2019 Community Health Needs Assessment

CHI St. Vincent

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A note from our Chief Executive Officer

In January 2019, Catholic Health Initiatives and Dignity Health joined forces with a common vision to build healthier communities, advocate for those who are poor and vulnerable, and create innovative solutions to the most complex healthcare problems in the United States. Together as CommonSpirit Health, we have a rich history and tradition of ministry service that is far-reaching, and we follow the example given to us by the sixteen congregations of women religious who founded the many hospitals that now comprise our health system. CHI St. Vincent – as a member of CommonSpirit Health - continues its 130 year legacy built on the provision of safe, high-quality healthcare services, health education and extensive community outreach. Our vision is and has always been to improve the overall health of the communities we serve.

The pages that follow outline the most pressing health issues facing Arkansans as identified through our 2019 Community Health Needs Assessment (CHNA) process. This work reflects hours of research, conversation with our community members and thoughtful reflection on our ever-evolving role as partners with those we serve. Our findings affirm the importance of our community outreach efforts and guide our actions as we strive to build healthier communities. Through a new look at population health and a renewed interest in the social determinants of health, this report guides CHI St. Vincent in addressing identified health needs.

We are grateful for every partner who joined with us in the CHNA process, and we look forward to building new partnerships in health as we take our next steps forward in this work. Our pathway is paved by compassion, a commitment to social justice and the common good, and our desire to recognize the dignity of every individual we encounter in our work.

We are proud of the work we are undertaking as a vital mission-driven partner in our local communities. Our plan is to create new and innovative ways to address the most challenging health needs across Arkansas. Moving forward, we will enhance existing partnerships and build new ones to ensure that every brick we lay in our journey will pave the way for a healthier tomorrow. We look forward to our next steps taken in partnership with all those who share our mission and vision for community health on behalf of all Arkansans. Thank you for your willingness to walk that path with us!

Sincerely,

Chad Aduddell, CEO
CHI St. Vincent

"Now to each one the manifestation of the Spirit is given for the common good."

(1 Corinthians 12:7 NIV)

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Acknowledgments

CHI St. Vincent recognizes the importance of partnerships in building healthy communities. We thank the many individuals and agencies (Appendix A) who contributed to the creation of the 2019 Community Health Needs Assessment and Implementation Strategy. Without them, this project would not have been possible, and we look forward to all the work with them that is yet to come in promoting health for all Arkansans.

Our deep gratitude also goes out to the nearly 100 individuals who participated in our community focus groups. Your candor and willingness to share your triumphs and challenges as residents of your local communities helped to shape our work in ways we never would have thought possible. Thank you!

We offer a special thanks to our graduate assistant, Rebecca Stone, for her expertise, insights and tenacity throughout the process. Her work on this project brought our community health outreach efforts to an entirely new level of potential.

Executive Summary

Living our Mission

Driven by its deep commitment to reduce suffering and promote human flourishing, CHI St. Vincent continues to focus its resources on the health needs of all Arkansans. Following the example of our founding Sisters of Charity of Nazareth Kentucky and Sisters of Mercy, our ministry places special emphasis on serving those who are poor and vulnerable in our local communities. This has been and will continue to be our commitment to the people of Arkansas. The triennial community health needs assessment (CHNA) is a mission-driven, values-based framework that guides the health system in ensuring it continues its charitable purpose in service to all those who need care.

This report outlines the 2019 CHNA process and outcomes for each of our hospital facilities. Information is divided into chapters representing the unique assessment data and community health needs for each location:

- CHI St. Vincent Infirmary – Little Rock, Pulaski County
- CHI St. Vincent North – Sherwood, Pulaski County
- CHI St. Vincent Hot Springs – Hot Springs, Garland County; in partnership with Christus Dubuis Hospital located within the Hot Springs facility
- CHI St. Vincent Morrilton – Morrilton, Conway County

2019 CHNA Methodology

The CHNA process is formalized by section 501(r)(3) of the Affordable Care Act, which requires non-profit, tax-exempt hospital organizations to conduct a community health need assessment (CHNA) every three years and to adopt an implementation strategy to meet the community health needs identified through the CHNA. Although the IRS requires the completion of this process in order to justify tax-exemption, CHI St. Vincent does so because it reflects our commitment to serve all those who need care within our hospitals and beyond.

The *County Health Rankings Model* (CHRM) guided the 2019 CHNA research methodology. The CHRM, funded by the Robert Wood Johnson Foundation, is based on a framework for population health that emphasizes health factors influencing how long people live and their quality of life while alive. The factors include: 1) physical environment, 2) social and economic factors, 3) clinical care and 4) health behaviors. The CHRM includes 30 measures across the four factors that describe the overall health of county residents, making the model a useful design tool for the CHNA process.

In accordance with IRS guidelines for identifying target populations, CHI St. Vincent defined its commitment areas as the geographical regions from which the majority of its patient populations originate. Using records for unique hospital admissions and based on patients' zip codes of residence, the CHNA team identified three counties as the primary commitment areas for FY20-FY23 community health efforts (Table 1). Counties immediately adjacent to each primary area were identified as secondary commitment areas.

Table 1. CHI St. Vincent Commitment Areas

Hospital(s)	Primary Commitment Areas	Secondary Commitment Areas (Counties)
CHI St. Vincent Infirmary	Pulaski County	Counties: Faulkner, Lonoke, Jefferson, Grant, Saline & Perry
CHI St. Vincent Hot Springs & CHRISTUS Dubuis Hospital	Garland County	Counties: Yell, Perry, Saline, Hot Spring, & Montgomery
CHI St. Vincent North	Pulaski County	Counties: Faulkner, Lonoke, Jefferson, Grant, Saline & Perry
CHI St. Vincent Morrilton	Conway County	Counties: Pope, Perry & Yell

Three research methodologies were used to gather quantitative and qualitative data:

1. *Secondary Data Review*. In November and December 2018, community health data was collected using publicly available sources at county, state and national levels (Appendix B).
2. *Key Informant Survey.* In February 2019, a survey (Appendix C) was distributed to more than 600 community agencies in the primary and secondary commitment areas including public health officials, public safety personnel, schools, churches, and medical providers. The survey assessed respondents' perspectives about the greatest health needs and most vulnerable populations in their communities. A total of 111 complete surveys were received, for a response rate of 18.5%.
3. *Community Focus Groups.* In February and March 2019, seven focus groups were conducted with community members of Pulaski, Garland and Conway counties including community residents and vulnerable populations. The focus groups emphasized discussions about community problems, resources and solutions. A total of 91 individuals between the ages of 18 and 84 with a diverse range of ethnicities, backgrounds and socioeconomic demographics participated in the focus groups.

2019 CHNA Priorities

Information from these three data sources was organized according to the County Health Rankings Model (CHRM) and analyzed to identify significant community health needs. From that process, two primary health needs emerged in all three of the target counties: 1) access to care and 2) mental health. Specific focus areas were then extracted from an assessment of causal factors for poor health as defined by the CHRM (Table 2). These focus areas helped to further build the architecture for implementation strategies that target upstream prevention.

Table 2. Community Health Focus Areas by Hospital

Facility	Focus Area(s)	
	Health Need: Access to Care	Health Need: Mental Health
Infirmary & North	1) Primary Care & Chronic Disease Management	2) Substance Use & Abuse (opioids) 3) Domestic Violence & Violent Crime
Hot Springs / Dubuis*	1) Primary Care (including perinatal care) & Chronic Disease Management 2) Geriatric Behavioral Health	3) Suicide Prevention 4) Substance Use & Abuse (opioids)
Morrilton	1) Primary Care (including perinatal care) & Chronic Disease Management	2) Substance Use & Abuse (opioids) 3) Family & Social Support

* Note: CMS regulations do not allow long-term acute care facilities to provide mental or behavioral services. Therefore CHRISTUS Dubuis Hospital will not address these health needs.

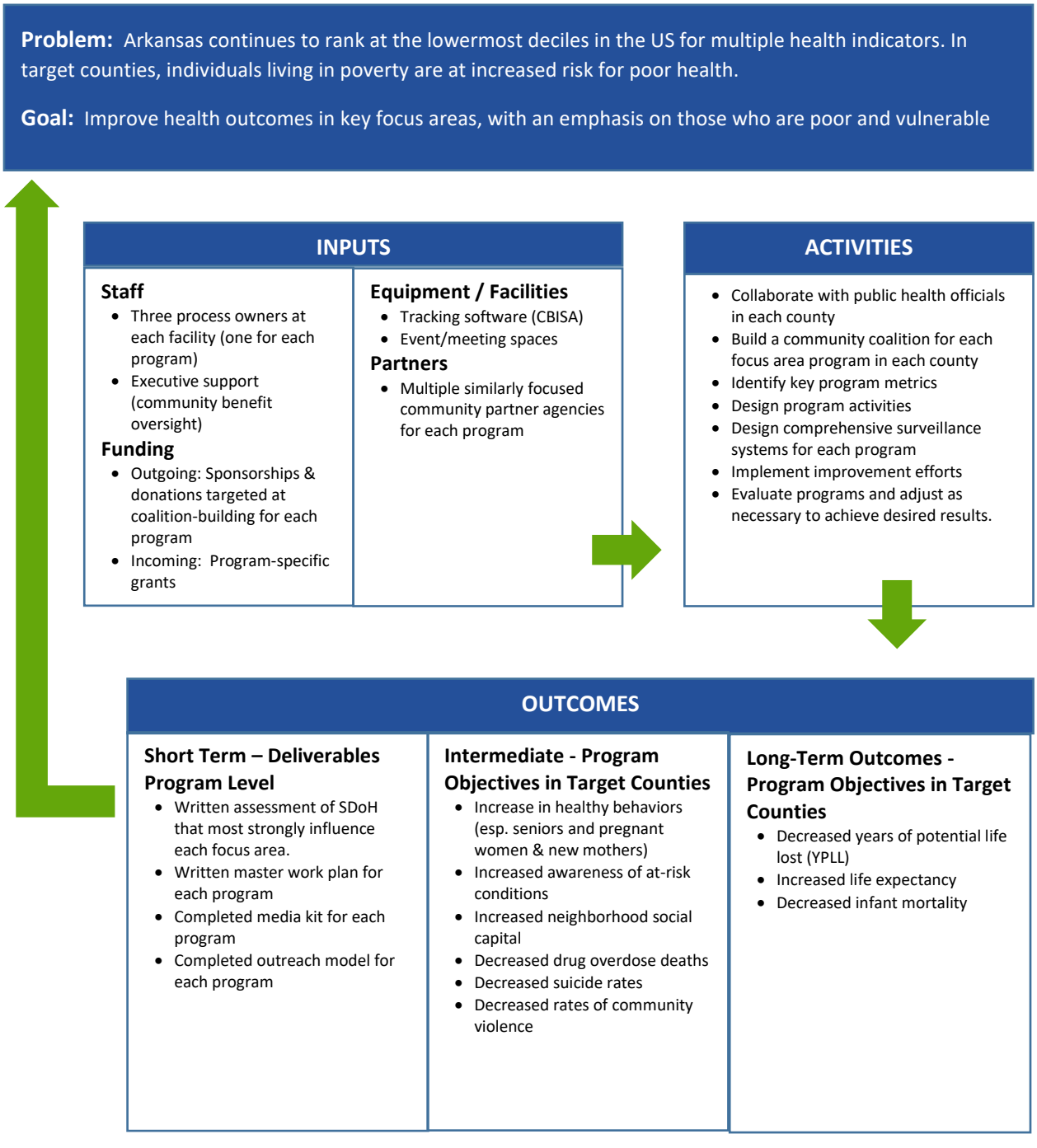
CHI St. Vincent – Implementation Strategy

The identified community health needs and focus areas were integrated into a three-year Community Health Implementation Strategy (CHIS) that will guide health improvement efforts for the next three years (FY20-FY23). An internal multidisciplinary workgroup comprised of process owners at each hospital will direct health improvement efforts. An additional coalition of external stakeholders will be convened to provide ongoing input and participation in community benefit activities.

In building the CHIS, the research team acknowledged the limitations and opportunities of community health improvement efforts. The overarching limitation is that individual hospital facilities cannot independently improve health outcomes at the population level. Nevertheless, doing so is one of CHI St. Vincent's strategic and operational priorities as a not-for-profit health system with a deep commitment to the communities it serves. Therefore, strengthening current affiliations and building new partnerships with similarly focused community agencies are essential components of the CHIS. Our key opportunity is to build a multifactorial approach to addressing upstream

health factors that influence health outcomes. The resulting focus on projects and programs with the greatest potential for impact will help CHI St. Vincent maximize resources and measure our efforts in key areas.

Figure 1. Arkansas Market - Implementation Strategy - Logic Model



Introduction

CHI St. Vincent has a long history of serving the health needs of Arkansans. With the Sisters of Charity of Nazareth, KY at the helm and at the bedside, the Little Rock Infirmary opened its doors to its first patient in the spring of 1888. Four months later, the Sisters of Mercy of Little Rock traveled to Hot Springs to open a new hospital thereby expanding the services available to Arkansans. Today, the Sisters' legacy in Arkansas healthcare includes four hospitals and a network of ambulatory clinics and specialty programs.

As Arkansas' oldest continuously operating hospital, CHI St. Vincent Infirmary sits in the city of Little Rock in the heart of Pulaski County. Originally known as Charity Hospital, the Sisters of Charity changed the hospital's name in 1890 to St. Vincent Infirmary in honor of St. Vincent DePaul, a 17th century Catholic priest whose life's mission was to serve those who were poor and vulnerable. In 1997, the hospital was rebranded as CHI St. Vincent Infirmary upon acquisition by Catholic Health Initiatives (CHI).

CHI St. Vincent Infirmary shares its history and heritage with CHI St. Vincent North located in the city of Sherwood in Pulaski County. In 1999, CHI St. Vincent opened the north facility to serve residents in northern Pulaski County and beyond. Today, the facility includes the Arkansas Neurosciences Institute and shares its campus with CHI St. Vincent Rehabilitation Hospital.

The second oldest hospital in Arkansas is CHI St. Vincent Hot Springs located in Garland County in the city of Hot Springs. At its opening, the Sisters of Mercy owned and operated the facility as St. Joseph Hospital. Ownership transferred in 2012 from the Sisters of Mercy to their corporate entity, Mercy Health, and the facility name was changed to Mercy Hot Springs Hospital. In 2014, Catholic Health Initiatives purchased the hospital and renamed it CHI St. Vincent Hot Springs.

One of the 29 critical access hospitals in Arkansas is CHI St. Vincent Morrilton (Rural Health Information Hub, 2019). In December of 1925, the Benedictine Sisters at St. Scholastica Monastery established the hospital as a 14-bed facility in a private home in the southern region of Conway County. In 1965, Conway County voters approved bonds to build a new, larger medical facility under the name of St. Anthony Medical Center. Catholic Health Initiatives purchased the hospital in 1994, and St. Anthony Hospital was renamed CHI St. Vincent Morrilton in 2011.

Also participating in the 2019 CHI St. Vincent CHNA process is Christus Dubius Hospital of Hot Springs. Co-owned and operated by LHC Group of Lafayette, LA and Christis Health, Dubuis Hospital is a long-term acute-care hospital (LTACH) located within the walls of CHI St. Vincent Hospital of Hot Springs. Currently licensed for 27 LTACH beds, the hospital opened in March of 1999 to provide care to medical complex patients who require continued acute-care services for long periods of time.

Even as the CHI St. Vincent health system has evolved over time to meet the ever-increasing challenges of the contemporary healthcare landscape, its mission in service to those who are sick – especially those who are poor and vulnerable – remains ever strong.

Driven by its deep commitment to reduce suffering and promote human flourishing, CHI St. Vincent continues to focus its resources on the health needs of Arkansas. The triennial community health needs assessment (CHNA) is a mission-driven, values-based framework that guides the health system in ensuring it continues its charitable purpose in service to all those who need care – just as the Sisters of Charity of Nazareth, Kentucky, the Sisters of Mercy and the Benedictine Sisters have always done.

Chapter 1. CHI St. Vincent Commitment Area

As a wholly owned subsidiary of Chicago-based CommonSpirit Health, the CHI St. Vincent health system is comprised of four (4) hospitals, more than seventy (70) clinics (Figure 2), and the largest clinically integrated health network in the state operating as the Arkansas Health Network (AHN). The health system serves patients in Arkansas and beyond. Christus Dubuis Hospital is located within the CHI St. Vincent Hot Springs facility.

Figure 2. CHI St. Vincent Hospital Facilities and Clinic Locations

CHI St. Vincent serves the entire state of Arkansas. The health system therefore refers to the entire state as its service area for the purposes of providing inpatient and outpatient health services. The community benefit planning team has identified specific regions as its commitment areas where outreach activities are to be focused. Doing so allows the planning team to demonstrate proper stewardship of resources while maximizing community health results.

