ARKANSAS RURAL
HEALTH PARTNERSHIP

ARKANSAS RURAL HEALTH PARTNERSHIP

Community Health Needs Assessment

2025

PREPARED FOR

DeWitt Hospital

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INTRODUCTION

DeWitt Hospital and Nursing Home (DHNH), a cornerstone of healthcare in Arkansas County since 1963, transitioned to a not-for-profit Rural Emergency Hospital (REH) in 2024 to stabilize finances and preserve essential services for the community. In compliance with Section 9007 of the Patient Protection and Affordable Care Act of 2010, DHNH partnered with the Arkansas Rural Health Partnership (ARHP) to undertake a triennial Community Health Needs Assessment (CHNA).

This CHNA was developed through an extensive, inclusive process involving community surveys, advisory committee insight, and detailed analysis of local, state, and national health data. The assessment incorporates the perspectives of community members, hospital leadership, local healthcare providers, and regional partners.

The 2025 CHNA is both a critical assessment and a call to action. Through collaborative partnerships, targeted resource deployment, and innovative solutions, DHNH is committed to improving access, equity, and quality of care for all residents, ensuring the hospital remains a resilient pillar of health and wellbeing in Southeast Arkansas.

Background

The 2025 Community Health Needs Assessment (CHNA) was undertaken amid profound shifts in the healthcare landscape. Rural communities nationwide continue to contend with chronic workforce shortages, hospital financial instability, uneven access to care and an aging population beset by rising rates of chronic disease. At the same time, an uncertain economic climate — with escalating healthcare costs, shrinking reimbursements and the search for sustainable funding models — places additional strain on rural health systems.

To ensure that our response is both targeted and effective, the Arkansas Rural Health Partnership (ARHP) and DeWitt Hospital and Nursing Home (DHNH) collaborated closely with hospital leadership, community members and key regional stakeholders throughout the CHNA process. Together, we gathered firsthand insights, quantified the most urgent health needs, and built consensus around priority areas for action.

This assessment not only pinpoints the critical health challenges facing Southeast Arkansas but also establishes a strategic foundation for the years ahead. Over the next three years, our hospitals and community partners will channel resources toward strengthening rural hospital sustainability, expanding access to essential medical services and enhancing overall healthcare resilience. By embracing technological innovations, fostering new collaborative models and continually evaluating our impact, we will adapt — and thrive — despite the evolving obstacles that rural health systems confront.

Key Challenges in Rural Healthcare in 2025

BEHAVIORAL HEALTH CRISIS

Rural communities are experiencing a mental health and substance use disorder epidemic, exacerbated by economic distress, social isolation, and limited access to behavioral health providers. Suicide rates, opioid overdoses, and alcohol-related health conditions have surged in rural areas — yet many counties lack inpatient psychiatric facilities, crisis intervention programs, or outpatient behavioral health services. Addressing this crisis requires expanded telepsychiatry services, recruitment incentives for behavioral health specialists, and enhanced community outreach programs to reduce stigma and improve access to care.

AGING POPULATION NEEDS

The rapidly aging population presents unique challenges for rural healthcare systems. Seniors require increased access to geriatric care, chronic disease management, long-term care facilities, and home health services. However, transportation barriers, social isolation, and financial constraints often prevent elderly individuals from receiving timely care. Expanding home-based healthcare programs, improving access to mobility and transportation services, and increasing caregiver support resources are essential to ensuring quality care for aging residents in rural communities.

HEALTHCARE WORKFORCE SHORTAGES

The rural healthcare workforce is facing a critical shortage of physicians, nurses, specialists, and support staff—which threatens the ability to provide consistent, high-quality care. Physician burnout, an aging workforce, and recruitment challenges have led to gaps in primary and specialty care services. Many rural providers have difficulty attracting and retaining healthcare professionals due to lower salaries, limited career advancement opportunities, and fewer amenities compared to urban settings. Solutions include loan repayment programs, residency and internship partnerships with medical schools, telemedicine integration, and pipeline programs that encourage local students to pursue careers in healthcare.

RURAL HOSPITAL STABILITY

The financial viability of rural hospitals remains a pressing issue, with closures continuing at an alarming rate. Many small hospitals operate on thin margins, struggling to balance rising operational costs with declining patient volumes. Medicaid expansion, reimbursement rate adjustments, and alternative payment models such as value-based care are being explored to help rural hospitals remain financially sustainable. In addition, collaborative healthcare networks, shared services agreements, and strategic partnerships with larger healthcare systems are essential for ensuring the long-term survival of rural hospitals and maintaining local access to emergency and specialty care.

HEALTH INFRASTRUCTURE & ACCESS BARRIERS

Rural healthcare systems continue to face infrastructure deficits, including outdated medical facilities, inadequate medical equipment, and limited broadband access. Many rural hospitals struggle with transportation barriers—making it difficult for patients to reach healthcare providers. Addressing these issues requires investment in modernizing rural healthcare infrastructure, expanding broadband access to support telehealth, and developing transportation assistance programs to improve access to essential health services.

CHRONIC DISEASE MANAGEMENT

Rural populations experience higher rates of chronic diseases such as diabetes, heart disease, and obesity—often due to limited access to preventive care, healthy food options, and fitness resources. Healthcare providers must implement community-based chronic disease management programs, integrate patient education initiatives, and expand access to specialty care to help patients manage and prevent long-term health complications.

Health Care Trends & Innovation in 2025

TELEHEALTH EXPANSION

Telehealth has revolutionized rural healthcare by providing virtual access to primary care physicians, specialists, and mental health professionals. The adoption of remote patient monitoring, mobile health applications, and AI-powered diagnostics has significantly improved care coordination, chronic disease management, and mental health support. However, persistent challenges such as broadband access, insurance reimbursement, and patient digital literacy must be addressed to maximize the impact of telehealth in rural communities.

HEALTHCARE ACCESSIBILITY

Healthcare disparities remain a major concern in rural areas—where social determinants of health (SDOH) such as income, education, transportation, and food security play a significant role in healthcare access and outcomes. Hospitals and public health agencies are increasingly focusing on initiatives that enhance healthcare availability, including community health worker programs, culturally tailored healthcare services, and policy advocacy for expanded Medicaid coverage. Strengthening partnerships between healthcare organizations, schools, and community-based organizations is critical to addressing these challenges.

ADVANCED DIAGNOSTICS & TREATMENT

Technological advancements are reshaping rural healthcare delivery. Artificial intelligence (AI) and machine learning algorithms are enhancing diagnostic accuracy, while wearable health devices enable continuous health monitoring for patients with chronic conditions. Additionally, 3D printing, precision medicine, and robotic-assisted procedures are improving patient outcomes by offering minimally invasive treatments and personalized care plans. Expanding access to these innovations in rural settings will require investment in infrastructure, workforce training, and regulatory support.

COMMUNITY-BASED HEALTHCARE MODELS

The shift toward patient-centered, community-based healthcare is gaining momentum in rural areas. Models such as mobile clinics, school-based health centers, and home healthcare services are increasing access to care, particularly for underserved populations. Federally Qualified Health Centers (FQHCs), rural health clinics, and partnerships with faith-based organizations are also playing a key role in expanding primary care services. By leveraging community resources and integrating multidisciplinary care teams, rural hospitals can enhance healthcare delivery and promote overall community well-being.

State Data: Arkansas

According to the United Health Foundation's 2024 America's Health Rankings Annual Report, Arkansas state health findings are as follows:

Arkansas Strengths
• Low prevalence of excessive drinking.
• High prevalence of fruit and vegetable consumption.
• Low percentage of households experiencing severe housing problems.
Arkansas Alarming Challenges
• Arkansas ranks #50 in food insecurity (% of households), with a 18.9% food insecurity per household rate.
• Arkansas ranks #48 in Adverse Childhood Experiences (% of children ages 0-17), with a rate of 21.3%.
Arkansas Highlights
• Smoking rate decreased by **39%** — from 24.7% to 15.0% of adults between 2014 and 2023.
• The population of uninsured decreased by **25%** — from 11.8% to 8.9% of the population between 2014 and 2023.
https://www.americashealthrankings.org/learn/reports/2024-annual-report/state-summaries-arkansas

Arkansas Measures

- Overall rank: 48

SOCIAL & ECONOMIC FACTORS			
Measure	**State Rank**	**State Value**	**U.S. Value**
Community and Family Safety			
• Homicide (Deaths per 100,000 population)	43	11.2	7.6
• Occupational Fatalities (Deaths per 100,000 workers)	39	5.5	4.2
Economic Resources			
• Economic Hardship Index (Index from 1-100)	44	82	—
• Food Insecurity (% of households)	50	18.9%	12.2%
• Income Inequality (80-20 Ratio)	34	4.77	4.87
Education			
• Fourth Grade Reading Proficiency (% of public school students)	38	29.7%	32.1%
• High School Completion (% of adults age 25+)	40	89.3%	89.8%
Social Support and Engagement			
• Adverse Childhood Experiences (% of children ages 0-17)	48	21.3%	14.5%
• High-Speed Internet (% of households)	46	91.1%	93.8%
• Volunteerism (% of population age 16+)	41	20.9%	23.2%

PHYSICAL ENVIRONMENT			
Measure	**State Rank**	**State Value**	**U.S. Value**
Air and Water Quality			
• Air Pollution (Micrograms of fine particles per cubic meter)	36	8.4	8.6
• Drinking Water Violations (Average violations per community water system)	44	3.3	2.8
• Water Fluoridation (% of population served)	18	86.8%	72.3%
Climate and Health			
• Climate Policies (Number out of four policies)	30	1	—

