BAPTIST®

MEMORIAL HOSPITAL

TIPTON

2012-2013

Community Health Needs Assessment Final Report

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

Built in 1964 by Tipton County, the hospital became a part of the Baptist Memorial Health Care System in 1981. Two physicians' office buildings were completed in 1983 and in 1993, and additional construction has increased the number of hospital beds to 100.

To continue meeting patient needs, Baptist Memorial Hospital-Tipton completed construction of a surgery center in 1998, adding four operating rooms and two surgery procedure rooms. Two new chest x-ray rooms and a mammography room were added in 2001.

A new sleep disorders lab opened in 1999, featuring three full-size beds and decorated to more closely resemble a patient's bedroom at home. In 2000, a new six-bed observation unit was opened in the lab, equipped with centralized monitoring systems. The systems provide a consolidated unit which allows monitoring of patients for up to 24 hours.

Definition of Service Area

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

38004	38015	38023	38058
38011	38019	38049	

CHNA Background

Baptist Memorial Hospital-Tipton, 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-Tipton 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-Tipton 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-Tipton 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 565 adults from the Baptist Memorial Hospital-Tipton service area. This included seven ZIP codes within Tipton County. 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 the surveys. Discussion topics included health knowledge, self-care behaviors, health care access, communication preferences, and desired support services. A discussion guide, developed in consultation with Baptist Memorial Health Care, was used to prompt discussion and guide the facilitation. Participants were recruited through telephone calls to households within the service area and through local health and human service organizations. Participants were pre-screened to ensure that they were either diabetic or pre-diabetic. Each session lasted approximately two hours and was facilitated by trained Holleran staff. In exchange for their participation, attendees were given a $50 cash incentive at the completion of the focus group; dinner was

also provided. It is important to note that the focus group results reflect the perceptions of a small sample of community members and may not necessarily represent all community members in the hospital's service area.

Community Representation

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

Research Limitations

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

Prioritization of Needs

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

Documentation

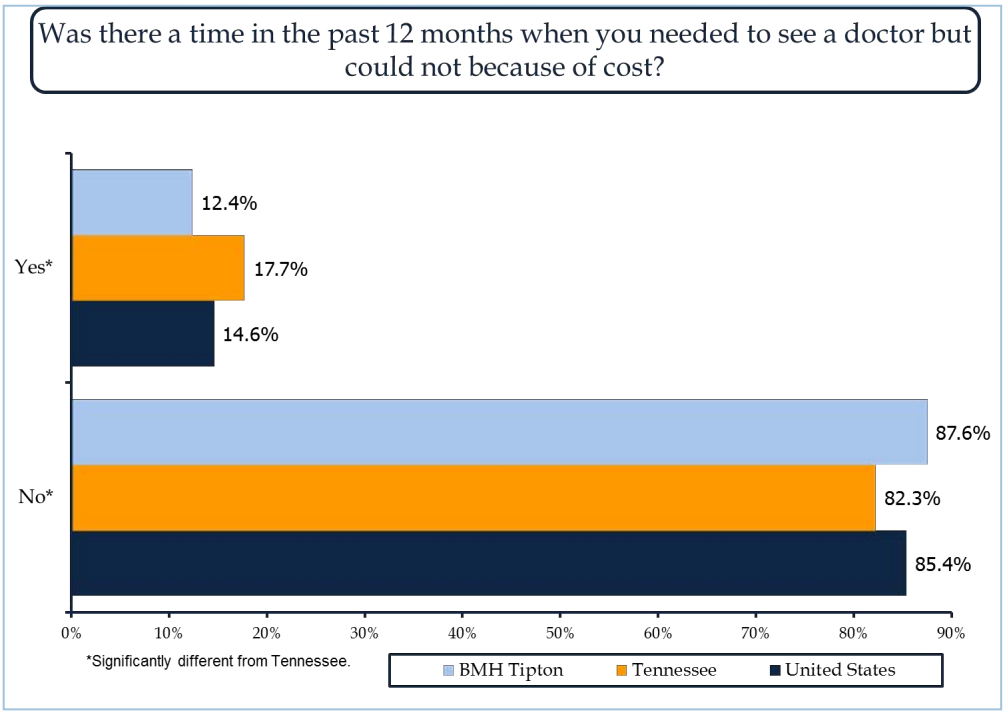
A report of the CHNA was made public on the hospital's website in September 2013. The Final Report serves as a compilation of the overall key findings of the CHNA. Detailed reports for each individual component were provided separately. An Implementation Strategy of how the hospital will address the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

KEY ASSESSMENT FINDINGS

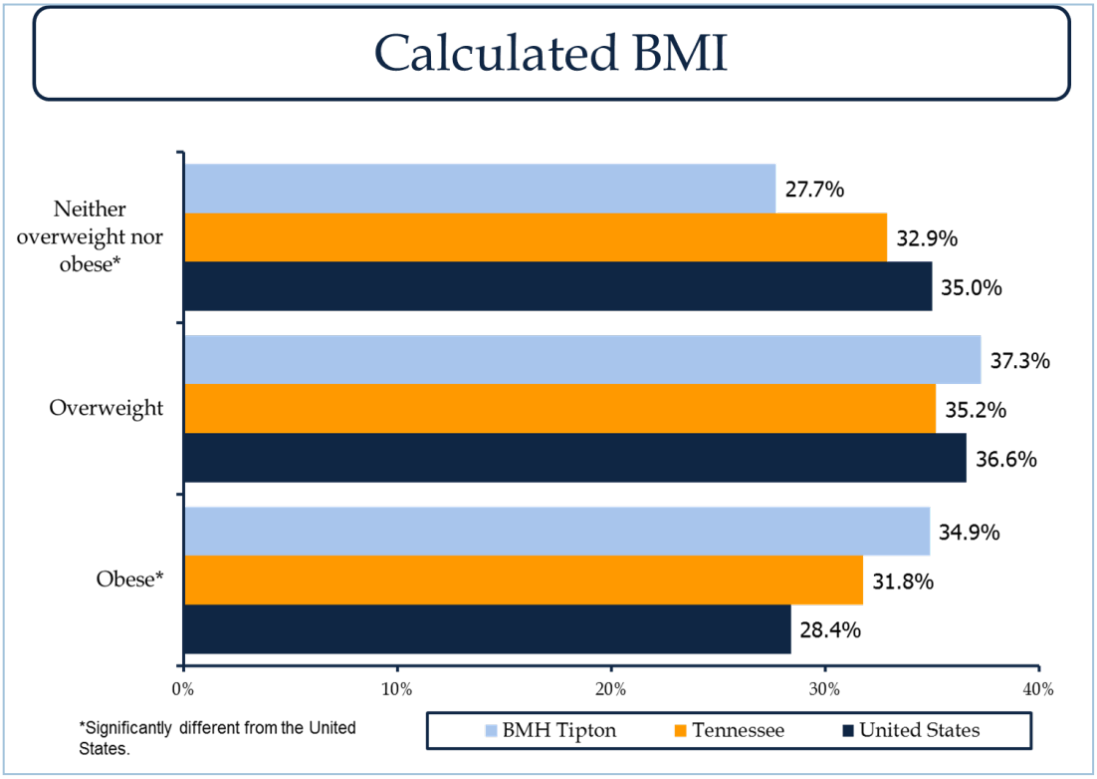
Household Survey Key Findings

A household survey of the Baptist Memorial Hospital-Tipton service area included 565 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. The majority (75.9%) stated that their **general health** is "good," "very good" or "excellent." Despite this strong majority, there were differences between residents locally and nationwide in their propensity to say "excellent" and "poor." Fewer adults locally responded "excellent" (14.8% vs. 20.4%) and more responded "poor" (9.8% vs. 4.4%) compared to the nation. Additionally, area residents were more likely to report days of poor mental and physical health than their peers statewide and nationally. Roughly 29% of area females stated their general health is "fair" or "poor," compared to 19% of males.

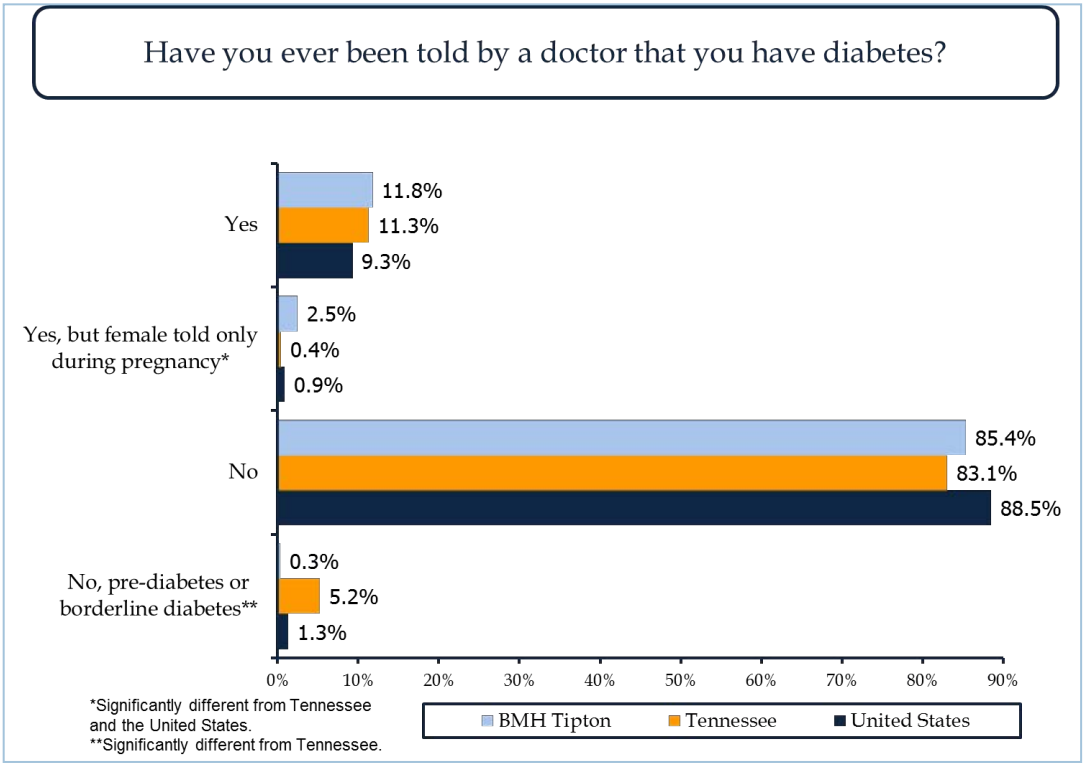
Access to care issues were assessed through questions regarding health insurance coverage, continuity of care and cost barriers. The majority, 86.9%, of area respondents have some form of health insurance coverage. This is similar to statewide (83.5%) and nationally (84.9%). No gender differences were uncovered with health insurance coverage, but when compared across races, White residents were more likely to have coverage than African American residents (88.3% vs. 84.2%). When asked if they have one person they think of as their personal doctor or health care provider, 84.5% stated that they have one or more than one person, which is similar to Tennessee and the U.S. as a whole. Males were significantly less likely to have someone they think of as their provider compared to females (76.8% vs. 92.5%). Cost was a barrier to seeing a doctor in the past year for 12.4% of area adults, which is better than the 17.7% throughout Tennessee. Cost prevented more African American residents than White residents from seeing a doctor in the past year (23.1% vs. 9.8%). Most area adults (77.1%) had a routine checkup in the past year.

