

Laird Hospital

CHNA Report

November 2019

Approved by
The Board of Directors of Laird Hospital
November 8, 2019



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EXECUTIVE SUMMARY

The purpose of this Community Health Needs Assessment (CHNA) report is to provide Laird Hospital (LH) 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's 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 October 2019.

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 and paid public notice. Additional information came from public databases, reports, and publications by state and national agencies.

The implementation describes the programs and activities that will address these health priorities over the next three years. The CHNA report is available on the hospital's website www.rushhealthsystems.org or a printed copy may be obtained from the hospital's administrative office.

We sincerely thank those who provided input for this assessment. We look forward to working closely with our community to help improve the overall health of those we serve.

Thomas Bartlett, FACHE, Administrator
Laird Hospital

ABOUT THE HOSPITAL

LAIRD 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. In 2017 an outpatient wound care clinic was added to provide residents in this area specialized wound care in the local setting. In late 2017, we also started outpatient Pulmonary Rehab. In 2019 outpatient echo, cardiac nuclear stress testing, and Better Breathers Club was added.

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

A 24-hour emergency department is staffed with qualified emergency room hospitalists and family nurse practitioners 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 fracture or an extended medical illness and hospitalization can choose to rehabilitate at Laird Hospital, whether or not they were hospitalized in another location. In 2017, Laird Hospital also began a Chronic Vent Program which is designed to help wean patients off the ventilator and remove trachs when possible before discharge to home. The program also focuses on building strength, endurance and helping with dietary needs.

The hospital is a trusted member of 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 (CHNA) defines opportunities for healthcare 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 healthcare providers build stronger relationships with their communities, identify needs, and dedicate funding and other resources toward programs that clearly benefit local residents.

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 2016. Hopefully, you will find ways you can personally improve your own health and contribute to creating a healthier community.

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: collected by the assessment team directly from the community through conversations, telephone interviews, focus groups and community forums; the most current information available.

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

Secondary Data Sources

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

ABOUT THE COMMUNITY

DEMOGRAPHICS

SERVICE AREA

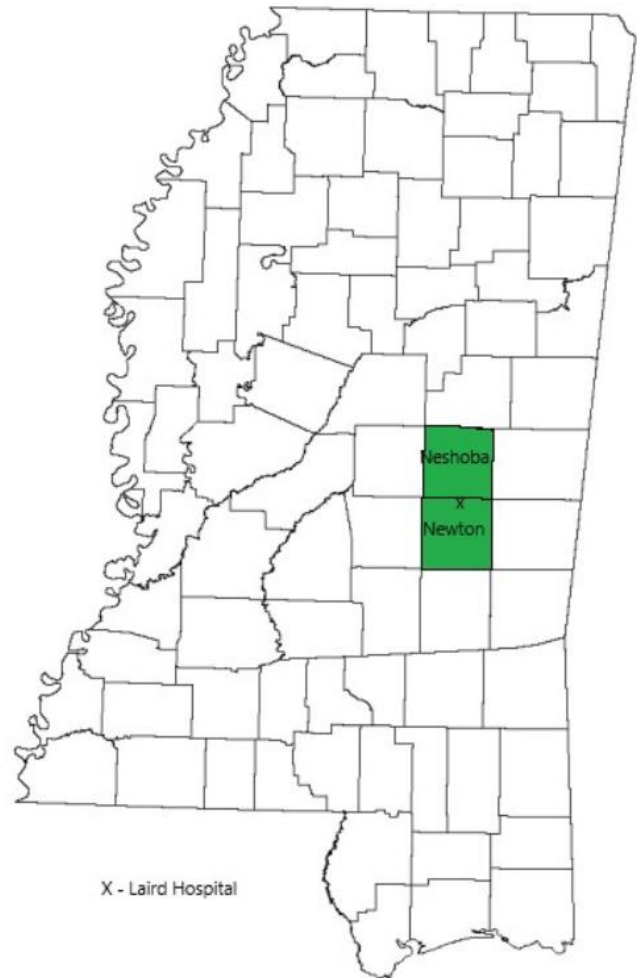
Primary: Newton County and Southern Neshoba County

ABOUT THE SERVICE AREA

Newton County is a county located in east central Mississippi. The county was founded in 1836 and named after the famous scientist and philosopher “Sir Issac Newton”. The county seat is Decatur. According to the U.S. Census Bureau, the county has a total area of 580 square miles, of which 578.5 square miles (99.65%) is land and 1.5 square miles (0.35%) is water. *

PATIENT ORIGIN

Laird Hospital is in the town of Union which is situated on the county line of Newton and Neshoba County. As a result, the hospital serves all of Newton County and portions of southern Neshoba County. Of these two populations, approximately 61.2% of Medicare inpatients seen over the past twelve months reside in Newton County, Mississippi while 27.2% of them resided in Neshoba County, Mississippi totaling 88.4% of Medicare Inpatients. Almost 40% of those patients in Newton and Neshoba County (88.4% of the total Medicare inpatients seen last year) reside in Union. An additional 13.5% & 12.4% of total Medicare inpatients seen reside in the towns of Newton & Decatur also located in Newton County. Of the remaining patient population, 7.7% resided in Philadelphia located in Neshoba County, MS while 6.5% resided in adjacent Jasper County, MS. The remaining population represents a variety of locations mostly outside of the primary service area.



*NEWTON COUNTY, MISSISSIPPI (2017 Census Publications State and County Profiles Mississippi.USDA Census of Agriculture, 2017).

POPULATION AND RACIAL MIX DATA*

NEWTON COUNTY		
Population	21,437	
Racial Mix	White	13,181
	African American	6,426
	American Indian	1,088
	Hispanic	387
	Other	355
Median Household Income	\$37,643	

NESHOPA COUNTY		
Population	29,437	
Racial Mix	White	17,324
	African American	6,146
	American Indian	4,635
	Hispanic	573
	Other	759
Median Household Income	\$36,755	

* Sources: U.S. Census Bureau, 2017 estimates and U.S. Census Bureau, 2013-2017 American Community Survey

COMMUNITY INPUT

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.

