2023-2025

COMMUNITY HEALTH NEEDS ASSESSMENT

Baptist Health

contents

Baptist Health Of Arkansas:
Dedicated To Wellness, Driven By Purpose

On February 16, 1921, The Pulaski County Circuit Court Ordered The Incorporation Of Baptist State Hospital, And The Organization That Would Eventually Grow Into The Baptist Health System Was Born.

Though The Original Hospital Opened Its Doors In Little Rock With Less Than A Hundred Beds In A Small Building, The Purpose Was Significant – Create A Healthier Community Through Christian Compassion And Innovative Services. While Much Has Changed Over The Past Century, Our Goal Has Remained The Same And Has Served As The Driving Force Behind All We've Accomplished.

Today, Baptist Health Is Arkansas' Most Comprehensive Healthcare Organization With More Than 200 Points Of Access That Include 11 Hospitals, Urgent Care Centers, A Senior Living Community, And Over 100 Primary And Specialty Care Clinics In Arkansas And Eastern Oklahoma. The System Additionally Offers A College With Studies In Nursing And Allied Health, A Graduate Residency Program, And Access To Virtual Care Through A Mobile App. Baptist Health, As The Largest Not-For-Profit Health Care Organization Based In Arkansas, Provides Care To Patients Wherever They Are Through The Support Of Approximately 11,000 Employees, Groundbreaking Treatments, Renowned Physicians, And Community Outreach Programs.

OUR 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.

OUR 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.

OUR VALUES

In Fulfilling Our Mission, We Place Special Emphasis On The Values Of:
Service • Honesty • Respect • Stewardship • Performance

Community Health Needs Assessment Overview

The 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.

The CHNA written report must include descriptions of the following:

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

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

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

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

Community Health Needs Assessment Process Map

In order to complete a comprehensive assessment of the needs of the community, the Arkansas Center for Health Improvement's (ACHI) 9-step Community Health Assessment Process was utilized as an organizing methodology. The Baptist Health Community Outreach Department lead the process of conducting the Community Health Needs Assessment (CHNA) with input from Marketing & Communications and Regional Hospital staff.

Methodology And Data Sources

Baptist Health engaged the Arkansas Center for Health Improvement (ACHI) to conduct the quantitative data collection and analysis for the 2022 Community Health Needs Assessment (CHNA) process. Baptist Health provided ACHI with the counties served for each of its 11 hospital facilities in the state — i.e., the hospital communities. A total of 15 Arkansas counties and two Oklahoma counties were included in the CHNA. This document is a summary of the methods used to conduct the quantitative portion of the CHNA.

Methods

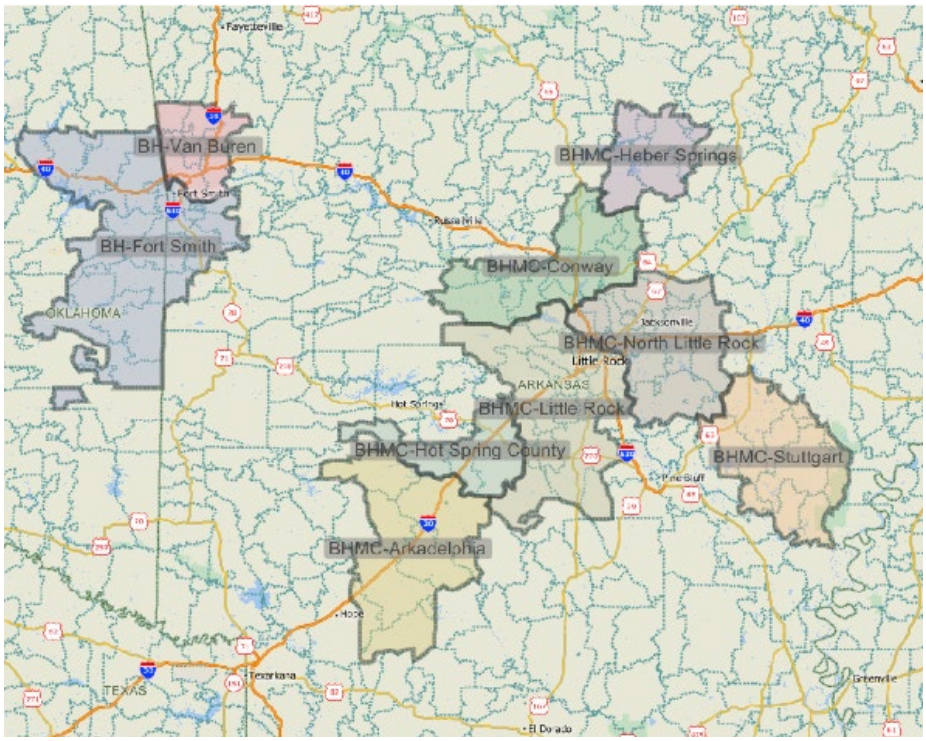
For 2019, communities served for acute care hospitals was defined using zip codes that represent greater than or equal to 2 percent of the hospital's combined inpatient/outpatient visits AND in which the hospital's inpatient market share is greater than or equal to 20 percent. Communities for Extended Care Hospital and Rehabilitation Institute were defined by the disease/injury state of patients served by the seven acute care hospitals in Central Arkansas. Attention was also paid to Arkansas's ranking in respect to major health issues when compared to other states.

Central Arkansas
BHMC-LR: Pulaski (South), Saline, Grant
BHMC-NLR: Pulaski (North), Lonoke
BHMC-A: Clark, Nevada
BHMC-HS: Cleburne
BHMC-HSC: Hot Spring
BHMC-S: Arkansas
BHMC-C*: Faulkner, Perry

*BHMC-Conway-new hospital in 2016, still establishing market share so no counties met the 20%> market share criteria.

Western Arkansas/Easter Oklahoma
BH-FS**: Sebastian, LeFlore (OK), Sequoyah (OK)
BH-VB***: Crawford

**BH-FS, ***BH-VB-new hospitals for Baptist Health in 2018. Zip code level data not available for volume or market share determination. CHNA market determined by IP Medicare Market Share Primary Market area.



Data Analysis

To assess the health-related needs of each hospital's community, ACHI gathered, synthesized, and analyzed data for 98 health indicators and demographic measurements from several data resources, including:

- AFMC
- Arkansas All-Payer Claims Database (APCD)
- American Community Survey (ACS)
- Arkansas Center for Health Improvement (ACHI)
- Arkansas Department of Health (ADH)
- Arkansas Health Data Initiative (HDI)
- Arkansas Prevention Needs Assessment Survey (APNA)
- Behavioral Risk Factors Surveillance System (BRFSS)
- County Health Rankings
- National Center for Health Statistics (NCHS)
- National Institute on Minority Health and Health Disparities (NIMHD) HDPulse: An Ecosystem of Minority Health and Health Disparities Resources
- Small Area Health Insurance Estimates (SAHIE)
- SparkMap

Social Determinants of Health

Traditionally, community health was measured and discussed in terms of diabetes, obesity, heart disease or stroke. A traditional look at personal behaviors included topics such as physical activity, healthy eating, tobacco use and its effect on overall health. The data is showing that all of these factors continue to affect health outcomes, but alone may not be enough to create the healthy communities we desire. Our environment, where we live, work and play also contribute to our health outcomes. These environments are called Social Determinants of Health (SDOH). The Social Determinants of Health often times explain why people face a more difficult challenge in achieving and maintaining good health. The Centers for Disease Control and Prevention (CDC) diagram outlines the five key areas of (SDOH). Due to this focus you will see more data on areas like poverty, education and employment in this report.

For the 2023-2025 CHNA the Health indicators were organized into one of six categories. The categories and health indicator within each are as follows:

Table 1: Health Indicators Analyzed For The CHNA By Category

Health Outcomes
- Premature Death
- Poor or Fair Health
- Poor Physical Health Days
- Low Birthweight

Prevention
- No Pap Test
- No Colorectal Cancer Screening
- No Flu Shot
- No HIV Test
- No Dental Visit
- Blood Pressure Medication Non-Adherence
- No Annual Wellness Visit (Medicare)
- No Routine Check Up (Adults)

Diagnoses Incidence Within Hospital Community at Discharge
- Hypertension
- Hyperlipidemia
- Ischemic Heart Disease
- Arthritis
- Diabetes

Cause of Death
- All Causes
- Cancer
- Stroke
- Chronic Lower Respiratory Disease
- Diabetes
- Heart Disease
- Unintentional Injury
- Motor Vehicle Crash
- Alcohol-Involved Motor Vehicle Crash

Access
- Uninsured
- Primary Care Physicians
- Dentists
- Mental Health Providers
- Addiction or Substance Use Providers
- Buprenorphine Providers
- Preventable Hospital Stays
- Mammography
- Diabetic Monitoring

Mental Health and Substance Use
- Suicide Deaths
- Poor Mental Health
- Youth Depression
- Adult Depression
- Excessive Drinking
- Non-Fatal Opioid Overdoses
- Opioid Overdose Deaths
- Drug Overdose Deaths

Chronic Conditions
- High Blood Pressure
- Asthma
- Coronary Heart Disease
- Arthritis
- High Cholesterol
- Diabetes
- Adult Obesity
- Child Obesity

Social and Economic Factors
- Not High School Graduates
- High School Graduation in Four Years
- Some College
- Unemployment Rate
- Children in Poverty
- Population in Poverty
- Children in Single-Parent Households
- Homeless Children
- Food Insecurity
- Social Associations
- Violent Crimes

COVID-19
- COVID-19 Cases
- COVID-19 Deaths
- Adults Fully Vaccinated
- Adult COVID-19 Vaccine Hesitancy

Health Behaviors
- Adult Smoking
- Youth Vaping
- Sexually Transmitted Infections
- Physical Inactivity
- Teen Births

Environment
- Food Environment Index
- Access to Exercise Opportunities
- Drinking Water Violations
- Severe Housing Problems
- Broadband Access
- Long Commute Driving Alone

In addition to the health indicators, demographic data were collected for each community including sex, age, race, and type of insurance coverage. All data are presented at the county, state, and national level depending upon data availability.

The analytic sample for the indicators within the Diagnoses Incidence Within Hospital Community at Discharge category is comprised of all inpatient and outpatient hospital discharges for Arkansas in 2020 and restricted to adults 18 years of age and older living within the counties of interest. The ICD-10-CM diagnoses codes used for these conditions were obtained from the Center for Medicare and Medicaid Services Chronic Conditions Data Warehouse. Statistical Analysis System (SAS) software was used to analyze the primary and secondary diagnoses data. The number of discharges was divided by the estimated population (18 years and older) for each county to calculate the incidence of adults being discharged from the hospital diagnosed with the chronic conditions in 2020.

ACHI created a report for each hospital community to display the quantitative results. Each section includes a table with health indicator data for each county in the hospital community, a community average for each measurement, and data for the state of Arkansas and the United States. If data were not available or were suppressed, "Data Not Available" is displayed. Each section also includes graphics for various health indicator data.

COUNTY RANKINGS

To assist Baptist Health in identifying priority needs for the hospital communities, ACHI ranked counties with available data into tertiles for each health indicator. Figure 1 shows an example of the rankings for Prevention. See the Data Book for all rankings.

Table 1: Health Indicators Analyzed For The CHNA

County Ranking Key: Top Third | Middle Third | Bottom Third

	No Pap Test	No Colorectal Cancer Screening	No Flu Shot	No HIV Test	No Dental Visit
	Percent (Age-Adjusted)	*Percent (Age-Adjusted)*	*Percent*	*Percent*	*Percent (Age-Adjusted)*
Arkansas County	16.6	42.3	57.9	57.2	48.2
Clark County	14.9	37.9	59.7	57.6	41.0
Cleburne County	16.7	39.4	58.5	65.8	44.0
Crawford County	17.2	39.3	58.1	69.7	45.2
Faulkner County	15.4	35.0	55.8	63.9	40.8
Grant County	16.2	37.5	54.9	66.3	40.2
Hot Spring County	16.7	37.1	58.6	66.8	44.7
Le Flore County (OK)	18.8	49.4	58.4	Data Not Available	47.7
Lonoke County	15.8	37.7	60.8	64.2	42.9
Monroe County	17.9	43.5	60.5	63.3	54.2
Nevada County	16.7	41.2	59.4	64.1	50.6
Perry County	17.9	40.1	58.6	69.7	46.1
Prairie County	17.1	40.8	56.8	63.4	46.0
Pulaski County	14.0	28.5	54.0	54.8	35.4
Saline County	14.3	37.7	53.6	68.0	38.5
Sebastian County	17.4	41.7	57.1	67.7	47.1
Sequoyah County (OK)	20.0	48.9	59.4	Data Not Available	51.7
State	16.3	38.1	58.5	63.6	43.4
National	14.5	35.0	58.1	Data Not Available	33.8

The color-coded rankings are:

RED represents counties rated in the top third

ORANGE represents counties rated in the middle third

YELLOW represents counties rated in the bottom third

State Rankings and Additional Guidance:
America's Health Rankings

Introduction

Baptist Health engaged the Arkansas Center for Health Improvement (ACHI) to conduct the quantitative data collection and analysis for the 2022 Community Health Needs Assessment (CHNA) process. Baptist Health provided ACHI with the counties served for each of its 11 hospital communities. A total of 15 Arkansas counties and two Oklahoma counties were included in the CHNA.

This document provides national and state comparisons of the health indicators analyzed in the CHNA, additional guidance for selecting interventions, and a list of state- and local-level initiatives in Arkansas.

State Rankings

This section offers state and national rankings of the health indicators examined in the CHNA, using available data for 2021 from America's Health Rankings. Table 1 displays the health indicators, the state and national values for each indicator, and the state's ranking for each indicator, with "1" being the best possible ranking. Health indicators ranked 41st or worse are highlighted in red. Actual data and data sources may differ with county-level data elsewhere in the CHNA due to data availability.

While Arkansas's rankings relative to other states are critical to identify shared priorities, data show that each Baptist Health community performs differently compared to other communities and to the state average. For example, although Arkansas ranks 32nd in sexually transmitted infections at 570 cases of chlamydia per 100,000 population, the range within the Baptist Health communities is between 220 and 903 cases of chlamydia per 100,000 population.

Table 1: America's Health Rankings, 2021

Health Indicator	AR Value	U.S. Value	AR Rank
Asthma (Percent)	9	10	18
Cancer (Percent)	8	7	44
Cardiovascular Diseases (Percent)	12	8	48
Chlamydia (per 100K Population)*	570	551	32
Colorectal Cancer Screening (Percent)	71	74	35
Dental Care Providers (per 100K Population)	43	62	48
Dental Visit (Percent)	57	67	50
Depression (Percent)	24	20	45
Diabetes (Percent)	13	11	44
Drinking Water Violations (Percent)	0	1	24
Excessive Drinking (Percent)	16	18	15
Flu Vaccination (Percent)	48	47	22
Food Insecurity (Percent)	13	11	42
Poor Mental Health (Percent)**	18	13	50
Poor Physical Health (Percent)***	14	10	48
High Blood Pressure (Percent)	41	33	47
High Cholesterol (Percent)	37	33	47
High School Graduation (Percent)	88	86	16
High-Speed Internet (Percent)	84	89	48
Low Birthweight (Percent)	9	8	38
Mental Health Providers (per 100K Population)	254	284	30
Obesity (Percent)	36	32	41
Physical Inactivity (Percent)	30	22	47
Premature Death (per 100K Population)	9,796	7,337	44
Preventable Hospitalizations (per 100K Medicare beneficiaries)	4,198	3,770	35
Primary Care Providers (per 100K Population)	216	252	44
Severe Housing Problems (Percent)	14	17	19
Smoking (Percent)	21	16	48
Suicide (per 100K Population)	18	15	34
Teen Births (Births per 1,000 females ages 15-19)	30	17	50
Unemployment (Percent)	5	5	37
Uninsured (Percent)	9	9	31
Violent Crime (per 100K Population)	585	379	47

A rank of 41 or worse.

Source: America's Health Rankings, 2021 Report.

*Listed as "chlamydia" by America's Health Rankings.
** Listed as "frequent mental distress" by America's Health Rankings.
*** Listed as "frequent physical distress" by America's Health Rankings.

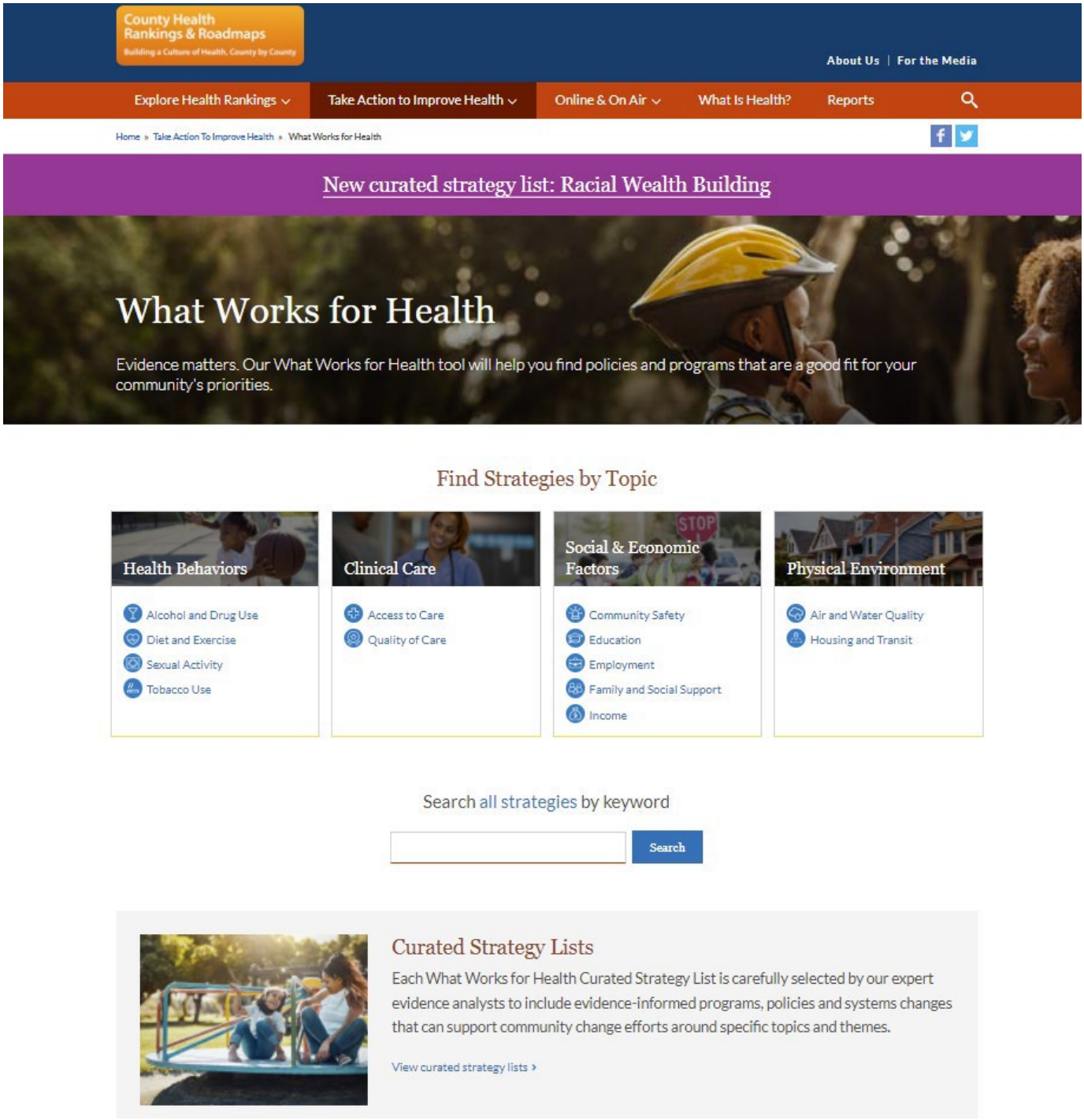
Additional Guidance

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 by Community Tool Box is commonly used to identify potential origins of an issue. 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. After the underlying factors are identified, further analysis may be necessary. Figure 1 provides a template to utilize the “But why?” technique.

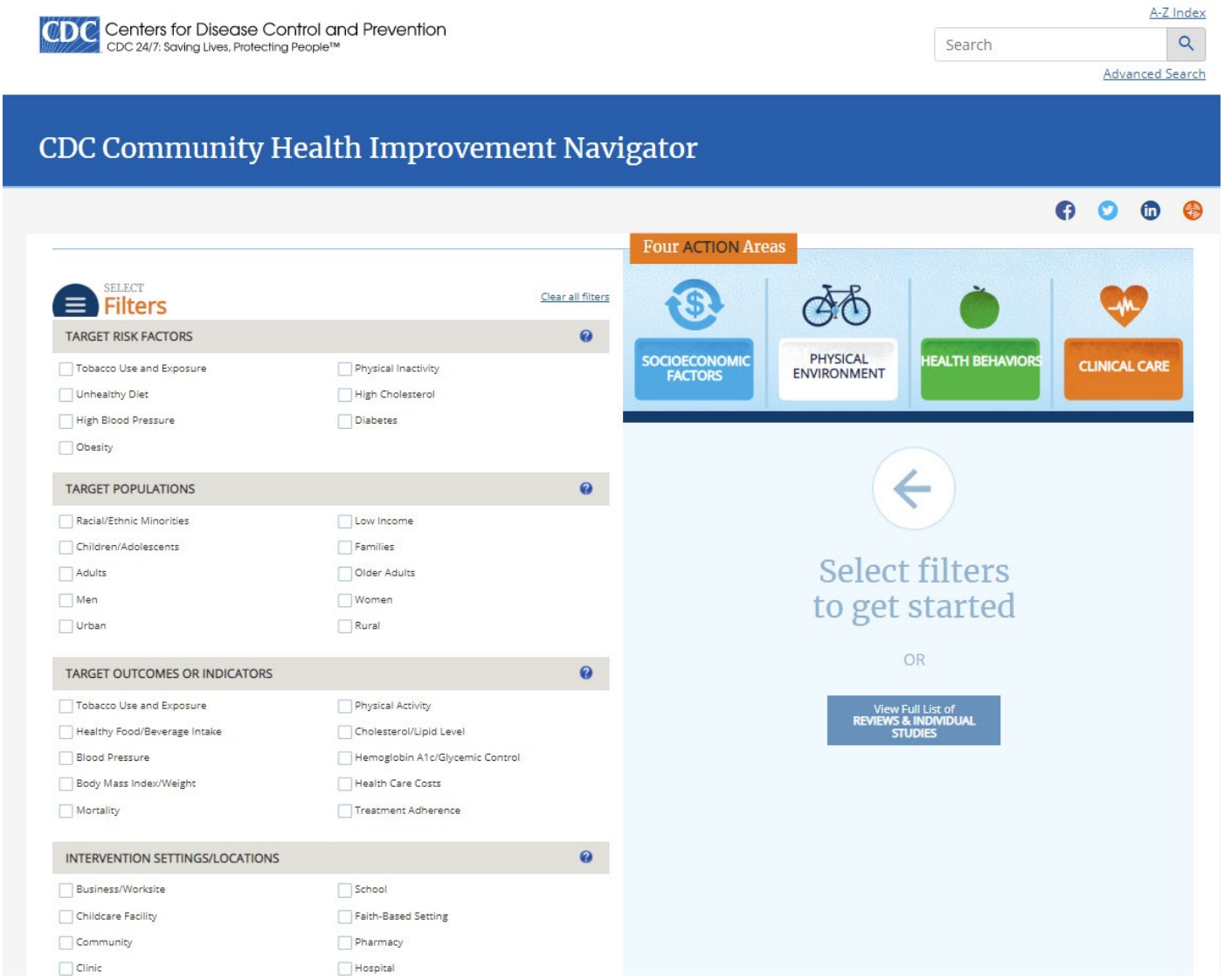
FIGURE 1: ‘BUT WHY?’ TEMPLATE

Selecting Interventions

Once Baptist Health is ready to review potential programs to address the identified priority needs, there are several resources available to help research effective, long-term interventions. One resource is County Health Rankings' What Works for Health tool, which showcases various policies and programs for communities to consider adopting to address their needs. The online tool allows the user to pick a health indicator and read about relevant interventions and how those interventions are supported (by expert opinion, individual experience/case study, or scientific study). Access the tool here: **https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health**



Another resource, the Centers for Disease Control and Prevention's Community Health Improvement Navigator, provides information similar to County Health Rankings' tool. 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**



A third resource is Healthy People 2030's list of evidence-based resources. These resources are based on published reviews of studies, and interventions and are organized by topic.

Objectives and Data | Tools for Action | Priority Areas | About | Custom List (0)

Healthy People 2030

Search

Home » Tools for Action » **Browse Evidence Based Resources**

Browse Evidence-Based Resources

Evidence-based resources are published reviews of studies and interventions to improve health. We've organized them into intuitive topics so you can easily find what you're looking for. Pick a topic you're interested in and explore relevant resources that can help you work to achieve Healthy People 2030 objectives.

Learn more about what EBRs are and how to use them.

On this page: Health Conditions | Health Behaviors | Populations | Settings and Systems | Social Determinants of Health

Health Conditions

Arthritis

Blood Disorders

Cancer

Chronic Kidney Disease

Chronic Pain

Dementias

Diabetes

Foodborne Illness

Health Care-Associated Infections

Heart Disease and Stroke

Infectious Disease

Mental Health and Mental Disorders

Oral Conditions

Osteoporosis

Overweight and Obesity

Pregnancy and Childbirth

Respiratory Disease

Sensory or Communication Disorders

Sexually Transmitted Infections

Initiatives In Arkansas

A number of current or proposed initiatives in Arkansas could serve well as community benefit activities and address the community needs identified in this report. For example, there are collaborative funding opportunities, made available by the American Rescue Plan Act (ARP), to address mental health and substance use issues. This is particularly important as the COVID-19 pandemic has worsened the existing mental health crisis for individuals of all ages. The ARP provides options for states, counties, and municipalities to invest in community- and school-based mental health services, and additional funding through the Elementary and Secondary School Emergency Relief Fund can support the mental health, emotional, social, and academic needs of students. Weaving these funding streams and hospital community benefit investments can create economies of scale and more sustainable approaches to ensuring access to mental health and substance use disorder services.

While still under review by the Centers for Medicare and Medicaid Services, the Life360 HOMEs approach — proposed as part of the revamped Medicaid expansion program, Arkansas Health and Opportunity for Me, or ARHOME — is an opportunity to improve the health of three targeted high-risk populations: rural residents, infants and pregnant women, and young adults at risk of long-term dependency. The proposed Maternal Life360 HOME will be an opportunity for hospitals to offer evidence-based home visiting services for women with high-risk pregnancies and children in the first two years of life. Combining hospital community benefit investments that target these high-risk populations with funding allocated by Medicaid for Life360 HOMEs could enhance individual and community impact through complementary services.

Below is a list of existing local-level and statewide initiatives in Arkansas. A brief description and website address (where available) are provided for each initiative. 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 those needs.

Local-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.
  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.
  arkansasobesity.org/initiatives/growing-healthy-communities/overview.html

- **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.
  dese.ade.arkansas.gov/Offices/learning-services/school-health-services/joint-use-agreement-jua#:~:text=The%20Arkansas%20Joint%20Use%20Agreement,the%20Arkansas%20Tobacco%20Excise%20Tax

- **Safe Routes to School (SRTS):** SRTS 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.
  ardot.gov/divisions/program-management/safe-routes-to-school/

- **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.
  dese.ade.arkansas.gov/Offices/learning-services/school-health-services/school-based-health-center-sbhc

- **ArCOP Arkansas Farmers' Markets Association:** The association's mission is to improve access to healthy, local foods through market analysis and data gathering. The association is also committed to supporting its members through branding, marketing, and advertising.
  arkansasobesity.org/afma/join-the-afma.html?fbclid=IwAR03ov46t7YMRsXg7IxWSNSS6surwfyjRJwPkSQxYrDeyszKhdf1j-PhjxM

STATEWIDE INITIATIVES

- **Arkansas Hospital Emergency Room Discharge Naloxone Program (NaloxHome):** The program aims to prevent opioid overdoses in communities statewide by working with hospitals to dispense naloxone at emergency room discharge to patients or caretakers of patients who are overdose survivors or have been identified as being at high risk of overdose. It is a statewide naloxone distribution program temporarily funded at the federal level by the Substance Abuse and Mental Health Services Administration and administered by the Arkansas Center for Health Improvement through a grant from the Arkansas Department of Human Services Division of Adult, Aging and Behavioral Health Services to combat opioid overdose-related deaths in Arkansas.

- **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.
  marchofdimes.org

- **Be Well Arkansas:** A public education campaign of the Arkansas Department of Health that offers tips and support for quitting tobacco and addressing diabetes and high blood pressure.
  bewellarkansas.org/

- **Arkansas Prostate Cancer Foundation (APCF):** APCF collaborates with local partners and medical volunteers to offer education and screening programs in communities across the state. At the events, APCF conducts education, administers the screenings, and provides all medical supplies. Through a partnership with Baptist Health, laboratory services are available. The screenings are free to men.
  arprostatecancer.org/services/screening/

- **Goodwill Industries of Arkansas:** The Excel Center at Goodwill offers adults an opportunity to earn a high school diploma. The school provides flexible class schedules, transportation assistance, free on-site childcare, and a life coach. Classes are free and open to anyone ages 19 or older.
  goodwillar.org/excel

ADDITIONAL RESOURCES

- **HDPulse: An Ecosystem of Health Disparities and Minority Health Resources:** A tool to provide access to data and interventions related to minority health and health disparities. It offers resources to identify, prioritize, and mitigate health disparities.
  hdpulse.nimhd.nih.gov/data/index.html

- **Community Tool Box:** A free online resource to promote community health and development.
  ctb.ku.edu/en

- **National Association of County and City Health Officials: Guide to Prioritization Techniques:** A guide that provides five methods for prioritization, including step-by-step instructions for implementation.
  naccho.org/uploads/downloadable-resources/Gudie-to-Prioritization-Techniques.pdf

- **Catholic Health Association: What Counts as Community Benefit:** Information on how to plan community benefit activities.
  chausa.org/communitybenefit/what-counts

- **Community Commons:** Portal with access to webinars for effectively using the CHNA, lists of initiatives and potential partnerships, and tools to map health indicators and outcomes.
  communitycommons.org/

Community Focus Group and Interview Questions

1. What Grade would you give the Health of your Community

2. What are the top 5 health issues you see in your community?
   - Access to Care/ Uninsured
   - Alzheimer's Disease
   - Cancer
   - Dental Health
   - Diabetes
   - High Blood Pressure
   - Heart Disease
   - Maternal/ Infant Health
   - Mental Health/ Suicide
   - Overweight/ Obesity
   - Sexually Transmitted Diseases
   - Stroke
   - Substance Abuse/ Alcohol Abuse
   - Tobacco Use
   - Other

3. Of those health issues mentioned, which one is the most significant?
   - Access to Care/ Uninsured
   - Cancer
   - Dental Health
   - Diabetes
   - Heart Disease
   - Maternal/ Infant Health
   - Mental Health/ Suicide
   - Overweight Obesity
   - Sexually Transmitted Diseases
   - Stroke
   - Substance Abuse/ Alcohol Abuse
   - Tobacco
   - Other

4. Please share any additional information regarding this health issues and your reasons for ranking them this way

5. On a scale of 1(strongly disagree) through 5 (strongly agree), please rate each of the following statements about Health Care Access in the area.?

	Strongly disagree↔Strongly agree
Residents in the area are able to access a primary care provided when needed. (Family Doctor, Pediatrician, General Practitioner	☐1 ☐2 ☐3 ☐4 ☐5
Residents in the area are able to access a medical specialist when needed.(Cardiologist, Dermatologist, Neurologist, etc.)	☐1 ☐2 ☐3 ☐4 ☐5
Residents in the area are able to access a dentist when needed.	☐1 ☐2 ☐3 ☐4 ☐5
There is a sufficient number of bilingual providers in the area.	☐1 ☐2 ☐3 ☐4 ☐5
There is a sufficient number of mental/ behavioral health providers in the area.	☐1 ☐2 ☐3 ☐4 ☐5
There is a sufficient number of providers accepting Medicaid and Medical Assistance	☐1 ☐2 ☐3 ☐4 ☐5
In the area.	☐1 ☐2 ☐3 ☐4 ☐5
Transportation for medical appointments is available to area residents when needed.	☐1 ☐2 ☐3 ☐4 ☐5

6. What are the most significant barriers that keep people in the community from accessing health care when they need it? (Select all that apply)
    - Availability of Providers/ Appointments
    - Basic Needs Not Met (Food/ Shelter)
    - Inability to Navigate Health Care System
    - Inability to Pay Out-of- Pocket Expenses (Co-pays, Prescriptions, etc)
    - Lack of Child Care
    - Lack of Health Insurance Coverage
    - Lack of Transportation
    - Lack of Trust
    - Language/ Cultural Barriers
    - Time Limitations (Long Wait Times, Limited Office Hours, Time off Work)
    - None/ No Barrier
    - Other (specify) :

7. Of those barriers mentioned, which one is the most significant?
    - Availability of Providers/ Appointments
    - Basic Needs Not Met(Food/ Shelter)
    - Inability to Navigate Health Care System
    - Inability to Pay Out-of- Pocket Expenses (Copays Prescriptions, etc.)
    - Lack of Child Care
    - Lack of Health Insurance Coverage
    - Lack of Transportation
    - Lack of Trust
    - Language/ Cultural Barriers
    - Time Limitations (Long Wait Times, Limited Office Hours, Time off Work)
    - None/ No Barriers
    - Other (specify)

8. Please share any additional information regarding barriers for health care:

9. Are there specific populations in this community that you think are not being adequately served by local health services? Yes or No

10. If yes, which populations are underserved? (Select all that apply)
    - Uninsured / Underinsured
    - Low-income/ Poor
    - Hispanic/ Latino
    - Black/ African American
    - Immigrant/ Refugee
    - Disabled
    - Children/ Youth
    - Young Adults
    - Senior/ Aging/ Elderly
    - Homeless
    - None
    - Other (specify) :

11. In general, where do you think MOST uninsured and underinsured individuals living in the area go when they are in need of medical care? (CHOOSE 1)
    - Doctor's Office
    - Health Clinic/ FQHC
    - Hospital Emergency Department
    - Walk-in/ Urgent Care Center
    - Don't Know
    - Other (specify):

12. Please share any additional information regarding Uninsured/ Underinsured Individuals & Underserved Populations

13. Related to health and quality of life, what resources or services do you think are missing in the community? (Select all that apply)
    - Prenatal Healthcare
    - Immunizations (childhood, covid, pneumonia, shingles)
    - Affordable Housing
    - Healthy Food Access
    - Free/ Low Cost Medical Care
    - Primary Care Providers
    - Medical Specialists
    - Mental Health Services
    - Substance Abuse Services
    - Bilingual Services
    - Transportation
    - Prescription Assistance
    - Health Education/ Information/ Outreach
    - Health Screenings
    - Social Services
    - None
    - Other (specify) :

Challenges & Solutions

14. What challenges do people in the community face in trying to maintain healthy lifestyles like exercising and eating healthy and/ or trying to manage chronic conditions like diabetes or heart disease?

15. In your opinion, what is being done well in the community in terms of health and quality of life? (Community Assets/ Strengths/ Successes)

16. What recommendations or suggestions do you have to improve health and quality of life in the community?

17. Name and Contact Information : (Note: Your name and organization is required to track survey participation. Your identity WILL NOT be associated with your responses.)

18. Which one of these categories would you say BEST represents your community affiliation? (CHOOSE 1)
    - Health Care/ Public Health Organization
    - Mental/ Behavioral Health Organization
    - Non Profit/ Social Services/ Aging Services
    - Faith- Based/ Cultural Organization
    - Education/ Youth Services
    - Government/ Housing/ Transportation Sector
    - Social Service Organization
    - Business Sector
    - Community Member
    - Other (specify)

Baptist Health Key Internal key Informant

Q1 What grade would you give the health of this Community?

Q2 What do you think are the top 3 health needs of the Community?

Q3 What do you think our Hospital is doing to address Access to Care?

Q4 What do you think our Hospital is doing to address Mental Health?

Q5 What do you think our Hospital is doing to address Obesity?

Q6 What do you think our Hospital is doing to address Food Insecurity?

Q7 What do you think our Hospital is doing to address Chronic Disease Education?

Q8 What do you think is the largest unmet healthcare need in the Community?

Q9 Are there any specific organizations int ehc Community in which you see as being a good partner with Baptist Health

Q10 What Community programs/events does your hospital participate in ?

What Hospital and Department do you work for?

Top Health Needs Identified by Community Survey Respondents

Little Rock:

- Mental Health
- Access to Care
- Health Literacy and Communication
- Physical Health (obesity and diet issues)
- Physical Infrastructure

North Little Rock:

- Access to Healthcare
- Health Education (healthy eating, obesity and resulting morbidities)
- Drug Education
- Mental Health
- Access to Medication

Conway:

- Mental Health (including addictions)
- Obesity (and resulting morbidities, e.g. hypertension, cardiovascular disease)
- Access to Specialty Doctors

Heber Springs:

- Mental Health (including drug abuse)
- Obesity
- Lack of services
- Health Education

Hot Spring County:

- Mental Health (including drug addiction, suicide)
- Obesity
- Dental

Arkadelphia:

- Mental Health
- Obesity (resulting diseases, nutrition, prevention)
- Diabetes

Stuttgart:

- Obesity
- Drug Abuse
- Cancer
- Mental Health

Fort Smith:

- Mental Health
- Drugs
- Obesity
- Food Security

Van Buren:

- Access to Care
- Mental Health
- Obesity
- Physical Infrastructure

Agencies/Entities Represented for Interviews and Focus Group

Little Rock

- West Central Community Center
- Dunbar Center
- Southwest Center
- Jericho Way Clients
- Jim Daily Center Participants
- Baptist Health Employee Survey
- Baptist Health Key Informant Leaders
- Little Rock Pregnancy Center Participants
- El Zocalo, Inc.
- Girl Scouts Council
- Children's HealthWatch
- AR Department of Health
- Family Service Agency
- Saint Mark Baptist Church
- CATCH/City of Little Rock/ Collaborative
- Central Arkansas Library System
-

North Little Rock

- Department of Veterans
- Arkansas Blue Cross Blue Shield
- New Hope Baptist Church
- Arkansas Children Hospital
- Junior League of North Little Rock
- City of NLR
- Rose City Community Leaders
- Patrick Henry Hayes Center
- Heaven's Loft Participants
- Baptist Health Key Informant Leaders
- Lonoke Senior Center
- Baptist Health Employee Survey

Conway

- Community Service, Inc
- University of Central Arkansas
- Independent Living Services
- St. Joseph Schools
- Faulkner County Health Coalition Resources
- Baptist Health Key Informant Leaders

Heber Springs

- Heber Springs High School Superintendent
- Retired Community Leaders
- Baptist Health Key Informant Leaders
- BH Employee Survey
- Cleburne County Library
- Heber Springs School Teachers

Stuttgart

- PCCUA Community College
- Merchants & Planters Bank
- 4 PCCUA Community College
- Professional pharmacy
- RNT Calls Inc.
- Baptist Health Key Informant Leaders
- Baptist Health Employee Survey
-

Hot Spring County

- Central Arkansas Development
- Baptist Health Key Informant Leaders
- Baptist Health Employee Survey

Fort Smith

- Baptist Health Key Informant Leaders
- Baptist Health Employee Survey
- City Administrator
- City of Fort Smith
- United Way Data

Arkadelphia

- Baptist Health Key Informant Leaders
- Baptist Health Employee Survey
- Central Arkansas Development Council
- AHG Clinics
- Arkadelphia Clinic for Children and Young adults
- Ouachita Baptist University

Van Buren

- United Way Data
- Patient and Family Interviews
- Baptist Health Key Informant Leaders
- Baptist Health Employee Survey

Prioritization

A prioritization session was held for each hospital to choose priorities. A three-round, multi-voting technique was utilized to make final selections.

Round 1 Vote – Each participant voted for their top 6 highest priority items.

Round 2 Vote – Items receiving the most votes will move to the next vote. From this list each participant should vote for their top 4 highest priority items.

Round 3 Vote – Items receiving the most votes will move to the next vote. From this list each participant should vote for their top 1 highest priority items.

Criteria for Prioritization

The CHNA Guidelines require hospitals to disclose the prioritization criteria used during selection process. The criteria is developed at the discretion of the hospital system and must be included in the completed plan. The following criteria was used by the Baptist Health System in selecting the significant health needs in each community.

- Alignment with facility's strengths/priorities/mission
- Magnitude - number of people impacted by problem
- Severity - the rate or risk of morbidity and mortality
- Opportunity to intervene at prevention level
- Opportunity for partnership
- Addresses disparities of subgroups
- Existing resources and programs to address problem
- Availability of evidence-based approaches
- Importance of problem to community
- Need among vulnerable populations

In addition to quantitative data collection, focus groups, one on one interviews and surveys were utilized to acquire input from persons who represent the broad interest of the community served by each facility (A CHNA requirement).

Due to Covid-19 Baptist Health Community Outreach assessed the communities feedback in the following ways:

- Survey Tables with one-on-one discussions in hospital and community settings
- Surveyed Community Leaders & Key Informants
- Surveyed Key Informants internally at each hospital location

Participants included representatives from public health departments, local government offices, school districts, law enforcement, health care providers and representatives of the medically underserved, low-income and minority populations. A report for each hospital was created to display the quantitative results. Each report includes a table with health indicator data for each county in the hospital community, community averages (mean data for each indicator for all the hospital's counties), and averages for the State of Arkansas and the

The Prioritization Process resulted in the following Significant Health Needs by Facility.

Hospital	Priority 1	Priority 2	Priority 3
Little Rock	Mental Health	Access to Care	Nutrition Security
North Little Rock	Mental Health	Access to Care	Nutrition Security
Conway	Mental Health	Access to Care	Nutrition Security
Heber Springs	Mental Health	Access to Care	Nutrition Security
Stuttgart	Mental Health/Drug Abuse	Access to Care	Nutrition Security
Hot Spring County	Mental Health	Access to Care	Nutrition Security
Arkadelphia	Mental Health	Access to Care	Nutrition Security
Fort Smith	Mental Health	Access to Care	Nutrition Security
Van Buren	Mental Health	Access to Care	Nutrition Security
BHRI	Mental Health	Access to Care	Nutrition Security
Extended Care	Mental Health	Access to Care	Nutrition Security

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 readily available to the public as required by law.

Working for Impact

Through our 2023-2025 Implementation Strategy, our goal is to address all of the significant priority needs listed. We will also support other community based organizations, health care providers and public health departments in our community in partnership efforts to improve outcomes.

Logic Model for Community Based Programming

Many Community Based Programs primarily follow a Logic Model that maps the inputs and activities to the results we hope to achieve. This provides accountability and allows us to evaluate and improve upon programs to ensure that they are effective.

Inputs are the human, organizational, and community resources required to implement the program. For Example: staff resources, community partnerships, program supplies, dollars invested

Activities are the events, interventions, and other observable actions that occur during program implementation. Activities use program inputs to bring about the desired changes in the target population. Examples: educate and screen program participants

Outputs are the direct products or deliverables of the activities, expressed numerically, which ensure that the program is running according to plan. Examples: 500 participants served, 450 vaccinations delivered

Outcomes are changes in program participants caused by the program activities implemented. These can include changes in knowledge, skills, attitudes/beliefs, behavior, status, and/or level of functioning, and are further separated into short-term, medium-term, and long-term outcomes. Examples: Increased knowledge of how to monitor blood pressure in the home, weight loss

Impacts are long-term changes in the communities, organizations, or systems that the program targets. These can take up to 7-10 years or longer and involve the entire population or community. Examples: reduced burden of disease in community, reduced healthcare utilization, changes in social norms, legislation enacted

BAPTIST HEALTH MEDICAL CENTER

LITTLE ROCK

About Baptist Health Medical Center-Little Rock

For nearly 100 years, Baptist Health Medical Center-Little Rock has been delivering quality healthcare to the citizens of Arkansas. The 843-bed medical center is the largest private, not-for-profit hospital in the state and provides comprehensive services using the latest in innovative technology.

Why Choose Us
Baptist Health Medical Center-Little Rock was the first hospital in the U.S. to adopt EleGARD Patient Positioning System for CPR. The device precisely, rapidly and consistently positions the patient for CPR and airway management and raises the patient into a multi-level elevation to support the use of a new technique for resuscitation.

This facility also offers Invenia ABUS 2.0 (Automated Breast Ultrasound System) technology for breast cancer detection in women with dense breast tissue. This ultrasound procedure is the only ultrasound technology of its kind approved by the FDA and when used in addition to your mammogram, will provide a more complete evaluation of dense breast tissue. Learn more about ABUS 2.0.

Baptist Health Medical Center-Little Rock recently became the first hospital in Arkansas to utilize the Pipeline Flex Embolization Device with Shield Technology. This device is used to treat brain aneurysms by diverting blood flow away from a brain aneurysm and reconstructing the diseased section of the parent vessel. Learn more about the innovative Pipeline Flex Embolization Device.

Baptist Health Medical Center-Little Rock was one of the first hospitals in Arkansas to be awarded the Go Clear Award as a Gold Level. The Go Clear Award was given to Baptist Health Medical Center-Little Rock to recognize it as being committed to providing increased surgical safety by implementing practices that eliminate smoke caused by lasers and electrosurgery devices.

For more than 2 decades, Baptist Health Medical Center-Little Rock was named the winner of the Consumer Choice Award by National Research Corporation. The award identifies hospitals across the U.S. that local healthcare consumers choose as having the highest quality and image.

It was also one of the several Baptist Health facilities in Arkansas to receive honors from State and National Agencies for Stroke Care Quality. Baptist Health Medical Center-Little Rock was named to the Target: Stroke Elite Plus Honor Roll for its focus on improving acute ischemic stroke care.

2020-2022 Accomplishments

Baptist Health: Little Rock: Due to the Covid-19 Pandemic many community based organizations, projects partnership opportunities were limited.

MENTAL HEALTH:

- Offered Mental Health First Aid Classes for Staff and Community
- Offered Depression Screenings for New and Expectant Moms in the Community Prenatal Programs
- Provided Educational Materials on Mental Health in Community Based Wellness Centers
- Promoted the FindHelp app with patients in clinics and community programs to assist in finding mental health resources
- Provided in-patient psychiatric care for Adults and Geriatric Patients
- Increased the number of based by adding 22 making a total of 131 beds available system wide
- Opened a Covid-19 Psychiatric space during the Pandemic
- Expanded staff to help meet the Mental Health needs of the Community
- Utilized the Baptist Health Command Center to gain quick access to resources available and provided referrals

ACCESS TO CARE

- Purchased a New Mobile Health Unit to assist in improving Access to Care statewide. Year one the unit provided 8,000 Covid Vaccinations
- Identified and Recruited Physicians in a variety of Speciality areas including Orthopedic Surgery, Gastroenterology, General Surgery,,.
- Baptist Health received National Recognition from the American Heart Association for Stroke Care
- Added two dedicated ambulances one for Adult Critical Care and one Neonatal Intensive Care
- Improved access to innovative health care technology for treating artery disease and preventing future strokes
- Increased Access to Childhood Immunizations through Community Clinics reaching 600 children
- Increased Access to Community Health Screening through Community Wellness Centers with 4,000 patient visits
- Opened the Little Rock Pregnancy Wellness Center, averaging 90 - 100 patient visits annually.
- Established a Partnership with Little Rock Southwest Magnet High School for Medical Science to introduce students to the field of Medicine.

DIABETES

- Offered a Community Based Virtual and In-Person Diabetes Support Group for 50 individuals
- Offered an Evidence Based Diabetes Empowerment Education Class (DEEP) for Community Members
- Offered 300 Diabetes Risk Assessments Screenings for community events and wellness centers
- Community Outreach Received Full Recommendation for the Diabetes Prevention Program (DPP)
- The Diabetes Self Management Education and Support Services, Accredited by the American Diabetes Association offered in-person and virtual education to over 800 patients annually
- Implemented the Know it Control Hypertension Program emphasizing the connection between Hypertension and Diabetes
- Provided Glucometers and testing strips to low income patients
- Diabetes Risk Assessments were offered at Community Wellness Centers and Screening Events monthly

COMMUNITY HEALTH NEEDS ASSESSMENT – IMPLEMENTATION PLAN 2023-2025

Baptist Health Medical Center -Little Rock

IDENTIFIED COMMUNITY HEALTH NEED: **Access to Healthcare Services**

GOALS / OBJECTIVES:

Increase Access to Quality Health Care, Preventive Health Screenings, Vaccinations and Community Resources.

STRATEGY #1

Utilize the Mobile Health Unit (MHU) to provide preventive screenings and increase access to care.

Action Steps:

1. Utilize the MHU to offer back tol immunizations, flu shots and Covid-19 Vaccinations
2. Identify the communities in most need and schedule monthly screenings utilizing the MHU.
3. Partner with Regional Hospitals to utilize the MHU to deliver screenings in their service areas.
4. Register all participants in the Epic System.
5. Utilize Baptist Health Virtual Care on the MHU to offer additional care for patients in need.
6. Provide evening and weekend screening times to meet the needs of specific populations
7. Provide Preventative Health Screenings for Diabetes, Hypertension, Cholesterol and Covid-19.
8. Utilize the Findhelp.org system to refer and track patents in need of additional resources

PERFORMANCE METRICS:

1. Provide Preventative Screenings, Vaccinations and Services to at least 1,000 individuals
2. Track and report the number of patients utilizing virtual care on the MHU.
3. Track and report the number of patients enrolled in EPIC and MyChart.
4. Track and report the number of patients utilizing the Findhelp.org system for resources
5. Track and report the number of Regional Hospital Community Events offered via the MHU

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:

Baptist Health Regional Hospitals, Strategic Development, Goodwill, North Little Rock Housing Authority, Salvation Army, Little Rock Housing Authority and Community Centers

Resources Hospital Plans to Commit to Address Health Need:

- Staff and Printing

Estimated Completion Date:

- Ongoing

Person(s) / Department Responsible:

- Community Outreach Director, Nurse Manager and Mobile Health Unit Driver

COMMUNITY HEALTH NEEDS ASSESSMENT – IMPLEMENTATION PLAN 2023-2025

Baptist Health Medical Center - LITTLE ROCK

IDENTIFIED COMMUNITY HEALTH NEED: **Access to Healthcare Services**

GOALS / OBJECTIVES:

Improve access to health and quality of life information for individuals living with Chronic Diseases..

STRATEGY #2

Provide education and resources to prevent and improve diabetes self-management, Hypertension Management and Diabetes Prevention in order to reduce complications with a targeted group of patients.

Action Steps:

1. Increase screenings for Diabetes including glucose screenings and hbA1c screenings in community settings
2. Host and provide community based diabetes education classes
3. Provide evidence-based diabetes prevention programs
4. Utilize the Social Determinants Screening tool in Epic to identify barriers to resources.
5. Increase the number of patients screened and referred to community resources through findhelp.org
6. Partner with the Baptist Health's Health Management Center to develop a referral system for Diabetes and Nutrition Education to underserved patients.
7. Continue In-Patient Diabetes Self-Management Program

PERFORMANCE METRICS

Key factors that will be tracked to determine the impact of programs and services implemented, and relevance to internal and external public health goals

1. 1,000 Individuals will be screened for Diabetes via Community Events/Wellness Centers
2. 1,500 individuals will be screened for Hypertension via Community Events/Wellness Centers
3. 10 - Diabetes Education & Nutrition Classes will be held via Community Events/Wellness Centers
4. 4 - Managing Hypertension Classes will be held
5. 1000 Patients will be enrolled in the HMC Diabetes Self-Management Class
6. Track referrals for Diabetes related needs through Findhelp
7. Number of consults and referrals resulting from the Telehealth consults will be tracked and reported.

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:

Baptist Health Little Rock, Telehealth, Community Outreach, Health Management Center

Resources Hospital Plans to Commit to Address Health Need:	Estimated Completion Date:	Person(s) / Department Responsible:
• Community Outreach Staff, Health Management Center	• Ongoing	• Baptist Health Community Outreach Department

COMMUNITY HEALTH NEEDS ASSESSMENT – IMPLEMENTATION PLAN 2023-2025

Baptist Health Medical Center - LITTLE ROCK

IDENTIFIED COMMUNITY HEALTH NEED: Access to Healthcare Services

GOALS / OBJECTIVES:

Expand and improve community access comprehensive, quality health care services and providers as well as medical and non-medical services

STRATEGY #3

Improve and Expand access to essential health care services through community partnerships, virtual care, referrals and resources

Action Steps:

1. Assist patients in need of insurance through screenings, referrals and linkages to community resources through our Social Determinants of Health Screening Tool in patient and Community Settings
2. Expand access to essential health services through virtual care
3. Provide support to uninsured patients by assisting with enrollment to publicly funded programs and hospital charity care programs
4. Explore funding opportunities to assist patients with transportation needs in order to offer tokens or vouchers for healthcare appointments
5. Develop Pipelines of job opportunities focused on students in underserved areas to promote diversity of frontline clinical and non-clinical providers

PERFORMANCE METRICS:

Number of individuals receiving assistance for insurance enrollment will be tracked and reported

1. Number of virtual care appointments will be tracked and reported
2. Number of individuals enrolled in publicly funded programs and charity care will be tracked and reported
3. Number of patients assisted with transportation will be tracked and reported
4. Number of School Partnerships and students enrolled will be tracked and reported

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:

Baptist Health Little Rock, Community Outreach, Command Center, Human Resources

Resources Hospital Plans to Commit to Address Health Need:

- Community Outreach Staff

Estimated Completion Date:

- Ongoing

Person(s) / Department Responsible:

- Baptist Health Community Outreach Department , Baptist Health, AHG Clinics

COMMUNITY HEALTH NEEDS ASSESSMENT – IMPLEMENTATION PLAN 2023-2025

Baptist Health Medical Center - LITTLE ROCK

IDENTIFIED COMMUNITY HEALTH NEED: **Access to Healthcare Services**

GOALS / OBJECTIVES:

Expand and improve community access comprehensive, quality health care services and providers as well as medical and non-medical services with a focus on women's health

STRATEGY #4

Improve and Expand access to essential health care services through community partnerships, virtual care, referrals and resources

Action Steps:

1. Develop a System-Wide Comprehensive Women's Health plan to expand and improve women's health services
2. Implement a Marketing Campaign dedicated to increasing the awareness of Women's Health and services available
3. Explore the AR HOMES program to improve Prenatal Education and Postpartum Care
4. Explore opportunities to utilize the Mobile Health Unit for Prenatal Education, Care, and Screening
5. Utilize Grant Opportunities to provide free screening mammograms to women in need

PERFORMANCE METRICS:

1. Strategies and Goals Developed and Implemented
2. Number of Promotions internal and external focused on Women's Health will be tracked and reported
3. Number of AR Homes initiatives and partnerships will be tracked and reported
4. Number of prenatal, postpartum and educational materials implemented via the Mobile Health Unit will be tracked and reported.
5. Grant Funding Secured will be tracked and reported
6. Number of individuals benefiting from free mammograms will be tracked and reported

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:

Baptist Health Little Rock, Community Outreach, Command Center, Human Resources

Resources Hospital Plans to Commit to Address Health Need:

- Surgery, Women's and Children's, and Rehabilitation Services Community Outreach Staff

Estimated Completion Date:

- Ongoing

Person(s) / Department Responsible:

- Baptist Health Community Outreach Department , Baptist Health Marketing Department, Baptist Health Breast Center

COMMUNITY HEALTH NEEDS ASSESSMENT – IMPLEMENTATION PLAN 2023-2025

Baptist Health Medical Center -Little Rock

IDENTIFIED COMMUNITY HEALTH NEED: Mental Health

GOALS / OBJECTIVES:

Improve access to Mental Health Resources.

STRATEGY #1

Promote the established mental health resources and expand services to make a positive impact on the Mental Health of our community.

Action Steps:

1. Identify gaps in existing programs and determine additional training needs
2. Explore and Develop a system-wide plan to improve the Mental Health of Arkansans
3. Implement an internal and external communication plan to promote the Command Center
4. Explore opportunities to recruit additional mental health providers.
5. Explore opportunities to expand in-patient psychiatric services
6. Explore opportunities to partners with organizations targeting the unsheltered population to offer Mental Health Resource

PERFORMANCE METRICS:

1. Systemwide plan will be developed to address the mental health needs of the community
2. Number of communications pieces, interviews, promotions will be tracked and reported
3. Number of additional mental health providers recruited will be tracked and reported
4. Expansion of services and patient services will be tracked and reported
5. Number of Community partnerships and participant utilization will be tracked and reported

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:

Baptist Health Regional Hospitals, Baptist Health North Little Rock, Baptist Health Western Region, Baptist Health Conway

Resources Hospital Plans to Commit to Address Health Need:

- Community Outreach, AHG Clinics, Baptist Health Behavioral Health, Baptist Health Command Center, Marketing Department

Estimated Completion Date:

- Ongoing

Person(s) / Department Responsible:

- Baptist Health Behavioral Health, Community Outreach, Command Center, Marketing Department

COMMUNITY HEALTH NEEDS ASSESSMENT – IMPLEMENTATION PLAN 2023-2025

Baptist Health Medical Center - LITTLE ROCK

IDENTIFIED COMMUNITY HEALTH NEED: **Mental Health**

GOALS / OBJECTIVES:

Increase awareness and support of community members dealing with mental health concerns.

STRATEGY #2

Reduce the stigma associated with education and treatment of mental health illness through training and education.

Action Steps:

1. Pilot a "Make it Okay" campaign designed to reduce the stigma of mental illness in at least one community.
2. Offer Mental Health First Aid training to community groups and faith-based organizations.
3. Offer an annual Mental Health First Aid training for staff, pastoral care and other system-wide health care providers.
4. Host seminars, presentations with an emphasis on decreasing stigma.
5. Offer Depression and ACES Screening Tools in Community Wellness Centers.
6. Provide education and outreach efforts via seminars, events and telehealth on the relationship between substance abuse and mental health.
7. Offer Depression Screening at each Prenatal visit and 12 months postpartum for all prenatal programs

PERFORMANCE METRICS:

1. Number of individuals reached with the "Make it Okay" Initiative
2. Number of Mental Health First Aid Trainings for staff will be tracked and reported.
3. Number of Community Based Mental Health First Aid Presentations will be tracked and reported.
4. Number of referrals and follow-ups will be tracked and reported.
5. Number of seminars, presentations will be tracked and reported.

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:

Goodwill Industries, Faith Based Communities, Adverse Childhood Experiences Statewide Coalition

Resources Hospital Plans to Commit to Address Health Need:	Estimated Completion Date:	Person(s) / Department Responsible:
• Community Outreach Staff, Pastoral Care and Behavioral Healtht	• Ongoing	• Baptist Health Community Outreach, Baptist Health Behavioral Health

COMMUNITY HEALTH NEEDS ASSESSMENT – IMPLEMENTATION PLAN 2023-2025

Baptist Health Medical Center - Little Rock

IDENTIFIED COMMUNITY HEALTH NEED: Mental Health

GOALS / OBJECTIVES:

Increase awareness and support of community members about Mental Health

STRATEGY #3

Initiate a “Back to Basics” Mental Health Awareness Campaign during Mental Health Awareness Month In Partnership with Mental Health America

Action Steps:

1. Utilize the Mobile Health Unit to Screen individuals at Community events utilizing the www.MHAscreening.org website..
2. Work with the Marketing Department to promote mental health topics in all social media internal and external.
3. Initiate 4 Mental Health American Educational Initiatives including A) 4Mind4Body: Social Connections and Recreations, B) Fitness 4 Mind4Body: Diet and Nutrition, C) Fitness 4Mind4 Body: Sleep and D) Fitness 4Mind4Body: Exercise.

Performance Metrics:

1. Track and report the number of individuals screened on the Mobile Health Unit
2. Track and report the number of referrals for Mental Health Resource referrals
3. Track and report the number of articles, posts and promotional materials distributed to promote mental health awareness
4. Number of Mental Health referrals will be tracked and reported.
5. Track and report number of individuals participating in educational programs

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:

City Of Little Rock Wellness Centers, Community Churches

Resources Hospital Plans to Commit to Address Health Need:	Estimated Completion Date:	Person(s) / Department Responsible:
• Community Outreach Staff	• Ongoing	• Community Outreach Team

COMMUNITY HEALTH NEEDS ASSESSMENT – IMPLEMENTATION PLAN 2023-2025

Baptist Health Medical Center - LITTLE ROCK

IDENTIFIED COMMUNITY HEALTH NEED: **Nutrition & Food Security**

GOALS / OBJECTIVES:

Initiate Evidence Based Nutrition Security strategies to address obesity, diabetes, hypertension, and other diet-related chronic conditions.

STRATEGY #1

Increase access to nutrition education and information among community members

Action Steps:

1. Implement Maintain, Don't Gain holiday challenge program for adult community members that encourages using stress management strategies, physical activity, and healthful food choices during the holiday season to maintain one's physical and mental health and avoid holiday weight gain.
2. Implement Around the Table program targeting youth, young adults and parents of young children. This program focuses on creating healthy connections between food, oneself, and one's community.
3. Implement Eat Healthy, Be Active program for adult community members. a program based on the Dietary Guidelines and Physical Activity Guidelines for Americans and teaches participants to make incremental lifestyle changes to improve their health.
4. Implement Cooking Matters, grocery store tour and cooking program targeting adults and parents participating in the WIC program with the goal to empower participants with skills to shop for healthful foods on a budget to maximize limited food resources..
5. Implement Cooking with Community Outreach classes to empower participants to build cooking skills, cook more healthy meals, reduce food waste, and make healthier selections at the grocery store.

PERFORMANCE METRICS:

1. Number of Participants registered for educational Programs will be tracked and reported
2. Coordinate implementation of 3 Maintian, Don't Gain Holiday Challenge
3. Pilot 2 "Around the Table Series targeting Youth
4. Implement 2 Eat Healthy Be Active Programs
5. Implement 20 Cooking Matters Grocery Store Tours System-wide
6. Host 20 Community -Based Community Outreach Cooking Classes

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:

Arkansas Hunger Relief Alliance, Central AR Library System, Be Mighty

Resources Hospital Plans to Commit to Address Health Need:	Estimated Completion Date:	Person(s) / Department Responsible:
• Community Outreach Staff	• Ongoing	• Community Outreach Team

COMMUNITY HEALTH NEEDS ASSESSMENT – IMPLEMENTATION PLAN 2023-2025

Baptist Health Medical Center- LITTLE ROCK

IDENTIFIED COMMUNITY HEALTH NEED: Nutrition & Food Security

GOALS / OBJECTIVES: Initiate Evidence Based Nutrition Security strategies to address obesity, diabetes, hypertension, and other diet-related chronic conditions.

STRATEGY #2

Improve nutrition security to address obesity, diabetes, hypertension, and other diet-related chronic conditions.

Action Steps:

1. Continue the FoodRX initiative for Employees, AHG Clinics, PACE program, Community Wellness Center and the Positive Atmosphere Reaches Kids (P.A.RK.) Project
2. Pilot the Prescription FoodRX in Partnership with the Hunger Relief Alliance at 3 LR Wellness Centers
3. Increase access to Fresh Fruits and Vegetables for Drive Thru Food Pantry through Community Partnerships
4. Increase access to Protein for the Drive Thru Food Pantry through Community Partnerships
5. Offer information on Findhelp and SNAP applications for individuals to gain access to additional food resources
6. Partner with the BH Foundation to secure additional funding and grants to support the FoodRX program

PERFORMANCE METRICS:

1. Track and Report the number of individuals served by the FoodRX program
2. Track and Report number of bags provided annually through the FoodRX program
3. Track and Report the number of Participants in the Prescription FoodRX program including biometric improvements
4. Track and Report the number of Fresh Fruits and Veggies provided through FoodRX
5. Track and report number of participants assisted and referred to the SNAP program
6. Track and report number of individuals referred to additional resources through Findhelp.org
7. Track and report funding secured and partnerships developed to support the FoodRX program

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:

Arkansas Hunger Relief Alliance, Arkansas Health Group, Find Help,, Central Arkansas Library System

Resources Hospital Plans to Commit to Address Health Need:	Estimated Completion Date:	Person(s) / Department Responsible:
• Community Outreach Staff	• Ongoing	• Community Outreach Team

LITTLE ROCK

ASSESSMENT PREPARED BY ACHI
INSPIRING HEALTHY ACTS

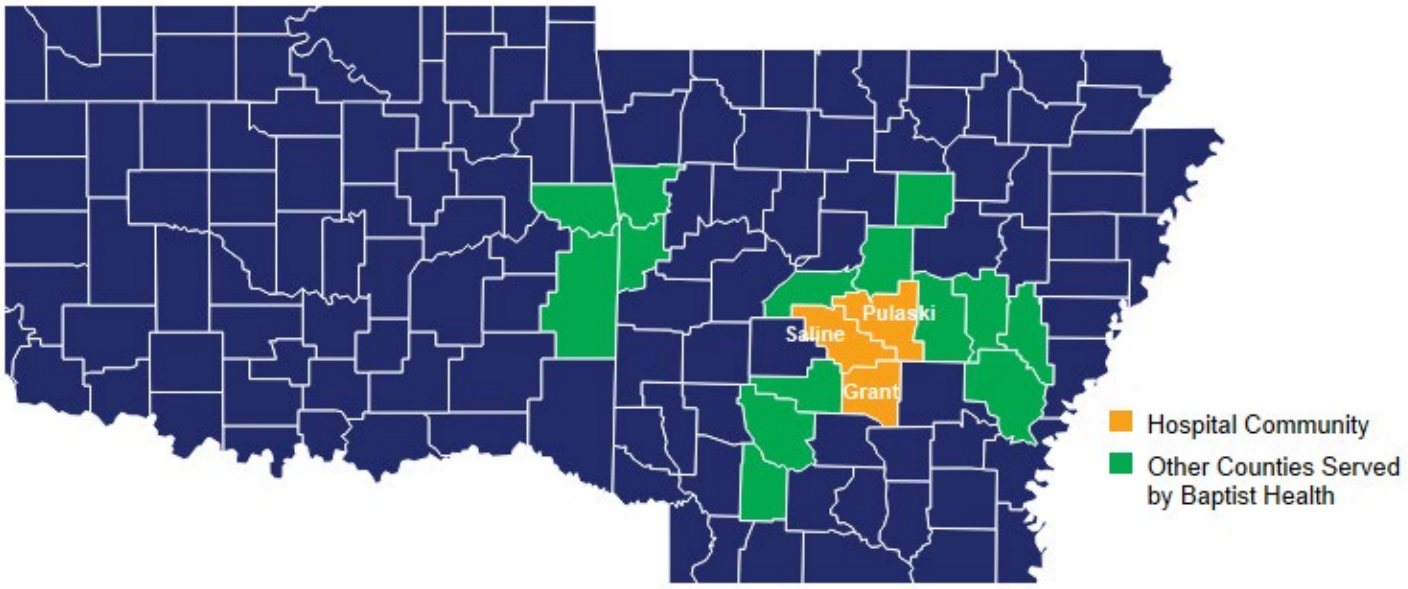
Introduction

Baptist Health engaged the Arkansas Center for Health Improvement (ACHI) to conduct the quantitative data collection and analysis for the 2022 Community Health Needs Assessment (CHNA) process. Baptist Health provided ACHI with the counties served for each of its 11 hospital communities. A total of 15 Arkansas counties and two Oklahoma counties were included in the CHNA.

This report shows the qualitative results from the CHNA for the Baptist Health Medical Center-Little Rock hospital community, which include Grant, Pulaski, and Saline counties.

Hospital Community

FIGURE 1: COUNTIES SERVED BY BAPTIST HEALTH MEDICAL CENTER-LITTLE ROCK



Qualitative Results

Quantitative results from the CHNA for the Baptist Health Medical Center-Little Rock hospital community are reported below. There are 12 sections: Demographics, Health Outcomes, Cause of Death, Chronic Conditions, Health Behaviors, Prevention, Access, Social and Economic Factors, Environment, Diagnoses Incidence Within Hospital Community at Discharge, Mental Health and Substance Use, and COVID-19.

Each section includes a table with health indicator data for each county in the hospital community, a community average for each measurement, and averages for the state of Arkansas and the United States. If data were not available or were suppressed, “Data Not Available” 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 document and Appendix 1.

DEMOGRAPHICS

TABLE 1: AGE AND SEX

		Grant County	Pulaski County	Saline County	State	National
Total Population	*Number*	18,126.0	392,967.0	119,415.0	2,999,370.0	324,697,795.0
Ages 0-4	*Percent*	5.3	6.7	5.9	6.3	6.1
Ages 5-17	*Percent*	17.2	16.6	17.6	17.2	16.5
Ages 18-24	*Percent*	7.4	8.8	7.3	9.5	9.4
Ages 25-34	*Percent*	12.1	14.9	12.8	13.1	13.9
Ages 35-44	*Percent*	12.3	12.8	13.7	12.3	12.6
Ages 45-54	*Percent*	14.1	12.3	12.8	12.4	13.0
Ages 55-64	*Percent*	13.9	13.0	12.4	12.7	12.9
Ages 65+	*Percent*	17.8	15.0	17.5	16.6	15.6
Male	*Percent*	49.1	47.8	49.1	49.1	49.2
Female	*Percent*	50.9	52.2	51.0	50.9	50.8

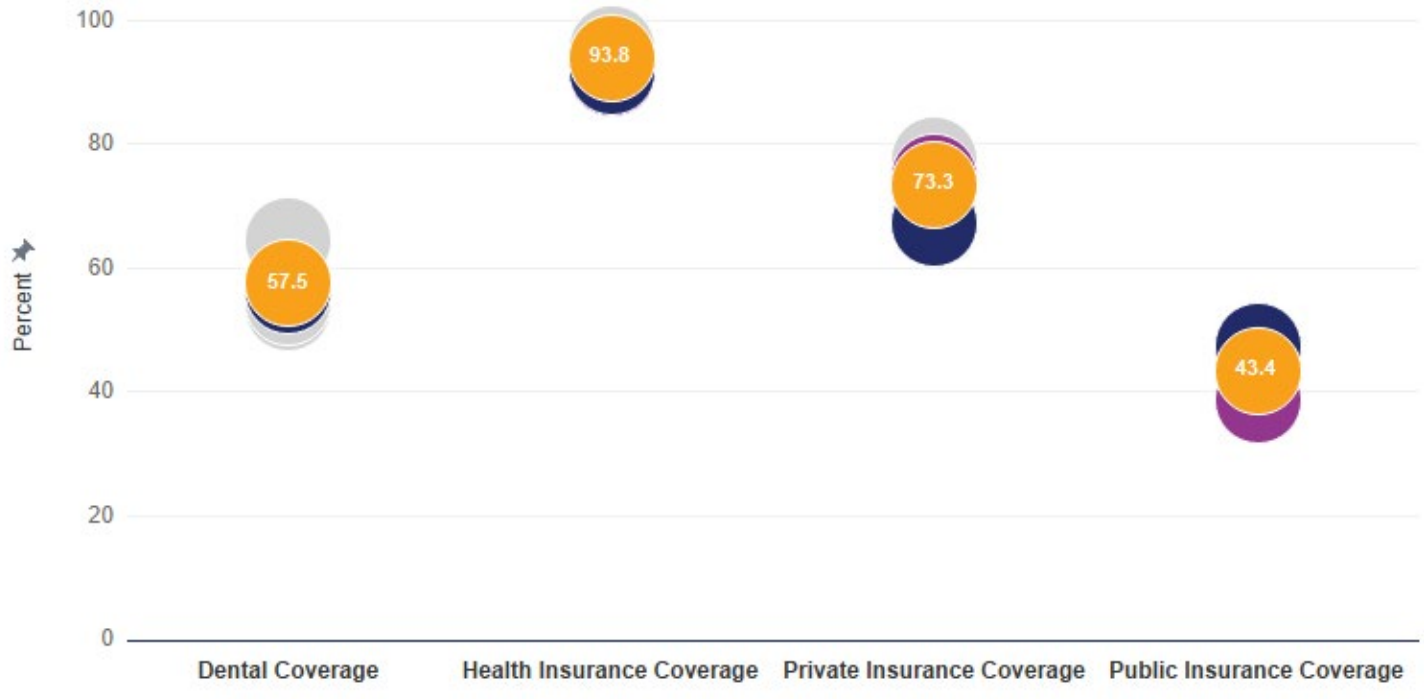
TABLE 2: RACE, ETHNICITY, AND LANGUAGE

		Grant County	Pulaski County	Saline County	State	National
Total Population	*Number*	18,126.0	392,967.0	119,415.0	2,999,370.0	324,697,795.0
Hispanic or Latino	*Percent*	2.8	6.2	4.8	7.5	18.0
Non-Hispanic White	*Percent*	92.6	52.3	84.6	72.4	60.7
Black or African American	*Percent*	2.7	36.9	7.1	15.3	12.7
Native American/Alaska Native	*Percent*	0.2	0.3	0.4	0.7	0.9
Asian	*Percent*	0.0	2.2	1.3	1.5	5.6
Native Hawaiian/Pacific Islander	*Percent*	0.1	0.1	0.1	0.3	0.2
Some Other Race	*Percent*	0.3	1.9	0.6	2.8	4.9
Two or More Races	*Percent*	2.0	2.8	2.0	2.7	3.3
Non-English Language Households	*Percent*	0.2	1.7	0.9	1.6	4.4

TABLE 3: INSURANCE COVERAGE

		Grant County	Pulaski County	Saline County	Community Average	State	National
Health Insurance Coverage	*Percentage of total civilian non-institutionalized population with health insurance coverage*	95.2	92.1	94.0	93.8	91.5	91.2
Private Insurance Coverage	*Percentage of total civilian non-institutionalized population with private health insurance coverage*	72.4	70.1	77.5	73.3	67.0	74.5
Public Insurance Coverage	*Percentage of total civilian non-institutionalized population with public health insurance coverage*	47.1	44.6	38.5	43.4	47.3	38.5
Dental Coverage	*Percentage of Arkansas residents with evidence of any dental coverage in the All-Payer Claims Database (APCD)*	54.5	64.4	53.6	57.5	56.2	Data Not Available

FIGURE 2: COMMUNITY, STATE, AND NATIONAL COMPARISON OF INSURANCE COVERAGE

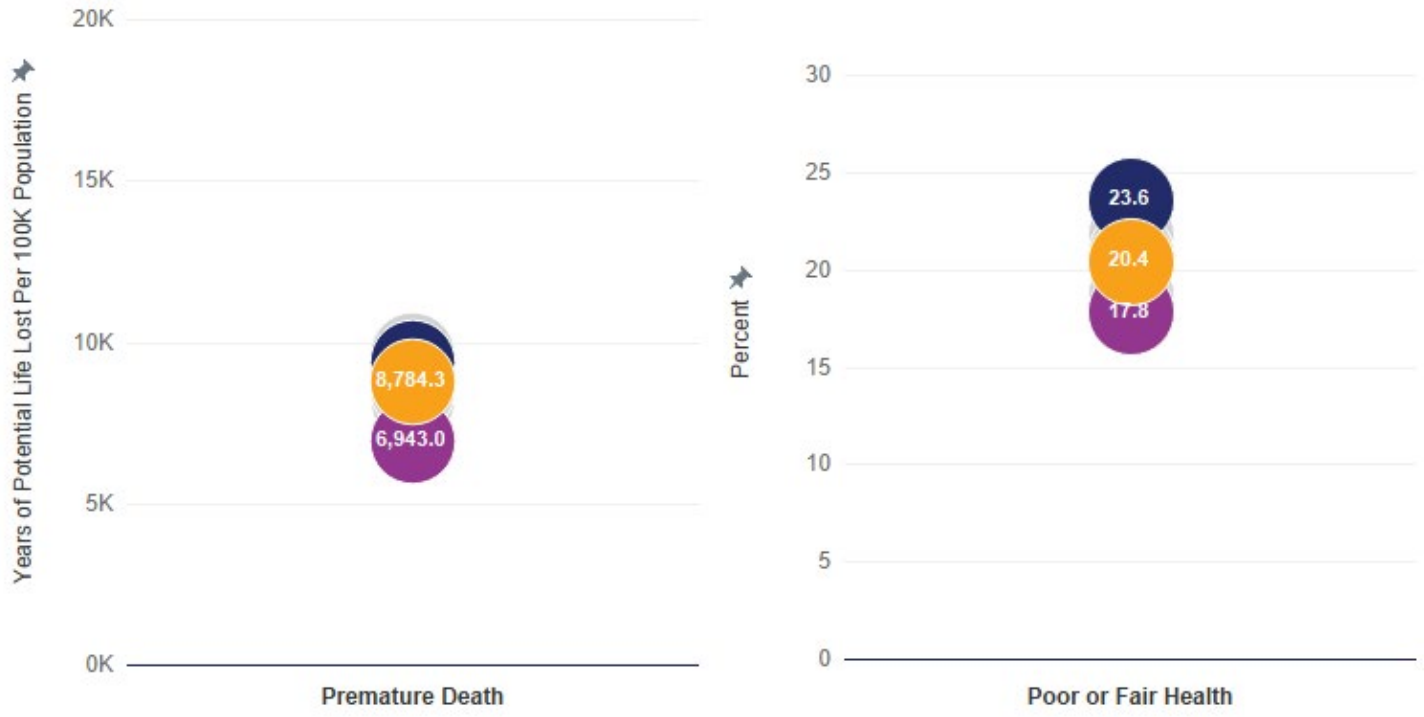


HEALTH OUTCOMES

TABLE 4: HEALTH OUTCOMES INDICATORS AND RATES

		Grant County	Pulaski County	Saline County	Community Average	State	National
Premature Death	*Years of potential life lost before age 75 per 100,000 population (age-adjusted)*	8,518.0	9,605.0	8,230.0	8,784.3	9,357.0	6,943.0
Poor or Fair Health	*Percentage of adults reporting poor or fair health*	20.8	21.7	18.7	20.4	23.6	17.8
Poor Physical Health Days	*Average number of physically unhealthy days reported in past 30 days (age-adjusted)*	4.8	4.6	4.2	4.5	4.9	4.0
Low Birthweight	*Percentage of live births with low birth weight (<2500g)*	8.8	10.9	7.9	9.2	9.1	8.2

FIGURE 3: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT HEALTH OUTCOMES INDICATORS

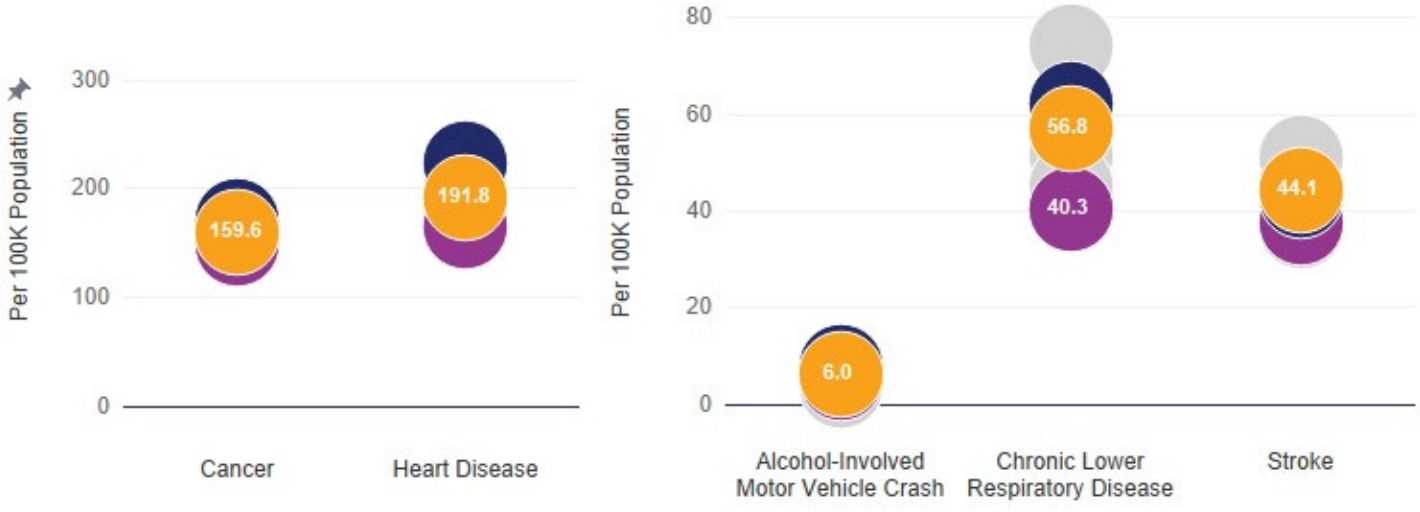


CAUSE OF DEATH

TABLE 5: CAUSE OF DEATH INDICATORS AND RATES

		Grant County	Pulaski County	Saline County	Community Average	State	National
All Causes	*All causes of deaths per 100,000 population (age-adjusted)*	886.3	854.2	816.7	852.4	888.4	727.2
Cancer	*5-year average rate of death due to malignant neoplasm (cancer) per 100,000 population (age-adjusted)*	169.0	155.2	154.7	159.6	170.1	149.4
Stroke	*5-year average rate of death due to cerebrovascular disease (stroke) per 100,000 population (age-adjusted)*	50.9	44.8	36.6	44.1	43.0	37.6
Chronic Lower Respiratory Disease	*Rate of deaths due to chronic lower respiratory disease per 100,000 population (age-adjusted)*	74.1	45.0	51.2	56.8	62.1	40.3
Diabetes	*Diabetes deaths per 100,000 population (age-adjusted)*	21.5	29.1	24.4	25.0	29.0	21.4
Heart Disease	*Rate of death due to heart disease per 100,000 population (age-adjusted)*	207.8	187.4	180.3	191.8	222.7	164.8
Unintentional Injury	*5-year average rate of death due to unintentional injury (accident) per 100,000 population (age-adjusted)*	54.3	52.9	54.0	53.7	51.7	50.4
Motor Vehicle Crash	*5-year average rate of death due to motor vehicle crash per 100,000 population (age-adjusted)*	23.0	16.7	13.8	17.8	18.9	11.5
Alcohol-Involved Motor Vehicle Crash	*Rate of persons killed in motor vehicle crashes involving alcohol as a rate per 100,000 population*	7.5	6.8	3.7	6.0	7.8	5.3