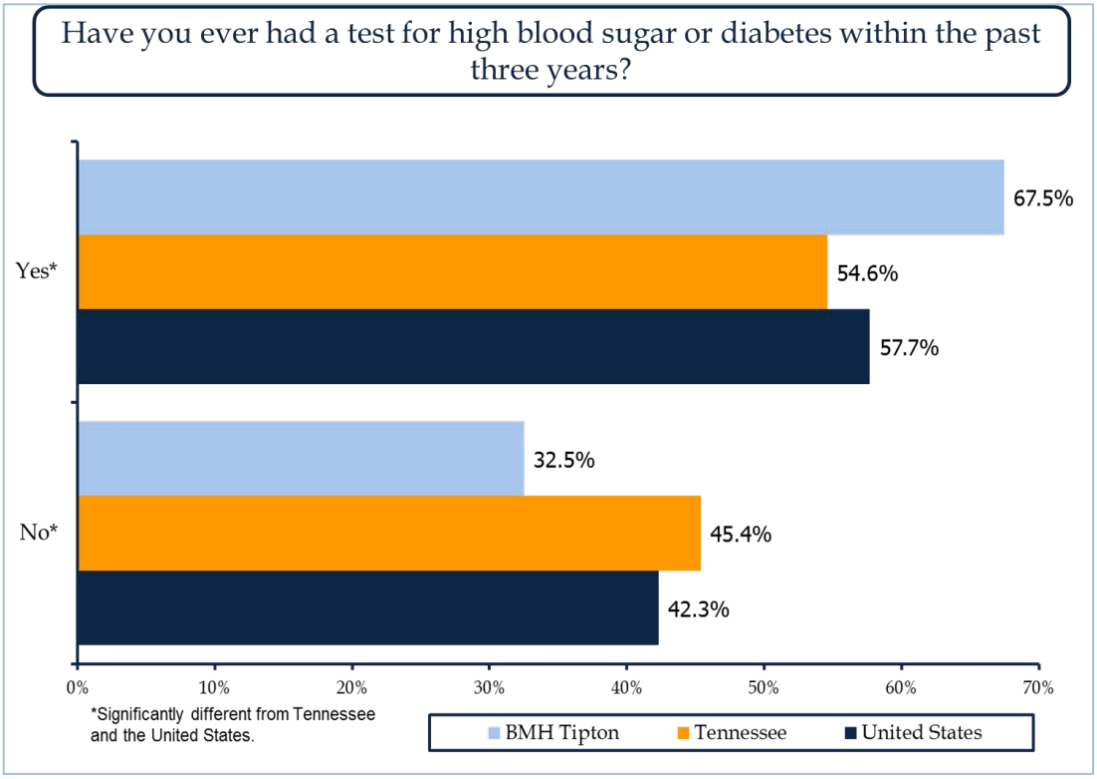


Body mass index (BMI) was calculated for each survey respondent based on self-reported information on height and weight. Nearly 35% of the adults surveyed are technically obese and an additional 37.3% are overweight. That is above the state and national figures for obese and overweight adults. Area adults are also significantly less likely than adults nationally to exercise in a typical month. Around seven out of 10 reported exercising in the previous month, which is similar to Tennessee, but less than what is seen throughout the U.S. Around 72% of males locally stated they engaged in some form of exercise in the previous month compared to 67.5% of area females. When looking at the results by race, 70.4% of White respondents reported exercising while 66% of African American respondents stated they exercised in the previous month. Reasons for not exercising included being limited by an illness or disability and simply that they "didn't feel like it." While 72% of those surveyed were technically obese or overweight, only about 26% stated that at some point in the previous two years, a doctor or health professional had told them that they were overweight. The majority, 68% reported that they do eat the recommended servings of fruits and vegetables on most days.

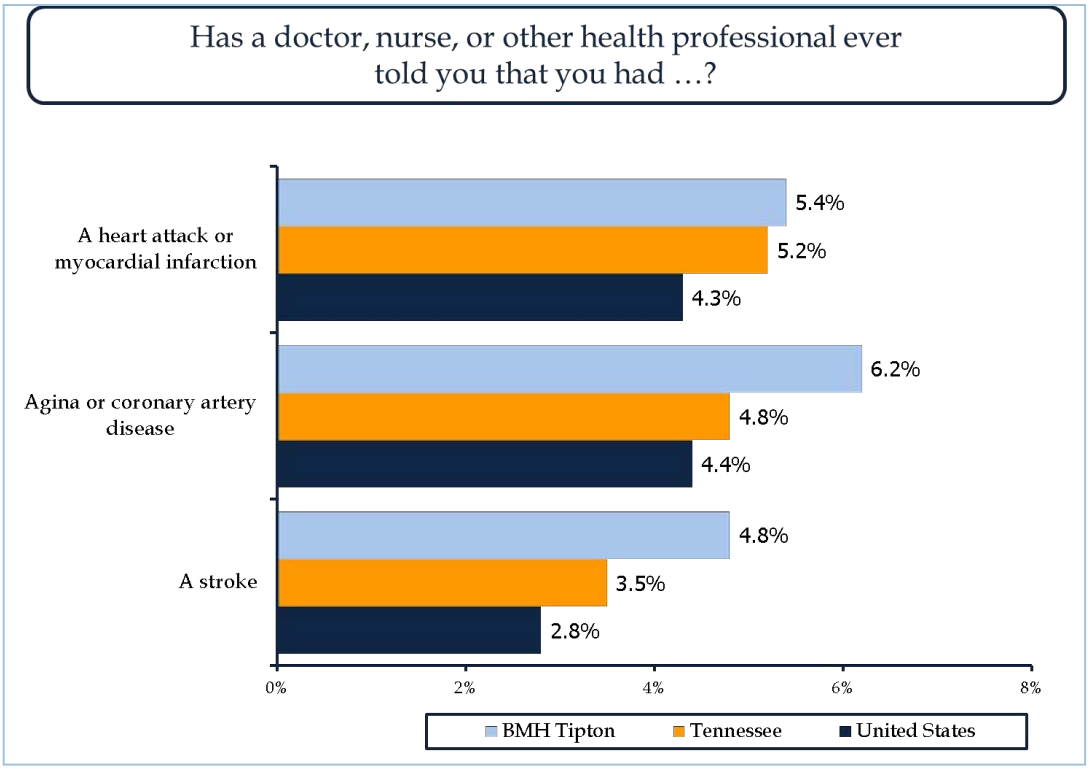


A number of questions on the survey gathered feedback regarding **diabetes** and pre-diabetic conditions. The incidence of diabetes does not differ from state and national figures with the exception of gestational diabetes. Locally, 11.8% reported that they have diabetes and another 2.5% reported gestational diabetes. A higher percentage, about half of those surveyed, stated that they do have a family history of diabetes. A family history of diabetes was much more pronounced among African American respondents compared to Whites (67.9% vs. 45.9%). Males and females living locally did not differ in their likelihood of having diabetes. When asked if they had ever taken a course or class in how to manage their diabetes, about 44% indicated that they had, which is slightly less than Tennessee overall (52.6%) and nationally (54.8%). All survey respondents were asked if they have had their blood sugar tested at some point in the past three years. Nearly 68% said they had, which is higher than statewide (54.6%) and the U.S. (57.7%).


Have you ever been told by a doctor that you have diabetes?
Yes
11.8%
11.3%
9.3%
Yes, but female told only during pregnancy*
2.5%
0.4%
0.9%
No
85.4%
83.1%
88.5%
No, pre-diabetes or borderline diabetes**
0.3%
5.2%
1.3%
0% 10% 20% 30% 40% 50% 60% 70% 80% 90%
*Significantly different from Tennessee and the United States.
**Significantly different from Tennessee.
BMH Tipton
Tennessee
United States


Have you ever had a test for high blood sugar or diabetes within the past three years?
Yes*
67.5%
54.6%
57.7%
No*
32.5%
45.4%
42.3%
0% 10% 20% 30% 40% 50% 60% 70%
*Significantly different from Tennessee and the United States.
BMH Tipton
Tennessee
United States

