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**MEMORIAL HOSPITAL**  

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**HUNTINGDON**



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-Huntingdon became the eighth hospital to affiliate with Baptist Memorial Health Care in 1983. Since then, Baptist Memorial Hospital-Huntingdon has experienced tremendous growth, adding a 5,000 square foot physician office building in 1989. In 1994, the hospital added a 40,000 square foot medical center, including expansion for health information management, information systems, home care and hospice and administration. Other expansions and enhancements include MRI services, occupational therapy and industrial services.

Baptist Memorial Hospital-Huntingdon offers internal medicine, family practice, general surgery, orthopedics, otolaryngology, pediatrics, urology, pathology, cardiology, gynecology, pain management and radiology.

Baptist Home Care and Hospice-Huntingdon has consistently ranked among the top home care agencies in the nation in the HomeCare Elite rankings. The HomeCare Elite list identifies the top 25 percent of home care agencies in the United States based on quality of care, quality improvement and financial performance. Baptist Memorial Hospital-Huntingdon is also a recipient of the prestigious Tennessee Quality Commitment Award.

### Definition of Service Area

Baptist Memorial Hospital-Huntingdon serves residents in Carroll County and the surrounding areas. For the purposes of the CHNA, the hospital focused on its primary service area of Carroll County, Tennessee. The following zip codes were included in the household study:

38201	38317	38342	38387
38220	38318	38344	38390
38258	38321	38348	

### CHNA Background

Baptist Memorial Hospital-Huntingdon, 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-Huntingdon 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-Huntingdon 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-Huntingdon 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 548 adults from the Baptist Memorial Hospital-Huntingdon 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. A list of participants can be found in Appendix A. 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. 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.

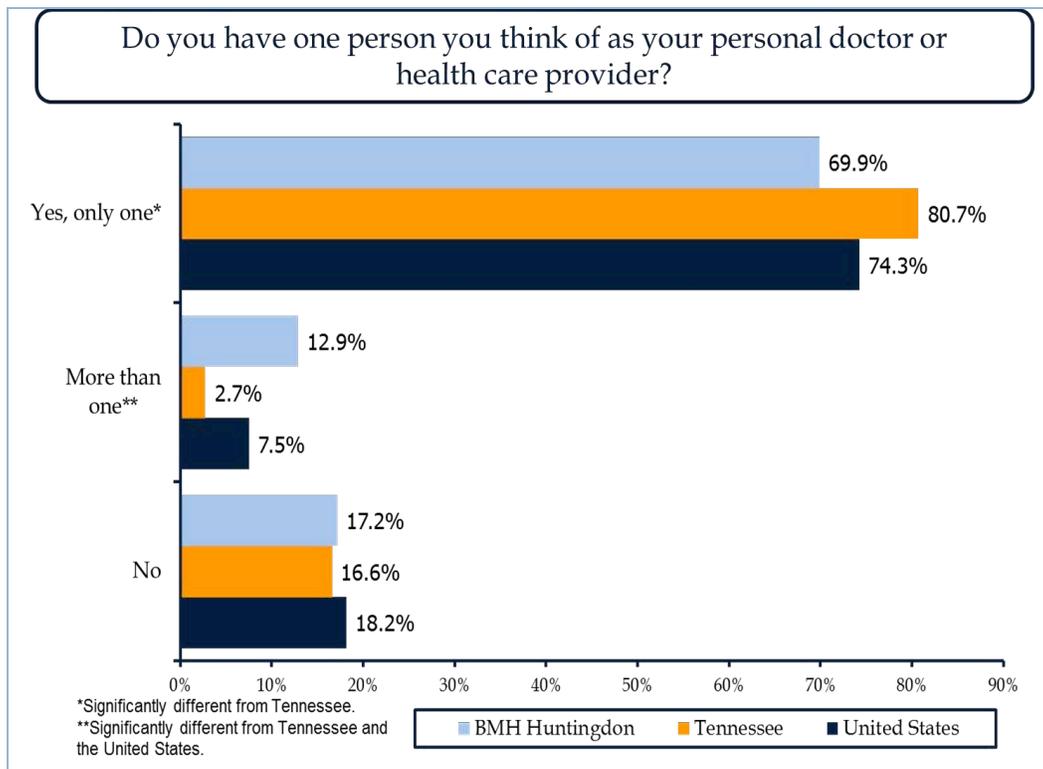
### Documentation

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

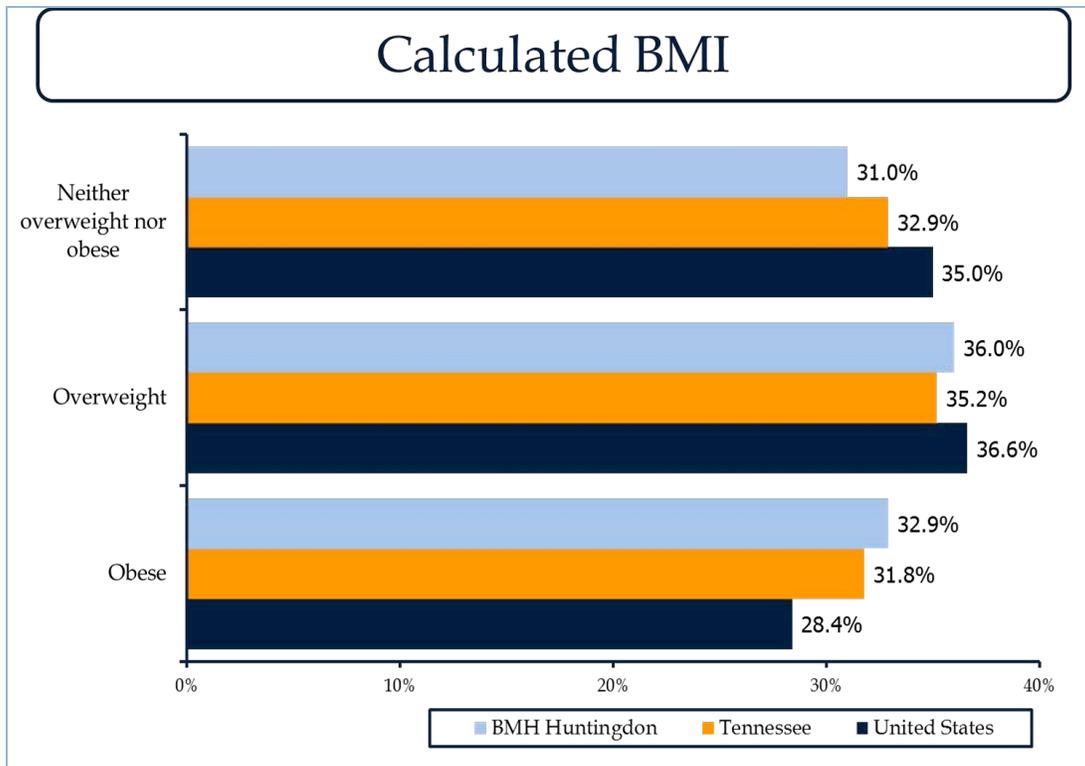
A household survey of the Baptist Memorial Hospital-Huntingdon service area included 548 randomly selected adults. The respondents were asked to rate their own health status, to provide information on behaviors and prevention activities, and to report the incidence of a variety of chronic illnesses such as diabetes and cardiovascular disease. When asked to rate their **general health**, nearly 70% responded “good,” “very good” or “excellent.” Despite this strong majority, this is below the Tennessee (80.5%) and U.S. (83.6%) percentages. Adults locally were more likely to say “poor” or “fair” compared to these benchmarks as well. In addition to lower ratings for general health, the adults that were surveyed also reported more days of poor physical or mental health and days where their health interfered with daily functioning. Area females were more likely to report days with poor physical or mental health compared to males.



