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-Booneville in northeast Mississippi joined Baptist Memorial Health Care in 1982. It was the first of the regional hospitals to establish, in conjunction with the Baptist Memorial Health Care Foundation, an endowment fund to help recruit and educate physicians, and has continued to aggressively pursue better medical care for its patients.

As part of the Baptist Memorial Health Care System, Baptist Memorial Hospital-Booneville has made many additions and improvements - all with the community in mind. They include an emergency room, a third floor patient wing and geriatric psychiatric services. These additions and new services, combined with a growing medical staff and caring employees help ensure that Baptist Memorial Hospital-Booneville is prepared to care for its community.

Definition of Service Area

Baptist Memorial Hospital-Booneville serves residents in northeast Mississippi. For the purposes of the CHNA, the hospital focused on its primary service area of Prentiss County, Mississippi. The following zip codes were included in the household study:

38824	38829	38856	38859

CHNA Background

Baptist Memorial Hospital-Booneville, 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-Booneville 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-Booneville 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-Booneville is committed to the people it serves and the communities they live in. Through this process, the hospital will be a stronger partner in the community and the health of those in the surrounding neighborhoods will be elevated. Healthy communities lead to lower health care costs, robust community partnerships, and an overall enhanced quality of life.

Research Partner

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

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

Research Methodology

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

A statistical household survey was completed with 533 adults from the Baptist Memorial Hospital-Booneville 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, health care consumers from the hospitals' service areas participated in focus groups. The focus groups addressed diabetes and pre-diabetes based on findings from household surveys. Discussion topics included health knowledge, self-care behaviors, health care access, communication preferences, and desired support services. A discussion guide, developed in consultation with Baptist Memorial Health Care, was used to prompt discussion and guide the

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

Community Representation

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

Research Limitations

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

Prioritization of Needs

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

Documentation

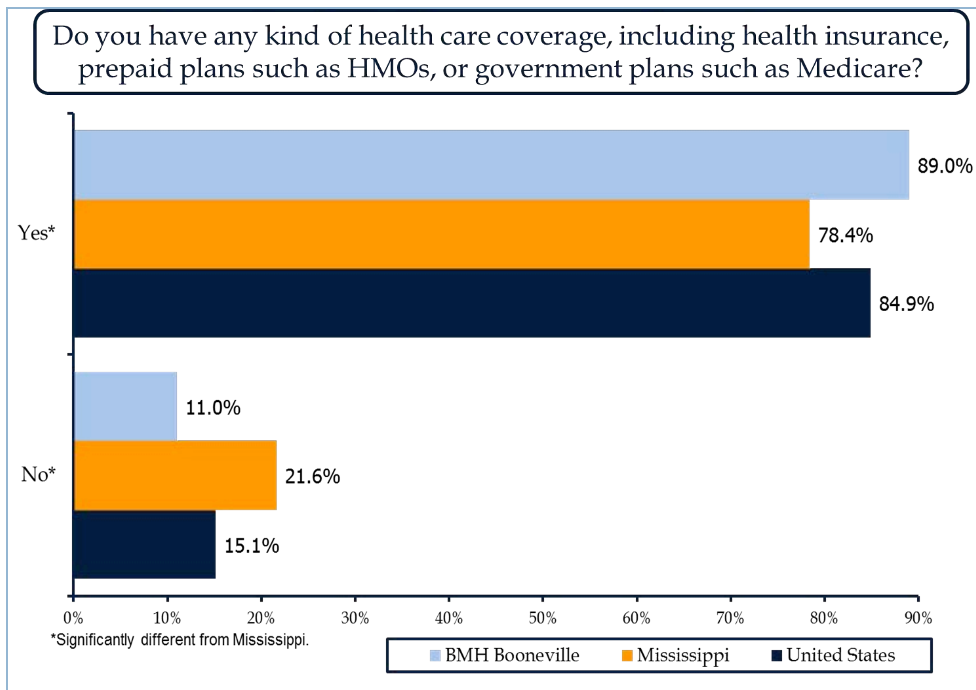
A report of the CHNA was made public on the hospital's website in September 2013. The Final Report serves as a compilation of the overall key findings of the CHNA. Detailed reports for each individual component were provided separately. An Implementation Strategy of how the hospital will address the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

KEY ASSESSMENT FINDINGS

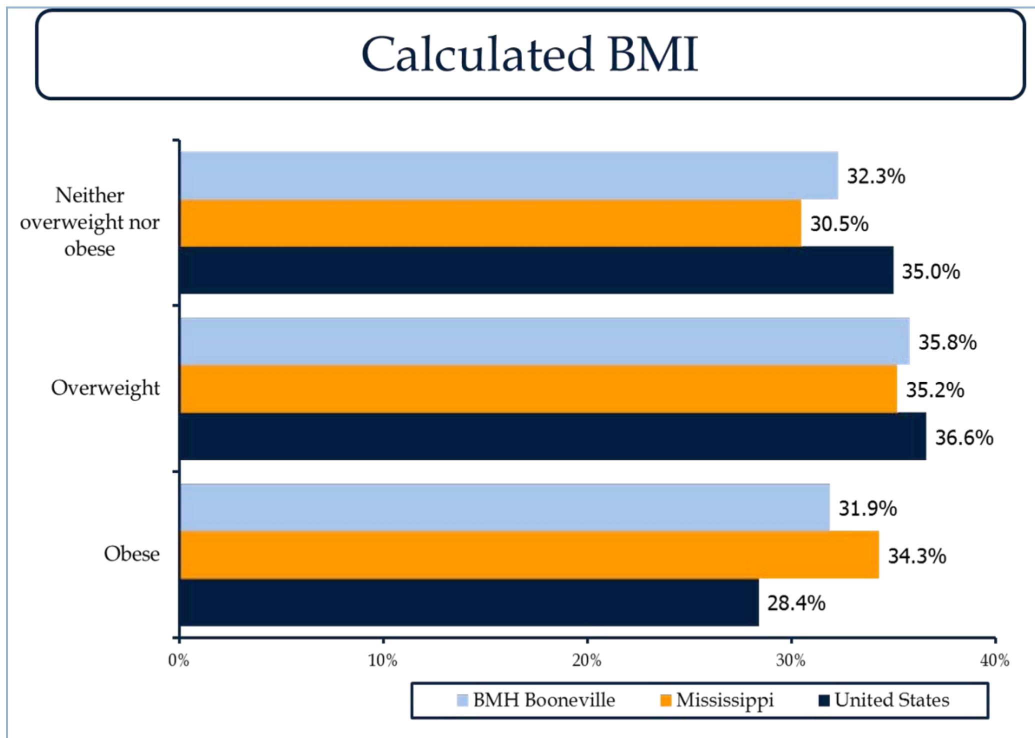
Household Survey Key Findings

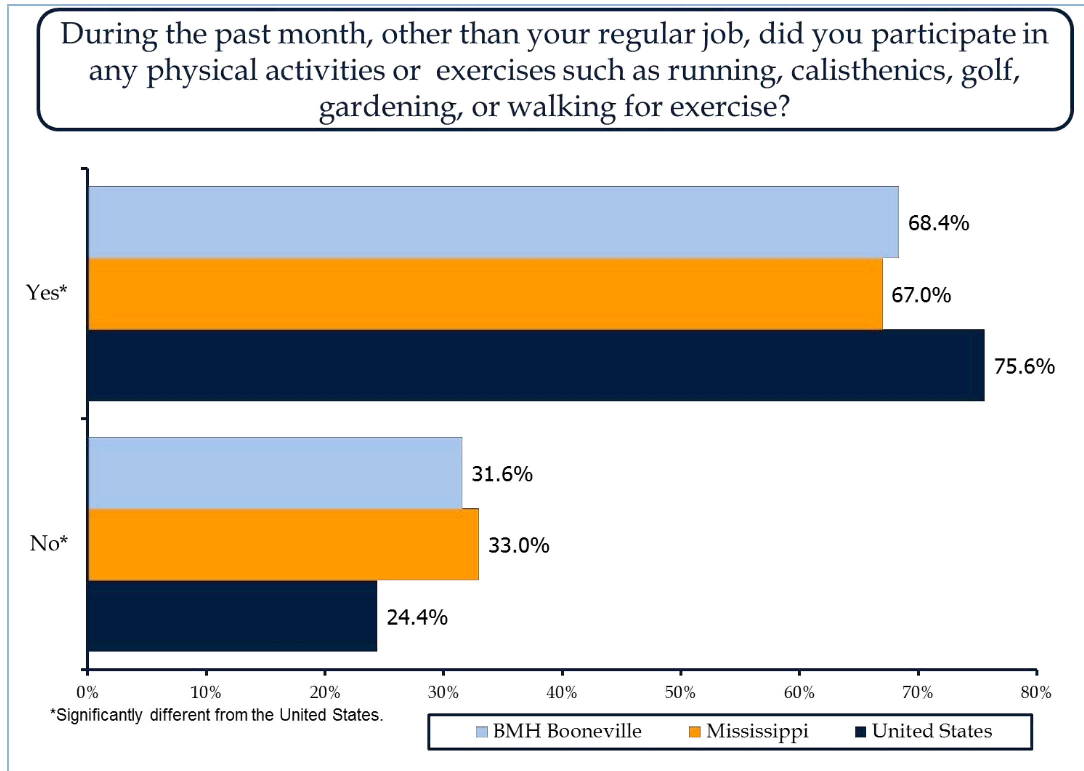
A household survey of the Baptist Memorial Hospital-Booneville service area included 533 randomly selected adults. The respondents were asked to rate their own health status, to provide information on behaviors and prevention activities, and to report the incidence of a variety of chronic illnesses such as diabetes and cardiovascular disease. When asked to rate their **general health**, 68.9% responded "good," "very good," or "excellent." Responses were less favorable than the benchmarks of Mississippi (76.3%) and the U.S. (83.6%). Area residents were also more likely to report more days of poor physical health in an average month. Ratings of poor mental health, on the other hand, were more favorable than the state and national benchmarks. Mental health ratings were poorer among Whites than African Americans in the hospital's service area. Males were more likely to report at least one day of poor mental health compared to area females (29.1% vs. 23.6%).

