2017
COMMUNITY HEALTH NEEDS ASSESSMENT

Baptist Health

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Introduction

Community Health Needs Assessment (CHNA) became 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 choose to address. Reports on progress with the Implementation Plans are required to be submitted annually. Every three years, this process must be repeated.

Baptist Health Mission, Vision and Values

Mission

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

Vision

Shared Christian values of service, honesty, respect, stewardship, and performance, combined with a commitment to customer satisfaction through continuous improvement, allows Baptist Health to unite Physicians, Nurses, Employees, Technology and Access into the most comprehensive healthcare provider, delivering total health services to the citizens of Arkansas. Serving the spiritual, emotional and physical needs of patients from the inception of life to support at life's end means compassionately providing total health from prevention to long-term care.

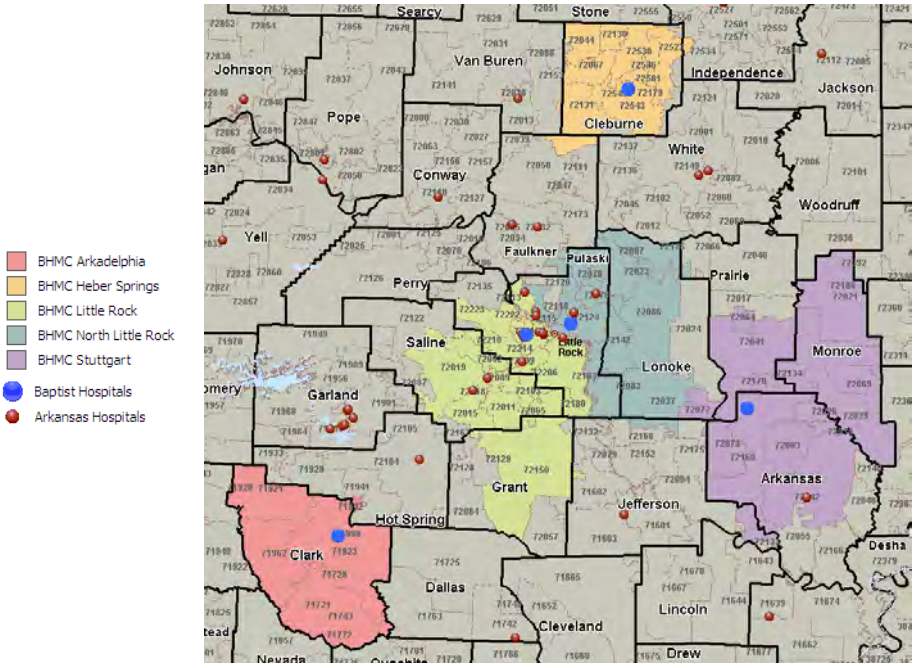
Values

In fulfilling our mission, we place special emphasis on the values of:
Service • Honesty • Respect • Stewardship • Performance

2013 Community Health Needs Assessment – A Look Back

In 2013, Baptist Health completed a CHNA for each of its seven facilities: BHMC–Little Rock, BHMC–North Little Rock, Baptist Health Extended Care Hospital, Baptist Health Rehabilitation Institute, BHMC–Stuttgart, BHMC–Arkadelphia, and BHMC–Heber Springs. This extensive process involved defining the community served, quantitative and qualitative assessment of health needs, prioritizing the health needs, developing and implementing plans to address the top needs, and measuring outcomes.

CHNA COMMUNITY SERVED DEFINITIONS DETAILED VIEW



TRUVEN HEALTH ANALYTICS

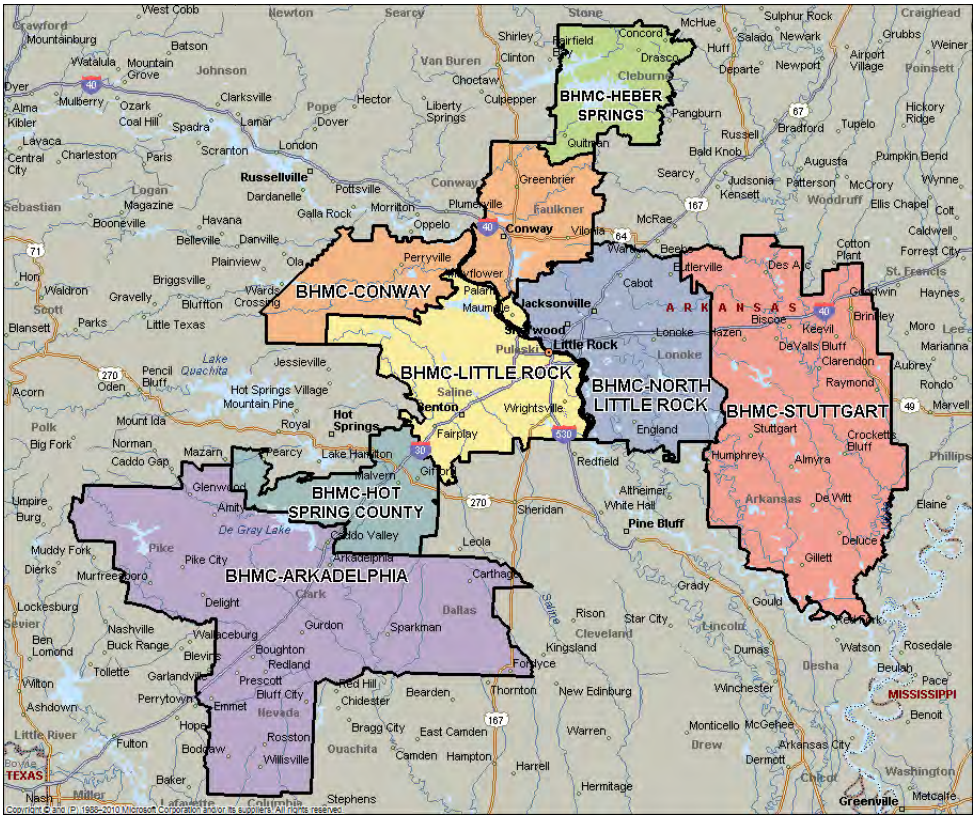
Defining communities served by each facility was based on a number of factors including market share and surrounding geography. With the exception of the Baptist Health critical access hospitals, the community was defined at the zip code level in an attempt to target needs more specifically. This presented a challenge as most quantitative and demographic data is only available at a county level.

In addition to numeric data collection, individual interviews and focus groups were utilized to acquire input from persons who represent the broad interests of the community served by each facility (a CHNA requirement). As a part of this process, 23 internal and 14 external interviews, as well as 8 focus groups were conducted. They included one for each acute care facility and one with clients from Baptist Health Wellness Centers. The Wellness Center focus group consisted primarily of medically underserved and minority individuals. Those participating in individual interviews included representatives from public health departments and local organizations, physicians and other health care providers, and representatives of medically underserved, low-income, and minority populations.

For the purposes of the 2013 CHNA, selection decisions regarding which health needs to address were at the discretion of each facility, based on that facility's priortization of the need, estimation of ability to address the need, and assessment of available/appropriate resources to implement action plans. Although each plan had measurable action steps, in some cases there appeared to be less than optimal results, with more emphasis on process measures than health outcomes. These results highlighted the limitations of trying to address community-based needs without including a much larger base of support. Individual people made positive progress, however, there was a much smaller community impact than was expected for the resources expended.

2016 Community Health Needs Assessment – A New Approach

By 2016, two additional facilities had become a part of Baptist Health. BHMC–Hot Spring County and BHMC–Conway were added to the CHNA process, for a total of nine facilities. The original CHNA process used by Baptist Health included inpatient and outpatient data, as well as market share data, to define the community served by each medical center. Those community definitions were generally preserved, however for 2016, counties initially identified through the zip code formula were utilized to define the communities, rather than the zip codes, to better align with state-wide availability of data. 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 seven acute care Baptist Health medical centers. Attention was also paid to Arkansas's ranking in respect to major health issues when compared to other states.



Methodology and Data Sources

To aid in the assessment process, the Arkansas Center for Health Improvement (ACHI) was engaged to conduct the quantitative data acquisition and analysis. National, state and county data were included.

Methods

Baptist Health provided ACHI with the counties served for each of its seven hospitals in the state—i.e., the hospital communities. A total of fifteen counties were included in the CHNA for the Baptist Health system. To assess the health-related needs of each hospital's community, ACHI gathered, synthesized, and analyzed data for approximately 70 health indicators from several data resources:

- American Community Survey (ACS)
- Arkansas Advocates for Children and Families (AACF)
- Arkansas Center for Health Improvement (ACHI)
- Arkansas Department of Health (ADH) Health Statistics Branch
- Arkansas Health Data Initiative (HDI)
- Behavioral Risk Factors Surveillance Survey (BRFSS)
- Bureau of Labor Statistics
- Centers for Disease Control (CDC) Diabetes Interactive Atlas
- CDC Wide-ranging Online Data for Epidemiologic Research (WONDER)
- Centers for Medicare and Medicaid Services (CMS)
- County Health Rankings
- EDFacts
- Fatality Analysis Reporting System

- Federal Bureau of Investigation (FBI)
- Kid Count Data Center
- National Center for Health Statistics (NCHS)
- National Vital Statistics System – Natality Files
- Sexually Transmitted Disease Surveillance System (STDSS)
- Small Area Income and Poverty Estimates (SAIPE)
- United States Department of Agriculture (USDA

Health indicators were organized into one of ten categories. The categories and health indicators within each are as follows:

1. **Health Outcomes:** Premature Death, Poor or Fair Health Status, Poor Physical Health Days, Poor Mental Health Days, Low Birth Weight
2. **Cause of Death:** All-Cause Mortality, Infant Mortality, Cancer, Stroke, Chronic Lower Respiratory, Disease, Diabetes, Heart Disease, Injury-Related Deaths, Motor Vehicle Deaths, Alcohol Impaired Driving Deaths
3. **Chronic Conditions:** Hypertension, Asthma, Coronary Heart Disease, Arthritis, High Cholesterol, Diabetes, Adult Obesity, Child Obesity
4. **Health Behaviors:** Adult Smoking, Excessive Drinking, Sexually Transmitted Infections, Fruit and Vegetable Consumption, Physical Inactivity, Teen Birth Rate, No First Trimester Health Care
5. **Prevention:** No Pap Test, No Colorectal Screening, No Flu Shot, No Prostate Screening, No HIV Test
6. **Access:** Uninsured, Primary Care Physicians, Dentists, Mental Health Providers, Preventable Hospital Stays, Mammography, Diabetic Monitoring
7. **Social and Economic:** Not High School Graduates, High School Graduation in 4 years, Some College, Unemployment, Median Household Income, Children in Poverty, Population in Poverty, Income Inequality, Children in Single-Parent Households, Social Associations, Violent Crime
8. **Environment:** Food Environment Index, Access to Exercise Opportunities, Air Pollution - Particulate Matter, Drinking Water Violations, Severe Housing Problems, Driving Alone to Work, Long Commute - Driving Alone
9. **Community Prevalence of Diagnoses:** Hypertension, Hyperlipidemia, Ischemic Heart Disease, Arthritis, Diabetes
10. **Spinal Cord Injury:** Injury Hospitalizations due to Motor Vehicle Accidents, Injury Hospitalizations due to Falls

In addition to the health indicators, demographic data were collected for each community including sex, age, race, and type of insurance coverage. All data is presented at the county, state, and national level depending upon data availability. With the exception of Community Prevalence of Diagnoses, all data were previously analyzed by publicly available resources.

Indicators within in the Diagnoses Prevalence category were obtained by ACHI from the Hospital Discharge Data in the Arkansas Health Data Initiative at ACHI. The analytic sample is comprised of all hospital discharges for Arkansas during the 2014 calendar year and restricted to adults 18 years of age and older. The five chronic conditions included in the Diagnoses Prevalence category are the five most prevalent conditions in Arkansas based on the Center for Medicare and Medicaid Services (CMS) 2014 Chronic Conditions Data Warehouse (CCW). The ICD-9-CM diagnosis codes used for these conditions were obtained from the CCW. Statistical Analysis System (SAS) software was used to analyze the primary and secondary diagnosis data. The number of discharges were divided by the estimated population (18 years and older) for each hospital's community to calculate the prevalence of adults being diagnosed with the chronic conditions in 2014.

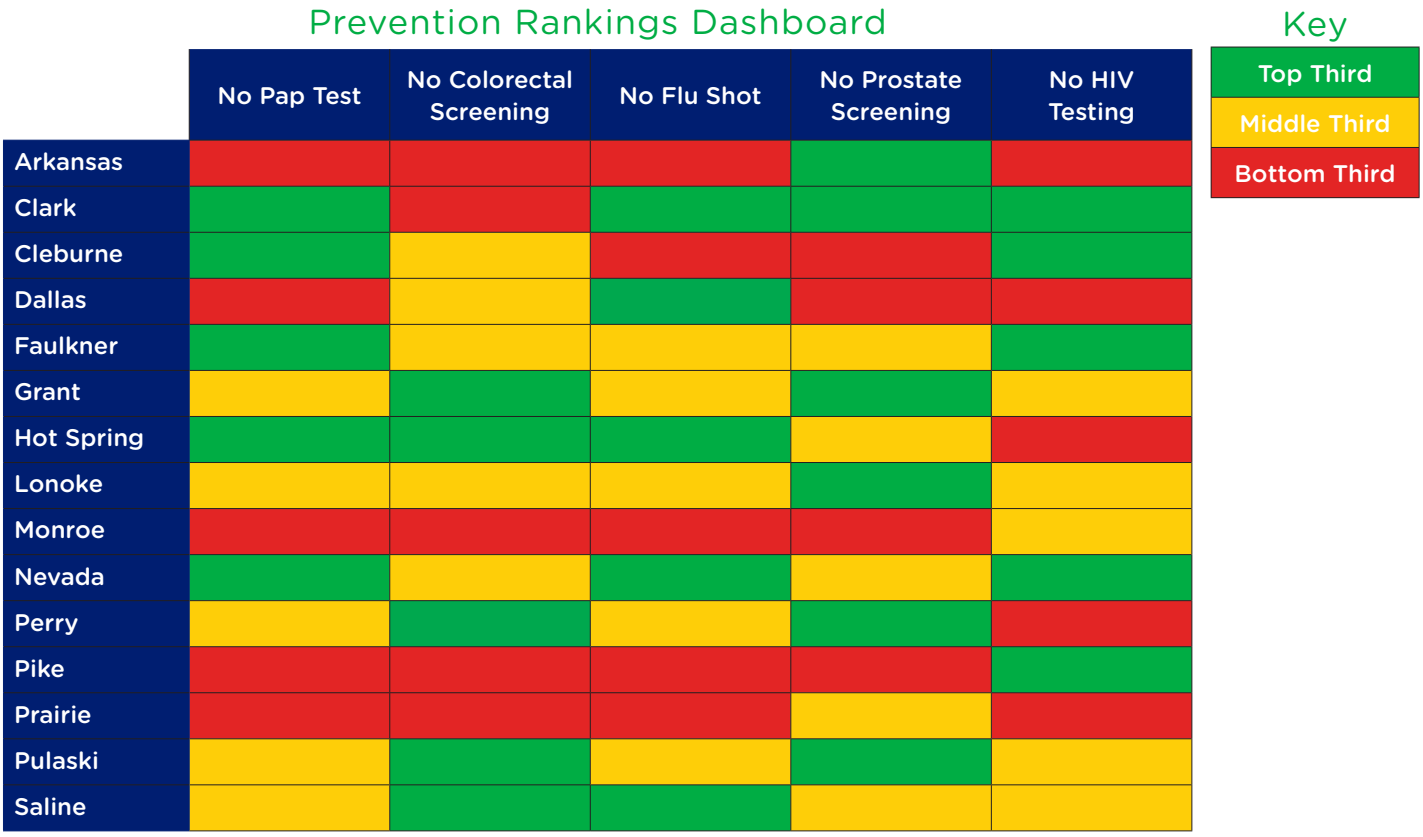
ACHI created a report for each hospital to display the quantitative results. Each report includes a table with health indicator data for each county in the hospital community, community averages (mean for each indicator for all of the hospital's counties), and averages for the State of Arkansas and the United States. If data were not available, a "NA" is displayed. Each section also includes select graphics for demographic and various health indicator data.

To assist Baptist Health in identifying priority needs for hospital communities, ACHI ranked the counties in the Baptist Health system for all health indicators in categories 1 through 9. Rankings are from 1 to 15 (with 1 representing the

highest performing county and 15 representing the lowest performing county) unless there was a tie among counties or there was missing data for counties. The rankings were then organized into quartiles and displayed on a dashboard by color for each health indicator:

- Green represents all counties rated in the top third (ranked 1 to 5)
- Yellow represents all counties rated in the middle third (ranked 6 to 10)
- Red represents all counties rated in the bottom third (ranked 11 to 15)

Below is a dashboard example for Prevention rankings:



Once the data collection and analyses were completed, a data quality check was performed to mitigate potential errors.

In addition to quantitative data collection, focus groups were utilized to acquire input from persons who represent the broad interests of the community served by each facility (a CHNA requirement). As a part of this process, Ariel Strategic Communications was contracted to conduct ten focus groups. Focus groups represented the defined community surrounding each acute care facility and one Wellness Center client-based group. Participants included representatives from public health departments and local organizations, physicians and other health care providers, and representatives of medically underserved, low-income, and minority populations.

The majority of individuals felt that the health status of the community they represent is fair to good. Issues similar to those in the 2013 CHNA were again topics of need. Obesity, diet-based problems, the need for more healthcare providers and services, and improved access to health care were identified. A significant new need identified was access to mental health services, which was discussed at a majority of the focus group meetings.

State Rankings and Additional Guidance
America's Health Rankings

As part of the community health needs assessment (CHNA), this document offers a comparison of the measurements examined in the CHNA to Arkansas's national rankings according to America's Health Rankings. Table 1 displays the health indicator and the state's ranking. The health indicators listed were used in both America's Health Rankings and the Baptist Health CHNA for each hospital. While Arkansas's rankings relative to other states is critical to identify shared priorities, examination of each of the Baptist Health communities shows that each performs differently compared to each other and to the state average. For example, although Arkansas ranks 43rd in Sexually Transmitted Infections at 524 cases of chlamydia per 100,000 population, the range within the Baptist Health communities is between 205 and 984 cases of chlamydia per 100,000. This detailed information is not available when only examining a state average.

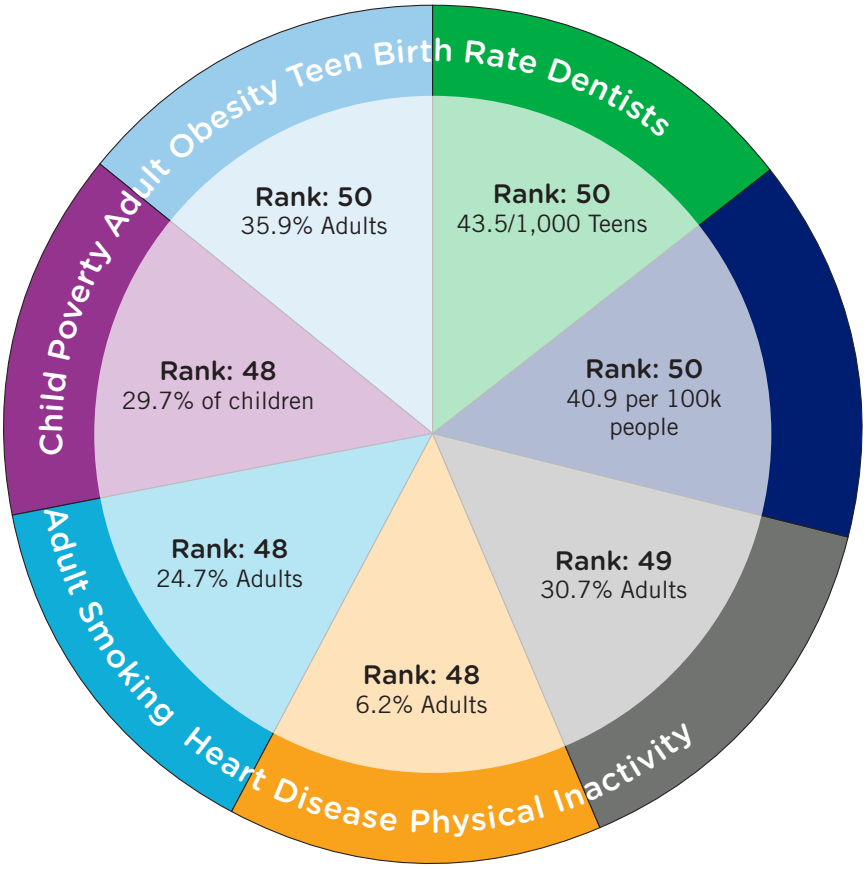


Figure 1 shows that Arkansas is the 49th most physically inactive state in the nation. This knowledge combined with county-level data in the CHNA about access to exercise opportunities, a predictor of physical activity, can help focus priorities and interventions. All of the Baptist Health communities have lower access to exercise opportunities when compared to the national average. Therefore a potential opportunity for a community benefit or building activity exists. Although America's Health Rankings can guide the search to improve health, the CHNA data offers a more detailed look at the diversity of Baptist Health communities.

Table 1. America's Health Rankings and CHNA Measures

Health Indicator*	Rank
Dentists	50
Adult Obesity	50
Teen Birth Rate	50
Physical Inactivity	49
Children in Poverty	48
Heart Disease	48
Smoking	48
Cardiovascular Deaths	47
Infant Mortality	47
Poor Physical Health Days	47
Cancer Deaths	46
Diabetes	46
High Cholesterol	46
Poor Mental Health Days	46
Preventable Hospitalizations	46
Premature Death	45
High Blood Pressure	44
Median Household Income	44
Chlamydia (Sexually Transmitted Infections)	43
Violent Crime	41
Low Birth Weight	40
Primary Care Physicians	39
Air Pollution	37
Lack of Health Insurance	35
Unemployment Rate, Annual	26
High School Graduation in 4 years	20
Binge Drinking	8

*Actual data and data source may differ with county-level data elsewhere in CHNA due to data availability

Focus Groups

Little Rock: Top Three to Four Health Needs of the Little Rock Area by Small Work Groups

Group 1 (11:30 to 2:00 p.m. Group)

- Access to/Awareness of Resources
- Education
- Mental Health

Group 2 (5:30 to 7:00 p.m. Group)

- Resources and Access
- Education for Disease/Care Process
- Obesity/Diet Issues
- Impact of Heart Disease

North Little Rock: Top Three to Four Health Needs of the North Little Rock Area by Small Work Groups

Group 1 (11:30 to 2:00 p.m. Group)

- Access to Care
- Mental Health
- Safe Neighborhoods Education-Health Issues

Group 2 (5:30 to 7:00 p.m. Group)

- Mental Health
- One Parent/No Parent Homes
- Obesity/Nutrition

Conway: Top Three to Four Health Needs of the Conway Area by Small Work Groups

Group 1 (11:30 to 2:00 p.m. Group)

- Substance Abuse
- Mental Health
- Awareness/Education
- Obesity/Nutrition

Group 2 (5:30 to 7:00 p.m. Group)

- Access to Care
- Mental Health
- Promotion of Health Habits
- Primary Care

Stuttgart: Top Three to Four Health Needs of the Stuttgart Area by Small Work Groups

Group 1 (11:30 to 2:00 p.m. Group)

- Need a Surgeon for the Community
- All Encompassing Health Fair (Diagnostics/Screenings/ Education)
- Affordable Senior Hosing/ Assisted Living
- More Providers

Heber Springs: Top Three to Four Health Needs of the Heber Springs Area by Small Work Groups

Group 1 (11:30 to 2:00 p.m. Group)

- After Hours/Urgent Care Clinics
- Addition/Mental Health Assistance
- Access to Specialized Care
- School Education Program

Malvern: Top Three to Four Health Needs of the Malvern Area by Small Work Groups

Group 1 (11:30 to 2:00 p.m. Group)

- Health Education
- Mental Illness
- Diabetes
- Obesity

Arkadelphia: Top Three to Four Health Needs of the Arkadelphia Area by Small Work Groups

Group 1 (11:30 to 2:00 p.m. Group)

- Obesity (diabetes, nutrition and heart disease)
- Mental Health
- Cancer
- Affordable Health Insurance

Data Analysis and Prioritization

To facilitate the CHNA process, 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 procedures. The CHNA Advisory Group then participated in the community health needs prioritization. Those individuals are also integral to planning and implementation processes to address health needs.

In July of 2016, qualitative and quantitative data from the community health needs assessments were presented to representatives of all Baptist Health Medical Centers and Hospitals. Data was consolidated into top findings for each facility's service area. In order to have a greater impact on population health, a change was made in the prioritization process, emphasizing selection of those health needs posing significant overall health risk. This also presented an opportunity for greater collaboration among Baptist Health facilities, with other community groups, and with state-wide organizations. It was determined that this approach would have a greater potential to positively impact more people and bring a higher level of overall awareness of health issues in the identified communities, as well as the state.

A prioritization session was held to choose two health needs to be addressed via a system-wide approach, and one additional need specific to each facility's defined community. A three-round, multi-voting technique was utilized to make final selections. Because there were similarities in some of the third needs selected, some medical centers chose to collaborate in the development action plans to achieve greater impact.

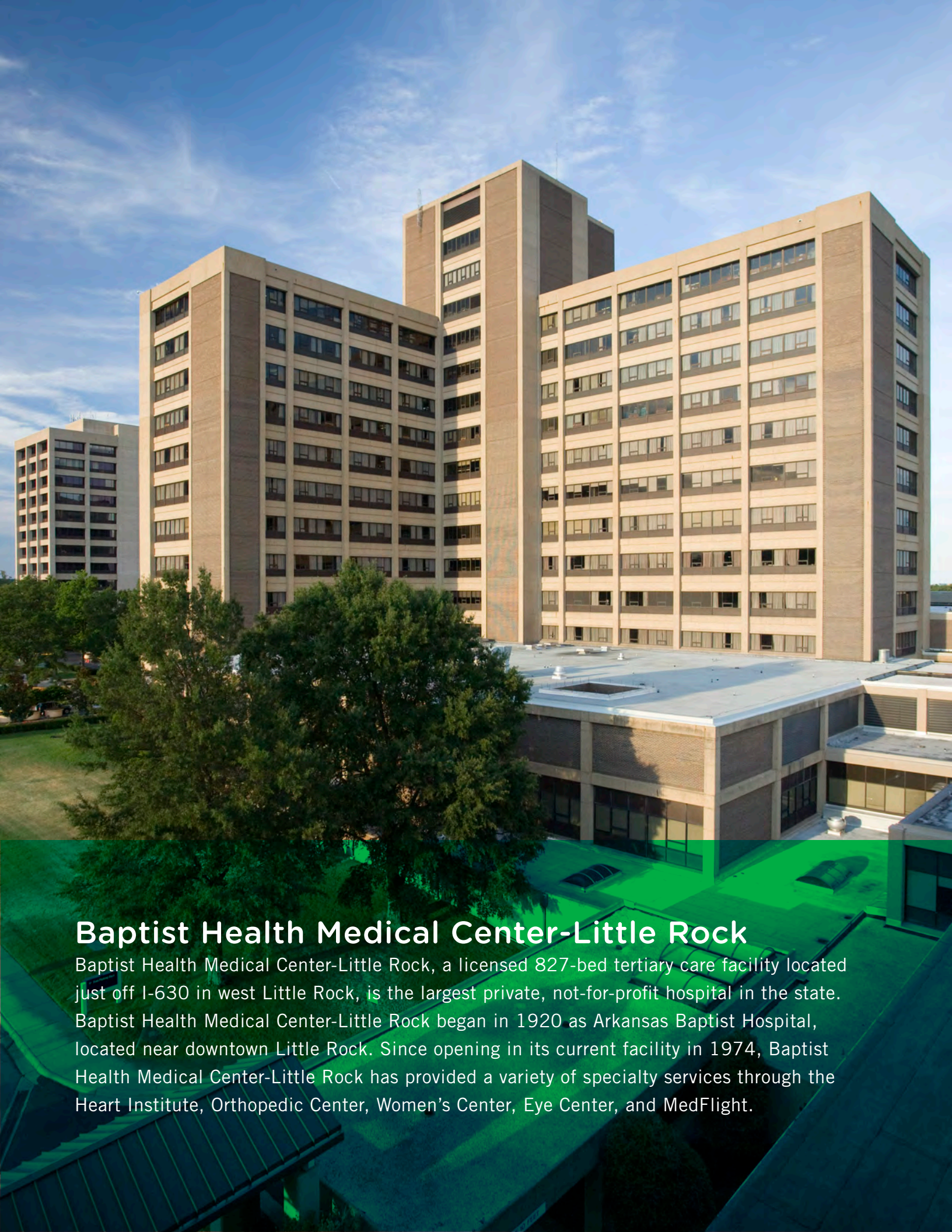
Results of the community health needs selection process determined Diabetes and Obesity would be the system-based needs addressed. In addition, Mental Health was selected by BHMC-Little Rock, BHMC-North Little Rock, and BHMC-Arkadelphia. Baptist Health Rehabilitation Institute (BHRI) elected to work on Smoking Cessation in the Post-Stroke population. Access to Healthcare was selected by BHMC-Stuttgart, BHMC-Conway, and BHMC-Heber Springs. General Health Education was chosen as the third area of emphasis by BHMC-Hot Spring County.

Focus Areas 2017-2019

Hospital	Priority 1	Priority 2	Priority 3
Little Rock	Diabetes	Obesity	Mental Health
North Little Rock	Diabetes	Obesity	Mental Health
Arkadelphia	Diabetes	Obesity	Mental Health
Conway	Diabetes	Obesity	Access to Healthcare
Heber Springs	Diabetes	Obesity	Access to Healthcare
Stuttgart	Diabetes	Obesity	Access to Healthcare
Hot Spring County	Diabetes	Obesity	Health Education
BHRI	Diabetes	Obesity	Smoking Cessation Post Stroke
BHECH	Diabetes	Obesity	NA

Action/Implementation Plans

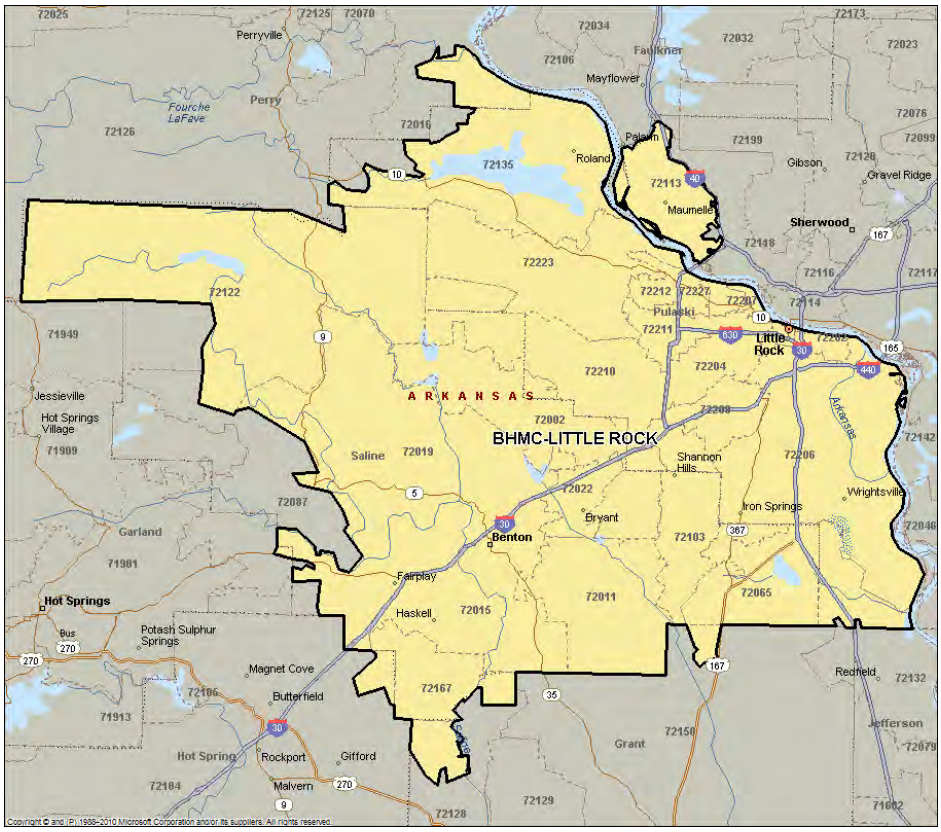
Action/Implementation Plans were developed for all prioritized needs, using a collaborative approach when multiple Baptist Health facilities and/or outside agencies could be included. For those needs not selected in the prioritization process, a rationale was developed to affirm those needs which were not addressed. All Action/Implementation Plans were approved by the Baptist Health governing body and attached to the IRS Form 990, Schedule H, as required by law.



Baptist Health Medical Center-Little Rock

Baptist Health Medical Center-Little Rock, a licensed 827-bed tertiary care facility located just off I-630 in west Little Rock, is the largest private, not-for-profit hospital in the state. Baptist Health Medical Center-Little Rock began in 1920 as Arkansas Baptist Hospital, located near downtown Little Rock. Since opening in its current facility in 1974, Baptist Health Medical Center-Little Rock has provided a variety of specialty services through the Heart Institute, Orthopedic Center, Women's Center, Eye Center, and MedFlight.

Community Served and Demographics



SEX AND AGE

	Grant County	Pulaski County	Saline County	State	Nation
Total Population	18,014	388,752	111,811	2,947,036	314,107,084
Percent Male	49.0%	48.0%	49.2%	49.1%	49.2%
Percent Female	51.0%	52.0%	50.8%	50.9%	50.8%
Age: 0 to 14	19.3%	20.1%	19.9%	20.1%	19.5%
Age: 15 to 19	6.8%	6.0%	6.1%	6.8%	6.8%
Age: under 18	23.8%	23.9%	24.0%	24.1%	23.5%
Age: 20 to 24	5.9%	7.0%	5.3%	7.0%	7.1%
Age: 25 to 34	12.2%	15.2%	13.0%	13.0%	13.5%
Age: 35 to 44	13.0%	12.9%	13.9%	12.5%	13.0%
Age: 45 to 54	15.0%	13.5%	13.5%	13.4%	14.1%
Age: 55 to 64	12.7%	12.6%	12.2%	12.3%	12.3%
Age: 65 and older	15.1%	12.7%	16.1%	15.0%	13.7%

ETHNICITY

		Grant County	Pulaski County	Saline County	State	Nation
Total Population		18,014	388,752	111,811	2,947,036	314,107,084
Hispanic		2.4%	5.9%	4.0%	6.7%	16.9%
Non-Hispanic	White	93.4%	54.6%	87.8%	73.9%	62.8%
	Black or African American	2.5%	35.3%	5.4%	15.5%	12.2%
	American Indian and Alaska Native	0.4%	0.3%	0.4%	0.6%	0.7%
	Asian	0.3%	2.1%	0.8%	1.3%	4.9%
	Pacific Islander	0.0%	0.0%	0.0%	0.2%	0.2%
	Other	0.0%	0.1%	0.0%	0.1%	0.2%
	Multiracial	0.8%	1.7%	1.6%	1.8%	2.1%

INSURANCE COVERAGE

	Grant County	Pulaski County	Saline County	State	Nation
Health Insurance Coverage	87.7%	85.2%	88.0%	84.2%	85.8%
Private Health Insurance Coverage	67.1%	63.4%	69.4%	59.1%	65.8%
Public Health Insurance Coverage	34.7%	32.8%	32.9%	37.2%	31.1%

Outcomes of 2014-2016

PREVENTABLE HOSPITAL STAYS - Baptist Health Medical Center-Little Rock implemented a Transitions and Telehealth Pilot Program focusing on heart failure, pneumonia, GI bleed, stroke and sepsis in collaboration with other hospitals. Through the program, 3,007 patients were monitored via telehealth. Homecare Coordinators were utilized as Transition Coaches providing care in three areas. Improved Case Management Services in the emergency department were implemented to include access to services seven days a week, hospice and palliative care services, and the emergency department case manager providing additional resources based on the patient's need. A Case Coordination Patient Flow Process was implemented to ensure patients are connected to primary care physicians and home health services if needed upon discharge. The Baptist Health Indigent Drug Program was utilized until enrollment in free or reduced medication programs were coordinated. "Med-to-Bed" was piloted to provide patients with medication and education prior to discharge. A grant was secured for diabetes supplies to be distributed in inpatient and outpatient settings.

DIABETES -Twenty Baptist Community Wellness Centers served as the sites for the promotion of diabetes awareness and education to over 25,000 patients during the 2014-2016 period. Diabetic risk assessment tests were administered to each new patient entering the Community Wellness Centers. In addition, those displaying an elevated risk were administered a blood glucose screening and those with a previous diabetes diagnoses were administered an A1C test. Health Education classes that ranged from cooking demonstrations to prescription medication were offered quarterly at various Community Wellness Centers. Two hundred thirty eight individuals identified as being diabetic were invited to participate in a Community Wellness Center-Based Diabetes Program and were monitored during the period with biometric screenings and education. Community Outreach secured a $427,701 grant from Verizon to implement a more aggressive diabetes program, "Leveraging Technology to Improve Diabetes Self-Management", targeting 250 individuals from the community. The program compared technology's role in self-management versus traditional self-management methods. Screening programs and services were further expanded through ongoing partnerships with the Arkansas Department of Health, Centers for Healing Hearts and Spirits, community churches and community groups, reaching and screening over 10,000 individuals.

SMOKING - Tobacco users were identified at the Community Wellness Centers and Community Health Events and offered tobacco cessation information and referrals. Tobacco Cessation Counseling services were offered to inpatients, with paperwork submitted for those expressing interest. Four staff members were trained as facilitators for the American Lung Association's Freedom From Smoking® program, a seven week course provided in a support group setting. Two Tobacco Treatment Specialists and a pharmacist were present during all of the classes.

OBESITY - Baptist Health's partnership with the national Healthy Hospitals Initiative led to the implementation of the BHealthy campaign that consists of major renovations to the cafeteria to include new healthy options; incorporation of New South Produce Cooperative community-supported agriculture program (previously Heifer USA Community Supported Agriculture program); an on-campus farmers market supporting local farmers; and changes to the employee health plan to promote healthy eating. The Community Walking Program, a 12-month physical activity program, was expanded to all regional hospitals and employees, enrolling 500 members over the 2014-2016 period and offering 10 educational classes. The National Institutes of Health's ***We Can!*** (**W**ays to **E**nhance **C**hildren's **A**ctivity & **N**utrition) initiative was adopted and two programs, ***We Can!*** CATCH Kids Club and ***We Can!*** Media Smart Youth, have been implemented at 58 sites and with presentations to over 1,600 students. Body Mass Index screenings are continually offered at 10 Community Wellness

Centers. The Sister-to-Sister Move More; Eat Better Program was implemented annually at two Community Wellness Centers with over 65 women participating.

LACK OF A PRIMARY CARE PHYSICIAN - Baptist Health's collaboration with Jefferson Comprehensive Care Systems, Inc. (JCCSI) led to opening the Little Rock Community Health Center and securing a primary care physician and advanced practice nurse for that location. Ten primary care providers were secured to practice in Pulaski, Saline and Grant counties. Opportunities were explored to add four physicians and a part-time advanced practice nurse in Benton, Little Rock, Maumelle, and North Little Rock. Fifty-one physicians specializing in general surgery, orthopedics, cardiology, nephrology, otolaryngology and vascular disease rotated through the Arkansas Health Group clinics in Grant, Pulaski and Saline counties.

2016 Process

Quantitative Data

The Arkansas Center for Health Improvement (ACHI) was engaged to conduct the quantitative data acquisition and analysis. National, state and county data were included.

Quantitative results from the 2016 Baptist Health Community Health Needs Assessment for the Little Rock hospital were obtained. There are ten sections including: Demographics, Health Outcomes, Cause of Death, Chronic Conditions, Health Behaviors, Prevention, Access, Social and Economic, Environment, and Community Prevalence of Diagnoses. Each section includes a table with health indicator data for each county in the hospital community, community averages (mean of all hospital counties), and averages for the State of Arkansas and the United States. If data were not available, a "NA" is displayed. Each section also includes graphics for various health indicator data. For more detailed information on methods, resources used, and outcomes please reference the Methods section and Appendix 1.

Interviews and Focus Groups

In addition to quantitative data collection, two focus groups were utilized to acquire input from persons who represent the broad interests of the BHMC-LR community. Participants included:

- Representative Frederick Love, Arkansas House of Representatives
- Ms. Doris Wright, Little Rock City Board of Directors
- Dr. Steven Collier, ARCare
- Ms. Karen Mays, Saline County Health Unit
- Chief Kenton Buckner, Little Rock Police Department
- Dr. Fitz Hill, Arkansas Baptist College
- Mr. Bentley Wallace, Pulaski Technical College
- Ms. Mary Jane Pfeiffer, Immanuel Baptist Church
- Ms. Ashley Carroll, University of Arkansas – Division of Agriculture
- Mr. Jason Lanier, P.A.R.K. (Positive Atmosphere Reaches Kids)
- Ms. Cynthia Hynes, Pulaski County Special School District
- Ms. Annette Lindsey, Center for Healing Hearts and Spirits
- Ms. Susan Cashion, Immanuel Baptist Church
- Dr. Joe Hargrove, Private Practice Physician
- Dr. John Ransom, Shepherd's Hope Clinic
- Ms. Lola Fish, Shepherd's Hope Clinic

Input from the Focus Groups revealed concerns regarding family structure/support, livable community, equipping people to get good jobs, dental treatment, lack of preventive health measures, effective mental health treatment and mental health awareness, substance abuse treatment, general health education, access to and education regarding health resources, obesity, under-insured for health needs, heart disease, and need for public school and church involvement in health education/programs.

Prioritized Health Needs

A prioritization session was held to choose two health needs to be addressed via a system-wide approach, and one additional need specific to each facility's defined community. A three-round, multi-voting technique was utilized to make final selections. Results of the Baptist Health community health needs selection process determined Diabetes and Obesity would be the system-based needs addressed. In addition, Mental Health was selected by BHMC-Little Rock.

Implementation Plans

Action/Implementation Plans were developed for all prioritized needs, using a collaborative approach when multiple Baptist Health facilities and/or outside agencies could be included. All plans will be reviewed and updated on an annual basis.

Information Available in Appendix

- Health Resources Available to Meet Needs
- Remainder of the Data

IDENTIFIED COMMUNITY HEALTH NEED: Obesity

GOALS/OBJECTIVES: To improve physical activity and nutrition awareness, knowledge, and behaviors among elementary-aged students by expanding the ***We Can!***® CATCH Kids club program throughout the state.

STRATEGY # 1: Expand ***We Can!*** (**W**ays to **E**nhance **C**hildren's **A**ctivity & **N**utrition).

ACTION STEPS:

1. Expand the partnership with the Arkansas Department of Health to include their statewide Community Health Program Specialists to expand reach outside of our service area.
2. Offer annual "Train the Trainer" events for staff and volunteers who are implementing the program.
3. Present six nutrition and physical activity lessons to elementary school students in 15 counties, focusing on the key concepts of Coordinated Approach to Child Health.
4. Expand the program to Regional Hospitals with identified staff.
5. Incorporate the American Heart Association's Ball to Ball initiative, donating athletic balls to schools to promote physical activity.

PERFORMANCE METRICS:

1. 2,000 students reached in 2017 with at least a 10% increase in participation in the following years.
2. 80% of students will show an increase in nutrition and physical activity awareness based on pretest/posttest/3-month delayed post-test.
3. Number of schools benefiting from the Heart Association's Ball to Ball program will be tracked and reported.

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:
Baptist Health Regional Hospitals, Arkansas Department of Health, Boys & Girls Club, HIPPY program coordinators, American Heart Association

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:
Community Outreach Staff

ESTIMATED COMPLETION DATE: Ongoing Project

PERSON(S)/DEPARTMENT RESPONSIBLE:
Baptist Health Community Outreach Driven - Teresa Conner, Leititia Bailey

IDENTIFIED COMMUNITY HEALTH NEED: Obesity

GOALS/OBJECTIVES: To educate parents, teachers, caregivers and adults on the basics of maintaining a healthy weight for their families and students.

STRATEGY # 2: Implement the ***We Can!*** (Energize Our Families: Parent Program).

ACTION STEPS:

1. Coordinate with School Wellness committees to offer the ***We Can!*** Parent Program to school teachers, parent/teacher associations.
2. Offer four nutrition and physical activity sessions to parents, caregivers and adults.
3. Utilize partnership with the Arkansas Department of Health's Community Health Program Specialist to expand beyond hospital service areas.
4. Offer grocery stores tours for participants.
5. Offer BH Farmers Market bucks as incentives to participants in program areas in central Arkansas.
6. Coordinate a grocery store tour for participants.

PERFORMANCE METRICS:

1. 8 programs will be implemented in 2017 with a 50% increase in programs in 2018 and 2019.
2. Number of participants will be tracked and reported.
3. 80% of participants will show an improvement in healthy behaviors based on pre and post assessments.
4. Pre and post test assessments will show a 75% knowledge gain.
5. Number of participants participating in the grocery store tour will be tracked and reported.

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:
Arkansas Hunger Relief Alliance, BH Foundation, Arkansas Department of Health

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:
Community Outreach Staff, Farmers Market Bucks

ESTIMATED COMPLETION DATE: Ongoing Project

PERSON(S)/DEPARTMENT RESPONSIBLE:
Baptist Health Community Outreach Driven - Teresa Conner, Leititia Bailey

IDENTIFIED COMMUNITY HEALTH NEED: Obesity

GOALS/OBJECTIVES: To educate children ages 6 and younger, parents, caregivers and adults on maintaining a healthy weight through improved food choices, increased physical activity and reduced screen time.

STRATEGY # 3: Implement the ***We Can!*** Eat, Play and Grow Program.

ACTION STEPS:

1. Pilot the eleven nutrition and physical activity sessions with children ages 6 and younger, including an at-home parent component.
2. Utilize the partnership with the Arkansas Department of Health's Community Health Program Specialist to expand beyond hospital service areas.
3. Explore opportunities to train Day Care workers to implement the program as a part of their curriculum targeting four-year-old students.
4. Pilot the program at the two Baptist Health Preschools.

PERFORMANCE METRICS:

1. Four programs piloted in 2017, with a 50% increase in programs in following years.
2. Number of sites will be tracked and reported.
3. Number of participants will be tracked and reported.
4. A process evaluation will be administered to all centers to evaluate quality and delivery of the program.

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:
Baptist Health Preschools, Little Rock School District, Arkansas Department of Health

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:
Community Outreach Staff

ESTIMATED COMPLETION DATE: Ongoing Project

PERSON(S)/DEPARTMENT RESPONSIBLE:
Baptist Health Community Outreach Driven - Teresa Conner, Leititia Bailey

IDENTIFIED COMMUNITY HEALTH NEED: Obesity

GOALS/OBJECTIVES: To increase the community's exposure to messages and tools that increase knowledge and skills for healthy living.

STRATEGY # 4: Develop an internal and external Obesity Awareness Strategy

ACTION STEPS:

1. Develop marketing efforts that encourage individuals and families to increase healthy eating and physical activity.
2. Support and expand programs and initiatives in partnership with Healthy Active Arkansas, Arkansas Obesity Coalition and Arkansas Department of Health's Hometown Health coalitions to promote healthy eating and physical activity.
3. Explore opportunities to incorporate a BH Healthy walk at Baptist Health facilities with a walking trail.
4. Incorporate healthy food in all community-based meetings to send a message to participants that Baptist Health is committed to their health.
5. Promote healthy recipes on the Baptist Health website.
6. Update and distribute the BH Fast Food Guide to include print and web downloading access availability for community events.
7. Participate in the National Healthier Hospital Initiative (HHI) in the challenge area of Healthy Food.
8. Educate patients, employees, guests and communities on the importance of eating healthy and the impact it has on overall health.
9. Increase awareness of employees and guests on the quality and variety of produce and healthy food choices available at an affordable price in all Baptist Health food service and retail locations.

PERFORMANCE METRICS:

1. Number of media releases will be tracked and reported.
2. Number of Fast Food Guides distributed will be tracked and reported.
3. Number of Fast Food Guides downloaded from the web will be tracked and reported.
4. Number of BH walking events will be tracked and reported.
5. Number of participants will be tracked and reported.
6. Number of views on the web of healthy cooking demonstrations will be tracked and reported.
7. National Healthier Hospital Initiative will be implemented.

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:

Baptist Health Community Outreach, Strategic Development, Healthy Active Arkansas, Arkansas Department of Health, Arkansas Obesity Coalition.

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:

Community Outreach Staff, Strategic Development, Regional Hospitals

ESTIMATED COMPLETION DATE: Ongoing Project

PERSON(S)/DEPARTMENT RESPONSIBLE: Margot Vogel, Teresa Conner

IDENTIFIED COMMUNITY HEALTH NEED: Obesity

GOALS/OBJECTIVES: Promote breastfeeding among expectant and new mothers, identifying the positive effect in reducing obesity and rates of chronic disease.

STRATEGY # 5: Incorporate breastfeeding information, education and support in all community-based prenatal classes and events.

ACTION STEPS:

1. Develop programs, provide support, and build awareness that breastfeeding is the optimal way of providing young infants with nutrients they need for healthy growth and development.
2. Promote evidence-based breastfeeding education and certification programs to the community outreach staff.
3. Provide evidence-based education/classes for families to promote breastfeeding with a focus on low-income patients in all prenatal programs.
4. Incorporate the lactation telehealth service administered by the Women's Health Center to include Community Outreach patients.
5. Maintain a dedicated room for breastfeeding moms in the Heaven's Loft Clinics.

PERFORMANCE METRICS:

1. Number of educational classes with pre/post testing showing knowledge gain will be implemented in all School-Based Prenatal Programs.
2. Two Safety Baby Showers will be implemented to include information on breastfeeding.
3. Number of telemonitoring lactation consultations will be tracked and reported
4. Number of classes offered on breastfeeding will be tracked and reported.
5. Number or participants in classes will be tracked and reported

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:
Community Outreach, Women's Resource Center, School Districts

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:
Community Outreach Staff, Telehealth–Women's Resource Center, Arkansas Department of Health, Healthy Active Arkansas Initiative

ESTIMATED COMPLETION DATE: Ongoing Project

PERSON(S)/DEPARTMENT RESPONSIBLE: Baptist Health Community Outreach Driven - Teresa Conner, Paula Launius, Kenley Throgmartin, Jenny Stanfield

IDENTIFIED COMMUNITY HEALTH NEED: Obesity

GOALS/OBJECTIVES: Promote walking as a form of increasing physical activity.

STRATEGY # 6: Expand the Community Walking Program in an effort to improve individual's physical activity knowledge and behaviors.

ACTION STEPS:

1. Evaluate and update current Community Walking Program structure to include identifying activity level at the beginning of the program.
2. Increase Community Walking Program participants, utilizing the current membership as the baseline data.
3. Provide participants with a t-shirt, pedometer, walking log and water bottle.
4. Offer quarterly educational classes on Physical Fitness and Nutrition.
5. Offer a monthly newsletter with healthy topics.
6. Offer participants monthly weigh-in opportunities at Community Wellness Centers.
7. Expand the program to Regional Hospitals, incorporating identified walking trails in each community for participants to utilize.
8. Offer incentives for participating, to include BH Farmers Market Bucks, Grocery store gift cards and a fitbit.
9. Identify and promote BH community walking locations.

PERFORMANCE METRICS:

1. 25% increase in enrollment each year based on 2016 baseline data.
2. 25% of participants will report walking 4 or more times a week.
3. 25% will have increased their overall physical activity habits (pre/post program self-reported assessment).
4. Number of classes will be tracked and reported.
5. Number of class participants will be tracked and reported.

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:
Baptist Health Congregational Health Initiative, City of Little Rock-Community Centers, Faith-based organizations

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:
Community Outreach Staff, Strategic Development, Health Management Center, Regional Hospitals, BHRI

ESTIMATED COMPLETION DATE: Ongoing Project

PERSON(S)/DEPARTMENT RESPONSIBLE: Baptist Health Community Outreach Driven - Teresa Conner, Leititia Bailey

IDENTIFIED COMMUNITY HEALTH NEED: Obesity

GOALS/OBJECTIVES: Through the BHealthy Farmers Market Program, provide access to local, healthy food and nutrition education to all populations, and in turn, help financially support Arkansas farmers.

STRATEGY # 7: Maintain and Expand the Baptist Health Farmers Market Program.

ACTION STEPS:

1. Continue weekly summer Farmers Markets at hospitals in Little Rock and North Little Rock.
2. Expand program reach by adding a Farmers Market program in the Conway area.
3. Provide free Cooking Matters classes in partnership with the Arkansas Hunger Relief Alliance.
4. Provide free cooking demonstrations, performed by local professional chefs, and through partnership with student chefs at the Pulaski Technical College Culinary Arts School.
5. Host both a Kids Day and a Teens Day to teach the importance of healthy eating and exercise for all ages.
6. Through the Healthy & Active Youth Program, supply free produce vouchers for each participant, and also provide an educational field trip to a local farm.
7. Through the BHealthy Mobile Farmers Market Program and in partnership with the FarmBox2Family Charity Food Box Program, pack and deliver free produce boxes and conduct healthy cooking demonstrations via a Mobile Kitchen Unit.
8. Through partnership with DHS, provide SNAP benefits and Double Dollars programs in all program markets.
9. Supply weekly vouchers to current Baptist Health breast cancer patients and heart patients for free produce and easy healthy recipes to encourage healthy eating during their illness and recovery.
10. Provide Arkansas farmers with a free location to sell their produce, as well as training opportunities and grant funding opportunities to assist in the continued success of their farms.

PERFORMANCE METRICS:

1. Expansion of Conway Farmers Market complete
2. Number of cooking classes will be tracked and reported
3. Number of participants in the cooking classes will be tracked and reported
4. 3,000 people will be served with the Charity Food Box Program
5. Number of free student vouchers redeemed will be tracked and reported
6. Number of vouchers provided to Breast Cancer patients and Heart patients will be tracked and reported
7. Number of farmers participating will be tracked and reported.
8. Number of participants utilizing SNAP will be tracked and reported.

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS: Arkansas Department of Human Services, Arkansas Hunger Alliance, Pulaski Technical College Culinary Arts Schools, Health Management Center, Community Outreach, Strategic Development, Nutrition and Food Services, Arkansas Obesity Coalition, Arkansas farmers

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:
Foundation Staff and Financial Support

ESTIMATED COMPLETION DATE: Ongoing

PERSON(S)/DEPARTMENT RESPONSIBLE: Baptist Health Foundation

IDENTIFIED COMMUNITY HEALTH NEED: Obesity

GOALS/OBJECTIVES: Develop and implement a year-round adolescent Healthy and Active Youth Program targeting overweight and obese teens and tweens.

STRATEGY # 8: Provide early intervention for young people who already have developed unhealthy habits in an effort to establish an understanding of the benefits of good nutrition and exercise and their positive effects on lifelong health.

ACTION STEPS:

1. Develop a year-round curriculum for improving nutrition and physical activity for individuals aged 11-18, employing incentives, and involving family of participants.
2. Develop a business plan for the program to include grant-funded scholarships for those who qualify for financial hardship.
3. Obtain authorization and secure program resources.
4. Market the service and implement.

PERFORMANCE METRICS:

1. Number of individuals achieving weight loss goals.
2. Number of individuals achieving fitness goals.

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:
Schools, Pediatricians

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:
0.5 FTE to start

ESTIMATED COMPLETION DATE: Mid-2017 to be operational, Ongoing

PERSON(S)/DEPARTMENT RESPONSIBLE: Weight Management in the Health Management Center

IDENTIFIED COMMUNITY HEALTH NEED: Mental Health

GOALS/OBJECTIVES: Improve community first responders' ability to effectively interact with psychiatric patients.

STRATEGY # 1: Provide training for MEMS, Fire Fighters and Police Officers.

ACTION STEPS:

1. Provide quarterly in-service/workshop for First Responders in Central Arkansas.
2. Include education on the different disease processes and intervention tools.
3. Offer opportunities for Psychiatric rotations for MEMS medical trainees.

PERFORMANCE METRICS:

1. Number of training sessions will be tracked and reported.
2. Number of participants will be tracked and reported.

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:
MEMS, Fire Department, Police Department

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:
Licensed Personnel (Therapists and RN's)

ESTIMATED COMPLETION DATE: Ongoing

PERSON(S)/DEPARTMENT RESPONSIBLE: Bob Burchfield

Community Health Needs Assessment – Implementation Plan 2017-2019

Baptist Health Medical Center-Little Rock

IDENTIFIED COMMUNITY HEALTH NEED: Mental Health

GOALS/OBJECTIVES: Increase awareness of Mental Health issues by increasing opportunities to receive depression screenings in the community.

STRATEGY # 2: Offer free depression screenings at the Baptist Health Community Wellness Centers.

ACTION STEPS:

1. Expand the partnership with the University of Arkansas at Little Rock to recruit Senior Level Psychiatric students to perform depression screenings.
2. Assign student/students to perform screenings, follow-up and referrals at the Baptist Health Community Wellness Centers annually.

PERFORMANCE METRICS:

1. Number of students recruited from UALR will be tracked and reported.
2. Number of depression risk assessments performed at 10 Baptist Health Community Wellness Centers will be reported.
3. Number of referrals and follow-ups will be tracked and reported.

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:
UALR

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:
Staff and Printing

ESTIMATED COMPLETION DATE: Ongoing

PERSON(S)/DEPARTMENT RESPONSIBLE: Amanda Thompson, Teresa Conner

IDENTIFIED COMMUNITY HEALTH NEED: Mental Health

GOALS/OBJECTIVES: To improve access to behavioral health services.

STRATEGY #3: Increase access for patients in the AHG/PP Clinics to receive mental health counseling through Telehealth.

ACTION STEPS:

1. Increase staffing in the Baptist Health Behavioral Health Center to include a Medical Doctor and an Advanced Nurse Practitioner to expand services to additional AHG/PP clinics.
2. Place a minimum of 23 Telehealth monitoring carts at AHG/PP clinics.
3. Utilize a Centralized Care Coordinator to support all AHG/PP clinics with their telehealth assessments and referrals.

PERFORMANCE METRICS:

1. Number of Telehealth Monitoring Carts will be tracked and reported.
2. Number of patient contacts will be tracked by Centralized Care Coordinator.
3. Number of referrals will be tracked and reported.

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:
Baptist Health Regional Hospitals

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:
Staff and Telehealth Carts

ESTIMATED COMPLETION DATE: Ongoing

PERSON(S)/DEPARTMENT RESPONSIBLE: Kourtney Matlock

IDENTIFIED COMMUNITY HEALTH NEED: Mental Health

GOALS/OBJECTIVES: To help meet behavioral health needs within Arkansas by improving access to Mental Health Resources.

STRATEGY # 4: Implement a call center that will allow 24-hour access to community members in need of mental health services.

ACTION STEPS:

1. Develop and maintain a call center with a toll- free number, available 24/7, in order to provide immediate access to a mental health provider.
2. Develop a plan to include evaluating patient calls to identify need for immediate care or referral appointments.
3. Develop an internal and external communication plan to promote the service.

PERFORMANCE METRICS:

1. Number of calls received on the call line will be tracked and reported.
2. Number of patients referred for additional care will be tracked and reported.
3. Number of patients referred to 911 will be tracked and reported.
4. Baseline data will be collected during the first year of operation and used to show growth.

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:
Baptist Health Regional Hospitals

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:
BHRI, Strategic Development

ESTIMATED COMPLETION DATE: Ongoing

PERSON(S)/DEPARTMENT RESPONSIBLE: Bob Burchfield

IDENTIFIED COMMUNITY HEALTH NEED: Mental Health

GOALS/OBJECTIVES: To help meet behavioral health needs within Arkansas by improving access to Mental Health Resources.

STRATEGY # 5: Identify and Promote Mental Health Resources in the Baptist Health Service Areas.

ACTION STEPS:

1. Develop a community-based resource guide to identify mental health resources available.
2. Make the resource guide available for download on the Baptist Health website.
3. Utilize Senior UALR students to assist with identifying available resources.
4. Develop an internal and external communication plan to promote the resource guide.

PERFORMANCE METRICS:

1. Development of the Guide (process evaluation).
2. Number of Guides distributed will be tracked and reported.
3. Number of Guides downloaded off the Baptist Health website will be tracked and reported.

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:
Baptist Health Regional Hospitals, Strategic Development

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:
Staff and Printing

ESTIMATED COMPLETION DATE: Ongoing

PERSON(S)/DEPARTMENT RESPONSIBLE: Teresa Conner, Community Outreach RN's

IDENTIFIED COMMUNITY HEALTH NEED: Mental Health

GOALS/OBJECTIVES: To help meet behavioral health needs within central Arkansas by improving access to Mental Health Resources.

STRATEGY # 6: Implement a Mental Health First Aid class for community leaders and care-givers.

ACTION STEPS:

1. Partner with faith-based community leaders to implement a Mental Health First Aid Class in central Arkansas and BH regional hospitals annually.
2. Pilot a Mental Health First Aid workshop in the Little Rock, Pulaski County and North Little Rock School Districts.
3. Provide a Mental Health Resource Guide to participants.

PERFORMANCE METRICS:

1. Number of new partnerships established will be tracked and reported.
2. Pre/Post test will be administered to assess knowledge gained.
3. Number of presentations will be tracked and reported.
4. Number of participants will be tracked and reported.

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:
Baptist Health Regional Hospitals, Congregational Health Project

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:
Community Outreach, Pastoral Care

ESTIMATED COMPLETION DATE: Ongoing

PERSON(S)/DEPARTMENT RESPONSIBLE: Stan Wilson, Teresa Conner, Cheryl Johnson

Community Health Needs Assessment – Implementation Plan 2017-2019

Baptist Health Medical Center-Little Rock

IDENTIFIED COMMUNITY HEALTH NEED: Diabetes

GOALS/OBJECTIVES: Improve the overall health and well-being of patients with diagnosed Type II diabetes who attend the Community Outreach Wellness Centers in Central Arkansas.

STRATEGY # 1: Provide evidence-based diabetes self-management education to improve diabetes management and reduce complications with a targeted group of patients.

ACTION STEPS:

1. Implement the use of electronic medical records in all community-based wellness center in an effort to provide more accurate tracking and reporting.
2. Recruit patients to participate in a nurse-led diabetes self-management program.
3. Provide evidence-based diabetes education.
4. Provide baseline biometric screenings.
5. Offer quarterly biometric screenings as check points for program adjustments for improved patient outcomes.
6. Offer monthly educational classes on diabetes at 4 community wellness centers, to include healthy cooking classes, medication usage and grocery store tours.
7. Maintain a Diabetes support group.
8. Pilot the use of a Telehealth cart in at least one community wellness center to improve access to a dietitian, social worker and additional certified diabetic educators.

PERFORMANCE METRICS:

1. Number of Diabetic patients recruited will be tracked and reported.
2. The following goals will be measured:
    a. 25% of patients will show an improvement in Blood Glucose Levels.
    b. 25% of patients will show an improvement in A1C by at least 1 percent.
    c. 25% of patients will show an improvement in total cholesterol.
    d. 10% of patients will show improvement in BMI.
    e. 10% of patients will have blood pressure readings less than or equal to 140/90.
    f. 100% of patients will be screenings for smoking, flu shots, dilated eye exams, annual foot exams, A1C, and dental exam.
3. Number of consults and referrals resulting from the Telehealth consults will be tracked and reported.

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS: Baptist Health North Little Rock, Telehealth

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED: Community Outreach Staff, Telehealth, Baptist Health IT

ESTIMATED COMPLETION DATE: Ongoing

PERSON(S)/DEPARTMENT RESPONSIBLE: Teresa Conner, Cheryl Johnson, Wendy Byrd, Rachel White

IDENTIFIED COMMUNITY HEALTH NEED: Diabetes

GOALS/OBJECTIVES: Expand the Community-Based Diabetes Self-Management Program in partnership with Verizon Wireless.

STRATEGY # 2: Evaluate the use of technology and its benefits in helping improve diabetes self-management at the community level.

ACTION STEPS:

1. Partner with Verizon Wireless to expand the "Leveraging Technology to Improve Diabetes Self-Management for the Medically Underserved" Grant.
2. Recruit 100 new patients between the ages of 18 and 40 as participants in Central Arkansas.
3. Provide monthly contact and monitoring through Telehealth equipment.
4. Provide screening supplies and equipment for participants.
5. Offer monthly educational classes with health care professionals to include CDE's, Dietitians, Social Workers, Pharmacists and Exercise Specialists.
6. Offer monthly support group meetings.
7. Provide evidence-based diabetes self-management practices.
8. Seek additional grant funds in year 2018, to continue in 2019.

PERFORMANCE METRICS:

1. Number of patients recruited.
2. A1C Readings: 75% of patients will show a reduction of greater than or equal to 1%.
3. Blood Pressure: 50% of participants will have a blood pressure equal to or less than 140/90.
4. Blood Sugar: 50% of patients will show improvement in blood sugar readings.
5. Weight Loss: 50% of patients will show an improvement in BMI numbers.
6. Increased Physical Activity: 75% of patients will show increased physical activity based on pre and post assessment, along with pedometer tracking.
7. Diabetes Education: 90% of patients will show an increased knowledge of diabetes self-management based on pre and post assessment.
8. Cholesterol Levels: 75% of participants will have a cholesterol level equal to or less than 200.

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS: Verizon Wireless, Care Innovations, Strategic Development

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED: Community Outreach Staff and funds from Verizon Wireless

ESTIMATED COMPLETION DATE: Ongoing

PERSON(S)/DEPARTMENT RESPONSIBLE: Community Outreach RN's, Teresa Conner, Wendy Byrd

IDENTIFIED COMMUNITY HEALTH NEED: Diabetes

GOALS/OBJECTIVES: Develop an internal and external plan to increase diabetes awareness.

STRATEGY # 3: Create, maintain, and share a continuously updated repository of diabetes public communication messages (addressing awareness, prevention, and control), along with objective data and case stories demonstrating their execution and effectiveness.

ACTION STEPS:

1. Collect, write, and distribute success stories of healthy diabetes self-management accomplishments by patients.
2. Promote community-based screening events using print, radio and social media.
3. Promote health information, resources and risk assessments on the Baptist Health website.
4. Update existing quality diabetes resources and tools, and create new resources and tools as needed.
5. Continue promotion of Diabetes Prevention and Control Program and Diabetes Advisory Group resources and tools developed through the Diabetes Advisory Committee Partnership.
6. Utilize Baptist Health clinical expertise to assist with delivery of consistent evidence-based health messages.
7. Implement evidence-based health communication strategies and messaging to reach audiences at increased risk for type 2 diabetes.
8. Identify benchmarks for measuring effectiveness of communication interventions over time (e.g., awareness, knowledge, attitude, beliefs, and actions).
9. Promote statewide resources, tools, and programs to ensure reach to all citizens.
10. Collaborate with communities, schools, and other care providers to facilitate educational opportunities, resources, and awareness campaigns for type 2 diabetes prevention and diabetes control.
11. Utilize the Baptist Health Huddles to promote Diabetes Awareness and Education during Diabetes Awareness Month and other appropriate times.