The 2019 CHNA defines its primary commitment areas per IRS guidelines as the demographic zones from which the majority of hospital admissions originate. Demographic zones are identified by zip codes for unique patient medical records. Zip codes are then plotted by county to identify primary commitment areas (Table 3). Secondary commitment areas are those counties immediately adjacent to primary commitment areas or those from which the majority of patient admissions originate (Table 4). Figure 3 identifies the commitment areas for all four hospitals. Although community benefit activities may reach beyond these demographic zones, efforts will be focused in these areas.

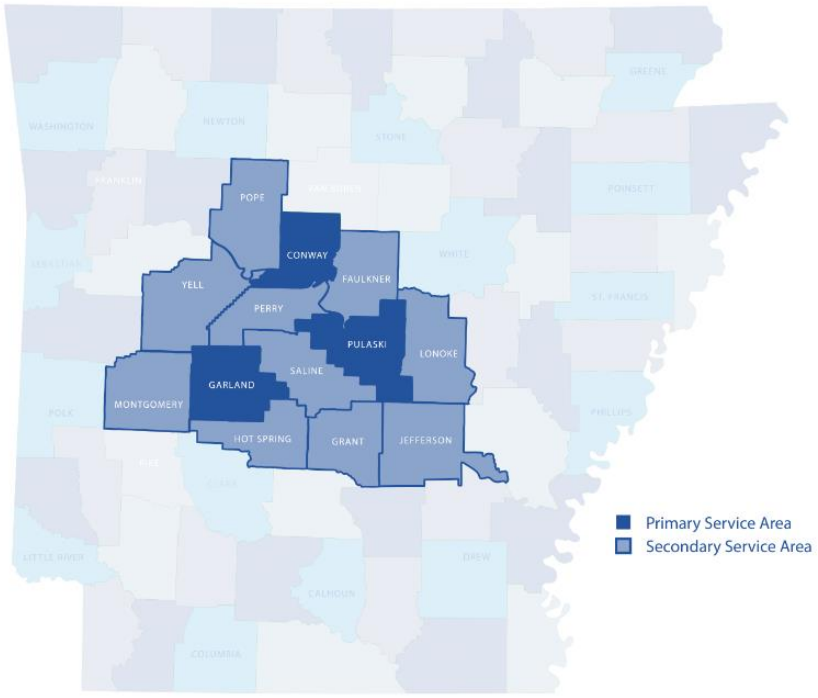
Table 3. CHI St. Vincent Health System Primary Committment Areas by Hospital Facility

Hospital Facility	Primary Commitment Area	% Unique Medical Records
CHI St. Vincent Infirmary	Pulaski County	58.0%
CHI St. Vincent North	Pulaski County	70.3%
CHI St. Vincent Hot Springs	Garland County	68.4%
CHI St. Vincent Morrilton	Conway County	60.9%

Table 4. CHI St. Vincent Health System Secondary Commitment Areas by Hospital Facility

Hospital Facility	Secondary Commitment Areas
CHI St. Vincent Infirmary	Saline County, Lonoke County, Faulkner County, Jefferson County, Perry Count and Grant County
CHI St. Vincent North	Lonoke County and Faulkner County
CHI St. Vincent Hot Springs	Perry County, Saline County, Hot Spring County, Montgomery County and Yell County
CHI St. Vincent Morrilton	Perry County, Pope County and Yell County

Figure 3. Primary/Secondary Commitment Areas in the State of Arkansas

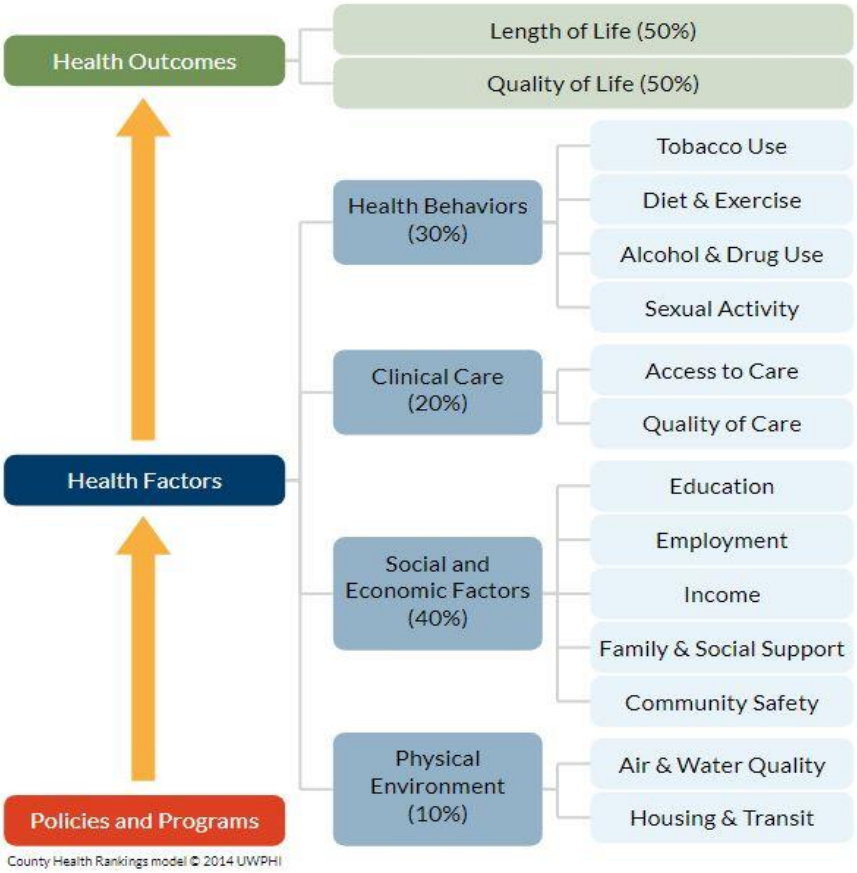


Chapter 2. Methodology and Key Findings

The CHNA process is formalized by section 501(r)(3) of the Affordable Care Act, which requires non-profit, tax-exempt hospital organizations to conduct a community health need assessment (CHNA) every three years and to adopt an implementation strategy to meet the community health needs identified through the CHNA. Per IRS requirements, the needs assessment must include input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health, and be made widely available to the public. Although the IRS requires the completion of this process in order to justify tax-exemption, CHI St. Vincent does so because it reflects our commitment to serve all those who need care within our hospitals and beyond.

The *County Health Rankings Model* (CHRM) guided the 2019 CHNA research methodology (Figure 4). The CHRM, funded by the Robert Wood Johnson Foundation, is based on a framework for population health that emphasizes health factors influencing how long people live and their quality of life while alive. The factors include: 1) physical environment, 2) social and economic factors, 3) clinical care and 4) health behaviors. The CHRM includes 30 measures across the four factors that describe the overall health of county residents, making the model a useful design tool for the CHNA process.

Figure 4. County Health Rankings Model (CHRM)



The research team used primary and second data sources during data collection. Three separate research methodologies were used to gather information for the assessment. The primary data review included key informant surveys and focus groups. Secondary data included multiple data sets from a variety of sources. Given the volume of available data, researchers directed data collection around the four health factors identified by the County Health Rankings Model: 1) physical environment, 2) social and economic factors, 3) clinical factors and 4) health behaviors. Each factor holds a weight percentage identifying the degree of influence each has on overall health outcomes. Although factors associated with physical environment and clinical care have an impact on overall health outcomes, social and economic factors and health behaviors are weighted the heaviest at 40% and 30% respectively. Information was gathered across all four factors with an emphasis on those with the highest percent of influence on health outcomes.

Secondary Data Review

Secondary data review was selected as the launch point for project research. This approach allowed researchers to compare population health trends among a variety of demographics over a wide range of time periods and create an overall analytical overview of community health needs. A comprehensive review of secondary data from publicly available sources at the county, state and national levels was conducted between October and December of 2018. Internal validity of secondary data was confirmed by comparing state ranking sources with those at the national level using America's Health Rankings website. County and state level health indicators were found to be consistent with state rankings.

The secondary data review revealed that Arkansas continues to rank in the lower quartile of most health indicators. In order to maximize community health efforts in the upcoming CHNA implementation cycle, the research team established a set of inclusion criteria that allowed them to narrow the focus to a few key health indicators in each demographic zone. Criteria for health indicators included: a) state or county rates higher than the national average by at least 50%, b) state ranking in the bottom quartile and c) no improvement in outcomes from previous CHNA cycle. This process resulted in the selection of specific health indicators that were further explored in subsequent research approaches. Refer to individual hospital chapters for a list of these health indicators by county.

Primary Data Review

The research team further refined the potential community health focus areas through two subsequent research methodologies: 1) survey research and 2) community focus groups. These approaches allowed the researchers to engage with and receive feedback from a broad range of stakeholders as per IRS requirements for non-profit hospitals.

Key Informant Survey

The Key Informant Survey, hosted on the Survey Monkey® online platform, was designed by the research team based on findings from the secondary data review and feedback from representatives of the Arkansas Center for Health Improvement. The final instrument consisted of 10 questions designed to identify stakeholders' view of the greatest community needs, most at risk populations and possible solutions. and consisted of multiple choice, ranking, and open-ended formats.

The survey link was distributed by email to more than 600 community stakeholders including physicians, hospital officials, churches, schools, community agencies, public safety and public health representatives across the three primary counties. Incomplete or abandoned surveys were excluded from the data set. At the conclusion of a three-week survey period beginning on February 25, 2019, 111 completed surveys were captured for a response rate of 18.5%.

Key findings included the top five most prevalent community health issues by county, the top five most influential socioeconomic factors, and the most vulnerable populations (Figures 4, 5 & 6). More than 50% of respondents

reported adult obesity and opioid/substance use in the top 5 most prevalent health issues followed closely by access to care and chronic diseases such as heart disease, diabetes and cancer at nearly 45% of respondents. Poverty-level household income level, living below the poverty line and lack of education were identified as the most influential socioeconomic factors, and the most vulnerable population was those who are uninsured or underinsured. Black/African Americans, seniors and those who are homeless were among the demographic populations identified as most vulnerable. Refer to hospital-specific chapters for more detailed analysis and key findings.

Focus Groups

Focus groups were held between February and March 2019 and were designed to allow for direct engagement with community members across a range of demographics. Sessions were held at senior centers, churches, schools, local businesses and non-profit organizations and included those who live and work in the primary commitment area counties. Seven (7) focus groups were held with a total of 91 participants from a variety of age groups and ethnicities. Refer to hospital-specific chapters for additional information. At the conclusion of each session, an evaluation tool was distributed to participants. The tool included process feedback and participant demographic information.

Approvals and Adoption

In February 2019, an overview of key findings from the secondary data review was presented to system and facility level leadership teams with both administrative and provider representation. Leaders were then invited to ask questions, offer insights and suggest gaps in data. The key findings overview was presented to the following leadership team: Executive Council (system), President's Council (system), Administrative Council (Hot Springs), Leadership Connect (Morrilton), and Community Health Outreach & Improvement Council CHOICE (Hot Springs/Infirmary).).

During the month of April 2019, a logic model of key findings from the secondary data, community stakeholder survey and focus groups was presented to system and facility level leadership teams. Leaders were invited to engage in dialogue and approve conclusions. The secondary and primary data key findings logic model was presented and approved by the following leadership teams: Executive Council (system), President's Council (system), Administrative Council (Hot Springs), Leadership Connect (Morrilton), Leadership Circle (North) and Community Health Outreach & Improvement Council CHOICE (Hot Springs/Infirmary).

On May 2, 2019 CHNA findings and identified priority focus areas were reviewed and approved by the CHI St. Vincent Board of Directors which governs all four hospital facilities. Following a set of questions and answers that focused primarily on resources for the plan and anticipated outcomes the board of directors formally adopted the community health implementation strategy.

Gaps and Limitations

Gaps and limitations the CHI St. Vincent health system's 2019 CHNA process are summarized below.

- At times county, state and national data had to be pulled from separate sources. A comprehensive list of sources is contained in Appendix B.
- Secondary data review includes a gap in quantitative data related to the homeless population.
- Time and resource constraints limited the number of focus groups facilitated in each hospital service area.
- Focus group participants and key informant survey respondents did not include representation from the adolescent population.

Chapter 3. CHI St. Vincent Infirmary and CHI St. Vincent North

CHI St. Vincent Infirmary and CHI St. Vincent North share a tax ID number and the primary and secondary commitment areas are the same. Therefore, the CHNA process was shared between the two. An implementation strategy was included for each separate facility based on results of leader discussions, key informant surveys and focus groups in each demographic zone.

Hospital Commitment Areas

The 2019 CHNA defines its primary commitment areas per IRS guidelines as the demographic zones from which the majority of hospital admissions originate. Demographic zones are identified by zip codes for unique patient medical records. Zip codes are then plotted by county to identify primary commitment areas (Figures 5 and 6). Secondary commitment areas are those counties immediately adjacent to primary commitment areas or those from which the largest number of hospital inpatient patient admissions originate. Although CHI ST. Vincent Infirmary and CHI St. Vincent North community benefit activities may reach beyond these demographic zones, efforts will be focused in these areas.

Figure 5. Primary Commitment Area - CHI St. Vincent Infirmary and CHI St. Vincent North