Housing and Transit			
• Drive Alone to Work (% of workers age 16+)*	47	78.3%	69.2%
• Housing With Lead Risk (% of housing stock)	9	9.7%	16.4%
• Severe Housing Problems (% of occupied housing units)	16	13.2%	16.8%
CLINICAL CARE			
Measure	**State Rank**	**State Value**	**U.S. Value**
Access to Care			
• Avoided Care Due to Cost (% of adults)	43	13.9%	10.6%
• Dental Care Providers (Number per 100,000 population)	48	45.3	65.8
• Mental Health Providers (Number per 100,000 population)	31	289.6	344.9
• Primary Care Providers (Number per 100,000 population)	43	241.4	283.4
• Uninsured (% of population)	36	8.9%	7.9%
Preventive Clinical Services			
• Childhood Immunizations (% of children by age 24 months)	46	62.0%	66.9%
• Colorectal Cancer Screening (% of adults ages 45-75)	41	56.4%	61.8%
• Dental Visit (% of adults)	49	55.6%	66.0%
• Flu Vaccination (% of adults)	29	40.0%	42.9%
• HPV Vaccination (% of adolescents ages 13-17)	43	52.9%	61.4%
Quality of Care			
• Dedicated Health Care Provider (% of adults)	20	84.8%	84.0%
• Preventable Hospitalizations (Discharges per 100,000 Medicare beneficiaries age 18+)	41	3,058	2,665
BEHAVIORS			
Measure	**State Rank**	**State Value**	**U.S. Value**
Nutrition and Physical Activity			
• Exercise (% of adults)	39	26.8%	30.4%
• Fruit and Vegetable Consumption (% of adults)	5	10.2%	7.4%
• Physical Inactivity (% of adults)	47	32.5%	24.2%

Sexual Health			
• Chlamydia (Cases per 100,000 population)	43	588.3	495.0
• High-Risk HIV Behaviors (% of adults)	34	6.2%	5.7%
• Teen Births (Births per 1,000 females ages 15-19)	49	24.6	13.6
Sleep Health			
• Insufficient Sleep (% of adults)	43	38.7%	35.5%
Smoking and Tobacco Use			
• E-Cigarette Use (% of adults)*	47	10.6%	7.7%
• Smoking (% of adults)	39	15.0%	12.1%

OVERALL HEALTH OUTCOMES

Measure	Value	Rank
• Overall Health Score	-0.759	48

BEHAVIORAL HEALTH OUTCOMES

Measure	Value	Rank
• Depression (% of adults)	26.6%	38
• Drug Deaths (per 100,000)	21.7	10
• Excessive Drinking (% of adults)	14.5%	6
• Frequent Mental Distress (% of adults)	18.9%	45
• Non-medical Drug Use (% of adults)	18.2%	34
• Suicide Rate (per 100,000)	18.0	30

MORTALITY

Measure	Value	Rank
• Premature Death (years lost before age 75 per 100,000)	11,504	42
• Premature Death Racial Disparity (ratio)	1.3	11

PHYSICAL HEALTH		
Measure	**Value**	**Rank**
• Frequent Physical Distress (% of adults)	16.1%	46
• High Health Status (% of adults reporting good or excellent health)	41.4%	46
• Low Birthweight (% of live births)	9.3%	39
• Low Birthweight Racial Disparity (ratio)	2.1	35
• Multiple Chronic Conditions (% of adults)	14.1%	44

CHRONIC DISEASES		
Measure	**Value**	**Rank**
• Arthritis (% of adults)	30.3%	42
• Asthma (% of adults)	9.9%	17
• Cancer (% of adults)	8.4%	23
• Cardiovascular Diseases (% of adults)	12.1%	46
• Chronic Kidney Disease (% of adults)	4.2%	35
• Chronic Obstructive Pulmonary Disease (% of adults)	9.0%	45
• Diabetes (% of adults)	14.5%	42

RISK FACTORS		
Measure	**Value**	**Rank**
• High Blood Pressure (% of adults)	42.5%	44
• High Cholesterol (% of adults)	40.2%	44
• Obesity (% of adults)	40.0%	46

Regional Data

Region	Median Household Income	Unemployment Rate	Persons Living in Poverty
Arkansas County	$52,100	3.3%	14.7%
Ashley County	$44,744	5.3%	22.7%
Bradley County	$43,184	5.2%	20.1%
Calhoun County	$46,417	5.5%	13.3%
Chicot County	$34,147	6.6%	24.4%
Columbia County	$47,300	4.4%	23%
Dallas County	$38,072	5.7%	11.2%
Desha County	$31,893	4.6%	28.9%
Drew County	$46,997	4.6%	22.7%
Grant County	$55,388	4.5%	12.3%
Jefferson County	$39,326	5.6%	20.6%
Lee County	$29,681	6.1%	27.7%
Lincoln County	$46,596	7.4%	17.7%
Lonoke County	$62,532	3.4%	11.10%
Monroe County	$38,468	4.8%	22.2%
Ouachita County	$35,425	5.0%	17.9%
Phillips County	$29,320	5.9%	28.7%
Polk County	$45,300	3.7%	20%
St. Francis County	$35,348	5.6%	27.8%
Sevier County	$49,400	3.9%	19.6%
Union County	$44,663	4.4%	19.4%
• State of Arkansas	$48,952	4.8%	15.55%
• United States	$65,712	3.8%	12.5%

*Note: Data reflects figures up to 2024 as reported by the *County Health Rankings & Roadmaps* and the US ACS 5-Year Estimates.

County Data

• Arkansas County

Based on the latest available data from the *2024 County Health Rankings & Roadmaps* by the Robert Wood Johnson Foundation, here is an updated overview of Arkansas County, Arkansas:

GENERAL DEMOGRAPHICS		
Demographic Metric	**Arkansas County**	**Arkansas**
• Population	15,612	3,067,732
• % Below 18 years of age	23.0%	23%
• % 65 and older	20.6%	18%
• % Non-Hispanic Black	24.3%	15.3%
• % American Indian or Alaska Native	0.5%	1.1%
• % Asian	0.8%	1.9%
• % Native Hawaiian or Other Pacific Islander	0.1%	0.5%
• % Hispanic	1.4%	9.2%
• % Non-Hispanic White	68.4%	70.2%
• % Male	48.9%	49.3%
• % Female	51.1%	50.7%

INCOME DEMOGRAPHICS		
Income Metric	**Arkansas County**	**Arkansas**
• Median Household Income	$52,100	$55,500

POVERTY STATISTICS			
Population Segment	**Arkansas County**	**Arkansas**	**United States**
• All Persons in Poverty	17%	16%	13%
• Under 18 Years of Age	17%	22%	17%
• 18 to 64 Years of Age	20%	14%	12%
• 65 and Older	20%	125	11%

*Note: Data reflects figures in 2024 as reported by the *United States Census Bureau* and up to 2024 as reported by the *County Health Rankings & Roadmap*

MIGRATION DEMOGRAPHICS

Migration Metric	Arkansas County	Arkansas
• Moved from a Different State	1.5%	2.1%
• Moved Within the Same County	10.9%	6.5%
• Moved from a Different County	3.1%	3.1%
• Moved Abroad	0.1%	0.4%

HEALTHCARE COVERAGE

Coverage Metric	Arkansas County	Arkansas
• Uninsured (%)	9%	8.9%

HEALTHCARE PROVIDER DEMOGRAPHICS

Population Segment	Arkansas County	Arkansas	U.S. Top Performing Counties
• Primary Care Physicians Ratio	1,370:1	1,480:1	1,330:1
• Dentists Ratio	2,570:1	2,040:1	1,360:1
• Mental Health Providers Ratio	420:1	380:1	320:1
• Preventable Hospital Stays (per 100,000)	3,821	3,015	2,681
• Mammography Screening (%)	40%	40%	43%
• Flu Vaccinations (%)	44%	45%	46%

*Note: Data reflects figures in 2024 as reported by the *United States Census Bureau* and up to 2024 as reported by the *County Health Rankings & Roadmap*

HEALTH STATISTICS

Health Metric	Arkansas County	Arkansas	U.S. Top Performing Counties
• Adult Smoking (%)	22%	22%	15%
• Adult Obesity (%)	38%	39%	34%
• Food Environment Index	5.3	4.7	7.7
• Physical Inactivity (%)	32%	30%	23%
• Access to Exercise Opportunities (%)	57%	64%	84%
• Alcohol-Impaired Driving Deaths (%)	35%	27%	26%
• Sexually Transmitted Infections (per 100,000)	675.8	592.8	495.0

*Note: Data reflects figures up to 2024 as reported by the *County Health Rankings & Roadmaps.**

Mission

To recruitment, retention, and development of qualified, responsible, and motivated individuals. We recognize the importance of each individual and his or her active role in the success of the entire hospital organizations. We are also committed to providing our patients with high quality health care. We are sensitive to our patients; overall needs and dedicated to their satisfaction.

History

The DeWitt Hospital & Nursing Home (DHNH) was established in 1963 as an integrated hospital and nursing home and has operated as a foundation healthcare pillar in Arkansas County since. For most of its history DHNH functioned as federal Critical Access Hospital (CAH) limited to 25 acute care beds. Facing mounting financial pressures common among rural hospitals, DHNH undertook a significant structural change in January 2010, converting its legal status from a public organization to a private, 501(c)3 not-for-profit organization. This conversion was not merely administrative; it was an essential, proactive financial intervention aimed at institutional solvency.

The principal driver for this strategic shift was to gain eligibility for the Special Medicaid Assessment Program. This financial lifeline, secured a decade prior to the final regulatory crisis, confirms that the traditional CAH reimbursement system was already demonstrating unsustainable flaws. The necessity for a non-patient revenue stream of this magnitude indicates that the underlying CAH funding mechanism was insufficient to cover basic operational costs, leading to sustained institutional stress.

The 501(c)3 status, while providing financial benefit, imposed corresponding regulatory requirements. Non-profit hospitals are obligated to provide community benefits and must, under the mandate of the Affordable Care Act, conduct a Community Health Needs Assessment at least every three years and adopt a plan to address the identified needs.

