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Introduction

DeWitt Hospital and Nursing Home is a critical access hospital and nursing home located in the city of DeWitt in Arkansas County, Arkansas is a 501 (c) 3 not for profit organization. Being a non-profit hospital, DeWitt Hospital and Nursing Home is eligible to participate in the Special Medicaid Assessment Program which provides Medicaid payment reimbursements to eligible hospitals; meaning approximately $1.0 million per year to a hospital the size of DeWitt Hospital and Nursing Home.

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. DeWitt Hospital and Nursing Home 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 DeWitt Hospital and Nursing Home conducts a survey assessing the needs of Arkansas County residents and hospital stakeholders in the surrounding area. The assessment includes input from persons representing broad interests of the community served by DeWitt Hospital and Nursing Home, 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 DeWitt Hospital and Nursing Home 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 DeWitt Hospital and Nursing Home 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.

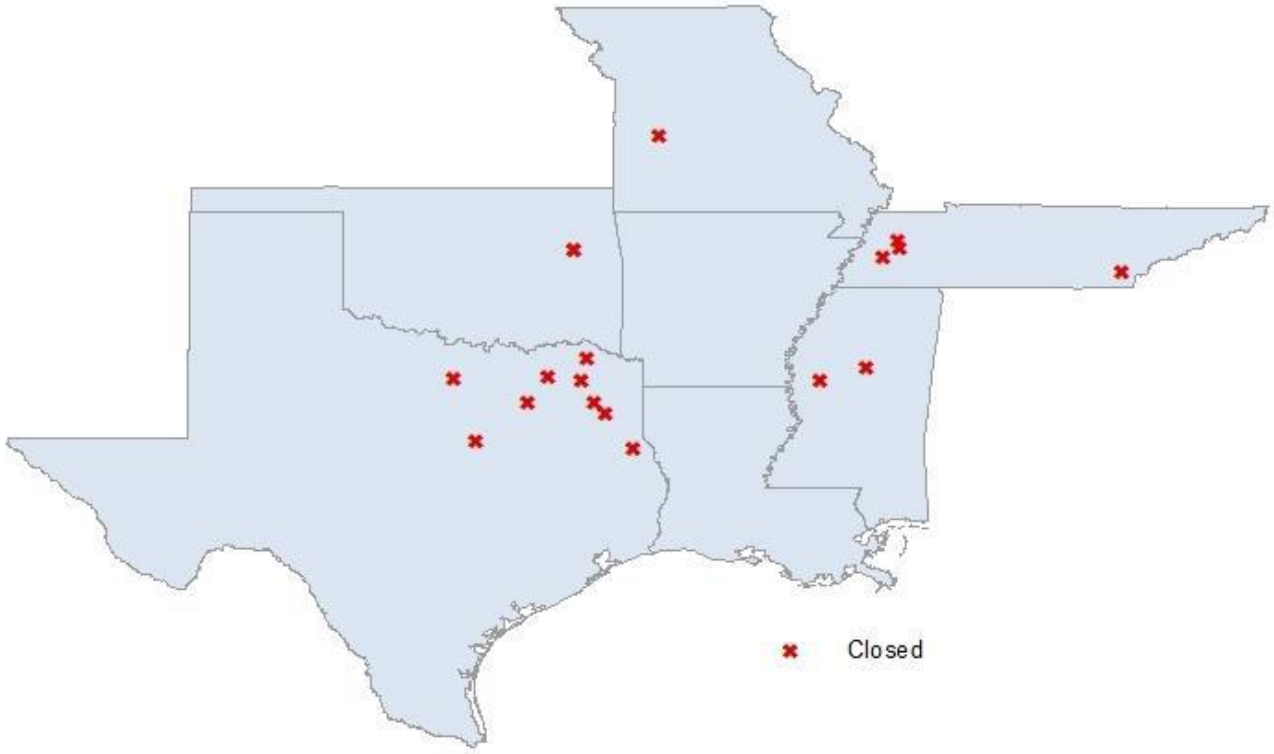
The healthcare industry tackles the opioid crisis: More and more emphasis will be put on helping patients stop addictions and regulating physicians on prescriptions. Data sharing across government agencies will be able to locate and target patients with addiction problems.

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 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 PREVENTATIVE CARE Focus on long-term prevention and management; Awareness campaigns and behavioral nudges toward healthy habits; Encouragement of healthy behavioral habits
COMPLIANCE & PATIENT SAFETY Technology to assess quality, safety, and effectiveness of medicine; New Regulatory Demands automating regulatory process and surveillance; Empowered consumers (patients) with their own information	GROWTH OF TELEMEDICINE 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.
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- 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	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

information on health indicators within the body to a smartphone	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 DHNH

MISSION

"Quality Healthcare, Under One Roof"

HISTORY

The DeWitt Hospital & Nursing Home is a 25 bed critical access hospital located in DeWitt, Arkansas County, Arkansas. DeWitt is a small town and serves as the county seat of the county's southern district. The population of DeWitt was 3,552 at the 2000 census. The hospital is located right near the DeWitt High School. The school district serves the towns of DeWitt, Humphrey, Gillett, ALmyra, St. Charles, and The hospital serves the areas of Arkansas Prairie, Jefferson, Desha, and Phillips counties.

Construction on the original facility began in 1962 and the first patients came through in December of 1963. Since then, the hospital and nursing home have had several expansions and improvements to help improve patient care and create areas for growth, including the acquisition of the Ferguson Rural Health Clinic. DHNH is a facility committed to the future and ready to embrace the changes that are coming to the health care industry, including Electronic Medical Records and the use of clinical applications to improve patient care.

