BAPTIST®

MEMORIAL HEALTH CARE

2012-2013

Community Health Needs Assessment Final Report

HOLLERAN

EXECUTIVE SUMMARY

CHNA Background

Baptist Memorial Health Care undertook a comprehensive Community Health Needs Assessment (CHNA) beginning in late 2011. Baptist Memorial Health Care has 14 affiliate hospitals serving 110 counties in Tennessee, Mississippi and Arkansas. The assessment was not only initiated to comply with current requirements set forth in the Affordable Care Act, but to further the health system's commitment to community health improvement. The findings from the assessment will be utilized by Baptist Memorial Health Care to guide various community initiatives and to engage appropriate partners to address the various needs that were identified. Baptist Memorial Health Care is committed to the people it serves and the communities they live in. Through this process, the hospital will be a stronger partner in the community and the health of those in the surrounding neighborhoods will be elevated.

The primary goals of the Community Health Needs Assessment were to:

- Provide baseline measure of key health indicators
- Establish benchmarks and monitor health trends
- Guide community benefit and community health improvement activities
- Provide a platform for collaboration among community groups
- Serve as a resource for individuals and agencies to identify community health needs
- Assist with community benefit requirements as outlined in Section 5007 of the ACA

CHNA Components

A variety of quantitative and qualitative research components were implemented as part of the CHNA. These components included the following:

- Statistical Household Survey
- Secondary Data Profiles
- Key Informant Interviews
- Focus Groups
- Prioritization
- Implementation Plan

Prioritized Community Needs

The findings from the CHNA were reviewed to identify the most vital community health needs. The following community health issues were identified as priority needs:

- Healthy Lifestyle Choices (Prevention & Education, Chronic Disease Prevention)
- Cancer
- Maternal and Women's Health (with a focus on Prenatal Care)
- Mental Health (with a focus on Caregivers and Alzheimer's Disease)

Documentation

A report of the CHNA was made public on the Baptist Memorial Health Care website in September 2013. An Implementation Strategy of how each Baptist hospital will address the identified priorities was developed and will be available on the website.

COMMUNITY HEALTH NEEDS ASSESSMENT OVERVIEW

Baptist Memorial Health Care Corporation Overview

Regarded as one of the premier health care systems in the nation, Baptist Memorial Health Care is an award-winning network dedicated to providing compassionate, high-quality care for patients. With 14 affiliate hospitals throughout the Mid-South, Baptist combines convenience with excellence of care—two reasons we have been named among the top health care systems in the country for several years. With the intention of caring for people close to their homes, the Baptist system also offers more than 3,100 affiliated physicians; home, hospice and psychiatric care; minor medical clinics; a network of surgery, rehabilitation and other outpatient centers; and an education system highlighted by the Baptist College of Health Sciences.

Since our modest beginning in 1912 with a 150-bed hospital, Baptist has grown to meet the expanding needs of the communities we serve, at one point becoming the largest privately owned hospital in the nation. But what has remained is the same caring atmosphere that inspired our founders. From our kitchen staff and office personnel to our experienced medical staff and renowned clinical services, that pervasive spirit of caring inspires every area of operation at Baptist.

Service Area

Baptist Memorial Health Care has 14 affiliate hospitals serving 110 counties in Tennessee, Mississippi, and Arkansas. For purposes of the CHNA, the study focused on the primary service area of each hospital to include the following counties:

- Arkansas: Craighead, Pointsett
- Mississippi: DeSoto, Lafayette, Lowndes, Prentiss, Union
- Tennessee: Carroll, Obion, Shelby, Tipton

CHNA Background

Baptist Memorial Health Care led a system-wide comprehensive Community Health Needs Assessment (CHNA) from October 2011 to September 2013. The assessment was conducted in a timeline to comply with requirements set forth in the Affordable Care Act, as well as to further the health care corporation's commitment to community health and population health management. The findings from the assessment will be utilized by Baptist Memorial Health Care to guide its community benefit initiatives and to engage partners to address the identified health needs.

The purpose of the CHNA was to gather information about local health needs and health behaviors in an effort to ensure hospital community health improvement initiatives and community benefit activities are aligned with community need. The assessment examined a variety of community, household, and health statistics to portray a full picture of the health and social determinants of health in the Baptist Memorial Health Care service area.

The findings from the CHNA were reviewed and health needs were prioritized to develop the hospitals' Community Health Implementation Strategy. Baptist Memorial Health Care is committed to the people it serves and the communities they live in. Through this process, the hospital will be a stronger partner in the community and the health of those in the surrounding neighborhoods will be elevated. Healthy communities lead to lower health care costs, robust community partnerships, and an overall enhanced quality of life.

Research Partner

Baptist Memorial Health Care contracted with Holleran, an independent research and consulting firm located in Lancaster, Pennsylvania, to conduct research in support of the CHNA. Holleran has 21 years of experience in conducting public health research and community health assessments. The firm provided the following assistance:

- Collected and interpreted Secondary Data
- Conducted, analyzed, and interpreted data from Household Telephone Survey
- Conducted, analyzed, and interpreted data from Key Informant Interviews
- Conducted Focus Groups with health care consumers
- Facilitated a Prioritization and Implementation Planning Session
- Prepared the Final Report and Implementation Strategy

Research Methodology

The health system undertook an in-depth, comprehensive approach to identifying the needs in the communities it serves. A variety of quantitative and qualitative research components were implemented as part of the CHNA. These components included the following:

A **statistical household survey** was completed with a total of 5,552 adults. Approximately 530 adults are represented for each of the 14 hospitals, with some individuals included in more than one hospital's report. This is due to overlapping service areas. The survey that was utilized aligns with the Behavioral Risk Factor Surveillance System (BRFSS) questionnaire that is annually conducted nationwide by the Centers for Disease Control and Prevention (CDC) and state health departments. The survey assessed indicators such as general health status, prevention activities (screenings, exercise, etc.), and risky behaviors (alcohol use, etc.). The results were also examined by a variety of demographic indicators such as age, race, ethnicity, and gender.

A number of existing resources were reviewed to fully understand **secondary data** trends. The secondary data that was analyzed included statistics such as mortality rates, cancer statistics, communicable disease data, social determinants of health (poverty, crime, education, etc.), among others. This information was used to supplement the primary data that was collected and flesh out research gaps not addressed in the household survey. The primary sources of the secondary data included the U.S. Census Bureau, state public health agencies, and the County Health Rankings reports. Where available, the local-level data was compared to state and national benchmarks.

Key informant interviews were conducted with 75 professionals and key contacts in the areas surrounding the 14-hospital service areas. Working with leadership from each of the system hospitals, Baptist identified specific individuals to be interviewed and invited them to participate in the study. The survey included a range of individuals, including elected officials, private physicians, health and human services experts, long-term care providers, representatives from the faith community, and educators. The content of the questionnaire focused on perceptions of community needs and strengths across three key domains: Perceived quality of care, key health issues prominent in the community, and quality of life issues.

In November 2012, health care consumers from the hospitals' service areas participated in **focus groups.** The focus groups addressed diabetes and pre-diabetes based on findings from household surveys. Discussion topics included health knowledge, self-care behaviors, health care access, communication preferences, and desired support services. A discussion guide, developed in

consultation with Baptist Memorial Health Care, was used to prompt discussion and guide the facilitation. Participants were recruited through telephone calls to households within the service area and through local health and human service organizations. Participants were pre-screened to ensure that they were either diabetic or pre-diabetic. Each session lasted approximately two hours and was facilitated by trained Holleran staff. In exchange for their participation, attendees were given a $50 cash incentive at the completion of the focus group; dinner was also provided. It is important to note that the focus group results reflect the perceptions of a small sample of community members and may not necessarily represent all community members in the hospital's service area.

