description	Website	Phone Number	State	County
Arkansas Department of Health – Hometown Health Improvement	HHI initiatives currently exist in every county around the state. HHI coalitions do powerful and unique work to improve the health of those in their communities. Once the coalition is established, many communities are choosing to conduct health behavior surveys to gain important information specific to their communities. Many coalitions are now implementing activities to affect the health of the community. Examples of some activities include: tobacco cessation programs for adolescents, household hazardous waste round-up, parenting support groups, local industry wellness programs, health fairs, and health resource guides.				X (All counties)

Program Name	Description	Website	Phone Number	State	County
Chronic Disease Self Management Program – Be Well Live Well	Developed by the Stanford Patient Education Research Center, the evidence based program teaches participants the skills needed to live well with chronic diseases. It also shows participants how to organize their lives, make and achieve goals, eat properly, exercise and communicate effectively with physicians and others. National outcome studies reveal that CDSMP participants experience a marked decrease in the number of hospital stays and doctor visits.	http://www.agec.org/2012/10/cdsmp-branded-for-arkansas-be-well-live-well/		X	

Chronic Conditions: Hypertension (Grant, Saline, Pulaski)

Program Name	Description	Website	Phone Number	State	County
Southern Ain't Fried Sundays - Arkansas Minority Health Commission	Faith Based Outreach Program SAFS is designed to educate African American churches and organizations about healthier alternatives to preparing and cooking southern-style foods. It is also a mechanism for partnering with these groups in an effort to educate their members about the signs and symptoms of stroke, diabetes, and heart attacks. The program is being revamped to expand its reach to the Hispanic communities and individual participants.	http://www.arminorityhealth.com/programs_saf.html	877-264-2826		

Chronic Conditions: Asthma (Grant, Pulaski)

Program Name	Description	Website	Phone Number	State	County
The Delta Area Health Education Center (AHEC)	Utilizing the American Lung Association's curriculums, asthma education is provided to children, parents, caregivers and teachers.		870-572-2727		X Located in Pine Bluff (Jefferson County) Serving Grant County
Arkansas Respiratory Health Association	Services offered: Conduct asthma, COPD and tobacco/cessation educational programs for patients, the general public and schools. Coordinate support groups for COPD patients. Provide continuing educational opportunities for school and healthcare professionals.	http://www.arkresp.org	800-880-5864 ext. 100	X	

Chronic Conditions: Arthritis (Grant, Saline)

Program Name	Description	Website	Phone Number	State	County
Arkansas Arthritis Foundation	Various educational programs	http://www.arthritis.org/arkansas/		X	

Chronic Conditions: Diabetes (Pulaski)

Prevention: Diabetic Screening (Saline, Pulaski)

Program Name	Description	Website	Phone Number	State	County
American Diabetes Association	Educational Resources; Advocacy		(501) 221-7444		X (all counties)
Arkansas Health Care Access Foundation	Locates doctors to donate office visits; prescription assistance; free to those who qualify	http://ahcaf.org/			X (all counties)
Arkansas Wellness Coalition	Includes members of the health care and employer community whose goal is to improve the health and well-being of all Arkansans through the use of nationally recognized, peer reviewed, clinical guidelines for physician, consumer, and employer education. Develop materials referring to nationally recognized standards such as those put forth by Healthy People 2010, the National Committee of Quality Assurance, and other disease-specific organizations such as the American Diabetes Association and the American Heart Association.		501-661-2942	X	
Arkansas Chronic Illness Collaborative (ACIC)	The ACIC is a group of health care and public health professionals dedicated to improving the management of chronic diseases. The ACIC is a way for health care clinic teams to use the National Health Disparities Collaborative Chronic Care Model to share ideas and knowledge, learn and apply new techniques, and match medical practices with clinical guidelines based on scientific evidence about what works best (diabetes, cancer and cardiovascular diseases)	http://www.healthy.arkansas.gov/programsServices/chronicDisease/Initiatives/Pages/Acic.aspx		X	
Diabetes Education Program Sites – Pulaski County	Baptist Health Diabetes Self Mgmt Program – Little Rock The Arkansas Diabetes Self Mgmt Education Program – Little Rock		501-202-1877 501-296-1220 501-552-4763 501-202-3701		X

Program Name	Description	Website	Phone Number	State	County
Center for Healing Hearts and Spirits – Little Rock	Offers health education for diabetes.	http://www.hhscenter.org	501-372-3800		(Little Rock)

Health Behaviors: Obesity (Pulaski, Grant, Saline)

Socioeconomic & Environment: Access to Healthy Food (Pulaski, Grant, Saline)

Socioeconomic & Environment: Percentage of Fast Food Restaurants (Pulaski, Grant, Saline)

Program Name	Description	Website	Phone Number	State	County
Arkansas Department of Health Lifestage Health Branch	Mission is the prevention and reduction of obesity through the adoption of healthy eating practices and increased physical activity. Provides technical assistance, managing and supporting evidence-based programs, disseminating materials and resources, and skills-building within the Agency, in schools, at worksites, among partners and with the general public.		501-661-2099	X	
Arkansas Coalition for Obesity Prevention (ArCOP)	A coalition whose goal is to increase the percentage of Arkansans of all ages who have access to healthy and affordable food and who engage in regular physical activity. Coalition is structured around six working teams: Access to Healthy Foods; Built Environment; Early Childhood and Schools; Healthcare; Worksite Wellness; and Social Marketing	http://www.arkansasobesity.org/		X	
Southern Ain't Fried Sundays - Arkansas Minority Health Commission	Faith Based Outreach Program SAFS is designed to educate African American churches and organizations about healthier alternatives to preparing and cooking southern-style foods. It is also a mechanism for partnering with these groups in an effort to educate their members about the signs and symptoms of stroke, diabetes, and heart attacks. The program is being revamped to expand its reach to the Hispanic communities and individual participants.	http://www.arminorityhealth.com/programs_saf.html	877-264-2826	X	

Program Name	Description	Website	Phone Number	State	County
Arkansas Rice Depot	Arkansas Rice Depot's mission is to find sensible solutions to hunger in Arkansas. • Food For Families: Our statewide free food bank serves 300 church and community hunger organizations • Food For Kids: Backpacks of food and supplies are sent home with children having problems in school due to hunger at home, currently operating in more than 600 schools, serving over 35,000 students and siblings • Food For Seniors: Home-delivered food boxes given each month to seniors	http://ricedepot.org/		X	
Arkansas Department of Health - PEPPI	Peer Exercise Program Promotes Independence is a physical activity program specifically designed for older adults to increase and maintain their level of fitness and independence. The physical activity program includes strength training using resistance bands and walking. PEPPI program provides older Arkansans with the opportunity to learn how to exercise correctly (i.e. using correct techniques) in a safe environment, both physically (at the senior centers, churches, or other community groups), and mentally (among people of similar age and health conditions), and to increase their level of physical activity.	http://www.healthy.arkansas.gov/programsServices/chronicDisease/PhysicalActivity/Pages/default.aspx		X	
Arkansas Department of Health - WIC FMNP	The purposes of the WIC FMNP are to provide fresh, nutritious, unprepared fruits and vegetables from farmers' market to women and children who are nutritionally at risk and to expand the awareness and use of farmers' markets, as well as increase sales at such markets. During the farming season, WIC FMNP provides clients in the WIC Program with checks to purchase locally grown fresh fruits and vegetables sold by authorized farmers at authorized farmers' markets.	http://www.healthy.arkansas.gov/programsServices/WIC/Pages/FMNP.aspx		X	

Program Name	Description	Website	Phone Number	State	County
Arkansas Department of Health Pick a Better Snack Program	The Arkansas 5 A Day Coalition, a partnership of organizations whose mission is to increase Arkansans' consumption of fruits and vegetables, coordinated the implementation of this program in two elementary schools during the 2006-07 and 2007-08 school years. Using Food Stamp Nutrition Education funds, as well as private contributions, the Pick a Better Snack Program has been implemented in more than twenty schools throughout the State. The program has been well received by both teachers and students.	http://www.healthy.arkansas.gov/programsServices/chronicDisease/Nutrition/Pages/Programs.aspx		X	
Arkansas Department of Health Healthy Restaurant Award	The Healthy Arkansas Restaurant Award is a voluntary program that provides public recognition to restaurants that meet certain health criteria. Restaurants self-apply and self-report through a questionnaire-type application. Criteria considered include smoke-free status of facility, labeling of food items, and number and types of healthy nutrition choices that are offered. Applications must be completed by a designee of the restaurant. Menus, inserts or photo of menu board with nutrient information must be submitted with the application to confirm the information.	http://www.healthy.arkansas.gov/programsServices/chronicDisease/Nutrition/Pages/Programs.aspx		X	
Bess Chisum Stephens Community Center	Offers a variety of low-cost exercise classes to the community including aquatic classes	http://centersforyouthandfamilies.org/programs/bess-chisum-stephens-community-center/			X (Little Rock, Pulaski County)

Health Behaviors: Excessive Drinking (Grant, Pulaski)

Program Name	Description	Website	Phone Number	State	County
Arkansas Center for Addictions Research, Education, and Services (AR-CARES)	This comprehensive family treatment program called the Arkansas Center for Addictions Research, Education and Services (Arkansas CARES) focuses on breaking the cycle of maternal addiction.	http://methodistfamily.org/programs/arkansas-CARES.html			X (Little Rock, Pulaski County)

Health Behaviors: Sexually Transmitted Infections (Pulaski)

Program Name	Description	Website	Phone Number	State	County
Arkansas Department of Health STD Testing Center	Future Builders, Inc. 16117 Highway 365 Little Rock, Arkansas 72206 Thursday 10:30 am to 2:30 pm After hours by appointment only		501-897-5566		X
Pulaski County Health Unit Sites – STD Testing	Pulaski County Jacksonville 3000 N 1st Street Jacksonville 501-982-7477 Pulaski County College Station 4206 Frazier Pike College Station 501-490-1602 Pulaski County NLR Health Unit 2800 N Willow North Little Rock 501-791-8551 Pulaski Central Health Unit 3915 W 8th Street Little Rock 501-280-3100		501-982-7477 501-490-1602 501-791-8551 501-280-3100		X

Health Behaviors: Smoking (Grant, Saline)

Program Name	Description	Website	Phone Number	State	County
Stamp Out Smoking	Arkansas Tobacco Quitline: A 24-hour direct line to professionally trained Quit Coaches® waiting to help you fight the good fight, plus a 24-hour online community of support from others who've gone through exactly what you're facing … and you can even get a supply of the latest nicotine replacement therapy medications at no cost.	http://www.stampoutsmoking.com/get-help-to-quit/	1-800-QUIT NOW	x	
Arkansas Department of Health Tobacco Prevention and Cessation Program – STOP Program	The Systems Training Outreach Program (STOP) currently uses Outreach to provide education and support to providers. Increasing the capacity and efficiency of care systems by asking, documenting tobacco use and advising patients to stop, the Outreach Specialists educate healthcare providers to be aware of available and accessible cessation treatment interventions. In particular, the specialists will help providers systematically identify patients who are tobacco users, provide guidance to quit and connect them to available resources to successfully quit.	http://www.healthy.arkansas.gov/programsServices/chronicDisease/coalition/Pages/tobacco.aspx		x	

Access: Lack of PCPs (Grant, Saline)

Program Name	Description	Website	Phone Number	State	County
Arkansas Department of Health Office of Rural Health and Primary Care	Promotes the development of community-based health care services and systems throughout Arkansas to ensure that well managed, quality health services are available to all citizens		501-280-4560	X	
Area Health Education Centers (AHEC)	Programs provide access to medical services for rural residents and education for healthcare students and professionals.	http://ruralhealth.uams.edu/AHEC-Programs			X Located in Pine Bluff (Jefferson County) Serving Grant County
American Academy of Family Physicians	The Arkansas Academy of Family Physicians Foundation and TransforMED, a wholly owned subsidiary of the American Academy of Family Physicians, announced that three family medicine practices have been selected to receive facilitative and financial support as they implement a new model of health care known as the patient-centered medical home.	http://www.transformed.com/news-eventsdetailpage.cfm?listingID=102		X	
University of Arkansas Foundation	Education and Promotion of Physician Assistants in Arkansas	http://www.uamshealth.com/News/UAMSPhysicianAssistantNorthwestArkansasResidencyProgramsReceiveGrantsfromBlueYouFoundation?id=5349&showBack=true&PageIndex=0&cid=4		X	
ADH ConnectCare	ConnectCare works to connect Medicaid and ARKids recipients to a primary care physician and a medical home. Telephone Helpline Specialists who staff a toll-free telephone call center respond to Medicaid and ARKids recipient questions and concerns, give information and offer guidance on accessing resources, and assist clients in locating and assigning a primary care physician.	http://www.healthy.arkansas.gov/programsServices/familyHealth/HealthConnections/Pages/ConnectCare.aspx		X	
Christian Community Care Clinic	Since 1999, our clinic has been providing a variety of health care services to Saline County residents in need.	http://www.bentoncareclinic.com/	501-776-1703		X

Program Name	Description	Website	Phone Number	State	County
Harmony Health Clinic	Pulaski County clinics for low income and uninsured individuals in need	http://www.harmonyclinicar.org/			X
Open Hands		http://jcssi.org			
College Station Center		http://jcssi.org			
Shepherd's Hope Neighborhood Health Center		http://shepherdshopelr.org/			
Westside		http://www.dolr.org/offices/catholiccharities/westside.php			

Socioeconomic & Environment: Single-Parent Households (Pulaski)

Program Name	Description	Website	Phone Number	State	County
Arkansas Voices	To advocate for children left behind by incarceration or loss of a parent for any reason and to provide mentoring, services and supports for the children, their caregivers, and incarcerated parents, with the goal of strengthening and empowering the family unit.	http://www.arkansasvoices.org/		X	
Arkansas Single Parent Scholarship Fund	Single Parent Scholarships (SPSF) are given to low-income single parents who are pursuing post-secondary education in preparation for skilled employment. We organize affiliated scholarship funds that serve every county of Arkansas	http://www.aspsf.org/index.html		X	

Socioeconomic & Environment: Violent Crime (Pulaski)

Program Name	Description	Website	Phone Number	State	County
Black on Black Crime Coalition	Driven by its mission to increase public awareness and reduce black on black crime in Pulaski County, the Coalition has developed a plan of action that includes: an education/awareness campaign program initiatives with its partners collaborations with existing organizations that serve citizens and institutions directly and indirectly affected by black on black crime	http://www.hhscenter.org/bonbcrim.html			X

Program Name	Description	Website	Phone Number	State	County
City of Little Rock – Neighborhood Alert Centers	The aim of the Neighborhood Alert Centers is to meet 6 tactical objectives. • Build trust in City Services and Staff • Broadcast a sense of unified neighborhood intolerance for drug and criminal activity • Deny drug dealers and customers access to open space in the neighborhood • Remove the sense of impunity street market dealers feel • Clean up the neighborhoods • Create a climate of achievement and reclaim neighborhood power Alert Center team members have assisted residents to create neighborhood groups such as crime watches and neighborhood associations, as well as neighborhood business organizations and religious organization alliances. They have organized and participated in neighborhood clean-ups. Neighborhood facilitators approached City Hall with the idea of creating a tool lending library through the alert centers so residents would have access to yard tools and lawn mowers to promote neighborhood beautification. Frequent neighborhood functions, alert center open houses and block parties are held to boost neighbor-to-neighbor and neighbor-to-City Staff relations.	http://www.littlerock.org/citydepartments/housing_programs/alertcenters/goals.aspx			
Pulaski County Youth Services	Take a holistic approach to curb the problems of gangs, violence, crime and substance abuse while enhancing the well-being of the community, children, youth and families by getting parents and community members involved in the lives of children and youth.	http://co.pulaski.ar.us/youthservices.shtml	501-340-8250		X

BHMC-North Little Rock

Other Hospital Facilities

Hospital Name	Address	City	Owner Type	Type of Service
Central Arkansas Veteran's Healthcare Towbin Healthcare Center	2200 Fort Roots Dr.	North Little Rock	Veteran's Administration	General Medical & Surgical
St. Vincent Medical Center North	2215 Wildwood Ave.	Sherwood	Not-for-profit	General Medical & Surgical
North Metro Medical Center	1400 Braden St.	Jacksonville	Local Government	General Medical & Surgical
Arkansas Surgical Hospital	5201 N. Shore Dr.	North Little Rock	For Profit	Surgical
Allegiance Behavioral Health Hospital of Jacksonville	1400 W. Braden St.	Jacksonville	For Profit	Long Term Acute Care
St. Vincent North Rehabilitation Hospital (in partnership with Healthsouth)	2201 Wildwood Ave.	Sherwood	For Profit	Rehabilitation

Cause of Death: Stroke (Lonoke)

Chronic Conditions: Coronary Heart Disease (Pulaski, Lonoke)

Program Name	Description	Website	Phone Number	State	County
Arkansas Department of Health Heart Disease and Stroke Prevention			501-661-2942	x	
Arkansas Wellness Coalition (AWC)	Includes members of the health care and employer community whose goal is to improve the health and well-being of all Arkansans through the use of nationally recognized, peer reviewed, clinical guidelines for physician, consumer, and employer education. Develop materials referring to nationally recognized standards such as those put forth by Healthy People 2010, the National Committee of Quality Assurance, and other disease-specific organizations such as the American Diabetes Association and the American Heart Association.		501-661-2942	x	

Program Name	Description	Website	Phone Number	State	County
Southern Ain't Fried Sundays - Arkansas Minority Health Commission	Faith Based Outreach Program SAFS is designed to educate African American churches and organizations about healthier alternatives to preparing and cooking southern-style foods. It is also a mechanism for partnering with these groups in an effort to educate their members about the signs and symptoms of stroke, diabetes, and heart attacks. The program is being revamped to expand its reach to the Hispanic communities and individual participants.	http://www.arminorityhealth.com/programs_saf.html	877-264-2826	X	
ARCare	ARcare offers specialized treatment for a variety of cardiovascular conditions including coronary artery disease, heart attack, high blood pressure, high cholesterol, angina, and all other conditions related to the heart and its blood vessel system. Board-Certified Physicians will screen you for heart problems and educate you about healthy lifestyles, regardless of your ability to pay. At ARcare's Health Care, we offer state-of-the-art cardiology care for people with insurance, those without insurance, and those that are underinsured.	http://www.arcare.net/OurServices/OurServicesContinuedpart2/tabid/14185/Default.aspx#cardiology			X (Lonoke County)
UAMS Center for Distance Health AR SAVES Program (Stroke Assistance through Virtual Emergency Support	A stroke management system specifically targeting patients at rural hospitals to by increasing access to subspecialty expertise through telemedicine technology, thereby engineering a coordinated assessment and care-based plan for Arkansas' stroke patients. Ensuring timely administration of clot-busting drugs to improve the chances of recovery while reducing permanent, stroke-related disability and, quite possibly, mortality.		501-686-8514	X	

Program Name	Description	Website	Phone Number	State	County
Arkansas Chronic Illness Collaborative (ACIC)	The ACIC is a group of health care and public health professionals dedicated to improving the management of chronic diseases. The ACIC is a way for health care clinic teams to use the National Health Disparities Collaborative Chronic Care Model to share ideas and knowledge, learn and apply new techniques, and match medical practices with clinical guidelines based on scientific evidence about what works best (diabetes, cancer and cardiovascular diseases)	http://www.healthy.arkansas.gov/programsServices/chronicDisease/Initiatives/Pages/Acic.aspx		X	

Cause of Death: Cancer (Lonoke)

Program Name	Description	Website	Phone Number	State	County
Arkansas Cancer Coalition	The Arkansas Cancer Coalition exists to provide a favorable environment for cancer control partners to work to reduce, and ultimately eliminate, the burden of cancer for every person in the state. The Coalition is a partnership of individuals and organizations working together to: • Provide an overview of the current status of cancer control in Arkansas • Reduce the overall burden of cancer by providing and maintaining a plan of goals and strategies • Improve the quality of life for those personally affected by cancer by strengthening and sustaining the cancer control partnership support network	http://www.arcancercoalition.org/resources/reduce-your-risk		X	
Arkansas Chronic Illness Collaborative (ACIC)	The ACIC is a group of health care and public health professionals dedicated to improving the management of chronic diseases. The ACIC is a way for health care clinic teams to use the National Health Disparities Collaborative Chronic Care Model to share ideas and knowledge, learn and apply new techniques, and match medical practices with clinical guidelines based on scientific evidence about what works best (diabetes, cancer and cardiovascular diseases)	http://www.healthy.arkansas.gov/programsServices/chronicDisease/Initiatives/Pages/Acic.aspx		X	

Cause of Death: Chronic Lower Respiratory Disease (Lonoke)

Program Name	Description	Website	Phone Number	State	County
Arkansas Wellness Coalition (AWC)	Includes members of the health care and employer community whose goal is to improve the health and well-being of all Arkansans through the use of nationally recognized, peer reviewed, clinical guidelines for physician, consumer, and employer education. Develop materials referring to nationally recognized standards such as those put forth by Healthy People 2010, the National Committee of Quality Assurance, and other disease-specific organizations such as the American Diabetes Association and the American Heart Association.		501-661-2942	X	
Arkansas Chronic Illness Collaborative (ACIC)	The ACIC is a group of health care and public health professionals dedicated to improving the management of chronic diseases. The ACIC is a way for health care clinic teams to use the National Health Disparities Collaborative Chronic Care Model to share ideas and knowledge, learn and apply new techniques, and match medical practices with clinical guidelines based on scientific evidence about what works best (diabetes, cancer and cardiovascular diseases)	http://www.healthy.arkansas.gov/programsServices/chronicDisease/Initiatives/Pages/Acic.aspx		x	

Health Outcomes: Low Birth Weight (Pulaski)
Health Outcomes: Infant Mortality (Pulaski)

Program Name	Description	Website	Phone Number	State	County
Arkansas Department of Health	ADH provides prenatal care to an average of 5,000 women annually at many of the Local Health Units.		1-800-462-0599	X	
Arkansas Department of Health Nurse-Family Partnership	Nurse-Family Partnership is a free, voluntary program that partners first-time moms with registered nurses. NFP is available to any first-time mom who is under her 28th week of pregnancy, and who is below 200% of the Federal poverty level.	http://www.adhhomecare.org/nurse-family-arkansas.htm		X	

Health Outcomes: Poor or Fair Health Status (Lonoke)

Program Name	Description	Website	Phone Number	State	County
ADH – Hometown Health Improvement	Hometown Health Improvement initiatives currently exist in every county around the state. HHI coalitions do powerful and unique work to improve the health of those in their communities. Once the coalition is established, many communities are choosing to conduct health behavior surveys to gain important information specific to their communities. Many coalitions are now implementing activities to affect the health of the community. Examples of some activities include: tobacco cessation programs for adolescents, household hazardous waste round-up, parenting support groups, local industry wellness programs, health fairs, and health resource guides.				X (All counties)
Chronic Disease Self Management Program – Be Well Live Well	Developed by the Stanford Patient Education Research Center, the evidence based program teaches participants the skills needed to live well with chronic diseases. It also shows participants how to organize their lives, make and achieve goals, eat properly, exercise and communicate effectively with physicians and others. National outcome studies reveal that CDSMP participants experience a marked decrease in the number of hospital stays and doctor visits.	http://www.agec.org/2012/10/cdsmp-branded-for-arkansas-be-well-live-well/		X	

Chronic Conditions: Hypertension (Pulaski)

Program Name	Description	Website	Phone Number	State	County
Southern Ain't Fried Sundays - Arkansas Minority Health Commission	Faith Based Outreach Program SAFS is designed to educate African American churches and organizations about healthier alternatives to preparing and cooking southern-style foods. It is also a mechanism for partnering with these groups in an effort to educate their members about the signs and symptoms of stroke, diabetes, and heart attacks. The program is being revamped to expand its reach to the Hispanic communities and individual participants.	http://www.arminorityhealth.com/programs_saf.html	877-264-2826		

Chronic Conditions: Asthma (Pulaski)

Program Name	Description	Website	Phone Number	State	County
Arkansas Respiratory Health Association	Services offered: Conduct asthma, COPD and tobacco/cessation educational programs for patients, the general public and schools. Coordinate support groups for COPD patients. Provide continuing educational opportunities for school and healthcare professionals.	http://www.arkresp.org	800-880-5864 ext. 100	X	

Chronic Conditions: Diabetes (Pulaski, Lonoke)
Prevention: Diabetic Screening (Pulaski)

Program Name	Description	Website	Phone Number	State	County
American Diabetes Association	Educational Resources; Advocacy		(501) 221-7444		X (all counties)
Arkansas Health Care Access Foundation	Locates doctors to donate office visits; prescription assistance; free to those who qualify	http://ahcaf.org/			X (all counties)
Arkansas Wellness Coalition	Includes members of the health care and employer community whose goal is to improve the health and well-being of all Arkansans through the use of nationally recognized, peer reviewed, clinical guidelines for physician, consumer, and employer education. Develop materials referring to nationally recognized standards such as those put forth by Healthy People 2010, the National Committee of Quality Assurance, and other disease-specific organizations such as the American Diabetes Association and the American Heart Association.		501-661-2942	X	
Arkansas Chronic Illness Collaborative (ACIC)	The ACIC is a group of health care and public health professionals dedicated to improving the management of chronic diseases. The ACIC is a way for health care clinic teams to use the National Health Disparities Collaborative Chronic Care Model to share ideas and knowledge, learn and apply new techniques, and match medical practices with clinical guidelines based on scientific evidence about what works best (diabetes, cancer and cardiovascular diseases)	http://www.healthy.arkansas.gov/programsServices/chronicDisease/Initiatives/Pages/Acic.aspx		X	

Program Name	Description	Website	Phone Number	State	County
Diabetes Education Program Sites – Pulaski County	Baptist Health Diabetes Self Mgmt Program – Little Rock The Arkansas Diabetes Self Mgmt Education Program – Little Rock Baptist Health Diabetes Health Management Center–North Little Rock		501-202-1877 501-296-1220 501-202-3701		X
ARCare	The ARcare Diabetes Self-Management Program is an AADE recognized education program.	http://www.arcare.net/OurServices/OurServices Continued/tabid/13586/Default.aspx	870-347-2534		X (Lonoke County)
Arkansas Human Development Corporation - Lonoke	Assist the Hispanic and Latin American populations of Arkansas along with other individuals who are economically disadvantaged to learn skills that promote healthy lifestyles. Services: Diabetes, Sexuality/Reproductive Health Education, Health Fairs, Hypertension, Poison Safety Education, Sexually Transmitted Disease, Smoking Education/Prevention.	http://www.arhdc.org	501-676-2721		X

Health Behaviors: Obesity (Pulaski, Lonoke)

Socioeconomic & Environment: Access to Healthy Food (Pulaski, Lonoke)

Socioeconomic & Environment: Percentage of Fast Food Restaurants (Pulaski, Lonoke)

Program Name	Description	Website	Phone Number	State	County
Arkansas Department of Health Lifestage Health Branch	Mission is the prevention and reduction of obesity through the adoption of healthy eating practices and increased physical activity. Provides technical assistance, managing and supporting evidence-based programs, disseminating materials and resources, and skills-building within the Agency, in schools, at worksites, among partners and with the general public.		501-661-2099	X	
Arkansas Coalition for Obesity Prevention (ArCOP)	A coalition whose goal is to increase the percentage of Arkansans of all ages who have access to healthy and affordable food and who engage in regular physical activity. Coalition is structured around six working teams: Access to Healthy Foods; Built Environment; Early Childhood and Schools; Healthcare; Worksite Wellness; and Social Marketing	http://www.arkansasobesity.org/		X	

Program Name	Description	Website	Phone Number	State	County
Southern Ain't Fried Sundays - Arkansas Minority Health Commission	Faith Based Outreach Program SAFS is designed to educate African American churches and organizations about healthier alternatives to preparing and cooking southern-style foods. It is also a mechanism for partnering with these groups in an effort to educate their members about the signs and symptoms of stroke, diabetes, and heart attacks. The program is being revamped to expand its reach to the Hispanic communities and individual participants.	http://www.arminorityhealth.com/programs_saf.html	877-264-2826	X	
Arkansas Rice Depot	Arkansas Rice Depot's mission is to find sensible solutions to hunger in Arkansas. • Food For Families: Our statewide free food bank serves 300 church and community hunger organizations • Food For Kids: Backpacks of food and supplies are sent home with children having problems in school due to hunger at home, currently operating in more than 600 schools, serving over 35,000 students and siblings • Food For Seniors: Home-delivered food boxes given each month to seniors	http://ricedepot.org/		X	
ADH - PEPPI	Peer Exercise Program Promotes Independence is a physical activity program specifically designed for older adults to increase and maintain their level of fitness and independence. The physical activity program includes strength training using resistance bands and walking. PEPPI program provides older Arkansans with the opportunity to learn how to exercise correctly (i.e. using correct techniques) in a safe environment, both physically (at the senior centers, churches, or other community groups), and mentally (among people of similar age and health conditions), and to increase their level of physical activity.	http://www.healthy.arkansas.gov/programsServices/chronicDisease/PhysicalActivity/Pages/default.aspx		X	

Program Name	Description	Website	Phone Number	State	County
ADH - WIC FMNP	The purposes of the WIC FMNP are to provide fresh, nutritious, unprepared fruits and vegetables from farmers' market to women and children who are nutritionally at risk and to expand the awareness and use of farmers' markets, as well as increase sales at such markets. During the farming season, WIC FMNP provides clients in the WIC Program with checks to purchase locally grown fresh fruits and vegetables sold by authorized farmers at authorized farmers' markets.	http://www.healthy.arkansas.gov/programsServices/WIC/Pages/FMNP.aspx		X	
ADH Pick a Better Snack Program	The Arkansas 5 A Day Coalition, a partnership of organizations whose mission is to increase Arkansans' consumption of fruits and vegetables, coordinated the implementation of this program in two elementary schools during the 2006-07 and 2007-08 school years. Using Food Stamp Nutrition Education funds, as well as private contributions, the Pick a Better Snack Program has been implemented in more than twenty schools throughout the State. The program has been well received by both teachers and students.	http://www.healthy.arkansas.gov/programsServices/chronicDisease/Nutrition/Pages/Programs.aspx		X	
ADH Healthy Restaurant Award	The Healthy Arkansas Restaurant Award is a voluntary program that provides public recognition to restaurants that meet certain health criteria. Restaurants self-apply and self-report through a questionnaire-type application. Criteria considered include smoke-free status of facility, labeling of food items, and number and types of healthy nutrition choices that are offered. Applications must be completed by a designee of the restaurant. Menus, inserts or photo of menu board with nutrient information must be submitted with the application to confirm the information.	http://www.healthy.arkansas.gov/programsServices/chronicDisease/Nutrition/Pages/Programs.aspx		X	
ARCare – SilverSneakers Program	SilverSneakers offers an innovative blend of physical activity, healthy lifestyle, and socially oriented programming that allows older adults to take greater control of their health.	http://www.arcare.net/OurServices/OurServicesContinuedpart3/tabid/14186/Default.aspx#wellness	870-347-1137		X (Lonoke County)

Program Name	Description	Website	Phone Number	State	County
Bess Chisum Stephens Community Center	Offers a variety of low-cost exercise classes to the community including aquatic classes	http://centersforyouthandfamilies.org/programs/bess-chisum-stephens-community-center/			X (Pulaski County)

Health Behaviors: Excessive Drinking (Pulaski, Lonoke)

Program Name	Description	Website	Phone Number	State	County
Arkansas Center for Addictions Research, Education, and Services (AR-CARES)	This comprehensive family treatment program called the Arkansas Center for Addictions Research, Education and Services (Arkansas CARES) focuses on breaking the cycle of maternal addiction.	http://methodistfamily.org/programs/arkansas-CARES.html			X (Pulaski County)

Health Behaviors: Sexually Transmitted Infections (Pulaski)

Program Name	Description	Website	Phone Number	State	County
Arkansas Department of Health STD Testing Center	Future Builders, Inc. 16117 Highway 365 Little Rock, Arkansas 72206 Thursday 10:30 am to 2:30 pm After hours by appointment only		501-897-5566		X
Pulaski County Health Unit Sites – STD Testing	Pulaski County Jacksonville 3000 N 1st Street Jacksonville 501-982-7477 Pulaski County College Station 4206 Frazier Pike College Station 501-490-1602 Pulaski County NLR Health Unit 2800 N Willow North Little Rock 501-791-8551 Pulaski Central Health Unit 3915 W 8th Street Little Rock 501-280-3100		501-982-7477 501-490-1602 501-791-8551 501-280-3100		X

Health Behaviors: Smoking (Grant)

Program Name	Description	Website	Phone Number	State	County
Stamp Out Smoking	Arkansas Tobacco Quitline: A 24-hour direct line to professionally trained Quit Coaches® waiting to help you fight the good fight, plus a 24-hour online community of support from others who've gone through exactly what you're facing … and you can even get a supply of the latest nicotine replacement therapy medications at no cost.	http://www.stampoutsmoking.com/get-help-to-quit/	1-800-QUIT NOW	X	
Arkansas Department of Health Tobacco Prevention and Cessation Program – STOP Program	The Systems Training Outreach Program (STOP) currently uses Outreach to provide education and support to providers. Increasing the capacity and efficiency of care systems by asking, documenting tobacco use and advising patients to stop, the Outreach Specialists educate healthcare providers to be aware of available and accessible cessation treatment interventions. In particular, the specialists will help providers systematically identify patients who are tobacco users, provide guidance to quit and connect them to available resources to successfully quit.	http://www.healthy.arkansas.gov/programsServices/chronicDisease/coalition/Pages/tobacco.aspx		X	

Access: Lack of PCPs (Lonoke)

Program Name	Description	Website	Phone Number	State	County
Arkansas Department of Health Office of Rural Health and Primary Care	Promotes the development of community-based health care services and systems throughout Arkansas to ensure that well managed, quality health services are available to all citizens		501-280-4560	X	
Area Health Education Centers (AHEC)	Programs provide access to medical services for rural residents and education for healthcare students and professionals.	http://ruralhealth.uams.edu/AHEC-Programs			X Located in Pine Bluff (Jefferson County) Serving Lonoke County

Program Name	Description	Website	Phone Number	State	County
American Academy of Family Physicians	The Arkansas Academy of Family Physicians Foundation and TransforMED, a wholly owned subsidiary of the American Academy of Family Physicians, announced that three family medicine practices have been selected to receive facilitative and financial support as they implement a new model of health care known as the patient-centered medical home.	http://www.transformed.com/news-eventsdetailpage.cfm?listingID=102		X	
University of Arkansas Foundation	Education and Promotion of Physician Assistants in Arkansas	http://www.uamshealth.com/News/UAMSPhysicianAssistantNorthwestArkansasResidencyProgramsReceiveGrantsfromBlueYouFoundation?id=5349&showBack=true&PageIndex=0&cid=4		X	
ADH ConnectCare	ConnectCare works to connect Medicaid and ARKids recipients to a primary care physician and a medical home. Telephone Helpline Specialists who staff a toll-free telephone call center respond to Medicaid and ARKids recipient questions and concerns, give information and offer guidance on accessing resources, and assist clients in locating and assigning a primary care physician.	http://www.healthy.arkansas.gov/programsServices/familyHealth/HealthConnections/Pages/ConnectCare.aspx		X	
River City Ministry – North Little Rock	River City Ministry is a faith-based, nonprofit focused on "Opening Doors to God by Serving the Poor". River City Ministry seeks to: FEED the hungry by serving a hot lunch and operating a food pantry, CLOTHE those in need with our clothing bus, SHELTER the homeless with a safe, welcoming environment and through HUD housing programs, CARE for the sick through our pharmacy, medical, vision and dental clinics, and LOVE the unloved and underserved to show God's love!	http://www.rivercityministry.org/	501-376-6694		(North Little Rock)
Gardner Memorial Free Community Medical Clinic	To improve the health (mind, body, spirit) of the people of central Arkansas by assuring access to quality, culturally-sensitive care and health education along the continuum, working in collaboration with local communities and resources.	http://www.gardnermemorialumc.org/health_clinic.html	501-374-8852		Central AR

Program Name	Description	Website	Phone Number	State	County
AR Care – Lonoke County	Carlisle Medical Clinic (870) 552-7303 England Medical Clinic (501) 842-3131 Cabot Medical Clinic (501) 941-3522	http://www.arcare.net/OutLocations.aspx	See under description		X

Socioeconomic & Environment: Single-Parent Households (Pulaski)

Program Name	Description	Website	Phone Number	State	County
Arkansas Voices	To advocate for children left behind by incarceration or loss of a parent for any reason and to provide mentoring, services and supports for the children, their caregivers, and incarcerated parents, with the goal of strengthening and empowering the family unit.	http://www.arkansasvoices.org/		X	
Arkansas Single Parent Scholarship Fund	Single Parent Scholarships (SPSF) are given to low-income single parents who are pursuing post-secondary education in preparation for skilled employment. We organize affiliated scholarship funds that serve every county of Arkansas	http://www.aspsf.org/index.html		X	

Socioeconomic & Environment: Violent Crime (Pulaski)

Program Name	Description	Website	Phone Number	State	County
Black on Black Crime Coalition	Driven by its mission to increase public awareness and reduce black on black crime in Pulaski County, the Coalition has developed a plan of action that includes: • an education/awareness campaign • program initiatives with its partners • collaborations with existing organizations that serve citizens and institutions directly and indirectly affected by black on black crime	http://www.hhscenter.org/bonbcrim.html			X
Pulaski County Youth Services	Take a holistic approach to curb the problems of gangs, violence, crime and substance abuse while enhancing the well-being of the community, children, youth and families by getting parents and community members involved in the lives of children and youth.	http://co.pulaski.ar.us/youthservices.shtml	501-340-8250		X

Program Name	Description	Website	Phone Number	State	County
Mayor's Office of Youth Services – North Little Rock	The Mayor's Office of Youth Services provides an integral function in the reduction of juvenile crime by providing intervention and prevention programming support and consultation to the city's public, private and faith-based youth services agencies.	http://www.northlittlerock.ar.gov/programs-resources/Youth-Services/	501-340-5309		(North Little Rock)

BHMC-Stuttgart

Other Hospital Facilities

Hospital Name	Address	City	Owner Type	Type of Service
Dewitt City Hospital	1641 Whitehead Dr.	DeWitt	Local Government	General Medical & Surgical

Cause of Death: Heart Disease (Arkansas, Monroe, Prairie)

Cause of Death: Stroke (Arkansas, Monroe)

Chronic Conditions: Coronary Heart Disease (Arkansas, Monroe, Prairie)

Program Name	Description	Website	Phone Number	State	County
Arkansas Department of Health Heart Disease and Stroke Prevention			501-661-2942	X	
Arkansas Wellness Coalition (AWC)	Includes members of the health care and employer community whose goal is to improve the health and well-being of all Arkansans through the use of nationally recognized, peer reviewed, clinical guidelines for physician, consumer, and employer education. Develop materials referring to nationally recognized standards such as those put forth by Healthy People 2010, the National Committee of Quality Assurance, and other disease-specific organizations such as the American Diabetes Association and the American Heart Association.		501-661-2942	X	
ARCare	ARcare offers specialized treatment for a variety of cardiovascular conditions including coronary artery disease, heart attack, high blood pressure, high cholesterol, angina, and all other conditions related to the heart and its blood vessel system.	http://www.arcare.net/OurServices/OurServicesContinuedpart2/tabid/14185/Default.aspx#cardiology			X (Monroe, Prairie Counties)

Program Name	Description	Website	Phone Number	State	County
Southern Ain't Fried Sundays - Arkansas Minority Health Commission	Faith Based Outreach Program SAFS is designed to educate African American churches and organizations about healthier alternatives to preparing and cooking southern-style foods. It is also a mechanism for partnering with these groups in an effort to educate their members about the signs and symptoms of stroke, diabetes, and heart attacks. The program is being revamped to expand its reach to the Hispanic communities and individual participants.	http://www.arminorityhealth.com/programs_saf.html	877-264-2826	X	
UAMS Center for Distance Health AR SAVES Program (Stroke Assistance through Virtual Emergency Support	A stroke management system specifically targeting patients at rural hospitals to by increasing access to subspecialty expertise through telemedicine technology, thereby engineering a coordinated assessment and care-based plan for Arkansas' stroke patients. Ensuring timely administration of clot-busting drugs to improve the chances of recovery while reducing permanent, stroke-related disability and, quite possibly, mortality.		501-686-8514	X	
Arkansas Chronic Illness Collaborative (ACIC)	The ACIC is a group of health care and public health professionals dedicated to improving the management of chronic diseases. The ACIC is a way for health care clinic teams to use the National Health Disparities Collaborative Chronic Care Model to share ideas and knowledge, learn and apply new techniques, and match medical practices with clinical guidelines based on scientific evidence about what works best (diabetes, cancer and cardiovascular diseases)	http://www.healthy.arkansas.gov/programsServices/chronicDisease/Initiatives/Pages/Acic.aspx programsServices/chronicDisease/Initiatives/Pages/Acic.aspx		X	

Program Name	Description	Website	Phone Number	State	County
Arkansas Chronic Illness Collaborative (ACIC)	The ACIC is a group of health care and public health professionals dedicated to improving the management of chronic diseases. The ACIC is a way for health care clinic teams to use the National Health Disparities Collaborative Chronic Care Model to share ideas and knowledge, learn and apply new techniques, and match medical practices with clinical guidelines based on scientific evidence about what works best (diabetes, cancer and cardiovascular diseases)	http://www.healthy.arkansas.gov/programsServices/chronicDisease/Initiatives/Pages/Acic.aspx		X	

Cause of Death: Chronic Lower Respiratory Disease (Arkansas)

Program Name	Description	Website	Phone Number	State	County
Arkansas Wellness Coalition (AWC)	Includes members of the health care and employer community whose goal is to improve the health and well-being of all Arkansans through the use of nationally recognized, peer reviewed, clinical guidelines for physician, consumer, and employer education. Develop materials referring to nationally recognized standards such as those put forth by Healthy People 2010, the National Committee of Quality Assurance, and other disease-specific organizations such as the American Diabetes Association and the American Heart Association.		501-661-2942	X	
Arkansas Chronic Illness Collaborative (ACIC)	The ACIC is a group of health care and public health professionals dedicated to improving the management of chronic diseases. The ACIC is a way for health care clinic teams to use the National Health Disparities Collaborative Chronic Care Model to share ideas and knowledge, learn and apply new techniques, and match medical practices with clinical guidelines based on scientific evidence about what works best (diabetes, cancer and cardiovascular diseases)	http://www.healthy.arkansas.gov/programsServices/chronicDisease/Initiatives/Pages/Acic.aspx		X	

Cause of Death: Injury Related Deaths (Monroe)

Program Name	Description	Website	Phone Number	State	County
Arkansas Department of Health – Statewide Injury Prevention Program	The mission of the SIPP is to reduce the burden of injury mortality and morbidity in Arkansas through primary prevention of injuries. SIPP provides technical assistance and serves as a resource center for designated trauma centers, EMS providers, Hometown Health Improvement Coalitions, and Educational Service Cooperatives. SIPP also offers professional education opportunities through live presentations, webinars, and teleconferencing that provide tools to obtain grant funding, and tools to effectively identify, implement, and evaluate injury prevention initiatives at regional and local levels.	http://www.healthy.arkansas.gov/programsServices/injuryPreventionControl/injuryPrevention/SIPP/Pages/default.aspx		X	

Health Outcomes: Low Birth Weight (Arkansas, Monroe, Prairie)

Program Name	Description	Website	Phone Number	State	County
Arkansas Department of Health	ADH provides prenatal care to an average of 5,000 women annually at many of the Local Health Units.		1-800-462-0599	X	
Arkansas Department of Health Nurse-Family Partnership	Nurse-Family Partnership is a free, voluntary program that partners first-time moms with registered nurses. NFP is available to any first-time mom who is under her 28th week of pregnancy, and who is below 200% of the Federal poverty level.	http://www.adhhomecare.org/nurse-family-arkansas.htm		X	

Health Outcomes: Poor or Fair Health Status (Arkansas, Monroe, Prairie)

Program Name	Description	Website	Phone Number	State	County
ADH – Hometown Health Improvement	Hometown Health Improvement initiatives currently exist in every county around the state. HHI coalitions do powerful and unique work to improve the health of those in their communities. Once the coalition is established, many communities are choosing to conduct health behavior surveys to gain important information specific to their communities. Many coalitions are now implementing activities to affect the health of the community. Examples of some activities include: tobacco cessation programs for adolescents, household hazardous waste round-up, parenting support groups, local industry wellness programs, health fairs, and health resource guides.				X (All counties)
Chronic Disease Self Management Program – Be Well Live Well	Developed by the Stanford Patient Education Research Center, the evidence based program teaches participants the skills needed to live well with chronic diseases. It also shows participants how to organize their lives, make and achieve goals, eat properly, exercise and communicate effectively with physicians and others. National outcome studies reveal that CDSMP participants experience a marked decrease in the number of hospital stays and doctor visits.	http://www.agec.org/2012/10/cdsmp-branded-for-arkansas-be-well-live-well/		X	

Health Outcomes: Poor Physical Health and Mental Health Days (Arkansas, Monroe, Prairie)

Program Name	Description	Website	Phone Number	State	County
Chronic Disease Self Management Program – Be Well Live Well	Developed by the Stanford Patient Education Research Center, the evidence based program teaches participants the skills needed to live well with chronic diseases. It also shows participants how to organize their lives, make and achieve goals, eat properly, exercise and communicate effectively with physicians and others. National outcome studies reveal that CDSMP participants experience a marked decrease in the number of hospital stays and doctor visits.	http://www.agec.org/2012/10/cdsmp-branded-for-arkansas-be-well-live-well/		X	

Chronic Conditions: Hypertension (Arkansas)

Program Name	Description	Website	Phone Number	State	County
Southern Ain't Fried Sundays - Arkansas Minority Health Commission	Faith Based Outreach Program SAFS is designed to educate African American churches and organizations about healthier alternatives to preparing and cooking southern-style foods. It is also a mechanism for partnering with these groups in an effort to educate their members about the signs and symptoms of stroke, diabetes, and heart attacks. The program is being revamped to expand its reach to the Hispanic communities and individual participants.	http://www.arminorityhealth.com/programs_saf.html	877-264-2826		
Greater Delta Alliance for Health Mobile Health Screening Unit	GDAH has a fully equipped mobile unit that is utilized to offer free health screenings including breast exams, blood pressure, blood sugar, weight and BMI, HIV screening as well as specialized screenings through community health partners.	http://gdaharkansas.org/services			X (Arkansas County)
Area Health Education Centers (AHEC)	Health Education: Provides health education to adults on a variety of topics including diabetes, heart health, nutrition and healthy eating. Health Screening: Provides health screenings for area organizations and industry in conjunction with health fairs. Also provides information on how to deal with high blood pressure, cholesterol and glucose. Patients with abnormal readings are referred to health care providers		870-572-2727		X Located in Pine Bluff (Jefferson County) Serving Arkansas County

Chronic Conditions: High Cholesterol (Arkansas, Monroe, Prairie)

Program Name	Description	Website	Phone Number	State	County
Southern Ain't Fried Sundays - Arkansas Minority Health Commission	Faith Based Outreach Program SAFS is designed to educate African American churches and organizations about healthier alternatives to preparing and cooking southern-style foods. It is also a mechanism for partnering with these groups in an effort to educate their members about the signs and symptoms of stroke, diabetes, and heart attacks. The program is being revamped to expand its reach to the Hispanic communities and individual participants.	http://www.arminorityhealth.com/programs_saf.html	877-264-2826		

Program Name	Description	Website	Phone Number	State	County
Greater Delta Alliance for Health Mobile Health Screening Unit	GDAH has a fully equipped mobile unit that is utilized to offer free health screenings including breast exams, blood pressure, blood sugar, weight and BMI, HIV screening as well as specialized screenings through community health partners.	http://gdaharkansas.org/services			X (Arkansas County)
Area Health Education Centers (AHEC)	Health Education: Provides health education to adults on a variety of topics including diabetes, heart health, nutrition and healthy eating. Health Screening: Provides health screenings for area organizations and industry in conjunction with health fairs. Also provides information on how to deal with high blood pressure, cholesterol and glucose. Patients with abnormal readings are referred to health care providers		870-572-2727		X Located in Pine Bluff (Jefferson County) Serving Arkansas and Prairie Counties Located in Helena (Phillips County) Serving Monroe County

Chronic Conditions: Asthma (Monroe)

Program Name	Description	Website	Phone Number	State	County
The Delta Area Health Education Center (AHEC)	Utilizing the American Lung Association's curriculums, asthma education is provided to children, parents, caregivers and teachers.		870-572-2727		X (Monroe County)
Arkansas Respiratory Health Association	Services offered: Conduct asthma, COPD and tobacco/cessation educational programs for patients, the general public and schools. Coordinate support groups for COPD patients. Provide continuing educational opportunities for school and healthcare professionals.	http://www.arkresp.org	800-880-5864 ext. 100	X	

Chronic Conditions: Arthritis (Arkansas, Prairie)

Program Name	Description	Website	Phone Number	State	County
Arkansas Arthritis Foundation	Various educational programs	http://www.arthritis.org/arkansas/		X	

Chronic Conditions: Diabetes (Arkansas, Monroe, Prairie)

Program Name	Description	Website	Phone Number	State	County
American Diabetes Association	Educational Resources; Advocacy		(501) 221-7444		X (all counties)

Program Name	Description	Website	Phone Number	State	County
Arkansas Health Care Access Foundation	Locates doctors to donate office visits; prescription assistance; free to those who qualify	http://ahcaf.org/			X (all counties)
Arkansas Wellness Coalition	Includes members of the health care and employer community whose goal is to improve the health and well-being of all Arkansans through the use of nationally recognized, peer reviewed, clinical guidelines for physician, consumer, and employer education. Develop materials referring to nationally recognized standards such as those put forth by Healthy People 2010, the National Committee of Quality Assurance, and other disease-specific organizations such as the American Diabetes Association and the American Heart Association.		501-661-2942	X	
Arkansas Chronic Illness Collaborative (ACIC)	The ACIC is a group of health care and public health professionals dedicated to improving the management of chronic diseases. The ACIC is a way for health care clinic teams to use the National Health Disparities Collaborative Chronic Care Model to share ideas and knowledge, learn and apply new techniques, and match medical practices with clinical guidelines based on scientific evidence about what works best (diabetes, cancer and cardiovascular diseases)	http://www.healthy.arkansas.gov/programs Services/chronic Disease/Initiatives/Pages/Acic.aspx		X	
ARCare	The ARcare Diabetes Self-Management Program is an AADE recognized education program. Our Diabetes Self-Management Program offers individualized assessments and nutrition planning with a registered dietician. Our program also includes one-on-one education, classroom education, support group meetings, cooking classes, and exercise classes at two nursing homes.	http://www.arcare.net/OurServices/OurServices Continued/tabid/13586/Default.aspx	870-347-2534		X (Monroe, Prairie Counties)
Greater Delta Alliance for Health Diabetes Initiative	This project provides support to local diabetics by providing Diabetes Self-Management Education Program, free A1C screenings as well as diabetes awareness events and screenings throughout the six county service areas.	http://gdaharkansas.org/services			X (Arkansas County)
Des Arc Health Center	Diabetes education		870-256-4178		X (Des Arc, Prairie Counties)

Program Name	Description	Website	Phone Number	State	County
Devalls Bluff Health Center			870-998-2511		X (Prairie County)
Area Health Education Centers (AHEC)	Diabetes (1 on 1 and Group) –Provides diabetes education to individuals and groups. Diabetes Support Group - Offers a monthly support group to individuals with diabetes and their friends and families. Health Education: Provides health education to adults on a variety of topics including diabetes, heart health, nutrition and healthy eating. Health Screening: Provides health screenings for area organizations and industry in conjunction with health fairs. Also provides information on how to deal with high blood pressure, cholesterol and glucose. Patients with abnormal readings are referred to health care providers How Healthy is Your Church? -- Provides free health screenings, information and counseling to area churches.		870-572-2727		X Located in Pine Bluff (Jefferson County) Serving Arkansas and Prairie Counties Located in Helena (Phillips County) Serving Monroe County

Health Behaviors: Obesity (Arkansas, Monroe, Prairie)

Health Behaviors: Physical Inactivity (Arkansas, Monroe, Prairie)

Health Behaviors: Lack of Healthy Eating (Arkansas, Monroe, Prairie)

Socioeconomic & Environment: Percentage of Fast Food Restaurants (Arkansas, Monroe)

Program Name	Description	Website	Phone Number	State	County
Arkansas Department of Health Lifestage Health Branch	Mission is the prevention and reduction of obesity through the adoption of healthy eating practices and increased physical activity. Provides technical assistance, managing and supporting evidence-based programs, disseminating materials and resources, and skills-building within the Agency, in schools, at worksites, among partners and with the general public.		501-661-2099	X	
Arkansas Coalition for Obesity Prevention (ArCOP)	A coalition whose goal is to increase the percentage of Arkansans of all ages who have access to healthy and affordable food and who engage in regular physical activity. Coalition is structured around six working teams: Access to Healthy Foods; Built Environment; Early Childhood and Schools; Healthcare; Worksite Wellness; and Social Marketing	http://www.arkansasobesity.org/		X	

Program Name	Description	Website	Phone Number	State	County
Southern Ain't Fried Sundays - Arkansas Minority Health Commission	Faith Based Outreach Program SAFS is designed to educate African American churches and organizations about healthier alternatives to preparing and cooking southern-style foods. It is also a mechanism for partnering with these groups in an effort to educate their members about the signs and symptoms of stroke, diabetes, and heart attacks. The program is being revamped to expand its reach to the Hispanic communities and individual participants.	http://www.arminorityhealth.com/programs_saf.html	877-264-2826	X	
ARCare – SilverSneakers Program	SilverSneakers offers an innovative blend of physical activity, healthy lifestyle, and socially oriented programming that allows older adults to take greater control of their health.	http://www.arcare.net/OurServices/OurServicesContinuedpart3/tabid/14186/Default.aspx#wellness	870-347-1137		X (Monroe, Prairie)
The Monroe County Hometown Health Community Garden	Provides a community garden to the citizens of Monroe County to grow fruits and vegetables				X Brinkley (Monroe County)
Greater Delta Alliance for Health Mobile Health Screening Unit	GDAH has a fully equipped mobile unit that is utilized to offer free health screenings including breast exams, blood pressure, blood sugar, weight and BMI, HIV screening as well as specialized screenings through community health partners.	http://gdaharkansas.org/services			X (Arkansas County)
Area Health Education Centers (AHEC)	Health Education: Provides health education to adults on a variety of topics including diabetes, heart health, nutrition and healthy eating. Health Screening: Provides health screenings for area organizations and industry in conjunction with health fairs. Also provides information on how to deal with high blood pressure, cholesterol and glucose. Patients with abnormal readings are referred to health care providers How Healthy is Your Church? -- Provides free health screenings, information and counseling to area churches.		870-572-2727		X Located in Pine Bluff (Jefferson County) Serving Arkansas and Prairie Counties Located in Helena (Phillips County) Serving Monroe County

Health Behaviors: Sexually Transmitted Infections (Arkansas, Monroe)

Program Name	Description	Website	Phone Number	State	County
Arkansas County Health Unit – STD Testing	Arkansas County Dewitt Health 1616 South Madison De Witt 870-946-2934 Arkansas County Stuttgart 1602 N Buerkle Road Stuttgart 870-673-6601		870-946-2934 870-673-6601		X (Arkansas County)
Monroe County Health Unit – STD testing	306 W Kings Drive Brinkley, AR		870-734-1461		X (Monroe County)

Health Behaviors: Teen Birth Rate (Monroe)

Program Name	Description	Website	Phone Number	State	County
Area Health Education Centers (AHEC)	Teen Pregnancy Prevention Program: Provides prevention education in area schools. The curriculum focuses on refusal skills and making safe choices.		870-572-2727		X Located in Pine Bluff (Jefferson County) Serving Arkansas and Prairie Counties Located in Helena (Phillips County) Serving Monroe County
Arkansas Department of Health	Family Planning Services are provided to teens, women, men and couples, making it possible for them to choose the number and spacing of their children and to prevent unwanted pregnancies	http://www.healthy.arkansas.gov/programsServices/familyHealth/HealthConnections/Pages/ConnectCare.aspx			

Prevention: Colorectal Screening (Arkansas, Monroe, Prairie)

Program Name	Description	Website	Phone Number	State	County
The Colorectal Cancer Screening Program (CCSP)	The Colorectal Cancer Screening Program (CCSP) is committed to prevention, early detection and treatment of colorectal cancer. The program is designed to provide equitable access to colorectal cancer screenings throughout the state. CCSP targets its services to minorities and people from disadvantaged socioeconomic backgrounds or underserved communities. Participants in need of follow-up are referred to the appropriate services.	http://cancer.uams.edu/?id=11145&sid=2	877-749-4085 or 501-526-7045	X	

Prevention: Mammography (Arkansas, Monroe, Prairie)

Program Name	Description	Website	Phone Number	State	County
ARCare	The ARcare Comprehensive Breast Program is a service administered by ARcare to meet the needs of uninsured and underinsured women under age 59 who are in need of breast care education, screening, diagnostic, and treatment services. This program provides free clinical breast exams, breast care education, mammograms, and surgical consultation to women who have no coverage for these services	http://www.arcare.net/OurServices/OurServices Continued/tabid/13586/Default.aspx	870-347-2534		X (Monroe, Prairie)
Arkansas' BreastCare Program	BreastCare's mission is to increase the rate of early detection of breast and cervical cancer and reduce the morbidity and mortality rates among women in Arkansas by lowering barriers to screening that result from lack of information, financial means, or access to quality services.	http://www.healthy.arkansas.gov/programs services/chronicdisease /arbreastcare/pages/default.aspx		X	
Greater Delta Alliance for Health Mobile Health Screening Unit	GDAH has a fully equipped mobile unit that is utilized to offer free health screenings including breast exams, blood pressure, blood sugar, weight and BMI, HIV screening as well as specialized screenings through community health partners.	http://gdaharkansas.org/services			X (Arkansas County)
Greater Delta Alliance for Health Access Project Pink	Access Project Pink-Southeast Arkansas is a collaborative effort to provide free mammograms, ultrasounds, and free breast exams to the rural, underserved population of women in fifteen counties in Southeast Arkansas.	http://gdaharkansas.org/services			X (Arkansas County)

Prevention: Flu Shots (Arkansas, Monroe, Prairie)

Program Name	Description	Website	Phone Number	State	County
Arkansas, Monroe and Prairie County Health Units	Mass Flu Clinic: A Mass Flu Clinic is a day-long event during which the community comes together to immunize as many people as possible. Arkansas Department of Health (ADH) staff, health professionals and volunteers work as a team to provide vaccine. Some clinics offer "drive-thrus" – you don't even leave your car.	http://www.healthy.arkansas.gov/programsServices/infectiousDisease/Immunizations/SeasonalFlu/Pages/MassFluClinics.aspx	501-362-7581		X

Prevention: Diabetic Screening (Arkansas, Monroe)

Program Name	Description	Website	Phone Number	State	County
Greater Delta Alliance for Health Diabetes Initiative	This project provides support to local diabetics by providing Diabetes Self-Management Education Program, free A1C screenings as well as diabetes awareness events and screenings throughout the six county service area.	http://gdaharkansas.org/services			X (Arkansas County)

Access: Lack of PCPs (Monroe, Prairie)

Program Name	Description	Website	Phone Number	State	County
ADH Office of Rural Health and Primary Care	Promotes the development of community-based health care services and systems throughout Arkansas to ensure that well managed, quality health services are available to all citizens		501-280-4560	X	
Area Health Education Centers (AHEC)	Programs provide access to medical services for rural residents and education for healthcare students and professionals.	http://ruralhealth.uams.edu/AHEC-Programs			

Access: Uninsured (Arkansas, Monroe, Prairie)

Program Name	Description	Website	Phone Number	State	County
Arkansas Health Care Access Foundation	Serves all qualified applicants who are low-income, uninsured citizens throughout Arkansas. Arkansas Health Care Access Foundation (AHCAF) is a statewide volunteer health care program to help low-income, medically uninsured gain access to non-emergency medical care	http://ahcaf.org/			X (all counties)
Brinkley Health Center and Pharmacy (ARcare)	Offering Pharmacy, Pediatrics, Cardiology, Oral Health & Dentistry, Family Practice, Women's Health, Diabetes Self-Management, HIV/AIDS Care Program, Prescription Medication Assistance Program	http://www.arcare.net	870-734-1150		Brinkley (Monroe County)
Holly Grove Health Center	Offering Dental Care Services, Enabling Services, Primary Medical Care		870-462-3393		Holly Grove (Monroe County)
Mid-Delta Health Systems, Inc	Offering comprehensive primary healthcare services to the entire family. Services include primary medical, dental, mental health and preventive health services.		870-747-3381		Clarendon (Monroe County)

Program Name	Description	Website	Phone Number	State	County
Des Arc Health Center (ARcare)	Offering Pharmacy, Pediatrics, Cardiology, Oral Health & Dentistry, Family Practice, Women's Health, Diabetes Self-Management, HIV/AIDS Care Program, Prescription Medication Assistance Program	http://www.arcare.net	870-256-4178		Des Arc (Prairie County)
Hazen Medical Clinic (ARcare)	Offering Pharmacy, Pediatrics, Cardiology, Oral Health & Dentistry, Family Practice, Women's Health, HIV/AIDS Care Program, Prescription Medication Assistance Program	http://www.arcare.net	870-255-3696		Prairie County
Greater Delta Alliance for Health Medicine Assistance Program	The Delta Medicine Assistance Program (DMAP) is designed to assist persons who have difficulty obtaining prescription medication due to fixed incomes, lack of insurance, or other circumstances that limit their ability to fully comply with their physician's protocol to treat chronic health conditions	http://gdaharkansas.org/services			X (Arkansas County)