A community survey was developed by the hospital. Members of the general public were encouraged to participate in the following online survey. The data collected from the survey was part of the input used by the Steering Committee in establishing priorities.



Community Health Needs Assessment - Laird Hospital

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 this survey. Thanks 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 Newton or Neshoba County that you are aware of?

6. Have you participated in any of Laird Hospital's wellness events (in-services, health fairs, lunch & learns, etc.)?

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

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.



HOSPITAL STEERING COMMITTEE

Tommy Bartlett – FACHE, Hospital Administrator

Cindy Beckham – Utilization Review / Compliance Manager / Patient Advocate

James Bradshaw, DO – Decatur Family Medical Group

Matt Edwards, RN, MSN – Director of Nurses / Risk Manager

Brandi Keith – FNP-BC, Nursing Instructor/Educator East Central Community College

Casey Mars – Director of Laboratory Services / Infection Preventionist

Tammy Miller – Health Information Management Director / Business Office Manager

Connie Moore RN, BSN – Emergency Department

COMMUNITY FOCUS GROUP

A community focus group was held at Laird Hospital on Monday, October 28, 2019. 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 healthcare consultants 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.

PARTICIPANTS IN THE COMMUNITY FORUM

Romonica Evans – Alderwoman Newton, MS
Rita Jackson – Hickory, MS Laird Board Member
Angie Jay – Rush Medical Clinic, Philadelphia
Brandi Keith – FNP-BC, Nursing Instructor/Educator East Central Community College
David Marshall – Mayor of Decatur
Tim Munn – Union Police Department
Tesa Quinn – Quinn’s Family Pharmacy, Union
Wayne Welch – Mayor of Union
Lori Wilcher – Union Public Schools
Derrick Mason – Consultant, HORNE LLP
Barry Plunkett – Consultant, HORNE LLP

INVITED BUT UNABLE TO ATTEND

The hospital made a deliberate effort to include in the Community Focus Group a diverse cross section of the community served. Those who were unable to attend the meeting on October 28, were made aware of the purpose of the gathering and the importance of the input from the businesses, civic groups, or population segments they represent. Open dialogue remains fluid with the hospital’s administration and the Focus Group members.

Lundy Brantley – Neshoba Central School
Tyler Hansford – Union Public Schools
Adam Mars – Community member, Philadelphia
Brother Jon Martin – First Baptist Church, Union
Brother Chris Shelton – Presbyterian Church, Union
Billy Pat Walker – Union Police Department
Jessie Walsh – Mayor of Hickory
Murray Weems – Mayor of Newton

RURAL HEALTH DISPARITIES

Rural Americans are a population group that experiences significant health disparities. Health disparities are differences in health status when compared to the population overall, often characterized by indicators such as higher incidence of disease and/or disability, increased mortality rates, lower life expectancies, and higher rates of pain and suffering. Rural risk factors for health disparities include geographic isolation, lower socioeconomic status, higher rates of health risk behaviors, limited access to healthcare specialists and subspecialists, and limited job opportunities. This inequality is intensified as rural residents are less likely to have employer-provided health insurance coverage, and if they are poor, often are not covered by Medicaid.

Federal and state agencies, membership organizations, and foundations are working to reduce these disparities and improve the health and overall well-being of rural Americans. Some organizations provide funding, information, and technical assistance to be used at the state, regional, and local level, while others work with policymakers to help them understand the issues affecting population health and healthcare in rural America.

WHAT ARE THE CAUSES OF RURAL HEALTH DISPARITIES?

The origins of health disparities in rural America are numerous and vary by region. Some frequently cited factors underlying rural health disparities include healthcare access, socioeconomic status, health-related behaviors, and chronic conditions.

ACCESS TO HEALTHCARE

Rural populations can experience many barriers to healthcare access, which can contribute to health disparities. A 2019 *JAMA Internal Medicine* article, "Association of Primary Care Physician Supply with Population Mortality in the United States, 2005-2015," found lower mortality was associated with an increase of 10 primary care physicians per 100,000 population. The following factors create challenges or barriers to accessing healthcare services for rural Americans:

- There are higher rates of uninsured individuals residing in rural or nonmetro counties compared to their counterparts in urban or metro counties, as reported by a 2018 CDC report "Health, United States, 2017: With Special Feature on Mortality."
- Healthcare workforce shortages are prevalent throughout rural America. The 2014 National Center for Health Workforce Analysis report, "Distribution of U.S. Health Care Providers Residing in Rural and Urban Areas," found a greater representation of workers with less education and training living in rural areas and highlights data showing less than 8% of all physicians and surgeons choose to practice in rural settings.
- Specialty and subspecialty healthcare services are less likely to be available in rural areas and are less likely to include specialized and highly sophisticated or high-intensity care. This exacerbates problems for rural patients seeking specialized care who are faced with traveling significant distances for treatment.
- Reliable transportation to care can also be a barrier for rural residents due to long distances, poor road conditions, and the limited availability of public transportation options in rural areas. For more information on rural transportation programs and the impact on health of not having transport available in rural communities, see RHIhub's Transportation to Support Rural Healthcare topic guide.

- For additional information regarding healthcare access in rural areas and other barriers rural populations face related to access to care, see RHIhub's "Healthcare Access in Rural Communities" topic guide."

SOCIOECONOMIC STATUS

According to a 2014 Kaiser Commission on Medicaid and the Uninsured issue brief, "The Affordable Care Act and Insurance Coverage in Rural Areas," rural populations have higher rates of low to moderate income, are less likely to have employer-sponsored health insurance coverage and are more likely to be a beneficiary of Medicaid or another form of public health insurance. The brief found that rural residents are more likely to be unemployed, have less post-secondary education, and have lower median household incomes compared to urban residents.

HEALTH BEHAVIORS

Whether or not populations adopt positive health behaviors can have an impact on the rates of disparities in their health status and mortality. A 2017 CDC MMWR, "Health-Related Behaviors by Urban-Rural County Classification — United States, 2013," examined the prevalence of 5 key health-related behaviors by urban-rural status. Urban residents were more likely to report 4 or 5 of the positive health behaviors.

With all-cause mortality rates higher in rural areas, it is no surprise that mortality related to certain causes are also higher in rural areas. The table below compares several cause-specific mortality rates for rural and urban counties.

