Ouachita County Medical Center

Camden, Arkansas

Community Health Needs Assessment
and Implementation Strategy

Adopted by Board Resolution September 19, 2016[1]

OCMC Ouachita County Medical Center

[1]Response to Schedule h (Form 990) Part V B 4 & Schedule h (Form 990) Part V B 9

OCMC Ouachita County Medical Center

Dear Community Member:

At Ouachita County Medical Center (OCMC), we have spent 64 years providing high-quality compassionate healthcare to the greater Camden community. The “2016 Community Health Needs Assessment” identifies local health and medical needs and provides a plan of how OCMC will respond to such needs. This document illustrates one way we are meeting our obligations to efficiently deliver medical services.

In compliance with the Affordable Care Act, all not-for-profit hospitals are required to develop a report on the medical and health needs of the communities they serve. We welcome you to review this document not just as part of our compliance with federal law, but of our continuing efforts to meet your health and medical needs.

OCMC will conduct this effort at least once every three years. The report produced three years ago is also available for your review and comment. As you review this plan, please see if, in your opinion, we have identified the primary needs of the community and if you think our intended response will lead to needed improvements.

We do not have adequate resources to solve all the problems identified. Some issues are beyond the mission of the hospital and action is best suited for a response by others. Some improvements will require personal actions by individuals rather than the response of an organization. We view this as a plan for how we, along with other area organizations and agencies, can collaborate to bring the best each has to offer to support change and to address the most pressing identified needs.

Because this report is a response to a federal requirement of not-for-profit hospitals to identify the community benefit they provide in responding to documented community need, footnotes are provided to answer specific tax form questions; for most purposes, they may be ignored. Most importantly, this report is intended to guide our actions and the efforts of others to make needed health and medical improvements in our area.

I invite your response to this report. As you read, please think about how to help us improve health and medical services in our area. We all live in, work in, and enjoy this wonderful community, and together, we can make our community healthier for every one of us.

Thank You,

Peggy L. Abbott,
Chief Executive Officer
Ouachita County Medical Center

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EXECUTIVE SUMMARY

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Ouachita County Medical Center ("OCMC" or the "Hospital") has performed a Community Health Needs Assessment to determine the health needs of the local community, develop an implementation plan to outline and organize how to meet those needs, and fulfill federal requirements.

Data was gathered from multiple well-respected secondary sources to build an accurate picture of the current community and its health needs. A survey of a select group of Local Experts was performed to review the prior CHNA and provide feedback, and to ascertain whether the previously identified needs are still a priority. A second survey was distributed to the same group that reviewed the data gathered from the secondary sources and determined the Significant Health Needs for the community.

The Significant Health Needs for Ouachita County are:

1. Heart Disease
2. Obesity
3. Physicians
4. Cancer
5. Diabetes
6. Mental Health/Suicide
7. Accessibility/Affordability

The Hospital has developed implementation strategies for all of the seven needs including activities to continue/pursue, community partners to work alongside, and leading and lagging indicators to track.

APPROACH

APPROACH

Ouachita County Medical Center (OCMC) is organized as a not-for-profit hospital. A Community Health Needs Assessment (CHNA) is part of the required hospital documentation of "Community Benefit" under the Affordable Care Act (ACA), required of all not-for-profit hospitals as a condition of retaining tax-exempt status. A CHNA helps the OCMC identify and respond to the primary health needs of its residents.

This study is designed to comply with standards required of a not-for-profit hospital.[2] Tax reporting citations in this report are superseded by the most recent 990 h filings made by the hospital.

In addition to completing a CHNA and funding necessary improvements, a not-for-profit hospital must document the following:

- Financial assistance policy and policies relating to emergency medical care
- Billing and collections
- Charges for medical care

Further explanation and specific regulations are available from Health and Human Services (HHS), the Internal Revenue Service (IRS), and the U.S. Department of the Treasury.[3]

Project Objectives

OCMC partnered with Quorum Health Resources (Quorum) to:[4]

- Complete a CHNA report, compliant with Treasury – IRS
- Provide the Hospital with information required to complete the IRS – 990h schedule
- Produce the information necessary for the Hospital to issue an assessment of community health needs and document its intended response

Overview of Community Health Needs Assessment

Typically, non-profit hospitals qualify for tax-exempt status as a Charitable Organization, described in Section 501(c)(3) of the Internal Revenue Code; however, the term 'Charitable Organization' is undefined. Prior to the passage of Medicare, charity was generally recognized as care provided those who did not have means to pay. With the introduction of Medicare, the government met the burden of providing compensation for such care.

In response, IRS Revenue ruling 69-545 eliminated the Charitable Organization standard and established the Community Benefit Standard as the basis for tax-exemption. Community Benefit determines if hospitals promote the health of a broad class of individuals in the community, based on factors including:

- An Emergency Room open to all, regardless of ability to pay

[2] Federal Register Vol. 79 No. 250, Wednesday December 31, 2014. Part II Department of the Treasury Internal Revenue Service 26 CFR Parts 1, 53, and 602
[3] As of the date of this report all tax questions and suggested answers relate to 2014 Draft Federal 990 schedule h instructions i990sh—dft(2) and tax form
[4] Part 3 Treasury/IRS – 2011 – 52 Section 3.03 (2) third party disclosure notice & Schedule h (Form 990) V B 6 b

- Surplus funds used to improve patient care, expand facilities, train, etc.
- A board controlled by independent civic leaders
- All available and qualified physicians granted hospital privileges

Specifically, the IRS requires:

- Effective on tax years beginning after March 23, 2012, each 501(c)(3) hospital facility must conduct a CHNA at least once every three taxable years, and adopt an implementation strategy to meet the community needs identified through the assessment.
- The assessment may be based on current information collected by a public health agency or non-profit organization, and may be conducted together with one or more other organizations, including related organizations.
- The assessment process must take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge or expertise of public health issues.
- The hospital must disclose in its annual information report to the IRS (Form 990 and related schedules) how it is addressing the needs identified in the assessment and, if all identified needs are not addressed, the reasons why (e.g., lack of financial or human resources).
- Each hospital facility is required to make the assessment widely available and downloadable from the hospital website.
- Failure to complete a CHNA in any applicable three-year period results in an excise tax to the organization of $50,000. For example, if a facility does not complete a CHNA in taxable years one, two, or three, it is subject to the penalty in year three. If it then fails to complete a CHNA in year four, it is subject to another penalty in year four (for failing to satisfy the requirement during the three-year period beginning with taxable year two and ending with taxable year four).
- An organization that fails to disclose how it is meeting needs identified in the assessment is subject to existing incomplete return penalties.[5]

Community Health Needs Assessment Subsequent to Initial Assessment

The Final Regulations establish a required step for a CHNA developed after the initial report. This requirement calls for considering written comments received on the prior CHNA and Implementation Strategy as a component of the development of the next CHNA and Implementation Strategy. The specific requirement is:

> *"The 2013 proposed regulations provided that, in assessing the health needs of its community, a hospital facility must take into account input received from, at a minimum, the following three sources:*
>
> *(1) At least one state, local, tribal, or regional governmental public health department (or equivalent department or agency) with knowledge, information, or expertise relevant to*

[5] Section 6652

the health needs of the community;

(2) members of medically underserved, low-income, and minority populations in the community, or individuals or organizations serving or representing the interests of such populations; and

(3) written comments received on the hospital facility's most recently conducted CHNA and most recently adopted implementation strategy.[6]

…the final regulations retain the three categories of persons representing the broad interests of the community specified in the 2013 proposed regulations but clarify that a hospital facility must ''solicit'' input from these categories and take into account the input ''received.'' The Treasury Department and the IRS expect, however, that a hospital facility claiming that it solicited, but could not obtain, input from one of the required categories of persons will be able to document that it made reasonable efforts to obtain such input, and the final regulations require the CHNA report to describe any such efforts."

Representatives of the various diverse constituencies outlined by regulation to be active participants in this process were actively solicited to obtain their written opinion. Opinions obtained formed the introductory step in this Assessment.

To complete a CHNA:

"… the final regulations provide that a hospital facility must document its CHNA in a CHNA report that is adopted by an authorized body of the hospital facility and includes:

(1) A definition of the community served by the hospital facility and a description of how the community was determined;

(2) a description of the process and methods used to conduct the CHNA;

(3) a description of how the hospital facility solicited and took into account input received from persons who represent the broad interests of the community it serves;

(4) a prioritized description of the significant health needs of the community identified through the CHNA, along with a description of the process and criteria used in identifying certain health needs as significant and prioritizing those significant health needs; and

(5) a description of resources potentially available to address the significant health needs identified through the CHNA.

… final regulations provide that a CHNA report will be considered to describe the process and methods used to conduct the CHNA if the CHNA report describes the data and other information used in the assessment, as well as the methods of collecting and analyzing this data and information, and identifies any parties with whom the hospital facility collaborated, or with whom it contracted for assistance, in

[6] Federal Register Vol. 79 No. 250, Wednesday December 31, 2014. Part II Department of the Treasury Internal Revenue Service 26 CFR Parts 1, 53, and 602 P. 78963 and 78964

conducting the CHNA."[7]

Additionally, a CHNA developed subsequent to the initial Assessment must consider written commentary received regarding the prior Assessment and Implementation Strategy efforts. We followed the Federal requirements in the solicitation of written comments by securing characteristics of individuals providing written comment but did not maintain identification data.

> *"…the final regulations provide that a CHNA report does not need to name or otherwise identify any specific individual providing input on the CHNA, which would include input provided by individuals in the form of written comments."*[8]

Quorum takes a comprehensive approach to the solicitation of written comments. As previously cited, we obtained input from the required three minimum sources and expanded input to include other representative groups. We asked all participating in the written comment solicitation process to self-identify themselves into any of the following representative classifications, which is detailed in an Appendix to this report. Written comment participants self-identified into the following classifications:

(1) Public Health – Persons with special knowledge of or expertise in public health

(2) Departments and Agencies – Federal, tribal, regional, State, or local health or other departments or agencies, with current data or other information relevant to the health needs of the community served by the hospital facility

(3) Priority Populations – Leaders, representatives, or members of medically underserved, low income, and minority populations, and populations with chronic disease needs in the community served by the hospital facility. Also, in other federal regulations the term Priority Populations, which include rural residents and LGBT interests, is employed and for consistency is included in this definition

(4) Chronic Disease Groups – Representative of or member of Chronic Disease Group or Organization, including mental and oral health

(5) Broad Interest of the Community – Individuals, volunteers, civic leaders, medical personnel, and others to fulfill the spirit of broad input required by the federal regulations

Other (please specify)

Quorum also takes a comprehensive approach to assess community health needs. We perform several independent data analyses based on secondary source data, augment this with Local Expert Advisor[9] opinions, and resolve any data inconsistency or discrepancies by reviewing the combined opinions formed from local experts. We rely on secondary source data, and most secondary sources use the county as the smallest unit of analysis. We asked our local expert area residents to note if they perceived the problems or needs identified by secondary sources existed in their portion of the

[7] Federal Register Op. cit. P 78966 As previously noted the Hospital collaborated and obtained assistance in conducting this CHNA from Quorum Health Resources. Response to Schedule h (Form 990) B 6 b

[8] Federal Register Op. cit. P 78967 & Response to Schedule h (Form 990) B 3 h

[9] "Local Expert" is an advisory group of at least 15 local residents, inclusive of at least one member self-identifying with each of the five Quorum written comment solicitation classifications, with whom the Hospital solicited to participate in the Quorum/Hospital CHNA process. Response to Schedule h (Form 990) V B 3 h

county.[10]

Most data used in the analysis is available from public Internet sources and Quorum proprietary data from Truven. Any critical data needed to address specific regulations or developed by the Local Expert Advisor individuals cooperating with us in this study are displayed in the CHNA report appendix.

Data sources include:[11]

Website or Data Source	Data Element	Date Accessed	Data Date
www.countyhealthrankings.org	Assessment of health needs of Daviess County compared to all State counties	July 25, 2016	2012
www.cdc.gov/communityhealth	Assessment of health needs of Daviess County compared to its national set of "peer counties"	July 25, 2016	2011
Truven (formerly known as Thompson) Market Planner	Assess characteristics of the hospital's primary service area, at a zip code level, based on classifying the population into various socio-economic groups, determining the health and medical tendencies of each group and creating an aggregate composition of the service area according to the proportion of each group in the entire area; and, to access population size, trends and socio-economic characteristics	July 25, 2016	2016
www.capc.org and www.getpalliativecare.org	To identify the availability of Palliative Care programs and services in the area	July 25, 2016	2015
www.caringinfo.org and iweb.nhpco.org	To identify the availability of hospice programs in the county	July 25, 2016	2015
www.healthmetricsandevaluation.org	To examine the prevalence of diabetic conditions and change in life expectancy	July 25, 2016	2010
www.cdc.gov	To examine area trends for heart disease and stroke	July 25, 2016	2010

[10] Response to Schedule h (Form 990) Part V B 3 i

[11] The final regulations clarify that a hospital facility may rely on (and the CHNA report may describe) data collected or created by others in conducting its CHNA and, in such cases, may simply cite the data sources rather than describe the ''methods of collecting'' the data. Federal Register Op. cit. P 78967 & Response to Schedule h (Form 990) Part V B 3 d

http://svi.cdc.gov	To identify the Social Vulnerability Index value	July 25, 2016	2010
www.CHNA.org	To identify potential needs from a variety of resources and health need metrics	July 25, 2016	2015
www.datawarehouse.hrsa.gov	To identify applicable manpower shortage designations	July 25, 2016	2015
www.worldlifeexpectancy.com/usa-health-rankings	To determine relative importance among 15 top causes of death	July 25, 2016	2015

Federal regulations surrounding CHNA require local input from representatives of particular demographic sectors. For this reason, Quorum developed a standard process of gathering community input. In addition to gathering data from the above sources:

- We deployed a CHNA "Round 1" survey to our Local Expert Advisors to gain input on local health needs and the needs of priority populations. Local Expert Advisors were local individuals selected according to criteria required by the Federal guidelines and regulations and the Hospital's desire to represent the region's geographically and ethnically diverse population. We received community input from 26 Local Expert Advisors. Survey responses started July 7, 2016 and ended with the last response on July 22, 2016.
- Information analysis augmented by local opinions showed how Ouachita County relates to its peers in terms of primary and chronic needs and other issues of uninsured persons, low-income persons, and minority groups. Respondents commented on whether they believe certain population groups ("Priority Populations") need help to improve their condition, and if so, who needs to do what to improve the conditions of these groups.[12]
- Local opinions of the needs of Priority Populations, while presented in its entirety in the Appendix, was abstracted in the following "take-away" bulleted comments
  - There is an abundance of lower income groups in Ouachita County
  - The community has a lack of transportation to access specialized treatment
  - There is a limited number of physicians to care for the priority populations in the area

When the analysis was complete, we put the information and summary conclusions before our Local Expert Advisors[13] who were asked to agree or disagree with the summary conclusions. They were free to augment potential conclusions with additional comments of need, and new needs did emerge from this exchange.[14] Consultation with 27 Local Experts occurred again via an internet-based survey (explained below) beginning August 5, 2016 and ending August 25, 2016.

Having taken steps to identify potential community needs, the Local Experts then participated in a structured

[12] Response to Schedule h (Form 990) Part V B 3 f
[13] Response to Schedule h (Form 990) Part V B 3 h
[14] Response to Schedule h (Form 990) Part V B 3 h

communication technique called a "Wisdom of Crowds" method. The premise of this approach relies on a panel of experts with the assumption that the collective wisdom of participants is superior to the opinion of any one individual, regardless of their professional credentials.[15]

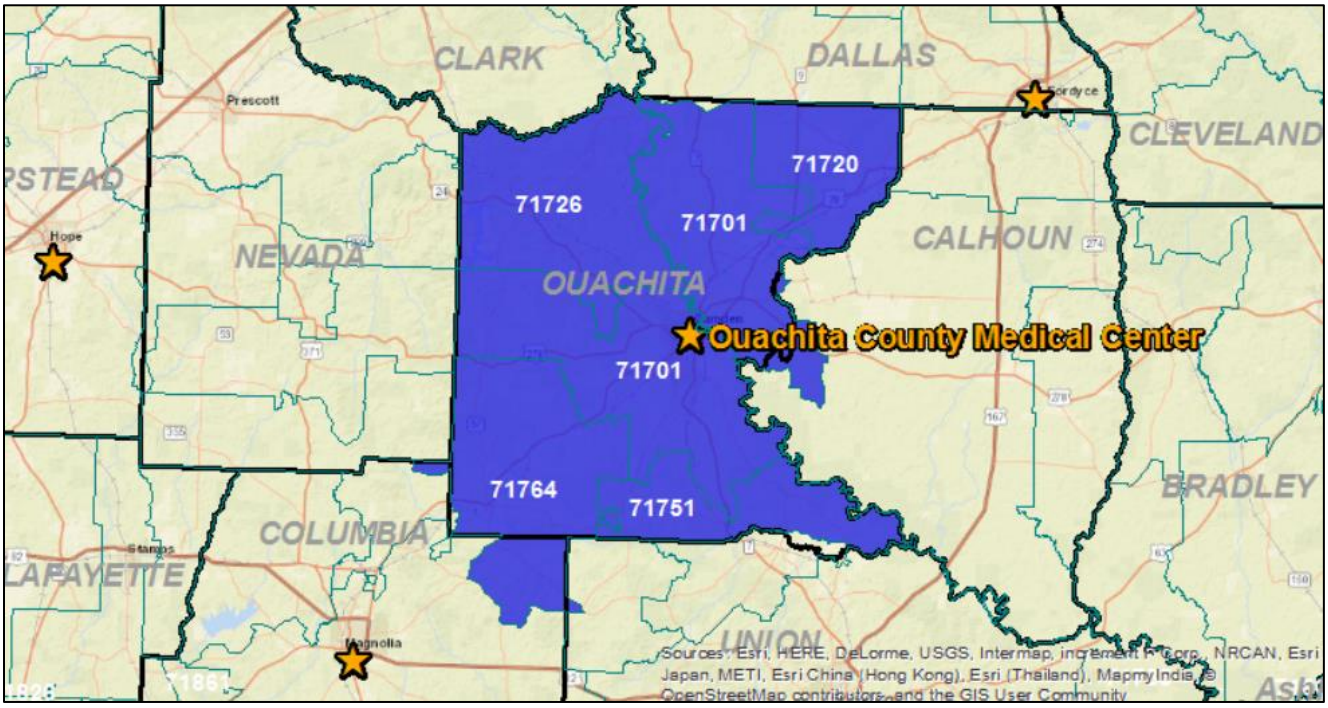
In the OCMC process, each Local Expert had the opportunity to introduce needs previously unidentified and to challenge conclusions developed from the data analysis. While there were a few opinions of the data conclusions not being completely accurate, the vast majority of comments agreed with our findings. We developed a summary of all needs identified by any of the analyzed data sets. The Local Experts then allocated 100 points among the potential significant need candidates, including the opportunity to again present additional needs that were not identified from the data. A rank order of priorities emerged, with some needs receiving none or virtually no support, and other needs receiving identical point allocations.

