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MEMORIAL HOSPITAL

NORTH MISSISSIPPI

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 hospital's website in September 2013. An Implementation Strategy of how the hospital will address the identified priorities was developed and will be available on the website.

COMMUNITY HEALTH NEEDS ASSESSMENT OVERVIEW

Hospital Overview

Baptist Memorial Hospital-North Mississippi in Oxford is a 217-bed acute care facility serving the northern third of Mississippi. One of the fastest growing hospitals in the region, Baptist Memorial Hospital-North Mississippi has more than 90 medical and surgical specialists representing more than 30 specialty areas such as cardiology, radiation oncology and neurosurgery.

Since joining the Baptist Memorial Health Care System in 1989, Baptist has invested more than $150 million into the hospital, and the facility has experienced continuous renovation and construction, including a new bed tower, medical office building and multi-level parking garage. In addition to the facility expansion, the medical staff has more than tripled since 1989.

Baptist's Heart Care Center offers a number of heart care services, from noninvasive diagnostic testing to heart catheterization, cardiovascular surgery and rehabilitation.

Comprehensive cancer care is close to home at Baptist. Medical and radiation oncologists use leading technology to deliver high-quality cancer treatments typically seen in a metropolitan area. Baptist Centers for Cancer Care in Oxford recently received accreditation from the American College of Surgeons' Commission on Cancer. This prestigious commendation establishes a set of nationally recognized criteria that only the most comprehensive centers can attain. Baptist Memorial Hospital-North Mississippi is one of the only two accredited cancer centers in the northern half of Mississippi.

Baptist Rehabilitative Services provides a full spectrum of therapy care. Physical, occupational and speech therapists are available to provide treatments in inpatient as well as outpatient settings. The Acute Rehabilitation Unit is a 13-bed wing designed to meet the specific needs of the rehab patient. The Baptist Outpatient Rehabilitation clinic is located on North Lamar. Patients include those recently released from the hospital who are recovering from an injury, surgery, or illness. Therapists at Baptist specialize in sports medicine, athletic training, speech therapy, swallowing difficulties using VitalStim, and lymphedema, to name a few.

Baptist Memorial Hospital-North Mississippi Sleep Disorders Center is the first sleep disorders center in North Mississippi to earn accreditation from The American Academy of Sleep Medicine. The center has four hotel-style observation suites and specializes in the treatment of disorders such as sleep apnea, insomnia, sleep walking, sleep talking, night terrors and involuntary limb movement.

The Women's Pavilion at Baptist Memorial Hospital-North Mississippi recognizes the different stages of a woman's life and is dedicated to meeting the needs of all women. Our experienced OB/GYNs, nursing staff and patient educators work together to provide excellent patient care.

Baptist Home Care & Hospice provides a variety of health care services to a wide range of patients. Home care services are designed especially for the patient who is recovering from an injury, illness or medical procedure and requires follow-up care on an intermittent basis. Hospice is a special program designed to support patients and their families in the final stages of a terminal illness.

In 2005, the Baptist Weight Loss Center was designated a Bariatric Surgery Center of Excellence by the American Society of Metabolic and Bariatric Surgeons. More than 1,000 patients have changed the course of their lives through weight loss surgery at Baptist Memorial Hospital-North Mississippi.

September 2001 saw the opening of the Oxford Surgery Center, an outpatient facility with four operating suites and two procedure rooms. The center, located on Azalea Drive, is a joint partnership between Baptist Memorial Hospital-North Mississippi and physician investors.

Nestled in the rolling hills of North Mississippi, Oxford has much to offer, including arts, literature, educational opportunities, sporting events and, of course, health care. With its vast opportunities and exceptional quality of life, Oxford is continually voted one of the most livable communities in the United States.

Definition of Service Area

Baptist Memorial Hospital-North Mississippi serves residents in North Mississippi. For the purposes of the CHNA, the hospital focused on its primary service area of Lafayette and Panola Counties, Mississippi. The following zip codes were included in the household study:

38601	38655
38606	38658
38619	38666
38620	38673
38621	38949

CHNA Background

Baptist Memorial Hospital-North Mississippi, part of the Baptist Memorial Health Care system, participated in 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 hospital's commitment to community health and population health management. The findings from the assessment will be utilized by Baptist Memorial Hospital-North Mississippi 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 Hospital-North Mississippi service area.

The findings from the CHNA were reviewed and health needs were prioritized to develop the hospital's Community Health Implementation Strategy. Baptist Memorial Hospital-North Mississippi 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 healthcare 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 517 adults from the Baptist Memorial Hospital-North Mississippi service area. 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, healthcare consumers from the hospitals' service areas participated in **focus groups**. The focus groups addressed diabetes and pre-diabetes based on findings from the 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.

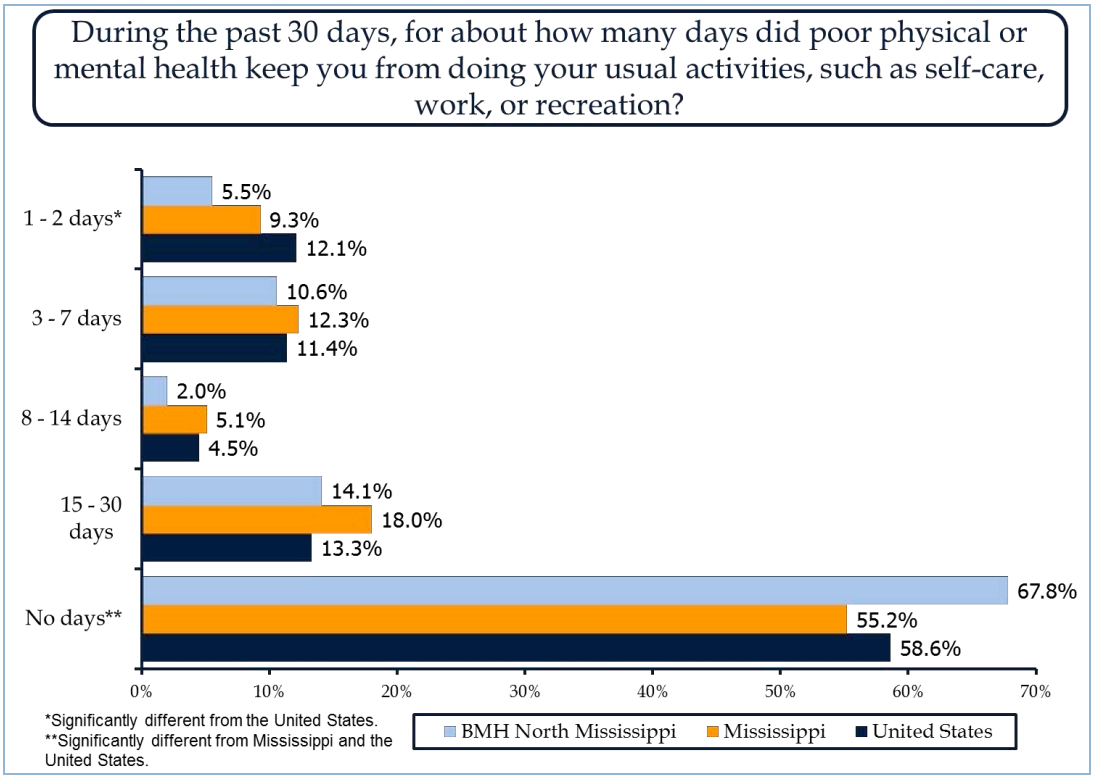
Documentation

A report of the CHNA was made public on the hospital's 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.

