Jefferson Regional

COMMUNITY HEALTH NEEDS ASSESSMENT

Approved: June 27, 2019
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Implementation Strategies:

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As required by section 501(r)(3) of the Internal Revenue Code, Jefferson Regional Medical Center must conduct a Community Health Needs Assessment (CHNA) every three years. Jefferson Regional's fiscal year runs from July 1 to June 30 of the following calendar year. The last CHNA was conducted in fiscal year 2016. Therefore, Jefferson Regional is required to conduct a CHNA in fiscal year 2019, which ends June 30, 2019. This report documents the assessment that was performed and the needs identified by Jefferson Regional in its 2019 CHNA.

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Introduction

Jefferson Hospital Association, Inc. is a 501(c)(3), not-for-profit organization incorporated in the State of Arkansas. Jefferson Hospital Association's primary purpose is to provide healthcare to the citizens of Southeast Arkansas. Jefferson Hospital Association, Inc., d/b/a Jefferson Regional Medical Center (JRMC), the only general acute care hospital in Jefferson County, is licensed for 258 acute care beds and currently operates available 371 beds. JRMC serves residents of an 11-county area that includes Jefferson, Cleveland and Lincoln counties (primary service area) and Arkansas, Ashley, Bradley, Chicot, Dallas, Desha, Drew and Grant counties (secondary service area). It is estimated that approximately 77 percent of JRMC's patients originate from its primary service area with 19 percent originating from the secondary service area.

In order to fulfill the hospital's mission and retain tax exempt status, it must provide programs and services that intentionally assess and respond to local community health needs. Jefferson Regional Medical Center provides community benefits by offering health education, free community health screenings, support for local community activities, and several community health initiatives. Further, every three years Jefferson Regional Medical Center conducts a survey assessing the needs of Jefferson County residents and hospital stakeholders in the surrounding area. The assessment includes input from persons representing broad interests of the community served by Jefferson Regional Medical Center, including those with public health expertise. These individuals form the community advisory committee. The community advisory committee assisted hospital staff in collecting survey data that indicate the most pressing health concerns in the hospital service area. Upon identifying the health issue priorities, the Jefferson Regional Medical Center's community needs assessment steering committee will create an action plan to address some of these issues through resources available to the hospital. The completed report will be made available to the public. The Jefferson Regional Medical Center 2019 Community Health Needs Assessment is prepared by Mellie Bridewell, CEO of Arkansas Rural Health Partnership, in accordance with the requirements of Section 9007 of the Patient Protection and Affordable Care Act of 2010.

Healthcare in 2019

This Community Health Needs Assessment was prepared during a period of transition and uncertainty both in the health care industry and the political environment in the country. Healthcare—a sector that accounts for one-sixth of the U.S. economy—contributes to the biggest tensions between economics and politics and remains a concern for millions of families. This is true for the past few years and will continue to be so in 2019 moving forward.

Healthcare issues . . .

Healthcare Reform isn't over, it's just more complicated: Politicians and policymakers at the state level may be making key decisions in healthcare if many healthcare reforms are enacted. Health organizations need to focus on understanding how policies will affect their business financially. One example looking forward will include reimbursement on telehealth services.

The healthcare industry tackles the opioid crisis: More and more emphasis will be put on helping patients stop addictions and regulating physicians on prescriptions. Data sharing across government agencies will be able to locate and target patients with addiction problems.

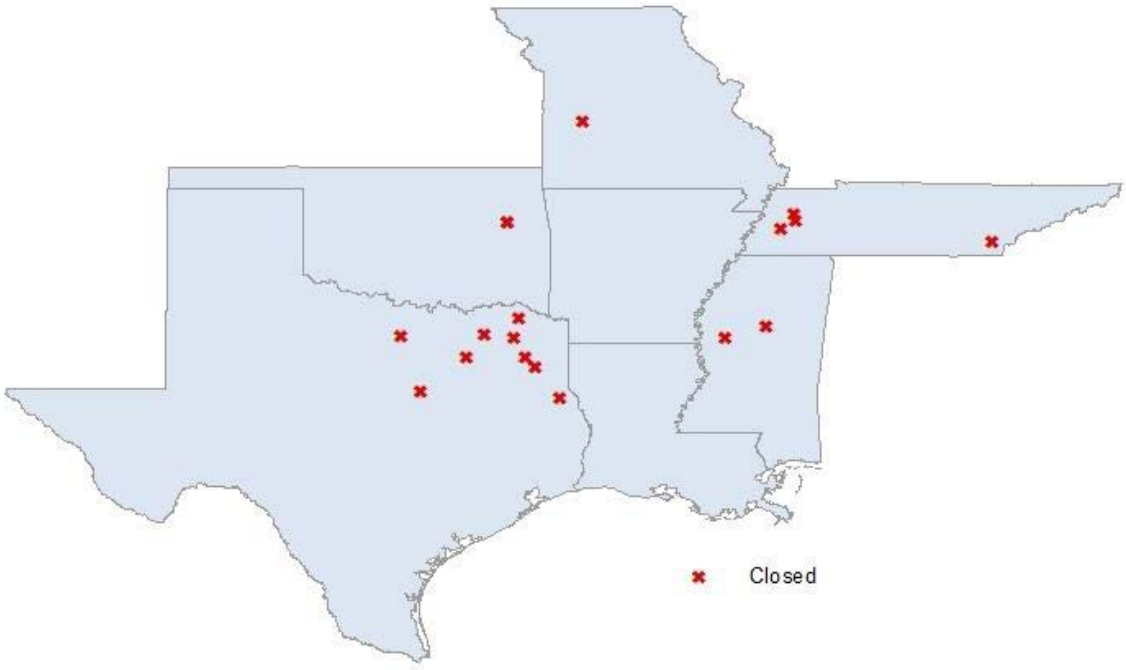
Medicare Advantage swells: The federal government is ramping up Medicare Advantage plans and to avoid penalties, health insurers should manage risk by focusing on members, paying particular attention to services such as timely member notifications, an adequate network, and up-to-date provider directories.

Securing the Internet: There will be more cybersecurity breaches and hospitals and health systems must be prepared. The financial and reputational cost of a breach affecting patient health can exceed the lost revenue from interruption of business.

Rural Hospital Closings: One of the biggest concerns for rural hospitals is the closing of so many of these facilities across the country. Eighty-nine rural hospitals have closed since 2010, and those closures are spread across 26 states, according to research from the North Carolina Rural Health Research Program. Of the 26 states that have seen at least one rural

hospital close since 2010, those with the most closures are located in the South, according to research from the North Carolina Rural Health Research Program. Seventeen hospitals in Texas have closed since 2010, the most of any state. Tennessee has seen the second-most closures, with nine hospitals closing since 2010. In third place is Georgia with seven closures. Across the U.S., more than 600 rural hospitals are vulnerable to closure, according to an estimate from iVantage Health Analytics, a firm that compiles a hospital strength index based on data about financial stability, patients and quality indicators.

Rural Hospital Closings in Surrounding States since 2015



Exciting trends and innovation ….

Across the healthcare sector, 2019 will be a year of value-based care as we expect the "outcomes-based care" focus to become more global and healthcare industry to continue to transition to the value-based model. It is anticipated that up to 15% of global healthcare spending will be tied in some form with value/outcome based care concepts. (Forbes Health News). During 2019, the application of digital health will continue to go far beyond the traditional system and empower individuals to be able to manage their own health. Increasing cost burden from chronic health conditions and aging population will be the chief driver for digital health solutions. Furthermore, favorable reimbursement policies towards clinically relevant digital health applications will continue to expand care delivery models beyond physical medicine to include behavioral health, digital wellness therapies, dentistry, nutrition, and prescription management.

Common to healthcare will be telehealth services expanding from emergency and specialty practices to bring telehealth technology to clinical use cases such as elderly care, chronic condition management, and mental/behavioral health. Telehealth- also known as telemedicine- will become a significant part of the healthcare system. Not only will telehealth provide convenience for patients and family members, especially in rural communities, but it is positive for the hospital's bottom line. Telehealth will enable hospitals to monitor patients once they are home or in many cases allow patients to go home earlier with the hospital providing monitoring and mobile health teams to respond and check on patients.

Hospitals will continue to be crucial in communities to provide acute, complex care; including handling emergencies and performing surgeries. Smaller, rural hospitals will adapt by diversifying and possibly becoming part of larger health systems. Instead of all hospitals providing all services; hospitals will work together to specialize and create specialty hubs that are geographically dispersed across an entire market area. Keith Mueller, director of the RUPRI Center for Rural Health Policy Analysis, said he expects smaller hospitals- both rural and urban- to continue to affiliate with other hospitals. This will give them the larger scale they need for greater purchasing power, delivery of services, and negotiating with insurers. While rural hospitals have started to partner with large urban health centers, they are beginning to partner with other rural hospitals and rural community health centers.

Healthcare everywhere: Mobile health applications, telemedicine, mHealth, remote monitoring, and ingestible sensors generating streams of data will allow doctors and patients themselves to track every heartbeat, sneeze, or symptom in real time. The following are predicted healthcare trends of 2020:

ERA OF DIGITAL MEDICINE	**FOCUS ON PREVENTATIVE CARE**
Medical Care is no longer confined to clinicians in clinics and hospitals; Telemedicine enabled e-visits, mHealth, and tele-monitoring; Virtual doctor-patient contact; Sensor Technology	Focus on long-term prevention and management; Awareness campaigns and behavioral nudges toward healthy habits; Encouragement of healthy behavioral habits
COMPLIANCE & PATIENT SAFETY	**GROWTH OF TELEMEDICINE**
Technology to assess quality, safety, and effectiveness of medicine; New Regulatory Demands automating regulatory process and surveillance; Empowered consumers (patients) with their own information	Communication infrastructure improves to extend healthcare; Local physicians can consult with specialists; consumers can receive specialty care at local level; provides more

	services to be delivered at the local level creating provider networks to form
EXPANDED DEFINITION OF HEALTH Healthcare systems evolve from sick care to wellness; Nutritional, behavioral, environmental and social networks are vital foundations; Convergence of physical and behavioral medical management	**OUT-COME BASED PAYMENT** Price of care linked to the value of the performance or outcome; Payment driven by hospital re-admissions or patient ratings; Doctor's payment linked to patient's health; Holding medical practitioners accountable
COMMUNITIES AS HEALTH CARE PROVIDERS Aging population & growing disease burden raise the demand for skilled health care professionals creating a shortage; Healthcare systems increasingly rely on community outreach, peer-support and family care-giving to supplement care	**RISE OF PRIVATE INSURANCE EXCHANGES** Private players form health insurance exchanges; New exchange products offered through technology offer customers more options; Private exchanges match public ones and offer competitive prices
INTEGRATED CARE Accountable care organizations, patient-centered medical homes, outcome-based payment models, providers, physicians, and payers join together to provide patients with bundled services at lower cost; Hospital-physician alignment allows prioritized treatment for patients requiring urgent care	**HEALTH CARE ROBOTICS** Robots sterilize surgical tools without human intervention, reducing incidences of infections and freeing up hospital staff time; Robotic systems dispense drugs in pharmacies with zero errors; Automated kiosks allow patients to enter medical symptoms and receive customized recommendations and information
PARTICIPATORY MEDICINE Patients use their own health data to make better decisions. Apps designed to help people better manage their health, share best practices with fellow patients and lower medical costs by tapping into the knowledge of the crowd	**3D PRINTING IN HEALTHCARE** 3D printing technology revolutionizes surgical practices, giving practitioners access to identical replicas of certain body structures-and eventually organs. It reduces surgical errors and improves rehabilitation in post-op. Joint replacements become cheaper
HOLOGRAPHY-ASSISTED SURGERY Specialized surgeons perform holography-assisted surgery to treat patients remotely and instruct other physicians on operating procedures; Makes surgery less invasive and potentially offers better outcomes for patients, while also freeing up surgeon time	**THE M HEALTH REVOLUTION** Mobile phones and growing health needs make "mHealth" affordable and easily accessible alternatives to traditional healthcare; Advanced mHealth applications include telemedicine, sophisticated diagnostics through attachments plugged into smartphones, personalized services and self-monitoring.

SOCIAL MEDIA- THE NEW HEALTH EXCHANGE Health care organizations engage with patients through social media, regularly gauging their needs and driving them to appropriate products and services; Online patient communities grow providing needed information and navigation for patients to services and resources	**EVIDENCED-BASED CARE** Doctors use databases to diagnose and treat patient conditions from electronic medical records (EMRs) which provide best treatment options; 2020 sees the creation of warehouses of health data which will assist with identifying patterns and inform public health decisions and research
REMOTE MONITORING Sensor-enabled remote monitoring devices transmit patient biometrics to physicians and other caregivers in real time; Use of ingestible "smart pills" with sensors to wirelessly relay information on health indicators within the body to a smartphone	**REAL-TIME CLINICAL INFORMATION** Advanced data sharing networks allow insurance companies/payors and providers to access real-time patient information allowing health plans to assess the quality of care offered based on patient diagnosis and treatment
HOSPITAL & CLINIC COLLABORATION Hospitals and clinics are merging, both in urban and rural settings, due to changes in integrated care and reimbursement structure; Rural hospitals, especially, will see clinics diversify in hospital settings to address mental and behavioral health along with primary care	**HOSPITAL TRANSITIONS** Rural hospitals, specifically, will transition and diversify; there will be fewer hospital beds in the small rural hospitals and services such as rehabilitation, mental and behavioral health (in-patient and out-patient), emergent care, and primary care services will be offered in these facilities

The recommendations in this report should be considered with respect for the uncertainties, trends, and changes noted above.

About Our Hospital

MISSION

Jefferson Regional Medical Center is committed to providing measurable quality health services in a caring environment, which fulfill the needs of our patients, physicians, employers, employees and community.

VISION

Jefferson Regional Medical Center will be widely recognized as the healthcare leader and referral center of choice for Southeast Arkansas by providing quality healthcare services in a cost-effective manner.

VALUES

Jefferson Regional Medical Center, as a community-owned, not-for-profit health care provider, is guided by a core set of values known as "STEER" which provides direction to the organization in achieving our mission. These values are as follows:

- **Stewardship** – We use our resources in an effective and efficient manner.
- **Trust** – We conduct ourselves with honesty, reliability and integrity.
- **Excellence** – We perform at a level that meets or exceeds expectations.
- **Ethics** – We hold ourselves to a high level of personal and corporate responsibility.
- **Respect** – We show consideration, fairness and dignity to others.

STRATEGIC PLAN: ASCEND

Affiliate, Align & Grow
• Align Interests of SEARK Healthcare Providers • Strengthen Relationships with UAMS, Arkansas Children's Hospital and Others • Continue to Improve Image and Service, Meeting or Exceeding Expectations • Improve Market Share • Generate new Revenue

• Increase Referrals • Tell our story and improve visibility
Strengthen our Workforce & Medical Manpower
• Recruit Physicians • Recruit Nurses & Other Healthcare Professionals • Prime the Pipeline • Equip and Lead the Workforce
Conduct a Modern Facility
• Facility Planning, Development and Modernization
Emphasize Efficiency & Utilization
• Focus on efficiency, utilization and reimbursement to improve financial performance
Nurture Health & Community
• Provide Mutually Beneficial Community Health Services • Launch/Support Health Campaigns • Develop Sense of Ownership & Loyalty by and to the Community • Continually Improve Quality and Safety
Deliver Safe, High Quality Care
• Improve the Patient, Family & Visitor Experience • Innovate

SERVICE AREA

JRMC is the sole hospital located in Jefferson County, Arkansas. Furthermore, JRMC is the primary general acute care hospital serving Cleveland and Lincoln counties, as there is no hospital located in either of these counties. Together, Jefferson, Cleveland and Lincoln counties form the Pine Bluff Metropolitan Statistical Area, which coincides with JRMC's primary service area. Based on calendar 2015 data, 77% of all JRMC inpatient admissions and 84% of all JRMC outpatient visits originate from these three counties. JRMC's secondary

service area consists of Arkansas, Ashley, Bradley, Chicot, Dallas, Desha, Drew and Grant counties. 19% of calendar 2015 inpatient admissions at JRMC originated from these eight counties as well as 12% of outpatient visits. The primary and secondary service areas defined above are the source of 96% of all JRMC patients. JRMC identifies this 11-county service area as its community for purposes of this CHNA.

2019 HOSPITAL STAFFING CHART

See Jefferson Regional Medical Center's 2019 Staff Chart in Attachments

2019 HOSPITAL GOVERNANCE

Jefferson Hospital Association, Inc. is comprised of 30 members with the primary responsibility of electing the Board of Directors. A 13 voting member Board of Directors conducts the business of the Association. Thirteen members are elected for four-year terms by the membership of the Association following recommendations of a Nominating Committee. In addition to the elected Directors, the Chief Executive Officer of the Association and the Chief of the Medical Staff of Jefferson Regional Medical Center are non-voting, ex-officio members of the Board of Directors as long as they hold those positions. There are also two non-voting emeritus members. Brian Thomas is the current Chief Executive Officer of Jefferson Regional Medical Center.

Jefferson Regional Medical Center is a member of the Arkansas Hospital Association. They are also a member of the Arkansas Rural Health Partnership, a twelve hospital non-profit organization that works together to reduce costs by group purchasing and negotiation of contracts as well as provide several outreach projects in the Southeast Arkansas region.

JEFFERSON REGIONAL MEDICAL CENTER Board of Directors 2019	
Annette Kline, Chair Strong Manufacturing Company	**Scott Pittillo, Vice Chair** Relyance Bank
Ford Trotter, III, Treasurer Trotter Auto Group	**Drew Atkinson, Secretary** Pine Bluff Sand & Gravel

Janice Acosta Relyance Bank	**Frank Anthony** Retired School Superintendent
David Bridgforth Ramsay Bridgforth Law	**David Brown** Arkansas Mill Supply Company
James A. Campbell, MD James A. Campbell Jr MD & Associates	**Marty Casteel** Simmons Bank
Michelle Eckert, MD JRMC General Surgeon	**Archie Sanders** State Farm Insurance
George Makris, Emeritus (non-voting) Simmons First National Corp	**Joann Mays, MD** JRMC Pediatrician
Chuck Morgan, Emeritus (non-voting) Relyance Bank	**Lee Forestiere, MD,** ex officio (non-voting) JRMC Chief of Staff
Brian Thomas, ex officio (non-voting) JRMC President & CEO	

PROVIDERS

Anesthesiology
Ferdinand K. Samuel, MD
Fawad H Walajahi, MD
Cardiology (Heart and Vascular Care)
Ayman A. Alshami, MD, FACC
Ricki Fram, MD
Shabbir A. Dharamsey, MD, FACC
Sadeem Mahmood, MD, FACC
Abdul Ezeldin, MD, FACC, FSCAI, FASE, FSVM, FASNC
Nicolas Willis, MD
Dermatology (Skin Care)
Don Lum, MD, FAAD
Danel F. Smith, MD
Emergency Medicine
Hassan Alakshar, MD
Jeremiah Keng, DO
Hamida Saba, MD
Kayhan Bangash, MD

Tim McClure, MD
Shahid Shah, MD
Janet Curry, MD
Currin M. Nichol, MD
John T. Skowronski, MD, FACEP
Endocrinology (Diabetes, Thyroid, and Hormone Conditions)
Maher Alesali, MD
Family Medicine
Lester Alexander, MD
R. Douglas Coleman, MD
Kenneth Dill, MD
Kimberly Golden, MD
H. Marks Attwood, MD
Jason Cobb, MD
Herbert F. Fendley, MD
John E. Harris, MD
Keith Bennett, MD
Paul W. Davis, MD
Martha Ann Flowers, MD
Richard D. Justiss, MD
Larisa Kachowshi, MD
Herschel C. Marcus, MD
Darrel Over, MD
Anna Redman, MD
Tim T. Wilkin, DO
Manuel R. Kelley, MD
Toni Middleton, MD
Michele Al Paskevich, MD
Timm Reece, MD
Nancy Williams, MD
James A. Lindsey, MD
Scott Nichols, MD
Mark Ramiro, MD
Atiya N. Waheed, MD
Gastroenterology (Digestive System Conditions)
Meer Akbar Ali, MD

Ali A. Hussain, MD
Cyrus P. Tamboli, MD
General Surgery (Comprehensive Surgical Services)
Lon G. Bitzer, MD
Micelle Eckert, Md, FACS
Lee A. Forestiere, MD, FACS
Heather LeBlanc, MD, FACS
Charles D. Mabry, MD, FACS
Sarahrose Webster, MD
Hematology & Oncology (Blood & Cancer Conditions)
Omar T. Atiq, MD, FACP
Abid Mohiuddin, MD, FACP
Shahid Hameed, MD
Asif Masood, MD
Hospitalist (Hospital Medicine)
Revecca Aleck, DO
Sara Hanna, MD
Abrar Khan, MD
Tiffany Smith, MD
Jesse Cooper, MD
Nnamdi Ifediora, MD
Carla Pumphrey, MD
Nauman Yunus, MD, FACP
Jemeca Edwards, MD
Nazin Jamal, MD
Joseph Rose, MD
Internal Medicine
James Steven Cash, MD
John D. Dedman, MD
Olabode Olumofin, MD, MPH
Nephrology (Kidney Care)
M. Ahmer Kashif, MD
Stevn H. Wright, MD
James A. Campbell, Jr, MD