Community Representation

Community engagement and feedback were an integral part of the CHNA process. A statistically valid sampling strategy ensured community representation in the household survey. Public health experts, health care professionals, and representatives of underserved populations shared knowledge and expertise about community health issues as part of the key informant interviews. Health care consumers, including medically underserved individuals and chronically-ill patients, were included in the focus groups.

Research Limitations

It should be noted that the availability and time lag of secondary data, as well as the ability to reach all segments of the population via the telephone survey, may present research limitations in the study. Baptist Memorial Health Care sought to mitigate limitations by including representatives of diverse and underserved populations throughout the research components.

Prioritization of Needs

Following the completion of the CHNA research, Baptist Memorial Health Care prioritized community health issues and developed an implementation plan to address prioritized community needs.

Documentation

A report of the CHNA was made public on the Baptist Memorial Health Care website in September 2013. The Final Report serves as a compilation of the overall key findings of the CHNA. Detailed reports for each individual component were provided separately. An Implementation Strategy of how the hospital will address the identified priorities was developed and will be available on the website.

KEY ASSESSMENT FINDINGS

Household Survey Key Findings

The same survey instrument was utilized across all regions of Baptist Memorial Health Care's service area. A number of similarities were noted across each of the 14 hospitals, along with some variations. These aggregate results, trends and comparisons to state and national benchmarks are detailed further in this section.

The survey gathered general ratings of **health status**, physical health, mental health, and any limitations in daily functioning because of poor health. As shown in the table below, respondents living in the areas served by Baptist hospitals, report poorer general health than respondents throughout the country. The table ranks hospitals from the fewest individuals reporting "fair" or "poor" health to the greatest. As can be seen, all of the hospitals have ratings below the U.S., Arkansas and Tennessee. With two exceptions, all are below the Mississippi average as well. BMH-North Mississippi has the fewest respondents reporting fair or poor health (22.3%) while NEA Baptist and BMH-Booneville have the greatest, with 31.1% falling into that category.

Hospital	% Fair or Poor Health
United States	**16.3%**
Arkansas	19.1%
Tennessee	19.5%
BMH-North Mississippi	22.3%
BMH-DeSoto	22.5%
Mississippi	23.7%
BMH-Tipton	24.0%
BMH-Golden Triangle	24.3%
BM Restorative Care	25.7%
BMH for Women	26.9%
BMH-Memphis	26.9%
BMH-Germantown	27.4%
BMH-Union City	28.4%
BMH-Collierville	28.5%
BMH-Huntingdon	30.2%
BMH-Union County	30.6%
BMH-Booneville	31.1%
NEA Baptist	31.1%

A number of questions on the household survey assessed **access to care** issues. These included items about health care coverage, having a usual doctor or health care provider, and cost as a potential barrier to seeing a doctor. There was variation across the hospitals with regard to each of these issues and racial and gender differences were uncovered in certain regions as well. Across the Baptist hospitals, the percentage of uninsured ranged from 11% in the BMH-Booneville service area to 23.1% in the BMH-DeSoto service area. The national average for individuals without health insurance is 15.1%. The states in the Baptist region of service, Tennessee, Arkansas, and Mississippi are all states that have higher proportions of uninsured adults than the nation.

Hospital	% Without Health Insurance
BMH-Booneville	11.0%
BMH-Collierville	11.8%
BMH-Tipton	13.1%
BMH-Germantown	15.0%
BMH-Union City	15.0%
United States	**15.1%**
BM Restorative Care	15.4%
BMH-Union County	15.5%
BMH for Women	16.1%
BMH-Memphis	16.1%
Tennessee	16.5%
BMH-Huntingdon	17.1%
BMH-North Mississippi	17.7%
NEA Baptist	20.2%
Arkansas	21.3%
Mississippi	21.6%
BMH-Golden Triangle	21.7%
BMH-DeSoto	23.1%

Body Mass Index (BMI) was calculated for each survey respondent through a self-report of height and weight. Survey respondents were classified as either "obese," "overweight," or "neither obese nor overweight." The state and national comparisons are included as well. In most cases, individuals living in the Baptist service areas have higher obesity rates than nationally, and the national statistics are not positive. Nationally, 65% of adults are overweight or obese. The state and national benchmarks are given for reference, but it is still important to consider the scope of the issue and the number of individuals impacted in the community. BMH-Tipton and BMH-DeSoto have the highest proportion of adults who are overweight or obese with nearly seven out of 10 falling into one of these two categories. It is also important to note that in the hospital service areas; only about two in 10 survey respondents indicated that they had been told by their doctor or health care provider that they are overweight or obese. This suggests a significant area of opportunity among health care professionals.

Hospital	% Overweight or Obese
BMH-North Mississippi	64.7%
United States	**65.0%**
BMH-Union City	66.8%
BM Restorative Care	67.0%
Tennessee	67.0%
BMH-Germantown	67.1%
BMH-Collierville	67.2%
BMH for Women	67.2%
BMH-Memphis	67.2%
BMH-Booneville	67.7%
NEA Baptist	68.1%
BMH-Union County	68.2%
Arkansas	68.3%
BMH-Huntingdon	68.9%
Mississippi	69.5%
BMH-Golden Triangle	70.6%
BMH-DeSoto	71.5%
BMH-Tipton	72.2%

Closely related to obesity is **diabetes**. Many studies have noted the connection between being overweight and the prevention and management of chronic illness. Individuals were asked whether they had ever been told by a doctor or health care professional that they had diabetes. In every region served by a Baptist hospital, the percentage reporting diabetes was higher than nationally, however some differences are not significantly different. Additionally, local statistics related to diabetes are typically higher than statewide figures. Interestingly, while BMH-Tipton had the highest BMI levels, they had the fewest adults reporting diabetes (11.8%). BMH-Huntingdon had nearly 20% of its survey respondents reporting a diabetes diagnosis. Additional survey questions assessed the management of diabetes from monitoring blood sugar levels to checking feet for sores and irritations. While some differences were noted across hospitals, such as the age of onset of diabetes, most diabetes management questions were similar to statewide and national statistic. The one area where most scored lower than national and statewide was in the percentage of those with diabetes who have taken a course or class in how to manage their diabetes.

Hospital	% With Diabetes
United States	**9.3%**
Arkansas	9.6%
Tennessee	11.3%
BMH-Tipton	11.8%
BMH-North Mississippi	11.9%
Mississippi	12.4%
BMH-Germantown	13.7%
BMH for Women	13.7%
BMH-Memphis	13.7%
BM Restorative Care	14.2%
NEA Baptist	14.2%
BMH-Golden Triangle	15.3%
BMH-Booneville	16.2%
BMH-Union City	16.6%
BMH-DeSoto	17.1%
BMH-Collierville	17.2%
BMH-Union County	17.2%
BMH-Huntingdon	19.2%

Cardiovascular health was assessed by asking individuals if they have ever had a heart attack or stroke and whether or not they have coronary heart disease. It should be noted that the secondary data collected as part of the full needs assessment also examined mortality rates due to heart disease. As displayed in the full table, the aggregate hospital data shows that for all three indicators, the local data is above the national percentage, although some of the deviations are not statistically significant. The rank order from highest to lowest is fairly similar when looking at heart attack and coronary heart disease, with BMH-Union City reporting the highest percentages. Stroke, however, does not necessarily follow the same pattern. The range across hospitals for incidence of stroke is from a low of 4.4% (BMH-DeSoto) to a high of 5.7% for both BMH-Collierville and NEA Baptist. The survey also asked about family history of heart disease. The majority reported that they have a family history of heart disease, roughly 40-50% in most cases.