BHMC-Heber Springs

Other Hospital Facilities

Hospital Name	Address	City	Owner Type	Type of Service
-	-	-	-	-

Cause of Death: Heart Disease

Chronic Conditions: Coronary Heart Disease

Program Name	Description	Website	Phone Number	State	County
Arkansas Department of Health Heart Disease and Stroke Prevention			501-661-2942	x	

Program Name	Description	Website	Phone Number	State	County
Arkansas Wellness Coalition (AWC)	Includes members of the health care and employer community whose goal is to improve the health and well-being of all Arkansans through the use of nationally recognized, peer reviewed, clinical guidelines for physician, consumer, and employer education. Develop materials referring to nationally recognized standards such as those put forth by Healthy People 2010, the National Committee of Quality Assurance, and other disease-specific organizations such as the American Diabetes Association and the American Heart Association.		501-661-2942	x	
ARCare	ARcare offers specialized treatment for a variety of cardiovascular conditions including coronary artery disease, heart attack, high blood pressure, high cholesterol, angina, and all other conditions related to the heart and its blood vessel system.	http://www.arcare.net/OurServices/OurServices Continuedpart2/tabid/14185/Default.aspx#cardiology			X
Arkansas Chronic Illness Collaborative (ACIC)	The ACIC is a group of health care and public health professionals dedicated to improving the management of chronic diseases. The ACIC is a way for health care clinic teams to use the National Health Disparities Collaborative Chronic Care Model to share ideas and knowledge, learn and apply new techniques, and match medical practices with clinical guidelines based on scientific evidence about what works best (diabetes, cancer and cardiovascular diseases)	http://www.healthy.arkansas.gov/programsServices/chronicDisease/Initiatives/Pages/Acic.aspx		X	

Cause of Death: Chronic Lower Respiratory Disease

Program Name	Description	Website	Phone Number	State	County
Arkansas Wellness Coalition (AWC)	Includes members of the health care and employer community whose goal is to improve the health and well-being of all Arkansans through the use of nationally recognized, peer reviewed, clinical guidelines for physician, consumer, and employer education. Develop materials referring to nationally recognized standards such as those put forth by Healthy People 2010, the National Committee of Quality Assurance, and other disease-specific organizations such as the American Diabetes Association and the American Heart Association.		501-661-2942	x	
Arkansas Chronic Illness Collaborative (ACIC)	The ACIC is a group of health care and public health professionals dedicated to improving the management of chronic diseases. The ACIC is a way for health care clinic teams to use the National Health Disparities Collaborative Chronic Care Model to share ideas and knowledge, learn and apply new techniques, and match medical practices with clinical guidelines based on scientific evidence about what works best (diabetes, cancer and cardiovascular diseases)	http://www.healthy.arkansas.gov/programsServices/chronicDisease/Initiatives/Pages/Acic.aspx		x	

Health Outcomes: Low Birth Weight

Program Name	Description	Website	Phone Number	State	County
Arkansas Department of Health	ADH provides prenatal care to an average of 5,000 women annually at many of the Local Health Units.		1-800-462-0599	X	
Arkansas Department of Health Nurse-Family Partnership	Nurse-Family Partnership is a free, voluntary program that partners first-time moms with registered nurses. NFP is available to any first-time mom who is under her 28th week of pregnancy, and who is below 200% of the Federal poverty level.	http://www.adhhomecare.org/nurse-family-arkansas.htm		X	

Program Name	Description	Website	Phone Number	State	County
Antenatal & Neonatal Guidelines, Education, and Learning System	ANGELS links clinicians and patients across the state with the University of Arkansas for Medical Sciences, with high-risk pregnancy services, maternal–fetal medicine specialists, and prenatal genetic counselors. The program facilitates telehealth consultation between patients, their local physicians, and medical center specialists through a statewide telemedicine network.	http://www.innovations.ahrq.gov/content.aspx?id=1706		X	

Health Outcomes: Poor or Fair Health Status

Program Name	Description	Website	Phone Number	State	County
Chronic Disease Self Management Program – Be Well Live Well	Developed by the Stanford Patient Education Research Center, the evidence based program teaches participants the skills needed to live well with chronic diseases. It also shows participants how to organize their lives, make and achieve goals, eat properly, exercise and communicate effectively with physicians and others. National outcome studies reveal that CDSMP participants experience a marked decrease in the number of hospital stays and doctor visits.	http://www.agec.org/2012/10/cdsmp-branded-for-arkansas-be-well-live-well/		X	
Arkansas Department of Health – Hometown Health Improvement	Hometown Health Improvement initiatives currently exist in every county around the state. HHI coalitions do powerful and unique work to improve the health of those in their communities. Once the coalition is established, many communities are choosing to conduct health behavior surveys to gain important information specific to their communities. Many coalitions are now implementing activities to affect the health of the community. Examples of some activities include: tobacco cessation programs for adolescents, household hazardous waste round-up, parenting support groups, local industry wellness programs, health fairs, and health resource guides.				X (All counties)

Health Outcomes: Poor Physical Health Days

Program Name	Description	Website	Phone Number	State	County
Chronic Disease Self Management Program – Be Well Live Well	Developed by the Stanford Patient Education Research Center, the evidence based program teaches participants the skills needed to live well with chronic diseases. It also shows participants how to organize their lives, make and achieve goals, eat properly, exercise and communicate effectively with physicians and others. National outcome studies reveal that CDSMP participants experience a marked decrease in the number of hospital stays and doctor visits.	http://www.agec.org/2012/10/cdsmp-branded-for-arkansas-be-well-live-well/		X	
Arkansas Department of Health – Hometown Health Improvement	Hometown Health Improvement initiatives currently exist in every county around the state. HHI coalitions do powerful and unique work to improve the health of those in their communities. Once the coalition is established, many communities are choosing to conduct health behavior surveys to gain important information specific to their communities. Many coalitions are now implementing activities to affect the health of the community. Examples of some activities include: tobacco cessation programs for adolescents, household hazardous waste round-up, parenting support groups, local industry wellness programs, health fairs, and health resource guides.				X (All counties)

Chronic Conditions: Arthritis

Program Name	Description	Website	Phone Number	State	County
City of Heber Springs	Arthritis Foundation Exercise Classes - Recreational exercise program that is designed to address specific therapeutic problems, reduce pain and stiffness, restore or maintain muscle strength & range of motion, improve balance & coordination, decrease fatigue and increase endurance and improve an overall quality of life. Each class is held in the warm water Therapy Pool and is conducted by an Arthritis Foundation certified	http://www.hebersprings parksandrec.com/aquatics/exercisetraining.html	501-661-2942		X (Heber Springs)
Arkansas Arthritis Foundation	Various educational programs	http://www.arthritis.org/arkansas/		X	

Chronic Conditions: High Cholesterol

Program Name	Description	Website	Phone Number	State	County
Southern Ain't Fried Sundays - Arkansas Minority Health Commission	Faith Based Outreach Program SAFS is designed to educate African American churches and organizations about healthier alternatives to preparing and cooking southern-style foods. It is also a mechanism for partnering with these groups in an effort to educate their members about the signs and symptoms of stroke, diabetes, and heart attacks. The program is being revamped to expand its reach to the Hispanic communities and individual participants.	http://www.arminorityhealth.com/programs_saf.html	877-264-2826		

Chronic Conditions: Diabetes

Program Name	Description	Website	Phone Number	State	County
American Diabetes Association	Educational Resources; Advocacy		(501) 221-7444		X (all counties)
Arkansas Health Care Access Foundation	Locates doctors to donate office visits; prescription assistance; free to those who qualify	http://ahcaf.org/			X (all counties)
Arkansas Wellness Coalition	Includes members of the health care and employer community whose goal is to improve the health and well-being of all Arkansans through the use of nationally recognized, peer reviewed, clinical guidelines for physician, consumer, and employer education. Develop materials referring to nationally recognized standards such as those put forth by Healthy People 2010, the National Committee of Quality Assurance, and other disease-specific organizations such as the American Diabetes Association and the American Heart Association.		501-661-2942	X	

Program Name	Description	Website	Phone Number	State	County
Arkansas Chronic Illness Collaborative (ACIC)	The ACIC is a group of health care and public health professionals dedicated to improving the management of chronic diseases. The ACIC is a way for health care clinic teams to use the National Health Disparities Collaborative Chronic Care Model to share ideas and knowledge, learn and apply new techniques, and match medical practices with clinical guidelines based on scientific evidence about what works best (diabetes, cancer and cardiovascular diseases)	http://www.healthy.arkansas.gov/programsServices/chronicDisease/Initiatives/Pages/Acic.aspx		X	
ARCare	The ARcare Diabetes Self-Management Program is an AADE recognized education program. Our Diabetes Self-Management Program offers individualized assessments and nutrition planning with a registered dietitian.	http://www.arcare.net/OurServices/OurServicesContinued/tabid/13586/Default.aspx	870-347-2534		X (Cleburne County)

Health Behaviors: Smoking

Program Name	Description	Website	Phone Number	State	County
Stamp Out Smoking	Arkansas Tobacco Quitline: A 24-hour direct line to professionally trained Quit Coaches® waiting to help you fight the good fight, plus a 24-hour online community of support from others who've gone through exactly what you're facing … and you can even get a supply of the latest nicotine replacement therapy medications at no cost.	http://www.stampoutsmoking.com/get-help-to-quit/	1-800-QUIT NOW	X	
Arkansas Department of Health Tobacco Prevention and Cessation Program – STOP Program	The Systems Training Outreach Program (STOP) currently uses Outreach to provide education and support to providers. Increasing the capacity and efficiency of care systems by asking, documenting tobacco use and advising patients to stop, the Outreach Specialists educate healthcare providers to be aware of available and accessible cessation treatment interventions. In particular, the specialists will help providers systematically identify patients who are tobacco users, provide guidance to quit and connect them to available resources to successfully quit.	http://www.healthy.arkansas.gov/programsServices/chronicDisease/coalition/Pages/tobacco.aspx		X	

Health Behaviors: Physical Inactivity

Program Name	Description	Website	Phone Number	State	County
ARCare – SilverSneakers Program	SilverSneakers offers an innovative blend of physical activity, healthy lifestyle, and socially oriented programming that allows older adults to take greater control of their health.	http://www.arcare.net/OurServices/OurServicesContinuedpart3/tabid/14186/Default.aspx#wellness	870-347-1137		X

Health Behaviors: Excessive Drinking

Program Name	Description	Website	Phone Number	State	County
Health Resources of Arkansas	The Region 3 Prevention Resource Center (PRC), housed at Health Resources is one of 13 centers operated throughout the state. The PRC is a link into the community to promote healthy behaviors and lifestyle changes to prevent the use and abuse of substances.	http://www.healthresourcesofarkansas.com/prevention.php			X

Prevention: Colorectal Screening

Program Name	Description	Website	Phone Number	State	County
The Colorectal Cancer Screening Program (CCSP)	The Colorectal Cancer Screening Program (CCSP) is committed to prevention, early detection and treatment of colorectal cancer. The program is designed to provide equitable access to colorectal cancer screenings throughout the state. CCSP targets its services to minorities and people from disadvantaged socioeconomic backgrounds or underserved communities. Participants in need of follow-up are referred to the appropriate services.	http://cancer.uams.edu/?id=11145&sid=2	877-749-4085 or 501-526-7045	X	

Prevention: Mammography

Program Name	Description	Website	Phone Number	State	County
ARCare	The ARcare Comprehensive Breast Program is a service administered by ARcare to meet the needs of uninsured and underinsured women under age 59 who are in need of breast care education, screening, diagnostic, and treatment services. This program provides free clinical breast exams, breast care education, mammograms, and surgical consultation to women who have no coverage for these services. The target population of the program includes low-income women who are uninsured or underinsured and are living in or can travel to the ARcare service area and meet income and insurance coverage guidelines.	http://www.arcare.net/OurServices/OurServices Continued/tabid/13586/Default.aspx	870-347-2534		x (Cleburne County)
Arkansas' BreastCare Program	BreastCare's mission is to increase the rate of early detection of breast and cervical cancer and reduce the morbidity and mortality rates among women in Arkansas by lowering barriers to screening that result from lack of information, financial means, or access to quality services.	http://www.healthy.arkansas.gov/programs services/chronicdisease/arbreastcare/pages/default.aspx		X	

Prevention: Prostate Screening

Program Name	Description	Website	Phone Number	State	County
Arkansas Prostate Cancer Foundation	Free screenings and education sessions provided throughout Arkansas Mobile Van: Mobile screening unit has a private exam room for men to have a digital rectal exam (DRE) draw blood and preserve it until taken to the lab for analysis. This service is provided free to men who do not have a diagnosis of prostate cancer and are between ages 40 and 75. African-American men and men with a family history of the disease are eligible to begin screening at age 35.	http://www.arprostatecancer.org/home/programs/	501-748-1249	X	

Prevention: Flu Shots

Program Name	Description	Website	Phone Number	State	County
Cleburne County Health Unit	Mass Flu Clinic: A Mass Flu Clinic is a day-long event during which the community comes together to immunize as many people as possible. Arkansas Department of Health (ADH) staff, health professionals and volunteers work as a team to provide vaccine. Some clinics offer "drive-thrus" – you don't even leave your car.	http://www.healthy.arkansas.gov/programsServices/infectiousDisease/Immunizations/SeasonalFlu/Pages/MassFluClinics.aspx	501-362-7581		X

Access: Lack of PCPs

Program Name	Description	Website	Phone Number	State	County
ADH Office of Rural Health and Primary Care	Promotes the development of community-based health care services and systems throughout Arkansas to ensure that well managed, quality health services are available to all citizens		501-280-4560	X	
Area Health Education Centers (AHEC)	Programs provide access to medical services for rural residents and education for healthcare students and professionals.	http://ruralhealth.uams.edu/AHEC-Programs		X	X Located in Batesville (Independence County) Serving Cleburne County

Access: No Personal Doctor

Program Name	Description	Website	Phone Number	State	County
Arkansas Department of Health Office of Rural Health and Primary Care	Promotes the development of community-based health care services and systems throughout Arkansas to ensure that well managed, quality health services are available to all citizens		501-280-4560	X	
ARCare – Heber Springs Family Care Clinic	ARcare offers family practice care to people with insurance, those without insurance, and those who are underinsured	http://www.arcare.net/OurServices/OurServices Continued/tabid/13586/Default.aspx	(501) 362-9426		X (Heber Springs)
Heber Springs Family Health Center	This is a health care center funded by the federal government. This health center can cover services such as checkups, treatment, pregnancy, immunizations and child care prescription medicine and mental and substance abuse where applicable		501-362-9426		X (Heber Springs)

Christian Health Center	The Christian Health Center of Heber Springs, Arkansas provides basic primary care services for the uninsured adults living in and around Cleburne County.	http://www.chcheberspring s.org/			X (Heber Springs)

BHMC-Arkadelphia

Other Hospital Facilities

Hospital Name	Address	City	Owner Type	Type of Service
-	-	-	-	-

Cause of Death: Stroke

Program Name	Description	Website	Phone Number	State	County
Arkansas Department of Health Heart Disease and Stroke Prevention			501-661-2942	x	
Arkansas Wellness Coalition (AWC)	Includes members of the health care and employer community whose goal is to improve the health and well-being of all Arkansans through the use of nationally recognized, peer reviewed, clinical guidelines for physician, consumer, and employer education. Develop materials referring to nationally recognized standards such as those put forth by Healthy People 2010, the National Committee of Quality Assurance, and other disease-specific organizations such as the American Diabetes Association and the American Heart Association.		501-661-2942	x	
UAMS Center for Distance Health AR SAVES Program (Stroke Assistance through Virtual Emergency Support)	A stroke management system specifically targeting patients at rural hospitals to by increasing access to subspecialty expertise through telemedicine technology, thereby engineering a coordinated assessment and care-based plan for Arkansas' stroke patients. Ensuring timely administration of clot-busting drugs to improve the chances of recovery while reducing permanent, stroke-related disability and, quite possibly, mortality.		501-686-8514	X	

Program Name	Description	Website	Phone Number	State	County
Arkansas Chronic Illness Collaborative (ACIC)	The ACIC is a group of health care and public health professionals dedicated to improving the management of chronic diseases. The ACIC is a way for health care clinic teams to use the National Health Disparities Collaborative Chronic Care Model to share ideas and knowledge, learn and apply new techniques, and match medical practices with clinical guidelines based on scientific evidence about what works best (diabetes, cancer and cardiovascular diseases)	http://www.healthy.arkansas.gov/programsServices/chronicDisease/Initiatives/Pages/Acic.aspx		X	

Cause of Death: Diabetes

Chronic Conditions: Diabetes

Program Name	Description	Website	Phone Number	State	County
American Diabetes Association	Educational Resources; Advocacy		(501) 221-7444		X (all counties)
Arkansas Health Care Access Foundation	Locates doctors to donate office visits; prescription assistance; free to those who qualify	http://ahcaf.org/			X (all counties)
AllCare Pharmacy	Diabetes Education and Support Group.		(870) 246-3044		Arkadelphia
Clark County Charitable Health Service	Basic physician visits with lab; Assist with writing patient grants; Patient education following ADA guidelines. Available to uninsured and 185% of poverty line.		(870) 230-1309		X (Clark County)
Amity Community Health Center	Assistance with Medical Services; Diabetes Education. Sliding Scale available		(870) 342-5606		Amity
Arkansas Wellness Coalition	Includes members of the health care and employer community whose goal is to improve the health and well-being of all Arkansans through the use of nationally recognized, peer reviewed, clinical guidelines for physician, consumer, and employer education. Develop materials referring to nationally recognized standards such as those put forth by Healthy People 2010, the National Committee of Quality Assurance, and other disease-specific organizations such as the American Diabetes Association and the American Heart Association.		501-661-2942	X	

Program Name	Description	Website	Phone Number	State	County
Arkansas Chronic Illness Collaborative (ACIC)	The ACIC is a group of health care and public health professionals dedicated to improving the management of chronic diseases. The ACIC is a way for health care clinic teams to use the National Health Disparities Collaborative Chronic Care Model to share ideas and knowledge, learn and apply new techniques, and match medical practices with clinical guidelines based on scientific evidence about what works best (diabetes, cancer and cardiovascular diseases)	http://www.healthy.arkansas.gov/programsServices/chronicDisease/Initiatives/Pages/Acic.aspx		X	

Health Outcomes: Poor Physical Health Days

Program Name	Description	Website	Phone Number	State	County
Arkansas Department of Health – Hometown Health Improvement	HHI initiatives currently exist in every county around the state. HHI coalitions do powerful and unique work to improve the health of those in their communities. Once the coalition is established, many communities are choosing to conduct health behavior surveys to gain important information specific to their communities. Many coalitions are now implementing activities to affect the health of the community. Examples of some activities include: tobacco cessation programs for adolescents, household hazardous waste round-up, parenting support groups, local industry wellness programs, health fairs, and health resource guides.				X (All counties)
Chronic Disease Self Management Program – Be Well Live Well	Developed by the Stanford Patient Education Research Center, the evidence based program teaches participants the skills needed to live well with chronic diseases. It also shows participants how to organize their lives, make and achieve goals, eat properly, exercise and communicate effectively with physicians and others. National outcome studies reveal that CDSMP participants experience a marked decrease in the number of hospital stays and doctor visits.	http://www.agec.org/2012/10/cdsmp-branded-for-arkansas-be-well-live-well/		X	

Chronic Conditions: Hypertension

Program Name	Description	Website	Phone Number	State	County
Arkansas Wellness Coalition	Includes members of the health care and employer community whose goal is to improve the health and well-being of all Arkansans through the use of nationally recognized, peer reviewed, clinical guidelines for physician, consumer, and employer education. Develop materials referring to nationally recognized standards such as those put forth by Healthy People 2010, the National Committee of Quality Assurance, and other disease-specific organizations such as the American Diabetes Association and the American Heart Association.		501-661-2942	X	

Chronic Conditions: Arthritis

Program Name	Description	Website	Phone Number	State	County
Arkansas Arthritis Foundation	Various educational programs	http://www.arthritis.org/arkansas/		X	

Health Behaviors: Obesity

Socioeconomic & Environment: Percentage of Fast Food Restaurants

Program Name	Description	Website	Phone Number	State	County
Arkansas Department of Health Lifestage Health Branch	Mission is the prevention and reduction of obesity through the adoption of healthy eating practices and increased physical activity. Provides technical assistance, managing and supporting evidence-based programs, disseminating materials and resources, and skills-building within the Agency, in schools, at worksites, among partners and with the general public.		501-661-2099	X	

Program Name	Description	Website	Phone Number	State	County
Arkansas Coalition for Obesity Prevention (ArCOP)	• A coalition whose goal is to increase the percentage of Arkansans of all ages who have access to healthy and affordable food and who engage in regular physical activity. Coalition is structured around six working teams: Access to Healthy Foods; Built Environment; Early Childhood and Schools; Healthcare; Worksite Wellness; and Social Marketing	http://www.arkansasobesity.org/		X	
Southern Ain't Fried Sundays - Arkansas Minority Health Commission	Faith Based Outreach Program SAFS is designed to educate African American churches and organizations about healthier alternatives to preparing and cooking southern-style foods. It is also a mechanism for partnering with these groups in an effort to educate their members about the signs and symptoms of stroke, diabetes, and heart attacks. The program is being revamped to expand its reach to the Hispanic communities and individual participants.	http://www.arminorityhealth.com/programs_saf.html	877-264-2826	X	
Arkansas Department of Health - WIC FMNP	The purposes of the WIC FMNP are to provide fresh, nutritious, unprepared fruits and vegetables from farmers' market to women and children who are nutritionally at risk and to expand the awareness and use of farmers' markets, as well as increase sales at such markets. During the farming season, WIC FMNP provides clients in the WIC Program with checks to purchase locally grown fresh fruits and vegetables sold by authorized farmers at authorized farmers' markets.	http://www.healthy.arkansas.gov/programsServices/WIC/Pages/FMNP.aspx		X	

Program Name	Description	Website	Phone Number	State	County
Arkansas Department of Health Healthy Restaurant Award	The Healthy Arkansas Restaurant Award is a voluntary program that provides public recognition to restaurants that meet certain health criteria. Restaurants self-apply and self-report through a questionnaire-type application. Criteria considered include smoke-free status of facility, labeling of food items, and number and types of healthy nutrition choices that are offered. Applications must be completed by a designee of the restaurant. Menus, inserts or photo of menu board with nutrient information must be submitted with the application to confirm the information.	http://www.healthy.arkansas.gov/programsServices/chronicDisease/Nutrition/Pages/Programs.aspx		X	

Health Behaviors: Sexually Transmitted Infections

Program Name	Description	Website	Phone Number	State	County
Clark County Health Unit	HIV/ Sexually Transmitted Diseases Counseling, testing and treatment		870-246-4471		X (Clark County)

Prevention: Colorectal Screening

Program Name	Description	Website	Phone Number	State	County
The Colorectal Cancer Screening Program (CCSP)	The Colorectal Cancer Screening Program (CCSP) is committed to prevention, early detection and treatment of colorectal cancer. The program is designed to provide equitable access to colorectal cancer screenings throughout the state. CCSP targets its services to minorities and people from disadvantaged socioeconomic backgrounds or underserved communities. Participants in need of follow-up are referred to the appropriate services.	http://cancer.uams.edu/?id=11145&sid=2	877-749-4085 or 501-526-7045	X	

Prevention: Mammography

Program Name	Description	Website	Phone Number	State	County
BreastCare - Clark County Health Unit	BreastCare offers FREE screening and diagnostic services for Arkansas women along with public and professional education. Free services for those that qualify: Mammograms, Clinical Breast Exams, Pelvic Exams and Pap Tests, Follow-up Tests, if Needed.		870-246-4471		X (Clark County)

Program Name	Description	Website	Phone Number	State	County
Arkansas' BreastCare Program	BreastCare's mission is to increase the rate of early detection of breast and cervical cancer and reduce the morbidity and mortality rates among women in Arkansas by lowering barriers to screening that result from lack of information, financial means, or access to quality services.	http://www.healthy.arkansas.gov/programsservices/chronicdisease/arbreastcare/pages/default.aspx		X	

Access: Lack of PCPs

Program Name	Description	Website	Phone Number	State	County
ADH Office of Rural Health and Primary Care	Promotes the development of community-based health care services and systems throughout Arkansas to ensure that well managed, quality health services are available to all citizens		501-280-4560	X	

Access: Uninsured

Program Name	Description	Website	Phone Number	State	County
Arkansas Health Care Access Foundation	Serves all qualified applicants who are low-income, uninsured citizens throughout Arkansas. Arkansas Health Care Access Foundation (AHCAF) is a statewide volunteer health care program which was developed to help low-income, medically uninsured Arkansans gain access to non-emergency medical care	http://ahcaf.org/			X (all counties)
The Clark County Charitable Health Service (CCCHS)	The Clark County Charitable Health Service provides basic health care for Clark County residents without any form of insurance, including Medicare and Medicaid. Patients must be approved for eligibility. They must meet income requirements based on the national poverty level. All services provided through the clinic are performed in the private offices of local volunteer health care providers, and the services are provided in Clark County five days a week.		(870) 230-1309		X (Clark County)

Socioeconomic & Environment: Single-Parent Households

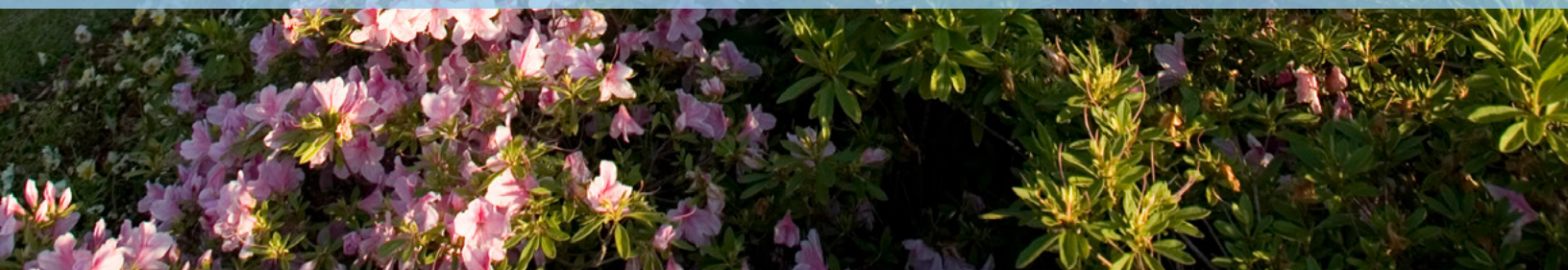
Program Name	Description	Website	Phone Number	State	County
Clark County WIC					X (Clark County)



Community Needs Assessment

Baptist Health Extended Care Hospital

December 2013

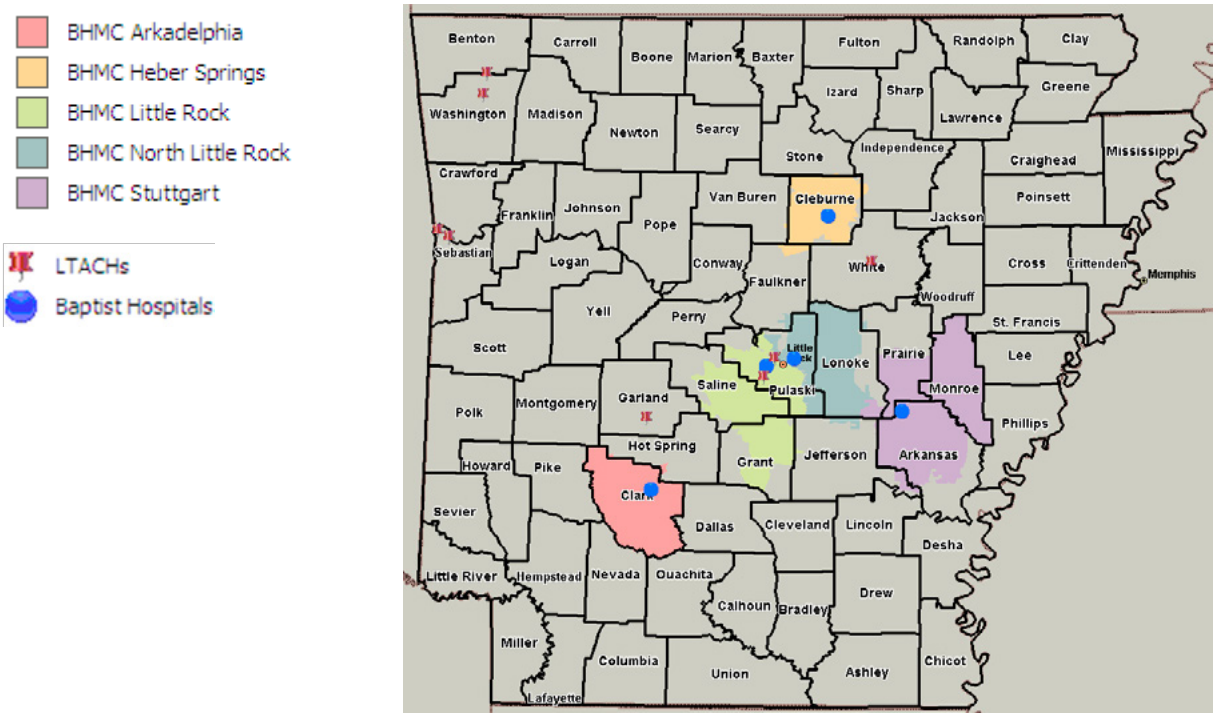


Baptist Health Extended Care Hospital

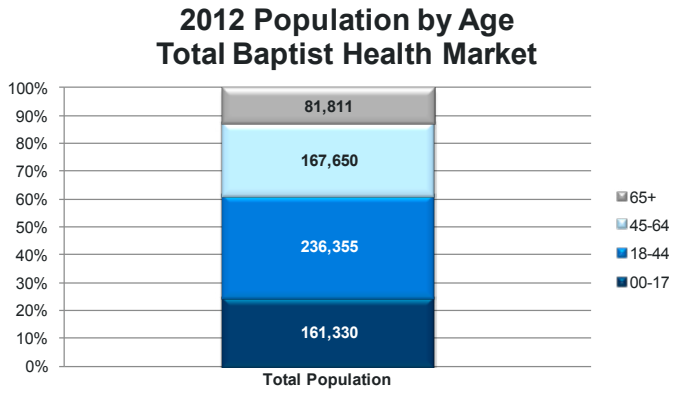
Baptist Health Extended Care Hospital (BHECH) is a state-of-the-art facility that provides long-term acute care to patients with complex medical conditions. BHECH provides the following services pulmonary care, ventilator weaning, infectious disease management, cardiac and multi-system failure, complex wound care, post-op complications, and low tolerance rehabilitation.

Community Served and Demographics

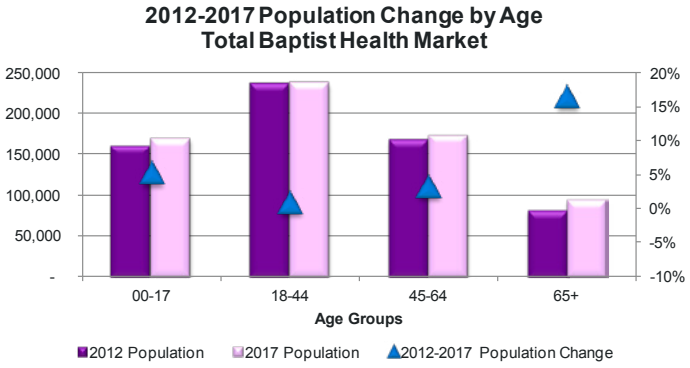
The community served for BHECH is defined as individuals in the communities served by Baptist Health acute-care hospitals who are in need of long-term acute care for complex medical conditions such as pulmonary care, ventilator weaning, infectious diseases, complex wound care, cardiac and multi-system failure, and post-operative complications. Ninety-six ZIP codes constitute the five Baptist Health acute-care hospital communities and represent the area served for BHECH. A detailed list of the ZIP codes can be found in the **Baptist Health Extended Care Hospital Appendix.** Below is a map that illustrates the geography of the BHECH community served which is comprised of each of the five shaded areas.



The BHECH community served total population is currently estimated at 647,146. By 2017, this population is projected to grow 4.7 percent with the fastest growth in the BHMC-Little Rock (5.4 percent) and BHMC–North Little Rock (5.2 percent) communities. While the largest portion of the population is made up of white non-Hispanics (429,530), in the next five years the largest percentages of growth will be in the Hispanic (+29 percent, +9,891 individuals) and Asian non-Hispanics (+20 percent, +2,018 individuals) populations. The largest growth in population will take place among black non-Hispanics (+11,794 individuals) between 2012 and 2017.



The 18-44 age group constitutes the largest portion of the BHECH community served, followed by the 45-64 age group.



By 2017, the 65 plus population will have the largest percentage of growth.

The median household income for the BHECH community served is $40,965. More than 54 percent of individuals have private insurance — either employer-sponsored insurance (48 percent) or individually purchased (6 percent). Another 15 percent are covered by Medicaid, 16 percent are uninsured and 15 percent are covered by Medicare or are Medicare dual eligible.

Interviews & Focus Groups

Interviewees and focus group participants were categorized into representative groups. In the chart below, an "I" indicates an interview and "FG" indicates participation in a focus group. For individuals outside Baptist Health, representative organizations have been listed.

Community Leaders/ Groups	Other Providers	BHECH
Thompson, M.D., Joe (AR Surgeon General/ AR Ctr for Health Improvement, I)	Presley, Blair (Arkansas Hospice, I)	Smith, Diane (BH Extended Care, I)
	Dziga, Linda (Arkansas Hospice, I)	Lee, Lorie (BH Extended Care, I)
	Mantuano, Michelle (United Home Medical, I)	Stuckey-Duvall, Amy (BH Extended Care, I)
		Shockey, Carol (BH Extended Care, I)
		Perkins, Mike (BH Extended Care, I)

The individuals highlighted in purple indicate Health Department representatives (local, regional, or state), as well as individuals representing or serving medically underserved, low-income, or minority populations.

In the interview process, the majority of individuals said the current health status of the community is either "fair" or "poor." The major issues contributing to this health status include an unhealthy population and lack of access to healthcare.

For the BHECH community, the top five health needs identified include:

1. Healthcare Provider/Services
2. Chronic Diseases
3. Care Coordination
4. Obesity
5. Food/Nutrition

Barriers to good health care in this community include socioeconomic factors, health education, and access to care. The elderly, poor, and minority populations were identified as vulnerable groups that will need special attention when addressing health needs.

The BHMC–Little Rock Focus Group served as the focus group for the BHECH community given the BHECH physical location on the BHMC–Little Rock campus. Focus group participants were asked to grade the health of the community based on an A-F scale, provide feedback in terms of that grade, and work in small groups to determine the top three health needs of the community. For the BHMC–Little Rock group, the average grade for the health of the community was a C. Much of this was attributed to the prevalence of chronic diseases/conditions, overconsumption of fast food, nicotine use/smoking, and alcohol consumption. While there have been improvements to dental care for children and trail systems for the community, there are still opportunities to raise the level of awareness of services available and create affordable access to health-care for minority populations.

The focus group split into two smaller groups to determine the top three health needs of the community. Group 1 selected access to a dental-care clinic (free or affordable), substance abuse, and obesity. Group 2 selected health education, more health-care clinics (free or affordable), and access to care to connect people to the health resources already in place.

In the same small groups, focus group participants were asked to identify community resources that could help address the health issues in the community. Some of the resources identified include:

• Churches • Mosaic • P.A.R.K and other after school programs • Boys and Girls Club • Colleges	• City/state government • Friendly Chapel • Watershed • Goodwill • Our House	• Police department • Homeless shelters • Trail systems • Library • Hospitals

The Baptist Health Extended Care Hospital Appendix includes a more comprehensive list of existing community resources available to address the health needs of the community.

Health Indicators

While the community served was defined at the ZIP code level, the most geographically detailed health indicators were only available at the county level. For that reason, health indicators for BHECH were evaluated for Grant County, Saline County, Pulaski County, Lonoke County, Arkansas County, Monroe County, Prairie County, Cleburne County, and Clark County. These counties represent the ZIP codes within the community served.

Health needs were identified for BHECH when a majority of the counties did not meet the state benchmark and the indicator is relevant to long-term acute care:

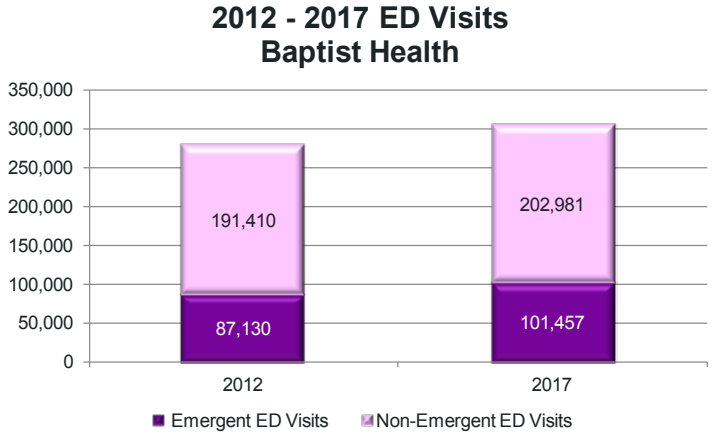
Cause of Death • Stroke • Chronic Lower Respiratory Disease **Health Outcomes** • Poor or Fair Health Status • Poor Physical Health & Mental Health Days	**Chronic Conditions** • Hypertension • Asthma • Diabetes • Coronary Heart Disease • Arthritis **Health Behaviors** • Smoking • Obesity	**Prevention** • Colorectal Screening • Mammography **Spinal Cord Injury** • Injury Hospitalizations due to motor vehicle accidents/ falls **Socioeconomic & Environment** • Access to Recreational Facilities • Percentage of Fast Food Restaurants

Truven Health Analytics supplemented the publically available data with estimates of disease prevalence for heart disease and cancer, emergency department visit estimates, and the community need index.

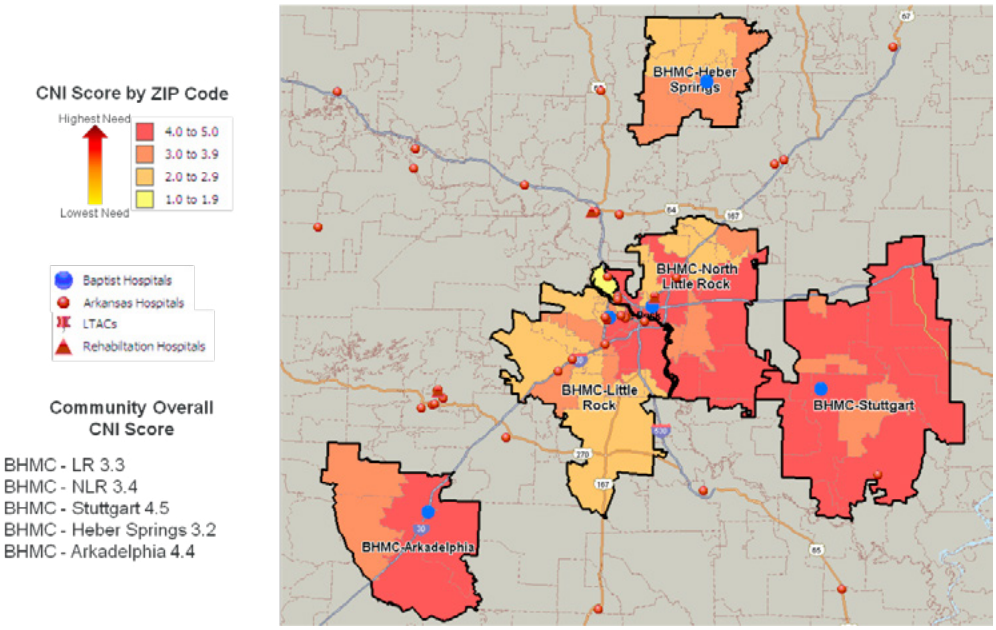
Heart disease estimates indicate a prevalence of 213,634 cases for the BHECH community served. The majority (69 percent) of the 2011 estimates of heart disease prevalence indicate hypertension as the primary diagnosis. Other diagnoses include arrhythmias (12 percent), ischemic heart disease (13 percent), and congestive heart failure (6 percent).

The 2011 cancer incidence estimates reveal at least 500 new cases of each of the following types of cancer: prostate, breast, and lung. For the community served, it is estimated that there will be 3,976 new cancer cases.

Emergency department visits are slated to grow by approximately 25,000 visits between 2012 and 2017.



The Truven Health Community Need Index (CNI) is a statistical approach to identifying health needs in a community. The CNI takes into account vital socio-economic factors (income, cultural, education, insurance, and housing) about a community to generate a CNI score for every populated ZIP code in the United States. The CNI is strongly linked to variations in community health-care needs and is a strong indicator of a community's demand for various health-care services.



For the Baptist Health communities served by BHECH, the BHMC–Stuttgart community had the highest CNI of 4.5 on a scale of 1.0 (lowest needs) to 5.0 (highest needs). This is followed closely by BHMC-Arkadelphia with a score of 4.4.

Prioritized Health Needs

From BHECH Mike Perkins , vice president and administrator, participated in the prioritization meeting.

Using the criteria selected by the larger group, the five health needs that scored the highest in the prioritization process for BHECH were:

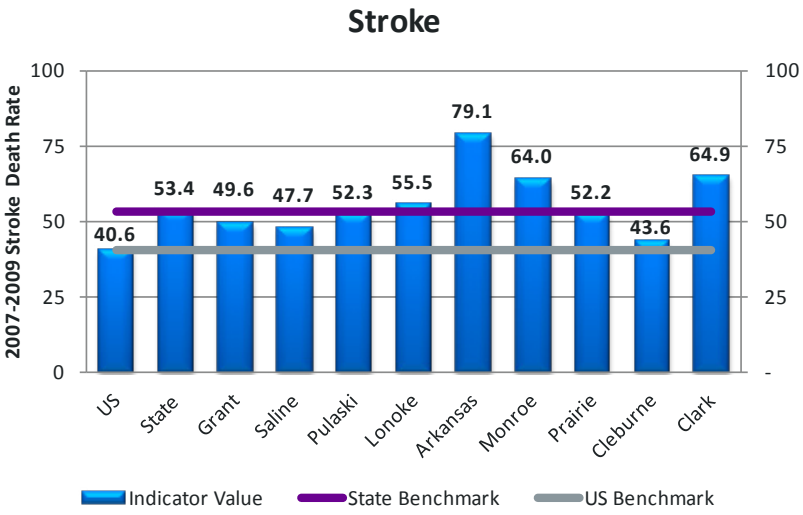
1. Stroke (cause of death)
2. Diabetes
3. Injuries due to motor vehicle accidents/falls
4. Hypertension
5. Asthma

HEALTH NEED	BHECH
Cause of Death	
• Stroke	X
• Chronic Lower Respiratory Disease	X
Health Outcomes	
• Poor or Fair Health Status	X
• Poor Physical Health & Mental Health Days	X
Chronic Conditions	
• Hypertension	X
• Asthma	X
• Diabetes	X
• Coronary Heart Disease	X
Health Behaviors	
• Smoking	X
• Obesity	X
Prevention	
• Colorectal Screening	X
Socioeconomic & Environment	
• Access to Recreational Facilities	X
• Percentage of Fast Food Restaurants	X
Spinal Cord Injury	
• Injury Hospitalizations due to Motor Vehicle Accidents/Falls	X

The table to the left indicates the health needs identified for the BHECH community. The highlighted boxes are the five health needs that scored the highest in the prioritization process.

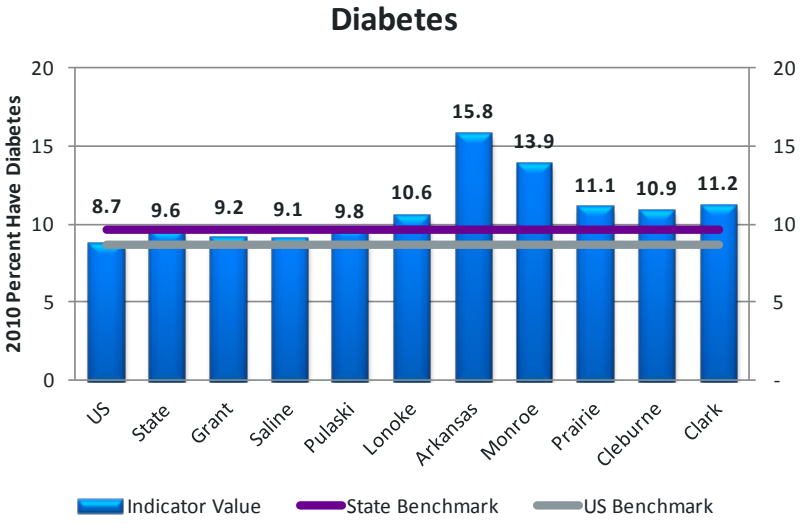
Even though the highlighted health needs had the highest scores, the needs that will actually be addressed for the purposes of the CHNA are at the discretion of BHECH.

For each of the prioritized health needs, the comparative benchmark graph has been provided to illustrate gaps between county indicators for the community served and the state benchmark (purple).



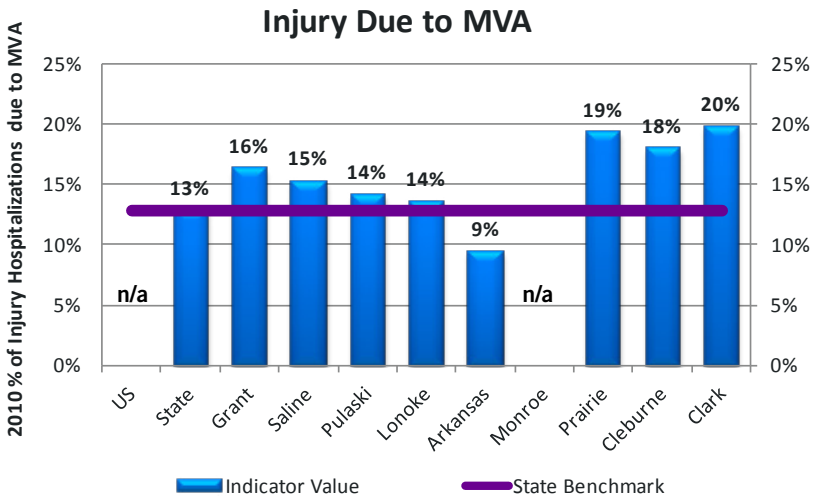
Source: National Vital Statistics System-Mortality (CDC, NCHS)

Notes: 2007-2009 Stroke death rate (per 100,000)



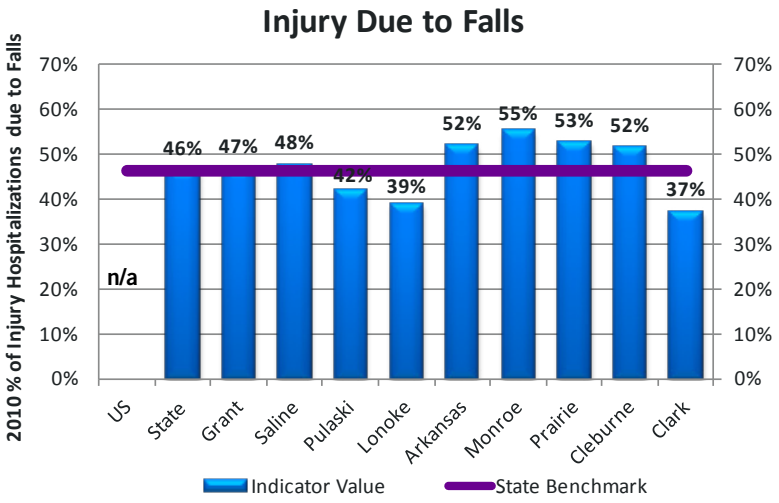
Source: Arkansas Department of Health BRFSS

Notes: Percent of adults that report having been diagnosed as having diabetes



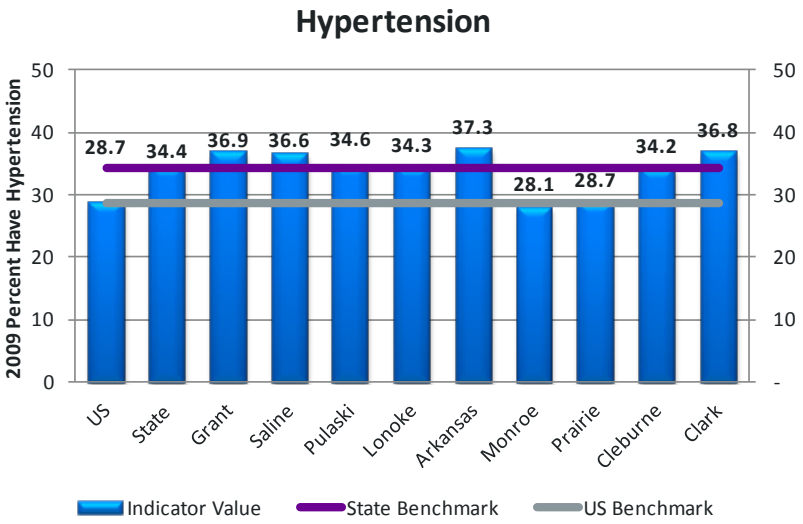
Source: ADH (AR Hospital Discharge Data System)

Notes: Percent of injury discharges with cause due to MVA (not age-adjusted)

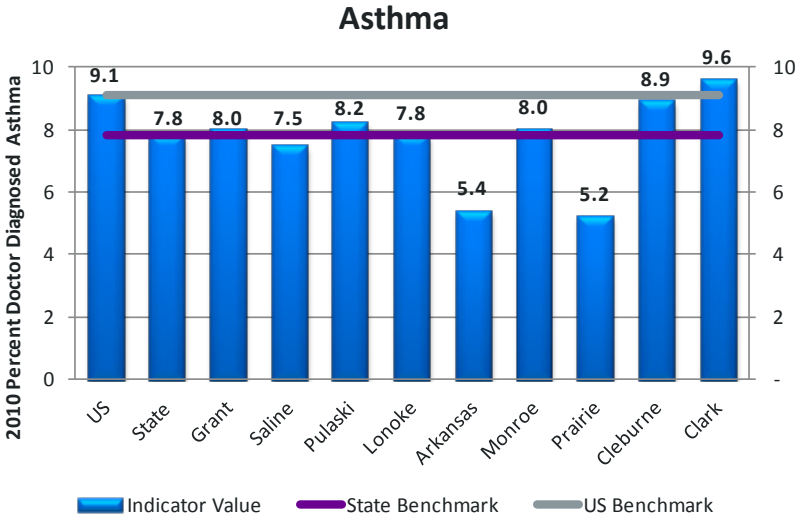


Source: ADH (AR Hospital Discharge Data System)

Notes: Percent of injury discharges with cause due to Falls (not age-adjusted)



Source: Arkansas Department of Health BRFSS Notes: Percent of adults that report having been diagnosed with high blood pressure



Source: Arkansas Department of Health BRFSS

Notes: Percent of adults that report having been diagnosed with asthma

Summary

The community health needs assessment for the BHECH community served revealed a number of health issues related to disease management, lifestyle choices, and socioeconomic or environmental factors. By weighing the qualitative feedback and the quantitative data, along with the prioritization criteria, the top health needs identified include stroke, diabetes, injuries due to motor vehicle accidents/falls, hypertension, and asthma.

BHECH will be working with internal stakeholders to determine the community health needs to be addressed. With the goal of improving the health of the community, implementation plans with specific tactics and time frames will be developed to address these health needs.

Baptist Health Extended Care Hospital Appendix

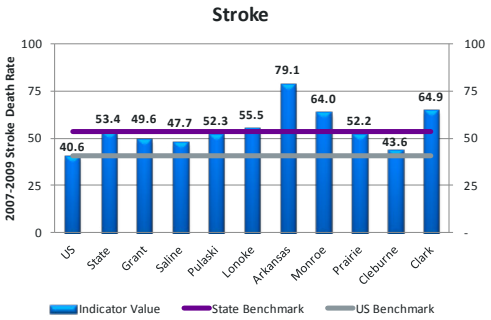
BHECH Community Served Definition ZIP Code Table

BAPTIST HEALTH COMMUNITY	ZIP	PONAME	COUNTY NAME	CBSANAME
BHMC-Little Rock	72002	Alexander	Saline, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72011	Bauxite	Saline, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72015	Benton	Saline, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72018	Benton	Saline, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72019	Benton	Saline, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72022	Bryant	Saline, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72053	Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72065	Hensley	Saline, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72089	Bryant	Saline, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72103	Mabelvale	Saline, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72113	Maumelle	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72150	Sheridan	Grant, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72158	Benton	Saline, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72164	Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72180	Hensley	Saline, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72183	Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72201	Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72202	Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72203	Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72204	Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72205	Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72206	Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72207	Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72209	Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72210	Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72211	Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72212	Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72214	Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72215	Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72216	Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72217	Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72219	Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72221	Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72222	Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72223	Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72225	Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72227	Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72260	Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Little Rock	72295	Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro

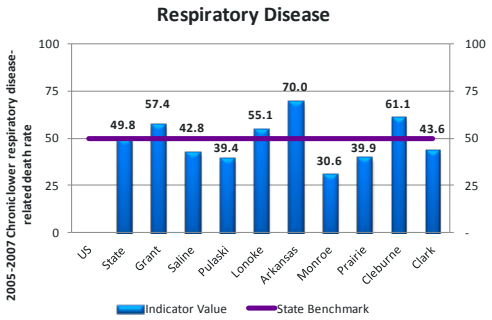
BAPTIST HEALTH COMMUNITY	ZIP	PONAME	COUNTY NAME	CBSANAME
BHMC-North Little Rock	72007	Austin	Lonoke, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-North Little Rock	72023	Cabot	Lonoke, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-North Little Rock	72037	England	Lonoke, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-North Little Rock	72046	England	Lonoke, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-North Little Rock	72076	Jacksonville	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-North Little Rock	72078	Jacksonville	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-North Little Rock	72083	Keo	Lonoke, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-North Little Rock	72086	Lonoke	Lonoke, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-North Little Rock	72099	Little Rock Air Force Bas	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-North Little Rock	72114	North Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-North Little Rock	72115	North Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-North Little Rock	72116	North Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-North Little Rock	72117	North Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-North Little Rock	72118	North Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-North Little Rock	72119	North Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-North Little Rock	72120	Sherwood	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-North Little Rock	72124	Sherwood	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-North Little Rock	72142	Scott	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-North Little Rock	72176	Ward	Lonoke, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-North Little Rock	72190	North Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-North Little Rock	72231	North Little Rock	Pulaski, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Stuttgart	72003	Almyra	Arkansas, AR	Unassigned Area in Arkansas
BHMC-Stuttgart	72021	Brinkley	Monroe, AR	Unassigned Area in Arkansas
BHMC-Stuttgart	72026	Casscoe	Arkansas, AR	Unassigned Area in Arkansas
BHMC-Stuttgart	72029	Clarendon	Monroe, AR	Unassigned Area in Arkansas
BHMC-Stuttgart	72038	Crocketts Bluff	Arkansas, AR	Unassigned Area in Arkansas
BHMC-Stuttgart	72041	De Valls Bluff	Prairie, AR	Unassigned Area in Arkansas
BHMC-Stuttgart	72042	De Witt	Arkansas, AR	Unassigned Area in Arkansas
BHMC-Stuttgart	72064	Hazen	Prairie, AR	Unassigned Area in Arkansas
BHMC-Stuttgart	72069	Holly Grove	Monroe, AR	Unassigned Area in Arkansas
BHMC-Stuttgart	72072	Humnoke	Lonoke, AR	Little Rock-North Little Rock-Conway, AR Metro
BHMC-Stuttgart	72073	Humphrey	Arkansas, AR	Unassigned Area in Arkansas
BHMC-Stuttgart	72108	Brinkley	Monroe, AR	Unassigned Area in Arkansas
BHMC-Stuttgart	72134	Roe	Monroe, AR	Unassigned Area in Arkansas
BHMC-Stuttgart	72160	Stuttgart	Arkansas, AR	Unassigned Area in Arkansas
BHMC-Stuttgart	72170	Ulm	Prairie, AR	Unassigned Area in Arkansas
BHMC-Arkadelphia	71721	Gurdon	Clark, AR	Arkadelphia, AR Micro
BHMC-Arkadelphia	71728	Gurdon	Clark, AR	Arkadelphia, AR Micro
BHMC-Arkadelphia	71743	Gurdon	Clark, AR	Arkadelphia, AR Micro
BHMC-Arkadelphia	71772	Gurdon	Clark, AR	Arkadelphia, AR Micro
BHMC-Arkadelphia	71920	Amity	Clark, AR	Arkadelphia, AR Micro
BHMC-Arkadelphia	71921	Amity	Clark, AR	Arkadelphia, AR Micro
BHMC-Arkadelphia	71923	Arkadelphia	Clark, AR	Arkadelphia, AR Micro
BHMC-Arkadelphia	71962	Okolona	Clark, AR	Arkadelphia, AR Micro
BHMC-Arkadelphia	71998	Arkadelphia	Clark, AR	Arkadelphia, AR Micro
BHMC-Arkadelphia	71999	Arkadelphia	Clark, AR	Arkadelphia, AR Micro
BHMC-Heber Springs	72044	Edgemont	Cleburne, AR	Unassigned Area in Arkansas
BHMC-Heber Springs	72067	Higden	Cleburne, AR	Unassigned Area in Arkansas
BHMC-Heber Springs	72130	Prim	Cleburne, AR	Unassigned Area in Arkansas
BHMC-Heber Springs	72131	Quitman	Cleburne, AR	Unassigned Area in Arkansas
BHMC-Heber Springs	72179	Wilburn	Cleburne, AR	Unassigned Area in Arkansas
BHMC-Heber Springs	72523	Concord	Cleburne, AR	Unassigned Area in Arkansas
BHMC-Heber Springs	72530	Drasco	Cleburne, AR	Unassigned Area in Arkansas
BHMC-Heber Springs	72543	Heber Springs	Cleburne, AR	Unassigned Area in Arkansas
BHMC-Heber Springs	72545	Heber Springs	Cleburne, AR	Unassigned Area in Arkansas
BHMC-Heber Springs	72546	Ida	Cleburne, AR	Unassigned Area in Arkansas
BHMC-Heber Springs	72581	Tumbling Shoals	Cleburne, AR	Unassigned Area in Arkansas

Health Indicator Analysis

BHECH: CAUSE OF DEATH



Source: National Vital Statistics System-Mortality (CDC, NCHS)
Notes: 2007-2009 Stroke death rate (per 100,000)

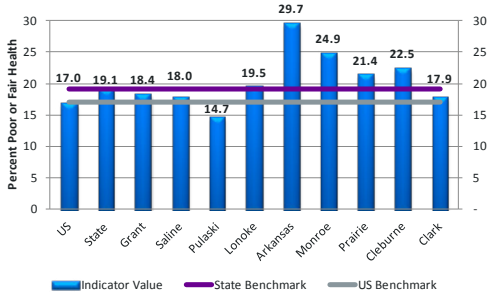


Source: Health Statistics Branch, ADH
Notes: 2005-2007 Chronic lower respiratory disease-related deaths (per 100,000)

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

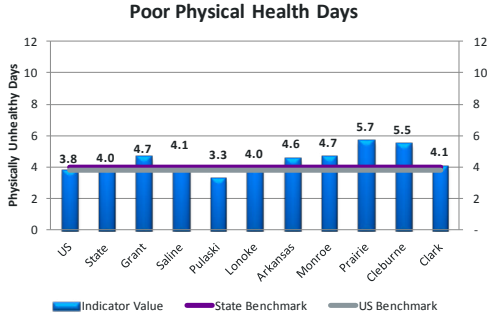
BHECH: HEALTH OUTCOMES

Poor or Fair Health



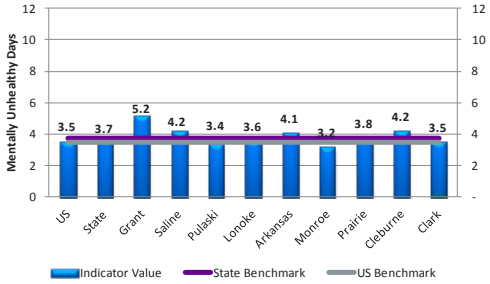
Source: County Health Rankings (BRFSS)
Notes: Percent of adults reporting fair or poor health (age-adjusted)

Poor Physical Health Days



Source: County Health Rankings (BRFSS)
Notes: Average number of physically unhealthy days reported in past 30 days (age-adjusted)

Poor Mental Health Days

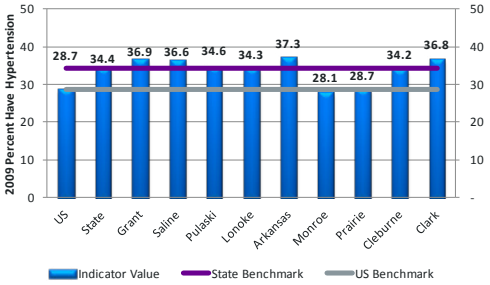


Source: County Health Rankings (BRFSS)
Notes: Average number of mentally unhealthy days reported in past 30 days (age-adjusted)

