2026 / 2029 BAPTIST HEALTH

Community Health Needs Assessment

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About Us

Baptist Health: Dedicated to Wellness, Driven by Purpose

On February 16, 1921, the Pulaski County Circuit Court ordered the incorporation of Baptist State Hospital, and the organization that would eventually grow into the Baptist Health System was born.

Though the original hospital opened its doors in Little Rock with less than a hundred beds in a small building, the purpose was significant – create a healthier community through christian compassion and innovative services. While much has changed over the past century, our goal has remained the same and has served as the driving force behind all we've accomplished.

For more than a century, Baptist Health has delivered all our best in health care through Christian compassion and innovative services. Baptist Health, Arkansas' most comprehensive health care organization, is here For You. For Life. – with more than 300 points of access that include 12 hospitals; urgent care centers; a senior living community; over 75 primary and specialty care clinics; a college with studies in nursing and allied health; and a graduate residency program. It is also the largest private not-for-profit health care organization based in Arkansas, providing care through the support of approximately 12,000 employees, groundbreaking treatments, renowned physicians and community outreach programs. Baptist Health is certified as a Great Place to Work and is honored by Newsweek as one of America's Most Admired Workplaces 2026.

Mission

Baptist Health exists to provide quality patient-centered services, promote and protect the voluntary not-for-profit health care system, provide quality health education, and respond to the changing health needs of those we serve with Christian compassion and personal concern.

Vision

Baptist Health will be the most trusted and innovative health care system in Arkansas.

Belief

Baptist Health is more than just a business —it is a healing ministry. Our healing ministry is based on the revelation of God through creation, the Bible, and Jesus Christ. At Baptist Health, care of the whole person — body, mind, and spirit — is an expression of Christian faith. We are instruments of God's restorative power and are responsible for giving compassionate care.

The Community Health Needs Assessment (CHNA) became required of all not-for-profit hospitals beginning in 2013, as part of the U.S. Patient Protection and Affordable Care Act. Schedule H of the IRS Form 990 further outlines not-for-profit hospitals evaluate the health needs of the communities they serve and make plans to manage or make progress towards addressing those health needs. This implementation strategy must demonstrate the proposed method to address these needs and be done every three years to comply with and maintain not-for-profit status.

The CHNA is required to include:

- The geographical area defined as the hospital community and how it was determined
- The process and methods used to gather sources of data as well as the analytical methods applied to identify the health needs of the community
- How persons representing the broad interests of the community served by the hospital were utilized to gather input, including how and when they were consulted
- The health needs chosen to be addressed as well as the process and/or criteria used to prioritize the identified health needs
- Health care facilities and resources within the community that are also available to meet health needs or work in collaboration with to address the needs.

Another requirement of the CHNA is that hospitals adopt an implementation strategy to outline how it plans to address the identified health needs. **The plan must include the following:**

- List of identified health needs that will be addressed by the hospital facility
- The specific actions and the anticipated impact of each health need
- The resources that will be used by the facility to address the health needs
- Planned collaboration with other facilities or organizations to address the health need

A CHNA is considered conducted in the taxable year that the written report of its findings, as described above, is approved by the hospital governing body and made widely available to the public. The Implementation plan is considered implemented on the date it is approved by the governing body. Conducting the CHNA and approval of the Implementation Strategy must occur in the same fiscal year. CHNA compliance is reported on IRS Form 990, Schedule H.

To complete a comprehensive assessment of the needs of the community, Baptist Health utilized the nine step process by the American Hospital Association's Community Health Improvement network. This process, depicted below, was led by the Baptist Health Community Outreach Department in collaboration with all regional hospitals and the Marketing & Communications team.

Methodology and Data Sources

Process & Methods Used

Baptist Health engaged the Arkansas Center for Health Improvement (ACHI) to conduct the quantitative data collection and analysis for the 2025 Community Health Needs Assessment (CHNA) process. Baptist Health provided ACHI with the counties served for each of its 12 hospital facilities in the state — i.e., the hospital communities. A total of 14 Arkansas counties and two Oklahoma counties were included in the CHNA. This document is a summary of the methods used to conduct the quantitative portion of the CHNA.

For 2025, communities served for acute care hospitals were defined using zip codes that represent greater than or equal to 2 percent of the hospital's combined inpatient/outpatient visits AND in which the hospital's inpatient market share is greater than or equal to 20 percent. Communities for Extended Care Hospital and Rehabilitation Institute were defined by the disease/injury state of patients served by the eight acute care hospitals in Central Arkansas. Attention was also paid to Arkansas's ranking in respect to major health issues when compared to other states.

Central Arkansas

- BHMC-Little Rock: Pulaski (South), Saline, Grant
- BHMC-North Little Rock: Pulaski (North), Lonoke
- BHMC-Arkadelphia: Clark, Nevada
- BHMC-Conway: Faulkner, Perry
- BHMC-Drew County: Drew
- BHMC-Heber Springs: Cleburne
- BHMC-Hot Spring County: Hot Spring
- BHMC-Stuttgart: Arkansas
- Baptist Health Rehabilitation Insitute-Little Rock
- Baptist Health Exteneded Care Hospital

Western Arkansas/ Eastern Oklahoma

- BH-Fort Smith: Sebastian, LeFlore (OK), Sequoyah (OK)
- BH-Van Buren***: Crawford

****Given that BH-Van Buren services are limited, BH-Fort Smith will also share Crawford county in their CHNA service area as a part of the entire Baptist Health Western Arkansas/ Eastern Oklahoma area.*

To support the 2025 Community Health Needs Assessment (CHNA), ACHI compiled a comprehensive dataset of 103 health and demographic indicators for the communities served by Baptist Health's 12 hospital locations. This section provides an overview of these indicators across the full CHNA service area and offers multiple views for understanding and comparing county-level and community-level data. Data are grouped into the following 14 categories based on the source-defined domains outlined in the data source reference sheet:

1. Demographics
    a. Age
    b. Sex
    c. Race, Ethnicity, and Language
2. Insurance Coverage
3. Access to Care
4. Cause of Death
5. Chronic Conditions
6. Diagnoses at Hospital Discharge
7. Environment
8. Health Behaviors
9. Health Outcomes
10. Healthcare Expenditures
11. Maternal and Infant Health
12. Mental Health and Substance Use
13. Prevention
14. Social and Economic Factors

**Measurements for these categories will be displayed in each section.*

Methodology and Data Sources

Top Health Needs Identified

SOCIAL DETERMINANTS OF HEALTH

Though a major contributing factor, individual health behaviors, such as physical activity, eating habits and tobacco use, do not alone account for the entire picture of one's health. Research and data has shown that factors–some outside of an individual's direct control–have an effect on health outcomes. These factors have been defined by the U.S. Department of Health and Human Services as "...the conditions in the environments where people are born, live, learn, work, play, worship, and age..." as they can directly affect quality-of-life and health outcomes. These social determinants of health (SDOH) are: economic stability, education access and quality, health care access and quality, neighborhood and built environment, and social and community context. When addressed, these factors can work to create healthier communities as a whole, and the CHNA allows for work to be done in these areas to address health needs from a more well-rounded approach. As such, you will see data from these areas.

For the 2026-2028 CHNA, health indicators and their respective categories are listed below:

Cause of Death
- All Causes
- Premature Death
- Heart Disease
- Cancer
- Unintentional Injury
- Stroke
- Chronic Lower Respiratory Disease
- Diabetes Mortality
- Suicide Deaths
- Motor Vehicle Crash
- Alcohol-involved Motor Vehicle Crash

Chronic Conditions
- Child Obesity
- High Cholesterol
- Adult Obesity
- High Blood Pressure
- Arthritis
- Diabetes Prevalence
- Asthma
- Coronary Heart Disease

Diagnosis at Hospital Discharge
- Hypertension
- Hyperlipidemia
- Diabetes
- Ischemic Heart Disease
- Arthritis

Environment
- Food Environment Index
- Drinking Water Violations
- Access to Exercise Opportunities
- Broadband Access
- Long Commute Driving Alone
- Severe Housing Problems

Health Behaviors
- Physical Inactivity
- Adult Smoking
- Youth Vaping
- Sexually Transmitted Infections

Health Outcomes
- Poor Physical Health Days
- Poor or Fair Health

Maternal & Infant Health
- Active OB-GYN Physicians
- Teen Births
- C-Section Rate
- C-Section Rate, First Birth
- Low Birthweight
- Preterm Birth
- Median Travel Time to Delivery

Mental Health & Substance Abuse
- Adult Depression
- Excessive Drinking
- Poor Mental Health
- Youth Depression
- Drug Overdose Deaths
- Non-Fatal Drug Overdoses

Prevention
- Cervical Cancer Screening
- Colorectal Cancer Screening
- Dental Care Utilization
- High Blood Pressure Management
- Prevention-Seasonal Influenza Vaccine
- Annual Wellness Exam (Medicare)
- No HIV Test

In addition to the health indicators, demographic data were collected for each community including sex, age, race, and type of insurance coverage. All data are presented at the county, state, and national level depending upon data availability. The analytic sample for the indicators within the Diagnoses Incidence Within Hospital Community at Discharge category is comprised of all inpatient and outpatient hospital discharges for Arkansas in 2020 and restricted to adults 18 years of age and older living within the counties of interest. The ICD-10-CM diagnoses codes used for these conditions were obtained from the Center for Medicare and Medicaid Services Chronic Conditions Data Warehouse. Statistical Analysis System (SAS) software was used to analyze the primary and secondary diagnoses data. The number of discharges was divided by the estimated population (18 years and older) for each county to calculate the incidence of adults being discharged from the hospital diagnosed with the chronic conditions in 2020. ACHI created a report for each hospital community to display the quantitative results. Each section includes a table with health indicator data for each county in the hospital community, a community average for each measurement, and data for the state of Arkansas and the United States. If data were not available or were suppressed, “Data Not Available” is displayed. Each section also includes graphics for various health indicator data.

COUNTY RANKINGS

To assist Baptist Health in identifying priority needs for the hospital communities, ACHI ranked counties with available data into tertiles for each health indicator. Figure 1 shows an example of the rankings for Prevention. See the Data Book for all rankings.

Table 13: Health Indicators Analyzed For The CHNA

Least favorable third
Middle third
Most favorable third

	Annual Wellness Exam (Medicare) (Percent)	Cervical Cancer Screening (Percent)	Colorectal Cancer Screening (Percent)	Dental Care Utilization (Percent)	High Blood Pressure Management (Percent)	No HIV Test (Percent)	Prevention - Seasonal Influenza Vaccine (Percent)
Arkansas County	11.00%	80.10%	61.00%	47.80%	62.90%	60.50%	42.50%
Clark County	35.00%	81.00%	62.40%	50.60%	63.20%	75.00%	42.50%
Cleburne County	49.00%	80.10%	68.00%	53.00%	59.70%	65.60%	44.70%
Crawford County	47.00%	79.80%	61.70%	54.20%	60.70%	70.00%	47.50%
Drew County	38.00%	80.80%	62.70%	51.30%	64.00%	67.60%	36.90%
Faulkner County	40.00%	82.20%	60.10%	59.30%	61.50%	62.00%	47.70%
Grant County	47.00%	81.90%	63.40%	53.90%	60.00%	63.10%	44.70%
Hot Spring County	52.00%	80.50%	61.70%	51.20%	61.20%	70.80%	40.50%
Le Flore County (OK)	31.00%	78.60%	55.60%	48.10%	61.80%	Not Available	34.50%
Lonoke County	44.00%	81.30%	63.30%	57.20%	60.60%	59.80%	38.80%
Monroe County	32.00%	80.10%	60.80%	45.90%	64.70%	67.40%	43.50%
Nevada County	36.00%	81.00%	60.10%	47.10%	63.10%	73.80%	46.10%
Perry County	40.00%	80.10%	60.00%	53.40%	60.60%	64.20%	43.60%
Prairie County	20.00%	80.50%	60.50%	49.00%	60.90%	65.80%	43.50%
Pulaski County	47.00%	83.90%	64.40%	58.40%	61.50%	60.80%	51.50%
Saline County	47.00%	83.10%	60.90%	62.40%	59.70%	63.40%	47.10%
Sebastian County	46.00%	79.30%	60.90%	52.50%	60.40%	68.30%	44.20%
Sequoyah County (OK)	38.00%	78.10%	57.50%	48.60%	60.50%	Not Available	35.90%
State	46.00%	81.20%	61.60%	54.10%	61.40%	66.10%	43.20%
National	44.00%	83.70%	66.30%	63.40%	58.90%	Not Available	44.80%

Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Retrieved [October 2025], from https://health.gov/healthypeople/objectives-and-data/social-determinants-health

STATE RANKINGS

This section presents state rankings and national comparisons for selected health indicators reviewed as part of the CHNA support materials. The table below highlights changes in Arkansas's rankings from 2021 to 2024 using data from America's Health Rankings.

Table 2: Selected Health Indicator Rankings for Arkansas, 2021 vs. 2024

Health Indicators	2021 Rank	2024 Rank
Cardiovascular Disease	48	46
Colorectal Cancer Screening	35	41
Depression	45	38
Diabetes	44	42
Food Insecurity	42	50
High Blood Pressure	47	44
High Cholesterol	47	44
Obesity	41	46
Physical Inactivity	47	47
Premature Death	44	42
Smoking	48	39
Teen Births	50	49

While Arkansas's rankings help identify shared statewide priorities, data also show that individual Baptist Health communities perform differently compared to one another and to the state average. For example:

- **Access to Exercise Opportunities:** The best community average was 79.0% in North Little Rock; the lowest was 19.7% in Hot Spring County (source: County Health Rankings & Roadmaps).
- **Active Primary Care Physicians:** The highest supply was 24.3 per 10,000 residents in North Little Rock; the lowest was 11.30 per 10,000 in Van Buren (source: ACHI).
- **Adult Obesity:** Van Buren had the highest rate at 36.2%; Hot Spring County had the lowest at 25.8% (source: SparkMap).
- **Death Due to Stroke:** The highest community average was 83.6 per 100,000 in Stuttgart; the lowest was 51.6 per 100,000 in Little Rock (source: SparkMap).
- **Violent Crimes:** North Little Rock had the highest rate at 1003.1 per 100,000; the lowest was 286.6 per 100,000 in Hot Spring County (source: SparkMap).

Methodology and Data Sources

Prioritization of Health Needs

TRANSLATING DATA INTO ACTION: SELECTING INTERVENTIONS

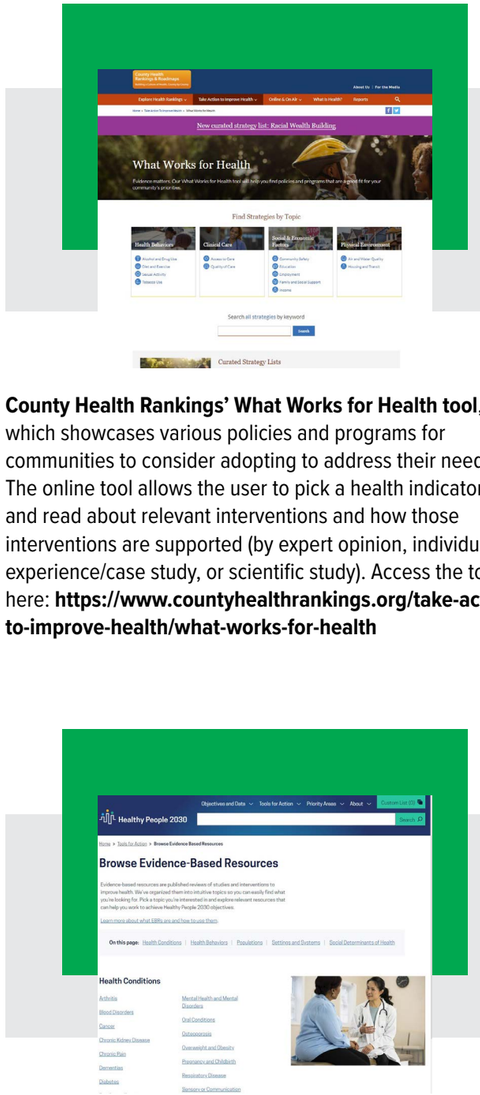
CHNA typically uses both primary and secondary data sources to get a picture of the health of the community. Baptist Health gathered first-hand data through community and internal surveys, key informant interviews and focus groups with a diverse sampling of community members. Secondary data was collected and synthesized by the Arkansas Center for Health Improvement. The indicators in the secondary data were used to compare trends and help prioritize health needs to address and improve outcomes. The process to select programs and interventions begins with identifying the health problem (using primary and secondary data) and then using the "But Why?" questioning strategy to determine a root cause. Once root cause(s) has been established, evidence-based tools are used to move into evidence-based action planning from the Centers of Disease Control's guidance.

Table 3: “But Why?” Stragegy

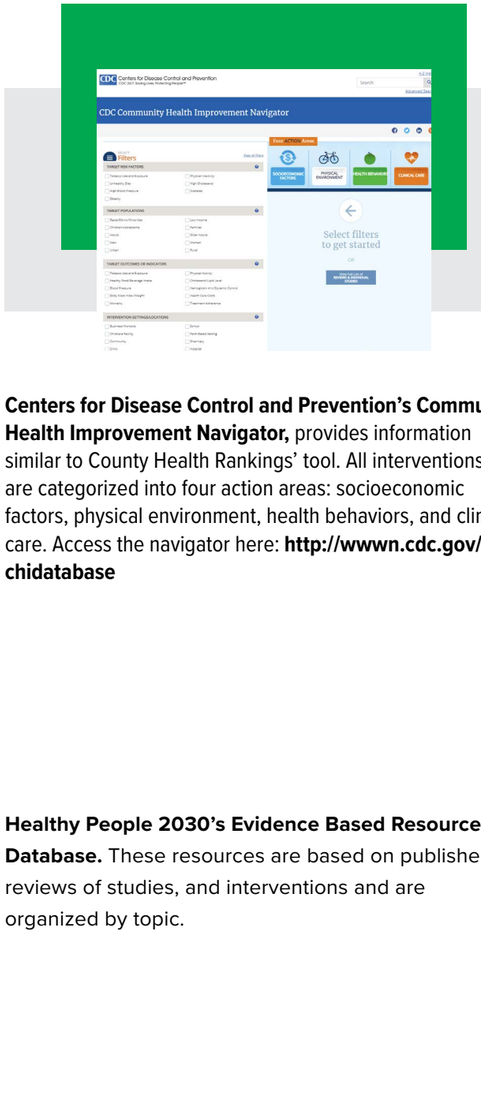
The following evidence based resources are utilized to select interventions and programs for action items:

- Healthy People 2030 Evidence Based Resources Database
- Published reviews of interventions to improve health, organized by health topic.
- County Health Rankings & Roadmaps: What Works for Health
- Tool to find policies and programs to fit the community's needs, organized by topics, including social determinants of health.
- University of Kansas Center for Community Health and Development: Community Tool Box
- Collection of resources to teach, train and take action in organizing community development by providing tools to plan evaluations that address social determinants of health and create plans of action that can be sustained over time.

Once Baptist Health is ready to review potential programs to address the identified priority needs, there are several resources available to help research effective, long-term interventions.



County Health Rankings’ What Works for Health tool, which showcases various policies and programs for communities to consider adopting to address their needs. The online tool allows the user to pick a health indicator and read about relevant interventions and how those interventions are supported (by expert opinion, individual experience/case study, or scientific study). Access the tool here: **https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health**



Centers for Disease Control and Prevention’s Community Health Improvement Navigator, provides information similar to County Health Rankings’ tool. All interventions are categorized into four action areas: socioeconomic factors, physical environment, health behaviors, and clinical care. Access the navigator here: **http://wwwn.cdc.gov/chidatabase**

Healthy People 2030’s Evidence Based Resources Database. These resources are based on published reviews of studies, and interventions and are organized by topic.

INITIATIVES IN ARKANSAS

A range of recent and ongoing state-supported initiatives are working to address healthcare needs across Arkansas. The following efforts reflect policy changes, funding investments, and program expansions that align with identified health priorities.

- **Life360 HOMEs:** The Life360 HOMEs model was approved by the Centers for Medicare and Medicaid Services and is now serving high-risk populations. Baptist Health is partnering with the Arkansas Department of Human Services to implement the Maternal Life360 HOME programs in Pulaski, Saline, and Faulkner counties and plans to expand to serve additional counties. Other Maternal Life360 programs operate in Craighead County (St. Bernards) and in Independence County (White River Health System).
- **Behavioral Health Infrastructure Investment:** Arkansas has expanded its behavioral health infrastructure through federal grants and state-level investment. In 2023, the Arkansas Department of Human Services received federal funding to support its crisis stabilization units, which provide short-term, community-based services to stabilize individuals experiencing behavioral health emergencies. Additionally, the state received an Arkansas AWARE (Advancing Wellness and Resiliency in Education) grant to increase mental health awareness and access in schools. The grant supports efforts to train educators and connect students and families with local behavioral health resources.
- **Workforce Compact Participation:** Arkansas has joined multiple interstate licensure compacts for physicians, nurses, and behavioral health professionals. These compacts allow licensed providers to practice across state lines more easily, helping to mitigate workforce shortages and improve access to care in rural and underserved areas.
- **SNAP-Ed Program:** Supplemental Nutrition Assistance Program–Education (SNAP-Ed) is a federally funded program that provides nutrition education and obesity prevention to SNAP participants and low-income individuals. In Arkansas, SNAP-Ed has supported nutrition classes, school gardens, early childcare interventions, and healthier retail initiatives across schools and communities. However, the federal budget reconciliation bill signed into law on July 4, 2025, terminated federal SNAP-Ed funding, which will leave substantial gaps in programming statewide. The loss is expected to disproportionately impact rural and high-poverty areas where local capacity for alternative nutrition outreach is limited.

STATEWIDE SUPPORT ORGANIZATIONS

- **Arkansas Cancer Coalition:** The Arkansas Cancer Coalition serves as the state's comprehensive cancer control partnership. It is a network of cancer control members and organizations that work together to reduce the burden of cancer. The Cancer Coalition also directs GOALS/OBJECTIVE and strategies in the Arkansas Cancer Plan. ***arcancercoalition.org/***
- **Arkansas Rural Health Partnership (ARHP):** ARHP is a nonprofit organization that actively engages 22 rural hospitals, three medical teaching institutions, and four federally qualified health centers as members to serve communities throughout the state. AHRP works to develop, implement, and sustain initiatives that meet demonstrated local needs impacting rural healthcare. ***arruralhealth.org/***
- **Arkansas Chronic Disease Coordinating Council (CDCC):** A partnership of organizations consisting of program managers of the Arkansas Department of Health chronic disease programs, chairs of the various chronic disease coalitions, and a number of other organizational representatives. The CDCC's mission is to increase the quality and years of healthy life for all Arkansans by reducing the burden of chronic disease through leadership and collaborative action impacting policy, system and environment changes. ***arcdcc.org/***
- **March of Dimes:** Through programs and services in communities across Arkansas, March of Dimes promotes healthy pregnancies and babies, and works to prevent premature birth and birth defects through educating moms and supporting families in need. ***marchofdimes.org***
- **Be Well Arkansas:** A public education campaign of the Arkansas Department of Health that offers tips and support for quitting tobacco and addressing diabetes and high blood pressure. ***bewellarkansas.org/***
- **Arkansas Prostate Cancer Foundation (APCF):** APCF collaborates with local partners and medical volunteers to offer education and screening programs in communities across the state. At the events, APCF conducts education, administers the screenings, and provides all medical supplies. Through a partnership with Baptist Health, laboratory services are available. The screenings are free to men. ***arprostatecancer.org/services/screening/***
- **Goodwill Industries of Arkansas:** The Excel Center at Goodwill offers adults an opportunity to earn a high school diploma. The school provides flexible class schedules, transportation assistance, free on-site childcare, and a life coach. Classes are free and open to anyone ages 19 or older. ***https://www.goodwilltec.org/o/gtec/page/our-locationsexcel***

ADDITIONAL RESOURCES

- **HDPulse:** An Ecosystem of Health Disparities and Minority Health Resources: An interactive tool providing access to data and evidence-informed strategies to support community health and improve outcomes in underserved populations. ***https://hdpulse.nimhd.nih.gov/index.html***
- **CDC PLACES:** Local-level chronic disease data at the ZIP code and census tract level. ***https://www.cdc.gov/places/***
- Build Healthy Places Network: Guidance for cross-sector collaboration between healthcare and community development. ***https://www.buildhealthyplaces.org***
- RHIhub Rural Community Health Toolkit: Offers models and strategies to enhance health outcomes in rural communities through systems-based approaches and cross-sector engagement. ***https://www.ruralhealthinfo.org/toolkits/rural-toolkit***

Methodology and Data Sources

General Community Survey

Question 1:

What is your age range?

- ❑ 18-24
- ❑ 25-34
- ❑ 35-54
- ❑ 55-64
- ❑ 65 and above

Question 2:

What is your racial and/or ethnic background? (choose all that apply)

- ❑ Alaskan Native or American Indian
- ❑ Asian
- ❑ Black or African American
- ❑ Hispanic or Latino
- ❑ Native Hawaiian or Pacific Islander
- ❑ White
- ❑ Other

Question 3:

What is your highest level of education?

- ❑ High School Diploma/GED
- ❑ Associate's Degree
- ❑ Bachelor's Degree
- ❑ Professional/Trade Certification
- ❑ Master's Degree
- ❑ Doctorate or higher

Question 4:

What letter grade do you give the health of this community?

Question 5:

What letter grade would you give your own health?

Question 6:

Do you currently have a Primary Care Provider?

Question 7:

Do you visit your regular care provider at least once a year for a checkup?

Question 8:

What is your current insurance status?

- ❑ Medicaid
- ❑ Medicare
- ❑ No insurance
- ❑ Private insurance

Question 9:

As an ADULT, have you ever been told by a health professional that you have any of the following conditions? (Please select all that apply.)

- ❑ Diabetes (not during pregnancy)
- ❑ High Blood Pressure
- ❑ Depression/Anxiety Disorder/ Mental Health Disorder
- ❑ Asthma/COPD
- ❑ Arthritis/Lupus
- ❑ Osteoporosis
- ❑ High Cholesterol
- ❑ Overweight/Obesity
- ❑ Kidney Disease
- ❑ Heart Disease
- ❑ Liver Disease
- ❑ Cancer
- ❑ Lung Disease
- ❑ Substance Misuse
- ❑ Other (please specify)

Question 10:

When you get sick, where do you go to get care? (Please check only one.)

- ❑ Primary Care Doctor (PCP)
- ❑ Emergency Room
- ❑ Urgent Care
- ❑ Delay Care (i.e., not get care due to cost, transportation, or other)

Question 11:

What are the Top FIVE (5) Health Issues you see in your community? (Please choose five.)

- ❑ Access to Care/Uninsured
- ❑ Alzheimer/Dementia
- ❑ Anxiety/Depression
- ❑ Cancer
- ❑ Chronic Pain
- ❑ Dental Health
- ❑ Diabetes (not during pregnancy)
- ❑ High Blood Pressure
- ❑ Depression/Anxiety Disorder/ Mental Health Disorder
- ❑ Asthma/COPD
- ❑ Arthritis/Lupus
- ❑ Osteoporosis
- ❑ High Cholesterol
- ❑ Overweight/Obesity
- ❑ Kidney Disease
- ❑ Heart Disease
- ❑ Liver Disease
- ❑ Maternal/Infant Health
- ❑ Mental Health/Suicide
- ❑ Lung Disease
- ❑ Stroke
- ❑ Substance Abuse/Misuse
- ❑ Sexually Transmitted Disease
- ❑ Tobacco Use/Vaping

Question 12:

Are you worried or concerned that in the next two months you may not have stable housing? (rent, own, or stay in as part of a household)

- ❑ Often True
- ❑ Sometimes True
- ❑ Never True

Question 13:

In the past 12 months, have you ever worried that food would run out before you had the money to buy more? (Please choose only one.)

- ❑ Often True
- ❑ Sometimes True
- ❑ Never True

Question 14:

In the past 12 months, has the food you bought ran out and you did not have money to get more? (Please choose only one.)

- ❑ Often True
- ❑ Sometimes True
- ❑ Never True

Question 15:

In the last year, was there a time you needed mental health counseling but could not get it?

Question 16:

If you answered YES to the previous question, why weren't you able to get mental health counseling? (Please choose all that apply.)

- ❑ I didn't have insurance
- ❑ I couldn't afford to pay my co-pay or deductible
- ❑ I didn't have any way to get to a counselor
- ❑ The counselor refused to take my insurance or Medicaid
- ❑ I didn't know how to find a counselor
- ❑ Too long to wait for an appointment
- ❑ Fear
- ❑ Embarrassment
- ❑ Other (please specify)

Question 17:

What are some of the barriers that might prevent you or other people in your community from receiving available health services?

- ❑ Location of services
- ❑ Hours of operation
- ❑ Companion at the doctor's office
- ❑ Insurance doesn't cover services
- ❑ Cost of care
- ❑ Transportation
- ❑ Lack of providers
- ❑ Other (please specify)

Question 18:

Are there specific types of health services you feel are missing or need improvement in your community?

Question 19:

What are your experiences with health services in your community? What has been positive, and what could be improved?

Question 20:

Do you feel you have a trusted place to go for health information and advice in your community?

Question 21:

Are you familiar with the Community Outreach programs provided by Baptist Health?

Community Focus Group and Interview Questions

Question 1:

On a scale of A to F what letter grade would you give the overall health of your community and why?

Question 2:

Thinking about that grade,what does a healthy community look like to you? What does it feel like?

Question 3:

When people in your community need healthcare, what gets in the way and why? What makes it hard for them to get care?

Question 4:

Tell me about experiences (your personal, friends, family, co-workers, etc) using or attempting to use health care services in your community: What types of services, were you able to get an appointment, was there a long wait, etc.?

Question 5:

What are some of the top (most significant) health concerns in the area? (List all that you can think of.)

Question 6:

Of all the concerns we discussed which 5 concerns you feel are most urgent and why?

Question 7:

Who seems to be most affected by these health problems?

Question 8:

What resources (e.g., agencies, institutions, programs) do we have in our community that seem to be working to address these issues?

Question 9:

What other resources would you suggest that aren't currently available? In other words, what are some solutions to these problems?

Question 10:

What could be done to improve the health and health equity in your community?

Question 11:

If you had a magic wand and could change one thing tomorrow to improve the health of your community what would that be?

Question 12:

Do you see any emerging health needs or are there additional health concerns we have not covered?

Internal Key Informant Questions

Question 1:

What grade would you give the overall health of this Community?

Question 2:

In your opinion, what are the top five (5) health needs of the community?

Question 3:

Considering the five (5) needs you previously identified, which one do you consider the most critical?

Question 4:

What do you think our hospital has done to improve or increase access to care within the last three (3) years?

Question 5:

What do you think our hospital has done to increase access to or improve mental health in the last three (3) years?

Question 6:

What do you think our hospital has done to increase or improve chronic disease management in the last three (3) years?

Question 7:

What do you feel our hospital has done to address social determinants of health in the last three (3) years? (e.g., housing stability, food insecurity, language barriers, health literacy, transportation, medication assistance)

Question 8:

If you had one wish to improve the health of this community, what would it be?

Question 9:

Are there any ways that Baptist Health could improve communication with and better involve the community in health improvement efforts?

Question 10:

What community programs and events does the hospital participate in?

Question 11:

What is your name?

Question 12:

What is your job title?

Methodology and Data Sources

Top Health Needs Identified by Community Survey and Focus Group Respondents

Arkadelphia

- Diabetes
- Cancer
- High Blood Pressure
- Heart Disease
- Stroke
- Access to Care
- Mental Health
- Food Insecurity
- Health Literacy

Conway

- Access to Care/Uninsured
- Overweight/Obesity
- Substance Abuse/Alcohol Abuse
- Heart Disease
- Tobacco Use/Vaping
- Mental Health
- Maternal Health
- Health Literacy
- Physical Health (Nutrition/Food Insecurity)

Drew County

- Mental Health
- Maternal Health
- Obesity
- Elderly Care
- Chronic Diseases(diabetes, COPD)
- Access to Care
- Health Literacy

Heber Springs

- Cancer
- Overweight Obesity
- High Blood Pressure
- Substance Abuse/Alcohol Abuse
- Access to Care
- Health Literacy
- Mental Health
- Senior Care

Hot Spring County

- Mental Health
- Access to Care
- Food Insecurity
- Maternal Health
- Diabetes
- Hypertension
- Health Literacy

Fort Smith/Van Buren

- Overweight/Obesity
- Diabetes
- High Blood Pressure
- Access to Care/Uninsured
- Mental Health/Suicide/Substance Abuse/Misuse
- Health Literacy
- Tobacco Use/Vaping
- Substance Abuse/Misuse

Little Rock

- High Blood Pressure
- Overweight/Obesity
- Diabetes
- Dental Health
- Cancer
- Access to Care
- Mental Health
- Food Insecurity
- Homelessness
- Health Literacy

North Little Rock

- Overweight/Obesity
- High Blood Pressure
- Anxiety/Depression
- Depression/Anxiety Disorder/Mental Disorders
- Diabetes
- Access to Care
- Food Insecurity

Stuttgart

- Overweight/Obesity
- Access to Care/Uninsured
- Mental Health/Suicide
- Tobacco Use/Vaping
- Cancer
- Health Literacy
- Food Insecurity

Methodology and Data Sources

Agencies/Entities Represented for Interviews and Focus Groups

Arkadelphia

- Ouachita Baptist University School of Nursing
- BHMC-A Director of Pharmacy
- Clark County, Arkansas Extension Service
- Valor EMS
- Community Family Enrichment Center

Conway

- Morrilton College
- Ujima Maternity Network
- Bethlehem House
- United Way
- Arkansas Department of Health
- Community Connections
- Morrilton & Perry County Chambers of Commerce
- City of Conway
- University of Arkansas Community College at Morrilton
- Central Baptist College
- University of Central Arkansas - Community Care Clinic

Drew County

- University of Arkansas at Monticello
- Mainline Health Clinic
- Nutrien Ag Solutions
- BHMC-DC Director of Pharmacy

Heber Springs

- BHMC-HS Respiratory Team Lead
- BHMC-HS Director of Hospital Operations
- BHMC-HS Operating Room Staff
- Emergency Department Operations
- Spark Community of North Central Arkansas

Hot Spring County

- BHMC-HSC Director of Pharmacy
- BHMC-HSC VP of Operations
- Harbor House Inc.
- AR Department of Health
- Revive Health
- Ouachita Children Youth and Family Services
- Rural health clinic president
- Truma Coo**
- AR Co-op Extension Service, Hot Spring Co.

Fort Smith

- United Way
- ArcBest
- Fort Smith Public Schools
- Arkansas College of Health Education
- Cancer Support House
- Comprehensive Juvenile Services
- River Valley Regional Foodbank
- McGill Center

Little Rock

- LR Community Wellness Group
- AR Dept Health
- Central AR Veterans Healthcare System
- American Heart Association Arkansas

Stuttgart

- BHMC-Stuttgart President
- Delta Region Community Health Champion
- Stuttgart School District
- Phillips Community College Stuttgart

North Little Rock

- AR Dept Health
- Central AR Veterans Healthcare System
- American Heart Association Arkansas
- Arkansas Minority Health Commission

Van Buren

- Van Buren/Crawford County Elected Officials
- Comprehensive Juvenile Services
- River Valley Regional Foodbank
- City of Van Buren
- Southwest EMS

Methodology and Data Sources

Prioritized Health Needs

The CHNA Guidelines require hospitals to disclose the prioritization criteria used during the selection process. The criteria is developed at the discretion of the hospital system and must be included in the completed plan. The following criteria was used by the Baptist Health System in selecting the significant health needs in each hospital community.

- Alignment with facility's strengths/priorities/mission
- Magnitude - number of people impacted by problem
- Severity - the rate or risk of morbidity and mortality
- Opportunity to intervene at prevention level
- Opportunity for partnership
- Addressing disparities of subgroups
- Existing resources and programs to address problem
- Availability of evidence-based approaches
- IImportance of problem to community
- Need among vulnerable populations

In addition to quantitative data collection, focus groups, one on one interviews and surveys were utilized to acquire input from persons who represent the broad interest of the community served by each facility (A CHNA requirement).

The prioritization process resulted in the following health needs as a focus for the CHNA Implementation Plans

Little Rock

- Access to Care & Education
- Mental Health
- Nutrition Security

North Little Rock

- Access to Care
- Mental Health
- Nutrition Security

Conway

- Access to Care
- Mental Health
- Nutrition Security

Heber Springs

- Access to Care
- Mental Health
- Nutrition Security

Stuttgart

- Access to Care
- Mental Health
- Nutrition Security

Hot Spring County

- Access to Care
- Mental Health
- Nutrition Security

Lack of transportation—whether due to personal vehicle issues, costs, or inadequate public transit—is a major obstacle that prevents patients from keeping appointments, with distance in rural areas and unreliable schedules in urban settings serving as significant barriers to care.

The barrier of healthcare costs extends beyond simple lack of insurance coverage, forcing individuals to avoid seeking care until they end up in the ER, or to forego unaffordable medications upon discharge leading to readmission, as they are often unable to prioritize health costs over the costs of basic needs.

Arkadelphia

- Access to Care
- Mental Health
- Nutrition Security

Fort Smith

- Access to Care
- Mental Health
- Nutrition Security

Van Buren

- Access to Care
- Mental Health
- Nutrition Security

Rehabilitation Institute

- Access to Care
- Mental Health
- Nutrition Security

Extended Care Hospital

- Access to Care
- Mental Health
- Nutrition Security

Drew County

- Access to Care
- Mental Health
- Nutrition Security

BAPTIST HEALTH MEDICAL CENTER
Little Rock

About Us

For nearly 100 years, Baptist Health Medical Center-Little Rock has been delivering quality healthcare to the citizens of Arkansas. The 843-bed medical center is the largest private, not-for-profit hospital in the state and provides comprehensive services using the latest in innovative technology.

Baptist Health Medical Center-Little Rock was the first hospital in the U.S. to adopt EleGARD Patient Positioning System for CPR. The device precisely, rapidly and consistently positions the patient for CPR and airway management and raises the patient into a multi-level elevation to support the use of a new technique for resuscitation.

This facility also offers Invenia ABUS 2.0 (Automated Breast Ultrasound System) technology for breast cancer detection in women with dense breast tissue. This ultrasound procedure is the only ultrasound technology of its kind approved by the FDA and when used in addition to your mammogram, will provide a more complete evaluation of dense breast tissue.

Baptist Health Medical Center-Little Rock recently became the first hospital in Arkansas to utilize the Pipeline Flex Embolization Device with Shield Technology. This device is used to treat brain aneurysms by diverting blood flow away from a brain aneurysm and reconstructing the diseased section of the parent vessel.

Baptist Health Medical Center-Little Rock was one of the first hospitals in Arkansas to be awarded the Go Clear Award as a Gold Level. The Go Clear Award was given

to Baptist Health Medical Center-Little Rock to recognize it as being committed to providing increased surgical safety by implementing practices that eliminate smoke caused by lasers and electrosurgery devices.

For more than 2 decades, Baptist Health Medical Center-Little Rock was named the winner of the Consumer Choice Award by National Research Corporation. The award identifies hospitals across the U.S. that local healthcare consumers choose as having the highest quality and image.

It was also one of the several Baptist Health facilities in Arkansas to receive honors from State and National Agencies for Stroke Care Quality. Baptist Health Medical Center-Little Rock was named to the Target: Stroke Elite Plus Honor Roll for its focus on improving acute ischemic stroke care.

Community Health Needs Assessment 2026-2028
Baptist Health Medical Center-Little Rock

HIGHLIGHTS OF COMMUNITY HEALTH NEEDS ASSESSMENT ACCOMPLISHMENTS 2023-2025

Access to Care

- Equipped High-Need Patients: Provided essential home monitoring devices including blood pressure machines, glucose monitors with supplies, scales and educational materials to patients with demonstrated needs
- Mass Immunization Delivery: Successfully administered more than 2,000 childhood immunizations and adult vaccinations
- Sustained Screening Encounters: Facilitated 5,504 patient encounters across city wellness centers (2023-2025), providing vital screenings for blood pressure, blood sugar, and cholesterol
- Chronic Disease Education: Delivered 72 focused education sessions (65 diabetes and 7 hypertension) resulting in 547 participant encounters to improve chronic disease self-management
- Targeted Brain Health: Hosted 3 brain health/Alzheimer's class sessions, engaging 56 participants in critical awareness and education
- Unhoused Population Outreach: Conducted 6 events with more than 100 encounters annually for unhoused populations, providing immediate aid, warm clothing, food, and essential vaccinations/screenings
- Future Workforce Development: Human Resources Developed a job pipeline that provided promotion and exposure of clinical and non-clinical careers to high school students
- Critical Transportation Access: Assisted 2,724 patients with transportation needs through Case Coordination, directly addressing a major barrier to hospital follow-up care
- Breast Center secured funding through the Baptist Health Foundation to offer free screening and diagnostic mammograms to individuals with limited resources
- Launched the ARHOME initiative (Baptist Health Maternal Infant Home Visiting Program - MIHOW) to improve outcomes for at-risk populations, specifically by providing free, home-based support to high-risk pregnant and new mothers
- Expanded Maternal Health offerings by opening a Community-Prenatal Clinic with a Medical Doctor and two APRNs. In the first year more than 3,500 patient visits and over 200 deliveries
- Little Rock Pregnancy Clinic Launched the "hello pregnancy" mobile application to provide 24/7 access to critical perinatal health information and support, including access to a registered nurse
- As a Healthcare System participated in the Increased Virtual Care Access: 30,000 outpatient virtual care encounters
- As a Healthcare System participated in Enhancing Remote Patient Monitoring: 40,000 remote patient encounters for cardiac care provided

Mental Health Awareness

- The ARHOME visiting team coordinated a critical monthly Perinatal Support Group to directly address the mental health crisis among expectant and new mothers. The group provides ongoing, expert-led intervention for conditions including postpartum depression and anxiety disorders, leveraging the reach of our maternal health program
- Comprehensive system-wide Behavioral health services booklet developed to educate on resources available
- Provided comprehensive, hands-on crisis preparedness training to the community, by offering free Mental Health First Aid classes
- Expanded community capacity for immediate crisis response by offering specialized training Stop the Bleed training

Food Insecurity/Nutrition Education

- Distributed 4,920 bags of food, providing approximately 102,500 meals of essential, shelf-stable nutrition to the community, including patients and employees
- Led 31 "Cooking with Community Outreach" classes, generating 313 participant encounters focused on skill-building and healthy eating
- Through a strategic partnership with the P.A.R.K. Program Community Outreach stabilized the nutrition of underserved children in after-school tutoring by providing sustained access to over 10,000 hot dinners and 20,000 supplementary snacks
- Conducted two comprehensive 8-week "Weight Wise" series, successfully engaging 48 participants in long-term health and weight management education
- Delivered six "Eat Smart Live Strong" classes, resulting in 57 participant encounters focused on improving nutrition for older adults
- Offered seven "Wellness Meetups" to foster community health and connection
- Executed one "Move with Ease" class, directly benefiting participants with targeted mobility instruction
- Successfully launched and managed two system-wide, 6-week holiday virtual wellness programs, achieving a robust 525 participant encounters and promoting employee health during a high-stress period
- Delivered three system-wide virtual cooking classes, directly engaging 16 participants and expanding access to hands-on nutritional education across the organization
- Successfully launched the Healthy Active Youth and Families Program

2025 BAPTIST HEALTH COMMUNITY HEALTH NEEDS ASSESSMENT: LITTLE ROCK

ACHI
August 2025

Baptist Health

PREPARED BY:
ACHI
INSPIRING HEALTHY ACTS

Introduction

Baptist Health engaged the Arkansas Center for Health Improvement (ACHI) to conduct the quantitative data collection and analysis for the 2025 Community Health Needs Assessment (CHNA) process. Baptist Health provided ACHI with the counties served by each of its 12 hospital communities. A total of 16 Arkansas counties and two Oklahoma counties were included.

Each report presents community-level data for a hospital community, including tables and figures for each indicator, along with comparisons to Arkansas and U.S. benchmarks. Dot graphs are provided to visualize performance across selected indicators. All reports are prepared using the same methodology to ensure consistency and comparability across Baptist Health hospital communities.

Methodology

A summary of sources, definitions, indicator criteria, and suppression rules can be found in the methods and sources document.

Community Profile Summary

To support the 2025 Community Health Needs Assessment (CHNA), ACHI compiled a comprehensive dataset of 103 health and demographic indicators for the communities served by Baptist Health's 12 hospital locations. This section provides an overview of these indicators across the full CHNA service area and offers multiple views for understanding and comparing county-level and community-level data.

Data are grouped into the following 14 categories, based on the source-defined domains outlined in the data source reference sheet:

1. Demographics
    a. Age
    b. Sex
    c. Race, Ethnicity, and Language
2. Insurance Coverage
3. Access to Care
4. Cause of Death
5. Chronic Conditions
6. Diagnoses Incidence at Discharge
7. Environment
8. Health Behaviors
9. Health Outcomes
10. Healthcare Expenditures
11. Maternal and Infant Health
12. Mental Health and Substance Use
13. Prevention
14. Social and Economic Factors

Measurements for these categories will be displayed in the following sections.

Hospital Community Indicator

The hospital community indicator snapshots offer an at-a-glance view of how each hospital community compares to state and national benchmarks, as well as the counties that make up the community.

Each table presents the data values for selected indicators across the 14 CHNA domains, and each corresponding visual uses proportionally scaled circular markers to illustrate performance. This format is designed to quickly convey how each hospital community aligns with or diverges from broader benchmarks in key population health metrics.

Each displays four comparison points:

- **Purple** – Represents the national value for the indicator.
- **Blue** – Represents the value for the state of Arkansas.
- **Gold** – Represents the weighted average for all counties in the hospital's defined service area.
- **Gray** – Represent the values of each county assigned to that hospital community.

Where available, data for each indicator are shown for all four categories. If a value is not available or is suppressed for a contributing county, it is noted as "Not Available" in the table and excluded from the visual display. No color ranking is applied; the visuals and tables are intended to illustrate relative placement, not comparative rank.

