White River HEALTH

Caring Beyond Healthcare

# Community Health Needs Assessment September 2022

# Table of Contents

## Introduction

The White River Health (WRH) Community Health Needs Assessment (CHNA) identifies the health needs of the communities served by the organization and identifies initiatives to meet those needs. The CHNA complies with Internal Revenue Service (IRS) regulations for nonprofit hospitals. The CHNA documents WRH's compliance with IRS Code Section 501(r).

The CHNA, implementation strategy, and action plan for WRH, which includes White River Medical Center (WRMC) and Stone County Medical Center (SCMC), were approved by the WRH Board of Directors September 27, 2022.

## Organization Description

WRH is a 501(c) (3) nonprofit, integrated health system. The organization includes: WRMC, an acute care hospital in Batesville; SCMC, a critical access hospital in Mountain View; a satellite emergency department in Cherokee Village, Rural Health Clinics (RHC), primary care and specialty clinics, and outpatient diagnostic and treatment centers throughout North Central Arkansas.

WRH employs 62 physicians, 51 mid-level providers, and 1,840 total employees. The WRH Internal Medicine Residency achieved accreditation from the Accreditation Council for Graduate Medical Education (ACGME) and in 2018, achieved continued accreditation status. Through a collaborative agreement with the University of Arkansas for Medical Sciences (UAMS), White River Medical Center serves as a training site for UAMS Family Medicine Residents.

## Community Demographics

WRH's Service Area includes six (6) counties (Cleburne, Independence, Izard, Jackson, Sharp, and Stone) in North Central Arkansas. WRH's extended Service Area includes an additional four (4) counties. The healthcare needs of the extended Service Area are addressed by the CHNA of area healthcare providers.

Located in the Ozark Mountains, most of the 3,751 square miles of the six counties of the Service area are rural with small cities scattered among the mountains and valleys of the region. Small to medium industries are in the city centers; however, agriculture and tourism are the primary economic engines in the region. On average, there are 32 people per square mile in the Service Area.

## Table 1 – Demographics

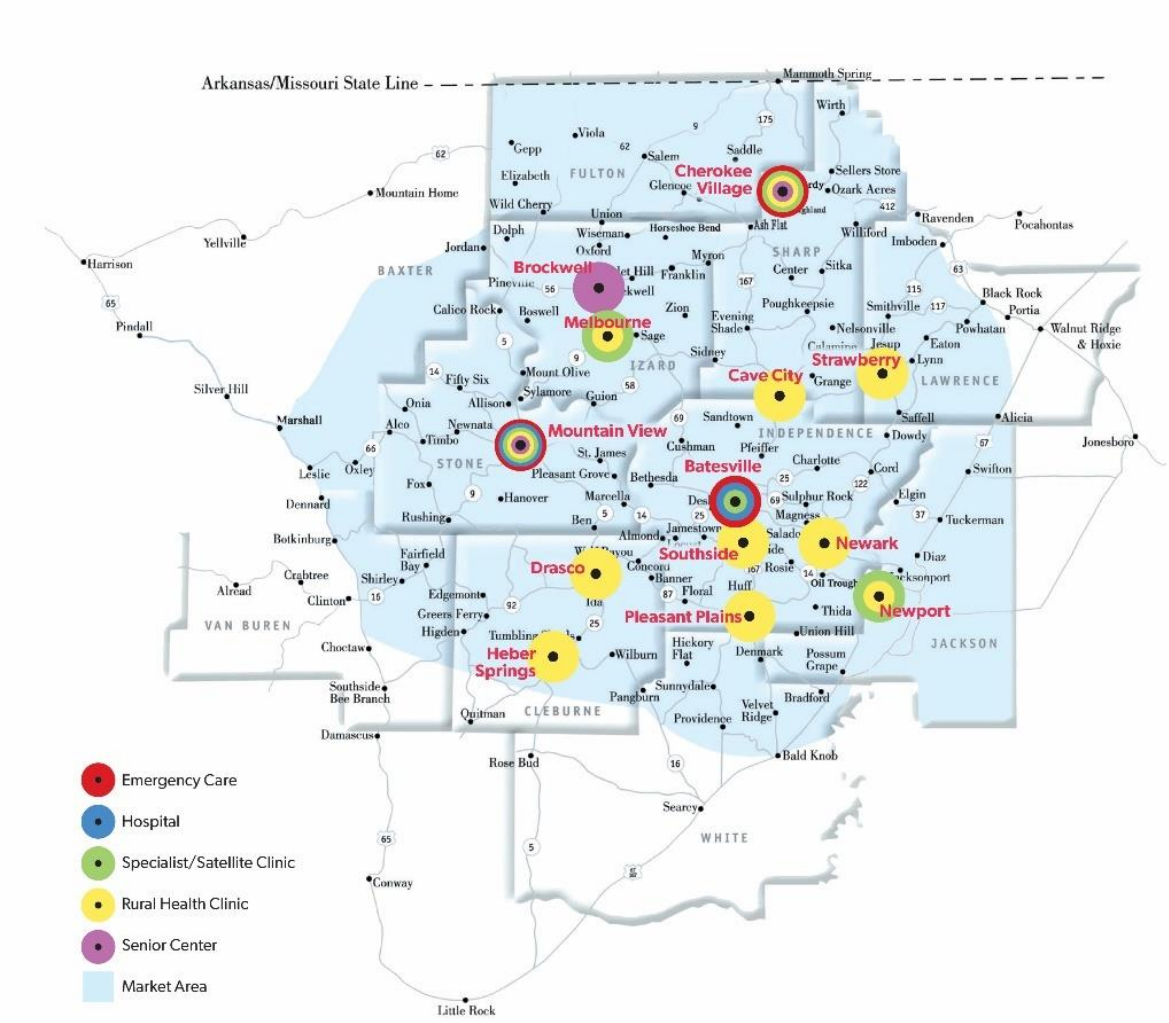
| | Cleburne | Independence | Izard | Jackson | Sharp | Stone |
|---|---|---|---|---|---|---|
| **Total Population (2021 Population Estimate)** | 25,230 | 37,264 | 13,559 | 16,908 | 17,043 | 12,446 |
| Birth to 9 | 2,466 | 4,982 | 1,167 | 1,835 | 1,919 | 1,238 |
| 10-19 | 2,803 | 4,926 | 1,617 | 1,880 | 2,048 | 1,347 |
| 20-64 | 13,264 | 20,958 | 7,395 | 10,172 | 8,708 | 6,578 |
| 65 + | 6,697 | 6,398 | 3,380 | 3,021 | 4,366 | 3,283 |
| | | | | | | |
| **Race** | | | | | | |
| White | 24,079 | 33,044 | 12,382 | 13,769 | 16,452 | 11,817 |
| African American | 227 | 1,184 | 142 | 2,357 | 176 | 130 |
| Asian | 83 | 417 | 23 | 9 | 3 | 64 |
| Hispanic | 606 | 2,489 | 326 | 501 | 412 | 245 |
| All Other | 652 | 130 | 686 | 532 | 347 | 190 |
| | | | | | | |
| **Language/Education** | | | | | | |
| Language Other than English Spoken at Home | 2.1% | 5.0% | 2.4% | 2.2% | 1.1% | 1.3% |
| High School Graduate (residents aged 25 and over) | 86.6% | 85.6% | 82.0% | 83.2% | 83.5% | 79.4% |
| Bachelor's Degree or Higher | 16.7% | 18.5% | 14.5% | 11.7% | 10.5% | 12.6% |
| | | | | | | |
| **Income** | | | | | | |
| Median Household Income | $48,972 | $48,972 | $39,135 | $32,783 | $31,792 | $33,091 |

| | | | | | | |
|---|---|---|---|---|---|---|
| % Persons Living Below Poverty Level | 15% | 15% | 17.7 % | 25.1% | 23.3% | 24.2% |

Source: United States Census Bureau; American Community Survey

## Figure 1 – Service Area Map

As seen in the following Service Area map, White River Health provides services in 12 communities.



## Methods and Processes

In accordance with the Patient Protection and Affordable Care Act of 2010, and IRS regulations for nonprofit hospitals, WRH conducted a CHNA to identify the health needs of the residents we serve and recommend actions to address identified needs.

The WRH CHNA utilized the following sources to develop the process for the CHNA and to gather the needed data: 1) Community Survey made available online and promoted via email and social media, 2) county level census data, and 3) 2021 county health rankings from the Building a Culture of Health Report by the Robert Wood Johnson Foundation.

The team was given an overview of the last CHNA (2019), the Implementation Update Report (Titled Bridge Document, Appendix B), and updated community demographics, and initial data.

We obtained feedback from stakeholders and community leaders regarding the 2019 CHNA. This included positive feedback regarding the detail shared, structure, and organization of the document. An opportunity to improve the CHNA included summarizing areas to shorten the length of the document. This feedback was taken into consideration and applied where applicable to the 2022 CHNA.

The team assisted in editing the CHNA survey and evaluating the data. The survey was made available online via Survey Monkey in English and Spanish. The survey was promoted on White River Health, White River Health Foundation, and Stone County Medical Center social media. The CHNA team emailed survey links to community stakeholders, organizations who represent medically underserved residents, minority groups and low-income residents, and White River Health Board of Directors, physicians, and employees.

Qualitative and quantitative health needs data were collected from digital surveys. The survey is attached in Appendix C.

The data from the digital survey were aggregated into charts for comparison to County Health Rankings and evaluated together to determine the highest priority needs in the communities served by WRH. The team assessed and analyzed data summaries to assist in determining significant health needs. This team assisted with planning and timelines, served as local experts, and made recommendations regarding the plans for development, implementation, and communication of the CHNA. The preliminary data and CHNA report, with suggested findings of community health needs and action steps, were presented to WRH Administration for feedback prior to presentation to the WRH Board of Directors for approval.

The CHNA Team included: Jeff Angel, MD, Outpatient Chief Medical Officer; John Bradley, Information Systems Analyst; Jackie Crain, Director Population Health; Amy Finster, Community Engagement Supervisor; Sheila Mace, Public Relations and Foundation Development Coordinator; Chris Poole, Quality Engineer and Dana Vannatter, Director Respiratory Therapy and Sleep Center.

## Data Results

### Demographic Profile of Survey Respondents

This category collected the economic and social demographic of survey respondents (figure 2 -7) for comparison to census data and County Health Rankings. In addition to age, education, income, race, and residence questions, the survey included a question about the household make up. The team included the question about household makeup to address challenges faced by families in foster parent, grandparent, single parent, and teen parent households.