Hospital	% Who Have Had a Heart Attack	% Who Have Coronary Heart Disease	% Who Have Had a Stroke
United States	**4.3%**	**4.4%**	**2.8%**
Tennessee	5.2%	4.8%	3.5%
Arkansas	5.4%	5.1%	3.6%
BMH-Tipton	5.4%	6.2%	4.8%
Mississippi	5.4%	4.4%	4.0%
NEA Baptist	5.4%	6.9%	5.7%
BMH for Women	5.5%	7.9%	4.8%
BMH-Memphis	5.5%	7.9%	4.8%
BMH-Germantown	5.6%	8.0%	4.8%
BMH-North Mississippi	6.0%	6.2%	4.9%
BMH-Golden Triangle	6.0%	6.7%	4.6%
BM Restorative Care	6.2%	9.2%	5.0%
BMH-DeSoto	6.4%	8.3%	4.4%
BMH-Collierville	6.6%	8.5%	5.7%
BMH-Union County	6.6%	6.3%	4.9%
BMH-Booneville	8.1%	9.0%	5.4%
BMH-Huntingdon	9.8%	9.6%	4.8%
BMH-Union City	11.2%	9.9%	4.9%

Awareness of the proportion of individuals struggling with various chronic illnesses is important to know, but it's the extent to which their health impacts their daily functioning that is often telling. Roughly 25% to 35% of adults reported that they are limited by some type of **disability**. The national number is closer to 21%. A proportion of these individuals also stated that they are dependent on equipment such as canes, wheelchairs or other assistive devices. BMH-Union County and BMH-Huntingdon have the highest percentages of disability.

Hospital	% With a disability
United States	**20.8%**
Tennessee	23.9%
Arkansas	24.7%
BMH-North Mississippi	24.7%
Mississippi	25.3%
BM Restorative Care	26.3%
BMH-Golden Triangle	26.6%
BMH for Women	27.0%
BMH-Memphis	27.0%
BMH-Germantown	27.4%
BMH-Collierville	30.0%
BMH-Booneville	31.2%
BMH-DeSoto	31.5%
NEA Baptist	32.5%
BMH-Tipton	33.1%
BMH-Union City	33.7%
BMH-Huntingdon	34.8%
BMH-Union County	34.9%

Tobacco use is linked to many other health risks such as cancer and respiratory illnesses such as asthma. The challenge for Baptist Memorial hospitals is that they are located in some of the highest areas of tobacco use in the country, Mississippi in particular. Survey respondents were initially asked if they had smoked at least 100 cigarettes in their lifetime. These proportions varied across the hospitals with some local areas having higher rates than state and national data and others much below the statewide and U.S. figures. Survey respondents who said "yes" to smoking at least 100 cigarettes in their life, were then asked if they currently smoke some days, every day or not at all. Nationally, 40.6% of these individuals now smoke some days or every day, and are considered regular smokers. Among the Baptist hospitals, BMH-DeSoto, BMH-Huntingdon and BMH-Union City have the highest rates of regular smokers. These statistics should be examined in conjunction with the secondary data regarding lung cancer incidence and mortality.

Hospital	% Smoking Every Day or Some Days
BMH-Collierville	32.6%
BMH-Germantown	40.4%
United States	**40.6%**
BMH for Women	40.9%
BMH-Memphis	40.9%
BM Restorative Care	42.2%
BMH-Golden Triangle	43.4%
BMH-Booneville	44.7%
Tennessee	46.7%
BMH-Union County	47.3%
BMH-Tipton	47.5%
BMH-North Mississippi	47.9%
NEA Baptist	48.2%
Arkansas	48.7%
BMH-DeSoto	50.1%
BMH-Huntingdon	50.3%
BMH-Union City	50.5%
Mississippi	51.1%

**Among individuals who have smoked at least 100 cigarettes in their lifetime*

Preventive screenings are a large part of **women's health** issues. Statistics were gathered on mammograms, clinical breast exams and Pap tests as well as a few other indicators. These statistics reflect whether or not respondents have had these tests and how recently the tests were conducted. In many instances, more females in the area have had a mammogram than statewide and nationally. Around 68% of females have had a mammogram in the U.S. With the exception of BMH-North Mississippi, NEA Baptist, and BMH-Union County, all other areas had higher percentages. BMH-Mississippi has a dramatically lower percentage, with only 57.1% of females having had a mammogram. Clinical breast exams were also largely equal to or above national rates and with the exception of NEA Baptist, Pap test rates were similar to or above national as well. It is important, however, to acknowledge that these statistics do not tell the reason a particular test was conducted. It may mean a greater focus on prevention or may be a function of increased risk factors.

Hospital	% Who Have Had a Mammogram	% Who Have Had a Clinical Breast Exam	% Who Have Had a Pap Test
BMH-North Mississippi	57.1%	89.2%	93.1%
NEA Baptist	62.8%	75.0%	77.5%
BMH-Union County	64.2%	85.4%	90.7%
Arkansas	65.6%	89.0%	93.1%
Mississippi	66.3%	88.6%	94.2%
United States	**67.7%**	**89.8%**	**93.8%**
BMH-Golden Triangle	68.2%	92.6%	96.9%
Tennessee	69.0%	87.8%	91.6%
BMH-Tipton	71.0%	91.1%	93.2%
BMH-Booneville	72.6%	88.6%	93.6%
BMH-Germantown	75.5%	88.2%	94.2%
BM Restorative Care	75.9%	90.5%	96.3%
BMH for Women	76.1%	87.9%	94.6%
BMH-Memphis	76.1%	87.9%	94.6%
BMH-DeSoto	76.3%	87.5%	88.8%
BMH-Union City	79.4%	94.7%	97.4%
BMH-Huntingdon	81.6%	91.3%	94.9%
BMH-Collierville	86.1%	88.5%	94.3%

Male-specific health questions were also assessed. Specifically, **prostate cancer** screening questions related to prostate antigen (PSA) tests and digital rectal exams were asked. These questions were only asked of individuals 40 years and older. Most males served by area hospitals are more likely to have had a PSA test than nationally (65%). As a state, Tennessee rates the lowest with PSA tests (58.8%). The percentage of males who have had a digital rectal exam is 73.4% nationally and once again, the lowest throughout Tennessee (57.7%). Eight of the 14 hospitals have percentages lower than the nation for digital rectal exams. The incidence of prostate cancer was above state and national figures for some hospitals, but similar to or lower than state and national comparisons for other hospitals. Again, as with the women's health questions, the rationale for having the test is unknown, so a higher or lower percentage could be a positive or negative item. This is why the prostate cancer incidence and mortality statistics should be examined further as well.

Hospital	% Who Have Had a PSA Test	% Who Have Had a Digital Rectal Exam
Tennessee	58.8%	57.7%
BMH-North Mississippi	58.9%	56.6%
BMH-DeSoto	60.8%	70.3%
BMH-Union City	64.6%	72.3%
United States	**65.0%**	**73.4%**
Mississippi	65.3%	69.8%
BMH-Huntingdon	68.4%	68.6%
BMH-Tipton	70.2%	70.9%
BMH-Union County	70.3%	61.4%
Arkansas	70.3%	75.6%
BMH-Golden Triangle	73.0%	75.8%
NEA Baptist	73.9%	74.9%
BM Restorative Care	74.8%	83.8%
BMH-Germantown	77.8%	82.0%
BMH-Collierville	77.8%	82.0%
BMH for Women	78.2%	81.0%
BMH-Memphis	78.2%	81.0%
BMH-Booneville	79.7%	75.3%

Colorectal cancer screening questions were included in the survey as well for individuals 50 years of age and older. The table below outlines the figures for colonoscopies and sigmoidoscopies. Nine of the 14 hospitals have statistics that are equal to or better than national statistics and nearly all have higher percentages than the state. The lowest levels of adults having a colonoscopy or sigmoidoscopy are within the BMH-DeSoto service area. The highest rates of compliance with this recommended screening are within the BMH-Union City service area. In most areas, African Americans were less likely to have had this screening than Whites. There were no consistent patterns with regard to gender.