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. Eighty-nine percent (89%) of those surveyed reported that they have some form of health insurance. This compares to 78.4% statewide and 84.9% nationally. When asked if they have someone they think of as their regular doctor or health care provider, 85.2% said "yes;" a higher response than Mississippi (79.7%) and the U.S. (81.8%). There were no gender differences with regard to insurance coverage, but area Whites were more likely to be insured than area African Americans (89.6% vs. 84%). Around 14% of area adults reported that at some point in the past year, cost kept them from seeing a doctor, similar to the U.S., but better than Mississippi.

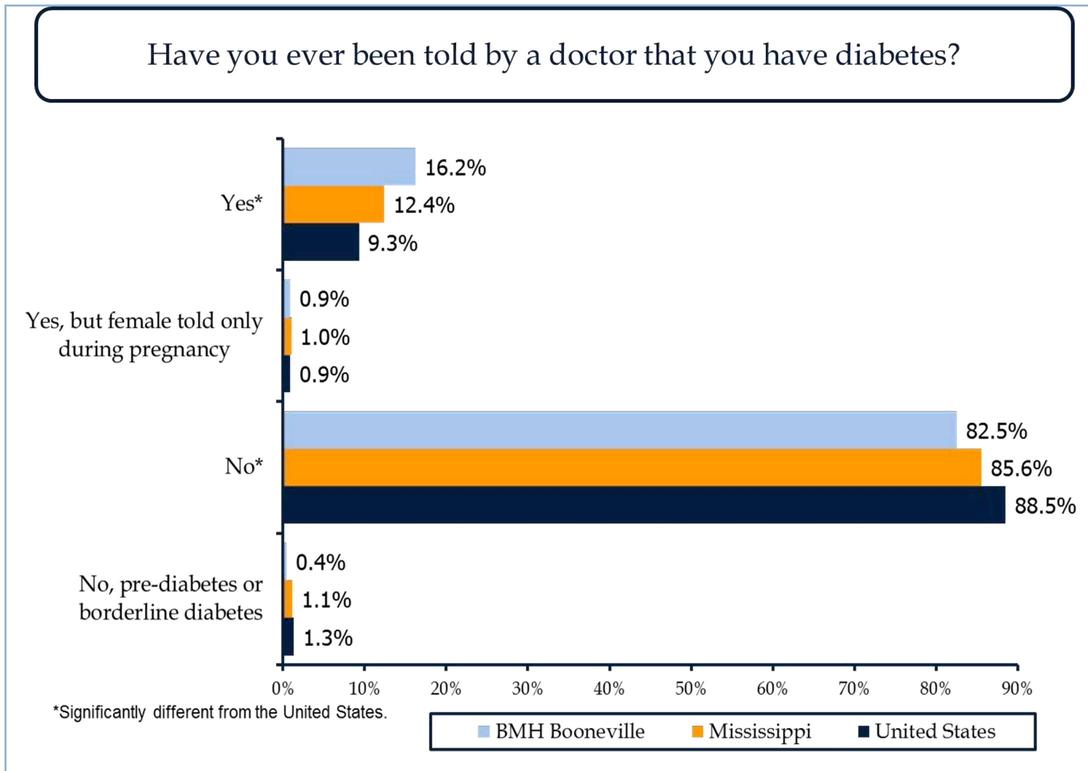


Weight and nutrition were assessed as well. **BMI (Body Mass Index)** was calculated for each survey respondent based on their reported height and weight. As shown in the graph below, approximately 31.9% of area adults are obese. An additional 35.8% are overweight. Area residents are similar to Mississippi in their likelihood of being overweight or obese, but compare less favorably to National statistics. When asked if they exercised in the previous month, 68.4% indicated they had. This is similar to the 67% for Mississippi, but below the U.S. percent (75.6%). While the majority of area residents are overweight or obese (67.7%), only 22% indicated that their doctor or health care provider told them that they were overweight. Interestingly, African American residents were more likely to report being told this by their health care provider than White residents (36.7% vs. 19.6%).



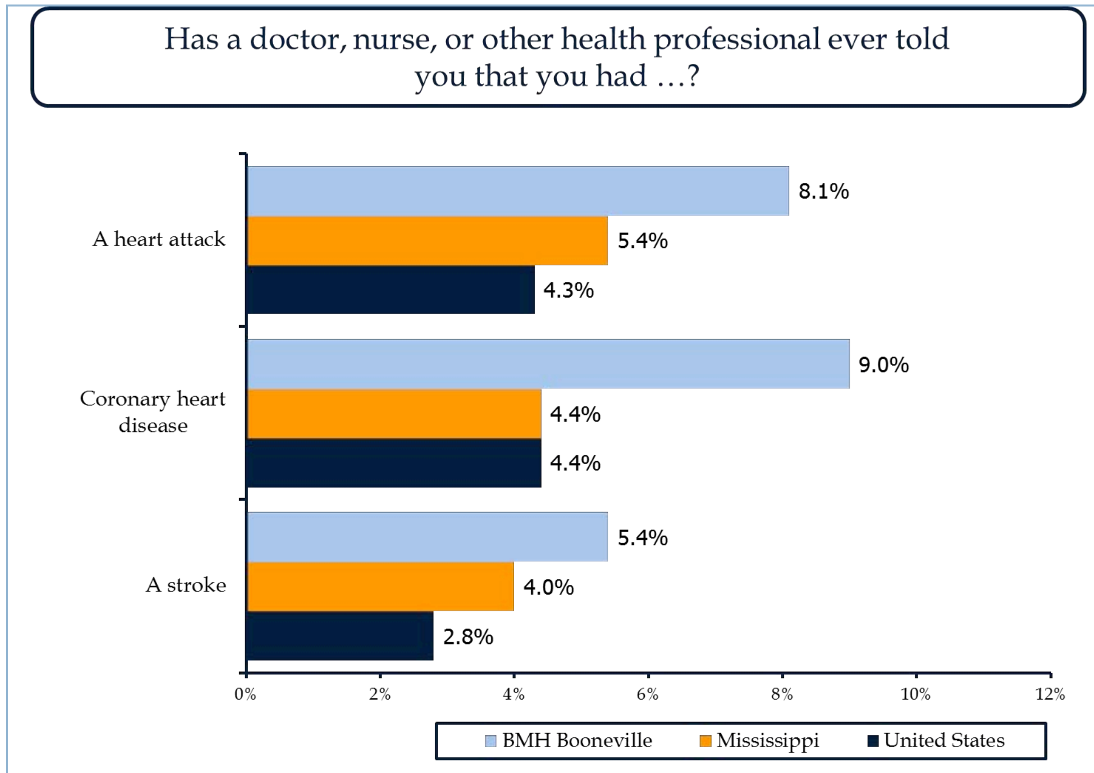


Closely linked to overweight and obesity is the incidence of **diabetes**. Roughly 16% of the survey respondents reported being told by a doctor that they have diabetes. This is above Mississippi (12.4%) as well as the Nation (9.3%). When asked about a family history, half of the respondents (49.9%) indicated that they have a family member with diabetes. Fewer individuals with diabetes reported that they have taken a course or class in how to manage their diabetes. Nearly 41% of local diabetics have taken a class, fewer than throughout Mississippi (44.2%) and also lower than throughout the U.S. (54.8%). Around 20% of African American residents reported having diabetes compared to 14% of White residents. Males and females did not significantly differ in their incidence of diabetes.