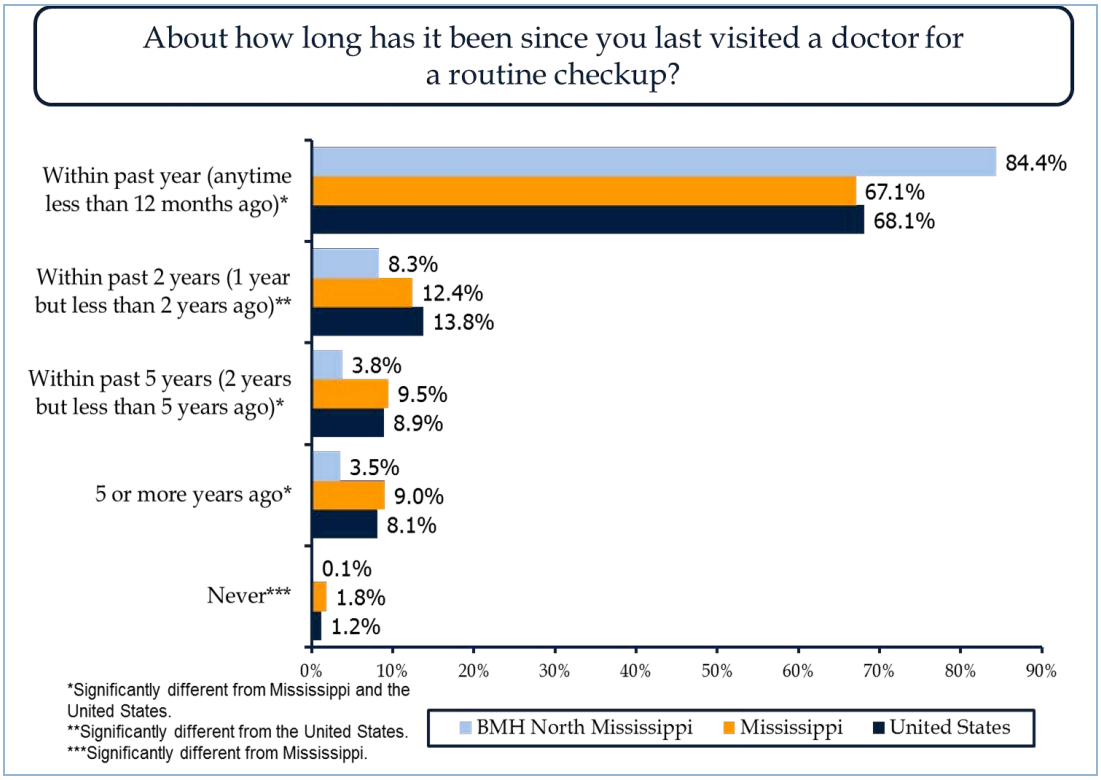
KEY ASSESSMENT FINDINGS

Household Survey Key Findings

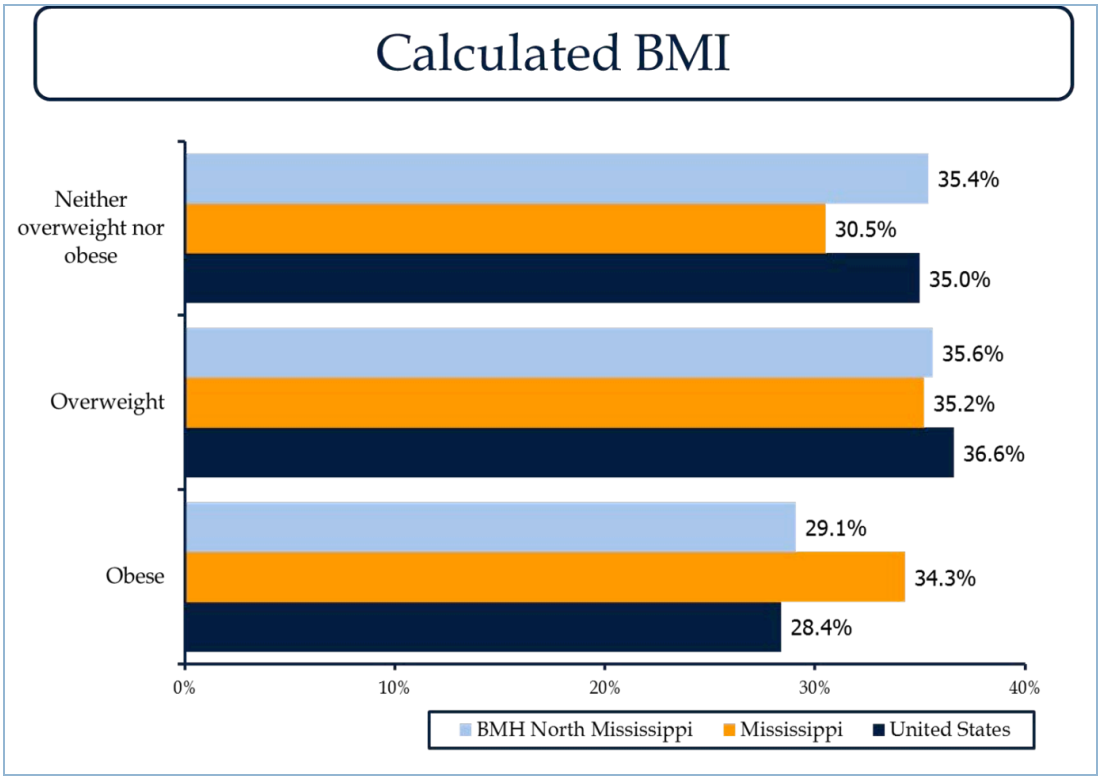
A household survey of the Baptist Memorial Hospital-North Mississippi service area included 517 randomly selected adults. The respondents were asked to rate their own health status, to provide information on behaviors and prevention activities, and to report the incidence of a variety of chronic illnesses such as diabetes and cardiovascular disease. When asked to rate their **general health**, 77.6% responded "good," "very good" or "excellent." This is similar to what is seen throughout Mississippi (76.3%), but below the rates that are typically seen throughout the U.S. (83.6%). Area residents were also asked about days of poor physical and mental health. While local residents were more likely to report at least one day of poor physical or mental health when compared against Mississippi and the U.S., most reported just "1 or 2 days" of poor health. On a positive note, fewer adults locally reported limitations because of poor physical or mental health. As shown in the graph below, nearly 68% of those surveyed stated that they have not had any days where they have been limited because of poor physical or mental health. This compares to 55.2% statewide and 58.6% nationally.



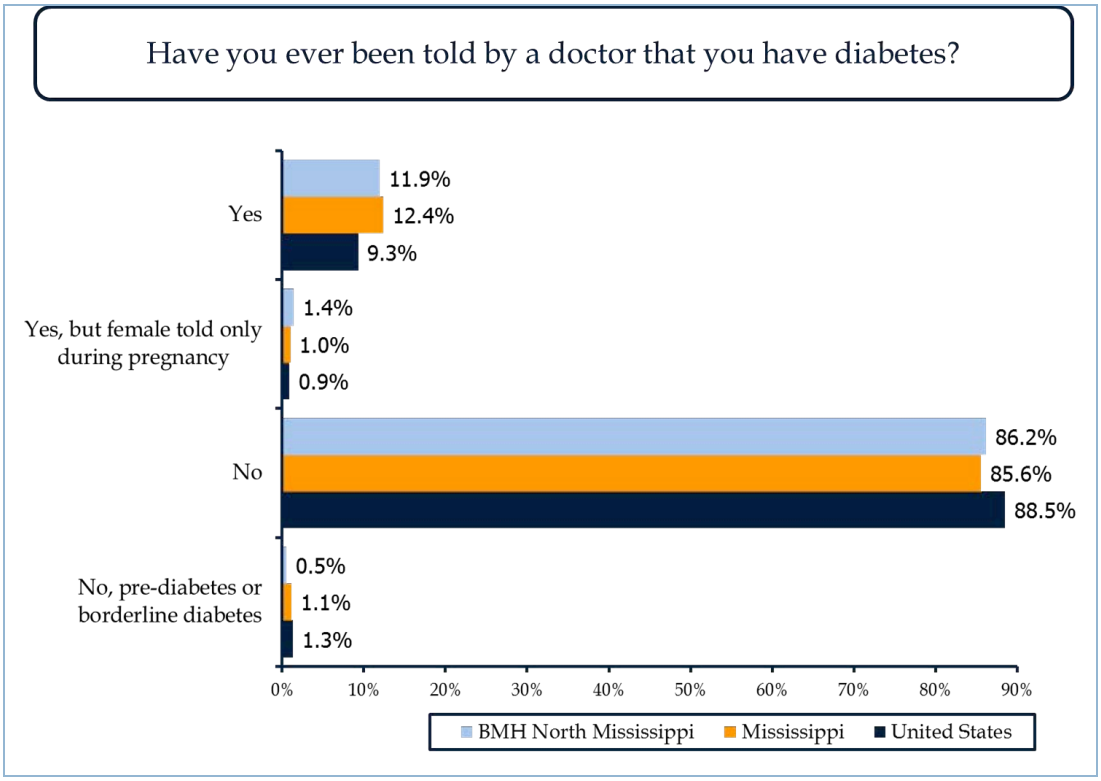
Access to care issues were assessed by asking several survey questions about health insurance coverage, cost as a barrier to seeking care, and whether or not there is a regular source of health care. Roughly eighty-two percent (82.3%) of those surveyed reported that they have some form of health insurance. This compares to 78.4% statewide and 84.9% nationally. Locally, males were more likely to report having health insurance than females (88.2% vs. 77.1%). White residents were also more likely to have coverage than African American residents (86.2% vs. 75.1%). When asked if they have someone they think of as their regular doctor or healthcare provider, 86.8% said "yes." This is better than Mississippi (79.7%) and the U.S. (81.8%). Around 16% of area adults reported that at some point in the past year, cost kept them from seeing a doctor, similar to the U.S. (14.6%), but better than Mississippi (20.9%). On a positive note, the vast majority (84.4%) have had a regular checkup in the past year compared to Mississippi (67.1%) and the U.S. (68.1%).


About how long has it been since you last visited a doctor for a routine checkup?
Within past year (anytime less than 12 months ago)*
84.4%
67.1%
68.1%
Within past 2 years (1 year but less than 2 years ago)**
8.3%
12.4%
13.8%
Within past 5 years (2 years but less than 5 years ago)*
3.8%
9.5%
8.9%
5 or more years ago*
3.5%
9.0%
8.1%
Never***
0.1%
1.8%
1.2%
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
*Significantly different from Mississippi and the United States.
**Significantly different from the United States.
***Significantly different from Mississippi.
BMH North Mississippi
Mississippi
United States

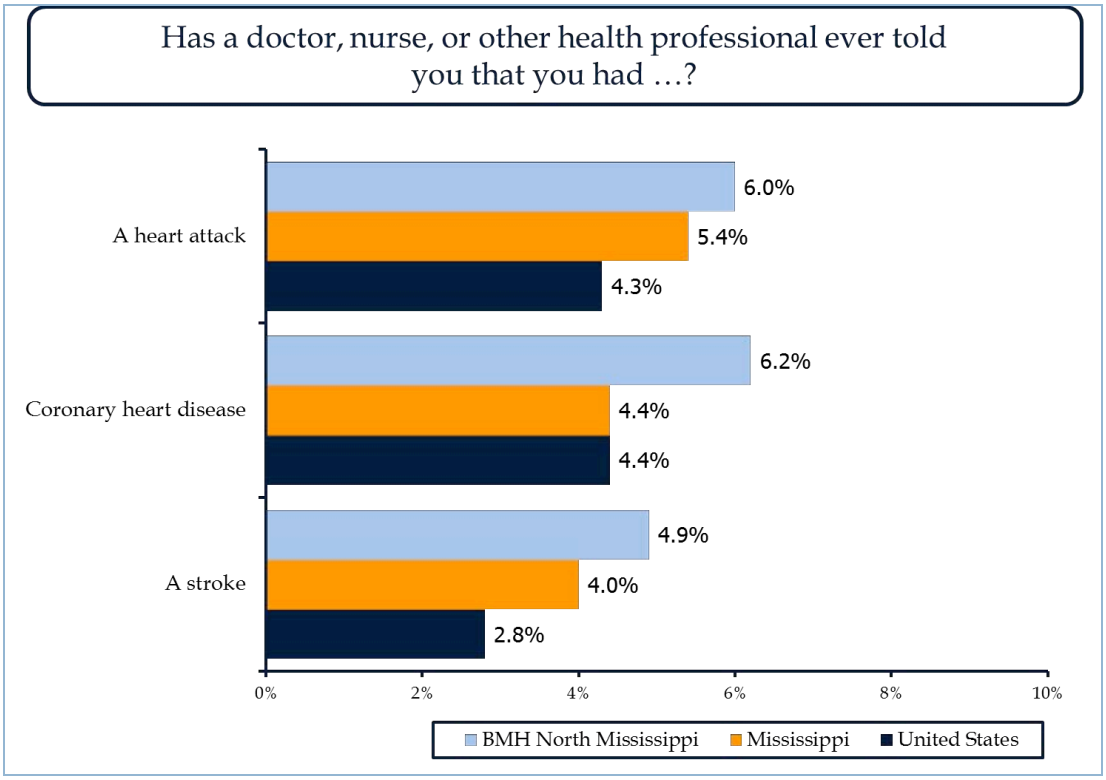
Weight and nutrition was assessed as well. **Body Mass Index (BMI)** was calculated for each survey respondent based on their reported height and weight. As shown in the graph below, approximately 29.1% of area adults are obese. An additional 35.6% are overweight. Area residents are similar to the U.S. in their likelihood of being overweight or obese and fare better than residents throughout Mississippi. When asked if they exercised in the previous month, 75.1% indicated they had. This is better than Mississippi (67%), but similar to the U.S. (75.6%). While the majority of area residents are overweight or obese (64.7%), only 26.6% indicated that their doctor or healthcare provided told them that they were overweight. The survey revealed a few racial differences with regard to exercise and weight management. The percentage of White respondents who reported exercising is 82.9% compared to 61.9% among African Americans. Additionally, African American respondents were more likely to report that a doctor or nurse told them they were overweight or obese compared to White respondents (43% vs. 16.8%).