Hospital	% Who Have Had a Sigmoidoscopy or Colonoscopy
Mississippi	59.5%
Tennessee	60.5%
BMH-DeSoto	60.7%
Arkansas	61.0%
BMH-North Mississippi	61.8%
BMH-Huntingdon	62.3%
NEA Baptist	62.5%
BMH-Union County	64.5%
United States	**65.6%**
BMH-Golden Triangle	65.7%
BMH-Booneville	65.7%
BMH-Tipton	67.2%
BMH for Women	69.1%
BMH-Memphis	69.1%
BMH-Germantown	70.0%
BM Restorative Care	70.1%
BMH-Collierville	73.2%
BMH-Union City	75.2%

Cancer incidence rates were assessed by asking survey respondents if they had ever been told by a doctor or health professional that they had cancer. Nationally, 9.4% of respondents have been diagnosed with cancer. Within the Baptist system, the figures ranged from 7% (BMH-North Mississippi) to 17.7% (BMH-Union County). In nearly all cases, the percentage of African American respondents reporting cancer was lower than White respondents in the area. The most commonly reported cancers included breast, prostate, skin, lung, and colorectal cancer. It should be noted that there were no state comparisons available within this section of the survey.

Hospital	% Who Have Had Cancer
BMH-North Mississippi	7.0%
BMH-Golden Triangle	8.0%
BMH-Tipton	8.4%
BMH-DeSoto	9.2%
United States	**9.4%**
BMH for Women	9.4%
BMH-Memphis	9.4%
BMH-Germantown	9.4%
BM Restorative Care	9.4%
NEA Baptist	9.7%
BMH-Union City	10.3%
BMH-Booneville	11.0%
BMH-Huntingdon	12.0%
BMH-Collierville	12.3%
BMH-Union County	17.7%
Mississippi	N/A
Tennessee	N/A
Arkansas	N/A

The final section of the survey focused on **care giving**. Care giving is defined as providing care to a friend or family member on a regular basis to assist with activities of daily living. Every hospital within the health system significantly exceeded the national percentage of 16.8%. Between 22% and 31% of adults surveyed reported that they are taking care of another individual on a regular or semi-regular basis. Most are providing care to an older adult (65 and over) and most are female care givers.

Hospital	% Who Are a Caregiver to a Friend or Family Member
United States	**16.8%**
BMH-Union City	21.5%
BMH-Golden Triangle	21.7%
BMH-North Mississippi	22.1%
BMH-DeSoto	24.0%
BMH-Collierville	26.7%
BMH-Union County	26.8%
BMH-Tipton	26.9%
BMH for Women	26.9%
BMH-Memphis	26.9%
NEA Baptist	27.4%
BM Restorative Care	27.7%
BMH-Germantown	28.0%
BMH-Huntingdon	29.2%
BMH-Booneville	30.9%
Mississippi	N/A
Tennessee	N/A
Arkansas	N/A

In closing, there is poorer health outcomes related to general health status and chronic health diseases throughout the areas served by Baptist Memorial Health Care. Specifically, obesity and diabetes are significant health concerns system-wide. A gap between the number of residents that are obese or overweight and are also being coached and educated by their health care providers was noted. Other statistics, such as smoking, show that certain risky behaviors are more prevalent in the region. Residents are more likely than to receive preventive screenings than the state benchmark; however, this may be due to increased risk. While each region and local community has its own unique issues, a number of clear patterns emerged in the household survey.

The household survey results were correlated with secondary data statistics and the qualitative research to determine key community health needs across all research components.

Secondary Data Key Findings

The **demographic and household statistics** of an area, as well as population shifts, can have a dramatic impact on the health care system. For each hospital's service area, the population growth or decline, between 2000 and 2010, was examined. As anticipated, there was much variation between counties; some counties saw significant population growth, others had dramatic population decline. In addition to population shifts, age demographics and racial composition were examined. The tables below show highlights for each state. Favorable statistics are those that compare positively against state and/or national benchmarks. Those that are noted as "unhealthy," are areas that compare negatively to U.S. and/or state data points.

Arkansas

Favorable trends/statistics	Unhealthy trends/statistics
• **Craighead County** (increase in population; vacant homes) • **Poinsett County** (vacant homes)	• **Craighead County** (income & poverty levels; education levels) • **Poinsett County** (population decrease; single-parent households; divorce rates; income & poverty levels; education levels)

Mississippi

Favorable trends/statistics	Unhealthy trends/statistics
• **DeSoto County** (population growth; occupied housing units; income & education levels) • **Lafayette County** (population growth; single-mother households; education levels) • **Union County** (single-mother households)	• **Benton County** (vacant housing units; single-mother households; median home values; household income & poverty; education levels) • **Lafayette County** (vacant housing) • **Lowndes County** (decrease in population; single-mother households; more rental households; income & poverty) • **Panola County** (home values; single-mother households; income levels & poverty; education levels) • **Prentiss County** (decrease in population; higher 65+ population; home values; poverty; education levels) • **Union County** (median home values; household income & poverty; education levels)

Tennessee

Favorable trends/statistics	Unhealthy trends/statistics
• **Tipton County** (population growth; vacant housing units; seniors living in poverty)	• **Carroll County** (decrease in population; higher 65+ population; vacant homes; home values; income levels & poverty; education levels) • **Obion County** (decrease in population; higher 65+ population; income & home values; education levels) • **Shelby County** (poverty rates; home values; education levels) • **Tipton County** (single-mother households living in poverty; education levels)

The overall age-adjusted **mortality rates** were examined across each county as well. While there were some exceptions, an examination of the mortality rates by race reveals a higher death rate among African Americans compared to Whites. The leading causes of death were also examined. Most areas had mortality rates due to heart disease higher than nationally and many had elevated rates for cancer, stroke, and chronic lower respiratory disease.

Arkansas

Favorable trends/statistics	Unhealthy trends/statistics
• NONE	• **Craighead County** (overall mortality rate; deaths due to stroke & accidents) • **Poinsett County** (overall mortality rate; deaths due to heart disease, cancer, stroke, accidents & chronic lower respiratory disease)

Mississippi

Favorable trends/statistics	Unhealthy trends/statistics
• **Lafayette County** (deaths due to cancer & heart disease) • **Prentiss County** (more owner-occupied households) • **DeSoto County** (deaths due to heart disease & stroke)	• **Benton County** (overall mortality rates; deaths due to heart disease, cancer, stroke, chronic lower respiratory disease, diabetes, and accidents) • **DeSoto County** (overall mortality rate) • **Lafayette County** (overall mortality rate) • **Lowndes County** (overall mortality rate; deaths due to heart disease) • **Panola County** (overall mortality rate; deaths due to heart disease & cancer) • **Prentiss County** (overall mortality rates; deaths due to heart disease, stroke, lower respiratory disease, accidents) • **Union County** (overall mortality rates; deaths due to heart disease, cancer, stroke, chronic lower respiratory disease, diabetes, and accidents)

Tennessee

Favorable trends/statistics	Unhealthy trends/statistics
• NONE	• **Carroll County** (overall mortality rate; deaths due to heart disease, cancer, chronic lower respiratory disease) • **Obion County** (overall mortality rate; deaths due to heart disease, cancer, chronic lower respiratory disease and suicide) • **Shelby County** (overall mortality rate; deaths due to heart disease, stroke, chronic lower respiratory disease) • **Tipton County** (overall mortality rate; deaths due to heart disease & cancer)

In addition to examining adult mortality rates, overall **infant mortality rates** were examined within each county. Additionally, statistics regarding maternal and child health such as the number of teen pregnancies, prenatal care in the first trimester, and the percentage of low birth-weight infants were gathered.