In May 2024, DHNH converted to a Rural Emergency Hospital (REH) demonstrating a profound institutional resilience and an adaptable operational strategy. DHNH has successfully navigated severe systemic headwinds to ensure continuous healthcare access for the population of Arkansas County.

The financial stability achieved through the REH conversion is paramount, ensuring DHNH can dedicate operational and fiscal resources toward addressing the specific health disparities and priorities identified in this Community Health Needs Assessment.

Leadership

- Brian Miller
  Chief Executive Officer

Organizational Chart included as Attachment D.

Governance

- David Jessup, *Stone Bank*, *President*
- Rick Duffield, *CEO Black Inc.*, *Secretary*
- Dean Watts, *Dean's Pharmacy*, *Board Member*
- Dr. Stan Burleson, *Physician*, *Board Member*
- Warren Jennings, Jr., *Southern Bancorp*, *Board Member*

Healthcare Services

- Cardiology
- Emergency Department
- Lab
- Mobile MRI
- Nursing Home
- Orthopedic
- Radiology
- Respiratory
- Social Services
- Rural Health Clinic
- Sleep Clinic
- Women's Services
- Wound Clinic

Providers

CARDIOLOGIST

- Ramsey Marshell, MD

FAMILY MEDICINE

- Hayden Leibrock, MD
- Ralph Maxwell, DO
- Stanley Burleson, MD
- Olivia Scherm, PA-C

ORTHOPEDICS

- Stacy Busby, MD

Following the survey and community advisory board discussions, DeWitt Hospital and Nursing Home (DHNH) has identified two key focus areas for the next three years: expanding the availability of specialty services and increasing awareness of available healthcare services.

Availability of specialty services.

FEDERAL

The rural-urban divide in specialty care access continues to grow, with rural areas averaging 30 physicians (including specialists and primary care) per 100,000 people, compared to 263 physicians per 100,000 in urban areas (HRSA, 2024). Specialist shortages are particularly concerning in maternal health; more than one-third of U.S. counties lack obstetric care, a critical gap that contributes to higher maternal and infant mortality rates (March of Dimes, 2024). Other fields — including cardiology, general surgery, and dermatology — face significant workforce shortages, leading to increased wait times and long-distance travel for care (American Medical Association, 2024).

All sources referenced (Appendix A).

ARKANSAS

Arkansas continues to experience severe shortages of specialty providers, with only 289 OB/GYNs and 405 pediatricians statewide, leading to longer wait times and referral delays for specialized care (Arkansas Center for Health Improvement, 2024). Many rural hospitals have reduced or eliminated specialty services, forcing patients to travel long distances to major medical centers in Little Rock or Memphis for treatment (Arkansas Department of Health, 2024). Telemedicine initiatives have helped increase access to specialists, but in-person specialty care remains limited in many areas.

All sources referenced (Appendix A).

ARKANSAS COUNTY

Awareness of available healthcare services in Arkansas County, Arkansas, appears to be a multi-faceted issue influenced by factors such as rurality, health literacy, and socioeconomic status. The DHNH hosts an annual Spring Fling to bring other healthcare organizations together to promote services available to residents of Arkansas County. This and other initiatives aim to increase public knowledge about specific health topics and available services. However, broader studies on health in Arkansas, such as those from the Arkansas Center for Health Improvement (ACHI) and the Arkansas Department of Health, indicate that rural communities often face barriers to accessing care, including a shortage of primary care physicians and transportation issues. Limited health literacy is also a significant barrier statewide, with one study noting that low-income Arkansans often struggle to understand available services and make informed health decisions (PMC). These reports suggest that despite specific educational efforts by local healthcare providers, a general lack of awareness, compounded by systemic challenges, persists in the region.

All sources referenced (Appendix A).

Increase awareness of available healthcare services.

FEDERAL

Health literacy remains a nationwide concern, with only 12% of American adults considered proficient in health literacy, meaning nearly 9 in 10 struggle to understand and apply health information in medical decision-making (Centers for Disease Control and Prevention, 2025). Additionally, digital literacy gaps prevent some populations from benefiting from telehealth services and online health resources. Misinformation in healthcare settings has also been a growing challenge, highlighting the importance of clear and effective health communication strategies (Centers for Disease Control and Prevention, 2025).

All sources referenced (Appendix A).

ARKANSAS

Arkansas faces some of the highest rates of health illiteracy in the country, with 37% of adults struggling to understand and use medical information effectively (Arkansas Literacy Councils, 2024). Additionally, disparities in digital access contribute to limited healthcare engagement; only 61% of rural Arkansans have broadband internet access, compared to 89% in urban areas (Arkansas Economic Development Institute, 2024). These barriers make it difficult for many residents to utilize telehealth and other digital healthcare services. Efforts to bridge these gaps have included mobile health units, public health campaigns, and in-person enrollment assistance to help residents better navigate healthcare options (Arkansas Department of Health, 2024).

All sources referenced (Appendix A).

ARKANSAS COUNTY

In Arkansas County, communication barriers between residents and healthcare providers have been consistently identified as a concern in community surveys. Many residents report being unaware of available healthcare services-- underscoring the need for improved outreach and educational initiatives. DeWitt Hospital and Nursing Home has responded by expanding its community engagement efforts to increase public health education events and enhancing patient navigation programs. However, language barriers, digital access issues, and trust in healthcare providers remain ongoing challenges that require sustained investment.

All sources referenced (Appendix A).

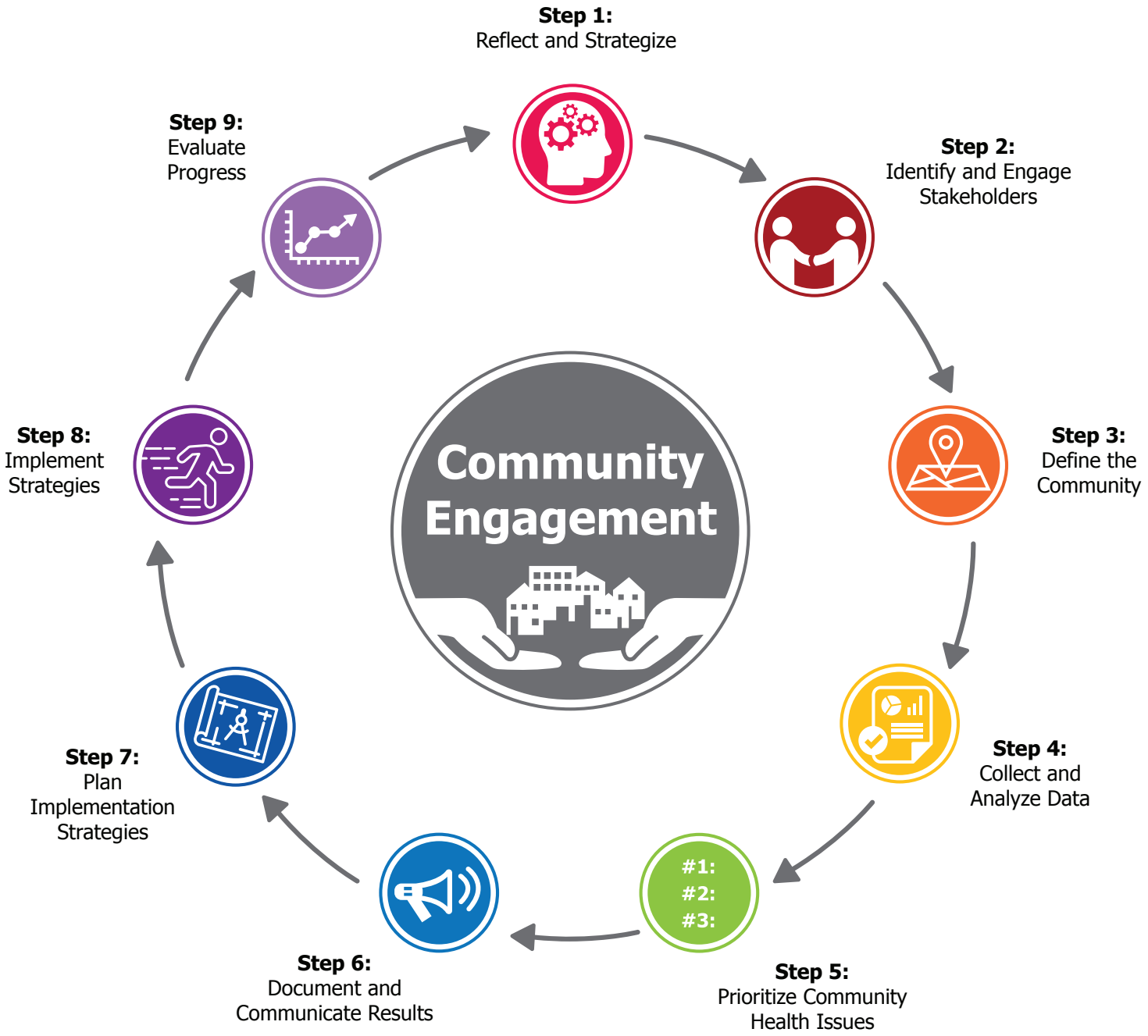
COMMUNITY HEALTH INITIATIVES

DeWitt Hospital and Nursing Home (DHNH) is deeply committed to improving the health and well-being of the communities it serves, aligning with its mission to be a community-focused Rural Emergency Hospital. DHNH actively engages in a variety of programs and initiatives to promote health education, rural health-care workforce development, community engagement, and safety preparedness.