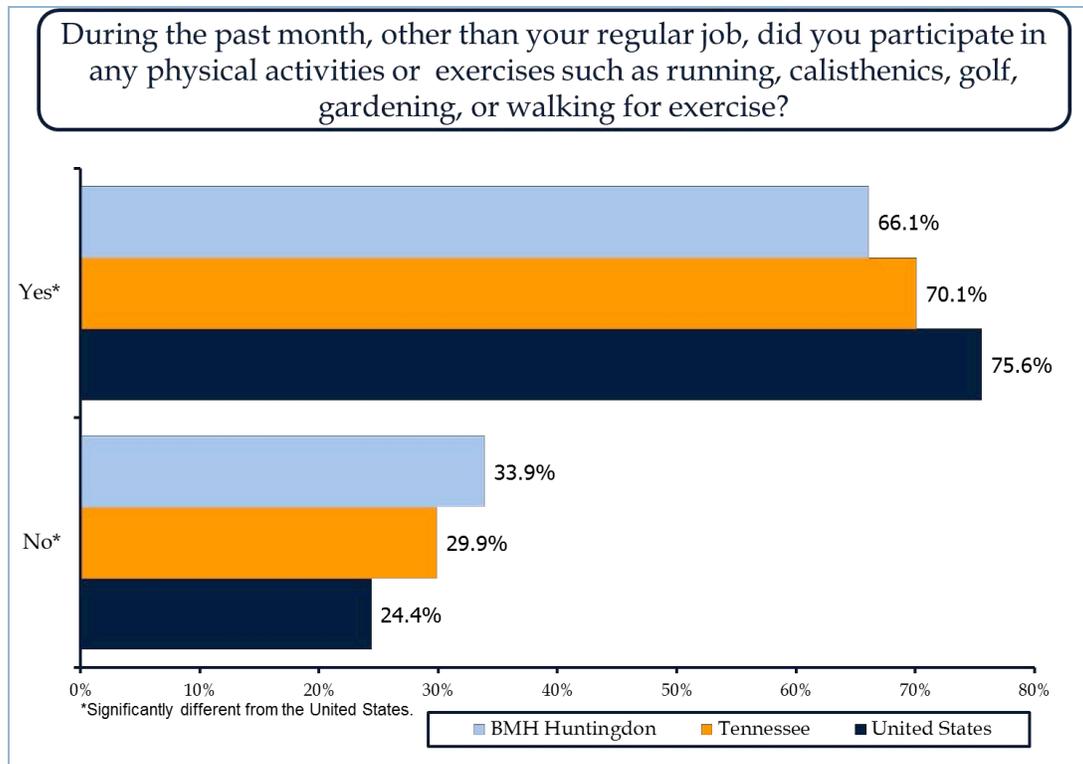
**Access to care** issues were assessed by asking several survey questions about health insurance coverage, cost as a barrier to seeking care, and whether or not there is a regular source of health care. Approximately 83% of those surveyed reported that they have some form of health insurance. This is similar to Tennessee (83.5%) and the U.S. (84.9%) figures. Nearly 88% of area females reported having health insurance, which is above the 78.2% of area males reporting insurance. Nearly 16% reported that there was a time in the previous year when they were unable to see a doctor because of cost, similar to statewide and nationally. When asked if there is one person they think of as their usual doctor or health care provider, nearly 83% reported “yes.” Of this 83%, roughly 70% reported only one person and 13% stated that there was more than one. This may reflect a primary care provider and any specialists seen on a regular basis. However, area adults are more likely to have multiple providers involved in their care. It should

be noted that males are less likely to have a usual provider for care than area females (62.2% vs. 78.1%). The majority of area adults (77.6%) reported having had a regular checkup in the previous year. This is consistent with what was seen throughout Tennessee (78.2%), but higher than the U.S. figure (68.1%).

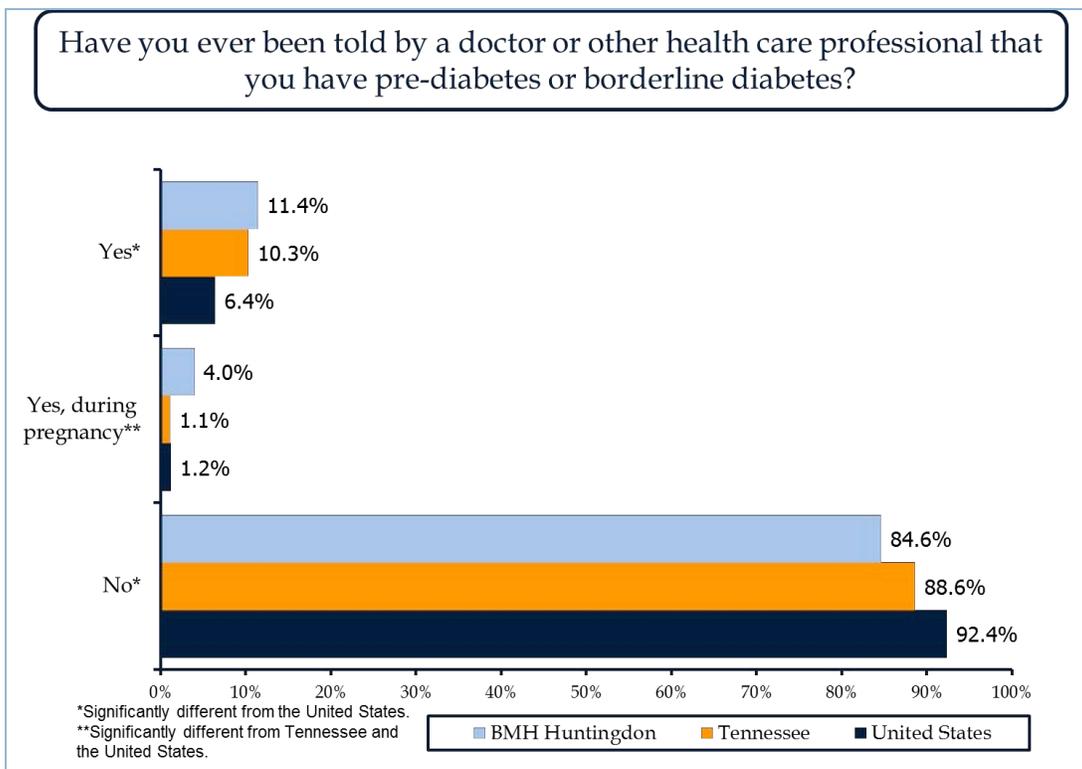
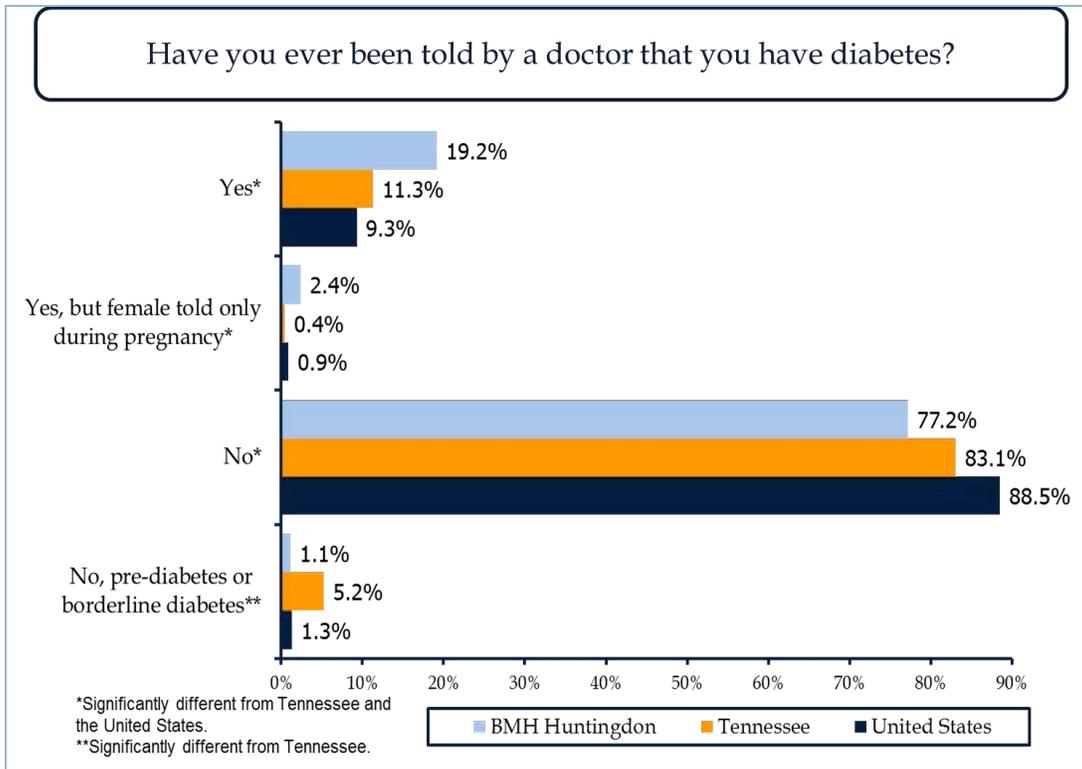
Weight and nutrition was assessed as well. **Body Mass Index (BMI)** was calculated for each survey respondent based on their reported height and weight. As shown in the graph below, one-third of area adults are technically obese and another 36% are overweight. This looks similar to the weight statistics for the state of Tennessee, but compares less favorably to the U.S. statistics.