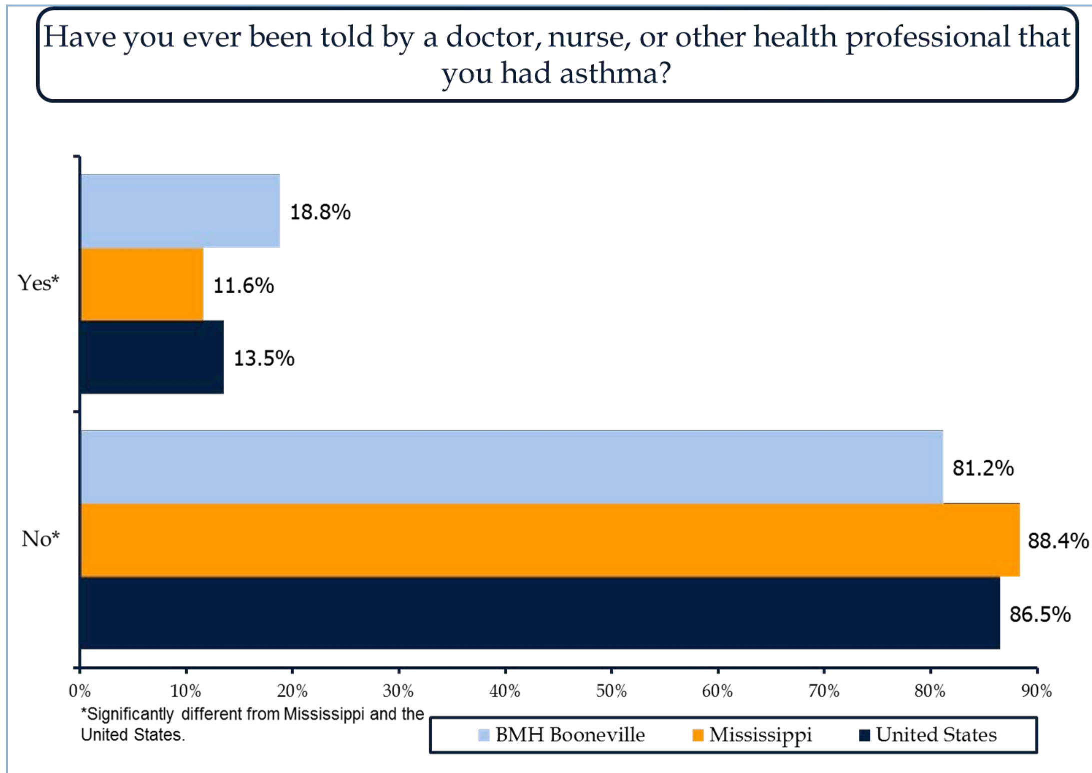


The survey assessed **oral health** as well. Around 58% of those surveyed stated that they have had at least one tooth pulled because of gum disease or tooth decay. This is similar to Mississippi (56.1%), but above the U.S. percentage (45.5%).

Cardiovascular disease was assessed through questions about heart attacks, heart disease, and stroke. As detailed in the next graph, the incidence of heart disease and likelihood of having had a heart attack or stroke is higher locally than statewide and nationally. Around 56% of area adults locally indicated that they also have a family history of heart disease. Heart attacks and heart disease rates were also higher among White residents locally than African American residents. There were no significant differences for stroke.

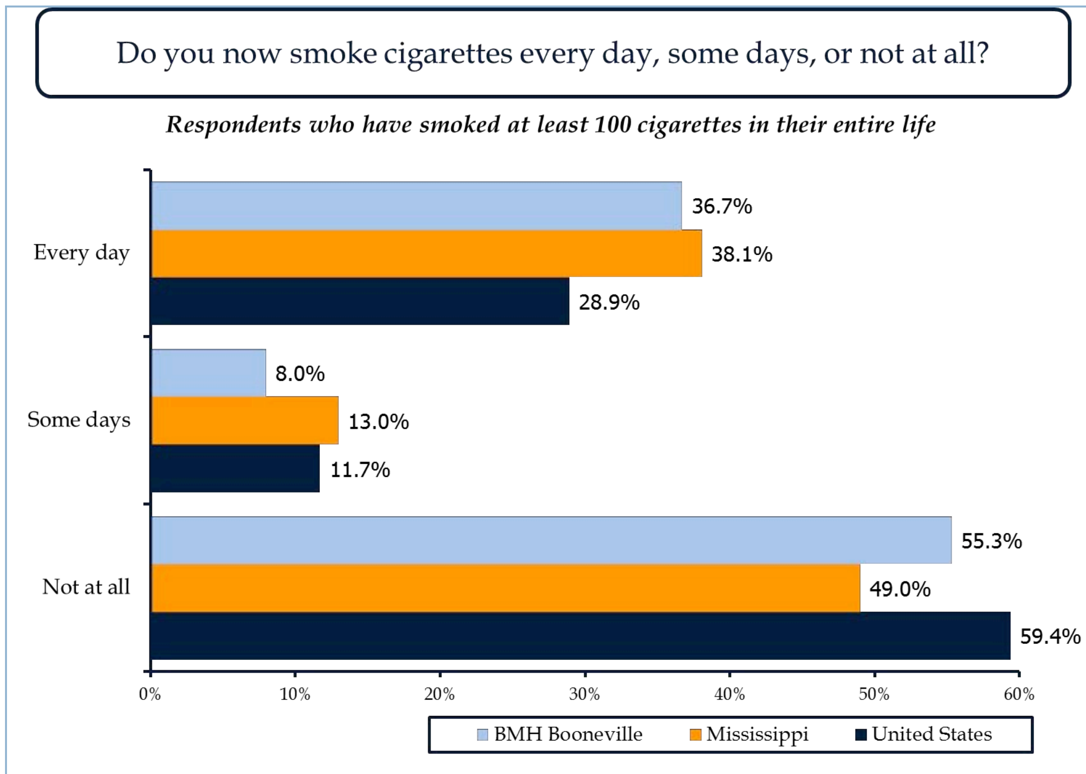


Asthma rates are also higher among adults in the hospital service area. Nearly 19% reported having asthma in their lifetime and within that group, 71.6% still have asthma. These figures exceed statewide and national percentages. When asked about the age of onset for the asthma, local residents are more likely than others to have been diagnosed at age 10 or younger. On a positive note, those locally with asthma are less likely than those statewide or nationally to have had an asthma attack in the past year. African American residents are more likely to have had asthma in their lifetime than White residents (21.4% vs. 18.3%).



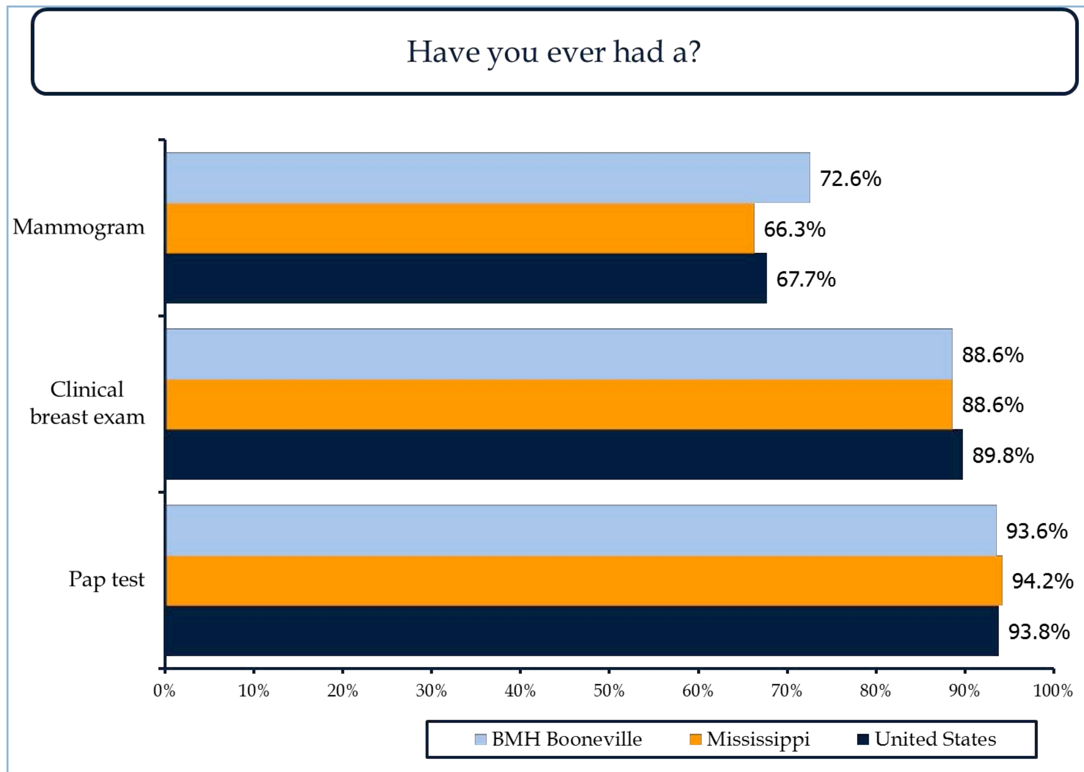
Disability was assessed through questions regarding limitations and special equipment needs. Roughly 31% of the survey respondents reported being limited in some way because of physical, mental or emotional problems. This is above the statewide percentage (25.3%) and the U.S. percentage (20.8%). Additionally, 15% 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. Nearly 43% of those surveyed stated that they have smoked at least 100 cigarettes in their lifetime. This is statistically similar to Mississippi overall (45%) and the U.S. (42%). Among those who have smoked 100 cigarettes, less than half (44.7%) now smoke some days or every day. In general, adults locally are less likely to currently smoke than adults throughout Mississippi. Area males were significantly more likely to have smoked at least 100 cigarettes than area females (48.7% vs. 35.6%). White respondents also reported higher rates of smoking than African Americans.

