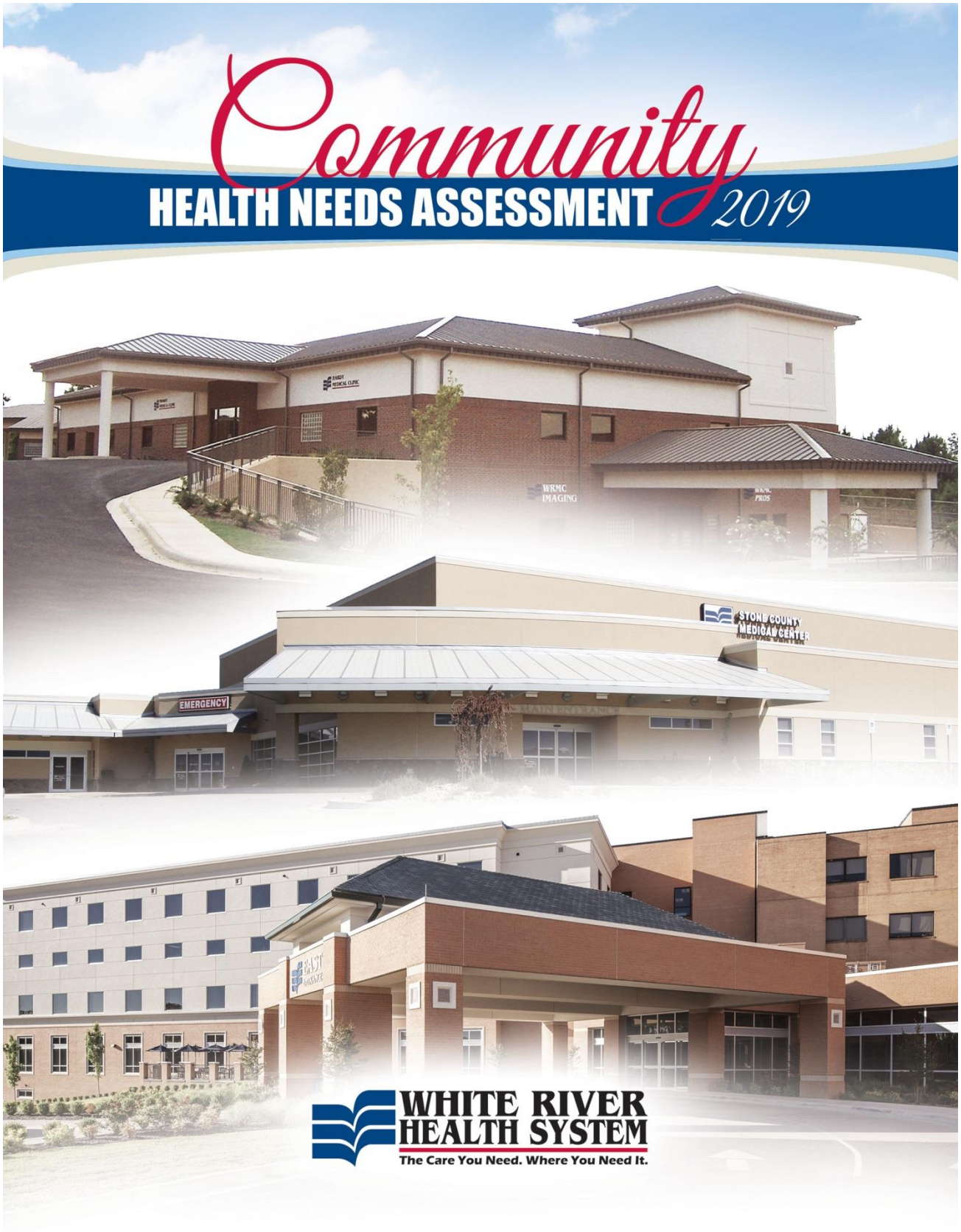
Community HEALTH NEEDS ASSESSMENT 2019



WHITE RIVER HEALTH SYSTEM

The Care You Need. Where You Need It.

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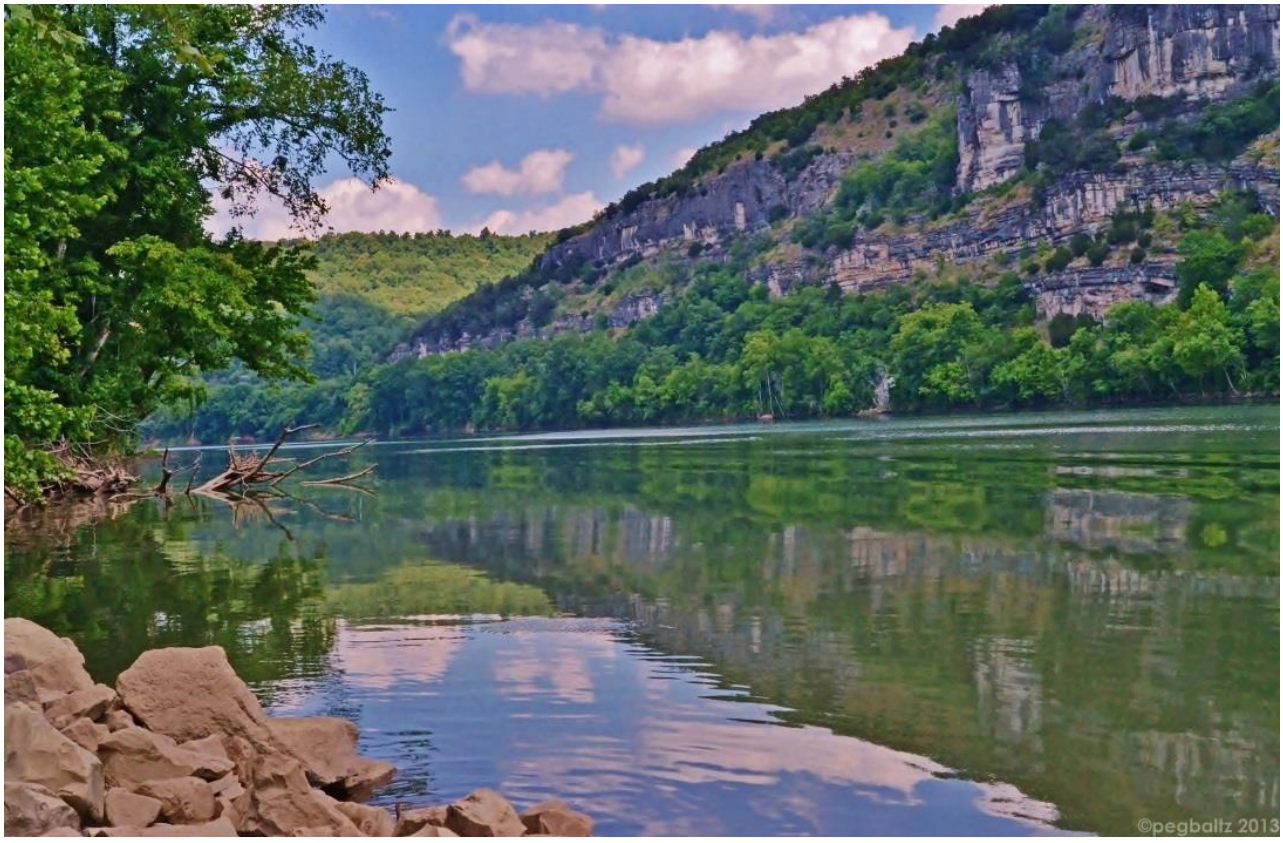
Introduction

The White River Health System (WRHS) Community Health Needs Assessment (CHNA) has been prepared to identify the health needs of the communities served and identify initiatives to meet those needs and comply with Internal Revenue Service (IRS) regulations for nonprofit hospitals. The CHNA is intended to document WRHS's compliance with IRS Code Section 501(r).

The CHNA, implementation strategy, and action plan for WRHS, which includes White River Medical Center (WRMC) and Stone County Medical Center (SCMC), were approved by the WRHS Board of Directors September 24, 2019.

Organization Description

WRHS is a 501(c) (3) nonprofit, integrated health system. The organization includes: WRMC, an acute care hospital in Batesville; SCMC, a critical access hospital in Mountain View; a satellite emergency department in Cherokee Village, Rural Health Clinics (RHC), primary care and specialty clinics, and outpatient diagnostic and treatment centers throughout North Central Arkansas.



White River Scenery

WRHS employs 64 physicians, 43 mid-level providers, and 1,792 total employees. The WRHS Internal Medicine Residency achieved accreditation from the Accreditation Council for Graduate Medical Education (ACGME) and in 2018, achieved continued accreditation status. Through a collaborative agreement with the University of Arkansas for Medical Sciences (UAMS), White

River Medical Center will serve as a training site for UAMS Family Medicine Residents who began training in July 2019.

Community Demographics

WRHS's Service Area includes six (6) counties (Cleburne, Independence, Izard, Jackson, Sharp, and Stone) in North Central Arkansas. WRHS's extended Service Area an additional four (4) counties. The healthcare needs of the extended Service Area are addressed by the CHNA of area healthcare providers.