FIGURE 4: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT CAUSE OF DEATH INDICATORS

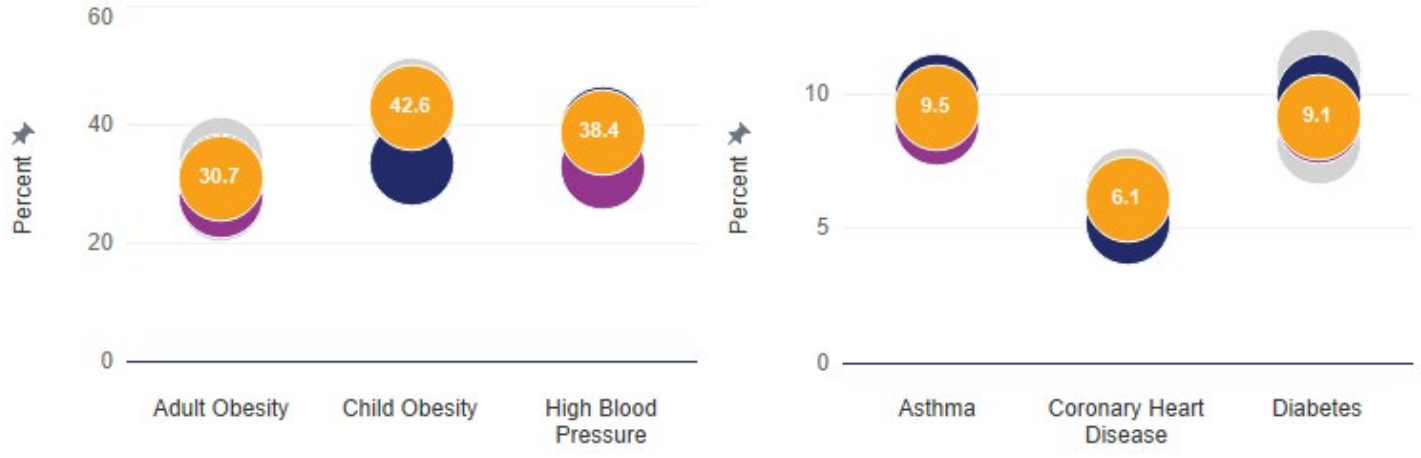


CHRONIC CONDITIONS

TABLE 6: CHRONIC CONDITIONS INDICATORS AND RATES

		Grant County	Pulaski County	Saline County	Community Average	State	National
High Blood Pressure	*Percentage of adults who have been told they have high blood pressure*	38.9	39.4	36.9	38.4	39.0	32.6
Asthma	*Percentage of adults who have been told they currently have asthma (age-adjusted)*	9.5	9.8	9.1	9.5	9.9	8.9
Coronary Heart Disease	*Percentage of adults who have been told they have angina or coronary heart disease (age-adjusted)*	6.4	6.1	5.7	6.1	5.2	5.4
Arthritis	*Percentage of adults ages 18 or older diagnosed with some form of arthritis*	33.3	32.1	36.4	33.9	34.3	Data Not Available
High Cholesterol	*Percentage of adults who have had their blood cholesterol checked and have been told it was high*	38.2	35.2	37.1	36.8	36.7	33.6
Diabetes	*Percentage of adults ages 20 and older who have ever been told by a doctor that they have diabetes (age-adjusted)*	8.2	10.8	8.3	9.1	9.9	9.0
Adult Obesity	*Percentage of adults ages 20 and older who report a BMI higher than 30*	27.0	34.0	31.0	30.7	31.0	27.6
Child Obesity	*Percentage of students classified as overweight or obese, by county location of school*	43.8	42.6	41.2	42.6	33.1	Data Not Available

FIGURE 5: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT CHRONIC CONDITIONS INDICATORS

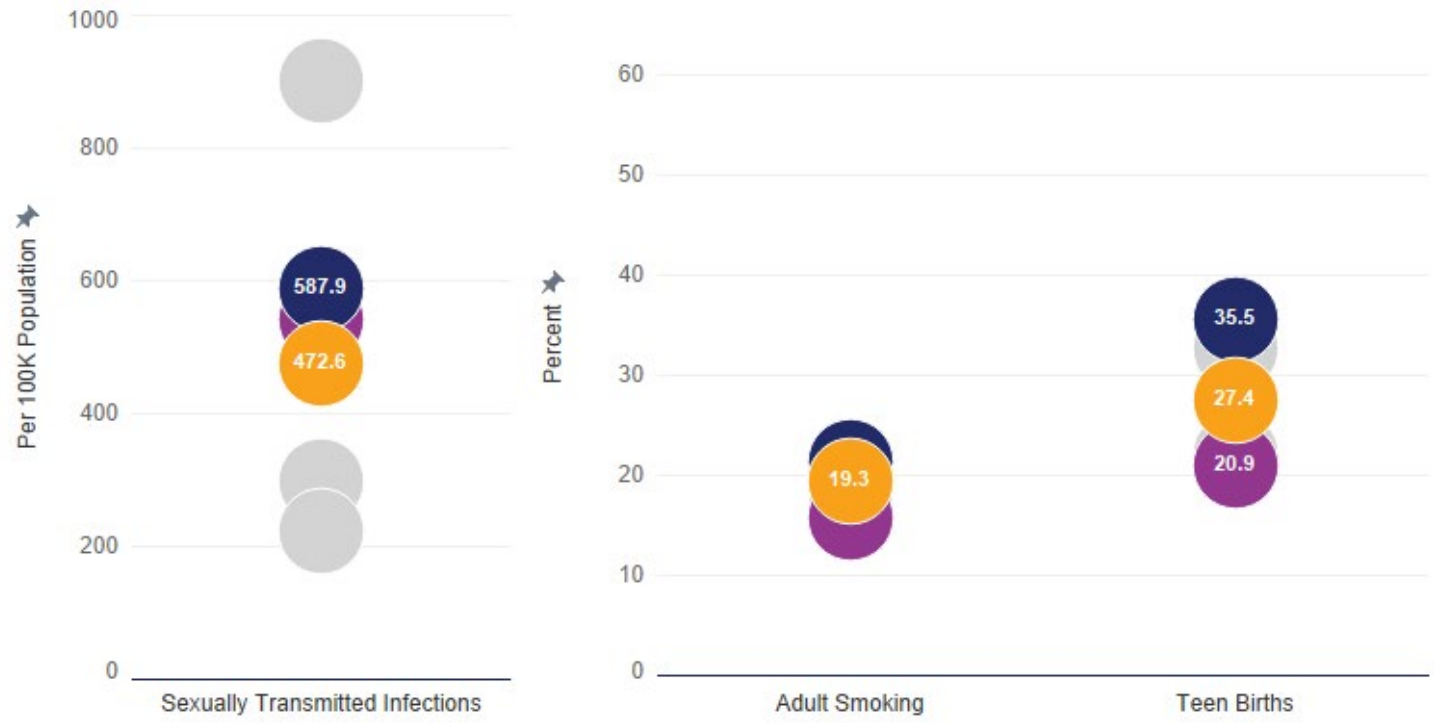


HEALTH BEHAVIORS

TABLE 7: HEALTH BEHAVIORS INDICATORS AND RATES

		Grant County	Pulaski County	Saline County	Community Average	State	National
Adult Smoking	*Percentage of adults who are current smokers (age-adjusted)*	21.3	19.6	17.1	19.3	21.2	15.7
Youth Vaping	*Percentage of public school students in 6th, 8th, 10th, and 12th grade who used any vape in the past 30 days*	10.6	8.2	8.4	9.1	11.7	Data Not Available
Physical Inactivity	*Percentage of adults ages 20 or older reporting no physical activity in the past month*	24.7	25.9	24.8	25.1	26.2	22.0
Sexually Transmitted Infections	*Number of newly diagnosed chlamydia cases per 100,000 population*	220.2	901.9	295.8	472.6	587.9	539.9
Teen Births	*The seven-year average number of teen births per 1,000 female population, ages 15-19*	27.5	32.6	22.1	27.4	35.5	20.9

FIGURE 6: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT HEALTH BEHAVIORS INDICATORS

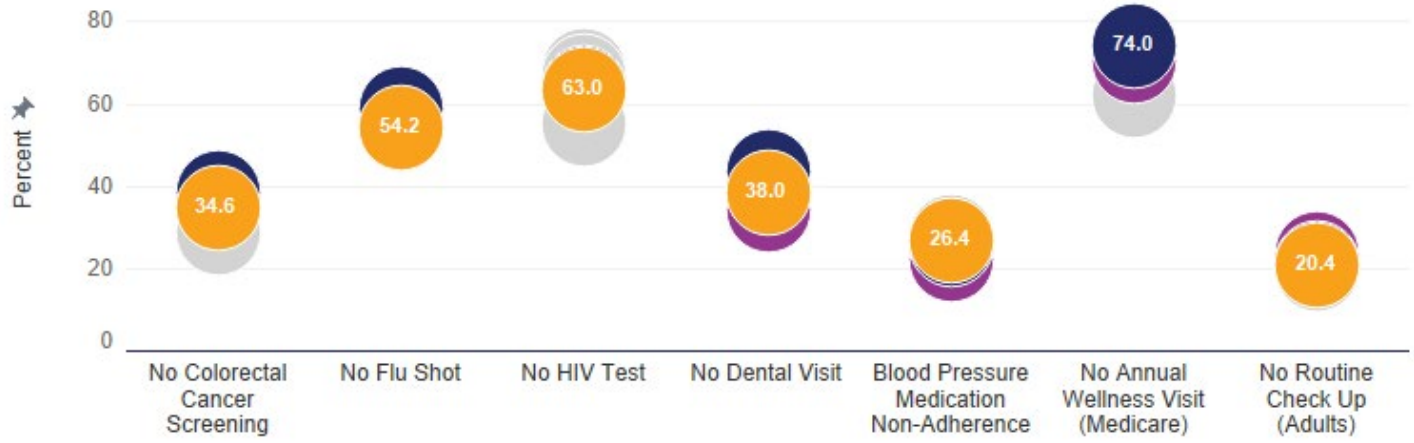


PREVENTION

TABLE 8: PREVENTION INDICATORS AND RATES

		Grant County	Pulaski County	Saline County	Community Average	State	National
No Pap Test	*Percentage of women ages 21 to 65 who have not had a pap test within the past 3 years (age-adjusted)*	16.2	14.0	14.3	14.8	16.3	14.5
No Colorectal Cancer Screening	*Percentage of adults ages 50-75 who have never had either a sigmoidoscopy or colonoscopy (age-adjusted)*	37.5	28.5	37.7	34.6	38.1	35.0
No Flu Shot	*Percentage of adults ages 18 or older who have not had a flu shot in the past year*	54.9	54.0	53.6	54.2	58.5	58.1
No HIV Test	*Percentage of adults ages 18 or older who have never been screened for HIV*	66.3	54.8	68.0	63.0	63.6	Data Not Available
No Dental Visit	*Percentage of adults ages 18 or older who have not had a dentist or dental clinic visit in the previous year (age-adjusted)*	40.2	35.4	38.5	38.0	43.4	33.8
Blood Pressure Medication Non-Adherence	*The percentage of Medicare enrollees who did not adhere to blood pressure medication schedules*	26.2	27.3	25.7	26.4	25.9	21.8
No Annual Wellness Visit (Medicare)	*The percentage of Medicare enrollees who did not have an annual wellness visit in the past year*	62.0	Data Not Available	72.0	Data Not Available	74.0	70.0
No Routine Check Up (Adults)	*The percentage of adults age 18 or older with no routine check up with a doctor in the past year*	21.9	19.5	19.9	20.4	21.0	23.4

FIGURE 7: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT PREVENTION INDICATORS



ACCESS

TABLE 9: ACCESS INDICATORS AND RATES

		Grant County	Pulaski County	Saline County	Community Average	State	National
Mammography	*Percentage of female Medicare enrollees ages 65-74 who received an annual mammography screening*	37.0	39.0	34.0	36.7	38.0	42.0
Diabetic Monitoring	*Percentage of diabetic Medicare enrollees over age 65 who had a hemoglobin A1c test in the past year*	87.9	88.6	88.8	88.4	88.5	87.5
Uninsured	*Percentage of adults under age 65 without health insurance coverage*	7.6	10.0	8.5	8.7	10.8	10.8
Primary Care Physicians	*Ratio of population to one primary care physician*	9,094.0	837.3	2,168.2	4,033.2	1,506.9	1,319.0
Dentists	*Ratio of population to one dentist*	2,283.1	1,289.2	3,309.1	2,293.8	2,103.0	1,404.5
Mental Health Providers	*Ratio of population to one mental health provider*	961.3	223.2	737.6	640.7	421.4	382.3
Addiction or Substance Use Providers	*Rate of addiction or substance use providers per 100,000 population*	5.6	7.8	0.8	4.7	4.4	20.4
Buprenorphine Providers	*Rate of buprenorphine providers per 100,000 population*	5.5	20.3	1.7	9.2	4.8	7.6
Preventable Hospital Stays	*Number of hospital stays for ambulatory care-sensitive conditions per 1,000 Medicare enrollees*	5,009.0	4,072.0	4,637.0	4,572.7	4,769.0	4,236.0

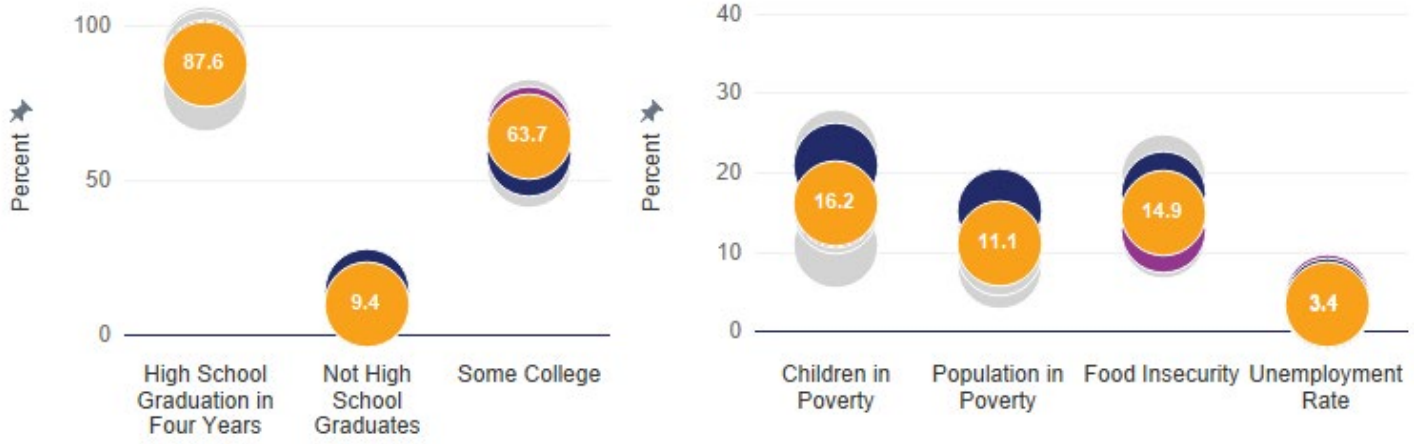
FIGURE 8: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT ACCESS INDICATORS

SOCIAL AND ECONOMIC FACTORS

TABLE 10: SOCIAL AND ECONOMIC FACTORS INDICATORS AND RATES

		Grant County	Pulaski County	Saline County	Community Average	State	National
Not High School Graduates	*Percentage of adults ages 25 or older without a high school diploma*	9.2	9.6	9.4	9.4	13.4	12.0
High School Graduation in Four Years	*Percentage of ninth-grade cohort who graduated in four years*	91.2	79.4	92.2	87.6	88.2	87.7
Some College	*Percentage of adults ages 25-44 with some post-secondary education*	54.8	68.8	67.6	63.7	58.5	66.1
Unemployment Rate	*Unemployment rate among civilian non-institutionalized population age 16 and older in January 2022*	3.1	4.3	2.9	3.4	3.8	4.4
Children in Poverty	*Percentage of children under age 18 below the poverty line*	15.2	22.5	10.8	16.2	20.8	15.7
Population in Poverty	*Percentage of population below the federal poverty line*	9.9	15.3	8.2	11.1	15.2	11.9
Children in Single-Parent Households	*Percentage of children who live in a household headed by single parent*	19.4	39.3	23.3	27.3	28.9	25.5
Homeless Children	*Rate of homelessness among public school students*	0.9	2.1	0.8	1.3	2.8	2.8
Food Insecurity	*Percentage of the population that experienced food insecurity in the report year*	13.4	19.3	11.9	14.9	17.3	12.6
Social Associations	*Number of membership associations per 100,000 population*	89.6	167.0	85.0	113.8	126.5	105.0
Violent Crimes	*Annual rate of reported violent crimes per 100,000 population*	295.5	1,121.8	300.9	572.7	549.2	416.0

FIGURE 9: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT SOCIAL AND ECONOMIC FACTORS INDICATORS



ENVIRONMENT

TABLE 11: ENVIRONMENT INDICATORS AND RATES

		Grant County	Pulaski County	Saline County	Community Average	State	National
Food Environment Index	*Index of factors that contribute to a healthy food environment, 0 (worst) to 10 (best)*	7.4	6.6	7.7	7.2	5.1	7.8
Drinking Water Violations	*The total number of drinking water violations recorded in a two-year period*	0.0	0.0	0.0	0.0	118.0	4,739.0
Access to Exercise Opportunities	*Percentage of population with adequate access to locations for physical activity*	26.6	83.6	58.6	56.3	63.5	84.2
Severe Housing Problems	*Percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, or lack of kitchen or plumbing*	13.4	16.3	9.6	13.1	14.1	17.5
Broadband Access	*Percentage of population in a high-speed internet service area; access to DL speeds > 25MBPS (2020)*	85.7	99.3	96.0	93.7	91.4	97.5
Long Commute Driving Alone	*Among workers who commute in their car alone, the percentage who commute more than 30 minutes*	52.1	20.3	40.7	37.7	27.0	36.6

FIGURE 10: COMMUNITY, STATE, AND NATIONAL COMPARISON OF THE FOOD ENVIRONMENT INDEX INDICATOR

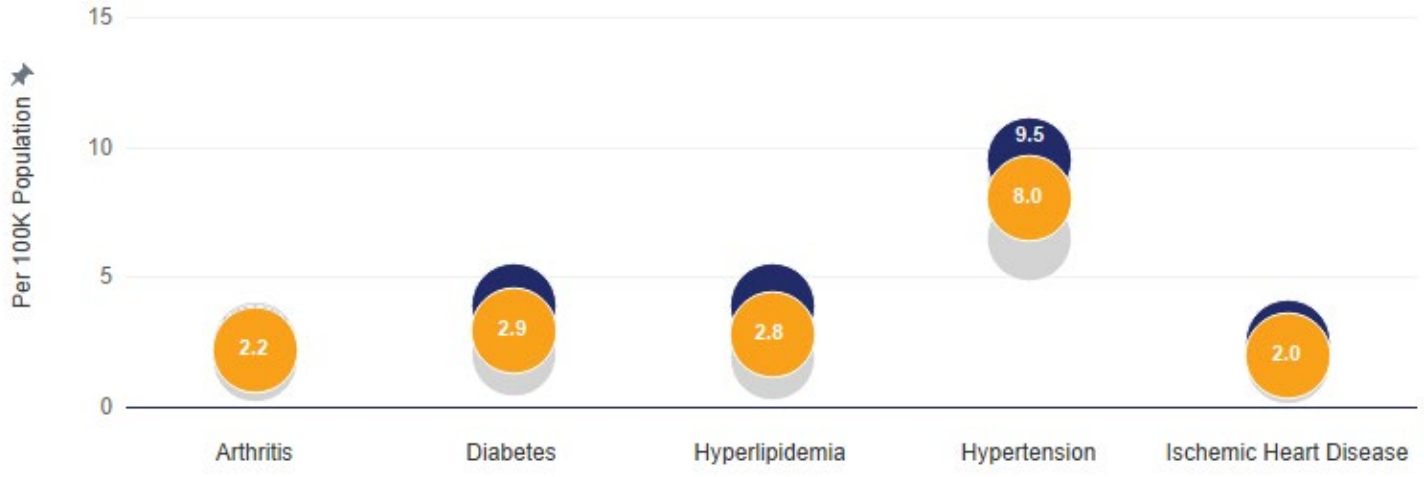
FIGURE 11: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT ENVIRONMENT INDICATORS

DIAGNOSES INCIDENCE WITHIN HOSPITAL COMMUNITY AT DISCHARGE

TABLE 12: DIAGNOSES INCIDENCE WITHIN HOSPITAL COMMUNITY AT DISCHARGE INDICATORS AND RATES

		Grant County	Pulaski County	Saline County	Community Average	State
Arthritis	*Number of individuals 18 years and older discharged with a primary or secondary arthritis diagnosis as a percentage of the population 18 years and older*	2.5	2.4	1.8	2.2	2.3
Diabetes	*Number of individuals 18 years and older discharged with a primary or secondary diabetes diagnosis as a percentage of the population 18 years and older*	3.3	3.5	2.1	2.9	3.9
Hyperlipidemia	*Number of individuals 18 years and older discharged with a primary or secondary hyperlipidemia diagnosis as a percentage of the population 18 years and older*	3.2	3.2	1.9	2.8	3.9
Hypertension	*Number of individuals 18 years and older discharged with a primary or secondary hypertension diagnosis as a percentage of the population 18 years and older*	8.7	9.0	6.4	8.0	9.5
Ischemic Heart Disease	*Number of individuals 18 years and older discharged with a primary or secondary ischemic heart disease diagnosis as a percentage of the population 18 years and older*	2.5	1.7	1.7	2.0	2.5

FIGURE 12: DIAGNOSES INCIDENCE WITHIN HOSPITAL COMMUNITY AT DISCHARGE INDICATORS



MENTAL HEALTH AND SUBSTANCE USE

TABLE 13: MENTAL HEALTH AND SUBSTANCE USE INDICATORS AND RATES

		Grant County	Pulaski County	Saline County	Community Average	State	National
Excessive Drinking	*Percentage of adults reporting binge or heavy drinking*	17.7	17.6	17.3	17.6	17.3	19.2
Poor Mental Health	*Percentage of adults ages 18 or older reporting poor mental health for 14 or more days*	18.1	16.6	16.3	17.0	18.0	13.9
Youth Depression	*Percentage of public school students in 6th, 8th, 10th, and 12th grade who had feelings of depression all of the time in the past 30 days*	14.9	12.9	8.5	12.1	12.1	Data Not Available
Adult Depression	*The prevalence of depression among Medicare fee-for-service beneficiaries*	21.8	18.8	16.8	19.1	18.7	18.4
Suicide Deaths	*The rate of deaths by suicide (ICD-10 codes U03, X60-X84, Y87.0) per 100,000 population (age-adjusted)*	Data Not Available	17.0	20.5	Data Not Available	18.8	13.8
Non-Fatal Opioid Overdoses	*Non-fatal opioid overdoses per 100,00 population (based on county of occurrence)*	27.8	26.6	15.4	23.3	17.7	Data Not Available
Opioid Overdose Deaths	*Opioid-related deaths per 100,00 population (based on county of occurrence)*	5.6	22.0	14.6	14.1	9.2	Data Not Available
Drug Overdose Deaths	*Opioid-related deaths per 100,00 population (based on county of occurrence)*	11.1	34.3	20.3	21.9	16.7	Data Not Available

FIGURE 13: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT MENTAL HEALTH AND SUBSTANCE USE INDICATORS

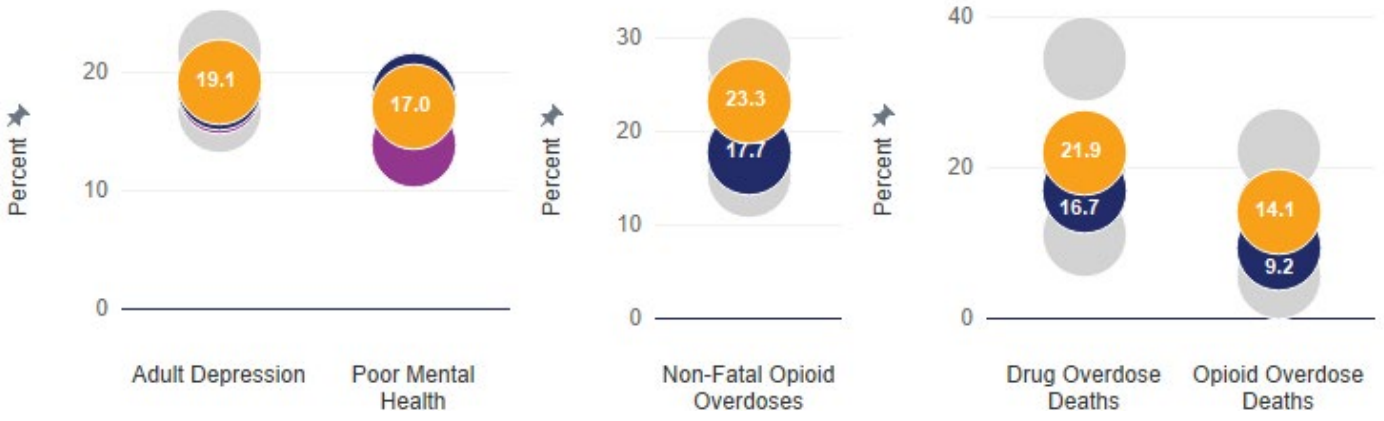
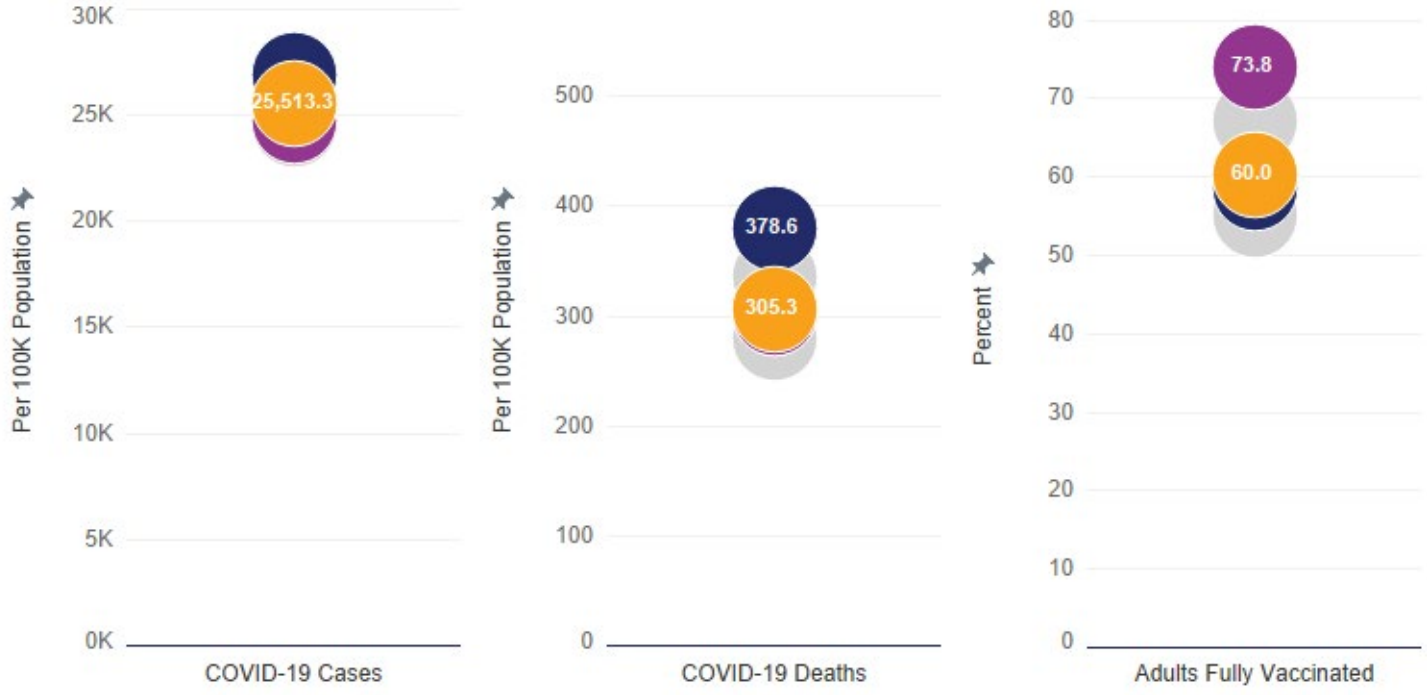


TABLE 14: COVID-19 INDICATORS AND RATES

		Grant County	Pulaski County	Saline County	Community Average	State	National
COVID-19 Cases	*The incidence rate of confirmed COVID-19 cases per 100,000 population, as of May 12, 2022*	24,560.2	26,444.7	25,535.1	25,513.3	26,900.1	24,718.7
COVID-19 Deaths	*The rate of deaths among patients with confirmed cases of COVID-19 per 100,000 population, as of May 12, 2022*	335.4	301.3	279.2	305.3	378.6	301.3
Adults Fully Vaccinated	*The percentage of adults fully vaccinated for COVID-19, as of May 11, 2022*	54.9	67.1	58.1	60.0	58.4	73.8
Adult COVID-19 Vaccine Hesitancy	*The percentage of the population estimated to be hesitant toward receiving a COVID-19 vaccine*	20.4	17.8	19.8	19.3	20.4	10.3

FIGURE 14: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT COVID-19 INDICATORS



BAPTIST HEALTH MEDICAL CENTER

NORTH LITTLE ROCK

About Baptist Health Medical Center-North Little Rock

Baptist Health Medical Center-North Little Rock became part of Baptist Health in 1962. The medical center offers comprehensive services delivered in an inviting, less institutionalized setting. The design was based on community research with a focus on patient-centered care. There are 225 patient beds ensuring timely admissions to the hospital. Two medical office buildings are located on the campus, allowing doctors and patients convenient access to the hospital.

The Emergency Department at Baptist Health Medical Center-North Little Rock provides emergency care for adult and pediatric patients 24 hours per day, seven days per week, supported by our full-service hospital. Our experienced physicians are dedicated to providing high-quality, patient-centered care for emergency medical conditions including heart attack, stroke, injuries, major illness and more. We employ APRNs in triage areas for faster screening and easier access, and we have Level III trauma services, providing prompt assessment, resuscitation, surgery, intensive care and stabilization of injured patients and emergency operations.

This facility also offers Invenia ABUS 2.0 (Automated Breast Ultrasound System) technology for breast cancer detection in women with dense breast tissue. This ultrasound procedure is the only ultrasound technology of its kind approved by the FDA and when used in addition to your mammogram, will provide a more complete evaluation of dense breast tissue. Learn more about ABUS 2.0.

2020-2022 Accomplishments

Mental Health

- Mental Health First Aid Training provided for the North Little Rock School District
- Offered Virtual Classes on Depression for Community Members
- GME program opened a outpatient psychiatry clinic in December 2020 seeing over 15,000 patient visits
- GME Psychiatric residents began enrollment
- Screenings for Depression were offered in the Heaven's Loft Prenatal Program

Hypertension

- The City of North Little Rock partnered with Baptist Health to break grounds on a new health clinic in Rose City.
- Opened an Urgent Care Clinic in the Beebe community.
- Baptist Health Community Outreach's mobile health unit travels to Brinkley and Hazen for mobile vaccine clinics and preventive health screenings.
- Opened the first UAMS Baptist Health Cancer Center which brings the full spectrum of cancer research.
- Two Know It, Control It Blood Pressure were implemented, one physical, one virtual.
- Hypertension education classes were held virtually.
- The Know It Control program was held at the Cabot Senior Center.
- Hypertension Screening and education was offered in all Community Wellness Centers in North Little, Cabot, Lonoke and Jacksonville

Infant Mortality

- Provided the Heaven's Loft Prenatal Program for new and expectant mothers with more than 300 patients visits.
- APRN provided needed health care and referrals to mothers in need
- Process 125 Medicaid referrals Applications by APRN
- Health Screenings and Vaccinations were provided to new and expectant mothers.
- Established a food pantry to assist moms who were food insecure
- Provided 100 Car seats and Infant Car seat training to mothers
- Provided 50 Safe sleep environments to mothers in need
- Recruited a New APRN for the Women's Clinic

COMMUNITY HEALTH NEEDS ASSESSMENT – IMPLEMENTATION PLAN 2023-2025

Baptist Health Medical Center- North Little Rock

IDENTIFIED COMMUNITY HEALTH NEED: **Access to Healthcare Services**

GOALS / OBJECTIVES:

Increase Access to Quality Health Care, Preventive Health Screenings, Vaccinations and Community Resources.

STRATEGY #1

Expand care by utilizing the Mobile Health Unit (MHU) and new clinics to provide preventive screenings and increase access to care.

Action Steps:

1. Utilize the MHU to offer back to school immunizations, flu shots and Covid-19 Vaccinations
2. Register all participants in the Epic System.
3. Utilize Baptist Health Virtual Care on the MHU to offer additional care for patients in need.
4. Provide Preventative Health Screenings for Diabetes, Hypertension, Cholesterol and Covid-19.
5. Utilize the Findhelp.org system to refer and track patents in need of additional resources
6. Expand Health Care Services in the Rose City Community by building a new Healthcare Clinic
7. Develop Pipelines of job opportunities focused on students in underserved areas to promote diversity of frontline clinical and non-clinical providers through school partnerships

PERFORMANCE METRICS:

1. Provide Preventative Screenings, Vaccinations and Services to at least 1,000 individuals
2. Track and report the number of patients utilizing virtual care on the MHU.
3. Track and report the number of patients enrolled in EPIC and MyChart.
4. Track and report the number of preventative health screenings and referrals for follow-up
5. Track and report the number of patients utilizing the Findhelp.org system for resources
6. Open Community Clinic in Rose City by January 2024
7. Establish a Partnership with the North Little Rock School District by January 2024

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:

Community Outreach Strategic Development, Little Rock Housing Authority and Community Centers

Resources Hospital Plans to Commit to Address Health Need:

- Staff and Community Partnerships

Estimated Completion Date:

- Ongoing

Person(s) / Department Responsible:

- Community Outreach, BHNLR Leadership, Human Resources Department, GME Program

COMMUNITY HEALTH NEEDS ASSESSMENT – IMPLEMENTATION PLAN 2023-2025

Baptist Health Medical Center - North Little Rock

IDENTIFIED COMMUNITY HEALTH NEED: **Access to Healthcare Services**

GOALS / OBJECTIVES:

Improve access to health and quality of life information for individuals living with Chronic Diseases.

STRATEGY #2

Provide education and resources to prevent and improve diabetes self-management, Hypertension Management and Diabetes Prevention in order to reduce complications with a targeted group of patients.

Action Steps:

1. Increase screenings for Diabetes including glucose screenings and hbA1c screenings in community settings
2. Host and provide community based diabetes education classes
3. Provide evidence-based diabetes prevention programs
4. Utilize the Social Determinants Screening tool in Epic to identify barriers to resources.
5. Increase the number of patients screened and referred to community resources through findhelp.org
6. Partner with the Baptist Health's Health Management Center to develop a referral system for Diabetes and Nutrition Education to underserved patients.
7. Continue In-Patient Diabetes Self-Management Program

PERFORMANCE METRICS:

Key factors that will be tracked to determine the impact of programs and services implemented, and relevance to internal and external public health goals

1. 500 Individuals will be screened for Diabetes via Community Events/Wellness Centers
2. 500 individuals will be screened for Hypertension via Community Events/Wellness Centers
3. 4- Diabetes Education & Nutrition Classes will be held via Community Events/Wellness Centers
4. 4 - Managing Hypertension Classes will be held
5. 200 Patients will be enrolled in the HMC Diabetes Self-Management Class
6. Track referrals for Diabetes related needs through Findhelp
7. Number of consults and referrals resulting from the Telehealth consults will be tracked and reported.

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:

Baptist Health Little Rock, Telehealth, Community Outreach, Health Management Center

Resources Hospital Plans to Commit to Address Health Need:	Estimated Completion Date:	Person(s) / Department Responsible:
• Community Outreach Staff, Health Management Center	• Ongoing	• Baptist Health Community Outreach Department, Baptist Health North Little Rock

COMMUNITY HEALTH NEEDS ASSESSMENT – IMPLEMENTATION PLAN 2023-2025

Baptist Health Medical Center - North Little Rock

IDENTIFIED COMMUNITY HEALTH NEED: **Access to Healthcare Services**

GOALS / OBJECTIVES:

Expand and improve community access comprehensive, quality health care services and providers as well as medical and non-medical services with a focus on women's health

STRATEGY # 3

Improve and Expand access to essential health care services through community partnerships, virtual care, referrals and resources

Action Steps:

1. Develop a System-Wide Comprehensive Women's Health plan to expand and improve women's health services
2. Implement a Marketing Campaign dedicated to increasing the awareness of Women's Health and services available
3. Explore the AR HOMES program to improve Prenatal Education and Postpartum Care
4. Explore opportunities to utilize the Mobile Health Unit for Prenatal Education, Care, and Screening
5. Utilize Grant Opportunities to provide free screening mammograms to women in need

PERFORMANCE METRICS:

Key factors that will be tracked to determine the impact of programs and services implemented, and relevance to internal and external public health goals

1. Strategies and Goals Developed and Implemented
2. Number of Promotions internal and external focused on Women's Health will be tracked and reported
3. Number of AR Homes initiatives and partnerships will be tracked and reported
4. Number of prenatal, postpartum and educational materials implemented via the Mobile Health Unit will be tracked and reported.
5. Grant Funding Secured will be tracked and reported
6. Number of individuals benefiting from free mammograms will be tracked and reported

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:

Baptist Health Little Rock, Community Outreach, Command Center, Human Resources

Resources Hospital Plans to Commit to Address Health Need:	Estimated Completion Date:	Person(s) / Department Responsible:
• Community Outreach Staff	• Ongoing	• Baptist Health North Little Rock, Baptist Health Community Outreach Department , Baptist Health Marketing Department, Baptist Health Breast Center

COMMUNITY HEALTH NEEDS ASSESSMENT – IMPLEMENTATION PLAN 2023-2025

Baptist Health Medical Center - North Little Rock

IDENTIFIED COMMUNITY HEALTH NEED: Mental Health

GOALS / OBJECTIVES:

Improve access to Mental Health Resources.

STRATEGY #1

Promote the established mental health resources and expand services to make a positive impact on the Mental Health of our community.

Action Steps:

1. Continue and promote onsite Behavioral Health Clinics
2. Identify gaps in existing programs and determine additional training needs
3. Explore and Develop a system-wide plan to improve the Mental Health of Arkansans
4. Implement an internal and external communication plan to promote the Command Center
5. Explore opportunities to recruit additional mental health providers.
6. Explore opportunities to expand in-patient psychiatric services
7. Explore opportunities to partners with organizations targeting the unsheltered population to offer Mental Health Resource
8. Expand the GME Collaboration with UAMS to include a Psychiatry Residency Program

PERFORMANCE METRICS:

1. Number of Individuals reached through the Behavioral Health Clinic will be tracked and reported
2. Systemwide plan will be developed to address the mental health needs of the community
3. Number of communications pieces, interviews, promotions will be tracked and reported
4. Number of additional mental health providers recruited will be tracked and reported
5. Expansion of services and patient services will be tracked and reported
6. Number of Community partnerships and participant utilization will be tracked and reported
7. Number of enrollees and graduates in the Psychiatry Residency Program will be tracked and reported

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:

Baptist Health Regional Hospitals, Baptist Health North Little Rock, Baptist Health Western Region, Baptist Health Conway

Resources Hospital Plans to Commit to Address Health Need:

- AHG Clinics, Baptist Health Behavioral Health, Baptist Health Command Center, Marketing Department

Estimated Completion Date:

- Ongoing

Person(s) / Department Responsible:

- Baptist Health North Little Rock Leadership, Graduate Medical Education Program Leadership, Behavioral Health, Community Outreach, Command Center, Marketing Department,

COMMUNITY HEALTH NEEDS ASSESSMENT – IMPLEMENTATION PLAN 2023-2025

Baptist Health Medical Center - North Little Rock

IDENTIFIED COMMUNITY HEALTH NEED: **Mental Health**

GOALS / OBJECTIVES:

Increase awareness and support of community members dealing with mental health concerns.

STRATEGY #2

Reduce the stigma associated with education and treatment of mental health illness through training and education.

Action Steps:

1. Pilot a “Make it Okay” campaign designed to reduce the stigma of mental illness in at least one community.
2. Offer Mental Health First Aid trainings to community groups and faith-based organizations.
3. Offer an annual Mental Health First Aid training for staff, pastoral care and other system-wide health care providers.
4. Host seminars, presentations with an emphasis on decreasing stigma.
5. Offer Depression and ACES Screening Tools in Community Wellness Centers.
6. Provide education and outreach efforts via seminars, events and telehealth on the relationship between substance abuse and mental health.

PERFORMANCE METRICS:

1. Number of individuals reached with the “Make it Okay” Initiative
2. Number of Mental Health First Aid Trainings for staff will be tracked and reported.
3. Number of Community Based Mental Health First Aid Presentations will be tracked and reported.
4. Number of referrals and follow-ups will be tracked and reported.
5. Number of seminars, presentations will be tracked and reported.

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:

Faith Based Communities

Resources Hospital Plans to Commit to Address Health Need:

- Community Outreach Staff, Pastoral Care and Behavioral Health

Estimated Completion Date:

- Ongoing

Person(s) / Department Responsible:

- Baptist Health Community Outreach, Baptist Health Behavioral Health, Baptist Health North Little Rock Leadership

COMMUNITY HEALTH NEEDS ASSESSMENT – IMPLEMENTATION PLAN 2023-2025

Baptist Health Medical Center- North Little Rock

IDENTIFIED COMMUNITY HEALTH NEED: Nutrition & Food Security

GOALS / OBJECTIVES:

Initiate Evidence Based Nutrition Security strategies to address obesity, diabetes, hypertension, and other diet-related chronic conditions.

STRATEGY #1

Increase access to nutrition education and information among community members

Action Steps:

1. Implement Maintain, Don't Gain holiday challenge program for adult community members that encourages using stress management strategies, physical activity, and healthful food choices during the holiday season to maintain one's physical and mental health and avoid holiday weight gain.
2. Implement Around the Table program targeting youth, young adults and parents of young children. This program focuses on creating healthy connections between food, oneself, and one's community.
3. Implement Eat Healthy, Be Active program for adult community members. a program based on the Dietary Guidelines and Physical Activity Guidelines for Americans and teaches participants to make incremental lifestyle changes to improve their health.
4. Implement Cooking Matters, grocery store tour and cooking program targeting adults and parents participating in the WIC program with the goal to empower participants with skills to shop for healthful foods on a budget to maximize limited food resources..
5. Implement Cooking with Community Outreach classes to empower participants to build cooking skills, cook more healthy meals, reduce food waste, and make healthier selections at the grocery store.
6. Increase access to Food in the Rose City Community through the FoodRX program

PERFORMANCE METRICS:

1. Number of Participants registered for educational Programs will be tracked and reported
2. Coordinate implementation of 3 Maintian, Don't Gain Holiday Challenge
3. Pilot 2 "Around the Table Series targeting Youth
4. Implement 2 Eat Healthy Be Active Programs
5. Implement 2 Cooking Matters Grocery Store Tours
6. Host 2 Community -Based Community Outreach Cooking Classes
7. Establish and Track number of Patients in the New Rose City clinic participating in FoodRX

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:

Arkansas Hunger Relief Alliance, Arkansas Hunger Alliance,

Resources Hospital Plans to Commit to Address Health Need:	Estimated Completion Date:	Person(s) / Department Responsible:
• Community Outreach Staff	• Ongoing	• Community Outreach Team, North Little Rock Leadership

NORTH LITTLE ROCK

ASSESSMENT PREPARED BY ACHI
INSPIRING HEALTHY ACTS

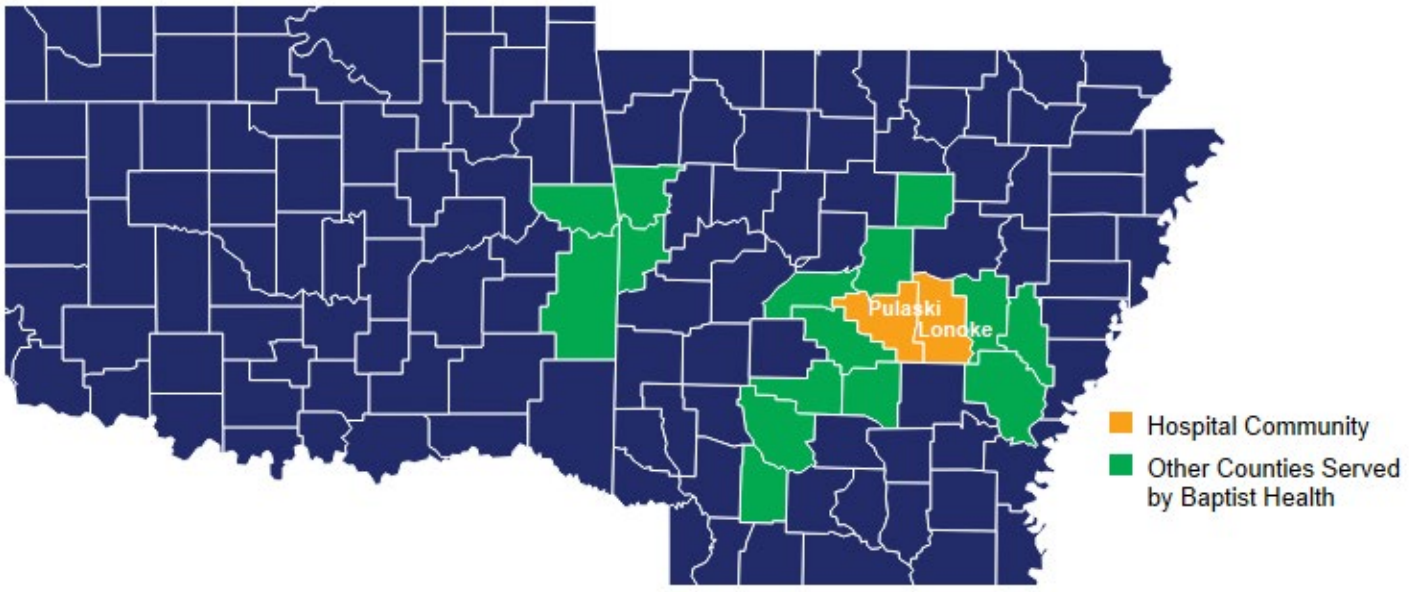
Introduction

Baptist Health engaged the Arkansas Center for Health Improvement (ACHI) to conduct the quantitative data collection and analysis for the 2022 Community Health Needs Assessment (CHNA) process. Baptist Health provided ACHI with the counties served for each of its 11 hospital communities. A total of 15 Arkansas counties and two Oklahoma counties were included in the CHNA.

This report shows the qualitative results from the CHNA for the Baptist Health Medical Center-North Little Rock hospital community, which include Lonoke and Pulaski counties.

HOSPITAL COMMUNITY

FIGURE 1: COUNTIES SERVED BY BAPTIST HEALTH MEDICAL CENTER-NORTH LITTLE ROCK



Qualitative Results

Quantitative results from the CHNA for the Baptist Health Medical Center-North Little Rock hospital community are reported below. There are 12 sections: Demographics, Health Outcomes, Cause of Death, Chronic Conditions, Health Behaviors, Prevention, Access, Social and Economic Factors, Environment, Diagnoses Incidence Within Hospital Community at Discharge, Mental Health and Substance Use, and COVID-19.

Each section includes a table with health indicator data for each county in the hospital community, a community average for each measurement, and averages for the state of Arkansas and the United States. If data were not available or were suppressed, “Data Not Available” 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 document and Appendix 1.

DEMOGRAPHICS

TABLE 1: AGE AND SEX

		Lonoke County	Pulaski County	State	National
Total Population	*Number*	72,528.0	392,967.0	2,999,370.0	324,697,795.0
Ages 0-4	*Percent*	6.8	6.7	6.3	6.1
Ages 5-17	*Percent*	19.1	16.6	17.2	16.5
Ages 18-24	*Percent*	7.6	8.8	9.5	9.4
Ages 25-34	*Percent*	14.8	14.9	13.1	13.9
Ages 35-44	*Percent*	13.7	12.8	12.3	12.6
Ages 45-54	*Percent*	13.0	12.3	12.4	13.0
Ages 55-64	*Percent*	11.9	13.0	12.7	12.9
Ages 65+	*Percent*	13.2	15.0	16.6	15.6
Male	*Percent*	49.2	47.8	49.1	49.2
Female	*Percent*	50.8	52.2	50.9	50.8

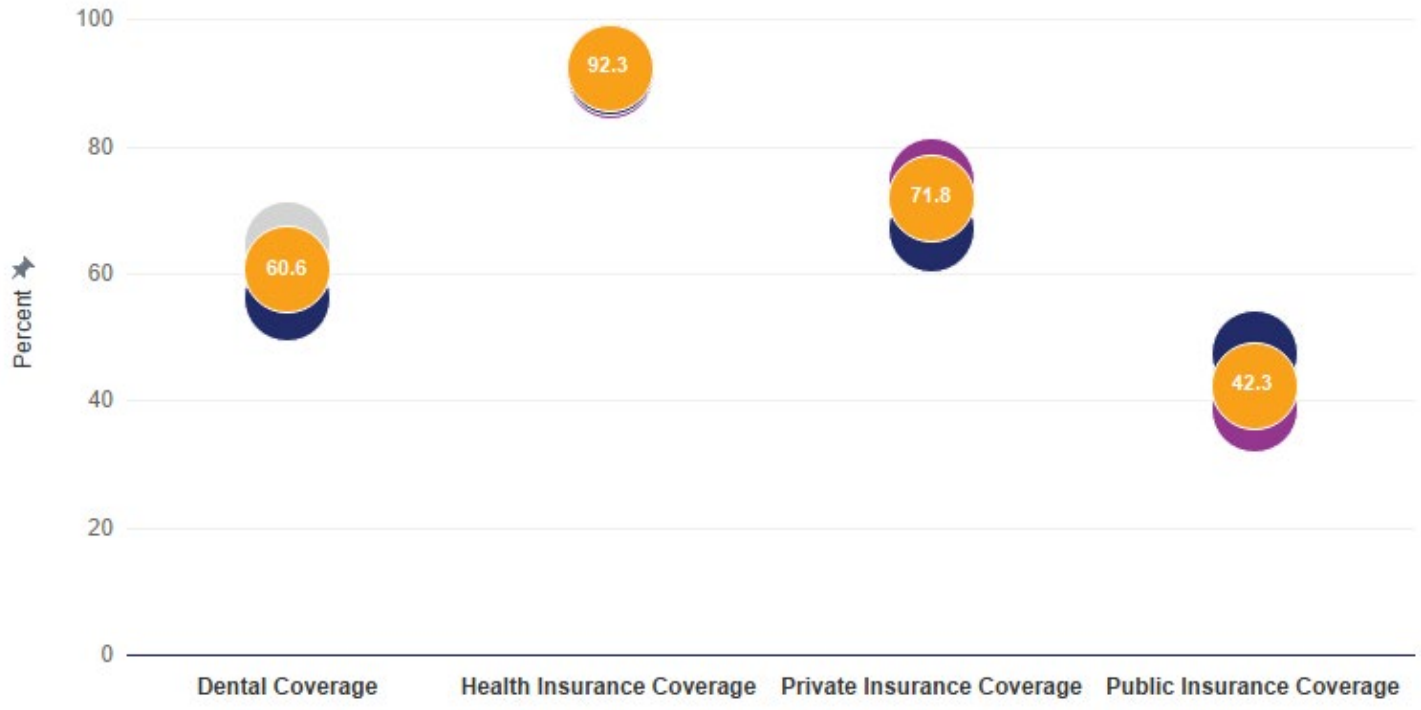
TABLE 2: RACE, ETHNICITY, AND LANGUAGE

		Lonoke County	Pulaski County	State	National
Total Population	*Number*	72,528.0	392,967.0	2,999,370.0	324,697,795.0
Hispanic or Latino	*Percent*	4.5	6.2	7.5	18.0
Non-Hispanic White	*Percent*	86.0	52.3	72.4	60.7
Black or African American	*Percent*	5.7	36.9	15.3	12.7
Native American/Alaska Native	*Percent*	0.7	0.3	0.7	0.9
Asian	*Percent*	0.9	2.2	1.5	5.6
Native Hawaiian/Pacific Islander	*Percent*	0.3	0.1	0.3	0.2
Some Other Race	*Percent*	1.3	1.9	2.8	4.9
Two or More Races	*Percent*	2.4	2.8	2.7	3.3
Non-English Language Households	*Percent*	0.3	1.7	1.6	4.4

TABLE 3: INSURANCE COVERAGE

		Pulaski County	Lonoke County	Community Average	State	National
Health Insurance Coverage	*Percentage of total civilian non-institutionalized population with health insurance coverage*	92.1	92.4	92.3	91.5	91.2
Private Insurance Coverage	*Percentage of total civilian non-institutionalized population with private health insurance coverage*	70.1	73.6	71.8	67.0	74.5
Public Insurance Coverage	*Percentage of total civilian non-institutionalized population with public health insurance coverage*	44.6	40.1	42.3	47.3	38.5
Dental Coverage	*Percentage of Arkansas residents with evidence of any dental coverage in the All-Payer Claims Database (APCD)*	64.4	56.7	60.6	56.2	Data Not Available

FIGURE 2: COMMUNITY, STATE, AND NATIONAL COMPARISON OF INSURANCE COVERAGE

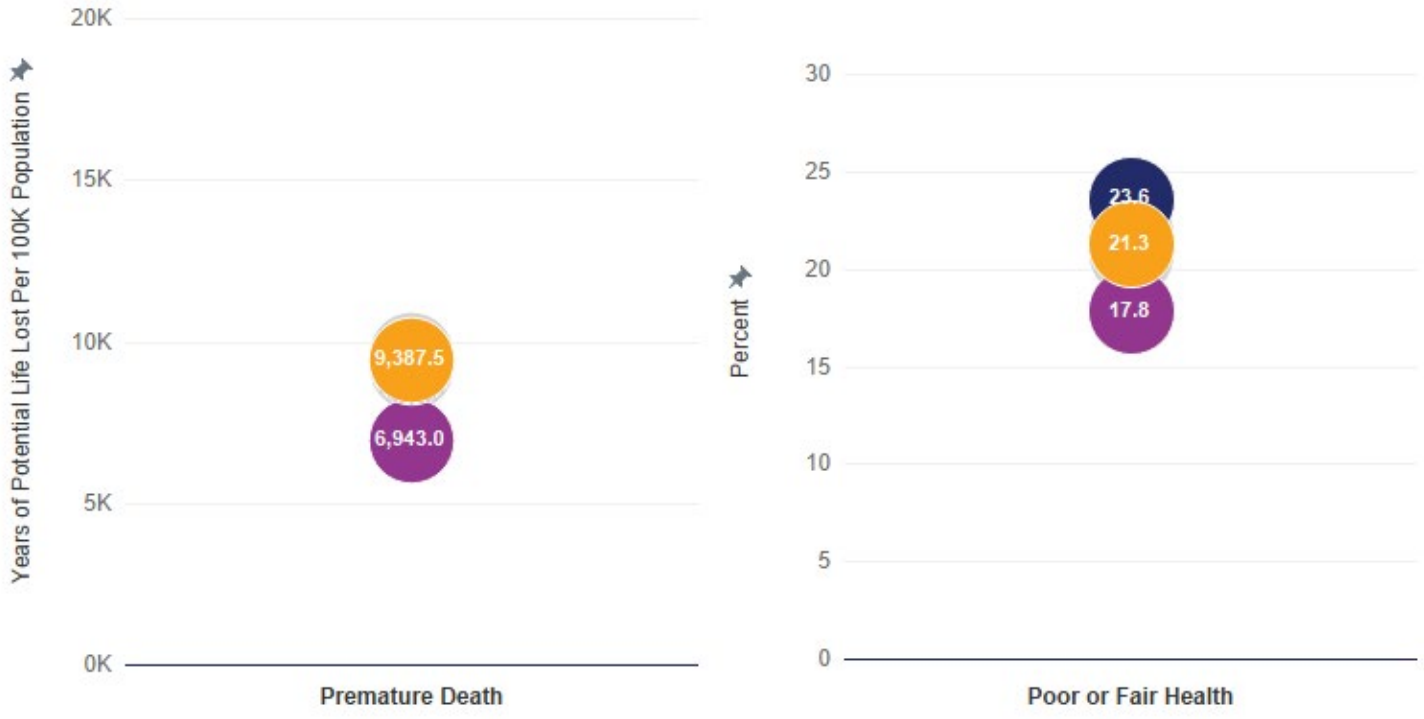


HEALTH OUTCOMES

TABLE 4: HEALTH OUTCOMES INDICATORS AND RATES

		Lonoke County	Pulaski County	Community Average	State	National
Premature Death	*Years of potential life lost before age 75 per 100,000 population (age-adjusted)*	9,170.0	9,605.0	9,387.5	9,357.0	6,943.0
Poor or Fair Health	*Percentage of adults reporting poor or fair health*	20.8	21.7	21.3	23.6	17.8
Poor Physical Health Days	*Average number of physically unhealthy days reported in past 30 days (age-adjusted)*	4.9	4.6	4.8	4.9	4.0
Low Birthweight	*Percentage of live births with low birth weight (<2500g)*	7.9	10.9	9.4	9.1	8.2

FIGURE 3: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT HEALTH OUTCOMES INDICATORS

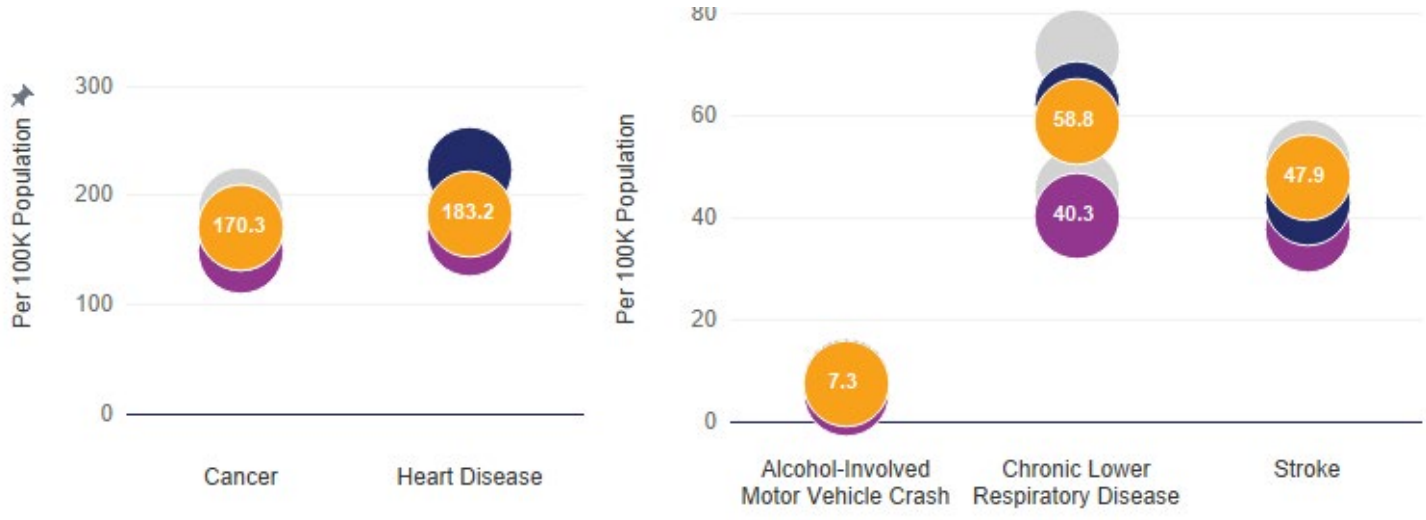


CAUSE OF DEATH

TABLE 5: CAUSE OF DEATH INDICATORS AND RATES

		Pulaski County	Lonoke County	Community Average	State	National
All Causes	*All causes of deaths per 100,000 population (age-adjusted)*	854.2	968.0	911.1	888.4	727.2
Cancer	*5-year average rate of death due to malignant neoplasm (cancer) per 100,000 population (age-adjusted)*	155.2	185.3	170.3	170.1	149.4
Stroke	*5-year average rate of death due to cerebrovascular disease (stroke) per 100,000 population (age-adjusted)*	44.8	50.9	47.9	43.0	37.6
Chronic Lower Respiratory Disease	*Rate of deaths due to chronic lower respiratory disease per 100,000 population (age-adjusted)*	45.0	72.5	58.8	62.1	40.3
Diabetes	*Diabetes deaths per 100,000 population (age-adjusted)*	29.1	37.7	33.4	29.0	21.4
Heart Disease	*Rate of death due to heart disease per 100,000 population (age-adjusted)*	187.4	178.9	183.2	222.7	164.8
Unintentional Injury	*5-year average rate of death due to unintentional injury (accident) per 100,000 population (age-adjusted)*	52.9	55.6	54.3	51.7	50.4
Motor Vehicle Crash	*5-year average rate of death due to motor vehicle crash per 100,000 population (age-adjusted)*	16.7	18.7	17.7	18.9	11.5
Alcohol-Involved Motor Vehicle Crash	*Rate of persons killed in motor vehicle crashes involving alcohol as a rate per 100,000 population*	6.8	7.8	7.3	7.8	5.3

FIGURE 4: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT CAUSE OF DEATH INDICATORS

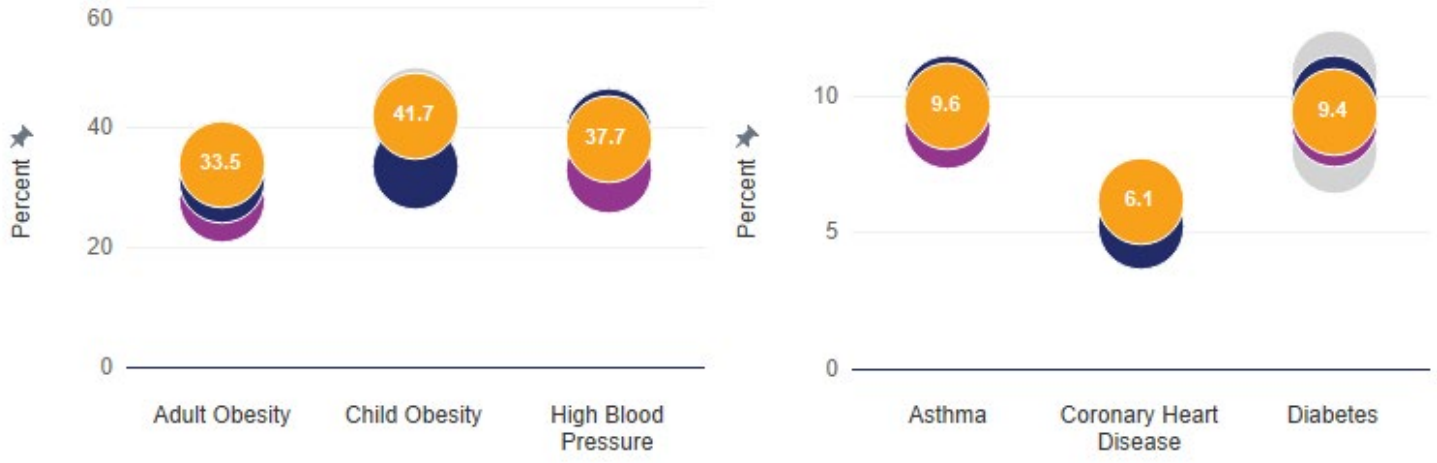


CHRONIC CONDITIONS

TABLE 6: CHRONIC CONDITIONS INDICATORS AND RATES

		Lonoke County	Pulaski County	Community Average	State	National
High Blood Pressure	*Percentage of adults who have been told they have high blood pressure*	36.0	39.4	37.7	39.0	32.6
Asthma	*Percentage of adults who have been told they currently have asthma (age-adjusted)*	9.4	9.8	9.6	9.9	8.9
Coronary Heart Disease	*Percentage of adults who have been told they have angina or coronary heart disease (age-adjusted)*	6.1	6.1	6.1	5.2	5.4
Arthritis	*Percentage of adults ages 18 or older diagnosed with some form of arthritis*	36.3	32.1	34.2	34.3	Data Not Available
High Cholesterol	*Percentage of adults who have had their blood cholesterol checked and have been told it was high*	36.2	35.2	35.7	36.7	33.6
Diabetes	*Percentage of adults ages 20 and older who have ever been told by a doctor that they have diabetes (age-adjusted)*	8.0	10.8	9.4	9.9	9.0
Adult Obesity	*Percentage of adults ages 20 and older who report a BMI higher than 30*	33.0	34.0	33.5	31.0	27.6
Child Obesity	*Percentage of students classified as overweight or obese, by county location of school*	40.8	42.6	41.7	33.1	Data Not Available

FIGURE 5: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT CHRONIC CONDITIONS INDICATORS

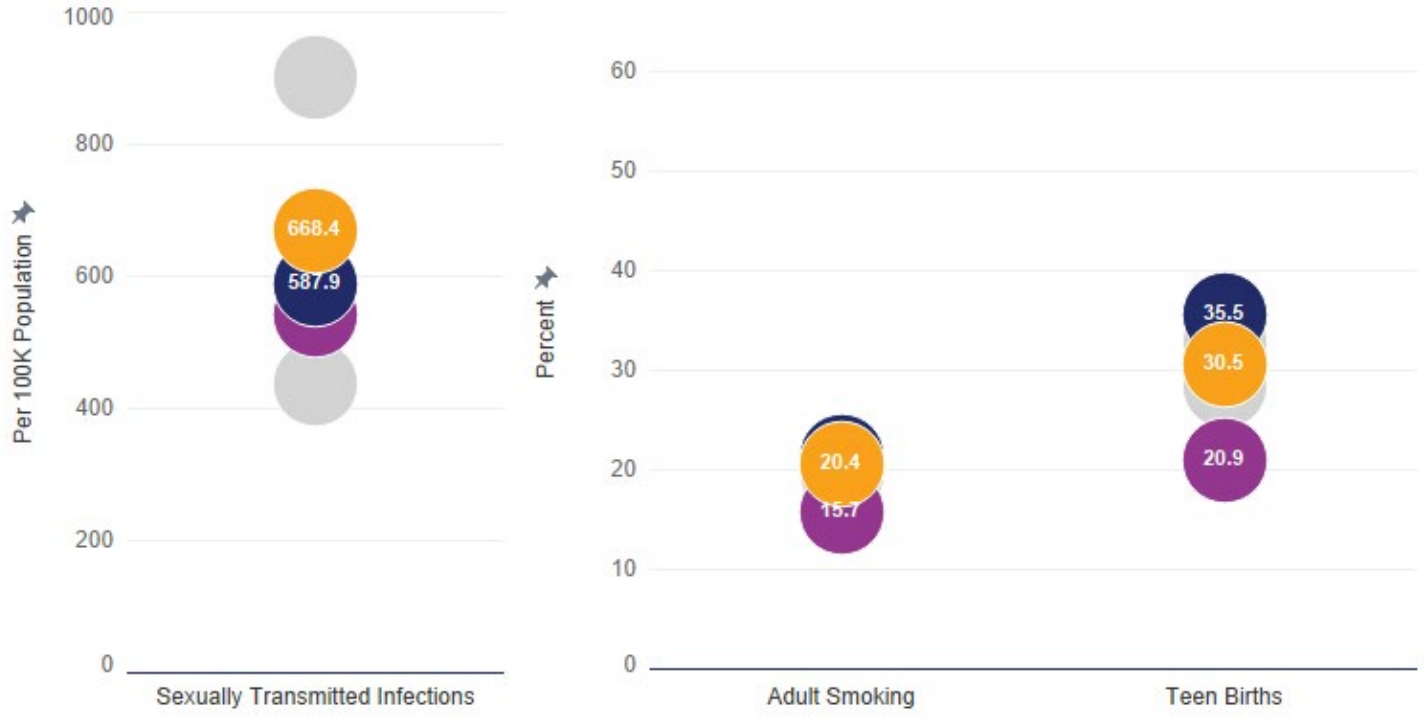


HEALTH BEHAVIORS

TABLE 7: HEALTH BEHAVIORS INDICATORS AND RATES

		Lonoke County	Pulaski County	Community Average	State	National
Adult Smoking	*Percentage of adults who are current smokers (age-adjusted)*	21.2	19.6	20.4	21.2	15.7
Youth Vaping	*Percentage of public school students in 6th, 8th, 10th, and 12th grade who used any vape in the past 30 days*	20.5	8.2	14.4	11.7	Data Not Available
Physical Inactivity	*Percentage of adults ages 20 or older reporting no physical activity in the past month*	27.3	25.9	26.6	26.2	22.0
Sexually Transmitted Infections	*Number of newly diagnosed chlamydia cases per 100,000 population*	434.9	901.9	668.4	587.9	539.9
Teen Births	*The seven-year average number of teen births per 1,000 female population, ages 15-19*	28.4	32.6	30.5	35.5	20.9

FIGURE 6: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT HEALTH BEHAVIORS INDICATORS

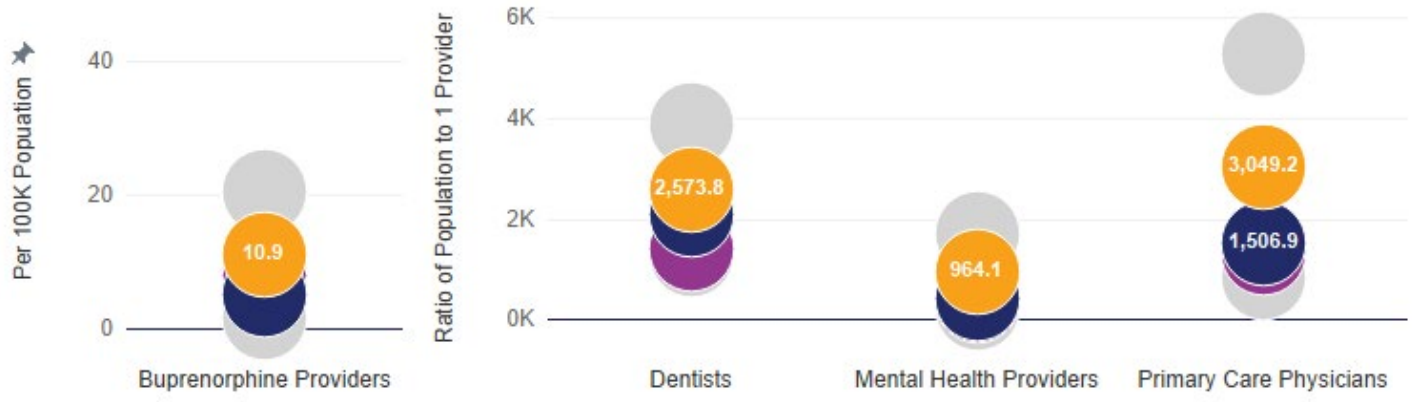


PREVENTION

TABLE 8: PREVENTION INDICATORS AND RATES

		Lonoke County	Pulaski County	Community Average	State	National
No Pap Test	*Percentage of women ages 21 to 65 who have not had a pap test within the past 3 years (age-adjusted)*	15.8	14.0	14.9	16.3	14.5
No Colorectal Cancer Screening	*Percentage of adults ages 50-75 who have never had either a sigmoidoscopy or colonoscopy (age-adjusted)*	37.7	28.5	33.1	38.1	35.0
No Flu Shot	*Percentage of adults ages 18 or older who have not had a flu shot in the past year*	60.8	54.0	57.4	58.5	58.1
No HIV Test	*Percentage of adults ages 18 or older who have never been screened for HIV*	64.2	54.8	59.5	63.6	Data Not Available
No Dental Visit	*Percentage of adults ages 18 or older who have not had a dentist or dental clinic visit in the previous year (age-adjusted)*	42.9	35.4	39.2	43.4	33.8
Blood Pressure Medication Non-Adherence	*The percentage of Medicare enrollees who did not adhere to blood pressure medication schedules*	25.4	27.3	26.4	25.9	21.8
No Annual Wellness Visit (Medicare)	*The percentage of Medicare enrollees who did not have an annual wellness visit in the past year*	68.0	Data Not Available	Data Not Available	74.0	70.0
No Routine Check Up (Adults)	*The percentage of adults age 18 or older with no routine check up with a doctor in the past year*	22.7	19.5	21.1	21.0	23.4

FIGURE 8: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT ACCESS INDICATORS

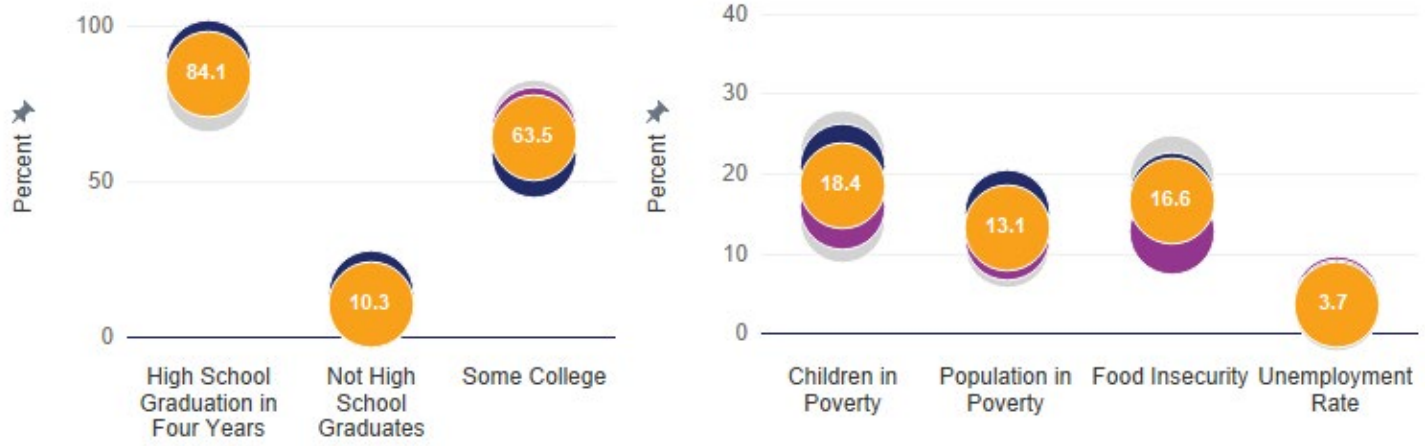


SOCIAL AND ECONOMIC FACTORS

TABLE 10: SOCIAL AND ECONOMIC FACTORS INDICATORS AND RATES

		Lonoke County	Pulaski County	Community Average	State	National
Not High School Graduates	*Percentage of adults ages 25 or older without a high school diploma*	10.9	9.6	10.3	13.4	12.0
High School Graduation in Four Years	*Percentage of ninth-grade cohort who graduated in four years*	88.8	79.4	84.1	88.2	87.7
Some College	*Percentage of adults ages 25-44 with some post-secondary education*	58.2	68.8	63.5	58.5	66.1
Unemployment Rate	*Unemployment rate among civilian non-institutionalized population age 16 and older in January 2022*	3.1	4.3	3.7	3.8	4.4
Children in Poverty	*Percentage of children under age 18 below the poverty line*	14.2	22.5	18.4	20.8	15.7
Population in Poverty	*Percentage of population below the federal poverty line*	10.9	15.3	13.1	15.2	11.9
Children in Single-Parent Households	*Percentage of children who live in a household headed by single parent*	20.9	39.3	30.1	28.9	25.5
Homeless Children	*Rate of homelessness among public school students*	1.6	2.1	1.9	2.8	2.8
Food Insecurity	*Percentage of the population that experienced food insecurity in the report year*	13.9	19.3	16.6	17.3	12.6
Social Associations	*Number of membership associations per 100,000 population*	86.3	167.0	126.6	126.5	105.0
Violent Crimes	*Annual rate of reported violent crimes per 100,000 population*	369.3	1,121.8	745.6	549.2	416.0

FIGURE 9: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT SOCIAL AND ECONOMIC FACTORS INDICATORS



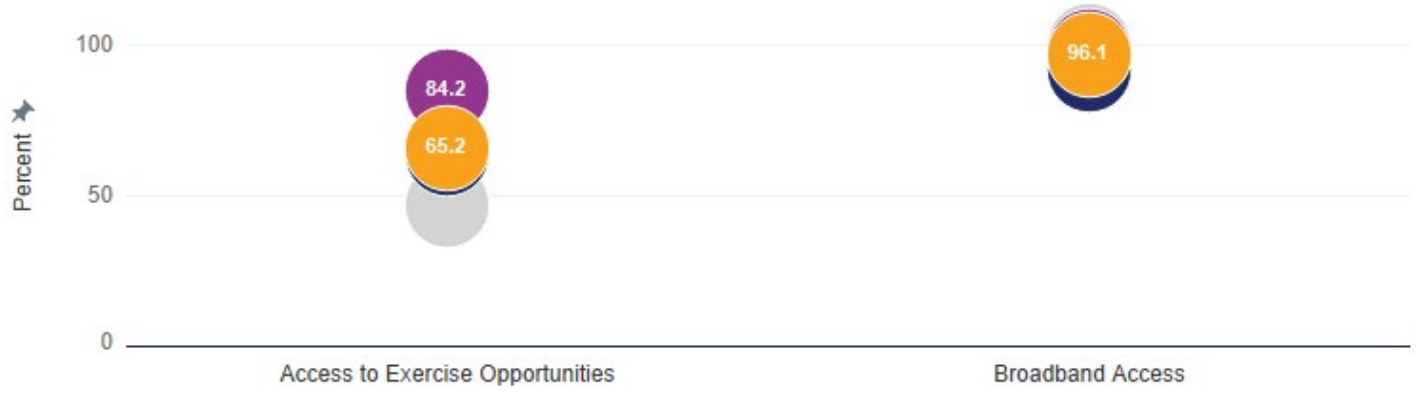
ENVIRONMENT

TABLE 11: ENVIRONMENT INDICATORS AND RATES

		Lonoke County	Pulaski County	Community Average	State	National
Food Environment Index	*Index of factors that contribute to a healthy food environment, 0 (worst) to 10 (best)*	7.5	6.6	7.1	5.1	7.8
Drinking Water Violations	*The total number of drinking water violations recorded in a two-year period*	3.0	0.0	1.5	118.0	4,739.0
Access to Exercise Opportunities	*Percentage of population with adequate access to locations for physical activity*	46.7	83.6	65.2	63.5	84.2
Severe Housing Problems	*Percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, or lack of kitchen or plumbing*	12.7	16.3	14.5	14.1	17.5
Broadband Access	*Percentage of population in a high-speed internet service area; access to DL speeds > 25MBPS (2020)*	93.0	99.3	96.1	91.4	97.5
Long Commute Driving Alone	*Among workers who commute in their car alone, the percentage who commute more than 30 minutes*	47.7	20.3	34.0	27.0	36.6

FIGURE 10: COMMUNITY, STATE, AND NATIONAL COMPARISON OF THE FOOD ENVIRONMENT INDEX INDICATOR

FIGURE 11: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT ENVIRONMENT INDICATORS



DIAGNOSES INCIDENCE WITHIN HOSPITAL COMMUNITY AT DISCHARGE

TABLE 12: DIAGNOSES INCIDENCE WITHIN HOSPITAL COMMUNITY AT DISCHARGE INDICATORS AND RATES

		Lonoke County	Pulaski County	Community Average	State
Arthritis	*Number of individuals 18 years and older discharged with a primary or secondary arthritis diagnosis as a percentage of the population 18 years and older*	2.3	2.4	2.3	2.3
Diabetes	*Number of individuals 18 years and older discharged with a primary or secondary diabetes diagnosis as a percentage of the population 18 years and older*	3.2	3.5	3.4	3.9
Hyperlipidemia	*Number of individuals 18 years and older discharged with a primary or secondary hyperlipidemia diagnosis as a percentage of the population 18 years and older*	3.3	3.2	3.2	3.9
Hypertension	*Number of individuals 18 years and older discharged with a primary or secondary hypertension diagnosis as a percentage of the population 18 years and older*	7.6	9.0	8.3	9.5
Ischemic Heart Disease	*Number of individuals 18 years and older discharged with a primary or secondary ischemic heart disease diagnosis as a percentage of the population 18 years and older*	2.0	1.7	1.9	2.5

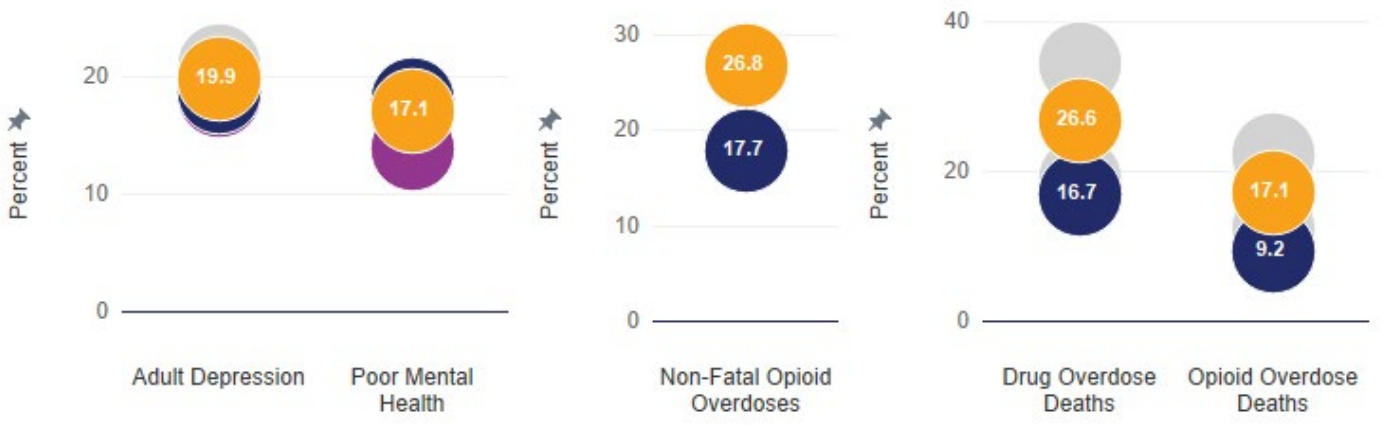
FIGURE 12: DIAGNOSES INCIDENCE WITHIN HOSPITAL COMMUNITY AT DISCHARGE INDICATORS

MENTAL HEALTH AND SUBSTANCE USE

TABLE 13: MENTAL HEALTH AND SUBSTANCE USE INDICATORS AND RATES

		Lonoke County	Pulaski County	Community Average	State	National
Excessive Drinking	*Percentage of adults reporting binge or heavy drinking*	18.1	17.6	17.9	17.3	19.2
Poor Mental Health	*Percentage of adults ages 18 or older reporting poor mental health for 14 or more days*	17.5	16.6	17.1	18.0	13.9
Youth Depression	*Percentage of public school students in 6th, 8th, 10th, and 12th grade who had feelings of depression all of the time in the past 30 days*	12.8	12.9	12.9	12.1	Data Not Available
Adult Depression	*The prevalence of depression among Medicare fee-for-service beneficiaries*	20.9	18.8	19.9	18.7	18.4
Suicide Deaths	*The rate of deaths by suicide (ICD-10 codes U03, X60-X84, Y87.0) per 100,000 population (age-adjusted)*	19.7	17.0	18.4	18.8	13.8
Non-Fatal Opioid Overdoses	*Non-fatal opioid overdoses per 100,00 population (based on county of occurrence)*	27.0	26.6	26.8	17.7	Data Not Available
Opioid Overdose Deaths	*Opioid-related deaths per 100,00 population (based on county of occurrence)*	12.2	22.0	17.1	9.2	Data Not Available
Drug Overdose Deaths	*Opioid-related deaths per 100,00 population (based on county of occurrence)*	18.9	34.3	26.6	16.7	Data Not Available

FIGURE 13: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT MENTAL HEALTH AND SUBSTANCE USE INDICATORS

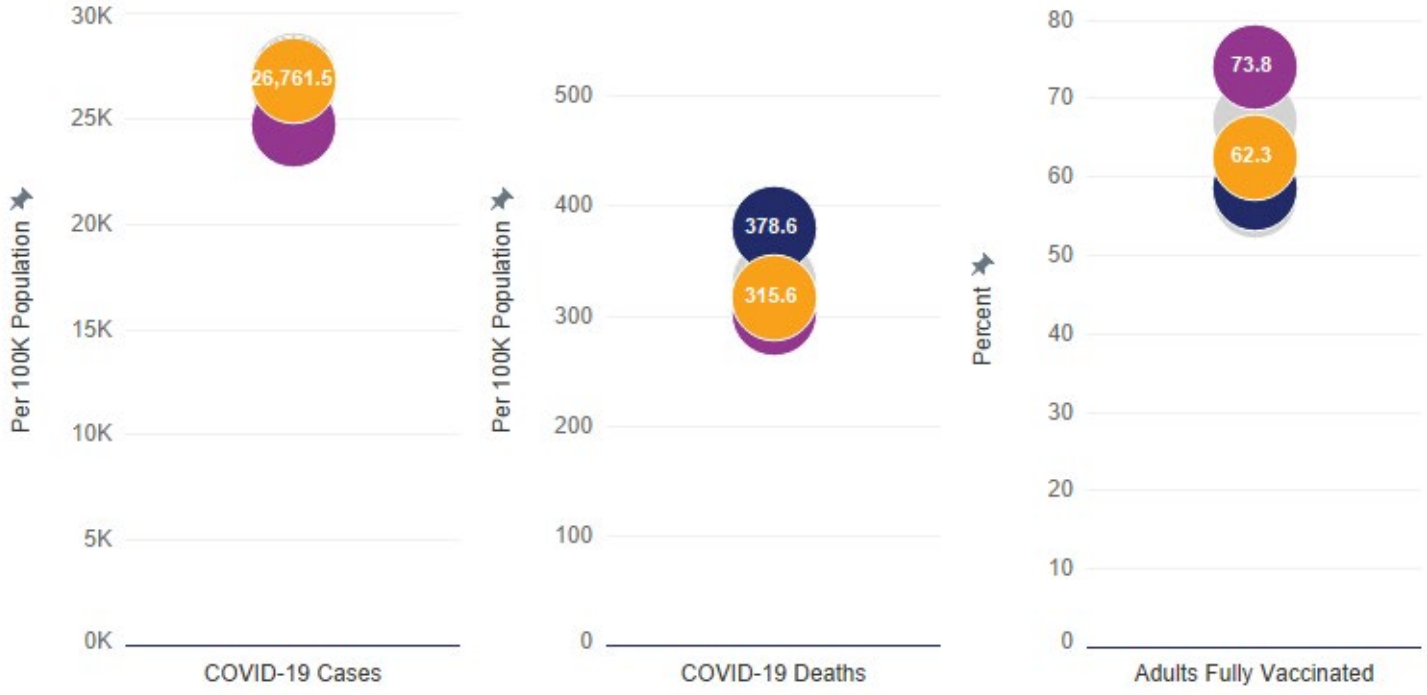


COVID-19

TABLE 14: COVID-19 INDICATORS AND RATES

		Lonoke County	Pulaski County	Community Average	State	National
COVID-19 Cases	*The incidence rate of confirmed COVID-19 cases per 100,000 population, as of May 12, 2022*	27,078.2	26,444.7	26,761.5	26,900.1	24,718.7
COVID-19 Deaths	*The rate of deaths among patients with confirmed cases of COVID-19 per 100,000 population, as of May 12, 2022*	329.9	301.3	315.6	378.6	301.3
Adults Fully Vaccinated	*The percentage of adults fully vaccinated for COVID-19, as of May 11, 2022*	57.4	67.1	62.3	58.4	73.8
Adult COVID-19 Vaccine Hesitancy	*The percentage of the population estimated to be hesitant toward receiving a COVID-19 vaccine*	21.0	17.8	19.4	20.4	10.3

FIGURE 14: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT COVID-19 INDICATORS



BAPTIST HEALTH MEDICAL CENTER

HEBER SPRINGS

About Baptist Health Medical Center-Heber Springs

Baptist Health Medical Center-Heber Springs has been committed to serving Heber Springs and surrounding communities with a complete range of medical services and support groups since its opening in 1968. The 25-bed hospital became part of Baptist Health in 1996 and was relocated to a new location in 2007. The facility includes an expanded emergency department and operating suite, centralized outpatient clinic, in-house MRI services, two covered entrances, a large cafeteria, and updated inpatient rooms.