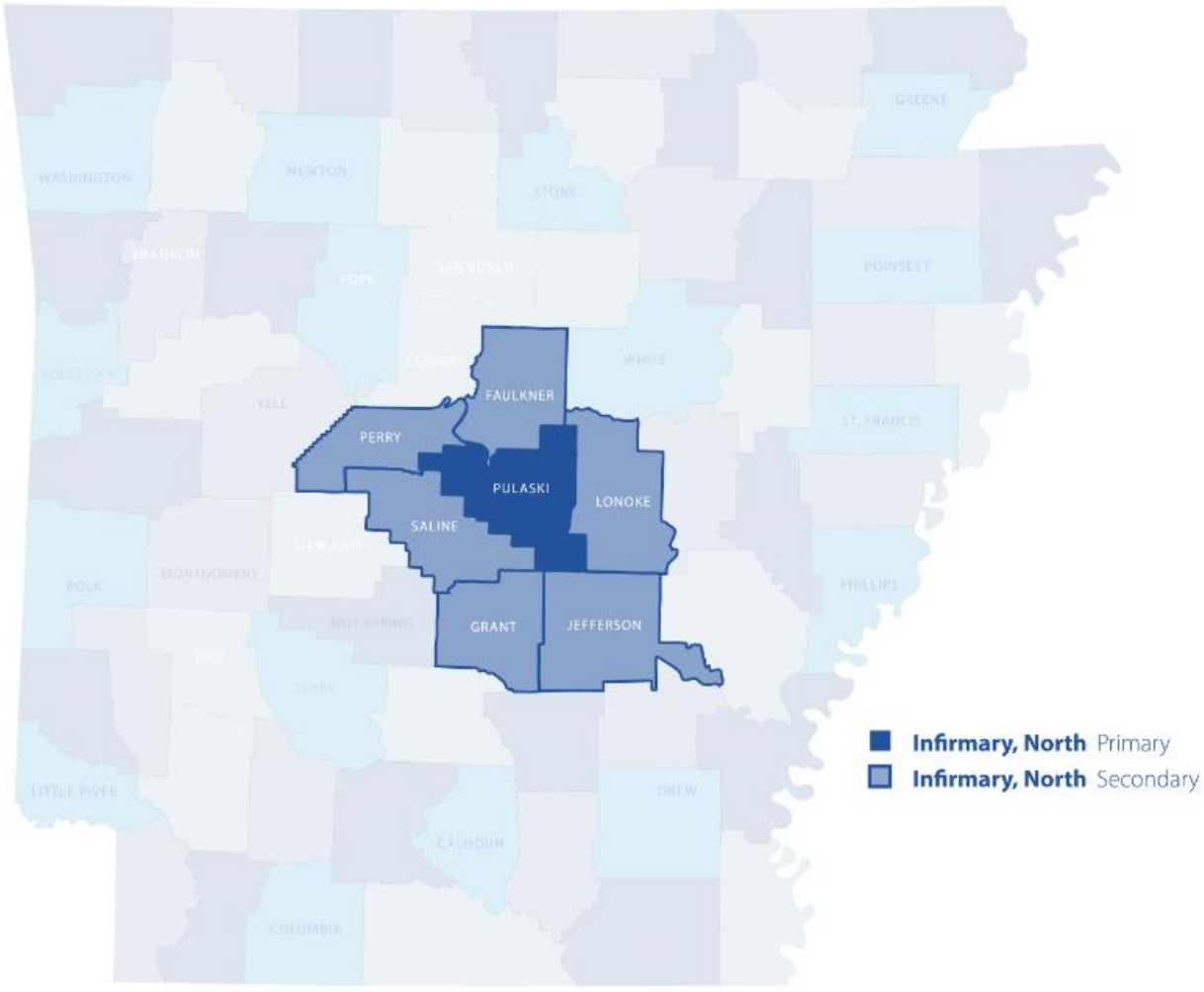
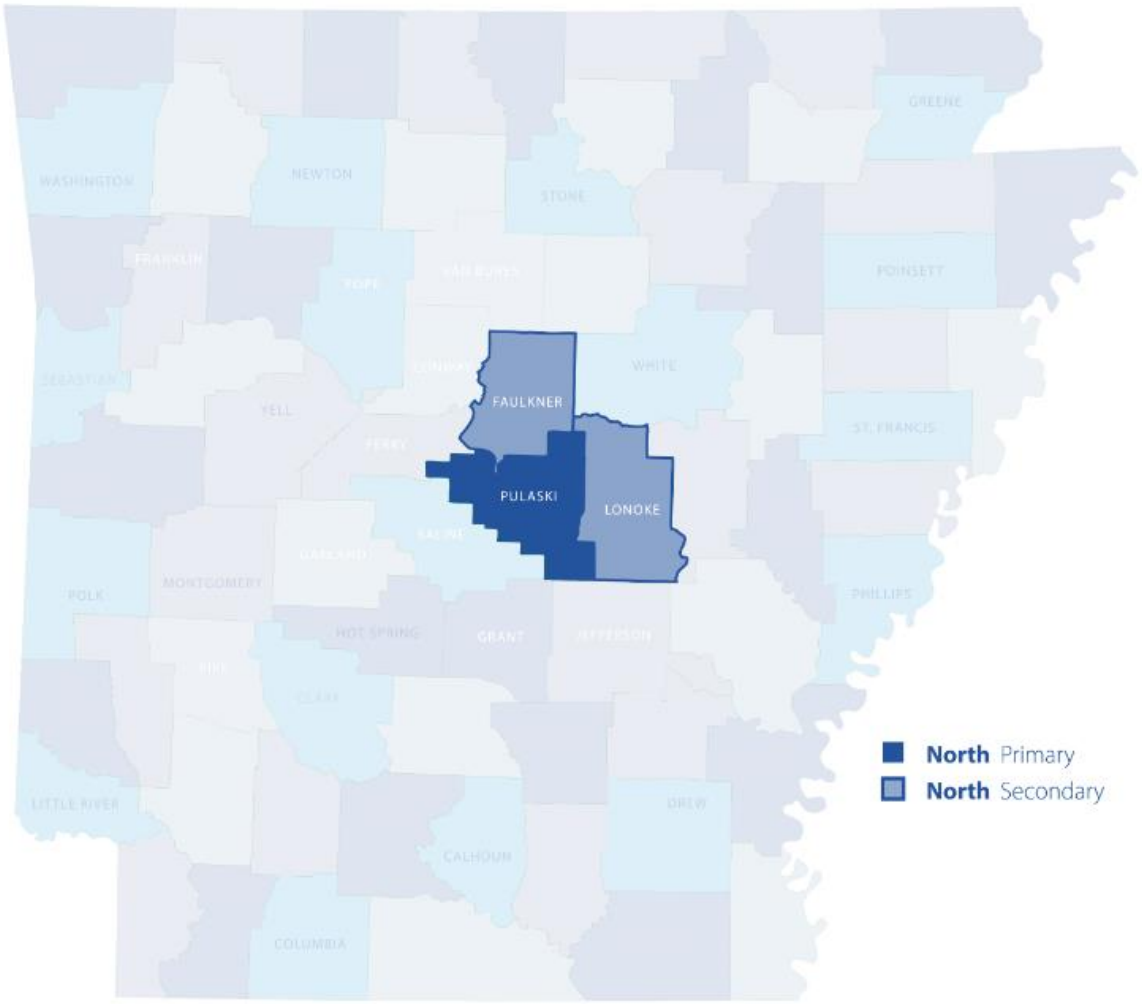


Figure 6. CHI St. Vincent North Commitment Area



Secondary Data Review

A detailed review and analysis of publicly available data was conducted as the starting point for data collection. Demographic profiles were reviewed in primary and secondary commitment as noted above.

Several findings are notable in the demographic information for Pulaski County (Table 5). While the population of Black/African Americans across the state varies only slightly from the national average, this population in Pulaski county is more than 177% higher than the national average. At the same time, the total population living below the poverty line is 22% higher than the national average while the median household income is 15% lower.

Table 5. CHI St. Vincent Infirmary - Pulaski County Demographic Profile

Measurement	Pulaski County		Benchmarks	
	Health Indicator	% Differ from U.S. Avg	Arkansas	United States
Population Growth Rate	2.9%	-47.3%	2.9%	5.5%
Median Household Income	$47,101	-14.9%	$42,336	$55,322
Total Population Below Poverty Line	15.0%	22.0%	16.4%	12.3%
Persons Without Health Coverage	7.9%	-22.5%	9.3%	10.2%
High School Degree	90.1%	3.6%	85.2%	87.0%
Bachelor's Degree or Higher	32.9%	8.6%	21.5%	30.3%
Race & Ethnicity				
White	52.4%	-13.7%	72.5%	60.7%
Black or African American	37.2%	177.6%	15.7%	13.4%
American Indian/Alaskan Native	0.5%	-61.5%	1.0%	1.3%
Asian	2.3%	-60.3%	1.6%	5.8%
Native Hawaiian/Other Pacific Islander	0.1%	-50.0%	0.3%	0.2%
Two or More Races	2.1%	-22.2%	2.1%	2.7%
Hispanic or Latino	6.2%	-65.7%	7.6%	18.1%
Age				
Children/Youth (Under 18 Years)	23.6%	3.1%	23.7%	22.9%
Adults (19-64 Years)	62.4%	0.3%	60.3%	62.2%
Seniors (65+ Years)	14.0%	-6.0%	16.0%	14.9%

Through the secondary data review, several key community health focus areas were identified (Table 6). The most prominent is the rate of pregnant women who do not receive prenatal care in the first trimester. At 27% this rate is 352% higher than the national average, placing Arkansas at 47th in state rankings for this measure. Although the rate of opioid prescriptions written across the state is significantly higher than the national average, the rate in Pulaski county is 68% higher. Violent crime rates were identified as a focus area at 162% higher than the national average.

Health issues associated with chronic disease management were also identified as key findings. Although these needs did not meet the selection criteria for inclusion as focus areas, internal hospital stakeholders nevertheless identified them as important in the health and well-being of the populations served (Table 7).

Table 6. CHI St. Vincent Infirmary and CHI St. Vincent North - Primary Focus Areas

Focus Areas	Pulaski County	National	% Difference	State Rank '18
No First Trimester Care	27% of pregnant women	6%	352%	47
Violent Crime	996 / 100,000	380	162%	45
STIs - Chlamydia	864 / 100,000	479	81%	42
Opioid Prescriptions	98 / 100,000	59	68%	49
Teen Births	42 / 100,000	27	56%	50 *(2015)*
Food Insecurity	20% of screened individuals	13%	54%	48

Table 7. CHI St. Vincent Infirmary and CHI St. Vincent North - Chronic Disease Factors

Health Indicator	Pulaski County	National	% Difference	State Rank '18
Stroke	46	38	21%	50
Hypertension	47%	33%	40%	48
Coronary Heart Disease	8%	5.7%	40%	48
Heart Disease Mortality	262	219	20%	47
Cancer	165	156	7%	47
Adult Obesity	32%	28%	11%	44
Diabetes	15%	10.5%	40%	42
Mental Health – Suicide	16	14	17%	37

Talking points for the Infirmary and North's community health needs critical focus areas were developed to assist with internal and external communications. This information was included on the infographic placements for use with focus groups.

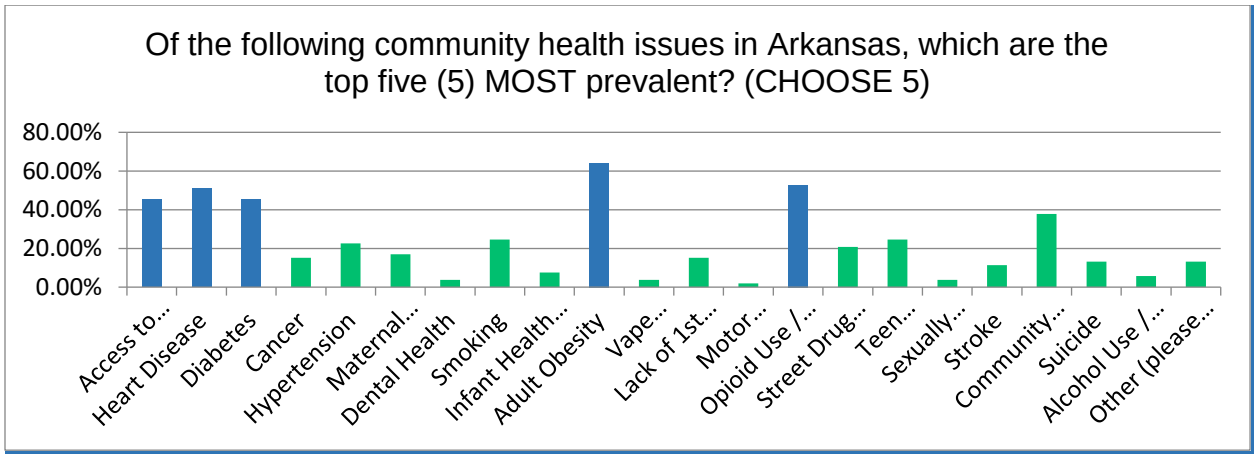
- 1 in 4 mothers in Pulaski County go without prenatal care beginning in the first trimester. This is 4.5 times higher than the national average.
- 1 in 10 babies in Pulaski County are born at a low birth weight (less than 5.5lbs). This is 1.3 times higher than the national average.
- 1 in 120 babies born in Pulaski County die within the first year. This is 1.4 times higher than the national average.
- 1 in 24 teenagers, ages 15 to 19, will give birth each year in Pulaski County. This is 1.5 times higher than the national average.
- 1 in 5 Pulaski County residents lack reliable access to an adequate quantity of affordable nutritious food.
- 1 in 10 Pulaski residents have limited access to fruits and vegetables.

- 1 in 100 Pulaski County residents will experience a violent crime (homicide, rape, robbery or aggravated assault) each year.
- There are more opioid prescriptions in Arkansas than there are residents at 1.1 prescriptions per person.

Key Informant Survey

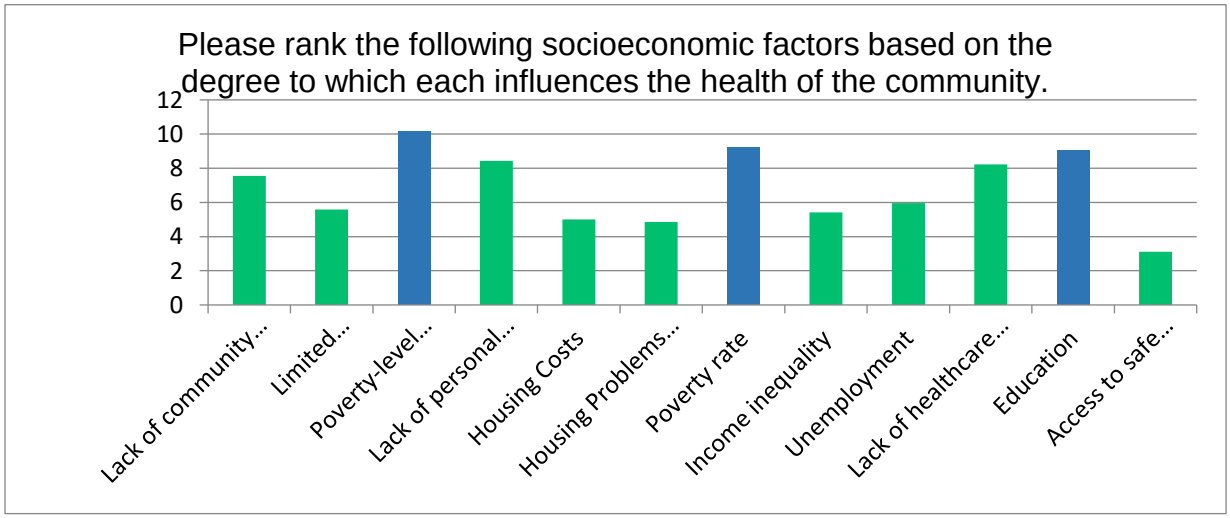
The key informant survey for Pulaski and surrounding counties produced 78 completed responses. Respondents identified adult obesity and opioid/substance use as the most prevalent health issues in the county (Figure 9). Heart disease surfaced as the most prevalent chronic condition followed closely by diabetes. Access to healthcare was also an issue; however, respondent comments suggested issues with access to medications was the more prevalent concern. Comments also noted transportation as a barrier to healthcare access.

Figure 7. Pulaski County - Most Prevalent Health Issues



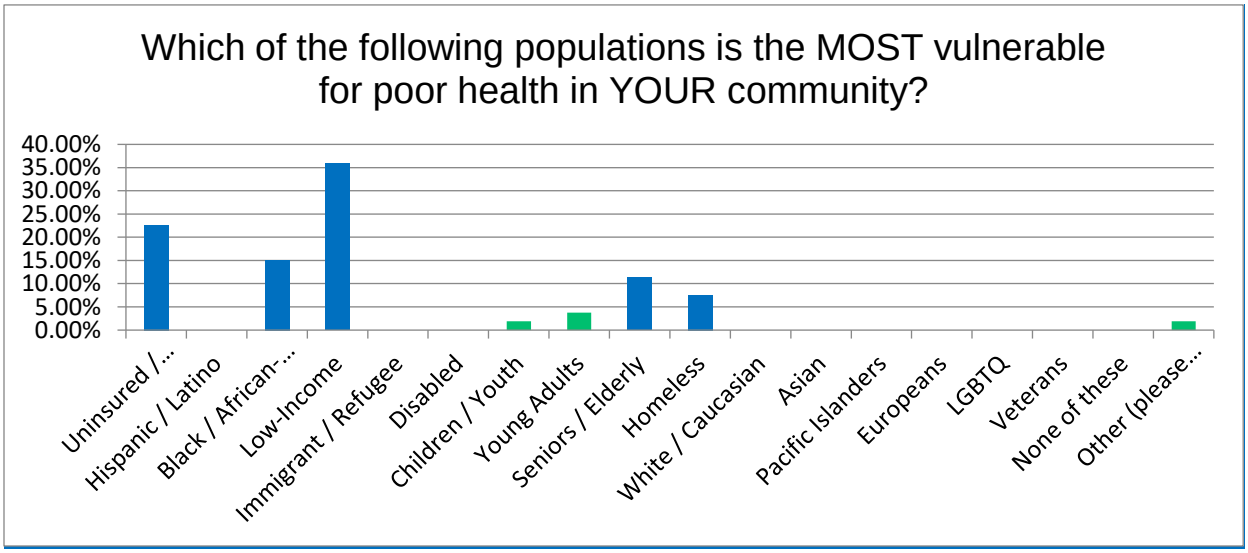
Among the socioeconomic factors influencing health, respondents ranked poverty and household income as the most prevalent (Figure 8). Education was ranked third although respondent comments suggested that lack of education about healthy behaviors was more predominant that formal education.

Figure 8. Pulaski County - Most Influential Socioeconomic Factors



Furthermore, survey results indicated that low income, uninsured and underinsured individuals were most vulnerable to poor health (Figure 9). Black/African Americans, senior citizens and those who are homeless were also identified as at-risk.

Figure 9. Pulaski County - Most Vulnerable Populations



Respondents were given the opportunity to share additional thoughts in an open response format. A sample of their quotes are listed below.

- "Invest in spiritual health simultaneously with physical health to achieve better health outcomes for the vulnerable."
- "A caring family or church family can make tons of difference for the person hurting."
- "The hospital has the right mission and the right people but need to inform the community of its vast resources."
- "We need more better access to medications. Low income people cannot afford the drugs they need, even if they can get a visit with their primary care doctor."
- "People do not know – or are not willing to acknowledge – their own responsibility for their health."
- "Patients can get appointments, but they can't get to those appointments without transportation."

Focus Groups

Two focus groups were held in Pulaski County with a total of 35 participants (Table 8). The first focus group was conducted at Jericho Way, a homeless resource center funded by the cities of Little Rock and North Little Rock. Session evaluations revealed that participant ages ranged from 18 to 65, and one participant selected the "65 years or older" age group. Five individuals identified as Caucasian and three identified as Black/African American.