**Age-Adjusted Death Rates for the Five Leading Causes of Death per 100,000
Population: United States, 2014**

Cause of Death	Nonmetro Areas	Metro Areas
Heart Disease	193.5	161.7
Cancer	176.2	158.3
Unintentional injury	54.3	38.2
Chronic lower respiratory disease	54.3	38.0
Stroke	41.5	35.4

Source: Leading Causes of Death in Nonmetropolitan and Metropolitan Areas — United States, 1999–2014, [Supplemental Tables](#), *Morbidity and Mortality Weekly Report*, 66(1), 1-8, January 2017

THE UNHEALTHIEST STATE IN THE UNITED STATES

A list of the top ten unhealthiest states was created. It is based on data compiled by the American Public Health Association and the United Health Foundation, which rank U.S. states on their per-capita rates of obesity, child poverty, smoking, cancer-related deaths, cardiovascular disease, and other risk factors.

MISSISSIPPI IS NUMBER ONE

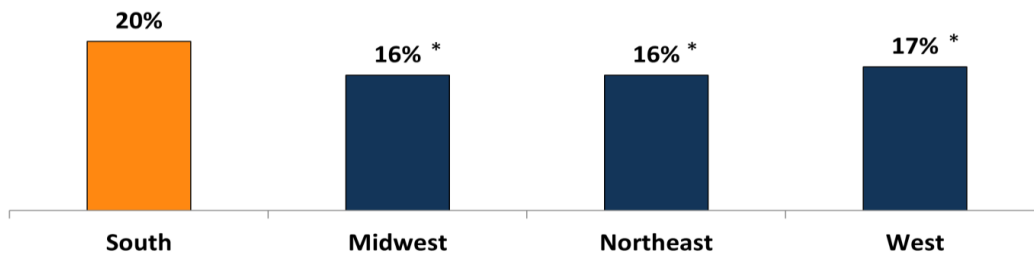
Unfortunately, that is not a ranking that we as a state can be proud. Along with having among the highest rates of cardiovascular disease, smoking, and obesity in America, the Magnolia State unfortunately touts the nation's largest percentage (25 percent) of youths living in poverty. All of these factors combined to put Mississippi at the number-one spot fighting an uphill battle against obesity, cancer, and cardiovascular-related deaths.

Being aware of this lifestyle disparity, the Steering Committee was diligent in addressing these chronic illnesses which lead to a disproportionate number of deaths. Also, the quality of life in our state is negatively impacted by these conditions that rob our citizens of the ability to enjoy good health daily.



Figure 4

Percent of Adults Reporting Fair or Poor Health Status by Region, 2014



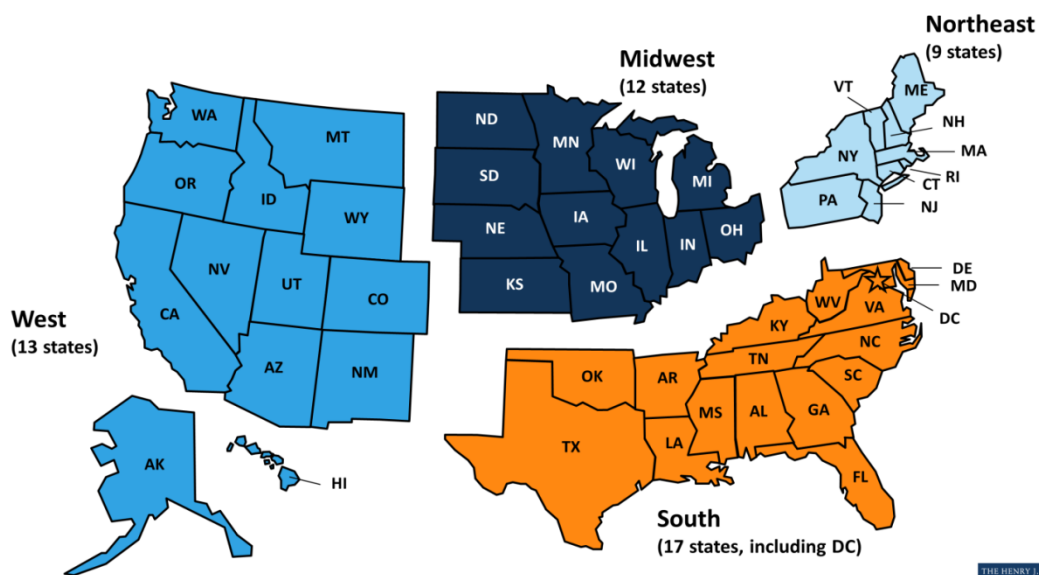
* Indicates a statistically significant difference from the South at $p < .05$ level.

Source: KCMU analysis of the Centers for Disease Control and Prevention (CDC)'s Behavioral Risk Factor Surveillance System (BRFSS) 2014 Survey Results.