To better serve the community, Baptist Health Family Clinic-Greers Ferry, Baptist Health Family Clinic-Heber Springs, and Baptist Health-Heber Springs Campus Clinic are operated by Baptist Health Medical Center-Heber Springs.

2020-2022 Accomplishments

Diabetes:

- Partnered with Community Outreach to offer Diabetes Support Groups
- Provided education on Fall prevention for Community Wellness Centers
- Educated Family members and Caregivers on Home Safety

Mental Health/Drug Abuse

- Utilized the Suicide Screening tools on all patients discharged.
- Educated patients and care-givers on the 24-hour behavioral health-line available to staff and patients
- Partnered with Community Outreach to implement a Mental Health First Aid class

Access:

- Offered Med to Bed Access for patients who could utilize the program
- Provided information/ education to patients and caregivers for additional services resources needed upon discharge

COMMUNITY HEALTH NEEDS ASSESSMENT – IMPLEMENTATION PLAN 2023-2025

Baptist Health Medical Center - Heber Springs

IDENTIFIED COMMUNITY HEALTH NEED: **Access to Healthcare Services**

GOALS / OBJECTIVES:

Increase Access to Quality Health Care through Education and Community Resources.

STRATEGY #1

Improve health outcomes through patient education and partnerships with patients and families

Action Steps:

1. Partner with Community Outreach to provide Education and Information on Fall Prevention at Southwest and Dunbar Community Centers
2. Partner with Community Outreach to develop and promote information Safety in the home for Community Events and Wellness Centers
3. Offer Medication Safety Classes at Baptist Health Diabetes and Stroke Support Groups
4. Implement a Community Class on Heart Failure for patients and community members

Performance Metrics:

1. Track and Report the number of individuals participating in Fall Prevention Classes
2. Track and report the number of Home Safety Materials distributed in the Community
3. Track and Report the number of individuals participating in Medication Safety Classes
4. Number of Support Group Presentations and Individuals attending will be tracked and reported

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:

Community Centers, Little Rock Community Centers

Resources Hospital Plans to Commit to Address Health Need:

- Staff and Printing

Estimated Completion Date:

- Ongoing

Person(s) / Department Responsible:

- Community Outreach Department, AHEC Administration

COMMUNITY HEALTH NEEDS ASSESSMENT – IMPLEMENTATION PLAN 2023-2025

Baptist Health Medical Center - Heber Springs

IDENTIFIED COMMUNITY HEALTH NEED: **Mental Health**

GOALS / OBJECTIVES:

Increase awareness and support of patients, caregivers and community members dealing with mental health concerns.

STRATEGY #1

Reduce the stigma associated with mental health through education and treatment .

Action Steps:

1. Continue to utilize the Suicide Screening tools on all patients discharged.
2. Educate patients and care-givers on the 24-hour behavioral health-line available to staff and patients.
3. Provide educational materials for patients and care-givers on stress management, depression, self-care during Mental Health Awareness Month
4. Offer Mental health activities that promote self-care, relaxation, and mindfulness including information on yoga, journaling, spending time in nature, art therapy, and music therapy at Community and recruitment events.

Performance Metrics:

1. Number of suicide referrals will be tracked and reported.
2. Number of Individuals reached during Mental Health Awareness Month will be tracked and reported
3. Number of individuals provided mental health activities will be tracked and reported

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:

Resources Hospital Plans to Commit to Address Health Need:	Estimated Completion Date:	Person(s) / Department Responsible:
• Community Outreach Staff, Pharmacy, Behavioral Health	• Ongoing	• Baptist Health Community Outreach, BHEC Administration

COMMUNITY HEALTH NEEDS ASSESSMENT – IMPLEMENTATION PLAN 2023-2025

Baptist Health Medical Center - Heber Springs

IDENTIFIED COMMUNITY HEALTH NEED: **Nutrition & Food Security**

GOALS / OBJECTIVES:

Initiate Evidence Based Nutrition Security strategies to address diabetes, Chronic Heart Disease, Hypertension, and other diet-related chronic conditions.

STRATEGY #1

Increase access to nutrition education and information among community members, caregivers, families and staff

Action Steps:

1. Utilize the Epic System to screening for Food Insecurity for inpatients visits and
2. Partner with Community Outreach's FoodRX Program to provide Healthy snacks and ready made food for patient caregivers and families who are food insecure
3. Provide education on the relationship between nutrition and pressure sores to caregivers
4. Provide education to families and caregivers nutritional needs based on oral problems, height and weight change, nutrition problems (altered taste, hunger, uneaten meals), approaches to nutritional care (nutrition support, mechanically altered food, therapeutic diets), and food intake.
5. Partner with Community Outreach to provide presentations to Community Wellness Centers on relationships between food and Chronic Disease Management

PERFORMANCE METRICS:

1. Number of Participants screened for Food Insecurity
2. Number of Individuals served by the FoodRX program will be tracked and reported
3. Number of Educational encounters will be tracked and reported
4. Number of Presentations in the Community Outreach Senior Wellness Centers will be tracked and reported

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:

Community Outreach

Resources Hospital Plans to Commit to Address Health Need:	Estimated Completion Date:	Person(s) / Department Responsible:
• Community Outreach Staff , BHEC Administration	• Ongoing	• Community Outreach Team, BHEC Administration

HEBER SPRINGS

ASSESSMENT PREPARED BY ACHI
INSPIRING HEALTHY ACTS

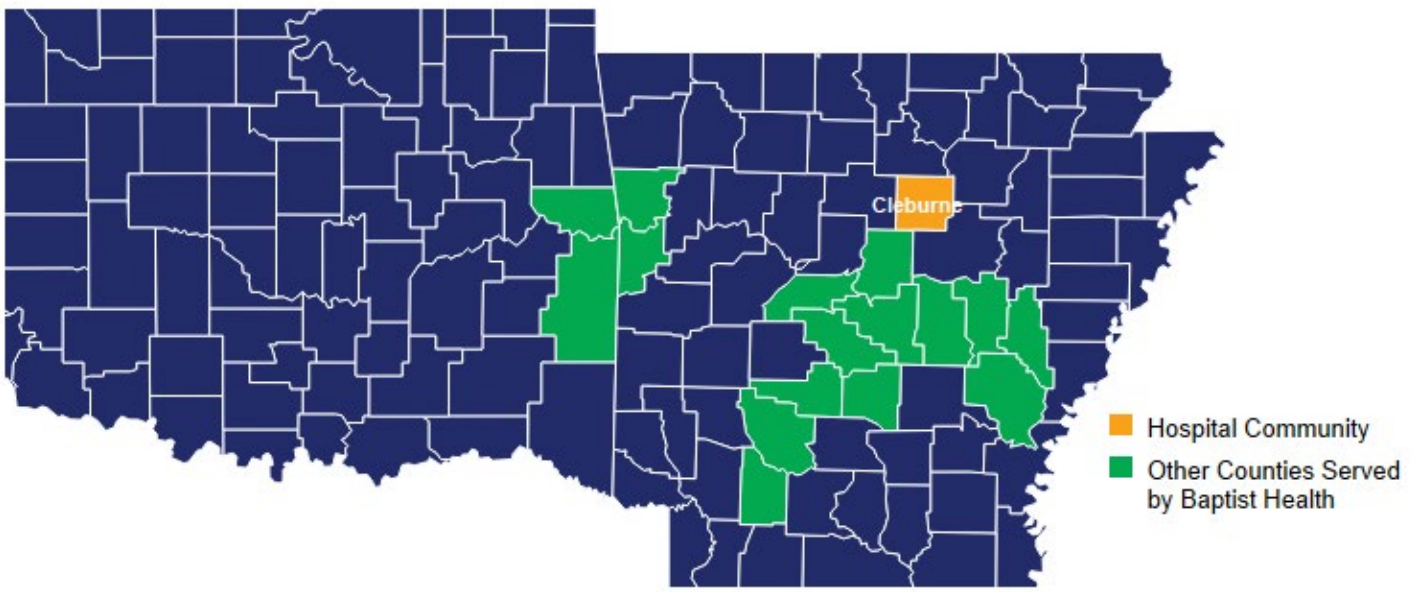
Introduction

Baptist Health engaged the Arkansas Center for Health Improvement (ACHI) to conduct the quantitative data collection and analysis for the 2022 Community Health Needs Assessment (CHNA) process. Baptist Health provided ACHI with the counties served for each of its 11 hospital communities. A total of 15 Arkansas counties and two Oklahoma counties were included in the CHNA.

This report shows the qualitative results from the CHNA for the Baptist Health Medical Center-Heber Springs hospital community, which includes Cleburne County.

HOSPITAL COMMUNITY

FIGURE 1: COUNTIES SERVED BY BAPTIST HEALTH MEDICAL CENTER-HEBER SPRINGS



Qualitative Results

Quantitative results from the CHNA for the Baptist Health Medical Center-Heber Springs hospital community are reported below. There are 12 sections: Demographics, Health Outcomes, Cause of Death, Chronic Conditions, Health Behaviors, Prevention, Access, Social and Economic Factors, Environment, Diagnoses Incidence Within Hospital Community at Discharge, Mental Health and Substance Use, and COVID-19.

Each section includes a table with health indicator data for each county in the hospital community, a community average for each measurement, and averages for the state of Arkansas and the United States. If data were not available or were suppressed, “Data Not Available” 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 document and Appendix 1.

DEMOGRAPHICS

TABLE 1: AGE AND SEX

		Cleburne County	State	National
Total Population	*Number*	25,100.0	2,999,370.0	324,697,795.0
Ages 0-4	*Percent*	4.7	6.3	6.1
Ages 5-17	*Percent*	14.4	17.2	16.5
Ages 18-24	*Percent*	6.4	9.5	9.4
Ages 25-34	*Percent*	9.8	13.1	13.9
Ages 35-44	*Percent*	10.6	12.3	12.6
Ages 45-54	*Percent*	12.1	12.4	13.0
Ages 55-64	*Percent*	15.2	12.7	12.9
Ages 65+	*Percent*	26.8	16.6	15.6
Male	*Percent*	49.5	49.1	49.2
Female	*Percent*	50.5	50.9	50.8

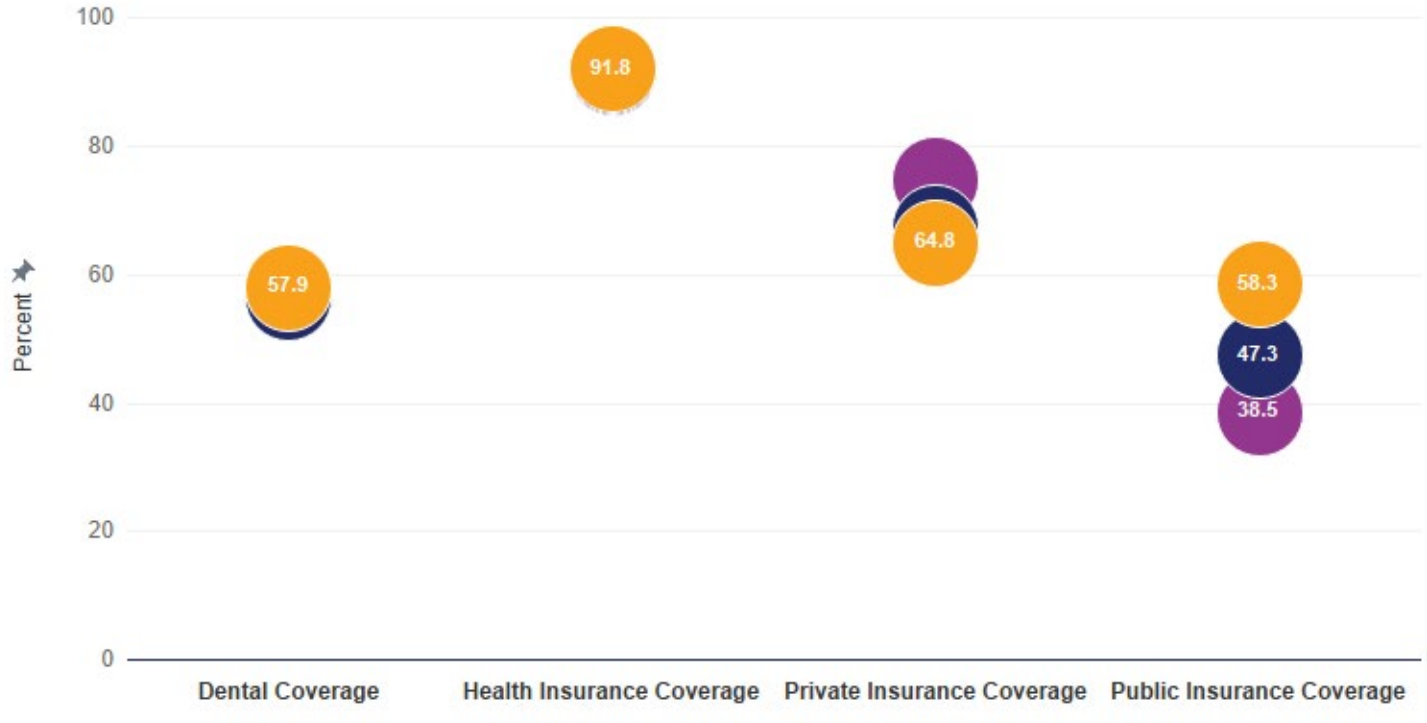
TABLE 2: RACE, ETHNICITY, AND LANGUAGE

		Cleburne County	State	National
Total Population	*Number*	25,100.0	2,999,370.0	324,697,795.0
Hispanic or Latino	*Percent*	2.4	7.5	18.0
Non-Hispanic White	*Percent*	94.7	72.4	60.7
Black or African American	*Percent*	0.4	15.3	12.7
Native American/Alaska Native	*Percent*	1.2	0.7	0.9
Asian	*Percent*	0.7	1.5	5.6
Native Hawaiian/Pacific Islander	*Percent*	0.0	0.3	0.2
Some Other Race	*Percent*	0.0	2.8	4.9
Two or More Races	*Percent*	0.8	2.7	3.3
Non-English Language Households	*Percent*	0.1	1.6	4.4

TABLE 3: INSURANCE COVERAGE

		Cleburne County	Community Average	State	National
Health Insurance Coverage	*Percentage of total civilian non-institutionalized population with health insurance coverage*	91.8	91.8	91.5	91.2
Private Insurance Coverage	*Percentage of total civilian non-institutionalized population with private health insurance coverage*	64.8	64.8	67.0	74.5
Public Insurance Coverage	*Percentage of total civilian non-institutionalized population with public health insurance coverage*	58.3	58.3	47.3	38.5
Dental Coverage	*Percentage of Arkansas residents with evidence of any dental coverage in the All-Payer Claims Database (APCD)*	57.9	57.9	56.2	Data Not Available

FIGURE 2: COMMUNITY, STATE, AND NATIONAL COMPARISON OF INSURANCE



HEALTH OUTCOMES

TABLE 4: HEALTH OUTCOMES INDICATORS AND RATES

		Cleburne County	Community Average	State	National
Premature Death	*Years of potential life lost before age 75 per 100,000 population (age-adjusted)*	10,985.0	10,985.0	9,357.0	6,943.0
Poor or Fair Health	*Percentage of adults reporting poor or fair health*	22.4	22.4	23.6	17.8
Poor Physical Health Days	*Average number of physically unhealthy days reported in past 30 days (age-adjusted)*	5.0	5.0	4.9	4.0
Low Birthweight	*Percentage of live births with low birth weight (<2500g)*	8.2	8.2	9.1	8.2

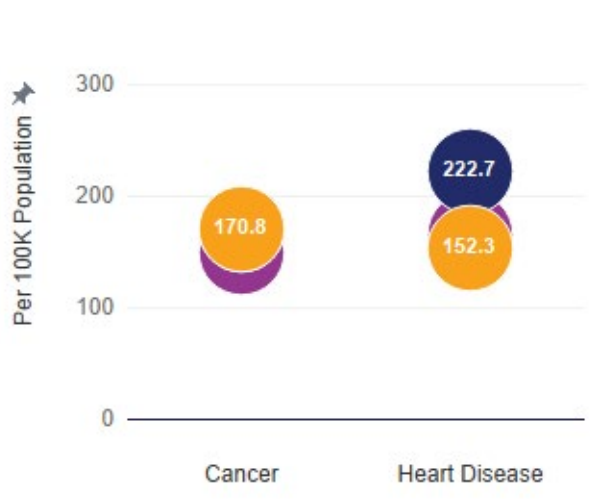
FIGURE 3: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT HEALTH OUTCOMES INDICATORS

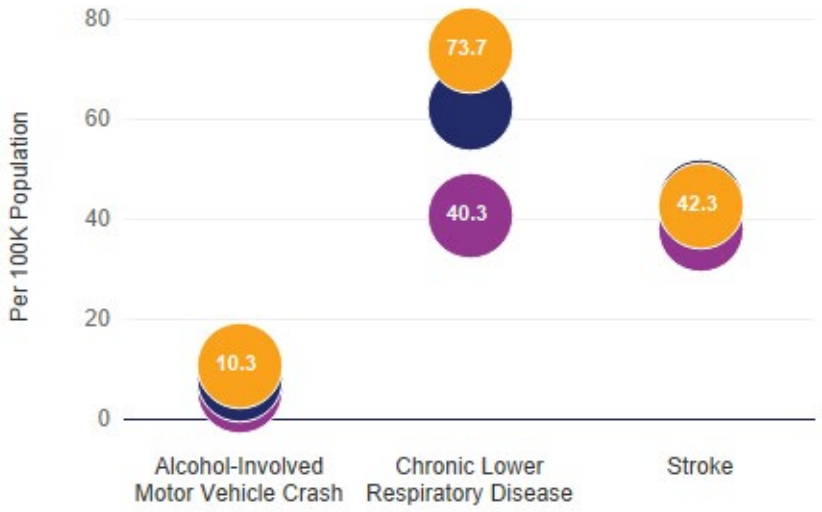
CAUSE OF DEATH

TABLE 5: CAUSE OF DEATH INDICATORS AND RATES

		Cleburne County	Community Average	State	National
All Causes	*All causes of deaths per 100,000 population (age-adjusted)*	866.5	866.5	888.4	727.2
Cancer	*5-year average rate of death due to malignant neoplasm (cancer) per 100,000 population (age-adjusted)*	170.8	170.8	170.1	149.4
Stroke	*5-year average rate of death due to cerebrovascular disease (stroke) per 100,000 population (age-adjusted)*	42.3	42.3	43.0	37.6
Chronic Lower Respiratory Disease	*Rate of deaths due to chronic lower respiratory disease per 100,000 population (age-adjusted)*	73.7	73.7	62.1	40.3
Diabetes	*Diabetes deaths per 100,000 population (age-adjusted)*	28.2	28.2	29.0	21.4
Heart Disease	*Rate of death due to heart disease per 100,000 population (age-adjusted)*	152.3	152.3	222.7	164.8
Unintentional Injury	*5-year average rate of death due to unintentional injury (accident) per 100,000 population (age-adjusted)*	65.6	65.6	51.7	50.4
Motor Vehicle Crash	*5-year average rate of death due to motor vehicle crash per 100,000 population (age-adjusted)*	26.4	26.4	18.9	11.5
Alcohol-Involved Motor Vehicle Crash	*Rate of persons killed in motor vehicle crashes involving alcohol as a rate per 100,000 population*	10.3	10.3	7.8	5.3

FIGURE 4: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT CAUSE OF DEATH INDICATORS



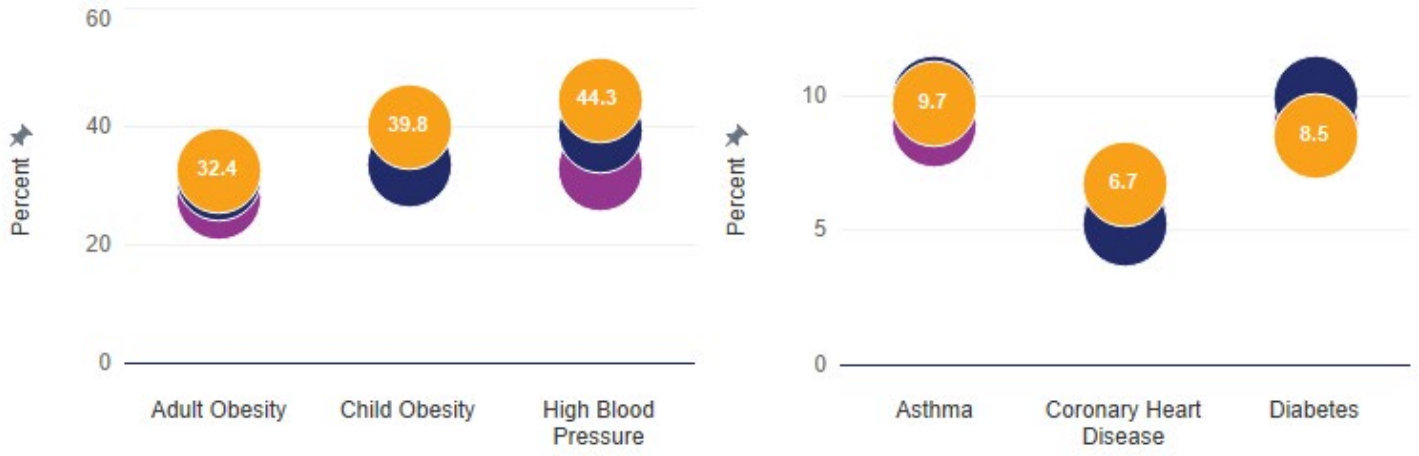


CHRONIC CONDITIONS

TABLE 6: CHRONIC CONDITIONS INDICATORS AND RATES

		Cleburne County	Community Average	State	National
High Blood Pressure	*Percentage of adults who have been told they have high blood pressure*	44.3	44.3	39.0	32.6
Asthma	*Percentage of adults who have been told they currently have asthma (age-adjusted)*	9.7	9.7	9.9	8.9
Coronary Heart Disease	*Percentage of adults who have been told they have angina or coronary heart disease (age-adjusted)*	6.7	6.7	5.2	5.4
Arthritis	*Percentage of adults ages 18 or older diagnosed with some form of arthritis*	37.7	37.7	34.3	Data Not Available
High Cholesterol	*Percentage of adults who have had their blood cholesterol checked and have been told it was high*	42.6	42.6	36.7	33.6
Diabetes	*Percentage of adults ages 20 and older who have ever been told by a doctor that they have diabetes (age-adjusted)*	8.5	8.5	9.9	9.0
Adult Obesity	*Percentage of adults ages 20 and older who report a BMI higher than 30*	32.4	32.4	31.0	27.6
Child Obesity	*Percentage of students classified as overweight or obese, by county location of school*	39.8	39.8	33.1	Data Not Available

FIGURE 5: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT CHRONIC CONDITIONS INDICATORS



HEALTH BEHAVIORS

TABLE 7: HEALTH BEHAVIORS INDICATORS AND RATES

		Cleburne County	Community Average	State	National
Adult Smoking	*Percentage of adults who are current smokers (age-adjusted)*	24.4	24.4	21.2	15.7
Youth Vaping	*Percentage of public school students in 6th, 8th, 10th, and 12th grade who used any vape in the past 30 days*	Data Not Available	Data Not Available	11.7	Data Not Available
Physical Inactivity	*Percentage of adults ages 20 or older reporting no physical activity in the past month*	26.2	26.2	26.2	22.0
Sexually Transmitted Infections	*Number of newly diagnosed chlamydia cases per 100,000 population*	267.5	267.5	587.9	539.9
Teen Births	*The seven-year average number of teen births per 1,000 female population, ages 15-19*	38.0	38.0	35.5	20.9

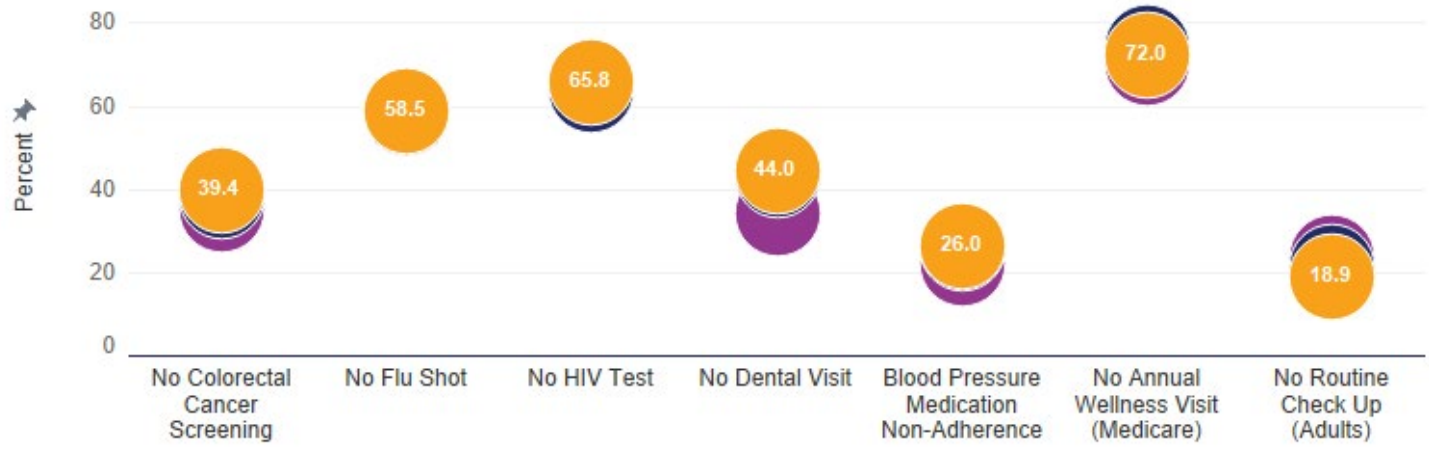
FIGURE 6: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT HEALTH BEHAVIORS INDICATORS

PREVENTION

TABLE 8: PREVENTION INDICATORS AND RATES

		Cleburne County	Community Average	State	National
No Pap Test	*Percentage of women ages 21 to 65 who have not had a pap test within the past 3 years (age-adjusted)*	16.7	16.7	16.3	14.5
No Colorectal Cancer Screening	*Percentage of adults ages 50-75 who have never had either a sigmoidoscopy or colonoscopy (age-adjusted)*	39.4	39.4	38.1	35.0
No Flu Shot	*Percentage of adults ages 18 or older who have not had a flu shot in the past year*	58.5	58.5	58.5	58.1
No HIV Test	*Percentage of adults ages 18 or older who have never been screened for HIV*	65.8	65.8	63.6	Data Not Available
No Dental Visit	*Percentage of adults ages 18 or older who have not had a dentist or dental clinic visit in the previous year (age-adjusted)*	44.0	44.0	43.4	33.8
Blood Pressure Medication Non-Adherence	*The percentage of Medicare enrollees who did not adhere to blood pressure medication schedules*	26.0	26.0	25.9	21.8
No Annual Wellness Visit (Medicare)	*The percentage of Medicare enrollees who did not have an annual wellness visit in the past year*	72.0	72.0	74.0	70.0
No Routine Check Up (Adults)	*The percentage of adults age 18 or older with no routine check up with a doctor in the past year*	18.9	18.9	21.0	23.4

FIGURE 7: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT PREVENTION INDICATORS

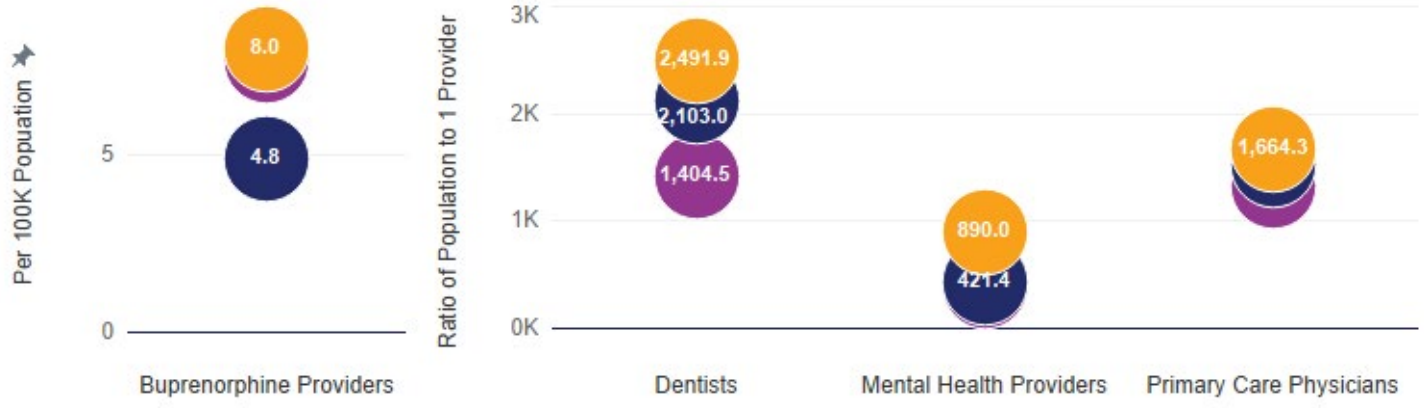


ACCESS

TABLE 9: ACCESS INDICATORS AND RATES

		Cleburne County	Community Average	State	National
Mammography	*Percentage of female Medicare enrollees ages 65-74 who received an annual mammography screening*	40.0	40.0	38.0	42.0
Diabetic Monitoring	*Percentage of diabetic Medicare enrollees over age 65 who had a hemoglobin A1c test in the past year*	90.9	90.9	88.5	87.5
Uninsured	*Percentage of adults under age 65 without health insurance coverage*	10.6	10.6	10.8	10.8
Primary Care Physicians	*Ratio of population to one primary care physician*	1,664.3	1,664.3	1,506.9	1,319.0
Dentists	*Ratio of population to one dentist*	2,491.9	2,491.9	2,103.0	1,404.5
Mental Health Providers	*Ratio of population to one mental health provider*	890.0	890.0	421.4	382.3
Addiction or Substance Use Providers	*Rate of addiction or substance use providers per 100,000 population*	0.0	0.0	4.4	20.4
Buprenorphine Providers	*Rate of buprenorphine providers per 100,000 population*	8.0	8.0	4.8	7.6
Preventable Hospital Stays	*Number of hospital stays for ambulatory care-sensitive conditions per 1,000 Medicare enrollees*	3,801.0	3,801.0	4,769.0	4,236.0

FIGURE 8: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT ACCESS INDICATORS

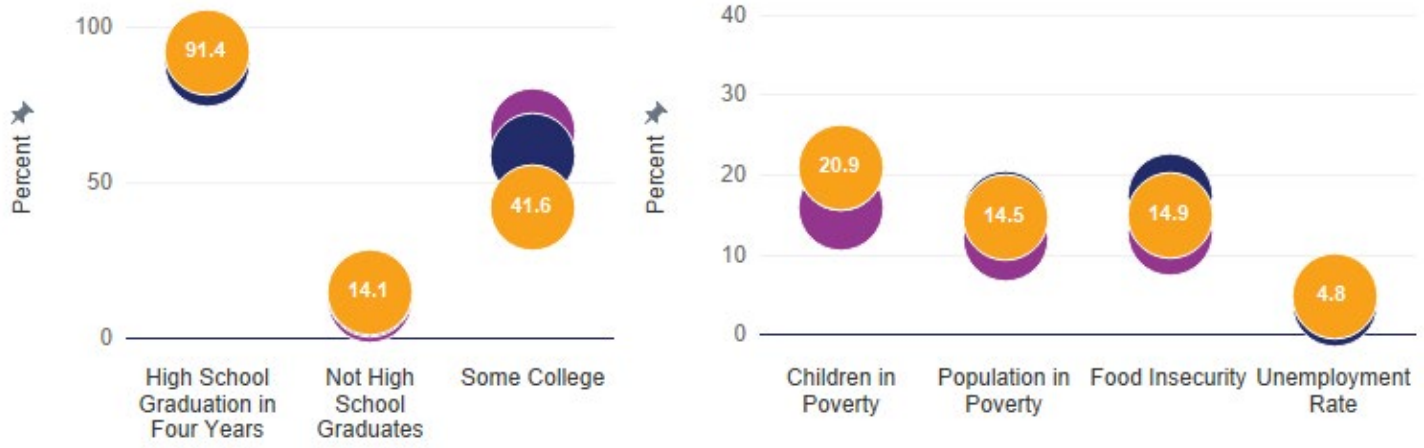


SOCIAL AND ECONOMIC FACTORS

TABLE 10: SOCIAL AND ECONOMIC FACTORS INDICATORS AND RATES

		Cleburne County	Community Average	State	National
Not High School Graduates	*Percentage of adults ages 25 or older without a high school diploma*	14.1	14.1	13.4	12.0
High School Graduation in Four Years	*Percentage of ninth-grade cohort who graduated in four years*	91.4	91.4	88.2	87.7
Some College	*Percentage of adults ages 25-44 with some post-secondary education*	41.6	41.6	58.5	66.1
Unemployment Rate	*Unemployment rate among civilian non-institutionalized population age 16 and older in January 2022*	4.8	4.8	3.8	4.4
Children in Poverty	*Percentage of children under age 18 below the poverty line*	20.9	20.9	20.8	15.7
Population in Poverty	*Percentage of population below the federal poverty line*	14.5	14.5	15.2	11.9
Children in Single-Parent Households	*Percentage of children who live in a household headed by single parent*	17.6	17.6	28.9	25.5
Homeless Children	*Rate of homelessness among public school students*	4.9	4.9	2.8	2.8
Food Insecurity	*Percentage of the population that experienced food insecurity in the report year*	14.9	14.9	17.3	12.6
Social Associations	*Number of membership associations per 100,000 population*	138.6	138.6	126.5	105.0
Violent Crimes	*Annual rate of reported violent crimes per 100,000 population*	376.7	376.7	549.2	416.0

FIGURE 9: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT SOCIAL AND ECONOMIC FACTORS INDICATORS



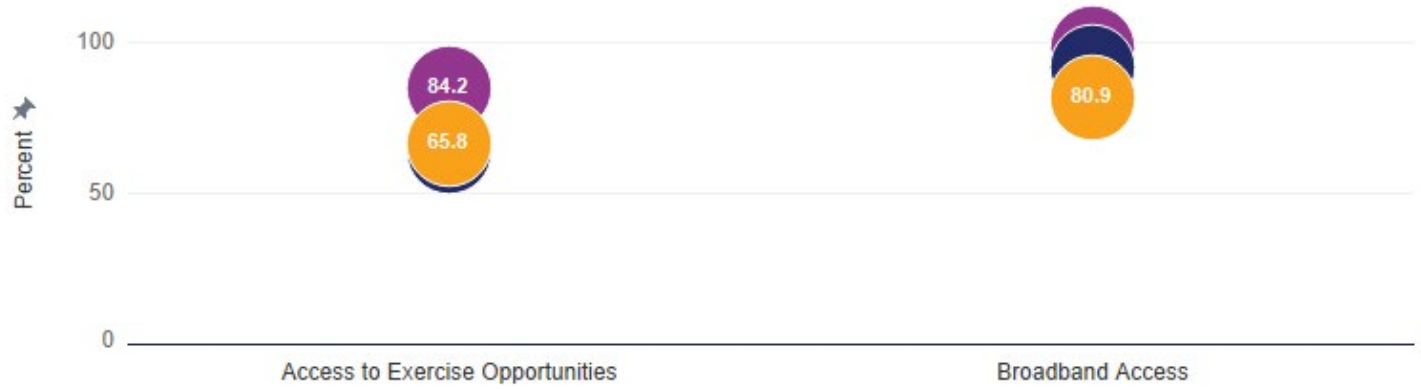
ENVIRONMENT

TABLE 11: ENVIRONMENT INDICATORS AND RATES

		Cleburne County	Community Average	State	National
Food Environment Index	*Index of factors that contribute to a healthy food environment, 0 (worst) to 10 (best)*	7.3	7.3	5.1	7.8
Drinking Water Violations	*The total number of drinking water violations recorded in a two-year period*	0.0	0.0	118.0	4,739.0
Access to Exercise Opportunities	*Percentage of population with adequate access to locations for physical activity*	65.8	65.8	63.5	84.2
Severe Housing Problems	*Percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, or lack of kitchen or plumbing*	10.5	10.5	14.1	17.5
Broadband Access	*Percentage of population in a high-speed internet service area; access to DL speeds > 25MBPS (2020)*	80.9	80.9	91.4	97.5
Long Commute Driving Alone	*Among workers who commute in their car alone, the percentage who commute more than 30 minutes*	32.5	32.5	27.0	36.6

FIGURE 10: COMMUNITY, STATE, AND NATIONAL COMPARISON OF THE FOOD ENVIRONMENT INDEX INDICATOR

FIGURE 11: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT ENVIRONMENT INDICATORS



DIAGNOSES INCIDENCE WITHIN HOSPITAL COMMUNITY AT DISCHARGE

TABLE 12: DIAGNOSES INCIDENCE WITHIN HOSPITAL COMMUNITY AT DISCHARGE INDICATORS AND

		Cleburne County	Community Average	State
Arthritis	*Number of individuals 18 years and older discharged with a primary or secondary arthritis diagnosis as a percentage of the population 18 years and older*	4.3	4.3	2.3
Diabetes	*Number of individuals 18 years and older discharged with a primary or secondary diabetes diagnosis as a percentage of the population 18 years and older*	5.4	5.4	3.9
Hyperlipidemia	*Number of individuals 18 years and older discharged with a primary or secondary hyperlipidemia diagnosis as a percentage of the population 18 years and older*	6.5	6.5	3.9
Hypertension	*Number of individuals 18 years and older discharged with a primary or secondary hypertension diagnosis as a percentage of the population 18 years and older*	12.9	12.9	9.5
Ischemic Heart Disease	*Number of individuals 18 years and older discharged with a primary or secondary ischemic heart disease diagnosis as a percentage of the population 18 years and older*	3.2	3.2	2.5

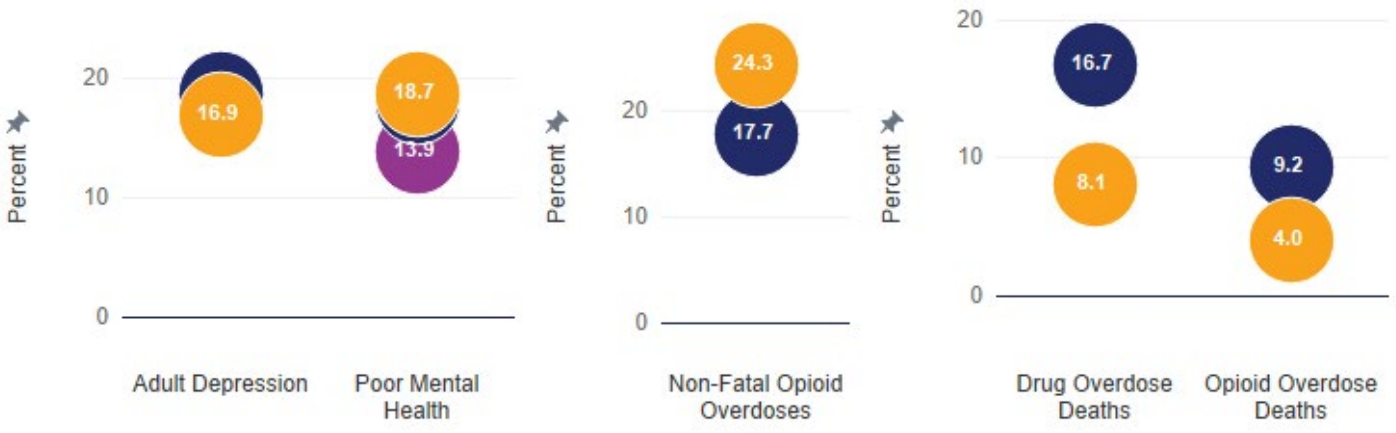
FIGURE 12: DIAGNOSES INCIDENCE WITHIN HOSPITAL COMMUNITY AT DISCHARGE INDICATORS

MENTAL HEALTH AND SUBSTANCE USE

TABLE 13: MENTAL HEALTH AND SUBSTANCE USE INDICATORS AND RATES

		Cleburne County	Community Average	State	National
Excessive Drinking	*Percentage of adults reporting binge or heavy drinking*	17.8	17.8	17.3	19.2
Poor Mental Health	*Percentage of adults ages 18 or older reporting poor mental health for 14 or more days*	18.7	18.7	18.0	13.9
Youth Depression	*Percentage of public school students in 6th, 8th, 10th, and 12th grade who had feelings of depression all of the time in the past 30 days*	Data Not Available	Data Not Available	12.1	Data Not Available
Adult Depression	*The prevalence of depression among Medicare fee-for-service beneficiaries*	16.9	16.9	18.7	18.4
Suicide Deaths	*The rate of deaths by suicide (ICD-10 codes U03, X60-X84, Y87.0) per 100,000 population (age-adjusted)*	20.6	20.6	18.8	13.8
Non-Fatal Opioid Overdoses	*Non-fatal opioid overdoses per 100,00 population (based on county of occurrence)*	24.3	24.3	17.7	Data Not Available
Opioid Overdose Deaths	*Opioid-related deaths per 100,00 population (based on county of occurrence)*	4.0	4.0	9.2	Data Not Available
Drug Overdose Deaths	*Opioid-related deaths per 100,00 population (based on county of occurrence)*	8.1	8.1	16.7	Data Not Available

FIGURE 13: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT MENTAL HEALTH AND SUBSTANCE USE INDICATORS

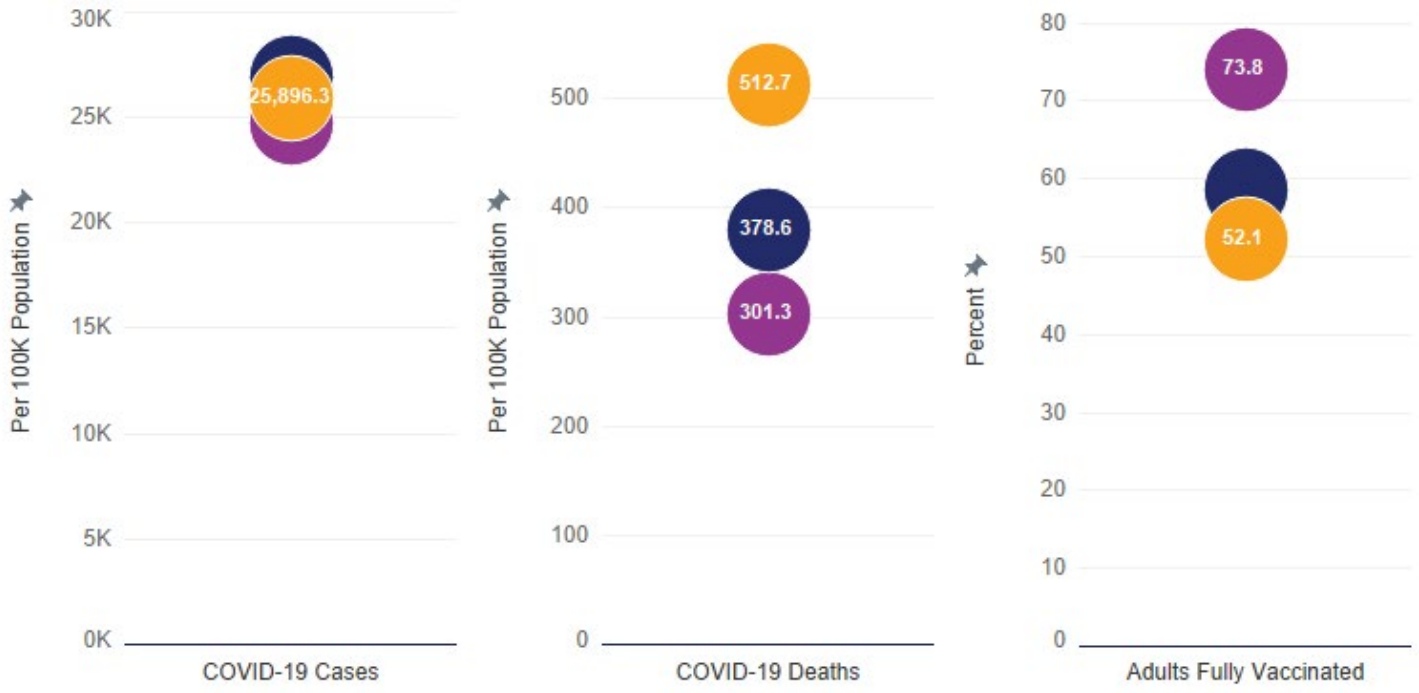


COVID-19

TABLE 14: COVID-19 INDICATORS AND RATES

		Cleburne County	Community Average	State	National
COVID-19 Cases	*The incidence rate of confirmed COVID-19 cases per 100,000 population, as of May 12, 2022*	25,896.3	25,896.3	26,900.1	24,718.7
COVID-19 Deaths	*The rate of deaths among patients with confirmed cases of COVID-19 per 100,000 population, as of May 12, 2022*	512.7	512.7	378.6	301.3
Adults Fully Vaccinated	*The percentage of adults fully vaccinated for COVID-19, as of May 11, 2022*	52.1	52.1	58.4	73.8
Adult COVID-19 Vaccine Hesitancy	*The percentage of the population estimated to be hesitant toward receiving a COVID-19 vaccine*	21.8	21.8	20.4	10.3

FIGURE 14: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT COVID-19 INDICATORS



BAPTIST HEALTH MEDICAL CENTER

ARKADELPHIA

About Baptist Health Medical Center-Arkadelphia

Baptist Health Medical Center-Arkadelphia has been committed to serving the citizens of southwest Arkansas since 1981. Our 25-bed hospital provides comprehensive services including emergency services, CT Scan, MRI, digital mammography, labor and delivery, orthopedics and sleep studies.

Our Labor/Delivery/Recovery/Postpartum rooms are designed to allow families to bond with their infant. They are modern and spacious with calming decor and beautiful views. Special meals are offered to new parents after delivery, we provide one-on-one care and offer telehealth for breastfeeding assistance. Childbirth education is offered onsite and tours are available by calling 870-245-1221. As with any service provided at our hospital, new moms have direct access to specialized care areas at Baptist Health Medical Center-Little Rock such as neonatology, maternal-fetal medicine and high-risk OB.

To better serve the community, Baptist Health Arkadelphia Medical Clinic, Baptist Health Family Clinic-Caddo Valley, Baptist Health Family Clinic-Bismarck, Baptist Health Family Clinic-Gurdon, Baptist Health Family Clinic-Prescott, and Baptist Health Family Clinic Sparkman is operated by Baptist Health Medical Center-Arkadelphia.

Awards & Recognitions

- American Heart Association's Get with the Guidelines Stroke Gold Award

2020-2022 Accomplishments

Diabetes:

- Virtual Diabetes Classes offered System-wide for individuals and families affected by Diabetes
- Offered telehealth diabetes education and support classes and sessions and BHMC-Arkadelphia and clinics
- Implemented the TMF Diabetes Self-Management Education Program

Mental Health:

- Partner with Baptist Health -Little rock to increase access to mental health assistance through distance counseling services. This type of telehealth allows individuals across the state to talk to a counselor located in Little Rock via video, email or phone.
- Utilized Baptist Health Command Center to reduce barriers to access to Behavioral Health services.

Obesity

- Developed relationships with the school to offer a nutrition and education program after campuses opened back up due to Covid-19
- Received a QuickWin Grant to implement healthy cooking classes for parents and children
- Partnered with the AHG Clinic in Sparkman to screen patients for food insecurity and provide food for those in need.

COMMUNITY HEALTH NEEDS ASSESSMENT – IMPLEMENTATION PLAN 2023-2025

Baptist Health Medical Center - Arkadelphia

IDENTIFIED COMMUNITY HEALTH NEED: **Access to Healthcare Services**

GOALS / OBJECTIVES:

Increase Access to Quality Health Care, Preventive Health Screenings, Vaccinations and Community Resources.

STRATEGY #1

Utilize the Mobile Health Unit (MHU) to provide preventive screenings and increase access to care.

Action Steps:

1. Utilize the MHU to offer back tol immunizations, flu shots and Covid-19 Vaccinations
2. Identify the communities in most need and schedule monthly screenings utilizing the MHU.
3. Partner with Regional Hospitals to utilize the MHU to deliver screenings in their service areas.
4. Register all participants in the Epic System.
5. Utilize Baptist Health Virtual Care on the MHU to offer additional care for patients in need.
6. Provide evening and weekend screening times to meet the needs of specific populations
7. Provide Preventative Health Screenings for Diabetes, Hypertension, Cholesterol and Covid-19.
8. Utilize the Findhelp.org system to refer and track patents in need of additional resources

Performance Metrics:

1. Track and Report the number of individuals screened and vaccinated on the Mobile Health Unit
2. Track and report the number of patients utilizing virtual care on the MHU.
3. Track and report the number of patients enrolled in EPIC and MyChart.
4. Track and report the number of patients utilizing the Findhelp.org system for resources
5. Track and report the number of Regional Hospital Community Events offered via the MHU

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:

Community Centers, Local schools, faith based community and other not-for-profit agencies

Resources Hospital Plans to Commit to Address Health Need:	Estimated Completion Date:	Person(s) / Department Responsible:
• Staff and Printing	• Ongoing	• Pharmacy Manager, Community Outreach Director, Mobile Health Unit Driver

COMMUNITY HEALTH NEEDS ASSESSMENT – IMPLEMENTATION PLAN 2023-2025

Baptist Health Medical Center - Arkadelphia

IDENTIFIED COMMUNITY HEALTH NEED: **Mental Health**

GOALS / OBJECTIVES:

Increase awareness and support of community members dealing with mental health concerns.

STRATEGY #1

Reduce the stigma associated with mental health through education and treatment .

Action Steps:

1. Pilot a “Make it Okay” campaign designed to reduce the stigma of mental illness in at least one community.
2. Offer annual based Mental Health First Aid presentations to community groups and faith-based organizations.
3. Offer an annual Mental Health First Aid training for staff, pastoral care and other system-wide health care providers.
4. Host seminars, presentations with an emphasis on decreasing stigma.
5. Offer Depression and ACES Screening Tools at Community events.
6. Provide education and outreach efforts via seminars, events and telehealth on the relationship between substance abuse and mental health.
7. Continue to offer psychiatric care and referrals
8. Utilize Findhelp.org and the 211 system to refer individuals for Mental Health Services

Performance Metrics:

1. Number of individuals reached with the “Make it Okay” Initiative
2. Number of Mental Health First Aid Trainings for staff will be tracked and reported.
3. Number of Community Based Mental Health First Aid Presentations will be tracked and reported.
4. Number of Depression Screening will be tracked and reported
5. Number of referrals and follow-ups will be tracked and reported.
6. Number of seminars, presentations will be tracked and reported.
7. Track the number of individuals referred for additional resources and services

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:

Faith Based Communities, Adverse Childhood Experiences Statewide Coalition

Resources Hospital Plans to Commit to Address Health Need:	Estimated Completion Date:	Person(s) / Department Responsible:
• Community Outreach Staff, Pharmacy, Pastoral Care and Behavioral Health	• Ongoing	• Baptist Health Community Outreach, Nursing Department

COMMUNITY HEALTH NEEDS ASSESSMENT – IMPLEMENTATION PLAN 2023-2025

Baptist Health Medical Center - Arkadelphia

IDENTIFIED COMMUNITY HEALTH NEED: **Nutrition & Food Security**

GOALS / OBJECTIVES:

Initiate Evidence Based Nutrition Security strategies to address obesity, diabetes, hypertension, and other diet-related chronic conditions.

STRATEGY #1

Increase access to nutrition education and information among community members

Action Steps:

1. Implement Maintain, Don't Gain holiday challenge program for adult community members that encourages using stress management strategies, physical activity, and healthful food choices during the holiday season to maintain one's physical and mental health and avoid holiday weight gain.
2. Implement Around the Table program targeting youth, young adults and parents of young children focusing on creating healthy connections between food, oneself, and one's community.
3. Implement Eat Healthy, Be Active program for adult community members. a program based on the Dietary Guidelines and Physical Activity Guidelines for Americans and teaches participants to make incremental lifestyle changes to improve their health.
4. Implement Cooking Matters, grocery store tour and cooking program targeting adults and parents participating in the WIC program with the goal to empower participants with skills to shop for healthful foods on a budget to maximize limited food resources..
5. Implement Cooking with Community Outreach classes to empower participants to build cooking skills, cook more healthy meals, reduce food waste, and make healthier selections at the grocery store.
6. Utilize the Epic System to screening for Food Insecurity for inpatients visits
7. Partner with AHG clinics to screen for Food Insecurity and provide food through the FoodRX program for those in need

Performance Metrics:

1. Number of Participants registered for educational Programs will be tracked and reported
2. Coordinate implementation of 3 Maintian, Don't Gain Holiday Challenge
3. Pilot 2 "Around the Table Series targeting Youth
4. Implement 2 Eat Healthy Be Active Programs
5. Implement 3 Cooking Matters Grocery Store Tours

Performance Metrics: (continued)

1. Host 2 Community -Based Community Outreach Cooking Classes
2. Track and report the number of patents screened for Food insecurity
3. Track and report the number of patients receiving services from the FoodRX program

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:

Arkansas Hunger Relief Alliance, Central AR Library System, Be Mighty

Resources Hospital Plans to Commit to Address Health Need:	Estimated Completion Date:	Person(s) / Department Responsible:
• Community Outreach Staff, Pharmacy Manager	• Ongoing	• Community Outreach Team, Nursing Department

ARKADELPHIA

ASSESSMENT PREPARED BY ACHI
INSPIRING HEALTHY ACTS

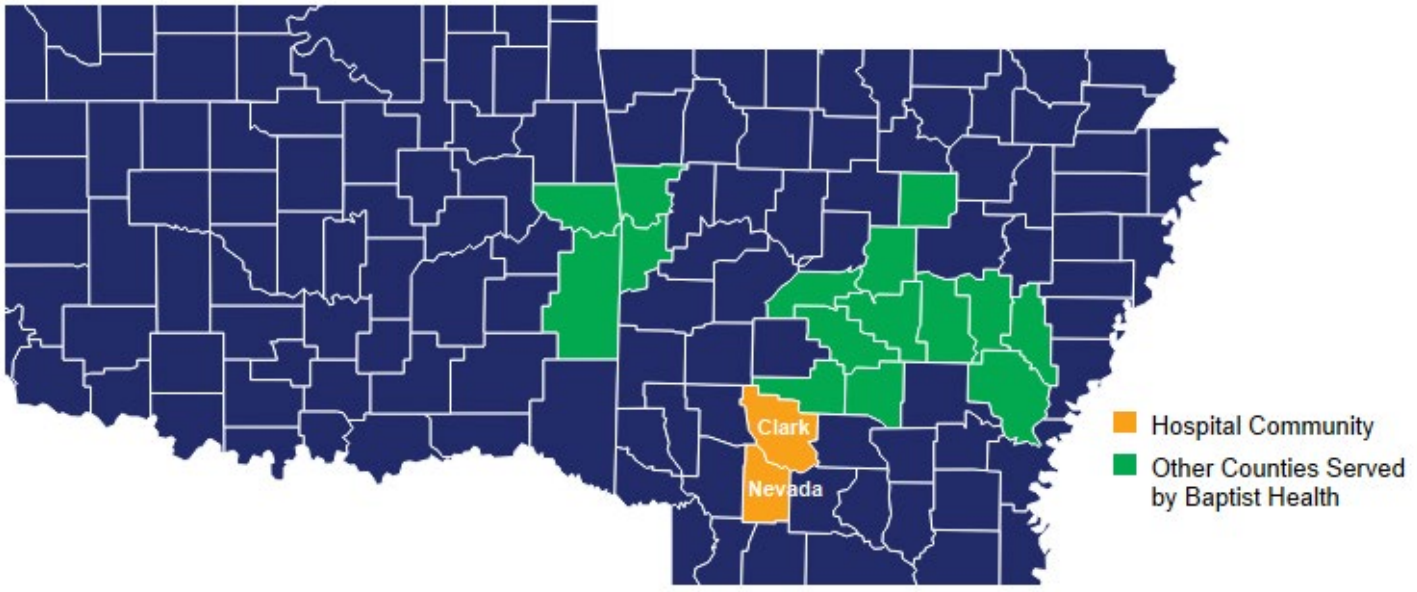
Introduction

Baptist Health engaged the Arkansas Center for Health Improvement (ACHI) to conduct the quantitative data collection and analysis for the 2022 Community Health Needs Assessment (CHNA) process. Baptist Health provided ACHI with the counties served for each of its 11 hospital communities. A total of 15 Arkansas counties and two Oklahoma counties were included in the CHNA.

This report shows the qualitative results from the CHNA for the Baptist Health Medical Center-Arkadelphia hospital community, which includes Clark and Nevada counties.

HOSPITAL COMMUNITY

FIGURE 1: COUNTIES SERVED BY BAPTIST HEALTH MEDICAL CENTER-ARKADELPHIA



Qualitative Results

Quantitative results from the CHNA for the Baptist Health Medical Center-Arkadelphia hospital community are reported below. There are 12 sections: Demographics, Health Outcomes, Cause of Death, Chronic Conditions, Health Behaviors, Prevention, Access, Social and Economic Factors, Environment, Diagnoses Incidence Within Hospital Community at Discharge, Mental Health and Substance Use, and COVID-19.

Each section includes a table with health indicator data for each county in the hospital community, a community average for each measurement, and averages for the state of Arkansas and the United States. If data were not available or were suppressed, “Data Not Available” 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 document and Appendix 1.

DEMOGRAPHICS

TABLE 1: AGE AND SEX

		Clark County	Nevada County	State	National
Total Population	*Number*	22,386.0	8,351.0	2,999,370.0	324,697,795.0
Ages 0-4	*Percent*	5.4	6.0	6.3	6.1
Ages 5-17	*Percent*	13.6	16.7	17.2	16.5
Ages 18-24	*Percent*	22.2	7.3	9.5	9.4
Ages 25-34	*Percent*	9.8	10.2	13.1	13.9
Ages 35-44	*Percent*	10.1	10.7	12.3	12.6
Ages 45-54	*Percent*	11.1	14.1	12.4	13.0
Ages 55-64	*Percent*	11.5	14.7	12.7	12.9
Ages 65+	*Percent*	16.2	20.3	16.6	15.6
Male	*Percent*	46.9	50.7	49.1	49.2
Female	*Percent*	53.1	49.3	50.9	50.8

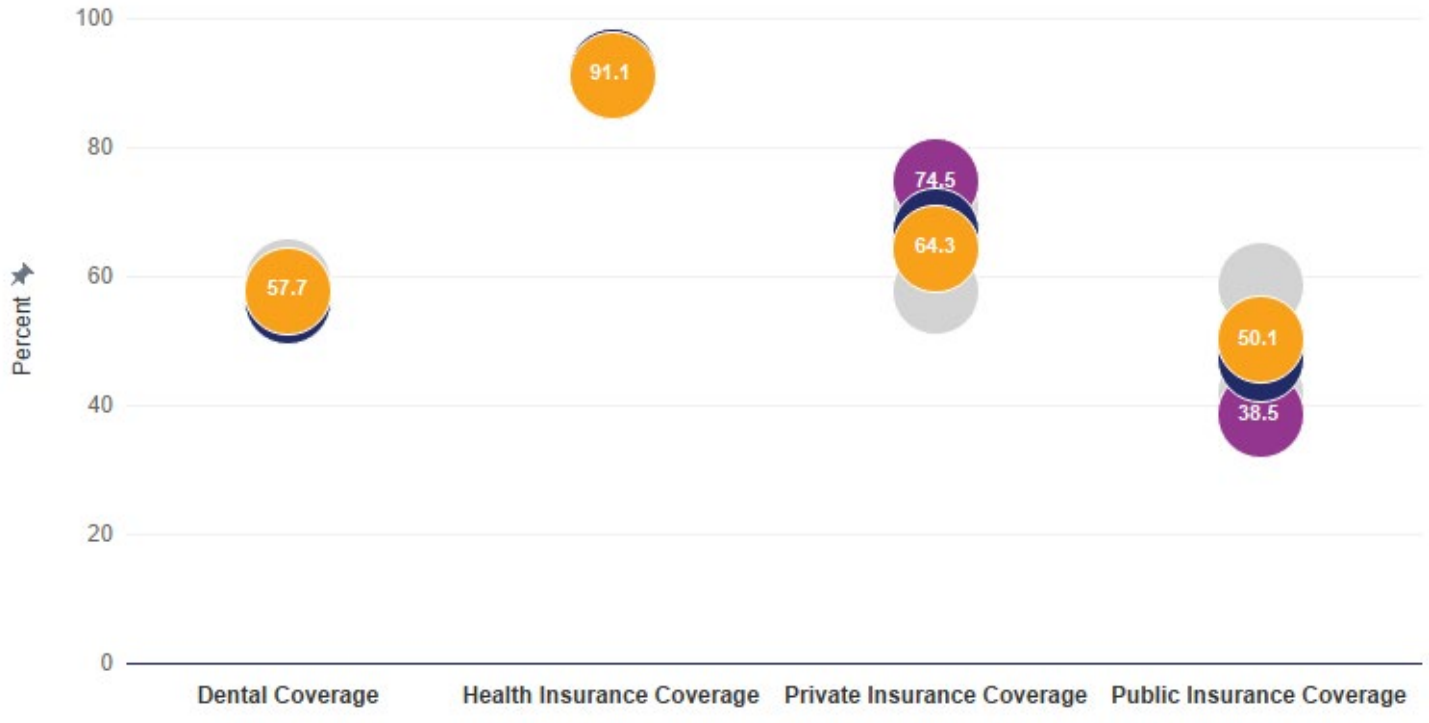
TABLE 2: RACE, ETHNICITY, AND LANGUAGE

		Clark County	Nevada County	State	National
Total Population	*Number*	22,386.0	8,351.0	2,999,370.0	324,697,795.0
Hispanic or Latino	*Percent*	4.7	0.0	7.5	18.0
Non-Hispanic White	*Percent*	68.7	62.8	72.4	60.7
Black or African American	*Percent*	24.3	34.5	15.3	12.7
Native American/Alaska Native	*Percent*	0.4	0.2	0.7	0.9
Asian	*Percent*	0.7	0.0	1.5	5.6
Native Hawaiian/Pacific Islander	*Percent*	0.0	0.0	0.3	0.2
Some Other Race	*Percent*	3.1	0.0	2.8	4.9
Two or More Races	*Percent*	1.3	2.4	2.7	3.3
Non-English Language Households	*Percent*	1.5	0.0	1.6	4.4

TABLE 3: INSURANCE COVERAGE

		Clark County	Nevada County	Community Average	State	National
Health Insurance Coverage	*Percentage of total civilian non-institutionalized population with health insurance coverage*	91.5	90.6	91.1	91.5	91.2
Private Insurance Coverage	*Percentage of total civilian non-institutionalized population with private health insurance coverage*	70.8	57.7	64.3	67.0	74.5
Public Insurance Coverage	*Percentage of total civilian non-institutionalized population with public health insurance coverage*	41.9	58.4	50.1	47.3	38.5
Dental Coverage	*Percentage of Arkansas residents with evidence of any dental coverage in the All-Payer Claims Database (APCD)*	56.3	59.0	57.7	56.2	Data Not Available

FIGURE 2: COMMUNITY, STATE, AND NATIONAL COMPARISON OF INSURANCE COVERAGE

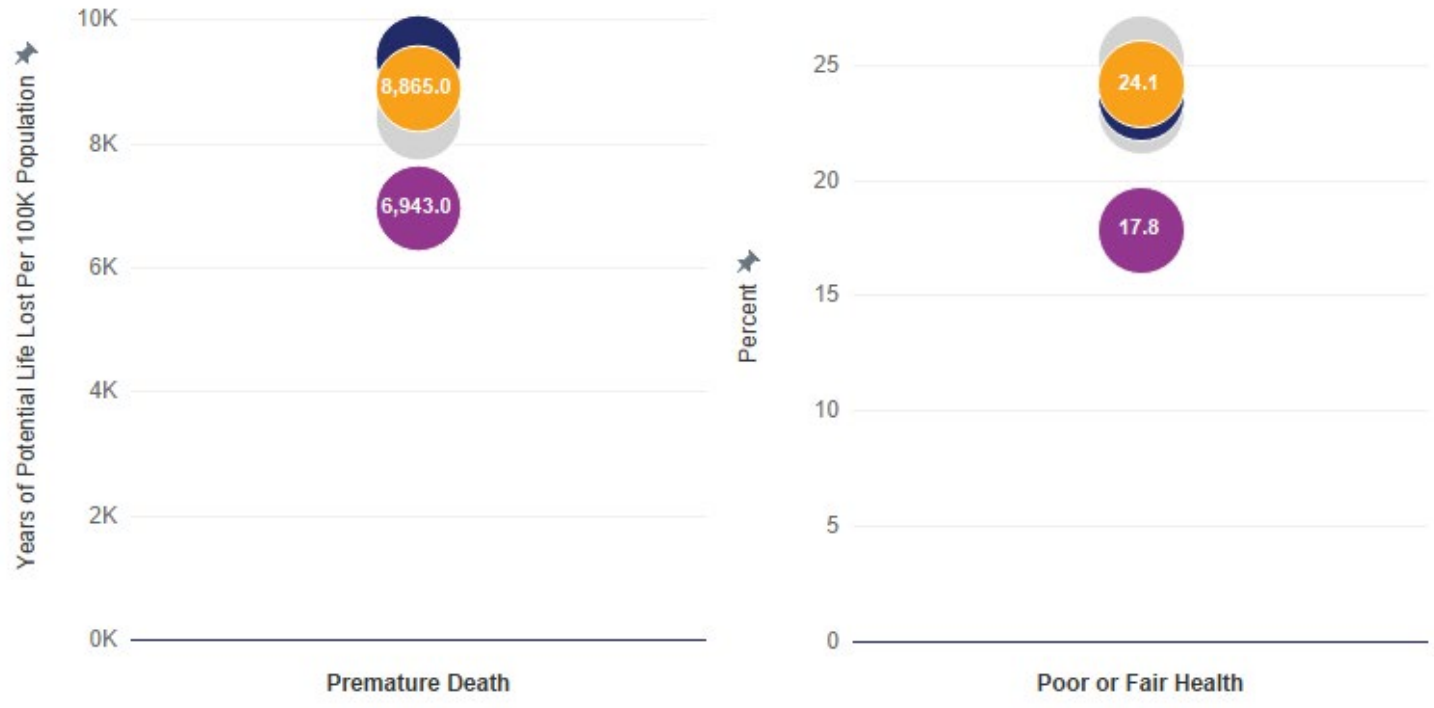


HEALTH OUTCOMES

TABLE 4: HEALTH OUTCOMES INDICATORS AND RATES

		Clark County	Nevada County	Community Average	State	National
Premature Death	*Years of potential life lost before age 75 per 100,000 population (age-adjusted)*	8,398.0	9,332.0	8,865.0	9,357.0	6,943.0
Poor or Fair Health	*Percentage of adults reporting poor or fair health*	23.0	25.2	24.1	23.6	17.8
Poor Physical Health Days	*Average number of physically unhealthy days reported in past 30 days (age-adjusted)*	4.8	5.5	5.2	4.9	4.0
Low Birthweight	*Percentage of live births with low birth weight (<2500g)*	9.2	10.4	9.8	9.1	8.2

FIGURE 3: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT HEALTH OUTCOMES INDICATORS

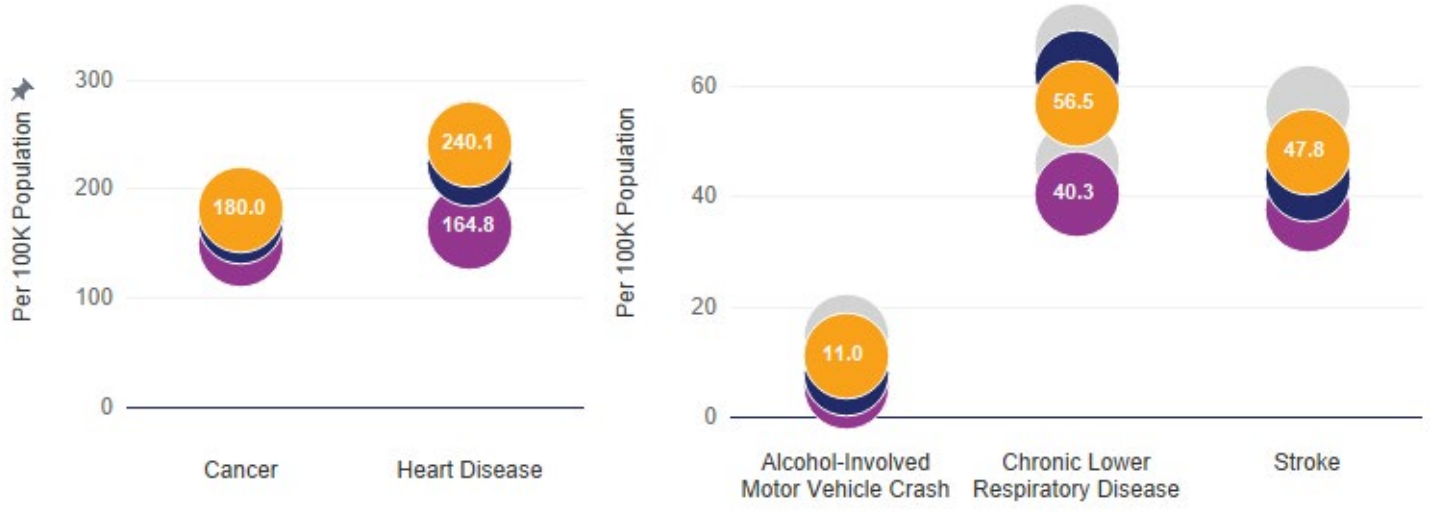


CAUSE OF DEATH

TABLE 5: CAUSE OF DEATH INDICATORS AND RATES

		Clark County	Nevada County	Community Average	State	National
All Causes	*All causes of deaths per 100,000 population (age-adjusted)*	917.1	972.7	944.9	888.4	727.2
Cancer	*5-year average rate of death due to malignant neoplasm (cancer) per 100,000 population (age-adjusted)*	181.4	178.5	180.0	170.1	149.4
Stroke	*5-year average rate of death due to cerebrovascular disease (stroke) per 100,000 population (age-adjusted)*	39.6	55.9	47.8	43.0	37.6
Chronic Lower Respiratory Disease	*Rate of deaths due to chronic lower respiratory disease per 100,000 population (age-adjusted)*	45.7	67.2	56.5	62.1	40.3
Diabetes	*Diabetes deaths per 100,000 population (age-adjusted)*	30.5	Data Not Available	Data Not Available	29.0	21.4
Heart Disease	*Rate of death due to heart disease per 100,000 population (age-adjusted)*	238.4	241.8	240.1	222.7	164.8
Unintentional Injury	*5-year average rate of death due to unintentional injury (accident) per 100,000 population (age-adjusted)*	40.5	70.5	55.5	51.7	50.4
Motor Vehicle Crash	*5-year average rate of death due to motor vehicle crash per 100,000 population (age-adjusted)*	19.1	Data Not Available	Data Not Available	18.9	11.5
Alcohol-Involved Motor Vehicle Crash	*Rate of persons killed in motor vehicle crashes involving alcohol as a rate per 100,000 population*	14.5	7.4	11.0	7.8	5.3

FIGURE 4: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT CAUSE OF DEATH INDICATORS