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

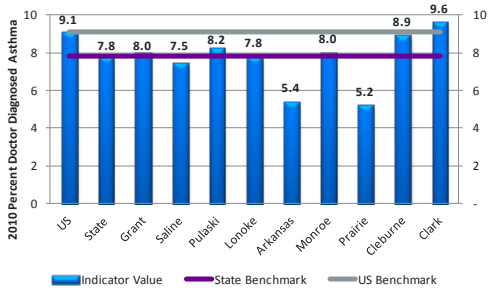
BHECH: CHRONIC CONDITIONS

Hypertension



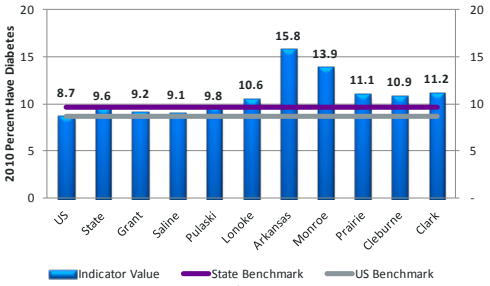
Source: Arkansas Department of Health BRFSS
Notes: Percent of adults that report having been diagnosed with high blood pressure

Asthma



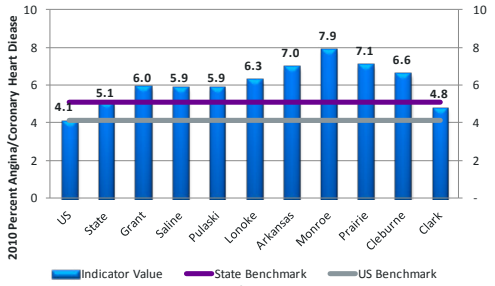
Source: Arkansas Department of Health BRFSS
Notes: Percent of adults that report having been diagnosed with asthma

Diabetes



Source: Arkansas Department of Health BRFSS
Notes: Percent of adults that report having been diagnosed as having diabetes

Coronary Heart Disease

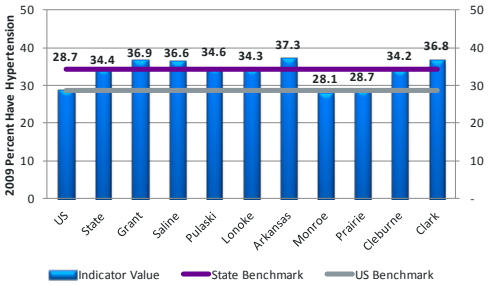


Source: Arkansas Department of Health BRFSS
Notes: Percent of adults that report having been diagnosed as having Coronary Heart Disease

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BHECH: CHRONIC CONDITIONS

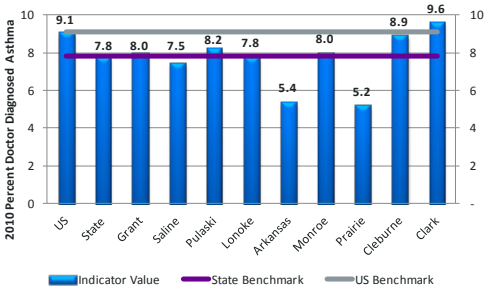
Hypertension



Source: Arkansas Department of Health BRFSS

Notes: Percent of adults that report having been diagnosed with high blood pressure

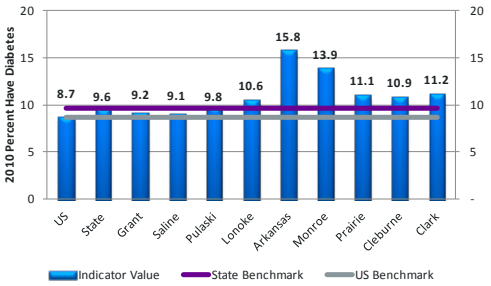
Asthma



Source: Arkansas Department of Health BRFSS

Notes: Percent of adults that report having been diagnosed with asthma

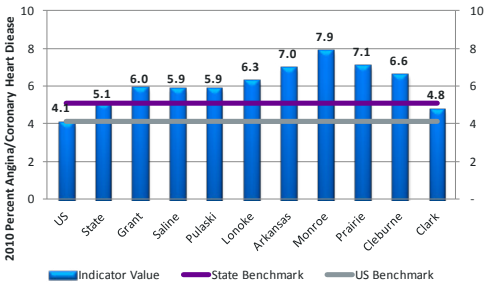
Diabetes



Source: Arkansas Department of Health BRFSS

Notes: Percent of adults that report having been diagnosed as having diabetes

Coronary Heart Disease



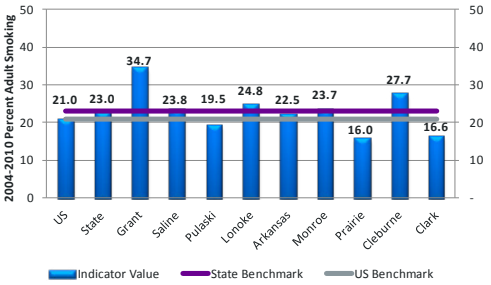
Source: Arkansas Department of Health BRFSS

Notes: Percent of adults that report having been diagnosed as having Coronary Heart Disease

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BHECH: HEALTH BEHAVIORS

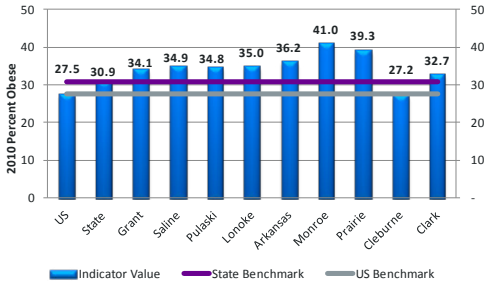
Adult Smoking



Source: County Health Rankings (BRFSS), Arkansas Department of Health BRFSS

Notes: Percent of adults 18 years+ that report currently smoking cigarettes

Adult Obesity

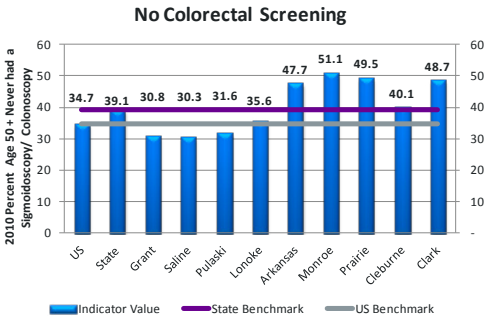


Source: Arkansas Department of Health BRFSS

Notes: Percent of adults 18 years and over that report BMI >= 30 (per self-reported weight/height)

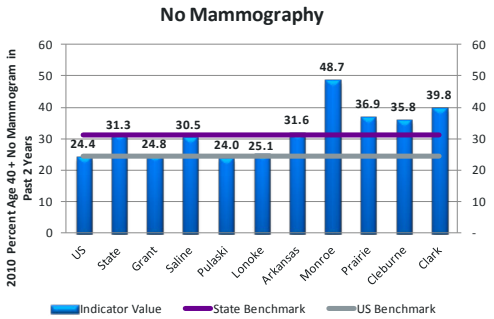
Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BHECH: PREVENTION



Source: Arkansas Department of Health BRFSS

Notes: Percent of adults age 50+ that report never having had a sigmoidoscopy or colonoscopy

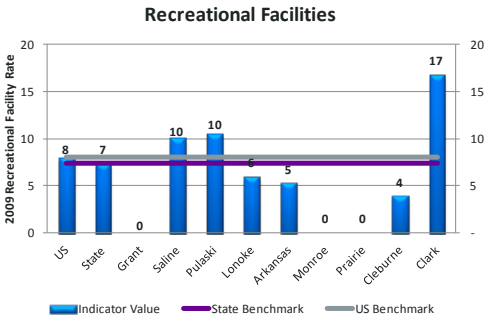


Source: Arkansas Department of Health BRFSS

Notes: Percent of women age 50+ that report no mammogram in the past 2 years

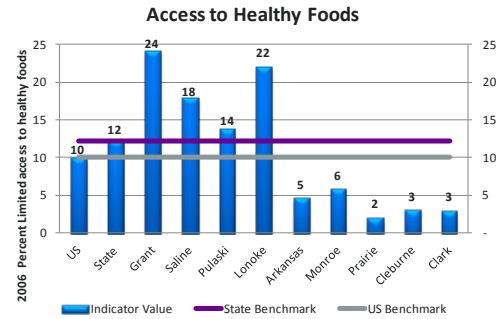
Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BHECH: ENVIRONMENT



Source: County Health Rankings (Census County Business Patterns)

Notes: Rate of recreational facilities per 100,000 population

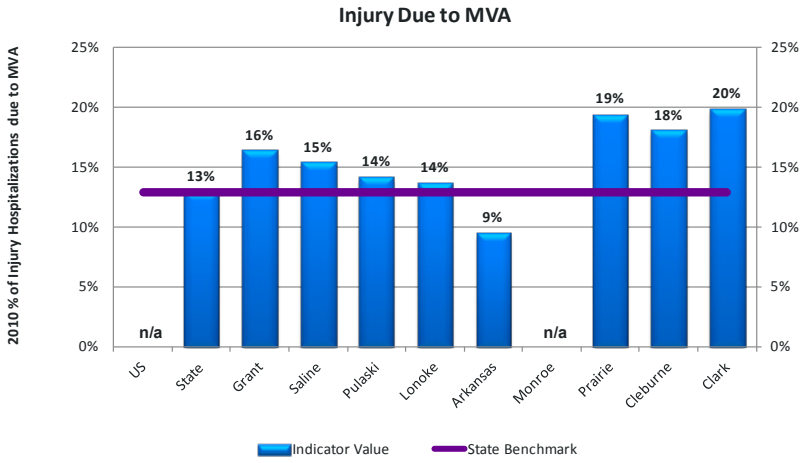


Source: CHR (USDA)

Notes: Percent of population who are low-income and do not live close to a grocery store

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

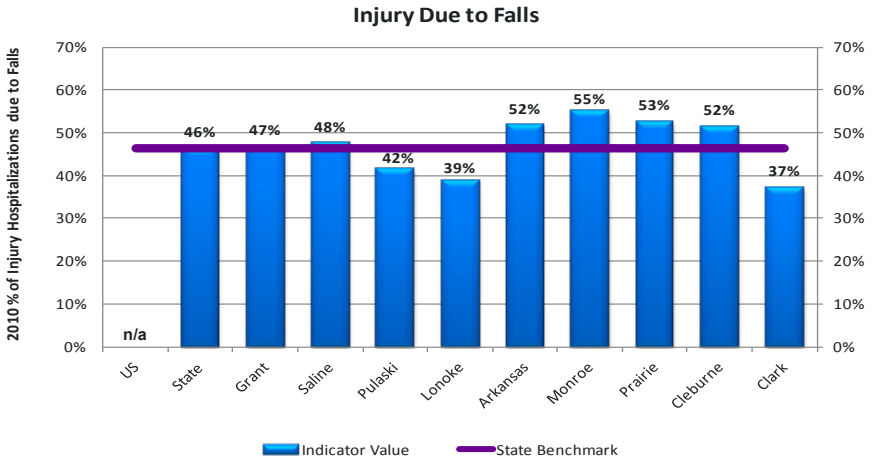
BHECH: SCI- MOTOR VEHICLE ACCIDENTS



Source: ADH (AR Hospital Discharge Data System)
Notes: Percent of injury discharges with cause due to MVA (not age-adjusted)

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BHECH: SCI- FALLS



Source: ADH (AR Hospital Discharge Data System)
Notes: Percent of injury discharges with cause due to Falls (not age-adjusted)

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

Community Need Index (CNI)

BAPTIST HEALTH
CNI BARRIER SCORE BY ZIP CODE

Baptist Health Community	Zip	2011 Population	Overall CNI Score	Income Rank	Education Rank	Culture Rank	Insurance Rank	Housing Rank
BHMC Little Rock	72204	33,910	5	4	4	5	5	5
	72206	24,819	5	4	4	5	5	5
	72202	10,992	5	5	4	5	5	5
	72201	842	5	4	4	5	5	5
	72209	31,911	4	4	3	5	5	5
	72015	28,918	4	4	3	3	3	5
	72205	23,824	3	2	1	5	4	5
	72211	21,414	3	1	1	4	2	5
	72210	13,432	3	3	2	4	3	4
	72103	12,751	3	3	3	4	3	4
	72150	12,585	3	4	3	2	2	3
	72002	12,289	3	2	3	3	2	3
	72227	11,848	3	3	1	4	3	5
	72207	11,394	3	2	1	3	2	5
	72011	3,922	3	3	3	2	2	3
	72019	22,349	2	2	1	3	2	4
	72113	21,622	2	1	1	3	1	3
	72223	18,422	2	2	1	4	1	4
	72022	12,673	2	2	2	3	2	3
	72212	12,558	2	2	1	4	1	4
	72065	4,609	2	2	3	3	2	1

The CNI score is an average of five different barrier scores that measure various socio-economic indicators of each community. The CNI is strongly linked to variations in community healthcare needs and is a strong indicator of a community's demand for various healthcare services.

Baptist Health Community	Zip	2011 Population	Overall CNI Score	Income Rank	Education Rank	Culture Rank	Insurance Rank	Housing Rank
BHMC North Little Rock	72114	13,255	5	5	5	5	5	5
	72117	12,228	5	4	5	5	5	5
	72046	4,653	5	4	5	5	4	5
	72076	40,524	4	4	3	5	4	5
	72118	21,826	4	3	3	5	4	5
	72086	10,111	4	4	4	4	4	4
	72142	2,266	4	3	5	4	3	4
	72099	1,630	4	4	3	4	4	5
	72083	222	4	5	3	4	4	4
	72120	31,253	3	2	1	4	2	4
	72116	21,356	3	1	1	4	2	5
	72176	7,459	3	3	3	2	3	4
	72023	36,790	2	3	2	2	2	3
	72007	6,787	2	2	3	2	2	2

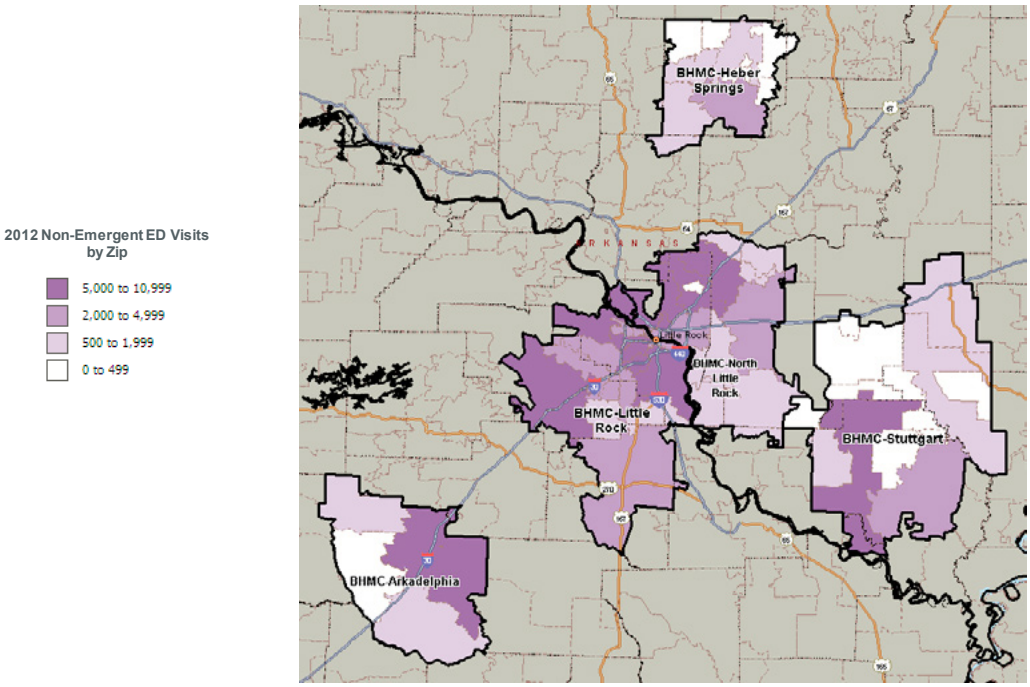
Baptist Health Community	Zip	2011 Population	Overall CNI Score	Income Rank	Education Rank	Culture Rank	Insurance Rank	Housing Rank
BHMC-Stuttgart	72021	4,158	5	5	5	5	5	5
	72069	1,148	5	5	5	5	5	5
	72042	5,275	5	5	5	4	5	5
	72029	2,233	5	5	5	4	5	5
	72073	1,189	5	5	5	5	5	4
	72134	281	5	5	5	4	4	5
	72160	10,128	4	4	4	5	4	5
	72072	396	4	4	5	4	5	4
	72041	1,559	4	4	5	4	4	4
	72064	1,929	4	4	4	3	4	4
	72003	741	3	2	4	3	3	4
	72026	365	3	4	3	4	2	3
	72170	262	3	1	5	3	3	4
	72038	58	3	4	3	4	2	3

Baptist Health Community	Zip	2011 Population	Overall CNI Score	Income Rank	Education Rank	Culture Rank	Insurance Rank	Housing Rank
BHMC Heber Springs	72543	12,503	4	4	4	2	4	4
	72523	1,086	3	5	5	1	4	1
	72131	4,112	3	3	4	2	3	3
	72179	518	3	5	4	1	4	1
	72067	2,759	3	3	4	2	4	1
	72530	1,988	3	4	4	1	3	2
	72581	1,047	3	4	4	1	3	2
	72044	795	3	4	4	1	4	1
	72130	397	3	4	5	1	3	1
	72546	118	2	1	4	1	3	2

Baptist Health Community	Zip	2011 Population	Overall CNI Score	Income Rank	Education Rank	Culture Rank	Insurance Rank	Housing Rank
BHMC-Arkadelphia	71923	16,945	5	5	4	4	5	5
	71743	4,120	4	4	5	4	5	4
	71999	17	4	5	1	5	5	5
	71921	2,985	4	4	5	3	5	2
	71962	945	3	2	5	4	5	1
	71998	259	3	1	1	3	4	5

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BAPTIST HEALTH
NON-EMERGENT ED VISITS BY ZIP



Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BAPTIST HEALTH
2012 – 2017 ED VISITS BY ZIP

Little Rock

Zip Code	2012 Total ED Visits	2012 Non-Emergent ED Visits	2012 % Non-Emergent	2017 Total ED Visits	2017 Non-Emergent ED Visits	2017 % Non-Emergent	2012 - 2017 % Chg Non-Emergent
72002	5,868	4,599	78%	6,614	5,052	76%	10%
72011	1,865	1,486	80%	2,142	1,672	78%	13%
72015	11,850	9,252	78%	13,338	10,201	76%	10%
72019	10,274	7,983	78%	11,646	8,855	76%	11%
72022	6,101	4,809	79%	7,006	5,407	77%	12%
72065	2,128	1,673	79%	2,359	1,814	77%	8%
72103	5,380	4,240	79%	5,764	4,431	77%	5%
72113	8,635	5,867	68%	10,301	6,844	66%	17%
72150	5,126	3,554	69%	5,591	3,764	67%	6%
72201	463	300	65%	543	329	61%	10%
72202	4,462	2,974	67%	4,726	2,976	63%	0%
72204	13,558	9,388	69%	14,446	9,619	67%	2%
72205	9,585	6,177	64%	9,888	6,160	62%	0%
72206	10,834	7,244	67%	11,439	7,381	65%	2%
72207	4,479	2,854	64%	4,602	2,865	62%	0%
72209	13,429	9,596	71%	14,343	9,854	69%	3%
72210	6,220	4,203	68%	7,164	4,700	66%	12%
72211	8,377	5,757	69%	9,082	6,076	67%	6%
72212	4,972	3,235	65%	5,344	3,435	64%	6%
72223	7,889	5,302	67%	9,212	6,092	66%	15%
72227	4,889	3,059	63%	5,029	3,065	61%	0%
Total	**146,384**	**103,552**	**71%**	**160,579**	**110,592**	**69%**	**7%**

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

North Little Rock

Zip Code	2012 Total ED Visits	2012 Non-Emergent ED Visits	2012 % Non-Emergent	2017 Total ED Visits	2017 Non-Emergent ED Visits	2017 % Non-Emergent	2012 - 2017 % Chg Non-Emergent
72007	3,115	1,920	62%	3,732	2,219	59%	16%
72023	13,478	8,428	63%	15,730	9,520	61%	13%
72046	1,871	1,125	60%	2,007	1,156	58%	3%
72076	15,767	10,878	69%	16,839	11,246	67%	3%
72083	108	66	61%	125	73	58%	11%
72086	4,214	2,548	60%	4,743	2,769	58%	9%
72099	289	218	75%	298	221	74%	1%
72114	5,824	4,102	70%	6,299	4,160	66%	1%
72116	8,815	5,478	62%	9,191	5,596	61%	2%
72117	5,405	3,655	68%	5,812	3,787	65%	4%
72118	9,349	6,285	67%	9,989	6,529	65%	4%
72120	12,900	8,668	67%	14,066	9,243	66%	7%
72142	1,065	701	66%	1,208	771	64%	10%
72176	3,127	1,995	64%	3,780	2,331	62%	17%
Total	**85,327**	**56,067**	**66%**	**93,819**	**59,621**	**64%**	**6%**

Stuttgart

Zip Code	2012 Total ED Visits	2012 Non-Emergent ED Visits	2012 % Non-Emergent	2017 Total ED Visits	2017 Non-Emergent ED Visits	2017 % Non-Emergent	2012 - 2017 % Chg Non-Emergent
72003	415	345	83%	416	340	82%	-1%
72021	2,160	1,490	69%	2,092	1,380	66%	-7%
72026	175	143	82%	176	142	81%	-1%
72029	1,024	690	67%	1,019	656	64%	-5%
72038	29	24	83%	29	23	79%	-4%
72041	629	396	63%	636	381	60%	-4%
72042	3,137	2,598	83%	3,193	2,589	81%	0%
72064	789	482	61%	820	483	59%	0%
72069	558	374	67%	541	340	63%	-9%
72072	231	140	61%	257	149	58%	6%
72073	618	515	83%	598	489	82%	-5%
72134	140	93	66%	144	93	65%	0%
72160	6,249	5,193	83%	6,410	5,229	82%	1%
72170	108	67	62%	111	66	59%	-1%
Total	**16,262**	**12,550**	**77%**	**16,442**	**12,360**	**75%**	**-2%**

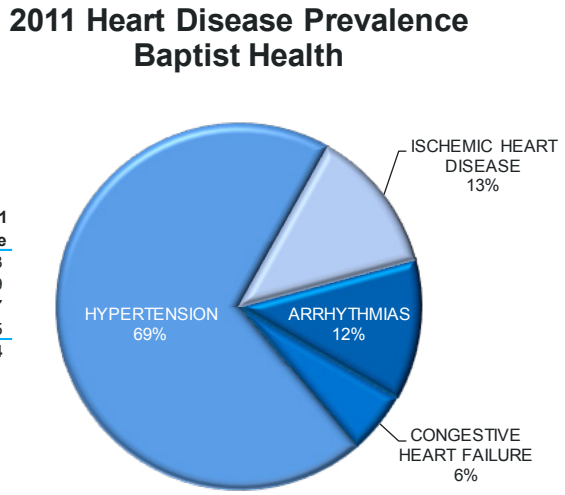
Heber Springs

Zip Code	2012 Total ED Visits	2012 Non-Emergent ED Visits	2012 % Non-Emergent	2017 Total ED Visits	2017 Non-Emergent ED Visits	2017 % Non-Emergent	2012 - 2017 % Chg Non-Emergent
72044	548	312	57%	597	329	55%	5%
72067	1,579	931	59%	1,722	982	57%	5%
72130	251	158	63%	283	173	61%	9%
72131	2,586	1,653	64%	2,855	1,781	62%	8%
72179	311	199	64%	349	212	61%	7%
72523	614	399	65%	658	411	62%	3%
72530	1,165	737	63%	1,290	792	61%	7%
72543	7,782	4,700	60%	8,611	5,019	58%	7%
72546	67	43	64%	73	44	60%	2%
72581	612	372	61%	673	394	59%	6%
Total	**15,515**	**9,504**	**61%**	**17,111**	**10,137**	**59%**	**7%**

Arkadelphia

Zip Code	2012 Total ED Visits	2012 Non-Emergent ED Visits	2012 % Non-Emergent	2017 Total ED Visits	2017 Non-Emergent ED Visits	2017 % Non-Emergent	2012 - 2017 % Chg Non-Emergent
71743	2,438	1,558	64%	2,620	1,614	62%	4%
71921	1,823	1,137	62%	2,062	1,234	60%	9%
71923	9,758	6,342	65%	10,678	6,684	63%	5%
71962	512	316	62%	561	332	59%	5%
71998	236	177	75%	259	191	74%	8%
71999	285	207	73%	307	216	70%	4%
Total	**15,052**	**9,737**	**65%**	**16,487**	**10,271**	**62%**	**5%**

BAPTIST HEALTH
2011 ESTIMATED HEART DISEASE PREVALENCE



Baptist Health

Heart Disease Type	2011 Prevalence
ARRHYTHMIAS	26,633
CONGESTIVE HEART FAILURE	11,729
HYPERTENSION	148,097
ISCHEMIC HEART DISEASE	27,175
Grand Total	**213,634**

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

Little Rock

Zip Code	ARRHYTHMIAS 2011 Prevalence	CONGESTIVE HEART FAILURE 2011 Prevalence	HYPERTENSION 2011 Prevalence	ISCHEMIC HEART DISEASE 2011 Prevalence	TOTAL HEART DISEASE 2011 Prevalence
72002	480	189	2,554	447	3,670
72011	135	52	739	121	1,047
72015	1,225	476	6,004	1,122	8,827
72019	965	381	4,869	911	7,126
72022	506	197	2,591	463	3,757
72065	177	69	943	165	1,354
72103	484	188	2,547	444	3,663
72113	817	352	5,178	812	7,159
72150	576	258	3,184	672	4,690
72201	39	17	234	40	330
72202	518	221	2,826	511	4,076
72204	1,282	535	7,688	1,207	10,712
72205	1,209	518	6,469	1,192	9,388
72206	1,119	478	6,262	1,118	8,977
72207	563	242	3,072	562	4,439
72209	1,033	420	6,418	944	8,815
72210	544	233	3,277	544	4,598
72211	771	323	4,821	729	6,644
72212	593	259	3,380	610	4,842
72223	724	314	4,485	735	6,258
72227	634	274	3,367	646	4,921
Total	**14,394**	**5,996**	**80,908**	**13,995**	**115,293**

North Little Rock

Zip Code	ARRHYTHMIAS 2011 Prevalence	CONGESTIVE HEART FAILURE 2011 Prevalence	HYPERTENSION 2011 Prevalence	ISCHEMIC HEART DISEASE 2011 Prevalence	TOTAL HEART DISEASE 2011 Prevalence
72007	221	121	1,473	282	2,097
72023	1,113	603	7,568	1,389	10,673
72046	183	101	1,079	237	1,600
72076	1,478	614	8,850	1,420	12,362
72083	9	5	52	12	78
72086	372	204	2,273	477	3,326
72099	29	8	261	16	314
72114	512	213	2,869	487	4,081
72116	1,174	510	6,175	1,202	9,061
72117	532	225	2,961	526	4,244
72118	960	408	5,384	952	7,704
72120	1,313	559	7,673	1,307	10,852
72142	104	45	602	108	859
72176	212	113	1,427	260	2,012
Total	**8,212**	**3,729**	**48,647**	**8,675**	**69,263**

Stuttgart

Zip Code	ARRHYTHMIAS 2011 Prevalence	CONGESTIVE HEART FAILURE 2011 Prevalence	HYPERTENSION 2011 Prevalence	ISCHEMIC HEART DISEASE 2011 Prevalence	TOTAL HEART DISEASE 2011 Prevalence
72003	32	17	136	39	224
72021	184	110	914	213	1,421
72026	16	9	71	20	116
72029	101	61	514	118	794
72038	3	1	11	3	18
72041	82	42	385	97	606
72042	251	137	1,007	303	1,698
72064	112	58	500	134	804
72069	57	34	276	66	433
72072	14	8	90	19	131
72073	50	27	214	60	351
72134	11	7	61	13	92
72160	451	246	1,850	536	3,083
72170	14	7	67	16	104
Total	**1,378**	**764**	**6,096**	**1,637**	**9,875**

Arkadelphia

Zip Code	ARRHYTHMIAS 2011 Prevalence	CONGESTIVE HEART FAILURE 2011 Prevalence	HYPERTENSION 2011 Prevalence	ISCHEMIC HEART DISEASE 2011 Prevalence	TOTAL HEART DISEASE 2011 Prevalence
71743	202	84	967	189	1,442
71921	157	65	728	150	1,100
71923	773	310	3,765	687	5,535
71962	51	22	241	50	364
71998	5	1	36	2	44
71999	0	0	3	0	3
Total	**1,188**	**482**	**5,740**	**1,078**	**8,488**

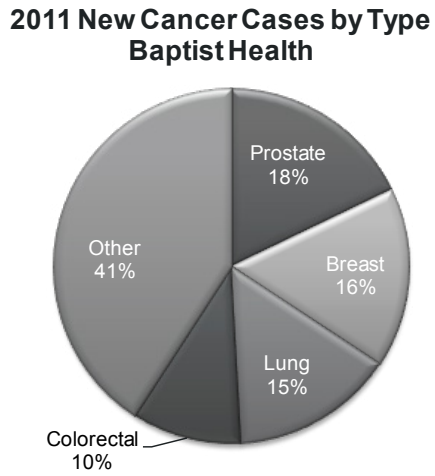
Heber Springs

Zip Code	ARRHYTHMIAS 2011 Prevalence	CONGESTIVE HEART FAILURE 2011 Prevalence	HYPERTENSION 2011 Prevalence	ISCHEMIC HEART DISEASE 2011 Prevalence	TOTAL HEART DISEASE 2011 Prevalence
72044	57	30	242	72	401
72067	176	92	792	223	1,283
72130	21	11	99	25	156
72131	210	108	997	255	1,570
72179	26	13	129	31	199
72523	51	26	254	61	392
72530	100	52	495	122	769
72543	755	392	3,385	920	5,452
72546	6	3	30	8	47
72581	59	31	283	73	446
Total	**1,461**	**758**	**6,706**	**1,790**	**10,715**

BAPTIST HEALTH
2011 ESTIMATED CANCER INCIDENCE

Baptist Health

Cancer Type	2011 Incidence (new Cancer cases)
PROSTATE	709
BREAST	655
LUNG	589
OTHER	412
COLORECTAL	398
NH LYMPHOMA	162
KIDNEY	132
MELANOMA	127
BLADDER	123
LEUKEMIA	119
PANCREAS	108
ORAL CAVITY	96
UTERINE	89
STOMACH	65
OVARIAN	63
BRAIN	55
THYROID	54
CERVICAL	19
Grand Total	**3,976**



Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

Little Rock

Zip Code	BREAST 2011 Incidence	COLORECTAL 2011 Incidence	LUNG 2011 Incidence	PROSTATE 2011 Incidence	OTHER 2011 Incidence
72002	12	7	10	13	30
72011	3	2	3	4	9
72015	29	18	25	30	73
72019	23	14	20	25	60
72022	12	7	10	13	31
72065	4	3	4	5	11
72103	12	7	10	13	30
72113	22	11	17	22	52
72150	13	9	13	15	35
72201	1	1	1	1	2
72202	12	8	12	15	28
72204	32	19	29	37	72
72205	30	17	26	28	68
72206	26	17	26	34	63
72207	14	8	12	13	33
72209	26	15	22	27	59
72210	14	8	12	15	33
72211	20	10	16	18	46
72212	15	8	13	16	36
72223	18	10	16	20	46
72227	15	9	14	15	37
Total	**354**	**208**	**309**	**378**	**855**

North Little Rock

Zip Code	BREAST 2011 Incidence	COLORECTAL 2011 Incidence	LUNG 2011 Incidence	PROSTATE 2011 Incidence	OTHER 2011 Incidence
72007	6	4	6	7	17
72023	33	19	28	33	86
72046	5	3	5	6	13
72076	36	20	30	38	88
72083	0	0	0	0	1
72086	10	6	10	11	27
72099	0	0	0	0	2
72114	12	8	11	14	28
72116	28	16	26	28	69
72117	12	8	12	15	30
72118	23	13	21	24	56
72120	32	18	28	33	80
72142	2	2	2	3	6
72176	6	3	5	6	16
Total	**208**	**121**	**186**	**221**	**517**

Stuttgart

Zip Code	BREAST 2011 Incidence	COLORECTAL 2011 Incidence	LUNG 2011 Incidence	PROSTATE 2011 Incidence	OTHER 2011 Incidence
72003	1	1	1	1	2
72021	5	4	6	6	14
72026	0	0	0	1	1
72029	3	2	3	3	8
72038	0	0	0	0	0
72041	2	1	2	3	5
72042	7	4	6	7	16
72064	3	2	3	3	7
72069	2	1	2	2	4
72072	0	0	0	0	1
72073	1	1	1	2	3
72134	0	0	0	0	1
72160	12	8	12	14	29
72170	0	0	0	0	1
Total	**37**	**24**	**37**	**42**	**92**

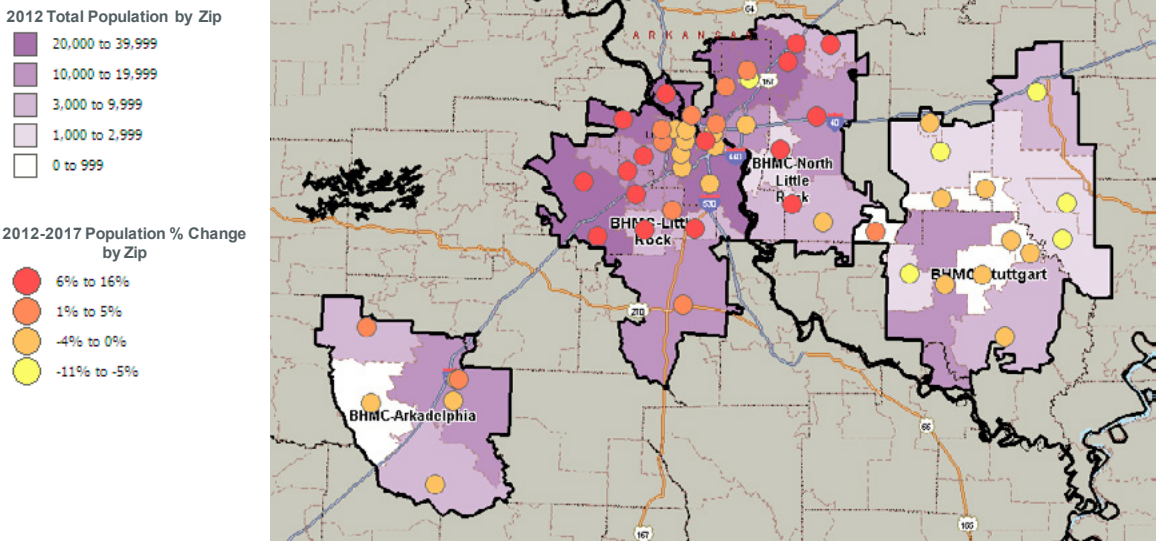
Arkadelphia

Zip Code	BREAST 2011 Incidence	COLORECTAL 2011 Incidence	LUNG 2011 Incidence	PROSTATE 2011 Incidence	OTHER 2011 Incidence
71743	4	3	4	5	12
71921	3	3	3	4	9
71923	15	12	14	16	44
71962	1	1	1	1	3
71998	0	0	0	0	0
71999	0	0	0	0	0
Total	**23**	**19**	**22**	**26**	**68**

Heber Springs

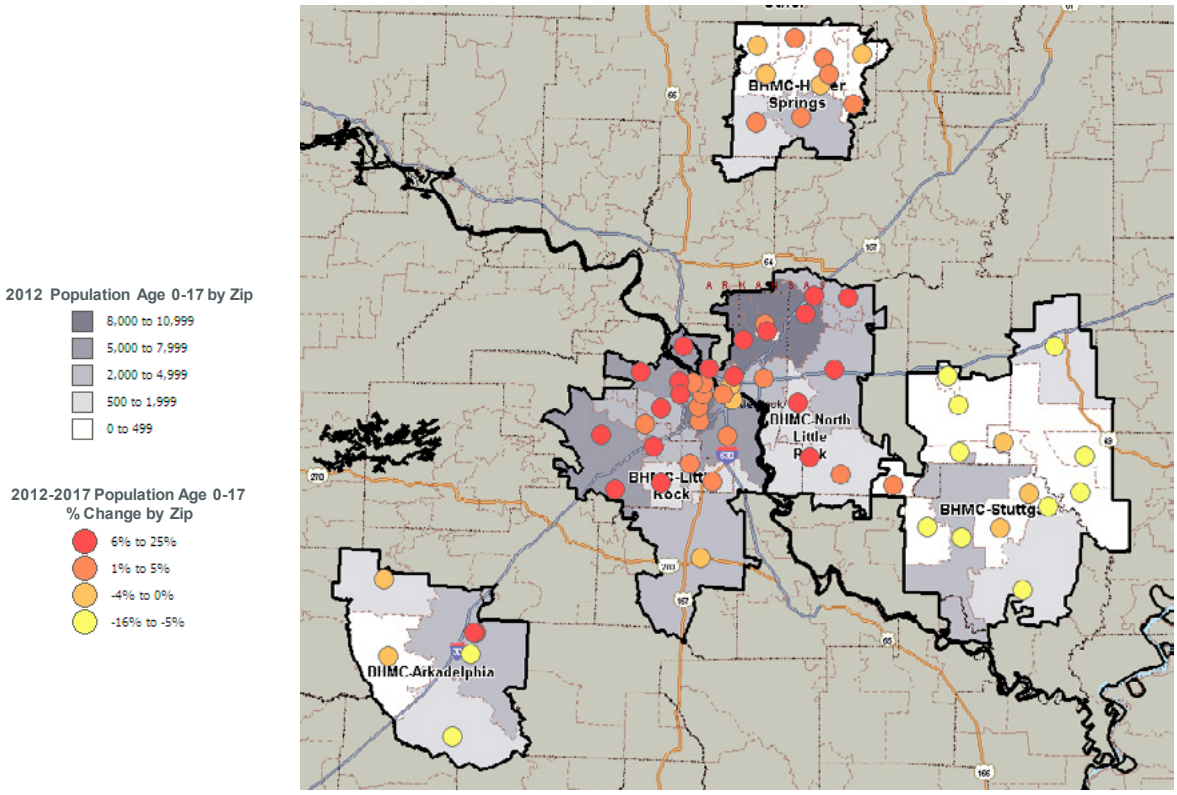
Zip Code	BREAST 2011 Incidence	COLORECTAL 2011 Incidence	LUNG 2011 Incidence	PROSTATE 2011 Incidence	OTHER 2011 Incidence
72044	1	1	1	2	4
72067	4	3	4	6	11
72130	0	0	1	1	1
72131	5	4	5	6	13
72179	1	0	1	1	2
72523	1	1	1	1	3
72530	2	2	2	3	7
72543	17	14	18	21	47
72546	0	0	0	0	0
72581	1	1	1	2	4
Total	**33**	**26**	**36**	**42**	**92**

BAPTIST HEALTH
2012 – 2017 TOTAL POPULATION



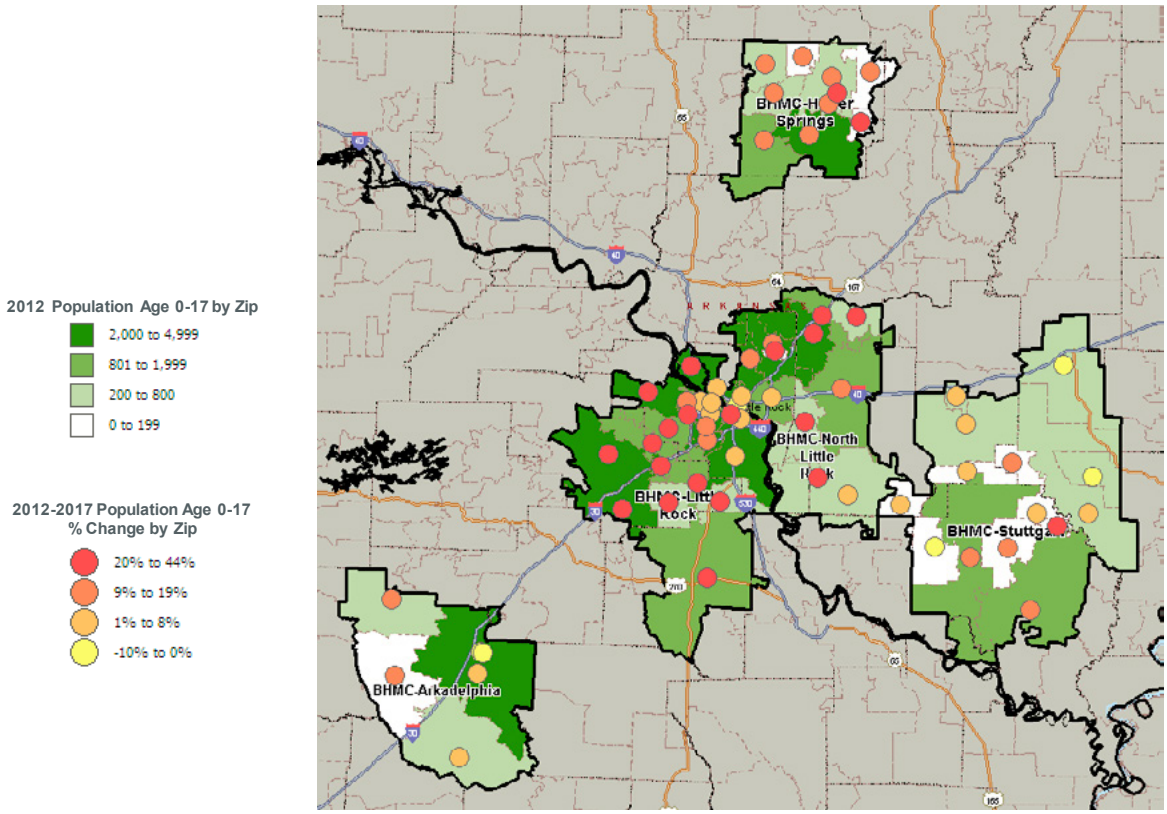
Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BAPTIST HEALTH
2012 – 2017 POPULATION CHILDREN AGE 0-17



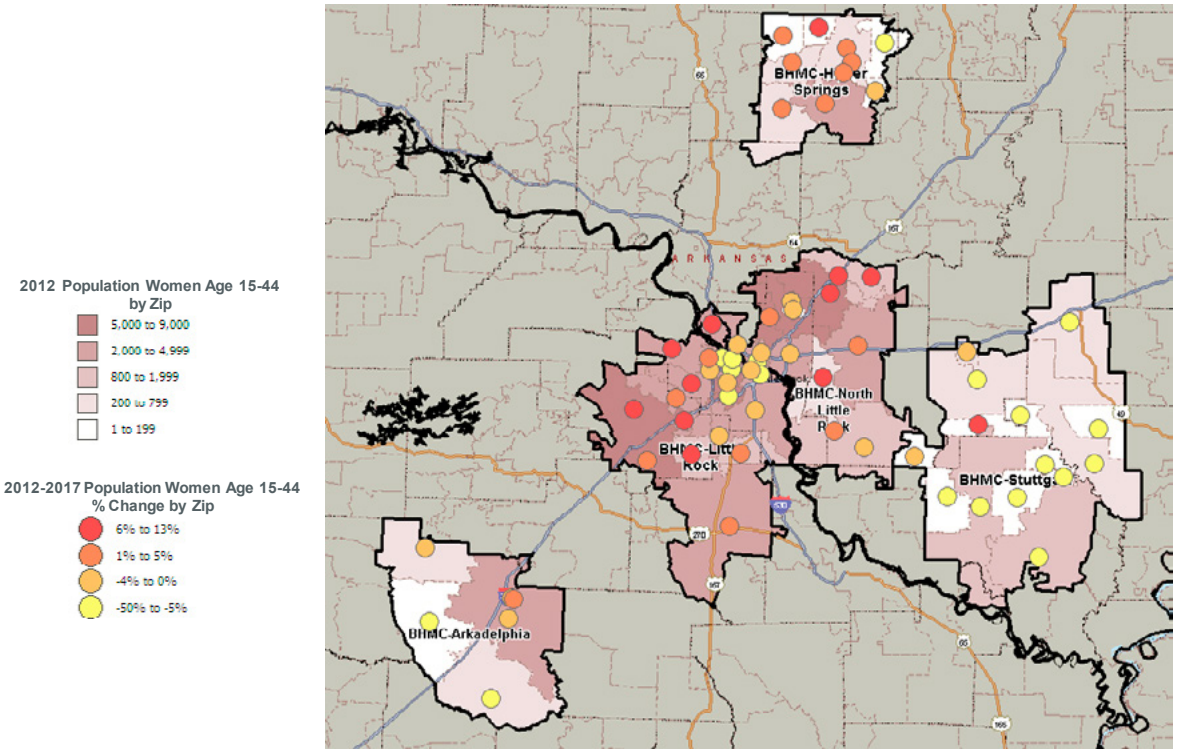
Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BAPTIST HEALTH
2012 – 2017 POPULATION AGE 65+



Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BAPTIST HEALTH
2012–2017 POPULATION WOMEN CHILDBEARING AGE



Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BAPTIST HEALTH
2012 – 2017 POPULATION BY AGE GROUP BY ZIP

LITTLE ROCK

Zip Code	Age Group	2000 Population	2012 Population	2017 Population	2012-2017 Change
72207	00-17	2,140	2,426	2,518	4%
72207	18-44	4,549	3,770	3,465	-8%
72207	45-64	2,693	3,087	3,145	2%
72207	65+	1,777	1,765	1,899	8%
72209	00-17	10,299	10,088	10,195	1%
72209	18-44	13,156	12,830	12,467	-3%
72209	45-64	5,671	6,689	6,754	1%
72209	65+	2,575	2,787	3,093	11%
72210	00-17	2,600	3,915	4,519	15%
72210	18-44	4,433	5,583	5,913	6%
72210	45-64	2,868	4,397	4,642	6%
72210	65+	932	1,752	2,282	30%
72211	00-17	3,963	5,441	5,977	10%
72211	18-44	8,996	8,414	8,047	-4%
72211	45-64	3,737	5,458	6,006	10%
72211	65+	1,612	2,024	2,506	24%
72212	00-17	2,679	2,997	3,314	11%
72212	18-44	3,636	3,919	4,077	4%
72212	45-64	3,365	3,808	3,588	-6%
72212	65+	1,329	1,769	2,063	17%
72223	00-17	3,490	5,589	6,445	15%
72223	18-44	4,917	6,325	6,946	10%
72223	45-64	3,376	6,238	6,640	6%
72223	65+	992	2,257	2,966	31%
72227	00-17	2,381	2,238	2,345	5%
72227	18-44	4,315	3,975	3,804	-4%
72227	45-64	3,207	3,286	3,111	-5%
72227	65+	1,939	2,143	2,314	8%

LITTLE ROCK

Zip Code	Age Group	2000 Population	2012 Population	2017 Population	2012-2017 Change
72002	00-17	2,849	3,503	3,658	4%
72002	18-44	4,304	5,382	5,651	5%
72002	45-64	2,659	4,048	4,491	11%
72002	65+	894	1,383	1,912	38%
72011	00-17	946	1,197	1,284	7%
72011	18-44	1,361	1,817	1,944	7%
72011	45-64	645	1,132	1,351	19%
72011	65+	227	357	497	39%
72015	00-17	5,451	7,286	7,799	7%
72015	18-44	8,579	10,714	11,127	4%
72015	45-64	4,677	6,809	7,747	14%
72015	65+	3,022	3,338	4,009	20%
72019	00-17	4,853	5,945	6,385	7%
72019	18-44	7,003	9,272	9,987	8%
72019	45-64	4,691	7,112	7,700	8%
72019	65+	2,169	2,784	3,738	34%
72022	00-17	2,772	3,901	4,240	9%
72022	18-44	3,841	5,527	5,966	8%
72022	45-64	2,259	3,865	4,432	15%
72022	65+	1,040	1,407	1,886	34%
72065	00-17	1,022	1,211	1,259	4%
72065	18-44	1,705	2,142	2,201	3%
72065	45-64	1,008	1,426	1,539	8%
72065	65+	319	473	657	39%
72103	00-17	3,284	3,384	3,421	1%
72103	18-44	4,822	4,934	4,884	-1%
72103	45-64	2,861	3,383	3,520	4%
72103	65+	973	1,239	1,615	30%

LITTLE ROCK

Zip Code	Age Group	2000 Population	2012 Population	2017 Population	2012-2017 Change
72113	00-17	3,429	5,977	7,033	18%
72113	18-44	5,235	7,442	8,081	9%
72113	45-64	3,309	6,899	7,708	12%
72113	65+	880	2,202	3,099	41%
72150	00-17	2,966	3,011	2,954	-2%
72150	18-44	4,318	4,361	4,453	2%
72150	45-64	2,765	3,528	3,696	5%
72150	65+	1,392	1,689	2,061	22%
72201	00-17	60	101	105	4%
72201	18-44	424	433	431	0%
72201	45-64	187	302	341	13%
72201	65+	80	142	174	23%
72202	00-17	2,381	1,864	1,857	0%
72202	18-44	4,782	3,995	3,705	-7%
72202	45-64	2,564	2,352	2,319	-1%
72202	65+	1,569	1,412	1,475	4%
72204	00-17	8,717	8,249	8,499	3%
72204	18-44	14,035	13,066	12,682	-3%
72204	45-64	6,657	7,328	7,118	-3%
72204	65+	3,449	3,489	3,819	9%
72205	00-17	4,327	4,477	4,573	2%
72205	18-44	10,435	8,681	8,000	-8%
72205	45-64	5,064	5,939	5,978	1%
72205	65+	3,915	3,646	3,935	8%
72206	00-17	6,926	6,094	6,242	2%
72206	18-44	10,389	9,461	9,299	-2%
72206	45-64	6,688	6,545	6,181	-6%
72206	65+	3,572	3,526	3,768	7%

NORTH LITTLE ROCK

Zip Code	Age Group	2000 Population	2012 Population	2017 Population	2012-2017 Change
72007	00-17	1,405	2,067	2,232	8%
72007	18-44	1,955	3,100	3,431	11%
72007	45-64	1,094	2,217	2,649	19%
72007	65+	419	859	1,179	37%
72023	00-17	7,409	9,840	10,678	9%
72023	18-44	10,001	13,379	14,339	7%
72023	45-64	5,331	9,044	10,477	16%
72023	65+	1,981	3,492	4,655	33%
72046	00-17	1,243	1,190	1,204	1%
72046	18-44	1,684	1,584	1,573	-1%
72046	45-64	1,100	1,055	1,038	-2%
72046	65+	759	674	713	6%
72076	00-17	11,463	10,533	11,013	5%
72076	18-44	16,987	14,642	14,315	-2%
72076	45-64	7,802	9,096	9,104	0%
72076	65+	3,178	4,195	4,750	13%
72083	00-17	59	73	81	11%
72083	18-44	79	94	95	1%
72083	45-64	53	74	82	11%
72083	65+	30	33	42	27%
72086	00-17	2,496	2,846	3,033	7%
72086	18-44	3,455	3,837	3,982	4%
72086	45-64	2,202	2,544	2,708	6%
72086	65+	1,219	1,432	1,688	18%
72099	00-17	90	33	36	9%
72099	18-44	1,224	648	605	-7%
72099	45-64	69	33	37	12%
72099	65+	16	13	18	38%

NORTH LITTLE ROCK

Zip Code	Age Group	2000 Population	2012 Population	2017 Population	2012-2017 Change
72114	00-17	4,756	3,913	3,820	-2%
72114	18-44	5,323	4,720	4,629	-2%
72114	45-64	2,614	2,562	2,438	-5%
72114	65+	1,951	1,514	1,504	-1%
72116	00-17	4,098	4,178	4,466	7%
72116	18-44	7,432	7,112	6,985	-2%
72116	45-64	5,481	6,037	5,917	-2%
72116	65+	3,612	3,969	4,302	8%
72117	00-17	3,499	3,160	3,307	5%
72117	18-44	4,510	4,659	4,644	0%
72117	45-64	2,774	2,900	2,778	-4%
72117	65+	1,563	1,714	1,778	4%
72118	00-17	5,470	5,707	6,136	8%
72118	18-44	8,748	8,242	8,061	-2%
72118	45-64	4,802	5,694	5,709	0%
72118	65+	2,835	2,931	3,158	8%
72120	00-17	6,834	8,100	8,889	10%
72120	18-44	10,861	11,781	11,899	1%
72120	45-64	6,918	8,713	8,839	1%
72120	65+	2,756	3,831	4,584	20%
72142	00-17	497	599	657	10%
72142	18-44	768	906	967	7%
72142	45-64	577	782	814	4%
72142	65+	253	359	438	22%
72176	00-17	1,632	2,494	2,810	13%
72176	18-44	2,189	3,179	3,468	9%
72176	45-64	1,031	1,783	2,238	26%
72176	65+	407	757	978	29%

ARKADELPHIA

Zip Code	Age Group	2000 Population	2012 Population	2017 Population	2012-2017 Change
71743	00-17	1,184	1,058	1,012	-4%
71743	18-44	1,593	1,345	1,357	1%
71743	45-64	977	1,046	980	-6%
71743	65+	662	596	640	7%
71921	00-17	686	757	744	-2%
71921	18-44	931	966	1,024	6%
71921	45-64	661	792	787	-1%
71921	65+	437	503	574	14%
71923	00-17	3,289	3,225	3,064	-5%
71923	18-44	7,352	6,902	6,993	1%
71923	45-64	3,081	3,344	3,163	-5%
71923	65+	2,346	2,189	2,337	7%
71962	00-17	200	210	202	-4%
71962	18-44	275	243	251	3%
71962	45-64	233	250	235	-6%
71962	65+	136	146	165	13%
71998	00-17	16	8	10	25%
71998	18-44	265	317	318	0%
71998	45-64	16	8	13	63%
71998	65+	13	10	9	-10%
71999	00-17	47	25	27	8%
71999	18-44	353	354	341	-4%
71999	45-64	28	27	22	-19%
71999	65+	28	21	20	-5%

HEBER SPRINGS

Zip Code	Age Group	2000 Population	2012 Population	2017 Population	2012-2017 Change
72044	00-17	149	156	155	-1%
72044	18-44	188	202	217	7%
72044	45-64	268	259	246	-5%
72044	65+	229	268	296	10%
72067	00-17	502	480	479	0%
72067	18-44	681	637	675	6%
72067	45-64	799	858	817	-5%
72067	65+	605	668	762	14%
72130	00-17	89	96	97	1%
72130	18-44	126	124	134	8%
72130	45-64	104	123	125	2%
72130	65+	68	84	96	14%
72131	00-17	907	1,070	1,117	4%
72131	18-44	1,257	1,310	1,360	4%
72131	45-64	970	1,173	1,185	1%
72131	65+	740	821	911	11%
72179	00-17	104	112	116	4%
72179	18-44	158	156	157	1%
72179	45-64	137	171	167	-2%
72179	65+	71	91	120	32%

HEBER SPRINGS

Zip Code	Age Group	2000 Population	2012 Population	2017 Population	2012-2017 Change
72523	00-17	268	231	222	-4%
72523	18-44	366	347	332	-4%
72523	45-64	265	290	303	4%
72523	65+	157	172	191	11%
72530	00-17	396	434	442	2%
72530	18-44	618	584	616	5%
72530	45-64	513	613	632	3%
72530	65+	308	367	412	12%
72543	00-17	2,380	2,464	2,497	1%
72543	18-44	3,420	3,571	3,665	3%
72543	45-64	2,844	3,515	3,545	1%
72543	65+	2,541	3,117	3,542	14%
72546	00-17	22	25	26	4%
72546	18-44	35	35	33	-6%
72546	45-64	32	36	36	0%
72546	65+	19	19	25	32%
72581	00-17	177	184	184	0%
72581	18-44	310	286	297	4%
72581	45-64	300	343	339	-1%
72581	65+	191	223	260	17%

STUTTGART

Zip Code	Age Group	2000 Population	2012 Population	2017 Population	2012-2017 Change
72003	00-17	189	173	167	-3%
72003	18-44	307	228	215	-6%
72003	45-64	225	227	219	-4%
72003	65+	115	105	115	10%
72021	00-17	1,641	1,127	1,005	-11%
72021	18-44	1,714	1,181	1,088	-8%
72021	45-64	1,271	1,258	1,059	-16%
72021	65+	919	793	769	-3%
72026	00-17	83	70	69	-1%
72026	18-44	129	87	82	-6%
72026	45-64	108	112	110	-2%
72026	65+	57	52	55	6%
72029	00-17	701	444	404	-9%
72029	18-44	894	599	537	-10%
72029	45-64	685	664	602	-9%
72029	65+	468	398	415	4%
72038	00-17	12	13	11	-15%
72038	18-44	20	14	13	-7%
72038	45-64	18	19	18	-5%
72038	65+	12	7	10	43%
72041	00-17	429	317	293	-8%
72041	18-44	576	476	442	-7%
72041	45-64	456	466	431	-8%
72041	65+	298	292	311	7%
72042	00-17	1,379	1,253	1,194	-5%
72042	18-44	2,004	1,604	1,552	-3%
72042	45-64	1,419	1,498	1,389	-7%
72042	65+	1,019	866	947	9%

STUTTGART

Zip Code	Age Group	2000 Population	2012 Population	2017 Population	2012-2017 Change
72064	00-17	505	403	378	-6%
72064	18-44	703	573	564	-2%
72064	45-64	536	570	548	-4%
72064	65+	430	421	444	5%
72069	00-17	409	215	182	-15%
72069	18-44	466	290	259	-11%
72069	45-64	331	319	277	-13%
72069	65+	311	226	221	-2%
72072	00-17	146	135	142	5%
72072	18-44	215	214	218	2%
72072	45-64	127	123	129	5%
72072	65+	79	77	81	5%
72073	00-17	361	242	215	-11%
72073	18-44	462	325	304	-6%
72073	45-64	334	300	269	-10%
72073	65+	199	155	150	-3%
72134	00-17	82	61	61	0%
72134	18-44	114	83	79	-5%
72134	45-64	90	100	91	-9%
72134	65+	52	55	61	11%
72160	00-17	2,902	2,660	2,534	-5%
72160	18-44	3,880	3,298	3,256	-1%
72160	45-64	2,636	2,890	2,711	-6%
72160	65+	1,758	1,660	1,840	11%
72170	00-17	67	55	49	-11%
72170	18-44	97	78	80	3%
72170	45-64	80	91	84	-8%
72170	65+	44	52	56	8%

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BAPTIST HEALTH
2012 – 2017 WOMEN CHILDBEARING AGE BY ZIP

BHMC-LITTLE ROCK

Zip Code	2012 Population	2017 Population	2012-2017 Change
72002	2,972	3,104	4%
72011	1,015	1,087	7%
72015	5,778	6,112	5%
72019	5,081	5,502	8%
72022	3,192	3,465	8%
72065	1,043	1,075	3%
72103	2,756	2,719	-1%
72113	4,268	4,613	7%
72150	2,462	2,493	1%
72201	196	196	0%
72202	2,170	2,007	-8%
72204	7,146	6,874	-4%
72205	4,747	4,410	-8%
72206	4,975	4,800	-4%
72207	2,205	2,061	-7%
72209	7,748	7,422	-4%
72210	3,226	3,442	6%
72211	4,796	4,659	-3%
72212	2,345	2,402	2%
72223	3,792	4,079	7%
72227	2,281	2,189	-4%
TOTAL	**74,194**	**74,711**	**0.7%**

BHMC-NORTH LITTLE ROCK

Zip Code	2012 Population	2017 Population	2012-2017 Change
72007	1,802	1,950	8%
72023	7,586	8,129	7%
72046	920	927	1%
72076	8,256	8,091	-2%
72083	53	56	5%
72086	2,079	2,190	5%
72099	118	116	-2%
72114	2,871	2,740	-5%
72116	3,970	3,901	-2%
72117	2,651	2,575	-3%
72118	4,653	4,566	-2%
72120	6,576	6,647	1%
72142	480	523	8%
72176	1,797	1,985	9%
TOTAL	**43,812**	**44,396**	**1.3%**

BHMC-ARKADELPHIA

Zip Code	2012 Population	2017 Population	2012-2017 Change
71743	798	763	-4%
71921	546	549	1%
71923	3,817	3754	-2%
71962	140	134	-4%
71998	153	156	2%
71999	176	171	-3%
TOTAL	**5,630**	**5,527**	**-1.8%**

BHMC-STUTTGART

Zip Code	2012 Population	2017 Population	2012-2017 Change
72003	125	119	-5%
72021	728	653	-10%
72026	47	45	-4%
72029	323	288	-11%
72038	9	6	-33%
72041	280	259	-8%
72042	920	880	-4%
72064	322	311	-3%
72069	170	148	-13%
72072	119	120	1%
72073	191	172	-10%
72134	43	41	-5%
72160	1,969	1,878	-5%
72170	40	46	15%
TOTAL	**5,286**	**4,966**	**-6.1%**