Closely linked to being overweight or obese is the incidence of **diabetes**. Roughly 12% of survey respondents reported being told by a doctor that they have diabetes. This is similar to Mississippi (12.4%) and not statistically different than the rest of the country (9.3%). The diabetes figure for African American survey respondents was 15.2% compared to 8.6% among Whites. When asked about a family history, more than half (56.5%) indicated that they have a family member with diabetes. The survey asked a number of additional questions for those with diabetes. These questions included further probing about testing for blood sugar, A1C levels, checking for sores on their feet, and visits to the doctor. Statistics reported for diabetics in the services were similar to the benchmarks, with two exceptions: the number of diabetics who reported eye difficulties or retinopathy exceeded state and national rates; and fewer diabetics in the service area reported that they had taken a course or class on how to manage their diabetes. About 32% reported they had taken a class or course compared to 44.2% statewide and 54.8% nationally. More adults in the area have had their blood checked for high blood sugar levels when compared to Mississippi and the U.S.



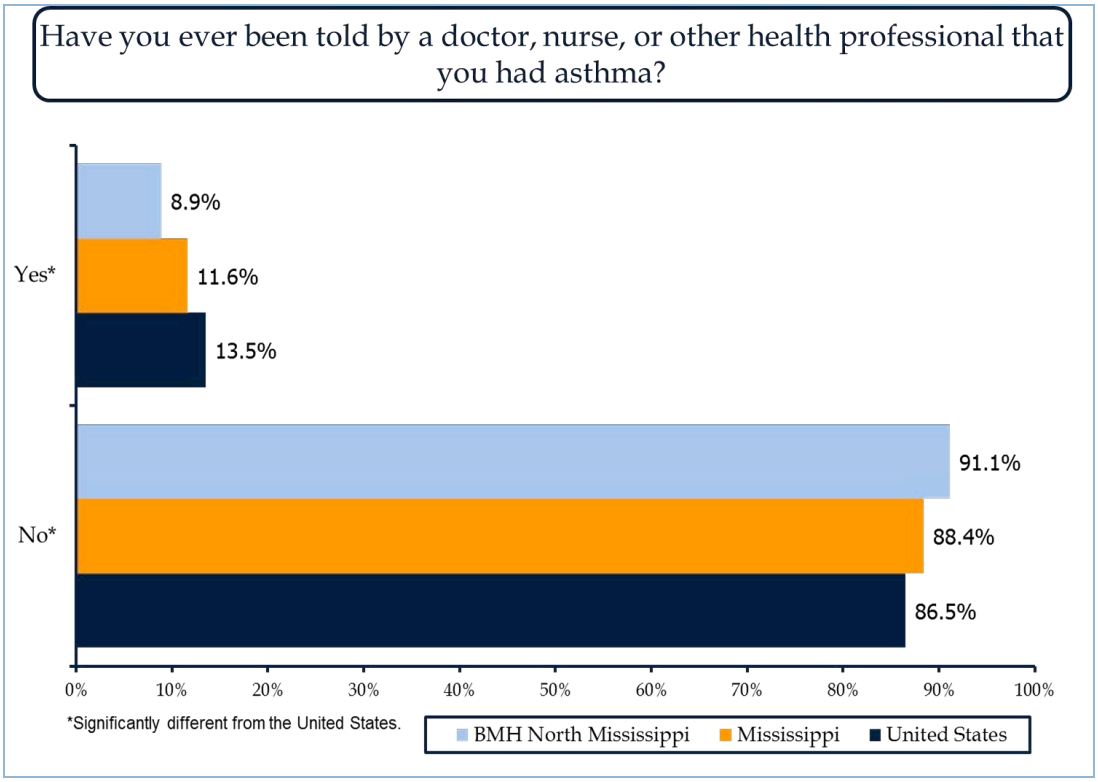
Cardiovascular disease was assessed through questions about heart attacks, heart disease, and stroke. As detailed in the graph below, the cardiovascular health statistics for North Mississippi's service area look similar to statewide and national rates. Six percent (6%) have had a heart attack, 6.2% have angina or coronary heart disease, and 4.9% have had a stroke. Around 55% of area adults locally indicated that they also have a family history of heart disease. Locally, males are more likely to have had a heart attack than females (9.3% vs. 3.1%). No other gender differences were revealed. With regard to racial differences, a significant difference was noted with the likelihood of having had a stroke. Around 3% of Whites locally have had a stroke compared to 7.6% of African Americans.



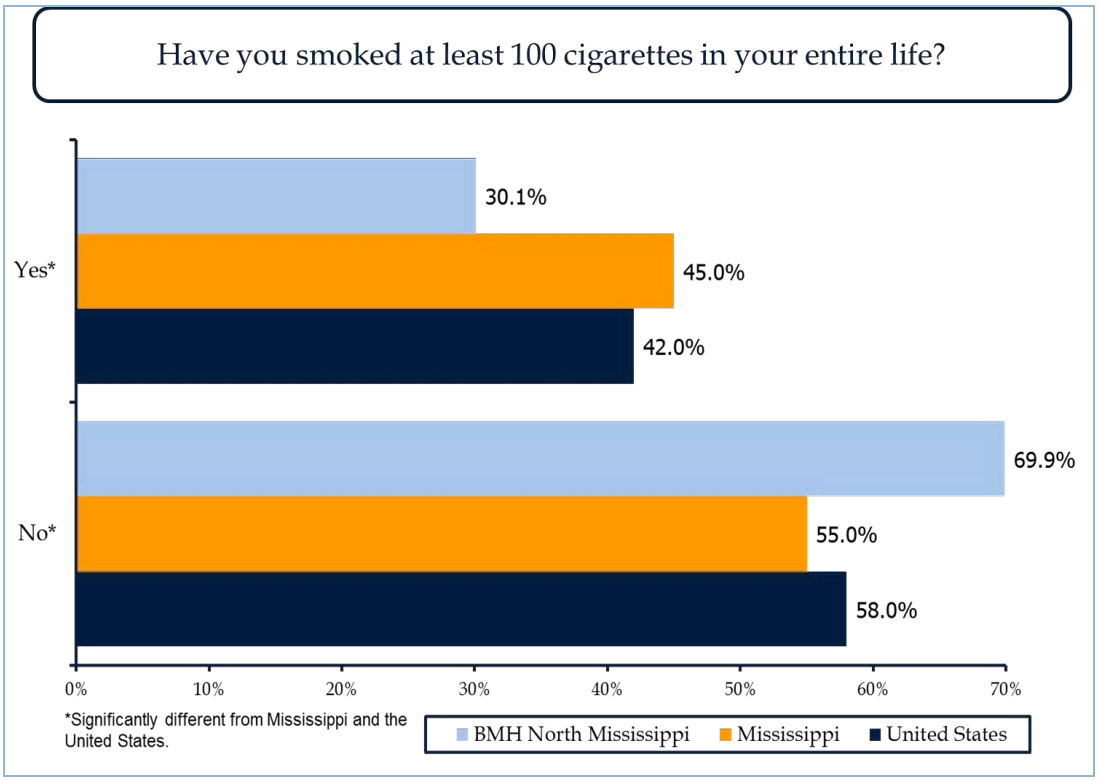
The survey assessed **oral health** as well. Around 48% of those surveyed stated that they have had at least one tooth pulled because of gum disease or tooth decay. This is better than Mississippi (56.1%), but above the U.S. percentage (45.5%).