Located in the Ozark Mountains, most of the 3,751 square miles of the six counties of the Service area are rural with small cities scattered among the mountains and valleys of the region. Small to medium industries are in the city centers; however, agriculture and tourism are the primary economic engines in the region. On average, there are 32 people per square mile in the Service Area.

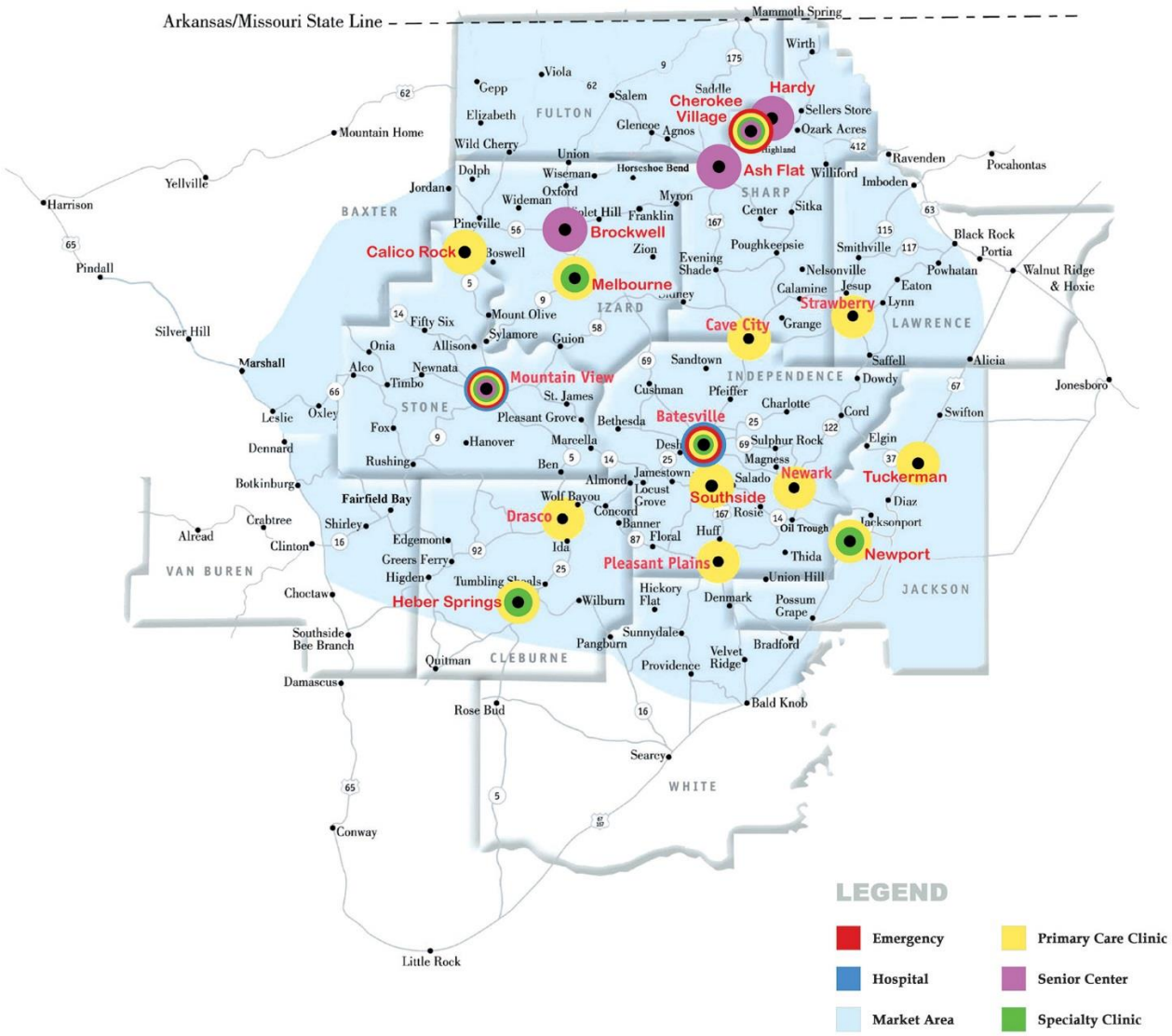
Table 1 – Demographics

	Cleburne	Independence	Izard	Jackson	Sharp	Stone
Total Population	25,361	37,097	13,521	17,429	17,041	12,443
Birth to 9	2,515	4,998	1,160	1,978	1,919	1,200
10-19	2,862	4,809	1,565	1,864	2,048	1,467
20-64	13,388	21,015	7,444	10,739	8,708	6,564
65 +	6,596	6,275	3,352	2,848	4,366	3,212
Race						
White	24,048	33,074	12,646	13,460	15,996	11,814
African American	150	723	258	2,953	69	10
Asian	205	257	23	8	72	11
Hispanic	623	2,258	284	476	364	227
All Other	345	785	310	532	540	381
Language/Education						
Language Other than English Spoken at Home	2.9%	4.4%	4.1%	1.4%	1.8%	1.4%
High School Graduate	84.4%	85%	82.9%	77.4%	82.8%	76.8%
Bachelor's Degree or Higher	17.9%	18%	13.4%	9.2%	10.5%	13.4%
Income						
Median Household Income	$42,312	$39,945	$39,135	$32,783	$31,792	$33,091
% Persons Living Below Poverty Level	15.4%	18.5%	17.7 %	25.1%	23.3%	24.2%

Source: United States Census Bureau; Community Fact Finder

As seen in the following Service Area map, White River Health System provides services in 17 Communities.

Figure 1 – Service Area Map



Methods and Processes Used for the Community Health Needs Assessment

In accordance with the Patient Protection and Affordable Care Act of 2010, and IRS regulations for nonprofit hospitals, WRHS conducted a CHNA to identify the health needs of the residents we serve and recommend actions to address identified needs.

The WRHS CHNA utilized the following sources to develop the process for the CHNA and to gather the needed data: 1) Community Survey made available online and promoted via email and social media, 2)The University of Arkansas for Medical Sciences (UAMS) Public Health in Arkansas' Communities Search (PHACS), and 3) public data sources.

The team was given an overview of the last CHNA (2016), the Implementation Update Report (Titled Bridge Document, Appendix B), and given an update on our community demographics and initial data gathered. The team assisted in editing the CHNA survey and evaluating the data. The survey link was emailed community stakeholders who represent medically underserved residents, minority groups, and low-income residents in the survey process.

Qualitative and quantitative health needs data were collected from: 1) digital surveys and 2) UAMS PHACS data. The survey is attached in Appendix C.

The county profile reports for Cleburne, Independence, Izard, Jackson, Sharp, and Stone counties were retrieved from UAMS PHACS, which was last updated January 29, 2019. The information can be retrieved online at http://www.uams.edu/phacs/. This data is a summary of key indicators that are used to assist in interpreting the health of Arkansans in the categories of social/economic factors, access to healthcare, risk behaviors, preventive behaviors, and health outcomes. The work of PHACS is supported by the Arkansas Center for Health Disparities and the Arkansas Prevention Research Center. This county specific data was utilized to assist the team in identifying indicators that can affect the health of residents in the Service Area. The indicators for each county with the least favorable ratings (e.g. based upon quintile rankings against all other counties in the state) were selected as potential areas of focus. These were tabulated to identify the indicators which occur most frequently across the Service Area and then compiled into general categories similar to those for the surveys administered. The data was collected and placed into charts. (See Figures 2 – 6).

The data from the digital survey were aggregated into charts for comparison (Figures 7 – 9). The tabulated results of the surveys, along with the compiled results from the UAMS PHACS were evaluated together to determine which constituted the greatest, highest priority needs in the communities served by WRHS. The team assessed and analyzed the entire data summary to assist in determining significant health needs. This team also assisted with planning and timelines, served as local experts, and made recommendations regarding the plans for development, implementation, and communication of the CHNA. The preliminary data and CHNA report, with suggested findings of community health needs and action steps, were presented to WRHS Administration for feedback prior to presentation to the WRHS Board of Directors for approval.

The CHNA Team included: Lindsey Castleberry, Vice President Human Resources and General Counsel; Jackie Crain, Population Health Manager; Laura Garrett, Executive Assistant; Tammy Gavin, Vice President Telehealth Services; Shawna Ives, Controller; Sheila Mace, Public Relations Coordinator; Chris Poole, Quality Engineer; Jody Smotherman, VP of Community Engagement;

Kevin Spears, Chief Operating Officer; Chris Steel, MD, Chief Quality Officer; and Michele Wood, Marketing Director.