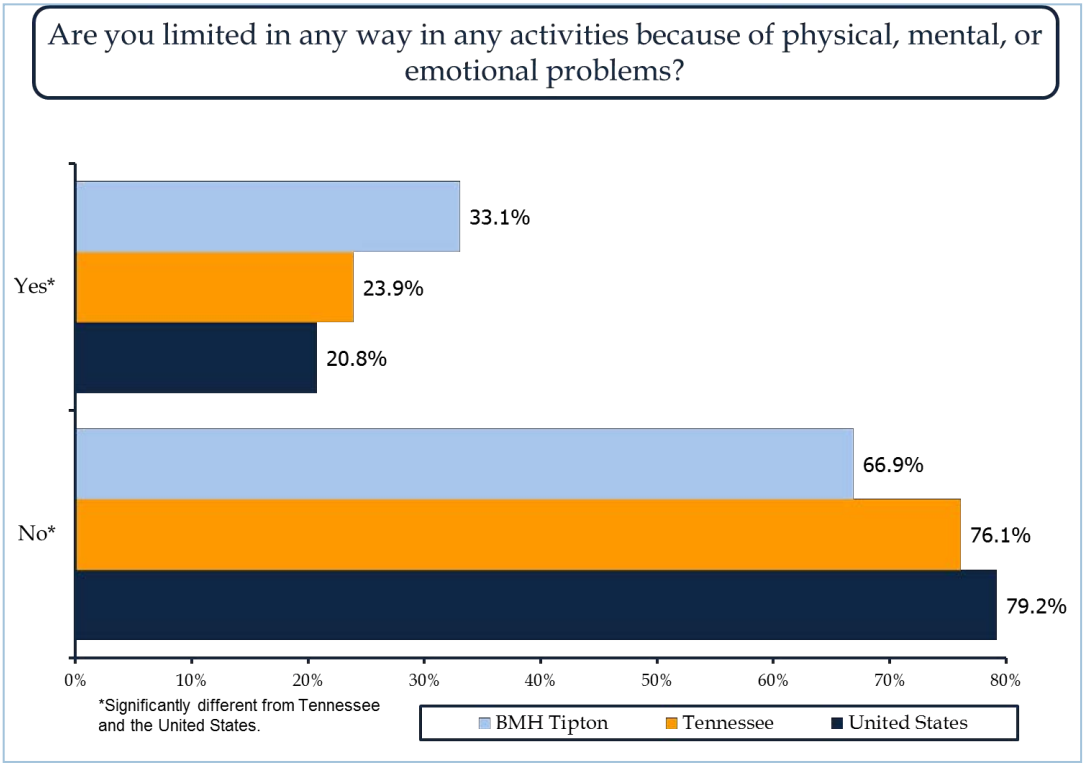
The **cardiovascular health** issues were evaluated using questions about heart attacks, coronary heart disease and stroke. Area adults were no different than adults nationally and statewide to have had a heart attack, to have angina or coronary heart disease, or to have had a stroke. A large percentage, however, have a family history of heart disease (49.1%). Area respondents who are White were more likely to report having had a stroke than the African American survey respondents (5.7% vs. 7.0%).



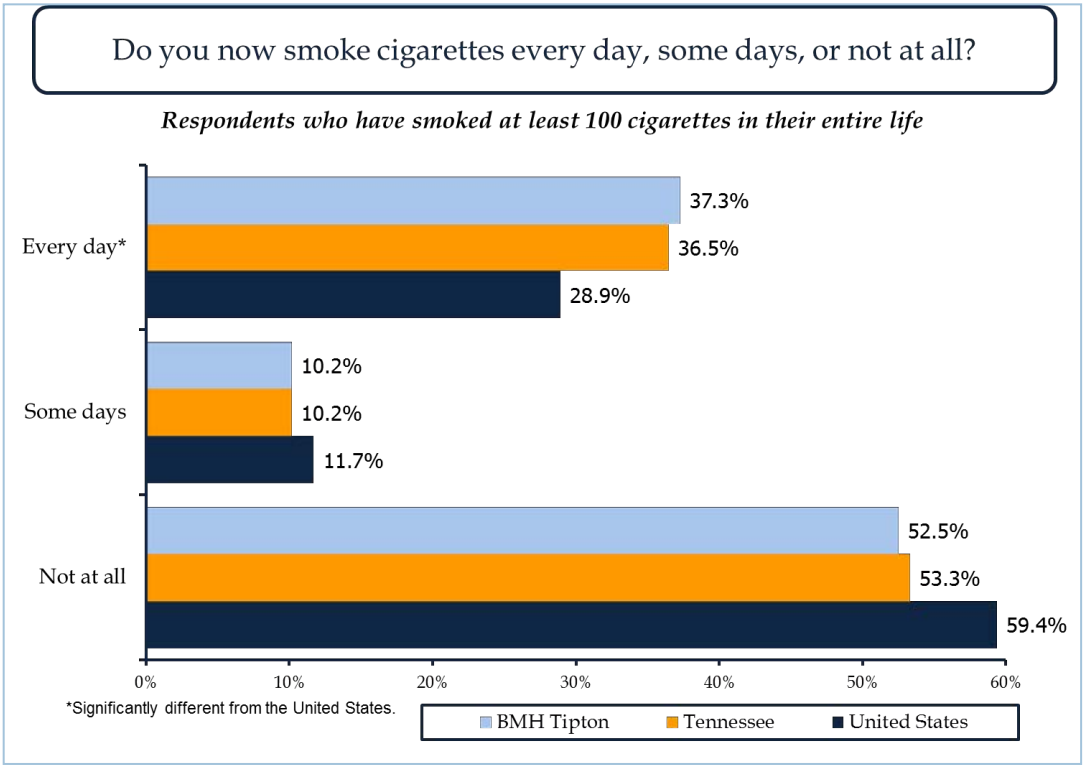
Asthma rates were slightly elevated in the area, but not above what is seen nationally. Thirteen percent (13%) of area adults stated that at one point in their life they had asthma. This is higher than Tennessee (9.3%), but similar to the U.S. (13.5%). Approximately half of those individuals still have asthma (52.2%). This compares to 64.3% statewide and 65.5% nationally. The fact that fewer adults now have asthma compared to nationally and the reported age of being diagnosed with asthma (the largest proportion of those diagnosed at 10 or younger), suggests more of an issue with childhood asthma than asthma into adulthood.

Area respondents are similar to their peers throughout Tennessee as it relates to their **oral health**. When asked if they have ever had any of their teeth pulled because of gum disease or decay, 54.1% indicated that they've had at least one tooth pulled. This is greater than the national percentage. On a positive note, the largest proportion had between one and five teeth pulled and are less likely than Tennessee residents overall to have all teeth pulled.

Reported **disability** is higher locally than what is typically seen throughout Tennessee and nationally. The survey asked if the respondents were limited in any way due to physical, mental or emotional problems. One-third of the respondents (33.1%) stated that they are limited in some way, which is higher than nationally (20.8%) and statewide (23.9%). Males and females did not differ locally, but White adults were more likely to report limitations than African American adults (35% vs. 27%). Both, however, are still above the state and national disability figures.

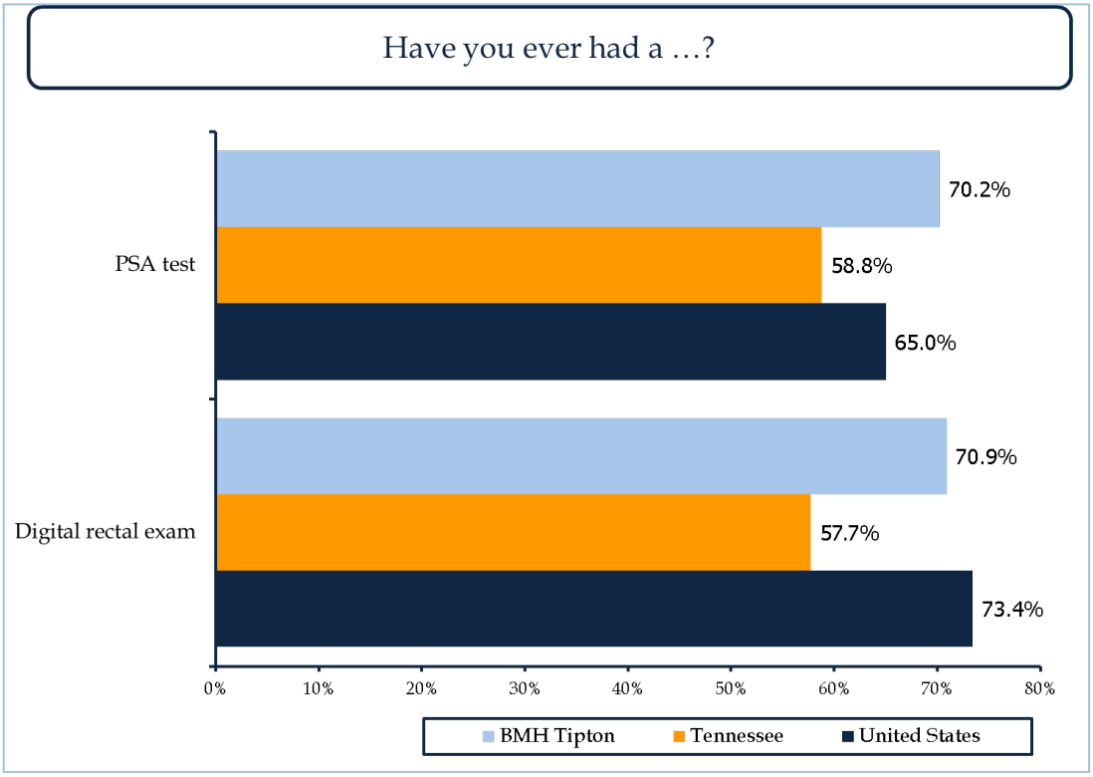


About 47% of the adults in the area have smoked at least 100 **cigarettes** in their lifetime. This is not statistically different from the 43% statewide and 42% nationally. Among that group, however, is a larger portion that now smokes every day. Area residents look very similar to Tennessee as a whole, but not as favorable as nationally. What is similar to both statewide and nationally is the proportion of current smokers who have attempted to quit. Roughly 61% of current smokers locally reported quitting for one day or longer in the previous year. This is compared to 60.8% for Tennessee and 59% for the U.S. Use of chewing tobacco on a daily basis, while a small percentage (3.6%), is above the national percentage (1.6%). Similar to nationally, area males are more likely to use chewing tobacco than females. Males and females do not significantly differ with cigarette smoking, but area Whites and African Americans show differences. Area Whites are more likely than their African American neighbors to have smoked 100 cigarettes and to now smoke every day. Whites are also more likely to use chewing tobacco.