Hospital Community: Little Rock (Grant, Pulaski, and Saline Counties)

Figure 1. Counties Served by Baptist Health Medical Center–Little Rock

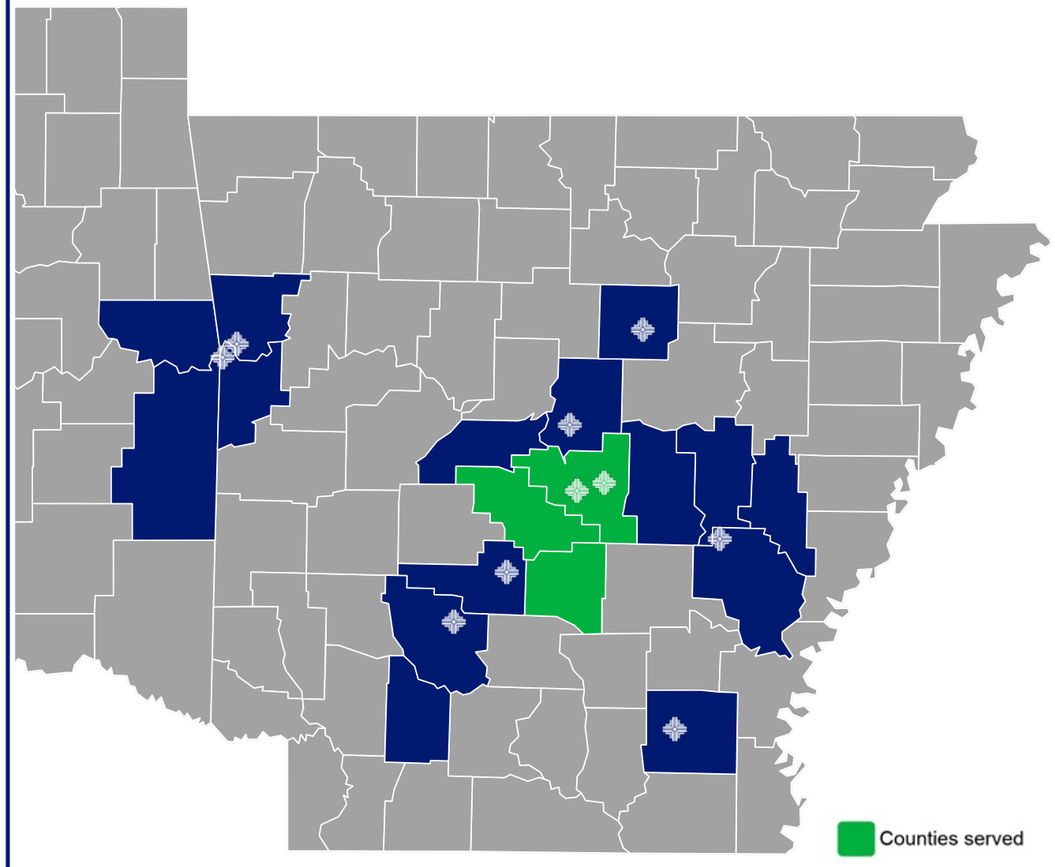


Table 1. Demographics: Age and Sex

		Grant County	Saline County	Pulaski County	Community Average	State	National
Total Population	*Number*	18,111	125,724	398,949	542,784	3,032,651	332,387,540
Female	*Percent*	49.66%	51.03%	52.15%	51.81%	50.67%	50.50%
Male	*Percent*	50.34%	48.97%	47.85%	48.19%	49.33%	49.50%
Ages 0-4	*Percent*	5.33%	5.59%	6.34%	6.13%	6.02%	5.70%
Ages 5-17	*Percent*	16.03%	17.78%	17.08%	17.21%	17.26%	16.46%
Ages 18-24	*Percent*	8.39%	7.34%	8.77%	8.43%	9.33%	9.12%
Ages 25-34	*Percent*	12.71%	12.16%	14.42%	13.84%	12.93%	13.69%
Ages 35-44	*Percent*	12.31%	13.93%	13.05%	13.23%	12.66%	13.08%
Ages 45-54	*Percent*	12.91%	12.53%	11.73%	11.95%	11.84%	12.29%
Ages 55-64	*Percent*	14.17%	12.51%	12.35%	12.45%	12.64%	12.82%
Ages 65+	*Percent*	18.15%	18.16%	16.25%	16.76%	17.33%	16.84%

Figure 2. Demographics: Age and Sex

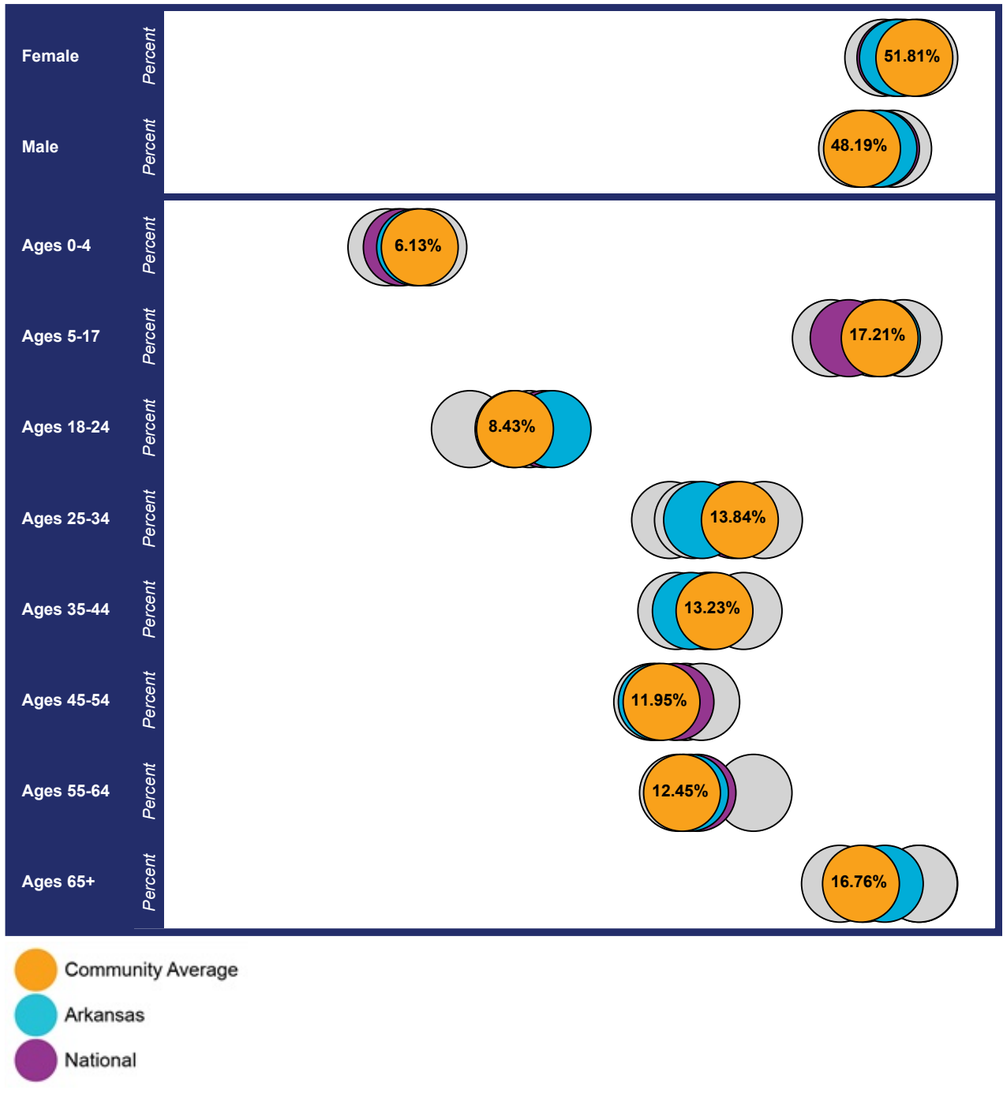


Table 2. Demographics: Race, Ethnicity, and Language

		Grant County	Saline County	Pulaski County	Community Average	State	National
Total Population	*Number*	18,111	125,724	398,949	542,784	3,032,651	332,387,540
Asian	*Percent*	0.36%	1.03%	2.13%	1.82%	1.53%	5.75%
Black or African American	*Percent*	2.59%	8.25%	36.72%	28.99%	14.84%	12.03%
Hispanic	*Percent*	2.71%	6.98%	8.20%	7.73%	8.77%	18.99%
Multiple Races	*Percent*	2.14%	3.70%	3.69%	3.64%	5.50%	3.87%
Native American/ Alaska Native	*Percent*	0.11%	0.19%	0.21%	0.20%	0.36%	0.53%
Native Hawaiian/ Pacific Islander	*Percent*	0.19%	0.00%	0.04%	0.04%	0.39%	0.17%
Other Races	*Percent*	0.48%	0.49%	0.30%	0.35%	0.26%	0.50%
White	*Percent*	91.43%	79.36%	48.70%	57.23%	68.36%	58.17%
Non-English Language Households	*Percent*	0.20%	2.10%	1.80%	1.82%	1.50%	4.20%

Figure 3. Demographics: Race, Ethnicity, and Language

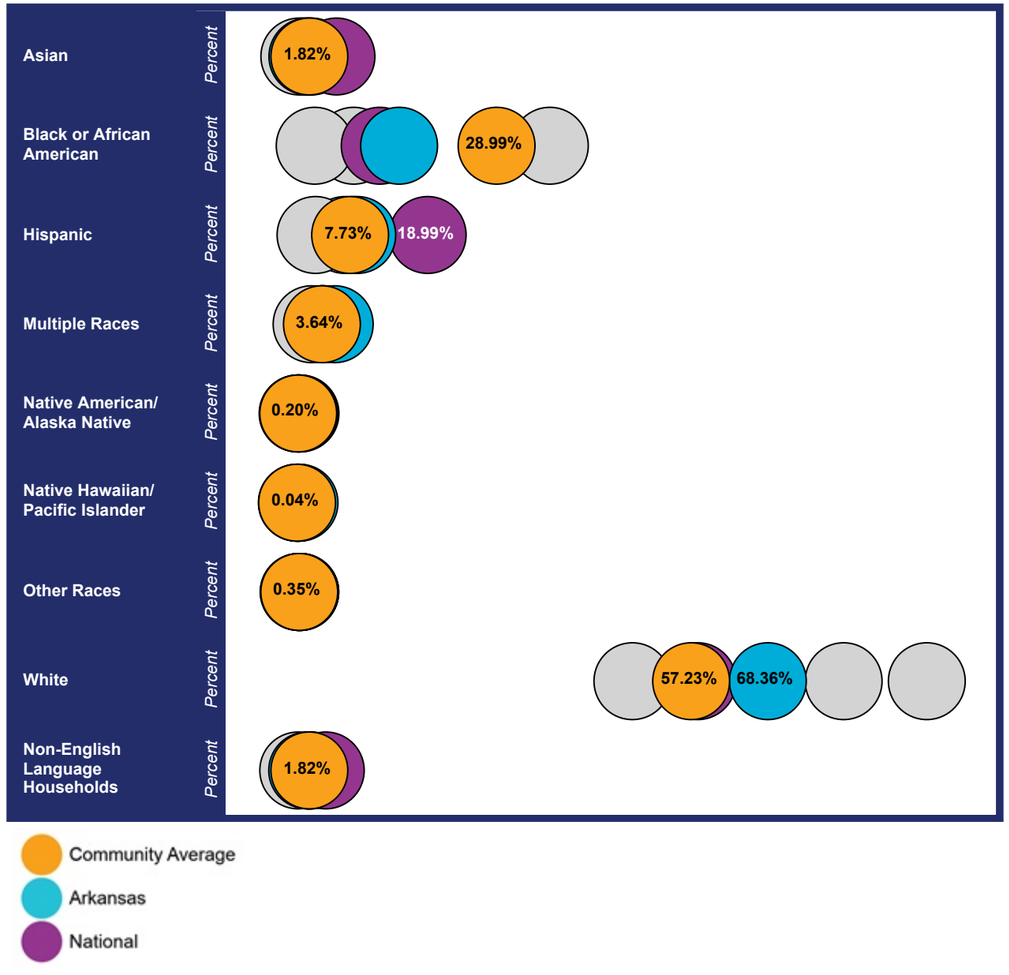


Table 3. Insurance Coverage

		Grant County	Saline County	Pulaski County	Community Average	State	National
Private Health Insurance Coverage	*Percentage of the total civilian non-institutionalized population for whom insurance status is determined that is covered by private health insurance*	71.02%	75.34%	68.22%	69.96%	65.37%	73.62%
Public Health Insurance Coverage	*Percentage of the total civilian non-institutionalized population for whom insurance status is determined that is covered by public health insurance*	47.46%	39.32%	45.65%	44.24%	48.21%	39.70%
Uninsured	*Percentage of adults under age 65 without health insurance coverage*	7.10%	8.20%	9.00%	8.75%	10.00%	9.50%

Figure 4. Insurance Coverage

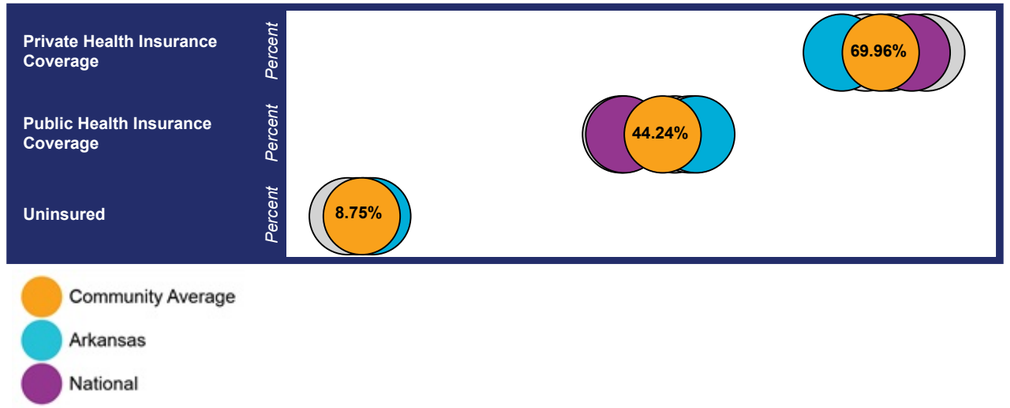


Table 4. Access to Care

		Grant County	Saline County	Pulaski County	Community Average	State	National
Primary Care Physicians	*Ratio of population to one primary care physician*	9045:1	2555:1	848:1	1517:1	1478:1	1334:1
Mental Health Providers	*Ratio of population to one mental health provider*	765:1	617:1	189:1	232:1	367:1	300:1
Dentists	*Ratio of population to one dentist*	2594:1	2961:1	1300:1	1523:1	2044:1	1361:1
Active Primary Care Physicians	*Rate per 10,000 county residents of primary care physicians who provided evaluation and management services to at least two patients on the same day at least once during the year*	4.50	9.20	27.60	22.57	9.20	Not Available
Addiction or Substance Use Providers	*Rate of addiction or substance use providers per 100,000 population*	5.57	1.62	10.52	8.29	5.98	29.43
Buprenorphine Providers	*Rate of buprenorphine providers per 100,000 population*	5.52	2.39	19.35	14.96	9.81	14.87
Preventable Hospital Stays (Medicare)	*Rate of hospital stays for ambulatory care-sensitive conditions per 100,000 Medicare enrollees*	2813.00	3492.00	2682.00	2873.99	3014.00	2666.00
Diabetic Monitoring (Medicare)	*Percentage of Medicare enrollees aged 65 and older with diabetes who received a hemoglobin A1c (HbA1c) test within the past year.*	87.91%	88.80%	88.61%	88.63%	88.47%	87.53%
Mammography	*Percentage of female Medicare enrollees ages 65-74 who received an annual mammography screening*	39.00%	36.00%	45.00%	42.72%	41.00%	44.00%

Figure 5. Access to Care

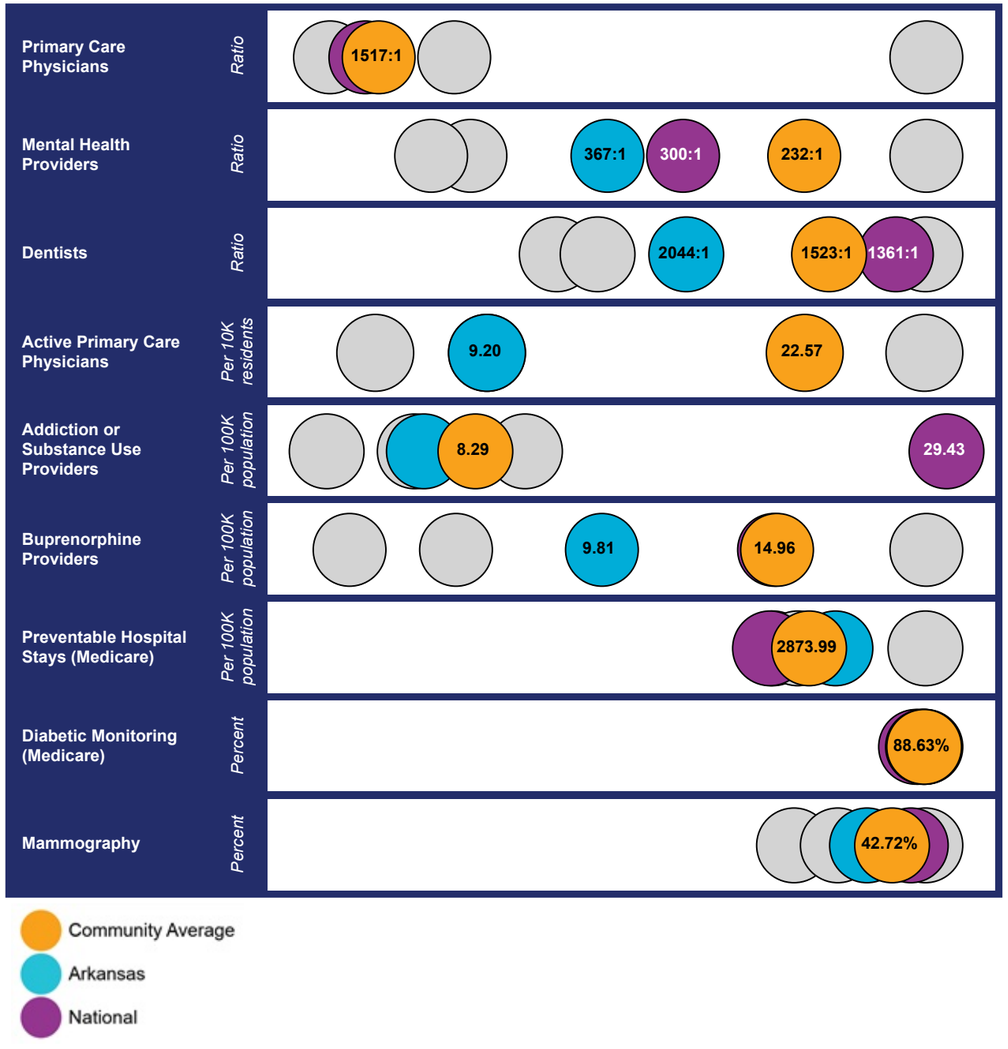


Table 5. Cause of Death

		Grant County	Saline County	Pulaski County	Community Average	State	National
All Causes	*Rate of deaths by all causes per 100,000 population (age-adjusted)*	1060.40	910.90	955.20	948.45	1001.70	805.60
Premature Death	*Number of deaths among residents under age 75 per 100,000 population (age-adjusted)*	562.31	468.31	545.57	528.23	552.47	406.59
Heart Disease	*Rate of death due to heart disease (ICD-10 Codes I00-I09, I11, I13, I20-I151) per 100,000 population*	306.50	235.30	222.80	228.49	282.80	207.20
Cancer	*5-year average rate of death due to cancer per 100,000 population*	241.90	199.20	188.90	193.05	215.90	182.70
Unintentional Injury	*5-year average rate of death due to unintentional injury (accident) per 100,000 population*	72.30	67.30	69.90	69.38	61.90	63.30
Stroke	*5-year average rate of death due to cerebrovascular disease (stroke) per 100,000 population (age-adjusted)*	43.80	46.80	53.50	51.62	57.40	48.30
Chronic Lower Respiratory Disease	*Rate of deaths due to chronic lower respiratory disease per 100,000 population (age-adjusted)*	76.50	51.10	41.70	45.04	61.00	35.90
Diabetes Mortality	*Rate of deaths due to diabetes per 100,000 population (age-adjusted)*	24.50	32.10	40.80	38.24	34.70	23.90
Suicide Deaths	*This indicator reports the 2019-2023 five-year average rate of death due to intentional self-harm (suicide) per 100, 000 population. Figures are reported as crude rates*	25.20	22.60	16.10	17.91	19.20	14.50
Motor Vehicle Crash	*5-year average rate of death due to motor vehicle crash per 100,000 population (age-adjusted)*	31.80	15.40	20.80	19.92	20.60	12.80
Alcohol-Involved Motor Vehicle Crash	*Rate of persons killed in motor vehicle crashes involving alcohol as a rate per 100,000 population*	0.00	2.10	3.80	3.28	3.10	2.30

Figure 6. Cause of Death

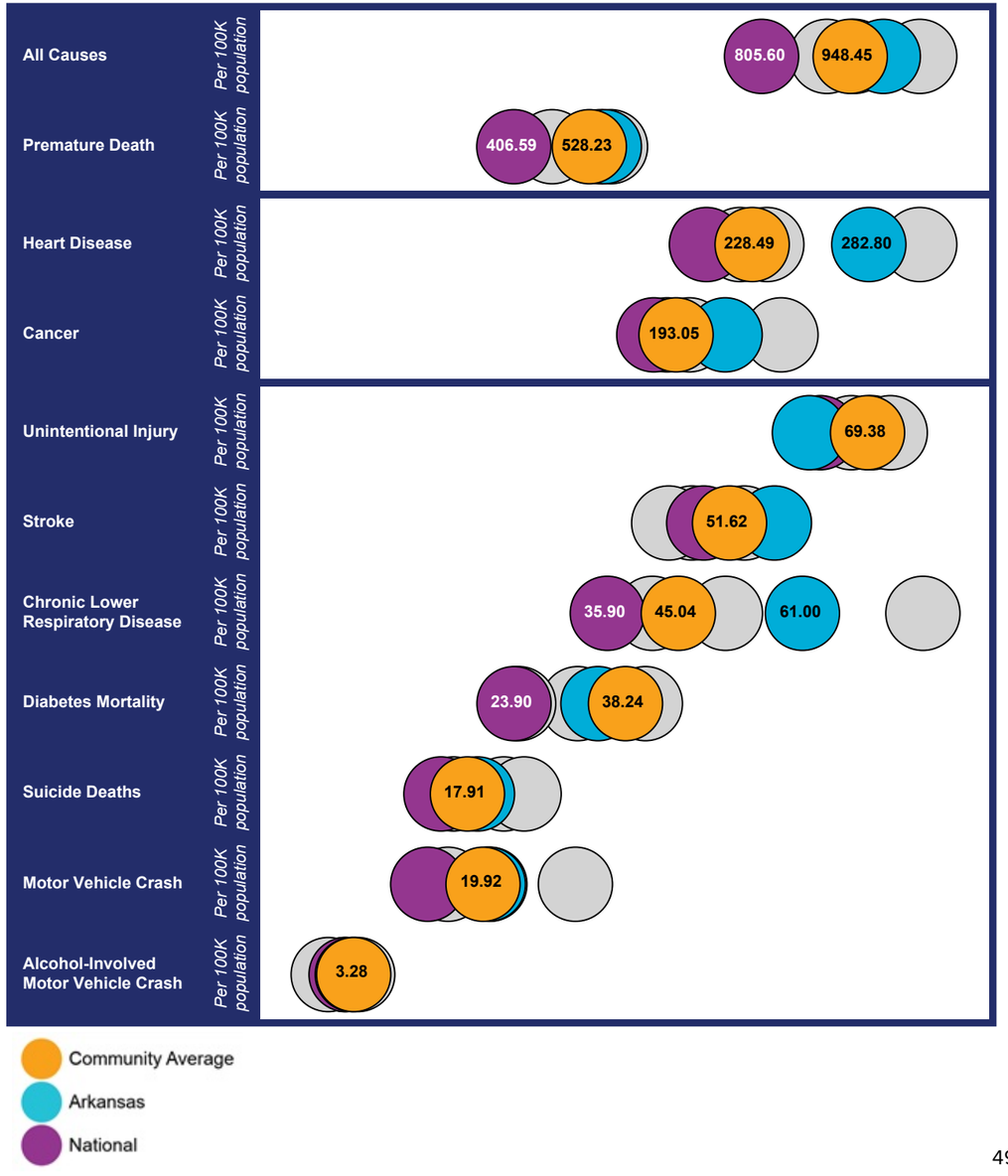


Table 6. Chronic Condtions

		Grant County	Saline County	Pulaski County	Community Average	State	National
Child Obesity	*Percentage of students classified as overweight to severely obese, by county location of school*	35.00%	38.71%	38.89%	38.72%	40.10%	Not Available
High Cholesterol	*Percentage of adults who have had their blood cholesterol checked and have been told it was high (age-adjusted)*	32.00%	31.60%	30.10%	30.51%	31.80%	30.40%
Adult Obesity	*Percentage of adults ages 20 and older who report a BMI higher than 30*	33.90%	33.20%	34.90%	34.47%	31.90%	30.10%
High Blood Pressure	*Percentage of adults who have been told they have high blood pressure (age-adjusted)*	34.50%	34.70%	38.00%	37.12%	36.50%	29.60%
Arthritis	*Percentage of adults ages 18 or older diagnosed with some form of arthritis*	30.40%	30.20%	28.00%	28.59%	32.60%	Not Available
Diabetes Prevalence	*Percentage of adults age 18 and older who report ever been told that they have diabetes other than diabetes during pregnancy (age-adjusted)*	11.00%	10.60%	12.70%	12.16%	12.70%	10.40%
Asthma	*Percentage of adults who have been told they currently have asthma (age-adjusted)*	10.90%	10.10%	10.80%	10.64%	11.00%	9.90%
Coronary Heart Disease	*Percentage of adults age 18 and older who report ever having been told by that they had angina or coronary heart disease (CHD) (age-adjusted)*	6.90%	6.20%	6.60%	6.52%	7.20%	5.70%

Figure 7. Chronic Conditions

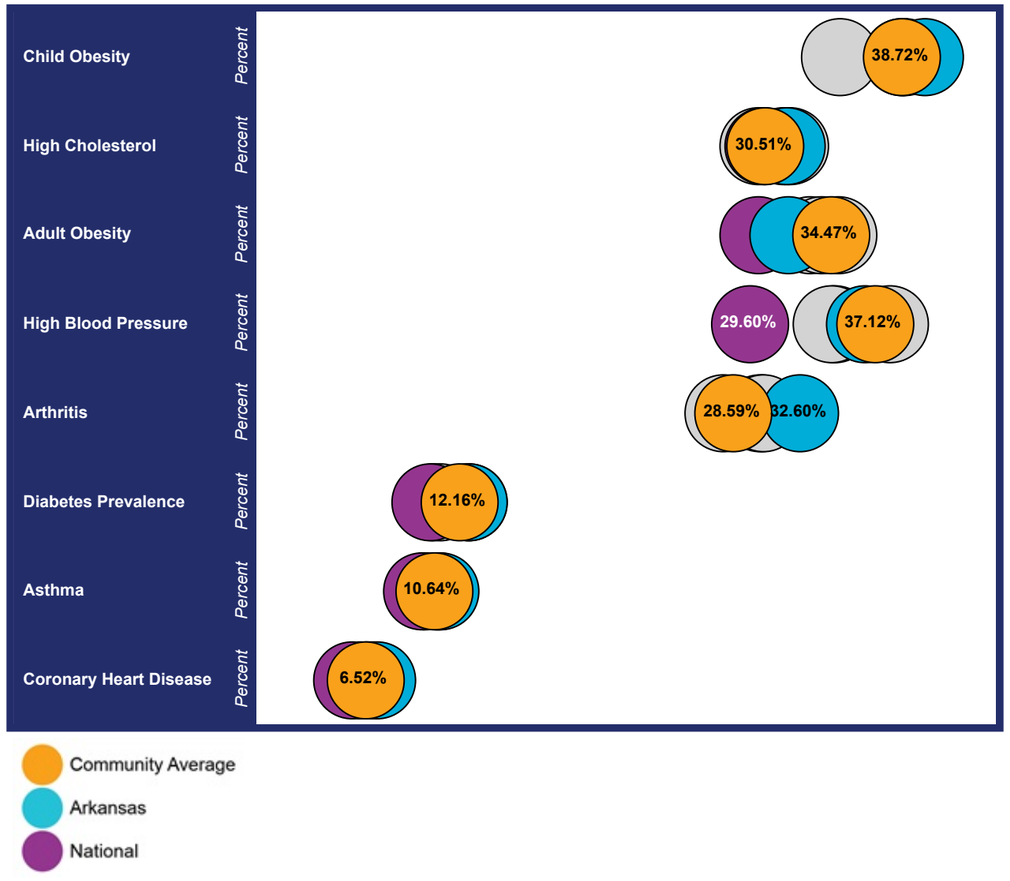


Table 7. Diagnoses at Discharge

		Grant County	Saline County	Pulaski County	Community Average	State
Hypertension	*Number of individuals 18 years and older discharged with a primary or secondary hypertension diagnosis as a percentage of the population 18 years and older*	7.86%	8.19%	8.12%	8.13%	8.70%
Hyperlipidemia	*Number of individuals 18 years and older discharged with a primary or secondary hyperlipidemia diagnosis as a percentage of the population 18 years and older*	3.08%	3.32%	2.77%	2.91%	3.90%
Diabetes	*Rate of individuals 18 years and older discharged with a primary or secondary diabetes diagnosis as a percentage of the population 18 years and older*	3.07%	2.77%	3.13%	3.04%	3.70%
Ischemic Heart Disease	*Number of individuals 18 years and older discharged with a primary or secondary ischemic heart disease diagnosis as a percentage of the population 18 years and older*	2.65%	2.44%	1.54%	1.79%	2.50%
Arthritis	*Rate of individuals 18 years and older discharged with a primary or secondary arthritis diagnosis as a percentage of the population 18 years and older*	1.44%	1.52%	1.42%	1.44%	1.90%

Figure 8. Diagnoses at Discharge

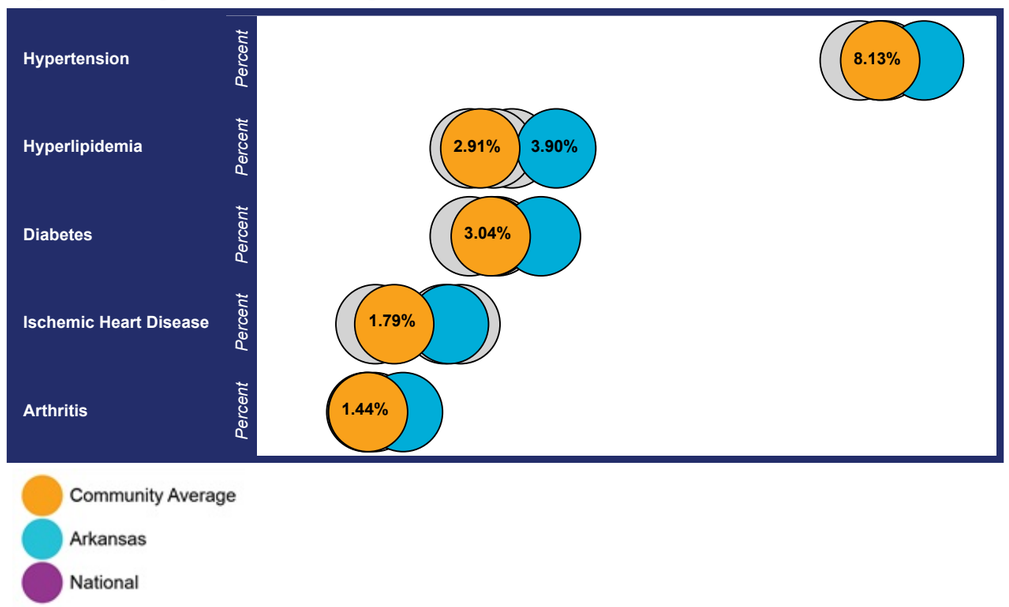


Table 8. Environment

		Grant County	Saline County	Pulaski County	Community Average	State	National
Food Environment Index	*Index of factors that contribute to a healthy food environment, 0 (worst) to 10 (best)*	6.40	7.40	6.60	6.78	4.40	7.40
Drinking Water Violations	*The total number of drinking water violations recorded in a two-year period*	0	0	0	0	321	16,107
Access to Exercise Opportunities	*Percentage of population with adequate access to locations for physical activity*	35.10%	51.50%	84.98%	75.56%	63.36%	84.45%
Broadband Access	*Percentage of population in a high-speed internet service area; access to DL speeds >= 25MBPS and UL speeds >= 3 MBPS*	95.54%	97.75%	99.09%	98.66%	94.04%	96.78%
Long Commute Driving Alone	*Among workers who commute in their car alone, the percentage who commute more than 30 minutes*	54.80%	42.60%	20.80%	26.98%	28.10%	36.50%
Severe Housing Problems	*Percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities*	9.27%	10.07%	16.37%	14.67%	13.23%	16.84%

Figure 9. Environment

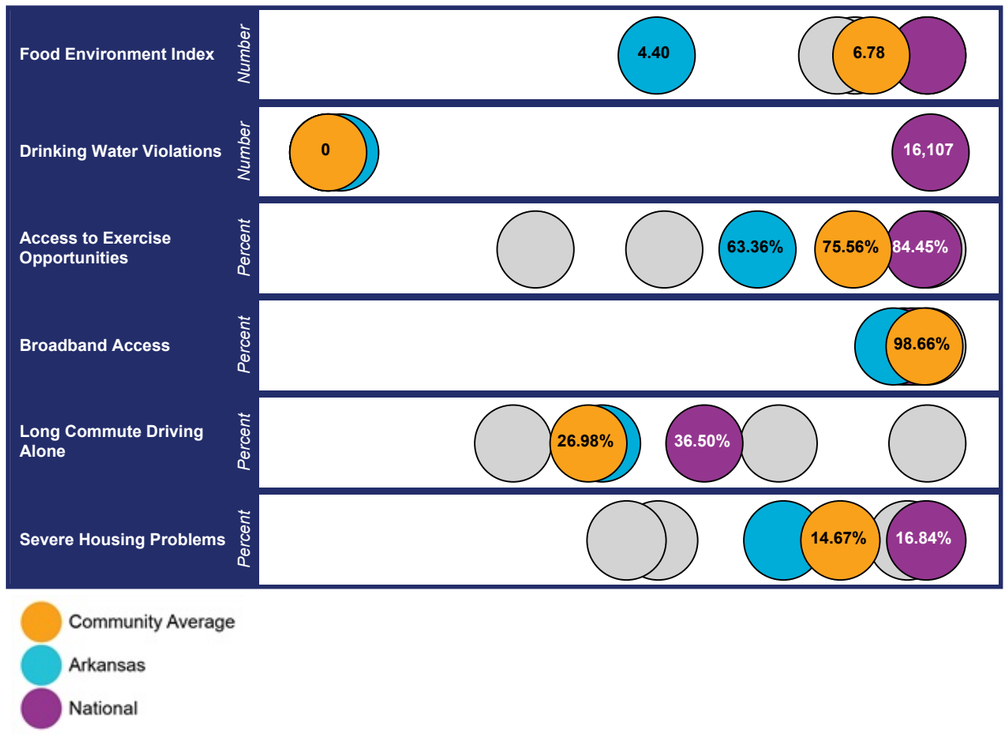


Table 9. Health Behaviors

		Grant County	Saline County	Pulaski County	Community Average	State	National
Physical Inactivity	*Percentage of adults aged 20 and older who self-report no leisure time for activity*	22.00%	21.60%	22.80%	22.50%	23.60%	19.50%
Adult Smoking	*Percentage of adults ages 18 and older who are current smokers (age-adjusted)*	20.40%	15.00%	16.70%	16.43%	19.20%	13.20%
Youth Vaping	*Percentage of public school students in 6th, 8th, 10th, and 12th grade who used any vape in the past 30 days*	10.00%	6.40%	6.90%	6.89%	8.10%	Not Available
Sexually Transmitted Infections	*Number of newly diagnosed chlamydia cases per 100,000 population*	357.90	363.50	969.80	808.95	588.30	495.00

Figure 10. Health Behaviors

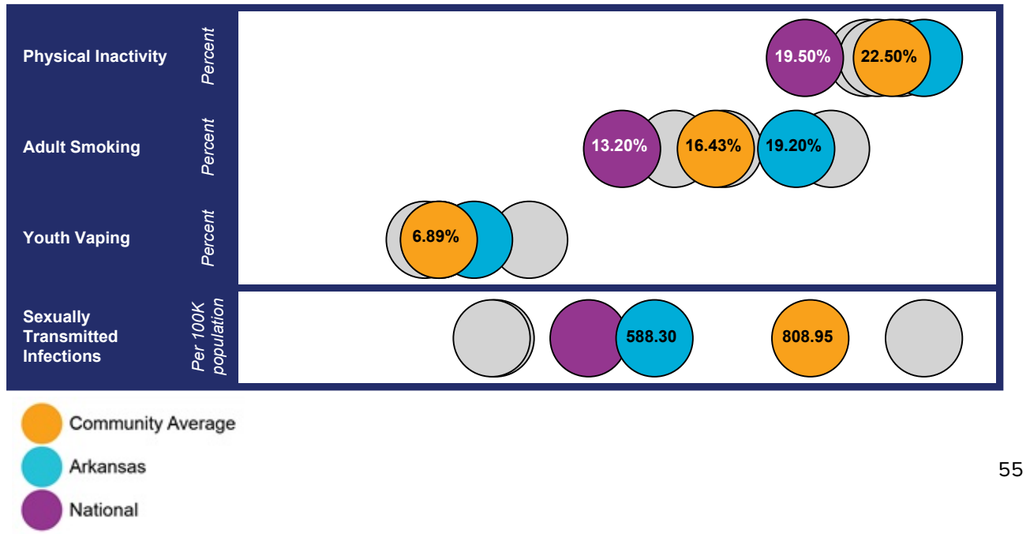


Table 10. Health Outcomes

		Grant County	Saline County	Pulaski County	Community Average	State	National
Poor Physical Health Days	*Average number of physically unhealthy days reported in past 30 days (age-adjusted)*	4.80	4.40	4.70	4.63	5.20	3.90
Poor or Fair Health	*Percentage of adults age 18 and older who self-report their general health status as "fair" or "poor" (age-adjusted)*	20.80%	17.20%	20.20%	19.53%	22.60%	17.00%

Figure 11. Health Outcomes

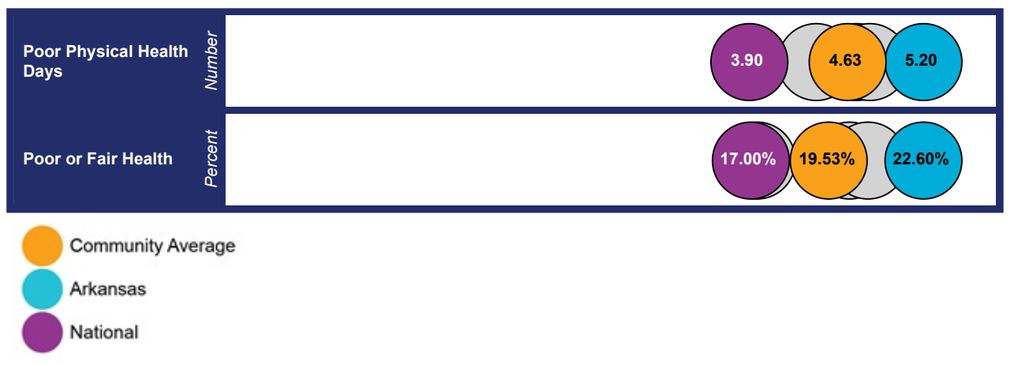


Table 11. Healthcare Expenditures

		Grant County	Saline County	Pulaski County	Community Average	State	National
Average Annualized Expenditures	*Average annualized per-person spending on all covered healthcare services.*	$10,931	$10,903	$10,003	$10,242	$10,116	Not Available
Average Annualized Expenditures (Medical Only)	*Average annualized per-person spending on medical services, based on medical claims.*	$7,599	$7,750	$7,131	$7,289	$7,252	Not Available
Average Annualized Expenditures (Pharmacy Only)	*Average annualized per-person spending on prescription drugs, based on pharmacy claims.*	$3,073	$2,842	$2,579	$2,656	$2,609	Not Available

Figure 12. Healthcare Expenditures

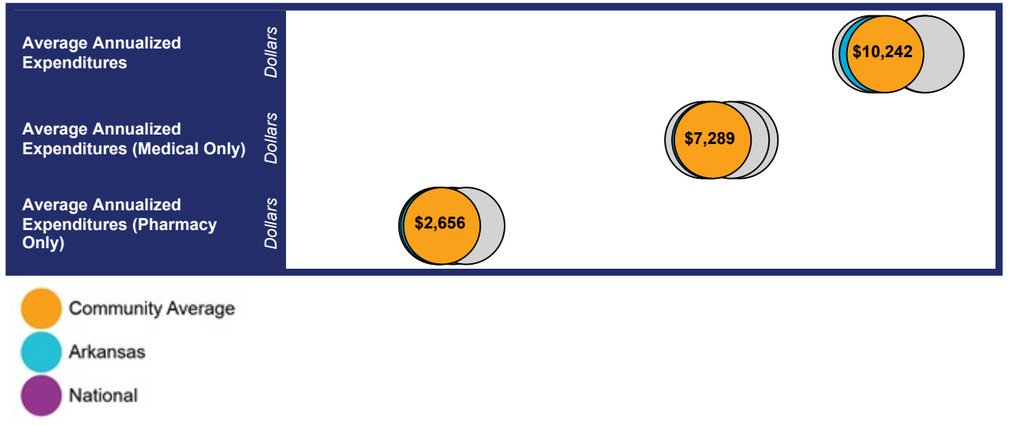


Table 12. Maternal and Infant Health

		Grant County	Saline County	Pulaski County	Community Average	State	National
Active Obstetrics and Gynecology Physicians	*Active OB-GYN physicians are defined as those who provided evaluation and management services to at least two female patients ages 12-55 on the same day or performed a qualifying procedure (e.g., delivery) at least once during the year.*	2.00	3.20	8.20	6.83	3.20	Not Available
Teen Births	*The seven-year average number of teen births per 1,000 female population, ages 15-19*	23.50	17.70	26.50	24.36	27.90	15.50
C-Section Rate	*Percentage of live births delivered via cesarean section among all deliveries, calculated by the mother's county of residence.*	33.99%	33.62%	33.87%	33.82%	33.48%	Not Available
C-Section Rate, First Birth	*Percentage of first-birth deliveries (full-term singleton pregnancies in a head-down position) delivered via cesarean section, calculated by the mother's county of residence.*	21.99%	27.87%	29.11%	28.58%	27.58%	Not Available
Low Birthweight	*Percentage of live births where the infant weighed less than 2, 500 grams (approximately 5 lbs., 8 oz.)*	10.30%	8.30%	11.70%	10.87%	9.40%	8.40%
Preterm Birth	*Percentage of live births that are preterm (<37 weeks), calculated as a three-year average.*	13.90%	11.80%	13.60%	13.19%	11.90%	10.35%
Median Travel Time to Delivery	*Median number of minutes Arkansas mothers traveled from their home ZIP code to the delivery facility, calculated using birth records and facility addresses. Travel time estimates include in-state and out-of-state facilities.*	41.00	21.00	13.00	15.79	16.00	Not Available

Figure 13. Maternal and Infant Health

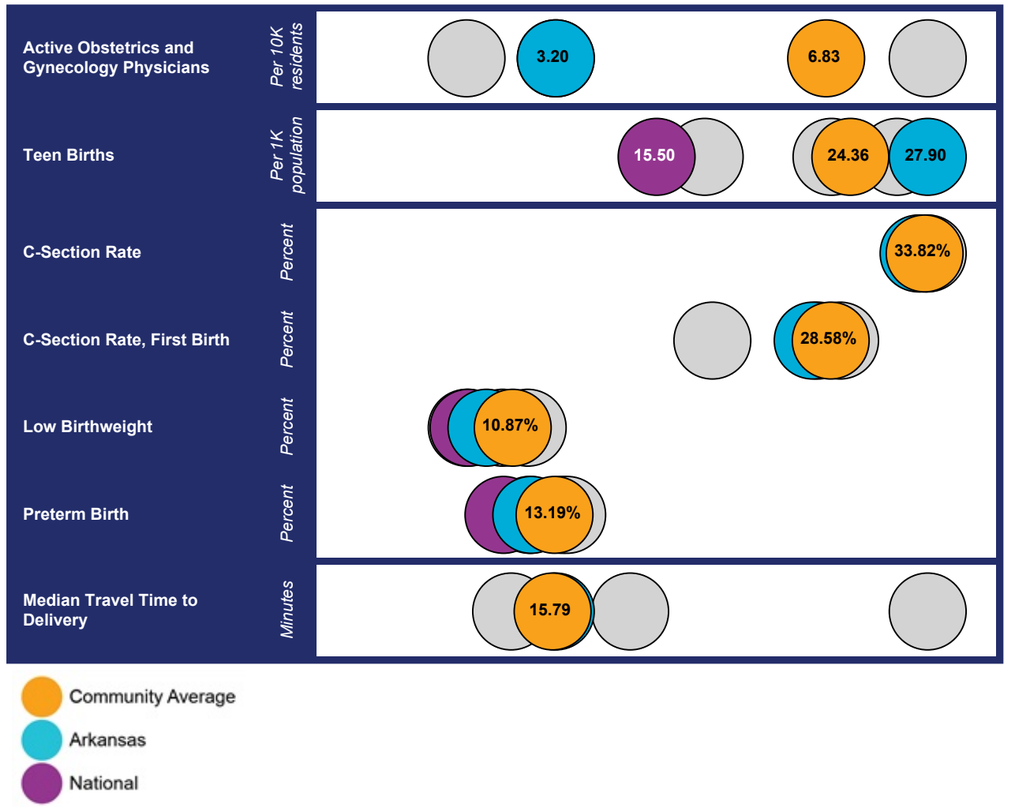


Table 13. Mental Health and Substance Use

		Grant County	Saline County	Pulaski County	Community Average	State	National
Adult Depression	*Percentage of adults age 18 and older who report having been told that they had depressive disorder*	28.90%	27.10%	25.80%	26.20%	27.50%	21.10%
Excessive Drinking	*Percentage of adults reporting binge or heavy drinking*	20.58%	19.85%	19.60%	19.69%	18.99%	19.35%
Poor Mental Health	*Percentage of adults age 18 or older reporting poor mental health for 14 or more days (age-adjusted)*	21.30%	19.30%	19.30%	19.37%	20.50%	16.40%
Youth Depression	*Percentage of public school students in 6th, 8th, 10th, and 12th grade who had feelings of depression all of the time in the past 30 days*	9.90%	5.90%	11.00%	9.78%	9.20%	Not Available
Drug Overdose Deaths	*Age-adjusted rate of fatal drug overdoses per 100,000 residents*	Not Available	Not Available	20.56	20.56	Not Available	Not Available
Non-Fatal Drug Overdoses	*Age-adjusted rate of non-fatal drug overdoses per 100,000 residents*	Not Available	18.72	29.43	26.86	Not Available	Not Available

Figure 14. Mental Health and Substance Use

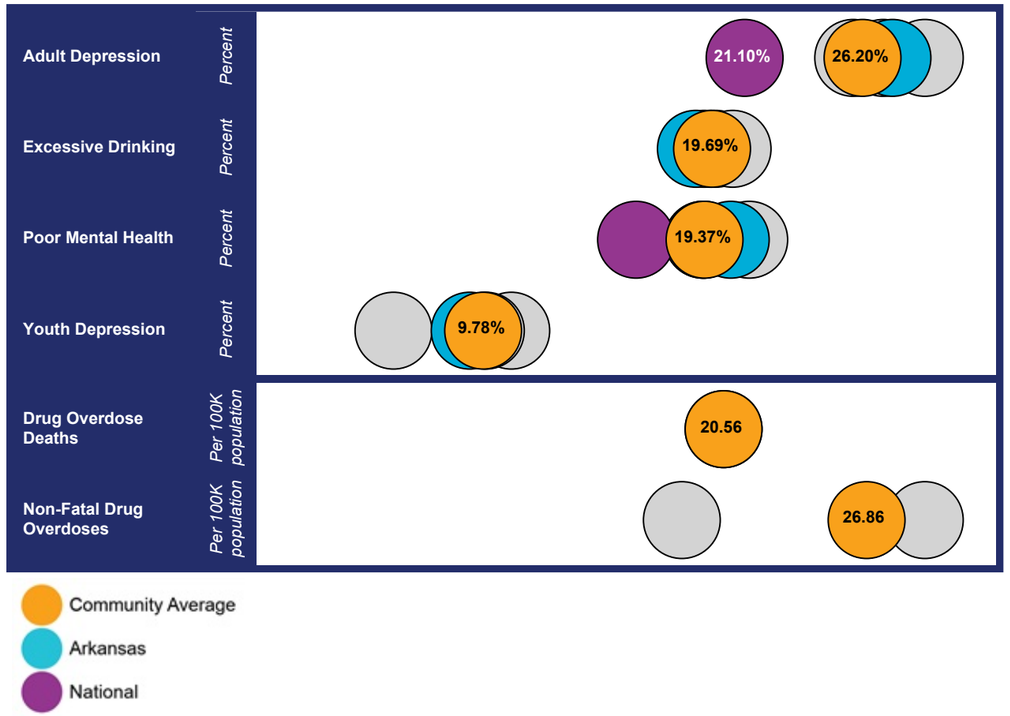


Table 14. Prevention

		Grant County	Saline County	Pulaski County	Community Average	State	National
Cervical Cancer Screening	*Percentage of females age 21–65 years who report having had recommended cervical cancer screening test (age-adjusted)*	81.90%	83.10%	83.90%	83.65%	81.20%	83.70%
Colorectal Cancer Screening	*Percentage of adults age 45-75 who have had a recent colorecal cancer screening*	63.40%	60.90%	64.40%	63.56%	61.60%	66.30%
Dental Care Utilization	*Dental care visit (past 1 year), age-adjusted percentage of adults age 18+ by county*	53.90%	62.40%	58.40%	59.18%	54.10%	63.40%
High Blood Pressure Management	*Percentage of adults age 18 and older with high blood pressure who report taking blood pressure medication (age-adjusted)*	60.00%	59.70%	61.50%	61.03%	61.40%	58.90%
Prevention - Seasonal Influenza Vaccine	*Percentage of adults aged 18 and older who report receiving an influenza vaccination in the past 12 months*	44.70%	47.10%	51.50%	50.25%	43.20%	44.80%
Annual Wellness Exam (Medicare)	*Percentage of annual wellness visits among the Medicare fee-for-service (FFS) population*	47.00%	47.00%	47.00%	47.00%	46.00%	44.00%
No HIV Test	*Percentage of adults ages 18 or older who have never been screened for HIV*	63.10%	63.40%	60.80%	61.48%	66.10%	Not Available

Figure 15. Prevention

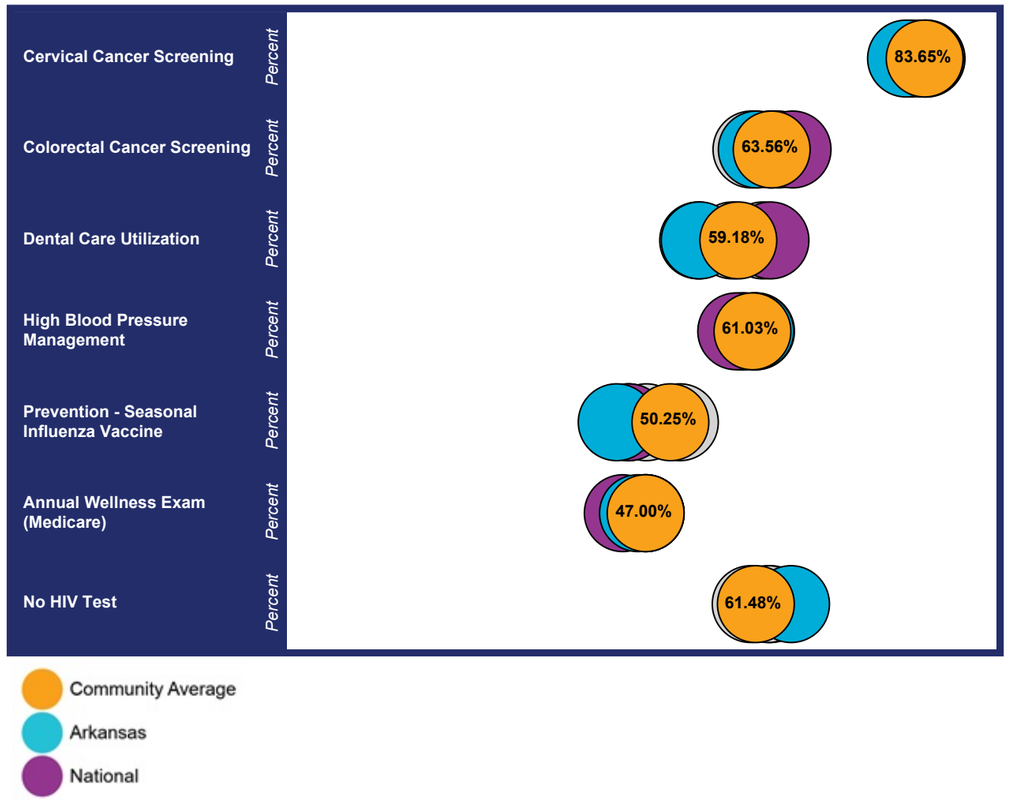
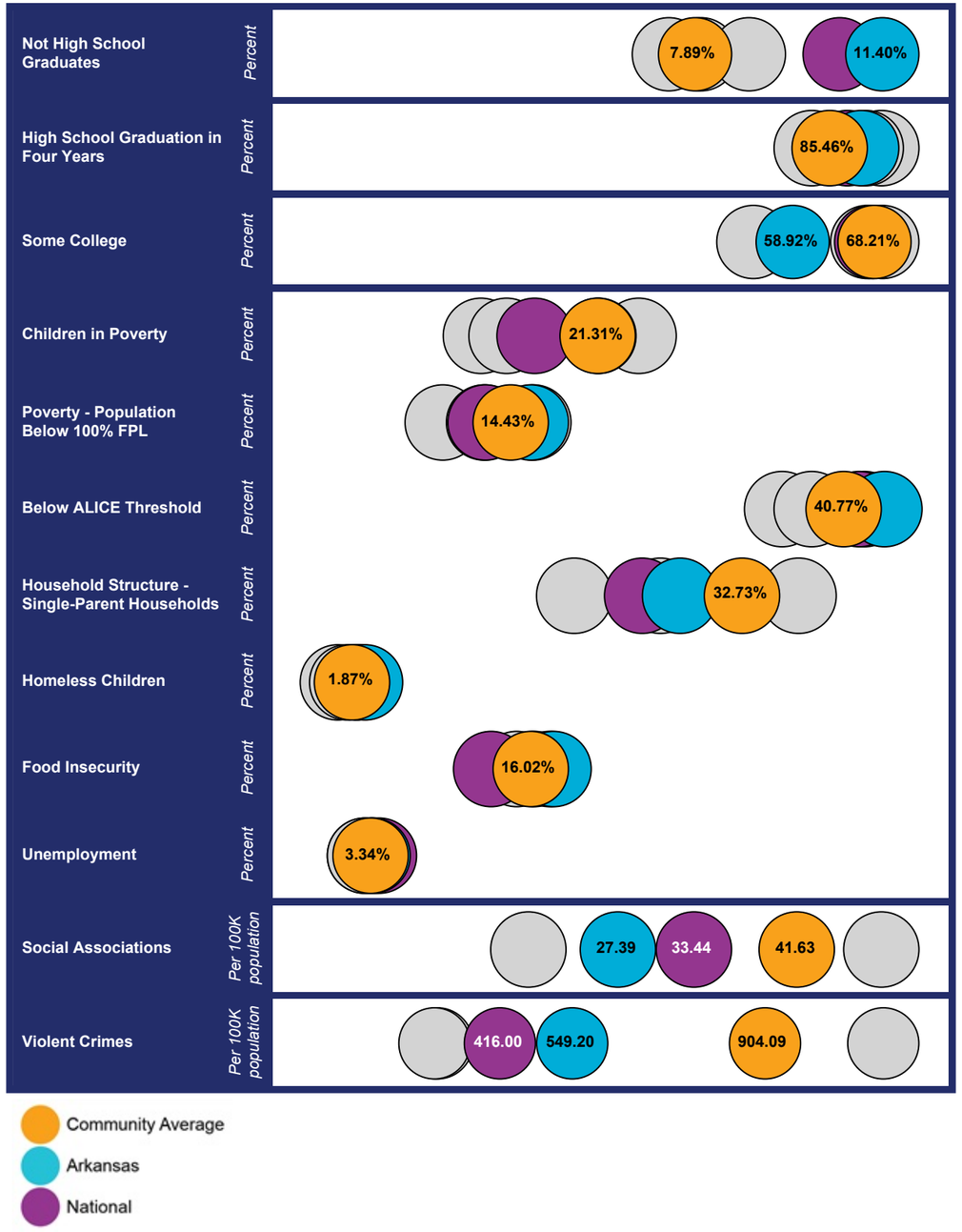


Table 15. Social and Economic Factors

		Grant County	Saline County	Pulaski County	Community Average	State	National
Not High School Graduates	*Percentage of adults without a high school diploma*	8.90%	7.40%	8.00%	7.89%	11.40%	10.60%
High School Graduation in Four Years	*Percentage of ninth-grade cohort who graduated in four years*	91.00%	93.40%	82.70%	85.46%	90.30%	88.20%
Some College	*Percentage of adults ages 25-44 with some post-secondary education*	54.45%	67.38%	69.10%	68.21%	58.92%	67.83%
Children in Poverty	*Percentage of children under age 18 below the poverty line*	14.10%	12.07%	24.55%	21.31%	21.37%	16.32%
Poverty - Population Below 100% FPL	*Percentage of the population living in households with income below the federal poverty level*	12.32%	9.05%	16.22%	14.43%	16.02%	12.44%
Below ALICE Threshold	*Percentage of households living in poverty or classified as ALICE (Asset Limited, Income Constrained, Employed)*	38.25%	35.91%	42.42%	40.77%	44.00%	42.00%
Household Structure - Single-Parent Households	*Percentage of children who live in households where only one parent is present*	26.27%	19.45%	37.21%	32.73%	27.83%	24.83%
Homeless Children	*Percentage of students experiencing homelessness enrolled in the public school system*	1.49%	0.75%	2.24%	1.87%	2.90%	2.31%
Food Insecurity	*Percentage of the population that experienced food insecurity in the report year*	17.50%	14.90%	16.30%	16.02%	17.82%	12.88 %
Unemployment	*Percentage of the civilian non-institutionalized population age 16 and older that is unemployed (non-seasonally adjusted)*	2.90%	2.90%	3.50%	3.34%	3.50%	4.00%
Social Associations	*Establishments, rate per 100,000 population*	Not Available	20.26	48.36	41.63	27.39	33.44
Violent Crimes	*Annual rate of reported violent crimes per 100,000 population*	295.50	300.90	1121.80	904.09	549.20	416.00

Figure 16. Social and Economic Factors



IDENTIFIED NEED 1:
Increase Access to Care and Education

GOALS/OBJECTIVE/OBJECTIVES:
Increase access to quality health care, preventive screenings, vaccinations, and community health resources for Pulaski County.