Comparison of the data showed respondents reported a higher income and education attainment than the general population. The team determined that community stakeholders completed the survey from the perspective of their personal health due to the survey design. The Health Rankings from the Robert Woods Johnson provide important comparison data.

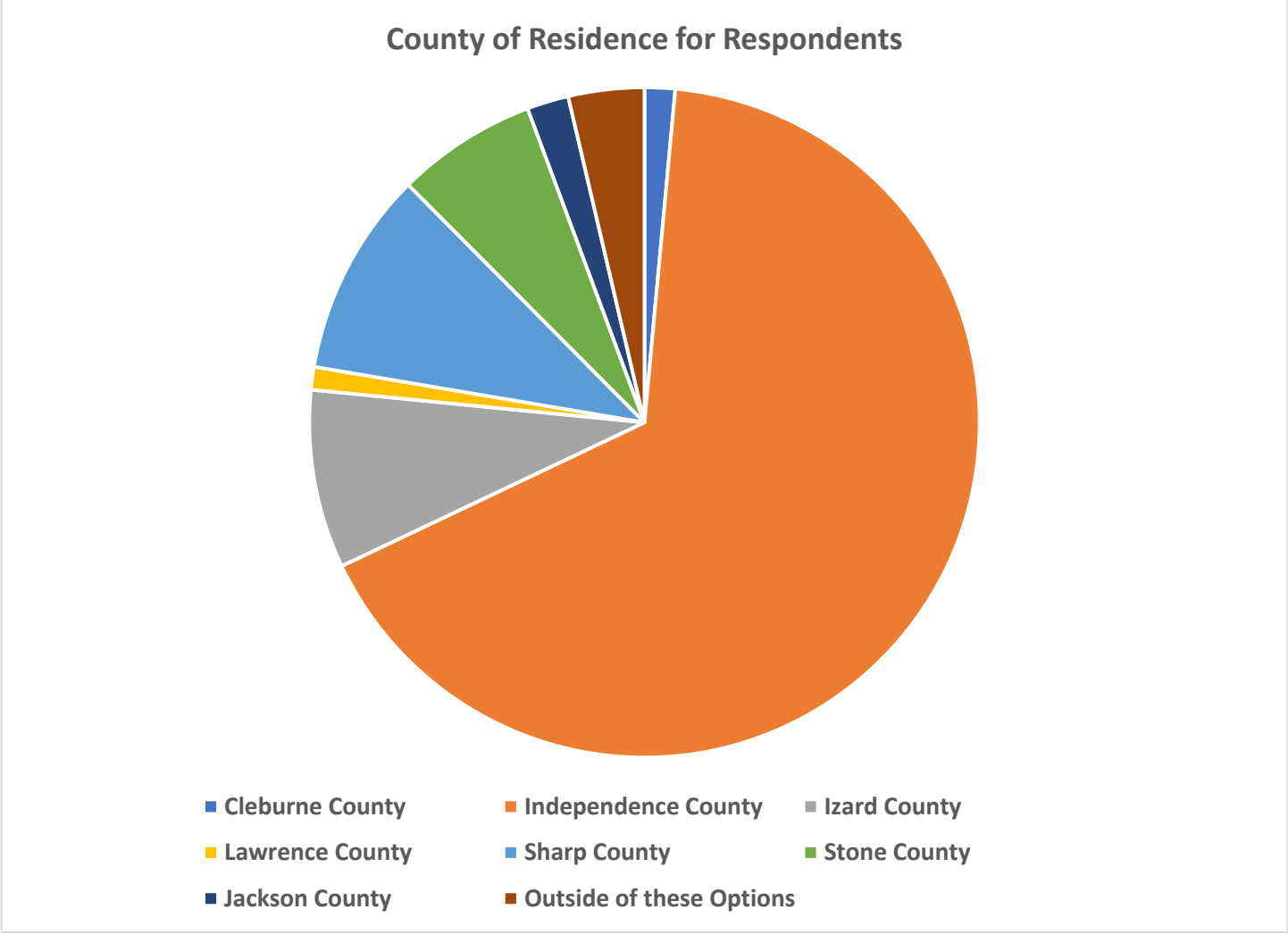



Figure 2

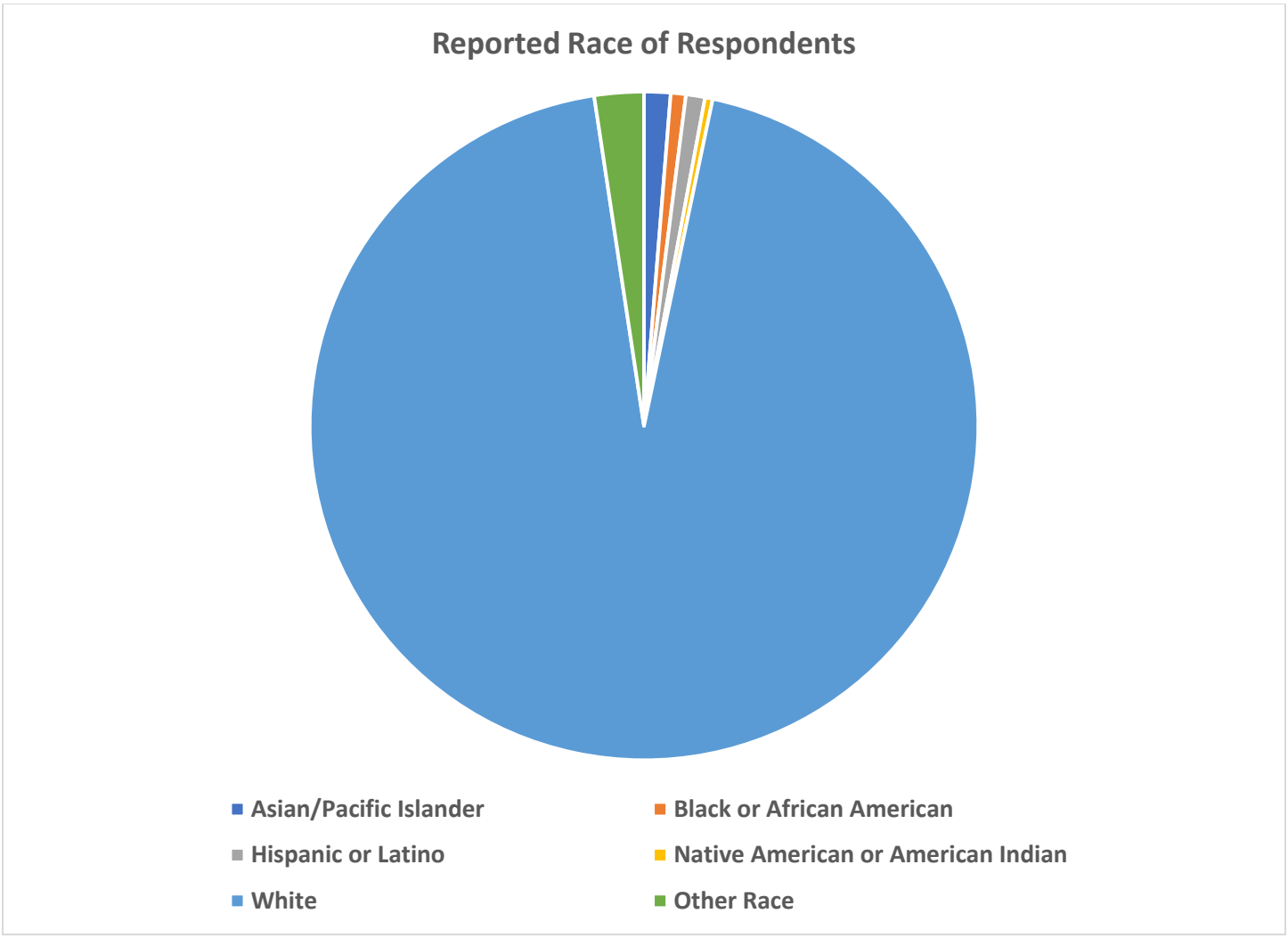

Reported Race of Respondents
Asian/Pacific Islander
Black or African American
Hispanic or Latino
Native American or American Indian
White
Other Race