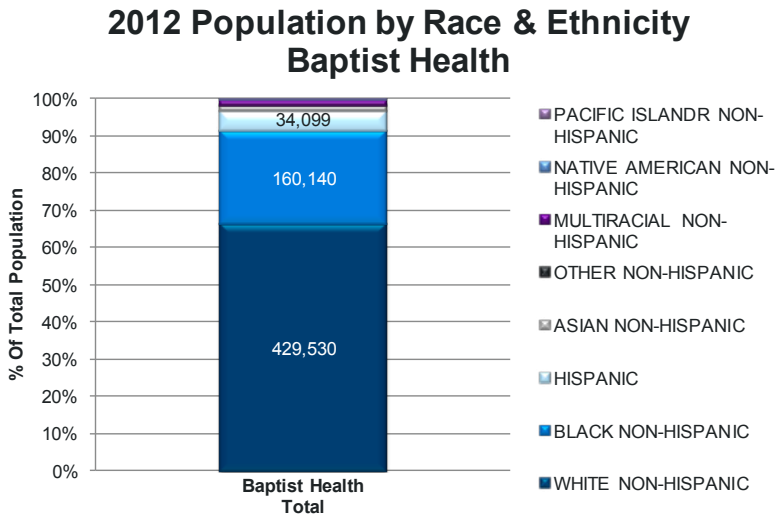
BHMC-HEBER SPRINGS

Zip Code	2012 Population	2017 Population	2012-2017 Change
72044	119	121	2%
72067	356	363	2%
72130	68	75	10%
72131	751	767	2%
72179	93	93	0%
72523	185	175	-5%
72530	324	339	5%
72543	2,017	2,048	2%
72546	19	20	5%
72581	162	167	3%
TOTAL	**4,094**	**4,168**	**1.8%**

Note: women childbearing age = females age 15-44

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BAPTIST HEALTH
2012 POPULATION BY RACE & ETHNICITY



Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BAPTIST HEALTH
2012-2017 POPULATION BY RACE & ETHNICITY

	BHMC-Little Rock				BHMC-North Little Rock			
Race/Ethnicity	2012 Population	2017 Population	2012-2017 Population Chg	2012-2017 Population % Chg	2012 Population	2017 Population	2012-2017 Population Chg	2012-2017 Population % Chg
WHITE NON-HISPANIC	222,836	225,977	3,141	1%	144,752	146,754	2,002	1%
BLACK NON-HISPANIC	97,998	105,106	7,108	7%	47,987	52,817	4,830	10%
HISPANIC	21,397	27,935	6,538	31%	10,381	13,291	2,910	28%
ASIAN NON-HISPANIC	7,215	8,827	1,612	22%	2,352	2,743	391	17%
OTHER NON-HISPANIC	462	586	124	27%	235	276	41	17%
MULTIRACIAL NON-HISPANIC	4,917	5,701	784	16%	4,206	5,033	827	20%
NATIVE AMERICAN NON-HISPANIC	1,241	1,296	55	4%	902	935	33	4%
PACIFIC ISLANDR NON-HISPANIC	86	99	13	15%	108	121	13	12%
Grand Total	**356,152**	**375,527**	**19,375**	**5%**	**210,923**	**221,970**	**11,047**	**5%**

	BHMC-Arkadelphia				BHMC-Heber Springs			
Race/Ethnicity	2012 Population	2017 Population	2012-2017 Population Chg	2012-2017 Population % Chg	2012 Population	2017 Population	2012-2017 Population Chg	2012-2017 Population % Chg
WHITE NON-HISPANIC	17,297	16,937	(360)	-2%	24,567	25,453	886	4%
BLACK NON-HISPANIC	5,445	5,562	117	2%	75	93	18	24%
HISPANIC	1,035	1,205	170	16%	555	680	125	23%
ASIAN NON-HISPANIC	127	122	(5)	-4%	56	61	5	9%
OTHER NON-HISPANIC	28	35	7	25%	2	3	1	50%
MULTIRACIAL NON-HISPANIC	317	337	20	6%	325	389	64	20%
NATIVE AMERICAN NON-HISPANIC	89	85	(4)	-4%	128	144	16	13%
PACIFIC ISLANDR NON-HISPANIC	4	5	1	25%	7	8	1	14%
Grand Total	**24,342**	**24,288**	**(54)**	**0%**	**25,715**	**26,831**	**1,116**	**4%**

	BHMC-Stuttgart			
Race/Ethnicity	2012 Population	2017 Population	2012-2017 Population Chg	2012-2017 Population % Chg
WHITE NON-HISPANIC	20,078	18,953	(1,125)	-6%
BLACK NON-HISPANIC	8,635	8,356	(279)	-3%
HISPANIC	731	879	148	20%
ASIAN NON-HISPANIC	134	149	15	11%
OTHER NON-HISPANIC	18	18	-	0%
MULTIRACIAL NON-HISPANIC	351	384	33	9%
NATIVE AMERICAN NON-HISPANIC	65	63	(2)	-3%
PACIFIC ISLANDR NON-HISPANIC	2	3	1	50%
Grand Total	**30,014**	**28,805**	**(1,209)**	**-4%**

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BAPTIST HEALTH
RACE & ETHNICITY BY ZIP

BHMC-Little Rock

Zip Code	Ethnicity	2000 Population	2012 Population	2017 Population	2012-2017 Change
72002	ASIAN NON-HISPANIC	54	94	111	18%
72002	BLACK NON-HISPANIC	308	1,364	1,867	37%
72002	HISPANIC	138	965	1,388	44%
72002	MULTIRACIAL NON-HISPANIC	103	213	266	25%
72002	NATIVE AMERICAN NON-HISPANIC	72	76	76	0%
72002	OTHER NON-HISPANIC	2	13	17	31%
72002	PACIFIC ISLANDR NON-HISPANIC	1	1	1	0%
72002	WHITE NON-HISPANIC	10,028	11,590	11,986	3%
72011	ASIAN NON-HISPANIC	5	12	15	25%
72011	BLACK NON-HISPANIC	19	99	141	42%
72011	HISPANIC	36	170	242	42%
72011	MULTIRACIAL NON-HISPANIC	14	44	61	39%
72011	NATIVE AMERICAN NON-HISPANIC	19	18	16	-11%
72011	OTHER NON-HISPANIC	3	1	2	100%
72011	PACIFIC ISLANDR NON-HISPANIC	1	-	-	0%
72011	WHITE NON-HISPANIC	3,082	4,159	4,599	11%
72015	ASIAN NON-HISPANIC	75	183	239	31%
72015	BLACK NON-HISPANIC	1,036	1,635	1,991	22%
72015	HISPANIC	425	1,313	1,734	32%
72015	MULTIRACIAL NON-HISPANIC	229	372	444	19%
72015	NATIVE AMERICAN NON-HISPANIC	96	164	193	18%
72015	OTHER NON-HISPANIC	5	28	40	43%
72015	PACIFIC ISLANDR NON-HISPANIC	6	6	4	-33%
72015	WHITE NON-HISPANIC	19,857	24,446	26,037	7%
72019	ASIAN NON-HISPANIC	85	183	236	29%
72019	BLACK NON-HISPANIC	157	699	975	39%
72019	HISPANIC	198	750	1,068	42%
72019	MULTIRACIAL NON-HISPANIC	131	243	294	21%
72019	NATIVE AMERICAN NON-HISPANIC	73	72	77	7%
72019	OTHER NON-HISPANIC	3	6	8	33%
72019	PACIFIC ISLANDR NON-HISPANIC	14	1	1	0%
72019	WHITE NON-HISPANIC	18,055	23,159	25,151	9%

BHMC-Little Rock

Zip Code	Ethnicity	2000 Population	2012 Population	2017 Population	2012-2017 Change
72022	ASIAN NON-HISPANIC	98	265	352	33%
72022	BLACK NON-HISPANIC	236	1,262	1,798	42%
72022	HISPANIC	105	871	1,289	48%
72022	MULTIRACIAL NON-HISPANIC	75	200	256	28%
72022	NATIVE AMERICAN NON-HISPANIC	42	71	80	13%
72022	OTHER NON-HISPANIC	2	26	36	38%
72022	PACIFIC ISLANDR NON-HISPANIC	-	1	-	-100%
72022	WHITE NON-HISPANIC	9,354	12,004	12,713	6%
72065	ASIAN NON-HISPANIC	40	99	125	26%
72065	BLACK NON-HISPANIC	321	493	527	7%
72065	HISPANIC	36	147	198	35%
72065	MULTIRACIAL NON-HISPANIC	60	62	62	0%
72065	NATIVE AMERICAN NON-HISPANIC	20	22	21	-5%
72065	OTHER NON-HISPANIC	-	6	8	33%
72065	PACIFIC ISLANDR NON-HISPANIC	-	-	1	0%
72065	WHITE NON-HISPANIC	3,577	4,423	4,714	7%
72103	ASIAN NON-HISPANIC	99	140	156	11%
72103	BLACK NON-HISPANIC	1,786	2,624	2,862	9%
72103	HISPANIC	211	1,096	1,443	32%
72103	MULTIRACIAL NON-HISPANIC	152	196	220	12%
72103	NATIVE AMERICAN NON-HISPANIC	59	66	72	9%
72103	OTHER NON-HISPANIC	4	13	15	15%
72103	PACIFIC ISLANDR NON-HISPANIC	1	5	5	0%
72103	WHITE NON-HISPANIC	9,628	8,800	8,667	-2%
72113	ASIAN NON-HISPANIC	96	517	729	41%
72113	BLACK NON-HISPANIC	1,026	3,543	4,888	38%
72113	HISPANIC	230	803	1,125	40%
72113	MULTIRACIAL NON-HISPANIC	127	334	437	31%
72113	NATIVE AMERICAN NON-HISPANIC	64	78	75	-4%
72113	OTHER NON-HISPANIC	3	47	68	45%
72113	PACIFIC ISLANDR NON-HISPANIC	-	12	17	42%
72113	WHITE NON-HISPANIC	11,307	17,186	18,582	8%

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BHMC-Little Rock

Zip Code	Ethnicity	2000 Population	2012 Population	2017 Population	2012-2017 Change
72150	ASIAN NON-HISPANIC	18	44	57	30%
72150	BLACK NON-HISPANIC	123	171	190	11%
72150	HISPANIC	75	221	289	31%
72150	MULTIRACIAL NON-HISPANIC	67	126	149	18%
72150	NATIVE AMERICAN NON-HISPANIC	43	51	55	8%
72150	OTHER NON-HISPANIC	2	2	2	0%
72150	PACIFIC ISLANDR NON-HISPANIC	3	-	-	0%
72150	WHITE NON-HISPANIC	11,110	11,974	12,422	4%
72201	ASIAN NON-HISPANIC	4	14	18	29%
72201	BLACK NON-HISPANIC	395	287	241	-16%
72201	HISPANIC	14	31	42	35%
72201	MULTIRACIAL NON-HISPANIC	8	16	20	25%
72201	NATIVE AMERICAN NON-HISPANIC	4	5	4	-20%
72201	OTHER NON-HISPANIC	1	1	1	0%
72201	PACIFIC ISLANDR NON-HISPANIC	-	-	-	0%
72201	WHITE NON-HISPANIC	325	624	725	16%
72202	ASIAN NON-HISPANIC	73	186	218	17%
72202	BLACK NON-HISPANIC	7,024	5,264	4,898	-7%
72202	HISPANIC	164	264	312	18%
72202	MULTIRACIAL NON-HISPANIC	104	150	170	13%
72202	NATIVE AMERICAN NON-HISPANIC	34	31	28	-10%
72202	OTHER NON-HISPANIC	10	10	12	20%
72202	PACIFIC ISLANDR NON-HISPANIC	2	6	7	17%
72202	WHITE NON-HISPANIC	3,885	3,712	3,711	0%
72204	ASIAN NON-HISPANIC	351	391	409	5%
72204	BLACK NON-HISPANIC	22,198	22,184	22,340	1%
72204	HISPANIC	993	2,479	3,166	28%
72204	MULTIRACIAL NON-HISPANIC	361	520	582	12%
72204	NATIVE AMERICAN NON-HISPANIC	76	88	89	1%
72204	OTHER NON-HISPANIC	27	67	80	19%
72204	PACIFIC ISLANDR NON-HISPANIC	11	2	3	50%
72204	WHITE NON-HISPANIC	8,841	6,401	5,449	-15%

BHMC-Little Rock

Zip Code	Ethnicity	2000 Population	2012 Population	2017 Population	2012-2017 Change
72205	ASIAN NON-HISPANIC	355	552	606	10%
72205	BLACK NON-HISPANIC	5,614	6,420	6,758	5%
72205	HISPANIC	431	797	971	22%
72205	MULTIRACIAL NON-HISPANIC	269	362	398	10%
72205	NATIVE AMERICAN NON-HISPANIC	63	85	93	9%
72205	OTHER NON-HISPANIC	21	37	43	16%
72205	PACIFIC ISLANDR NON-HISPANIC	6	8	9	13%
72205	WHITE NON-HISPANIC	16,982	14,482	13,608	-6%
72206	ASIAN NON-HISPANIC	108	185	216	17%
72206	BLACK NON-HISPANIC	14,717	12,563	12,234	-3%
72206	HISPANIC	357	1,097	1,436	31%
72206	MULTIRACIAL NON-HISPANIC	286	434	492	13%
72206	NATIVE AMERICAN NON-HISPANIC	84	84	88	5%
72206	OTHER NON-HISPANIC	12	15	18	20%
72206	PACIFIC ISLANDR NON-HISPANIC	4	13	14	8%
72206	WHITE NON-HISPANIC	12,007	11,235	10,992	-2%
72207	ASIAN NON-HISPANIC	136	127	121	-5%
72207	BLACK NON-HISPANIC	754	1,405	1,637	17%
72207	HISPANIC	114	243	301	24%
72207	MULTIRACIAL NON-HISPANIC	87	141	164	16%
72207	NATIVE AMERICAN NON-HISPANIC	21	30	35	17%
72207	OTHER NON-HISPANIC	9	6	8	33%
72207	PACIFIC ISLANDR NON-HISPANIC	3	2	3	50%
72207	WHITE NON-HISPANIC	10,035	9,094	8,758	-4%
72209	ASIAN NON-HISPANIC	231	126	106	-16%
72209	BLACK NON-HISPANIC	19,372	21,177	20,936	-1%
72209	HISPANIC	1,810	6,565	8,104	23%
72209	MULTIRACIAL NON-HISPANIC	445	391	359	-8%
72209	NATIVE AMERICAN NON-HISPANIC	76	65	55	-15%
72209	OTHER NON-HISPANIC	29	55	62	13%
72209	PACIFIC ISLANDR NON-HISPANIC	8	5	6	20%
72209	WHITE NON-HISPANIC	9,730	4,010	2,881	-28%

BHMC-Little Rock

Zip Code	Ethnicity	2000 Population	2012 Population	2017 Population	2012-2017 Change
72210	ASIAN NON-HISPANIC	90	475	642	35%
72210	BLACK NON-HISPANIC	1,416	5,547	7,404	33%
72210	HISPANIC	167	1,131	1,629	44%
72210	MULTIRACIAL NON-HISPANIC	98	237	297	25%
72210	NATIVE AMERICAN NON-HISPANIC	60	51	44	-14%
72210	OTHER NON-HISPANIC	5	26	33	27%
72210	PACIFIC ISLANDR NON-HISPANIC	-	1	2	100%
72210	WHITE NON-HISPANIC	8,997	8,179	7,305	-11%
72211	ASIAN NON-HISPANIC	712	1,713	2,131	24%
72211	BLACK NON-HISPANIC	2,513	4,771	5,654	19%
72211	HISPANIC	437	1,124	1,468	31%
72211	MULTIRACIAL NON-HISPANIC	214	325	388	19%
72211	NATIVE AMERICAN NON-HISPANIC	49	53	53	0%
72211	OTHER NON-HISPANIC	17	47	59	26%
72211	PACIFIC ISLANDR NON-HISPANIC	5	13	15	15%
72211	WHITE NON-HISPANIC	14,361	13,291	12,768	-4%
72212	ASIAN NON-HISPANIC	401	597	680	14%
72212	BLACK NON-HISPANIC	896	1,698	2,015	19%
72212	HISPANIC	131	282	368	30%
72212	MULTIRACIAL NON-HISPANIC	102	162	189	17%
72212	NATIVE AMERICAN NON-HISPANIC	21	28	29	4%
72212	OTHER NON-HISPANIC	4	10	12	20%
72212	PACIFIC ISLANDR NON-HISPANIC	1	3	4	33%
72212	WHITE NON-HISPANIC	9,453	9,713	9,745	0%

BHMC-Little Rock

Zip Code	Ethnicity	2000 Population	2012 Population	2017 Population	2012-2017 Change
72223	ASIAN NON-HISPANIC	344	1,129	1,504	33%
72223	BLACK NON-HISPANIC	860	2,159	2,755	28%
72223	HISPANIC	172	469	651	39%
72223	MULTIRACIAL NON-HISPANIC	130	239	293	23%
72223	NATIVE AMERICAN NON-HISPANIC	41	74	84	14%
72223	OTHER NON-HISPANIC	13	38	54	42%
72223	PACIFIC ISLANDR NON-HISPANIC	1	6	6	0%
72223	WHITE NON-HISPANIC	11,214	16,295	17,650	8%
72227	ASIAN NON-HISPANIC	270	183	156	-15%
72227	BLACK NON-HISPANIC	1,597	2,633	2,995	14%
72227	HISPANIC	282	579	711	23%
72227	MULTIRACIAL NON-HISPANIC	116	150	160	7%
72227	NATIVE AMERICAN NON-HISPANIC	25	29	29	0%
72227	OTHER NON-HISPANIC	12	8	8	0%
72227	PACIFIC ISLANDR NON-HISPANIC	1	1	1	0%
72227	WHITE NON-HISPANIC	9,539	8,059	7,514	-7%

BHMC-North Little Rock

Zip Code	Ethnicity	2000 Population	2012 Population	2017 Population	2012-2017 Change
72007	ASIAN NON-HISPANIC	15	65	90	38%
72007	BLACK NON-HISPANIC	9	91	128	41%
72007	HISPANIC	85	224	291	30%
72007	MULTIRACIAL NON-HISPANIC	46	135	184	36%
72007	NATIVE AMERICAN NON-HISPANIC	26	44	50	14%
72007	OTHER NON-HISPANIC	1	3	4	33%
72007	PACIFIC ISLANDR NON-HISPANIC	2	4	7	75%
72007	WHITE NON-HISPANIC	4,689	7,677	8,737	14%
72023	ASIAN NON-HISPANIC	165	434	577	33%
72023	BLACK NON-HISPANIC	92	546	747	37%
72023	HISPANIC	424	1,379	1,889	37%
72023	MULTIRACIAL NON-HISPANIC	266	579	738	27%
72023	NATIVE AMERICAN NON-HISPANIC	112	171	196	15%
72023	OTHER NON-HISPANIC	10	26	33	27%
72023	PACIFIC ISLANDR NON-HISPANIC	9	17	21	24%
72023	WHITE NON-HISPANIC	23,644	32,603	35,948	10%
72046	ASIAN NON-HISPANIC	3	5	7	40%
72046	BLACK NON-HISPANIC	1,377	1,240	1,192	-4%
72046	HISPANIC	61	127	151	19%
72046	MULTIRACIAL NON-HISPANIC	31	72	90	25%
72046	NATIVE AMERICAN NON-HISPANIC	16	9	9	0%
72046	OTHER NON-HISPANIC	1	7	10	43%
72046	PACIFIC ISLANDR NON-HISPANIC	1	-	-	0%
72046	WHITE NON-HISPANIC	3,296	3,043	3,069	1%
72076	ASIAN NON-HISPANIC	630	652	666	2%
72076	BLACK NON-HISPANIC	7,808	10,712	11,981	12%
72076	HISPANIC	1,199	2,332	2,911	25%
72076	MULTIRACIAL NON-HISPANIC	799	1,201	1,385	15%
72076	NATIVE AMERICAN NON-HISPANIC	200	182	185	2%
72076	OTHER NON-HISPANIC	56	51	56	10%
72076	PACIFIC ISLANDR NON-HISPANIC	33	26	26	0%
72076	WHITE NON-HISPANIC	28,705	23,310	21,972	-6%

BHMC-North Little Rock

Zip Code	Ethnicity	2000 Population	2012 Population	2017 Population	2012-2017 Change
72083	ASIAN NON-HISPANIC	1	-	-	0%
72083	BLACK NON-HISPANIC	29	30	30	0%
72083	HISPANIC	4	11	11	0%
72083	MULTIRACIAL NON-HISPANIC	1	4	6	50%
72083	NATIVE AMERICAN NON-HISPANIC	1	1	-	-100%
72083	OTHER NON-HISPANIC	-	-	-	0%
72083	PACIFIC ISLANDR NON-HISPANIC	-	-	-	0%
72083	WHITE NON-HISPANIC	185	228	253	11%
72086	ASIAN NON-HISPANIC	26	57	75	32%
72086	BLACK NON-HISPANIC	1,187	1,388	1,439	4%
72086	HISPANIC	199	406	515	27%
72086	MULTIRACIAL NON-HISPANIC	80	140	172	23%
72086	NATIVE AMERICAN NON-HISPANIC	53	35	33	-6%
72086	OTHER NON-HISPANIC	2	5	7	40%
72086	PACIFIC ISLANDR NON-HISPANIC	1	2	1	-50%
72086	WHITE NON-HISPANIC	7,824	8,626	9,169	6%
72099	ASIAN NON-HISPANIC	16	7	5	-29%
72099	BLACK NON-HISPANIC	297	55	44	-20%
72099	HISPANIC	37	64	76	19%
72099	MULTIRACIAL NON-HISPANIC	19	15	16	7%
72099	NATIVE AMERICAN NON-HISPANIC	12	2	-	-100%
72099	OTHER NON-HISPANIC	1	2	3	50%
72099	PACIFIC ISLANDR NON-HISPANIC	2	-	-	0%
72099	WHITE NON-HISPANIC	1,015	582	552	-5%
72114	ASIAN NON-HISPANIC	44	45	48	7%
72114	BLACK NON-HISPANIC	10,536	9,040	8,736	-3%
72114	HISPANIC	300	614	744	21%
72114	MULTIRACIAL NON-HISPANIC	184	243	266	9%
72114	NATIVE AMERICAN NON-HISPANIC	50	36	35	-3%
72114	OTHER NON-HISPANIC	11	7	5	-29%
72114	PACIFIC ISLANDR NON-HISPANIC	5	26	31	19%
72114	WHITE NON-HISPANIC	3,514	2,698	2,526	-6%

BHMC-North Little Rock

Zip Code	Ethnicity	2000 Population	2012 Population	2017 Population	2012-2017 Change
72116	ASIAN NON-HISPANIC	195	359	410	14%
72116	BLACK NON-HISPANIC	1,767	3,131	3,659	17%
72116	HISPANIC	337	818	1,054	29%
72116	MULTIRACIAL NON-HISPANIC	194	364	433	19%
72116	NATIVE AMERICAN NON-HISPANIC	82	78	77	-1%
72116	OTHER NON-HISPANIC	7	25	32	28%
72116	PACIFIC ISLANDR NON-HISPANIC	6	10	10	0%
72116	WHITE NON-HISPANIC	18,035	16,511	15,995	-3%
72117	ASIAN NON-HISPANIC	26	48	54	13%
72117	BLACK NON-HISPANIC	6,498	7,918	8,458	7%
72117	HISPANIC	177	558	717	28%
72117	MULTIRACIAL NON-HISPANIC	171	204	215	5%
72117	NATIVE AMERICAN NON-HISPANIC	54	44	44	0%
72117	OTHER NON-HISPANIC	12	20	22	10%
72117	PACIFIC ISLANDR NON-HISPANIC	3	-	-	0%
72117	WHITE NON-HISPANIC	5,405	3,641	2,997	-18%
72118	ASIAN NON-HISPANIC	92	163	191	17%
72118	BLACK NON-HISPANIC	4,529	7,468	8,590	15%
72118	HISPANIC	785	2,279	2,914	28%
72118	MULTIRACIAL NON-HISPANIC	246	414	485	17%
72118	NATIVE AMERICAN NON-HISPANIC	104	80	70	-13%
72118	OTHER NON-HISPANIC	17	34	41	21%
72118	PACIFIC ISLANDR NON-HISPANIC	7	1	2	100%
72118	WHITE NON-HISPANIC	16,075	12,135	10,771	-11%
72120	ASIAN NON-HISPANIC	238	470	560	19%
72120	BLACK NON-HISPANIC	2,522	5,557	6,853	23%
72120	HISPANIC	570	1,269	1,627	28%
72120	MULTIRACIAL NON-HISPANIC	318	635	775	22%
72120	NATIVE AMERICAN NON-HISPANIC	136	145	149	3%
72120	OTHER NON-HISPANIC	33	40	40	0%
72120	PACIFIC ISLANDR NON-HISPANIC	14	21	22	5%
72120	WHITE NON-HISPANIC	23,538	24,288	24,185	0%

BHMC-North Little Rock

Zip Code	Ethnicity	2000 Population	2012 Population	2017 Population	2012-2017 Change
72142	ASIAN NON-HISPANIC	1	10	13	30%
72142	BLACK NON-HISPANIC	444	725	840	16%
72142	HISPANIC	62	66	74	12%
72142	MULTIRACIAL NON-HISPANIC	18	50	66	32%
72142	NATIVE AMERICAN NON-HISPANIC	8	5	5	0%
72142	OTHER NON-HISPANIC	1	2	2	0%
72142	PACIFIC ISLANDR NON-HISPANIC	2	-	-	0%
72142	WHITE NON-HISPANIC	1,559	1,788	1,876	5%
72176	ASIAN NON-HISPANIC	14	37	47	27%
72176	BLACK NON-HISPANIC	9	86	120	40%
72176	HISPANIC	81	234	317	35%
72176	MULTIRACIAL NON-HISPANIC	55	150	202	35%
72176	NATIVE AMERICAN NON-HISPANIC	37	70	82	17%
72176	OTHER NON-HISPANIC	-	13	21	62%
72176	PACIFIC ISLANDR NON-HISPANIC	-	1	1	0%
72176	WHITE NON-HISPANIC	5,063	7,622	8,704	14%

BHMC-Stuttgart

Zip Code	Ethnicity	2000 Population	2012 Population	2017 Population	2012-2017 Change
72003	ASIAN NON-HISPANIC	-	1	1	0%
72003	BLACK NON-HISPANIC	68	50	47	-6%
72003	HISPANIC	2	4	5	25%
72003	MULTIRACIAL NON-HISPANIC	4	4	3	-25%
72003	NATIVE AMERICAN NON-HISPANIC	2	-	-	0%
72003	OTHER NON-HISPANIC	-	-	-	0%
72003	PACIFIC ISLANDR NON-HISPANIC	-	-	-	0%
72003	WHITE NON-HISPANIC	760	674	660	-2%
72021	ASIAN NON-HISPANIC	7	35	43	23%
72021	BLACK NON-HISPANIC	2,293	1,896	1,745	-8%
72021	HISPANIC	66	57	51	-11%
72021	MULTIRACIAL NON-HISPANIC	64	42	35	-17%
72021	NATIVE AMERICAN NON-HISPANIC	12	12	14	17%
72021	OTHER NON-HISPANIC	9	5	3	-40%
72021	PACIFIC ISLANDR NON-HISPANIC	2	-	-	0%
72021	WHITE NON-HISPANIC	3,092	2,312	2,030	-12%
72026	ASIAN NON-HISPANIC	-	-	-	0%
72026	BLACK NON-HISPANIC	92	52	41	-21%
72026	HISPANIC	-	2	3	50%
72026	MULTIRACIAL NON-HISPANIC	4	3	3	0%
72026	NATIVE AMERICAN NON-HISPANIC	1	-	-	0%
72026	OTHER NON-HISPANIC	1	1	-	-100%
72026	PACIFIC ISLANDR NON-HISPANIC	-	-	-	0%
72026	WHITE NON-HISPANIC	279	263	269	2%
72029	ASIAN NON-HISPANIC	3	2	2	0%
72029	BLACK NON-HISPANIC	732	602	581	-3%
72029	HISPANIC	53	58	59	2%
72029	MULTIRACIAL NON-HISPANIC	30	26	26	0%
72029	NATIVE AMERICAN NON-HISPANIC	11	13	14	8%
72029	OTHER NON-HISPANIC	-	-	-	0%
72029	PACIFIC ISLANDR NON-HISPANIC	-	-	-	0%
72029	WHITE NON-HISPANIC	1,919	1,404	1,276	-9%

BHMC-Stuttgart

Zip Code	Ethnicity	2000 Population	2012 Population	2017 Population	2012-2017 Change
72038	ASIAN NON-HISPANIC	-	-	-	0%
72038	BLACK NON-HISPANIC	15	8	7	-13%
72038	HISPANIC	-	1	-	-100%
72038	MULTIRACIAL NON-HISPANIC	1	1	1	0%
72038	NATIVE AMERICAN NON-HISPANIC	-	-	-	0%
72038	OTHER NON-HISPANIC	-	-	-	0%
72038	PACIFIC ISLANDR NON-HISPANIC	-	-	-	0%
72038	WHITE NON-HISPANIC	46	43	44	2%
72041	ASIAN NON-HISPANIC	1	1	-	-100%
72041	BLACK NON-HISPANIC	318	242	217	-10%
72041	HISPANIC	7	13	15	15%
72041	MULTIRACIAL NON-HISPANIC	10	5	4	-20%
72041	NATIVE AMERICAN NON-HISPANIC	2	1	-	-100%
72041	OTHER NON-HISPANIC	1	-	-	0%
72041	PACIFIC ISLANDR NON-HISPANIC	-	-	-	0%
72041	WHITE NON-HISPANIC	1,420	1,289	1,241	-4%
72042	ASIAN NON-HISPANIC	9	18	20	11%
72042	BLACK NON-HISPANIC	813	740	724	-2%
72042	HISPANIC	37	163	204	25%
72042	MULTIRACIAL NON-HISPANIC	39	54	61	13%
72042	NATIVE AMERICAN NON-HISPANIC	8	5	4	-20%
72042	OTHER NON-HISPANIC	-	2	3	50%
72042	PACIFIC ISLANDR NON-HISPANIC	-	-	-	0%
72042	WHITE NON-HISPANIC	4,915	4,239	4,066	-4%
72064	ASIAN NON-HISPANIC	-	2	2	0%
72064	BLACK NON-HISPANIC	305	319	325	2%
72064	HISPANIC	15	18	18	0%
72064	MULTIRACIAL NON-HISPANIC	10	20	24	20%
72064	NATIVE AMERICAN NON-HISPANIC	14	6	5	-17%
72064	OTHER NON-HISPANIC	-	-	-	0%
72064	PACIFIC ISLANDR NON-HISPANIC	-	-	-	0%
72064	WHITE NON-HISPANIC	1,830	1,602	1,560	-3%

BHMC-Stuttgart

Zip Code	Ethnicity	2000 Population	2012 Population	2017 Population	2012-2017 Change
72069	ASIAN NON-HISPANIC	1	1	-	-100%
72069	BLACK NON-HISPANIC	856	652	594	-9%
72069	HISPANIC	8	10	12	20%
72069	MULTIRACIAL NON-HISPANIC	6	9	9	0%
72069	NATIVE AMERICAN NON-HISPANIC	1	2	1	-50%
72069	OTHER NON-HISPANIC	-	-	-	0%
72069	PACIFIC ISLANDR NON-HISPANIC	-	-	-	0%
72069	WHITE NON-HISPANIC	645	376	323	-14%
72072	ASIAN NON-HISPANIC	-	-	-	0%
72072	BLACK NON-HISPANIC	160	146	140	-4%
72072	HISPANIC	8	6	7	17%
72072	MULTIRACIAL NON-HISPANIC	4	12	16	33%
72072	NATIVE AMERICAN NON-HISPANIC	4	-	1	0%
72072	OTHER NON-HISPANIC	-	-	-	0%
72072	PACIFIC ISLANDR NON-HISPANIC	-	-	-	0%
72072	WHITE NON-HISPANIC	391	385	406	5%
72073	ASIAN NON-HISPANIC	2	1	1	0%
72073	BLACK NON-HISPANIC	479	282	235	-17%
72073	HISPANIC	15	10	12	20%
72073	MULTIRACIAL NON-HISPANIC	25	7	6	-14%
72073	NATIVE AMERICAN NON-HISPANIC	2	4	4	0%
72073	OTHER NON-HISPANIC	-	-	-	0%
72073	PACIFIC ISLANDR NON-HISPANIC	-	-	-	0%
72073	WHITE NON-HISPANIC	833	718	680	-5%
72134	ASIAN NON-HISPANIC	1	-	-	0%
72134	BLACK NON-HISPANIC	52	59	63	7%
72134	HISPANIC	2	7	8	14%
72134	MULTIRACIAL NON-HISPANIC	7	4	3	-25%
72134	NATIVE AMERICAN NON-HISPANIC	1	2	2	0%
72134	OTHER NON-HISPANIC	-	-	-	0%
72134	PACIFIC ISLANDR NON-HISPANIC	-	-	-	0%
72134	WHITE NON-HISPANIC	275	227	216	-5%

BHMC-Stuttgart

Zip Code	Ethnicity	2000 Population	2012 Population	2017 Population	2012-2017 Change
72160	ASIAN NON-HISPANIC	63	73	80	10%
72160	BLACK NON-HISPANIC	3,504	3,562	3,612	1%
72160	HISPANIC	93	380	483	27%
72160	MULTIRACIAL NON-HISPANIC	64	163	192	18%
72160	NATIVE AMERICAN NON-HISPANIC	25	20	18	-10%
72160	OTHER NON-HISPANIC	2	10	12	20%
72160	PACIFIC ISLANDR NON-HISPANIC	1	2	3	50%
72160	WHITE NON-HISPANIC	7,424	6,298	5,941	-6%
72170	ASIAN NON-HISPANIC	-	-	-	0%
72170	BLACK NON-HISPANIC	23	25	25	0%
72170	HISPANIC	1	2	2	0%
72170	MULTIRACIAL NON-HISPANIC	2	1	1	0%
72170	NATIVE AMERICAN NON-HISPANIC	-	-	-	0%
72170	OTHER NON-HISPANIC	-	-	-	0%
72170	PACIFIC ISLANDR NON-HISPANIC	-	-	-	0%
72170	WHITE NON-HISPANIC	262	248	241	-3%

BHMC - Heber Springs

Zip Code	Ethnicity	2000 Population	2012 Population	2017 Population	2012-2017 Change
72044	ASIAN NON-HISPANIC	1	2	2	0%
72044	BLACK NON-HISPANIC	-	2	3	50%
72044	HISPANIC	3	10	15	50%
72044	MULTIRACIAL NON-HISPANIC	10	7	6	-14%
72044	NATIVE AMERICAN NON-HISPANIC	3	3	4	33%
72044	OTHER NON-HISPANIC	-	-	-	0%
72044	PACIFIC ISLANDR NON-HISPANIC	1	-	-	0%
72044	WHITE NON-HISPANIC	816	861	884	3%
72067	ASIAN NON-HISPANIC	3	5	6	20%
72067	BLACK NON-HISPANIC	2	4	3	-25%
72067	HISPANIC	28	39	46	18%
72067	MULTIRACIAL NON-HISPANIC	36	29	31	7%
72067	NATIVE AMERICAN NON-HISPANIC	12	16	17	6%
72067	OTHER NON-HISPANIC	-	-	1	0%
72067	PACIFIC ISLANDR NON-HISPANIC	1	-	1	0%
72067	WHITE NON-HISPANIC	2,505	2,550	2,628	3%
72130	ASIAN NON-HISPANIC	-	1	1	0%
72130	BLACK NON-HISPANIC	-	1	-	-100%
72130	HISPANIC	1	5	6	20%
72130	MULTIRACIAL NON-HISPANIC	2	5	6	20%
72130	NATIVE AMERICAN NON-HISPANIC	3	3	5	67%
72130	OTHER NON-HISPANIC	-	-	-	0%
72130	PACIFIC ISLANDR NON-HISPANIC	-	-	-	0%
72130	WHITE NON-HISPANIC	381	412	434	5%
72131	ASIAN NON-HISPANIC	1	7	7	0%
72131	BLACK NON-HISPANIC	2	15	21	40%
72131	HISPANIC	63	78	93	19%
72131	MULTIRACIAL NON-HISPANIC	31	81	104	28%
72131	NATIVE AMERICAN NON-HISPANIC	16	20	21	5%
72131	OTHER NON-HISPANIC	-	-	-	0%
72131	PACIFIC ISLANDR NON-HISPANIC	-	2	2	0%
72131	WHITE NON-HISPANIC	3,761	4,171	4,325	4%
72179	ASIAN NON-HISPANIC	-	1	2	100%
72179	BLACK NON-HISPANIC	1	-	-	0%
72179	HISPANIC	2	8	10	25%
72179	MULTIRACIAL NON-HISPANIC	5	6	6	0%
72179	NATIVE AMERICAN NON-HISPANIC	1	2	3	50%
72179	OTHER NON-HISPANIC	-	-	-	0%
72179	PACIFIC ISLANDR NON-HISPANIC	-	-	-	0%
72179	WHITE NON-HISPANIC	461	513	539	5%

BHMC - Heber Springs

Zip Code	Ethnicity	2000 Population	2012 Population	2017 Population	2012-2017 Change
72523	ASIAN NON-HISPANIC	1	2	1	-50%
72523	BLACK NON-HISPANIC	-	-	-	0%
72523	HISPANIC	11	15	18	20%
72523	MULTIRACIAL NON-HISPANIC	14	6	5	-17%
72523	NATIVE AMERICAN NON-HISPANIC	3	3	3	0%
72523	OTHER NON-HISPANIC	-	-	-	0%
72523	PACIFIC ISLANDR NON-HISPANIC	-	-	-	0%
72523	WHITE NON-HISPANIC	1,027	1,014	1,021	1%
72530	ASIAN NON-HISPANIC	1	7	8	14%
72530	BLACK NON-HISPANIC	1	2	3	50%
72530	HISPANIC	11	18	23	28%
72530	MULTIRACIAL NON-HISPANIC	14	18	19	6%
72530	NATIVE AMERICAN NON-HISPANIC	9	12	14	17%
72530	OTHER NON-HISPANIC	-	-	-	0%
72530	PACIFIC ISLANDR NON-HISPANIC	-	1	1	0%
72530	WHITE NON-HISPANIC	1,799	1,940	2,034	5%
72543	ASIAN NON-HISPANIC	28	26	29	12%
72543	BLACK NON-HISPANIC	22	48	58	21%
72543	HISPANIC	161	367	451	23%
72543	MULTIRACIAL NON-HISPANIC	71	168	208	24%
72543	NATIVE AMERICAN NON-HISPANIC	47	64	71	11%
72543	OTHER NON-HISPANIC	2	2	2	0%
72543	PACIFIC ISLANDR NON-HISPANIC	4	3	3	0%
72543	WHITE NON-HISPANIC	10,850	11,989	12,427	4%
72546	ASIAN NON-HISPANIC	-	1	1	0%
72546	BLACK NON-HISPANIC	-	-	-	0%
72546	HISPANIC	1	2	1	-50%
72546	MULTIRACIAL NON-HISPANIC	1	-	1	0%
72546	NATIVE AMERICAN NON-HISPANIC	-	-	-	0%
72546	OTHER NON-HISPANIC	-	-	-	0%
72546	PACIFIC ISLANDR NON-HISPANIC	-	-	-	0%
72546	WHITE NON-HISPANIC	106	112	117	4%
72581	ASIAN NON-HISPANIC	-	4	4	0%
72581	BLACK NON-HISPANIC	-	3	5	67%
72581	HISPANIC	5	13	17	31%
72581	MULTIRACIAL NON-HISPANIC	7	5	3	-40%
72581	NATIVE AMERICAN NON-HISPANIC	3	5	6	20%
72581	OTHER NON-HISPANIC	-	-	-	0%
72581	PACIFIC ISLANDR NON-HISPANIC	-	1	1	0%
72581	WHITE NON-HISPANIC	963	1,005	1,044	4%

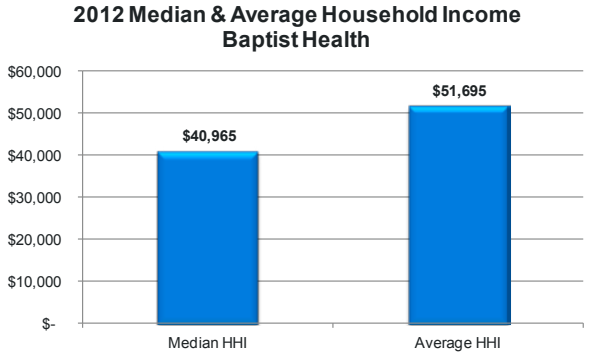
BHMC-Arkadelphia

Zip Code	Ethnicity	2000 Population	2012 Population	2017 Population	2012-2017 Change
71743	ASIAN NON-HISPANIC	2	10	13	30%
71743	BLACK NON-HISPANIC	1,129	1,055	1,056	0%
71743	HISPANIC	144	420	516	23%
71743	MULTIRACIAL NON-HISPANIC	29	51	60	18%
71743	NATIVE AMERICAN NON-HISPANIC	14	10	9	-10%
71743	OTHER NON-HISPANIC	-	2	3	50%
71743	PACIFIC ISLANDR NON-HISPANIC	2	1	1	0%
71743	WHITE NON-HISPANIC	3,096	2,496	2,331	-7%
71921	ASIAN NON-HISPANIC	3	24	29	21%
71921	BLACK NON-HISPANIC	16	16	16	0%
71921	HISPANIC	78	119	141	18%
71921	MULTIRACIAL NON-HISPANIC	19	30	33	10%
71921	NATIVE AMERICAN NON-HISPANIC	17	21	22	5%
71921	OTHER NON-HISPANIC	-	3	4	33%
71921	PACIFIC ISLANDR NON-HISPANIC	-	-	-	0%
71921	WHITE NON-HISPANIC	2,582	2,805	2,884	3%
71923	ASIAN NON-HISPANIC	123	87	74	-15%
71923	BLACK NON-HISPANIC	3,803	4,087	4,199	3%
71923	HISPANIC	344	461	512	11%
71923	MULTIRACIAL NON-HISPANIC	199	214	220	3%
71923	NATIVE AMERICAN NON-HISPANIC	66	50	47	-6%
71923	OTHER NON-HISPANIC	3	20	27	35%
71923	PACIFIC ISLANDR NON-HISPANIC	6	2	3	50%
71923	WHITE NON-HISPANIC	11,524	10,739	10,475	-2%

BHMC-Arkadelphia

Zip Code	Ethnicity	2000 Population	2012 Population	2017 Population	2012-2017 Change
71962	ASIAN NON-HISPANIC	-	-	2	0%
71962	BLACK NON-HISPANIC	148	129	123	-5%
71962	HISPANIC	7	13	14	8%
71962	MULTIRACIAL NON-HISPANIC	13	14	15	7%
71962	NATIVE AMERICAN NON-HISPANIC	3	1	1	0%
71962	OTHER NON-HISPANIC	-	1	-	-100%
71962	PACIFIC ISLANDR NON-HISPANIC	-	-	-	0%
71962	WHITE NON-HISPANIC	673	691	698	1%
71998	ASIAN NON-HISPANIC	5	1	1	0%
71998	BLACK NON-HISPANIC	17	43	51	19%
71998	HISPANIC	4	5	7	40%
71998	MULTIRACIAL NON-HISPANIC	4	3	4	33%
71998	NATIVE AMERICAN NON-HISPANIC	-	3	2	-33%
71998	OTHER NON-HISPANIC	1	2	1	-50%
71998	PACIFIC ISLANDR NON-HISPANIC	-	-	-	0%
71998	WHITE NON-HISPANIC	279	286	284	-1%
71999	ASIAN NON-HISPANIC	14	5	3	-40%
71999	BLACK NON-HISPANIC	101	115	117	2%
71999	HISPANIC	18	17	15	-12%
71999	MULTIRACIAL NON-HISPANIC	3	5	5	0%
71999	NATIVE AMERICAN NON-HISPANIC	4	4	4	0%
71999	OTHER NON-HISPANIC	1	-	-	0%
71999	PACIFIC ISLANDR NON-HISPANIC	1	1	1	0%
71999	WHITE NON-HISPANIC	314	280	265	-5%

BAPTIST HEALTH
HOUSEHOLD INCOME



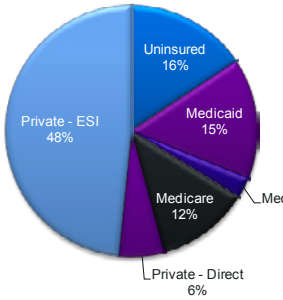
BHMC Community	Zip Code	2012 Total Households	2012 Average Household Income	2012 Median Household Income
Arkadelphia	71743	1,673	$40,655	$32,814
Arkadelphia	71921	1,193	$42,104	$31,658
Arkadelphia	71923	5,993	$41,882	$31,363
Arkadelphia	71962	361	$41,690	$33,673
Arkadelphia	71998	43	$64,767	$42,500
Arkadelphia	71999	92	$36,957	$25,000
Heber Springs	72044	414	$39,185	$31,957
Heber Springs	72067	1,236	$49,284	$38,391
Heber Springs	72130	181	$39,848	$33,030
Heber Springs	72131	1,827	$43,058	$35,602
Heber Springs	72179	228	$45,340	$35,714
Heber Springs	72523	417	$40,588	$33,309
Heber Springs	72530	852	$42,884	$36,250
Heber Springs	72543	5,329	$48,741	$35,479
Heber Springs	72546	50	$49,900	$38,000
Heber Springs	72581	465	$46,435	$41,181
Stuttgart	72003	321	$60,717	$50,469
Stuttgart	72021	1,849	$37,353	$25,247
Stuttgart	72026	150	$56,517	$54,245
Stuttgart	72029	950	$41,695	$30,329
Stuttgart	72038	25	$50,800	$51,389
Stuttgart	72041	705	$39,521	$31,919
Stuttgart	72042	2,202	$42,523	$31,789
Stuttgart	72064	829	$43,305	$34,038
Stuttgart	72069	457	$31,018	$21,037
Stuttgart	72072	223	$38,935	$28,621
Stuttgart	72073	457	$40,700	$31,146
Stuttgart	72134	134	$49,160	$38,158
Stuttgart	72160	4,389	$47,159	$36,364
Stuttgart	72170	121	$41,446	$36,389

BHMC Community	Zip Code	2012 Total Households	2012 Average Household Income	2012 Median Household Income
Little Rock	72002	5,355	$54,340	$46,974
Little Rock	72011	1,626	$53,327	$47,931
Little Rock	72015	10,583	$51,882	$43,648
Little Rock	72019	9,639	$65,603	$52,846
Little Rock	72022	5,919	$62,862	$54,434
Little Rock	72065	1,830	$61,807	$56,670
Little Rock	72103	4,836	$48,600	$41,816
Little Rock	72113	9,451	$85,085	$69,096
Little Rock	72150	4,960	$55,778	$45,146
Little Rock	72201	611	$36,477	$24,928
Little Rock	72202	5,143	$42,521	$24,299
Little Rock	72204	12,033	$39,864	$31,844
Little Rock	72205	11,071	$54,534	$41,054
Little Rock	72206	10,176	$44,143	$34,522
Little Rock	72207	5,471	$86,968	$57,507
Little Rock	72209	11,674	$39,117	$31,672
Little Rock	72210	6,483	$64,564	$51,125
Little Rock	72211	9,932	$71,734	$56,961
Little Rock	72212	5,229	$103,138	$76,206
Little Rock	72223	7,976	$115,345	$85,828
Little Rock	72227	5,420	$74,891	$49,362
North Little Rock	72007	2,947	$61,874	$53,044
North Little Rock	72023	13,193	$62,726	$54,931
North Little Rock	72046	1,856	$41,709	$31,957
North Little Rock	72076	15,332	$46,206	$38,735
North Little Rock	72083	105	$50,143	$38,088
North Little Rock	72086	4,023	$51,021	$42,933
North Little Rock	72099	55	$44,545	$37,500
North Little Rock	72114	5,415	$28,230	$19,902
North Little Rock	72116	9,725	$67,764	$54,453
North Little Rock	72117	4,755	$37,346	$29,879
North Little Rock	72118	9,272	$47,468	$39,136
North Little Rock	72120	13,205	$60,146	$50,550
North Little Rock	72142	1,046	$62,980	$47,857
North Little Rock	72176	3,021	$51,267	$42,858

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BAPTIST HEALTH
INSURANCE COVERAGE

2012 Insurance Coverage by Insurance Type
Baptist Health



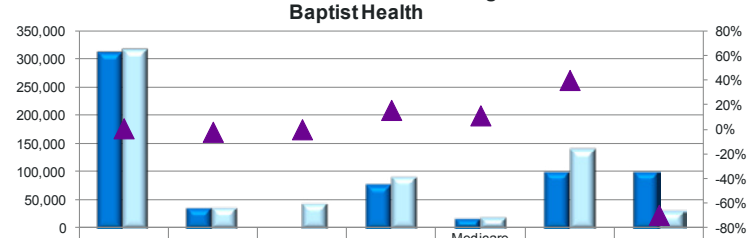
Private ESI (Employer Sponsored Insurance) = Plans offered through an employer

Private Exchanges = Plans purchased via an insurance exchange or insurance market place

Medicare Dual Eligible = Medicare enrollees receiving additional benefits via Medicaid

Private Direct = Individuals who purchase insurance directly from an insurance provider

2012 - 2017 Insurance Coverage
Baptist Health



	Private - ESI	Private - Direct	Private - Exchange	Medicare	Medicare Dual Eligible	Medicaid	Uninsured
2012 Covered Lives	313,129	36,883	0	78,454	17,415	100,104	101,174
2017 Covered Lives	315,620	36,131	44,476	90,794	19,384	140,216	30,789
% Chg	1%	-2%	0%	16%	11%	40%	-70%

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BAPTIST HEALTH
INSURANCE COVERAGE BY ZIP

BHMC-Little Rock

Zip Code	Insurance Type	2012 Covered Lives	2017 Covered Lives	% Chg
72002	Private - ESI	8,829	9,195	4%
72002	Private - Direct	1,033	1,051	2%
72002	Private - Exchange	0	930	N/A
72002	Medicare	1,077	1,481	38%
72002	Medicare Dual Eligible	139	185	33%
72002	Medicaid	1,746	2,348	34%
72002	Uninsured	1,492	522	-65%
72011	Private - ESI	3,052	3,268	7%
72011	Private - Direct	358	377	5%
72011	Private - Exchange	0	294	N/A
72011	Medicare	277	385	39%
72011	Medicare Dual Eligible	37	51	38%
72011	Medicaid	421	578	37%
72011	Uninsured	359	123	-66%
72015	Private - ESI	15,276	16,027	5%
72015	Private - Direct	1,796	1,819	1%
72015	Private - Exchange	0	1,988	N/A
72015	Medicare	2,609	3,135	20%
72015	Medicare Dual Eligible	325	389	20%
72015	Medicaid	4,388	6,042	38%
72015	Uninsured	3,752	1,283	-66%
72019	Private - ESI	16,261	17,053	5%
72019	Private - Direct	1,907	1,970	3%
72019	Private - Exchange	0	1,485	N/A
72019	Medicare	2,175	2,906	34%
72019	Medicare Dual Eligible	274	357	30%
72019	Medicaid	2,424	3,303	36%
72019	Uninsured	2,072	736	-64%

BHMC-Little Rock

Zip Code	Insurance Type	2012 Covered Lives	2017 Covered Lives	% Chg
72022	Private - ESI	9,294	9,979	7%
72022	Private - Direct	1,089	1,153	6%
72022	Private - Exchange	0	937	N/A
72022	Medicare	1,096	1,464	34%
72022	Medicare Dual Eligible	143	185	29%
72022	Medicaid	1,661	2,285	38%
72022	Uninsured	1,420	521	-63%
72065	Private - ESI	3,429	3,493	2%
72065	Private - Direct	404	406	0%
72065	Private - Exchange	0	332	N/A
72065	Medicare	368	507	38%
72065	Medicare Dual Eligible	48	64	33%
72065	Medicaid	541	699	29%
72065	Uninsured	463	156	-66%
72103	Private - ESI	7,762	7,635	-2%
72103	Private - Direct	911	868	-5%
72103	Private - Exchange	0	824	N/A
72103	Medicare	965	1,250	30%
72103	Medicare Dual Eligible	124	156	26%
72103	Medicaid	1,712	2,241	31%
72103	Uninsured	1,463	468	-68%
72113	Private - ESI	14,506	15,711	8%
72113	Private - Direct	1,702	1,846	8%
72113	Private - Exchange	0	1,339	N/A
72113	Medicare	2,218	3,057	38%
72113	Medicare Dual Eligible	514	654	27%
72113	Medicaid	1,784	2,628	47%
72113	Uninsured	1,794	687	-62%

Source: Truven Health Analytics, 2012 (refer to appendix for detailed source notes)

BHMC-Little Rock

Zip Code	Insurance Type	2012 Covered Lives	2017 Covered Lives	% Chg
72150	Private - ESI	6,855	6,765	-1%
72150	Private - Direct	806	774	-4%
72150	Private - Exchange	0	760	N/A
72150	Medicare	1,617	1,953	21%
72150	Medicare Dual Eligible	331	388	17%
72150	Medicaid	1,587	2,081	31%
72150	Uninsured	1,392	444	-68%
72201	Private - ESI	115	124	8%
72201	Private - Direct	14	13	-7%
72201	Private - Exchange	0	88	N/A
72201	Medicare	143	177	24%
72201	Medicare Dual Eligible	34	39	15%
72201	Medicaid	336	507	51%
72201	Uninsured	338	103	-70%
72202	Private - ESI	1,170	1,142	-2%
72202	Private - Direct	138	119	-14%
72202	Private - Exchange	0	788	N/A
72202	Medicare	1,431	1,503	5%
72202	Medicare Dual Eligible	322	336	4%
72202	Medicaid	3,272	4,579	40%
72202	Uninsured	3,290	891	-73%
72204	Private - ESI	10,891	10,507	-4%
72204	Private - Direct	1,289	1,166	-10%
72204	Private - Exchange	0	2,733	N/A
72204	Medicare	3,506	3,835	9%
72204	Medicare Dual Eligible	823	879	7%
72204	Medicaid	7,790	10,846	39%
72204	Uninsured	7,834	2,154	-73%

BHMC-Little Rock

Zip Code	Insurance Type	2012 Covered Lives	2017 Covered Lives	% Chg
72205	Private - ESI	9,740	9,167	-6%
72205	Private - Direct	1,148	1,036	-10%
72205	Private - Exchange	0	1,504	N/A
72205	Medicare	3,671	3,965	8%
72205	Medicare Dual Eligible	853	900	6%
72205	Medicaid	3,656	4,876	33%
72205	Uninsured	3,675	1,038	-72%
72206	Private - ESI	8,485	8,130	-4%
72206	Private - Direct	1,003	907	-10%
72206	Private - Exchange	0	2,051	N/A
72206	Medicare	3,577	3,818	7%
72206	Medicare Dual Eligible	798	836	5%
72206	Medicaid	5,865	8,054	37%
72206	Uninsured	5,898	1,692	-71%
72207	Private - ESI	5,983	5,672	-5%
72207	Private - Direct	705	657	-7%
72207	Private - Exchange	0	572	N/A
72207	Medicare	1,782	1,919	8%
72207	Medicare Dual Eligible	409	432	6%
72207	Medicaid	1,083	1,429	32%
72207	Uninsured	1,089	346	-68%
72209	Private - ESI	12,653	12,243	-3%
72209	Private - Direct	1,492	1,353	-9%
72209	Private - Exchange	0	2,690	N/A
72209	Medicare	2,793	3,095	11%
72209	Medicare Dual Eligible	665	721	8%
72209	Medicaid	7,376	10,325	40%
72209	Uninsured	7,416	2,080	-72%

BHMC-Little Rock

Zip Code	Insurance Type	2012 Covered Lives	2017 Covered Lives	% Chg
72210	Private - ESI	8,480	8,901	5%
72210	Private - Direct	999	1,028	3%
72210	Private - Exchange	0	1,061	N/A
72210	Medicare	1,771	2,269	28%
72210	Medicare Dual Eligible	404	488	21%
72210	Medicaid	1,990	2,921	47%
72210	Uninsured	2,001	689	-66%
72211	Private - ESI	13,260	13,259	0%
72211	Private - Direct	1,564	1,539	-2%
72211	Private - Exchange	0	1,262	N/A
72211	Medicare	2,022	2,482	23%
72211	Medicare Dual Eligible	489	567	16%
72211	Medicaid	1,995	2,778	39%
72211	Uninsured	2,007	647	-68%
72212	Private - ESI	7,870	7,750	-2%
72212	Private - Direct	928	919	-1%
72212	Private - Exchange	0	579	N/A
72212	Medicare	1,795	2,069	15%
72212	Medicare Dual Eligible	399	437	10%
72212	Medicaid	748	1,029	38%
72212	Uninsured	752	257	-66%

BHMC-Little Rock

Zip Code	Insurance Type	2012 Covered Lives	2017 Covered Lives	% Chg
72223	Private - ESI	13,288	14,131	6%
72223	Private - Direct	1,561	1,668	7%
72223	Private - Exchange	0	1,063	N/A
72223	Medicare	2,284	2,959	30%
72223	Medicare Dual Eligible	516	624	21%
72223	Medicaid	1,375	2,025	47%
72223	Uninsured	1,383	527	-62%
72227	Private - ESI	5,386	5,072	-6%
72227	Private - Direct	636	585	-8%
72227	Private - Exchange	0	664	N/A
72227	Medicare	2,176	2,337	7%
72227	Medicare Dual Eligible	483	507	5%
72227	Medicaid	1,477	1,964	33%
72227	Uninsured	1,485	446	-70%
BHMC-Little Rock Total		**356,153**	**375,531**	**5%**

BHMC-North Little Rock

Zip Code	Insurance Type	2012 Covered Lives	2017 Covered Lives	% Chg
72007	Private - ESI	5,125	5,576	9%
72007	Private - Direct	602	646	7%
72007	Private - Exchange	0	523	N/A
72007	Medicare	834	1,132	36%
72007	Medicare Dual Eligible	182	240	32%
72007	Medicaid	809	1,129	40%
72007	Uninsured	691	244	-65%
72023	Private - ESI	22,100	23,503	6%
72023	Private - Direct	2,606	2,733	5%
72023	Private - Exchange	0	2,277	N/A
72023	Medicare	3,381	4,455	32%
72023	Medicare Dual Eligible	748	953	27%
72023	Medicaid	3,731	5,116	37%
72023	Uninsured	3,189	1,111	-65%
72046	Private - ESI	1,425	1,388	-3%
72046	Private - Direct	167	152	-9%
72046	Private - Exchange	0	325	N/A
72046	Medicare	658	697	6%
72046	Medicare Dual Eligible	140	147	5%
72046	Medicaid	1,140	1,531	34%
72046	Uninsured	974	286	-71%
72076	Private - ESI	17,416	16,982	-2%
72076	Private - Direct	2,058	1,922	-7%
72076	Private - Exchange	0	2,914	N/A
72076	Medicare	4,227	4,769	13%
72076	Medicare Dual Eligible	978	1,072	10%
72076	Medicaid	6,874	9,495	38%
72076	Uninsured	6,912	2,025	-71%

BHMC-North Little Rock

Zip Code	Insurance Type	2012 Covered Lives	2017 Covered Lives	% Chg
72083	Private - ESI	121	124	2%
72083	Private - Direct	14	13	-7%
72083	Private - Exchange	0	18	N/A
72083	Medicare	33	41	24%
72083	Medicare Dual Eligible	7	8	14%
72083	Medicaid	54	78	44%
72083	Uninsured	46	15	-67%
72086	Private - ESI	4,917	5,038	2%
72086	Private - Direct	581	575	-1%
72086	Private - Exchange	0	764	N/A
72086	Medicare	1,391	1,634	17%
72086	Medicare Dual Eligible	302	349	16%
72086	Medicaid	1,871	2,541	36%
72086	Uninsured	1,599	510	-68%
72099	Private - ESI	371	339	-9%
72099	Private - Direct	47	41	-13%
72099	Private - Exchange	0	86	N/A
72099	Medicare	12	17	42%
72099	Medicare Dual Eligible	3	5	67%
72099	Medicaid	145	180	24%
72099	Uninsured	147	28	-81%
72114	Private - ESI	583	605	4%
72114	Private - Direct	68	58	-15%
72114	Private - Exchange	0	1,057	N/A
72114	Medicare	1,533	1,545	1%
72114	Medicare Dual Eligible	345	352	2%
72114	Medicaid	5,076	7,334	44%
72114	Uninsured	5,104	1,441	-72%

BHMC-North Little Rock

Zip Code	Insurance Type	2012 Covered Lives	2017 Covered Lives	% Chg
72116	Private - ESI	11,097	10,704	-4%
72116	Private - Direct	1,310	1,252	-4%
72116	Private - Exchange	0	1,135	N/A
72116	Medicare	4,023	4,365	9%
72116	Medicare Dual Eligible	902	958	6%
72116	Medicaid	1,977	2,630	33%
72116	Uninsured	1,988	626	-69%
72117	Private - ESI	3,264	3,200	-2%
72117	Private - Direct	384	351	-9%
72117	Private - Exchange	0	1,080	N/A
72117	Medicare	1,739	1,817	4%
72117	Medicare Dual Eligible	387	404	4%
72117	Medicaid	3,319	4,717	42%
72117	Uninsured	3,337	938	-72%
72118	Private - ESI	9,715	9,535	-2%
72118	Private - Direct	1,145	1,079	-6%
72118	Private - Exchange	0	1,685	N/A
72118	Medicare	2,960	3,204	8%
72118	Medicare Dual Eligible	678	723	7%
72118	Medicaid	4,027	5,628	40%
72118	Uninsured	4,050	1,210	-70%
72120	Private - ESI	18,863	18,826	0%
72120	Private - Direct	2,230	2,193	-2%
72120	Private - Exchange	0	2,004	N/A
72120	Medicare	3,866	4,578	18%
72120	Medicare Dual Eligible	886	1,004	13%
72120	Medicaid	3,280	4,551	39%
72120	Uninsured	3,298	1,054	-68%