PERFORMANCE METRICS:

1. Number of stories featured in print, radio and social media promoting diabetes awareness will be tracked and reported.
2. Number of interviews featuring diabetes awareness, prevention and/or management will be tracked and reported.
3. Number of community presentations on diabetes awareness, prevention and management will be tracked and reported.
4. Number of new and existing partnerships maintained that focus on diabetes will be tracked and progress reported.
5. Number of Huddles focused on diabetes will be tracked and reported.

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS: Baptist Health Regional Hospitals, Arkansas Department of Health, Diabetes Advisory Committee

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED: Staff and Printing

ESTIMATED COMPLETION DATE: Ongoing

PERSON(S)/DEPARTMENT RESPONSIBLE: Strategic Development Staff, Teresa Conner, Wendy Byrd

IDENTIFIED COMMUNITY HEALTH NEED: Diabetes

GOALS/OBJECTIVES: Develop an internal and external plan to increase diabetes awareness.

STRATEGY # 4: Promote early detection of diabetes and prevention of type 2 diabetes across the life span through collaboration with organizations, faith-based entities and communities in hospital service areas.

ACTION STEPS:

1. Offer diabetes risk assessment tests at community screening events.
2. Utilize the monthly diabetes support group to provide current diabetes education and self-management skills.
3. Partner with the Arkansas Department of Health to implement the Arkansas Barber and Beauty shop screening initiative annually.
4. Establish and maintain community partnerships to promote and conduct glucose screenings for pre-diabetes and diabetes.
5. Implement a referral process for patients identified at high risk or with undiagnosed diabetes.
6. Partner with schools to offer diabetes education and screening for appropriate personnel.

PERFORMANCE METRICS:

1. Number of patients identified and referred for follow-up who scored at risk on the diabetes risk assessment test will be tracked and reported.
2. Number of patients reached and referred during the Arkansas Barber and Beauty Shop initiative will be tracked and reported.
3. Number of community partnerships established and maintained, to include successes, will be tracked and reported.
4. Number of school-based screenings will be tracked and reported.
5. Number of community screenings with results will be tracked and reported.

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:
Baptist Health North Little Rock

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:
Staff and Screening supplies

ESTIMATED COMPLETION DATE: Ongoing

PERSON(S)/DEPARTMENT RESPONSIBLE: Teresa Conner, Leititia Bailey, Community Outreach RN staff

IDENTIFIED COMMUNITY HEALTH NEED: Diabetes

GOALS / OBJECTIVES: Reduce the overall costs associated with diabetes management in identified populations.

STRATEGY # 5: Offer remote monitoring via Health Harmony to high risk diabetic plan members at Baptist Health. Patients will receive continuous monitoring, medication education and teaching via telehealth through this program to assess the cost impact this program would have on high risk populations overall.

ACTION STEPS:

1. Identify population and baseline costs (via Crimson).
2. Host patient sign up programs.
3. Use Transition Care Nurses and centralized diabetic educators to manage the patients and their daily results.

PERFORMANCE METRICS:

1. Baseline healthcare costs vs. 6 months of costs associated with remote monitoring.

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:
Arkansas Blue Cross Blue Shield

RESOURCES HOSPITAL PLANS TO COMMITT TO ADDRESS HEALTH NEED: Part-Time Transition of Care Nurse, Baptist Health Physician Partners or certified diabetic educator

ESTIMATED COMPLETION DATE: 1/1/2017 – 9/30/2017 (cost data is based on claims and will have a 3 to 6 month lag)

PERSON(S) / DEPARTMENT RESPONSIBLE: Kourtney Matlock and Shannon Clark

Community Health Needs Not Being Addressed

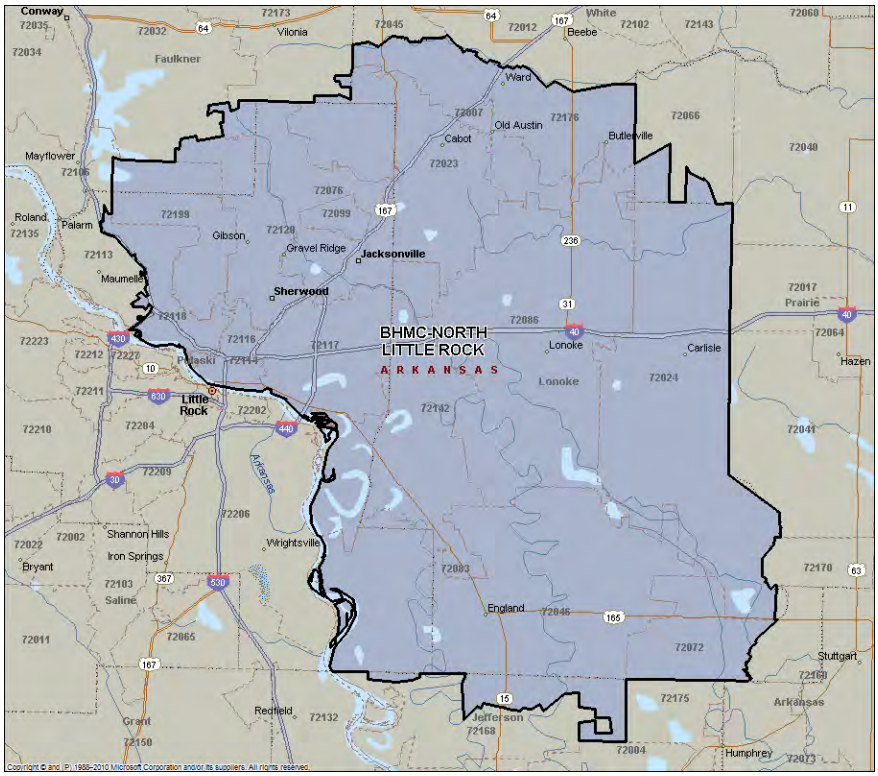
Baptist Health Medical Center-Little Rock

Baptist Health acknowledges that the implementation strategy adopted does not address all the community health needs identified and that all of the identified needs are important. 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 from the focus groups and data collection was reviewed and prioritized. We do believe the focus areas selected will indirectly have a positive impact on many of the other items identified in the Community Health Needs Assessment. While we can't address every need, Baptist Health plans to share information on appropriate resources for the communities we serve.

Baptist Health Medical Center-North Little Rock

Baptist Health Medical Center-North Little Rock, a 220-bed hospital located at the Springhill exit off of I-40, became a part of Baptist Health in 1962. Originally named Memorial Hospital and located on Pershing, the hospital moved to its current location in 1999. Baptist Health Medical Center-North Little Rock's innovative design was based on community research with a focus on patient-centered care in order to better serve the needs of north central Arkansas.

Community Served and Demographics



SEX AND AGE

	Lonoke County	Pulaski County	State	Nation
Total Population	70,118	388,752	2,947,036	314,107,084
Percent Male	49.2%	48.0%	49.1%	49.2%
Percent Female	50.8%	52.0%	50.9%	50.8%
Age: 0 to 14	22.4%	20.1%	20.1%	19.5%
Age: 15 to 19	7.0%	6.0%	6.8%	6.8%
Age: under 18	27.0%	23.9%	24.1%	23.5%
Age: 20 to 24	5.9%	7.0%	7.0%	7.1%
Age: 25 to 34	14.1%	15.2%	13.0%	13.5%
Age: 35 to 44	14.2%	12.9%	12.5%	13.0%
Age: 45 to 54	13.6%	13.5%	13.4%	14.1%
Age: 55 to 64	10.8%	12.6%	12.3%	12.3%
Age: 65 and older	11.9%	12.7%	15.0%	13.7%

ETHNICITY

		Lonoke County	Pulaski County	State	Nation
Total Population		70,118	388,752	2,947,036	314,107,084
Hispanic		3.7%	5.9%	6.7%	16.9%
Non-Hispanic	White	87.3%	54.6%	73.9%	62.8%
	Black or African American	6.2%	35.3%	15.5%	12.2%
	American Indian and Alaska Native	0.4%	0.3%	0.6%	0.7%
	Asian	0.6%	2.1%	1.3%	4.9%
	Pacific Islander	0.0%	0.0%	0.2%	0.2%
	Other	0.1%	0.1%	0.1%	0.2%
	Multiracial	1.7%	1.7%	1.8%	2.1%

INSURANCE COVERAGE

	Lonoke County	Pulaski County	State	Nation
Health Insurance Coverage	87.3%	85.2%	84.2%	85.8%
Private Health Insurance Coverage	69.0%	63.4%	59.1%	65.8%
Public Health Insurance Coverage	31.4%	32.8%	37.2%	31.1%

Outcomes of 2014-2016

PREVENTABLE HOSPITAL STAYS – Baptist Health Medical Center–North Little Rock adopted a Transition Model designed to educate and monitor "at risk" patients for 30 days post-hospital discharge. Under the Transition Model, the Transitions of Care (TOC) team has reduced the readmissions of the high risk population from 14.4% to 10.3%. In addition, LPN Call Nurses were added to identify discharged patients that have a high likelihood of re-admission. On average, about 22 patients have been identified per month who were in need of assistance and were referred to the TOC team. The Risk for Readmission Tool was administered during all nursing admission assessments. The Nursing Home and Hospital Liaison Committee was expanded to include other health care providers. A community-based flu vaccination program, in partnership with Baptist Health Medical Center – Little Rock, was implemented serving nearing 1,500 individuals at Community Wellness Centers and events.

DIABETES – A community-based gestational diabetes program was developed through the Heaven's Loft Community Wellness Center to monitor and educate women on diabetes during and post-pregnancy. The Diabetes Risk Assessment test, adopted from the American Diabetes Association, and blood glucose screenings were administered in partnership with Baptist Health Medical Center in Little Rock to over 10,000 individuals attending community health fairs and events. Individuals identified as being diabetic were invited to participate in a Community Wellness Center-Based Diabetes Program and were monitored with biometric screenings and educated The Head North to Health event, held annually, provided health screenings to over 400 North Little Rock and surrounding city residents. Baptist Health Medical Center – North Little Rock partnered with Baptist Health Medical Center – Little Rock and the Arkansas Department of Health for the annual Arkansas Minority Barber and Beauty Shop Health Initiative, reaching one thousand individuals.

REDUCTION OF INFANT MORTALITY - Reducing the infant mortality rate at Baptist Health Medical Center – North Little Rock has been achieved through decreasing non-medically indicated Early Elective Deliveries (EED); administering the Critical Congenital Heart Disease (CCHD) screening for 100% of non-transferred newborns; providing Neonatal Car Seat Screening and Angle Tolerance Test for 100% of newborns meeting the criteria; providing access to Lactation Consultants; improving the percentage of newborns exclusively fed breast milk during hospitalizations; and providing the Centers for Disease Control and Prevention's recommended vaccinations to 100% of non-immunized post-partum patients. In the community, Perinatal and Well Baby Care Education was promoted through the Heaven's Loft Wellness Center with educational classes, weekly screenings and access to other needed resources. Infant safety was promoted through a Child Passenger Safety Program, Summer Safety Program and annual Safety Baby Showers. Nearly 300 car seats were distributed and installed through the Child Passenger Safety Program. During the 2014-2016 period, nearly 2,900 expectant and new mothers visited Heaven's Loft for services. A partnership with North Little Rock High School provided a school-based perinatal and well-baby educational program for expectant young women.

2016 Process

Quantitative Data

The Arkansas Center for Health Improvement (ACHI) was engaged to conduct the quantitative data acquisition and analysis. National, state and county data were included.

Quantitative results from the 2016 Baptist Health Community Health Needs Assessment for the North Little Rock hospital

were obtained. There are ten sections including: Demographics, Health Outcomes, Cause of Death, Chronic Conditions, Health Behaviors, Prevention, Access, Social and Economic, Environment, and Community Prevalence of Diagnoses. Each section includes a table with health indicator data for each county in the hospital community, community averages (mean of all hospital counties), and averages for the State of Arkansas and the United States. If data were not available, a "NA" is displayed. Each section also includes graphics for various health indicator data. For more detailed information on methods, resources used, and outcomes, please reference the Methods section and Appendix 1.

Interviews and Focus Groups

In addition to quantitative data collection, two focus groups were utilized to acquire input from persons who represent the broad interests of the BHMC-NLR community. Participants included:

- Ms. Tjuana Byrd, Attorney
- Ms. Beth White, North Little Rock Alderman
- Mr. Danny Bradley, Chief of Staff – NLR Mayor's Office
- Ms. Ashley Hight, NLR Chamber of Commerce
- Pastor Ken Shaddox, Parkhill Baptist Church
- Mr. Steve Canady, NLR School District
- Ms. Carey Woods, NLR Health Department
- Dr. Karen Burks, Physician
- Ms. Lynn Welsh, Meadow Park Neighborhood Association
- Officer Tommy Norman, NLR Police Department

Input from the Focus Groups revealed concerns regarding obesity/nutrition; mental health access and medication adherence for all ages; unsafe neighborhoods with one-parent or no-parent homes; access to healthcare, healthy food and physical activity; and health/disease education.

Prioritized Health Needs

A prioritization session was held to choose two health needs to be addressed via a system-wide approach, and one additional need specific to each facility's defined community. A three-round, multi-voting technique was utilized to make final selections. Results of the Baptist Health community health needs selection process determined Diabetes and Obesity would be the system-based needs addressed. In addition, Mental Health was selected by BHMC-North Little Rock.

Implementation Plans

Action/Implementation Plans were developed for all prioritized needs, using a collaborative approach when multiple Baptist Health facilities and/or outside agencies could be included. All plans will be reviewed and updated on an annual basis.

Appendix

- Health Resources Available to Meet Needs
- Remainder of the Data

IDENTIFIED COMMUNITY HEALTH NEED: Obesity

GOALS/OBJECTIVES: To improve physical activity and nutrition awareness, knowledge, and behaviors among elementary-aged students by expanding the ***We Can!*** CATCH Kids club program throughout the North Little Rock service area.

STRATEGY # 1: Expand ***We Can!*** (**W**ays to **E**nhance **C**hildren's **A**ctivity & **N**utrition).

ACTION STEPS:

1. Expand the partnership with the Arkansas Department of Health to include their statewide Community Health Program Specialists to expand reach students in the service area.
2. Participate in the annual "Train the Trainer" events for staff and volunteers who are implementing the program.
3. Offer six nutrition and physical activity lessons to elementary school students in 15 counties focusing on the key concepts of Coordinated Approach to Child Health.
4. Expand the program among Regional Hospitals with identified staff.
5. Explore partnerships with boys and girls clubs to implement the program.

PERFORMANCE METRICS:

1. Students reached in 2017 will serve as a baseline. Increase participation by 10% in 2018 and 2019.
2. 80% of students will show an increase in nutrition and physical activity awareness based on pretest/posttest/3-month delayed post-test.

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:
Baptist Health Little Rock, Arkansas Department of Health, Boys & Girls Club, School Districts

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:
Community Outreach Staff

ESTIMATED COMPLETION DATE: Ongoing Project

PERSON(S)/DEPARTMENT RESPONSIBLE:
Baptist Health Community Outreach Driven - Teresa Conner, Leititia Bailey

IDENTIFIED COMMUNITY HEALTH NEED: Obesity

GOALS/OBJECTIVES: To educate parents, teachers, caregivers and adults on the basics of maintaining a healthy weight for their families and students.

STRATEGY #2: Implement the ***We Can!*** (Energize Our Families: Parent Program).

ACTION STEPS:

1. Coordinate with School Wellness Committees to offer the ***We Can!*** Parent Program to school teachers, parent/teacher associations.
2. Offer four nutrition and physical activity sessions to parents, caregivers and adults.
3. Utilize partnership with the Arkansas Department of Health's Community Health Program Specialist to expand beyond hospital service areas.
4. Offer Grocery store tours for participants.
5. Offer BH Farmers Market bucks as incentives to participants in program areas in central Arkansas.

PERFORMANCE METRICS:

1. Four programs implemented in 2017 with a 50% increase in programs in 2018 and 2019.
2. Number of participants will be tracked and reported.
3. 80% of participants will show an improvement in healthy behaviors based on pre and post assessments.
4. Pre and post-test assessments will show a 75% knowledge gain.
5. Number of participants participating in the grocery store tours will be tracked and reported.

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:
Arkansas Hunger Relief Alliance, BH Foundation, Arkansas Department of Health, School Districts

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:
Community Outreach Staff, Farmers Market Bucks

ESTIMATED COMPLETION DATE: Ongoing Project

PERSON(S)/DEPARTMENT RESPONSIBLE: Baptist Health Community Outreach Driven - Teresa Conner, Leititia Bailey

IDENTIFIED COMMUNITY HEALTH NEED: Obesity

GOALS/OBJECTIVES: To educate children ages 6 and younger, parents, caregivers and adults on maintaining a healthy weight through improved food choices, increased physical activity and reduced screen time.

STRATEGY # 3: Implement the ***We Can!*** Eat, Play and Grow Program.

ACTION STEPS:

1. Pilot the eleven session nutrition and physical activity sessions with children ages 6 and younger, including an at-home parent component.
2. Utilize partnership with the Arkansas Department of Health's Community Health Program Specialist to expand beyond hospital service areas.
3. Explore opportunities to train Day Care workers to implement the program as a part of their curriculum targeting four-year-old students.
4. Pilot the program at the Baptist Health Preschool in North Little Rock.

PERFORMANCE METRICS:

1. Four programs piloted in 2017, with a 50% increase in programs in following years in Central Arkansas.
2. Number of sites will be tracked and reported.
3. Number of participants will be tracked and reported.
4. A process evaluation will be administered to all centers to evaluate quality and delivery of the program.

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:
Baptist Health Preschool, North Little Rock School District, Arkansas Department of Health

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:
Community Outreach Staff

ESTIMATED COMPLETION DATE: Ongoing Project

PERSON(S)/DEPARTMENT RESPONSIBLE: Baptist Health Community Outreach Driven - Teresa Conner, Leititia Bailey

IDENTIFIED COMMUNITY HEALTH NEED: Obesity

GOALS/OBJECTIVES: Increase the community's exposure to messages and tools that increase knowledge and skills for healthy living and physical activity.

STRATEGY # 4: Support an internal and external Obesity Awareness Strategy.

ACTION STEPS:

1. Partner with Strategic Development to develop marketing efforts that encourage individuals and families to increase healthy eating and physical activity.
2. Support and expand programs and initiatives in partnership with Healthy Active Arkansas, Arkansas Obesity Coalition and Hometown Health coalitions to promote healthy eating and physical activity.
3. Explore opportunities to incorporate a BH Healthy Walk at Baptist Health Facilities with a walking trail.
4. Incorporate healthy food in all community-based meetings to send a message to participants that Baptist Health is committed to their health.
5. Promote healthy recipes on the Baptist Health website.
6. Update and distribute the BH Fast Food Guide to include print and web downloading access to increase availability for community events.
7. Educate patients, employees, guests and communities on the importance of eating healthy and the impact it has on overall health.
8. Increase awareness of employees and guests on the quality and variety of produce and healthy food choices available at an affordable price in all Baptist Health food service and retail locations.

PERFORMANCE METRICS:

1. Number of media releases will be tracked and reported.
2. Number of Fast Food Guides distributed will be tracked and reported.
3. Number of Fast Food Guides downloaded from the web will be tracked and reported.
4. Number of BH walking events will be tracked and reported.
5. Number of participants will be tracked and reported.
6. Number of views on the web of healthy cooking demonstrations will be tracked and reported.
7. National Healthier Hospital Initiative will be implemented.

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:
Baptist Health Community Outreach, Strategic Development, Healthy Active Arkansas, Arkansas Department of Health, Arkansas Obesity Coalition

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:
Community Outreach Staff, Strategic Development, Baptist Health Regional Hospitals

ESTIMATED COMPLETION DATE: Ongoing Project
PERSON(S)/DEPARTMENT RESPONSIBLE: Margot Vogel, Teresa Conner

IDENTIFIED COMMUNITY HEALTH NEED: Obesity

GOALS/OBJECTIVES: Promote breastfeeding among expectant and new mothers, identifying the positive effect in reducing obesity and rates of chronic disease.

STRATEGY # 5: Incorporate breastfeeding information, education and support at Heaven's Loft.

ACTION STEPS:

1. Develop programs, provide support, and build awareness that breastfeeding is the optimal way of providing young infants with nutrients they need for healthy growth and development.
2. Provide evidence-based education/classes for families to promote breastfeeding with a focus on low-income participants at Heaven's Loft.
3. Incorporate the lactation telehealth service administered by the Women's Health Center to include Community Outreach patients.
4. Maintain a dedicated room for breastfeeding moms in the Heaven's Loft Clinics.

PERFORMANCE METRICS:

1. Number of Educational Classes with pre/post testing showing knowledge gain will be implemented in all School-Based Prenatal Programs.
2. Two Safety Baby Showers will be implemented to include information on breastfeeding.
3. Number of telemonitoring lactation consultations will be tracked and reported.
4. Four Classes will be held on breastfeeding at Heaven's Loft.
5. Number of participants in all classes will be tracked and reported.

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:
Community Outreach, Women's Resource Center

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED: Community Outreach Staff, Telehealth, Women's Resource Center, Arkansas Department of Health, Healthy Active Arkansas Initiative

ESTIMATED COMPLETION DATE: Ongoing Project

PERSON(S)/DEPARTMENT RESPONSIBLE: Baptist Health Community Outreach Driven - Teresa Conner, Paula Launius, Kenley Throgmartin, Jenny Stanfield

IDENTIFIED COMMUNITY HEALTH NEED: Obesity

GOALS/OBJECTIVES: Promote walking as a form of increasing physical activity.

STRATEGY # 6: Expand the Community Walking Program in an effort to improve individual physical activity knowledge and behaviors.

ACTION STEPS:

1. Increase the Community Walking Program participants, utilizing current membership as the baseline data.
2. Provide participants with a t-shirt, pedometer, walking log and water bottle.
3. Offer quarterly educational classes on Physical Fitness and Nutrition.
4. Offer a monthly newsletter with healthy topics.
5. Offer Participants monthly weigh-in opportunities at Community Wellness Centers.
6. Expand the Program to Regional Hospitals, incorporating identified walking trails in each community for participants to utilize.
7. Offer incentives for participating, to include BH Farmers Market Bucks, Grocery store gift cards, and a fitbit.
8. Identify and promote BH community walking locations.

PERFORMANCE METRICS:

1. 25% increase in enrollment each year.
2. 25% of participants will report walking 4 or more times a week.
3. 25% will have increased their overall physical activity habits (pre/post program self-reported assessment).
4. Number of classes will be tracked and reported.
5. Number of class participants will be tracked and reported.

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:
Baptist Health Congregational Health Initiative, City of Little Rock-Community Centers, Faith-based organizations

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:
Community Outreach Staff, Strategic Development, Health Management Center, Regional Hospitals

ESTIMATED COMPLETION DATE: Ongoing Project

PERSON(S)/DEPARTMENT RESPONSIBLE: Baptist Health Community Outreach Driven - Teresa Conner, Leititia Bailey

IDENTIFIED COMMUNITY HEALTH NEED: Obesity

GOALS/OBJECTIVES: Through the BHealthy Farmers Market Program, provide access to local, healthy food and nutrition education to all populations, and in turn, help to financially support Arkansas farmers.

STRATEGY #7: Maintain and expand the Baptist Health Farmers Market Program.

ACTION STEPS:

1. Continue weekly summer Farmers Markets at hospitals in Little Rock and North Little Rock.
2. Provide free Cooking Matters classes in partnership with the Arkansas Hunger Relief Alliance.
3. Provide free cooking demonstrations, performed by local professional chefs, and through partnership with student chefs at the Pulaski Technical College Culinary Arts School.
4. Through the Healthy & Active Youth Program, supply free produce vouchers for each participant, as well as an educational field trip to a local farm.
5. Through the BHealthy Mobile Farmers Market Program and in partnership with the FarmBox2Family Charity Food Box Program, pack and deliver free produce boxes, and conduct healthy cooking demonstrations via a Mobile Kitchen Unit.
6. Through partnership with DHS, provide SNAP benefits and Double Dollars programs in all of our markets.
7. Supply weekly vouchers to current Baptist Health breast cancer patients and heart patients for free produce and easy healthy recipes to encourage healthy eating during their illness and recovery.
8. Provide Arkansas farmers with a free location to sell their produce, as well as training opportunities and grant funding opportunities to assist in the continued success of their farms.

PERFORMANCE METRICS:

1. Number of farmers participating will be tracked and reported.
2. Number of cooking classes will be tracked and reported.
3. Number of participants in the cooking classes will be tracked and reported.
4. Number of people served with the Charity Food Box Program will be tracked and reported.
5. Number of free student vouchers redeemed will be tracked and reported.
6. Number of vouchers provided to Breast Cancer patients and Heart patients will be tracked and reported.
7. Number of participants utilizing SNAP benefits will be tracked and reported.

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:
Arkansas Department of Human Services, Arkansas Hunger Relief Alliance, Pulaski Technical College Culinary Arts Schools, Health Management Center, Community Outreach, Strategic Development, Nutrition and Food Services, Arkansas Obesity Coalition, Arkansas farmers

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:
Staff and Financial Support

ESTIMATED COMPLETION DATE: Ongoing

PERSON(S)/DEPARTMENT RESPONSIBLE: Baptist Health Foundation

IDENTIFIED COMMUNITY HEALTH NEED: Mental Health

GOALS/OBJECTIVES: Improve community first responders' ability to effectively interact with psychiatric patients.

STRATEGY # 1: Provide training for MEMS, Fire Fighters and Police Officers.

ACTION STEPS:

1. Provide quarterly in-service/workshop for First Responders in Central Arkansas.
2. Include education on different disease processes and intervention tools.
3. Offer Opportunities for Psychiatric rotations for MEMS medical trainees.

PERFORMANCE METRICS:

1. Number of training sessions will be tracked and reported.
2. Number of participants will be tracked and reported.

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:
MEMS, Fire Department, Police Department

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:
Licensed Personnel (Therapists and RN's)

ESTIMATED COMPLETION DATE: Ongoing

PERSON(S)/DEPARTMENT RESPONSIBLE: Bob Burchfield

IDENTIFIED COMMUNITY HEALTH NEED: Mental Health

GOALS/OBJECTIVES: Increase awareness of Mental Health issues by increasing opportunities to receive depression screenings in the community.

STRATEGY # 2: Offer free depression screenings at the Baptist Health Community Wellness Centers and appropriate community events.

ACTION STEPS:

1. Expand the partnership with the University of Arkansas at Little Rock to recruit Senior Level Psychiatric students to perform depression screenings.
2. Assign students to perform screenings, follow-up and referrals at the Baptist Health Community Wellness Centers annually.
3. Provide depression screening during the annual Head North to Health event.

PERFORMANCE METRICS:

1. Number of students recruited from UALR will be tracked and reported.
2. Depression risk assessments will be conducted at 8 Baptist Health Community Wellness Centers.
3. Number of referrals and follow-ups will be tracked and reported.

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS: UALR

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED: Staff and Printing

ESTIMATED COMPLETION DATE: Ongoing

PERSON(S)/DEPARTMENT RESPONSIBLE: Amanda Thompson, Teresa Conner

IDENTIFIED COMMUNITY HEALTH NEED: Mental Health

GOALS/OBJECTIVES: To improve access to behavioral health services.

STRATEGY #3: Increase access for patients in the AHG/PP Clinics to receive mental health counseling through Telehealth.

ACTION STEPS:

1. Increase staffing in the Baptist Health Behavioral Health Center to include a Medical Doctor and an Advanced Nurse Practitioner to expand services to additional AHG/PP clinics.
2. Place Telehealth carts in selected AHG/PP clinics.
3. Utilize a Centralized Care Coordinator to support all AHG/PP clinics with their Telehealth assessments and referrals.

PERFORMANCE METRICS:

1. Number of Telehealth Monitoring Carts will be tracked and reported.
2. Number of patient contacts will be tracked by Centralized Care Coordinator.
3. Number of referrals will be tracked and reported.

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:
Baptist Health regional facilities

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:
Staff and Telehealth Carts

ESTIMATED COMPLETION DATE: Ongoing

PERSON(S)/DEPARTMENT RESPONSIBLE: Kourtney Matlock

IDENTIFIED COMMUNITY HEALTH NEED: Mental Health

GOALS/OBJECTIVES: To help meet behavioral health needs within Arkansas by improving access to Mental Health Resources.

STRATEGY # 4: Develop and promote a call center that will allow for 24 hour access to community members in need of mental health services.

ACTION STEPS:

1. Develop and refer patients and community members in need to the call center which will provide 24 hour/ 7 days per week immediate access to a mental health provider.
2. Participate in an internal and external communication plan to promote the service.

PERFORMANCE METRICS:

1. Number of patients referred for additional care will be tracked and reported.
2. Number of patients referred to 911 will be tracked and reported.

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:
Baptist Health Regional Hospitals

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:
BHRI, Strategic Development

ESTIMATED COMPLETION DATE: Ongoing

PERSON(S)/DEPARTMENT RESPONSIBLE: Bob Burchfield

IDENTIFIED COMMUNITY HEALTH NEED: Mental Health

GOALS/OBJECTIVES: To help meet behavioral health needs within central Arkansas by improving access to Mental Health Resources.

STRATEGY # 5: Implement a Mental Health First Aid class for community leaders and care-givers.

ACTION STEPS:

1. Partner with faith-based community leaders to implement a Mental Health First Aid Class in central Arkansas and BH regional hospitals annually.
2. Pilot a Mental Health First Aid workshop in the Little Rock, Pulaski County and North Little Rock School Districts.
3. Provide a Mental Health Resource Guide to participants.

PERFORMANCE METRICS:

1. Number of new partnerships established will be tracked and reported.
2. Pre/Post test will be administered to assess knowledge gain.
3. Number of presentations will be tracked and reported.
4. Number of participants will be tracked and reported.

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:
Baptist Health Regional Hospitals, Congregational Health Project

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:
Community Outreach, Pastoral Care

ESTIMATED COMPLETION DATE: Ongoing

PERSON(S)/DEPARTMENT RESPONSIBLE: Stan Wilson, Teresa Conner, Cheryl Johnson

IDENTIFIED COMMUNITY HEALTH NEED: Diabetes

GOALS/OBJECTIVES: Improve the overall health and well-being of patients with diagnosed Type II diabetes who attend the Community Outreach Wellness Centers in Central Arkansas.

STRATEGY # 1: Provide evidence-based diabetes self-management education to improve diabetes management and reduce complications with a targeted group of patients.

ACTION STEPS:

1. Implement the use of electronic medical records in all community-based wellness centers in an effort to provide more accurate tracking and reporting.
2. Recruit patients to participate in a nurse-led diabetes self-management program.
3. Provide evidence-based diabetes education.
4. Provide baseline biometric screenings.
5. Offer quarterly biometric screenings as check points for program adjustments for improved patient outcomes.
6. Offer monthly educational classes on diabetes at 4 community wellness centers, to include healthy cooking classes, medication usage and grocery store tours.
7. Maintain a Diabetes support group.
8. Pilot the use of a Telehealth cart in at least one community wellness center to improve access to a dietitian, social worker and additional certified diabetic educators.

PERFORMANCE METRICS:

1. Number of Diabetic patients recruited will be tracked and reported.
2. The following goals will be measured:
    a. 25% of patients will show an improvement in Blood Glucose Levels.
    b. 25% of patients will show an improvement in A1C by at least 1 percent.
    c. 25% of patients will show an improvement in total cholesterol.
    d. 10% of patients will show improvement in BMI.
    e. 10% of patients will have blood pressure readings less than or equal to 140/90.
    f. 100% of patients will be screenings for smoking, flu shots, dilated eye exams, annual foot exams A1C, and dental exam.
3. Number of consults and referrals resulting from the Telehealth consults will be tracked and reported.

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS: BHMC – Little Rock, Telehealth

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED: Community Outreach Staff, Telehealth, Baptist Health IT

ESTIMATED COMPLETION DATE: Ongoing

PERSON(S)/DEPARTMENT RESPONSIBLE: Teresa Conner, Cheryl Johnson, Wendy Byrd, Rachel White

IDENTIFIED COMMUNITY HEALTH NEED: Diabetes

GOALS/OBJECTIVES: Expand the Community-Based Diabetes Self-Management Program in partnership with Verizon Wireless.

STRATEGY # 2: Evaluate the use of technology and its benefits in helping improve diabetes self-management at a community level.

ACTION STEPS:

1. Partner with Verizon Wireless to expand the "Leveraging Technology to Improve Diabetes Self-Management for the Medically Underserved" grant.
2. Recruit 100 new patients between the ages of 18 and 40 as participants in Central Arkansas.
3. Provide monthly contact and monitoring through Telehealth equipment.
4. Provide screening supplies and equipment for participants.
5. Offer monthly educational classes with health care professionals, to include CDE's, Dietitians, Social Workers, Pharmacists and Exercise Specialists.
6. Offer monthly support group meetings.
7. Provide evidence-based diabetes self-management practices.
8. Seek additional grant funds in year 2018, to continue in 2019.

PERFORMANCE METRICS:

1. Number of patients recruited.
2. A1C Readings: 75% of patients will show a reduction of greater than or equal to 1%.
3. Blood Pressure: 50% of participants will have a blood pressure equal to or less than 140/90.
4. Blood Sugar: 50% of patients will show improvement in blood sugar readings.
5. Weight Loss: 50% of patients will show an improvement in BMI numbers.
6. Increased Physical Activity: 75% of patients will show increased physical activity based on pre and post assessment, along with pedometer tracking.
7. Diabetes Education: 90% of patients will show increased knowledge of diabetes self-management based on pre/post-assessment.
8. Cholesterol Levels: 75% of participants will have a cholesterol level equal to or less than 200.

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS: BHMC – Little Rock , Verizon Wireless, Care Innovations, Strategic Development

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED: Community Outreach Staff and funds from Verizon Wireless

ESTIMATED COMPLETION DATE: Ongoing

PERSON(S)/DEPARTMENT RESPONSIBLE: Community Outreach RN's, Teresa Conner, Wendy Byrd

IDENTIFIED COMMUNITY HEALTH NEED: Diabetes

GOALS/OBJECTIVES: Implement an internal and external plan to increase diabetes awareness.

STRATEGY # 3: Create, maintain, and share a continuously updated repository of diabetes public communication messages (addressing awareness, prevention, and control), along with objective data and case stories demonstrating their effectiveness.

ACTION STEPS:

1. Collect, write, and distribute local success stories of healthy diabetes self-management accomplishments by patients.
2. Promote community-based screening events using print, radio and social media.
3. Promote Health information, resources and risk assessments on the Baptist Health website.
4. Collaborate to update existing quality diabetes resources and tools and create new resources and tools as needed.
5. Continue promotion of the Diabetes Prevention and Control Program and Diabetes Advisory Group resources and tools developed through the Diabetes Advisory Committee Partnership.
6. Utilize Baptist Health clinical expertise to assist with delivery of consistent evidence-based health messages.
7. Implement evidence-based health communication strategies and messaging to reach audiences at increased risk for type 2 diabetes.
8. Promote statewide resources, tools, and programs to ensure reach to all citizens.
9. Collaborate with communities, schools, and other care providers to facilitate educational opportunities, use of resources, and awareness campaigns for type 2 diabetes prevention and diabetes control.
10. Utilize the Baptist Health Huddles to promote Diabetes Awareness and Education during Diabetes Awareness Month and other appropriate times.

PERFORMANCE METRICS:

1. Number of stories featured in print, radio and social media promoting diabetes awareness will be tracked and reported.
2. Number of interviews featuring diabetes awareness, prevention and/or management will be tracked and reported.
3. Number of community presentations on diabetes awareness, prevention and management will be tracked and reported.
4. Number of new and existing partnerships maintained that focus on diabetes will be tracked and progress reported.
5. Number of Huddles focused on Diabetes will be tracked and reported.

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS: BHMC – Little Rock, Arkansas Department of Health, Diabetes Advisory Committee

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED: Staff and Printing

ESTIMATED COMPLETION DATE: Ongoing

PERSON(S)/DEPARTMENT RESPONSIBLE: Strategic Development Staff, Teresa Conner, Wendy Byrd

IDENTIFIED COMMUNITY HEALTH NEED: Diabetes

GOALS/OBJECTIVES: Develop an internal and external plan to increase diabetes awareness.

STRATEGY # 4: Promote early detection of diabetes and prevention of type 2 diabetes across the life span through collaboration with organizations, faith-based entities and communities in hospital service areas.

ACTION STEPS:

1. Offer diabetes risk assessment tests at community screening events.
2. Utilize the monthly diabetes support group to provide current diabetes education and self-management skills.
3. Partner with the Arkansas Department of Health to implement the Arkansas Barber and Beauty shop screening initiative annually.
4. Establish and maintain community partnerships to promote and conduct glucose screenings for pre-diabetes and diabetes.
5. Implement a referral process for patients identified at high risk or with undiagnosed diabetes.
6. Partner with schools to offer diabetes education and screening for appropriate personnel.
7. Partner with McCain Mall in North Little Rock to sponsor the Head North to Health screening event, to include diabetes screening.

PERFORMANCE METRICS:

1. Number of patients identified and referred for follow-up who scored "at risk" on the diabetes risk assessment test will be tracked and reported.
2. Number of patients reached and referred during the Arkansas Barber and Beauty Shop initiative will be tracked and reported.
3. Number of community partnerships established and maintained, to include successes, will be tracked and reported.
4. Number of school-based screenings will be tracked and reported.
5. Number of community screenings with results will be tracked and reported.
6. Number of participants at Head North to Health screened, identified with elevated blood sugar and referred will be tracked and reported.

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:
BHMC – Little Rock, McCain Mall

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:
Staff and Screening supplies, Strategic Development staff

ESTIMATED COMPLETION DATE: Ongoing

PERSON(S)/DEPARTMENT RESPONSIBLE: Teresa Conner, Leititia Bailey, Community Outreach RN staff

IDENTIFIED COMMUNITY HEALTH NEED: Diabetes

GOALS/OBJECTIVES: To educate new and expectant mothers on the risk associated with Gestational Diabetes.

STRATEGY # 5: Implement a community-based gestational diabetes program based on best practices at Heaven's Loft.

ACTION STEPS:

1. Develop a community gestational diabetes education program.
2. Screen new and expectant mothers for diabetes risk.
3. Provide all new and expectant moms with a baseline glucose test upon enrollment.
4. Offer monthly weight checks for all new and expectant mothers.
5. Provide identified gestational diabetes moms with a copy of the Department of Health and Human Services Guide, "Managing Gestational Diabetes – A Guide to a Healthy Pregnancy."
6. Provide follow-up recommendations based on the March of Dimes guidelines.
7. Provide consults with a dietitian for all patients diagnosed with Gestational Diabetes.
8. Offer a diabetes class delivered by a certified diabetic educator.
9. Offer healthy cooking demonstrations for new and expectant mothers quarterly.

PERFORMANCE METRICS:

1. Number of patients with baseline glucose reading will be tracked and reported.
2. Number of patients identified as "at risk" for Gestational Diabetes will be tracked and reported.
3. Number of new and expectant mothers referred will be tracked and reported.
4. Number of sessions conducted by the Certified Diabetes Educator will be tracked and reported.
5. Number of sessions conducted by the Dietitian will be tracked and reported.
6. Number of cooking demonstrations hosted at Heaven's Loft will be tracked and reported.

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:
BHMC – Little Rock

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:
Staff and Screening supplies, Strategic Development staff

ESTIMATED COMPLETION DATE: Ongoing

PERSON(S)/DEPARTMENT RESPONSIBLE: Community Outreach RN staff, Teresa Conner

Community Health Needs Not Being Addressed

Baptist Health Medical Center-North Little Rock

Baptist Health acknowledges that the implementation strategy adopted does not address all the community health needs identified and that all of the identified needs are important. 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 from the focus groups and data collection was reviewed and prioritized. We do believe the focus areas selected will indirectly have a positive impact on many of the other items identified in the Community Health Needs Assessment. While we can't address every need, Baptist Health plans to share information on appropriate resources for the communities we serve.

Baptist Health Medical Center-Heber Springs

Baptist Health Medical Center-Heber Springs, a 25-bed acute care hospital located on Highway 25, became a part of Baptist Health in 1996. Originally named Cleburne County Hospital and located on Highway 110, the hospital moved to its current location in 2007. Baptist Health Medical Center-Heber Springs has a complete range of medical offerings including cardiology, eICU care, neurology, nephrology, orthopedics, urology, dermatology, otolaryngology, ophthalmology, podiatry, gynecology, pulmonology, radiology, and emergency services to serve the needs of Cleburne County and north central Arkansas.

Community Served and Demographics

SEX AND AGE

	Cleburne County	State	Nation
Total Population	25,793	2,947,036	314,107,084
Percent Male	49.8%	49.1%	49.2%
Percent Female	50.2%	50.9%	50.8%
Age: 0 to 14	16.5%	20.1%	19.5%
Age: 15 to 19	5.3%	6.8%	6.8%
Age: under 18	19.9%	24.1%	23.5%
Age: 20 to 24	5.0%	7.0%	7.1%
Age: 25 to 34	10.0%	13.0%	13.5%
Age: 35 to 44	10.3%	12.5%	13.0%
Age: 45 to 54	14.0%	13.4%	14.1%
Age: 55 to 64	14.2%	12.3%	12.3%
Age: 65 and older	24.7%	15.0%	13.7%

ETHNICITY

		Cleburne County	State	Nation
Total Population		25,793	2,947,036	314,107,084
Hispanic		2.3%	6.7%	16.9%
Non-Hispanic	White	95.3%	73.9%	62.8%
	Black or African American	0.4%	15.5%	12.2%
	American Indian and Alaska Native	0.5%	0.6%	0.7%
	Asian	0.2%	1.3%	4.9%
	Pacific Islander	0.0%	0.2%	0.2%
	Other	0.0%	0.1%	0.2%
	Multiracial	1.3%	1.8%	2.1%

INSURANCE COVERAGE

	Cleburne County	State	Nation
Health Insurance Coverage	82.0%	84.2%	85.8%
Private Health Insurance Coverage	58.2%	59.1%	65.8%
Public Health Insurance Coverage	42.8%	37.2%	31.1%

Outcomes of 2014-2016

PROSTATE SCREENING - Baptist Health Medical Center- Heber Springs partnered with the Arkansas Prostate Cancer Foundation and the Arkansas Urology clinic to host a Health Expo. Participants in the Expo were screened and provided educational materials. The screening results included 19 men with the average age of 58. Two were identified for follow-up screening based on results. Educational materials on prostate health were distributed at the Senior Wellness Centers and various community events reaching more than 600 individuals. Educational presentations were also delivered to members participating in the Business Expo, Ozark Trail Festival, Quitmanfest, Cove Creek and Pearson's Health and Safety Fair. Prostate Health was highlighted during National Men's Health Month and Prostate Awareness month.

DIABETES – Educational information and materials were shared at the Community Wellness Centers on a monthly basis reaching with more than 276 patients contacts through 2015. During Diabetes Awareness month in November, informational booths, diabetes risk assessments and free glucose screenings were offered in the hospital lobby. A monthly Diabetes support was implemented for the community at large. A diabetes education component was included during the Junior and High school students CHAMPS and MASH program each year. Civic groups were also included in our efforts to educate the community about diabetes, presentations were made to the local Rotary clubs and other sorority groups.

LACK OF PRIMARY CARE PHYSICIANS - Baptist Health Medical Center-Heber Springs explored opportunities to recruit primary care physicians, physician extenders and provide additional points of access for the undeserved in Cleburne County. A Physician Assistant and two Advanced Practitioner Nurses were added to increase primary care resources. Nearly three hundred and fifty free transports were made available to ARCare through Baptist Health Transportation services.

2016 Process

Quantitative Data

The Arkansas Center for Health Improvement (ACHI) was engaged to conduct the quantitative data acquisition and analysis. National, state and county data were included.

Quantitative results from the 2016 Baptist Health Community Health Needs Assessment for the Heber Springs hospital were obtained. There are ten sections including: Demographics, Health Outcomes, Cause of Death, Chronic Conditions, Health Behaviors, Prevention, Access, Social and Economic, Environment, and Community Prevalence of Diagnoses. Each section includes a table with health indicator data for Cleburne County (the hospital community) and averages for the State of Arkansas and the United States. If data were not available, a "NA" is displayed. Each section also includes graphics for various health indicator data. For more detailed information on methods, resources used, and outcomes please reference the Methods section and Appendix 1.

Interviews and Focus Groups

In addition to quantitative data collection, a focus groups was utilized to acquire input from persons who represent the broad interests of the BHMC-HS community. Participants included:

- Ms. Charmaine Allen, Heber Springs Community Member

- Dr. Mickey Barnett, Retired Physician
- Ms. Andrea Notz, Fairfield Bay Community Member
- Ms. Hazel Thompson, Cleburne County Health Unit
- Ms. Ruth Hyslip, BHMC-HS Auxiliary
- Ms. Brenda Gulledge, Cleburne County Judge's Office
- Ms. Leslie Williams, Heber Springs Community Member
- Ms. Shoshana Wells, Heber Springs Community Member,
- Ms. Leslie Price, Heber Springs Community Member
- Ms. Donna Baugh, Arkansas Dream Center
- Chief Bobby Walker, Heber Springs Police Department
- Ms. Brenda Hill, Cleburne County Community Foundation
- Ms. Delite Fife, Concord School District
- Mr. Jay Cupit, The Other Side – A Local Mission

Input from the Focus Group revealed concerns regarding obesity/nutrition; mental health access and care for all ages; diabetes; access to healthcare, especially emergency, after hours and specialty care; and health/disease education.

Prioritized Health Needs

A prioritization session was held to choose two health needs to be addressed via a system-wide approach, and one additional need specific to each facility's defined community. A three-round, multi-voting technique was utilized to make final selections. Results of the Baptist Health community health needs selection process determined Diabetes and Obesity would be the system-based needs addressed. In addition, Access to Healthcare was selected by BHMC-Heber Springs.

Implementation Plans

Action/Implementation Plans were developed for all prioritized needs, using a collaborative approach when multiple Baptist Health facilities and/or outside agencies could be included. All plans will be reviewed and updated on an annual basis.

Appendix

- Health Resources Available to Meet Needs
- Remainder of the Data

Community Health Needs Assessment – Implementation Plan 2017-2019

Baptist Health Medical Center-Heber Springs

IDENTIFIED COMMUNITY HEALTH NEED: Obesity

GOALS/OBJECTIVES: To improve physical activity and nutrition awareness, knowledge, and behaviors among elementary-aged students by expanding the ***We Can!*** CATCH Kids club program throughout Cleburne County.

STRATEGY # 1: Expand ***We Can!*** (**W**ays to **E**nhance **C**hildren's **A**ctivity & **N**utrition).

ACTION STEPS:

1. Pilot the ***We Can!*** Program in the Heber Springs School District.
2. Participate in the "Train the Trainer" program with Baptist Health Community Outreach.
3. Present six nutrition and physical activity lessons to elementary school students, focusing on the key concepts of Coordinated Approach to Child Health.

PERFORMANCE METRICS:

1. Partner with at least one elementary school to implement the program with the goal of increasing the number of schools each year.
2. 80% of students will show an increase in nutrition and physical activity awareness based on pretest/posttest/3-month delayed post-test.

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:
Baptist Health Community Outreach, Rural Health Clinics, Schools

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:
Community Outreach Staff

ESTIMATED COMPLETION DATE: Ongoing Project

PERSON(S)/DEPARTMENT RESPONSIBLE: Teresa Conner, Leititia Bailey, Bridget Moix (PT), Tamara McKee (Community Health Nurse), Charmaine Allen (Nursing Ops Manager)

IDENTIFIED COMMUNITY HEALTH NEED: Obesity

GOALS/OBJECTIVES: Support community members in achieving knowledge pertaining to management of a healthy weight through nutrition education and fitness activities.

STRATEGY # 2: Educate the community at health fairs, schools, and community events on contributing factors related to obesity.

ACTION STEPS:

1. Distribute material educating the community on how to make healthy meal choices on a limited budget.
2. Provide education at community events on the importance of portion sizes.
3. Educate about BMI and the associated health risks. Measure BMI at all health and wellness fairs.
4. Promote fitness activities at all appropriate Baptist Health events, community clinics, churches, and health and wellness fairs.
5. Promote physical activities among employees and families.

PERFORMANCE METRICS:

1. Number of BMI measurements and people educated at health and wellness fairs will be tracked.
2. Healthy eating educational packets distributed to the community will be counted.

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:
Rural Health Clinics, schools, community center, Greers Ferry Lake Trail Council, Arkansas Deptartment of Health

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:
N/FS, PT, Sleep Center, Community Center, Patient Educator, Nursing

ESTIMATED COMPLETION DATE: Ongoing

PERSON(S)/DEPARTMENT RESPONSIBLE:
Bridget Moix (PT), Tamara McKee (Community Health Nurse), Charmaine Allen (Nursing Ops Manager)

IDENTIFIED COMMUNITY HEALTH NEED: Obesity

GOALS/OBJECTIVES: Promote walking as a form of increasing physical activity.

STRATEGY # 3: Implement the Community Walking Program in an effort to improve individual's physical activity knowledge and behaviors.

ACTION STEPS:

1. Partner with Baptist Health Little Rock to pilot the Community Walking Program.
2. Provide participants with a t-shirt, pedometer, walking log and water bottle.
3. Offer annual educational classes on Physical Fitness and Nutrition.
4. Partner with Baptist Health Little Rock to provide a quarterly newsletter with health topics.
5. Partner with Baptist Health Little Rock to offer program incentives to encourage consistency.
6. Identify and promote BH community walking locations.

PERFORMANCE METRICS:

1. Baseline data will be collected for year 1 in Heber Springs with a 25% target increase in 2018 and 2019.
2. 25% of participants will report walking 4 or more times a week.
3. 25% will have increased their overall physical activity habits (pre/post program self-reported assessment).
4. Number of classes will be tracked and reported.
5. Number of class participants will be tracked and reported.

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:
Baptist Health Community Outreach

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:
Community Outreach Staff, Strategic Development

ESTIMATED COMPLETION DATE: Ongoing

PERSON(S)/DEPARTMENT RESPONSIBLE: Baptist Health Community Outreach - Teresa Conner, Leititia Bailey, Bridget Moix (PT), Tamara McKee(Community Health Nurse, Charmaine Allen (Nursing Ops Manager

Community Health Needs Assessment – Implementation Plan 2017-2019

Baptist Health Medical Center-Heber Springs

IDENTIFIED COMMUNITY HEALTH NEED: Access to Health Care

GOALS/OBJECTIVES: Increase healthcare services in the Cleburne County area by increasing accessibility to medical care after hours.

STRATEGY # 1: Expand after-hours services in health clinics to provide nonemergent healthcare accessibility to the Cleburne County area.

ACTION STEPS:

1. Identify patient catchment area needing after hours service.
2. Modify staff shifts to include scheduling after 5:00 p.m.
3. Develop after-hour services, marketing with Strategic Development.

PERFORMANCE METRICS:

1. Number of after-hours patient visits will be tracked to validate need.
2. Data will be tracked and reported on the number of patients left without being seen in the ER.
3. Document and track ER Length of Stay for improved patient flow.

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:

BHFC-GF, HS, FFB, and P.
Practice Plus
Chamber of Commerce

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:

Recruit additional primary care resources and support staff.
Strategic Development

ESTIMATED COMPLETION DATE: Ongoing for assessment period.

PERSON(S)/DEPARTMENT RESPONSIBLE: Ed Lacy, Krista Baily, Bonnie Schreiber

IDENTIFIED COMMUNITY HEALTH NEED: Access to Health Care

GOALS/OBJECTIVES: Increase healthcare services in the Cleburne County area by increasing accessibility to medical care.

STRATEGY # 2: Increase medical specialty access to provide improved accessibility to the Cleburne County area.

ACTION STEPS:

1. Recruit physicians in areas of identified concern.
2. Develop marketing strategies to increase awareness of services available.
3. Participate in community events to distribute brochures promoting health care services available.

PERFORMANCE METRICS:

1. Number of patient visits will be tracked.
2. Number increased specialists added will be tracked.
3. Number of increased services available will be tracked.
4. Number of brochures distributed at community events will be tracked.
5. Number of community events attended will be tracked.

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:

Chamber of Commerce
Primary Care Physicians

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:

Recruit specialty care resources
AHG/PP
Strategic Development

ESTIMATED COMPLETION DATE: Ongoing for assessment period.

PERSON(S)/DEPARTMENT RESPONSIBLE: Ed Lacy, Charmaine Allen, Jennifer Dennis, Practice Plus

IDENTIFIED COMMUNITY HEALTH NEED: Diabetes

GOALS/OBJECTIVES: Identify adults at risk of, or with, undiagnosed diabetes through blood sugar screenings and risk assessment tools. Provide diabetes education and support to diabetic patients and patients at risk for diabetes.

STRATEGY # 1: Enhance community education of diabetes awareness, prevention and management.

ACTION STEPS:

1. Conduct community blood sugar screenings and provide risk assessment, material/resources. Refer all people with abnormal blood sugars to appropriate medical services.
2. Increase community awareness of contributing factors via support groups, community events, health fairs, and schools.
3. Provide Telehealth education on diabetes management.
4. Work with community-based organizations to distribute diabetes educational material to residents.

PERFORMANCE METRICS:

1. Number of education opportunities and number of attendees will be tracked and reported.
2. Number of people screened will be tracked and reported.
3. Number of people with elevated blood sugars referred to PCP.
4. Number of people attending the diabetes support group.

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:
Rural Health Clinics, schools, community center, Greers Ferry Lake Trail Council, Strategic Development

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED: Nutrition/Food Service, Physical Therapy, Sleep Center, Nursing, Community Center, Health Department, patient educator, nursing

ESTIMATED COMPLETION DATE: Ongoing.

PERSON(S)/DEPARTMENT RESPONSIBLE:
Regina McCormick, Hazel Thompson, Tamara McKee, Charmaine Allen, Dr. Barnett.

IDENTIFIED COMMUNITY HEALTH NEED: Diabetes

GOALS/OBJECTIVES: Implement an internal and external plan to increase awareness about diabetes in the community.

STRATEGY # 2: Partner with Strategic Development to create, maintain, and share an updated repository of diabetes public communication messages (addressing awareness, prevention, and control), along with objective data and case stories demonstrating their effectiveness.

ACTION STEPS:

1. Partner with Strategic Development to collect, write, and distribute local success stories of healthy diabetes self-management accomplishments by patients.
2. Promote health information, resources and risk assessments on the Baptist Health website.
3. Collaborate to update existing quality diabetes resources and tools and create new resources and tools, as needed.
4. Utilize Baptist Health clinical expertise to assist with delivery of consistent evidence-based health messages.
5. Increase stratgic collaboration and coordination of communication interventions and strategies.
6. Promote statewide resources, tools, and programs to ensure reach to all citizens.
7. Explore opportunities to present diabetes information to community groups and organizations.

PERFORMANCE METRICS:

1. Number of stories featured in print will be tracked and reported.
2. Number of community presentations on diabetes awareness and prevention.
3. Number of PSA's placed on local radio stations will be tracked and reported.

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS: BHMC – Little Rock

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED: Staff and Printing

ESTIMATED COMPLETION DATE: Ongoing

PERSON(S)/DEPARTMENT RESPONSIBLE: Strategic Development Staff, Community Outreach, Tamara McKee, Regina McCormick

Community Health Needs Not Being Addressed

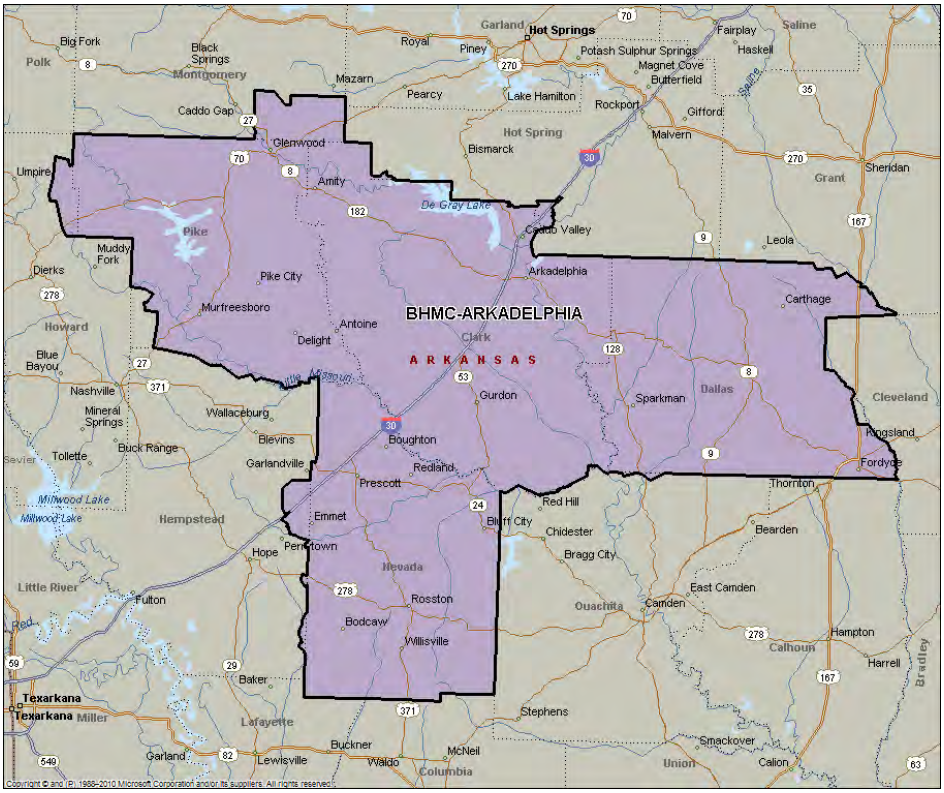
Baptist Health Medical Center-Heber Springs

Baptist Health acknowledges that the implementation strategy adopted does not address all the community health needs identified and that all of the identified needs are important. 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 from the focus groups and data collection was reviewed and prioritized. We do believe the focus areas selected will indirectly have a positive impact on many of the other items identified in the Community Health Needs Assessment. While we can't address every need, Baptist Health plans to share information on appropriate resources for the communities we serve.

Baptist Health Medical Center-Arkadelphia

Baptist Health Medical Center-Arkadelphia, a 25-bed acute care hospital located just off of I-30, became a part of Baptist Health in 1981. Originally named Clark County Hospital and located on Pine Street, it moved to it's current location in 1983. Baptist Health Medical Center-Arkadelphia has a complete range of medical offerings including cardiology, orthopedics, eICU care, otolaryngology, gynecology/obstetrics, pediatrics, ophthalmology, radiology, outpatient and emergency services to serve the needs of southwest Arkansas.

Community Served and Demographics



SEX AND AGE

	Clark County	Dallas County	Nevada County	Pike County	State	Nation
Total Population	22,800	7,954	8,877	11,187	2,947,036	314,107,084
Percent Male	47.3%	50.1%	49.1%	49.3%	49.1%	49.2%
Percent Female	52.7%	49.9%	50.9%	50.7%	50.9%	50.8%
Age: 0 to 14	16.2%	19.1%	19.9%	19.7%	20.1%	19.5%
Age: 15 to 19	11.1%	6.6%	7.6%	6.6%	6.8%	6.8%
Age: under 18	19.7%	23.7%	23.8%	24.0%	24.1%	23.5%
Age: 20 to 24	14.4%	5.8%	4.8%	5.1%	7.0%	7.1%
Age: 25 to 34	9.0%	8.2%	10.0%	10.5%	13.0%	13.5%
Age: 35 to 44	11.1%	13.2%	10.8%	13.5%	12.5%	13.0%
Age: 45 to 54	11.8%	13.2%	13.8%	14.0%	13.4%	14.1%
Age: 55 to 64	11.2%	14.7%	14.0%	12.7%	12.3%	12.3%
Age: 65 and older	15.3%	19.2%	19.2%	17.9%	15.0%	13.7%

ETHNICITY

		Clark County	Dallas County	Nevada County	Pike County	State	Nation
Total Population		22,800	7,954	8,877	11,187	2,947,036	314,107,084
Hispanic		4.3%	2.5%	3.0%	6.6%	6.7%	16.9%
Non-Hispanic	White	69.8%	53.9%	64.4%	87.8%	73.9%	62.8%
	Black or African American	23.9%	41.3%	30.4%	2.9%	15.5%	12.2%
	American Indian and Alaska Native	0.1%	0.0%	0.3%	0.1%	0.6%	0.7%
	Asian	0.6%	2.0%	1.4%	0.5%	1.3%	4.9%
	Pacific Islander	0.0%	0.0%	0.0%	0.0%	0.2%	0.2%
	Other	0.0%	0.0%	0.0%	0.1%	0.1%	0.2%
	Multiracial	1.3%	0.3%	0.4%	2.1%	1.8%	2.1%

INSURANCE COVERAGE

	Clark County	Dallas County	Nevada County	Pike County	State Average	National Average
Health Insurance Coverage	85.9%	82.5%	83.9%	82.4%	84.2%	85.8%
Private Health Insurance Coverage	63.5%	54.4%	50.2%	49.3%	59.1%	65.8%
Public Health Insurance Coverage	35.6%	43.7%	46.7%	45.9%	37.2%	31.1%

Outcomes of 2014-2016

COLORECTAL SCREENING - Baptist Health Medical Center-Arkadelphia partnered with local county health units and area physicians to provide over 400 colorectal screenings. Four physicians and additional staff were recruited to assist with the increase in screenings. Colorectal education was made available to over 6,200 individuals at community events, health fairs and through civic group meetings.

MAMMOGRAPHY - Over 6,400 women received screening and diagnostic mammograms from local physicians and health department referrals. Mammography education was made available at civic group meetings, faith-based organizations, health fairs and community events to over 6,400 individuals. Breast health information was advertised in the local newspapers for one week during each quarter.

STROKE - A partnership with Arkansas Saves Stroke Initiative reached and educated over 7,900 individuals about stroke at physician offices, police departments, faith-based organizations, food pantries, senior centers and community events. Baptist Health Medical Center-Arkadelphia staff was regularly educated about stroke through Arkansas Saves Strokes Initiative webinars, in-services and by having the "ACT FAST" reminder cards adhered to their employee badges.

2016 Process

Quantitative Data

The Arkansas Center for Health Improvement (ACHI) was engaged to conduct the quantitative data acquisition and analysis. National, state and county data were included.

Quantitative results from the 2016 Baptist Health Community Health Needs Assessment for the Arkadelphia hospital were obtained. There are ten sections including: Demographics, Health Outcomes, Cause of Death, Chronic Conditions, Health Behaviors, Prevention, Access, Social and Economic, Environment, and Community Prevalence of Diagnoses. Each section includes a table with health indicator data for each county in the hospital community, community averages (mean of all hospital counties), and averages for the State of Arkansas and the United States. If data were not available, a "NA" is displayed. Each section also includes graphics for various health indicator data. For more detailed information on methods. resources used, and outcomes please reference the Methods section and Appendix 1.

Interviews and Focus Groups

In addition to quantitative data collection, a focus group was utilized to acquire input from persons who represent the broad interests of the BHMC-Arkadelphia community. Participants included:

- Mr. Glen Shuffield, Food Pantry – Point Cedar
- Ms. Susan Peters, Prescott Community Member
- Mr. Bruce Thornton, Bismark Community Member
- Ms. Becky Jester, BHMC-A Advisory Board Member
- Pastor Greg Latham, Third Baptist Church
- Ms. Patricia Wright, Community Family Enrichment Center

- Ms. Shelley Loe, Arkadelphia Chamber of Commerce
- Ms. Christa Neal, Percy & Donna Malone Child Safety Center
- Mr. Bill Wright, Southern Bancorp

Input from the Focus Group revealed concerns regarding obesity/nutrition; mental health access and care for all ages; cancer; affordable health insurance; and veterans services.

Prioritized Health Needs

A prioritization session was held to choose two health needs to be addressed via a system-wide approach, and one additional need specific to each facility's defined community. A three-round, multi-voting technique was utilized to make final selections. Results of the Baptist Health community health needs selection process determined Diabetes and Obesity would be the system-based needs addressed. In addition, Mental Health was selected by BHMC-Arkadelphia.

Implementation Plans

Action/Implementation Plans were developed for all prioritized needs, using a collaborative approach when multiple Baptist Health facilities and/or outside agencies could be included. All plans will be reviewed and updated on an annual basis.

Appendix

- Health Resources Available to Meet Needs
- Remainder of the Data

IDENTIFIED COMMUNITY HEALTH NEED: Obesity

GOALS/OBJECTIVES: To improve nutrition and physical activity awareness, knowledge and behaviors within the Clark County community.

STRATEGY: To promote physical activity and healthy eating to improve individuals' health outcomes and quality of life.

ACTION STEPS:

1. Distribute material educating the community on how to make healthy meal choices on a limited budget and awareness/mindfulness about portion sizes.
2. Measure BMI and educate the community about the associated risks of obesity.
3. Promote fitness activities at all appropriate Baptist Health events, community centers, senior centers and health and wellness fairs.
4. Identify and promote community Farmers Markets and Food Pantries in an effort to educate community on fresh fruits and vegetable availability.
5. Offer community-based healthy cooking demonstrations.

PERFORMANCE METRICS:

1. The number of community health fairs and health events will be tracked and reported.
2. The number of cooking demonstrations and participants will be tracked and reported.
3. The number BMI assessments and results will be tracked an reported.
4. The number of Farmers Markets identified will be reported.

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:
Local County Extension Services, Food Pantries, Farmers Markets, Schools, Senior Centers, City Officials

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:
BHMC-LR Information Technology Department, Nursing, TMF Quality Improvement Network

ESTIMATED COMPLETION DATE: Ongoing

PERSON(S)/DEPARTMENT RESPONSIBLE: Loretta Kitts, Nutrition and Food Service Manager; Holly Kyzer, Clinical Dietitian, Pam Green, RN Supervisor; Nathan Adams, Pharmacist; Donna McMillian, Clinic Manager; Richard Pope, Nursing Operation Manager, Tony Hardage, Adminstrator

Community Health Needs Assessment – Implementation Plan 2017-2019

Baptist Health Medical Center-Arkadelphia

IDENTIFIED COMMUNITY HEALTH NEED: Mental Health

GOALS/OBJECTIVES: To increase mental health awareness, access, education and support to individuals in Clark County.