Arkansas

Favorable trends/statistics	Unhealthy trends/statistics
• NONE	• **Craighead County** (infant mortality rate overall) • **Poinsett County** (infant mortality rate overall; low birth-weight newborns; teen pregnancies)

Mississippi

Favorable trends/statistics	Unhealthy trends/statistics
• **Benton County** (overall infant mortality rates) • **DeSoto County** (low birth-weight newborns) • **Lowndes County** (low birth-weight newborns; prenatal care in first trimester) • **Prentiss County** (prenatal care 1st trimester among African Americans)	• **Union County** (overall infant mortality rates-African Americans; low birth-weight newborns) • **Benton County** (low birth-weight newborns; prenatal care in first trimester) • **DeSoto County** (prenatal care in first trimester) • **Lafayette County** (prenatal care in first trimester) • **Panola County** (low birth-weight newborns; teen pregnancies; prenatal care in first trimester) • **Prentiss County** (teen pregnancies)

Tennessee

Favorable trends/statistics	Unhealthy trends/statistics
• NONE	• **Carroll County** (overall infant mortality) • **Obion County** (overall infant mortality; low birth weight newborns) • **Shelby County** (overall infant mortality; low birth weights; prenatal care in first trimester; incidence of sexually transmitted illnesses)

The overall **cancer** incidence and mortality rates were examined for each county.

Arkansas

Favorable trends/statistics	Unhealthy trends/statistics
• **Craighead County** (overall cancer incidence rate; mortality rates for prostate & lung cancers)	• **Craighead County** (incidence rate for lung cancer) • **Poinsett County** (overall cancer incidence & mortality rates; lung cancer incidence & mortality; incidence & mortality colorectal cancer; incidence & mortality prostate cancer)

Mississippi

Favorable trends/statistics	Unhealthy trends/statistics
• **Benton County** (overall cancer incidence rates; prostate cancer incidence; lung cancer incidence; breast cancer incidence) • **DeSoto County** (overall cancer incidence; prostate cancer incidence & mortality) • **Lafayette County** (incidence of prostate, lung & colorectal cancers; mortality lung & breast cancers) • **Lowndes County** (overall cancer incidence & mortality) • **Panola County** (incidence of prostate cancer) • **Prentiss County** (prostate cancer mortality; breast cancer incidence) • **Union County** (prostate cancer incidence; breast cancer incidence; overall cancer mortality; breast cancer mortality)	• **Benton County** (breast cancer mortality; prostate cancer mortality) • **DeSoto County** (lung cancer incidence) • **Lafayette County** (incidence of breast cancer; mortality rate for prostate & colorectal cancers) • **Lowndes County** (lung cancer incidence & mortality) • **Panola County** (incidence of breast cancer; mortality rate for prostate and lung cancer) • **Prentiss County** (overall cancer incidence and mortality; incidence of lung and colorectal cancers; mortality rate for lung and breast cancers) • **Union County** (overall cancer incidence; lung cancer incidence)

Tennessee

Favorable trends/statistics	Unhealthy trends/statistics
• **Carroll County** (prostate cancer incidence) • **Obion County** (incidence & mortality rates for prostate cancer; incidence rate for breast cancer) • **Tipton County** (overall cancer incidence; incidence & mortality of breast cancer; mortality due to prostate cancer)	• **Carroll County** (overall cancer incidence & mortality; lung cancer incidence & mortality; colorectal cancer incidence) • **Obion County** (overall cancer mortality rate; incidence & mortality rates for lung and colorectal cancers) • **Shelby County** (incidence of prostate, colorectal cancers; mortality rates due to breast, colorectal, prostate and all cancers overall) • **Tipton County**(incidence of prostate cancer; incidence & mortality of lung and colorectal cancers)

Health risk factors such as smoking, excessive drinking, and an unhealthy weight are all related to poorer health outcomes. Unfortunately for the counties assessed, most of these statistics are higher than statewide and nationally.

Arkansas

Favorable trends/statistics	Unhealthy trends/statistics
• NONE	• **Craighead County** (obesity; excessive drinking) • **Poinsett County** (obesity; excessive drinking; adult smoking)

Mississippi

Favorable trends/statistics	Unhealthy trends/statistics
• **Benton County** (excessive drinking) • **Prentiss County** (excessive drinking)	• **Benton County** (obesity, adult smoking, motor vehicle accidents) • **DeSoto County** (excessive drinking, adult smoking, obesity) • **Lafayette County** (excessive drinking, adult smoking, obesity) • **Lowndes County** (excessive drinking, adult smoking, obesity) • **Panola County** (excessive drinking, adult smoking, obesity) • **Prentiss County** (adult smoking; obesity) • **Union County** (obesity, adult smoking, motor vehicle accidents)

Tennessee

Favorable trends/statistics	Unhealthy trends/statistics
• NONE	• **Carroll County** (obesity, adult smoking) • **Obion County** (obesity, adult smoking) • **Shelby County** (adult smoking; excessive alcohol use; obesity) • **Tipton County** (adult smoking; excessive alcohol use; obesity; motor vehicle accidents)

In closing, the secondary data points to some key opportunities and strengths across the counties. The most consistent themes for all counties across each of the three states are related to health risk behaviors. Rates of smoking, excessive drinking, and obesity are all higher than national rates.

The secondary data were correlated with household survey findings and the qualitative research to determine key community health needs across all research components.

Key Informant Interviews Key Findings

The key informant surveys gathered feedback on issues such as the overall quality of health care in the area, prominent health issues and barriers, and perceived quality of life. The initial section of the survey evaluated the quality of care, which included accessibility and availability of services such as primary care, dental care, and bilingual care. As detailed below, the area professionals were least likely to agree that there are a sufficient number of bilingual providers in the community.

On a scale of 1 (strongly disagree) through 5 (strongly agree), please rate each of the following statements:

Factor	Mean Response
The majority of residents in the community are able to access a primary care provider.	3.5
The majority of residents in the community are able to access a dentist when needed.	3.5
The majority of residents in the community are able to access a medical specialist.	3.2
There are a sufficient number of providers accepting Medicaid or other forms of medical assistance.	3.2
Transportation for medical appointments is available to the majority of residents.	3.0
There are a sufficient number of bilingual providers in the community.	2.2

Transportation for medical appointments garnered the second-lowest average rating (3.0) and the availability of medical specialists and the number of providers accepting Medicaid or other forms of medical assistance obtained ratings averaging 3.2 on the five-point scale. While overall, access to primary care and dental care were rated the highest, other comments throughout the survey suggest that significant barriers exist. The survey asked respondents what health care services were currently not provided in the community and medical specialists were noted by the majority. Specifically, mental and behavioral health specialists were listed along with endocrinologists, dieticians, dentists, cardiologists, and pediatricians.

When asked to select the three most significant health issues in the community, obesity, diabetes, and heart disease were selected the most often. Other common mentions included heart disease, cancer, and substance abuse.

"We have a lot of primary care physicians, but many of them do not accept Medicaid. As for a safety net, we have some private Federally Qualified Health Centers, but those in between-such as the working poor-are caught in the middle and do not have enough places to go."

What do you perceive as the three most significant (most severe or most serious) health issues in the community?

Factor	Number of Mentions	Percent of Respondents (%)
Obesity	43	57.3
Diabetes	40	53.3
Heart Disease	32	42.7
Cancer	19	25.3
Substance Abuse	10	13.3

The questionnaire was not limited to the clinical aspects of community health, but also solicited feedback on several quality of life factors, including the availability of recreational activities, neighborhood safety, air and water quality, and job opportunities. A 1-5 scale (1=very poor; 5=excellent) was used to gather feedback on these aspects. The quality of the air and water was rated the highest in the communities, followed by road/traffic conditions, the availability of recreational activities, and the schools/education. The lowest ratings were given for job opportunities (3.1 average) and neighborhood safety (3.3 average).