Table 8. CHI St. Vincent Infirmary and CHI St. Vincent North - Focus Groups

Date	Meeting Space	Facilitator(s)	Scribe	# Attended
March 8, 2019	Jericho Way Resource Center	Rebecca Stone	Celina Miranda Suma Ashok	20
March 14, 2019	Central Arkansas Water	Celina Miranda	Rebecca Stone	15

Key community problems or concerns discussed during the focus group included:

- Chronic Homelessness (social stigma and personal mindset)
- Lack of Housing and Work for Criminal Offenders
- Lack of Sufficient Transportation
- Nutrition for Homeless Diabetics
- Food Insecurity / Hunger (access to fruits and vegetables)
- Lack of Resources
- No Focus on Spiritual Health

The second focus group was held with employees of Central Arkansas Water. Evaluation demographic responses, completed by all participants, indicated that the focus group had representation from 15 adults age 18 to 65. In that group, six individuals identified as Caucasian and nine identified as Black/African American.

Key community problems or concerns discussed during the focus group included:

- Violence (tied to mental health)
- Limited Access to Mental Health Care (sessions limited)
- Mental Health Insurance Coverage / Cost of Care
- Cost of Prescriptions / Medication / Medical Care
- High Poverty Rates
- Access to Healthy Foods (location and affordability)
- Lack of Walkability
- Elderly at Risk (income, transportation)
- Hispanic at Risk (language barrier)
- Homeless at Risk (lack of resources / medical care)

Data Mapping and Analysis

Through rigorous data analysis, two key themes emerged: 1) access to healthcare and 2) mental health. Chronic disease management was added as a third theme given internal stakeholders' preference for it as a focus area. The research team then evaluated the underlying causes of poor health outcomes to determine key community health focus areas for CHI St. Vincent Infirmary and CHI St. Vincent North. A data model of key community health needs and underlying factors was constructed from all data sources (Figure 10). The data model was reviewed with several key contributors (Appendix A) for feedback and refinement.

Community Health Priorities

In April of 2019, the research team presented an analytical overview of findings and the model of key community health needs to CHI St. Vincent Infirmary and CHI St. Vincent North leadership teams. Following rigorous dialogue and debate, the Infirmary leadership team selected six focus areas across the two key themes and the North leaders selected five focus areas (Table 9). These focus areas will serve as the targets for community health efforts throughout the upcoming CHNA/CHIS cycle. Although chronic disease management was identified as a third significant theme, hospital leaders agreed to view this theme as a focus area given its relationship to healthcare

access. As noted in Chapter 2, the CHI ST. Vincent health system board of directors reviewed and approved both the prioritized focus areas and the implementation strategy in May of 2019.

Figure 10. CHI St. Vincent Infirmary & North - Data Model

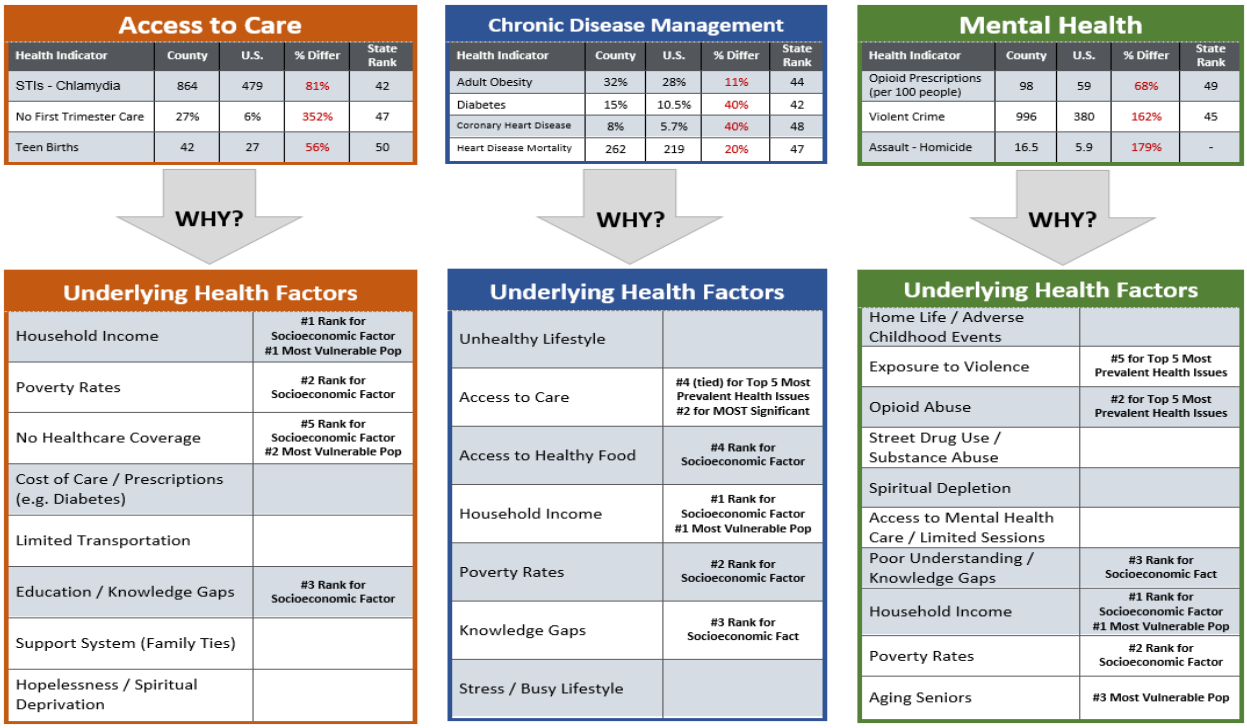


Table 9. CHI St. Vincent Infirmary & North - Prioritized Community Health Needs

CHI St. Vincent Infirmary		
Prioritized Community Health Need	**Focus Area(s)**	**Population(s)**
Access to Healthcare Services	• Primary Care • Chronic Disease Management	• Individuals living in poverty
Mental Health	• Substance Use & Abuse (including opioid use)	• Individuals living in poverty
	• Domestic Violence & Violent Crime	• Individuals living in poverty • Women & children
	• Suicide Prevention	• Teens and adolescents
	• Behavioral health access	• Seniors ages 65 and older
CHI St. Vincent North		
Prioritized Community Health Need	**Focus Area(s)**	**Population(s)**
Access to Healthcare Services	• Primary Care • Chronic Disease Management	• Individuals living in poverty
Mental Health	• Substance Use & Abuse (including opioid use)	• Individuals living in poverty
	• Suicide Prevention	• Adults and families (emphasis on children ages 13 to 19) • Individuals living in poverty
	• Domestic violence and violent crime	• Women & children • Individuals living in poverty

CHI St. Vincent Infirmary and CHI St. Vincent North - Implementation Strategy

Problem: Arkansas continues to rank at the lowermost deciles in the US for multiple health indicators. In target counties, individuals living in poverty are at increased risk for poor health.

Goal: Improve health outcomes in key focus areas, with an emphasis on those who are poor and vulnerable

INPUTS

Staff
- One team sponsor
- Internal stakeholder group (including physicians and nurses)
- One project owner for each focus area

Funding
- Outgoing: Sponsorships & donations targeted at coalition-building for each program
- Incoming: Program-specific grants

Equipment / Facilities
- Tracking software (CBISA)
- Event/meeting spaces
- Screening supplies

Partners
- Multiple similarly focused community partner agencies for each program

ACTIVITIES

- Build a community coalition for each focus area
- Continue to provide care for medically underserved persons.
- Partner with local schools to develop healthy behaviors, and build pathways to higher education for low-income students
- Build community coalitions for each focus area.
- Design and implement improvement programs (metrics, surveillance, and outcomes).

OUTCOMES

Short Term – Deliverables Program Level
- Written assessment of SDoH that most strongly influence each focus area.
- Written master work plan for each program
- Completed media kit for each program
- Completed outreach model for each program

Intermediate - Program Objectives in Target Counties
- Increased observance of healthy behaviors among low-income populations (esp. Black/African Americans).
- Increased neighborhood social capital
- Decreased number of opioid prescriptions written per capita
- Decreased drug overdose deaths
- Decreased suicide rates
- Decreased rates of community violence

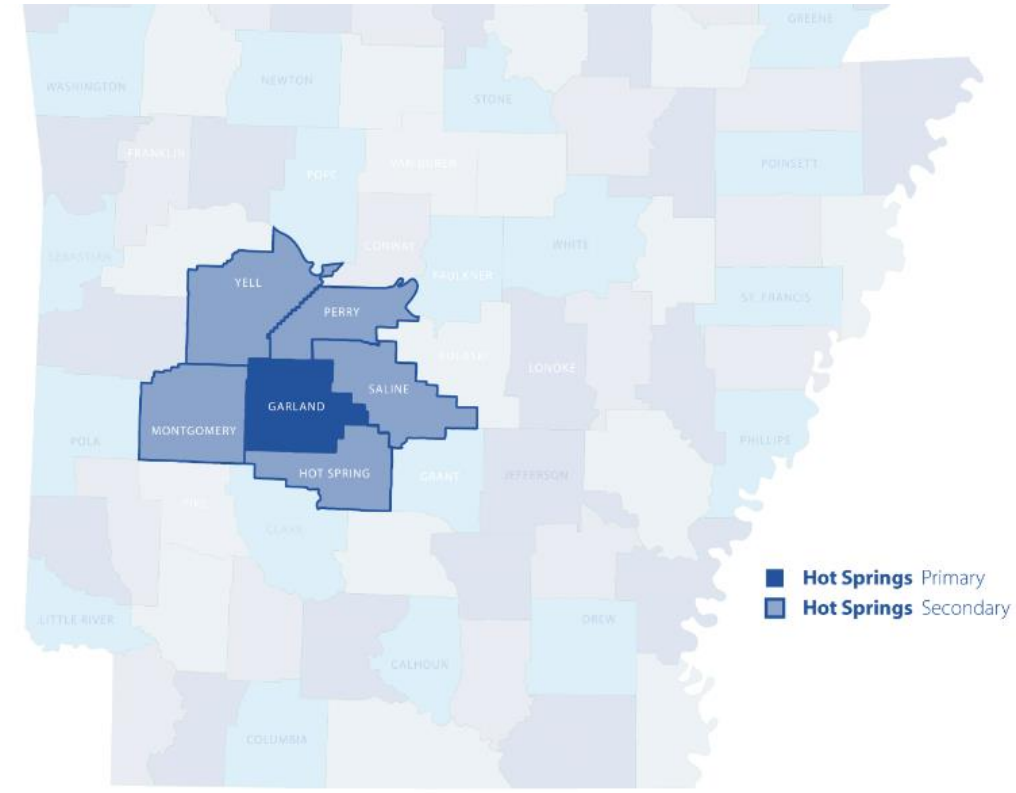
Long-Term Outcomes - Program Objectives in Target Counties
- Decreased years of potential life lost (YPLL)
- Increased life expectancy
- Decreased infant mortality

Chapter 4. CHI St. Vincent Hot Springs and CHRISTUS Dubuis Hospital

Hospital Commitment Area

The 2019 CHNA defines its primary commitment areas per IRS guidelines as the demographic zones from which the majority of hospital admissions originate. Demographic zones are identified by zip codes for unique patient medical records. Zip codes are then plotted by county to identify primary commitment areas (Figure 11). Secondary commitment areas are those counties immediately adjacent to primary commitment areas or those from which the largest number of hospital inpatient patient admissions originate. Although CHI ST. Vincent Hot Springs and Christus Dubuis Hospital community benefit activities may reach beyond these demographic zones, efforts will be focused in these areas.

Figure 11. CHI St. Vincent Hot Springs / Christus Dubuis Hospital Commitment Areas



Secondary Data Review

A detailed review and analysis of publicly available data was conducted as the starting point for data collection. Demographic profiles were reviewed in primary and secondary commitment areas as noted above.

Several findings are notable in the demographic information for Garland and surrounding counties (Table 10). First, the predominant race is white. At just over 82% of the population, this demographic is more than 35% higher than

the national average. Also of note, there is a disproportionately high population of adults over the age of 65 concentrated in Garland County. Nearly 23% of county residents are in this age group, which is higher than any other county in the state. Furthermore, the proportion of adults over the age of 65 is more than 50% higher than the national average. Concurrently, the number of persons living in poverty is nearly 30% higher than the national average. From this, researchers concluded that low-income seniors were a particularly vulnerable population in Garland County.

Table 10. CHI St. Vincent Hot Springs / Christus Dubuis Hospital - Demographic Data

Measurement	Pulaski County		Benchmarks	
	Health Indicator	% Differ from U.S. Avg	Arkansas	United States
Population Growth Rate	2.8%	-49.1%	2.9%	5.5%
Median Household Income	$40,011	-27.7%	$42,336	$55,322
Total Population Below Poverty Line	15.9%	29.3%	16.4%	12.3%
Persons Without Health Coverage	10.2%	0.0%	9.3%	10.2%
High School Degree	88.4%	1.6%	85.2%	87.0%
Bachelor's Degree or Higher	20.6%	-32.0%	21.5%	30.3%
Race & Ethnicity				
White	82.1%	35.3%	72.5%	60.7%
Black or African American	8.7%	-35.1%	15.7%	13.4%
American Indian/Alaskan Native	0.8%	-38.5%	1.0%	1.3%
Asian	0.8%	-86.2%	1.6%	5.8%
Native Hawaiian/Other Pacific Islander	0.1%	-50.0%	0.3%	0.2%
Two or More Races	2.5%	-7.4%	2.1%	2.7%
Hispanic or Latino	5.7%	-68.5%	7.6%	18.1%
Age				
Children/Youth (Under 18 Years)	20.50%	-10.5%	23.7%	22.9%
Adults (19-64 Years)	56.9%	-8.5%	60.3%	62.2%
Seniors (65+ Years)	22.60%	51.7%	16.0%	14.9%

Through the secondary data review, several key community health focus areas were identified (Table 11). The most prominent is the rate of pregnant women who do not receive prenatal care in the first trimester. At 28%, this rate is 365% higher than the national average. Although the rate of opioid prescriptions written across the state is significantly higher than the national average, the rate in Garland County is nearly 170% higher. Suicide rates remain disproportionately high in Garland County despite previous efforts at prevention.

Healthcare mapping information across the state revealed that Hot Springs is the only designated trauma center serving residents in the southwest corridor. Without the Hot Springs trauma center, residents would need to travel to upwards of three hours to receive trauma-related services. In addition, CHI St. Vincent Hot Springs has the only available clinic serving low-income pregnant women in Garland and surrounding counties. In addition, there is a paucity of available inpatient behavior health facilities in that same region.

Health issues associated with chronic disease management were also identified as key findings. Although these needs did not meet the selection criteria for inclusion as focus areas, internal hospital stakeholders nevertheless identified them as important in the health and well-being of the populations served (Table 12).

Table 11. CHI St. Vincent Hot Springs / Christus Dubuis Hospital - Primary Focus Areas

Focus Areas	Garland County	National	% Difference	State Rank '18
No First Trimester Care	28% of pregnant women	6%	365%	47
Opioid Prescriptions	158 / 100,000	59	169%	49
Depression	27% of screened individuals	17%	63%	35
Suicide	29 / 100,000	14	112%	37
Motor Vehicle Death	26 / 100,000	12	111%	-
Drug Overdose Deaths	26 / 100l000	17	54%	14

Table 12. CHI St. Vincent Hot Springs / Christus Dubuis Hospital - Chronic Disease Factors

Health Indicator	Garland County	National	% Difference	State Rank '18
Stroke	47	38	**25%**	50
Hypertension	44%	33%	33%	48
Coronary Heart Disease	8%	5.7%	40%	48
Heart Disease Mortality	289	219	32%	47
Cancer	169	156	9%	47
Adult Obesity	31%	28%	14%	44
Diabetes	14%	10.5%	37%	42

Talking points for the CHI St. Vincent Hot Springs and Christus Dubuis Hospital community health needs critical focus areas were developed to assist with internal and external communications. This information was included on the infographic placements for use with focus groups.

- 1 in 4 mothers in Garland County go without prenatal care beginning in the first trimester. This is 4.6 times higher than the national average.
- 1 in 10 babies in Garland County are born at a low birth weight (less than 5.5lbs). This is 1.1 times higher than the national average.

- 1 in 140 babies born in Garland County die within the first year. This is 1.4 times higher than the national average.
- 1 in 3 Garland County residents have been told they have Depressive Disorder by a health provider. This is 1.6 times higher than the national average.
- The Suicide rate in Garland County is twice as high as the national average. Garland County's rate is 29 in 100,000.
- Garland County opioid prescription rates are 2.7 times higher than the national average.
    - There are more opioid prescriptions in Garland County than there are residents at 1.6 prescriptions per person.
- Motor-vehicle fatalities in Garland County are 2.1 times higher than the national average at nearly 26 in 100,000.