Figure 3

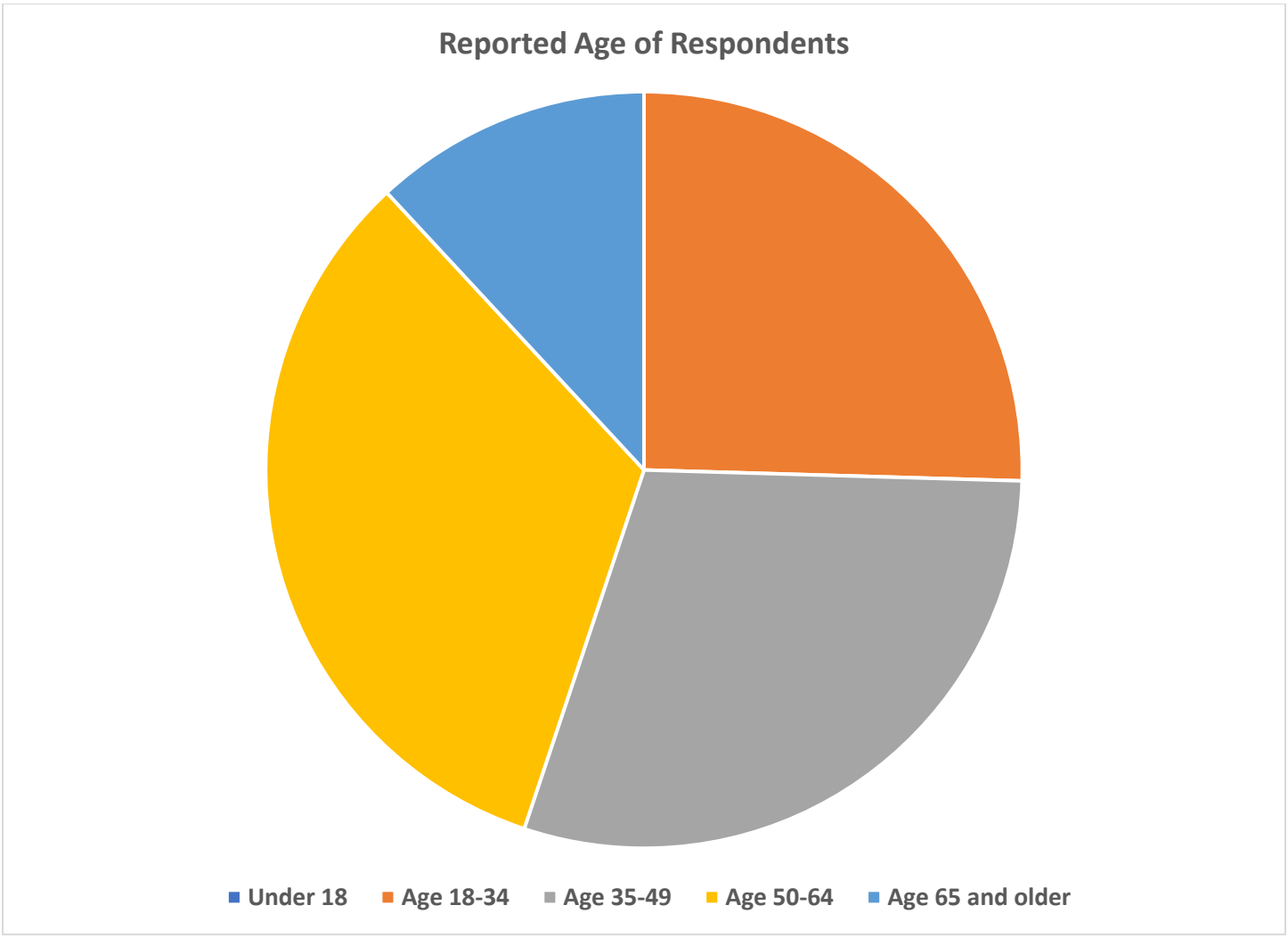

Reported Age of Respondents
Under 18
Age 18-34
Age 35-49
Age 50-64
Age 65 and older

Figure 4

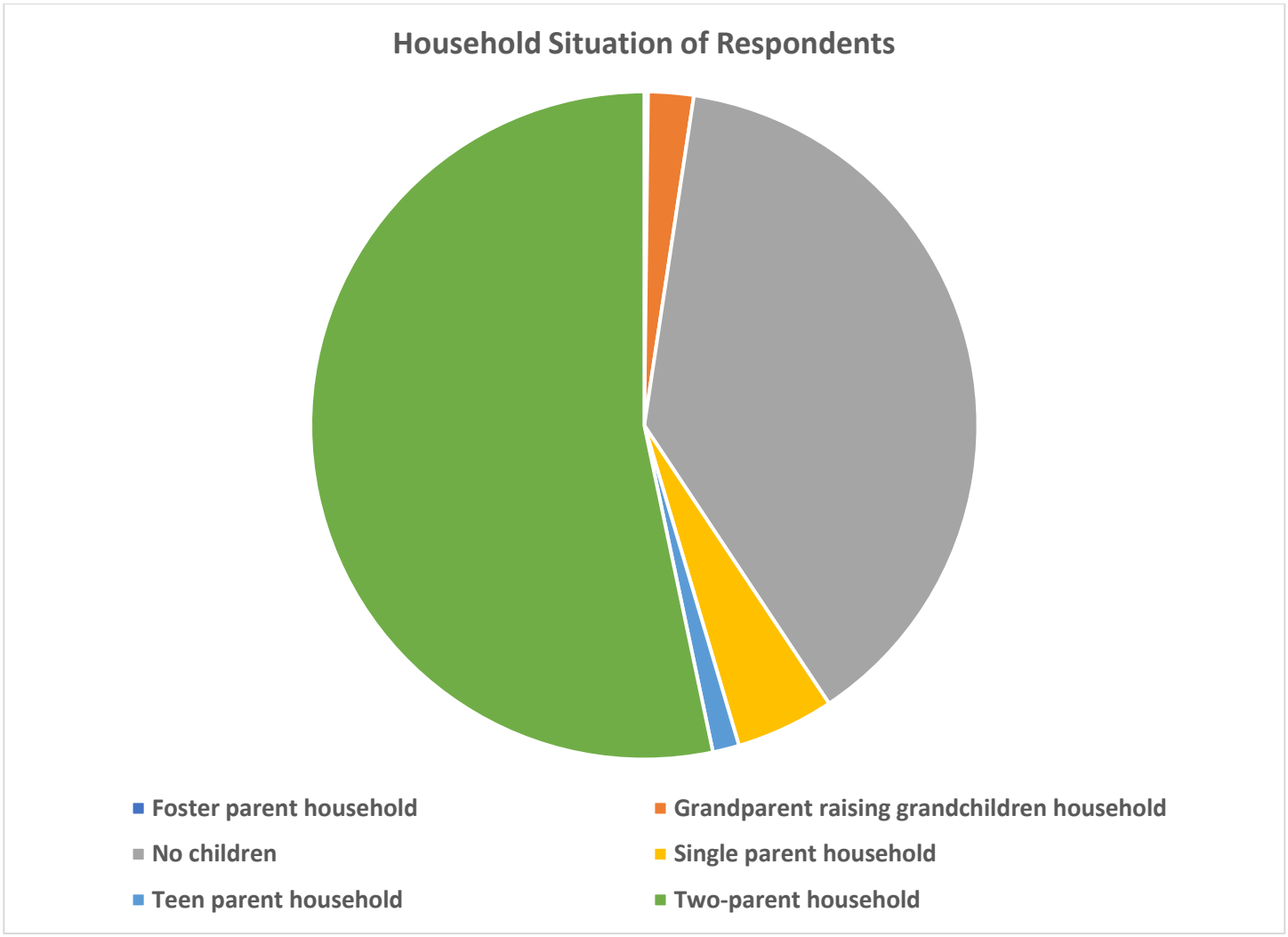

Household Situation of Respondents
Foster parent household
Grandparent raising grandchildren household
No children
Single parent household
Teen parent household
Two-parent household

Figure 5

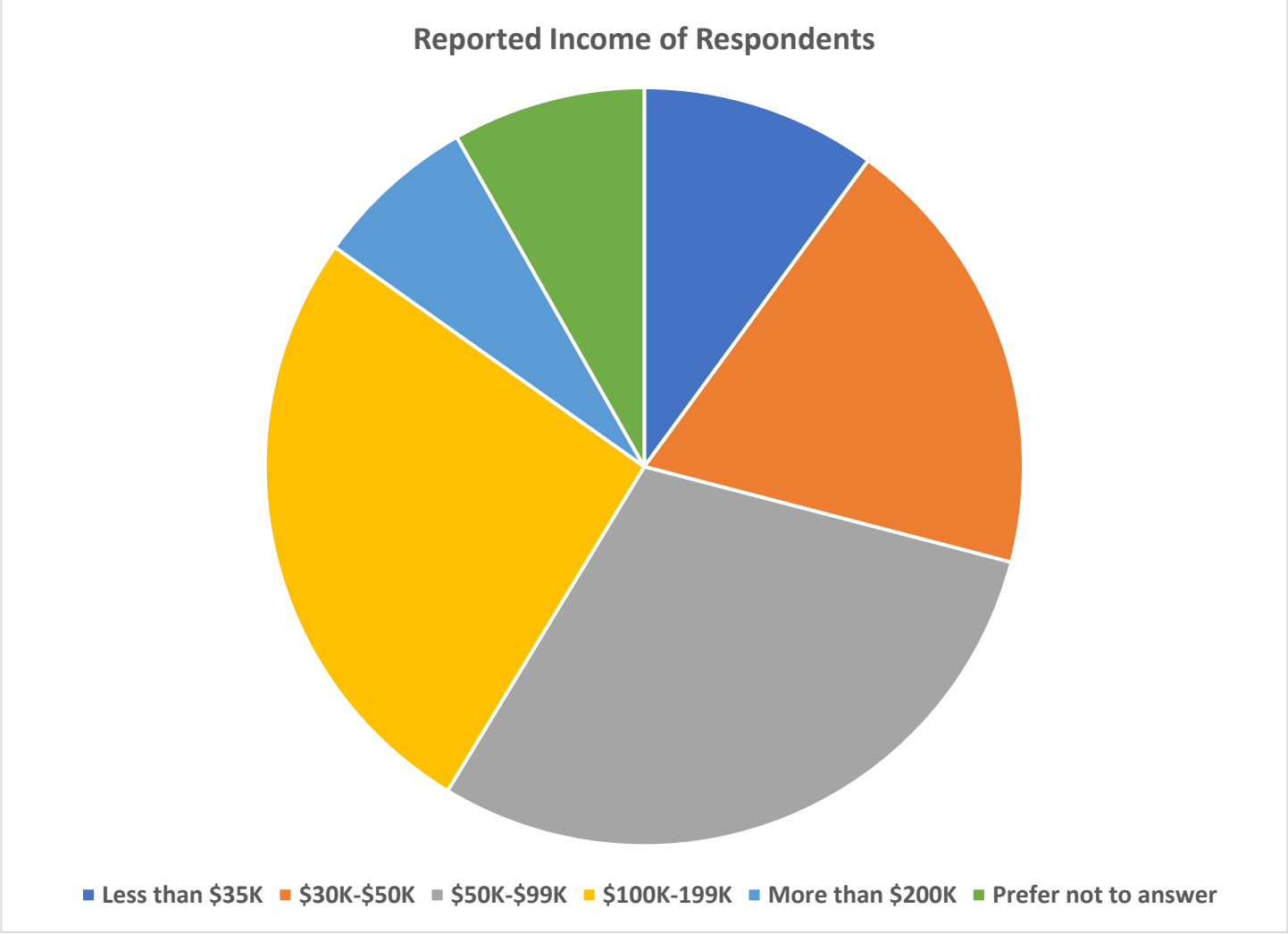

Reported Income of Respondents
Less than $35K
$30K-$50K
$50K-$99K
$100K-199K
More than $200K
Prefer not to answer