KEY INITIATIVES

- **Annual "Spring Fling":** DHNH hosts a major annual event dedicated to health education for community members. This large-scale event serves as a central platform for disseminating vital health information and resources to the public.
- **Volunteer Clinical Site:** Recognizing the need to develop the rural healthcare workforce, DHNH serves as a volunteer clinical site. This initiative provides essential rural training opportunities for aspiring healthcare professionals.
- **Active Community Volunteerism:** DHNH staff and resources are highly visible and active in local community events. This engagement includes dedicated volunteering at key local institutions, such as schools and faith-based organizations, ensuring health promotion reaches diverse community sectors.
- **Safety Preparedness Training:** DHNH is proactive in safeguarding the community by offering safety preparedness training. These programs equip community members with the knowledge and skills necessary to respond effectively to emergencies.

Community Engagement Process



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

CHNA Facilitation Process

The Community Health Needs Assessment (CHNA) Toolkit—developed by the National Center for Rural Health Works at Oklahoma State University and the Center for Rural Health in collaboration with the Oklahoma Office of Rural Health—guided the CHNA facilitation process (National. This structured approach involved two community meetings coordinated by a facilitator and a steering committee responsible for establishing and overseeing a Community Advisory Committee (CAC). The CAC comprised approximately 16 community members who participated actively throughout the assessment to formulate a strategic plan addressing the community's health priorities.

Public participation was intentionally positioned as a cornerstone of the process. The DeWitt Hospital and Nursing Home steering committee collaborated with the Arkansas Rural Health Partnership (ARHP) to design a robust model for community engagement. Together with ARHP staff, the steering committee organized hybrid community meetings and coordinated the development of both the Community Health Needs Assessment (CHNA) and the subsequent implementation plan.

To gather a wide range of perspectives, the steering committee created a Community Advisory Committee with local leaders and health professionals. This committee was key to the success of the Community Health Needs Assessment (CHNA), using their local connections and knowledge of the community to ensure a broad representation of the population. This approach made the process more efficient and ensured the CHNA was deeply rooted in the community, leading to a more accurate and comprehensive understanding of local health needs.

During CHNA meetings, staff from the Arkansas Rural Health Partnership (ARHP) presented an overview of the CHNA framework, shared local health statistics, and guided participants through the 2025 CHNA survey. Committee members then helped distribute the survey by engaging neighbors, colleagues, and local organizations. To make sure the survey was accessible to everyone, it was also made available online on the DeWitt Hospital and Nursing Home and ARHP websites, along with other community platforms.

Following the collection of survey responses, ARHP staff conducted a detailed data analysis and presented the findings during an advisory committee meeting. During this session, participants reviewed survey results, engaged in structured discussion regarding the most pressing health issues, and collaboratively identified key community priorities. These priorities became the foundation for a comprehensive implementation plan developed by the steering committee, with the goal of generating measurable and sustainable improvements in community health.

Implementation of these strategic action plans will occur over a three-year period, with the hospital steering committee convening annually with the advisory committee to monitor progress and make necessary adjustments.

Steering Committee

- Brian Miller, *Chief Executive Officer, DeWitt Hospital and Nursing Home*
- Brook Bradberry, *Administrative Assistant, DeWitt Hospital and Nursing Homer*
- Lynn Hawkins, *Chief Operating Officer, Arkansas Rural Health Partnership*
- Camille Watson, *Chief Program Officer, Arkansas Rural Health Partnership*

RESULTS OVERVIEW: DEWITT HOSPITAL AND NURSING HOME'S 2025 COMMUNITY HEALTH NEEDS ASSESSMENT

There were **167** completed surveys through DeWitt Hospital and Nursing Home's 2025 Community Health Needs Assessment process. All of the results of the survey can be found in *Attachment D*.

TOP ISSUES IDENTIFIED

Availability of Specialty Services.

The survey identified that increasing specialty services locally would reduce the need for residents to travel long distances for care, which was specifically mentioned as a challenge for the community, particularly the elderly.

Awareness of Available Healthcare Services.

Survey findings suggested increasing awareness and education about available healthcare services by utilizing effective strategies that involve clearly communicating "where and what the services are" and making health education approachable, consistent, and personalized.

DEWITT HOSPITAL AND NURSING HOME STRATEGIC IMPLEMENTATION PLAN (2025–2028)

The 2025-2028 Strategic Implementation Plan serves as an action-driven framework to address the priority health issues identified in the DeWitt Hospital and Nursing Home Community Health Needs Assessment (CHNA). This plan is currently being developed through a collaborative effort between the Arkansas Rural Health Partnership (ARHP) and the DeWitt Hospital and Nursing Home Board of Directors, with ongoing progress reports submitted to the Internal Revenue Service in compliance with federal regulations. As part of this initiative, hard copies of the assessment were available upon request at DeWitt Hospital and Nursing Home, and the full report is also accessible online via the DeWitt Hospital and Nursing Home website. Additionally, Arkansas Rural Health Partnership is in the process of expanding this strategic plan to incorporate input from all ARHP member hospitals. Through shared funding, resource allocation, and regional collaboration, the implementation plan is expected to drive significant community health improvements across rural Arkansas. This multi-year strategic initiative remains in progress—with an emphasis on enhancing healthcare access, addressing disparities, and fostering long-term sustainability for rural health systems throughout the regions.

Priority 1. Expand Availability of Specialty Services

- **OBJECTIVE:** To increase the accessibility and range of specialty medical services available to patients at DHNH.

- **Activity 1:** Explore Increasing the Frequency of Visiting Specialists by strengthening partnerships with regional specialty providers to bring ENT, cardiology, and OB/GYN specialists to DHNH on a regular basis.
- **Activity 2:** Enhance Tele-Specialty Care: Expand telehealth consultations for ENT, cardiology, endocrinology, prenatal care, and behavioral therapy, reducing the need for patients to travel out of the county.
- **Activity 3:** Establish Specialty Care Coordination Services: Develop a patient referral network in collaboration with ARHP and partners, ensuring efficient referrals to out-of-county specialists when necessary.

Priority 2. Enhancing Awareness of Available Healthcare Services.

- **OBJECTIVE:** To significantly improve the community's knowledge and understanding of the healthcare services available.

- **Activity 1:** Develop a Community Outreach & Education Initiative: Launch a targeted outreach campaign using social media, local newspapers, and community events to increase awareness of healthcare services at DHNH.
- **Activity 2:** Revisit Partnerships with Local Organizations to Strengthen Partnerships: Work with churches, schools, businesses, and civic groups to distribute healthcare information and host educational events.
- **Activity 3:** Enhance Direct Patient Communication: Explore Community Health Worker opportunities and ways to grow these services to ensure residents receive personalized guidance on available healthcare options.

QUALIFICATIONS OF THE REPORT PREPARER

Arkansas Rural Health Partnership (ARHP) was founded by a handful of rural hospital leaders who knew the significance and stabilizing force of home, community, and local healthcare. ARHP members recognized early on that if they wanted to continue to shape the health, wellness, and lives of their communities, they had to work together — hand-in-hand with local leaders, other rural healthcare providers, state and federal partners, and community members themselves — to truly address the needs of rural south Arkansas residents. Since its inception, ARHP has become a reference point and model for rural health innovation and collaboration across the state and nation. As an organization, ARHP is committed to paving the road for rural communities to come together and turn the tide for rural healthcare — across rural south Arkansas and beyond.

Lynn Hawkins, Chief Operations Officer, and Camille Watson, Chief Projects Officer, were designated to serve as leads on DeWitt Hospital and Nursing Home's 2025 Community Health Needs Assessments due to their expertise in rural healthcare, as well as data collection, analysis, and evaluation.

ABOUT THE ARKANSAS RURAL HEALTH PARTNERSHIP

The Arkansas Rural Health Partnership (ARHP) is a non-profit horizontal hospital and economic development organization composed of 22 Arkansas rural hospitals, 8 Federally Qualified Health Centers (FQHCs), 3 teaching medical institutions, and the Community Health Centers of Arkansas, Inc. (FQHC State Primary Care Association). This unique network is the largest healthcare service provider in the area and serves as a hub for economic growth and development across the region. ARHP efforts aim to support and improve existing healthcare infrastructure while strengthening healthcare delivery across rural Arkansas.

DOCUMENTATION

The following documentation of DeWitt Hospital and Nursing Home's 2025 Community Health Needs Assessment presentations, agendas, attendance, and survey results is included in the following attachments, which can be found at the end of this report:

- **Attachment A.** Community Advisory Committee Education and 2025 DeWitt Hospital and Nursing Home Survey Results PowerPoint Presentation.
- **Attachment B.** Community Advisory Committee Meeting Agenda.
- **Attachment C.** Community Advisory Attendance Roster.
- **Attachment D.** Organizational Chart

DeWitt Hospital & Nursing Home

COMMUNITY HEALTH NEEDS ASSESSMENT

2025

MEETING AGENDA

01 **Introductions**

02 **The CHNA Process**

03 **Survey Results**

04 **Discussion/Plans**

05 **Questions**

WHY DO WE DO A COMMUNITY HEALTH NEEDS ASSESSMENT?

DeWitt Hospital & Nursing Home is a not for profit private 501(c) 3 organization because:

- Allows the hospital to be eligible to participate in the Special Medicaid Assessment Program which increases Medicaid reimbursements.
- Allows fewer regulations than a public organization.
- Receives a variety of tax exemptions form federal, state, and local governments.

In return, the Internal Revenue Service (IRS) mandates that, like other non-profit organizations benefiting from this status, community benefit must be center to the mission of a non-profit hospital.

COMMUNITY BENEFIT MEANS . . .

According to the Internal Revenue Service (IRS) community benefit means programs and services designed to address identified needs and improve community health and must meet at least one of the following criteria:

- **Improve access to healthcare services**
- **Enhance health of the community**
- **Advance medical or health knowledge**
- **Relieve/reduce the burden of other community efforts.**

THEREFORE, ALL NON-PROFIT HOSPITALS MUST . . .