The hospital is owned and operated by the DeWitt Hospital and Nursing Home Inc not-for-profit organization, which was founded by three local community members who were also presidents of local banks. DeWitt Nursing Home is locally owned and operated by citizens of DeWitt. The nursing home is a 60 bed facility fully certified for Medicare and Medicaid. It provides private and semi-private rooms and offers an array of services such as short-term rehabilitation services, long term skilled nursing care, physical therapy and dietary and recreational programs. The facility provides additional activities such as games, music, religious programs, and short trips.

The DeWitt Hospital and Nursing Home is a level 4 trauma center and provides ancillary services including outpatient CT scans, X-rays, and lab work. Within the facility, DeWitt Hospital has an

outpatient clinic, used by physicians from the Arkansas Heart Hospital as well as an Internal Medicine physician who comes monthly to treat local patients who cannot travel. DeWitt Hospital is an active participant in the Arkansas Saves program, a stroke trauma program through University of Arkansas for Medical Sciences.

The hospital provides services such as an emergency department, ambulance service, laboratory, respiratory therapy, bone density exams, a rural health clinic and a nursing home. The hospital's current goals in these departments are to better identify their customers and to acquire and provide access to procedures and equipment that they are unable to obtain elsewhere.

DHNH's nursing staff has a greater amount of time to spend with each patient because of the fewer number of patients that the hospital serves. When patients come to DHNH, they can expect a clean facility with new patient service equipment and a staff that will make them feel respected and comfortable, all while maintaining privacy. DHNH likes to keep things simple. The hospital strives to allow plenty of time to spend with each patient and to give them the information that they need to know and make sure they understand the treatment they are receiving.

2019 HOSPITAL GOVERNANCE

DeWitt Hospital and Nursing Home is a private not for profit facility which is governed by a five member Board of Directors, along with the hospital CEO. The facility is a member of the Arkansas Hospital Association and the American Hospital Association. They are also a member of the Arkansas Rural Health Partnership, an twelve hospital 501 (c) 3 organization that works together to reduce cost by group purchasing and negotiation of contracts as well as provide several outreach projects in the Southeast Arkansas region.

DEWITT HOSPITAL AND NURSING HOME BOARD OF DIRECTORS	
David Jessup Bank President P.O. Drawer 71 DeWitt, AR 72042	**Dean Watts** Dean's Pharmacy, Owner 1640 S. Whitehead Drive DeWitt, AR 72042
Rick Duffield	**Warren Jennings, Jr.**

CEO Black Inc. PO Box 288 DeWitt, AR 72042	Bank President P.O. Box 511 DeWitt, AR 72042
Dr. Stan Burleson, MD Physician P.O. Box 352 DeWitt, AR 72042	**Brian Miller, CEO** DeWitt Hospital & Nursing Home 1641 S. Whitehead Drive DeWitt, Arkansas 724042

SERVICE AREA

DeWitt Hospital and Nursing Home's primary service area encompasses the communities of Arkansas, Phillips, Desha, Jefferson, and Praire counties that are located near DeWitt including the residents in towns including Gillett, St. Charles, Almyra, Crocketts Bluff, Casscoe, Ethel, Tichnor, and Reydell. DeWitt residents make up the majority of both inpatient and emergency room patients. Those remaining are, for the most part, residents of Phillips, Desha, Jefferson, and Prairie counties and are considered the secondary service area.

Arkansas County is a county located in the U.S. state of Arkansas. As of the 2018 U.S. census, the population was 17,769. The county has two county seats, De Witt and Stuttgart. The first of the state's 75 present-day counties to be created, Arkansas County was formed on December 13, 1813, when this area was part of the Missouri Territory, and is named after the Arkansas Indian tribe. Arkansas County is one of seven counties in the United States to share the same name as the state it is located in (the other six counties being Utah County, Hawaii County, Idaho County, Iowa County, New York County, and Oklahoma County).

2019 HOSPITAL STAFFING CHART

See DeWitt Hospital & Nursing Home's 2019 Staff Chart in Attachments

PROVIDERS

Stanley Burleson, MD Family Practice
George Covert, MD Family Practice
Charles Jones Jr., MD Family Practice
Ralph Maxwell, DO General Practice
James Renfroe, MD Family Practice
Stefanie Rust, DO Family Practice
Philip Terry, MD Family Practice
Wallace Tracy, MD Family Practice
Carolyn Vogler, MD Family Practice
Kenneth Wright, MD Family Practice

HEALTH CARE SERVICES

Currently DeWitt Hospital and Nursing Home provides general medical and surgical care for inpatient, outpatient, and emergency room. The hospital participates in the Medicare, Medicaid programs and accepts most major health insurance programs. Services provided by DeWitt Hospital and Nursing Home include:

DHNH SERVICES
Acute (Hospital) Health Care
Physical Therapy
Nursing Home- Long Term Care
24-Hour Physician ER Coverage
Clinical Laboratory

Social Work
Electronic Health Records
Post Acute-Care (Swing Beds)
Respiratory Therapy Services
Pulmonary Function Testing
Holter Monitoring
Sleep Studies
Arterial Blood Gas
EKG
Tobacco Cessation
Disease Self-Management Planning
ARSAVES Stroke Center
ED Mental Health Assessments
Prescription Assistance
Insurance Enrollment Assistance
Medicare Enrollment Assistance
Mental Health First Aid Training

DEWITT NURSING HOME

The Dewitt Hospital Nursing Home is a 60-bed facility fully certified for Medicare and Medicaid. We provide private and semi-private rooms. Our facility offers an array of services such as short-term rehabilitation services, long-term skilled nursing care, physical therapy and dietary and recreational programs. Our residents enjoy games, music, religious programs, and short trips.