Neurology (Nerves and Nervous System Care)
Jacquelyn Sue Frigon, MD
Srilatha Thadur, MD
Obstetrics & Gynecology (Womens Health)
Calvin M. Bracy, MD, FACOG
Kenneth J. Lambert, MD
Amy B. Cahill; MD, FACOG
Reid G. Pierce, MD, FACOG
Tochi Keeton, MD
Ruston Pierce, MD, FACOG
Ophthamology (Eye Care)
David T. Nixon, MD
Spine Surgery (Spine & Back Care)
Jason Smith, MD
Orthopaedic Surgery (Bone, Joint, and Muscle Care)
Gordon Troy Birk, MD
Roy Burrell, MD
J. Alan Pollard, MD
Otolaryngology (Ear, Nose, and Throat Care)
Stephen D. Shorts, MD
Pain Specialist (Interventional Pain Management)
Navdeep Dogra, MD
Pathology
Julie Harris, MD
Pediatrics (Infants, Children, and Adolescents)
Sevilay Dalabih, MD
Horace Green, MD
Joann B. Mays, MD
Julie MacNeil, MD
Psychiatry (Mental Health)
Stephen A. Broughton, MD
Abeer Washington, MD
Pulmonary Medicine (Lung, Respiratory, and Critical Care)
Yathreb Alaali, MD
Ali Al-Nashif, MD

Khalid Mohammad, MD
Radiology (Medical Imaging)
Albert Alexander, MD
Paolo Lim, MD
Ronald Owens, MD
Shannor Turner, MD
Benjamin Bartnicke, MD
Wilma Matchett, MD
Karl Schultz, MD
Bill Deaton, MD
John Meadors, MD
Kathleen Sitarik, MD
Urology (Urinary and Reproductive Conditions)
David C. Jacks, MD, FACS
Gail Reede Jones, MD
Wound Care
James Cagle, MD

HEALTH CARE SERVICES

For more than 100 years Jefferson Regional Medical Center has provided a wide-range of medical services to the citizens of Southeast Arkansas.

- Heart & Vascular Care (Cardiology)
- Digestive Care (G.I. Services)
- Women's Health
- Pain Management
- Respiratory Care (Pulmonology)
- Rehabilitation & Therapy
- Hospital Medicine & Intensive Care
- Emergency Services
- Clinic Laboratory & Pathology
- Inpatient Hospice
- Psychiatric Services
- Ambulatory Surgery Center
- Wellness Centers
- Pediatrics
- General Surgery
- Orthopaedics & Spine
- Urinary & Reproductive (Urology)
- Nervous System (Neurology)
- Diabetic Care & Education
- Imaging Services
- Anesthesiology
- Infusion Center
- Pharmacy
- Urgent Care Center
- Health & Wellness Programs
- Pastoral Care

FUTURE PLANS

JRMC is finalizing plans to build a new facility to replace substantial portions of the current hospital. This will impact the health, wellness and economy throughout Southeast Arkansas for generations to come and will fulfill JRMC's promise to provide quality health services to all members of our community.

Community Health Initiatives

Jefferson Regional Medical Center is active throughout Jefferson County in sponsoring health fairs, health education programs, free health screenings and other activities to promote the health of the citizens of Jefferson County and surrounding communities.

Communities throughout Southeast Arkansas, like many rural areas in the Delta, face numerous socioeconomic challenges. Our focus has been to identify those factors, which are closely related to our mission, vision and values and support such development accordingly. While the benefit to the community is quite visible, the connection to the community's economy may require a bit more thought. However, when the community's socioeconomic challenges are improved, the community becomes stronger and healthier.

Our hospital contributes to the following organizations and events:

50 for the Future
American Heart Association
Arkansas Community Foundation
Go Forward Pine Bluff
ICVR Kingfest
Local youth sports programs
Neighbor to Neighbor
Pine Bluff Rotary
Seabrook YMCA
South Arkansas Chambers of Commerce
Special Olympics
United Way of Southeast Arkansas
Voice for Children
Watson Chapel Lions Club
American Cancer Society's Relay for Life
American Hospital Association
Arts and Science Center for Southeast Arkansas
The CASA Women's Shelter
Jefferson County Industrial Foundation
March of Dimes
Pine Bluff Chapter of Links, Inc.
Quapaw Area Council
SEARK College Foundation
Southeast Arkansas School Districts
Susan G. Komen Race for the Cure
UAPB's Chancellor's Benefit for the Arts
Walk to Cure Diabetes
White Hall Police Association

JRMC also provides a vast array of educational classes, events and forums designed to raise awareness about health and wellness issues for every segment of our population. We see health education outreach as a major part of our mission.

Our hospital offers the following educational opportunities:

Maternal Child Classes
Child Passenger Safety Program
Colorectal Screening
March of Dimes Walk America
Flu Shot Clinics
Diabetes Education
CPR Training
Access Project Pink
Community Health Fairs
Walk to Cure Diabetes
SEALife Educational Stories

JRMC Wellness Centers

JRMC has two Wellness Centers located in Pine Bluff and White Hall. These centers offer a full range of programs to meet the wellness and fitness needs of the entire family. Facilities are equipped with state-of-the-art cardio equipment, strength equipment, free weights, group exercise classes, studio cycling, walking tracks and personal trainers.

Arkansas Rural Health Partnership

Jefferson Regional Medical Center currently participates in several health outreach efforts through its affiliation with the Arkansas Rural Health Partnership (ARHP). Arkansas Rural Health Partnership (formerly known as Greater Delta Alliance for Health) is a 501(c)3 non-profit, horizontal hospital organization comprised of twelve, independently owned, South Arkansas rural hospitals committed to working together throughout the South Arkansas Delta region to: Improve the delivery of healthcare services, Increase access to health care services & programs, Provide healthcare provider education opportunities, Increase the utilization of tele health & tele medicine technology, Promote healthy lifestyles, Assist community members with patient assistance programs, and Reduce service & operational costs for hospital members through collaborative negotiation and purchasing. Arkansas Rural Health Partnership members include Ashley County Medical Center (Crossett, AR), Baptist Health-Stuttgart (Stuttgart, AR), Bradley County Medical Center (Warren, AR), Chicot Memorial Medical Center (Lake Village, AR), Dallas County Medical Center (Fordyce, AR), Delta Memorial Health System (Monticello, AR) Medical Center of South Arkansas (El Dorado, AR), McGehee Hospital (McGehee, AR), Magnolia Regional Medical Center (Magnolia, AR), and

Jefferson Regional Medical Center (Pine Bluff, AR). The organization was founded to help local hospitals address the financial burdens of their individual organizations and work to provide health outreach to the region through funding opportunities.

Currently, ARHP provides the following outreach and education programs to its members, patients, and communities:

Healthcare Provider Training & Education

- On-Site Simulation Trauma Training
- On-Site Simulation Coding Training
- On-Line Healthcare Education
- Diabetes Site Accreditation Assistance
- DEEP training & certification
- Medication Assistance for OUD Patients
- On-Site Simulation OB Certification
- On-Site Simulation ASLS Certification
- On-Line Healthcare Orientation
- Diabetes Certification Assistance
- SAMHSA's SBIRT training
- Mental Health First Aid Training

Patient Education & Outreach Services

- Opioid Use Disorder (OUD) Education & Navigation
- Free Breast Screening & Diagnostic Services
- Insurance & Medicare Assistance & Enrollment
- Diabetes Empowerment Education Program (DEEP)
- Opioid Use Disorder Case Management/Counseling
- Emergency Department Mental Health Assessments
- Prescription Assistance Services
- Cooking Matters Classes
- Diabetes Prevention Program
- Mental Health First Aid Training
- Patient Navigation
- Diabetes Self-Management

Telehealth Services

- Opioid Use Disorder Case Management/Counseling
- Emergency Department Mental Health Assessments
- Patient Navigation

Community Education & Outreach Services

- Insurance & Medicare Assistance & Enrollment
- Diabetes Empowerment Education Program (DEEP)
- Opioid Use Disorder (OUD) Education
- ArCOP Community Grants
- Health Fairs
- Cooking Matters Classes
- Diabetes Prevention (DPP)
- Mental Health First Aid Training
- Health Resource Directory
- EMT Certification

2016 CHNA UPDATE

2016 CHNA GOALS

Goal I. Improve Physician Access
IMPLEMENTATION STRATEGY
Continue physician recruitment based upon medical manpower plan priorities • Continue support of UAMS-AHEC Family Practice residency program • Work with UAMS and others to establish alternative approaches to place specialists in SEARK • Continue recruitment of PAs and APNs to complement and extend physicians where appropriate • Continue expansion of satellite clinics to provide specialty care closer to patient homes
Goal II. Healthcare Workforce Development
IMPLEMENTATION STRATEGY
Continue to support and operate JRMC School of Nursing. • Continue to provide support for clinical rotations for UAPB, UAM, SEARK and other nursing programs. • Continue to serve as a rotation site for SEARK and other teaching/training programs in fields such as radiology, respiratory therapy, medical technology, etc. • Continue to provide tuition reimbursement for JRMC employees to further their education and training.
Goal III. Education, Prevention, and Management of Chronic Diseases (Heart Disease, Obesity, and Diabetes)
IMPLEMENTATION STRATEGY
Develop or partner with other healthcare providers to add to the current offering of education on prevention and/or self-management. • Continue to offer workplace screenings and outreach to schools and churches. • Continue the LEAP program and other educational offerings to diabetic patients and families on nutrition, exercise, medications and self-management. Continue to provide health fairs and outreach programs to local businesses, churches and the general public. • Work with local home health agencies to ensure education and assistance is available and provided in the home. • Expand the role of case management to assist with coordination of post-acute care management