- **Conduct a formal community health needs assessment every three years**
- **Widely publicize these assessment results by the end of the fiscal year.**
- **Adopt an implementation strategy to meet needs identified by the assessment.**
- **Provide the Secretary of the Treasury with an annual report of how the organization is addressing the needs identified in each community health needs assessment.**

- **FAILURE TO MEET THE NEW REQUIREMENTS IN ANY TAXABLE YEAR WILL RESULT IN A $50,000 EXCISE TAX AS WELL AS POSSIBLE REVOCATION OF THE TAX-EXEMPT STATUS.**

COMMUNITY ENGAGEMENT IS CENTRAL . . . .

Benefits for Your Hospital:

- **A clearer understanding of the community (health issues, availability of resources).**
- **Strengthened bonds between community and hospital; increased collaboration**
- **Greater community buy-in and a sense of shared commitment to community health.**
- **Stronger relationships with individuals/organizations that are assets for improving community health.**
- **Healthier communities where individuals have access to care; potentially leading to lower costs for the hospital.**

Benefits for Your Community:

- **A different perspective of the community and the hospital's role in health promotion.**
- **Improved communication between community and hospital**
- **Potential community coalitions/collaborative improvement efforts.**
- **The ability to apply knowledge and experiences to improve the health of the community.**
- **The opportunity for leadership development and capacity-building.**
- **The potential for a healthier community.**

THE CHNA PROCESS

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

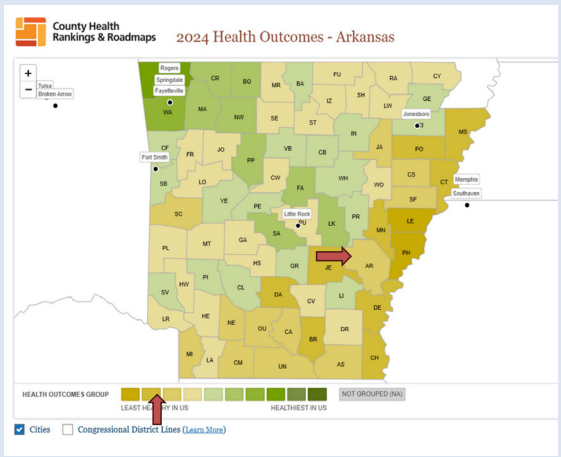
DEFINE THE COMMUNITY | STEP THREE

While DeWitt Hospital & Nursing Home primarily serves patients from Arkansas County, patients are also served by residents from neighboring counties.

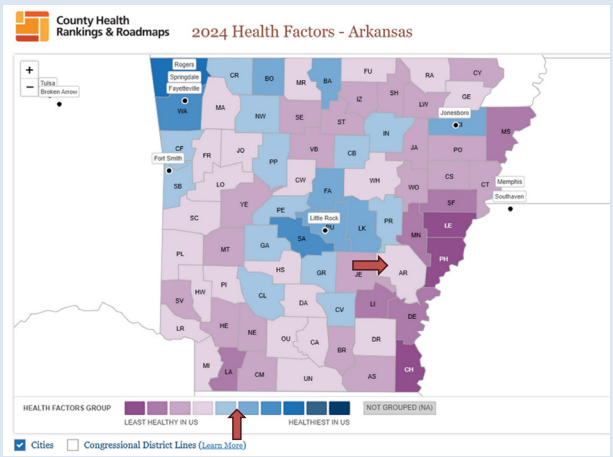
ARKANSAS COUNTY, ARKANSAS

- Arkansas County, Arkansas, which is located in the state's southern and Delta regions, was ranked among the counties with less favorable health outcomes but ranks higher in health factors in the 2024 County Health Rankings by the University of Wisconsin Population Health Institute. This ranking is common in these regions, often due to socioeconomic challenges that contribute to poorer health. The state of Arkansas has 75 counties in total

Health Outcomes



Health Factors



DATA ANALYSIS

- **Survey responses (N=157) were analyzed to assess community health priorities–focusing on representation across key demographic groups, including gender, age, and race.**
- **The analysis ensured that results accurately reflected the community's perspectives; however, demographic comparisons revealed certain gaps–highlighting opportunities for more targeted outreach to improve representation among specific populations.**

COLLECT & ANALYZE DATA | **STEP FOUR**

DATA COLLECTION PROCESS

The assessment was conducted through multiple methods to maximize engagement and ensure broad representation.

- **digital outreach via social media platforms**
- **traditional word-of-mouth methods**
- **direct interactions with healthcare providers**
- **online surveys**
- **community events**
- **local businesses**

Surveys were made available from August 1st to October 10th.

COLLECT & ANALYZE DATA | **STEP FOUR**

WHO IS ARKANSAS COUNTY?

Key insights per the CHNA survey

167 SURVEY RESPONSES WERE RECEIVED

89% of the respondents were from Arkansas County. Additional responses were received from Ashley, Chicot, Craighead, Drew, Jefferson, Lincoln, Lonoke, Monroe, and Phillips. The remaining responses were from Desha, Drew, Morehouse Parish, LA, and one who replied they lived in the USA.

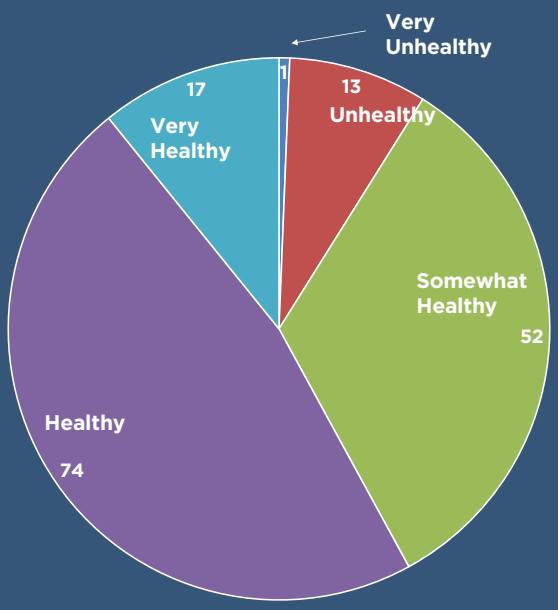
36 to 45 was the largest age group to respond at 22%. Remaining age groups responded in the following order: 46 to 55 (19%), 56 to 65 (20%), 26 to 35 (17%), 56 to 65 (15%), 66 to 75 (14%),18 to 25 (11%), and the remaining at 76 to 85.

76% of respondents were female and 22% male, and the remaining chose "Prefer Not to Say".

89% of the respondents were Caucasian, with the second largest response being black or African American, at .06%, and the remaining Hispanic or Latino, White; Hispanic or Latino, White; Native American or American Indian or prefer not to say.

PERSONAL HEALTH PERCEPTION: OVERALL, HOW WOULD YOU RATE YOUR PERSONAL HEALTH?

Key Insight: The majority of survey respondents perceive themselves as healthy or somewhat healthy.

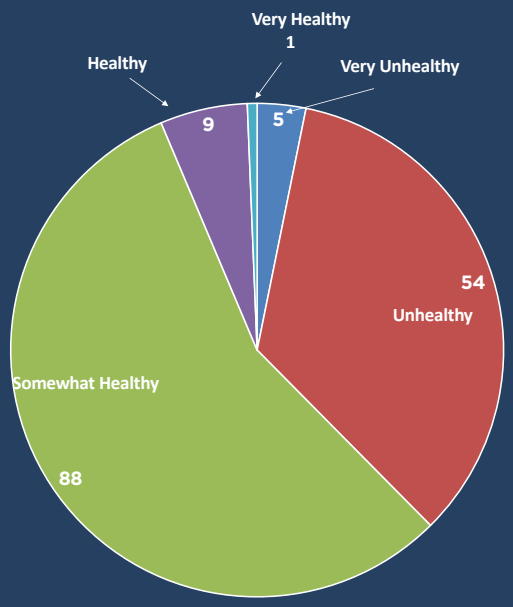


PERCEPTION OF COMMUNITY HEALTH: HOW WOULD YOU RATE THE GENERAL HEALTH OF YOUR COMMUNITY?

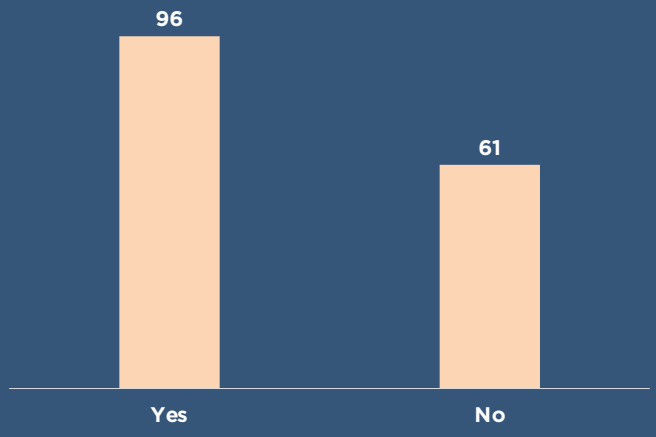
Key Insight: A large majority of the survey respondents perceive themselves healthier than their perception of their community's health.

