LAIRD HOSPITAL

CHNA REPORT

NOVEMBER 2016

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EXECUTIVE SUMMARY

The purpose of this Community Health Needs Assessment (CHNA) report is to provide Laird Hospital with a functioning tool to guide the hospital as it works to improve the health of the community it serves. In addition, the report meets the guidelines of the Internal Revenue Service.

The results of the CHNA will guide the development of Laird Hospital community health improvement initiatives and implementation strategies. This is a report that may be used by many of the hospital's collaborative partners in the community.

The assessment was performed and the implementation strategies were created by the Community Health Needs Assessment Steering Committee with assistance from HORNE LLP. The assessment was conducted in September and October 2016.

The main input was provided by previous patients, employees and community representatives. An opportunity to offer input was made available to the entire community through word of mouth plus a published and publicly available survey. Additional information came from public databases, reports, and publications by state and national agencies.

The *response* section of this report describes how the hospital and its collaborative partners worked together to address identified health needs in our community during the past three years. In this report, we also discuss the health priorities that we will focus on over the next three years. The CHNA report is available on the hospital's website www.lairdhospital.com or a printed copy may be obtained from the hospital's administrative office.

We sincerely appreciate the opportunity to be a part of this community. Our hospital is growing and your opinions matter. We look forward to working with you to improve the overall health of those we serve.

Thomas Bartlett, FACHE, Administrator
Laird Hospital

ABOUT THE HOSPITAL

Laird Hospital is a 25-bed acute-care hospital that provides a wide range of inpatient, outpatient and emergency services. Patients can be admitted to the hospital if their medical needs make that the best option. A variety of other services are available on an inpatient and outpatient basis through the hospital's imaging, laboratory and rehabilitative services, including physical, occupational and speech therapy.

Patients are cared for under the direction of their physician by a licensed health care team including registered nurses, physical therapists, social workers, dietitians, pharmacists and other ancillary staff, depending on the patient's medical needs.

A 24-hour emergency department is staffed with qualified emergency room hospitalists and is open 24 hours a day, seven days a week. The hospitalists also act as hospital physicians which means they can admit and care for patients who do not have a physician that regularly admits patients at the hospital.

Skilled nursing and rehabilitative care are available at Laird Hospital through the Swing Bed Program. Those recovering from surgery, a stroke, a fracture or an extended medical illness and hospitalization can choose to rehabilitate at Laird Hospital, whether or not they were hospitalized in another location.

The hospital is a trusted member of the Union community. The citizens depend on the hospital to not only provide for their needs when they are ill, but they also turn to the hospital as a source of health and wellness information. The hospital's full service dining room is a favorite dining destination for many of the citizens of the community.

THE COMMUNITY HEALTH NEEDS ASSESSMENT

The Community Health Needs Assessment defines opportunities for health care improvement, creates a collaborative community environment to engage multiple change agents, and is an open and transparent process to listen and truly understand the health needs of Newton County. It also provides an opportunity for the hospital to identify valuable collaborative partners as we try to better serve the community and improve the health of our citizens.

The federal government now requires that non-profit hospitals conduct a community health assessment. These collaborative studies help health care providers build stronger relationships with their communities, identify needs, and dedicate funding and other resources toward programs that clearly benefit local residents.

COMMUNITY HEALTH NEEDS ASSESSMENT STEERING COMMITTEE

The Committee is responsible for the oversight, design, and implementation of the CHNA. It will continue to collect information, establish community relationships and oversee the budget and funding sources. Adhering to an agreed upon timeline, the Committee will generate, prioritize, and select approaches to address community health needs.

The hospital's administrator developed a hospital steering committee. The appointed members are listed below. Other members may serve on the Steering Committee as the Committee's work progresses.

Thomas Bartlett, FACHE - Hospital Administrator
Pam Rigdon, RN - Director of Nursing
Cindy Beckham - Compliance Manager

COMMUNITY ENGAGEMENT AND TRANSPARENCY

We are pleased to share with our community the results of our Community Health Needs Assessment. The following pages offer a review of the strategic activities we have undertaken, over the last three years, as we responded to specific health needs we identified in our community. The report also highlights the updated key findings of the assessment. We hope you will take time to review the health needs of our community as the findings impact each and every citizen of our rural Mississippi community. Also, review our activities that were in response to the needs identified in 2013. Hopefully, you will find ways you can personally improve your own health and contribute to creating a healthier community.

THE COMMUNITY HEALTH NEEDS ASSESSMENT

DATA COLLECTION

Primary and secondary data was gathered, reviewed, and analyzed so that the most accurate information was available in determining the community's health needs and appropriate implementation process.

Primary Data Primary data is that which is collected by the assessment team. It is data collected through conversations, telephone interviews, focus groups and community forums. This data was collected directly from the community and is the most current information available.

Secondary Data Secondary data is that which is collected from sources outside the community and from sources other than the assessment team. This information has already been collected, collated, and analyzed. It provides an accurate look at the overall status of the community.

Secondary data sources included:

The United States Census Bureau
Centers for Disease Control and Prevention
Laird Hospital Medical Records Department
US Department of Health & Human Services
Mississippi Center for Obesity Research, University of Mississippi Medical Center
Mississippi State Department of Health, Office of Health Data and Research
Mississippi State Department of Health
American Heart Association
Trust for America's Health

COMMUNITY INPUT

COMMUNITY FOCUS GROUP

A community focus group was held at Laird Hospital on Wednesday October 26, 2016. The participants in the group were carefully selected because they each represented a specific segment of the populations served. In addition, they can act as a continuous conduit between the community and the leadership of the hospital. These participants contributed to a structured discussion which was impartially facilitated by a healthcare consultant from Horne LLP of Ridgeland, Mississippi.

This focus group provided a deliberative venue for learning, trust-building, creative problem solving, and information gathering which ultimately served as a valuable resource for the CHNA Steering Committee as it developed the hospital's health priorities for the next three years. Since the focus group was based on open communication and critical deliberation, it will hopefully lead to improved community relations, trust and collaborative partnerships as the hospital strives to improve the overall health of the community.