Figure 6

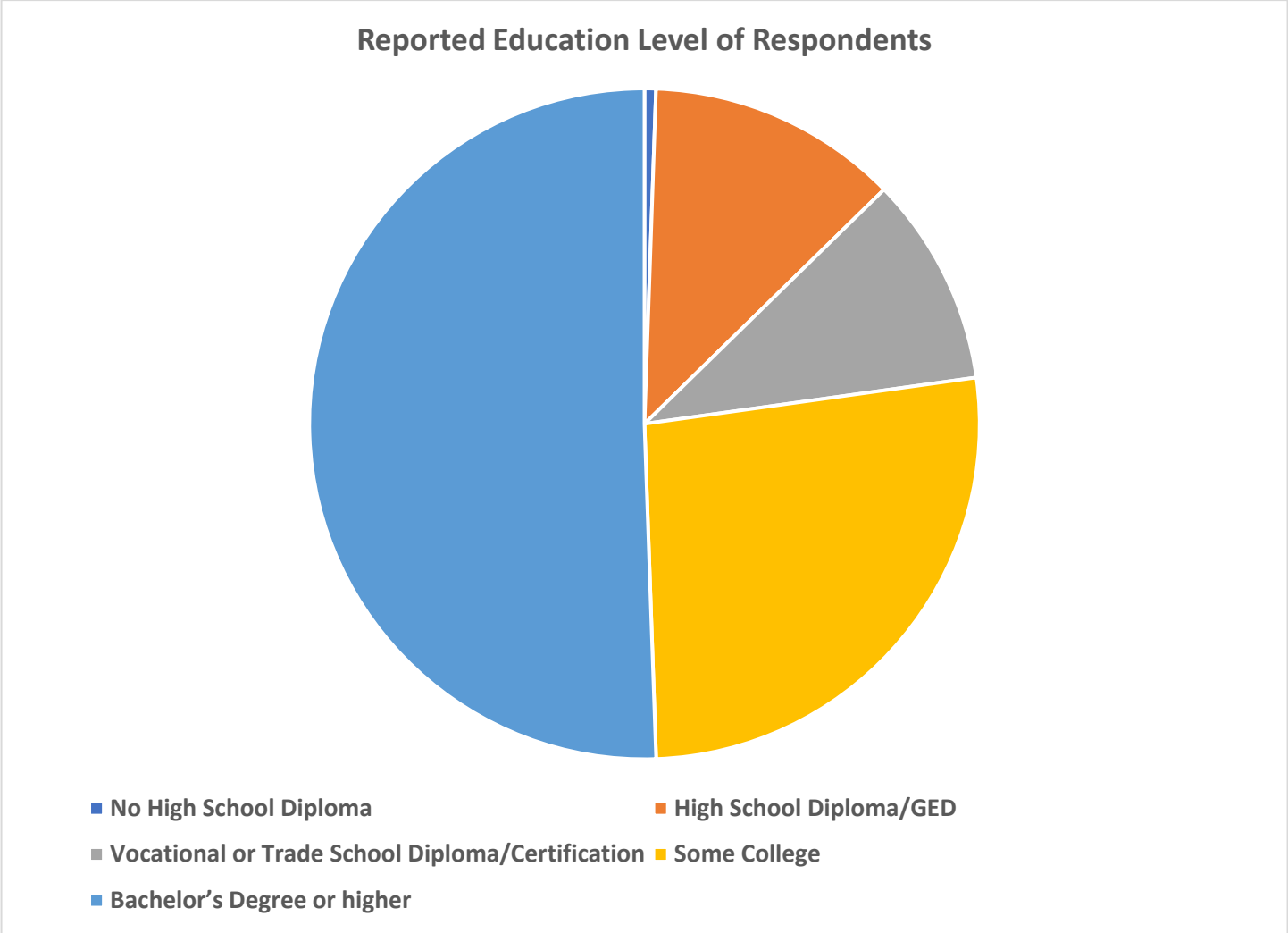



Figure 7

## Identified Health Needs

As leading regional provider of healthcare services, WRH offers services and programs to meet the healthcare needs of the population we serve. The CHNA is a resource used by leaders to seek input and determine healthcare needs. Changes to community age, education, income, and social demographics impact the health and healthcare needs of a residents in the communities served by WRH. It is imperative that WRH adapt clinical programs and services to achieve our mission of improving the health of our communities and fulfilling our responsibility as a tax-exempt organization.

Survey respondents reported mental health treatment, substance abuse treatment, weight management, health education, and fitness and exercise opportunities as the greatest healthcare needs.

The 2019 CHNA and 2021 County Health Rankings list similar needs. In the 2019 CHNA behavioral health, substance abuse treatment, obesity treatment, and health education and wellness were listed as health needs. In the 2021 County Health Ranking poor mental health days, adult obesity, physical

inactivity, and a lack of mental health providers are listed as needs. Adult obesity and physical inactivity are contributing factors to heart disease and diabetes. Comparisons of three data sources validate the organization's focus on mental health, cardiovascular health, and community engagement.

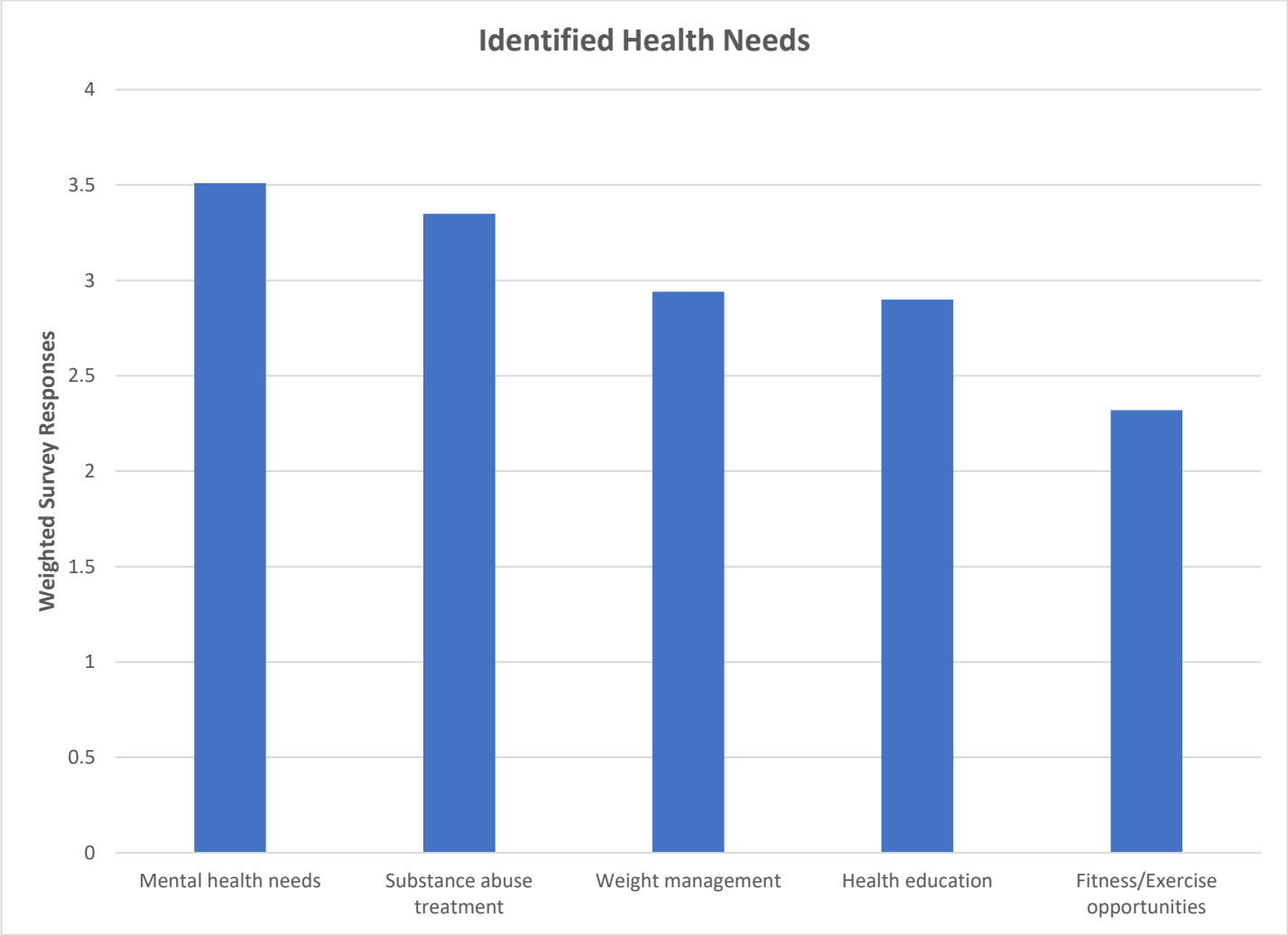



Figure 8

## Identified Barriers to Healthcare

The input from digital surveys indicates that the costs associated with provider office visits and medication are the top two barriers to healthcare. Cardiovascular disease, diabetes, and hyperlipidemia, conditions related to physical inactivity, smoking and obesity may be expensive, especially to patients whose health insurance coverage may not include prescription drug benefits. While access to a primary care physician ranked 4$^{th}$, the county health ranking report indicates counties in the service area are medically underserved. The survey result is likely affected by the high percentage of responses from Independence County where the resident to primary care physician ratio is lower than the state average and significantly lower in the other counties of our service area. In rural, lower income communities, residents may live more than an hour from the nearest clinic or healthcare facility and lack access to public transportation.