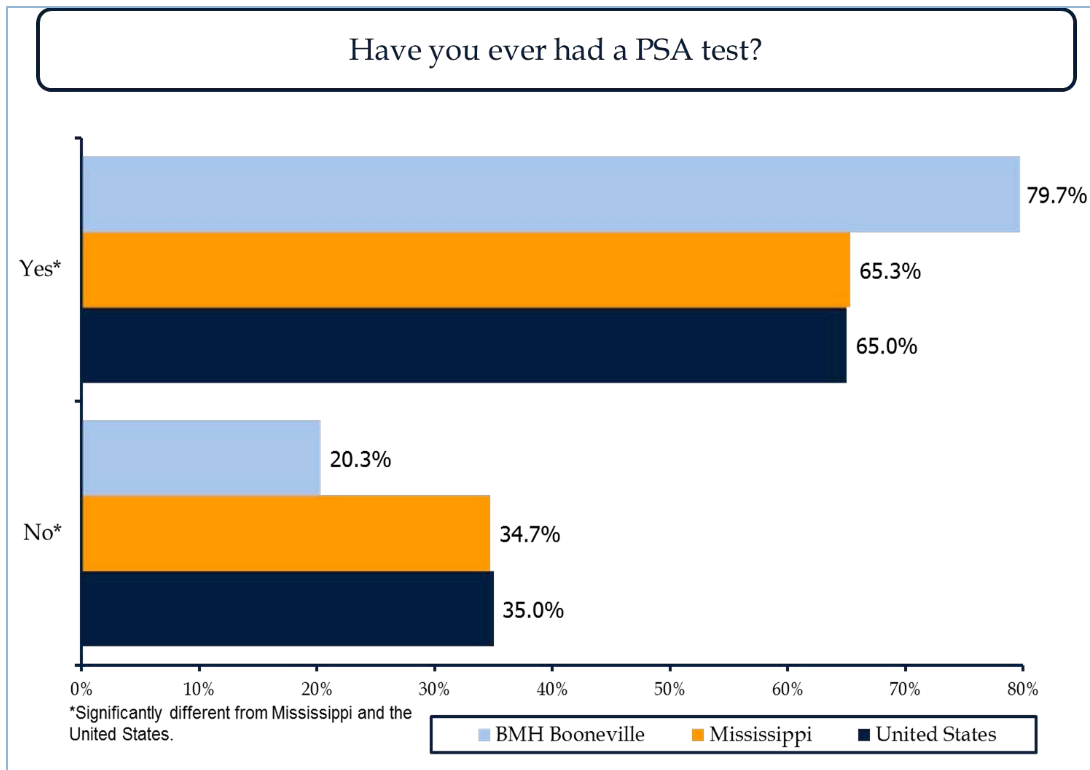


Seat belt use is a concern for local adults compared to adults nationwide. Adults in the hospital service area are less likely than adults nationwide to always wear a seatbelt. Nearly 81% always wear a seatbelt, which is similar to Mississippi (80.6%), but lower than throughout the U.S. (86.6%).

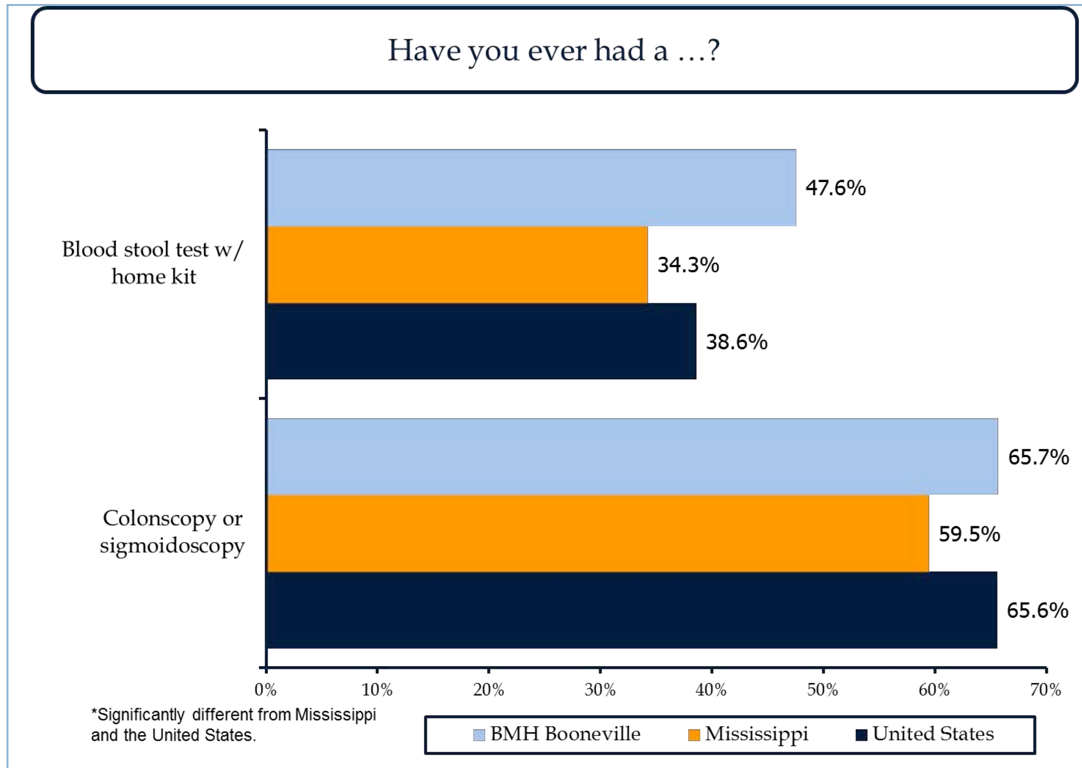
Female respondents were asked a variety of **women's health** questions. The vast majority of females that were surveyed locally have had a mammogram at some point in their lifetime (72.6%). This is above the percentage throughout Mississippi (66.3%) and the U.S. (67.7%). Rates for clinical breast exams 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 locally to have had a mammogram (83.2% vs. 69.1%) and to have had a clinical breast exam (91.3% vs. 87.7%). No racial differences were noted with respect to Pap tests.



Tests for **prostate cancer** include Prostate Specific Antigen (PSA) tests and digital rectal exams. These questions were asked of area males 40 and older. Approximately 80% of the males in this age range have had a PSA test, which is above Mississippi (65.3%) and the U.S. (65%). A smaller percentage of males have had a digital rectal exam. Locally, 75.3% 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, 2.3% of males in this age group indicated that they have. This is slightly lower than the state (4.7%) and national (4.3%) percentages for prostate cancer. White males were more likely to have had a PSA test than African American males (80.9% vs. 75%), but were less likely to have had a digital rectal exam (72.4% vs. 89.3%).



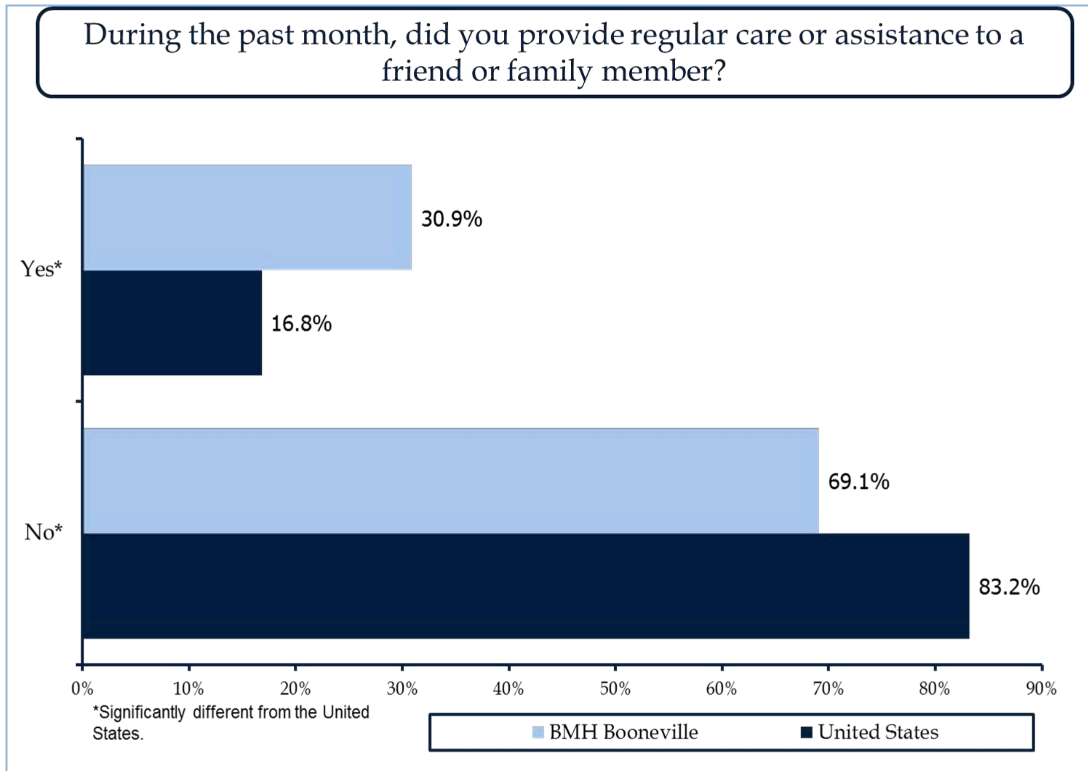
Colorectal cancer screening questions were included in the survey as well. Around 48% of adults 50 and older have had a blood stool test using a home kit, which is above the percentage statewide (34.3%) and nationally (38.6%). A higher percentage also reported having had a colonoscopy or sigmoidoscopy. Around 66% of adults 50 and older have had a sigmoidoscopy or colonoscopy, above the 59.5% throughout Mississippi and similar to the 65.6% throughout the U.S. African American residents were less likely to have had a colonoscopy or sigmoidoscopy than Whites locally (52.9% vs. 65.4%).



Eleven percent (11%) 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 colon, breast, and non-melanoma skin cancer. More White respondents in the area reported having had cancer at some point in their lifetime than African American respondents (10.8% vs. 6.3%).

Arthritis was reported by 39.7% of area adults. This is above 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 (38% vs. 46.3%).