Previously, respondents reported themselves as "Healthy or Very Healthy" (91) and their community as "Unhealthy or Very Unhealthy" (59)

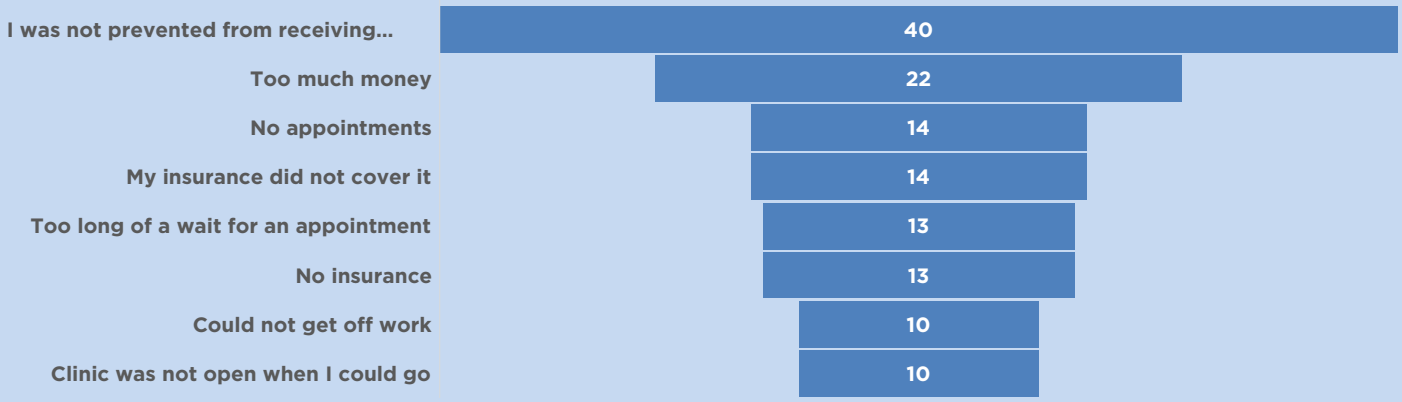
The perception of "Somewhat Healthy" for the respondents were noted at 52 and for their community at "54".



DID YOU OR SOMEONE IN YOUR HOUSEHOLD GO WITHOUT HEALTHCARE OR DELAYED RECEIVING HEALTHCARE IN THE PAST THREE YEARS?

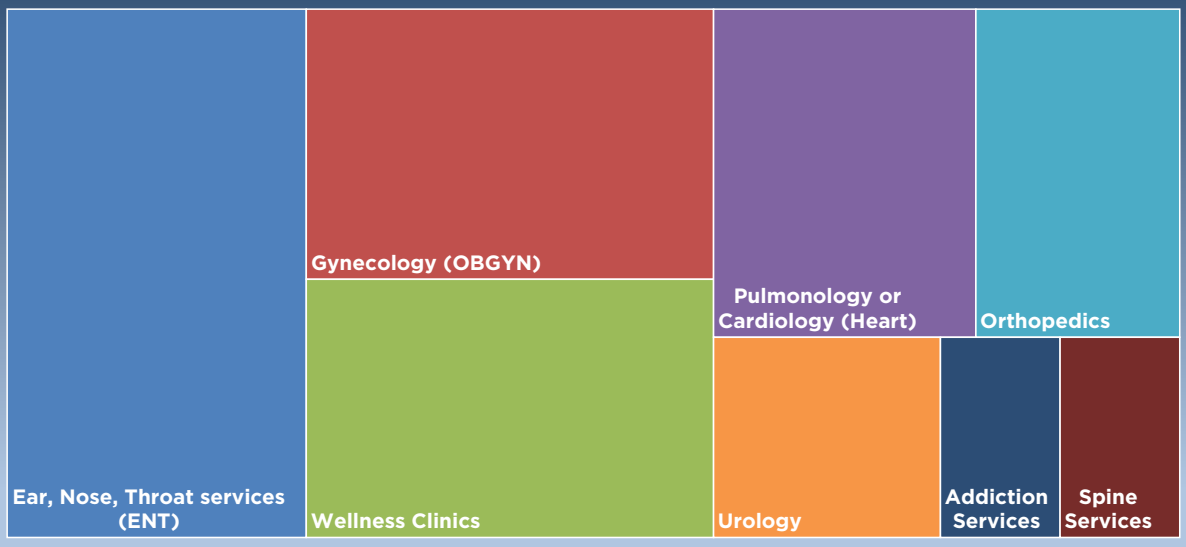


WHEN ASKED WHY HEALTHCARE WAS NOT RECEIVED, THE MOST NOTABLE RESPONSES ARE IDENTIFIED BELOW:



Key Insight: While the majority of respondents reported having no barrier to receiving healthcare, the most common reason cited by those who did face a barrier was financial, with "too much money" being the top response.

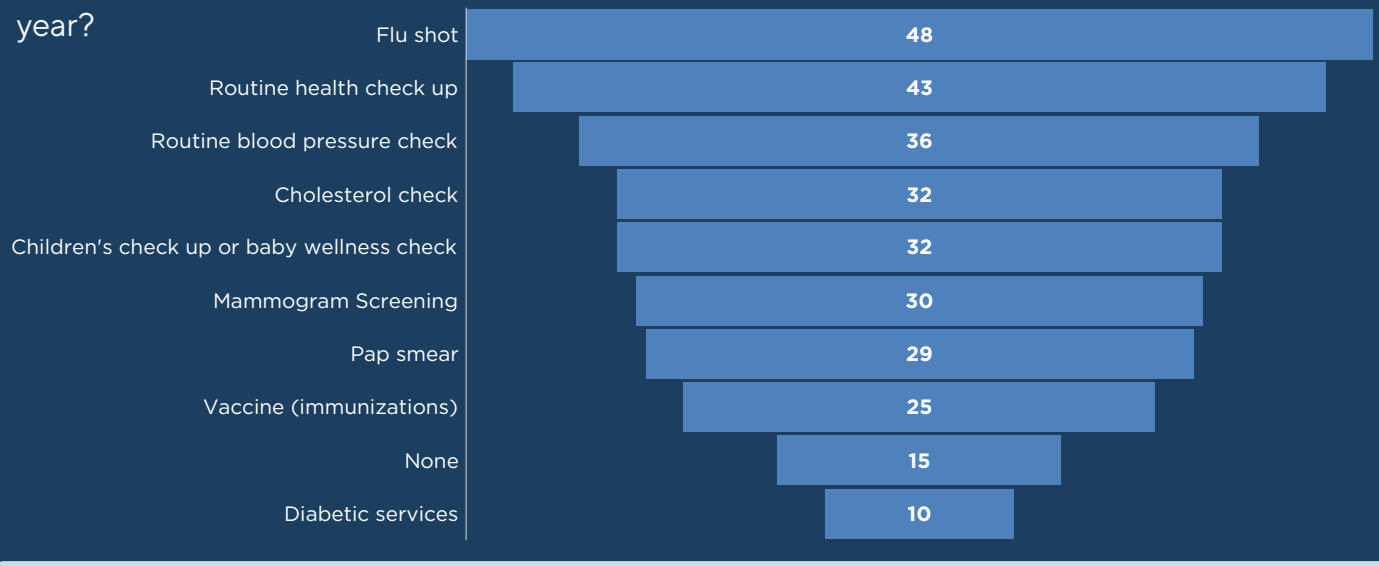
MOST NEEDED HEALTHCARE SERVICES: WHAT HEALTHCARE SERVICES WOULD YOU USE IF THEY WERE AVAILABLE?



Key Insights: The most desired healthcare services among respondents were ENT, OBGYN/Gynecology, and Wellness Clinics.

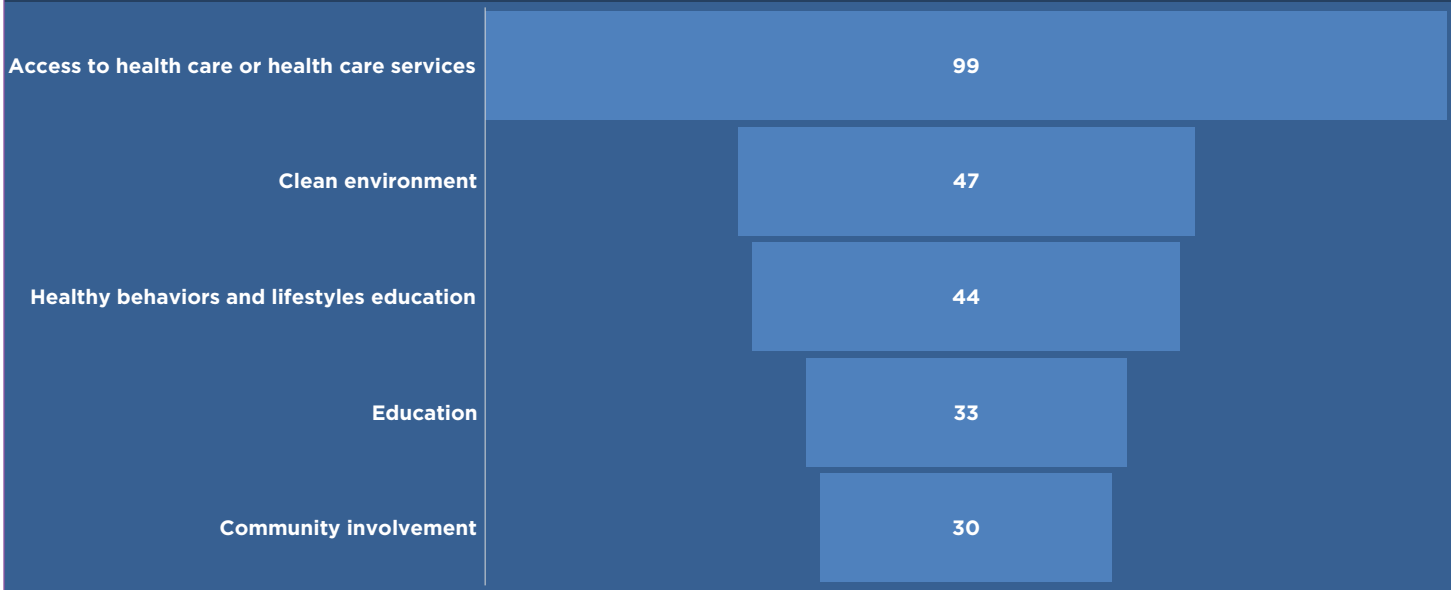
USE OF PREVENTATIVE HEALTH SERVICES:

Preventative testing and services help to prolong the length of living and can lead to early diagnosis of serious health problems. Which of the following services have you used in the past year?