OTHER HEALTHCARE PROVIDERS IN THE AREA

The major competitors in the service area are primarily private, nonprofit, critical access hospitals which offer similar services. Several of those nearest to DeWitt are members of the Arkansas Rural Health Partnership through which they work closely together to reduce costs by sharing services and negotiating contracts. One facility located in the larger community of Monticello (Drew County) is an acute care rural hospital with 49 beds. Jefferson Regional Medical Center in Pine Bluff is 53 miles away with 471 beds.

LOCATION	HOSPITAL NAME	MEDICARE CLASSIFICATION	# OF LICENSED BEDS	HOME HEALTH	DISTANCE FROM DHNH
Crossett	Ashley County Medical Center	Critical Access	25	No	106
Warren	Bradley County Medical Center	Critical Access	25	Yes	83
Lake Village	Chicot Memorial Medical Center	Critical Access	25	Yes	75
Monticello	Drew Memorial Hospital	Rural Acute Care	49	Yes	65
Pine Bluff	Jefferson Regional Medical Center	Regional	471	Yes	53
Stuttgart	Baptist Health-Stuttgart	Critical Access	25	Yes	27
Dumas	Delta Memorial Hospital	Critical Access	25	Yes	34

Community Initiatives

DeWitt Hospital and Nursing Home is active throughout Arkansas County in sponsoring health fairs, educational programs, free health screenings and other activities to promote the health of the citizens of Arkansas County.

Arkansas County Hometown Health Coalition

DHNH is an active member of the Arkansas County Hometown Health Initiative Project, which is a program of the Arkansas Department of Health. The Hometown Health Initiative (HHI) brings together a wide range of people and organizations including consumers, business leaders, and health care providers of all types, to develop and implement ways to solve health issues in each county. The D-HHIP stresses:

- Collaboration,
- Coalition building,
- Community health assessments,
- Prioritization of health issues, and
- The development and implementation of community health strategies that are locally designed and sustained

DeWitt Hospital & Nursing Home

Our hospital offers the following education and outreach opportunities:

EDUCATION & OUTREACH
ED Mental Health Assessments
Prescription Assistance
Insurance Enrollment Assistance
Medicare Enrollment Assistance
Community Health Fairs

Project Pink
Mental Health First Aid Training

Arkansas Rural Health Partnership

DeWitt Hospital & Nursing Home 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 Jefferson Regional Medical Center (Pine Bluff, 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 Medical Center (Dumas, AR), Dewitt Hospital & Nursing Home (DeWitt, AR), Drew 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:

Healthcare Provider Training & Education	
On-Site Simulation Trauma Training	On-Site Simulation OB Certification

On-Site Simulation Coding Training

On-Site Simulation ASLS Certification

On-Line Healthcare Education

On-Line Healthcare Orientation

Diabetes Site Accreditation Assistance

Diabetes Certification Assistance

DEEP training & certification

SAMHSA's SBIRT training

Medication Assistance for OUD Patients

Mental Health First Aid Training

Patient Education & Outreach Services

Opioid Use Disorder (OUD) Education & Navigation

Prescription Assistance Services

Free Breast Screening & Diagnostic Services

Cooking Matters Classes

Insurance & Medicare Assistance & Enrollment

Diabetes Prevention Program

Diabetes Empowerment Education Program (DEEP)

Mental Health First Aid Training

Opioid Use Disorder Case Management/Counseling

Patient Navigation

Emergency Department Mental Health Assessments

Diabetes Self-Management

Telehealth Services

Opioid Use Disorder Case Management/Counseling

Patient Navigation

Emergency Department Mental Health Assessments

Community Education & Outreach Services

Insurance & Medicare Assistance & Enrollment

Cooking Matters Classes

Diabetes Empowerment Education Program (DEEP)

Diabetes Prevention (DPP)

Opioid Use Disorder (OUD) Education

Mental Health First Aid Training

ArCOP Community Grants

Health Resource Directory

2016 CHNA Update

2016 CHNA GOALS

Goal I. Improve the health of residents in the service area
IMPLEMENTATION STRATEGY
*Increase efforts to provide health education and programs throughout the county *Increase efforts to obtain more funding for health education programs and health services *Collaborate with community leaders and organizations for support
Goal II. Improve access to care for the residents in the service area
IMPLEMENTATION STRATEGY
*Increase public relations efforts; promotion of programs and services throughout the service area *Collaborate with community leaders and organizations for support
Goal III. Increase public relations and communications efforts; promotion of services throughout service area