Caregiving is increasingly an issue throughout the country as the number of older adults continues to grow. Nearly 31% of those surveyed reported that they provide regular care or assistance to a friend or family member. This is well above the figure nationwide (16.8%). The largest proportion (60.2%) takes care of someone who is 65 years or older. In the hospital service area, females and Whites are more likely to provide caregiving to a friend or family member.



In summary, the household survey results reveal a number of areas of opportunity throughout the hospital's service area, as well as some areas of strengths. Area adults reported a lower general health status compared to state and national figures, but more favorable levels of mental health. Local statistics are less healthy for obesity, diabetes, and cardiovascular disease (heart attacks, stroke). The rate of uninsured individuals in the hospital's service area is more favorable than what is seen nationally and throughout Mississippi. In addition, area adults are more likely to obtain certain preventive screenings such as mammograms, PSA tests, and blood stool tests.

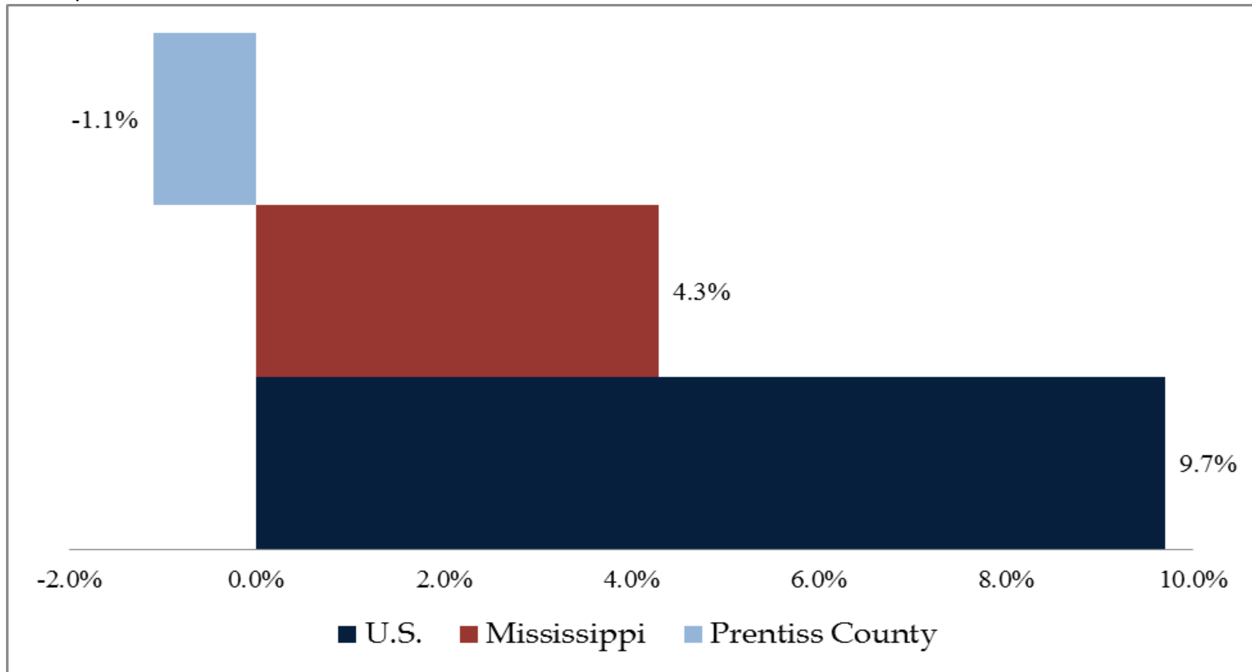
The household survey results were correlated with secondary data statistics and the qualitative research to determine key community health needs across all research components.

Secondary Data Key Findings

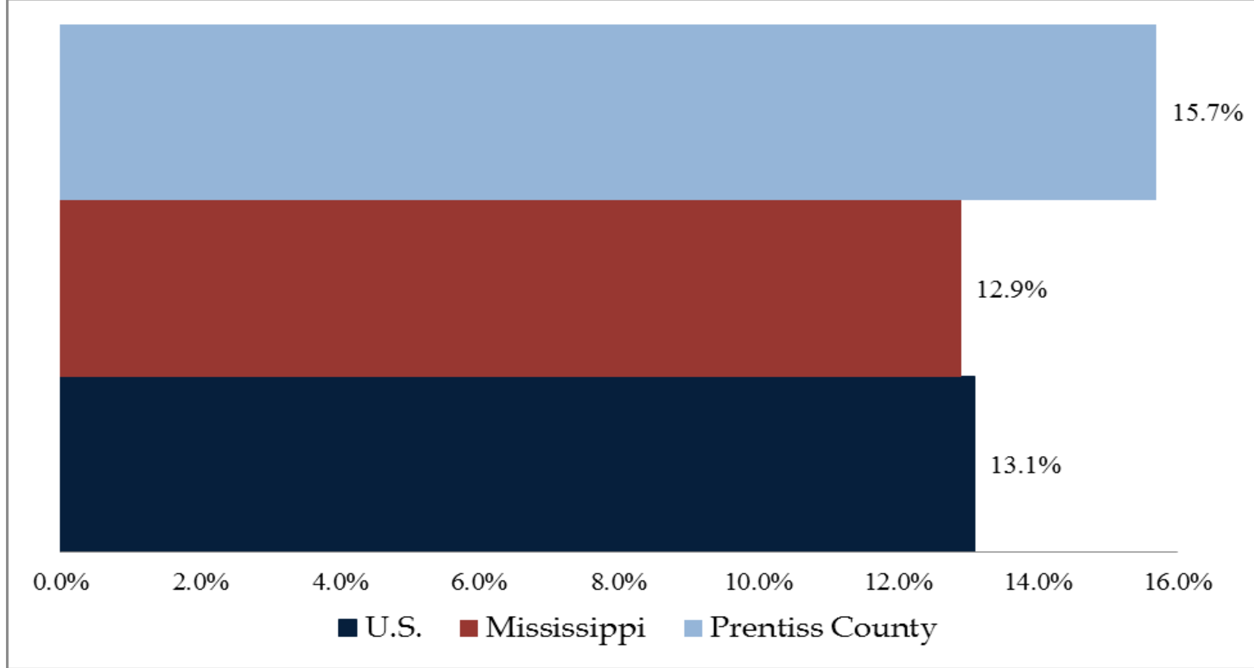
A number of data points were gathered to lend insight into the demographics, quality of life, and morbidity and mortality figures for Prentiss County, Mississippi, the home county for Baptist Memorial Hospital-Booneville. A summary of the key findings is outlined below. All county data points were compared to state and national benchmarks and were evaluated as being favorable or unfavorable to the 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, Prentiss County saw a 1.1% decrease in its population while the rest of the country had population growth. The proportion of seniors living in the county is higher than what is seen statewide and nationally. Nearly 16% of area residents are 65 or older compared to 12.9% statewide and 13.1% throughout the country. Around 84% of the county is White, 13.8% African American, and 1.2% are of Hispanic or Latino descent.

Population percentage change, Prentiss County compared to Mississippi and U.S. (2000 – 2010).



Percent of population aged 65 years and over, Prentiss County compared to Mississippi and U.S. (2010).



Household statistics reveal a higher proportion of individuals who own their homes as opposed to rent (74.4% vs. 25.6%). The number of households with females 65 and older is higher than what is seen statewide and nationally. Median home values are below Mississippi and U.S. median values.

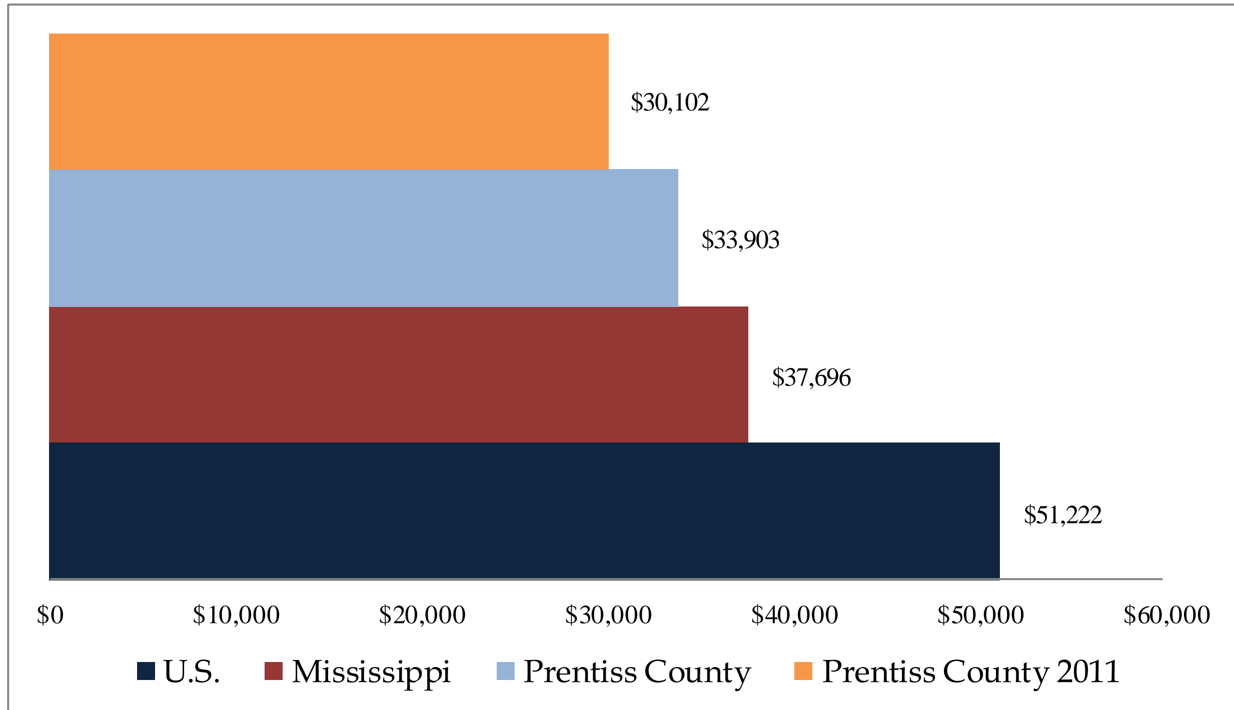
Households by Occupancy, Type, and Value (2010)