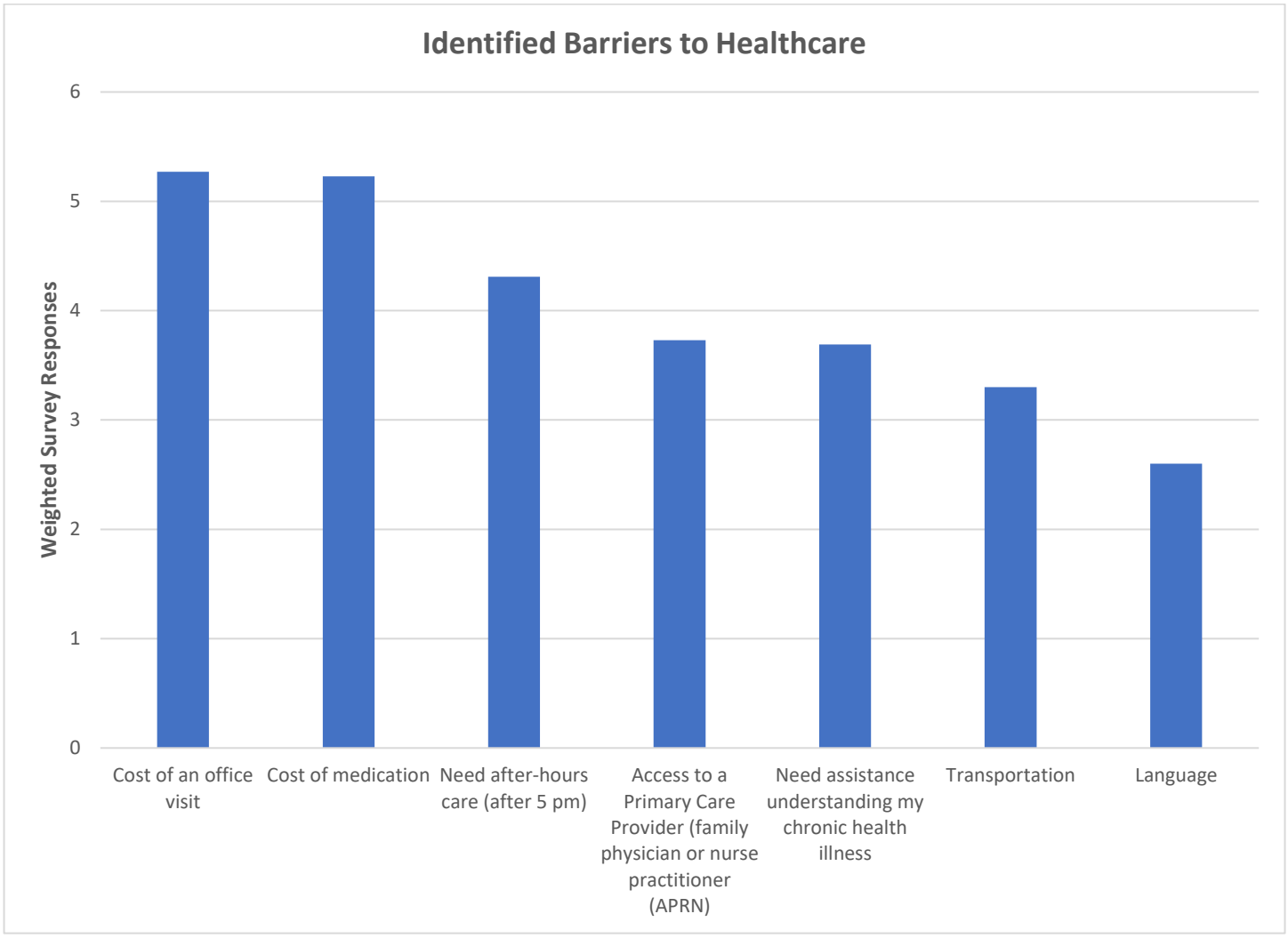

Identified Barriers to Healthcare
Weighted Survey Responses
6
5
4
3
2
1
0
Cost of an office visit
Cost of medication
Need after-hours care (after 5 pm)
Access to a Primary Care Provider (family physician or nurse practitioner (APRN)
Need assistance understanding my chronic health illness
Transportation
Language

Figure 9

## Substances Identified by Respondents as Being Abused or Misused by Youth

Substance abuse affects the lives of abusers and those close to them. It can negatively impact health, relationships, financial security, and personal safety. To effectively address substance abuse treatment needs, it is important to establish a demographic profile of the abuser and identify substances abused in the communities we service.

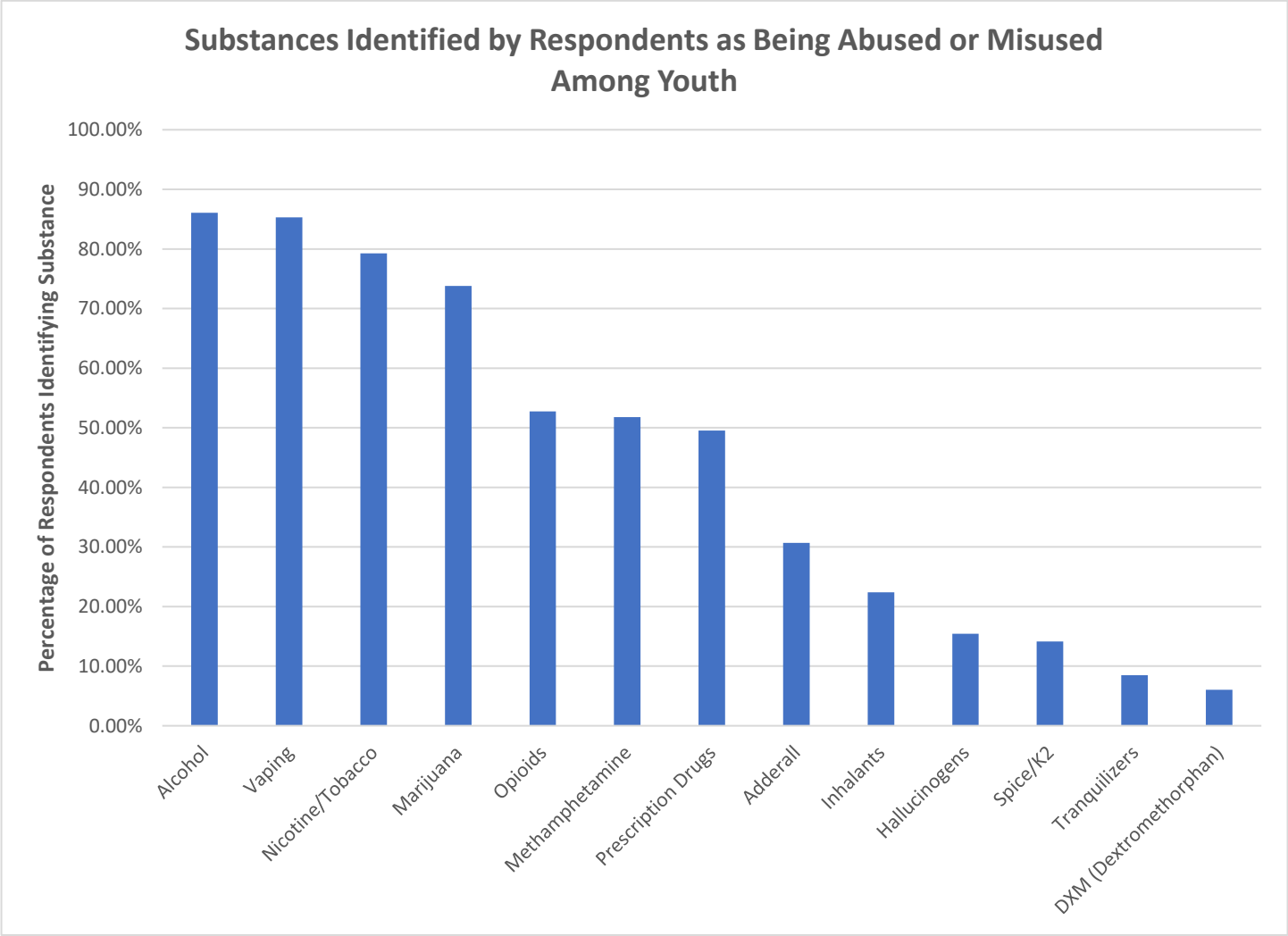



Figure 10

## Where Respondents Seek Care and Wellness Services

Survey respondents overwhelmingly reported that they seek primary healthcare and preventive healthcare from a Family Medicine Physician or Nurse Practitioner. Less than 1% of respondents reported using the Emergency Department for primary healthcare services. Most survey respondents, 83%, reported receiving annual wellness visits. These findings are inconsistent with 2021 county health rankings and may be attributed to the income and education level of survey respondents.