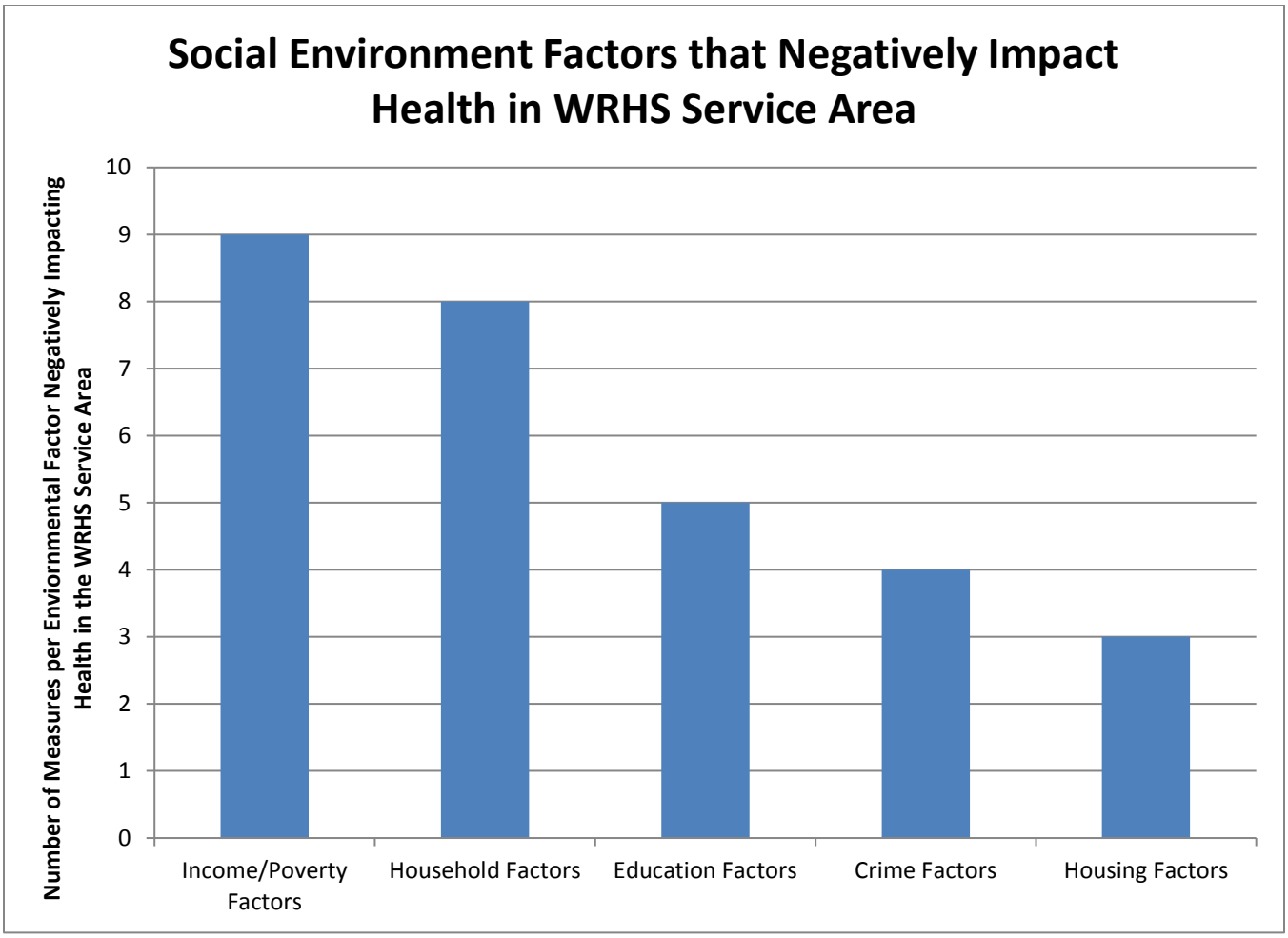
Data Results

Figures 2-6 represent the top risk factors from UAMS PHACS that impact the health status of the residents within the Service Area. The data was collected from several data sources and then the data was grouped into categories. The counties within Arkansas were then ranked according to high levels of risk categories. The higher the number in Figures 2 through 6, the more problematic these categories are, which results in negative impacts on the health of our area residents.

Social and Economic Factors

This category includes interactions with family, friends, co-workers, and others in the community. It also encompasses social institutions, such as law enforcement, the workplace, places of worship, and schools. Housing, public transportation, and the presence or absence of violence in the community are among other components of the social environment. The social environment has a profound effect on individual health, as well as on the health of the larger community, and is unique because of cultural customs, language, and personal religious, or spiritual beliefs. At the same time, individuals and their behaviors contribute to the quality of the social environment. Source: UAMS PHACS.

Figure 2

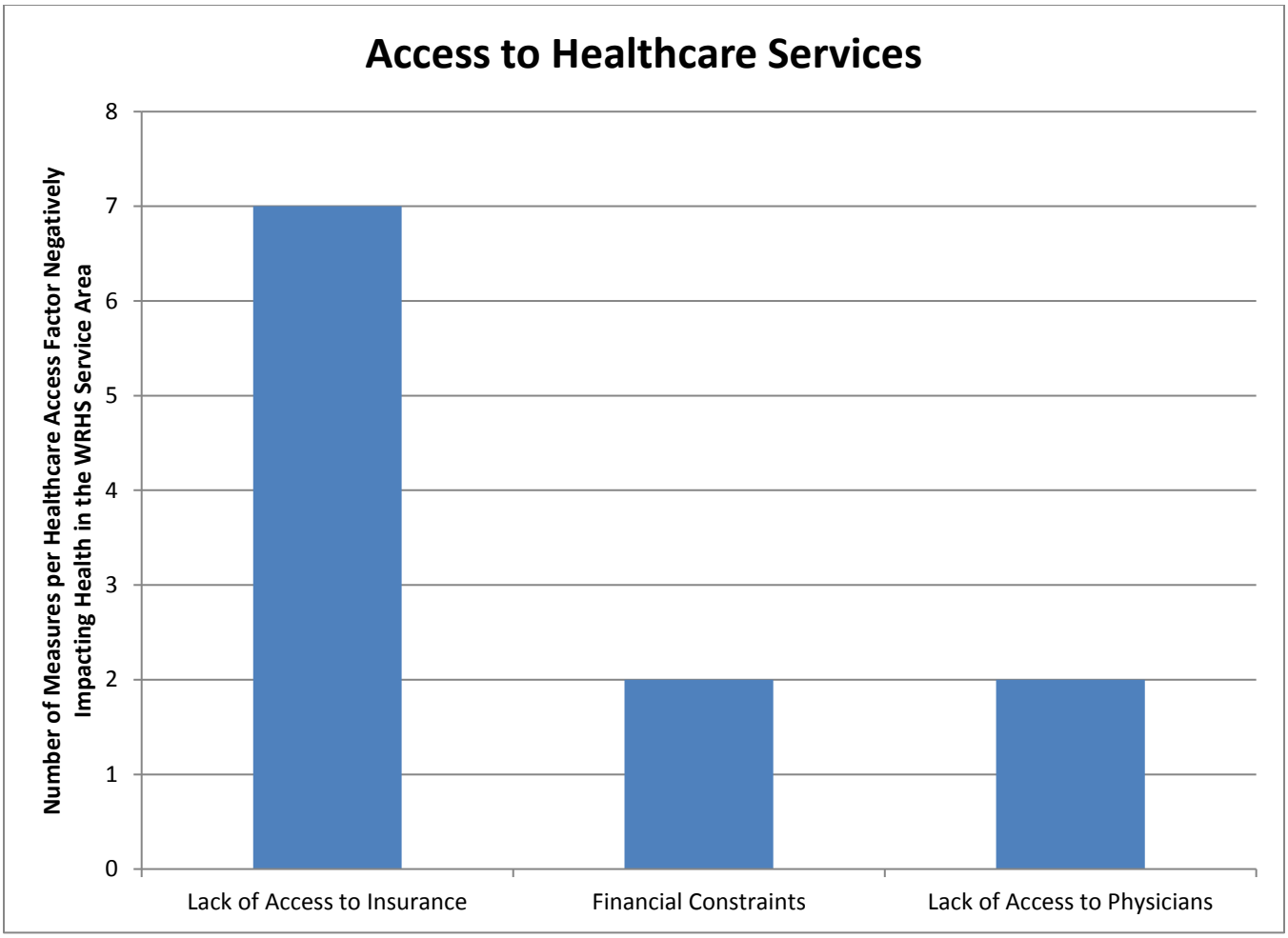


As seen in figure 2, within the six-county Service Area, social, and economic factors impact the health of Service Area residents. From left to right; 1) Income/poverty, 2) household factors such as single head of household and/or grandparents as primary caregivers, 3) low educational attainment, 4) crime rate, 5) residents with unstable or unsafe housing.

Access to Healthcare Services

The health of individuals and communities also depends on access to quality healthcare. Expanding access to quality healthcare is important to eliminate health disparities and to increase the quality and years of healthy life for all people. Access to healthcare includes services received from healthcare providers and from other community-based organizations. As seen in Figure 3 lack of affordable health insurance is a barrier to healthcare in most counties of the WRHS Service Area. Within the WRHS six county Service Area, access to primary care providers is inconsistent. For example, Izard County is a healthcare professional shortage area, while Independence County is not (Source UAMS PHACS). Arkansas ranks 47th in the number of active patient care physicians per 100,000 residents in the United States according to the Association of American Medical Colleges. Equally important, 40% of the physician workforce is at retirement age or older. Therefore, lack of affordable insurance and access to primary care providers are barriers that negatively impact the health of communities served by WRHS.