STRATEGY: Expand mental health resources in efforts to increase mental health access, awareness, education and support in Clark County.

ACTION STEPS:

1. Offer mental health education and information at health fairs and health events sponsored by BHMC-Arkadelphia, churches, and civic organizations.
2. Explore opportunities for training on how to recognize and address individuals with mental health issues and challenges for pastors, public officials, emergency responders, and an advanced practice registered nurse (APRN).
3. Partner with public schools, Ouachita Baptist University (OBU) and Henderson State University (HSU) to educate students, parents, staff and teachers.
4. Utilize telehealth education at BHMC-Arkadelphia, churches, and civic organizations to bring awareness and educate individuals.
5. Disseminate mental health resources to direct individuals to services such as, but not limited to, prescription medication assistance and counseling.
6. Utilize telehealth education with mental health personnel to provide counseling and referrals.
7. Partner with the Pregnancy Resource Center for dissemination of mental health information.

PERFORMANCE METRICS:

1. The number of health fairs and health events will be tracked and reported.
2. The number of Mental Health training sessions and participants will be tracked and reported.
3. The number of school-based sessions and participants will be tracked and reported.
4. The number of telehealth education sessions and participants will be tracked and reported.
5. The number of prescription assistance referrals will be tracked and reported.
6. The number of telehealth counseling sessions and referrals will be tracked and reported.
7. The number of individuals receiving information at the Pregnancy Resource Center will be tracked and reported.

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:
Percy and Donna Malone Child Safety Center, public schools, OBU, HSU, city and county officials, churches, Pregnancy Resource Center, emergency responders

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:
BH Information Technology Department, Nursing, TMF Quality Improvement Network

ESTIMATED COMPLETION DATE: Ongoing

PERSON(S)/DEPARTMENT RESPONSIBLE: Pam Green, RN Supervisor; Nathan Adams, Pharmacist; Donna McMillian, Clinic Manager; Richard Pope, Nursing Operation Manager

IDENTIFIED COMMUNITY HEALTH NEED: Diabetes

GOALS/OBJECTIVES: To increase diabetes awareness, education and support to individuals in Clark County.

STRATEGY: Expand diabetes services in efforts to increase diabetes awareness, education and support in Clark County.

ACTION STEPS:

1. Identify individuals at risk for diabetes and diabetics through partnerships with Rural Health Clinics (RHC), civic organizations, senior centers, food pantries, and churches. Services will include blood sugar screenings, diabetes risk assessments and diabetes education.
2. Offer diabetes education classes, to include cooking demonstrations, at Rural Health Clinics (RHC) and BHMC-Arkadelphia.
3. Develop a diabetes support group at BHMC-Arkadelphia and clinics.
4. Utilize various media to increase awareness and knowledge of diabetes. Media will include print (flyers, brochures, pamphlets) and electronic (Facebook, YouTube, Twitter etc.) sources.
5. Offer telehealth diabetes education and support classes and sessions at BHMC-Arkadelphia and clinics.
6. Implement the TMF Diabetes Self-Management Education program.

PERFORMANCE METRICS:

1. The number of education classes, events, and support group meetings will be tracked and reported.
2. The number of individuals screened for diabetes will be tracked and reported.
3. The number of individuals receiving print media and viewing social media will be tracked and reported.
4. The number of individuals receiving telehealth diabetes education will be tracked and reported.

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS: Becoming a Healthy Clark County Coalition (BaHCC), Clark County Cooperative Extension Services, senior centers, Rural Health Centers, churches, and local food pantries

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED: BH Information Technology Department, Nursing, TMF Quality Improvement Network

ESTIMATED COMPLETION DATE: Ongoing

PERSON(S)/DEPARTMENT RESPONSIBLE: Holly Kyzer, Clinical Dietitian; Loretta Kitts, Nutrition and Food Service Manager; Pam Green, RN Supervisor; Nathan Adams, Pharmacist; Donna McMillian, Clinic Manager; Richard Pope, Nursing Operation Manager; Tony Hardage, Administrator

Community Health Needs Not Being Addressed

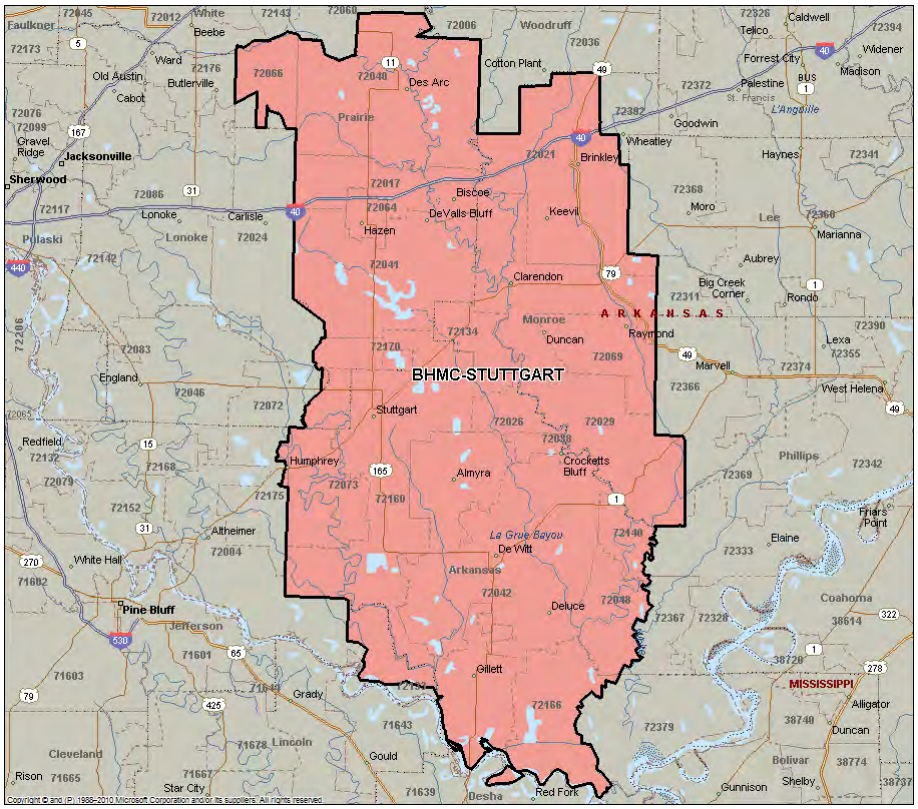
Baptist Health Medical Center-Arkadelphia

Baptist Health acknowledges that the implementation strategy adopted does not address all the community health needs identified and that all of the identified needs are important. 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 from the focus groups and data collection was reviewed and prioritized. We do believe the focus areas selected will indirectly have a positive impact on many of the other items identified in the Community Health Needs Assessment. While we can't address every need, Baptist Health plans to share information on appropriate resources for the communities we serve.

Baptist Health Medical Center-Stuttgart

Baptist Health Medical Center-Stuttgart, a 49-bed acute care hospital located on North Buerkle, became a part of Baptist Health in 2009. It was originally named Stuttgart Memorial Hospital and opened in 1957. Baptist Health Medical Center-Stuttgart has a complete range of medical offerings including cardiology, dermatology, gastroenerology, gynecology/obstetrics, nephrology, oncology, ophthalmology, orthopedics, pediatrics, radiology, rheumatology, urology, outpatient and emergency services to serve the needs of Arkansas county and surrounding areas.

Community Served and Demographics



SEX AND AGE

	Arkansas County	Lonoke County	Monroe County	Prairie County	State	Nation
Total Population	18,861	70,118	7,855	8,475	2,947,036	314,107,084
Percent Male	48.2%	49.2%	48.1%	49.1%	49.1%	49.2%
Percent Female	51.8%	50.8%	51.9%	50.9%	50.9%	50.8%
Age: 0 to 14	19.3%	22.4%	18.2%	16.9%	20.1%	19.5%
Age: 15 to 19	5.8%	7.0%	6.4%	5.8%	6.8%	6.8%
Age: under 18	23.4%	27.0%	22.3%	21.1%	24.1%	23.5%
Age: 20 to 24	5.8%	5.9%	5.6%	5.3%	7.0%	7.1%
Age: 25 to 34	12.1%	14.1%	9.2%	10.3%	13.0%	13.5%
Age: 35 to 44	11.9%	14.2%	10.9%	11.3%	12.5%	13.0%
Age: 45 to 54	13.6%	13.6%	14.6%	14.9%	13.4%	14.1%
Age: 55 to 64	14.4%	10.8%	15.3%	14.6%	12.3%	12.3%
Age: 65 and older	17.1%	11.9%	19.8%	20.8%	15.0%	13.7%

ETHNICITY

		Arkansas County	Lonoke County	Monroe County	Prairie County	State	Nation
Total Population		18,861	70,118	7,855	8,475	2,947,036	314,107,084
Hispanic		2.9%	3.7%	2.0%	1.0%	6.7%	16.9%
Non-Hispanic	White	70.5%	87.3%	55.3%	85.5%	73.9%	62.8%
	Black or African American	25.1%	6.2%	41.3%	12.4%	15.5%	12.2%
	American Indian and Alaska Native	0.2%	0.4%	0.1%	0.1%	0.6%	0.7%
	Asian	0.4%	0.6%	0.2%	0.2%	1.3%	4.9%
	Pacific Islander	0.0%	0.0%	0.0%	0.0%	0.2%	0.2%
	Other	0.0%	0.1%	0.0%	0.0%	0.1%	0.2%
	Multiracial	0.9%	1.7%	1.1%	0.8%	1.8%	2.1%

INSURANCE COVERAGE

	Arkansas County	Lonoke County	Monroe County	Prairie County	State Average	National Average
Health Insurance Coverage	86.9%	87.3%	84.3%	84.6%	84.2%	85.8%
Private Health Insurance Coverage	55.0%	69.0%	43.5%	52.0%	59.1%	65.8%
Public Health Insurance Coverage	44.1%	31.4%	54.3%	44.4%	37.2%	31.1%

Outcomes of 2014-2016

SMOKING - Baptist Health Medical Center – Stuttgart developed a hospital-based tobacco initiative to identify tobacco users through the nursing admission and assessment processes. Collaboration with the Arkansas Stamp Out Smoking Program provided education, support and nicotine supplies to identified tobacco users. A Smoking Cessation Education campaign was developed and promoted through the Baptist Health Medical Center – Stuttgart Fitness Center and through rural health clinics in Arkansas, Prairie and Monroe counties. Smoking Cessation packets were mailed to 200 random residential homes each year.

DIABETES – A Diabetes Self-Management Education Program was implemented through a partnership with Baptist Health Medical Center – Heber Springs. Accreditation was received for the Diabetes Self-Management Education Program. A Diabetes Advisory Committee was established from this implementation. A Baptist Health Medical Center-Stuttgart patient educator obtained Certified Diabetes Educator® (CDE®) status. A diabetes referral process was developed for the rural clinic physicians. Partnerships with the Arkansas County Partners in Health and Greater Delta Alliance for Health provided additional diabetic resources for individuals. Diabetes education, including free glucose screenings, diabetes risk assessments and nutrition education was provided to hospital employees and the community each year during National Diabetes Month. Also during National Diabetes Month, free screenings were held at Phillips Community College. A Diabetes Support Group was implemented and classes are offered quarterly. Two direct mailings to 200 random residents were completed each year. Financial assistance processes were implemented for diabetic medication and supplies.

OBESITY – A physical activity initiative was implemented that included development of the American Heart Association START Walking Path, promotion of the Baptist Health Community Walking Program, and Body Mass Index (BMI) Program. Inpatient/Outpatient Nutrition Education Initiative was implemented, promoting optimal nutrition. Staff participated in the Arkansas Obesity Coalition Regional Training. A Healthy Lifestyles packet was developed containing various health and wellness resources and continuously mailed to 200 Stuttgart residents.

2016 Process

Quantitative Data

The Arkansas Center for Health Improvement (ACHI) was engaged to conduct the quantitative data acquisition and analysis. National, state and county data were included.

Quantitative results from the 2016 Baptist Health Community Health Needs Assessment for the Stuttgart hospital were obtained. There are ten sections including: Demographics, Health Outcomes, Cause of Death, Chronic Conditions, Health Behaviors, Prevention, Access, Social and Economic, Environment, and Community Prevalence of Diagnoses. Each section includes a table with health indicator data for each county in the hospital community, community averages (mean of all hospital counties), and averages for the State of Arkansas and the United States. If data were not available, a “NA” is displayed. Each section also includes graphics for various health indicator data. For more detailed information on methods, resources used, and outcomes please reference the Methods section and Appendix 1.

Interviews and Focus Groups

In addition to quantitative data collection, a focus group was utilized to acquire input from persons who represent the broad interests of the BHMC-Stuttgart community. Participants included:

- Ms. Virginia Holt, Former Stuttgart City Council Member
- Ms. Leah Carter, RSVP
- Ms. Gayla Goetz, Greater Delta Alliance for Health
- Mr. Benny Petrus, Petrus Automobile
- Ms. Paula Hocks, Hazen Family Medical Clinic
- Mr. Kent Lockwood, Producers Rice Mill
- Dr. Sam Roberts, First Baptist Church
- Mr. Thomas E. Best, County Judge
- Ms. Ruby Allen, County Judge's Office
- Mr. Jim McGee, Wilkerson's Jewelry
- Mr. Wendell Stratton, Stratton Seed
- Ms. Lee Long, BHMC-S Social Worker

Input from the Focus Group revealed concerns regarding needs for more physicians and other healthcare providers; health screening and education; affordable senior housing and assisted living; and a wellness center.

Prioritized Health Needs

A prioritization session was held to choose two health needs to be addressed via a system-wide approach, and one additional need specific to each facility's defined community. A three-round, multi-voting technique was utilized to make final selections. Results of the Baptist Health community health needs selection process determined Diabetes and Obesity would be the system-based needs addressed. In addition, Access to Healthcare was selected by BHMC-Stuttgart.

Implementation Plans

Action/Implementation Plans were developed for all prioritized needs, using a collaborative approach when multiple Baptist Health facilities and/or outside agencies could be included. All plans will be reviewed and updated on an annual basis.

Appendix

- Health Resources Available to Meet Needs
- Remainder of the Data

IDENTIFIED COMMUNITY HEALTH NEED: Obesity

GOALS/OBJECTIVES: To increase nutrition and physical activity awareness, knowledge and behaviors by implementing health education classes and events, and disseminating health education materials.

STRATEGY # 1: Implement health education classes and events, and disseminate health education materials.

ACTION STEPS:

1. Offer community education events each quarter at a health expo, school, church, or senior living center.
2. Offer a cooking demonstration during the Baptist Health Stuttgart annual health expo.
3. Develop a healthy budget-friendly menu for dissemination at all community education events.
4. Disseminate educational materials and healthy budget-friendly menus at local food pantries.
5. Explore opportunities to implement a local 5K walk/run.

PERFORMANCE METRICS:

1. The number of individuals attending the quarterly educational events will be tracked and reported.
2. The number of individuals attending the annual Baptist Health Stuttgart health expo will be tracked and reported.
3. The number of healthy budget-friendly menus will be tracked and reported.
4. The number of individuals receiving health materials from local food pantries will be tracked and reported.

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:
Civic organizations, schools, churches, clinics, senior living centers, local food pantries

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:
Nutrition and Food Services, Physical Therapy, Nursing, Strategic Development

ESTIMATED COMPLETION DATE: Ongoing

PERSON(S)/DEPARTMENT RESPONSIBLE: Physical Therapy, Nutrition and Food Services

IDENTIFIED COMMUNITY HEALTH NEED: Access to Healthcare

GOALS/OBJECTIVES: Increase access to healthcare in the community, to include maintaining the Health Professional Shortage Area (designation).

STRATEGY # 1: Expand health services in efforts to increase access to healthcare.

ACTION STEPS:

1. Recruit two obstetrics and gynecology (OB/GYN) physicians and a General Surgeon.
2. Incorporate Total Joint Services in Surgery Services.
3. Recruit a family practitioner to service Rural Health Clinics (RHC) in Hazen and England.
4. Recruit a second midlevel provider to serve the RHC in DeWitt.
5. Achieve Health Professional Shortage Area (HPSA) status for Arkansas County.

PERFORMANCE METRICS:

1. The number of patient visits to the OB/GYN and General Surgeon will be tracked and reported.
2. The number of total joint visits and surgeries will be tracked and reported.
3. The number of patient visits to the RHCs in England, Hazen and DeWitt will be tracked and reported.

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:
External recruiting agency, Physician/Healthcare provider recruitment, AHG, local medical staff

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:
BH Strategic Development, AHG, internal staff, funding

ESTIMATED COMPLETION DATE: Ongoing

PERSON(S)/DEPARTMENT RESPONSIBLE: Kevin Storey, Lauren Reynolds, Kristen Staton-OB, Cathy Prislovsky & Kim Lock –Surgery

IDENTIFIED COMMUNITY HEALTH NEED: Access to Healthcare

GOALS/OBJECTIVES: Promote new and existing healthcare services to the community.

STRATEGY # 2: Develop a plan to educate the community on new and existing services.

ACTION STEPS:

1. Work with Strategic Development to develop a marketing campaign to inform the community of new and existing services by utilizing mailers, website, social media, television and radio.
2. Partner with church health ministries and civic organizations to promote services.
3. Display marketing materials at Rural Health Clinics (RHC), physician offices and civic organizations.

PERFORMANCE METRICS:

1. Promotional materials will be made available to 100% of Rural Health Clinics (RHC) in the area.
2. The number of distributed marketing tools will be tracked and reported.
3. The number of individual visits to social media sites will be tracked and reported.

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:
Rural Health Clinics, physician offices, churches, civic organizations

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:
Baptist Health Strategic Development

ESTIMATED COMPLETION DATE: Ongoing

PERSON(S)/DEPARTMENT RESPONSIBLE:
Kevin Storey, Lauren Reynolds, Kristen Staton-OB, Cathy Prislovsky & Kim Lock –Surgery

IDENTIFIED COMMUNITY HEALTH NEED: Diabetes

GOALS/OBJECTIVES: Increase access to diabetes education within the community.

STRATEGY # 1: Implement telehealth education and educational classes to increase diabetes education within the community.

ACTION STEPS:

1. Provide telehealth diabetes education to gestational diabetes patients identified in Obstetrics and Gynecology (OB/GYN) clinics.
2. Offer telehealth diabetes education, open to the public, featuring information on early signs of diabetes.
3. Offer diabetes education classes to schools, churches or senior living centers quarterly.
4. Provide educational materials at local food pantries.
5. Provide a quarterly diabetes support group.
6. Offer free glucose screenings at appropriate community events.

PERFORMANCE METRICS:

1. The number of gestational diabetes patients identified and receiving telehealth diabetes education will be tracked and reported.
2. The number of individuals receiving quarterly telehealth diabetes education will be tracked and reported.
3. The number of diabetes education classes and participants will be tracked and reported.
4. The number of individuals receiving educational materials at local food pantries will be tracked and reported.
5. The number of people in the community receiving glucose screenings will be tracked and reported.

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:
Schools, churches, local food pantries and senior living centers, OB/GYN offices

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:
Baptist Health Information Technology Department, Nursing, Nutrition and Food Services, Baptist Health Community Outreach

ESTIMATED COMPLETION DATE: Ongoing

PERSON(S)/DEPARTMENT RESPONSIBLE: Regina McCormick

Community Health Needs Not Being Addressed

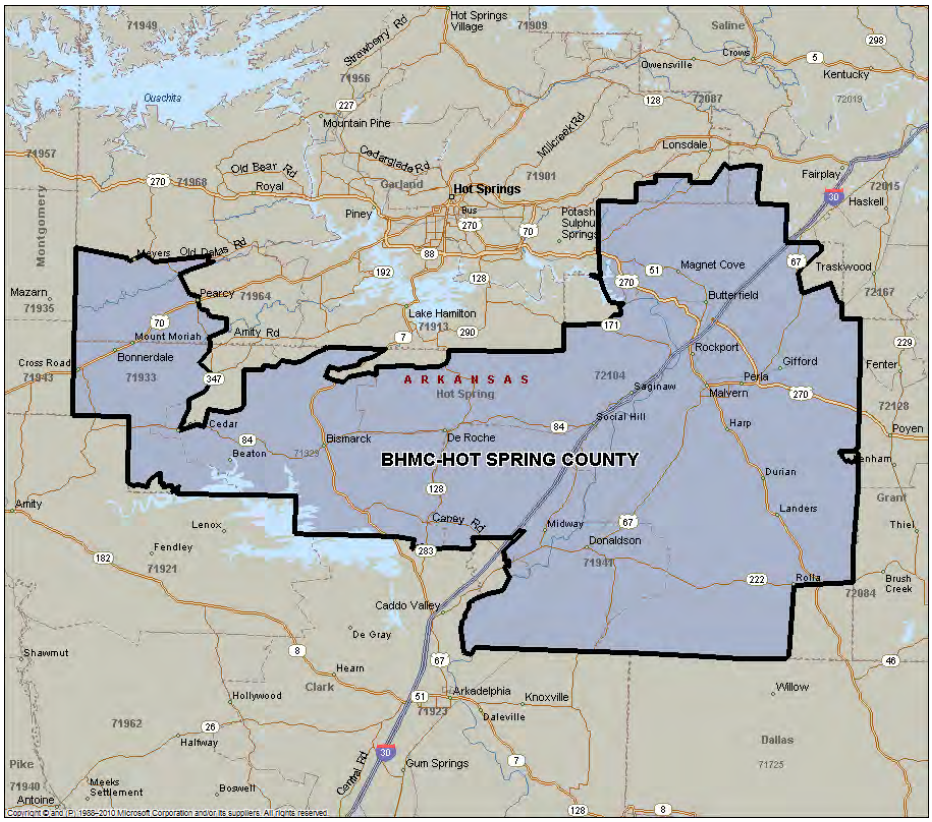
Baptist Health Medical Center-Stuttgart

Baptist Health acknowledges that the implementation strategy adopted does not address all the community health needs identified and that all of the identified needs are important. 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 from the focus groups and data collection was reviewed and prioritized. We do believe the focus areas selected will indirectly have a positive impact on many of the other items identified in the Community Health Needs Assessment. While we can't address every need, Baptist Health plans to share information on appropriate resources for the communities we serve.

Baptist Health Medical Center-Hot Spring County

Baptist Health Medical Center-Hot Spring County is a 72-bed community hospital with a long tradition of providing great patient care since it opened in 1923. The hospital joined Baptist Health Jan. 1, 2014, making it the eighth hospital in the system. To better serve the healthcare needs of the community, Baptist Health Medical Center-Hot Spring County offers a variety of specialized services including MRI, CT scan, digital mammography, echocardiogram, home health and hospice, physical therapy, psychiatric care and wound care.

Community Served and Demographics



SEX AND AGE

	Hot Spring County	State	Nation
Total Population	33,277	2,947,036	314,107,084
Percent Male	51.0%	49.1%	49.2%
Percent Female	49.0%	50.9%	50.8%
Age: 0 to 14	17.8%	20.1%	19.5%
Age: 15 to 19	6.3%	6.8%	6.8%
Age: under 18	22.2%	24.1%	23.5%
Age: 20 to 24	6.3%	7.0%	7.1%
Age: 25 to 34	12.8%	13.0%	13.5%
Age: 35 to 44	12.3%	12.5%	13.0%
Age: 45 to 54	14.1%	13.4%	14.1%
Age: 55 to 64	13.8%	12.3%	12.3%
Age: 65 and older	16.5%	15.0%	13.7%

ETHNICITY

		Hot Spring County	State	Nation
Total Population		33,277	2,947,036	314,107,084
Hispanic		3.0%	6.7%	16.9%
Non-Hispanic	White	83.3%	73.9%	62.8%
	Black or African American	11.8%	15.5%	12.2%
	American Indian and Alaska Native	0.5%	0.6%	0.7%
	Asian	0.1%	1.3%	4.9%
	Pacific Islander	0.0%	0.2%	0.2%
	Other	0.0%	0.1%	0.2%
	Multiracial	1.2%	1.8%	2.1%

INSURANCE COVERAGE

	Hot Spring County	State	Nation
Health Insurance Coverage	83.4%	84.2%	85.8%
Private Health Insurance Coverage	59.3%	59.1%	65.8%
Public Health Insurance Coverage	38.5%	37.2%	31.1%

Outcomes of 2014-2016

MAMMOGRAPHY - Baptist Health Medical Center-Hot Spring County developed a mammography awareness and education program for the community through social and print media. The campaign included educational presentations and booths at community events and faith-based organizations. Women aged 40 and older were targeted during hospital admission assessment and educated upon discharge on the importance of mammography. "Bring a Relative or Friend" campaign was developed for hospital staff to expand mammography education and awareness. Over 2,730 mammograms were performed during the 2014-2016 period.

HYPERTENSION - A campaign was developed promoting healthy lifestyle choices to prevent hypertension that included installing a blood pressure kiosk in the hospital lobby and administering weekly blood pressure screenings at the Senior Adult Center. Stroke and Hypertension presentations, Community Diabetic Support Group and Healthy Eating education were also incorporated. Over 3,900 individuals received blood pressure screening through the campaign. A trifold blood pressure wallet-size card was made available to patients through a collaboration with local physician offices. Educational articles were featured in the Malvern Daily Record newspaper.

STROKE - A stroke awareness and education campaign was developed for staff and the community. Stroke education information was added to all discharge instructions and placed in the Emergency Department's lobby. A stroke education module was created for nurses to provide better patient education at discharge. Stroke presentations and education were provided to community leaders, faith-based organizations, and community and civic groups. A partnership with the University of Arkansas for Medical Sciences (UAMS) was formed to implement the Arkansas Stroke Assistance through Virtual Emergency Support (AR Saves) Program. Emergency Department staff have been trained on the AR Saves program and certified in the National Institutes of Health Stroke program. The AR Saves program has been used with 23 patients since 2015. Stroke education articles were featured in the Malvern Daily Record newspaper.

MENTAL HEALTH - A mental health campaign was implemented that included the development of a depression screening tool and mental health presentations and education. Over 1,700 individuals were admitted to the Mental Health unit.

LACK OF PCP'S - The number of primary care physicians was increased to include one full time hospitalist and eight primary care physicians.

2016 Process

Quantitative Data

The Arkansas Center for Health Improvement (ACHI) was engaged to conduct the quantitative data acquisition and analysis. National, state and county data were included.

Quantitative results from the 2016 Baptist Health Community Health Needs Assessment for the Malvern hospital were obtained. There are ten sections including: Demographics, Health Outcomes, Cause of Death, Chronic Conditions, Health Behaviors, Prevention, Access, Social and Economic, Environment, and Community Prevalence of Diagnoses. Each section includes a table with health indicator data for Hot Spring County (the hospital community) and averages for the State of

Arkansas and the United States. If data were not available, a "NA" is displayed. Each section also includes graphics for various health indicator data. For more detailed information on methods, resources used, and outcomes please reference the Methods section and Appendix 1.

Interviews and Focus Groups

In addition to quantitative data collection, a focus group was utilized to acquire input from persons who represent the broad interests of the BHMC-Hot Spring County community. Participants included:

- Dr. Shawn Purifoy, Private Practice Physician
- Ms. Linda Fite, Malvern Community Member
- Ms. Jayne West, Encore Healthcare and Rehabilitation
- Mr. Dennis Bailey, Arkansas Department of Human Services
- Ms. Pat Simms, College of the Ouachitas
- Mr. Danny Riggin, Malvern Chamber of Commerce
- Dr. Ray Bollen, Private Practice Physician
- Dr. Bruce Burton, Private Practice Physician

Input from the Focus Group revealed concerns regarding needs for health education on numerous topics; access to urgent and chronic care for those with mental illness; diabetes; obesity; and transportation to address health needs.

Prioritized Health Needs

A prioritization session was held to choose two health needs to be addressed via a system-wide approach, and one additional need specific to each facility's defined community. A three-round, multi-voting technique was utilized to make final selections. Results of the Baptist Health community health needs selection process determined Diabetes and Obesity would be the system-based needs addressed. In addition, Health Education was selected by BHMC-Hot Spring County.

Implementation Plans

Action/Implementation Plans were developed for all prioritized needs, using a collaborative approach when multiple Baptist Health facilities and/or outside agencies could be included. All plans will be reviewed and updated on an annual basis.

Appendix

- Health Resources Available to Meet Needs
- Remainder of the Data

Community Health Needs Assessment – Implementation Plan 2017-2019

Baptist Health Medical Center-Hot Spring County

IDENTIFIED COMMUNITY HEALTH NEED: Obesity

GOALS/OBJECTIVES: Support community members in achieving a healthy weight through nutrition education and fitness activities.

STRATEGY # 1: Implement strategies to enhance education on healthy eating and promote physical activity.

ACTION STEPS:

1. Distribute material educating the community on how to make healthy meal choices on a limited budget and awareness/mindfulness about portion sizes.
2. Create a brochure and distribute to the public about the local Farmer's Market and fresh produce preparation.
3. Explore options to potentially position a Farmer's Market at Baptist Health Medical Center – HSC to facilitate access to fresh fruits and vegetables.
4. Educate the public about BMI and the associated health risks. Measure BMI at all health and wellness fairs.
5. Promote fitness activities at all appropriate Baptist Health events, community clinics, churches, and health and wellness fairs.
6. Explore plans to create a local 5K run/walk promoting physical activity.
7. Promote physical activities among employees and families.

PERFORMANCE METRICS:

1. Track the number of healthy eating educational material packets distributed to the community.
2. Track the number of BMI measurements at health and wellness fairs.

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:

Local Physicians, local school districts, AR Department of Health, Hot Spring County Extension Services

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:

Commit necessary staff time and funding needed to accomplish the goals/objectives.

ESTIMATED COMPLETION DATE: Ongoing, 2017-2019

PERSON(S)/DEPARTMENT RESPONSIBLE:

Ashley Evans, Clinical Dietitian
Jim Whitley, Nursing Operations Manager
Martin Milner, Physical Therapy Manager

IDENTIFIED COMMUNITY HEALTH NEED: Obesity

GOALS/OBJECTIVES: To improve physical activity and nutrition awareness, knowledge, and behaviors among elementary-aged students by expanding the ***We Can!*** CATCH Kids club program throughout the state.

STRATEGY # 2: Expand ***We Can!*** (**W**ays to **E**nhance **C**hildren's **A**ctivity & **N**utrition).

ACTION STEPS:

1. Expand the ***We Can!*** program to schools in Hot Spring County and surrounding areas.
2. Participate in annual "Train the Trainer" events for staff and volunteers who are implementing the program.
3. Present six nutrition and physical activity lessons to elementary school students in Hot Spring County, focusing on the key concepts of Coordinated Approach to Child Health.
4. Expand the program to surrounding service areas, as staffing permits.

PERFORMANCE METRICS:

1. 100 students will be reached in 2017, with at least a 10% increase in participation in following years.
2. 80% of students will show an increase in nutrition and physical activity awareness based on pretest/posttest/3-month delayed post-test.

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:
Baptist Health Community Outreach, Baptist Health – Stuttgart, Arkansas Department of Health, Boys & Girls Club, HIPPY program coordinators

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:
Community Outreach Staff

ESTIMATED COMPLETION DATE: Ongoing Project

PERSON(S)/DEPARTMENT RESPONSIBLE: Patrick Jackson, Baptist Health Community Outreach - Teresa Conner, Leititia Bailey

Community Health Needs Assessment – Implementation Plan 2017-2019

Baptist Health Medical Center-Hot Spring County

IDENTIFIED COMMUNITY HEALTH NEED: Health Education

GOALS/OBJECTIVES: Educate the community about chronic disease management and prevention. Promote safety and wellness to improve overall quality of life.

STRATEGY # 1: Implement a community health education strategy for Hot Spring County and surrounding service areas.

ACTION STEPS:

1. Partner with community-based organizations to develop and distribute educational materials for underserved residents.
2. Educate the community on prevention and management of chronic diseases, including, but not limited to, respiratory, cardiovascular, and mental health disorders as well as the importance of early detection of breast cancer. Accomplish these actions through community awareness programs, health and wellness fairs, and distributing educational material throughout the community.
3. Raise awareness of the warning signs of stroke. Utilize AR Saves to support activities focused on community education and outreach on stroke prevention.
4. Continue an education campaign regarding the risks of hypertension and the potential health complications of uncontrolled hypertension.
5. Provide health management presentations to community civic organizations, senior centers, churches, and local businesses.
6. Submit health education articles to the local newspaper.
7. Provide speaking engagements to promote health and wellness within the community.
8. Promote the 24-Hour access line for Mental Health needs developed and monitored by BHMC – Little Rock.

PERFORMANCE METRICS:

1. Measure number of educational material packets distributed to the community.
2. Measure number of speaking engagements and attendance.
3. Measure number of health education articles appearing in the local newspaper.
4. Measure number of blood pressure screenings.
5. Measure number of elevated blood pressure readings indicating uncontrolled hypertension.

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:
Local Physicians, AR Saves, Malvern Daily Record, Hot Spring County Extension Services, Local Senior Center, Churches, College of the Ouachitas, civic organizations, social services organizations, Baptist Health Little Rock.

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED: Commit necessary staff time and funding needed to accomplish the goals/objectives

ESTIMATED COMPLETION DATE: Ongoing, 2017-2019

PERSON(S)/DEPARTMENT RESPONSIBLE: Jim Whitley, Nursing Operations Manager, David Hennessee, Director of Radiology, Stephen Doan, Respiratory Therapy Manager, Patrick Jackson, Director of Pharmacy

Community Health Needs Assessment – Implementation Plan 2017-2019

Baptist Health Medical Center-Hot Spring County

IDENTIFIED COMMUNITY HEALTH NEED: Diabetes

GOALS/OBJECTIVES: Identify adults at risk of, or with, undiagnosed diabetes through blood sugar screenings and risk assessment tools. Provide diabetes education and support to diabetic patients and patients at risk for diabetes.

STRATEGY # 1: Conduct diabetes risk assessments and community blood sugar screenings at all appropriate Baptist Health events, health and wellness fairs, senior centers, etc.

ACTION STEPS:

1. Conduct community blood sugar screenings and provide risk assessment material/resources. Refer all people with abnormal blood sugars to appropriate medical services.
2. Work with community-based organizations to distribute diabetes educational materials to residents.
3. Partner with Arkansas Foundation for Medical Care and TMF Quality Improvement Network to participate in the "Everyone with Diabetes Counts Initiative" to improve access to diabetes self-management education workshops for patients identified with diabetes.
4. Provide a diabetic support group through which patients learn about disease management, meal planning, diet modification, weight control, exercise, and medications.
5. Enhance community education of diabetes awareness, prevention, and management through distribution of educational materials and diabetes self-management programs.
6. Provide diabetic foot assessments and general foot self-care education. Refer all people with abnormal foot assessments to the appropriate medical services.

PERFORMANCE METRICS:

1. Measure number of events providing blood sugar screenings.
2. Measure number of people screened.
3. Measure number of people with elevated blood sugar referred to primary care services, or emergency services, as needed.
4. Measure number of diabetes educational material packets distributed to the community.
5. Measure number of patients participating in the diabetic support group.
6. Measure number of enrolled adults who have successfully completed all sessions of the "Everyone with Diabetes Counts Initiative" self-management education program.
7. Measure the number of diabetic foot assessments performed.

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS: Local Physicians, Arkansas Foundation for Medical Care, Hot Spring County Extension Services, Local Senior Center, College of the Ouachitas

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED: Commit necessary staff time and funding needed to accomplish the goals/objectives.

ESTIMATED COMPLETION DATE: Ongoing

PERSON(S)/DEPARTMENT RESPONSIBLE: Ashley Evans, Clinical Dietitian, Jim Whitley, Nursing Operations Manager, Patrick Jackson, Director of Pharmacy

IDENTIFIED COMMUNITY HEALTH NEED: Diabetes

GOALS/OBJECTIVES: Implement an internal and external plan to increase diabetes awareness.

STRATEGY # 2: Create, maintain, and share a continuously updated repository of diabetes public communication messages (addressing awareness, prevention, and control), along with objective data and case stories demonstrating their effectiveness.

ACTION STEPS:

1. Collect, write, and distribute local success stories of healthy diabetes self-management accomplishments by patients.
2. Promote community-based screening events using print, radio and social media.
3. Promote health information, resources and risk assessments on the Baptist Health website.
4. Collaborate to update existing quality diabetes resources and tools and create new resources and tools, as needed.
5. Continue promotion of Diabetes Prevention and Control Program and Diabetes Advisory Group resources and tools developed through the Diabetes Advisory Committee Partnership.
6. Utilize Baptist Health clinical expertise to assist with delivery of consistent evidence-based health messages.
7. Implement evidence-based health communication strategies and messaging to reach audiences at increased risk for type 2 diabetes.
8. Promote statewide resources, tools, and programs to ensure reach to all citizens.
9. Collaborate with communities, schools, and other care providers to facilitate educational opportunities, resources, and awareness campaigns on type 2 diabetes prevention and diabetes control.
10. Utilize the Baptist Health Huddles to promote diabetes awareness and education during Diabetes Awareness Month and other appropriate times.

PERFORMANCE METRICS:

1. Number of stories featured in print, radio and social media promoting diabetes awareness will be tracked and reported.
2. Number of interviews featuring diabetes awareness, prevention and/or management will be tracked and reported.
3. Number of community presentations on diabetes awareness, prevention and management will be tracked and reported.
4. Number of new and existing partnerships maintained that focus on diabetes will be tracked and progress reported.
5. Number of Huddles focused on Diabetes will be tracked and reported.

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS: BHMC – Little Rock, Arkansas Department of Health

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED: Staff and Printing

ESTIMATED COMPLETION DATE: Ongoing

PERSON(S)/DEPARTMENT RESPONSIBLE: Strategic Development Staff, Teresa Conner, Jim Whitley, Patrick Jackson

Community Health Needs Not Being Addressed

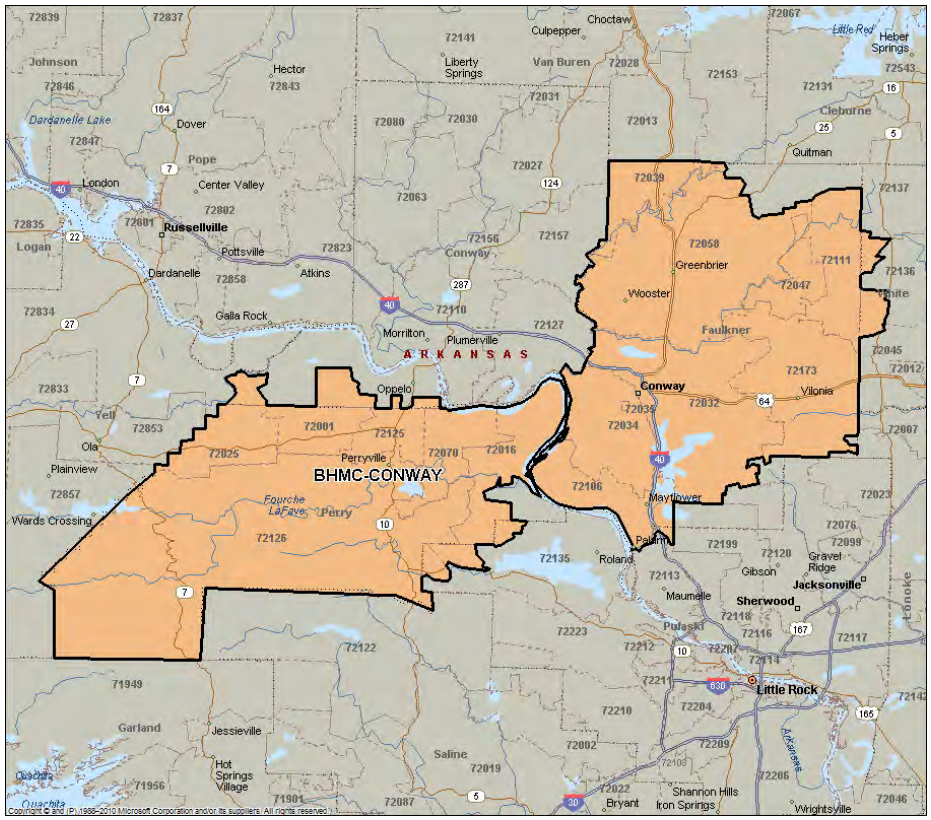
Baptist Health Medical Center-Hot Spring County

Baptist Health acknowledges that the implementation strategy adopted does not address all the community health needs identified and that all of the identified needs are important. After establishing criteria based on the Baptist Health mission, as well as BHMC-HSC clinical strengths, resources and infrastructure to maintain programs, each of the identified needs from the focus groups and data collection was reviewed and prioritized. We do believe the focus areas selected will indirectly have a positive impact on many of the other items identified in the Community Health Needs Assessment. While we can't address every need, Baptist Health plans to share information on appropriate resources for the communities we serve.

Baptist Health Medical Center-Conway

Baptist Health Medical Center-Conway, a 260,000 square-foot facility featuring 111 beds and eight operating rooms, opened in 2016. Comprehensive services include labor and delivery, surgical care, cardiac care, orthopedic care, imaging services (MRI and CAT), respiratory care, physical therapy, and emergency services. It features the most advanced technology available, and was designed around the patient.

Community Served and Demographics



SEX AND AGE

	Faulkner County	Perry County	State	Nation
Total Population	117,804	10,350	2,947,036	314,107,084
Percent Male	49.0%	50.0%	49.1%	49.2%
Percent Female	51.0%	50.0%	50.9%	50.8%
Age: 0 to 14	20.3%	18.0%	20.1%	19.5%
Age: 15 to 19	7.8%	6.7%	6.8%	6.8%
Age: under 18	24.2%	22.5%	24.1%	23.5%
Age: 20 to 24	11.7%	5.6%	7.0%	7.1%
Age: 25 to 34	14.7%	11.0%	13.0%	13.5%
Age: 35 to 44	12.7%	12.0%	12.5%	13.0%
Age: 45 to 54	12.4%	14.7%	13.4%	14.1%
Age: 55 to 64	10.0%	14.3%	12.3%	12.3%
Age: 65 and older	10.5%	17.6%	15.0%	13.7%

ETHNICITY

		Faulkner County	Perry County	State	Nation
Total Population		117,804	10,350	2,947,036	314,107,084
Hispanic		4.0%	2.7%	6.7%	16.9%
Non-Hispanic	White	81.8%	92.9%	73.9%	62.8%
	Black or African American	10.9%	3.0%	15.5%	12.2%
	American Indian and Alaska Native	0.3%	0.2%	0.6%	0.7%
	Asian	1.2%	0.1%	1.3%	4.9%
	Pacific Islander	0.0%	0.0%	0.2%	0.2%
	Other	0.1%	0.0%	0.1%	0.2%
	Multiracial	1.7%	1.1%	1.8%	2.1%

INSURANCE COVERAGE

	Faulkner County	Perry County	State	Nation
Health Insurance Coverage	86.2%	88.8%	84.2%	85.8%
Private Health Insurance Coverage	68.5%	62.5%	59.1%	65.8%
Public Health Insurance Coverage	27.7%	39.9%	37.2%	31.1%

2016 Process

Quantitative Data

The Arkansas Center for Health Improvement (ACHI) was engaged to conduct the quantitative data acquisition and analysis. National, state and county data were included.

Quantitative results from the 2016 Baptist Health Community Health Needs Assessment for the Conway hospital were obtained. There are ten sections including: Demographics, Health Outcomes, Cause of Death, Chronic Conditions, Health Behaviors, Prevention, Access, Social and Economic, Environment, and Community Prevalence of Diagnoses. Each section includes a table with health indicator data for each county in the hospital community, community averages (mean of all hospital counties), and averages for the State of Arkansas and the United States. If data were not available, a "NA" is displayed. Each section also includes graphics for various health indicator data. For more detailed information on methods, resources used, and outcomes please reference the Methods section and Appendix 1.

Interviews and Focus Groups

In addition to quantitative data collection, two focus groups were utilized to acquire input from persons who represent the broad interests of the BHMC-Conway community. Participants included:

- Mr. Richie Arnold, Conway Corp
- Mr. Brett Carroll, Conway Corp
- Pastor Blake Harrell, Lifeline Church
- Chief Mike Winter, Conway Fire Department
- Mr. Greg Murray, Conway School District
- Mr. Terry Kimbrow, Central Baptist College
- Mr. Brad Teague, University of Central Arkansas
- Chief Jody Spradlin, Conway Police Department
- Ms. Anna Ruth Merritt, Conway Ministry Center
- Mr. Royce Shipman, Conway Community Member
- Mr. Scott Shipman, Conway Community Member
- Ms. Charlotte Green, Conway Public Schools
- Ms. Spring Hunter, Conway Community Member
- Ms. Liza Bray, Conway Community Member
- Mr. Gerard Newsom, Conway Community Member

Input from the Focus Groups revealed concerns regarding needs for access to mental health care, crisis intervention and education for first responders on dealing with individuals with mental illness; substance abuse assistance; health education

to promote healthy habits; obesity/nutrition; and access to health services.

Prioritized Health Needs

A prioritization session was held to choose two health needs to be addressed via a system-wide approach, and one additional need specific to each facility's defined community. A three-round, multi-voting technique was utilized to make final selections. Results of the Baptist Health community health needs selection process determined Diabetes and Obesity would be the system-based needs addressed. In addition, Access to Healthcare was selected by BHMC-Conway.

Implementation Plans

Action/Implementation Plans were developed for all prioritized needs, using a collaborative approach when multiple Baptist Health facilities and/or outside agencies could be included. All plans will be reviewed and updated on an annual basis.

Appendix

- Health Resources Available to Meet Needs
- Remainder of the Data

Community Health Needs Assessment – Implementation Plan 2017-2019

Baptist Health Medical Center-Conway

IDENTIFIED COMMUNITY HEALTH NEED: Obesity

GOALS/OBJECTIVES: To improve physical activity and nutrition awareness, knowledge, and behaviors among elementary-aged students by expanding the ***We Can!*** CATCH Kids club program throughout the state.

STRATEGY # 1: Expand ***We Can!*** (**W**ays to **E**nhance **C**hildren's **A**ctivity & **N**utrition) in Conway.

ACTION STEPS:

1. Expand the Partnership with the Arkansas Department of Health to includes their statewide Community Health Program Specialists to expand reach outside of our service area.
2. Participate in a "Train the Trainer" event for staff and volunteers who are implementing the program.
3. Present six nutrition and physical activity lessons to elementary school students in Faulkner County schools focusing on the key concepts of Coordinated Approach to Child Health.
4. Explore the opportunity to implement the program at the Boys & Girls Club.

PERFORMANCE METRICS:

1. 500 students reached in 2017, with at least a 10% increase in participation in following years.
2. 80% of students will show an increase in nutrition and physical activity awareness based on pretest/posttest/3-month delayed post-test.

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:
Baptist Health Community Outreach, Arkansas Department of Health, Boys & Girls Club

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:
Community Outreach Staff

ESTIMATED COMPLETION DATE: Ongoing Project

PERSON(S)/DEPARTMENT RESPONSIBLE: Baptist Health Community Outreach Driven - Teresa Conner, Leititia Bailey, Tamara Wright, Laurie Cox

Community Health Needs Assessment – Implementation Plan 2017-2019

Baptist Health Medical Center-Conway

IDENTIFIED COMMUNITY HEALTH NEED: Obesity

GOALS/OBJECTIVES: To educate parents, teachers, caregivers and adults on the basics of maintaining a healthy weight for their families and students.

STRATEGY # 2: To implement the ***We Can!*** (Energize Our Families: Parent Program) in Conway.

ACTION STEPS:

1. Coordinate with School Wellness Committees to offer the ***We Can!*** Parent Program to school teachers and parent/teacher associations.
2. Present four nutrition and physical activity sessions to parents, caregivers and adults.
3. Utilize partnership with the Arkansas Department of Health's Community Health Program Specialists to assist with program implementation.
4. Offer Grocery stores tours for participants.
5. Offer BH Farmers Market bucks as incentives to participants.

PERFORMANCE METRICS:

1. 2 programs implemented in 2017, with a 50% increase in programs in 2018 and 2019.
2. 80% of participants will show an improvement in healthy behaviors based on pre and post assessments.
3. Pre and Posttest assessments will show a 75% knowledge gain.
4. Number of participants will be tracked and reported.
5. Number of Farmers Market Bucks distributed will be tracked and reported.

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:

Arkansas Hunger Relief Alliance, BH Foundation, Arkansas Department of Health, Local School Districts

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:

Community Outreach Staff, Farmers Market Bucks

ESTIMATED COMPLETION DATE: Ongoing Project

PERSON(S)/DEPARTMENT RESPONSIBLE: Baptist Health Community Outreach Driven - Teresa Conner, Leititia Bailey, Tamara Wright. Laurie Cox

IDENTIFIED COMMUNITY HEALTH NEED: Obesity

GOALS/OBJECTIVES: To educate children ages 6 and younger, parents, caregivers and adults on maintaining a healthy weight through improved food choices, increased physical activity and reduced screen time.

STRATEGY # 3: Expand the ***We Can!*** Eat Play and Grow Program.

ACTION STEPS:

1. Pilot the 11 nutrition and physical activity program to children ages 6 and younger, to include the at-home parent component in Faulkner County.
2. Utilize the partnership with the Arkansas Department of Health's Community Health Specialists to expand reach.
3. Explore opportunities to train Preschool workers to implement the program as a part of their curriculum, targeting four-year-old students.

PERFORMANCE METRICS:

1. 100 students reached in 2017, with at least a 10% increase in participation in 2018 and 2019.
2. 80% of students will show an increase in nutrition and physical activity awareness based on pretest/posttest/3-month delayed post-test.

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:
Baptist Health Community Outreach, Arkansas Department of Health, Boys & Girls Club

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED: Community Outreach Staff

ESTIMATED COMPLETION DATE: Ongoing Project

PERSON(S)/DEPARTMENT RESPONSIBLE: Baptist Health Community Outreach Driven - Teresa Conner, Leititia Bailey, Tamara Wright, Laurie Cox

Community Health Needs Assessment – Implementation Plan 2017-2019

Baptist Health Medical Center-Conway

IDENTIFIED COMMUNITY HEALTH NEED: Obesity

GOALS/OBJECTIVES: Increase the community's exposure to messages and tools that increase knowledge and skills for healthy living.

STRATEGY # 4: Develop an internal and external Obesity Awareness Strategy.

ACTION STEPS:

1. Develop marketing efforts that encourage individuals and families to increase healthy eating and physical activity.
2. Support and expand programs and initiatives in partnership with Healthy Active Arkansas, Arkansas Obesity Coalition and Arkansas Department of Health Hometown Health coalitions to promote healthy eating and physical activity.
3. Explore opportunities to incorporate a BH Healthy walk at Baptist Health facilities with a walking trail.
4. Incorporate healthy food in all community-based meetings to send a message to participants that Baptist Health is committed to their health.
5. Promote healthy recipes on the Baptist Health website.
6. Update and distribute the BH Fast Food Guide to include print and web downloading access, and make it available for community events.
7. Participate in the National Healthier Hospital Initiative (HHI) in the challenge area of Healthy Food.
8. Educate patients, employees, guests, and communities on the importance of eating healthy and the impact it has on overall health.
9. Increase awareness of employees and guests on the quality and variety of produce and healthy food choices available at an affordable price in all Baptist Health food service and retail locations.
10. Incorporate Diabetes Education in the Huddles during National Diabetes Awareness Month.

PERFORMANCE METRICS:

1. Number of media releases will be tracked and reported.
2. Number of Fast Food Guides distributed will be tracked and reported.
3. Number of Fast Food Guides downloaded from the web will be tracked and reported.
4. Number of BH walking events will be tracked and reported.
5. Number of participants will be tracked and reported.
6. Number of views on the web of healthy cooking demonstrations will be tracked and reported.
7. National Healthier Hospital Initiative will be implemented.

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS: Baptist Health Community Outreach, Strategic Development, Healthy Active Arkansas, AR Obesity Coalition, Arkansas Department of Health

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED: Community Outreach Staff, Strategic Development, Regional Hospital

PERSON(S)/DEPARTMENT RESPONSIBLE: Baptist Health Community Outreach Driven - Teresa Conner, Leititia Bailey, Tamara Wright, Laurie Cox

Community Health Needs Assessment – Implementation Plan 2017-2019

Baptist Health Medical Center-Conway

IDENTIFIED COMMUNITY HEALTH NEED: Obesity

GOALS/OBJECTIVES: Promote walking as a form of increasing physical activity.

STRATEGY # 5: Expand the Community Walking Program in Faulkner County in an effort promote physical activity.

ACTION STEPS:

1. Expand the Community Walking Program using 2017 membership as the baseline data.
2. Provide participants with a t-shirt, pedometer, walking log and water bottle.
3. Offer quarterly educational classes on Physical Fitness and Nutrition.
4. Offer a quarterly newsletter and monthly health promotion topics.
5. Offer participants monthly weigh in opportunities at Community Wellness Centers.
6. Promote identified walking trails in Faulkner County, including Baptist Health-sponsored trails.
7. Offer incentives for participating, to include BH Farmers Market Bucks, grocery store gift cards, and a fitbit.

PERFORMANCE METRICS:

1. Baseline data will be collected for year 1 in Conway with a 25% target increase in enrollment in 2018 and 2019.
2. 25% of participants will report walking 4 or more times a week.
3. 25% will have increased their overall physical activity habits (pre/post program self-reported assessment).
4. Number of classes will be tracked and reported.
5. Number of class participants will be tracked and reported.

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:

Baptist Health Conway, BH Foundation Farmers Market

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:

Community Outreach Staff, Strategic Development

PERSON(S)/DEPARTMENT RESPONSIBLE: Baptist Health Community Outreach Driven - Teresa Conner, Leititia Bailey

IDENTIFIED COMMUNITY HEALTH NEED: Obesity

GOALS/OBJECTIVES: Through the BHealthy Farmers Market Program, provide access to local, healthy food and nutrition education to all populations, and in turn, help to financially support Arkansas farmers.

STRATEGY # 6: Expand the Baptist Health Farmers Market into Conway.

ACTION STEPS:

1. Expand program each by incorporating the Farmers Market program into the Conway area.
2. Provide free Cooking Matters classes in partnership with the Arkansas Hunger Relief Alliance.
3. Through the BHealthy Mobile Farmers Market Program, and in partnership with the FarmBox2Family Charity Food Box Program, pack and deliver free produce boxes and conduct healthy cooking demonstrations via a Mobile Kitchen Unit.
4. Through partnership with DHS, provide SNAP benefits and Double Dollars programs in the Conway market.
5. Provide Arkansas farmers with a free location to sell their produce, as well as training opportunities and grant funding opportunities to assist in the continued success of their farms.

PERFORMANCE METRICS:

1. Expansion of Conway Farmers Market completed.
2. Number of Cooking Classes will be tracked and reported.
3. Number of participants in the cooking classes will be tracked and reported.
4. Number of people served by the Charity Food Box Program will be tracked and reported.
5. Number of farmers participating will be tracked and reported.
6. Number of SNAP program dollars accepted will be tracked and reported.

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS: Arkansas Department of Human Services, Arkansas Hunger Relief Alliance, Pulaski Technical College Culinary Arts Schools, Health Management Center, Community Outreach, Strategic Development, Nutrition and Food Services, Arkansas Obesity Coalition, Arkansas Farmers

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:
Baptist Health Staff and Financial Support

ESTIMATED COMPLETION DATE: Ongoing

PERSON(S)/DEPARTMENT RESPONSIBLE: Baptist Health Foundation

IDENTIFIED COMMUNITY HEALTH NEED: Obesity

GOALS/OBJECTIVES: To enhance children's consumption of fresh fruits and vegetables.

STRATEGY # 7: Partner with school districts to support the School Gardens and Farm to School Initiative.

ACTION STEPS:

1. Provide a school in need of support with mini grants to purchase garden supplies.
2. Partner with a school to offer a healthy cooking demonstration.
3. Implement a Baptist Health Volunteer Day to support partner schools with community gardens.

PERFORMANCE METRICS:

1. Number of School Gardens supported will be tracked and reported.
2. Number of new School Gardens started by Baptist Health will be tracked and reported.
3. Number of participants in the cooking demonstrations will be tracked and reported.
4. Number of Baptist Health employee volunteer hours dedicated to school gardens will be tracked and reported.

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:
School District, Arkansas Hunger Relief Alliance, Arkansas Farmers

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:
Baptist Health Staff, Financial Support, Strategic Development, Baptist Health Foundation Mobile Unit

ESTIMATED COMPLETION DATE: Ongoing

PERSON(S)/DEPARTMENT RESPONSIBLE: Teresa Conner, Margot Vogel

IDENTIFIED COMMUNITY HEALTH NEED: Access to Healthcare

GOALS/OBJECTIVES: Assist meeting the need of limited access to healthcare with transportation.

STRATEGY # 1: Secure funding to purchase a handicap-accessible van for transporting patients in need.

ACTION STEPS:

1. Apply for grant funding from Arkansas Highway and Transportation for purchase of a handicap-accessible van.
2. Secure a full time employee (FTE) for transporting patients to physician and clinic appointments.
3. Develop processes for transportation services.
4. Promote services via local newspaper, local television stations and print media.

PERFORMANCE METRICS:

1. The number of individuals transported for appointments will be tracked and reported.

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:
Churches, MEMS/EMS, local newspaper, local television stations

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:
Full Time Employee, Scheduling Department, Strategic Development

ESTIMATED COMPLETION DATE: Ongoing

PERSON(S)/DEPARTMENT RESPONSIBLE: Rhonda Adams, Jacob Robinson

IDENTIFIED COMMUNITY HEALTH NEED: Access to Healthcare

GOALS/OBJECTIVES: Improve access to care for the homeless population.

STRATEGY # 2: Partner with community groups to provide access to screenings and resources for the homeless population.

ACTION STEPS:

1. Explore opportunities to partner with community groups to provide an ongoing wellness center targeting the homeless population.
2. Utilize the Baptist Health Mobile Health Unit to offer flu shots during the fall.
3. Partner with the Salvation Army to coordinate a clothing drive for the homeless population.
4. Develop a resource guide of available services to be distributed to the community.
5. Explore opportunities to distribute food left over from the cafeteria to programs that serve the homeless.

PERFORMANCE METRICS:

1. Wellness Center development.
2. Number of locations and people served with the flu shot campaign will be tracked and reported.
3. Number of referrals for assistance to the Salvation Army will be tracked and reported.
4. Number of meals donated will be tracked and reported.

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:
Baptist Health Community Outreach, churches, Salvation Army

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:
Staff and printing

ESTIMATED COMPLETION DATE: Ongoing

PERSON(S)/DEPARTMENT RESPONSIBLE: Laurie Cox, Tamara Wright

Community Health Needs Assessment – Implementation Plan 2017-2019

Baptist Health Medical Center-Conway

IDENTIFIED COMMUNITY HEALTH NEED: Diabetes

GOALS/OBJECTIVES: Improve the overall health and wellbeing of patients with diagnosed Type II diabetes who attend the Community Outreach Wellness Centers in Central Arkansas.

STRATEGY #1: Provide evidence-based diabetes self-management education to improve diabetes management and reduce complications with a targeted group of patients.

ACTION STEPS:

1. Implement the use of electronic medical records in all community-based wellness centers in an effort to provide more accurate tracking and reporting.
2. Recruit patients to participate in a nurse-led diabetes self-management program.
3. Provide evidence-based diabetes education.
4. Provide baseline biometric screenings.
5. Offer quarterly biometric screenings as check points for program adjustments for improved patient outcomes.
6. Offer monthly educational classes on diabetes at community wellness centers to include healthy cooking classes, medication usage and grocery store tours.

PERFORMANCE METRICS:

1. Diabetic patients will be recruited.
2. The following goals will be measured:
    a. 25% of patients will show an improvement in Blood Glucose levels.
    b. 25% of patients will show an improvement in A1C by at least 1 percent.
    c. 25% of patients will show an improvement in total cholesterol.
    d. 10% of patients will show improvement in BMI.
    e. 10% of patients will have blood pressure less than or equal to 140/90.
    f. 100% of patients will be screened for smoking, flu shots, dilated eye exams, annual foot exams, A1C, and dental exam.
3. Number of consults and referrals resulting from the telehealth consults will be tracked and reported.

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATION:
Staff and Telehealth

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:
Community Outreach Staff, Telehealth, Baptist Health IT

ESTIMATED COMPLETION DATE: Ongoing

PERSON (S)/DEPARTMENT RESPONSIBLE: Community Outreach RN's, Teresa Conner

IDENTIFIED COMMUNITY HEALTH NEED: Diabetes

GOALS/OBJECTIVES: Develop an internal and external plan to increase awareness about diabetes in the community.

STRATEGY # 2: Partner with Strategic Development to create, maintain, and share an updated repository of diabetes public communication messages (addressing awareness, prevention, and control), along with objective data and case histories demonstrating their effectiveness.

ACTION STEPS:

1. Partner with Strategic Development to collect, write, and distribute local success stories of healthy diabetes self-management accomplishments by patients.
2. Promote health information, resources and diabetes risk assessments on the Baptist Health website.
3. Collaborate to update existing quality diabetes resources and tools, and create new resources and tools, as needed.
4. Utilize Baptist Health clinical expertise to assist with delivery of consistent evidence-based health messages.
5. Increase strategic collaboration and coordination of communication interventions and strategies.
6. Promote statewide resources, tools, and programs to ensure reach to all citizens.
7. Explore opportunities to present diabetes to community groups and organizations.

PERFORMANCE METRICS:

1. Number of news releases printed in the Log Cabin paper will be tracked and reported.
2. Number of community presentations on diabetes awareness and prevention will be tracked and reported.
3. Number of PSA's placed on local radio stations will be tracked and reported.

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:
BHMC – Little Rock

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS HEALTH NEED:
Staff and Printing Resources

ESTIMATED COMPLETION DATE: Ongoing

PERSON(S)/DEPARTMENT RESPONSIBLE: Strategic Development Marketing Staff, Community Outreach

Community Health Needs Not Being Addressed

Baptist Health Medical Center-Conway

Baptist Health acknowledges that the implementation strategy adopted does not address all the community health needs identified and that all of the identified needs are important. After establishing criteria based on the Baptist Health mission, as well as BHMC-Conway clinical strengths, resources and infrastructure to maintain programs, each of the identified needs from the focus groups and data collection was reviewed and prioritized. We do believe the focus areas selected will indirectly have a positive impact on many of the other items identified in the Community Health Needs Assessment. While we can't address every need, Baptist Health plans to share information on appropriate resources for the communities we serve.

Baptist Health Extended Care Hospital

Baptist Health Extended Care Hospital, a 37-bed long-term acute care hospital, is located on the campus of Baptist Health Medical Center-Little Rock. It is designed to provide long-term care to patients with complex medical conditions. Baptist Health Extended Care Hospital provides interdisciplinary care for unique patient needs including pulmonary, ventilator weaning, infectious disease management, cardiac and multi-system failure, post-op complications and low tolerance rehabilitation.

Community Served and Demographics

Outcomes of 2014-2016

STROKE PREVENTION - Educational materials were provided for every appropriate patient and family members at patient discharge. Educational materials on stroke and how stroke affects the brain were provided at 20 community-based wellness centers. The community-based wellness centers have more than 9,000 patient visits annually. Stroke information was also provided during the Annual Barber and Beauty shop program in partnership with the Arkansas Department of Health.

The Community Resource Directory was shared with community members and hospital staff. The guide is scheduled to be updated and this initiative will continue.

INJURY PREVENTION - Educational materials were provided to all patients and families upon discharge relating to fall and injury prevention. Fall Prevention risk assessments and presentations were conducted in four Community-Based Wellness Centers, reaching 70 seniors. The Centers participating were Dunbar Senior Center, Southwest Senior Center, East Little Rock Senior Center and Stephens Community Center. This is an important concern for our seniors, and will be continued.

2016 Process

The communities served for the Baptist Health Extended Care Hospital (BHECH) were defined by the diseases and injury states of patients in the communities served by the seven acute care Baptist Health Medical Centers. The Arkansas Center for Health Improvement (ACHI) was engaged to conduct the quantitative data acquisition and analysis, utilizing national, state and county data. Ariel Strategic Communications conducted focus groups in all of the hospitals' defined communities to seek opinions on health needs from representatives of state and local government, community organizations, healthcare providers, and minority and underserved populations.

Prioritized Health Needs

A prioritization session was held to choose two health needs to be addressed via a system-wide approach, and one additional need specific to each facility's defined community. A three-round, multi-voting technique was utilized to make final selections. Results of the Baptist Health community health needs selection process determined Diabetes and Obesity would be the system-based needs addressed. BHECH made the determination to address only the two system-wide health needs due to limited resources.

Implementation Plans

Action/Implementation Plans were developed for all prioritized needs, using a collaborative approach when multiple Baptist Health facilities and/or outside agencies could be included. All plans will be reviewed and updated on an annual basis.

Appendix

- Health Resources Available to Meet Needs
- Remainder of the Data

IDENTIFIED COMMUNITY HEALTH NEED: Diabetes

GOALS / OBJECTIVES: To provide the tools and education to patients with diabetes who are at high risk of falls on how to reduce their risk.

STRATEGY # 1: Develop a community-based Fall Risk Prevention plan, based on best practices.

ACTION STEPS:

1. Partner with the city of Little Rock to implement a Fall Risk Prevention program in 4 Senior Centers.
2. Partner with Pharmacists to promote medication reviews with patients in the senior centers.
3. Provide seniors with a list of existing resources for home modifications and assistive devices.
4. Provide a chair exercise demonstration for patients while educating on the benefits of exercise in reducing fall risk factors.
5. Educate all participants about home safety measures that reduce home hazards and lower risks for falling.
6. Implement a pre-test to identify the number of patients who have fallen in the past.
7. Administer a post-test to identify any home modifications implemented to reduce risk.

PERFORMANCE METRICS:

1. Number of senior centers reached will be tracked and reported.
2. Number of participants will be tracked and reported.
3. Number of medication risks identified by pharmacists will be tracked and reported.
4. Number of referrals for follow-up to physician will be tracked and reported.
5. Number of physical activity demonstrations implemented will be tracked and reported.
6. Pre/Post assessment scores will be tabulated and reported.

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:
Baptist Health Community Outreach

RESOURCES HOSPITAL PLANS TO COMMITT TO ADDRESS HEALTH NEED:
Community Outreach Staff

ESTIMATED COMPLETION DATE: Ongoing Project

PERSON(S) / DEPARTMENT RESPONSIBLE: Baptist Health Community Outreach Driven - Teresa Conner, Cheryl Johnson, Mike Perkins

IDENTIFIED COMMUNITY HEALTH NEED: Obesity

GOALS / OBJECTIVES: Develop community-based interventions that cultivate sustainable food systems to promote health, prevent obesity, and improve food security.

STRATEGY # 1: Develop a community-based food insecurity risk identification program.