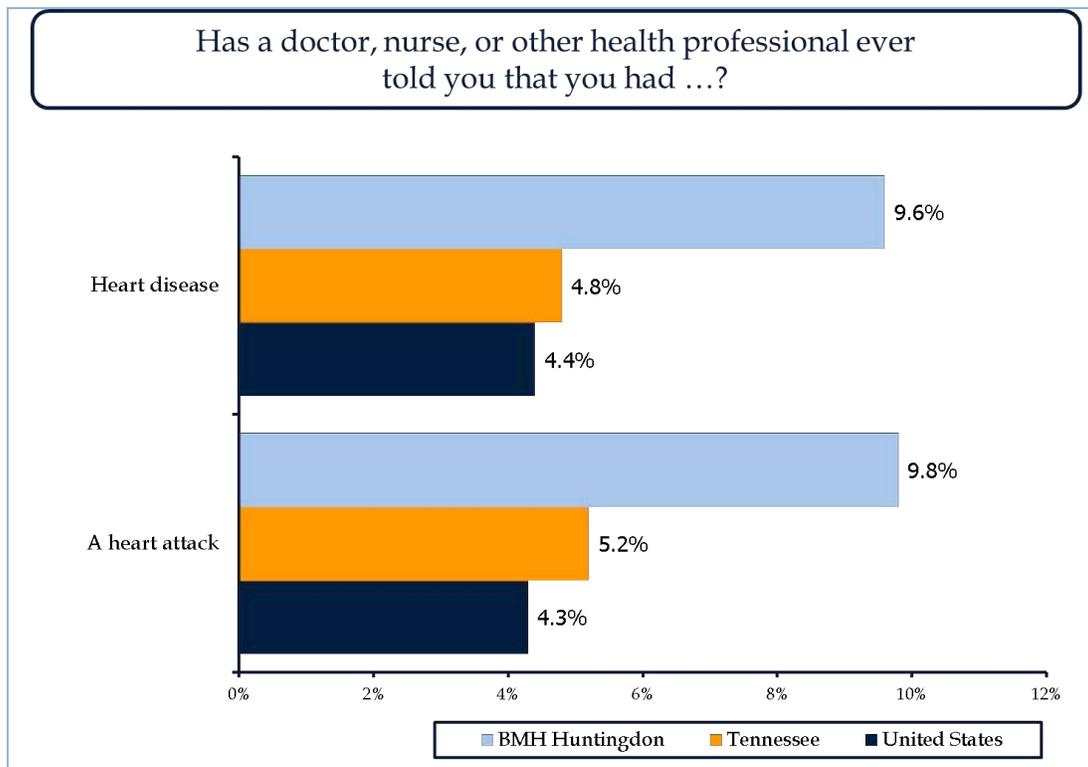
Additionally, 66% of those surveyed exercise in a typical month. This is below the 70.1% statewide and 75.6% nationally. Seven out of 10 males in the area reported exercising compared to around six out of 10 area females. Interestingly, while the BMI statistics show that 68.9% of area adults are overweight or obese, only 21.3% stated that they had been told by a health professional in the past two years that they were overweight or obese. Female survey respondents were more likely to report being told they were overweight by a health provider compared to males (27.6% vs. 15.8%). Also recall that area males are less likely to have one person they think of as their usual doctor or health care provider.



Closely linked to being overweight or obese is the incidence of **diabetes**. Roughly 19% of the survey respondents reported being told by a doctor that they have diabetes, another 1.1% pre-diabetes, and another 2.4% gestational diabetes. The diabetes rates and gestational diabetes rates are significantly above Tennessee and the U.S. More than half of those surveyed (53.5%) also reported a family history of diabetes. The age of onset for respondent's diabetes is similar to what is seen nationally, but the proportion of those with diabetes who are insulin-dependent is above state and national figures. Approximately 44% of those with diabetes locally report taking insulin. Respondents were also more likely to check their blood sugar levels daily and to check their feet for sores and irritations than others with diabetes. About half of area individuals with diabetes (49.2%) have taken a course or class in how to manage their diabetes compared to 52.6% statewide and 54.8% throughout the country. The only statistically significant gender differences related to the diagnosis of diabetes. Males were less likely to report having diabetes than area females (15.9% vs. 22.9%).



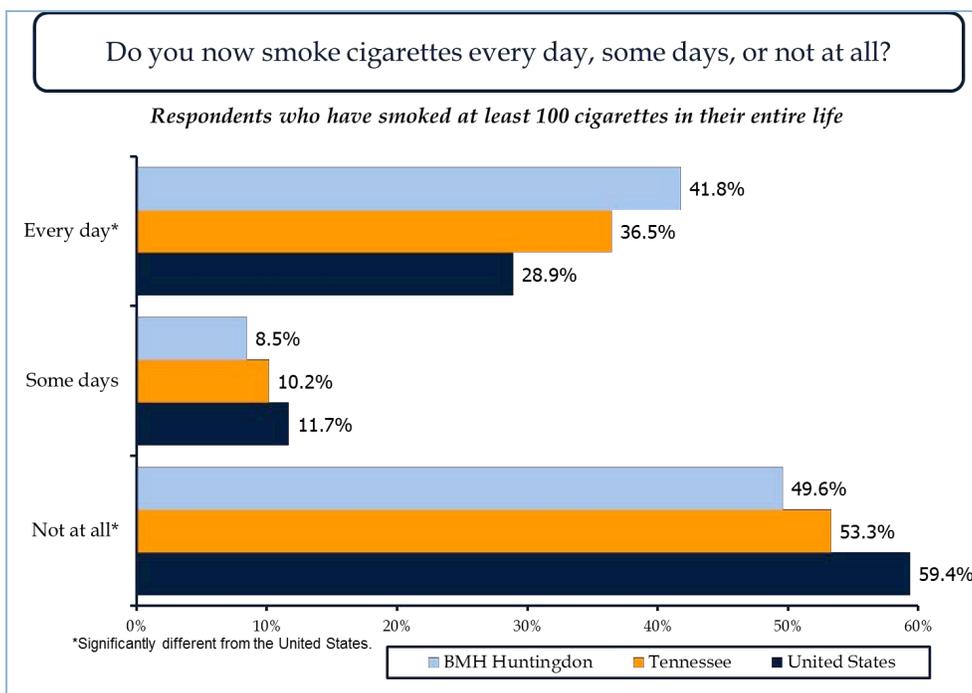
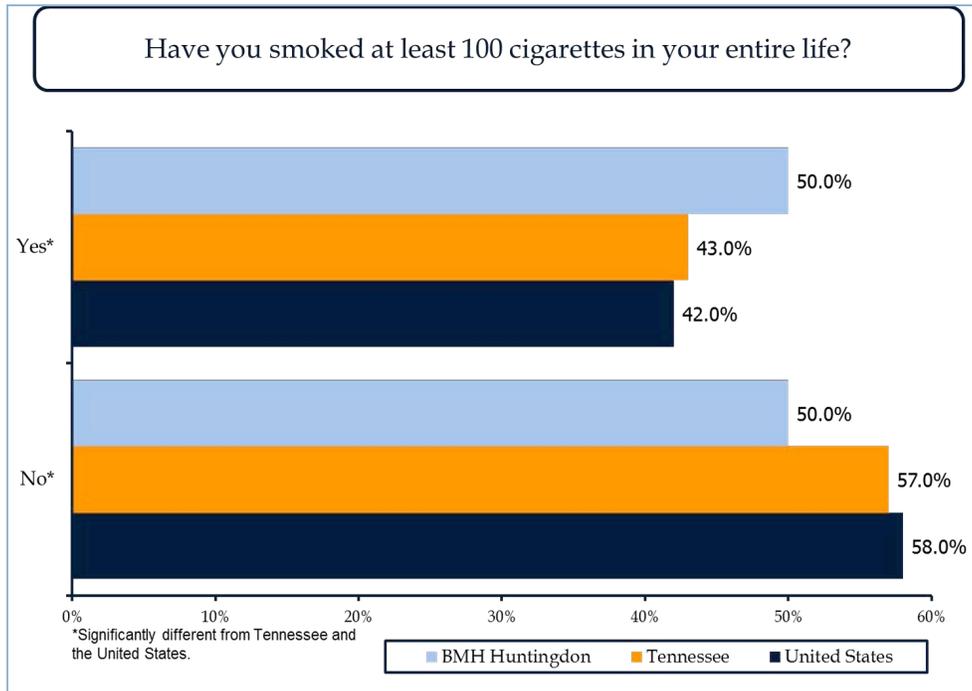
**Cardiovascular disease** indicators show less than favorable comparisons to the state and U.S. benchmarks. When asked if they have ever had a heart attack or myocardial infarction, 9.8% of respondents said, “yes.” This is above the 5.2% for Tennessee and 4.3% for the U.S. A similar pattern emerges with respect to angina or coronary heart disease. Locally, 9.6% have this diagnosis, compared to the state average of 4.8% and the U.S. average of 4.4%. No significant differences were noted with the incidence of stroke. When asked about family history, 57% of those surveyed indicated that there is a family history of heart disease. No statistically significant differences were noted between males and females for any of the cardiovascular disease items.