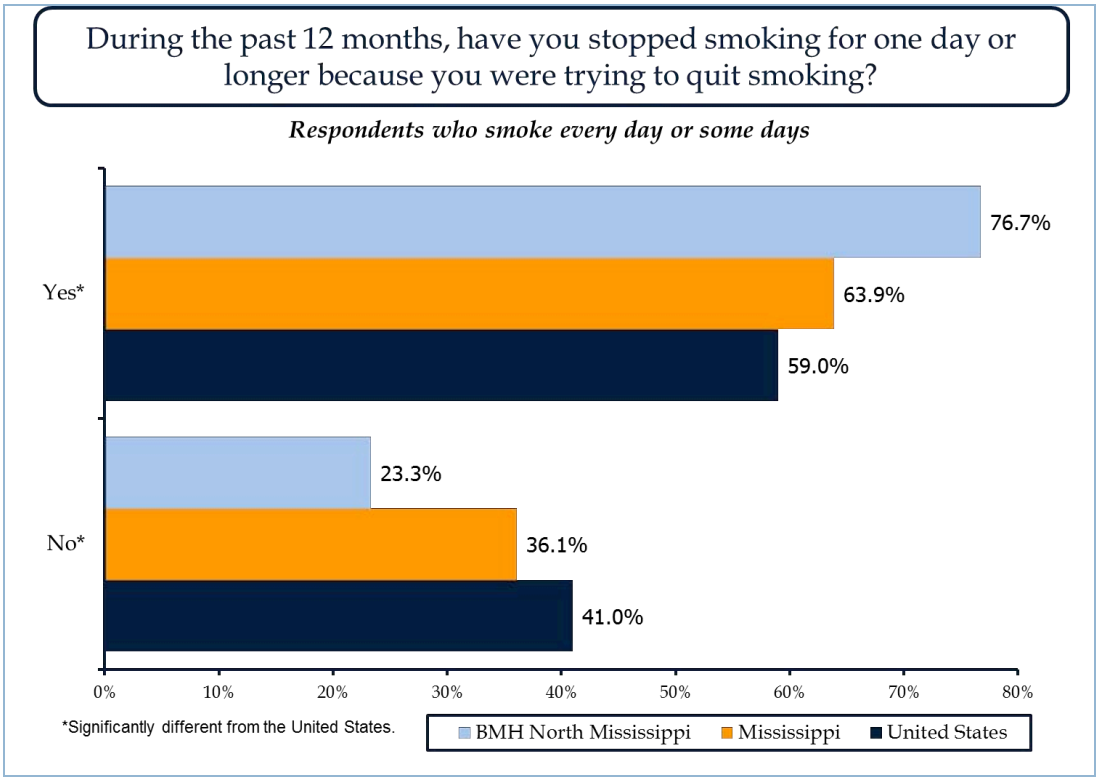
Roughly 25% of survey respondents reported being limited in some way because of physical, mental, or emotional problems. This is similar to the statewide percentage (25.3%), but above the U.S. percentage (20.8%). Additionally, 10.5% reported that they have a health problem that requires the use of some form of special equipment (e.g. cane, wheelchair, etc.). African American survey respondents reported a significantly higher rate of disability than White survey respondents (32.5% vs. 20.1%).

Asthma rates are lower among adults locally. Nearly 9% reported having asthma in their lifetime and within that group, 58% still have asthma. These figures are lower than statewide and national percentages.

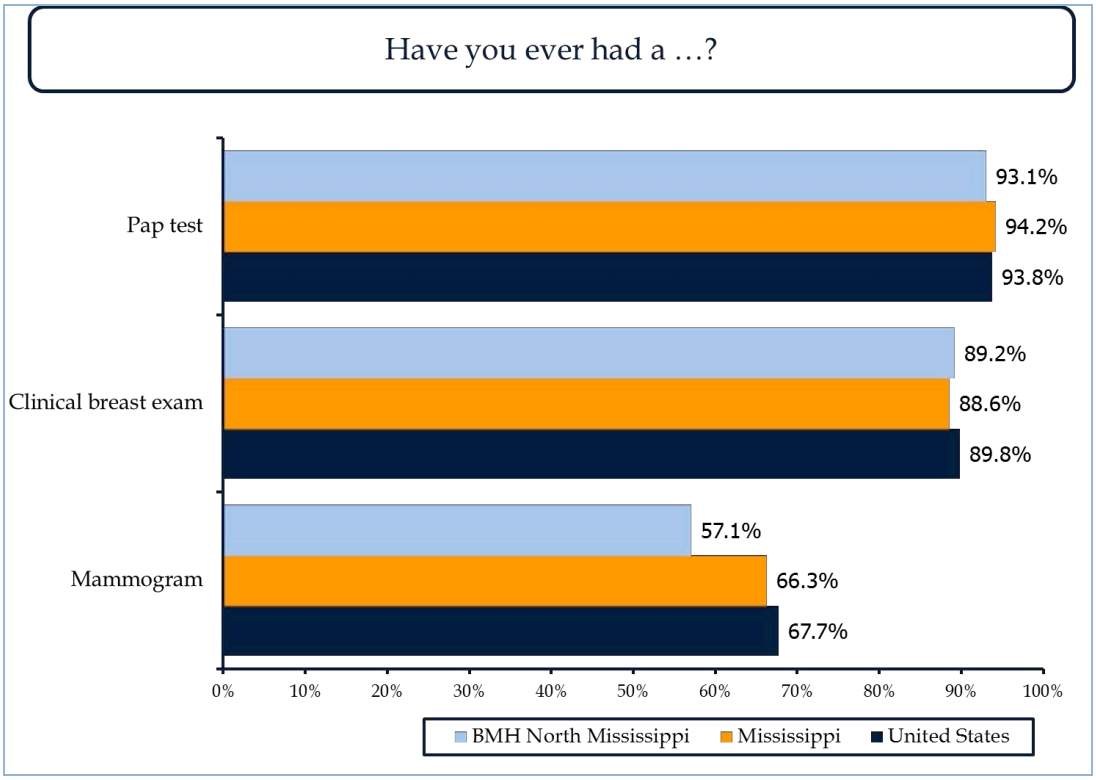


Tobacco use was assessed through questions regarding cigarette smoking and chewing tobacco. Approximately three out of 10 respondents stated that they have smoked at least 100 cigarettes in their lifetime. This is significantly below the percentage for Mississippi (45%) and the U.S. (42%). Among those who have smoked 100 cigarettes, less than half (47.9%) now smoke some days or every day. Among those who do currently smoke, the majority (76.7%) indicated that they had stopped smoking for at least one day in the past year. This is well above statewide and national attempts to quit smoking. Area adults are also less likely than statewide or nationally to use chewing tobacco or snuff. Locally, 2.5% reported using chewing tobacco compared to 7.4% throughout Mississippi and 3.2% across the U.S. Area males were more likely to have smoked at least 100 cigarettes than area females (38% vs. 23.1%).

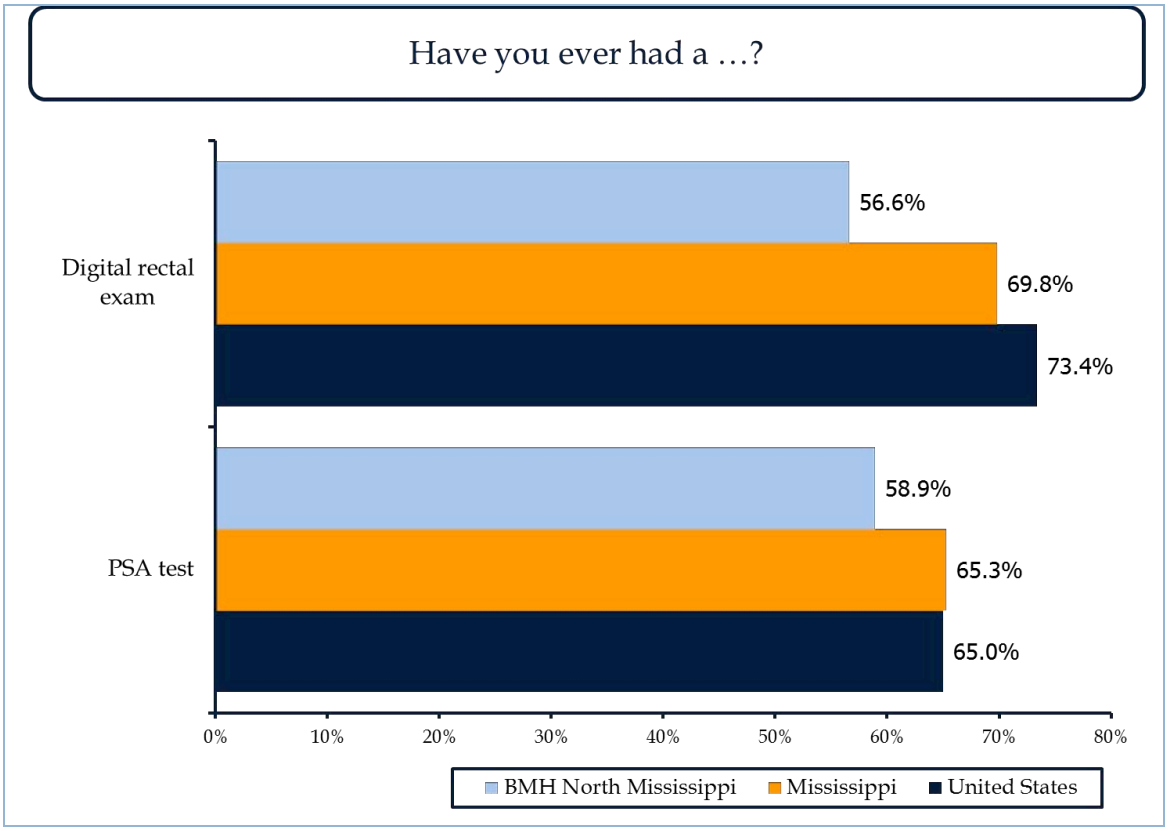

Have you smoked at least 100 cigarettes in your entire life?
Yes*
30.1%
45.0%
42.0%
No*
69.9%
55.0%
58.0%
0%
10%
20%
30%
40%
50%
60%
70%
*Significantly different from Mississippi and the United States.
BMH North Mississippi
Mississippi
United States


During the past 12 months, have you stopped smoking for one day or longer because you were trying to quit smoking?
Respondents who smoke every day or some days
Yes*
76.7%
63.9%
59.0%
No*
23.3%
36.1%
41.0%
0%
10%
20%
30%
40%
50%
60%
70%
80%
*Significantly different from the United States.
BMH North Mississippi
Mississippi
United States

Female respondents were asked a variety of **women's health** questions. Approximately 57% of local females reported that they have had a mammogram at some point in their lifetime. This is well below the percentage throughout Mississippi (66.3%) and the U.S. (67.7%). Rates for clinical breast exams are similar to what is seen statewide and nationally as are the rates for Pap tests. African American females were more likely than White females to have had a mammogram (64.6% vs. 48.6%). The pattern is reversed, however, with respect to clinical breast exams and Pap tests. The percentage of African American females who have had a clinical breast exam is 77.3% compared to 97.6% among White females. For Pap tests, 85.5% of African American females have had this test compared to 99.3% of White females.



Tests for **prostate cancer** include Prostate Specific Antigen (PSA) tests and digital rectal exams. These questions were asked of area males 40 years and older. Local statistics reveal a smaller proportion of males in this age group who have had the recommended screenings. Approximately 59% of the males in this age range have had a PSA test, which is below Mississippi (65.3%) and the U.S. (65%). A similar percentage of males have had a digital rectal exam. Locally, 56.6% of males 40 and older have had this exam compared to 69.8% statewide and 73.4% nationally. When asked if they have ever had prostate cancer, 5.9% of males in this age group indicated that they have. This is statistically similar to the state (4.7%) and national (4.3%) percentages. White males were more likely than African American males to have had a PSA test (61.7% vs. 54.3%) and a digital rectal exam (65.2% vs. 44.7%).