ACTION STEPS:

1. Develop a food insecurity screening assessment tool to be used at community wellness centers and appropriate community events.
2. Provide education to community members on the link between obesity and food insecurity.
3. Develop a food pantry resource guide to distribute to patients in need of food.
4. Develop a farmers market resource guide to distribute to patients in need of food, including the mobile food markets
5. Explore partnering with Baptist Heath Farmers Market to submit names for the donation boxes.
6. Partner with agencies to do on-site enrollment for the Supplemental Nutrition Assistance Program (SNAP) in the Community Wellness Centers.
7. Implement a cooking class based on foods purchased with a limited income.
8. Partner with agencies to do on-site enrollment for WIC services for new and expectant mothers.
9. Explore opportunities to implement a food insecurity assessment for patients being discharged from the hospital.

PERFORMANCE METRICS:

1. Number of patients screened will be tracked and reported.
2. Number of patients referred for food assistance will be tracked and reported.
3. Development of the resource guide for food pantries will be reported.
4. Development of the resource guide for farmers markets will be reported.
5. Number of patients benefiting from the BH Farmers Market free food box will be tracked and reported.
6. Number of patients signing up for SNAP at community wellness centers or events will be tracked and reported.
7. Number of patients signing up for WIC at community wellness centers or events will be tracked and reported.

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS: Baptist Health Community Outreach, Baptist Health Foundation, Arkansas Department of Health, Arkansas Hunger Relief Alliance.

RESOURCES HOSPITAL PLANS TO COMMITT TO ADDRESS HEALTH NEED:
Community Outreach Staff, Print Shop

ESTIMATED COMPLETION DATE: Ongoing Project

PERSON(S) / DEPARTMENT RESPONSIBLE: Baptist Health Community Outreach Driven - Teresa Conner, Cheryl Johnson, Mike Perkins

IDENTIFIED COMMUNITY HEALTH NEED: Obesity

GOALS / OBJECTIVES: Promote walking as a form of increasing physical activity.

STRATEGY # 2: Expand the Community Walking Program in an effort to improve individual's physical activity knowledge and behaviors.

ACTION STEPS:

1. Support the expansion of the Community Walking Program.
2. Provide participants with a t-shirt, pedometer, walking log and water bottle.
3. Offer Quarterly Educational classes on Physical Fitness and Nutrition.
4. Offer a monthly newsletter with healthy topics.
5. Offer Participants monthly weigh-in opportunities at Community Wellness Centers.
6. Partner with BHMC – Little Rock to offer incentives for participating, to include BH Farmers Market Bucks, Grocery store gift cards, and a fitbit.
7. Identify and promote BH community walking locations.

PERFORMANCE METRICS:

1. 25% increase in enrollment each year.
2. 25% of participants will report walking 4 or more times a week.
3. 25% will have increased their overall physical activity habits (pre/post program self-reported assessment).
4. Number of classes will be tracked and reported.
5. Number of class participants will be tracked and reported.

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:
BHMC – Little Rock, BH Foundation Farmers Market

RESOURCES HOSPITAL PLANS TO COMMITT TO ADDRESS HEALTH NEED:
Community Outreach Staff, Strategic Development

PERSON(S) / DEPARTMENT RESPONSIBLE: Baptist Health Community Outreach Driven - Teresa Conner, Leititia Bailey

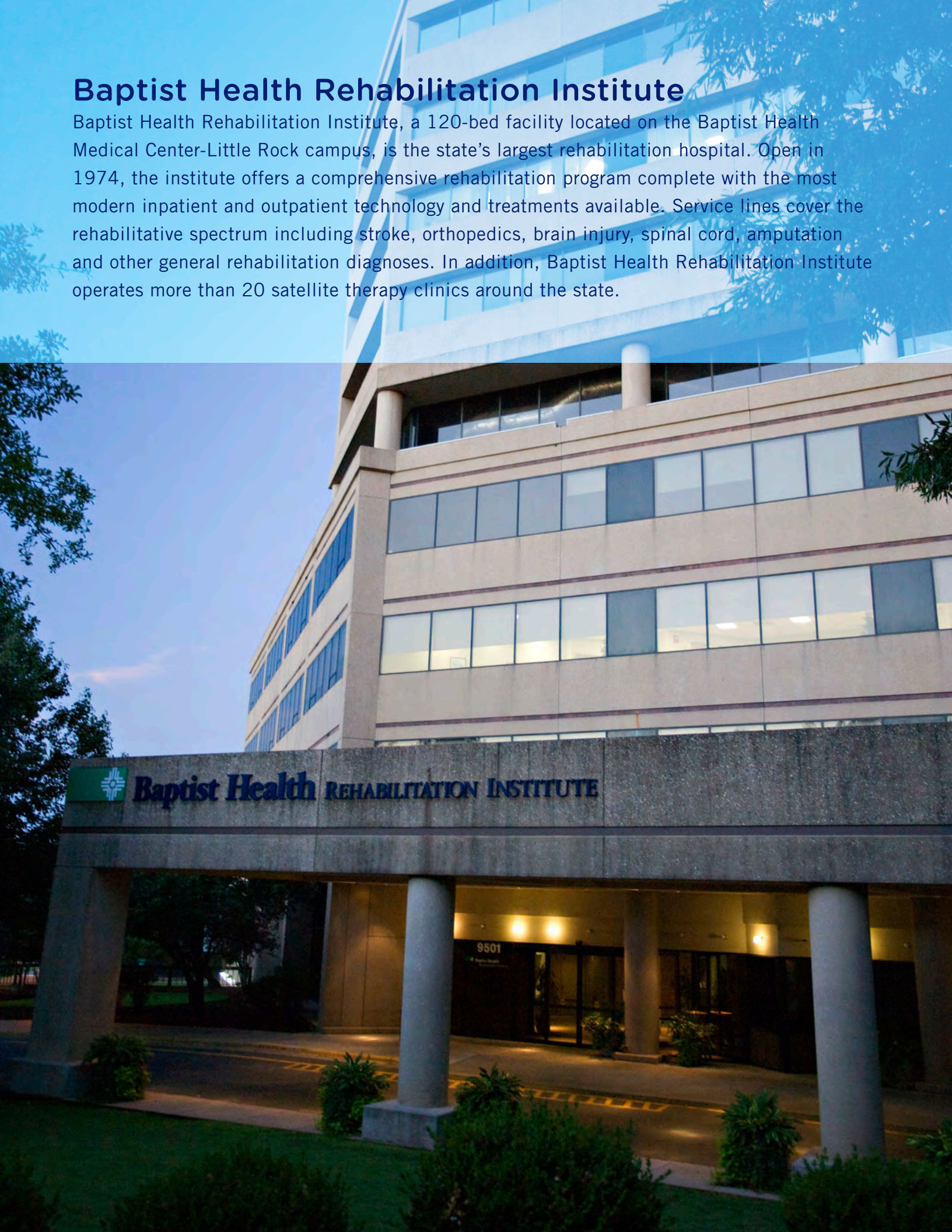
Community Health Needs Not Being Addressed

Baptist Health Extended Care Hospital

Baptist Health acknowledges that the implementation strategy adopted does not address all the community health needs identified and that all of the identified needs are important. 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 from the focus groups and data collection was reviewed and prioritized. We do believe the focus areas selected will indirectly have a positive impact on many of the other items identified in the Community Health Needs Assessment. While we can't address every need, Baptist Health plans to share information on appropriate resources for the communities we serve.

Baptist Health Rehabilitation Institute

Baptist Health Rehabilitation Institute, a 120-bed facility located on the Baptist Health Medical Center-Little Rock campus, is the state's largest rehabilitation hospital. Open in 1974, the institute offers a comprehensive rehabilitation program complete with the most modern inpatient and outpatient technology and treatments available. Service lines cover the rehabilitative spectrum including stroke, orthopedics, brain injury, spinal cord, amputation and other general rehabilitation diagnoses. In addition, Baptist Health Rehabilitation Institute operates more than 20 satellite therapy clinics around the state.



Community Served and Demographics

2013 Outcomes

INJURY PREVENTION - On a monthly basis, running clinics were held annually at the Fleet Feet clinic in Little Rock. The goal of this program was to promote injury prevention while running casually and competitively. More than 100 individuals participated. Free Brain Injury support groups, which are held on a monthly basis, included educational components on fall prevention. Educational lectures were held on brain injury and spinal cord injuries for students at Arkansas Tech. Baptist Health also cosponsored the Arkansas Trauma Rehabilitation Conference. The "Think First" program was not implemented in the schools due the changes in the program guidelines.

OBESITY - Educational Programs entitled "Recharge Your Health", with a focus on heart healthy eating and physical fitness were presented. Healthy eating and nutrition were also the focus of an employee health fair with over 200 participants. Presentations on physical fitness were made at the Center for Youth and Families to 15 participants and were a part of the Community Outreach Sister-to-Sister program. Presentations also included "How to change Your Body" for 30 individuals. Internal partnerships with the Baptist Health preschools in Little Rock and North Little Rock allowed the hospital to provide physical fitness and nutrition information to youth under the age of 5.

An internal partnership was formed with the Health Management Center to implement an annual summer Adolescent Weight Loss Program. A grant was received from the Steve Landers Automotive Group for this program. The ten week program targeted ages 11 to 17. Of the 15 children participating in year one, there was a 24% decrease in the time

needed to complete a mile run/walk. All participants lost inches. The program is scheduled to continue with the goal of making it a year-round program.

STROKE PREVENTION - Stroke Prevention education and promotion was offered at several community events including the Derek Lewis Foundation Community Events, to University of Central Arkansas students, Baptist Health Cardiology Conference and Community Outreach's Sister-to-Sister program. The Rehabilitation Institute also sponsored and staffed a monthly Stroke Support Group.

2016 Process

The communities served for the Baptist Health Rehabilitation Institute were defined by the diseases and injury states of patients in the communities served by the seven acute care Baptist Health Medical Centers. The Arkansas Center for Health Improvement (ACHI) was engaged to conduct the quantitative data acquisition and analysis, utilizing national, state and county data. Ariel Strategic Communications conducted focus groups in all of the hospitals' defined communities to seek opinions on health needs from representatives of state and local government, community organizations, healthcare providers, and minority and underserved populations.

Prioritized Health Needs

A prioritization session was held to choose two health needs to be addressed via a system-wide approach, and one additional need specific to each facility's defined community. A three-round, multi-voting technique was utilized to make final selections. Results of the Baptist Health community health needs selection process determined Diabetes and Obesity would be the system-based needs addressed. In addition, Smoking Cessation in Post-Stroke Patients was selected by the Baptist Health Rehabilitation Institute.

Implementation Plans

Action/Implementation Plans were developed for all prioritized needs, using a collaborative approach when multiple Baptist Health facilities and/or outside agencies could be included. All plans will be reviewed and updated on an annual basis.

Appendix

- Health Resources Available to Meet Needs
- Remainder of the Data

IDENTIFIED COMMUNITY HEALTH NEED: Diabetes

GOALS / OBJECTIVES: To improve diabetic management for individuals.

STRATEGY # 1: Develop chair exercise routines for individuals with diabetes.

ACTION STEPS:

1. Develop a chair exercise video.
2. Make the chair exercise video available through Vidyo and on the Baptist Health website for home viewing.
3. Promote the Vidyo at the Diabetes Support group annually.

PERFORMANCE METRICS:

1. The number of views from Vidyo and the Baptist Health website will be tracked and reported.
2. An evaluation of the benefit of the Vidyo will be incorporated.

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:
BHMC – Little Rock

RESOURCES HOSPITAL PLANS TO COMMITT TO ADDRESS HEALTH NEED:
Baptist Health Strategic Development , Community Outreach

ESTIMATED COMPLETION DATE: Ongoing

PERSON(S) / DEPARTMENT RESPONSIBLE: Baptist Health Fitness Center

IDENTIFIED COMMUNITY HEALTH NEED: Diabetes

GOALS / OBJECTIVES: To improve community awareness of diabetes prevention and management.

STRATEGY # 2: Provide diabetes education presentations in the community.

ACTION STEPS:

1. Offer diabetes presentations to community groups such as Electric Cooperative, Retired Teachers Association, Baptist Health Community Outreach's Sister-to-Sister and Community Walking programs.
2. Provide health education materials and resources to individuals.
3. Explore other opportunities to provide diabetes education.

PERFORMANCE METRICS:

1. A pretest and posttest will be administered to individuals to evaluate knowledge gain.
2. Number of presentations to community groups will be tracked and reported.

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:
Electric Cooperative, Retired Teachers Association, Baptist Health Community Outreach

RESOURCES HOSPITAL PLANS TO COMMITT TO ADDRESS HEALTH NEED:
Printing and promotion resources

ESTIMATED COMPLETION DATE: Ongoing

PERSON(S) / DEPARTMENT RESPONSIBLE: Baptist Health Fitness Center

IDENTIFIED COMMUNITY HEALTH NEED: Obesity

GOALS / OBJECTIVES: To encourage a physically active lifestyle in efforts to develop and maintain a healthy weight.

STRATEGY # 1: Implement a "Biggest Loser" Contest within the community.

ACTION STEPS:

1. Partner with an external group such as Electric Cooperative for implementation of a 12 week "Biggest Loser" contest for their employees.
2. Provide physical activity instruction and health education.
3. Offer incentives to sustain participation.
4. Explore opportunities to partner with additional groups in 2018 and 2019.

PERFORMANCE METRICS:

1. Individuals will have pre and post screenings and assessments.
2. Goals will be set and evaluated for progress and reported.

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:
Electric Cooperative, other identified groups

RESOURCES HOSPITAL PLANS TO COMMITT TO ADDRESS HEALTH NEED:
4 Baptist Health Fitness Center memberships

ESTIMATED COMPLETION DATE: Ongoing

PERSON(S) / DEPARTMENT RESPONSIBLE: Baptist Health Fitness Center

IDENTIFIED COMMUNITY HEALTH NEED: Obesity

GOALS / OBJECTIVES: To encourage a physically active lifestyle.

STRATEGY #2: To provide physical activity sessions and encourage increased physical activity in a community-based program.

ACTION STEPS:

1. Partner with Baptist Health Community Outreach's Sister-to-Sister: Move More, Eat Better program to increase physical activity levels of program members.
2. Offer at least 2 physical activity and physical activity education classes for the Sister-to-Sister program.
3. Offer an annual fitness center membership for the overall program winner.
4. Develop a fitness program for the overall winner.
5. Monitor the overall winner's participation and progress towards goals set.

PERFORMANCE METRICS:

1. Individuals will be administered a pretest and posttest at education classes.
2. Number of Classes presented to the Sister-to-Sister Program.
3. Goals will be set and evaluated for progress and reported.

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:
Baptist Health Community Outreach

RESOURCES HOSPITAL PLANS TO COMMITT TO ADDRESS HEALTH NEED:
Baptist Health Fitness Center membership

ESTIMATED COMPLETION DATE: Ongoing

PERSON(S) / DEPARTMENT RESPONSIBLE: Baptist Health Fitness Center

IDENTIFIED COMMUNITY HEALTH NEED: Smoking Cessation

GOALS / OBJECTIVES: To reduce the number of Baptist Health Rehabilitation Institute patients who continue to smoke following a stroke.

STRATEGY # 1: Educate patients on smoking cessation following a stroke.

ACTION STEPS:

1. Provide smoking cessation information to stroke patients and their caregivers.
2. Offer patients and caregivers the Arkansas Tobacco Quitline's telephone number.
3. Offer patients and caregivers information on a smoking cessation program that meets their needs.
4. Provide patient education on smoking and cessation programs to stroke support group patients.

PERFORMANCE METRICS:

1. A follow-up survey on lifestyle changes will be mailed to the patients six months after discharge.
2. Completed education on smoking and cessation at stroke support groups annually.

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:
Arkansas Department of Health Tobacco Prevention and Cessation Program

RESOURCES HOSPITAL PLANS TO COMMITT TO ADDRESS HEALTH NEED: Baptist Health Print Shop

ESTIMATED COMPLETION DATE: Ongoing

PERSON(S) / DEPARTMENT RESPONSIBLE: Baptist Health Rehabilitation Nursing Department

Community Health Needs Not Being Addressed

Baptist Health Rehabilitation Institute

Baptist Health acknowledges that the implementation strategy adopted does not address all the community health needs identified and that all of the identified needs are important. 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 from the focus groups and data collection was reviewed and prioritized. We do believe the focus areas selected will indirectly have a positive impact on many of the other items identified in the Community Health Needs Assessment. While we can't address every need, Baptist Health plans to share information on appropriate resources for the communities we serve.

Appendix

State Rankings and Additional Guidance

ACHI Assessment — Baptist Health Medical Center–Little Rock

ACHI Assessment — Baptist Health Medical Center–North Little Rock

ACHI Assessment — Baptist Health Medical Center–Heber Springs

ACHI Assessment — Baptist Health Medical Center–Arkadelphia

ACHI Assessment — Baptist Health Medical Center–Stuttgart

ACHI Assessment — Baptist Health Medical Center–Hot Spring County

ACHI Assessment — Baptist Health Medical Center–Conway

Baptist Health 2016 Community Health Needs Assessment: State Rankings and Additional Guidance

AMERICA'S HEALTH RANKINGS

As part of the community health needs assessment (CHNA), this document offers a comparison of the measurements examined in the CHNA to Arkansas's national rankings according to America's Health Rankings. Table 1 displays the health indicator and the state's ranking. The health indicators listed were used in both America's Health Rankings and the Baptist Health CHNA for each hospital. While Arkansas's rankings relative to other states is critical to identify shared priorities, examination of each of the Baptist Health communities shows that each performs differently compared to each other and to the state average. For example, although Arkansas ranks 43rd in Sexually Transmitted Infections at 524 cases of chlamydia per 100,000 population, the range within the Baptist Health communities is between 205 and 984 cases of chlamydia per 100,000. This detailed information is not available when only examining a state average.

Figure 1. Arkansas's Worst Rankings

Figure 1 shows that Arkansas is the 49th most physically inactive state in the nation. This knowledge combined with county-level data in the CHNA about access to exercise opportunities, a predictor of physical activity, can help focus priorities and interventions. All of the Baptist Health communities have lower access to exercise opportunities when compared to the national average. Therefore a potential opportunity for a community benefit or building activity exists. Although America's Health Rankings can guide the search to improve health, the CHNA data offers a more detailed look at the diversity of Baptist Health communities.

Table 1. America's Health Rankings and CHNA Measures

Health Indicator*	Rank
Dentists	50
Adult Obesity	50
Teen Birth Rate	50
Physical Inactivity	49
Children in Poverty	48
Heart Disease	48
Smoking	48
Cardiovascular Deaths	47
Infant Mortality	47
Poor Physical Health Days	47
Cancer Deaths	46
Diabetes	46
High Cholesterol	46
Poor Mental Health Days	46
Preventable Hospitalizations	46
Premature Death	45
High Blood Pressure	44
Median Household Income	44
Chlamydia (Sexually Transmitted Infections)	43
Violent Crime	41
Low Birth Weight	40
Primary Care Physicians	39
Air Pollution	37
Lack of Health Insurance	35
Unemployment Rate, Annual	26
High School Graduation in 4 years	20
Binge Drinking	8

*Actual data and data source may differ with county-level data elsewhere in CHNA due to data availability

IDENTIFYING CAUSES AND ADDITIONAL DATA SOURCES

As priority needs are identified for Baptist Health communities, it is important to understand the underlying drivers of these needs to appropriately examine additional data. Recognizing root causes can aid in identifying reasons a problem or issue exists. The "*But Why?*" strategy is commonly used to identify potential origins of an issue.[1] Beginning with the health issue or indicator, continue to ask "*But Why?*" until the root cause is reached. This technique can be used to discover individual factors or broader social determinants including cultural, economic, or political factors. This may be done as an organization or at the community level by involving key stakeholders and individuals living in the community who experience factors associated with poor health. Figure 2 provides a template to utilize the "*But Why?*" technique.

Figure 2. *But Why?* Template

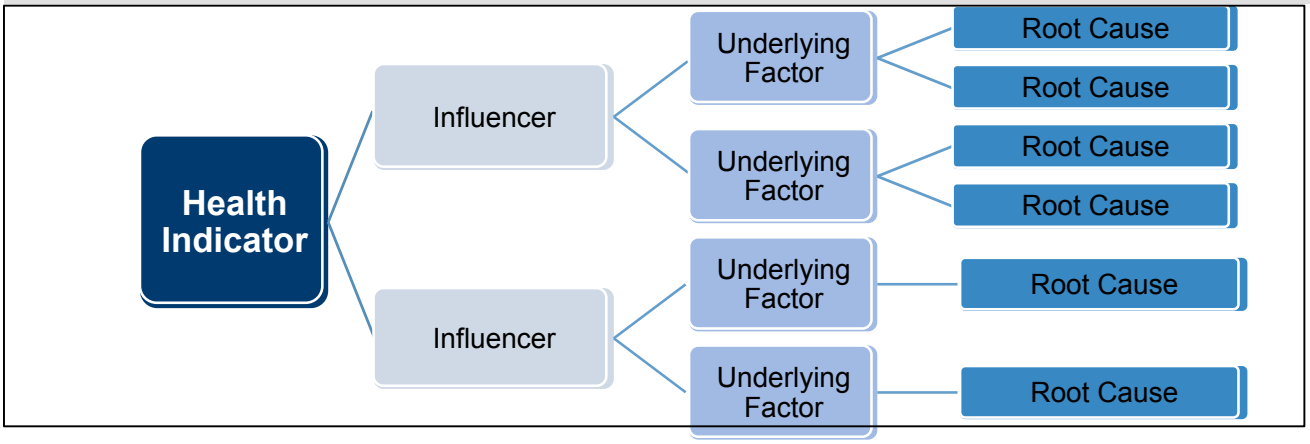
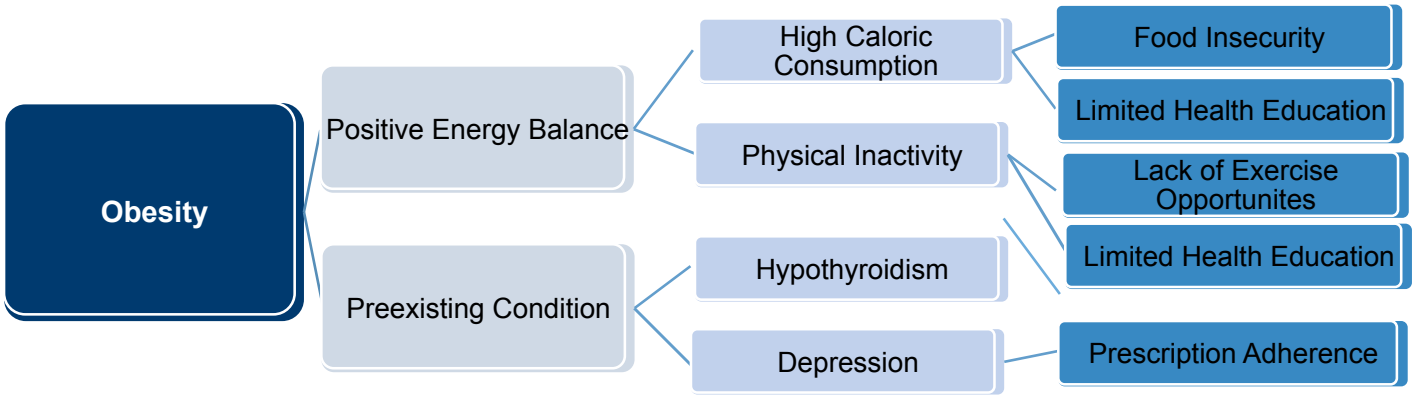


Figure 3 provides a non-exhaustive example when looking at adult obesity in asking the "*But Why*" question for each layer.

Figure 3. *But Why?* Example - Obesity



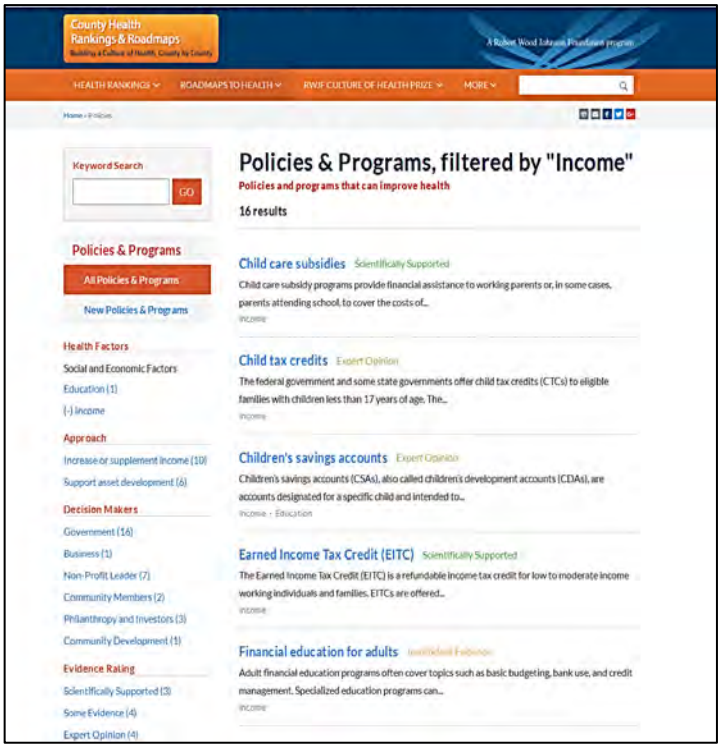
Once the underlying factors are identified, further analysis may be necessary (see Appendix 1). Using Food Insecurity from Figure 3 an example, the factor could be examined in more detail by determining how many grocery

[1] For additional information visit: http://ctb.ku.edu/en/table-of-contents/analyze/analyze-community-problems-and-solutions/root-causes/main

stores there are in an area or gathering information about the number of farmers' markets accepting SNAP benefits in the community.

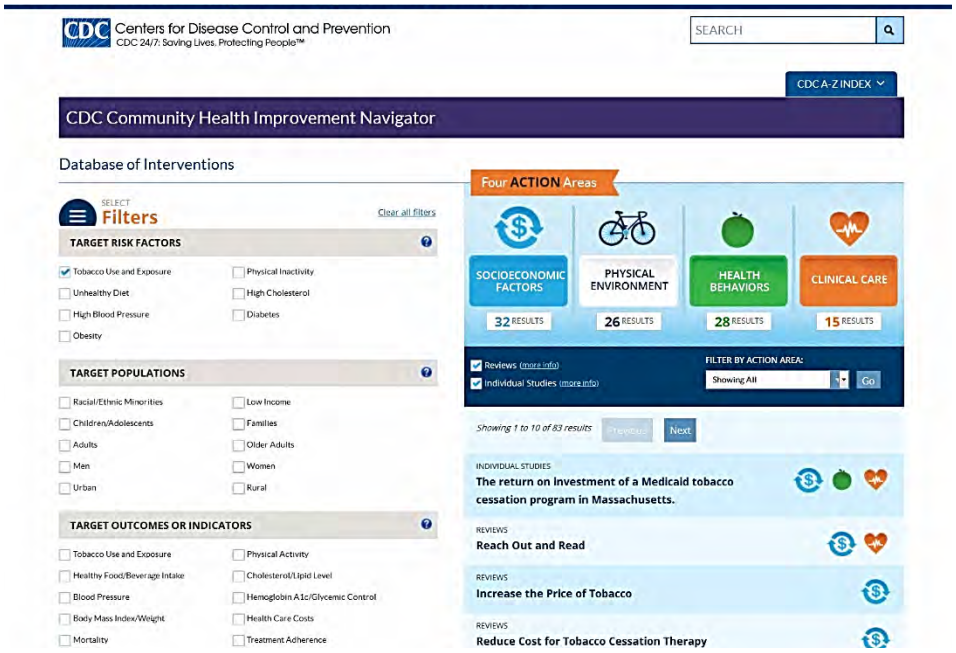
SELECTING INTERVENTIONS

Once Baptist Health is ready to review potential programs for the identified priority needs, there are several resources available to research effective, long-term interventions. One resource is through the County Health Rankings policies and programs page. The website is set up for users to pick the type of health indicator and then provides results of interventions and how the intervention is supported (expert opinion, individual experience/case study, or scientific study). Access the available policies and programs here:



http://www.countyhealthrankings.org/policies.

A second resource, the CDC's Community Health Improvement Navigator, provides similar information as County Health Rankings. All interventions are categorized into four action areas: socioeconomic factors, physical environment, health behaviors, and clinical care. Access the navigator here: http://wwwn.cdc.gov/chidatabase.



Finally, the Healthy Active Arkansas plan provides a framework of evidence-based approaches to guide community-based efforts with a focus on reducing obesity. The framework's priority areas include the physical and built environment, nutritional standards, physical education and activity in schools, healthy worksites, access to healthy foods, sugar-sweetened beverage reduction, breastfeeding, and marketing programs. Each priority area includes supporting evidence along with strategy and action steps. Access the plan here: http://www.healthyactive.org/

ADDITIONAL RESOURCES

- Community Tool Box, a free online resource to promote community health and development: http://ctb.ku.edu/en/table-of-contents
- Guide to prioritization techniques: http://archived.naccho.org/topics/infrastructure/accreditation/upload/Prioritization-Summaries-and-Examples-2.pdf
- Information on how to plan community benefit activities: https://www.chausa.org/communitybenefit/what-counts
- Recommendations for CHNA IRS requirements: http://www.astho.org/Programs/Access/Community-Health-Needs-Assessments/
- Guide to how states use America's Health Rankings to promote change: http://www.astho.org/americashealthrankings/state-snapshots/
- Portal with access webinars for effectively using the CHNA, lists of initiatives and potential partnerships, and tools to map health indicators and outcomes: http://www.communitycommons.org/

ACHI
Arkansas Center for Health Improvement

Produced for Baptist Health by the Arkansas Center for Health Improvement

APPENDIX 1

Using America's Health Rankings, ACHI is providing a list of additional data sources for the health indicators that Arkansas ranks 48 and below in table 2.

Table 2. Additional Measurements			
Health Indicator	**Additional Measurement[2]**	**Data Source**	**Year(s)**
Dentists	Adults Age 18+ Without Dental Exam in Past 12 Months	BRFSS	2006-2010
Adult Obesity	Food Consumption	USDA Food Environment Atlas	2006
	Low Income Population Living Near a Farmer's Market	USDA Agricultural Marketing Service	2016
Teen Birth Rate	Birth Data[3]	Arkansas Department of Health	2015
	Arkansas Department of Health	National Vital Statistics System	2007-2010
	Arkansas Prevention Needs Assessment Student Survey	DHS Division of Behavioral Health Services	2014
Physical Inactivity	Population with Park Access (within ½ mile)	National Environmental Public Health Tracking Network	2010
Children in Poverty	Students Eligible for Reduced Price or Free Lunch	National Center for Education Statistics	2009-2010
	Youths Not Enrolled in School	American Community Survey	2010-2014
	Children Age 2-4 Obese, Low-Income	Pediatric Nutrition Surveillance System	2009-2011
	Access to Child Day Care Services	County Business Patters	2013
Heart Disease	Medicare Beneficiaries with Heart Attack, CHF, or Ischemic Heart Disease	Center for Medicare and Medicaid Services	2012
	Annual Visit to Primary Care Physician	Dartmouth Atlas of Health Care	2012
	Access to Pharmacies and Drug Stores	County Business Patterns	2013
Adult Smoking	Cigarette Expenditures	Nielsen	2014

[2] With the exception of Birth Data, all measurements are accessible at: http://www.communitycommons.org/maps-data/
[3] Accessible at: http://www.healthy.arkansas.gov/programsServices/healthStatistics/Pages/CurrentBirthData.aspx

Baptist Health 2016 Community Health Needs Assessment: LITTLE ROCK

Quantitative results from the 2016 Baptist Health Community Health Needs Assessment for the Little Rock hospital are reported below. There are ten sections including: Demographics, Health Outcomes, Cause of Death, Chronic Conditions, Health Behaviors, Prevention, Access, Social and Economic, Environment, and Community Prevalence of Diagnoses. Each section includes a table with health indicator data for each county in the hospital community, community averages (mean of all hospital counties), and averages for the State of Arkansas and the United States. If data were not available, a "NA" is displayed. Each section also includes graphics for various health indicator data. For more detailed information on methods and resources used, please reference the Methods section and Appendix 1.

DEMOGRAPHICS

Sex and Age

	Grant County	Pulaski County	Saline County	State	Nation
Total Population	18,014	388,752	111,811	2,947,036	314,107,084
Percent Male	49.0%	48.0%	49.2%	49.1%	49.2%
Percent Female	51.0%	52.0%	50.8%	50.9%	50.8%
Age: 0 to 14	19.3%	20.1%	19.9%	20.1%	19.5%
Age: 15 to 19	6.8%	6.0%	6.1%	6.8%	6.8%
Age: under 18	23.8%	23.9%	24.0%	24.1%	23.5%
Age: 20 to 24	5.9%	7.0%	5.3%	7.0%	7.1%
Age: 25 to 34	12.2%	15.2%	13.0%	13.0%	13.5%
Age: 35 to 44	13.0%	12.9%	13.9%	12.5%	13.0%
Age: 45 to 54	15.0%	13.5%	13.5%	13.4%	14.1%
Age: 55 to 64	12.7%	12.6%	12.2%	12.3%	12.3%
Age: 65 and older	15.1%	12.7%	16.1%	15.0%	13.7%

Ethnicity

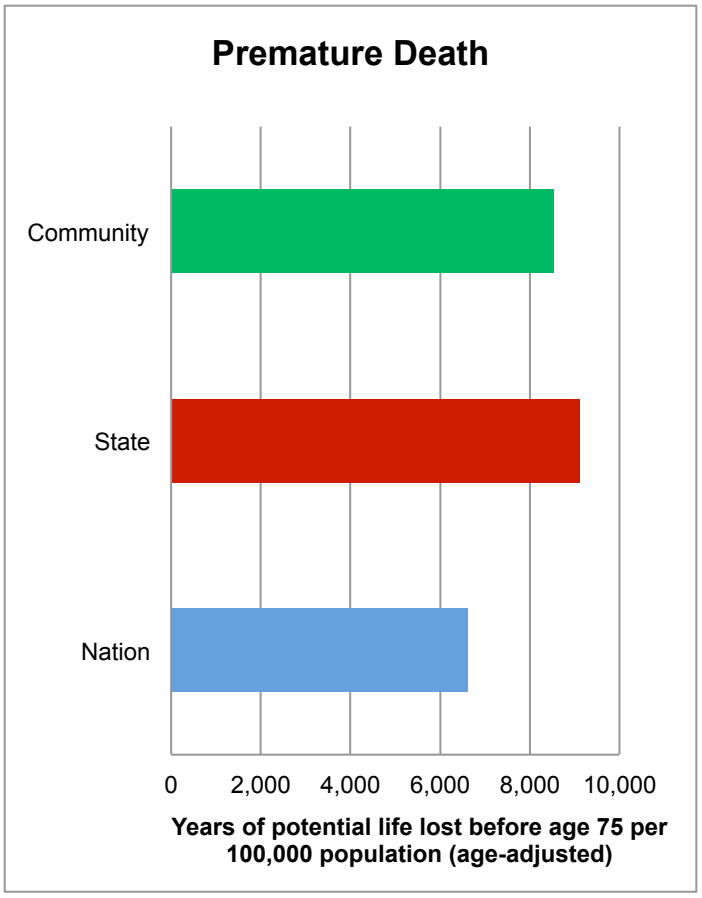
		Grant County	Pulaski County	Saline County	State	Nation
Total Population		18,014	388,752	111,811	2,947,036	314,107,084
Hispanic		2.4%	5.9%	4.0%	6.7%	16.9%
Non-Hispanic	White	93.4%	54.6%	87.8%	73.9%	62.8%
	Black or African American	2.5%	35.3%	5.4%	15.5%	12.2%
	American Indian and Alaska Native	0.4%	0.3%	0.4%	0.6%	0.7%
	Asian	0.3%	2.1%	0.8%	1.3%	4.9%
	Pacific Islander	0.0%	0.0%	0.0%	0.2%	0.2%
	Other	0.0%	0.1%	0.0%	0.1%	0.2%
	Multiracial	0.8%	1.7%	1.6%	1.8%	2.1%

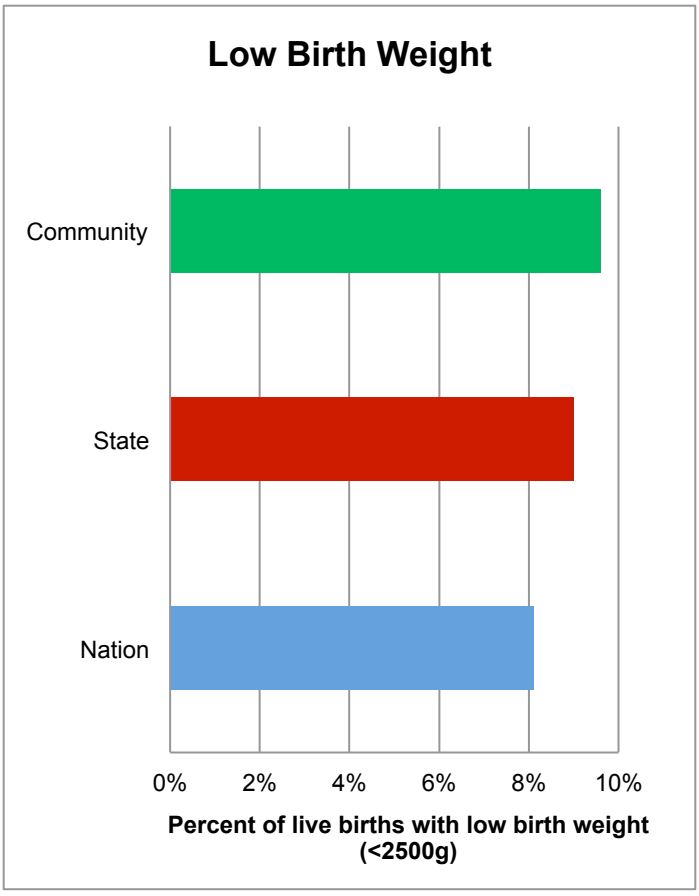
Insurance Coverage

	Grant County	Pulaski County	Saline County	State	Nation
Health Insurance Coverage	87.7%	85.2%	88.0%	84.2%	85.8%
Private Health Insurance Coverage	67.1%	63.4%	69.4%	59.1%	65.8%
Public Health Insurance Coverage	34.7%	32.8%	32.9%	37.2%	31.1%

HEALTH OUTCOMES

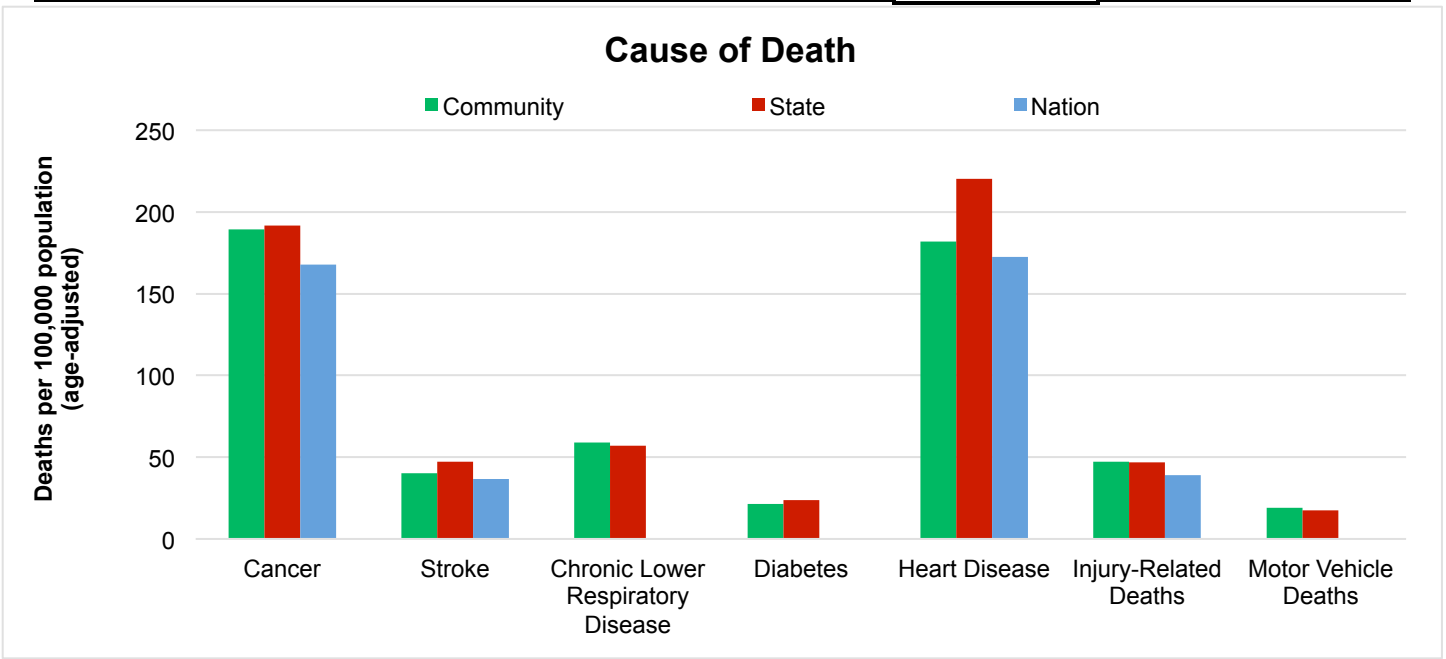
Measurement	Grant County	Pulaski County	Saline County	Community Average	State Average	National Average
Premature Death Years of potential life lost before age 75 per 100,000 population (age-adjusted)	8,661	9,288	7,644	8,531	9,099	6,600
Poor or Fair Health Status Percent of adults reporting fair or poor health (age-adjusted)	18.0%	18.0%	15.0%	17.0%	21.0%	14.0%
Poor Physical Health Days Average number of physically unhealthy days reported in past 30 days (age adjusted)	4.2	3.9	3.9	4.0	4.6	3.5
Poor Mental Health Days Average number of mentally unhealthy days reported in past 30 days (age-adjusted)	4.0	3.8	3.6	3.8	4.2	3.5
Low Birth Weight Percent of live births with low birth weight (<2500g)	10.1%	10.5%	8.3%	9.6%	9.0%	8.1%





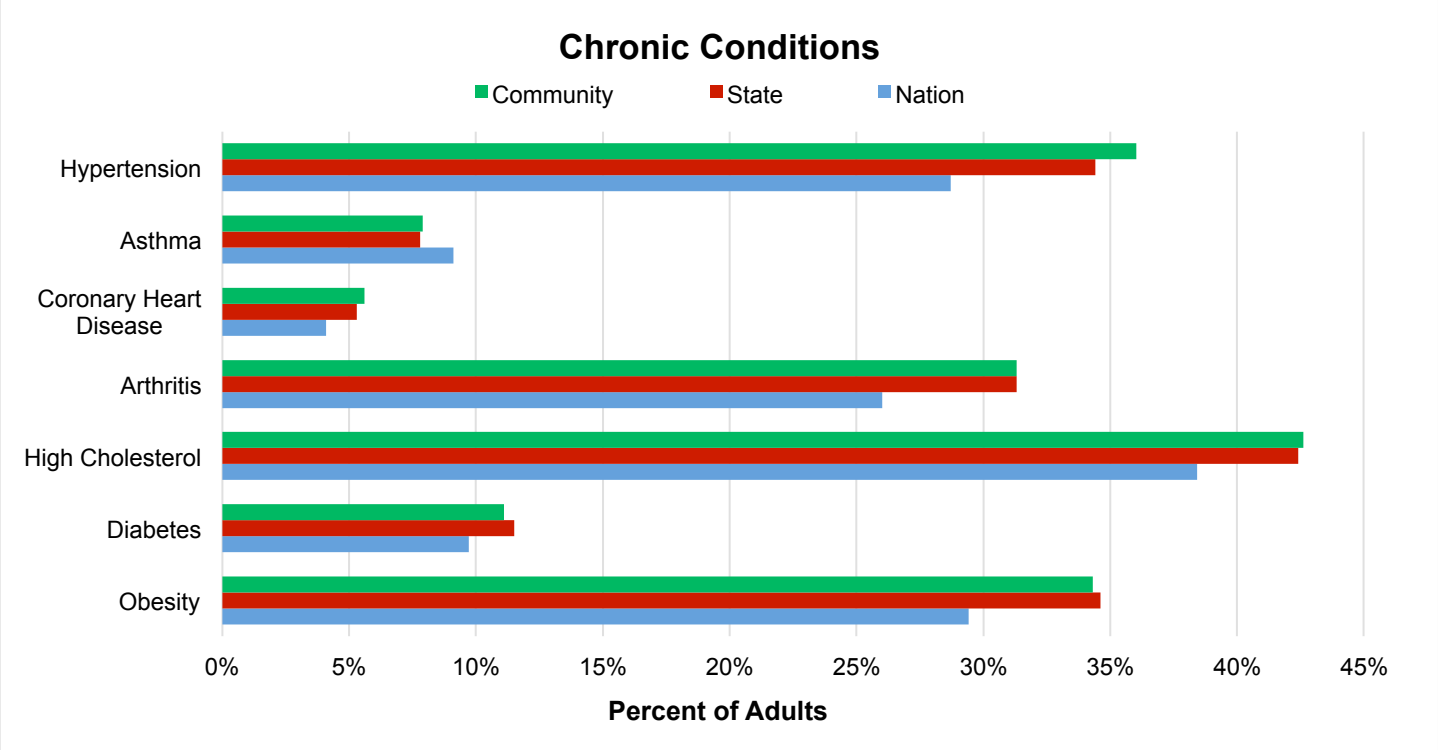
CAUSE OF DEATH

Measurement	Grant County	Pulaski County	Saline County	Community Average	State Average	National Average
All-Cause Mortality All Causes per 100,000 (age-adjusted)	905.80	866.00	794.80	855.53	891.60	729.60
Infant Mortality Rate of all infant deaths (within 1 year), per 1,000 live births	5.03	7.65	7.98	6.89	6.69	6.00
Cancer Neoplasms per 100,000 population (age-adjusted)	214.50	178.60	174.80	189.30	191.90	167.90
Stroke Cerebrovascular diseases per 100,000 population (age-adjusted)	38.20	46.80	35.50	40.17	47.40	36.50
Chronic Lower Respiratory Disease Chronic lower respiratory diseases per 100,000 population (age-adjusted)	81.63	42.99	51.88	58.83	57.05	NA
Diabetes Diabetes mellitus per 100,000 population (age-adjusted)	23.08	17.14	24.44	21.55	23.58	NA
Heart Disease Essential (primary) hypertension, hypertensive heart disease with (congestive) heart failure per 100,000 population (age-adjusted)	182.10	195.90	167.80	181.93	220.20	172.4
Injury-Related Accidents (unintentional injuries) per 100,000 population (age-adjusted)	55.90	43.80	41.70	47.13	46.90	39.10
Motor Vehicle Motor Vehicle Accidents per 100,000 population (age-adjusted)	26.95	14.79	16.01	19.25	17.40	NA
Alcohol Impaired Driving Percent of driving deaths with alcohol involved	15%	36%	26%	26%	30%	31%



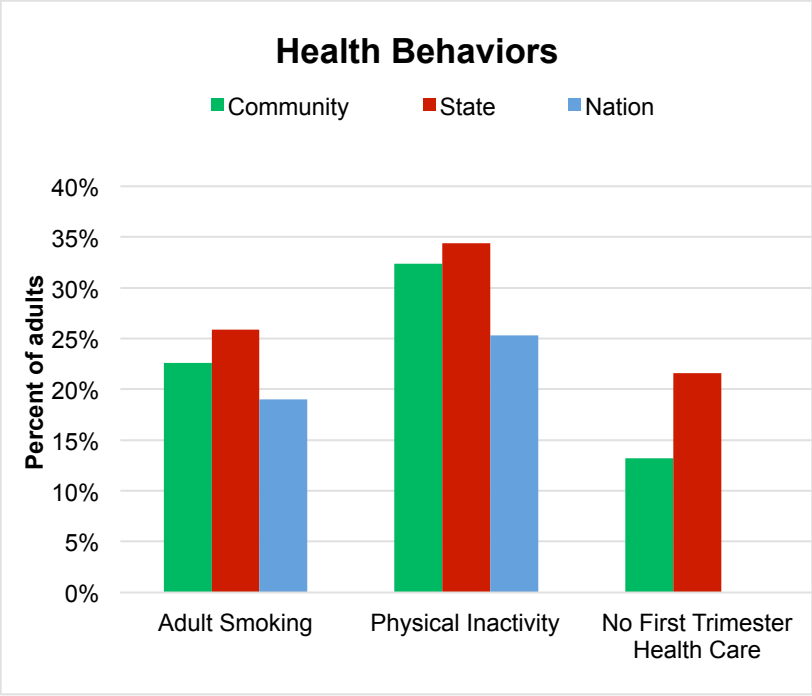
CHRONIC CONDITIONS

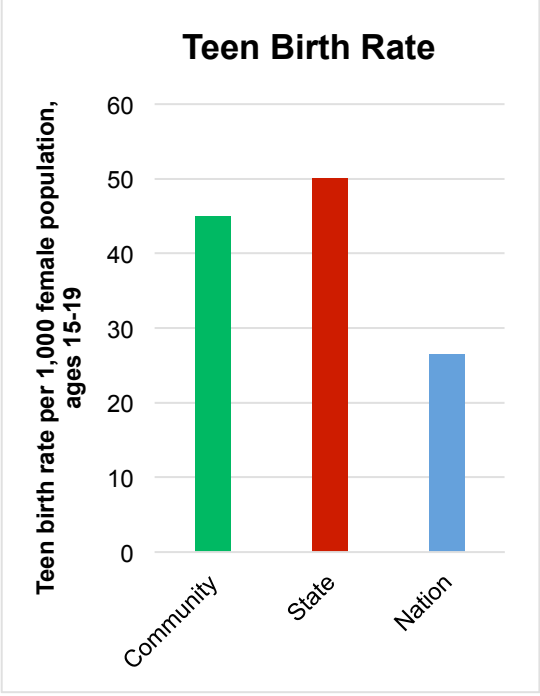
Measurement	Grant County	Pulaski County	Saline County	Community Average	State Average	National Average
Hypertension Percent of adults who have been told they have high blood pressure	36.9%	34.6%	36.6%	36.0%	34.4%	28.7%
Asthma Percent of adults who have been told they currently have asthma	8.0%	8.2%	7.5%	7.9%	7.8%	9.1%
Coronary Heart Disease Percent of adults who have been told they have angina or coronary heart disease	5.5%	5.1%	6.1%	5.6%	5.3%	4.1%
Arthritis Percent of adults who have been told they have arthritis	32.2%	28.8%	32.9%	31.3%	31.3%	26.0%
High Cholesterol Percent of adults who have had their blood cholesterol checked and have been told it was high	42.5%	40.7%	44.7%	42.6%	42.4%	38.4%
Diabetes Percent of adults reporting diabetes	11.3%	10.7%	11.2%	11.1%	11.5%	9.7%
Adult Obesity Percent of adults who report a BMI higher than 30	35.7%	32.7%	34.4%	34.3%	34.6%	29.4%
Childhood Obesity Percent of children who have a measured BMI for age greater than or equal to 95th percentile	22.0%	21.1%	19.4%	20.8%	23.3%	NA



HEALTH BEHAVIORS

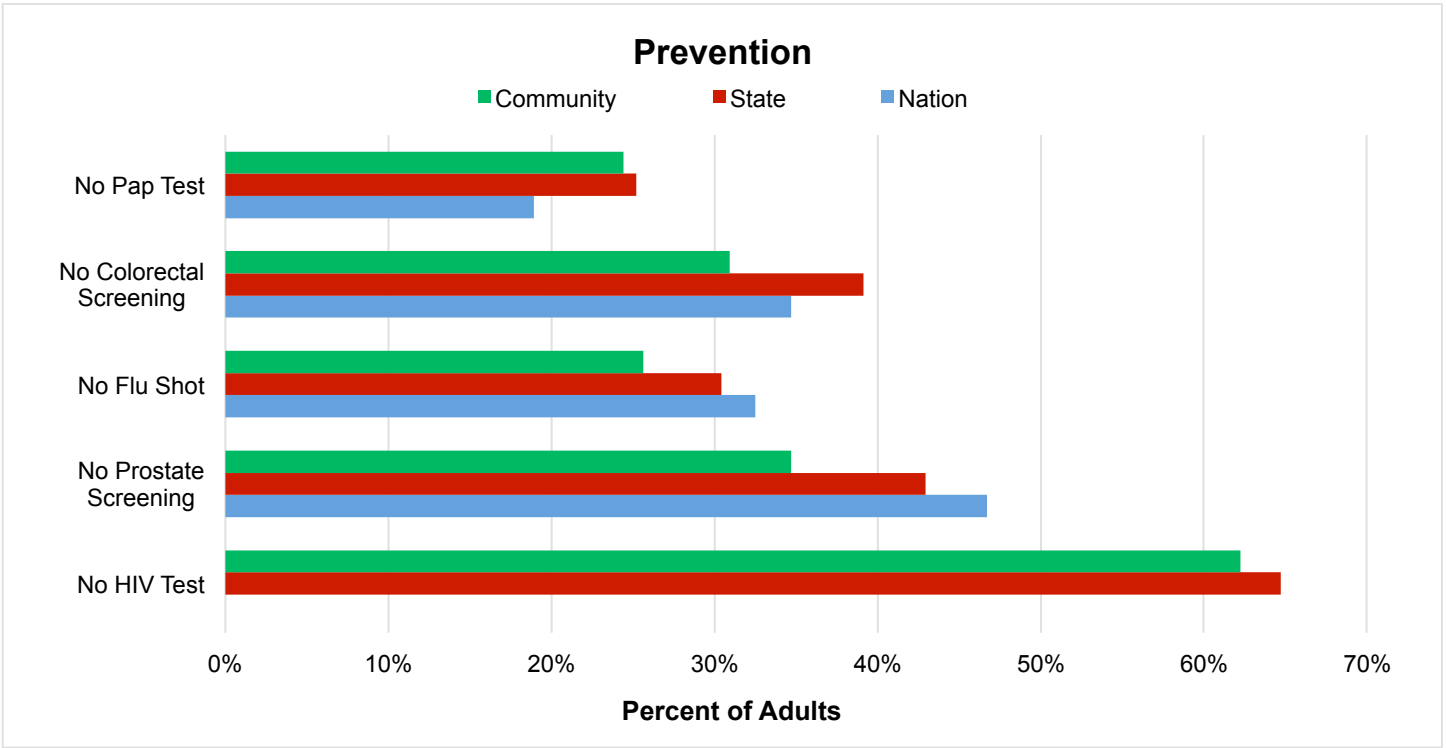
Measurement	Grant County	Pulaski County	Saline County	Community Average	State Average	National Average
Adult Smoking Percent of adults who are current smokers	22.6%	21.4%	23.8%	22.6%	25.9%	19.0%
Excessive Drinking Percent of adults reporting binge or heavy drinking	16.0%	16.0%	16.0%	16.0%	15.0%	18.0%
Sexually Transmitted Infections Number of newly diagnosed chlamydia cases per 100,000 population	206	771	244	407	524	447
Fruit & Vegetable Consumption Percent of adults reporting not consuming recommended five servings of fruit and vegetables	86.7%	86.0%	86.8%	86.5%	NA	NA
Physical Inactivity Percent of adults reporting no physical activity in the past month	32.6%	31.1%	33.6%	32.4%	34.4%	25.3%
Teen Birth Rate Teen birth rate per 1,000 female population, ages 15-19	49.8	50.3	34.6	44.9	50.1	26.5
No First Trimester Health Care Percent of pregnant women who received no first trimester health care	14.8%	11.1%	13.6%	13.2%	21.6%	NA





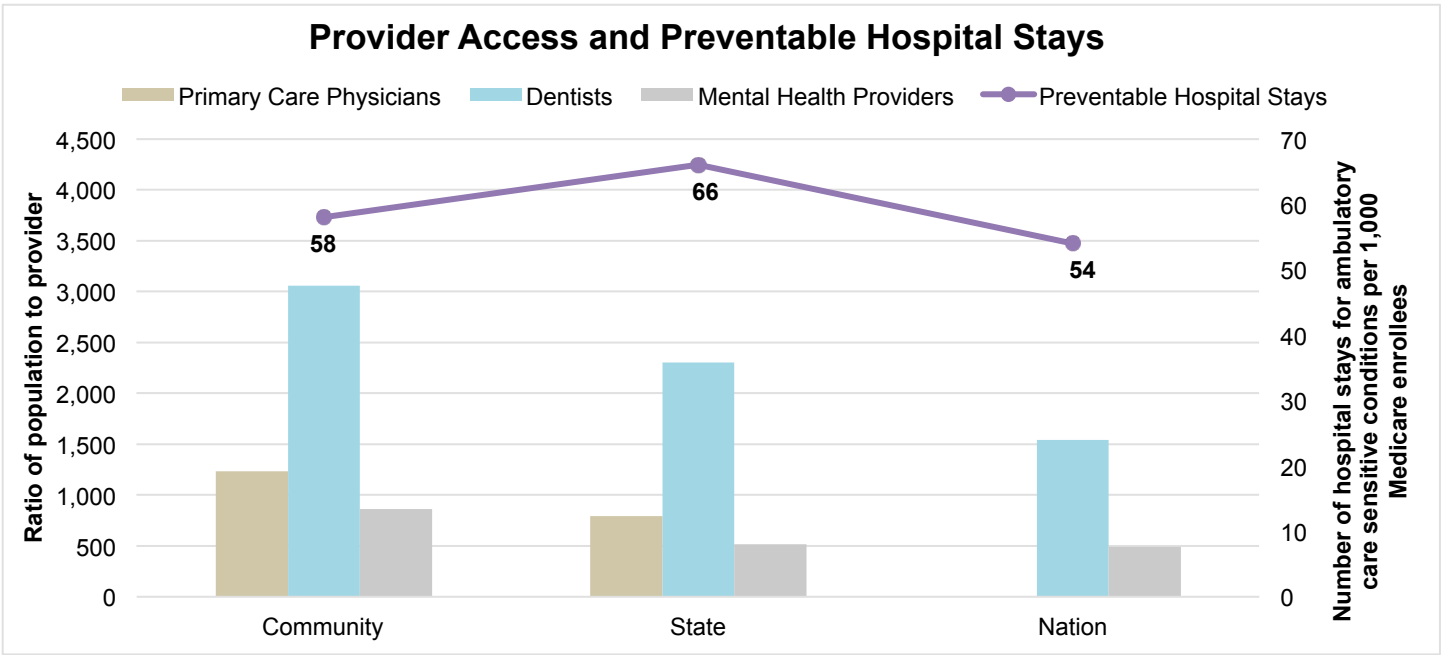
PREVENTION

Measurement	Grant County	Pulaski County	Saline County	Community Average	State Average	National Average
No Pap Test Percent of women aged 18+ who have not had a pap test within the past 3 years	25.6%	24.0%	23.5%	24.4%	25.2%	18.9%
No Colorectal Screening Percent of adults age 50+ who have never had either a sigmoidoscopy or colonoscopy	30.8%	31.6%	30.3%	30.9%	39.1%	34.7%
No Flu Shot Percent of adults aged 65+ who have not had a flu shot in the past year	24.8%	27.4%	24.5%	25.6%	30.4%	32.5%
No Prostate Screening Percent of men aged 40+ who have not had a PSA test within the past two years	34.6%	33.1%	36.3%	34.7%	42.9%	46.7%
No HIV Test Percent of adults who have never been tested for HIV	62.1%	61.3%	63.1%	62.2%	64.7%	NA



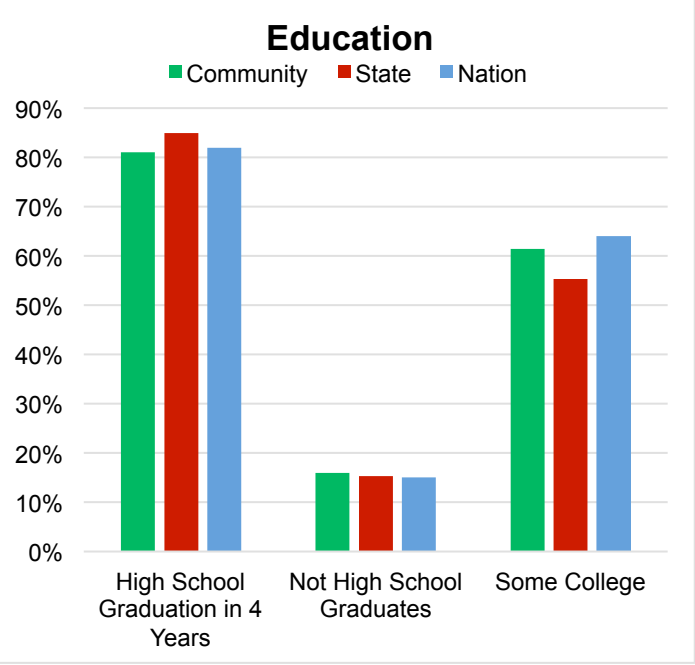
ACCESS

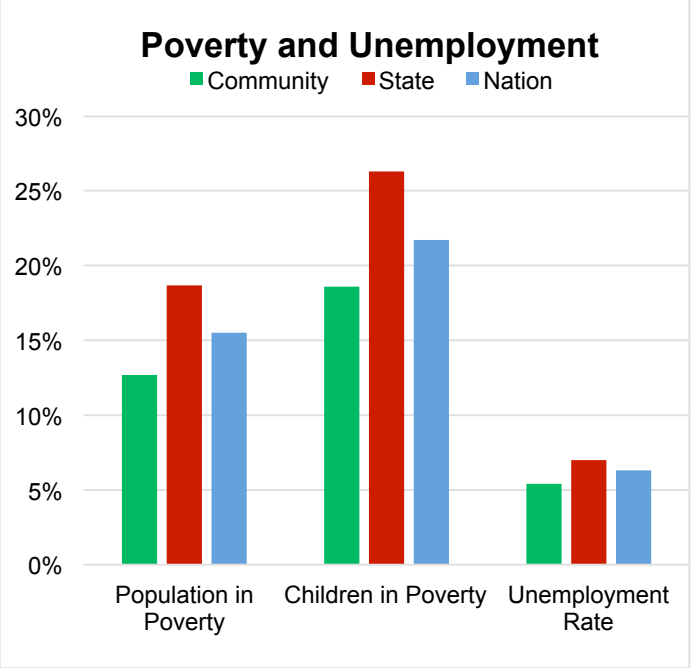
Measurement	Grant County	Pulaski County	Saline County	Community Average	State Average	National Average
Uninsured Percent of non-institutionalized population uninsured	12.3%	14.8%	12.0%	13.0%	15.8%	14.2%
Primary Care Physicians Ratio of population to primary care physicians (ratio to 1)	3,002	320	374	1,232	792	NA
Dentists Ratio of population to dentists (ratio to 1)	3,629	1,403	4,133	3,055	2,303	1,540
Mental Health Providers Ratio of population to mental health providers (ratio to 1)	1,512	275	809	865	517	490
Preventable Hospital Stays Number of hospital stays for ambulatory care sensitive conditions per 1,000 Medicare enrollees	65	56	53	58	66	54
Mammography Percent of female Medicare enrollees ages 67-69 who receive mammography screening	51.0%	62.0%	64.0%	59.0%	58.0%	63.0%
Diabetic Monitoring Percent of diabetic Medicare enrollees ages 65-75 who receive HbA1c monitoring	86.0%	84.0%	84.0%	84.7%	83.0%	85.0%



SOCIAL AND ECONOMIC

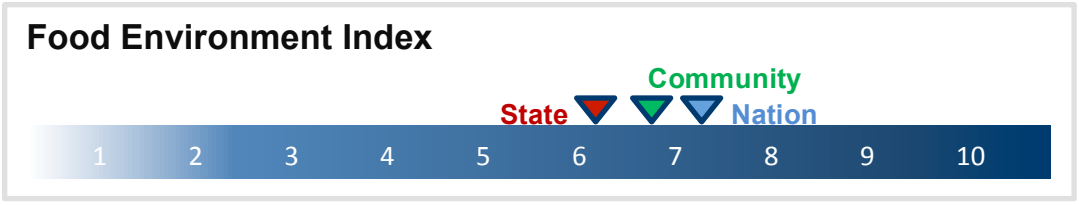
Measurement	Grant County	Pulaski County	Saline County	Community Average	State Average	National Average
Not High School Graduates Percent age 18 to 24 years without a high school diploma	13.2%	13.7%	20.7%	15.9%	15.3%	15.0%
High School Graduation in 4 years Percent of ninth-grade cohort that graduates in four years	86.0%	72.0%	85.0%	81.0%	85.0%	82.0%
Some College Percent of adults ages 25-44 with some post-secondary education	56.0%	66.3%	62.3%	61.5%	55.3%	64.0%
Unemployment Rate Number of unemployed people as a percent of the labor force	5.6%	5.6%	4.9%	5.4%	7.00%	6.3%
Median Household Income	$46,067	$45,698	$55,915	$49,227	$41,335	$53,657
Children in Poverty Percent of children under age 18 below the federal poverty line	18.7%	23.8%	13.4%	18.6%	26.3%	21.7%
Population in Poverty Percent of population below the federal poverty line	13.3%	16.1%	8.7%	12.7%	18.7%	15.5%
Income Inequality Ratio of household income at the 80th percentile to income at 20th percentile	3.9	4.9	3.7	4.2	4.8	4.7
Children in Single-Parent Households Percent of children who live in a household headed by a single parent	27%	44%	30%	34%	37%	34%
Social Associations Number of membership associations per 10,000 population	12.8	16.2	8.1	12.4	12.0	9.0
Violent Crime Number of reported crime offenses per 100,000 population	221	1068	253	514	484	392

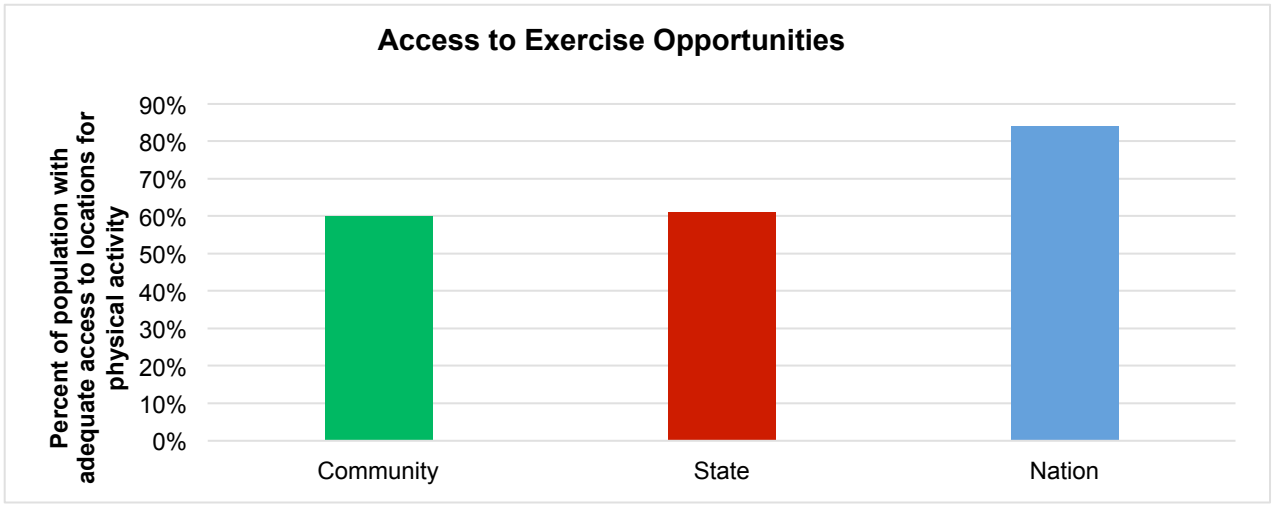




ENVIRONMENT

Measurement	Grant County	Pulaski County	Saline County	Community Average	State Average	National Average
Food Environment Index Index of factors that contribute to a healthy food environment, 0 (worst) to 10 (best)	7.4	5.5	7.3	6.7	6.1	7.2
Access to Exercise Opportunities Percent of population with adequate access to locations for physical activity	21%	84%	74%	60%	61%	84%
Air Pollution Average daily density of fine particulate matter in micrograms per cubic meter (PM2.5)	11.9	11.9	11.8	11.9	11.8	11.1
Drinking Water Violations Percent of population potentially exposed to water exceeding a violation limit during the last year	0%	7%	1%	3%	9%	7%
Severe Housing Problems Percent of households with at least 1 of 4 housing problems: overcrowding, high housing costs, or lack of kitchen or plumbing	10%	16%	11%	12%	15%	19%
Driving Alone to Work Percent of the workforce who drive alone to work	83%	85%	86%	85%	82%	76%
Long Commute - Driving Alone Among workers who commute in their car alone, the percent who commute more than 30 minutes	51%	19%	43%	38%	26%	31%

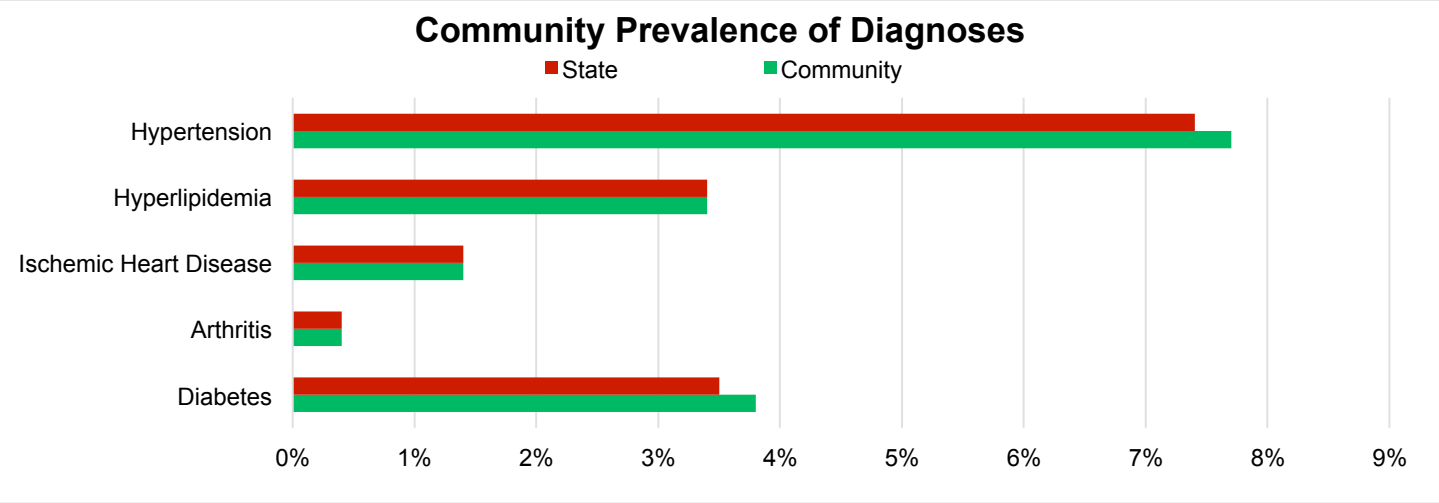




COMMUNITY PREVALENCE OF DIAGNOSES

Measurement*	Grant County	Pulaski County	Saline County	Community Average	State Average
Hypertension	8.0%	7.9%	7.4%	7.7%	7.4%
Hyperlipidemia	3.7%	3.1%	3.3%	3.4%	3.4%
Ischemic Heart Disease	1.6%	1.3%	1.4%	1.4%	1.4%
Arthritis	0.5%	0.4%	0.4%	0.4%	0.4%
Diabetes	4.3%	3.5%	3.5%	3.8%	3.5%

*Number of individuals discharged for a primary or secondary diagnoses as a percent of the population (18 years and older)



Produced on behalf of Baptist Health by the Arkansas Center for Health Improvement.