We dichotomized the rank order of prioritized needs into two groups: “Significant” and “Other Identified Needs.” Our criteria for identifying and prioritizing Significant Needs was based on a descending frequency rank order of the needs based on total points cast by the Local Experts, further ranked by a descending frequency count of the number of local experts casting any points for the need. By our definition, a Significant Need had to include all rank ordered needs until at least fifty percent (50%) of all points were included and to the extent possible, represented points allocated by a majority of voting local experts. The determination of the break point — “Significant” as opposed to “Other” — was a qualitative interpretation by Quorum and the OCMC executive team where a reasonable break point in rank order occurred.[16]

[15] Response to Schedule h (Form 990) Part V B 5
[16] Response to Schedule h (Form 990) Part V B 3 g

COMMUNITY CHARACTERISTICS

Definition of Area Served by the Hospital[17]



Ouachita County Medical Center, in conjunction with Quorum, defines its service area as Ouachita County in Arkansas, which includes the following ZIP codes:[18]

71701 – Camden 71720 – Bearden 71726 – Chidester 71751 – Louann 71764 – Stephens

In 2014, the Hospital received 77.2% of its patients from this area.[19]

[17] Responds to IRS Schedule h (Form 990) Part V B 3 a
[18] The map above amalgamates zip code areas and does not necessarily display all county zip codes represented below
[19] Truven MEDPAR patient origin data for the hospital; Responds to IRS Schedule h (Form 990) Part V B 3 a

Demographics of the Community[20] [21]

	County	State	U.S.
2016 Population[22]	**25,106**	**2,980,525**	**322,431,073**
% Increase/Decline	**-3.3%**	**1.9%**	**3.7%**
Estimated Population in 2021	**24,275**	**3,037,958**	**334,341,965**
% White, non-Hispanic	**55.9%**	**72.8%**	**61.3%**
% Black, non-Hispanic	**39.0%**	**15.3%**	**12.3%**
Median Age	**42.6**	**38.0**	**38.0**
Median Household Income	**$32,013**	**$42,989**	**$55,072**
Unemployment Rate (May 2016)	**4.6%**	**3.5%**	**4.5%**
% Population >65	**19.0%**	**16.2%**	**15.1%**
% Women of Childbearing Age	**17.3%**	**19.2%**	**19.6%**

Demographics Expert 2.7
2016 Demographic Snapshot
Area: Ouachita County
Level of Geography: ZIP Code

DEMOGRAPHIC CHARACTERISTICS

	Selected Area	USA
2010 Total Population	26,842	308,745,538
2016 Total Population	25,106	322,431,073
2021 Total Population	24,275	334,341,965
% Change 2016 - 2021	-3.3%	3.7%
Average Household Income	$44,171	$77,135

	2016	2021	% Change
Total Male Population	11,894	11,511	-3.2%
Total Female Population	13,212	12,764	-3.4%
Females, Child Bearing Age (15-44)	4,345	4,194	-3.5%

POPULATION DISTRIBUTION

	Age Distribution				
Age Group	2016	% of Total	2021	% of Total	USA 2016 % of Total
0-14	4,786	19.1%	4,527	18.6%	19.0%
15-17	923	3.7%	948	3.9%	4.0%
18-24	2,025	8.1%	2,018	8.3%	9.8%
25-34	2,797	11.1%	2,724	11.2%	13.3%
35-54	5,879	23.4%	5,206	21.4%	26.0%
55-64	3,938	15.7%	3,707	15.3%	12.8%
65+	4,758	19.0%	5,145	21.2%	15.1%
Total	25,106	100.0%	24,275	100.0%	100.0%

HOUSEHOLD INCOME DISTRIBUTION

	Income Distribution		
2016 Household Income	HH Count	% of Total	USA % of Total
<$15K	2,530	23.5%	12.3%
$15-25K	1,752	16.3%	10.4%
$25-50K	2,981	27.7%	23.4%
$50-75K	1,801	16.8%	17.6%
$75-100K	810	7.5%	12.0%
Over $100K	873	8.1%	24.3%
Total	10,747	100.0%	100.0%

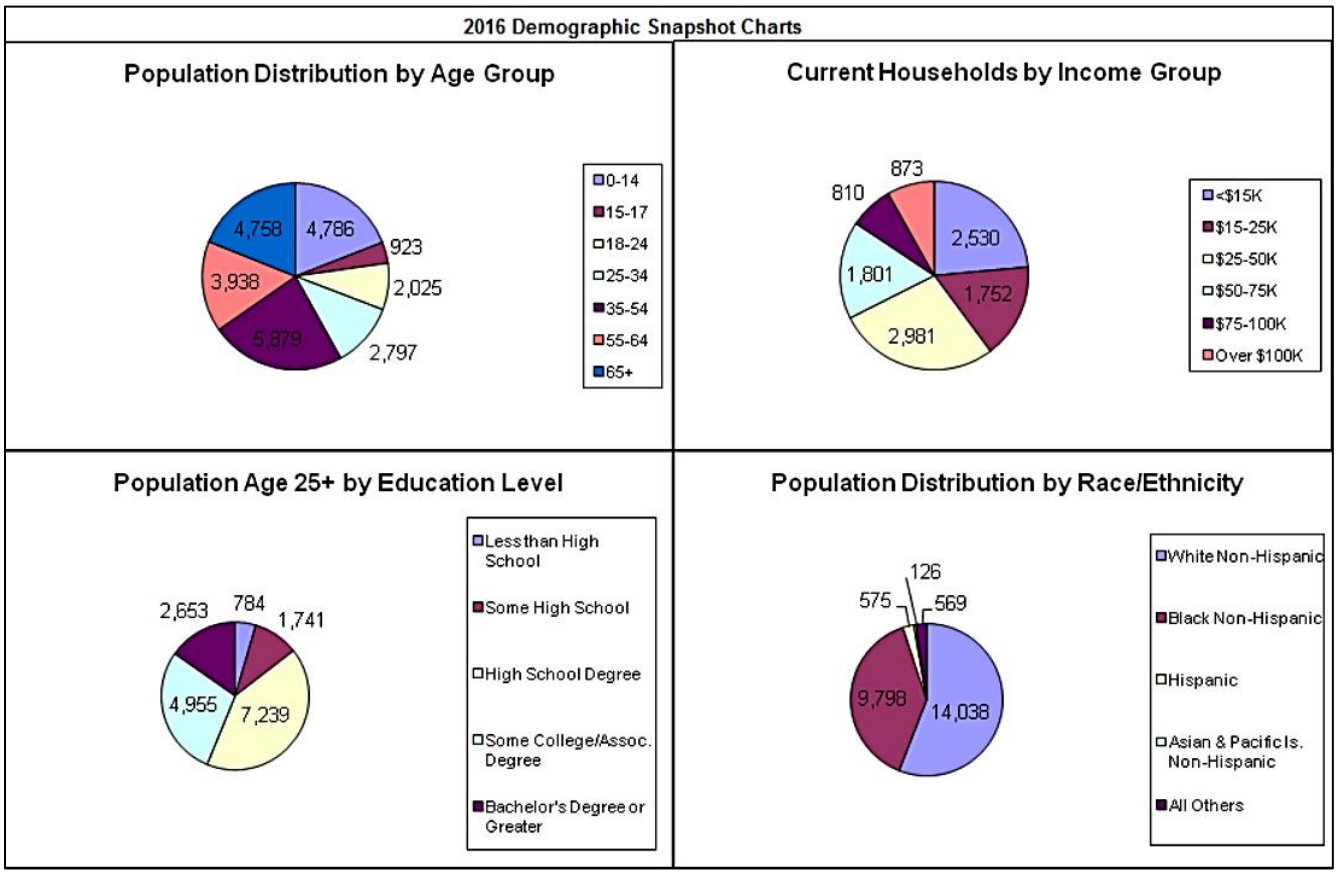
EDUCATION LEVEL

	Education Level Distribution		
2016 Adult Education Level	Pop Age 25+	% of Total	USA % of Total
Less than High School	784	4.5%	5.8%
Some High School	1,741	10.0%	7.8%
High School Degree	7,239	41.7%	27.9%
Some College/Assoc. Degree	4,955	28.5%	29.2%
Bachelor's Degree or Greater	2,653	15.3%	29.4%
Total	17,372	100.0%	100.0%

RACE/ETHNICITY

	Race/Ethnicity Distribution		
Race/Ethnicity	2016 Pop	% of Total	USA % of Total
White Non-Hispanic	14,038	55.9%	61.3%
Black Non-Hispanic	9,798	39.0%	12.3%
Hispanic	575	2.3%	17.8%
Asian & Pacific Is. Non-Hispanic	126	0.5%	5.4%
All Others	569	2.3%	3.1%
Total	25,106	100.0%	100.0%

[20] Responds to IRS Schedule h (Form 990) Part V B 3 b
[21] The tables below were created by Truven Market Planner, a national marketing company
[22] All population information, unless otherwise cited, sourced from Truven (formally Thomson) Market Planner



2016 Benchmarks
Area: Ouachita County
Level of Geography: ZIP Code

Area	2016-2021 % Population Change	Median Age	Population 65+ % of Total Population	Population 65+ % Change 2016-2021	Females 15-44 % of Total Population	Females 15-44 % Change 2016-2021	Median Household Income	Median Household Wealth	Median Home Value
USA	3.7%	38.0	15.1%	17.6%	19.6%	1.5%	$55,072	$54,224	$192,364
Arkansas	1.9%	38.0	16.2%	13.3%	19.2%	0.7%	$42,989	$44,358	$116,253
Selected Area	-3.3%	42.6	19.0%	8.1%	17.3%	-3.5%	$32,013	$35,666	$77,580

Demographics Expert 2.7
DEMO0003.SQP

Customer Segmentation

The population was also examined according to characteristics presented in the Claritas Prizm customer segmentation data. This system segments the population into 66 demographically and behaviorally distinct groups. Each group, based on annual survey data, is documented as exhibiting specific health behaviors. The top three segments in Ouachita County are:

Claritas Prizm Segments	Characteristics
Segment #1 (22%)	Segment #1 is mostly a retirement lifestyle, dominated by downscale singles and couples over 65 years old. Found in small bucolic towns around the country, these high school-educated seniors live in small apartments on less than $35,000 a year; more than one in five reside in a nursing home. For these elderly residents, daily life is often a succession of sedentary activities such as reading, watching TV, playing bingo, and doing craft projects.
Segment #2 (22%)	Segment #2 consists of economically challenged families in small, isolated towns located throughout the nation's heartland. With modest educations, sprawling families, and service jobs, many of these residents struggle to make ends meet. Rich in scenery, Segment #2 is a haven for fishing, hunting, hiking, and camping.
Segment #3 (18%)	Strewn among remote farm communities across the nation, Segment #3 is a long way away from economic paradise. The residents tend to be low income, over 65 years old, and living in older, modest-sized homes and manufactured housing. Typically, life in this segment is a throwback to an earlier era when farming dominated the American landscape.

The makeup of the service area, according to the mix of Prizm segments and its characteristics, is contrasted to the national population averages to determine probable lifestyle and medical conditions present in the population. The national average, or norm, is represented as 100%. Where Ouachita County varies more than 5% above or below that norm (that is, less than 95% or greater than 105%), it is considered significant.

Items in the table with red text are viewed as statistically important adverse potential findings—in other words, these are health areas that need improvement in the Ouachita County area. Items with blue text are viewed as statistically important potential beneficial findings—in other words, these are areas in which Ouachita County is doing better than other parts of the country. Items with black text are viewed as either not statistically different from the national norm or neither a favorable nor unfavorable finding—in other words more or less on par with national trends.

Health Service Topic	Demand as % of National	% of Population Affected	Health Service Topic	Demand as % of National	% of Population Affected
Weight / Lifestyle			**Cancer**		
BMI: Morbid/Obese	110.0%	33.0%	Mammography in Past Yr	98.6%	44.9%
Vigorous Exercise	93.0%	52.5%	Cancer Screen: Colorectal 2 yr	99.4%	25.3%
Chronic Diabetes	151.5%	18.5%	Cancer Screen: Pap/Cerv Test 2 yr	85.3%	51.2%
Healthy Eating Habits	91.4%	27.1%	Routine Screen: Prostate 2 yr	99.9%	32.0%
Ate Breakfast Yesterday	106.3%	67.7%	**Orthopedic**		
Slept Less Than 6 Hours	110.2%	17.9%	Chronic Lower Back Pain	132.2%	31.0%
Consumed Alcohol in the Past 30 Days	78.1%	42.8%	Chronic Osteoporosis	134.6%	13.2%
Consumed 3+ Drinks Per Session	111.6%	30.3%	**Routine Services**		
Behavior			FP/GP: 1+ Visit	103.7%	91.5%
I Will Travel to Obtain Medical Care	94.4%	22.4%	Used Midlevel in last 6 Months	103.2%	42.7%
I am Responsible for My Health	93.4%	61.0%	OB/Gyn 1+ Visit	78.5%	36.3%
I Follow Treatment Recommendations	89.5%	46.5%	Medication: Received Prescription	99.8%	54.8%
Pulmonary			**Internet Usage**		
Chronic COPD	148.2%	5.9%	Use Internet to Talk to MD	68.0%	8.5%
Tobacco Use: Cigarettes	122.0%	31.1%	Facebook Opinions	94.9%	9.8%
Heart			Looked for Provider Rating	83.1%	11.9%
Chronic High Cholesterol	134.7%	29.6%	**Emergency Service**		
Routine Cholesterol Screening	90.0%	45.7%	Emergency Room Use	108.5%	36.7%
Chronic Heart Failure	158.2%	7.0%	Urgent Care Use	87.3%	20.4%

Leading Causes of Death

Cause of Death			Rank among all counties in AR (#1 rank = worst in state)	Rate of Death per 100,000 age adjusted		Observation (Compared to U.S.)
AR Rank	Ouachita Rank	Condition		AR	Ouachita	
1	**1**	Heart Disease	26 of 75	281.3	217.5	Higher than expected
2	**2**	Cancer	29 of 75	183.1	210.5	Higher than expected
5	**3**	Lung	65 of 75	58.9	42.8	As expected
3	**4**	Stroke	9 of 75	45.5	78.5	Higher than expected
4	**5**	Accidents	30 of 75	47.4	58.7	Higher than expected
6	**6**	Alzheimer's	14 of 75	34.8	30.3	Higher than expected
7	**7**	Diabetes	26 of 75	24.0	28.2	As expected
8	**8**	Flu - Pneumonia	31 of 75	20.8	27.3	Higher than expected
9	**9**	Kidney	27 of 75	19.2	22.7	Higher than expected
10	**10**	Blood Poisoning	14 of 75	15.8	21.5	Higher than expected
12	**11**	Suicide	65 of 75	17.3	11.1	As expected
13	**12**	Liver	33 of 75	10.4	8.6	As expected
15	**13**	Hypertension	55 of 75	7.8	4.7	Lower than expected
11	**14**	Homicide	11 of 75	7.7	12.8	Higher than expected
14	**15**	Parkinson's	22 of 75	6.2	5.6	As expected

Priority Populations[23]

Information about Priority Populations in the service area of the Hospital is difficult to encounter if it exists. Our approach is to understand the general trends of issues impacting Priority Populations and to interact with our Local Experts to discern if local conditions exhibit any similar or contrary trends. The following discussion examines findings about Priority Populations from a national perspective.

We begin by analyzing the National Healthcare Quality and Disparities Reports (QDR), which are annual reports to Congress mandated in the Healthcare Research and Quality Act of 1999 (P.L. 106-129). These reports provide a comprehensive overview of the quality of healthcare received by the general U.S. population and disparities in care experienced by different racial, ethnic, and socioeconomic groups. The purpose of the reports is to assess the performance of our health system and to identify areas of strengths and weaknesses in the healthcare system along three main axes: **access to healthcare**, **quality of healthcare**, and **priorities of the National Quality Strategy** (NQS). The complete report is provided in Appendix C.