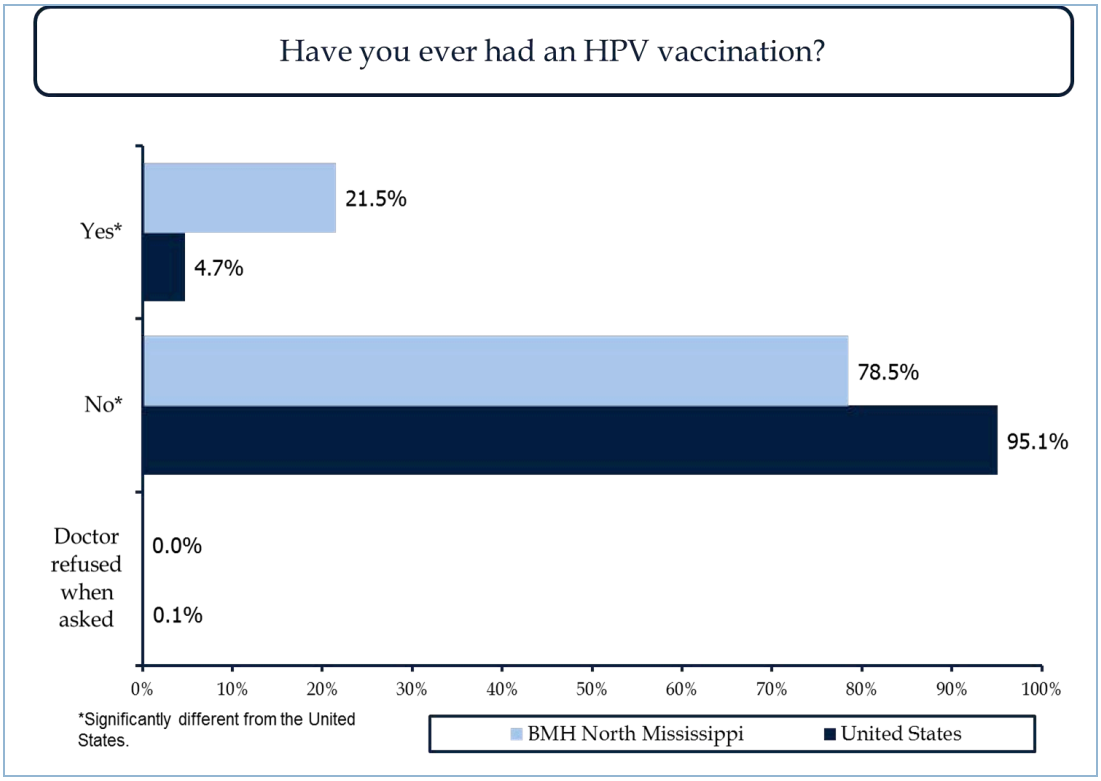


Colorectal cancer screening questions were included in the survey as well. Around 38.5% of adults 50 years and older have had a blood stool test using a home kit, which is similar to the percentage statewide (34.3%) and nationally (38.6%). A higher percentage reported having had a colonoscopy or sigmoidoscopy. Around 62% of adults 50 years and older have had a sigmoidoscopy or colonoscopy, which is equivalent to the 59.5% throughout Mississippi and the 65.6% throughout the U.S. African Americans living locally were less likely to have had a colonoscopy or sigmoidoscopy than Whites (57.4% vs. 65.7%) and were also less likely to have had a blood stool test using a home kit than Whites (33.2% vs. 42.9%).

Seven percent (7%) of adults surveyed reported that they have had **cancer** at some point in their lifetime. This is compared to 9.4% nationally. The most commonly reported types of cancers were breast, colon, prostate, and skin cancers. More White residents in the area reported having had cancer at some point in their lifetime than African American residents (8.6% vs. 3.9%). No gender differences were uncovered in the survey results with respect to cancer.

Arthritis was reported by 25.3% of area adults. This is below the Mississippi (31%) and U.S. (30.3%) figures. Locally, Whites were less likely to report being diagnosed with some form of arthritis, gout, lupus, or fibromyalgia compared to African Americans (20.1% vs. 34.6%).

The survey also asked whether or not respondents have had the **HPV (Human Papilloma Virus) vaccination**. A significantly higher proportion of adults locally responded that they have. Nearly 22% have had the vaccination locally compared to 4.7% throughout the U.S. None of the African American survey respondents indicated they have had the vaccination compared to 31.7% of Whites. Additionally, males were more likely to report that they had the vaccination than females (41.5% vs. 2%).



Caregiving is increasingly an issue throughout the country as the number of older adults continues to grow. Approximately 22% of those surveyed reported that they provide regular care or assistance to a friend or family member. This is slightly above the figure nationwide (16.8%). The largest proportion (70.5%) takes care of someone who is 65 years or older.

Adults in the service area were more likely to report that they **never wear a seatbelt** when driving or riding in a car compared to statewide and nationally. Nearly 7% reported that they never wear a seatbelt, which is above Mississippi (1.2%) and the U.S. (1.5%).

In summary, the household survey results reveal a number of areas of opportunity and strength throughout the hospital's service area. Area adults reported a lower general health status compared to state and national figures and higher rates of disability. While BMI statistics in the service area are better than Mississippi, the majority of the population is still overweight or obese. Diabetes rates are elevated compared to national figures. Screenings for prostate cancer are lower among males 40 years and older, as are mammograms among females. On the positive side, more adults have a regular source of health

care and usually have routine checkups on an annual basis. Smoking rates are lower in the area, as are asthma rates.

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

A number of data points were gathered to lend insight into the demographics, quality of life, and morbidity and mortality figures for Lafayette County and Panola County, Mississippi. The hospital is located in Lafayette County, but also serves a significant portion of Panola County. A summary of the key findings is outlined below. All county data points were compared to state and national benchmarks and were evaluated as being more favorable or unfavorable to these comparisons.

The **demographics** of an area, as well as demographic shifts, can have a dramatic impact on the health care system. Between 2000 and 2010, Lafayette County saw a dramatic increase in population (22.2%) while Panola County saw a more modest increase (1.3%). The proportion of seniors living in the two counties varies slightly. Lafayette County has a smaller proportion of adults 65 and older (10.4%) while Panola County is very similar to Mississippi and the U.S. at 12.7%. Panola County is much more diverse than Lafayette County, with racial demographics fairly similar to Mississippi overall.

Overall Population (2010)

	U.S.	Mississippi	Lafayette County	Panola County
Population	308,745,538	2,967,297	47,351	34,707
Population Change *('00 – '10)*	9.7%	4.3%	22.2%	1.3%

Source: U.S. Census Bureau, 2010

Racial Breakdown (2010) [a]

	U.S.	Mississippi	Lafayette County	Panola County
	%	%	%	%
White	72.4	59.1	71.8	49.4
African American/African American	12.6	37.0	23.7	48.6
Asian	4.8	0.9	2.1	0.2
American Indian/Alaska Native	0.9	0.5	0.3	0.2
Native Hawaiian or Other Pacific Islander	0.2	0.0	0.0	0.0
Two or more races	2.9	1.1	1.0	0.9
Hispanic or Latino (*of any race*)[b]	16.3	2.7	2.3	1.4

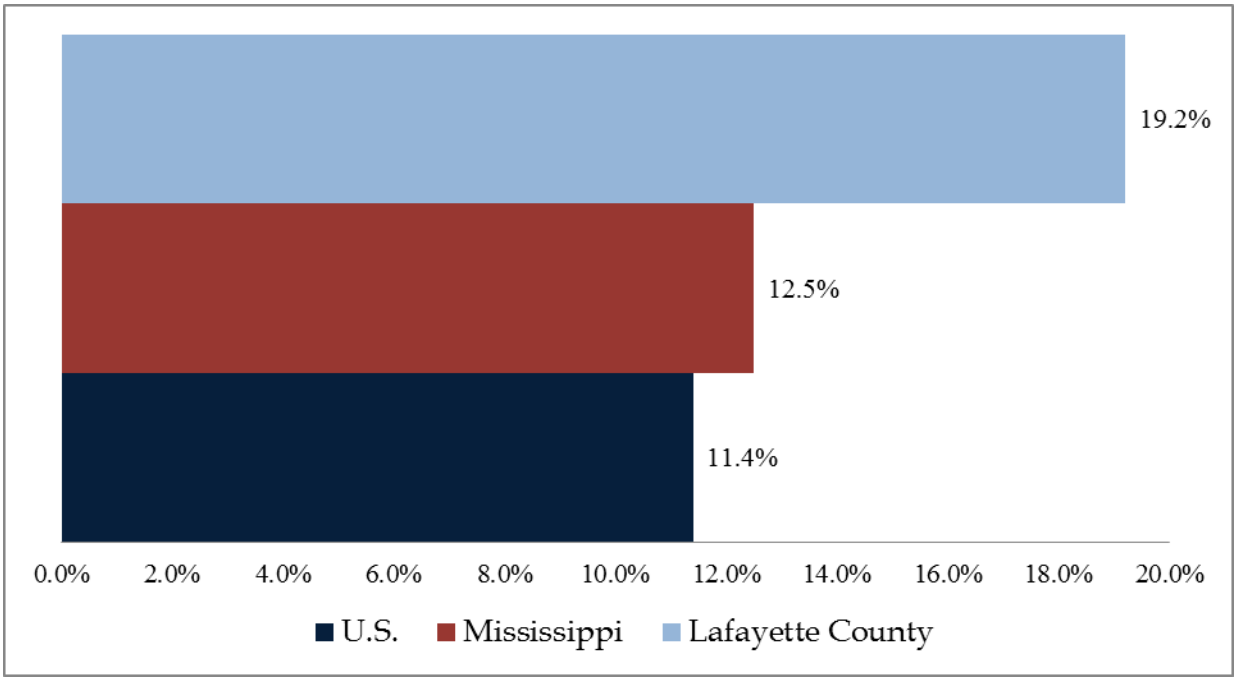
Source: U.S. Census Bureau, 2010

[a] Percentages may equal more than 100% as individuals may report more than one race

[b] Hispanic/Latino residents can be of any race

Household statistics reveal a higher percentage of vacant housing units in Lafayette County compared to Mississippi and the U.S. The percentage in Lafayette County is roughly 19%, which is not only above the state (12.5%) and national figure (11.4%), but also higher than Panola County (12.6%). Home values differ dramatically between Lafayette and Panola Counties, but both are lower than national values. The median home value in Lafayette County is $156,800 compared to $76,100 in Panola County. There are also fewer family households in Lafayette County than in Panola County, statewide, and nationally.