Figure 1

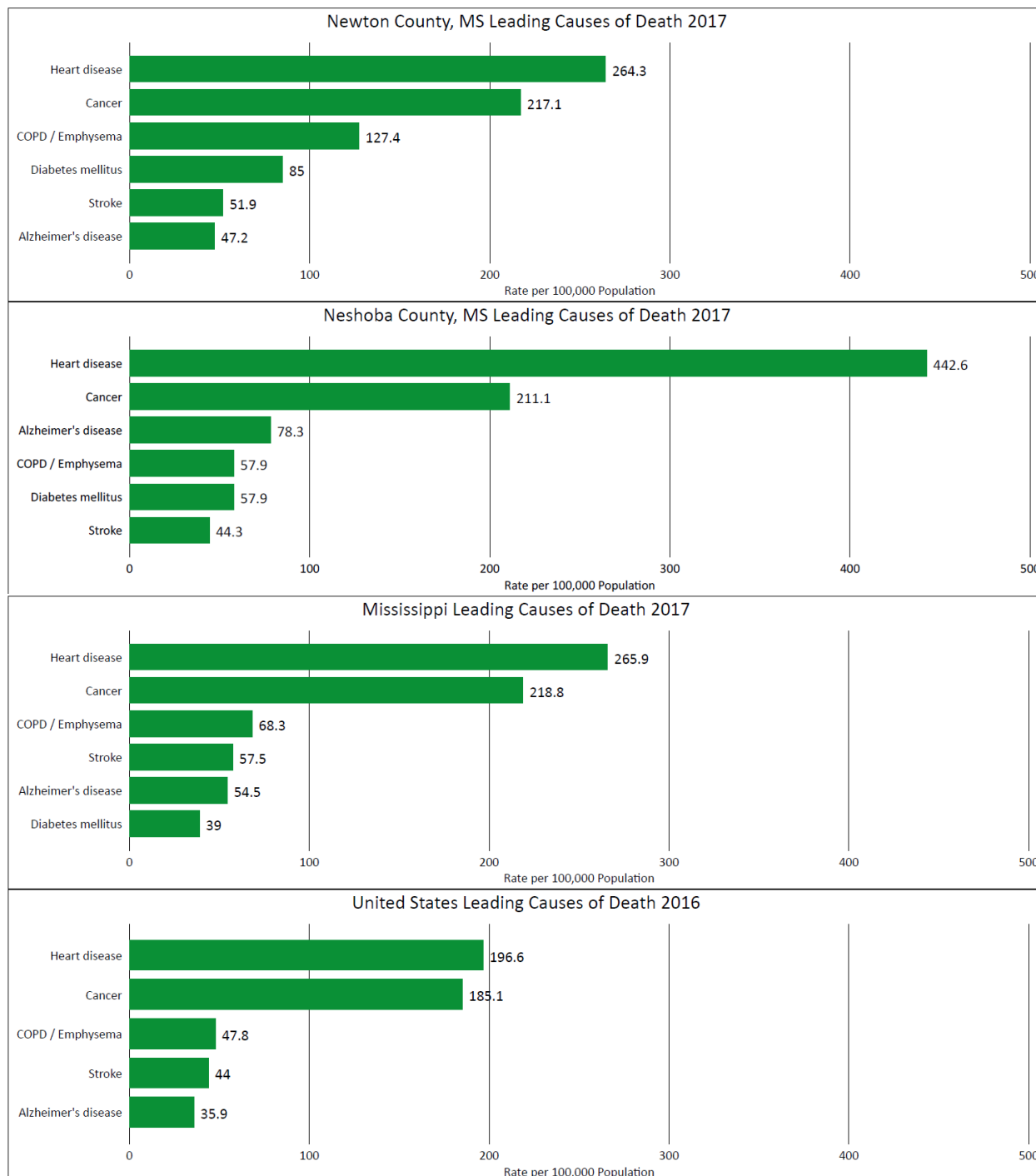
Census Regions and Divisions of the United States



Source: http://www2.census.gov/geo/pdfs/maps-data/maps/reference/us_regdiv.pdf

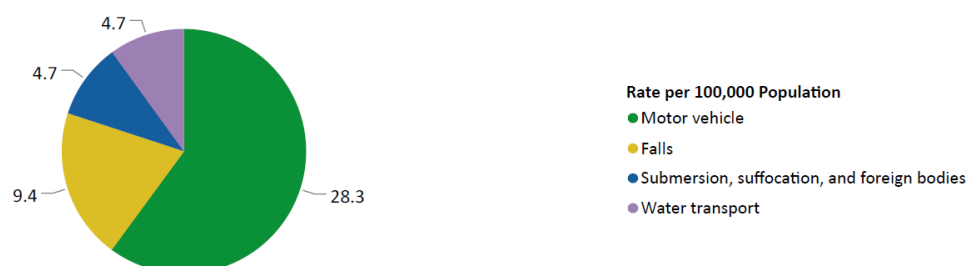


CAUSES OF DEATH



ACCIDENTAL DEATHS

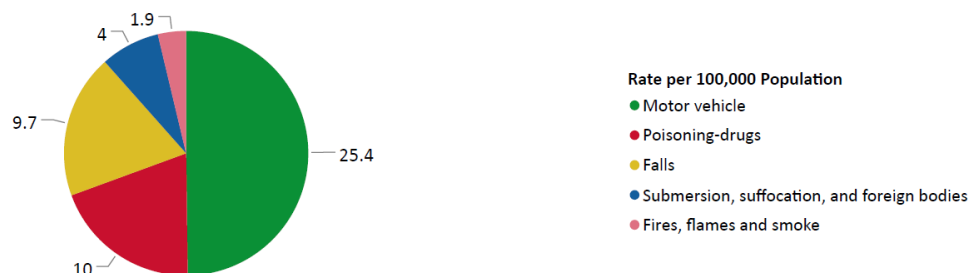
Newton County, MS Top Accidental Deaths 2017



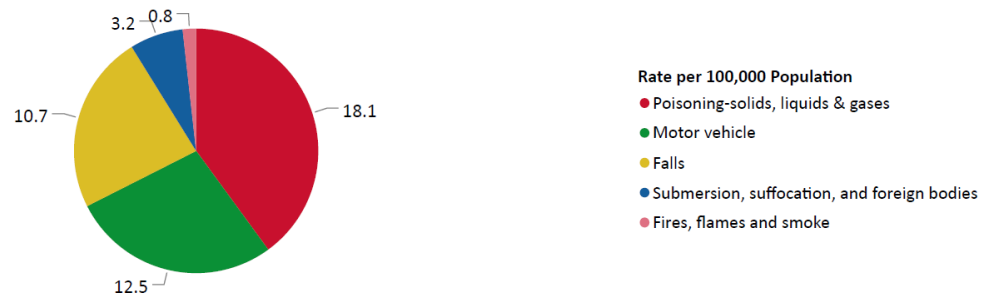
Neshoba County, MS Top Accidental Deaths 2017