Mayor Patrick O'Neill - Decatur Mayor
Mayor Wayne Welch - Union Mayor
Mayor David Carr - Newton Mayor
Lundy Brantley – Superintendent, Union School
Virginia Young – Superintendent, Newton City School
J.O. Amis – Superintendent, Newton County School
Bro. Jon Martin – Pastor, First Baptist Church of Union
Brandi Keith, FNP - Decatur Medical Clinic

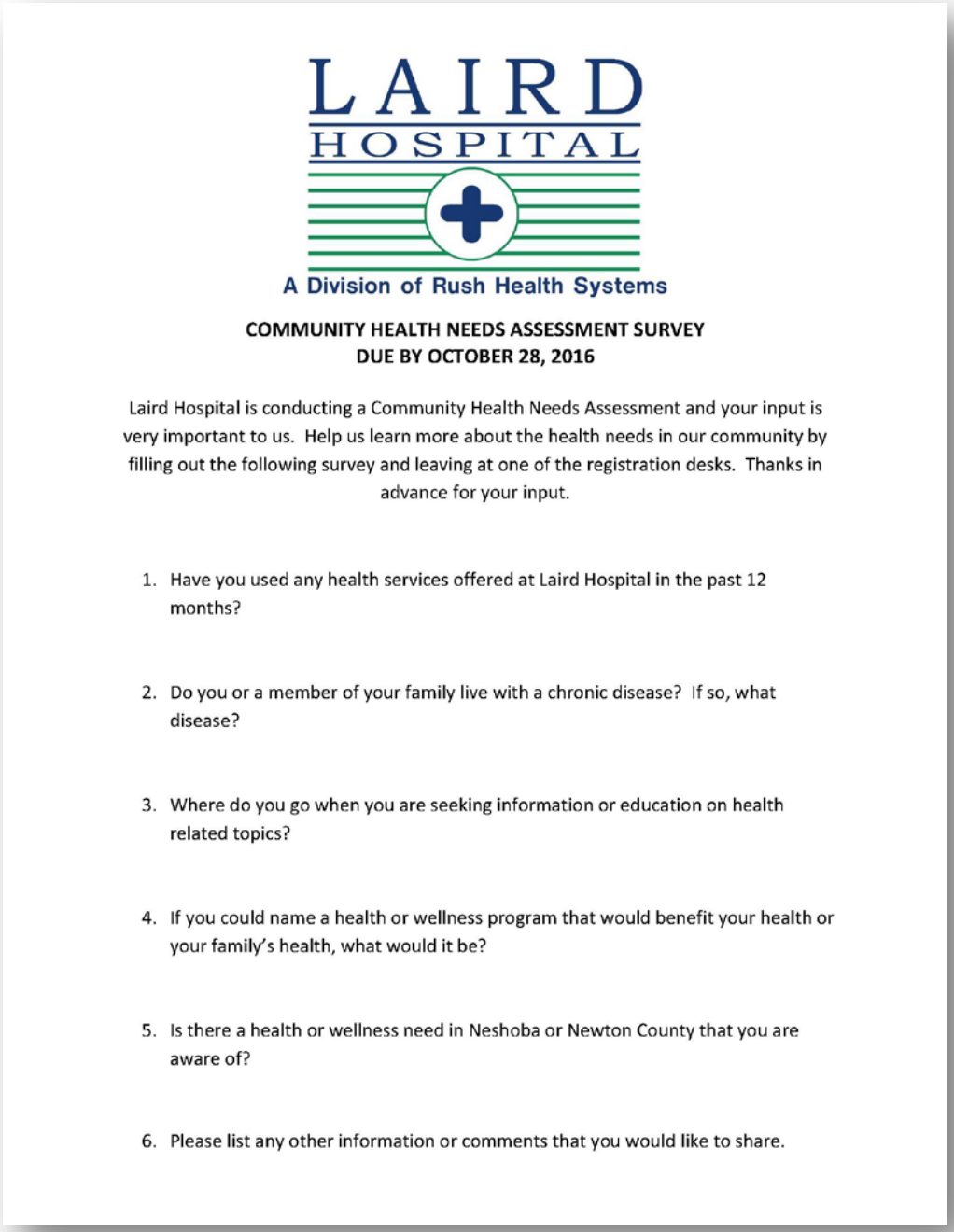
COMMUNITY SURVEY

Community health needs were identified by collecting and analyzing data and information from multiple quantitative and qualitative sources. Considering information from a variety of sources is important when assessing community health needs, to ensure the assessment captures a wide range of facts and perspectives and to assist in identifying the highest-priority health needs. One of the most important sources is to seek input directly from those we serve.

In order to provide citizens of our services area with an opportunity to provide us their valuable insight, a Community Survey was published in the local paper. The survey ran in *The Newton County Appeal.* It was published on Wednesday, October 19, 2016. *The Appeal* has a readership that covers Newton County and surrounding areas.

COMMUNITY INPUT

In addition, the survey was made available in public areas of the hospital and distributed through members of the CHNA Focus Group. Collection boxes were available in the hospital's lobbies.



LAIRD HOSPITAL

A Division of Rush Health Systems

COMMUNITY HEALTH NEEDS ASSESSMENT SURVEY
DUE BY OCTOBER 28, 2016

Laird Hospital is conducting a Community Health Needs Assessment and your input is very important to us. Help us learn more about the health needs in our community by filling out the following survey and leaving at one of the registration desks. Thanks in advance for your input.

1. Have you used any health services offered at Laird Hospital in the past 12 months?

2. Do you or a member of your family live with a chronic disease? If so, what disease?

3. Where do you go when you are seeking information or education on health related topics?

4. If you could name a health or wellness program that would benefit your health or your family's health, what would it be?

5. Is there a health or wellness need in Neshoba or Newton County that you are aware of?

6. Please list any other information or comments that you would like to share.

COMMUNITY INPUT

INPUT FROM THE COMMUNITY

Through internal conversations at the hospital, one-on-one interviews with community leaders, and a hospital focus group, much information was gathered which was influential as the CHNA Steering Committee developed the hospital's implementation plan.

There were health needs identified that can be addressed and met by the hospital and others that must be referred to other local organizations or health agencies. Several health improvement opportunities were identified where the hospital will try to act as a community catalyst for action but are not part of the hospital's implementation plan.

The community felt that the adult population of the county was the segment that had the greatest health risks in regards to lifestyle impacted diseases such as heart disease and diabetes. Poor nutritional habits are prevalent in the South, especially in rural communities.

It was felt that the communities in the service area could benefit from educational opportunities emphasizing healthy eating.

The senior population was also recognized as an "at risk" population due to lack of transportation, few senior health opportunities, poor nutritional habits plus limited access to fresh produce, and minimal physical activities.

Suggestions included:

- Coordinating group-led health education classes with the local churches, school systems and other local health agencies
- Having more visible health and wellness activities in various locations throughout the county
- Creating a culture of community health and responsibility
- Developing an initiative with all county health providers to empower the community to take individual ownership in his or her health.

ABOUT THE COMMUNITY

Newton County is a county located in central Mississippi on the eastern border of the state, adjacent to the state of Alabama. The county seat is Decatur. The county has a total area of 580 square miles, of which 99.65% is land and .35% is water. According to the estimates of the 2015 Census, there were approximately 21,747 people residing in the county. Population has increased .1% since 2010.

Newton County, Mississippi

(2007 Census Publications State and County Profiles Mississippi. *USDA Census of Agriculture*,2007).

ABOUT THE COMMUNITY

DEMOGRAPHICS

As of the census 2010, there were 21,720 people. According to the 2015 estimates, there is a decrease in population of almost 2,000 residents. There were approximately 8,214 households, and 5,802 families residing in the county. The population density is about 37.6 people per square mile. There were 9,373 housing units at an average density of 16.2 per square mile (Community Facts, United States Population, 2010).

According to the 2015 estimates, the racial makeup of the county was 63.0% White, 30.6% Black or African American, 5.0% Native American, 0.4% Asian, and 1.0% from two or more races. 1.8% of the population was Hispanic or Latino of any race (Community Facts, United States Population, 2010).