Women's health questions on the survey asked about preventive screenings such as mammograms, breast exams, and Pap tests. Nearly 86% of the females surveyed had given birth during their lifetime. Among that group, 26.4% gave birth to their first child between the ages of 13 and 18 years. Seven out of 10 area females have had a mammogram, nine out of 10 have had a clinical breast exam and 93.2% have had a Pap test. All of these are consistent with state and national benchmarks. The one exception is the frequency of having Pap tests. Area females are not as likely to have Pap tests as regularly as females statewide. A few differences were also uncovered between White and African American females in the area. African American females were more likely than White females to have their first child at a younger age. Thirty-seven percent (37.1%) of African American females surveyed reported giving birth for the first time between the ages of 13 and 18 compared to 22.9% of White females. The likelihood of ever having had a mammogram was also higher among African American females compared to White females (89.7% vs. 64.8%).

Males age 40 years and older were asked a series of questions regarding **prostate cancer** and recommended screenings. Area males were more likely to have had a PSA (Prostate Specific Antigen) test compared to Tennessee males who are 40 years and older (70.2% vs. 58.8%). A similar pattern emerges with respect to digital rectal exams. Nearly 71% of area males have had this test compared to 57.7% statewide. For both PSA tests and digital rectal exams, area males look similar to males nationally. When asked about whether or not they have ever been diagnosed with prostate cancer, 4.9% indicated that they had, which is no different than the percentage for Tennessee overall (3.7%) and the U.S. (4.3%). The graph below details the results from the preventive screenings.

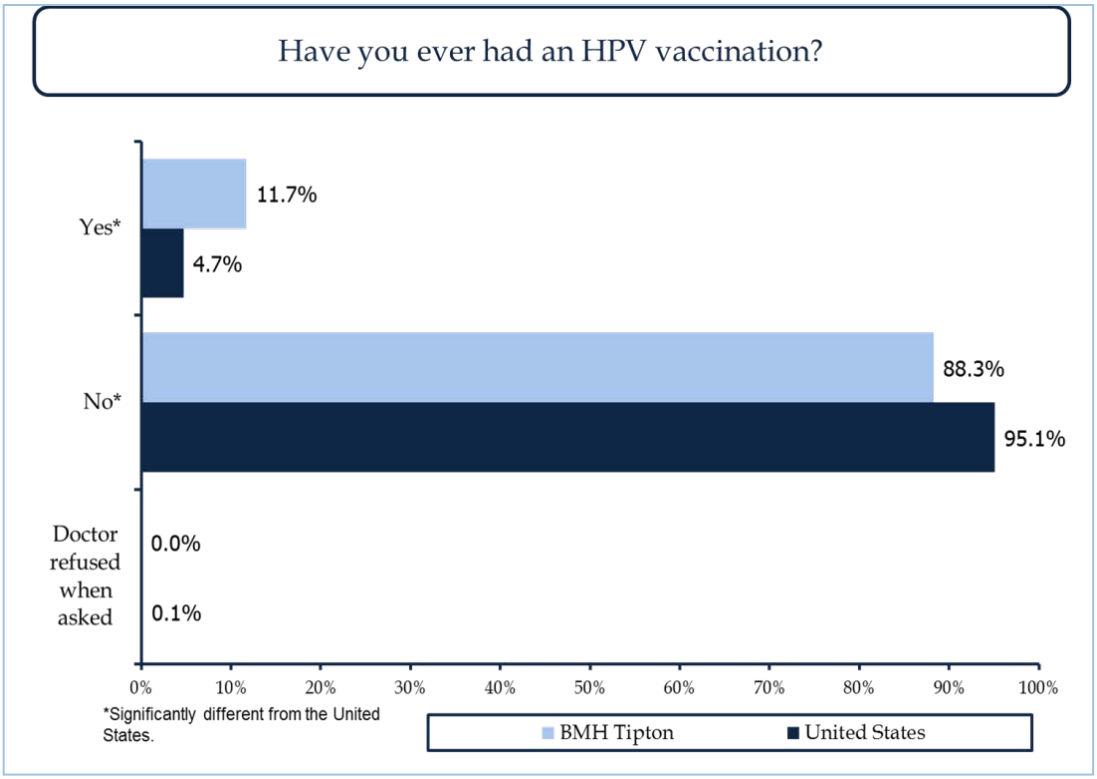


Colorectal cancer screening questions were asked of survey respondents age 50 years and older. Roughly 31% of adults in this age group have had a blood stool test using a home kit. This compares against 34.3% statewide and 38.6% nationally. Approximately sixty seven percent (67.2%) of respondents have also had a sigmoidoscopy or colonoscopy, which is similar to the U.S. percentage (65.6%), but slightly higher than Tennessee (60.5%). Males and females did not differ in their likelihood of having had any of these tests. The only racial differences found were with the percentage of respondents who have had a blood stool test at home. Thirty-three percent of the White survey respondents had this test compared to 21.2% of African American respondents.

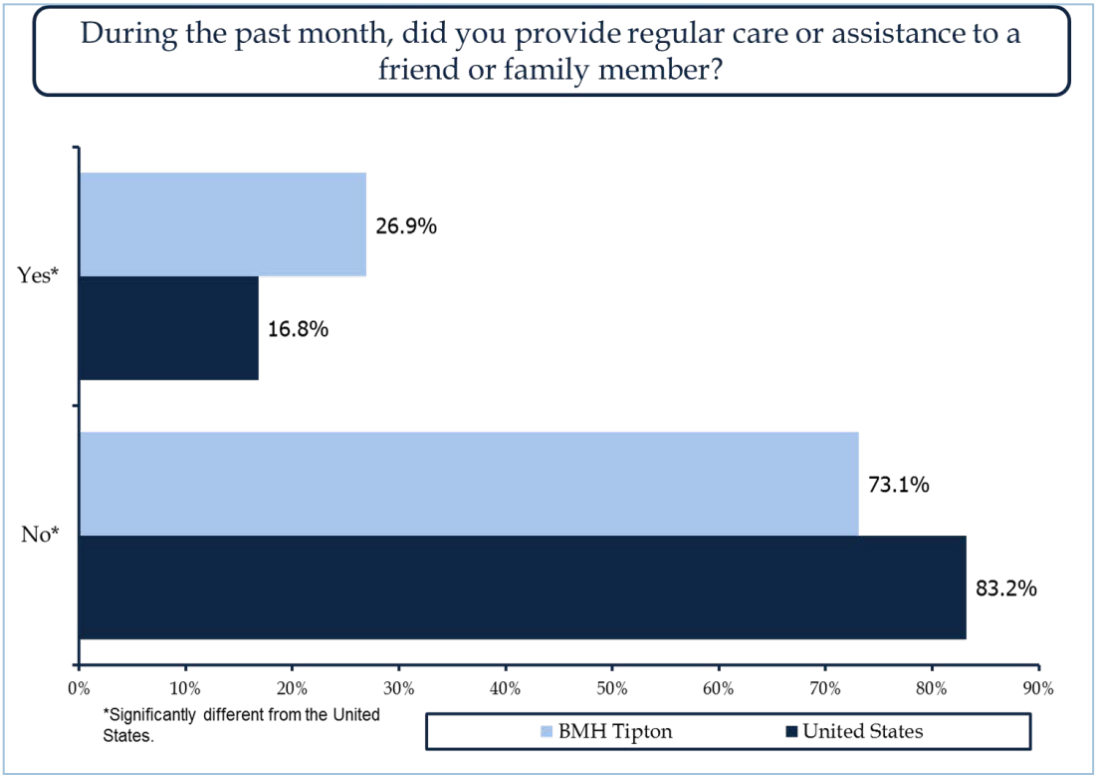
The likelihood of having **cancer**, per the survey, is no greater in the Tipton service area than nationally. When asked if they had ever been told by a doctor, nurse, or other health professional if they had cancer, 8.4% indicated that they had. This compares to 9.4% nationally who responded "yes" to the same question. Of those who had some form of cancer, prostate cancer, non-melanoma skin cancer, breast cancer, and colon cancer were the most commonly reported. The survey did not reveal any significant gender differences or racial differences.

Survey respondents were more likely to report having **cataracts** than nationally. Around 28% have or had cataracts at some point compared to 21.4% throughout the U.S. Males and females were similar in this regard as were other racial groups.

A section on the survey was devoted to the **HPV (Human Papilloma Virus)** vaccine. The percentage of respondents who have had this vaccination is significantly higher than nationally. Nearly 12% of area adults reported that they have had the HPV vaccination compared to 4.7% throughout the U.S. White survey respondents were more likely to have had the vaccination compared to African American survey respondents (13.3% vs. 7.4%).



Caregiving is becoming an increasing burden in the U.S as the population continues to age. Several questions assessed this issue locally. When asked if they had provided regular assistance to a friend or family member in the previous month, 26.9% said they had. This is above the 16.8% nationally who provided the same care. Area respondents who are African American were more likely to have provided care for another than area Whites (36.9% vs. 24.1%). Most (67.7%) reported giving care to someone who is 65 years or older, which is consistent with caregiving nationally. Area males were just as likely to provide caregiving as area females.



In summary, the household survey results reveal a number of areas of opportunity and areas of strength in the community. Area adults are more likely to report poor physical or mental health, limitations due to illness or disability and are more likely to be obese with little exercise in their daily routine. Positive findings show that fewer area adults are uninsured and see cost as a barrier to obtaining needed health care. The likelihood of having a number of preventive screenings is also higher than what is typically seen statewide or nationally. This includes being tested for high blood sugar, prostate cancer, cervical cancer, and colorectal cancer. While these rates are higher, the rationale for having the tests is unknown. It could be that the population is more focused on compliance with these screenings or that there are more risk factors, thus triggering a higher frequency of these exams.