	U.S.		Mississippi		Prentiss County	
Occupancy (2010 U.S. Census)	n	%	n	%	n	%
Occupied housing units	116,716,292	88.6	1,115,768	87.5	9,812	88.8
Owner-occupied	75,986,074	65.1	777,073	69.6	7,296	74.4
Renter-occupied	40,730,218	34.9	338,695	30.4	2,516	25.6
Household Type (2010 U.S. Census)	n	%	n	%	n	%
Family households	77,538,296	66.4	770,266	69.0	6,915	70.5
Husband-wife families	56,510,377	48.4	506,633	45.4	5,020	51.2
Value for Owner-Occupied Units (2008-2010 ACS estimates)	n	%	n	%	n	%
Median value (dollars)	187,500		99,800		73,600	

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

Household **income** levels in Prentiss County are below Mississippi and the U.S. overall. The median household income in the area is roughly $33,000. This compares to $37,000 statewide and $51,000 for the U.S. overall. The median family income in the county ($45,696) is again below the national figure ($62,112), but is similar to Mississippi's family income ($46,746). Countywide, poverty rates are higher than national rates and similar to or higher than rates throughout Mississippi.

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



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

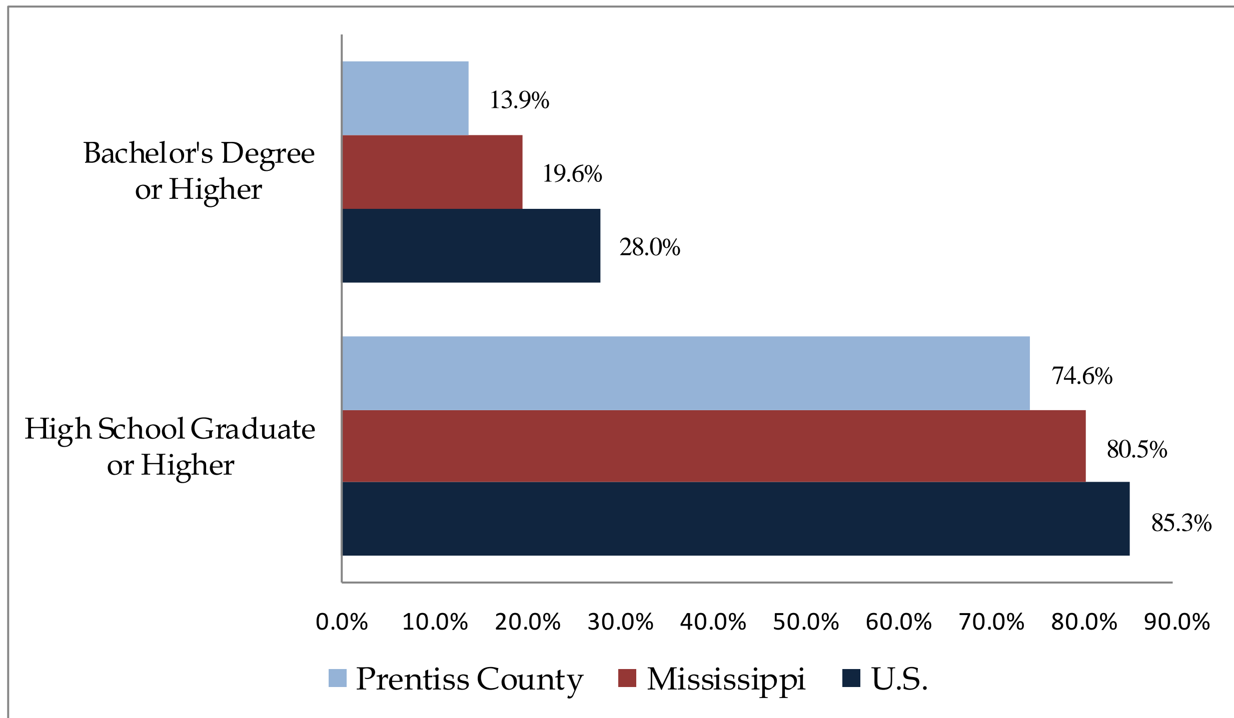
	U.S.	Mississippi	Prentiss County
All families	10.5%	17.2%	16.4%
With related children under 18 years	16.5%	25.9%	22.4%
With related children under 5 years only	17.9%	27.0%	42.0%
Married couple families	5.1%	7.1%	11.1%
Families with female householder, no husband present	29.2%	41.7%	29.3%
All people	14.4%	21.8%	20.9%
Under 18 years	20.1%	31.6%	25.7%
Related children under 18 years	19.7%	31.3%	26.0%
18 years and over	12.5%	18.4%	19.4%
65 years and over	9.4%	14.7%	23.1%

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

Around 57% of county residents 16 years of age and older are in the labor force; this is below both Mississippi (59.6%) and the U.S. (65.1%). A larger proportion of employees locally are in the production, transportation, and material moving industry.

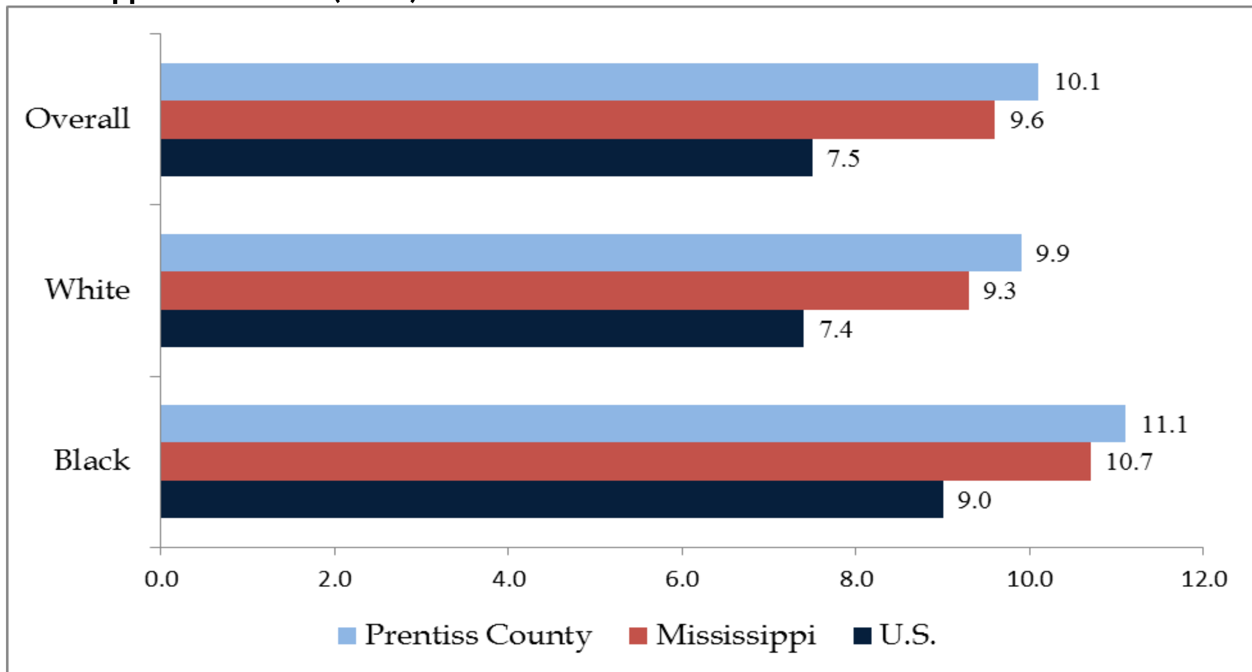
It is estimated that around 17% of residents in the hospital's service area are uninsured, which compares similarly to 17.7% for Mississippi, but above 15% nationwide. The educational attainment in the county is below what is seen throughout the state and U.S. As depicted below, the proportion those who have at least a high school diploma and the percentage with a college degree is lower than nation levels.