Goal IV. Education, Prevention, and Management of Other Chronic Health Conditions (Teen Pregnancy, Low Birth Weights, Sexually Transmitted Diseases)
IMPLEMENTATION STRATEGY
This need is presently out of the scope of JRMC
Goal V. Improve Hospital Services (including Emergency Services, Surgical Services, and Diagnostic Services
IMPLEMENTATION STRATEGY
Continue to provide emergency services as a level III trauma center. • Continue to provide urgent care services for urgent, but non-emergent patients. • Maintain cooperative relationship with other SEARK hospitals through transfer and referral agreements and partnership through the Greater Delta Health Alliance. • Maintain and further develop relationships with SEARK EMS providers • Continue to provide sufficient inpatient and outpatient surgical facilities. • Continue to invest in the latest technologies for surgical services that are appropriate for a hospital the size and scope of JRMC

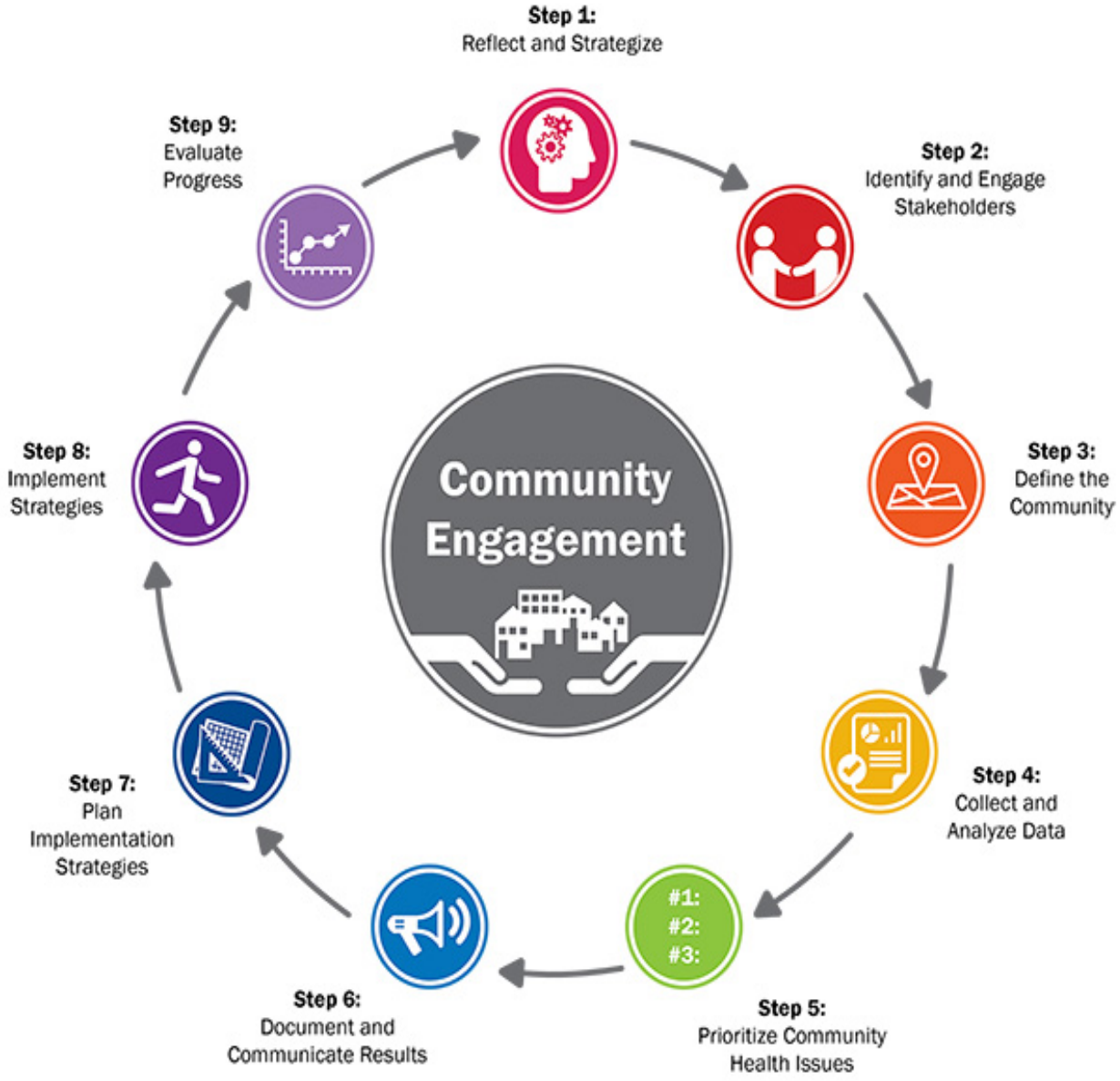
2016 CHNA PROGRESS

Goal I. Improve Physician Access
PROGRESS
Built two new floors for the Residency Program to consolidate clinic operations; UAMS has a 20 year lease on new space; new satellite clinics were opened
Goal II. Healthcare Workforce Development
PROGRESS
The School of Nursing transitioned from a diploma program to an Associate's Degree program

Goal III. Education, Prevention, and Management of Chronic Diseases (Heart Disease, Obesity, and Diabetes)
PROGRESS
JRMC is currently becoming certified as a DSME site and has provided Cooking Matters in the community and assisted with community grants for gardens.
Goal IV. Education, Prevention, and Management of Other Chronic Health Conditions (Teen Pregnancy, Low Birth Weights, Sexually Transmitted Diseases)
PROGRESS
Not Addressed
Goal V. Improve Hospital Services (including Emergency Services, Surgical Services, and Diagnostic Services
PROGRESS
JRMC has continued to improve and provide these services and staff has participated in on-site simulation certification trainings

2019 CHNA

COMMUNITY ENGAGEMENT PROCESS



http://www.healthycommunities.org/Education/toolkit/files/community-engagement.shtml#.XEnj7bLru70

CHNA FACILITATION PROCESS

The Community Health Needs Assessment Toolkit developed by the National Center for Rural Health Works at Oklahoma State University and Center for Rural Health and Oklahoma Office of Rural Health was utilized as a guide for the CHNA facilitation process. The process was designed to be conducted through an intensive two-hour community meeting. The facilitator and the steering committee oversee the entire process of organizing and determining a Community Advisory Committee of 20-30 community members that meet throughout the process to develop a strategic plan for the hospital to address the health needs of the community.

Overview of the Community Health Needs Assessment Process

Step 1: STEERING COMMITTEE

Select Community Advisory Committee Members

Select Community Meeting Dates

Invite Community Advisory Committee Members

Step 2: COMMUNITY SURVEY

Publicize survey via social media

Make survey available through website & social media

Collect survey data

Compile survey data

Step 3: COMMUNITY MEETING

Overview of CHNA Process

Responsibilities of Community Advisory Committee

Present Health/Hospital Data & Services

Present Survey Results/Outcomes

Group Discussion on Community Health Needs

Develop a Work Plan to Address Survey Results

Step 4: POST ASSESSMENT ACTIVITIES

Develop & Finalize Action Plan

Hospital Board Approval of CHNA Report

CHNA Report available to the Public

Report CHNA Activities/Plan to IRS

Public input is essential in the development of a Community Health Needs Assessment. To begin the process, the JRMC staff steering committee members convened with Mellie Bridewell of the Arkansas Rural Health Partnership to assess community member involvement. The JRMC staff steering committee included Bryan Jackson (JRMC Chief Financial Officer), Debbie Tole (JRMC Administrative Assistant), Mellie Bridewell (CEO of the Arkansas Rural Health Partnership), and Lynn Hawkins (COO of the Arkansas Rural Health Partnership) participated and provided assistance with organizing the community meetings as well as development of the assessment and strategic implementation plan.

Due to the size of the service area, the steering committee chose to conduct their assessment through a focus group of community leaders and individuals in health-related fields. Approximately 60 Individuals from the community were selected for invitation to the focus group, or community advisory committee, by the Jefferson Regional Medical Center staff steering committee. Those accepting the invitation – approximately 21 – attended the meeting of the community advisory committee.

The steering committee assisted in the distribution of the surveys to neighbors, colleagues, and friends. Surveys were available electronically on the JRMC website, the ARHP website, and various social media sites throughout the service area. At the meeting, members were presented what was expected of them through the process, facts and statistics on the region, results of the surveys and then discussed some of the questions and responses as a group and proceeded to prioritize community health concerns. These priorities led the staff steering committee to develop a more detailed implementation plan to address those issues and create community benefit. Over the next three years, the action plans will be implemented for each issue and the hospital steering committee will meet annually with the advisory committee to assess progress.

Steering Committee

Mellie Bridewell	Chief Executive Officer	Arkansas Rural Health Partnership
Bryan Jackson	Chief Financial Officer	Jefferson Regional Medical Center
Debbie Tole	Administrative Assistant	Jefferson Regional Medical Center
Lynn Hawkins	Chief Operations Officer	Arkansas Rural Health Partnership

Community Advisory Committee

Name	Occupation
David Bridgforth	Ramsay, Bridgforth, Robinson, and Raley LLP
Janice Acosta	Relyance Bank
Frank Anthony	Retired
James Campbell, MD	Physician
Lee Forestiere, MD	JRMC Chief of Staff
Annette Kline	Strong Manufacturing
Joann Mays, MD	Physician
Julie Bridgforth	Relyance Bank
Nancy Oudin	Oudin Properties
Cindy Trotter	Trotter Auto Group
Ryan Watley	Go Forward Pine Bluff
Debe Hollingsworth	JRMC Foundation
David Beck	First Arkansas Insurance
Joy Blankenship	Pine Bluff Downtown Development
Steven Brown	Relyance Bank
Rev. Jimmy Fisher, Sr.	Greater Mt. Calvary Baptist Church
Chris Hart	Central Moloney
Carla Martin	University of Arkansas at Pine Bluff
Harvey Sizemore	Sizemore Properties
Diane Tatum	Retired
Amy Cahill, MD	Physician
Walter Cash	Wells Fargo Advisors
Wes McNulty	Farming
Fred Reed	Reed Architectural Firm
Adam Robinson	Ralph Robinson & Son Funeral Directors
Bryan Robinson	Pine Bluff Sand & Gravel
George Talbot	Simmons Bank
John Lawson	Express Employment Professionals
John Lytle	Physician
Jerrel Boast	Retired
Claire Campbell	Retired
Daniel Robinson	Simmons Bank

Donald Hatchett	Pine Bluff City Council
Win Trafford	Pine Bluff City Council
Shirley Washington	Mayor of the City of Pine Bluff
Noel Foster	Mayor of the City of White Hall
Lee Turner	Department of Human Services
Duncan Bellingrath	Simmons Bank
Janet Hartz	Hartz Honey Hole
Laurie McAfee	Pine Bluff Country Club
Donna Stone	Trinity Village
Dr. Laurence Alexander	University of Arkansas at Pine Bluff
Steven Bloomberg	SEARK College
Diann Williams	University of Arkansas at Pine Bluff
Joyce Scott	SEARK College
Rev. Derick Easter	New St. Hurricane Church
Charlotte England	Neighbor to Neighbor
Lawrence Fikes	Arkansas Community Foundation
Lisa Kosmitis	Civic Auditorium Complex Commission
Nancy McNew	Pine Bluff Chamber of Commerce
Matt Mosler	New Life Church
LouAnn Nisbett	Jefferson County Alliance
Neil Quick	Harmony Missionary Baptist Church
Rev. Kenneth Thorton	First Baptist Church, Pine Bluff
Kathy Tynes	Area Agency on Aging
Marlyn Simpson	JRMC Auxiliary
Gerald Robinson	County Judge of Jefferson County
Doug Dorris	White Hall School District
Daniel Robinson	Simmons Bank
Eugene Hunt	Hunt Law Firm

RESULTS OVERVIEW

There were 84 completed surveys through the 2019 CHNA process. All of the results of the survey can be found in Attachment C: 2019 Jefferson Regional Medical Center Survey Results.