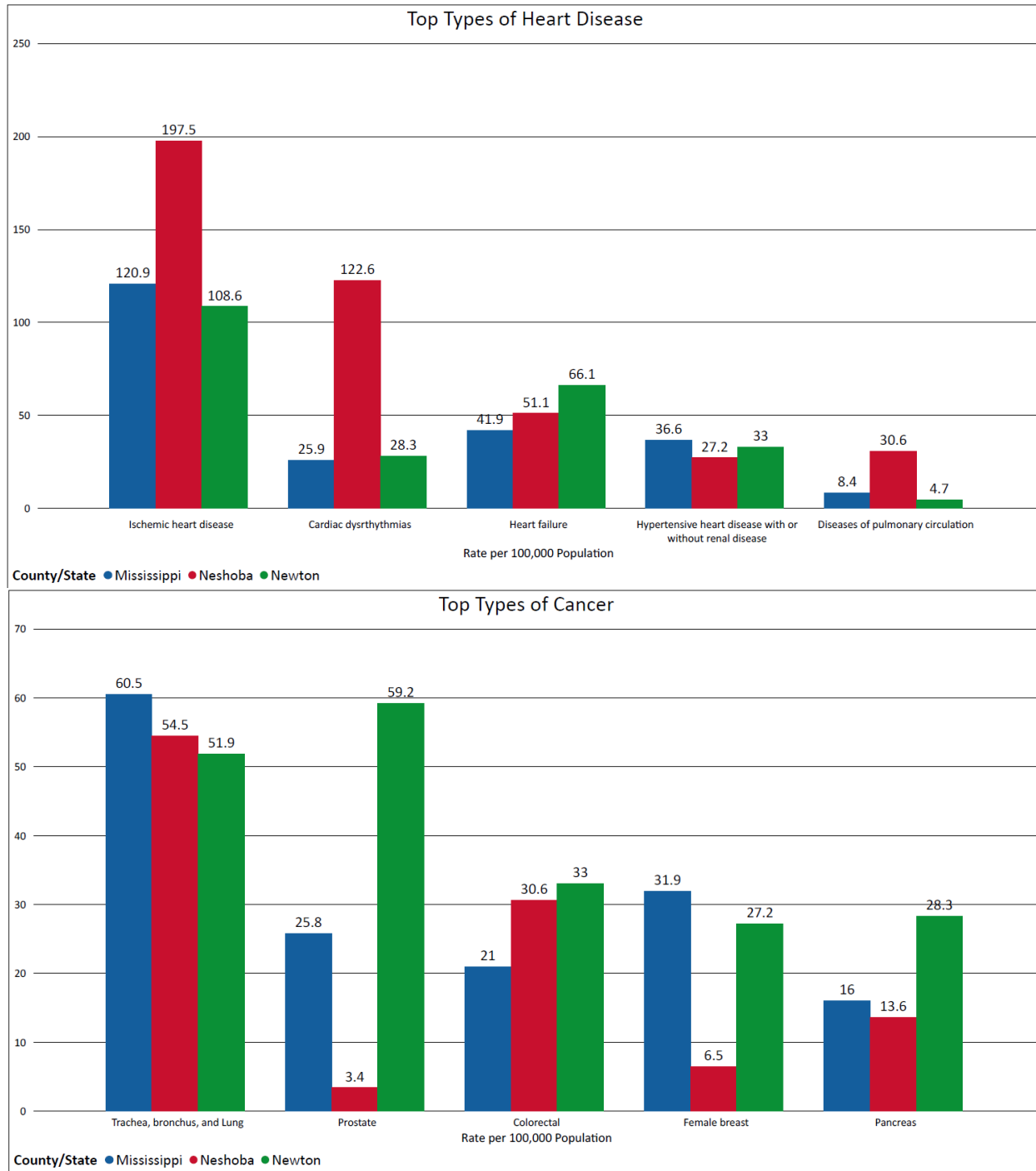
Mississippi Top 5 Accidental Deaths 2017



United States Top 5 Accidental Deaths 2016



HEART AND CANCER STATISTICS



2016 CHNA STRATEGIC ACTION RESPONSES

INITIATIVE 1: STRENGTHEN HEALTH EDUCATION AND MANAGEMENT PROGRAMS

1. STRENGTHEN HEALTH EDUCATION AND KNOWLEDGE OF AVAILABLE HEALTH SERVICES

Target Population

The target population to help strengthen knowledge of available health services is all citizens in Newton County and our surrounding communities with a focus on the elderly and low-income groups. We have programs in place at Laird Hospital and in our rural health clinics in Union, Decatur, Collinsville, Philadelphia and Meridian.

Goal, Desired Outcome

Our goal is to provide education to our patients and the public concerning health services that are available to them through different resources so that they 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 participated in Health Fairs at Union Public Schools in 2017, 2018, and 2019 with emphasis on exercise and making good nutritional choices. The swing bed coordinator at Laird Hospital continues to attend the bimonthly Bone and Joint Class at Rush Hospital to help educate the elderly population about resources available to them following joint replacements. In 2017 Laird Hospital began a chronic vent program which expanded in 2018 to be able to care for more chronic vent patients. Staff has and continues to market throughout the state of MS to make the public aware of the chronic vent program offered at Laird and the benefits of those in need of vent weaning and trach removal. Laird hosts a community blood drive quarterly. In 2018 MORA provided education on organ donation awareness and the community was invited. In 2018 hospital, clinic and sleep clinic employees participated in Union Day to educate the public on services provided by Laird with emphasis on the sleep disorder clinic which is available at Laird every Friday and at the Rush Clinic in Philadelphia every Wednesday with OP sleep studies available at both locations. Both hospital and clinic employees also participated in Union Day this year handing out information regarding services available at Laird Hospital. Laird Hospital participated in a back to school bash at Whitestone Baptist Church in Lawrence, MS on July 20, 2019, educating the children on healthy food choices. Approximately 150-200 children and parents were present for this event.



Health Fairs and Job Fairs

Health service information has been passed out at various health fairs and job fairs including: 2017, 2018, and 2019 East Central Community College Business, Education, and Healthcare Expo. 2017 Social Work Resource Education Fair at UMMC. In 2018 Laird employees attended a job fair with the MS Band of Choctaw Indians. In 2017 Rush Medical Clinic of Philadelphia participated in the Pearl River Resort Employee Health Fair. January through May 2017 Family Medical Group of Decatur



participated with ECCC for Warrior Wellness checking Cholesterol and Glucose. In November 2018 Laird employees participated in the MDOT health fair. In 2019 Rush Medical Clinic of Philadelphia participated in the MCC Job Fair.