We asked a specific question to our Local Expert Advisors about unique needs of Priority Populations. We reviewed their responses to identify if any of the report trends were obvious in the service area. Accordingly, we place great reliance on the commentary received from our Local Expert Advisors to identify unique population needs to which we should respond. Specific opinions from the Local Expert Advisors are summarized below:[24]

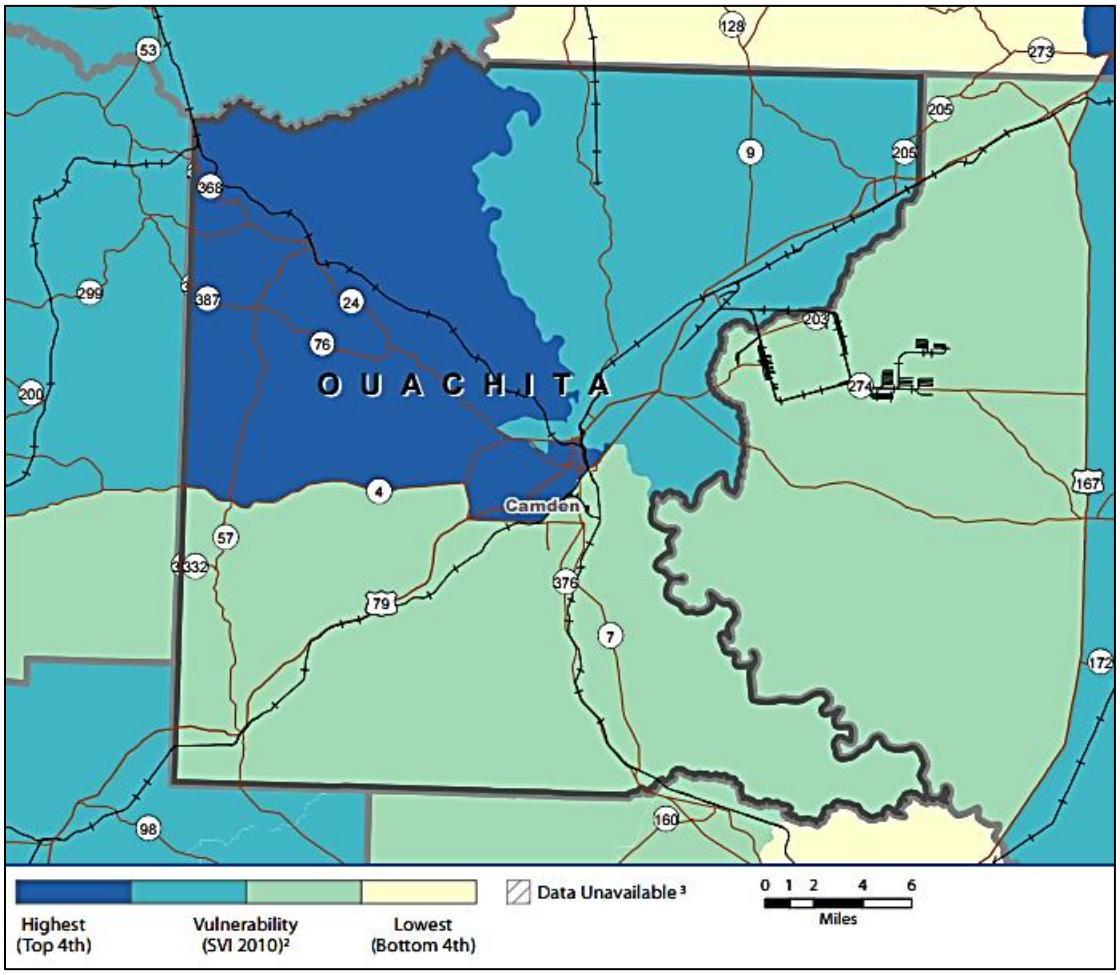
- There is an abundance of lower income groups in Ouachita County
- The community has a lack of transportation to access specialized treatment
- There is a limited number of physicians to care for the priority populations in the area

[23] http://www.ahrq.gov/research/findings/nhqrdr/nhqdr14/index.html Responds to IRS Schedule h (Form 990) Part V B 3 i
[24] All comments and the analytical framework behind developing this summary appear in Appendix A

Social Vulnerability

Social vulnerability refers to the resilience of communities when confronted by external stresses on human health, stresses such as natural or human-caused disasters, or disease outbreaks.

- Northwest Ouachita County is in the highest quartile of social vulnerability
- Northeast Ouachita County is in the second highest quartile
- Southern Ouachita County is in the second lowest quartile



Summary of Survey Results on Prior CHNA

In the Round 1 survey, a group of 26 individuals provided feedback on the 2013 CHNA. Complete results, including *verbatim* written comments, can be found in Appendix A.

Commenter characteristics:

Local Experts Offering Solicited Written Comments on 2013 Priorities and Implementation Strategy	Yes (Applies to Me)	No (Does Not Apply to Me)	Response Count
1) Public Health Expertise	8	15	23
2) Departments and Agencies with relevant data/information regarding health needs of the community served by the hospital	4	16	20
3) Priority Populations	11	11	22
4) Representative/Member of Chronic Disease Group or Organization	2	18	20
5) Represents the Broad Interest of the Community	24	1	25
Other			
Answered Question			26
Skipped Question			0

Priorities from the last assessment where the Hospital intended to seek improvement:

- Heart Disease
- Mental Health/Suicide
- Obesity
- Diabetes
- Physicians
- Accessibility/Affordability
- Stroke
- Smoking

OCMC received the following responses to the question: **"Should the hospital continue to consider the needs identified as most important in the 2013 CHNA as the most important set of health needs currently confronting residents in the county?**

	Yes	No	No Opinion
Heart Disease	25	0	0
Mental Health/Suicide	25	0	0
Obesity	24	1	0
Diabetes	24	0	1
Physicians	25	0	0
Accessibility/Affordability	24	1	0
Stroke	24	0	1
Smoking	24	1	0

OCMC received the following responses to the question: **"Should the Hospital continue to allocate resources to help improve the needs identified in the 2013 CHNA?"**

	Yes	No	No Opinion
Heart Disease	23	0	1
Mental Health/Suicide	24	0	0
Obesity	22	1	1
Diabetes	23	0	1
Physicians	23	0	1
Accessibility/Affordability	22	1	1
Stroke	23	0	1
Smoking	18	4	2

Comparison to Other State Counties

To better understand the community, Ouachita County has been compared to all 75 counties in the state of Arkansas across five areas: Health Outcomes, Health Behaviors, Clinical Care, Social & Economic Factors, and Physical Environment. The last four areas are all Health Factors that ultimately affect the Health Outcomes of Length (Mortality) and Quality of Life (Morbidity).

In the chart below, the county's rank compared to all counties is listed along with any measures in each area that are ***worse than*** the state average and U.S. Best (90th percentile).

	Ouachita County	Arkansas	U.S. Best
Health Outcomes			
Overall Rank *(best being #1)*	61/75		
Premature Death (deaths prior to age 75)	11,200	9,100	5,200
Health Behaviors			
Overall Rank *(best being #1)*	58/75		
Adult Obesity	38%	33%	25%
Physical Inactivity	38%	32%	20%
Access to Exercise Opportunities	39%	61%	91%
Sexually Transmitted Infections (per 100,000)	945.0	523.8	134.1
Teen Births (per 1,000 female population ages 15-19)	72	53	19
Clinical Care			
Overall Rank *(best being #1)*	7/75		
Population to Primary Care Physicians	1,670:1	1,540:1	1,040:1
Population to Dentists	2,760:1	2,300:1	1,340:1
Population to Mental Health Providers	730:1	520:1	370:1
Social & Economic Factors			
Overall Rank *(best being #1)*	55/75		
Some College	52%	55%	72%
Unemployment	8.1%	6.1%	3.5%
Children in Poverty	32%	26%	13%
Children in Single-Parent Households	45%	37%	21%

Injury Deaths (per 100,000)	86	77	51
Physical Environment			
Overall Rank *(best being #1)*	40/75		

Comparison to Peer Counties

The Federal Government administers a process to allocate all 3,143 U.S. counties into "Peer" groups. County "Peer" groups have similar social, economic, and demographic characteristics. The counties are ranked across six health and wellness categories and divided into quartiles: Better (top quartile), Moderate (middle two quartiles), and Worse (bottom quartile). In the below chart, Ouachita County is compared to its peer counties and the U.S. average, but only areas where the county is Better or Worse are listed. (The list and number of peer counties used in each ranking may differ.)

	Ouachita County	Peer Ranking	U.S. Average
Mortality			
Better			
Chronic Lower Respiratory Disease Deaths (per 100,000)	39.3	6/43	49.6
Worse			
Coronary Heart Disease Deaths (per 100,000)	187.4	35/43	126.7
Female Life Expectancy	76.2	38/43	79.8
Male Life Expectancy	70.5	37/43	75.0
Stroke Deaths (per 100,000)	65.8	39/43	46.0
Morbidity			
Better			
Adult Diabetes	8.1%	7/43	8.1%
Worse			
Alzheimer's Disease/Dementia	14.0%	38/43	10.3%
Gonorrhea (per 100,000)	258.9	42/43	30.5
HIV (per 100,000)	216.2	31/37	105.5
Syphilis (per 100,000)	7.7	41/43	0.0
Healthcare Access & Quality			
Better			
Older Adult Preventable Hospitalizations (per 1,000)	63.2	2/43	71.3
Primary Care Provider Access (per 100,000)	58.0	10/43	48.0
Uninsured	17.7%	10/43	17.7%
Worse			
Cost Barrier to Care	24.4%	31/37	15.6%

	Ouachita County	Peer Ranking	U.S. Average
Health Behaviors			
Better			
Nothing	--	--	--
Worse			
Teen Births (per 1,000)	75.9	42/43	42.1
Adult Binge Drinking	13.9%	16/19	16.3%
Adult Physical Inactivity	37.8%	33/42	25.9%
Social Factors			
Better			
Nothing	--	--	--
Worse			
Children in Single Parent Households	43.1%	33/43	30.8%
Inadequate Social Support	35.5%	35/38	19.6%
Violent Crime (per 100,000)	345.6	34/38	199.2
Physical Environment			
Better			
Access to Parks	23.0%	3/43	14.0%
Air Quality	11.1 (µg/m^3)	9/43	10.7 (µg/m3)
Living Near Highways	0.0%	1/43	1.5%
Worse			
Limited Access to Healthy Food	15.4%	39/43	6.2%

Conclusions from Demographic Analysis Compared to National Averages

The following areas were identified from a comparison of the county to national averages. **Adverse** metrics impacting more than 30% of the population and statistically significantly different from the national average include:

- **BMI: Morbid/Obese** = 10.0% above average, 33.0%
- **Vigorous Exercise** = 7.0% below average, 52.5%
- **Consumed 3+ Drinks Per Session** = 11.6 above average, 30.3%
- **I Am Responsible for my Health** = 6.6% below average, 61.0%
- **I Follow Treatment Recommendations** = 10.5 below average, 46.5%
- **Tobacco Use: Cigarettes** = 22.0% above average, 31.1%
- **Routine Cholesterol Screening** = 10.0% below average, 45.7%
- **Cervical Cancer Screening** = 14.7% below average, 51.2%
- **Chronic Lower Back Pain** = 32.2% above average, 31.0%
- **OB/GYN Visit** = 21.5% below average, 36.3%
- **Emergency Room Use** = 8.5% above average, 36.7%

Beneficial metrics impacting more than 30% of the population and statistically significantly different from the national average include:

- **Ate Breakfast Yesterday** = 6.3% above average, 67.7%
- **Consumed Alcohol in the Past 30 Days** = 21.9% below average, 42.8%

Conclusions from Other Statistical Data

The Institute for Health Metrics and Evaluation at the University of Washington analyzed all 3,143 U.S. counties or equivalents applying small area estimation techniques to the most recent county information. The below chart compares Ouachita County statistics to the U.S. average, and lists the change since the last date of measurement.

	Current Date of Data	Statistic	Percent Change	Last Date of Data
UNFAVORABLE COUNTY measures that are **WORSE** than the U.S. average and had an **UNFAVORABLE** change				
Female Life Expectancy	2013	76.2 years	-0.4 years	1985
Female Obesity	2011	47.5%	9.9% pts	2001
Male Obesity	2011	39.8%	8.0% pts	2001
Male Physical Activity	2011	47.3%	-3.1% pts	2001
UNFAVORABLE COUNTY measures that are **WORSE** than the U.S. average and had an **FAVORABLE** change				
Male Life Expectancy	2013	70.1 years	1.4 years	1985
Female Smoking	2012	24.0%	0.0% pts	1996
Male Smoking	2012	30.3%	-1.4% pts	1996
Female Physical Activity	2011	43.2%	7.0% pts	2001
DESIRABLE COUNTY measures that are **BETTER** than the US average and had an **UNFAVORABLE** change				
Female Heavy Drinking	2012	4.3%	1.6% pts	2005
Male Heavy Drinking	2012	8.8%	1.5% pts	2005
Female Binge Drinking	2012	7.9%	0.6% pts	2002
Male Binge Drinking	2012	21.2%	0.2% pts	2002
DESIRABLE COUNTY measures that are **BETTER** than the US average and had an **FAVORABLE** change				
None	--	--	--	--

Community Benefit

Worksheet 4 of Form 990 h can be used to report the net cost of community health improvement services and community benefit operations.

> *"Community health improvement services" means activities or programs, subsidized by the health care organization, carried out or supported for the express purpose of improving community health. Such services do not generate inpatient or outpatient revenue, although there may be a nominal patient fee or sliding scale fee for these services.*
>
> *"Community benefit operations" means:*
>
> - *activities associated with community health needs assessments, administration, and*
> - *the organization's activities associated with fundraising or grant-writing for community benefit programs.*

Activities or programs cannot be reported if they are provided primarily for marketing purposes or if they are more beneficial to the organization than to the community. For example, the activity or program may not be reported if it is designed primarily to increase referrals of patients with third-party coverage, required for licensure or accreditation, or restricted to individuals affiliated with the organization (employees and physicians of the organization).

To be reported, community need for the activity or program must be established. Community need can be demonstrated through the following:

- A CHNA conducted or accessed by the organization.
- Documentation that demonstrated community need or a request from a public health agency or community group was the basis for initiating or continuing the activity or program.
- The involvement of unrelated, collaborative tax-exempt or government organizations as partners in the activity or program carried out for the express purpose of improving community health.

Community benefit activities or programs also seek to achieve a community benefit objective, including improving access to health services, enhancing public health, advancing increased general knowledge, and relief of a government burden to improve health. This includes activities or programs that do the following:

- Are available broadly to the public and serve low-income consumers.
- Reduce geographic, financial, or cultural barriers to accessing health services, and if they ceased would result in access problems (for example, longer wait times or increased travel distances).
- Address federal, state, or local public health priorities such as eliminating disparities in access to healthcare services or disparities in health status among different populations.
- Leverage or enhance public health department activities such as childhood immunization efforts.
- Otherwise would become the responsibility of government or another tax-exempt organization.
- Advance increased general knowledge through education or research that benefits the public.

Activities reported by the Hospital in its implementation efforts and/or its prior year tax reporting included:

- $117,990

IMPLEMENTATION STRATEGY

Significant Health Needs

We used the priority ranking of area health needs by the Local Expert Advisors to organize the search for locally available resources as well as the response to the needs by OCMC.[25] The following list:

- Identifies the rank order of each identified Significant Need
- Presents the factors considered in developing the ranking
- Establishes a Problem Statement to specify the problem indicated by use of the Significant Need term
- Identifies OCMC current efforts responding to the need including any written comments received regarding prior OCMC implementation actions
- Establishes the Implementation Strategy programs and resources OCMC will devote to attempt to achieve improvements
- Documents the Leading Indicators OCMC will use to measure progress
- Presents the Lagging Indicators OCMC believes the Leading Indicators will influence in a positive fashion, and
- Presents the locally available resources noted during the development of this report as believed to be currently available to respond to this need.

In general, Ouachita County Medical Center is the major hospital in the service area. OCMC is a 98-bed, acute care medical facility located in Camden, Arkansas. The next closest facilities are outside the service area and include:

- Dallas County Medical Center in Fordyce, AR, 32 miles (34 minutes)
- Medical Center of South Arkansas in El Dorado, AR, 30 miles (36 minutes)
- Magnolia Hospital in Magnolia, AR, 36 miles (45 minutes)

All data items analyzed to determine significant needs are “Lagging Indicators,” measures presenting results after a period of time, characterizing historical performance. Lagging Indicators tell you nothing about how the outcomes were achieved. In contrast, the OCMC Implementation Strategy uses “Leading Indicators.” Leading Indicators anticipate change in the Lagging Indicator. Leading Indicators focus on short-term performance, and if accurately selected, anticipate the broader achievement of desired change in the Lagging Indicator. In the QHR application, Leading Indicators also must be within the ability of the hospital to influence and measure.

[25] Response to IRS Schedule h (Form 990) Part V B 3 e

1. **HEART DISEASE** – 2013 Significant Need; #1 leading cause of death; chronic heart disease deaths 9th worst among peers; routine cholesterol screening 10.0% below average
2. **OBESITY** – 2013 Significant Need; adult obesity above the AR and US average; BMI: Morbid/Obese 10.0% above average; male and female obesity worse than US average

Due to the similarity of these two health needs, only one implementation strategy has been created.

Public comments received on previously adopted implementation strategy for Heart Disease:

- *Hospital continually focuses on public awareness and prevention of disease.*
- *Due to the fact that I don't know all the steps that the hospital has taken, I have no comments.*
- *Our ER does a wonderful job getting patients stable and transferring them to a heart-care facility.*
- *Education provided for patients. Care coordination between hospital and PCP.*
- *expanded/upgraded their critical and icu areas*
- *By having health fairs that target health screenings, many people learn they have a health issue. This is very important to our community.*
- *Publicity regarding health improvements thru media, hospital employees, Doctors and program education.*
- *N/a*
- *The local hospital hosts groups - such as A Healthy Ouachita County and the H.O.P.E. group - that address the county's health issues, and there are diabetes-information classes and Weight Watchers meetings that are also hosted by OCMC.*
- *Our sedentary lifestyle leads to most of these problems and I applaud any actions our hospital/ community can do in getting us off the couch.*
- *N/A*

Public comments received on previously adopted implementation strategy for Obesity:

- *Hospital needs to continue education and awareness of this issue.*
- *Due to the lack of knowledge the hospital has implemented, I have no comment.*
- *Education provided for patients. Care coordination between hospital and PCP.*
- *Do not know*
- *They participate in a county wide walking/exercise campaign with their staff. This also encourages other organizations to participate. They are leading by example and identifying exercise as an important part of their mission.*
- *Publicity regarding health improvements thru media, hospital employees, Doctors and program education.*
- *N/a*

- *The hospital hosts the local Weight Watchers group, and also provides information about adopting healthier eating habits. It also employs a dietician who is available to those who want to make healthier food choices and those who need to do so due to diabetes, obesity and other health factors.*
- *Any actions the hospital takes to get our community moving away from the couch is in the right direction.*
- *I am not sure how to attack this problem, what we have done in the past has not worked.*
- *N/A*
- *I think the hospital could get involved more in the community by offering fun, engaging group activities that educate people on to do better. Maybe local contests, weekly meetings, etc.*

OCMC services, programs, and resources available to respond to this need include:[26]

- Space and facilities provided for cardiology practices that offer clinic several times per month
- Hold several health fairs on site that include education on services available, dietary and nutrition counseling, diabetes management, and free screenings including BMI, cholesterol, blood sugar, etc.
- Providers participate in health fairs that include education and free screenings at local universities and employers
- Health information posted monthly on website covering topics like heart health, nutrition, weight loss, etc.
- PSAs on health and wellness and events at the hospital are published in the local newspaper
- Free CPR training classes are held on site and are open to the community
- Hospital provides free space to local Weight Watchers group for the weekly meeting
- Free fitness classes are provided on site in the conference center and are open to employees and the community
- Employees are encouraged to walk around campus and get out and get exercise even during work hours
- Wellness program available to employees and families through insurance plan includes free screenings for cholesterol, blood sugar, etc.
- Hospital cafeteria is open to the public and provides healthy food options, fresh fruits and vegetables, and calorie counts on food items

Additionally, OCMC plans to take the following steps to address this need:

- Research adding fitness facility/gymnasium for employee use
- Add calorie counts to prepared food items on cafeteria menus
- Look into adding signage/distance markers on walking trails around campus
- Look into adding free A1C screenings

[26] This section in each need for which the hospital plans an implementation strategy responds to Schedule h (Form 990) Part V Section B 3 c

OCMC evaluation of impact of actions taken since the immediately preceding CHNA:

- Hospital sponsored a team for Walk Across Ouachita County to encourage physical activity and benefits of walking and exercise

Anticipated results from OCMC Implementation Strategy

Community Benefit Attribute Element	Yes, Implementation Strategy Addresses	Implementation Strategy Does Not Address
1. Available to public and serves low income consumers	X	
2. Reduces barriers to access services (or, if ceased, would result in access problems)	X	
3. Addresses disparities in health status among different populations	X	
4. Enhances public health activities	X	
5. Improves ability to withstand public health emergency		X
6. Otherwise would become responsibility of government or another tax-exempt organization	X	
7. Increases knowledge; then benefits the public	X	

The strategy to evaluate OCMC intended actions is to monitor change in the following Leading Indicator:

- Number of cholesterol screenings provided at health fairs = start tracking in 2016

The change in the Leading Indicator anticipates appropriate change in the following Lagging Indicator:

- Coronary Heart Disease Deaths = 187.4 per 100,000[27]
- Adult Obesity = 38%[28]

OCMC anticipates collaborating with the following other facilities and organizations to address this Significant Need:

Organization	Contact Name	Contact Information
The Camden News		113 Madison Ave NE, Camden, AR 71701 (870) 836-8192 www.camdenarknews.com

[27] CHSI. Age adjusted coronary heart disease death rate. Rank #35 out of 43 peer counties. 2005-2011.
[28] County Health Rankings. Percentage of adults that report a BMI of 30 or more. Ouachita County, age 20+, 2012.