STRATEGY 1:
Expand community outreach and strengthen partnerships with local nonprofits, schools, and employers to improve access and awareness.

ACTION STEPS:

- Host annual free flu shot events & childhood immunization clinics
- Partner with local businesses and organizations to offer free health education and on-site screenings (e.g., blood sugar, blood pressure, BMI) and facilitate scheduling for primary care and mammogram appointments.
- Continue local and regional partnerships and collaborations to expand access to care and reduce barriers to care
- Explore Resource Hub opportunities with area agencies to identify and promote community resources and social drivers of health support
- Maintain the financial assistance policy for patients who are uninsured, underinsured, ineligible for a government health care program, or otherwise unable to pay, for medically necessary or emergent care.
- Continue to evaluate the need to recruit physicians, advanced practice providers and support staff as necessary to meet community needs.
- Continue to provide education and wellness tips on news segments and social media.
- Expand maternal health initiatives including ARHOME and a New Prenatal Clinic
- Increase and expand Prenatal Wellness Center program and utilization of Hello Pregnancy app and women's clinics
- Prioritize utilizing the Mobile Health Unit to provide preventative health screening education and referrals to counties with a A.L.I.C.E. threshold of 50% or greater.
- Continue preventative health screening and referrals at Community Wellness Centers

PERFORMANCE METRICS:

- Provide preventive screenings, vaccinations, and related services to at least 200 community members
- Track and report the number of community outreach events hosted or attended by Baptist Health
- Measure and report the number of community members reached through health education, screenings, and outreach efforts
- Evaluate referral and follow-up rates for individuals connected to primary or specialty care through outreach initiatives
- Track maternal health program progress and growth
- Track Mobile Health Unit utilization and referral data

COLLABORATIONS WITH ORGANIZATIONS: Local nonprofits, faith-based organizations, community organizations

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS NEED: Staff time and clinical expertise, marketing and educational materials, community health supplies, vaccination resources, and ongoing support from the Marketing & Communications and Community Outreach

ESTIMATED COMPLETION DATE: Ongoing through 2028

PERSON(S)/DEPARTMENT RESPONSIBLE: Community Outreach, Pregnancy Clinic Team, ARHOME Team, Marketing and Communications

IDENTIFIED NEED 1:
Increase Access to Care and Education

GOALS/OBJECTIVE/OBJECTIVE:
Increase equitable access to specialized NICU and pediatric care for families facing geographic, financial, and emotional barriers through the Ronald McDonald House on the Little Rock campus.

STRATEGY 2:
Partner with the Ronald McDonald House (RMH) to provide essential supportive services on the Baptist Health campus that enable family presence and participation in care, thereby improving health outcomes and reducing disparities.

ACTION STEPS:
- Formalize Partnership and Referral Pathways: Establish a formal agreement with RMH to streamline the referral process for NICU and pediatric families in need of lodging and support.
- Educate Healthcare Staff and Families: Develop and disseminate educational materials for hospital staff and families about the benefits and services offered by RMH, emphasizing its role in supporting family-centered care.
- Integrate RMH Support into Discharge Planning: Incorporate RMH resources into discharge planning for NICU and pediatric patients, ensuring families are prepared for post-discharge care and have access to ongoing support.
- Collaborate on Ancillary Service Provision: Work with RMH to connect families with additional wraparound services such as meals, transportation, support groups, and sibling care, reducing family stress and allowing greater focus on patient care.

KEY PERFORMANCE METRICS:
- Number of families housed by RMH annually
- Average length of stay at RMH: Monitor the average duration families reside at RMH, correlating with the length of hospital stay.
- Average Distance from home annually
- Community Awareness Campaigns: Track coverage, printed and social media
- Capital Funding Secured: Track and report percentage of funding secured for implementation
- Reduction in NICU readmission rates tracked annually.

COLLABORATIONS WITH ORGANIZATIONS: Ronald McDonald House Charities of Arkansas & North Louisianal Baptist Health-Little Rock

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS NEED: Staff time and clinical expertise, marketing and educational materials, ongoing support from the Marketing & Communications

ESTIMATED COMPLETION DATE: Ongoing

PERSON(S)/DEPARTMENT RESPONSIBLE: Baptist Health Leadership

IDENTIFIED NEED 1:
Increase Access to Care and Education

GOAL/OBJECTIVE:
To improve community health by increasing health literacy and reducing barriers to accessing healthcare through community-led, culturally appropriate education and navigation support.

STRATEGY 3:
Health Literacy & Access to Healthcare

ACTION STEPS:
- Establish a Community Health Literacy committee to plan implementation and collaboration opportunities
- Equip internal staff and community leaders to train utilizing an evidence based curriculum for delivery.
- Identify target populations based on data and community need
- Launch community in-person, and virtual workshops to cover topics including understanding health information, communicating with healthcare providers, navigating healthcare, self-management and preventive health, understanding prescriptions, telehealth, patient rights
- Train community-based clinical and non-clinical staff in health-literate communication (e.g., Teach-Back, plain language)
- Evaluate impact and build sustainability plan

KEY PERFORMANCE METRICS:
- Curriculum identified and vetted for implementation
- Track the number of classes offered and participants
- Track pre/post test results to determine knowledge gained
- Track number of staff trained to implement the program
- Identified number of encounters using the Teach-Back method

COLLABORATIONS WITH ORGANIZATIONS: Cooperative Extension services, faith-based community leaders, local non-profit organizations

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS NEED: Staff time and clinical expertise, marketing and educational materials, ongoing support from the Marketing & Communications

ESTIMATED COMPLETION DATE: Ongoing

PERSON(S)/DEPARTMENT RESPONSIBLE: Community Outreach, Marketing & Communications

IDENTIFIED NEED 1:
Increase Access to Care and Education

GOALS/OBJECTIVE/OBJECTIVE:
Financial Empowerment for Healthcare: The goal is to move participants from financial crisis management to proactive planning. Show how sound budgeting and saving habits directly support access to care and health stability.

STRATEGY 4:
Financial Literacy & Access to Healthcare

ACTION STEPS:

- Identify a local Bank or Credit Union to partner in program delivery
- Partner with Community groups and organizations to implement class
- Incorporate Financial Literacy in Community Wellness Centers
- Incorporate Financial Literacy in Community Wellness Centers and Prenatal/Postpartum program by including the following educational topics
  - Control Your Money: Budgeting101
  - Understanding needs vs. wants, building a savings
  - Building a Savings for Emergencies and healthcare
  - Avoiding Money Traps: Debts & Credits
  - Protect Your Health: Financial Literacy
- Include information in all FoodRx bags (if applicable)
- Identify additional resources for referrals beyond classes

KEY PERFORMANCE METRICS

- Track the number of classes offered and number of participants
- Utilize pre and post test to determine knowledge gain
- Track number of community partners identified and utilized for implementation
- Track number of referrals for financial assistance

COLLABORATIONS WITH ORGANIZATIONS: Local Bank, Baptist Health Foundation, faith-based community leaders, local non-profit organizations

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS NEED: Staff time and clinical expertise, marketing and educational materials, ongoing support from the Marketing & Communications

ESTIMATED COMPLETION DATE: Ongoing

PERSON(S)/DEPARTMENT RESPONSIBLE: Community Outreach, Marketing & Communications

IDENTIFIED NEED 2:
Community Mental Health Strategy: Access, Education, Acceptance

GOALS/OBJECTIVE/OBJECTIVE:
Improve and increase access to mental health services, reduce stigma, and promote emotional well-being for residents of the Pulaski County

STRATEGY 1:
Strengthen collaboration with employers, healthcare providers, and community organizations to expand mental health education, increase access to counseling and crisis resources, and promote early intervention and resilience-building initiatives.

ACTION STEPS:

- Partner with healthcare organizations, locally and statewide, to increase the capacity to provide additional mental health services.
- Implementation Project to increase in-patient mental and behavioral health services.
- Provide Mental Health First Aid training to local schools, colleges, and community or faith-based organizations.
- Provide Community-based Stop the Bleed Trainings
- Participate in System-wide Mental Health Awareness Campaigns
- Integrate Mental Health Education and Awareness materials into Schools, Workplaces and community events
- Utilize Telepsych for patients in need of Telemedicine services
- Utilize Command Center to increase access and reduce barriers to mental health care in a timely manner
- Provide mental health screenings for pregnant and postpartum wellness center patients.
- Provide mental health education materials to new patients of the Little Rock and Southwest Pregnancy Clinics.
- Implement Wellness Meetups, a monthly wellness program that focuses on helping participants set SMART GOALS/OBJECTIVE related to mental health.

KEY PERFORMANCE METRICS:

- Track number of patient encounters in-patient withdrawal management services
- Track number of patient encounters utilizing Telepsych services
- Report number of Community partners and events for mental health services
- Track the number of mental health first aid and Stop the Bleed classes and participants
- Track the number of Mental Health First Aid trainings and attendance
- Measure campaign's reach through social media engagement, website visits, and printed material distribution.

IDENTIFIED NEED 2:
Community Mental Health Strategy: Access, Education, Acceptance

COLLABORATIONS WITH ORGANIZATIONS: Local schools, universities and businesses, non-profits and faith-based organizations

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS NEED: Staff time and clinical expertise, marketing and educational materials, community health supplies and ongoing support from the Marketing & Communications and behavioral health, command center and Community Outreach teams.

ESTIMATED COMPLETION DATE: Ongoing through 2028

PERSON(S)/DEPARTMENT RESPONSIBLE: Leadership, Behavioral Health, Community Outreach Marketing & Communications Manager, Case Management, Command Center

IDENTIFIED NEED 3:
Closing the Gap: A Strategy for Healthy Communities and Nutrition Security

GOALS/OBJECTIVE/OBJECTIVE: Increase knowledge of healthful food choices education and increasing access to food through the FoodRx initiative.

STRATEGY 1:
Increase access to nutrition education for community members.

ACTION STEPS:

- Implement Cooking with Community Outreach classes to empower participants to build cooking skills, cook more healthy meals, reduce food waste, and make healthier selections at the grocery store.
- Implement Maintain, Don't Gain holiday challenge program for adult community members that encourages using stress management strategies, physical activity, and healthful food choices during the holiday season to maintain one's physical and mental health and avoid holiday weight gain.
- Implement Wellness Meetups, a monthly wellness program that focuses on nutrition, physical activity, mental health, or other wellness areas.
- Implement nutrition education for pregnant and postpartum mothers to also empower healthier food choices for mom, baby and family.
- Implement the Healthy Active Youth and Families (HAYF) nutrition and physical activity program.
- Utilize the FoodRx program for Employees, AHG Clinics, PACE program, and Community Wellness Centers to provide food.
- Implement Arkansas Fruit and Vegetable Prescription Program with the Arkansas Hunger Relief Alliance to distribute fresh produce to food-insecure patients with a diet-related chronic health condition.

KEY PERFORMANCE METRICS

- Implementation of two Cooking With Community Outreach classes per year.
- Track number of FoodRx program participants, programs and food distributions.
- Offer three nutrition or diet-related Wellness Meetup programs each year.
- Track participants of "mom and tot" hands on cooking classes.
- Track number of participants for lactation support classes for nursing mothers.
- Track number of HAYF program series offered and number of participants.
- Measure skin carotenoid levels using Veggie Meter before and after HAYF program implementation.

COLLABORATIONS WITH ORGANIZATIONS: Arkansas Foodbank, Arkansas Hunger Relief Alliance

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS NEED: Staff time and clinical expertise, marketing and educational materials, ongoing support from the Marketing & Communications

ESTIMATED COMPLETION DATE: Ongoing

PERSON(S)/DEPARTMENT RESPONSIBLE: Community Outreach, Marketing & Communications

IDENTIFIED NEED 3:
Closing the Gap: A Strategy for Healthy Communities and Nutrition Security

STRATEGY 2:
Mobile Health Unit (MHU) "Food as Medicine" Initiative
To improve the health and nutritional well-being of underserved community members by utilizing the Mobile Health Unit (MHU) to proactively identify individuals experiencing food insecurity, provide immediate relief through nutritious food access, and ensure sustainable connectivity to community food resources.

ACTION STEPS:

- Utilize the Standardized Food Insecurity Screening Protocol to screen all patients/individuals at pre-determined locations
- Develop and deploy food boxes in cooperation with the Arkansas Foodbank
- Identify and schedule high-need service locations. Using Arkansas Foodbank data and existing CHNA data (low-income census tracts, areas with high chronic disease rates, or known food deserts) to create a quarterly MHU route schedule.
- Identify key preventative screenings to be offered at each distribution event
- Promote the schedule through local channels (churches, community centers, public libraries) using clear, accessible flyers and social media to maximize attendance for free health screenings.
- Implement a short-term follow-up mechanism to measure the impact of referrals.

KEY PERFORMANCE METRICS:

- Number of scheduled MHU visits that occurred in high need areas
- Track and report the number of bags and pounds of food distributed
- Track and report health outcomes for the population being screened
- Percentage of food-insecure clients who confirm they utilized at least one resource on the provided local pantry list during the 30-day follow-up call.
- Track other social determinants of health identified and referrals

COLLABORATIONS WITH ORGANIZATIONS: Arkansas Foodbank, Arkansas Hunger Relief Alliance

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS NEED: Staff time and clinical expertise, marketing and educational materials, ongoing support from the Marketing & Communications

ESTIMATED COMPLETION DATE: Ongoing

PERSON(S)/DEPARTMENT RESPONSIBLE: Community Outreach, Marketing & Communications

BAPTIST HEALTH MEDICAL CENTER
Conway

About Us

Baptist Health Medical Center-Conway is a faith-based, state-of-the-art facility offering an integrated healing environment for the care and comfort of patients and families. Our 260,000 square-foot facility features 111 beds and eight operating rooms. Our care teams, nurses and physicians are here to provide amazing care to keep you and your family healthy and well.

Baptist Health Medical Center-Conway provides comprehensive medical services within our hospital facility as well as offerings for care at a number of conveniently located family clinics and specialty clinics in and around the Conway area.

Community Health Needs Assessment 2026-2028
Baptist Health Medical Center-Conway

HIGHLIGHTS OF COMMUNITY HEALTH NEEDS ASSESSMENT ACCOMPLISHMENTS 2023-2025

Access to Care:

- Expanded Specialty Women's Health: Welcomed Danica Ordonez, MD, an American Board of Obstetrics and Gynecology certified physician, to the Baptist Health Women's Clinic-Conway team. Dr. Micah Wiegel was also added to the clinic.
- Promoted access to three new urgent care centers
- Strengthened Primary Care Network (Conway): Added three new family medicine providers—Dr. Meryem Maras-Casey, Dr. Jovan Baker, and the opening of the Baptist Health Family Clinic-Conway West.
- Expanded Gastroenterology Services: Added three new advanced practice registered nurses (Brandy Eason, Sarah Atkins, and Kara "Lindsey" Sierra, APRNs) to the Baptist Health Gastroenterology Clinic-Conway.
- Introduced Key Endocrinology Specialist: Joined with Dr. Anvitha Ankireddypalli to expand Endocrinology services.
- Established New Russellville Presence: Opened the Baptist Health Family Clinic-Russellville, staffed by a physician and two APRNs/DNPs, and opened two new Baptist Health Urgent Care locations in Russellville.
- Launched Outreach Clinics for Cardiology and General Surgery in Russellville.
- Ensured 24/7/365 OB Emergency Access: Implemented an OB Hospitalist program to provide 24/7/365 physician coverage for pregnant women in the OB Emergency Department.
- Achieved Elite Stroke Care Recognition: Baptist Health Medical Center-Conway earned the Silver Plus with Target: Stroke Honor Roll Elite for high-quality stroke care.
- Recognized for Organ Donor Engagement: Earned national recognition from HRSA for outstanding efforts in increasing organ, tissue, and eye donor awareness through the DoNation Campaign.
- Awarded for Superior Maternity Safety: Named one of the best hospitals in the nation for maternity care by both the Leapfrog Hospital Safety Grade (based on an A/B grade and high safety standards) and the Leapfrog Group.
- Achieved Exclusive "Baby-Friendly" Status: Became the only hospital in Faulkner County accredited as "Baby-Friendly USA," recognizing optimal care for breastfeeding mothers and infants.
- Designated as a Level III Trauma Center: The Conway Emergency Department is equipped as a Level III Trauma Center to provide advanced trauma life support.
- Boosted Community Vaccination Efforts: Partnered with Goodwill Industries to offer free Flu Vaccinations.
- Increased Preventative Screening Access: Offered access to preventative health screenings and vaccinations to community groups at major local events, including the Conway Business Expo and Toad Suck Days
- As a Healthcare System participated in the Increased Virtual Care Access: 30,000 outpatient virtual care encounters
- As a Healthcare System participated in Enhancing Remote Patient Monitoring: 40,000 remote patient encounters for cardiac care provided.
- Partnered with PBS Television Station providing First Aid and education for its annual Family Day and Education during PBS Television StationFamily Day

Mental Health Awareness:

- Provided "Make it Okay" mental health awareness information at screening events to reduce the stigma of mental illness in at least one community
- System-wide Behavioral Health services developed for distribution
- Partnered with Community Connections to sponsor annual event designed to improve lives of children and families with special needs
- Telepsychiatry visits provided for in-patients

Food Insecurity

- Offered access to FoodRx program internally for employees and patients who are food insecure.for 394 visits
- Partner with 7 AHG clinics to screen for Food Insecurity and provide 273 bags of food through the FoodRx program for those in need
- Promoted a six week virtual "Maintain, Don't Gain" holiday challenge program for adult community members that encourages using stress management strategies, physical activity, and healthful food choices during the holiday season to maintain one's physical and mental health and avoid holiday weight gain
- 100% of Virtual Admission Patients screened for Food In-security
- Partnered with Sallie Cone Preschool to offer a cooking with Community Outreach class.
- The Oakwood Apartment living for seniors were provided food boxes by the P.A.C.E. program

2025 BAPTIST HEALTH COMMUNITY HEALTH NEEDS ASSESSMENT: CONWAY

ACHI
August 2025

Baptist Health

PREPARED BY:
ACHI
INSPIRING HEALTHY ACTS

Introduction

Baptist Health engaged the Arkansas Center for Health Improvement (ACHI) to conduct the quantitative data collection and analysis for the 2025 Community Health Needs Assessment (CHNA) process. Baptist Health provided ACHI with the counties served by each of its 12 hospital communities. A total of 16 Arkansas counties and two Oklahoma counties were included.

Each report presents community-level data for a hospital community, including tables and figures for each indicator, along with comparisons to Arkansas and U.S. benchmarks. Dot graphs are provided to visualize performance across selected indicators. All reports are prepared using the same methodology to ensure consistency and comparability across Baptist Health hospital communities.

Methodology

A summary of sources, definitions, indicator criteria, and suppression rules can be found in the methods and sources document.

Community Profile Summary

To support the 2025 Community Health Needs Assessment (CHNA), ACHI compiled a comprehensive dataset of 103 health and demographic indicators for the communities served by Baptist Health's 12 hospital locations. This section provides an overview of these indicators across the full CHNA service area and offers multiple views for understanding and comparing county-level and community-level data.

Data are grouped into the following 14 categories, based on the source-defined domains outlined in the data source reference sheet:

1. Demographics
    a. Age
    b. Sex
    c. Race, Ethnicity, and Language
2. Insurance Coverage
3. Access to Care
4. Cause of Death
5. Chronic Conditions
6. Diagnoses Incidence at Discharge
7. Environment
8. Health Behaviors
9. Health Outcomes
10. Healthcare Expenditures
11. Maternal and Infant Health
12. Mental Health and Substance Use
13. Prevention
14. Social and Economic Factors

Measurements for these categories will be displayed in the following sections.

Hospital Community Indicator

The hospital community indicator snapshots offer an at-a-glance view of how each hospital community compares to state and national benchmarks, as well as the counties that make up the community.

Each table presents the data values for selected indicators across the 14 CHNA domains, and each corresponding visual uses proportionally scaled circular markers to illustrate performance. This format is designed to quickly convey how each hospital community aligns with or diverges from broader benchmarks in key population health metrics.

Each displays four comparison points:

- **Purple** – Represents the national value for the indicator.
- **Blue** – Represents the value for the state of Arkansas.
- **Gold** – Represents the weighted average for all counties in the hospital's defined service area.
- **Gray** – Represent the values of each county assigned to that hospital community.

Where available, data for each indicator are shown for all four categories. If a value is not available or is suppressed for a contributing county, it is noted as "Not Available" in the table and excluded from the visual display. No color ranking is applied; the visuals and tables are intended to illustrate relative placement, not comparative rank.

Hospital Community: Conway (Faulkner and Perry Counties)

Figure 1. Counties Served by Baptist Health Medical Center–Conway

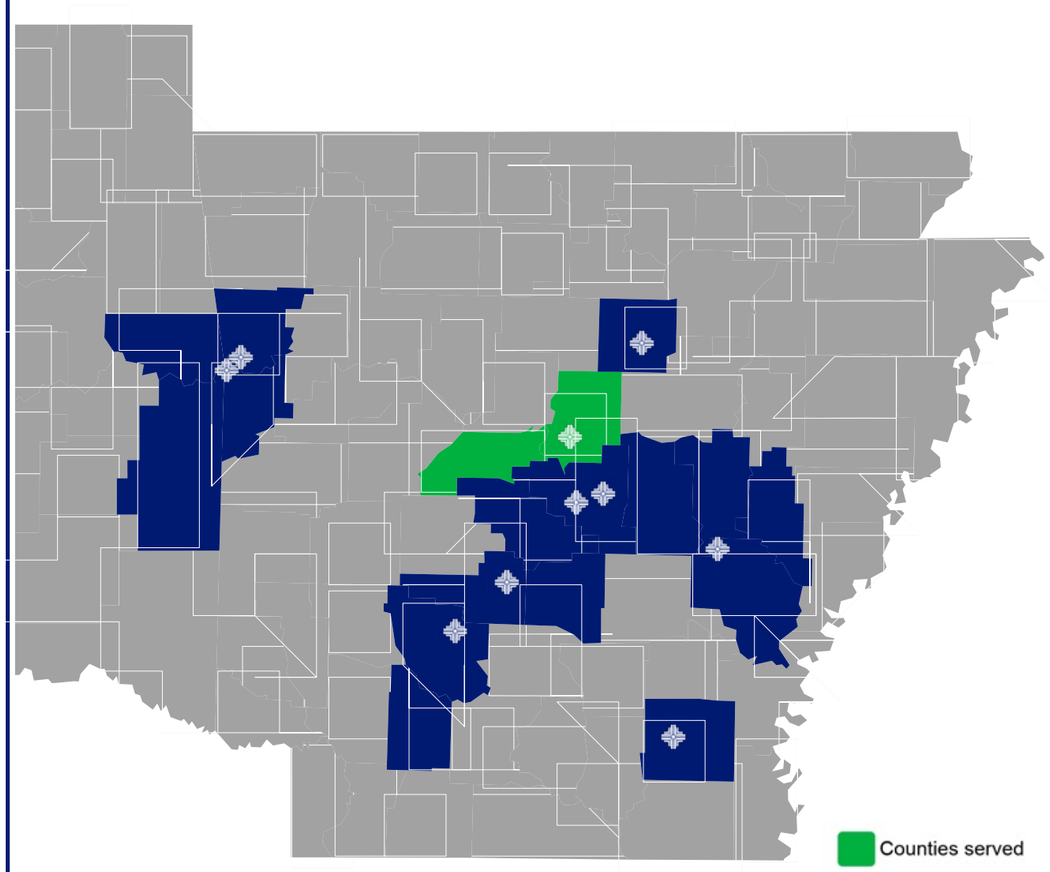


Table 1. Demographics: Age and Sex

		Perry County	Faulkner County	Community Average	State	National
Total Population	*Number*	10,073	126,001	136,074	3,032,651	332,387,540
Female	*Percent*	49.17%	51.25%	51.10%	50.67%	50.50%
Male	*Percent*	50.83%	48.75%	48.90%	49.33%	49.50%
Ages 0-4	*Percent*	4.88%	5.88%	5.81%	6.02%	5.70%
Ages 5-17	*Percent*	16.96%	16.91%	16.91%	17.26%	16.46%
Ages 18-24	*Percent*	6.30%	14.95%	14.31%	9.33%	9.12%
Ages 25-34	*Percent*	10.56%	13.76%	13.52%	12.93%	13.69%
Ages 35-44	*Percent*	12.76%	12.94%	12.93%	12.66%	13.08%
Ages 45-54	*Percent*	13.17%	11.04%	11.20%	11.84%	12.29%
Ages 55-64	*Percent*	14.84%	11.09%	11.37%	12.64%	12.82%
Ages 65+	*Percent*	20.52%	13.43%	13.95%	17.33%	16.84%

Figure 2. Demographics: Age and Sex

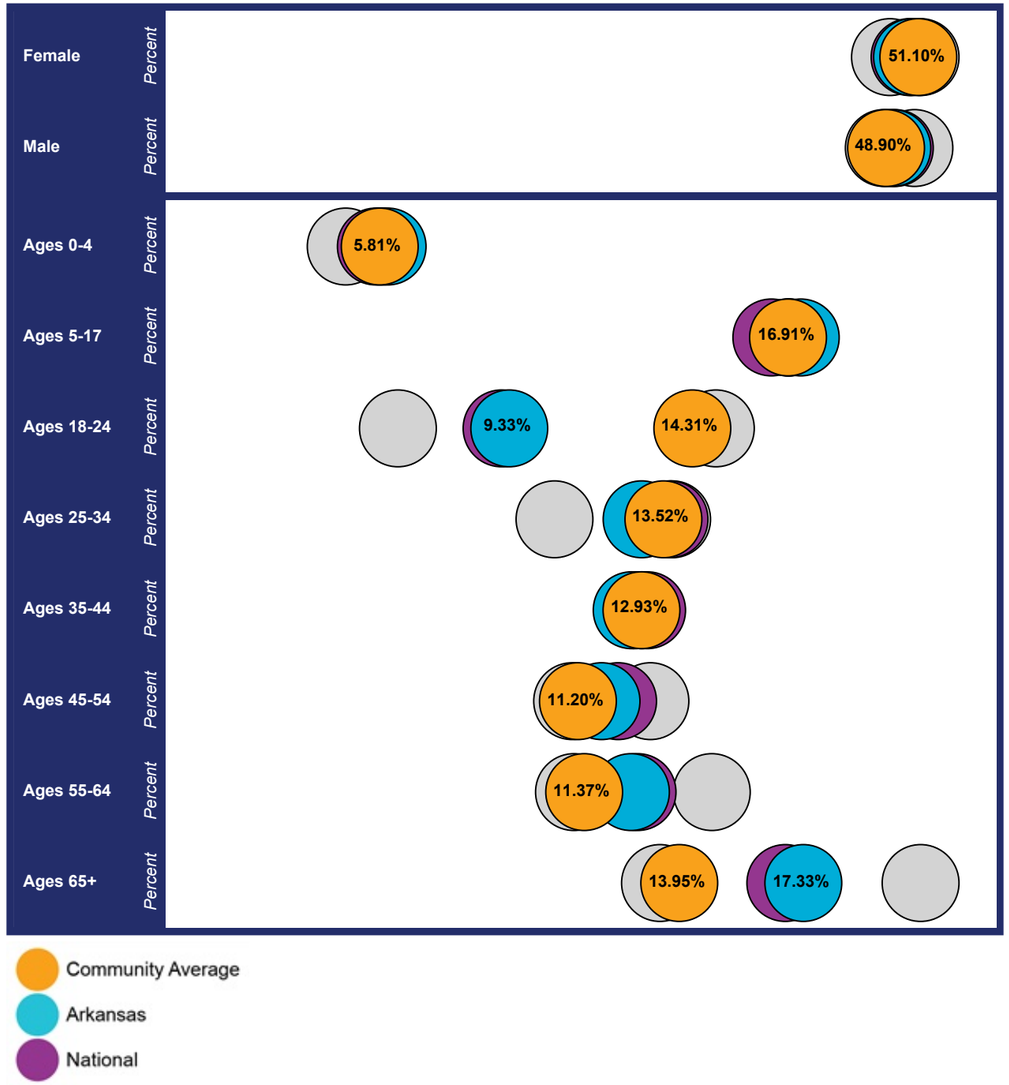


Table 2. Demographics: Race, Ethnicity, and Language

		Perry County	Faulkner County	Community Average	State	National
Total Population	*Number*	10,073	126,001	136,074	3,032,651	332,387,540
Asian	*Percent*	0.41%	1.05%	1.00%	1.53%	5.75%
Black or African American	*Percent*	1.78%	11.73%	10.99%	14.84%	12.03%
Hispanic	*Percent*	3.30%	5.52%	5.36%	8.77%	18.99%
Multiple Races	*Percent*	4.23%	3.50%	3.55%	5.50%	3.87%
Native American/ Alaska Native	*Percent*	0.20%	0.22%	0.22%	0.36%	0.53%
Native Hawaiian/ Pacific Islander	*Percent*	0.00%	0.03%	0.03%	0.39%	0.17%
Other Races	*Percent*	0.00%	0.28%	0.26%	0.26%	0.50%
White	*Percent*	90.09%	77.67%	78.59%	68.36%	58.17%
Non-English Language Households	*Percent*	0.00%	0.90%	0.83%	1.50%	4.20%

Figure 3. Demographics: Race, Ethnicity, and Language

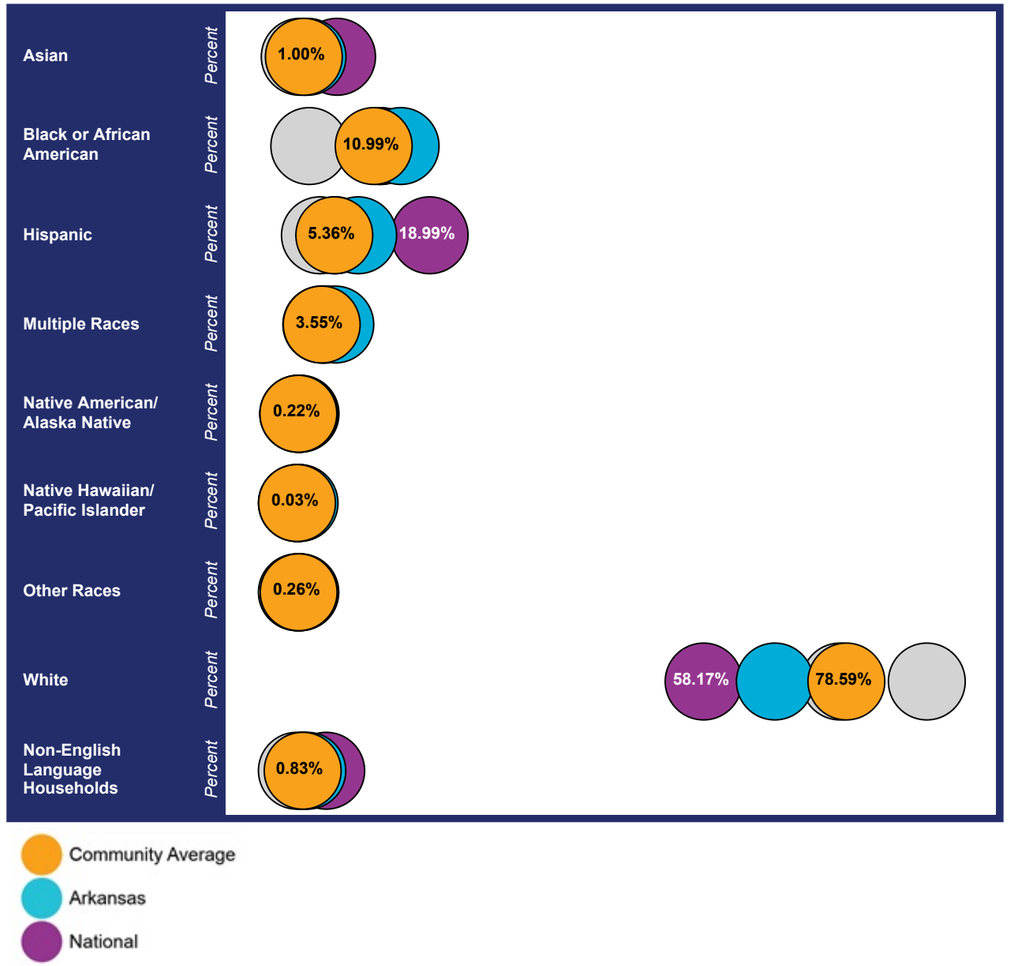


Table 3. Insurance Coverage

		Perry County	Faulkner County	Community Average	State	National
Private Health Insurance Coverage	*Percentage of the total civilian non-institutionalized population for whom insurance status is determined that is covered by private health insurance*	64.50%	74.39%	73.66%	65.37%	73.62%
Public Health Insurance Coverage	*Percentage of the total civilian non-institutionalized population for whom insurance status is determined that is covered by public health insurance*	50.29%	37.54%	38.48%	48.21%	39.70%
Uninsured	*Percentage of adults under age 65 without health insurance coverage*	9.10%	7.60%	7.71%	10.00%	9.50%

Figure 4. Insurance Coverage

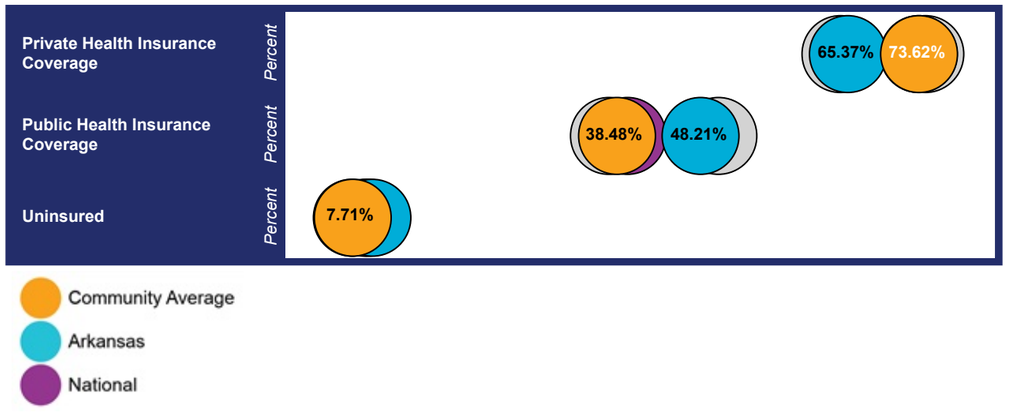


Table 4. Access to Care

		Perry County	Faulkner County	Community Average	State	National
Primary Care Physicians	*Ratio of population to one primary care physician*	4982:1	1690:1	1934:1	1478:1	1334:1
Mental Health Providers	*Ratio of population to one mental health provider*	Not Available	513:1	513:1	367:1	300:1
Dentists	*Ratio of population to one dentist*	Not Available	2321:1	2321:1	2044:1	1361:1
Active Primary Care Physicians	*Rate per 10,000 county residents of primary care physicians who provided evaluation and management services to at least two patients on the same day at least once during the year*	3.00	13.40	12.63	9.20	Not Available
Addiction or Substance Use Providers	*Rate of addiction or substance use providers per 100,000 population*	0.00	3.24	3.00	5.98	29.43
Buprenorphine Providers	*Rate of buprenorphine providers per 100,000 population*	0.00	4.78	4.43	9.81	14.87
Preventable Hospital Stays (Medicare)	*Rate of hospital stays for ambulatory care-sensitive conditions per 100,000 Medicare enrollees*	3292.00	2654.00	2701.23	3014.00	2666.00
Diabetic Monitoring (Medicare)	*Percentage of Medicare enrollees aged 65 and older with diabetes who received a hemoglobin A1c (HbA1c) test within the past year.*	89.24%	87.73%	87.84%	88.47%	87.53%
Mammography	*Percentage of female Medicare enrollees ages 65-74 who received an annual mammography screening*	43.00%	42.00%	42.07%	41.00%	44.00%

Figure 5. Access to Care

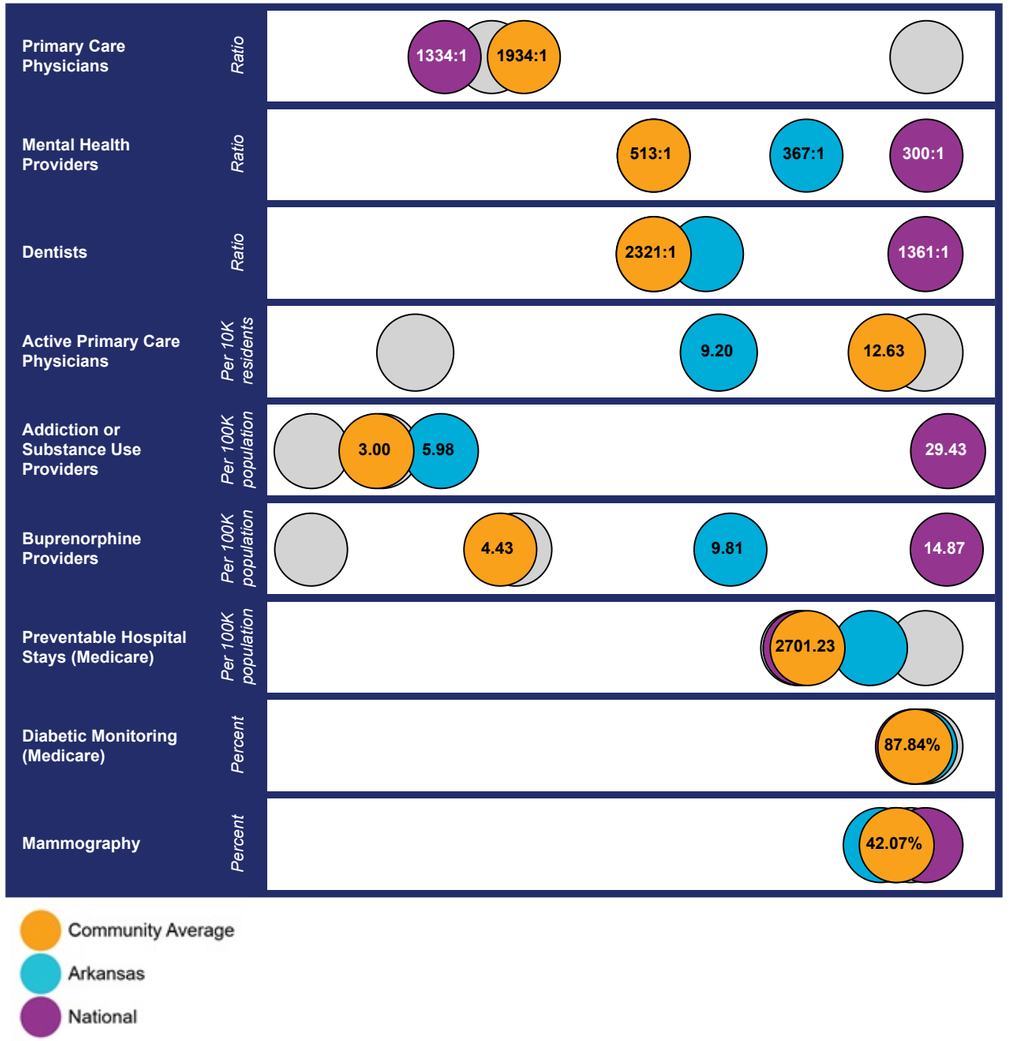


Table 5. Cause of Death

		Perry County	Faulkner County	Community Average	State	National
All Causes	*Rate of deaths by all causes per 100,000 population (age-adjusted)*	1009.00	914.30	921.31	1001.70	805.60
Premature Death	*Number of deaths among residents under age 75 per 100,000 population (age-adjusted)*	516.77	453.73	458.39	552.47	406.59
Heart Disease	*Rate of death due to heart disease (ICD-10 Codes I00-I09, I11, I13, I20-I151) per 100,000 population*	296.10	186.60	194.71	282.80	207.20
Cancer	*5-year average rate of death due to cancer per 100,000 population*	270.60	154.80	163.37	215.90	182.70
Unintentional Injury	*5-year average rate of death due to unintentional injury (accident) per 100,000 population*	70.60	46.90	48.65	61.90	63.30
Stroke	*5-year average rate of death due to cerebrovascular disease (stroke) per 100,000 population (age-adjusted)*	82.40	57.30	59.16	57.40	48.30
Chronic Lower Respiratory Disease	*Rate of deaths due to chronic lower respiratory disease per 100,000 population (age-adjusted)*	72.50	56.60	57.78	61.00	35.90
Diabetes Mortality	*Rate of deaths due to diabetes per 100,000 population (age-adjusted)*	32.20	23.80	24.42	34.70	23.90
Suicide Deaths	*This indicator reports the 2019-2023 five-year average rate of death due to intentional self-harm (suicide) per 100, 000 population. Figures are reported as crude rates*	Not Available	15.70	15.70	19.20	14.50
Motor Vehicle Crash	*5-year average rate of death due to motor vehicle crash per 100,000 population (age-adjusted)*	Not Available	14.00	14.00	20.60	12.80
Alcohol-	*Rate of persons killed in motor vehicle*					

Figure 6. Cause of Death

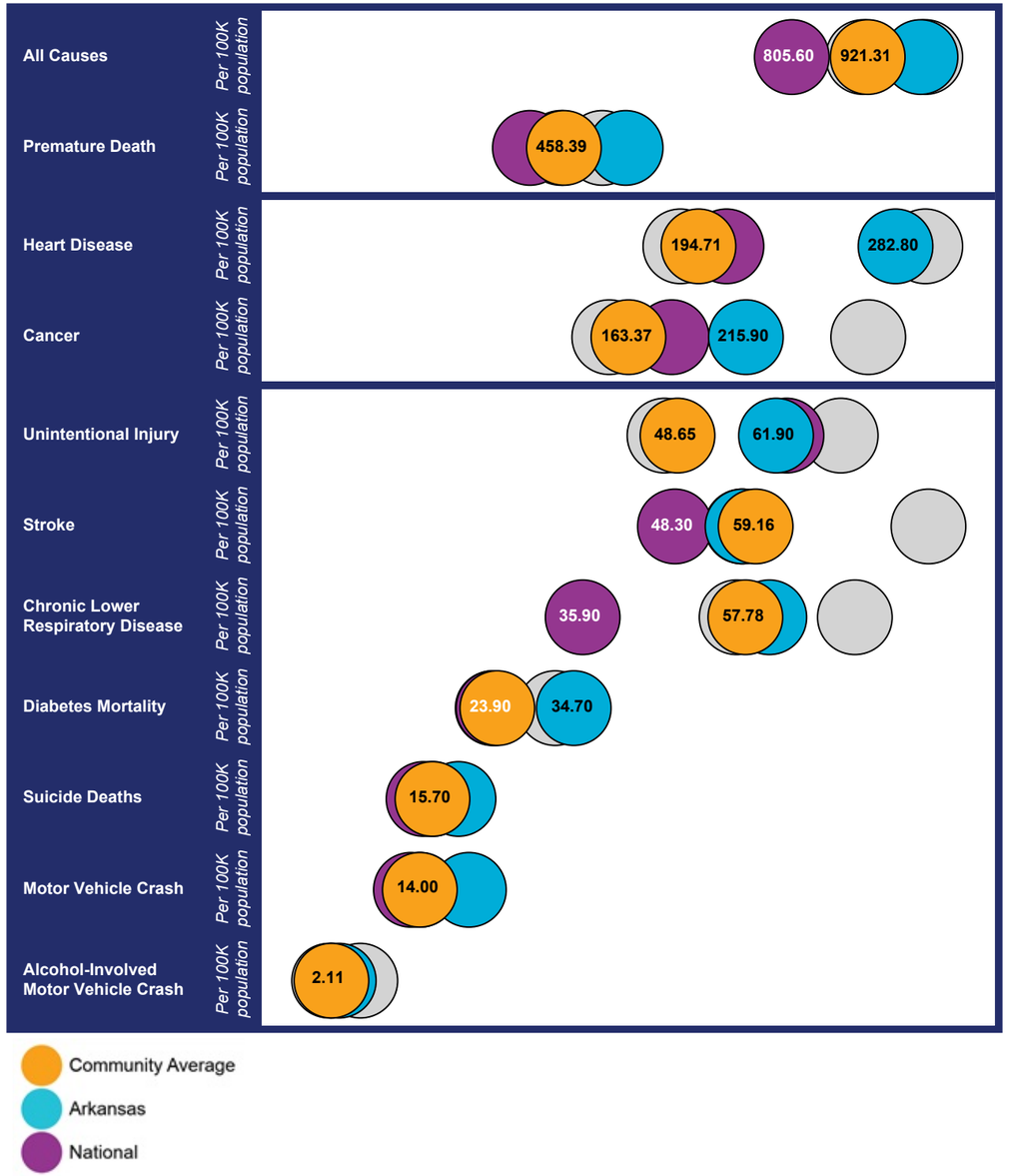


Table 6. Chronic Condtions

		Perry County	Faulkner County	Community Average	State	National
Child Obesity	*Percentage of students classified as overweight to severely obese, by county location of school*	42.04%	38.38%	38.65%	40.10%	Not Available
High Cholesterol	*Percentage of adults who have had their blood cholesterol checked and have been told it was high (age-adjusted)*	31.80%	31.50%	31.52%	31.80%	30.40%
Adult Obesity	*Percentage of adults ages 20 and older who report a BMI higher than 30*	23.40%	31.50%	30.90%	31.90%	30.10%
High Blood Pressure	*Percentage of adults who have been told they have high blood pressure (age-adjusted)*	35.50%	34.70%	34.76%	36.50%	29.60%
Arthritis	*Percentage of adults ages 18 or older diagnosed with some form of arthritis*	32.70%	27.10%	27.51%	32.60%	Not Available
Diabetes Prevalence	*Percentage of adults age 18 and older who report ever been told that they have diabetes other than diabetes during pregnancy (age-adjusted)*	12.20%	11.90%	11.92%	12.70%	10.40%
Asthma	*Percentage of adults who have been told they currently have asthma (age-adjusted)*	11.00%	10.60%	10.63%	11.00%	9.90%
Coronary Heart Disease	*Percentage of adults age 18 and older who report ever having been told by that they had angina or coronary heart disease (CHD) (age-adjusted)*	7.40%	6.70%	6.75%	7.20%	5.70%

Figure 7. Chronic Conditions

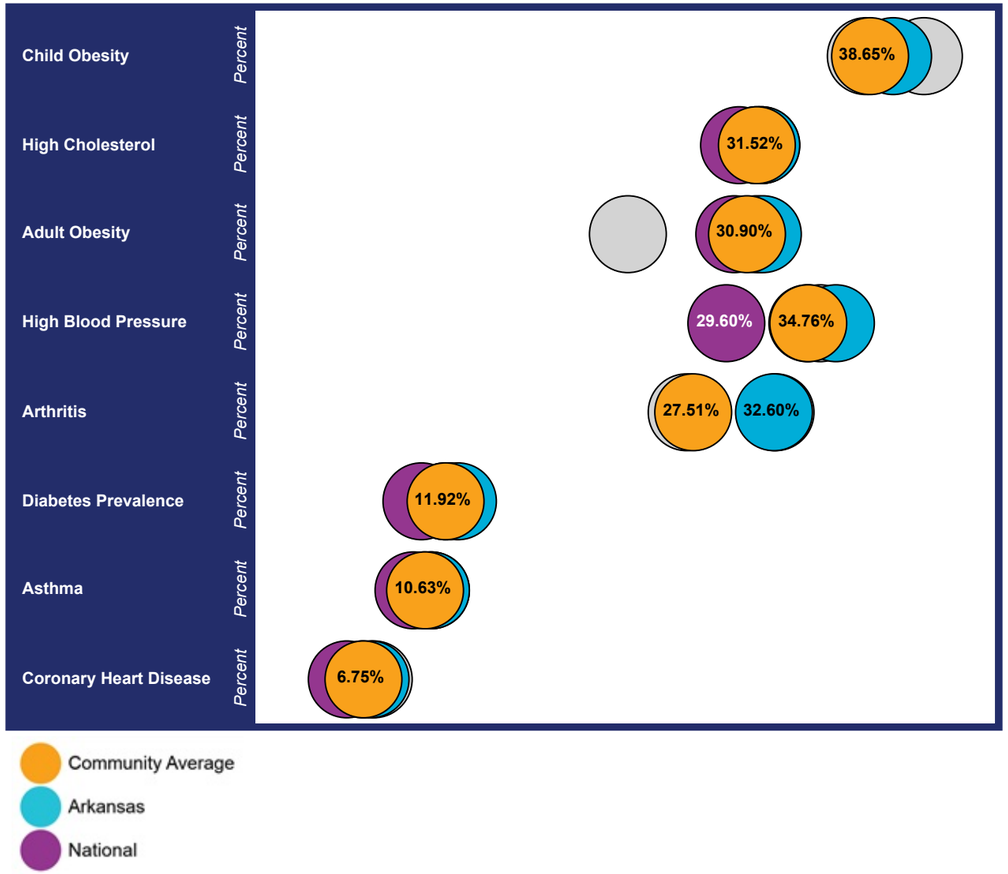


Table 7. Diagnoses at Discharge

		Perry County	Faulkner County	Community Average	State
Hypertension	*Number of individuals 18 years and older discharged with a primary or secondary hypertension diagnosis as a percentage of the population 18 years and older*	10.89%	7.22%	7.49%	8.70%
Hyperlipidemia	*Number of individuals 18 years and older discharged with a primary or secondary hyperlipidemia diagnosis as a percentage of the population 18 years and older*	4.57%	3.15%	3.26%	3.90%
Diabetes	*Rate of individuals 18 years and older discharged with a primary or secondary diabetes diagnosis as a percentage of the population 18 years and older*	4.69%	3.11%	3.23%	3.70%
Ischemic Heart Disease	*Number of individuals 18 years and older discharged with a primary or secondary ischemic heart disease diagnosis as a percentage of the population 18 years and older*	3.08%	1.61%	1.72%	2.50%
Arthritis	*Rate of individuals 18 years and older discharged with a primary or secondary arthritis diagnosis as a percentage of the population 18 years and older*	2.22%	1.55%	1.60%	1.90%