Those surveyed were asked a number of questions regarding **asthma**. Approximately 17% of area adults reported that they have had asthma at some point in their lifetime and within that group, 51.5% still have asthma. Ever being diagnosed with asthma is higher locally than statewide (9.3%), but similar to the U.S. percentage. Also similar to the benchmark data is the age of onset, the frequency of asthma attacks, visits to the hospital because of the asthma, and being limited in activities because of asthma.

**Disability** was assessed through questions regarding limitations and special equipment needs. Roughly 35% of the survey respondents reported being limited in some way because of physical, mental or emotional problems. Additionally, 13.8% reported that they have a health problem that requires the use of some form of special equipment (e.g. cane, wheelchair, etc.). While the household survey data was statistically weighted to account for any demographic imbalances, such as age, a higher proportion of older adults in the survey sample may have an impact on the results of these particular questions.

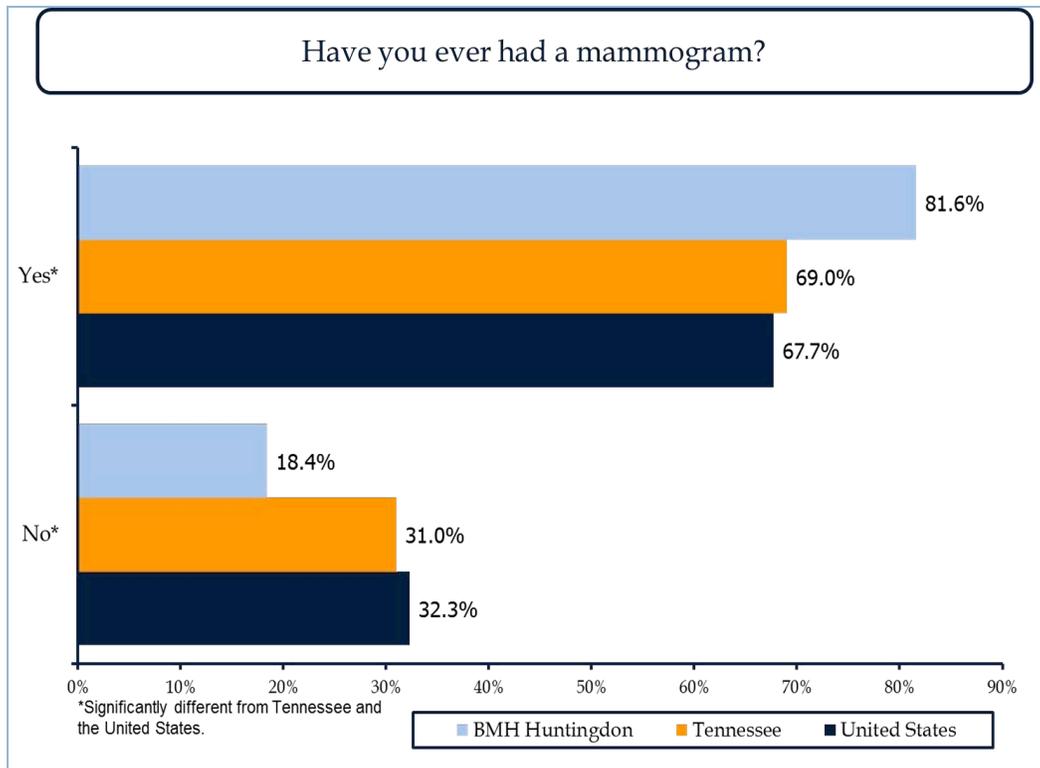
**Tobacco use** was assessed through questions regarding cigarette smoking and chewing tobacco. One half (50%) of those surveyed stated that they have smoked at least 100 cigarettes in their lifetime. This is significantly above both Tennessee (43%) and the U.S. (42%). As depicted in the following graph, 41.8% of these adults now smoke “every day” and another 8.5% smoke on “some days.” This is a higher proportion of regular smokers than what is seen nationally. While there were no gender differences locally with regard to cigarette smoking, area males are more likely to use chewing tobacco than females.



**Seatbelt use** stood out as an area of concern in the hospital service area. The proportion of residents (75.8%) that reported they “always” wear their seatbelt is below the state (85.4%) and national (86.6%) benchmarks.

The status of residents’ **oral health** was assessed by asking a question regarding tooth decay and gum disease. Around 57% of those surveyed indicated that they have had at least one tooth removed because of gum disease or tooth decay. This is similar to what is seen throughout the state of Tennessee (54.9%), but is greater than what is seen throughout the U.S. (45.5%).

Female respondents were asked a variety of **women’s health** questions. About eight out of 10 area females have had a mammogram during their lifetime. This is above the 69% statewide and 67.7% nationally. A similar comparison is revealed with respect to clinical breast exams. Roughly 91% of females locally have had a clinical breast exam compared to 87.8% for Tennessee and 89.8% for the U.S. Approximately 95% of females have had a Pap test during their lifetime, similar to Tennessee (91.6%) and the U.S. (93.8%).



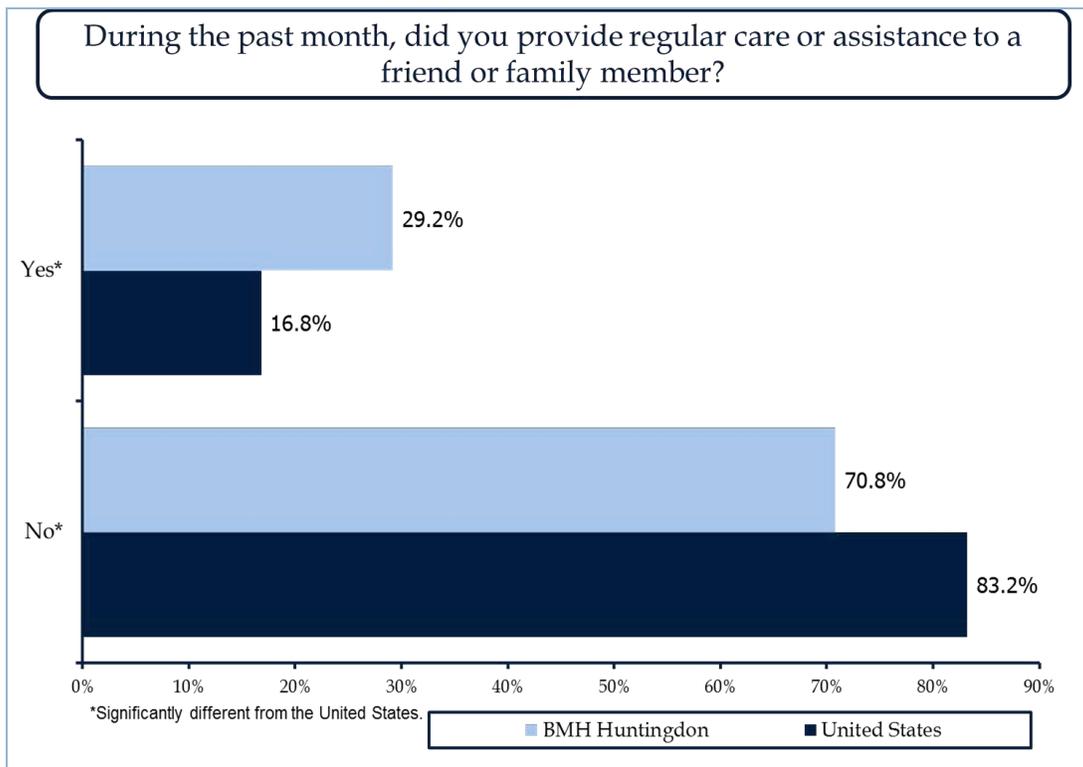
Tests for **prostate cancer** include Prostate Specific Antigen (PSA) tests and digital rectal exams. Questions related to these tests were asked of area males 40 and older. Approximately 68% of the males in this age range have had a PSA test, which is above Tennessee (58.8%), but similar to the U.S. (65%). A similar percentage of males have had a digital rectal exam. Locally, 68.6% of males 40 and older have had this exam compared to 57.7% statewide and 73.4% nationally. While the likelihood of ever having had a digital rectal exam compares favorably, the regularity of the test does not. Around 35% have had the test in the past year compared to six out of 10 statewide and five out of 10 nationally. When asked if they ever had a diagnosis of prostate cancer, 4.6% confirmed they had, similar to the state and national percentages.