Percentage of vacant housing units, Lafayette County compared to Mississippi and U.S. (2010).



Households by Occupancy, Type, and Value (2010)

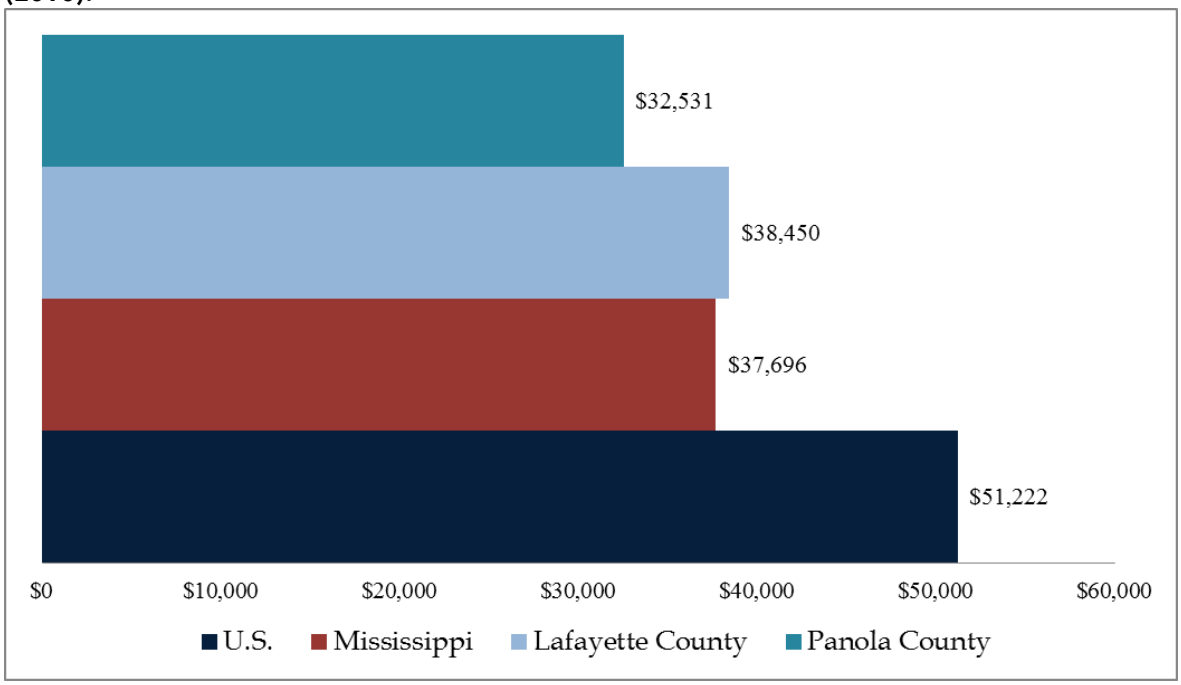
	U.S.		Mississippi		Lafayette County		Panola County	
Household Type[a]	n	%	n	%	n	%	n	%
Family households	77,538,296	66.4	770,266	69.0	10,038	54.7	9,086	70.8
Male householder, no wife present	5,777,570	5.0	57,661	5.2	770	4.2	768	6.0
Female householder, no husband present	15,250,349	13.1	205,972	18.5	2,129	11.6	2,726	21.2
Husband-wife families	56,510,377	48.4	506,633	45.4	7,139	38.9	5,592	43.6
Nonfamily households	39,177,996	33.6	345,502	31.0	8,318	45.3	3,753	29.2
Median home value (dollars)	187,500		99,800		156,800		76,100	

Sources: U.S. Census Bureau, 2010; U.S. Census Bureau, 2008-2010 ACS 3-year estimates

[a] Data is based on U.S. Census Bureau, 2010

Household **income** levels in both Lafayette and Panola Counties are below the U.S. overall and more aligned with Mississippi values. The median household income in Lafayette County is roughly $38,000 and in Panola County is $32,000. This compares to $37,000 statewide and $51,000 for the U.S. overall. With respect to poverty rates, Lafayette County is similar to or better than the Mississippi poverty figures. However, the percentage of all people in the county living in poverty is higher than nationally. For Panola County, nearly all poverty rates are higher than both statewide and nationally. Nearly 30% of all people living in Panola County are impoverished.

Median household income, Lafayette County and Panola County compared to Mississippi and U.S. (2010).



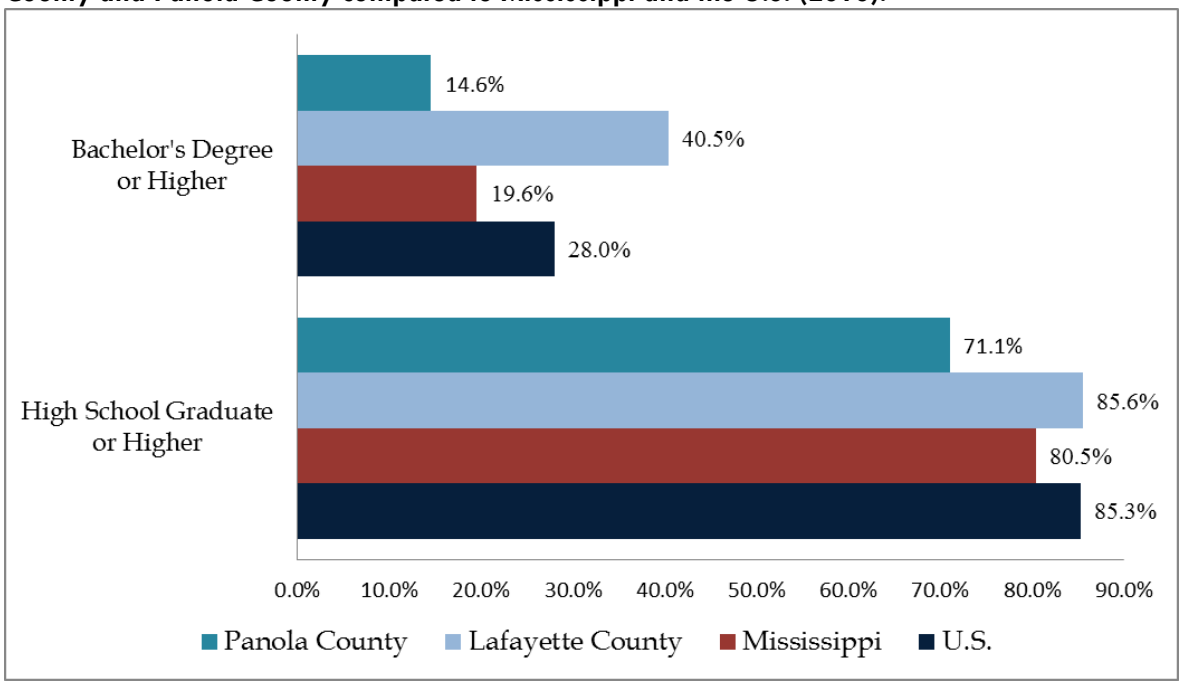
Poverty Status of Families and People in the Past 12 Months (2010)

	U.S.	Mississippi	Lafayette County	Panola County
All families	10.5%	17.2%	11.6%	24.3%
With related children under 18 yrs.	16.5%	25.9%	17.5%	33.9%
With related children under 5 yrs. only	17.9%	27.0%	29.1%	20.4%
Married couple families	5.1%	7.1%	4.3%	10.5%
Families with female householder, no husband	29.2%	41.7%	24.2%	44.6%
All people	14.4%	21.8%	24.2%	29.9%
Under 18 years	20.1%	31.6%	20.1%	45.9%
Related children under 18 years	19.7%	31.3%	19.5%	44.6%
65 years and over	9.4%	14.7%	12.0%	18.1%

Source: U.S. Census Bureau, 2008-2010 ACS 3-year estimates

Employment statistics reveal fewer adults in Panola County in the labor force compared to Lafayette County (51.5% vs. 59.9%). While Lafayette County is similar to Mississippi (59.6%), both counties have fewer adults in the labor force than nationally (65.1%). Those employed in Panola County have longer commutes to work than those in Lafayette County. The estimates for health insurance coverage vary slightly between the two counties. In Lafayette County, it is estimated that 16.4% are uninsured compared to 17.8% in Panola County. These are similar to the figure for Mississippi (17.7%), but slightly above the U.S. (15%). **Educational attainment** is also dramatically different between the two counties. Nearly four in 10 in Lafayette County have a bachelor's degree or higher compared to less than 15% in Panola County.

Educational attainment percentages for population 25 years and over, Lafayette County and Panola County compared to Mississippi and the U.S. (2010).



The overall age-adjusted **mortality rate** for both counties is higher than what is seen nationally. The rates for Lafayette County (9.3) and Panola County (9.9) look similar to Mississippi (9.6), but exceed the U.S. rate (7.5). An examination of the mortality rates by race reveal a disparity in the rate of death, especially in Lafayette County. The age-adjusted mortality rate for African Americans in Lafayette County is 12.0 compared to 9.5 in Panola County, 10.7 throughout Mississippi, and 9.0 nationally. Deaths due to accidents are higher in both counties than in the U.S. and throughout Mississippi. Mortality due to heart disease and cancer are actually lower in Lafayette County than statewide and nationally, while in Panola County, they are above nationwide statistics.