In 2010, there were 8,214 households out of which 35.7% had children under the age of 18 living with them, 48.90% were married couples living together, 16.7% had a female householder with no husband present, and 29.4% were non-families. 26.2% of all households were made up of individuals and 28.8% had someone living alone who was 65 years of age or older. The average household size was 2.57, and the average family size was 3.10 (Community Facts, United States Population, 2010).

The median income for a household in the county was $38,265 (2010-2014), and the per capita income for the county was $21,157 (2010-2014). About 12% of families and 17% of the population were below the poverty line, including 29.9% of those under age 18 and 9.0% of those ages 65 or over (Community Facts, United States Population, 2010).

PATIENT ORIGIN

Approximately 58% of the patients seen at Laird Hospital over the past twelve months reside in Neshoba County, Mississippi. About 27% of patients reside in Newton County, where the hospital is located. 11% of inpatients in Newton County reside in Decatur, the county seat of Newton. Lauderdale County had about 4.6% of the inpatient total. The remaining 6% of the patient population represents a variety of locations outside of the primary service area. Almost 46% of the patient population resides in Union, which is in both Neshoba County and Newton County.

ABOUT THE COMMUNITY

SERVICE AREA

While it may seem that Neshoba County is part of the primary service area for Laird Hospital, the majority of those patients from Neshoba County reside in the southern portion of the county, in particular Union. Neshoba County is home to an acute care facility as well as a hospital run by Indian Health Services. Therefore, we will only consider the southern portion of the county as part of the primary service area for Laird Hospital.

Newton County is also part of the primary service area. Within Newton County are the city of Newton; the towns of Union, Decatur, Hickory, and Lake; as well as six unincorporated communities.

CHARACTERISTICS OF THE HEALTH OF THE SOUTHERN RURAL COMMUNITY

All rural areas in the U.S. are unique with extensive geographic and economic variations. When compared to urban populations, however, rural populations are often characterized as being older and less educated; more likely to be covered by public health insurance; having higher rates of poverty, chronic disease, suicide, deaths from unintentional injuries and motor vehicle accidents; having little or no access to transportation; and having limited economic diversity. All of these issues create challenges and opportunities to improve the health of those living in the rural South, and they play a role in understanding some of the underlying causes associated with issues related to the rural health workforce, health services, and special populations. These unique population and health issues were taken into consideration as the Steering Committee evaluated health and wellness opportunities to address. Some can be approached through initiatives of the hospital and others will best be approached through a cooperative effort of local government, state agencies, churches, volunteer programs and the hospital.

OBESITY IN MISSISSIPPI

The cost to the state of Mississippi due to obesity in terms of our heart health, quality of life, healthcare costs and life spans is astronomical. Obesity contributes to heart disease, stroke, diabetes and a myriad of orthopedic conditions (Coakley, Must, Spadano, 1999).

Over the past few decades, obesity has become a serious health care issue in the United States. The obesity rate for adults was 13 percent in 1962; it now stands at over two and half times that. Today, 17 percent of children are obese.

As a health condition, it costs the country nearly $150 billion every year. But obesity is not just a health condition anymore, at least according to the American Medical Association. The nation's largest group of doctors voted in June 2013 to classify obesity as a disease.

Obesity has become the greatest threat to the health of Mississippians, and if left unchecked will overwhelm our health-care system. Without action, what is now a ripple effect of negative health consequences will become a tidal wave of disease, disability and premature death.

The uncontrolled epidemic of obesity is wreaking havoc on our state. One out of every three adults in Mississippi is considered obese. Obesity predisposes to a whole host of chronic diseases, and it produces a ripple effect of negative health consequences: hypertension, heart disease, stroke, kidney disease, neurodegenerative disease, diabetes and even cancer. These conditions contribute to the death of many Mississippians each year and, at a minimum, decrease our quality of life.

CHARACTERISTICS OF THE HEALTH OF THE SOUTHERN RURAL COMMUNITY

Obesity is hurting Mississippi's economy. An obese person generates 40 percent more in medical costs per year than a non-obese person. In 2008, Mississippi spent $925 million in health-care costs directly related to obesity. If the trend continues, obesity related health-care costs will be $3.9 billion by 2018. Obese adults miss work more often than other workers, impacting productivity. As a result, obesity hurts Mississippi's business competiveness and ability to attract new industry.

Obesity is harming Mississippi's children. Mississippi has the highest rate of childhood obesity in the nation. Nearly half of Mississippi children are overweight or obese. Children as young as eight years old are being treated for Type II diabetes and high cholesterol. This was unheard of just a decade ago. The idea that children will be sick and die younger than their parents is not acceptable.

While the obesity rate for Mississippi's children has stabilized, the same cannot be said of adults. A recent study shows that by 2030, 67 percent of Mississippi's adults are projected to be obese.

HEART DISEASE AND STROKE IN MISSISSIPPI

Mississippi has the highest death rate from cardiovascular disease (CVD) in the country and heart disease is the No. 1 killer in Mississippi. In 2014, 7,539 people in Mississippi died of heart disease. Unfortunately, CVD kills more Mississippians than all forms of cancer combined.

Stroke is the No. 5 killer in Mississippi. In Mississippi, 1,587 people died of stroke in 2014.

Heart Disease and Stroke Risk Factors in Mississippi

In Mississippi		In America
26.0%	Adults are current smokers	21.1%
40.0%	Adults participate in 150+ min of aerobic physical activity per week	51.6%
68.9%	Adults who are overweight or obese	63.5%
5.4%	Adults who have been told that they have had a heart attack	4.4%
4.0%	Adults who have been told that they have had a stroke	2.9%
4.6%	Adults who have been told that they have angina or coronary heart disease	4.1%
69.3%	Population of adults (18-64) who have some kind of health care coverage	78.9%
15.8%	High school students who are obese	13.1%

Disability and death from CVD are related to a number of modifiable risk factors, including high blood pressure, high blood cholesterol, smoking, lack of regular physical activity, diabetes, and being overweight. While it affects persons of all ages in Mississippi, CVD is the leading cause of death for persons age 75 and over.

CHARACTERISTICS OF THE HEALTH OF THE SOUTHERN RURAL COMMUNITY

Seventy-three percent of the population ages 60 to 79 have CVD compared to 40 percent of the population ages 40 to 59 (Older Americans & Cardiovascular Diseases, 2016).

The No. 5 killer in Mississippi and the No. 4 killer in Newton County is stroke, another disease greatly impacted by lifestyle. Hypertension, obesity, smoking and lack of exercise are typically associated with the health status of the stroke victim. Unfortunately, these lifestyle habits are prevalent in the rural south.

There are nine areas of lifestyle and disease related problems that are significant factors in the higher levels of heart disease and stroke in Mississippi. They are:

- Physical Inactivity
- Improper Nutrition
- Tobacco Use
- Socio-cultural Factors
- Hypertension
- Obesity
- Abnormal Cholesterol
- Diabetes
- Acute Event

LIFESTYLE AND DISEASE

Modified lifestyle diseases are illnesses that can potentially be prevented by changes in diet, environment, physical activity and other lifestyle factors. These diseases include heart disease, stroke, obesity, diabetes and some types of cancer.