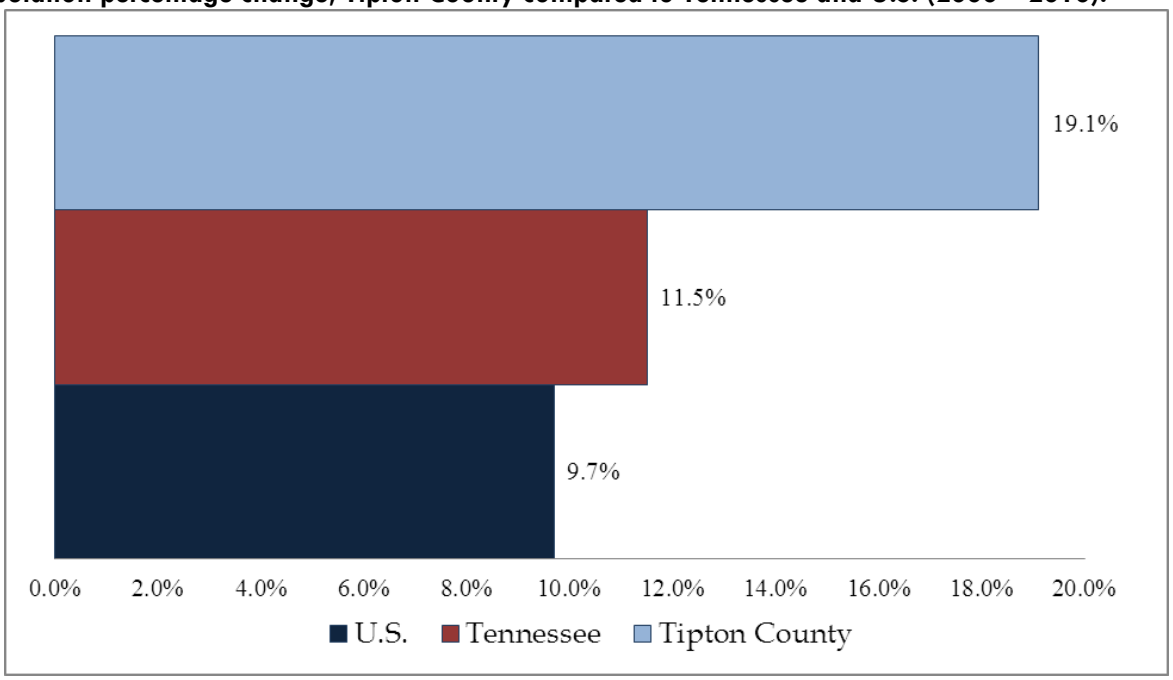
The household survey results were correlated with secondary data statistics and the qualitative research to determine key community health needs across all research components.

Secondary Data

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

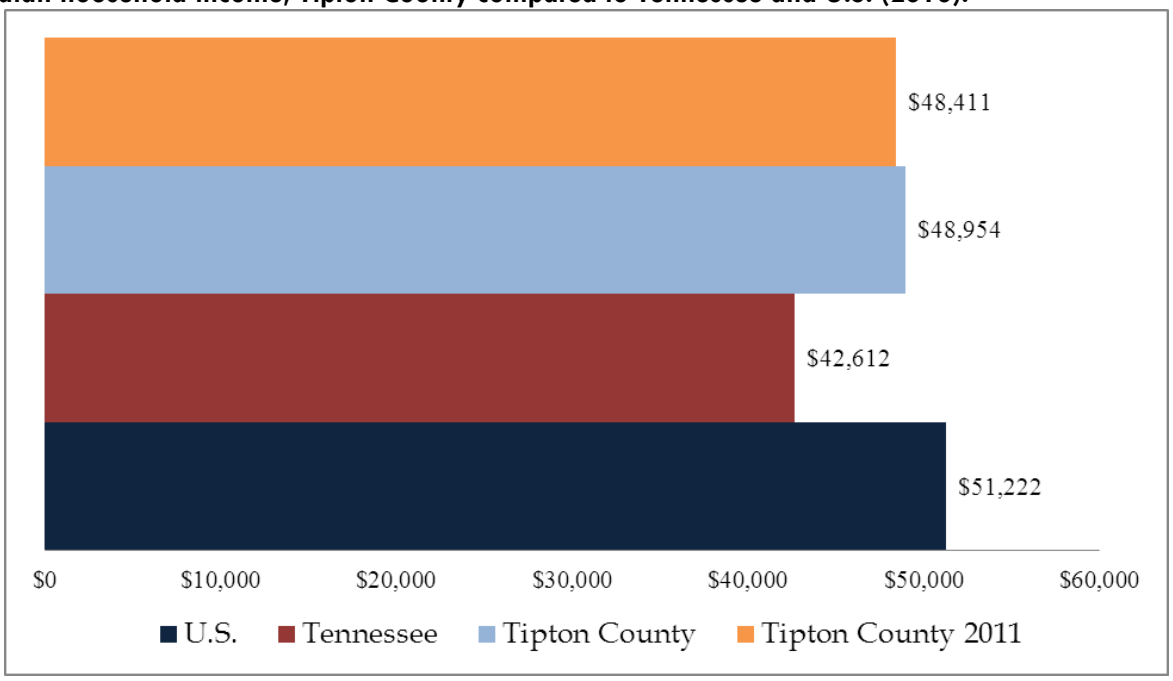
The **demographics** of an area, as well as demographic shifts, can have a dramatic impact on the health care system. Tipton County, Tennessee, is estimated to have a population of 61,081, which is an increase of 19.1% between 2000 and 2010. This is a much higher growth in population that what was seen across Tennessee and the U.S. during the same time period. Eleven percent (11%) of the population is 65 years and over, which is similar nationally and statewide. The racial and ethnic demographics are similar to Tennessee and the U.S. with the exception of a smaller number of Hispanic/Latino residents locally. Approximately 78% of the county residents are White and nearly 98% of households are English speaking only.

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



Tipton County compares better than or similar to Tennessee across various **household statistics,** including housing occupancy. Less than 7% of housing units are vacant in the county, which is better than the 11.3% statewide and 11.4% nationally. Nearly 16% (15.7%) of households are single-mother households, which is slightly above Tennessee (13.9%) and the U.S. (13.1%). Approximately 12% of adults 15 years and older are divorced, which compares to 12.4% for Tennessee and 10.7% for the U.S. overall. The median household income for Tipton County is roughly $48,000, which is slightly above the state median figure, but below the national median. Roughly 14% of all individuals living in Tipton County are living in poverty, with the highest rates of poverty among single-mother households with young children under age five. Fifty-six percent (56%) of single-mother households with children under five live in poverty and 47.8% of those with children who are under 18 years of age live in poverty. These figures are slightly higher than Tennessee and the U.S. Fewer seniors live in poverty in Tipton County (6.9%) compared to statewide (10.7%) and throughout the U.S. (9.4%).

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



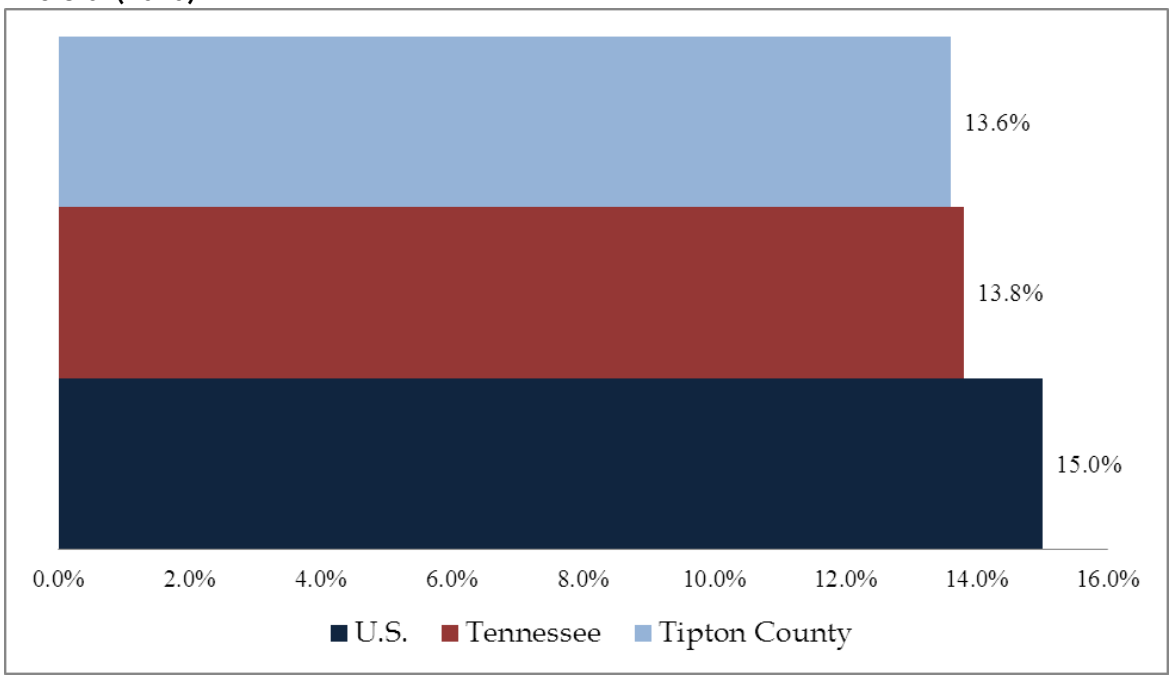
Poverty Status of Families and People in the Past 12 Months (2010)

	U.S.	Tennessee	Tipton County
All families	10.5%	12.7%	12.8%
With related children under 18 years	16.5%	20.0%	18.0%
With related children under 5 years only	17.9%	23.8%	25.3%
Married couple families	5.1%	6.4%	4.5%
With related children under 18 years	7.5%	9.0%	5.6%
With related children under 5 years only	6.8%	10.0%	14.1%
Families with female householder, no husband	29.2%	34.1%	39.9%
With related children under 18 years	38.1%	43.5%	47.8%
With related children under 5 years only	46.1%	54.5%	56.0%
All people	14.4%	16.9%	14.2%
Under 18 years	20.1%	24.0%	17.5%
Related children under 18 years	19.7%	23.7%	17.3%
18 years and over	12.5%	14.7%	13.0%
65 years and over	9.4%	10.7%	6.9%
Unrelated individuals 15 years and over	25.4%	28.9%	31.0%