Mortality, All Ages by Race (2010)[a]

[a] *Rates per 1,000 population*	U.S.	Mississippi	Lafayette County	Panola County
Age-Adjusted Rate	7.5	9.6	9.3	9.9
White	7.4	9.3	8.7	10.0
African American	9.0	10.7	12.0	9.5

Sources: Mississippi Department of Health, 2010
Center for Disease Control and Prevention, 2010

The **infant mortality rates** across both counties are higher than national rates, but slightly below statewide rates. Specifically, the rates among Non-Whites are higher than among Whites. This is especially true in Lafayette County where the rate of infant mortality among Non-Whites is five times the rate among Whites. The percentage of newborns born at a low birth-weight in Lafayette County is similar to or better than the U.S. rate. For Panola County, however, the rates are well above what is seen statewide and nationally. Teen pregnancy rates are also much higher in Panola County than Lafayette County (95.9 vs. 24.1). Conversely, Lafayette County has a higher rate of births to mothers who are 40 years and older compared to Panola County (10.3 vs. 2.9). Prenatal care in the first trimester is lower in both counties compared to statewide and nationally.

Infant Mortality Rates by Race (2006 – 2010, 5 - year averages)[a]

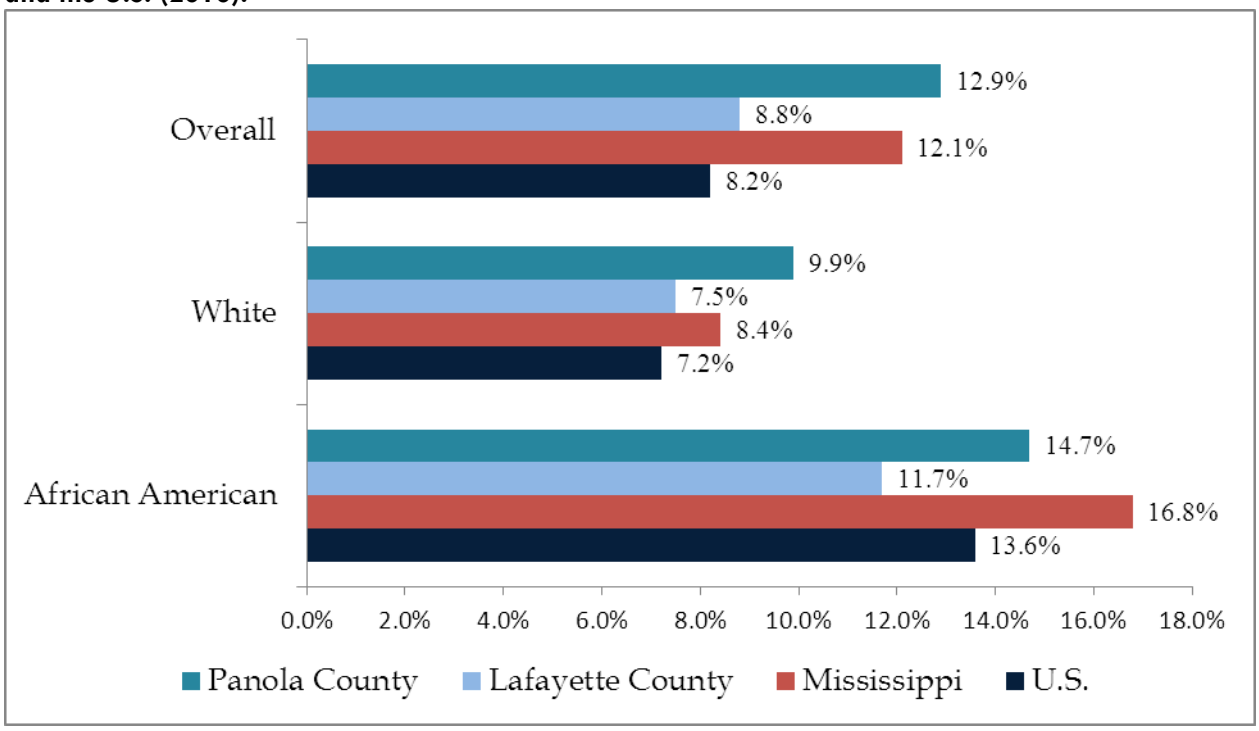
	U.S.[b]	Mississippi	Lafayette County	Panola County
Infant	6.5	10.0	8.4	9.3
White	6.2	6.9	3.5	4.3
Non-White	13.1	13.7	17.6	12.8

Sources: Mississippi Department of Health, 2006 - 2010
Centers for Disease Control and Prevention, 2006 - 2010

[a] Rate per 1,000 live births

[b] Data reflects White/African American race categories

Percentage of low birth weight by race, Lafayette County and Panola County compared to Mississippi and the U.S. (2010).



Prenatal Care in First Trimester by Race (2010)

	U.S		Mississippi		Lafayette County		Panola County	
	Number	%	Number	%	Number	%	Number	%
White	1,729,684	88.1	18,973	87.4	259	75.1	155	69.8
African American	319,812	76.1	13,571	77.6	83	57.2	173	57.7

Sources: Mississippi Department of Health, 2006 - 2010
Centers for Disease Control and Prevention, 2006

Communicable disease rates in Panola County are above Lafayette County, Arkansas, and national rates. Specifically, the rates for chlamydia and gonorrhea are higher in Panola County. Lafayette County's gonorrhea rates are also higher than the U.S. While small in numbers, the tuberculosis rates are also higher in both counties compared to statewide and nationally.

Sexually Transmitted Illness Cases (2010)[a]

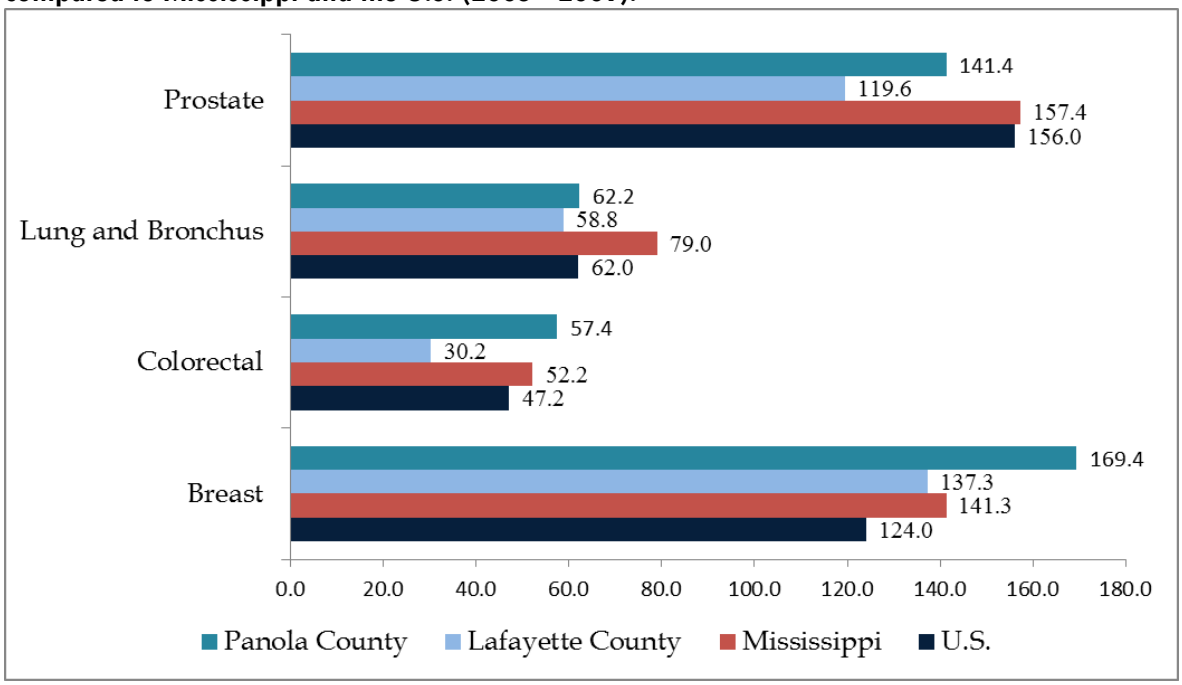
	U.S		Mississippi		Lafayette County		Panola County	
	Number	Rate	Number	Rate	Number	Rate	Number	Rate
Chlamydia	1,307,893	426.0	21,422	725.7	206	468.4	317	899.4
Gonorrhea	309,341	100.8	6,196	209.9	56	127.3	95	269.5

Sources: Mississippi Department Health, 2010
Centers for Disease Control and Prevention, 2008
Centers for Disease Control and Prevention, 2010

[a] Rates per 100,000 population

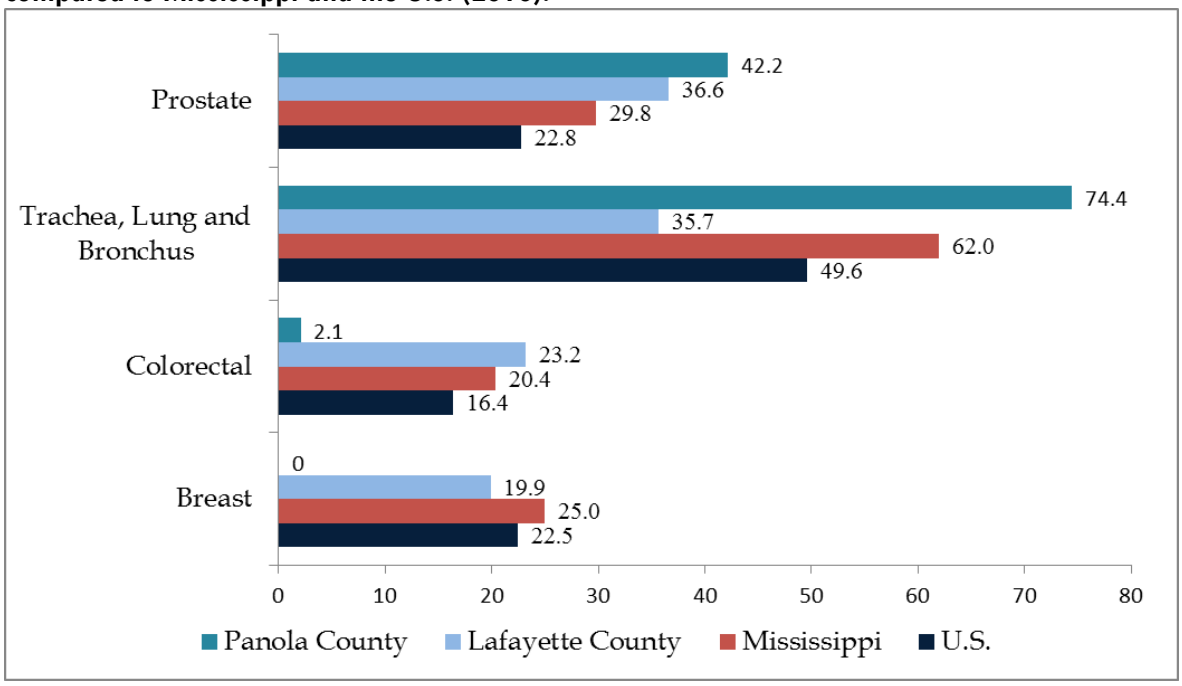
The overall **cancer** incidence rates across the two counties are roughly equal to the U.S., but slightly below Mississippi. Cancers among males in Lafayette County, however, are significantly higher than cancer rates among males statewide and nationally. This pattern is not the case for males living in Panola County. The graphs below show that breast cancer is the one cancer that stands out as an area of concern across both counties with rates higher than statewide and nationally.