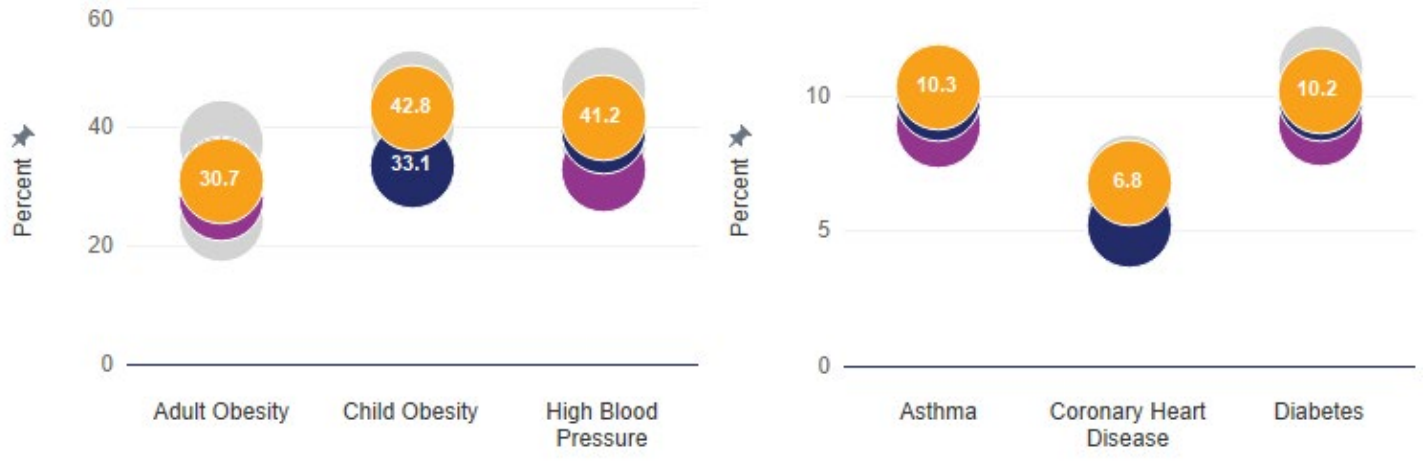


CHRONIC CONDITIONS

TABLE 6: CHRONIC CONDITIONS INDICATORS AND RATES

		Clark County	Nevada County	Community Average	State	National
High Blood Pressure	*Percentage of adults who have been told they have high blood pressure*	36.3	46.0	41.2	39.0	32.6
Asthma	*Percentage of adults who have been told they currently have asthma (age-adjusted)*	10.2	10.4	10.3	9.9	8.9
Coronary Heart Disease	*Percentage of adults who have been told they have angina or coronary heart disease (age-adjusted)*	6.6	7.0	6.8	5.2	5.4
Arthritis	*Percentage of adults ages 18 or older diagnosed with some form of arthritis*	39.2	43.6	41.4	34.3	Data Not Available
High Cholesterol	*Percentage of adults who have had their blood cholesterol checked and have been told it was high*	35.1	40.1	37.6	36.7	33.6
Diabetes	*Percentage of adults ages 20 and older who have ever been told by a doctor that they have diabetes (age-adjusted)*	11.0	9.3	10.2	9.9	9.0
Adult Obesity	*Percentage of adults ages 20 and older who report a BMI higher than 30*	37.2	24.1	30.7	31.0	27.6
Child Obesity	*Percentage of students classified as overweight or obese, by county location of school*	45.5	40.1	42.8	33.1	Data Not Available

FIGURE 5: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT CHRONIC CONDITIONS INDICATORS

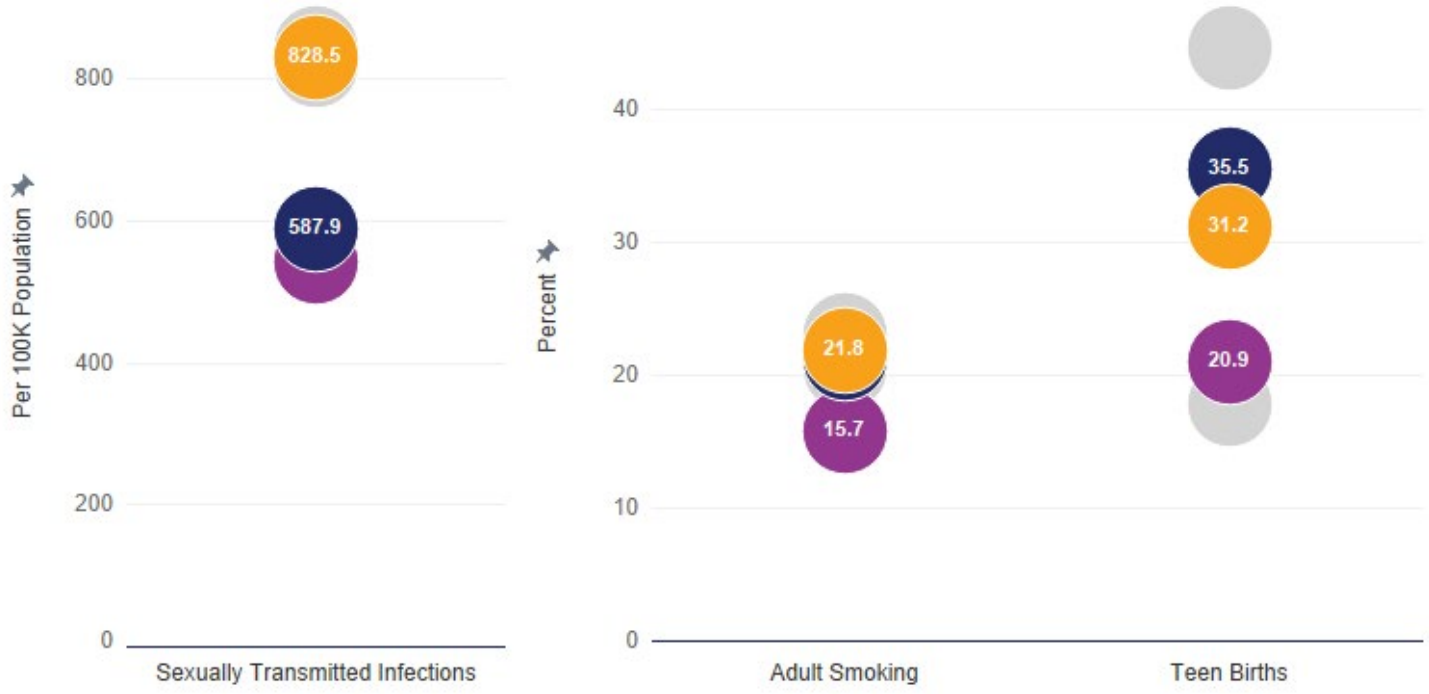


HEALTH BEHAVIORS

TABLE 7: HEALTH BEHAVIORS INDICATORS AND RATES

		Clark County	Nevada County	Community Average	State	National
Adult Smoking	*Percentage of adults who are current smokers (age-adjusted)*	20.5	23.0	21.8	21.2	15.7
Youth Vaping	*Percentage of public school students in 6th, 8th, 10th, and 12th grade who used any vape in the past 30 days*	13.0	7.6	10.3	11.7	Data Not Available
Physical Inactivity	*Percentage of adults ages 20 or older reporting no physical activity in the past month*	28.8	21.3	25.1	26.2	22.0
Sexually Transmitted Infections	*Number of newly diagnosed chlamydia cases per 100,000 population*	816.4	840.6	828.5	587.9	539.9
Teen Births	*The seven-year average number of teen births per 1,000 female population, ages 15-19*	17.8	44.5	31.2	35.5	20.9

FIGURE 6: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT HEALTH BEHAVIORS INDICATORS

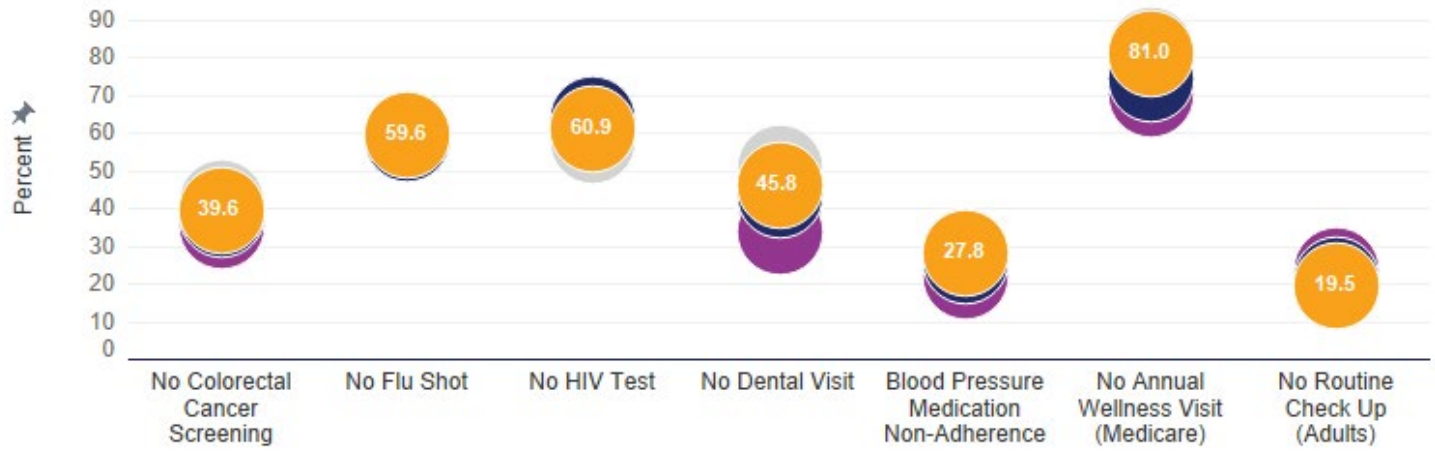


PREVENTION

TABLE 8: PREVENTION INDICATORS AND RATES

		Clark County	Nevada County	Community Average	State	National
No Pap Test	*Percentage of women ages 21 to 65 who have not had a pap test within the past 3 years (age-adjusted)*	14.9	16.7	15.8	16.3	14.5
No Colorectal Cancer Screening	*Percentage of adults ages 50-75 who have never had either a sigmoidoscopy or colonoscopy (age-adjusted)*	37.9	41.2	39.6	38.1	35.0
No Flu Shot	*Percentage of adults ages 18 or older who have not had a flu shot in the past year*	59.7	59.4	59.6	58.5	58.1
No HIV Test	*Percentage of adults ages 18 or older who have never been screened for HIV*	57.6	64.1	60.9	63.6	Data Not Available
No Dental Visit	*Percentage of adults ages 18 or older who have not had a dentist or dental clinic visit in the previous year (age-adjusted)*	41.0	50.6	45.8	43.4	33.8
Blood Pressure Medication Non-Adherence	*The percentage of Medicare enrollees who did not adhere to blood pressure medication schedules*	27.2	28.4	27.8	25.9	21.8
No Annual Wellness Visit (Medicare)	*The percentage of Medicare enrollees who did not have an annual wellness visit in the past year*	82.0	80.0	81.0	74.0	70.0
No Routine Check Up (Adults)	*The percentage of adults age 18 or older with no routine check up with a doctor in the past year*	20.1	18.9	19.5	21.0	23.4

FIGURE 7: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT PREVENTION INDICATORS



ACCESS

TABLE 9: ACCESS INDICATORS AND RATES

		Clark County	Nevada County	Community Average	State	National
Mammography	*Percentage of female Medicare enrollees ages 65-74 who received an annual mammography screening*	38.0	36.0	37.0	38.0	42.0
Diabetic Monitoring	*Percentage of diabetic Medicare enrollees over age 65 who had a hemoglobin A1c test in the past year*	89.2	86.0	87.6	88.5	87.5
Uninsured	*Percentage of adults under age 65 without health insurance coverage*	9.4	8.5	9.0	10.8	10.8
Primary Care Physicians	*Ratio of population to one primary care physician*	2,206.1	2,775.3	2,490.7	1,506.9	1,319.0
Dentists	*Ratio of population to one dentist*	2,029.1	Data Not Available	Data Not Available	2,103.0	1,404.5
Mental Health Providers	*Ratio of population to one mental health provider*	360.0	1,178.9	769.5	421.4	382.3
Addiction or Substance Use Providers	*Rate of addiction or substance use providers per 100,000 population*	0.0	0.0	0.0	4.4	20.4
Buprenorphine Providers	*Rate of buprenorphine providers per 100,000 population*	0.0	0.0	0.0	4.8	7.6
Preventable Hospital Stays	*Number of hospital stays for ambulatory care-sensitive conditions per 1,000 Medicare enrollees*	3,367.0	5,053.0	4,210.0	4,769.0	4,236.0

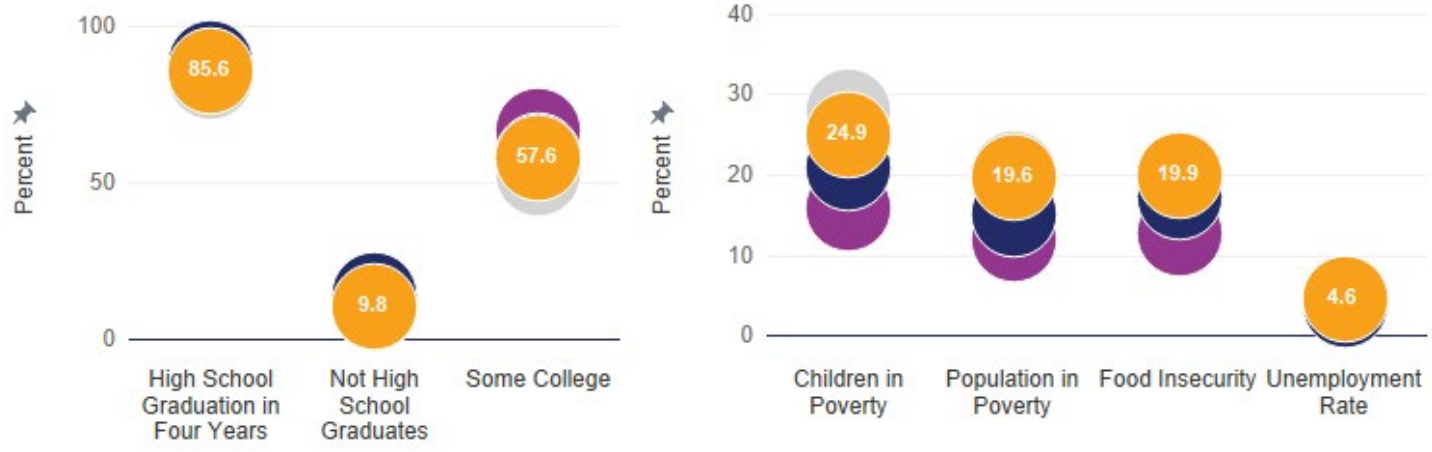
FIGURE 8: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT ACCESS INDICATORS

SOCIAL AND ECONOMIC FACTORS

TABLE 10: SOCIAL AND ECONOMIC FACTORS INDICATORS AND RATES

		Clark County	Nevada County	Community Average	State	National
Not High School Graduates	*Percentage of adults ages 25 or older without a high school diploma*	10.0	9.6	9.8	13.4	12.0
High School Graduation in Four Years	*Percentage of ninth-grade cohort who graduated in four years*	83.4	87.8	85.6	88.2	87.7
Some College	*Percentage of adults ages 25-44 with some post-secondary education*	62.3	52.9	57.6	58.5	66.1
Unemployment Rate	*Unemployment rate among civilian non-institutionalized population age 16 and older in January 2022*	4.6	4.5	4.6	3.8	4.4
Children in Poverty	*Percentage of children under age 18 below the poverty line*	22.0	27.8	24.9	20.8	15.7
Population in Poverty	*Percentage of population below the federal poverty line*	20.1	19.1	19.6	15.2	11.9
Children in Single-Parent Households	*Percentage of children who live in a household headed by single parent*	35.5	42.9	39.2	28.9	25.5
Homeless Children	*Rate of homelessness among public school students*	1.0	9.2	5.1	2.8	2.8
Food Insecurity	*Percentage of the population that experienced food insecurity in the report year*	19.5	20.2	19.9	17.3	12.6
Social Associations	*Number of membership associations per 100,000 population*	139.2	55.6	97.4	126.5	105.0
Violent Crimes	*Annual rate of reported violent crimes per 100,000 population*	426.9	589.4	508.2	549.2	416.0

FIGURE 9: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT SOCIAL AND ECONOMIC FACTORS INDICATORS



ENVIRONMENT

TABLE 11: ENVIRONMENT INDICATORS AND RATES

		Clark County	Nevada County	Community Average	State	National
Food Environment Index	*Index of factors that contribute to a healthy food environment, 0 (worst) to 10 (best)*	5.5	5.4	5.5	5.1	7.8
Drinking Water Violations	*The total number of drinking water violations recorded in a two-year period*	0.0	2.0	1.0	118.0	4,739.0
Access to Exercise Opportunities	*Percentage of population with adequate access to locations for physical activity*	66.9	40.4	53.6	63.5	84.2
Severe Housing Problems	*Percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, or lack of kitchen or plumbing*	12.9	12.0	12.4	14.1	17.5
Broadband Access	*Percentage of population in a high-speed internet service area; access to DL speeds > 25MBPS (2020)*	94.8	75.9	85.3	91.4	97.5
Long Commute Driving Alone	*Among workers who commute in their car alone, the percentage who commute more than 30 minutes*	25.8	51.6	38.7	27.0	36.6

FIGURE 10: COMMUNITY, STATE, AND NATIONAL COMPARISON OF THE FOOD ENVIRONMENT INDEX INDICATOR

FIGURE 11: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT ENVIRONMENT INDICATORS

DIAGNOSES INCIDENCE WITHIN HOSPITAL COMMUNITY AT DISCHARGE

TABLE 12: DIAGNOSES INCIDENCE WITHIN HOSPITAL COMMUNITY AT DISCHARGE INDICATORS AND RATES

		Clark County	Nevada County	Community Average	State
Arthritis	*Number of individuals 18 years and older discharged with a primary or secondary arthritis diagnosis as a percentage of the population 18 years and older*	4.0	2.2	3.1	2.3
Diabetes	*Number of individuals 18 years and older discharged with a primary or secondary diabetes diagnosis as a percentage of the population 18 years and older*	4.7	3.3	4.0	3.9
Hyperlipidemia	*Number of individuals 18 years and older discharged with a primary or secondary hyperlipidemia diagnosis as a percentage of the population 18 years and older*	4.8	2.6	3.7	3.9
Hypertension	*Number of individuals 18 years and older discharged with a primary or secondary hypertension diagnosis as a percentage of the population 18 years and older*	11.7	8.2	9.9	9.5
Ischemic Heart Disease	*Number of individuals 18 years and older discharged with a primary or secondary ischemic heart disease diagnosis as a percentage of the population 18 years and older*	2.6	1.7	2.1	2.5

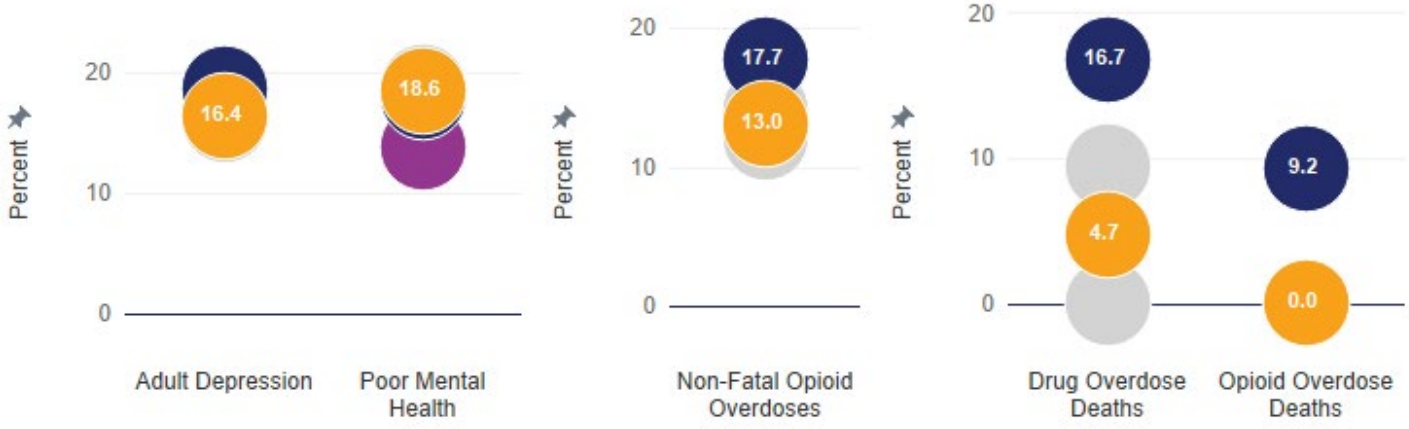
FIGURE 12: DIAGNOSES INCIDENCE WITHIN HOSPITAL COMMUNITY AT DISCHARGE INDICATORS

MENTAL HEALTH AND SUBSTANCE USE

TABLE 13: MENTAL HEALTH AND SUBSTANCE USE INDICATORS AND RATES

		Clark County	Nevada County	Community Average	State	National
Excessive Drinking	*Percentage of adults reporting binge or heavy drinking*	15.5	15.0	15.2	17.3	19.2
Poor Mental Health	*Percentage of adults ages 18 or older reporting poor mental health for 14 or more days*	18.3	18.8	18.6	18.0	13.9
Youth Depression	*Percentage of public school students in 6th, 8th, 10th, and 12th grade who had feelings of depression all of the time in the past 30 days*	11.8	10.4	11.1	12.1	Data Not Available
Adult Depression	*The prevalence of depression among Medicare fee-for-service beneficiaries*	16.6	16.1	16.4	18.7	18.4
Suicide Deaths	*The rate of deaths by suicide (ICD-10 codes U03, X60-X84, Y87.0) per 100,000 population (age-adjusted)*	Data Not Available	Data Not Available	Data Not Available	18.8	13.8
Non-Fatal Opioid Overdoses	*Non-fatal opioid overdoses per 100,00 population (based on county of occurrence)*	14.0	12.0	13.0	17.7	Data Not Available
Opioid Overdose Deaths	*Opioid-related deaths per 100,00 population (based on county of occurrence)*	0.0	0.0	0.0	9.2	Data Not Available
Drug Overdose Deaths	*Opioid-related deaths per 100,00 population (based on county of occurrence)*	9.3	0.0	4.7	16.7	Data Not Available

FIGURE 13: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT MENTAL HEALTH AND SUBSTANCE USE INDICATORS

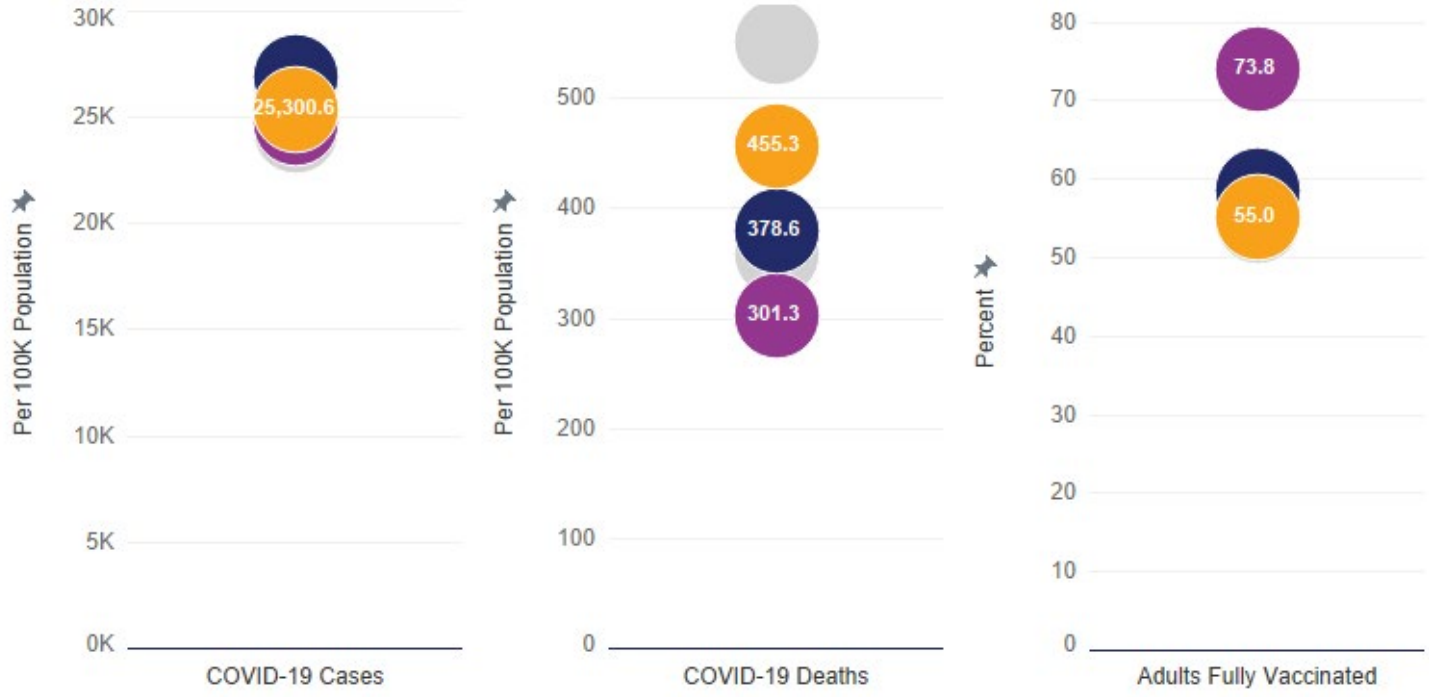


COVID-19

TABLE 14: COVID-19 INDICATORS AND RATES

		Clark County	Nevada County	Community Average	State	National
COVID-19 Cases	*The incidence rate of confirmed COVID-19 cases per 100,000 population, as of May 12, 2022*	24,346.1	26,255.1	25,300.6	26,900.1	24,718.7
COVID-19 Deaths	*The rate of deaths among patients with confirmed cases of COVID-19 per 100,000 population, as of May 12, 2022*	358.1	552.5	455.3	378.6	301.3
Adults Fully Vaccinated	*The percentage of adults fully vaccinated for COVID-19, as of May 11, 2022*	55.5	54.5	55.0	58.4	73.8
Adult COVID-19 Vaccine Hesitancy	*The percentage of the population estimated to be hesitant toward receiving a COVID-19 vaccine*	20.3	21.1	20.7	20.4	10.3

FIGURE 14: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT COVID-19 INDICATORS



BAPTIST HEALTH MEDICAL CENTER

FORT SMITH

About Baptist Health-Fort Smith

Baptist Health-Fort Smith was the first hospital built in Arkansas in 1887. It is currently a 492-bed medical center accredited by The Joint Commission. In addition to operating one of the busiest emergency departments in the state, the hospital offers providers who specialize in areas such as cardiology, cardiovascular and thoracic surgery, interventional radiology and stroke care, orthopedics, general and trauma surgery, labor and delivery, pediatrics, and many more.

From screenings to expert treatment to surgical procedures, we provide advanced, state-of-the-art services to ensure you get the best possible results from your care including the minimally-invasive da Vinci surgical system.

In addition, we offer Aquablation therapy— an advanced, minimally invasive treatment of lower urinary tract symptoms (LUTS) due to benign prostatic hyperplasia (BPH).

Another unique attribute is the hospital's gym, Marvin Altman Fitness Center, which features a junior Olympic-size indoor pool, indoor rubberized track, yoga studios, massage therapy, and cardiac rehabilitation services.

Awards & Recognitions

- American Heart Association's Get with the Guidelines Stroke Gold Plus with Honor Roll Achievement Award.
- Baptist Health-Fort Smith received the American Heart Association's Gold Plus and Target Type 2 Diabetes Honor Roll Get With The Guidelines award for their commitment to ensuring stroke patients receive the most appropriate treatment according to nationally recognized research-based guidelines. Learn more about the providers at Baptist Health Neuroscience Center-Fort Smith.
- Baptist Health-Fort Smith has demonstrated sustained achievement in the Chest Pain MI Registry for four consecutive quarters during 2020 and performed with distinction in specific performance measures to receive this 2021 award.
- Baptist Health-Fort Smith was also recognized by the American Heart Association for its commitment to safety and quality care for patients with heart failure. Learn more about our cardiologists at Baptist Health Cardiology Center-Fort Smith.

2020-2022 Accomplishments

Access to Care:

- Opened a New Urgent Care Clinic
- Opened a Walk-in Clinic in October 2022
- Increased access to care by recruiting; nuclear cardiologist, Physician Assistant to provide care for oncology patients, a new trauma surgeon, a new Endocrinologist, a hand specialist for the Orthopedic Department.
- Received a Center of Distinction award by achieving outstanding clinical outcomes for twelve consecutive months.
- Opened a Pain Management Clinic.
- Recruited an APRN for the Labor and Delivery department
- Partnered with Eastern Oklahoma to provide convenient obstetric and gynecological care for patients in eastern Oklahoma.
- Hosted a free community event aimed to improve the health of the Spanish speaking community in the River Valley.
- Opened a primary care clinic that aims to help eliminate language barriers for Spanish- speaking residents seeking health care services in the River Valley.
- Partnered with the Arkansas Blood Institute to provide health screening targeting Hispanic Heritage Month
- Partnered with Community Outreach to offer vaccinations for flu and Covid-19

Obesity:

- Partnered with Local schools to promote healthy eating and nutrition
- Partnered with schools to promote physical activity utilizing the Smoothie making bicycle
- Implemented a National Walking Day to promote health and wellness

Mental Health:

- Partnered with the Community Based Provided (Guidance Center) to do Crisis Prevention Training for the Fort Smith Police Department- Quarterly (4 per year)
- Partnered with the City of Fort Smith to offer Mental Health presentation and training for employees
- Offered In-Patient Geriatric Psychiatric Program
- Participated in the Sebastian County Opioid Task Force

COMMUNITY HEALTH NEEDS ASSESSMENT – IMPLEMENTATION PLAN 2023-2025

Baptist Health Medical Center- Fort Smith

IDENTIFIED COMMUNITY HEALTH NEED: **Access to Healthcare Services**

GOALS / OBJECTIVES:

Increase Access to Quality Health Care, Preventive Health Screenings, Vaccinations and Community Resources.

STRATEGY #1

Utilize the Mobile Health Unit (MHU) and Community Partnerships to provide preventive screenings and increase access to care.

Action Steps:

1. Utilize the MHU to immunizations, flu shots and Covid-19 Vaccinations
2. Provide Community Based Preventative Health Screenings for Diabetes, Hypertension, Cholesterol and Covid-19.
3. Utilize the Findhelp.org system to refer and track patents in need of additional resources
4. Continue to promote and utilize local Baptist Health Urgent Care facilities to meet community needs
5. Continue support of the Good Samaritan Clinic to serve the underserved, uninsured and under-insured populations

Performance Metrics:

1. Track and Report the number of individuals screened and vaccinated on the Mobile Health Unit
2. Track and report the number of patients utilizing virtual care on the MHU.
3. Track and report the number of referrals submitted through the Findhelp.org system
4. Track and report the number of Preventative Health Screenings and referrals
5. Track and report the number of patients utilizing the Findhelp.org system for resources

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:

Community Centers, Local schools, faith based community and other not-for-profit agencies

Resources Hospital Plans to Commit to Address Health Need:

- Staff and Printing

Estimated Completion Date:

- Ongoing

Person(s) / Department Responsible:

- Community OutreachTeam, Mobile Health Unit Driver, Nursing Staff

COMMUNITY HEALTH NEEDS ASSESSMENT – IMPLEMENTATION PLAN 2023-2025

Baptist Health Medical Center- Fort Smith

IDENTIFIED COMMUNITY HEALTH NEED: **Mental Health**

GOALS / OBJECTIVES:

Increase awareness and support of community members dealing with mental health concerns.

STRATEGY #1

Reduce the stigma associated with mental health through education and treatment .

Action Steps:

1. Offer annual based Mental Health First Aid presentations to community groups and faith-based organizations.
2. Host seminars, presentations with an emphasis on decreasing stigma.
3. Offer Depression and ACES Screening Tools at Community events.
4. Provide education and outreach efforts via seminars, events and telehealth on the relationship between substance abuse and mental health.
5. Explore the opportunity to expand Adult Psychiatric Care
6. Continue to offer psychiatric care and referrals
7. Utilize Findhelp.org and the 211 system to refer individuals for Mental Health Services
8. Participate in the Sebastian County Opioid Task Force Coalition

Performance Metrics:

1. Number of Community Based Mental Health First Aid Presentations will be tracked and reported.
2. Number of Depression Screening will be tracked and reported
3. Number of referrals and follow-ups will be tracked and reported.
4. Number of seminars, presentations will be tracked and reported.
5. Track the number of individuals referred for additional resources and services
6. Track and report projects implemented via the Opioid Task Force

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:

Faith Based Communities

Resources Hospital Plans to Commit to Address Health Need:	Estimated Completion Date:	Person(s) / Department Responsible:
• Community Outreach Staff, Behavioral Health	• Ongoing	• Community Outreach Team, Behavioral Health

COMMUNITY HEALTH NEEDS ASSESSMENT – IMPLEMENTATION PLAN 2023-2025

Baptist Health Medical Center- Fort Smith

IDENTIFIED COMMUNITY HEALTH NEED: **Nutrition & Food Security**

GOALS / OBJECTIVES:

Initiate Evidence Based Nutrition Security strategies to address obesity, diabetes, hypertension, and other diet-related chronic conditions.

STRATEGY #1

Increase access to nutrition education and information among community members

Action Steps:

1. Implement a Virtual Maintain, Don't Gain holiday challenge program for adult community members that encourages using stress management strategies, physical activity, and healthful food choices during the holiday season to maintain one's physical and mental health and avoid holiday weight gain.
2. Implement Eat Healthy, Be Active program for adult community members. a program based on the Dietary Guidelines and Physical Activity Guidelines for Americans and teaches participants to make incremental lifestyle changes to improve their health.
3. Implement Cooking with Community Outreach classes to empower participants to build cooking skills, cook more healthy meals, reduce food waste, and make healthier selections at the grocery store.
4. Utilize the Epic System to screening for Food Insecurity for inpatients visits
5. Explore opportunity to partner with AHG clinics to screen for Food Insecurity and provide food through the FoodRX program for those in need

PERFORMANCE METRICS:

1. Number of Participants registered for educational Programs will be tracked and reported
2. Coordinate implementation of the Maintain, Don't Gain Holiday Challenge
3. Number of participants in the Eat Healthy Be Active Programs will be tracked and reported
4. Partner with Community Outreach to implement 2 Community -Based Community Outreach Cooking Classes
5. Track and report the number of patents screened for Food insecurity
6. Track and report the number of patients receiving services from the FoodRX program

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:

Arkansas Hunger Relief Alliance, Central AR Library System, Be Mighty

Resources Hospital Plans to Commit to Address Health Need:

- Community Outreach Staff, Pharmacy Manager

Estimated Completion Date:

- Ongoing

Person(s) / Department Responsible:

- Community Outreach Team, Fort Smith Leadership Team

FORT SMITH

ASSESSMENT PREPARED BY ACHI
INSPIRING HEALTHY ACTS

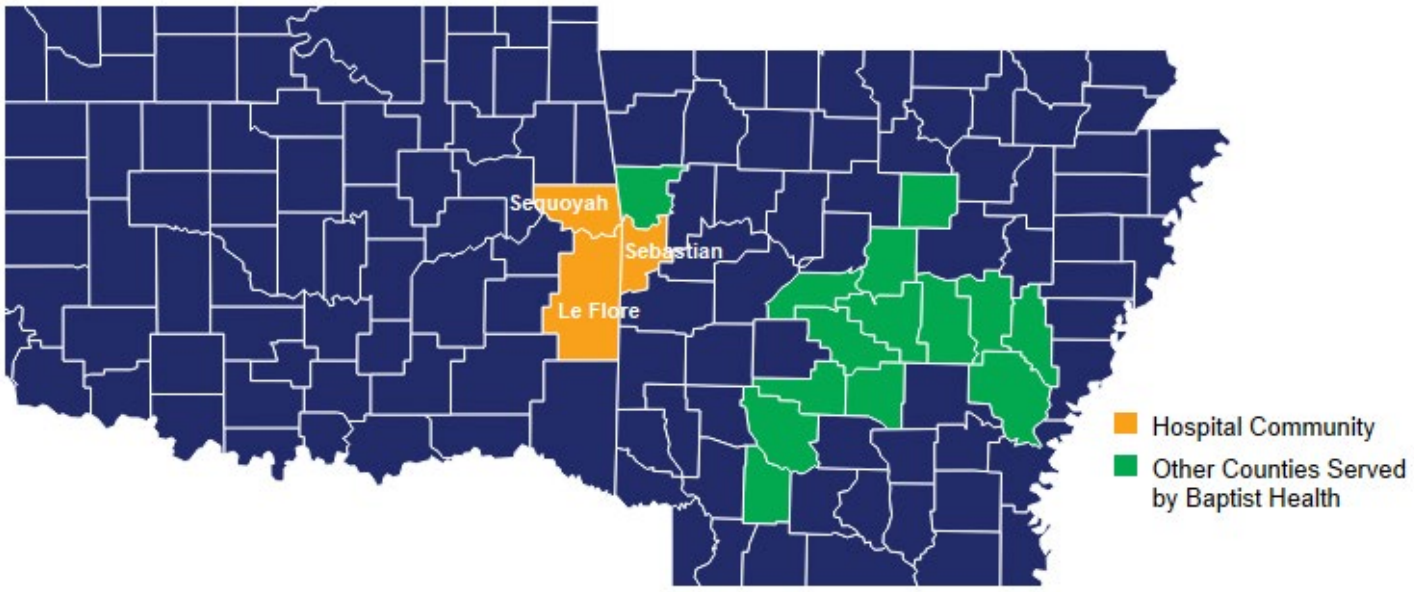
Introduction

Baptist Health engaged the Arkansas Center for Health Improvement (ACHI) to conduct the quantitative data collection and analysis for the 2022 Community Health Needs Assessment (CHNA) process. Baptist Health provided ACHI with the counties served for each of its 11 hospital communities. A total of 15 Arkansas counties and two Oklahoma counties were included in the CHNA.

This report shows the qualitative results from the CHNA for the Baptist Health-Fort Smith hospital community, which include Sebastian county in Arkansas and Le Flore and Sequoyah counties in Oklahoma.

HOSPITAL COMMUNITY

FIGURE 1: COUNTIES SERVED BY BAPTIST HEALTH-FORT SMITH



Qualitative Results

Quantitative results from the CHNA for the Baptist Health-Fort Smith hospital community are reported below. There are 12 sections: Demographics, Health Outcomes, Cause of Death, Chronic Conditions, Health Behaviors, Prevention, Access, Social and Economic Factors, Environment, Diagnoses Incidence Within Hospital Community at Discharge, Mental Health and Substance Use, and COVID-19.

Each section includes a table with health indicator data for each county in the hospital community, a community average for each measurement, and averages for the state of Arkansas and the United States. If data were not available or were suppressed, “Data Not Available” 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 document and Appendix 1.

DEMOGRAPHICS

TABLE 1: AGE AND SEX

		Le Flore County (OK)	Sebastian County	Sequoyah County (OK)	State	National
Total Population	*Number*	50,026.0	127,591.0	41,709.0	2,999,370.0	324,697,795.0
Ages 0-4	*Percent*	6.4	6.6	6.4	6.3	6.1
Ages 5-17	*Percent*	17.9	17.6	17.3	17.2	16.5
Ages 18-24	*Percent*	8.1	9.2	8.2	9.5	9.4
Ages 25-34	*Percent*	12.1	13.2	11.8	13.1	13.9
Ages 35-44	*Percent*	12.3	12.3	11.5	12.3	12.6
Ages 45-54	*Percent*	12.5	12.9	13.6	12.4	13.0
Ages 55-64	*Percent*	13.2	12.7	13.2	12.7	12.9
Ages 65+	*Percent*	17.5	15.6	18.1	16.6	15.6
Male	*Percent*	50.1	48.9	49.3	49.1	49.2
Female	*Percent*	49.9	51.1	50.7	50.9	50.8

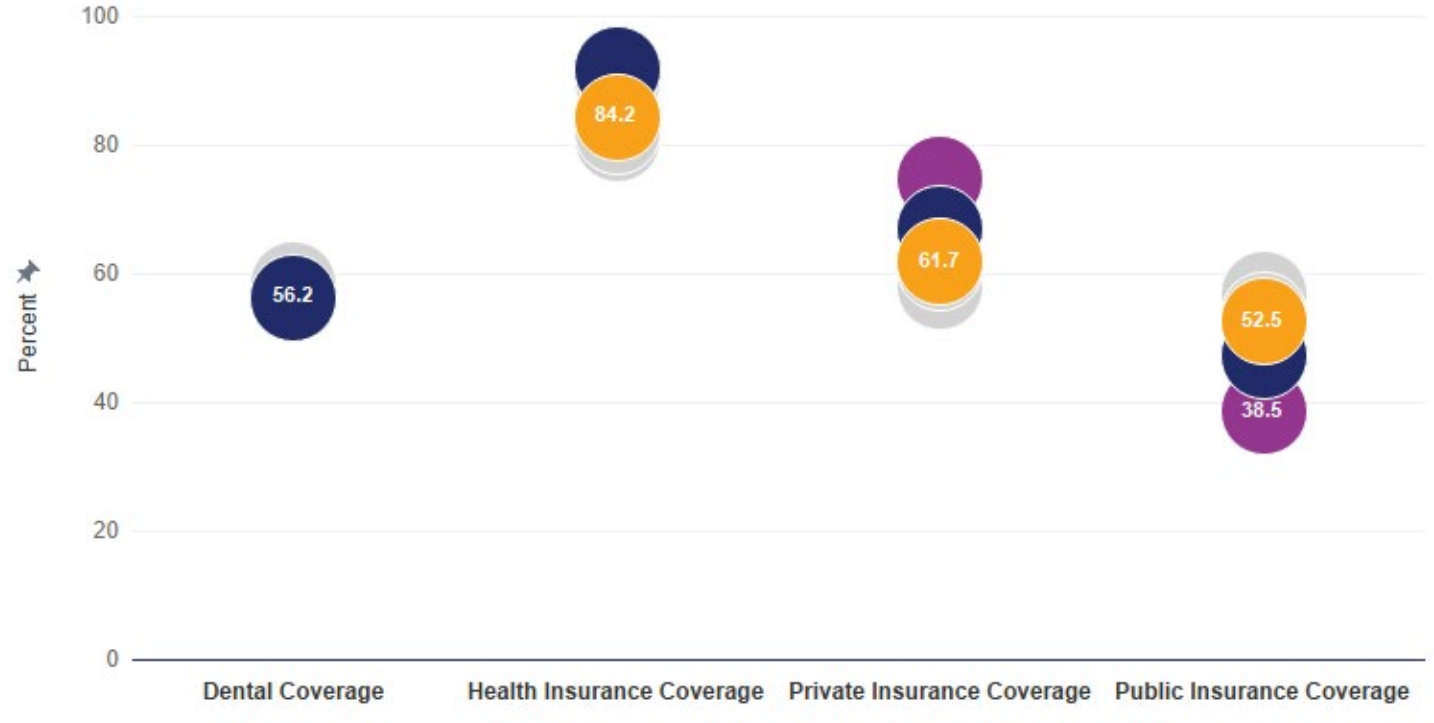
TABLE 2: RACE, ETHNICITY, AND LANGUAGE

		Le Flore County (OK)	Sebastian County	Sequoyah County (OK)	State	National
Total Population	*Number*	50,026.0	127,591.0	41,709.0	2,999,370.0	324,697,795.0
Hispanic or Latino	*Percent*	7.0	14.2	4.2	7.5	18.0
Non-Hispanic White	*Percent*	71.3	69.6	62.5	72.4	60.7
Black or African American	*Percent*	1.9	6.8	2.0	15.3	12.7
Native American/Alaska Native	*Percent*	11.3	1.1	19.9	0.7	0.9
Asian	*Percent*	0.7	4.5	0.8	1.5	5.6
Native Hawaiian/Pacific Islander	*Percent*	0.0	0.0	0.1	0.3	0.2
Some Other Race	*Percent*	1.9	9.4	1.4	2.8	4.9
Two or More Races	*Percent*	8.7	4.7	11.7	2.7	3.3
Non-English Language Households	*Percent*	1.8	3.1	0.7	1.6	4.4

TABLE 3: INSURANCE COVERAGE

		Le Flore County	Sebastian County	Sequoyah County	Community Average	State	National
Health Insurance Coverage	*Percentage of total civilian non-institutionalized population with health insurance coverage*	82.0	89.6	81.0	84.2	91.5	91.2
Private Insurance Coverage	*Percentage of total civilian non-institutionalized population with private health insurance coverage*	61.0	66.2	57.9	61.7	67.0	74.5
Public Insurance Coverage	*Percentage of total civilian non-institutionalized population with public health insurance coverage*	53.4	47.6	56.6	52.5	47.3	38.5
Dental Coverage	*Percentage of Arkansas residents with evidence of any dental coverage in the All-Payer Claims Database (APCD)*	Data Not Available	58.1	Data Not Available	Data Not Available	56.2	Data Not Available

FIGURE 2: COMMUNITY, STATE, AND NATIONAL COMPARISON OF INSURANCE COVERAGE

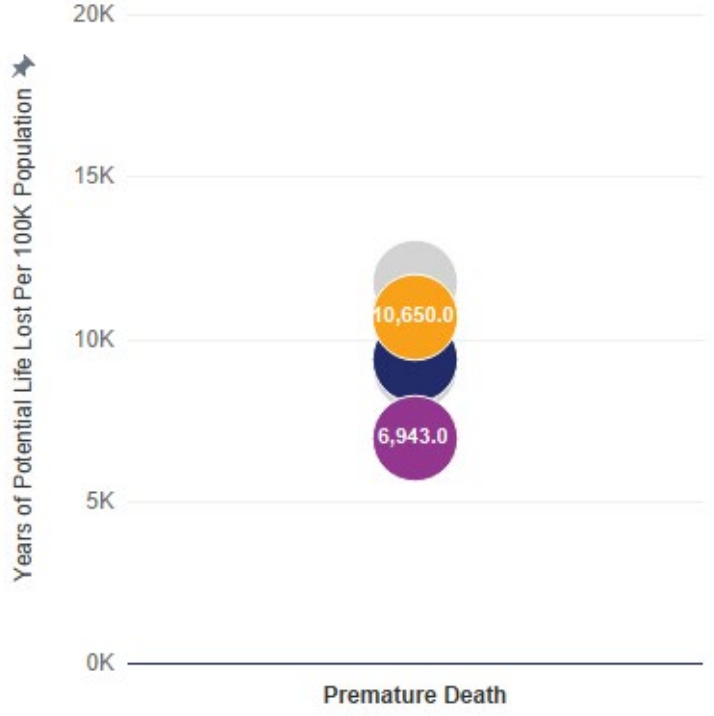


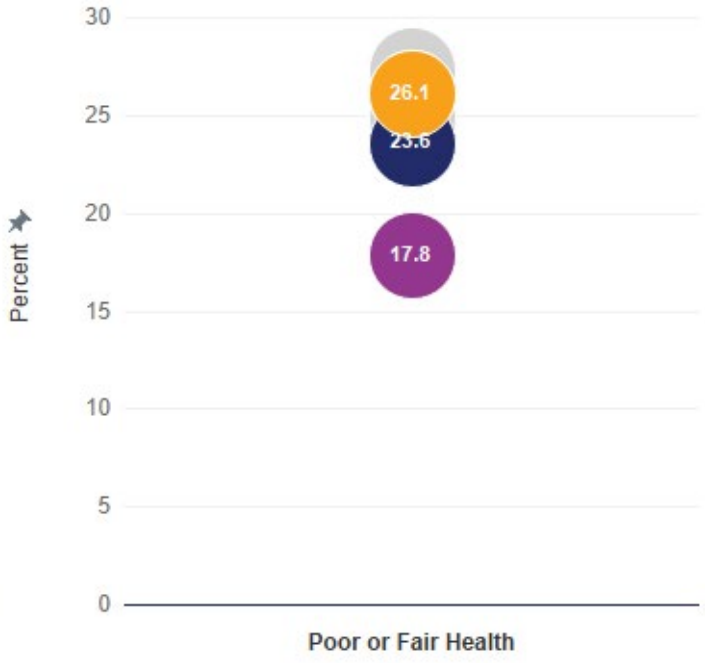
HEALTH OUTCOMES

TABLE 4: HEALTH OUTCOMES INDICATORS AND RATES

		Le Flore County	Sebastian County	Sequoyah County	Community Average	State	National
Premature Death	*Years of potential life lost before age 75 per 100,000 population (age-adjusted)*	11,717.0	9,121.0	11,112.0	10,650.0	9,357.0	6,943.0
Poor or Fair Health	*Percentage of adults reporting poor or fair health*	26.1	24.8	27.3	26.1	23.6	17.8
Poor Physical Health Days	*Average number of physically unhealthy days reported in past 30 days (age-adjusted)*	5.6	5.3	5.9	5.6	4.9	4.0
Low Birthweight	*Percentage of live births with low birth weight (<2500g)*	7.8	8.1	7.8	7.9	9.1	8.2

FIGURE 3: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT HEALTH OUTCOMES INDICATORS



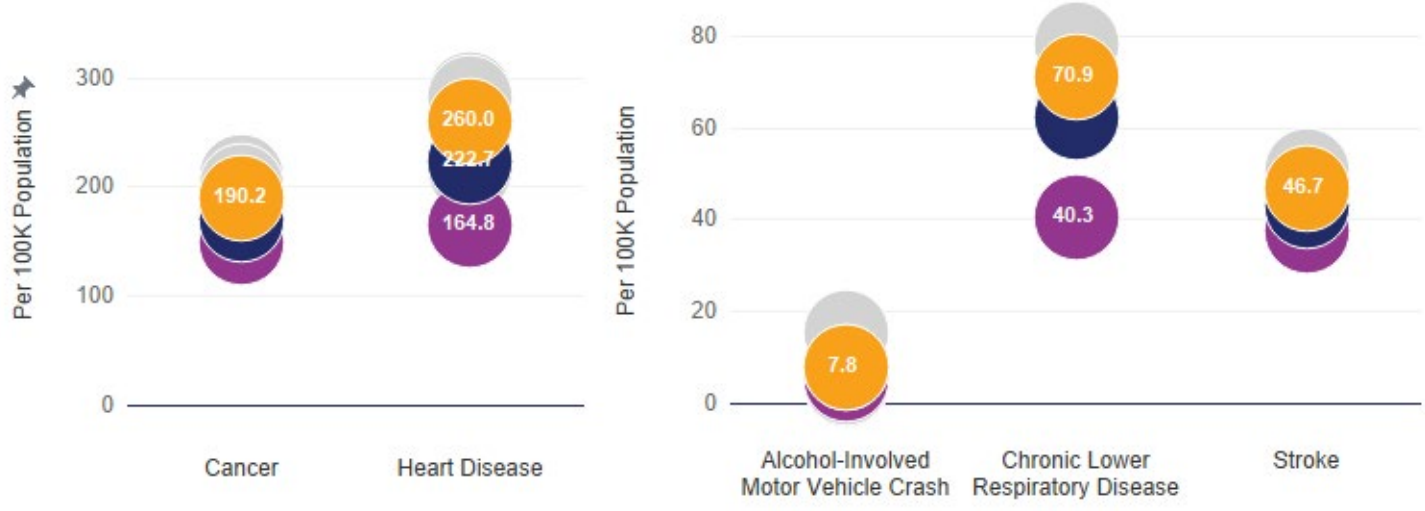


CAUSE OF DEATH

TABLE 5: CAUSE OF DEATH INDICATORS AND RATES

		Le Flore County	Sebastian County	Sequoyah County	Community Average	State	National
All Causes	*All causes of deaths per 100,000 population (age-adjusted)*	1,035.3	883.9	1,022.6	980.6	888.4	727.2
Cancer	*5-year average rate of death due to malignant neoplasm (cancer) per 100,000 population (age-adjusted)*	199.6	162.1	208.8	190.2	170.1	149.4
Stroke	*5-year average rate of death due to cerebrovascular disease (stroke) per 100,000 population (age-adjusted)*	46.2	50.5	43.5	46.7	43.0	37.6
Chronic Lower Respiratory Disease	*Rate of deaths due to chronic lower respiratory disease per 100,000 population (age-adjusted)*	78.4	64.1	70.3	70.9	62.1	40.3
Diabetes	*Diabetes deaths per 100,000 population (age-adjusted)*	30.1	31.4	32.2	31.2	29.0	21.4
Heart Disease	*Rate of death due to heart disease per 100,000 population (age-adjusted)*	281.5	215.2	283.4	260.0	222.7	164.8
Unintentional Injury	*5-year average rate of death due to unintentional injury (accident) per 100,000 population (age-adjusted)*	75.3	45.4	64.7	61.8	51.7	50.4
Motor Vehicle Crash	*5-year average rate of death due to motor vehicle crash per 100,000 population (age-adjusted)*	28.8	12.4	14.5	18.6	18.9	11.5
Alcohol-Involved Motor Vehicle Crash	*Rate of persons killed in motor vehicle crashes involving alcohol as a rate per 100,000 population*	15.2	4.2	3.9	7.8	7.8	5.3

FIGURE 4: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT CAUSE OF DEATH INDICATORS

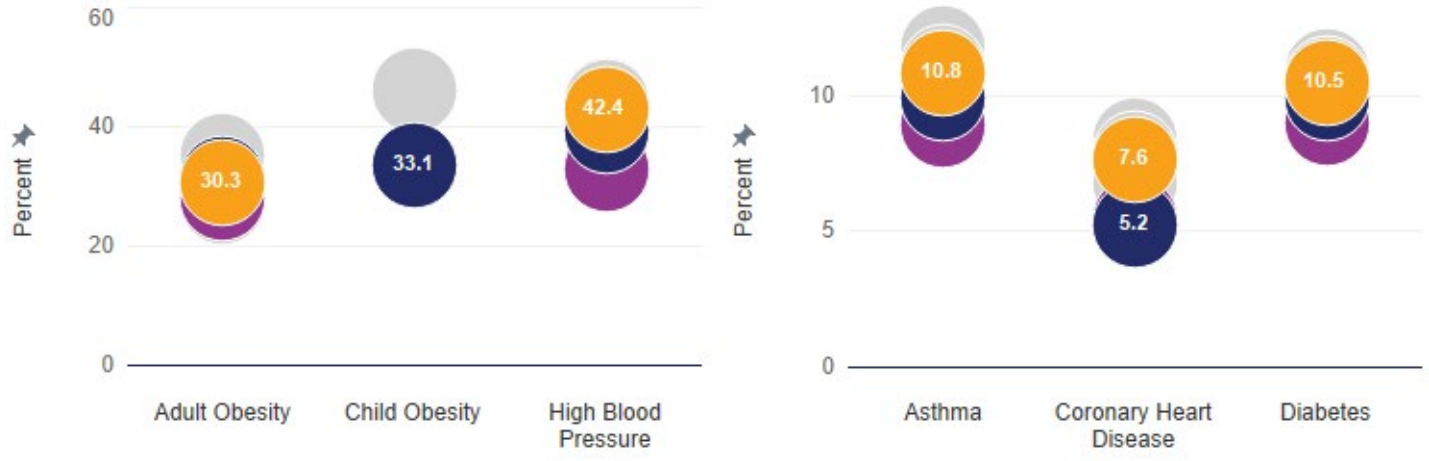


CHRONIC CONDITIONS

TABLE 6: CHRONIC CONDITIONS INDICATORS AND RATES

		Le Flore County	Sebastian County	Sequoyah County	Community Average	State	National
High Blood Pressure	*Percentage of adults who have been told they have high blood pressure*	43.8	39.3	44.2	42.4	39.0	32.6
Asthma	*Percentage of adults who have been told they currently have asthma (age-adjusted)*	11.0	9.7	11.8	10.8	9.9	8.9
Coronary Heart Disease	*Percentage of adults who have been told they have angina or coronary heart disease (age-adjusted)*	7.8	6.8	8.3	7.6	5.2	5.4
Arthritis	*Percentage of adults ages 18 or older diagnosed with some form of arthritis*	Data Not Available	27.1	Data Not Available	Data Not Available	34.3	Data Not Available
High Cholesterol	*Percentage of adults who have had their blood cholesterol checked and have been told it was high*	39.0	38.1	37.8	38.3	36.7	33.6
Diabetes	*Percentage of adults ages 20 and older who have ever been told by a doctor that they have diabetes (age-adjusted)*	10.6	10.9	9.9	10.5	9.9	9.0
Adult Obesity	*Percentage of adults ages 20 and older who report a BMI higher than 30*	34.8	28.9	27.2	30.3	31.0	27.6
Child Obesity	*Percentage of students classified as overweight or obese, by county location of school*	Data Not Available	45.8	Data Not Available	Data Not Available	33.1	Data Not Available

FIGURE 5: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT CHRONIC CONDITIONS INDICATORS

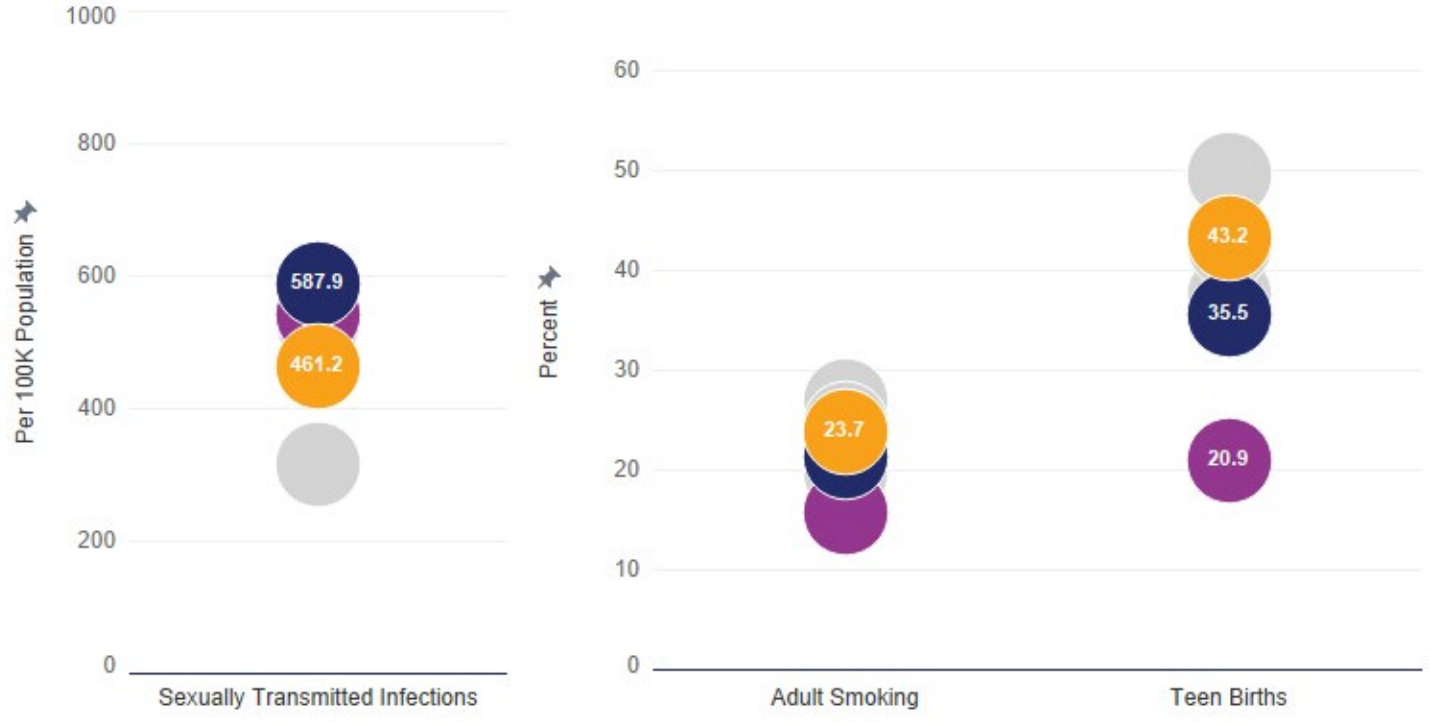


HEALTH BEHAVIORS

TABLE 7: HEALTH BEHAVIORS INDICATORS AND RATES

		Le Flore County	Sebastian County	Sequoyah County	Community Average	State	National
Adult Smoking	*Percentage of adults who are current smokers (age-adjusted)*	24.5	19.8	26.8	23.7	21.2	15.7
Youth Vaping	*Percentage of public school students in 6th, 8th, 10th, and 12th grade who used any vape in the past 30 days*	Data Not Available	12.2	Data Not Available	Data Not Available	11.7	Data Not Available
Physical Inactivity	*Percentage of adults ages 20 or older reporting no physical activity in the past month*	35.1	28.5	32.8	32.1	26.2	22.0
Sexually Transmitted Infections	*Number of newly diagnosed chlamydia cases per 100,000 population*	540.9	527.7	315.1	461.2	587.9	539.9
Teen Births	*The seven-year average number of teen births per 1,000 female population, ages 15-19*	42.4	37.5	49.6	43.2	35.5	20.9

FIGURE 6: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT HEALTH BEHAVIORS INDICATORS

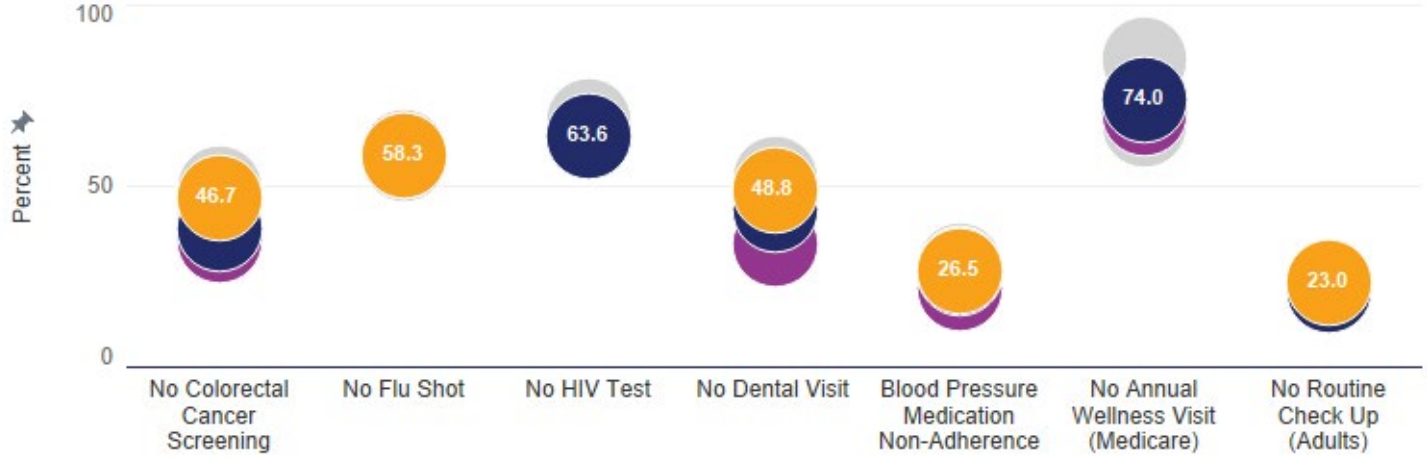


PREVENTION

TABLE 8: PREVENTION INDICATORS AND RATES

		Le Flore County	Sebastian County	Sequoyah County	Community Average	State	National
No Pap Test	*Percentage of women ages 21 to 65 who have not had a pap test within the past 3 years (age-adjusted)*	18.8	17.4	20.0	18.7	16.3	14.5
No Colorectal Cancer Screening	*Percentage of adults ages 50-75 who have never had either a sigmoidoscopy or colonoscopy (age-adjusted)*	49.4	41.7	48.9	46.7	38.1	35.0
No Flu Shot	*Percentage of adults ages 18 or older who have not had a flu shot in the past year*	58.4	57.1	59.4	58.3	58.5	58.1
No HIV Test	*Percentage of adults ages 18 or older who have never been screened for HIV*	Data Not Available	67.7	Data Not Available	Data Not Available	63.6	Data Not Available
No Dental Visit	*Percentage of adults ages 18 or older who have not had a dentist or dental clinic visit in the previous year (age-adjusted)*	47.7	47.1	51.7	48.8	43.4	33.8
Blood Pressure Medication Non-Adherence	*The percentage of Medicare enrollees who did not adhere to blood pressure medication schedules*	27.1	24.6	27.9	26.5	25.9	21.8
No Annual Wellness Visit (Medicare)	*The percentage of Medicare enrollees who did not have an annual wellness visit in the past year*	Data Not Available	67.0	85.0	Data Not Available	74.0	70.0
No Routine Check Up (Adults)	*The percentage of adults age 18 or older with no routine check up with a doctor in the past year*	23.4	22.8	22.8	23.0	21.0	23.4

FIGURE 7: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT PREVENTION INDICATORS

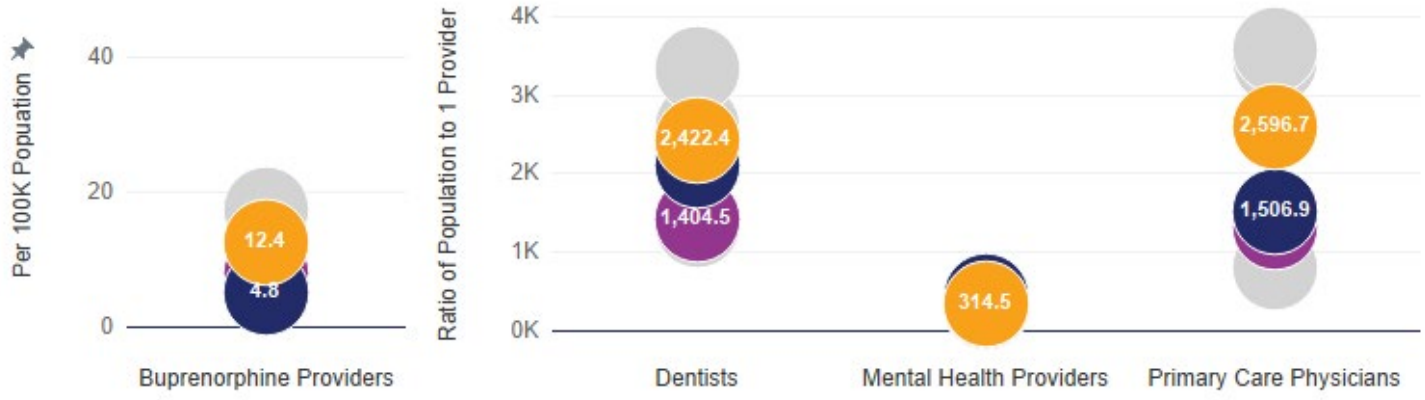


ACCESS

TABLE 9: ACCESS INDICATORS AND RATES

		Le Flore County	Sebastian County	Sequoyah County	Community Average	State	National
Mammography	*Percentage of female Medicare enrollees ages 65-74 who received an annual mammography screening*	32.0	42.0	30.0	34.7	38.0	42.0
Diabetic Monitoring	*Percentage of diabetic Medicare enrollees over age 65 who had a hemoglobin A1c test in the past year*	73.7	87.7	67.7	76.4	88.5	87.5
Uninsured	*Percentage of adults under age 65 without health insurance coverage*	22.4	14.2	21.3	19.3	10.8	10.8
Primary Care Physicians	*Ratio of population to one primary care physician*	3,570.0	788.6	3,431.6	2,596.7	1,506.9	1,319.0
Dentists	*Ratio of population to one dentist*	3,323.5	1,345.5	2,598.1	2,422.4	2,103.0	1,404.5
Mental Health Providers	*Ratio of population to one mental health provider*	309.6	278.5	355.3	314.5	421.4	382.3
Addiction or Substance Use Providers	*Rate of addiction or substance use providers per 100,000 population*	29.1	16.4	38.2	27.9	4.4	20.4
Buprenorphine Providers	*Rate of buprenorphine providers per 100,000 population*	8.0	17.2	12.0	12.4	4.8	7.6
Preventable Hospital Stays	*Number of hospital stays for ambulatory care-sensitive conditions per 1,000 Medicare enrollees*	6,439.0	4,654.0	5,693.0	5,595.3	4,769.0	4,236.0

FIGURE 8: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT ACCESS INDICATORS

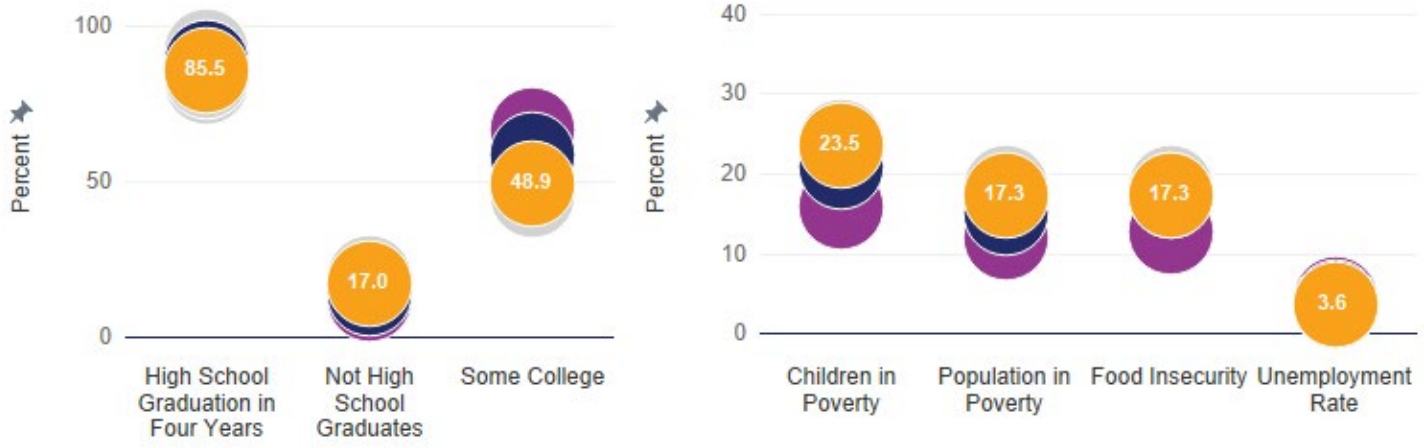


SOCIAL AND ECONOMIC FACTORS

TABLE 10: SOCIAL AND ECONOMIC FACTORS INDICATORS AND RATES

		Le Flore County	Sebastian County	Sequoyah County	Community Average	State	National
Not High School Graduates	*Percentage of adults ages 25 or older without a high school diploma*	16.5	15.9	18.7	17.0	13.4	12.0
High School Graduation in Four Years	*Percentage of ninth-grade cohort who graduated in four years*	83.3	91.7	81.6	85.5	88.2	87.7
Some College	*Percentage of adults ages 25-44 with some post-secondary education*	45.5	54.4	46.8	48.9	58.5	66.1
Unemployment Rate	*Unemployment rate among civilian non-institutionalized population age 16 and older in January 2022*	3.8	3.4	3.6	3.6	3.8	4.4
Children in Poverty	*Percentage of children under age 18 below the poverty line*	23.2	24.0	23.2	23.5	20.8	15.7
Population in Poverty	*Percentage of population below the federal poverty line*	18.1	16.8	16.9	17.3	15.2	11.9
Children in Single-Parent Households	*Percentage of children who live in a household headed by single parent*	26.3	28.7	30.0	28.3	28.9	25.5
Homeless Children	*Rate of homelessness among public school students*	3.9	1.9	1.2	2.3	2.8	2.8
Food Insecurity	*Percentage of the population that experienced food insecurity in the report year*	17.1	16.5	18.2	17.3	17.3	12.6
Social Associations	*Number of membership associations per 100,000 population*	71.5	107.4	61.3	80.0	126.5	105.0
Violent Crimes	*Annual rate of reported violent crimes per 100,000 population*	280.6	664.5	369.6	438.2	549.2	416.0

FIGURE 9: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT SOCIAL AND ECONOMIC FACTORS INDICATORS



ENVIRONMENT

TABLE 11: ENVIRONMENT INDICATORS AND RATES

		Le Flore County	Sebastian County	Sequoyah County	Community Average	State	National
Food Environment Index	*Index of factors that contribute to a healthy food environment, 0 (worst) to 10 (best)*	6.6	7.0	6.7	6.8	5.1	7.8
Drinking Water Violations	*The total number of drinking water violations recorded in a two-year period*	25.0	6.0	7.0	12.7	118.0	4,739.0
Access to Exercise Opportunities	*Percentage of population with adequate access to locations for physical activity*	30.5	78.2	38.6	49.1	63.5	84.2
Severe Housing Problems	*Percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, or lack of kitchen or plumbing*	12.1	15.7	15.2	14.4	14.1	17.5
Broadband Access	*Percentage of population in a high-speed internet service area; access to DL speeds > 25MBPS (2020)*	76.8	98.4	54.1	76.4	91.4	97.5
Long Commute Driving Alone	*Among workers who commute in their car alone, the percentage who commute more than 30 minutes*	31.2	17.7	35.4	28.1	27.0	36.6

FIGURE 10: COMMUNITY, STATE, AND NATIONAL COMPARISON OF THE FOOD ENVIRONMENT INDEX INDICATOR

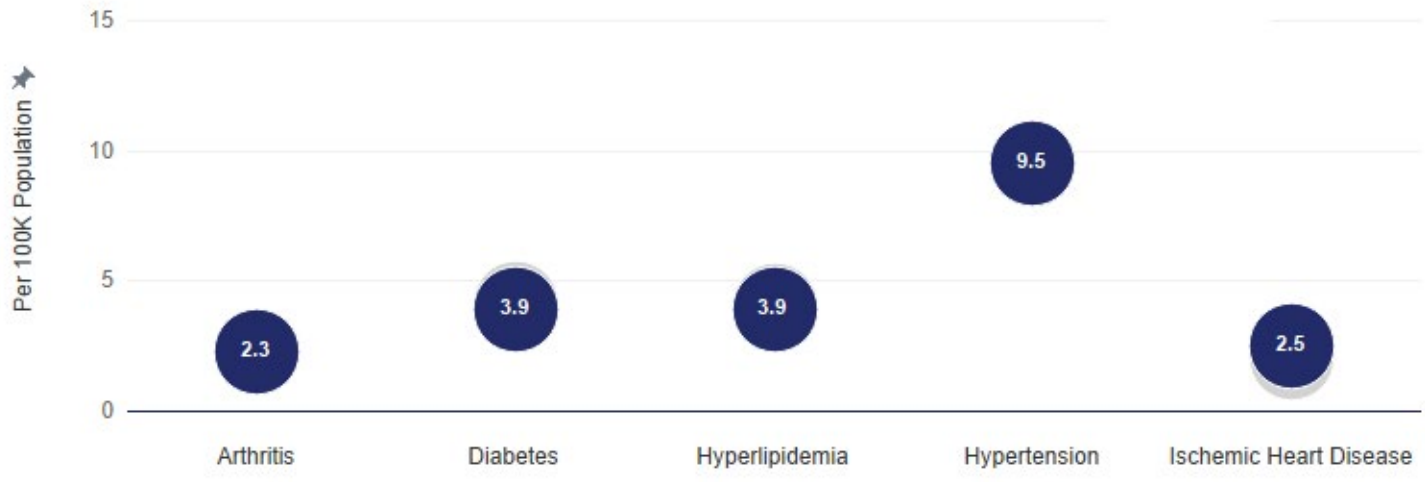
FIGURE 11: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT ENVIRONMENT INDICATORS

DIAGNOSES INCIDENCE WITHIN HOSPITAL COMMUNITY AT DISCHARGE

TABLE 12: DIAGNOSES INCIDENCE WITHIN HOSPITAL COMMUNITY AT DISCHARGE INDICATORS AND RATES

		Le Flore County	Sebastian County	Sequoyah County	Community Average	State
Arthritis	*Number of individuals 18 years and older discharged with a primary or secondary arthritis diagnosis as a percentage of the population 18 years and older*	Data Not Available	2.3	Data Not Available	Data Not Available	2.3
Diabetes	*Number of individuals 18 years and older discharged with a primary or secondary diabetes diagnosis as a percentage of the population 18 years and older*	Data Not Available	4.1	Data Not Available	Data Not Available	3.9
Hyperlipidemia	*Number of individuals 18 years and older discharged with a primary or secondary hyperlipidemia diagnosis as a percentage of the population 18 years and older*	Data Not Available	4.0	Data Not Available	Data Not Available	3.9
Hypertension	*Number of individuals 18 years and older discharged with a primary or secondary hypertension diagnosis as a percentage of the population 18 years and older*	Data Not Available	9.4	Data Not Available	Data Not Available	9.5
Ischemic Heart Disease	*Number of individuals 18 years and older discharged with a primary or secondary ischemic heart disease diagnosis as a percentage of the population 18 years and older*	Data Not Available	2.0	Data Not Available	Data Not Available	2.5

FIGURE 12: DIAGNOSES INCIDENCE WITHIN HOSPITAL COMMUNITY AT DISCHARGE INDICATORS

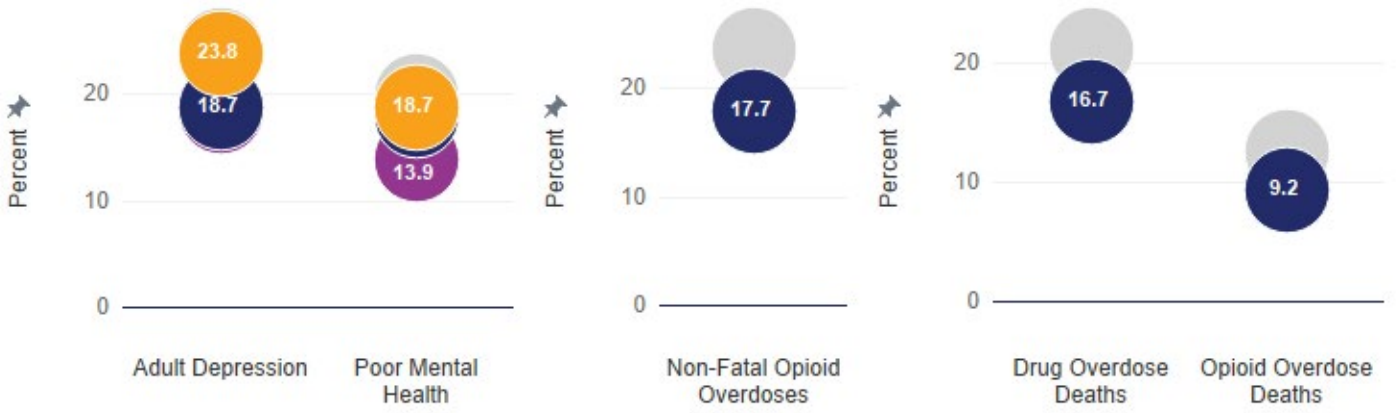


MENTAL HEALTH AND SUBSTANCE USE

TABLE 13: MENTAL HEALTH AND SUBSTANCE USE INDICATORS AND RATES

		Le Flore County	Sebastian County	Sequoyah County	Community Average	State	National
Excessive Drinking	*Percentage of adults reporting binge or heavy drinking*	13.8	14.2	13.7	13.9	17.3	19.2
Poor Mental Health	*Percentage of adults ages 18 or older reporting poor mental health for 14 or more days*	18.5	17.9	19.8	18.7	18.0	13.9
Youth Depression	*Percentage of public school students in 6th, 8th, 10th, and 12th grade who had feelings of depression all of the time in the past 30 days*	Data Not Available	11.4	Data Not Available	Data Not Available	12.1	Data Not Available
Adult Depression	*The prevalence of depression among Medicare fee-for-service beneficiaries*	24.2	23.7	23.4	23.8	18.7	18.4
Suicide Deaths	*The rate of deaths by suicide (ICD-10 codes U03, X60-X84, Y87.0) per 100,000 population (age-adjusted)*	19.7	18.1	19.4	19.1	18.8	13.8
Non-Fatal Opioid Overdoses	*Non-fatal opioid overdoses per 100,00 population (based on county of occurrence)*	Data Not Available	23.5	Data Not Available	Data Not Available	17.7	Data Not Available
Opioid Overdose Deaths	*Opioid-related deaths per 100,00 population (based on county of occurrence)*	Data Not Available	12.5	Data Not Available	Data Not Available	9.2	Data Not Available
Drug Overdose Deaths	*Opioid-related deaths per 100,00 population (based on county of occurrence)*	Data Not Available	21.1	Data Not Available	Data Not Available	16.7	Data Not Available

FIGURE 13: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT MENTAL HEALTH AND SUBSTANCE USE INDICATORS



COVID-19

TABLE 14: COVID-19 INDICATORS AND RATES

		Le Flore County	Sebastian County	Sequoyah County	Community Average	State	National
COVID-19 Cases	*The incidence rate of confirmed COVID-19 cases per 100,000 population, as of May 12, 2022*	24,990.0	25,692.6	25,821.4	25,501.3	26,900.1	24,718.7
COVID-19 Deaths	*The rate of deaths among patients with confirmed cases of COVID-19 per 100,000 population, as of May 12, 2022*	214.1	411.7	257.4	294.4	378.6	301.3
Adults Fully Vaccinated	*The percentage of adults fully vaccinated for COVID-19, as of May 11, 2022*	48.3	59.0	49.5	52.3	58.4	73.8
Adult COVID-19 Vaccine Hesitancy	*The percentage of the population estimated to be hesitant toward receiving a COVID-19 vaccine*	20.6	20.7	21.4	20.9	20.4	10.3

FIGURE 14: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT COVID-19 INDICATORS

BAPTIST HEALTH MEDICAL CENTER

STUTTGART

About Baptist Health Medical Center-Stuttgart

The original Stuttgart Memorial Hospital opened in 1957. In 2009 the facility became a part of the Baptist Health system. Baptist Health Medical Center-Stuttgart is licensed by the state of Arkansas for 49 acute care beds.