Key Informant Survey

The key informant survey for Garland and surrounding counties produced 56 completed responses. Respondents identified opioid/substance use – including street drugs – and suicide as the most prevalent health issues (Figure 12). Heart disease surfaced as the most prevalent chronic condition. Access to healthcare services was also an issue; however, respondent comments suggested issues with high copays and costs of medications as a key concern. Respondents rated poverty and lack of personal resources as the most significant factor influencing the health of residents in their community (Figure 13). The most vulnerable populations identified were those who are low income and uninsured/underinsured as were senior citizens/elderly persons (Figure 14).

Figure 12. CHI St. Vincent Hot Springs / Christus Dubuis Hospital - Most Prevalent Health Issues

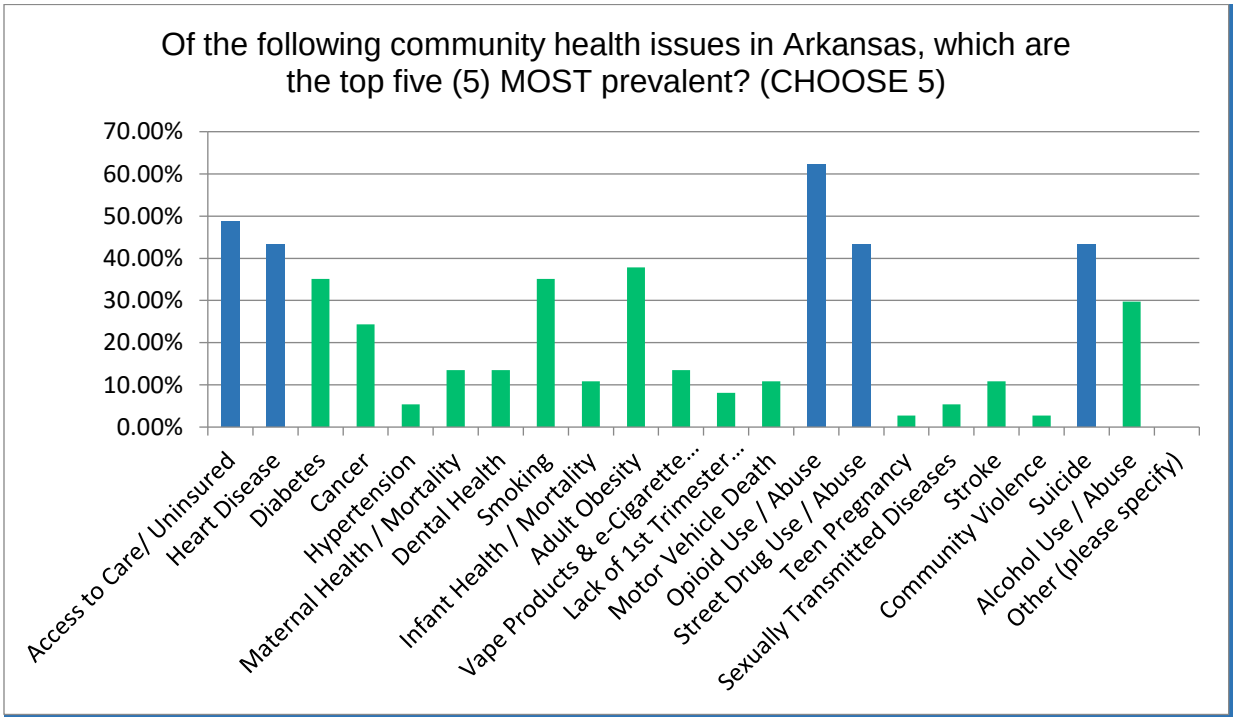


Figure 13. CHI St. Vincent Hot Springs / Christus Dubuis Hospital - Most Influential Socioeconomic Factors

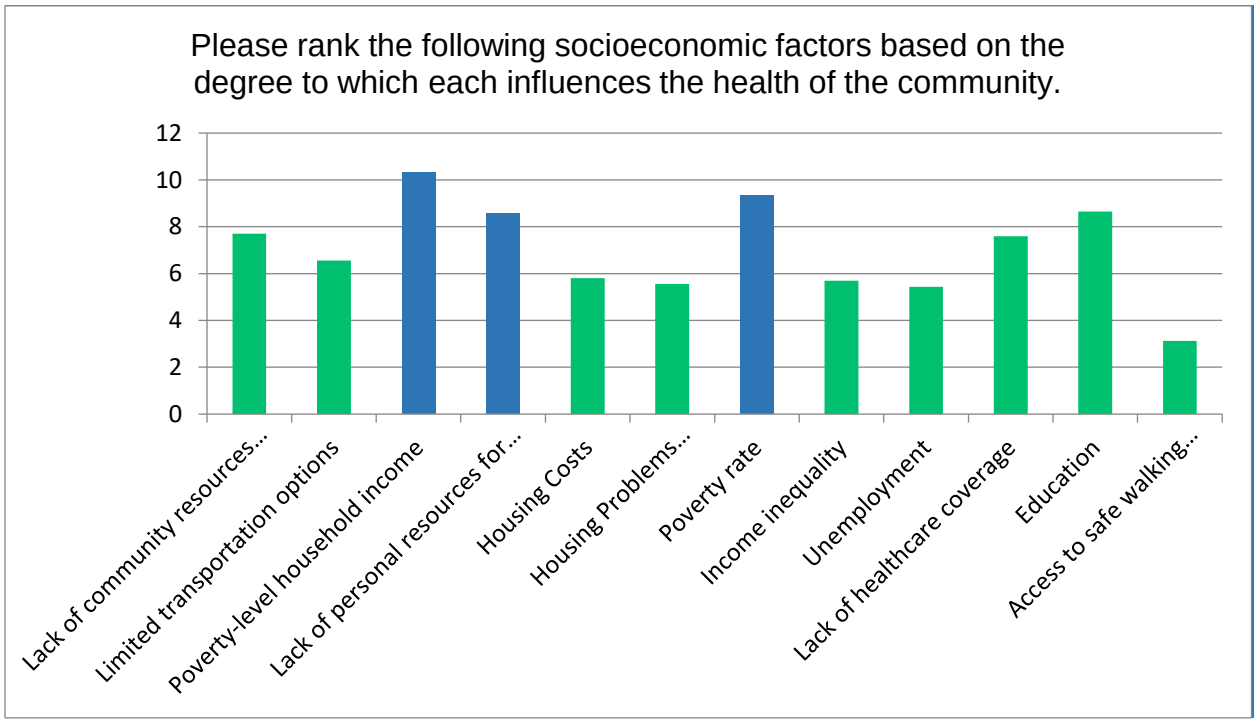
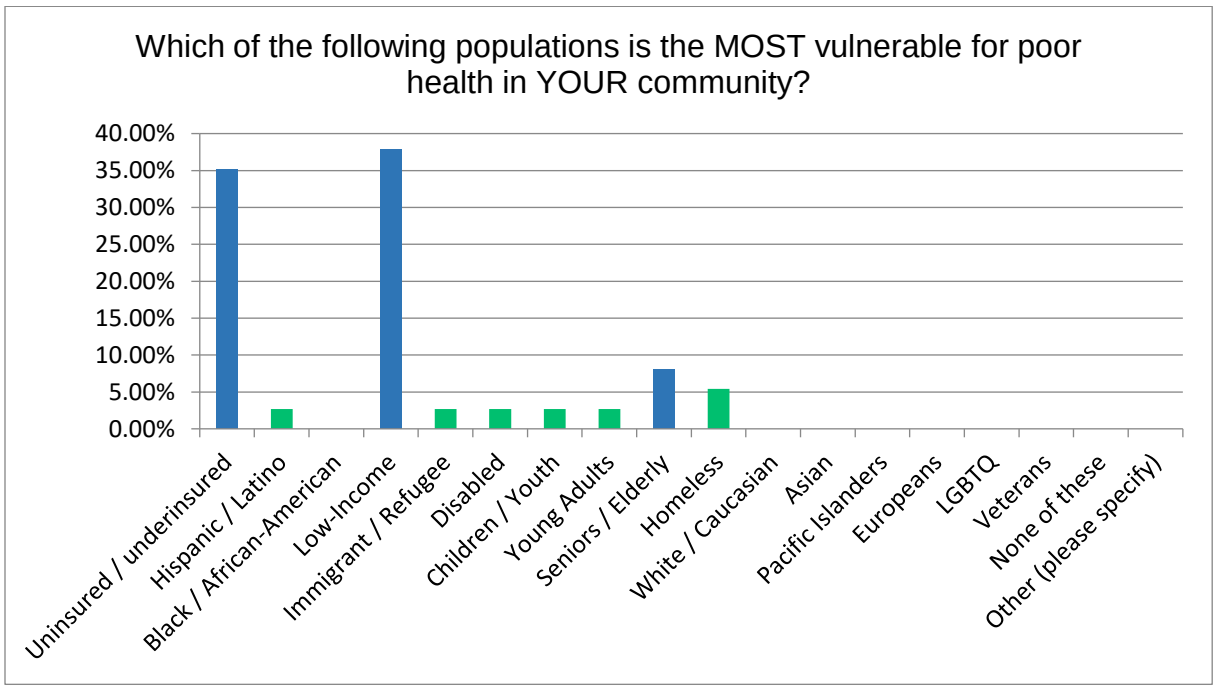


Figure 14. CHI St. Vincent Hot Springs / Christus Dubuis Hospital - Most Vulnerable Populations



Respondents were given the opportunity to share additional thoughts in an open response format. Below is a sampling of their quotes:

- "I consider my family as middle class. I have insurance through my job but the co-pay and cost of meds are ridiculous."
- "It is very difficult to see a physician in this community even with health insurance."
- "People in poverty do not use routine preventative health care."

Focus Groups

Three focus groups were conducted in Garland County with a total of 39 participants (Table 13).

Table 13. CHI St. Vincent Hot Springs / Christus Dubuis Hospital - Focus Groups

Date	Meeting Space	Facilitator(s)	Scribe	# Attended
March 11, 2019	CHI SV McAuley Senior Center	Rebecca Stone	Celina Miranda	13
March 14, 2019	Lakeside High School	Rebecca Stone	Deb Roybal	6
March 21	Trinity Church of Hot Springs	Rebecca Stone	--	20

The first focus group was held at CHI St. Vincent McAuley Senior Center, a resource center that provides nutritious meals and social events for seniors age 60 and older. All participating individuals identified as Caucasian. Key community problems or concerns discussed during the focus group are listed below.

- No Caregiver Support (Particularly for Dementia)
- Long Wait Times for Non-Emergency, Preventive Care Services (e.g. Cardiology)
- Overprescribing of Medications
- Pain Control – Sudden Loss of Opioid Prescription with no Dual Treatment
- Cost of Care for Seniors / Elderly
- Lack of Employment Opportunities

The second focus group was conducted with adult employees of Lakeside High School, including teachers and administrators. Although the school community was invited, none opted to participate. All participants were between the ages of 18 and 65, and all identified as Caucasian. Key community problems or concerns discussed during the focus group are listed below.

- Children's Mental Health
- Poor Understanding of Mental Health / Professionals Cannot Agree on Treatment
- Lack of Services / Inadequate Frequency of Services
- Turnover of Mental Health Staff
- Adverse Childhood Events
- Home Environment (Instability of Parents) / Changes in Family Structure (Grandparents as Guardians)

- Poor Social Networks
- Poor Nutrition / Lack of Access to Healthy Food
- Factors Leading to Poor School Attendance
- Stress for School Staff
- Busy Professionals Face Challenges of having Nutritious Diets and Exercise
- Motor Vehicle Accidents due to Motorcycles, Alcohol at local Race Track and Narrow Roads

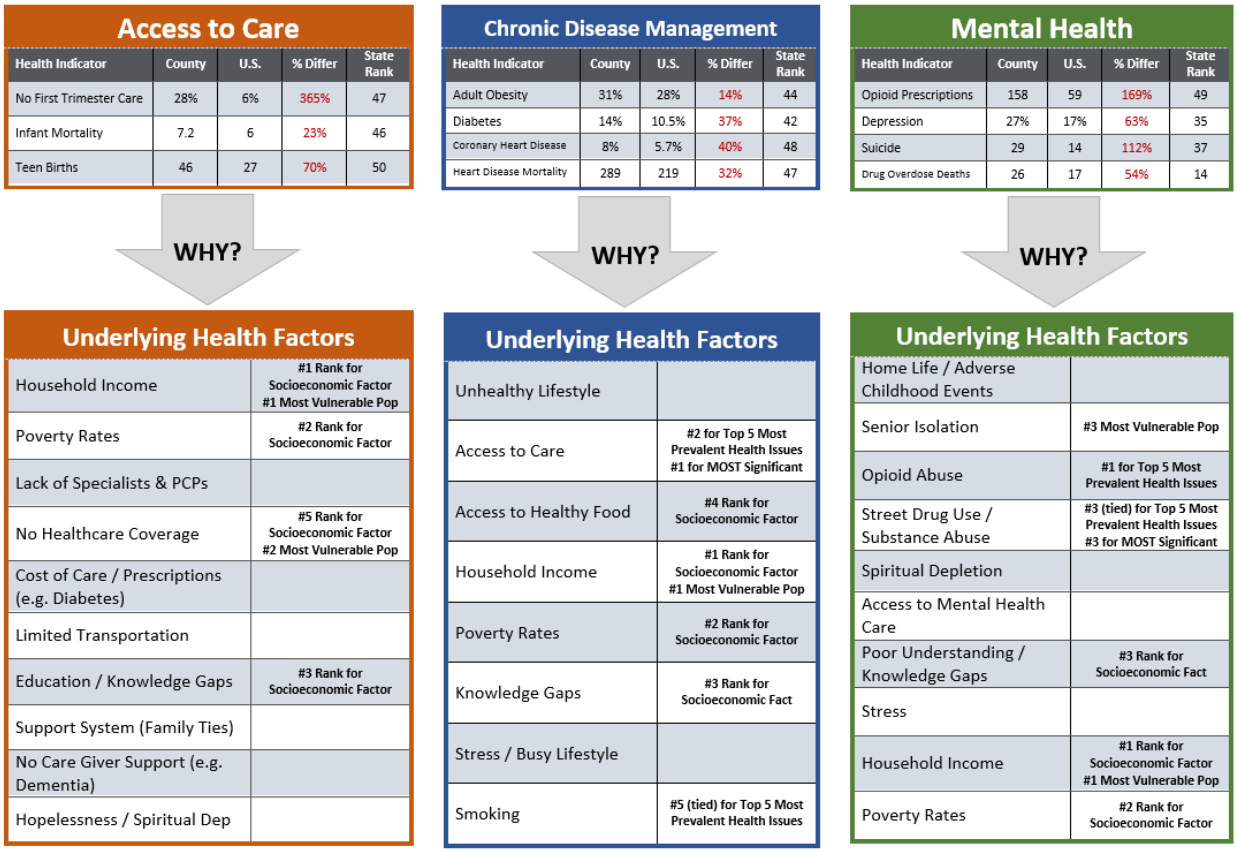
The third focus group was conducted at Trinity Church of Hot Springs. Participants ranged in age from 18 to 65, and five (5) were over the age of 65. In this group, the majority were Caucasian and three identified as Black/African American. Key community problems or concerns discussed during the focus group are listed below.

- Lack of Mental Health Services (Psychiatric Unite Closed)
- ED wait times/discharge time
- Long Wait Times for Appointments PCP / Lack of Specialists (e.g. Rheumatology)
- Cost of medication/lack education of generic (ex. Diabetes meds)
- EMRs in Hot Springs and Little Rock don't communicate / If you go to LR, referred in LR
- Limited Insurance Enrollment
- Mental health/depression not identified during health visits
- Process of interpretation for the deaf, etc.
- Poor nutrition/lack of education
- Communication between VA and CI for opioids- cut off suddenly
- School Education does not include practical matters
- Large Homeless Population
- Some providers do no take Medicaid
- Lack of Resources for Lupus, sickle cell anemia
- Some insurance doesn't cover occupational therapy and speech
- Difficult for children to receive services like counseling, occupational therapy, etc.
- Poor bus system, costly

Data Mapping and Analysis

Through rigorous data analysis, two key themes emerged: 1) access to healthcare and 2) mental health. Chronic disease management was added as a third theme given internal stakeholders' preference for it as a focus area. The research team then evaluated the underlying causes of poor health outcomes to determine key community health focus areas for CHI St. Vincent Hot Springs and Christus Dubuis Hospital. A data model of key community health needs and underlying factors was constructed from all data sources (Figure 15). The data model was reviewed with several key contributors (Appendix A) for feedback and refinement.