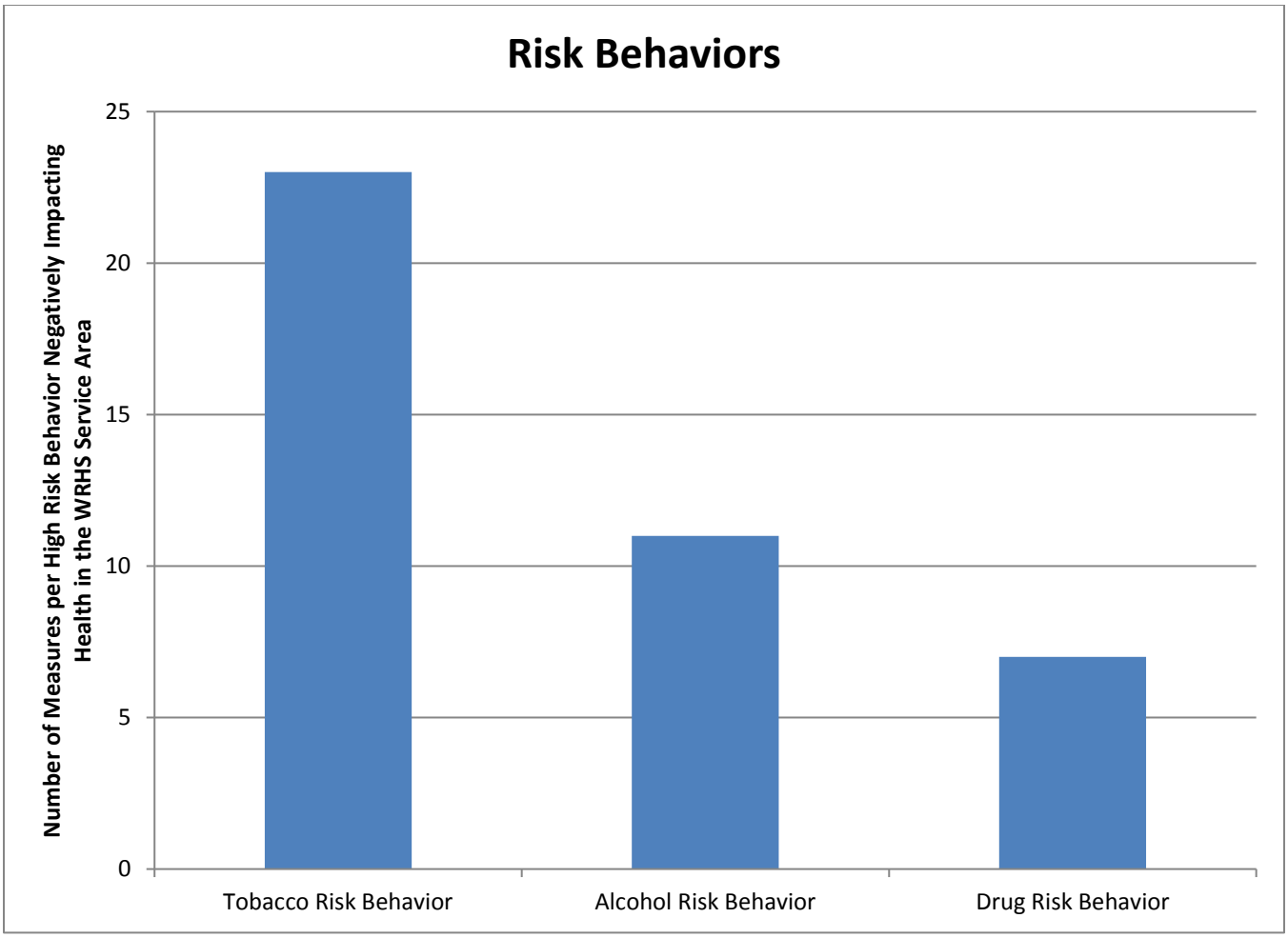
Figure 3



Risk Behaviors

Individuals engage in behaviors that may put their health at risk (i.e. health risk behaviors). The more frequent area residents engage these behaviors, the more likely their health is negatively impacted. Figure 4 shows the categories of health risk behaviors in our Service Area. The higher the number, the more frequent harmful behaviors are present in the WRHS Service Area. Initiatives in Preventive Healthcare Management and Wellness outline WRHS strategies to address risk behaviors.

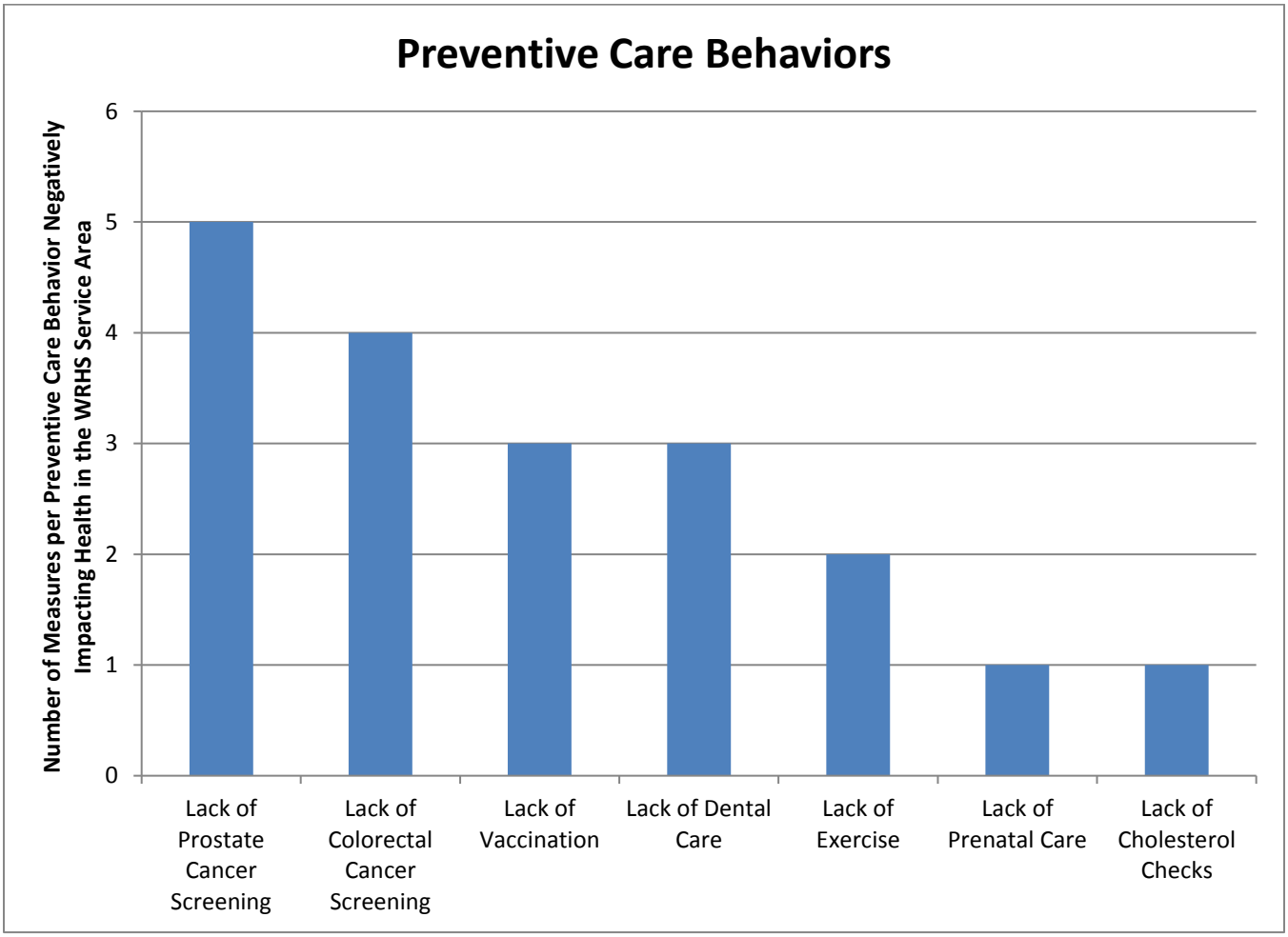
Figure 4


Risk Behaviors
Number of Measures per High Risk Behavior Negatively Impacting Health in the WRHS Service Area
25
20
15
10
5
0
Tobacco Risk Behavior
Alcohol Risk Behavior
Drug Risk Behavior

Preventive Behaviors

Preventive behaviors include individual behaviors such as physical activity and preventive healthcare services such as flu shots, colorectal exams, etc. that help a person stay healthy and detect and/or treat diseases early. Figure 5 illustrates the lack of preventive behaviors by residents in the WRHS Service Area. Initiatives in Preventive Healthcare Management and Wellness outline WRHS strategies to improve utilization of preventive care services.