Cancer age-adjusted incidence rates per 100,000 population, Lafayette County and Panola County compared to Mississippi and the U.S. (2005 - 2009).



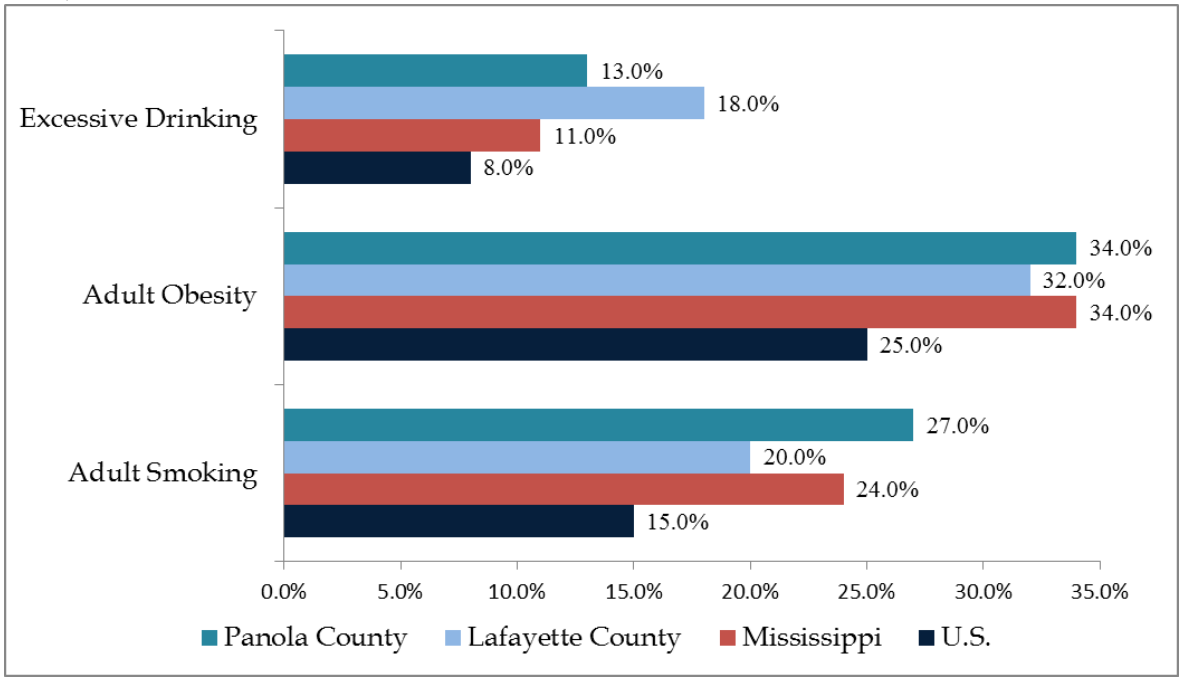
Cancer mortality rates are lower in Lafayette County than Panola County (154.1 vs. 196.6). However, prostate cancer mortality rates compare less favorably for both counties when compared to Arkansas and the nation.

Cancer age-adjusted mortality rates per 100,000 population, Lafayette County and Panola County compared to Mississippi and the U.S. (2010).



Health risk factors such as smoking, excessive drinking, and an unhealthy weight are all related to poorer health outcomes. Unfortunately in both Lafayette and Panola Counties, the majority of these statistics are higher than statewide and nationally. Residents living in Lafayette County are less likely to be obese and are less likely to smoke than Panola County residents, but are more likely to drink excessively.

Health behavior status percentages, Lafayette County compared to Mississippi and the U.S. benchmark (2011).



Lafayette and Panola Counties present very different demographics and health risks. In general, Panola County appears less healthy than Lafayette County. Opportunities that present in both counties include poverty levels, overall mortality rates, and infant mortality rates, especially among African Americans. Prenatal care in the first trimester, sexually transmitted illness rates, breast cancer incidence rates, obesity, alcohol use, and prostate cancer mortality rates also present as challenges in the area. The secondary data should be interpreted in conjunction with the primary household data, focus group feedback and key informant perspectives.

Key Informant Interviews Key Findings

The key informant surveys gathered feedback on issues such as the overall quality of healthcare 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 healthcare 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 healthcare 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 healthcare 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.

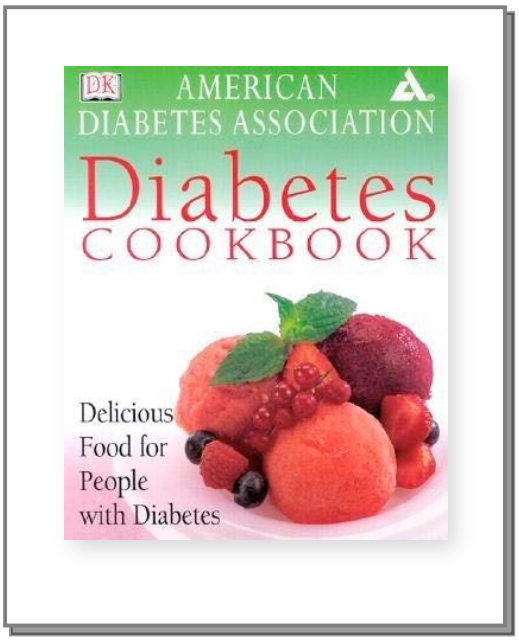
When asked where uninsured and underinsured individuals go for health care, participants indicated that uninsured residents often utilize the Emergency Department for primary health care because the Emergency Department will not turn them away if they do not have insurance. Others forgo care. Co-pays, 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

The four research components reveal a number of overlapping health issues for residents living in the Baptist Memorial Hospital-North Mississippi service area. The following list outlines the key needs that were identified.

- **Access to care:** Access to primary care, as well as access to preventative care, is increasingly an issue throughout the country. The poverty rates in both counties suggest that cost is one of the greatest access to care barriers. It is likely than this is a greater issue in Panola County than Lafayette County.

- **Diabetes:** Related to obesity, as well as a number of other chronic illnesses, is the incidence rate of diabetes. There are more individuals in the hospital's service area who have been diagnosed with diabetes when compared against the U.S. overall. Focus group participants elaborated on their experiences with diabetes and difficulties with self-management of diet and general physical health. They anecdotally shared of the comorbidity between diabetes and other chronic illnesses. While the focus group participants spoke of the need for greater awareness of available services and increased need for education, the household survey identified that fewer individuals with diabetes have attended a class or course on how to manage their diabetes.

- **Breast cancer:** The incidence rates for breast cancer in both Panola and Lafayette Counties are well above state and national figures. The household survey also revealed that fewer women in the area are having mammograms when compared to statewide and nationally. The survey also revealed that more African Americans females have had mammograms than White females. The reverse was true with respect to clinical breast exams.

- **Maternal & infant health:** The infant mortality rates across both counties are higher than what is seen nationally. This is especially true for African American infants. Birth weights are lower in Panola County and fewer mothers across both counties receive prenatal care in the first trimester. There is a higher proportion of teen pregnancies in Panola County and older (40 years or more) pregnancies in Lafayette County.

- **Obesity:** All four research components pointed to local issues with obesity. The household survey and the secondary data profile identified that the majority of local adults are overweight or obese. It should be noted that the household survey revealed statistics that were aligned with the U.S. figures. The household survey also revealed that the majority of overweight or obese adults in the area have not been told by their doctor or health care provider that they are obese or overweight. The connection between obesity and chronic illness (e.g. diabetes) was noted multiple times during the focus groups and in the key informant interviews as well. Many suggestions were made to improve accessibility to healthy foods as well as recreational opportunities such as walking paths, community parks, etc.

- **Racial disparities:** The household survey and secondary data clearly identified significant disparities between White and African American residents living in the hospital's service area. African Americans in the area have higher mortality rates (both adults and infants) and are more likely to report poor health status compared to Whites.

- **Prostate cancer:** The household survey revealed that significantly fewer men in the area are having the recommended screening tests (PSA tests and digital rectal exams) for prostate cancer. While the incidence rates do not significantly differ for prostate cancer, the mortality rates in the area are well above statewide and nationally. This might suggest that the men who have prostate cancer are being diagnosed at a much later stage, leading to a more negative prognosis.

- **Sexually transmitted illnesses:** Locally, rates of gonorrhea, chlamydia, and tuberculosis are higher than statewide and nationally. This is especially true for Panola County. The household survey identified that more adults in the area have had the HPV vaccination. This initially can be interpreted as a positive finding, but given the statistics on the sexually transmitted illnesses, this may be due to a higher proportion of individuals being at risk.

- **Social determinants of health:** The data reveals an area where many residents live in poverty and there are a larger proportion of unoccupied housing units. The figures for Panola County in particular reveal lower rates of education, lower incomes, and fewer individuals in the labor force. The connection between poverty and health outcomes has been noted in many studies and is an area of concern.

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 Mater 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 Hospital-North Mississippi 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 Hospital-North Mississippi 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 Hospital-North Mississippi 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 Hospital-North Mississippi 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 Hospital-North Mississippi 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

The CHNA Summary Report was posted on the hospital's website in September 2013 to ensure it was widely available to the community. The hospital's Board of Directors will review and adopt an Implementation Strategy and the plan will be available on the website.