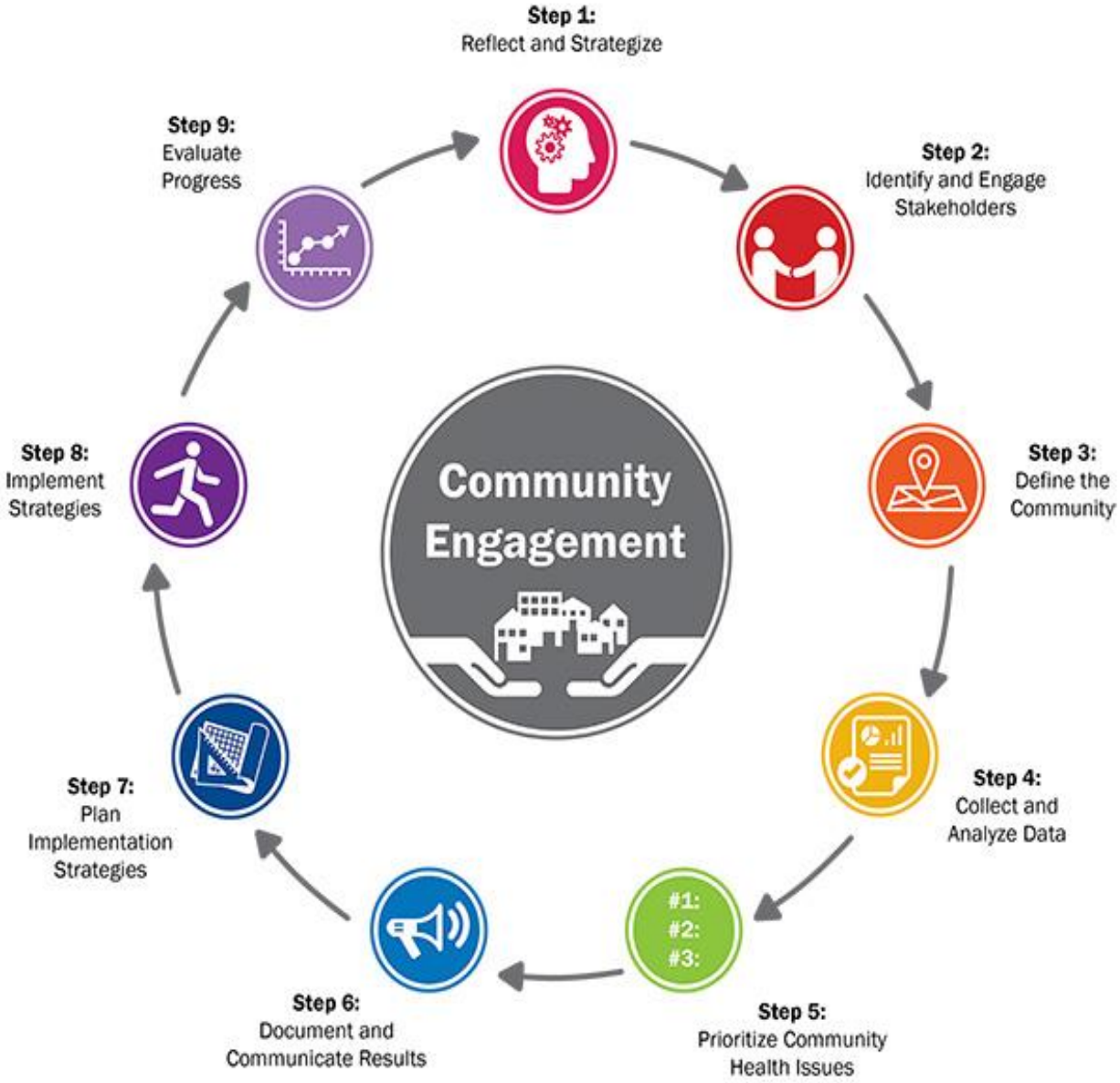
2016 CHNA PROGRESS

Goal I. Improve the health of residents in the service area
PROGRESS
* Provided health education at the Arkansas County Fair *Secured a full-time physician for the FRHC *Offer on-site MRI and cardiology services *Provided CPR classes/community education in the school system *Actively participate in the AR SAVES program *Actively participated in the DCHIP community meetings providing updates on programs and services

Goal II. Improve access to care for the residents in the service area
PROGRESS
* Hosted the MASH program designed to educate high school students on health care opportunities *Organize & facilitate the DHNH annual health fair to provide health information and health screenings to residents. *ER staff has received training on the ARHP Mental Health ER assessments *Respiratory department provides CPR classes/community education within the school system. *Actively participated in the DCHIP community meetings providing updates on programs and services

2019 CHNA

COMMUNITY ENGAGEMENT PROCESS



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

OVERVIEW OF THE 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 two community meetings. The facilitator and the steering committee oversee the entire process of organizing and determining a Community Advisory Committee of 20-60 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 MEETING #1
Overview of CHNA Process
Responsibilities of Community Advisory Committee
Present Health/Hospital Data & Services
Present Community Input Tool
Distribute Survey

Step 3: COMMUNITY MEETING #2
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 DeWitt Hospital & Nursing Home (DHNH) staff steering committee members convened with Mellie Bridewell of the Arkansas Rural Health Partnership to assess community member involvement. The DeWitt Hospital & Nursing Home (DHNH) staff steering committee included Brian Miller (DHNH Chief Executive Officer), Kendra Otto (Administrative Assistant), Mellie Bridewell (CEO of the Arkansas Rural Health Partnership), and Lynn Hawkins (CPO of the Arkansas Rural Health Partnership) participated and would provide 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 28 Individuals from the community were selected for invitation to the focus group, or community advisory committee, by the DeWitt Hospital & Nursing Home (DHNH) staff steering committee. Of those 28 invitees, 23 community members attended the first meeting of the advisory committee. A few additional advisory committee members, who were unable to attend the first meeting, joined the second meeting after being briefed.