BHMC-North Little Rock

Zip Code	Insurance Type	2012 Covered Lives	2017 Covered Lives	% Chg
72142	Private - ESI	1,260	1,303	3%
72142	Private - Direct	150	150	0%
72142	Private - Exchange	0	190	N/A
72142	Medicare	367	443	21%
72142	Medicare Dual Eligible	80	93	16%
72142	Medicaid	395	563	43%
72142	Uninsured	397	133	-66%
72176	Private - ESI	4,608	5,095	11%
72176	Private - Direct	544	579	6%
72176	Private - Exchange	0	597	N/A
72176	Medicare	732	946	29%
72176	Medicare Dual Eligible	163	209	28%
72176	Medicaid	1,168	1,725	48%
72176	Uninsured	999	343	-66%
BHMC-North Little Rock Total		**210,925**	**221,959**	**5%**

BHMC-Stuttgart

Zip Code	Insurance Type	2012 Covered Lives	2017 Covered Lives	% Chg
72003	Private - ESI	377	348	-8%
72003	Private - Direct	44	40	-9%
72003	Private - Exchange	0	43	N/A
72003	Medicare	99	109	10%
72003	Medicare Dual Eligible	29	32	10%
72003	Medicaid	89	115	29%
72003	Uninsured	94	30	-68%
72021	Private - ESI	956	816	-15%
72021	Private - Direct	112	88	-21%
72021	Private - Exchange	0	295	N/A
72021	Medicare	632	612	-3%
72021	Medicare Dual Eligible	340	323	-5%
72021	Medicaid	1,038	1,431	38%
72021	Uninsured	1,282	356	-72%
72026	Private - ESI	171	160	-6%
72026	Private - Direct	21	18	-14%
72026	Private - Exchange	0	18	N/A
72026	Medicare	49	52	6%
72026	Medicare Dual Eligible	15	15	0%
72026	Medicaid	32	41	28%
72026	Uninsured	34	11	-68%
72029	Private - ESI	554	486	-12%
72029	Private - Direct	65	53	-18%
72029	Private - Exchange	0	146	N/A
72029	Medicare	318	330	4%
72029	Medicare Dual Eligible	170	172	1%
72029	Medicaid	447	613	37%
72029	Uninsured	551	158	-71%

BHMC-Stuttgart

Zip Code	Insurance Type	2012 Covered Lives	2017 Covered Lives	% Chg
72038	Private - ESI	29	26	-10%
72038	Private - Direct	4	3	-25%
72038	Private - Exchange	0	3	N/A
72038	Medicare	6	9	50%
72038	Medicare Dual Eligible	2	3	50%
72038	Medicaid	6	7	17%
72038	Uninsured	6	2	-67%
72041	Private - ESI	543	490	-10%
72041	Private - Direct	63	54	-14%
72041	Private - Exchange	0	97	N/A
72041	Medicare	246	261	6%
72041	Medicare Dual Eligible	80	83	4%
72041	Medicaid	298	398	34%
72041	Uninsured	324	94	-71%
72042	Private - ESI	1,721	1,585	-8%
72042	Private - Direct	201	175	-13%
72042	Private - Exchange	0	361	N/A
72042	Medicare	807	874	8%
72042	Medicare Dual Eligible	249	261	5%
72042	Medicaid	1,091	1,483	36%
72042	Uninsured	1,150	339	-71%
72064	Private - ESI	792	740	-7%
72064	Private - Direct	93	82	-12%
72064	Private - Exchange	0	116	N/A
72064	Medicare	352	373	6%
72064	Medicare Dual Eligible	116	121	4%
72064	Medicaid	294	406	38%
72064	Uninsured	320	97	-70%

BHMC-Stuttgart

Zip Code	Insurance Type	2012 Covered Lives	2017 Covered Lives	% Chg
72069	Private - ESI	97	85	-12%
72069	Private - Direct	12	9	-25%
72069	Private - Exchange	0	68	N/A
72069	Medicare	180	176	-2%
72069	Medicare Dual Eligible	98	94	-4%
72069	Medicaid	298	409	37%
72069	Uninsured	367	98	-73%
72072	Private - ESI	156	158	1%
72072	Private - Direct	18	17	-6%
72072	Private - Exchange	0	42	N/A
72072	Medicare	75	80	7%
72072	Medicare Dual Eligible	17	18	6%
72072	Medicaid	154	217	41%
72072	Uninsured	131	38	-71%
72073	Private - ESI	324	286	-12%
72073	Private - Direct	37	32	-14%
72073	Private - Exchange	0	70	N/A
72073	Medicare	145	140	-3%
72073	Medicare Dual Eligible	44	43	-2%
72073	Medicaid	230	298	30%
72073	Uninsured	242	68	-72%
72134	Private - ESI	110	100	-9%
72134	Private - Direct	13	11	-15%
72134	Private - Exchange	0	21	N/A
72134	Medicare	43	48	12%
72134	Medicare Dual Eligible	24	25	4%
72134	Medicaid	49	68	39%
72134	Uninsured	60	18	-70%

BHMC-Stuttgart

Zip Code	Insurance Type	2012 Covered Lives	2017 Covered Lives	% Chg
72160	Private - ESI	4,126	3,840	-7%
72160	Private - Direct	485	428	-12%
72160	Private - Exchange	0	710	N/A
72160	Medicare	1,543	1,692	10%
72160	Medicare Dual Eligible	482	514	7%
72160	Medicaid	1,885	2,558	36%
72160	Uninsured	1,988	599	-70%
72170	Private - ESI	120	112	-7%
72170	Private - Direct	15	12	-20%
72170	Private - Exchange	0	17	N/A
72170	Medicare	44	48	9%
72170	Medicare Dual Eligible	15	16	7%
72170	Medicaid	40	52	30%
72170	Uninsured	43	12	-72%
BHMC-Stuttgart Total		**30,022**	**28,801**	**-4%**

BHMC-Heber Springs

Zip Code	Insurance Type	2012 Covered Lives	2017 Covered Lives	% Chg
72044	Private - ESI	298	287	-4%
72044	Private - Direct	36	32	-11%
72044	Private - Exchange	0	49	N/A
72044	Medicare	255	280	10%
72044	Medicare Dual Eligible	42	46	10%
72044	Medicaid	116	176	52%
72044	Uninsured	139	47	-66%
72067	Private - ESI	1,058	1,019	-4%
72067	Private - Direct	124	117	-6%
72067	Private - Exchange	0	155	N/A
72067	Medicare	635	720	13%
72067	Medicare Dual Eligible	105	116	10%
72067	Medicaid	327	474	45%
72067	Uninsured	393	134	-66%
72130	Private - ESI	195	193	-1%
72130	Private - Direct	23	21	-9%
72130	Private - Exchange	0	27	N/A
72130	Medicare	80	91	14%
72130	Medicare Dual Eligible	15	16	7%
72130	Medicaid	53	82	55%
72130	Uninsured	65	21	-68%
72131	Private - ESI	2,017	1,996	-1%
72131	Private - Direct	237	223	-6%
72131	Private - Exchange	0	290	N/A
72131	Medicare	772	856	11%
72131	Medicare Dual Eligible	138	151	9%
72131	Medicaid	549	844	54%
72131	Uninsured	661	213	-68%
72179	Private - ESI	247	241	-2%
72179	Private - Direct	28	27	-4%
72179	Private - Exchange	0	33	N/A
72179	Medicare	86	112	30%
72179	Medicare Dual Eligible	16	19	19%
72179	Medicaid	68	102	50%
72179	Uninsured	84	27	-68%

BHMC-Heber Springs

Zip Code	Insurance Type	2012 Covered Lives	2017 Covered Lives	% Chg
72523	Private - ESI	450	430	-4%
72523	Private - Direct	53	48	-9%
72523	Private - Exchange	0	72	N/A
72523	Medicare	161	179	11%
72523	Medicare Dual Eligible	30	33	10%
72523	Medicaid	157	228	45%
72523	Uninsured	189	57	-70%
72530	Private - ESI	929	930	0%
72530	Private - Direct	109	104	-5%
72530	Private - Exchange	0	131	N/A
72530	Medicare	345	390	13%
72530	Medicare Dual Eligible	62	68	10%
72530	Medicaid	251	378	51%
72530	Uninsured	302	101	-67%
72543	Private - ESI	4,749	4,671	-2%
72543	Private - Direct	558	521	-7%
72543	Private - Exchange	0	804	N/A
72543	Medicare	2,935	3,324	13%
72543	Medicare Dual Eligible	518	577	11%
72543	Medicaid	1,774	2,669	50%
72543	Uninsured	2,132	683	-68%
72546	Private - ESI	56	54	-4%
72546	Private - Direct	7	6	-14%
72546	Private - Exchange	0	6	N/A
72546	Medicare	17	23	35%
72546	Medicare Dual Eligible	3	4	33%
72546	Medicaid	14	20	43%
72546	Uninsured	17	5	-71%
72581	Private - ESI	451	442	-2%
72581	Private - Direct	54	50	-7%
72581	Private - Exchange	0	62	N/A
72581	Medicare	211	244	16%
72581	Medicare Dual Eligible	36	41	14%
72581	Medicaid	130	187	44%
72581	Uninsured	155	52	-66%
BHMC-Heber Springs Total		**25,717**	**26,831**	**4%**

BHMC-Arkadelphia

Zip Code	Insurance Type	2012 Covered Lives	2017 Covered Lives	% Chg
71743	Private - ESI	1,666	1,550	-7%
71743	Private - Direct	196	172	-12%
71743	Private - Exchange	0	334	N/A
71743	Medicare	570	610	7%
71743	Medicare Dual Eligible	143	149	4%
71743	Medicaid	534	899	68%
71743	Uninsured	935	275	-71%
71921	Private - ESI	1,156	1,129	-2%
71921	Private - Direct	136	125	-8%
71921	Private - Exchange	0	255	N/A
71921	Medicare	484	548	13%
71921	Medicare Dual Eligible	118	130	10%
71921	Medicaid	409	718	76%
71921	Uninsured	715	226	-68%
71923	Private - ESI	5,634	5,346	-5%
71923	Private - Direct	667	591	-11%
71923	Private - Exchange	0	1,497	N/A
71923	Medicare	2,086	2,219	6%
71923	Medicare Dual Eligible	535	557	4%
71923	Medicaid	2,449	4,197	71%
71923	Uninsured	4,289	1,151	-73%

BHMC-Arkadelphia

Zip Code	Insurance Type	2012 Covered Lives	2017 Covered Lives	% Chg
71962	Private - ESI	328	307	-6%
71962	Private - Direct	38	34	-11%
71962	Private - Exchange	0	68	N/A
71962	Medicare	141	158	12%
71962	Medicare Dual Eligible	33	36	9%
71962	Medicaid	112	188	68%
71962	Uninsured	196	62	-68%
71998	Private - ESI	202	198	-2%
71998	Private - Direct	25	23	-8%
71998	Private - Exchange	0	37	N/A
71998	Medicare	8	9	13%
71998	Medicare Dual Eligible	3	3	0%
71998	Medicaid	38	65	71%
71998	Uninsured	67	13	-81%
71999	Private - ESI	167	153	-8%
71999	Private - Direct	20	17	-15%
71999	Private - Exchange	0	50	N/A
71999	Medicare	20	18	-10%
71999	Medicare Dual Eligible	6	6	0%
71999	Medicaid	79	137	73%
71999	Uninsured	137	28	-80%
BHMC- Arkadelphia Total		**24,342**	**24,288**	**0%**

Interview & Focus Group Analysis

INTERVIEW ANALYSIS APPROACH

- Coded participants and consolidated interview responses
- Participant responses were parsed by question/topic and categorized
    - Participants gave multiple responses per question – each response recorded individually
    - Therefore, response count can be greater than number of participants
- Density analysis conducted on responses by category

Interview questions were designed to approach some subjects in a multitude of ways and give the interviewer flexibility in conducting the interview. Therefore not every question is represented with a response table as some question responses were collapsed while others eliminated due to time constraints. Additionally some questions were not designed for response consolidation but used to inform other sections of the analysis.

BHECH INTERVIEW SUMMARY

Questions 1 and 2 were background/ice-breaker questions regarding the community or organization each person represented.

03. What would you say is the current health status of the community?

Response Category	Response Count	Percent of Responses
Fair	5	42%
Poor	4	33%
Fair-Poor	1	8%
Good	1	8%
Very Good	1	8%
Grand Total	**12**	**100%**

03a. Reasoning?

Response Category	Response Count	Percent of Responses
Unhealthy Population	2	40%
Lack of Access to Healthcare	1	20%
Good Access to Healthcare	1	20%
Other	1	20%
Grand Total	**5**	**100%**

04. Top health needs of the community?

Response Category	Response Count	Percent of Responses
Healthcare Providers/Services	8	27%
Chronic Diseases	3	10%
Care Coordination	3	10%
Obesity	3	10%
Food/Nutrition	3	10%
Access	2	7%
Prevention/Lifestyle Modification	2	7%
Cardiovascular	1	3%
Dental	1	3%
Affordable Care	1	3%
Socioeconomic	1	3%
No Needs	1	3%
Sexual Health	1	3%
Grand Total	**30**	**100%**

4c. What is the number one barrier to good health care?

Response Category	Response Count	Percent of Responses
Socioeconomic	6	33%
Health Education	4	22%
Access	3	17%
Food/Nutrition	1	6%
Culture	1	6%
Prevention/Lifestyle Modification	1	6%
Transportation	1	6%
Healthcare Policy/Regulation	1	6%
Grand Total	**18**	**100%**

4d. What concerns you the most about the health of the community?

Response Category	Response Count	Percent of Responses
Socioeconomic	2	33%
Chronic/Other Diseases	2	33%
Obesity	2	33%
Grand Total	**6**	**100%**

05. Leading social determinants of health?

Response Category	Response Count	Percent of Responses
Socioeconomic	17	50%
Culture	4	12%
Food/Nutrition	4	12%
Alcohol/Drug Abuse	3	9%
Transportation	2	6%
Violence/Crime	1	3%
Health Education	1	3%
Smoking	1	3%
Prevention/Lifestyle Modification	1	3%
Grand Total	**34**	**100%**

06. primary health indicators?

Response Category	Response Count	Percent of Responses
Condition/Disease Rates	19	43%
Obesity	6	14%
Hospital/Public Health Measures	4	9%
Smoking	3	7%
Lifestyle Measures	2	5%
Socioeconomic	2	5%
Preventative Care Rates	2	5%
Mortality/Life Expectancy Rates	2	5%
Insurance Coverage	1	2%
ER Visits	1	2%
Injury/Disability Rates	1	2%
Teen Pregnancy	1	2%
Grand Total	**44**	**100%**

07. vulnerable groups/populations?

Response Category	Response Count	Percent of Responses
Elderly	6	32%
Poor	2	11%
Minorities	2	11%
Rural	1	5%
LTAC	1	5%
Un/UnderInsured	1	5%
Other	1	5%
Homeless	1	5%
Women	1	5%
Children/Teens	1	5%
Middle Aged	1	5%
Mental Health	1	5%
Grand Total	**19**	**100%**

09. In terms of specific actions/programs, what do you think could be done to address the health needs we've discussed?

Response Category	Response Count	Percent of Responses
Public Health/Health Outcomes	4	20%
Access/Affordable Care	3	15%
Community Outreach/Education	3	15%
Transportation	2	10%
Specialty Providers/Services	1	5%
Recreation	1	5%
Crime/Violence	1	5%
Social Resources	1	5%
Care Coordination	1	5%
Non-English Speaking Programs	1	5%
Lifestyle	1	5%
Policy	1	5%
Grand Total	**20**	**100%**

10. What are some ways Baptist Health or other organizations can engage the community in addressing health needs?

Response Category	Response Count	Percent of Responses
Community Outreach/Education	4	33%
Community Collaboration	3	25%
Access/Affordable Care	2	17%
Prevention/Screenings	1	8%
Specialty Providers/Services	1	8%
Environment/Socioeconomic	1	8%
Grand Total	**12**	**100%**

13a. Are there any specific organizations in the community that would be a good fit for Baptist Health to partner with to address health needs?

Response Category	Response Count	Percent of Responses
Other LTACHs in the area/region for vent beds; dialysis	1	33%
Disease Specific Organizations (American Heart Association, American Diabetes Association, etc.)	1	33%
DaVita and Fresenius could partner with some of the larger facilities to provide vent/trach services	1	33%
Grand Total	**3**	**100%**

11. What do you consider Baptist Health's role to be in the community?

Response Category	Response Count	Percent of Responses
Leadership	1	100%
Grand Total	**1**	**100%**

12. How is Baptist Health currently meeting the health needs of the community?

Response Category	Response Count	Percent of Responses
Charitable Care	1	50%
Leadership	1	50%
Grand Total	**2**	**100%**

BHMC-Little Rock Focus Group Summary

LOCATION: BHMC-LITTLE ROCK DATE: 9/10/12

DISCUSSION 1:

- What grade do you give the health of this community (A-F)?
    - Write the Grade down on sticky note and place on flipchart/white board
- Discuss as a group the grade chosen
    - What factors did you consider when you chose a grade?
    - What do you think of when you think of health?

RESPONSES:

When asked to grade the health of the community served by BHMC-Little Rock, focus group participants provided three C's, one C-, one D, and one B+. Contributing factors to the lower grades include poor physical health, chronic health conditions such as diabetes, high blood pressure, high rates of stroke, and obesity. Among children, there has been an increase in the rates of Type 1 and Type 2 diabetes.

While Pulaski County ranks well in terms of health compared to other counties in the state, lifestyle choices such as consumption of fast food, use of nicotine/smoking, and alcohol contribute to poor health. Where healthy foods are expensive and possibly difficult to access, fast food outlets provide several cheap options.

Other barriers to good health include transportation and access to affordable care. The Latino community is especially challenged because they do not have insurance, experience long wait times for appointments at the free clinic and usually end up utilizing the emergency department for basic health services. After hours clinics are also not utilized effectively as focus group participants felt there was a low level of awareness of these services, especially among female teenagers. In general, there is a feeling that more clinics are needed in the city to serve the vulnerable populations.

Culturally, a good portion of the community does not have high rates of health literacy and do not understand the value and importance of preventive and screening services. Churches are working to better understand the needs of the community and in general feel the needs of the underserved community are overwhelming.

Engaging the younger population in their healthcare is one way to begin improvement efforts. Access to dental care for children has improved and the trail systems also support a healthier lifestyle. Improved advertising of the after-hours clinic may also help improve access to those who need healthcare services.

DISCUSSION 2:

- Break into 2-3 smaller groups
- As a group identify the top 3 health needs of the community
    - Agree upon the top 3 needs and why
    - Write each need on sticky note and place on flipchart/white board
    - One person from the group share with the larger group why those needs were chosen

RESPONSES:

GROUP 1:

1. Access to a dental care clinic
    a. There is only one free dental clinic.
    b. Dental care is important because it can lead to more serious health problems.
2. Substance abuse
    a. Severe shortage of substance abuse programs.
3. Obesity
    a. Cause of many other health problems
    b. Occurring more frequently in children and resulting in adolescent diabetes. A child in the school system died last week because he had undiagnosed diabetes. It is important to get the parents to understand health problems in their children.
    c. Presence of food deserts

GROUP 2:

1. Education
    a. Need more community outreach to churches, schools, and the police department.
    b. Diabetes and obesity is a huge problem that needs to be addressed.
    c. Mental health and stress is also an important problem. There needs to be more activity around these topics.
    d. Services for disabled children who are not able to exercise
2. More health clinics
    a. When there is no access to trails/parks or other recreational activities, people turn to drugs and alcohol when they are stressed.
3. Improve access to care by connecting people to the resources that are already in place
    a. There is a lack of finances to get the appropriate care.

DISCUSSION 3:

- Stay the same smaller groups
- As a group identify up to 10 community resources (health/community organizations)
    - Work together to identify resources and list on flipchart paper
    - Discuss ways these resources could work together to address the health needs discussed
    - One person from the group share with larger group 2-3 ideas from discussion

RESPONSES:

In general, there is a need for resources to collaborate to get the information and knowledge out to the community. Churches are good instruments for communicating information as they have the attention of large congregations. Disseminating healthcare information should be like communication during a natural disaster – information and help must be readily available. Getting the media (local television stations) involved would help the relay the message of available health services.

GROUP 1:

- Friendly Chapel (soup kitchen)
- Mosaic/Churches
- P.A.R.K. and after school programs
- Boys and Girls Club
- River City Ministry
- Watershed
- Food banks
- Schools
- Goodwill
- Our House
- Hospitals/free clinics
- Homeless shelters
- Trail systems
- Police department
- Colleges

GROUP 2:

- Library
- Community Centers
- Schools
- Churches
- Public services (police department)
- Port authority
- Hospitals
- City/state government
- Police department
- Homeless shelters
- TV/Media

DISCUSSION 4:

- Stay the same smaller groups
- As a group, choose one of the health needs your group identified earlier
- Identify two goals you'd like to accomplish related to the need
    - Goals should be SMART (Specific, Measurable, Attainable, Realistic, Time-sensitive)
- For each goal identify 2-3 action steps that would help achieve the goal

RESPONSES:

Unfortunately, there was no time for this exercise during this focus group session.

Health Resources Available to Meet Identified Needs

BHMC-Little Rock

Other Hospital Facilities

Hospital Name	Address	City	Owner Type	Type of Service
St. Vincent Doctors Hospital	3101 Saint Vincent Cir.	Little Rock	Not-for-Profit	General Medical & Surgical
JL McClellan Memorial VA Hospital	4300 W. 7th St.	Little Rock	Veteran's Administration	General Medical & Surgical
St. Vincent Infirmary Medical Center	2 Saint Vincent Cir.	Little Rock	Not-for-Profit	General Medical & Surgical
Saline Memorial Hospital	1 Medical Park Dr.	Benton	Not-for-Profit	General Medical & Surgical
UAMS Medical Center	4301 W. Markham St.	Little Rock	Local Government	General Medical & Surgical
Arkansas Children's Hospital	1 Children's Way	Little Rock	Nonprofit	Children's General
Rivendell Behavioral Health Services	100 Rivendell Dr.	Benton	For Profit	Children's Psychiatric
Select Specialty Hospital- Little Rock	2 Saint Vincent Cir.	Little Rock	For Profit	Long Term Acute Care
Pinnacle Pointe Behavioral Health	11501 Financial Centre Pkwy.	Little Rock	For Profit	Psychiatric
The BridgeWay Hospital	21 Bridgeway Rd.	North Little Rock	For Profit	Psychiatric
United Methodist Behavioral Hospital	1601 Murphy Dr.	Maumelle	For Profit	Psychiatric
Arkansas State Hospital	305 S. Palm St.	Little Rock	Local Government	Psychiatric
Arkansas Heart Hospital	1701 S. Shackleford Rd.	Little Rock	For Profit	Heart Specialty

Cause of Death: Stroke

Chronic Conditions: Coronary Heart Disease (Pulaski, Grant, Saline)

Program Name	Description	Website	Phone Number	State	County
Arkansas Department of Health Heart Disease and Stroke Prevention			501-661-2942	X	

Program Name	Description	Website	Phone Number	State	County
Arkansas Wellness Coalition (AWC)	Includes members of the health care and employer community whose goal is to improve the health and well-being of all Arkansans through the use of nationally recognized, peer reviewed, clinical guidelines for physician, consumer, and employer education. Develop materials referring to nationally recognized standards such as those put forth by Healthy People 2010, the National Committee of Quality Assurance, and other disease-specific organizations such as the American Diabetes Association and the American Heart Association.		501-661-2942	X	
Southern Ain't Fried Sundays - Arkansas Minority Health Commission	Faith Based Outreach Program SAFS is designed to educate African American churches and organizations about healthier alternatives to preparing and cooking southern-style foods. It is also a mechanism for partnering with these groups in an effort to educate their members about the signs and symptoms of stroke, diabetes, and heart attacks. The program is being revamped to expand its reach to the Hispanic communities and individual participants.	http://www.arminorityhealth.com/programs_saf.html	877-264-2826	X	
UAMS Center for Distance Health AR SAVES Program (Stroke Assistance through Virtual Emergency Support)	A stroke management system specifically targeting patients at rural hospitals to by increasing access to subspecialty expertise through telemedicine technology, thereby engineering a coordinated assessment and care-based plan for Arkansas' stroke patients. Ensuring timely administration of clot-busting drugs to improve the chances of recovery while reducing permanent, stroke-related disability and, quite possibly, mortality.		501-686-8514	X	
Arkansas Chronic Illness Collaborative (ACIC)	The ACIC is a group of health care and public health professionals dedicated to improving the management of chronic diseases. The ACIC is a way for health care clinic teams to use the National Health Disparities Collaborative Chronic Care Model to share ideas and knowledge, learn and apply new techniques, and match medical practices with clinical guidelines based on scientific evidence about what works best (diabetes, cancer and cardiovascular diseases)	http://www.healthy.arkansas.gov/programsServices/chronicDisease/Initiatives/Pages/Acic.aspx		X	

Cause of Death: Cancer (Grant)

Program Name	Description	Website	Phone Number	State	County
Arkansas Cancer Coalition	The Arkansas Cancer Coalition exists to provide a favorable environment for cancer control partners to work to reduce, and ultimately eliminate, the burden of cancer for every person in the state. The Coalition is a partnership of individuals and organizations working together to: Provide an overview of the current status of cancer control in Arkansas Reduce the overall burden of cancer by providing and maintaining a plan of goals and strategies Improve the quality of life for those personally affected by cancer by strengthening and sustaining the cancer control partnership support network	http://www.arcancercoalition.org/resources/reduce-your-risk		X	
Arkansas Chronic Illness Collaborative (ACIC)	The ACIC is a group of health care and public health professionals dedicated to improving the management of chronic diseases. The ACIC is a way for health care clinic teams to use the National Health Disparities Collaborative Chronic Care Model to share ideas and knowledge, learn and apply new techniques, and match medical practices with clinical guidelines based on scientific evidence about what works best (diabetes, cancer and cardiovascular diseases)	http://www.healthy.arkansas.gov/programsServices/chronicDisease/Initiatives/Pages/Acic.aspx		X	

Cause of Death: Chronic Lower Respiratory Disease (Grant)

Program Name	Description	Website	Phone Number	State	County
Arkansas Wellness Coalition (AWC)	Includes members of the health care and employer community whose goal is to improve the health and well-being of all Arkansans through the use of nationally recognized, peer reviewed, clinical guidelines for physician, consumer, and employer education. Develop materials referring to nationally recognized standards such as those put forth by Healthy People 2010, the National Committee of Quality Assurance, and other disease-specific organizations such as the American Diabetes Association and the American Heart Association.		501-661-2942	X	
Arkansas Chronic Illness Collaborative (ACIC)	The ACIC is a group of health care and public health professionals dedicated to improving the management of chronic diseases. The ACIC is a way for health care clinic teams to use the National Health Disparities Collaborative Chronic Care Model to share ideas and knowledge, learn and apply new techniques, and match medical practices with clinical guidelines based on scientific evidence about what works best (diabetes, cancer and cardiovascular diseases)	http://www.healthy.arkansas.gov/programsServices/chronicDisease/Initiatives/Pages/Acic.aspx		X	

Health Outcomes: Low Birth Weight (Grant, Pulaski)

Health Outcomes: Infant Mortality (Pulaski)

Program Name	Description	Website	Phone Number	State	County
Arkansas Department of Health	ADH provides prenatal care to an average of 5,000 women annually at many of the Local Health Units.		1-800-462-0599	X	
Arkansas Department of Health Nurse-Family Partnership	Nurse-Family Partnership is a free, voluntary program that partners first-time moms with registered nurses. NFP is available to any first-time mom who is under her 28th week of pregnancy, and who is below 200% of the Federal poverty level.	http://www.adhhomecare.org/nurse-family-arkansas.htm		X	

Health Outcomes: Poor Physical Health and Mental Health Days (Grant, Saline)

Program Name	Description	Website	Phone Number	State	County
Arkansas Department of Health – Hometown Health Improvement	HHI initiatives currently exist in every county around the state. HHI coalitions do powerful and unique work to improve the health of those in their communities. Once the coalition is established, many communities are choosing to conduct health behavior surveys to gain important information specific to their communities. Many coalitions are now implementing activities to affect the health of the community. Examples of some activities include: tobacco cessation programs for adolescents, household hazardous waste round-up, parenting support groups, local industry wellness programs, health fairs, and health resource guides.				X (All counties)
Chronic Disease Self Management Program – Be Well Live Well	Developed by the Stanford Patient Education Research Center, the evidence based program teaches participants the skills needed to live well with chronic diseases. It also shows participants how to organize their lives, make and achieve goals, eat properly, exercise and communicate effectively with physicians and others. National outcome studies reveal that CDSMP participants experience a marked decrease in the number of hospital stays and doctor visits.	http://www.agec.org/2012/10/cdsmp-branded-for-arkansas-be-well-live-well/		X	

Chronic Conditions: Hypertension (Grant, Saline, Pulaski)

Program Name	Description	Website	Phone Number	State	County
Southern Ain't Fried Sundays - Arkansas Minority Health Commission	Faith Based Outreach Program SAFS is designed to educate African American churches and organizations about healthier alternatives to preparing and cooking southern-style foods. It is also a mechanism for partnering with these groups in an effort to educate their members about the signs and symptoms of stroke, diabetes, and heart attacks. The program is being revamped to expand its reach to the Hispanic communities and individual participants.	http://www.arminorityhealth.com/programs_saf.html	877-264-2826		

Chronic Conditions: Asthma (Grant, Pulaski)

Program Name	Description	Website	Phone Number	State	County
The Delta Area Health Education Center (AHEC)	Utilizing the American Lung Association's curriculums, asthma education is provided to children, parents, caregivers and teachers.		870-572-2727		X Located in Pine Bluff (Jefferson County) Serving Grant County
Arkansas Respiratory Health Association	Services offered: Conduct asthma, COPD and tobacco/cessation educational programs for patients, the general public and schools. Coordinate support groups for COPD patients. Provide continuing educational opportunities for school and healthcare professionals.	http://www.arkresp.org	800-880-5864 ext. 100	X	

Chronic Conditions: Arthritis (Grant, Saline)

Program Name	Description	Website	Phone Number	State	County
Arkansas Arthritis Foundation	Various educational programs	http://www.arthritis.org/arkansas/		X	

Chronic Conditions: Diabetes (Pulaski)
Prevention: Diabetic Screening (Saline, Pulaski)

Program Name	Description	Website	Phone Number	State	County
American Diabetes Association	Educational Resources; Advocacy		(501) 221-7444		X (all counties)
Arkansas Health Care Access Foundation	Locates doctors to donate office visits; prescription assistance; free to those who qualify	http://ahcaf.org/			X (all counties)
Arkansas Wellness Coalition	Includes members of the health care and employer community whose goal is to improve the health and well-being of all Arkansans through the use of nationally recognized, peer reviewed, clinical guidelines for physician, consumer, and employer education. Develop materials referring to nationally recognized standards such as those put forth by Healthy People 2010, the National Committee of Quality Assurance, and other disease-specific organizations such as the American Diabetes Association and the American Heart Association.		501-661-2942	X	

Program Name	Description	Website	Phone Number	State	County
Arkansas Chronic Illness Collaborative (ACIC)	The ACIC is a group of health care and public health professionals dedicated to improving the management of chronic diseases. The ACIC is a way for health care clinic teams to use the National Health Disparities Collaborative Chronic Care Model to share ideas and knowledge, learn and apply new techniques, and match medical practices with clinical guidelines based on scientific evidence about what works best (diabetes, cancer and cardiovascular diseases)	http://www.healthy.arkansas.gov/programsServices/chronicDisease/Initiatives/Pages/Acic.aspx		X	
Diabetes Education Program Sites – Pulaski County	Baptist Health Diabetes Self Mgmt Program – Little Rock The Arkansas Diabetes Self Mgmt Education Program – Little Rock		501-202-1877 501-296-1220 501-552-4763 501-202-3701		X
Center for Healing Hearts and Spirits – Little Rock	Offers health education for diabetes.	http://www.hhscenter.org	501-372-3800		(Little Rock)

Health Behaviors: Obesity (Pulaski, Grant, Saline)

Socioeconomic & Environment: Access to Healthy Food (Pulaski, Grant, Saline)

Socioeconomic & Environment: Percentage of Fast Food Restaurants (Pulaski, Grant, Saline)

Program Name	Description	Website	Phone Number	State	County
Arkansas Department of Health Lifestage Health Branch	Mission is the prevention and reduction of obesity through the adoption of healthy eating practices and increased physical activity. Provides technical assistance, managing and supporting evidence-based programs, disseminating materials and resources, and skills-building within the Agency, in schools, at worksites, among partners and with the general public.		501-661-2099	X	
Arkansas Coalition for Obesity Prevention (ArCOP)	A coalition whose goal is to increase the percentage of Arkansans of all ages who have access to healthy and affordable food and who engage in regular physical activity. Coalition is structured around six working teams: Access to Healthy Foods; Built Environment; Early Childhood and Schools; Healthcare; Worksite Wellness; and Social Marketing	http://www.arkansasobesity.org/		X	

Program Name	Description	Website	Phone Number	State	County
Southern Ain't Fried Sundays - Arkansas Minority Health Commission	Faith Based Outreach Program SAFS is designed to educate African American churches and organizations about healthier alternatives to preparing and cooking southern-style foods. It is also a mechanism for partnering with these groups in an effort to educate their members about the signs and symptoms of stroke, diabetes, and heart attacks. The program is being revamped to expand its reach to the Hispanic communities and individual participants.	http://www.arminorityhealth.com/programs_saf.html	877-264-2826	X	
Arkansas Rice Depot	Arkansas Rice Depot's mission is to find sensible solutions to hunger in Arkansas. • Food For Families: Our statewide free food bank serves 300 church and community hunger organizations • Food For Kids: Backpacks of food and supplies are sent home with children having problems in school due to hunger at home, currently operating in more than 600 schools, serving over 35,000 students and siblings • Food For Seniors: Home-delivered food boxes given each month to seniors	http://ricedepot.org/		X	
Arkansas Department of Health - PEPPI	Peer Exercise Program Promotes Independence is a physical activity program specifically designed for older adults to increase and maintain their level of fitness and independence. The physical activity program includes strength training using resistance bands and walking. PEPPI program provides older Arkansans with the opportunity to learn how to exercise correctly (i.e. using correct techniques) in a safe environment, both physically (at the senior centers, churches, or other community groups), and mentally (among people of similar age and health conditions), and to increase their level of physical activity.	http://www.healthy.arkansas.gov/programsServices/chronicDisease/PhysicalActivity/Pages/default.aspx		X	

Program Name	Description	Website	Phone Number	State	County
Arkansas Department of Health - WIC FMNP	The purposes of the WIC FMNP are to provide fresh, nutritious, unprepared fruits and vegetables from farmers' market to women and children who are nutritionally at risk and to expand the awareness and use of farmers' markets, as well as increase sales at such markets. During the farming season, WIC FMNP provides clients in the WIC Program with checks to purchase locally grown fresh fruits and vegetables sold by authorized farmers at authorized farmers' markets.	http://www.healthy.arkansas.gov/programsServices/WIC/Pages/FMNP.aspx		X	
Arkansas Department of Health Pick a Better Snack Program	The Arkansas 5 A Day Coalition, a partnership of organizations whose mission is to increase Arkansans' consumption of fruits and vegetables, coordinated the implementation of this program in two elementary schools during the 2006-07 and 2007-08 school years. Using Food Stamp Nutrition Education funds, as well as private contributions, the Pick a Better Snack Program has been implemented in more than twenty schools throughout the State. The program has been well received by both teachers and students.	http://www.healthy.arkansas.gov/programsServices/chronicDisease/Nutrition/Pages/Programs.aspx		X	
Arkansas Department of Health Healthy Restaurant Award	The Healthy Arkansas Restaurant Award is a voluntary program that provides public recognition to restaurants that meet certain health criteria. Restaurants self-apply and self-report through a questionnaire-type application. Criteria considered include smoke-free status of facility, labeling of food items, and number and types of healthy nutrition choices that are offered. Applications must be completed by a designee of the restaurant. Menus, inserts or photo of menu board with nutrient information must be submitted with the application to confirm the information.	http://www.healthy.arkansas.gov/programsServices/chronicDisease/Nutrition/Pages/Programs.aspx		X	
Bess Chisum Stephens Community Center	Offers a variety of low-cost exercise classes to the community including aquatic classes	http://centersforyouthandfamilies.org/programs/bess-chisum-stephens-community-center/			X (Little Rock, Pulaski County)

Health Behaviors: Excessive Drinking (Grant, Pulaski)

Program Name	Description	Website	Phone Number	State	County
Arkansas Center for Addictions Research, Education, and Services (AR-CARES)	This comprehensive family treatment program called the Arkansas Center for Addictions Research, Education and Services (Arkansas CARES) focuses on breaking the cycle of maternal addiction.	http://methodistfamily.org/programs/arkansas-CARES.html			X (Little Rock, Pulaski County)

Health Behaviors: Sexually Transmitted Infections (Pulaski)

Program Name	Description	Website	Phone Number	State	County
Arkansas Department of Health STD Testing Center	Future Builders, Inc. 16117 Highway 365 Little Rock, Arkansas 72206 Thursday 10:30 am to 2:30 pm After hours by appointment only		501-897-5566		X
Pulaski County Health Unit Sites – STD Testing	Pulaski County Jacksonville 3000 N 1st Street Jacksonville 501-982-7477 Pulaski County College Station 4206 Frazier Pike College Station 501-490-1602 Pulaski County NLR Health Unit 2800 N Willow North Little Rock 501-791-8551 Pulaski Central Health Unit 3915 W 8th Street Little Rock 501-280-3100		501-982-7477 501-490-1602 501-791-8551 501-280-3100		X

Health Behaviors: Smoking (Grant, Saline)

Program Name	Description	Website	Phone Number	State	County
Stamp Out Smoking	Arkansas Tobacco Quitline: A 24-hour direct line to professionally trained Quit Coaches® waiting to help you fight the good fight, plus a 24-hour online community of support from others who've gone through exactly what you're facing … and you can even get a supply of the latest nicotine replacement therapy medications at no cost.	http://www.stampoutsmoking.com/get-help-to-quit/	1-800-QUIT NOW	x	

Program Name	Description	Website	Phone Number	State	County
Arkansas Department of Health Tobacco Prevention and Cessation Program – STOP Program	The Systems Training Outreach Program (STOP) currently uses Outreach to provide education and support to providers. Increasing the capacity and efficiency of care systems by asking, documenting tobacco use and advising patients to stop, the Outreach Specialists educate healthcare providers to be aware of available and accessible cessation treatment interventions. In particular, the specialists will help providers systematically identify patients who are tobacco users, provide guidance to quit and connect them to available resources to successfully quit.	http://www.healthy.arkansas.gov/programsServices/chronicDisease/coalition/Pages/tobacco.aspx		x	

Access: Lack of PCPs (Grant, Saline)

Program Name	Description	Website	Phone Number	State	County
Arkansas Department of Health Office of Rural Health and Primary Care	Promotes the development of community-based health care services and systems throughout Arkansas to ensure that well managed, quality health services are available to all citizens		501-280-4560	X	
Area Health Education Centers (AHEC)	Programs provide access to medical services for rural residents and education for healthcare students and professionals.	http://ruralhealth.uams.edu/AHEC-Programs			X Located in Pine Bluff (Jefferson County) Serving Grant County
American Academy of Family Physicians	The Arkansas Academy of Family Physicians Foundation and TransforMED, a wholly owned subsidiary of the American Academy of Family Physicians, announced that three family medicine practices have been selected to receive facilitative and financial support as they implement a new model of health care known as the patient-centered medical home.	http://www.transformed.com/news-eventsdetailpage.cfm?listingID=102		X	
University of Arkansas Foundation	Education and Promotion of Physician Assistants in Arkansas	http://www.uamshealth.com/News/UAMSPhysicianAssistantNorthwestArkansasResidencyProgramsReceiveGrantsfromBlueYouFoundation?id=5349&showBack=true&PageIndex=0&cid=4		X	

Program Name	Description	Website	Phone Number	State	County
ADH ConnectCare	ConnectCare works to connect Medicaid and ARKids recipients to a primary care physician and a medical home. Telephone Helpline Specialists who staff a toll-free telephone call center respond to Medicaid and ARKids recipient questions and concerns, give information and offer guidance on accessing resources, and assist clients in locating and assigning a primary care physician.	http://www.healthy.arkansas.gov/programsServices/familyHealth/HealthConnections/Pages/ConnectCare.aspx		X	
Christian Community Care Clinic	Since 1999, our clinic has been providing a variety of health care services to Saline County residents in need.	http://www.bentoncareclinic.com/	501-776-1703		X
Harmony Health Clinic Open Hands College Station Center Shepherd's Hope Neighborhood Health Center Westside	Pulaski County clinics for low income and uninsured individuals in need	http://www.harmonyclinicar.org/ http://jcssi.org http://jcssi.org http://shepherdshopelr.org/ http://www.dolr.org/offices/catholiccharities/westside.php			X

Socioeconomic & Environment: Single-Parent Households (Pulaski)

Program Name	Description	Website	Phone Number	State	County
Arkansas Voices	To advocate for children left behind by incarceration or loss of a parent for any reason and to provide mentoring, services and supports for the children, their caregivers, and incarcerated parents, with the goal of strengthening and empowering the family unit.	http://www.arkansasvoices.org/		X	
Arkansas Single Parent Scholarship Fund	Single Parent Scholarships (SPSF) are given to low-income single parents who are pursuing post-secondary education in preparation for skilled employment. We organize affiliated scholarship funds that serve every county of Arkansas	http://www.aspsf.org/index.html		X	

Socioeconomic & Environment: Violent Crime (Pulaski)

Program Name	Description	Website	Phone Number	State	County
Black on Black Crime Coalition	Driven by its mission to increase public awareness and reduce black on black crime in Pulaski County, the Coalition has developed a plan of action that includes: an education/awareness campaign program initiatives with its partners collaborations with existing organizations that serve citizens and institutions directly and indirectly affected by black on black crime	http://www.hhscenter.org/bonbcrim.html			X
City of Little Rock – Neighborhood Alert Centers	The aim of the Neighborhood Alert Centers is to meet 6 tactical objectives. • Build trust in City Services and Staff • Broadcast a sense of unified neighborhood intolerance for drug and criminal activity • Deny drug dealers and customers access to open space in the neighborhood • Remove the sense of impunity street market dealers feel • Clean up the neighborhoods • Create a climate of achievement and reclaim neighborhood power Alert Center team members have assisted residents to create neighborhood groups such as crime watches and neighborhood associations, as well as neighborhood business organizations and religious organization alliances. They have organized and participated in neighborhood clean-ups. Neighborhood facilitators approached City Hall with the idea of creating a tool lending library through the alert centers so residents would have access to yard tools and lawn mowers to promote neighborhood beautification. Frequent neighborhood functions, alert center open houses and block parties are held to boost neighbor-to-neighbor and neighbor-to-City Staff relations.	http://www.littlerock.org/citydepartments/housing_programs/alertcenters/goals.aspx			
Pulaski County Youth Services	Take a holistic approach to curb the problems of gangs, violence, crime and substance abuse while enhancing the well-being of the community, children, youth and families by getting parents and community members involved in the lives of children and youth.	http://co.pulaski.ar.us/youthservices.shtml	501-340-8250		X

BHMC-North Little Rock

Other Hospital Facilities

Hospital Name	Address	City	Owner Type	Type of Service
Central Arkansas Veteran's Healthcare Towbin Healthcare Center	2200 Fort Roots Dr.	North Little Rock	Veteran's Administration	General Medical & Surgical
St. Vincent Medical Center North	2215 Wildwood Ave.	Sherwood	Not-for-profit	General Medical & Surgical
North Metro Medical Center	1400 Braden St.	Jacksonville	Local Government	General Medical & Surgical
Arkansas Surgical Hospital	5201 N. Shore Dr.	North Little Rock	For Profit	Surgical
Allegiance Behavioral Health Hospital of Jacksonville	1400 W. Braden St.	Jacksonville	For Profit	Long Term Acute Care
St. Vincent North Rehabilitation Hospital (in partnership with Healthsouth)	2201 Wildwood Ave.	Sherwood	For Profit	Rehabilitation

Cause of Death: Stroke (Lonoke)

Chronic Conditions: Coronary Heart Disease (Pulaski, Lonoke)

Program Name	Description	Website	Phone Number	State	County
Arkansas Department of Health Heart Disease and Stroke Prevention			501-661-2942	x	
Arkansas Wellness Coalition (AWC)	Includes members of the health care and employer community whose goal is to improve the health and well-being of all Arkansans through the use of nationally recognized, peer reviewed, clinical guidelines for physician, consumer, and employer education. Develop materials referring to nationally recognized standards such as those put forth by Healthy People 2010, the National Committee of Quality Assurance, and other disease-specific organizations such as the American Diabetes Association and the American Heart Association.		501-661-2942	x	

Program Name	Description	Website	Phone Number	State	County
Southern Ain't Fried Sundays - Arkansas Minority Health Commission	Faith Based Outreach Program SAFS is designed to educate African American churches and organizations about healthier alternatives to preparing and cooking southern-style foods. It is also a mechanism for partnering with these groups in an effort to educate their members about the signs and symptoms of stroke, diabetes, and heart attacks. The program is being revamped to expand its reach to the Hispanic communities and individual participants.	http://www.arminorityhealth.com/programs_saf.html	877-264-2826	X	
ARCare	ARcare offers specialized treatment for a variety of cardiovascular conditions including coronary artery disease, heart attack, high blood pressure, high cholesterol, angina, and all other conditions related to the heart and its blood vessel system. Board-Certified Physicians will screen you for heart problems and educate you about healthy lifestyles, regardless of your ability to pay. At ARcare's Health Care, we offer state-of-the-art cardiology care for people with insurance, those without insurance, and those that are underinsured.	http://www.arcare.net/OurServices/OurServicesContinuedpart2/tabid/14185/Default.aspx#cardiology			X (Lonoke County)
UAMS Center for Distance Health AR SAVES Program (Stroke Assistance through Virtual Emergency Support	A stroke management system specifically targeting patients at rural hospitals to by increasing access to subspecialty expertise through telemedicine technology, thereby engineering a coordinated assessment and care-based plan for Arkansas' stroke patients. Ensuring timely administration of clot-busting drugs to improve the chances of recovery while reducing permanent, stroke-related disability and, quite possibly, mortality.		501-686-8514	X	

Program Name	Description	Website	Phone Number	State	County
Arkansas Chronic Illness Collaborative (ACIC)	The ACIC is a group of health care and public health professionals dedicated to improving the management of chronic diseases. The ACIC is a way for health care clinic teams to use the National Health Disparities Collaborative Chronic Care Model to share ideas and knowledge, learn and apply new techniques, and match medical practices with clinical guidelines based on scientific evidence about what works best (diabetes, cancer and cardiovascular diseases)	http://www.healthy.arkansas.gov/programsServices/chronicDisease/Initiatives/Pages/Acic.aspx		X	

Cause of Death: Cancer (Lonoke)

Program Name	Description	Website	Phone Number	State	County
Arkansas Cancer Coalition	The Arkansas Cancer Coalition exists to provide a favorable environment for cancer control partners to work to reduce, and ultimately eliminate, the burden of cancer for every person in the state. The Coalition is a partnership of individuals and organizations working together to: • Provide an overview of the current status of cancer control in Arkansas • Reduce the overall burden of cancer by providing and maintaining a plan of goals and strategies • Improve the quality of life for those personally affected by cancer by strengthening and sustaining the cancer control partnership support network	http://www.arcancercoalition.org/resources/reduce-your-risk		X	

Arkansas Chronic Illness Collaborative (ACIC)	The ACIC is a group of health care and public health professionals dedicated to improving the management of chronic diseases. The ACIC is a way for health care clinic teams to use the National Health Disparities Collaborative Chronic Care Model to share ideas and knowledge, learn and apply new techniques, and match medical practices with clinical guidelines based on scientific evidence about what works best (diabetes, cancer and cardiovascular diseases)	http://www.healthy.arkansas.gov/programsServices/chronicDisease/Initiatives/Pages/Acic.aspx		X	

Cause of Death: Chronic Lower Respiratory Disease (Lonoke)

Program Name	Description	Website	Phone Number	State	County
Arkansas Wellness Coalition (AWC)	Includes members of the health care and employer community whose goal is to improve the health and well-being of all Arkansans through the use of nationally recognized, peer reviewed, clinical guidelines for physician, consumer, and employer education. Develop materials referring to nationally recognized standards such as those put forth by Healthy People 2010, the National Committee of Quality Assurance, and other disease-specific organizations such as the American Diabetes Association and the American Heart Association.		501-661-2942	X	
Arkansas Chronic Illness Collaborative (ACIC)	The ACIC is a group of health care and public health professionals dedicated to improving the management of chronic diseases. The ACIC is a way for health care clinic teams to use the National Health Disparities Collaborative Chronic Care Model to share ideas and knowledge, learn and apply new techniques, and match medical practices with clinical guidelines based on scientific evidence about what works best (diabetes, cancer and cardiovascular diseases)	http://www.healthy.arkansas.gov/programsServices/chronicDisease/Initiatives/Pages/Acic.aspx		x	

Health Outcomes: Low Birth Weight (Pulaski)
Health Outcomes: Infant Mortality (Pulaski)

Program Name	Description	Website	Phone Number	State	County
Arkansas Department of Health	ADH provides prenatal care to an average of 5,000 women annually at many of the Local Health Units.		1-800-462-0599	X	
Arkansas Department of Health Nurse-Family Partnership	Nurse-Family Partnership is a free, voluntary program that partners first-time moms with registered nurses. NFP is available to any first-time mom who is under her 28th week of pregnancy, and who is below 200% of the Federal poverty level.	http://www.adhhomecare.org/nurse-family-arkansas.htm		X	

Health Outcomes: Poor or Fair Health Status (Lonoke)

Program Name	Description	Website	Phone Number	State	County
ADH – Hometown Health Improvement	Hometown Health Improvement initiatives currently exist in every county around the state. HHI coalitions do powerful and unique work to improve the health of those in their communities. Once the coalition is established, many communities are choosing to conduct health behavior surveys to gain important information specific to their communities. Many coalitions are now implementing activities to affect the health of the community. Examples of some activities include: tobacco cessation programs for adolescents, household hazardous waste round-up, parenting support groups, local industry wellness programs, health fairs, and health resource guides.				X (All counties)
Chronic Disease Self Management Program – Be Well Live Well	Developed by the Stanford Patient Education Research Center, the evidence based program teaches participants the skills needed to live well with chronic diseases. It also shows participants how to organize their lives, make and achieve goals, eat properly, exercise and communicate effectively with physicians and others. National outcome studies reveal that CDSMP participants experience a marked decrease in the number of hospital stays and doctor visits.	http://www.agec.org/2012/10/cdsmp-branded-for-arkansas-be-well-live-well/		X	

Chronic Conditions: Hypertension (Pulaski)

Program Name	Description	Website	Phone Number	State	County
Southern Ain't Fried Sundays - Arkansas Minority Health Commission	Faith Based Outreach Program SAFS is designed to educate African American churches and organizations about healthier alternatives to preparing and cooking southern-style foods. It is also a mechanism for partnering with these groups in an effort to educate their members about the signs and symptoms of stroke, diabetes, and heart attacks. The program is being revamped to expand its reach to the Hispanic communities and individual participants.	http://www.arminorityhealth.com/programs_saf.html	877-264-2826		

Chronic Conditions: Asthma (Pulaski)

Program Name	Description	Website	Phone Number	State	County
Arkansas Respiratory Health Association	Services offered: Conduct asthma, COPD and tobacco/cessation educational programs for patients, the general public and schools. Coordinate support groups for COPD patients. Provide continuing educational opportunities for school and healthcare professionals.	http://www.arkresp.org	800-880-5864 ext. 100	X	

Chronic Conditions: Diabetes (Pulaski, Lonoke)
Prevention: Diabetic Screening (Pulaski)

Program Name	Description	Website	Phone Number	State	County
American Diabetes Association	Educational Resources; Advocacy		(501) 221-7444		X (all counties)
Arkansas Health Care Access Foundation	Locates doctors to donate office visits; prescription assistance; free to those who qualify	http://ahcaf.org/			X (all counties)

Program Name	Description	Website	Phone Number	State	County
Arkansas Wellness Coalition	Includes members of the health care and employer community whose goal is to improve the health and well-being of all Arkansans through the use of nationally recognized, peer reviewed, clinical guidelines for physician, consumer, and employer education. Develop materials referring to nationally recognized standards such as those put forth by Healthy People 2010, the National Committee of Quality Assurance, and other disease-specific organizations such as the American Diabetes Association and the American Heart Association.		501-661-2942	X	
Arkansas Chronic Illness Collaborative (ACIC)	The ACIC is a group of health care and public health professionals dedicated to improving the management of chronic diseases. The ACIC is a way for health care clinic teams to use the National Health Disparities Collaborative Chronic Care Model to share ideas and knowledge, learn and apply new techniques, and match medical practices with clinical guidelines based on scientific evidence about what works best (diabetes, cancer and cardiovascular diseases)	http://www.healthy.arkansas.gov/programsServices/chronicDisease/Initiatives/Pages/Acic.aspx		X	
Diabetes Education Program Sites – Pulaski County	Baptist Health Diabetes Self Mgmt Program – Little Rock The Arkansas Diabetes Self Mgmt Education Program – Little Rock Baptist Health Diabetes Health Management Center–North Little Rock		501-202-1877 501-296-1220 501-202-3701		X
ARCare	The ARcare Diabetes Self-Management Program is an AADE recognized education program.	http://www.arcare.net/OurServices/OurServicesContinued/tabid/13586/Default.aspx	870-347-2534		X (Lonoke County)
Arkansas Human Development Corporation - Lonoke	Assist the Hispanic and Latin American populations of Arkansas along with other individuals who are economically disadvantaged to learn skills that promote healthy lifestyles. Services: Diabetes, Sexuality/Reproductive Health Education, Health Fairs, Hypertension, Poison Safety Education, Sexually Transmitted Disease, Smoking Education/Prevention.	http://www.arhdc.org	501-676-2721		X

Health Behaviors: Obesity (Pulaski, Lonoke)

Socioeconomic & Environment: Access to Healthy Food (Pulaski, Lonoke)

Socioeconomic & Environment: Percentage of Fast Food Restaurants (Pulaski, Lonoke)

Program Name	Description	Website	Phone Number	State	County
Arkansas Department of Health Lifestage Health Branch	Mission is the prevention and reduction of obesity through the adoption of healthy eating practices and increased physical activity. Provides technical assistance, managing and supporting evidence-based programs, disseminating materials and resources, and skills-building within the Agency, in schools, at worksites, among partners and with the general public.		501-661-2099	X	
Arkansas Coalition for Obesity Prevention (ArCOP)	A coalition whose goal is to increase the percentage of Arkansans of all ages who have access to healthy and affordable food and who engage in regular physical activity. Coalition is structured around six working teams: Access to Healthy Foods; Built Environment; Early Childhood and Schools; Healthcare; Worksite Wellness; and Social Marketing	http://www.arkansasobesity.org/		X	
Southern Ain't Fried Sundays - Arkansas Minority Health Commission	Faith Based Outreach Program SAFS is designed to educate African American churches and organizations about healthier alternatives to preparing and cooking southern-style foods. It is also a mechanism for partnering with these groups in an effort to educate their members about the signs and symptoms of stroke, diabetes, and heart attacks. The program is being revamped to expand its reach to the Hispanic communities and individual participants.	http://www.arminorityhealth.com/programs_saf.html	877-264-2826	X	

Program Name	Description	Website	Phone Number	State	County
Arkansas Rice Depot	Arkansas Rice Depot's mission is to find sensible solutions to hunger in Arkansas. • Food For Families: Our statewide free food bank serves 300 church and community hunger organizations • Food For Kids: Backpacks of food and supplies are sent home with children having problems in school due to hunger at home, currently operating in more than 600 schools, serving over 35,000 students and siblings • Food For Seniors: Home-delivered food boxes given each month to seniors	http://ricedepot.org/		X	
ADH - PEPPI	Peer Exercise Program Promotes Independence is a physical activity program specifically designed for older adults to increase and maintain their level of fitness and independence. The physical activity program includes strength training using resistance bands and walking. PEPPI program provides older Arkansans with the opportunity to learn how to exercise correctly (i.e. using correct techniques) in a safe environment, both physically (at the senior centers, churches, or other community groups), and mentally (among people of similar age and health conditions), and to increase their level of physical activity.	http://www.healthy.arkansas.gov/programsServices/chronicDisease/PhysicalActivity/Pages/default.aspx		X	
ADH - WIC FMNP	The purposes of the WIC FMNP are to provide fresh, nutritious, unprepared fruits and vegetables from farmers' market to women and children who are nutritionally at risk and to expand the awareness and use of farmers' markets, as well as increase sales at such markets. During the farming season, WIC FMNP provides clients in the WIC Program with checks to purchase locally grown fresh fruits and vegetables sold by authorized farmers at authorized farmers' markets.	http://www.healthy.arkansas.gov/programsServices/WIC/Pages/FMNP.aspx		X	

Program Name	Description	Website	Phone Number	State	County
ADH Pick a Better Snack Program	The Arkansas 5 A Day Coalition, a partnership of organizations whose mission is to increase Arkansans' consumption of fruits and vegetables, coordinated the implementation of this program in two elementary schools during the 2006-07 and 2007-08 school years. Using Food Stamp Nutrition Education funds, as well as private contributions, the Pick a Better Snack Program has been implemented in more than twenty schools throughout the State. The program has been well received by both teachers and students.	http://www.healthy.arkansas.gov/programsServices/chronicDisease/Nutrition/Pages/Programs.aspx		X	
ADH Healthy Restaurant Award	The Healthy Arkansas Restaurant Award is a voluntary program that provides public recognition to restaurants that meet certain health criteria. Restaurants self-apply and self-report through a questionnaire-type application. Criteria considered include smoke-free status of facility, labeling of food items, and number and types of healthy nutrition choices that are offered. Applications must be completed by a designee of the restaurant. Menus, inserts or photo of menu board with nutrient information must be submitted with the application to confirm the information.	http://www.healthy.arkansas.gov/programsServices/chronicDisease/Nutrition/Pages/Programs.aspx		X	
ARCare – SilverSneakers Program	SilverSneakers offers an innovative blend of physical activity, healthy lifestyle, and socially oriented programming that allows older adults to take greater control of their health.	http://www.arcare.net/OurServices/OurServicesContinuedpart3/tabid/14186/Default.aspx#wellness	870-347-1137		X (Lonoke County)
Bess Chisum Stephens Community Center	Offers a variety of low-cost exercise classes to the community including aquatic classes	http://centersforyouthandfamilies.org/programs/bess-chisum-stephens-community-center/			X (Pulaski County)

Health Behaviors: Excessive Drinking (Pulaski, Lonoke)

Program Name	Description	Website	Phone Number	State	County
Arkansas Center for Addictions Research, Education, and Services (AR-CARES)	This comprehensive family treatment program called the Arkansas Center for Addictions Research, Education and Services (Arkansas CARES) focuses on breaking the cycle of maternal addiction.	http://methodistfamily.org/programs/arkansas-CARES.html			X (Pulaski County)

Health Behaviors: Sexually Transmitted Infections (Pulaski)

Program Name	Description	Website	Phone Number	State	County
Arkansas Department of Health STD Testing Center	Future Builders, Inc. 16117 Highway 365 Little Rock, Arkansas 72206 Thursday 10:30 am to 2:30 pm After hours by appointment only		501-897-5566		X
Pulaski County Health Unit Sites – STD Testing	Pulaski County Jacksonville 3000 N 1st Street Jacksonville 501-982-7477 Pulaski County College Station 4206 Frazier Pike College Station 501-490-1602 Pulaski County NLR Health Unit 2800 N Willow North Little Rock 501-791-8551 Pulaski Central Health Unit 3915 W 8th Street Little Rock 501-280-3100		501-982-7477 501-490-1602 501-791-8551 501-280-3100		X

Health Behaviors: Smoking (Grant)

Program Name	Description	Website	Phone Number	State	County
Stamp Out Smoking	Arkansas Tobacco Quitline: A 24-hour direct line to professionally trained Quit Coaches® waiting to help you fight the good fight, plus a 24-hour online community of support from others who've gone through exactly what you're facing … and you can even get a supply of the latest nicotine replacement therapy medications at no cost.	http://www.stampoutsmoking.com/get-help-to-quit/	1-800-QUIT NOW	X	

Program Name	Description	Website	Phone Number	State	County
Arkansas Department of Health Tobacco Prevention and Cessation Program – STOP Program	The Systems Training Outreach Program (STOP) currently uses Outreach to provide education and support to providers. Increasing the capacity and efficiency of care systems by asking, documenting tobacco use and advising patients to stop, the Outreach Specialists educate healthcare providers to be aware of available and accessible cessation treatment interventions. In particular, the specialists will help providers systematically identify patients who are tobacco users, provide guidance to quit and connect them to available resources to successfully quit.	http://www.healthy.arkansas.gov/programsServices/chronicDisease/coalition/Pages/tobacco.aspx		X	

Access: Lack of PCPs (Lonoke)