Organization	Contact Name	Contact Information
Weight Watchers		https://www.weightwatchers.com/us/find-a-meeting/17523/ouachita-county-medical-center-camden-ar
Local churches and employers (health fairs)		
Cardiology groups		
Ouachita County Health Unit	Rebecca Wright	740 California Ave SW, Camden, AR 71701 (870) 836-5033 http://www.healthy.arkansas.gov/programsServices/localPublicHealthOffices/Pages/huDetails.aspx?show=Ouachita%20County%20Health%20Unit%20-%20Camden
A Healthy Ouachita County (AHOC)		https://www.facebook.com/AHOCcoalition

Other local resources identified during the CHNA process that are believed available to respond to this need:[29]

Organization	Contact Name	Contact Information
HOPE Health Commission (Healthy Outcomes Positive Effects)		1115 Fairview Rd SW, Camden, AR 71701 (870) 231-1111 www.facebook.com/HOPE-Health-Commission-of-Ouachita-County

[29] This section in each need for which the hospital plans an implementation strategy responds to Schedule h (form 990) Part V Section B 3 c and Schedule h (Form 990) Part V Section B 11

3. **PHYSICIANS** – 2013 Significant Need; Local Expert concern; population to primary care physician ratio worse than AR and US average

Public comments received on previously adopted implementation strategy:

- *The hospital continually strives to recruit physicians.*
- *OCMC CEO, Peggy Abbott does a tremendous job focusing on this significant issue and is proactive seeking high caliber physicians.*
- *I believe the hospital is headed in the right direction in regards to the recruitment of physicians.*
- *I am thankful we were able to fill the gap in our ER staff so quickly! The addition of hospital physicians is also a positive step.*
- *I think our hospital is doing well in trying to recruit physicians. They have recently made progress in having several physicians coming to our town on a once a month or once a week basis which is very helpful to our area.*
- *See 14*
- *They have made it possible for specialist to come to Camden from other large cities by providing them clinic space.*
- *CEO is diligent in recruitment of highly qualified physicians.*
- *N/A*
- *The hospital has been able to fill those needed physician positions to help serve the medical needs of the community.*
- *The hospital has renovated the main facility, improved satellite facilities and fought to fill existing facilities with competent, caring medical professionals.*
- *This is out of my realm of expertise but I would think if we can improve our county and bring in more jobs and activities that draw people to move to a community, then recruitment of physicians would be easier.*
- *Not sure.*
- *We must have reputable physicians to have better care.*

OCMC services, programs, and resources available to respond to this need include:

- Partnered with local family practice group and have successfully recruited an FP/OB and additional family nurse practitioner
- Recruited OB/GYN to start in 2017
- Opened Urgent Care facility in July 2016 to provide faster, lower cost alternative to ER, and recruited family practitioner to be director of the clinic
- Space and facilities provided for cardiology practices that offer clinic several times per month
- Family practice clinic available that recently increased hours to provide additional access
- Hospital provides access to specialty services locally, including: otolaryngology/ENT, audiology, orthopedics, ophthalmology, urology, oncology, sleep lab, nephrology, and pathology

- Hospital has invested in tele-medicine options, including: neurology/stroke (ARSAVES program), neo-natal (UAMS & Arkansas Children's), neo-natal and lactation consulting (Baptist Med)
- Hospital provides the following tests locally: EEG, nerve-conduction study, MRI, CT, mammography, interventional radiology
- Ongoing recruitment for general surgeon and family practice
- Hospital offers educational assistance to providers who want to advance their education

Additionally, OCMC plans to take the following steps to address this need:

- Adding 3D digital mammography in October 2016
- Upgrading MRI machine
- Expanding OR to increase volume
- Providing educational assistance to help employee attend medical school

OCMC evaluation of impact of actions taken since the immediately preceding CHNA:

- Renovation and expansion of ER

Anticipated results from OCMC Implementation Strategy

Community Benefit Attribute Element	Yes, Implementation Strategy Addresses	Implementation Strategy Does Not Address
1. Available to public and serves low income consumers	X	
2. Reduces barriers to access services (or, if ceased, would result in access problems)	X	
3. Addresses disparities in health status among different populations	X	
4. Enhances public health activities		X
5. Improves ability to withstand public health emergency		X
6. Otherwise would become responsibility of government or another tax-exempt organization	X	
7. Increases knowledge; then benefits the public		X

The strategy to evaluate OCMC intended actions is to monitor change in the following Leading Indicator:

- Number of providers recruited = In 2016, three physicians and one mid-level

The change in the Leading Indicator anticipates appropriate change in the following Lagging Indicator:

- Population to Primary Care Provider Ratio = 1,670:1[30]

OCMC anticipates collaborating with the following other facilities and organizations to address this Significant Need:

Organization	Contact Name	Contact Information
University of Arkansas Medical Science (UAMS)		(501) 686-7000 www.uams.edu
Arkansas Children's Hospital		(501) 364-1100 www.archildrens.org
Baptist Health Medical Center		(501) 202-2000 www.baptist-health.com
Ouachita Valley Family Clinic		353 Cash Rd SW, Camden, AR 71701 (870) 836-8101 https://www.baptist-health.com/location/ouachita-valley-family-clinic-baptist-health-affiliate-baptist-health-affiliate
Cardiology groups		

[30] County Health Rankings. Ratio of population to primary care physicians. 2013.

4. **CANCER** – Local Expert concern; #2 leading cause of death; cervical cancer screening 14.7% below average

Public comments received on previously adopted implementation strategy:

This was not a Significant Need identified in 2013 so no written public comments about this need were solicited

OCMC services, programs, and resources available to respond to this need include:

- Mammography screenings provided at Hospital, and free mammography screenings provided during Breast Cancer Awareness Month
- OCMC Auxiliary provides funds designated for mammography screenings for under- and un-insured populations
- Sponsor of a Relay for Life team
- Chemotherapy and infusion therapy services are provided on site; interventional radiology is available for liver and breast biopsies
- Colonoscopies are provided on site; some colo-rectal screening kits are distributed at no charge
- Hospital helps cover costs for anesthesiologist for some cancer screenings for uninsured
- Pathology available for frozen sections on-site
- Hospital promotes breast cancer awareness month including educational materials, giveaways, and drawings
- Oncology clinic available weekly
- Wellness program available to employees and families through insurance plan includes free screenings for mammography, PSA, and colonoscopy
- Provide space at no charge for local American Cancer Society group

Additionally, OCMC plans to take the following steps to address this need:

- Adding 3D digital mammography in October 2016

Anticipated results from OCMC Implementation Strategy

Community Benefit Attribute Element	Yes, Implementation Strategy Addresses	Implementation Strategy Does Not Address
1. Available to public and serves low income consumers	X	
2. Reduces barriers to access services (or, if ceased, would result in access problems)	X	
3. Addresses disparities in health status among different populations	X	
4. Enhances public health activities	X	
5. Improves ability to withstand public health emergency		X
6. Otherwise would become responsibility of government or another tax-exempt organization	X	

Community Benefit Attribute Element	Yes, Implementation Strategy Addresses	Implementation Strategy Does Not Address
7. Increases knowledge; then benefits the public	X	

The strategy to evaluate OCMC intended actions is to monitor change in the following Leading Indicator:

- Number of mammograms covered through OCMC Auxiliary = 3 in 2016 (calendar year-to-date)
- Number of free colo-rectal screening kits provided = 200/year

The change in the Leading Indicator anticipates appropriate change in the following Lagging Indicator:

- Cancer deaths = 208.7 per 100,000[31]

OCMC anticipates collaborating with the following other facilities and organizations to address this Significant Need:

Organization	Contact Name	Contact Information
OCMC Auxiliary		https://www.ouachitamedcenter.com/auxiliaryvolunteers
Relay for Life – American Cancer Society		255 Pope Ave, Camden, AR 71701-4210 http://main.acsevents.org/site/TR/RelayForLife/RFLCY16MS?pg=entry&fr_id=73658

Other local resources identified during the CHNA process that are believed available to respond to this need:

Organization	Contact Name	Contact Information
Ouachita County Health Unit	Rebecca Wright	740 California Ave SW, Camden, AR 71701 (870) 836-5033 http://www.healthy.arkansas.gov/programsServices/localPublicHealthOffices/Pages/huDetails.aspx?show=Ouachita%20County%20Health%20Unit%20-%20Camden
A Healthy Ouachita County (AHOC)		https://www.facebook.com/AHOCcoalition

[31] CHSI. Age adjusted cancer death rate. Rank #27 out of 43 peer counties. 2005-2011.

Organization	Contact Name	Contact Information
HOPE Health Commission (Healthy Outcomes Positive Effects)		1115 Fairview Rd SW, Camden, AR 71701 (870) 231-1111 www.facebook.com/HOPE-Health-Commission-of-Ouachita-County
Genesis Cancer Center		133 Harmony Park Cir, Hot Springs, AR 71913 (501) 624-7700

5. DIABETES – 2013 Significant Need; #7 leading cause of death

Public comments received on previously adopted implementation strategy:

- *Hospital needs to continue education and awareness of this issue.*
- *I have can't address this because of limited knowledge in this area.*
- *Having a grandfather who suffered from diabetes, I feel it is so important to continue to have this as one of your main emphasis points as many in our community (many due to obesity) have this health issue as well.*
- *Education provided for patients. Care coordination between hospital and PCP.*
- *Do not know of any*
- *I have been at some of these events where individuals were identified as diabetic and were unaware. This made a big difference to these citizens and encouraged them to go to the doctor and help.*
- *Publicity regarding health improvements thru media, hospital employees, Doctors and program education.*
- *N/A*
- *As stated earlier, the hospital employs a dietician who is available to those who want to make healthier food choices and those who need to do so due to diabetes, obesity and other health factors. Also, members of the hospital staff have presented the public with classes about the management of diabetes.*
- *Healthy eating and education on healthy lifestyles is always stressed, but seldom followed by we the people.*
- *I am not sure how to attack this problem, what we have done in the past has not worked. There are all types of programs for diabetics in our area (not just hospital but other organizations) but the people are just not interested in improving their health, until it gets too late.*
- *N/A*
- *I don't have anyone personally that I am connected to that has diabetes, so I am unaware of what is currently being done.*

OCMC services, programs, and resources available to respond to this need include:

- Diabetic Support Group hosted on site by the director of education; provides education on healthy meals, healthy cooking, lifestyle choices and changes
- Director of Education works with new diabetics (inpatient and outpatient) to educate them on how to manage the condition (blood sugar testing, etc.)
- Wound Care Clinic available to help residents with diabetes
- Hold several health fairs on site that include education on services available, dietary and nutrition counseling, diabetes management, and free screenings including BMI, cholesterol, blood sugar, etc.
- Providers participate in health fairs that include education and free screenings at local universities and employers
- Peripheral vascular program offered through cardiology clinics two days each month
- Home Health agency focuses on disease management, helping patients manage diabetes and drawing A1C on

initial appointment for baseline

- Health information posted monthly on website covering topics like heart health, nutrition, weight loss, etc.
- PSAs on health and wellness and events at the hospital are published in the local newspaper
- Free CPR training classes are held on site and are open to the community
- Hospital provides free space to local Weight Watchers group for the weekly meeting
- Free fitness classes are provided on site in the conference center and are open to employees and the community
- Employees are encouraged to walk around campus and get out and get exercise even during working hours
- Wellness program available to employees and families through insurance plan includes free screenings for cholesterol, blood sugar, etc.
- Hospital cafeteria is open to the public and provides healthy food options, fresh fruits and vegetables, and calorie counts on food items

Additionally, OCMC plans to take the following steps to address this need:

- Research adding fitness facility/gymnasium for employee use
- Add calorie counts to prepared food items on cafeteria menus
- Look into adding signage/distance markers on walking trails around campus
- Look into adding free A1C screenings

Anticipated results from OCMC Implementation Strategy

Community Benefit Attribute Element	Yes, Implementation Strategy Addresses	Implementation Strategy Does Not Address
1. Available to public and serves low income consumers	X	
2. Reduces barriers to access services (or, if ceased, would result in access problems)	X	
3. Addresses disparities in health status among different populations	X	
4. Enhances public health activities	X	
5. Improves ability to withstand public health emergency		X
6. Otherwise would become responsibility of government or another tax-exempt organization	X	
7. Increases knowledge; then benefits the public	X	

The strategy to evaluate OCMC intended actions is to monitor change in the following Leading Indicator:

- Number of blood sugar screenings provided at health fairs = start tracking in 2016

The change in the Leading Indicator anticipates appropriate change in the following Lagging Indicator:

- Diabetes deaths = 27.3 per 100,000[32]

OCMC anticipates collaborating with the following other facilities and organizations to address this Significant Need:

Organization	Contact Name	Contact Information
The Camden News		113 Madison Ave NE, Camden, AR 71701 (870) 836-8192 www.camdenarknews.com
Weight Watchers		https://www.weightwatchers.com/us/find-a-meeting/17523/ouachita-county-medical-center-camden-ar
Cardiology groups		
Ouachita County Health Unit	Rebecca Wright	740 California Ave SW, Camden, AR 71701 (870) 836-5033 http://www.healthy.arkansas.gov/programsServices/localPublicHealthOffices/Pages/huDetails.aspx?show=Ouachita%20County%20Health%20Unit%20-%20Camden

[32] CHSI. Age adjusted diabetes death rate. Ranks #19 out of 37 peer counties. 2005-2011.

6. **MENTAL HEALTH/SUICIDE** – 2013 Significant Need; Local Expert concern; population to mental health provider ratio worse than AR and US average

15. **SUBSTANCE ABUSE** – While not deemed a Significant Need, this need is also being addressed with the response to Mental Health/Suicide.

Public comments received on previously adopted implementation strategy for Mental Health/Suicide:

- *OCMC has a dynamic rehab program and continues to focus on providing assistance to those in need in our community.*
- *As stated above, it continues to be a need in the community and the hospital should provide service.*
- *Education provided for patients. Care coordination between hospital and PCP.*
- *Do not know*
- *Publicity regarding health improvements thru media, hospital employees, Doctors and program education. Exceptional hospital program!*
- *I don't have knowledge on this matter.*
- *The hospital does provide information and recommendations to those who suffer from mental-health issues and to the families of those who have those issues, and those who have attempted suicide and/or have a family member who has done so.*
- *I am not sure how to attack this problem, what we have done in the past has not worked.*
- *The hospital have gotten our clients placed into a facility to get stable on there medication.*
- *I am not familiar with what the hospital is doing with this. Maybe fliers could be placed around town letting people know that this type of care is available.*

OCMC services, programs, and resources available to respond to this need include:

- Substance Abuse Treatment Program – 28-day inpatient program and intensive outpatient services; ongoing support called “After Care” provided at no cost to participants; managed by certified counselors/social workers
- Dedicated psych room provided in ER until placed at mental health facility
- Providers perform suicide risk assessments and can assign a one-on-one attendant for patients with an affirmative assessment until patient can be transferred
- Provide licensed counseling services through Employee Assistance Programs in partnership with local employers
- Provide clinic space for a licensed, certified social worker
- Hospital director of mental health provides education and supervisory training for businesses and organizations on substance and prescription drug abuse
- Mental health director speaks at local events on suicide prevention and depression screening
- Hospital home health service assists home health patients and elderly patients in inventorying medications and provides instruction on how to properly dispose of prescriptions, especially narcotics and medications prone to

abuse

- Hospital provided site and hosted training for first responders to recognize mental illness and address appropriately

Additionally, OCMC plans to take the following steps to address this need:

- Research options for providing tele-psych services
- Implementing post-partum depression screenings in OB program

OCMC evaluation of impact of actions taken since the immediately preceding CHNA:

- Rachel's Challenge – anti-bullying campaign hosted at local high school and attended by students across the county
- Provided drug take-back service at local health fair (in partnership with local sheriff's office)
- Implemented an opiate prescription policy to have providers check statewide database and limit amount prescribed

Anticipated results from OCMC Implementation Strategy

Community Benefit Attribute Element	Yes, Implementation Strategy Addresses	Implementation Strategy Does Not Address
1. Available to public and serves low income consumers	X	
2. Reduces barriers to access services (or, if ceased, would result in access problems)	X	
3. Addresses disparities in health status among different populations	X	
4. Enhances public health activities	X	
5. Improves ability to withstand public health emergency		X
6. Otherwise would become responsibility of government or another tax-exempt organization	X	
7. Increases knowledge; then benefits the public	X	

The strategy to evaluate OCMC intended actions is to monitor change in the following Leading Indicator:

- Number of patients seen in After-Care program = Average of 45 visits per week, 220 unique patients per year

The change in the Leading Indicator anticipates appropriate change in the following Lagging Indicator:

- Frequent mental distress = 14%[33]

OCMC anticipates collaborating with the following other facilities and organizations to address this Significant Need:

[33] County Health Rankings. Percentage of adults reporting more than 14 days of poor mental health per month. 2014.