**Colorectal cancer** screening questions were included in the survey as well. Around 29% of adults 50 and older have had a blood stool test using a home kit, similar to statewide (34.3%), but slightly lower than nationally (38.6%). A higher percentage reported having had a colonoscopy or sigmoidoscopy. Around 62% of adults 50 and older have had a sigmoidoscopy or colonoscopy, similar to the 60.5% throughout Tennessee and 65.6% throughout the U.S.

Twelve percent (12%) of adults surveyed reported that they have had **cancer** at some point in their lifetime. This compares to 9.4% nationally. The most commonly reported cancers on the survey were non-melanoma skin cancer, melanoma and prostate cancer. Of those who have had cancer, 7.5% are currently receiving treatment for their cancer. On the survey, there were no statistically significant differences between males and females and their likelihood of having cancer.

**Arthritis** was reported by 38% of area adults. This is above what is seen nationally (30.3%). Locally, females were more likely to report being diagnosed with some form of arthritis, gout, lupus or fibromyalgia compared to males (46.3% vs. 30.6%).

**Caregiving** is increasingly an issue throughout the country as the number of older adults continues to grow. Approximately 29% of those surveyed reported that they provide regular care or assistance to a friend or family member. This compares to 16.8% nationwide. The largest proportion (72.2%) take care of someone who is 65 years or older. Females are more likely to have provided care for a friend or family member than males (34.4% vs. 24.3%).



In summary, the household survey results reveal a number of areas of opportunity throughout the hospital’s service area. Area adults reported a lower general health status compared to state and national figures. Local statistics are less healthy for obesity, diabetes, exercise and oral

health. Additionally, heart attacks are more prevalent locally and heart disease rates are higher among local adults than those statewide and nationally. Additional risky behaviors such as regular cigarette smoking and lower use of seatbelts also put area adults at increased risk for poorer health outcomes.

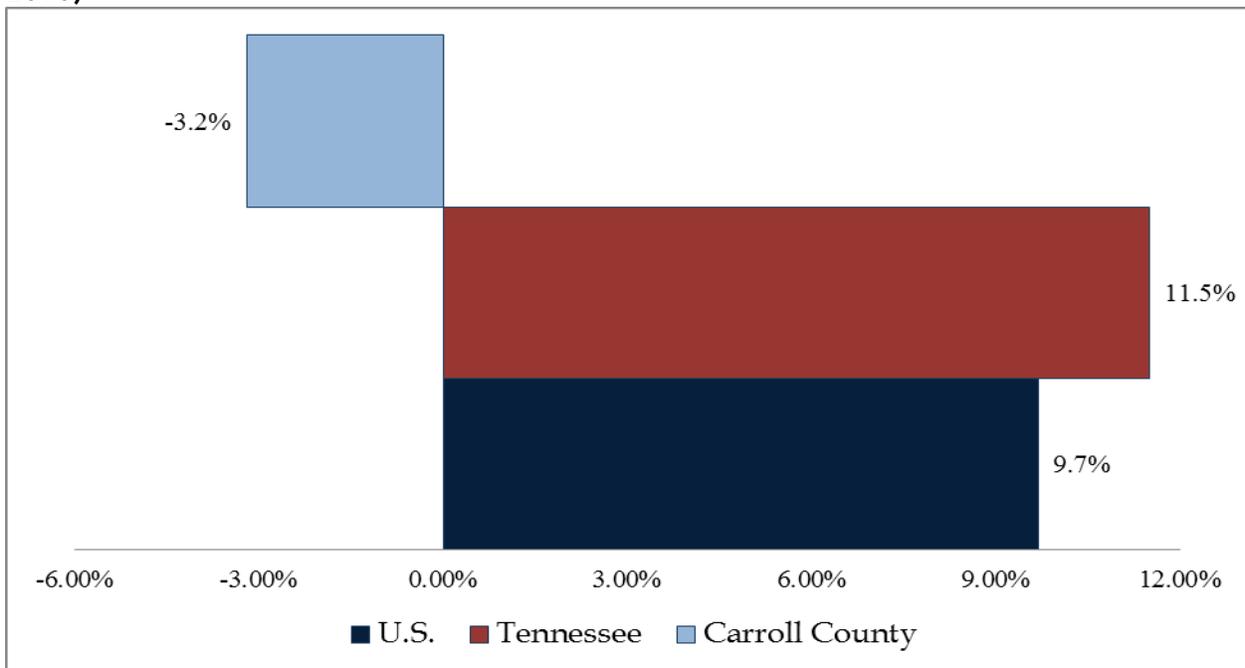
The household survey results were correlated with secondary data statistics and the qualitative research to determine key community health needs across all research components.

## Secondary Data Key Findings

A number of data points were gathered to lend insight into the demographics, quality of life, morbidity, and mortality figures for Carroll County, Tennessee. 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.

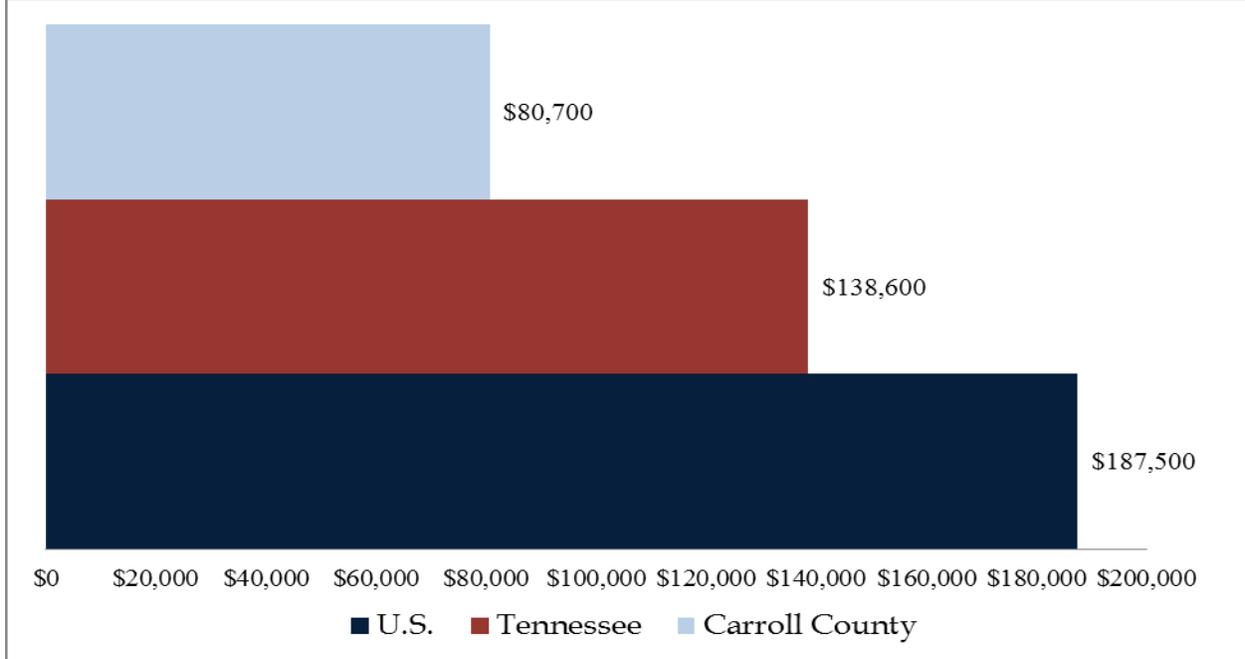
The **demographics** of an area, as well as demographic shifts, can have a dramatic impact on the health care system. Carroll County, Tennessee is estimated to have a population of 28,522 individuals. This is actually a 3.2% dip in population from 2000. While the rest of the country saw populations increase, this area declined in the number of residents. At the same time, the percentage of older adults (65+) in the area (17.9%) is above Tennessee (13.5%) and U.S. percentages (13.1%). The largest proportion of adults is White (86.8%) and 98.5% of households speak only English in their homes.