In Newton County, the three major diseases that result in the most deaths are lifestyle diseases. They are heart disease, cancer and stroke.

This is why the CHNA Committee has chosen to address educational and lifestyle initiatives to assist in lowering the incidence of these diseases. The initiatives are outlined later in the report under the implementation plan.

RURAL HEALTH DISPARITIES

Although the term *disparities* is often interpreted to mean racial or ethnic disparities, many dimensions of disparity exist in the United States, particularly in health. If a health outcome is seen to a greater or lesser extent between populations, there is disparity. Race or ethnicity, sex, sexual identity, age, disability, socioeconomic status, and geographic location all contribute to an individual's ability to achieve good health. It is important to recognize the impact that social determinants have on health outcomes of specific populations. *Healthy People 2020,* a federal

CHARACTERISTICS OF THE HEALTH OF THE SOUTHERN RURAL COMMUNITY

project of the Office of Disease Prevention and Health Promotion, strives to improve the health of all groups.

Healthy People 2020 defines a *health disparity* as "a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion."

Over the years, efforts to eliminate disparities and achieve health equity have focused primarily on diseases or illnesses and on health care services. However, the absence of disease does not automatically equate to good health.

Powerful, complex relationships exist between health and biology, genetics, and individual behavior, and between health and health services, socioeconomic status, the physical environment, discrimination, racism, literacy levels, and legislative policies. These factors, which influence an individual's or population's health, are known as *determinants of health*.

For all Americans, other influences on health include the availability of and access to:

- High-quality education
- Nutritious food
- Decent and safe housing
- Affordable, reliable public transportation
- Culturally sensitive health care providers
- Health insurance
- Clean water and non-polluted air

According to an article published in December, 2014, by Business Insider, for the third year in a row, America's Health Rankings, an annual accounting of Americans' health, has found that Mississippi is the least healthy state in the US (Friedman, L., 2014).

Since the rankings began in 1990, Mississippi — which has high rates of obesity and diabetes, low availability of primary care, and high incidence of infectious disease — has always ranked among the bottom three. Hawaii — which has low rates of obesity, smoking, cancer deaths, and preventable hospitalizations — has always been among the top six.

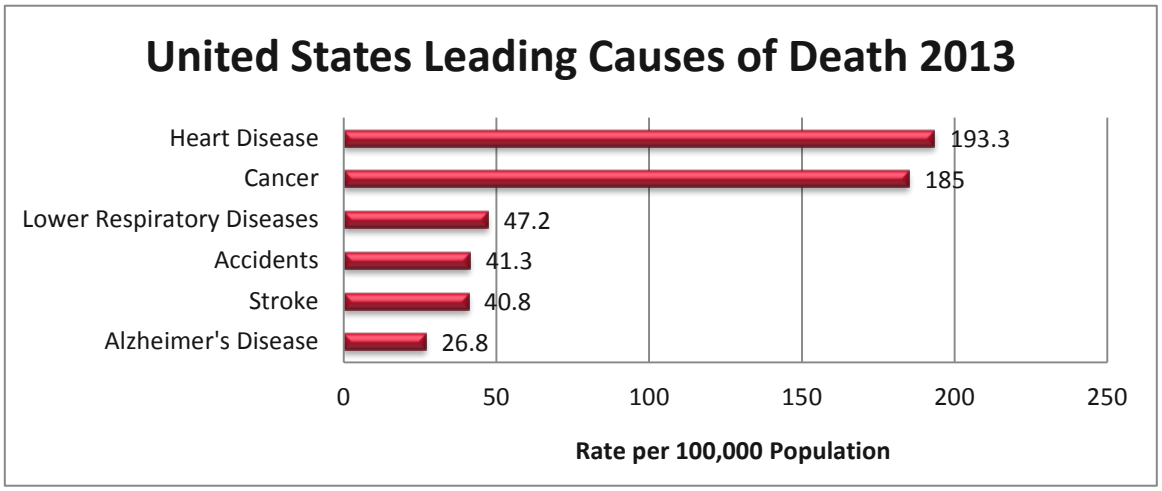
CHARACTERISTICS OF THE HEALTH OF THE SOUTHERN RURAL COMMUNITY

The rankings are funded by the United Health Foundation and are based on data from the Centers for Disease Control and Prevention, the American Medical Association, the Census Bureau, and other sources. They take into account 27 distinct measures including rates of smoking, obesity, drug deaths, education, violent crime, pollution, childhood poverty, infectious disease, and infant mortality.

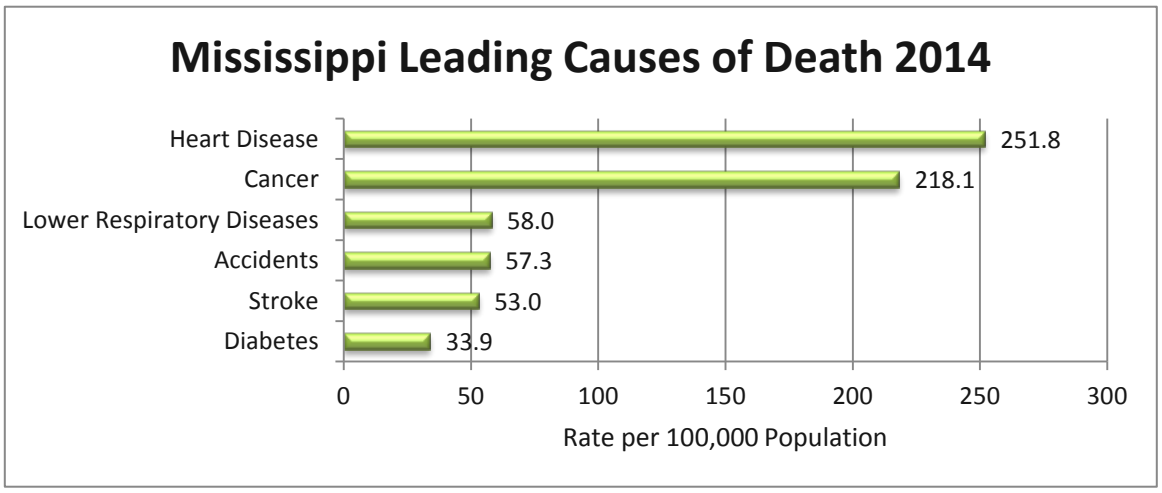
Overall, the rankings showed progress in some areas and not in others. The 2014 analysis found increases from the previous year in obesity and physical inactivity and decreases in infant mortality and smoking rates.

In the past 25 years, there have been some notable changes. Since 1990, there have been major reductions in infant mortality (down 41%), death from heart disease (down 38%), and premature death (down 20%). In 1990, 29.5% of Americans smoked; in 2014, 19% smoke, though smoking remains "the leading cause of preventable death in the country," a press release noted. Unfortunately, in that same time period, rates of diabetes and obesity have more than doubled.

There has also been an 8% decline in cancer mortality since its peak in 1996. Cancer is the second leading cause of death in the US (heart disease is number one), and 2014 saw an estimated 1.6 million new diagnoses.