This hospital is one of eleven Baptist Health hospitals in Arkansas and is a member of the Arkansas and American Hospital Association, major health networks, and is Medicare certified.

Baptist Health Medical Center-Stuttgart is a growing healthcare facility dedicated to serving the people of Arkansas County and surrounding areas with quality care delivered by knowledgeable and caring professionals. To better serve the community, Baptist Health Family Clinic-Brinkley, Baptist Health Family Clinic-Clarendon, Baptist Health Family Clinic-DeWitt, Baptist Health Family Clinic-England, Baptist Health Family Clinic-Hazen, Baptist Health Stuttgart Medical Clinic, and Baptist Health Therapy Center-Stuttgart are operated by Baptist Health Medical Center-Stuttgart.

2020-2022 Accomplishments

Cancer:

- Increased Access to Cancer related screenings by the following; Completing a total of 552 colonoscopies from 2020-2022
- Completed 227 Mammogram Screenings for Riceland Foods
- Hosted a Meet and Greet with a family medical doctor and APRN to address concerns about health.

Mental Health/Drug Abuse:

- Partnered with Baptist Health -Little rock to increase access to mental health assistance through distance counseling services. This type of telehealth allows individuals across the state to talk to a counselor located in Little Rock via video, email or phone.
- Utilized Baptist Health Command Center to reduce barriers to access to Behavioral Health services.

COMMUNITY HEALTH NEEDS ASSESSMENT – IMPLEMENTATION PLAN 2023-2025

Baptist Health Medical Center - Stuttgart

IDENTIFIED COMMUNITY HEALTH NEED: **Access to Healthcare Services**

GOALS / OBJECTIVES:

Utilize the Mobile Health Unit (MHU) to provide preventive screenings and increase access to care.

STRATEGY #1

Utilize the Mobile Health Unit (MHU) and Community Partnerships to provide preventive screenings and increase access to care.

Action Steps:

1. Utilize the MHU to offer back tol immunizations, flu shots and Covid-19 Vaccinations
2. Identify the communities in most need and schedule monthly screenings utilizing the MHU.
3. Partner with Regional Hospitals to utilize the MHU to deliver screenings in their service areas.
4. Register all participants in the Epic System.
5. Utilize Baptist Health Virtual Care on the MHU to offer additional care for patients in need.
6. Provide evening and weekend screening times to meet the needs of specific populations
7. Provide Preventative Health Screenings for Diabetes, Hypertension, Cholesterol and Covid-19.
8. Utilize the Findhelp.org system to refer and track patents in need of additional resources

Performance Metrics:

1. Track and Report the number of individuals screened and vaccinated on the Mobile Health Unit
2. Track and report the number of patients utilizing virtual care on the MHU.
3. Track and report the number of patients enrolled in EPIC and MyChart.
4. Track and report the number of patients utilizing the Findhelp.org system for resources
5. Track and report the number of Regional Hospital Community Events offered via the MHU

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:

Community Centers, Local schools, faith based community and other not-for-profit agencies

Resources Hospital Plans to Commit to Address Health Need:	Estimated Completion Date:	Person(s) / Department Responsible:
• Staff and Printing	• Ongoing	• Nursing Department, Community Outreach Director, Mobile Health Unit Driver

COMMUNITY HEALTH NEEDS ASSESSMENT – IMPLEMENTATION PLAN 2023-2025

Baptist Health Medical Center - Stuttgart

IDENTIFIED COMMUNITY HEALTH NEED: **Mental Health**

GOALS / OBJECTIVES:

Increase awareness and support of community members dealing with mental health concerns.

STRATEGY #1

Reduce the stigma associated with mental health through education and treatment .

Action Steps:

1. Pilot a “Make it Okay” campaign designed to reduce the stigma of mental illness in at least one community.
2. Offer annual based Mental Health First Aid presentations to community groups and faith-based organizations.
3. Offer an annual Mental Health First Aid training for staff, pastoral care and other system-wide health care providers.
4. Host seminars, presentations with an emphasis on decreasing stigma.
5. Offer Depression and ACES Screening Tools at Community events.
6. Provide education and outreach efforts via seminars, events and telehealth on the relationship between substance abuse and mental health.
7. Continue to offer psychiatric care and referrals
8. Utilize Findhelp.org and the 211 system to refer individuals for Mental Health Services

Performance Metrics:

1. Number of individuals reached with the “Make it Okay” Initiative
2. Number of Mental Health First Aid Trainings for staff will be tracked and reported.
3. Number of Community Based Mental Health First Aid Presentations will be tracked and reported.
4. Number of Depression Screening will be tracked and reported
5. Number of referrals and follow-ups will be tracked and reported.
6. Number of seminars, presentations will be tracked and reported.
7. Track the number of individuals referred for additional resources and services

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:

Faith Based Communities, Adverse Childhood Experiences Statewide Coalition

Resources Hospital Plans to Commit to Address Health Need:	Estimated Completion Date:	Person(s) / Department Responsible:
• Community Outreach Staff, Pharmacy, Pastoral Care and Behavioral Health	• Ongoing	• Baptist Health Community Outreach, Nursing Department

COMMUNITY HEALTH NEEDS ASSESSMENT – IMPLEMENTATION PLAN 2023-2025

Baptist Health Medical Center - Stuttgart

IDENTIFIED COMMUNITY HEALTH NEED: **Nutrition & Food Security**

GOALS / OBJECTIVES:

Initiate Evidence Based Nutrition Security strategies to address obesity, diabetes, hypertension, and other diet-related chronic conditions.

STRATEGY #1

Increase access to nutrition education and information among community members

Action Steps:

1. Implement Maintain, Don't Gain holiday challenge program for adult community members that encourages using stress management strategies, physical activity, and healthful food choices during the holiday season to maintain one's physical and mental health and avoid holiday weight gain.
2. Implement Around the Table program targeting youth, young adults and parents of young children focusing on creating healthy connections between food, oneself, and one's community.
3. Implement Eat Healthy, Be Active program for adult community members. a program based on the Dietary Guidelines and Physical Activity Guidelines for Americans and teaches participants to make incremental lifestyle changes to improve their health.
4. Implement Cooking Matters, grocery store tour and cooking program targeting adults and parents participating in the WIC program with the goal to empower participants with skills to shop for healthful foods on a budget to maximize limited food resources..
5. Implement Cooking with Community Outreach classes to empower participants to build cooking skills, cook more healthy meals, reduce food waste, and make healthier selections at the grocery store.
6. Utilize the Epic System to screening for Food Insecurity for inpatients visits
7. Partner with AHG clinics to screen for Food Insecurity and provide food through the FoodRX program for those in need

Performance Metrics:

1. Number of Participants registered for educational Programs will be tracked and reported
2. Coordinate implementation of 3 Maintian, Don't Gain Holiday Challenge
3. Pilot 2 "Around the Table Series targeting Youth
4. Implement 2 Eat Healthy Be Active Programs
5. Implement 3 Cooking Matters Grocery Store Tours

Performance Metrics: (continued)

6. Host 2 Community -Based Community Outreach Cooking Classes
7. Track and report the number of patents screened for Food insecurity
8. Track and report the number of patients receiving services from the FoodRX program

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:

Arkansas Hunger Relief Alliance, Central AR Library System, Be Mighty

Resources Hospital Plans to Commit to Address Health Need:	Estimated Completion Date:	Person(s) / Department Responsible:
• Community Outreach Staff, Pharmacy Manager	• Ongoing	• Community Outreach Team, Nursing Department

STUTTGART

ASSESSMENT PREPARED BY ACHI
INSPIRING HEALTHY ACTS

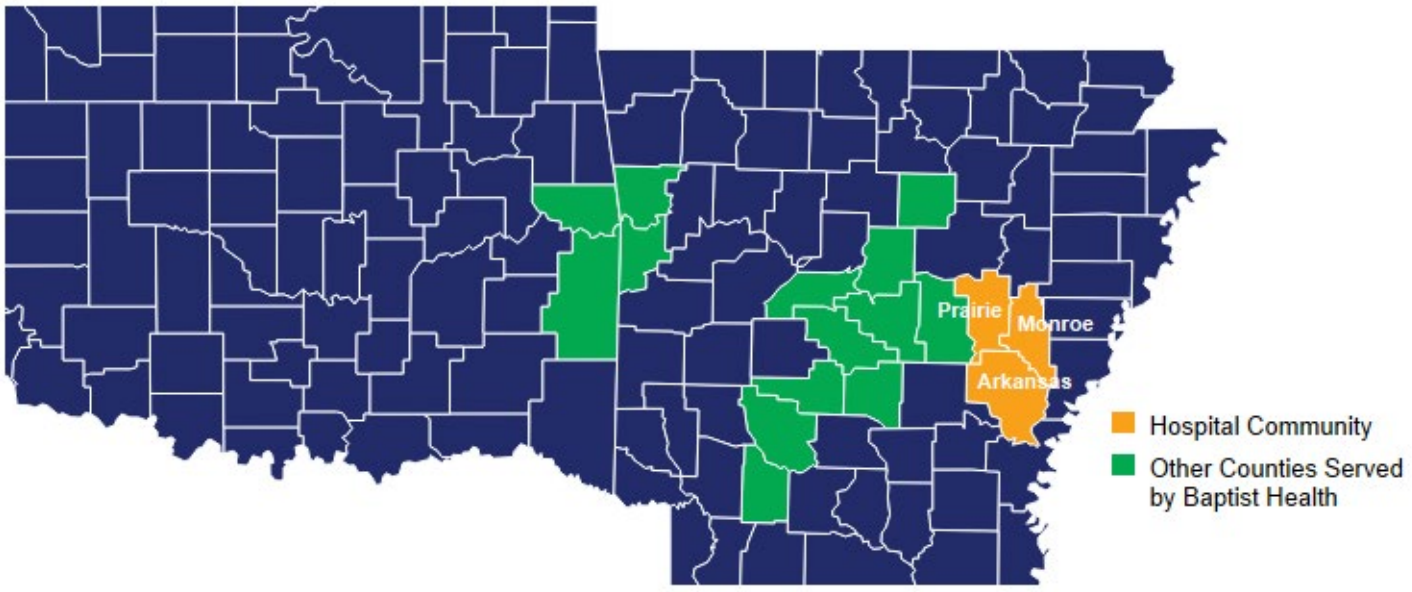
Introduction

Baptist Health engaged the Arkansas Center for Health Improvement (ACHI) to conduct the quantitative data collection and analysis for the 2022 Community Health Needs Assessment (CHNA) process. Baptist Health provided ACHI with the counties served for each of its 11 hospital communities. A total of 15 Arkansas counties and two Oklahoma counties were included in the CHNA.

This report shows the qualitative results from the CHNA for the Baptist Health Medical Center-Stuttgart hospital community, which include Arkansas, Prairie, and Monroe counties.

HOSPITAL COMMUNITY

FIGURE 1: COUNTIES SERVED BY BAPTIST HEALTH MEDICAL CENTER-STUTTGART



Qualitative Results

Quantitative results from the CHNA for the Baptist Health Medical Center-Stuttgart hospital community are reported below. There are 12 sections: Demographics, Health Outcomes, Cause of Death, Chronic Conditions, Health Behaviors, Prevention, Access, Social and Economic Factors, Environment, Diagnoses Incidence Within Hospital Community at Discharge, Mental Health and Substance Use, and COVID-19.

Each section includes a table with health indicator data for each county in the hospital community, a community average for each measurement, and averages for the state of Arkansas and the United States. If data were not available or were suppressed, “Data Not Available” 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 document and Appendix 1.

DEMOGRAPHICS

TABLE 1: AGE AND SEX

		Arkansas County	Monroe County	Prairie County	State	National
Total Population	*Number*	17,914.0	7,050.0	8,189.0	2,999,370.0	324,697,795.0
Ages 0-4	*Percent*	6.4	6.2	5.4	6.3	6.1
Ages 5-17	*Percent*	16.5	14.8	14.7	17.2	16.5
Ages 18-24	*Percent*	7.8	7.7	6.9	9.5	9.4
Ages 25-34	*Percent*	11.6	9.3	10.6	13.1	13.9
Ages 35-44	*Percent*	11.5	10.3	10.5	12.3	12.6
Ages 45-54	*Percent*	12.6	13.1	13.5	12.4	13.0
Ages 55-64	*Percent*	14.7	15.9	15.1	12.7	12.9
Ages 65+	*Percent*	19.0	22.8	23.4	16.6	15.6
Male	*Percent*	47.8	46.9	50.0	49.1	49.2
Female	*Percent*	52.2	53.1	50.0	50.9	50.8

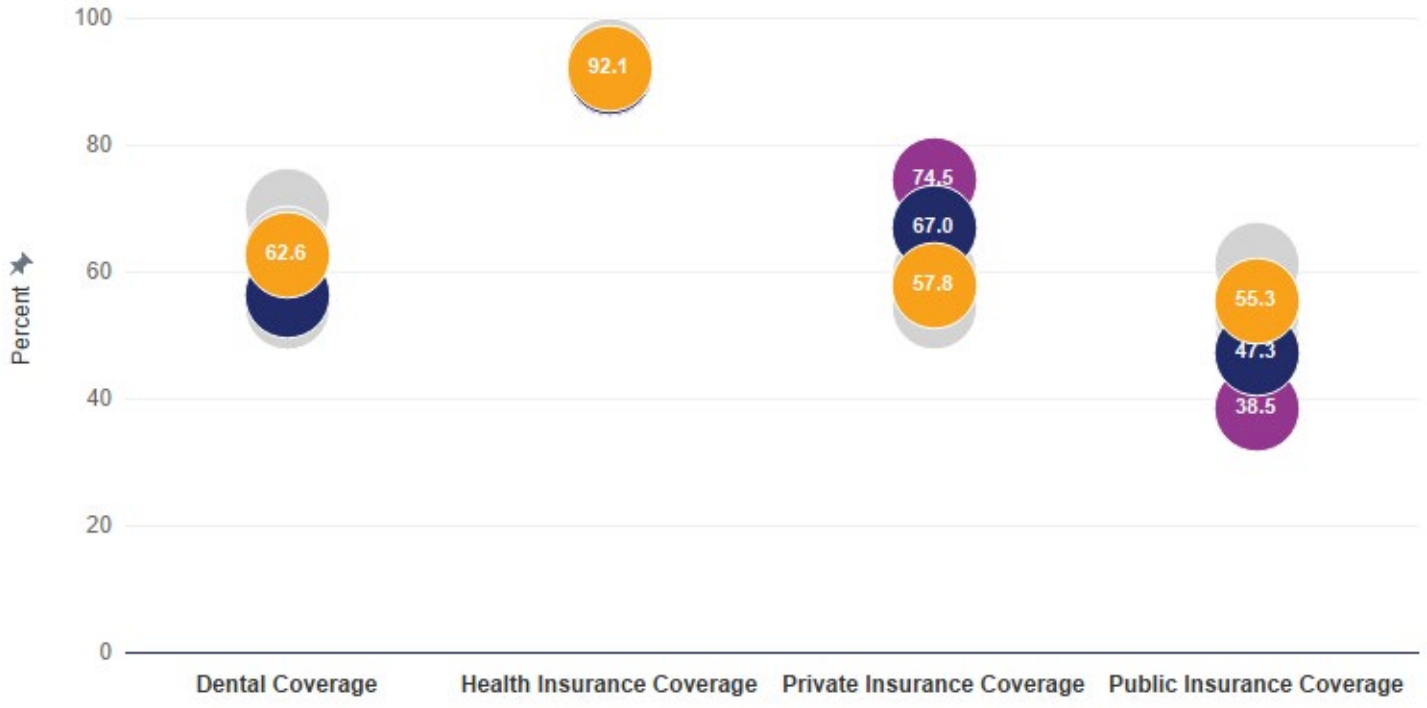
TABLE 2: RACE, ETHNICITY, AND LANGUAGE

		Arkansas County	Monroe County	Prairie County	State	National
Total Population	*Number*	17,914.0	7,050.0	8,189.0	2,999,370.0	324,697,795.0
Hispanic or Latino	*Percent*	3.2	0.6	1.7	7.5	18.0
Non-Hispanic White	*Percent*	69.8	54.2	84.7	72.4	60.7
Black or African American	*Percent*	25.9	43.0	12.4	15.3	12.7
Native American/Alaska Native	*Percent*	0.2	0.3	0.4	0.7	0.9
Asian	*Percent*	0.0	0.4	0.2	1.5	5.6
Native Hawaiian/Pacific Islander	*Percent*	0.0	0.0	0.0	0.3	0.2
Some Other Race	*Percent*	0.5	0.2	0.7	2.8	4.9
Two or More Races	*Percent*	1.3	1.6	0.6	2.7	3.3
Non-English Language Households	*Percent*	0.5	0.0	0.2	1.6	4.4

TABLE 3: INSURANCE COVERAGE

		Arkansas County	Monroe County	Prairie County	Community Average	State	National
Health Insurance Coverage	*Percentage of total civilian non-institutionalized population with health insurance coverage*	93.2	91.1	92.2	92.1	91.5	91.2
Private Insurance Coverage	*Percentage of total civilian non-institutionalized population with private health insurance coverage*	59.7	54.5	59.3	57.8	67.0	74.5
Public Insurance Coverage	*Percentage of total civilian non-institutionalized population with public health insurance coverage*	53.3	61.1	51.5	55.3	47.3	38.5
Dental Coverage	*Percentage of Arkansas residents with evidence of any dental coverage in the All-Payer Claims Database (APCD)*	63.6	69.6	54.5	62.6	56.2	Data Not Available

FIGURE 2: COMMUNITY, STATE, AND NATIONAL COMPARISON OF INSURANCE COVERAGE

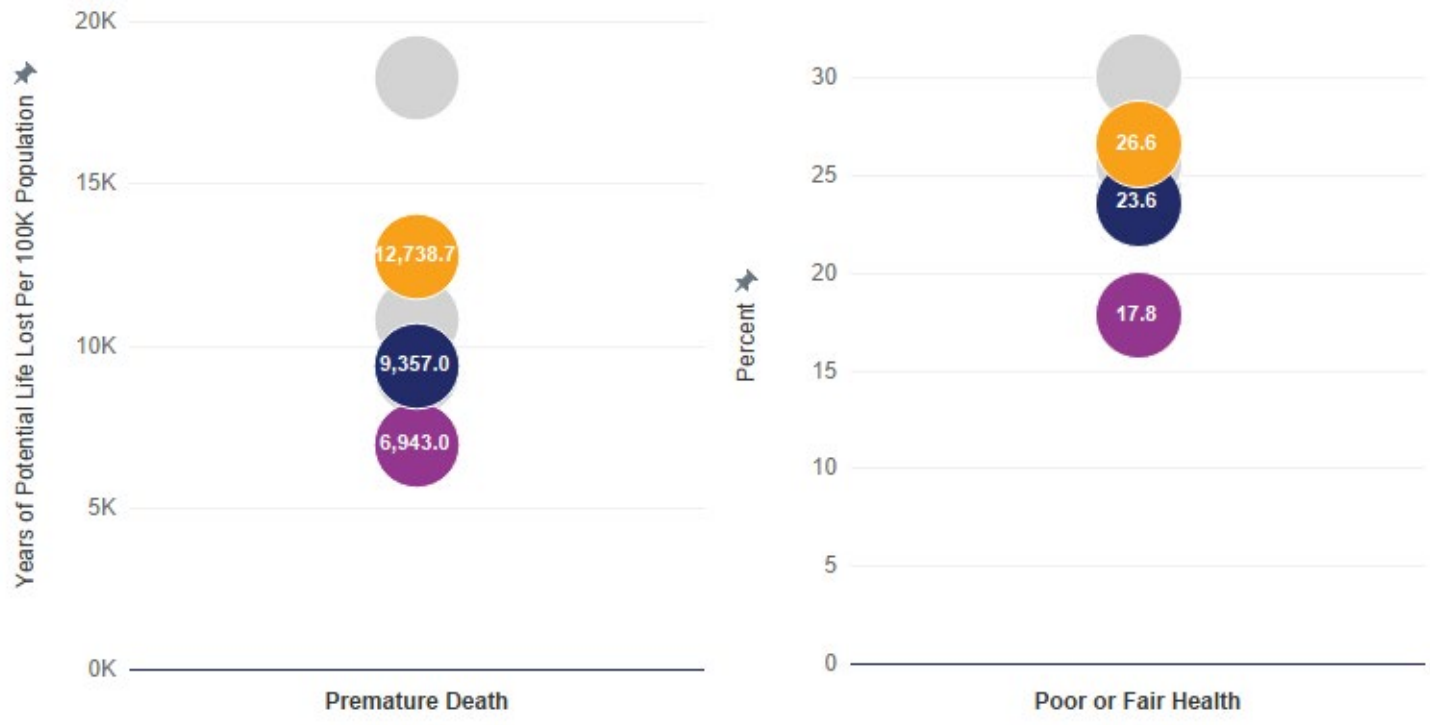


HEALTH OUTCOMES

TABLE 4: HEALTH OUTCOMES INDICATORS AND RATES

		Arkansas County	Monroe County	Prairie County	Community Average	State	National
Premature Death	*Years of potential life lost before age 75 per 100,000 population (age-adjusted)*	10,791.0	18,263.0	9,162.0	12,738.7	9,357.0	6,943.0
Poor or Fair Health	*Percentage of adults reporting poor or fair health*	25.6	30.0	24.1	26.6	23.6	17.8
Poor Physical Health Days	*Average number of physically unhealthy days reported in past 30 days (age-adjusted)*	5.5	6.0	5.3	5.6	4.9	4.0
Low Birthweight	*Percentage of live births with low birth weight (<2500g)*	9.9	11.7	8.6	10.1	9.1	8.2

FIGURE 3: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT HEALTH OUTCOMES INDICATORS

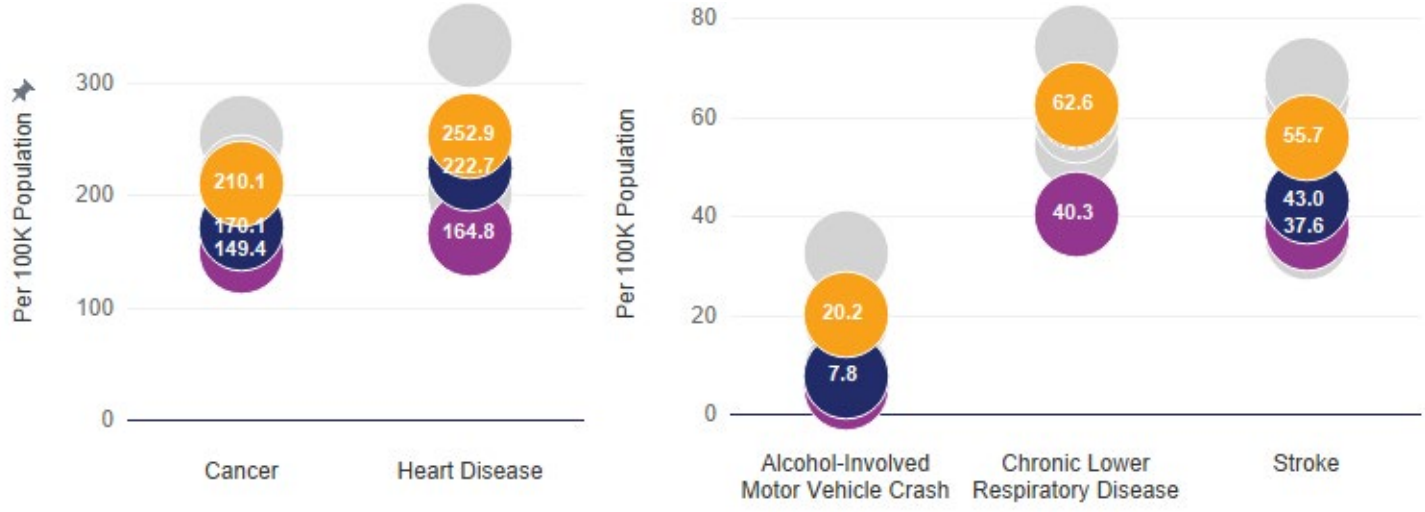


CAUSE OF DEATH

TABLE 5: CAUSE OF DEATH INDICATORS AND RATES

		Arkansas County	Monroe County	Prairie County	Community Average	State	National
All Causes	*All causes of deaths per 100,000 population (age-adjusted)*	1,006.4	1,133.2	808.6	982.7	888.4	727.2
Cancer	*5-year average rate of death due to malignant neoplasm (cancer) per 100,000 population (age-adjusted)*	215.3	250.7	164.2	210.1	170.1	149.4
Stroke	*5-year average rate of death due to cerebrovascular disease (stroke) per 100,000 population (age-adjusted)*	67.7	63.9	35.5	55.7	43.0	37.6
Chronic Lower Respiratory Disease	*Rate of deaths due to chronic lower respiratory disease per 100,000 population (age-adjusted)*	59.3	54.2	74.3	62.6	62.1	40.3
Diabetes	*Diabetes deaths per 100,000 population (age-adjusted)*	39.7	Data Not Available	43.7	Data Not Available	29.0	21.4
Heart Disease	*Rate of death due to heart disease per 100,000 population (age-adjusted)*	223.9	333.2	201.5	252.9	222.7	164.8
Unintentional Injury	*5-year average rate of death due to unintentional injury (accident) per 100,000 population (age-adjusted)*	73.9	104.5	41.0	73.1	51.7	50.4
Motor Vehicle Crash	*5-year average rate of death due to motor vehicle crash per 100,000 population (age-adjusted)*	32.1	Data Not Available	Data Not Available	Data Not Available	18.9	11.5
Alcohol-Involved Motor Vehicle Crash	*Rate of persons killed in motor vehicle crashes involving alcohol as a rate per 100,000 population*	8.8	32.7	19.1	20.2	7.8	5.3

FIGURE 4: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT CAUSE OF DEATH INDICATORS

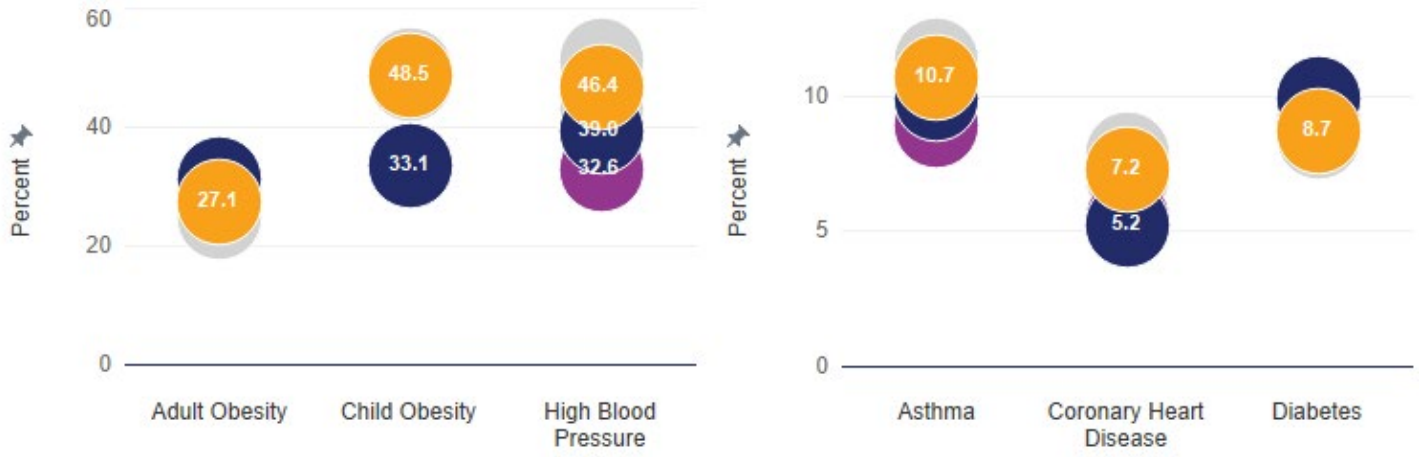


CHRONIC CONDITIONS

TABLE 6: CHRONIC CONDITIONS INDICATORS AND RATES

		Arkansas County	Monroe County	Prairie County	Community Average	State	National
High Blood Pressure	*Percentage of adults who have been told they have high blood pressure*	42.9	51.0	45.3	46.4	39.0	32.6
Asthma	*Percentage of adults who have been told they currently have asthma (age-adjusted)*	10.5	11.3	10.2	10.7	9.9	8.9
Coronary Heart Disease	*Percentage of adults who have been told they have angina or coronary heart disease (age-adjusted)*	7.0	7.8	6.9	7.2	5.2	5.4
Arthritis	*Percentage of adults ages 18 or older diagnosed with some form of arthritis*	32.4	27.9	36.8	32.4	34.3	Data Not Available
High Cholesterol	*Percentage of adults who have had their blood cholesterol checked and have been told it was high*	39.0	42.0	41.2	40.7	36.7	33.6
Diabetes	*Percentage of adults ages 20 and older who have ever been told by a doctor that they have diabetes (age-adjusted)*	8.5	8.9	8.7	8.7	9.9	9.0
Adult Obesity	*Percentage of adults ages 20 and older who report a BMI higher than 30*	30.1	24.4	26.8	27.1	31.0	27.6
Child Obesity	*Percentage of students classified as overweight or obese, by county location of school*	49.2	48.7	47.6	48.5	33.1	Data Not Available

FIGURE 5: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT CHRONIC CONDITIONS INDICATORS



HEALTH BEHAVIORS

TABLE 7: HEALTH BEHAVIORS INDICATORS AND RATES

		Arkansas County	Monroe County	Prairie County	Community Average	State	National
Adult Smoking	*Percentage of adults who are current smokers (age-adjusted)*	23.7	25.9	23.2	24.3	21.2	15.7
Youth Vaping	*Percentage of public school students in 6th, 8th, 10th, and 12th grade who used any vape in the past 30 days*	17.0	Data Not Available	Data Not Available	Data Not Available	11.7	Data Not Available
Physical Inactivity	*Percentage of adults ages 20 or older reporting no physical activity in the past month*	28.9	22.7	23.3	25.0	26.2	22.0
Sexually Transmitted Infections	*Number of newly diagnosed chlamydia cases per 100,000 population*	645.6	903.3	375.8	641.6	587.9	539.9
Teen Births	*The seven-year average number of teen births per 1,000 female population, ages 15-19*	53.5	59.6	44.0	52.4	35.5	20.9

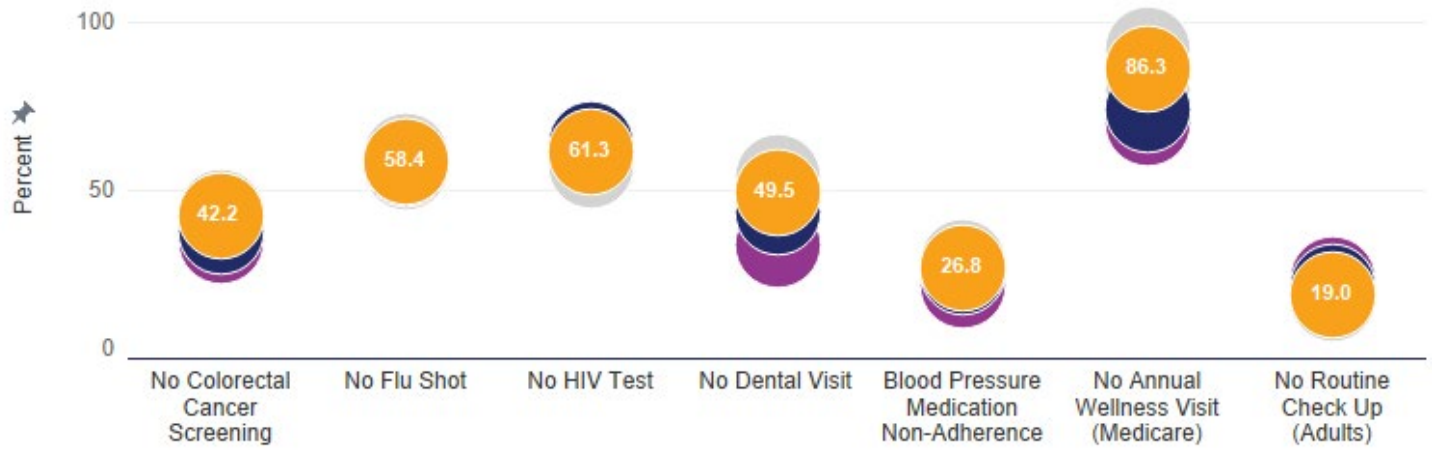
FIGURE 6: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT HEALTH BEHAVIORS INDICATORS

PREVENTION

TABLE 8: PREVENTION INDICATORS AND RATES

		Arkansas County	Monroe County	Prairie County	Community Average	State	National
No Pap Test	*Percentage of women ages 21 to 65 who have not had a pap test within the past 3 years (age-adjusted)*	16.6	17.9	17.1	17.2	16.3	14.5
No Colorectal Cancer Screening	*Percentage of adults ages 50-75 who have never had either a sigmoidoscopy or colonoscopy (age-adjusted)*	42.3	43.5	40.8	42.2	38.1	35.0
No Flu Shot	*Percentage of adults ages 18 or older who have not had a flu shot in the past year*	57.9	60.5	56.8	58.4	58.5	58.1
No HIV Test	*Percentage of adults ages 18 or older who have never been screened for HIV*	57.2	63.3	63.4	61.3	63.6	Data Not Available
No Dental Visit	*Percentage of adults ages 18 or older who have not had a dentist or dental clinic visit in the previous year (age-adjusted)*	48.2	54.2	46.0	49.5	43.4	33.8
Blood Pressure Medication Non-Adherence	*The percentage of Medicare enrollees who did not adhere to blood pressure medication schedules*	28.4	25.0	27.0	26.8	25.9	21.8
No Annual Wellness Visit (Medicare)	*The percentage of Medicare enrollees who did not have an annual wellness visit in the past year*	92.0	87.0	80.0	86.3	74.0	70.0
No Routine Check Up (Adults)	*The percentage of adults age 18 or older with no routine check up with a doctor in the past year*	20.1	17.5	19.3	19.0	21.0	23.4

FIGURE 7: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT PREVENTION INDICATORS

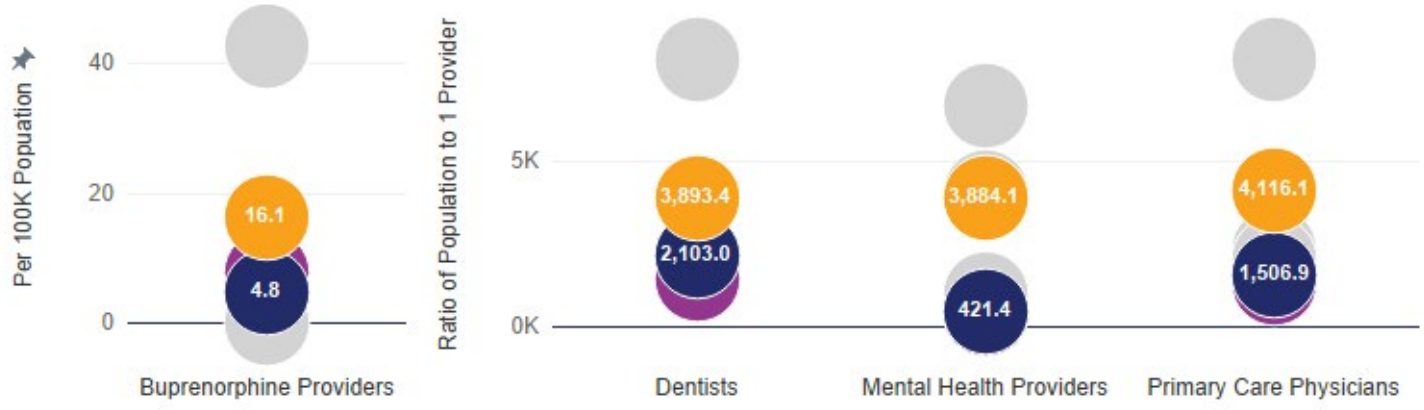


ACCESS

TABLE 9: ACCESS INDICATORS AND RATES

		Arkansas County	Monroe County	Prairie County	Community Average	State	National
Mammography	*Percentage of female Medicare enrollees ages 65-74 who received an annual mammography screening*	34.0	32.0	37.0	34.3	38.0	42.0
Diabetic Monitoring	*Percentage of diabetic Medicare enrollees over age 65 who had a hemoglobin A1c test in the past year*	78.9	91.2	90.6	86.9	88.5	87.5
Uninsured	*Percentage of adults under age 65 without health insurance coverage*	9.8	9.6	9.6	9.7	10.8	10.8
Primary Care Physicians	*Ratio of population to one primary care physician*	1,974.3	2,300.0	8,074.0	4,116.1	1,506.9	1,319.0
Dentists	*Ratio of population to one dentist*	1,942.9	1,675.3	8,062.0	3,893.4	2,103.0	1,404.5
Mental Health Providers	*Ratio of population to one mental health provider*	920.3	6,701.0	4,031.0	3,884.1	421.4	382.3
Addiction or Substance Use Providers	*Rate of addiction or substance use providers per 100,000 population*	0.0	0.0	0.0	0.0	4.4	20.4
Buprenorphine Providers	*Rate of buprenorphine providers per 100,000 population*	5.6	42.8	0.0	16.1	4.8	7.6
Preventable Hospital Stays	*Number of hospital stays for ambulatory care-sensitive conditions per 1,000 Medicare enrollees*	4,981.0	4,403.0	5,202.0	4,862.0	4,769.0	4,236.0

FIGURE 8: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT ACCESS INDICATORS

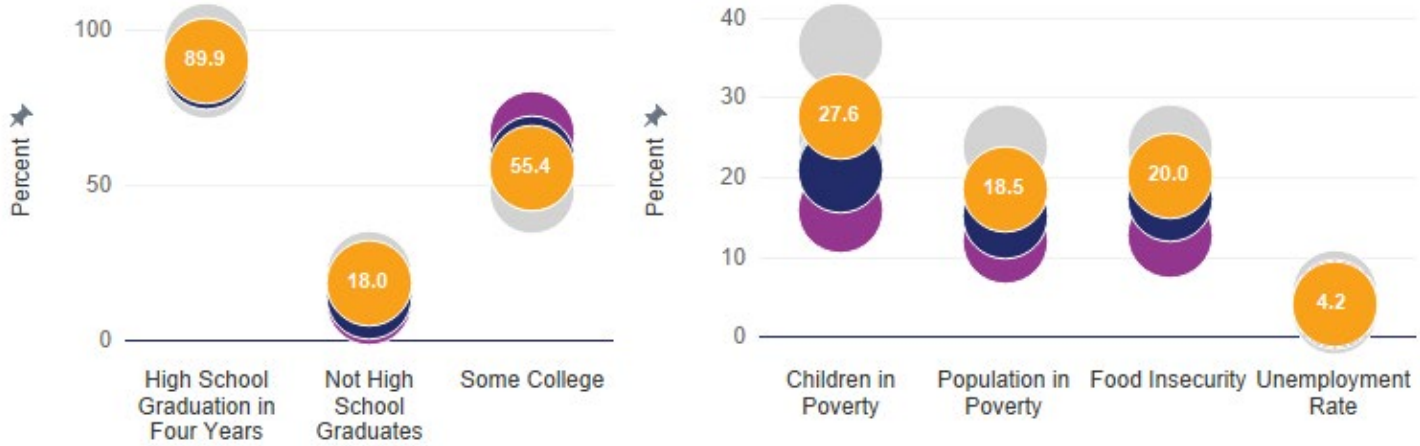


SOCIAL AND ECONOMIC FACTORS

TABLE 10: SOCIAL AND ECONOMIC FACTORS INDICATORS AND RATES

		Arkansas County	Monroe County	Prairie County	Community Average	State	National
Not High School Graduates	*Percentage of adults ages 25 or older without a high school diploma*	16.1	21.1	16.8	18.0	13.4	12.0
High School Graduation in Four Years	*Percentage of ninth-grade cohort who graduated in four years*	84.7	90.0	94.9	89.9	88.2	87.7
Some College	*Percentage of adults ages 25-44 with some post-secondary education*	55.4	47.9	62.9	55.4	58.5	66.1
Unemployment Rate	*Unemployment rate among civilian non-institutionalized population age 16 and older in January 2022*	3.9	5.4	3.2	4.2	3.8	4.4
Children in Poverty	*Percentage of children under age 18 below the poverty line*	21.8	36.5	24.4	27.6	20.8	15.7
Population in Poverty	*Percentage of population below the federal poverty line*	17.2	23.8	14.5	18.5	15.2	11.9
Children in Single-Parent Households	*Percentage of children who live in a household headed by single parent*	31.0	57.1	23.2	37.1	28.9	25.5
Homeless Children	*Rate of homelessness among public school students*	3.3	4.7	4.2	4.1	2.8	2.8
Food Insecurity	*Percentage of the population that experienced food insecurity in the report year*	19.4	23.8	16.9	20.0	17.3	12.6
Social Associations	*Number of membership associations per 100,000 population*	120.9	85.9	149.2	118.7	126.5	105.0
Violent Crimes	*Annual rate of reported violent crimes per 100,000 population*	586.3	659.6	154.4	466.8	549.2	416.0

FIGURE 9: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT SOCIAL AND ECONOMIC FACTORS INDICATORS



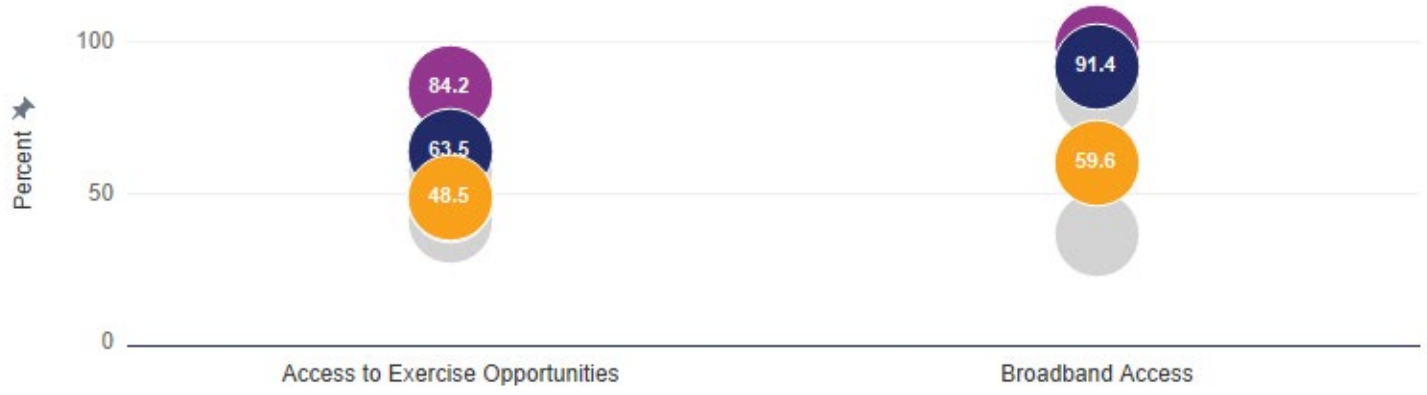
ENVIRONMENT

TABLE 11: ENVIRONMENT INDICATORS AND RATES

		Arkansas County	Monroe County	Prairie County	Community Average	State	National
Food Environment Index	*Index of factors that contribute to a healthy food environment, 0 (worst) to 10 (best)*	5.4	5.9	5.7	5.7	5.1	7.8
Drinking Water Violations	*The total number of drinking water violations recorded in a two-year period*	0.0	5.0	0.0	1.7	118.0	4,739.0
Access to Exercise Opportunities	*Percentage of population with adequate access to locations for physical activity*	48.0	57.0	40.7	48.5	63.5	84.2
Severe Housing Problems	*Percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, or lack of kitchen or plumbing*	9.8	13.7	11.2	11.6	14.1	17.5
Broadband Access	*Percentage of population in a high-speed internet service area; access to DL speeds > 25MBPS (2020)*	82.2	36.4	60.1	59.6	91.4	97.5
Long Commute Driving Alone	*Among workers who commute in their car alone, the percentage who commute more than 30 minutes*	15.1	32.6	42.1	29.9	27.0	36.6

FIGURE 10: COMMUNITY, STATE, AND NATIONAL COMPARISON OF THE FOOD ENVIRONMENT INDEX INDICATOR

FIGURE 11: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT ENVIRONMENT INDICATORS



DIAGNOSES INCIDENCE WITHIN HOSPITAL COMMUNITY AT DISCHARGE

TABLE 12: DIAGNOSES INCIDENCE WITHIN HOSPITAL COMMUNITY AT DISCHARGE INDICATORS AND RATES

		Arkansas County	Monroe County	Prairie County	Community Average	State
Arthritis	*Number of individuals 18 years and older discharged with a primary or secondary arthritis diagnosis as a percentage of the population 18 years and older*	3.3	4.2	3.6	3.7	2.3
Diabetes	*Number of individuals 18 years and older discharged with a primary or secondary diabetes diagnosis as a percentage of the population 18 years and older*	4.2	5.9	5.1	5.1	3.9
Hyperlipidemia	*Number of individuals 18 years and older discharged with a primary or secondary hyperlipidemia diagnosis as a percentage of the population 18 years and older*	3.8	6.1	5.5	5.1	3.9
Hypertension	*Number of individuals 18 years and older discharged with a primary or secondary hypertension diagnosis as a percentage of the population 18 years and older*	10.9	14.2	11.7	12.2	9.5
Ischemic Heart Disease	*Number of individuals 18 years and older discharged with a primary or secondary ischemic heart disease diagnosis as a percentage of the population 18 years and older*	2.3	2.9	3.3	2.8	2.5

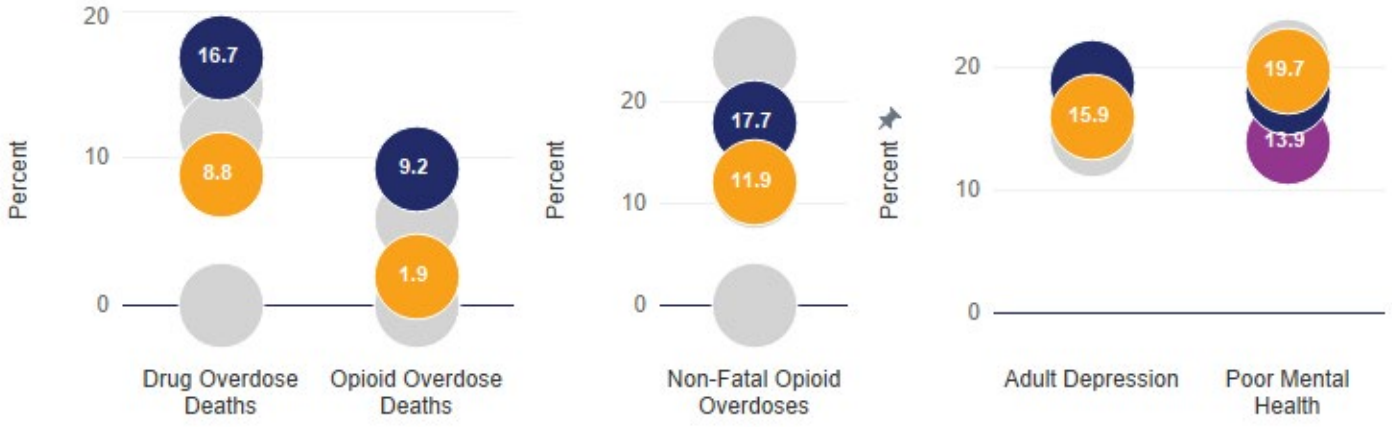
FIGURE 12: DIAGNOSES INCIDENCE WITHIN HOSPITAL COMMUNITY AT DISCHARGE INDICATORS

MENTAL HEALTH AND SUBSTANCE USE

TABLE 13: MENTAL HEALTH AND SUBSTANCE USE INDICATORS AND RATES

		Arkansas County	Monroe County	Prairie County	Community Average	State	National
Excessive Drinking	*Percentage of adults reporting binge or heavy drinking*	14.9	13.6	16.6	15.0	17.3	19.2
Poor Mental Health	*Percentage of adults ages 18 or older reporting poor mental health for 14 or more days*	19.3	20.5	19.3	19.7	18.0	13.9
Youth Depression	*Percentage of public school students in 6th, 8th, 10th, and 12th grade who had feelings of depression all of the time in the past 30 days*	14.3	Data Not Available	Data Not Available	Data Not Available	12.1	Data Not Available
Adult Depression	*The prevalence of depression among Medicare fee-for-service beneficiaries*	14.4	15.0	18.4	15.9	18.7	18.4
Suicide Deaths	*The rate of deaths by suicide (ICD-10 codes U03, X60-X84, Y87.0) per 100,000 population (age-adjusted)*	Data Not Available	Data Not Available	Data Not Available	Data Not Available	18.8	13.8
Non-Fatal Opioid Overdoses	*Non-fatal opioid overdoses per 100,00 population (based on county of occurrence)*	11.7	0.0	24.1	11.9	17.7	Data Not Available
Opioid Overdose Deaths	*Opioid-related deaths per 100,00 population (based on county of occurrence)*	5.8	0.0	0.0	1.9	9.2	Data Not Available
Drug Overdose Deaths	*Opioid-related deaths per 100,00 population (based on county of occurrence)*	11.7	14.7	0.0	8.8	16.7	Data Not Available

FIGURE 13: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT MENTAL HEALTH AND SUBSTANCE USE INDICATORS



COVID-19

TABLE 14: COVID-19 INDICATORS AND RATES

		Arkansas County	Monroe County	Prairie County	Community Average	State	National
COVID-19 Cases	*The incidence rate of confirmed COVID-19 cases per 100,000 population, as of May 12, 2022*	32,050.2	28,058.0	24,325.0	28,144.4	26,900.1	24,718.7
COVID-19 Deaths	*The rate of deaths among patients with confirmed cases of COVID-19 per 100,000 population, as of May 12, 2022*	444.6	507.3	532.6	494.8	378.6	301.3
Adults Fully Vaccinated	*The percentage of adults fully vaccinated for COVID-19, as of May 11, 2022*	66.7	65.4	51.6	61.2	58.4	73.8
Adult COVID-19 Vaccine Hesitancy	*The percentage of the population estimated to be hesitant toward receiving a COVID-19 vaccine*	21.2	22.8	22.7	22.2	20.4	10.3

FIGURE 14: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT COVID-19 INDICATORS

BAPTIST HEALTH MEDICAL CENTER

HOT SPRINGS COUNTY

About 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 on Jan. 1, 2014, making it the eighth hospital in the system.

Baptist Health Medical Center-Hot Spring County built a walking trail to give our employees, volunteers and community a safe place to walk. In partnership with our hospital Auxiliary, we were able to construct a path that spans 1,056 feet on part of our campus. So five loops around and you have one mile! Join the community walking program today!

Awards & Recognitions

- American Heart Association's Get with the Guidelines Stroke Silver Award
- Top 100 Hospitals by Fortune/ IBM Watson Health

2020-2022 Accomplishments

Diabetes:

- Hosted free diabetes education classes and how it relates to health, weight, and nutrition.
- Offer telehealth diabetes education and support classes and sessions and BHMC-Arkadelphia and clinics.
- Implemented the TMF Diabetes Self-Management Education program
- Promoted Virtual Diabetes Support Group Initiative
- Provided Screenings for Diabetes at the Malvern Senior Center

Obesity:

- Provided Educational materials on Diabetes at Community events
- Hosted educational classes nutrition for community members
- Established a relationship with the elementary school to offer nutrition classes for kids. Program postponed due to Covid.

Mental Health:

- Offered in-patient psychiatric treatment
- Offered a evidence based detox program
- Enhanced the systems use of the Command Center to improve access to mental health services
- Baptist Health has been committed to leading the state in providing acute, inpatient care to Arkansans who suffer with the most profound exacerbation of psychiatric symptoms in our Psychiatric Intensive Care Unit and are on course to expand that unit by 50% early next year.
- In addition to our psychiatric services, Baptist Health assists those who are experiencing drug and alcohol addiction. On average, over 1,000 Arkansans were helped to safely detox and get closer to the recovery process.

COMMUNITY HEALTH NEEDS ASSESSMENT – IMPLEMENTATION PLAN 2023-2025

Baptist Health Medical Center - Hot Spring County

IDENTIFIED COMMUNITY HEALTH NEED: **Access to Healthcare Services**

GOALS / OBJECTIVES:

Increase Access to Quality Health Care, Preventive Health Screenings, Vaccinations and Community Resources.

STRATEGY #1

Utilize the Mobile Health Unit (MHU) to provide preventive screenings and increase access to care.

Action Steps:

1. Utilize the MHU to offer back tol immunizations, flu shots and Covid-19 Vaccinations
2. Identify the communities in most need and schedule monthly screenings utilizing the MHU.
3. Partner with Regional Hospitals to utilize the MHU to deliver screenings in their service areas.
4. Register all participants in the Epic System.
5. Utilize Baptist Health Virtual Care on the MHU to offer additional care for patients in need.
6. Provide evening and weekend screening times to meet the needs of specific populations
7. Provide Preventative Health Screenings for Diabetes, Hypertension, Cholesterol and Covid-19.
8. Utilize the Findhelp.org system to refer and track patents in need of additional resources

Performance Metrics:

1. Track and Report the number of individuals screened and vaccinated on the Mobile Health Unit
2. Track and report the number of patients utilizing virtual care on the MHU.
3. Track and report the number of patients enrolled in EPIC and MyChart.
4. Track and report the number of patients utilizing the Findhelp.org system for resources
5. Track and report the number of Regional Hospital Community Events offered via the MHU

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:

Community Centers, Local schools, faith based community and other not-for-profit agencies

Resources Hospital Plans to Commit to Address Health Need:	Estimated Completion Date:	Person(s) / Department Responsible:
• Staff and Printing	• Ongoing	• Pharmacy Manager, Community Outreach Director, Mobile Health Unit Driver

COMMUNITY HEALTH NEEDS ASSESSMENT – IMPLEMENTATION PLAN 2023-2025

Baptist Health Medical Center - Hot Spring County

IDENTIFIED COMMUNITY HEALTH NEED: **Mental Health**

GOALS / OBJECTIVES:

Increase awareness and support of community members dealing with mental health concerns.

STRATEGY #1

Reduce the stigma associated with mental health through education and treatment .

Action Steps:

1. Pilot a “Make it Okay” campaign designed to reduce the stigma of mental illness in at least one community.
2. Offer annual based Mental Health First Aid presentations to community groups and faith-based organizations.
3. Offer an annual Mental Health First Aid training for staff, pastoral care and other system-wide health care providers.
4. Host seminars, presentations with an emphasis on decreasing stigma.
5. Offer Depression and ACES Screening Tools at Community events.
6. Provide education and outreach efforts via seminars, events and telehealth on the relationship between substance abuse and mental health.
7. Continue to offer psychiatric care and referrals
8. Utilize Findhelp.org and the 211 system to refer individuals for Mental Health Services

Performance Metrics:

1. Number of individuals reached with the “Make it Okay” Initiative
2. Number of Mental Health First Aid Trainings for staff will be tracked and reported.
3. Number of Community Based Mental Health First Aid Presentations will be tracked and reported.
4. Number of Depression Screening will be tracked and reported
5. Number of referrals and follow-ups will be tracked and reported.
6. Number of seminars, presentations will be tracked and reported.
7. Track the number of individuals referred for additional resources and services

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:

Faith Based Communities, Adverse Childhood Experiences Statewide Coalition

Resources Hospital Plans to Commit to Address Health Need:	Estimated Completion Date:	Person(s) / Department Responsible:
• Community Outreach Staff, Pharmacy, Pastoral Care and Behavioral Health	• Ongoing	• Baptist Health Community Outreach, Nursing Department

COMMUNITY HEALTH NEEDS ASSESSMENT – IMPLEMENTATION PLAN 2023-2025

Baptist Health Medical Center - Hot Spring County

IDENTIFIED COMMUNITY HEALTH NEED: Nutrition & Food Security

GOALS / OBJECTIVES:

Initiate Evidence Based Nutrition Security strategies to address obesity, diabetes, hypertension, and other diet-related chronic conditions.

STRATEGY #1

Increase access to nutrition education and information among community members

Action Steps:

1. Implement Maintain, Don't Gain holiday challenge program for adult community members that encourages using stress management strategies, physical activity, and healthful food choices during the holiday season to maintain one's physical and mental health and avoid holiday weight gain.
2. Implement Around the Table program targeting youth, young adults and parents of young children focusing on creating healthy connections between food, oneself, and one's community.
3. Implement Eat Healthy, Be Active program for adult community members. a program based on the Dietary Guidelines and Physical Activity Guidelines for Americans and teaches participants to make incremental lifestyle changes to improve their health.
4. Implement Cooking Matters, grocery store tour and cooking program targeting adults and parents participating in the WIC program with the goal to empower participants with skills to shop for healthful foods on a budget to maximize limited food resources..
5. Implement Cooking with Community Outreach classes to empower participants to build cooking skills, cook more healthy meals, reduce food waste, and make healthier selections at the grocery store.
6. Utilize the Epic System to screening for Food Insecurity for inpatients visits
7. Partner with AHG clinics to screen for Food Insecurity and provide food through the FoodRX program for those in need

Performance Metrics:

1. Number of Participants registered for educational Programs will be tracked and reported
2. Coordinate implementation of 3 Maintian, Don't Gain Holiday Challenge
3. Pilot 2 "Around the Table Series targeting Youth
4. Implement 2 Eat Healthy Be Active Programs
5. Implement 3 Cooking Matters Grocery Store Tours
6. Host 20 Community -Based Community Outreach Cooking Classes
7. Track and report the number of patents screened for Food insecurity
8. Track and report the number of patients receiving services from the FoodRX program

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:

Arkansas Hunger Relief Alliance, Central AR Library System, Be Mighty

Resources Hospital Plans to Commit to Address Health Need:

- Community Outreach Staff, Pharmacy Manager

Estimated Completion Date:

- Ongoing

Person(s) / Department Responsible:

- Community Outreach Team, Pharmacy Manager

HOT SPRINGS COUNTY

ASSESSMENT PREPARED BY ACHI
INSPIRING HEALTHY ACTS

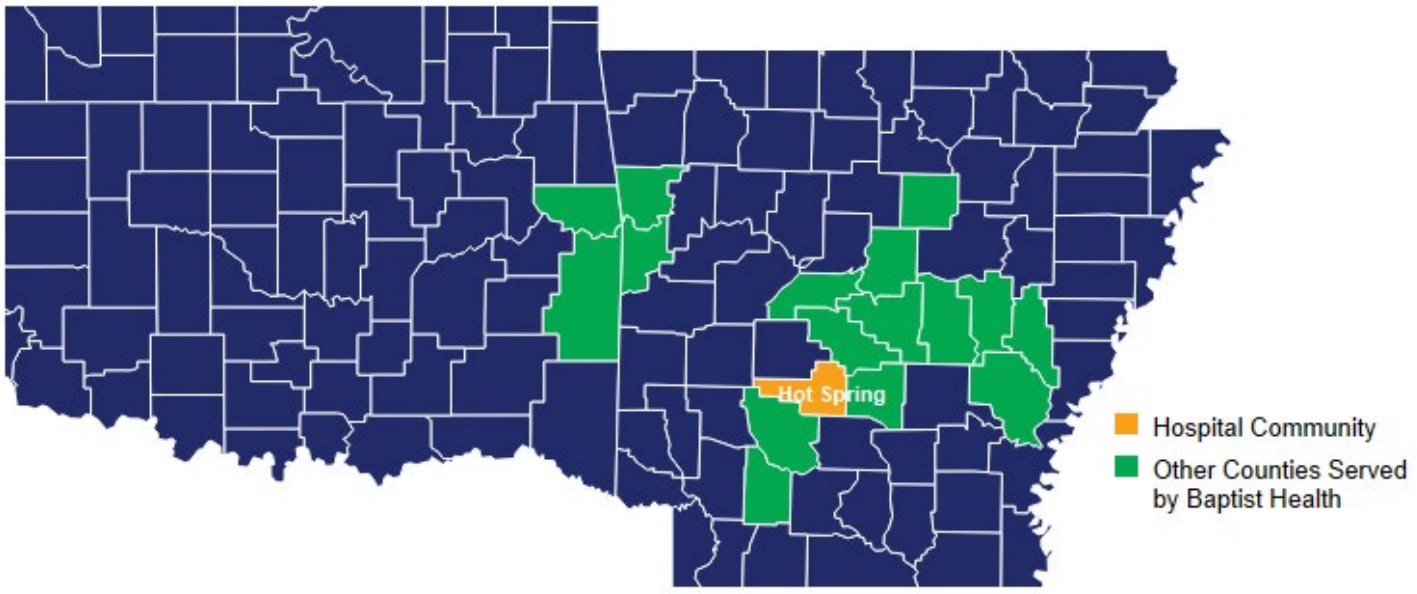
Introduction

Baptist Health engaged the Arkansas Center for Health Improvement (ACHI) to conduct the quantitative data collection and analysis for the 2022 Community Health Needs Assessment (CHNA) process. Baptist Health provided ACHI with the counties served for each of its 11 hospital communities. A total of 15 Arkansas counties and two Oklahoma counties were included in the CHNA.

This report shows the qualitative results from the CHNA for the Baptist Health Medical Center-Hot Spring County hospital community, which includes Hot Spring County.

HOSPITAL COMMUNITY

FIGURE 1: COUNTIES SERVED BY BAPTIST HEALTH MEDICAL CENTER-HOT SPRING COUNTY



Qualitative Results

Quantitative results from the CHNA for the Baptist Health Medical Center-Hot Spring County hospital community are reported below. There are 12 sections: Demographics, Health Outcomes, Cause of Death, Chronic Conditions, Health Behaviors, Prevention, Access, Social and Economic Factors, Environment, Diagnoses Incidence Within Hospital Community at Discharge, Mental Health and Substance Use, and COVID-19.

Each section includes a table with health indicator data for each county in the hospital community, a community average for each measurement, and averages for the state of Arkansas and the United States. If data were not available or were suppressed, “Data Not Available” 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 document and Appendix 1.

DEMOGRAPHICS

TABLE 1: AGE AND SEX

		Hot Spring County	State	National
Total Population	*Number*	33,597.0	2,999,370.0	324,697,795.0
Ages 0-4	*Percent*	4.9	6.3	6.1
Ages 5-17	*Percent*	15.7	17.2	16.5
Ages 18-24	*Percent*	7.2	9.5	9.4
Ages 25-34	*Percent*	14.0	13.1	13.9
Ages 35-44	*Percent*	12.3	12.3	12.6
Ages 45-54	*Percent*	13.3	12.4	13.0
Ages 55-64	*Percent*	14.0	12.7	12.9
Ages 65+	*Percent*	18.7	16.6	15.6
Male	*Percent*	52.0	49.1	49.2
Female	*Percent*	48.0	50.9	50.8

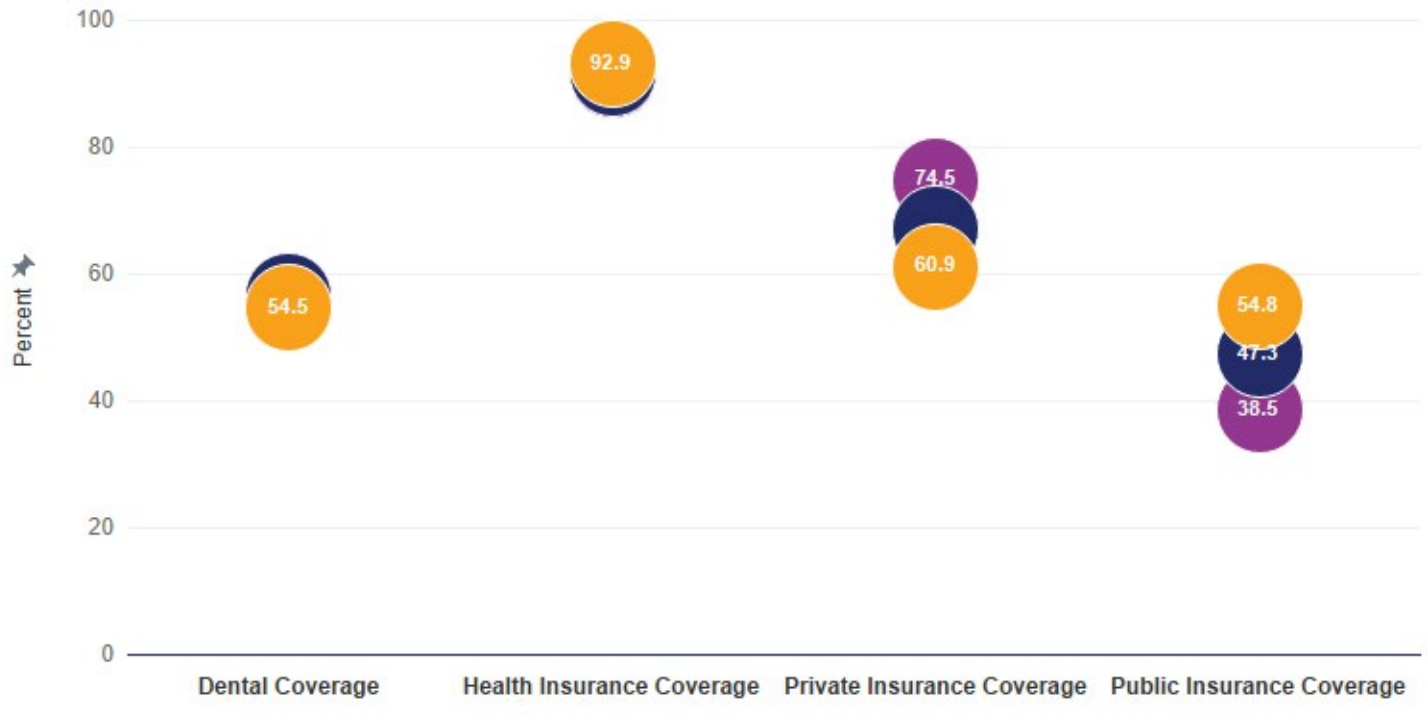
TABLE 2: RACE, ETHNICITY, AND LANGUAGE

		Hot Spring County	State	National
Total Population	*Number*	33,597.0	2,999,370.0	324,697,795.0
Hispanic or Latino	*Percent*	3.5	7.5	18.0
Non-Hispanic White	*Percent*	82.5	72.4	60.7
Black or African American	*Percent*	11.4	15.3	12.7
Native American/Alaska Native	*Percent*	0.5	0.7	0.9
Asian	*Percent*	0.4	1.5	5.6
Native Hawaiian/Pacific Islander	*Percent*	0.0	0.3	0.2
Some Other Race	*Percent*	1.4	2.8	4.9
Two or More Races	*Percent*	1.7	2.7	3.3
Non-English Language Households	*Percent*	1.2	1.6	4.4

TABLE 3: INSURANCE COVERAGE

		Hot Spring County	Community Average	State	National
Health Insurance Coverage	*Percentage of total civilian non-institutionalized population with health insurance coverage*	92.9	92.9	91.5	91.2
Private Insurance Coverage	*Percentage of total civilian non-institutionalized population with private health insurance coverage*	60.9	60.9	67.0	74.5
Public Insurance Coverage	*Percentage of total civilian non-institutionalized population with public health insurance coverage*	54.8	54.8	47.3	38.5
Dental Coverage	*Percentage of Arkansas residents with evidence of any dental coverage in the All-Payer Claims Database (APCD)*	54.5	54.5	56.2	Data Not Available

FIGURE 2: COMMUNITY, STATE, AND NATIONAL COMPARISON OF INSURANCE COVERAGE

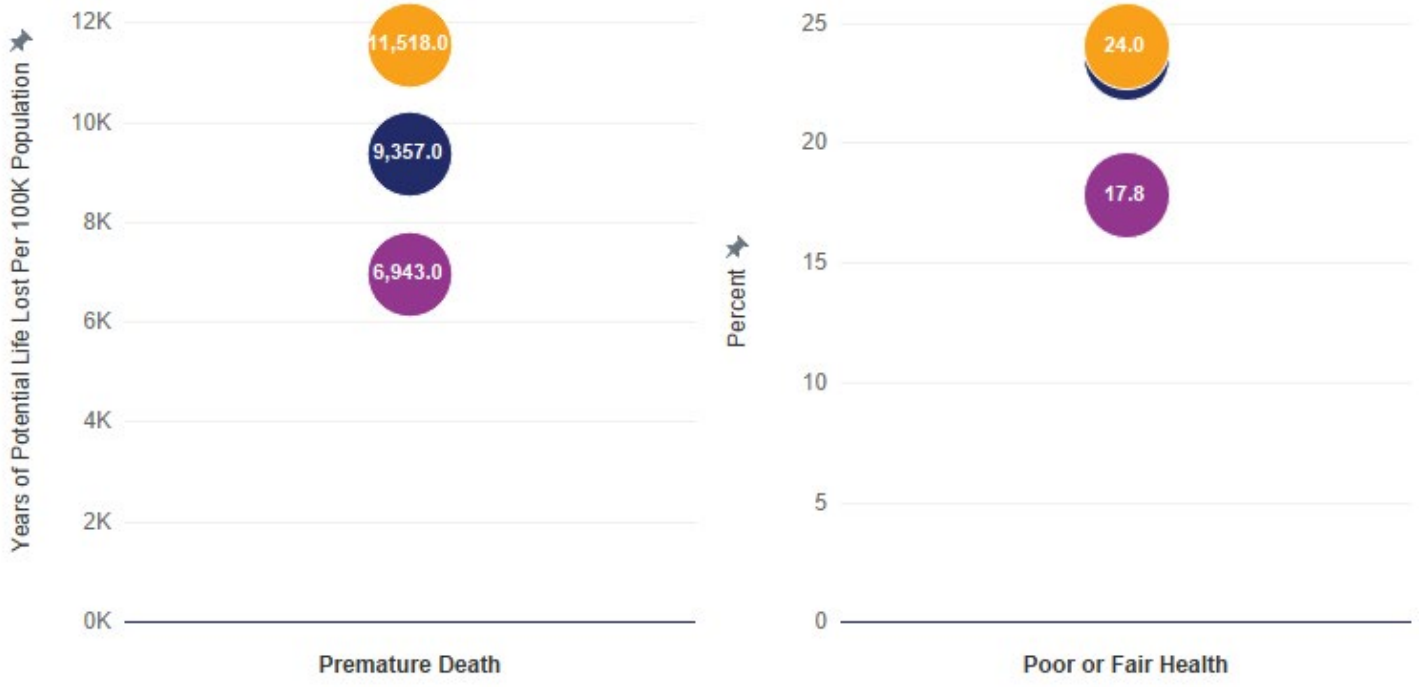


HEALTH OUTCOMES

TABLE 4: HEALTH OUTCOMES INDICATORS AND RATES

		Hot Spring County	Community Average	State	National
Premature Death	*Years of potential life lost before age 75 per 100,000 population (age-adjusted)*	11,518.0	11,518.0	9,357.0	6,943.0
Poor or Fair Health	*Percentage of adults reporting poor or fair health*	24.0	24.0	23.6	17.8
Poor Physical Health Days	*Average number of physically unhealthy days reported in past 30 days (age-adjusted)*	5.1	5.1	4.9	4.0
Low Birthweight	*Percentage of live births with low birth weight (<2500g)*	9.8	9.8	9.1	8.2

FIGURE 3: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT HEALTH OUTCOMES INDICATORS

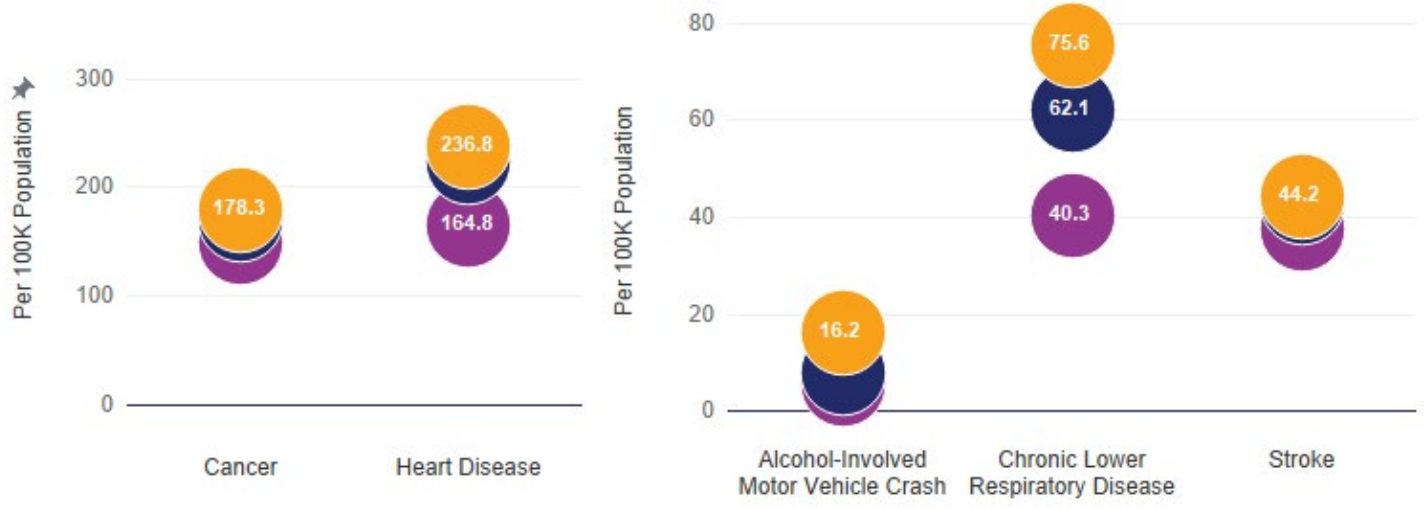


CAUSE OF DEATH

TABLE 5: CAUSE OF DEATH INDICATORS AND RATES

		Hot Spring County	Community Average	State	National
All Causes	*All causes of deaths per 100,000 population (age-adjusted)*	988.6	988.6	888.4	727.2
Cancer	*5-year average rate of death due to malignant neoplasm (cancer) per 100,000 population (age-adjusted)*	178.3	178.3	170.1	149.4
Stroke	*5-year average rate of death due to cerebrovascular disease (stroke) per 100,000 population (age-adjusted)*	44.2	44.2	43.0	37.6
Chronic Lower Respiratory Disease	*Rate of deaths due to chronic lower respiratory disease per 100,000 population (age-adjusted)*	75.6	75.6	62.1	40.3
Diabetes	*Diabetes deaths per 100,000 population (age-adjusted)*	23.3	23.3	29.0	21.4
Heart Disease	*Rate of death due to heart disease per 100,000 population (age-adjusted)*	236.8	236.8	222.7	164.8
Unintentional Injury	*5-year average rate of death due to unintentional injury (accident) per 100,000 population (age-adjusted)*	62.6	62.6	51.7	50.4
Motor Vehicle Crash	*5-year average rate of death due to motor vehicle crash per 100,000 population (age-adjusted)*	21.0	21.0	18.9	11.5
Alcohol-Involved Motor Vehicle Crash	*Rate of persons killed in motor vehicle crashes involving alcohol as a rate per 100,000 population*	16.2	16.2	7.8	5.3

FIGURE 4: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT CAUSE OF DEATH INDICATORS

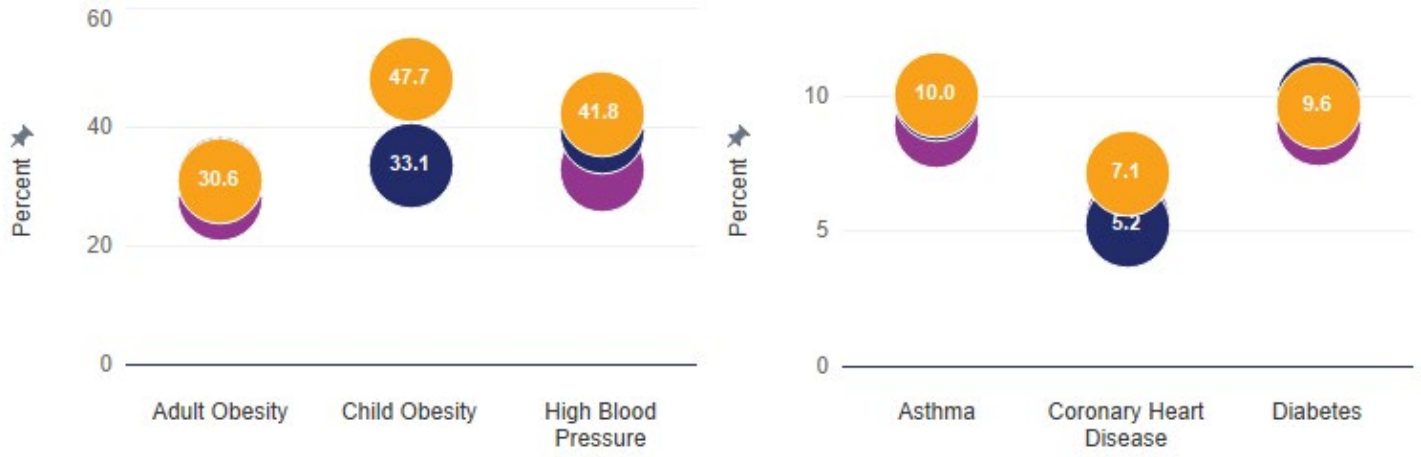


CHRONIC CONDITIONS

TABLE 6: CHRONIC CONDITIONS INDICATORS AND RATES

		Hot Spring County	Community Average	State	National
High Blood Pressure	*Percentage of adults who have been told they have high blood pressure*	41.8	41.8	39.0	32.6
Asthma	*Percentage of adults who have been told they currently have asthma (age-adjusted)*	10.0	10.0	9.9	8.9
Coronary Heart Disease	*Percentage of adults who have been told they have angina or coronary heart disease (age-adjusted)*	7.1	7.1	5.2	5.4
Arthritis	*Percentage of adults ages 18 or older diagnosed with some form of arthritis*	33.5	33.5	34.3	Data Not Available
High Cholesterol	*Percentage of adults who have had their blood cholesterol checked and have been told it was high*	39.3	39.3	36.7	33.6
Diabetes	*Percentage of adults ages 20 and older who have ever been told by a doctor that they have diabetes (age-adjusted)*	9.6	9.6	9.9	9.0
Adult Obesity	*Percentage of adults ages 20 and older who report a BMI higher than 30*	30.6	30.6	31.0	27.6
Child Obesity	*Percentage of students classified as overweight or obese, by county location of school*	47.7	47.7	33.1	Data Not Available

FIGURE 5: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT CHRONIC CONDITIONS INDICATORS

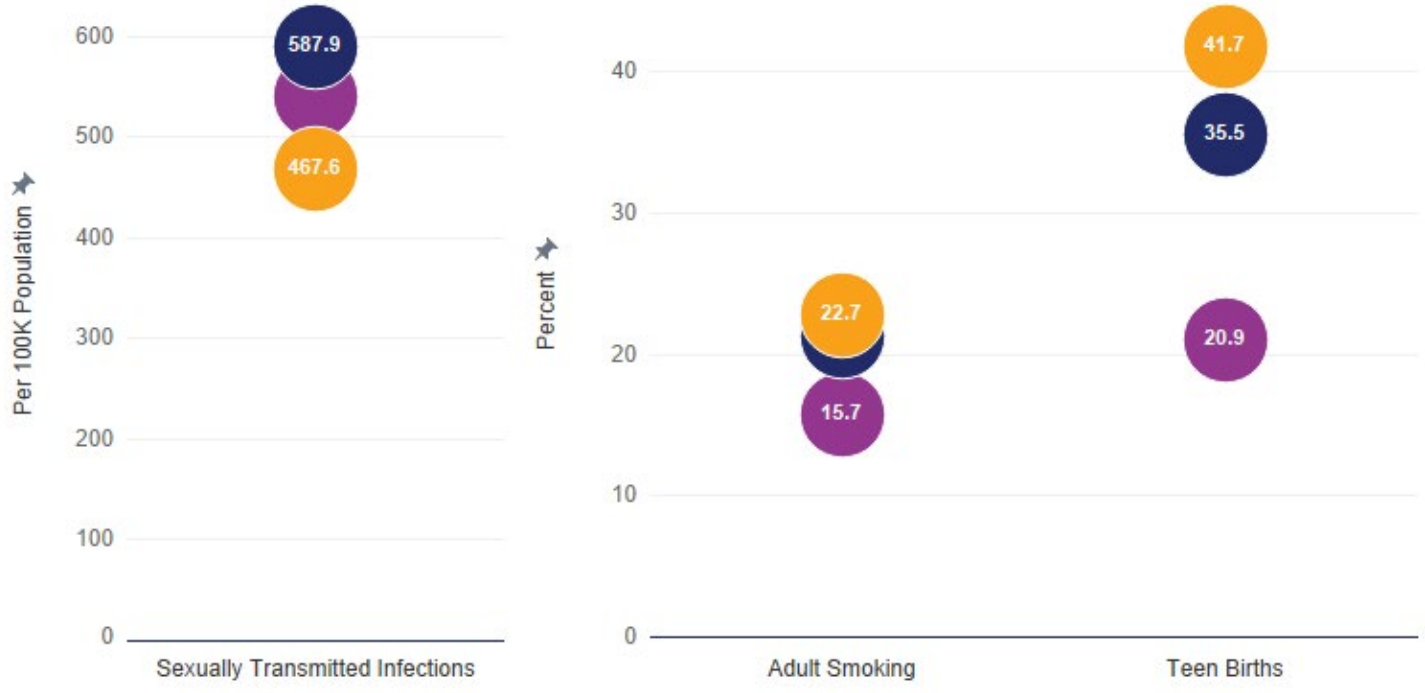


HEALTH BEHAVIORS

TABLE 7: HEALTH BEHAVIORS INDICATORS AND RATES

		Hot Spring County	Community Average	State	National
Adult Smoking	*Percentage of adults who are current smokers (age-adjusted)*	22.7	22.7	21.2	15.7
Youth Vaping	*Percentage of public school students in 6th, 8th, 10th, and 12th grade who used any vape in the past 30 days*	18.5	18.5	11.7	Data Not Available
Physical Inactivity	*Percentage of adults ages 20 or older reporting no physical activity in the past month*	23.4	23.4	26.2	22.0
Sexually Transmitted Infections	*Number of newly diagnosed chlamydia cases per 100,000 population*	467.6	467.6	587.9	539.9
Teen Births	*The seven-year average number of teen births per 1,000 female population, ages 15-19*	41.7	41.7	35.5	20.9