Program Name	Description	Website	Phone Number	State	County
Arkansas Department of Health Office of Rural Health and Primary Care	Promotes the development of community-based health care services and systems throughout Arkansas to ensure that well managed, quality health services are available to all citizens		501-280-4560	X	
Area Health Education Centers (AHEC)	Programs provide access to medical services for rural residents and education for healthcare students and professionals.	http://ruralhealth.uams.edu/AHEC-Programs			X Located in Pine Bluff (Jefferson County) Serving Lonoke County
American Academy of Family Physicians	The Arkansas Academy of Family Physicians Foundation and TransforMED, a wholly owned subsidiary of the American Academy of Family Physicians, announced that three family medicine practices have been selected to receive facilitative and financial support as they implement a new model of health care known as the patient-centered medical home.	http://www.transformed.com/news-eventsdetailpage.cfm?listingID=102		X	

Program Name	Description	Website	Phone Number	State	County
University of Arkansas Foundation	Education and Promotion of Physician Assistants in Arkansas	http://www.uamshealth.com/News/UAMSPhysicianAssistantNorthwestArkansasResidencyProgramsReceiveGrantsfromBlueYouFoundation?id=5349&showBack=true&PageIndex=0&cid=4		X	
ADH ConnectCare	ConnectCare works to connect Medicaid and ARKids recipients to a primary care physician and a medical home. Telephone Helpline Specialists who staff a toll-free telephone call center respond to Medicaid and ARKids recipient questions and concerns, give information and offer guidance on accessing resources, and assist clients in locating and assigning a primary care physician.	http://www.healthy.arkansas.gov/programsServices/familyHealth/HealthConnections/Pages/ConnectCare.aspx		X	
River City Ministry – North Little Rock	River City Ministry is a faith-based, nonprofit focused on "Opening Doors to God by Serving the Poor". River City Ministry seeks to: FEED the hungry by serving a hot lunch and operating a food pantry, CLOTHE those in need with our clothing bus, SHELTER the homeless with a safe, welcoming environment and through HUD housing programs, CARE for the sick through our pharmacy, medical, vision and dental clinics, and LOVE the unloved and underserved to show God's love!	http://www.rivercityministry.org/	501-376-6694		(North Little Rock)
Gardner Memorial Free Community Medical Clinic	To improve the health (mind, body, spirit) of the people of central Arkansas by assuring access to quality, culturally-sensitive care and health education along the continuum, working in collaboration with local communities and resources.	http://www.gardnermemorialumc.org/health_clinic.html	501-374-8852		Central AR
AR Care – Lonoke County	Carlisle Medical Clinic (870) 552-7303 England Medical Clinic (501) 842-3131 Cabot Medical Clinic (501) 941-3522	http://www.arcare.net/OutLocations.aspx	See under description		X

Socioeconomic & Environment: Single-Parent Households (Pulaski)

Program Name	Description	Website	Phone Number	State	County
Arkansas Voices	To advocate for children left behind by incarceration or loss of a parent for any reason and to provide mentoring, services and supports for the children, their caregivers, and incarcerated parents, with the goal of strengthening and empowering the family unit.	http://www.arkansasvoices.org/		X	
Arkansas Single Parent Scholarship Fund	Single Parent Scholarships (SPSF) are given to low-income single parents who are pursuing post-secondary education in preparation for skilled employment. We organize affiliated scholarship funds that serve every county of Arkansas	http://www.aspsf.org/index.html		X	

Socioeconomic & Environment: Violent Crime (Pulaski)

Program Name	Description	Website	Phone Number	State	County
Black on Black Crime Coalition	Driven by its mission to increase public awareness and reduce black on black crime in Pulaski County, the Coalition has developed a plan of action that includes: • an education/awareness campaign • program initiatives with its partners • collaborations with existing organizations that serve citizens and institutions directly and indirectly affected by black on black crime	http://www.hhscenter.org/bonbcrim.html			X
Pulaski County Youth Services	Take a holistic approach to curb the problems of gangs, violence, crime and substance abuse while enhancing the well-being of the community, children, youth and families by getting parents and community members involved in the lives of children and youth.	http://co.pulaski.ar.us/youthservices.shtml	501-340-8250		X
Mayor's Office of Youth Services – North Little Rock	The Mayor's Office of Youth Services provides an integral function in the reduction of juvenile crime by providing intervention and prevention programming support and consultation to the city's public, private and faith-based youth services agencies.	http://www.northlittlerock.ar.gov/programs-resources/Youth-Services/	501-340-5309		(North Little Rock)

BHMC-Stuttgart

Other Hospital Facilities

Hospital Name	Address	City	Owner Type	Type of Service
Dewitt City Hospital	1641 Whitehead Dr.	DeWitt	Local Government	General Medical & Surgical

Cause of Death: Heart Disease (Arkansas, Monroe, Prairie)

Cause of Death: Stroke (Arkansas, Monroe)

Chronic Conditions: Coronary Heart Disease (Arkansas, Monroe, Prairie)

Program Name	Description	Website	Phone Number	State	County
Arkansas Department of Health Heart Disease and Stroke Prevention			501-661-2942	X	
Arkansas Wellness Coalition (AWC)	Includes members of the health care and employer community whose goal is to improve the health and well-being of all Arkansans through the use of nationally recognized, peer reviewed, clinical guidelines for physician, consumer, and employer education. Develop materials referring to nationally recognized standards such as those put forth by Healthy People 2010, the National Committee of Quality Assurance, and other disease-specific organizations such as the American Diabetes Association and the American Heart Association.		501-661-2942	X	
ARCare	ARcare offers specialized treatment for a variety of cardiovascular conditions including coronary artery disease, heart attack, high blood pressure, high cholesterol, angina, and all other conditions related to the heart and its blood vessel system.	http://www.arcare.net/OurServices/OurServicesContinuedpart2/tabid/14185/Default.aspx#cardiology			X (Monroe, Prairie Counties)

Program Name	Description	Website	Phone Number	State	County
Southern Ain't Fried Sundays - Arkansas Minority Health Commission	Faith Based Outreach Program SAFS is designed to educate African American churches and organizations about healthier alternatives to preparing and cooking southern-style foods. It is also a mechanism for partnering with these groups in an effort to educate their members about the signs and symptoms of stroke, diabetes, and heart attacks. The program is being revamped to expand its reach to the Hispanic communities and individual participants.	http://www.arminorityhealth.com/programs_saf.html	877-264-2826	X	
UAMS Center for Distance Health AR SAVES Program (Stroke Assistance through Virtual Emergency Support	A stroke management system specifically targeting patients at rural hospitals to by increasing access to subspecialty expertise through telemedicine technology, thereby engineering a coordinated assessment and care-based plan for Arkansas' stroke patients. Ensuring timely administration of clot-busting drugs to improve the chances of recovery while reducing permanent, stroke-related disability and, quite possibly, mortality.		501-686-8514	X	
Arkansas Chronic Illness Collaborative (ACIC)	The ACIC is a group of health care and public health professionals dedicated to improving the management of chronic diseases. The ACIC is a way for health care clinic teams to use the National Health Disparities Collaborative Chronic Care Model to share ideas and knowledge, learn and apply new techniques, and match medical practices with clinical guidelines based on scientific evidence about what works best (diabetes, cancer and cardiovascular diseases)	http://www.healthy.arkansas.gov/programsServices/chronicDisease/Initiatives/Pages/Acic.aspx programsServices/chronicDisease/Initiatives/Pages/Acic.aspx		X	

Program Name	Description	Website	Phone Number	State	County
Arkansas Chronic Illness Collaborative (ACIC)	The ACIC is a group of health care and public health professionals dedicated to improving the management of chronic diseases. The ACIC is a way for health care clinic teams to use the National Health Disparities Collaborative Chronic Care Model to share ideas and knowledge, learn and apply new techniques, and match medical practices with clinical guidelines based on scientific evidence about what works best (diabetes, cancer and cardiovascular diseases)	http://www.healthy.arkansas.gov/programsServices/chronicDisease/Initiatives/Pages/Acic.aspx		X	

Cause of Death: Chronic Lower Respiratory Disease (Arkansas)

Program Name	Description	Website	Phone Number	State	County
Arkansas Wellness Coalition (AWC)	Includes members of the health care and employer community whose goal is to improve the health and well-being of all Arkansans through the use of nationally recognized, peer reviewed, clinical guidelines for physician, consumer, and employer education. Develop materials referring to nationally recognized standards such as those put forth by Healthy People 2010, the National Committee of Quality Assurance, and other disease-specific organizations such as the American Diabetes Association and the American Heart Association.		501-661-2942	X	
Arkansas Chronic Illness Collaborative (ACIC)	The ACIC is a group of health care and public health professionals dedicated to improving the management of chronic diseases. The ACIC is a way for health care clinic teams to use the National Health Disparities Collaborative Chronic Care Model to share ideas and knowledge, learn and apply new techniques, and match medical practices with clinical guidelines based on scientific evidence about what works best (diabetes, cancer and cardiovascular diseases)	http://www.healthy.arkansas.gov/programsServices/chronicDisease/Initiatives/Pages/Acic.aspx		X	

Cause of Death: Injury Related Deaths (Monroe)

Program Name	Description	Website	Phone Number	State	County
Arkansas Department of Health – Statewide Injury Prevention Program	The mission of the SIPP is to reduce the burden of injury mortality and morbidity in Arkansas through primary prevention of injuries. SIPP provides technical assistance and serves as a resource center for designated trauma centers, EMS providers, Hometown Health Improvement Coalitions, and Educational Service Cooperatives. SIPP also offers professional education opportunities through live presentations, webinars, and teleconferencing that provide tools to obtain grant funding, and tools to effectively identify, implement, and evaluate injury prevention initiatives at regional and local levels.	http://www.healthy.arkansas.gov/programsServices/injuryPreventionControl/injuryPrevention/SIPP/Pages/default.aspx		X	

Health Outcomes: Low Birth Weight (Arkansas, Monroe, Prairie)

Program Name	Description	Website	Phone Number	State	County
Arkansas Department of Health	ADH provides prenatal care to an average of 5,000 women annually at many of the Local Health Units.		1-800-462-0599	X	
Arkansas Department of Health Nurse-Family Partnership	Nurse-Family Partnership is a free, voluntary program that partners first-time moms with registered nurses. NFP is available to any first-time mom who is under her 28th week of pregnancy, and who is below 200% of the Federal poverty level.	http://www.adhhomecare.org/nurse-family-arkansas.htm		X	

Health Outcomes: Poor or Fair Health Status (Arkansas, Monroe, Prairie)

Program Name	Description	Website	Phone Number	State	County
ADH – Hometown Health Improvement	Hometown Health Improvement initiatives currently exist in every county around the state. HHI coalitions do powerful and unique work to improve the health of those in their communities. Once the coalition is established, many communities are choosing to conduct health behavior surveys to gain important information specific to their communities. Many coalitions are now implementing activities to affect the health of the community. Examples of some activities include: tobacco cessation programs for adolescents, household hazardous waste round-up, parenting support groups, local industry wellness programs, health fairs, and health resource guides.				X (All counties)
Chronic Disease Self Management Program – Be Well Live Well	Developed by the Stanford Patient Education Research Center, the evidence based program teaches participants the skills needed to live well with chronic diseases. It also shows participants how to organize their lives, make and achieve goals, eat properly, exercise and communicate effectively with physicians and others. National outcome studies reveal that CDSMP participants experience a marked decrease in the number of hospital stays and doctor visits.	http://www.agec.org/2012/10/cdsmp-branded-for-arkansas-be-well-live-well/		X	

Health Outcomes: Poor Physical Health and Mental Health Days (Arkansas, Monroe, Prairie)

Program Name	Description	Website	Phone Number	State	County
Chronic Disease Self Management Program – Be Well Live Well	Developed by the Stanford Patient Education Research Center, the evidence based program teaches participants the skills needed to live well with chronic diseases. It also shows participants how to organize their lives, make and achieve goals, eat properly, exercise and communicate effectively with physicians and others. National outcome studies reveal that CDSMP participants experience a marked decrease in the number of hospital stays and doctor visits.	http://www.agec.org/2012/10/cdsmp-branded-for-arkansas-be-well-live-well/		X	

Chronic Conditions: Hypertension (Arkansas)

Program Name	Description	Website	Phone Number	State	County
Southern Ain't Fried Sundays - Arkansas Minority Health Commission	Faith Based Outreach Program SAFS is designed to educate African American churches and organizations about healthier alternatives to preparing and cooking southern-style foods. It is also a mechanism for partnering with these groups in an effort to educate their members about the signs and symptoms of stroke, diabetes, and heart attacks. The program is being revamped to expand its reach to the Hispanic communities and individual participants.	http://www.arminorityhealth.com/programs_saf.html	877-264-2826		
Greater Delta Alliance for Health Mobile Health Screening Unit	GDAH has a fully equipped mobile unit that is utilized to offer free health screenings including breast exams, blood pressure, blood sugar, weight and BMI, HIV screening as well as specialized screenings through community health partners.	http://gdaharkansas.org/services			X (Arkansas County)
Area Health Education Centers (AHEC)	Health Education: Provides health education to adults on a variety of topics including diabetes, heart health, nutrition and healthy eating. Health Screening: Provides health screenings for area organizations and industry in conjunction with health fairs. Also provides information on how to deal with high blood pressure, cholesterol and glucose. Patients with abnormal readings are referred to health care providers		870-572-2727		X Located in Pine Bluff (Jefferson County) Serving Arkansas County

Chronic Conditions: High Cholesterol (Arkansas, Monroe, Prairie)

Program Name	Description	Website	Phone Number	State	County
Southern Ain't Fried Sundays - Arkansas Minority Health Commission	Faith Based Outreach Program SAFS is designed to educate African American churches and organizations about healthier alternatives to preparing and cooking southern-style foods. It is also a mechanism for partnering with these groups in an effort to educate their members about the signs and symptoms of stroke, diabetes, and heart attacks. The program is being revamped to expand its reach to the Hispanic communities and individual participants.	http://www.arminorityhealth.com/programs_saf.html	877-264-2826		

Program Name	Description	Website	Phone Number	State	County
Greater Delta Alliance for Health Mobile Health Screening Unit	GDAH has a fully equipped mobile unit that is utilized to offer free health screenings including breast exams, blood pressure, blood sugar, weight and BMI, HIV screening as well as specialized screenings through community health partners.	http://gdaharkansas.org/services			X (Arkansas County)
Area Health Education Centers (AHEC)	Health Education: Provides health education to adults on a variety of topics including diabetes, heart health, nutrition and healthy eating. Health Screening: Provides health screenings for area organizations and industry in conjunction with health fairs. Also provides information on how to deal with high blood pressure, cholesterol and glucose. Patients with abnormal readings are referred to health care providers		870-572-2727		X Located in Pine Bluff (Jefferson County) Serving Arkansas and Prairie Counties Located in Helena (Phillips County) Serving Monroe County

Chronic Conditions: Asthma (Monroe)

Program Name	Description	Website	Phone Number	State	County
The Delta Area Health Education Center (AHEC)	Utilizing the American Lung Association's curriculums, asthma education is provided to children, parents, caregivers and teachers.		870-572-2727		X (Monroe County)
Arkansas Respiratory Health Association	Services offered: Conduct asthma, COPD and tobacco/cessation educational programs for patients, the general public and schools. Coordinate support groups for COPD patients. Provide continuing educational opportunities for school and healthcare professionals.	http://www.arkresp.org	800-880-5864 ext. 100	X	

Chronic Conditions: Arthritis (Arkansas, Prairie)

Program Name	Description	Website	Phone Number	State	County
Arkansas Arthritis Foundation	Various educational programs	http://www.arthritis.org/arkansas/		X	

Chronic Conditions: Diabetes (Arkansas, Monroe, Prairie)

Program Name	Description	Website	Phone Number	State	County
American Diabetes Association	Educational Resources; Advocacy		(501) 221-7444		X (all counties)

Program Name	Description	Website	Phone Number	State	County
Arkansas Health Care Access Foundation	Locates doctors to donate office visits; prescription assistance; free to those who qualify	http://ahcaf.org/			X (all counties)
Arkansas Wellness Coalition	Includes members of the health care and employer community whose goal is to improve the health and well-being of all Arkansans through the use of nationally recognized, peer reviewed, clinical guidelines for physician, consumer, and employer education. Develop materials referring to nationally recognized standards such as those put forth by Healthy People 2010, the National Committee of Quality Assurance, and other disease-specific organizations such as the American Diabetes Association and the American Heart Association.		501-661-2942	X	
Arkansas Chronic Illness Collaborative (ACIC)	The ACIC is a group of health care and public health professionals dedicated to improving the management of chronic diseases. The ACIC is a way for health care clinic teams to use the National Health Disparities Collaborative Chronic Care Model to share ideas and knowledge, learn and apply new techniques, and match medical practices with clinical guidelines based on scientific evidence about what works best (diabetes, cancer and cardiovascular diseases)	http://www.healthy.arkansas.gov/programs Services/chronic Disease/Initiatives/Pages/Acic.aspx		X	
ARCare	The ARcare Diabetes Self-Management Program is an AADE recognized education program. Our Diabetes Self-Management Program offers individualized assessments and nutrition planning with a registered dietician. Our program also includes one-on-one education, classroom education, support group meetings, cooking classes, and exercise classes at two nursing homes.	http://www.arcare.net/OurServices/OurServices Continued/tabid/13586/Default.aspx	870-347-2534		X (Monroe, Prairie Counties)
Greater Delta Alliance for Health Diabetes Initiative	This project provides support to local diabetics by providing Diabetes Self-Management Education Program, free A1C screenings as well as diabetes awareness events and screenings throughout the six county service areas.	http://gdaharkansas.org/services			X (Arkansas County)
Des Arc Health Center	Diabetes education		870-256-4178		X (Des Arc, Prairie Counties)

Program Name	Description	Website	Phone Number	State	County
Devalls Bluff Health Center			870-998-2511		X (Prairie County)
Area Health Education Centers (AHEC)	Diabetes (1 on 1 and Group) –Provides diabetes education to individuals and groups. Diabetes Support Group - Offers a monthly support group to individuals with diabetes and their friends and families. Health Education: Provides health education to adults on a variety of topics including diabetes, heart health, nutrition and healthy eating. Health Screening: Provides health screenings for area organizations and industry in conjunction with health fairs. Also provides information on how to deal with high blood pressure, cholesterol and glucose. Patients with abnormal readings are referred to health care providers How Healthy is Your Church? -- Provides free health screenings, information and counseling to area churches.		870-572-2727		X Located in Pine Bluff (Jefferson County) Serving Arkansas and Prairie Counties Located in Helena (Phillips County) Serving Monroe County

Health Behaviors: Obesity (Arkansas, Monroe, Prairie)

Health Behaviors: Physical Inactivity (Arkansas, Monroe, Prairie)

Health Behaviors: Lack of Healthy Eating (Arkansas, Monroe, Prairie)

Socioeconomic & Environment: Percentage of Fast Food Restaurants (Arkansas, Monroe)

Program Name	Description	Website	Phone Number	State	County
Arkansas Department of Health Lifestage Health Branch	Mission is the prevention and reduction of obesity through the adoption of healthy eating practices and increased physical activity. Provides technical assistance, managing and supporting evidence-based programs, disseminating materials and resources, and skills-building within the Agency, in schools, at worksites, among partners and with the general public.		501-661-2099	X	

Program Name	Description	Website	Phone Number	State	County
Arkansas Coalition for Obesity Prevention (ArCOP)	A coalition whose goal is to increase the percentage of Arkansans of all ages who have access to healthy and affordable food and who engage in regular physical activity. Coalition is structured around six working teams: Access to Healthy Foods; Built Environment; Early Childhood and Schools; Healthcare; Worksite Wellness; and Social Marketing	http://www.arkansasobesity.org/		X	
Southern Ain't Fried Sundays - Arkansas Minority Health Commission	Faith Based Outreach Program SAFS is designed to educate African American churches and organizations about healthier alternatives to preparing and cooking southern-style foods. It is also a mechanism for partnering with these groups in an effort to educate their members about the signs and symptoms of stroke, diabetes, and heart attacks. The program is being revamped to expand its reach to the Hispanic communities and individual participants.	http://www.arminorityhealth.com/programs_saf.html	877-264-2826	X	
ARCare – SilverSneakers Program	SilverSneakers offers an innovative blend of physical activity, healthy lifestyle, and socially oriented programming that allows older adults to take greater control of their health.	http://www.arcare.net/OurServices/OurServicesContinuedpart3/tabid/14186/Default.aspx#wellness	870-347-1137		X (Monroe, Prairie)
The Monroe County Hometown Health Community Garden	Provides a community garden to the citizens of Monroe County to grow fruits and vegetables				X Brinkley (Monroe County)
Greater Delta Alliance for Health Mobile Health Screening Unit	GDAH has a fully equipped mobile unit that is utilized to offer free health screenings including breast exams, blood pressure, blood sugar, weight and BMI, HIV screening as well as specialized screenings through community health partners.	http://gdaharkansas.org/services			X (Arkansas County)

Program Name	Description	Website	Phone Number	State	County
Area Health Education Centers (AHEC)	Health Education: Provides health education to adults on a variety of topics including diabetes, heart health, nutrition and healthy eating. Health Screening: Provides health screenings for area organizations and industry in conjunction with health fairs. Also provides information on how to deal with high blood pressure, cholesterol and glucose. Patients with abnormal readings are referred to health care providers How Healthy is Your Church? -- Provides free health screenings, information and counseling to area churches.		870-572-2727		X Located in Pine Bluff (Jefferson County) Serving Arkansas and Prairie Counties Located in Helena (Phillips County) Serving Monroe County

Health Behaviors: Sexually Transmitted Infections (Arkansas, Monroe)

Program Name	Description	Website	Phone Number	State	County
Arkansas County Health Unit – STD Testing	Arkansas County Dewitt Health 1616 South Madison De Witt 870-946-2934 Arkansas County Stuttgart 1602 N Buerkle Road Stuttgart 870-673-6601		870-946-2934 870-673-6601		X (Arkansas County)
Monroe County Health Unit – STD testing	306 W Kings Drive Brinkley, AR		870-734-1461		X (Monroe County)

Health Behaviors: Teen Birth Rate (Monroe)

Program Name	Description	Website	Phone Number	State	County
Area Health Education Centers (AHEC)	Teen Pregnancy Prevention Program: Provides prevention education in area schools. The curriculum focuses on refusal skills and making safe choices.		870-572-2727		X Located in Pine Bluff (Jefferson County) Serving Arkansas and Prairie Counties Located in Helena (Phillips County) Serving Monroe County

Arkansas Department of Health	Family Planning Services are provided to teens, women, men and couples, making it possible for them to choose the number and spacing of their children and to prevent unwanted pregnancies	http://www.healthy.arkansas.gov/programs Services/family Health/Health Connections/Pages/Connect Care.aspx			

Prevention: Colorectal Screening (Arkansas, Monroe, Prairie)

Program Name	Description	Website	Phone Number	State	County
The Colorectal Cancer Screening Program (CCSP)	The Colorectal Cancer Screening Program (CCSP) is committed to prevention, early detection and treatment of colorectal cancer. The program is designed to provide equitable access to colorectal cancer screenings throughout the state. CCSP targets its services to minorities and people from disadvantaged socioeconomic backgrounds or underserved communities. Participants in need of follow-up are referred to the appropriate services.	http://cancer.uams.edu/?id=11145&sid=2	877-749-4085 or 501-526-7045	X	

Prevention: Mammography (Arkansas, Monroe, Prairie)

Program Name	Description	Website	Phone Number	State	County
ARCare	The ARcare Comprehensive Breast Program is a service administered by ARcare to meet the needs of uninsured and underinsured women under age 59 who are in need of breast care education, screening, diagnostic, and treatment services. This program provides free clinical breast exams, breast care education, mammograms, and surgical consultation to women who have no coverage for these services	http://www.arcare.net/OurServices/OurServices Continued/tabid/13586/Default.aspx	870-347-2534		X (Monroe, Prairie)
Arkansas' BreastCare Program	BreastCare's mission is to increase the rate of early detection of breast and cervical cancer and reduce the morbidity and mortality rates among women in Arkansas by lowering barriers to screening that result from lack of information, financial means, or access to quality services.	http://www.healthy.arkansas.gov/programs services/chronicdisease /arbreastcare/pages/default.aspx		X	
Greater Delta Alliance for Health Mobile Health Screening Unit	GDAH has a fully equipped mobile unit that is utilized to offer free health screenings including breast exams, blood pressure, blood sugar, weight and BMI, HIV screening as well as specialized screenings through community health partners.	http://gdaharkansas.org/services			X (Arkansas County)

Greater Delta Alliance for Health Access Project Pink	Access Project Pink-Southeast Arkansas is a collaborative effort to provide free mammograms, ultrasounds, and free breast exams to the rural, underserved population of women in fifteen counties in Southeast Arkansas.	http://gdaharkansas.org/services			X (Arkansas County)

Prevention: Flu Shots (Arkansas, Monroe, Prairie)

Program Name	Description	Website	Phone Number	State	County
Arkansas, Monroe and Prairie County Health Units	Mass Flu Clinic: A Mass Flu Clinic is a day-long event during which the community comes together to immunize as many people as possible. Arkansas Department of Health (ADH) staff, health professionals and volunteers work as a team to provide vaccine. Some clinics offer "drive-thrus" – you don't even leave your car.	http://www.healthy.arkansas.gov/programsServices/infectiousDisease/Immunizations/SeasonalFlu/Pages/MassFluClinics.aspx	501-362-7581		X

Prevention: Diabetic Screening (Arkansas, Monroe)

Program Name	Description	Website	Phone Number	State	County
Greater Delta Alliance for Health Diabetes Initiative	This project provides support to local diabetics by providing Diabetes Self-Management Education Program, free A1C screenings as well as diabetes awareness events and screenings throughout the six county service area.	http://gdaharkansas.org/services			X (Arkansas County)

Access: Lack of PCPs (Monroe, Prairie)

Program Name	Description	Website	Phone Number	State	County
ADH Office of Rural Health and Primary Care	Promotes the development of community-based health care services and systems throughout Arkansas to ensure that well managed, quality health services are available to all citizens		501-280-4560	X	
Area Health Education Centers (AHEC)	Programs provide access to medical services for rural residents and education for healthcare students and professionals.	http://ruralhealth.uams.edu/AHEC-Programs			

Access: Uninsured (Arkansas, Monroe, Prairie)

Program Name	Description	Website	Phone Number	State	County
Arkansas Health Care Access Foundation	Serves all qualified applicants who are low-income, uninsured citizens throughout Arkansas. Arkansas Health Care Access Foundation (AHCAF) is a statewide volunteer health care program to help low-income, medically uninsured gain access to non-emergency medical care	http://ahcaf.org/			X (all counties)
Brinkley Health Center and Pharmacy (ARcare)	Offering Pharmacy, Pediatrics, Cardiology, Oral Health & Dentistry, Family Practice, Women's Health, Diabetes Self-Management, HIV/AIDS Care Program, Prescription Medication Assistance Program	http://www.arcare.net	870-734-1150		Brinkley (Monroe County)
Holly Grove Health Center	Offering Dental Care Services, Enabling Services, Primary Medical Care		870-462-3393		Holly Grove (Monroe County)
Mid-Delta Health Systems, Inc	Offering comprehensive primary healthcare services to the entire family. Services include primary medical, dental, mental health and preventive health services.		870-747-3381		Clarendon (Monroe County)
Des Arc Health Center (ARcare)	Offering Pharmacy, Pediatrics, Cardiology, Oral Health & Dentistry, Family Practice, Women's Health, Diabetes Self-Management, HIV/AIDS Care Program, Prescription Medication Assistance Program	http://www.arcare.net	870-256-4178		Des Arc (Prairie County)
Hazen Medical Clinic (ARcare)	Offering Pharmacy, Pediatrics, Cardiology, Oral Health & Dentistry, Family Practice, Women's Health, HIV/AIDS Care Program, Prescription Medication Assistance Program	http://www.arcare.net	870-255-3696		Prairie County
Greater Delta Alliance for Health Medicine Assistance Program	The Delta Medicine Assistance Program (DMAP) is designed to assist persons who have difficulty obtaining prescription medication due to fixed incomes, lack of insurance, or other circumstances that limit their ability to fully comply with their physician's protocol to treat chronic health conditions	http://gdaharkansas.org/services			X (Arkansas County)

BHMC-Heber Springs

Other Hospital Facilities

Hospital Name	Address	City	Owner Type	Type of Service
-	-	-	-	-

Cause of Death: Heart Disease

Chronic Conditions: Coronary Heart Disease

Program Name	Description	Website	Phone Number	State	County
Arkansas Department of Health Heart Disease and Stroke Prevention			501-661-2942	x	
Arkansas Wellness Coalition (AWC)	Includes members of the health care and employer community whose goal is to improve the health and well-being of all Arkansans through the use of nationally recognized, peer reviewed, clinical guidelines for physician, consumer, and employer education. Develop materials referring to nationally recognized standards such as those put forth by Healthy People 2010, the National Committee of Quality Assurance, and other disease-specific organizations such as the American Diabetes Association and the American Heart Association.		501-661-2942	x	
ARCare	ARcare offers specialized treatment for a variety of cardiovascular conditions including coronary artery disease, heart attack, high blood pressure, high cholesterol, angina, and all other conditions related to the heart and its blood vessel system.	http://www.arcare.net/OurServices/OurServicesContinuedpart2/tabid/14185/Default.aspx#cardiology			X
Arkansas Chronic Illness Collaborative (ACIC)	The ACIC is a group of health care and public health professionals dedicated to improving the management of chronic diseases. The ACIC is a way for health care clinic teams to use the National Health Disparities Collaborative Chronic Care Model to share ideas and knowledge, learn and apply new techniques, and match medical practices with clinical guidelines based on scientific evidence about what works best (diabetes, cancer and cardiovascular diseases)	http://www.healthy.arkansas.gov/programsServices/chronicDisease/Initiatives/Pages/Acic.aspx		X	

Cause of Death: Chronic Lower Respiratory Disease

Program Name	Description	Website	Phone Number	State	County
Arkansas Wellness Coalition (AWC)	Includes members of the health care and employer community whose goal is to improve the health and well-being of all Arkansans through the use of nationally recognized, peer reviewed, clinical guidelines for physician, consumer, and employer education. Develop materials referring to nationally recognized standards such as those put forth by Healthy People 2010, the National Committee of Quality Assurance, and other disease-specific organizations such as the American Diabetes Association and the American Heart Association.		501-661-2942	x	
Arkansas Chronic Illness Collaborative (ACIC)	The ACIC is a group of health care and public health professionals dedicated to improving the management of chronic diseases. The ACIC is a way for health care clinic teams to use the National Health Disparities Collaborative Chronic Care Model to share ideas and knowledge, learn and apply new techniques, and match medical practices with clinical guidelines based on scientific evidence about what works best (diabetes, cancer and cardiovascular diseases)	http://www.healthy.arkansas.gov/programsServices/chronicDisease/Initiatives/Pages/Acic.aspx		x	

Health Outcomes: Low Birth Weight

Program Name	Description	Website	Phone Number	State	County
Arkansas Department of Health	ADH provides prenatal care to an average of 5,000 women annually at many of the Local Health Units.		1-800-462-0599	X	
Arkansas Department of Health Nurse-Family Partnership	Nurse-Family Partnership is a free, voluntary program that partners first-time moms with registered nurses. NFP is available to any first-time mom who is under her 28th week of pregnancy, and who is below 200% of the Federal poverty level.	http://www.adhhomecare.org/nurse-family-arkansas.htm		X	

Program Name	Description	Website	Phone Number	State	County
Antenatal & Neonatal Guidelines, Education, and Learning System	ANGELS links clinicians and patients across the state with the University of Arkansas for Medical Sciences, with high-risk pregnancy services, maternal–fetal medicine specialists, and prenatal genetic counselors. The program facilitates telehealth consultation between patients, their local physicians, and medical center specialists through a statewide telemedicine network.	http://www.innovations.ahrq.gov/content.aspx?id=1706		X	

Health Outcomes: Poor or Fair Health Status

Program Name	Description	Website	Phone Number	State	County
Chronic Disease Self Management Program – Be Well Live Well	Developed by the Stanford Patient Education Research Center, the evidence based program teaches participants the skills needed to live well with chronic diseases. It also shows participants how to organize their lives, make and achieve goals, eat properly, exercise and communicate effectively with physicians and others. National outcome studies reveal that CDSMP participants experience a marked decrease in the number of hospital stays and doctor visits.	http://www.agec.org/2012/10/cdsmp-branded-for-arkansas-be-well-live-well/		X	
Arkansas Department of Health – Hometown Health Improvement	Hometown Health Improvement initiatives currently exist in every county around the state. HHI coalitions do powerful and unique work to improve the health of those in their communities. Once the coalition is established, many communities are choosing to conduct health behavior surveys to gain important information specific to their communities. Many coalitions are now implementing activities to affect the health of the community. Examples of some activities include: tobacco cessation programs for adolescents, household hazardous waste round-up, parenting support groups, local industry wellness programs, health fairs, and health resource guides.				X (All counties)

Health Outcomes: Poor Physical Health Days

Program Name	Description	Website	Phone Number	State	County
Chronic Disease Self Management Program – Be Well Live Well	Developed by the Stanford Patient Education Research Center, the evidence based program teaches participants the skills needed to live well with chronic diseases. It also shows participants how to organize their lives, make and achieve goals, eat properly, exercise and communicate effectively with physicians and others. National outcome studies reveal that CDSMP participants experience a marked decrease in the number of hospital stays and doctor visits.	http://www.agec.org/2012/10/cdsmp-branded-for-arkansas-be-well-live-well/		X	
Arkansas Department of Health – Hometown Health Improvement	Hometown Health Improvement initiatives currently exist in every county around the state. HHI coalitions do powerful and unique work to improve the health of those in their communities. Once the coalition is established, many communities are choosing to conduct health behavior surveys to gain important information specific to their communities. Many coalitions are now implementing activities to affect the health of the community. Examples of some activities include: tobacco cessation programs for adolescents, household hazardous waste round-up, parenting support groups, local industry wellness programs, health fairs, and health resource guides.				X (All counties)

Chronic Conditions: Arthritis

Program Name	Description	Website	Phone Number	State	County
City of Heber Springs	Arthritis Foundation Exercise Classes - Recreational exercise program that is designed to address specific therapeutic problems, reduce pain and stiffness, restore or maintain muscle strength & range of motion, improve balance & coordination, decrease fatigue and increase endurance and improve an overall quality of life. Each class is held in the warm water Therapy Pool and is conducted by an Arthritis Foundation certified	http://www.hebersprings parksandrec.com/aquatics/exercisetraining.html	501-661-2942		X (Heber Springs)
Arkansas Arthritis Foundation	Various educational programs	http://www.arthritis.org/arkansas/		X	

Chronic Conditions: High Cholesterol

Program Name	Description	Website	Phone Number	State	County
Southern Ain't Fried Sundays - Arkansas Minority Health Commission	Faith Based Outreach Program SAFS is designed to educate African American churches and organizations about healthier alternatives to preparing and cooking southern-style foods. It is also a mechanism for partnering with these groups in an effort to educate their members about the signs and symptoms of stroke, diabetes, and heart attacks. The program is being revamped to expand its reach to the Hispanic communities and individual participants.	http://www.arminorityhealth.com/programs_saf.html	877-264-2826		

Chronic Conditions: Diabetes

Program Name	Description	Website	Phone Number	State	County
American Diabetes Association	Educational Resources; Advocacy		(501) 221-7444		X (all counties)
Arkansas Health Care Access Foundation	Locates doctors to donate office visits; prescription assistance; free to those who qualify	http://ahcaf.org/			X (all counties)
Arkansas Wellness Coalition	Includes members of the health care and employer community whose goal is to improve the health and well-being of all Arkansans through the use of nationally recognized, peer reviewed, clinical guidelines for physician, consumer, and employer education. Develop materials referring to nationally recognized standards such as those put forth by Healthy People 2010, the National Committee of Quality Assurance, and other disease-specific organizations such as the American Diabetes Association and the American Heart Association.		501-661-2942	X	

Program Name	Description	Website	Phone Number	State	County
Arkansas Chronic Illness Collaborative (ACIC)	The ACIC is a group of health care and public health professionals dedicated to improving the management of chronic diseases. The ACIC is a way for health care clinic teams to use the National Health Disparities Collaborative Chronic Care Model to share ideas and knowledge, learn and apply new techniques, and match medical practices with clinical guidelines based on scientific evidence about what works best (diabetes, cancer and cardiovascular diseases)	http://www.healthy.arkansas.gov/programsServices/chronicDisease/Initiatives/Pages/Acic.aspx		X	
ARCare	The ARcare Diabetes Self-Management Program is an AADE recognized education program. Our Diabetes Self-Management Program offers individualized assessments and nutrition planning with a registered dietitian.	http://www.arcare.net/OurServices/OurServicesContinued/tabid/13586/Default.aspx	870-347-2534		X (Cleburne County)

Health Behaviors: Smoking

Program Name	Description	Website	Phone Number	State	County
Stamp Out Smoking	Arkansas Tobacco Quitline: A 24-hour direct line to professionally trained Quit Coaches® waiting to help you fight the good fight, plus a 24-hour online community of support from others who've gone through exactly what you're facing … and you can even get a supply of the latest nicotine replacement therapy medications at no cost.	http://www.stampoutsmoking.com/get-help-to-quit/	1-800-QUIT NOW	X	
Arkansas Department of Health Tobacco Prevention and Cessation Program – STOP Program	The Systems Training Outreach Program (STOP) currently uses Outreach to provide education and support to providers. Increasing the capacity and efficiency of care systems by asking, documenting tobacco use and advising patients to stop, the Outreach Specialists educate healthcare providers to be aware of available and accessible cessation treatment interventions. In particular, the specialists will help providers systematically identify patients who are tobacco users, provide guidance to quit and connect them to available resources to successfully quit.	http://www.healthy.arkansas.gov/programsServices/chronicDisease/coalition/Pages/tobacco.aspx		X	

Health Behaviors: Physical Inactivity

Program Name	Description	Website	Phone Number	State	County
ARCare – SilverSneakers Program	SilverSneakers offers an innovative blend of physical activity, healthy lifestyle, and socially oriented programming that allows older adults to take greater control of their health.	http://www.arcare.net/OurServices/OurServicesContinuedpart3/tabid/14186/Default.aspx#wellness	870-347-1137		X

Health Behaviors: Excessive Drinking

Program Name	Description	Website	Phone Number	State	County
Health Resources of Arkansas	The Region 3 Prevention Resource Center (PRC), housed at Health Resources is one of 13 centers operated throughout the state. The PRC is a link into the community to promote healthy behaviors and lifestyle changes to prevent the use and abuse of substances.	http://www.healthresourcesofarkansas.com/prevention.php			X

Prevention: Colorectal Screening

Program Name	Description	Website	Phone Number	State	County
The Colorectal Cancer Screening Program (CCSP)	The Colorectal Cancer Screening Program (CCSP) is committed to prevention, early detection and treatment of colorectal cancer. The program is designed to provide equitable access to colorectal cancer screenings throughout the state. CCSP targets its services to minorities and people from disadvantaged socioeconomic backgrounds or underserved communities. Participants in need of follow-up are referred to the appropriate services.	http://cancer.uams.edu/?id=11145&sid=2	877-749-4085 or 501-526-7045	X	

Prevention: Mammography

Program Name	Description	Website	Phone Number	State	County
ARCare	The ARcare Comprehensive Breast Program is a service administered by ARcare to meet the needs of uninsured and underinsured women under age 59 who are in need of breast care education, screening, diagnostic, and treatment services. This program provides free clinical breast exams, breast care education, mammograms, and surgical consultation to women who have no coverage for these services. The target population of the program includes low-income women who are uninsured or underinsured and are living in or can travel to the ARcare service area and meet income and insurance coverage guidelines.	http://www.arcare.net/OurServices/OurServices Continued/tabid/13586/Default.aspx	870-347-2534		x (Cleburne County)
Arkansas' BreastCare Program	BreastCare's mission is to increase the rate of early detection of breast and cervical cancer and reduce the morbidity and mortality rates among women in Arkansas by lowering barriers to screening that result from lack of information, financial means, or access to quality services.	http://www.healthy.arkansas.gov/programs services/chronicdisease/arbreastcare/pages/default.aspx		X	

Prevention: Prostate Screening

Program Name	Description	Website	Phone Number	State	County
Arkansas Prostate Cancer Foundation	Free screenings and education sessions provided throughout Arkansas Mobile Van: Mobile screening unit has a private exam room for men to have a digital rectal exam (DRE) draw blood and preserve it until taken to the lab for analysis. This service is provided free to men who do not have a diagnosis of prostate cancer and are between ages 40 and 75. African-American men and men with a family history of the disease are eligible to begin screening at age 35.	http://www.arprostatecancer.org/home/programs/	501-748-1249	X	

Prevention: Flu Shots

Program Name	Description	Website	Phone Number	State	County
Cleburne County Health Unit	Mass Flu Clinic: A Mass Flu Clinic is a day-long event during which the community comes together to immunize as many people as possible. Arkansas Department of Health (ADH) staff, health professionals and volunteers work as a team to provide vaccine. Some clinics offer "drive-thrus" – you don't even leave your car.	http://www.healthy.arkansas.gov/programsServices/infectiousDisease/Immunizations/SeasonalFlu/Pages/MassFluClinics.aspx	501-362-7581		X

Access: Lack of PCPs

Program Name	Description	Website	Phone Number	State	County
ADH Office of Rural Health and Primary Care	Promotes the development of community-based health care services and systems throughout Arkansas to ensure that well managed, quality health services are available to all citizens		501-280-4560	X	
Area Health Education Centers (AHEC)	Programs provide access to medical services for rural residents and education for healthcare students and professionals.	http://ruralhealth.uams.edu/AHEC-Programs		X	X Located in Batesville (Independence County) Serving Cleburne County

Access: No Personal Doctor

Program Name	Description	Website	Phone Number	State	County
Arkansas Department of Health Office of Rural Health and Primary Care	Promotes the development of community-based health care services and systems throughout Arkansas to ensure that well managed, quality health services are available to all citizens		501-280-4560	X	
ARCare – Heber Springs Family Care Clinic	ARcare offers family practice care to people with insurance, those without insurance, and those who are underinsured	http://www.arcare.net/OurServices/OurServices Continued/tabid/13586/Default.aspx	(501) 362-9426		X (Heber Springs)
Heber Springs Family Health Center	This is a health care center funded by the federal government. This health center can cover services such as checkups, treatment, pregnancy, immunizations and child care prescription medicine and mental and substance abuse where applicable		501-362-9426		X (Heber Springs)

Program Name	Description	Website	Phone Number	State	County
Christian Health Center	The Christian Health Center of Heber Springs, Arkansas provides basic primary care services for the uninsured adults living in and around Cleburne County.	http://www.chchebersprings.org/			X (Heber Springs)

BHMC-Arkadelphia

Other Hospital Facilities

Hospital Name	Address	City	Owner Type	Type of Service
-	-	-	-	-

Cause of Death: Stroke

Program Name	Description	Website	Phone Number	State	County
Arkansas Department of Health Heart Disease and Stroke Prevention			501-661-2942	x	
Arkansas Wellness Coalition (AWC)	Includes members of the health care and employer community whose goal is to improve the health and well-being of all Arkansans through the use of nationally recognized, peer reviewed, clinical guidelines for physician, consumer, and employer education. Develop materials referring to nationally recognized standards such as those put forth by Healthy People 2010, the National Committee of Quality Assurance, and other disease-specific organizations such as the American Diabetes Association and the American Heart Association.		501-661-2942	x	
UAMS Center for Distance Health AR SAVES Program (Stroke Assistance through Virtual Emergency Support)	A stroke management system specifically targeting patients at rural hospitals to by increasing access to subspecialty expertise through telemedicine technology, thereby engineering a coordinated assessment and care-based plan for Arkansas' stroke patients. Ensuring timely administration of clot-busting drugs to improve the chances of recovery while reducing permanent, stroke-related disability and, quite possibly, mortality.		501-686-8514	X	

Program Name	Description	Website	Phone Number	State	County
Arkansas Chronic Illness Collaborative (ACIC)	The ACIC is a group of health care and public health professionals dedicated to improving the management of chronic diseases. The ACIC is a way for health care clinic teams to use the National Health Disparities Collaborative Chronic Care Model to share ideas and knowledge, learn and apply new techniques, and match medical practices with clinical guidelines based on scientific evidence about what works best (diabetes, cancer and cardiovascular diseases)	http://www.healthy.arkansas.gov/programsServices/chronicDisease/Initiatives/Pages/Acic.aspx		X	

Cause of Death: Diabetes

Chronic Conditions: Diabetes

Program Name	Description	Website	Phone Number	State	County
American Diabetes Association	Educational Resources; Advocacy		(501) 221-7444		X (all counties)
Arkansas Health Care Access Foundation	Locates doctors to donate office visits; prescription assistance; free to those who qualify	http://ahcaf.org/			X (all counties)
AllCare Pharmacy	Diabetes Education and Support Group.		(870) 246-3044		Arkadelphia
Clark County Charitable Health Service	Basic physician visits with lab; Assist with writing patient grants; Patient education following ADA guidelines. Available to uninsured and 185% of poverty line.		(870) 230-1309		X (Clark County)
Amity Community Health Center	Assistance with Medical Services; Diabetes Education. Sliding Scale available		(870) 342-5606		Amity
Arkansas Wellness Coalition	Includes members of the health care and employer community whose goal is to improve the health and well-being of all Arkansans through the use of nationally recognized, peer reviewed, clinical guidelines for physician, consumer, and employer education. Develop materials referring to nationally recognized standards such as those put forth by Healthy People 2010, the National Committee of Quality Assurance, and other disease-specific organizations such as the American Diabetes Association and the American Heart Association.		501-661-2942	X	

Program Name	Description	Website	Phone Number	State	County
Arkansas Chronic Illness Collaborative (ACIC)	The ACIC is a group of health care and public health professionals dedicated to improving the management of chronic diseases. The ACIC is a way for health care clinic teams to use the National Health Disparities Collaborative Chronic Care Model to share ideas and knowledge, learn and apply new techniques, and match medical practices with clinical guidelines based on scientific evidence about what works best (diabetes, cancer and cardiovascular diseases)	http://www.healthy.arkansas.gov/programsServices/chronicDisease/Initiatives/Pages/Acic.aspx		X	

Health Outcomes: Poor Physical Health Days

Program Name	Description	Website	Phone Number	State	County
Arkansas Department of Health – Hometown Health Improvement	HHI initiatives currently exist in every county around the state. HHI coalitions do powerful and unique work to improve the health of those in their communities. Once the coalition is established, many communities are choosing to conduct health behavior surveys to gain important information specific to their communities. Many coalitions are now implementing activities to affect the health of the community. Examples of some activities include: tobacco cessation programs for adolescents, household hazardous waste round-up, parenting support groups, local industry wellness programs, health fairs, and health resource guides.				X (All counties)
Chronic Disease Self Management Program – Be Well Live Well	Developed by the Stanford Patient Education Research Center, the evidence based program teaches participants the skills needed to live well with chronic diseases. It also shows participants how to organize their lives, make and achieve goals, eat properly, exercise and communicate effectively with physicians and others. National outcome studies reveal that CDSMP participants experience a marked decrease in the number of hospital stays and doctor visits.	http://www.agec.org/2012/10/cdsmp-branded-for-arkansas-be-well-live-well/		X	

Chronic Conditions: Hypertension

Program Name	Description	Website	Phone Number	State	County
Arkansas Wellness Coalition	Includes members of the health care and employer community whose goal is to improve the health and well-being of all Arkansans through the use of nationally recognized, peer reviewed, clinical guidelines for physician, consumer, and employer education. Develop materials referring to nationally recognized standards such as those put forth by Healthy People 2010, the National Committee of Quality Assurance, and other disease-specific organizations such as the American Diabetes Association and the American Heart Association.		501-661-2942	X	

Chronic Conditions: Arthritis

Program Name	Description	Website	Phone Number	State	County
Arkansas Arthritis Foundation	Various educational programs	http://www.arthritis.org/arkansas/		X	

Health Behaviors: Obesity

Socioeconomic & Environment: Percentage of Fast Food Restaurants

Program Name	Description	Website	Phone Number	State	County
Arkansas Department of Health Lifestage Health Branch	Mission is the prevention and reduction of obesity through the adoption of healthy eating practices and increased physical activity. Provides technical assistance, managing and supporting evidence-based programs, disseminating materials and resources, and skills-building within the Agency, in schools, at worksites, among partners and with the general public.		501-661-2099	X	

Program Name	Description	Website	Phone Number	State	County
Arkansas Coalition for Obesity Prevention (ArCOP)	• A coalition whose goal is to increase the percentage of Arkansans of all ages who have access to healthy and affordable food and who engage in regular physical activity. Coalition is structured around six working teams: Access to Healthy Foods; Built Environment; Early Childhood and Schools; Healthcare; Worksite Wellness; and Social Marketing	http://www.arkansasobesity.org/		X	
Southern Ain't Fried Sundays - Arkansas Minority Health Commission	Faith Based Outreach Program SAFS is designed to educate African American churches and organizations about healthier alternatives to preparing and cooking southern-style foods. It is also a mechanism for partnering with these groups in an effort to educate their members about the signs and symptoms of stroke, diabetes, and heart attacks. The program is being revamped to expand its reach to the Hispanic communities and individual participants.	http://www.arminorityhealth.com/programs_saf.html	877-264-2826	X	
Arkansas Department of Health - WIC FMNP	The purposes of the WIC FMNP are to provide fresh, nutritious, unprepared fruits and vegetables from farmers' market to women and children who are nutritionally at risk and to expand the awareness and use of farmers' markets, as well as increase sales at such markets. During the farming season, WIC FMNP provides clients in the WIC Program with checks to purchase locally grown fresh fruits and vegetables sold by authorized farmers at authorized farmers' markets.	http://www.healthy.arkansas.gov/programsServices/WIC/Pages/FMNP.aspx		X	

Program Name	Description	Website	Phone Number	State	County
Arkansas Department of Health Healthy Restaurant Award	The Healthy Arkansas Restaurant Award is a voluntary program that provides public recognition to restaurants that meet certain health criteria. Restaurants self-apply and self-report through a questionnaire-type application. Criteria considered include smoke-free status of facility, labeling of food items, and number and types of healthy nutrition choices that are offered. Applications must be completed by a designee of the restaurant. Menus, inserts or photo of menu board with nutrient information must be submitted with the application to confirm the information.	http://www.healthy.arkansas.gov/programsServices/chronicDisease/Nutrition/Pages/Programs.aspx		X	

Health Behaviors: Sexually Transmitted Infections

Program Name	Description	Website	Phone Number	State	County
Clark County Health Unit	HIV/ Sexually Transmitted Diseases Counseling, testing and treatment		870-246-4471		X (Clark County)

Prevention: Colorectal Screening

Program Name	Description	Website	Phone Number	State	County
The Colorectal Cancer Screening Program (CCSP)	The Colorectal Cancer Screening Program (CCSP) is committed to prevention, early detection and treatment of colorectal cancer. The program is designed to provide equitable access to colorectal cancer screenings throughout the state. CCSP targets its services to minorities and people from disadvantaged socioeconomic backgrounds or underserved communities. Participants in need of follow-up are referred to the appropriate services.	http://cancer.uams.edu/?id=11145&sid=2	877-749-4085 or 501-526-7045	X	

Prevention: Mammography

Program Name	Description	Website	Phone Number	State	County
BreastCare - Clark County Health Unit	BreastCare offers FREE screening and diagnostic services for Arkansas women along with public and professional education. Free services for those that qualify: Mammograms, Clinical Breast Exams, Pelvic Exams and Pap Tests, Follow-up Tests, if Needed.		870-246-4471		X (Clark County)

Arkansas' BreastCare Program	BreastCare's mission is to increase the rate of early detection of breast and cervical cancer and reduce the morbidity and mortality rates among women in Arkansas by lowering barriers to screening that result from lack of information, financial means, or access to quality services.	http://www.healthy.arkansas.gov/programsservices/chronicdisease/arbreastcare/pages/default.aspx		X	

Access: Lack of PCPs

Program Name	Description	Website	Phone Number	State	County
ADH Office of Rural Health and Primary Care	Promotes the development of community-based health care services and systems throughout Arkansas to ensure that well managed, quality health services are available to all citizens		501-280-4560	X	

Access: Uninsured

Program Name	Description	Website	Phone Number	State	County
Arkansas Health Care Access Foundation	Serves all qualified applicants who are low-income, uninsured citizens throughout Arkansas. Arkansas Health Care Access Foundation (AHCAF) is a statewide volunteer health care program which was developed to help low-income, medically uninsured Arkansans gain access to non-emergency medical care	http://ahcaf.org/			X (all counties)
The Clark County Charitable Health Service (CCCHS)	The Clark County Charitable Health Service provides basic health care for Clark County residents without any form of insurance, including Medicare and Medicaid. Patients must be approved for eligibility. They must meet income requirements based on the national poverty level. All services provided through the clinic are performed in the private offices of local volunteer health care providers, and the services are provided in Clark County five days a week.		(870) 230-1309		X (Clark County)

Socioeconomic & Environment: Single-Parent Households

Program Name	Description	Website	Phone Number	State	County
Clark County WIC					X (Clark County)

Appendix A – Community Health Needs Assessment Data Sources

Health Indicators Warehouse

www.healthindicators.gov

National Vital Statistics System-Mortality (CDC, NCHS)

- 2007-2009 Heart disease death rate
- 2007-2009 Overall cancer death rate
- 2007-2009 Stroke death rate
- 2007-2009 Injury death rate

Linked Birth/Infant Death Data Set (CDC, NCHS)

- 1998-2008 Infant mortality

Arkansas Department of Health

http://www.healthy.arkansas.gov/programsServices/healthstatistics/Pages/default.aspx

Health Statistics Branch (ADH, HSBCS)

- 2005-2007 Chronic lower respiratory disease-related death rate
- 2005-2007 Diabetes-related death rate
- 2010 Injury hospitalization due to MVA
- 2010 Injury hospitalization due to falls
- 2010 Injury hospitalization due to violence

Arkansas Department of Health BRFSS

- 2009 Hypertension
- 2009 High cholesterol
- 2009 Arthritis
- 2009 Consume less than 5 fruits & vegetables per day
- 2010 Doctor diagnosed asthma
- 2010 Diabetes
- 2010 Angina/coronary heart disease
- 2010 Obesity
- 2010 Age 50+ Never had a sigmoidoscopy or colonoscopy
- 2010 Age 40+ No mammogram in past 2 years
- 2010 Age 18+ No pap test in past 3 years
- 2010 Age 40+ No PSA test in 2 years
- 2010 Age 65+ No flu shot in past year
- 2010 Adults Ages 18-64 No HIV test
- 2010 No personal doctor
- 2010 No exercise

- 2004-2010 Binge drinker (Cleburne County)
- 2004-2010 Adult smoking (Cleburne County)

County Health Rankings

http://www.countyhealthrankings.org/

County Health Rankings (NCHS)

- 2002-2008 Low birth weight
- 2002-2008 Teen birth rate
- 2006-2008 YPLL rate

County Health Rankings (BRFSS)

- 2004-2010 Adult Smoking
- 2004-2010 Binge Drinker
- 2006-2010 No emotional support
- 2010 Adults reporting fair or poor health
- 2010 Physically unhealthy days
- 2010 Mentally unhealthy days

County Health Rankings (NCHHSTP)

- 2009 Sexually transmitted infections

County Health Rankings (Medicare/Dartmouth Institute)

- 2009 Diabetic screening
- 2009 Preventable hospital stays

County Health Rankings (Health Resources & Services Administration)

- 2010 Primary care physicians

County Health Rankings (American Community Survey)

- 2006-2010 Single-parent households

County Health Rankings (FBI)

- 2007-2009 Violent crime

County Health Rankings (USDA)

- 2006 Limited access to healthy foods

County Health Rankings (Census County Business Patterns)

- 2009 Fast food restaurants
- 2009 Recreational facility rate

Truven Health Community Need Index

OVERVIEW

Not for profit and community based health systems have long considered community need a core component of their mission of service to local communities. While specific initiatives designed to address health disparities vary across local communities (outreach to migrant farm workers, asthma programs for inner city children, etc), the need to prioritize and effectively distribute hospital resources is a common thread among all providers.

Give the increased transparency of hospital operations (quality report cards, financial disclosures, etc), community benefit efforts need to become increasingly strategic and targeted in order to illustrate to a variety of audiences how specific programs have been designed and developed. While local community needs assessments will always play a central role in this process, they are often voluminous, difficult to communicate, and may lack necessary qualitative and statistical justification for choosing specific communities as having the "greatest need."

Because of such challenges, Dignity Health (formerly Catholic Healthcare West) and Truven Health jointly developed a Community Need Index (CNI) in 2004 to assist in the process of gathering vital socio-economic factors in the community. The CNI is strongly liked to variations in community healthcare needs and is a strong indicator of a community's demand for various healthcare services.

Based on a wide array of demographic and economic statistics, the CNI provides a score for every populated ZIP code in the United States on a scale of 1.0 to 5.0. A score of 1.0 indicates a ZIP code with the least need, while a score of 5.0 represents a ZIP code with the most need. The CNI should be used as part of your larger community need assessment, and can help pinpoint specific areas that have greater need than others. The CNI should be shared with your community partners and used to justify grants or resource allocations for community initiatives.

DATA SOURCES

- 2011 Demographic Data, Nielsen Claritas, Inc.
- 2011 Poverty Data, Nielsen Claritas, Inc.
- 2011 Insurance Coverage Estimates, Truven Health

METHODOLOGY

The CNI score is an average of five different barrier scores that measure various socio-economic indicators of each community. The five barriers are listed on the next page along with the individual statistics that are analyzed for each barrier. These barriers, and the statistics that comprise them, were carefully chosen and tested individually by both Dignity Health and Truven Health.

1. Income Barrier
    - Percentage of households below poverty line, with head of household age 65 or more
    - Percentage of families with children under 18 below poverty line
    - Percentage of single female-headed families with children under 18 below poverty line
2. Cultural Barrier
    - Percentage of population that is minority (including Hispanic ethnicity)
    - Percentage of population over age 5 that speaks English poorly or not at all
3. Education Barrier

- Percentage of population over 25 without a high school diploma

4. Insurance Barrier
    - Percentage of population in the labor force, aged 16 or more, without employment
    - Percentage of population without health insurance
5. Housing Barrier
    - Percentage of households renting their home

Every populated ZIP code in the United States is assigned a barrier score of 1, 2, 3, 4, or 5 depending upon the ZIP code's national rank (quintile). A score of 1 represents the lowest rank nationally for the statistics listed, while a score of 5 indicates the highest rank nationally. For example, ZIP codes that score a 1 for the Education Barrier contain highly educated populations; ZIP codes with a score of 5 have a very small percentage of high school graduates.

For the two barriers with only one statistic each (education and housing), Truven Health used only the single statistic listed to calculate the barrier score. For the three barriers with more than one component statistic (income, cultural and insurance), Truven Health analyzed the variation and contribution of each statistics for its barrier; Truven Health then weighted each component statistic appropriately when calculating the barrier score.

Once each ZIP code is assigned its barrier scores from 1 to 5, all five barrier scores for each ZIP code are averaged together to yield the CNI score. Each of the five barrier scores receives equal weight (20% each) in the CNI score. A score of 1.0 indicates a ZIP code with the least need, while a score of 5.0 represents a ZIP code with the most need.

APPLICATIONS AND CAVEATS

When calculating the CNI score for a set of ZIP codes representing an entire community, CNI scores for all component ZIP codes should be averaged using a weighting factor based either upon 2011 population or a specific hospital's discharges. The following step-by-step formula helps walk you through building an accurate weighted average for the CNI using 2011 population. Alternatively, hospital discharge volume can be used for the weighting in place of the total population.

To calculate a weighted average for the community as a whole, first multiply the CNI score for each ZIP code times the 2011 population for that same ZIP code to give you the cross product for each ZIP code. Next add up the cross product for all ZIP codes to obtain a total cross product for the entire community. Next add up the 2011 population for all ZIP codes to get the total 2011 for the entire population. Finally, divide the total cross product for the community by the total 2011 population for the community. The result will yield a weighted CNI average for all the ZIP codes combined.

CNI scores are not calculated for non-populated ZIP codes. These include such areas as national parks, public spaces, post office boxes and large unoccupied buildings.

CNI scores for ZIP codes with small populations (especially less than 100 people) may be less accurate. This is due to the fact that the sample of respondents to the 2000 census is too small to provide accurate statistics for such ZIP codes. This issue is mitigated by either eliminating such ZIP codes from your analysis completely, or by making sure that low population ZIP codes are combined with other surrounding ZIP codes.

Truven Health Analytics Emergency Department Estimates

OVERVIEW

Truven Health Emergency Department Estimates (EDE) predicts the total annual volume of emergency department (ED) visits by ZIP Code, age group, sex, and level of acuity for every market in the United States. Visits are broken out into emergent and non-emergent visits to identify the volume of visits that could be seen in a less-acute setting, for example, a fast-track ED or an urgent care facility. Truven health used an extensive supply of proprietary claims, public claims, and Federal surveys to construct population-based use rates for all payers by age and sex. These use rates are then applied to demographic and insurance coverage projections by ZIP Code to estimate ED utilization for 2012 and 2017.

DATA SOURCES

Truven Health is committed to providing the most comprehensive and timely information available. To do so, Truven Health utilizes data from a number of proprietary and public claims streams.