Figure 15. CHI St. Vincent Hot Springs / Christus Dubuis Hospital - Data Model



Community Health Priorities

In May of 2019, the research team presented an analytical overview of findings and the model of key community health needs to CHI St. Vincent Hot Springs leadership teams. The community benefit coordinator for Christus Dubuis Hospital also received a copy of the findings. Following rigorous dialogue and debate, the leadership team selected six focus areas across the two key themes (Table 14). These focus areas will serve as the targets for community health efforts throughout the upcoming CHNA/CHIS cycle. Although chronic disease management was identified as a third significant theme, hospital leaders agreed to view this theme as a focus area given its relationship to healthcare access. As noted in Chapter 2, the CHI ST. Vincent health system board of directors reviewed and approved both the prioritized focus areas and the implementation strategy in May of 2019. In addition, the CHI St. Vincent Hot Springs board of directors reviewed and approved the CHNA and implementation strategy in September 2019.

Table 14. CHI St. Vincent Hot Springs / Christus Dubuis Hospital - Prioritized Community Health Needs

CHI St. Vincent Hot Springs and Christus Dubuis Hospital		
Prioritized Community Health Need	**Focus Area(s)**	**Population(s)**
Access to Healthcare Services	• Primary Care (including perinatal care) • Chronic Disease Management • Trauma Services	• Seniors (ages 65 and older) • Individuals living in poverty
Mental Health*	• Substance Use & Abuse (including opioid use)	• Seniors (ages 65 and older) • Pregnant and parenting women
	• Suicide Prevention	• Seniors (ages 65 and older)
	• Behavioral health access	• Seniors (ages 65 and older)

*NOTE: Christus Dubuis Hospital does not plan to address mental health issues as CMS regulations do not allow long-term acute care facilities to provide mental health services.

CHI St. Vincent Hot Springs – Implementation Strategy

Problem: Arkansas continues to rank at the lowermost deciles in the US for multiple health indicators. In target counties, individuals living in poverty are at increased risk for poor health.

Goal: Improve health outcomes in key focus areas, with an emphasis on those who are poor and vulnerable

INPUTS

Staff
- One team sponsor
- Internal stakeholder group (including physicians and nurses)
- One project owner for each focus area

Funding
- Outgoing: Sponsorships & donations targeted at coalition-building for each program
- Incoming: Program-specific grants

Equipment / Facilities
- Tracking software (CBISA)
- Event/meeting spaces
- Screening supplies

Partners
- Multiple similarly focused community partner agencies for each program

ACTIVITIES

- Build a community coalition for each focus area
- Continue to provide care for medically underserved persons with emphasis on residents of rural areas and low-income pregnant women.
- Assess need for behavioral health and define strategy.
- Continue to provide Level II trauma services.
- Design and implement improvement programs (metrics, surveillance, and outcomes).

OUTCOMES

Short Term – Deliverables Program Level
- Written assessment of SDoH that most strongly influence each focus area.
- Written master work plan for each program
- Completed media kit for each program
- Completed outreach model for each program

Intermediate - Program Objectives in Target Counties
- Increased observance of healthy behaviors among low-income pregnant women.
- Decreased number of opioid prescriptions written per capita
- Decreased drug overdose deaths
- Decreased suicide rates
- Increase in number of patients with access to inpatient behavioral health services

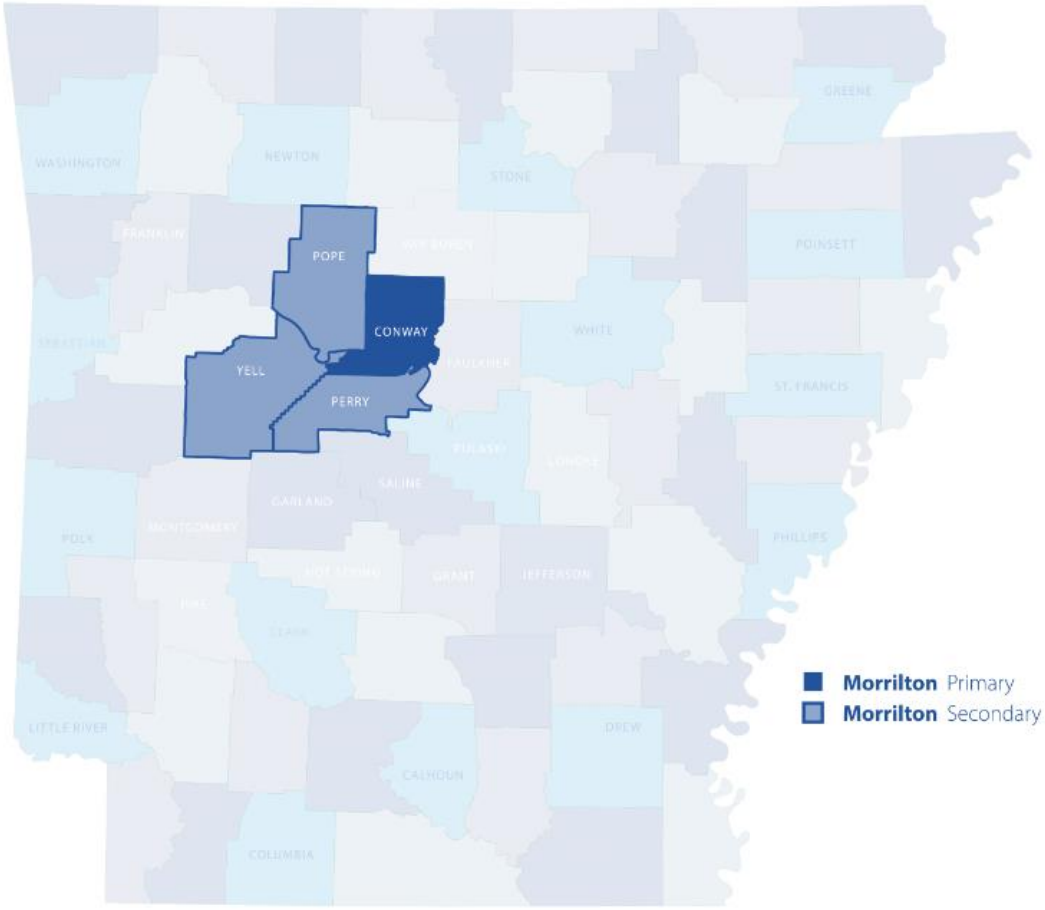
Long-Term Outcomes - Program Objectives in Target Counties
- Decreased years of potential life lost (YPLL)
- Increased life expectancy
- Decreased infant mortality

Chapter 5. CHI St. Vincent Morrilton

Hospital Service Area

The 2019 CHNA defines its primary commitment areas per IRS guidelines as the demographic zones from which the majority of hospital admissions originate. Demographic zones are identified by zip codes for unique patient medical records. Zip codes are then plotted by county to identify primary commitment areas (Figures 16). Secondary commitment areas are those counties immediately adjacent to primary commitment areas or those from which the largest number of hospital inpatient patient admissions originate. Although CHI ST. Vincent Morrilton community benefit activities may reach beyond these demographic zones, efforts will be focused in these areas.

Figure 16. CHI St. Vincent Morrilton - Primary and Secondary Commitment Areas



Secondary Data Review

A detailed review and analysis of publicly available data was conducted as the starting point for data collection. Demographic profiles were reviewed in primary and secondary commitment as noted above.

Several findings are notable in the demographic information for Conway County (Table 15). First, population growth is behind the national average by more than 130%. Concurrently, the median household income for county residents is slightly below $40,000 per year as compared to the national average of more than $55,000 annually, and only 16%

of the population hold a bachelor's degree compared to the national average of nearly 30%. Conway County lacks racial diversity in that approximately 85% of the total population is white. The proportion of seniors living in the community is more than 20% higher than the national average.

Table 15. CHI St. Vincent Morrilton - Demographic Data

Measurement	Conway County		Benchmarks	
	Health Indicator	% Differ from U.S. Avg	Arkansas	United States
Population Growth Rate	-1.7%	-130.9%	2.9%	5.5%
Median Household Income	$39,638	-28.4%	$42,336	$55,322
Total Population Below Poverty Line	17.2%	39.8%	16.4%	12.3%
Persons Without Health Coverage	8.8%	-13.7%	9.3%	10.2%
High School Degree	85.2%	-2.1%	85.2%	87.0%
Bachelor's Degree or Higher	15.8%	-47.9%	21.5%	30.3%
Race & Ethnicity				
White	84.9%	39.9%	72.5%	60.7%
Black or African American	11.4%	-14.9%	15.7%	13.4%
American Indian/Alaskan Native	0.8%	-38.5%	1.0%	1.3%
Asian	0.5%	-91.4%	1.6%	5.8%
Native Hawaiian/Other Pacific Islander	0.0%	-100.0%	0.3%	0.2%
Two or More Races	2.4%	-11.1%	2.1%	2.7%
Hispanic or Latino	3.9%	-78.5%	7.6%	18.1%
Age				
Children/Youth (Under 18 Years)	23.1%	0.9%	23.7%	22.9%
Adults (19-64 Years)	58.4%	-6.1%	60.3%	62.2%
Seniors (65+ Years)	18.5%	24.2%	16.0%	14.9%

Through the secondary data review, several key community health focus areas were identified (Table 16). The most prominent is the rate of pregnant women who do not receive prenatal care in the first trimester. When compared to the national average, women in Conway county are 450% less likely to receive necessary early prenatal care. Teen pregnancy and infant mortality rates are both nearly 100% higher than the national average. Another prevalent health indicator is the rate of opioid prescriptions. With 122 prescriptions written for every 100,000 in the population, the prescribing rate exceeds the national average by 108%. Rates of depression and suicide are also significantly higher than the national average.

Health issues associated with chronic disease management were also identified as key findings. Although these needs did not meet the selection criteria for inclusion as focus areas, internal hospital stakeholders nevertheless identified them as important in the health and well-being of the populations served (Table 17).

Table 16. CHI St. Vincent Morrilton – Primary Focus Areas

Focus Areas	Conway County	National	% Difference	State Rank '18
No First Trimester Care	33% of pregnant women	6%	448%	47
Opioid Prescriptions	122 / 100,000	59	108%	49
Infant Mortality	11 / 100,000	6	94%	46
Teen Births	52 / 100,000	27	93%	50 *(2015)*
Suicide	22 / 100,000	14	65%	37
Depression	25% of screened individuals	17%	50%	35

Table 17. CHI St. Vincent Morrilton - Chronic Disease Factors

Health Indicator	Conway County	National	% Difference	State Rank '18
Stroke	70	38	87%	50
Hypertension	42%	33%	25%	48
Coronary Heart Disease	6.4%	5.7%	12%	48
Heart Disease Mortality	321	219	27%	47
Cancer	191	156	23%	47
Adult Obesity	38%	28%	36%	44
Diabetes	14%	10.5%	35%	42

Talking points for the CHI St. Vincent Morrilton community health needs critical focus areas were developed to assist with internal and external communications. This information was included on the infographic placements for use with focus groups.

- 1 in 3 mothers in Conway County go without prenatal care beginning in the first trimester. This is 5.5 times higher than the national average.
- 1 in 12 babies in Conway County are born at a low birth weight (less than 5.5lbs).
- 1 in 88 babies born in Conway County die within the first year. This is 1.9 times higher than the national average.
- 1 in 19 teenagers, ages 15 to 19, will give birth each year in Conway County. This is 1.9 times higher than the national average.
    - In 2015, Arkansas had the highest teen pregnancy rate in America.

- 1 in 4 Conway County residents have been told they have Depressive Disorder by a health provider. This is 1.5 times higher than the national average.
- The Suicide rate in Conway County is 1.6 times higher than the national average. Conway County's rate is 22 in 100,000.
- Conway County opioid prescription rates are 2.1 times higher than the national average.
    - There are more opioid prescriptions in Conway County than there are residents at 1.2 prescriptions per person.

Key Informant Survey

The key informant survey for Conway and surrounding counties produced 19 completed responses. As noted in Figure 17, respondents identified adult obesity and substance use – including smoking and opioids – as the most prevalent health issues. Diabetes surfaced as the most prevalent chronic condition. Access to healthcare services was also named as a key community health issue. In addition to poverty, respondents also noted lack of healthcare coverage as one of the socioeconomic factors with the greatest influence on health (Figure 18). Similarly, the most vulnerable populations identified were those with incomes at or below poverty level and those who are uninsured or underinsured (Figure 19).