Prioritized Health Needs Identified through CHNA Process
Need for more Mental and Behavioral Health Resources
Suggestions for addressing need: ❖ Consider partnering with South East Behavioral and Jenkins to increase behavioral health services ❖ Need more resources ❖ Provide counseling services at the local level for OUD patients ❖ Provide transportation for patients needing in-patient placement ❖ Facilitate development of short-term facility ❖ Increase mental and behavioral health resources at the local level
Need for Community Education; Insurance, Medicare, and prescription assistance
Suggestions for addressing need: ❖ Provide Patient Navigators in the hospital and clinics ❖ Provide training for insurance enrollment, Medicare, and assistance services ❖ Provide community outreach (churches, events, salons, parent nights at schools) ❖ Provide direct assistance with insurance and Medicare enrollment ❖ Provide Billboards and Marketing of assistance services ❖ Distribute brochures and information at physician offices ❖ Increase outreach and education through the churches ❖ Establish a prescription assistance program
Need for more Healthcare Specialists
Suggestions for addressing need: ❖ Need to build better relations with Southeast Behavioral Health Services ❖ Recruit physicians to address healthcare for senior citizens ❖ Provide competitive compensation ❖ Be more proactive & get more than you need ❖ Make community attractive ❖ Grow your own ❖ Uplift your own hospital. PB is a good place to live ❖ In long term get kids focused on promoting healthcare

❖ Now can have consulting physicians ❖ Currently have an aggressive Hospitalist team that can do some of the work for the "ologists"
Transportation is a big obstacle
Suggestions for addressing need: ❖ Transportation resources are out there but we need to find a way to let the community know what we already have ❖ Create marketing brochures that list the transportation agencies in plain view in doctor's offices, Salvation Army ❖ Consider use of outpatient primary care clinics staffed with APRN. ❖ Use telehealth & telemedicine when possible

In conclusion, JRMC Steering committee will develop a strategic implementation plan prior to August 30, 2019 to address the following priorities:

- Increase mental and behavioral health services and programs in the service area
- Increase healthcare specialty services in the region through recruitment and tele health
- Provide community outreach efforts around prescription assistance, Medicare, and insurance enrollment
- Increase transportation efforts to patients in Southeast Arkansas

DOCUMENTATION

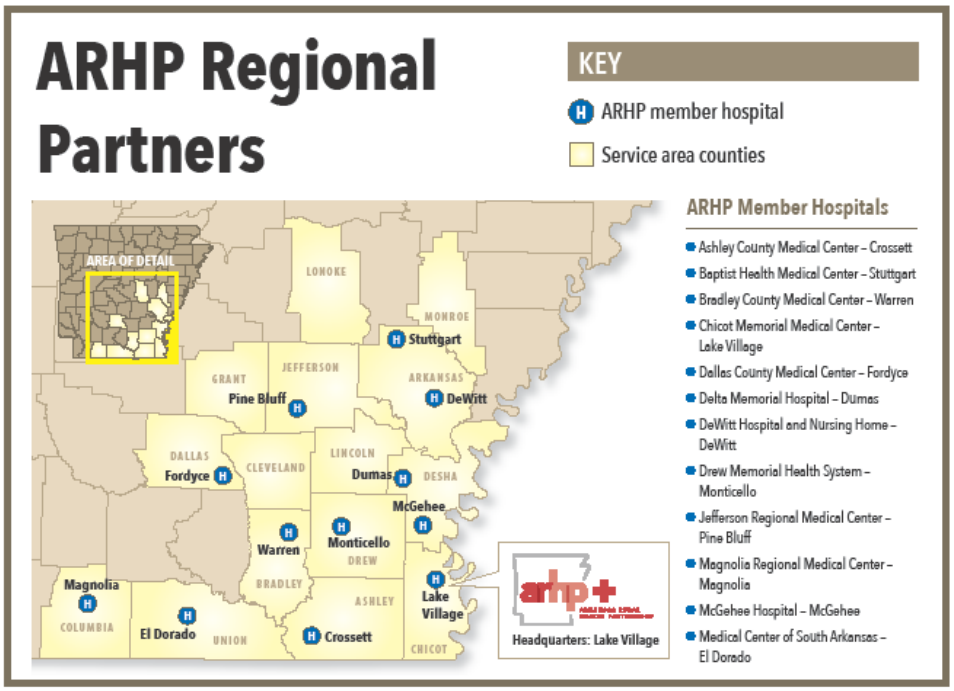
The following documentation of 2019 CHNA presentations, agendas, sign-in sheets, and survey results are included in the following attachments which can be found at the end of this report.

- **Jefferson Regional Medical Center 2019 Staff Chart**
- **Attachment A.** Community Advisory Committee Meeting Sign-in Sheet
- **Attachment B.** Community Advisory Committee Meeting PowerPoint Presentation
- **Attachment C.** 2019 Jefferson Regional Medical Center Survey Results

Relevant Data

REGIONAL & STATE DATA

For the purposes of this assessment, regional demographics include the counties served by Jefferson Regional Medical Center and the direct counties of the hospitals of the Arkansas Rural Health Partnership (ARHP). ARHP, a non-profit hospital network of 12 hospitals in South Arkansas, will be submitting a full regional report for purposes of utilizing the CHNA information for future programs and priorities. Jefferson Regional Medical Center plays a leading role in ARHP funded projects and programs. The estimated size of the general population within the nine service area counties is 205,800 residents (US Census, 2016). Below is a map of all Arkansas Rural Health Partnership hospitals (June 2019).



The geographic region is known as the south Arkansas Delta which predominantly covers the southeast corner of the state of Arkansas. The flat landscape of the service area borders the Mississippi River, which is a significant transportation artery connecting the Missouri and Ohio River tributaries (World Atlas, 2017). The flat, fertile land is the backbone of predominant industry in the region: agriculture and agribusiness. The

region is very rural; Pine Bluff is the largest town in the Delta, home 42,984 residents (US Census, 2017). Every county within the service area is designated as a Medically Underserved Area (HRSA Data Warehouse, 2018).

Within the service area, approximately 6.0% of the general population is below the age of five (ranging from 5.1% in Dallas County and 6.9% in Desha County). This is slightly below the state and U.S. averages for the age bracket. Increasing the age parameters to persons under 18 years of age shows another perspective of the number of children below 10 years. The average percentage of persons under 18 years in the service area is 22.6%, which is the same as the U.S. and slightly lower than the state. Ranges within the service area include 20.7% in Columbia County and 25.8% in Desha County. To further estimate the target population, new approximations from the Office of Adolescent Health were considered, which shows that adolescents (individuals age 10-19) make up approximately 13.2 percent of the U.S. population (The Changing Face of America's Adolescents, Office of Adolescent Health, HHS, 2018). The focus of Substance Use Disorder (SUD) prevention, treatment, and recovery planning efforts will focus on adolescents (beginning at age 10) and adults in the service area, roughly estimated to be about 90% of the service area population.

Demographic & Socioeconomic Profile Comparison (County, State, Nation)

County	Population	Median Household Income	People w/o Insurance	Population Decline (2010-18)	Persons Living in Poverty
Arkansas County	17,769	$38,532	8.9%	-8.2%	19.9%
Ashley County	20,042	$36,310	9.2%	-6.5%	17.9%
Bradley County	10,897	$34,665	11.6%	-5.3%	20.9%
Chicot County	10,438	$32,412	8.9%	-11.5%	30.1%
Columbia County	23,537	$37,072	8.3%	-4.1%	25.5%
Cleveland County	8,018	$44,840	8.9%	-7.8%	14.3%
Dallas County	7,182	$35,794	8.1%	-11.6%	21%
Desha County	11,512	$27,036	9.5%	-11.5%	29%
Drew County	18,328	$36,092	8.4%	-1%	20.3%
Grant County	18,188	$49,968	6.1%	+1.9%	12.2%
Jefferson County	68,114	$37,630	7.2%	-12.1%	23.5%
Lincoln County	13,383	$38,873	9.4%	-5.4%	23.4%
Union County	39,126	$41,106	8.9%	-6.0%	17.5%

State of AR	3,013,825	$43,813	9.3%	-12.1%	16.4%
U.S.	327,167,434	$57,652	10.2%	-7.8$	12.3%

(US Census, Quick Facts, based on July 2018)

Health disparities, poverty, lack of transportation, low educational attainment, poor access to health care, and poor health outcomes- the Mississippi Delta Region represents an amalgam of societal difficulties that affect each of its residents. One Delta state's Office of Minority Health publication states that health disparities of the people living in the Delta are "due to gaps in access to care and an inadequate public health infrastructure – especially difficult to maintain in the small, isolated, rural communities that make up so much of the Delta region (Graham, 2008)." On average, one in four persons in the service area is living below poverty level, making it one of the poorest areas of the state.

According to recent US Census Data (2017), individuals within the service area experience greater economic hardship compared to those in other regions of the state and nation. This includes a lower median household income and higher poverty rate. This can be contributed to lower levels of educational attainment, with most county residents having lower high school graduation rates compared to the state and nation. Unemployment is also significantly higher in eight out of nine service area counties as compared to the state and nation.