Baptist Health 2016 Community Health Needs Assessment: NORTH LITTLE ROCK

Quantitative results from the 2016 Baptist Health Community Health Needs Assessment for the North Little Rock hospital are reported below. There are ten sections including: Demographics, Health Outcomes, Cause of Death, Chronic Conditions, Health Behaviors, Prevention, Access, Social and Economic, Environment, and Community Prevalence of Diagnoses. Each section includes a table with health indicator data for each county in the hospital community, community averages (mean of all hospital counties), and averages for the State of Arkansas and the United States. If data were not available, a "NA" is displayed. Each section also includes graphics for various health indicator data. For more detailed information on methods and resources used, please reference the Methods section and Appendix 1.

DEMOGRAPHICS

Sex and Age

	Lonoke County	Pulaski County	State	Nation
Total Population	70,118	388,752	2,947,036	314,107,084
Percent Male	49.2%	48.0%	49.1%	49.2%
Percent Female	50.8%	52.0%	50.9%	50.8%
Age: 0 to 14	22.4%	20.1%	20.1%	19.5%
Age: 15 to 19	7.0%	6.0%	6.8%	6.8%
Age: under 18	27.0%	23.9%	24.1%	23.5%
Age: 20 to 24	5.9%	7.0%	7.0%	7.1%
Age: 25 to 34	14.1%	15.2%	13.0%	13.5%
Age: 35 to 44	14.2%	12.9%	12.5%	13.0%
Age: 45 to 54	13.6%	13.5%	13.4%	14.1%
Age: 55 to 64	10.8%	12.6%	12.3%	12.3%
Age: 65 and older	11.9%	12.7%	15.0%	13.7%

Ethnicity

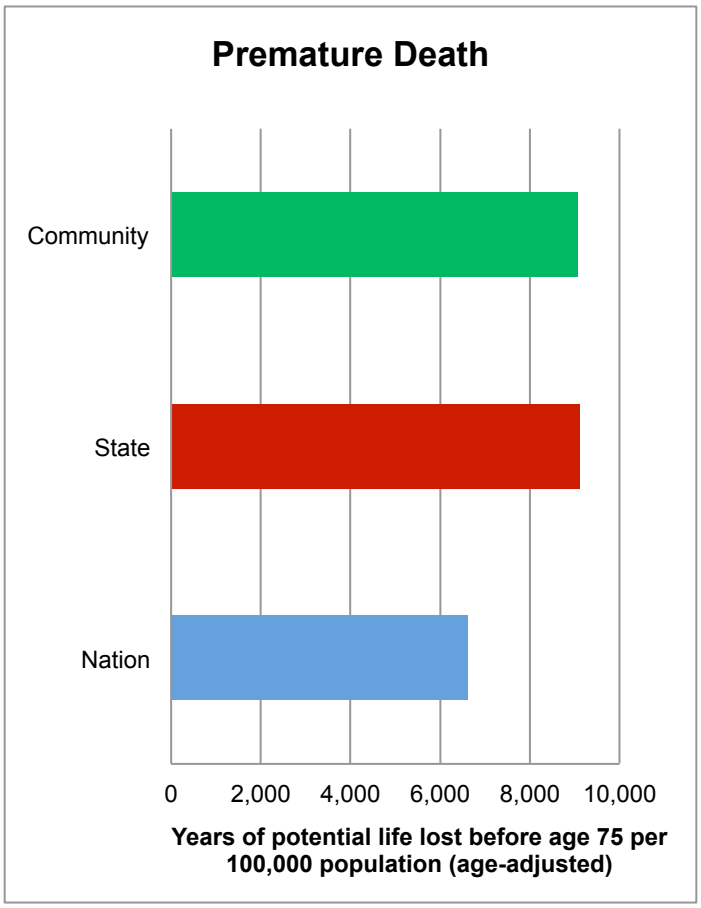
		Lonoke County	Pulaski County	State	Nation
Total Population		70,118	388,752	2,947,036	314,107,084
Hispanic		3.7%	5.9%	6.7%	16.9%
Non-Hispanic	White	87.3%	54.6%	73.9%	62.8%
	Black or African American	6.2%	35.3%	15.5%	12.2%
	American Indian and Alaska Native	0.4%	0.3%	0.6%	0.7%
	Asian	0.6%	2.1%	1.3%	4.9%
	Pacific Islander	0.0%	0.0%	0.2%	0.2%
	Other	0.1%	0.1%	0.1%	0.2%
	Multiracial	1.7%	1.7%	1.8%	2.1%

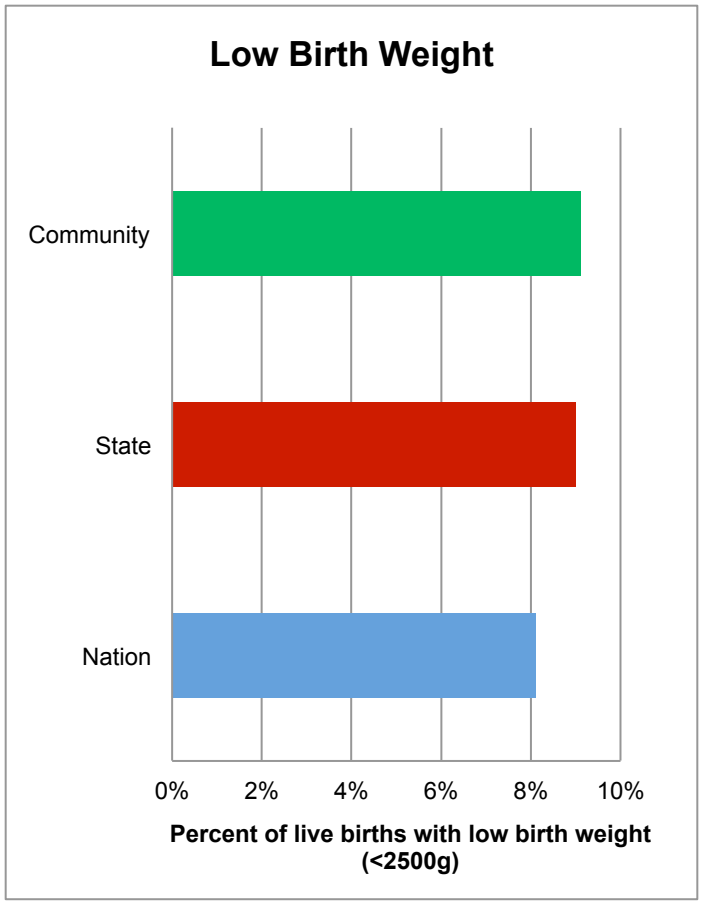
Insurance Coverage

	Lonoke County	Pulaski County	State	National
Health Insurance Coverage	87.3%	85.2%	84.2%	85.8%
Private Health Insurance Coverage	69.0%	63.4%	59.1%	65.8%
Public Health Insurance Coverage	31.4%	32.8%	37.2%	31.1%

HEALTH OUTCOMES

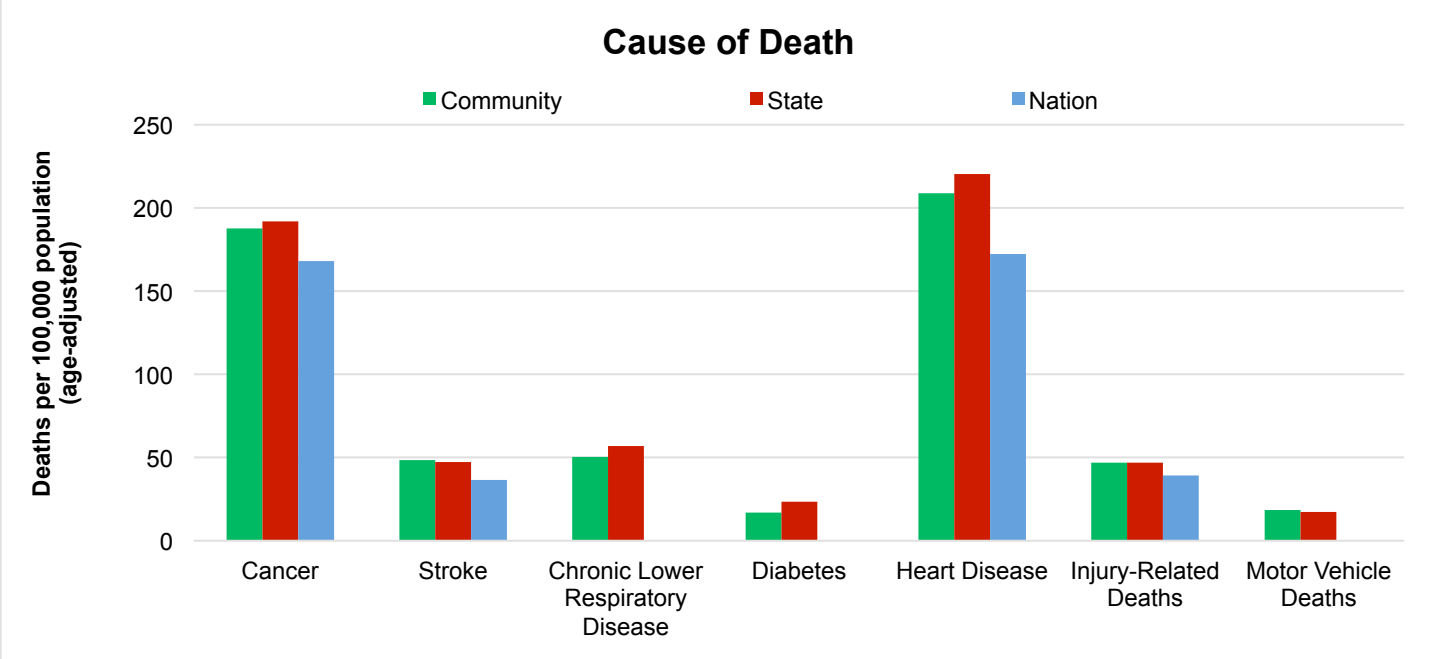
Measurement	Lonoke County	Pulaski County	Community Average	State Average	National Average
Premature Death Years of potential life lost before age 75 per 100,000 population (age-adjusted)	8,838	9,288	9,063	9,099	6,600
Poor or Fair Health Status Percent of adults reporting fair or poor health (age-adjusted)	18.0%	18.0%	18.0%	21.0%	14.0%
Poor Physical Health Days Average number of physically unhealthy days reported in past 30 days (age adjusted)	4.1	3.9	4.0	4.6	3.5
Poor Mental Health Days Average number of mentally unhealthy days reported in past 30 days (age-adjusted)	3.9	3.8	3.9	4.2	3.5
Low Birth Weight Percent of live births with low birth weight (<2500g)	7.6%	10.5%	9.1%	9.0%	8.1%





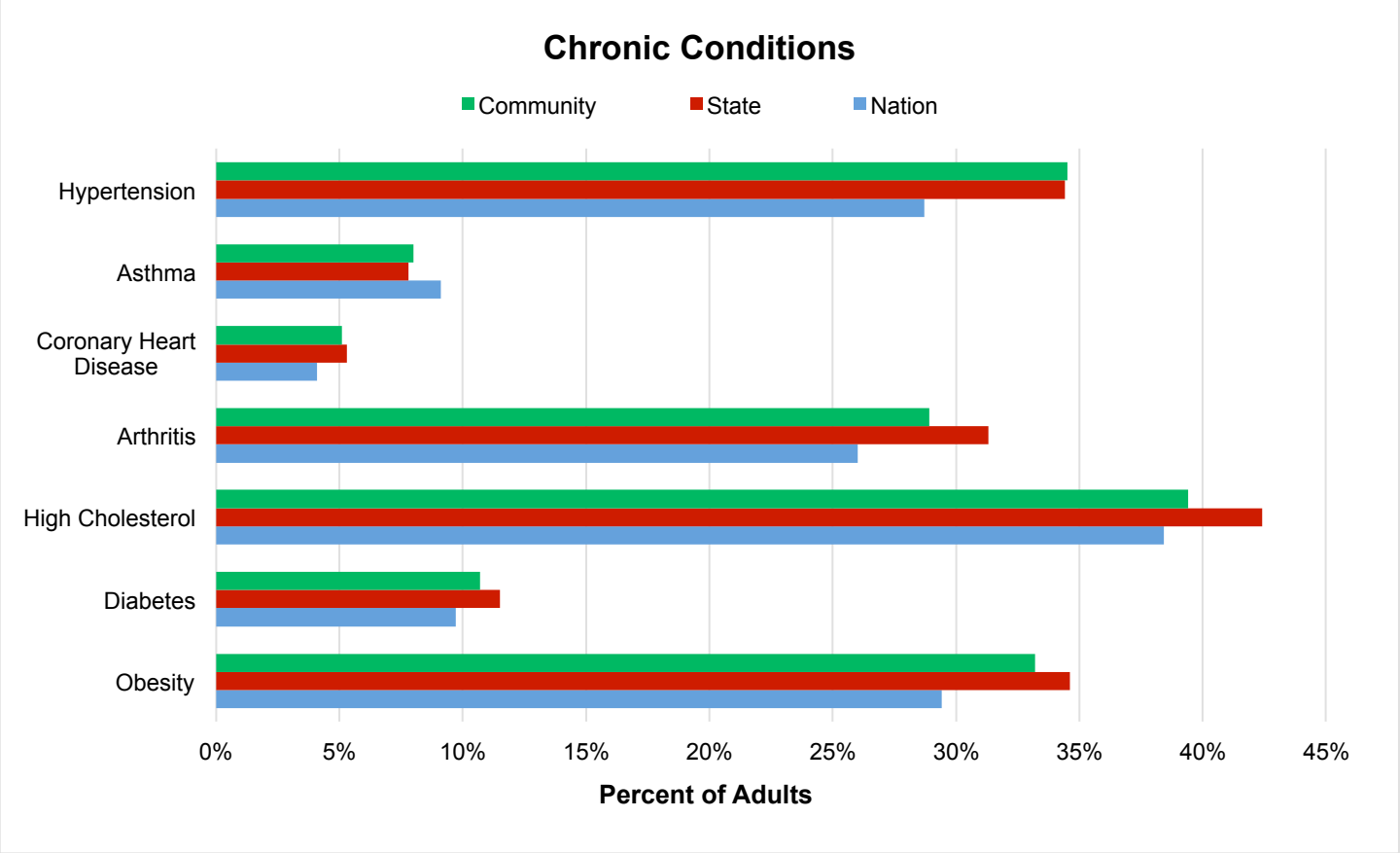
CAUSE OF DEATH

Measurement	Lonoke County	Pulaski County	Community Average	State Average	National Average
All-Cause Mortality All Causes per 100,000 (age-adjusted)	939.20	866.00	902.60	891.60	729.6
Infant Mortality Rate of all infant deaths (within 1 year), per 1,000 live births	3.77	7.65	5.71	6.69	6.00
Cancer Neoplasms per 100,000 population (age-adjusted)	196.90	178.60	187.75	191.90	167.90
Stroke Cerebrovascular diseases per 100,000 population (age-adjusted)	50.20	46.80	48.50	47.40	36.50
Chronic Lower Respiratory Disease Chronic lower respiratory diseases per 100,000 population (age-adjusted)	57.36	42.99	50.18	57.05	NA
Diabetes Diabetes mellitus per 100,000 population (age-adjusted)	16.93	17.14	17.04	23.58	NA
Heart Disease Essential (primary) hypertension, hypertensive heart disease with (congestive) heart failure per 100,000 population (age-adjusted)	222.00	195.90	208.95	220.20	172.4
Injury-Related Accidents (unintentional injuries) per 100,000 population (age-adjusted)	50.30	43.80	47.05	46.90	39.10
Motor Vehicle Motor Vehicle Accidents per 100,000 population (age-adjusted)	21.98	14.79	18.39	17.40	NA
Alcohol Impaired Driving Percent of driving deaths with alcohol involved	29%	36%	33%	30%	31%



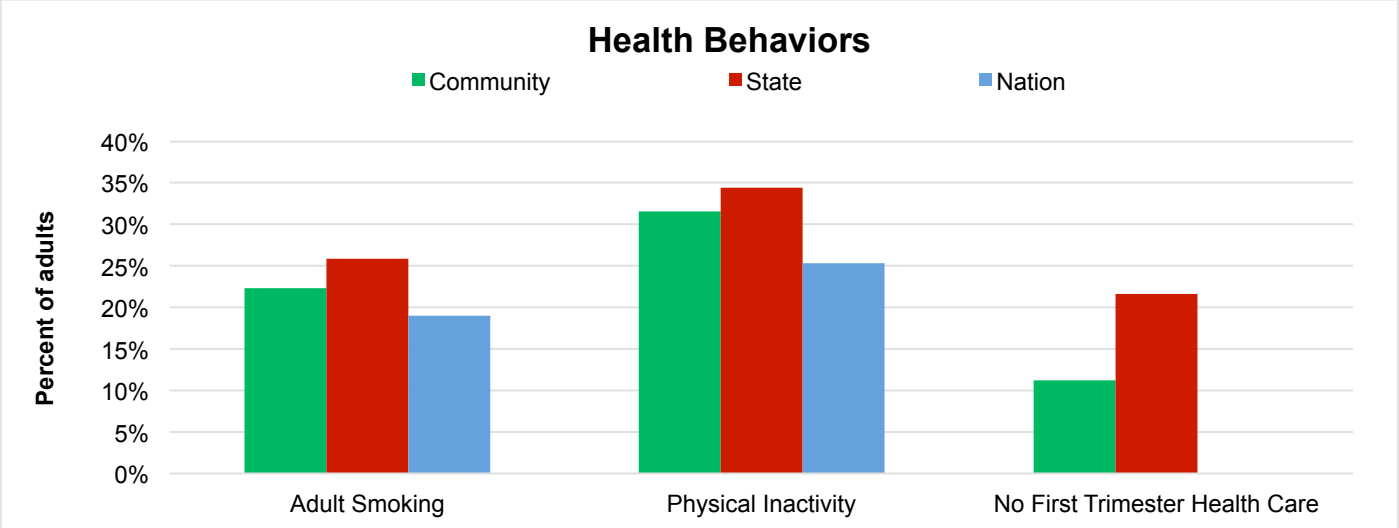
CHRONIC CONDITIONS

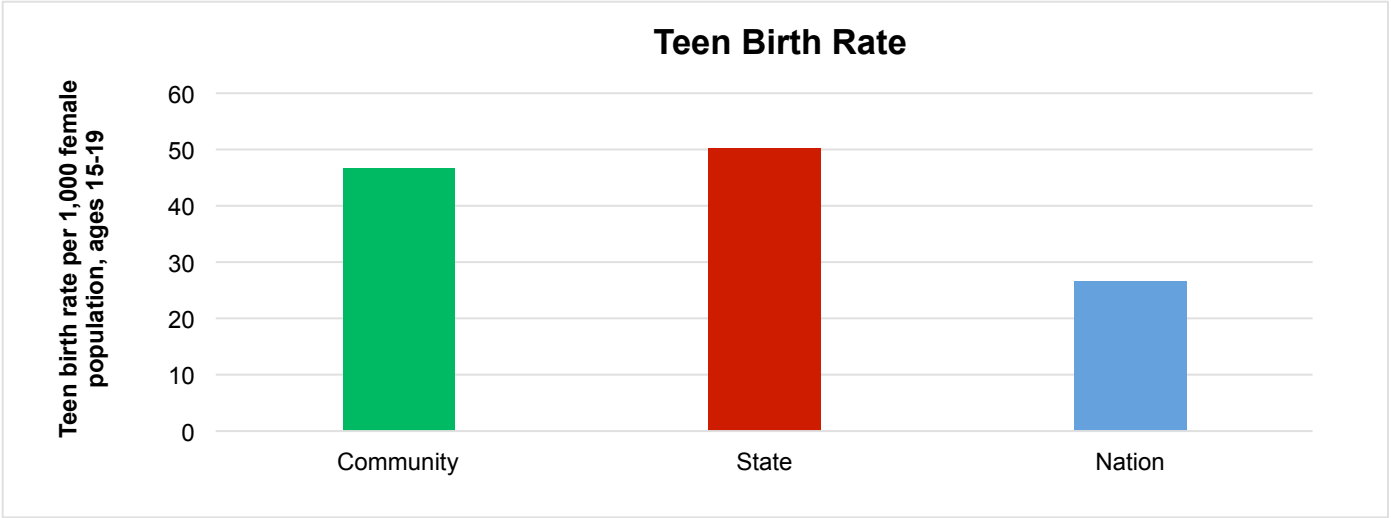
Measurement	Lonoke County	Pulaski County	Community Average	State Average	National Average
Hypertension Percent of adults who have been told they have high blood pressure	34.3%	34.6%	34.5%	34.4%	28.7%
Asthma Percent of adults who have been told they currently have asthma	7.8%	8.2%	8.0%	7.8%	9.1%
Coronary Heart Disease Percent of adults who have been told they have angina or coronary heart disease	5.0%	5.1%	5.1%	5.3%	4.1%
Arthritis Percent of adults who have been told they have arthritis	29.0%	28.8%	28.9%	31.3%	26.0%
High Cholesterol Percent of adults who have had their blood cholesterol checked and have been told it was high	38.1%	40.7%	39.4%	42.4%	38.4%
Diabetes Percent of adults reporting diabetes	10.7%	10.7%	10.7%	11.5%	9.7%
Adult Obesity Percent of adults who report a BMI higher than 30	33.6%	32.7%	33.2%	34.6%	29.4%
Childhood Obesity Percent of children who have a measured BMI for age greater than or equal to 95th percentile	18.9%	21.1%	20.0%	23.3%	NA



HEALTH BEHAVIORS

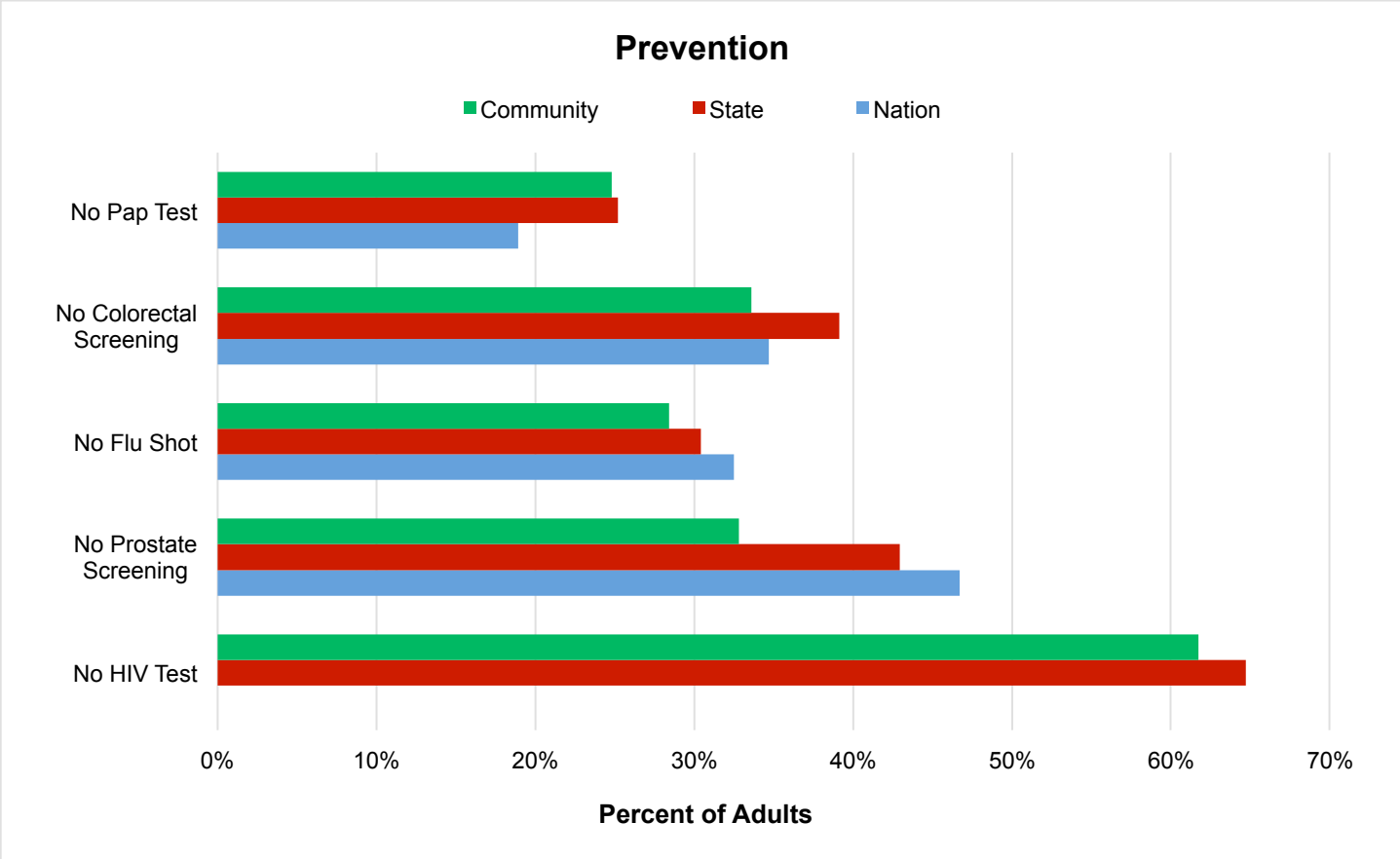
Measurement	Lonoke County	Pulaski County	Community Average	State Average	National Average
Adult Smoking Percent of adults who are current smokers	23.1%	21.4%	22.3%	25.9%	19.0%
Excessive Drinking Percent of adults reporting binge or heavy drinking	16.0%	16.0%	16.0%	15.0%	18.0%
Sexually Transmitted Infections Number of newly diagnosed chlamydia cases per 100,000 population	347	771	559	524	447
Fruit & Vegetable Consumption Percent of adults reporting not consuming recommended five servings of fruit and vegetables	86.2%	86.0%	86.1%	NA	NA
Physical Inactivity Percent of adults reporting no physical activity in the past month	32.1%	31.1%	31.6%	34.4%	25.3%
Teen Birth Rate Teen birth rate per 1,000 female population, ages 15-19	43.1	50.3	46.7	50.1	26.5
No First Trimester Health Care Percent of pregnant women who received no first trimester health care	11.2%	11.1%	11.2%	21.6%	NA





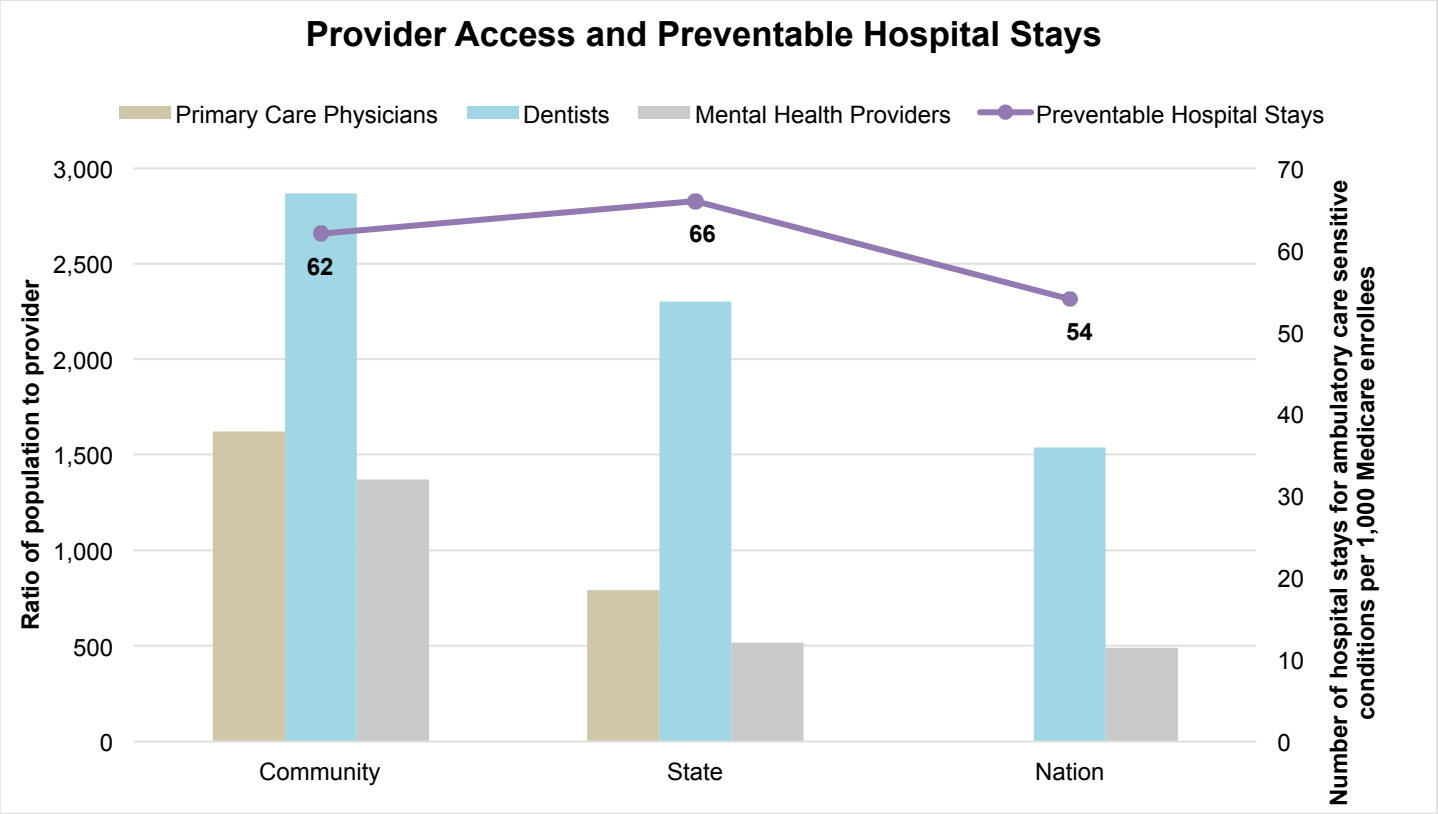
PREVENTION

Measurement	Lonoke County	Pulaski County	Community Average	State Average	National Average
No Pap Test Percent of women aged 18+ who have not had a pap test within the past 3 years	25.6%	24.0%	24.8%	25.2%	18.9%
No Colorectal Screening Percent of adults age 50+ who have never had either a sigmoidoscopy or colonoscopy	35.6%	31.6%	33.6%	39.1%	34.7%
No Flu Shot Percent of adults aged 65+ who have not had a flu shot in the past year	29.4%	27.4%	28.4%	30.4%	32.5%
No Prostate Screening Percent of men aged 40+ who have not had a PSA test within the past two years	32.4%	33.1%	32.8%	42.9%	46.7%
No HIV Test Percent of adults who have never been tested for HIV	62.1%	61.3%	61.7%	64.7%	NA



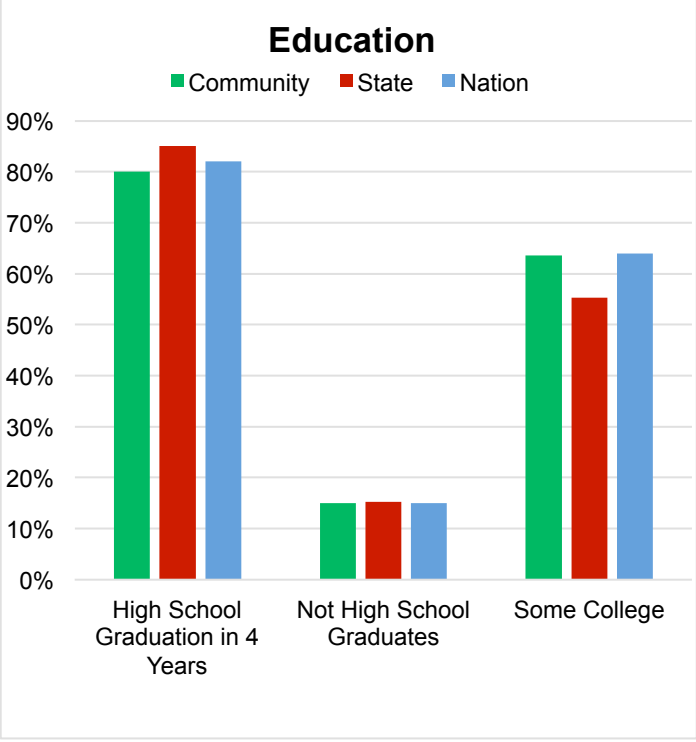
ACCESS

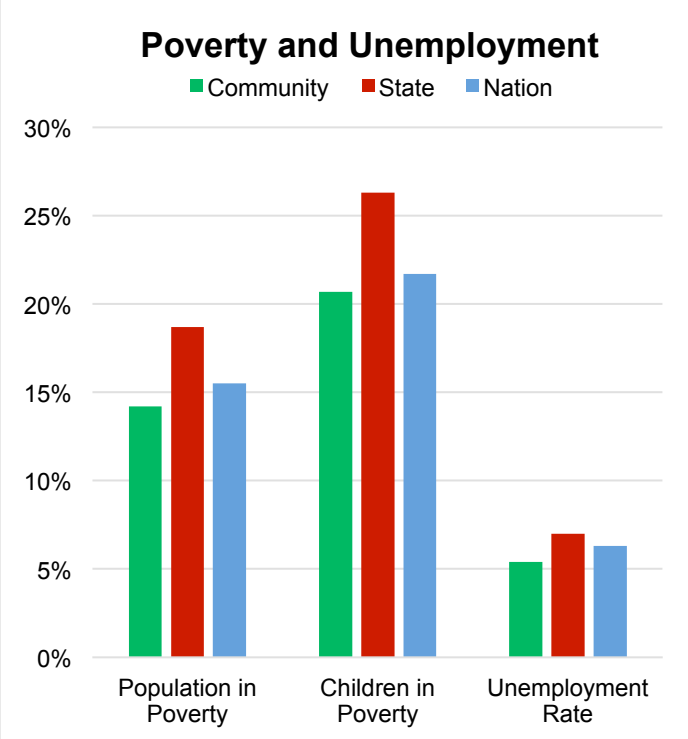
Measurement	Lonoke County	Pulaski County	Community Average	State Average	National Average
Uninsured Percent of non-institutionalized population uninsured	12.7%	14.8%	13.8%	15.8%	14.2%
Primary Care Physicians Ratio of population to primary care physicians (ratio to 1)	2,922	320	1,621	792	NA
Dentists Ratio of population to dentists (ratio to 1)	3,975	1,403	2,689	2,303	1,540
Mental Health Providers Ratio of population to mental health providers (ratio to 1)	2,467	275	1,371	517	490
Preventable Hospital Stays Number of hospital stays for ambulatory care sensitive conditions per 1,000 Medicare enrollees	67	56	62	66	54
Mammography Percent of female Medicare enrollees ages 67-69 who receive mammography screening	59.0%	62.0%	60.5%	58.0%	63.0%
Diabetic Monitoring Percent of diabetic Medicare enrollees ages 65-75 who receive HbA1c monitoring	83.0%	84.0%	83.5%	83.0%	85.0%



SOCIAL AND ECONOMIC

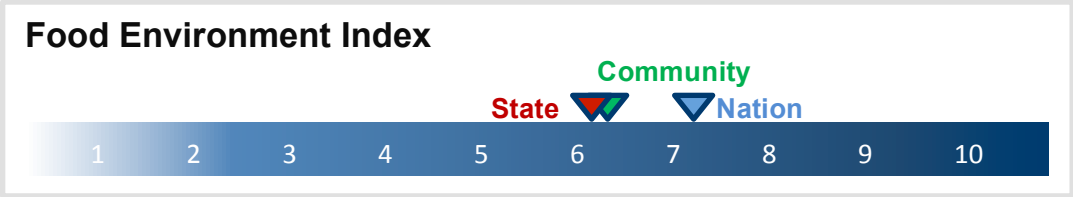
Measurement	Lonoke County	Pulaski County	Community Average	State Average	National Average
Not High School Graduates Percent age 18 to 24 years without a high school diploma	16.2%	13.7%	15.0%	15.3%	15.0%
High School Graduation in 4 years Percent of ninth-grade cohort that graduates in four years	88.0%	72.0%	80.0%	85.0%	82.0%
Some College Percent of adults ages 25-44 with some post-secondary education	60.9%	66.3%	63.6%	55.3%	64.0%
Unemployment Rate Number of unemployed people as a percent of the labor force	5.20%	5.60%	5.4%	7.00%	6.3%
Median Household Income	$54,459	$45,698	$50,079	$41,335	$53,657
Children in Poverty Percent of children under age 18 below the federal poverty line	17.6%	23.8%	20.7%	26.3%	21.7%
Population in Poverty Percent of population below the federal poverty line	12.3%	16.1%	14.2%	18.7%	15.5%
Income Inequality Ratio of household income at the 80th percentile to income at 20th percentile	4.0	4.9	4.5	4.8	4.7
Children in Single-Parent Households Percent of children who live in a household headed by a single parent	28%	44%	36%	37%	34%
Social Associations Number of membership associations per 10,000 population	7.6	16.2	11.9	12.0	9.0
Violent Crime Number of reported crime offenses per 100,000 population	350	1068	709	484	392

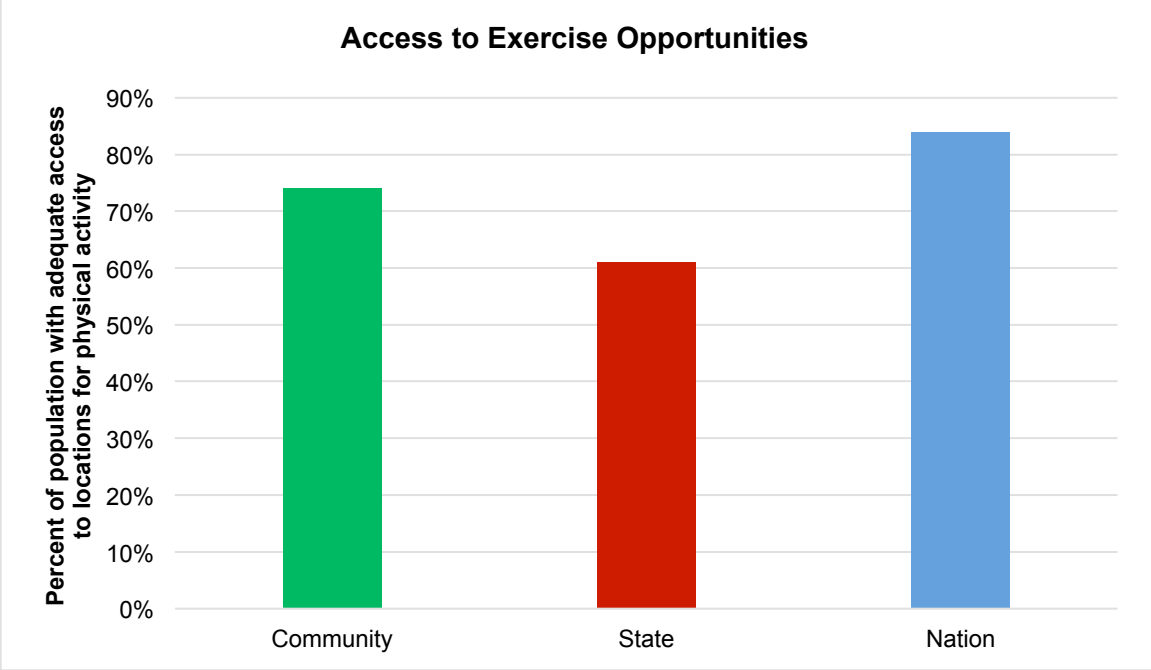




ENVIRONMENT

Measurement	Lonoke County	Pulaski County	Community Average	State Average	National Average
Food Environment Index Index of factors that contribute to a healthy food environment, 0 (worst) to 10 (best)	6.9	5.5	6.2	6.1	7.2
Access to Exercise Opportunities Percent of population with adequate access to locations for physical activity	63%	84%	74%	61%	84%
Air Pollution Average daily density of fine particulate matter in micrograms per cubic meter (PM2.5)	12.1	11.9	12.0	11.8	11.1
Drinking Water Violations Percent of population potentially exposed to water exceeding a violation limit during the last year	0%	7%	4%	9%	7%
Severe Housing Problems Percent of households with at least 1 of 4 housing problems: overcrowding, high housing costs, or lack of kitchen or plumbing	11%	16%	14%	15%	19%
Driving Alone to Work Percent of the workforce who drive alone to work	83%	85%	84%	82%	76%
Long Commute - Driving Alone Among workers who commute in their car alone, the percent who commute more than 30 minutes	44%	19%	32%	26%	31%

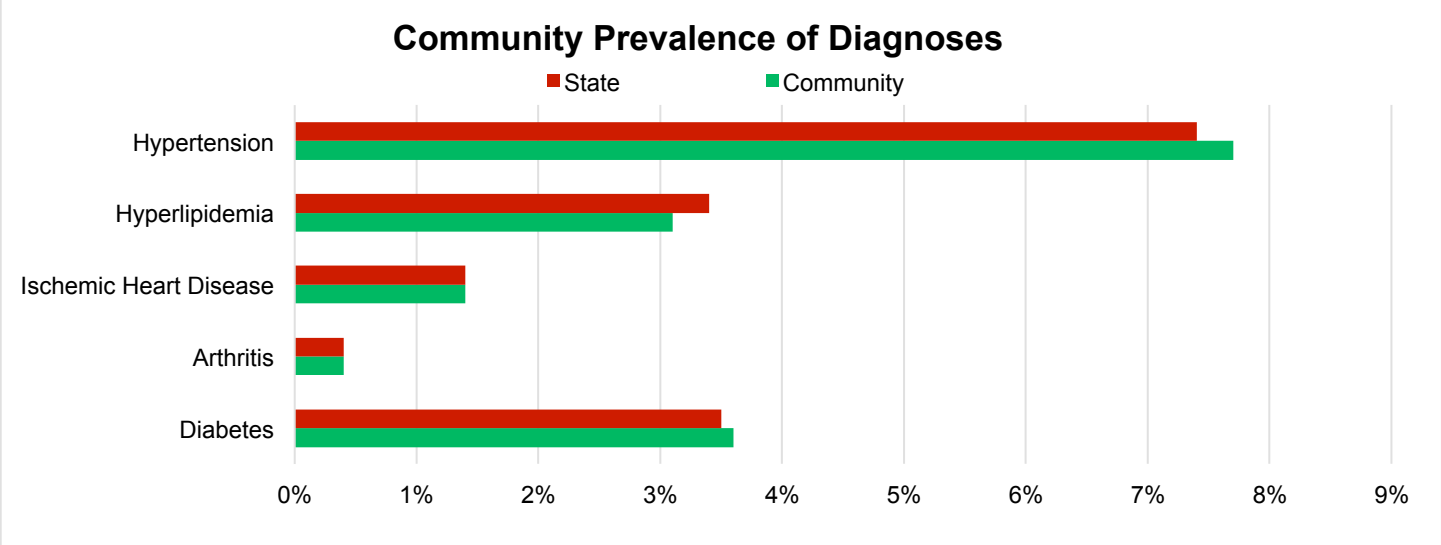




COMMUNITY PREVALENCE OF DIAGNOSES

Measurement*	Lonoke County	Pulaski County	Community Average	State Average
Hypertension	7.5%	7.9%	7.7%	7.4%
Hyperlipidemia	3.1%	3.1%	3.1%	3.4%
Ischemic Heart Disease	1.6%	1.3%	1.4%	1.4%
Arthritis	0.5%	0.4%	0.4%	0.4%
Diabetes	3.6%	3.5%	3.6%	3.5%

*Number of individuals discharged for a primary or secondary diagnoses as a percent of the population (18 years and older)



Produced on behalf of Baptist Health by the Arkansas Center for Health Improvement.

Baptist Health 2016 Community Health Needs Assessment: HEBER SPRINGS

Quantitative results from the 2016 Baptist Health Community Health Needs Assessment for the Heber Springs hospital are reported below. There are ten sections including: Demographics, Health Outcomes, Cause of Death, Chronic Conditions, Health Behaviors, Prevention, Access, Social and Economic, Environment, and Community Prevalence of Diagnoses. Each section includes a table with health indicator data for Cleburne County (the hospital community) and averages for the State of Arkansas and the United States. If data were not available, a "NA" is displayed. Each section also includes graphics for various health indicator data. For more detailed information on methods and resources used, please reference the Methods section and Appendix 1.

DEMOGRAPHICS

Sex and Age

	Cleburne County	State	Nation
Total Population	25,793	2,947,036	314,107,084
Percent Male	49.8%	49.1%	49.2%
Percent Female	50.2%	50.9%	50.8%
Age: 0 to 14	16.5%	20.1%	19.5%
Age: 15 to 19	5.3%	6.8%	6.8%
Age: under 18	19.9%	24.1%	23.5%
Age: 20 to 24	5.0%	7.0%	7.1%
Age: 25 to 34	10.0%	13.0%	13.5%
Age: 35 to 44	10.3%	12.5%	13.0%
Age: 45 to 54	14.0%	13.4%	14.1%
Age: 55 to 64	14.2%	12.3%	12.3%
Age: 65 and older	24.7%	15.0%	13.7%

Ethnicity

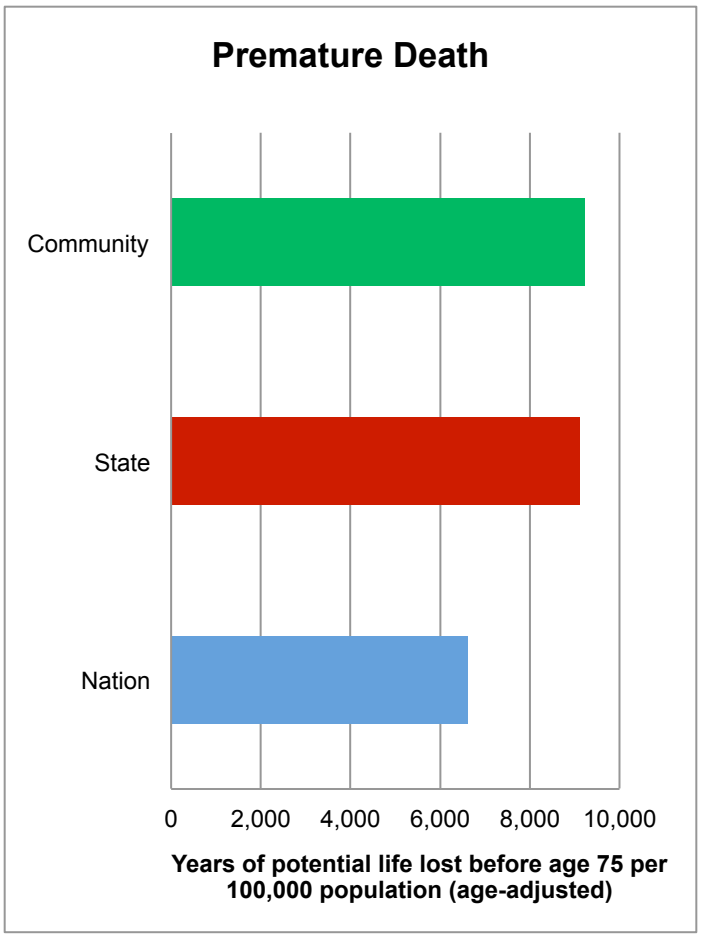
		Cleburne County	State	Nation
Total Population		25,793	2,947,036	314,107,084
Hispanic		2.3%	6.7%	16.9%
Non-Hispanic	White	95.3%	73.9%	62.8%
	Black or African American	0.4%	15.5%	12.2%
	American Indian and Alaska Native	0.5%	0.6%	0.7%
	Asian	0.2%	1.3%	4.9%
	Pacific Islander	0.0%	0.2%	0.2%
	Other	0.0%	0.1%	0.2%
	Multiracial	1.3%	1.8%	2.1%

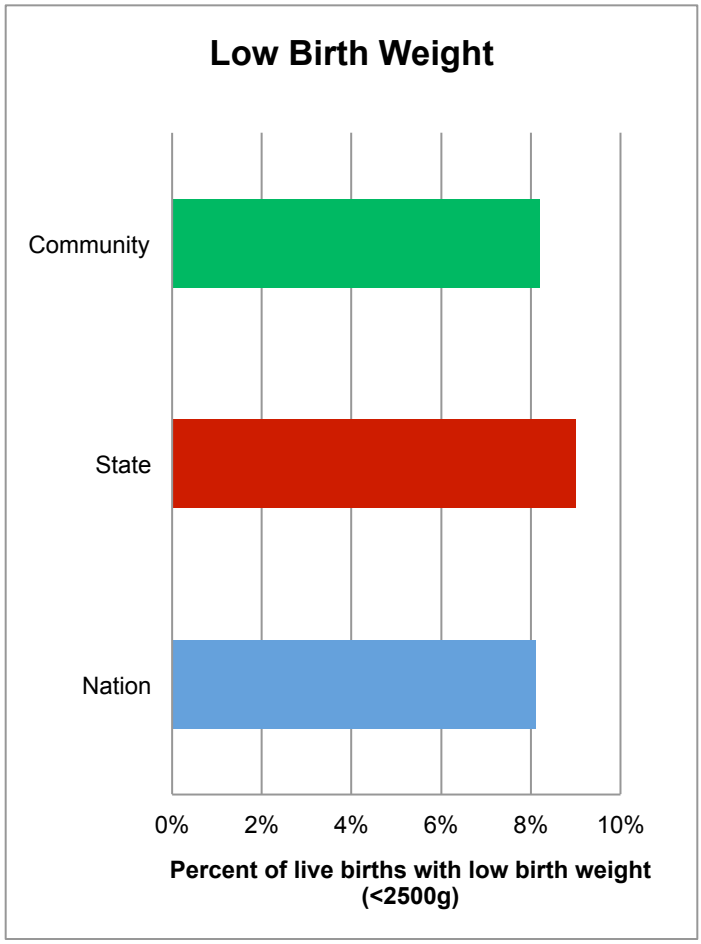
Insurance Coverage

	Cleburne County	State Average	National Average
Health Insurance Coverage	82.0%	84.2%	85.8%
Private Health Insurance Coverage	58.2%	59.1%	65.8%
Public Health Insurance Coverage	42.8%	37.2%	31.1%

HEALTH OUTCOMES

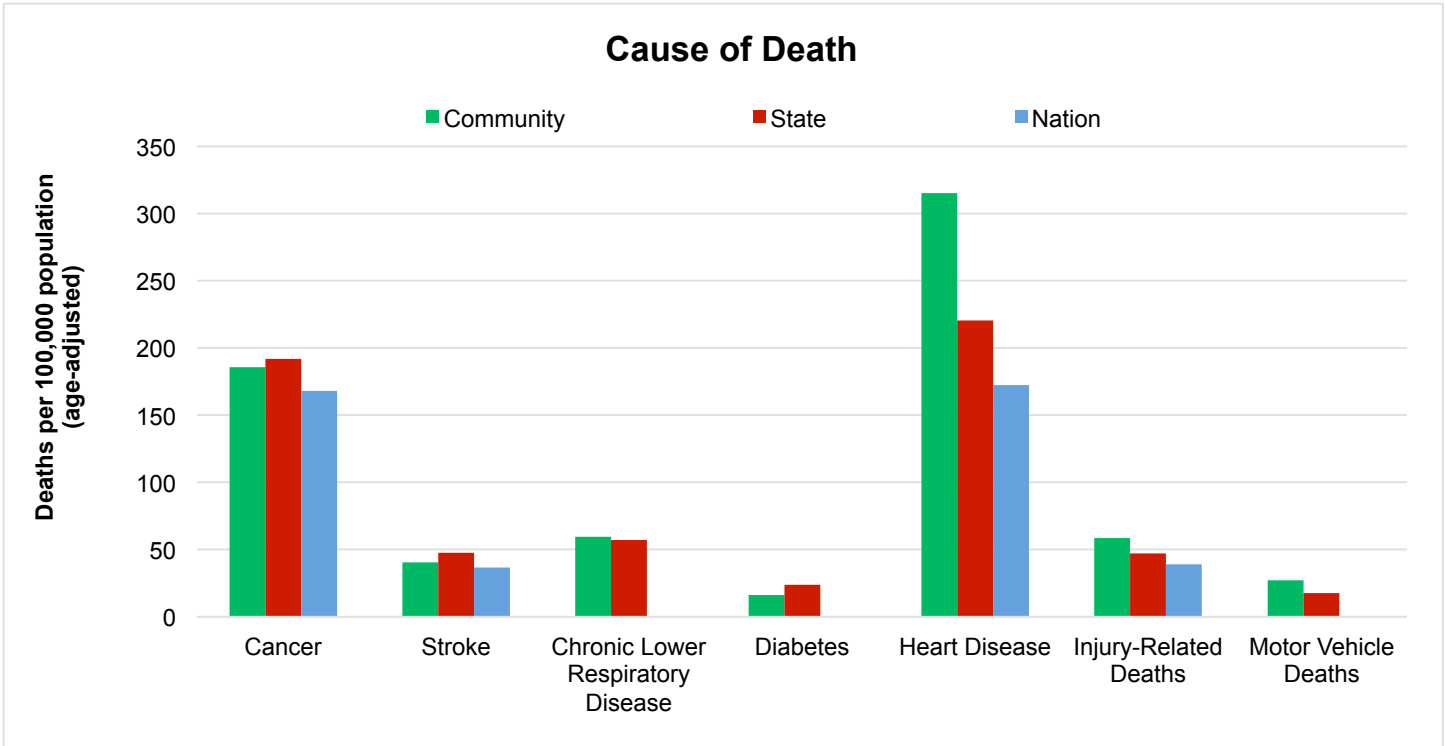
Measurement	Cleburne County	State Average	National Average
Premature Death Years of potential life lost before age 75 per 100,000 population (age-adjusted)	9,212	9,099	6,600
Poor or Fair Health Status Percent of adults reporting fair or poor health (age-adjusted)	19.0%	21.0%	14.0%
Poor Physical Health Days Average number of physically unhealthy days reported in past 30 days (age adjusted)	4.4	4.6	3.5
Poor Mental Health Days Average number of mentally unhealthy days reported in past 30 days (age-adjusted)	4.1	4.2	3.5
Low Birth Weight Percent of live births with low birth weight (<2500g)	8.2%	9.0%	8.1%





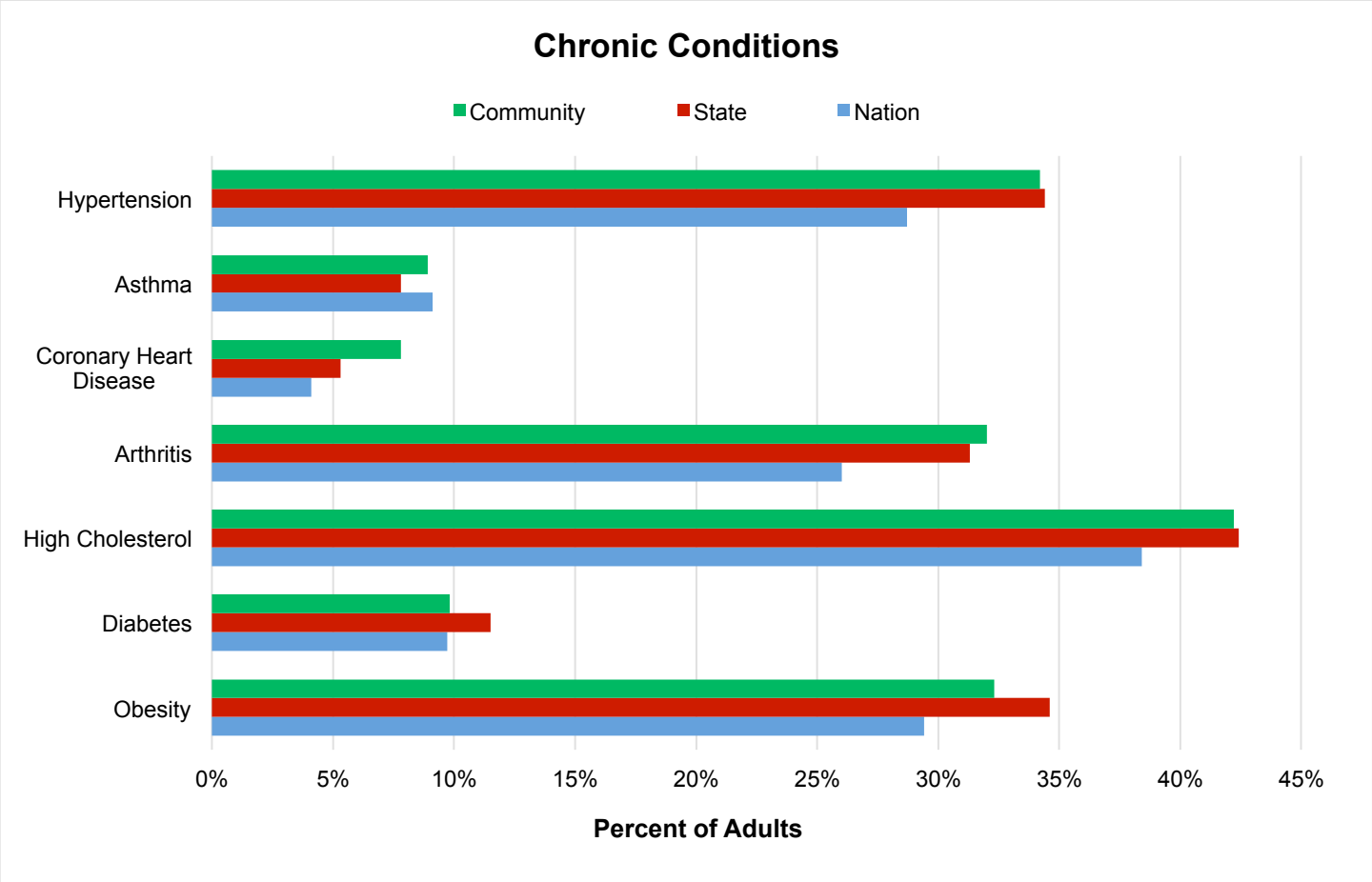
CAUSE OF DEATH

Measurement	Cleburne County	State Average	National Average
All-Cause Mortality All Causes per 100,000 (age-adjusted)	821.40	891.60	729.60
Infant Mortality Rate of all infant deaths (within 1 year), per 1,000 live births	4.17	6.69	6.00
Cancer Neoplasms per 100,000 population (age-adjusted)	185.50	191.90	167.90
Stroke Cerebrovascular diseases per 100,000 population (age-adjusted)	40.70	47.40	36.50
Chronic Lower Respiratory Disease Chronic lower respiratory diseases per 100,000 population (age-adjusted)	59.44	57.05	NA
Diabetes Diabetes mellitus per 100,000 population (age-adjusted)	15.96	23.58	NA
Heart Disease Essential (primary) hypertension, hypertensive heart disease with (congestive) heart failure per 100,000 population (age-adjusted)	315.10	220.20	172.4
Injury-Related Accidents (unintentional injuries) per 100,000 population (age-adjusted)	58.70	46.90	39.10
Motor Vehicle Motor Vehicle Accidents per 100,000 population (age-adjusted)	27.15	17.40	NA
Alcohol Impaired Driving Percent of driving deaths with alcohol involved	45%	30%	31%