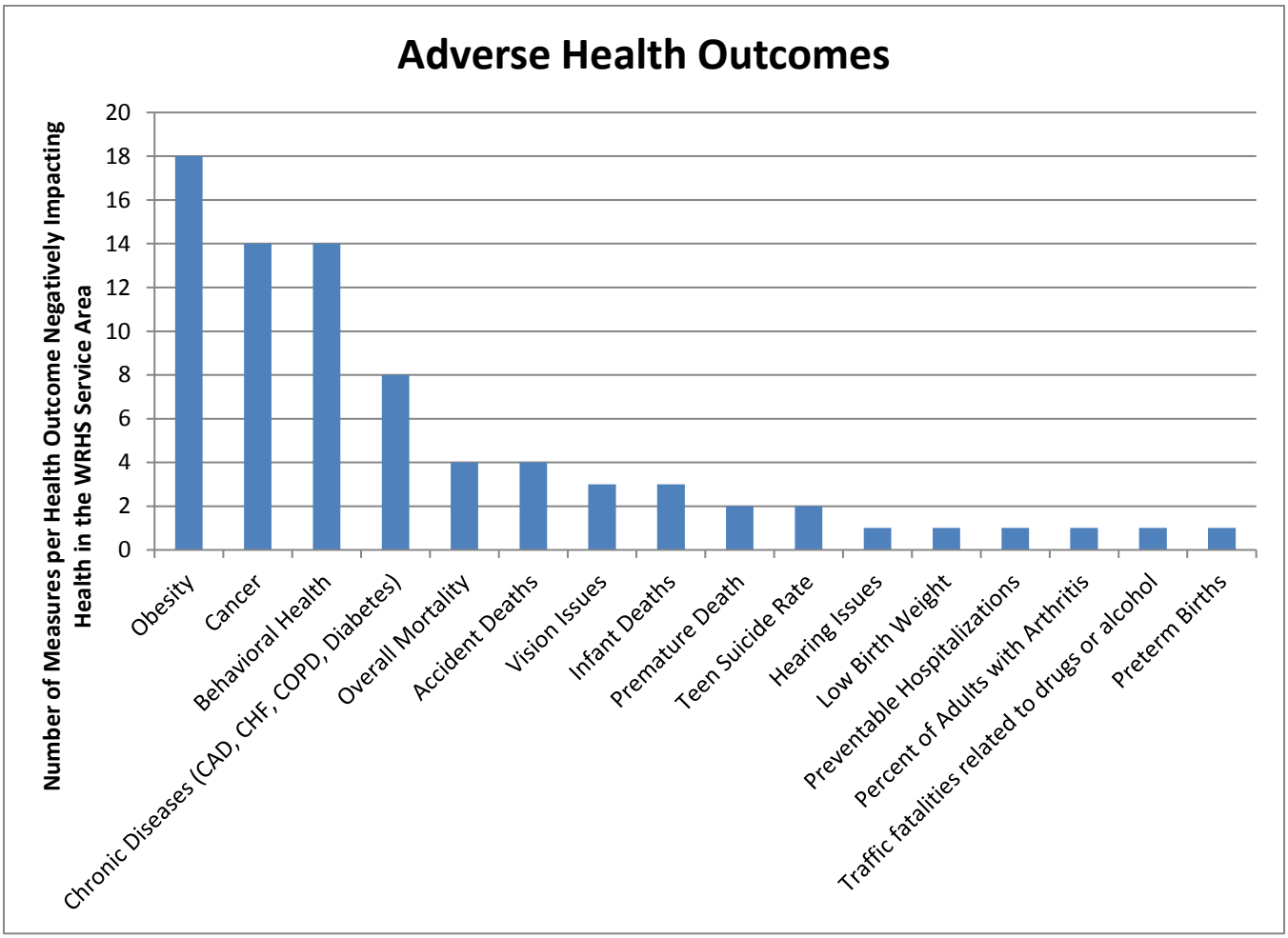
Figure 5



Poor Health Factors

Health status is a combination of factors present in the population. In Figure 6, adverse health outcomes from the UAMS PHACS for each county in the WRHS Service Area were compiled. The higher number indicates a higher incidence of an adverse outcome; therefore, a lower health status for the WRHS Service Area. For example, the percentage of adults who report being overweight or obese is high. Studies show that high obesity rates are linked to higher incidence of diabetes and cardiovascular disease, which in turn are linked to higher incidence of premature death. Initiatives in Chronic Disease Management and Education outline WRHS strategies to improve health outcomes.

Figure 6



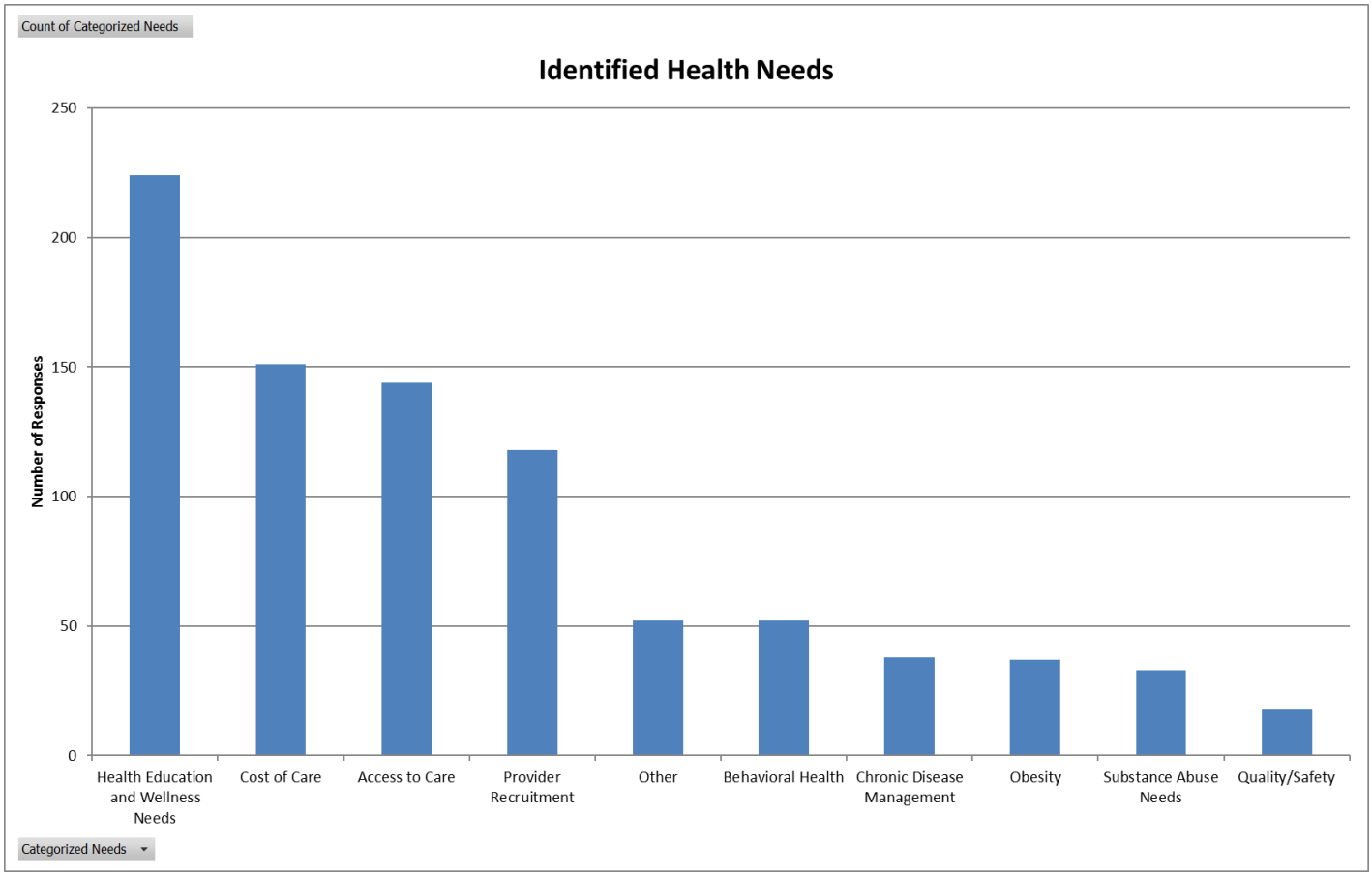
Digital Surveys

As part of the CHNA process, WRHS collected qualitative and quantitate data through an online survey. The survey questions represented three large categories: 1) Healthcare needs within our Service Area; 2) Barriers to healthcare (Social and Economic factors); and 3) Healthcare resources needed in our Service Area. Figures 7 – 9 are the results.

Healthcare Needs

Figure 7 illustrates the perception of healthcare needs within our Service Area based on results of digital survey.