Figure 8. Diagnoses at Discharge

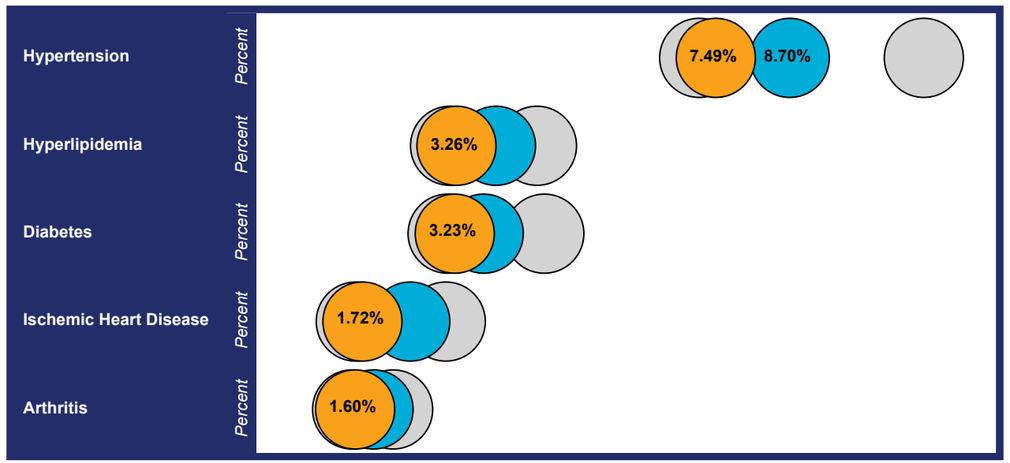


Table 8. Environment

		Perry County	Faulkner County	Community Average	State	National
Food Environment Index	*Index of factors that contribute to a healthy food environment, 0 (worst) to 10 (best)*	6.70	6.60	6.61	4.40	7.40
Drinking Water Violations	*The total number of drinking water violations recorded in a two-year period*	0	4	3	321	16,107
Access to Exercise Opportunities	*Percentage of population with adequate access to locations for physical activity*	47.79%	64.57%	63.32%	63.36%	84.45%
Broadband Access	*Percentage of population in a high-speed internet service area; access to DL speeds >= 25MBPS and UL speeds >= 3 MBPS*	99.20%	93.17%	93.62%	94.04%	96.78%
Long Commute Driving Alone	*Among workers who commute in their car alone, the percentage who commute more than 30 minutes*	59.10%	40.20%	41.60%	28.10%	36.50%
Severe Housing Problems	*Percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities*	8.85%	15.74%	15.23%	13.23%	16.84%

Community Average
Arkansas
National

Figure 9. Environment

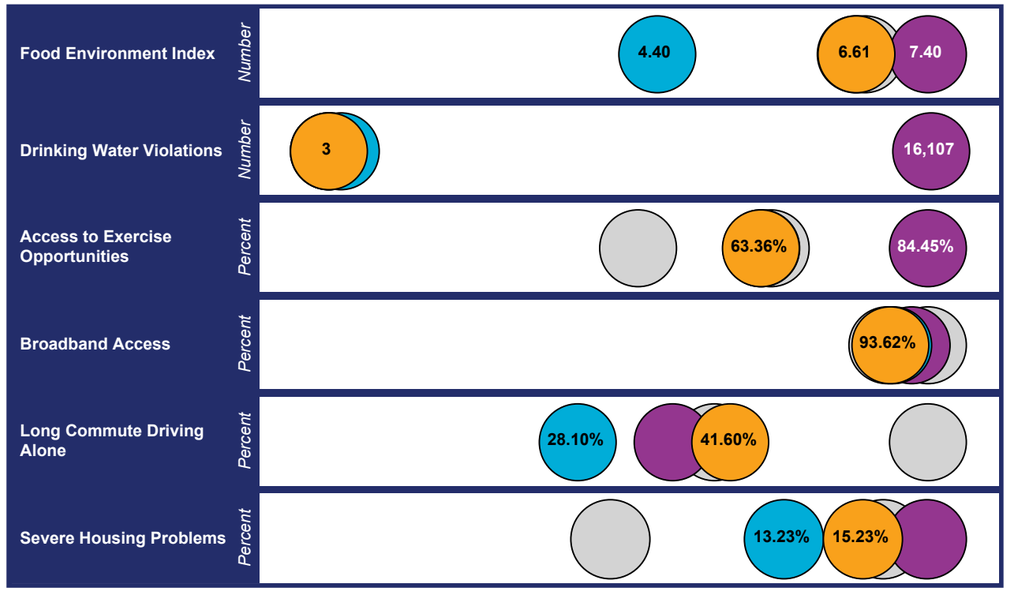


Table 9. Health Behaviors

		Perry County	Faulkner County	Community Average	State	National
Physical Inactivity	*Percentage of adults aged 20 and older who self-report no leisure time for activity*	19.50%	22.30%	22.09%	23.60%	19.50%
Adult Smoking	*Percentage of adults ages 18 and older who are current smokers (age-adjusted)*	20.40%	16.10%	16.42%	19.20%	13.20%
Youth Vaping	*Percentage of public school students in 6th, 8th, 10th, and 12th grade who used any vape in the past 30 days*	Not Available	10.00%	10.00%	8.10%	Not Available
Sexually Transmitted Infections	*Number of newly diagnosed chlamydia cases per 100,000 population*	198.70	524.80	500.66	588.30	495.00

Figure 10. Health Behaviors

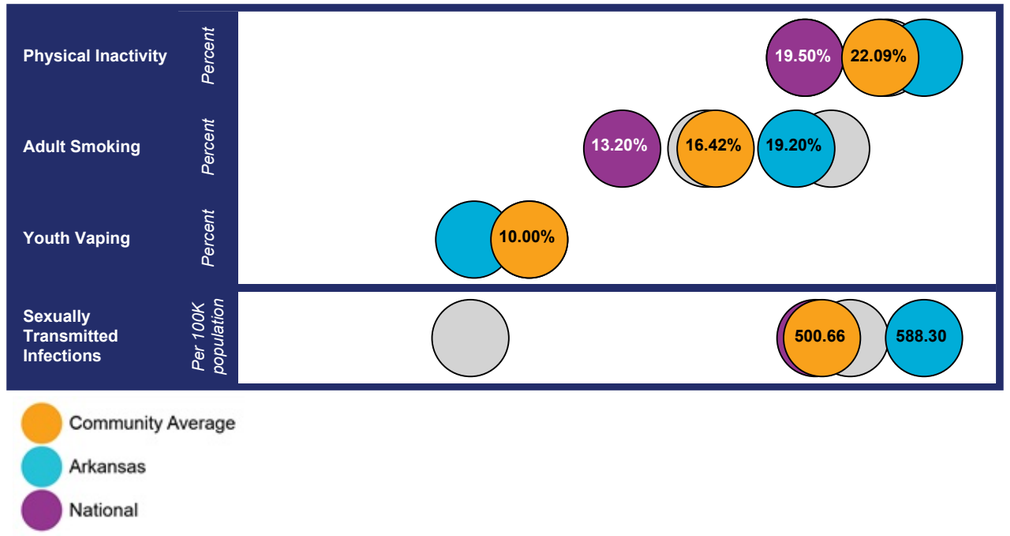


Table 10. Health Outcomes

		Perry County	Faulkner County	Community Average	State	National
Poor Physical Health Days	*Average number of physically unhealthy days reported in past 30 days (age-adjusted)*	**5.30**	**5.00**	**5.02**	**5.20**	**3.90**
Poor or Fair Health	*Percentage of adults age 18 and older who self-report their general health status as "fair" or "poor" (age-adjusted)*	**21.80%**	**19.40%**	**19.58%**	**22.60%**	**17.00%**

Figure 11. Health Outcomes

Table 11. Healthcare Expenditures

		Perry County	Faulkner County	Community Average	State	National
Average Annualized Expenditures	*Average annualized per-person spending on all covered healthcare services.*	**$10,314**	**$11,098**	**$11,039**	**$10,116**	**Not Available**
Average Annualized Expenditures (Medical Only)	*Average annualized per-person spending on medical services, based on medical claims.*	**$7,203**	**$7,982**	**$7,924**	**$7,252**	**Not Available**
Average Annualized Expenditures (Pharmacy Only)	*Average annualized per-person spending on prescription drugs, based on pharmacy claims.*	**$2,800**	**$2,838**	**$2,835**	**$2,609**	**Not Available**

Figure 12. Healthcare Expenditures

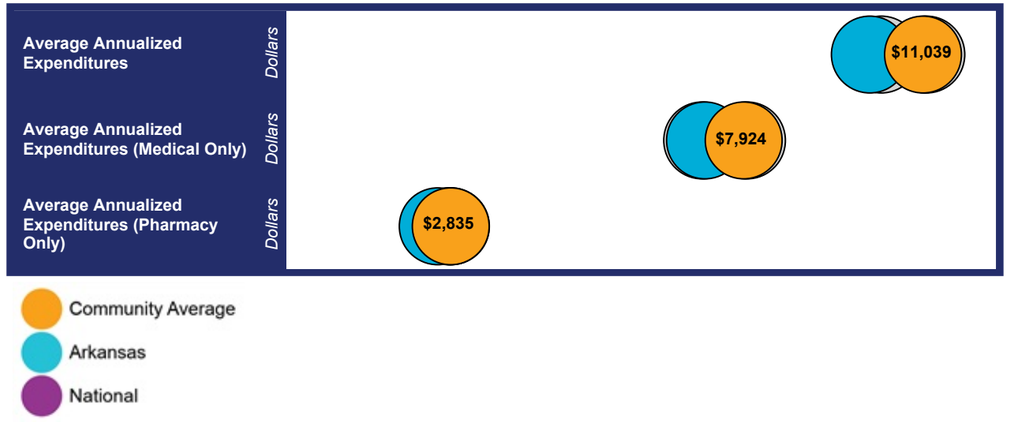


Table 12. Maternal and Infant Health

		Perry County	Faulkner County	Community Average	State	National
Active Obstetrics and Gynecology Physicians	*Active OB-GYN physicians are defined as those who provided evaluation and management services to at least two female patients ages 12-55 on the same day or performed a qualifying procedure (e.g., delivery) at least once during the year.*	**0.00**	**6.00**	**5.56**	**3.20**	**Not Available**
Teen Births	*The seven-year average number of teen births per 1,000 female population, ages 15-19*	**25.60**	**16.20**	**16.90**	**27.90**	**15.50**
C-Section Rate	*Percentage of live births delivered via cesarean section among all deliveries, calculated by the mother's county of residence.*	**43.46%**	**34.64%**	**35.30%**	**33.48%**	**Not Available**
C-Section Rate, First Birth	*Percentage of first-birth deliveries (full-term singleton pregnancies in a head-down position) delivered via cesarean section, calculated by the mother's county of residence.*	**32.05%**	**28.70%**	**28.95%**	**27.58%**	**Not Available**
Low Birthweight	*Percentage of live births where the infant weighed less than 2, 500 grams (approximately 5 lbs., 8 oz.)*	**8.70%**	**8.50%**	**8.51%**	**9.40%**	**8.40%**
Preterm Birth	*Percentage of live births that are preterm (<37 weeks), calculated as a three-year average.*	**11.20%**	**11.50%**	**11.48%**	**11.90%**	**10.35%**
Median Travel Time to Delivery	*Median number of minutes Arkansas mothers traveled from their home ZIP code to the delivery facility, calculated using birth records and*	**31.00**	**7.00**	**8.78**	**16.00**	**Not Available**

Figure 13. Maternal and Infant Health

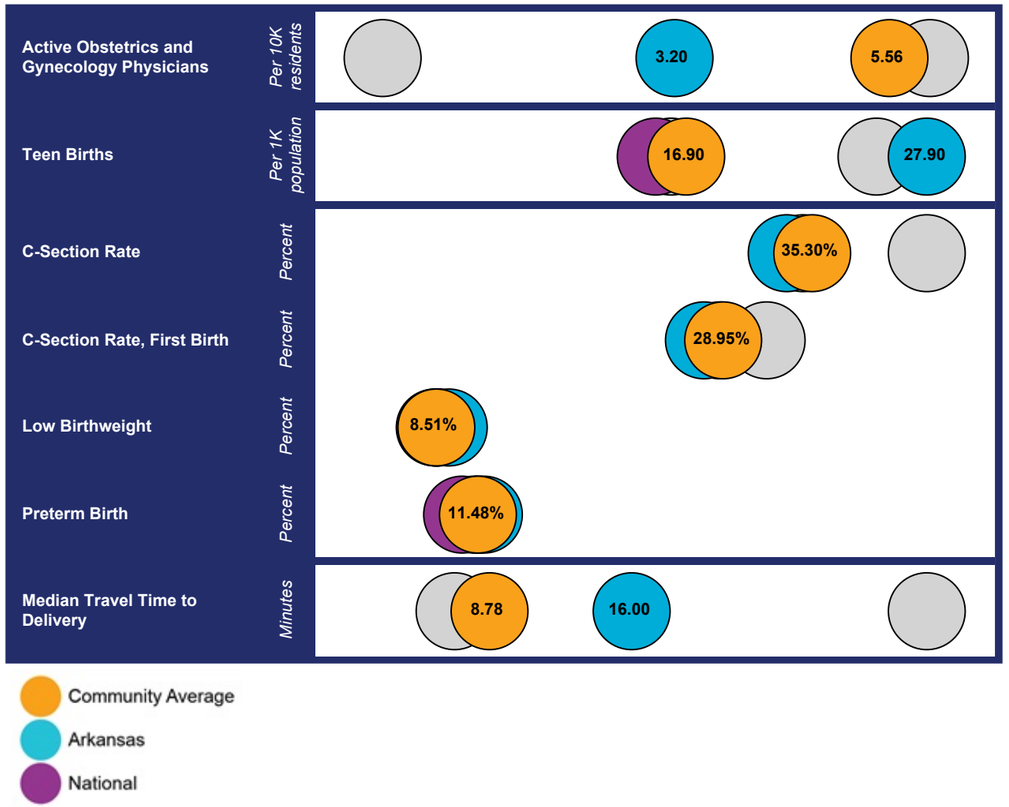


Table 13. Mental Health and Substance Use

		Perry County	Faulkner County	Community Average	State	National
Adult Depression	*Percentage of adults age 18 and older who report having been told that they had depressive disorder*	29.20%	27.50%	27.63%	27.50%	21.10%
Excessive Drinking	*Percentage of adults reporting binge or heavy drinking*	19.53%	17.77%	17.90%	18.99%	19.35%
Poor Mental Health	*Percentage of adults age 18 or older reporting poor mental health for 14 or more days (age-adjusted)*	21.40%	19.60%	19.73%	20.50%	16.40%
Youth Depression	*Percentage of public school students in 6th, 8th, 10th, and 12th grade who had feelings of depression all of the time in the past 30 days*	Not Available	14.30%	14.30%	9.20%	Not Available
Drug Overdose Deaths	*Age-adjusted rate of fatal drug overdoses per 100,000 residents*	0.00	Not Available	0.00	Not Available	Not Available
Non-Fatal Drug Overdoses	*Age-adjusted rate of non-fatal drug overdoses per 100,000 residents*	Not Available	49.71	49.71	Not Available	Not Available

Figure 14. Mental Health and Substance Use

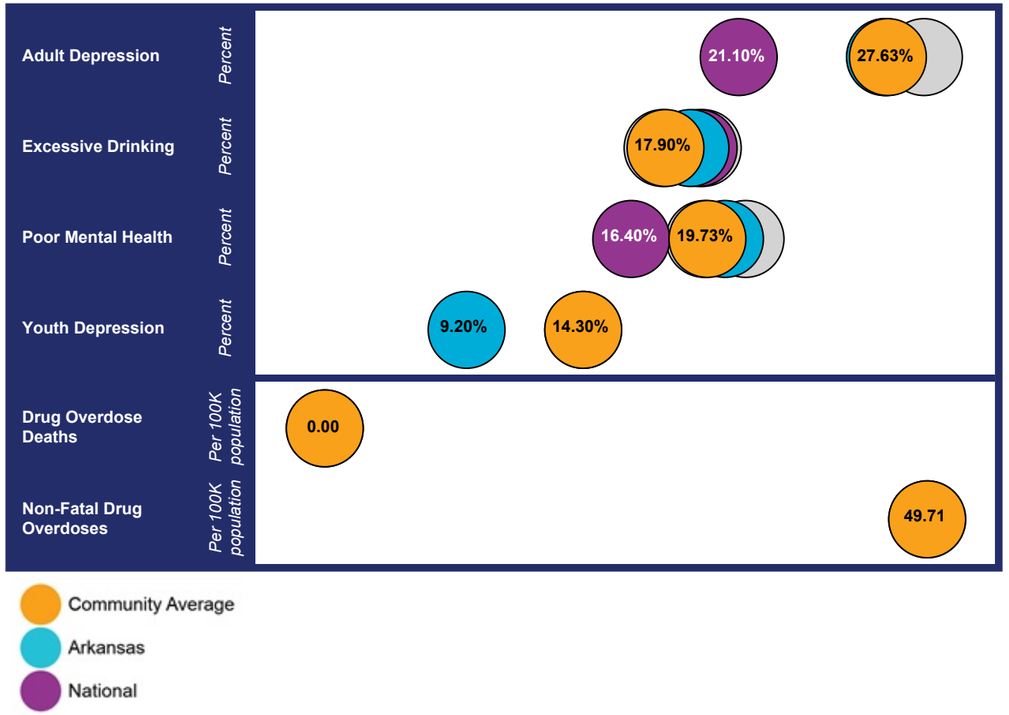


Table 14. Prevention

		Faulkner County	Perry County	Community Average	State	National
Cervical Cancer Screening	*Percentage of females age 21–65 years who report having had recommended cervical cancer screening test (age-adjusted)*	82.20%	80.10%	82.04%	81.20%	83.70%
Colorectal Cancer Screening	*Percentage of adults age 45-75 who have had a recent colorecal cancer screening*	60.10%	60.00%	60.09%	61.60%	66.30%
Dental Care Utilization	*Dental care visit (past 1 year), age-adjusted percentage of adults age 18+ by county*	59.30%	53.40%	58.86%	54.10%	63.40%
High Blood Pressure Management	*Percentage of adults age 18 and older with high blood pressure who report taking blood pressure medication (age-adjusted)*	61.50%	60.60%	61.43%	61.40%	58.90%
Prevention - Seasonal Influenza Vaccine	*Percentage of adults aged 18 and older who report receiving an influenza vaccination in the past 12 months*	47.70%	43.60%	47.40%	43.20%	44.80%
Annual Wellness Exam (Medicare)	*Percentage of annual wellness visits among the Medicare fee-for-service (FFS) population*	40.00%	40.00%	40.00%	46.00%	44.00%
No HIV Test	*Percentage of adults ages 18 or older who have never been screened for HIV*	62.00%	64.20%	62.16%	66.10%	Not Available

Figure 15. Prevention

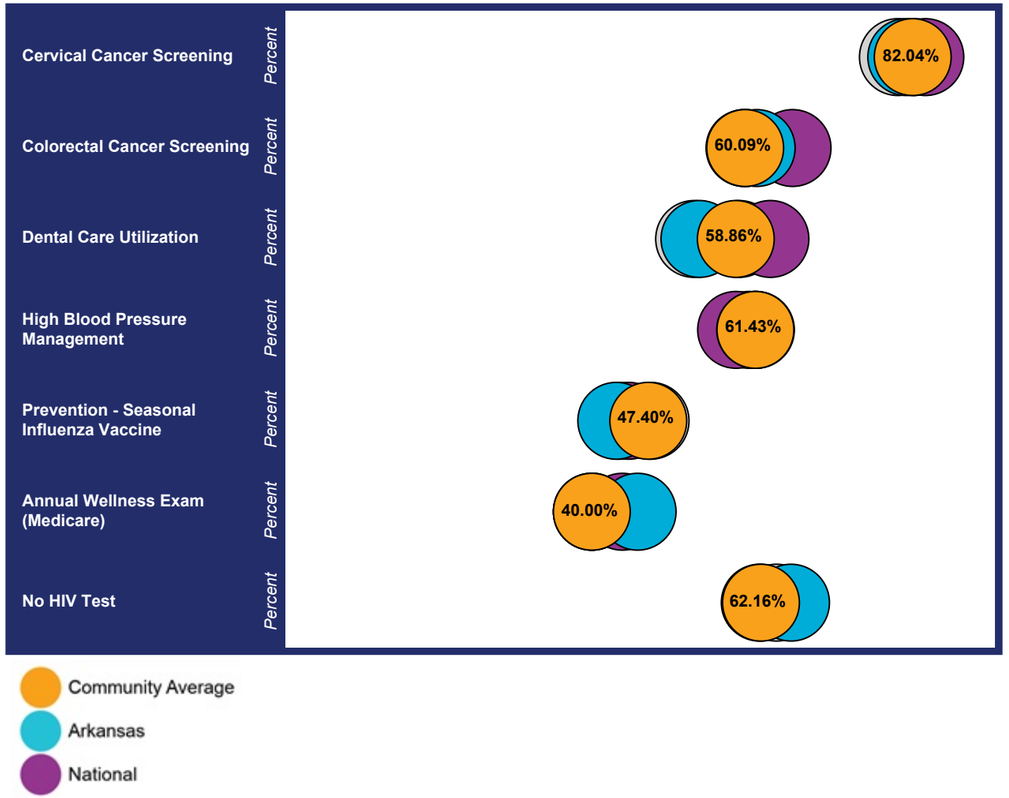
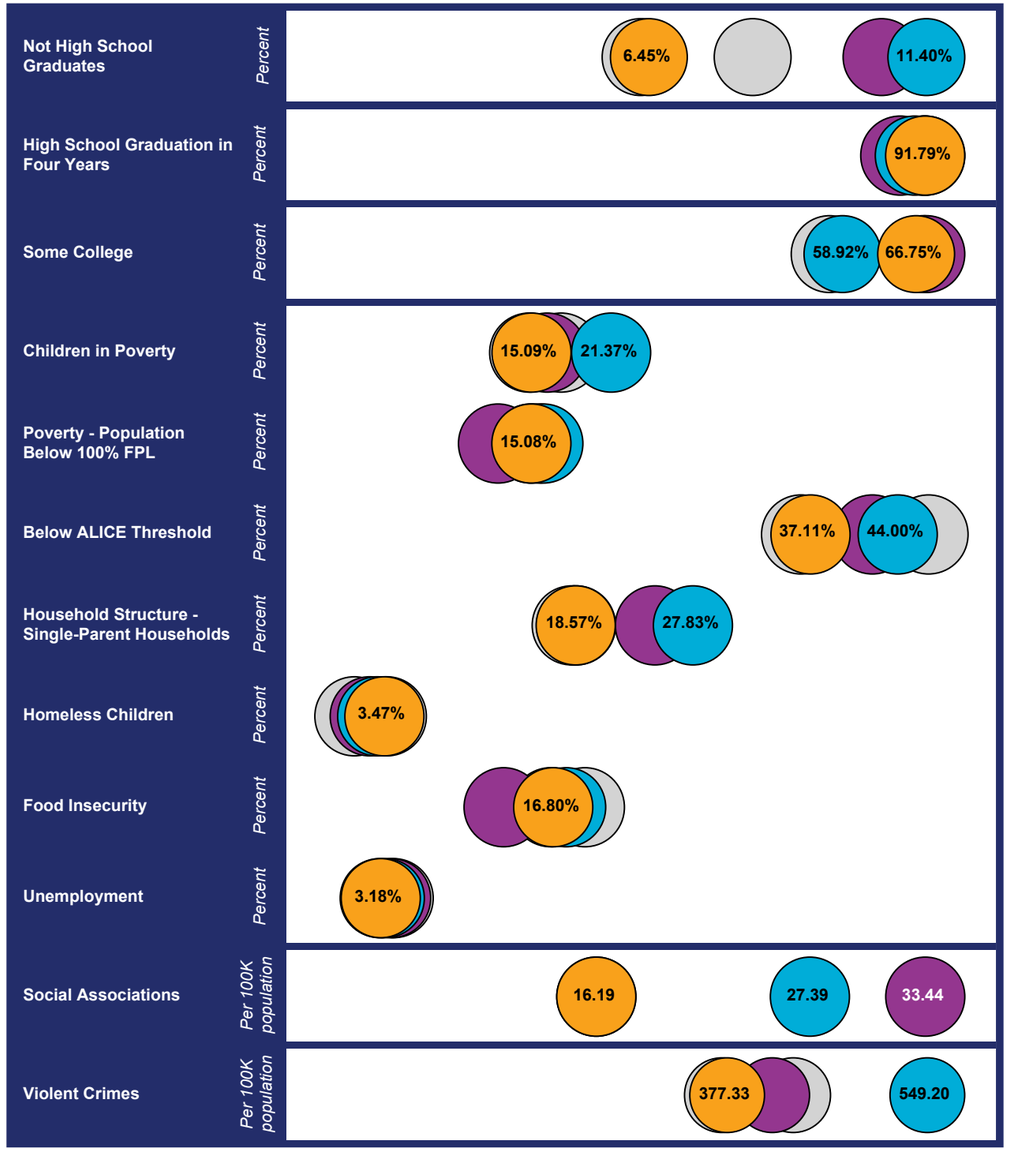


Table 15. Social and Economic Factors

		Perry County	Faulkner County	Community Average	State	National
Not High School Graduates	*Percentage of adults without a high school diploma*	8.30%	6.30%	6.45%	11.40%	10.60%
High School Graduation in Four Years	*Percentage of ninth-grade cohort who graduated in four years*	91.60%	91.80%	91.79%	90.30%	88.20%
Some College	*Percentage of adults ages 25-44 with some post-secondary education*	57.56%	67.48%	66.75%	58.92%	67.83%
Children in Poverty	*Percentage of children under age 18 below the poverty line*	17.41%	14.90%	15.09%	21.37%	16.32%
Poverty - Population Below 100% FPL	*Percentage of the population living in households with income below the federal poverty level*	15.64%	15.03%	15.08%	16.02%	12.44%
Below ALICE Threshold	*Percentage of households living in poverty or classified as ALICE (Asset Limited, Income Constrained, Employed)*	46.43%	36.37%	37.11%	44.00%	42.00%
Household Structure - Single-Parent Households	*Percentage of children who live in households where only one parent is present*	18.26%	18.60%	18.57%	27.83%	24.83%
Homeless Children	*Percentage of students experiencing homelessness enrolled in the public school system*	1.10%	3.66%	3.47%	2.90%	2.31%
Food Insecurity	*Percentage of the population that experienced food insecurity in the report year*	19.30%	16.60%	16.80%	17.82%	12.88%
Unemployment	*Percentage of the civilian non-institutionalized population age 16 and older that is unemployed (non-seasonally adjusted)*	4.20%	3.10%	3.18%	3.50%	4.00%
Social Associations	*Establishments, rate per 100,000 population*	Not Available	16.19	16.19	27.39	33.44

Figure 16. Social and Economic Factors



IDENTIFIED NEED 1:
Increase Access to Care and Education

GOALS/OBJECTIVE/OBJECTIVES:
Improve health outcomes by increasing access to preventative health services, care providers via telehealth and comprehensive health education.

STRATEGY 1:
Increase access to health-related care needs and health education.

ACTION STEPS:
- Provide preventative immunizations & flu vaccinations to school-aged children and adults
- Explore and establish methods to provide telehealth services on MHU to provide access to providers not readily accessible for community members.
- Offer community-based maternal health education classes including prenatal, postpartum and infant safety and breast feeding
- Offer access to the MIHOW home visiting program for pregnant women and families
- Promote access to expert insights tailored to all stages of the pregnancy journey through the Hello Pregnancy app
- Provide free chronic disease management and education classes, seminars and presentations
- Provide community-based preventative health screenings utilizing the Mobile Health unit and community partners
- Explore partnerships with local senior centers to open a community wellness center

KEY PERFORMANCE METRICS
- The number of screening events and immunizations projects will be tracked and reported
- The number of patient encounters and special events on MHU will be tracked and reported.
- Number of participants for classes will be tracked and reported
- Hello Pregnancy app utilization will be tracked and reported
- Number of individuals receiving service through the MIHOW program will be tracked and reported

COLLABORATIONS WITH ORGANIZATIONS: Local non-profits, faith-based community, community groups,

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS NEED: Staff time and clinical expertise, marketing and educational materials, community health supplies and ongoing support from the Marketing & Communications and Community Outreach teams.

ESTIMATED COMPLETION DATE: Ongoing through 2028

PERSON(S)/DEPARTMENT RESPONSIBLE: Leadership, Community Outreach Team, Marketing & Communications Manager, Case Management

IDENTIFIED NEED 1:
Increase Access to Care and Education

GOALS/OBJECTIVE/OBJECTIVE:
To improve community health by increasing health literacy and reducing barriers to accessing healthcare through community-led, culturally appropriate education and navigation support.

STRATEGY 2:
Health Literacy & Access to Healthcare

ACTION STEPS:
- Establish a Community Health Literacy committee plan implementation and collaboration opportunities
- Equip internal staff and community leaders to train utilizing an evidence based curriculum for delivery.
- Identify target populations based on data and community need
- Launch community in-person, and virtual workshops to cover topics including understanding health information, communicating with healthcare providers, navigating healthcare, self-management and preventive health, understanding prescriptions, telehealth, patient rights
- Train community-based clinical and non-clinical staff in health-literate communication (e.g., Teach-Back, plain language)
- Evaluate impact and build sustainability plan

KEY PERFORMANCE METRICS:
- Curriculum identified and vetted for implementation
- Track the number of classes offered and participants
- Track pre/post test results to determine knowledge gained
- Track number of staff trained to implement the program
- Identified number of encounters using the Teach-Back method

COLLABORATIONS WITH ORGANIZATIONS: Local non-profits, faith-based community, community groups

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS NEED: Staff time and clinical expertise, marketing and educational materials, community health supplies and ongoing support from the Marketing & Communications and Community Outreach teams.

ESTIMATED COMPLETION DATE: Ongoing through 2028

PERSON(S)/DEPARTMENT RESPONSIBLE: Leadership, Community Outreach Team, Marketing & Communications Manager, Case Management

IDENTIFIED NEED 1:
Increase Access to Care and Education

GOALS/OBJECTIVE/OBJECTIVE:
Financial Empowerment for Healthcare: The goal is to move participants from financial crisis management to proactive planning. Show how sound budgeting and saving habits directly support access to care and health stability.

STRATEGY 3:
Financial Literacy & Access to Healthcare

ACTION STEPS:
- Identify a local Bank or Credit Union to partner in program delivery
- Partner with Community groups and organizations to implement class
- Incorporate Financial Literacy in Community Wellness Centers
- Incorporate Financial Literacy in Community Wellness Centers and Prenatal/Postpartum program by including the following educational topics
  - Control Your Money: Budgeting101
  - Understanding needs vs. wants, building a savings
  - Building a Savings for Emergencies
  - Avoiding Money Traps: Debts & Credits
  - Protect Your Health: Financial Literacy
- Include information in all FoodRx bags (if applicable)
- Identify additional resources for referrals beyond classes

KEY PERFORMANCE METRICS
- Track the number of classes offered and number of participants
- Utilize pre and post test to determine knowledge gain
- Track number of community partners identified and utilized for implementation
- Track number of referrals for financial assistance

COLLABORATIONS WITH ORGANIZATIONS: Local non-profits, faith-based community, community groups local banks,

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS NEED: Staff time and clinical expertise, marketing and educational materials, community health supplies and ongoing support from the Marketing & Communications and Community Outreach teams.

ESTIMATED COMPLETION DATE: Ongoing through 2028

PERSON(S)/DEPARTMENT RESPONSIBLE: Leadership, Community Outreach Team, Marketing & Communications Manager, Case Management

IDENTIFIED NEED 2:
Community Mental Health Strategy: Access, Education, Acceptance

GOALS/OBJECTIVE:
Improve and increase access to mental health services, reduce stigma, and promote emotional well-being for residents of the Faulkner County

STRATEGY:
Strengthen collaboration with employers, healthcare providers, and community organizations to expand mental health education, increase access to counseling and crisis resources, and promote early intervention and resilience-building initiatives.

ACTION STEPS:
- Partner with healthcare organizations, locally and statewide, to increase the capacity to provide additional mental health services.
- Provide Mental Health First Aid training to local schools, colleges, and community or faith-based organizations.
- Provide Community-based Stop the Bleed Trainings
- Participate in System-wide Mental Health Awareness Campaigns
- Partner with local schools and colleges to increase mental health awareness
- Integrate Mental Health Education and Awareness materials into Schools and Workplaces
- Utilize Telepsych for patients in need of Telemedicine services

PERFORMANCE METRICS:
- Track number of patient encounters in-patient withdrawal management services
- Track number of patient encounters utilizing Telepsych services
- Report number of Community partners and events for mental health services
- Track the number of mental health first aid and Stop the Bleed classes and participants
- Track the number of Mental Health First Aid trainings and attendance
- Measure campaign's reach through social media engagement, website visits, and printed material distribution.

COLLABORATIONS WITH ORGANIZATIONS: Local schools, universities and businesses, non-profits and faith-based organizations

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS NEED: Staff time and clinical expertise, marketing and educational materials, community health supplies and ongoing support from the Marketing & Communications and behavioral health, command center and Community Outreach teams.

ESTIMATED COMPLETION DATE: Ongoing through 2028

PERSON(S)/DEPARTMENT RESPONSIBLE: Leadership, Behavioral Health, Community Outreach Director Marketing & Communications Manager, Case Management

IDENTIFIED NEED 3:
Closing the Gap: A Strategy for Healthy Communities and Nutrition Security

GOALS/OBJECTIVE:
Reduce food insecurity for inpatients and improve nutrition knowledge among in-patients and general community through education, outreach, and collaboration with local partners.

STRATEGY:
Expand community partnerships and implement interactive nutrition education programs that empower residents with practical skills and resources to reduce food insecurity and promote healthier eating habits.

ACTION STEPS:
- Expand FoodRx Program for inpatients identified as food insecure.
- Explore funding opportunities in partnership with Baptist Health Foundation to expand FoodRx Program and or Blessing box to employees
- Implement Arkansas Fruit and Vegetable Prescription Program with the Arkansas Hunger Relief Alliance to distribute fresh produce to food-insecure patients with a diet-related chronic health condition.
- Continue partnering with the Baptist Health Community Outreach Department, community organizations—including local school districts to provide free, engaging education on healthy eating and nutrition.
- Educate staff on food insecurity and resources within our community that can benefit our patients and fellow staff members.
- Launch a “Wellness Meet-Up Series” open to the public, featuring monthly sessions on key wellness topics such as physical activity, mindful eating, stress management, and sleep health.
- Implement a “Maintain Don’t Gain” Holiday nutrition education challenge in partnership with Community Outreach
- Provide community-based cooking and educational classes
- Implement nutrition education for pregnant and postpartum mothers to also empower healthier food choices for mom, baby and family.
- Implement the Healthy Active Youth and Families (HAYF) nutrition and physical activity program

PERFORMANCE METRICS:
- Track percentage of patients screened for food insecurity and referrals for food resources
- Track number of educational classes and participants in nutrition education classes
- Track and report number of FoodRx bags given to patients during timeframe
- Track the amount of grant/external funding secured toward the sustainability goal
- Track number of participants in educational programs and screening events
- Track healthy active youth program participants and screening results

IDENTIFIED NEED 3:
Closing the Gap: A Strategy for Healthy Communities and Nutrition Security

COLLABORATIONS WITH ORGANIZATIONS: Arkansas Foodbank, local non-profits, local food pantries,

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS NEED: Staff time and clinical expertise, marketing and educational materials, community health supplies and ongoing support from the Marketing & Communications and Community Outreach teams.

E**STIMATED COMPLETION DATE:** Ongoing through 2028

PERSON(S)/DEPARTMENT RESPONSIBLE: Leadership, Community Outreach Team, Marketing & Communications Manager, Case Management

BAPTIST HEALTH MEDICAL CENTER
Drew County

About Us

Baptist Health Medical Center-Drew County is a faith-based, state-of-the-art facility offering an integrated healing environment for the care and comfort of patients and families. Our 60-bed acute care facility serves approximately 200,000 residents in southeast Arkansas. Our care teams, nurses, and physicians are here to provide amazing care to keep you and your family healthy and well.

Baptist Health Medical Center-Drew County provides comprehensive medical services at our hospital, as well as care at a number of conveniently located family and specialty clinics in and around the Monticello area.

Community Health Needs Assessment 2026-2028
Baptist Health Medical Center-Drew County

HIGHLIGHTS OF COMMUNITY HEALTH NEEDS ASSESSMENT ACCOMPLISHMENTS 2023-2025

Mental Health & Substance Abuse

- Expanded mental health service capacity by developing and implementing a new staffing plan for both Adult and Youth services through the Department of Mental Health Services (DMHS).
- Launched the Reflections Geri-Psych Unit, immediately increasing specialized inpatient psychiatric care access for the geriatric population.
- Secured Specialized Withdrawal Care: Formalized a critical partnership with the New Visions Withdrawal Management program to ensure the continued delivery of specialized inpatient withdrawal management services at DMHS.
- Sustained vital participation in the Arkansas Rural Health Partnership's task force, ensuring a consistent voice in improving rural mental and behavioral health services across the state.
- Ensured continuity of specialized care by continuing the New Vision program, providing a critical inpatient medical detox option for community members struggling with opioid addiction.

Obesity & Diabetes

- Equipped parents with practical skills during local school parent nights, focusing on selecting healthy fast food, cooking inexpensive meals, and making healthy choices for diabetic diets.
- Partnered with Baptist Health Community Outreach to provide Healthy information, diabetes risk assessments during Immunization events.
- Boosted community health awareness by utilizing social media (e.g., BHMC-DC Facebook) to specifically promote and share diabetes education resources.
- Increased access to diabetes education by continuing to promote and grow the current DMHS program via monthly informational links shared online.
- Driven strategic weight management GOALS/OBJECTIVE by successfully promoting new weight-loss programs developed through DMHS initiatives.

Healthcare Workforce

- First year of assessment, Increased ICU capacity at BHMC-DC by successfully recruiting staff, leveraging telemedicine to enhance specialist coverage and support
- Significantly grew the specialist workforce by successfully recruiting providers (including Dr. Link, Dr. Dent -Family Practice/OB-, Dr. Norwood, Dr. Von Edwins, and Dr. Hanberry) to enhance services in ENT, OB/GYN, Orthopedics, Cardiology, and Urology.
- Increased local access to surgical procedures by partnering with regional PCPs to utilize on-site facilities for scopes and other surgeries.
- Cultivated the next generation of physicians by actively encouraging and hosting student doctor rotations from UAMS, ACOM, and NYIT, strengthening the pipeline, particularly in the Emergency Department
- Leveraged medical staff and local providers to actively recruit additional physicians, demonstrated by Dr. Shrum's facilitation of student OB/GYN rotations to showcase the practice environment.
- Cultivated the future healthcare workforce through a continued ARHP partnership, successfully launching an apprenticeship/internship program that provided practical experience to local students in key departments like Med Surg.
- Enhanced physician network and referral base through targeted relationship development, successfully boosting visits and collaboration with oncologists and other local and specialty providers
- Drove Healthcare Workforce Development by sustaining key partnerships with ARHP, JRMC, and UAM-Technical Campus, resulting in successful student nurse, radiology, and therapy preceptorships, internships, and clinical rotations.
- Strengthened the Future Talent Pipeline by having staff serve on education boards and task forces, actively promoting ARHP scholarship opportunities, and formalizing an apprenticeship program that successfully placed candidates in departments like Med Surg.

2025 BAPTIST HEALTH COMMUNITY HEALTH NEEDS ASSESSMENT: DREW COUNTY

ACHI
August 2025

Baptist Health

PREPARED BY:
ACHI
INSPIRING HEALTHY ACTS

Introduction

Baptist Health engaged the Arkansas Center for Health Improvement (ACHI) to conduct the quantitative data collection and analysis for the 2025 Community Health Needs Assessment (CHNA) process. Baptist Health provided ACHI with the counties served by each of its 12 hospital communities. A total of 16 Arkansas counties and two Oklahoma counties were included.

Each report presents community-level data for a hospital community, including tables and figures for each indicator, along with comparisons to Arkansas and U.S. benchmarks. Dot graphs are provided to visualize performance across selected indicators. All reports are prepared using the same methodology to ensure consistency and comparability across Baptist Health hospital communities.

Methodology

A summary of sources, definitions, indicator criteria, and suppression rules can be found in the methods and sources document.

Community Profile Summary

To support the 2025 Community Health Needs Assessment (CHNA), ACHI compiled a comprehensive dataset of 103 health and demographic indicators for the communities served by Baptist Health's 12 hospital locations. This section provides an overview of these indicators across the full CHNA service area and offers multiple views for understanding and comparing county-level and community-level data.

Data are grouped into the following 14 categories, based on the source-defined domains outlined in the data source reference sheet:

1. Demographics
    a. Age
    b. Sex
    c. Race, Ethnicity, and Language
2. Insurance Coverage
3. Access to Care
4. Cause of Death
5. Chronic Conditions
6. Diagnoses Incidence at Discharge
7. Environment
8. Health Behaviors
9. Health Outcomes
10. Healthcare Expenditures
11. Maternal and Infant Health
12. Mental Health and Substance Use
13. Prevention
14. Social and Economic Factors

Measurements for these categories will be displayed in the following sections.

Hospital Community Indicator

The hospital community indicator snapshots offer an at-a-glance view of how each hospital community compares to state and national benchmarks, as well as the counties that make up the community.

Each table presents the data values for selected indicators across the 14 CHNA domains, and each corresponding visual uses proportionally scaled circular markers to illustrate performance. This format is designed to quickly convey how each hospital community aligns with or diverges from broader benchmarks in key population health metrics.

Each displays four comparison points:

- **Purple** – Represents the national value for the indicator.
- **Blue** – Represents the value for the state of Arkansas.
- **Gold** – Represents the weighted average for all counties in the hospital's defined service area.
- **Gray** – Represent the values of each county assigned to that hospital community.

Where available, data for each indicator are shown for all four categories. If a value is not available or is suppressed for a contributing county, it is noted as "Not Available" in the table and excluded from the visual display. No color ranking is applied; the visuals and tables are intended to illustrate relative placement, not comparative rank.

Hospital Community: Drew County

Figure 1. Counties Served by Baptist Health Medical Center–Drew County

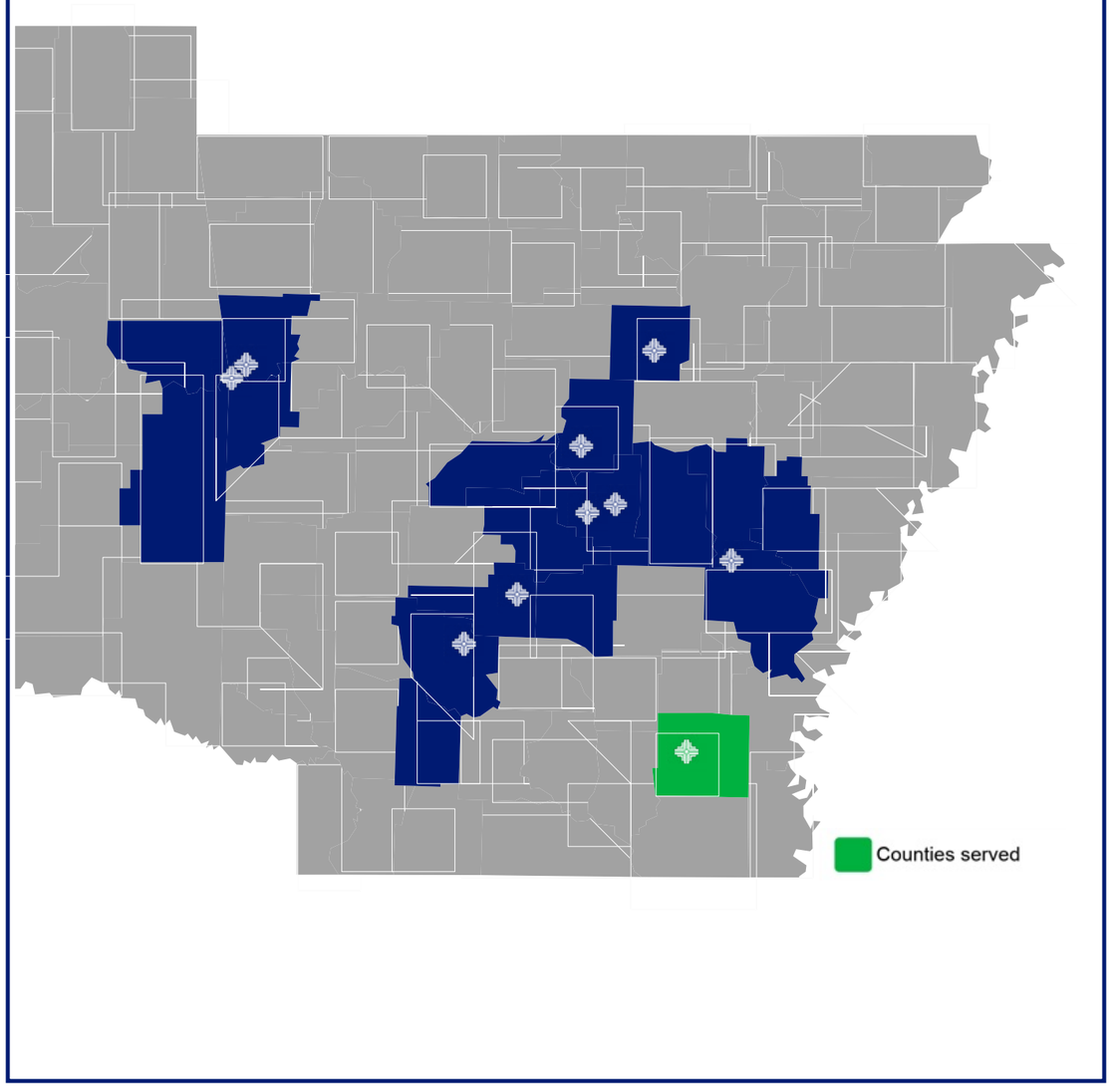


Table 1. Demographics: Age and Sex

		Drew County	Community Average	State	National
Total Population	*Number*	17,143	17,143	3,032,651	332,387,540
Female	*Percent*	51.32%	51.32%	50.67%	50.50%
Male	*Percent*	48.68%	48.68%	49.33%	49.50%
Ages 0-4	*Percent*	5.85%	5.85%	6.02%	5.70%
Ages 5-17	*Percent*	16.34%	16.34%	17.26%	16.46%
Ages 18-24	*Percent*	13.83%	13.83%	9.33%	9.12%
Ages 25-34	*Percent*	11.14%	11.14%	12.93%	13.69%
Ages 35-44	*Percent*	10.91%	10.91%	12.66%	13.08%
Ages 45-54	*Percent*	11.23%	11.23%	11.84%	12.29%
Ages 55-64	*Percent*	12.75%	12.75%	12.64%	12.82%
Ages 65+	*Percent*	17.95%	17.95%	17.33%	16.84%

Figure 2. Demographics: Age and Sex

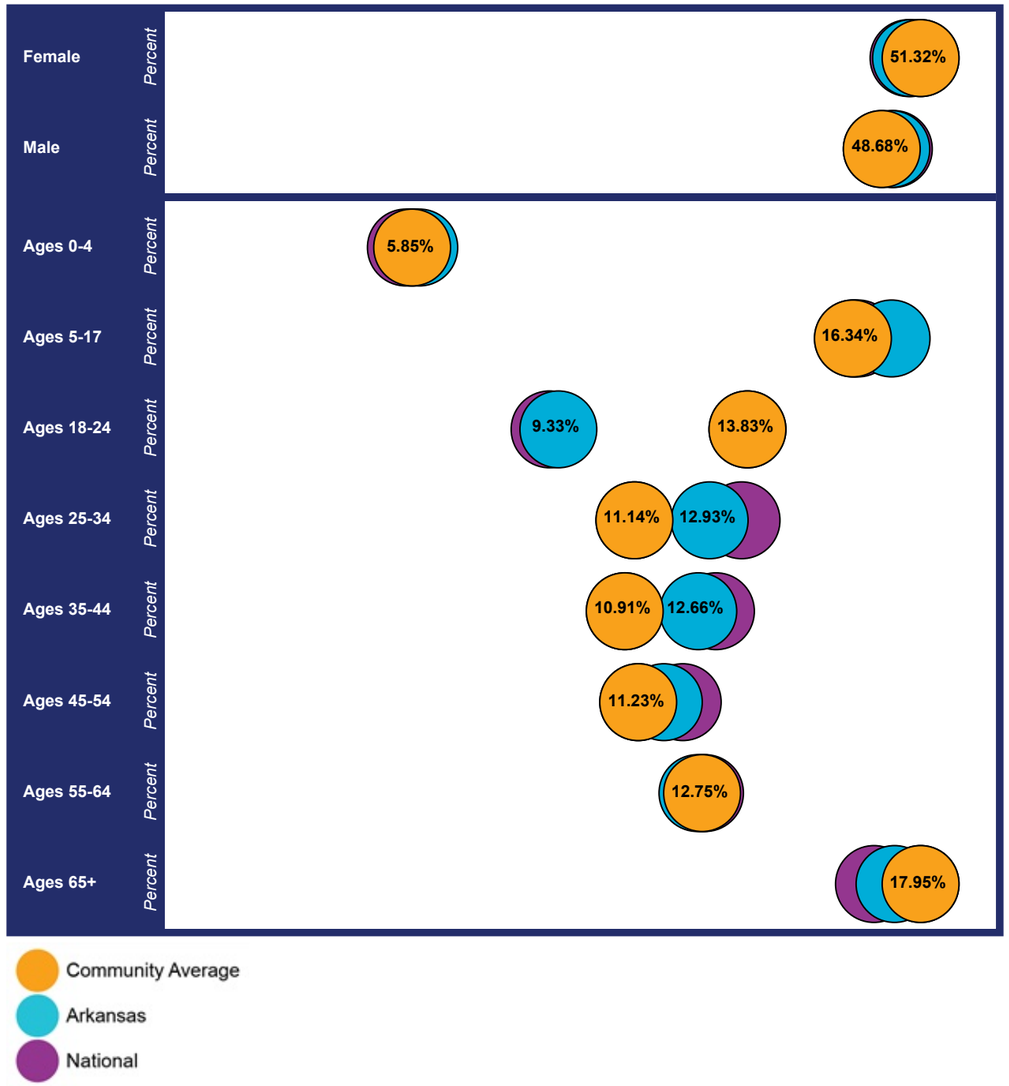


Table 2. Demographics: Race, Ethnicity, and Language

		Drew County	Community Average	State	National
Total Population	*Number*	17,143	17,143	3,032,651	332,387,540
Asian	*Percent*	0.71%	0.71%	1.53%	5.75%
Black or African American	*Percent*	26.68%	26.68%	14.84%	12.03%
Hispanic	*Percent*	4.12%	4.12%	8.77%	18.99%
Multiple Races	*Percent*	3.60%	3.60%	5.50%	3.87%
Native American/ Alaska Native	*Percent*	0.00%	0.00%	0.36%	0.53%
Native Hawaiian/ Pacific Islander	*Percent*	0.00%	0.00%	0.39%	0.17%
Other Races	*Percent*	0.00%	0.00%	0.26%	0.50%
White	*Percent*	64.89%	64.89%	68.36%	58.17%
Non-English Language Households	*Percent*	0.00%	0.00%	1.50%	4.20%