(Heron, M., 2016)



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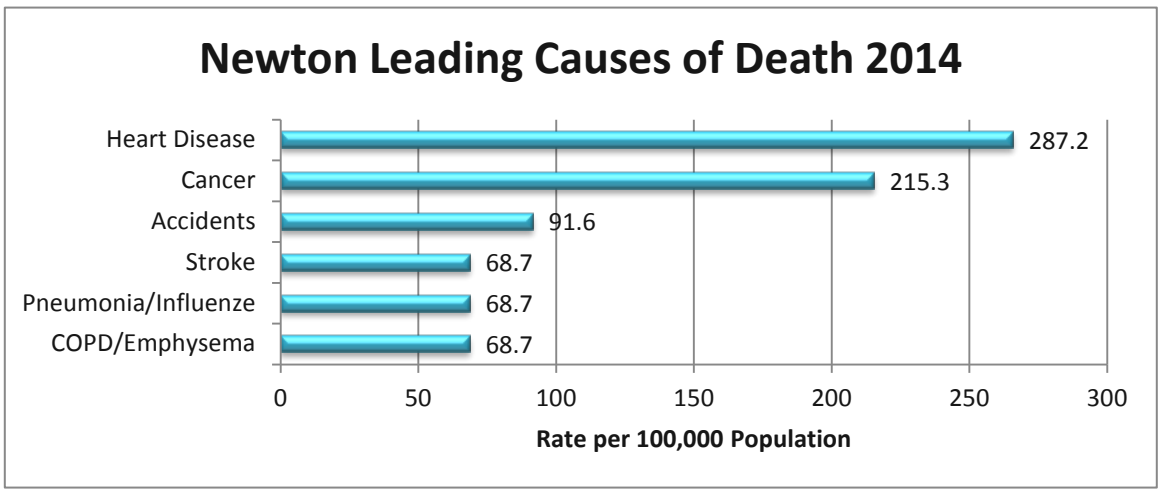

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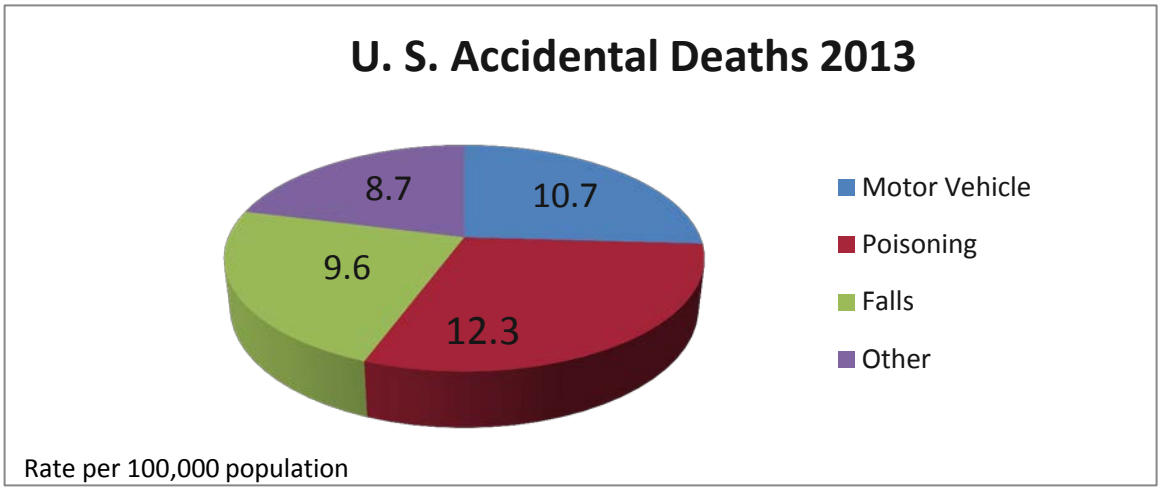

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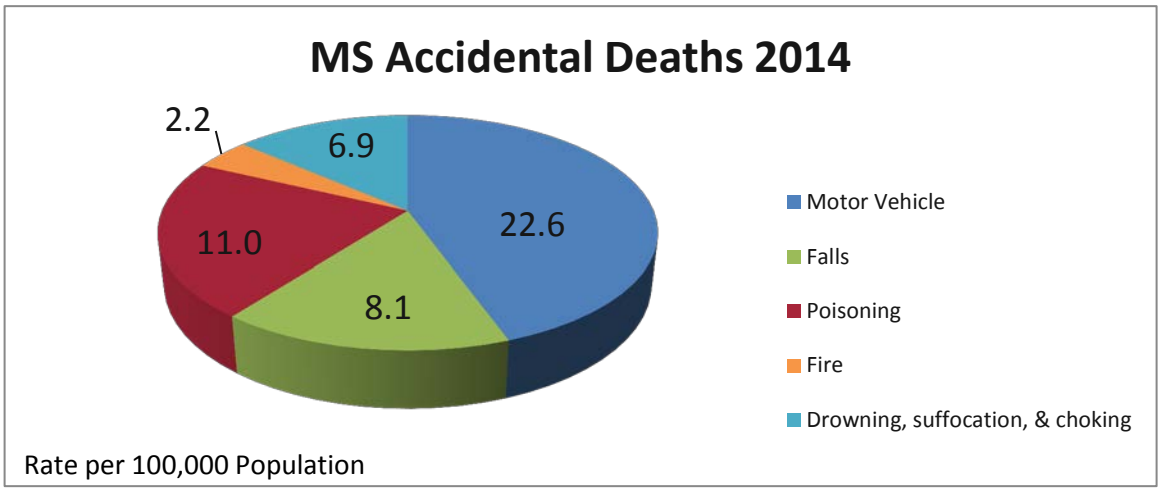

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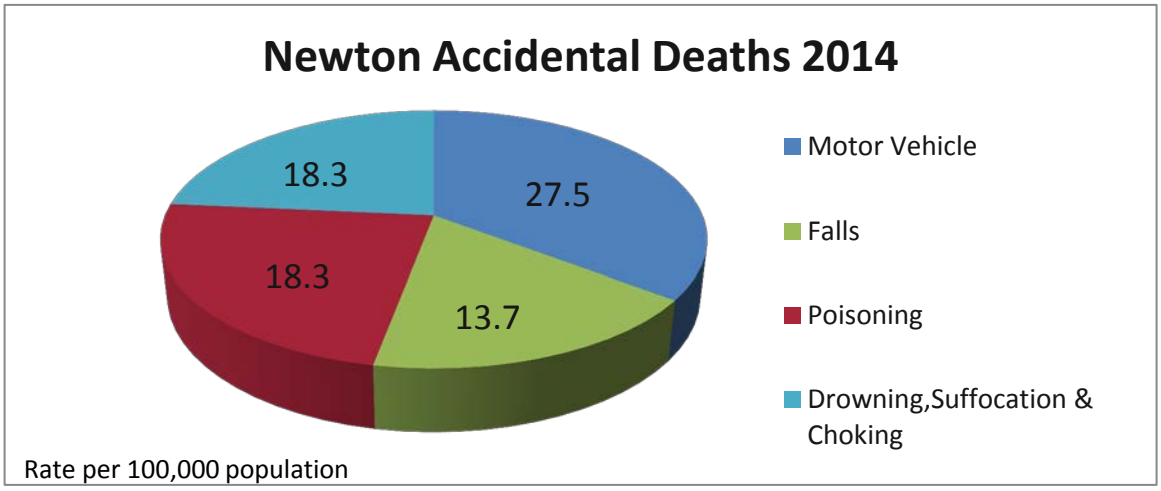

(Generated Statistical Table-MSTAHRS, Newton, Unintentional Injury, 2016)

CHNA STRATEGIC ACTION RESPONSES

STRATEGIC ACTION RESPONSES

Access, affordable care, a lack of knowledge about healthy lifestyles and the relationship to chronic diseases, plus a lack of awareness of available health and wellness services contribute to a wide range of health care needs among rural communities in Mississippi.