Figure 17. CHI St. Vincent Morrilton - Most Prevalent Health Issues

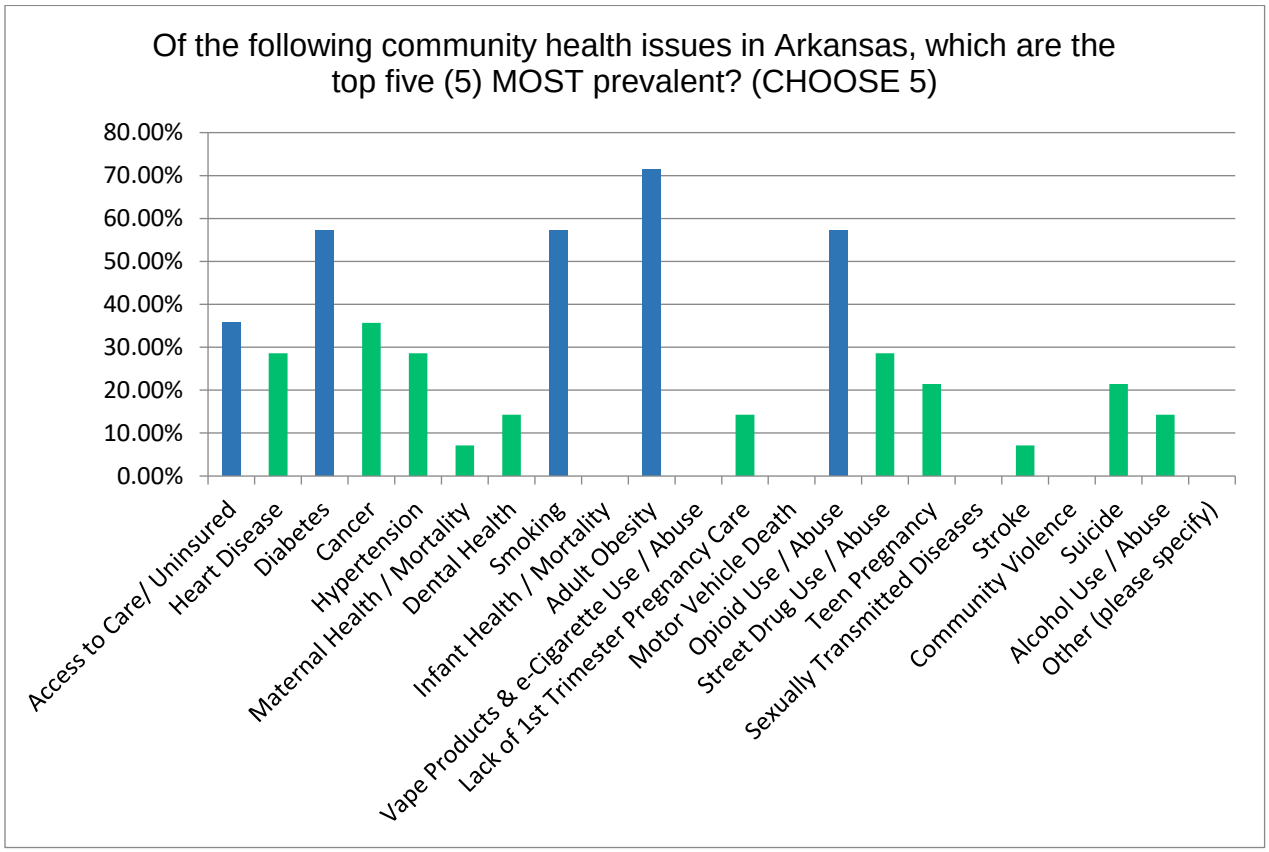


Figure 18. CHI St. Vincent Morrilton - Most Influential Socioeconomic Factors

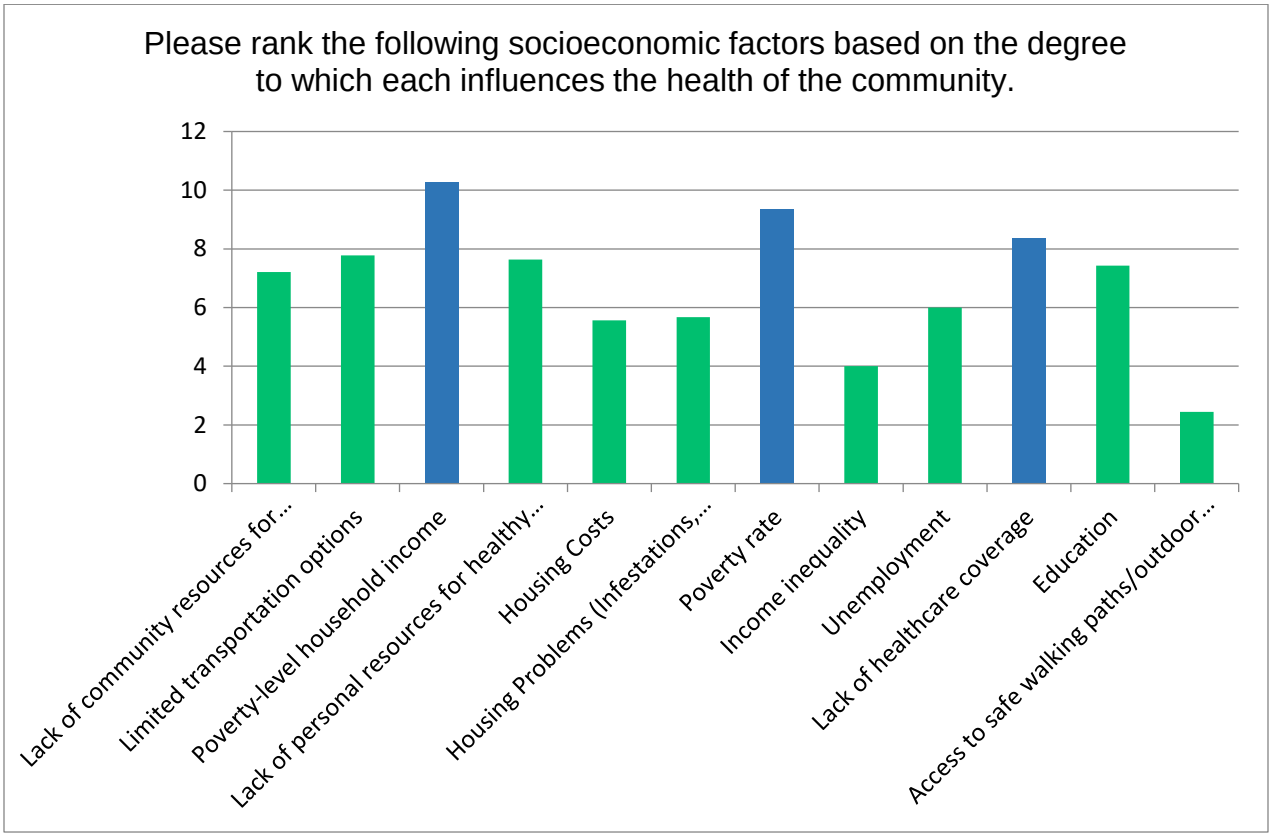
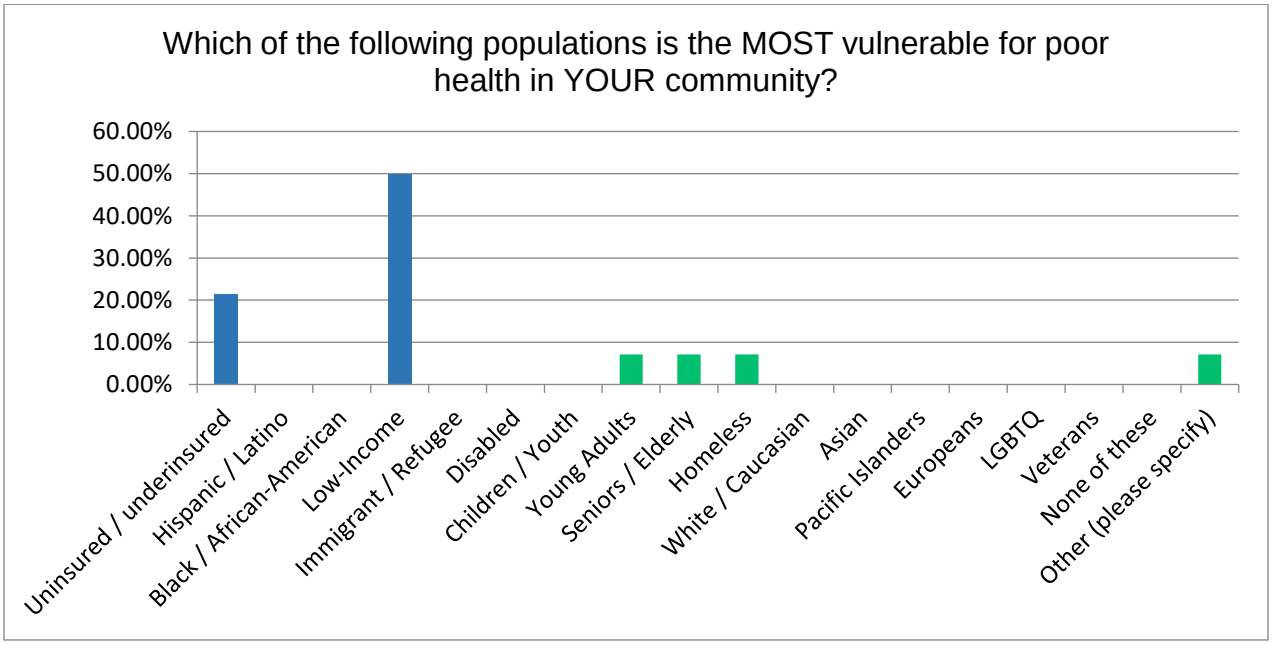


Figure 19. CHI St. Vincent Morrilton - Most Vulnerable Populations



Respondents were given the opportunity to share additional thoughts in an open response format. A sample of their quotes are listed below.

- "Growing old is not pretty even if you have money to pay the bills."
- "It would be nice if there was more free transportation options for seniors to get to places such as the Senior Adult Center, Community Center for exercise, grocery shopping, etc."
- "Conway County did have a free clinic a few years ago, not sure what happened to it."

Focus Groups

A total of 2 focus groups were conducted in Conway County capturing the perspectives of 17 community members (Table 18).

Table 18. CHI St. Vincent Morrilton - Focus Groups.

Date	Meeting Space	Facilitator(s)	Scribe	# Attended
February 26, 2019	CHI St. Vincent Morrilton Hospital	Deb Roybal	--	8
February 28, 2019	CHI St. Vincent Morrilton Hospital	Rebecca Stone	--	9

The first focus group was conducted at CHI St. Vincent Morrilton hospital with representatives of the auxiliary team, which is comprised of community members actively volunteering at the hospital. All members of this focus group identified as more than 65 years in age and two self-identified as Caucasian. Other participants did not complete race/ethnicity information on the post-session evaluation form.

Key community problems or concerns discussed during the focus group included:

- Senior Isolation / Mental Health
- Teen Pregnancy
- Drug Abuse (all ages)
- Unhealthy Lifestyle Choices (i.e. eating at McDonalds)
- Disjointed Family Units (seniors raising grandchildren)

The second focus group was conducted with employees at CHI St. Vincent Morrilton hospital who live in the community. The focus group had representation from 9 adults who identified themselves on the post-session evaluation form as between the ages of 18 and 65. Seven of the participants identified themselves as Caucasian and two identified themselves as Black/African American.

Key community problems or concerns discussed during the focus group included:

- Prevalence of Diabetes
- Lack of Access to PCPs and Specialists (e.g. no OBGYN in the community)
- Prevalence of Teen Pregnancies
- High Prevalence of Drug Abuse
- Lack of Resources for Mental Health

Data Mapping and Analysis

Through rigorous data analysis, two key themes emerged: 1) access to healthcare and 2) mental health. Chronic disease management was added as a third theme given internal stakeholders' preference for it as a focus area. The research team then evaluated the underlying causes of poor health outcomes to determine key community health focus areas for CHI St. Vincent Morrilton. A data model of key community health needs and underlying factors was constructed from all data sources (Figure 20). The data model was reviewed with several key contributors (Appendix A) for feedback and refinement.

Figure 20. CHI St. Vincent Morrilton - Data Model

Access to Care

Health Indicator	County	U.S.	% Differ	State Rank
No First Trimester Care	33%	6%	448%	47
Infant Mortality	11	6	94%	46
Teen Births	52	27	93%	50

Chronic Disease Management

Health Indicator	County	U.S.	% Differ	State Rank
Adult Obesity	38%	28%	36%	44
Diabetes	14%	10.5%	35%	42
Cancer	191	156	23%	47

Mental Health

Health Indicator	County	U.S.	% Differ	State Rank
Suicide	22	14	65%	37
Depression	25%	17%	50%	35
Opioid Prescriptions	122	59	108%	49

WHY?

WHY?

WHY?

Underlying Health Factors

Household Income	#1 Rank for Socioeconomic Factor
Poverty Rates	#2 Rank for Socioeconomic Factor
Lack of Specialists & PCPs (e.g. OBGYN)	
No Healthcare Coverage	#3 Rank for Socioeconomic Factor #2 Most Vulnerable Pop
Cost of Prescriptions (e.g. Diabetes)	
Limited Transportation	#4 Rank for Socioeconomic Factor
Education / Knowledge Gaps	
Support System (Family Ties)	
Vouchers for Appointments	
Hopelessness / Spiritual Dep	

Underlying Health Factors

Unhealthy Lifestyle	
Access to Care	#5 Rank for Top 5 Most Prevalent Health Issues #2 MOST Significant
Access to Healthy Food	
Household Income	#1 Rank for Socioeconomic Factor
Poverty Rates	#2 Rank for Socioeconomic Factor
Knowledge Gaps	
Stress	
Smoking	#2 (tied) Rank for MOST Significant Health Issue
Occupational Hazards	

Underlying Health Factors

Home Life / Adverse Childhood Events	
Senior Isolation	
Opioid Abuse	#2 (tied) Rank for MOST Significant Health Issue
Spiritual Depletion	
Access to Mental Health Care	
Stress	
Household Income	#1 Rank for Socioeconomic Factor
Poverty Rates	#2 Rank for Socioeconomic Factor

Community Health Priorities

In May of 2019, the research team presented an analytical overview of findings and the model of key community health needs to the CHI St. Vincent Morrilton leadership team. The leadership team identified three focus areas between the two themes (Table 19). These focus areas will serve as the targets for community health efforts throughout the upcoming CHNA/CHIS cycle. Although chronic disease management was identified as a third significant theme, hospital leaders agreed to view this theme as a focus area given its relationship to healthcare access. As noted in Chapter 2, the CHI ST. Vincent health system board of directors reviewed and approved both the prioritized focus areas and the implementation strategy in May of 2019. In addition, the CHI St. Vincent Morrilton Springs board of directors reviewed and approved the CHNA and implementation strategy in August 2019.

Table 19. CHI St. Vincent Morrilton - Prioritized Health Needs.

CHI St. Vincent Morrilton		
Prioritized Community Health Need	**Focus Area(s)**	**Population(s)**
Access to Healthcare Services	• Primary Care, including perinatal care • Chronic Disease Management	• Seniors (ages 65 and older) • Individuals living in poverty
Mental Health	• Senior isolation	• Seniors (ages 65 and older)

CHI St. Vincent Morrilton - Implementation Strategy

Problem: Arkansas continues to rank at the lowermost deciles in the US for multiple health indicators. In target counties, individuals living in poverty are at increased risk for poor health.

Goal: Improve health outcomes in key focus areas, with an emphasis on those who are poor and vulnerable

INPUTS

Staff
- One team sponsor
- Internal stakeholder group (including physicians and nurses)
- One project owner for each focus area

Funding
- Outgoing: Sponsorships & donations targeted at coalition-building for each program
- Incoming: Program-specific grants

Equipment / Facilities
- Tracking software (CBISA)
- Event/meeting spaces
- Screening supplies

Partners
- Multiple similarly focused community partner agencies for each program

ACTIVITIES

- Build a community coalition for each focus area
- Create a charity care clinic in the primary commitment area
- Partner with local senior center in offering social activities for seniors
- Design and implement improvement programs (metrics, surveillance, and outcomes).

OUTCOMES

Short Term – Deliverables Program Level
- Written assessment of SDoH that most strongly influence each focus area.
- Written master work plan for each program
- Completed media kit for each program
- Completed outreach model for each program

Intermediate - Program Objectives in Target Counties
- Increased number of seniors participating in social activities
- Decreased number of opioid prescriptions written per capita
- Increased number of community members receiving primary care and prenatal visits

Long-Term Outcomes - Program Objectives in Target Counties
- Decreased years of potential life lost (YPLL)
- Increased life expectancy
- Decreased infant mortality

Chapter 6. Impact Evaluation – 2016 CHI St. Vincent CHIP

CHI St. Vincent Infirmary

The CHI St. Vincent Infirmary Community Health Needs Assessment was developed in 2016 and identified seven priority areas which the hospital addressed in its Community Health Implementation Plan (CHIP). CHI St. Vincent Infirmary's work to address these priorities over the past 3 years is summarized below.

Obesity

- CHI SVI created 3 indoor and outdoor walking paths that promote exercise to visiting community members.
- CHI SVI conducts weekly produce markets in the cafeteria that offer assorted seasonal produce procured from local sources when available.

Health Promotion and Education

- CHI SV provides nutrition education utilizing Well-Fed Me curriculum in the format of monthly e-newsletters to 3,800 subscribers and the distribution of 10,000 booklets per year.
- CHI SVI supported the Arkansas United Soccer Club in 2017 through a $15,000 sponsorship.

Chronic Disease Management

- CHI SVI promoted chronic disease management through community health fairs and screenings, which included 26 health fairs and physicals from FY16 to FY18 that served 5,685 community members.
- CHI SV promotes chronic disease management through the Arkansas Health Network, CHI SV's clinically integrated network, which managed 53,937 lives in FY16, 71,416 lives in FY17 and 92,298 in FY18.

Latino Health

- CHI SVI conducted a health fair for the Latino community at the St. Teresa's Church on June 30, 2016 that served 75 community members.

Mental Health

- CHI SV provided Mental Health First Aid trainings to 45 hospital staff across the four facilities and 100 community members.
- CHI SV facilitated the evidenced-based safeTALK program which reached 83 professionals/community members and 53 youth, ages 15 to 21.

Access to Care

- CHI SVI provided charity care, defined as self-pay and Medicaid shortfalls, which totaled in charges at $6.9M in FY16, $11.0M in FY17 and $27.4M in FY18.
- CHI SVI conducted a total of 26 health fairs and physicals from FY16 to FY18 in the community that served 5,685 community members.

Senior Health

- CHI SV promotes chronic disease management through the Arkansas Health Network, CHI SV's clinically integrated network, which managed 4.062 senior lives in FY16, 4,413 senior lives in FY17 and 6,209 senior lives in FY18.

CHI St. Vincent Hot Springs

The CHI St. Vincent Hot Springs Community Health Needs Assessment was developed in 2016 and identified seven priority areas which the hospital addressed in its Community Health Implementation Plan (CHIP). CHI St. Vincent Hot Spring's work to address these priorities over the past 3 years is summarized below.

Obesity

- CHI SVHS created 3 indoor and outdoor walking paths that promote exercise to visiting community members.
- CHI SVHS conducts weekly produce markets in the cafeteria that offer assorted seasonal produce procured from local sources when available.

Health Promotion and Education

- CHI SV provides nutrition education utilizing Well-Fed Me curriculum in the format of monthly e-newsletters to 3,800 subscribers and the distribution of 10,000 booklets per year.
- CHI SVHS facilitated community health education in cancer, diabetes, heart disease, substance abuse and women's health from FY16 to FY18 that reached 1,178 community members.

Chronic Disease Management

- CHI SVHS promoted chronic disease management through community health fairs and screenings, which included 22 health fairs and physicals from FY16 to FY18 that served 2,972 community members.
- CHI SV promotes chronic disease management through the Arkansas Health Network, CHI SV's clinically integrated network, which managed 53,937 lives in FY16, 71,416 lives in FY17 and 92,298 in FY18.

Latino Health

- CHI SVHS conducted a health fair for the Latino community at Our Lady of Guadalupe Church in Glenwood on September 17, 2016 that served 102 community members.

Mental Health

- CHI SVHS facilitated a total of 46 mental health educations in the form of trainings and conference presentations that reached 3,713 persons.
- CHI SV provided Mental Health First Aid trainings to 45 hospital staff across the four facilities and 100 community members.
- CHI SV facilitated the evidenced-based safeTALK program which reached 83 professionals/community members and 53 youth, ages 15 to 21.

Access to Care

- CHI SVHS provided charity care, defined as self-pay and Medicaid shortfalls, which totaled in charges at $22.7M in FY16, $15.6M in FY17 and $15.1M in FY18.
- CHI SVHS conducted a total of 22 health fairs and physicals from FY16 to FY18 that served 2,972 community members.

Senior Health

- CHI SV promotes chronic disease management through the Arkansas Health Network, CHI SV's clinically integrated network, which managed 4.062 senior lives in FY16, 4,413 senior lives in FY17 and 6,209 senior lives in FY18.