FIGURE 6: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT HEALTH BEHAVIORS INDICATORS

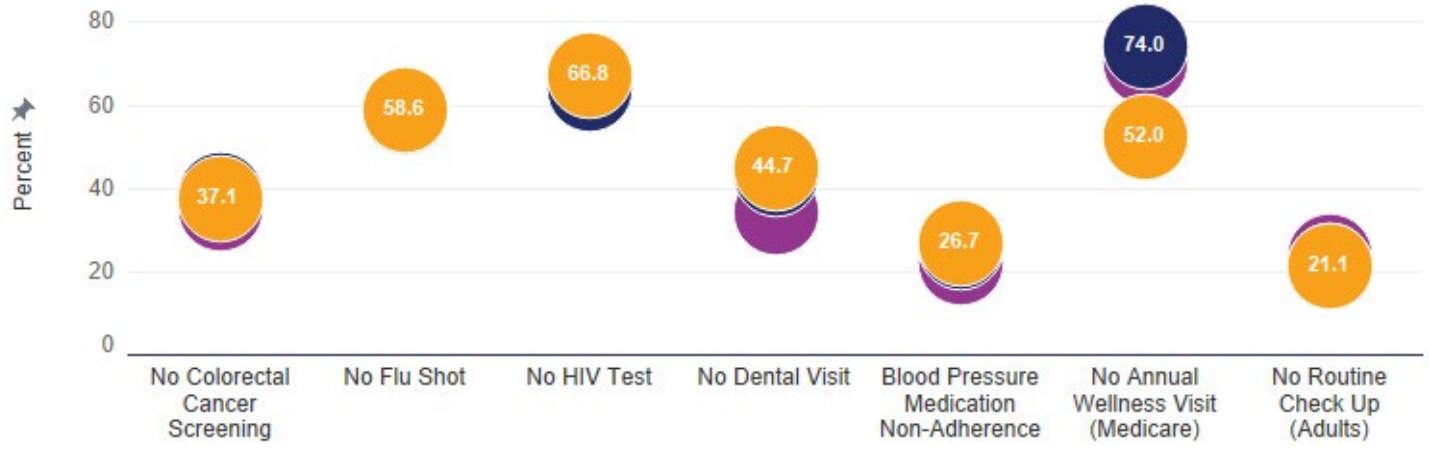


PREVENTION

TABLE 8: PREVENTION INDICATORS AND RATES

		Hot Spring County	Community Average	State	National
No Pap Test	*Percentage of women ages 21 to 65 who have not had a pap test within the past 3 years (age-adjusted)*	16.7	16.7	16.3	14.5
No Colorectal Cancer Screening	*Percentage of adults ages 50-75 who have never had either a sigmoidoscopy or colonoscopy (age-adjusted)*	37.1	37.1	38.1	35.0
No Flu Shot	*Percentage of adults ages 18 or older who have not had a flu shot in the past year*	58.6	58.6	58.5	58.1
No HIV Test	*Percentage of adults ages 18 or older who have never been screened for HIV*	66.8	66.8	63.6	Data Not Available
No Dental Visit	*Percentage of adults ages 18 or older who have not had a dentist or dental clinic visit in the previous year (age-adjusted)*	44.7	44.7	43.4	33.8
Blood Pressure Medication Non-Adherence	*The percentage of Medicare enrollees who did not adhere to blood pressure medication schedules*	26.7	26.7	25.9	21.8
No Annual Wellness Visit (Medicare)	*The percentage of Medicare enrollees who did not have an annual wellness visit in the past year*	52.0	52.0	74.0	70.0
No Routine Check Up (Adults)	*The percentage of adults age 18 or older with no routine check up with a doctor in the past year*	21.1	21.1	21.0	23.4

FIGURE 7: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT PREVENTION INDICATORS

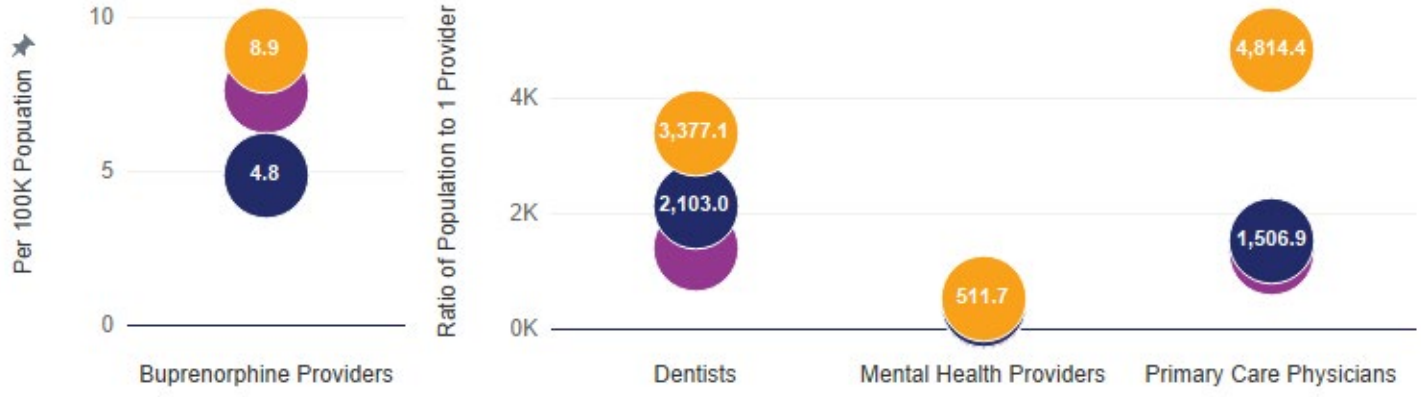


ACCESS

TABLE 9: ACCESS INDICATORS AND RATES

		Hot Spring County	Community Average	State	National
Mammography	*Percentage of female Medicare enrollees ages 65-74 who received an annual mammography screening*	34.0	34.0	38.0	42.0
Diabetic Monitoring	*Percentage of diabetic Medicare enrollees over age 65 who had a hemoglobin A1c test in the past year*	89.6	89.6	88.5	87.5
Uninsured	*Percentage of adults under age 65 without health insurance coverage*	9.2	9.2	10.8	10.8
Primary Care Physicians	*Ratio of population to one primary care physician*	4,814.4	4,814.4	1,506.9	1,319.0
Dentists	*Ratio of population to one dentist*	3,377.1	3,377.1	2,103.0	1,404.5
Mental Health Providers	*Ratio of population to one mental health provider*	511.7	511.7	421.4	382.3
Addiction or Substance Use Providers	*Rate of addiction or substance use providers per 100,000 population*	0.0	0.0	4.4	20.4
Buprenorphine Providers	*Rate of buprenorphine providers per 100,000 population*	8.9	8.9	4.8	7.6
Preventable Hospital Stays	*Number of hospital stays for ambulatory care-sensitive conditions per 1,000 Medicare enrollees*	4,879.0	4,879.0	4,769.0	4,236.0

FIGURE 8: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT ACCESS INDICATORS

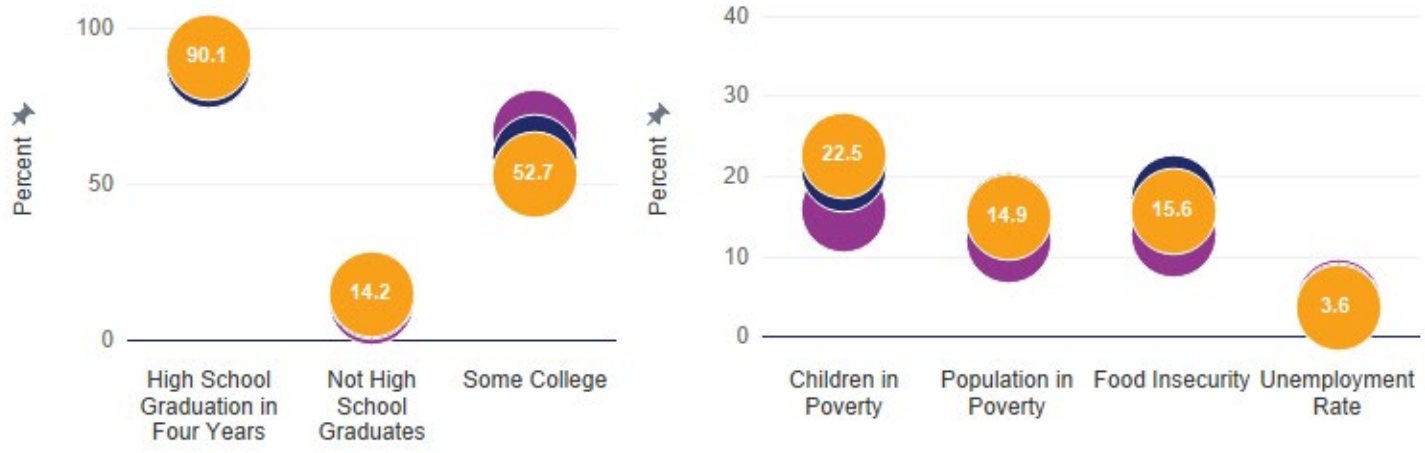


SOCIAL AND ECONOMIC FACTORS

TABLE 10: SOCIAL AND ECONOMIC FACTORS INDICATORS AND RATES

		Hot Spring County	Community Average	State	National
Not High School Graduates	*Percentage of adults ages 25 or older without a high school diploma*	14.2	14.2	13.4	12.0
High School Graduation in Four Years	*Percentage of ninth-grade cohort who graduated in four years*	90.1	90.1	88.2	87.7
Some College	*Percentage of adults ages 25-44 with some post-secondary education*	52.7	52.7	58.5	66.1
Unemployment Rate	*Unemployment rate among civilian non-institutionalized population age 16 and older in January 2022*	3.6	3.6	3.8	4.4
Children in Poverty	*Percentage of children under age 18 below the poverty line*	22.5	22.5	20.8	15.7
Population in Poverty	*Percentage of population below the federal poverty line*	14.9	14.9	15.2	11.9
Children in Single-Parent Households	*Percentage of children who live in a household headed by single parent*	25.6	25.6	28.9	25.5
Homeless Children	*Rate of homelessness among public school students*	3.1	3.1	2.8	2.8
Food Insecurity	*Percentage of the population that experienced food insecurity in the report year*	15.6	15.6	17.3	12.6
Social Associations	*Number of membership associations per 100,000 population*	106.3	106.3	126.5	105.0
Violent Crimes	*Annual rate of reported violent crimes per 100,000 population*	286.6	286.6	549.2	416.0

FIGURE 9: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT SOCIAL AND ECONOMIC FACTORS INDICATORS



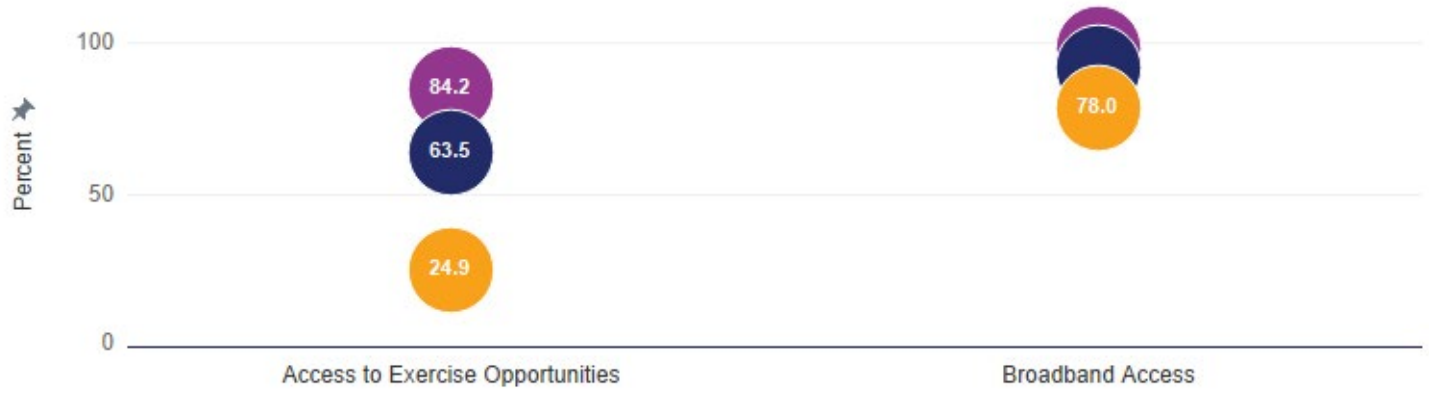
ENVIRONMENT

TABLE 11: ENVIRONMENT INDICATORS AND RATES

		Hot Spring County	Community Average	State	National
Food Environment Index	*Index of factors that contribute to a healthy food environment, 0 (worst) to 10 (best)*	6.7	6.7	5.1	7.8
Drinking Water Violations	*The total number of drinking water violations recorded in a two-year period*	0.0	0.0	118.0	4,739.0
Access to Exercise Opportunities	*Percentage of population with adequate access to locations for physical activity*	24.9	24.9	63.5	84.2
Severe Housing Problems	*Percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, or lack of kitchen or plumbing*	12.6	12.6	14.1	17.5
Broadband Access	*Percentage of population in a high-speed internet service area; access to DL speeds > 25MBPS (2020)*	78.0	78.0	91.4	97.5
Long Commute Driving Alone	*Among workers who commute in their car alone, the percentage who commute more than 30 minutes*	43.3	43.3	27.0	36.6

FIGURE 10: COMMUNITY, STATE, AND NATIONAL COMPARISON OF THE FOOD ENVIRONMENT INDEX INDICATOR

FIGURE 11: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT ENVIRONMENT INDICATORS



DIAGNOSES INCIDENCE WITHIN HOSPITAL COMMUNITY AT DISCHARGE

TABLE 12: DIAGNOSES INCIDENCE WITHIN HOSPITAL COMMUNITY AT DISCHARGE INDICATORS AND RATES

		Hot Spring County	Community Average	State
Arthritis	*Number of individuals 18 years and older discharged with a primary or secondary arthritis diagnosis as a percentage of the population 18 years and older*	4.0	4.0	2.3
Diabetes	*Number of individuals 18 years and older discharged with a primary or secondary diabetes diagnosis as a percentage of the population 18 years and older*	5.8	5.8	3.9
Hyperlipidemia	*Number of individuals 18 years and older discharged with a primary or secondary hyperlipidemia diagnosis as a percentage of the population 18 years and older*	5.5	5.5	3.9
Hypertension	*Number of individuals 18 years and older discharged with a primary or secondary hypertension diagnosis as a percentage of the population 18 years and older*	12.9	12.9	9.5
Ischemic Heart Disease	*Number of individuals 18 years and older discharged with a primary or secondary ischemic heart disease diagnosis as a percentage of the population 18 years and older*	3.4	3.4	2.5

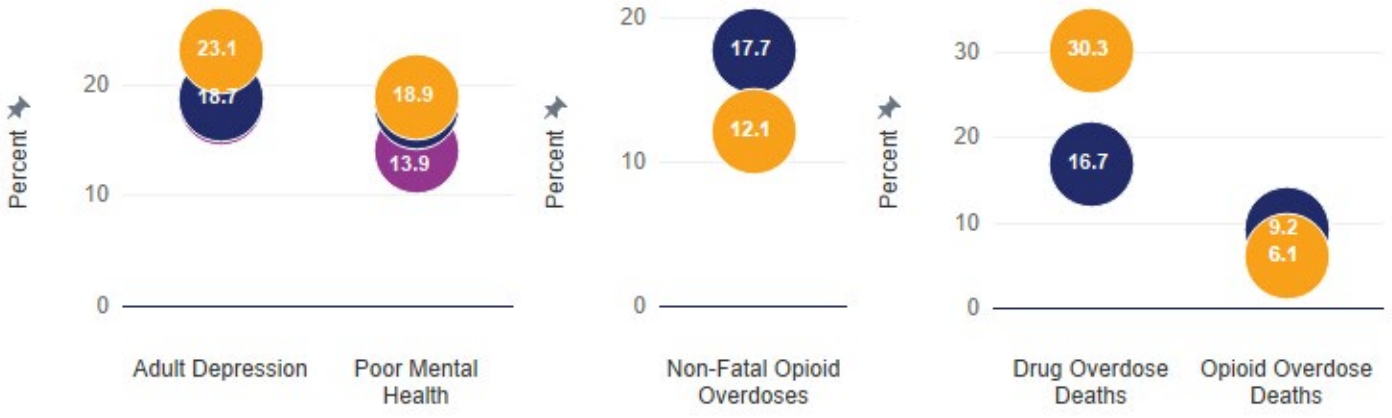
FIGURE 12: DIAGNOSES INCIDENCE WITHIN HOSPITAL COMMUNITY AT DISCHARGE INDICATORS

MENTAL HEALTH AND SUBSTANCE USE

TABLE 13: MENTAL HEALTH AND SUBSTANCE USE INDICATORS AND RATES

		Hot Spring County	Community Average	State	National
Excessive Drinking	*Percentage of adults reporting binge or heavy drinking*	16.5	16.5	17.3	19.2
Poor Mental Health	*Percentage of adults ages 18 or older reporting poor mental health for 14 or more days*	18.9	18.9	18.0	13.9
Youth Depression	*Percentage of public school students in 6th, 8th, 10th, and 12th grade who had feelings of depression all of the time in the past 30 days*	12.4	12.4	12.1	Data Not Available
Adult Depression	*The prevalence of depression among Medicare fee-for-service beneficiaries*	23.1	23.1	18.7	18.4
Suicide Deaths	*The rate of deaths by suicide (ICD-10 codes U03, X60-X84, Y87.0) per 100,000 population (age-adjusted)*	30.1	30.1	18.8	13.8
Non-Fatal Opioid Overdoses	*Non-fatal opioid overdoses per 100,00 population (based on county of occurrence)*	12.1	12.1	17.7	Data Not Available
Opioid Overdose Deaths	*Opioid-related deaths per 100,00 population (based on county of occurrence)*	6.1	6.1	9.2	Data Not Available
Drug Overdose Deaths	*Opioid-related deaths per 100,00 population (based on county of occurrence)*	30.3	30.3	16.7	Data Not Available

FIGURE 13: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT MENTAL HEALTH AND SUBSTANCE USE INDICATORS

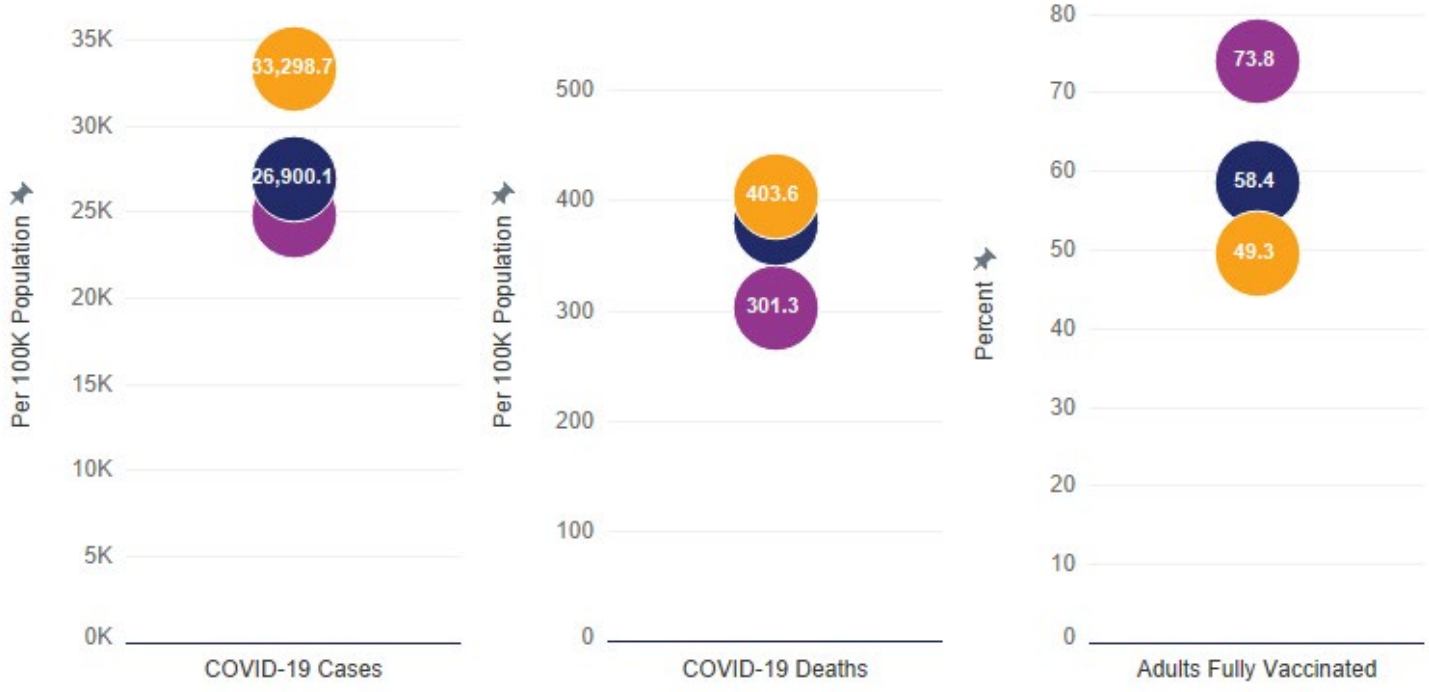


COVID-19

TABLE 14: COVID-19 INDICATORS AND RATES

		Hot Spring County	Community Average	State	National
COVID-19 Cases	*The incidence rate of confirmed COVID-19 cases per 100,000 population, as of May 12, 2022*	33,298.7	33,298.7	26,900.1	24,718.7
COVID-19 Deaths	*The rate of deaths among patients with confirmed cases of COVID-19 per 100,000 population, as of May 12, 2022*	403.6	403.6	378.6	301.3
Adults Fully Vaccinated	*The percentage of adults fully vaccinated for COVID-19, as of May 11, 2022*	49.3	49.3	58.4	73.8
Adult COVID-19 Vaccine Hesitancy	*The percentage of the population estimated to be hesitant toward receiving a COVID-19 vaccine*	20.3	20.3	20.4	10.3

FIGURE 14: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT COVID-19 INDICATORS



BAPTIST HEALTH MEDICAL CENTER

CONWAY

About Baptist Health Medical Center-Conway

Baptist Health Medical Center-Conway is a faith-based, state-of-the-art facility offering an integrated healing environment for the care and comfort of patients and families. Our 260,000 square-foot facility features 111 beds and eight operating rooms. Our care teams, nurses and physicians are here to provide amazing care to keep you and your family healthy and well.

Baptist Health Medical Center-Conway provides comprehensive medical services within our hospital facility as well as offerings for care at a number of conveniently located family clinics and specialty clinics in and around the Conway area. Listed below are many of the services we provide to Faulkner County and surrounding communities.

2020-2022 Accomplishments

Infant Mortality:

- Received National Recognition in the Leapfrog survey as one of the best in the Nation for Safe Maternity Care
- Partnered with BH Community Outreach to provide Prenatal Education and Post Partum education
- Provide Safe Sleep education to all patients and provide free Sleep Sacks upon discharge.
- Provided car seats for moms upon discharge who were in need
- Recruited a board certified general pediatrician.

Obesity:

- Participated in the Healthy Faulkner County Coalition to support initiatives around health and education.
- Continued support of the farm-to-table program to educate children on healthy eating with local schools.
- Continued support for schools including installing a track for students and the community at Jim Stone Elementary.

Stroke Cardiovascular:

- Partnered with the Community Based Provided (Guidance Center) to do Crisis Prevention Training for the Fort Smith Police Department- Quarterly (4 per year)
- Partnered with the City of Fort Smith to offer Mental Health presentation and training for employees
- Offered In-Patient Geriatric Psychiatric Program
- Participated in the Sebastian County Opioid Task Force

COMMUNITY HEALTH NEEDS ASSESSMENT – IMPLEMENTATION PLAN 2023-2025

Baptist Health Medical Center - Conway

IDENTIFIED COMMUNITY HEALTH NEED: **Access to Healthcare Services**

GOALS / OBJECTIVES:

Increase Access to Quality Health Care, Preventive Health Screenings, Vaccinations and Community Resources.

STRATEGY #1

Utilize the Mobile Health Unit (MHU) to provide preventive screenings and increase access to care.

Action Steps:

1. Utilize the MHU to offer back tol immunizations, flu shots and Covid-19 Vaccinations
2. Identify the communities in most need and schedule monthly screenings utilizing the MHU.
3. Partner with Regional Hospitals to utilize the MHU to deliver screenings in their service areas.
4. Register all participants in the Epic System.
5. Utilize Baptist Health Virtual Care on the MHU to offer additional care for patients in need.
6. Provide evening and weekend screening times to meet the needs of specific populations
7. Provide Preventative Health Screenings for Diabetes, Hypertension, Cholesterol and Covid-19.
8. Utilize the Findhelp.org system to refer and track patents in need of additional resources

Performance Metrics:

1. Track and Report the number of individuals screened and vaccinated on the Mobile Health Unit
2. Track and report the number of patients utilizing virtual care on the MHU.
3. Track and report the number of patients enrolled in EPIC and MyChart.
4. Track and report the number of patients utilizing the Findhelp.org system for resources
5. Track and report the number of Regional Hospital Community Events offered via the MHU

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:

Community Centers, Local schools, faith based community and other not-for-profit agencies

Resources Hospital Plans to Commit to Address Health Need:	Estimated Completion Date:	Person(s) / Department Responsible:
• Community Centers, Local schools, faith based community and other not-for-profit agencies	• Ongoing	• Nursing Department, Community Outreach Director, Mobile Health Unit Driver

COMMUNITY HEALTH NEEDS ASSESSMENT – IMPLEMENTATION PLAN 2023-2025

Baptist Health Medical Center - Conway

IDENTIFIED COMMUNITY HEALTH NEED: Mental Health

GOALS / OBJECTIVES:

Increase awareness and support of community members dealing with mental health concerns.

STRATEGY #2

Reduce the stigma associated with mental health through education and treatment.

Action Steps:

1. Pilot a "Make it Okay" campaign designed to reduce the stigma of mental illness in at least one community.
2. Offer annual based Mental Health First Aid presentations to community groups and faith-based organizations.
3. Offer an annual Mental Health First Aid training for staff, pastoral care and other system-wide health care providers.
4. Host seminars, presentations with an emphasis on decreasing stigma.
5. Offer Depression and ACES Screening Tools at Community events.
6. Provide education and outreach efforts via seminars, events and telehealth on the relationship between substance abuse and mental health.
7. Continue to offer psychiatric care and referrals
8. Utilize Findhelp.org and the 211 system to refer individuals for Mental Health Services

Performance Metrics:

1. Number of individuals reached with the "Make it Okay" Initiative
2. Number of Mental Health First Aid Trainings for staff will be tracked and reported.
3. Number of Community Based Mental Health First Aid Presentations will be tracked and reported.
4. Number of Depression Screening will be tracked and reported
5. Number of referrals and follow-ups will be tracked and reported.
6. Number of seminars, presentations will be tracked and reported.
7. Track the number of individuals referred for additional resources and services

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:

Faith Based Communities, Adverse Childhood Experiences Statewide Coalition

Resources Hospital Plans to Commit to Address Health Need:	Estimated Completion Date:	Person(s) / Department Responsible:
• Community Outreach Staff, Pharmacy, Pastoral Care and Behavioral Health	• Ongoing	• Baptist Health Community Outreach, Nursing Department

COMMUNITY HEALTH NEEDS ASSESSMENT – IMPLEMENTATION PLAN 2023-2025

Baptist Health Medical Center - Conway

IDENTIFIED COMMUNITY HEALTH NEED: **Nutrition & Food Security**

GOALS / OBJECTIVES:

Initiate Evidence Based Nutrition Security strategies to address obesity, diabetes, hypertension, and other diet-related chronic conditions.

STRATEGY #1

Increase access to nutrition education and information among community members

Action Steps:

1. Implement Maintain, Don't Gain holiday challenge program for adult community members that encourages using stress management strategies, physical activity, and healthful food choices during the holiday season to maintain one's physical and mental health and avoid holiday weight gain.
2. Implement Around the Table program targeting youth, young adults and parents of young children focusing on creating healthy connections between food, oneself, and one's community.
3. Implement Eat Healthy, Be Active program for adult community members. a program based on the Dietary Guidelines and Physical Activity Guidelines for Americans and teaches participants to make incremental lifestyle changes to improve their health.
4. Implement Cooking Matters, grocery store tour and cooking program targeting adults and parents participating in the WIC program with the goal to empower participants with skills to shop for healthful foods on a budget to maximize limited food resources..
5. Implement Cooking with Community Outreach classes to empower participants to build cooking skills, cook more healthy meals, reduce food waste, and make healthier selections at the grocery store.
6. Utilize the Epic System to screening for Food Insecurity for inpatients visits
7. Partner with AHG clinics to screen for Food Insecurity and provide food through the FoodRX program for those in need

Performance Metrics:

1. Number of Participants registered for educational Programs will be tracked and reported
2. Coordinate implementation of 3 Maintian, Don't Gain Holiday Challenge
3. Pilot 2 "Around the Table Series targeting Youth
4. Implement 2 Eat Healthy Be Active Programs
5. Implement 3 Cooking Matters Grocery Store Tours
6. Host 2 Community -Based Community Outreach Cooking Classes
7. Track and report the number of patents screened for Food insecurity
8. Track and report the number of patients receiving services from the FoodRX program

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:

Arkansas Hunger Relief Alliance, Central AR Library System, Be Mighty

Resources Hospital Plans to Commit to Address Health Need:

- Community Outreach Staff , Pharmacy Manager

Estimated Completion Date:

- Ongoing

Person(s) / Department Responsible:

- Community Outreach Team, Nursing Department

CONWAY

ASSESSMENT PREPARED BY ACHI
INSPIRING HEALTHY ACTS

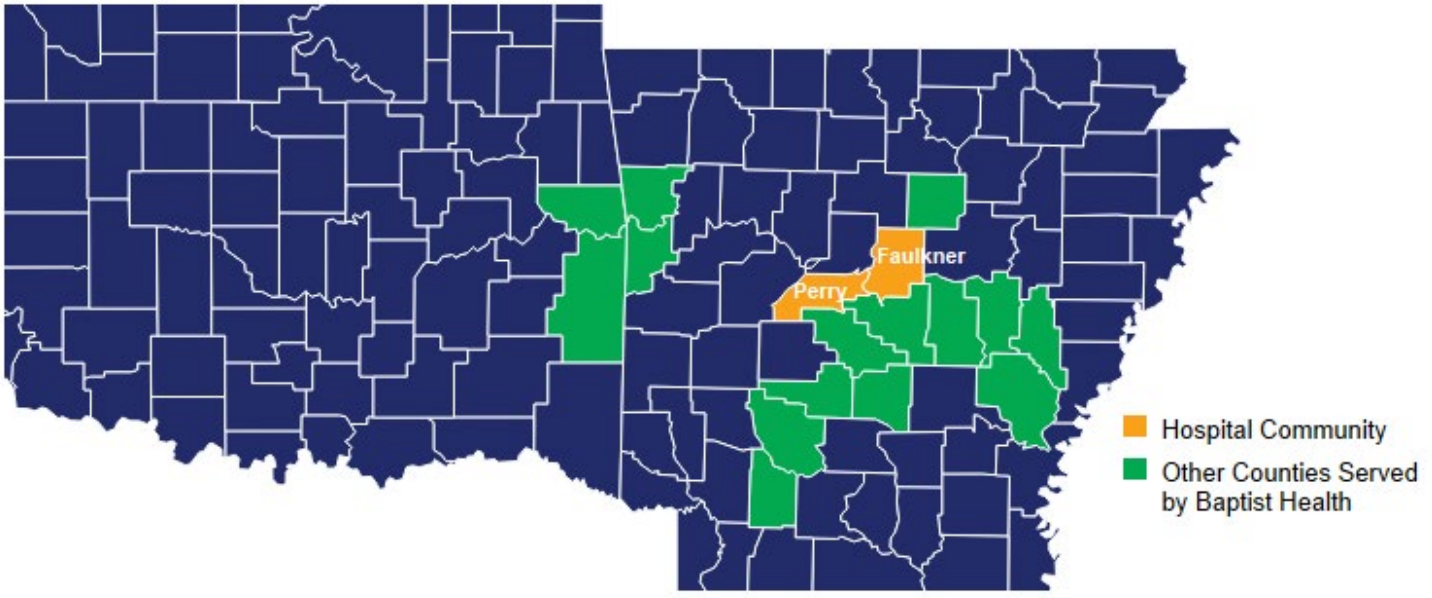
Introduction

Baptist Health engaged the Arkansas Center for Health Improvement (ACHI) to conduct the quantitative data collection and analysis for the 2022 Community Health Needs Assessment (CHNA) process. Baptist Health provided ACHI with the counties served for each of its 11 hospital communities. A total of 15 Arkansas counties and two Oklahoma counties were included in the CHNA.

This report shows the qualitative results from the CHNA for the Baptist Health Medical Center-Conway hospital community, which includes Faulkner and Perry counties.

HOSPITAL COMMUNITY

FIGURE 1: COUNTIES SERVED BY BAPTIST HEALTH MEDICAL CENTER-CONWAY



Qualitative Results

Quantitative results from the CHNA for the Baptist Health Medical Center-Conway hospital community are reported below. There are 12 sections: Demographics, Health Outcomes, Cause of Death, Chronic Conditions, Health Behaviors, Prevention, Access, Social and Economic Factors, Environment, Diagnoses Incidence Within Hospital Community at Discharge, Mental Health and Substance Use, and COVID-19.

Each section includes a table with health indicator data for each county in the hospital community, a community average for each measurement, and averages for the state of Arkansas and the United States. If data were not available or were suppressed, “Data Not Available” 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 document and Appendix 1.

DEMOGRAPHICS

TABLE 1: AGE AND SEX

		Faulkner County	Perry County	State	National
Total Population	*Number*	123,624.0	10,355.0	2,999,370.0	324,697,795.0
Ages 0-4	*Percent*	6.2	5.6	6.3	6.1
Ages 5-17	*Percent*	17.1	16.9	17.2	16.5
Ages 18-24	*Percent*	15.4	7.5	9.5	9.4
Ages 25-34	*Percent*	14.2	10.6	13.1	13.9
Ages 35-44	*Percent*	12.5	11.2	12.3	12.6
Ages 45-54	*Percent*	11.8	13.8	12.4	13.0
Ages 55-64	*Percent*	10.7	14.6	12.7	12.9
Ages 65+	*Percent*	12.2	19.9	16.6	15.6
Male	*Percent*	48.9	50.0	49.1	49.2
Female	*Percent*	51.2	50.1	50.9	50.8

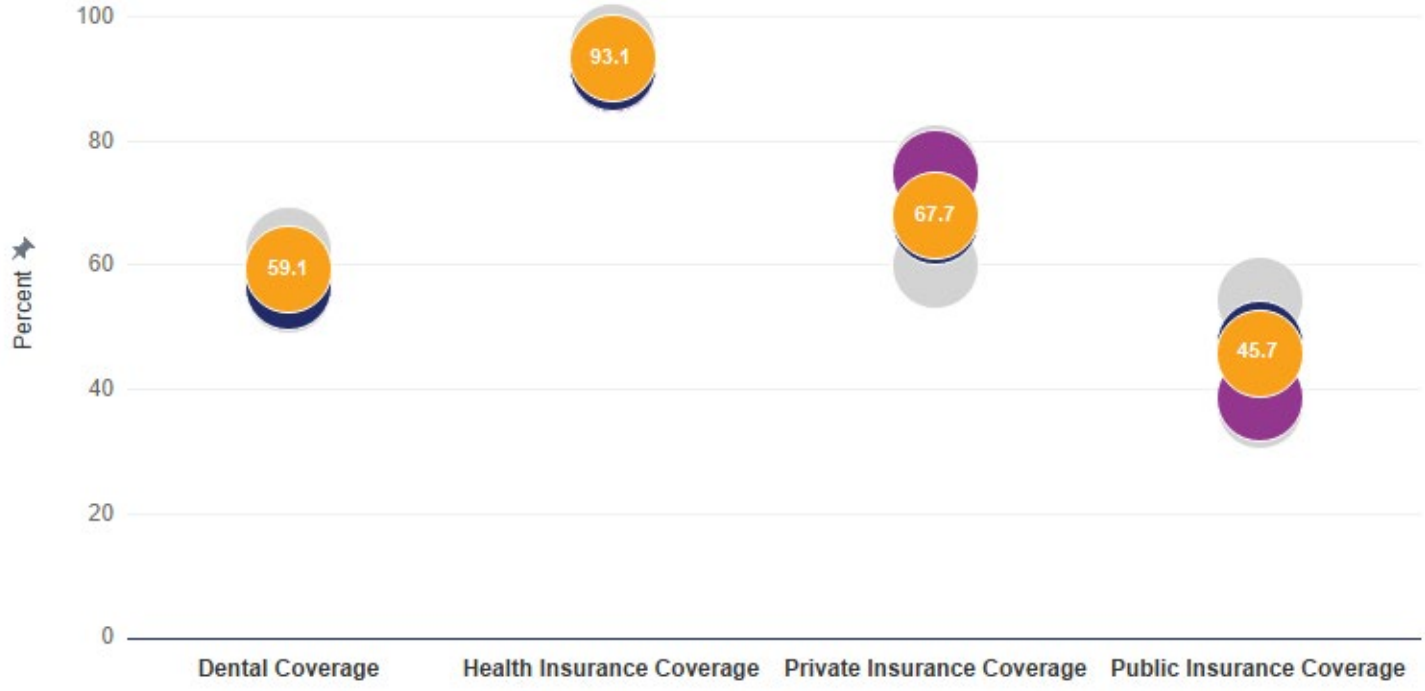
TABLE 2: RACE, ETHNICITY, AND LANGUAGE

		Faulkner County	Perry County	State	National
Total Population	*Number*	123,624.0	10,355.0	2,999,370.0	324,697,795.0
Hispanic or Latino	*Percent*	4.1	2.9	7.5	18.0
Non-Hispanic White	*Percent*	80.0	95.5	72.4	60.7
Black or African American	*Percent*	11.4	0.7	15.3	12.7
Native American/Alaska Native	*Percent*	0.4	0.1	0.7	0.9
Asian	*Percent*	1.3	0.0	1.5	5.6
Native Hawaiian/Pacific Islander	*Percent*	0.1	0.0	0.3	0.2
Some Other Race	*Percent*	2.0	1.8	2.8	4.9
Two or More Races	*Percent*	2.7	1.2	2.7	3.3
Non-English Language Households	*Percent*	0.6	0.0	1.6	4.4

TABLE 3: INSURANCE COVERAGE

		Faulkner County	Perry County	Community Average	State	National
Health Insurance Coverage	*Percentage of total civilian non-institutionalized population with health insurance coverage*	91.2	94.9	93.1	91.5	91.2
Private Insurance Coverage	*Percentage of total civilian non-institutionalized population with private health insurance coverage*	75.4	59.9	67.7	67.0	74.5
Public Insurance Coverage	*Percentage of total civilian non-institutionalized population with public health insurance coverage*	37.2	54.2	45.7	47.3	38.5
Dental Coverage	*Percentage of Arkansas residents with evidence of any dental coverage in the All-Payer Claims Database (APCD)*	55.8	62.3	59.1	56.2	Data Not Available

FIGURE 2: COMMUNITY, STATE, AND NATIONAL COMPARISON OF INSURANCE COVERAGE

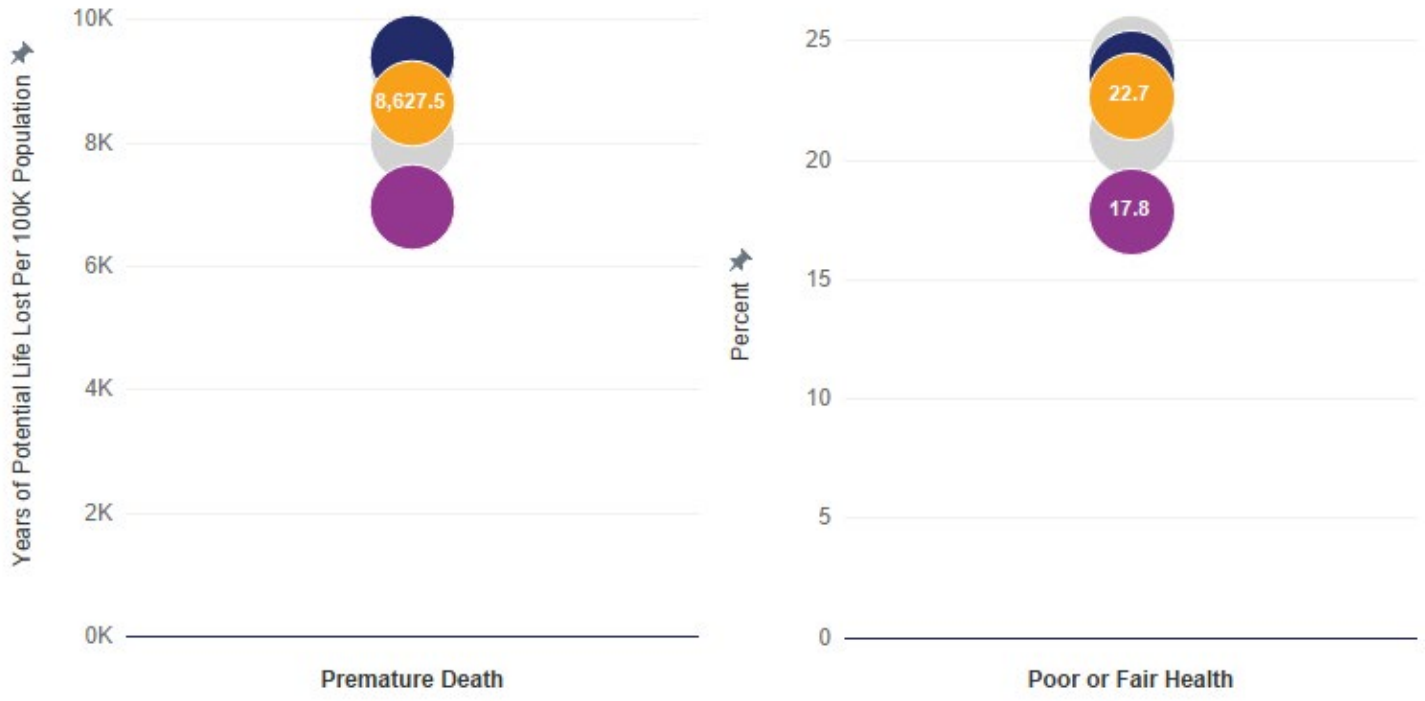


HEALTH OUTCOMES

TABLE 4: HEALTH OUTCOMES INDICATORS AND RATES

		Faulkner County	Perry County	Community Average	State	National
Premature Death	*Years of potential life lost before age 75 per 100,000 population (age-adjusted)*	8,034.0	9,221.0	8,627.5	9,357.0	6,943.0
Poor or Fair Health	*Percentage of adults reporting poor or fair health*	21.1	24.2	22.7	23.6	17.8
Poor Physical Health Days	*Average number of physically unhealthy days reported in past 30 days (age-adjusted)*	4.8	5.5	5.2	4.9	4.0
Low Birthweight	*Percentage of live births with low birth weight (<2500g)*	7.4	8.2	7.8	9.1	8.2

FIGURE 3: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT HEALTH OUTCOMES INDICATORS

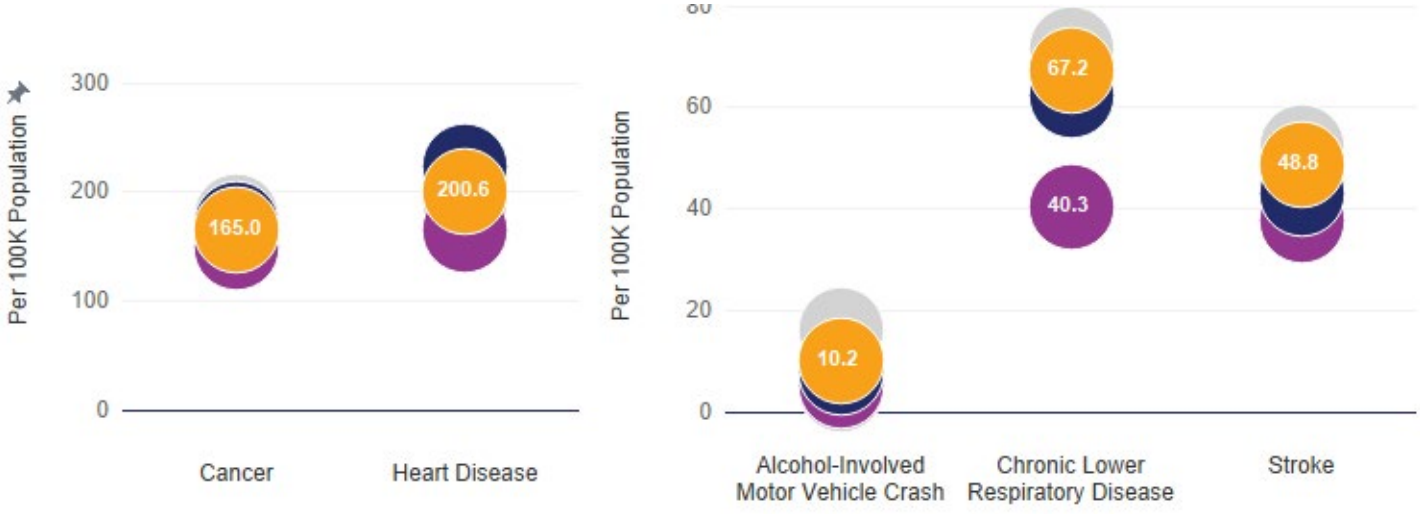


CAUSE OF DEATH

TABLE 5: CAUSE OF DEATH INDICATORS AND RATES

		Faulkner County	Perry County	Community Average	State	National
All Causes	*All causes of deaths per 100,000 population (age-adjusted)*	884.8	883.0	883.9	888.4	727.2
Cancer	*5-year average rate of death due to malignant neoplasm (cancer) per 100,000 population (age-adjusted)*	153.8	176.2	165.0	170.1	149.4
Stroke	*5-year average rate of death due to cerebrovascular disease (stroke) per 100,000 population (age-adjusted)*	52.1	45.4	48.8	43.0	37.6
Chronic Lower Respiratory Disease	*Rate of deaths due to chronic lower respiratory disease per 100,000 population (age-adjusted)*	62.8	71.5	67.2	62.1	40.3
Diabetes	*Diabetes deaths per 100,000 population (age-adjusted)*	11.8	28.0	19.9	29.0	21.4
Heart Disease	*Rate of death due to heart disease per 100,000 population (age-adjusted)*	189.5	211.6	200.6	222.7	164.8
Unintentional Injury	*5-year average rate of death due to unintentional injury (accident) per 100,000 population (age-adjusted)*	45.1	60.1	52.6	51.7	50.4
Motor Vehicle Crash	*5-year average rate of death due to motor vehicle crash per 100,000 population (age-adjusted)*	14.6	Data Not Available	Data Not Available	18.9	11.5
Alcohol-Involved Motor Vehicle Crash	*Rate of persons killed in motor vehicle crashes involving alcohol as a rate per 100,000 population*	4.4	16.0	10.2	7.8	5.3

FIGURE 4: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT CAUSE OF DEATH INDICATORS

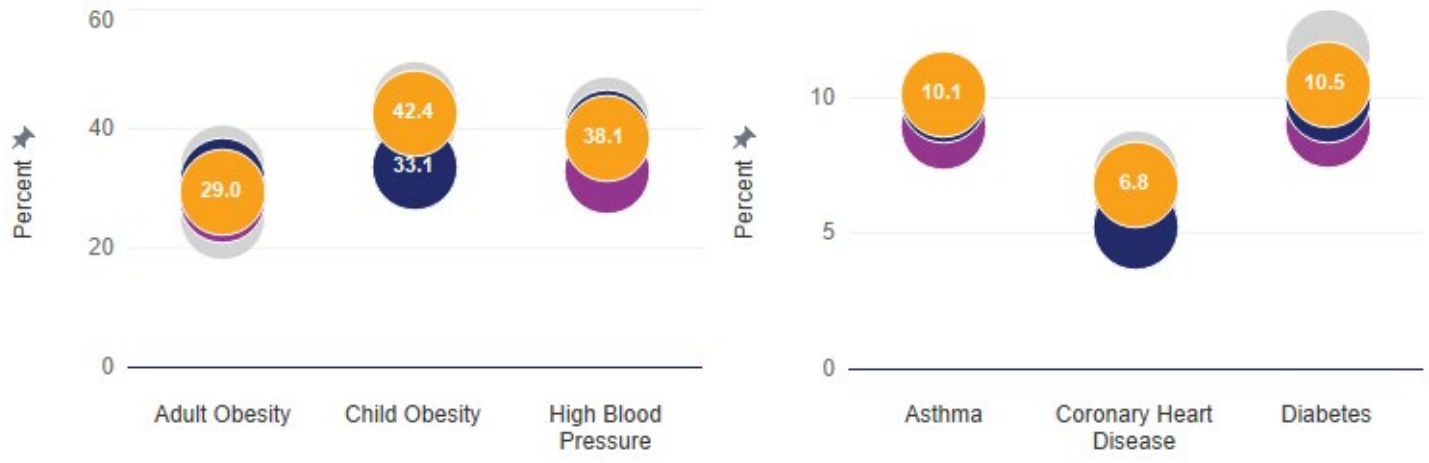


CHRONIC CONDITIONS

TABLE 6: CHRONIC CONDITIONS INDICATORS AND RATES

		Faulkner County	Perry County	Community Average	State	National
High Blood Pressure	*Percentage of adults who have been told they have high blood pressure*	34.9	41.2	38.1	39.0	32.6
Asthma	*Percentage of adults who have been told they currently have asthma (age-adjusted)*	10.2	10.0	10.1	9.9	8.9
Coronary Heart Disease	*Percentage of adults who have been told they have angina or coronary heart disease (age-adjusted)*	6.4	7.2	6.8	5.2	5.4
Arthritis	*Percentage of adults ages 18 or older diagnosed with some form of arthritis*	35.5	37.4	36.5	34.3	Data Not Available
High Cholesterol	*Percentage of adults who have had their blood cholesterol checked and have been told it was high*	34.8	40.3	37.6	36.7	33.6
Diabetes	*Percentage of adults ages 20 and older who have ever been told by a doctor that they have diabetes (age-adjusted)*	11.7	9.2	10.5	9.9	9.0
Adult Obesity	*Percentage of adults ages 20 and older who report a BMI higher than 30*	33.2	24.7	29.0	31.0	27.6
Child Obesity	*Percentage of students classified as overweight or obese, by county location of school*	40.8	43.9	42.4	33.1	Data Not Available

FIGURE 5: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT CHRONIC CONDITIONS INDICATORS

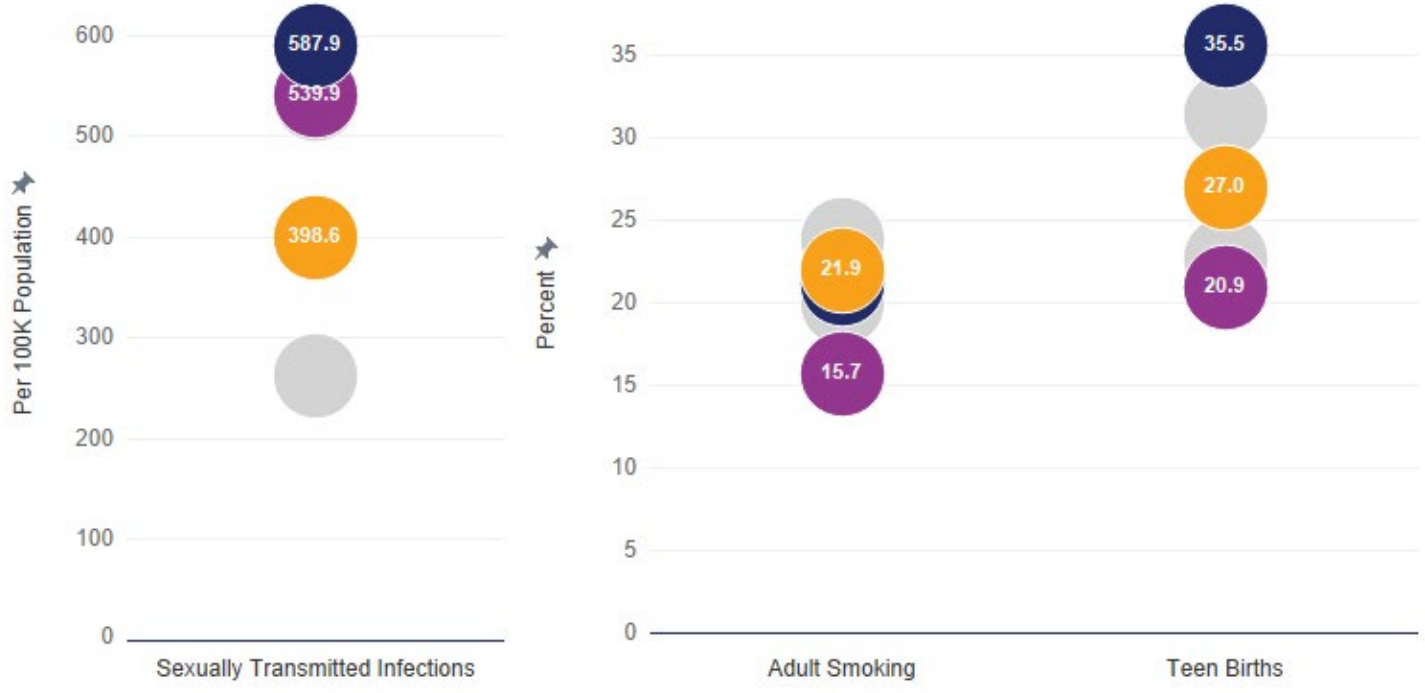


HEALTH BEHAVIORS

TABLE 7: HEALTH BEHAVIORS INDICATORS AND RATES

		Faulkner County	Perry County	Community Average	State	National
Adult Smoking	*Percentage of adults who are current smokers (age-adjusted)*	20.0	23.8	21.9	21.2	15.7
Youth Vaping	*Percentage of public school students in 6th, 8th, 10th, and 12th grade who used any vape in the past 30 days*	15.3	Data Not Available	Data Not Available	11.7	Data Not Available
Physical Inactivity	*Percentage of adults ages 20 or older reporting no physical activity in the past month*	28.5	23.9	26.2	26.2	22.0
Sexually Transmitted Infections	*Number of newly diagnosed chlamydia cases per 100,000 population*	536.2	260.9	398.6	587.9	539.9
Teen Births	*The seven-year average number of teen births per 1,000 female population, ages 15-19*	22.6	31.4	27.0	35.5	20.9

FIGURE 6: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT HEALTH BEHAVIORS INDICATORS

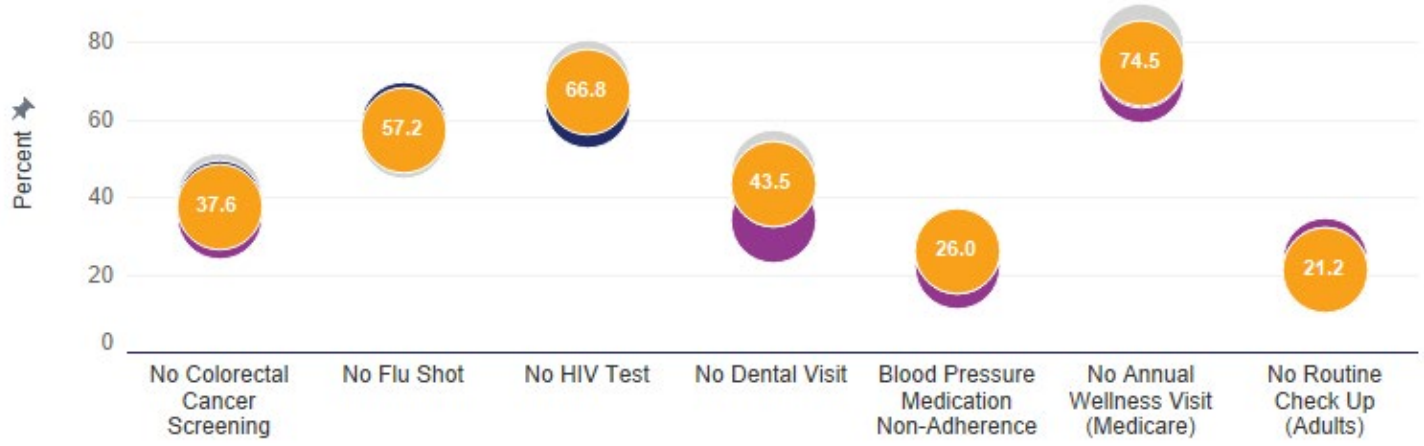


PREVENTION

TABLE 8: PREVENTION INDICATORS AND RATES

		Faulkner County	Perry County	Community Average	State	National
No Pap Test	*Percentage of women ages 21 to 65 who have not had a pap test within the past 3 years (age-adjusted)*	15.4	17.9	16.7	16.3	14.5
No Colorectal Cancer Screening	*Percentage of adults ages 50-75 who have never had either a sigmoidoscopy or colonoscopy (age-adjusted)*	35.0	40.1	37.6	38.1	35.0
No Flu Shot	*Percentage of adults ages 18 or older who have not had a flu shot in the past year*	55.8	58.6	57.2	58.5	58.1
No HIV Test	*Percentage of adults ages 18 or older who have never been screened for HIV*	63.9	69.7	66.8	63.6	Data Not Available
No Dental Visit	*Percentage of adults ages 18 or older who have not had a dentist or dental clinic visit in the previous year (age-adjusted)*	40.8	46.1	43.5	43.4	33.8
Blood Pressure Medication Non-Adherence	*The percentage of Medicare enrollees who did not adhere to blood pressure medication schedules*	26.0	26.0	26.0	25.9	21.8
No Annual Wellness Visit (Medicare)	*The percentage of Medicare enrollees who did not have an annual wellness visit in the past year*	70.0	79.0	74.5	74.0	70.0
No Routine Check Up (Adults)	*The percentage of adults age 18 or older with no routine check up with a doctor in the past year*	21.1	21.2	21.2	21.0	23.4

FIGURE 7: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT PREVENTION INDICATORS



ACCESS

TABLE 9: ACCESS INDICATORS AND RATES

		Faulkner County	Perry County	Community Average	State	National
Mammography	*Percentage of female Medicare enrollees ages 65-74 who received an annual mammography screening*	37.0	34.0	35.5	38.0	42.0
Diabetic Monitoring	*Percentage of diabetic Medicare enrollees over age 65 who had a hemoglobin A1c test in the past year*	87.7	89.2	88.5	88.5	87.5
Uninsured	*Percentage of adults under age 65 without health insurance coverage*	9.3	9.8	9.6	10.8	10.8
Primary Care Physicians	*Ratio of population to one primary care physician*	1,862.8	5,176.0	3,519.4	1,506.9	1,319.0
Dentists	*Ratio of population to one dentist*	2,520.1	Data Not Available	Data Not Available	2,103.0	1,404.5
Mental Health Providers	*Ratio of population to one mental health provider*	663.2	Data Not Available	Data Not Available	421.4	382.3
Addiction or Substance Use Providers	*Rate of addiction or substance use providers per 100,000 population*	2.4	0.0	1.2	4.4	20.4
Buprenorphine Providers	*Rate of buprenorphine providers per 100,000 population*	3.2	0.0	1.6	4.8	7.6
Preventable Hospital Stays	*Number of hospital stays for ambulatory care-sensitive conditions per 1,000 Medicare enrollees*	4,169.0	4,390.0	4,279.5	4,769.0	4,236.0

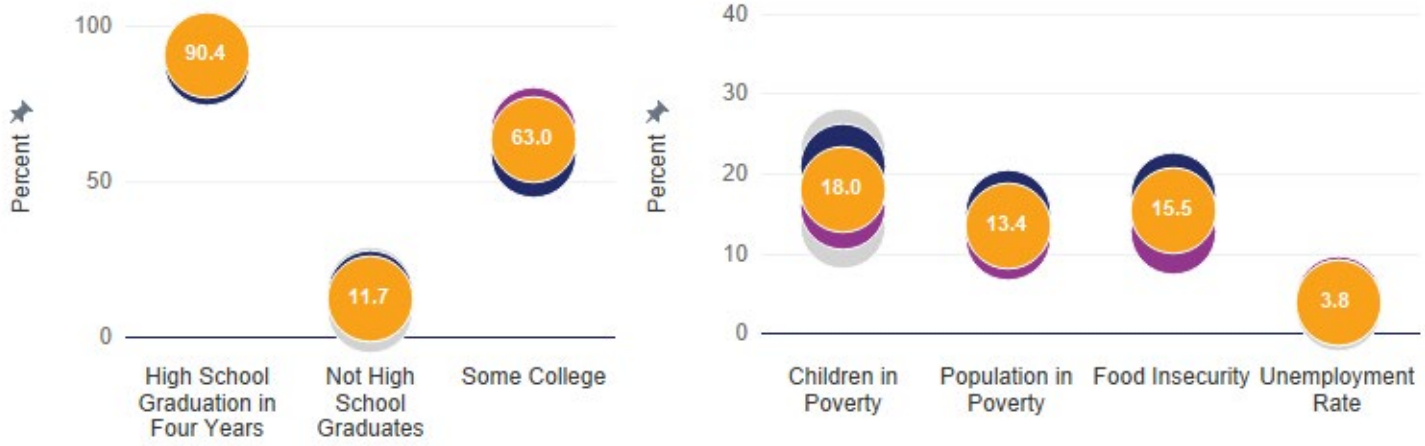
FIGURE 8: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT ACCESS INDICATORS

SOCIAL AND ECONOMIC FACTORS

TABLE 10: SOCIAL AND ECONOMIC FACTORS INDICATORS AND RATES

		Faulkner County	Perry County	Community Average	State	National
Not High School Graduates	*Percentage of adults ages 25 or older without a high school diploma*	8.2	15.2	11.7	13.4	12.0
High School Graduation in Four Years	*Percentage of ninth-grade cohort who graduated in four years*	90.9	89.8	90.4	88.2	87.7
Some College	*Percentage of adults ages 25-44 with some post-secondary education*	66.8	59.2	63.0	58.5	66.1
Unemployment Rate	*Unemployment rate among civilian non-institutionalized population age 16 and older in January 2022*	3.2	4.4	3.8	3.8	4.4
Children in Poverty	*Percentage of children under age 18 below the poverty line*	13.3	22.7	18.0	20.8	15.7
Population in Poverty	*Percentage of population below the federal poverty line*	12.0	14.7	13.4	15.2	11.9
Children in Single-Parent Households	*Percentage of children who live in a household headed by single parent*	22.4	23.4	22.9	28.9	25.5
Homeless Children	*Rate of homelessness among public school students*	3.4	0.9	2.2	2.8	2.8
Food Insecurity	*Percentage of the population that experienced food insecurity in the report year*	16.2	14.7	15.5	17.3	12.6
Social Associations	*Number of membership associations per 100,000 population*	101.6	86.2	93.9	126.5	105.0
Violent Crimes	*Annual rate of reported violent crimes per 100,000 population*	372.8	434.0	403.4	549.2	416.0

FIGURE 9: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT SOCIAL AND ECONOMIC FACTORS INDICATORS



ENVIRONMENT

TABLE 11: ENVIRONMENT INDICATORS AND RATES

		Faulkner County	Perry County	Community Average	State	National
Food Environment Index	*Index of factors that contribute to a healthy food environment, 0 (worst) to 10 (best)*	7.2	6.8	7.0	5.1	7.8
Drinking Water Violations	*The total number of drinking water violations recorded in a two-year period*	0.0	2.0	1.0	118.0	4,739.0
Access to Exercise Opportunities	*Percentage of population with adequate access to locations for physical activity*	55.2	46.1	50.6	63.5	84.2
Severe Housing Problems	*Percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, or lack of kitchen or plumbing*	16.2	7.7	12.0	14.1	17.5
Broadband Access	*Percentage of population in a high-speed internet service area; access to DL speeds > 25MBPS (2020)*	98.9	87.4	93.1	91.4	97.5
Long Commute Driving Alone	*Among workers who commute in their car alone, the percentage who commute more than 30 minutes*	38.2	62.4	50.3	27.0	36.6

FIGURE 10: COMMUNITY, STATE, AND NATIONAL COMPARISON OF THE FOOD ENVIRONMENT INDEX INDICATOR

FIGURE 11: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT ENVIRONMENT INDICATORS

DIAGNOSES INCIDENCE WITHIN HOSPITAL COMMUNITY AT DISCHARGE

TABLE 12: DIAGNOSES INCIDENCE WITHIN HOSPITAL COMMUNITY AT DISCHARGE INDICATORS AND RATES

		Faulkner County	Perry County	Community Average	State
Arthritis	*Number of individuals 18 years and older discharged with a primary or secondary arthritis diagnosis as a percentage of the population 18 years and older*	2.2	2.8	2.5	2.3
Diabetes	*Number of individuals 18 years and older discharged with a primary or secondary diabetes diagnosis as a percentage of the population 18 years and older*	3.2	4.9	4.1	3.9
Hyperlipidemia	*Number of individuals 18 years and older discharged with a primary or secondary hyperlipidemia diagnosis as a percentage of the population 18 years and older*	3.5	4.5	4.0	3.9
Hypertension	*Number of individuals 18 years and older discharged with a primary or secondary hypertension diagnosis as a percentage of the population 18 years and older*	8.1	11.3	9.7	9.5
Ischemic Heart Disease	*Number of individuals 18 years and older discharged with a primary or secondary ischemic heart disease diagnosis as a percentage of the population 18 years and older*	1.7	3.1	2.4	2.5

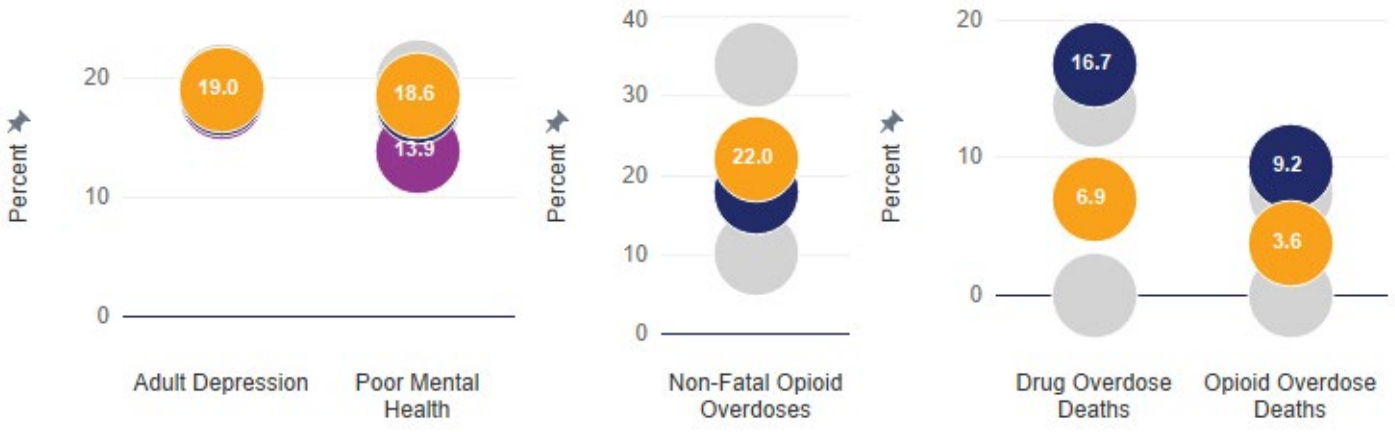
FIGURE 12: DIAGNOSES INCIDENCE WITHIN HOSPITAL COMMUNITY AT DISCHARGE INDICATORS

MENTAL HEALTH AND SUBSTANCE USE

TABLE 13: MENTAL HEALTH AND SUBSTANCE USE INDICATORS AND RATES

		Faulkner County	Perry County	Community Average	State	National
Excessive Drinking	*Percentage of adults reporting binge or heavy drinking*	17.1	17.2	17.2	17.3	19.2
Poor Mental Health	*Percentage of adults ages 18 or older reporting poor mental health for 14 or more days*	17.4	19.7	18.6	18.0	13.9
Youth Depression	*Percentage of public school students in 6th, 8th, 10th, and 12th grade who had feelings of depression all of the time in the past 30 days*	11.5	Data Not Available	Data Not Available	12.1	Data Not Available
Adult Depression	*The prevalence of depression among Medicare fee-for-service beneficiaries*	19.3	18.6	19.0	18.7	18.4
Suicide Deaths	*The rate of deaths by suicide (ICD-10 codes U03, X60-X84, Y87.0) per 100,000 population (age-adjusted)*	16.4	Data Not Available	Data Not Available	18.8	13.8
Non-Fatal Opioid Overdoses	*Non-fatal opioid overdoses per 100,00 population (based on county of occurrence)*	34.0	10.0	22.0	17.7	Data Not Available
Opioid Overdose Deaths	*Opioid-related deaths per 100,00 population (based on county of occurrence)*	7.3	0.0	3.6	9.2	Data Not Available
Drug Overdose Deaths	*Opioid-related deaths per 100,00 population (based on county of occurrence)*	13.8	0.0	6.9	16.7	Data Not Available

FIGURE 13: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT MENTAL HEALTH AND SUBSTANCE USE INDICATORS

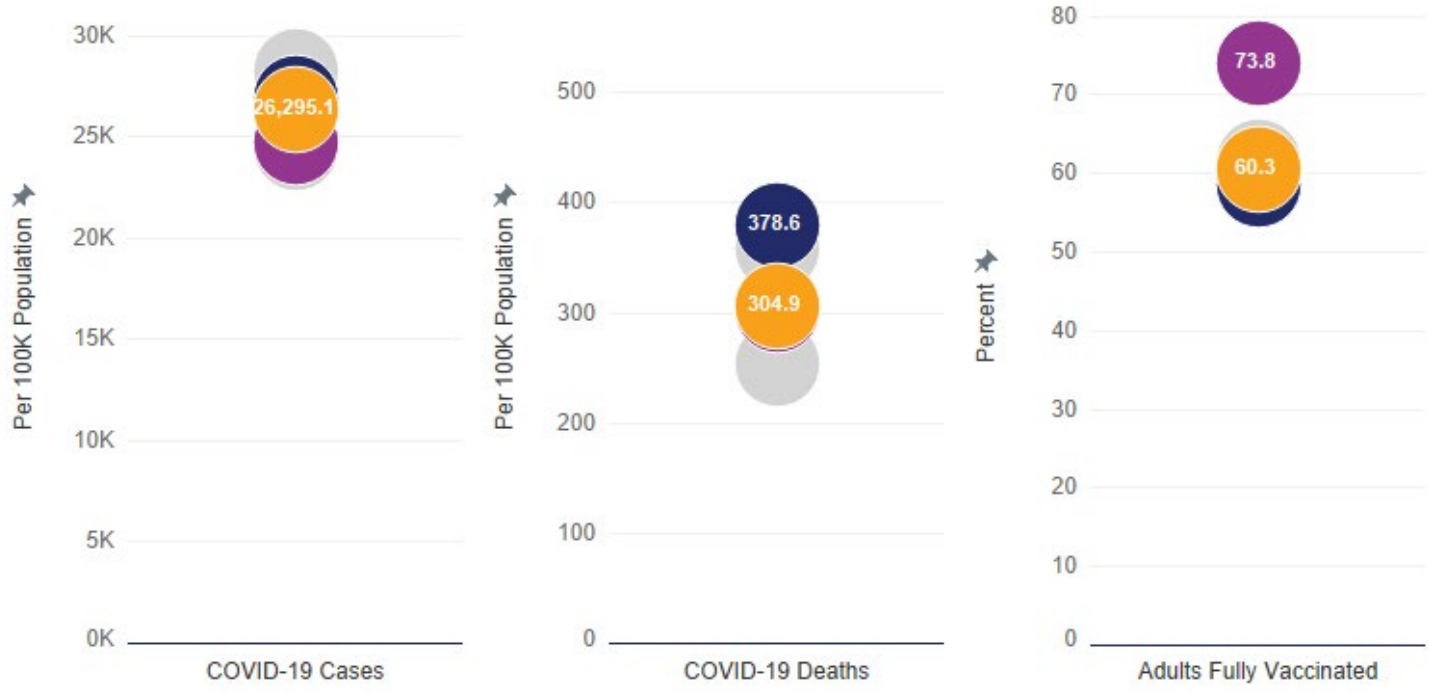


COVID-19

TABLE 14: COVID-19 INDICATORS AND RATES

		Faulkner County	Perry County	Community Average	State	National
COVID-19 Cases	*The incidence rate of confirmed COVID-19 cases per 100,000 population, as of May 12, 2022*	28,218.2	24,372.1	26,295.1	26,900.1	24,718.7
COVID-19 Deaths	*The rate of deaths among patients with confirmed cases of COVID-19 per 100,000 population, as of May 12, 2022*	252.4	357.4	304.9	378.6	301.3
Adults Fully Vaccinated	*The percentage of adults fully vaccinated for COVID-19, as of May 11, 2022*	59.3	61.3	60.3	58.4	73.8
Adult COVID-19 Vaccine Hesitancy	*The percentage of the population estimated to be hesitant toward receiving a COVID-19 vaccine*	21.0	20.9	20.9	20.4	10.3

FIGURE 14: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT COVID-19 INDICATORS



BAPTIST HEALTH MEDICAL CENTER

VAN BUREN

About Baptist Health-Van Buren

Located in historic Van Buren, Arkansas, Baptist Health-Van Buren is a 103-bed acute care hospital and is accredited by the Joint Commission. The hospital has received Quality Improvement and Innovator awards from the Arkansas Foundation for Medical Care. We offer comprehensive medical services with an emphasis on customer service. Our goal is to provide you and your family exceptional care in a comfortable setting.

2020-2022 Accomplishments

Access to Care

- Recruited a new APRN for the Baptist Health Family Clinic-Alma
- Opened a new Urgent Care Clinic
- Partnered with Community Outreach to offer a Flu Shot clinic
- Emergency Room recognized as Level IV trauma center, having the ability to provide advanced trauma life support (ATLS) prior to the transfer of patients to a higher-level trauma center. Obesity:
- Promoted Baptist Health Virtual Care Program to improve access to care

Mental Health:

- Utilized Social Media to promote Mental Health Awareness

Obesity

- Baptist Health Physicians partnered with Butterfield Trail Middle School to provide education on health eating and exercise
- Utilized the Smoothie Bike in schools to promote the connection between healthy eating and physical fitness
- Offered low cost membership to the Marvin Altman Fitness Center to promote physical activity

COMMUNITY HEALTH NEEDS ASSESSMENT – IMPLEMENTATION PLAN 2023-2025

Baptist Health Medical Center - Van Buren

IDENTIFIED COMMUNITY HEALTH NEED: **Access to Healthcare Services**

GOALS / OBJECTIVES:

Increase Access to Quality Health Care, Preventive Health Screenings, Vaccinations and Community Resources.

STRATEGY #1

Utilize the Mobile Health Unit (MHU) and Community Partnerships to provide preventive screenings and increase access to care.

Action Steps:

1. Utilize the MHU to immunizations, flu shots and Covid-19 Vaccinations
2. Provide Community Based Preventative Health Screenings for Diabetes, Hypertension, Cholesterol and Covid-19.
3. Utilize the Findhelp.org system to refer and track patents in need of additional resources
4. Continue to promote and utilize local Baptist Health Urgent Care facilities to meet community needs
5. Continue support of the Good Samaritan Clinic to serve the underserved, uninsured and under-insured populations

Performance Metrics:

1. Track and Report the number of individuals screened and vaccinated on the Mobile Health Unit
2. Track and report the number of patients utilizing virtual care on the MHU.
3. Track and report the number of referrals submitted through the Findhelp.org system
4. Track and report the number of Preventative Health Screenings and referrals
5. Track and report the number of patients utilizing the Findhelp.org system for resources

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:

Community Centers, Local schools, faith based community and other not-for-profit agencies

Resources Hospital Plans to Commit to Address Health Need:	Estimated Completion Date:	Person(s) / Department Responsible:
• Staff and Printing	• Ongoing	• Community OutreachTeam, Mobile Health Unit Driver, Nursing Staff

COMMUNITY HEALTH NEEDS ASSESSMENT – IMPLEMENTATION PLAN 2023-2025

Baptist Health Medical Center - Van Buren

IDENTIFIED COMMUNITY HEALTH NEED: **Mental Health**

GOALS / OBJECTIVES:

Increase awareness and support of community members dealing with mental health concerns.

STRATEGY #1

Reduce the stigma associated with mental health through education and treatment .

Action Steps:

1. Offer annual based Mental Health First Aid presentations to community groups and faith-based organizations.
2. Host seminars, presentations with an emphasis on decreasing stigma.
3. Provide education and outreach efforts via seminars, events and telehealth on the relationship between substance abuse and mental health.
4. Utilize Findhelp.org and the 211 system to refer individuals for Mental Health Services
5. Participate in the Sebastian County Opioid Task Force Coalition

Performance Metrics:

1. Number of Community Based Mental Health First Aid Presentations will be tracked and reported.
2. Number of seminars, presentations will be tracked and reported.
3. Track the number of individuals referred for additional resources and services
4. Track and report projects implemented via the Opioid Task Force

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:

Faith Based Communities, Adverse Childhood Experiences Statewide Coalition

Resources Hospital Plans to Commit to Address Health Need:	Estimated Completion Date:	Person(s) / Department Responsible:
• Community Outreach Staff, Behavioral Health	• Ongoing	• Community Outreach Team, Behavioral Health

COMMUNITY HEALTH NEEDS ASSESSMENT – IMPLEMENTATION PLAN 2023-2025

Baptist Health Medical Center - Van Buren

IDENTIFIED COMMUNITY HEALTH NEED: **Nutrition & Food Security**

GOALS / OBJECTIVES:

Initiate Evidence Based Nutrition Security strategies to address obesity, diabetes, hypertension, and other diet-related chronic conditions.

STRATEGY #1

Initiate Evidence Based Nutrition Security strategies to address obesity, diabetes, hypertension, and other diet-related chronic conditions.