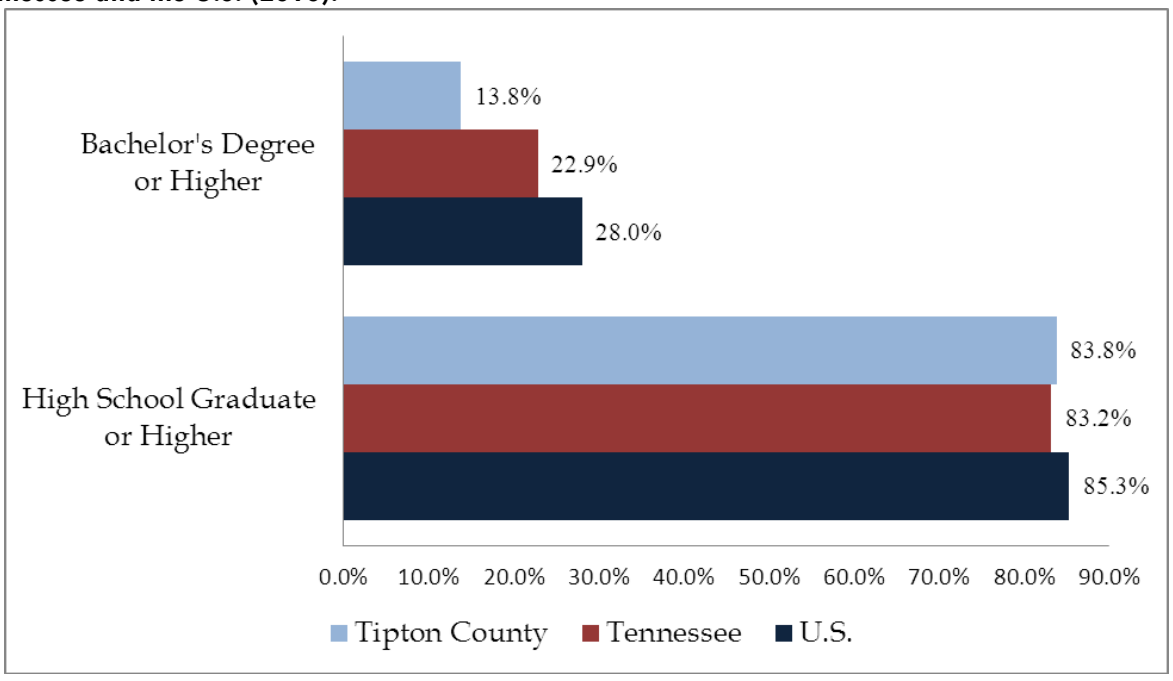
Source: U.S. Census Bureau, 2008-2010 ACS 3-year estimates

Tipton County residents travel further for work than others throughout the state with a mean travel time of 32.3 minutes. Tennessee workers average 24 minutes for their commute and workers nationally commute 25.3 minutes. The majority of Tipton County residents (74.6%) are private wage and salary workers and another 18.3% are government workers. The percentage of government workers is slightly higher than statewide and nationally. While high-school graduation rates do not differ, the proportion of adults locally with a bachelor's degree or higher (13.8%) is lower than Tennessee (22.9%) and the rest of the country (28%). Three-year estimates from the U.S. Census Bureau show that 86.4% of county residents carry some form of health insurance coverage, which is equitable to statewide (86.2%) and throughout the country (85%).

Percentage of population without health insurance coverage, Tipton County compared to Tennessee and the U.S. (2010).

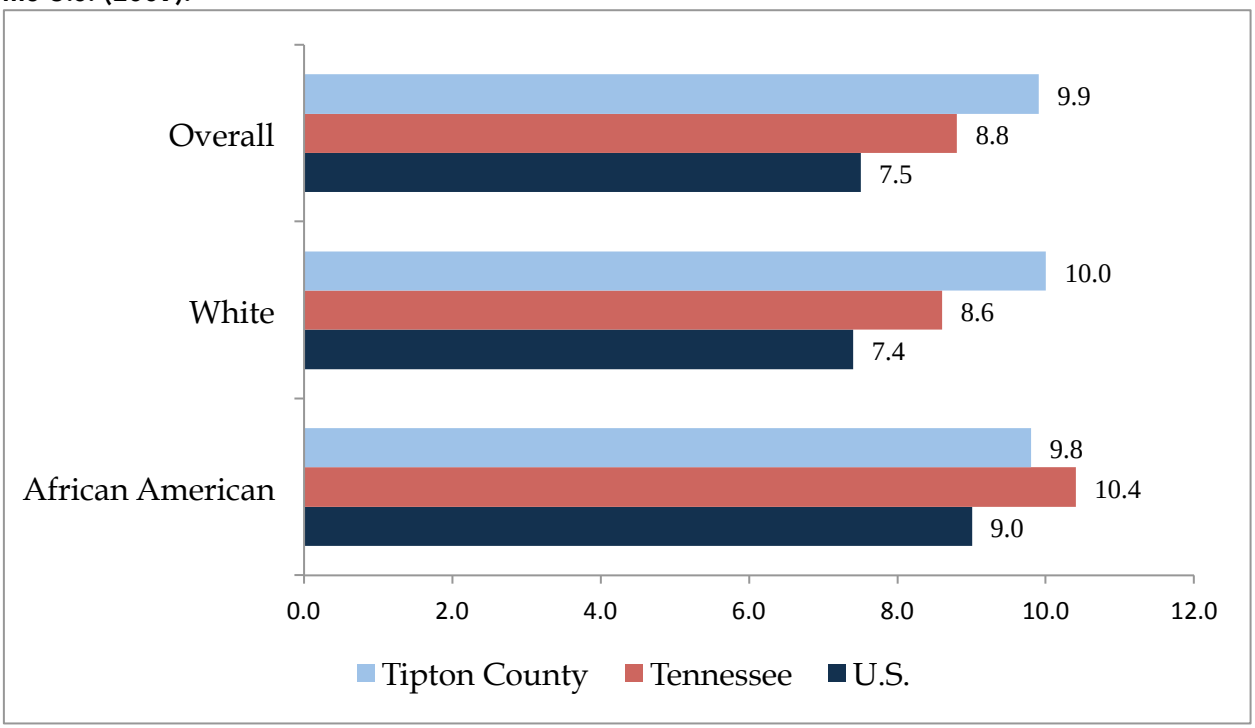


Educational attainment percentages for population 25 years and over, Tipton County compared to Tennessee and the U.S. (2010).



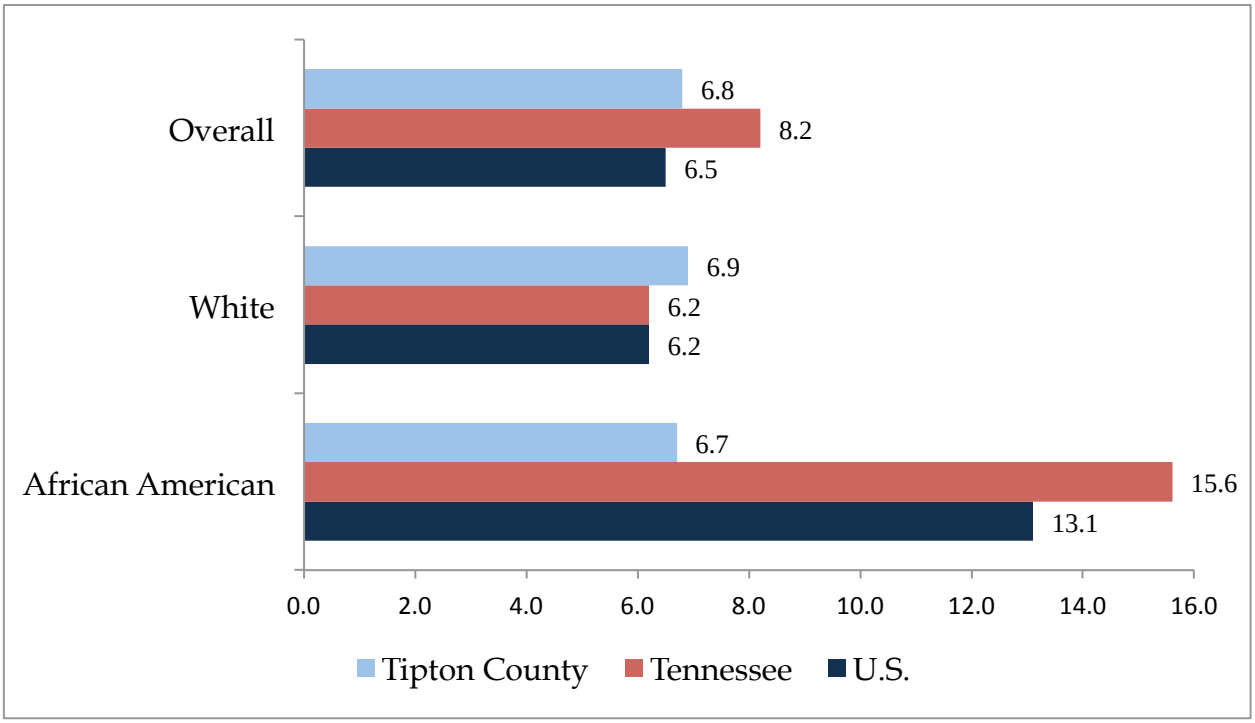
The overall age-adjusted **mortality rate** for Tipton County is 9.9 per 1,000 population. This is not far above the Tennessee rate (8.8), but noticeably higher than the U.S. average (7.5). The rate between White and African American Tipton County residents does not significantly differ. Nationally, the mortality rate for African Americans is worse than it is for Whites. For Tipton County, however, the White age-adjusted mortality rate is equivalent to what is seen nationally for African Americans. Heart disease and cancer are the leading causes of death locally as they are statewide and nationally. The county age-adjusted rates for both cancer and heart disease are slightly higher than Tennessee and above the U.S. rates. The graph below depicts these comparisons.