### Population percentage change, Carroll County compared to Tennessee and U.S. (2000 – 2010).



**Household statistics** for Carroll County show that 12.7% of households are vacant, which compares to 11.3% within Tennessee and 11.4% within the U.S. The majority of homes (68.4%) are family households and the median home value is \$80,700. This value is lower than the median Tennessee value and median U.S. value. These figures are detailed below.

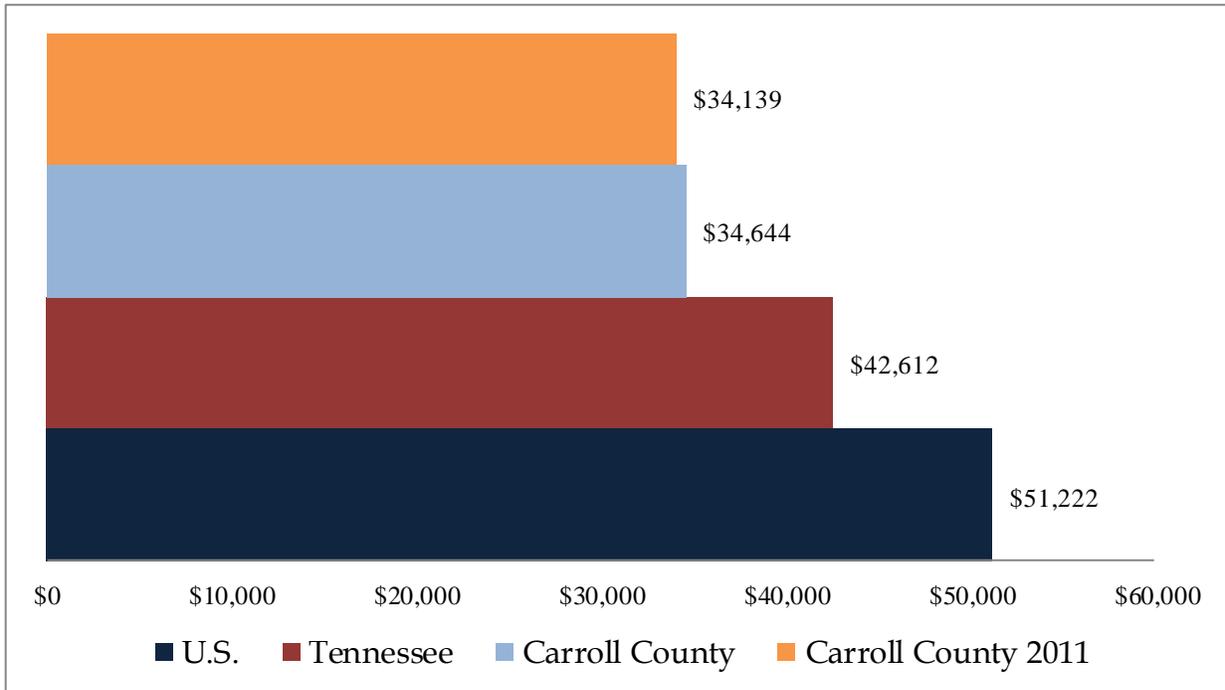
### Median value for owner-occupied unit, Carroll County compared to Tennessee and U.S. (2010).



As with home values, income levels in the county are lower than state and national averages. Median household incomes in Carroll County are roughly \$9,000 less than Tennessee and more than \$16,000 below the U.S. Male full-time workers in the county make nearly \$7,500 more than female full-time workers. This is a pattern consistent with state and national comparisons. When looking at poverty statistics, 18.3% of individuals in the county live in poverty. This compares to 16.9% for Tennessee and 14.4% throughout the U.S. In Carroll County, those 18 years of age and older as well as seniors (65+) are more likely to live in poverty than their peer demographic groups statewide and nationally. On a positive note, households that are led by single mothers are less likely to live in poverty than single-mother households throughout Tennessee and the U.S.

Roughly 31% of those living in Carroll County are employed in management, business or science and another 27.7% in production, transportation or material moving. Less than 1% take public transportation to work and the average travel time to their place of employment is 25.6 minutes. Education levels in Carroll County are less than what is seen statewide and nationally. Roughly 79% of area adults have a high school diploma or equivalent. This is below the statewide and U.S. rates (83.2% and 85.3% respectively). Nearly 17% in Carroll County have a bachelor's degree or higher, which is also below Tennessee (22.9%) and nation (28%).

**Median household income, Carroll County compared to Tennessee and U.S. (2010).**



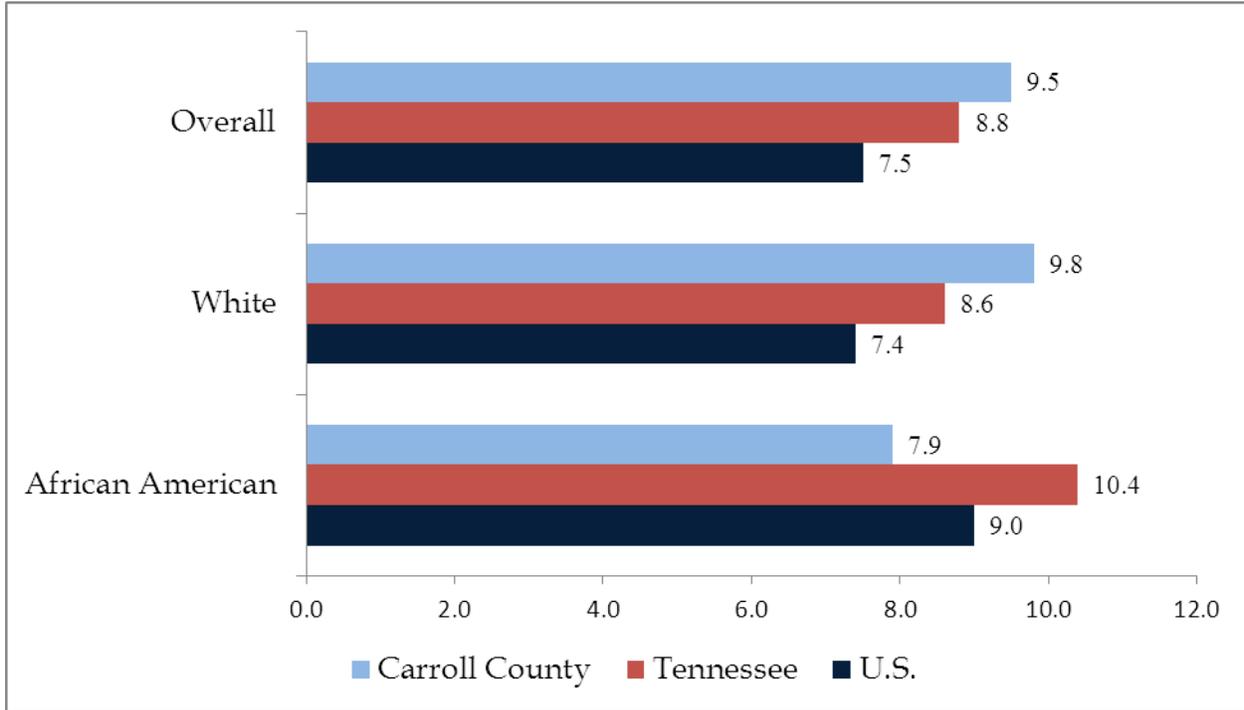
**Poverty Status of Families and People in the Past 12 Months (2010)**

	U.S.	Tennessee	Carroll County
All families	10.5%	12.7%	12.2%
With related children under 18 years	16.5%	20.0%	20.4%
With related children under 5 years only	17.9%	23.8%	24.0%
Married couple families	5.1%	6.4%	9.1%
With related children under 18 years	7.5%	9.0%	16.0%
With related children under 5 years only	6.8%	10.0%	14.6%
Families with female householder, no husband present	29.2%	34.1%	22.4%
With related children under 18 years	38.1%	43.5%	29.4%
With related children under 5 years only	46.1%	54.5%	54.3%
All people	14.4%	16.9%	18.3%
Under 18 years	20.1%	24.0%	21.1%
Related children under 18 years	19.7%	23.7%	21.1%
18 years and over	12.5%	14.7%	17.5%
65 years and over	9.4%	10.7%	13.9%
Unrelated individuals 15 years and over	25.4%	28.9%	37.8%

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

The overall age-adjusted **mortality rate** for Carroll County (9.5 per 1,000 population) exceeds the state rate (8.8) and U.S. rate (7.5). The death rate for Whites in the county exceeds African Americans, which is the inverse of what is seen throughout the country. The death rates for heart disease, malignant neoplasms (cancer), and chronic lower respiratory disease are all above the national rates.