All data sources used in construction of 2012 Emergency Department Estimates are detailed below:

- 2011 – 2008 Proprietary Physician and Hospital Facility Claims, Truven Health
- 2010 - 2001 Physician/Supplier Procedure Summary File, CMS
- 2010 - 2001 Outpatient 100% SAF, CMS
- 2010 - 2004 The MarketScan® Claims Database, Truven Health
- 2010 - 2001 Physician/Supplier Part B 5% SAF, CMS
- 2009 - 2004 National Ambulatory Medical Care Survey
- 2009 - 2004 National Hospital Ambulatory Medical Care Survey
- 2010 - 2005 National Health Interview Survey
- 2010 - 2001 Medicare 5% and 100% Denominator Files, CMS
- 2009 - Medical Expenditure Panel Survey
- 2012 Insurance Coverage Estimates, Truven Health
- 2012/2017/2022 population and income demographic estimates, The Nielsen Company
- Long Term State Population Projections, Census 2000 (released 2005)
- Long Term national Population Projections, Census 2000 (Released 2009)
- December, 2010 CMS Medicaid State summaries
- July, 2011 county-level enrollment data, HealthLeaders-InterStudy
- 2009, 2010 SAF 100% Denominator file, CMS
- 2010 American Community Survey (ACS)
- 2006 - 2011 Current Population Survey Social and Economic Supplement
- Congressional Budget Office's (CBO) Updated Estimates for the Insurance Coverage Provisions of the Affordable Care Act (March, 2012)
- Medicaid/CHIP Eligibility information from www.statehealthfacts.org (Kaiser Family Foundation)
- 2010 National Health Interview Survey (NHIS)

METHODOLOGY

Truven Health created Emergency Department Estimates by constructing ambulatory utilization rates by payer, age, sex, acuity level, and county, and then multiplied these rates by their appropriate populations to yield visit volume estimates at the ZIP Code level. The majority of the utilization rates are built directly from public and private claims streams that Truven Health processes. In addition, national Federal survey data also are used to create some of the use rates and to validate the claims-based use rates.

To ensure local specificity, Truven Health uses Medicare data to adjust utilization rates at the local level. In situations where the local Medicare samples are large enough, these adjustments are applied at the county level.

When the local Medicare sample is below 50 procedures, local adjustments are calculated at the state level. To ensure that all emergent visits are captured, including those resulting in inpatient admissions, the national utilization rates for emergent visits in EDE are based primarily on physician claim streams rather than outpatient facility claim streams. Facility claims are presumed to exclude emergent visits that result in inpatient admissions.

CLAIMS ANALYSIS

Use rates created from payer claims streams are very accurate and complete because all claims utilization is captured for a group of covered lives regardless of the provider or site of care. Truven Health carefully scrutinizes all of the claims streams used to create rates to ensure they are clean and accurate. Claims sources that are incomplete or poorly coded are discarded and not used in the construction of these rates. Every effort is made to account for each service once and only once. For example, surgical claims submitted by assistant surgeons are excluded to avoid double counting of major surgeries.

USE RATE CONSTRUCTION

Healthcare utilization differs dramatically by age, sex, payer, and county of residence. Truven Health builds rates that reflect all of these variables so that final estimates are very precise and specific. Truven Health uses claims data to directly track outpatient care for the Medicare and commercially-insured populations. Because reliable physician claims are not available for the Medicaid and uninsured populations, Federal surveys are used to supplement hospital claims when constructing use rates for those groups.

Because Truven Health analyzes claims from every U.S. county, rates have been carefully calibrated to take into account local differences in outpatient utilization. Rates are thus adjusted for each county based on its unique epidemiology, patterns of access, and healthcare practices.

POPULATION DATA

To yield estimates of ED visits demanded by a given population for 2012 and 2017, the use rates described above are applied to demographic data at the ZIP Code level. Truven Health factors in the age, sex, and insurance mix of each population to ensure that estimates reflect local variation. Age and sex statistics at the ZIP Code level are obtained from 2012/2017 Claritas Demographics data. Insurance mix for the population comes from Truven Health 2012 Insurance Coverage Estimates database, which estimates the number of people covered by various health insurance arrangements at the ZIP Code level.

EMERGENT VS. NON-EMERGENT ED VISITS

Emergency department visits are defined by the presence of specific CPT® * codes in claims. Non-emergent visits do not necessarily require treatment in a hospital emergency department and can potentially be treated in a fast-track ED, an urgent care treatment center, or even a clinic or a physician's private office. Emergent visits require immediate treatment in a hospital

emergency department due to the severity of illness. Non-emergent encounters are defined by CPT codes 99281, 99282, 99283, and G0380, G0381, G0382. Emergent encounters are defined by CPT codes 99284, 99285, 99288, and, G0383, G0384.

APPLICATIONS AND CAVEATS

These data represent estimates of emergency department utilization and are not a perfect accounting of every single emergency department visit that did occur. While Truven Health uses a vast amount of claims at a local level, these estimates may vary from actual experience.

- Emergent cases that result in a subsequent inpatient admission are included in these estimates.
- Workers' compensation ambulatory utilization is not included in EDE.

The following counties do not contain the majority of population for any ZIP Code. As such, their volume is represented in neighboring counties. This is consistent with the previous EDE release:

- Bedford City, Virginia (SCFIPS 51515) included in Bedford County, Virginia (51019)
- Covington City, Virginia (SCFIPS 51580) included in Alleghany County, Virginia (51005)
- Emporia City, Virginia (SCFIPS 51595) included in Greensville County, Virginia (51081)
- Fairfax City, Virginia (SCFIPS 51600) included in Fairfax County, Virginia (51059)
- Lexington City, Virginia (SCFIPS 51678) included in Rockbridge County, Virginia (51163)
- Manassas Park City, Virginia (SCFIPS 51685) included in Prince William County, Virginia (51153)
- Martinsville City, Virginia (SCFIPS 51690) included in Henry County, Virginia (51089)
- King County, Texas (SCFIPS 48269) included in Cottle County, Texas (48101)

RELATED DOCUMENTS

Release Notes for 2012 Emergency Department Estimates are available from Truven Health upon request.

Truven Health Heart Disease Estimates

OVERVIEW

Heart Disease Estimates predicts the number of cases by heart disease type and ZIP Code for every market in the United States. Truven Health used public and private claims data as well as epidemiological data from the National Health and Nutritional Examination Survey to build local estimates of heart disease prevalence for 2011 population.

DATA SOURCES

- 2011 Demographic Projections, Claritas, Inc.
- 2008-2010 Medicare Physician Standard Analytical File
- 2009, 2010 MarketScan® Research Databases from Truven Health Analytics
- 2005-2010 National Health and Nutritional Examination Survey (NHANES)

METHODOLOGY

Truven Health builds county-level models by age and sex, and then applies those models to the underlying demographics of specific geographies to estimate the number of patients with specific types of heart disease.

Disease Types – Four different types of heart disease are profiled in Heart Disease Estimates. The types of disease are defined by groupings of ICD-9 diagnosis codes. See below for the definitions for the 4 types of heart disease. If only a 3-digit code is shown, that means that all sub-codes (including the 5th and 6th digits) are also included.

Disease Type	ICD-9 Diagnosis Codes
Hypertension	401.1; 401.9
Ischemic heart disease	411; 412; 413; 414.00; 414.01; 414.03; 414.06; 414.8; 414.9; V4581; V4582
Arrhythmias	427.0; 427.1; 427.2; 427.31; 427.32; 427.60; 427.61; 427.69; 427.81; 427.89; 427.9; 785.0; 785.1
Congestive Heart Failure	398.91; 428

PREVALENCE

Prevalence indicates the total number of cases of a given disease that exist in a population at a specific point in time. Heart Disease Estimates include only those people diagnosed with the disease and does not count undiagnosed cases. Truven Health first used the NHANES survey, Medicare claims and commercial claims to determine the national age and sex prevalence rates of the four types of heart disease listed above.

Because prevalence rates vary tremendously from one geographic area to the next, Truven Health used claims data to adjust these national heart disease rates to reflect county-level variation for each of the 4 types of heart disease. These local area prevalence patterns can be attributed to environmental, social, economic, or preventive medicine factors. Medicare claims for every county in the U.S. are used to provide county-level variation in prevalence rates for all ages. Final prevalence rates are applied to the age and sex demographics of each ZIP Code to yield the number of heart disease cases currently diagnosed.

APPLICATIONS AND CAVEATS

This data consists of estimates and does not represent a perfect accounting of all heart disease cases that are present in a market. While Truven Health uses a vast amount of data at a local level, these estimates may vary from actual experience. Prevalence indicates the total number of cases of a given disease that exist in a population at a specific point in time.

Because of substantial co-morbidity, each type of heart disease should be examined separately from other heart conditions. Combining prevalence across multiple heart disease classifications will result in substantial overestimation of cases and will lead to inaccurate results.

Heart Disease Estimates include only those people diagnosed with the disease.

RELEASE NOTES

Release Notes for Heart Disease are available from Truven Health upon request.

Truven Health Cancer Estimate

OVERVIEW

Cancer Estimates predicts the number of annual new cancer cases by cancer type, ZIP Code, age group, and sex for every market in the United States. To build local estimates of cancer incidence for the 2011 and 2016 populations, Truven Health used public data as well as epidemiological data from the National Cancer Institute.

DATA SOURCES

- 2011 and 2016 Demographic Projections, Nielsen
- 2008-2010 Medicare Physician Standard Analytical File
- 1990-2009 Surveillance, Epidemiology, and End Results (SEER) Database, National Cancer Institute

METHODOLOGY

Truven Health builds county-level models by age, sex, and race, and then applies those models to the underlying demographics of specific geographies to estimate the number of new cancer cases annually (incidence) of all cancer patients.

CANCER TYPE

All types of cancer are included in the database, which reports the seventeen most common cancers and a single category including all other types of cancer combined. All cancer types are defined using ICD-9 diagnosis codes.

ICD-9 codes can have up to five digits — three numbers before the decimal point and two after. In defining cancer types, Truven Health used only the three digits before the decimal point.

The following are definitions for the most prominent types of cancer:

- Bladder: 188
- Brain (including Central Nervous System): 191, 192
- Breast, male and female: 174, 175
- Cervical: 180
- Colorectal: 153, 154
- Kidney (including Renal Pelvis and Urinary): 189
- Leukemia: 204, 205, 206, 207, 208
- Lung: 162
- Melanoma, skin: 172
- Non-Hodgkin lymphoma: 200, 202
- Oral cavity: 140, 141, 142, 143, 144, 145, 146, 147, 148, 149
- Ovarian: 183
- Pancreas: 157
- Prostate: 185
- Stomach: 151
- Thyroid: 193

- Uterine: 182
- Other: All codes including and between 140 and 208 that are not mentioned above

INCIDENCE

Incidence is defined as the number of new cancer patients (cases) diagnosed within one year for a given population. To build the foundation of incidence rates, Truven Health uses the SEER database from the National Cancer Institute. SEER contains incidence rates by age, sex, race, and type of cancer for several markets in the nation. Because SEER does not profile all markets, Truven Health first builds a national model for incidence rates built from all of the participating markets in SEER.

Because incidence rates vary tremendously from one geographic area to the next, Truven Health uses claims data to adjust national SEER rates to reflect county-level variation for each of the 18 types of cancer. These local area incidence patterns can be attributed to environmental, social, economic, or preventive medicine factors. To provide county-level variation in incidence rates for all ages, Truven Health uses Medicare claims for every county in the U.S. To yield the number of new cancer cases diagnosed within a single year, final incidence rates are applied to the age, sex, and race demographics of each ZIP Code.

In forecasting future cancer incidence, Truven Health has studied historical trends over the past ten and twenty years. Regression models of incidence trends have been applied to the SEER national model to forecast future incidence for each of the eighteen cancer categories.

APPLICATIONS AND CAVEATS

These data consist of estimates and do not represent a perfect accounting of all cancer cases that will occur in a market. While Truven Health uses a vast amount of data at a local level, these estimates may vary from actual experience.

Incidence is defined as the number of new cancer patients (cases) diagnosed within one year for a given population.

All types of cancers are included in the database, which reports the seventeen most common cancers and a single category including all other types of cancers combined.

RELATED DOCUMENTS

Release Notes for Cancer Estimates are available from Truven Health upon request.

Truven Health Demographics

OVERVIEW

Demographics provide essential facts about a market's current and future population, including distribution of people by age, sex, race, and ethnicity. In addition, demographic data includes important information about households, such as average income and median age.

DATA SOURCES

2000, 2012, and 2017 ZIP Code estimates, Nielsen

METHODOLOGY

Truven Health acquires all of its demographic data from Nielsen, including 2000, 2012, and 2017 statistics for every ZIP Code in the United States. Full methodology notes from Nielsen are available from Truven Health upon request.

APPLICATIONS AND CAVEATS

- These data are estimates, and do not represent a perfect accounting of all population within a market.
- Average and median values are created at the ZIP Code level, when ZIP Code data are aggregated to a community level the values are averaged.

Truven Health Insurance Coverage Estimates

Overview

Truven Health Insurance Coverage Estimates (ICE) reports the total number of people covered by seven different types of insurance by ZIP Code, age group, and sex for every market in the United States. Every person in each ZIP Code is assigned an insurance category based on his or her primary insurance coverage. To construct these local, yearly estimates from 2012 through 2022, Truven Health used multiple sources of insurance coverage data and various models. The estimates include the impact of the healthcare reform legislation, Patient Protection and Affordable Care Act (PPACA), on the local insurance coverage.

Data Sources

- 2012/2017/2022 population and income demographic estimates, The Nielsen Company
- Long Term State Population Projections, Census 2000 (released 2005)
- Long Term national Population Projections, Census 2000 (Released 2009)
- December, 2010 CMS Medicaid State summaries
- July, 2011 county-level enrollment data, HealthLeaders-InterStudy
- 2009, 2010 SAF 100% Denominator file, CMS
- 2010 American Community Survey (ACS)
- 2006 – 2011 Current Population Survey Social and Economic Supplement
- Congressional Budget Office's (CBO) Updated Estimates for the Insurance Coverage Provisions of the Affordable Care Act (March, 2012)
- Medicaid/CHIP Eligibility information from www.statehealthfacts.org (Kaiser Family Foundation)
- 2010 National Health Interview Survey (NHIS)

Methodology

Insurance Coverage Estimates are constructed in four steps:

- First, population totals by Age, Sex, and ZIP Code are broken into categories that represent principal source of healthcare payment using sources from HealthLeaders-Interstudy, the Current Population Survey, the National Health Interview Survey, and the American Community Survey.
- Next, long term demographic forecasts from Nielsen and from the U.S. Census are used to extrapolate the influence of population growth on payer mix for each of the next ten years. These estimates then are adjusted using the Congressional Budget Office's expectations of the year-over-year change due to economic and social factors in the absence of healthcare reform. These "baseline" estimates also incorporate empirical evidence of healthcare enrollment from the American Community Survey, as well as Medicaid state summaries.
- The next stage of the process creates transition estimates based on the projected impact of the Patient Protection and Affordable Care Act (PPACA). These transition estimates project the movement of population segments between insurance types. Year to year changes are constrained to match the most recent Congressional Budget Office national simulations. The behavior of individual segments is based on data from several years of the Current Population Survey, following enrollment changes due to the introduction of Insurance Reform in Massachusetts.
- Finally, the transition estimates are applied to the baseline version of the ICE to create final ten year forecasts that reflect population changes, economic changes, and the impact of PPACA. The final numbers agree exactly with the original population totals by Age, Sex, ZIP, and Year derived from Nielsen and census forecasts.

The seven Truven Health insurance categories, and the types of coverage contained in each, are listed below.

Insurance Type	Coverage
Medicaid	Includes all individuals in traditional Medicaid and HMO Medicaid who are not also receiving Medicare benefits.
Medicare	Includes all individuals in traditional Medicare and Medicare HMO who are not also receiving additional benefits through Medicaid.
Dual Eligible	The population currently enrolled in traditional Medicare and Medicare HMO who also receive additional benefits through Medicaid.
Private Employer Sponsored	Includes all individuals in HMO, Fee for Service (FFS), or PPO plans offered as part of an employment arrangement.
Private Exchanges	Includes all individuals who purchase insurance through an insurance exchange or insurance market place, not associated with employment.
Private Direct	Includes all individuals who purchase insurance directly from an insurance provider, not through an employment agreement or through an insurance exchange.
Uninsured	Includes all individuals without any insurance coverage.

County-Level Method

Truven Health first assembles county-level insurance coverage totals using the latest information available for every county in the United States. Truven Health directly collects enrollment statistics for the following payers at the county level: Medicare, Medicaid, Dual Enrollment, and Private Risk.

Due to the lack of reliable local data, Truven Health estimates county-level Private Non-Risk, and Uninsured, using statistical models based on surveys and demographic information. State-level Medicaid totals are leveraged to ensure that the corresponding estimates in ICE reflect the reported figures accurately.

The uninsured are estimated by starting with state-level totals of uninsured individuals gathered from the Current Population Survey. These state totals are then allocated down to a county level based on the county distribution of persons living in households with income under $20,000 and headed by a person under 65 years of age. Private Non-Risk totals at the county level are determined by subtracting the sum of the six other insurance categories from the total population of each county.

Next, Private Risk and Non Risk are combined and allocated into Employee Sponsored, Exchange, and Direct. The Truven Health model for Private Exchange enrollment is based on a longitudinal study of the active exchanges in Massachusetts. The Private Direct baseline estimate is based on local information derived from the American Community Survey.

Finally, totals by payer are broken out into age and sex cohorts based on local information from the ACS for Medicaid, and national age/sex breakouts by payer from NHIS for all other payers.

ZIP Code Estimation Method

Since accurate insurance coverage statistics are not available at the ZIP Code level, Truven Health uses models to allocate the county-level totals (described above) into ZIP Codes. For Medicaid and Uninsured populations, the county totals are allocated down to a ZIP Code level based on the ZIP Code distribution of persons living in households with income under $20,000 and headed by a person under 65 years of age. For the Medicare population, Truven Health uses ZIP Code level distribution of the senior population (over age 65) to allocate individuals into ZIP Codes.

Reporting of Medicaid Population

To determine county-level Medicaid population, Truven Health relies on data reported by Center for Medicare & Medicaid Services (CMS), and by local health plan administrators. A study of historic trends determined that at times these sources may underreport or, less frequently, over report covered lives for individual counties. To account for this, extreme changes in county-level source data for Medicaid population are attenuated, unless there is a corresponding demographic explanation for such a change.

Forecast Methodology

The 2012 release also includes additional modeling that examines the effect of the Patient Protection and Affordable Care Act (PPACA) on plan type enrollment. The new estimates incorporate the PPACA effect in year-over-year estimates between 2012 and 2022, with significance changes occurring in 2014.

The transition estimates are created with a series of statistical models that predict how populations will move from one insurance class to another under healthcare reform. Many of the models are based on the experience of the similar healthcare reform bill passed by the Massachusetts legislature in 2006. These models are applied at the ZIP level using local baseline conditions including: population by plan type, federal poverty level (FPL), age, gender, and current state-level Medicaid eligibility regulations. The transitions between plan types are adjusted to match control totals at the state and national level to ensure agreement with the CBO report. The CBO report is an economic microsimulation which is the main source for long-term predictions of the legislations future impact on the budget and deficits.

The transition estimates move populations from one payer in the baseline estimates to a different payer in the healthcare reform version. The transitions considered by Truven Health include:

- Uninsured, Currently Medicaid Eligible to Medicaid
- Uninsured, Not Currently Medicaid Eligible to Medicaid
- Uninsured to Private Employer Sponsored Insurance
- Uninsured to Private Exchanges
- Private Direct to Private Employer Sponsored Insurance
- Private Direct to Private Exchanges
- Private Employer Sponsored to Private Exchanges
- Private Employer Sponsored to Medicaid
- Medicaid to Private Employee Sponsored

The specific transitions represent the various components of the healthcare reform legislation. For example, the law requires states to establish healthcare exchanges and to also extend Medicaid eligibility. Enrollment in the new Private Exchanges is expected to come mainly from the currently uninsured population, but will also include some who are privately insured. New Medicaid enrollees will come from uninsured populations previously not eligible for Medicaid, as well as others who may have been eligible but had not previously enrolled.

All the estimates are based on actual observations available in the data sources and not supposition.

The percentages of people currently uninsured that will now be eligible for Medicaid varies from state to state because many states have opted to extend eligibility rules. Our Medicaid transition models represent a comprehensive analysis of the state-specific eligibility rules. The result is a set of models that accurately reflect the current state of insurance coverage and the potential impact of healthcare reform.

Applications And Caveats

- While Truven Health uses a vast amount of data at the local level, these data are estimates and may not represent a perfect accounting of insurance coverage that exists in every market.
- Every person is assigned an insurance category based on his or her primary insurance coverage, regardless of any secondary coverage.
- The sum of covered lives in the seven insurance segments for a given population – either county or ZIP Code – will almost perfectly match the total population for the geography by age and sex. Any discrepancies are due to rounding of estimates.

Related Documents

Release Notes for 2012 Insurance Coverage Estimates are available from Truven Health upon request.

BHMC-LR Implementation Plans

Baptist Health Medical Center – Little Rock

Community Health Needs Implementation Plan

IDENTIFIED COMMUNITY HEALTH NEED #1: Preventable Hospital Stays

GOALS / OBJECTIVES:

Reduce the number of unnecessary hospitalizations through improved primary prevention, improved control of chronic diseases, and expanded case management for patients seen in the Emergency Department.

STRATEGY #1:

Utilize the Baptist Health Home Health Teleheath program to monitor patients with chronic conditions at home.

ACTION STEP #1:

Develop criteria to identify appropriate patients with chronic conditions who would benefit from a telehealth program.

ACTION STEP #2:

Investigate grant funding opportunities to provide telehealth units to qualified patients.

ACTION STEP #3:

Once funded, implement, monitor and provide any necessary interventions with telehealth patients.

DESCRIBE ANTICIPATED IMPACT OF ACTIONS TO BE TAKEN:

Interventions will be prompt, appropriate and cost effective to both the patient and hospital to reduce the number of patients who are admitted with chronic conditions. This process will also maintain the patient in their home environment.

DESCRIBE COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:

Baptist Health Medical Center- Little Rock will work with the Baptist Health Home Health network to manage these patients in the homes with the telehealth units. Home Health nurses will provide the patient monitoring and medical intervention in the homes.

DESCRIBE RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:

Case Coordination staff, nurses and social workers, and Home Health staff will be needed to identify patients who qualify for the telehealth units. The Baptist Health Foundation will assist with finding grant money or other funds needed to purchase units to put in the homes of patients and to provide aircards for wireless internet. Interpretation services will also be used for those patients who need translation. Physicians will be used as needed to provide the referral and medical support.

PERFORMANCE METRICS:

Attempts to secure grant funding will begin in the first quarter of 2014. If grant funding can be obtained, readmission tracking for those patients enrolled in the program and placed on Telehealth units will be monitored and results reported annually. The goal is to reduce the readmissions of those patients placed on Telehealth units by 5% when compared to their previous 12 month history of readmissions.

PROJECT LENGTH / ESTIMATED COMPLETION DATE:

This project will be ongoing, as long as funds are available to install telehealth units in patient homes, over the next three years 2014-2016.

PERSON / DEPARTMENT RESPONSIBLE:

Case Coordination – Sandy Guthrie

Baptist Health Home Health- Becky Pryor

Baptist Health Foundation- Missy Lewis

PROGRESS UPDATE:

Progress will be updated annually throughout the assessment period.

STRATEGY #2:

Initiate proactive approaches to care for patients seen in the Emergency Department to mitigate the need for frequent emergency/acute interventions.

ACTION STEP #1:

Provide Case Management Services seven (7) days per week.

ACTION STEP #2:

Ensure as many patients as possible are connected to a Primary Care Physician with an appointment made within three days of discharge, and if needed, Home Health services.

ACTION STEP #3:

Arrange enrollment in free or reduced cost medication programs for all patients who qualify.

ACTION STEP #4:

Investigate options for diabetic patients who cannot afford measurement strips for blood sugar meters and/or insulin syringes.

DESCRIBE ANTICIPATED IMPACT OF ACTIONS TO BE TAKEN:

Assisting patients with access to resources which facilitate compliance with recommended treatments will prevent chronic conditions from deteriorating into acute problems requiring emergency intervention. This will also link patients to the appropriate levels of care for follow up.

DESCRIBE COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:

Baptist Health Medical Center- Little Rock will work with physicians in the Baptist Health network and Baptist Health Home Health to manage patients with on-going health needs. Partnerships with drug companies and supply companies will also be pursued.

DESCRIBE RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:

Case Coordination staff, nurses and social workers, will be needed to assess patient needs for discharge and coordinate services. Pharmacy staff will be needed to evaluate poly-pharmacy issues. Health Management Center staff will assist in investigating diabetes supply needs. Physicians will be used as needed to order needed services and supplies.

PERFORMANCE METRICS:

Case Management services will be provided in the ED seven (7) days per week in January of 2014. The number of patients enrolled in reduced cost medication programs will be tracked on a monthly basis.

PROJECT LENGTH / ESTIMATED COMPLETION DATE:

This project will be ongoing as patients will continue to be identified, over the next three years 2014-2016.

PERSON / DEPARTMENT RESPONSIBLE:

Case Coordination - Sandy Guthrie

Baptist Health Home Health - Becky Pryor

Health Management Center - Ryan Reed

Pharmacy – David Cobb

PROGRESS UPDATE:

Progress will be updated annually throughout the assessment period.

STRATEGY #3:

Develop methods to regularly monitor Nursing Home patients who are at higher risk for readmission based on known disease progression factors and intervene early to mitigate the need for frequent emergency/acute interventions.

ACTION STEP #1:

Educate Nursing Homes on the need to perform daily weight and blood pressure checks on patients with chronic kidney disease who are not on dialysis or with congestive heart failure.

ACTION STEP #2:

Investigate use of a pilot eICU service in a Nursing Home with a high volume of readmissions.

DESCRIBE ANTICIPATED IMPACT OF ACTIONS TO BE TAKEN:

Interventions are prompt, appropriate and cost effective to both the patient and hospital to reduce the number of patients who are admitted with chronic conditions that became acute. This will also maintain the patient in their regular environment.

DESCRIBE COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:

Baptist Health Medical Center- Little Rock will work with local Nursing Homes to manage patients with complex health needs, and with physicians to provide orders for interventions that support care in the patient's regular environment.

DESCRIBE RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:

Community Outreach and Case Coordination staff will be needed to conduct regular meetings with Nursing Home representatives to provide education and come to consensus on patient management approaches. Staff from Network Development will assess capability and cost of using an eICU service in a Nursing Home environment.

PERFORMANCE METRICS:

Reduce the number of inpatient admissions from the Emergency Department by targeted Nursing Homes by 5% using pre- and post-initiative comparison.

PROJECT LENGTH / ESTIMATED COMPLETION DATE:

This project will be ongoing as patients will continue to be identified, over the next three years 2014-2016.

PERSON / DEPARTMENT RESPONSIBLE:

Case Coordination - Sandy Guthrie

Community Outreach - Teresa Conner

Network Development - Leila Dockery

PROGRESS UPDATE:

Progress will be updated annually throughout the assessment period.

Baptist Health Medical Center – Little Rock

Community Health Needs Implementation Plan

IDENTIFIED COMMUNITY HEALTH NEED #2 – Diabetic Screening

GOALS / OBJECTIVES:

Promote diabetes awareness and education to increase diabetic screenings

STRATEGY #1:

Develop a diabetes awareness education campaign to build support and understanding among the general public regarding diabetes prevention, early detection and treatment methods.

STRATEGY #2:

Promote the Diabetic Risk Assessment Test to patients entering the Community Outreach Wellness Centers.

STRATEGY #3:

Implement community-based diabetes education classes and screenings.

STRATEGY #4:

Offer A1C testing to Wellness Center patients who have a previous diagnosis of diabetes. Individuals found to have elevated levels will be offered care coordination by the Community Education Nurse.

STRATEGY #5:

Expand screening programs and services for high-risk groups: minorities, elders, tobacco users, caregivers, underinsured, and non-insured by targeted screening events.

STRATEGY #6:

Enhance school-based Diabetes education and screening.

ACTION STEP #1*:*

Work with Strategic Development to develop an educational campaign to increase the awareness of Diabetes prevention, screening and management. The campaign will include mailers, web-site, social media and television.

ACTION STEP #2:

Provide counseling regarding nutrition, weight control, and appropriate physical activity to patients identified as having high risk factors for diabetes. Advise identified patients to have periodic future screening for diabetes.

ACTION STEP #3*:*

Promote diabetes screenings and education classes. Quarterly diabetes educational programs will be implemented at various Community Wellness Centers that include an educational presentation component, healthy cooking demonstrations and physical activity.

ACTION STEP #4:

Offer participation in the community- based diabetes management program for all individuals identified and diagnosed as diabetic by a health care provider. The program will include reminders for patients to follow-up on their eye, foot and oral exams. Patients will also receive A1C and cholesterol screenings, if needed.

ACTION STEP #5:

Partner with community churches, community groups and Hometown Health Coalitions in identified areas to increase the number of screenings and risk assessment tests provided for the identified population.

ACTION STEP #6:

Support the Arkansas Department of Health's initiative in expanding diabetes screening of targeted middle school children, along with their scoliosis screening. Assist in teaching diabetes prevention, risk factors, symptoms and the consequences of diabetes. Provide assistance in teaching students and school health providers, as needed.

DESCRIBE ANTICIPATED IMPACT OF ACTIONS TO BE TAKEN:

The awareness of the diabetes epidemic and its severity will lead to an increased knowledge by the general public. Community members will be aware of the signs and symptoms of diabetes and the need for a risk assessment test. This will lead to an increase in the desire to be screened. Depending on the results, patients will receive the referrals needed.

DESCRIBE COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:

Baptist Health will partner with the Arkansas Department of Health's Diabetes Task Force, the American Diabetes Association of Arkansas, the Hometown Health Coalitions, the Arkansas Center for Health Improvement, and locations which support the BH community wellness centers.

DESCRIBE RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:

The resources needed to implement this project include staff from the following departments: Community Outreach, Strategic Development and the Print Shop. Additional resources will be needed to purchase educational and promotional materials.

PERFORMANCE METRICS:

The Diabetes Education Risk Assessment test will be available at all Community Wellness Centers and all screening events. 100% of patients scoring "at risk" will be offered a blood sugar screening at the Wellness Centers. Blood Sugar

screenings will be offered on a monthly basis at 10 access points. 2014 will serve as a baseline year for data collection on the number of blood sugar screenings and educational activities offered, with a goal of increasing numbers in subsequent years.

PROJECT LENGTH / ESTIMATED COMPLETION DATE:

This project will be on-going over the next three years 2014-2016

PERSON / DEPARTMENT RESPONSIBLE:

The Baptist Health Community Outreach Department will be responsible for the implementation, evaluation and follow-up of this program.

PROGRESS UPDATE:

Metrics will be available on a monthly basis and the program will be updated on an annual basis throughout the assessment period.

Baptist Health Medical Center – Little Rock

Community Health Needs Implementation Plan

IDENTIFIED COMMUNITY HEALTH NEED #3 – Smoking (Tobacco-Use Cessation)

GOALS / OBJECTIVES:

Promote smoking cessation within the hospital and at the community level

STRATEGY #1:

Implement a hospital-based tobacco education/cessation program

ACTION STEP #1:

Identify patients who smoke or use smokeless tobacco products from the nursing admission assessment.

ACTION STEP #2:

Order Tobacco Cessation Education from the Respiratory Care Department.

ACTION STEP #3:

Provide education on the harmful effects of using tobacco products and assess the patient's readiness to quit.

ACTION STEP #4:

Have identified patients sign a form to participate in the Arkansas Stamp Out Smoking initiative. Fax the form to the Arkansas Tobacco Quit Line (1-800-QUITNOW).

DESCRIBE ANTICIPATED IMPACT OF ACTIONS TO BE TAKEN:

Interventions are prompt, appropriate and cost effective to both the patient and the community to reduce the number of people who use tobacco products. The Stamp Out Smoking program matches assistance to patient needs, including education, support, nicotine gum and patches.

DESCRIBE COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:

Baptist Health Medical Center- Little Rock will work with the Arkansas Stamp Out Smoking program.

DESCRIBE RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:

Nursing staff will be needed to identify patients who use tobacco products. The Team Leaders and Patient Care Coordinators in the Respiratory Care department will be trained to educate patients and assess their readiness to discontinue use of tobacco products. The Director of the Respiratory Care department will coordinate the service and review outcomes.

PERFORMANCE METRICS:

The annual goal is to educate and assess readiness of at least 70% of identified patients prior to discharge. All patients who choose to be referred will be referred. Referral outcomes will be monitored via data provided by the Arkansas Tobacco Quitline Referral Program Fax Referral Reporting.

PROJECT LENGTH / ESTIMATED COMPLETION DATE:

This pilot will last approximately one year (2014). Evaluation will be made after the first year to determine the continuation of the program for 2015 and 2016.

PERSON / DEPARTMENT RESPONSIBLE:

Nursing - Jill Massiet

Respiratory Care - Shelly Brown

PROGRESS UPDATE:

Progress will be reviewed at the end of the year (2014).

STRATEGY #2:

Implement a Smoking Cessation Referral Program in the Community Wellness Centers.

ACTION STEP #1*:*

Identify individuals who utilize tobacco products during health history assessment at the Wellness Centers.

ACTION STEP #2:

Provide individuals with information regarding the Arkansas Tobacco Quitline Program. Upon a patient's acknowledgement of desire to discontinue tobacco utilization, the Community Education nurse will ask the patient to consent to have the Arkansas Tobacco Quitline contact them via the HIPAA Compliant Referral Form.

DESCRIBE ANTICIPATED IMPACT OF ACTIONS TO BE TAKEN:

Patients will become aware of the risk of tobacco use and the resources available to assist them in quitting.

DESCRIBE COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:

The Baptist Health Community Outreach Department will partner with the Arkansas Department of Health, the Coalition for Tobacco Free Arkansas, and locations which support the BH community wellness centers.

DESCRIBE RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:

The resources needed to implement this project include staff from the following departments: Community Outreach Department, Strategic Development and the Print Shop. Additional resource will be utilized to purchase items such as Carbon Monoxide monitors and educational materials.

PERFORMANCE METRICS:

The goal is to provide referral information for tobacco cessation intervention to 100% of all identified tobacco users, which will be recorded in the patient's Wellness Center file. Referral outcomes will be monitored via data provided by the Arkansas Tobacco Quitline Referral Program Fax Referral Reporting.

PROJECT LENGTH / ESTIMATED COMPLETION DATE:

This project will be on-going over the next three years 2014-2016.

PERSON / DEPARTMENT RESPONSIBLE:

Baptist Health Community Outreach – Community Wellness Center Education Nurses

PROGRESS UPDATE:

Progress will be reviewed on a monthly basis and reported on the Community Wellness Center's Monthly Health Service Report throughout the assessment period.

Baptist Health Medical Center – Little Rock

Community Health Needs Implementation Plan

IDENTIFIED COMMUNITY HEALTH NEED #4 – Obesity

GOALS / OBJECTIVES:

Increase opportunities to participate in activities that promote good nutrition and physical activity in maintaining health and reducing obesity.

STRATEGY #1:

Expand the Community Walking Program

ACTION STEP #1:

Enhance Baptist Health's partnership with the City of Little Rock by offering to make the Community Walking Program available at ten (10) of its public facilities through the Parks and Recreation department.

ACTION STEP #2:

Provide free BMI assessments at ten (10) of the Baptist Health Community Wellness Centers.

ACTION STEP #3:

Offer one educational classes annually at four (4) Little Rock community centers, focusing on healthy eating and physical fitness.

DESCRIBE ANTICIPATED IMPACT OF ACTIONS TO BE TAKEN:

Enrollment will increase, providing increased opportunity for exposure to learning how to prepare healthy meals and the benefits of adding exercise to their daily lives.

DESCRIBE COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:

The collaboration with the City of Little Rock will offer a wider base for promoting not only the Community Walking program but also services offered at the Community Wellness Centers, which are hosted at a number of different churches and community centers. These initiatives will aid in increasing awareness and reducing the numbers of overweight and obese adults.

DESCRIBE RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:

Resources needed to implement this program include staff from the following departments: Community Outreach, Nutrition and Food Services, the Fitness Center, and Strategic Development. Educational materials will be provided and incentives will also be purchased by the hospital.

PERFORMANCE METRICS:

The goal is to increase the number of adults enrolled in the Community Walking Program by 25% compared to 2013.

PROJECT LENGTH / ESTIMATED COMPLETION DATE:

The program duration is one year (2014), but enrollment/re-enrollment is conducted annually (2015-2016).

PERSON / DEPARTMENT RESPONSIBLE:

The Community Outreach department will be responsible for implementing and evaluating the program.

PROGRESS UPDATE:

Progress will be updated annually throughout the assessment period.

STRATEGY #2:

Expand the We Can CATCH Kids Club Program

ACTION STEP #1:

Partner with the Boys and Girls Club of Central Arkansas.

ACTION STEP #2:

Partner with the City of Little Rock's Summer Playground Program.

ACTION STEP #3:

Implement the We Can Catch Kids Program in the Little Rock School District. Investigate implementation in Benton, Bryant and Sheridan.

DESCRIBE ANTICIPATED IMPACT OF ACTIONS TO BE TAKEN:

Studies show that regular physical activity in children and adolescents promotes health and fitness. Compared to those who are inactive, physically active youth have higher levels of cardio respiratory fitness and stronger muscles. The We Can Catch kids program will address the growing concerns of childhood obesity by educating children and families on the benefit of good nutrition and exercise.

DESCRIBE COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:

Baptist Health will partner with the Little Rock School District, the Boys and Girls Clubs of Arkansas, the City of Little Rock, Arkansas Department of Health and potentially schools and community groups in Benton, Bryant and Sheridan.

DESCRIBE RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH

The resources needed to implement this project include staff from the following departments: Community Outreach, Strategic Development, Print Shop, Nutrition and Food Services and the Fitness Center. Additional resources will be utilized to purchase promotional and educational materials.

PERFORMANCE METRICS:

The goal is to provide sessions at three (3) sites in 2014. Additional goals will be determined for 2015-2016 once the baseline year (2014) is complete.

PROJECT LENGTH / ESTIMATED COMPLETION DATE:

This project will be on-going over the next three years 2014-2016.

PERSON / DEPARTMENT RESPONSIBLE:

The Community Outreach department will be responsible for implementing and evaluating the program.

PROGRESS UPDATE:

Progress will be updated annually throughout the assessment period.

STRATEGY # 3:

Promote Healthy Eating and Active Living to Reduce the Prevalence of Obesity.

ACTION STEP #1:

Provide support for the Arkansas Coalition against Obesity and the statewide goals. Baptist Health will participate in planning and implementation of initiatives, as applicable.

ACTION STEP #2:

Provide nutrition and physical activity education to the community through educational programs at Baptist Health wellness centers, special events and community health fairs. Social media, the Baptist Health Web-site and television interviews will also be utilized to promote Healthy Eating and Active Living.

ACTION STEP #3:

Pilot the Sister to Sister: Move More, Eat Better program at one new community center in 2014. The program targets African American women and promotes increased physical activity and adopting health eating habits.

DESCRIBE ANTICIPATED IMPACT OF ACTIONS TO BE TAKEN:

A comprehensive approach to educating the community about the hazards of obesity through participation in programs and attendance at educational classes will help them make better choices.

DESCRIBE COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:

Baptist Health will partner with the Arkansas Department of Health, Hometown Health Coalitions, and the City of Little Rock.

DESCRIBE RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH

The resources needed to implement this project include staff from the following departments: Community Outreach, Occupational Health, Strategic Development, Nutrition and Food Services and the Fitness Center. Additional resource will be utilized to purchase promotional and educational materials.

PERFORMANCE METRICS:

The Sister to Sister: Move More Eat Better program will show annual improvement in participant data from pre and post-tests to demonstrate knowledge gained.

PROJECT LENGTH / ESTIMATED COMPLETION DATE:

This project will be on-going over the next three years 2014-2016

PERSON / DEPARTMENT RESPONSIBLE:

The Community Outreach department will be responsible for implementing and evaluating the program.

PROGRESS UPDATE:

Progress will be updated annually throughout the assessment period.

Baptist Health Medical Center – Little Rock

Community Health Needs Implementation Plan

IDENTIFIED COMMUNITY HEALTH NEED #5 – Lack of a Primary Care Physician

GOALS / OBJECTIVES:

Increase the number of people living in the identified counties of Pulaski, Saline and Grant that have access to a Primary Care Physician.

STRATEGY #1:

Work with Practice Plus and Arkansas Health Group to increase the number of Primary Care physicians in Pulaski, Saline and Grant counties.

ACTION STEP #1*:*

Support Practice Plus/AHG physician recruiting efforts for Pulaski, Saline and Grant counties with physician recruiters.

ACTION STEP #2:

Provide Baptist Health Healthline patient referral and scheduling for primary care practices.

ACTION STEP #3:

Provide specialty support via the Baptist Health network of physicians to primary care physicians.

DESCRIBE ANTICIPATED IMPACT OF ACTIONS TO BE TAKEN:

By providing increased physician coverage throughout the identified three-county area, primary care services will be more accessible, improving continuity of care.

DESCRIBE COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:

Baptist Health Medical Center- Little Rock will continue its partnership with Community Health Centers of Arkansas to provide access to Primary Care Physicians. Baptist Health Medical Center- Little Rock will also collaborate with Arkansas Health Group and Practice Plus to identify physicians who may be willing to volunteer their time and services in free clinics in the identified three-county area. Communication with the free clinics in these areas will identify the needs of each clinic and what resources Baptist Health may be able to provide.

DESCRIBE RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:

Physician time will be needed. Additionally, grant money could be used to fund needed medications for these patients and possibly to reimburse physicians for their time.

PERFORMANCE METRICS:

Contacts with potential primary care physician candidates and numbers of physicians recruited will be tracked on a quarterly basis.

PROJECT LENGTH / ESTIMATED COMPLETION DATE:

The project will be ongoing.

PERSON / DEPARTMENT RESPONSIBLE:

Practice Plus/Arkansas Health Group – Will Rusher

Baptist Health Healthline – Mark Lowman/Cara Wade

Baptist Health Network Development – Leila Dockery

PROGRESS UPDATE:

Status will be updated annually.

STRATEGY #2:

Collaborate with Jefferson Comprehensive Care System, Inc. (JCCSI), one of the Community Health Center (CHC) networks affiliated with Baptist Health, to re-open the Little Rock Community Health Center. CHCs are 501(c)3 Healthcare Organizations which provide or make provisions for primary medical, dental, mental health, pharmacy, preventive, and support services to uninsured and underinsured individuals, as well as to those who are covered by Medicare, Medicaid, and private insurance. The service area for JCCSI includes Jefferson, Cleveland and Pulaski Counties. JCCSI operates two clinics in Pulaski County currently – one at College Station and one for the homeless on MLK Drive.

ACTION STEP #1:

Assist in the recruitment of provider staffing for the clinic. Provider staff could be employed directly by JCCSI or by contract through AHG/Practice Plus.

ACTION STEP #2:

Develop a process for referral of patients without a PCP from BH Emergency Rooms to the clinic for ongoing primary care in a more appropriate setting.

ACTION STEP #3:

Assist with funding of the Community Health Centers of Arkansas, which supports the Jefferson Comprehensive Care System, Inc.

DESCRIBE ANTICIPATED IMPACT OF ACTIONS TO BE TAKEN:

By providing a new point of access for primary care, individuals with little or no health insurance coverage will have a healthcare home and receive ongoing preventive and primary care as well as access to specialty care as needed.

DESCRIBE COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:

Baptist Health Medical Center – Little Rock will collaborate with JCCSI and AHG/Practice Plus to open the clinic and to identify additional resources which

may need to be provided. Doing so will need to be in full compliance with the requirements of the Health Resources and Services Administration, an agency of the United States Department of Health and Human Services.

DESCRIBE RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:

BH will accept referrals for outpatient tests/procedures as well as inpatient care as needed. BH will assist JCCSI in identifying specialty physicians to take referrals as needed. BH will provide other operational expertise as needed.

PERFORMANCE METRICS:

Provider staffing will be solicited in the first half of 2014. If obtained, numbers of patients, encounters, medication assistance, and other statistics will be reported monthly. Monetary contributions will be reported on the BH Form 990H.

PROJECT LENGTH:

The clinic will be a permanent, full-time operation.

PERSON/DEPARTMENT RESPONSIBLE:

CHC Affiliation – Leila Dockery

AHG/Practice Plus – Will Rusher

Community Outreach – Teresa Conner

PROGRESS UPDATE:

Progress will be updated annually throughout the assessment period.

COMMUNITY HEALTH NEEDS NOT BEING ADDRESSED

Baptist Health Medical Center – Little Rock

Arkansas is a state with many health needs, ranking 47th of 50 in overall health status. It is also a state with a higher proportion of underserved and uninsured individuals. Recognizing that although all of the identified needs are important, all of them cannot be pursued by BHMC-LR, and choices had to be made. After establishing criteria based on the Baptist Health mission, as well as BHMC-LR clinical strengths, resources and infrastructure to maintain programs, each of the identified needs was reviewed. The following community health needs will not be addressed in the BHMC-LR Implementation Plan.

Diabetes (Death) - This need is currently addressed by the Arkansas Department of Health, Arkansas Foundation for Medical Care, the American Diabetes Association of Arkansas and other local healthcare providers.

Infant Mortality - This need is currently being addressed by various organizations including Baptist Health Medical Center - North Little Rock, the March of Dimes of Arkansas, Arkansas Department of Health and other local healthcare providers.

Low Birth Weight - This need is being addressed by the March of Dimes, the Arkansas Department of Health and other local healthcare providers.

Diabetes (Chronic Conditions) - This need is currently addressed by the Arkansas Department of Health, Arkansas Foundation for Medical Care, the American Diabetes Association of Arkansas, the Arkansas Wellness Coalition and other local healthcare providers.

Hypertension - This need is currently being addressed by the Arkansas Department of Health.

Coronary Heart Disease - This need is currently being addressed through the Arkansas Department of Health's Million Hearts program, the American Heart Association, and other local healthcare providers.

PAP Test - This need is currently being implemented by the Arkansas Department of Health through their Family Planning program and other local healthcare providers.

Stroke - This initiative is currently being addressed by the Arkansas Department of Health and the American Heart Association.

Access to Healthy Food - This need is currently being addressed by the City of Little Rock, the City of North Little Rock, the University of Arkansas Division of Agriculture and the Arkansas Department of Health.

Cancer - This need is currently being addressed by the Susan G. Komen Foundation, the American Cancer Society, the Arkansas Department of Health, the Arkansas Cancer Coalition, the Prostate Cancer Foundation and other local healthcare providers.

Arthritis - This need is currently being addressed by the Arthritis Foundation of Arkansas.

Asthma - This need is currently being addressed by the Arkansas Foundation for Medical Care.

Chronic Lower Respiratory - Due to limited resources, this need will not be addressed at this time.

Sexually Transmitted Infections - This need is currently being addressed by the Arkansas Department of Health.

Access to Recreational Facilities - This need is currently being addressed by the City of Little Rock, the City of North Little Rock, Community Centers and the Boys and Girls Clubs of Arkansas.

Excessive Drinking - This need is currently being addressed by the Arkansas Department of Health and Human Services.

Children with Single Parent Households - This need are currently being addressed by the Arkansas Department of Health and Human Services.

Poor or Fair Health Status - Due to limited resources, this need will not be addressed at this time.

Poor Physical/Mental Days - This need is currently being addressed by the Arkansas Community Mental Health Centers.

Percentage of Fast Food Restaurants – This need is not an area of expertise for Baptist Health. Due to limited resources, this need will not be addressed at this time.

Premature Death - This need is currently being addressed by the Arkansas Department of Health.

Violent Crime - This need is currently being addressed by the City of Little Rock.

BHMC-NLR
Implementation Plans

Baptist Health Medical Center – North Little Rock

Community Health Needs Implementation Plan

IDENTIFIED COMMUNITY HEALTH NEED #1 – Preventable Hospital Stays

GOALS / OBJECTIVES:

Reduce excess readmission ratio to ≤ CMS goal. Readmission reductions focus will be on patients who have the highest risk for readmission. Due to limited resources and the current focus on these two conditions by CMS for purposes of reimbursement, BHMC-NLR plans to monitor the impact of these techniques and employ successful strategies into the future to include post-acute case management.

STRATEGY #1:

Develop tools and support mechanisms, both inpatient and post hospital, to reduce inappropriate readmissions.

ACTION STEP #1*:*

Adopt a Transition Model: After research of literature and networking with colleagues across the country, BHMC-NLR will adopt the Sutter Care Home Model, which includes Medication Management, Early Follow-up and Symptom Management.

ACTION STEP #2:

Implement a Patient Assessment Tool/Questionnaire to determine reasons for readmission. Case Management Will Meet with Each Readmission

1. Did you understand your discharge instructions?
2. When was your follow up appointment?
3. Were you able to go to your appointment?
    a. If not, determine reasons, e.g., transportation, financial, scheduling, etc.

4. Determine knowledge of medications, e.g., use, taking as prescribed, new meds, getting them filled
5. Understanding signs and symptoms of their disease process and what to do when they occur.
6. Community services received and help at home.

ACTION STEP #3:

Establish a Care Partner: Nursing and Case Management will work with the patient and family to determine who will be a responsible partner in caring for the patient. The care partner role has been added to the communication board in each patient's room.

DESCRIBE ANTICIPATED IMPACT OF ACTIONS TO BE TAKEN:

Through collaborative efforts, the following is expected:

1. Identify the patients who are the highest risk for readmission.
2. Patients and family will be educated with the appropriate follow up care instructions to prevent inappropriate readmission.

DESCRIBE COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:

Baptist Health Medical Center- NLR is collaborating with area Home Health agencies to begin early patient education (within three days of discharge, when possible), and establish processes to seek medical attention without readmitting to an acute care setting.

DESCRIBE RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:

Baptist Health Medical Center – NLR will provide staff from Nursing and Case Coordination as well as facility/equipment.

PERFORMANCE METRICS:

Reduce readmission ratio for identified groups to an index of less than 1.00, using CMS data and recommendations.

Reduce in-hospital readmission rate, rolling year, index and rate with national comparator (Data Source: American Data Network).

PROJECT LENGTH / ESTIMATED COMPLETION DATE:

This project will be on-going over the next three years 2014-2016

PERSON / DEPARTMENT RESPONSIBLE:

Baptist Health Community Outreach

Baptist Health Medical Center – NLR Nursing and Case Coordination.

PROGRESS UPDATE:

Progress will be updated annually throughout the assessment period.

STRATEGY #2:

Expand the Nursing Home/Hospital Liaison Committee to include other post-hospital providers.

ACTION STEP #1*:*

Host meetings on a quarterly basis

ACTION STEP #2:

Identify problematic areas and practices and set in place effective and efficient standards to address these issues.

ACTION STEP #3:

Identify barriers to care which will prevent inappropriate readmissions from the nursing home to the hospital.

DESCRIBE ANTICIPATED IMPACT OF ACTIONS TO BE TAKEN:

Post-acute care facilities will have improved processes to deal with potential patient health issues.

DESCRIBE COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:

Baptist Health Medical Center North Little Rock will collaborate with nursing homes, LTACHs, acute rehabilitation centers, ambulance providers, and home health agencies to improve outcomes and reduce readmissions for identified patients.

DESCRIBE RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:

Nurses, Case Coordination, Emergency Department personnel, pharmacists and hospitalists will be needed to participate in the quarterly meetings as well as identify areas for improvement.

PERFORMANCE METRICS:

A minimum of four meetings annually to discuss opportunities to improve patient outcomes and provider processes. Readmissions will be measured using CMS data.
Processes for tracking post-acute setting readmissions is currently being developed to identify which post-acute settings are readmitting more frequently and why. This will enable BHMC-NLR to work with these providers to reduce readmissions and improve patient outcomes.

PROJECT LENGTH / ESTIMATED COMPLETION DATE:

This project will be on-going over the next three years 2014-2016.

PERSON / DEPARTMENT RESPONSIBLE:

Nursing Staff

Case Coordination

PROGRESS UPDATE:

Progress will be updated annually throughout the assessment period.

STRATEGY #3:

Community Based Flu Vaccination Program

ACTION STEP #1*:*

Provide flu shots at Community Wellness Centers and targeted communities.

ACTION STEP #2:

Collaborate with the Arkansas Department of Health in their mass flu shot campaign.

DESCRIBE ANTICIPATED IMPACT OF ACTIONS TO BE TAKEN:

Fewer people will contract the flu or will have milder symptoms.

DESCRIBE COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:

Baptist Health Medical Center North Little Rock will collaborate with the Arkansas Department of Health.

DESCRIBE RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:

The resources needed to achieve this strategy include Baptist Health staff from Community Outreach and the Pharmacy.

PERFORMANCE METRICS:

Baptist Health will offer Flu shots at 10 Community Wellness Centers/Screening sites annually beginning in October 2014.

Baptist Health will participate in two Arkansas Department of Health Mass Flu Clinics beginning October 2014.

Baptist Health will track and record the number of vaccinations given at all events.

PROJECT LENGTH / ESTIMATED COMPLETION DATE:

This project will be on-going over the next three years 2014-2016.

PERSON / DEPARTMENT RESPONSIBLE:

The Baptist Health Community Outreach department will be responsible for the implementation, evaluation and follow up of the program.

PROGRESS UPDATE:

Progress will be updated annually throughout the assessment period.

Baptist Health Medical Center – North Little Rock

Community Health Needs Implementation Plan

IDENTIFIED COMMUNITY HEALTH NEED #2 – Diabetic Screening

GOALS / OBJECTIVES:

Promote diabetes awareness and education to increase diabetic screenings

STRATEGY #1:

Develop a diabetes awareness education campaign to build support and understanding among the general public regarding diabetes prevention, early detection and treatment methods.

STRATEGY #2:

Promote the Diabetic Risk Assessment Test to all patients entering the Community Outreach Wellness Centers.

STRATEGY #3:

Implement community-based diabetes education classes and screenings.

STRATEGY #4:

Offer A1C testing to Wellness Center patients who have a previous diagnosis of diabetes. Individuals found to have elevated levels will be offered care coordination by the Community Education Nurse.

STRATEGY #5:

Expand screening programs and services for high-risk groups: minorities, elders, tobacco users, caregivers, underinsured, and non-insured by targeted screening events.

STRATEGY #6:

Enhance school-based Diabetes education and screening.

ACTION STEP #1*:*

Work with Strategic Development to develop an educational campaign to increase the awareness of Diabetes prevention, screening and management. The campaign will include mailers, web-site, social media and television.

ACTION STEP #2:

Provide counseling regarding nutrition, weight control, and appropriate physical activity to patients identified as having high risk factors for diabetes. Advise identified patients to have periodic future screening for diabetes.

ACTION STEP #3*:*

Promote diabetes screenings and education classes. Quarterly diabetes educational programs will be implemented at various Community Wellness Centers that include an educational presentation component, healthy cooking demonstrations and physical activity.

ACTION STEP #4:

Offer participation in the community- based diabetes management program for all individuals identified and diagnosed as diabetic by a health care provider. The program will include reminders for patients to follow-up on their eye, foot and oral exams. Patients will also receive A1C and cholesterol screenings, if needed.

ACTION STEP #5:

Continue to partner with community churches, community groups and Hometown Health Coalitions in identified areas to increase the number of screenings and risk assessment tests provided for the identified population.

ACTION STEP #6:

Support the Arkansas Department of Health's initiative in expanding diabetes screening of targeted middle school children, along with their scoliosis screening. Assist in teaching diabetes prevention, risk factors, symptoms and the consequences of diabetes. Provide assistance in teaching students and school health providers, as needed.

DESCRIBE ANTICIPATED IMPACT OF ACTIONS TO BE TAKEN:

The awareness of the diabetes epidemic and its severity will lead to an increased knowledge by the general public. Community members will be aware of the signs and symptoms of diabetes and the need for a risk assessment test. This will lead to an increase in the desire to be screened. Depending on the results, patients will receive the referrals needed.

DESCRIBE COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:

Baptist Health will partner with the Arkansas Department of Health's Diabetes Task Force, the American Diabetes Association of Arkansas, the Hometown Health Coalitions, the Arkansas Center for Health Improvement, and locations which support BH community wellness centers.

DESCRIBE RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:

The resources needed to implement this project include staff from the following departments: Community Outreach, Strategic Development and the Print Shop. Additional resources will be needed to purchase educational and promotional materials.

PERFORMANCE METRICS:

The Diabetes Education Risk Assessment test will be available at all Community Wellness Centers and all screening events. 100% of patients scoring "at risk" will be offered a blood sugar screening at the Wellness Centers. Blood Sugar

screenings will be offered on a monthly basis at 10 access points. 2014 will serve as a baseline year for data collection on the number of blood sugar screenings and educational activities offered, with a goal of increasing numbers in subsequent years.

PROJECT LENGTH / ESTIMATED COMPLETION DATE:

This project will be on-going over the next three years 2014-2016.

PERSON / DEPARTMENT RESPONSIBLE:

The Baptist Health Community Outreach Department will be responsible for the implementation, evaluation and follow-up of this program.

PROGRESS UPDATE:

Metrics will be available on a monthly basis and the program will be updated on an annual basis throughout the assessment period.

Baptist Health Medical Center-North Little Rock

Community Health Needs Implementation Plan

IDENTIFIED COMMUNITY HEALTH NEED #3 – Reduction of Infant Mortality

GOALS / OBJECTIVES:

A decrease in the infant mortality rate by .5%

STRATEGY #1:

Improve the overall health of newborns

ACTION STEP #1:

Decrease non-medically indicated Early Elective Delivery (EED) deliveries before 39 weeks gestation to 7.5 %. Participate and follow the guidelines developed by the Arkansas Foundation for Medical Care.

ACTION STEP #2:

Provide Critical Congenital Heart Disease (CCHD) screening for 100% of non-transferred newborns. Pulse oximetry readings of the right hand and foot will be done between 24-48 hours of birth. Screening criteria will follow guidelines developed in collaboration with Arkansas Children's Hospital and the University of Arkansas for Medical Science.

ACTION STEP #3:

Give Tetanus, Diphtheria and Pertussis (Tdap) and Measles, Mumps and Rubella (MMR) immunizations to postpartum patients. Following the recommendation of the CDC, all postpartum mothers who did not receive a Tdap during pregnancy will be offered and encouraged to receive the vaccination immediately after delivery. All rubella non-immune patients will be offered and encouraged to receive an MMR. Goal is to offer immunization for Tdap and MMR to 100% of non-immunized post-partum patients.

ACTION STEP #4:

Provide the Neonatal Car Seat Screening/and Angel Tolerance Test for 100% newborns that meet the following criteria: less than 37 weeks gestation, less than 5 pounds or discharging on oxygen or an apnea monitor.

ACTION STEP #5:

Provide breastfeeding support services to include: prenatal education on breastfeeding; access to a Lactation Consultant; outpatient consultations; and onsite breast pump rentals. Improve percentage of newborns exclusively fed breast milk during hospitalization by 5%.

DESCRIBE ANTICIPATED IMPACT OF ACTIONS TO BE TAKEN:

Newborn health will be improved by decreasing risk of premature birth with the EED Program. Screening for CCHD and positional hypoxia will lead to the provision of early treatment. Immunizations of the mother will lower the risk of communicable diseases to the newborn. Breast fed newborns will have greater immunity through their mother's immunoglobulins.

DESCRIBE COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:

Baptist Health Medical Center-North Little Rock will collaborate with the Arkansas State Health Department and OB/GYNs in the communities served.

DESCRIBE RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:

Baptist Health Medical Center- North Little Rock will provide nursing staff and Lactation Consultants.

PERFORMANCE METRICS:

Early Elective Delivery percentage is monitored quarterly through the BHMC-NLR internal Quality Department as well as the VHA and March of Dimes. The goal is to decrease to 7.5 % by December 2014.

Non- transferred newborns receive CCHD screenings. Data will be measured through the BHMC-NLR electronic medical record (EMR). The goal is to achieve 100% by December 2014.

The Angle Tolerance Test is given to select newborns. Data will be measured through the BHMC-NLR electronic medical record (EMR). The goal is to test 100% of newborns meeting criteria by December 2014.

The Arkansas Medicaid program measures the 100% Exclusive Breastfeeding and provides reports. The goal is to improve by 5% by the final quarter of 2014.

Postpartum immunizations will be monitored internally by data collected in the EMR. The goal will be to offer Tdap and MMR immunization to 100% of non-immunized mothers by December 2014.

PROJECT LENGTH / ESTIMATED COMPLETION DATE:

This project will be on-going over the next three years 2014-2016.

PERSON / DEPARTMENT RESPONSIBLE:

The Baptist Health Medical Center North Little Rock Women's Center Staff.

PROGRESS UPDATE:

Progress will be updated annually throughout the assessment period.

STRATEGY #2:

Promote Perinatal and Well Baby Care Education in the Community

ACTION STEP #1:

Utilize the Heaven's Loft Wellness Center Program to provide perinatal and infant care education and resources to clients, utilizing a voucher incentive component to reward expectant and new mothers for attendance and participation.

ACTION STEP #2:

Screen expectant mothers for potential issues in relation to hypertension and gestational diabetes on a weekly basis.

ACTION STEP #3:

Provide two school-based perinatal and well-baby care educational classes in the North Little Rock School District.