These community advisory committee members met initially to discuss health statistics affecting the hospital service area, and to individually complete the 2019 health needs survey. Advisory committee members assisted in the distribution of the surveys to neighbors, colleagues, and friends prior to the second meeting. Surveys were also available electronically on the DHNH website, DHNH Facebook Page, the ARHP website, and various sites throughout the service area. At the second committee meeting, members were presented with the results of the surveys and discussed some of the questions and responses as a group and 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
Brian Miller	Chief Executive Officer	DeWitt Hospital & Nursing Home
Kendra Otto	Administrative Assistant	DeWitt Hospital & Nursing Home
Lynn Hawkins	Chief Programs Officer	Arkansas Rural Health Partnership

Community Advisory Committee

Name	Occupation
Jimmy Black	Mayor of DeWitt
Eddie Best	Arkansas County Judge
David Jessup	Board Chairman
Rick Duffield	Board Secretary
Dean Watts	Board Member
Dr. Stan Burleson	Board Member
Warren Jennings, Jr.	Board Member
Dr. Wallace Tracy	Hospital Physician
Nick Hill	School Superintendent
Bobbie Lynn Steeland	School Principal
Steven Bobo	DeWitt Chief of Police
Caroline Turner	PCCUA Vice Chancellor
Bill Adams	President/ Adams Fertilizer
Barry Barnette	President/ Farmers & Merchant Bank
Michael Burford	City Council Member
Debbie Fox	City Council Member
Brent London	City Council Member
Perry Simpson	City Council Member
Dallas Traylor	City Council Member
Robert Young	City Council Member
Charlotte Purdy	DeWitt Newspaper
Bobby Webb	Webb's Sporting Goods
Tommy Black	Tommy's Rexall
Billy Ullrich	New Life Ministry/ Pastor

Jimmy Albrecht	Frist Baptist Church/ Pastor
Donald Ruffin	Faith Baptist Church/ Pastor
Tony Hill	First United Methodist Church/ Pastor

RESULTS OVERVIEW

There were 105 completed surveys through the 2019 CHNA process. All of the results of the survey can be found in Attachment C: 2019 DeWitt Hospital & Nursing Home Survey Results.

TOP ISSUES IDENTIFIED BY THE 2019 CHNA PROCESS
Need for more Mental and Behavioral Health Resources
Suggestions for addressing need: ❖ Provide therapy and counseling support services by adding qualified staff to provide therapy along with medication assistance ❖ Pursue implementing services in hospital, clinics, schools, etc. via telehealth ❖ To improve community outreach and support through structured services for behavioral health ❖ To improve community outreach and support through structured services for mental health ❖ Promote current programs already in existence ❖ To continue to work with Arkansas Rural Health Partners to increase mental and behavioral health services; both in-patient and out-patient.

Lack of Doctors; Aging Doctors

Suggestions for addressing need

- Administration continue to recruit and hire more physicians
- Keep an open line of communications between hospital and medical students in the state
- Continue to work with ARHP partners to implement a rural residency training program in and rotation opportunities for medical students from UAMS, ARCOM, and NYIT in Southeast Arkansas
- Continue to pursue opportunities for community match dollars for potential physicians for Arkansas county

Need for Community Education and dissemination of health resources

Suggestions for addressing need:

- Increase community outreach activities to educate community
- Increase available health education and assistance programs in the community
- Provide community outreach (churches, events, salons, parent nights at schools); where they are
- Assist ARHP with publicizing and recruiting participants to programs already in existence
- 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
- ❖ Increase marketing of available hospital resources throughout the county

In conclusion, DHNH Steering committee will develop a strategic implementation plan prior to December 31, 2019 to address the following public concerns:

- Need for mental and behavioral health resources in the community
- Lack of Doctors
- Need for healthcare community education, outreach, and resources

DOCUMENTATION

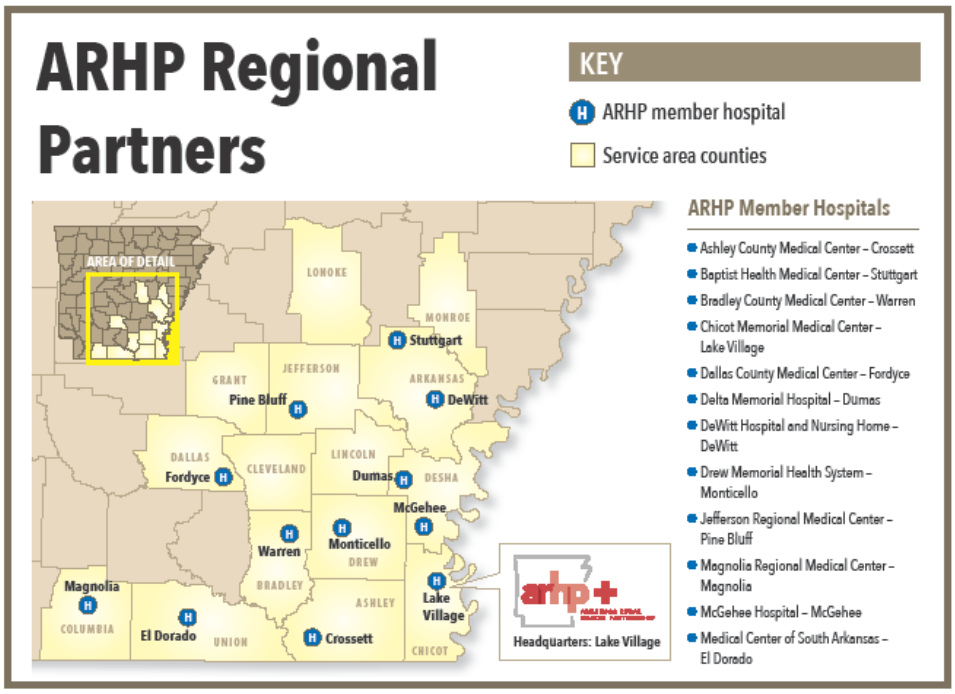
The following documentation of 2019 CHNA presentations, agendas, sign-in sheets, and survey results are included in the following attachments which can be found at the end of this report.