Figure 3. Demographics: Race, Ethnicity, and Language

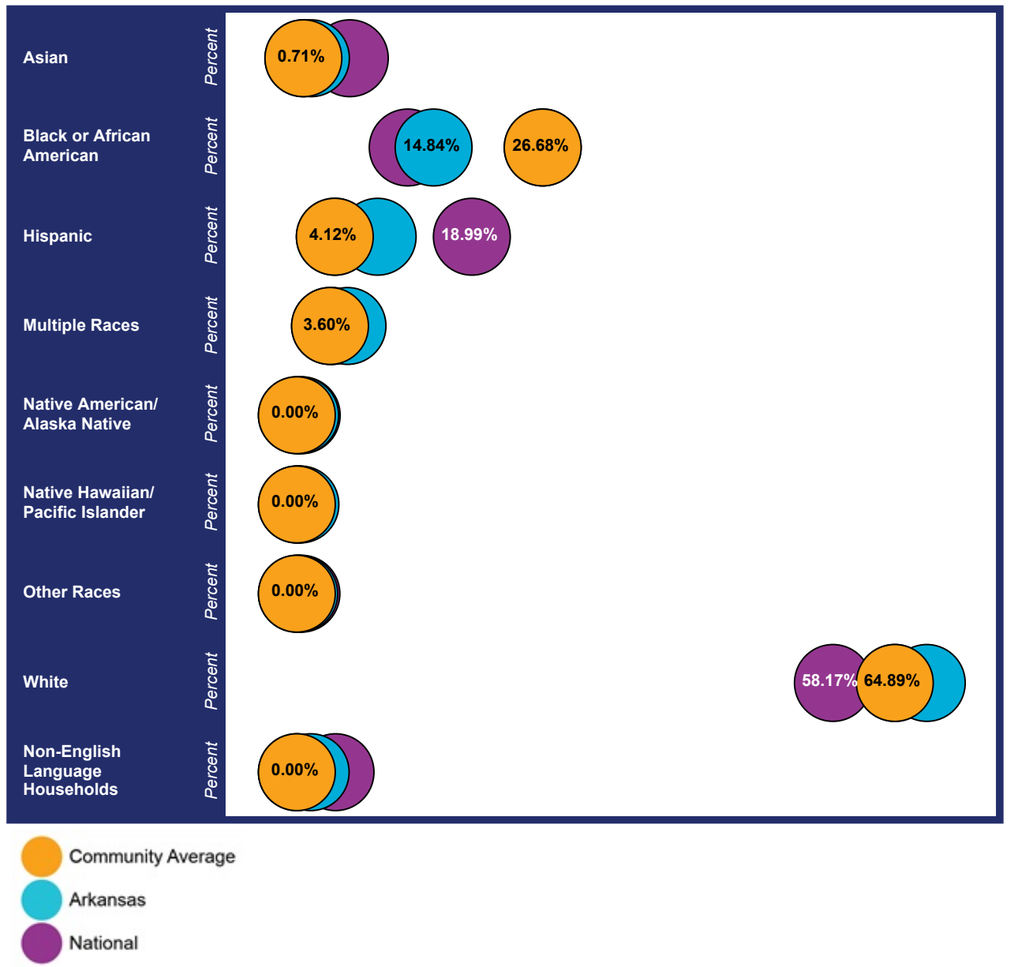


Table 3. Insurance Coverage

		Drew County	Community Average	State	National
Private Health Insurance Coverage	*Percentage of the total civilian non-institutionalized population for whom insurance status is determined that is covered by private health insurance*	57.22%	57.22%	65.37%	73.62%
Public Health Insurance Coverage	*Percentage of the total civilian non-institutionalized population for whom insurance status is determined that is covered by public health insurance*	57.32%	57.32%	48.21%	39.70%
Uninsured	*Percentage of adults under age 65 without health insurance coverage*	8.70%	8.70%	10.00%	9.50%

Figure 4. Insurance Coverage

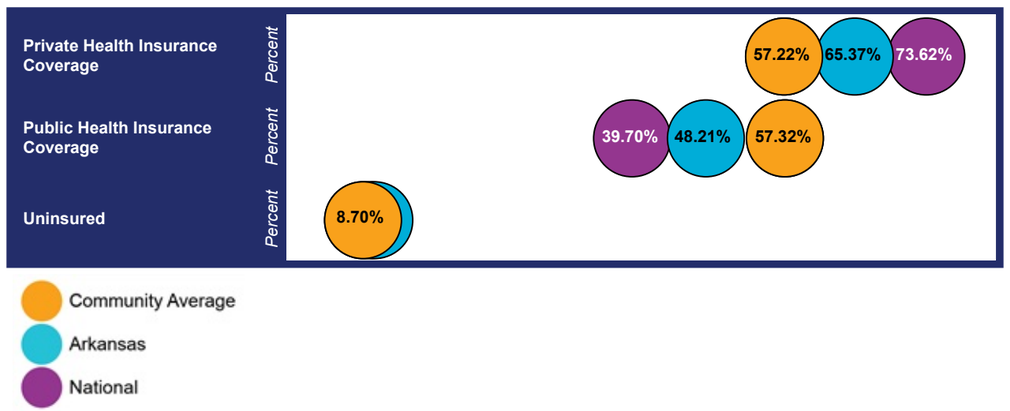


Table 4. Access to Care

		Drew County	Community Average	State	National
Primary Care Physicians	*Ratio of population to one primary care physician*	1069:1	1069:1	1478:1	1334:1
Mental Health Providers	*Ratio of population to one mental health provider*	149:1	149:1	367:1	300:1
Dentists	*Ratio of population to one dentist*	3382:1	3382:1	2044:1	1361:1
Active Primary Care Physicians	*Rate per 10,000 county residents of primary care physicians who provided evaluation and management services to at least two patients on the same day at least once during the year*	21.30	21.30	9.20	Not Available
Addiction or Substance Use Providers	*Rate of addiction or substance use providers per 100,000 population*	0.00	0.00	5.98	29.43
Buprenorphine Providers	*Rate of buprenorphine providers per 100,000 population*	11.72	11.72	9.81	14.87
Preventable Hospital Stays (Medicare)	*Rate of hospital stays for ambulatory care-sensitive conditions per 100,000 Medicare enrollees*	6173.00	6173.00	3014.00	2666.00
Diabetic Monitoring (Medicare)	*Percentage of Medicare enrollees aged 65 and older with diabetes who received a hemoglobin A1c (HbA1c) test within the past year.*	86.16%	86.16%	88.47%	87.53%
Mammography	*Percentage of female Medicare enrollees ages 65-74 who received an annual mammography screening*	37.00%	37.00%	41.00%	44.00%

Figure 5. Access to Care

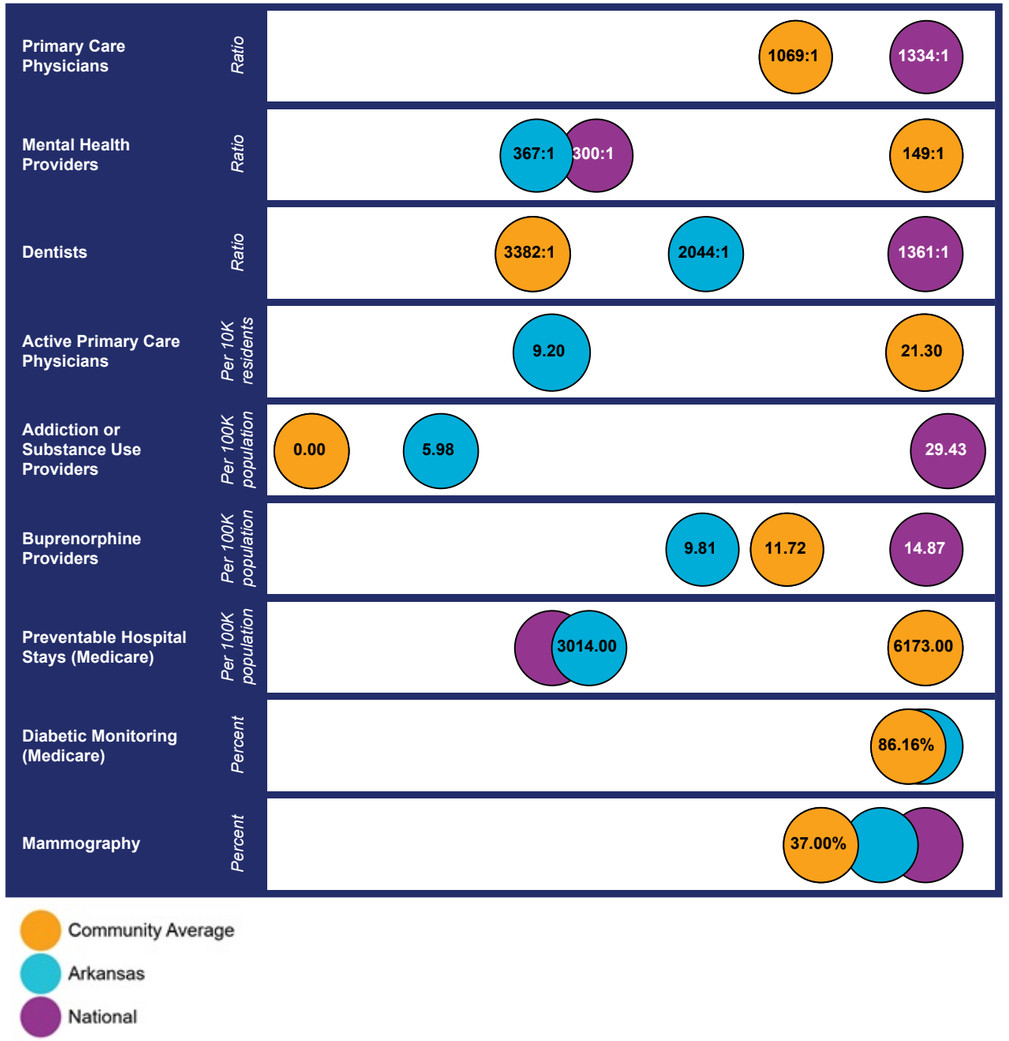


Table 5. Cause of Death

		Drew County	Community Average	State	National
All Causes	*Rate of deaths by all causes per 100,000 population (age-adjusted)*	**1056.60**	**1056.60**	**1001.70**	**805.60**
Premature Death	*Number of deaths among residents under age 75 per 100,000 population (age-adjusted)*	**632.96**	**632.96**	**552.47**	**406.59**
Heart Disease	*Rate of death due to heart disease (ICD-10 Codes I00-I09, I11, I13, I20-I151) per 100,000 population*	**308.60**	**308.60**	**282.80**	**207.20**
Cancer	*5-year average rate of death due to cancer per 100,000 population*	**232.90**	**232.90**	**215.90**	**182.70**
Unintentional Injury	*5-year average rate of death due to unintentional injury (accident) per 100,000 population*	**65.40**	**65.40**	**61.90**	**63.30**
Stroke	*5-year average rate of death due to cerebrovascular disease (stroke) per 100,000 population (age-adjusted)*	**59.70**	**59.70**	**57.40**	**48.30**
Chronic Lower Respiratory Disease	*Rate of deaths due to chronic lower respiratory disease per 100,000 population (age-adjusted)*	**62.00**	**62.00**	**61.00**	**35.90**
Diabetes Mortality	*Rate of deaths due to diabetes per 100,000 population (age-adjusted)*	**33.50**	**33.50**	**34.70**	**23.90**
Suicide Deaths	*This indicator reports the 2019-2023 five-year average rate of death due to intentional self-harm (suicide) per 100, 000 population. Figures are reported as crude rates*	**25.20**	**25.20**	**19.20**	**14.50**
Motor Vehicle Crash	*5-year average rate of death due to motor vehicle crash per 100,000 population (age-adjusted)*	**Not Available**	**Not Available**	**20.60**	**12.80**
Alcohol-Involved Motor Vehicle Crash	*Rate of persons killed in motor vehicle crashes involving alcohol as a rate per 100,000 population*	**8.10**	**8.10**	**3.10**	**2.30**

Figure 6. Cause of Death

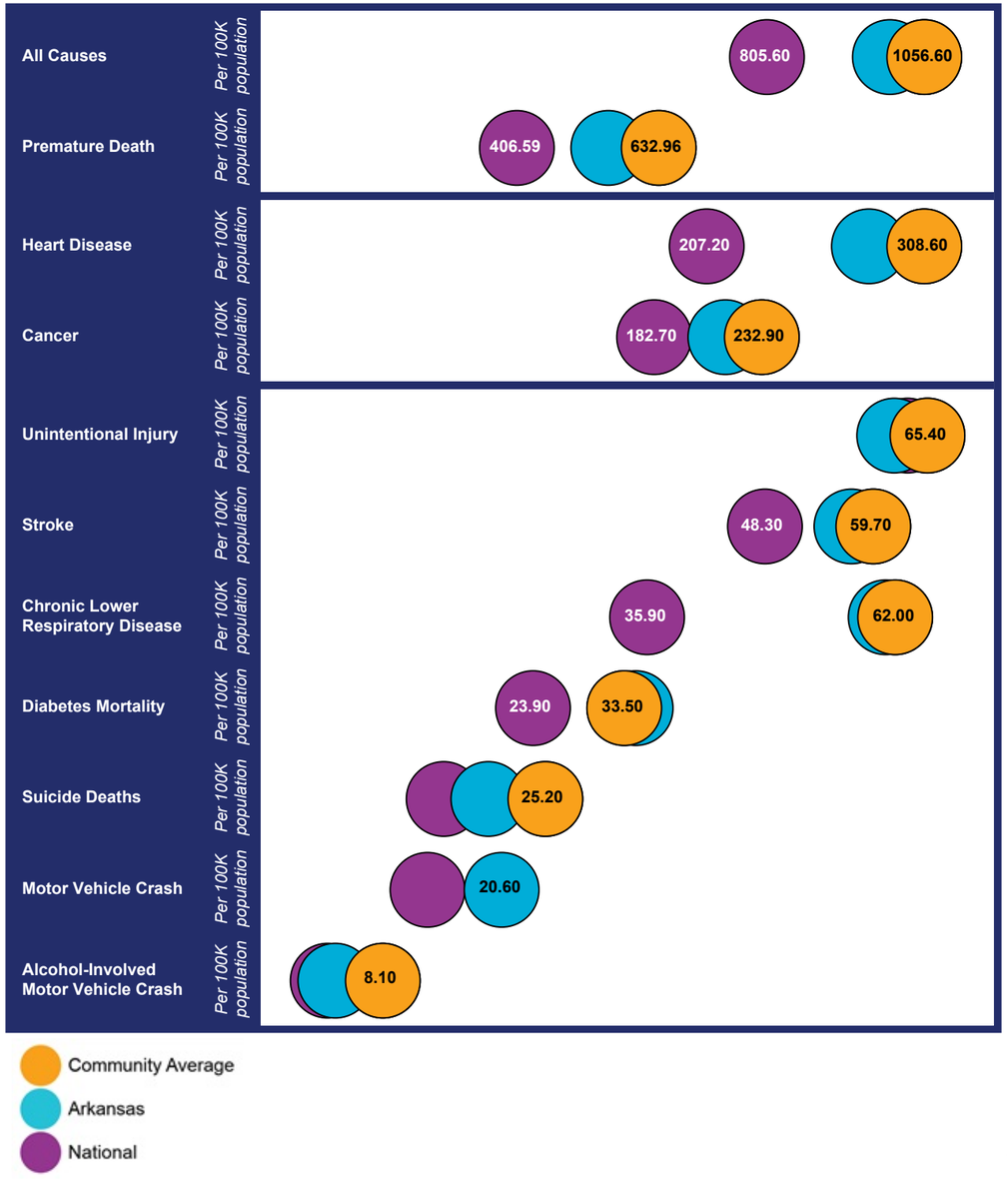


Table 6. Chronic Condtions

		Drew County	Community Average	State	National
Child Obesity	*Percentage of students classified as overweight to severely obese, by county location of school*	**41.79%**	**41.79%**	**40.10%**	**Not Available**
High Cholesterol	*Percentage of adults who have had their blood cholesterol checked and have been told it was high (age-adjusted)*	**32.30%**	**32.30%**	**31.80%**	**30.40%**
Adult Obesity	*Percentage of adults ages 20 and older who report a BMI higher than 30*	**26.90%**	**26.90%**	**31.90%**	**30.10%**
High Blood Pressure	*Percentage of adults who have been told they have high blood pressure (age-adjusted)*	**39.10%**	**39.10%**	**36.50%**	**29.60%**
Arthritis	*Percentage of adults ages 18 or older diagnosed with some form of arthritis*	**44.10%**	**44.10%**	**32.60%**	**Not Available**
Diabetes Prevalence	*Percentage of adults age 18 and older who report ever been told that they have diabetes other than diabetes during pregnancy (age-adjusted)*	**13.70%**	**13.70%**	**12.70%**	**10.40%**
Asthma	*Percentage of adults who have been told they currently have asthma (age-adjusted)*	**11.40%**	**11.40%**	**11.00%**	**9.90%**
Coronary Heart Disease	*Percentage of adults age 18 and older who report ever having been told by that they had angina or coronary heart disease (CHD) (age-adjusted)*	**7.30%**	**7.30%**	**7.20%**	**5.70%**

Figure 7. Chronic Conditions

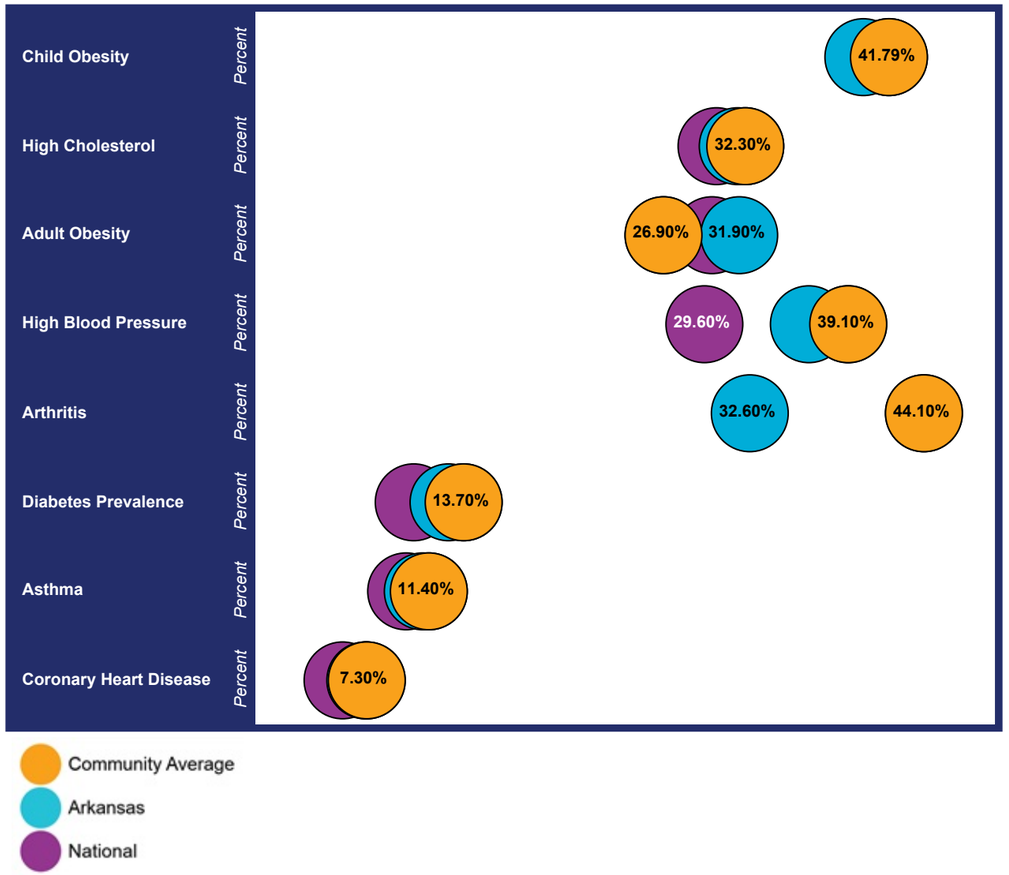


Table 7. Diagnoses at Discharge

		Drew County	Community Average	State
Hypertension	*Number of individuals 18 years and older discharged with a primary or secondary hypertension diagnosis as a percentage of the population 18 years and older*	8.96%	8.96%	8.70%
Hyperlipidemia	*Number of individuals 18 years and older discharged with a primary or secondary hyperlipidemia diagnosis as a percentage of the population 18 years and older*	3.44%	3.44%	3.90%
Diabetes	*Rate of individuals 18 years and older discharged with a primary or secondary diabetes diagnosis as a percentage of the population 18 years and older*	4.02%	4.02%	3.70%
Ischemic Heart Disease	*Number of individuals 18 years and older discharged with a primary or secondary ischemic heart disease diagnosis as a percentage of the population 18 years and older*	2.39%	2.39%	2.50%
Arthritis	*Rate of individuals 18 years and older discharged with a primary or secondary arthritis diagnosis as a percentage of the population 18 years and older*	1.58%	1.58%	1.90%

Figure 8. Diagnoses at Discharge

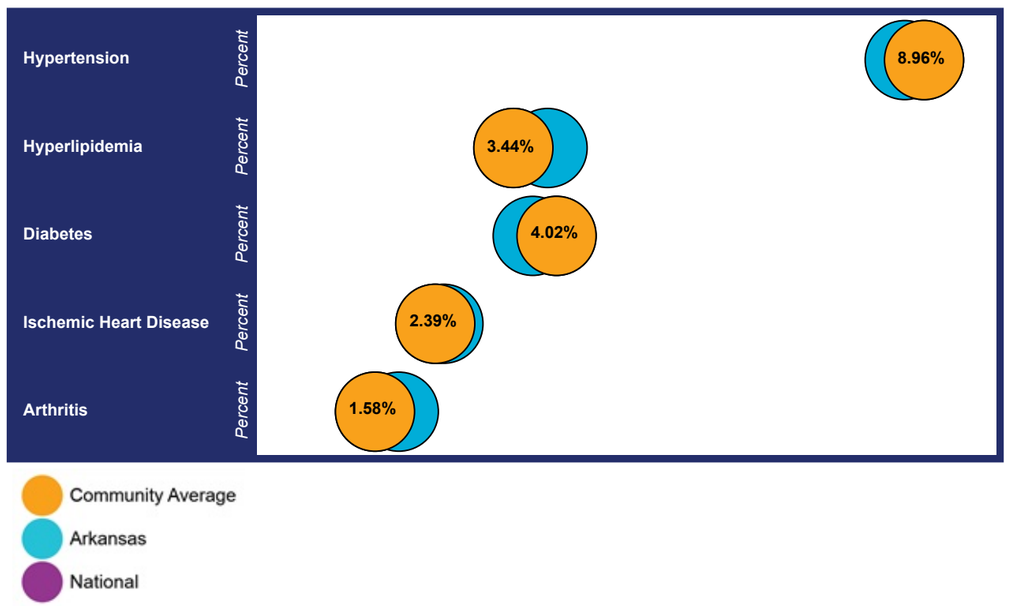


Table 8. Environment

		Drew County	Community Average	State	National
Food Environment Index	*Index of factors that contribute to a healthy food environment, 0 (worst) to 10 (best)*	6.50	6.50	4.40	7.40
Drinking Water Violations	*The total number of drinking water violations recorded in a two-year period*	0	0	321	16,107
Access to Exercise Opportunities	*Percentage of population with adequate access to locations for physical activity*	66.22%	66.22%	63.36%	84.45%
Broadband Access	*Percentage of population in a high-speed internet service area; access to DL speeds >= 25MBPS and UL speeds >= 3 MBPS*	74.93%	74.93%	94.04%	96.78%
Long Commute Driving Alone	*Among workers who commute in their car alone, the percentage who commute more than 30 minutes*	24.20%	24.20%	28.10%	36.50%
Severe Housing Problems	*Percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities*	11.26%	11.26%	13.23%	16.84%

Figure 9. Environment

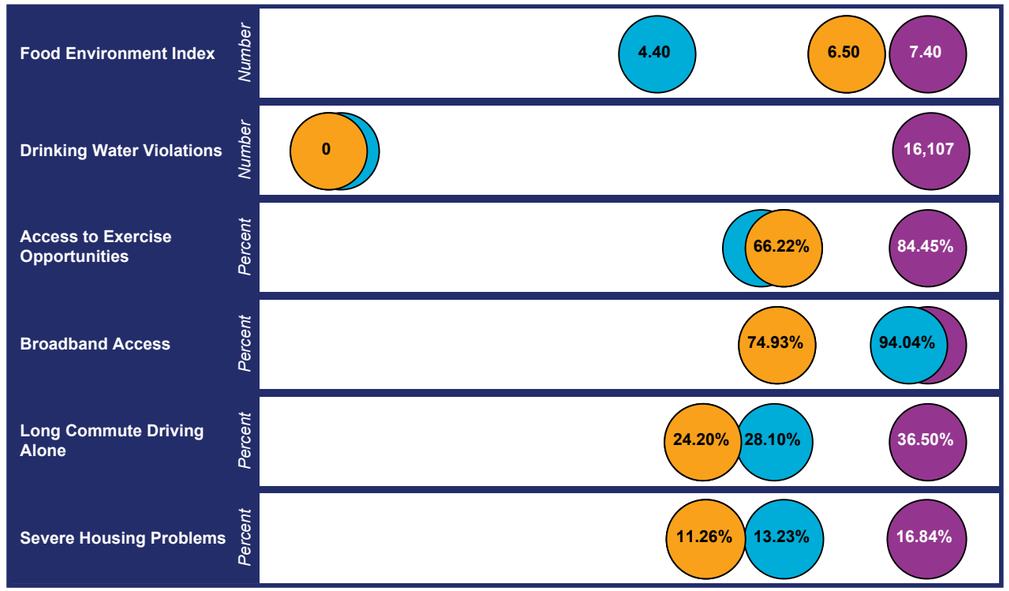


Table 9. Health Behaviors

		Drew County	Community Average	State	National
Physical Inactivity	*Percentage of adults aged 20 and older who self-report no leisure time for activity*	21.20%	21.20%	23.60%	19.50%
Adult Smoking	*Percentage of adults ages 18 and older who are current smokers (age-adjusted)*	20.80%	20.80%	19.20%	13.20%
Youth Vaping	*Percentage of public school students in 6th, 8th, 10th, and 12th grade who used any vape in the past 30 days*	Not Available	Not Available	8.10%	Not Available
Sexually Transmitted Infections	*Number of newly diagnosed chlamydia cases per 100,000 population*	685.90	685.90	588.30	495.00

Figure 10. Health Behaviors

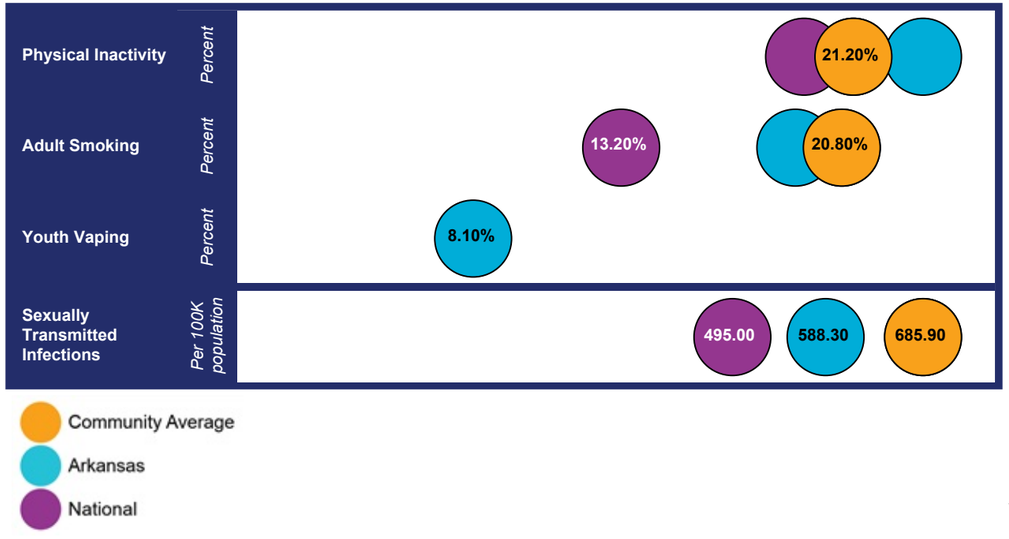


Table 10. Health Outcomes

		Drew County	Community Average	State	National
Poor Physical Health Days	*Average number of physically unhealthy days reported in past 30 days (age-adjusted)*	**5.50**	**5.50**	**5.20**	**3.90**
Poor or Fair Health	*Percentage of adults age 18 and older who self-report their general health status as "fair" or "poor" (age-adjusted)*	**24.60%**	**24.60%**	**22.60%**	**17.00%**

Figure 11. Health Outcomes

Table 11. Healthcare Expenditures

		Drew County	Community Average	State	National
Average Annualized Expenditures	*Average annualized per-person spending on all covered healthcare services.*	**$10,476**	**$10,476**	**$10,116**	**Not Available**
Average Annualized Expenditures (Medical Only)	*Average annualized per-person spending on medical services, based on medical claims.*	**$7,280**	**$7,280**	**$7,252**	**Not Available**
Average Annualized Expenditures (Pharmacy Only)	*Average annualized per-person spending on prescription drugs, based on pharmacy claims.*	**$3,000**	**$3,000**	**$2,609**	**Not Available**

Figure 12. Healthcare Expenditures

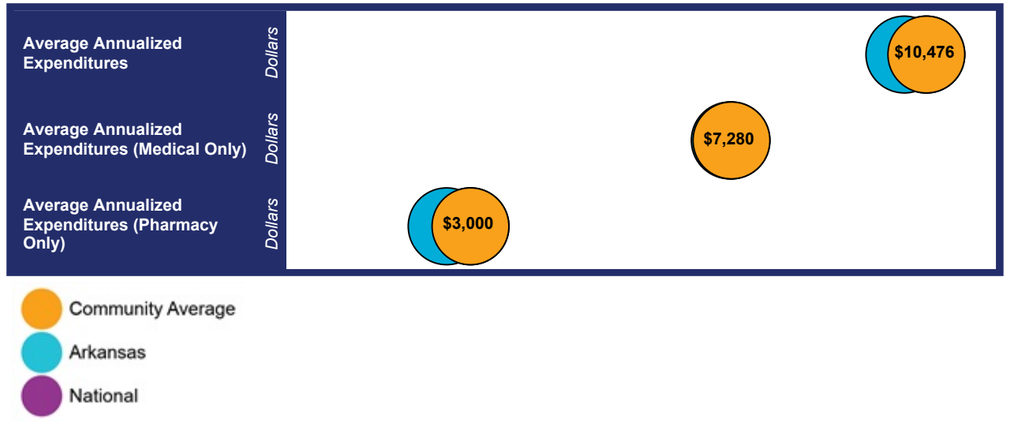


Table 12. Maternal and Infant Health

		Drew County	Community Average	State	National
Active Obstetrics and Gynecology Physicians	*Active OB-GYN physicians are defined as those who provided evaluation and management services to at least two female patients ages 12-55 on the same day or performed a qualifying procedure (e.g., delivery) at least once during the year.*	2.00	2.00	3.20	Not Available
Teen Births	*The seven-year average number of teen births per 1,000 female population, ages 15-19*	28.90	28.90	27.90	15.50
C-Section Rate	*Percentage of live births delivered via cesarean section among all deliveries, calculated by the mother's county of residence.*	42.53%	42.53%	33.48%	Not Available
C-Section Rate, First Birth	*Percentage of first-birth deliveries (full-term singleton pregnancies in a head-down position) delivered via cesarean section, calculated by the mother's county of residence.*	37.56%	37.56%	27.58%	Not Available
Low Birthweight	*Percentage of live births where the infant weighed less than 2, 500 grams (approximately 5 lbs., 8 oz.)*	9.80%	9.80%	9.40%	8.40%
Preterm Birth	*Percentage of live births that are preterm (<37 weeks), calculated as a three-year average.*	12.30%	12.30%	11.90%	10.35%
Median Travel Time to Delivery	*Median number of minutes Arkansas mothers traveled from their home ZIP code to the delivery facility, calculated using birth records and facility addresses. Travel time estimates include in-state and out-of-state facilities.*	7.00	7.00	16.00	Not Available

Figure 13. Maternal and Infant Health

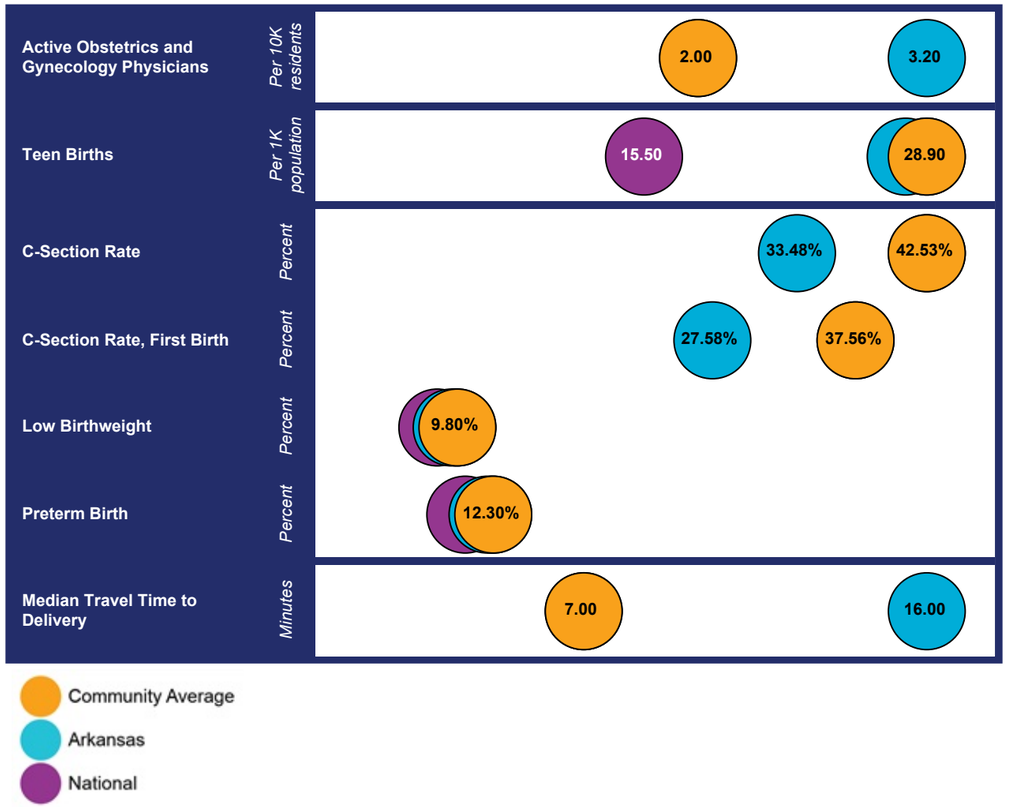


Table 13. Mental Health and Substance Use

		Drew County	Community Average	State	National
Adult Depression	*Percentage of adults age 18 and older who report having been told that they had depressive disorder*	**27.70%**	**27.70%**	**27.50%**	**21.10%**
Excessive Drinking	*Percentage of adults reporting binge or heavy drinking*	**17.89%**	**17.89%**	**18.99%**	**19.35%**
Poor Mental Health	*Percentage of adults age 18 or older reporting poor mental health for 14 or more days (age-adjusted)*	**21.60%**	**21.60%**	**20.50%**	**16.40%**
Youth Depression	*Percentage of public school students in 6th, 8th, 10th, and 12th grade who had feelings of depression all of the time in the past 30 days*	**Not Available**	**Not Available**	**9.20%**	**Not Available**
Drug Overdose Deaths	*Age-adjusted rate of fatal drug overdoses per 100,000 residents*	**Not Available**	**Not Available**	**Not Available**	**Not Available**
Non-Fatal Drug Overdoses	*Age-adjusted rate of non-fatal drug overdoses per 100,000 residents*	**Not Available**	**Not Available**	**Not Available**	**Not Available**

Figure 14. Mental Health and Substance Use

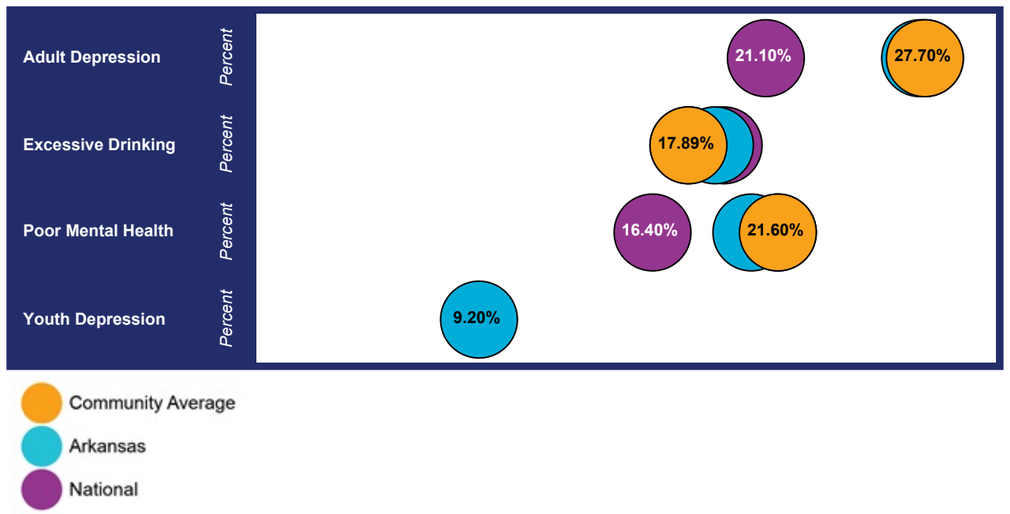


Table 14. Prevention

		Drew County	Community Average	State	National
Cervical Cancer Screening	*Percentage of females age 21–65 years who report having had recommended cervical cancer screening test (age-adjusted)*	80.80%	80.80%	81.20%	83.70%
Colorectal Cancer Screening	*Percentage of adults age 45-75 who have had a recent colorecal cancer screening*	62.70%	62.70%	61.60%	66.30%
Dental Care Utilization	*Dental care visit (past 1 year), age-adjusted percentage of adults age 18+ by county*	51.30%	51.30%	54.10%	63.40%
High Blood Pressure Management	*Percentage of adults age 18 and older with high blood pressure who report taking blood pressure medication (age-adjusted)*	64.00%	64.00%	61.40%	58.90%
Prevention - Seasonal Influenza Vaccine	*Percentage of adults aged 18 and older who report receiving an influenza vaccination in the past 12 months*	36.90%	36.90%	43.20%	44.80%
Annual Wellness Exam (Medicare)	*Percentage of annual wellness visits among the Medicare fee-for-service (FFS) population*	38.00%	38.00%	46.00%	44.00%
No HIV Test	*Percentage of adults ages 18 or older who have never been screened for HIV*	67.60%	67.60%	66.10%	Not Available

Figure 15. Prevention

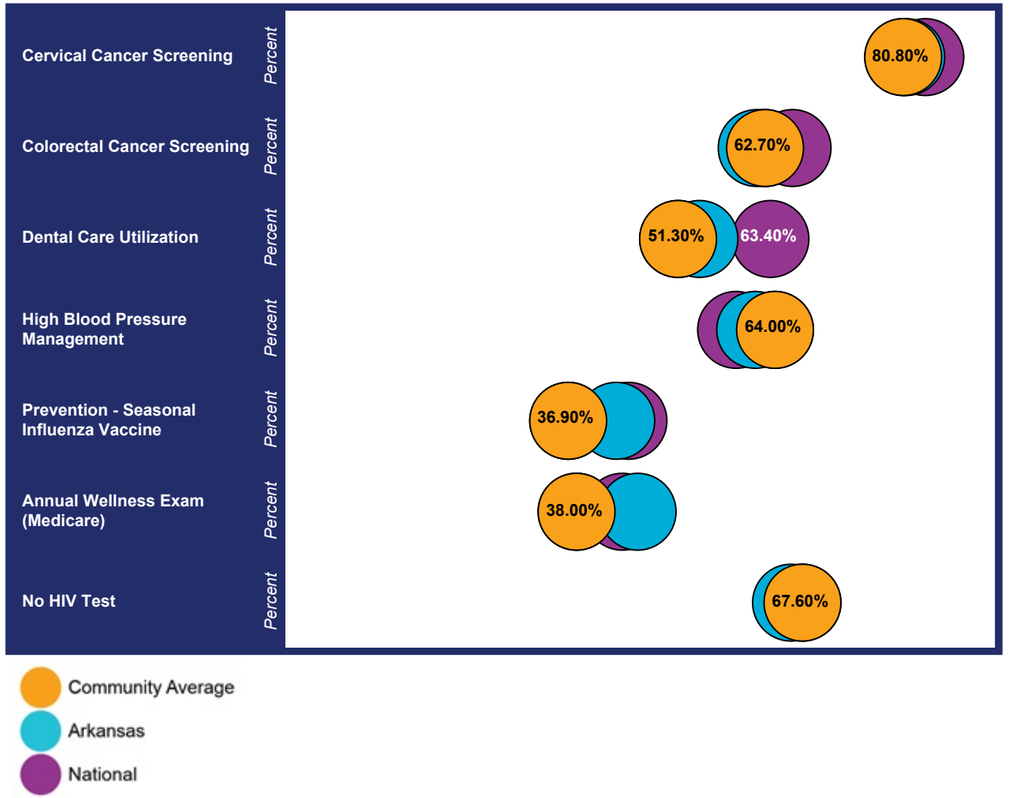
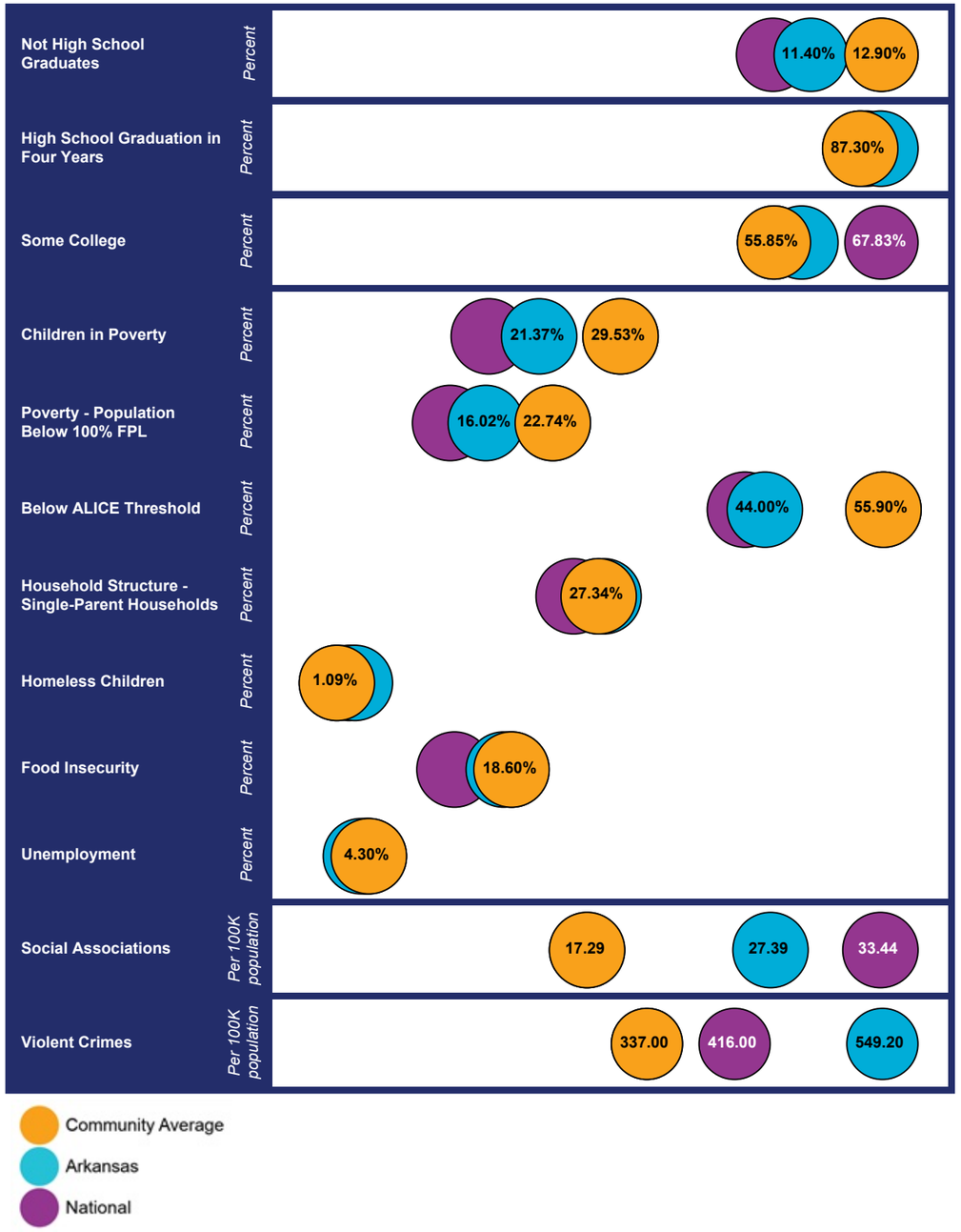


Table 15. Social and Economic Factors

		Drew County	Community Average	State	National
Not High School Graduates	*Percentage of adults without a high school diploma*	12.90%	12.90%	11.40%	10.60%
High School Graduation in Four Years	*Percentage of ninth-grade cohort who graduated in four years*	87.30%	87.30%	90.30%	88.20%
Some College	*Percentage of adults ages 25-44 with some post-secondary education*	55.85%	55.85%	58.92%	67.83%
Children in Poverty	*Percentage of children under age 18 below the poverty line*	29.53%	29.53%	21.37%	16.32%
Poverty - Population Below 100% FPL	*Percentage of the population living in households with income below the federal poverty level*	22.74%	22.74%	16.02%	12.44%
Below ALICE Threshold	*Percentage of households living in poverty or classified as ALICE (Asset Limited, Income Constrained, Employed)*	55.90%	55.90%	44.00%	42.00%
Household Structure - Single-Parent Households	*Percentage of children who live in households where only one parent is present*	27.34%	27.34%	27.83%	24.83%
Homeless Children	*Percentage of students experiencing homelessness enrolled in the public school system*	1.09%	1.09%	2.90%	2.31%
Food Insecurity	*Percentage of the population that experienced food insecurity in the report year*	18.60%	18.60%	17.82%	12.88%
Unemployment	*Percentage of the civilian non-institutionalized population age 16 and older that is unemployed (non-seasonally adjusted)*	4.30%	4.30%	3.50%	4.00%
Social Associations	*Establishments, rate per 100,000 population*	17.29	17.29	27.39	33.44
Violent Crimes	*Annual rate of reported violent crimes per 100,000 population*	337.00	337.00	549.20	416.00

Figure 16. Social and Economic Factors



IDENTIFIED NEED 1:
Increase Access to Care and Education

GOALS/OBJECTIVE/OBJECTIVES: Increase access to quality health care, preventive screenings, vaccinations, and community health resources for Drew County.

STRATEGY 1:
Expand community outreach and strengthen partnerships with local nonprofits, schools, and employers to improve access and awareness.

ACTION STEPS:

- Host annual free flu shot events & childhood immunization clinics
- Launch a “Wellness Meet-Up Series” open to the public, featuring monthly sessions on key wellness topics such as physical activity, mindful eating, stress management, and sleep health.
- Partner with local businesses and organizations to offer free health education and on-site screenings (e.g., blood sugar, blood pressure, BMI) and facilitate scheduling for primary care and mammogram appointments.
- Continue local and regional partnerships and collaborations to expand access to care and reduce barriers to care
- Explore Resource Hub opportunities with area agencies to identify and promote community resources and social drivers of health support
- Maintain the financial assistance policy for patients who are uninsured, underinsured, ineligible for a government health care program, or otherwise unable to pay, for medically necessary or emergent care.
- Continue to evaluate the need to recruit physicians, advanced practice providers and support staff as necessary to meet community needs.
- Continue to provide education and wellness tips on news segments and social media.

KEY PERFORMANCE METRICS:

- Provide preventive screenings, vaccinations, and related services to at least 200 community members
- Track and report the number of community outreach events hosted or attended by Baptist Health–Monticello.
- Measure and report the number of community members reached through health education, screenings, and outreach efforts.
- Evaluate referral and follow-up rates for individuals connected to primary or specialty care through outreach initiatives.

COLLABORATIONS WITH ORGANIZATIONS:
Local nonprofits, faith-based organizations, Mainline

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS NEED:
Staff time and clinical expertise, marketing and educational materials, community health supplies, vaccination resources, and ongoing support from the Marketing & Communications and Community Outreach

ESTIMATED COMPLETION DATE: Ongoing through 2028

PERSON(S)/DEPARTMENT RESPONSIBLE: Vice-President of Operations, Community Outreach

IDENTIFIED NEED 1:
Increase Access to Care and Education

GOALS/OBJECTIVE/OBJECTIVES:
To improve community health by increasing health literacy and reducing barriers to accessing healthcare through community-led, culturally appropriate education and navigation support.

STRATEGY: 2
Health Literacy & Access to Healthcare

ACTION STEPS:

- Establish a Community Health Literacy committee including patient representatives, clinical staff, and community partners) to finalize the curriculum, set implementation timelines
- Identify target populations based on data and community need
- Launch community in-person, and virtual workshops to cover topics including understanding health information, communicating with healthcare providers, navigating healthcare, self-management and preventive health, understanding prescriptions, telehealth, patient rights
- Train community-based clinical and non-clinical staff in health-literate communication (e.g., Teach-Back, plain language)

KEY PERFORMANCE METRICS:

- Curriculum identified and vetted for implementation
- Track the number of classes offered and participants
- Track pre/post test results to determine knowledge gained
- Track number of staff trained to implement the program
- Identified number of encounters using the Teach-Back method

COLLABORATIONS WITH ORGANIZATIONS: Local nonprofits, faith-based organizations

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS NEED:
Staff time and clinical expertise, marketing and educational materials, community health supplies, vaccination resources, and ongoing support from the Marketing & Communications and Community Outreach

ESTIMATED COMPLETION DATE: Ongoing through 2028

PERSON(S)/DEPARTMENT RESPONSIBLE: Vice-President of Operations, Community Outreach

IDENTIFIED NEED 1:
Increase Access to Care and Education

GOALS/OBJECTIVE/OBJECTIVE:
Financial Empowerment for Healthcare: The goal is to move participants from financial crisis management to proactive planning. show how sound budgeting and saving habits directly support access to care and health stability.

Strategy 3:
Financial Literacy & Access to Healthcare

ACTION STEPS:

- Identify a local Bank or Credit Union to partner in program delivery
- Partner with Community groups and organizations to implement class
- Incorporate Financial Literacy in Community Wellness Centers
- Incorporate Financial Literacy in Community Wellness Centers and Prenatal/Postpartum program by including the following educational topics
  - Control Your Money: Budgeting101
  - Understanding needs vs. wants, building a savings
  - Building a Savings for Emergencies and healthcare
  - Avoiding Money Traps: Debts & Credits
  - Protect Your Health: Financial Literacy
- Include information in all FoodRx bags (if applicable)
- Identify additional resources for referrals beyond classes

KEY PERFORMANCE METRICS

- Track the number of classes offered and number of participants
- Utilize pre and post test to determine knowledge gain
- Track number of community partners identified and utilized for implementation
- Track number of referrals for financial assistance

COLLABORATIONS WITH ORGANIZATIONS: Local nonprofits, local banks, cooperative extension organizations

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS NEED:
Staff time and clinical expertise, marketing and educational materials, community health supplies, vaccination resources, and ongoing support from the Marketing & Communications and Community Outreach

ESTIMATED COMPLETION DATE: Ongoing through 2028

PERSON(S)/DEPARTMENT RESPONSIBLE: Vice-President of Operations, Community Outreach

IDENTIFIED NEED 2:
The Community Mental Health Strategy: Access, Education, Acceptance

GOALS/OBJECTIVE: Improve and increase access to mental health services, reduce stigma, and promote emotional well-being for residents of the Drew County

STRATEGY:
Strengthen collaboration with employers, healthcare providers, and community organizations to expand mental health education, increase access to counseling and crisis resources, and promote early intervention and resilience-building initiatives.

ACTION STEPS:

- Continue to provide in-patient withdrawal management services.
- Partner with healthcare organizations, locally and statewide, to increase the capacity to provide additional mental health services.
- Continue to participate in the Arkansas Rural Health Partnership's Mental/Behavioral Health Task Force.
- Participate in the Arkansas Rural Health Partnership's Opioid Community Response Implementation Project to increase in-patient mental and behavioral health services.
- Provide Mental Health First Aid training to local schools, colleges, and community or faith-based organizations.
- Provide Community-based Stop the Bleed Trainings
- Participate in System-wide Mental Health Awareness Campaigns
- Partner with local schools and college to increase mental health awareness
- Integrate Mental Health Education and Awareness materials into Schools and Workplaces
- Utilize Telepsych for patients in need of Telemedicine services

KEY PERFORMANCE METRICS:

- Track number of patient encounters in-patient withdrawal management services
- Track number of patient encounters utilizing Telepsych services
- Report number of Community partners and events for mental health services
- Track the number of mental health first aid and Stop the Bleed classes and participants
- Track the number of Mental Health First Aid trainings and attendance
- Measure campaign's reach through social media engagement, website visits, and printed material distribution.

COLLABORATIONS WITH ORGANIZATIONS: Local schools, universities and businesses, non-profits and faith-based organizations

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS NEED: Staff time and clinical expertise, marketing and educational materials, community health supplies and ongoing support from the Marketing & Communications and behavioral health, command center and Community Outreach teams.