Organization	Contact Name	Contact Information
Wellness Solutions LLC	Rebekah Dixon	
South Arkansas Regional Health Center		715 N College Ave, El Dorado, AR 71730 (870) 862-7921 www.sarhc.org
Ouachita County Sheriff's Department		109 Goodgame St, Camden, AR 71701 (870) 231-5300 www.ouachitacountysheriff.org
Local school districts		
University of Arkansas Medical Science (UAMS) (tele-psych)		(501) 686-7000 www.uams.edu

Other local resources identified during the CHNA process that are believed available to respond to this need:

Organization	Contact Name	Contact Information
Local AA group		www.aawestcentralarkansas.org
Local NA group		972 West Washington Street #F, Camden, AR 71701 805 Monroe Avenue, Camden, AR 71701
Victory Church "Celebrating Recovery"		www.victorychurch.com/connections/groups-classes/celebrate-recovery
Junior Auxiliary of Camden Arkansas		www.facebook.com/juniorauxiliaryofcamden/

7. **ACCESSIBILITY/AFFORDABILITY** – 2013 Significant Need; Local Expert concern; cost barrier to care 7th worst among peers; emergency room use 8.5% above average

Public comments received on previously adopted implementation strategy:

- *The hospital promotes financial assistance availability and strived to keep costs limited ad possible.*
- *OCMC is aware of high poverty and uninsured rate and provides professional services for all walks of life whether insured or uninsured.*
- *I have no knowledge of the implementation actions by the hospital.*
- *The Urgent Care facility will be a positive step in a good direction.*
- *Do not know*
- *Hospital provides care to all levels of income.*
- *The hospital has offered classes to help residents learn about how to choose the best insurance plan.*
- *The hospital will work with ANY one who receives care and has an outstanding bill. Medical services do not appear to be any higher in Camden than anywhere else.*
- *I feel the hospital does what it can to help the community in this area.*
- *Not sure.*

OCMC services, programs, and resources available to respond to this need include:

- Financial assistance policy available with sliding fee scale
- Financial assistance counselors available to help people manage bills
- Navigator available to help uninsured sign up for Medicaid, Medicare, and the Marketplace
- Hold several health fairs on site that include education on services available, dietary and nutrition counseling, diabetes management, and free screenings including BMI, cholesterol, blood sugar, etc.
- Providers participate in health fairs that include education and free screenings at local universities and employers
- Health information posted monthly on website covering topics like heart health, nutrition, weight loss, etc.
- PSAs on health and wellness and events at the hospital are published in the local newspaper
- Free CPR training classes are held on site and are open to the community
- Free fitness classes are provided on site in the conference center and are open to employees and the community
- Partnered with local family practice group and have successfully recruited an FP/OB and additional family nurse practitioner
- Space and facilities provided for cardiology practices that offer clinic several times per month
- Hospital provides access to specialty services locally, including: otolaryngology/ENT, audiology, orthopedics, ophthalmology, urology, oncology, sleep lab, nephrology, and pathology

- Hospital has invested in tele-medicine options, including: neurology/stroke (ARSAVES program), neo-natal (UAMS & Arkansas Children's), neo-natal and lactation consulting (Baptist Med)
- Hospital provides the following tests locally: EEG, nerve-conduction study, MRI, CT, mammography, interventional radiology
- Ongoing recruitment for general surgeon and family practice
- Hospital offers educational assistance to providers who want to advance their education
- Flu clinics for free flu shots held across the county
- Hospital manages county-wide ACLS ambulance service
- Nurses go to local schools to provide free sports physicals
- Physical therapy staff are present at local football games to assess injuries
- ER treats non-emergent patients without charging up-front fee, unlike other regional facilities
- Free childbirth classes offered

OCMC evaluation of impact of actions taken since the immediately preceding CHNA:

- Opened Urgent Care facility in July 2016 to provide faster, lower cost alternative to ER, and recruited family practitioner to be director of the clinic
- Expanded hours at Rural Health Clinic to increase access to care
- Recruited OB/GYN to start in 2017

Anticipated results from OCMC Implementation Strategy

Community Benefit Attribute Element	Yes, Implementation Strategy Addresses	Implementation Strategy Does Not Address
1. Available to public and serves low income consumers	X	
2. Reduces barriers to access services (or, if ceased, would result in access problems)	X	
3. Addresses disparities in health status among different populations	X	
4. Enhances public health activities	X	
5. Improves ability to withstand public health emergency	X	
6. Otherwise would become responsibility of government or another tax-exempt organization	X	
7. Increases knowledge; then benefits the public	X	

The strategy to evaluate OCMC intended actions is to monitor change in the following Leading Indicator:

- Number of people Navigator signs up for Medicaid/Medicare/Marketplace = 10 "sign-ups" per week (estimate)

The change in the Leading Indicator anticipates appropriate change in the following Lagging Indicator:

- Uninsured rate = 17.7%[34]

OCMC anticipates collaborating with the following other facilities and organizations to address this Significant Need:

Organization	Contact Name	Contact Information
Local schools		
Precision One Therapy & Associates (physical therapists)		(870) 836-1346
ARSAVES		arsaves.uams.edu
University of Arkansas Medical Science (UAMS)		(501) 686-7000 www.uams.edu
Arkansas Children's Hospital		(501) 364-1100 www.archildrens.org
Baptist Health Medical Center		(501) 202-2000 www.baptist-health.com
American Heart Association		http://www.heart.org/HEARTORG/Affiliate/Welcome-to-Little-Rock_UCM_SWA022_AffiliatePage.jsp
The Camden News		113 Madison Ave NE, Camden, AR 71701 (870) 836-8192 www.camdenarknews.com

Other local resources identified during the CHNA process that are believed available to respond to this need:

Organization	Contact Name	Contact Information

[34] CHSI. Percent of the population under age 65 without health insurance. Ranks #10 out of 43 peer counties. 2011.

Organization	Contact Name	Contact Information
Ouachita County Health Unit	Rebecca Wright	740 California Ave SW, Camden, AR 71701 (870) 836-5033 http://www.healthy.arkansas.gov/programsServices/localPublicHealthOffices/Pages/huDetails.aspx?show=Ouachita%20County%20Health%20Unit%20-%20Camden
A Healthy Ouachita County (AHOC)		https://www.facebook.com/AHOCcoalition
HOPE Health Commission (Healthy Outcomes Positive Effects)		1115 Fairview Rd SW, Camden, AR 71701 (870) 231-1111 www.facebook.com/HOPE-Health-Commission-of-Ouachita-County
Christian Health Center		1115 Fairview Rd SW, Camden, AR 71701 (870) 231-1111 https://christianhealthcenter.wordpress.com/

Other Needs Identified During CHNA Process

8. **STROKE – 2013 Significant Need**
9. **ALZHEIMER'S**
10. **COMPLIANCE BEHAVIOR**
11. **SMOKING – 2013 Significant Need**
12. **ACCIDENTS**
13. **BLOOD POISONING**
14. **CHRONIC LOWER BACK PAIN**
16. **SOCIAL FACTORS**
17. **PHYSICAL INACTIVITY**
18. **DENTAL**
19. **LIFE EXPECTANCY**
20. **LUNG DISEASE**
21. **MATERNAL/INFANT MEASURES**
22. **KIDNEY DISEASE**
23. **SEXUALLY TRANSMITTED INFECTION**
24. **FLU/PNEUMONIA**

Overall Community Need Statement and Priority Ranking Score

Significant needs where hospital has implementation responsibility[35]

1. Heart Disease
2. Obesity
3. Physicians
4. Cancer
5. Diabetes
6. Mental Health/Suicide
7. Accessibility/Affordability

Significant needs where hospital did not develop implementation strategy[36]

None

Other needs where hospital developed implementation strategy

15. Substance Abuse

Other needs where hospital did not develop implementation strategy

8. Stroke
9. Alzheimer's
10. Compliance Behavior
11. Smoking
12. Accidents
13. Blood Poisoning
14. Chronic Lower Back Pain
16. Social Factors
17. Physical Inactivity
18. Dental

[35] Responds to Schedule h (Form 990) Part V B 8
[36] Responds to Schedule h (Form 990) Part V Section B 8

19. Life Expectancy
20. Lung Disease
21. Maternal/Infant Measures
22. Kidney Disease
23. Sexually Transmitted Infection
24. Flu/Pneumonia

APPENDIX

Appendix A – Written Commentary on Prior CHNA (Round 1)

Hospital solicited written comments about its 2013 CHNA.[37] 26 individuals responded to the request for comments. The following presents the information received in response to the solicitation efforts by the hospital. No unsolicited comments have been received.

1. **Please indicate which (if any) of the following characteristics apply to you. If none of the following choices apply to you, please give a description of your role in the community.**

Local Experts Offering Solicited Written Comments on 2013 Priorities and Implementation Strategy	Yes (Applies to Me)	No (Does Not Apply to Me)	Response Count
1) Public Health Expertise	8	15	23
2) Departments and Agencies with relevant data/information regarding health needs of the community served by the hospital	4	16	20
3) Priority Populations	11	11	22
4) Representative/Member of Chronic Disease Group or Organization	2	18	20
5) Represents the Broad Interest of the Community	24	1	25
Other			
Answered Question			26
Skipped Question			0

Congress defines "Priority Populations" to include:

- **Racial and ethnic minority groups**
- **Low-income groups**
- **Women**
- **Children**
- **Older Adults**
- **Residents of rural areas**
- **Individuals with special needs including those with disabilities, in need of chronic care, or in need of end-of-life care**
- **Lesbian Gay Bisexual Transsexual (LGBT)**
- **People with major comorbidity and complications**

2. **Do any of these populations exist in your community, and if so, do they have any unique needs that should be addressed?**

- *Yes*
- *Yes*
- *All of above exist. I'm not aware of any unique needs other than general concerns.*
- *We live in a community that has a vast majority of all the priority populations. We have a abundance of*

[37] Responds to IRS Schedule h (Form 990) Part V B 5

lower income groups in all ages. Our community is working together to try and form a "Hub" for lower income families to try to receive resources, instead of multiple groups duplicating services for the same ones over and over. We also are in need of additional physicians (General Medicine) and nurse practioners to serve our community

- *Yes, nearly all of these populations exist in our community unfortunately we do not have enough providers to care for them all.*
- *Yes.*
- *No*
- *yes, Need transportation to health care.*
- *We have a high minority population. However, our greatest problem is poverty. Somewhere between 1/4 and 1/3 of our population lives at or below the poverty level. This may or may not impact the availability to healthcare. It definitely impacts (1) the ability to recognize the need for healthcare and (2) the commitment to long-term care and prevention.*
- *Our community has a large low income group. We have a large percentage of our population that are aging and many are in rural areas. We also are above average on teenage pregnancy rates.*
- *Yes, all these groups are represented in our community.*
- *Yes. Adult day care.*
- *Yes. All of the above. Education through multiple pathways.*
- *Yes and all require health needs related to their particular health issue.*
- *yes these priority populations exist in Ouachita County. We have sexually transmitted diseases that are in the LGBT community that need more attention. The low income groups need ways to help them get jobs and support themselves.*
- *All areas apply.*
- *Yes, all of the above. Yes, their needs should be addressed.*
- *According to www.encyclopediaofarkansas.com and the 2010 U.S. Census, Ouachita County is 57-percent white, and 40-percent African American. Regarding the low-income category, the county has 21.9 percent of its population in the category described as "below the poverty line," according to 2009 statistics. The county is a rural area in Arkansas, and there are several older adults in the region, therefore, there is a need for chronic care and end-of-life care. The county also has 38 percent adult obesity, and a high rate of teen births.*
- *There is a large population of LMI in our community equally balanced in all minority groupings that have normal medical needs without the ability to pay for services.*
- *Yes*
- *We have all these populations in our community. We have a limited number of physicians to treat an overabundance of patients. We have generational poverty that promotes a lot of the health problems in our community. Since we are a rural community, we do not have easy access to specialized treatment because of*

transportation problems and financial costs involved. Probably the only population listed that we do not need help with would be the end-of-life care. We have an excellent hospice program run through the local hospital.

- *Low income/Women/Minority Groups/Children Preventive care. Making sure they know how to be healthy and lead healthy lives.*
- *With our community being so rural we provide services to more victims who live in low income homes with lack of community resources and a mass transit system to provide transportation.*
- *These populations exist in my community. I am not aware of unique needs of any of these groups.*

In the 2013 CHNA, there were 8 health needs identified as "significant" or most important:

1. **Heart Disease**
2. **Mental Health/Suicide**
3. **Obesity**
4. **Diabetes**
5. **Physicians**
6. **Accessibility/Affordability**
7. **Stroke**
8. **Smoking**

3. **Should the hospital continue to consider the needs identified as most important in the 2013 CHNA as the most important set of health needs currently confronting residents in the county?**

	Yes	No	No Opinion
Heart Disease	25	0	0
Mental Health/Suicide	25	0	0
Obesity	24	1	0
Diabetes	24	0	1
Physicians	25	0	0
Accessibility/Affordability	24	1	0
Stroke	24	0	1
Smoking	24	1	0

4. **Should the Hospital continue to allocate resources to help improve the needs identified in the 2013 CHNA?**

	Yes	No	No Opinion
Heart Disease	23	0	1
Mental Health/Suicide	24	0	0
Obesity	22	1	1
Diabetes	23	0	1

	Yes	No	No Opinion
Physicians	23	0	1
Accessibility/Affordability	22	1	1
Stroke	23	0	1
Smoking	18	4	2

5. Are there any new or additional health needs the Hospital should address? Are there any new or additional implementation efforts the Hospital should take? Please describe.

- *Access to non-emergent medical care. Cancer and the care associated with it.*
- *No known additional health needs at this time.*
- *Our local hospital is very pro active about addressing the needs of our community*
- *No*
- *None*
- *The availability to healthcare professionals is a challenge. Our doctors are maxed out. That term doesn't even begin to describe our issue with mental health care in Ouachita County. The death of Dr. McFarland has escalated the need for a urologist in our community. Having one that comes one day a month will not even be a "drop in the bucket" for us.*
- *I am very happy to see that our hospital is working on opening an urgent care clinic. I believe this will help relieve the emergency room to be able to concentrate on true emergencies.*
- *Having rarely utilized the emergency room services, we were unaware of the check-in procedure. There needs to be a clearer plan in place that better walks people through the process (as far as where to go, what is needed) because the few times we HAVE had to visit the ER it was like we were expected to know exactly what to do. When you're in the middle of an emergency, a little more help and compassion would go a long way.*
- *None*
- *I would like to see more sub specialties in our hospital as our patients often do not comply with referrals/tests ordered out of town due to inability to afford transportation.*
- *Yes, continue to bring in more specialist for the local community.*
- *Not at this time.*
- *The local hospital is doing a wonderful job in addressing the above-mentioned needs. There are new doctors in the area, plans for an "Urgent Care" facility, and the Ouachita County Medical Center also hosts meetings that help explain insurance coverage such as Medicare and Medicaid.*
- *See answer to #4. The Hub is a new organization developed to address the poverty in our area and to offer help to the underprivileged and those in need.*
- *Develop a policy on how to provide services to clients with mental and physical disabilities.*

6. **Please share comments or observations about keeping <u>Heart Disease</u> among the most significant needs for the Hospital to address.**

- *Important. Perhaps cardiac rehab program should be considered.*
- *With heart disease being the #1 cause of death, we need to focus effort on this health issue.*
- *Since heart disease is the number one cause of death, it should still be considered by the hospital to be a significant need for the community.*
- *As a minister, we have sent three members of our church to the hospital in the past two weeks with heart issues. It remains a top priority! This issue does not seem to be going away anytime soon - at least not until we address obesity, exercise and other cardio issues.*
- *With an aging population I believe it is important to address the need in Heart Disease. People need to be treated as quickly as possible before being sent to a hospital that specializes in heart care. We also have a significant percentage of our population that do not have transportation. Having some form of care in this area would be extremely important for this segment of citizens.*
- *It is still the number one killer.*
- *Education provided for patients. Care coordination between hospital and PCP.*
- *continue to educate community as a whole*
- *When they address Heart Disease, it will also be making an impact on stroke, diabetes, obesity, mental health/ suicide and tobacco use. These are all linked together many times.*
- *With heart disease as the #1 leading cause of death, let's continue to emphasize heart health awareness.*
- *Major issue for every socioeconomic level. Education on prevention would be helpful.*
- *Heart disease runs in my family on my mother's side, so I am aware of the importance of having available, adequate care for those who have this condition. The area's doctors are also aware of this need, and they - from my own family's experiences - are doing all they can to help those with heart disease learn how to live a productive life despite the diagnosis. They are also very competent at teaching heart-disease patients about healthier diets and the need for exercise - if the person is able to do so.*
- *Heart disease should remain a significant need due to our fat and lazy lifestyle.*
- *yes, it is in the top diseases that cause death in our area.*
- *N/A*
- *There are many precursors to this disease. I think if we made a community movement to live better, we'd see less of this. Until we do that, I guess it needs to be among the most significant.*

7. **Please share comments or observations about the implementation actions the Hospital has taken to address <u>Heart Disease</u>.**

- *Hospital continually focuses on public awareness and prevention of disease.*

- *Due to the fact that I don't know all the steps that the hospital has taken, I have no comments.*
- *Our ER does a wonderful job getting patients stable and transferring them to a heart-care facility.*
- *Education provided for patients. Care coordination between hospital and PCP.*
- *expanded/upgraded their critical and icu areas*
- *By having health fairs that target health screenings, many people learn they have a health issue. This is very important to our community.*
- *Publicity regarding health improvements thru media, hospital employees, Doctors and program education.*
- *N/a*
- *The local hospital hosts groups - such as A Healthy Ouachita County and the H.O.P.E. group - that address the county's health issues, and there are diabetes-information classes and Weight Watchers meetings that are also hosted by OCMC.*
- *Our sedentary lifestyle leads to most of these problems and I applaud any actions our hospital/ community can do in getting us off the couch.*
- *N/A*

8. **Please share comments or observations about keeping <u>Mental Health/Suicide</u> among the most significant needs for the Hospital to address.**
    - *Extremely important as mental he's.th issues continue to increase. Access to outpatient care is needed. The community needs a psychiatrist locally accessible for outpatient follow up.*
    - *With significant drug use and Rx abuse in Ouachita County, this issue is most definitely needs to remain significant.*
    - *It continues to be a need for the community.*
    - *The lack of mental health professionals is significant!*
    - *There isn't enough mental health counselors in this area. In working with groups that are trying to help people if becomes increasing frustrating to try to find help in this area and to be told that a person can not get an appointment for a long time or in many cases that the counselors are so booked up that they can no longer take new patients.*
    - *Our community has a tremendous need for this service.*
    - *We need greater access to mental health facilities/care. Education provided for patients. Care coordination between hospital and PCP.*
    - *Educate through meetings and seminars*
    - *Ouachita County's mental health/suicide rates have been climbing. It seems no one else is interested in addressing this issue.*
    - *With this being a community need, we certainly need to promote and educate regarding this issue.*

- *There is a growing need for this kind of help. Many mentally ill people on this community and not enough treatment choices or facilities for immediate take ins.*
- *As a newspaper reporter, I am extremely aware of the suicides that have taken place throughout the county in recent years. Unfortunately, suicide have affected people from every age group, every race, and every walk of life. Also, I am aware of police and sheriff's reports that tell of law enforcement being called to a residence because a person is having a mental health breakdown. Because of all this, there is a definite need to address mental health and suicide prevention in Ouachita County.*
- *It appears that there are programs to assist the mentally ill, but it is difficult to monitor their ability to take their medication properly. My opinion is we are way to medicated weather it be prescribed or unauthorized RX. It is sad, but the system/ our health care system rather than family is the only home for the mentally ill.*
- *yes, our community has a lot of mental health patients*
- *30% of the clients we serve in our agency have severe mental issues and are suicidal due to being in a abusive relationship. It is very important for our local hospital to be able keep providing services to mental health/suicidal survivors because we live in such a rural community we lack other available emergency resources.*
- *Seeing more and more of this. Again, we need to be proactive and motivate people to be open to receiving help at the onset.*

9. Please share comments or observations about the implementation actions the Hospital has taken to address <u>Mental Health/Suicide</u>.