Lack of insurance and inability to pay for health care services or prevention were seen as the most significant barriers that keep people in the community from accessing care when they need it. Cost was a factor not only in affording health insurance, but in covering co-pays and prescription medication. Low-income seniors were specifically mentioned as having greater barriers as well as members of racial minority groups such as the African American, Hispanic/Latino, and Asian communities. Transportation was also seen as a significant barrier. The need for mobile health vans or buses was mentioned a number of times as a potential remedy to transportation barriers. Another common theme was that the average consumer does not understand how to effectively navigate the health care system. There is a lack of awareness of what is available and a perception of limited health literacy across a number of area residents.

"Hospitals need to focus on preventive care instead of sick care."

While the survey was aimed at identifying gaps in services and community needs, it was also important to identify existing assets and strengths in the community. Area hospitals were noted as assets in the community as well as area clinics which provide services for the uninsured and under-insured. Public health agencies and not-for-profit community organizations were also praised for their outreach efforts.

Prevention and education were seen as the two greatest opportunities for achieving optimal health and well-being. Most key informants suggested continued or increased community outreach regarding healthy lifestyle choices, nutrition, exercise, and chronic disease management. Opportunities to partner with community and faith-based organizations were acknowledged.

Several respondents also noted the opportunity for policy change. Specifically, suggestions were made to consider land use and local regulations and make healthy foods more available. A number of mentions were made to focus on the children and youth in the community. Outreach through schools and churches were seen as worthwhile so that behavior change can potentially continue into adulthood.

In conclusion, more than half of the respondents listed the health care system as the greatest community asset. Many specifically listed Baptist Memorial Hospitals and acknowledged their high quality of care and community commitment. The quality of life in the communities was also seen a strength. Respondents indicated a strong sense of community and respect of community leadership. These strengths should be utilized to address the community needs identified. Specific needs that were apparent throughout the feedback include barriers to health care for low-income and minority groups, increased need for health literacy, and a focus on prevention and healthy living.

The Key Informant Survey results were correlated with the household study, secondary data statistics, and focus groups findings to determine key community health needs across all research components.

Focus Groups Key Findings

The focus groups addressed diabetes and pre-diabetes, including questions about health literacy, self-care, health care access, and awareness of services. The summary is broken out by feedback about self-care and disease management, followed by access to care issues, and health education and communication.

> *"I've seen family members suffer from it. My grandmother lost her sight and her legs. I'm pre-diabetic now, and I feel resigned that I will get diabetes."*

Knowledge of diabetes and self-care management

The focus groups began with a discussion about the participants' knowledge of diabetes. The group was asked what having diabetes meant to them. While the feedback varied somewhat, much of the discussion was about how diabetes has limited their life. According to one participant, having diabetes is a "huge hassle." Another said that it means "watching everything." Other participants commented that having diabetes affects your quality of life. "I can't do everything I want anymore," said one participant. Several participants talked about having to make significant changes to their lifestyle because of diabetes. One participant commented, "You need to change your whole lifestyle. If you don't maintain a regime, it just isn't going to work." Another stated that "Diabetes is like an addiction, and you have to take it one day at a time." Participants discussed having to change their eating habits. One said, "You can't enjoy foods you grew up with."

The participants also spoke of physical complications such as foot problems and deteriorating vision. One participant commented, "I have neuropathy in my feet. When you feel that tingling and burning in your feet, that's your nerve endings dying. Once you've lost it, it's gone." A few participants had to have toes, feet, and even legs amputated due to complications from their diabetes. Several participants discussed vision problems and fear of diabetes causing damage to their eyes. One participant shared, "I worry more about my eyes than anything else." Others explained that having diabetes "means you could go blind." Another participant commented, "I have diabetic retinopathy. I am legally blind." Others explained that having diabetes puts them at risk for other health complications such as heart problems/heart failure and kidney problems/kidney failure.

In addition to physical complications, participants explained that diabetes also has psychological effects. One participant commented that "Having diabetes takes a toll on you – mentally and physically." Several participants complained of being tired or sluggish and having difficulty sleeping. Some felt that diabetes and depression seemed to go hand in hand and that dealing with fear, stress, and mood changes complicated their disease management. One participant shared, "The first few weeks after I was diagnosed, I didn't want to do anything. I just sat in my chair and watched TV." Another stated, "I just want to have a normal life again. Sometimes it makes you depressed."

When asked how they believe they got diabetes or became pre-diabetic, many spoke of a genetic link where parents and/or grandparents had diabetes. One participant said, "My mother had diabetes and her mother had diabetes. I figured I would get it someday, too." Another commented, "I have aunts and uncles who lost all their limbs to diabetes." While factors such as

nutrition and obesity were mentioned as risks by some, there was a sentiment of helplessness due to the hereditary link. Several did point to poor eating habits and lack of exercise as factors that increased the risk of getting diabetes. One participant said, "Anybody who lives in this world, if you don't eat right, you can get it." Others commented that being overweight is what led to their diabetes. In addition, participants mentioned a number of other potential causes to their diabetes including stress, fatigue/sleep deprivation, thyroid problems, steroids, other diseases, caffeine, drinking, smoking, vaccines, and exposure to chemicals/environmental pollutants.

When asked what they do on a daily basis to care for their diabetes, participants emphasized the importance of checking their blood sugar/glucose. One participant stated, "The first thing I do when I get up is do a glucose test." Another explained, "You have to get up, take your medications, check your sugar, then I take my shot, then I eat, then wait two hours and check it again. It has to be a routine. If it's not a routine, you'll forget and you won't do it. It's a regiment." Most checked their blood one to three times a day. "I'm supposed to test twice a day, but I only do it once," admitted one participant. Another said they check their glucose every four hours. One participant complained that constantly having to poke her fingers made them sore and sensitive.

Participants also discussed having to take medications. Some were taking pills to control their diabetes while others took insulin shots. Some participants expressed fear and apprehension about the prospect of having to switch from pills to injections to control their diabetes. "I don't want the needle. Thinking of that makes me sick," said one participant. Participants talked about planning and monitoring their diet in order to control their diabetes. One participant stated, "I have to think about it all the time. Do I have time to eat small meals? Will I have access to healthy choices or do I need to bring food with me?" While another said, "I spend a lot of time thinking about what I am going to eat."

Routine exercise is also an important part of diabetes management. Many participants were trying to get regular exercise in a variety of ways including walking/running, biking, swimming, yoga, dancing, and group exercise classes. One participant shared, "Exercise, along with watching my diet helps. I walk at least 10 minutes at a pretty good clip, best I can. I do that two to three times a week. I don't do it every day." One older woman stated that she walks almost every day to manage her diabetes. Another stated, "I started doing yoga three years ago. I go three days a week. I lost weight and feel more connected with my body." Some members of the group admitted that they did not get enough exercise, if any. Some had difficulty finding the time or motivation while others had physical complications that made it difficult for them to exercise.

When asked what barriers people face when trying to take care of their diabetes, participants suggested a number of challenges. Specifically, they mentioned the following common challenges to eating healthy and exercising regularly:

- Cost
- Motivation/Effort
- Time/Convenience

- Education/Knowledge

Several participants indicated that cost is a barrier. They explained that healthy foods like fresh fruits and vegetables can be expensive, and unhealthy food is often cheaper. Participants mentioned that there are some local Farmer's Markets that increase access to fresh produce, but not everyone can afford to buy it. One woman stated, "A lot of people don't know how to cook healthy foods that are affordable." A participant shared that his family relies on food stamps and food pantries for food and that their options are often limited. Another participant commented, "It's cheaper and easier to go to the dollar menu at McDonald's than to buy food and cook it."