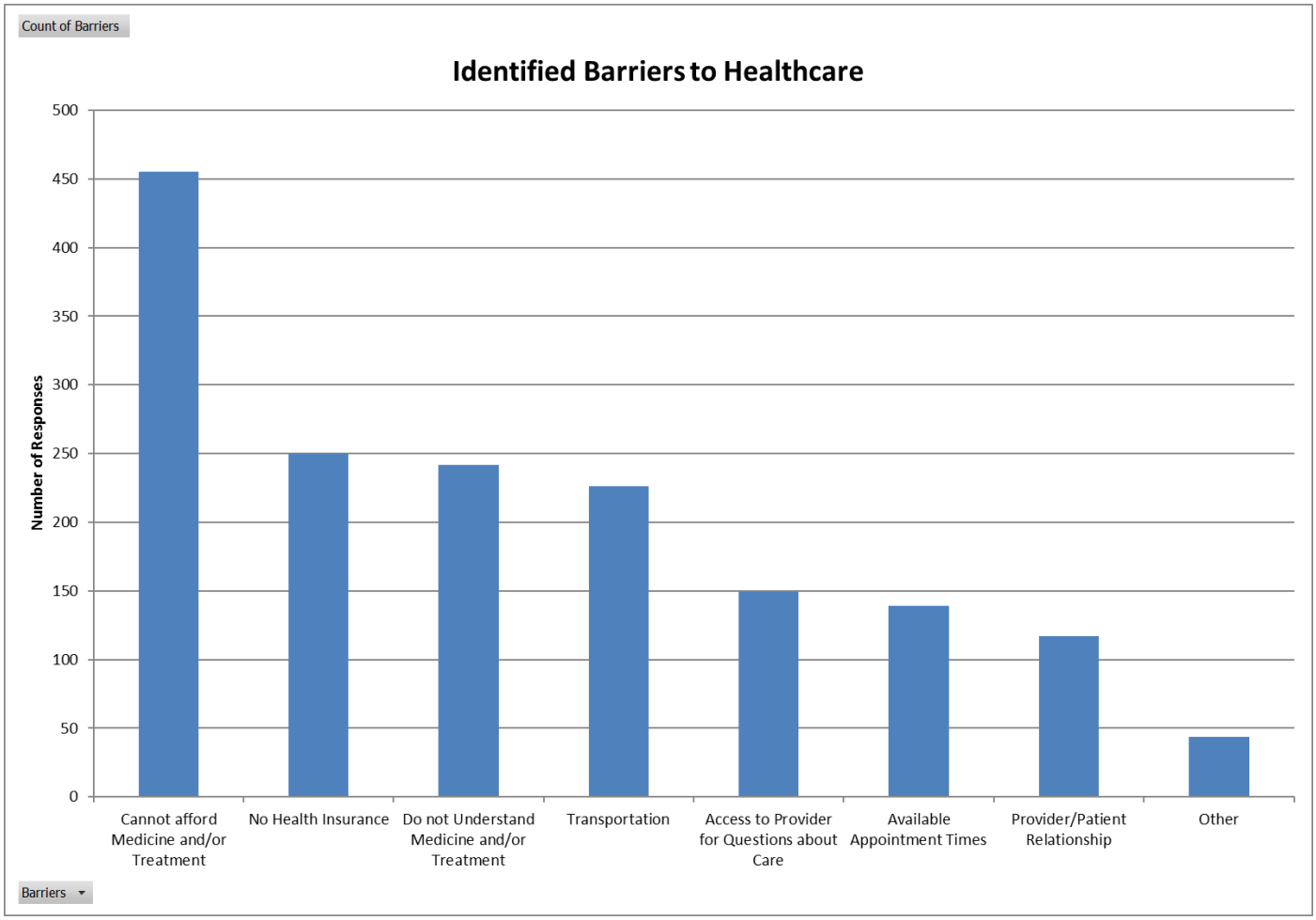
Figure 7



Identified Barriers to Healthcare

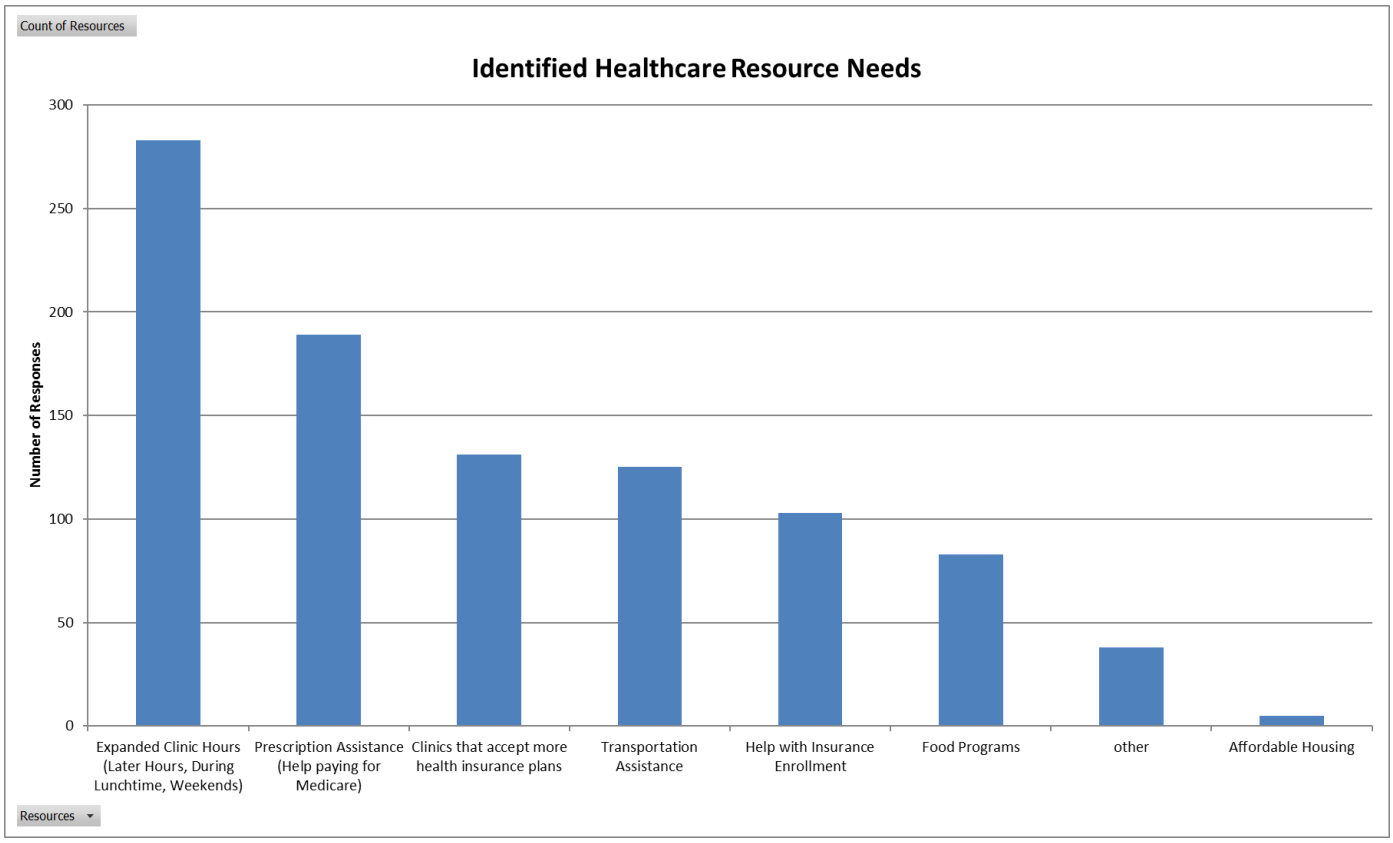
The input from digital surveys indicated that income may be a barrier to being healthy. Results also indicated that Service Area residents have difficulty accessing healthcare and that due to lower educational attainment, health literacy is problematic.

Figure 8



The Survey further asked respondents, what is needed to help the residents of our Service Area become healthier. Figure 9 illustrates results of the input from surveys conducted online.

Figure 9



Interpretation and Findings

The overall health status and needs of the community residents were summarized from the data collected. There are several socio-economic factors that influence the health of our residents, which underpin the poor health status of Arkansans. High levels of poverty, low educational attainment which leads to low health literacy, low insured rates, the rural landscape, and healthcare provider shortages are a few of the leading factors propelling poor health status in the Service Area. The demographic and health data are noteworthy and assisted the team in the summary of the most urgent community health needs.

After collecting and analyzing the demographic, qualitative and quantitative health related data from UAMS PHACS, as well as data from the surveys conducted online, (Illustrated in Figures 2-9); the following categories of health needs were identified:

- **Improve Access to Healthcare Services** (social and economic factors)
  - *High number of adults who lack access to affordable insurance*
  - *High number of adults who lack access to providers*
  - *High number of adults with financial constraints*

- **Improve Preventive Healthcare Management & Wellness** (preventive behaviors and risk behaviors)
  - *High incidence of adults with no colorectal screening*
  - *High incidence of adults not having cholesterol check*
  - *High incidence of adults with no dental care*
  - *High incidence of adults not meeting exercise recommendations*
  - *High incidence of men with no recent prostate cancer screening*
  - *High incidence of drug use*
  - *High incidence of excessive alcohol use*
  - *High incidence of tobacco use*
  - *Low incidence of children with age appropriate vaccinations*
  - *Low incidence of women with early prenatal care*

- **Improve Chronic Disease Management & Education** (health outcomes)
  - *High incidence of adults with arthritis*
  - *High incidence of adults with Chronic Diseases (Coronary Artery Disease (CAD), Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure (CHF), and Diabetes)*
  - *High incidence of adults who report obesity and/or overweight*
  - *High incidence of adults reporting poor mental*
  - *High incidence of accidental deaths*
  - *High incidence of cancer and/or deaths*
  - *High incidence of hearing issues*
  - *High incidence of infant deaths*
  - *High incidence of low birth weight*
  - *High incidence of mortality*
  - *High incidence of premature deaths*
  - *High incidence of preterm births*
  - *High incidence of preventable hospitalizations*
  - *High incidence of teen suicide*
  - *High incidence of traffic fatalities related to drugs or alcohol*
  - *High incidence of vision issues*