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



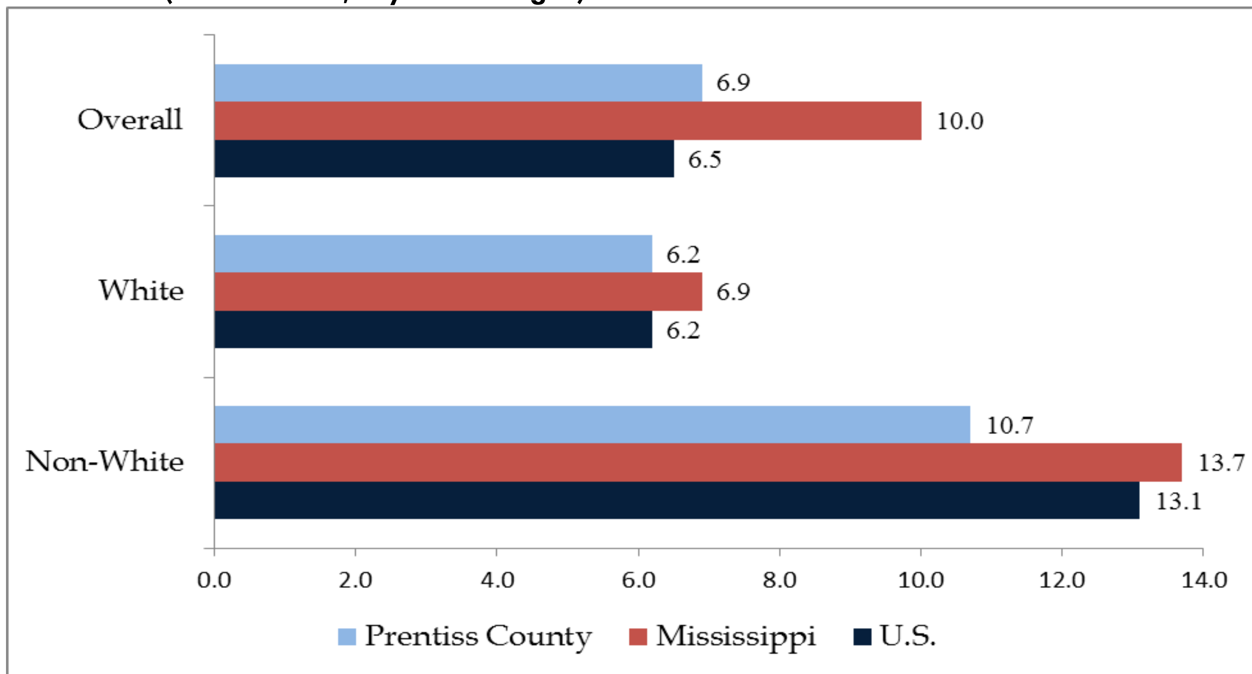
The overall age-adjusted **mortality rate** for Prentiss County is 10.1 per 1,000 population. This rate exceeds the state rate (9.6) and the U.S. rate (7.5). An examination of mortality rates by race reveals a disparity in the rate of death. Locally, African Americans have a higher death rate than Whites (11.1 vs. 9.9). Mortality rates for most of the leading causes of death are all higher locally when compared to national rates. This includes deaths due to heart disease, stroke, chronic lower respiratory disease, and accidents.

Age-adjusted mortality rates by race per 1,000 population, Prentiss County compared to Mississippi and the U.S. (2010).



The county's **infant mortality rate** is similar to the national rate, but less than the rate throughout Mississippi. While the infant mortality rates in the county are higher among Non-Whites than Whites, both rates are below their peers statewide and for Non-Whites, below nationally as well. Often related to infant mortality is low birth weight. The percent of infants locally born at a low birth weight is 10.1%, which is lower than Mississippi (12.1%), but higher than what is seen nationally (8.2%). When looking at low birth weight statistics by race, the frequency among Whites is actually higher than among African Americans locally. Birth rates among teens in Prentiss County are higher than what is seen among teens throughout the U.S. and Mississippi. Prenatal care in the first trimester is just as high among White mothers locally as among White mothers nationally. African American mothers in the hospital's service area are more likely than African American mothers statewide and nationally to have prenatal care in the first trimester.

Infant mortality rates by race per 1,000 population, Prentiss County compared to Mississippi and the U.S. (2006 – 2010, 5-year averages).



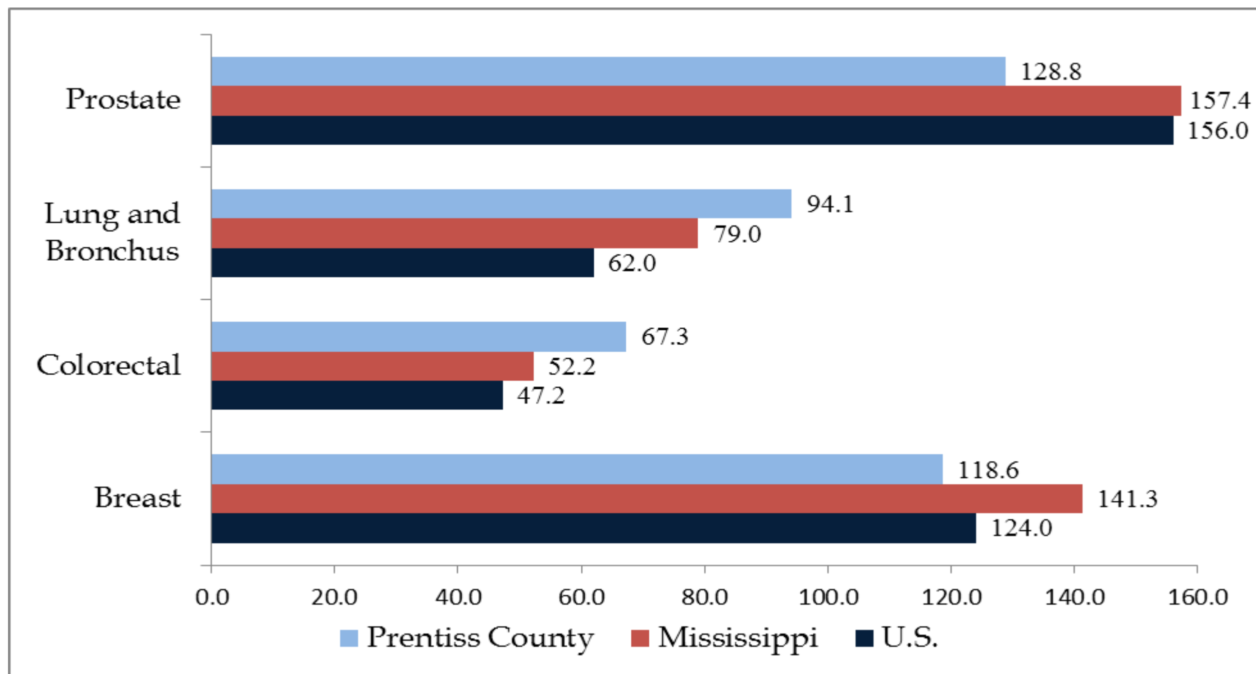
Birth Weight by Race (2010)

	U.S.[a]		Mississippi		Prentiss County	
	Number	%[b]	Number	%[b]	Number	%[b]
Low birth weight	336,747	8.2	4,847	12.1	35	10.1
White	158,954	7.2	1,828	8.4	29	9.8
African American	82,861	13.6	2,941	16.8	6	11.8

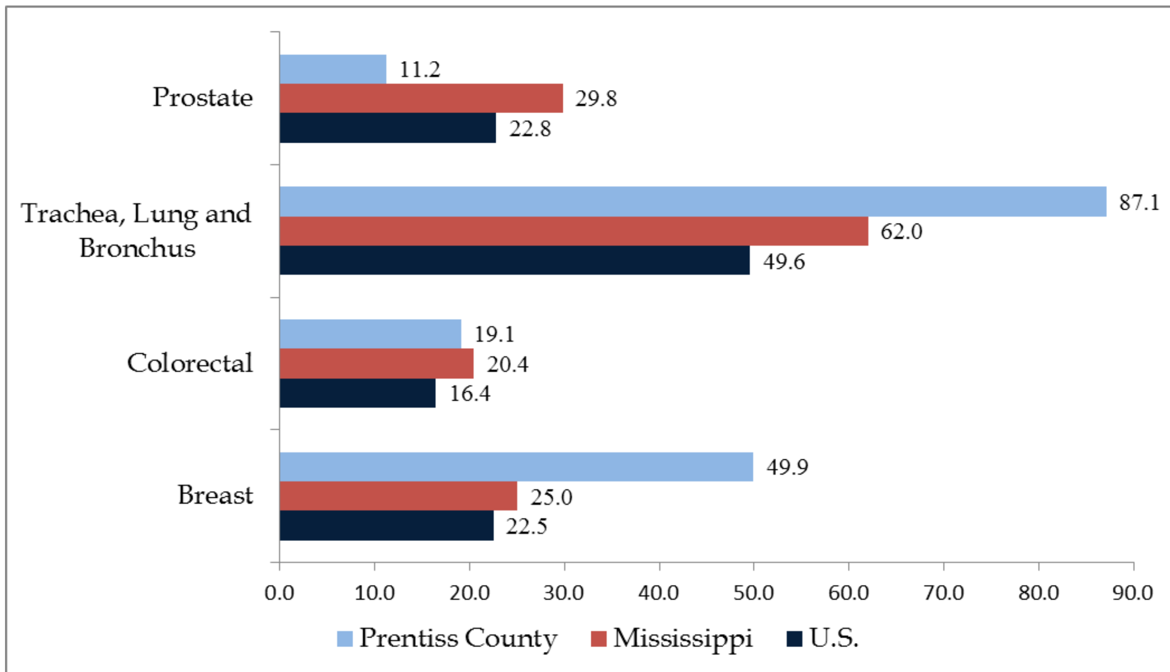
Sources: Mississippi Department of Health, 2010
Centers for Disease Control and Prevention, 2009
[a] Statistics are based on 2009 data; [b] Calculated as the percent of total live births

The overall **cancer** incidence rate within Prentiss County is similar to Mississippi, but slightly above the U.S. The overall cancer incidence rate within the county is 491.7 per 100,000 individuals, 503.9 throughout Mississippi and 464.4 across the U.S. When looking at the incident rates by type of cancer, rates are higher for lung cancer and colorectal cancer when compared against Mississippi and the U.S. Conversely, incidence rates for prostate cancer and breast cancer are lower than state and national rates. The cancer mortality rates reveal a less than ideal pattern. The overall mortality rate due to cancer is 235.5 throughout Prentiss County compared to 201.1 statewide and 175.8 nationally. There are differences by cancer type with respect the state and U.S. statistics. Mortality rates for lung cancer and colorectal cancer are above statewide and national levels. Prostate cancer, on the other hand, has a mortality rate well below Mississippi and the U.S.