ESTIMATED COMPLETION DATE: Ongoing through 2028

PERSON(S)/DEPARTMENT RESPONSIBLE: VP of Operations, Behavioral Health, Community Outreach Director Marketing & Communications Manager, Case Management

IDENTIFIED NEED 3:
Closing the Gap: A Strategy for Healthy Communities and Nutrition Security

GOALS/OBJECTIVE:
GOALS/OBJECTIVE/OBJECTIVES:
Reduce food insecurity for inpatients and improve nutrition knowledge among in-patients and general community through education, outreach, and collaboration with local partners.

STRATEGY 1:
Expand community partnerships and implement interactive nutrition education programs that empower residents with practical skills and resources to reduce food insecurity and promote healthier eating habits.

ACTION STEPS:
- Pilot FoodRx Program for inpatients identified as food insecure.
- Explore funding opportunities in partnership with Baptist Health Foundation to expand FoodRx Program to employees and contractors of Baptist Health to surrounding
- Continue partnering with the Baptist Health Community Outreach Department, community organizations—including local school districts to provide free, engaging education on healthy eating and nutrition.
- Educate staff on food insecurity and resources within our community that can benefit our patients and fellow staff members.
- Launch a “Wellness Meet-Up Series” open to the public, featuring monthly sessions on key wellness topics such as physical activity, mindful eating, stress management, and sleep health.
- Implement a “Maintain Don’t Gain” Holiday nutrition education challenge in partnership with Community Outreach

PERFORMANCE METRICS:
- Track percentage of patients screened for food insecurity
- Track and report number of patients identified as food insecure during screening
- Track number of referrals for food resources
- Track and report number of FoodRx bags given to patients during timeframe
- Track and report number of FoodRx bags given to employees (if funding is secured to expand program)
- Track the amount of grant/external funding secured toward the sustainability goal

COLLABORATIONS WITH ORGANIZATIONS: Arkansas Foodbank, , local non-profits, local food pantries

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS NEED: Staff time and clinical expertise, marketing and educational materials, community health supplies and ongoing support from the Marketing & Communications and Community Outreach teams.

ESTIMATED COMPLETION DATE: Ongoing through 2028

PERSON(S)/DEPARTMENT RESPONSIBLE: VP of Operations, Community Outreach Team, Marketing & Communications Manager, Case Management

IDENTIFIED NEED 3:
Closing the Gap: A Strategy for Healthy Communities and Nutrition Security

STRATEGY 2:
Mobile Health Unit (MHU) "Food as Medicine" Initiative
To improve the health and nutritional well-being of underserved community members by utilizing the Mobile Health Unit to proactively identify individuals experiencing food insecurity, provide immediate relief through nutritious food access, and ensure sustainable connectivity to community food resources.

ACTION STEPS:
- Utilize Baptist Health Community Outreach and Mobile Health unit to screen community members for food insecurity.
- Develop and deploy food boxes in cooperation with the Arkansas Foodbank
- Identify key preventative screenings to be offered at each distribution event
- Develop a tracking system including baseline results, post results, local healthcare and social drivers of health referrals
- Promote the schedule through local channels (churches, community centers, public libraries) using clear, accessible flyers and social media to maximize attendance for free health screenings.
- Implement a short-term follow-up mechanism to measure the impact of referrals.

KEY PERFORMANCE METRICS:
- Number of scheduled MHU visits that occurred in high need areas
- Track and report the number of bags and pounds of food distributed
- Track and report health outcomes for the population being screened
- Percentage of food-insecure clients who confirm they utilized at least one resource on the provided local pantry list during the 30-day follow-up call.
- Track other social determinants of health identified and referrals
- Track the amount of grant/external funding secured toward the sustainability goal

COLLABORATIONS WITH ORGANIZATIONS: Arkansas Foodbank, local food banks, local food pantries, faith-based community partners

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS NEED: Staff time and clinical expertise, marketing and educational materials, ongoing support from the Marketing & Communications

ESTIMATED COMPLETION DATE: Ongoing

PERSON(S)/DEPARTMENT RESPONSIBLE: Baptist Health Community Outreach, Baptist Health Leadership, Marketing & Communications

BAPTIST HEALTH MEDICAL CENTER
Stuttgart

About Us

The original Stuttgart Memorial Hospital opened in 1957. In 2009 the facility became a part of the Baptist Health system. Baptist Health Medical Center-Stuttgart is licensed by the state of Arkansas for 49 acute care beds.

This hospital is one of twelve Baptist Health hospitals in Arkansas and is a member of the Arkansas and American Hospital Association, major health networks, and is Medicare certified.

Baptist Health Medical Center-Stuttgart is a growing healthcare facility dedicated to serving the people of Arkansas County and surrounding areas with quality care delivered by knowledgeable and caring professionals. To better serve the community, Baptist Health Family Clinic-Brinkley, Baptist Health Family Clinic-Clarendon, Baptist Health Family Clinic-DeWitt, Baptist Health Family Clinic-England, Baptist Health Family Clinic-Hazen, Baptist Health Stuttgart Medical Clinic, and Baptist Health Therapy Center-Stuttgart are operated by Baptist Health Medical Center-Stuttgart.

Community Health Needs Assessment 2026-2028
Baptist Health Medical Center-Stuttgart

HIGHLIGHTS OF COMMUNITY HEALTH NEEDS ASSESSMENT ACCOMPLISHMENTS 2023-2025

Access to Care

- Hospital recognized as a Top 100 Rural & Community Hospital by The Chartis Center for Rural Health.
- Stuttgart is designated as an Arkansas Stroke Ready Hospital by the Arkansas Department of Health,
- Utilized the Command Center to increase access and decrease barriers to care
- Vaccination events were held with 36 individuals receiving flu vaccines, 12 COVID-19 vaccines in 2023 and childhood immunizations were offered. There is one more planned event before the conclusion of 2025.
- Through three events, there were 70 patient encounters where individuals received blood pressure, blood sugar and cholesterol screenings
- Four diabetes education class sessions were held with 32 participant encounters and a heart health education class with 16 participant encounters
- A hypertension program with 2 class sessions was offered with 15 participant encounters.

Mental Health Awareness

- Utilize Telepsych services for Community members
- Provided mental health education during community presentations on Chronic Diseases
- Partnered with Community Outreach to office 6-month virtual wellness meet-ups
- A system-wide Behavioral Health Vice President was hired to establish a system-wide comprehensive plan to address and expand mental heath services

Food and Nutrition

- Conducted six hands-on grocery store tours at Walmart using the Cooking Matters curriculum, directly empowering 28 participants with practical skills in budgeting and healthy food choices
- Delivered five "Cooking Matters" educational classes at the local library, generating 50 participant encounters focused on skill development and improved nutrition.
- Identify and refer patients to community-based food resources

2025 BAPTIST HEALTH COMMUNITY HEALTH NEEDS ASSESSMENT: STUTTGART

ACHI
August 2025

Baptist Health

PREPARED BY:
ACHI
INSPIRING HEALTHY ACTS

Introduction

Baptist Health engaged the Arkansas Center for Health Improvement (ACHI) to conduct the quantitative data collection and analysis for the 2025 Community Health Needs Assessment (CHNA) process. Baptist Health provided ACHI with the counties served by each of its 12 hospital communities. A total of 16 Arkansas counties and two Oklahoma counties were included.

Each report presents community-level data for a hospital community, including tables and figures for each indicator, along with comparisons to Arkansas and U.S. benchmarks. Dot graphs are provided to visualize performance across selected indicators. All reports are prepared using the same methodology to ensure consistency and comparability across Baptist Health hospital communities.

Methodology

A summary of sources, definitions, indicator criteria, and suppression rules can be found in the methods and sources document.

Community Profile Summary

To support the 2025 Community Health Needs Assessment (CHNA), ACHI compiled a comprehensive dataset of 103 health and demographic indicators for the communities served by Baptist Health's 12 hospital locations. This section provides an overview of these indicators across the full CHNA service area and offers multiple views for understanding and comparing county-level and community-level data.

Data are grouped into the following 14 categories, based on the source-defined domains outlined in the data source reference sheet:

1. Demographics
    a. Age
    b. Sex
    c. Race, Ethnicity, and Language
2. Insurance Coverage
3. Access to Care
4. Cause of Death
5. Chronic Conditions
6. Diagnoses Incidence at Discharge
7. Environment
8. Health Behaviors
9. Health Outcomes
10. Healthcare Expenditures
11. Maternal and Infant Health
12. Mental Health and Substance Use
13. Prevention
14. Social and Economic Factors

Measurements for these categories will be displayed in the following sections.

Hospital Community Indicator

The hospital community indicator snapshots offer an at-a-glance view of how each hospital community compares to state and national benchmarks, as well as the counties that make up the community.

Each table presents the data values for selected indicators across the 14 CHNA domains, and each corresponding visual uses proportionally scaled circular markers to illustrate performance. This format is designed to quickly convey how each hospital community aligns with or diverges from broader benchmarks in key population health metrics.

Each displays four comparison points:

- **Purple** – Represents the national value for the indicator.
- **Blue** – Represents the value for the state of Arkansas.
- **Gold** – Represents the weighted average for all counties in the hospital's defined service area.
- **Gray** – Represent the values of each county assigned to that hospital community.

Where available, data for each indicator are shown for all four categories. If a value is not available or is suppressed for a contributing county, it is noted as "Not Available" in the table and excluded from the visual display. No color ranking is applied; the visuals and tables are intended to illustrate relative placement, not comparative rank.

Hospital Community: Stuttgart (Arkansas, Prairie, and Monroe Counties)

Figure 1. Counties Served by Baptist Health Medical Center–Stuttgart

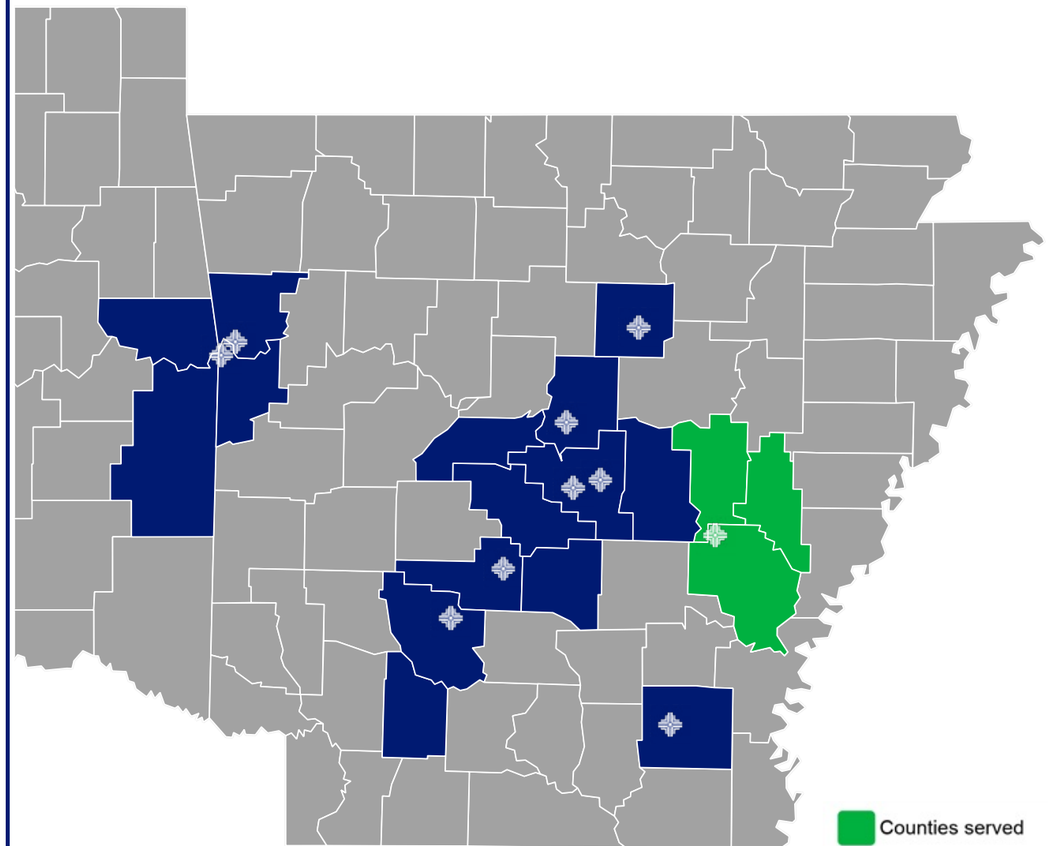


Table 1. Demographics: Age and Sex

		Monroe County	Prairie County	Arkansas County	Community Average	State	National
Total Population	*Number*	6,681	8,162	16,773	31,616	3,032,651	332,387,540
Female	*Percent*	51.79%	49.56%	51.12%	50.86%	50.67%	50.50%
Male	*Percent*	48.21%	50.44%	48.88%	49.14%	49.33%	49.50%
Ages 0-4	*Percent*	6.15%	4.57%	6.06%	5.69%	6.02%	5.70%
Ages 5-17	*Percent*	16.96%	15.63%	17.13%	16.71%	17.26%	16.46%
Ages 18-24	*Percent*	6.06%	7.12%	7.41%	7.05%	9.33%	9.12%
Ages 25-34	*Percent*	10.25%	10.50%	11.57%	11.01%	12.93%	13.69%
Ages 35-44	*Percent*	10.28%	10.62%	11.73%	11.14%	12.66%	13.08%
Ages 45-54	*Percent*	11.20%	13.16%	11.97%	12.11%	11.84%	12.29%
Ages 55-64	*Percent*	15.84%	14.84%	14.20%	14.71%	12.64%	12.82%
Ages 65+	*Percent*	23.26%	23.56%	19.92%	21.57%	17.33%	16.84%

Figure 2. Demographics: Age and Sex

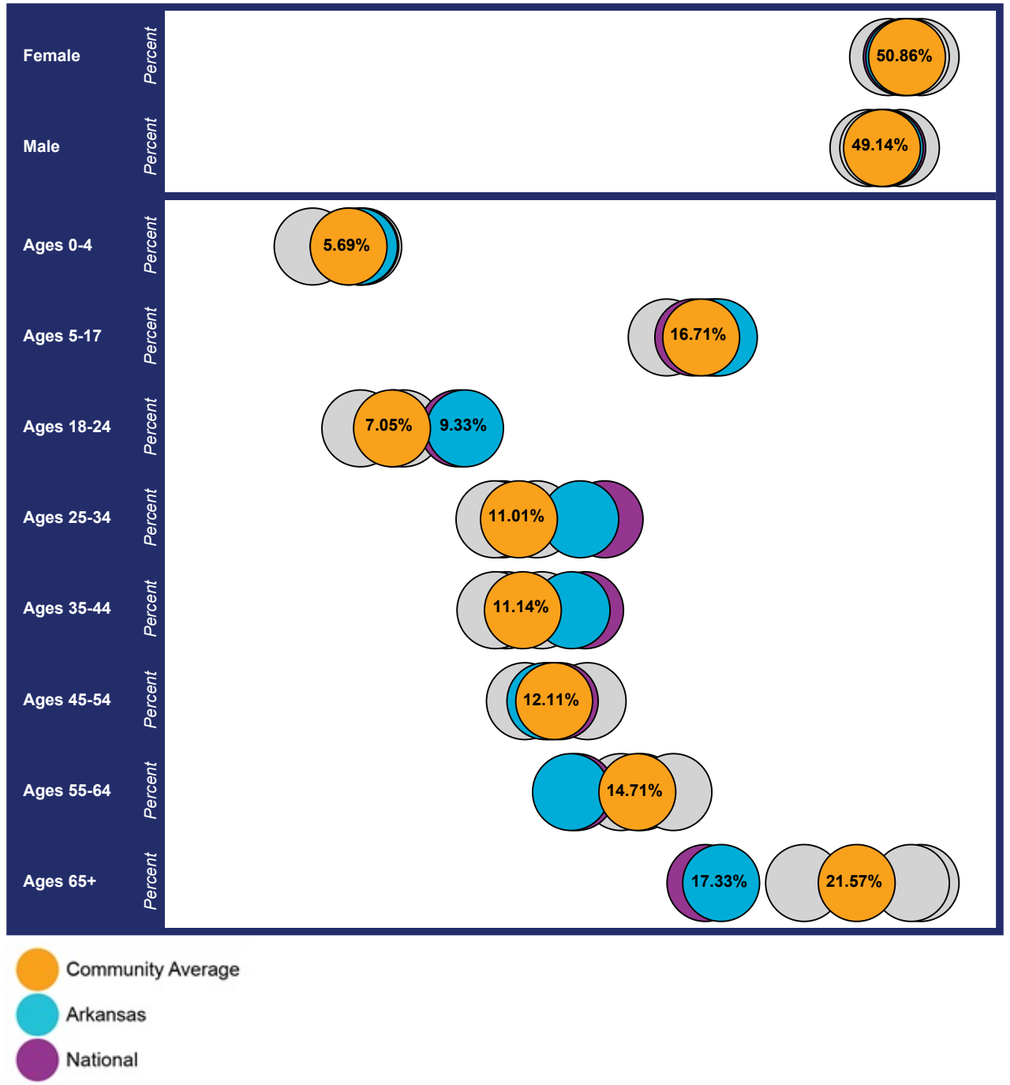


Table 2. Demographics: Race, Ethnicity, and Language

		Monroe County	Prairie County	Arkansas County	Community Average	State	National
Total Population	*Number*	6,681	8,162	16,773	31,616	3,032,651	332,387,540
Asian	*Percent*	0.99%	0.00%	0.08%	0.25%	1.53%	5.75%
Black or African American	*Percent*	40.20%	10.50%	25.75%	24.87%	14.84%	12.03%
Hispanic	*Percent*	2.83%	2.19%	3.94%	3.25%	8.77%	18.99%
Multiple Races	*Percent*	2.54%	3.23%	2.53%	2.71%	5.50%	3.87%
Native American/ Alaska Native	*Percent*	0.00%	0.05%	0.10%	0.07%	0.36%	0.53%
Native Hawaiian/ Pacific Islander	*Percent*	0.00%	0.00%	0.00%	0.00%	0.39%	0.17%
Other Races	*Percent*	0.09%	0.15%	0.00%	0.06%	0.26%	0.50%
White	*Percent*	53.35%	83.88%	67.60%	68.79%	68.36%	58.17%
Non-English Language Households	*Percent*	0.10%	0.00%	0.90%	0.50%	1.50%	4.20%

Figure 3. Demographics: Race, Ethnicity, and Language

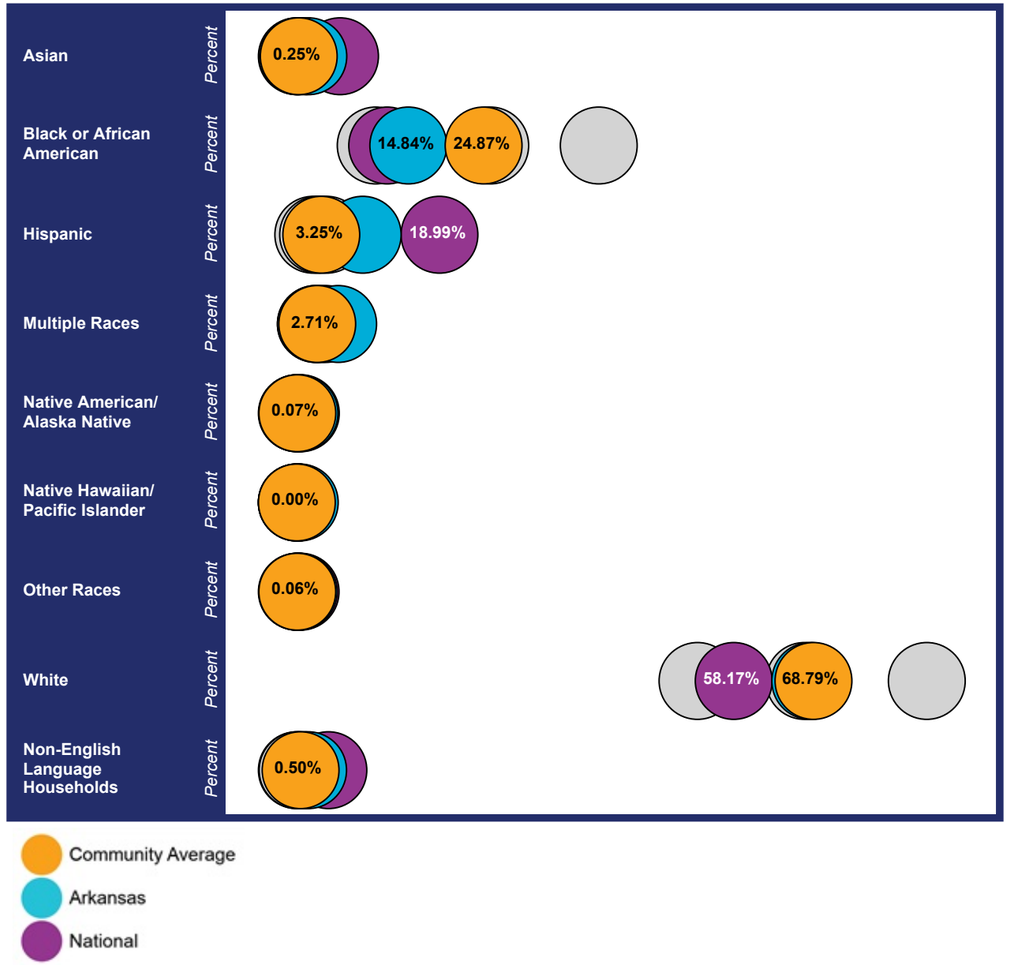


Table 3. Insurance Coverage

		Monroe County	Prairie County	Arkansas County	Community Average	State	National
Private Health Insurance Coverage	*Percentage of the total civilian non-institutionalized population for whom insurance status is determined that is covered by private health insurance*	55.27%	62.22%	62.42%	60.86%	65.37%	73.62%
Public Health Insurance Coverage	*Percentage of the total civilian non-institutionalized population for whom insurance status is determined that is covered by public health insurance*	60.18%	50.83%	52.69%	53.79%	48.21%	39.70%
Uninsured	*Percentage of adults under age 65 without health insurance coverage*	11.10%	9.00%	8.20%	9.02%	10.00%	9.50%

Figure 4. Insurance Coverage

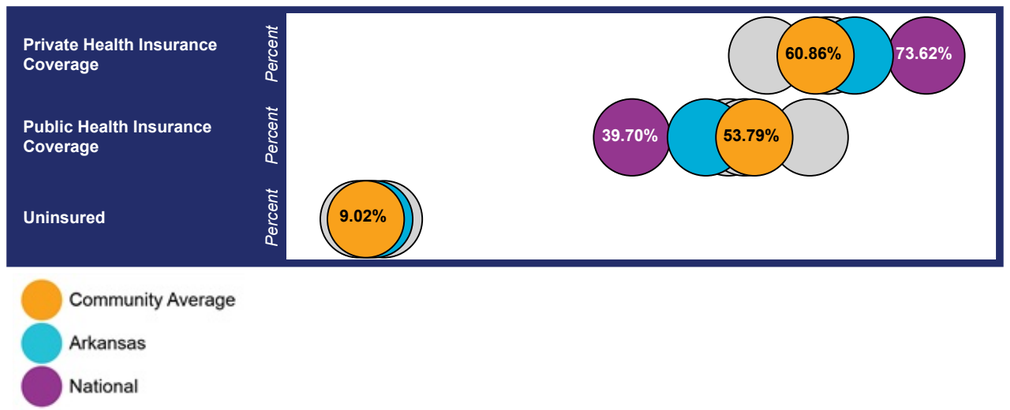


Table 4. Access to Care

		Monroe County	Prairie County	Arkansas County	Community Average	State	National
Primary Care Physicians	*Ratio of population to one primary care physician*	2227:1	8135:1	2090:1	3679:1	1478:1	1334:1
Mental Health Providers	*Ratio of population to one mental health provider*	3256:1	4018:1	709:1	1139:1	367:1	300:1
Dentists	*Ratio of population to one dentist*	1640:1	8069:1	2064:1	2393:1	2044:1	1361:1
Active Primary Care Physicians	*Rate per 10,000 county residents of primary care physicians who provided evaluation and management services to at least two patients on the same day at least once during the year*	17.60	9.70	19.20	16.41	9.20	Not Available
Addiction or Substance Use Providers	*Rate of addiction or substance use providers per 100,000 population*	0.00	0.00	0.00	0.00	5.98	29.43
Buprenorphine Providers	*Rate of buprenorphine providers per 100,000 population*	45.15	0.00	6.00	12.72	9.81	14.87
Preventable Hospital Stays (Medicare)	*Rate of hospital stays for ambulatory care-sensitive conditions per 100,000 Medicare enrollees*	3637.00	3165.00	2909.00	3128.93	3014.00	2666.00
Diabetic Monitoring (Medicare)	*Percentage of Medicare enrollees aged 65 and older with diabetes who received a hemoglobin A1c (HbA1c) test within the past year.*	91.22%	90.57%	78.87%	84.50%	88.47%	87.53%
Mammography	*Percentage of female Medicare enrollees ages 65-74 who received an annual mammography screening*	41.00%	38.00%	37.00%	38.10%	41.00%	44.00%

Figure 5. Access to Care

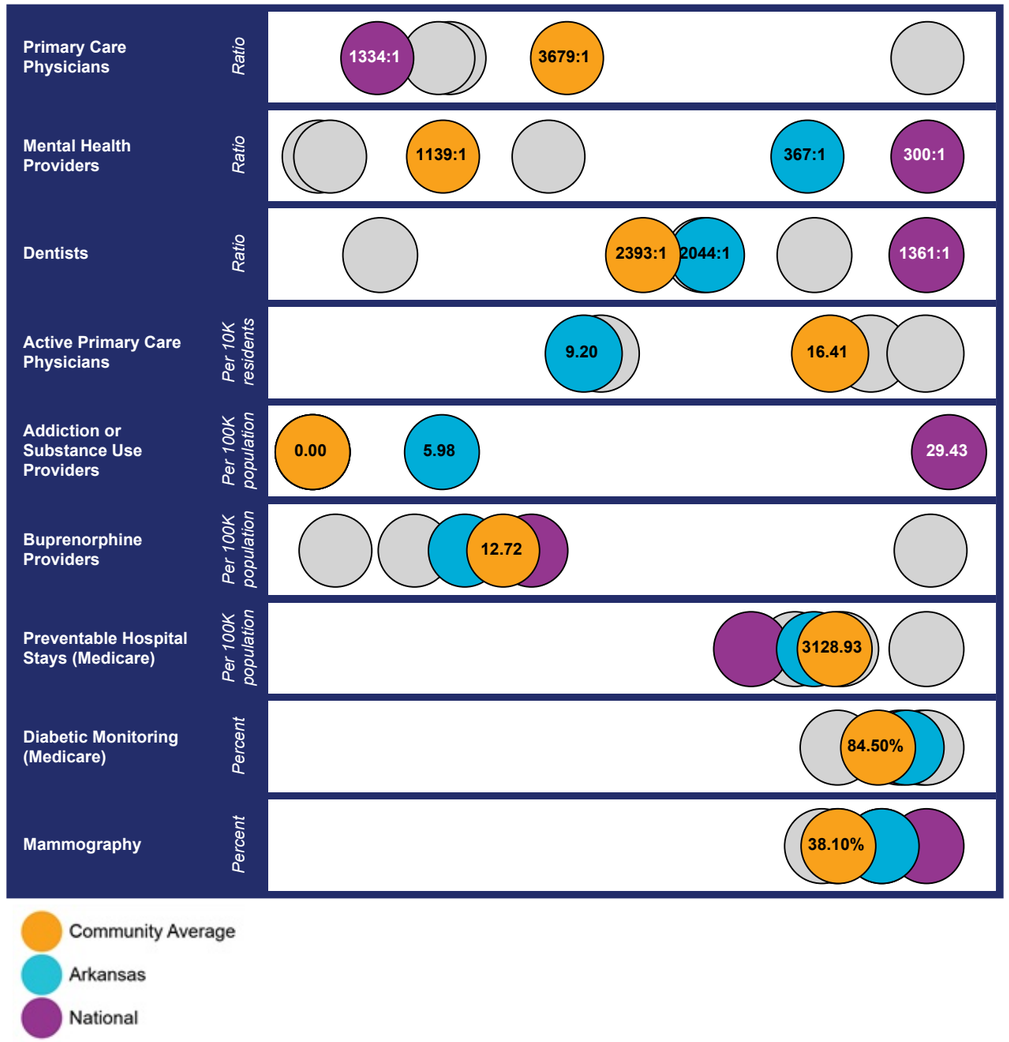


Table 5. Cause of Death

		Monroe County	Prairie County	Arkansas County	Community Average	State	National
All Causes	*Rate of deaths by all causes per 100,000 population (age-adjusted)*	1243.40	995.00	1274.00	1195.51	1001.70	805.60
Premature Death	*Number of deaths among residents under age 75 per 100,000 population (age-adjusted)*	825.22	644.88	816.66	774.12	552.47	406.59
Heart Disease	*Rate of death due to heart disease (ICD-10 Codes I00-I09, I11, I13, I20-I151) per 100,000 population*	441.80	357.60	370.80	382.40	282.80	207.20
Cancer	*5-year average rate of death due to cancer per 100,000 population*	351.10	293.00	316.30	317.64	215.90	182.70
Unintentional Injury	*5-year average rate of death due to unintentional injury (accident) per 100,000 population*	115.00	72.00	86.50	88.78	61.90	63.30
Stroke	*5-year average rate of death due to cerebrovascular disease (stroke) per 100,000 population (age-adjusted)*	93.80	54.60	93.60	83.57	57.40	48.30
Chronic Lower Respiratory Disease	*Rate of deaths due to chronic lower respiratory disease per 100,000 population (age-adjusted)*	82.10	55.60	85.10	76.85	61.00	35.90
Diabetes Mortality	*Rate of deaths due to diabetes per 100,000 population (age-adjusted)*	43.10	43.90	68.80	56.94	34.70	23.90
Suicide Deaths	*This indicator reports the 2019-2023 five-year average rate of death due to intentional self-harm (suicide) per 100, 000 population. Figures are reported as crude rates*	Not Available	Not Available	Not Available	Not Available	19.20	14.50
Motor Vehicle Crash	*5-year average rate of death due to motor vehicle crash per 100,000 population (age-adjusted)*	Not Available	Not Available	33.20	33.20	20.60	12.80
Alcohol-Involved Motor Vehicle Crash	*Rate of persons killed in motor vehicle crashes involving alcohol as a rate per 100,000 population*	2.90	7.20	4.70	4.97	3.10	2.30

Figure 6. Cause of Death

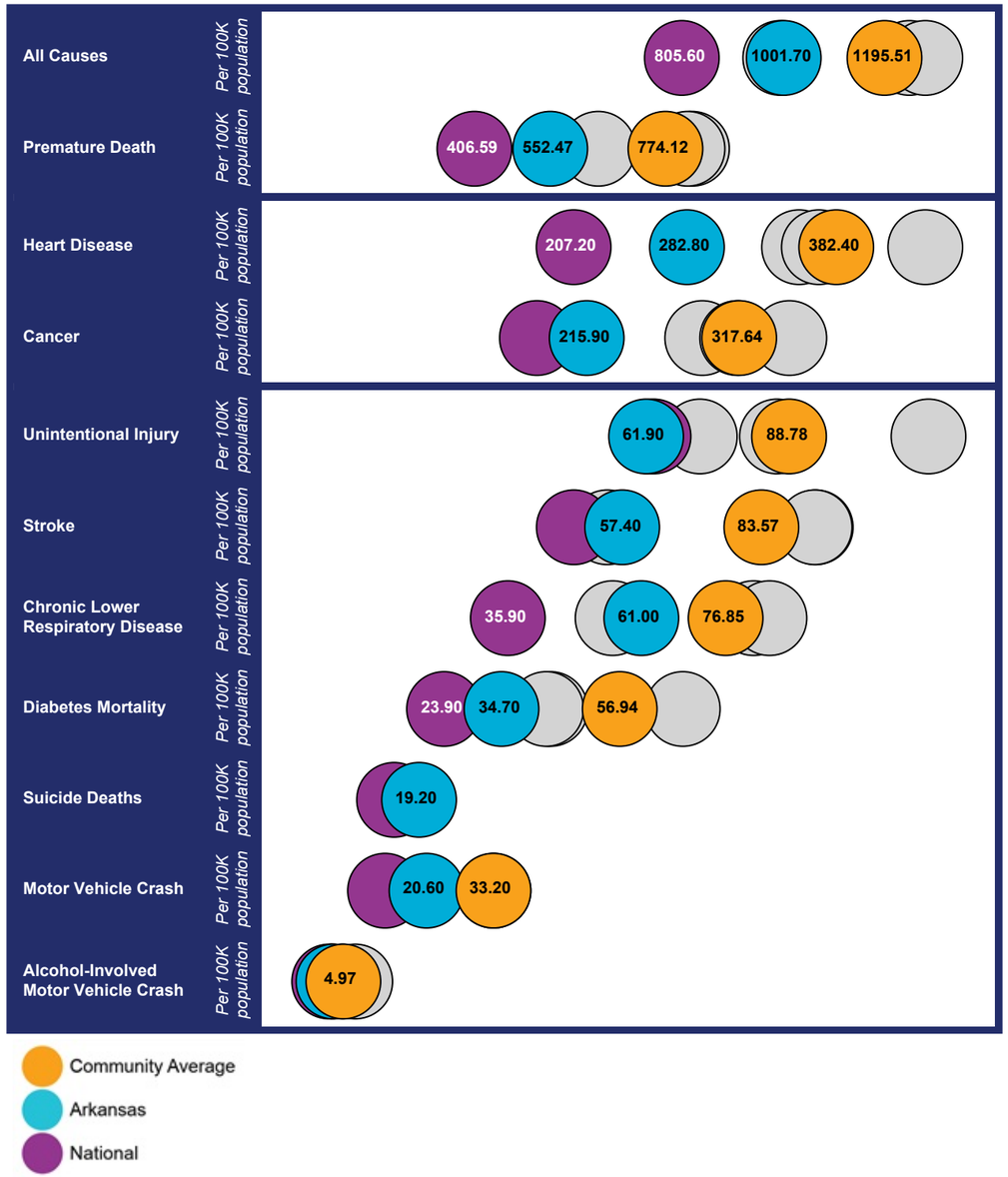


Table 6. Chronic Condtions

		Monroe County	Prairie County	Arkansas County	Community Average	State	National
Child Obesity	*Percentage of students classified as overweight to severely obese, by county location of school*	**45.53%**	**43.68%**	**44.23%**	**44.36%**	**40.10%**	**Not Available**
High Cholesterol	*Percentage of adults who have had their blood cholesterol checked and have been told it was high (age-adjusted)*	**32.90%**	**31.90%**	**29.50%**	**30.84%**	**31.80%**	**30.40%**
Adult Obesity	*Percentage of adults ages 20 and older who report a BMI higher than 30*	**23.20%**	**24.40%**	**32.10%**	**28.23%**	**31.90%**	**30.10%**
High Blood Pressure	*Percentage of adults who have been told they have high blood pressure (age-adjusted)*	**42.00%**	**35.80%**	**36.50%**	**37.48%**	**36.50%**	**29.60%**
Arthritis	*Percentage of adults ages 18 or older diagnosed with some form of arthritis*	**44.20%**	**38.50%**	**32.90%**	**36.73%**	**32.60%**	**Not Available**
Diabetes Prevalence	*Percentage of adults age 18 and older who report ever been told that they have diabetes other than diabetes during pregnancy (age-adjusted)*	**15.50%**	**12.40%**	**13.70%**	**13.74%**	**12.70%**	**10.40%**
Asthma	*Percentage of adults who have been told they currently have asthma (age-adjusted)*	**12.10%**	**11.90%**	**11.70%**	**11.84%**	**11.00%**	**9.90%**
Coronary Heart Disease	*Percentage of adults age 18 and older who report ever having been told by that they had angina or coronary heart disease (CHD) (age-adjusted)*	**7.90%**	**7.30%**	**7.50%**	**7.53%**	**7.20%**	**5.70%**

Figure 7. Chronic Conditions

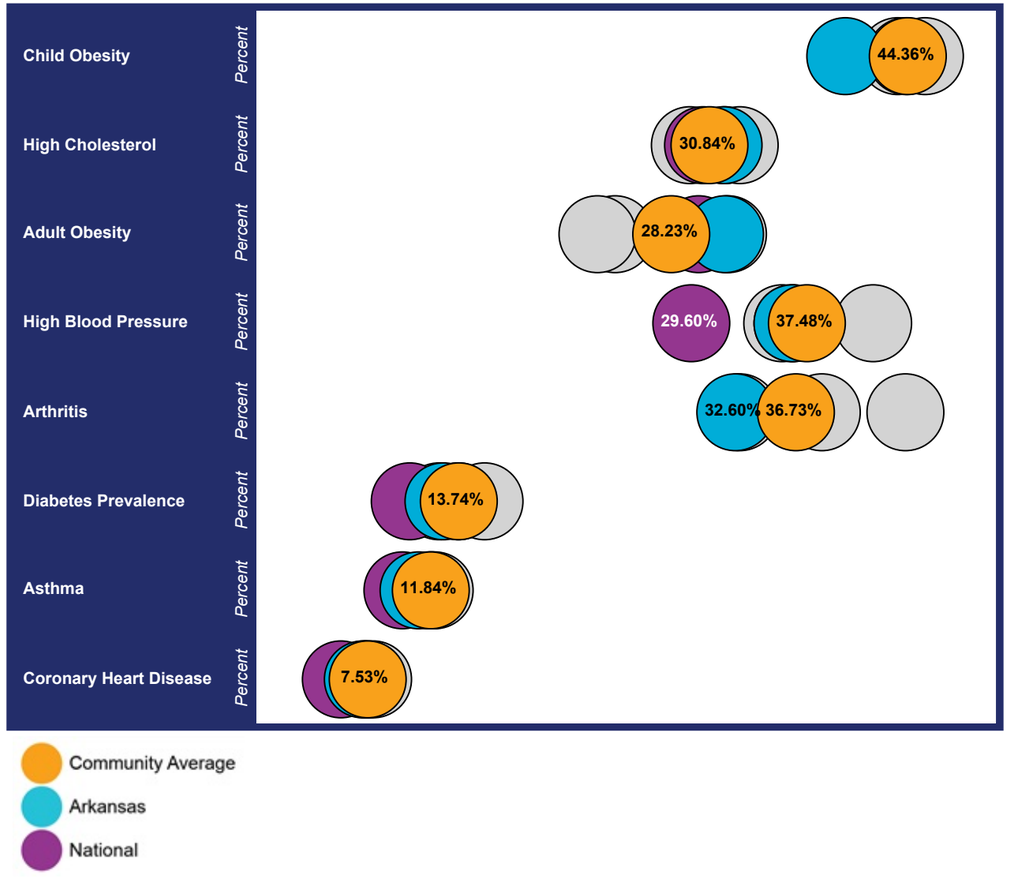


Table 7. Diagnoses at Discharge

		Monroe County	Prairie County	Arkansas County	Community Average	State
Hypertension	*Number of individuals 18 years and older discharged with a primary or secondary hypertension diagnosis as a percentage of the population 18 years and older*	9.01%	8.94%	10.46%	9.76%	8.70%
Hyperlipidemia	*Number of individuals 18 years and older discharged with a primary or secondary hyperlipidemia diagnosis as a percentage of the population 18 years and older*	2.02%	3.37%	2.02%	2.37%	3.90%
Diabetes	*Rate of individuals 18 years and older discharged with a primary or secondary diabetes diagnosis as a percentage of the population 18 years and older*	3.50%	3.43%	3.46%	3.46%	3.70%
Ischemic Heart Disease	*Number of individuals 18 years and older discharged with a primary or secondary ischemic heart disease diagnosis as a percentage of the population 18 years and older*	1.62%	2.44%	1.97%	2.02%	2.50%
Arthritis	*Rate of individuals 18 years and older discharged with a primary or secondary arthritis diagnosis as a percentage of the population 18 years and older*	1.03%	1.84%	1.17%	1.31%	1.90%

Figure 8. Diagnoses at Discharge

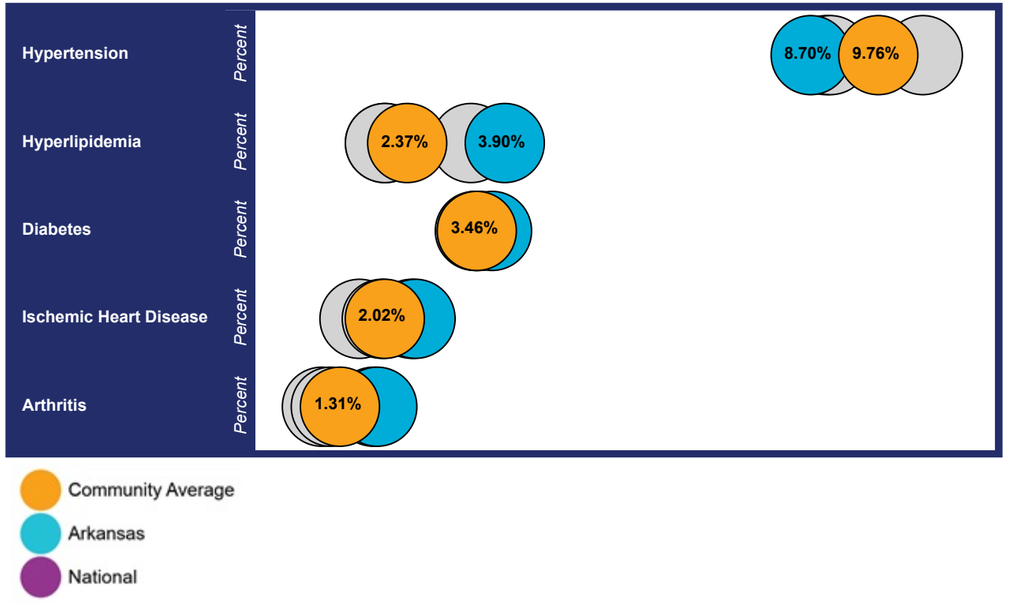


Table 8. Environment

		Monroe County	Prairie County	Arkansas County	Community Average	State	National
Food Environment Index	*Index of factors that contribute to a healthy food environment, 0 (worst) to 10 (best)*	5.50	7.60	5.10	5.83	4.40	7.40
Drinking Water Violations	*The total number of drinking water violations recorded in a two-year period*	0	4	10	6	321	16,107
Access to Exercise Opportunities	*Percentage of population with adequate access to locations for physical activity*	66.20%	32.42%	56.83%	52.51%	63.36%	84.45%
Broadband Access	*Percentage of population in a high-speed internet service area; access to DL speeds >= 25MBPS and UL speeds >= 3 MBPS*	93.11%	94.33%	95.34%	94.61%	94.04%	96.78%
Long Commute Driving Alone	*Among workers who commute in their car alone, the percentage who commute more than 30 minutes*	42.50%	43.00%	22.00%	31.75%	28.10%	36.50%
Severe Housing Problems	*Percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities*	14.39%	6.50%	10.61%	10.35%	13.23%	16.84%

Figure 9. Environment

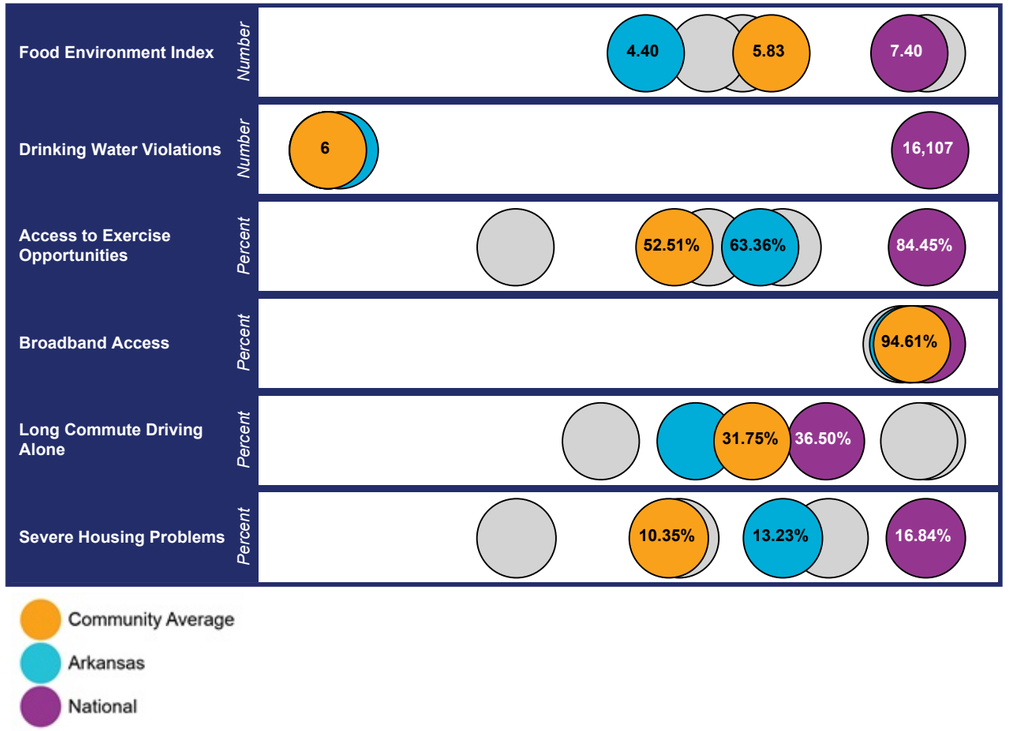


Table 9. Health Behaviors

		Monroe County	Prairie County	Arkansas County	Community Average	State	National
Physical Inactivity	*Percentage of adults aged 20 and older who self-report no leisure time for activity*	28.00%	21.90%	30.10%	27.54%	23.60%	19.50%
Adult Smoking	*Percentage of adults ages 18 and older who are current smokers (age-adjusted)*	24.20%	24.30%	22.80%	23.48%	19.20%	13.20%
Youth Vaping	*Percentage of public school students in 6th, 8th, 10th, and 12th grade who used any vape in the past 30 days*	Not Available	Not Available	14.00%	14.00%	8.10%	Not Available
Sexually Transmitted Infections	*Number of newly diagnosed chlamydia cases per 100,000 population*	929.30	470.90	781.20	732.39	588.30	495.00

Figure 10. Health Behaviors

Table 10. Health Outcomes

		Monroe County	Prairie County	Arkansas County	Community Average	State	National
Poor Physical Health Days	*Average number of physically unhealthy days reported in past 30 days (age-adjusted)*	5.80	5.30	5.20	5.35	5.20	3.90
Poor or Fair Health	*Percentage of adults age 18 and older who self-report their general health status as "fair" or "poor" (age-adjusted)*	28.70%	26.00%	26.20%	26.68%	22.60%	17.00%

Figure 11. Health Outcomes

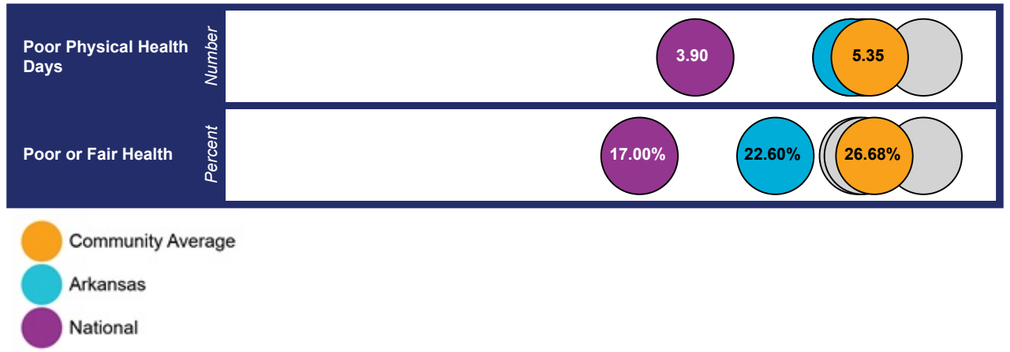


Table 11. Healthcare Expenditures

		Monroe County	Prairie County	Arkansas County	Community Average	State	National
Average Annualized Expenditures	*Average annualized per-person spending on all covered healthcare services.*	**$11,764**	**$12,189**	**$9,862**	**$10,864**	**$10,116**	**Not Available**
Average Annualized Expenditures (Medical Only)	*Average annualized per-person spending on medical services, based on medical claims.*	**$8,009**	**$8,936**	**$6,932**	**$7,676**	**$7,252**	**Not Available**
Average Annualized Expenditures (Pharmacy Only)	*Average annualized per-person spending on prescription drugs, based on pharmacy claims.*	**$3,576**	**$3,020**	**$2,727**	**$2,982**	**$2,609**	**Not Available**

Figure 12. Healthcare Expenditures

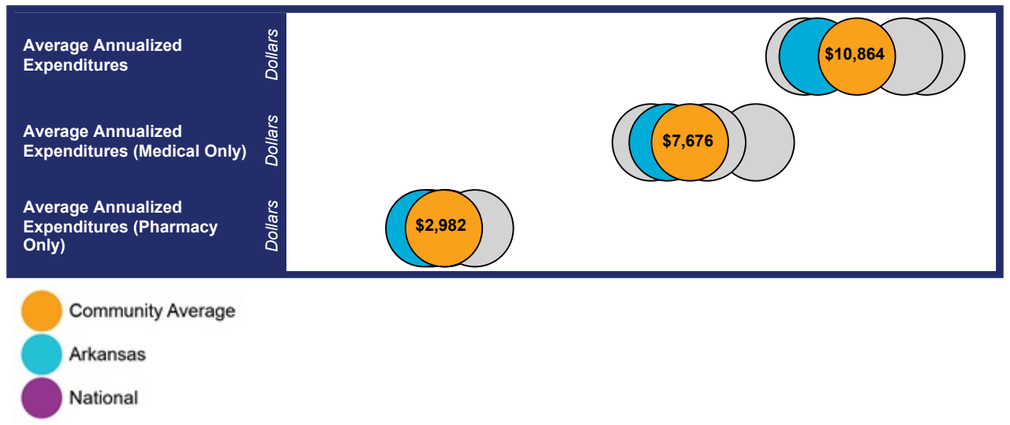


Table 12. Maternal and Infant Health

		Monroe County	Prairie County	Arkansas County	Community Average	State	National
Active Obstetrics and Gynecology Physicians	*Active OB-GYN physicians are defined as those who provided evaluation and management services to at least two female patients ages 12-55 on the same day or performed a qualifying procedure (e.g., delivery) at least once during the year.*	**6.20**	**0.00**	**6.60**	**4.81**	**3.20**	**Not Available**
Teen Births	*The seven-year average number of teen births per 1,000 female population, ages 15-19*	**60.50**	**29.60**	**39.30**	**41.28**	**27.90**	**15.50**
C-Section Rate	*Percentage of live births delivered via cesarean section among all deliveries, calculated by the mother's county of residence.*	**36.77%**	**37.39%**	**42.69%**	**40.07%**	**33.48%**	**Not Available**
C-Section Rate, First Birth	*Percentage of first-birth deliveries (full-term singleton pregnancies in a head-down position) delivered via cesarean section, calculated by the mother's county of residence.*	**34.38%**	**30.30%**	**33.13%**	**32.66%**	**27.58%**	**Not Available**
Low Birthweight	*Percentage of live births where the infant weighed less than 2, 500 grams (approximately 5 lbs., 8 oz.)*	**9.30%**	**8.60%**	**11.50%**	**10.29%**	**9.40%**	**8.40%**
Preterm Birth	*Percentage of live births that are preterm (<37 weeks), calculated as a three-year average.*	**10.70%**	**11.40%**	**12.70%**	**11.94%**	**11.90%**	**10.35%**
Median Travel Time to Delivery	*Median number of minutes Arkansas mothers traveled from their home ZIP code to the delivery facility, calculated using birth records and facility addresses. Travel time estimates include in-state and out-of-state facilities.*	**48.00**	**42.00**	**63.00**	**54.41**	**16.00**	**Not Available**