The majority of Southeast Arkansas Delta residents are Caucasian (*average of 64.9%*), which is less than the state (*79.3%*). African Americans are the largest minority in the service area (*average of 32.4%*), which is significantly higher than the state (*15.7%*). The Hispanic population is small, but growing (*average of 4.7% in service area vs. 7.6 % across state)*.

Race & Ethnic Diversity Profile Comparison (Service Area Counties & State)

Region	Black	White	Hispanic	Total Population
Arkansas County	25%	71.9%	3.1%	17,769
Ashley County	25%	72.5%	5.4%	20,042
Bradley County	27.8%	68.5%	15.6%	10,897
Chicot County	54.2%	43.6%	5.4%	10,438
Cleveland County	11.3%	86.5%	2.3%	8,018
Columbia County	36%	61%	2.7%	23,537

Dallas County	41.7%	55.6%	3.2%	7,182
Desha County	47.3%	50.3%	6.7%	11,512
Drew County	28.2%	69.4%	3.5%	18,328
Grant County	2.8%	94.7%	2.6%	18,188
Jefferson County	57%	40.3%	2.1%	68,114
Lincoln County	30.6%	67.3%	3.6%	13,383
Union County	32.8%	64.2%	4.1%	39,129
State of Arkansas	15.7%	79.3%	7.6%	3,013,825

(United States Census Bureau, Population Estimates, 2018)

Health Disparities in the Service Area. Health disparities within the state of Arkansas are literally making headlines and the differences are easily noticeable with a glimpse of a map. In 2018, individuals living in northwest Arkansas experienced life expectancies of ten years or more than their rural, eastern Arkansas neighbors. In fact, the life expectancy of individuals in the service area are some of the poorest in the state. This is based on many factors, including differences in physical activity, smoking, preventable hospital stays, and violent crime rates (County Health Rankings and Roadmaps, 2018). Perhaps the most critical determinant of these factors is access, including access to education, employment, transportation, and healthcare providers (preventive, primary & emergent services). See Table 5 below.

2018 County Health Rankings: Measure Comparison (Nation, State, Service Area)

Measure	Description	US Median	State Overall	Service Area Min.	Service Area Max.	Service Area Ave.
Health Outcomes						
Premature death	Years of potential life lost before age 75 per 100,000 population	6,700	9,200	10,100	12,800	11,333
Poor or fair health	% of adults reporting fair or poor health	16%	24%	23%	30%	26%
Poor physical health days	Average # of physically unhealthy days reported in past 30 days	3.7	5.0	4.7	5.6	5.06
Poor mental health days	Average # of mentally unhealthy days reported in past 30 days	3.8	5.2	4.7	5.2	4.98
Clinical Care						
Uninsured	% of population under age 65 without health insurance	11%	11%	9%	15%	10.77%
Primary care physicians	Ratio of population to primary care physicians	1,320:1	1,520:1	2,980:1	1000:1	1,825:1
Mental health providers	Ratio of population to mental health providers	1,480:1	490:1	11,000:1	160:1	1,898:1

(County Health Rankings & Roadmaps: 2018 County Health Rankings: Arkansas)

JEFFERSON COUNTY

Jefferson County is a county located in the area known as the Arkansas Delta that extends west of the Mississippi. Jefferson County is Arkansas's 21st county, formed on November 2, 1829 from portions of Arkansas and Pulaski counties. It is named for Thomas Jefferson, the third President of the United States.

According to the Robert Wood Johnson Foundation County Health Rankings and Roadmap study, Jefferson County is considered one of the unhealthiest counties in the state of Arkansas; ranking #73 in overall health outcomes and #70 in overall health outcomes out of 75 counties in Arkansas. This chart demonstrates Jefferson County rankings within the 75 counties of Arkansas.

HEALTH OUTCOMES	**70**
Length of Life	67
Quality of Life	66
HEALTH FACTORS	**68**
Health Behaviors	69
Clinical Care	13
Social & Economic Factors	70
Physical Environment	55

The charts below and the map on the next page demonstrate Jefferson County's ranking in demographics, economics, injury, health indicators, and health risk factors.

Major Health Risk Factors	Description	Number	Percent	Rank	State Rate
Food Insecurity	The population who did not have access to a reliable source of food during the past year.	19,460	26.5%	70	18.4%
Physical Inactivity	Adults (Age 18+) reporting no leisure-time physical activity .	17,120	31.7%	23	32.5%
Obesity (adults)	Adults (Age 18+) reporting being obese (BMI >= 30.0)	21,127	39.1%	49	35.7%
Overweight (adults)	Adults (Age 18+) reporting being overweight (BMI >=25.0 - 29.9).	17,118	31.7%	21	32.5%
Obesity (youth)	Students grades K-10 with a BMI >= 95th percentile for age and sex.	3,051	24.7%	47	22.0%
Overweight (youth)	Students grades K-10 with a BMI >=85th percentile to <95th percentile for age and sex.	2,202	17.8%	49	17.0%
Low Health literacy	Adults with basic or below basic health literacy skills.	24,766	44.2%	64	37.1%
Substance Abuse (youth)‡	Students grades 6-12 reporting using drugs in the past 30 days.	727	12.5%	63	9.9%

‡Student response rate was below sufficient level (< 40% overall valid participation or < 25% valid participation rate from one or more of the four grades surveyed) and may not reflect the actual level of use.

Health Indicators†	Description	Number	Percent	Rank	State %
Current adult smokers	Adults (18 +) reporting being current smokers.	11,783	21.4%	53	24.9%
Current youth smokers‡	Students grades 6-12 reporting being current smokers.	204	3.5%	7	5.6%
Low Birth-Weight Babies	Live births where the infant weighed less than 2,500 grams (5 lbs., 8 oz.), 5-year average.	113	12.4%	71	8.8%
Life Expectancy	The average expected life time (in years) from birth.	73.5 yrs.	N/A	67	76.0 yrs.
Natural Teeth	Adults 65+ who have had all their natural teeth extracted.	8,303	15.4%	18	23.0%
Water Systems with Fluoridation	Public water systems containing enough fluoride to protect teeth.	3	20.0%	62	49.7%
		Number	**Rate**	**Rank**	**State Rate**
Infant Mortality, 2012-2016	Measures the number of deaths among children less than one year of age .	44	9.6	67	7.1
Teen births	Births to mothers aged 15 to 19 years, 5-year average.	121	47.9	47	39.5

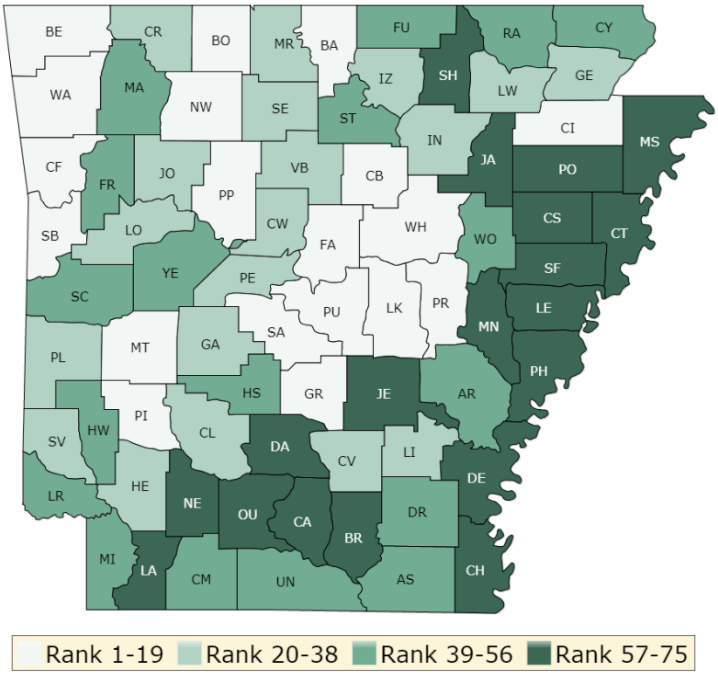
†5-year average is shown for low birth-weight babies and teen births and indicates the number of births on average each year for the most recent 5 years of available data; Infant mortality number is the total number of deaths over the most recent 5 years available and infant mortality rate is an estimate of the number of infant deaths for every 1,000 live births; Teen birth rates are per 1,000 female population ages 15-19 years.

Demographics	Description	Number	Percent	Rank	State %
Total Population	The number of people who live in the county.	72,385	N/A	10	2.4%
White (Non-Hispanic)		28,877	39.9%	73	73.4%
Black (Non-Hispanic)		40,590	56.1%	3	15.4%
Hispanic or Latino Origin		1,369	1.9%	59	7.0%

U.S. Census Bureau, 2012-2016 Population Estimates: Ranks are based on the percent of the total population. Ranks are 1= highest and 75 = lowest.

Economic Indicators	Description	Number	Percent	Rank	State %
Median Household Income	The income at which half the households earn more and half the households earn less.	$36,377	N/A	37	$42,336
People of All Ages in Poverty	People of all ages living below the Federal Poverty Line (FPL).	18,458	25.5%	63	18.8%
Children in Poverty	Children under age 18 living below the Federal Poverty Line (FPL).	6,439	38.6%	66	26.8%
Children in Single Parent Homes	Children that live in a household headed by single parent.	8,759	52.5%	70	35.4%
Uninsured	Population under age 65 without health insurance.	7,118	12.4%	7	14.5%
No transportation	Households with no transportation.	2,481	9.0%	61	6.4%
Injury*	**Description**	**Number**	**Rate**	**Rank**	**State Rate**
Injury Related Hospital Discharges	All injury related hospital discharges.	2,112	529.9	36	512.6
Unintentional Fall Discharges	Hospital discharges from falls due to loss of balance and not due to paralysis or injury.	923	209.5	25	222.8
Motor Vehicle Accident Discharges	Hospital discharges from motor vehicle accidents including cars, motorcycles and ATVs.	335	88.5	49	69,5
Traumatic Brain Injury Discharges	Hospital discharges due to injury resulting from external mechanical forces.	115	30.8	65	20.9
Deaths from Injury	Deaths from intentional and unintentional (accidental) injuries, 5-year average.	63	86.6	37	78.5

**When low numbers result in unstable injury or death rates, rates are not displayed. Rank was calculated for those counties where rates were available. Rates are per 100,000 population. Injury related discharges are 5-year averages. 5-year average indicates the average number of annual deaths for the most recent 5 years of available data.*



TOPIC SPECIFIC DATA

At the conclusion of the Jefferson Regional Medical Center survey and community advisory board processes, there were four priorities that were targeted for the hospital to address over the next three years: **Mental and Behavioral Health Services, Patient Navigation, Transportation, and Physician Recruitment (Specialists).** The following data highlights the issues around these topics at the federal, state, and local level.