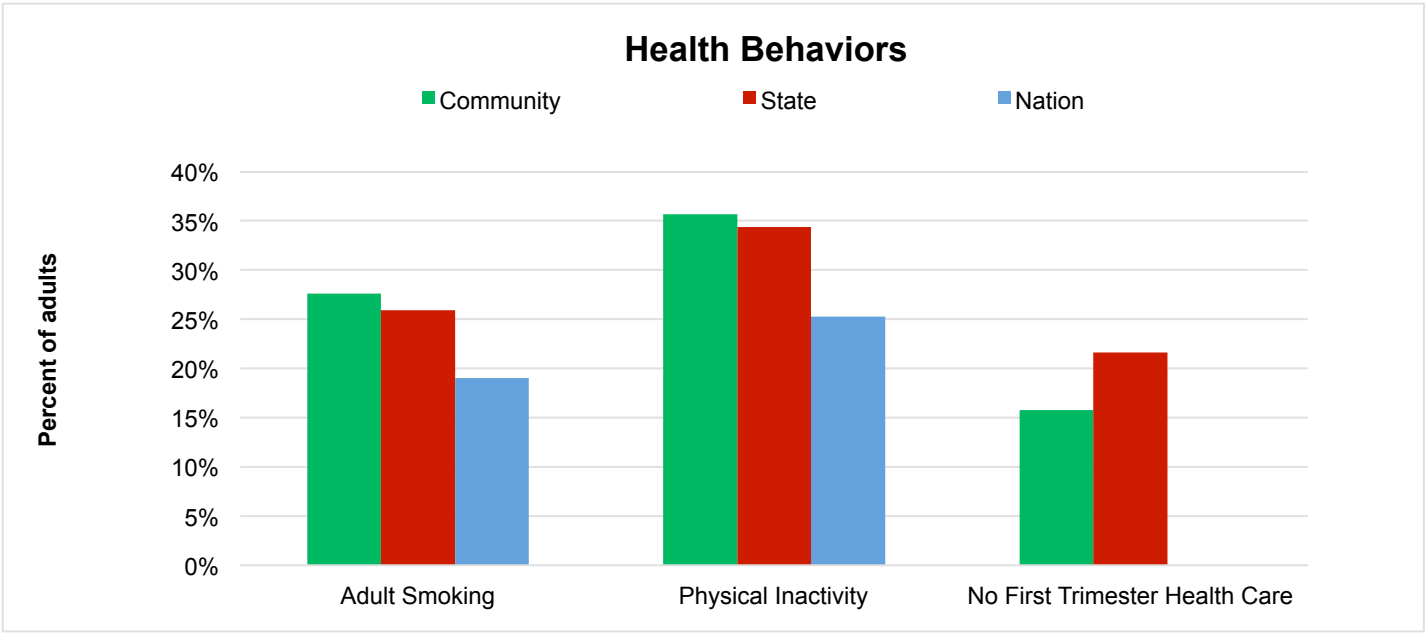
CHRONIC CONDITIONS

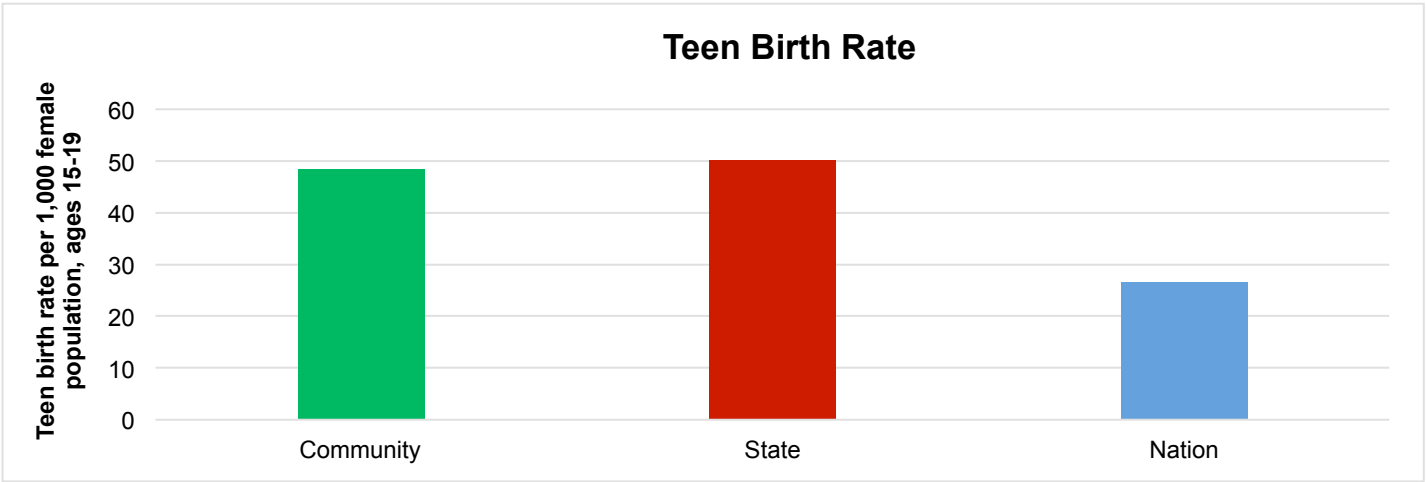
Measurement	Cleburne County	State Average	National Average
Hypertension Percent of adults who have been told they have high blood pressure	34.2%	34.4%	28.7%
Asthma Percent of adults who have been told they currently have asthma	8.9%	7.8%	9.1%
Coronary Heart Disease Percent of adults who have been told they have angina or coronary heart disease	7.8%	5.3%	4.1%
Arthritis Percent of adults who have been told they have arthritis	32.0%	31.3%	26.0%
High Cholesterol Percent of adults who have had their blood cholesterol checked and have been told it was high	42.2%	42.4%	38.4%
Diabetes Percent of adults reporting diabetes	9.8%	11.5%	9.7%
Adult Obesity Percent of adults who report a BMI higher than 30	32.3%	34.6%	29.4%
Childhood Obesity Percent of children who have a measured BMI for age greater than or equal to 95th percentile	19.6%	23.3%	NA



HEALTH BEHAVIORS

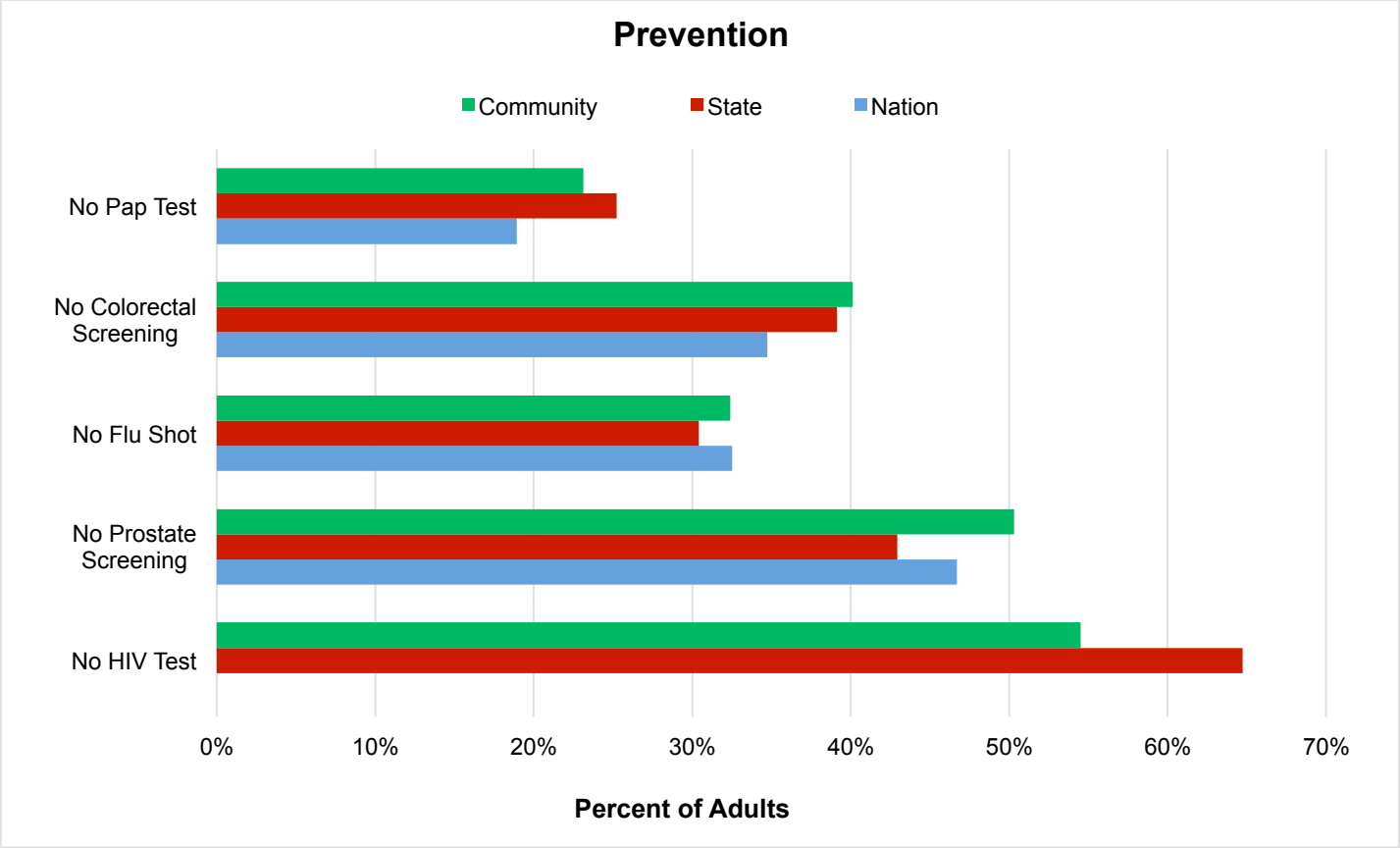
Measurement	Cleburne County	State Average	National Average
Adult Smoking Percent of adults who are current smokers	27.6%	25.9%	19.0%
Excessive Drinking Percent of adults reporting binge or heavy drinking	14.0%	15.0%	18.0%
Sexually Transmitted Infections Number of newly diagnosed chlamydia cases per 100,000 population	205	524	447
Fruit & Vegetable Consumption Percent of adults reporting not consuming recommended five servings of fruit and vegetables	85.4%	NA	NA
Physical Inactivity Percent of adults reporting no physical activity in the past month	35.7%	34.4%	25.3%
Teen Birth Rate Teen birth rate per 1,000 female population, ages 15-19	48.5	50.1	26.5
No First Trimester Health Care Percent of pregnant women who received no first trimester health care	15.8%	21.6%	NA





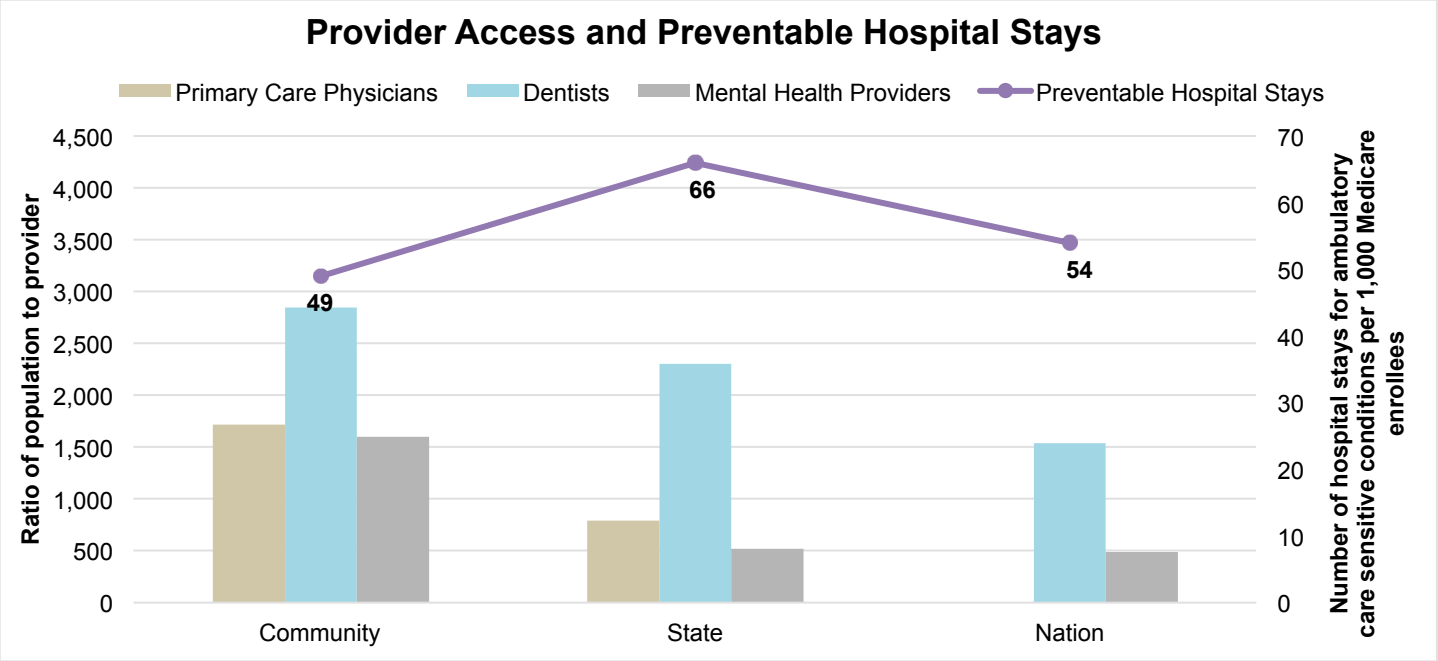
PREVENTION

Measurement	Cleburne County	State Average	National Average
No Pap Test Percent of women aged 18+ who have not had a pap test within the past 3 years	23.1%	25.2%	18.9%
No Colorectal Screening Percent of adults age 50+ who have never had either a sigmoidoscopy or colonoscopy	40.1%	39.1%	34.7%
No Flu Shot Percent of adults aged 65+ who have not had a flu shot in the past year	32.4%	30.4%	32.5%
No Prostate Screening Percent of men aged 40+ who have not had a PSA test within the past two years	50.3%	42.9%	46.7%
No HIV Test Percent of adults who have never been tested for HIV	54.5%	64.7%	NA



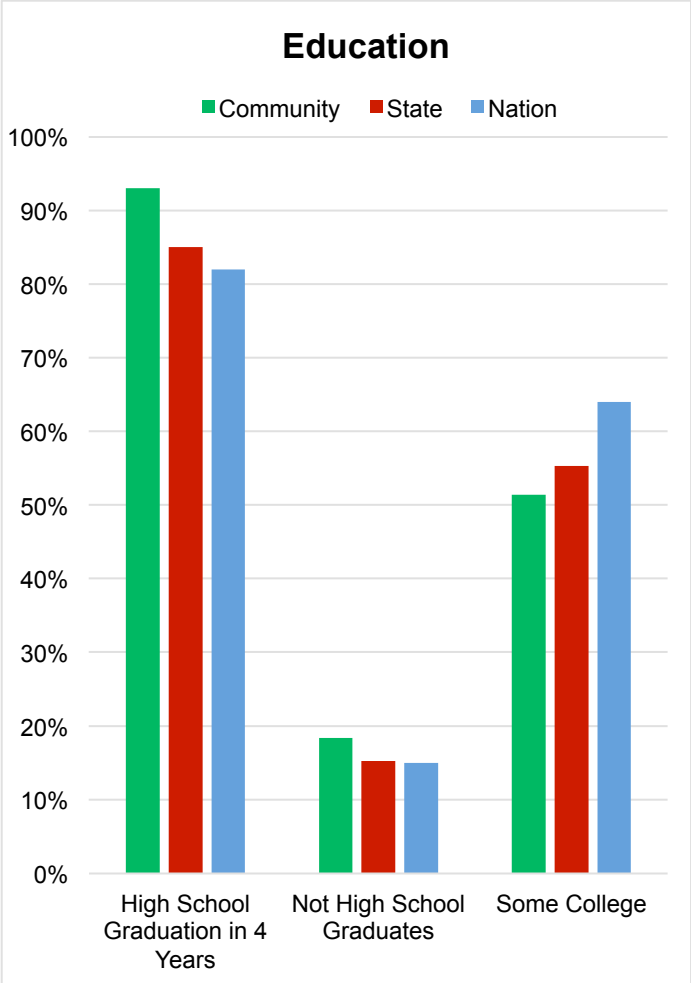
ACCESS

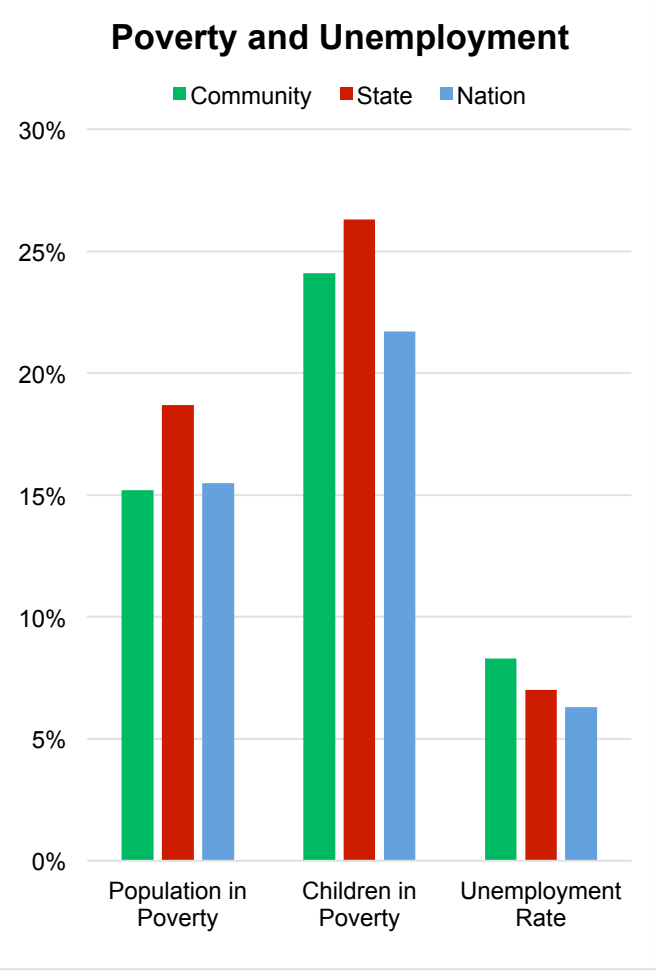
Measurement	Cleburne County	State Average	National Average
Uninsured Percent of non-institutionalized population uninsured	18.0%	15.8%	14.2%
Primary Care Physicians Ratio of population to primary care physicians (ratio to 1)	1,720	792	NA
Dentists Ratio of population to dentists (ratio to 1)	2,848	2,303	1,540
Mental Health Providers Ratio of population to mental health providers (ratio to 1)	1,602	517	490
Preventable Hospital Stays Number of hospital stays for ambulatory care sensitive conditions per 1,000 Medicare enrollees	49	66	54
Mammography Percent of female Medicare enrollees ages 67-69 who receive mammography screening	58.0%	58.0%	63.0%
Diabetic Monitoring Percent of diabetic Medicare enrollees ages 65-75 who receive HbA1c monitoring	86.0%	83.0%	85.0%



SOCIAL AND ECONOMIC

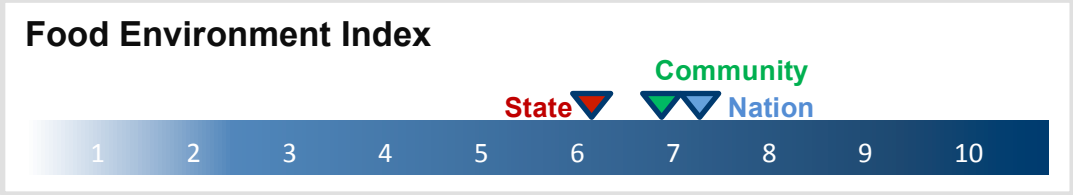
Measurement	Cleburne County	State Average	National Average
Not High School Graduates Percent age 18 to 24 years without a high school diploma	18.4%	15.3%	15.0%
High School Graduation in 4 Years Percent of ninth-grade cohort that graduates in four years	93.0%	85.0%	82.0%
Some College Percent of adults ages 25-44 with some post-secondary education	51.4%	55.3%	64.0%
Unemployment Rate Number of unemployed people as a percent of the labor force	8.3%	7.0%	6.3%
Median Household Income	$40,555	$41,335	$53,657
Children in Poverty Percent of children under age 18 below the federal poverty line	24.1%	26.3%	21.7%
Population in Poverty Percent of population below the federal poverty line	15.2%	18.7%	15.5%
Income Inequality Ratio of household income at the 80th percentile to income at 20th percentile	4.6	4.8	4.7
Children in Single-Parent Households Percent of children who live in a household headed by a single parent	30%	37%	34%
Social Associations Number of membership associations per 10,000 population	16.4	12.0	9.0
Violent Crime Number of reported crime offenses per 100,000 population	221	484	392

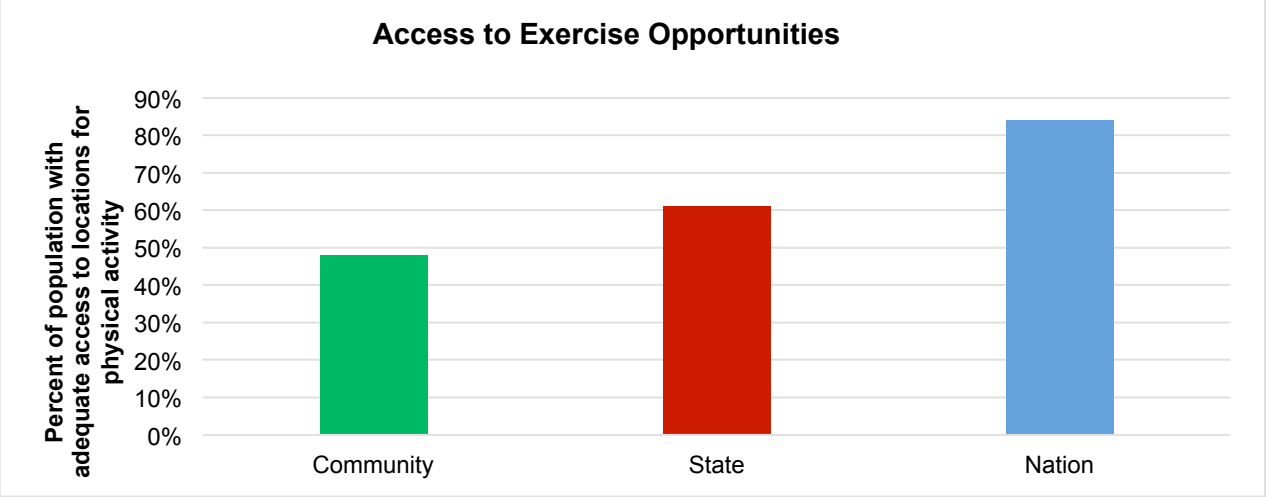




ENVIRONMENT

Measurement	Cleburne County	State Average	National Average
Food Environment Index Index of factors that contribute to a healthy food environment, 0 (worst) to 10 (best)	6.9	6.1	7.2
Access to Exercise Opportunities Percent of population with adequate access to locations for physical activity	48%	61%	84%
Air Pollution Average daily density of fine particulate matter in micrograms per cubic meter (PM2.5)	12.0	11.8	11.1
Drinking Water Violations Percent of population potentially exposed to water exceeding a violation limit during the last year	21%	9%	7%
Severe Housing Problems Percent of households with at least 1 of 4 housing problems: overcrowding, high housing costs, or lack of kitchen or plumbing	12%	15%	19%
Driving Alone to Work Percent of the workforce who drive alone to work	82%	82%	76%
Long Commute - Driving Alone Among workers who commute in their car alone, the percent who commute more than 30 minutes	34%	26%	31%

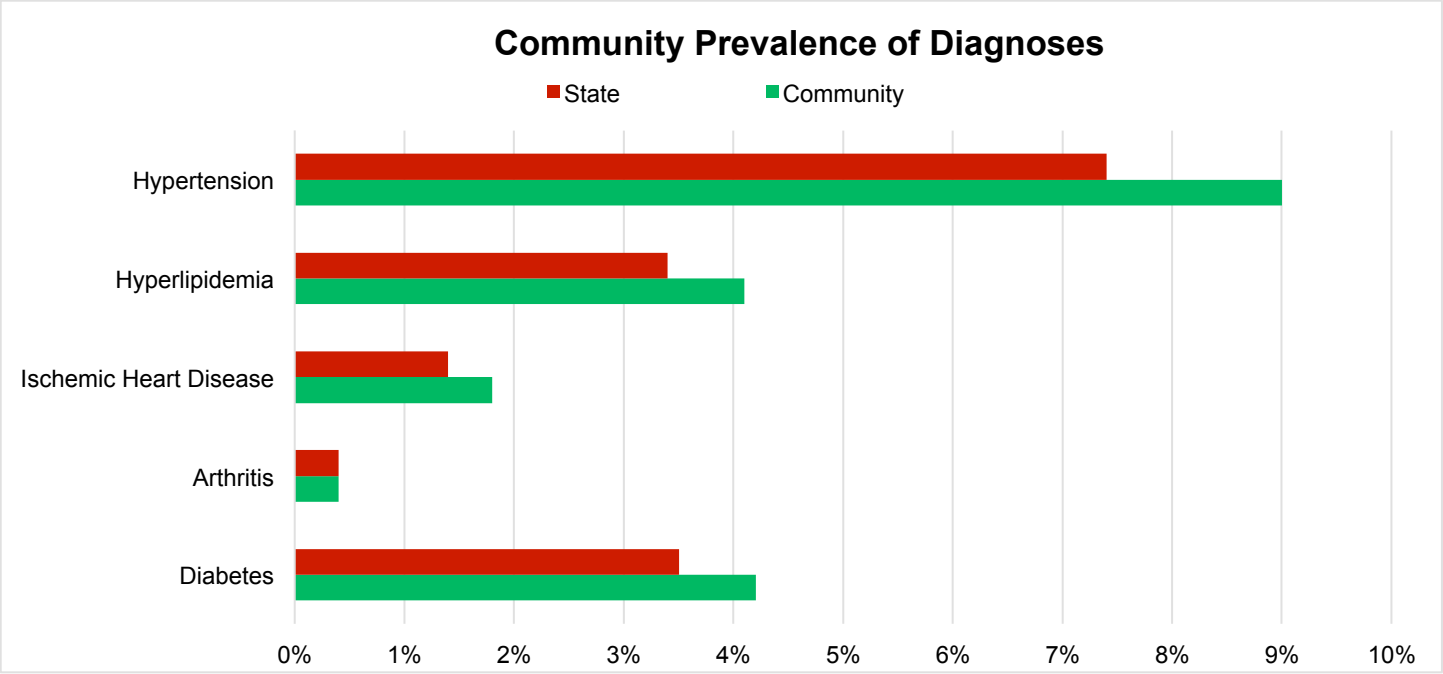




COMMUNITY PREVALENCE OF DIAGNOSES

Measurement*	Cleburne County	State Average
Hypertension	9.0%	7.4%
Hyperlipidemia	4.1%	3.4%
Ischemic Heart Disease	1.8%	1.4%
Arthritis	0.4%	0.4%
Diabetes	4.2%	3.5%

*Number of individuals discharged for a primary or secondary diagnoses as a percent of the population (18 years and older)



Produced on behalf of Baptist Health by the Arkansas Center for Health Improvement.

Baptist Health 2016 Community Health Needs Assessment: ARKADELPHIA

Quantitative results from the 2016 Baptist Health Community Health Needs Assessment for the Arkadelphia hospital are reported below. There are ten sections including: Demographics, Health Outcomes, Cause of Death, Chronic Conditions, Health Behaviors, Prevention, Access, Social and Economic, Environment, and Community Prevalence of Diagnoses. Each section includes a table with health indicator data for each county in the hospital community, community averages (mean of all hospital counties), and averages for the State of Arkansas and the United States. If data were not available, a "NA" is displayed. Each section also includes graphics for various health indicator data. For more detailed information on methods and resources used, please reference the Methods section and Appendix 1.

DEMOGRAPHICS

Sex and Age

	Clark County	Dallas County	Nevada County	Pike County	State	Nation
Total Population	22,800	7,954	8,877	11,187	2,947,036	314,107,084
Percent Male	47.3%	50.1%	49.1%	49.3%	49.1%	49.2%
Percent Female	52.7%	49.9%	50.9%	50.7%	50.9%	50.8%
Age: 0 to 14	16.2%	19.1%	19.9%	19.7%	20.1%	19.5%
Age: 15 to 19	11.1%	6.6%	7.6%	6.6%	6.8%	6.8%
Age: under 18	19.7%	23.7%	23.8%	24.0%	24.1%	23.5%
Age: 20 to 24	14.4%	5.8%	4.8%	5.1%	7.0%	7.1%
Age: 25 to 34	9.0%	8.2%	10.0%	10.5%	13.0%	13.5%
Age: 35 to 44	11.1%	13.2%	10.8%	13.5%	12.5%	13.0%
Age: 45 to 54	11.8%	13.2%	13.8%	14.0%	13.4%	14.1%
Age: 55 to 64	11.2%	14.7%	14.0%	12.7%	12.3%	12.3%
Age: 65 and older	15.3%	19.2%	19.2%	17.9%	15.0%	13.7%

Ethnicity

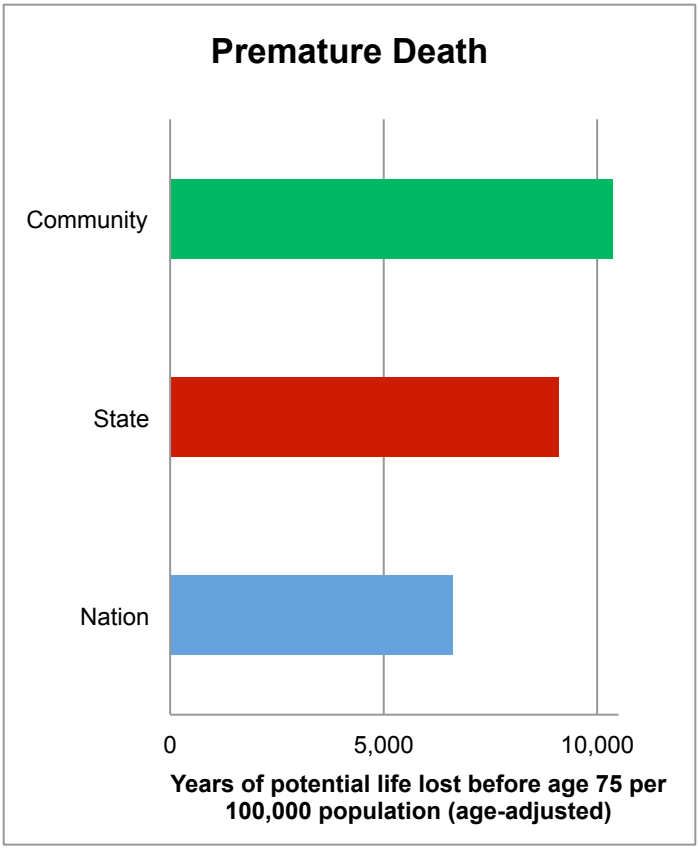
		Clark County	Dallas County	Nevada County	Pike County	State	Nation
Total Population		22,800	7,954	8,877	11,187	2,947,036	314,107,084
Hispanic		4.3%	2.5%	3.0%	6.6%	6.7%	16.9%
Non-Hispanic	White	69.8%	53.9%	64.4%	87.8%	73.9%	62.8%
	Black or African American	23.9%	41.3%	30.4%	2.9%	15.5%	12.2%
	American Indian and Alaska Native	0.1%	0.0%	0.3%	0.1%	0.6%	0.7%
	Asian	0.6%	2.0%	1.4%	0.5%	1.3%	4.9%
	Pacific Islander	0.0%	0.0%	0.0%	0.0%	0.2%	0.2%
	Other	0.0%	0.0%	0.0%	0.1%	0.1%	0.2%
	Multiracial	1.3%	0.3%	0.4%	2.1%	1.8%	2.1%

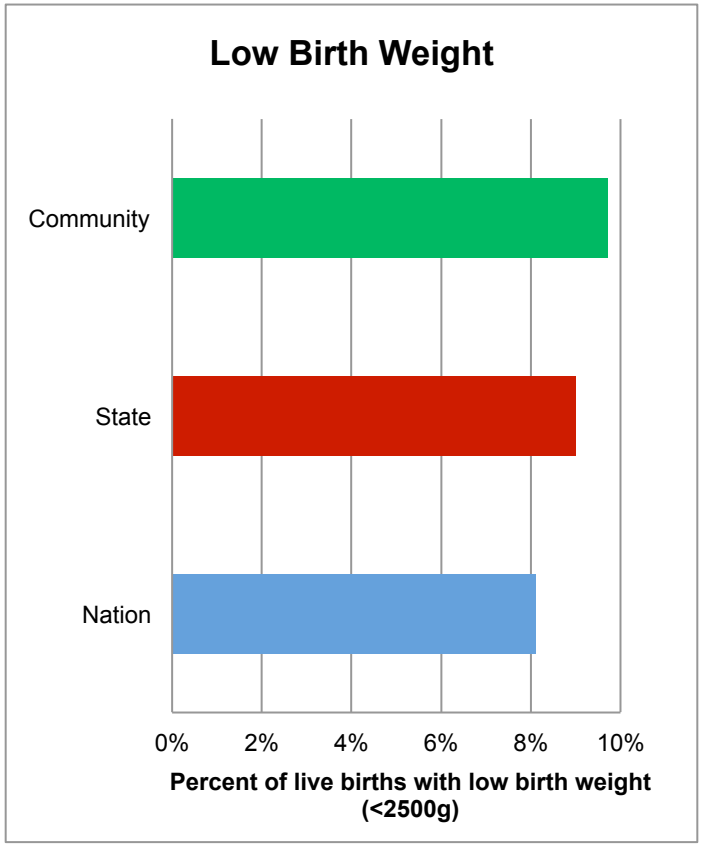
Insurance Coverage

	Clark County	Dallas County	Nevada County	Pike County	State Average	National Average
Health Insurance Coverage	85.9%	82.5%	83.9%	82.4%	84.2%	85.8%
Private Health Insurance Coverage	63.5%	54.4%	50.2%	49.3%	59.1%	65.8%
Public Health Insurance Coverage	35.6%	43.7%	46.7%	45.9%	37.2%	31.1%

HEALTH OUTCOMES

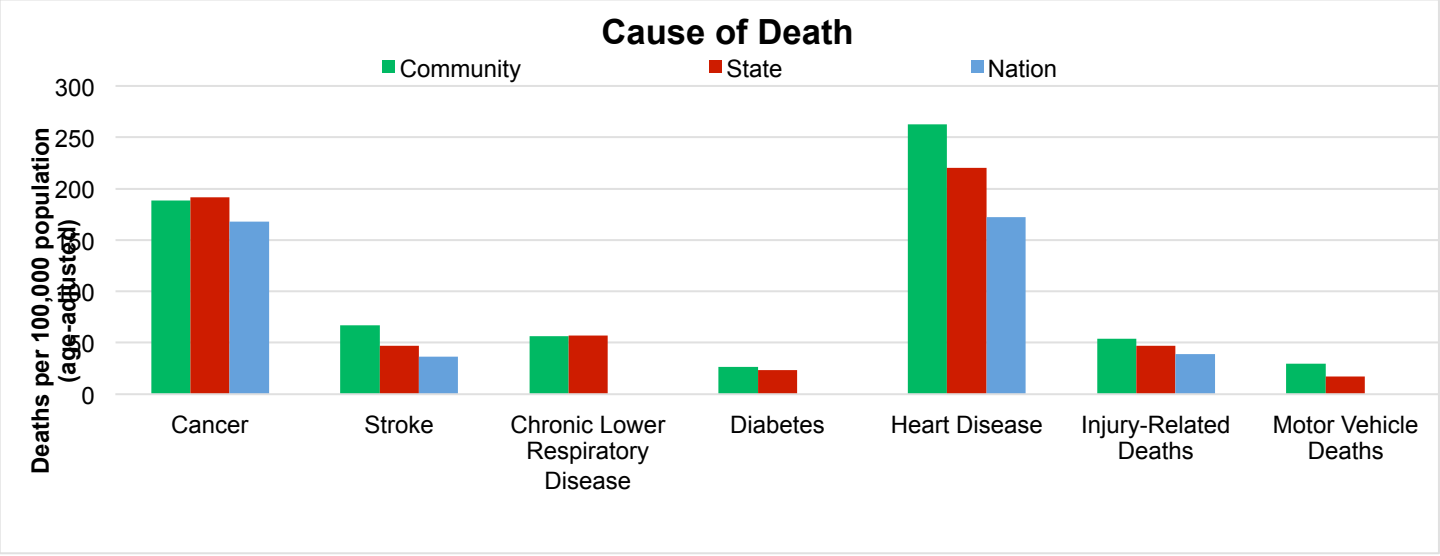
Measurement	Clark County	Dallas County	Nevada County	Pike County	Community Average	State Average	National Average
Premature Death Years of potential life lost before age 75 per 100,000 population (age-adjusted)	9,988	9,126	12,426	9,901	10,360	9,099	6,600
Poor or Fair Health Status Percent of adults reporting fair or poor health (age-adjusted)	22.0%	24.0%	29.0%	23.0%	24.5%	21.0%	14.0%
Poor Physical Health Days Average number of physically unhealthy days reported in past 30 days (age adjusted)	4.7	4.9	5.7	4.9	5.1	4.6	3.5
Poor Mental Health Days Average number of mentally unhealthy days reported in past 30 days (age-adjusted)	4.4	4.3	4.9	4.4	4.5	4.2	3.5
Low Birth Weight Percent of live births with low birth weight (<2500g)	8.0%	12.9%	9.5%	8.2%	9.7%	9.0%	8.1%





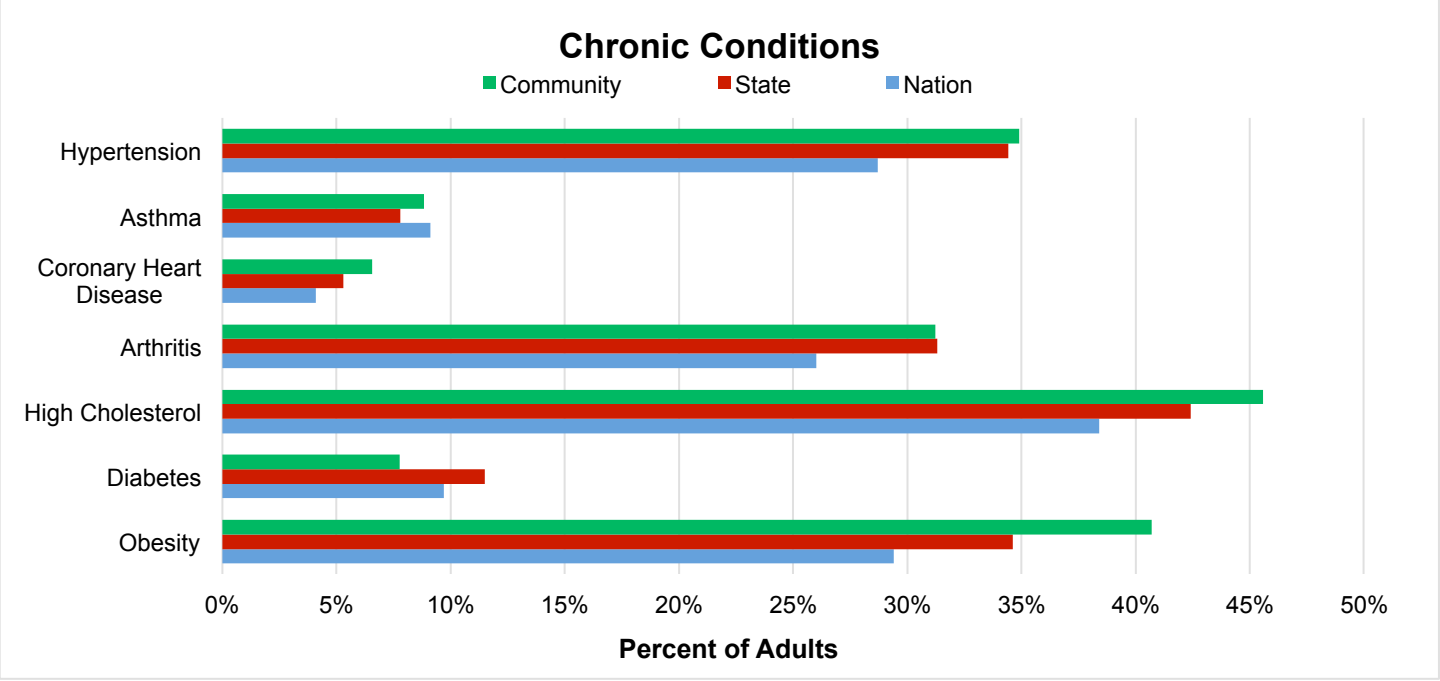
CAUSE OF DEATH

Measurement	Clark County	Dallas County	Nevada County	Pike County	Community Average	State Average	National Average
All-Cause Mortality All Causes per 100,000 (age-adjusted)	951.70	942.20	1007.50	1060.50	990.48	891.60	729.60
Infant Mortality Rate of all infant deaths (within 1 year), per 1,000 live births	9.86	0.00	5.92	8.72	6.13	6.69	6.00
Cancer Neoplasms per 100,000 population (age-adjusted)	166.60	209.30	188.20	190.00	188.53	191.90	167.90
Stroke Cerebrovascular diseases per 100,000 population (age-adjusted)	66.00	75.90	57.20	69.00	67.03	47.40	36.50
Chronic Lower Respiratory Disease Chronic lower respiratory diseases per 100,000 population (age-adjusted)	40.76	36.88	55.34	93.79	56.69	57.05	NA
Diabetes Diabetes mellitus per 100,000 population (age-adjusted)	20.67	44.61	10.49	30.51	26.57	23.58	NA
Heart Disease Essential (primary) hypertension, hypertensive heart disease with (congestive) heart failure per 100,000 population (age-adjusted)	222.30	273.90	235.30	319.50	262.75	220.20	172.4
Injury-Related Accidents (unintentional injuries) per 100,000 population (age-adjusted)	51.20	56.10	60.10	48.80	54.05	46.90	39.10
Motor Vehicle Motor Vehicle Accidents per 100,000 population (age-adjusted)	25.44	39.04	29.31	24.39	29.55	17.40	NA
Alcohol Impaired Driving Percent of driving deaths with alcohol involved	27%	33%	31%	29%	30%	30%	31%



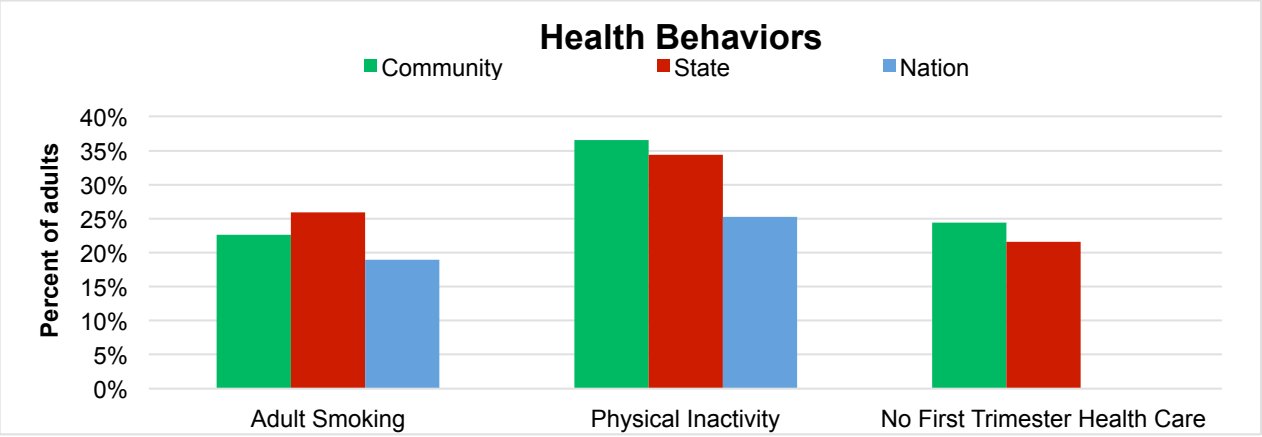
CHRONIC CONDITIONS

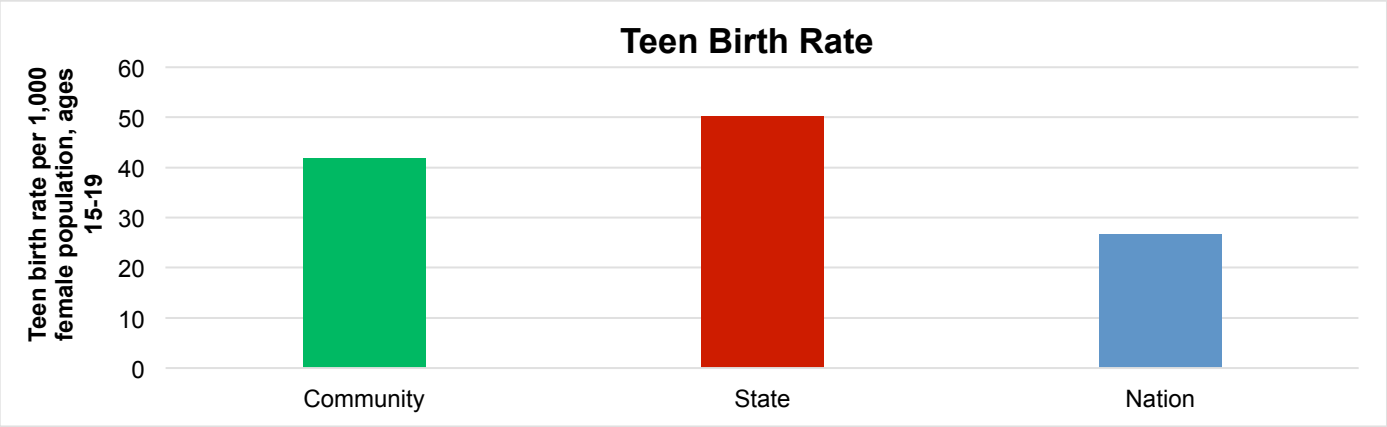
Measurement	Clark County	Dallas County	Nevada County	Pike County	Community Average	State Average	National Average
Hypertension Percent of adults who have been told they have high blood pressure	36.8%	36.4%	35.4%	30.9%	34.9%	34.4%	28.7%
Asthma Percent of adults who have been told they currently have asthma	9.6%	12.3%	7.7%	5.7%	8.8%	7.8%	9.1%
Coronary Heart Disease Percent of adults who have been told they have angina or coronary heart disease	6.5%	6.5%	7.3%	5.9%	6.6%	5.3%	4.1%
Arthritis Percent of adults who have been told they have arthritis	33.6%	36.9%	30.1%	24.3%	31.2%	31.3%	26.0%
High Cholesterol Percent of adults who have had their blood cholesterol checked and have been told it was high	42.1%	48.3%	46.3%	45.5%	45.6%	42.4%	38.4%
Diabetes Percent of adults reporting diabetes	6.7%	8.0%	9.9%	6.5%	7.8%	11.5%	9.7%
Adult Obesity Percent of adults who report a BMI higher than 30	42.2%	43.1%	39.0%	38.4%	40.7%	34.6%	29.4%
Childhood Obesity Percent of children who have a measured BMI for age greater than or equal to 95th percentile	23.6%	25.0%	24.1%	21.0%	23.4%	23.3%	NA



HEALTH BEHAVIORS

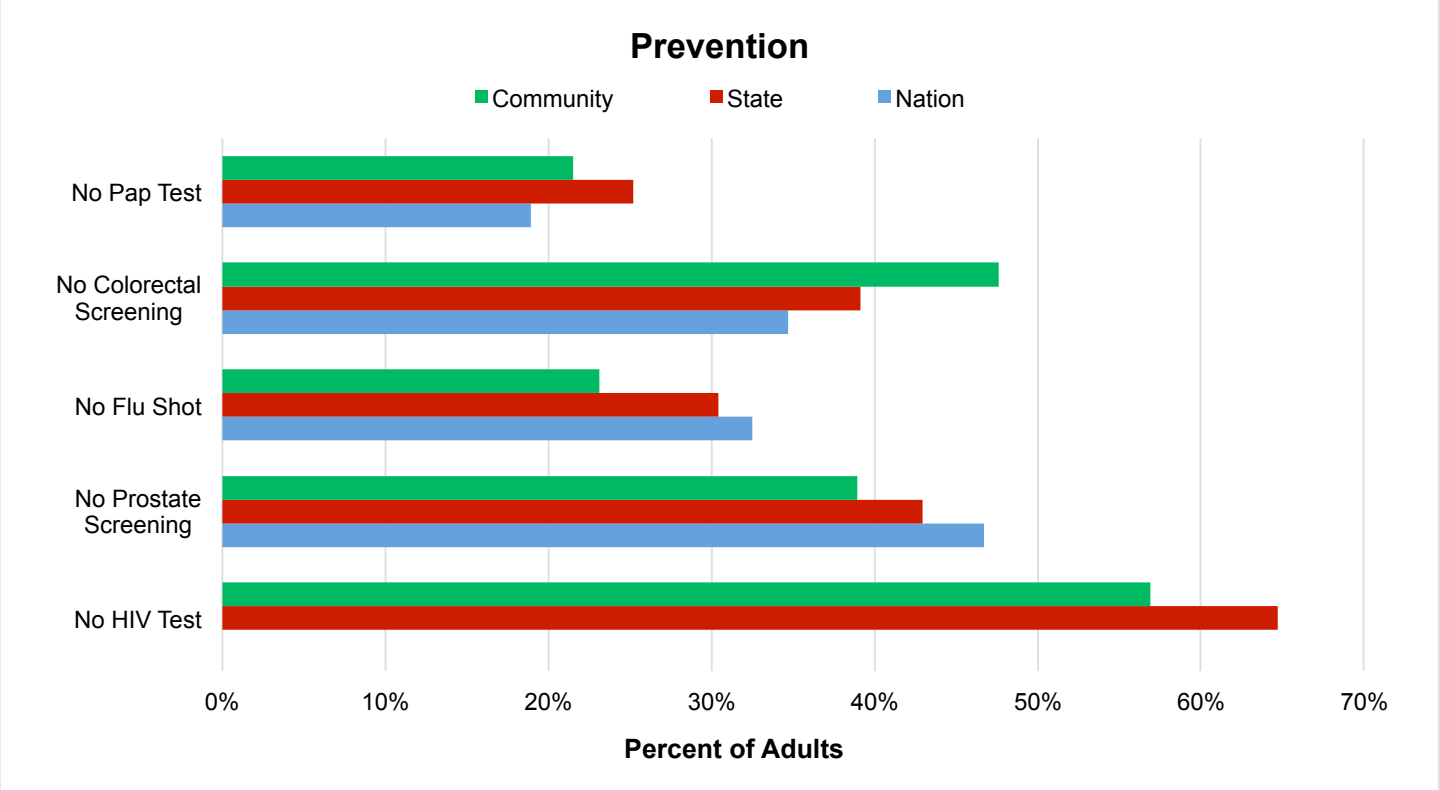
Measurement	Clark County	Dallas County	Nevada County	Pike County	Community Average	State Average	National Average
Adult Smoking Percent of adults who are current smokers	23.7%	22.2%	17.9%	22.5%	22.6%	25.9%	19.0%
Excessive Drinking Percent of adults reporting binge or heavy drinking	15.0%	13.0%	12.0%	14.0%	13.5%	15.0%	18.0%
Sexually Transmitted Infections Number of newly diagnosed chlamydia cases per 100,000 population	737	689	560	329	579	524	447
Fruit & Vegetable Consumption Percent of adults reporting not consuming recommended five servings of fruit and vegetables	90.8%	90.4%	88.9%	89.4%	89.9%	NA	NA
Physical Inactivity Percent of adults reporting no physical activity in the past month	30.5%	34.6%	39.8%	41.4%	36.6%	34.4%	25.3%
Teen Birth Rate Teen birth rate per 1,000 female population, ages 15-19	22.2	48.0	57.5	39.7	41.85	50.1	26.5
No First Trimester Health Care Percent of pregnant women who received no first trimester health care	19.7%	21.9%	27.0%	28.8%	24.4%	21.6%	NA





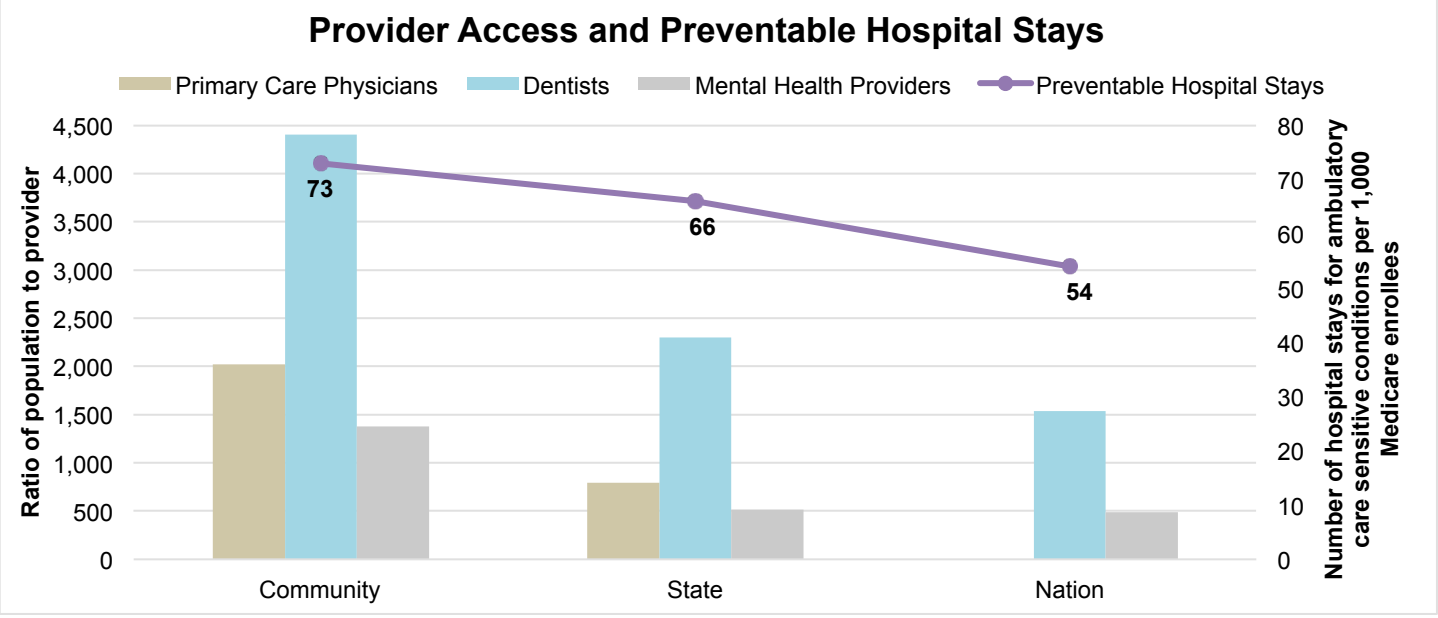
PREVENTION

Measurement	Clark County	Dallas County	Nevada County	Pike County	Community Average	State Average	National Average
No Pap Test Percent of women aged 18+ who have not had a pap test within the past 3 years	17.1%	25.7%	17.5%	25.8%	21.5%	25.2%	18.9%
No Colorectal Screening Percent of adults age 50+ who have never had either a sigmoidoscopy or colonoscopy	48.7%	42.0%	46.7%	53.0%	47.6%	39.1%	34.7%
No Flu Shot Percent of adults aged 65+ who have not had a flu shot in the past year	21.2%	15.9%	22.5%	32.7%	23.1%	30.4%	32.5%
No Prostate Screening Percent of men aged 40+ who have not had a PSA test within the past two years	35.7%	42.1%	37.5%	40.3%	38.9%	42.9%	46.7%
No HIV Test Percent of adults who have never been tested for HIV	54.8%	64.3%	52.1%	56.2%	56.9%	64.7%	NA



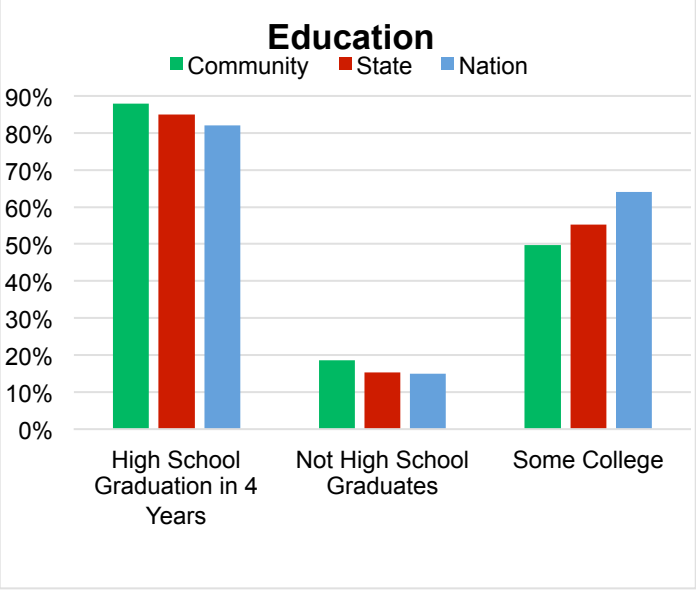
ACCESS

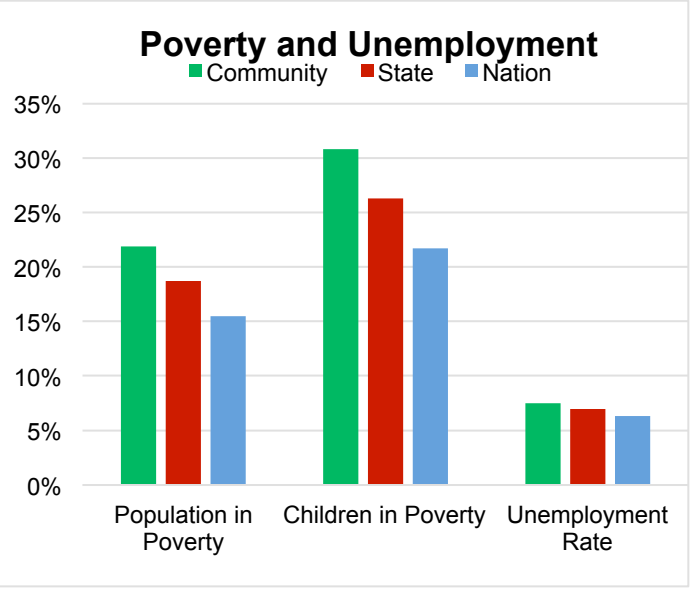
Measurement	Clark County	Dallas County	Nevada County	Pike County	Community Average	State Average	National Average
Uninsured Percent of non-institutionalized population uninsured	14.1%	17.5%	16.1%	17.6%	16.3%	15.8%	14.2%
Primary Care Physicians Ratio of population to primary care physicians (ratio to 1)	1,267	1,989	2,959	1,865	2,020	792	NA
Dentists Ratio of population to dentists (ratio to 1)	2,258	3,878	8,723	2,756	4,404	2,303	1,540
Mental Health Providers Ratio of population to mental health providers (ratio to 1)	470	485	872	3,675	1,376	517	490
Preventable Hospital Stays Number of hospital stays for ambulatory care sensitive conditions per 1,000 Medicare enrollees	58	84	87	64	73	66	54
Mammography Percent of female Medicare enrollees ages 67-69 who receive mammography screening	60.0%	57.0%	59.0%	45.0%	55.3%	58.0%	63.0%
Diabetic Monitoring Percent of diabetic Medicare enrollees ages 65-75 who receive HbA1c monitoring	85.0%	82.0%	85.0%	85.0%	84.3%	83.0%	85.0%



SOCIAL AND ECONOMIC

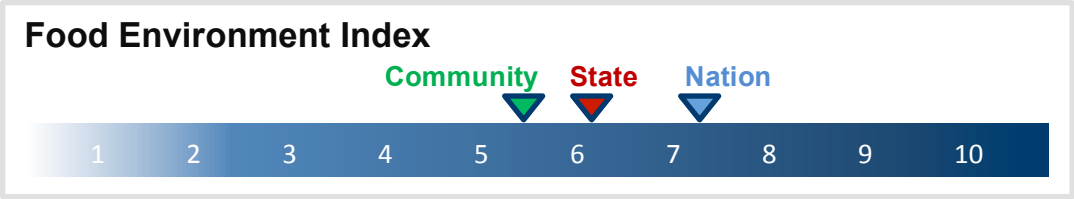
Measurement	Clark County	Dallas County	Nevada County	Pike County	Community Average	State Average	National Average
Not High School Graduates Percent age 18 to 24 years without a high school diploma	5.7%	23.9%	21.0%	23.8%	18.6%	15.3%	15.0%
High School Graduation in 4 years Percent of ninth-grade cohort that graduates in four years	81.0%	98.0%	84.0%	89.0%	88.0%	85.0%	82.0%
Some College Percent of adults ages 25-44 with some post-secondary education	57.9%	38.1%	47.9%	54.9%	49.7%	55.3%	64.0%
Unemployment Rate Number of unemployed people as a percent of the labor force	7.0%	9.5%	6.1%	7.5%	7.5%	7.00%	6.3%
Median Household Income	$38,504	$34,018	$30,935	$36,893	$35,088	$41,335	$53,657
Children in Poverty Percent of children under age 18 below the federal poverty line	28.2%	31.5%	33.5%	29.8%	30.8%	26.3%	21.7%
Population in Poverty Percent of population below the federal poverty line	21.5%	21.0%	25.1%	20.0%	21.9%	18.7%	15.5%
Income Inequality Ratio of household income at the 80th percentile to income at 20th percentile	5.3	4.1	5.2	4.4	4.8	4.8	4.7
Children in Single-Parent Households Percent of children who live in a household headed by a single parent	36%	30%	35%	40%	35%	37%	34%
Social Associations Number of membership associations per 10,000 population	18.5	22.7	13.6	9.8	16.2	12.0	9.0
Violent Crime Number of reported crime offenses per 100,000 population	391	365	232	147	NA	484	392

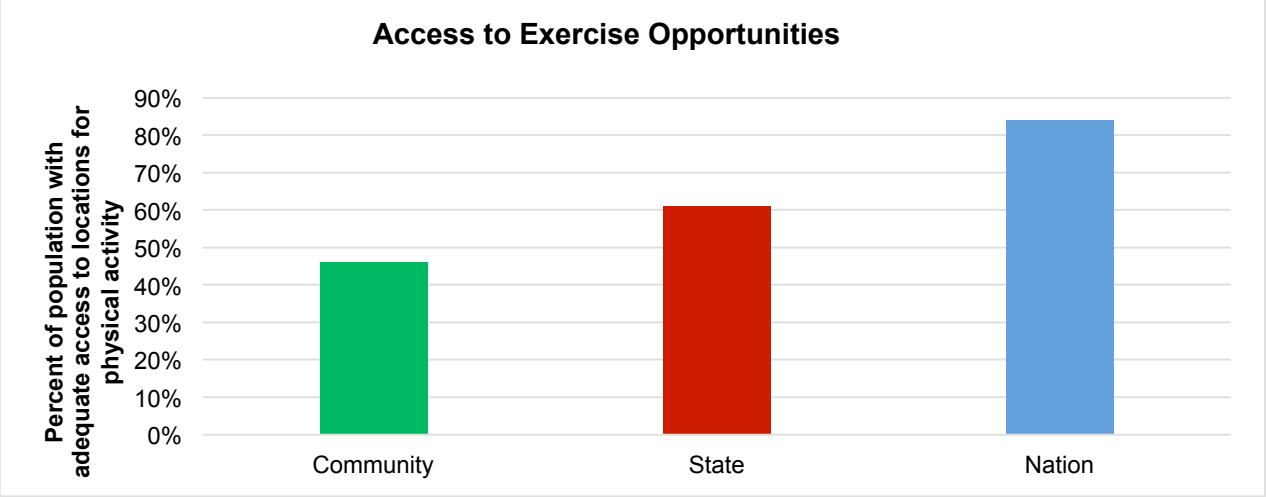




ENVIRONMENT

Measurement	Clark County	Dallas County	Nevada County	Pike County	Community Average	State Average	National Average
Food Environment Index Index of factors that contribute to a healthy food environment, 0 (worst) to 10 (best)	5.8	4.9	5.2	5.9	5.5	6.1	7.2
Access to Exercise Opportunities Percent of population with adequate access to locations for physical activity	65%	36%	29%	54%	46%	61%	84%
Air Pollution Average daily density of fine particulate matter in micrograms per cubic meter (PM2.5)	11.5	11.7	11.3	11.2	11.4	11.8	11.1
Drinking Water Violations Percent of population potentially exposed to water exceeding a violation limit during the last year	2%	8%	5%	24%	10%	9%	7%
Severe Housing Problems Percent of households with at least 1 of 4 housing problems: overcrowding, high housing costs, or lack of kitchen or plumbing	17%	15%	14%	12%	15%	15%	19%
Driving Alone to Work Percent of the workforce who drive alone to work	77%	75%	87%	78%	79%	82%	76%
Long Commute - Driving Alone Among workers who commute in their car alone, the percent who commute more than 30 minutes	27%	36%	36%	40%	35%	26%	31%

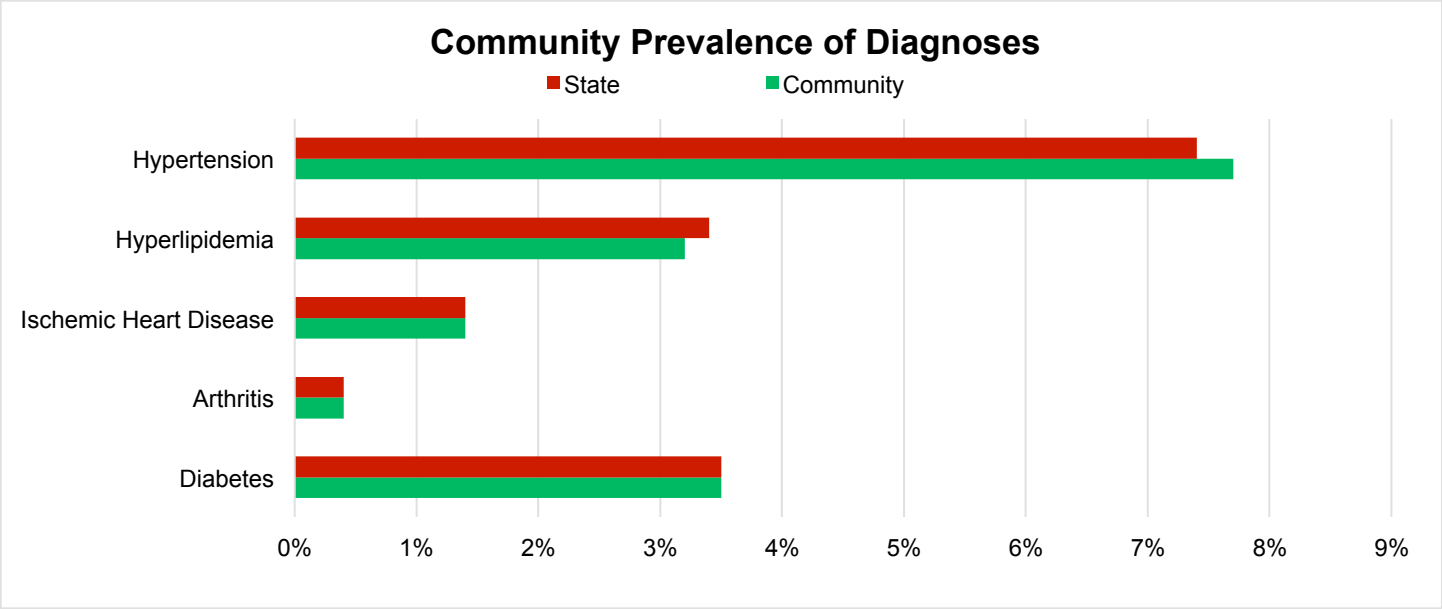




COMMUNITY PREVALENCE OF DIAGNOSES

Measurement*	Clark County	Dallas County	Nevada County	Pike County	Community Average	State Average
Hypertension	6.7%	10.1%	5.8%	8.1%	7.7%	7.4%
Hyperlipidemia	2.4%	3.4%	2.5%	4.6%	3.2%	3.4%
Ischemic Heart Disease	1.1%	1.5%	1.4%	1.8%	1.4%	1.4%
Arthritis	0.3%	0.4%	0.4%	0.6%	0.4%	0.4%
Diabetes	3.0%	5.0%	2.4%	3.5%	3.5%	3.5%

*Number of individuals discharged for a primary or secondary diagnoses as a percent of the population (18 years and older)



Produced on behalf of Baptist Health by the Arkansas Center for Health Improvement.