- **DeWitt Hospital & Nursing Home 2019 Staff Chart**
- **Attachment A.** Community Advisory Committee Meeting I Sign-in Sheet
- **Attachment B.** Community Advisory Meeting II PowerPoint Presentation
- **Attachment C.** 2019 DeWitt Hospital & Nursing Home CHNA Survey Results
- **Attachment D.** Community Advisory Committee Meeting II Sign-in Sheet
- **Attachment E.** Community Advisory Meeting II PowerPoint Presentation

Relevant Data

REGIONAL & STATE DATA

For the purposes of this assessment, regional demographics include the counties served by DeWitt Hospital & Nursing Home 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. DeWitt Hospital & Nursing Home 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 annually (*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)

ARKANSAS COUNTY

Community Demographics

DeWitt Hospital and Nursing Home is located in Arkansas County in Southeast Arkansas. Arkansas County is the oldest county in Arkansas, and it has a rich history behind it. The only American Revolutionary battle fought west of the Mississippi (1783), was fought in Arkansas County. A dual county seat with courthouses in Dewitt and Stuttgart, the oldest records in Arkansas are kept in the (Stuttgart) courthouse. They date from 1796 and are written in Spanish. The landscape of the county is rich, flat, delta farmland. DeWitt Hospital and Nursing Home, like most healthcare facilities located in the Delta, struggle with bad debt, poor health outcomes and relies on the support of the government and local taxes to keep from closing. Arkansas County is considered exceptionally rural and communities are separated by miles and miles of farmland. When viewing population trends, Arkansas County has experienced a decline in population of 8.2% in the past eight years; compared to the national average, which has increased by 6 percent. This out-migration has had a negative impact on the area's economy and the rural service area's ability to attract healthcare specialists. While the problems in the service area are growing, as in many rural communities, the health-care system is an influential and critical component of the system that can help to resolve economical, educational, healthcare quality, and healthcare access issues as well as reduce the burden of health disparities and the disease burden. (U.S. Census, 2018)

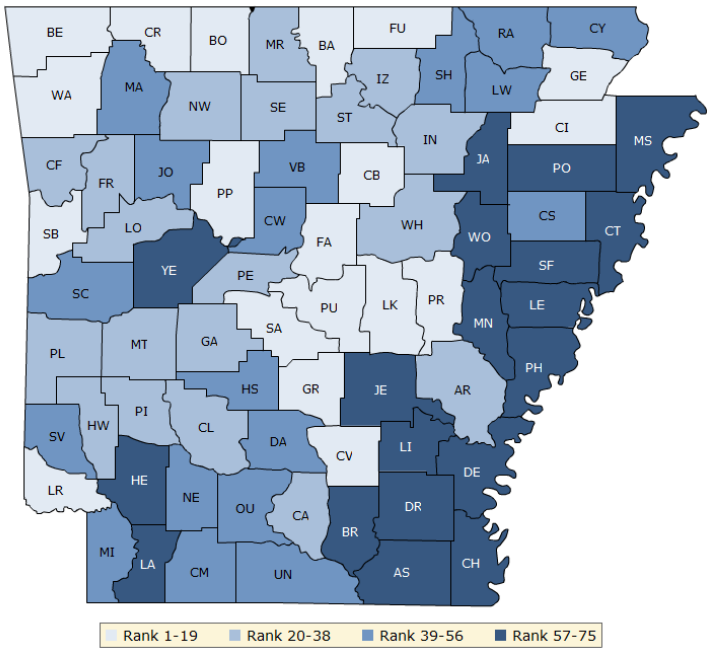
According to the Robert Wood Johnson Foundation County Health Rankings and Roadmap study, Ashley County is considered one of the healthiest counties in the southeast corner of the state of Arkansas; ranking #43 in overall health outcomes and #59 in overall health factors out of 75 counties in Arkansas. This chart demonstrates Ashley County rankings within the 75 counties of Arkansas.

HEALTH OUTCOMES	**43**
Length of Life	30
Quality of Life	59
HEALTH FACTORS	**59**
Health Behaviors	55
Clinical Care	45
Social & Economic Factors	61
Physical Environment	32

The charts below and the map on the next page demonstrate Ashley County's health statistics:

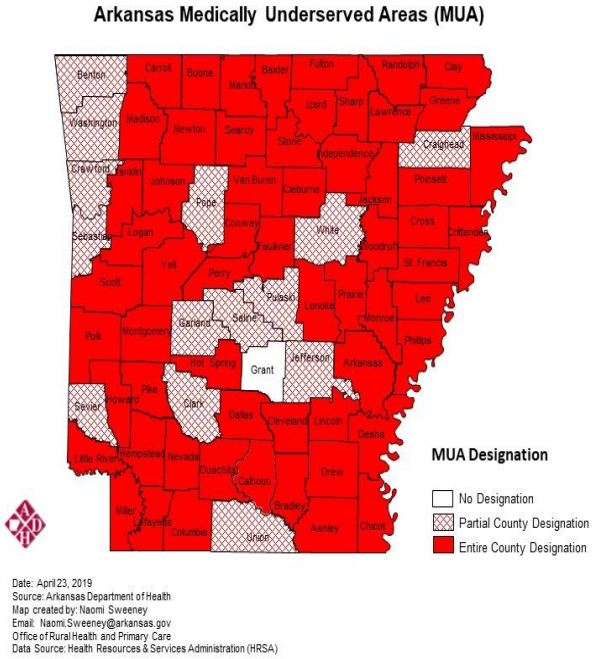
	Arkansas County	**United States**	**Arkansas**
Poor/Fair Health	24%	12%	24%
Poor Physical Health Days	4.7	3.0	5.0
Poor Mental Health Days	4.9	3.1	5.2
Low Birthrate	11%	6%	9%
Adult Smoking	19%	14%	24%
Adult Obesity	33%	26%	35%
Physical Inactivity	35%	19%	31%
Teen Births	56	14	41
Preventable hospital stays	6,718	2,765	5,075
Mammography screening	29%	49%	35%
High School Graduation	82%	52%	44%
Some College	51%	73%	57%
Unemployment	3.3%	2.9%	3.7%
Children in Poverty	26%	11%	23%
Violent Crime	473	63	516
Injury Deaths	103	57	81