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



Infant mortality rates for Tipton County are below Tennessee rates and aligned with U.S. rates. The overall infant mortality rate is 6.8 per 1,000 live births for the county compared to 8.2 for Tennessee and 6.5 nationally. Racial disparities for infant mortality are not as prominent as they are throughout Tennessee and the U.S. The percentage of low and very low birth weight babies in the county is also equal to or below Tennessee and the U.S. While the numbers are small, there is indication that African American newborns are more likely to be of low birth weight than White newborns. The percent of low birth weight babies among Tipton County African American infants is 13.5% compared to 7% among White infants. The graph below details the mortality rate figures overall and by race.

Infant mortality rate by race per 1,000 live births, Tipton County compared to Tennessee and the U.S. (2006 – 2010, 5-year averages).



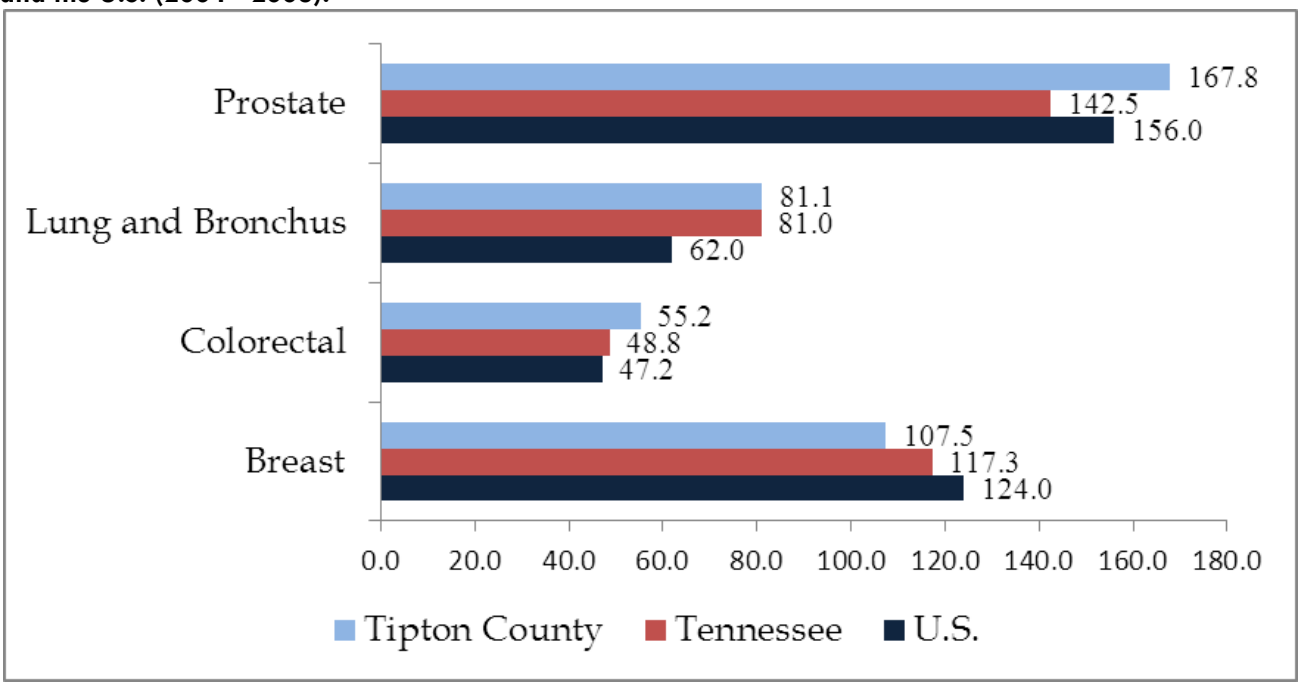
The **communicable disease** statistics show mixed results. Chlamydia rates in Tipton County (532.1 per 100,000 population) exceed the rates statewide (449.9) and nationally (426.0). Conversely, county adults are less likely to have gonorrhea. The county rate is 85.1 per 100,000 population compared to 113.1 for Tennessee and 100.8 for the U.S. Hepatitis and tuberculosis rates are more favorable than the state and country, but MRSA (Methicillin Resistant Staphylococcus Aureus) cases in 2010 were higher in Tipton County (37.7 per 100,000) compared to statewide (29.5).

Cancer statistics reveal an overall more favorable picture within the county when compared against state and national rates, however, gender differences are noted. The incidence rate for all cancers among males is 574.1 per 100,000, which is above the 559.1 for Tennessee males and 541.0 for males throughout the U.S. Specifically, prostate cancer is higher among county males compared to statewide and nationally. Overall, the county rates are higher than national rates in the incidence of prostate, lung, and colorectal cancer. County mortality rates for lung cancer and colorectal cancer are also less favorable than state and national rates. Prostate cancer mortality rates among males locally do not differ from the state and U.S. rates.

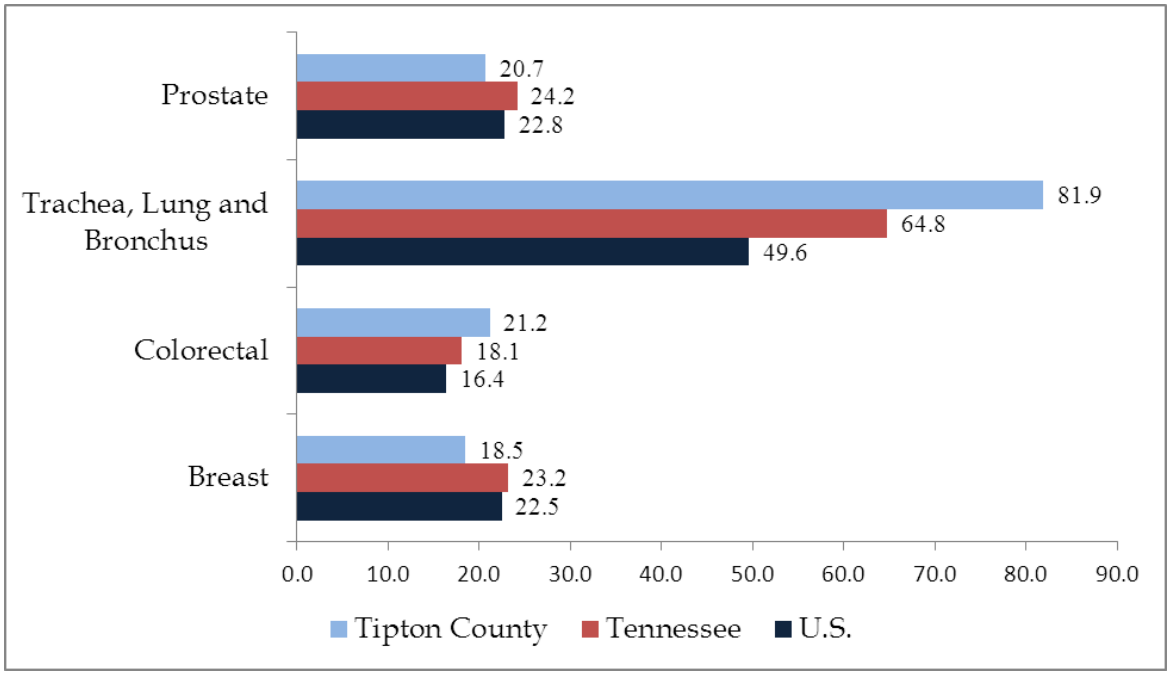
Cancer Incidence by Site and Gender (2004 – 2008)[a]

	U.S.	Tennessee	Tipton County
Breast (Female only)	124.0	117.3	107.5
Colorectal	47.2	48.8	55.2
Male	55.0	57.5	52.8
Female	41.0	42.2	56.3
Lung and bronchus	62.0	81.0	81.1
Male	75.2	108.8	112.0
Female	52.3	60.8	58.6
Prostate	156.0	142.5	167.8
All Sites	**464.4**	**467.8**	**457.9**
Male	**541.0**	**559.1**	**574.1**
Female	**411.6**	**405.3**	**377.4**

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



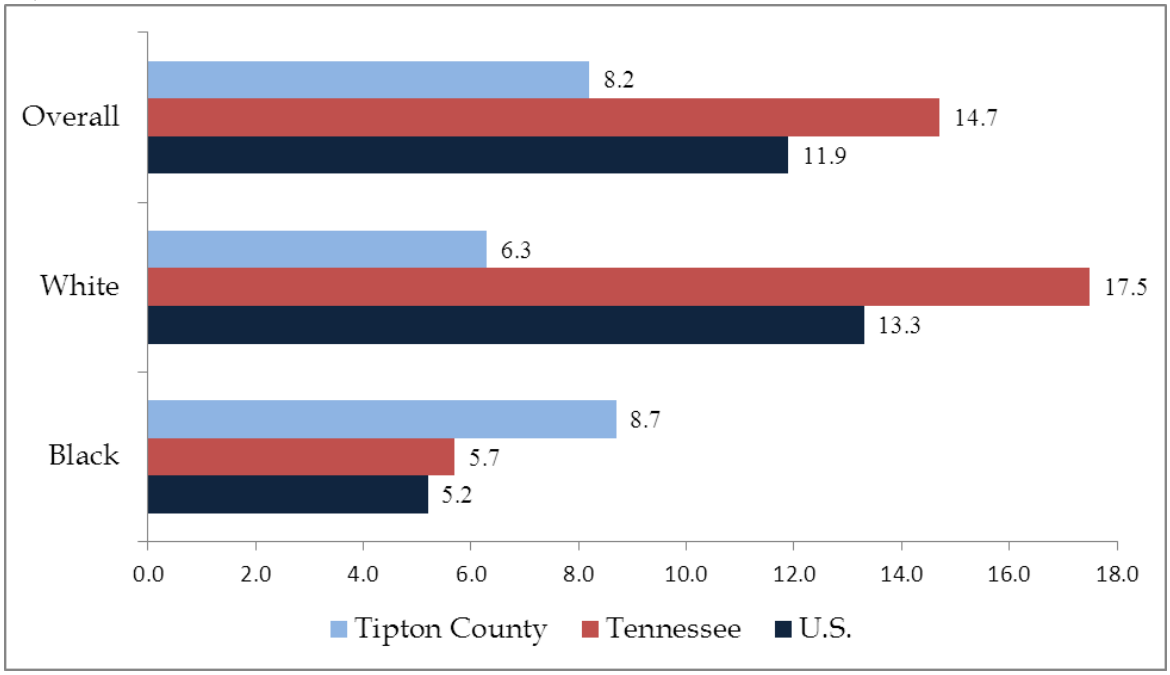
Cancer age-adjusted mortality rates per 100,000 population, Tipton County compared to Tennessee and the U.S. (2009).