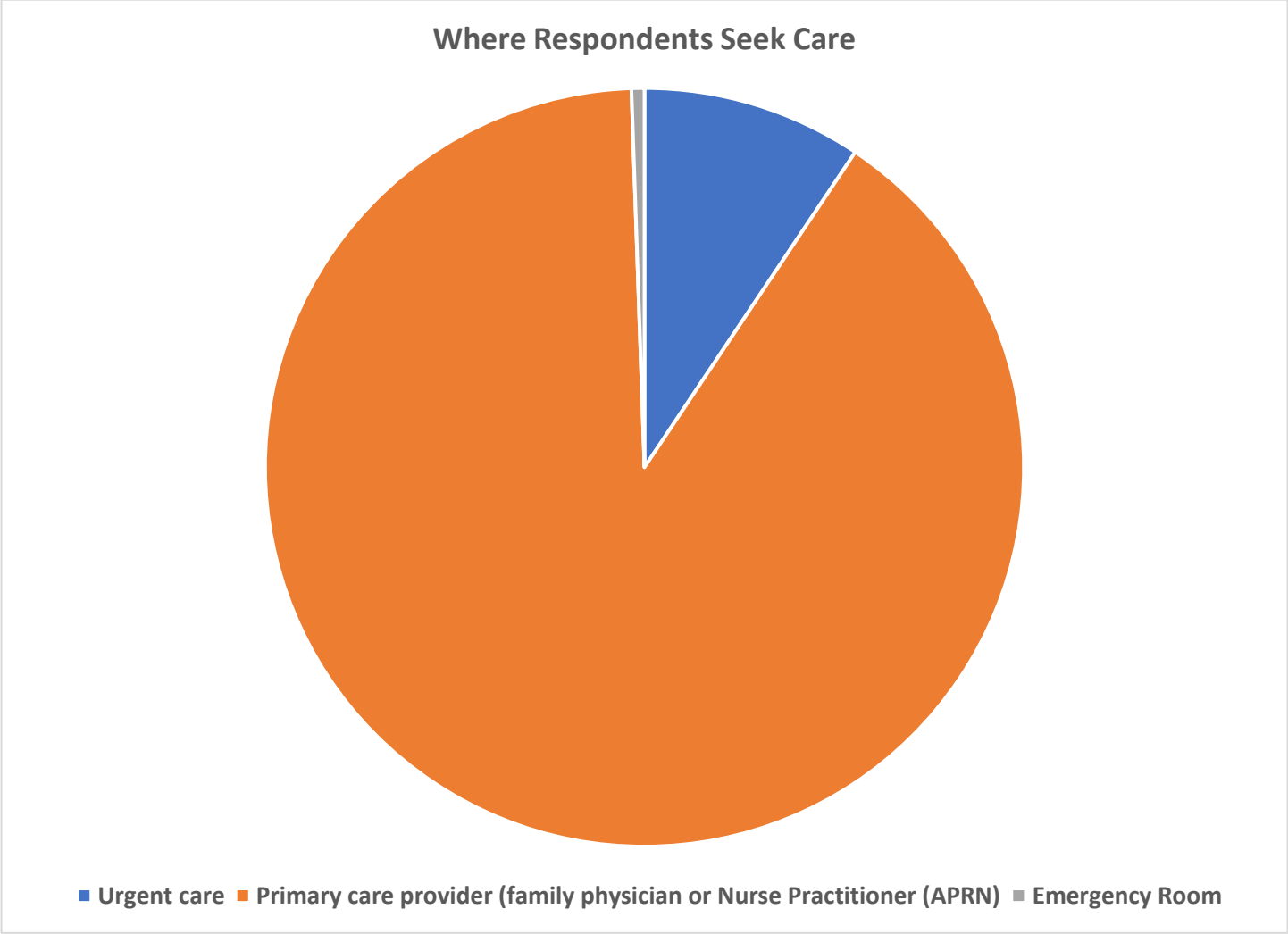
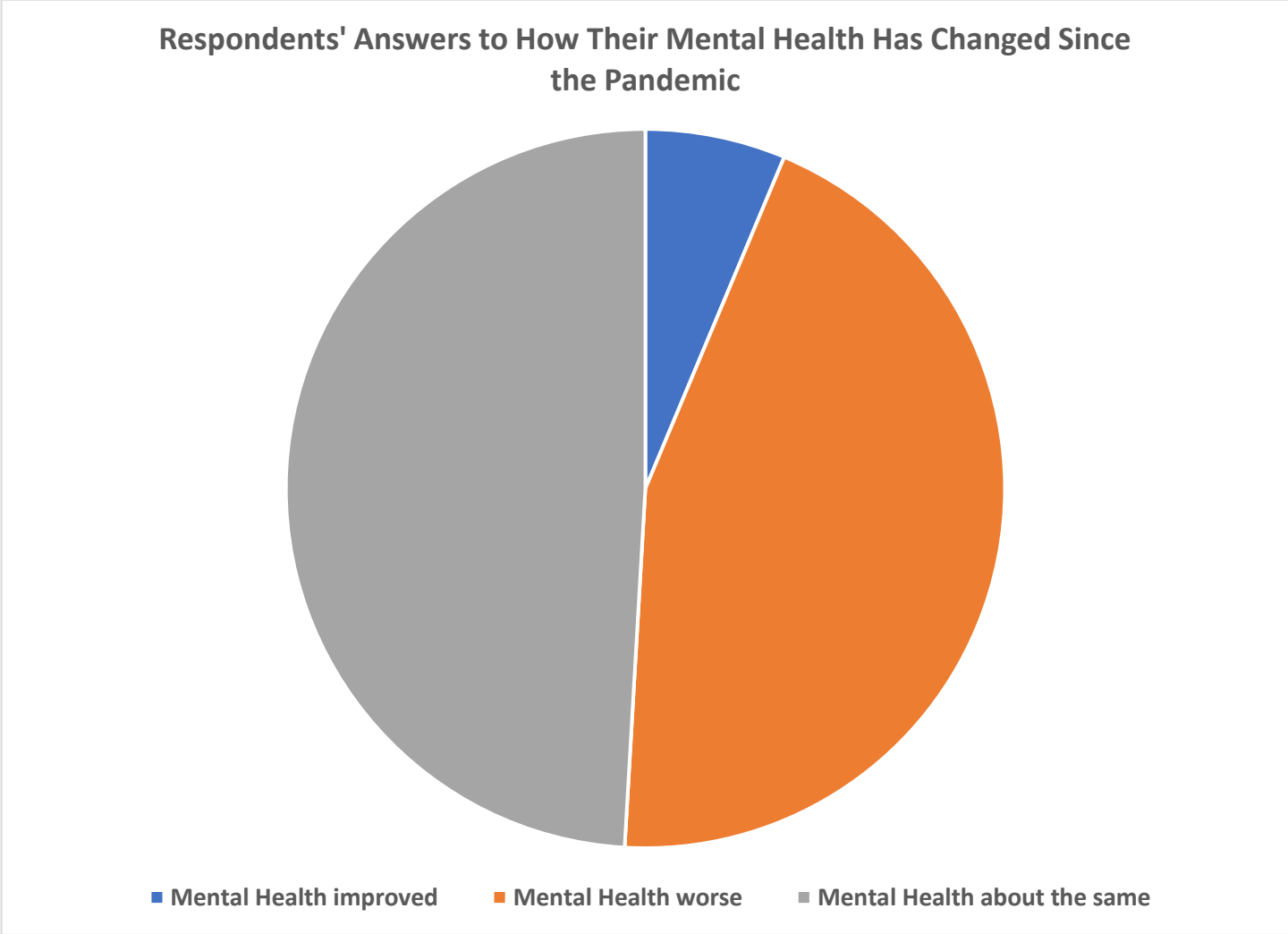
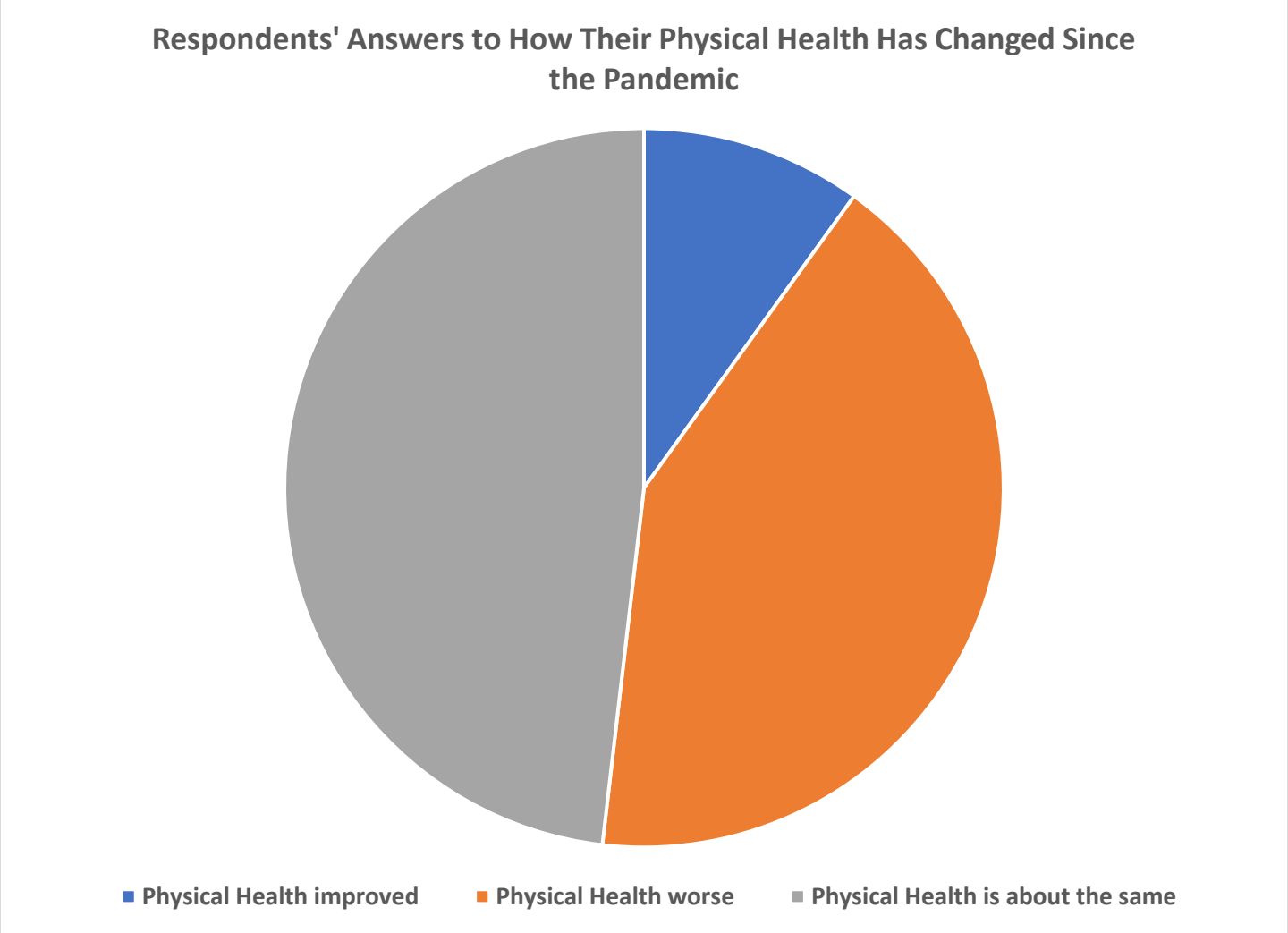



Figure 11

## Mental and Physical Health

The COVID-19 global pandemic affected the physical and mental health, and economic stability of many residents across our service area. Survey respondents report negative impacts to their mental (40%) and physical (39%), consistent with County Health Rankings that report poor mental and physical health days higher than the Arkansas average.




Respondents' Answers to How Their Physical Health Has Changed Since the Pandemic
Physical Health improved
Physical Health worse
Physical Health is about the same

## Interpretation and Findings

The overall health status and needs of the community residents were summarized from the data collected. Socio-economic factors that influence the health of our residents and contribute to the poor health status of Arkansans. High levels of poverty, low educational attainment which leads to low health literacy, low insured rates, the rural landscape, and healthcare provider shortages are a few of the leading factors propelling poor health status in the Service Area. The demographic and health data were used to assist the team in the summary of the most urgent community health needs.

After collecting and analyzing the demographic, qualitative and quantitative health related data from County Health Rankings and online survey data, the following categories of health needs were identified.