2017 Health Factors Map



www.countyhealthrankings.org

2019 Arkansas Medically Underserved Areas (MUA)

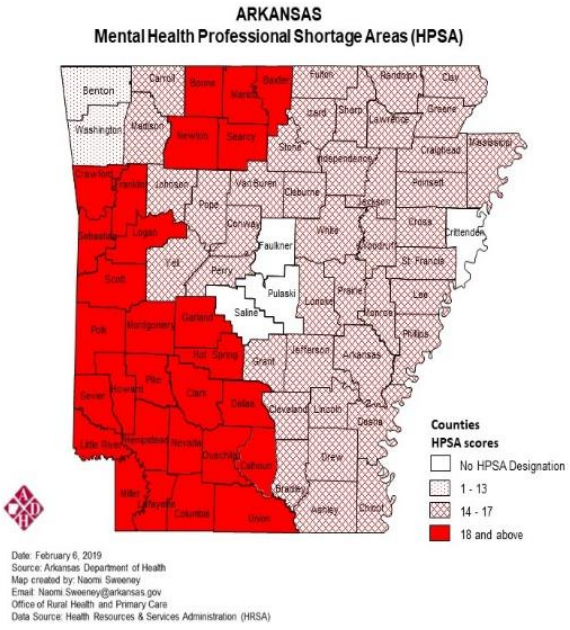


TOPIC SPECIFIC DATA

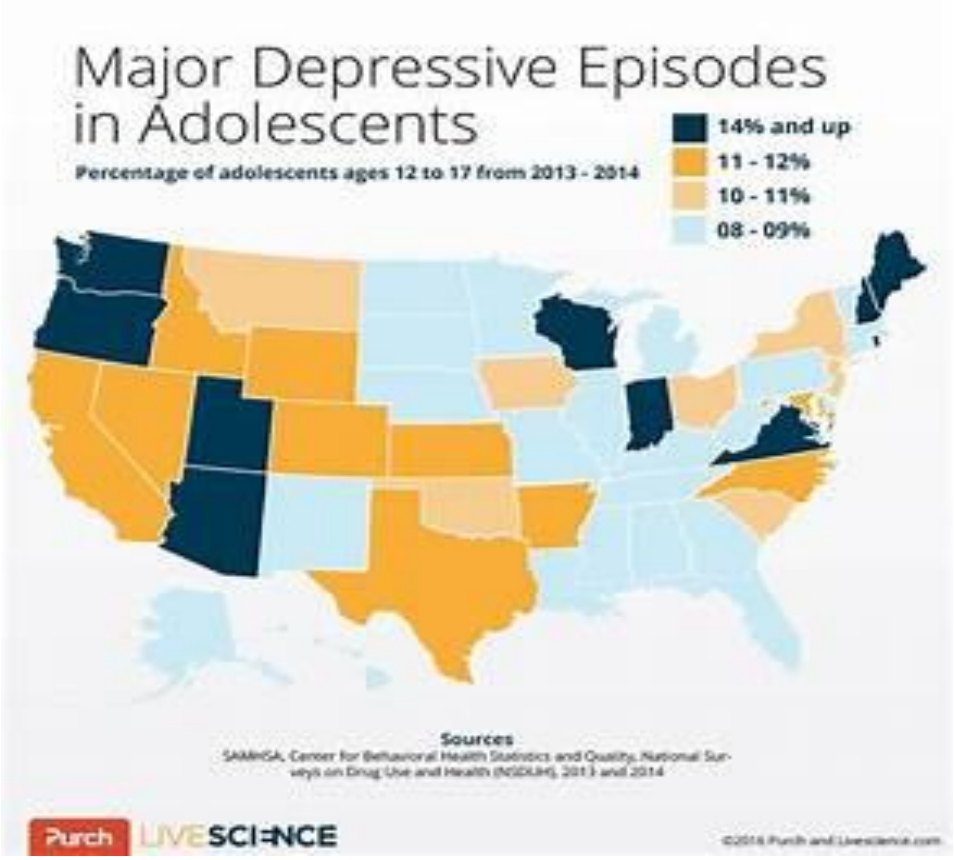
At the conclusion of the DeWitt Hospital & Nursing Home survey and community advisory board processes, there were three priorities that were targeted for the hospital to address over the next three years: **Mental and Behavioral Health Services, Patient Resources & Education, & Lack of Physicians and Specialty Care.** 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)

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 Resources & Education

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 this is included below.

Local Health Workforce within Service Area by County, 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 Desha 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).