Education Courses

In 2017, The Rush Medical Clinic on Highway 19, Meridian provided education on three different occasions to Hope Village. In February a Healthy Heart Workshop, in August back to school/ healthy sleep habits, and in September healthy eating, dealing with stress, changes of the body that occur during puberty.

Union Public Schools- School Health Committee

In 2017, Family Medical Group of Union staff members met with the Union Public Schools- School Health Committee four times on tobacco, teen pregnancy, obesity, exercise and lifestyle habits implementation into the school curriculum.

Present-Day Club

In 2019, Glenda Barrett, FNP of Family Medical Group of Union spoke to the Present-Day Club regarding wellness visits, heart health for women and Color Me Healthy.

Free Vein Screenings

In 2019, Dr. Farrar performed free vein screenings at the Rush Medical Clinic in Philadelphia.

Educating Students

Union Public Schools and Newton County Schools Allied Health Department brings students to the hospital weekly during the school year so that those students can shadow our employees rotating through the different departments. East Central Community College does clinical rotations at Laird. The DON at Laird goes to the nursing school at ECCC for orientation with new students and then again at 4th semester to let them know about job openings. Sharon Turcotte is a preceptor for the Masters Program affiliated with the University of Southern and the University of South Alabama at Mobile. All the Laird Clinic nurse practitioners serve as preceptors for students. In 2018, ECCC initiated a pilot phlebotomy class with Rush Medical Clinic of Philadelphia lab employees instructing the class. Ten students participated in both the pilot program and the spring class of 2019.

Collaboration

Norvatis Diabetic Education Newton and Decatur Clinics – Because we do not have a diabetic educator in these areas available in 2017-2018.

All rural clinics are now a part of systems spread with the MSDH MSQ2 diabetes/hypertension program that monitors A1C, blood pressure, tobacco cessation, obesity, and community resources. Reporting for this project started in 2013 for one of the systems' rural clinics with protocols being spread to our Laird clinics. Reporting from Laird clinics did not begin until 2016 however improvements were noted prior to reporting as a result of the implementation on the protocols. This continued in 2017 and 2018.

Wellcare and Humana – Diabetes and BMI Wellcare and Humana notifies clinics of patients at high risk (care gaps) will pay 100% for preventive visits.



2. DEVELOP EFFECTIVE CHRONIC DISEASE MANAGEMENT PROGRAMS FOR PEOPLE WITH DIABETES

Target Population

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

Goal, Desired Outcome

Our main goal is 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 is to identify at risk individuals and educate them on prevention

During the rural health clinic annual wellness visit if patients are not diabetic or they are pre-diabetic they are identified and referred for diabetes screening. When the patient's results are reviewed by the provider and patient is identified as diabetic or pre-diabetic they are referred for the appropriate counseling and education either to Laird's Outpatient Diabetic Education Program or to one of our outlying clinics as per patient's request. Patients who are identified during hospital or emergency room admissions with uncontrolled diabetes will be referred to the primary care provider for further evaluation and treatment.

Laird Hospital provides an outpatient diabetic education program free of charge to patients who are referred. The program is divided into 3 visits with a registered dietician. The first visit is “What is Diabetes” and a healthy meal planning guide which includes diet, nutrition, portion sizes, and counting carbohydrates. The second visit is “What is Exercise the Importance of Physical Activity.” This visit includes education regarding monitoring blood sugars via accucheck and explains about the different medications and exercise. The third visit is “Risk Factors Associated with Diabetes and Coping with Diabetes”. This visit includes education regarding the complications from diabetes including neuropathy and retinopathy, etc. Once the patient completes all 3 classes the dietician contacts them at 6 months from their last class and at a year. At the follow ups the dietician calls the clinic to get current labs and follows up with the patient to see if they need more education. After the year follow up the dietician does not do any further education with the patient unless they are referred again.

The Laird outpatient diabetic program, in 2017, received three referrals with two completing all three classes and one completing only one class. In 2018, there were seven referrals with one completing all three classes and the other six are still enrolled but have not come for any more visits. In 2019, there have been four referrals with three completing all three classes and one is still enrolled but has not started yet.

We have a Registered Dietician who is also a Certified Diabetic Educator (CDE) 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. In 2019, the CDE performed 345 diabetic coaching visits in our rural health clinics.

Medicare Chronic Care Management Services was a new service added in 2017. This service is offered to our Medicare population with two or more chronic conditions to help reduce exacerbations of disease processes, unnecessary emergency room and hospital admissions and readmissions and increase compliance with medication and treatment plans during this service. The program continues to grow and facilitate the continuity of care of our patients.

During this time period, we have added A1c machines in our clinics. This allows the provider the ability to address results and treatment plans during the time of the face to face visit. Through all the above we are seeing better control of the A1c results and patient compliance.

Our health care system has now become a Blue Model Home offering chronic care management of diabetes, hypertension, and lipid disorders through the Color Me Healthy Program in collaboration with Blue Cross Blue Shield of MS. Through this program, patient’s lives are attributed to our different providers. We receive reports to identify wellness visits eligible as well as chronic disease care gap opportunities. The patients are scheduled for wellness visits and wellness plan and biometrics are entered into a Blue Cross web interface which identifies the patients as being eligible for additional lab services and office visits related to abnormal findings. Our Population Health team members then make arrangements with the patient and the providers for these services to be rendered. We receive quarterly reports on our progress and these reports are compared to local and regional results from other facilities. Blue Cross has taken our process and is sharing it with other facilities because of the results that we have achieved across our health system and the process was piloted in the Laird facilities.

INITIATIVE 2: REDUCE OBESITY THROUGH EDUCATION

TARGET POPULATION

The target population for the obesity reduction program is all age groups in Newton County and our surrounding communities. We have programs in place in our rural health clinics in Union, Decatur, Collinsville, Philadelphia, and Meridian.