- *OCMC has a dynamic rehab program and continues to focus on providing assistance to those in need in our community.*
- *As stated above, it continues to be a need in the community and the hospital should provide service.*
- *Education provided for patients. Care coordination between hospital and PCP.*
- *Do not know*
- *Publicity regarding health improvements thru media, hospital employees, Doctors and program education. Exceptional hospital program!*
- *I don't have knowledge on this matter.*
- *The hospital does provide information and recommendations to those who suffer from mental-health issues and to the families of those who have those issues, and those who have attempted suicide and/or have a family member who has done so.*
- *I am not sure how to attack this problem, what we have done in the past has not worked.*
- *The hospital have gotten our clients placed into a facility to get stable on there medication.*
- *I am not familiar with what the hospital is doing with this. Maybe fliers could be placed around town letting people know that this type of care is available.*

10. Please share comments or observations about keeping <u>Obesity</u> among the most significant needs for the Hospital

to address.

- *Important.*
- *With Arkansas obesity rates significantly higher than US rates, we need to continue public education regarding this issue.*
- *Obesity continues to be a national problem and the local hospital should do all it can to assist in this much needed service.*
- *We need a nutritionist in our health care system. Those in our community who most need education in this area are unable to receive it in Ouachita County.*
- *As our county has become more aware of this problem I believe several steps have been taken, but we also need to continue to do more. Several gyms are reaching out to more citizens to get on board with physical exercise. There has been more promotion of a community farmer's market. All of these are good, but just need to continue with these efforts and find more education and hands on experiences to help.*
- *Working with children daily, it is so important to teach from a young age those healthy eating habits to prevent obesity. Maybe having health personnel coming into the schools a few times a year would be a way to emphasize the importance of eating healthier.*
- *Education provided for patients. Care coordination between hospital and PCP.*
- *Do no know of any at present*
- *Again, the Health screenings they provide at their health fairs has brought attention to obesity in our community.*
- *With community need, awareness needs to be continually emphasized by city, state and nationally.*
- *Being one of the most cities in AR, we must continue to try to find services and education for this epidemic.*
- *At one point recently, Ouachita County was named the most unhealthy. Due to this, plans have been implemented in the area for a walking/biking trail and other healthy activities.*
- *Our inactivity and lazy lifestyle/ obesity is a path to heart disease, diabetes and stroke. We the people are the cause.*
- *yes obesity is a major cause of death in our community.*
- *N/A*
- *Definitely keep this we rank really high in this area as compared to other counties in the state.*

11. **Please share comments or observations about the implementation actions the Hospital has taken to address <u>Obesity</u>.**

- *Hospital needs to continue education and awareness of this issue.*
- *Due to the lack of knowledge the hospital has implemented, I have no comment.*
- *Education provided for patients. Care coordination between hospital and PCP.*

- *Do not know*
- *They participate in a county wide walking/exercise campaign with their staff. This also encourages other organizations to participate. They are leading by example and identifying exercise as an important part of their mission.*
- *Publicity regarding health improvements thru media, hospital employees, Doctors and program education.*
- *N/a*
- *The hospital hosts the local Weight Watchers group, and also provides information about adopting healthier eating habits. It also employs a dietician who is available to those who want to make healthier food choices and those who need to do so due to diabetes, obesity and other health factors.*
- *Any actions the hospital takes to get our community moving away from the couch is in the right direction.*
- *I am not sure how to attack this problem, what we have done in the past has not worked.*
- *N/A*
- *I think the hospital could get involved more in the community by offering fun, engaging group activities that educate people on to do better. Maybe local contests, weekly meetings, etc.*

12. Please share comments or observations about keeping <u>Diabetes</u> among the most significant needs for the Hospital to address.

- *Most definitely a significant issue especially with the county being higher than the national average.*
- *Due to the increasing number of the population being diagnosed with diabetes, the hospital should have a continued focus on educating and treating people with complications from having diabetes.*
- *This ranks up in the same category with heart care and obesity. Again, in our small congregation, the number of people who suffer from diabetes is far above any average.*
- *Diabetes is a problem in our county and seems to be increasing in the younger population. It would be good to have education booths at more events...such as "National Night Out", "Barn Sale", "Daffodil Festival" as well as some health screenings and educational opportunities with schools.*
- *Education provided for patients. Care coordination between hospital and PCP.*
- *Do not know*
- *Health screenings is a great way to identify individuals that do not know they are diabetic. The hospital partners with other businesses and events to provide screening as well as their health fairs.*
- *Diabetes is certainly rampant and needs to remain a significant category.*
- *Diabetes is rampant here. This has to be a top priority. Educating and following up on pt's progress is valuable in giving people best treatment outcome.*
- *According to the Robert Wood Johnson Foundation, Ouachita County has 87 percent diabetic monitoring. This means there is a high number of diabetics in the area.*
- *We are way above state and national averages. This affects all areas of our community and our inability to*

exercise and eat right compound the problem.

- *Yes, continues to be a major problem in our area*
- *N/A*
- *This area is still in need.*

13. Please share comments or observations about the implementation actions the Hospital has taken to address <u>Diabetes</u>.

- *Hospital needs to continue education and awareness of this issue.*
- *I have can't address this because of limited knowledge in this area.*
- *Having a grandfather who suffered from diabetes, I feel it is so important to continue to have this as one of your main emphasis points as many in our community (many due to obesity) have this health issue as well.*
- *Education provided for patients. Care coordination between hospital and PCP.*
- *Do not know of any*
- *I have been at some of these events where individuals were identified as diabetic and were unaware. This made a big difference to these citizens and encouraged them to go to the doctor and help.*
- *Publicity regarding health improvements thru media, hospital employees, Doctors and program education.*
- *N/A*
- *As stated earlier, the hospital employs a dietician who is available to those who want to make healthier food choices and those who need to do so due to diabetes, obesity and other health factors. Also, members of the hospital staff have presented the public with classes about the management of diabetes.*
- *Healthy eating and education on healthy lifestyles is always stressed, but seldom followed by we the people.*
- *I am not sure how to attack this problem, what we have done in the past has not worked. There are all types of programs for diabetics in our area (not just hospital but other organizations) but the people are just not interested in improving their health, until it gets too late.*
- *N/A*
- *I don't have anyone personally that I am connected to that has diabetes, so I am unaware of what is currently being done.*

14. Please share comments or observations about keeping <u>Physicians</u> among the most significant needs for the Hospital to address.

- *Extremely important, but challenging for a rural community.*
- *Physician recruitment and retainment is a significant community issue.*
- *We need to continue to recruit physicians to keep up with the needs of population.*
- *Family physicians and specialty doctors are still needed.*
- *We have some of the MOST WONDERFUL, COMPASSIONATE physicians in our little community. I feel salaries*

and benefit packages need to continue being competitive to continue attracting young, outstanding physicians to Camden.

- *Active communication with local physicians along with incentives for providers.*
- *Have brought in some new general medicine doctors and at least two specialist*
- *we have had several doctors retire and some to even pass away in the last several years. This is why there is a need to keep recruiting physicians to our community. If they don't our citizens will go to other counties to see a doctor.*
- *Doctor shortage is a major problem in South Arkansas and greatly needs to remain as a significant issue.*
- *I feel like this is so important. From the Dr's standpoint and the patient's standpoint, there are not enough Drs to serve our community effectively.*
- *Recently, there have been a couple of deaths in our physician community: One due to advanced age - although he worked through the age of 80; and another due to a sudden heart attack.*
- *It must be difficult to recruit to this community and from the wait times to see physicians in our community there is a definite need.*
- *I feel this should be a top priority. I know the hospital and local clinic have tried for years to recruit new physicians to the area but have been unsuccessful. With the new Affordable Care Act, there are more people with insurance but they cannot get in to see a doctor because of the patient overload on our physicians. To my knowledge there is not a physician in town that is currently taking new patients.*
- *A client that has been battered or sexually assaulted need to be able to feel that they have a well trained physician with the qualifications the handle there immediate needs. Continuous physician recruitment is a must.*
- *Yes, yes and yes!*

15. Please share comments or observations about the implementation actions the Hospital has taken to address <u>Physicians</u>.

- *The hospital continually strives to recruit physicians.*
- *OCMC CEO, Peggy Abbott does a tremendous job focusing on this significant issue and is proactive seeking high caliber physicians.*
- *I believe the hospital is headed in the right direction in regards to the recruitment of physicians.*
- *I am thankful we were able to fill the gap in our ER staff so quickly! The addition of hospital physicians is also a positive step.*
- *I think our hospital is doing well in trying to recruit physicians. They have recently made progress in having several physicians coming to our town on a once a month or once a week basis which is very helpful to our area.*
- *See 14*
- *They have made it possible for specialist to come to Camden from other large cities by providing them clinic*

space.

- *CEO is diligent in recruitment of highly qualified physicians.*
- *N/A*
- *The hospital has been able to fill those needed physician positions to help serve the medical needs of the community.*
- *The hospital has renovated the main facility, improved satellite facilities and fought to fill existing facilities with competent, caring medical professionals.*
- *This is out of my realm of expertise but I would think if we can improve our county and bring in more jobs and activities that draw people to move to a community, then recruitment of physicians would be easier.*
- *Not sure.*
- *We must have reputable physicians to have better care.*

16. Please share comments or observations about keeping <u>Accessibility/Affordability</u> among the most significant needs for the Hospital to address.

- *Affordability is important, but I feel this could be removed at this time.*
- *Affordability needs to remain as significant issue.*
- *Due to a significant portion of our population that lives below the poverty line this is sorely needed.*
- *Healthcare costs were 15% of my total personal budget in 2015. It's incredible to consider how much a normal family is having to pay - even with good insurance.*
- *Everything seems to go up but peoples' salaries, so keeping hospital prices down is very much appreciated (especially in a community where many struggle financially).*
- *Our hospital accepts a variety of insurances and works with patients on bill payment. They are also very diligent about meeting criteria for tests/procedures ordered in an effort to reduce cost all around.*
- *This is above my level of input*
- *Affordability is essential in a low income area.*
- *Since there is a 32 percent poverty rate in Ouachita County, there is definitely a need for affordable health care.*
- *This is a very difficult situation and health care is very expensive. There is a problem with we the people when we would rather drive a nice car than pay for the care given us at our hospital.*
- *This continues to be a problem because of our poor economic status in a rural South Arkansas community.*
- *There are a lot of people that don't have or can't afford to get medical insurance. By offering affordable medical services will lower the statistics on a lot of the medical issues we face that has gone untreated because the people in the community can't afford to seek medical treatment.*
- *Of course. I would like to see the opportunity for those who have private insurance to get a break every now*

and then if they pay their bills regularly.

17. **Please share comments or observations about the implementation actions the Hospital has taken to address <u>Accessibility/Affordability</u>.**

- *The hospital promotes financial assistance availability and strived to keep costs limited ad possible.*
- *OCMC is aware of high poverty and uninsured rate and provides professional services for all walks of life whether insured or uninsured.*
- *I have no knowledge of the implementation actions by the hospital.*
- *The Urgent Care facility will be a positive step in a good direction.*
- *Do not know*
- *Hospital provides care to all levels of income.*
- *The hospital has offered classes to help residents learn about how to choose the best insurance plan.*
- *The hospital will work with ANY one who receives care and has an outstanding bill. Medical services do not appear to be any higher in Camden than anywhere else.*
- *I feel the hospital does what it can to help the community in this area.*
- *Not sure.*

18. **Please share comments or observations about keeping <u>Stroke</u> among the most significant needs for the Hospital to address.**

- *Important.*
- *With stroke being the #3 cause of death, stroke needs to remain significant issue.*
- *Continue to keep stroke a high priority by the hospital.*
- *In our church's food pantry, we see some of the poorest in our community. All the issues we have discussed are quite visible each week as we distribute groceries. We have now gotten to the point where we carry groceries to each person's vehicle - mainly because of poor health concerns such as heart, obesity, diabetes and stroke-related mobility issues.*
- *Education provided for patients. Care coordination between hospital and PCP. Our ER has a program with neurology in Little Rock to expedite stroke care.*
- *Do not know of any*
- *Most definitely needs to remain significant.*
- *Stroke is a very important need to continue to focus on due to high heart disease, diabetes, and obesity rates in our community.*
- *With a population that has several of its residents in the older-age category, there is a need for awareness about the prevention of strokes.*
- *As stated earlier, our lifestyle of poor eating habits and lack of physical exercise all lead to poor physical*

health.

- *Not sure about the stats on stroke. I am unaware if this continues to be a major problem or not.*
- *N/A*
- *Keep it*

19. Please share comments or observations about the implementation actions the Hospital has taken to address <u>Stroke</u>.

- *Excellent. The hospital participates in the ARSAVES Program.important*
- *Hospital needs to continue education and awareness of this issue.*
- *I believe the treatment and education about strokes should be continued by the hospital.*
- *Education provided for patients. Care coordination between hospital and PCP.*
- *See answer 18*
- *Screening during their health fairs show the importance of addressing stroke prevention in our community.*
- *Publicity regarding health improvements thru media, hospital employees, Doctors and program education.*
- *N/A*
- *The hospital and its staff does provide information about helping older residents learn about stroke prevention, and about the signs and symptoms of stroke.*
- *I applaud any efforts the hospital can do to affect any change in we the people.*
- *N/A*
- *The high percentage show the need.*

20. Please share comments or observations about keeping <u>Smoking</u> among the most significant needs for the Hospital to address.

- *Important.*
- *With our county having such a high rate of smokers, issue needs to remain significant.*
- *Should continue to a significant focus by the hospital.*
- *This has to be one of the greatest community concerns - both from a health care standpoint and economic. People who can least afford to continue this habit still light up or dip.*
- *Education provided for patients. Care coordination between hospital and PCP.*
- *Smoke free campus would help. Worst offenders are some of their on employees*
- *They have made their work campus smoke free and took a lead in our community so others have followed and done the same.*
- *Significant community need.*

- *The RWJF states that Ouachita County has 23 percent of its residents who have reported that they smoke.*
- *Smoking is a lifestyle choice, a poor lifestyle choice, but one our community embraces.*
- *I do not feel we can do anything else with cessation of smoking until the person wants to quit.*
- *N/A*
- *Not sure. People seem to know what it will do to you and continue doing it.*

21. Please share comments or observations about the implementation actions the Hospital has taken to address <u>Smoking</u>.

- *Excellent approach.*
- *Hospital needs to continue education and awareness of this issue.*
- *I don't have enough information to elaborate on this matter.*
- *It's great that your facility is now smoke-free. It is most dis-heartening to see medical care professionals walk a significant distance just to light up. One might think - given all they see - that they would have dropped the habit by now.*
- *See 20 above*
- *Publicity regarding health improvements thru media, hospital employees, Doctors and program education.*
- *Information about the benefits of quitting smoking is provided by the hospital.*
- *Any plan or program our hospital an do to help anyone stop smoking will make our community healthier.*
- *I feel the hospital does what it can to help the community in this area. Maybe attach the school age kids so that they do not start smoking. Offer available cessation programs, but that is already being done in our community and not just through the hospital.*
- *N/A*
- *Seems like maybe if you don't smoke you can get a discount on your bill.*

22. Finally, after thinking about our questions and the information we seek, is there anything else you think is important as we review and revise our thinking about significant health needs in the county?