At the conclusion of the 2013 Community Health Needs Assessment conducted by Laird Hospital the CHNA Steering Committee identified critical areas of health needs for the people in our service areas. The group's vision was to improve population health in the area by addressing gaps that prevent access to quality, integrated health care and improving access to resources that support a healthy lifestyle.

In support of the 2013 Community Health Needs Assessment, and ongoing community benefit initiatives, Laird Hospital implemented the following strategies to positively impact and measure community health improvement.

CHNA STRATEGIC ACTION RESPONSES

DIABETES AWARENESS

TARGET POPULATION:

The target population for the diabetic management program was Newton County and our surrounding communities. We have programs in place in our rural health clinics in Union, Decatur, Newton, Collinsville, Philadelphia and Meridian.

GOAL, DESIRED OUTCOME:

Our main goal was to provide education to those who have diabetes so that a better understanding of the disease process can be achieved to help prevent further health issues. Another main goal was to identify at risk individuals and educate them on prevention.

PROCESS/TIME FRAME/LOCATION:

Laird Hospital provided an outpatient diabetic education program free of charge to patients who are referred. The program was divided into three visits, two of which were with a registered dietitian. The first visit provided an introduction into diabetes and explains complications from the disease process and coping strategies. The second visit with the dietitian provided diet, nutrition, portion sizes, counting carbohydrates and meal planning. The third visit was with an RN who educated regarding monitoring of the blood sugar via accucheck, and explained about medications and exercise.

The Laird outpatient diabetic program during 2014, 2015, 2016 had 175 patient education visits made. During 2014, 52 referrals were made from Union with 16 patients completing the program, and 20 referrals were made from Newton with 7 patients completing the program. During 2015, 38 referrals were made from Union with 14 patients completing the program, and 2 completing 1 class only; and 29 referrals from Newton with 4 patients completing the program and 2 completing 1 or 2 classes only. During 2016 through June, there have been 5 referrals from Union with 2 patients completing the program and 8 referrals from Newton with 3 patients completing the program. Patients attending this outpatient diabetic program were mainly from Newton and Neshoba counties but there were also patients from Leake, Scott, Jasper, Clark and Winston counties.

We have a Registered Dietitian who is also a Certified Diabetic Educator who does diabetic education by referral in the following Laird rural health clinics, Rush Medical Group at Philadelphia, Family Medical Group of Union, Rush Medical Group of Collinsville, and she has serviced our Family Medical Clinic of Meridian in the North Hills facility. Mrs. Luke has performed diabetic education as

CHNA STRATEGIC ACTION RESPONSES

follows: in our Collinsville clinic in 2013 she educated 84 patients; in 2014, 141 patients; in 2015, 138 patients and so far in 2016, 112 patients; in our Philadelphia clinic in 2015 she educated 8 patients; in 2016, 82 patients; in our Family Medical Group of Union clinic in 2015 she educated 40 patients, and to date in 2016 she has had 48 referrals that received counseling.

Our Laird clinics in 2016 joined into a spread program with our sister clinic North Hills from Meridian. This clinic and two others in our Rural Health Clinic system have participated in a Cohort program with the MSDH for the past three years to reduce uncontrolled diabetes and increase awareness to those at risk.

Norvatis Diabetic Education has sent a representative to the Newton Family Medical Clinic and Decatur Family Medical Clinic biweekly to help educate patients since there was not a diabetic educator in these areas. This service was provided free of charge.

Wellcare has a diabetic and BMI program that will notify clinics of patients who are at high risk (care gaps) and pay 100% for preventive visits.

CHNA STRATEGIC ACTION RESPONSES

HEALTH EDUCATION AND KNOWLEDGE

TARGET POPULATION:

Our target population is all citizens in Newton County and our surrounding communities with a focus on the elderly and low-income groups.

GOAL, DESIRED OUTCOME:

Our goal was to provide education to our patients and the public concerning health services that are available to them through different resources so that we can have a healthier community.

PROCESS/TIME FRAME/LOCATION:

During the past three years, Laird Hospital along with the rural health clinic staff have participated in different community service areas to help assure that the community is made aware of health service resources available to them which have included all age groups. Staff members have also participated in Health Fairs at Union Public Schools and other locations. The swing bed coordinator at Laird Hospital has attended the bimonthly Bone and Joint Class at Rush Hospital every month which actually began prior to 2014. This targets the elderly population, letting them know the resources available to them at Laird Hospital following joint replacements. Laird Hospital staff and Family Medical Group Staff have attended Health Fairs at Union Public schools in 2014, 2015, 2016 with emphasis on diet and exercise. During 2014 rural health clinic staff performed education at the Louisville Public School System, Neshoba County School Board, Newton County School System, the Union Public School Health Committee Meeting and Union Public Schools Kindergarten Registration regarding the wellness checks and other children's health services available at the different rural health clinics. Health service information has been passed out at various health fairs and job fairs including: in 2014 - Newton County Votech Student Job Fair, Scott Regional Health Fair, UMC Medical Mall, St. Dominic's Health Fair and Newton Depot Vendor's Fair; in 2015 - UMC Health Fair, ECCC Business, Education, and Healthcare Expo, Scott County Health Fair at Morton, Meridian Community College Spring Job Fair; in 2016 - ECCC Business, Education, and Healthcare Expo, St. Dominic Health Fair, and UMC Health Fair. Laird Hospital and Family Medical Group of Union participated yearly at Union's Country Day event passing out brochures regarding services offered by Laird including Senior Care Services. Hospital staff attended the Union Chamber Banquet yearly and gave out brochures regarding available services. In 2014, the Rush Medical Clinic of Philadelphia gave flu shots and handed out brochures at the Casino at Choctaw, MS. In 2014 and 2015 Newton Family Medical Clinic had a Go Red day which included blood pressure checks and pamphlets regarding heart along with viewing a video from the American Heart Association. Staff from Family Medical Group of Union passed out brochures and did education on programs and services offered

CHNA STRATEGIC ACTION RESPONSES

by Laird Hospital and the rural health clinics to the Conehatta Community Club. In 2014, rural health clinic staff hosted Lunch and Learns with County Line Baptist Church, Union promoting the Medicare annual wellness programs, *A Journey to Healthy Living*, Tobacco Cessation program, Mammograms, C Scopes and other services; with First Baptist Church Senior Citizens, Union promoting diet, exercise, healthy eating and living, explanation of the swing bed program; and with First Baptist Church, Philadelphia promoting the Medicare Annual Wellness program. In 2015, Dr. Veronica Johnson participated in a Breast Cancer Awareness Brunch/Fund Raiser at Union Station in Meridian and passed out educational material. During 2016, Laird and Newton Family Medical Clinic staff participated in a Health and Safety event at Esco Corp. in Newton, MS featuring CPR and First Aid.