Action Steps:

1. Implement a Virtual Maintain, Don't Gain holiday challenge program for adult community members that encourages using stress management strategies, physical activity, and healthful food choices during the holiday season to maintain one's physical and mental health and avoid holiday weight gain.
2. Implement Cooking with Community Outreach classes to empower participants to build cooking skills, cook more healthy meals, reduce food waste, and make healthier selections at the grocery store.
3. Utilize the Epic System to screening for Food Insecurity for inpatients visits
4. Explore opportunity to partner with AHG clinics to screen for Food Insecurity and provide food through the FoodRX program for those in need

Performance Metrics:

1. Coordinate implementation of the Maintain, Don't Gain Holiday Challenge
2. Partner with Community Outreach to implement a Community -Based Community Outreach Cooking Classes
3. Track and report the number of patents screened for Food insecurity
4. Track and report the number of patients receiving services from the FoodRX program

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:

Arkansas Hunger Relief Alliance, Central AR Library System, Be Might

Resources Hospital Plans to Commit to Address Health Need:

- Community Outreach Staff , Pharmacy Manager

Estimated Completion Date:

- Ongoing

Person(s) / Department Responsible:

- Community Outreach Team, Fort Smith Leadership Team

VAN BUREN

ASSESSMENT PREPARED BY ACHI
INSPIRING HEALTHY ACTS

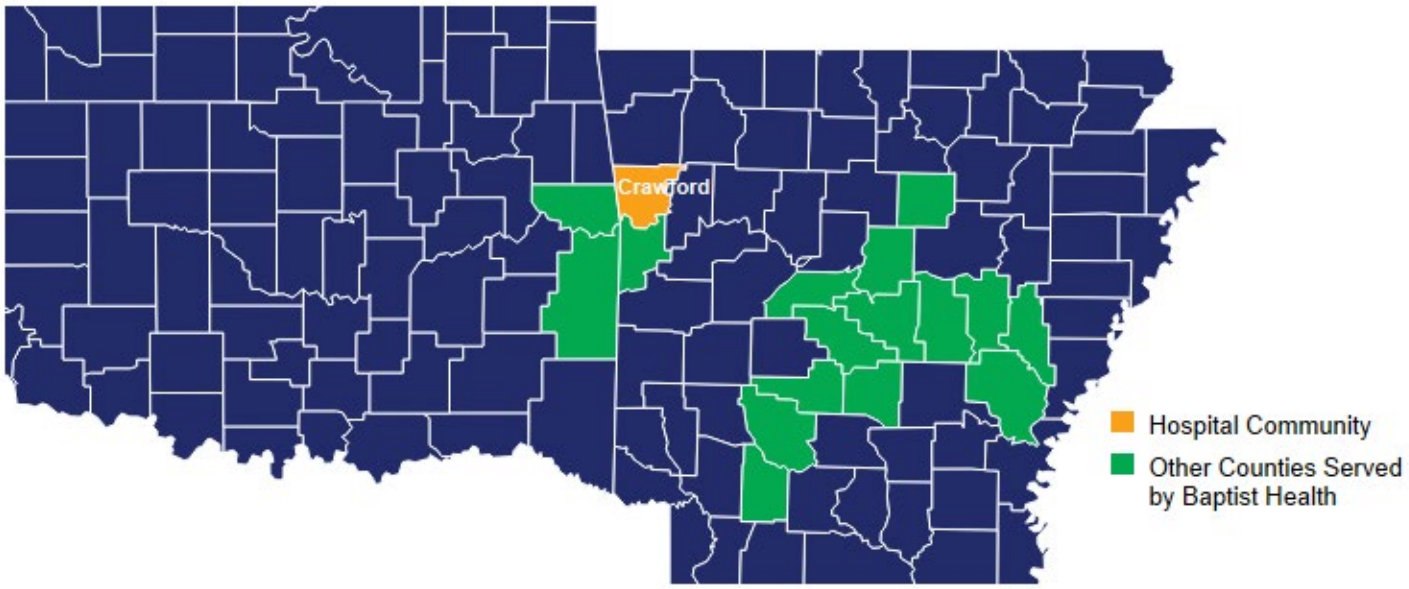
Introduction

Baptist Health engaged the Arkansas Center for Health Improvement (ACHI) to conduct the quantitative data collection and analysis for the 2022 Community Health Needs Assessment (CHNA) process. Baptist Health provided ACHI with the counties served for each of its 11 hospital communities. A total of 15 Arkansas counties and two Oklahoma counties were included in the CHNA.

This report shows the qualitative results from the CHNA for the Baptist Health-Van Buren hospital community, which includes Crawford County.

HOSPITAL COMMUNITY

FIGURE 1: COUNTIES SERVED BY BAPTIST HEALTH MEDICAL CENTER-VAN BUREN



Qualitative Results

Quantitative results from the CHNA for the Baptist Health-Van Buren hospital community are reported below. There are 12 sections: Demographics, Health Outcomes, Cause of Death, Chronic Conditions, Health Behaviors, Prevention, Access, Social and Economic Factors, Environment, Diagnoses Incidence Within Hospital Community at Discharge, Mental Health and Substance Use, and COVID-19.

Each section includes a table with health indicator data for each county in the hospital community, a community average for each measurement, and averages for the state of Arkansas and the United States. If data were not available or were suppressed, “Data Not Available” 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 document and Appendix 1.

DEMOGRAPHICS

TABLE 1: AGE AND SEX

		Crawford County	State	National
Total Population	*Number*	62,739.0	2,999,370.0	324,697,795.0
Ages 0-4	*Percent*	6.3	6.3	6.1
Ages 5-17	*Percent*	18.4	17.2	16.5
Ages 18-24	*Percent*	8.0	9.5	9.4
Ages 25-34	*Percent*	12.6	13.1	13.9
Ages 35-44	*Percent*	12.2	12.3	12.6
Ages 45-54	*Percent*	13.1	12.4	13.0
Ages 55-64	*Percent*	13.2	12.7	12.9
Ages 65+	*Percent*	16.4	16.6	15.6
Male	*Percent*	49.3	49.1	49.2
Female	*Percent*	50.7	50.9	50.8

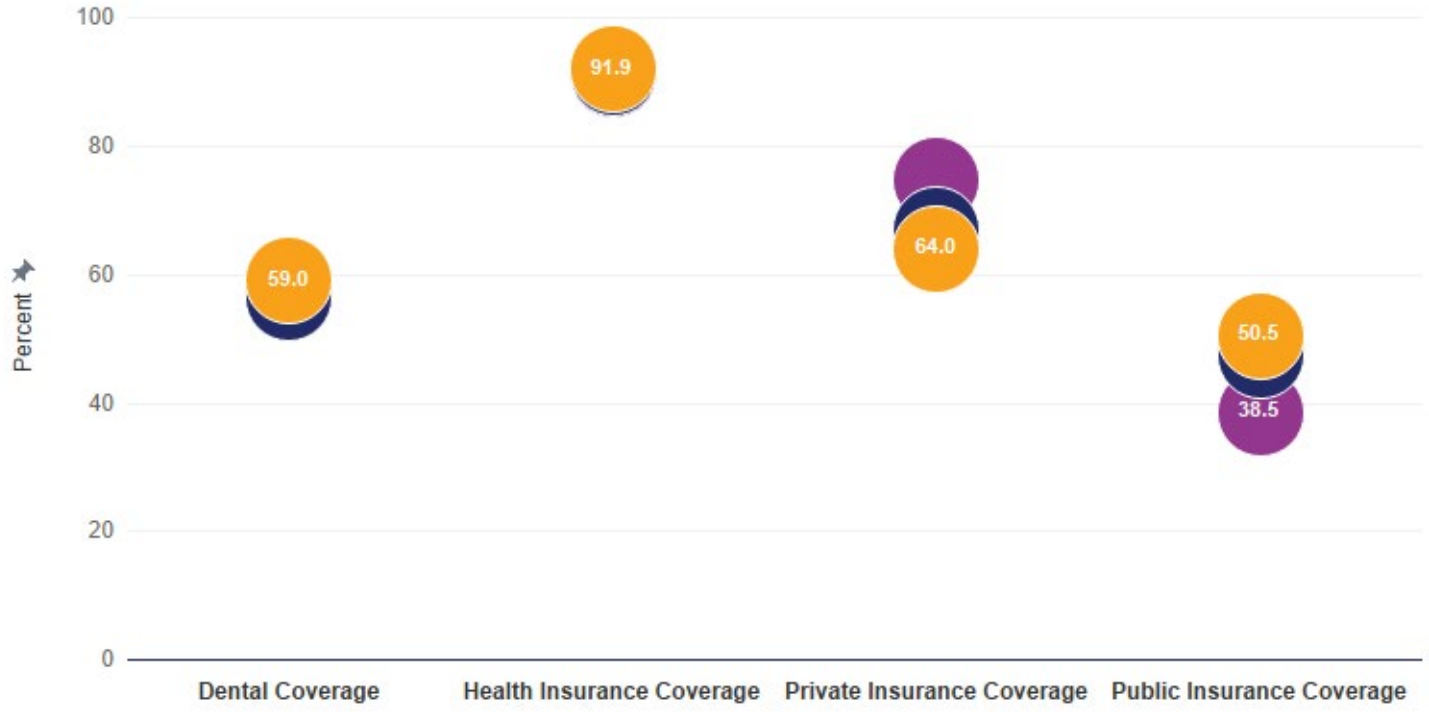
TABLE 2: RACE, ETHNICITY, AND LANGUAGE

		Crawford County	State	National
Total Population	*Number*	62,739.0	2,999,370.0	324,697,795.0
Hispanic or Latino	*Percent*	7.7	7.5	18.0
Non-Hispanic White	*Percent*	84.3	72.4	60.7
Black or African American	*Percent*	1.6	15.3	12.7
Native American/Alaska Native	*Percent*	2.3	0.7	0.9
Asian	*Percent*	1.9	1.5	5.6
Native Hawaiian/Pacific Islander	*Percent*	0.0	0.3	0.2
Some Other Race	*Percent*	3.0	2.8	4.9
Two or More Races	*Percent*	3.2	2.7	3.3
Non-English Language Households	*Percent*	1.7	1.6	4.4

TABLE 3: INSURANCE COVERAGE

		Crawford County	Community Average	State	National
Health Insurance Coverage	*Percentage of total civilian non-institutionalized population with health insurance coverage*	91.9	91.9	91.5	91.2
Private Insurance Coverage	*Percentage of total civilian non-institutionalized population with private health insurance coverage*	64.0	64.0	67.0	74.5
Public Insurance Coverage	*Percentage of total civilian non-institutionalized population with public health insurance coverage*	50.5	50.5	47.3	38.5
Dental Coverage	*Percentage of Arkansas residents with evidence of any dental coverage in the All-Payer Claims Database (APCD)*	59.0	59.0	56.2	Data Not Available

FIGURE 2: COMMUNITY, STATE, AND NATIONAL COMPARISON OF INSURANCE COVERAGE

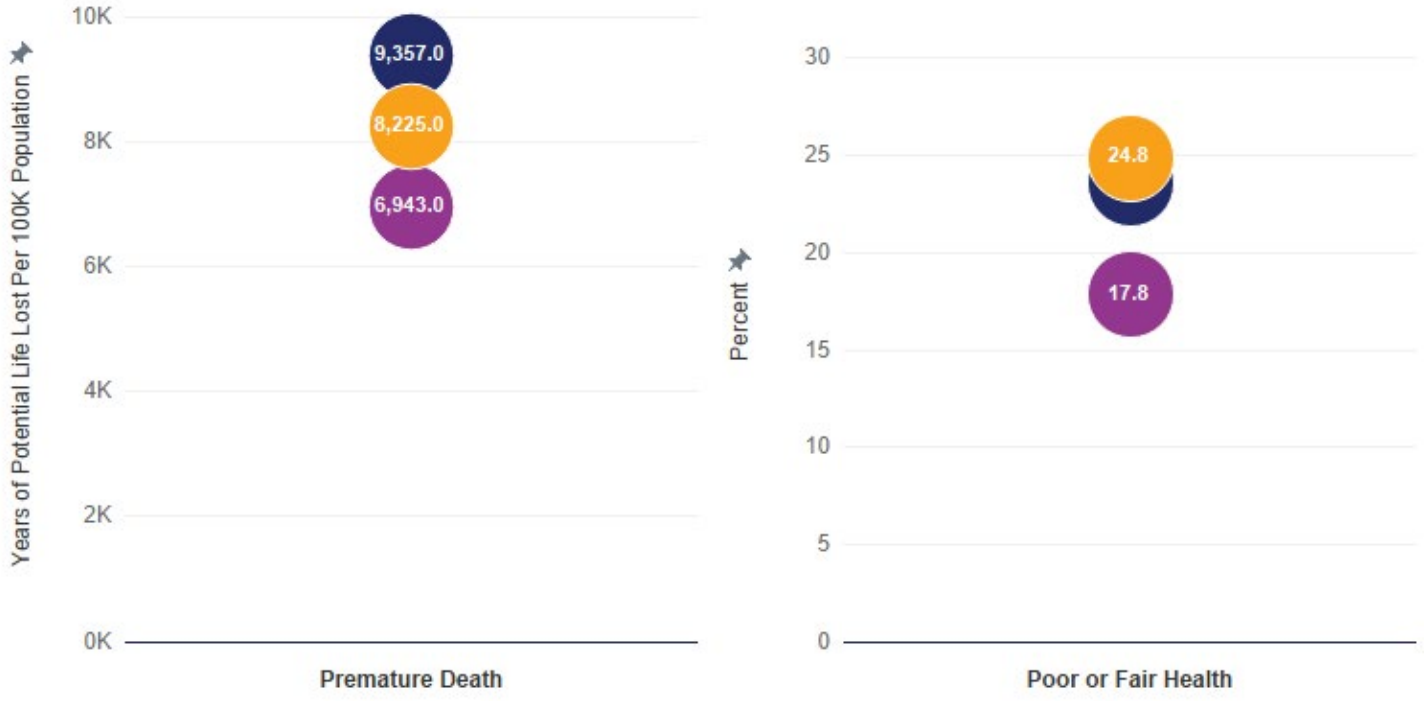


HEALTH OUTCOMES

TABLE 4: HEALTH OUTCOMES INDICATORS AND RATES

		Crawford County	Community Average	State	National
Premature Death	*Years of potential life lost before age 75 per 100,000 population (age-adjusted)*	8,225.0	8,225.0	9,357.0	6,943.0
Poor or Fair Health	*Percentage of adults reporting poor or fair health*	24.8	24.8	23.6	17.8
Poor Physical Health Days	*Average number of physically unhealthy days reported in past 30 days (age-adjusted)*	5.4	5.4	4.9	4.0
Low Birthweight	*Percentage of live births with low birth weight (<2500g)*	8.1	8.1	9.1	8.2

FIGURE 3: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT HEALTH OUTCOMES INDICATORS

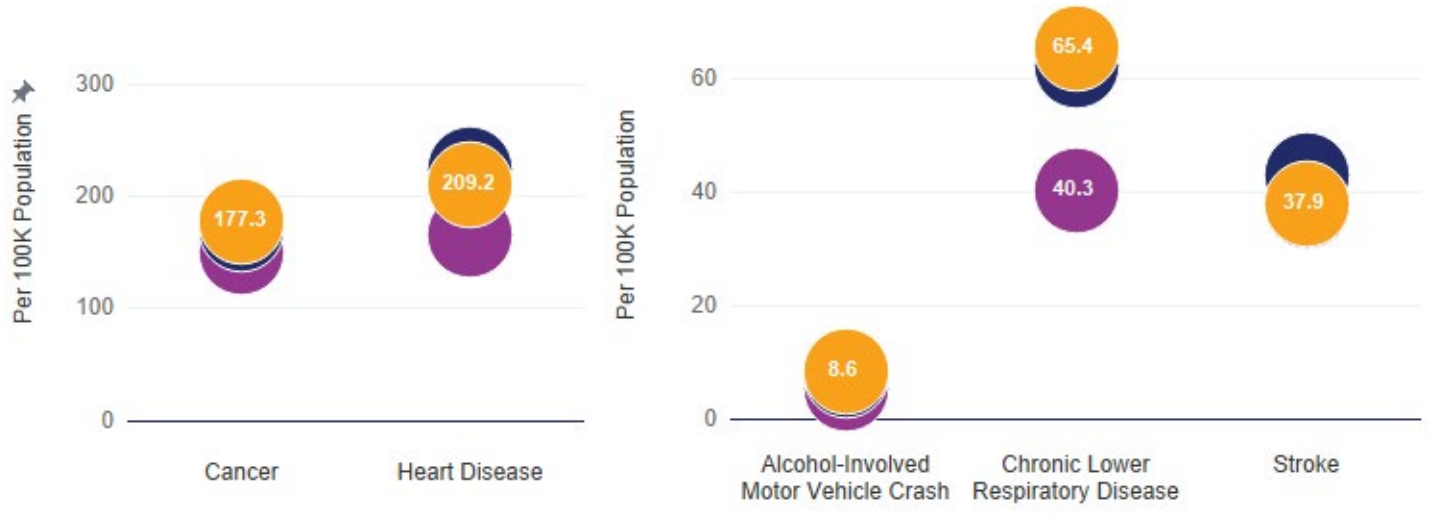


CAUSE OF DEATH

TABLE 5: CAUSE OF DEATH INDICATORS AND RATES

		Crawford County	Community Average	State	National
All Causes	*All causes of deaths per 100,000 population (age-adjusted)*	867.3	867.3	888.4	727.2
Cancer	*5-year average rate of death due to malignant neoplasm (cancer) per 100,000 population (age-adjusted)*	177.3	177.3	170.1	149.4
Stroke	*5-year average rate of death due to cerebrovascular disease (stroke) per 100,000 population (age-adjusted)*	37.9	37.9	43.0	37.6
Chronic Lower Respiratory Disease	*Rate of deaths due to chronic lower respiratory disease per 100,000 population (age-adjusted)*	65.4	65.4	62.1	40.3
Diabetes	*Diabetes deaths per 100,000 population (age-adjusted)*	23.7	23.7	29.0	21.4
Heart Disease	*Rate of death due to heart disease per 100,000 population (age-adjusted)*	209.2	209.2	222.7	164.8
Unintentional Injury	*5-year average rate of death due to unintentional injury (accident) per 100,000 population (age-adjusted)*	40.8	40.8	51.7	50.4
Motor Vehicle Crash	*5-year average rate of death due to motor vehicle crash per 100,000 population (age-adjusted)*	15.0	15.0	18.9	11.5
Alcohol-Involved Motor Vehicle Crash	*Rate of persons killed in motor vehicle crashes involving alcohol as a rate per 100,000 population*	8.6	8.6	7.8	5.3

FIGURE 4: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT CAUSE OF DEATH INDICATORS

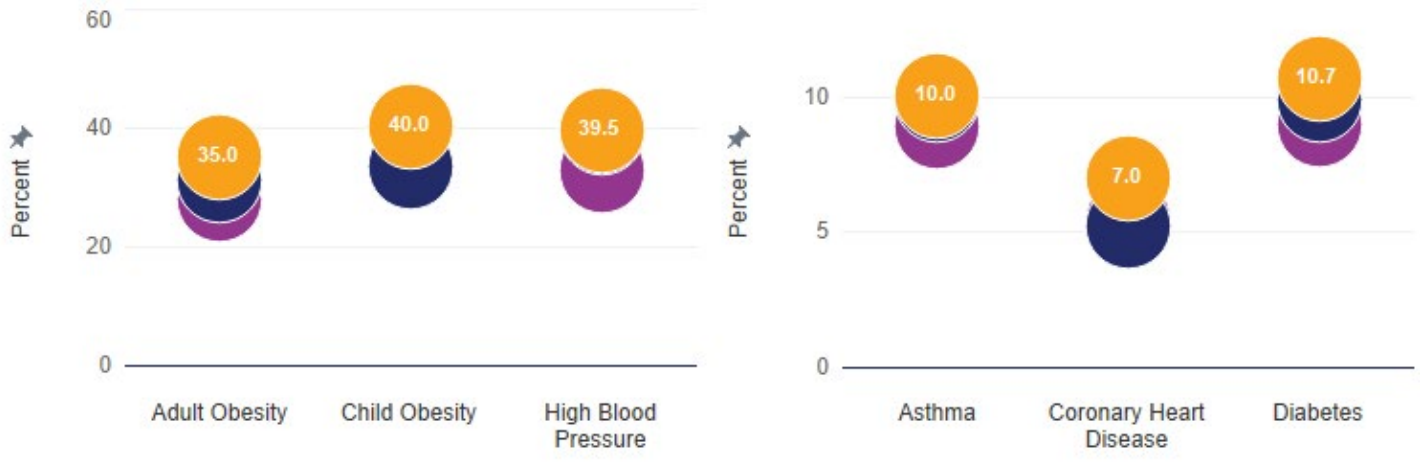


CHRONIC CONDITIONS

TABLE 6: CHRONIC CONDITIONS INDICATORS AND RATES

		Crawford County	Community Average	State	National
High Blood Pressure	*Percentage of adults who have been told they have high blood pressure*	39.5	39.5	39.0	32.6
Asthma	*Percentage of adults who have been told they currently have asthma (age-adjusted)*	10.0	10.0	9.9	8.9
Coronary Heart Disease	*Percentage of adults who have been told they have angina or coronary heart disease (age-adjusted)*	7.0	7.0	5.2	5.4
Arthritis	*Percentage of adults ages 18 or older diagnosed with some form of arthritis*	31.2	31.2	34.3	Data Not Available
High Cholesterol	*Percentage of adults who have had their blood cholesterol checked and have been told it was high*	38.9	38.9	36.7	33.6
Diabetes	*Percentage of adults ages 20 and older who have ever been told by a doctor that they have diabetes (age-adjusted)*	10.7	10.7	9.9	9.0
Adult Obesity	*Percentage of adults ages 20 and older who report a BMI higher than 30*	35.0	35.0	31.0	27.6
Child Obesity	*Percentage of students classified as overweight or obese, by county location of school*	40.0	40.0	33.1	Data Not Available

FIGURE 5: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT CHRONIC CONDITIONS INDICATORS



HEALTH BEHAVIORS

TABLE 7: HEALTH BEHAVIORS INDICATORS AND RATES

		Crawford County	Community Average	State	National
Adult Smoking	*Percentage of adults who are current smokers (age-adjusted)*	22.7	22.7	21.2	15.7
Youth Vaping	*Percentage of public school students in 6th, 8th, 10th, and 12th grade who used any vape in the past 30 days*	Data Not Available	Data Not Available	11.7	Data Not Available
Physical Inactivity	*Percentage of adults ages 20 or older reporting no physical activity in the past month*	27.2	27.2	26.2	22.0
Sexually Transmitted Infections	*Number of newly diagnosed chlamydia cases per 100,000 population*	347.6	347.6	587.9	539.9
Teen Births	*The seven-year average number of teen births per 1,000 female population, ages 15-19*	38.7	38.7	35.5	20.9

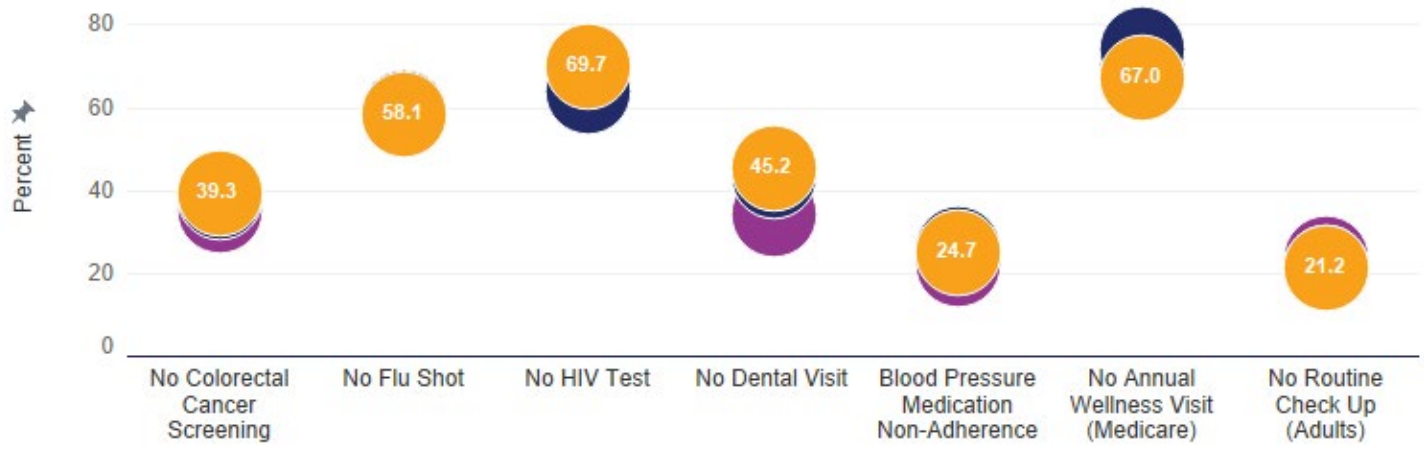
FIGURE 6: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT HEALTH BEHAVIORS INDICATORS

PREVENTION

TABLE 8: PREVENTION INDICATORS AND RATES

		Crawford County	Community Average	State	National
No Pap Test	*Percentage of women ages 21 to 65 who have not had a pap test within the past 3 years (age-adjusted)*	17.2	17.2	16.3	14.5
No Colorectal Cancer Screening	*Percentage of adults ages 50-75 who have never had either a sigmoidoscopy or colonoscopy (age-adjusted)*	39.3	39.3	38.1	35.0
No Flu Shot	*Percentage of adults ages 18 or older who have not had a flu shot in the past year*	58.1	58.1	58.5	58.1
No HIV Test	*Percentage of adults ages 18 or older who have never been screened for HIV*	69.7	69.7	63.6	Data Not Available
No Dental Visit	*Percentage of adults ages 18 or older who have not had a dentist or dental clinic visit in the previous year (age-adjusted)*	45.2	45.2	43.4	33.8
Blood Pressure Medication Non-Adherence	*The percentage of Medicare enrollees who did not adhere to blood pressure medication schedules*	24.7	24.7	25.9	21.8
No Annual Wellness Visit (Medicare)	*The percentage of Medicare enrollees who did not have an annual wellness visit in the past year*	67.0	67.0	74.0	70.0
No Routine Check Up (Adults)	*The percentage of adults age 18 or older with no routine check up with a doctor in the past year*	21.2	21.2	21.0	23.4

FIGURE 7: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT PREVENTION INDICATORS

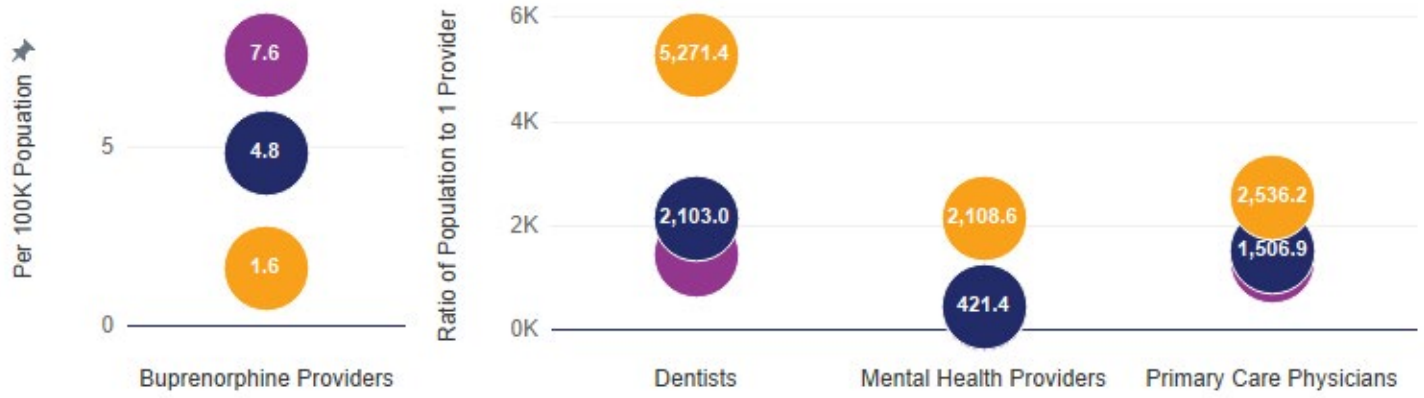


ACCESS

TABLE 9: ACCESS INDICATORS AND RATES

		Crawford County	Community Average	State	National
Mammography	*Percentage of female Medicare enrollees ages 65-74 who received an annual mammography screening*	38.0	38.0	38.0	42.0
Diabetic Monitoring	*Percentage of diabetic Medicare enrollees over age 65 who had a hemoglobin A1c test in the past year*	87.5	87.5	88.5	87.5
Uninsured	*Percentage of adults under age 65 without health insurance coverage*	11.2	11.2	10.8	10.8
Primary Care Physicians	*Ratio of population to one primary care physician*	2,536.2	2,536.2	1,506.9	1,319.0
Dentists	*Ratio of population to one dentist*	5,271.4	5,271.4	2,103.0	1,404.5
Mental Health Providers	*Ratio of population to one mental health provider*	2,108.6	2,108.6	421.4	382.3
Addiction or Substance Use Providers	*Rate of addiction or substance use providers per 100,000 population*	0.0	0.0	4.4	20.4
Buprenorphine Providers	*Rate of buprenorphine providers per 100,000 population*	1.6	1.6	4.8	7.6
Preventable Hospital Stays	*Number of hospital stays for ambulatory care-sensitive conditions per 1,000 Medicare enrollees*	4,683.0	4,683.0	4,769.0	4,236.0

FIGURE 8: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT ACCESS INDICATORS

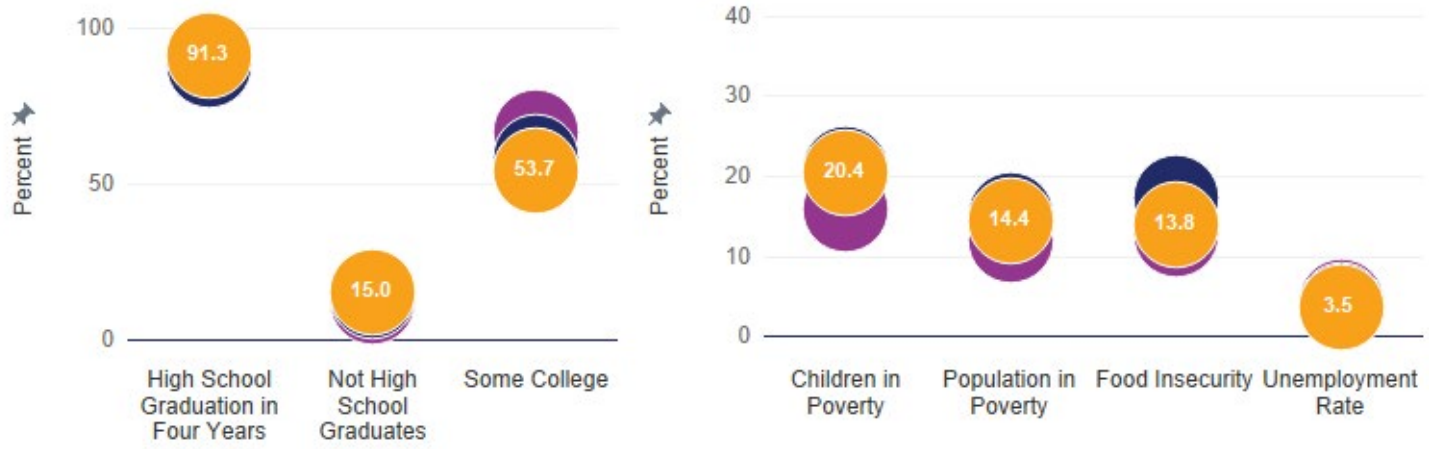


SOCIAL AND ECONOMIC FACTORS

TABLE 10: SOCIAL AND ECONOMIC FACTORS INDICATORS AND RATES

		Crawford County	Community Average	State	National
Not High School Graduates	*Percentage of adults ages 25 or older without a high school diploma*	15.0	15.0	13.4	12.0
High School Graduation in Four Years	*Percentage of ninth-grade cohort who graduated in four years*	91.3	91.3	88.2	87.7
Some College	*Percentage of adults ages 25-44 with some post-secondary education*	53.7	53.7	58.5	66.1
Unemployment Rate	*Unemployment rate among civilian non-institutionalized population age 16 and older in January 2022*	3.5	3.5	3.8	4.4
Children in Poverty	*Percentage of children under age 18 below the poverty line*	20.4	20.4	20.8	15.7
Population in Poverty	*Percentage of population below the federal poverty line*	14.4	14.4	15.2	11.9
Children in Single-Parent Households	*Percentage of children who live in a household headed by single parent*	27.2	27.2	28.9	25.5
Homeless Children	*Rate of homelessness among public school students*	2.5	2.5	2.8	2.8
Food Insecurity	*Percentage of the population that experienced food insecurity in the report year*	13.8	13.8	17.3	12.6
Social Associations	*Number of membership associations per 100,000 population*	74.3	74.3	126.5	105.0
Violent Crimes	*Annual rate of reported violent crimes per 100,000 population*	378.9	378.9	549.2	416.0

FIGURE 9: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT SOCIAL AND ECONOMIC FACTORS INDICATORS



ENVIRONMENT

TABLE 11: ENVIRONMENT INDICATORS AND RATES

		Crawford County	Community Average	State	National
Food Environment Index	*Index of factors that contribute to a healthy food environment, 0 (worst) to 10 (best)*	7.0	7.0	5.1	7.8
Drinking Water Violations	*The total number of drinking water violations recorded in a two-year period*	0.0	0.0	118.0	4,739.0
Access to Exercise Opportunities	*Percentage of population with adequate access to locations for physical activity*	74.4	74.4	63.5	84.2
Severe Housing Problems	*Percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, or lack of kitchen or plumbing*	12.0	12.0	14.1	17.5
Broadband Access	*Percentage of population in a high-speed internet service area; access to DL speeds > 25MBPS (2020)*	95.8	95.8	91.4	97.5
Long Commute Driving Alone	*Among workers who commute in their car alone, the percentage who commute more than 30 minutes*	26.1	26.1	27.0	36.6

FIGURE 10: COMMUNITY, STATE, AND NATIONAL COMPARISON OF THE FOOD ENVIRONMENT INDEX INDICATOR

FIGURE 11: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT ENVIRONMENT INDICATORS

DIAGNOSES INCIDENCE WITHIN HOSPITAL COMMUNITY AT DISCHARGE

TABLE 12: DIAGNOSES INCIDENCE WITHIN HOSPITAL COMMUNITY AT DISCHARGE INDICATORS AND RATES

		Crawford County	Community Average	State
Arthritis	*Number of individuals 18 years and older discharged with a primary or secondary arthritis diagnosis as a percentage of the population 18 years and older*	2.7	2.7	2.3
Diabetes	*Number of individuals 18 years and older discharged with a primary or secondary diabetes diagnosis as a percentage of the population 18 years and older*	4.4	4.4	3.9
Hyperlipidemia	*Number of individuals 18 years and older discharged with a primary or secondary hyperlipidemia diagnosis as a percentage of the population 18 years and older*	4.9	4.9	3.9
Hypertension	*Number of individuals 18 years and older discharged with a primary or secondary hypertension diagnosis as a percentage of the population 18 years and older*	10.6	10.6	9.5
Ischemic Heart Disease	*Number of individuals 18 years and older discharged with a primary or secondary ischemic heart disease diagnosis as a percentage of the population 18 years and older*	2.2	2.2	2.5

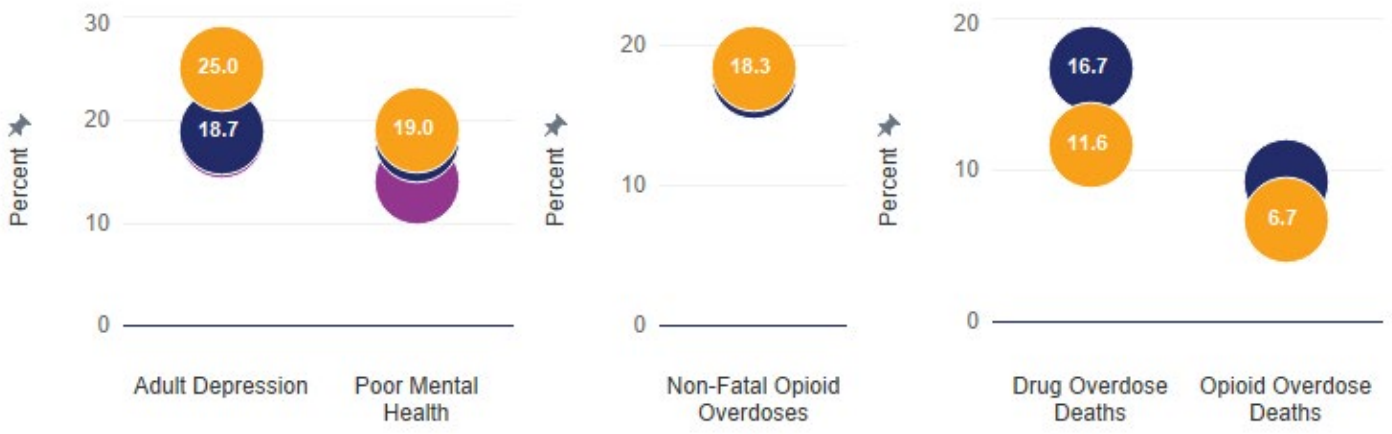
FIGURE 12: DIAGNOSES INCIDENCE WITHIN HOSPITAL COMMUNITY AT DISCHARGE INDICATORS

MENTAL HEALTH AND SUBSTANCE USE

TABLE 13: MENTAL HEALTH AND SUBSTANCE USE INDICATORS AND RATES

		Crawford County	Community Average	State	National
Excessive Drinking	*Percentage of adults reporting binge or heavy drinking*	15.6	15.6	17.3	19.2
Poor Mental Health	*Percentage of adults ages 18 or older reporting poor mental health for 14 or more days*	19.0	19.0	18.0	13.9
Youth Depression	*Percentage of public school students in 6th, 8th, 10th, and 12th grade who had feelings of depression all of the time in the past 30 days*	Data Not Available	Data Not Available	12.1	Data Not Available
Adult Depression	*The prevalence of depression among Medicare fee-for-service beneficiaries*	25.0	25.0	18.7	18.4
Suicide Deaths	*The rate of deaths by suicide (ICD-10 codes U03, X60-X84, Y87.0) per 100,000 population (age-adjusted)*	23.7	23.7	18.8	13.8
Non-Fatal Opioid Overdoses	*Non-fatal opioid overdoses per 100,00 population (based on county of occurrence)*	18.3	18.3	17.7	Data Not Available
Opioid Overdose Deaths	*Opioid-related deaths per 100,00 population (based on county of occurrence)*	6.7	6.7	9.2	Data Not Available
Drug Overdose Deaths	*Opioid-related deaths per 100,00 population (based on county of occurrence)*	11.6	11.6	16.7	Data Not Available

FIGURE 13: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT MENTAL HEALTH AND SUBSTANCE USE INDICATORS



COVID-19

TABLE 14: COVID-19 INDICATORS AND RATES

		Crawford County	Community Average	State	National
COVID-19 Cases	*The incidence rate of confirmed COVID-19 cases per 100,000 population, as of May 12, 2022*	25,038.6	25,038.6	26,900.1	24,718.7
COVID-19 Deaths	*The rate of deaths among patients with confirmed cases of COVID-19 per 100,000 population, as of May 12, 2022*	392.7	392.7	378.6	301.3
Adults Fully Vaccinated	*The percentage of adults fully vaccinated for COVID-19, as of May 11, 2022*	55.2	55.2	58.4	73.8
Adult COVID-19 Vaccine Hesitancy	*The percentage of the population estimated to be hesitant toward receiving a COVID-19 vaccine*	20.7	20.7	20.4	10.3

FIGURE 14: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT COVID-19 INDICATORS

BAPTIST HEALTH

REHABILITATION INSTITUTE

About Baptist Health Rehabilitation Institute-Little Rock

Open since 1974, Baptist Health Rehabilitation Institute-Little Rock is Arkansas' largest and most comprehensive physical medicine and rehabilitation hospital. Located on the Baptist Health Medical Center-Little Rock campus, the Rehab Institute allows convenient, 24-hour access to specialized services such as laboratory and pharmacy. In addition to specially-trained physical medicine and rehabilitation physicians, there are staff physicians in-house to respond to medical emergencies every weeknight from 5 pm to 8 am, and 24 hours a day on the weekends. This continual availability of specialized services and medical staff ensures timeliness of results reporting and responsiveness to orders.

The types of conditions that require rehabilitation are sometimes tragic and life-changing. Even the less complex rehabilitation issues can significantly impact one's day-to-day living. Baptist Health Rehabilitation Institute-Little Rock's team of physicians and therapists works with patients and their family members to achieve the goals that restore them to their highest level of function.

2020-2022 Accomplishments

Injury Prevention:

- Community Outreach Department offered Infant Car Seat safety training
- Community Outreach Department Safe sleep environment/ training for underserved populations
- Fall Risk prevention information was
- Provided safety training for Mems Training for safety transfer for spinal cord injured prevention
- Provide injury prevention education and training as our Southwest High School Academy

Obesity:

- Partnered with Community Outreach to implement the Sister to Sister Move More, Eat Less Campaign
- Offered discounts to community members utilizing the fitness center under the Buddy Program Initiative.
- Develop a promotional campaign to educate the community about the Buddy Program for the Fitness Center via web-site and social media
- Partnered with Community Outreach to implement a chair exercise initiative.

Mental Health:

- Partnered with Community Outreach to offer a Mental Health First Aid Training
- Promote the Baptist Health 24-hour behavioral Health-Line internally and externally.
- Little Rock Campus increased the number of based by adding 22 making a total of 131 beds available system wide
- Little Rock Campus Opened a Covid-19 Psychiatric space during the Pandemic
- Utilized the Baptist Health Command Center to gain quick access to resources available and provided referrals

COMMUNITY HEALTH NEEDS ASSESSMENT – IMPLEMENTATION PLAN 2023-2025

BHMC - Baptist Health Rehabilitation Institute

IDENTIFIED COMMUNITY HEALTH NEED: Access to Healthcare Services

GOALS / OBJECTIVES:

Increase Access to Quality Health Care through Education and Community Resources.

STRATEGY #1

Improve health outcomes through patient education and partnerships with patients and families

Action Steps:

1. Partner with Community Outreach and Health Management Center to Increase access to Diabetes complication prevention services and self-management resources including Diabetes Support Group.
2. Partner with Community Outreach to Increase access to Stroke complication prevention services and self-management resources including Stroke Support Group
3. Increase access to education on traumatic brain injuries, spinal cord injuries, strokes, amputations, orthopedic injuries and surgeries, sports related injuries, work-related injuries for community groups, MEMS and schools.

PERFORMANCE METRICS:

1. Track and Report the number of individuals Diabetes Education referrals
2. Track and report the number of Stroke Education Referrals
3. Track and Report the number of individuals participating education classes

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:

Community Centers, Little Rock Community Centers

Resources Hospital Plans to Commit to Address Health Need:	Estimated Completion Date:	Person(s) / Department Responsible:
• Staff and Printing	• Ongoing	• Community Outreach Department, Baptist Health Rehabilitation Institute Administration

COMMUNITY HEALTH NEEDS ASSESSMENT – IMPLEMENTATION PLAN 2023-2025

BHMC - Baptist Health Rehabilitation Institute

IDENTIFIED COMMUNITY HEALTH NEED: Mental Health

GOALS / OBJECTIVES:

Increase awareness and support of patients, caregivers and community members dealing with mental health concerns.

STRATEGY #1

Reduce the stigma associated with mental health through education and treatment .

Action Steps:

1. Continue to utilize the Suicide Screening tools on all patients discharged.
2. Educate patients and care-givers on the 24-hour behavioral health-line available to staff and patients.
3. Provide educational materials for patients and care-givers on stress management, depression, self-care during Mental Health Awareness Month
4. Offer Mental health activities that promote self-care, relaxation, and mindfulness including information on yoga, journaling, spending time in nature, art therapy, and music therapy at Community and recruitment events.

PERFORMANCE METRICS:

1. Number of suicide referrals will be tracked and reported.
2. Number of Individuals reached during Mental Health Awareness Month will be tracked and reported
3. Number of individuals provided mental health activities will be tracked and reported

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:

Resources Hospital Plans to Commit to Address Health Need:	Estimated Completion Date:	Person(s) / Department Responsible:
• Community Outreach Staff, Pharmacy, Behavioral Health	• Ongoing	• Baptist Health Community Outreach, Baptist Health Rehabilitation Institute Administration

COMMUNITY HEALTH NEEDS ASSESSMENT – IMPLEMENTATION PLAN 2023-2025

BHMC - Baptist Health Rehabilitation Institute

IDENTIFIED COMMUNITY HEALTH NEED: **Nutrition & Food Security**

GOALS / OBJECTIVES:

Initiate Evidence Based Nutrition Security strategies to address diabetes, Chronic Heart Disease, Hypertension, and other diet-related chronic conditions.

STRATEGY #1

Increase access to nutrition education and information among community members, caregivers, families and staff

Action Steps:

1. Utilize the Epic System to screening for Food Insecurity for inpatients visits and
2. Partner with Community Outreach's FoodRX Program to provide Healthy snacks and ready made food for patient caregivers and families who are food insecure
3. Provide health education materials and recipes on healthy eating to patients and families
4. Provide education to families and caregivers nutritional needs based on oral problems, height and weight, weight change, nutrition problems (altered taste, hunger, uneaten meals), approaches to nutritional care (nutrition support, mechanically altered food, therapeutic diets), and food intake.

PERFORMANCE METRICS:

1. Number of Participants screened for Food Insecurity
2. Number of Individuals served by the FoodRX program will be tracked and reported
3. Number of Educational encounters will be tracked and reported

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:

Community Outreach

Resources Hospital Plans to Commit to Address Health Need:

- Community Outreach Staff, Baptist Health Rehabilitation Institute Administration

Estimated Completion Date:

- Ongoing

Person(s) / Department Responsible:

- Baptist Health Community Outreach, Baptist Health Rehabilitation Institute Administration

BAPTIST HEALTH REHABILITATION INSTITUTE

ASSESSMENT PREPARED BY ACHI
INSPIRING HEALTHY ACTS

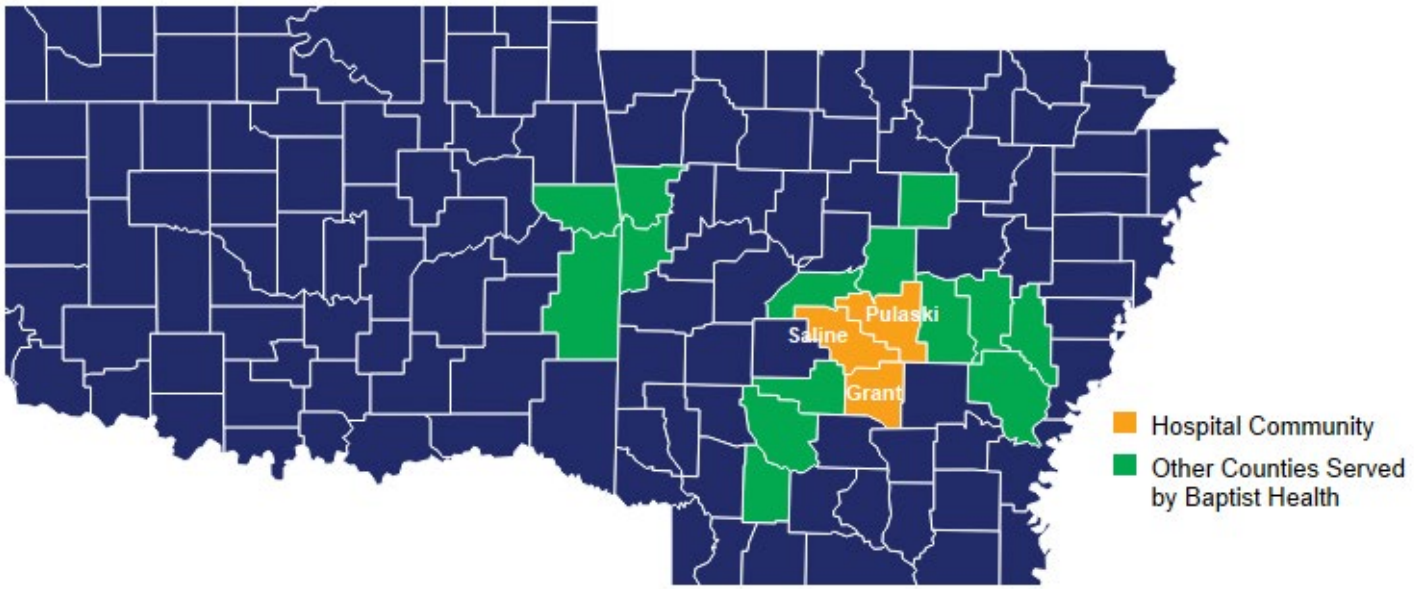
Introduction

Baptist Health engaged the Arkansas Center for Health Improvement (ACHI) to conduct the quantitative data collection and analysis for the 2022 Community Health Needs Assessment (CHNA) process. Baptist Health provided ACHI with the counties served for each of its 11 hospital communities. A total of 15 Arkansas counties and two Oklahoma counties were included in the CHNA.

This report shows the qualitative results from the CHNA for the Baptist Health Rehabilitation Institute hospital community, which include Grant, Pulaski, and Saline counties.

HOSPITAL COMMUNITY

FIGURE 1: COUNTIES SERVED BY BAPTIST HEALTH REHABILITATION INSTITUTE



Qualitative Results

Quantitative results from the CHNA for the Baptist Health Rehabilitation Institute hospital community are reported below. There are 12 sections: Demographics, Health Outcomes, Cause of Death, Chronic Conditions, Health Behaviors, Prevention, Access, Social and Economic Factors, Environment, Diagnoses Incidence Within Hospital Community at Discharge, Mental Health and Substance Use, and COVID-19.

Each section includes a table with health indicator data for each county in the hospital community, a community average for each measurement, and averages for the state of Arkansas and the United States. If data were not available or were suppressed, “Data Not Available” 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 document and Appendix 1.

DEMOGRAPHICS

TABLE 1: AGE AND SEX

		Grant County	Pulaski County	Saline County	State	National
Total Population	*Number*	18,126.0	392,967.0	119,415.0	2,999,370.0	324,697,795.0
Ages 0-4	*Percent*	5.3	6.7	5.9	6.3	6.1
Ages 5-17	*Percent*	17.2	16.6	17.6	17.2	16.5
Ages 18-24	*Percent*	7.4	8.8	7.3	9.5	9.4
Ages 25-34	*Percent*	12.1	14.9	12.8	13.1	13.9
Ages 35-44	*Percent*	12.3	12.8	13.7	12.3	12.6
Ages 45-54	*Percent*	14.1	12.3	12.8	12.4	13.0
Ages 55-64	*Percent*	13.9	13.0	12.4	12.7	12.9
Ages 65+	*Percent*	17.8	15.0	17.5	16.6	15.6
Male	*Percent*	49.1	47.8	49.1	49.1	49.2
Female	*Percent*	50.9	52.2	51.0	50.9	50.8

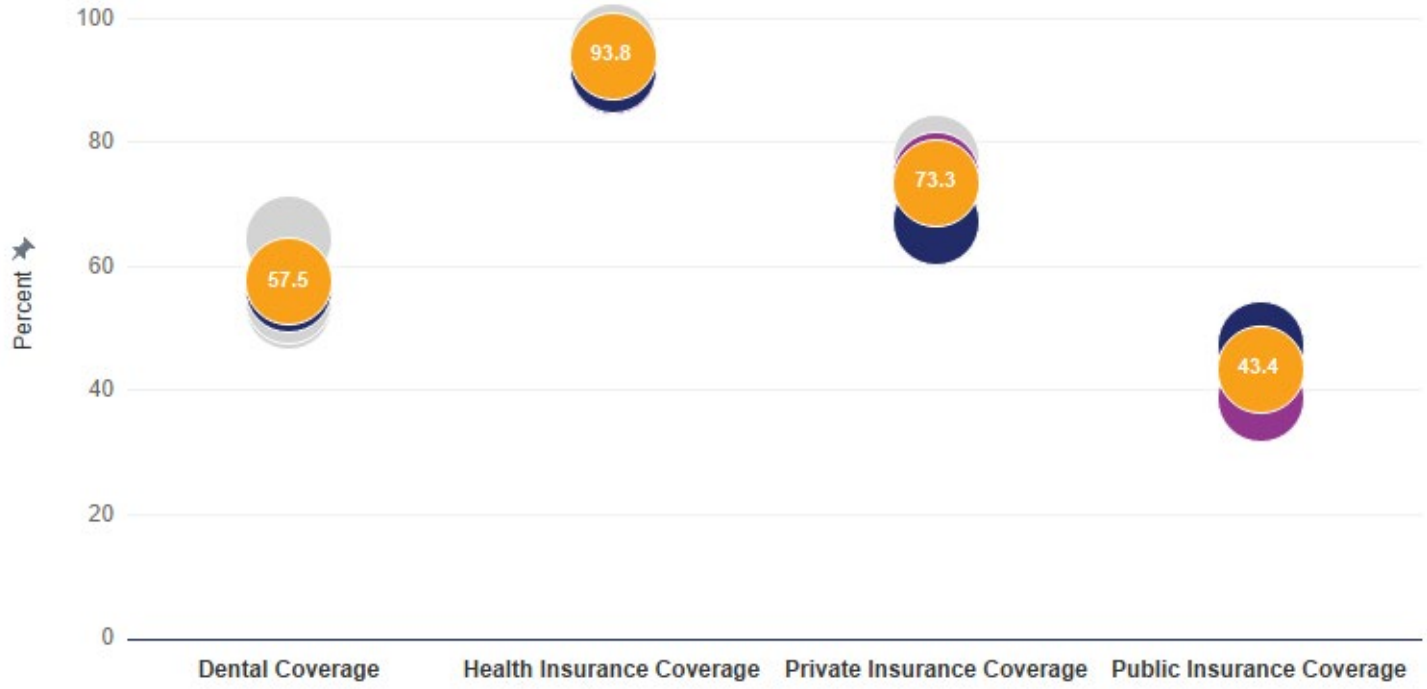
TABLE 2: RACE, ETHNICITY, AND LANGUAGE

		Grant County	Pulaski County	Saline County	State	National
Total Population	*Number*	18,126.0	392,967.0	119,415.0	2,999,370.0	324,697,795.0
Hispanic or Latino	*Percent*	2.8	6.2	4.8	7.5	18.0
Non-Hispanic White	*Percent*	92.6	52.3	84.6	72.4	60.7
Black or African American	*Percent*	2.7	36.9	7.1	15.3	12.7
Native American/Alaska Native	*Percent*	0.2	0.3	0.4	0.7	0.9
Asian	*Percent*	0.0	2.2	1.3	1.5	5.6
Native Hawaiian/Pacific Islander	*Percent*	0.1	0.1	0.1	0.3	0.2
Some Other Race	*Percent*	0.3	1.9	0.6	2.8	4.9
Two or More Races	*Percent*	2.0	2.8	2.0	2.7	3.3
Non-English Language Households	*Percent*	0.2	1.7	0.9	1.6	4.4

TABLE 3: INSURANCE COVERAGE

		Grant County	Pulaski County	Saline County	Community Average	State	National
Health Insurance Coverage	*Percentage of total civilian non-institutionalized population with health insurance coverage*	95.2	92.1	94.0	93.8	91.5	91.2
Private Insurance Coverage	*Percentage of total civilian non-institutionalized population with private health insurance coverage*	72.4	70.1	77.5	73.3	67.0	74.5
Public Insurance Coverage	*Percentage of total civilian non-institutionalized population with public health insurance coverage*	47.1	44.6	38.5	43.4	47.3	38.5
Dental Coverage	*Percentage of Arkansas residents with evidence of any dental coverage in the All-Payer Claims Database (APCD)*	54.5	64.4	53.6	57.5	56.2	Data Not Available

FIGURE 2: COMMUNITY, STATE, AND NATIONAL COMPARISON OF INSURANCE COVERAGE

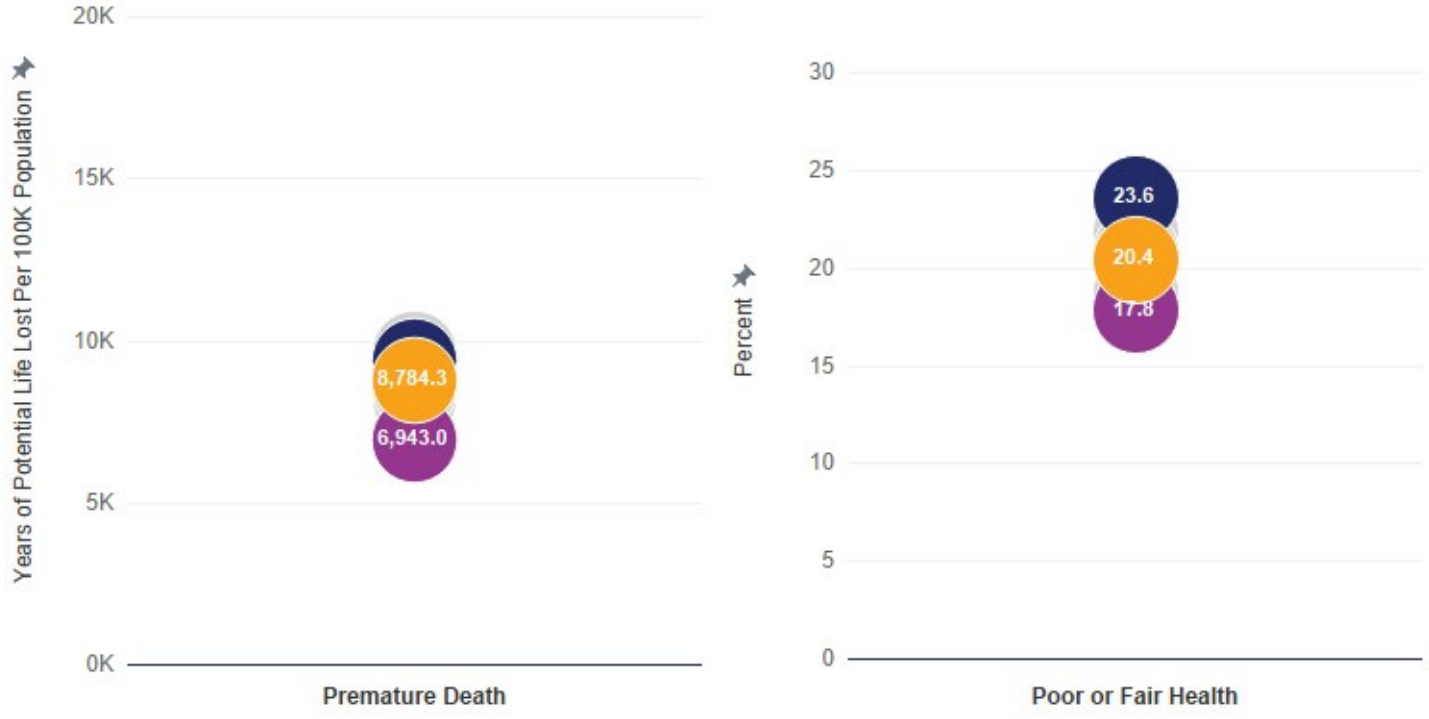


HEALTH OUTCOMES

TABLE 4: HEALTH OUTCOMES INDICATORS AND RATES

		Grant County	Pulaski County	Saline County	Community Average	State	National
Premature Death	*Years of potential life lost before age 75 per 100,000 population (age-adjusted)*	8,518.0	9,605.0	8,230.0	8,784.3	9,357.0	6,943.0
Poor or Fair Health	*Percentage of adults reporting poor or fair health*	20.8	21.7	18.7	20.4	23.6	17.8
Poor Physical Health Days	*Average number of physically unhealthy days reported in past 30 days (age-adjusted)*	4.8	4.6	4.2	4.5	4.9	4.0
Low Birthweight	*Percentage of live births with low birth weight (<2500g)*	8.8	10.9	7.9	9.2	9.1	8.2

FIGURE 3: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT HEALTH OUTCOMES INDICATORS

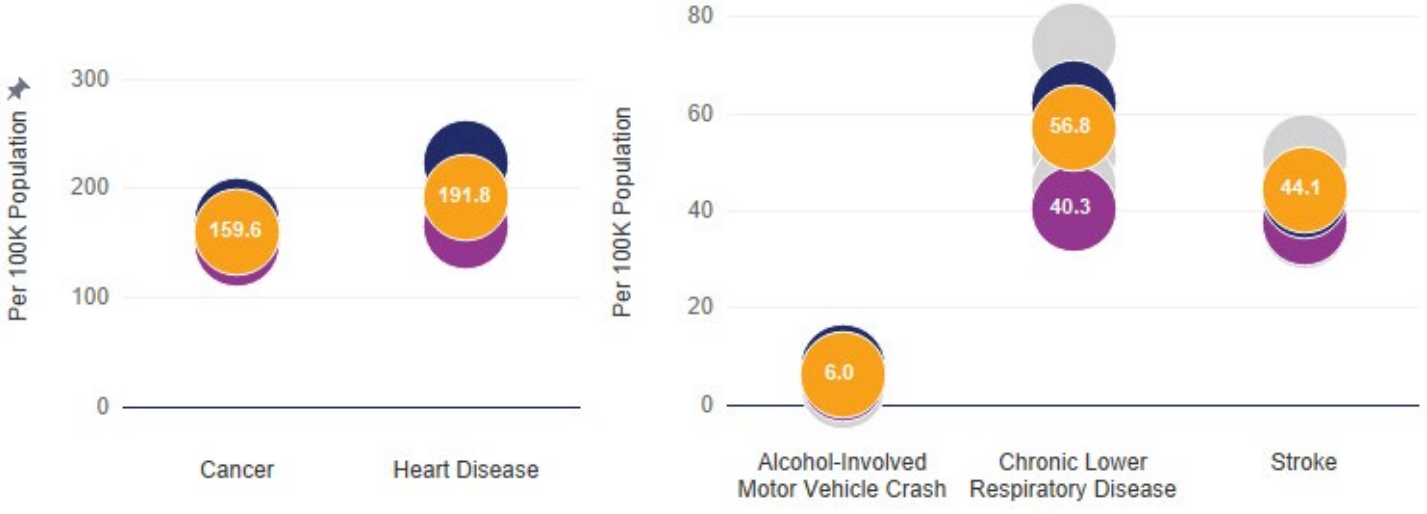


CAUSE OF DEATH

TABLE 5: CAUSE OF DEATH INDICATORS AND RATES

		Grant County	Pulaski County	Saline County	Community Average	State	National
All Causes	*All causes of deaths per 100,000 population (age-adjusted)*	886.3	854.2	816.7	852.4	888.4	727.2
Cancer	*5-year average rate of death due to malignant neoplasm (cancer) per 100,000 population (age-adjusted)*	169.0	155.2	154.7	159.6	170.1	149.4
Stroke	*5-year average rate of death due to cerebrovascular disease (stroke) per 100,000 population (age-adjusted)*	50.9	44.8	36.6	44.1	43.0	37.6
Chronic Lower Respiratory Disease	*Rate of deaths due to chronic lower respiratory disease per 100,000 population (age-adjusted)*	74.1	45.0	51.2	56.8	62.1	40.3
Diabetes	*Diabetes deaths per 100,000 population (age-adjusted)*	21.5	29.1	24.4	25.0	29.0	21.4
Heart Disease	*Rate of death due to heart disease per 100,000 population (age-adjusted)*	207.8	187.4	180.3	191.8	222.7	164.8
Unintentional Injury	*5-year average rate of death due to unintentional injury (accident) per 100,000 population (age-adjusted)*	54.3	52.9	54.0	53.7	51.7	50.4
Motor Vehicle Crash	*5-year average rate of death due to motor vehicle crash per 100,000 population (age-adjusted)*	23.0	16.7	13.8	17.8	18.9	11.5
Alcohol-Involved Motor Vehicle Crash	*Rate of persons killed in motor vehicle crashes involving alcohol as a rate per 100,000 population*	7.5	6.8	3.7	6.0	7.8	5.3

FIGURE 4: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT CAUSE OF DEATH INDICATORS

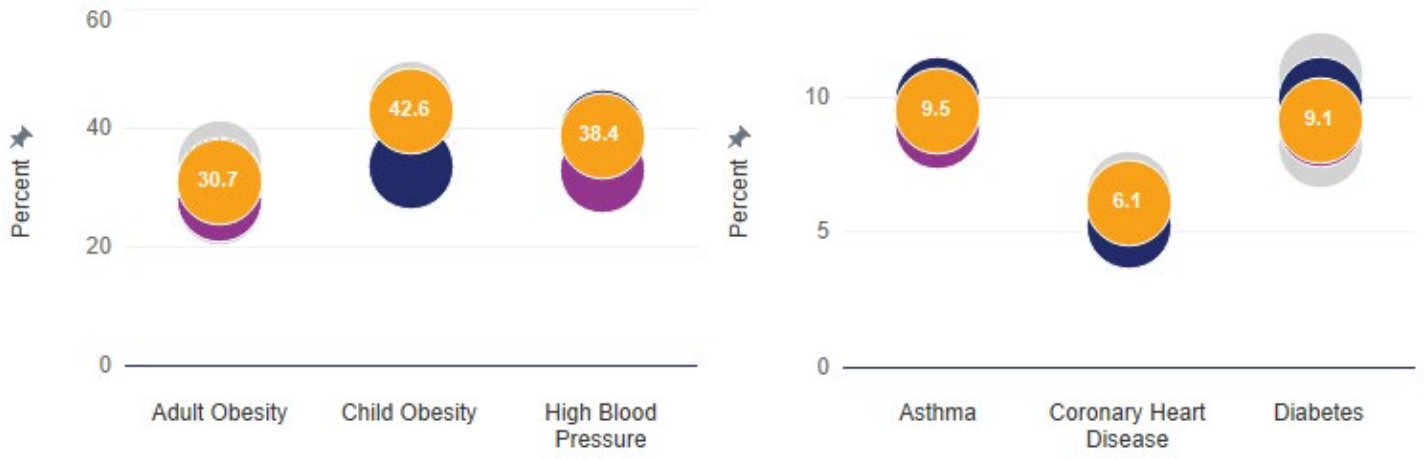


CHRONIC CONDITIONS

TABLE 6: CHRONIC CONDITIONS INDICATORS AND RATES

		Grant County	Pulaski County	Saline County	Community Average	State	National
High Blood Pressure	*Percentage of adults who have been told they have high blood pressure*	38.9	39.4	36.9	38.4	39.0	32.6
Asthma	*Percentage of adults who have been told they currently have asthma (age-adjusted)*	9.5	9.8	9.1	9.5	9.9	8.9
Coronary Heart Disease	*Percentage of adults who have been told they have angina or coronary heart disease (age-adjusted)*	6.4	6.1	5.7	6.1	5.2	5.4
Arthritis	*Percentage of adults ages 18 or older diagnosed with some form of arthritis*	33.3	32.1	36.4	33.9	34.3	Data Not Available
High Cholesterol	*Percentage of adults who have had their blood cholesterol checked and have been told it was high*	38.2	35.2	37.1	36.8	36.7	33.6
Diabetes	*Percentage of adults ages 20 and older who have ever been told by a doctor that they have diabetes (age-adjusted)*	8.2	10.8	8.3	9.1	9.9	9.0
Adult Obesity	*Percentage of adults ages 20 and older who report a BMI higher than 30*	27.0	34.0	31.0	30.7	31.0	27.6
Child Obesity	*Percentage of students classified as overweight or obese, by county location of school*	43.8	42.6	41.2	42.6	33.1	Data Not Available

FIGURE 5: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT CHRONIC CONDITIONS INDICATORS

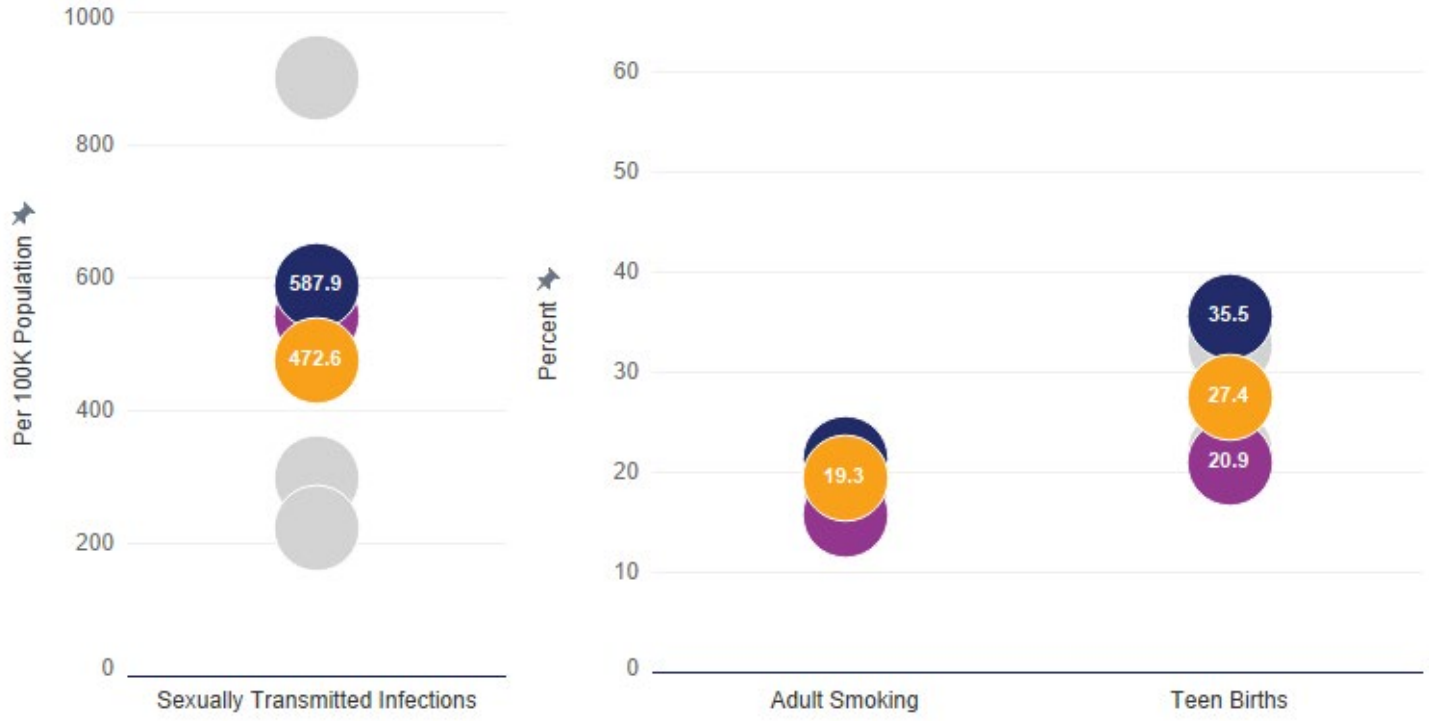


HEALTH BEHAVIORS

TABLE 7: HEALTH BEHAVIORS INDICATORS AND RATES

		Grant County	Pulaski County	Saline County	Community Average	State	National
Adult Smoking	*Percentage of adults who are current smokers (age-adjusted)*	21.3	19.6	17.1	19.3	21.2	15.7
Youth Vaping	*Percentage of public school students in 6th, 8th, 10th, and 12th grade who used any vape in the past 30 days*	10.6	8.2	8.4	9.1	11.7	Data Not Available
Physical Inactivity	*Percentage of adults ages 20 or older reporting no physical activity in the past month*	24.7	25.9	24.8	25.1	26.2	22.0
Sexually Transmitted Infections	*Number of newly diagnosed chlamydia cases per 100,000 population*	220.2	901.9	295.8	472.6	587.9	539.9
Teen Births	*The seven-year average number of teen births per 1,000 female population, ages 15-19*	27.5	32.6	22.1	27.4	35.5	20.9

FIGURE 6: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT HEALTH BEHAVIORS INDICATORS

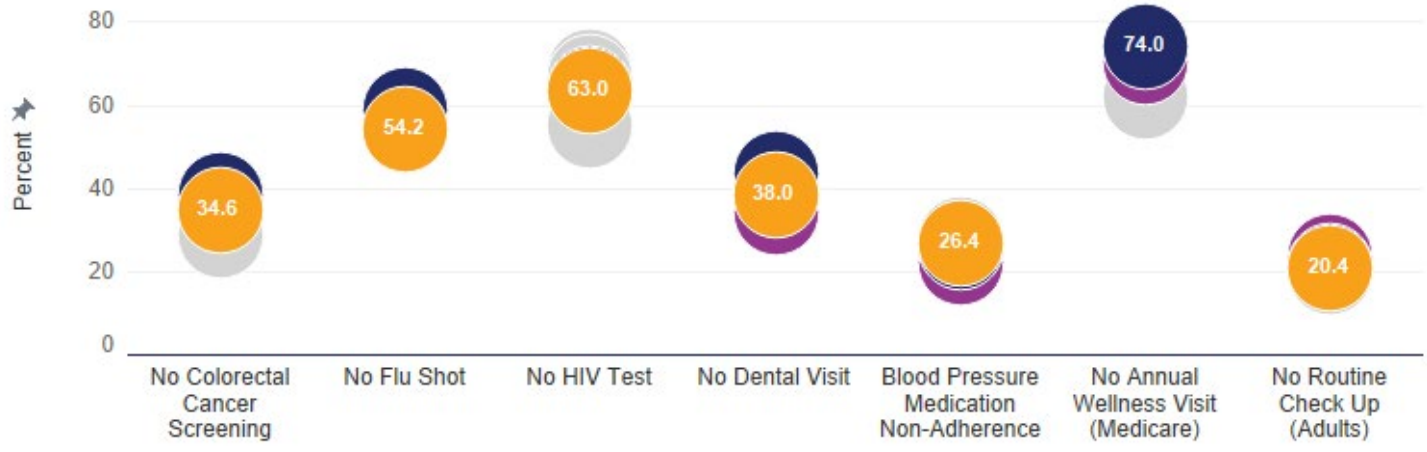


PREVENTION

TABLE 8: PREVENTION INDICATORS AND RATES

		Grant County	Pulaski County	Saline County	Community Average	State	National
No Pap Test	*Percentage of women ages 21 to 65 who have not had a pap test within the past 3 years (age-adjusted)*	16.2	14.0	14.3	14.8	16.3	14.5
No Colorectal Cancer Screening	*Percentage of adults ages 50-75 who have never had either a sigmoidoscopy or colonoscopy (age-adjusted)*	37.5	28.5	37.7	34.6	38.1	35.0
No Flu Shot	*Percentage of adults ages 18 or older who have not had a flu shot in the past year*	54.9	54.0	53.6	54.2	58.5	58.1
No HIV Test	*Percentage of adults ages 18 or older who have never been screened for HIV*	66.3	54.8	68.0	63.0	63.6	Data Not Available
No Dental Visit	*Percentage of adults ages 18 or older who have not had a dentist or dental clinic visit in the previous year (age-adjusted)*	40.2	35.4	38.5	38.0	43.4	33.8
Blood Pressure Medication Non-Adherence	*The percentage of Medicare enrollees who did not adhere to blood pressure medication schedules*	26.2	27.3	25.7	26.4	25.9	21.8
No Annual Wellness Visit (Medicare)	*The percentage of Medicare enrollees who did not have an annual wellness visit in the past year*	62.0	Data Not Available	72.0	Data Not Available	74.0	70.0
No Routine Check Up (Adults)	*The percentage of adults age 18 or older with no routine check up with a doctor in the past year*	21.9	19.5	19.9	20.4	21.0	23.4

FIGURE 7: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT PREVENTION INDICATORS

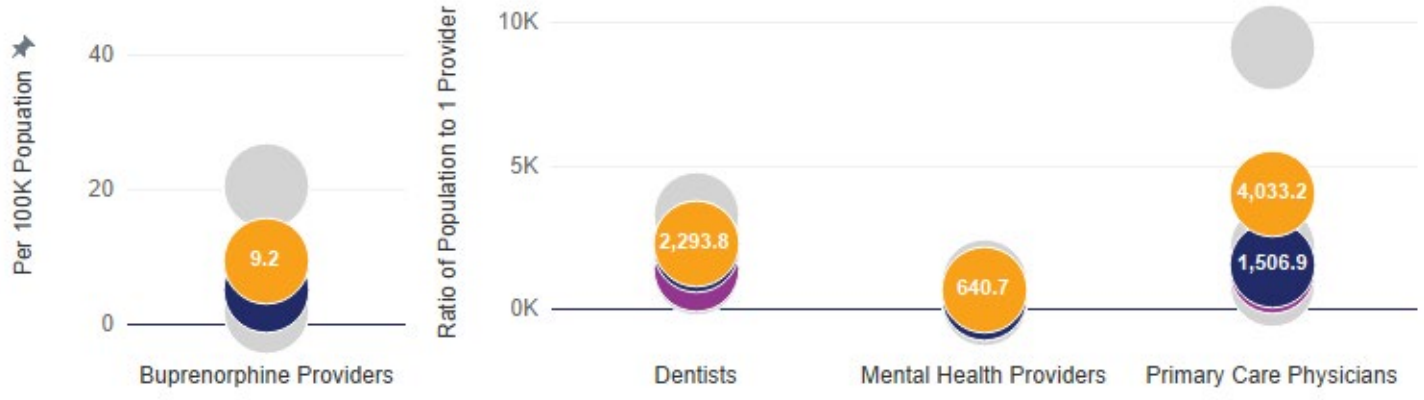


ACCESS

TABLE 9: ACCESS INDICATORS AND RATES

		Grant County	Pulaski County	Saline County	Community Average	State	National
Mammography	*Percentage of female Medicare enrollees ages 65-74 who received an annual mammography screening*	37.0	39.0	34.0	36.7	38.0	42.0
Diabetic Monitoring	*Percentage of diabetic Medicare enrollees over age 65 who had a hemoglobin A1c test in the past year*	87.9	88.6	88.8	88.4	88.5	87.5
Uninsured	*Percentage of adults under age 65 without health insurance coverage*	7.6	10.0	8.5	8.7	10.8	10.8
Primary Care Physicians	*Ratio of population to one primary care physician*	9,094.0	837.3	2,168.2	4,033.2	1,506.9	1,319.0
Dentists	*Ratio of population to one dentist*	2,283.1	1,289.2	3,309.1	2,293.8	2,103.0	1,404.5
Mental Health Providers	*Ratio of population to one mental health provider*	961.3	223.2	737.6	640.7	421.4	382.3
Addiction or Substance Use Providers	*Rate of addiction or substance use providers per 100,000 population*	5.6	7.8	0.8	4.7	4.4	20.4
Buprenorphine Providers	*Rate of buprenorphine providers per 100,000 population*	5.5	20.3	1.7	9.2	4.8	7.6
Preventable Hospital Stays	*Number of hospital stays for ambulatory care-sensitive conditions per 1,000 Medicare enrollees*	5,009.0	4,072.0	4,637.0	4,572.7	4,769.0	4,236.0

FIGURE 8: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT ACCESS INDICATORS

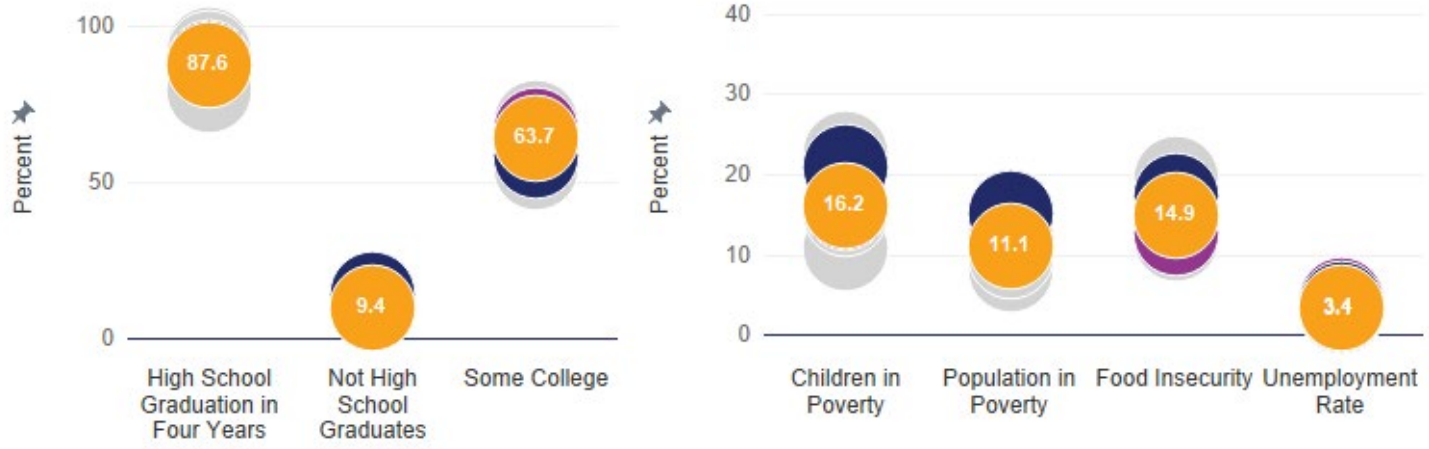


SOCIAL AND ECONOMIC FACTORS

TABLE 10: SOCIAL AND ECONOMIC FACTORS INDICATORS AND RATES

		Grant County	Pulaski County	Saline County	Community Average	State	National
Not High School Graduates	*Percentage of adults ages 25 or older without a high school diploma*	9.2	9.6	9.4	9.4	13.4	12.0
High School Graduation in Four Years	*Percentage of ninth-grade cohort who graduated in four years*	91.2	79.4	92.2	87.6	88.2	87.7
Some College	*Percentage of adults ages 25-44 with some post-secondary education*	54.8	68.8	67.6	63.7	58.5	66.1
Unemployment Rate	*Unemployment rate among civilian non-institutionalized population age 16 and older in January 2022*	3.1	4.3	2.9	3.4	3.8	4.4
Children in Poverty	*Percentage of children under age 18 below the poverty line*	15.2	22.5	10.8	16.2	20.8	15.7
Population in Poverty	*Percentage of population below the federal poverty line*	9.9	15.3	8.2	11.1	15.2	11.9
Children in Single-Parent Households	*Percentage of children who live in a household headed by single parent*	19.4	39.3	23.3	27.3	28.9	25.5
Homeless Children	*Rate of homelessness among public school students*	0.9	2.1	0.8	1.3	2.8	2.8
Food Insecurity	*Percentage of the population that experienced food insecurity in the report year*	13.4	19.3	11.9	14.9	17.3	12.6
Social Associations	*Number of membership associations per 100,000 population*	89.6	167.0	85.0	113.8	126.5	105.0
Violent Crimes	*Annual rate of reported violent crimes per 100,000 population*	295.5	1,121.8	300.9	572.7	549.2	416.0

FIGURE 9: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT SOCIAL AND ECONOMIC FACTORS INDICATORS



ENVIRONMENT

TABLE 11: ENVIRONMENT INDICATORS AND RATES

		Grant County	Pulaski County	Saline County	Community Average	State	National
Food Environment Index	*Index of factors that contribute to a healthy food environment, 0 (worst) to 10 (best)*	7.4	6.6	7.7	7.2	5.1	7.8
Drinking Water Violations	*The total number of drinking water violations recorded in a two-year period*	0.0	0.0	0.0	0.0	118.0	4,739.0
Access to Exercise Opportunities	*Percentage of population with adequate access to locations for physical activity*	26.6	83.6	58.6	56.3	63.5	84.2
Severe Housing Problems	*Percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, or lack of kitchen or plumbing*	13.4	16.3	9.6	13.1	14.1	17.5
Broadband Access	*Percentage of population in a high-speed internet service area; access to DL speeds > 25MBPS (2020)*	85.7	99.3	96.0	93.7	91.4	97.5
Long Commute Driving Alone	*Among workers who commute in their car alone, the percentage who commute more than 30 minutes*	52.1	20.3	40.7	37.7	27.0	36.6

FIGURE 10: COMMUNITY, STATE, AND NATIONAL COMPARISON OF THE FOOD ENVIRONMENT INDEX INDICATOR

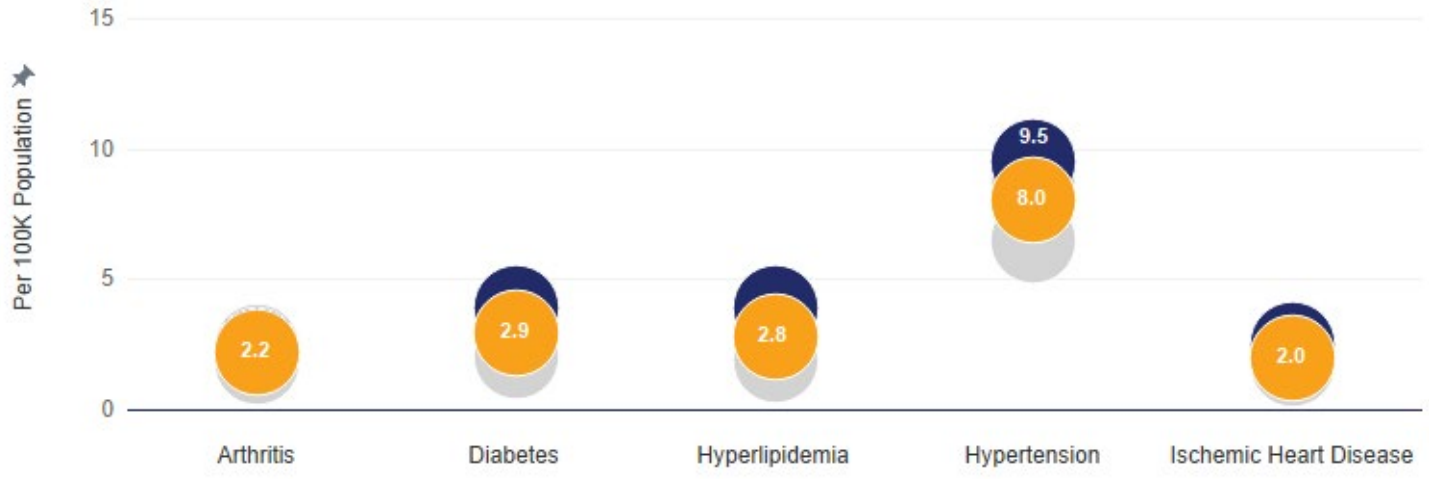
FIGURE 11: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT ENVIRONMENT INDICATORS

DIAGNOSES INCIDENCE WITHIN HOSPITAL COMMUNITY AT DISCHARGE

TABLE 12: DIAGNOSES INCIDENCE WITHIN HOSPITAL COMMUNITY AT DISCHARGE INDICATORS AND RATES

		Grant County	Pulaski County	Saline County	Community Average	State
Arthritis	*Number of individuals 18 years and older discharged with a primary or secondary arthritis diagnosis as a percentage of the population 18 years and older*	2.5	2.4	1.8	2.2	2.3
Diabetes	*Number of individuals 18 years and older discharged with a primary or secondary diabetes diagnosis as a percentage of the population 18 years and older*	3.3	3.5	2.1	2.9	3.9
Hyperlipidemia	*Number of individuals 18 years and older discharged with a primary or secondary hyperlipidemia diagnosis as a percentage of the population 18 years and older*	3.2	3.2	1.9	2.8	3.9
Hypertension	*Number of individuals 18 years and older discharged with a primary or secondary hypertension diagnosis as a percentage of the population 18 years and older*	8.7	9.0	6.4	8.0	9.5
Ischemic Heart Disease	*Number of individuals 18 years and older discharged with a primary or secondary ischemic heart disease diagnosis as a percentage of the population 18 years and older*	2.5	1.7	1.7	2.0	2.5

FIGURE 12: DIAGNOSES INCIDENCE WITHIN HOSPITAL COMMUNITY AT DISCHARGE INDICATORS

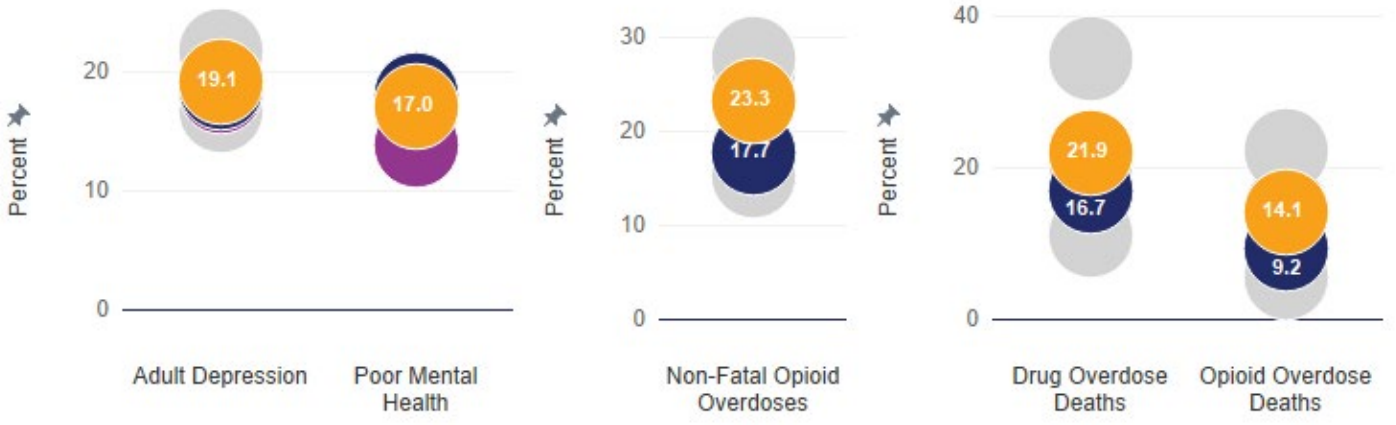


MENTAL HEALTH AND SUBSTANCE USE

TABLE 13: MENTAL HEALTH AND SUBSTANCE USE INDICATORS AND RATES

		Grant County	Pulaski County	Saline County	Community Average	State	National
Excessive Drinking	*Percentage of adults reporting binge or heavy drinking*	17.7	17.6	17.3	17.6	17.3	19.2
Poor Mental Health	*Percentage of adults ages 18 or older reporting poor mental health for 14 or more days*	18.1	16.6	16.3	17.0	18.0	13.9
Youth Depression	*Percentage of public school students in 6th, 8th, 10th, and 12th grade who had feelings of depression all of the time in the past 30 days*	14.9	12.9	8.5	12.1	12.1	Data Not Available
Adult Depression	*The prevalence of depression among Medicare fee-for-service beneficiaries*	21.8	18.8	16.8	19.1	18.7	18.4
Suicide Deaths	*The rate of deaths by suicide (ICD-10 codes U03, X60-X84, Y87.0) per 100,000 population (age-adjusted)*	Data Not Available	17.0	20.5	Data Not Available	18.8	13.8
Non-Fatal Opioid Overdoses	*Non-fatal opioid overdoses per 100,00 population (based on county of occurrence)*	27.8	26.6	15.4	23.3	17.7	Data Not Available
Opioid Overdose Deaths	*Opioid-related deaths per 100,00 population (based on county of occurrence)*	5.6	22.0	14.6	14.1	9.2	Data Not Available
Drug Overdose Deaths	*Opioid-related deaths per 100,00 population (based on county of occurrence)*	11.1	34.3	20.3	21.9	16.7	Data Not Available

FIGURE 13: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT MENTAL HEALTH AND SUBSTANCE USE INDICATORS



COVID-19

TABLE 14: COVID-19 INDICATORS AND RATES

		Grant County	Pulaski County	Saline County	Community Average	State	National
COVID-19 Cases	*The incidence rate of confirmed COVID-19 cases per 100,000 population, as of May 12, 2022*	24,560.2	26,444.7	25,535.1	25,513.3	26,900.1	24,718.7
COVID-19 Deaths	*The rate of deaths among patients with confirmed cases of COVID-19 per 100,000 population, as of May 12, 2022*	335.4	301.3	279.2	305.3	378.6	301.3
Adults Fully Vaccinated	*The percentage of adults fully vaccinated for COVID-19, as of May 11, 2022*	54.9	67.1	58.1	60.0	58.4	73.8
Adult COVID-19 Vaccine Hesitancy	*The percentage of the population estimated to be hesitant toward receiving a COVID-19 vaccine*	20.4	17.8	19.8	19.3	20.4	10.3

FIGURE 14: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT COVID-19 INDICATORS

BAPTIST HEALTH

EXTENDED CARE HOSPITAL

About Baptist Health Extended Care Hospital

Baptist Health Extended Care Hospital, a state-of-the-art facility located on the campus of Baptist Health Medical Center-Little Rock, provides long-term acute care to patients with complex medical conditions.