Participants also discussed time as a major barrier to proper diabetes management. One participant commented, "I'm supposed to eat six small meals a day, but I can't do that. I work full-time. Who has the time?" Several participants explained that travel can be difficult because it changes their regular routine and can sometimes limit the control they have over their food choices. One participant says when she travels she has to remember to take measuring cups, a food scale, food, and medications. There were also discussions about having difficulty breaking old unhealthy habits. One participant said, "You gotta wanna quit, before you can quit. I drank a fifth of whiskey Friday, Saturday, and Sunday night. I stopped all that after I was diagnosed, but changing my diet was the hardest."

Attendees discussed how attitudes and behaviors related to food are often established at a young age. They grew up eating certain foods, and now they need to change their eating habits. Several participants explained that they were raised to eat everything on their plate and not waste food. Learning proper portion control has been challenging for some participants. Many participants mentioned that family and friends can be barriers to maintaining healthy habits. They explained that it is hard when you are the only one in the family that has diabetes. Most have family that do not understand or support their diet.

When asked what kinds of things were helpful to participants when they tried to be physically fit and eat healthier, the participants mentioned the following supports:

- Making health a priority
- Creating a plan and establishing goals
- Cooking simply
- Cutting out soda and junk food
- Trying to be a role model for children/family
- Making a commitment to having family dinner
- Having a buddy/mentor to help with motivation
- Group/team-based physical activity like walking clubs
- Finding a type of exercise you enjoy doing – make it fun

Access to Health Care

When asked how often they need to see a doctor for their pre-diabetes/diabetes care, most stated that they see the doctor every three months or as needed depending on their recent A1C tests. Some go every month. One participant explained, "My last test was high, and they read me the riot act. I have to go back every month now and I'm working on keeping my levels down." A few only go twice a year. Usually they need to see the doctor to check their A1C and get a new prescription for their medication. Some indicated that their appointments only last 10 minutes

while others last 30-40 minutes. Some participants felt that every three months was often enough, while a few said they would go more frequently if it was more affordable.
Some indicated that doctors did foot checks as a routine part of the check-up, but many others did not get foot checks from their doctor. The majority of participants said diet and exercise were rarely mentioned at the ongoing appointments. In most cases, participants received literature at diagnosis and there was little follow up regarding behavior. Some were referred to classes and support programs, but many others weren't. There was clearly a lot of variation in their experiences with their doctors. When asked where they usually seek health care, the majority of participants indicated a primary care/family doctor or practice for their diabetes care. In addition, many see an endocrinologist and an eye doctor for diabetes care.

Participants were asked about barriers to accessing health care services in the community. Several participants indicated that they or someone they know have had difficulty obtaining health care services. The groups discussed how the economic downturn has further complicated access to health care. A few participants were newly unemployed and struggling to manage their disease after losing health care coverage. Participants indicated that lack of insurance coverage and inability to pay were major barriers to accessing health care services in the community.

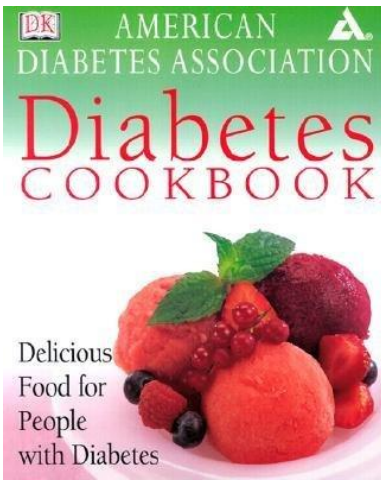
When asked where uninsured and underinsured individuals go for health care, participants indicated that uninsured residents often utilize the Emergency Department for primary health care because the Emergency Department will not turn them away if they do not have insurance. Others forgo care. Co-pays, deductibles, and prescription costs also present challenges in accessing health care. One participant commented, "I don't have any money to pay the co-pay." Some participants shared information about prescription discount cards and prescription assistance programs through pharmaceutical companies, but most were unaware of these resources. Several participants mentioned that testing strips are expensive and that supplies are not always covered by insurance. Several participants expressed frustration that their insurance does not adequately cover specialty services related to their diabetes such as podiatrists, endocrinologists, optometrists, nutritionists, dieticians, and exercise physiologists. Even some participants with comprehensive insurance had difficulty accessing specialists because there were usually four to six month waiting lists for endocrinologists.

When asked whether there are services or resources needed to support diabetes management, participants had a number of suggestions.

- Financial Assistance
- Food Assistance
- Transportation Assistance
- Patient Navigation Services
- Information & Referral Resources
- Prescription Assistance Programs
- Discounted Medical Supplies
- Oral Health Services
- Nutrition Counseling & Nutrition Programs
- Health Coaches
- Optometrists
- Endocrinologists
- Podiatry Services/Foot Care
- Physician Education/Training on Diabetes
- Exercise Physiologists
- Exercise Programs including walking programs and aquatic programs
- Chronic Disease Management Programs/Workshops
- Support Groups

Health Education and Communication

The groups discussed where they received health information, what education options were currently available, and what they would like to see to assist them in managing their diabetes. When asked where participants generally get health information, most said they had received written literature (brochures/pamphlets) from their health provider when they were first diagnosed. While most considered their physician as a source of information, some physicians were viewed as more knowledgeable than others. Several participants commented that they received a lot of valuable information from their insurance provider. In addition, participants indicated that they get information from newspapers, magazines, hospital newsletters, insurance mailers, flyers, brochures, church bulletins, and church leaders. The school systems, libraries, the health department, and community agencies were also mentioned as resources for information. In some cases, they learn about programs and services through word of mouth from friends, family, and neighbors. Several participants indicated that they also get health information online and through television programs like Dr. Oz. Participants also suggested that they are becoming increasingly reliant on the internet for information and suggested that easily accessible websites and social media were great tools to share information.



Participants indicated that they would appreciate a short informational video/DVD explaining diabetes and diabetes management in addition to written information. Several participants suggested that a monthly newsletter with healthy recipes and health tips about diabetes management would be a great way to connect to diabetes patients and encourage them to maintain healthy habits. Some would prefer this in an e-newsletter format while others still like to receive hard copies in the mail. In addition, participants also felt it would be helpful to speak to a nurse practitioner, physician's assistant, health educator, or nutritionist after being diagnosed. Some participants did receive diabetes nutritional education at the onset of diabetes, but then never had another opportunity to ask additional questions.

Participants who had attended diabetes management workshops felt they received the most valuable information through those programs. The majority of participants felt that group workshops were effective ways to disseminate information and many wished they had been referred to available programs. Several participants were interested in support groups. They felt there was a lot to learn from each other and were encouraged to see that they were not alone in their struggles.

Overall, focus group participants had common experiences and concerns across the geographic areas. Individuals living closer to larger population centers were more likely to have access to supportive services, programs, and resources to assist them in their diabetes management. Participants emphasized the need to improve communication and awareness about existing services.

Based on the feedback from the focus group participants, several themes appeared as areas of opportunity.

- Lack of awareness/knowledge about Diabetes, Diabetes prevention and Diabetes management
- Lack of access to affordable health care for people with diabetes including specialty services (podiatry, optometry, endocrinology, dental health)
- Need for assistance with prescription, medical supplies, and healthy food

- Lack of community awareness of available programs and resources
- Need for collaborative provider network with efficient referral system
- Need for health education programs including nutrition, exercise, diabetes management
- Need for supportive services such as support groups and health coaches

The Focus Group results were correlated with the household study, secondary data statistics, and key informant interview findings to determine key community health needs across all research components.

CONCLUSIONS

Conclusions should be made individually for each hospital as it is important to recognize the unique attributes of each community. However, it is also valuable to acknowledge where clear patterns emerge throughout the Baptist Memorial Health Care service area. The table below is intended to summarize the main conclusions from each hospital and to visualize overlap with sister hospitals. This list is not intended to be fully exhaustive, but rather a summary of the most prominent themes.