Baptist Health 2016 Community Health Needs Assessment: STUTTGART

Quantitative results from the 2016 Baptist Health Community Health Needs Assessment for the Stuttgart hospital are reported below. There are ten sections including: Demographics, Health Outcomes, Cause of Death, Chronic Conditions, Health Behaviors, Prevention, Access, Social and Economic, Environment, and Community Prevalence of Diagnoses. Each section includes a table with health indicator data for each county in the hospital community, community averages (mean of all hospital counties), and averages for the State of Arkansas and the United States. If data were not available, a "NA" is displayed. Each section also includes graphics for various health indicator data. For more detailed information on methods and resources used, please reference the Methods section and Appendix 1.

DEMOGRAPHICS

Sex and Age

	Arkansas County	Lonoke County	Monroe County	Prairie County	State	Nation
Total Population	18,861	70,118	7,855	8,475	2,947,036	314,107,084
Percent Male	48.2%	49.2%	48.1%	49.1%	49.1%	49.2%
Percent Female	51.8%	50.8%	51.9%	50.9%	50.9%	50.8%
Age: 0 to 14	19.3%	22.4%	18.2%	16.9%	20.1%	19.5%
Age: 15 to 19	5.8%	7.0%	6.4%	5.8%	6.8%	6.8%
Age: under 18	23.4%	27.0%	22.3%	21.1%	24.1%	23.5%
Age: 20 to 24	5.8%	5.9%	5.6%	5.3%	7.0%	7.1%
Age: 25 to 34	12.1%	14.1%	9.2%	10.3%	13.0%	13.5%
Age: 35 to 44	11.9%	14.2%	10.9%	11.3%	12.5%	13.0%
Age: 45 to 54	13.6%	13.6%	14.6%	14.9%	13.4%	14.1%
Age: 55 to 64	14.4%	10.8%	15.3%	14.6%	12.3%	12.3%
Age: 65 and older	17.1%	11.9%	19.8%	20.8%	15.0%	13.7%

Ethnicity

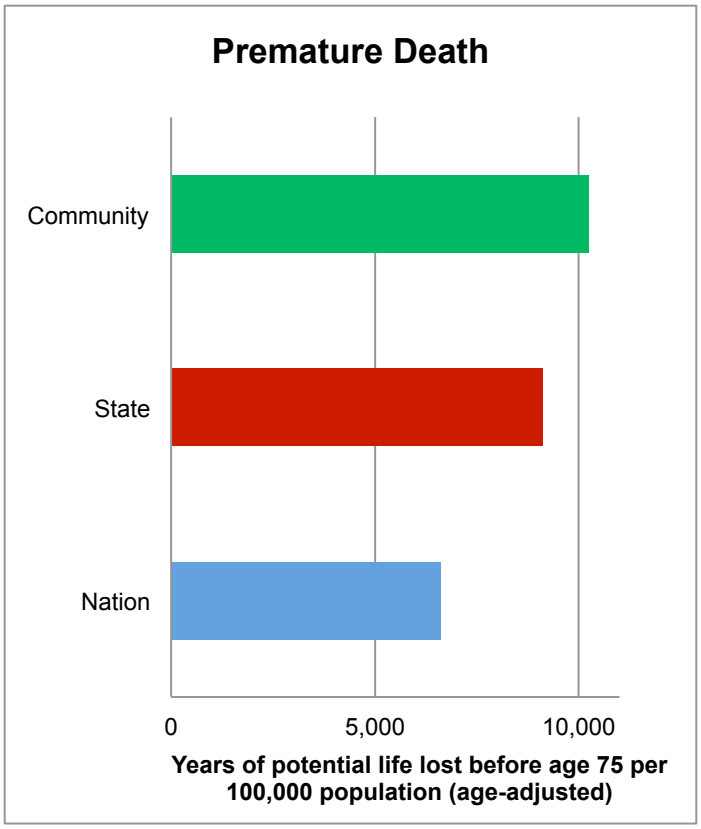
		Arkansas County	Lonoke County	Monroe County	Prairie County	State	Nation
Total Population		18,861	70,118	7,855	8,475	2,947,036	314,107,084
Hispanic		2.9%	3.7%	2.0%	1.0%	6.7%	16.9%
Non-Hispanic	White	70.5%	87.3%	55.3%	85.5%	73.9%	62.8%
	Black or African American	25.1%	6.2%	41.3%	12.4%	15.5%	12.2%
	American Indian and Alaska Native	0.2%	0.4%	0.1%	0.1%	0.6%	0.7%
	Asian	0.4%	0.6%	0.2%	0.2%	1.3%	4.9%
	Pacific Islander	0.0%	0.0%	0.0%	0.0%	0.2%	0.2%
	Other	0.0%	0.1%	0.0%	0.0%	0.1%	0.2%
	Multiracial	0.9%	1.7%	1.1%	0.8%	1.8%	2.1%

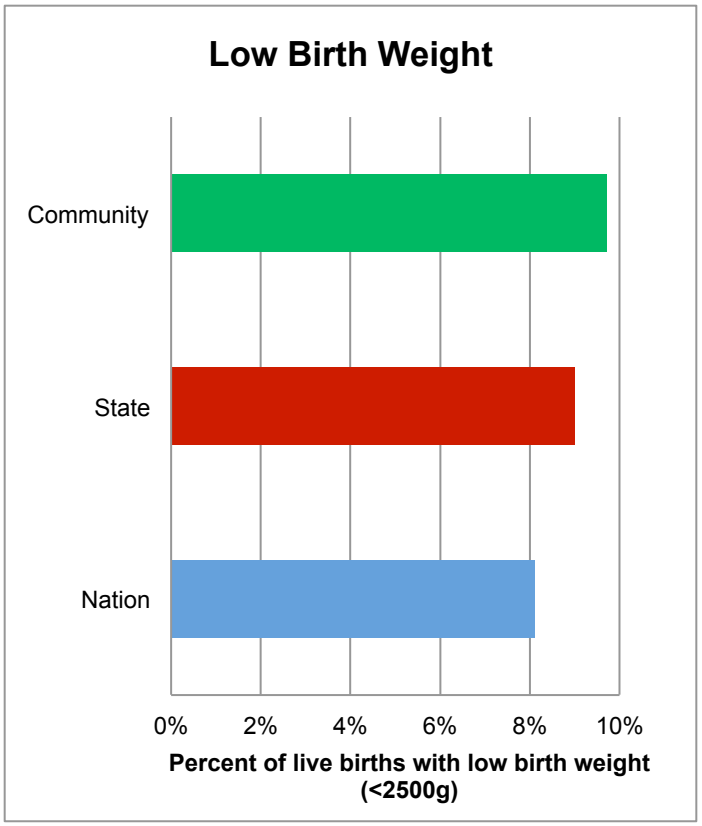
Insurance Coverage

	Arkansas County	Lonoke County	Monroe County	Prairie County	State	Nation
Health Insurance Coverage	86.9%	87.3%	84.3%	84.6%	84.2%	85.8%
Private Health Insurance Coverage	55.0%	69.0%	43.5%	52.0%	59.1%	65.8%
Public Health Insurance Coverage	44.1%	31.4%	54.3%	44.4%	37.2%	31.1%

HEALTH OUTCOMES

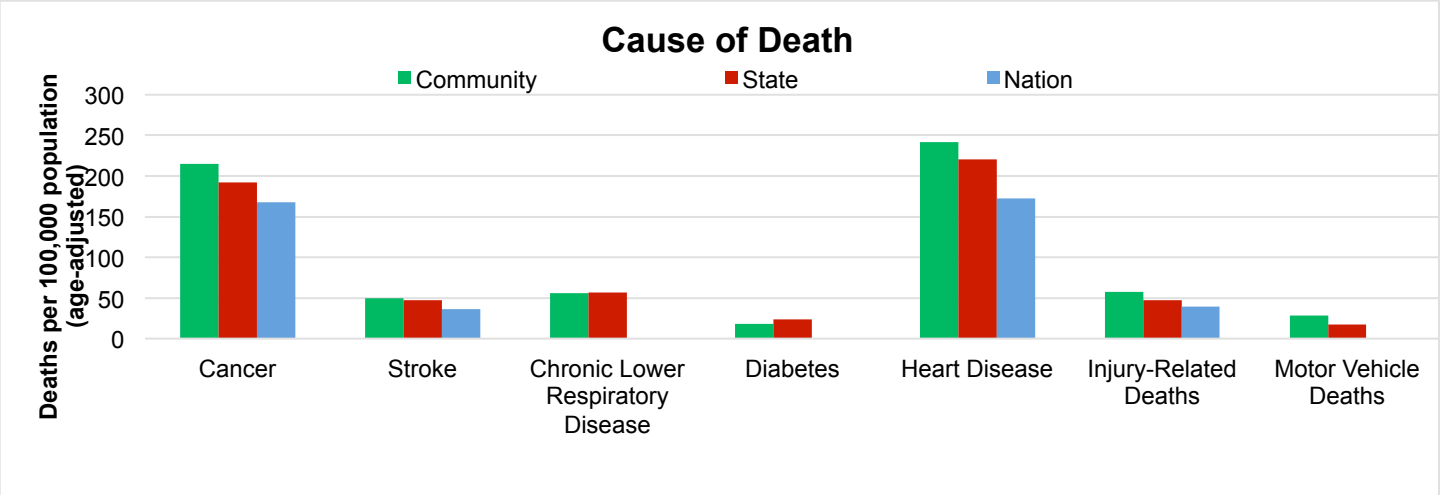
Measurement	Arkansas County	Lonoke County	Monroe County	Prairie County	Community Average	State Average	National Average
Premature Death Years of potential life lost before age 75 per 100,000 population (age-adjusted)	10,678	8,838	10,455	11,010	10,245	9,099	6,600
Poor or Fair Health Status Percent of adults reporting fair or poor health (age-adjusted)	21.0%	18.0%	30.0%	22.0%	22.8%	21.0%	14.0%
Poor Physical Health Days Average number of physically unhealthy days reported in past 30 days (age adjusted)	4.6	4.1	5.7	4.8	4.8	4.6	3.5
Poor Mental Health Days Average number of mentally unhealthy days reported in past 30 days (age-adjusted)	4.2	3.9	4.7	4.3	4.3	4.2	3.5
Low Birth Weight Percent of live births with low birth weight (<2500g)	11.4%	7.6%	11.9%	7.8%	9.7%	9.0%	8.1%





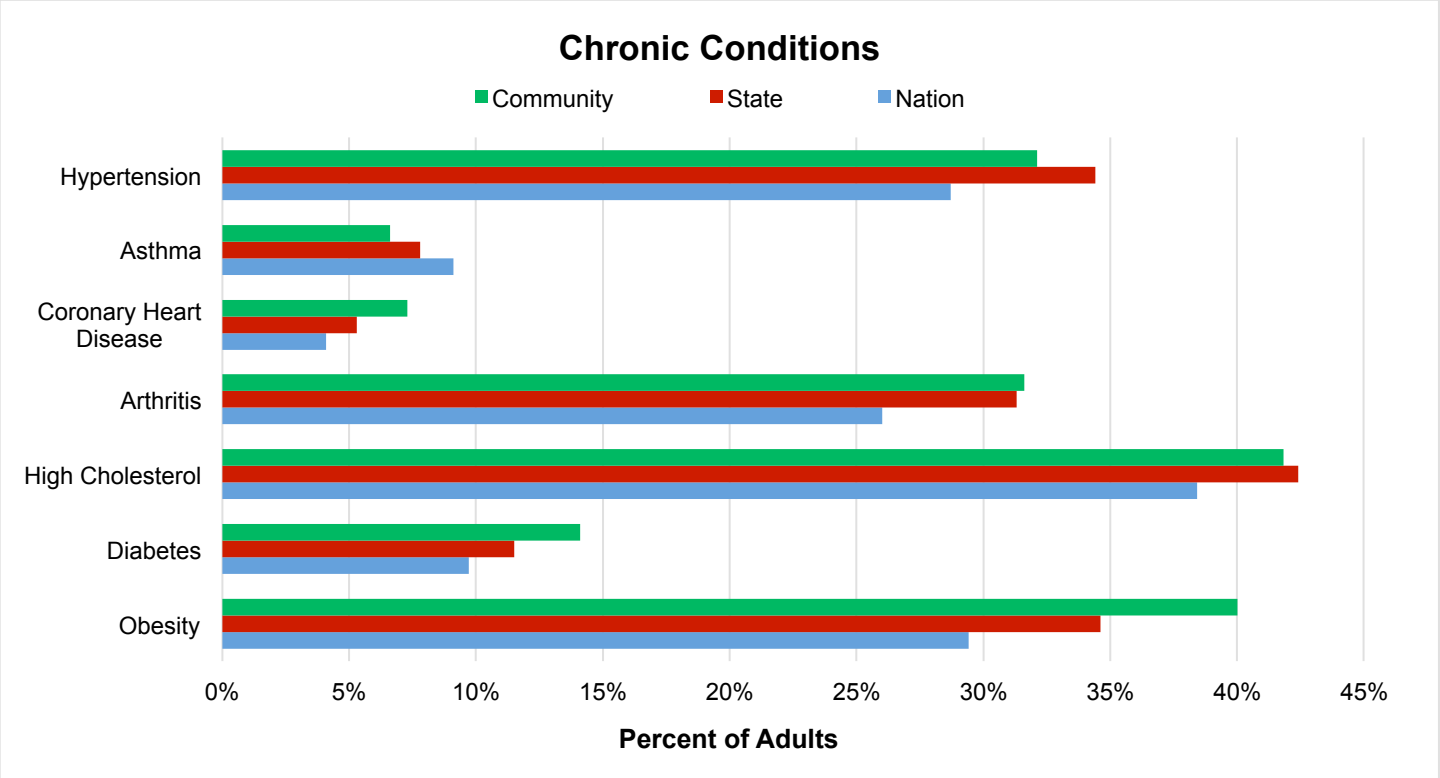
CAUSE OF DEATH

Measurement	Arkansas County	Lonoke County	Monroe County	Prairie County	Community Average	State Average	National Average
All-Cause Mortality All Causes per 100,000 (age-adjusted)	950.40	939.20	1029.50	845.00	941.03	891.60	729.60
Infant Mortality Rate of all infant deaths (within 1 year), per 1,000 live births	11.73	3.77	3.86	3.97	5.83	6.69	6.00
Cancer Neoplasms per 100,000 population (age-adjusted)	191.80	196.90	257.60	214.40	215.18	191.90	167.90
Stroke Cerebrovascular diseases per 100,000 population (age-adjusted)	54.00	50.20	71.10	23.20	49.63	47.40	36.50
Chronic Lower Respiratory Disease Chronic lower respiratory diseases per 100,000 population (age-adjusted)	59.11	57.36	50.36	56.08	55.73	57.05	NA
Diabetes Diabetes mellitus per 100,000 population (age-adjusted)	24.86	16.93	12.54	19.25	18.40	23.58	NA
Heart Disease Essential (primary) hypertension, hypertensive heart disease with (congestive) heart failure per 100,000 population (age-adjusted)	239.00	222.00	281.00	225.20	241.80	220.20	172.4
Injury-Related Accidents (unintentional injuries) per 100,000 population (age-adjusted)	50.70	50.30	59.60	70.70	57.83	46.90	39.10
Motor Vehicle Motor Vehicle Accidents per 100,000 population (age-adjusted)	16.24	21.98	29.48	46.36	28.52	17.40	NA
Alcohol Impaired Driving Percent of driving deaths with alcohol involved	38%	29%	37%	26%	33%	30%	31%



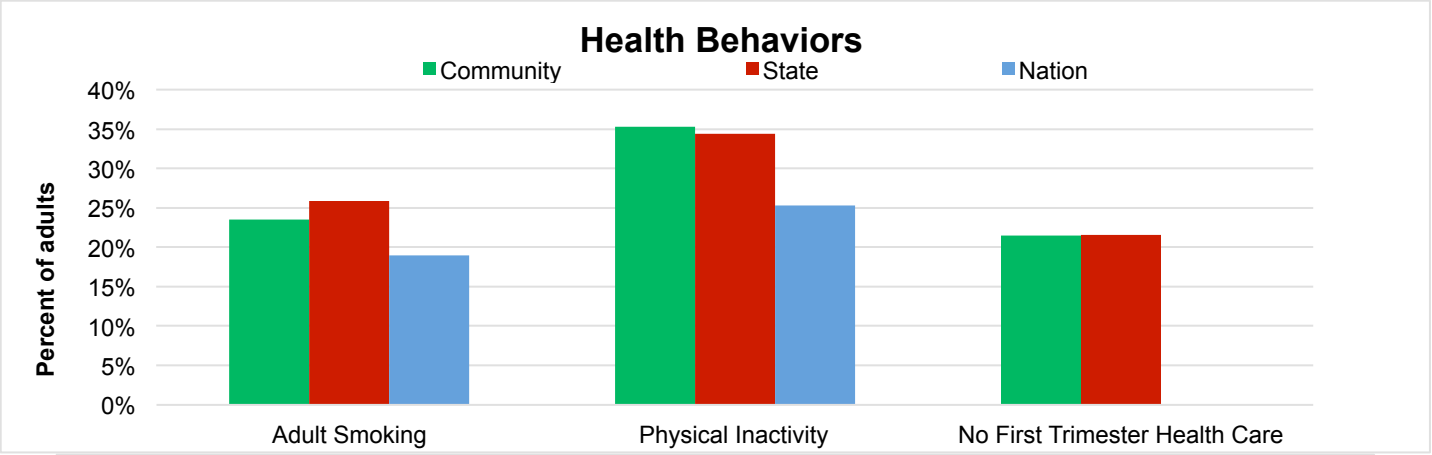
CHRONIC CONDITIONS

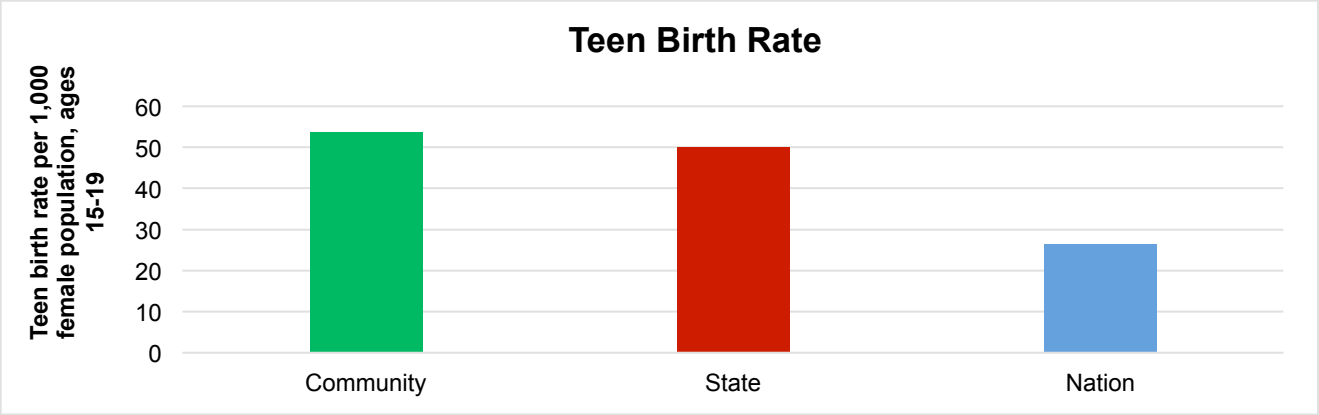
Measurement	Arkansas County	Lonoke County	Monroe County	Prairie County	Community Average	State Average	National Average
Hypertension Percent of adults who have been told they have high blood pressure	37.3%	34.3%	28.1%	28.7%	32.1%	34.4%	28.7%
Asthma Percent of adults who have been told they currently have asthma	5.4%	7.8%	8.0%	5.2%	6.6%	7.8%	9.1%
Coronary Heart Disease Percent of adults who have been told they have angina or coronary heart disease	6.9%	5.0%	9.4%	7.7%	7.3%	5.3%	4.1%
Arthritis Percent of adults who have been told they have arthritis	35.8%	29.0%	29.3%	32.3%	31.6%	31.3%	26.0%
High Cholesterol Percent of adults who have had their blood cholesterol checked and have been told it was high	38.9%	38.1%	52.3%	38.0%	41.8%	42.4%	38.4%
Diabetes Percent of adults reporting diabetes	12.4%	10.7%	19.4%	13.8%	14.1%	11.5%	9.7%
Adult Obesity Percent of adults who report a BMI higher than 30	38.1%	33.6%	45.6%	42.7%	40.0%	34.6%	29.4%
Childhood Obesity Percent of children who have a measured BMI for age greater than or equal to 95th percentile	25.8%	18.9%	23.7%	27.0%	23.8%	23.3%	NA



HEALTH BEHAVIORS

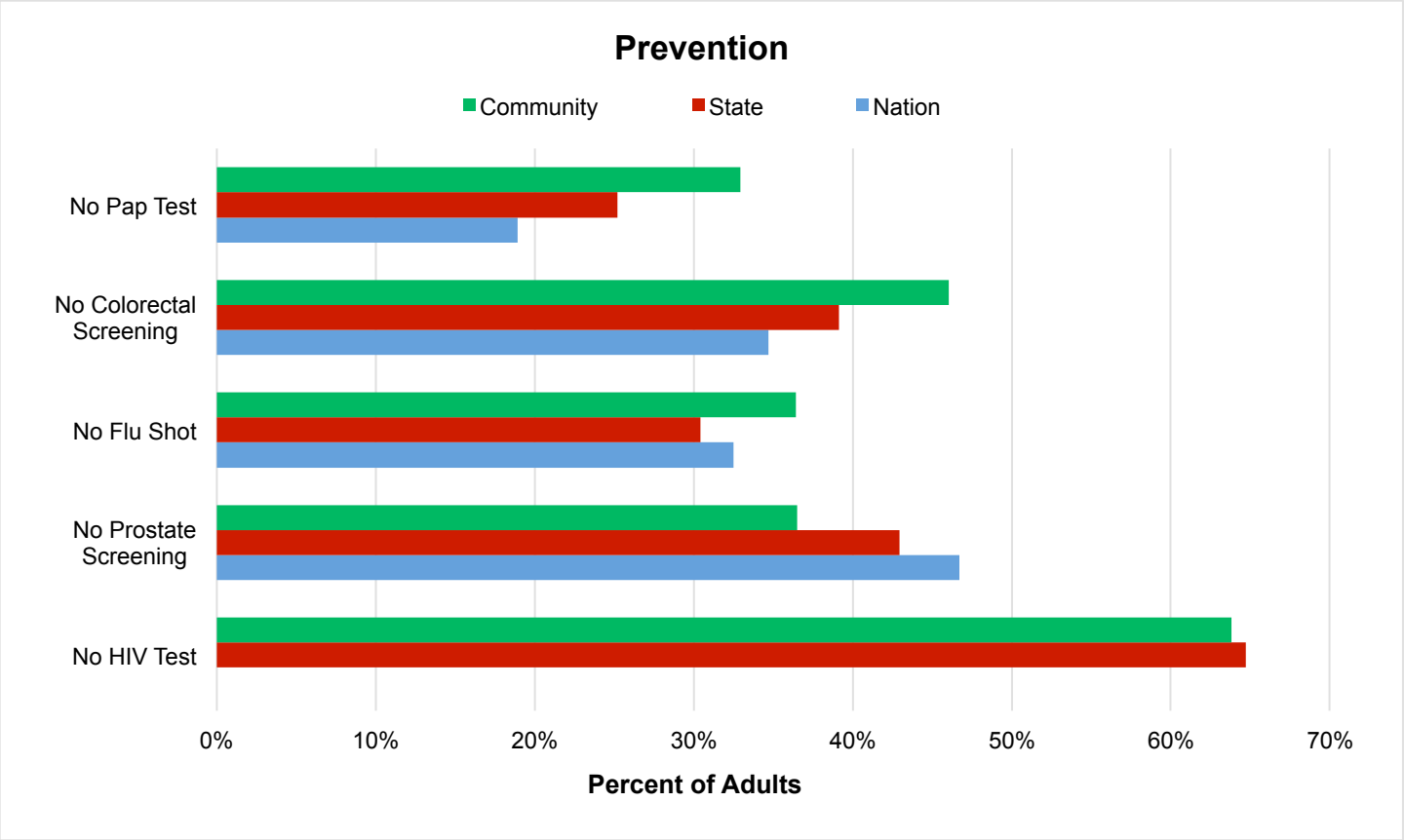
Measurement	Arkansas County	Lonoke County	Monroe County	Prairie County	Community Average	State Average	National Average
Adult Smoking Percent of adults who are current smokers	24.2%	23.1%	19.6%	26.9%	23.5%	25.9%	19.0%
Excessive Drinking Percent of adults reporting binge or heavy drinking	14.0%	16.0%	11.0%	13.0%	13.5%	15.0%	18.0%
Sexually Transmitted Infections Number of newly diagnosed chlamydia cases per 100,000 population	593	347	984	296	555	524	447
Fruit & Vegetable Consumption Percent of adults reporting not consuming recommended five servings of fruit and vegetables	89.8%	86.2%	89.8%	87.4%	88.3%	NA	NA
Physical Inactivity Percent of adults reporting no physical activity in the past month	35.7%	32.1%	36.6%	36.8%	35.3%	34.4%	25.3%
Teen Birth Rate Teen birth rate per 1,000 female population, ages 15-19	64.0	43.1	65.3	42.2	53.7	50.1	26.5
No First Trimester Health Care Percent of pregnant women who received no first trimester health care	31.1%	11.2%	23.3%	20.3%	21.5%	21.6%	NA





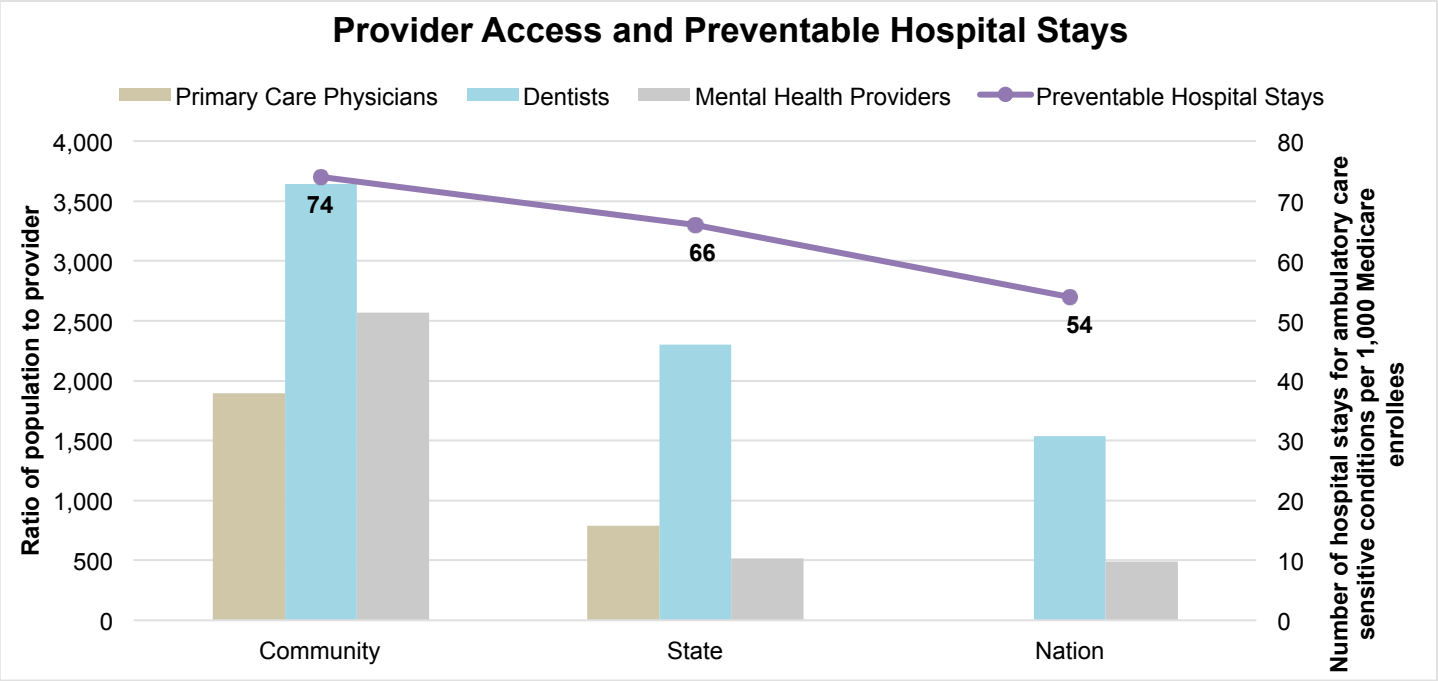
PREVENTION

Measurement	Arkansas County	Lonoke County	Monroe County	Prairie County	Community Average	State Average	National Average
No Pap Test Percent of women aged 18+ who have not had a pap test within the past 3 years	28.7%	25.6%	37.8%	39.5%	32.9%	25.2%	18.9%
No Colorectal Screening Percent of adults age 50+ who have never had either a sigmoidoscopy or colonoscopy	47.7%	35.6%	51.1%	49.5%	46.0%	39.1%	34.7%
No Flu Shot Percent of adults aged 65+ who have not had a flu shot in the past year	40.3%	29.4%	44.6%	31.3%	36.4%	30.4%	32.5%
No Prostate Screening Percent of men aged 40+ who have not had a PSA test within the past two years	32.7%	32.4%	42.8%	38.1%	36.5%	42.9%	46.7%
No HIV Test Percent of adults who have never been tested for HIV	63.8%	62.1%	62.9%	66.3%	63.8%	64.7%	NA



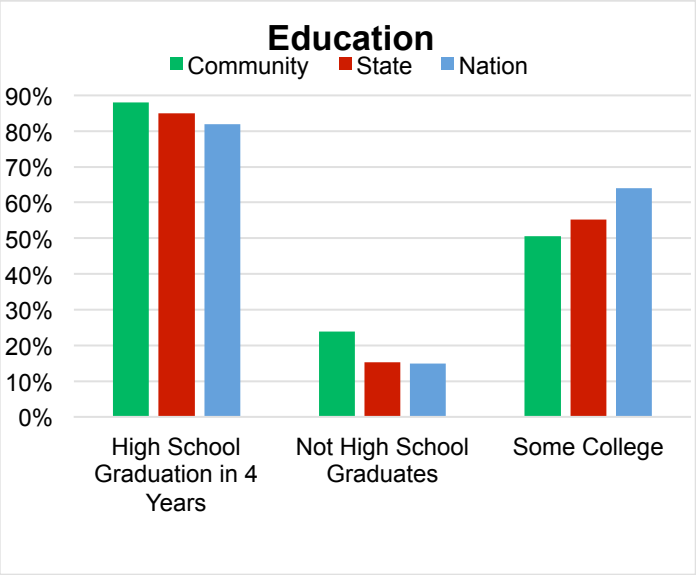
ACCESS

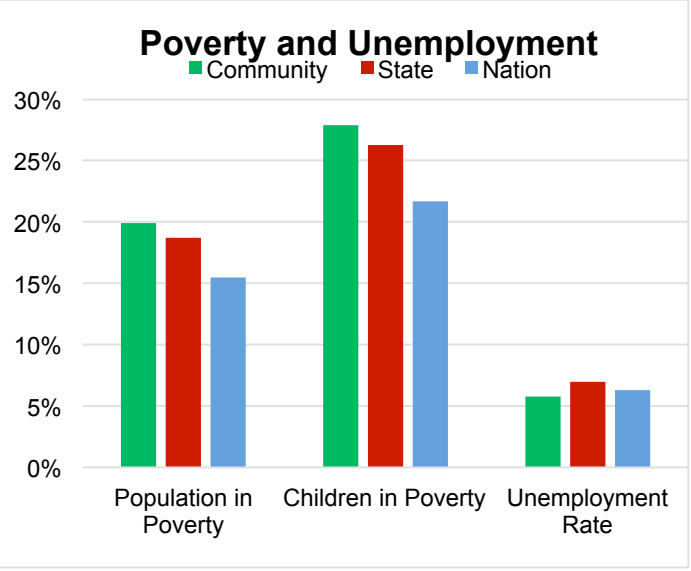
Measurement	Arkansas County	Lonoke County	Monroe County	Prairie County	Community Average	State Average	National Average
Uninsured Percent of non-institutionalized population uninsured	13.1%	12.7%	15.7%	15.4%	14.2%	15.8%	14.2%
Primary Care Physicians Ratio of population to primary care physicians (ratio to 1)	1,451	2,922	1,309	NA	1,894	792	NA
Dentists Ratio of population to dentists (ratio to 1)	2,656	3,975	3,791	4,152	3,644	2,303	1,540
Mental Health Providers Ratio of population to mental health providers (ratio to 1)	1,240	2,467	3,791	2,768	2,567	517	490
Preventable Hospital Stays Number of hospital stays for ambulatory care sensitive conditions per 1,000 Medicare enrollees	84	67	79	66	74	66	54
Mammography Percent of female Medicare enrollees ages 67-69 who receive mammography screening	48.0%	59.0%	62.0%	62.0%	57.8%	58.0%	63.0%
Diabetic Monitoring Percent of diabetic Medicare enrollees ages 65-75 who receive HbA1c monitoring	82.0%	83.0%	79.0%	81.0%	81.3%	83.0%	85.0%



SOCIAL AND ECONOMIC

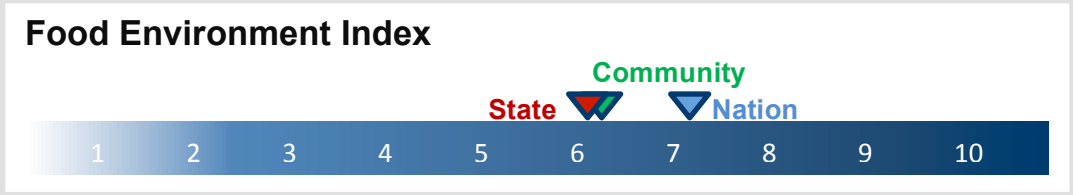
Measurement	Arkansas County	Lonoke County	Monroe County	Prairie County	Community Average	State Average	National Average
Not High School Graduates Percent age 18 to 24 years without a high school diploma	13.8%	16.2%	36.3%	29.1%	23.9%	15.3%	15.0%
High School Graduation in 4 years Percent of ninth-grade cohort that graduates in four years	88.0%	88.0%	NA	NA	88.0%	85.0%	82.0%
Some College Percent of adults ages 25-44 with some post-secondary education	47.6%	60.9%	45.5%	48.3%	50.6%	55.3%	64.0%
Unemployment Rate Number of unemployed people as a percent of the labor force	5.4%	5.2%	6.8%	5.9%	5.8%	7.00%	6.3%
Median Household Income	$36,409	$54,459	$30,682	$39,896	$40,362	$41,335	$53,657
Children in Poverty Percent of children under 18 below the federal poverty line	28.6%	17.6%	38.7%	26.7%	27.9%	26.3%	21.7%
Population in Poverty Percent of population below the federal poverty line	20.4%	12.3%	28.1%	18.7%	19.9%	18.7%	15.5%
Income Inequality Ratio of household income at the 80th percentile to income at 20th percentile	4.3	4.0	6.4	4.3	4.8	4.8	4.7
Children in Single-Parent Households Percent of children who live in a household headed by single parent	36%	28%	57%	34%	39%	37%	34%
Social Associations Number of membership associations per 10,000 population	17.0	7.6	10.4	14.3	12.3	12.0	9.0
Violent Crime Number of reported crime offenses per 100,000 population	411	350	345	84	298	484	392

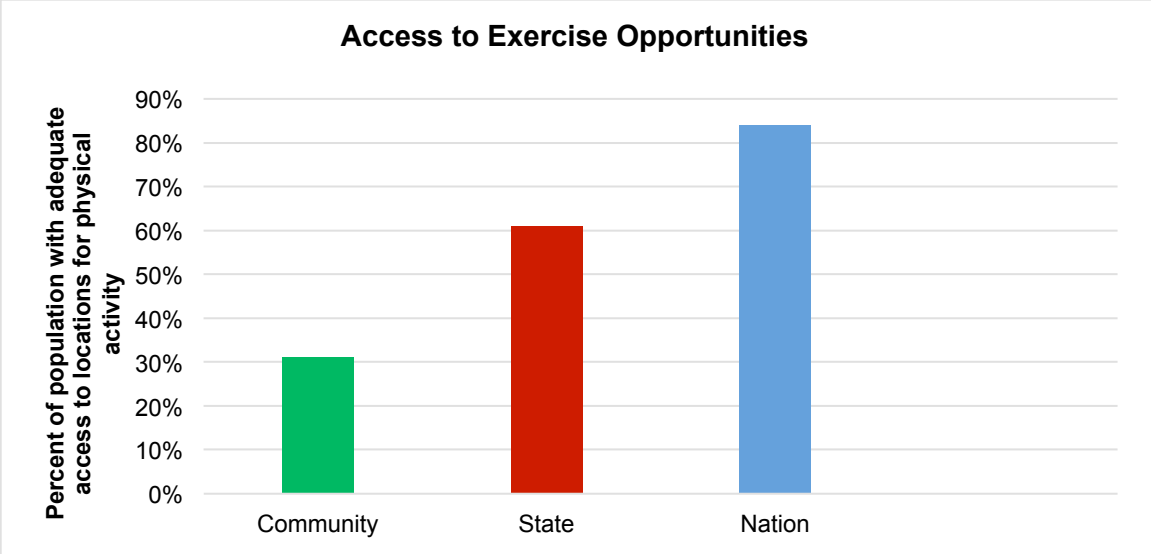




ENVIRONMENT

Measurement	Arkansas County	Lonoke County	Monroe County	Prairie County	Community Average	State Average	National Average
Food Environment Index Index of factors that contribute to a healthy food environment, 0 (worst) to 10 (best)	6.0	6.9	5.1	6.7	6.2	6.1	7.2
Access to Exercise Opportunities Percent of population with adequate access to locations for physical activity	48%	63%	7%	7%	31%	61%	84%
Air Pollution Average daily density of fine particulate matter in micrograms per cubic meter (PM2.5)	12.3	12.1	12.3	12.3	12.3	11.8	11.1
Drinking Water Violations Percent of population potentially exposed to water exceeding a violation limit during the last year	2%	0%	34%	0%	9%	9%	7%
Severe Housing Problems Percent of households with at least 1 of 4 housing problems: overcrowding, high housing costs, or lack of kitchen or plumbing	10%	11%	15%	11%	12%	15%	19%
Driving Alone to Work Percent of the workforce who drive alone to work	82%	83%	77%	80%	81%	82%	76%
Long Commute - Driving Alone Among workers who commute in their car alone, the percent who commute more than 30 minutes	16%	44%	30%	37%	32%	26%	31%

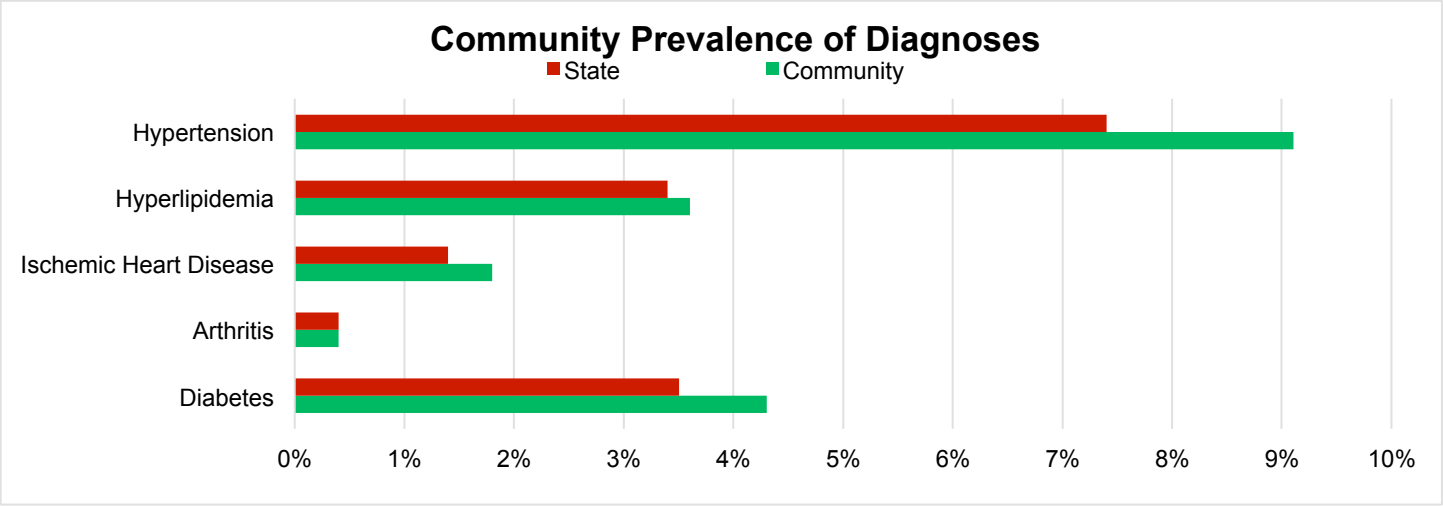




COMMUNITY PREVALENCE OF DIAGNOSES

Measurement*	Arkansas County	Lonoke County	Monroe County	Prairie County	Community Average	State Average
Hypertension	9.2%	7.5%	10.1%	9.5%	9.1%	7.4%
Hyperlipidemia	3.4%	3.1%	3.8%	3.9%	3.6%	3.4%
Ischemic Heart Disease	1.6%	1.6%	1.9%	2.1%	1.8%	1.4%
Arthritis	0.4%	0.5%	0.3%	0.6%	0.4%	0.4%
Diabetes	4.4%	3.6%	4.5%	4.7%	4.3%	3.5%

*Number of individuals discharged for a primary or secondary diagnoses as a percent of the population (18 years and older)



Produced on behalf of Baptist Health by the Arkansas Center for Health Improvement.

Baptist Health 2016 Community Health Needs Assessment: MALVERN

Quantitative results from the 2016 Baptist Health Community Health Needs Assessment for the Malvern hospital are reported below. There are ten sections including: Demographics, Health Outcomes, Cause of Death, Chronic Conditions, Health Behaviors, Prevention, Access, Social and Economic, Environment, and Community Prevalence of Diagnoses. Each section includes a table with health indicator data for Hot Spring County (the hospital community) and averages for the State of Arkansas and the United States. If data were not available, a "NA" is displayed. Each section also includes graphics for various health indicator data. For more detailed information on methods and resources used, please reference the Methods section and Appendix 1.

DEMOGRAPHICS

Sex and Age

	Hot Spring County	State	Nation
Total Population	33,277	2,947,036	314,107,084
Percent Male	51.0%	49.1%	49.2%
Percent Female	49.0%	50.9%	50.8%
Age: 0 to 14	17.8%	20.1%	19.5%
Age: 15 to 19	6.3%	6.8%	6.8%
Age: under 18	22.2%	24.1%	23.5%
Age: 20 to 24	6.3%	7.0%	7.1%
Age: 25 to 34	12.8%	13.0%	13.5%
Age: 35 to 44	12.3%	12.5%	13.0%
Age: 45 to 54	14.1%	13.4%	14.1%
Age: 55 to 64	13.8%	12.3%	12.3%
Age: 65 and older	16.5%	15.0%	13.7%

Ethnicity

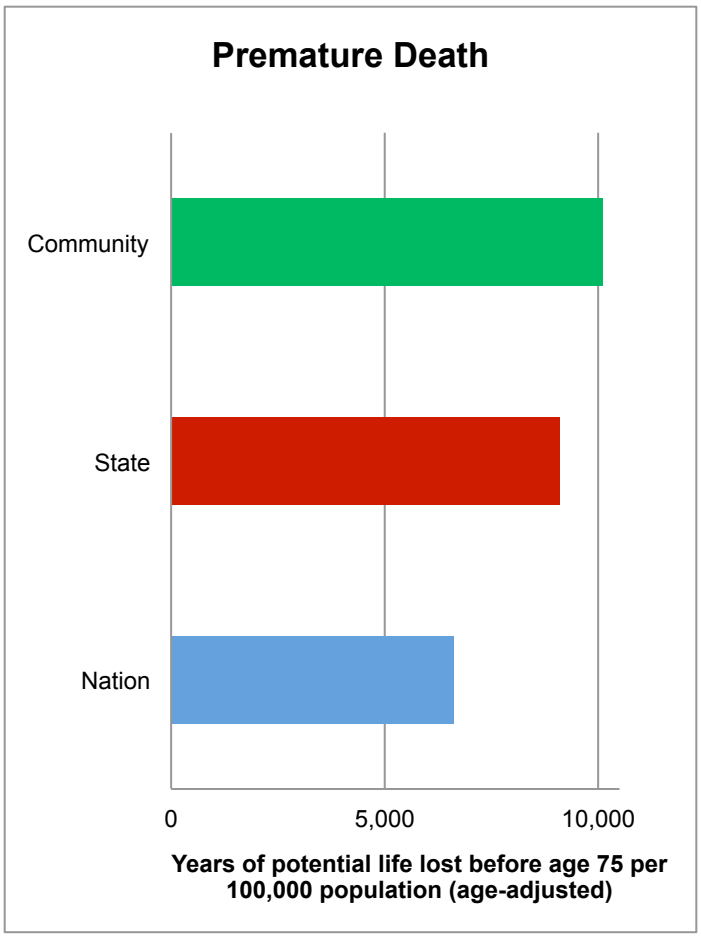
		Hot Spring County	State	Nation
Total Population		33,277	2,947,036	314,107,084
Hispanic		3.0%	6.7%	16.9%
Non-Hispanic	White	83.3%	73.9%	62.8%
	Black or African American	11.8%	15.5%	12.2%
	American Indian and Alaska	0.5%	0.6%	0.7%
	Asian	0.1%	1.3%	4.9%
	Pacific Islander	0.0%	0.2%	0.2%
	Other	0.0%	0.1%	0.2%
	Multiracial	1.2%	1.8%	2.1%

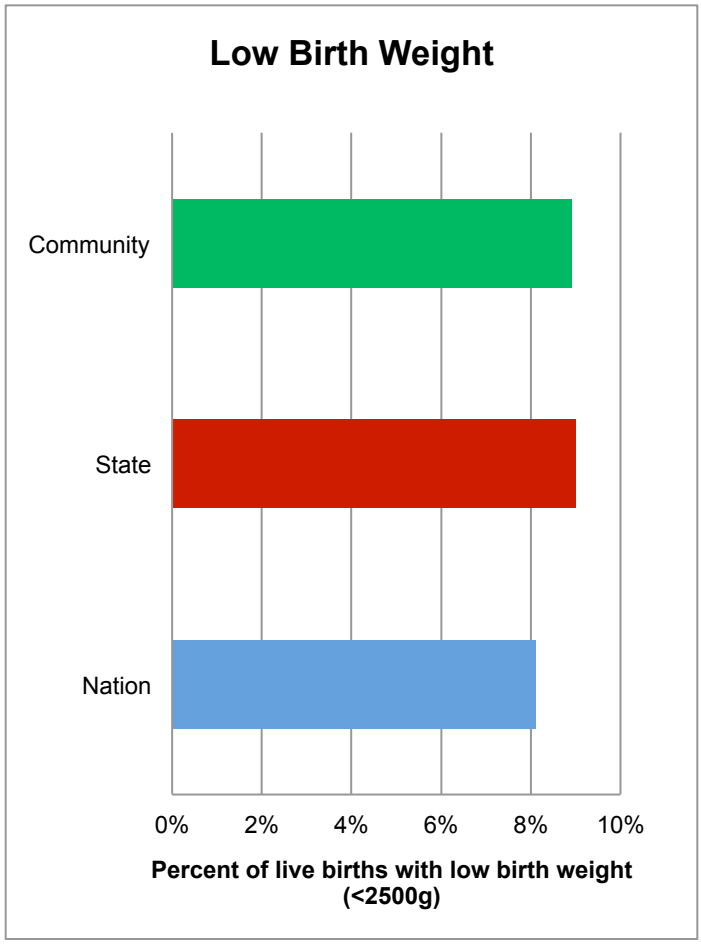
Insurance Coverage

	Hot Spring County	State	Nation
Health Insurance Coverage	83.4%	84.2%	85.8%
Private Health Insurance Coverage	59.3%	59.1%	65.8%
Public Health Insurance Coverage	38.5%	37.2%	31.1%

HEALTH OUTCOMES

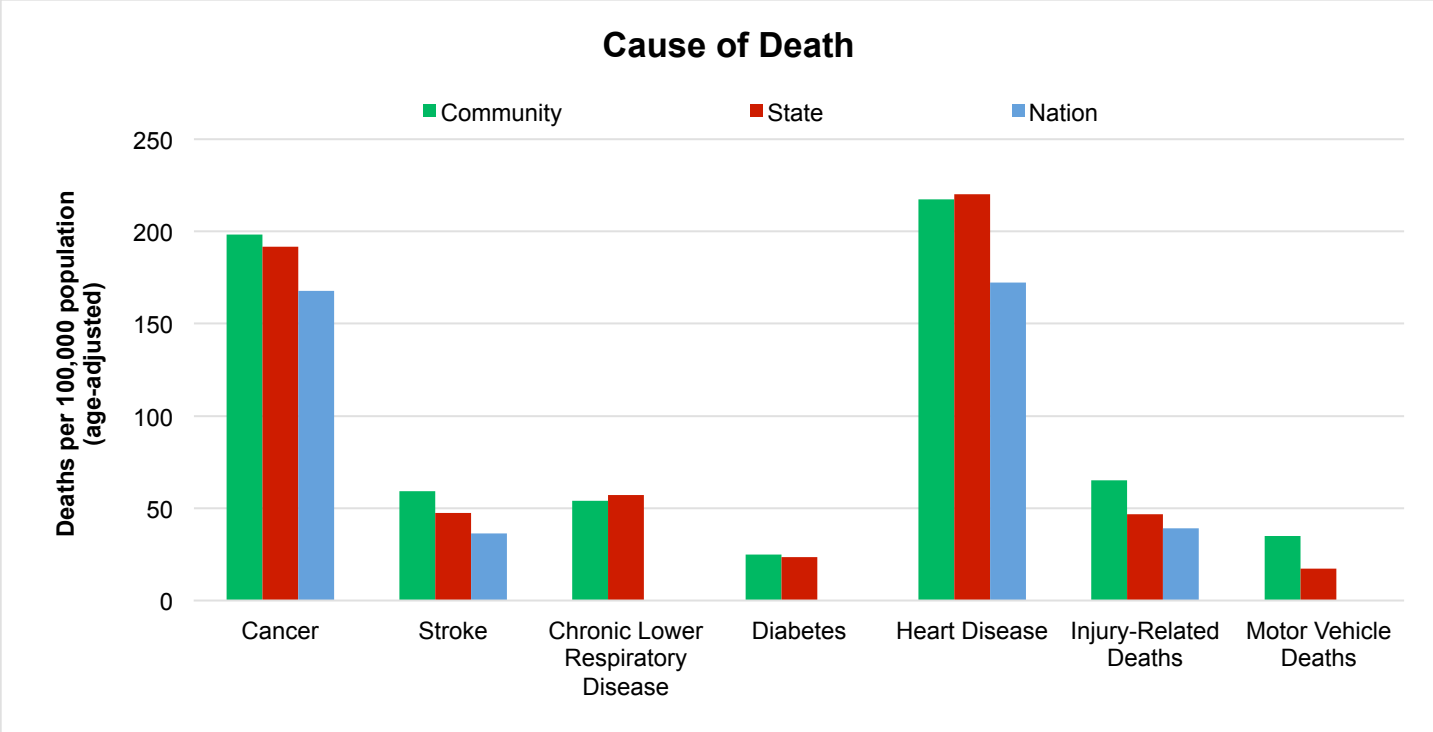
Measurement	Hot Spring County	State Average	National Average
Premature Death Years of potential life lost before age 75 per 100,000 population (age-adjusted)	10,096	9,099	6,600
Poor or Fair Health Status Percent of adults reporting fair or poor health (age-adjusted)	19.0%	21.0%	14.0%
Poor Physical Health Days Average number of physically unhealthy days reported in past 30 days (age adjusted)	4.4	4.6	3.5
Poor Mental Health Days Average number of mentally unhealthy days reported in past 30 days (age-adjusted)	4.0	4.2	3.5
Low Birth Weight Percent of live births with low birth weight (<2500g)	8.9%	9.0%	8.1%





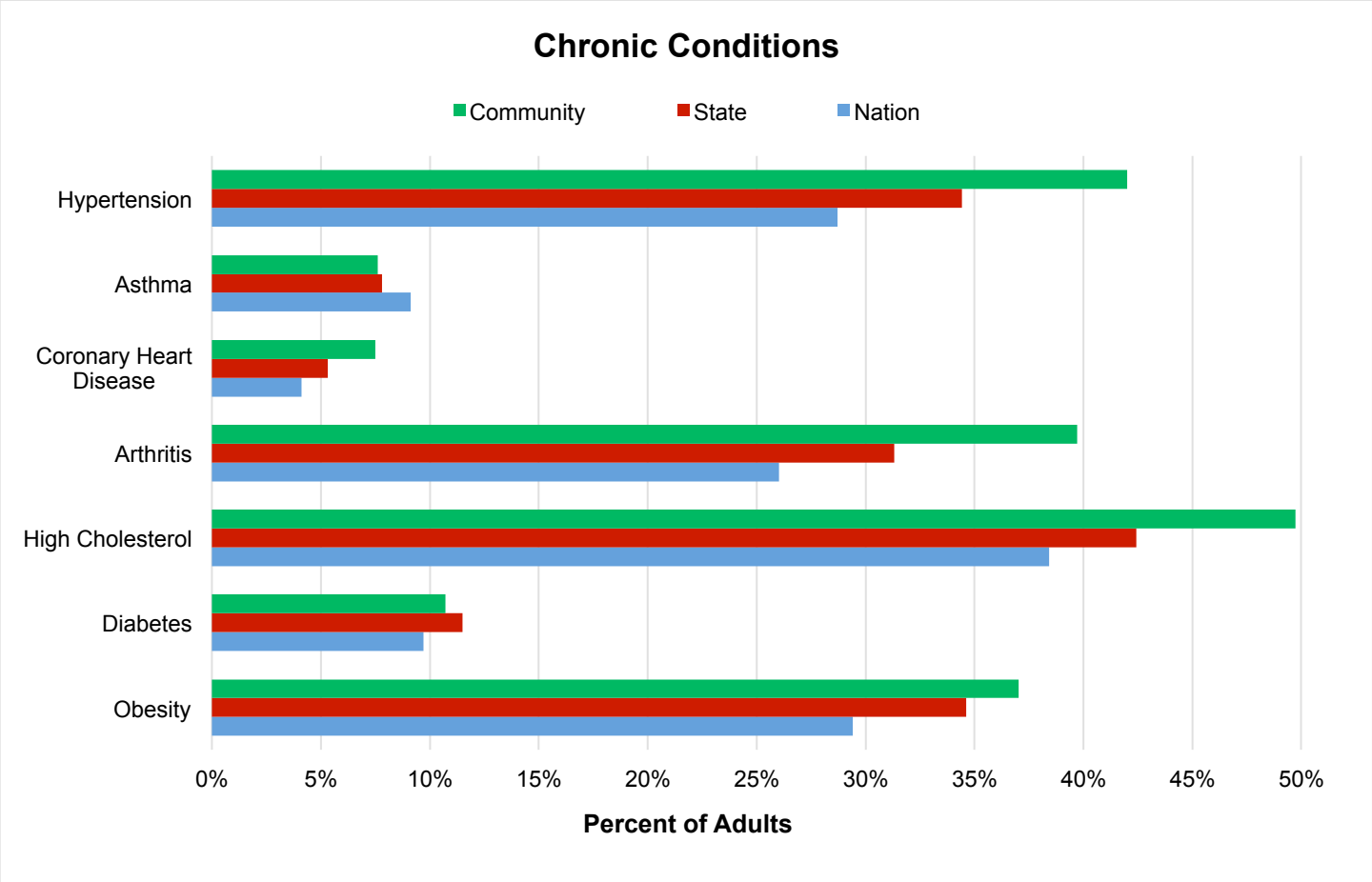
CAUSE OF DEATH

Measurement	Hot Spring County	State Average	National Average
All-Cause Mortality All Causes per 100,000 (age-adjusted)	964.00	891.60	729.60
Infant Mortality Rate of all infant deaths (within 1 year), per 1,000 live births	5.75	6.69	6.00
Cancer Neoplasms per 100,000 population (age-adjusted)	198.30	191.90	167.90
Stroke Cerebrovascular diseases per 100,000 population (age-adjusted)	59.10	47.40	36.50
Chronic Lower Respiratory Disease Chronic lower respiratory diseases per 100,000 population (age-adjusted)	53.88	57.05	NA
Diabetes Diabetes mellitus per 100,000 population (age-adjusted)	24.84	23.58	NA
Heart Disease Essential (primary) hypertension, hypertensive heart disease with (congestive) heart failure per 100,000 population (age-adjusted)	217.40	220.20	172.4
Injury-Related Accidents (unintentional injuries) per 100,000 population (age-adjusted)	65.30	46.90	39.10
Motor Vehicle Motor Vehicle Accidents per 100,000 population (age-adjusted)	34.87	17.40	NA
Alcohol Impaired Driving Percent of driving deaths with alcohol involved	17%	30%	31%



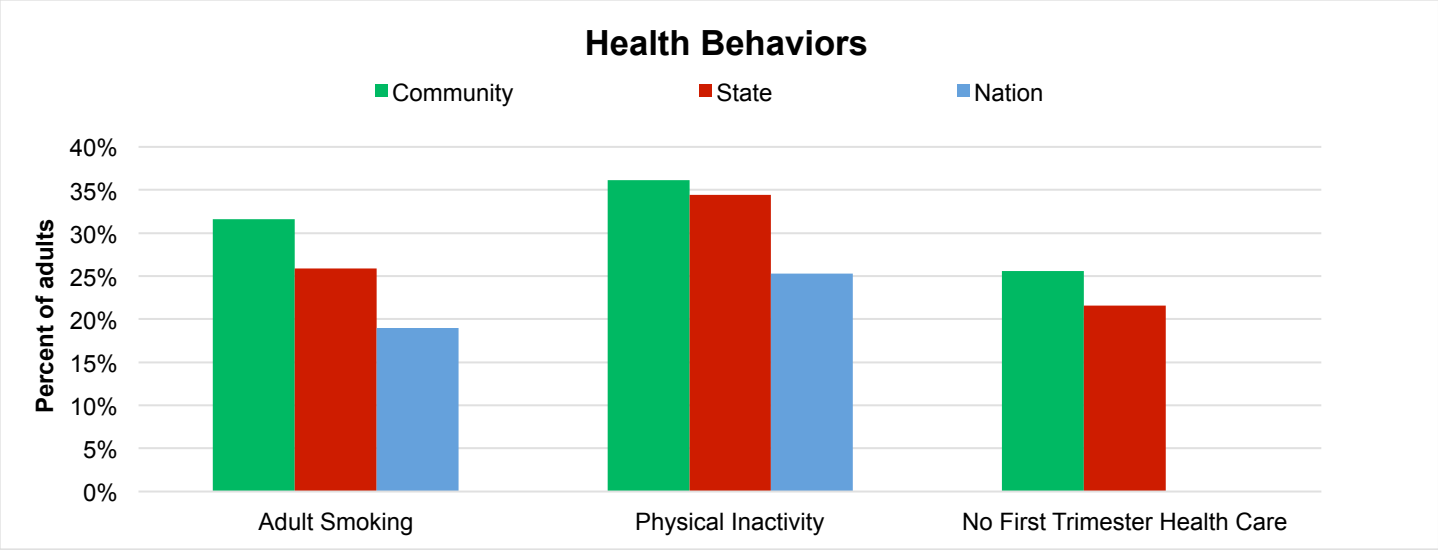
CHRONIC CONDITIONS

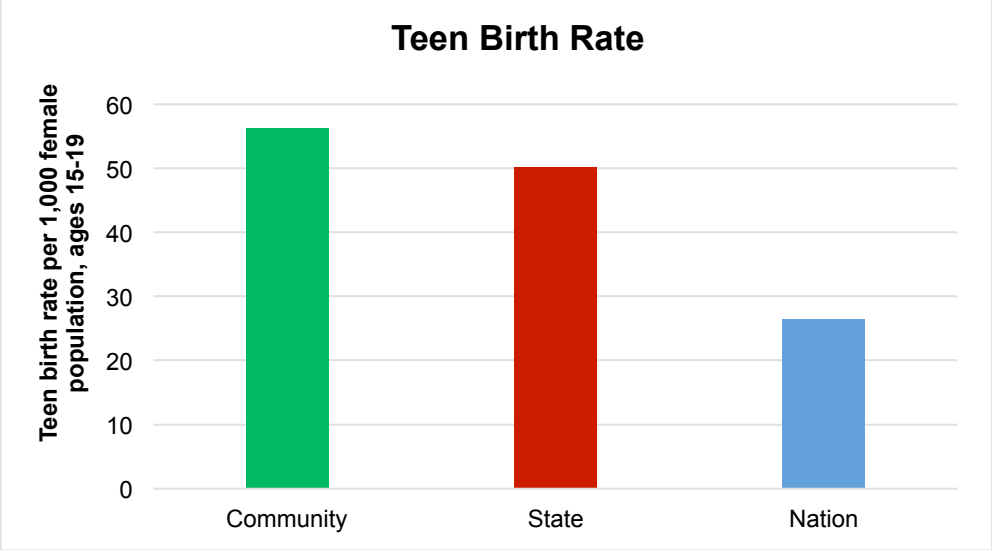
Measurement	Hot Spring County	State Average	National Average
Hypertension Percent of adults who have been told they have high blood pressure	42.0%	34.4%	28.7%
Asthma Percent of adults who have been told they currently have asthma	7.6%	7.8%	9.1%
Coronary Heart Disease Percent of adults who have been told they have angina or coronary heart disease	7.5%	5.3%	4.1%
Arthritis Percent of adults who have been told they have arthritis	39.7%	31.3%	26.0%
High Cholesterol Percent of adults who have had their blood cholesterol checked and have been told it was high	49.7%	42.4%	38.4%
Diabetes Percent of adults reporting diabetes	10.7%	11.5%	9.7%
Adult Obesity Percent of adults who report a BMI higher than 30	37.0%	34.6%	29.4%
Childhood Obesity Percent of children who have a measured BMI for age greater than or equal to 95th percentile	25.1%	23.3%	NA



HEALTH BEHAVIORS

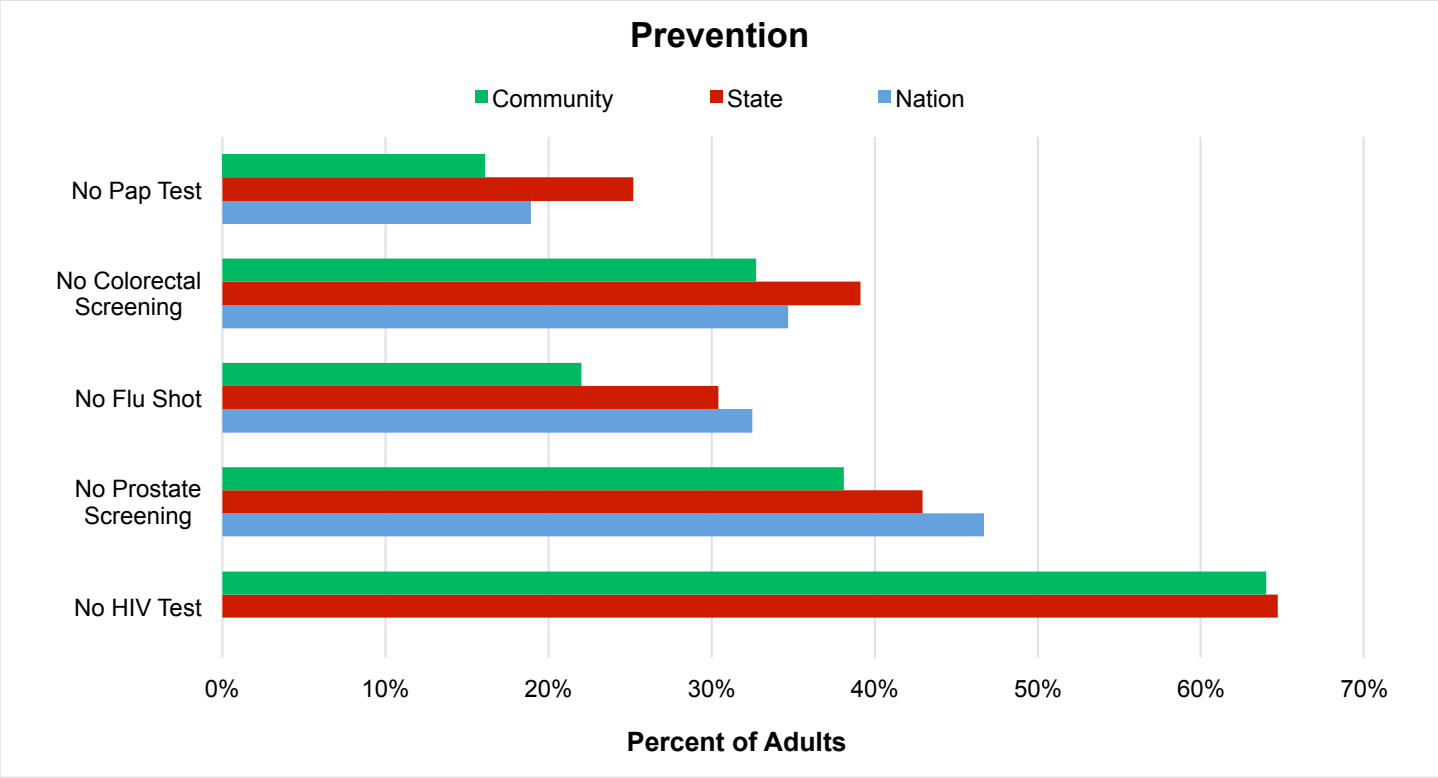
Measurement	Hot Spring County	State Average	National Average
Adult Smoking Percent of adults who are current smokers	31.6%	25.9%	19.0%
Excessive Drinking Percent of adults reporting binge or heavy drinking	16.0%	15.0%	18.0%
Sexually Transmitted Infections Number of newly diagnosed chlamydia cases per 100,000 population	407	524	447
Fruit & Vegetable Consumption Percent of adults reporting not consuming recommended five servings of fruit and vegetables	89.1%	NA	NA
Physical Inactivity Percent of adults reporting no physical activity in the past month	36.1%	34.4%	25.3%
Teen Birth Rate Teen birth rate per 1,000 female population, ages 15-19	56.2	50.1	26.5
No First Trimester Health Care Percent of pregnant women who received no first trimester health care	25.6%	21.6%	NA