Key Insight: The chart displays the most commonly reported preventive services among survey respondents. Services mentioned fewer than 10 times are not included.

KEY FACTORS FOR A HEALTHY COMMUNITY: SELECT THE MOST IMPORTANT FOR CREATING A HEALTHY COMMUNITY

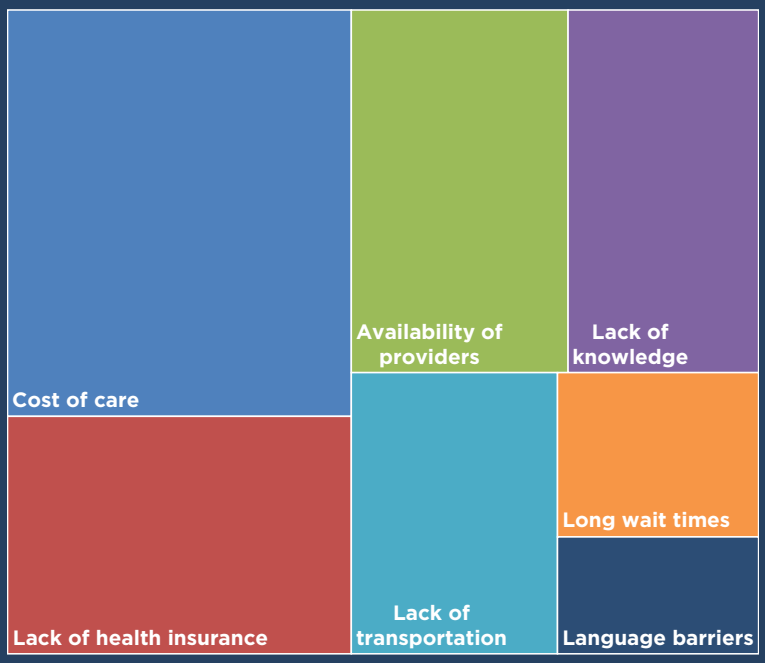


Key Insight: Other factors mentioned 3 or fewer times: Transportation, lower or no cost clinics, and low cost, high quality meat, fresh fruit and vegetables.

BARRIERS TO HEALTHCARE ACCESS: WHAT ARE THE BIGGEST CHALLENGES TO ACCESSING HEALTHCARE IN YOUR COMMUNITY?

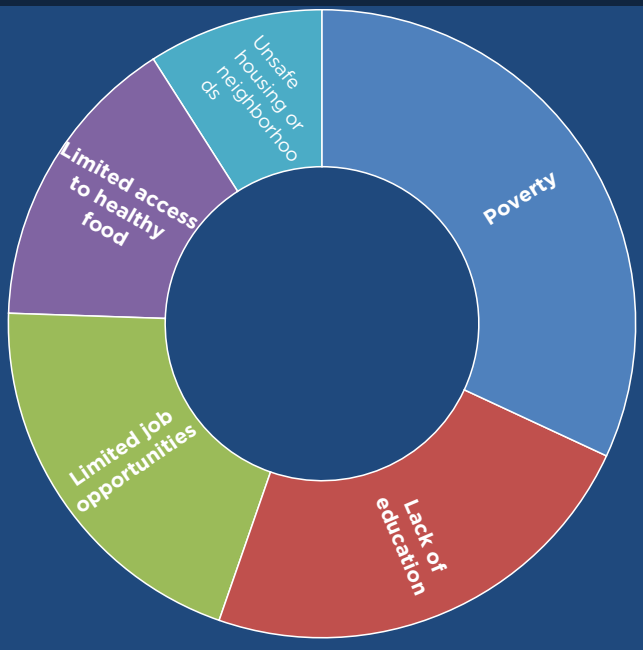
Key Insights:. *When combined "Cost of Care" and "lack of Health Insurance" represent the dominant portion of the total barriers, highlighting that financial factors are the biggest obstacles to healthcare access.*

A variety of non-financial barriers were noted but less often.

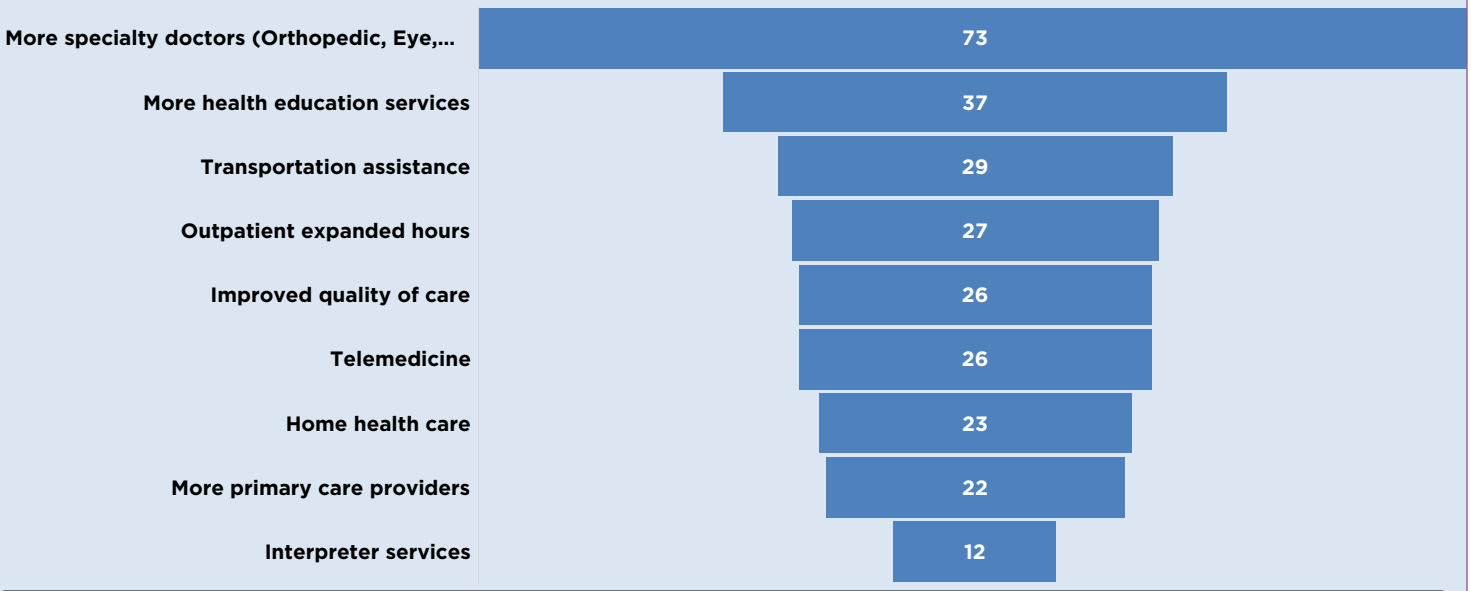


PERSPECTIVE ON FACTORS THAT CONTRIBUTE MOST TO HEALTH CONCERNS IN THE COMMUNITY

Key Insight: "Poverty" as the largest section, indicating it was cited most frequently as a contributing factor. The other factors listed are Lack of education, Limited job opportunities, Limited access to healthy food, and Unsafe housing or neighborhoods, which are also significant but smaller in proportion than poverty.

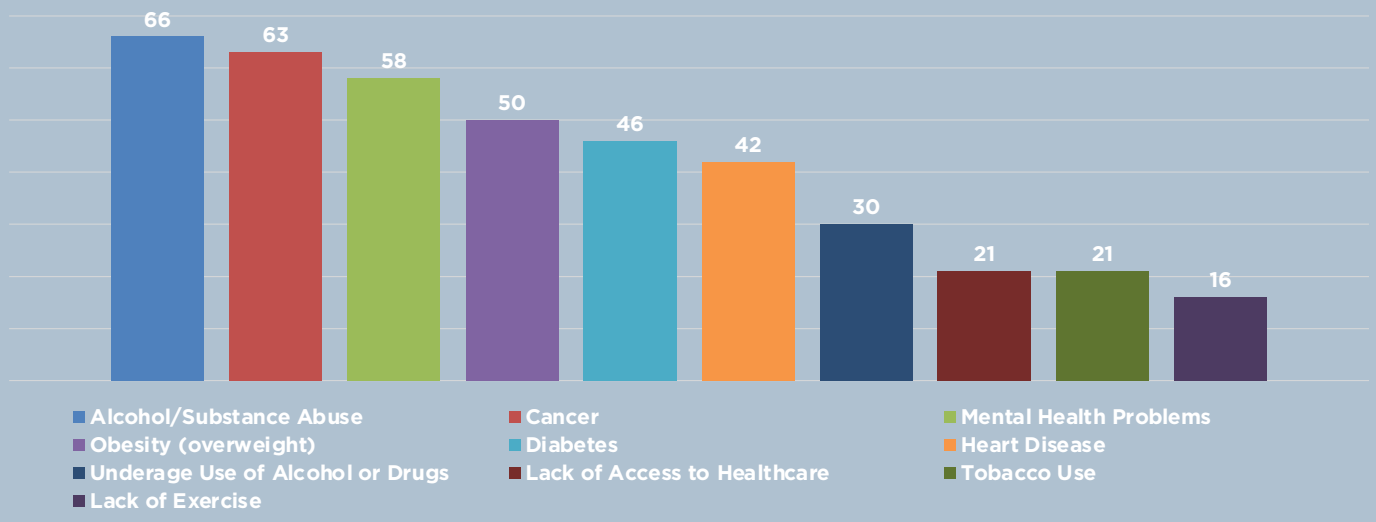


Community Perspective on how to improve the community's access to health care.