Percent of Students Meeting College Readiness Benchmarks per 2017 ACT, by School District

Participating School District	Math	English	Reading	Science	All Met
Crossett	14.4	30.6	22.5	12.6	5.4
Dermott	4.8	23.8	9.5	4.8	4.8

Drew Central	17.3	41.3	24.0	9.3	6.7
DeWitt	15.3	44.7	25.9	17.6	11.8
Dollarway	3.4	19.0	12.1	3.4	0.0
Dumas	11.8	45.1	15.7	10.8	6.9
Fordyce	12.5	33.3	20.8	14.6	8.3
Hamburg	18.5	29.2	16.2	10.8	8.5
Hermitage	7.4	22.2	18.5	7.4	7.4
Lakeside	12.1	34.5	17.2	5.2	1.7
McGehee	7.4	23.5	8.8	5.9	2.9
Monticello	17.7	42.7	22.6	17.7	6.7
Magnolia	15.3	36.3	17.8	19.1	8.9
Pine Bluff	3.3	13.4	4.0	1.8	0.7
Stuttgart	24.7	36.1	29.9	23.7	16.5
Warren	14.5	25.5	11.8	3.6	0.9
Watson Chapel	7.5	25.1	9.0	4.5	2.0
Combined Mean of Target Area	**12.2**	**31.0**	**16.8**	**10.2**	**5.97**

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.

Economically Disadvantaged Students & Educational Attainment by High School/School District

Partner High School/ School District	Percentage of economically disadvantaged students*	Drop Out of High School (2015-16)	Complete High School Only (2012-16)	Attend college within first year of high school graduation
Crossett	63.36%	16.1%	39.7%	50.9%
Dermott	94.46%	19.9%	42.0%	37.1%
Drew Central	73.21%	18.3%	36.9%	48.3%
DeWitt	61.97%	17.5%	40.6%	58.3%
Dollarway	93.29%	15.7%	38.4%	53.1%
Dumas	73.16%	23.9%	39.7%	50%
Fordyce	69.98%	16.6%	48.9%	39.8%
Hamburg	61.09%	16.1%	39.7%	50.9%
Hermitage	80.0%	20.1%	41.5%	48.1%
Lakeside	83.41%	19.9%	42.0%	37.1%
McGehee	73.20%	23.9%	39.7%	50%
Monticello	54.90%	18.3%	36.9%	48.3%
Magnolia	70.55%	14.8%	39.2%	52.2%

Pine Bluff	86.39%	15.7%	38.4%	53.1%
Stuttgart	64.12%	17.5%	40.6%	58.3%
Warren	72.02%	20.1%	41.5%	48.1%
Watson Chapel	74.31%	15.7%	38.4%	53.1%
Combined Mean of Target Area	**73.50%**	**18.2%**	**40.2%**	**49.2%**

** Determined by National School Lunch Program (2015-2016)*, Arkansas Board of Education, United States Department of Agriculture; Economic Research Service, ADHE

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, 2015-16

	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**

Access to Specialty Care

Access to specialty care is challenging in rural communities. Specialists offer more advanced care than primary care providers, but access is restricted based on physician referral, geographic location, and insurance type. Specialists also tend to be located in urban areas and there are fewer of them when compared to primary care providers. Rather than staffing remote locations with

specialty providers, telehealth allows specialists to connect with rural patients and providers virtually. This expands rural patients' access to specialty care and enables rural providers to engage and connect with specialty providers, allowing them to better serve their patients. Telehealth connects patients to specialized medical services that may be otherwise unavailable in their community. Telehealth also allows patients to avoid the time associated with traveling long distances in order to see a specialty service provider in-person. Additionally, patients can avoid extra visits, scheduling, and wait periods if the specialist is regularly available for telehealth appointments.

Research demonstrates that telehealth can help rural individuals receive effective care in many areas. Some of the specialty care services available to rural patients include dental care, cardiology, endocrinology, genetic counseling, dermatology, psychiatry, oncology, ophthalmology, and obstetrics. Many specialty care services are also available for children. Telehealth has many benefits for rural providers. Live-video teleconference and e-consultation are two telehealth methods most often used by rural providers to connect with specialty providers. Telehealth consults enable primary care providers and frontline physicians located in rural areas to receive real-time support from specialists, which increases their ability to make better diagnoses and develop appropriate care plans.

Telehealth can assist healthcare systems, organizations, and providers expand access to and improve the quality of rural healthcare. Using telehealth in rural areas to deliver and assist with the delivery of healthcare services can reduce or minimize challenges and burdens patients encounter, such as transportation issues related to traveling for specialty care. Telehealth can also improve monitoring, timeliness, and communications within the healthcare system. Telehealth uses telecommunications technology and other electronic data to assist with clinical healthcare services provided at a distance, which can also include providing education, administrative functions, and peer meetings.

2019 Strategic Implementation Plan

The forthcoming implementation plan will include an individual action plan for each of the priority health issues identified in the DeWitt Hospital & Nursing Home needs assessment. As recommended by Mellie Bridewell, the Chief Executive Officer for the Arkansas Rural Health Partnership, and approved by the Internal Revenue Service, DeWitt Hospital & Nursing Home will complete its implementation plan by October 2019, in conjunction with other ARHP member hospitals; all located in the South Delta region of Arkansas. While some concerns specific to the hospital may be included, most health issues affecting the DeWitt Hospital & Nursing Home service area will be shared concerns among the other ARHP members. By crafting an implementation plan with input among these 12 hospitals, ARHP members anticipate widespread community benefit throughout the Arkansas Delta region through sharing of funding and other resources.

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 $12 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 on the board 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.