GOAL, DESIRED OUTCOME

Our goal is to provide education to our patients and the public regarding a healthier lifestyle in regard 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. As mentioned in the previous CHNA report in 2016 one of the initiatives which was 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. Dr. Duggan the medical director for the ACO and the ACO staff continue to provide reports and education as resources to the providers and staff to continue in this effort. Tools have been put into place to identify patients who have care gaps such as the need for annual wellness visits, abnormal BMI's and other comorbid diseases associated with obesity. As a result of these processes being put into place we are seeing an overall improvement in identifying obesity and the treatment thereof. Please see the table below for preventive encounters where obesity is screened and addressed as appropriate:

Years	2017	2018	2019
12-17	678	790	911
18-34	208	287	528
35-39	81	119	200
40-49	207	287	452
50 and above	914	1251	1690

The 50 and above numbers in the previous chart were further broken down to reflect the actual number of Medicare recipients who received tobacco screening and counseling as appropriate. (The numbers below are included in the original chart above in the 50 and above row.) Through Medicare during an annual wellness visit patients who are identified as having an abnormal high BMI will receive education and can be referred to our Journey to Healthy Living visits which consist of 22 counseling visits to address obesity and lifestyle. This process is identified, and referrals are made during the annual wellness visit.

Years	2017	2018	2019
Medicare Annual Wellness Visit	441	633	814

Gayle Luke our Registered Dietitian is 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 and Family Medical in Meridian and Central Clinic can send their patients to the nearest location. In the multiple locations we are better able to accommodate our patients.

In November of 2019 our Family Medical Clinic of Meridian will add in partnership with Blue Cross Blue Shield a new service utilizing a Blue Cross life coach employee to do counseling and education with identified Blue Cross at-risk patients.

In addition to a concerted effort to address obesity with our adult population as noted above we are utilizing our well child visits to assess BMI and knowledge deficits for our children and adolescent population. During the last three years our Family Practice providers and Pediatric providers have performed approximately 8000 well child encounters and have assessed for obesity during those visits with education and counseling as appropriate.

INITIATIVE 3: REDUCE TOBACCO USE THROUGH SMOKING CESSATION PROGRAMS

TARGET POPULATION

The target population for the reduction of tobacco use is all age groups in Newton county and surrounding communities who use tobacco products or are exposed to tobacco use. We have programs in place in our rural health clinics in Union, Decatur, Collinsville, Philadelphia, and Meridian as well as Laird Hospital.

GOAL, DESIRED OUTCOME

Our goal is to provide education and resources to the community to encourage young people to never start smoking and smokers to quit. The ultimate goal is to have a smoke free community.

PROCESS/ TIME/ LOCATION

Through our rural health clinics tobacco screening and counseling is being completed as part of preventive counseling visits per best practice guidelines. As shown in the table below:

Years	2017	2018	2019
12-17	678	790	911
18-34	208	287	528
35-39	81	119	200
40-49	207	287	452
50 and above	914	1251	1690

The 50 and above numbers in the previous chart were further broken down to reflect the actual number of Medicare recipients who received tobacco screening and counseling as appropriate. (The numbers below are included in the original chart above in the 50 and above row.) 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. This process is identified, and referrals are made during the annual AWV.

Years	2017	2018	2019
Medicare Annual Wellness Visit	441	633	814

As part of the clinic triage process every patient is screened for tobacco use after the age of 13. If positive, the patient is offered education regarding Tobacco Cessation. Patients younger than 12 are screened for household member tobacco use and education is given as appropriate. As part of the triage process and screening vaping is addressed as well. To help with tobacco cessation, LH has multiple certified providers in clinics to carry out Blue Cross Blue Shield tobacco cessation. Blue Cross Blue Shield of MS offers a tobacco free program which covers medication and office visit for counseling. This has allowed for increase in compliance with their members.

As part of the admission to the hospital patients are screened concerning tobacco use and if positive are given educational materials regarding Tobacco Cessation programs. 90 patients were given smoking cessation education in 2017, 64 in 2018 and 47 in 2019. Patients are also given education regarding smoking cessation as applicable through the outpatient wound care clinic. Lastly, All of our campuses are tobacco free.

INITIATIVE 4: TEEN PREGNANCY

TARGET POPULATION

The target population for the teen pregnancy program begins with preadolescence group in 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 goal is to provide education, screening, support, and direction to other community resources and programs for reduction in teen pregnancy, infant mortality and earlier and improved prenatal care.

PROCESS/TIME FRAME/ LOCATION

Through our well child visits our providers utilize adolescent counseling as an opportunity to have open discussion of abstinence or protected sexual activity with the teens. See table below for preventive encounters which were completed by age group for each specific time period.

Years	2017	2018	2019
12-17	678	790	911

Family Medical Clinic of Union, Rush Medical Clinic of Philadelphia, and Newton Family Medical participate in the midwifery program which increases improvement and compliance with prenatal care.

By placing the midwives in our local clinics, the teen is in a familiar environment reducing the anxiety of unfamiliarity and also reducing noncompliance of prenatal visits by alleviating travel obstacles. The midwives collaborate with the OB-GYN as well as the neonatologist and pediatricians through a shared electronic health record. All these help to facilitate improved prenatal care as well as a reduced infant mortality. Lastly, the midwife program and the rural health clinics participate with the March of Dimes.

INITIATIVE 5: PERSONAL RESPONSIBILITY FOR BETTER HEALTH

TARGET POPULATION

The target population for personal responsibility for better health is Newton County and our surrounding communities. We have added programs at Laird and have programs in place in our rural health clinics in Union, Decatur, Philadelphia, Collinsville, and Meridian.

GOAL, DESIRED OUTCOME

Our main goal is to provide education, screening and support to our patients and the community so that they will choose to make lifestyle changes that will result in better health for them and their families.

RESTORIXHEALTH

In 2017, Laird Hospital contracted with RestorixHealth and began an outpatient wound clinic offering specialized wound care enabling patients to receive care locally instead of having to travel to a bigger city for this care. In 2017 the clinic had 306 visits. In 2018, three additional treatment rooms were added to the clinic with increase in visits to 592 and 517 thus far in 2019. During the clinic visit, wound care education is provided to patients in the following areas: prevention of diabetic and pressure ulcers; controlling blood sugars; Increase protein in diet; low sodium diet; elevate lower extremities to prevent swelling and changing positions frequently to prevent pressure ulcers; wearing compression socks to decrease edema and improve wound healing; proper dressing application and care; proper hygiene to facilitate wound healing; foot care and smoking cessation.