**Age-adjusted mortality rates by race per 1,000 population, Carroll County compared to Tennessee and the U.S. (2009).**



**Infant mortality rates** for Carroll County are similar to Tennessee, but above the U.S. overall. The infant mortality rate for Carroll County is 8.6 per 1,000 live births compared to 8.2 for Tennessee and 6.5 for the U.S. While the infant mortality rates are above the benchmark data, the birth rates are lower than state and national figures. Countywide, there are 11.3 births per 1,000 population. That is below 12.5 for Tennessee and 13.0 for the U.S. Higher than typical low-birth-weight babies may be related to the elevated infant mortality rates. The percentage of low-birth weight babies in Carroll County is 8.4% compared to 9% for Tennessee and 8.2% nationwide.

**Infant Mortality Rates by Race (2006 – 2010, 5 - year averages)<sup>a</sup>**

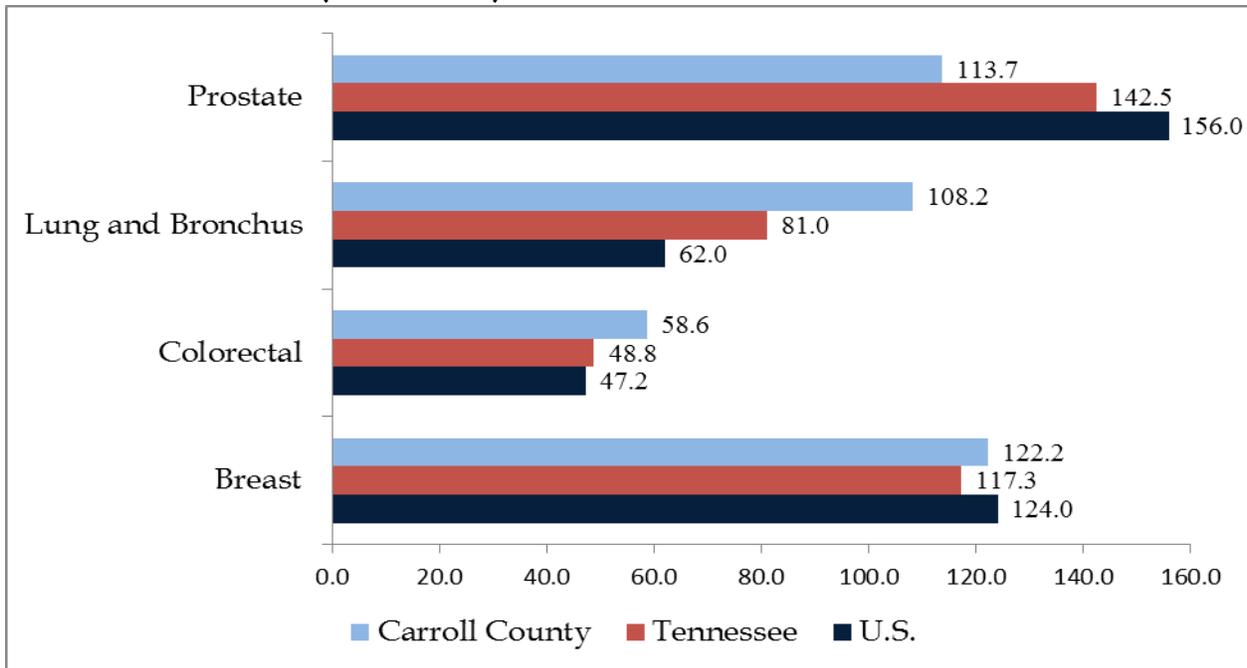
	U.S.	Tennessee	Carroll County
Infant	6.5	8.2	8.6
White	6.2	6.2	8.9
African American	13.1	15.6	6.2

Sources: Tennessee Department of Health, 2006 - 2010  
Centers for Disease Control and Prevention, 2006 – 2010; <sup>a</sup> Rate per 1,000 live births

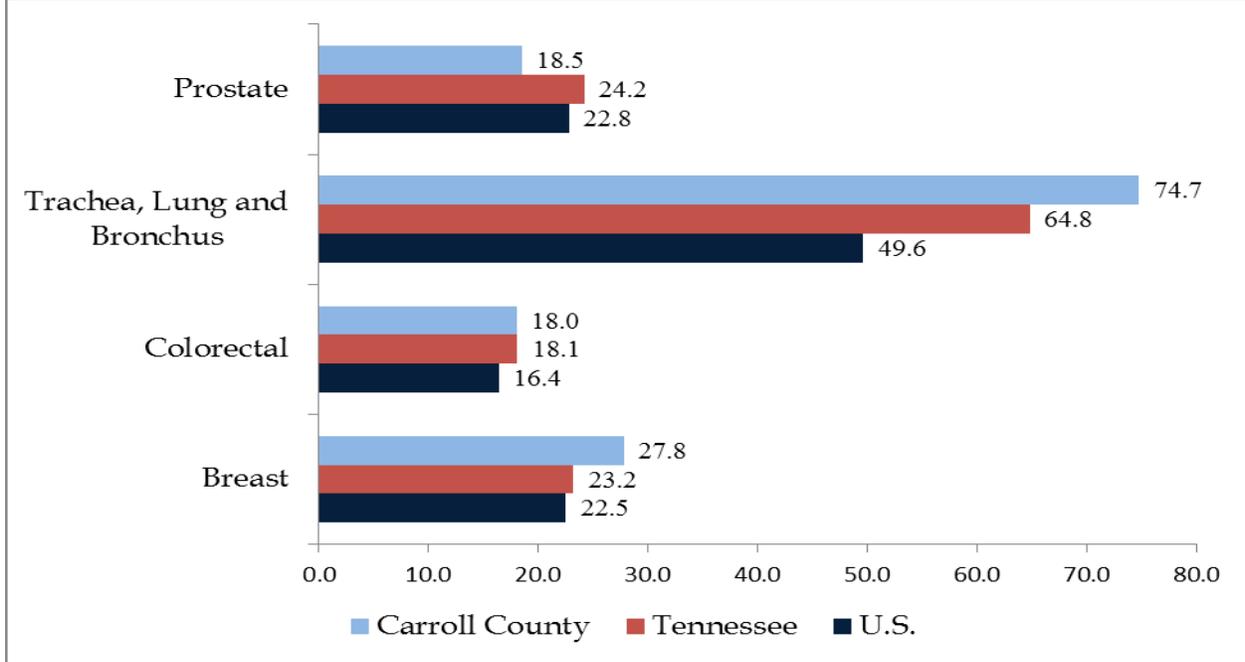
Overall **cancer** incidence rates are above Tennessee and U.S. rates. The overall incidence rate for all cancers in Carroll County is 529.8 per 100,000. Prostate cancer incidence is lower than the

state and national rates while lung cancer and colorectal cancer rates compare less favorably. Similar to the cancer incidence rates, the mortality rates for cancer do not compare positively to national rates. The age-adjusted mortality rate for cancer is 209.9 per 100,000 compared to 200.2 for Tennessee and 175.8 for the U.S. Specifically lung cancer death rates are higher for Carroll County. When looking at childhood cancer incidence, the numbers are relatively low (12 cases between 2004 and 2008), but the county rate (319.8) is above Tennessee (166.9) and the nation (169.0). The following graphs detail the overall cancer incidence and mortality rates.