Key Insights: ***Survey respondents perceived the most effective way to improve access to healthcare is by increasing the number of specialty doctors which was chosen 73 times. a significant amount more than any other selections.***

PERSPECTIVE ON MAJOR HEALTH CONCERNS IN THE COMMUNITY: IN THE FOLLOWING LIST, WHAT DO YOU THINK ARE THE THREE MOST SERIOUS HEALTH CONCERNS IN YOUR COMMUNITY?



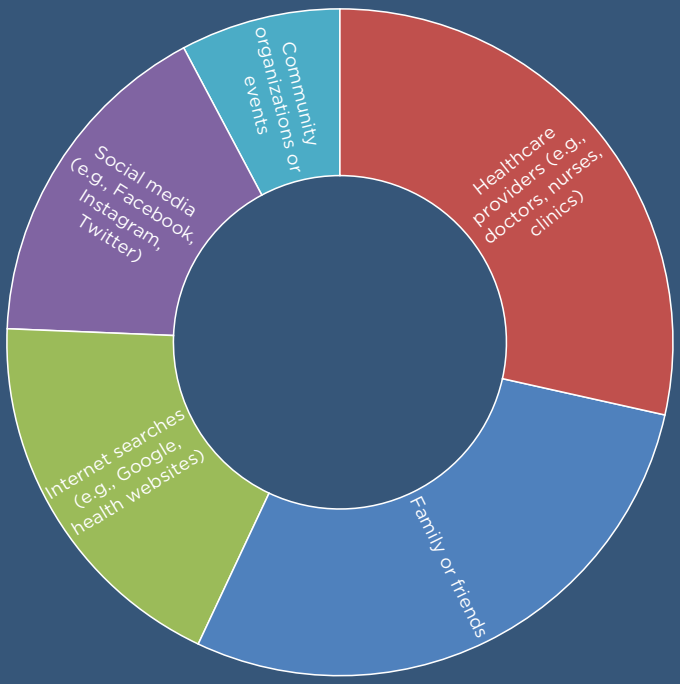
Key Insight: *The community perceives alcohol/substance abuse, cancer, mental health problems, obesity, diabetes, and heart disease as the most pressing health challenges, followed by underage use of alcohol, tobacco use, and lack of exercise.*

When asked how the respondents typically receive information regarding available health services, the replies were:

Key Insight: The most common way to receive information about available health services are family and friends and healthcare providers.

The next most selected: Internet, Social Media, and Community Organizations or Events.

And selected less the 10 times by respondents were: Faith-based organizations or places of worship, Flyers, posters, or brochures, Television or radio, and
Local newspapers or magazines.



Community Insights: A Qualitative Perspective

Overall insights from survey respondents:

The most notable responses provided were the need for more specialized care, specially for those suffering strokes, heart attacks, and need for childbirth. Also noted was the need for cardiology services and outpatient services to address those who struggle with transportation and after-hours care.

There were several comments regarding issues in the community with behavioral health regarding substance use and mental health needs.

A few comments from respondents:

- "Our community has a tremendous need for mental health services for all ages. We have very limited services in our area."
- "I have kids at school that have no support at home. They come to school hungry and not clean."

- **Behavioral Health (Alcohol, Substance Use, Mental Health)**
- **Specialty Providers/services needed**
- **Awareness of Healthcare Services/ Health Education**

PRIORITIZE COMMUNITY HEALTH ISSUES | STEP FIVE

DeWitt Hospital & Nursing Home must adopt an implementation strategy before the 15th day of the fifth month after the end of the taxable year in which the hospital finishes conducting the Community Health Needs Assessment.

https://www.irs.gov/charities-non-profits/community-health-needs-assessment-for-charitable-hospital-organizations-section-501r3

DOCUMENT & COMMUNICATE RESULTS | STEP SIX

THIS IS AN ONGOING PROCESS

- **Develop work groups**
- **Create measurable action plan recommendations based upon key themes identified (15 minutes)**
- **Consider potential barriers for implementation.**
  - ✓ **SWOT analysis, etc.**

PLAN IMPLEMENTATION STRATEGIES | STEP SEVEN

IMPLEMENT STRATEGIES & NEXT STEPS | STEP EIGHT

- Arkansas Rural Health Partnership will provide the DeWitt Hospital & Nursing Home with the Community Health Needs Assessment Report by November 21, 2025.
- ARHP and DeWitt Hospital and Nursing Home Steering Committee will draft the implementation plan and communicate back to the advisory committee.
- Conduct annual progress assessment with the advisory committee.

THANK YOU!

Arkansas Rural Health Partnership

Lynn Hawkins
Chief Operations Officer
lynnhawkins@arruralhealth.org

ATTACHMENT B.
Community Advisory Committee Meeting Agenda

MEETING AGENDA

01 **Introductions**

02 **The CHNA Process**

03 **Survey Results**

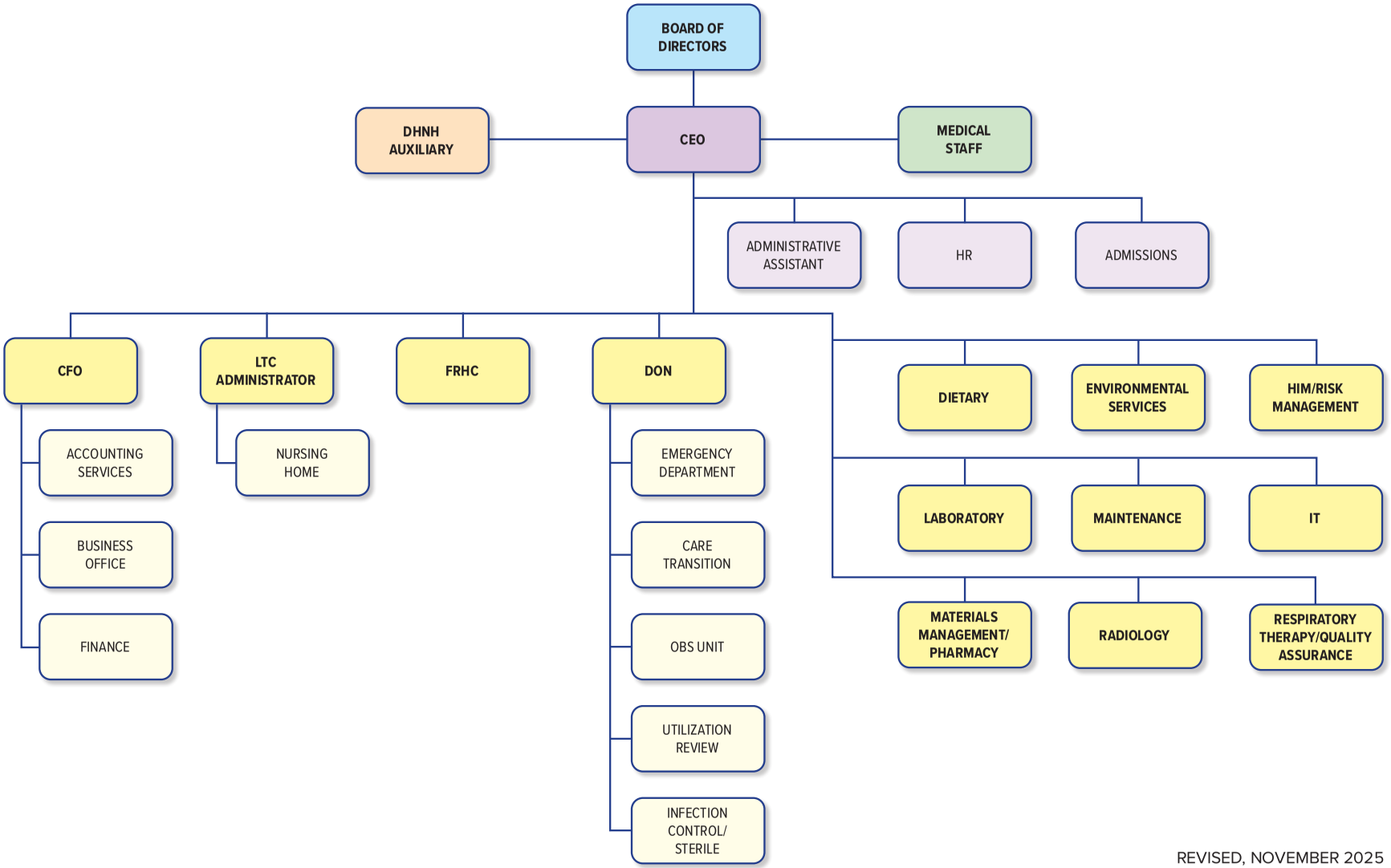
04 **Discussion/Plans**

05 **Questions**

ATTACHMENT C.
Community Advisory Attendance Roster

FIRST NAME	LAST NAME	ORGANIZATION
Brook	Bradberry	DeWitt Hospital & Nursing Home
Savanna	Bronson	Phillips Community College
Ja	Chambliss	Pattillo School
Rick	Duffield	Board Member
Angie	Duncan	DeWitt Hospital & Nursing Home
Farrah	Jones	DeWitt Hospital & Nursing Home
Kim	Kirby	Phillips Community College
Leigh Ann	Lammers	Mid-Delta Health Systems, Inc.
Brian	Miller	DeWitt Hospital & Nursing Home
Tammy	Pfaffenburger	Dana's House
Tiffany	Sherbert	DeWitt Hospital & Nursing Home
Hunter	Traynom	Mid-Delta Health Systems
Shawana	Wansley	Phillips Community College/DeWitt School Board
Tawana	Watson	DeWitt Hospital & Nursing Home
Ron	Worbington	ARM 180
Jennifer	Worbington	ARM 180

DeWitt Hospital and Nursing Home Corporation Organizational Chart



REVISED, NOVEMBER 2025

ATTACHMENT D.
Organizational Chart

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