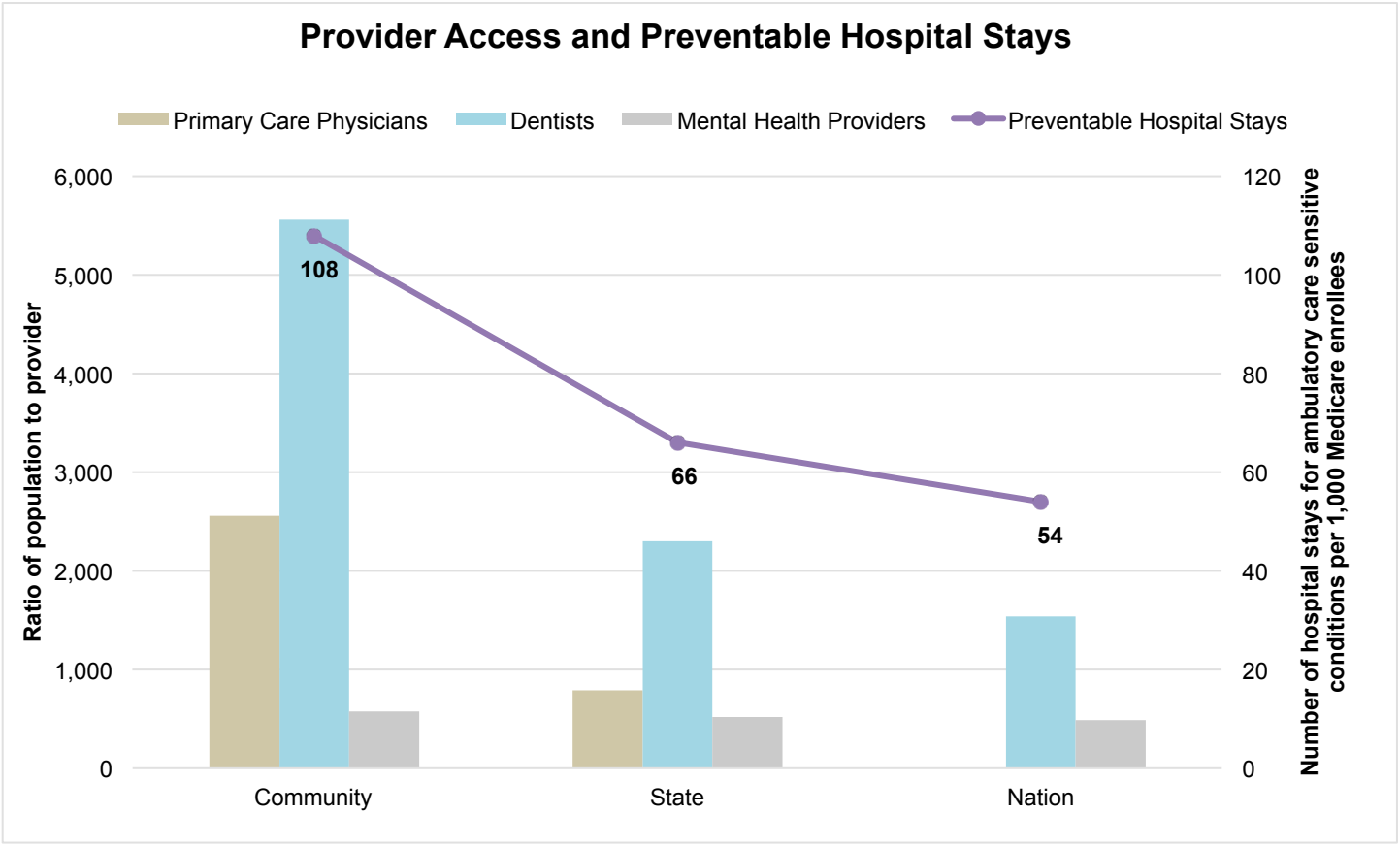
PREVENTION

Measurement	Hot Spring County	State Average	National Average
No Pap Test Percent of women aged 18+ who have not had a pap test within the past 3 years	16.1%	25.2%	18.9%
No Colorectal Screening Percent of adults age 50+ who have never had either a sigmoidoscopy or colonoscopy	32.7%	39.1%	34.7%
No Flu Shot Percent of adults aged 65+ who have not had a flu shot in the past year	22.0%	30.4%	32.5%
No Prostate Screening Percent of men aged 40+ who have not had a PSA test within the past two years	38.1%	42.9%	46.7%
No HIV Test Percent of adults who have never been tested for HIV	64.0%	64.7%	NA



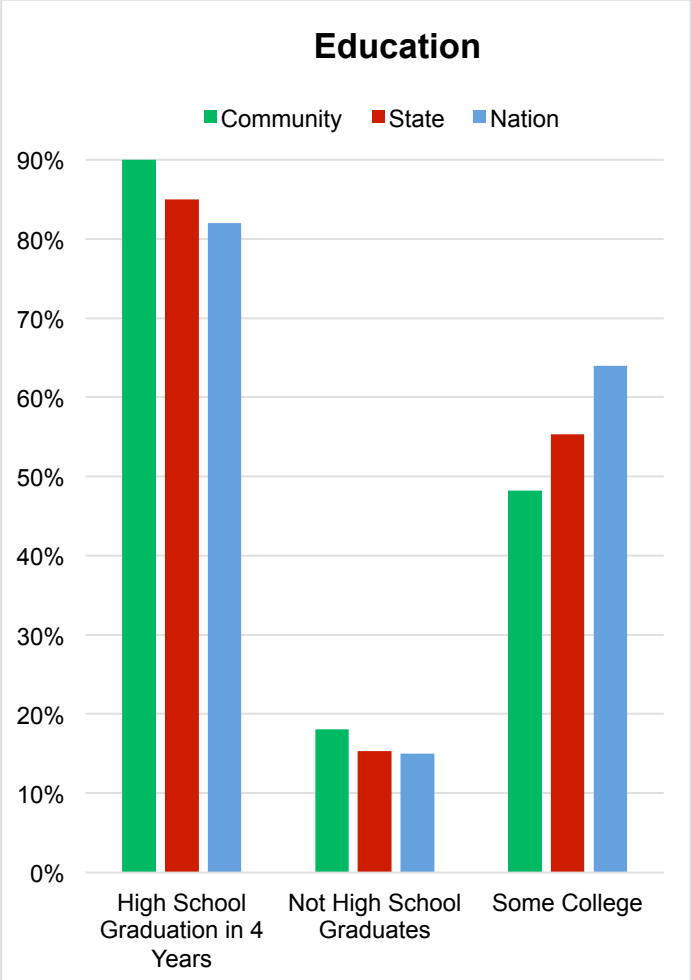
ACCESS

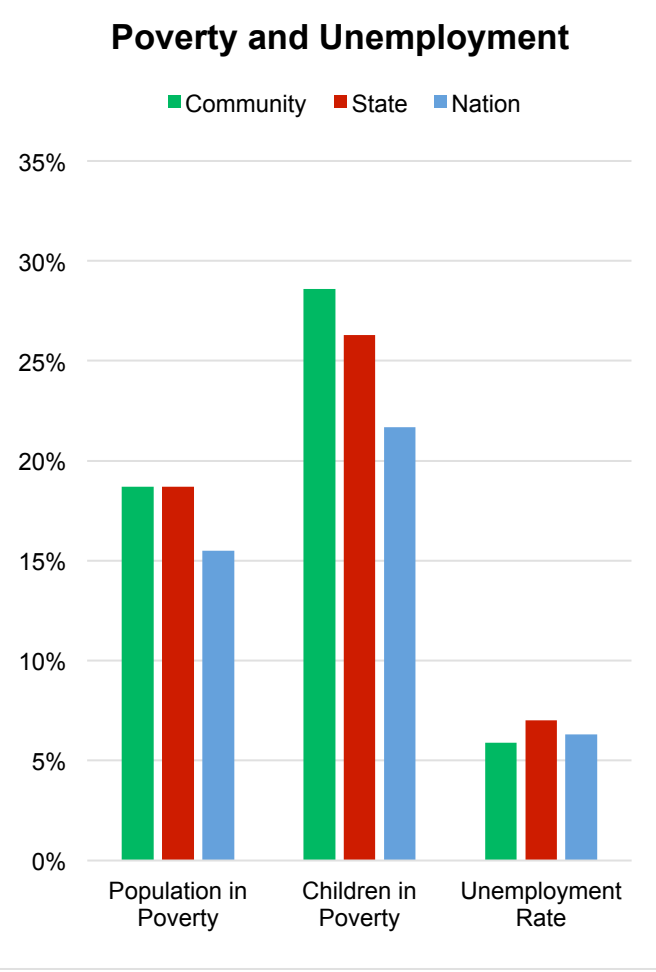
Measurement	Hot Spring County	State Average	National Average
Uninsured Percent of non-institutionalized population uninsured	16.6%	15.8%	14.2%
Primary Care Physicians Ratio of population to primary care physicians (ratio to 1)	2,560	792	NA
Dentists Ratio of population to dentists (ratio to 1)	5,561	2,303	1,540
Mental Health Providers Ratio of population to mental health providers (ratio to 1)	575	517	490
Preventable Hospital Stays Number of hospital stays for ambulatory care sensitive conditions per 1,000 Medicare enrollees	108	66	54
Mammography Percent of female Medicare enrollees ages 67-69 who receive mammography screening	45.0%	58.0%	63.0%
Diabetic Monitoring Percent of diabetic Medicare enrollees ages 65-75 who receive HbA1c monitoring	82.0%	83.0%	85.0%



SOCIAL AND ECONOMIC

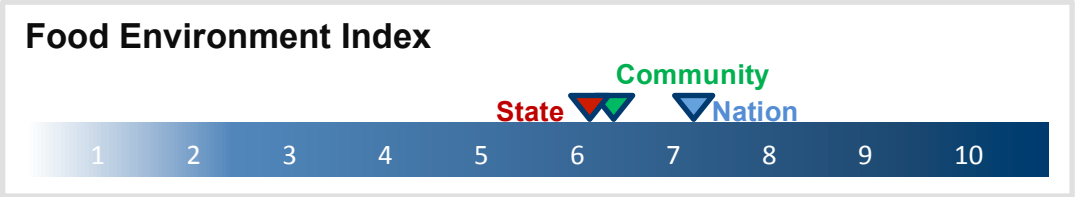
Measurement	Hot Spring County	State Average	National Average
Not High School Graduates Percent age 18 to 24 years without a high school diploma	18.1%	15.3%	15.0%
High School Graduation in 4 years Percent of ninth-grade cohort that graduates in four years	90.0%	85.0%	82.0%
Some College Percent of adults ages 25-44 with some post-secondary education	48.2%	55.3%	64.0%
Unemployment Rate Number of unemployed people as a percent of the labor force	5.9%	7.00%	6.3%
Median Household Income	$37,831	$41,335	$53,657
Children in Poverty Percent of children under 18 below the federal poverty line	28.6%	26.3%	21.7%
Population in Poverty Percent of population below the federal poverty line	18.7%	18.7%	15.5%
Income Inequality Ratio of household income at the 80th percentile to income at 20th percentile	4.4	4.8	4.7
Children in Single-Parent Households Percent of children who live in a household headed by a single parent	37%	37%	34%
Social Associations Number of membership associations per 10,000 population	11.0	12.0	9.0
Violent Crime Number of reported crime offenses per 100,000 population	NA	484	392

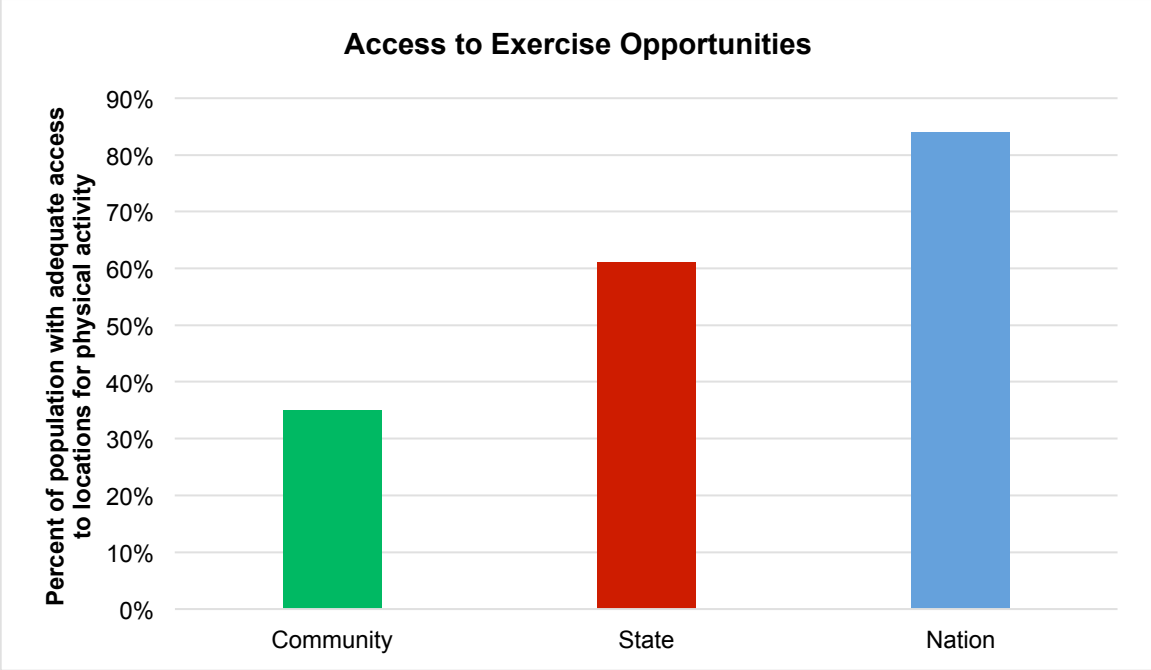




ENVIRONMENT

Measurement	Hot Spring County	State Average	National Average
Food Environment Index Index of factors that contribute to a healthy food environment, 0 (worst) to 10 (best)	6.3	6.1	7.2
Access to Exercise Opportunities Percent of population with adequate access to locations for physical activity	35%	61%	84%
Air Pollution Average daily density of fine particulate matter in micrograms per cubic meter (PM2.5)	11.6	11.8	11.1
Drinking Water Violations Percent of population potentially exposed to water exceeding a violation limit during the last year	16%	9%	7%
Severe Housing Problems Percent of households with at least 1 of 4 housing problems: overcrowding, high housing costs, or lack of kitchen or plumbing	12%	15%	19%
Driving Alone to Work Percent of the workforce who drive alone to work	85%	82%	76%
Long Commute - Driving Alone Among workers who commute in their car alone, the percent who commute more than 30 minutes	43%	26%	31%

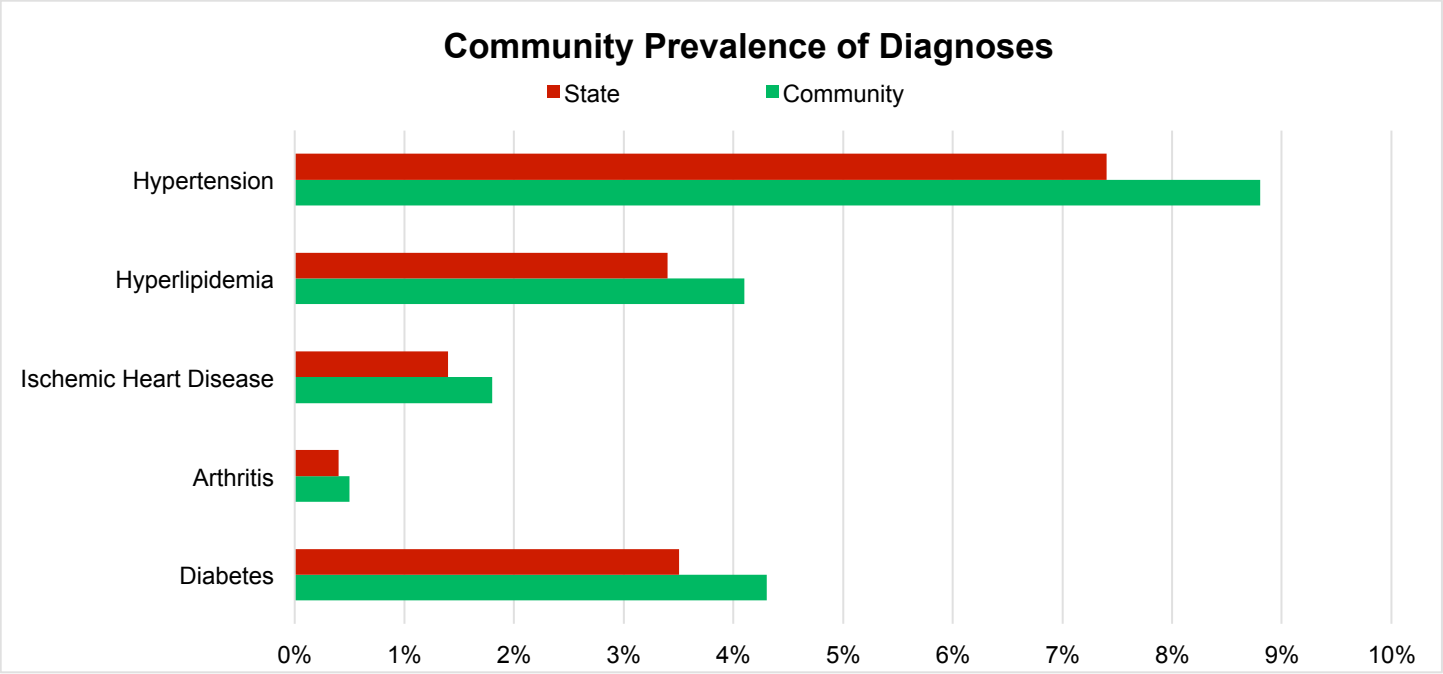




COMMUNITY PREVALENCE OF DIAGNOSES

Measurement*	Hot Spring County	State Average
Hypertension	8.8%	7.4%
Hyperlipidemia	4.1%	3.4%
Ischemic Heart Disease	1.8%	1.4%
Arthritis	0.5%	0.4%
Diabetes	4.3%	3.5%

*Number of individuals discharged for a primary or secondary diagnoses as a percent of the population (18 years and older)



Produced on behalf of Baptist Health by the Arkansas Center for Health Improvement.

Baptist Health 2016 Community Health Needs Assessment: CONWAY

Quantitative results from the 2016 Baptist Health Community Health Needs Assessment for the Conway hospital are reported below. There are ten sections including: Demographics, Health Outcomes, Cause of Death, Chronic Conditions, Health Behaviors, Prevention, Access, Social and Economic, Environment, and Community Prevalence of Diagnoses. Each section includes a table with health indicator data for each county in the hospital community, community averages (mean of all hospital counties), and averages for the State of Arkansas and the United States. If data were not available, a "NA" is displayed. Each section also includes graphics for various health indicator data. For more detailed information on methods and resources used, please reference the Methods section and Appendix 1.

DEMOGRAPHICS

Sex and Age

	Faulkner County	Perry County	State	Nation
Total Population	117,804	10,350	2,947,036	314,107,084
Percent Male	49.0%	50.0%	49.1%	49.2%
Percent Female	51.0%	50.0%	50.9%	50.8%
Age: 0 to 14	20.3%	18.0%	20.1%	19.5%
Age: 15 to 19	7.8%	6.7%	6.8%	6.8%
Age: under 18	24.2%	22.5%	24.1%	23.5%
Age: 20 to 24	11.7%	5.6%	7.0%	7.1%
Age: 25 to 34	14.7%	11.0%	13.0%	13.5%
Age: 35 to 44	12.7%	12.0%	12.5%	13.0%
Age: 45 to 54	12.4%	14.7%	13.4%	14.1%
Age: 55 to 64	10.0%	14.3%	12.3%	12.3%
Age: 65 and older	10.5%	17.6%	15.0%	13.7%

Ethnicity

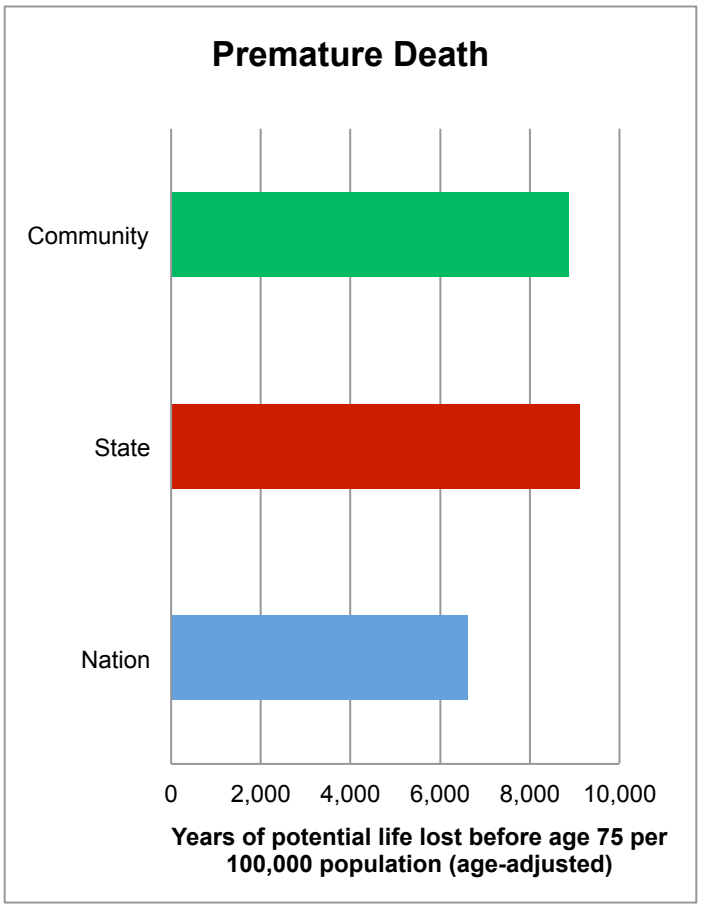
		Faulkner County	Perry County	State	Nation
Total Population		117,804	10,350	2,947,036	314,107,084
Hispanic		4.0%	2.7%	6.7%	16.9%
Non-Hispanic	White	81.8%	92.9%	73.9%	62.8%
	Black or African American	10.9%	3.0%	15.5%	12.2%
	American Indian and Alaska Native	0.3%	0.2%	0.6%	0.7%
	Asian	1.2%	0.1%	1.3%	4.9%
	Pacific Islander	0.0%	0.0%	0.2%	0.2%
	Other	0.1%	0.0%	0.1%	0.2%
	Multiracial	1.7%	1.1%	1.8%	2.1%

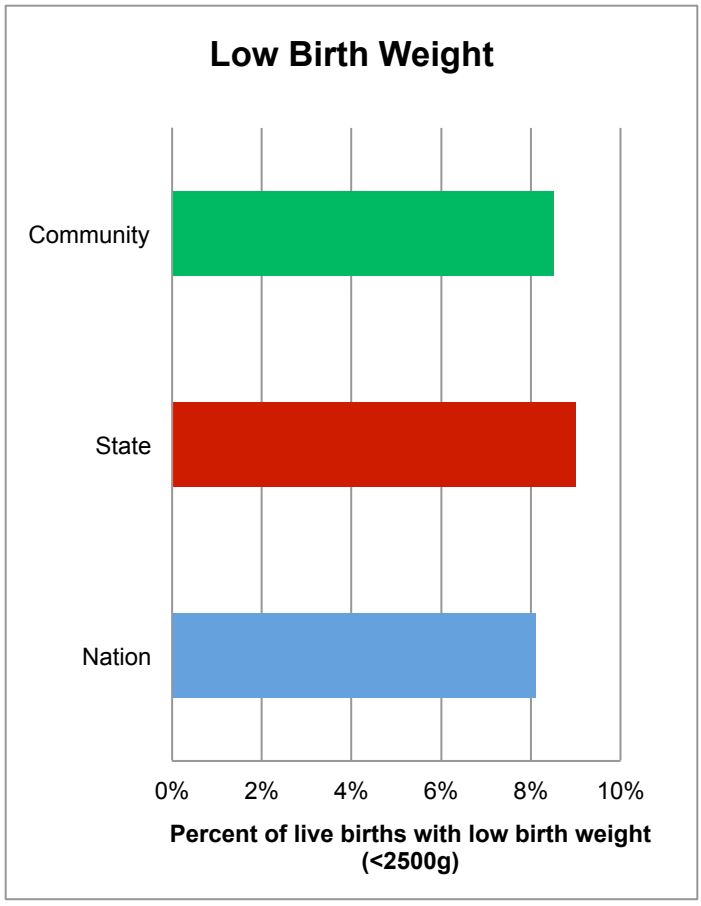
Insurance Coverage

	Faulkner County	Perry County	State	Nation
Health Insurance Coverage	86.2%	88.8%	84.2%	85.8%
Private Health Insurance Coverage	68.5%	62.5%	59.1%	65.8%
Public Health Insurance Coverage	27.7%	39.9%	37.2%	31.1%

HEALTH OUTCOMES

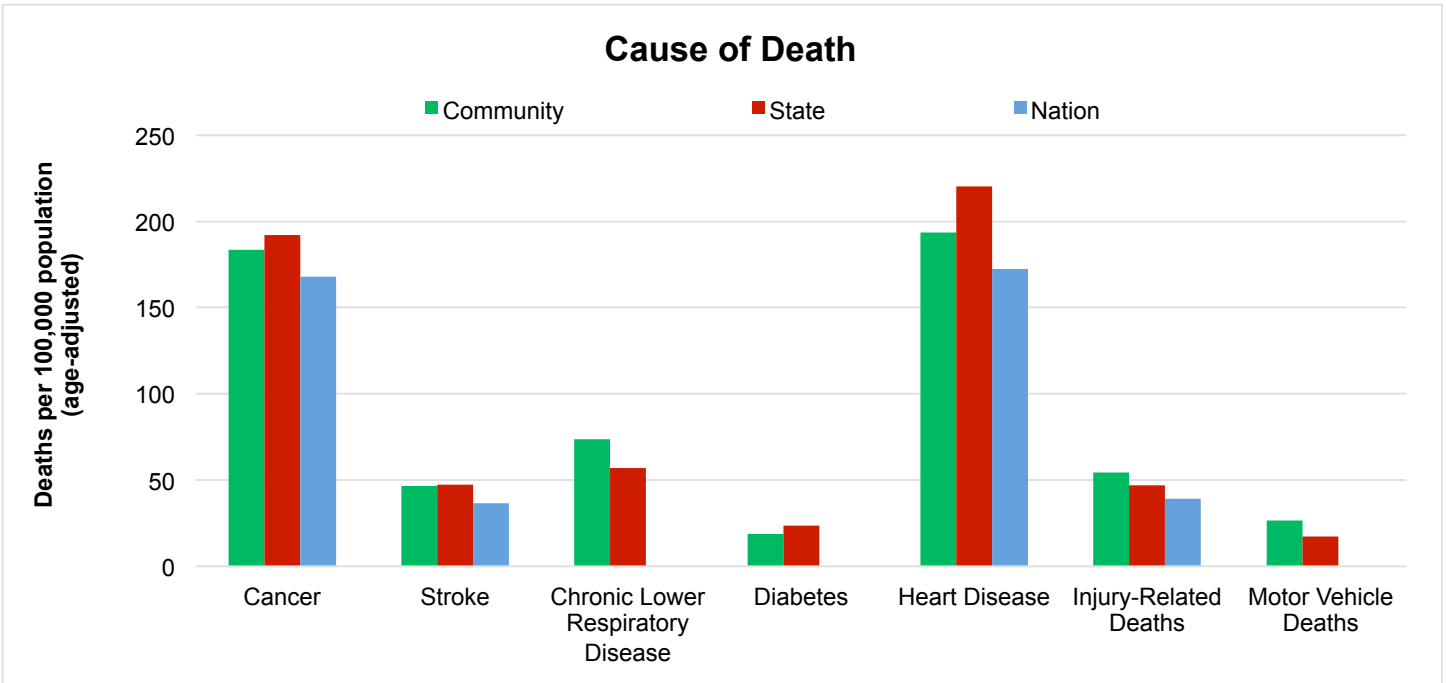
Measurement	Faulkner County	Perry County	Community Average	State Average	National Average
Premature Death Years of potential life lost before age 75 per 100,000 population (age-adjusted)	7,438	10,296	8,867	9,099	6,600
Poor or Fair Health Status Percent of adults reporting fair or poor health (age-adjusted)	19.0%	19.0%	19.0%	21.0%	14.0%
Poor Physical Health Days Average number of physically unhealthy days reported in past 30 days (age adjusted)	4.3	4.4	4.4	4.6	3.5
Poor Mental Health Days Average number of mentally unhealthy days reported in past 30 days (age-adjusted)	4.0	4.1	4.1	4.2	3.5
Low Birth Weight Percent of live births with low birth weight (<2500g)	7.9%	9.0%	8.5%	9.0%	8.1%





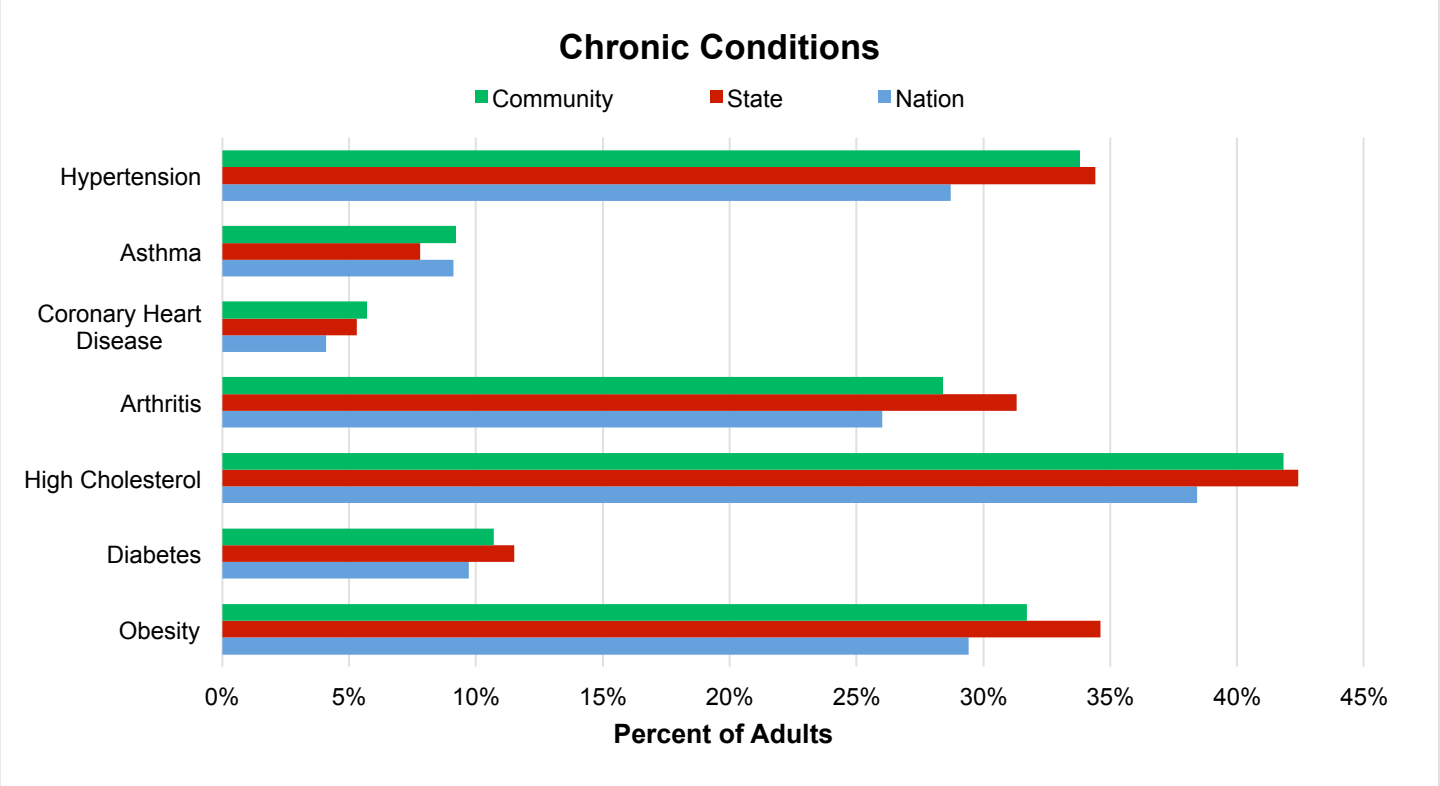
CAUSE OF DEATH

Measurement	Faulkner County	Perry County	Community Average	State Average	National Average
All-Cause Mortality All Causes per 100,000 (age-adjusted)	865.70	924.10	894.90	891.60	729.60
Infant Mortality Rate of all infant deaths (within 1 year), per 1,000 live births	7.56	9.62	8.59	6.69	6.00
Cancer Neoplasms per 100,000 population (age-adjusted)	177.20	190.00	183.60	191.90	167.90
Stroke Cerebrovascular diseases per 100,000 population (age-adjusted)	49.30	43.90	46.60	47.40	36.50
Chronic Lower Respiratory Disease Chronic lower respiratory diseases per 100,000 population (age-adjusted)	54.71	92.89	73.80	57.05	NA
Diabetes Diabetes mellitus per 100,000 population (age-adjusted)	13.19	24.48	18.84	23.58	NA
Heart Disease Essential (primary) hypertension, hypertensive heart disease with (congestive) heart failure per 100,000 population (age-adjusted)	179.70	207.40	193.55	220.20	172.4
Injury-Related Accidents (unintentional injuries) per 100,000 population (age-adjusted)	46.20	62.80	54.50	46.90	39.10
Motor Vehicle Motor Vehicle Accidents per 100,000 population (age-adjusted)	14.99	38.32	26.66	17.40	NA
Alcohol Impaired Driving Percent of driving deaths with alcohol involved	23%	21%	22%	30%	31%



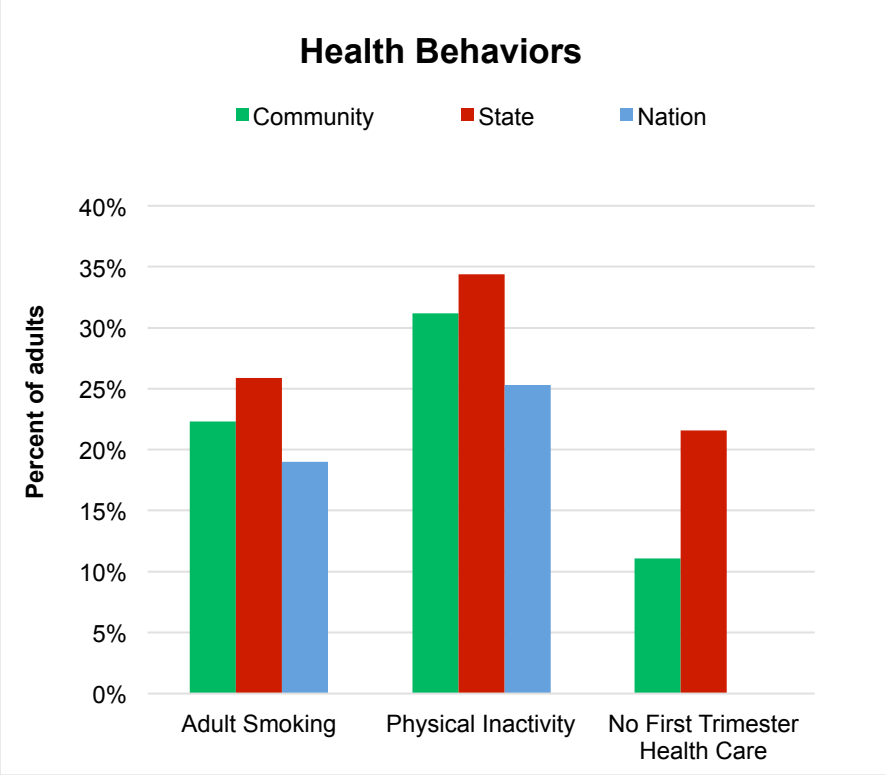
CHRONIC CONDITIONS

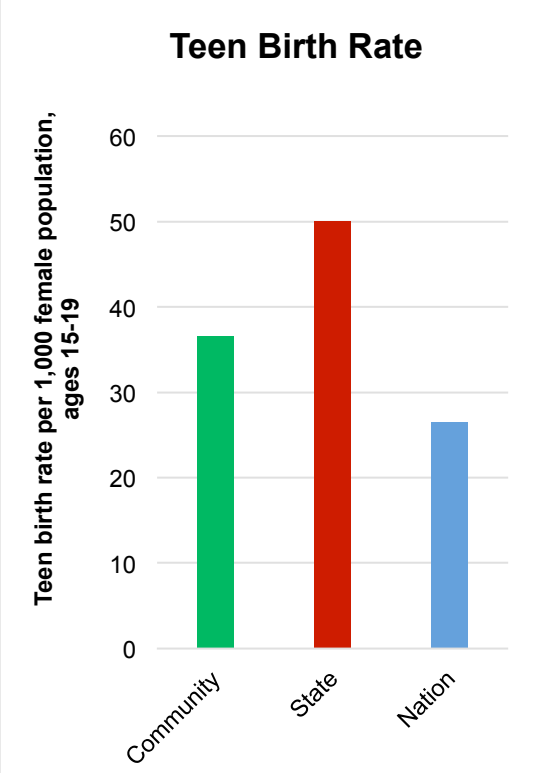
Measurement	Faulkner County	Perry County	Community Average	State Average	National Average
Hypertension Percent of adults who have been told they have high blood pressure	33.0%	34.5%	33.8%	34.4%	28.7%
Asthma Percent of adults who have been told they currently have asthma	9.5%	8.8%	9.2%	7.8%	9.1%
Coronary Heart Disease Percent of adults who have been told they have angina or coronary heart disease	4.5%	6.9%	5.7%	5.3%	4.1%
Arthritis Percent of adults who have been told they have arthritis	27.5%	29.2%	28.4%	31.3%	26.0%
High Cholesterol Percent of adults who have had their blood cholesterol checked and have been told it was high	37.5%	46.0%	41.8%	42.4%	38.4%
Diabetes Percent of adults reporting diabetes	8.8%	12.6%	10.7%	11.5%	9.7%
Adult Obesity Percent of adults who report a BMI higher than 30	30.9%	32.4%	31.7%	34.6%	29.4%
Childhood Obesity Percent of children who have a measured BMI for age greater than or equal to 95th percentile	18.1%	20.2%	19.1%	23.3%	NA



HEALTH BEHAVIORS

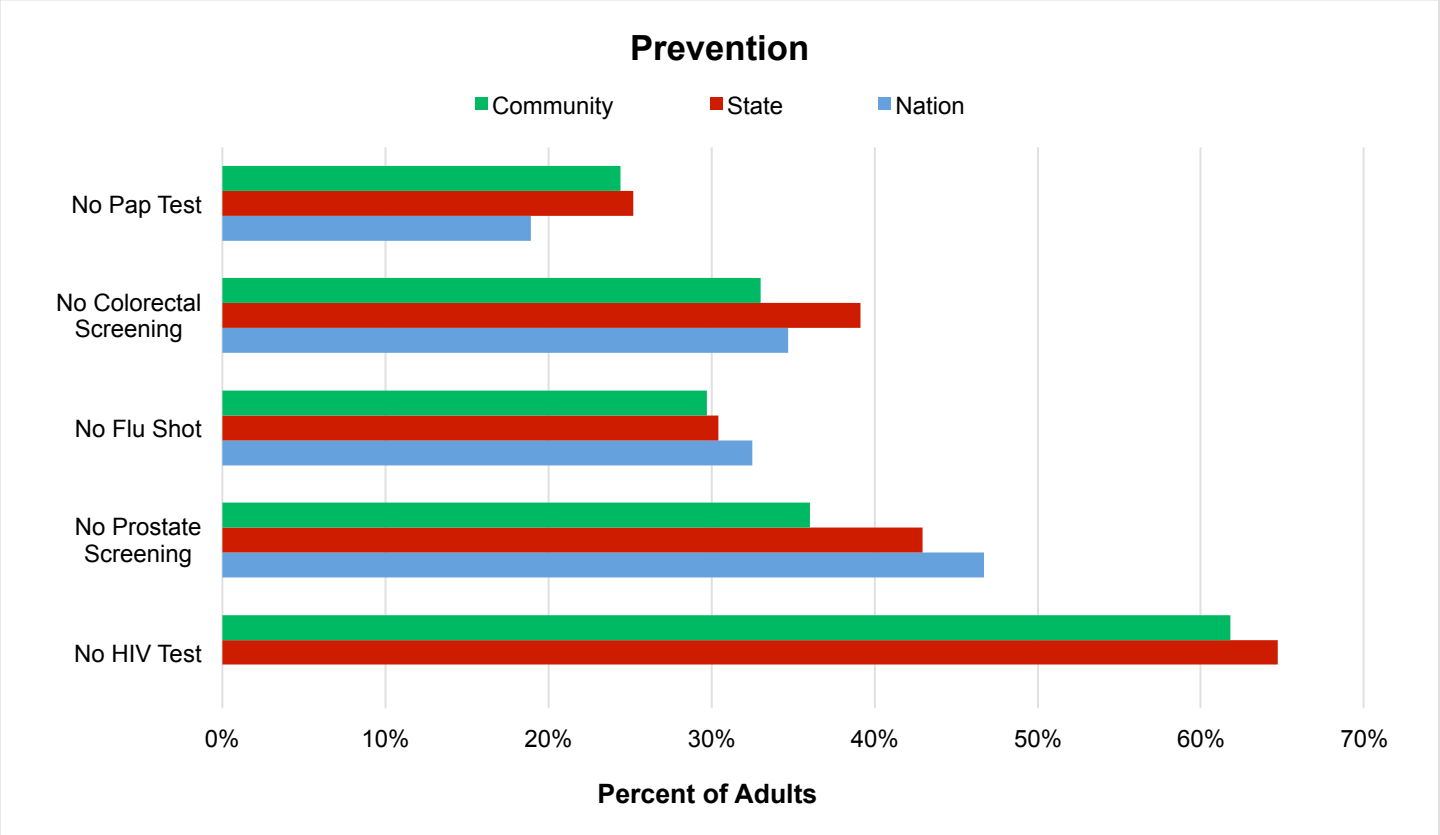
Measurement	Faulkner County	Perry County	Community Average	State Average	National Average
Adult Smoking Percent of adults who are current smokers	22.2%	22.3%	22.3%	25.9%	19.0%
Excessive Drinking Percent of adults reporting binge or heavy drinking	17.0%	16.0%	16.5%	15.0%	18.0%
Sexually Transmitted Infections Number of newly diagnosed chlamydia cases per 100,000 population	471	251	361	524	447
Fruit & Vegetable Consumption Percent of adults reporting not consuming recommended five servings of fruit and vegetables	85.9%	86.5%	86.2%	NA	NA
Physical Inactivity Percent of adults reporting no physical activity in the past month	29.5%	32.9%	31.2%	34.4%	25.3%
Teen Birth Rate Teen birth rate per 1,000 female population, ages 15-19	32.9	40.2	36.6	50.1	26.5
No First Trimester Health Care Percent of pregnant women who received no first trimester health care	10.1%	12.1%	11.1%	21.6%	NA





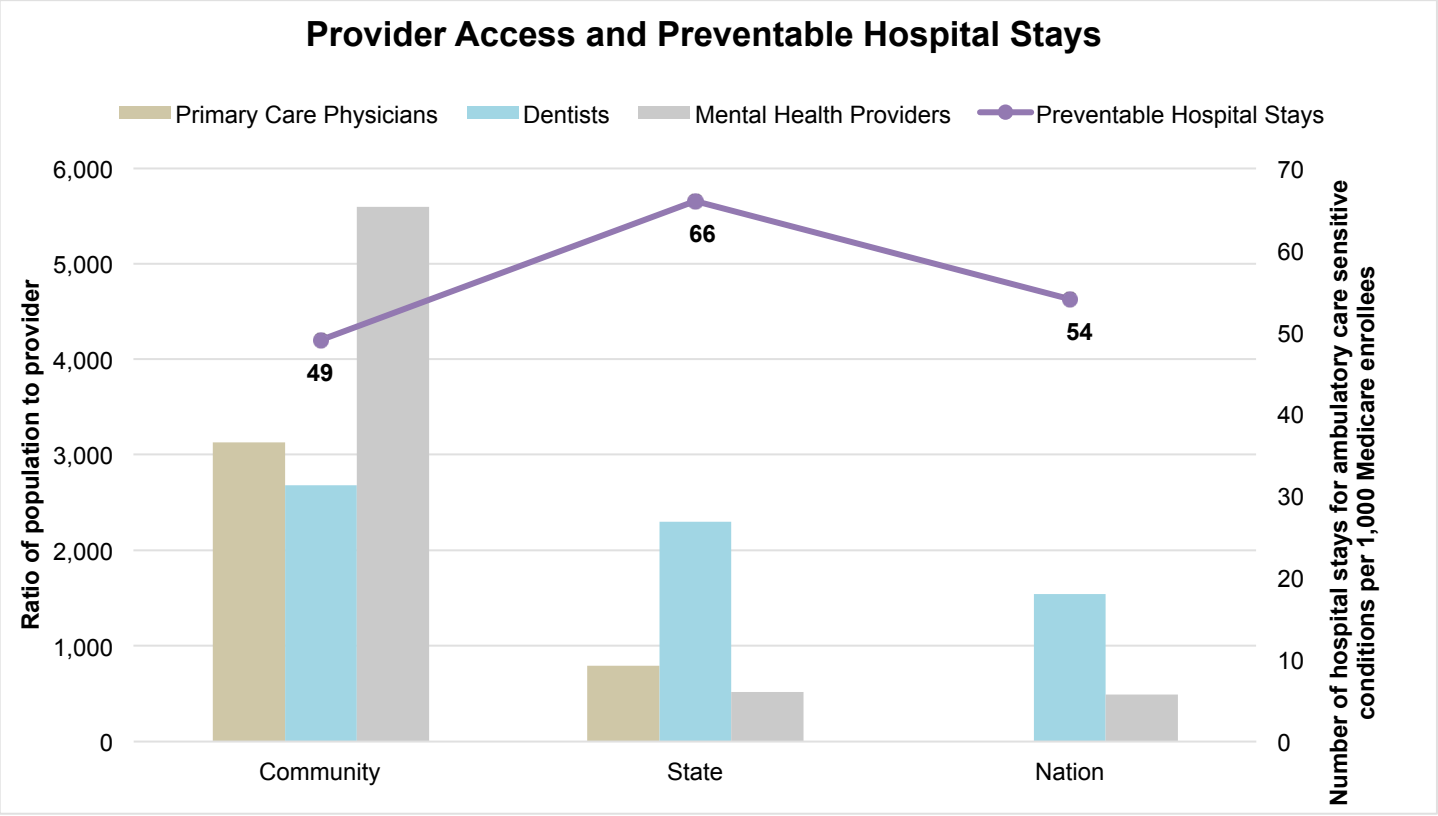
PREVENTION

Measurement	Faulkner County	Perry County	Community Average	State Average	National Average
No Pap Test Percent of women aged 18+ who have not had a pap test within the past 3 years	23.4%	25.4%	24.4%	25.2%	18.9%
No Colorectal Screening Percent of adults age 50+ who have never had either a sigmoidoscopy or colonoscopy	34.6%	31.4%	33.0%	39.1%	34.7%
No Flu Shot Percent of adults aged 65+ who have not had a flu shot in the past year	30.7%	28.6%	29.7%	30.4%	32.5%
No Prostate Screening Percent of men aged 40+ who have not had a PSA test within the past two years	36.2%	35.7%	36.0%	42.9%	46.7%
No HIV Test Percent of adults who have never been tested for HIV	60.2%	63.4%	61.8%	64.7%	NA



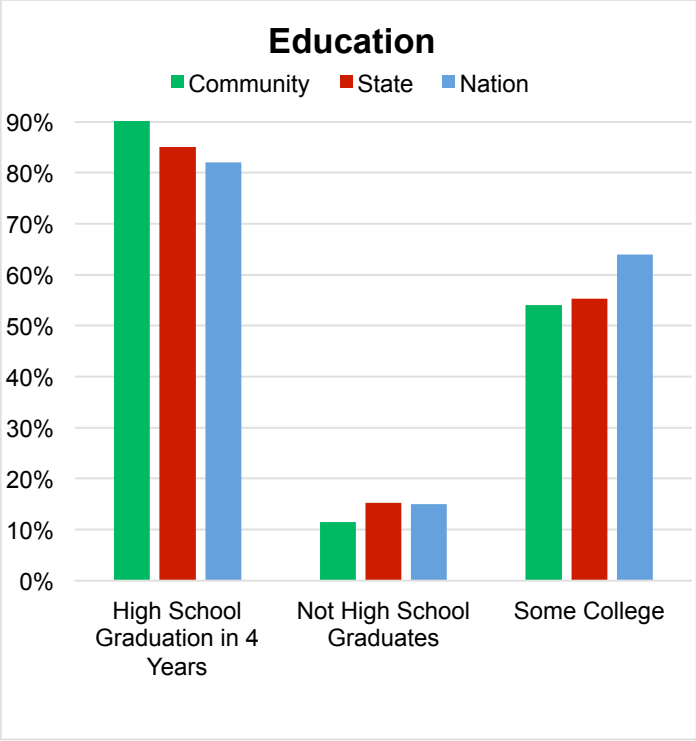
ACCESS

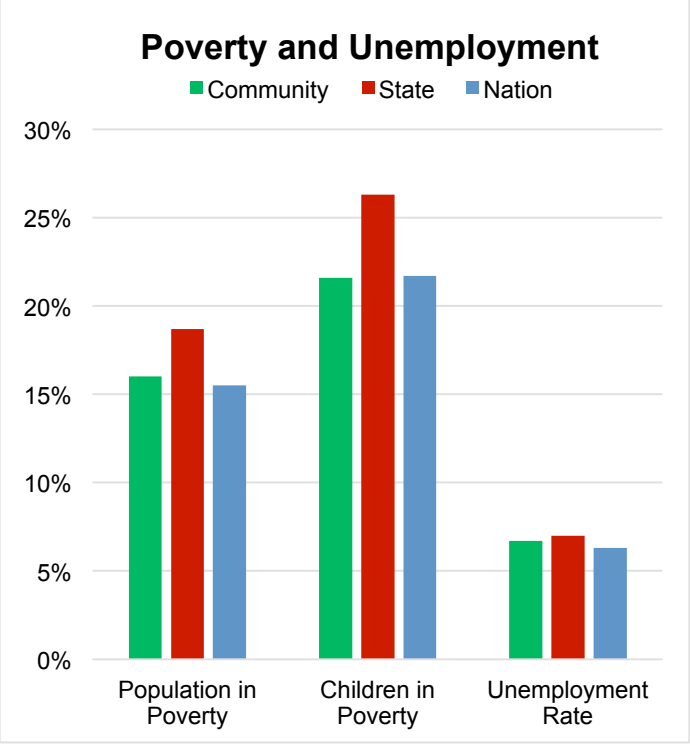
Measurement	Faulkner County	Perry County	Community Average	State Average	National Average
Uninsured Percent of non-institutionalized population uninsured	13.8%	11.2%	12.5%	15.8%	14.2%
Primary Care Physicians Ratio of population to primary care physicians (ratio to 1)	1,091	5,175	3,133	792	NA
Dentists Ratio of population to dentists (ratio to 1)	2,684	NA	2,684	2,303	1,540
Mental Health Providers Ratio of population to mental health providers (ratio to 1)	951	10,245	5,598	517	490
Preventable Hospital Stays Number of hospital stays for ambulatory care sensitive conditions per 1,000 Medicare enrollees	51	47	49	66	54
Mammography Percent of female Medicare enrollees ages 67-69 who receive mammography screening	59.0%	61.0%	60.0%	58.0%	63.0%
Diabetic Monitoring Percent of diabetic Medicare enrollees ages 65-75 who receive HbA1c monitoring	85.0%	83.0%	84.0%	83.0%	85.0%



SOCIAL AND ECONOMIC

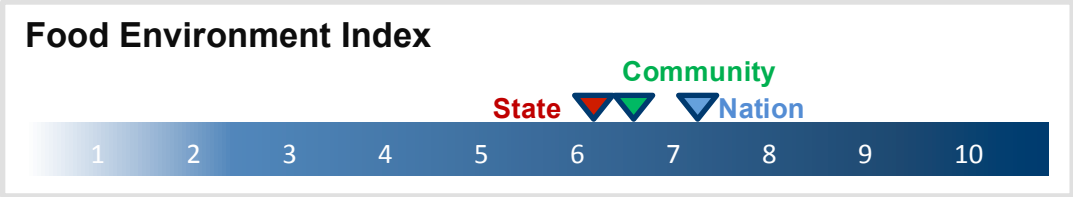
Measurement	Faulkner County	Perry County	Community Average	State Average	National Average
Not High School Graduates Percent age 18 to 24 years without a high school diploma	8.9%	14.0%	11.5%	15.3%	15.0%
High School Graduation in 4 years Percent of ninth-grade cohort that graduates in four years	90.0%	94.0%	92.0%	85.0%	82.0%
Some College Percent of adults ages 25-44 with some post-secondary education	64.4%	43.7%	54.1%	55.3%	64.0%
Unemployment Rate Number of unemployed people as a percent of the labor force	5.7%	7.7%	6.7%	7.00%	6.3%
Median Household Income	$51,436	$40,556	$45,996	$41,335	$53,657
Children in Poverty Percent of children under age18 below the federal poverty line	16.5%	26.7%	21.6%	26.3%	21.7%
Population in Poverty Percent of population below the federal poverty line	14.7%	17.3%	16.0%	18.7%	15.5%
Income Inequality Ratio of household income at the 80th percentile to income at 20th percentile	4.4	3.8	4.1	4.8	4.7
Children in Single-Parent Households Percent of children who live in a household headed by a single parent	31%	26%	29%	37%	34%
Social Associations Number of membership associations per 10,000 population	8.9	7.7	8.3	12.0	9.0
Violent Crime Number of reported crime offenses per 100,000 population	300	239	270	484	392

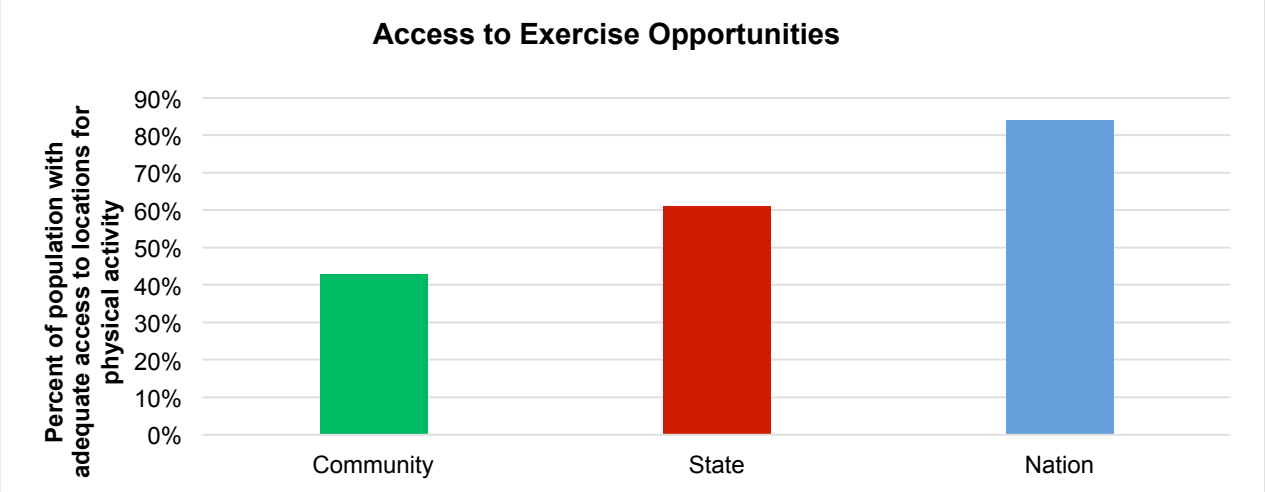




ENVIRONMENT

Measurement	Faulkner County	Perry County	Community Average	State Average	National Average
Food Environment Index Index of factors that contribute to a healthy food environment, 0 (worst) to 10 (best)	6.3	6.8	6.6	6.1	7.2
Access to Exercise Opportunities Percent of population with adequate access to locations for physical activity	71%	15%	43%	61%	84%
Air Pollution Average daily density of fine particulate matter in micrograms per cubic meter (PM2.5)	11.9	11.7	11.8	11.8	11.1
Drinking Water Violations Percent of population potentially exposed to water exceeding a violation limit during the last year	12%	0%	6%	9%	7%
Severe Housing Problems Percent of households with at least 1 of 4 housing problems: overcrowding, high housing costs, or lack of kitchen or plumbing	15%	10%	13%	15%	19%
Driving Alone to Work Percent of the workforce who drive alone to work	84%	79%	82%	82%	76%
Long Commute - Driving Alone Among workers who commute in their car alone, the percent who commute more than 30 minutes	35%	55%	45%	26%	31%

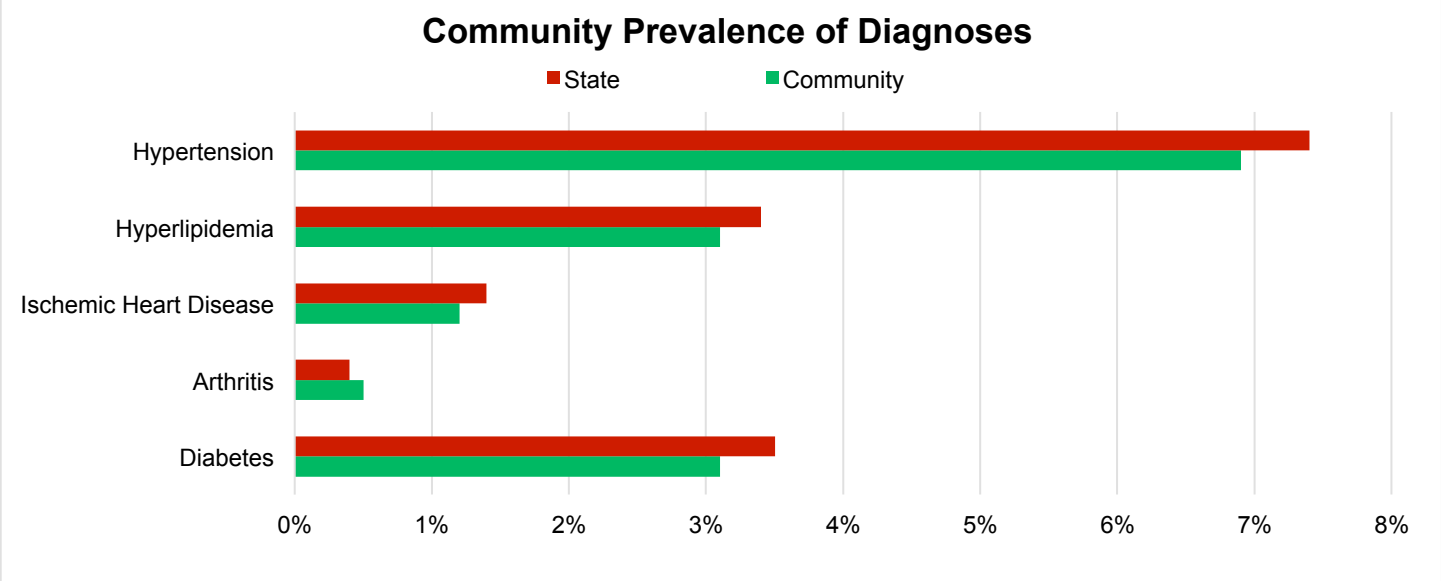




COMMUNITY PREVALENCE OF DIAGNOSES

Measurement*	Faulkner County	Perry County	Community Average	State Average
Hypertension	5.7%	8.2%	6.9%	7.4%
Hyperlipidemia	2.5%	3.7%	3.1%	3.4%
Ischemic Heart Disease	1.0%	1.4%	1.2%	1.4%
Arthritis	0.4%	0.6%	0.5%	0.4%
Diabetes	2.6%	3.5%	3.1%	3.5%

*Number of individuals discharged for a primary or secondary diagnoses as a percent of the population (18 years and older)



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Baptist Health 2016 Community Health Needs Assessment: Analysis of Initiatives in Arkansas

Below is a list of existing county-level and statewide initiatives in Arkansas. The county-level information includes a table identifying where initiatives are currently taking place in the fifteen counties served by Baptist Health. A brief description and website is provided for all county-level and statewide initiatives. This resource should not be considered an exhaustive list as other ongoing health improvement efforts in the state may not be identified below. However, once the priority needs areas are identified by Baptist Health, ACHI can, upon request, provide additional analysis of current initiatives specific to the identified priority needs.

	Fresh Fruit Vegetable	Growing Healthy Communities	Joint Use Agreements	Safe Routes to School	School Based Health Center	Farmers Markets	Arkansas Rural Health Clinics	Patient Centered Medical Homes
ARKANSAS	X					X	X	
CLARK	X		X		X	X		X
CLEBURNE				X		X	X	X
DALLAS	X	X					X	
FAULKNER	X	X	X	X		X	X	X
GRANT	X					X		
HOT SPRING	X					X		X
LONOKE	X		X	X		X		X
MONROE			X				X	
NEVADA		X						
PERRY			X			X		X
PIKE	X						X	
PRAIRIE	X		X				X	
PULASKI	X	X	X	X		X		X
SALINE		X	X	X		X		X

COUNTY-LEVEL INITIATIVES

Fresh Fruit and Vegetable Program (FFVP): FFVP is a federally assisted program providing free fresh fruits and vegetables to students in participating elementary schools during the school day. The FFVP will help schools create healthier school environments by providing healthier food choices, expanding the variety of fruits and vegetables children experience, and increasing children's fruit and vegetable consumption.
http://www.fns.usda.gov/ffvp/fresh-fruit-and-vegetable-program

Growing Healthy Communities (GHC): GHC is an initiative of the Arkansas Coalition for Obesity Prevention (ArCOP). Communities awarded with GHC recognition levels have set out to get healthier—economically, policy-wise, nutritionally and physically. In each Growing Healthy Community, there is an organized, multidisciplinary team working actively to drive health forward.
http://www.arkansasobesity.org/ghc/

Joint Use Agreements (JUAs): Arkansas was the first state to provide grant funding for the creation of formal agreements between schools and communities to share recreational resources. JUAs are focused on increasing opportunities for physical activity by making resources, like playgrounds, sports fields and gymnasiums available to the community during non-school hours when they would otherwise be closed.
http://www.arkansascsh.org/apply-it-in-your-school/584c0b1fb838fc7e23da42ce07caf9b3.php

Safe Routes to School (SRTS): STRS programs are sustained efforts by parents, schools, community leaders and local, state, and federal governments to improve the health and well-being of children by enabling and encouraging them to safely walk and bicycle to school.
http://www.arkansashighways.com/safe_route/safe_route.aspx

School Based Health Centers: School-Based Health Centers provide basic physical, mental, dental or other health services as needed. The school-based health center is required to maintain a working relationship with the physician of a child's medical home and to ensure that individual patient health plans are executed effectively and efficiently. Centers are typically located in the school or on school grounds.
http://www.arkansased.gov/divisions/learning-services/school-health-services/school-based-health-center

Arkansas Farmers' Markets Association: Established to represent all regions in the state to promote farmers' markets, increase access to healthy, locally-sourced food, and advocate for Arkansas farmers.
http://arkansasfarmersmarketassociation.com/

Arkansas Rural Health Clinics: Rural health clinics in Arkansas aim to improve health services in rural communities through increasing access to health services, reducing duplication of services, and providing a coordinated community-based continuum of care.
http://www.healthy.arkansas.gov/programsServices/hometownHealth/Pages/orhpc.aspx

Patient Centered Medical Homes (PCMH): PCMHs are at the heart of Arkansas's efforts to move from a sick care oriented fee-for-service payment system to one that is value-based and focused on helping people stay healthy. Through the PCMH, quality of care is improved through increased care coordination, with emphasis on preventive services and identifying and helping patients manage chronic conditions like diabetes.
http://www.paymentinitiative.org/medicalHomes/Pages/default.aspx

STATEWIDE INITIATIVES

Healthy Active Arkansas: A statewide movement surrounding a plan that provides a framework of research-based strategies to guide efforts to reduce obesity and improve health. The plan provides a series of long- and short-term goals supporting the idea that all Arkansas citizens, businesses, education centers, hospitals, community planners, policymakers, and others are stakeholders in creating a Healthy Active Arkansas.
http://www.healthyactive.org/

March of Dimes: Through programs and services in communities across Arkansas, March of Dimes promotes healthy pregnancies and babies, and works to prevent premature birth and birth defects through educating moms and supporting families in need.
http://www.marchofdimes.org/arkansas/

Child Passenger Safety (CPS): CPS emphasizes the correct and consistent use of proper passenger restraint in children ages 0-13, including children with special needs. CPS provides training classes to certify Child Passenger Safety Technicians throughout Arkansas.
http://www.healthy.arkansas.gov/programsServices/injuryPreventionControl/injuryPrevention/SIPP/Pages/MotorVehicleSafety.aspx

Stamp out Smoking (SOS): A program of the Arkansas Department of Health, SOS is dedicated to wiping out tobacco use among all Arkansans through advertising, grassroots outreach, education in grade school through adulthood, and providing materials to tobacco cessation advocates.
http://www.stampoutsmoking.com/

Arkansas Prostate Cancer Foundation (APCF): APCF collaborates with local partners and medical volunteers to offer education and screening programs in communities across the state. Local partners help APCF establish

screening events by scheduling facilities, soliciting medical volunteers from the local community (phlebotomists to draw blood for the PSA test, physicians or advance practice nurses to perform DREs), and pre-registering men for screening. The screenings are free to men age 45 to 70, who do not have a prostate cancer diagnosis. http://arprostatecancer.org/services/screening/

Goodwill Industries of Arkansas: Goodwill Industries of Arkansas Adult Education centers offer free in-person classes to prepare individuals for the GED (high school equivalency) test. Classes are free and open to all. http://www.goodwillar.org/career_training/education/ged.html

Housing Arkansas: Housing Arkansas's purpose includes speaking about and acting on the need for safe, decent and affordable housing for low income Arkansans through the funding of a state housing trust fund. http://www.housingar.org/

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