CHI St. Vincent Morrilton

The CHI St. Vincent Morrilton Community Health Needs Assessment was developed in 2016 and identified seven priority areas which the hospital addressed in its Community Health Implementation Plan (CHIP). CHI St. Vincent Morrilton's work to address these priorities over the past 3 years is summarized below.

Obesity

- CHI SVM created 1 outdoor walking path that promotes exercise to visiting community members.
- CHI SVM conducts weekly produce markets in the cafeteria that offer assorted seasonal produce procured from local sources when available.

Health Promotion and Education

- CHI SV provides nutrition education utilizing Well-Fed Me curriculum in the format of monthly e-newsletters to 3,800 subscribers and the distribution of 10,000 booklets per year.

Chronic Disease Management

- CHI SV promotes chronic disease management through the Arkansas Health Network, CHI SV's clinically integrated network, which managed 53,937 lives in FY16, 71,416 lives in FY17 and 92,298 in FY18.

Latino Health

- ???

Mental Health

- CHI SV provided Mental Health First Aid trainings to 45 hospital staff across the four facilities and 100 community members.
- CHI SV facilitated the evidenced-based safeTALK program which reached 83 professionals/community members and 53 youth, ages 15 to 21.

Access to Care

- CHI SVM provided charity care, defined as self-pay and Medicaid shortfalls, which totaled in charges at $481,990 in FY16, $475,408 in FY17 and $366,561 in FY18.

Senior Health

- CHI SV promotes chronic disease management through the Arkansas Health Network, CHI SV's clinically integrated network, which managed 4.062 senior lives in FY16, 4,413 senior lives in FY17 and 6,209 senior lives in FY18.

CHI St. Vincent North

The CHI St. Vincent North Community Health Needs Assessment was developed in 2016 and identified seven priority areas which the hospital addressed in its Community Health Implementation Plan (CHIP). CHI St. Vincent North's work to address these priorities over the past 3 years is summarized below.

Obesity

- CHI SVN created 2 indoor and outdoor walking paths that promote exercise to visiting community members.
- CHI SVN conducts weekly produce markets in the cafeteria that offer assorted seasonal produce procured from local sources when available.

Health Promotion and Education

- CHI SV provides nutrition education utilizing Well-Fed Me curriculum in the format of monthly e-newsletters to 3,800 subscribers and the distribution of 10,000 booklets per year.

Chronic Disease Management

- CHI SV promotes chronic disease management through the Arkansas Health Network, CHI SV's clinically integrated network, which managed 53,937 lives in FY16, 71,416 lives in FY17 and 92,298 in FY18.

Latino Health

- ???

Mental Health

- CHI SV provided Mental Health First Aid trainings to 45 hospital staff across the four facilities and 100 community members.
- CHI SV facilitated the evidenced-based safeTALK program which reached 83 professionals/community members and 53 youth, ages 15 to 21.

Access to Care

- CHI SVM provided charity care, defined as self-pay and Medicaid shortfalls, which totaled in charges at $652,368 in FY16, $1.1M in FY17 and $4.8M in FY18.

Senior Health

- CHI SV promotes chronic disease management through the Arkansas Health Network, CHI SV's clinically integrated network, which managed 4.062 senior lives in FY16, 4,413 senior lives in FY17 and 6,209 senior lives in FY18.

Appendices

Appendix A – Contributors

The following individuals and agencies contributed to the 2019 Community Health Needs Assessment process.

Name	Position	Organization	Contribution
Deb Roybal, RN, MS, PhD	SVP, Mission Integration	CHI St. Vincent	Project Lead/Champion
Rebecca Stone, MHA	Administrative Fellow	CHI St. Vincent	Project Manager
Celina Miranda	Unit Coordinator	CHI St. Vincent - North	Project Coordinator
Kathy McNespey	Executive Assistant	CHI St. Vincent - Infirmary	Administrative Support
Don Thompson	Program Mgr., Community Benefit	Christus Health	Project Champion
Gareth Patterson	Brand Specialist	CHI St. Vincent	Graphics & Design
Chad Dillard, MBA	Mkt VP of Marketing	CHI St. Vincent	Graphics & Design
Sarah Lehr	Communications Strategist	CHI St. Vincent	Graphics & Design
Craig Wilson, JD, MPA	Health Policy Director	Arkansas Center for Health Improvement (ACHI)	CHNA Collaboration Efforts
Pader Moua	Policy Analyst	Arkansas Center for Health Improvement (ACHI)	Data Collection Support
Anna Strong	Executive Director of Child Advocacy & Public Health	Arkansas Children's Hospital	Data Collection & Analysis Support
Craig Wilson, JD MPA	Directory, Health Policy	Arkansas Center for Health Improvement (ACHI)	Data Collection & Analysis Support
Suma Ashok, MHA	Planning Analyst	CHI St. Vincent	Data Collection Support Focus Group Support
Barbara Halford, MBA, PT	Planning Analyst	CHI St. Vincent	Data Collection Support
Megan Roberts, MHA	Planning Analyst	CHI St. Vincent - Infirmary	Data Collection Support
Lenlie Freeman, RN, CPA	Clinical Quality Specialist	CHI St. Vincent	Data Collection Support
Sara Bradley, CPA	Mkt VP of Operational Finance	CHI St. Vincent	Data Collection Support
Cindy Hulen	Senior Financial Planning Analyst	CHI St. Vincent	Data Collection Support
Mary Margaret Rogers, MBA	Business Development Coordinator	CHI St. Vincent Heart Institute	Data Collection Support
Vicky Sanders, MSN	Mkt Director of Nursing	CHI St. Vincent – Hot Springs	Data Collection Support
Patricia Jones	Director	CHI St. Vincent Medical Group	Data Collection Support
Susie Reynolds Reece	Violence Prevention Specialist	CHI St. Vincent – Hot Springs	Data Collection Support
Lindsay Mulkey	Substance Abuse Prevention Specialist	CHI St. Vincent – Hot Springs	Data Collection & Analysis Support

Wendi Summerville	Executive Assistant	CHI St. Vincent	Data Collection Support
Bonnie Ward	Senior Communications Strategist	CHI St. Vincent	Focus Group Support
Eddie Davis, MHSA, MBA, CHC	Corporate Responsibility Officer	Catholic Health Initiatives	Focus Group Support
Mandy Davis	Director	Jericho Way Resource Center	Focus Group Support
Kellie Chacon	Activities Coordinator	CHI St. Vincent - Hot Springs	Focus Group Support
Diane Harry	Senior Services Director	CHI St. Vincent - Hot Springs	Focus Group Support
Anthony Brunet	Assistant Principal	Lakewood High School – Hot Springs	Focus Group Support
Douglas Shackelford	Director of Public Affairs and Communications	Central AR Water	Focus Group Support
Matt Scully	Senior Pastor	Trinity Church of Hot Springs	Focus Group Support
Bob Thornton	Associate Pastor & Benevolence	Trinity Church of Hot Springs	Focus Group Support

Appendix B - Secondary Data Review Sources

Data for the 2019 Community Health Needs Assessment was drawn from the following sources:

- American Community Survey
- Area Health Resources File
- Arkansas Center for Health Improvement
- Arkansas Dept. of Health – Health Statistics Branch
- Arkansas Dept. of Human Services
- Arkansas Health Data Initiative
- Behavioral Risk Factors Surveillance Survey
- Bureau of Labor Statistics
- Centers for Disease Control (CDC)
- CDC US County Prescribing Rates (Opioids)
- CDC Drug Overdose Maps
- CDC Wide-Ranging Online data for Epidemiological Research
- Centers for Medicaid and Medicare Services
- County Health Rankings
- Dartmouth Atlas of Health Care
- EDFacts
- Fatality Analysis Reporting System
- Feeding America – Map the Meal Gap
- Kaiser Family Foundation – State Health Facts
- Kids Count Data Center
- National Center for Health Statistics
- National Institute on Drug Abuse – Arkansas Opioid Summary
- National Vital Statistics System – Natality Files
- US Census Bureau, Quick Facts & American Fact Finder
- US Census Bureau, SAIPE

Appendix C. Key Informant Survey Tool

2019 CHI ST. Vincent Community Health Needs Assessment

Key Informant Survey

CHI St. Vincent is in the midst of its triannual Community Health Needs Assessment (CHNA) process. You are invited to participate in a survey that will help identify the key areas of focus for our community health improvement efforts over the next three years. The survey consists of 10 multi-part questions and will take approximately 10 minutes to complete.

Survey results are shared in aggregate form in the final assessment report, and relevant quotes from your survey may be used to solidify data points. However, information that could reveal your individual identity will not be shared in association with any data points or quotes included in the final report.

At the conclusion of the survey, space is provided for any additional feedback you would like to share about CHI St. Vincent community health improvement efforts.

Thank you for taking the time to complete this survey.

1. Which of the following best represents your community affiliation? (CHOOSE 1)
   - Public Health
   - Public Safety (fire, police, emergency services)
   - Military
   - Mental/Behavioral Health
   - Non-Profit/Social Services
   - Elder Care
   - Faith-Based/Church/Parish Services
   - Youth Education (Grades K-12)
   - Higher Education
   - Youth Services
   - Business
   - Community Member

2. How long have you been in your current community position?
   a. 1 to 5 years
   b. 6 to 9 years
   c. 10 to 19 years
   d. 20 +

3. Of the following community health issues in Arkansas, which are the top five (5) MOST prevalent? (CHOOSE 5)

Access to Care/ Uninsured	Heart Disease	Diabetes
Cancer	Hypertension	Maternal Health / Mortality
Dental Health	Smoking	Infant Health / Mortality

Adult Obesity	Vape Products Use / Abuse	Lack of 1st Trimester Pregnancy Care
Motor Vehicle Death	Opioid Use / Abuse	Street Drug Use / Abuse
Teen Pregnancy	Sexually Transmitted Diseases	Stroke
Community Violence	Suicide	Alcohol Use / Abuse
Other (please list):		

4. Of the top five MOST prevalent health issues you identified, which is the MOST significant contributor to poor health in your community? (CHOOSE 1)

Access to Care/ Uninsured	Heart Disease	Diabetes
Cancer	Hypertension	Maternal Health / Mortality
Dental Health	Smoking	Infant Health / Mortality
Adult Obesity	Vape Products Use / Abuse	Lack of 1st Trimester Pregnancy Care
Motor Vehicle Death	Opioid Use / Abuse	Street Drug Use / Abuse
Teen Pregnancy	Sexually Transmitted Diseases	Stroke
Community Violence	Suicide	Alcohol Use / Abuse
Other (please list):		

5. Of the following socioeconomic factors, which has the MOST significant negative impact on the health of YOUR community? (CHOOSE 3)

Lack of community resources for healthy food	Limited transportation options	Poverty-level household income
Lack of personal resources for health food	Housing Costs	Housing Problems (Infestations, building conditions, etc.)
Poverty rate	Income inequality	Unemployment
Lack of healthcare coverage	Inadequate	Education
Other (please list):		

6. Of the three socioeconomic factors you selected, please rank them in the order in which they influence the health of YOUR community (1 = most significant; 3 = least significant):

Lack of community resources for healthy food	Limited transportation options	Poverty-level household income
Lack of personal resources for health food	Housing Costs	Housing Problems (Infestations, building conditions, etc.)
Poverty rate	Income inequality	Unemployment

Lack of healthcare coverage	Inadequate	Education
Other (please list):		

7. Which of the following populations are the MOST vulnerable for poor health in YOUR community?

Uninsured / underinsured	Hispanic / Latino	Black / African-American
Low-Income	Immigrant / Refugee	Disabled
Children / Youth	Young Adults	Seniors / Elderly
Homeless	White / Caucasian	Asian
Pacific Islanders	Europeans	None of these
LGBTQ	Veterans	
Other (please specify):		

8. For the populations you selected, please list two key health needs that most influence the health and well-being of the people in those populations:

9. For the populations you selected, please list two key interventions that would help to address their health needs:
10. Is there anything additional you would like to share?

Appendix D. Focus Group Toolkit

The focus group toolkit is designed to systematize the process of gathering information about health-related issues facing community members. Ensuring a consistent approach across all focus groups will strengthen data quality and the overall output from the Community Health Needs Assessment (CHNA) process.

The toolkit includes six tools:

1. Facilitation Agenda
2. Talking Points
3. Participant sign-in sheet
4. Evaluation form
5. Cover sheet
6. Documentation tables

Focus Group Process (modify as needed based on the group)

1. Preparation. Use a separate toolkit for each focus group. CHNA planners will confirm locations, dates, times and participants ahead of time. Each facilitator team is comprised of at least two individuals: one group facilitator and one scribe to capture the discussion on the flip charts.
    a. Items needed:
        i. Flip charts
        ii. Markers
        iii. Name badges
        iv. Copies of evaluation form (one for each participant)
        v. Infographic "placemats" (one for each participant)
        vi. Pens

2. Room Set-Up. Before the group arrives, tape up three flip chart pages (you will need more pages as the group begins responding to the facilitation questions). Label one sheet Problems/Concerns, one Resources/Barriers, and one Solutions. (See examples on Facilitation Agenda page).

    a. Place an infographic "placemat" at each seat
    b. Place the sign-in sheet where participants will see it upon entering, and encourage them to sign-in before they take a seat.

3. Agenda. See Facilitation Agenda for focus group questions, process-flow and data capture instructions.

4. Documentation. Transfer all flip chart notes to the documentation tables in the toolkit and complete the cover sheet using the demographic information from the evaluation. Save the file with the name of the focus group and the date (example: SVI_FG_StMaryChurch_03-04-19). Combine the original sign-in sheet and the evaluation form in the packet and submit to rkstone@stvincenthealth.com.

Facilitation Agenda:

Before beginning determine how much time you have to work with. The following time frame assumes 45 minutes total.

1. Introduction – 5 minutes

   - ☐ Invite participants to introduce themselves.
   - ☐ Provide a brief introduction to the Community Needs Assessment purpose and process (see "Talking Points")
   - ☐ Provide a very brief overview of the facilitation agenda so that participants know what to expect during the discussion. Emphasize that their input is vital in helping CHI St. Vincent to identify and prioritize needs, create solutions, and plan for services.
   - ☐ Explain that we are not trying to evaluate or judge any one person's opinions or experiences, rather the intent is to capture the thinking of as many people as possible.
   - ☐ Ask if there are any questions before you begin. Answer questions and then begin with the facilitation questions.

2. Problems/Concerns Identification – 20 minutes
   Ask the following questions and document answers on flipcharts.

   - ☐ What are the most significant problems related to health in your community? What ages are affected by the issue? What populations are most affected by these problems (seniors, children, Hispanics, etc.) *This question is designed to start the flow of dialogue about health issues in the community. If participants seem to be stuck, move on to the next question below. Facilitators can offer some possible issues/concerns to get the group going as long as they don't intentionally lead the discussion in a particular*

direction at this point.
5 minutes

- *Mentally assess what participants identified in the first prompt and consider where responses fit into four primary categories: health behaviors, clinical care, social & economic factors, physical environment). Prompt further discussion in any areas where you see gaps.*
  If discussion has been lagging in the first question, prompt further:
  What are the most significant problems related to health behaviors, clinical care, social & economic factors, or physical environment? What ages are affected by the issue? What populations are most affected by these problems? *Before moving from this question, be sure all four categories have been addressed with at least one response if possible.*
  5 minutes

- What have we missed in our list so far? What other problems or concerns significantly affect members of your community? What ages are affected? What populations are most affected by these problems?
  This question prompts for any health issues we may have missed in the dialogue to this point. It is intentionally broad to allow participants to respond in any way they need to.
  5 minutes

3. **Community Resources and Barriers** – 10 minutes
   Have participants look at the list of problems, issues and concerns, and then ask:

   - What resources are available in their community to address these issues? (List each resource on the left side of the flip chart page)

   - What are the barriers if any, to accessing these resources? (List barriers next to the resource to which they apply)

4. **Solutions.** – 10 minutes
   Have participants look at the list of problems, issues, resources and barriers, and then ask:

   - What actions, programs, strategies do they think would make the biggest difference in their community? (e.g., What solutions would help solve the problems and reduce/remove the barriers listed?)

Community Resources Available to Address Problems / Issues	Barriers to Accessing Available Resources
(List resources currently available community)	(List barriers next to the appropriate resources)

Solutions	Concern Area Affected			
(List each possible solution on a separate line and check the concern area the solution would address)	Health Behaviors	Clinical Care	Social & Economic Factors	Physical Environ

5. Conclusion. Thank participants for their time.
   Let them know we expect to have the data compiled, analyzed and a report posted to the CHI St. Vincent website by the end of June.

References

County Health Rankings (2014). Measures & data. A Robert Wood Johnson Foundation Program. Retrieved from https://www.countyhealthrankings.org/county-health-rankings-model

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