Childhood cancer was also looked at in terms of incidence rates and mortality rates. The incidence rate for cancers among children ages 0-19 in Tipton County is 190.2 compared to 166.9 for Tennessee and 169 for the U.S. overall. Mortality rates in children with cancer equal "zero" for the time period examined (2004-2008).

Mental health is often assessed by examining the suicide rates in an area. The county suicide rate is 8.2 per 100,000 population compared to 14.7 for Tennessee and 11.9 nationally. Tipton County statistics show an atypical pattern when examined by race. Generally what is seen nationally is higher suicide rates among Whites than African Americans. The opposite is true for Tipton County. The graph below shows this comparison. It should be noted that the rate for suicide among ages 10-19 is also reported in the full profile. While the rate is much higher than statewide or nationally, this only represents one individual. It is recommended that this not be interpreted as a cause for concern.

Suicide rates by race per 100,000 population, Tipton County compared to Tennessee and the U.S. (2010).



For childhood and adult **asthma**, the rates for inpatient hospitalizations and emergency room visits do not differ from statewide statistics. Despite the hospital rate for asthma being similar to the state as a whole, the childhood asthma burden ranking is 77 out of 95 for Tipton County (95 is the worst).

As indicated in the table below, Tipton County adults are more likely to engage in a number of **risky behaviors** than their counterparts statewide and nationally. Specifically, rates for smoking, excessive drinking, and obesity are higher countywide than they are throughout Tennessee and/or the country. Related to obesity is access to healthy foods and recreational facilities. Approximately 71% of county residents have access to food, which is better than Tennessee (57%), but falls below national standards (92%). Additionally, access to recreational facilities in lower in Tipton County (3.0 per 100,000) compared to Tennessee (8.0) and nationally (17.0). The rate for motor vehicle crash deaths is similar to the rate for Tennessee, but double what it is nationally.

Risky Health Behaviors (2011)

	National Benchmark	Tennessee	Tipton County
Adult smoking	15%	24%	31%
Adult obesity	25%	31%	34%
Excessive drinking	8%	9%	11%
Motor vehicle crash death rate	12.0	22.0	24.0

The primary care physician to patient ratio is 1,783:1 in Tipton County. This is much higher than statewide (837:1) and nationally (631:1).

In closing, the secondary data points to some key opportunities within Tipton County as well as a number of community strengths. Overall, poverty is lower in the county compared to statewide and nationally, as is the percentage of uninsured. Poverty is higher among families with young children, particularly single mother households. Racial disparities are less prominent in Tipton County. Infant mortality and overall birth weights are more favorable in the county than statewide and nationally, however, overall mortality rates are elevated compared to these benchmarks. Mortality rates for heart disease and cancer are above state and national rates. Specifically for cancer, Tipton County residents fare worse when looking at prostate cancer incidence, colorectal cancer incidence and mortality, and lung cancer incidence and mortality. For breast cancer, the county rates are better than the state and national comparisons. Other areas where Tipton County compares less favorably to the benchmark data include risky behaviors such as being at an unhealthy weight, smoking, and drinking.

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

Key Informant Interviews Key Findings

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

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

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

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

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

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

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

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

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

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

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

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

Prevention and education were seen as the two greatest opportunities for achieving optimal health and well-being. Most key informants suggested continued or increased community outreach regarding healthy lifestyle choices, nutrition, exercise, and chronic disease management. Opportunities to partner with community and faith-based organizations were acknowledged. Several respondents also noted the opportunity for policy change. Specifically, suggestions were made to consider land use and local regulations and make healthy foods more available. A number of mentions were made to focus on the children and youth in the community. Outreach through schools and churches were seen as worthwhile so that behavior change can potentially continue into adulthood.

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

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

Focus Groups Key Findings

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

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

Knowledge of diabetes and self-care management

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

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

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

When asked how they believe they got diabetes or became pre-diabetic, many spoke of a genetic link where parents and/or grandparents had diabetes. One participant said, "My mother had diabetes and her mother had diabetes. I figured I would get it someday, too." Another commented, "I have aunts and uncles who lost all their limbs to diabetes." While factors such as nutrition and obesity were mentioned as risks by some, there was a sentiment of helplessness due to the hereditary link. Several did point to poor eating habits and lack of exercise as factors that increased the risk of getting diabetes. One participant said, "Anybody who lives in this world, if you don't eat right, you can get it." Others commented that being overweight is what led to their diabetes. In addition, participants mentioned a number of other potential causes to their diabetes including stress, fatigue/sleep deprivation, thyroid problems, steroids, other diseases, caffeine, drinking, smoking, vaccines, and exposure to chemicals/environmental pollutants.

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

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

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

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

- Cost
- Motivation/Effort
- Time/Convenience
- Education/Knowledge

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

Participants also discussed time as a major barrier to proper diabetes management. One participant commented, "I'm supposed to eat six small meals a day, but I can't do that. I work full-time. Who has the

time?" Several participants explained that travel can be difficult because it changes their regular routine and can sometimes limit the control they have over their food choices. One participant says when she travels she has to remember to take measuring cups, a food scale, food, and medications. There were also discussions about having difficulty breaking old unhealthy habits. One participant said, "You gotta wanna quit, before you can quit. I drank a fifth of whiskey Friday, Saturday, and Sunday night. I stopped all that after I was diagnosed, but changing my diet was the hardest."

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

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

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

Access to Health Care

When asked how often they need to see a doctor for their pre-diabetes/diabetes care, most stated that they see the doctor every three months or as needed depending on their recent A1C tests. Some go every month. One participant explained, "My last test was high, and they read me the riot act. I have to go back every month now and I'm working on keeping my levels down." A few only go twice a year. Usually they need to see the doctor to check their A1C and get a new prescription for their medication. Some indicated that their appointments only last 10 minutes while others last 30-40 minutes. Some participants felt that every three months was often enough, while a few said they would go more frequently if it was more affordable.

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

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

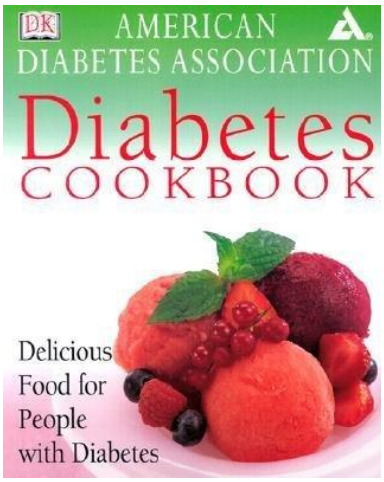
When asked where uninsured and underinsured individuals go for health care, participants indicated that uninsured residents often utilize the Emergency Department for primary health care because the Emergency Department will not turn them away if they do not have insurance. Others forgo care. Co-pays,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

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

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

Health Education and Communication

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



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

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

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

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

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

- Need for supportive services such as support groups and health coaches

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

CONCLUSIONS

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

- **Alcohol abuse:** Key informants rated substance abuse as one of the primary community health concerns. Additionally, the County Health Rankings report reveals that more county adults drink alcohol excessively compared to other counties throughout Tennessee as well as nationally. The household survey did not elicit responses regarding alcohol consumption.

- **Cancer:** Overall age-adjusted cancer incidence and mortality rates are higher for Tipton County compared to state and national benchmarks. Specifically, prostate cancer incidence rates, colorectal cancer incidence and mortality rates, and lung cancer incidence and mortality rates are high. The household survey identified that more adults in the hospital's service area are having preventive cancer screenings (PSA tests, colonoscopies, etc.). Given the incidence and mortality rates, the higher screening percentages may be a result of a family history and/or more risk factors for cancer. On a positive note, breast cancer does not stand out as an area of opportunity for Tipton County. However, key informants that were surveyed also identified cancer as one of their top health concerns.

- **Childhood asthma:** Adults who reported asthma during their lifetime were more likely to report asthma at an early age compared to nationally. Additionally, Tipton County ranks 77 out of 95 for childhood asthma burden. The adult smoking rates may be linked to childhood asthma statistics among local children.

- **Chlamydia:** For Tipton County overall, the chlamydia rate is significantly higher than statewide and nationally. Gonorrhea, on the other hand, is below the state and national average.

- **General health:** Several measures from the assessment evaluated overall indications of the community's health. The household survey had fewer adults reporting "excellent" health compared to statewide and nationally and the overall mortality rate for the county shows that adults are dying at a faster rate locally than is typically seen. Caregiving statistics are also higher locally than nationwide. All of these factors are adjusted for age and therefore represented the overall adult population in the county.

- **Heart disease:** The household survey did not reveal a higher incidence of heart disease or more individuals who have had a heart attack, however, the mortality rate for heart disease is slightly above state and national rates. The key informants also prioritized heart disease as one of the primary community health concerns among area adults.

- **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 and the country. The same is true of access to recreational opportunities. 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.

- **Single-mother households:** The proportion of single-mother households in the county is greater than the proportion statewide or nationally. Additionally, the poverty statistics for this demographic, along with their children, reveal higher figures than Tennessee and the U.S. These are the populations that have greater issues with accessing affordable health care locally.

- **Smoking:** Lung cancer incidence rates and mortality rates are much higher in Tipton County than statewide and nationally. The household survey also revealed that the percentage of "every day" smokers locally is above what is seen nationally. On the survey, White residents were more likely to be regular smokers than African Americans. The rates for males locally are also higher than for females.

- **Suicide:** The household survey pointed to suicide issues among African American adults in the county. The suicide rate for African Americans is considerably higher than among Whites, which is the inverse of what is typically seen nationally. The household survey also revealed that more adults in the hospital's service area reported being limited because of physical, emotional, or mental challenges.

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 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 (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-Tipton 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-Tipton 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-Tipton 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-Tipton 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-Tipton 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.