**Address Barriers to Healthcare**

- *High number of adults who report concerns about the cost of visit to healthcare provider.*
- *High number of adults who report concerns about the cost of medications.*
- *Lack of Access to Primary Care Providers*

**Address Healthcare Needs**

- *Mental Health Needs*
- *Physical Health Needs*
- *Substance Abuse Treatment Needs*

**Address Health Education Needs**

- *Understanding Chronic Conditions*
- *Understanding Treatment Plans*
- *Understanding Medications*

## Implementation Strategy/ Plan

| Address Barriers to Healthcare | Action Steps |
|---|---|
| • High Cost of Office Visit | • Educate the public about wellness services offered by insurance plans with low or no co-pay and deductible. Educate the public about sliding fee schedule services, and ensure eligible patients are enrolled in the appropriate assistance programs.<br>• Work collaboratively with insurers to promote incentives to patients for utilization of wellness benefits and screenings to improve health, and cost effectively manage chronic conditions.<br>• Promote WRH financial assistance programs through public education to ensure qualified patients receive assistance.<br>• WRH Foundation Ribbons of Hope and Patient Assistance fund provide direct to patient financial assistance to qualified patients for expenses related to medical care not covered by health insurance. |
| • High Cost of Medications | • Encourage providers to look for and use low-cost generic drugs when appropriate.<br>• Educate clinic staff and patients in the processes to take advantage of drug manufacturer programs for patient who cannot afford medications.<br>• Utilize clinical pharmacists to conduct medication reconciliation for patients to ensure medications are appropriately prescribed to patients who are treated by more than one provider and use medication to manage multiple chronic health conditions. |
| • Access to Primary Care Provider | • Work with local school districts to offers services of APRN providers via telemedicine during school hours.<br>• Continue to support Graduate Medical Education programs in Internal Medicine and Family Medicine.<br>• Provide Clinical training opportunities for candidates of Master's in Nursing programs.<br>• Continue to evaluate service area community for need and potential primary care Clinics; evaluate markets for rural health clinics. |

| | |
|---|---|
| | • Reopened Newark Medical Clinic in 2021. |
| **Address Mental Health Needs** | **Action Steps** |
| • Survey Respondents Report Mental Health Declined During Pandemic | • Utilize Licensed Clinical Social Workers in WRH Primary Care Clinics for depression and anxiety screenings and confidential counseling as needed to patients.<br>• Recruit and train mental health advocates as a resource for organization employee struggling with work and family stress.<br>• Actively recruit Psychiatrists and mental health professionals.<br>• Provide clinical training opportunities to Psychiatry Residents. |
| **Address Physical Health Needs** | **Action Steps** |
| • Survey Respondents Report Physical Health Declined During Pandemic | • Collaborate with Batesville Community and Aquatics Center to support and sponsor events and programs promoting physical activity.<br>• WRH Care Coordinators identify gaps, educate, and support patients including facilitating referrals to specialists and diagnostic procedures as needed.<br>• Utilize social media to increase awareness of and encourage health lifestyle choices and physical activity.<br>• Using funding from a Health and Human Services Administration grant, implement a program of screenings, diagnostic tests, treatment, and follow-up care to address cancer, diabetes, mental health, and vaccinations for medically underserved residents in the WRH service area. |
| • Incidence of Obesity/Need for Weight Management | • WRH Community Engagement Division develops and supports healthy living and physical activity through events in Cleburne, Independence, Sharp, and Stone counties. |

| | |
|---|---|
| • Maternal/Infant Mortality | • Utilize the services of Maternity Nurse Navigator to provide education, support, care coordination, and referrals to special services as needed. |
| • Cancer Related Illnesses | • Utilize the services of Oncology Nurse Navigator to provide care coordination, education, and support to patients during cancer treatment. The Oncology Nurse Navigator also offers support and care coordinator for cancer survivors and their families.<br>• Upgrade diagnostic imaging used in cancer detection and expand cancer treatment services. |
| • Reduce Number of Preventable Hospitalizations | • Health Coaches reinforce health education and work with primary care teams to connect patients with community and healthcare resources to prevent unintended hospital readmissions. |
| **Address Substance Abuse Treatment Needs** | **Action Steps** |
| • Acute Substance Abuse | • Voluntary Inpatient Detoxification Services at White River Medical Center.<br>• WRH Emergency Departments participation in the Arkansas *Naloxhome* Initiative. |
| • Substance Abuse Treatment and Prevention | • Offer medication assisted substance abuse treatment by Suboxone Certified Providers at WRH Behavioral Health and at WRH Family Care.<br>• Utilize Care Coordinator for screenings related to substance abuse and to facilitate referrals for the appropriate healthcare services to treat underlying health condition leading to substance abuse.<br>• Expand the use of Interventional Pain Management procedures to lessen use of oral narcotic medications to treat chronic pain.<br>• Use pre-operative screening, testing, and education to evaluate patients surgical pain management needs and utilize pain management strategies that minimize the need for narcotic medications to manage post operative pain. |

| Address Health Education Needs | |
|---|---|
| • Understanding Chronic Conditions | • Develop social media strategy of regular posts shared from National Institutes of Health and other healthcare organizations about managing chronic illness.<br>• Feature WRH Physicians in videos related to managing chronic health conditions and everyday health. Videos are published on social media and WRH website.<br>• Clinic Care Coordinators, Primary Care Providers, and Inpatient Case Managers provide chronic condition health education in-person, by phone, and telemedicine as needed.<br>• Lyon College pre-professional students assigned by WRH Health Coach program reinforce clinical education and help connect patients to services that assist patient with managing chronic conditions. |
| • Understanding Treatment Plans | • Clinic Care Coordinators and WRH Providers utilize tools like Motivational Interviewing to improve methods of communication to ensure a patient's understanding of their treatment plans.<br>• Clinic Care Coordinators and nursing team members follow up with patients post visits to further discuss treatment plans and answer patient questions. |
| • Understanding Medications | • WRH Providers utilize educational tools to share with patient information regarding medication management.<br>• WRH Pharmacists and Community Pharmacists work together to meet patients medication needs as applicable.<br>• Primary Care Clinics offer 24/7 access to a nurse on call to assist with after-hours questions. |

## Communications Plan

The approved WRH CHNA will be published on the WRH website, whiteriverhealth.org. It will be distributed electronically to WRH Administrative Team, Physicians, and Board Members, as well as Community Stakeholders. Printed copies will be available upon request by contacting WRH Marketing at (870) 262-6070.

# Appendix B
# Bridge Document

The White River Health Board of Directors approved the three-year Community Health Needs Assessment (CHNA) in September 2022. This bridge document identifies actions taken by White River Medical Center and Stone County Medical Center to meet the health of residents served by these institutions and outlined in the 2019 CHNA.

| Access to Healthcare Services | Action Steps |
|---|---|
| • High incidents of adults reporting a lack of access to a primary care provider, affordable insurance, and reported financial constraints | • Accredited Graduate Medical Education Program continues with Internal Medicine Residency that began July 2017<br>• The organization was accepted into the Care in the Community Network for Veterans providing a link to community providers and meeting the healthcare needs of Veterans<br>• Clinic locations are evaluated, and changes may be made to ensure efficiency and continued access to care.<br>• Continued Partnership with the University of Arkansas for Medical Sciences on a Family Medicine Residency that began in July 2019<br>• Extended hours of WRMC Medical Complex Southside to seven days from 8-6 pm<br>• Increased specialty physician services at WRHS facilities outside Batesville, including but not limited to Cardiology, Obstetrics/Gynecology, Oncology, Orthopedics, Pain Medicine, and Wound Care<br>• Ongoing recruitment of Primary Care providers<br>• Primary Care Provider utilization of telehealth resources to provide non-face-to-face visits when applicable<br>• Ribbons of Hope campaign through the WRHS Foundation allows donations to provide patient assistance with needs identified through our case managers<br>• Satellite clinic locations are now available in Cherokee Village, Melbourne, Mountain View, and Newport<br>• Train employees to appropriately screen patients at admission for financial assistance programs and charity care – WRHS added to Financial Counseling staff and revised Charity Care policy and application process to better serve patients including updates expanding services to better serve identified mental health needs and |

| | |
|---|---|
| | partnership with the MASH organization to ensure patients receive appropriate services |
| **Preventive Healthcare Management & Wellness** | **Action Steps** |
| • High incidence of men who report no recent Prostate Cancer Screening | • Continued participation in an Accountable Care Organization and multiple quality improvement programs with goals of meeting the quadruple aim<br>• WRHS provided free annual prostate cancer screening with PSA and rectal exam and expanded promotion to reach more counties to raise awareness of the screening opportunity through 2019 with a pause in 2020-2022 due to the COVID Pandemic. These services are reevaluated to be reinstated<br>• WRHS provided free community education events to educate the population on the importance of screening and lifestyle choices to decrease the incidence of disease in 2019 with a transition to a virtual education platform in 2020-2022 due to the COVID Pandemic |
| • High percentage of adults with no colorectal cancer screening | • Purchased state-of-the-art Olympus endoscopes and continued update of equipment as needed<br>• Support continued colorectal cancer awareness campaigns providing education regarding the various methods of cancer screening available<br>• Through community and quality improvement work WRHS identifies patient needs, provides education, and supports screening needs |
| • Low percent of children with age-appropriate vaccines | • Continued participation in AR Medicaid Patient-Centered Medical Home Program identifying patients in need of age-appropriate vaccines<br>• Improved access to Pediatricians and Pediatric APRNs through successful provider recruitment<br>• Partnerships with the local DHS supporting vaccination events<br>• Patient education shared through the pediatric clinic's annual education events shared both in-person and virtually |

| | |
|---|---|
| • High number of adults reporting no exercise | • Continued support of the Batesville Community and Aquatics Center through sponsorships and employee discounts<br>• Employee discounts for Stone County Medical Center employees at the local fitness center<br>• Exercise program offered at Senior Citizens Centers managed by WRHS<br>• Promote the Silver Sneakers program offered by local fitness centers in Independence, Izard, and Stone Counties<br>• Support and sponsor various exercise campaigns including 5Ks, Activity Challenges, and other physical activities within the communities of our service areas<br>• WRMC campus includes a walking track and park with a level, well-lit walking track for public use |
| • High number of adults in need of cholesterol assessment | • Community engagement to increase focus on health and wellness education in the communities we serve. Community engagement encourages healthy lifestyle choices with diet and exercise. The program offers community health and worksite screenings specifically to address the incidence of coronary artery disease, high blood cholesterol, diabetes, and hypertension. Collaborate with local schools on health and wellness and encourage healthy activity.<br>• WRHS Care Coordinators identify, and address identified gaps in care providing education and support for patients at risk of high cholesterol |
| • High number of adults lacking dental care | • Partner with credentialed dentists within the community<br>• Support dental health needs within the community and service areas through Acts 1:8 missions |
| • Low number of women receiving early prenatal care | • Provide support and education on prenatal care needs through our Nurse Navigator, online prenatal and breastfeeding classes with additional educational opportunities provided through community health luncheons with a focus on OB/GYN education (as applicable in the COVID Pandemic) |