Figure 13. Maternal and Infant Health

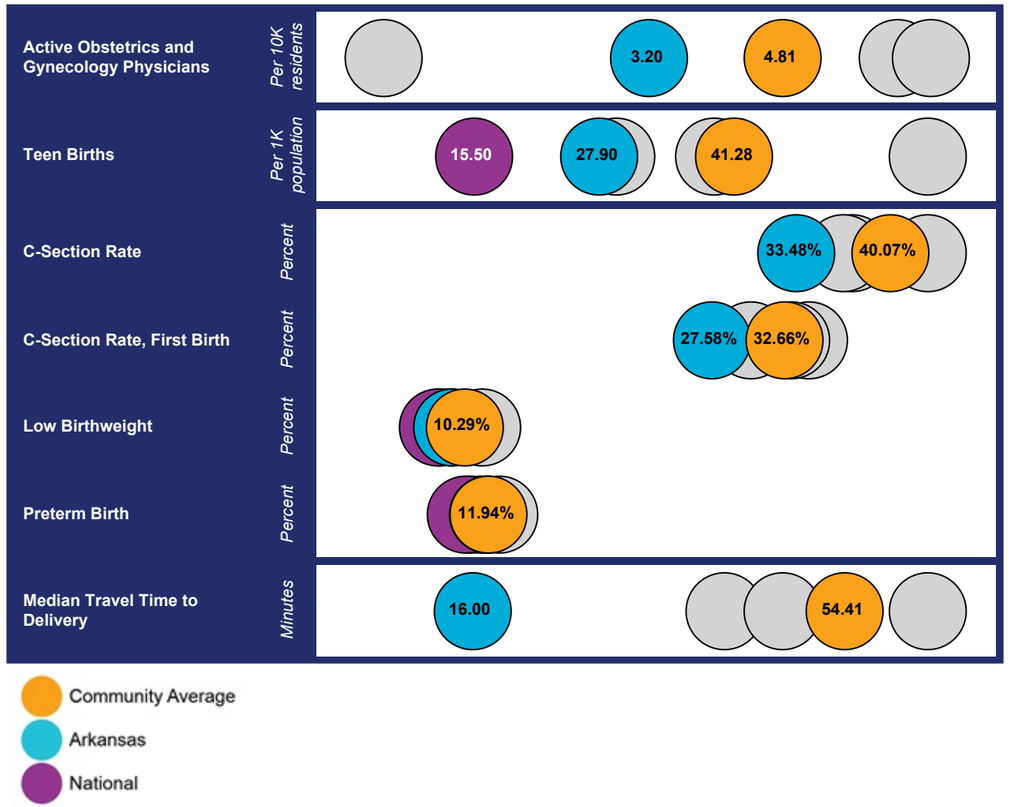


Table 13. Mental Health and Substance Use

		Monroe County	Prairie County	Arkansas County	Community Average	State	National
Adult Depression	*Percentage of adults age 18 and older who report having been told that they had depressive disorder*	26.70%	28.90%	27.80%	27.85%	27.50%	21.10%
Excessive Drinking	*Percentage of adults reporting binge or heavy drinking*	15.88%	19.16%	17.20%	17.43%	18.99%	19.35%
Poor Mental Health	*Percentage of adults age 18 or older reporting poor mental health for 14 or more days (age-adjusted)*	22.50%	22.80%	23.00%	22.84%	20.50%	16.40%
Youth Depression	*Percentage of public school students in 6th, 8th, 10th, and 12th grade who had feelings of depression all of the time in the past 30 days*	Not Available	Not Available	11.90%	11.90%	9.20%	Not Available
Drug Overdose Deaths	*Age-adjusted rate of fatal drug overdoses per 100,000 residents*	0.00	0.00	0.00	0.00	Not Available	Not Available
Non-Fatal Drug Overdoses	*Age-adjusted rate of non-fatal drug overdoses per 100,000 residents*	Not Available	0.00	82.45	55.46	Not Available	Not Available

Figure 14. Mental Health and Substance Use

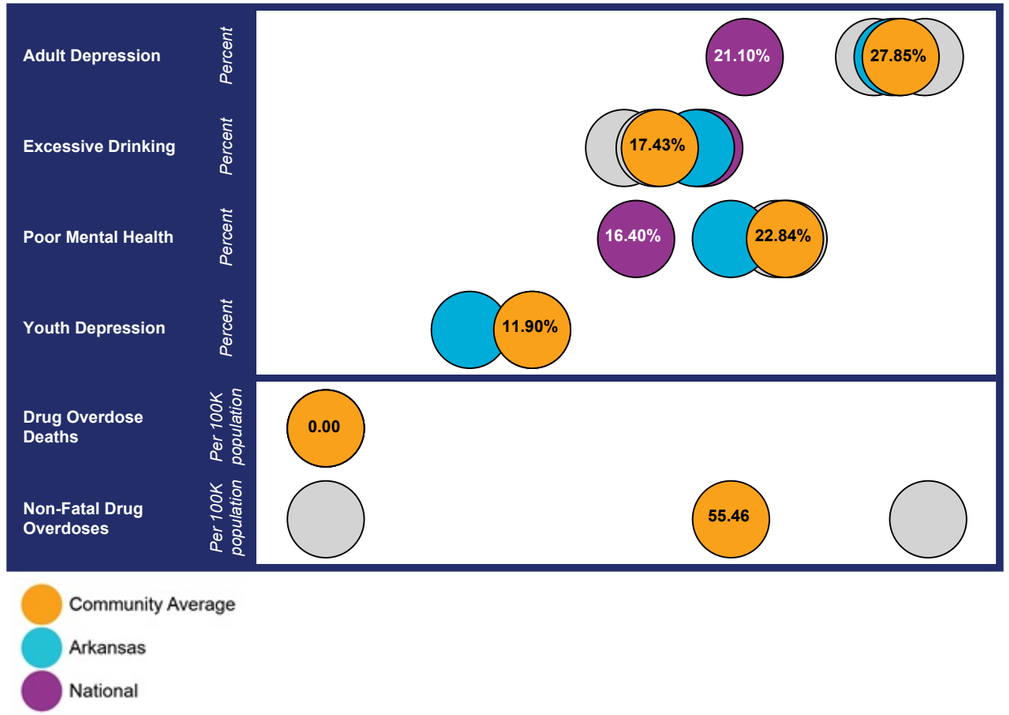


Table 14. Prevention

		Monroe County	Prairie County	Arkansas County	Community Average	State	National
Cervical Cancer Screening	*Percentage of females age 21–65 years who report having had recommended cervical cancer screening test (age-adjusted)*	80.10%	80.50%	80.10%	80.20%	81.20%	83.70%
Colorectal Cancer Screening	*Percentage of adults age 45-75 who have had a recent colorecal cancer screening*	60.80%	60.50%	61.00%	60.83%	61.60%	66.30%
Dental Care Utilization	*Dental care visit (past 1 year), age-adjusted percentage of adults age 18+ by county*	45.90%	49.00%	47.80%	47.71%	54.10%	63.40%
High Blood Pressure Management	*Percentage of adults age 18 and older with high blood pressure who report taking blood pressure medication (age-adjusted)*	64.70%	60.90%	62.90%	62.76%	61.40%	58.90%
Prevention - Seasonal Influenza Vaccine	*Percentage of adults aged 18 and older who report receiving an influenza vaccination in the past 12 months*	43.50%	43.50%	42.50%	42.97%	43.20%	44.80%
Annual Wellness Exam (Medicare)	*Percentage of annual wellness visits among the Medicare fee-for-service (FFS) population*	32.00%	20.00%	11.00%	17.76%	46.00%	44.00%
No HIV Test	*Percentage of adults ages 18 or older who have never been screened for HIV*	67.40%	65.80%	60.50%	63.33%	66.10%	Not Available

Figure 15. Prevention

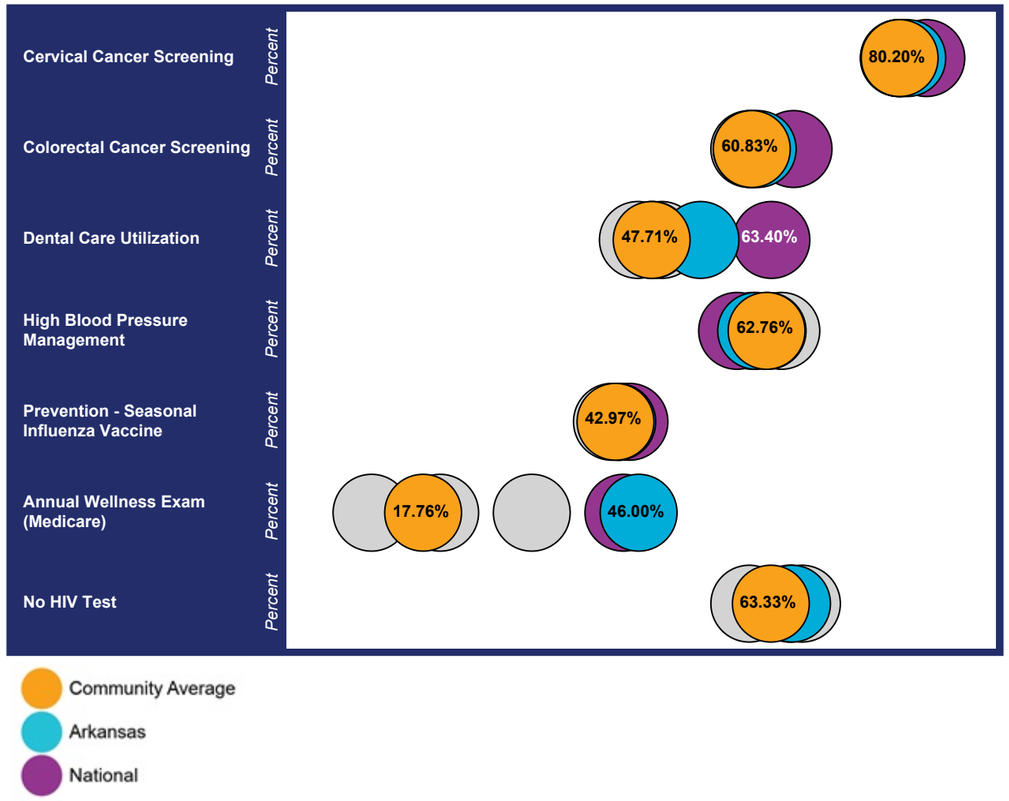
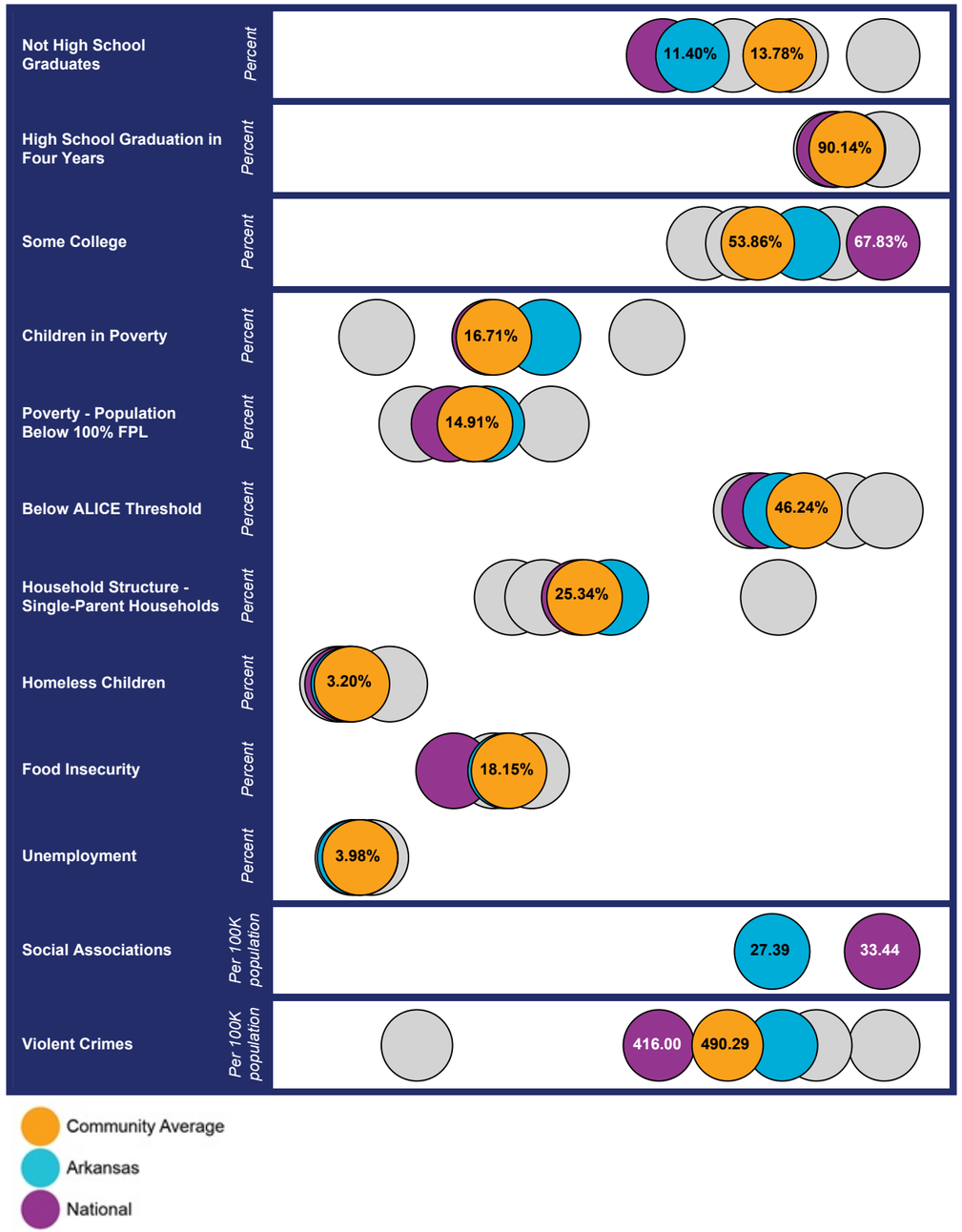


Table 15. Social and Economic Factors

		Monroe County	Prairie County	Arkansas County	Community Average	State	National
Not High School Graduates	*Percentage of adults without a high school diploma*	16.60%	14.10%	12.50%	13.78%	11.40%	10.60%
High School Graduation in Four Years	*Percentage of ninth-grade cohort who graduated in four years*	87.70%	95.70%	88.40%	90.14%	90.30%	88.20%
Some College	*Percentage of adults ages 25-44 with some post-secondary education*	47.81%	62.35%	52.14%	53.86%	58.92%	67.83%
Children in Poverty	*Percentage of children under age 18 below the poverty line*	31.27%	5.55%	16.34%	16.71%	21.37%	16.32%
Poverty - Population Below 100% FPL	*Percentage of the population living in households with income below the federal poverty level*	22.17%	9.37%	14.72%	14.91%	16.02%	12.44%
Below ALICE Threshold	*Percentage of households living in poverty or classified as ALICE (Asset Limited, Income Constrained, Employed)*	53.96%	50.26%	41.20%	46.24%	44.00%	42.00%
Household Structure - Single-Parent Households	*Percentage of children who live in households where only one parent is present*	43.78%	18.44%	21.35%	25.34%	27.83%	24.83%
Homeless Children	*Percentage of students experiencing homelessness enrolled in the public school system*	6.80%	3.05%	1.83%	3.20%	2.90%	2.31%
Food Insecurity	*Percentage of the population that experienced food insecurity in the report year*	20.30%	16.70%	18.00%	18.15%	17.82%	12.88%
Unemployment	*Percentage of the civilian non-institutionalized population age 16 and older that is unemployed (non-seasonally adjusted)*	5.00%	3.30%	3.90%	3.98%	3.50%	4.00%
Social Associations	*Establishments, rate per 100,000 population*	Not Available	Not Available	Not Available	Not Available	27.39	33.44
Violent Crimes	*Annual rate of reported violent crimes per 100,000 population*	659.60	154.40	586.30	490.29	549.20	416.00

Figure 16. Social and Economic Factors



IDENTIFIED NEED 1:
Increase Access to Care and Education

GOALS/OBJECTIVE/OBJECTIVES:
Increase access to quality health care, preventive screenings, vaccinations, and community health resources for Arkansas County.

STRATEGY 1:
Expand community outreach and strengthen partnerships with local nonprofits, schools, and employers to improve access and awareness.

ACTION STEPS:

- Utilize Telehealth and the Command Center to improve access and decrease barriers to care
- Host annual free flu shot events & childhood immunization clinics
- Launch a "Wellness Meet-Up Series" open to the public, featuring monthly sessions on key wellness topics such as physical activity, mindful eating, stress management, and sleep health.
- Partner with local businesses and organizations to offer free health education and on-site screenings (e.g., blood sugar, blood pressure, BMI) and facilitate scheduling for primary care and mammogram appointments.
- Provide home monitoring devices (blood pressure/ glucose monitors primary care clinics
- Continue local and collaborations to expand access and reduce barriers to care
- Explore Resource Hub opportunities with area agencies to identify and promote community resources and social drivers of health support
- Maintain the financial assistance policy for patients who are uninsured, underinsured, ineligible for a government health care program, or otherwise unable to pay, for medically necessary or emergent care.
- Continue to evaluate the need to recruit physicians, advanced practice providers and support staff as necessary to meet community needs.
- Continue to provide education and wellness tips on news segments and social media.
- Increase access to Community-based maternal health educational programs and services

KEY PERFORMANCE METRICS:

- Provide preventive screenings, vaccinations, and related services to at least 200 community members
- Track and report the number of community outreach events hosted or attended by Baptist Health
- Measure and report the number of community members reached through health education, screenings, and outreach efforts.
- Evaluate referral and follow-up rates for individuals connected to primary or specialty care through outreach initiatives.
- Number of providers recruited will be tracked
- Charity Care will be tracked and reported

COLLABORATIONS WITH ORGANIZATIONS: Local nonprofits, faith-based organizations, community-based organizations

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS NEED:
Staff time and clinical expertise, marketing and educational materials, community health supplies, vaccination resources, and ongoing support from the Marketing & Communications and Community Outreach

ESTIMATED COMPLETION DATE: Ongoing through 2028

PERSON(S)/DEPARTMENT RESPONSIBLE: Leadership Team Community Outreach

IDENTIFIED NEED 1:
Increase Access to Care and Education

GOALS/OBJECTIVE/OBJECTIVES:
To improve community health by increasing health literacy and reducing barriers to accessing healthcare through community-led, culturally appropriate education and navigation support.

STRATEGY: 2
Health Literacy & Access to Healthcare

ACTION STEPS:

- Establish a Community Health Literacy committee including patient representatives, clinical staff, and community partners) to finalize the curriculum, set implementation timelines
- Identify target populations based on data and community need
- Launch community in-person, and virtual workshops to cover topics including understanding health information, communicating with healthcare providers, navigating healthcare, self-management and preventive health, understanding prescriptions, telehealth, patient rights
- Train community-based clinical and non-clinical staff in health-literate communication (e.g., Teach-Back, plain language)

KEY PERFORMANCE METRICS:

- Curriculum identified and vetted for implementation
- Track the number of classes offered and participants
- Track pre/post test results to determine knowledge gained
- Track number of staff trained to implement the program
- Identified number of encounters using the Teach-Back method

COLLABORATIONS WITH ORGANIZATIONS: Local nonprofits, faith-based organizations, community-based organizations

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS NEED:
Staff time and clinical expertise, marketing and educational materials, community health supplies, vaccination resources, and ongoing support from the Marketing & Communications and Community Outreach

ESTIMATED COMPLETION DATE: Ongoing through 2028

PERSON(S)/DEPARTMENT RESPONSIBLE: Leadership, Community Outreach

IDENTIFIED NEED 1:
Increase Access to Care and Education

GOALS/OBJECTIVE/OBJECTIVE:
Financial Empowerment for Healthcare: The goal is to move participants from financial crisis management to proactive planning. show how sound budgeting and saving habits directly support access to care and health stability.

STRATEGY 3:
Financial Literacy & Access to Healthcare

ACTION STEPS:

- Identify a local Bank or Credit Union to partner in program delivery
- Partner with Community groups and organizations to implement class
- Incorporate Financial Literacy in Community Wellness Centers
- Incorporate Financial Literacy in Community Wellness Centers and Prenatal/Postpartum program by including the following educational topics
  - Control Your Money: Budgeting101
  - Understanding needs vs. wants, building a savings
  - Building a Savings for Emergencies and healthcare
  - Avoiding Money Traps: Debts & Credits
  - Protect Your Health: Financial Literacy
- Include information in all FoodRx bags (if applicable)
- Identify additional resources for referrals beyond classes

KEY PERFORMANCE METRICS

- Track the number of classes offered and number of participants
- Utilize pre and post test to determine knowledge gain
- Track number of community partners identified and utilized for implementation
- Track number of referrals for financial assistance

COLLABORATIONS WITH ORGANIZATIONS: Local nonprofits, local banks, cooperative extension organizations

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS NEED:
Staff time and clinical expertise, marketing and educational materials, community health supplies, vaccination resources, and ongoing support from the Marketing & Communications and Community Outreach

ESTIMATED COMPLETION DATE: Ongoing through 2028

PERSON(S)/DEPARTMENT RESPONSIBLE: Leadership Team, Community Outreach

IDENTIFIED NEED 2:
The Community Mental Health Strategy: Access, Education, Acceptance

GOALS/OBJECTIVE/OBJECTIVE:
Improve and increase access to mental health services, reduce stigma, and promote emotional well-being for residents of the Arkansas County

STRATEGY:
Strengthen collaboration with employers, healthcare providers, and community organizations to expand mental health education, increase access to counseling and crisis resources, and promote early intervention and resilience-building initiatives.

ACTION STEPS:
- Partner with healthcare organizations, locally and statewide, to increase the capacity to provide additional mental health services.
- Implementation Project to increase in-patient mental and behavioral health services.
- Provide Mental Health First Aid training to local schools, colleges, and community or faith-based organizations.
- Provide Community-based Stop the Bleed Trainings
- Participate in System-wide Mental Health Awareness Campaigns
- Partner with local schools and colleges to increase mental health awareness
- Integrate Mental Health Education and Awareness materials into Schools and Workplaces
- Utilize Telepsych for patients in need of Telemedicine services

KEY PERFORMANCE METRICS:
- Track number of patient encounters in-patient withdrawal management services
- Track number of patient encounters utilizing Telepsych services
- Report number of Community partners and events for mental health services
- Track the number of mental health first aid and Stop the Bleed classes and participants
- Track the number of Mental Health First Aid trainings and attendance
- Measure campaign's reach through social media engagement, website visits, and printed material distribution.

COLLABORATIONS WITH ORGANIZATIONS: Local schools, universities and businesses, non-profits and faith-based organizations

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS NEED: Staff time and clinical expertise, marketing and educational materials, community health supplies and ongoing support from the Marketing & Communications and behavioral health, command center and Community Outreach teams.

ESTIMATED COMPLETION DATE: Ongoing through 2028

PERSON(S)/DEPARTMENT RESPONSIBLE: Leadership, Behavioral Health, Community Outreach Marketing & Communications Manager, Case Management

IDENTIFIED NEED 3:
Closing the Gap: A Strategy for Healthy Communities and Nutrition Security

GOALS/OBJECTIVE/OBJECTIVES:
Improve nutrition security and health outcomes among underserved community members by integrating food insecurity screening, immediate nutrition support, and long-term resource connection through the Mobile Health Unit.

STRATEGY 1:
Mobile Health Unit "Food as Medicine" Initiative
To improve the health and nutritional well-being of underserved community members by utilizing the Mobile Health Unit to proactively identify individuals experiencing food insecurity, provide immediate relief through nutritious food access, and ensure sustainable connectivity to community food resources.

ACTION STEPS:
- Explore opportunity to participate in the Rural Hospital Food as Medicine Feasibility study
- Utilize the Standardized Food Insecurity Screening Protocol to screen all patients/individuals at pre-determined locations
- Develop and deploy food boxes in cooperation with the Arkansas Foodbank
- Identify and schedule high-need service locations. Using Arkansas Foodbank data and existing CHNA data (low-income census tracts, areas with high chronic disease rates, or known food deserts) to create a quarterly MHU route schedule.
- Identify key preventative screenings to be offered at each distribution event
- Promote the schedule through local channels (churches, community centers, public libraries) using clear, accessible flyers and social media to maximize attendance for free health screenings.
- Implement a short-term follow-up mechanism to measure the impact of referrals.

KEY PERFORMANCE METRICS:
- Number of scheduled MHU visits that occurred in high need areas
- Track and report the number of bags and pounds of food distributed
- Track and report health outcomes for the population being screened
- Percentage of food-insecure clients who confirm they utilized at least one resource on the provided local pantry list during the 30-day follow-up call.
- Track other social determinants of health identified and referrals

COLLABORATIONS WITH ORGANIZATIONS: Local schools, universities and businesses, non-profits and faith-based organizations

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS NEED: Staff time and clinical expertise, marketing and educational materials, community health supplies and ongoing support from the Marketing & Communications and behavioral health, command center and Community Outreach teams.

ESTIMATED COMPLETION DATE: Ongoing through 2028

PERSON(S)/DEPARTMENT RESPONSIBLE: Leadership, Behavioral Health, Community Outreach Marketing & Communications Manager, Case Management

BAPTIST HEALTH MEDICAL CENTER
Arkadelphia

About Us

Baptist Health Medical Center-Arkadelphia has been committed to serving the citizens of southwest Arkansas since 1981. Our 25-bed hospital provides comprehensive services including emergency services, CT Scan, MRI, digital mammography, labor and delivery, orthopedics and sleep studies.

Our Labor/Delivery/Recovery/Postpartum rooms are designed to allow families to bond with their infant. They are modern and spacious with calming decor and beautiful views. Special meals are offered to new parents after delivery, we provide one-on-one care and offer telehealth for breastfeeding assistance. Childbirth education is offered onsite and tours are available by calling 870-245-1221. As with any service provided at our hospital, new moms have direct access to specialized care areas at Baptist Health Medical Center-Little Rock such as neonatology, maternal-fetal medicine and high-risk OB.

To better serve the community, Baptist Health Arkadelphia Medical Clinic, Baptist Health Family Clinic-Caddo Valley, Baptist Health Family Clinic-Bismarck, Baptist Health Family Clinic-Gurdon, Baptist Health Family Clinic-Prescott, and Baptist Health Family Clinic Sparkman is operated by Baptist Health Medical Center-Arkadelphia.

Awards & Recognitions
American Heart Association's
Get with the Guidelines Stroke Gold Award

Community Health Needs Assessment 2026-2028
Baptist Health Medical Center-Arkadelphia

HIGHLIGHTS OF COMMUNITY HEALTH NEEDS ASSESSMENT ACCOMPLISHMENTS 2023-2025

Access to Care

- Provided access to lactation consultations for Community members
- Provided community-based education by physicians, nurses and pharmacist on chronic health conditions
- Provided community-based preventative health education at schools, community events, Manchester Pumpkin Days, Prescott fall festival and using the Baptist Mobile Health unit
- Partnered with Peake Elem & Goza Middle to assist with flu shot campaign
- Expanded Immunization Coverage to the community
- Addressing Critical Needs with Direct Support: Provided by providing blood pressure machines to a patient identified during a screening event
- Utilized Baptist Health Command Center to enhance access to care

Mental Health Awareness

- Pharmacy led community-based educational programs on mental health awareness and drug education to local schools.
- Provided mental health awareness information in partnership with Ouachita Baptist College
- Provided a booth to promote education and mental health awareness at the Clark County Fair
- Stop the Bleed education provided in partnership with trauma expert
- Provided telepsych program

Nutrition Education/Food Insecurity

- Successfully delivered six interactive grocery store tours utilizing the Cooking Matters at the Store curriculum, directly equipping 40 participants with practical skills in budgeting, label reading, and healthy food selection to maximize their food dollar and nutritional intake.
- Conducted two comprehensive five-week sessions of the Eat Healthy Be Active program, resulting in 151 recorded participant encounters (including repeat attendance) where individuals received education and support to adopt sustainable lifestyle changes related to improved nutrition and increased physical activity
- Launched and completed one hands-on Cooking with Community Outreach class, engaging 10 participants in a focused session designed to enhance culinary skills, promote shared learning, and foster stronger connections between participants and community -resources for healthy eating.

2025 BAPTIST HEALTH COMMUNITY HEALTH NEEDS ASSESSMENT: ARKADELPHIA

ACHI
August 2025

Baptist Health

PREPARED BY:
ACHI
INSPIRING HEALTHY ACTS

Introduction

Baptist Health engaged the Arkansas Center for Health Improvement (ACHI) to conduct the quantitative data collection and analysis for the 2025 Community Health Needs Assessment (CHNA) process. Baptist Health provided ACHI with the counties served by each of its 12 hospital communities. A total of 16 Arkansas counties and two Oklahoma counties were included.

Each report presents community-level data for a hospital community, including tables and figures for each indicator, along with comparisons to Arkansas and U.S. benchmarks. Dot graphs are provided to visualize performance across selected indicators. All reports are prepared using the same methodology to ensure consistency and comparability across Baptist Health hospital communities.

Methodology

A summary of sources, definitions, indicator criteria, and suppression rules can be found in the methods and sources document.

Community Profile Summary

To support the 2025 Community Health Needs Assessment (CHNA), ACHI compiled a comprehensive dataset of 103 health and demographic indicators for the communities served by Baptist Health's 12 hospital locations. This section provides an overview of these indicators across the full CHNA service area and offers multiple views for understanding and comparing county-level and community-level data.

Data are grouped into the following 14 categories, based on the source-defined domains outlined in the data source reference sheet:

1. Demographics
    a. Age
    b. Sex
    c. Race, Ethnicity, and Language
2. Insurance Coverage
3. Access to Care
4. Cause of Death
5. Chronic Conditions
6. Diagnoses Incidence at Discharge
7. Environment
8. Health Behaviors
9. Health Outcomes
10. Healthcare Expenditures
11. Maternal and Infant Health
12. Mental Health and Substance Use
13. Prevention
14. Social and Economic Factors

Measurements for these categories will be displayed in the following sections.

Hospital Community Indicator

The hospital community indicator snapshots offer an at-a-glance view of how each hospital community compares to state and national benchmarks, as well as the counties that make up the community.

Each table presents the data values for selected indicators across the 14 CHNA domains, and each corresponding visual uses proportionally scaled circular markers to illustrate performance. This format is designed to quickly convey how each hospital community aligns with or diverges from broader benchmarks in key population health metrics.

Each displays four comparison points:

- **Purple** – Represents the national value for the indicator.
- **Blue** – Represents the value for the state of Arkansas.
- **Gold** – Represents the weighted average for all counties in the hospital's defined service area.
- **Gray** – Represent the values of each county assigned to that hospital community.

Where available, data for each indicator are shown for all four categories. If a value is not available or is suppressed for a contributing county, it is noted as "Not Available" in the table and excluded from the visual display. No color ranking is applied; the visuals and tables are intended to illustrate relative placement, not comparative rank.

Hospital Community: Arkadelphia (Clark and Nevada Counties)

Figure 1. Counties Served by Baptist Health Medical Center–Arkadelphia

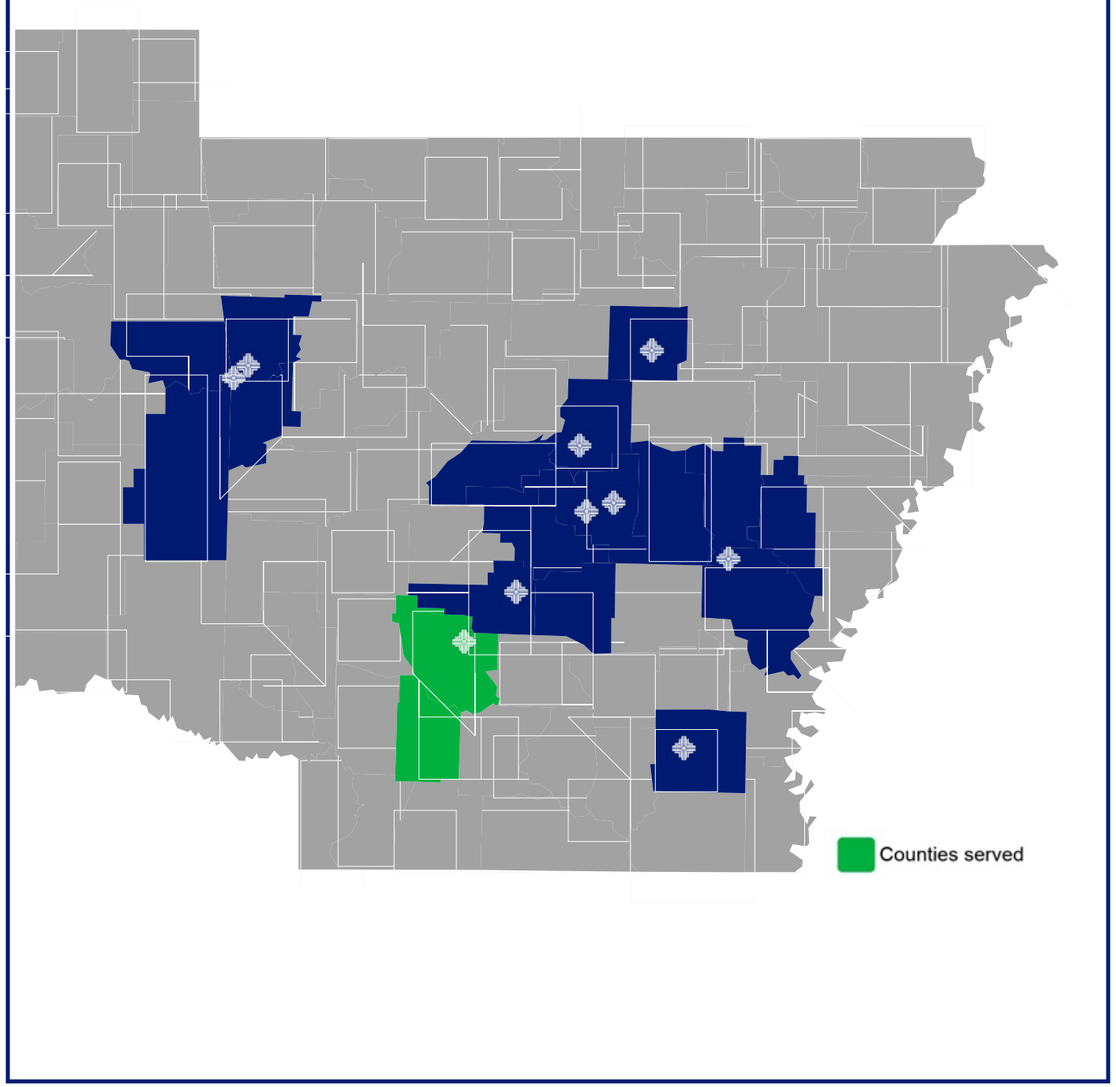


Table 1. Demographics: Age and Sex

		Nevada County	Clark County	Community Average	State	National
Total Population	*Number*	8,228	21,378	29,606	3,032,651	332,387,540
Female	*Percent*	51.13%	52.28%	51.96%	50.67%	50.50%
Male	*Percent*	48.87%	47.72%	48.04%	49.33%	49.50%
Ages 0-4	*Percent*	5.89%	5.00%	5.25%	6.02%	5.70%
Ages 5-17	*Percent*	16.50%	14.71%	15.21%	17.26%	16.46%
Ages 18-24	*Percent*	9.49%	22.39%	18.80%	9.33%	9.12%
Ages 25-34	*Percent*	7.16%	10.93%	9.88%	12.93%	13.69%
Ages 35-44	*Percent*	13.53%	9.74%	10.79%	12.66%	13.08%
Ages 45-54	*Percent*	11.93%	9.87%	10.44%	11.84%	12.29%
Ages 55-64	*Percent*	14.34%	11.12%	12.01%	12.64%	12.82%
Ages 65+	*Percent*	21.15%	16.23%	17.60%	17.33%	16.84%

Figure 2. Demographics: Age and Sex

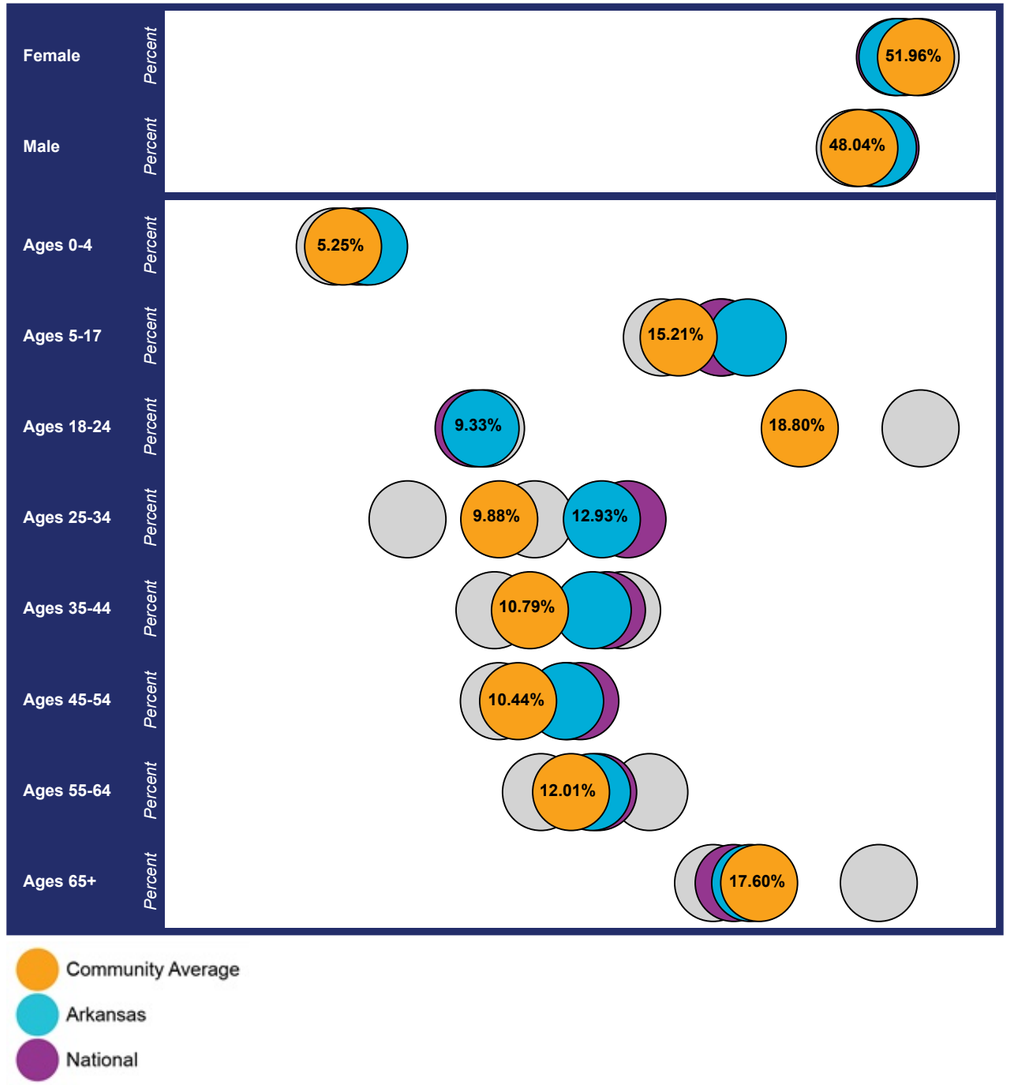


Table 2. Demographics: Race, Ethnicity, and Language

		Nevada County	Clark County	Community Average	State	National
Total Population	*Number*	8,228	21,378	29,606	3,032,651	332,387,540
Asian	*Percent*	0.00%	0.44%	0.32%	1.53%	5.75%
Black or African American	*Percent*	30.91%	23.63%	25.65%	14.84%	12.03%
Hispanic	*Percent*	4.61%	5.36%	5.15%	8.77%	18.99%
Multiple Races	*Percent*	1.57%	2.58%	2.30%	5.50%	3.87%
Native American/ Alaska Native	*Percent*	0.02%	0.06%	0.05%	0.36%	0.53%
Native Hawaiian/ Pacific Islander	*Percent*	0.09%	0.19%	0.16%	0.39%	0.17%
Other Races	*Percent*	0.12%	0.07%	0.08%	0.26%	0.50%
White	*Percent*	62.69%	67.67%	66.29%	68.36%	58.17%
Non-English Language Households	*Percent*	0.00%	0.70%	0.51%	1.50%	4.20%

Figure 3. Demographics: Race, Ethnicity, and Language

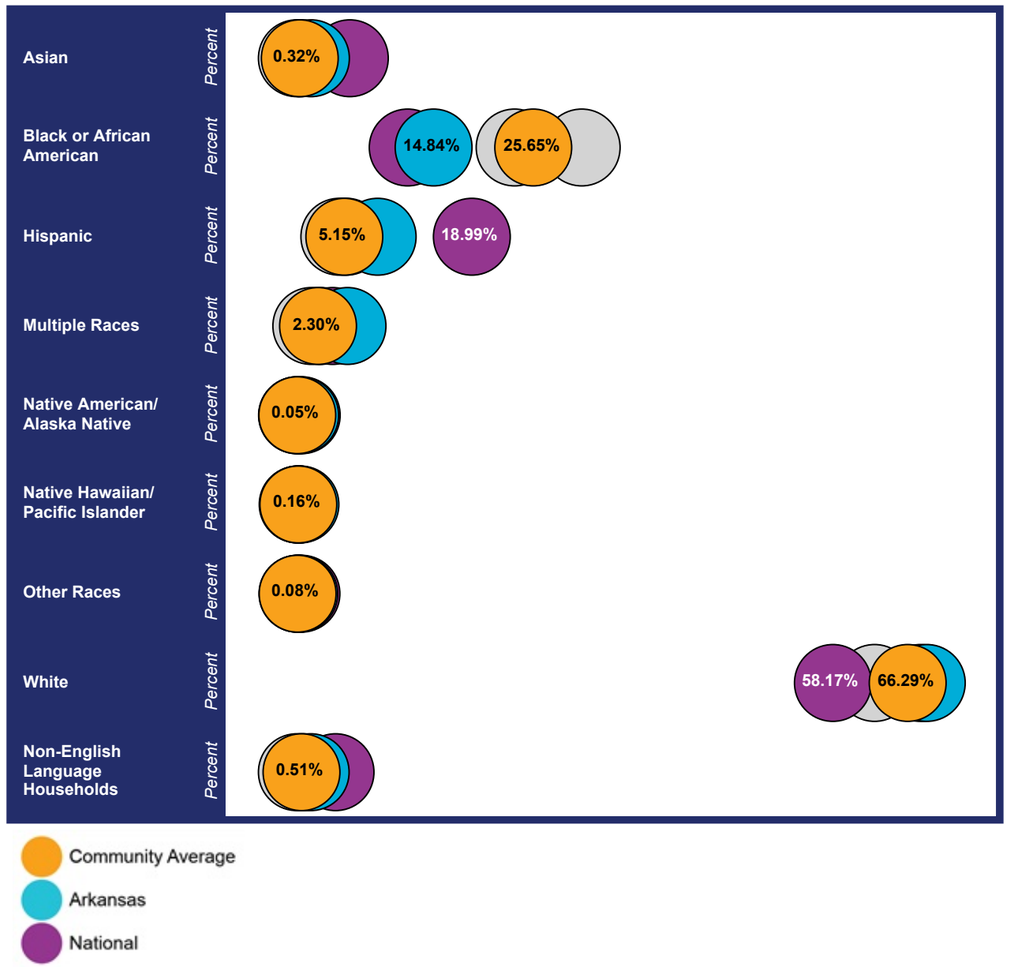


Table 3. Insurance Coverage

		Nevada County	Clark County	Community Average	State	National
Private Health Insurance Coverage	*Percentage of the total civilian non-institutionalized population for whom insurance status is determined that is covered by private health insurance*	**47.96%**	**65.09%**	**60.33%**	**65.37%**	**73.62%**
Public Health Insurance Coverage	*Percentage of the total civilian non-institutionalized population for whom insurance status is determined that is covered by public health insurance*	**66.68%**	**46.19%**	**51.88%**	**48.21%**	**39.70%**
Uninsured	*Percentage of adults under age 65 without health insurance coverage*	**7.40%**	**9.00%**	**8.56%**	**10.00%**	**9.50%**

Figure 4. Insurance Coverage

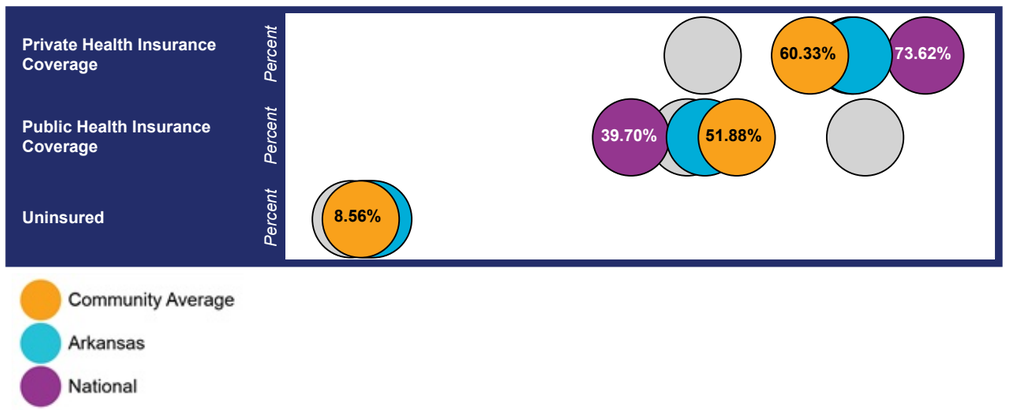


Table 4. Access to Care

		Nevada County	Clark County	Community Average	State	National
Primary Care Physicians	*Ratio of population to one primary care physician*	4093:1	2132:1	2677:1	1478:1	1334:1
Mental Health Providers	*Ratio of population to one mental health provider*	1159:1	303:1	382:1	367:1	300:1
Dentists	*Ratio of population to one dentist*	Not Available	1931:1	1931:1	2044:1	1361:1
Active Primary Care Physicians	*Rate per 10,000 county residents of primary care physicians who provided evaluation and management services to at least two patients on the same day at least once during the year*	6.00	15.40	12.79	9.20	Not Available
Addiction or Substance Use Providers	*Rate of addiction or substance use providers per 100,000 population*	0.00	0.00	0.00	5.98	29.43
Buprenorphine Providers	*Rate of buprenorphine providers per 100,000 population*	0.00	0.00	0.00	9.81	14.87
Preventable Hospital Stays (Medicare)	*Rate of hospital stays for ambulatory care-sensitive conditions per 100,000 Medicare enrollees*	2555.00	2009.00	2160.74	3014.00	2666.00
Diabetic Monitoring (Medicare)	*Percentage of Medicare enrollees aged 65 and older with diabetes who received a hemoglobin A1c (HbA1c) test within the past year.*	86.00%	89.21%	88.32%	88.47%	87.53%
Mammography	*Percentage of female Medicare enrollees ages 65-74 who received an annual mammography screening*	32.00%	43.00%	39.94%	41.00%	44.00%

Figure 5. Access to Care

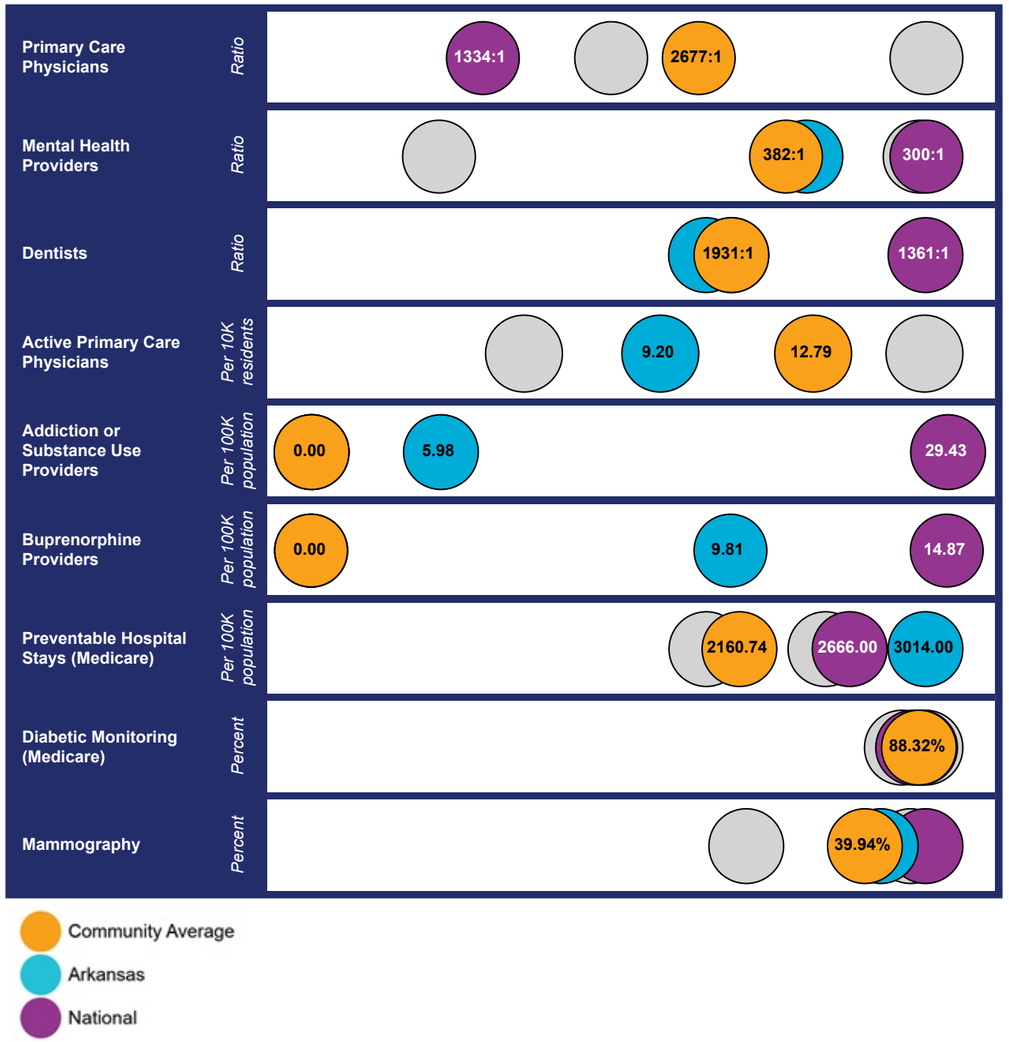


Table 5. Cause of Death

		Nevada County	Clark County	Community Average	State	National
All Causes	*Rate of deaths by all causes per 100,000 population (age-adjusted)*	1019.30	1164.30	1124.00	1001.70	805.60
Premature Death	*Number of deaths among residents under age 75 per 100,000 population (age-adjusted)*	601.40	630.57	622.47	552.47	406.59
Heart Disease	*Rate of death due to heart disease (ICD-10 Codes I00-I09, I11, I13, I20-I151) per 100,000 population*	367.30	293.70	314.15	282.80	207.20
Cancer	*5-year average rate of death due to cancer per 100,000 population*	276.70	218.90	234.96	215.90	182.70
Unintentional Injury	*5-year average rate of death due to unintentional injury (accident) per 100,000 population*	63.70	49.00	53.09	61.90	63.30
Stroke	*5-year average rate of death due to cerebrovascular disease (stroke) per 100,000 population (age-adjusted)*	83.30	62.80	68.50	57.40	48.30
Chronic Lower Respiratory Disease	*Rate of deaths due to chronic lower respiratory disease per 100,000 population (age-adjusted)*	46.70	65.60	60.35	61.00	35.90
Diabetes Mortality	*Rate of deaths due to diabetes per 100,000 population (age-adjusted)*	Not Available	41.20	41.20	34.70	23.90
Suicide Deaths	*This indicator reports the 2019-2023 five-year average rate of death due to intentional self-harm (suicide) per 100, 000 population. Figures are reported as crude rates*	Not Available	Not Available	Not Available	19.20	14.50
Motor Vehicle Crash	*5-year average rate of death due to motor vehicle crash per 100,000 population (age-adjusted)*	Not Available	Not Available	Not Available	20.60	12.80
Alcohol-Involved Motor Vehicle Crash	*Rate of persons killed in motor vehicle crashes involving alcohol as a rate per 100,000 population*	7.20	10.30	9.44	3.10	2.30