Mental and Behavioral Health Services

Poor mental and behavioral health have long been a major concern for communities across the nation. Stigma surrounding mental health and the lack of understanding and/or misunderstanding related to prevention and treatment options often keep individuals from seeking needed interventions before symptoms accelerate into a mental health crisis or even death. In rural communities, these issues are exacerbated as prevention, early detection, and treatment options related to mental health are limited. The number of mental health professionals are often extremely limited in rural settings, leaving crisis management and treatment responsibilities to poorly equipped laypersons, first responders, and health care professionals.

According to the CDC, the #10 leading cause of death in the nation for 2014, 2015, and 2016 was intentional self-harm (suicide). Interestingly enough, intentional self-harm held the same placeholder for the #10 national leading cause of death in 1980. In each year noted, suicide was the only leading top 10 cause of death that could be linked to poor mental and/or behavioral health. In comparison, a National Vital Statistics Report recently released by the CDC titled *Major Causes of Death, by County* showed that poor mental and/or behavioral health could be attributed to **three out of ten leading causes of death** in service area counties between 1980 and 2014. See table below for leading cause of death rankings by service area.

Top Ten Leading Causes of Death Linked to Poor Mental and/or Behavioral Health, Service Area

Leading Cause of Death	Arkansas County	Ashley County	Bradley County	Chicot County	Desha County	Drew County	Dallas County	Jefferson County	Lincoln County	Cleveland County	Grant County
Self-harm & interpersonal violence	#7	#8	#8	#8	#8	#8	#8	#7	#8	#8	#8
Cirrhosis & other chronic liver diseases	#9	#9	#9	#9	#9	#9	#9	#9	#9	#9	#9
Mental & substance use disorders	#10	#10	#10	#10	#10	#10	#10	#10	#10	#10	#10

(Major Causes of Death, by County, US County-Level Trends in Mortality Rates for Major Causes of Death, 1980-2014, National Vital Statistics, CDC, 2016)

In a report released in April 2016 by the Arkansas Department of Health, suicide is the leading cause of injury related deaths for Arkansans between the ages of 20 and 64 and the second leading cause of death among all other age groups according to Suicide Statistics Among Arkansans from 2009 to 2014 conducted by the Arkansas Department of Health, 2016. Suicide is a preventable cause of death. According to the 2017 State of Mental Health in America report, Arkansas ranks number 37 out of 51 with high prevalence of Mental Health illness. However, Arkansas ranks 44 in access to care. The rank shows that despite the high prevalence, access to care is low (National Alliance for the Mentally Ill, 2017).

Partner hospitals highlighted the number of patients within the target population utilizing the Emergency Department (ED), as well as those seeking out care for mental/behavioral health problems. See Table below.

Emergency Department Use in Service Area, Total vs. Mental Health Complaint

Emergency Department Use	2015	2016
Total number of patients utilizing the ED	88,673	89,965
Total number of patients (age 18-64) utilizing the ED	56,303	54,837

Number of patients (age 18-64) utilizing the ED for mental health/behavioral health problems	1,121	1,241

(This data includes 8 out of the 10 participating hospitals)

Hospital administrators have heard the complaint from healthcare providers within the Emergency Department (ED) that there is limited ability to correctly screen patients for psychiatric and mental health concerns. A dedicated mental health professional (via telemedicine) will significantly relieve the ED staff from completing these assessments, while also decreasing the hold time for these patients in the ED waiting for the assessment to be completed.

Emergency Department Psychiatric & Mental Health Screening Efforts

Screening & Assessment	2015	2016
Number of patients (age 18-64) undergoing a formal psychiatric evaluation in the ED	353	471
Number of patients (age 18-64) given a mental health screening/assessment in ED	1,108	1,233

(This data includes 8 out of the 10 participating hospitals)

Rural communities face distinct challenges in addressing mental and behavioral health concerns and their consequences. ARHP consortia members recognize that they have all the challenges listed:

- Behavioral and mental health resources and services are not as readily available and are often limited.
- The number of mental health professionals are very limited in rural areas, increasing access barriers for individuals in need of specialized care.
- Patients who require treatment for serious mental illness may need to travel long distances to access these services. This includes in-patient and out-patient treatment, as well as hospitalization for psychiatric diagnoses. Transportation from the emergency department to treatment facilities is often limited to EMS. In some counties, one or two EMS trucks cover an entire county with a one-hour driving radius.
- Rural first responders and rural hospital ED staff may have limited experience in providing care to a patient presenting in a mental health crisis.
- Prevention programs may be spread sparsely over large rural geographic areas.
- Patients seeking mental health treatment may be more hesitant to do so because of privacy issues associated with smaller communities.
- Stigma is a great concern for individuals in need of accessing treatment services,

particularly in rural areas where everyone knows that there are very limited locations to access services. Patients avoid care due to what their friends or neighbors will think if they see them enter the doors of a mental health department or therapist's office.

Need for Patient Navigation Services

According to recent US Census Data (2016), individuals within the service area experience greater economic hardship compared to those in other regions of the state and nation. This includes a lower median household income and higher poverty rate. This can be contributed to lower levels of educational attainment, with most county residents having lower high school graduation rates compared to the state and nation. Unemployment is also significantly higher in seven out of eight service area counties as compared to the state and nation. These social determinants of health compound to negatively impact the safety of residents as the service area reports some of the highest violent crime rates in the state.

Demographic & Socioeconomic Profile Comparison (County, State, Nation)

County	Median Household Income	High School Graduation	Unemployment State Ranking (75 counties)	Persons Living in Poverty
Arkansas County	$38,532	85%	17	19.9%
Ashley County	$36,310	82%	72	17.9%
Bradley County	$34,665	81%	48	20.9%
Chicot County	$32,412	92%	75	30.1%
Columbia County	$37,072	85%	40	25.5%
Cleveland County	$44,840	87%	30	14.3%
Dallas County	$35,794	93%	54	21%
Desha County	$27,036	85%	48	29%
Drew County	$36,092	86%	69	20.3%
Grant County	$49,968	90%	8	12.2%
Jefferson County	$37,630	85%	66	23.5%
Lincoln County	$38,873	80%	48	23.4%
Union County	$41,106	84%	65	17.5%
State of AR	$43,813	85%	-	16.4%
U.S.	$57,652	88Z%	-	12.3%

(US Census, 2018, 2017 Unemployment Rate Rankings for AR Counties, April 2019

For many of the people that are qualifying for the new public health coverage programs and those that are newly qualified for Medicare, this is the first time they have had to apply for and navigate the public assistance system. These changes can be very scary, especially for elderly residents who are unsure of who to turn to for assistance. It can also be unsettling for those that have held jobs with insurance and are proud that they have not had to access public assistance programs. It is these residents that need to be educated and assisted through this process more than anyone.

Many factors have caused the need for patient navigation services through the hospital in the service area; specifically, assistance programs including insurance, Medicare, prescription assistance, SNAP, and housing. Other factors include:

- A high percentage of individuals make negative lifestyle choices including smoking, poor nutrition, and lack of physical activity. Patients have multiple health issues and therefore many needs in an insurance program.
- A low level of health care literacy can impede access to information on available services and present difficulty in getting residents to understand their insurance. The average Arkansas Delta resident reads at a 3rd grade reading level. This can cause major issues with helping them understand paperwork.
- Many small business workers lost their insurance and were told to get on the exchange. They have never not had insurance provided and many were embarrassed by the fact they had to access a government program. We often see this with Medicare residents as well. They have never had to use programs and are unsure of how to navigate these programs like those that have been on government programs for years.
- Once Arkansans were on the Arkansas program many individuals fell out of compliance and were dropped from their insurance either because they could not pay their premiums, they did not renew their plan, or they did not fulfill the work requirements put in place with the state Arkansas Works plan.
- Despite the significant improvement in the number of enrollment options, many consumers still prefer enrolling with the help of a trusted person or organization from their community. Rural residents are not as trusting of help that comes from the outside. They live in small communities and are not always open to getting assistance from a stranger.

- There have been many insurance assisters in this region that came to assist residents but are no longer available. Many of them went away when they no longer had federal funds or were cut once Arkansas mandated that no state funding could go towards Private Option enrollment efforts. There have been a lot of efforts to assist residents in this region with health programs that have gone away because the funding no longer exists.

Recruitment of Health Care Providers

For over a decade, hospital partners across the service area have consistently identified health workforce shortages as a critical priority issue to address. Not only is there a lack of primary and specialty care physicians, but also mental health professionals. To make matters worse, many providers are aging out of jobs and into retirement, leaving vacancies that cannot be filled. Small rural hospitals with limited resources are forced to pay for costly locum providers to travel from urban centers to fill these gaps. Rural residents do not know or trust these out-of-area providers and often stop utilizing care because of this cultural disconnect. If local hospital systems want to keep their doors open and keep providing services to their community members, it is critical that there is an increase in local, homegrown health professionals and administrators.

In May 2018, Arkansas Rural Health Partnership did a survey of the current availability of local providers in the service area; the outcome is included below.

Local Health Workforce within Service Area by County (Counties with Hospitals), May 2018

Health Workforce Professional Type	Arkansas	Ashley	Bradley	Chicot	Columbia	Dallas	Desha	Drew	Jefferson	Total
Dietician	1	2	3	1	2	2	1	1	1	**14**
Paramedic	8	10	3	10	5	4	3	20	12	**75**
Radiology Technician	6	12	6	6	1	5	5	6	6	**53**
Respiratory Therapist	6	9	5	4	11	4	3	7	20	**69**
Physical Therapist	1	4	1	3	3	1	2	2	2	**19**
Occupational Therapist	1	1	1	2	2	1	0	2	2	**12**
Speech Therapist/Pathologist	1	3	1	1	1	2	0	5	2	**16**
Social Worker	2	4	3	1	2	1	1	1	3	**18**
Mental Health Counselor	3	3	3	2	3	1	2	9	6	**32**
Health Information Management	2	5	1	6	8	5	4	9	12	**52**
Health Administrator	2	1	1	1	1	1	2	1	1	**11**
Dental Hygienist	2	7	2	1	8	1	0	8	40	**69**
Dentist	2	7	2	1	5	2	2	11	10	**42**
Psychiatrist	1	0	1	1	1	0	0	2	1	**7**
Primary Care Physician	5	6	6	3	8	2	6	5	16	**57**

Specialty Physician	2	5	1	5	6	0	0	4	20	**43**
General Surgeon	0	1	0	2	2	1	1	2	7	**16**
Total Local Health Workforce by County	**45**	**80**	**40**	**50**	**69**	**33**	**32**	**95**	**161**	**605**

Self-Reported Data, Hospital Partners, May 2018

The obvious observation is that there are behavioral health workforce shortages across the board in counties like Desha, Bradley, Chicot, and Dallas. A little less obvious, but very clear is the inability to retain health professionals due to lack of resources and facilities. While there is definitely the need to grow more behavioral and mental health providers in the Arkansas Delta region due to the inability to recruit; it is obvious that in counties, such as Jefferson County, the absence of mental and behavioral health facilities is causing local providers to obtain employment outside of the service area.