- *Access continues to be problematic. The hospital us addressing this with the upcoming implementation of an urgent care clinic, but more primary care physicians are needed. Psychiatric care locally is needed.*
- *Not at this time.*
- *Continue to make health care accessible to all.*
- *Great survey. Important questions. Quite comprehensive. Thank you.*
- *I believe this will take networking together with many groups to help make the change needed in our area, but it can be done!.*
- *Urgent care*

- *I am a huge supporter of Ouachita County Medical Center. Thank you for all you do to keep Ouachita County residents healthy!*
- *no*
- *A medivac air service.*
- *All areas have been identified and need to remain as significant items.*
- *Prevention and education presented in schools, churches, etc. If you can build a foundation of good health and habits, so much of our communities problems could be eliminated.*
- *Not really.*
- *Our city/community/state/country need to exercise daily, eat less fast/ processed food and quit looking for a pill to cure everything.*
- *No*
- *Improving the overall culture of the county. We are so impoverished which lends itself to so many negative outcomes. People don't necessarily need to be rich to be happy. They just need to know they are cared about. Local "mission" type parties and services would let them know just that. Feeling that they have a place and a part would empower the citizens to be better people and give them reason to do better.*

Appendix B – Identification & Prioritization of Community Needs (Round 2)

Need Topic	Total Votes	Number of Local Experts Voting for Needs	Percent of Votes	Cumulative Votes	Need Determination
Heart Disease - 2013 Significant Need	308	19	10.44%	10.44%	Significant Needs
Obesity - 2013 Significant Need	297	19	10.07%	20.51%	
Physician - 2013 Significant Need	270	20	9.15%	29.66%	
Cancer	263	19	8.92%	38.58%	
Diabetes - 2013 Significant Need	254	18	8.61%	47.19%	
Mental Health/Suicide - 2013 Significant Need	248	18	8.41%	55.59%	
Accessibility/Affordability - 2013 Significant Need	211	18	7.15%	62.75%	
Stroke - 2013 Significant Need	177	17	6.00%	68.75%	Other Identified Needs
Alzheimer's	169	16	5.73%	74.47%	
Compliance Behavior	150	15	5.08%	79.56%	
Smoking - 2013 Significant Need	135	15	4.58%	84.14%	
Accidents	130	13	4.41%	88.54%	
Blood Poisoning	98	13	3.32%	91.86%	
Chronic Lower Back Pain	98	13	3.32%	95.19%	
Substance Abuse	19	19	0.64%	95.83%	
Social Factors	15	12	0.51%	96.34%	
Physical Inactivity	14	14	0.47%	96.81%	
Dental	13	13	0.44%	97.25%	
Life Expectancy	13	13	0.44%	97.69%	
Lung Disease	13	13	0.44%	98.14%	
Maternal/Infant Measures	13	13	0.44%	98.58%	
Kidney Disease	12	12	0.41%	98.98%	
Sexually Transmitted Infection	12	12	0.41%	99.39%	
Flu/Pneumonia	11	11	0.37%	99.76%	
Unallocated Points	7	2	0.24%	100.00%	
Total	2950		100.00%		

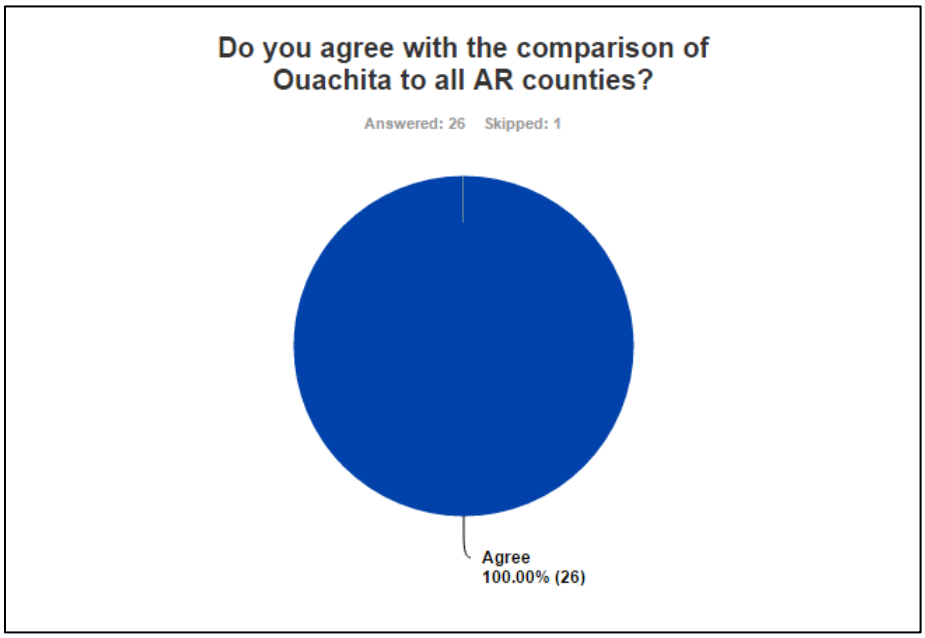
Individuals Participating as Local Expert Advisors[38]

	Yes (Applies to Me)	No (Does Not Apply to Me)	Response Count
1) Public Health Expertise	10	12	22
2) Departments and Agencies with relevant data/information regarding health needs of the community served by the hospital	5	12	17
3) Priority Populations	8	9	17
4) Representative/Member of Chronic Disease Group or Organization	1	15	16
5) Represents the Broad Interest of the Community	21	3	24
Other			
Answered Question			27
Skipped Question			0

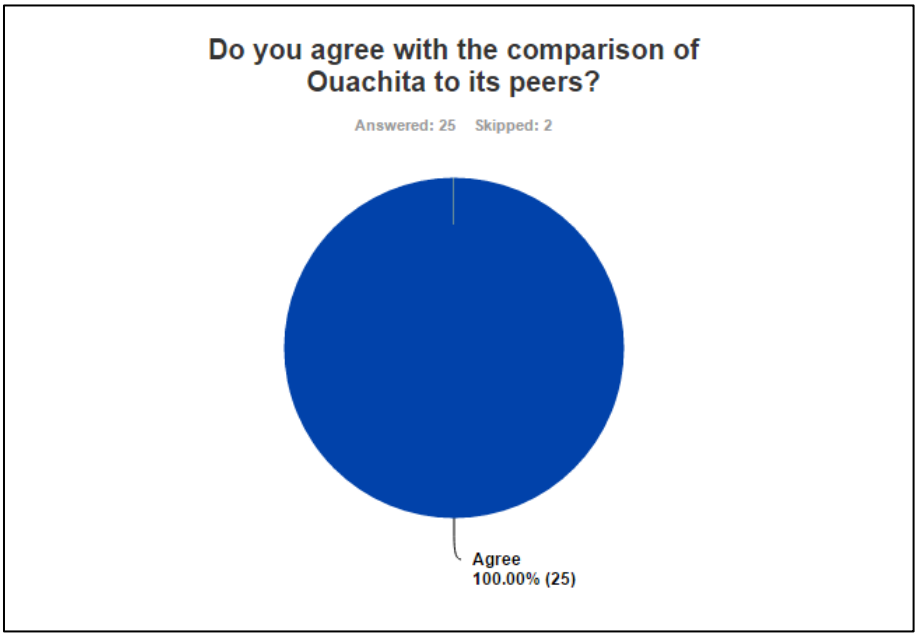
[38] Responds to IRS Schedule h (Form 990) Part V B 3 g

Advice Received from Local Expert Advisors

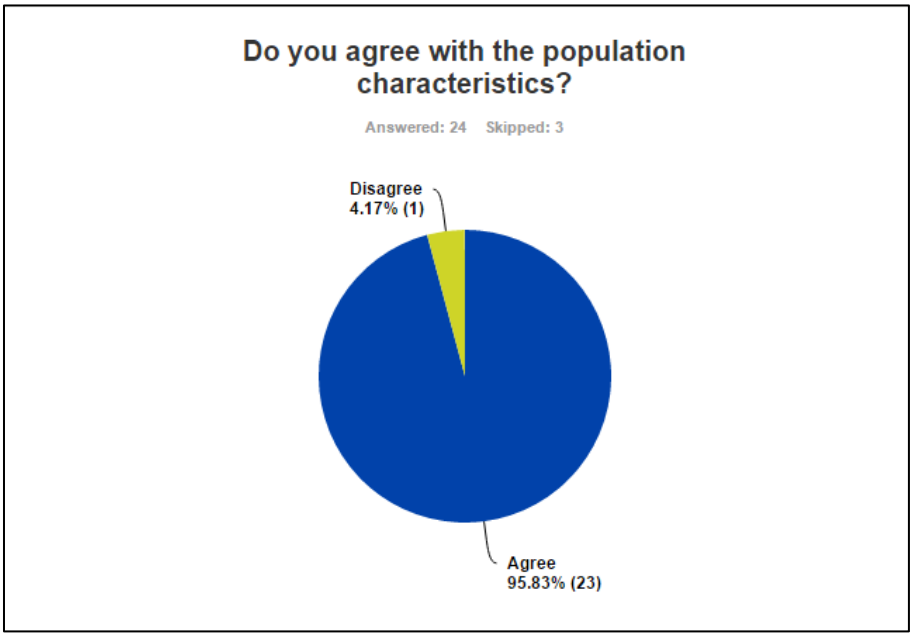
Question: Do you agree with the observations formed about the comparison of Ouachita County to all other Arkansas counties?



Question: Do you agree with the observations formed about the comparison of Ouachita County to its peer counties?



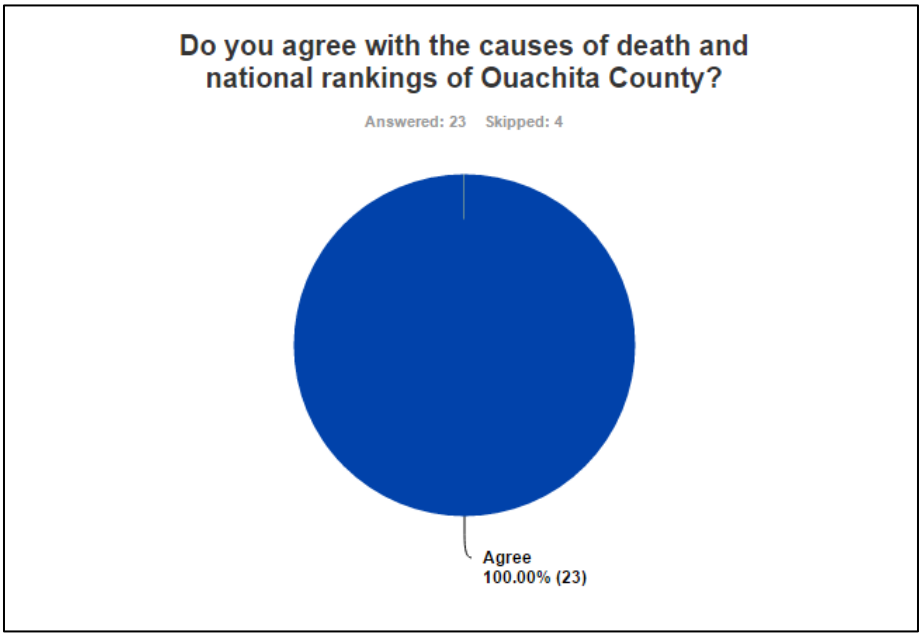
Question: Do you agree with the observations formed about the population characteristics of Ouachita County?



Comments:

- *Not sure of the above data collected.*
- *I believe with the recent opening of the OCMC Urgent care clinic this will change the use of the Emergency Room and bring that more in line with the average. Also there have been new gyms open up with various exercise options and many citizens are participating. This should change the stats on the BMI as well as the Vigorous Exercise catagories.*

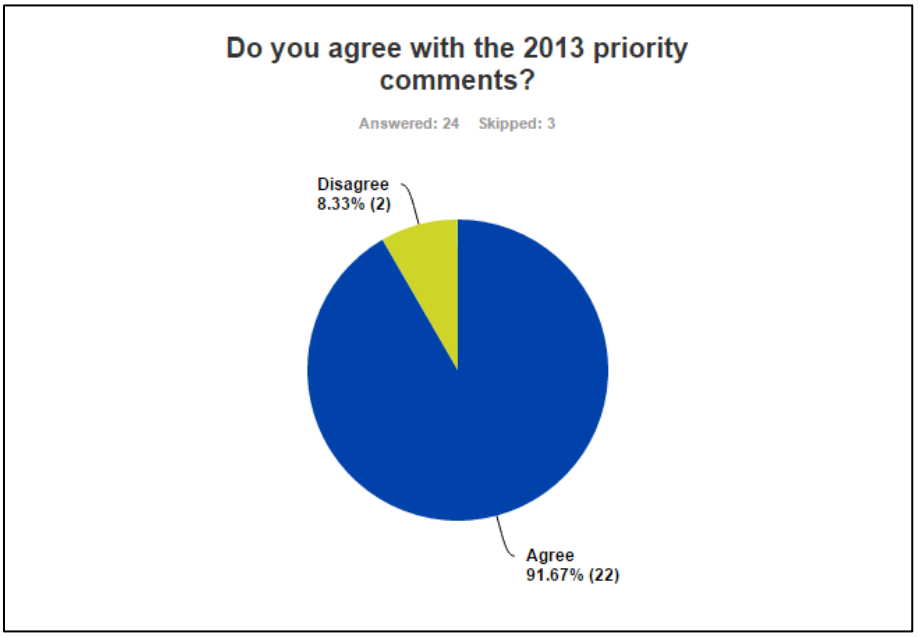
Question: Do you agree with the observations formed from the national rankings and leading causes of death?



Comments:

- *not sure of the data listed above.*

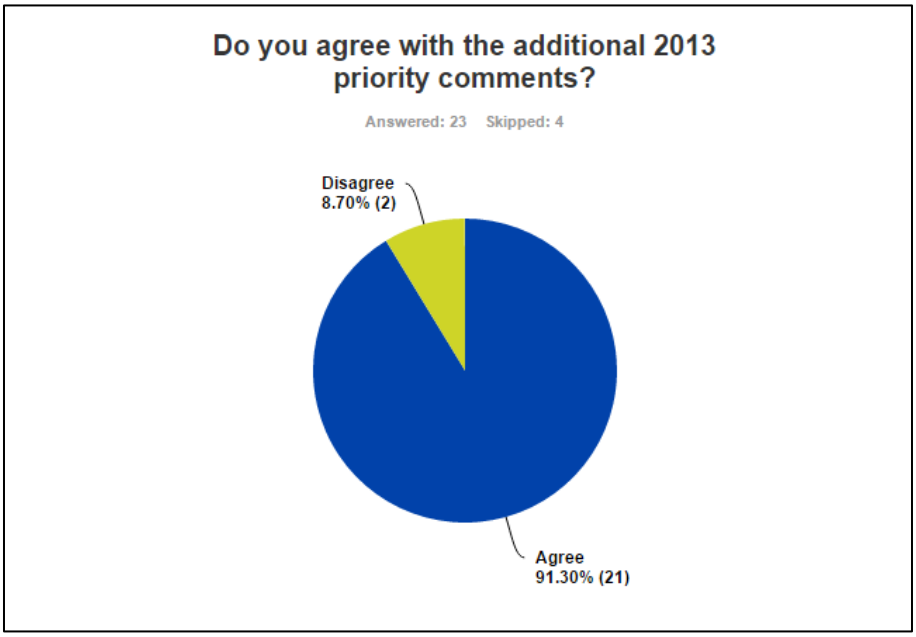
Question: Do you agree with the written comments received on the 2013 CHNA?



Comments:

- *Addictions is a primary factor in this county as well as the above.*
- *Because of the new ER doctor (Dr. Daniel), I think the ER is doing a great job. He is very compassionate and timely. Not sure what is meant about the policy to provide services for mental and physical disabilities. I agree with the rest of above statements.*
- *There are good comments that deserve the attention of local medical officials. The new urgent care is a positive move for our community. The lack of mental health officials is a HUGE concern among community and religious leaders.*

Question: Do you agree with the additional written comments received on the 2013 CHNA?



Comments:

- *I disagree with putting emphasis on smoking. Everyone knows that it is harmful to your health.*
- *I believe the response is clear - these issues remain important in our community.*

Appendix C – National Healthcare Quality and Disparities Report[39]

The National Healthcare Quality and Disparities Reports (QDR) (annual reports to Congress mandated in the Healthcare Research and Quality Act of 1999 (P.L. 106-129)) are based on more than 250 measures of quality and disparities covering a broad array of healthcare services and settings. Data are generally available through 2012, although rates of un-insurance have been tracked through the first half of 2014. The reports are produced with the help of an Interagency Work Group led by the Agency for Healthcare Research and Quality (AHRQ) and submitted on behalf of the Secretary of Health and Human Services (HHS).

Beginning with this 2014 report, findings on healthcare quality and healthcare disparities are integrated into a single document. This new National Healthcare Quality and Disparities Report (QDR) highlights the importance of examining quality and disparities together to gain a complete picture of healthcare. This document is also shorter and focuses on summarizing information over the many measures that are tracked; information on individual measures will still be available through chartbooks posted on the Web (www.ahrq.gov/research/findings/nhqrdr/2014chartbooks/).

The key findings of the 2014 QDR are organized around three axes: **access to healthcare**, **quality of healthcare**, and **NQS priorities**.

To obtain high-quality care, Americans must first gain entry into the healthcare system. Measures of access to care tracked in the QDR include having health insurance, having a usual source of care, encountering difficulties when seeking care, and receiving care as soon as wanted. Historically, Americans have experienced variable access to care based on race, ethnicity, socioeconomic status, age, sex, disability status, sexual orientation, and residence location.

ACCESS: After years without improvement, the rate of un-insurance among adults ages 18-64 decreased substantially during the first half of 2014.

The Affordable Care Act is the most far-reaching effort to improve access to care since the enactment of Medicare and Medicaid in 1965. Provisions to increase health insurance options for young adults, early retirees, and Americans with pre-existing conditions were implemented in 2010. Open enrollment in health insurance marketplaces began in October 2013 and coverage began in January 2014. Expanded access to Medicaid in many states began in January 2014, although a few had opted to expand Medicaid earlier.

Trends

- From 2000 to 2010, the percentage of adults ages 18-64 who reported they were without health insurance coverage at the time of interview increased from 18.7% to 22.3%.
- From 2010 to 2013, the percentage without health insurance decreased from 22.3% to 20.4%.
- During the first half of 2014, the percentage without health insurance decreased to 15.6%.
- Data from the Gallup-Healthways Well-Being Index indicate that the percentage of adults without health insurance continued to decrease through the end of 2014,[40] consistent with these trends.

[39] http://www.ahrq.gov/research/findings/nhqrdr/nhqdr14/index.html Responds to IRS Schedule h (Form 990) Part V B 3 i
[40] Levy J. In U.S., Uninsured Rate Sinks to 12.9%. http://www.gallup.com/poll/180425/uninsured-rate-sinks. aspx.

ACCESS: Between 2002 and 2012, access to health care improved for children but was unchanged or significantly worse for adults.

Trends

- From 2002 to 2012, the percentage of people who were able to get care and appointments as soon as wanted improved for children but did not improve for adults ages 18-64.

Disparities

- Children with only Medicaid or CHIP coverage were less likely to get care as soon as wanted compared with children with any private insurance in almost all years.
- Adults ages 18-64 who were uninsured or had only Medicaid coverage were less likely to get care as soon as wanted compared with adults with any private insurance in all years.

Trends

- Through 2012, most access measures improved for children. The median change was 5% per year.
- Few access measures improved substantially among adults. The median change was zero.

ACCESS DISPARITIES: During the first half of 2014, declines in rates of un-insurance were larger among Black and Hispanic adults ages 18-64 than among Whites, but racial differences in rates remained.