COLLABORATIVE PARTNERS:

In September 2016, Blue Cross Blue Shield started a new program called *Color Me Healthy* which is for chronic disease management including diabetes, obesity, and other high risk factors. Blue Cross pays 100% for 4 visits concerning these chronic conditions.

Context Media provided a free program to clinics to be able to have education through TV Screens in waiting areas and in exam rooms for education on disease processes. The clinics have focused on hypertension, obesity, diabetes, and tobacco cessation.

The Rush Medical Clinic of Philadelphia, Family Medical Clinic of Collinsville, and Decatur Family Medical Clinic were participating in a national Cosech project for hypertension reduction which addresses smoking cessation, weight loss and A1C.

All rural health clinics are now a part of systems spread with MSDH MSQ2 diabetes/hypertension program that monitors A1C, blood pressure, tobacco cessation, obesity, and community resources. Reporting for this program started in 2013 for one of the rural health systems' clinics with protocols being spread to the Laird rural health clinics. Reporting from Laird clinics did not begin until 2016; however, improvements were noted prior to reporting as a result of the implementation of the protocols.

During 2016, Laird rural health clinics began participation with ACO Rural Solutions for reporting access to Medicare Annual Wellness Visits, transitional care which improves continuity, Chronic Care Management which increased compliance and assisted with identification of additional community resources.

CHNA STRATEGIC ACTION RESPONSES

REDUCE OBESITY THROUGH EDUCATION

TARGET POPULATION:

Our target population for the obesity reduction program was all age groups in Newton County and our surrounding communities. Laird Hospital had programs in place in our rural health clinics in Union, Decatur, Newton, Collinsville, Philadelphia, and Meridian.

GOAL, DESIRED OUTCOME:

Our goal was to provide education to our patients and the public regarding a healthier lifestyle in regards to obesity.

PROCESS/TIME FRAME/LOCATION:

Our rural health clinic providers have always strongly encouraged annual wellness visits which would help identify any risk factors including obesity. During 2016, one of the initiatives set forth as a result of the partnership with the ACO was to educate all support staff and providers on the Medicare, Managed Care, and commercial insurance focus toward preventive medicine and self-management. Tools have been put into place to identify patients who have care gaps such as the need for annual wellness visits. Since we now have these tools, this program has been implemented into our other clinics. During 2016, the Family Medical Group of Union performed 79 Medicare annual wellness visits, Rush Medical Clinic of Philadelphia performed 29, Newton Family Medical Associates performed 11 and Decatur Family Medical performed 23. During the wellness visit the body mass index (BMI) was assessed, and if found to be abnormal, it was either addressed during the visit or the patient was brought back for the *A Journey to Healthy Living* program. During every clinic visit a BMI was performed in order to help identify those patients who are obese. A BMI over 30 would prompt obesity education. *A Journey to Healthy Living* was also offered which would be 22 visits of counseling over the course of a year to do one on one diet, exercise and healthy lifestyle education. During the visit the patient was weighed and coached according to results positive or negative to encourage them to continue weight loss. If the patients did not participate in *A Journey to Healthy Living* then the providers would educate during that visit and set goals with the patient. During 2014, Family Medical Group of Union had 5 patients participate in *A Journey to Healthy Living* with 22 visits. In 2016 they had 6 patients participate with 12 visits. *A Journey to Healthy Living* was also available in our clinics in Decatur, Newton, Collinsville, Philadelphia, and Meridian. Gayle Luke, our Registered Dietitian, was available to counsel the patient on diet and exercise and healthy lifestyle modification at no charge to the patient. She works out of the Philadelphia, Collinsville, Union and North Hills clinics. Decatur, Newton, and Family Medical in Meridian can send their patients to the nearest location. In the multiple locations, we are better able to accommodate our patients.

CHNA STRATEGIC ACTION RESPONSES

In addition to a concerted effort to address obesity with our adult population as noted above we utilized our well child visits to assess BMI and knowledge deficits for our children and adolescent population. During the course of the last three years our Family practice providers and Pediatric providers have performed not quite 6000 patient encounters to assess for obesity and education as appropriate.

CHNA STRATEGIC ACTION RESPONSES

TEEN PREGNANCY

TARGET POPULATION:

The target population for the teen pregnancy program began with preadolescence group in Newton County and our surrounding communities.

GOAL, DESIRED OUTCOME:

Our goal was to provide education, screening, support, and direction to other community resources and programs for reduction of teen pregnancy, infant mortality and earlier and improved prenatal care.

PROCESS/TIME FRAME/LOCATION:

Staff from Family Medical Group of Union participated with the Union Public School's health board in an advisory capacity. One of the measures approved by the health board was the abstinence only policy taught as a curriculum annually on the junior high level.

Through our well child visits our providers utilized adolescent counseling as an opportunity to have open discussion of abstinence or protected sexual activity with the teen. In 2014, Family Medical Clinic of Union had 5 patients participated in the adolescent counseling service. Decatur Family Medical Clinic had 1 participant in 2014, 47 in 2015 and 10 thus far in 2016. Newton Family Medical had 2 participants in 2016. Family Medical Clinic (Meridian) had 1 participant in 2015 and 4 in 2016.

Family Medical Clinic of Union, Rush Medical Clinic of Philadelphia, and Newton Family Medical participated in the midwifery program which increases improvement and compliance with prenatal care. By placing the midwives in our local clinics the teen was in a familiar environment reducing the anxiety of unfamiliarity and also reducing noncompliance of prenatal visits by alleviating travel obstacles. The midwives collaborated with the OB-GYN as well as the neonatologist and pediatricians through a shared electronic health record. All these helped to facilitate improved prenatal care as well as a reduced infant mortality. During 2014 Newton Family Medical Clinic saw one patient who had one visit. During 2015 Newton Family Medical Clinic saw 2 patients who had 3 visits, Family Medical Group of Union saw 1 patient with 1 visit. During 2016 Newton Family Medical Clinic saw 12 patients with 41 visits, Family Medical Group of Union saw 5 patients with 11 visits, Family Medical Clinic (Meridian) saw 1 patient with 10 visits, and Rush Medical Clinic of Philadelphia saw 5 patients with 18 visits. Our clinics continued to see increased compliance with prenatal care through the midwifery program in the rural health clinics as reflected in the numbers above. The midwife program as well as the rural health clinics participated with the March of Dimes.

CHNA STRATEGIC ACTION RESPONSES

TOBACCO USE

TARGET POPULATION:

The target population for the reduction of tobacco use was all age groups in Newton County and surrounding communities who use tobacco products or are exposed to tobacco use.