We offer a caring atmosphere where family involvement is supported and visitation is encouraged. With a dedicated staff of professionals, we provide interdisciplinary care for unique needs.

Our interdisciplinary team works with the patient, their family, and community providers to develop a discharge plan that enables each patient's return to daily living at the highest possible capacity.

2020-2022 Accomplishments

Diabetes:

- Partnered with Community Outreach to offer Diabetes Support Groups
- Provided education on Fall prevention for Community Wellness Centers
- Educated Family members and Caregivers on Home Safety

Mental Health/Drug Abuse

- Utilized the Suicide Screening tools on all patients discharged.
- Educated patients and care-givers on the 24-hour behavioral health-line available to staff and patients
- Partnered with Community Outreach to implement a Mental Health First Aid class

Access:

- Offered Med to Bed Access for patients who could utilize the program
- Provided information/ education to patients and caregivers for additional services resources needed upon discharge

COMMUNITY HEALTH NEEDS ASSESSMENT – IMPLEMENTATION PLAN 2023-2025

BHMC - Baptist Health Extended Care

IDENTIFIED COMMUNITY HEALTH NEED: **Access to Healthcare Services**

GOALS / OBJECTIVES:

Increase Access to Quality Health Care through Education and Community Resources.

STRATEGY #1

Improve health outcomes through patient education and partnerships with patients and families

Action Steps:

1. Partner with Community Outreach to provide Education and Information on Fall Prevention at Southwest and Dunbar Community Centers
2. Partner with Community Outreach to develop and promote information Safety in the home for Community Events and Wellness Centers
3. Offer Medication Safety Classes at Baptist Health Diabetes and Stroke Support Groups
4. Implement a Community Class on Heart Failure for patients and community members

PERFORMANCE METRICS:

1. Track and Report the number of individuals participating in Fall Prevention Classes
2. Track and report the number of Home Safety Materials distributed in the Community
3. Track and Report the number of individuals participating in Medication Safety Classes
4. Number of Support Group Presentations and Individuals attending will be tracked and reported

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:

Community Centers, Little Rock Community Centers

Resources Hospital Plans to Commit to Address Health Need:	Estimated Completion Date:	Person(s) / Department Responsible:
• Staff and Printing	• Ongoing	• Community Outreach Department, AHEC Administration

COMMUNITY HEALTH NEEDS ASSESSMENT – IMPLEMENTATION PLAN 2023-2025

BHMC - Baptist Health Extended Care

IDENTIFIED COMMUNITY HEALTH NEED: **Mental Health**

GOALS / OBJECTIVES:

Increase awareness and support of patients, caregivers and community members dealing with mental health concerns.

STRATEGY #1

Reduce the stigma associated with mental health through education and treatment .

Action Steps:

1. Continue to utilize the Suicide Screening tools on all patients discharged.
2. Educate patients and care-givers on the 24-hour behavioral health-line available to staff and patients.
3. Provide educational materials for patients and care-givers on stress management, depression, self-care during Mental Health Awareness Month
4. Offer Mental health activities that promote self-care, relaxation, and mindfulness including information on yoga, journaling, spending time in nature, art therapy, and music therapy at Community and recruitment events.

PERFORMANCE METRICS:

1. Number of suicide referrals will be tracked and reported.
2. Number of Individuals reached during Mental Health Awareness Month will be tracked and reported
3. Number of individuals provided mental health activities will be tracked and reported

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:

Resources Hospital Plans to Commit to Address Health Need:	Estimated Completion Date:	Person(s) / Department Responsible:
• Community Outreach Staff, Pharmacy, Behavioral Health	• Ongoing	• Baptist Health Community Outreach, BHEC Administration

COMMUNITY HEALTH NEEDS ASSESSMENT – IMPLEMENTATION PLAN 2023-2025

BHMC - Baptist Health Extended Care

IDENTIFIED COMMUNITY HEALTH NEED: Nutrition & Food Security

GOALS / OBJECTIVES:

Initiate Evidence Based Nutrition Security strategies to address diabetes, Chronic Heart Disease, Hypertension, and other diet-related chronic conditions.

STRATEGY #1

Increase access to nutrition education and information among community members, caregivers, families and staff

Action Steps:

1. Utilize the Epic System to screening for Food Insecurity for inpatients visits and
1. Partner with Community Outreach's FoodRX Program to provide Healthy snacks and ready made food for patient caregivers and families who are food insecure
1. Provide education on the relationship between nutrition and pressure sores to caregivers
1. Provide education to families and caregivers nutritional needs based on oral problems, height and weight, weight change, nutrition problems (altered taste, hunger, uneaten meals), approaches to nutritional care (nutrition support, mechanically altered food, therapeutic diets), and food intake.
1. Partner with Community Outreach to provide presentations to Community Wellness Centers on relationships between food and Chronic Disease Management

PERFORMANCE METRICS:

1. Number of Participants screened for Food Insecurity
1. Number of Individuals served by the FoodRX program will be tracked and reported
1. Number of Educational encounters will be tracked and reported
1. Number of Presentations in the Community Outreach Senior Wellness Centers will be tracked and reported

COLLABORATION WITH OTHER HOSPITALS OR COMMUNITY ORGANIZATIONS:

Community Outreach

Resources Hospital Plans to Commit to Address Health Need:	Estimated Completion Date:	Person(s) / Department Responsible:
• Community Outreach Staff , Baptist Health Extended Care Administration	• Ongoing	• Community Outreach Team, Baptist Health Extended Care Administration

BAPTIST HEALTH EXTENDED CARE HOSPITAL

ASSESSMENT PREPARED BY ACHI
INSPIRING HEALTHY ACTS

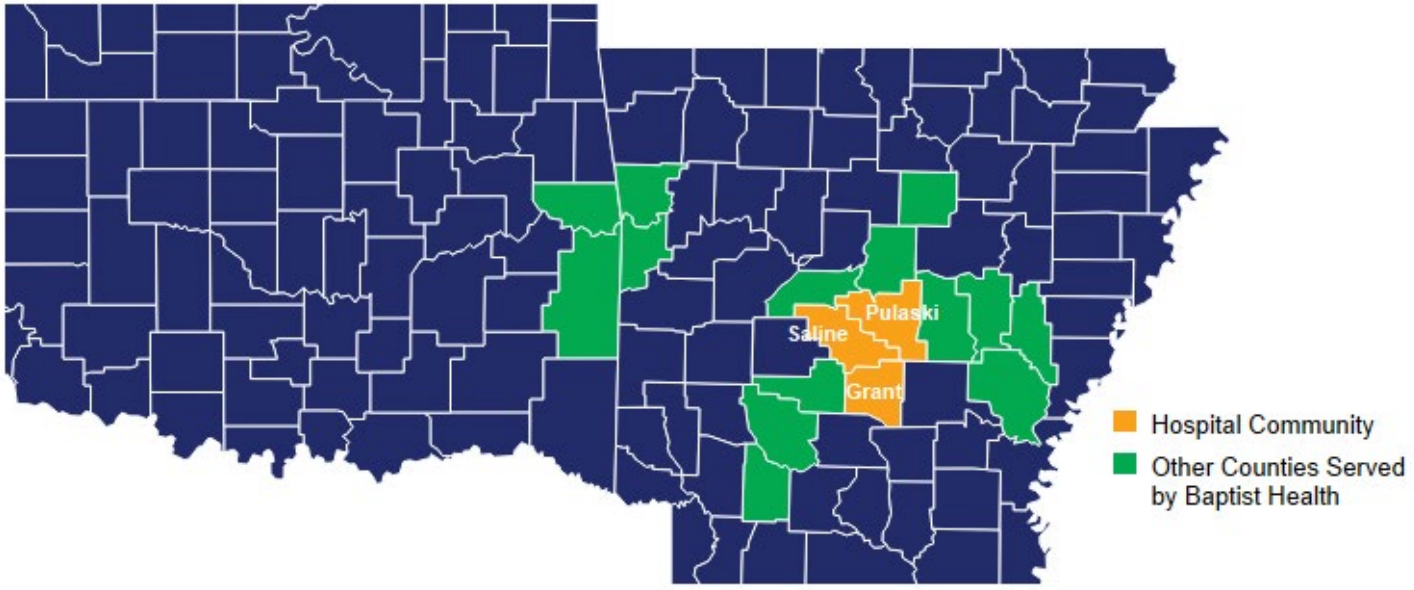
Introduction

Baptist Health engaged the Arkansas Center for Health Improvement (ACHI) to conduct the quantitative data collection and analysis for the 2022 Community Health Needs Assessment (CHNA) process. Baptist Health provided ACHI with the counties served for each of its 11 hospital communities. A total of 15 Arkansas counties and two Oklahoma counties were included in the CHNA.

This report shows the qualitative results from the CHNA for the hospital community for the Baptist Health Extended Care Hospital, which include Grant, Pulaski, and Saline counties.

HOSPITAL COMMUNITY

COUNTIES SERVED BY BAPTIST HEALTH EXTENDED CARE HOSPITAL



Qualitative Results

Quantitative results from the CHNA for the Baptist Health-Van Buren hospital community are reported below. There are 12 sections: Demographics, Health Outcomes, Cause of Death, Chronic Conditions, Health Behaviors, Prevention, Access, Social and Economic Factors, Environment, Diagnoses Incidence Within Hospital Community at Discharge, Mental Health and Substance Use, and COVID-19.

Each section includes a table with health indicator data for each county in the hospital community, a community average for each measurement, and averages for the state of Arkansas and the United States. If data were not available or were suppressed, “Data Not Available” 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 document and Appendix 1.

DEMOGRAPHICS

TABLE 1: AGE AND SEX

		Grant County	Pulaski County	Saline County	State	National
Total Population	*Number*	18,126.0	392,967.0	119,415.0	2,999,370.0	324,697,795.0
Ages 0-4	*Percent*	5.3	6.7	5.9	6.3	6.1
Ages 5-17	*Percent*	17.2	16.6	17.6	17.2	16.5
Ages 18-24	*Percent*	7.4	8.8	7.3	9.5	9.4
Ages 25-34	*Percent*	12.1	14.9	12.8	13.1	13.9
Ages 35-44	*Percent*	12.3	12.8	13.7	12.3	12.6
Ages 45-54	*Percent*	14.1	12.3	12.8	12.4	13.0
Ages 55-64	*Percent*	13.9	13.0	12.4	12.7	12.9
Ages 65+	*Percent*	17.8	15.0	17.5	16.6	15.6
Male	*Percent*	49.1	47.8	49.1	49.1	49.2
Female	*Percent*	50.9	52.2	51.0	50.9	50.8

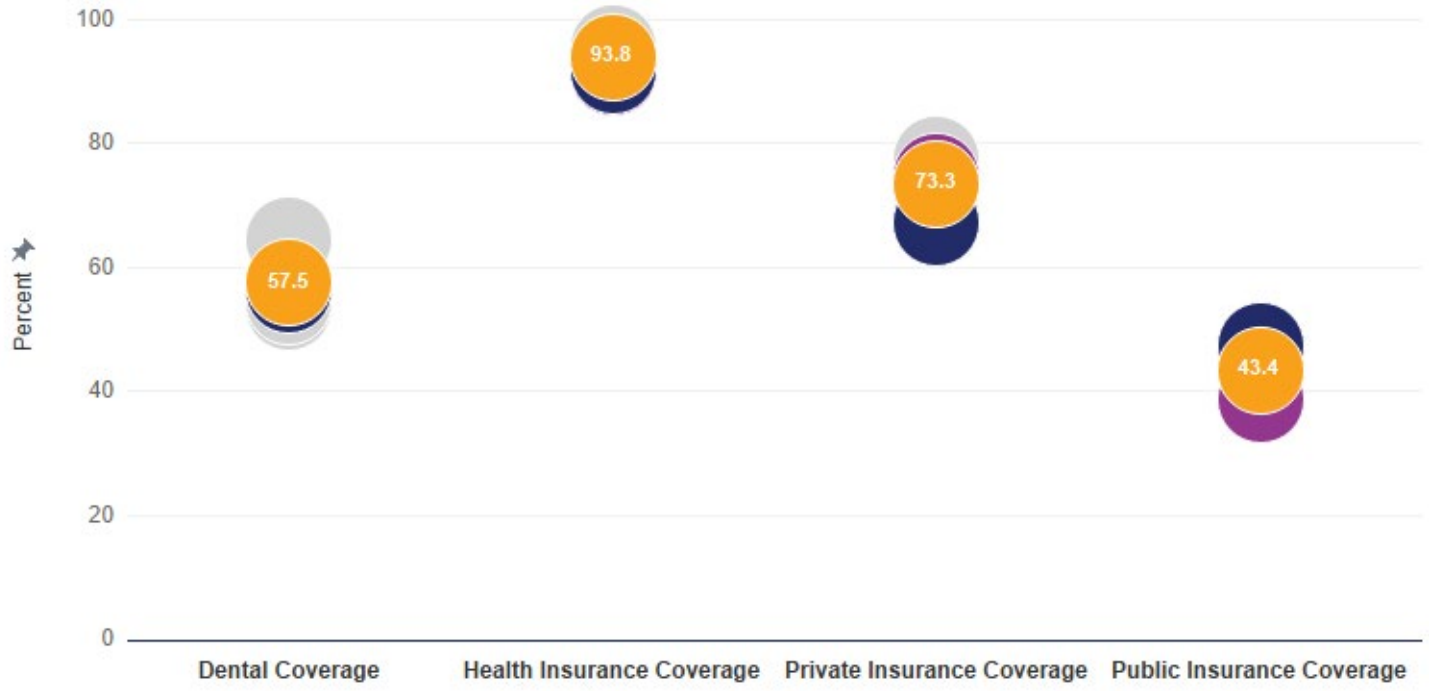
TABLE 2: RACE, ETHNICITY, AND LANGUAGE

		Grant County	Pulaski County	Saline County	State	National
Total Population	*Number*	18,126.0	392,967.0	119,415.0	2,999,370.0	324,697,795.0
Hispanic or Latino	*Percent*	2.8	6.2	4.8	7.5	18.0
Non-Hispanic White	*Percent*	92.6	52.3	84.6	72.4	60.7
Black or African American	*Percent*	2.7	36.9	7.1	15.3	12.7
Native American/Alaska Native	*Percent*	0.2	0.3	0.4	0.7	0.9
Asian	*Percent*	0.0	2.2	1.3	1.5	5.6
Native Hawaiian/Pacific Islander	*Percent*	0.1	0.1	0.1	0.3	0.2
Some Other Race	*Percent*	0.3	1.9	0.6	2.8	4.9
Two or More Races	*Percent*	2.0	2.8	2.0	2.7	3.3
Non-English Language Households	*Percent*	0.2	1.7	0.9	1.6	4.4

TABLE 3: INSURANCE COVERAGE

		Grant County	Pulaski County	Saline County	Community Average	State	National
Health Insurance Coverage	*Percentage of total civilian non-institutionalized population with health insurance coverage*	95.2	92.1	94.0	93.8	91.5	91.2
Private Insurance Coverage	*Percentage of total civilian non-institutionalized population with private health insurance coverage*	72.4	70.1	77.5	73.3	67.0	74.5
Public Insurance Coverage	*Percentage of total civilian non-institutionalized population with public health insurance coverage*	47.1	44.6	38.5	43.4	47.3	38.5
Dental Coverage	*Percentage of Arkansas residents with evidence of any dental coverage in the All-Payer Claims Database (APCD)*	54.5	64.4	53.6	57.5	56.2	Data Not Available

FIGURE 2: COMMUNITY, STATE, AND NATIONAL COMPARISON OF INSURANCE COVERAGE

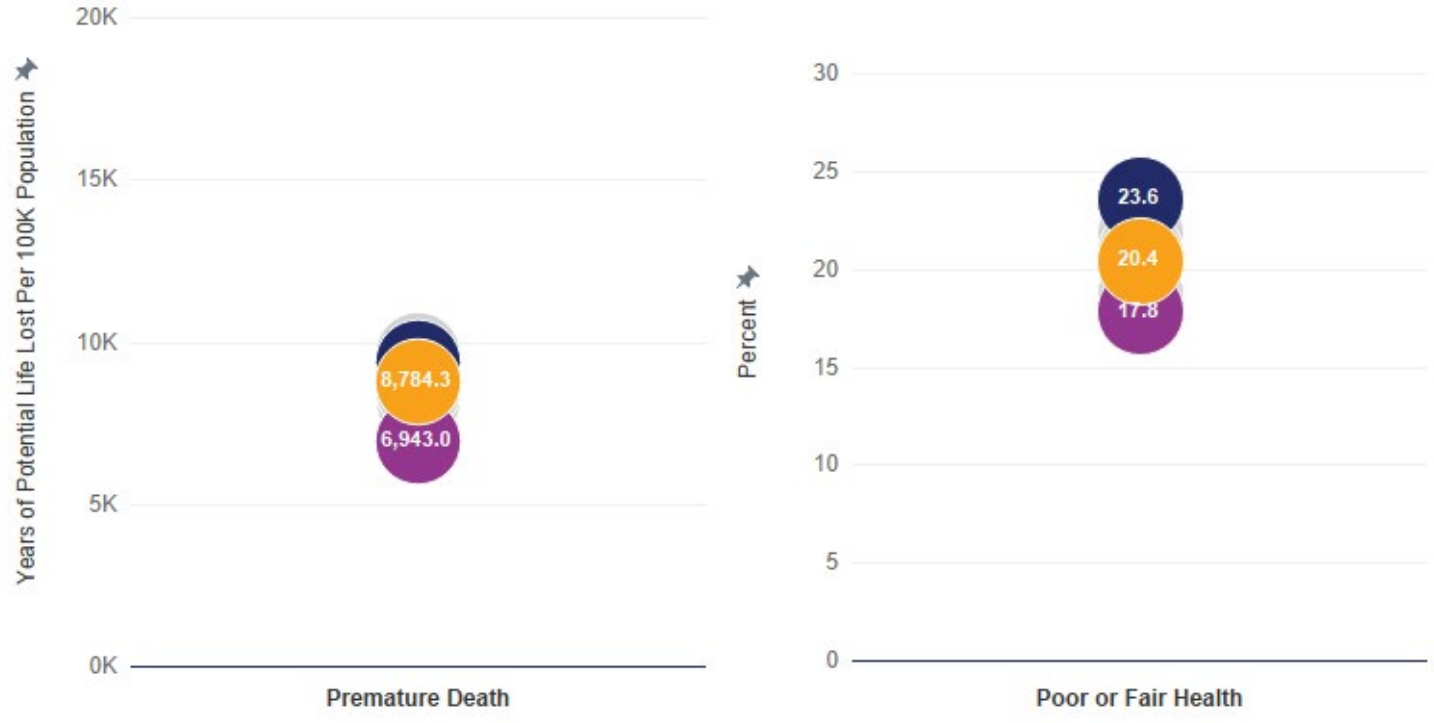


HEALTH OUTCOMES

TABLE 4: HEALTH OUTCOMES INDICATORS AND RATES

		Grant County	Pulaski County	Saline County	Community Average	State	National
Premature Death	*Years of potential life lost before age 75 per 100,000 population (age-adjusted)*	8,518.0	9,605.0	8,230.0	8,784.3	9,357.0	6,943.0
Poor or Fair Health	*Percentage of adults reporting poor or fair health*	20.8	21.7	18.7	20.4	23.6	17.8
Poor Physical Health Days	*Average number of physically unhealthy days reported in past 30 days (age-adjusted)*	4.8	4.6	4.2	4.5	4.9	4.0
Low Birthweight	*Percentage of live births with low birth weight (<2500g)*	8.8	10.9	7.9	9.2	9.1	8.2

FIGURE 3: COMMUNITY, STATE, AND NATIONAL COMPARISON OF

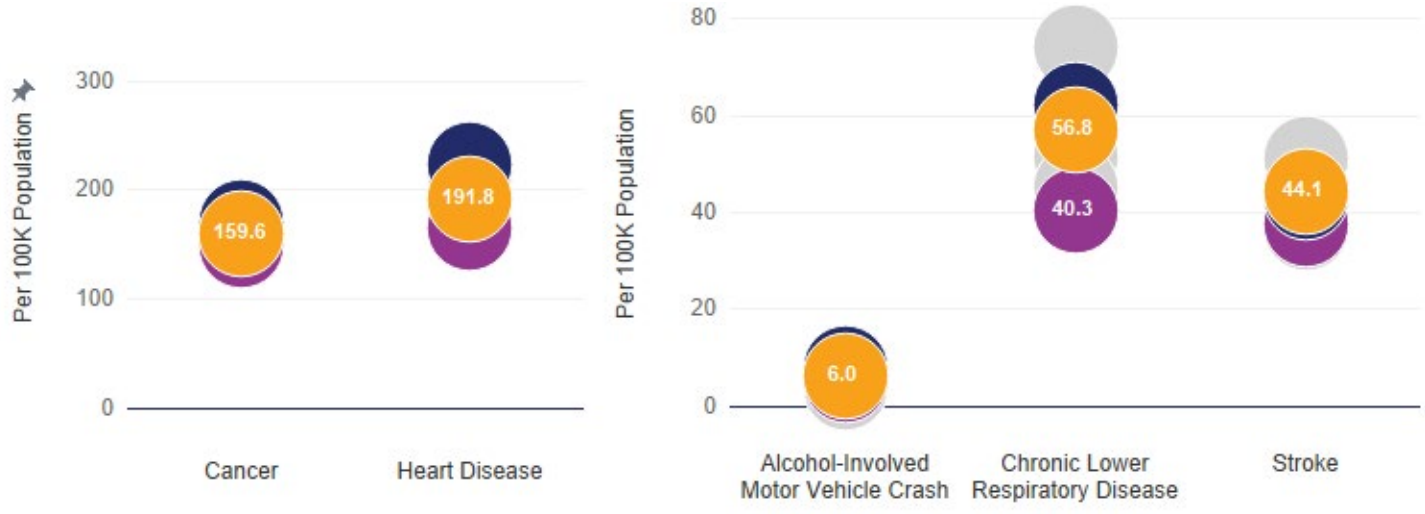


CAUSE OF DEATH

TABLE 5: CAUSE OF DEATH INDICATORS AND RATES

		Grant County	Pulaski County	Saline County	Community Average	State	National
All Causes	*All causes of deaths per 100,000 population (age-adjusted)*	886.3	854.2	816.7	852.4	888.4	727.2
Cancer	*5-year average rate of death due to malignant neoplasm (cancer) per 100,000 population (age-adjusted)*	169.0	155.2	154.7	159.6	170.1	149.4
Stroke	*5-year average rate of death due to cerebrovascular disease (stroke) per 100,000 population (age-adjusted)*	50.9	44.8	36.6	44.1	43.0	37.6
Chronic Lower Respiratory Disease	*Rate of deaths due to chronic lower respiratory disease per 100,000 population (age-adjusted)*	74.1	45.0	51.2	56.8	62.1	40.3
Diabetes	*Diabetes deaths per 100,000 population (age-adjusted)*	21.5	29.1	24.4	25.0	29.0	21.4
Heart Disease	*Rate of death due to heart disease per 100,000 population (age-adjusted)*	207.8	187.4	180.3	191.8	222.7	164.8
Unintentional Injury	*5-year average rate of death due to unintentional injury (accident) per 100,000 population (age-adjusted)*	54.3	52.9	54.0	53.7	51.7	50.4
Motor Vehicle Crash	*5-year average rate of death due to motor vehicle crash per 100,000 population (age-adjusted)*	23.0	16.7	13.8	17.8	18.9	11.5
Alcohol-Involved Motor Vehicle Crash	*Rate of persons killed in motor vehicle crashes involving alcohol as a rate per 100,000 population*	7.5	6.8	3.7	6.0	7.8	5.3

FIGURE 4: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT CAUSE OF DEATH INDICATORS

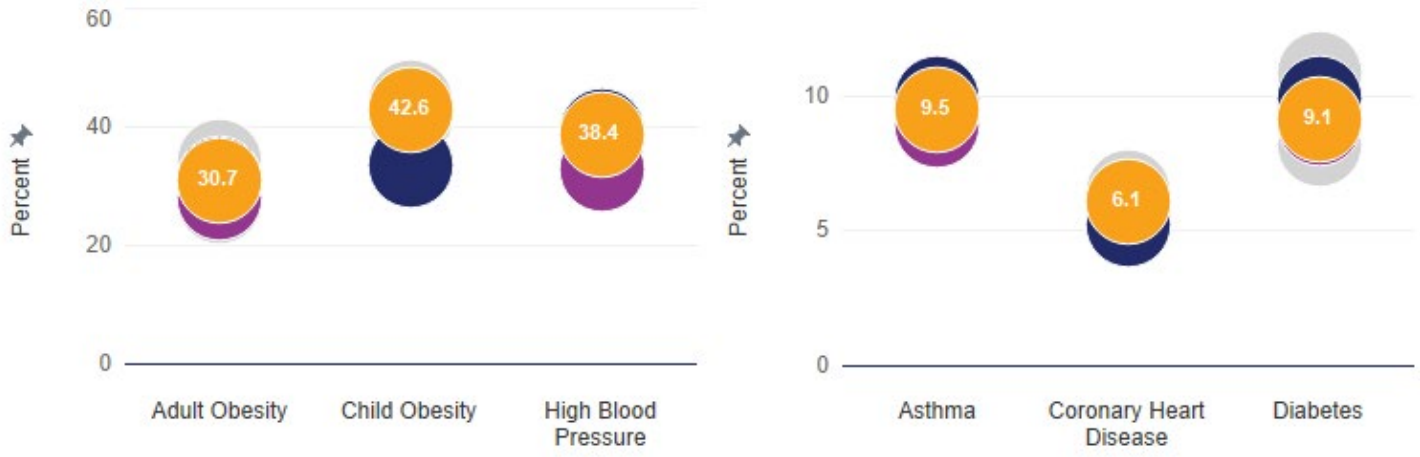


CHRONIC CONDITIONS

TABLE 6: CHRONIC CONDITIONS INDICATORS AND RATES

		Grant County	Pulaski County	Saline County	Community Average	State	National
High Blood Pressure	*Percentage of adults who have been told they have high blood pressure*	38.9	39.4	36.9	38.4	39.0	32.6
Asthma	*Percentage of adults who have been told they currently have asthma (age-adjusted)*	9.5	9.8	9.1	9.5	9.9	8.9
Coronary Heart Disease	*Percentage of adults who have been told they have angina or coronary heart disease (age-adjusted)*	6.4	6.1	5.7	6.1	5.2	5.4
Arthritis	*Percentage of adults ages 18 or older diagnosed with some form of arthritis*	33.3	32.1	36.4	33.9	34.3	Data Not Available
High Cholesterol	*Percentage of adults who have had their blood cholesterol checked and have been told it was high*	38.2	35.2	37.1	36.8	36.7	33.6
Diabetes	*Percentage of adults ages 20 and older who have ever been told by a doctor that they have diabetes (age-adjusted)*	8.2	10.8	8.3	9.1	9.9	9.0
Adult Obesity	*Percentage of adults ages 20 and older who report a BMI higher than 30*	27.0	34.0	31.0	30.7	31.0	27.6
Child Obesity	*Percentage of students classified as overweight or obese, by county location of school*	43.8	42.6	41.2	42.6	33.1	Data Not Available

FIGURE 5: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT CHRONIC CONDITIONS INDICATORS

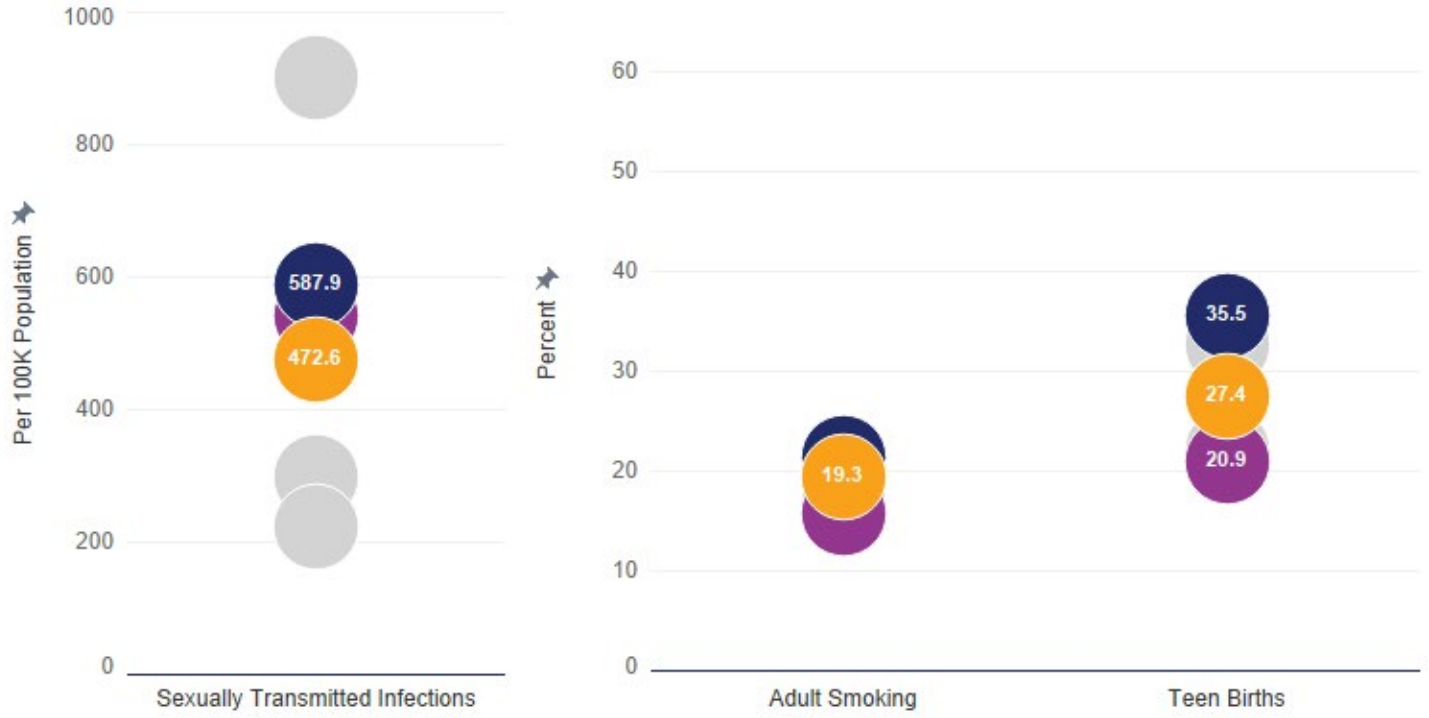


HEALTH BEHAVIORS

TABLE 7: HEALTH BEHAVIORS INDICATORS AND RATES

		Grant County	Pulaski County	Saline County	Community Average	State	National
Adult Smoking	*Percentage of adults who are current smokers (age-adjusted)*	21.3	19.6	17.1	19.3	21.2	15.7
Youth Vaping	*Percentage of public school students in 6th, 8th, 10th, and 12th grade who used any vape in the past 30 days*	10.6	8.2	8.4	9.1	11.7	Data Not Available
Physical Inactivity	*Percentage of adults ages 20 or older reporting no physical activity in the past month*	24.7	25.9	24.8	25.1	26.2	22.0
Sexually Transmitted Infections	*Number of newly diagnosed chlamydia cases per 100,000 population*	220.2	901.9	295.8	472.6	587.9	539.9
Teen Births	*The seven-year average number of teen births per 1,000 female population, ages 15-19*	27.5	32.6	22.1	27.4	35.5	20.9

FIGURE 6: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT HEALTH BEHAVIORS INDICATORS

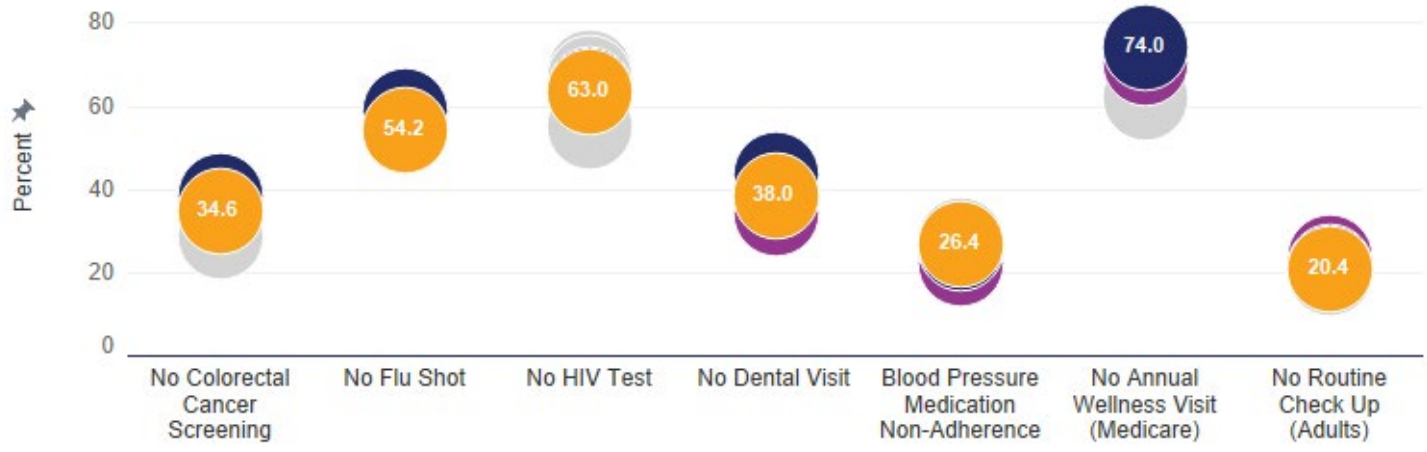


PREVENTION

TABLE 8: PREVENTION INDICATORS AND RATES

		Grant County	Pulaski County	Saline County	Community Average	State	National
No Pap Test	*Percentage of women ages 21 to 65 who have not had a pap test within the past 3 years (age-adjusted)*	16.2	14.0	14.3	14.8	16.3	14.5
No Colorectal Cancer Screening	*Percentage of adults ages 50-75 who have never had either a sigmoidoscopy or colonoscopy (age-adjusted)*	37.5	28.5	37.7	34.6	38.1	35.0
No Flu Shot	*Percentage of adults ages 18 or older who have not had a flu shot in the past year*	54.9	54.0	53.6	54.2	58.5	58.1
No HIV Test	*Percentage of adults ages 18 or older who have never been screened for HIV*	66.3	54.8	68.0	63.0	63.6	Data Not Available
No Dental Visit	*Percentage of adults ages 18 or older who have not had a dentist or dental clinic visit in the previous year (age-adjusted)*	40.2	35.4	38.5	38.0	43.4	33.8
Blood Pressure Medication Non-Adherence	*The percentage of Medicare enrollees who did not adhere to blood pressure medication schedules*	26.2	27.3	25.7	26.4	25.9	21.8
No Annual Wellness Visit (Medicare)	*The percentage of Medicare enrollees who did not have an annual wellness visit in the past year*	62.0	Data Not Available	72.0	Data Not Available	74.0	70.0
No Routine Check Up (Adults)	*The percentage of adults age 18 or older with no routine check up with a doctor in the past year*	21.9	19.5	19.9	20.4	21.0	23.4

FIGURE 7: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT PREVENTION INDICATORS

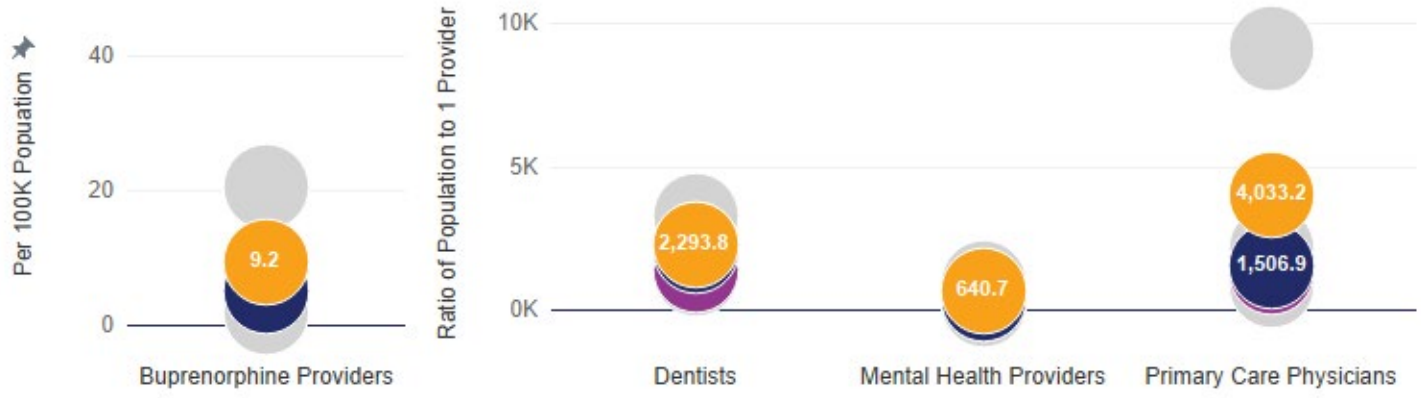


ACCESS

TABLE 9: ACCESS INDICATORS AND RATES

		Grant County	Pulaski County	Saline County	Community Average	State	National
Mammography	*Percentage of female Medicare enrollees ages 65-74 who received an annual mammography screening*	37.0	39.0	34.0	36.7	38.0	42.0
Diabetic Monitoring	*Percentage of diabetic Medicare enrollees over age 65 who had a hemoglobin A1c test in the past year*	87.9	88.6	88.8	88.4	88.5	87.5
Uninsured	*Percentage of adults under age 65 without health insurance coverage*	7.6	10.0	8.5	8.7	10.8	10.8
Primary Care Physicians	*Ratio of population to one primary care physician*	9,094.0	837.3	2,168.2	4,033.2	1,506.9	1,319.0
Dentists	*Ratio of population to one dentist*	2,283.1	1,289.2	3,309.1	2,293.8	2,103.0	1,404.5
Mental Health Providers	*Ratio of population to one mental health provider*	961.3	223.2	737.6	640.7	421.4	382.3
Addiction or Substance Use Providers	*Rate of addiction or substance use providers per 100,000 population*	5.6	7.8	0.8	4.7	4.4	20.4
Buprenorphine Providers	*Rate of buprenorphine providers per 100,000 population*	5.5	20.3	1.7	9.2	4.8	7.6
Preventable Hospital Stays	*Number of hospital stays for ambulatory care-sensitive conditions per 1,000 Medicare enrollees*	5,009.0	4,072.0	4,637.0	4,572.7	4,769.0	4,236.0

FIGURE 8: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT ACCESS INDICATORS

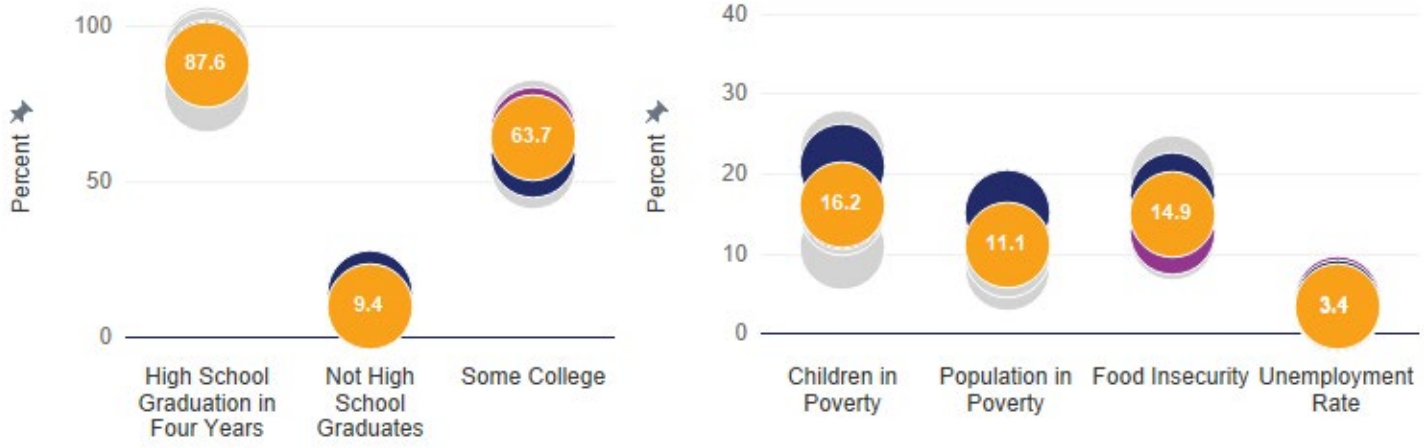


SOCIAL AND ECONOMIC FACTORS

TABLE 10: SOCIAL AND ECONOMIC FACTORS INDICATORS AND RATES

		Grant County	Pulaski County	Saline County	Community Average	State	National
Not High School Graduates	*Percentage of adults ages 25 or older without a high school diploma*	9.2	9.6	9.4	9.4	13.4	12.0
High School Graduation in Four Years	*Percentage of ninth-grade cohort who graduated in four years*	91.2	79.4	92.2	87.6	88.2	87.7
Some College	*Percentage of adults ages 25-44 with some post-secondary education*	54.8	68.8	67.6	63.7	58.5	66.1
Unemployment Rate	*Unemployment rate among civilian non-institutionalized population age 16 and older in January 2022*	3.1	4.3	2.9	3.4	3.8	4.4
Children in Poverty	*Percentage of children under age 18 below the poverty line*	15.2	22.5	10.8	16.2	20.8	15.7
Population in Poverty	*Percentage of population below the federal poverty line*	9.9	15.3	8.2	11.1	15.2	11.9
Children in Single-Parent Households	*Percentage of children who live in a household headed by single parent*	19.4	39.3	23.3	27.3	28.9	25.5
Homeless Children	*Rate of homelessness among public school students*	0.9	2.1	0.8	1.3	2.8	2.8
Food Insecurity	*Percentage of the population that experienced food insecurity in the report year*	13.4	19.3	11.9	14.9	17.3	12.6
Social Associations	*Number of membership associations per 100,000 population*	89.6	167.0	85.0	113.8	126.5	105.0
Violent Crimes	*Annual rate of reported violent crimes per 100,000 population*	295.5	1,121.8	300.9	572.7	549.2	416.0

FIGURE 9: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT SOCIAL AND ECONOMIC FACTORS INDICATORS



ENVIRONMENT

TABLE 11: ENVIRONMENT INDICATORS AND RATES

		Grant County	Pulaski County	Saline County	Community Average	State	National
Food Environment Index	*Index of factors that contribute to a healthy food environment, 0 (worst) to 10 (best)*	7.4	6.6	7.7	7.2	5.1	7.8
Drinking Water Violations	*The total number of drinking water violations recorded in a two-year period*	0.0	0.0	0.0	0.0	118.0	4,739.0
Access to Exercise Opportunities	*Percentage of population with adequate access to locations for physical activity*	26.6	83.6	58.6	56.3	63.5	84.2
Severe Housing Problems	*Percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, or lack of kitchen or plumbing*	13.4	16.3	9.6	13.1	14.1	17.5
Broadband Access	*Percentage of population in a high-speed internet service area; access to DL speeds > 25MBPS (2020)*	85.7	99.3	96.0	93.7	91.4	97.5
Long Commute Driving Alone	*Among workers who commute in their car alone, the percentage who commute more than 30 minutes*	52.1	20.3	40.7	37.7	27.0	36.6

FIGURE 10: COMMUNITY, STATE, AND NATIONAL COMPARISON OF THE FOOD ENVIRONMENT INDEX INDICATOR

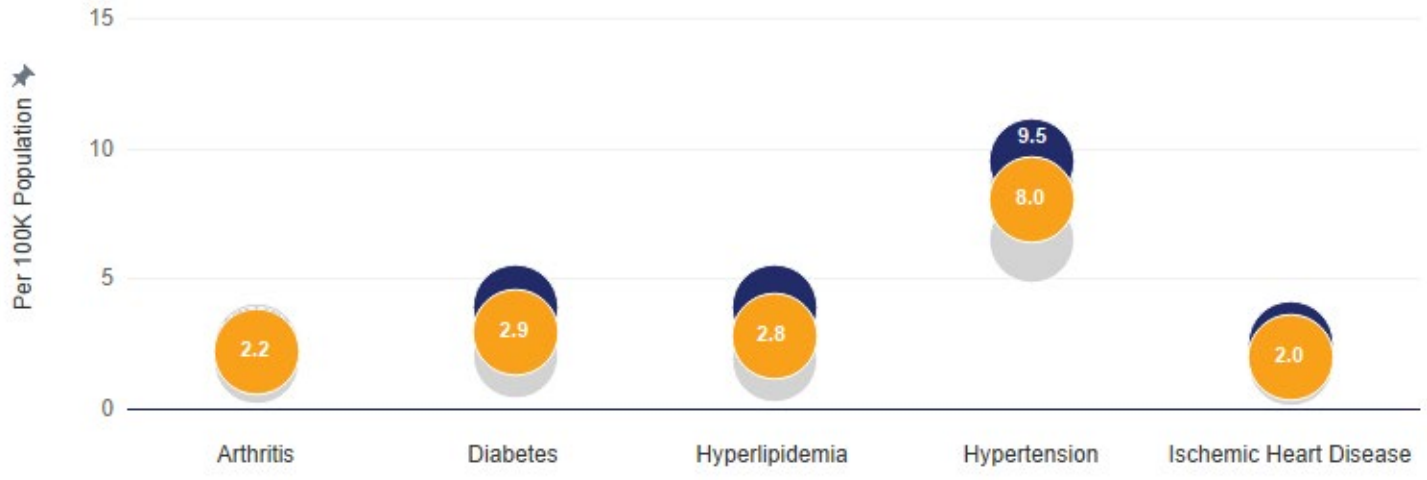
FIGURE 11: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT ENVIRONMENT INDICATORS

DIAGNOSES INCIDENCE WITHIN HOSPITAL COMMUNITY AT DISCHARGE

TABLE 12: DIAGNOSES INCIDENCE WITHIN HOSPITAL COMMUNITY AT DISCHARGE INDICATORS AND RATES

		Grant County	Pulaski County	Saline County	Community Average	State
Arthritis	*Number of individuals 18 years and older discharged with a primary or secondary arthritis diagnosis as a percentage of the population 18 years and older*	2.5	2.4	1.8	2.2	2.3
Diabetes	*Number of individuals 18 years and older discharged with a primary or secondary diabetes diagnosis as a percentage of the population 18 years and older*	3.3	3.5	2.1	2.9	3.9
Hyperlipidemia	*Number of individuals 18 years and older discharged with a primary or secondary hyperlipidemia diagnosis as a percentage of the population 18 years and older*	3.2	3.2	1.9	2.8	3.9
Hypertension	*Number of individuals 18 years and older discharged with a primary or secondary hypertension diagnosis as a percentage of the population 18 years and older*	8.7	9.0	6.4	8.0	9.5
Ischemic Heart Disease	*Number of individuals 18 years and older discharged with a primary or secondary ischemic heart disease diagnosis as a percentage of the population 18 years and older*	2.5	1.7	1.7	2.0	2.5

FIGURE 12: DIAGNOSES INCIDENCE WITHIN HOSPITAL COMMUNITY AT DISCHARGE INDICATORS

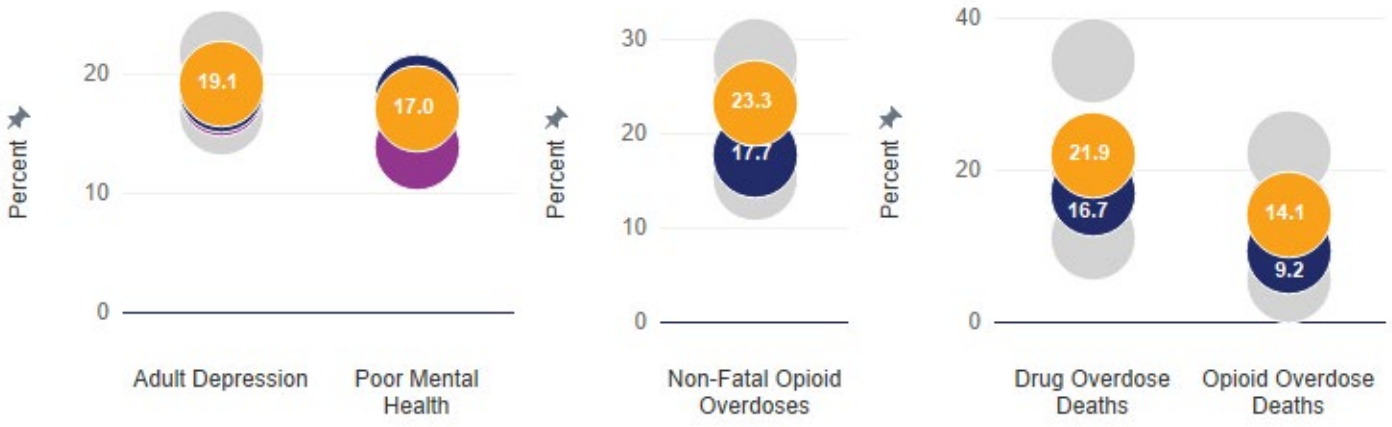


MENTAL HEALTH AND SUBSTANCE USE

TABLE 13: MENTAL HEALTH AND SUBSTANCE USE INDICATORS AND RATES

		Grant County	Pulaski County	Saline County	Community Average	State	National
Excessive Drinking	*Percentage of adults reporting binge or heavy drinking*	17.7	17.6	17.3	17.6	17.3	19.2
Poor Mental Health	*Percentage of adults ages 18 or older reporting poor mental health for 14 or more days*	18.1	16.6	16.3	17.0	18.0	13.9
Youth Depression	*Percentage of public school students in 6th, 8th, 10th, and 12th grade who had feelings of depression all of the time in the past 30 days*	14.9	12.9	8.5	12.1	12.1	Data Not Available
Adult Depression	*The prevalence of depression among Medicare fee-for-service beneficiaries*	21.8	18.8	16.8	19.1	18.7	18.4
Suicide Deaths	*The rate of deaths by suicide (ICD-10 codes U03, X60-X84, Y87.0) per 100,000 population (age-adjusted)*	Data Not Available	17.0	20.5	Data Not Available	18.8	13.8
Non-Fatal Opioid Overdoses	*Non-fatal opioid overdoses per 100,00 population (based on county of occurrence)*	27.8	26.6	15.4	23.3	17.7	Data Not Available
Opioid Overdose Deaths	*Opioid-related deaths per 100,00 population (based on county of occurrence)*	5.6	22.0	14.6	14.1	9.2	Data Not Available
Drug Overdose Deaths	*Opioid-related deaths per 100,00 population (based on county of occurrence)*	11.1	34.3	20.3	21.9	16.7	Data Not Available

FIGURE 13: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT MENTAL HEALTH AND SUBSTANCE USE INDICATORS

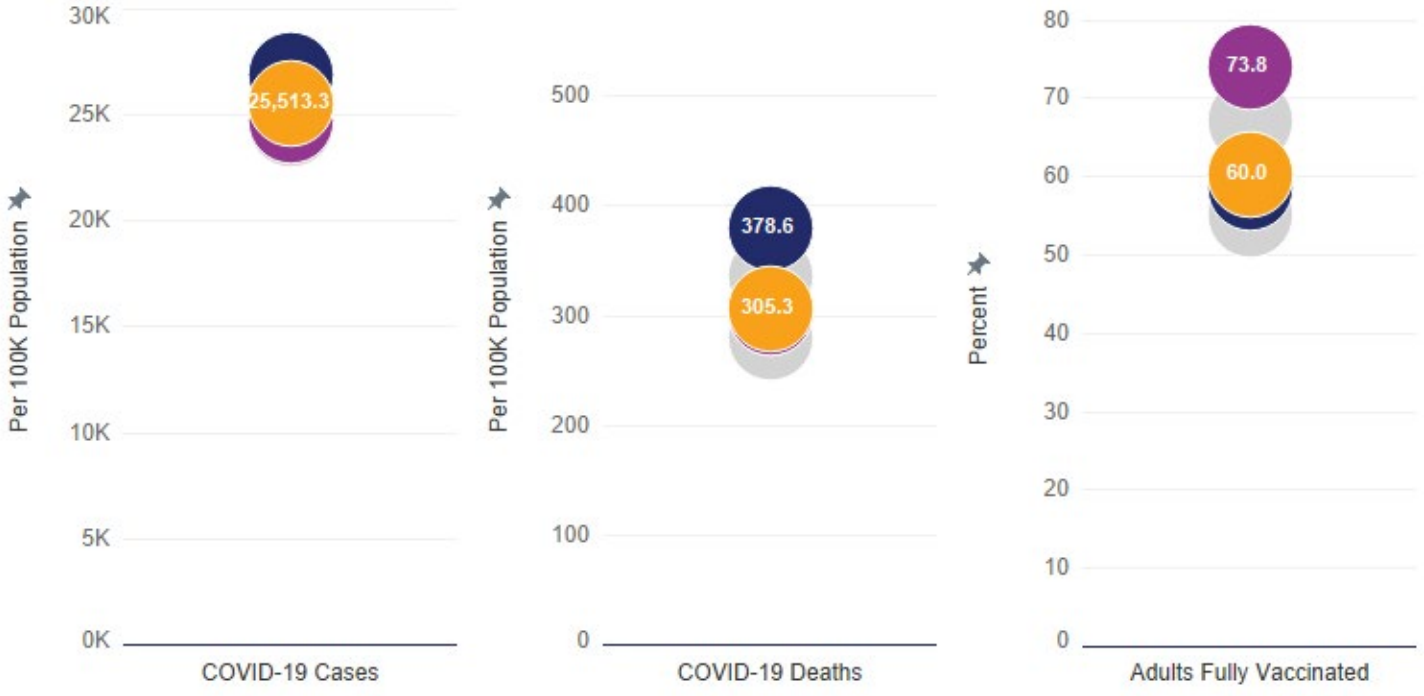


COVID-19

TABLE 14: COVID-19 INDICATORS AND RATES

		Grant County	Pulaski County	Saline County	Community Average	State	National
COVID-19 Cases	*The incidence rate of confirmed COVID-19 cases per 100,000 population, as of May 12, 2022*	24,560.2	26,444.7	25,535.1	25,513.3	26,900.1	24,718.7
COVID-19 Deaths	*The rate of deaths among patients with confirmed cases of COVID-19 per 100,000 population, as of May 12, 2022*	335.4	301.3	279.2	305.3	378.6	301.3
Adults Fully Vaccinated	*The percentage of adults fully vaccinated for COVID-19, as of May 11, 2022*	54.9	67.1	58.1	60.0	58.4	73.8
Adult COVID-19 Vaccine Hesitancy	*The percentage of the population estimated to be hesitant toward receiving a COVID-19 vaccine*	20.4	17.8	19.8	19.3	20.4	10.3

FIGURE 14: COMMUNITY, STATE, AND NATIONAL COMPARISON OF SELECT COVID-19 INDICATORS








APPENDIX 1:
MEASUREMENTS AND DATA SOURCE DESCRIPTIONS

Appendix 1: Measurements and Data Source Descriptions

Category	Measurement	Description	Data Year	Source
Access	Addiction or Substance Use Providers	Rate of addiction or substance use providers per 100,000 population	2021	SparkMap (CMS, National Plan and Provider Enumeration System)
	Buprenorphine Providers	Rate of buprenorphine providers per 100,000 population	2022	SparkMap (SAMHSA)
	Dentists	Ratio of population to one dentist	2019	County Health Rankings(Area Health Resource File/National Provider Identification file)
	Diabetic Monitoring	Percentage of diabetic Medicare enrollees over age 65 who had a hemoglobin A1c test in the past year	2019	SparkMap (Dartmouth Atlas of Health Care)
	Mammography	Percentage of female Medicare enrollees ages 65-74 who received an annual mammography screening	2018	County Health Rankings (CMS Office of Minority Health's Mapping Medicare Disparities (MMD))
	Mental Health Providers	Ratio of population to one mental health provider	2020	County Health Rankings (CMS, National Provider Identification File)
	Preventable Hospital Stays	Number of hospital stays for ambulatory care-sensitive conditions per 1,000 Medicare enrollees	2018	County Health Rankings (CMS Office of Minority Health's Mapping Medicare Disparities (MMD))
	Primary Care Physicians	Ratio of population to one primary care physician	2018	County Health Rankings (Area Health Resource File/American Medical Association)
	Uninsured	Percentage of adults under age 65 without health insurance coverage	2019	SAHIE
Cause of Death	Alcohol-Involved Motor Vehicle Crash	Rate of persons killed in motor vehicle crashes involving alcohol as a rate per 100,000 population	2015-2019	SparkMap (NHTSA, Fatality Analysis Reporting System)
	All Causes	Rate of deaths by all causes per 100,000 population (age-adjusted)	2015-2019	NIMHD HDPulse: An Ecosystem of Minority Health and Health Disparities Resources (NVSS)
	Cancer	5-year average rate of death due to malignant neoplasm (cancer) per 100,000 population (age-adjusted); ICD-10 codes C00-C97	2016-2020	SparkMap (CDC WONDER (NVSS))
	Chronic Lower Respiratory Disease	Rate of deaths due to chronic lower respiratory disease per 100,000 population (age-adjusted); ICD-10 codes J40-J47	2015-2019	NIMHD HDPulse: An Ecosystem of Minority Health and Health Disparities Resources (NVSS)
	Diabetes	Rate of deaths due to diabetes per 100,000 population (age-adjusted)	2015-2019	NIMHD HDPulse: An Ecosystem of Minority Health and Health Disparities Resources (NVSS)

	Heart Disease	Rate of death due to heart disease (ICD-10 Codes I00-I09, I11, I13, I20-I151) per 100,000 population (age-adjusted)	2016-2020	SparkMap (CDC WONDER (NVSS))
	Motor Vehicle Crash	5-year average rate of death due to motor vehicle crash per 100,000 population (age-adjusted)	2016-2020	SparkMap (CDC WONDER (NVSS))
	Stroke	5-year average rate of death due to cerebrovascular disease (stroke) per 100,000 population (age-adjusted)	2016-2020	SparkMap (CDC WONDER (NVSS))
	Unintentional Injury	5-year average rate of death due to unintentional injury (accident) per 100,000 population (age-adjusted)	2016-2020	SparkMap (CDC WONDER (NVSS))
Chronic Conditions	Adult Obesity	Percentage of adults ages 20 and older who report a BMI higher than 30	2019	SparkMap (CDC National Center for Chronic Disease Prevention and Health Promotion)
	Arthritis	Percentage of adults ages 18 or older diagnosed with some form of arthritis	2019	ADH (BRFSS)
	Asthma	Percentage of adults who have been told they currently have asthma (age-adjusted)	2019	SparkMap (via 500 Cities (BRFSS)
	Child Obesity	Percentage of students classified as overweight or obese, by county location of school	2020-2021	ACHI
	Coronary Heart Disease	Percentage of adults who have been told they have angina or coronary heart disease (age-adjusted)	2019	SparkMap (via PLACES (BRFSS)
	Diabetes	Percentage of adults ages 20 and older who have ever been told by a doctor that they have diabetes (age-adjusted)	2019	SparkMap (CDC National Center for Chronic Disease Prevention and Health Promotion)
	High Blood Pressure	Percentage of adults who have been told they have high blood pressure	2019	SparkMap (via 500 Cities (BRFSS)
	High Cholesterol	Percentage of adults who have had their blood cholesterol checked and have been told it was high	2019	SparkMap (via 500 Cities (BRFSS)
COVID-19	Adults Fully Vaccinated	The percentage of adults fully vaccinated for COVID-19, as of May 11, 2022	2022	SparkMap (CDC, NCHS)
	COVID-19 Cases	The incidence rate of confirmed COVID-19 cases per 100,000 population, as of May 12, 2022	2022	SparkMap (via ESRI (Johns Hopkins University))
	COVID-19 Deaths	The rate of deaths among patients with confirmed cases of COVID-19 per 100,000 population, as of May 12, 2022	2022	SparkMap (via ESRI (Johns Hopkins University))
	Adult COVID-19 Vaccine Hesitancy	The percentage of the population estimated to be hesitant toward receiving a COVID-19 vaccine	2022	SparkMap (CDC, NCHS)
Demographics	Ages 0-4	5-year population estimate	2015-2019	SparkMap (ACS)

	Ages 5-17	5-year population estimate	2015-2019	SparkMap (ACS)
	Ages 18-24	5-year population estimate	2015-2019	SparkMap (ACS)
	Ages 25-34	5-year population estimate	2015-2019	SparkMap (ACS)
	Ages 35-44	5-year population estimate	2015-2019	SparkMap (ACS)
	Ages 45-54	5-year population estimate	2015-2019	SparkMap (ACS)
	Ages 55-64	5-year population estimate	2015-2019	SparkMap (ACS)
	Ages 65+	5-year population estimate	2015-2019	SparkMap (ACS)
	Female	5-year population estimate	2015-2019	SparkMap (ACS)
	Male	5-year population estimate	2015-2019	SparkMap (ACS)
	Hispanic or Latino	5-year population estimate	2015-2019	SparkMap (ACS)
	Non-Hispanic White	5-year population estimate	2015-2019	SparkMap (ACS)
	Black or African American	5-year population estimate	2015-2019	SparkMap (ACS)
	Asian	5-year population estimate	2015-2019	SparkMap (ACS)
	Native American/Alaska Native	5-year population estimate	2015-2019	SparkMap (ACS)
	Native Hawaiian/Pacific Islander	5-year population estimate	2015-2019	SparkMap (ACS)
	Some Other Race	5-year population estimate	2015-2019	SparkMap (ACS)
	Total Population	5-year population estimate	2015-2019	SparkMap (ACS)
	Two or More Races	5-year population estimate	2015-2019	SparkMap (ACS)
	Non-English Language Households	Percentage of households where all members 14 years old and over have at least some difficulty with English	2015-2019	NIMHD HDPulse: An Ecosystem of Minority Health and Health Disparities Resources (Census and ACS)
Diagnoses Incidence Within Hospital Community at Discharge	Arthritis	Number of individuals 18 years and older discharged with a primary or secondary arthritis diagnosis as a percentage of the population 18 years and older	2020	ACHI
	Diabetes	Number of individuals 18 years and older discharged with a primary or secondary diabetis diagnosis as a percentage of the population 18 years and older	2020	ACHI

	Hyperlipidemia	Number of individuals 18 years and older discharged with a primary or secondary hyperlipidemia diagnosis as a percentage of the population 18 years and older	2020	ACHI
	Hypertension	Number of individuals 18 years and older discharged with a primary or secondary hypertension diagnosis as a percentage of the population 18 years and older	2020	ACHI
	Ischemic Heart Disease	Number of individuals 18 years and older discharged with a primary or secondary ischemic heart disease diagnosis as a percentage of the population 18 years and older	2020	ACHI
Environment	Access to Exercise Opportunities	Percentage of population with adequate access to locations for physical activity	2019	County Health Rankings (Business Analyst, Delorme map data, ESRI, & US Census Tigerline Files)
	Broadband Access	Percentage of population in a high-speed internet service area; access to DL speeds > 25MBPS (2020)	2020	SparkMap (FCC National Broadband Map)
	Drinking Water Violations	The total number of drinking water violations recorded in a two-year period	2018-2019	SparkMap (via County Health Rankings (Safe Drinking Water Information System))
	Food Environment Index	Index of factors that contribute to a healthy food environment, 0 (worst) to 10 (best)	2015 and 2018	County Health Rankings (USDA Food Environment Atlas, Map and the Meal Gap)
	Long Commute Driving Alone	Among workers who commute in their car alone, the percentage who commute more than 30 minutes	2015-2019	County Health Rankings (ACS)
	Severe Housing Problems	Percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, or lack of kitchen or plumbing	2015-2019	County Health Rankings (Comprehensive Housing Affordability Strategy Data)
Health Behaviors	Adult Smoking	Percentage of adults who are current smokers (age-adjusted)	2019	SparkMap (BRFSS)
	Physical Inactivity	Percentage of adults ages 20 or older reporting no physical activity in the past month	2019	SparkMap (National Center for Chronic Disease Prevention and Health Promotion)
	Sexually Transmitted Infections	Number of newly diagnosed chlamydia cases per 100,000 population	2018	County Health Rankings (NCHHSTP)
	Teen Births	The seven-year average number of teen births per 1,000 female population, ages 15-19	2013-2019	SparkMap (via County Health Rankings (NCHS - Natality files)
	Youth Vaping	Percentage of public school students in 6th, 8th, 10th, and 12th grade who used any vape in the past 30 days	2020-2021	Arkansas Prevention Needs Assessment Survey (APNA)

Health Outcomes	Low Birthweight	Percentage of live births with low birth weight (<2500g)	2013-2019	SparkMap (via County Health Rankings (National Vital Statistics System -Natality Files))
	Poor or Fair Health	Percentage of adults reporting poor or fair health	2019	SparkMap (via 500 Cities (BRFSS)
	Poor Physical Health Days	Average number of physically unhealthy days reported in past 30 days (age-adjusted)	2018	SparkMap (via County Health Rankings (BRFSS)
	Premature Death	Years of potential life lost before age 75 per 100,000 population (age-adjusted)	2017-2019	SparkMap (via County Health Rankings (NCHS-Mortality Files))
Insurance Coverage	Dental Coverage	Percentage of Arkansas residents with evidence of any dental coverage in the All-Payer Claims Database (APCD)	2019	ACHI (APCD)
	Health Insurance Coverage	Percentage of total civilian non-institutionalized population with health insurance coverage	2015-2019	SparkMap (ACS)
	Private Health Insurance Coverage	Percentage of total civilian non-institutionalized population with private health insurance coverage	2015-2019	SparkMap (ACS)
	Public Health Insurance Coverage	Percentage of total civilian non-institutionalized population with public health insurance coverage	2015-2019	SparkMap (ACS)
Mental Health and Substance Use	Adult Depression	The prevalence of depression among Medicare fee-for-service beneficiaries	2018	SparkMap (CMS)
	Drug Overdose Deaths	Opioid-related deaths per 100,00 population (based on county of occurrence)	2021 (provisional)	ADH via the AFMC Arkansas Opioid Response Dashboard
	Excessive Drinking	Percentage of adults reporting binge or heavy drinking	2018	SparkMap (County Health Rankings (BRFSS))
	Non-Fatal Opioid Overdoses	Non-fatal opioid overdoses per 100,00 population (based on county of occurrence)	2021 (provisional)	ADH via the AFMC Arkansas Opioid Response Dashboard
	Opioid Overdose Deaths	Opioid-related deaths per 100,00 population (based on county of occurrence)	2021 (provisional)	ADH via the AFMC Arkansas Opioid Response Dashboard
	Poor Mental Health	Percentage of adults ages 18 or older reporting poor mental health for 14 or more days	2019	SparkMap (BRFSS via PLACES Data Portal)
	Suicide Deaths	The rate of deaths by suicide (ICD-10 codes U03, X60-X84, Y87.0) per 100,000 population (age-adjusted)	2016-2020	SparkMap (CDC Wonder)
	Youth Depression	Percentage of public school students in 6th, 8th, 10th, and 12th grade who had feelings of depression all of the time in the past 30 days	2020-2021	Arkansas Prevention Needs Assessment Survey (APNA)
Prevention	No Colorectal Cancer Screening	Percentage of adults ages 50-75 who have never had either a sigmoidoscopy or colonoscopy (age-adjusted)	2018	SparkMap (via 500 Cities (BRFSS))
	No Dental Vist	Percentage of adults ages 18 or older who have not had a dentist or dental clinic visit in the previous year	2018	SparkMap (Via 500 Cities (BRFSS))

	No Flu Shot	Percentage of adults ages 18 or older who have not had a flu shot in the past year	2019-2020	SparkMap (CDC - FluVaxView)
	No HIV Test	Percentage of adults ages 18 or older who have never been screened for HIV	2019	ADH (BRFSS)
	No Pap Test	Percentage of women ages 21 to 65 who have not had a pap test within the past 3 years (age-adjusted)	2018	SparkMap (via 500 Cities (BRFSS))
	Blood Pressure Medication Non-Adherence	The percentage of Medicare enrollees who did not adhere to blood pressure medication schedules	2018	SparkMap (CDC - Atlas of Heart Disease and Stroke)
	No Annual Wellness Visit (Medicare)	The percentage of Medicare enrollees who did not have an annual wellness visit in the past year	2019	SparkMap ((CMS Office of Minority Health's Mapping Medicare Disparities (MMD))
	No Routine Check Up (Adults)	The percentage of adults age 18 or older with no routine check up with a doctor in the past year	2019	SparkMap (via PLACES (BRFSS)
Social and Economic	Children in Poverty	Percentage of children under age 18 below the poverty line	2020	SparkMap (SAIPE)
	Children in Single-Parent Households	Percentage of children who live in a household headed by single parent	2015-2019	SparkMap (via County Health Rankings (ACS))
	Food Insecurity	Percentage of the population that experienced food insecurity in the report year	2017	SparkMap (Feeding America)
	High School Graduation in Four Years	Percentage of ninth-grade cohort who graduated in four years	2018-2019	SparkMap (EDFacts)
	Homeless Children	Rate of homelessness among public school students	2019-2020	SparkMap (EDFacts)
	Not High School Graduates	Percentage of adults ages 25 or older without a high school diploma	2015-2019	SparkMap (ACS)
	Population in Poverty	Percentage of population below the federal poverty line	2020	SparkMap (SAIPE)
	Social Associations	Number of membership associations per 100,000 population	2019	SparkMap (via County Health Rankings (County Business Patterns))
	Some College	Percentage of adults ages 25-44 with some post-secondary education	2014-2018	SparkMap (ACS)
	Unemployment Rate	Unemployment rate among civilian non-institutionalized population age 16 and older in January 2022	January 2022	SparkMap (Bureau of Labor Statistics)
	Violent Crimes	Annual rate of reported violent crimes per 100,000 population	2014/2016	SparkMap (Inter-university Consortium for Political and Social Research. (Uniform Crime