Implementation Strategy/Plan

Access to Healthcare Services	Action Steps
• High number of adults who lack access to affordable insurance	• Educate the public by promoting WRHS Financial assistance program to ensure qualified patients receive assistance
• High number of adults who lack access to physicians	• Extend hours at WRHS Clinics in Service Area; hours seasonally adjusted to meet current demand for care • Increase specialty physician services at WRHS facilities outside Batesville, including but not limited to Cardiology, OB/GYN, Oncology, Orthopaedics, Pain Medicine, Wound Care • Recruit primary care providers • Use Rural Practice Program to recruit primary care physicians • Gain approval as Veterans Healthcare Community Care Network facility • Utilize telehealth services to meet primary care needs
• High number of adults with financial constraints	• Revise WRHS Charity Care Policy and application to better serve patients • Educate the public by promoting WRHS financial assistance program to ensure qualified patients receive assistance • WRHS Foundation fundraising to support patient needs
Preventive Healthcare Management & Wellness	**Action Steps**
• High incidence of men with no recent prostate cancer screening	• Offer annual free prostate cancer screening (PSA and rectal exam) and promote via direct mail, print media, radio, and social media throughout the Service Area • Host free Community Education events to educate population on the importance of screening and lifestyle choices to decrease incidence of disease • WRHS Care Coordinators identify high risk patients and provide education

• High incidence of adults with no colorectal screening	• Through community and quality improvement work, WRHS identifies patient needs, provides education, and supports screenings • Conduct annual colorectal awareness campaign to increase awareness and opportunities for screenings • Improve access to preventive care and screening via provider satellite clinics in Sharp and Jackson counties • Purchase of state-of-the-art Olympus endoscopes
• High incidence of adults lacking dental care	• Encourage collaboration with community events to support dental health needs • Surgical privileges for independent Dentist to prevent unnecessary travel by patients
• Low incidence of children with age appropriate vaccinations	• WRHS Care Coordinators identify gap, and educate and support parents, families, and caregivers to meet vaccination needs
• High incidence of adults not meeting exercise recommendations	• Collaborate with Batesville Community and Aquatics Center to support and sponsor events and programs promoting physical activity • WRHS Community Engagement Division develops and supports healthy living and physical activity through events in Cleburne, Independence, Sharp, and Stone counties • WRMC campus provides walking track and park with level, well-lit walking track for public use
• High incidence of adults not having cholesterol check	• WRHS Care Coordinators identify gaps, and educate and support patients at risk for high cholesterol • Community Engagement to increase focus on health and wellness education in the communities we serve. Community Engagement encourages healthy lifestyle choices with diet and exercise. Program offers community health and worksite screenings specifically to address incidence of Coronary Artery Disease, high blood cholesterol, diabetes, and hypertension. Collaborate with local schools on health and wellness and encourage healthy activity

• Low incidence of women with early prenatal care	• Expand availability of prenatal care through satellite OB/GYN Clinics in Jackson, Sharp, and Stone Counties • Expand educational programs of Maternity Nurse Navigator
• High incidence of drug use • High incidence of excessive alcohol use	• Through Behavioral Health integration and telehealth services, coordinate care, and provide services to patients with an identified need • Continue support of satellite Interventional Pain Management Clinics throughout the WRHS Service Area to decrease patients' dependence on prescription opioid medication • Through quality program work, providers and care team members screen and treat patient with identified needs • Support drug and alcohol-free events in local schools • Appropriately evaluate behavioral health needs of patients treated by pain management clinic and refer as needed to Behavioral Health services • Employ Family Medicine physician with Suboxone certification to offer opioid addiction treatment
• High incidence of tobacco use	• Through quality program work, providers and care team members screen and identify patients at risk and provide treatment • Expand Cardiopulmonary Rehabilitation Program to Sharp and Stone counties • Support patient safety policy to prescribe nicotine replacement therapy during hospitalization • Assess patient tobacco use, their willingness to change/quit, and support for cessation referral • Success in Medicaid IQI program in tobacco screening and cessation and commitment to continued improvement
Chronic Disease Management and Education	**Action Steps**
• High incidence of adults who report obesity and/or overweight	• WRHS Community Engagement Division develops and supports healthy living and physical activity through events in Cleburne, Independence, Sharp, and Stone counties • Collaborate community resources to provide a Farmers market on WRMC Campus • Incorporate Behavioral Health services in Primary Care Clinics to support behavior change to healthier lifestyle choices

	• Utilize social media to increase awareness of healthy living and physical activity • WRMC campus provides walking track and park with level, well-lit walking track for public use
• High incidence of adults with arthritis	• Rheumatology Infusion Center provides access to arthritis treatment in a central convenient location • Recruit Orthopaedic Surgeon to improve access to orthopaedic care • Add Orthopaedic satellite clinics to remove barriers to care • Add robotic assisted surgical technology for total joint replacement to improve surgical outcome, reduce pain, and speed recovery
• High incidence of cancer and/or deaths	• Cancer prevention initiatives provide education, early detection through screenings, and patient assistance • Direct mail campaigns in the Service Area to raise awareness of screening opportunities
• High incidence of adults reporting poor mental health	• Incorporate Behavioral Health professionals in Primary Care Clinics to support mental health needs • Utilize telehealth services to meet mental health needs • Through quality program work, WRHS Care Coordinators identify patients with mental health risks and coordinate care with Behavioral Health Services
• High incidence of teen suicide	• Collaborate with local schools and community events to educate on suicide awareness and prevention
• High incidence of adults with Chronic Diseases (CAD, CHF, COPD, and Diabetes)	• Through quality program work, Care Coordinators identify high-risk and high-utilization patients to provide coordination of care and meet educational needs • Host provider-led Free Community Education events educate the population and support self-management of chronic conditions • Expand Cardiopulmonary rehabilitation programs to Sharp and Stone counties • Provide low cost Cardiac Calcium Scoring CT to area residents with cardiovascular risk factors

• High incidence of mortality	• Through quality program work, Care Coordinators identify high-risk and high-utilization patients to provide coordination of care and meet educational needs • Host provider-Led Free Community Education events to educate population and support self-management of chronic conditions • WRHS Community Engagement Division develops and supports healthy living and physical activity through events in Cleburne, Independence, Sharp, and Stone counties
• High incidence of premature deaths	• Provide cardiac screening to student athletes during pre-season sports physical • Provide low cost Cardiac Calcium Scoring CT to area residents with cardiovascular risk factors
• High incidence of accidental deaths • High incidence of traffic fatalities related to drugs or alcohol	• WRHS Community Engagement development supports healthy living and physical activity • Support Survival Flight 4 Helicopter base at WRMC • Add helipad at WRMC Medical Complex Cherokee Village • Provide sponsorship and support of *Every 15 Minutes* and Distracted Driving Demonstrations in cooperation with local schools • Collaborate with local schools and businesses to educate and promote Stop the Bleed Program • Collaborate with Boy Scouts of America and local schools to provide Explorer Post Program to area youth
• High incidence of vision issues	• Collaborate with local Optometrists at community events to support vision health • Clinically Intergraded Network Accountable Care Organization collaborates with community Optometrist to provide education or meet needs
• High incidence of infant deaths • High incidence of low birth weight • High incidence of preterm births	• Maintain national certification as a Safe Sleep Hospital through the Cribs for Kids • Support infant safe sleep with gift of wearable blanket sleeper for every newborn • Expand prenatal care through satellite OB/GYN clinics in Jackson, Sharp, and Stone counties • Pediatric AR Medicaid Patient Centered Medical Home focuses on preventive care and education • WRHS Sponsors Safe Sitter Education Program • WRHS Maternity Nurse Navigator supports and provides education to expectant and new moms

	• Collaborate with Community Resources to support maternal needs and education • Certified WRMC Women and Newborn Care staff ensure all newborns leave the hospital in a properly installed approved car seat
• High incidence of hearing issues	• Recruit second ENT physician to Medical Staff • Employ Audiologist • Host provider led community education on hearing loss • Investigate partnerships with Audiology Clinics to improve access to ENT services
• High incidence of preventable hospitalizations	• Through quality program work, Care Coordinators identify patients with ambulatory care sensitive conditions and provide self-management support • Health Coaches educate and connect patients with community and healthcare resources to reduce unintended hospital readmission

Communications Plan

The approved WRHS CHNA will be published on the WRHS website, www.whiteriverhealthsystem.com. It will be distributed electronically to WRHS Administrative Team, Physicians, and Board Members, as well as Community Stakeholders. Printed copies will be available upon request by contacting WRHS Marketing at (870) 262-6070.

Appendix B
Bridge Document

The White River Health System Board of Directors approved the three-year Community Health Needs Assessment (CHNA) in September 2019. This bridge document identifies actions taken by White River Medical Center and Stone County Medical Center to meet the health of residents served by these institutions and outlined in the 2016 CHNA.