OUTPATIENT PULMONARY REHAB DEPARTMENT

In late 2017 Laird Hospital also started an Outpatient Pulmonary Rehab Department for patients with chronic lung diseases. This is a 12-week program which meets three days a week and is specifically designed to provide individualized treatment plans of exercise, activities of daily living, resources and education for people living with chronic pulmonary conditions. The goal is to help patients become stronger and help with their activities of daily living through exercising. Each patient's exercises are scaled to their specific needs and there are weekly educational topics that are discussed also. We saw 2 patients in 2017, 7 in 2018 and 5 thus far in 2019.

BETTER BREATHERS CLUB (BBC)

In June 2019 Laird started the Better Breathers Club (BBC) led by an employee who is a certified American Lung Association BBC facilitator. The BBC is a club through the American Lung Association which is open to anyone in the community living with chronic lung disease and their caregivers. It is an outreach for them to know that they are not alone suffering with this type of disease. Each month we have a topic that is discussed about their condition such as: When to know to go see the doctor, exercises that they can do at home to get stronger, and many other topics. We have 10 people who attend each monthly session, which include those that have a chronic lung disease and caregivers.



COUNSELING

As a focus on personal responsibility for better health our providers utilize the 5 A's approach to our counseling encounters. This process uses behavioral intervention which allows the patient to take ownership in setting goals allowing them to live healthier lives.

PATIENT POINT

All our rural health clinics are able to offer Patient Point which includes a 40-inch television screen in the waiting areas, exam room screens which patients can explore while waiting on the physician and can actually email information to themselves from the wall board. The clinics are also able to customize some of the content thereby being able to have certain focuses.

BOARD CERTIFIED ADDICTIONOLOGIST

We have a Board Certified Addictionologist on staff who treats patient's with drug and / or alcohol addictions and collaborates with Weems Mental Health for OP or IP residential services for these patients as needed. Clinics are also providing opioid abuse education.

MY RUSH HEALTH

Our clinic and hospital patients also have the ability to create an account with My Rush Health in order to have access to their health information, i.e., lab test results, procedure results, history, etc.



INITIATIVE 6: ACCIDENT PREVENTION

TARGET POPULATION

The target population for accident prevention is Newton County and our surrounding communities.

GOAL, DESIRED OUTCOME

The major goal is to provide education and awareness related to accident prevention.

RISK FOR FALLS

All patients are assessed for falls during clinic visits and hospital admissions. Patients admitted to the hospital who are found to be at Risk for Falls are given a special armband identifying them as at Risk which alerts staff from all departments to take special precautions and to insure the bed alarm is activated. Patients are also educated re; call for help when getting up to the bathroom, etc and Sign a Call Don't Fall agreement which provides the patient with education regarding different things to expect while in the hospital. Printed fall education material is given to patients who are at risk for falls. Patients found to be at risk for falls can be referred to Home Health for a Home safety evaluation at discharge if needed.

SAFETY SCREENS

During Medicare annual wellness visits at the rural health clinics a fall screen/home safety screen is performed, and any risk factors identified are discussed with the provider and patient and addressed with education or referrals as appropriate. During pediatric/adolescent well child visits age appropriate safety screens are performed, and counseling, education, and referrals performed as appropriate. See the table below for Annual Wellness Visits/ Well Child Visits.

Years	2017	2018	2019
8 days-	1600	2024	1665
3-11	112	139	103
12-17	678	790	911
18-34	208	287	528
35-39	81	119	200
40-49	207	287	452
50 and above	914	1251	1690

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, and lifestyle improvement.

Hypertension, heart disease, diabetes, weight loss/obesity and nutrition were all health needs identified by both the community members and the healthcare professionals. Members saw a need for increased education and preventive care in order to eliminate the path to chronic disease. There was much discussion about creating a more nurturing and healthful environment for the young people in the area, especially those who come from low income households. In addition, there was much discussion about the mental health challenges that the community faces. It is not only a health issue but a social and economic issue that must be addressed as a community, not just by the hospital. However, the hospital will continue to share the expressed concerns with the appropriate agencies and civic officials.

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 socio-economic groups.

PRIORITIZATION

The Steering Committee understood the facts the primary and secondary data communicated in reference to the health of the citizens of the primary focus area of Newton County.

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, to address some of the needs identified will require expertise and financial resources far beyond what the local community hospital can provide by itself.

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 service area. Laird Hospital has identified three significant initiatives it will undertake over the next three years. Each of these initiatives has multiple components. These collaborative projects should help improve the health and overall quality of life in our community. Each project is described in detail in the following 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 year.

2019 CHNA STRATEGIC ACTION INITIATIVES

INITIATIVE 1: LIFESTYLE IMPROVEMENT

Our goal is to focus on nutrition and exercise to help prevent comorbid diseases as well as provide education on health coverage to improve access to healthcare.

1. Health Coverage Education
2. Nutrition and Exercise Education with emphasis on lifestyle disease prevention
3. COPD education about prevention and maintenance.

INITIATIVE 2: CANCER AWARENESS

Our goal is to educate the community on early detection and the importance of follow up appointments. The focus will be on the following cancers:

1. Prostate
2. Pulmonary / Respiratory
3. Colorectal
4. Breast
5. Skin

INITIATIVE 3: ACCIDENT PREVENTION

Our goal is to educate and prevent accidental deaths. The areas of concentration will be:

1. MVA s (including ATVs)
2. Falls
3. Water Safety
4. Drug Abuse



THANK YOU

This comprehensive assessment will allow us to better understand the needs and concerns of our community. Laird Hospital is proud to be coming back stronger to even better serve our community. As always, through our commitment to compassionate and mission-focused healthcare, we are honored to work closely with our collaborative partners in our community to provide outstanding healthcare and create a healthier world for the residents of Newton County and surrounding area. Dedication to our values of performance, accountability, service, stewardship, integrity and teamwork has allowed us to continue, during these challenging months, to proudly serve our community.

Thanks to each of you who provided valuable insight into this report. Your participation in the data gathering, discussions and decision-making process helped make this a true community effort which will better serve all segments of our population

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