Trends

- Historically, Blacks and Hispanics have had higher rates of un-insurance than Whites.[41]

Disparities

- During the first half of 2014, the percentage of adults ages 18-64 without health insurance decreased more quickly among Blacks and Hispanics than Whites, but differences in un-insurance rates between groups remained.
- Data from the Urban Institute's Health Reform Monitoring System indicate that between September 2013 and September 2014, the percentage of Hispanic and non-White non-Hispanic adults ages 18-64 without health insurance decreased to a larger degree in states that expanded Medicaid under the Affordable Care Act than in states that did not expand Medicaid.[42]

ACCESS DISPARITIES: In 2012, disparities were observed across a broad spectrum of access measures. People in poor households experienced the largest number of disparities, followed by Hispanics and Blacks.

Disparities

- In 2012, people in poor households had worse access to care than people in high-income households on all access measures (green).

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[41] In this report, racial groups such as Blacks and Whites are non-Hispanic, and Hispanics include all races.
[42] Long SK, Karpman M, Shartzer A, et al. Taking Stock: Health Insurance Coverage under the ACA as of September 2014. http://hrms.urban.org/briefs/Health-Insurance-Coverage-under-the-ACA-as-of- September-2014.html

- Blacks had worse access to care than Whites for about half of access measures.
- Hispanics had worse access to care than Whites for two-thirds of access measures.
- Asians and American Indians and Alaska Natives had worse access to care than Whites for about one-third of access measures.

ACCESS DISPARITIES: Through 2012, across a broad spectrum of access measures, some disparities were reduced but most did not improve.

Disparity Trends

- Through 2012, most disparities in access to care related to race, ethnicity, or income showed no significant change (blue), neither getting smaller nor larger.
- I n four of the five comparisons shown above, the number of disparities that were improving (black) exceeded the number of disparities that were getting worse (green).

QUALITY: Quality of health care improved generally through 2012, but the pace of improvement varied by measure.

Trends

- Through 2012, across a broad spectrum of measures of health care quality, 60% showed improvement (black).
- Almost all measures of Person-Centered Care improved.
- About half of measures of Effective Treatment, Healthy Living, and Patient Safety improved.
- There are insufficient numbers of reliable measures of Care Coordination and Care Affordability to summarize in this way.

QUALITY: Through 2012, the pace of improvement varied across NQS priorities.

Trends

- Through 2012, quality of health care improved steadily but the median pace of change varied across NQS priorities:
  - Median change in quality was 3.6% per year among measures of Patient Safety.
  - Median improvement in quality was 2.9% per year among measures of Person-Centered Care.
  - Median improvement in quality was 1.7% per year among measures of Effective Treatment.
  - Median improvement in quality was 1.1% per year among measures of Healthy Living.
  - There were insufficient data to assess Care Coordination and Care Affordability.

QUALITY: Publicly reported CMS measures were much more likely than measures reported by other sources to achieve high levels of performance.

Achieved Success

Eleven quality measures achieved an overall performance level of 95% or better this year. At this level, additional improvement is limited, so these measures are no longer reported in the QDR. Of measures that achieved an overall

performance level of 95% or better this year, seven were publicly reported by CMS on the Hospital Compare website (italic).

- *Hospital patients with heart attack given percutaneous coronary intervention within 90 minutes*
- Adults with HIV and CD4 cell count of 350 or less who received highly active antiretroviral therapy during the year
- *Hospital patients with pneumonia who had blood cultures before antibiotics were administered*
- *Hospital patients age 65+ with pneumonia who received pneumococcal screening or vaccination*
- *Hospital patients age 50+ with pneumonia who received influenza screening or vaccination*
- *Hospital patients with heart failure and left ventricular systolic dysfunction who were prescribed angiotensin-converting enzyme or angiotensin receptor blocker at discharge*
- *Hospital patients with pneumonia who received the initial antibiotic dose consistent with current recommendations*
- *Hospital patients with pneumonia who received the initial antibiotic dose within 6 hours of arrival*
- Adults with HIV and CD4 cell counts of 200 or less who received Pneumocystis pneumonia prophylaxis during the year
- People with a usual source of care for whom health care providers explained and provided all treatment options
- Hospice patients who received the right amount of medicine for pain management

Last year, 14 of 16 quality measures that achieved an overall performance level of 95% or better were publicly reported by CMS. Measures that reach 95% and are no longer reported in the QDR continue to be monitored when data are available to ensure that they do not fall below 95%.

Improving Quickly

Through 2012, a number of measures showed rapid improvement, defined as an average annual rate of change greater than 10% per year. Of these measures that improved quickly, four are adolescent vaccination measures (italic).

- *Adolescents ages 16-17 years who received 1 or more doses of tetanus-diphtheria-acellular pertussis vaccine*
- *Adolescents ages 13-15 years who received 1 or more doses of tetanus-diphtheria-acellular pertussis vaccine*
- Hospital patients with heart failure who were given complete written discharge instructions
- *Adolescents ages 16-17 years who received 1 or more doses of meningococcal conjugate vaccine*
- *Adolescents ages 13-15 years who received 1 or more doses of meningococcal conjugate vaccine*
- Patients with colon cancer who received surgical resection that included 12+ lymph nodes pathologically examined
- Central line-associated bloodstream infection per 1,000 medical and surgical discharges, age 18+ or obstetric admissions
- Women with Stage I-IIb breast cancer who received axillary node dissection or sentinel lymph node biopsy at

time of surgery

Worsening

Through 2012, a number of measures showed worsening quality. Of these measures that showed declines in quality, three track chronic diseases (italic). Note that these declines occurred prior to implementation of most of the health insurance expansions included in the Affordable Care Act.

- Maternal deaths per 100,000 live births
- Children ages 19-35 months who received 3 or more doses of Haemophilus influenzae type b vaccine
- People who indicate a financial or insurance reason for not having a usual source of care
- Suicide deaths per 100,000 population
- Women ages 21-65 who received a Pap smear in the last 3 years
- *Admissions with diabetes with short-term complications per 100,000 population, age 18+*
- *Adults age 40+ with diagnosed diabetes who had their feet checked for sores or irritation in the calendar year*
- Women ages 50-74 who received a mammogram in the last 2 years
- Postoperative physiologic and metabolic derangements per 1,000 elective-surgery admissions, age 18+
- *People with current asthma who are now taking preventive medicine daily or almost daily*
- People unable to get or delayed in getting needed medical care, dental care, or prescription medicines due to financial or insurance reasons

QUALITY DISPARITIES: Disparities remained prevalent across a broad spectrum of quality measures. People in poor households experienced the largest number of disparities, followed by Blacks and Hispanics.

Disparities

- People in poor households received worse care than people in high-income households on more than half of quality measures (green).
- Blacks received worse care than Whites for about one-third of quality measures.
- Hispanics, American Indians and Alaska Natives, and Asians received worse care than Whites for some quality measures and better care for some measures.
- For each group, disparities in quality of care are similar to disparities in access to care, although access problems are more common than quality problems.

QUALITY DISPARITIES: Through 2012, some disparities were getting smaller but most were not improving across a broad spectrum of quality measures.

Disparity Trends

- Through 2012, most disparities in quality of care related to race, ethnicity, or income showed no significant change (blue), neither getting smaller nor larger.

- When changes in disparities occurred, measures of disparities were more likely to show improvement (black) than decline (green). However, for people in poor households, more measures showed worsening disparities than improvement.

QUALITY DISPARITIES: Through 2012, few disparities in quality of care were eliminated while a small number became larger.

Disparities Trends

- Through 2012, several disparities were eliminated.
  - One disparity in vaccination rates was eliminated for Blacks (measles-mumps-rubella), Asians (influenza), American Indians and Alaska Natives (hepatitis B), and people in poor households (human papillomavirus).
  - Four disparities related to hospital adverse events were eliminated for Blacks.
  - Three disparities related to chronic diseases and two disparities related to communication with providers were eliminated for Asians.
  - On the other hand, a few disparities grew larger because improvements in quality for Whites did not extend uniformly to other groups.
  - At least one disparity related to hospice care grew larger for Blacks, American Indians and Alaska Natives, and Hispanics.
  - People in poor households experienced worsening disparities related to chronic diseases.

QUALITY DISPARITIES: Overall quality and racial/ethnic disparities varied widely across states and often not in the same direction.

Geographic Disparities

- There was significant variation in quality among states. There was also significant variation in disparities.
- States in the New England, Middle Atlantic, West North Central, and Mountain census divisions tended to have higher overall quality while states in the South census region tended to have lower quality.
- States in the South Atlantic, West South Central, and Mountain census divisions tended to have fewer racial/ethnic disparities while states in the Middle Atlantic, West North Central, and Pacific census divisions tended to have more disparities.
- The variation in state performance on quality and disparities may point to differential strategies for improvement.

National Quality Strategy: Measures of Patient Safety improved, led by a 17% reduction in hospital-acquired conditions.

Hospital-acquired conditions have been targeted for improvement by the CMS Partnership for Patients initiative, a major public-private partnership working to improve the quality, safety, and affordability of health care for all Americans. As a result of this and other federal efforts, such as Medicare's Quality Improvement Organizations and the HHS National Action Plan to Prevent Health Care-Associated Infections, as well as the dedication of practitioners, the general trend in patient safety is one of improvement.

Trends

- From 2010 to 2013, the overall rate of hospital-acquired conditions declined from 145 to 121 per 1,000 hospital discharges.
- This decline is estimated to correspond to 1.3 million fewer hospital-acquired conditions, 50,000 fewer inpatient deaths, and $12 billion savings in health care costs.[43]
- Large declines were observed in rates of adverse drug events, healthcare-associated infections, and pressure ulcers.
- About half of all Patient Safety measures tracked in the QDR improved.
- One measure, admissions with central line-associated bloodstream infections, improved quickly, at an average annual rate of change above 10% per year.
- One measure, postoperative physiologic and metabolic derangements during elective-surgery admissions, got worse over time.

Disparities Trends

- Black-White differences in four Patient Safety measures were eliminated.
- Asian-White differences in admissions with iatrogenic pneumothorax grew larger.

National Quality Strategy: Measures of Person-Centered Care improved steadily, especially for children.

Trends

- From 2002 to 2012, the percentage of children whose parents reported poor communication significantly decreased overall and among all racial/ethnic and income groups.
- Almost all Person-Centered Care measures tracked in the QDR improved; no measure got worse.

Disparities

In almost all years, the percentage of children whose parents reported poor communication with their health providers was:

- Higher for Hispanics and Blacks compared with Whites.
- Higher for poor, low-income, and middle-income families compared with high-income families.

Disparities Trends

- Asian-White differences in two measures related to communication were eliminated.
- Four Person-Centered Care disparities related to hospice care grew larger.

National Quality Strategy: Measures of Care Coordination improved as providers enhanced discharge processes and adopted health information technologies.

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[43] Agency for Healthcare Research and Quality. Interim Update on 2013 Annual Hospital-Acquired Condition Rate and Estimates of Cost Savings and Deaths Averted From 2010 to 2013. http://www.ahrq.gov/professionals/quality-patient-safety/pfp/interimhacrate2013.html

Trends

- From 2005 to 2012, the percentage of hospital patients with heart failure who were given complete written discharge instructions increased overall, for both sexes, and for all racial/ethnic groups.
- There are few measures to assess trends in Care Coordination.

Disparities

- In all years, the percentage of hospital patients with heart failure who were given complete written discharge instructions was lower among American Indians and Alaska Natives compared with Whites.

National Quality Strategy: Many measures of Effective Treatment achieved high levels of performance, led by measures publicly reported by CMS on Hospital Compare.

Trends

- From 2005 to 2012, the percentage of hospital patients with heart attack given percutaneous coronary intervention within 90 minutes of arrival increased overall, for both sexes, and for all racial/ethnic groups.
- In 2012, the overall rate exceeded 95%; the measure will no longer be reported in the QDR.
- Eight other Effective Treatment measures achieved overall performance levels of 95% or better this year, including five measures of pneumonia care and two measures of HIV care.
- About half of all Effective Treatment measures tracked in the QDR improved.
- Two measures, both related to cancer treatment, improved quickly, at an average annual rate of change above 10% per year.
- Three measures related to management of chronic diseases got worse over time.

Disparities

- As rates topped out, absolute differences between groups became smaller. Hence, disparities often disappeared as measures achieved high levels of performance.

Disparities Trends

- Asian-White differences in three chronic disease management measures were eliminated but income-related disparities in two measures related to diabetes and joint symptoms grew larger.

National Quality Strategy: Healthy Living improved in about half of the measures followed, led by selected adolescent vaccines from 2008 to 2012.

Trends

- From 2008 to 2012, the percentage of adolescents ages 16-17 years who received 1 or more doses of meningococcal conjugate vaccine increased overall, for residents of both metropolitan and nonmetropolitan areas, and for all income groups.
- About half of all Healthy Living measures tracked in the QDR improved.

- Four measures, all related to adolescent immunizations, improved quickly, at an average annual rate of change above 10% per year (meningococcal vaccine ages 13-15 and ages 16-17; tetanusdiphteria-acellular pertussis vaccine ages 13-15 and ages 16-17).
- Two measures related to cancer screening got worse over time.

Disparities

- Adolescents ages 16-17 in nonmetropolitan areas were less likely to receive meningococcal conjugate vaccine than adolescents in metropolitan areas in all years.
- Adolescents in poor, low-income, and middle-income households were less likely to receive meningococcal conjugate vaccine than adolescents in high-income households in almost all years.

Disparities Trends

- Four disparities related to child and adult immunizations were eliminated.
- Black-White differences in two Healthy Living measures grew larger.

National Quality Strategy: Measures of Care Affordability worsened from 2002 to 2010 and then leveled off.

From 2002 to 2010, prior to the Affordable Care Act, care affordability was worsening. Since 2010, the Affordable Care Act has made health insurance accessible to many Americans with limited financial resources.

Trends

- From 2002 to 2010, the overall percentage of people unable to get or delayed in getting needed medical care, dental care, or prescription medicines and who indicated a financial or insurance reason rose from 61.2% to 71.4%.
- From 2002 to 2010, the rate worsened among people with any private insurance and among people from high- and middle-income families; changes were not statistically significant among other groups.
- After 2010, the rate leveled off, overall and for most insurance and income groups.
- Data from the Commonwealth Fund Biennial Health Insurance Survey indicate that cost-related problems getting needed care fell from 2012 to 2014 among adults.[44]
- Another Care Affordability measure, people without a usual source of care who indicate a financial or insurance reason for not having a source of care, also worsened from 2002 to 2010 and then leveled off.
- There are few measures to assess trends in Care Affordability.

Disparities

- In all years, the percentage of people unable to get or delayed in getting needed medical care, dental care, or prescription medicines who indicated a financial or insurance reason for the problem was:

[44] Collins SR, Rasmussen PW, Doty MM, et al. The Rise in Health Care Coverage and Affordability Since Health Reform Took Effect: Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2014. http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2015/jan/1800_collins_biennial_survey_brief.pdf?la=en

- Higher among uninsured people and people with public insurance compared with people with any private insurance.
- Higher among poor, low-income, and middle-income families compared with high-income families.

CONCLUSION

The 2014 Quality and Disparities Reports demonstrate that access to care improved. After years of stagnation, rates of un-insurance among adults decreased in the first half of 2014 as a result of Affordable Care Act insurance expansion. However, disparities in access to care, while diminishing, remained.

Quality of healthcare continued to improve, although wide variation across populations and parts of the country remained. Among the NQS priorities, measures of Person-Centered Care improved broadly. Most measures of Patient Safety, Effective Treatment, and Healthy Living also improved, but some measures of chronic disease management and cancer screening lagged behind and may benefit from additional attention. Data to assess Care Coordination and Affordable Care were limited and measurement of these priorities should be expanded.

Appendix D – Illustrative Schedule h (Form 990) Part V B Potential Response

Illustrative IRS Schedule h Part V Section B (Form 990)[45]

Community Health Need Assessment Illustrative Answers

1. **Was the hospital facility first licensed, registered, or similarly recognized by a State as a hospital facility in the current tax year or the immediately preceding tax year?**

   No

2. **Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C**

   No

3. **During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12. If "Yes," indicate what the CHNA report describes (check all that apply)**

   a. **A definition of the community served by the hospital facility**

      See footnotes 17 and 19 on page 12

   b. **Demographics of the community**

      See footnote 20 on page 13

   c. **Existing health care facilities and resources within the community that are available to respond to the health needs of the community**

      See footnote 26 on page 33 and footnote 29 on page 35

   d. **How data was obtained**

      See footnote 11 on page 8

   e. **The significant health needs of the community**

      See footnote 25 on page 31

   f. **Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups**

      See footnote 12 on page 9

   g. **The process for identifying and prioritizing community health needs and services to meet the community health needs**

      See footnote 38 on page 72

   h. **The process for consulting with persons representing the community's interests**

      See footnotes 8 and 9 on page 7

[45] Questions are drawn from 2014 Federal 990 schedule h.pdf and may change when the hospital is to make its 990 h filing

i. **Information gaps that limit the hospital facility's ability to assess the community's health needs**

See footnote 10 on page 8, footnotes 13 and 14 on page 9, and footnote 23 on page 18

j. **Other (describe in Section C)**

N/A

4. **Indicate the tax year the hospital facility last conducted a CHNA: 20__**

2013

5. **In conducting its most recent CHNA, did the hospital facility take into account 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? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted**

Yes; see footnote 15 on page 10 and footnote 37 on page 56

6. **a. Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C**

No

b. Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C

Yes; see footnote 4 on page 4 and footnote 7 on page 7

7. **Did the hospital facility make its CHNA report widely available to the public?**

Yes

If "Yes," indicate how the CHNA report was made widely available (check all that apply):

a. **Hospital facility's website (list URL)**

https://www.ouachitamedcenter.com/

https://www.ouachitamedcenter.com/Content/Uploads/ouachitamedcenter.com/files/CommunityHealthNeedsAssessment.pdf

b. **Other website (list URL)**

No other website

c. **Made a paper copy available for public inspection without charge at the hospital facility**

Yes

d. **Other (describe in Section C)**

No other effort

8. **Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11**

   Yes; see footnotes 35 and 36 on page 53

9. **Indicate the tax year the hospital facility last adopted an implementation strategy: 20__**

   2013

10. **Is the hospital facility's most recently adopted implementation strategy posted on a website?**

    a. **If "Yes," (list url):**

       Yes; https://www.ouachitamedcenter.com/

    b. **If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?**

11. **Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed**

    See footnote 26 on page 33

12. **a. Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r) (3)?**

    None incurred

    b. If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax?

    Nothing to report

    c. If "Yes" to line 12b, what is the total amount of section 4959 excise tax the organization reported on Form4720 for all of its hospital facilities?

    Nothing to report