Hospital	Access to Care	Cardiovascular Health	Diabetes	Maternal health	Cancer	Obesity	Smoking	Respiratory Disease	Suicide	Alcohol Consumption
BMH-Booneville	X	X	X	X	X	X	X	X		
BMH-Collierville	X	X	X	X	X	X		X	X	X
BMH-DeSoto	X	X	X	X	X	X	X		X	X
BMH-Germantown	X	X	X	X	X	X		X	X	X
BMH-Golden Triangle	X	X	X	X	X	X	X			X
BMH-Huntingdon	X	X	X	X	X	X	X	X		
BMH-Memphis	X	X	X	X	X	X		X	X	X
BMH-North Mississippi	X	X	X	X	X	X				
BM Restorative Care	X	X	X	X	X	X		X	X	X
BMH-Tipton	X	X	X	X	X	X	X		X	X
BMH-Union City	X	X	X	X	X	X	X	X	X	
BMH-Union County	X	X	X	X	X	X	X	X		
BMH for Women	X	X	X	X	X	X		X		X
NEA Baptist	X	X	X	X	X	X	X	X		X

PRIORITIZATION OF COMMUNITY HEALTH NEEDS

On February 25, 2013, 14 individuals from Baptist Memorial Health Care gathered to review the results of the CHNA. The goal of the meeting was to discuss and prioritize key findings from the CHNA. Baptist Memorial Health Care aimed to create system-wide priorities and set the stage for the development of each system hospital's Implementation Strategy.

The objectives of the half-day strategic planning session were to:

- Provide an overview of recently compiled community health data and highlight key research findings
- Initiate discussions around key health issues and prioritize needs based on select criteria
- Brainstorm goals and objectives to guide Baptist Memorial Health Care Hospitals' Implementation Plans
- Examine Baptist Memorial Health Care's role in addressing community health priorities

Prioritization Process

The meeting began with a research overview presented by Holleran Consulting. The presentation covered the purpose of the study, the research methodologies, and the key findings. Following the research overview, Holleran staff facilitated large group discussion to identify a "Master List of Needs" based the CHNA research and participant's knowledge of community issues. The following list was developed:

- Obesity & Related Chronic Conditions
- Access to Care
- Cardiovascular Health
- Diabetes
- Maternal and Women's Health
- Cancer
- Smoking
- Respiratory Disease
- Suicide
- Caregiver Needs
- Palliative Care
- Senior Health
- Services for Disabled Individuals
- Mental Health
- Substance/Alcohol Abuse
- Alzheimer's Disease
- Stress
- Health Literacy
- Nutrition
- Physical Activity
- Domestic Violence/Child Abuse
- Prenatal Care

The group discussed the inter-relationship of needs and special populations within the community. Social determinants of health, including education, poverty, access to care, and social norms were considered to better understand the issues. Participants worked to consolidate the master list by identifying overlapping issues, root causes of health, and the types of strategies which would be employed to address the needs. The Master List was consolidated to reflect the following cross-cutting issues as follows:

- Obesity & Related Chronic Conditions
- Access to Care & Preventive Health Education (Health Literacy, Nutrition, Physical Activity, Smoking)
- Diabetes
- Cardiovascular Disease
- Cancer (Lung Cancer)
- Maternal and Women's Health (Prenatal Care)

- Caregiver Needs (Palliative Care, Seniors, Disabled)
- Mental Health (Substance/Alcohol Abuse, Alzheimer's Disease, Stress)

Determination of Priority Areas

To determine community health priorities, participants were provided with information regarding the prioritization process, criteria to consider when evaluating key areas of focus, and other aspects of health improvement planning, such as goal setting and developing strategies and measures.

Holleran staff facilitated an open group discussion among attendees. The following criteria were used to identify the most pressing needs in the community:

- Scope of Issue (How many people are impacted?)
- Severity of Issue (What will happen if the issue is not addressed?)
- Ability to Impact the Issue (Are health and human services providers able to impact the need?)

Using these criteria and an understanding of the relationships between the needs and cross-cutting strategies, the participants agreed upon the following "Prioritized List of Needs:"

Prioritized List of Community Needs:

- Healthy Lifestyle Choices (Prevention & Education, Chronic Disease Prevention)
- Cancer
- Maternal and Women's Health (with a focus on Prenatal Care)
- Mental Health (with a focus on Caregivers, Alzheimer's Disease)

The group saw Access to Care as an overarching issue in delivering health care, managing chronic conditions, and providing preventative care and education. As such, it was agreed that strategies to address each of the prioritized needs would include elements to break down barriers to accessing care for residents.

IMPLEMENTATION STRATEGY

In support of the 2012-13 Community Health Needs Assessment, and ongoing community benefit initiatives, Baptist Memorial Hospitals developed an Implementation Strategy to guide community health improvement efforts and measure impact. The goals and objectives for each priority area are listed below. The full implementation strategy was developed and will be available on the website.

Healthy Lifestyle Choices

Recognizing the connection between Diabetes, Cardiovascular Disease, and other chronic conditions to healthy lifestyle choices, Baptist Memorial Health Care will seek to reduce these chronic conditions by focusing education and awareness on promoting healthy eating and physical activity. A reduction in chronic disease rates will likely not be seen in the initial three-year cycle, however, Baptist Memorial Health Care expects that success in increasing awareness of the relationship between healthy lifestyle choices and disease will impact the number of residents at risk for or diagnosed with Diabetes, Cardiovascular Disease, and other chronic conditions in the future.

GOAL: Reduce risk factors for chronic disease and improve management of chronic disease through healthy lifestyle choices.

OBJECTIVES:

- Provide education about healthy lifestyle choices.
- Increase residents' awareness of relationship between healthy lifestyle and chronic disease.
- Reduce prevalence of overweight and obesity for those at risk or diagnosed with chronic conditions.
- Decrease readmissions for chronic disease management.

Cancer

With the support of the Baptist Cancer Center, Baptist Memorial Health Care will seek to educate residents about the risk factors for Cancer and early detection, with the goal of improving Cancer mortality rates and quality of life for patients with Cancer.

GOAL: Provide early detection and treatment to reduce Cancer mortality rates and improve quality of life for patients living with Cancer.

OBJECTIVES:

- Invest in newest technologies for detection and care of Cancer.
- Increase community awareness of signs of Cancer and early detection.
- Improve availability of Cancer screenings and services.
- Provide free or reduced cost screenings and services.

Maternal & Women's Health

Improving outcomes for babies starts by ensuring pregnant mothers have access to early prenatal care and begin to make healthy lifestyle choices during pregnancy and continue healthy behaviors after giving birth.

GOAL: Promote prenatal wellness to improve outcomes for mother and child.

OBJECTIVES:

- Reduce low birth weight/premature birth
- Reduce infant mortality rates
- Improve healthy lifestyle choices for pregnant mothers

Mental Health

Recognizing the relationship between mental health and optimal physical health for patients and their caregivers, Baptist Memorial Health Care will aim to help residents identify the signs of dementia and/or Alzheimer's disease and provide support for caregivers.

GOAL: Increase early detection of dementia and provide support services for residents with dementia and/or Alzheimer's and their caregivers.

OBJECTIVES:

- Help residents identify early signs of dementia/Alzheimer's Disease.
- Promote support services for residents with dementia and/or Alzheimer's and their caregivers.

DOCUMENTATION

Each Baptist Hospital's CHNA Summary Report was posted on the hospital's website in September 2013 to ensure it was widely available to the community. In addition, this system-wide report was made public on the Baptist Memorial Health Care website. Each hospital's Board of Directors will review and adopt an Implementation Strategy and they will be available on the website.