In this poor Arkansas Delta region, social, financial, and academic support are of utmost importance if students are going to succeed. The majority of high school students in the target area do not have the support structures in place to learn and be academically successful. Most students in the region do not have educated parents, the economic means to seek a better education, and the necessary academic resources to assist them with their studies and testing skills. When a high school student only experiences an environment in which education is not prioritized and there is not a role model or encouraging mentor/parent in their life, their expectations are not very high for themselves. The poverty of the Delta region, the lack of parental guidance, and lack of prioritizing education in the home environment; all contribute to low test scores, low college admissions and applications, and, ultimately lack of healthcare professionals in the region.

Almost impossible to comprehend, there are multiple high schools/school districts in the service area with **less than 2%** of students meeting college readiness benchmarks. The combined mean of students meeting college readiness benchmarks for all subjects at Academy partner high schools in the service area is **less than 6%** (local data, 2018).

The number of economically disadvantaged high school students (determined by those eligible for free or reduced school lunch) is also exceedingly high, with an average of 73.5%. During the 2015-16 academic year, nearly one in five high school students in the region dropped out. Between 2012-16, 40% of students did not go on to attend school beyond high school. Less than 50% in the region attended college within the first year of high school graduation.

Four Year Adjusted Graduation Rates for Arkansas School

2017-2018

School District	Graduation Rate	Economic Disadvantaged Graduation Rate
Cleveland County School District	96%	93%
Crossett School District	89%	85%
Dermott School District	89%	85%
DeWitt School District	96%	94%
Dollarway School District	62%	62%
Drew Central School District	91%	91%
Dumas School District6	86%	86%
El Dorado School District	93%	90%
Fordyce School District	96%	98%
Hamburg School District	93%	92%
Lakeside School District	94%	94%
Magnolia School District	89%	85%
McGehee School District	87%	87%
Monticello School District	95%	92%
Pine Bluff School District	74%	75%
Sheridan School District	93%	88%
Stuttgart School District	86%	88%
Warren School District	88%	89%
Watson Chapel School District	90%	90%
White Hall School District	87%	83%

If the student beats the odds to successfully enter an undergraduate or graduate degree program, there are still significant academic and economic barriers to overcome. The table below demonstrates the high percentage of students at local colleges & universities qualifying as economically disadvantaged and the great need for financial assistance (self-reported data, partner colleges & universities, 2015-2016).

Student Need, Based on Financial Aid at Participating Colleges & Universities, 2015-2016

	Total School Enrollment	Pell Grants	Estimated # economically disadvantaged*	Federal Grants	Students taking out loans
Southeast Arkansas College	1,432	85%	1217	85%	29%
University of Arkansas-Monticello	3,854	41%	1580	72%	60%
Arkansas State University	13,144	46%	6046	54%	52%
Phillips Community College	1,797	76%	1365	100%	0%

East Arkansas Community College	1,270	64%	812	64%	5%
Southern Arkansas University	3,546	61%	2163	62%	54%
South Arkansas Community College	1,693	68%	1151	72%	22%
University of Arkansas-Pine Bluff	2,513	75%	1884	88%	65%

*** Number students receiving need-based financial aid/total school enrollment**

Transportation

(This section is cited on the RHI Hub University of Minnesota's Rural Health Research Center Policy Brief, November 2017; Rural Transportation: Challenges and Opportunities)

As a social determinant of health, access to high-quality, affordable transportation is fundamental to mental, physical, and emotional well-being. For individuals with disabilities, those with low incomes, older adults, and others who may not have reliable access to a vehicle or be able to safely drive themselves, public and private transportation is critical to access health services, obtain food and other necessities, and engage with their communities. Medicaid is currently an important source of transportation for individuals who qualify, providing emergency and non-emergency medical transportation. However, exact benefits vary by state, and the Centers for Medicare & Medicaid Services only permit reimbursement for "loaded" miles in which the beneficiary is in the vehicle. This puts rural transportation providers at a distinct disadvantage, since they need to bear the burden of driving more unreimbursed miles to pick up a passenger. Without reliable options for transportation, older adults are particularly vulnerable to isolation, which can lead to increased risk of morbidity and mortality. For example, feeling socially isolated is associated with significantly worse self-rated mental and physical health, even after controlling for health characteristics. Transportation is also vitally important to the provision of in-home care, including the mobility of the health care workforce throughout rural areas, and to the ability of informal caregivers to reach their loved ones and provide necessary resources and support. The issues of transportation and access to care are exacerbated in rural areas where distances are greater and transportation infrastructure is more limited. Beyond health care access, transportation impacts the well-being of rural residents from issues as varied as accessing food, social support, education, employment, recreation, and community services. Despite the importance of travel and mobility, transportation services are seriously lacking in many rural areas. Nearly four percent of rural households — almost two million rural residents — do not have access to a car; 9-10 rural areas are also much less likely to have access to public transportation .

IMPLEMENTATION STRATEGIES

Public Health Concern: Mental Health & Behavioral Health Services

GOAL I. Increase mental and behavioral health services in the service area
Objective 1. Provide additional behavioral health services
Activities: A. Provide counseling services at the local level for OUD patients via telehealth B. Develop more short-term behavioral health services at JRMC C. Expand JRMC's capacity to provide additional mental and behavioral health services
Objective 2. Expand mental and behavioral health services and programs in the service area through collaboration
Activities: A. Partner with existing mental and behavioral health organizations in the services area B. Continue to participate in the Arkansas Rural Health Partnership's Mental/Behavioral Health Task Force C. Participate in the Arkansas Rural Health Partnership's new Opioid Community Response Planning Project to increase long term care facilities for behavioral health patients D. Provide Mental Health First Aid to local schools and community organizations E. Continue to expand community education on drug abuse through marketing efforts F. Continue to encourage local physicians to assist with Medication Assistance Treatment (MAT) services
Objective 3. Provide transportation for behavioral and mental health patients needing in-patient placement
Activities: A. Continue to participate in the Arkansas Rural Health Partnership's Mental/Behavioral Health Task Force B. Participate in the Arkansas Rural Health Partnership's new Opioid Community Response Planning Project to increase long term care facilities for behavioral health patients C. Increase awareness of transportation services in the community through communication efforts

Public Health Concern: Lack of Transportation

GOAL II. Increase access to healthcare services by improving transportation
Objective 1. Increase awareness of available transportation resources
Activities: A. Market available transportation resources in the service area through brochures, posters, and flyers in local clinics and community sites. B. Work with providers throughout the region to build awareness of current transportation options for patients
Objective 2. Initiate local tele health services to decrease the need for transportation
Activities: A. Expand tele health and tele medicine services at JRMC and area clinics B. Increase the opportunities for care coordination via telehealth through the Clinically Integrated Network C. Continue to work with ARHP partnering hospitals to increase telehealth services in the hospital and clinics

Public Health Concern: Access to Healthcare Specialists

GOAL III. Increase healthcare provider/physician access; specifically specialty care
Objective 1. Provide more opportunities to train healthcare providers locally
Activities: A. Continue to provide clinical rotations for physicians and mid-level healthcare professionals in hospital and clinic by working with all medical schools in Arkansas B. Increase the number of local students going into healthcare professions by working with hospital partners to provide health career programs in local schools
Objective 2. Provide additional specialty services at JRMC
Activities: A. Increase specialty healthcare services via telehealth in clinic and hospital. B. Work with hospital and statewide partners to provide additional specialty clinics at JRMC through collaboration

Public Health Concern: Lack of Community Education & Assistance Programs

GOAL III. Increase access to Patient and Community Assistance Programs
Objective 1. Provide assistance and navigation for Insurance Enrollment, Medicare, Transportation, and other available Social Services for patients and residents in Chicot County
Activities: • Provide Patient Navigators for patients in the hospital and clinics • Provide training opportunities for staff on insurance enrollment, Medicare, and assistance services • Provide enrollment services through community outreach (churches, events, salons, parent nights at schools) • Provide direct assistance with insurance and Medicare enrollment • Market available insurance, Medicare, and prescription assistance services

Qualifications of Report Preparer

MELLIE BRIDEWELL, MSM

Ms. Mellie Bridewell, MSM is currently contracted to the Arkansas Rural Health Partnership as the Chief Executive Officer through the University of Arkansas for Medical Sciences (UAMS) Regional Programs. Mellie has eighteen years of experience in community and organizational networking, program development, grant writing, and program implementation. Mellie has been a critical component in the development of the Arkansas Rural Health Partnership organization which has grown from five founding member hospitals to the twelve member hospitals across the south Arkansas region.

Mellie has obtained over $10 million dollars in grant funds for Arkansas Rural Health Partnership to implement healthcare provide training opportunities, healthcare workforce initiatives, chronic disease programs, behavioral and mental health services, and access to care throughout the Arkansas Delta. Ms. Bridewell's reputation in the state of Arkansas and throughout the country as an ambassador for rural health infrastructure and rural health networks makes her the ideal facilitator for these assessments and plans. Ms. Bridewell was recently chosen as one of fifteen in the country to participate in the NRHA Rural Fellows program for 2019 and currently serves at Vice-President of the National Cooperative of Health Networks Association. Her ability to convene the appropriate partners and valuable stakeholders has led to state and national recognition. In 2016, Ms. Bridewell was acknowledged as a FORHP Rural Health Champion and the ARHP organization as a Rural Health Community Champion in 2017 for Collaborative Partnerships. She is known at the state and federal level for her ability to execute successful programs through collaboration with multiple partners and stakeholders. Mellie lives in Lake Village, Arkansas located in the Arkansas Delta region.

Ms. Bridewell has been designated to serve as a lead on ARHP hospital 2019 Community Health Needs Assessments due to her expertise in this area and the significant impact these assessments will have for the region that ARHP serves and well as the policy changes and program implementation essential to provide the needed services.