ACTION STEP #4:

Conduct outpatient prenatal classes

ACTION STEP #6:

Identify new and expectant mothers who smoke. Provide individuals with information regarding the Arkansas Tobacco Quitline Program. Upon the patient's acknowledgement of desire to discontinue tobacco utilization, the Community Education nurse will make the appropriate referral to the Arkansas Tobacco Quitline and/or others resources. The process will be implemented weekly on an annual basis.

ACTION STEP #7:

Provide one immunization clinic annually for children during National Immunization Month

DESCRIBE ANTICIPATED IMPACT OF ACTIONS TO BE TAKEN:

Women of childbearing age and expectant mothers participating in the programs will be educated on healthy preconception behaviors and the importance of medical care for a healthy pregnancy. Mothers will be educated on the impact of smoking, drugs, appropriate weight gain, folic acid, preterm labor, and other factors that affect infant mortality. Mothers will be educated on the importance of breast feeding, well baby care and routine immunizations for the lifelong health of their infant.

DESCRIBE COLLABORATIONS WITH OTHER HOSPITALS AND COMMUNITY ORGANIZATIONS:

Baptist Health will collaborate with the Arkansas Department of Health, Obstetricians, Pediatricians, Family Practice Physicians, the Crisis Pregnancy Center Program, the Cooperative Extension Program of the University of Arkansas, the United Way of Arkansas, Community Churches, Rhea Lana Events, as well as surrounding school districts.

DESCRIBE RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS THE HEALTH NEED:

The resources needed to implement this project include staff from the following Baptist Health departments: Community Outreach and Baptist Health Medical Center North Little Rock Women's Center, Strategic Development, and the Print Shop. Additional resources will be used to purchase educational and promotional materials, as well as newborn care items.

PERFORMANCE METRICS:

Two school based prenatal educational classes will be held at Jacksonville High School.

One Immunization clinic will be held at the Heaven's Loft Wellness Center. The number of immunizations and participants will be tracked and reported.

The number of expectant mothers referred to the Tobacco Quit Line on a weekly basis will be tracked and reported on a monthly basis.

PROJECT LENGTH / ESTIMATED COMPLETION DATE:

The projects will be on-going over the next three years 2014-2016.

PERSON / DEPARTMENT RESPONSIBLE:

The Baptist Health Community Outreach Department will be responsible for the implementation, evaluation, and follow-up of the programs.

PROGRESS UPDATE:

Progress will be updated annually throughout the assessment period.

STRATEGY #3:

Promotion of Infant Safety

ACTION STEP #1:

Provide infant CPR, Newborn Care, Childbirth Classes, and Safe Sitter Classes.

ACTION STEP #2:

Implement a Child Passenger Safety Program serving all mothers participating in the Heaven's Loft and the School-Based Prenatal Programs on an annual basis.

ACTION STEP #3:

Implement two Baby Safety Showers in English and Spanish for expectant and delivered mothers with babies less than 6 months of age. Provide safety items such as smoke alarms, cabinet latches, door handle safety knobs, bath thermometers and car seats. Promote safe infant sleep practices and prevention of shaken baby syndrome.

ACTION STEP #4:

Provide annual childhood immunizations for children during National Immunization Month

DESCRIBE ANTICIPATED IMPACT OF ACTIONS TO BE TAKEN:

Mothers will be educated on safe infant care and infant injury prevention, as well as learn how to properly install and use safety items provided.

DESCRIBE COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:

Baptist Health Medical Center North Little Rock will collaborate with the Arkansas Department of Health Injury Prevention and Immunization Programs, Arkansas Children's Hospital, the Safe Kids Coalition, Bank of America (Grant), local Police

and Fire Departments, University of Arkansas for Medical Sciences Child Passenger Safety Program, the North Little Rock Health Department and North Little Rock Physicians.

DESCRIBE RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALH NEED:

The resources needed to implement this project include staff from the following Baptist Health department: Community Outreach, Baptist Health Medical Center North Little Rock, Strategic Development, and the Print Shop. Additional resources will be utilized to purchase baby safety items and car seats.

PERFORMANCE METRICS:

Two Safety Baby Shower classes will be held at Heaven's Loft. One will be in English and one in Spanish.

One Immunization clinic will be held at the Heaven's Loft Wellness Center. The number of immunizations and participants will be tracked and reported.

Fifty car seats will be provided annually as a part of the Child Passenger Safety program.

The number of car seats distributed.

The number of immunizations administered.

PROJECT LENGTH / ESTIMATED COMPLETION DATE:

This project will be on-going over the next three years 2014-2016.

PERSON / DEPARTMENT RESPONSIBLE:

The Baptist Health Community Outreach Department will be responsible for the implementation, evaluation, and follow-up of the programs.

PROGRESS UPDATE:

Progress will be updated annually throughout the assessment period.

COMMUNITY HEALTH NEEDS NOT BEING ADDRESSED

Baptist Health Medical Center – North Little Rock

Arkansas is a state with many health needs, ranking 47th of 50 in overall health status. It is also a state with a higher proportion of underserved and uninsured individuals. Recognizing that although all of the identified needs are important, all of them cannot be pursued by BHMC-NLR, and choices had to be made. After establishing criteria based on the Baptist Health mission, as well as BHMC-NLR clinical strengths, resources and infrastructure to maintain programs, each of the identified needs was reviewed. The following community health needs will not be addressed in the BHMC-NLR Implementation Plan.

Diabetes (Death) - This need is currently addressed by the Arkansas Department of Health, Arkansas Foundation for Medical Care, the American Diabetes Association of Arkansas and other local healthcare providers.

Low Birth Weight - This need is being addressed by the March of Dimes, the Arkansas Department of Health and other local healthcare providers.

Diabetes (Chronic Conditions) - This need is currently addressed by the Arkansas Department of Health, Arkansas Foundation for Medical Care, the American Diabetes Association of Arkansas, the Arkansas Wellness Coalition and other local healthcare providers.

Hypertension - This need is currently being addressed by the Arkansas Department of Health.

Coronary Heart Disease - This need is currently being addressed through the Arkansas Department of Health's Million Hearts program, the American Heart Association, and other local healthcare providers.

PAP Test - This need is currently being implemented by the Arkansas Department of Health through their Family Planning program and other local healthcare providers.

Stroke - This initiative is currently being addressed by the Arkansas Department of Health and the American Heart Association.

Access to Healthy Food - This need is currently being addressed by the City of Little Rock, the City of North Little Rock, the University of Arkansas Division of Agriculture and the Arkansas Department of Health.

Cancer - This need is currently being addressed by the Susan G. Komen Foundation, the American Cancer Society, the Arkansas Department of Health, the Arkansas Cancer Coalition, the Prostate Cancer Foundation and other local healthcare providers.

Arthritis - This need is currently being addressed by the Arthritis Foundation of Arkansas.

Asthma - This need is currently being addressed by the Arkansas Foundation for Medical Care.

Chronic Lower Respiratory – This need was rated lower in the prioritization process, and due to limited resources will not be addressed at this time.

Sexually Transmitted Infections - This need is currently being addressed by the Arkansas Department of Health.

Access to Recreational Facilities - This need is currently being addressed by the City of Little Rock, the City of North Little Rock, Community Centers and the Boys and Girls Clubs of Arkansas.

Lack of PCP – The lack of PCP issue is currently being met by several free community clinics with the primary care issues addressing this concern in our market area. Limited resources also impact any initiative we may attempt.

Obesity - Currently the Arkansas Department of Health has a statewide Obesity Initiative

Smoking – The Arkansas Department of Health and the Stamp Out Smoking Initiative covers this area of concern.

Premature Death - This need is currently being addressed by the Arkansas Department of Health.

Poor or Fair Health Status - This need was rated lower in the prioritization process, and due to limited resources will not be addressed at this time.

Poor Physical/Mental Days - This need is currently being addressed by the Arkansas Community Mental Health Centers.

Excessive Drinking - This need is currently being addressed by the Arkansas Department of Health and Human Services.

Violent Crime - This need is currently being addressed by the City of North Little Rock.

Children with Single Parent Households - This need is currently being addressed by the Arkansas Department of Health and Human Services.

Percentage of Fast Food Restaurants - Due to limited resources and this need not being an area of expertise for BHMC-NLR, it will not be addressed at this time.

BHMC-A Implementation Plans

Baptist Health Medical Center – Arkadelphia

Community Health Needs Implementation Plan

IDENTIFIED COMMUNITY HEALTH NEED #1 – Colorectal Screening

GOALS / OBJECTIVES:

Increase the number of people who are educated about the importance of getting colorectal screenings.

Increase the number of screenings provided locally to identify health issues earlier.

STRATEGY #1:

Promote colorectal screenings with local county health department and area physicians on getting their patients screenings performed locally.

ACTION STEP #1:

Provide brochures to physician practices and the local health department with information about colorectal screenings available locally.

ACTION STEP #2:

Provide information to the public at community events, health fairs, and civic group meetings throughout the county.

Community Events

- Arkadelphia Community Health Fair
- Cruising in the Park
- Ladies Night Out

Civic Groups

- Red River Baptist Association
- Alpha Kappa Alpha Sorority, Inc. - Chi Nu Omega Chapter

- Arkadelphia Lions Club
- Arkadelphia Rotary Club
- Arkadelphia Rotary Sunrise Club
- Gurdon Rotary Club
- La Primera Inglesia Bautista
- National Association for the Advancement of Colored People
- The Sunshine Service Club

ACTION STEP #3:

Advertise in local and service area newspapers on a quarterly basis.

STRATEGY #2:

Increase the number of days the hospital offers screenings from one to two per week.

ACTION STEP #1:

Recruit one more local physician to perform additional screenings within the next two years.

ACTION STEP #2:

Identify time slots with schedulers within the next year.

ACTION STEP #3:

Train additional staff to accommodate the increase in screenings.

DESCRIBE ANTICIPATED IMPACT OF ACTIONS TO BE TAKEN:

Increase the number of colorectal screening performed at BHMC-Arkadelphia annually.

DESCRIBE COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANZIATIONS:

Partner with each of the medical practices in the service area.

DESCRIBE RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:

Resources needed to implement these goals include educational materials for the community and hospital staff, facility and equipment.

PERFORMANCE METRICS:

The number of people educated at community events and the number of colorectal screenings performed at BHMC-A. With a goal of 5% more educated and 2% more colorectal screenings within 3 years.

PROJECT LENGTH / ESTIMATED COMPLETION DATE

This project will be on-going over the next three years 2014-2016.

PERSON / DEPARTMENT RESPONSIBLE:

Sheree Hendrix, Director of Nursing

Diane Duren, OR/OPS/GI Unit Manager

PROGRESS UPDATE:

Progress will be updated annually throughout the assessment period.

Baptist Health Medical Center – Arkadelphia

Community Health Needs Implementation Plan

IDENTIFIED COMMUNITY HEALTH NEED #2 – Mammography Screening

GOALS / OBJECTIVES:

Increase the number of women who undergo mammography screenings locally.

Increase the number of women who are educated about importance of getting mammography screenings performed as recommended by the American Cancer Society.

STRATEGY #1:

Promote mammography screenings with local county health department and area physicians on getting their patients screenings performed locally.

ACTION STEP #1:

Provide brochures to physician practices and the local health department with information about mammography resources available locally.

ACTION STEP #2:

Provide information to the public at community events, health fairs, and civic group meetings throughout the county.

Community Events

- Arkadelphia Community Health Fair
- Cruising in the Park
- Ladies Night Out

Civic Groups

- Red River Baptist Association
- Alpha Kappa Alpha Sorority, Inc. - Chi Nu Omega Chapter
- Arkadelphia Lions Club
- Arkadelphia Rotary Club
- Arkadelphia Rotary Sunrise Club
- Gurdon Rotary Club
- La Primera Inglesia Bautista
- National Association for the Advancement of Colored People
- The Sunshine Service Club

ACTION STEP #3:

Advertise in local and service area newspapers on a quarterly basis.

DESCRIBE ANTICIPATED IMPACT OF ACTIONS TO BE TAKEN:

An increase in the number of mammography screenings performed locally that will increase/improve breast cancer survival rates in the service area.

DESCRIBE COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:

Partnerships with the Arkadelphia Medical Clinic, Baptist Health Family Clinic Gurdon, Compassions Women Clinic, Arkadelphia's Women Clinic, Clark County Health Department, and other local physicians in the service area.

DESCRIBE RESOURCES HOSPITALS PLANS TO COMMIT TO ADDRESS HEALTH NEED:

Resources needed to address this health need include brochures, scripts for various types of outreach, employee staff time, and display on mammography screening.

PERFORMANCE METRICS:

The number of mammograms performed at BHMC-Arkadelphia. 2014 will be the baseline with a goal of 5% increase per year in 2015 and 2016.

PROJECT LENGTH / ESTIMATED COMPLETION DATE:

This project will be on-going over the next three years 2014-2016.

PERSON / DEPARTMENT RESPONSIBLE:

David Hennessee – Radiology

Sheree Hendrix – Director of Nursing

PROGRESS UPDATE:

Progress will be updated annually throughout the assessment period.

Baptist Health Medical Center – Arkadelphia

Community Health Needs Implementation Plan

IDENTIFIED COMMUNITY HEALTH NEED #3 – Stroke

GOALS / OBJECTIVES:

Improve the community's awareness on stroke prevention and the warning signs/symptoms.

STRATEGY #1:

Promote stroke awareness in the service area.

ACTION STEP #1:

Post signage throughout the community and county.

- Exxon, 3036 Pine St, Arkadelphia, AR
- Citgo – Smithpeters Station, 410 South Front Street, Gurdon, AR
- Baptist Health Medical Center – Arkadelphia, Emergency Department
- Local physician offices

ACTION STEP #2:

Promote stroke awareness by participating in various community events such as Relay for Life and providing monthly presentations to local civic groups, churches and organizations.

ACTION STEP #3:

Provide hospital staff education about stroke through in-service and "ACT FAST" reminder cards attached to their badges.

DESCRIBE ANTICIPATED IMPACT OF ACTIONS TO BE TAKEN:

Early recognition and intervention of stroke signs and symptoms resulting in better health outcomes for people affected within the service area.

DESCRIBE COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:

UAMS Outreach Telehealth

DESCRIBE RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:

Educational materials and equipment used for presentations. Staff time for training in Nursing Administration, Routine Nursing, and Emergency Department.

PERFORMANCE METRICS:

The number of presentations made at community events.

The number of people who received stroke awareness through community presentations.

2014 will be the baseline year with goals sets in 2015 and 2016 based on initial year data.

PROJECT LENGTH / ESTIMATED COMPLETION DATE:

This project will have an initial timeframe for community event and education preparation of six months. This project will be on-going over the next three years 2014-2016.

PERSON / DEPARTMENT RESPONSIBLE:

Stephen Sanford, Emergency Room Manager

Sheree Hendrix, Director of Nursing

Steve Maxwell, ER/Ambulance Director

PROGRESS UPDATE:

Progress will be updated annually throughout the assessment period.

COMMUNITY HEALTH NEEDS NOT BEING ADDRESSED

Baptist Health Medical Center – Arkadelphia

Arkansas is a state with many health needs, ranking 47th of 50 in overall health status. It is also a state with a higher proportion of underserved and uninsured individuals. Recognizing that although all of the identified needs are important, all of them cannot be pursued by BHMC-A, and choices had to be made. After establishing criteria based on the Baptist Health mission, as well as BHMC-A clinical strengths, resources and infrastructure to maintain programs, each of the identified needs was reviewed. The following community health needs will not be addressed in the BHMC-A Implementation Plan.

Lack of PCP's - This is currently being addressed by other means within the community through recruiting efforts by AHG/Practice Plus.

Hypertension - This need is included within our Stroke plan.

Diabetes - This need is addressed by other facilities and/or organization in the community by AllCare Pharmacy.

Sexual Transmitted Infections - This need is being addressed through our local health unit, and college on-campus health units.

Obesity - This need is being address through the community "Healthier Clark County" campaign. A brochure is distributed through our local health department and schools within the county covering various activities promoting physical exercise.

Asthma - Low priority assigned to the need based on the criteria used by BHMC-A.

Arthritis - Low priority assigned to the need based on the criteria used by BHMC-A.

Poor Physical Health - This need is being addressed through the community "Healthier Clark County" campaign. A brochure is distributed through our local health department and schools covering various activities promoting physical exercise.

Fast Food Restaurants - Lack of expertise or competency to effectively address the need.

Single Parent Households - Due to lack of expertise or competency to effectively address the need, this need will not be addressed by BHMC-A at this time.

Uninsured - Due to limited resources this need will not be addressed by BHMC-A at this time. Also, this need is addressed by the community "Free Health Clinic".

BHMC-HS
Implementation Plans

Baptist Health Medical Center – Heber Springs

Community Health Needs Implementation Plan

IDENTIFIED COMMUNITY HEALTH NEED #1 – Prostate Screening

GOALS / OBJECTIVES:

Raise awareness in the community about prostate cancer and the importance of screening.

STRATEGY #1:

Develop a prostate cancer awareness campaign utilizing Arkansas Prostate Cancer Foundation.

ACTION STEP #1*:* Include information about the importance of prostate screenings in various primary healthcare provider promotions and at community wellness centers.

ACTION STEP #2 Host educational sessions about prostate health for the community.

ACTION STEP #3: Participate in Prostate Awareness Month (September) annually by offering discounted prostate screening and providing information through social and local media, Baptist Health websites, and in local primary care offices throughout the next three years.

DESCRIBE ANTICIPATED IMPACT OF ACTIONS TO BE TAKEN:

The community will take advantage of educational opportunities provided and participate in prostate screenings. The number of prostate screenings will increase by 5% each year after the established baseline year of 2014.

DESCRIBE COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:

BHMC-HS will collaborate with the following:
Heber Springs Community Center
Baptist Health Strategic Development
Arkansas Urology
Local Primary Care Providers

DESCRIBE RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:

The resources needed to implement this strategy will include staff from the following Baptist Health departments: Baptist Health Medical Center Heber Springs, Strategic Development, the BHMC-HS Auxiliary, and the Print Shop.

PERFORMANCE METRICS:

An internal database/data file will be built to document and track the number of prostate cancer screenings performed at BHMC-HS and the number of attendees at the educational sessions. 2014 will be the baseline year with a goal set of +5% for prostate screenings and session attendees in subsequent years of 2015 and 2016.

PROJECT LENGTH / ESTIMATED COMPLETION DATE:

This project will be on-going over the next three years 2014-2016

PERSON / DEPARTMENT RESPONSIBLE:

Community Outreach Nurse.

PROGRESS UPDATE:

Progress will be updated annually throughout the assessment period.

STRATEGY #2:

Establish an on-going community prostate screening program.

ACTION STEP #1:

Collect information about each person screened as a result of the outreach and education in strategy #1.

ACTION STEP #2:

Create a log or report of all prostate screenings and organize a process to notify the recipients of their recommended follow-up dates.

ACTION STEP #3:

Send reminders to each person screened in the Community Outreach Program as described in Strategy #1 when it is time to have their next screening.

DESCRIBE ANTICIPATED IMPACT OF ACTIONS TO BE TAKEN:

The community will take advantage of educational opportunities and have regular prostate screenings during this assessment period. The number of prostate screenings will increase by 5% each year after the established baseline year of 2014.

DESCRIBE COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:

BHMC-HS will collaborate with the following: Heber Springs Community Center; Baptist Health Strategic Development; Arkansas Urology and local primary care providers.

DESCRIBE RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:

The resources needed to implement this strategy will include staff from the following Baptist Health departments: Baptist Health Medical Center Heber Springs, Strategic Development, the BHMC-HS Auxiliary, and the Print Shop.

PERFORMANCE METRICS:

- The number of prostate cancer screenings performed during this assessment period.
- The number of reminder cards sent during this assessment period.

An internal database/data file will be built to document and track the number of prostate cancer screenings performed during the annual assessment periods (2014, 2015 and 2016) and the number of reminder cards sent. 2014 will be the baseline year with a goal set of +5% for prostate screenings and session attendees in subsequent years of 2015 and 2016.

PROJECT LENGTH / ESTIMATED COMPLETION DATE:

This project will be on-going over the next three years 2014-2016.

PERSON / DEPARTMENT RESPONSIBLE:

Community Outreach Nurse

PROGRESS UPDATE:

Progress will be updated annually throughout the assessment period.

Baptist Health Medical Center – Heber Springs

Community Health Needs Implementation Plan

IDENTIFIED COMMUNITY HEALTH NEED #2 – Lack of PCP/No Personal Doctor

GOALS / OBJECTIVES:

Increase accessibility for those living in the Cleburne County area to Primary Care Physicians.

STRATEGY #1:

Investigate the feasibility of recruiting additional PCP's for the Cleburne County area, including OB/Gyns.

DESCRIBE ANTICIPATED IMPACT OF ACTIONS TO BE TAKEN:

Increase availability of primary care resources in the Cleburne County area.

DESCRIBE COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:

BHMC-HS will collaborate with the following:
Baptist Health Strategic Development – utilizing results of PCP Outmigration Study which was conducted in 2012, promotion of primary care physician resources.
AHG/PP, BH Network Development – Potential physician recruitment
Chamber of Commerce – promote local clinics

DESCRIBE RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:

Recruit additional primary care resources.

Speakers

PERFORMANCE METRICS:

Number of physicians added during 2014-2016.

PROJECT LENGTH / ESTIMATED COMPLETION DATE:

This project will be on-going over the next three years 2014-2016

PERSON / DEPARTMENT RESPONSIBLE:

BHMC-HS VP & Administrator

BH Practice Plus

PROGRESS UPDATE:

Progress will be updated annually throughout the assessment period.

STRATEGY #2:

Investigate the possibility of increasing access to current primary care physicians in the Cleburne County area.

ACTION STEP #1:

Work with local PCPs to assess desire to utilize physician extenders (Nurse Practitioners, Physician Assistants, etc.) in current practices.

ACTION STEP #2:

Explore the need and options for extended clinic hours (nights, weekends)

DESCRIBE ANTICIPATED IMPACT OF ACTIONS TO BE TAKEN:

Increased availability of primary care resources in the Cleburne County area.

DESCRIBE COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:

BHMC-HS will collaborate with the following: ARCare

DESCRIBE RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:

Staff to coordinate services, as needed.

PERFORMANCE METRICS:

Number of physician extenders added to local area practices during 2014-2016.
Number of physician offices to begin offering non-traditional office hours (evening clinics, Saturdays, etc.) during 2014-2016.

PROJECT LENGTH/ESTIMATED COMPLETION DATE:

This project will be on-going over the next three years 2014-2016

PERSON/DEPARTMENT RESPONSIBLE:

BHMC-HS VP & Administrator; AHG/PP

PROGRESS UPDATE:

Progress will be updated annually throughout the assessment period.

STRATEGY # 3:

Provide additional points of access for underserved.

ACTION STEP #1

Free service through Christian Health Center.

ACTION STEP #2

Free transportation for tests, treatments.

DESCRIBE ANTICIPATED IMPACT OF ACTIONS TO BE TAKEN:

The underserved of Cleburne County will have increased availability of primary care resources.

PERFORMANCE METRICS:

2014 will be the baseline year in which data will be collected in a database/data spreadsheet.

Each year (2014-2016) the dollar amounts of services provided at the Christian Health Center will be calculated and tracked.

Each year (2014-2016) the number of van transports to the Christian Health Center will be documented and tracked.

PROJECT LENGTH/ESTIMATED COMPLETION DATE:

This project will be on-going over the next three years 2014-2016

PERSON/DEPARTMENT RESPONSIBLE:

BHMC-HS VP & Administrator

Director of Nursing

PROGRESS UPDATE:

Progress will be updated annually throughout the assessment period.

Baptist Health Medical Center – Heber Springs

Community Health Needs Implementation Plan

IDENTIFIED COMMUNITY HEALTH NEED #3 – Diabetes

GOALS / OBJECTIVES:

Raise awareness in the Cleburne County area about the risk factors and effects of Diabetes.

STRATEGY #1:

Provide educational opportunities to the public in various settings.

ACTION STEP #1*:*

Schedule annual community educational sessions at local wellness centers.

ACTION STEP # 2:

Provide diabetes education materials for programs and events.

ACTION STEP #3:

Explore opportunities to provide diabetes education to local civic groups and other non-profit organizations.

DESCRIBE ANTICIPATED IMPACT OF ACTIONS TO BE TAKEN:

The community will have additional opportunities to be exposed to information regarding the risk factors for diabetes and prevention of diabetes.

DESCRIBE COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:

BHMC-HS will collaborate with the following:
Heber Springs Hospital Auxiliary
Heber Springs Community Center

Area Chambers of Commerce
Practice Plus / AHG Physician Groups
Christian Health Center
ARCare

DESCRIBE RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:

Hospital staff will organize and host educational events throughout the year, focusing on the areas of need identified via the community health needs assessment.

PERFORMANCE METRICS:

The number of people attending the educational sessions offered for 2014, 2015, 2016. An internal database/data file will be built to document and track the number of attendees at the educational sessions. 2014 will be the baseline year with a goal set of +5% for session attendees in subsequent years of 2015 and 2016.

PROJECT LENGTH / ESTIMATED COMPLETION DATE:

This project will be on-going over the next three years 2014-2016.

PERSON / DEPARTMENT RESPONSIBLE:

Community Outreach Nurse

PROGRESS UPDATE:

Progress will be updated annually throughout the assessment period.

STRATEGY #2:

Provide education to community members in need of diabetes management education

ACTION STEP #1*:*

Provide diabetes education materials and screenings in the Community Wellness Centers, as well as referrals to PCPs when needed.

DESCRIBE ANTICIPATED IMPACT OF ACTIONS TO BE TAKEN:

Members of the community in need of diabetes education and support will have the opportunity to receive materials, screenings and referrals to PCPs will have an on-going resource available to them through the Community Wellness Centers.

DESCRIBE COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:

Locations for the Cleburne County Wellness Centers are provided by Waychoff Senior Center, Heber Springs and Renegar Apartments Community Room, Quitman.

DESCRIBE RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:

Educator and teaching supplies.

PERFORMANCE METRICS:

- The number of people attending sessions at the Community Wellness Clinics in 2014, 2015, 2016.
- The number of people who received the risk assessment.
- The number of people who received a diabetes screening.
- The number of people referred to a PCP.
  An internal database/data file will be built to document and track 1-4 above. 2014 will be the baseline year with a goal set of +5% for all measures 1-4 above in subsequent years of 2015 and 2016.

PROJECT LENGTH / ESTIMATED COMPLETION DATE:

This project will be on-going over the next three years 2014-2016

PERSON / DEPARTMENT RESPONSIBLE:

Community Outreach Nurse, Dietitian

PROGRESS UPDATE:

Progress to be updated annually throughout the assessment period.

COMMUNITY HEALTH NEEDS NOT BEING ADDRESSED

Baptist Health Medical Center – Heber Springs

Arkansas is a state with many health needs, ranking 47th of 50 in overall health status. It is also a state with a higher proportion of underserved and uninsured individuals. Recognizing that although all of the identified needs are important, all of them cannot be pursued by BHMC-HS, and choices had to be made. After establishing criteria based on the Baptist Health mission, as well as BHMC-HS clinical strengths, resources and infrastructure to maintain programs, each of the identified needs was reviewed. The following community health needs will not be addressed in the BHMC-HS Implementation Plan.

Flu Shots - This need is currently being addressed by the Cleburne County Health Department.

Mammograms - This need is currently being addressed by the Susan G. Komen Foundation, the American Cancer Society, the Arkansas Department of Health, and the Arkansas Cancer Coalition.

Colorectal - Focusing limited resources on other needs due to low priority need assessment of this issue.

High Cholesterol - This need is currently being addressed through the Arkansas Department of Health's Million Hearts program and the American Heart Association.

Smoking - This need is currently being addressed through the Arkansas Department of Health "Stamp Out Smoking" program.

Physical Activity - Heber Springs/Cleburne County offers a wealth of opportunities for physical activities through its various community organizations, private businesses, area parks and recreation. Additionally, the Heber Springs Community Center is addressing these issues with various exercise equipment and classes, including an aquatics center with classes for the elderly and arthritic.

Excessive Drinking - This need is addressed by the Arkansas / Cleburne County Health Department, as well as the Cleburne County Chapter of Mothers Against Drunk Driving (MADD).

Coronary Artery Disease - This need is currently being addressed through the Arkansas Department of Health's Million Hearts program and the American Heart Association.

Heart Disease - This need is currently being addressed through the Arkansas Department of Health's Million Hearts program and the American Heart Association.

Arthritis - This need is currently being addressed by the Arthritis Foundation of Arkansas.

Poor or Fair Health Status - Hometown health improvement is currently addressed by the Arkansas/Cleburne County Health Department.

Low Birth Weight - This need is being addressed by the March of Dimes, and the Arkansas/ Cleburne County Department of Health.

Poor Physical /Mental Health Days - This need is currently being addressed by the Arkansas/Cleburne County Health Department.

Chronic Lower Respiratory - Focusing limited resources on other needs due to low priority need assessment of this issue.

Asthma - This need is currently being addressed by the Arkansas Foundation for Medical Care.

Access to Recreational Facilities - Heber Springs/Cleburne County offers a wealth of opportunities for recreation through its various community organizations, private businesses, and area parks. Additionally, the Heber Springs Community Center is addressing these issues with various exercise equipment and classes, including an aquatics center with classes for the elderly and arthritic.

No Personal Doctor - This need is currently being met by several free community clinics with the primary care issues addressing this concern in our market area.

BHMC-S Implementation Plans

Baptist Health Medical Center – Stuttgart

Community Health Needs Implementation Plan

IDENTIFIED COMMUNITY HEALTH NEED #1 – Smoking

GOALS / OBJECTIVES:

Promote the reduction/cessation of tobacco use within the hospital and in the community

STRATEGY #1:

Implement and promote a hospital-based tobacco education /cessation program

ACTION STEP #1

Identify patients who use tobacco products

Identification of patients who use tobacco products will be made utilizing the nursing admission process and assessment.

ACTION STEP #2:

Order tobacco cessation education

Tobacco cessation education will be ordered from the Respiratory Care department by the nurse for relevant patients

ACTION STEP #3:

Assess patient's readiness for cessation of tobacco products use by asking the patient if he or she has an interest in tobacco cessation or desire to stop using tobacco.

Provide education on the harmful effects that result from the use of tobacco products to those who express affirmatively that they have a desire to stop smoking or an interest in receiving the information.

ACTION STEP #4:

Identified patients will be provided a form to sign to participate in the Arkansas Stamp Out Smoking initiative. This form will be faxed to the Arkansas Tobacco Quit Line (1-800-QUITNOW)

DESCRIBE ANTICIPATED IMPACT OF ACTIONS TO BE TAKEN:

To increase the number each year of patients who participate in education or sign up with the Stamp Out Smoking program. This approach is prompt, appropriate and cost effective for the patient, the community and the facility. The Stamp Out Smoking program will match assistance to quit to the individual patient's needs. The program includes education, support, nicotine gum and nicotine patches.

DESCRIBE COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:

Baptist Health Medical Center-Stuttgart will work in collaboration with the Arkansas Stamp Out Smoking program and with Baptist Health Medical Center-Little Rock Respiratory Care Department.

DESCRIBE RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:

Nursing staff will be utilized for the identification of patients for this initiative. The Respiratory staff will receive any needed training and the educational resources needed to provide as assessment on readiness to quit the use of tobacco products and to implement education on tobaccos harmful effects on the general health and well-being of patients. The Director or Team Leader will coordinate all services and monitor outcomes.

PERFORMANCE METRICS:

The goal for this initiative will be to identify, educate and assess the readiness to quit for a minimum of 70% of all patients admitted at Baptist Health Medical Center-Stuttgart prior to discharge. This data will be abstracted by our Quality department, reported through American Data Network and monitored by the

Respiratory Care department. The referral outcomes will be monitored thru the Arkansas Tobacco Quitline Referral Program Fax Referral Reporting.

PROJECT LENGTH / ESTIMATED COMPLETION DATE:

This project will be on-going over the next three years 2014-2016.

PERSON / DEPARTMENT RESPONSIBLE:

Nursing - Susan Williams, CNO

Respiratory Care - Clay Brazeal and Shelly Brown, Director

PROGRESS UPDATE:

Progress will be updated annually throughout the assessment period.

STRATEGY #2:

Implement Smoking Cessation education in the Fitness Center and market area

ACTION STEP #1:

Provide information and education through the Fitness Center and the Rural Health Clinic network for health benefits in Tobacco-Use Cessation

Educational information in the form of brochures and posters will be available in the fitness center and all Baptist Health- rural health clinics in Arkansas, Prairie and Monroe counties to promote Smoking/Tobacco-Use Cessation.

ACTION STEP #2:

Individuals who request information on tobacco cessation will be provided information

Individuals can request information on tobacco cessation at rural health clinic facilities and the Fitness Center.

ACTION STEP #3:

Refer individuals for needed assistance

Identified individuals will be provided a form to sign to participate in the Arkansas Stamp Out Smoking initiative. This form will be faxed to the Arkansas Tobacco Quit Line (1-800-QUITNOW)

ACTION STEP #4:

Complete two direct mailings annually in the market area, regarding tobacco cessation information.

DESCRIBE ANTICIPATED IMPACT OF ACTIONS TO BE TAKEN:

Employees and other members of the community who utilize the Fitness Center and the Rural Health Clinic network will gain knowledge on the benefits of health in tobacco-use cessation and be aware of the resources available to assist them in quitting. The market area population will receive information on resources available for tobacco cessation.

DESCRIBE COLLABORATION WITH OTHER HOSPITALS OR ANY COMMUNITY ORGANIZATION:

Baptist Health Medical Center-Stuttgart Fitness Center will partner with the Arkansas Department of Health and the Coalition for Tobacco Free Arkansas.

DESCRIBE RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEEDS:

Resources that will be available include the Fitness Center and the rural health clinic staff, brochures and educational resource information from the Arkansas Department of Health and the Coalition for Tobacco Free Arkansas, Baptist Health Strategic Development, Baptist Health Community Outreach and Print Shop.

PERFORMANCE METRICS:

The goal is to provide referral information to all Fitness Center members for tobacco cessation at 70% of all identified tobacco users annually. The referral outcomes will be monitored through the Arkansas Tobacco Quitline Referral Program Fax Referral Reporting.

Provide Tobacco Cessation information to 200 households in the defined market area annually. Data to support goal will be address roster for household mailed to be maintained annually.

PROJECT LENGTH/ESTIMATED COMPLETION DATE:

This project will be on-going over the next three years 2014-2016.

PERSON/DEPARTMENT RESPONSIBLE:

Nursing - Susan Williams, CNO

PROGRESS UPDATE:

Progress will be updated annually throughout the assessment period.

Baptist Health Medical Center – Stuttgart

Community Health Needs Implementation Plan

IDENTIFIED COMMUNITY HEALTH NEED #2 – Diabetes

GOALS / OBJECTIVES:

To promote the control of diabetes through raising awareness and knowledge of the benefits of regular exercise, good nutrition and healthy life styles.

STRATEGY #1:

Diabetes education will be provided for individuals with diabetes and those who are at risk for the development of diabetes.

ACTION STEP #1*:*

Identify individuals at risk

Identification of individuals will be achieved through the nursing admission assessment, the Fitness Center application, physician clinic referral and Health Expo screenings.

ACTION STEP #2:

Provide comprehensive instruction for successful self-management

Educational/instructional sessions will include information on understanding diabetes, self-monitoring, and medications used to treat, avoiding complications, coping, proper med administration, safe exercise, and nutrition therapy.

ACTION STEP #3:

Assess knowledge level

The individual's knowledge will be assessed at the beginning and the completion of the program utilizing a standardized clinical form.

ACTION STEP #4:

Community events will be held during National Diabetes Awareness month.

ACTION STEP #5:

Complete two (2) direct mailings annually, in the market area regarding resources available for screening for diabetes and self-management of known diabetes.

STRATEGY #2:

Financial assistance will be provided to individuals identified with a qualifying need for medication, equipment and supplies.

ACTION STEP #1:

Individuals will be referred to on-site Medication Assistance Liaison to initiate application process.

ACTION STEP #2:

Individuals approved for assistance will receive medications and supplies at discounted price and glucometers free of charge.

DESCRIBE ANTICIPATED IMPACT OF ACTIONS TO BE TAKEN:

Increased awareness, early screening and access to medication, glucometers and supplies will lead to better control of diabetes.

DESCRIBE COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:

Baptist Health Medical Center-Stuttgart collaborates with Arkansas County Partners in Health to provide funding for grants that are used to provide diabetic self-management educational material. Baptist Health Medical Center-Stuttgart also partners with Greater Delta Alliance for Health in the Southeast Diabetes Initiative.

DESCRIBE RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:

Resources will include Nutrition and Food Services staff, Registered Dietitian, Medical Social Worker, Medication Assist Liaison, Baptist Health Strategic Development, Print Shop and Baptist Health Community Outreach.

PERFORMANCE METRICS:

A 100% of all individuals identified through the process to be at risk or to have diabetes will be offered screenings, nutritional counseling and educational resources annually. Our goal includes providing 15 people with glucometers and 50 diabetic screening annually.

Provide diabetes information to 200 households in the defined market area as evidenced by 200 individual household mailings annually. A roster of household addresses that information is mailed to will be maintained annually.

PROJECT LENGTH / ESTIMATED COMPLETION DATE:

This project will be on-going over the next three years 2014-2016.

PERSON / DEPARTMENT RESPONSIBLE:

Nutrition & Food Services - Regina McCormick, Dietitian

Nursing - Lee Long, Social Services

PROGRESS UPDATE:

Progress will be updated annually throughout the assessment period.

Baptist Health Medical Center-Stuttgart

Community Health Needs Implementation Plan

IDENTIFIED COMMUNITY HEALTH NEED #3 – Obesity

GOALS / OBJECTIVES:

Raise awareness of the importance of good nutrition and physical activity/exercise to prevent obesity and improve the general overall health quality of each individual.

STRATEGY #1:

Promote physical activity to prevent or reduce obesity through indoor walking programs for employees and exercise programs for employees and individuals in the community as defined for CHNA.

ACTION STEP #1*:*

Hospital corridors will be marked with AHA START Walking Path markers

ACTION STEP #2:

Promote membership to fitness center

Allow for payroll deduction payments for membership and special rates for industry memberships that cover all employees

ACTION STEP #3:

Promote physical activity at different levels of physical ability through Fitness Center

Low to med level activity (aerobics), medium level activity (zumba) and high level activity (boot camp) will be held at different times throughout the year.

STRATEGY #2:

Provide information in rural health clinic regarding the community resources available for exercise

ACTION STEP #1:

Provide information regarding outdoor play areas, walking tracks and community outdoor activities at each rural health clinic location.

ACTION STEP #2:

Provide brochures and counseling on the benefits of exercise and good nutrition in each rural health clinic.

DESCRIBE ANTICIPATED IMPACT OF ACTIONS TO BE TAKEN:

Increased participation in the stated exercise programs and use of recreational areas available in the area.

DESCRIBE COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:

Baptist Health Community Outreach Program Walking Program

Arkansas County Partners in Health

Arkansas Department of Health-Health Hometown Program-Obesity Coalition

American Heart Association Learn and Live START Walking Path

DESCRIBE RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:

Baptist Health Medical Center-Stuttgart will provide memberships at reasonable rates for employees, the general population and group membership rates for local industry. Payroll deduction is an option for BH employees to pay for membership. Other resources include Baptist Health Strategic Development, Print Shop and Baptist Health Community Outreach.

PERFORMANCE METRICS:

Promote Fitness Center activities to 5 companies in 2014.

Register 50 people to participate in virtual walking programs annually, beginning in 2014. Baptist Health Community Outreach Walking Program will capture the data of BHMC-S market area participants, as defined by the CHNA for community.

PROJECT LENGTH / ESTIMATED COMPLETION DATE:

This project will be on-going over the next three years 2014-2016.

PERSON / DEPARTMENT RESPONSIBLE:

Nutrition & Food Services - Regina McCormick, Dietitian

Nursing - Susan Williams, RN CNO

PROGRESS UPDATE:

Progress will be updated annually throughout the assessment period.

COMMUNITY HEALTH NEEDS NOT BEING ADDRESSED

Baptist Health Medical Center – Stuttgart

Arkansas is a state with many health needs, ranking 47th of 50 in overall health status. It is also a state with a higher proportion of underserved and uninsured individuals. Recognizing that although all of the identified needs are important, all of them cannot be pursued by BHMC-S, and choices had to be made. After establishing criteria based on the Baptist Health mission, as well as BHMC-S clinical strengths, resources and infrastructure to maintain programs, each of the identified needs was reviewed. The following community health needs will not be addressed in the BHMC-S Implementation Plan.

Heart Disease - This need is currently being addressed through the Arkansas Department of Health and the American Heart Association

Cancer - This need is currently being addressed by the Susan G. Komen Foundation, the American Cancer Society, the Arkansas Department of Health, the Arkansas Cancer Coalition and the Prostate Cancer Foundation.

Stroke - This initiative is currently being addressed by the Arkansas Department of Health and the American Heart Association.

Chronic Lower Respiratory - Due to limited resources we will not address this issue at this time. Other needs were prioritized as a greater need according to the process of the CHNA.

Injury Related Deaths - This need is currently being addressed by the Arkansas Department of Health through the Trauma Program.

Premature Death - This need being is currently being addressed by the March of Dimes.

Low Birth Weight - This need is being addressed by the March of Dimes and the Arkansas Department of Health.

Poor or Fair Physical Health Status - Due to limited resources and other needs at a higher priority for this community we presently not be addressing this need.

Poor Physical & Mental Health Days - Due to limited resources we will not address this issue at this time.

Hypertension - This need is currently being addressed by the Arkansas Department of Health.

High Cholesterol - This need is currently being addressed by the American Heart Association, the Arkansas Heart Association, and Baptist Health Medical Center-Little Rock.

Asthma - This need is currently being addressed by the Arkansas Foundation for Medical Care.

Coronary Heart Disease - This need is currently being addressed through the Arkansas Department of Health's Million Hearts program and the American Heart Association

Arthritis - This need is currently being addressed by the Arthritis Foundation of Arkansas.

Physical Inactivity - This need is currently being addressed by the Baptist Health Medical Center- Stuttgart Obesity Strategy.

Sexually Transmitted Infections - This need is currently being addressed by the Arkansas Department of Health.

Excessive Drinking - This need is currently being addressed by Mothers Against Drunk Drivers and Students Against Drunk Drivers.

Teen Birth Rate - This need is currently being addressed by the Arkansas Department of Health through the Family Planning program.

Lack of Healthy Eating - This need is currently being addresses by the University Of Arkansas Division Of Agriculture and the Arkansas Department of Health.

Colorectal Screening - This need is currently being addressed by the American Cancer Society and the Arkansas Cancer Coalition.

Mammography - This need is presently being addressed by the Susan G. Komen Foundation and the Arkansas Department of Health.

PAP Test - This need is currently being implemented by the Arkansas Department of Health through their Family Planning program.

Flu Shot - This need is currently being addressed by the Arkansas Department of Health and Baptist Health

HIV Test - This need is currently being addressed by the Arkansas Department of Health.

Preventable Hospital Stays - This need is currently being addressed by the Arkansas Foundation for Medical Care

No Personal Doctor - This need is currently being addressed by community based Christian organizations for free health care in Dewitt and Stuttgart.

Lack of PCP - This need is currently being addressed by community based Christian organizations for free health care in Dewitt and Stuttgart.

Uninsured - Due to limited resources we will not address this issue at this time

Inadequate Social Support - Due to limited resources and the need not being in our area of expertise, we will not address this issue at this time.

Children in Single-Parent Homes - Due to limited resources and need not being in our area of expertise, we will not address this issue at this time.

Lack of Recreational Facilities - Due to limited resources and need not being in our area of expertise, we will not address this issue at this time.

Percentage of Fast Food Restaurants - Due to limited resources and need not being in our area of expertise, we will not address this issue at this time.

Diabetic Screening – This need is currently being addressed by the Arkansas Department of Health and the American Diabetes Association.

BHRI Implementation Plans

Baptist Health Rehabilitation Institute

Community Health Needs Implementation Plan

IDENTIFIED COMMUNITY HEALTH NEED #1 – Stroke Prevention

GOALS / OBJECTIVES:

Increase the number of people who are educated about the dietary and lifestyle patterns which increase the risk for strokes. Increase the number of people who are educated about the early warning signs of stroke and understand the appropriate action to take when these occur.

STRATEGY #1:

Promote healthy eating and lifestyle/exercise choices aimed at reducing the risk factors for stroke as well as recognition of early signs of stroke.

ACTION STEP #1:

Increase Baptist Health's partnership with churches and community organizations by involvement in health and wellness fairs and other educational opportunities.

ACTION STEP #2:

Create a brochure including information on stroke prevention; early warning signs and resources such as support groups, caregiver assistance, therapy options, etc. for those who have experienced a stroke and provide those free of charge to community programs and events as well as other entities specializing in aged adult care in Baptist Health communities.

DESCRIBE ANTICIPATED IMPACT OF ACTIONS TO BE TAKEN:

Individuals attending BHRI Education events or reading the Stroke Education Brochure will be exposed to dietary and other lifestyle choices to decrease the risk for stroke as well as stroke early warning signs and the importance of urgent response to these signs.

DESCRIBE COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:

The collaboration will be with churches, free clinics and adult day cares to increase stroke prevention and stroke treatment awareness in Baptist Health communities.

DESCRIBE RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:

Resources needed to implement this program include staff from the following departments: Community Outreach, BHRI Stroke Program Team, BH Fitness Center and Strategic Development. Education materials will be provided by BHRI.

PERFORMANCE METRICS:

The goal is to present the "Stroke prevention" program to at least six (6) community groups or organizations in 2014 (baseline year). Goals for 2015 and 2016 will be determined from the baseline year data.

PROJECT LENGTH / ESTIMATED COMPLETION DATE:

This project will be on-going over the next three years 2014-2016.

PERSON / DEPARTMENT RESPONSIBLE:

BHRI Stroke Team will be responsible for implementing and evaluating the program.

PROGRESS UPDATE:

Program progress will be reviewed annually.

Baptist Health Rehabilitation Institute

Community Health Needs Implementation Plan

IDENTIFIED COMMUNITY HEALTH NEED #2 – Injury Prevention

GOALS / OBJECTIVES:

Increase the number of people who are educated about the lifestyle and activity choices which may lead to Brain Injury and/or Spinal Cord Injury. Increase the number of people who are educated about how to minimize fall risks in their homes.

STRATEGY #1:

Promote lifestyle and home arrangement choices to decrease the likelihood of traumatic brain and spinal cord injuries as well as the likelihood of falls within the home.

ACTION STEP #1:

Increase Baptist Health's partnership with Middle Schools and High Schools in Baptist Health communities presenting the "Think First" Spinal Cord and Brain Injury Prevention Program.

ACTION STEP #2:

Provide "Fall Prevention in the Home" presentations and literature to, community programs and events as well as and other entities specializing in aged adult care in Baptist Health communities.

DESCRIBE ANTICIPATED IMPACT OF ACTIONS TO BE TAKEN:

Individuals attending the "Think First" presentations will have education on the consequences of traumatic brain and spinal cord injuries and have an understanding of ways to improve the likelihood of prevention of these through lifestyle choices. Individuals attending the "Fall Prevention" presentations or

reading the associated literature receive education regarding the actions to take to reduce the risk of falls in their homes.

DESCRIBE COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:

The collaboration will be with community groups and entities specializing in aged adult care to provide information on injury prevention in Baptist Health.

DESCRIBE RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH

The resources needed to implement this program include staff from the following departments: Community Outreach, The BHRI Think First and Fall Prevention Coordinator, Baptist Health Fitness Center, BHRI Physical and Occupational Departments and Strategic Development Educational Materials will be provided by BHRI.

PERFORMANCE METRICS:

Our first year goal is to present the "Think First" Injury Prevention Program to at least four (4) schools in 2014 (baseline year). We also want to present the "Injury Prevention in the Home" to at least four (4) community groups or organization in 2014. Goals for 2015 and 2016 will be determined from the baseline year data.

PROJECT LENGTH / ESTIMATED COMPLETION DATE:

This project will be on-going over the next three years 2014-2016.

PERSON / DEPARTMENT RESPONSIBLE:

BHRI "Think First" and "Fall Prevention" Coordinator will be responsible for implementing and evaluating the program.

PROGRESS UPDATE:

Progress will be updated annually throughout the assessment period.

Baptist Health Rehabilitation Institute

Community Health Needs Implementation Plan

IDENTIFIED COMMUNITY HEALTH NEED #3 – Obesity

GOALS / OBJECTIVES:

Increase the number of children and adults that understand the importance of good nutrition and physical activity in maintaining health and reducing obesity.

STRATEGY #1:

Promote Healthy Eating and Active Living to Reduce the Prevalence of Obesity.

ACTION STEP #1:

Work with Employers through Community Outreach's Corporate Wellness program to promote physical activity among employees during the work day.

ACTION STEP #2:

Provide nutrition and physical activity education to the community through educational programs at Baptist Health wellness centers, special events and community health fairs, churches and private businesses. Social media, the Baptist Health Web-site and television interviews will also be utilized to promote Healthy Eating and Active Living.

DESCRIBE ANTICIPATED IMPACT OF ACTIONS TO BE TAKEN:

A comprehensive approach to educating the community about the hazards of obesity through participation in programs and attendance at educational classes will help them make better choices.

DESCRIBE COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:

BHRI will partner with the Arkansas Department of Health, Hometown Health Coalitions, the City of Little Rock, Strategic Development and Corporate Partners.

DESCRIBE RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH

The resources needed to implement this project include staff from the following departments: Community Outreach, Strategic Development, Nutrition and Food Services and the Fitness Center. Additional resource will be utilized to purchase promotional and educational materials.

PERFORMANCE METRICS:

The goal is present the "healthy eating and active living" program to at least six (6) groups or organization in 2014 (baseline year) to reduce the prevalence of obesity. Goals for 2015 and 2016 will be determined from the baseline year data.

PROJECT LENGTH / ESTIMATED COMPLETION DATE:

This project will be on-going over the next three years 2014-2016.

PERSON / DEPARTMENT RESPONSIBLE:

The Fitness Center and Community Outreach department will be responsible for implementing and evaluating the program.

PROGRESS UPDATE:

Progress will be updated annually throughout the assessment period.

STRATEGY # 2:

Promote behavioral change in obese and morbidly obese adolescents.

ACTION STEP #1:

Obtain funding to conduct a summer adolescent weight loss program.

ACTION STEP #2:

Identify adolescents who are obese or morbidly obese and enroll them in the Baptist Health Adolescent Weight Loss Program. Have parents sign participation forms which will define expectation for participants and their families.

ACTION STEP #3:

Implement the program, which includes a curriculum of education, physical activity, socialization and reward.

DESCRIBE ANTICIPATED IMPACT OF ACTIONS TO BE TAKEN:

The Adolescent Weight Loss Program will involve the family unit in understanding and addressing the health risks of the participants through education, physical activity and reward. Additional medical and mental health service referrals will be provided, as needed.

DESCRIBE COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:

BHRI will work with the BHMC-LR Health Management Center, the Baptist Health Weight Loss Program and Community Outreach will partner with the Little Rock School District and the North Little Rock School District to identify candidates for participation.

DESCRIBE RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH

The resources needed to implement this project include staff from the following departments: BHRI Fitness Center, Health Management Center, BH Weight Loss Program, Community Outreach, Strategic Development, Print Shop, Nutrition and Food Services and the Fitness Center. The pool at BHRI will be used weekly to provide low impact exercise for these adolescents. Additional resources will be needed to purchase promotional and educational materials.

PERFORMANCE METRICS:

The goal is to sign up at least ten (10) adolescents to the weight loss program in 2014 (baseline year). The hope is they will lose weight and improve other health metrics, compared to baseline measures. Goals for 2015 and 2016 will be determined from the baseline year data.

PROJECT LENGTH / ESTIMATED COMPLETION DATE:

The project will last 10 weeks, during the summer 2014. Project will also be held in 2015 and 2016.

PERSON / DEPARTMENT RESPONSIBLE:

The BHRI Fitness Center in conjunction with the Health Management Center and the BH Weight Loss Program will be responsible for implementing and evaluating the program.

PROGRESS UPDATE:

Progress will be updated annually throughout the assessment period.

COMMUNITY HEALTH NEEDS NOT BEING ADDRESSED

Baptist Health Rehabilitation Institute (BHRI)

Arkansas is a state with many health needs, ranking 47th of 50 in overall health status. It is also a state with a higher proportion of underserved and uninsured individuals. Recognizing that although all of the identified needs are important, all of them cannot be pursued by BHRI, and choices had to be made. After establishing criteria based on the Baptist Health mission, as well as BHRI clinical strengths, resources and infrastructure to maintain programs, each of the identified needs was reviewed. The following community health needs will not be addressed in the BHRI Implementation Plan.

Diabetes (Death) - This need is currently addressed by the Arkansas Department of Health, Arkansas Foundation for Medical Care, the American Diabetes Association of Arkansas and other local healthcare providers.

Diabetes (Chronic Conditions) - This need is currently addressed by the Arkansas Department of Health, Arkansas Foundation for Medical Care, the American Diabetes Association of Arkansas, the Arkansas Wellness Coalition and other local healthcare providers.

Hypertension - This need is currently being addressed by the Arkansas Department of Health. We will focus our limited resources on the other needs identified.

Coronary Heart Disease - This need is currently being addressed through the Arkansas Department of Health's Million Hearts program, the American Heart Association, and other local healthcare providers.

Asthma - This need is currently being addressed by the Arkansas Foundation for Medical Care.

Chronic Lower Respiratory - Due to limited resources we will not address this issue at this time and will focus on the other prioritized needs identified in our assessment.

Access to Recreational Facilities - This need is currently being addressed by the City of Little Rock, the City of North Little Rock, Community Centers and the Boys and Girls Clubs of Arkansas.

Smoking - The Arkansas Department of Health and the Stamp Out Smoking Initiative covers this area of concern.

Mammography - This need is being addressed by the Arkansas Department of Health, the University of Arkansas for Medical Sciences Cancer Control Outreach Center and the Komen Foundation of Arkansas.

Poor or Fair Health Status - Due to limited resources, this need will not be addressed at this time.

Poor Physical/Mental Days - This need is currently being addressed by the Arkansas Community Mental Health Centers.

Colorectal Screening - This need is being addressed by the Arkansas Cancer Coalition and the University of Arkansas for Medical Sciences Cancer Control Outreach Center.

Percentage of Fast Food Restaurants – This need is not an area of expertise for Baptist Health. Due to limited resources, this need will not be addressed at this time.

BHECH Implementation Plans

Baptist Health Extended Care Hospital

Community Health Needs Implementation Plan

IDENTIFIED COMMUNITY HEALTH NEED #1 – Stroke Prevention

GOALS / OBJECTIVES:

Increase the number of BHECH stroke patients who receive information regarding the dietary, lifestyle and medication management patterns which increase the risk for secondary strokes. Increase the number of patients and their family members who can recognize the early warning signs of stroke and are aware of the appropriate action to take when these occur.

STRATEGY #1:

Promote risk reduction behaviors aimed at reducing the risk factors for secondary stroke, as well as recognition of early signs of stroke.

ACTION STEP #1:

Develop a secondary stroke prevention template for individualized instruction on diet, activity and medication management to mitigate risk factors for secondary stroke.

ACTION STEP #2:

Provide all patients/caregivers with the Community Resource Manual at the time of discharge to provide resources that will assist patients and their caregivers in reducing stroke risk.

ACTION STEP #3:

Participate in the Hospital/Nursing Home Liaison Committees at BHMC-Little Rock and BHMC-North Little Rock. Act as a resource related to stroke prevention and treatment. Provide copies of the Community Resource Manual to area nursing

homes to assist them in providing programs and resources for their clients and families.

DESCRIBE ANTICIPATED IMPACT OF ACTIONS TO BE TAKEN:

Patients and families of Baptist Health Extended Care Hospital and nursing home representatives will receive information regarding dietary and other lifestyle choices to decrease the risk for stroke, stroke early warning signs and the importance of urgent response to these signs, as well as community resources available to them in the area of stroke prevention.

DESCRIBE COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:

The collaboration will initially be with BHRI, BHMC-LR, BHMC-NLR, area community groups, and nursing homes to increase secondary stroke prevention and stroke treatment awareness in Central Arkansas.

DESCRIBE RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:

Resources needed to implement this program include staff from the following departments: Baptist Health Extended Care Hospital Case Management, Baptist Health Community Outreach, BHRI Stroke Program Team, and Strategic Development. Education materials will be provided by Baptist Health Extended Care Hospital and BHRI.

PERFORMANCE METRICS:

The number of individuals who receive education on secondary stroke prevention, early signs of stroke and proper response will be tracked on a monthly basis with annual reporting.

PROJECT LENGTH / ESTIMATED COMPLETION DATE:

This project will be on-going over the next three years 2014-2016

PERSON / DEPARTMENT RESPONSIBLE:

Baptist Health Extended Care Hospital Leadership Team, with assistance from the Baptist Health Community Outreach department.

PROGRESS UPDATE:

Progress to be updated annually throughout the assessment period.

Baptist Health Extended Care Hospital

Community Health Needs Implementation Plan

IDENTIFIED COMMUNITY HEALTH NEED #2 – Injury Prevention

GOALS / OBJECTIVES:

Increase the number of people who receive information regarding how to minimize injuries and fall risks.

STRATEGY #1:

Promote lifestyle and home arrangement choices to decrease the likelihood of injuries and falls.

ACTION STEP #1:

Provide all patients and families of Baptist Health Extended Care Hospital with fall prevention information upon discharge.

ACTION STEP #2:

Provide "Fall Prevention in the Home" presentations and literature to community groups and other entities specializing in aged adult care, in conjunction with BHRI.

ACTION STEP #3:

Participate actively in the Hospital /Nursing Home Liaison Committees at BHMC-Little Rock and BHMC-North Little Rock to act as a resource for injury and fall prevention to nursing homes in the Central Arkansas area.

DESCRIBE ANTICIPATED IMPACT OF ACTIONS TO BE TAKEN:

Individuals attending the "Fall Prevention" presentations or reading the associated literature will have a better understanding of actions to take in order to reduce the risk of falls in their homes.

DESCRIBE COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:

The collaboration will be with area community groups and entities specializing in aged adult care to provide information on injury and fall prevention.

DESCRIBE RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH

The resources needed to implement this program include staff from the following departments: Baptist Health Community Outreach, Baptist Health Extended Care Hospital staff, BHRI Physical and Occupational Therapy Departments and Strategic Development. Educational Materials will be provided by Baptist Health Extended Care Hospital and BHRI.

PERFORMANCE METRICS:

The number of individuals who attend presentations and/or receive information on Fall Prevention will be tracked on a monthly basis, with annual reporting.

PROJECT LENGTH / ESTIMATED COMPLETION DATE:

This project will be on-going over the next three years 2014-2016

PERSON / DEPARTMENT RESPONSIBLE:

Baptist Health Extended Care Hospital Leadership Team, with assistance from the Baptist Health Community Outreach department.

PROGRESS UPDATE:

Progress to be updated annually throughout the assessment period.

COMMUNITY HEALTH NEEDS NOT BEING ADDRESSED

Baptist Health Extended Care Hospital (BHECH)

Arkansas is a state with many health needs, ranking 47th of 50 in overall health status. It is also a state with a higher proportion of underserved and uninsured individuals. Recognizing that although all of the identified needs are important, all of them cannot be pursued by BHECH, and choices had to be made. After establishing criteria based on the Baptist Health mission, as well as BHECH clinical strengths, resources and infrastructure to maintain programs, each of the identified needs was reviewed. The following community health needs will not be addressed in the BHECH Implementation Plan.

Poor or Fair Health Status - This need is currently being addressed by the Arkansas Department of Health and numerous other healthcare organizations and entities.

Poor Physical Health and Mental Health Days - This need is currently being addressed by the Arkansas Department of Health, Community Mental Health Centers, and numerous healthcare and mental health organizations and providers.

Diabetes (Chronic Conditions) - This need is currently addressed by the Arkansas Department of Health, Arkansas Foundation for Medical Care, the American Diabetes Association of Arkansas, the Arkansas Wellness Coalition and other local healthcare providers.

Hypertension - This need is currently being addressed by the Arkansas Department of Health and the American Heart Association.

Coronary Heart Disease - This need is currently being addressed through the Arkansas Department of Health's Million Hearts program, the American Heart Association, and other local healthcare providers.

Asthma - This need is currently being addressed by the Arkansas Foundation for Medical Care and the Lung Association of Arkansas.

Chronic Lower Respiratory (Death) - Due to limited resources, this issue will not be addressed at this time. This was rated as a lower priority compared to other issues, so resources will be focused on higher priority issues.

Access to Recreational Facilities - This need is currently being addressed by the City of Little Rock, the City of North Little Rock, Community Centers and the Boys and Girls Clubs of Arkansas.

Percentage of Fast Food Restaurants - Due to limited resources and lack of expertise, this issue will not be addressed at this time.

Smoking- This need is currently being addressed by the Arkansas Department of Health, Lung Association of Arkansas, American Heart Association and numerous other healthcare providers and entities.

Obesity - This need is currently being addressed by the Arkansas Department of Health, numerous healthcare providers, and many community based programs and businesses.

Colorectal Screening- This need is currently being addressed by the American Cancer Society, the Arkansas Cancer Coalition, the Arkansas Department of Health, and other local healthcare providers.

Mammography- This need is currently being addressed by the American Cancer Society, the Arkansas Department of Health, the Susan G. Komen Foundation, and other local healthcare providers.