Access to Healthcare Services	Action Steps
• Adults reporting no personal physician	• Established an accredited Graduate Medical Education Program with Internal Medicine Residency in July 2017 • Partnered with the University of Arkansas for Medical Sciences on a Family Medicine Residency in July 2019 • Added WRHS owned Clinic in Fairfield Bay (Van Buren County), Heber Springs (Cleburne County) and Southside (Independence County). Clinic locations are evaluated and adjusted to ensure efficiency and continued access to care. • Extended hours at Melbourne Medical Clinic (Izard County) to provide services seven days a week – Clinic hours are adjusted to meet seasonal demand for care • Added Weekend Clinic in Newport (Jackson County) • Extended hours of operation at WRMC Medical Complex Southside to seven days • Increased specialty physician services at WRHS facilities outside Batesville, including but not limited to Cardiology, Obstetrics/Gynecology, Oncology, Orthopaedics, Pain Medicine, and Wound Care • Recruited Primary Care providers
• Lack of Health Insurance	• Worked with Arkansas Health Insurance Exchange to host enrollment events – Residents needs were met by online enrollment and in-person enrollment events were not required • Trained employees to appropriately screen patients at admission for financial assistance programs and charity care – WRHS added to Financial Counseling staff and revised Charity Care policy and application process to better serve patients

Preventive Healthcare Management & Wellness	Action Steps
• Low percentage of women receiving prenatal care	• Recruited additional Obstetrician/Gynecologist • Established satellite clinics in Jackson, Sharp, and Stone Counties • Established monthly Childbirth Education and Breastfeeding classes offered to expectant mothers free of charge
• High percentage of men who report no recent Prostate Cancer Screening	• WRHS provided free annual prostate cancer screening with PSA and rectal exam and expanded promotion to reach more counties to raise awareness of the screening opportunity • WRHS provided Free Community Education events to educate population on the importance of screening and life-style choices to decrease incidence of disease • Participated in an Accountable Care Organization and seven different quality programs with goals of meeting the quadruple aim
• Low percent of children with age appropriate vaccines	• Improved access to Pediatrician and Pediatric APRN through successful provider recruitment • Continued participation in AR Medicaid Patient Centered Medical Home
• High number of adults reporting no exercise	• Supported Batesville Community and Aquatics Center through sponsorships and employee discounts • Supported SCMC employees with discounts at local fitness center • Promoted Silver Sneakers program offered by local fitness center in Independence, Izard, and Stone Counties • Offered exercise program at WRHS managed Senior Citizens Centers • WRMC campus provided walking track and park with level, well-lit walking track for public use
• Adults reporting no pneumonia vaccine	• Provided patient education regarding importance of vaccine to at risk patients • Evaluated respiratory conditions and provided appropriate treatment, patient education, and medication access

Chronic Disease Management and Education	Action Steps
• High incidence of CAD, CHF, high cholesterol, diabetes, and hypertension	• Expanded Cardiology services to add Electrophysiology and satellite Cardiology clinics. • Expanded of Cardiac Rehabilitation Services in Stone and Sharp Counties • Changed CommHealth program to Community Engagement for increased focus with education on health and wellness in the communities we serve. Community Engagement encouraged healthy lifestyle choices with diet and exercise. Program continued to offer community health and worksite screenings specifically to address incidence of Coronary Artery Disease, high blood cholesterol, diabetes, and hypertension. Collaborated with local schools on health and wellness and encouraged healthy activity • Active participation of primary care providers and their patients in CMS CPC+ program beginning in 2017 • Hosted free community education by providers highlighting lifestyle choices to reduce risk • Active participation in AR SAVES Telemedicine Program for the prompt diagnosis and treatment of strokes and ongoing patient and community education • Improved patient understanding of disease processes and self-care through education • Care Coordinators ensured patients have access to glucose testing supplies, enrollment in Federal Nutrition Assistance programs, and access to other community support services
• High percentage of adults with arthritis	• Successful recruitment of a Rheumatologist to the WRMC Medical Staff • Established WRMC Perioperative Surgical Home program to optimize outcome for patients undergoing total joint replacement • Collaborated with City of Batesville to develop aquatic therapy program at Batesville Community and Aquatics Center

• High number of infant deaths	• Obtained national certification as a Safe Sleep Hospital through the Cribs for Kids and Taylor McKeen Shelton Foundation • Expanded availability of prenatal care through ongoing recruitment of Obstetrician/Gynecologist • Expanded access to pediatric care through ongoing recruitment of Pediatric providers • Participated in AR Medicaid Patient Centered Medical Home focusing on preventive care and education • Secured grant for birthing simulation equipment for clinical education to improve outcomes in high risk obstetrical cases • WRMC Sponsored of Safe Sitter Education Program
• High incidence of cancer deaths; specifically, breast, lung, and colorectal cancer	• Researched feasibility of creating an accredited Breast Center of Excellence; determined not feasible due to resource constraints • Implemented clinical protocol for lung CT screening of patients who meet CMS criteria • Primary Care providers and their patients participated in CMS CPC+ and other quality programs. • Obtained grant for Colorectal screening awareness programs • Added digital screening mammography to Sharp and Stone Counties • Provided Satellite Oncology Clinics in Sharp and Stone Counties
• High number of adults who report being overweight or obese	• Primary Care providers and their patients participated in CMS CPC+ and other quality programs. • WRMC provided a walking track and park with level, well-lit walking track for public use • WRMC Cardiac Rehabilitation Program provided a low-cost maintenance exercise program • Supported Batesville Community and Aquatics Center through sponsorships and employee discounts • Supported exercise programs at Senior Centers managed by WRHS
• High incidence of smoking and smokeless tobacco use	• Developed Pulmonary Rehabilitation Program • Supported patient safety policy to prescribe nicotine replacement therapy during hospitalization • Continued to assess patient tobacco use, their willingness to change/quit, and support for cessation referral

• High incidence of accidental death and traffic fatalities involving drugs and alcohol	• Provided support of Survival Flight 4 Helicopter base at WRMC • Sponsored and support of *Every 15 Minutes* and Distracted Driving Demonstrations in cooperation with local schools • Managed Satellite Emergency Department in Cherokee Village (Sharp County) • Expanded WRMC Emergency Department, specifically trauma capacity
• High incidence of excessive alcohol use and drug abuse	• Established satellite Interventional Pain Management Clinics in Cherokee Village (Sharp County), Mountain View, and Newport to decrease patients' dependence on prescription opioids • Supported drug and alcohol-free events in local schools
• High Incidence of Premature Death	• Addressed chronic health needs, improved access to care, and provided community education with the goal of reducing premature death from all causes

Appendix C

White River Medical Center

Community Health Needs Assessment
Community Resident Survey

Where do you live? (Check all that apply)

____ Cleburne
____ Independence
____ Izard
____ Jackson
____ Lawrence
____ Sharp
____ Stone
____ Other (specify) _____

Which best describes you?

____ Asian/Pacific Islander
____ Black or African American
____ Hispanic or Latino
____Native American or American Indian
____ White
____Other (please specify) _____

What best describes your age group? (Check all that apply)

____Younger than 6 years
____Ages 6-12
____Teens (ages 13-18)
____Adults (ages 19-64)
____Older Adults (ages 65 and older)

What is your gender?

____Male
____Female

Which best describes your household?

____ Foster Parent Household
____ Grandparent Raising Grandchildren Household
____ No Children Household
____ Single Parent Household
____ Teen Parent Household
____ Two-Parent Household

Which best describes your employment

____ Employed – Low Wage Job
____ Employed – Professional or Highly Skilled Job
____ Retired
____ Self Employed
____ Unemployed

Which describes your education level? (Check all that apply)

____ High School Graduate
____ College Graduate
____ Post Graduate Degree Completed
____ Enrolled in College – Undergraduate or Postgraduate
____ Enrolled in Vocational or Trade School
____ High School Dropout Enrolled in GED Program
____ High School Dropout without GED

How would you rate your health?

____Excellent
____Good
____Fair
____Poor
____Very Poor

Which health insurance do you have? (Check all that apply)
____ AR Kids
____ AR Medicaid
____ AR Works
____ Employer Sponsored Health
____ High Deductible Health Insurance
____ Individual Health Insurance
____No Health Insurance
____Other (specify) _____

If you do not have insurance, specify why.
_____
_____

Based on your experiences, what are the two greatest healthcare needs in our community?

1. _____
2. _____

Do you know of any programs implemented elsewhere in the state to address these needs and that could be implemented in our community? If so, please list the name of the program and the community where implemented.

1. _____
2. _____

Based on your experiences, what are the major barriers to healthcare? (Check all that apply)
____ Access to Provider for Questions about Care
____ Available Appointment Times
____ Cannot Afford Medicine and/or Treatment
____ Do not Understand Medicine and/or Treatment
____ Provider/Patient Relationship
____ Transportation
____ No Health Insurance
____ Other (Specify) _____

What resources would help you most?
____ Affordable Housing
____ Clinics that accept more health insurance plans
____ Expanded Clinic Hours (Later Hours, During Lunchtime, Weekends)
____ Food Programs
____ Help with Insurance Enrollment
____ Transportation Assistance
____ Prescription Assistance (help paying for Medicine)
____Other (specify) _____

THANK YOU!