| | |
|---|---|
| • High number of drugs, alcohol, and tobacco use | • Continued support of satellite Interventional Pain Management Clinics throughout the WRHS Service Area to decrease patients' dependence on prescription opioid medication including expansion of these services to satellite clinics in Cherokee Village, Mountain View, and Newport<br>• Continued screenings and assessments through all our primary care clinics treating patients as identified through applicable services in addition to connecting patients with behavioral health services as identified with an additional offering of behavioral health services provided within various primary care clinic locations through our Behavioral Health Integration program<br>• Evaluation of behavioral health needs of patients treated by pain management resulted in the opening of an inpatient detox unit<br>• Expanded services to provide Suboxone treatment through a certified primary care provider<br>• Expanded Cardiopulmonary Rehabilitation Program to Stone County<br>• Successfully met benchmarks in various quality program work to screen and provide tobacco cessation counseling and treatment as applicable<br>• Through Behavioral Health Integration and telehealth services, coordinate care, and provide services to patients with an identified need. |
| **Chronic Disease Management and Education** | **Action Steps** |
| • High incidence of adults who report obesity and/or overweight, | • Collaborate with community resources to provide healthy food choices through a Farmer's market on the WRMC campus and provide healthy meal options through the WRMC Café and Chef<br>• WRHS Community Engagement Division develops and supports healthy living and physical activity through events in service areas including utilizing social media to increase awareness of healthy living and physical activity |
| • High incidence of adults with Chronic Diseases (CAD, CHF, COPD, and Diabetes), and preventable hospitalizations | • Expanded Cardiopulmonary Rehabilitation Program to Stone County<br>• Through quality program work, Care Coordinators identify high-risk and high-utilization patients to provide coordination of care and meet educational needs<br>• Primary Care Providers and Care Coordinators provide transition of care services to patients discharged from the hospital providing education |

| | |
|---|---|
| | and assistance as patients navigate the healthcare system<br>• Provide low-cost Cardiac Calcium Scoring CT to area residents with cardiovascular risks<br>• WRHS partners with Lyon College educating pre-medical students in health coaching services provided to targeted patient populations |
| • High incidence of infant deaths/High incidence of low birth weight/High incidence of preterm births | • Expanded access to pediatric care through additional Pediatric providers<br>• Expanded availability of prenatal care through additional providers in Obstetrician/Gynecologists<br>• Maintained national certification as a Safe Sleep Hospital through the Cribs for Kids and Taylor McKeen Shelton Foundation<br>• Support infant safe sleep through a program providing a wearable blanket sleeper for every newborn in addition to displaying safe sleep practices through the Halo Sleep swaddles on infants while in the hospital<br>• WRHS Maternity Patient Educator and Liaison supports and provides education to expectant and new mothers in addition to providing education at community events including county fairs, and ensuring all newborns leave the hospital in a properly installed and approved care seat<br>• WRMC partnership with the local community college to support the Safe Sitter Education Program |
| • High incidence of premature deaths, accidental deaths, mortality, and high incidence of traffic fatalities related to drugs or alcohol | • Continued support of Survival Flight 4 Helicopter base at WRMC and at WRMC Medical Complex Cherokee Village in addition to providing continued support through the housing for flight crews<br>• Offer low-cost Cardiac Calcium Scoring CT to area residents with cardiovascular risk factors<br>• Provide sponsorship and support for local school events as applicable to provide educational opportunities to highlight the risks of premature deaths.<br>• WRMC provides cardiac screenings to student-athletes during pre-season sports physicals<br>• WRHS care teams work together to provide preventable health services and education through health screenings and education<br>• WRHS Community Engagement Coordinator continues developing relationships within service |

| | |
|---|---|
| | areas and supports ongoing healthy living and physical activity events. |
| • High incidence of cancer and/or deaths | • Added digital screening mammography to Sharp and Stone Counties.<br>• Cancer prevention initiatives provide education, early detection through screenings, and patient assistance<br>• Clinical protocols in place for lung CT screening of patients who meet CMS criteria<br>• Continued campaigns including social media and bi-annual publications of healthier living articles to increase awareness of risks of cancer and screening opportunities for early detection and treatment<br>• Provided Satellite Oncology Clinics in Sharp and Stone Counties |
| • High incidence of accidental death and traffic fatalities involving drugs and alcohol | • Continued support for Satellite Emergency Department in Cherokee Village (Sharp County)<br>• Expanded WRMC Emergency Department, specifically trauma capacity<br>• Provide sponsorship and support of *Every 15 Minutes* and Distracted Driving Demonstrations in cooperation with local schools<br>• Provide support for Survival Flight 4 Helicopter base at WRMC |
| • High incidence of adults reporting poor mental health and high incidence of teen suicide | • Continued collaboration with area schools and community events providing education on suicide awareness and prevention<br>• Expanded Behavioral Health Integration to additional Primary Care Clinics including the Children's Clinic utilizing telehealth services as needed<br>• Incorporated behavioral health services within Primary Care Clinics to support mental health needs<br>• Through quality program work, Care Coordinators identify patients with mental health risks and coordinate care with Behavioral Health Services |

| | |
|---|---|
| • High incidence of vision and hearing issues | • Continued collaboration with local Optometrists at community events to support vision health<br>• Continued evaluation and support of partnerships with Audiology Clinics to improve access to ENT services<br>• Continued support of provider-led community education on hearing loss<br>• Recruited second ENT physician to medical staff |

1. Where is the primary place you live?

- ◯ Cleburne County
- ◯ Independence County
- ◯ Izard County
- ◯ Lawrence County
- ◯ Sharp County
- ◯ Stone County
- ◯ Jackson County
- ◯ Outside of these Options

2. What is your race?

- ◯ Asian/Pacific Islander
- ◯ Black or African American
- ◯ Hispanic or Latino
- ◯ Native American or American Indian
- ◯ White
- ◯ Other Race

3. What is your age?

- ◯ Under 18
- ◯ Age 18-34
- ◯ Age 35-49
- ◯ Age 50-64
- ◯ Age 65 and older

4. Which best describes your household?

- ◯ Foster parent household
- ◯ Grandparent raising grandchildren household
- ◯ No children
- ◯ Single parent household
- ◯ Teen parent household
- ◯ Two-parent household

5. Which best describ  s your household income?

- ◯ Less than $35K
- ◯ $30K-$50K
- ◯ $50K-$99K
- ◯ $100K-199K
- ◯ More than $200K
- ◯ Prefer not to answer

6. Which best describes your highest level of education?

- ◯ No High School Diploma
- ◯ High School Diploma/GED
- ◯ Vocational or Trade School Diploma/Certification
- ◯ Some College
- ◯ Bachelor's Degree or higher

7. What is your preferred method of receiving health education?

- ◯ In-person
- ◯ Social media (Facebook, Instagram, YouTube)
- ◯ Virtual Meeting (Zoom, WebEx, Go-To-Meeting)
- ◯ Written material

8. How would you rate your health?

- ◯ Excellent
- ◯ Good
- ◯ Poor

9. Which health insurance do you have?

- ◯ Employer-Sponsored Health Insurance
- ◯ High Deductible Health Insurance
- ◯ Individual Health Insurance (Private and Marketplace)
- ◯ Medicaid
- ◯ Medicare Advantage
- ◯ Medicare and Medicaid
- ◯ No Health Insurance
- ◯ Traditional Medicare

10. Based on your knowl dge/experi nce, ho would your rate our community's greatest healthcare needs?

Fitness/Exercise opportunities

Substance abuse treatment

Health education

Weight management

Mental health needs

11. Based on your knowl dge/experi nce, ho would you rank the community's top barriers to healthcare?

Access to a Primary Care Provider (family physician or nurse practitioner (APRN)

Cost of an office visit

Cost of medication

Language

Need after-hours care (after 5 pm)

Need assistance understanding my chronic health illness

Transportation

12. Where do you seek healthcare services when sick?

- Urgent care
- Primary care provider (family physician or Nurse Practitioner (APRN)
- Emergency Room

13. Do you go to a primary care provider (physician or nurse practitioner (APRN) for an annual wellness visit?

- Yes
- No

14. Based on your knowledge/exp rience, hat substances are being abused or misused among youth under the age of 18 years old (select all that apply)

- [ ] Adderall
- [ ] Nicotine/Tobacco
- [ ] Alcohol
- [ ] Opioids
- [ ] DXM (Dextromethorphan)
- [ ] Prescription Drugs
- [ ] Hallucinogens
- [ ] Spice/K2
- [ ] Inhalants
- [ ] Tranquilizers
- [ ] Marijuana
- [ ] Vaping
- [ ] Methamphetamine

15. Based on your knowledge/experience, select how your health has changed since the beginning of the pandemic? (Select all that apply)

- [ ] Mental Health improved
- [ ] Mental Health worse
- [ ] Mental Health about the same
- [ ] Physical Health improved
- [ ] Physical Health worse
- [ ] Physical Health is about the same

16. Do you receive recommended vaccinations? (flu, pneumonia, shingles, COVID-19)

- ◯ All
- ◯ Some
- ◯ None

17. What keeps you from receiving a recommended vaccine?

- ◯ Availability
- ◯ Concerned about side effects or adverse reactions
- ◯ Cost
- ◯ Cultural or religious beliefs
- ◯ Fear of needles
- ◯ Medical (allergies, underlying health conditions)
- ◯ I do not have any problems receiving a recommended vaccine.

18. Did you know WRHS offers the below services? (select all services you are **NOT** aware of)

- ☐ Accepts all major insurance plans
- ☐ Assistance connecting with program resources
- ☐ Behavioral health services both in our behavioral health clinic and selected primary care clinics
- ☐ Language Assistance
- ☐ Program for financial assistance
- ☐ Telehealth (virtual) health services for Primary Care visits
- ☐ Primary Care Walk-in Clinic with weekend hours

19. Did you know WRHS supports the programs below? (Select all programs that you are **NOT** aware of)

- ☐ Provider and nurse recruitment
- ☐ Quality improvement
- ☐ Patient satisfaction
- ☐ Chronic disease management

20. Which of the following specialties do you identify as having adequate access to in our community? (Select all that apply)

- ☐ Endocrinology
- ☐ Gastroenterology
- ☐ Neurosurgery (Spine Specialist)
- ☐ Pediatric (Youth) Psychiatry
- ☐ Pediatrics
- ☐ Rheumatology