**Cancer age-adjusted incidence rates per 100,000 population, Carroll County compared to Tennessee and the U.S. (2004 - 2008).**

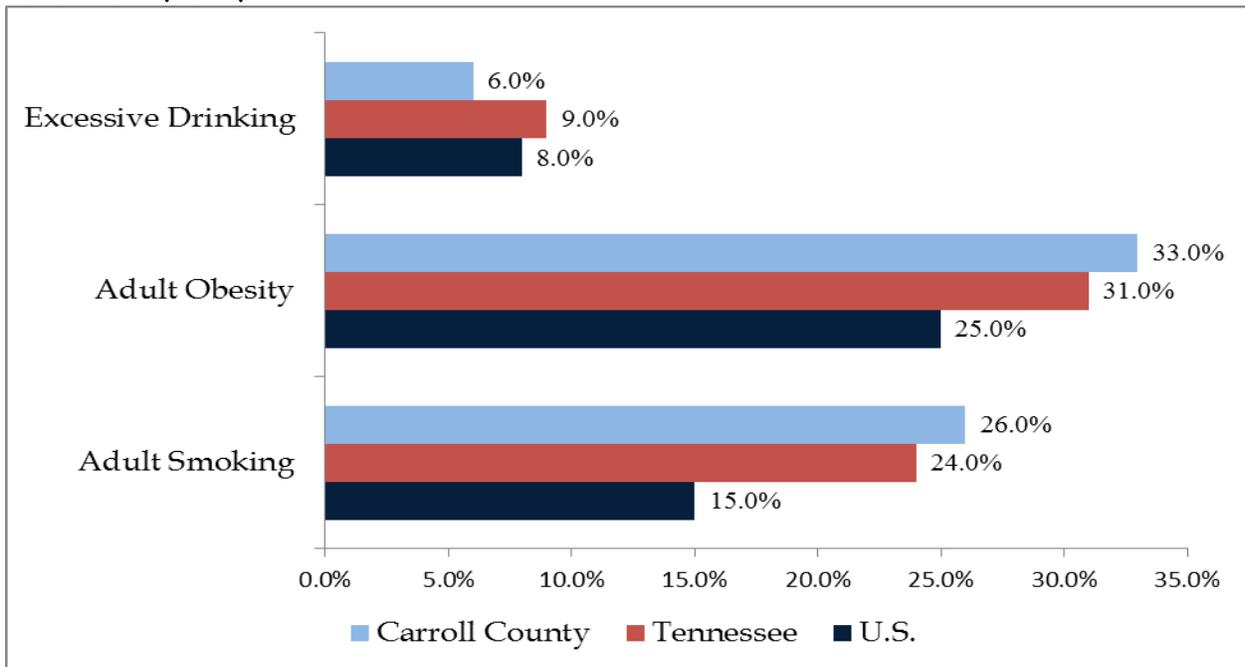


**Cancer age-adjusted mortality rates per 100,000 population, Carroll County compared to Tennessee and the U.S. (2009).**



**Health risk factors** such as smoking, excessive drinking and an unhealthy weight are all related to poorer health outcomes. The rates of alcohol use in Carroll County are slightly lower than state and national figures, but adult obesity and adult smoking percentages are higher than they are for Tennessee and the U.S. overall. These are detailed in the graph below. While a number of these risk factors are above state and national benchmarks, the number of primary care physicians in the county is below what is seen statewide and nationally. For every one primary care physician in Carroll County, there are 1,024 individuals. This compares to 837:1 for Tennessee and 631:1 for the U.S. per the County Health Rankings report. Carroll County also has less access to healthy foods and fewer recreational opportunities compared to statewide and nationally.

**Health behavior status percentages, Carroll County compared to Tennessee and the U.S. benchmark (2011).**



In closing, the secondary data points to some key opportunities within Carroll County. Between 2000 and 2010, the area saw a decrease in population while the rest of the country experienced growth. The proportion of older adults is greater in the county and income levels are lower than statewide and nationally. Mortality rates are above state and national rates and deaths due to heart disease, cancer, and chronic lower respiratory disease exceed state and national figures. Cancer incidence and mortality compare less favorably for Carroll County with the most dramatic statistics for lung cancer. County residents are also more likely to smoke cigarettes and be overweight or obese. On a positive note, single-mother households in the county are less likely to be living in poverty than similar households nationally. The area also has fewer communicable diseases and sexually transmitted illnesses.

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 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 TennCare. 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?**

<b>Factor</b>	<b>Number of Mentions</b>	<b>Percent of Respondents (%)</b>
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 does 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 Healthcare**

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.

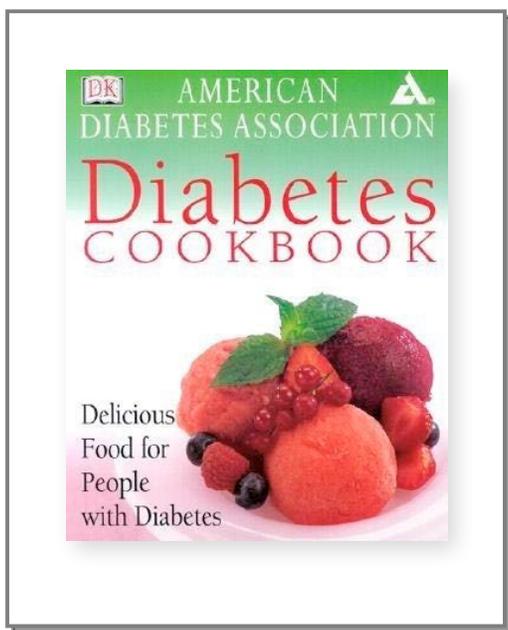
- Financial Assistance
- Food Assistance
- Transportation Assistance
- Patient Navigation Services
- Information & Referral Resources
- Prescription Assistance Programs
- Discounted Medical Supplies
- Oral Health Services
- Nutrition Counseling & Nutrition Programs
- Health Coaches
- Optometrists
- Endocrinologists
- 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-Huntingdon service area. The following list outlines the key needs that were identified.

- **Access to primary care:** The results are varied as it relates to access to care. Key informants spoke of the ongoing need for care for the uninsured and underinsured. Focus group participants shared that their insurance, or lack thereof, can interfere with obtaining needed medications and supplies (e.g. testing strips, etc.). Insurance co-pays are increasingly a deterrent for individuals. Relatively speaking, adults in the hospital's service area are just as likely as others to see cost as a barrier. The primary care provider statistics show that there are fewer primary care providers in Carroll County for every one individual. The resident to physician ratio throughout the state and country show higher provider rates.
- **Cancer (colorectal and lung):** Cancer incidence data from the Tennessee Department of Health show that colorectal cancer and lung cancer rates are higher in Carroll County compared to statewide and nationally. Not only do incidence rates differ, but so do mortality rates for lung cancer. The household survey also revealed a higher proportion of regular smokers. Key professionals that were surveyed also identified cancer as one of the top health concerns.
- **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 Tennessee and 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.
- **General health:** Several measures from the assessment evaluated overall indicators of the community's health. The household survey had fewer adults reporting "excellent" health and the overall mortality rate for the county shows that adults are dying at a faster rate locally than is typically seen. All of these factors are adjusted for age and therefore represent the overall adult population in the county.
- **Heart disease:** The county mortality rate for heart disease is above the state and national rate. Additionally, the household survey revealed a higher number of individuals who reported having a heart attack and more adults with a diagnosis of heart disease. The key informants also prioritized heart disease as one of the primary community health concerns among area adults.
- **Mortality rates (adults and infants):** The overall age-adjusted death rate for Carroll County exceeds state and national rates. This holds true for all ages as well as infants. Death rates for heart disease, cancers and chronic lower respiratory disease in Carroll County are higher than the state and national averages.

- **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. Access to healthy foods is limited in the county when compared to Tennessee overall and area adults are less likely to exercise in a typical month. Primary reasons for not exercising include limitations due to illness or disability as well as simply being too busy to exercise. 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.
- **Smoking:** Lung cancer incidence rates and mortality rates are much higher in Carroll County than statewide and nationally. The household survey also revealed that the percentage of “every day” smokers locally is above what is seen nationally. Chewing tobacco rates for the hospital’s service area exceed state and national rates.
- **Social determinants of health:** The demographics for Carroll County do not reflect favorably when compared to Tennessee and U.S. averages. Unlike increases that were seen nationally and statewide between 2000 and 2010, the population in Carroll County declined. The percent of seniors in the county is higher than the percent for Tennessee and the U.S. Additionally, average home values, income levels and education levels are lower than state and national benchmarks. These indicators are often referred to as social determinants of health as many studies have linked factors such as income and education to health status and outcomes.

## 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 | ➤ Senior Health                     |
| ➤ Access to Care                       | ➤ Services for Disabled Individuals |
| ➤ Cardiovascular Health                | ➤ Mental Health                     |
| ➤ Diabetes                             | ➤ Substance/Alcohol Abuse           |
| ➤ Maternal and Women's Health          | ➤ Alzheimer's Disease               |
| ➤ Cancer                               | ➤ Stress                            |
| ➤ Smoking                              | ➤ Health Literacy                   |
| ➤ Respiratory Disease                  | ➤ Nutrition                         |
| ➤ Suicide                              | ➤ Physical Activity                 |
| ➤ Caregiver Needs                      | ➤ Domestic Violence/Child Abuse     |
| ➤ Palliative Care                      | ➤ 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 community health issues:

- 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 (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-Huntingdon 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-Huntingdon 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-Huntingdon 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-Huntingdon 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-Huntingdon 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.