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

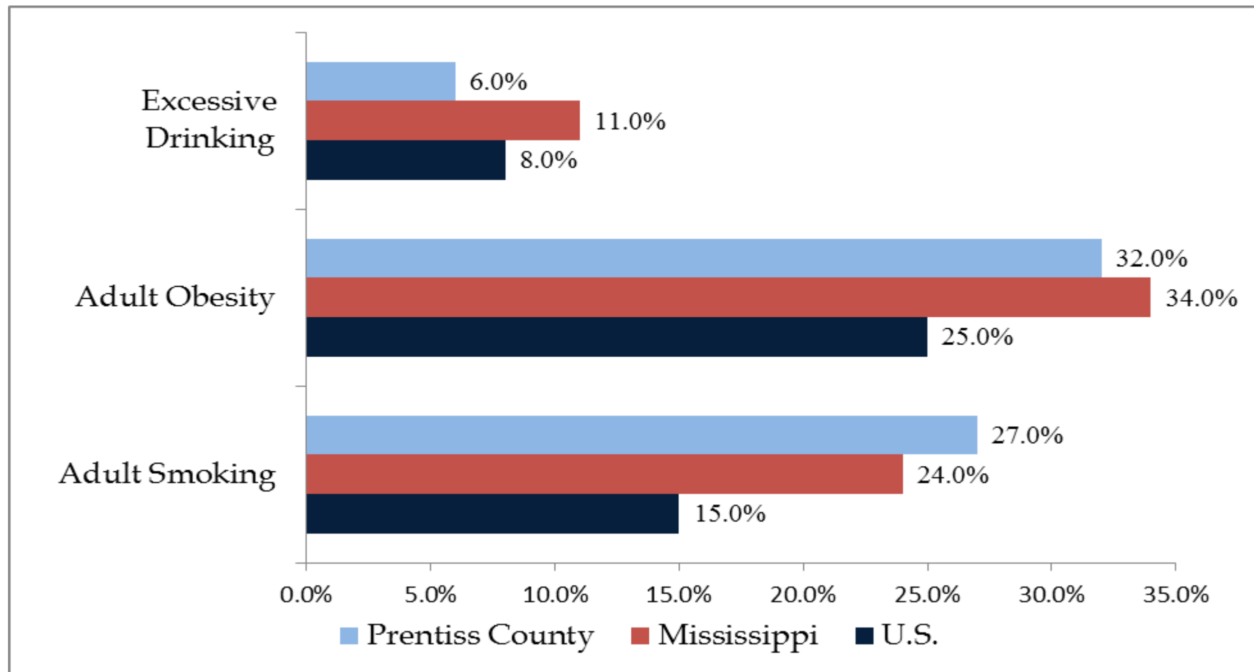


Cancer age-adjusted mortality rates per 100,000 population, Prentiss County compared to Mississippi and the U.S. (2010).



Health risk factors such as smoking, excessive drinking, and an unhealthy weight are all related to poorer health outcomes. Unfortunately in Prentiss County, a few of these indicators are more prevalent than throughout the U.S. Thirty-two percent (32%) are technically obese and 27% smoke cigarettes on a regular basis. These figures are above what is seen throughout the U.S. and with smoking, also above Mississippi. Conversely, (6%) of area adults drink excessively, which is lower than Mississippi (11%) and the U.S. (8%).

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



In closing, the secondary data points to a number of opportunities throughout Prentiss County. The socioeconomic indicators for the area point to lower income levels, higher unemployment rates, and a decreasing population. Additional statistics point to concerns with the rate of obesity and cigarette smoking. Lung cancer incidence rates and mortality rates are also higher locally than what is seen statewide and nationally. On a positive note, prostate cancer rates are lower than statewide and national rates, as are rates of excessive alcohol use.

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

Key Informant Interviews Key Findings

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

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

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

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

"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."

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.

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

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

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

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

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

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

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

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

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

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

Focus Groups Key Findings

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

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

Knowledge of diabetes and self-care management

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

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

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

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

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

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

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

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

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

- Cost
- Motivation/Effort
- Time/Convenience

- Education/Knowledge

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

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

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

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

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

Access to Health Care

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

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

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

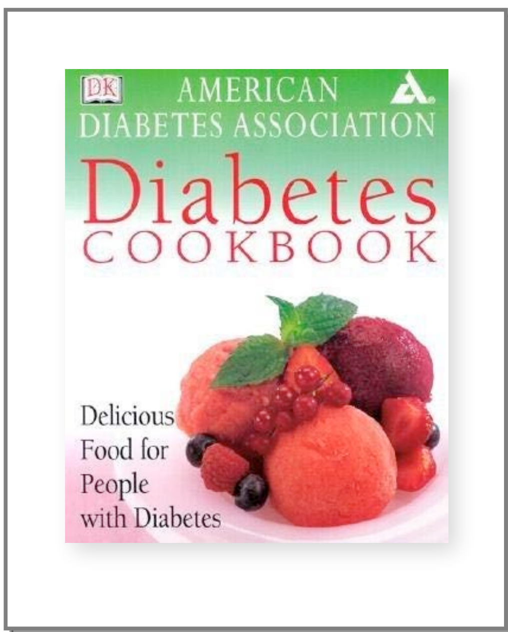
When asked where uninsured and underinsured individuals go for health care, participants indicated that uninsured residents often utilize the Emergency Department for primary health care because the Emergency Department will not turn them away if they do not have insurance. Others forgo care. Co-pays,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

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

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

Health Education and Communication

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



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

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

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

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

- Lack of awareness/knowledge about Diabetes, Diabetes prevention and Diabetes management
- Lack of access to affordable health care for people with diabetes including specialty services (podiatry, optometry, endocrinology, dental health)
- Need for assistance with prescription, medical supplies, and healthy food
- Lack of community awareness of available programs and resources
- Need for collaborative provider network with efficient referral system
- Need for health education programs including nutrition, exercise, diabetes management
- Need for supportive services such as support groups and health coaches

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

CONCLUSIONS

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

- **Access to care:** Access to primary care, as well as access to preventive care, is increasingly an issue throughout the country. These issues appear more pronounced locally. While the household survey identified rates similar to the nation, the secondary data showed rates higher than the U.S. The poverty rates in the county suggest that cost is a greater barrier to obtaining needed care than it may be in other areas throughout the state. Key informants and focus group participants shared concerns as well about the ability of residents to obtain the health care services that they need.

- **Cardiovascular health:** Incidence rates of heart disease and the percentage of individuals locally who have had a heart attack or a stroke exceeds Mississippi and the U.S. Mortality rates for heart disease and stroke are also elevated in Prentiss County when compared against state and national rates.

- **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 locally have attended a class or course on how to manage their diabetes.

- **Maternal health:** The percentage of low birth weight infants in Prentiss County exceeds the national rate. This is specifically the case for White newborns. Additionally, the number of teen births (age 15-19) in Prentiss County exceeds what is seen statewide and throughout the U.S. It should be noted that prenatal care and infant mortality rates are similar to or better than Mississippi and/or the U.S.

- **Lung cancer:** In general, cancer incidence rates in Prentiss County are equal to or below what is seen throughout the country. The exception is in the rates for lung cancer. In Prentiss County, more individuals have lung cancer and are more likely to die from the lung cancer than statewide and nationally.

- **Obesity:** All four research components pointed to issues with obesity. The household survey and secondary data profile identified that the majority of adults are overweight or obese. The household survey also revealed that the majority of overweight or obese adults 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. 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 the hospital's service area than statewide and nationally. The secondary data also revealed that more adults in the county smoke cigarettes than nationally.

- **Social determinants of health:** The data reveals an area where many residents live in poverty and fewer adults have advanced degrees. These statistics present a number of barriers to obtaining needed health care, to purchasing fresh fruits and vegetables, and living a life focused on prevention. The connection between poverty and health outcomes has been noted in many studies and is an area of concern locally.

PRIORITIZATION OF COMMUNITY HEALTH NEEDS

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

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

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

Prioritization Process

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

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

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

- Obesity & Related Chronic Conditions
- Access to Care & Preventive Health Education (Health Literacy, Nutrition, Physical Activity, Smoking)
- Diabetes
- Cardiovascular Disease
- Cancer (Lung Cancer)
- Maternal and Women's Health (Prenatal Care)
- Caregiver Needs (Palliative Care, Seniors, Disabled)
- Mental Health (Substance/Alcohol Abuse, Alzheimer's Disease, Stress)

Determination of Priority Areas

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

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

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

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

Prioritized List of Community Needs:

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

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

IMPLEMENTATION STRATEGY

In support of the 2012-13 Community Health Needs Assessment, and ongoing community benefit initiatives, Baptist Memorial Hospital-Booneville 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 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-Booneville 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-Booneville 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-Booneville 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-Booneville 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.