GOAL, DESIRED OUTCOME:

Our goal was for the clinics' and the hospital employees to identify the tobacco users and educate them on tobacco cessation. Through education of all age groups, regardless of tobacco status, we hoped to eventually have a tobacco free community.

PROCESS/TIME FRAME/LOCATION:

We worked with Union Public School during health fairs to help educate regarding the ill effects of tobacco use and tobacco cessation through hand outs and literature.

Through adolescent counseling 1605 adolescents were given this education during wellness visits in our clinics. In 2014 Decatur Family Medical Clinic counseled 166, Rush Medical Clinic of Philadelphia counseled 8 and Rush Medical Clinic of Collinsville counseled 2. In 2015 Decatur Family Medical Clinic counseled 217, Rush Medical Clinic of Philadelphia counseled 180, and Rush Medical Clinic of Collinsville counseled 90. In 2016 Decatur Family Medical Group counseled 190, Rush Medical Clinic of Philadelphia counseled 657, and Rush Medical Clinic of Collinsville counseled 95.

As part of the admission to the hospital, patients were screened concerning tobacco use, and if positive, they were given educational materials regarding Tobacco Cessation programs. The number of patients reached through the hospital was 252 in 2014, 137 in 2015 and 115 thus far in 2016.

As part of the clinic triage process every patient was screened for tobacco use after the age of 13. If positive, the patient was given educational materials regarding Tobacco Cessation programs.

As part of participation with Blue Cross Blue Shield of MS we have certified multiple providers in our clinics to do Blue Cross Blue Shield tobacco cessation. All of our campuses are tobacco free. Through Medicare during an annual wellness visit patients identified as a tobacco user can be referred to our providers for 8 covered tobacco cessation visits with no co-pay.

RESPONDING TO THE COMMUNITY

CLOSING THE GAP

The information gathered from the community was very uniform and was also consistent with the quantitative data. The most common needs mentioned by the community members were related to chronic diseases, health education, lifestyle improvement and access to emergency care.

Hypertension, heart disease, diabetes, weight loss/obesity and nutrition were all health needs identified by both the community members and health care professionals. Community members saw a need for increased education and preventive care in order to eliminate the path to chronic disease. Prevention is very cost effective compared to the catastrophic treatment needed when a chronic disease is unmanaged and leads to major health problems. Education related to nutrition was emphasized because of the link between obesity and so many chronic health conditions. Other community health needs that were expressed included a need for increased health literacy, and decreased health disparities among socioeconomic and racial groups.

PRIORITIZATION

The Steering Committee understood the facts the primary and secondary data communicated in reference to the health of the citizens of primarily Newton County:

- The County exceeds the State and U.S. in rate of deaths from heart disease.
- The County exceeds U.S. in rate of deaths from cancer but not the State.
- The County exceeds the State and U.S. in rate of deaths from stroke.
- The County exceeds the State and U.S. in rate of deaths from accidents.

A critical access hospital cannot provide the same level of care in the treatment of chronic disease as a hospital tertiary center. The critical access hospital can, however, work with acute care hospitals to assist patients in their access to an appropriate care center. The local hospital can provide emergency care and arrange expedited transportation to nearby tertiary facilities.

The critical access hospital can be the catalyst for community health education, prevention, and enhancement of community wellness activities. The local hospital can be invaluable in providing a community with the health resources for making wiser health and lifestyle decisions, thus being a major player in disease prevention.

In order to prioritize the identified needs that the hospital would use when creating strategies to close the gap, the Steering Committee compiled, read and analyzed all findings and data for needs and recurring themes within the identified needs.

RESPONDING TO THE COMMUNITY

- Reference was made to the content of the community input and the identified needs from those sources.
- Comparisons were made between the primary and secondary data and then compared to what was the common knowledge and experience of the clinical staff of the hospital.
- Based on what resources could be made available and what initiatives could have the most immediate and significant impact, the strategic initiatives were developed.

Implementation strategies that will address three major health issues were developed. The strategies will seek to leverage valuable partnerships that currently exist and to identify opportunities for synergy within the community. The outcomes and results of these interventions will be followed and reexamined in preparation for the next CHNA.

CARING FOR THE COMMUNITY

CARING FOR THE HEART OF THE COMMUNITY: In responding to the need for expert response to serious cardiac episodes, Rush participates in the STEMI (ST-Elevation Myocardial Infarction) program for early identification of Myocardial Infarctions. Rush Foundation Hospital and all 5 of its Critical Access Hospitals were recognized nationally for the quality of their cardiac response program.

Laird Hospital participates in this program by carefully following the protocol established by the American Heart Association and implemented by the skilled clinical staff at Rush. The 90-minute time frame guides the care of the cardiac patient as it provides prompt, seamless and effective treatment. The patient is quickly evaluated and, when necessary, transported quickly and professionally to a tertiary care center for possible intervention. By working together, the barriers that stand between STEMI patients and prompt appropriate care are being removed.

SPECIAL NEEDS OF THE SENIOR POPULATION: Laird Hospital provides community–based outpatient psychiatric care through the Senior Care Intensive Outpatient Therapy Program for senior adults, age 55 and older who suffer from depression anxiety and grief. The program does not require a physician referral for participation and also offers free transportation for participants who have that need.

IMPLEMENTATION PLANS

To be successful in creating a true sense of health in our community, it will be necessary to have collaborative partnerships which will bring together all of the care providers, the citizens, governments, plus business and industry, around an effective plan. Many needs have been identified through this process. Laird Hospital is proud to have been the catalyst in this effort. However, addressing some of the needs identified will require expertise and financial resources far beyond what a critical access hospital can provide.

RESPONDING TO THE COMMUNITY

The hospital is aware of many lifestyle issues that face citizens of a rural southern state. Many of the lifestyle habits negatively impact the overall health of our community and are major contributors to several of the leading causes of death in our county. Laird Hospital has identified three significant initiatives it will undertake over the next three years. These collaborative projects should help improve the health and overall quality of life in our community. Each project is described in another section of this report.

There are other health and wellness opportunities identified during the research portion of the CHNA. These possibilities will be considered as we develop our strategic action plans over the next three years.

HEALTH AND WELLNESS INITIATIVES

Over the next three years, Laird Hospital, in concert with its many community partners will focus its energy in these six areas:

- Health Education
  - For the community
    - Partner with schools, churches, local health agencies
  - For hospital patients
  - For clinic patients
    - Focus on lifestyle and disease
    - Major focus on diabetes

- Focus on Obesity
  - Education
  - Emphasis on young people
  - Nutrition awareness
  - Physical activity awareness

- Tobacco Use and Disease
  - Community Education
    - Smoking cessation programs
    - Tobacco use education

- Teen Pregnancy

- Personal Responsibility for Better Health
  - Educate the community about “Owning Ones Good Health”
  - Collaborate with community agencies
  - Find ways to empower individuals
  - Continue periodic dialogue with community leaders regarding population health

- Accident Prevention
  - Education and Awareness Activities
    - Motor vehicle accidents
    - Falls

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