Figure 6. Cause of Death

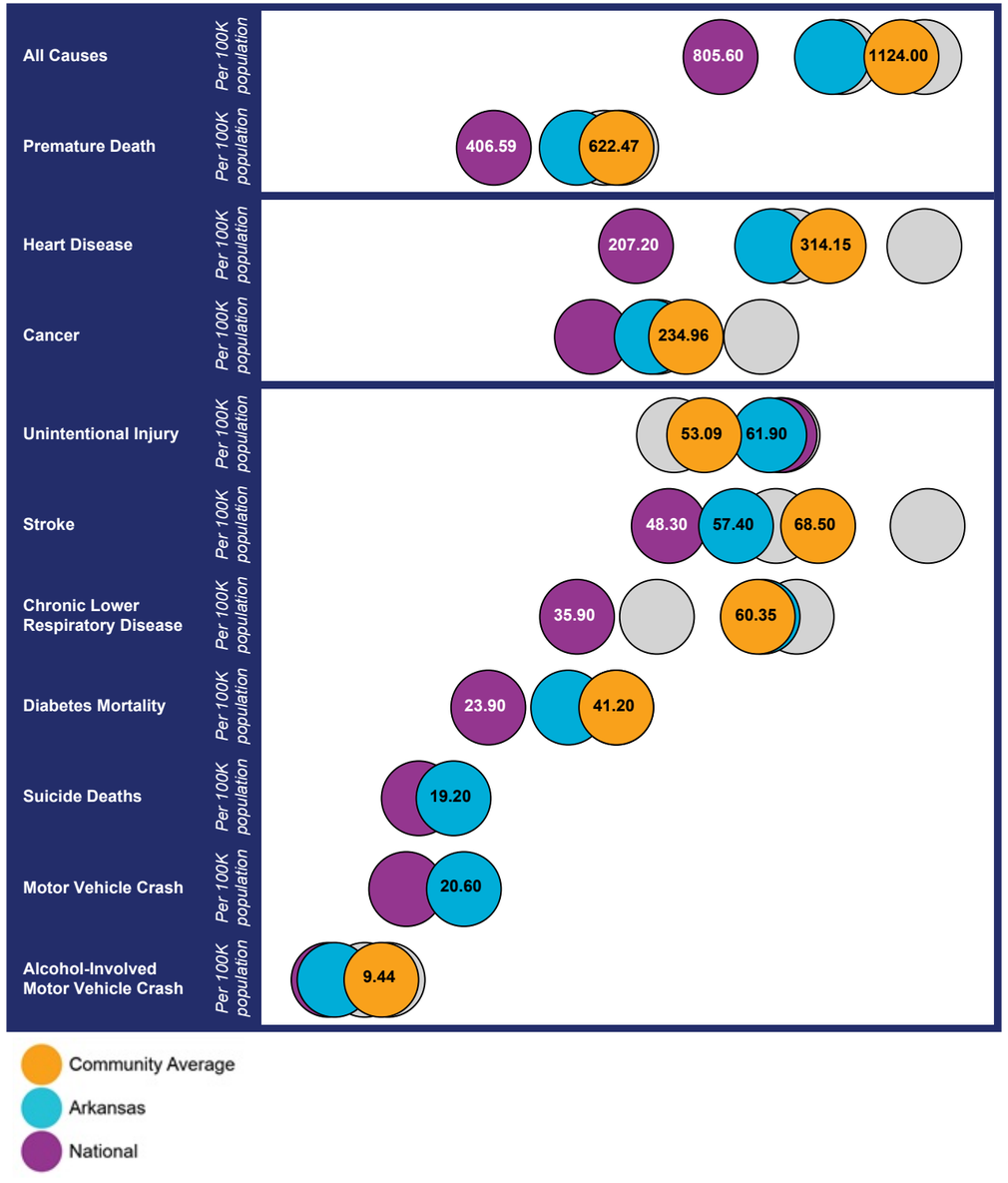


Table 6. Chronic Condtions

		Nevada County	Clark County	Community Average	State	National
Child Obesity	*Percentage of students classified as overweight to severely obese, by county location of school*	**43.55%**	**40.32%**	**41.22%**	**40.10%**	**Not Available**
High Cholesterol	*Percentage of adults who have had their blood cholesterol checked and have been told it was high (age-adjusted)*	**32.10%**	**30.60%**	**31.02%**	**31.80%**	**30.40%**
Adult Obesity	*Percentage of adults ages 20 and older who report a BMI higher than 30*	**22.00%**	**29.50%**	**27.42%**	**31.90%**	**30.10%**
High Blood Pressure	*Percentage of adults who have been told they have high blood pressure (age-adjusted)*	**40.40%**	**37.90%**	**38.59%**	**36.50%**	**29.60%**
Arthritis	*Percentage of adults ages 18 or older diagnosed with some form of arthritis*	**36.90%**	**37.70%**	**37.48%**	**32.60%**	**Not Available**
Diabetes Prevalence	*Percentage of adults age 18 and older who report ever been told that they have diabetes other than diabetes during pregnancy (age-adjusted)*	**14.80%**	**14.30%**	**14.44%**	**12.70%**	**10.40%**
Asthma	*Percentage of adults who have been told they currently have asthma (age-adjusted)*	**11.80%**	**11.80%**	**11.80%**	**11.00%**	**9.90%**
Coronary Heart Disease	*Percentage of adults age 18 and older who report ever having been told by that they had angina or coronary heart disease (CHD) (age-adjusted)*	**7.90%**	**7.80%**	**7.83%**	**7.20%**	**5.70%**

Figure 7. Chronic Conditions

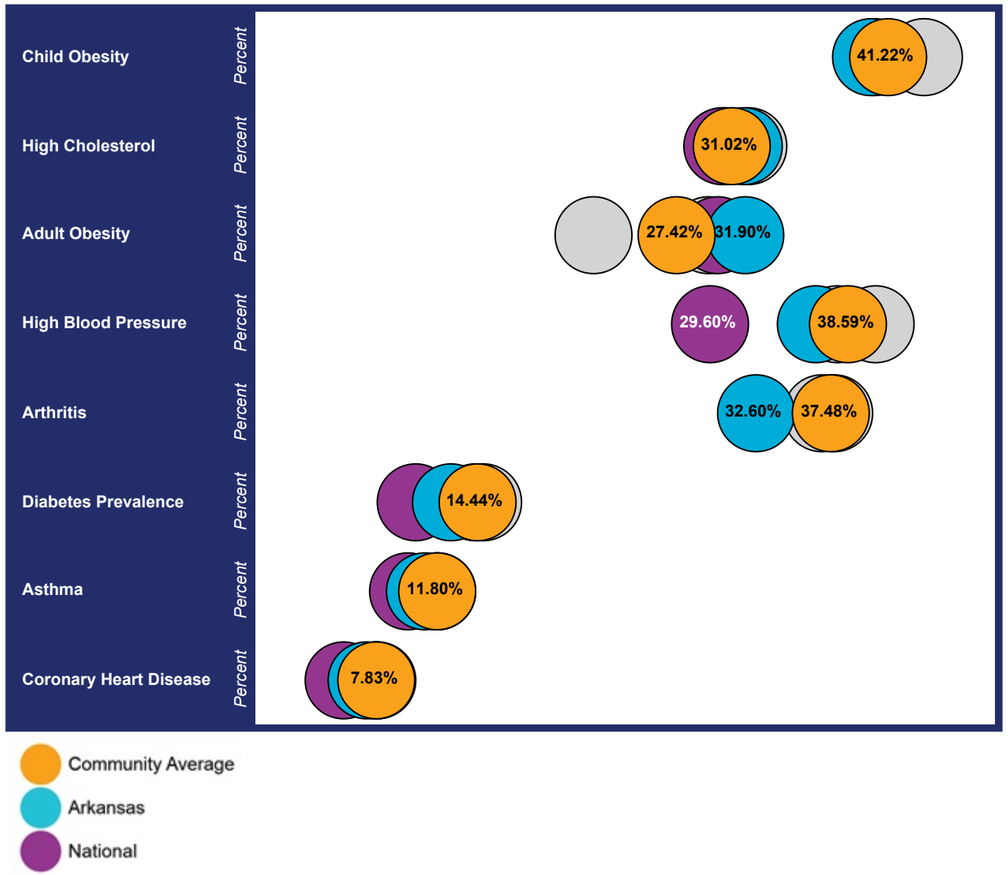


Table 7. Diagnoses at Discharge

		Nevada County	Clark County	Community Average	State
Hypertension	*Number of individuals 18 years and older discharged with a primary or secondary hypertension diagnosis as a percentage of the population 18 years and older*	7.69%	6.66%	6.95%	8.70%
Hyperlipidemia	*Number of individuals 18 years and older discharged with a primary or secondary hyperlipidemia diagnosis as a percentage of the population 18 years and older*	1.99%	2.21%	2.15%	3.90%
Diabetes	*Rate of individuals 18 years and older discharged with a primary or secondary diabetes diagnosis as a percentage of the population 18 years and older*	3.12%	2.67%	2.80%	3.70%
Ischemic Heart Disease	*Number of individuals 18 years and older discharged with a primary or secondary ischemic heart disease diagnosis as a percentage of the population 18 years and older*	1.71%	1.70%	1.70%	2.50%
Arthritis	*Rate of individuals 18 years and older discharged with a primary or secondary arthritis diagnosis as a percentage of the population 18 years and older*	1.02%	1.19%	1.14%	1.90%

Figure 8. Diagnoses at Discharge

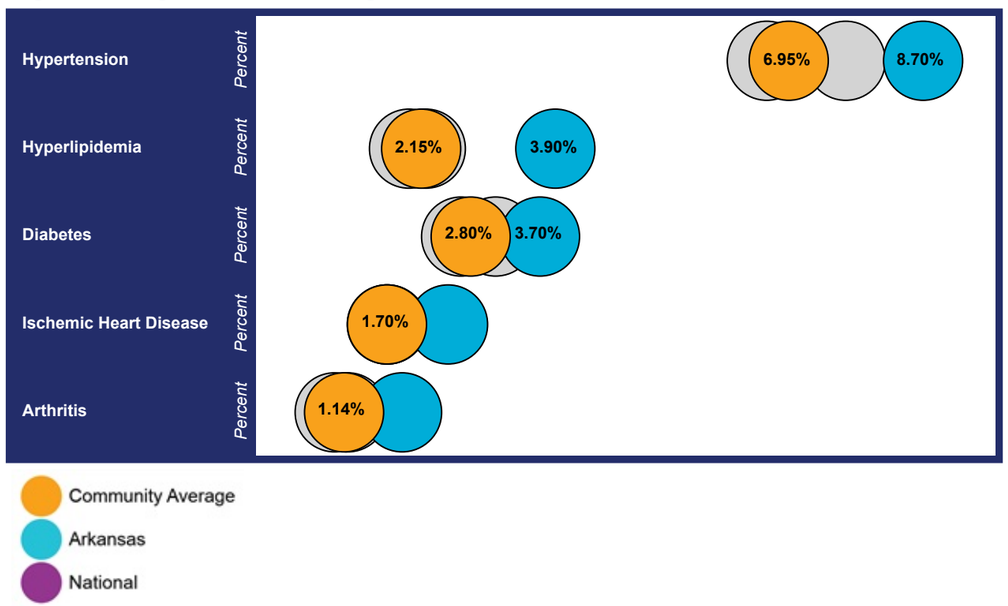


Table 8. Environment

		Nevada County	Clark County	Community Average	State	National
Food Environment Index	*Index of factors that contribute to a healthy food environment, 0 (worst) to 10 (best)*	3.90	6.20	5.56	4.40	7.40
Drinking Water Violations	*The total number of drinking water violations recorded in a two-year period*	6	1	2	321	16,107
Access to Exercise Opportunities	*Percentage of population with adequate access to locations for physical activity*	47.93%	48.40%	48.27%	63.36%	84.45%
Broadband Access	*Percentage of population in a high-speed internet service area; access to DL speeds >= 25MBPS and UL speeds >= 3 MBPS*	75.87%	99.27%	92.77%	94.04%	96.78%
Long Commute Driving Alone	*Among workers who commute in their car alone, the percentage who commute more than 30 minutes*	41.00%	26.00%	30.17%	28.10%	36.50%
Severe Housing Problems	*Percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities*	15.47%	14.28%	14.61%	13.23%	16.84%

Community Average
Arkansas
National

Figure 9. Environment

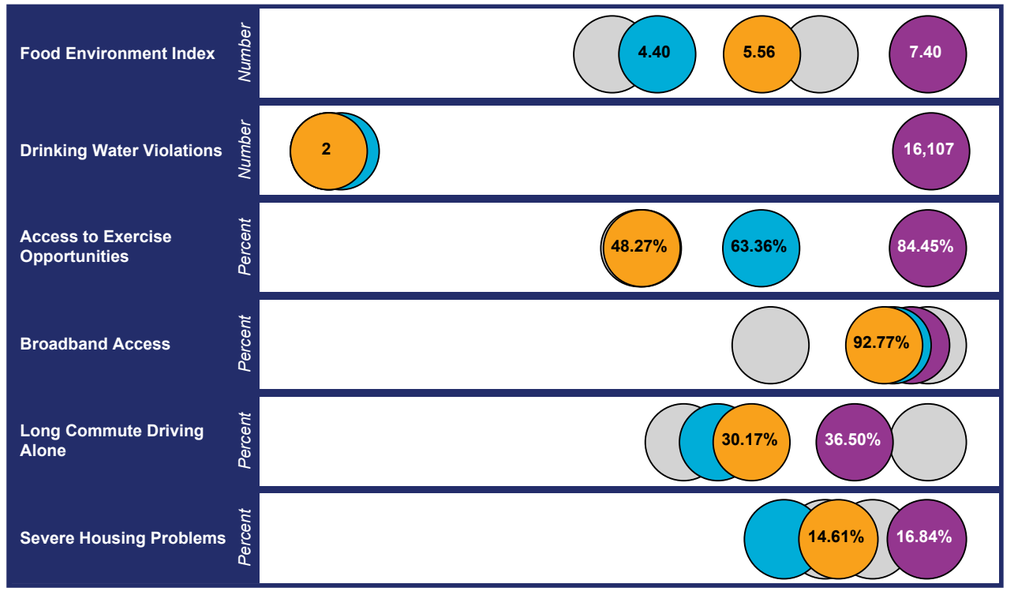


Table 9. Health Behaviors

		Nevada County	Clark County	Community Average	State	National
Physical Inactivity	*Percentage of adults aged 20 and older who self-report no leisure time for activity*	15.80%	26.20%	23.31%	23.60%	19.50%
Adult Smoking	*Percentage of adults ages 18 and older who are current smokers (age-adjusted)*	23.00%	21.50%	21.92%	19.20%	13.20%
Youth Vaping	*Percentage of public school students in 6th, 8th, 10th, and 12th grade who used any vape in the past 30 days*	17.90%	8.40%	11.04%	8.10%	Not Available
Sexually Transmitted Infections	*Number of newly diagnosed chlamydia cases per 100,000 population*	696.70	710.60	706.74	588.30	495.00

Figure 10. Health Behaviors

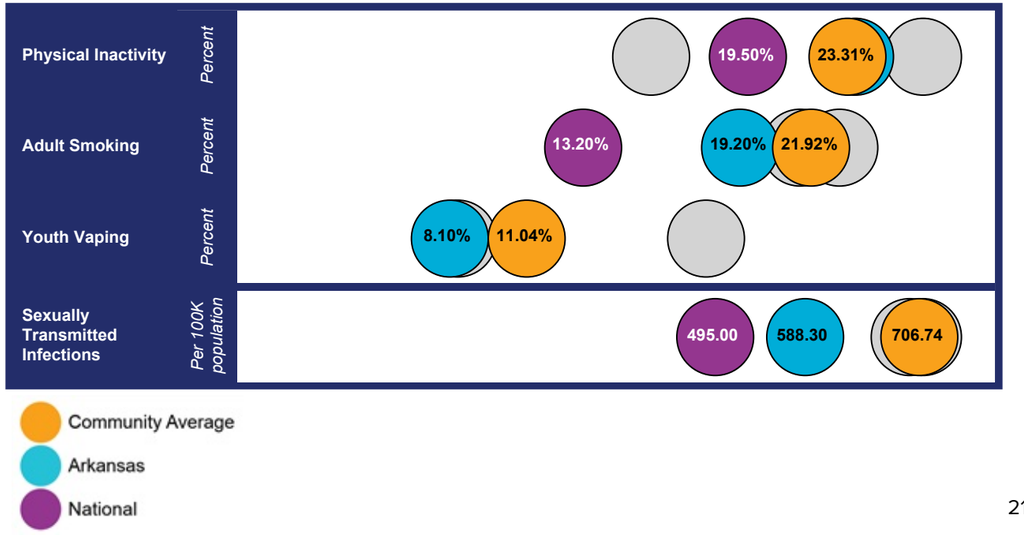


Table 10. Health Outcomes

		Nevada County	Clark County	Community Average	State	National
Poor Physical Health Days	*Average number of physically unhealthy days reported in past 30 days (age-adjusted)*	**5.70**	**5.20**	**5.34**	**5.20**	**3.90**
Poor or Fair Health	*Percentage of adults age 18 and older who self-report their general health status as "fair" or "poor" (age-adjusted)*	**27.10%**	**25.90%**	**26.23%**	**22.60%**	**17.00%**

Figure 11. Health Outcomes

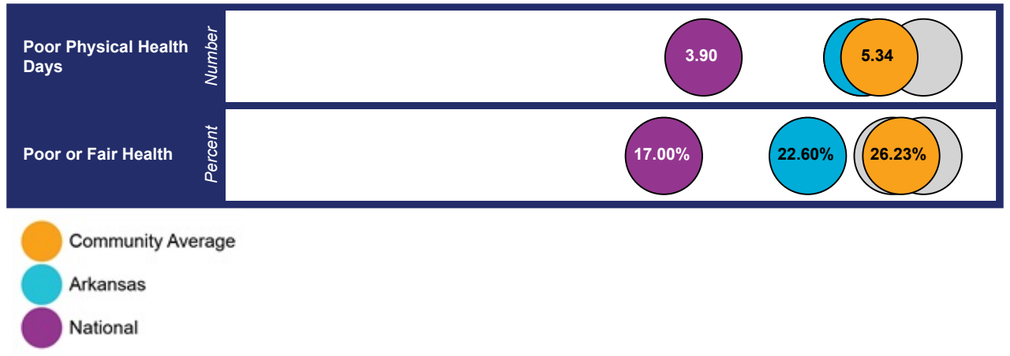


Table 11. Healthcare Expenditures

		Nevada County	Clark County	Community Average	State	National
Average Annualized Expenditures	*Average annualized per-person spending on all covered healthcare services.*	**$11,235**	**$11,891**	**$11,708**	**$10,116**	**Not Available**
Average Annualized Expenditures (Medical Only)	*Average annualized per-person spending on medical services, based on medical claims.*	**$8,166**	**$8,749**	**$8,586**	**$7,252**	**Not Available**
Average Annualized Expenditures (Pharmacy Only)	*Average annualized per-person spending on prescription drugs, based on pharmacy claims.*	**$2,821**	**$2,862**	**$2,850**	**$2,609**	**Not Available**

Figure 12. Healthcare Expenditures

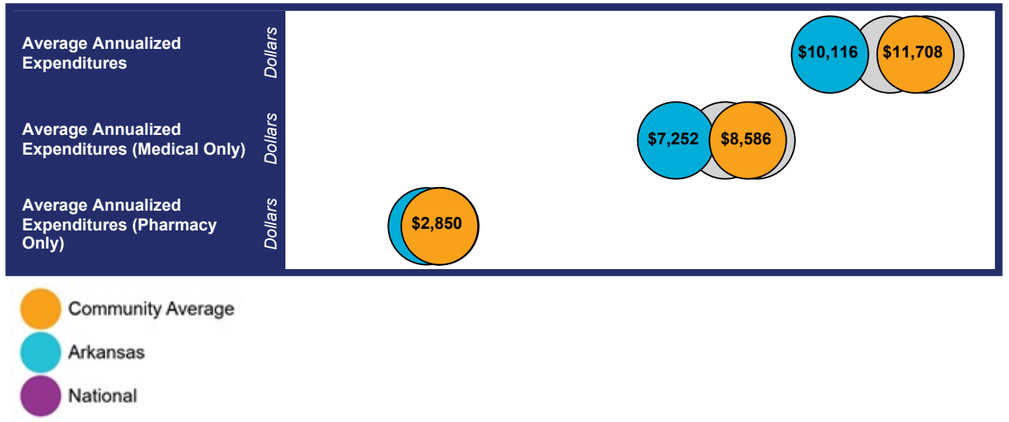


Table 12. Maternal and Infant Health

		Nevada County	Clark County	Community Average	State	National
Active Obstetrics and Gynecology Physicians	*Active OB-GYN physicians are defined as those who provided evaluation and management services to at least two female patients ages 12-55 on the same day or performed a qualifying procedure (e.g., delivery) at least once during the year.*	19.50	14.50	15.89	3.20	Not Available
Teen Births	*The seven-year average number of teen births per 1,000 female population, ages 15-19*	36.80	17.00	22.50	27.90	15.50
C-Section Rate	*Percentage of live births delivered via cesarean section among all deliveries, calculated by the mother's county of residence.*	32.12%	37.33%	35.88%	33.48%	Not Available
C-Section Rate, First Birth	*Percentage of first-birth deliveries (full-term singleton pregnancies in a head-down position) delivered via cesarean section, calculated by the mother's county of residence.*	22.92%	30.70%	28.54%	27.58%	Not Available
Low Birthweight	*Percentage of live births where the infant weighed less than 2, 500 grams (approximately 5 lbs., 8 oz.)*	12.40%	8.90%	9.87%	9.40%	8.40%
Preterm Birth	*Percentage of live births that are preterm (<37 weeks), calculated as a three-year average.*	14.70%	12.30%	12.97%	11.90%	10.35%
Median Travel Time to Delivery	*Median number of minutes Arkansas mothers traveled from their home ZIP code to the delivery facility, calculated using birth records and facility addresses. Travel time estimates include in-state and out-of-state facilities.*	37.00	41.00	39.89	16.00	Not Available

Figure 13. Maternal and Infant Health

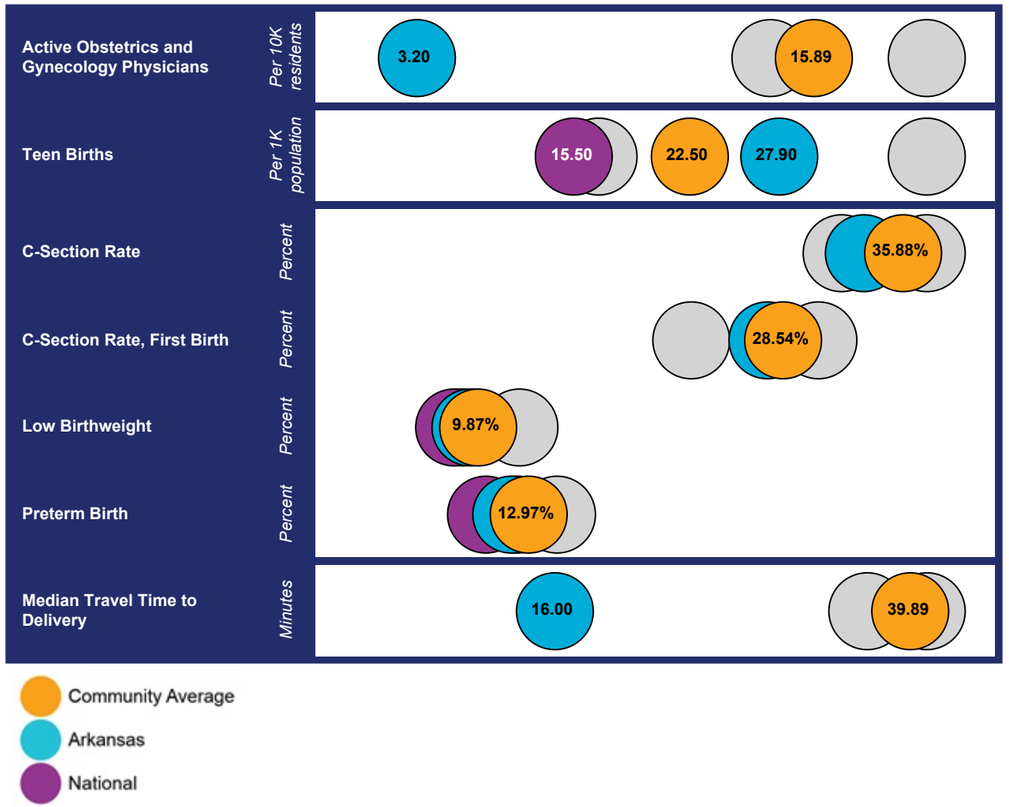


Table 13. Mental Health and Substance Use

		Nevada County	Clark County	Community Average	State	National
Adult Depression	*Percentage of adults age 18 and older who report having been told that they had depressive disorder*	27.30%	27.60%	27.52%	27.50%	21.10%
Excessive Drinking	*Percentage of adults reporting binge or heavy drinking*	16.31%	16.54%	16.48%	18.99%	19.35%
Poor Mental Health	*Percentage of adults age 18 or older reporting poor mental health for 14 or more days (age-adjusted)*	22.40%	21.60%	21.82%	20.50%	16.40%
Youth Depression	*Percentage of public school students in 6th, 8th, 10th, and 12th grade who had feelings of depression all of the time in the past 30 days*	14.90%	6.90%	9.12%	9.20%	Not Available
Drug Overdose Deaths	*Age-adjusted rate of fatal drug overdoses per 100,000 residents*	0.00	Not Available	0.00	Not Available	Not Available
Non-Fatal Drug Overdoses	*Age-adjusted rate of non-fatal drug overdoses per 100,000 residents*	0.00	Not Available	0.00	Not Available	Not Available

Figure 14. Mental Health and Substance Use

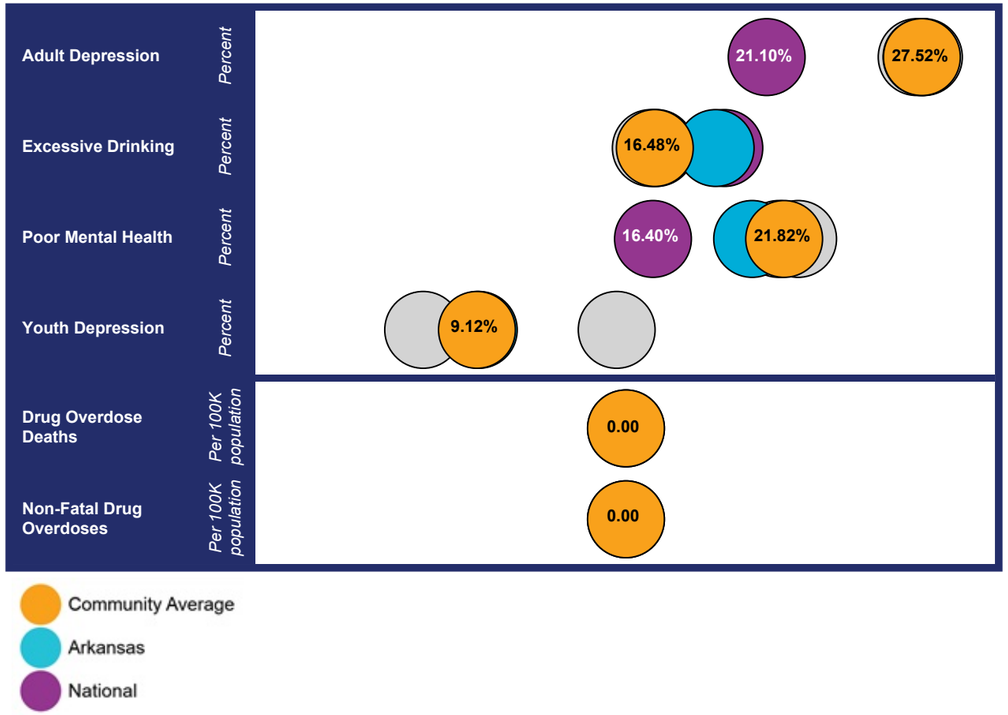


Table 14. Prevention

		Nevada County	Clark County	Community Average	State	National
Cervical Cancer Screening	*Percentage of females age 21–65 years who report having had recommended cervical cancer screening test (age-adjusted)*	81.00%	81.00%	81.00%	81.20%	83.70%
Colorectal Cancer Screening	*Percentage of adults age 45-75 who have had a recent colorecal cancer screening*	60.10%	62.40%	61.76%	61.60%	66.30%
Dental Care Utilization	*Dental care visit (past 1 year), age-adjusted percentage of adults age 18+ by county*	47.10%	50.60%	49.63%	54.10%	63.40%
High Blood Pressure Management	*Percentage of adults age 18 and older with high blood pressure who report taking blood pressure medication (age-adjusted)*	63.10%	63.20%	63.17%	61.40%	58.90%
Prevention - Seasonal Influenza Vaccine	*Percentage of adults aged 18 and older who report receiving an influenza vaccination in the past 12 months*	46.10%	42.50%	43.50%	43.20%	44.80%
Annual Wellness Exam (Medicare)	*Percentage of annual wellness visits among the Medicare fee-for-service (FFS) population*	36.00%	35.00%	35.28%	46.00%	44.00%
No HIV Test	*Percentage of adults ages 18 or older who have never been screened for HIV*	73.80%	75.00%	74.67%	66.10%	Not Available

Figure 15. Prevention

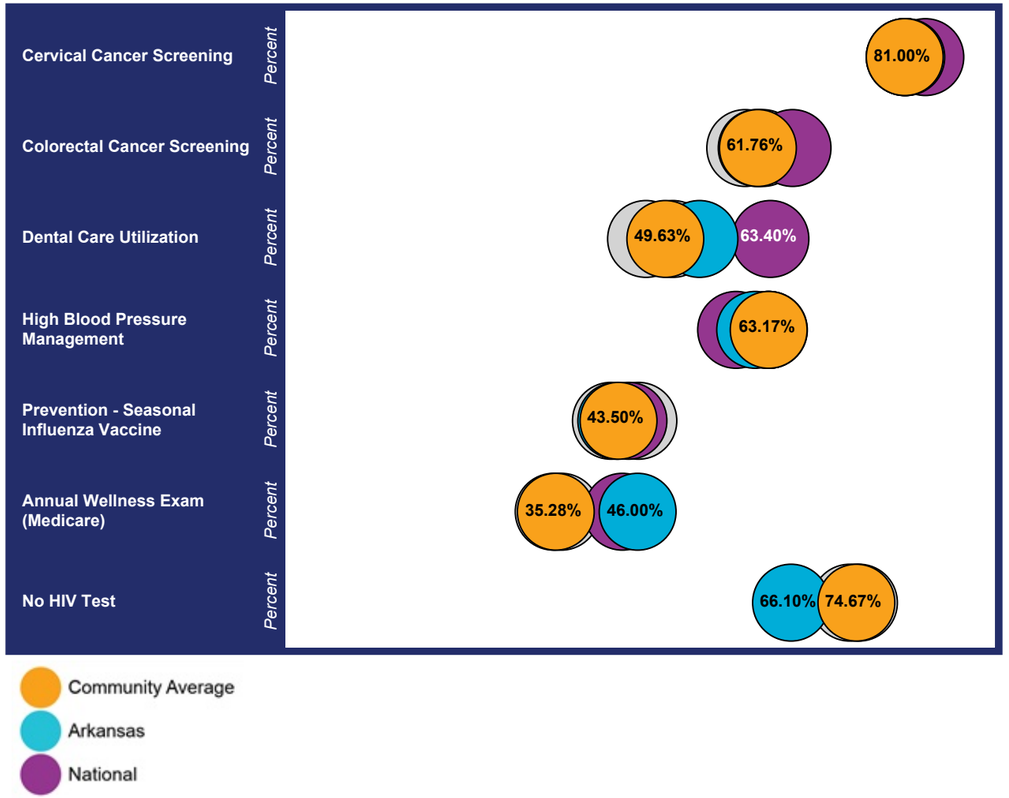
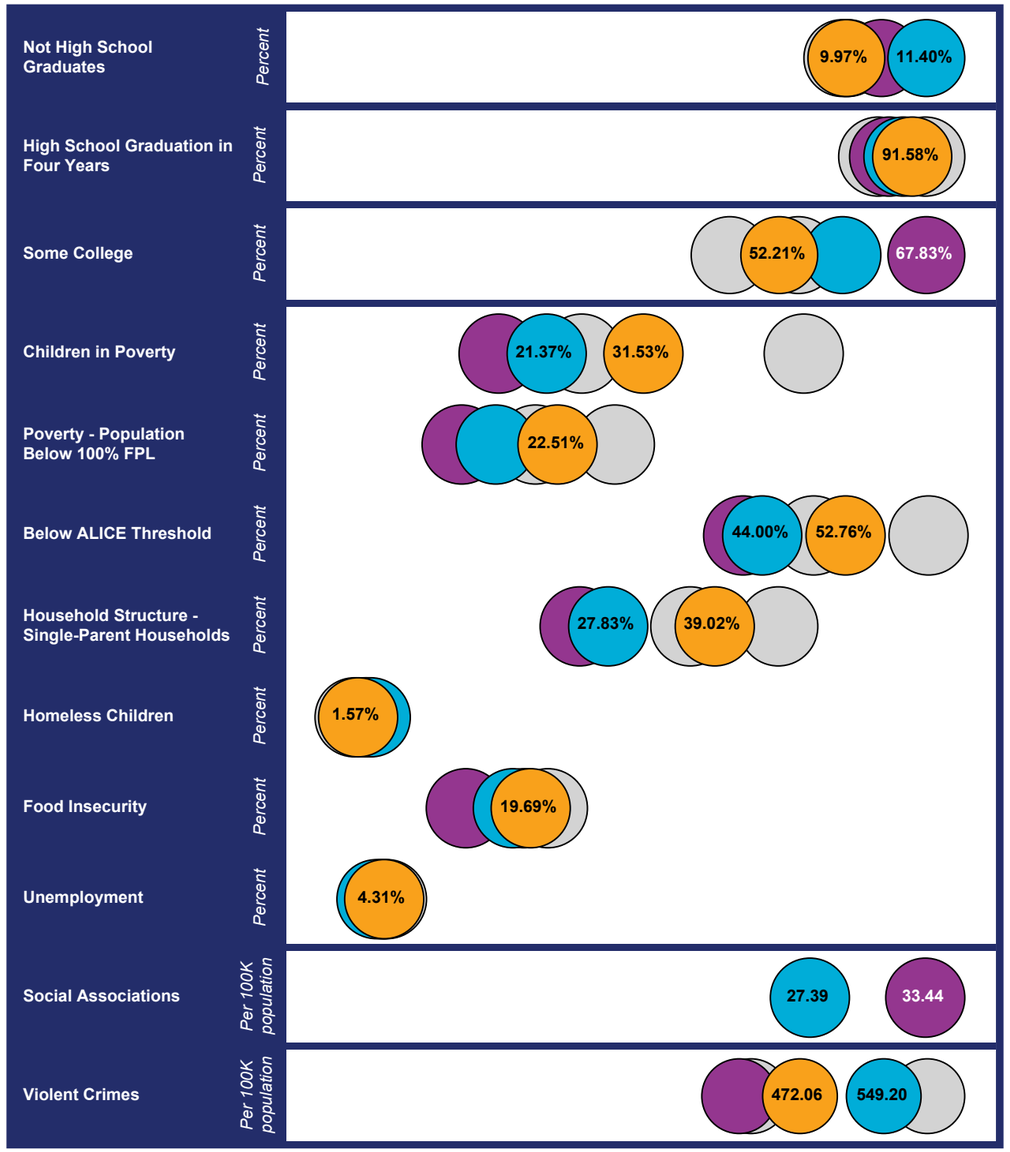


Table 15. Social and Economic Factors

		Nevada County	Clark County	Community Average	State	National
Not High School Graduates	*Percentage of adults without a high school diploma*	9.90%	10.00%	9.97%	11.40%	10.60%
High School Graduation in Four Years	*Percentage of ninth-grade cohort who graduated in four years*	86.60%	93.50%	91.58%	90.30%	88.20%
Some College	*Percentage of adults ages 25-44 with some post-secondary education*	46.94%	54.24%	52.21%	58.92%	67.83%
Children in Poverty	*Percentage of children under age 18 below the poverty line*	48.36%	25.05%	31.53%	21.37%	16.32%
Poverty - Population Below 100% FPL	*Percentage of the population living in households with income below the federal poverty level*	28.53%	20.19%	22.51%	16.02%	12.44%
Below ALICE Threshold	*Percentage of households living in poverty or classified as ALICE (Asset Limited, Income Constrained, Employed)*	61.46%	49.40%	52.76%	44.00%	42.00%
Household Structure - Single-Parent Households	*Percentage of children who live in households where only one parent is present*	45.69%	36.45%	39.02%	27.83%	24.83%
Homeless Children	*Percentage of students experiencing homelessness enrolled in the public school system*	2.53%	1.20%	1.57%	2.90%	2.31%
Food Insecurity	*Percentage of the population that experienced food insecurity in the report year*	21.50%	19.00%	19.69%	17.82%	12.88%
Unemployment	*Percentage of the civilian non-institutionalized population age 16 and older that is unemployed (non-seasonally adjusted)*	4.60%	4.20%	4.31%	3.50%	4.00%
Social Associations	*Establishments, rate per 100,000 population*	Not Available	Not Available	Not Available	27.39	33.44
Violent Crimes	*Annual rate of reported violent crimes per 100,000 population*	589.40	426.90	472.06	549.20	416.00

Figure 16. Social and Economic Factors



IDENTIFIED NEED 1:
Increase Access to Care and Education

GOALS/OBJECTIVE/OBJECTIVES:
Increase access to quality health care, preventive screenings, vaccinations, and community health resources for Clark County.

STRATEGY 1:
Expand community outreach and strengthen partnerships with local nonprofits, schools, and employers to improve access and awareness.

ACTION STEPS:

- Utilize Telehealth and the Command Center to improve access and decrease barriers to care
- Host annual free flu shot events & childhood immunization clinics
- Launch “Wellness Meet-Up Series” open to the public, featuring monthly sessions on key wellness topics such as physical activity, mindful eating, stress management, and sleep health.
- Partner with local businesses and organizations to offer free health education and on-site screenings (e.g., blood sugar, blood pressure, BMI) and facilitate scheduling for primary care and mammogram appointments.
- Provide home monitoring devices (blood pressure/ glucose monitors primary care clinics
- Continue local and collaborations to expand access and reduce barriers to care
- Explore Resource Hub opportunities with area agencies to identify and promote community resources and social drivers of health support
- Maintain the financial assistance policy for patients who are uninsured, underinsured, ineligible for a government health care program, or otherwise unable to pay, for medically necessary or emergent care.
- Continue to evaluate the need to recruit physicians, advanced practice providers and support staff as necessary to meet community needs.
- Continue to provide education and wellness tips on news segments and social media.
- Increase access to Community-based maternal health educational programs and services

KEY PERFORMANCE METRICS:

- Provide preventive screenings, vaccinations, and related services to at least 200 community members
- Track and report the number of community outreach events hosted or attended by Baptist Health
- Measure and report the number of community members reached through health education, screenings, and outreach efforts.
- Evaluate referral and follow-up rates for individuals connected to primary or specialty care through outreach initiatives.
- Number of providers recruited will be tracked
- Charity Care will be tracked and reported

COLLABORATIONS WITH ORGANIZATIONS: Local nonprofits, faith-based organizations, community-based organizations

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS NEED: Staff time and clinical expertise, marketing and educational materials, community health supplies, vaccination resources, and ongoing support from the Marketing & Communications and Community Outreach

ESTIMATED COMPLETION DATE: Ongoing through 2028

PERSON(S)/DEPARTMENT RESPONSIBLE: Vice-President of Operations, Pharmacy, Administration, Community Outreach

IDENTIFIED NEED 1:
Increase Access to Care and Education

GOALS/OBJECTIVE/OBJECTIVES:
To improve community health by increasing health literacy and reducing barriers to accessing healthcare through community-led, culturally appropriate education and navigation support.

STRATEGY 2:
Health Literacy & Access to Healthcare

ACTION STEPS:

- Establish a Community Health Literacy committee including patient representatives, clinical staff, and community partners) to finalize the curriculum, set implementation timelines
- Identify target populations based on data and community need
- Launch community in-person, and virtual workshops to cover topics including understanding health information, communicating with healthcare providers, navigating healthcare, self-management and preventive health, understanding prescriptions, telehealth, patient rights
- Train community-based clinical and non-clinical staff in health-literate communication (e.g., Teach-Back, plain language)

KEY PERFORMANCE METRICS:

- Curriculum identified and vetted for implementation
- Track the number of classes offered and participants
- Track pre/post test results to determine knowledge gained
- Track number of staff trained to implement the program
- Identified number of encounters using the Teach-Back method

COLLABORATIONS WITH ORGANIZATIONS: Local nonprofits, faith-based organizations, community-based organizations

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS NEED: Staff time and clinical expertise, marketing and educational materials, community health supplies, vaccination resources, and ongoing support from the Marketing & Communications and Community Outreach

ESTIMATED COMPLETION DATE: Ongoing through 2028

PERSON(S)/DEPARTMENT RESPONSIBLE: Vice-President of Operations, Pharmacy, Administration, Community Outreach

IDENTIFIED NEED 1:
Increase Access to Care and Education

GOALS/OBJECTIVE/OBJECTIVE:
Financial Empowerment for Healthcare: The goal is to move participants from financial crisis management to proactive planning. show how sound budgeting and saving habits directly support access to care and health stability.

STRATEGY: 3
Financial Literacy & Access to Healthcare

ACTION STEPS:

- Identify a local Bank or Credit Union to partner in program delivery
- Partner with Community groups and organizations to implement class
- Incorporate Financial Literacy in Community Wellness Centers
- Incorporate Financial Literacy in Community Wellness Centers and Prenatal/Postpartum program by including the following educational topics
  - Control Your Money: Budgeting101
  - Understanding needs vs. wants, building a savings
  - Building a Savings for Emergencies and healthcare
  - Avoiding Money Traps: Debts & Credits
  - Protect Your Health: Financial Literacy
- Include information in all FoodRx bags (if applicable)
- Identify additional resources for referrals beyond classes

KEY PERFORMANCE METRICS

- Track the number of classes offered and number of participants
- Utilize pre and post test to determine knowledge gain
- Track number of community partners identified and utilized for implementation
- Track number of referrals for financial assistance

COLLABORATIONS WITH ORGANIZATIONS: Local nonprofits, local banks, cooperative extension organizations

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS NEED: Staff time and clinical expertise, marketing and educational materials, community health supplies, vaccination resources, and ongoing support from the Marketing & Communications and Community Outreach

ESTIMATED COMPLETION DATE: Ongoing through 2028

PERSON(S)/DEPARTMENT RESPONSIBLE: Vice-President of Operations, Community Outreach

IDENTIFIED NEED 2:
The Community Mental Health Strategy: Access, Education, Acceptance

GOALS/OBJECTIVE:
Improve and increase access to mental health services, reduce stigma, and promote emotional well-being for residents of the Clark County

STRATEGY:
Strengthen collaboration with employers, healthcare providers, and community organizations to expand mental health education, increase access to counseling and crisis resources, and promote early intervention and resilience-building initiatives.

ACTION STEPS:
- Partner with healthcare organizations, locally and statewide, to increase the capacity to provide additional mental health services.
- Participate in the Arkansas Rural Health Partnership's Opioid Community Response Implementation Project to increase in-patient mental and behavioral health services.
- Provide Mental Health First Aid training to local schools, colleges, and community or faith-based organizations.
- Provide Community-based Stop the Bleed Trainings
- Participate in System-wide Mental Health Awareness Campaigns
- Partner with local schools and college to increase mental health awareness
- Integrate Mental Health Education and Awareness materials into Schools and Workplaces
- Utilize Telepsych for patients in need of Telemedicine services

KEY PERFORMANCE METRICS:
- Track number of patient encounters in-patient withdrawal management services
- Track number of patient encounters utilizing Telepsych services
- Report number of Community partners and events for mental health services
- Track the number of mental health first aid and Stop the Bleed classes and participants
- Track the number of Mental Health First Aid trainings and attendance
- Measure campaign's reach through social media engagement, website visits, and printed material distribution.

COLLABORATIONS WITH ORGANIZATIONS: Local schools, universities and businesses, non-profits and faith-based organizations

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS NEED: Staff time and clinical expertise, marketing and educational materials, community health supplies and ongoing support from the Marketing & Communications and behavioral health, command center and Community Outreach teams.

ESTIMATED COMPLETION DATE: Ongoing through 2028

PERSON(S)/DEPARTMENT RESPONSIBLE: VP of Operations, Behavioral Health, Community Outreach Director Marketing & Communications Manager, Case Management

IDENTIFIED NEED 3:
Closing the Gap: A Strategy for Healthy Communities and Nutrition Security

GOALS/OBJECTIVE:
Reduce food insecurity for inpatients and improve nutrition knowledge among in-patients and general community through education, outreach, and collaboration with local partners.

STRATEGY 1:
Expand community partnerships and implement interactive nutrition education programs that empower residents with practical skills and resources to reduce food insecurity and promote healthier eating habits.

ACTION STEPS:
- Pilot FoodRx Program for inpatients identified as food insecure.
- Explore funding opportunities in partnership with Baptist Health Foundation to expand FoodRx Program to employees
- Continue partnering with the Baptist Health Community Outreach Department, community organizations—including local school districts to provide free, engaging education on healthy eating and nutrition.
- Educate staff on food insecurity and resources within our community that can benefit our patients and fellow staff members.
- Launch a "Wellness Meet-Up Series" open to the public, featuring monthly sessions on key wellness topics such as physical activity, mindful eating, stress management, and sleep health.
- Implement a "Maintain Don't Gain" Holiday nutrition education challenge in partnership with Community Outreach

KEY PERFORMANCE METRICS:
- Track percentage of patients screened for food insecurity
- Track and report number of patients identified as food insecure during screening
- Track number of referrals for food resources
- Track and report number of FoodRx bags given to patients during timeframe
- Track and report number of FoodRx bags given to employees (if funding is secured to expand program)
- Track the amount of grant/external funding secured toward the sustainability goal

COLLABORATIONS WITH ORGANIZATIONS: Arkansas Foodbank, local non-profits, local food pantries

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS NEED: Staff time and clinical expertise, marketing and educational materials, community health supplies and ongoing support from the Marketing & Communications and Community Outreach teams.

ESTIMATED COMPLETION DATE: Ongoing through 2028

PERSON(S)/DEPARTMENT RESPONSIBLE: VP of Operations, Community Outreach Team, Marketing & Communications Manager, Case Management

IDENTIFIED NEED 3:
Closing the Gap: A Strategy for Healthy Communities and Nutrition Security

STRATEGY #2:
Mobile Health Unit (MHU) "Food as Medicine" Initiative
To improve the health and nutritional well-being of underserved community members by utilizing the Mobile Health Unit to proactively identify individuals experiencing food insecurity, provide immediate relief through nutritious food access, and ensure sustainable connectivity to community food resources.

ACTION STEPS:

- Utilize Baptist Health Community Outreach and Mobile Health unit to screen community members for food insecurity.
- Develop and deploy food boxes in cooperation with the Arkansas Foodbank
- Identify key preventative screenings to be offered at each distribution event
- Develop a tracking system including baseline results, post results, local healthcare and social drivers of health referrals
- Promote the schedule through local channels (churches, community centers, public libraries) using clear, accessible flyers and social media to maximize attendance for free health screenings.
- Implement a short-term follow-up mechanism to measure the impact of referrals.

KEY PERFORMANCE METRICS:

- Number of scheduled MHU visits that occurred in high need areas
- Track and report the number of bags and pounds of food distributed
- Track and report health outcomes for the population being screened
- Percentage of food-insecure clients who confirm they utilized at least one resource on the provided local pantry list during the 30-day follow-up call.
- Track other social determinants of health identified and referrals
- Track the amount of grant/external funding secured toward the sustainability goal

COLLABORATIONS WITH ORGANIZATIONS: Arkansas Foodbank, local food banks, local food pantries, faith-based community partners

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS NEED: Staff time and clinical expertise, marketing and educational materials, ongoing support from the Marketing & Communications

ESTIMATED COMPLETION DATE: Ongoing

PERSON(S)/DEPARTMENT RESPONSIBLE: Baptist Health Community Outreach, Baptist Health Leadership, Marketing & Communications

BAPTIST HEALTH MEDICAL CENTER
Heber Springs

About Us

Baptist Health Medical Center-Heber Springs has been committed to serving Heber Springs and surrounding communities with a complete range of medical services and support groups since its opening in 1968. The 25-bed hospital became part of Baptist Health in 1996 and was relocated to a new location in 2007. The facility includes an expanded emergency department and operating suite, centralized outpatient clinic, in-house MRI services, two covered entrances, a large cafeteria, and updated inpatient rooms.

To better serve the community, Baptist Health Family Clinic-Greers Ferry, Baptist Health Family Clinic-Heber Springs, and Baptist Health-Heber Springs Campus Clinic are operated by Baptist Health Medical Center-Heber Springs.

Community Health Needs Assessment 2026-2028
Baptist Health Medical Center-Heber Springs

HIGHLIGHTS OF COMMUNITY HEALTH NEEDS ASSESSMENT ACCOMPLISHMENTS 2023-2025

Access to Care

- Expanded access by opening a new Cancer Center
- Offered free Mammograms and additional breast imaging services for uninsured or low-income women, including Medicaid and Medicare recipients
- Provided eICU (electronic Intensive Care Unit), which provides 24-hour access to ICU physicians and nurses via two-way interactive technology
- Utilized the Command Center to increase access and decrease barriers to care
- Offered a free flu shot clinic
- Provided Community-based education on chronic disease, and health screenings in partnership with the Heber Springs Senior Citizen Center, pangburn high school, calvary missionary baptist church, West-side high school, Eagle Bank and other community groups.
- Utilized the Command Center to increase access and decrease barriers to care
- Provided community-based fall prevention education

Mental Health Awareness

- Utilize Telepsych services for Community members
- Provided mental health education during community presentations on Chronic Diseases
- Partnered with Community Outreach to office 6-month virtual wellness meet-ups
- A system-wide Behavioral Health Vice President was hired to establish a system-wide comprehensive plan to address and expand mental heath services.

Food and Nutrition

- Utilized to Food Insecurity Screening tool to identify food insecurity for inpatients
- Partnered with Community Outreach to implement a “Maintain Don’t Gain” virtual nutrition education program
- Partnered with Community Outreach on
- Identify and refer patients to community-based food resources
- FoodRx bags distribution and provided 103 bags to those with noted food insecurity.

2025 BAPTIST HEALTH COMMUNITY HEALTH NEEDS ASSESSMENT: HEBER SPRINGS

ACHI
August 2025

Baptist Health

PREPARED BY:
ACHI
INSPIRING HEALTHY ACTS

Introduction

Baptist Health engaged the Arkansas Center for Health Improvement (ACHI) to conduct the quantitative data collection and analysis for the 2025 Community Health Needs Assessment (CHNA) process. Baptist Health provided ACHI with the counties served by each of its 12 hospital communities. A total of 16 Arkansas counties and two Oklahoma counties were included.

Each report presents community-level data for a hospital community, including tables and figures for each indicator, along with comparisons to Arkansas and U.S. benchmarks. Dot graphs are provided to visualize performance across selected indicators. All reports are prepared using the same methodology to ensure consistency and comparability across Baptist Health hospital communities.

Methodology

A summary of sources, definitions, indicator criteria, and suppression rules can be found in the methods and sources document.

Community Profile Summary

To support the 2025 Community Health Needs Assessment (CHNA), ACHI compiled a comprehensive dataset of 103 health and demographic indicators for the communities served by Baptist Health's 12 hospital locations. This section provides an overview of these indicators across the full CHNA service area and offers multiple views for understanding and comparing county-level and community-level data.

Data are grouped into the following 14 categories, based on the source-defined domains outlined in the data source reference sheet:

1. Demographics
    a. Age
    b. Sex
    c. Race, Ethnicity, and Language
2. Insurance Coverage
3. Access to Care
4. Cause of Death
5. Chronic Conditions
6. Diagnoses Incidence at Discharge
7. Environment
8. Health Behaviors
9. Health Outcomes
10. Healthcare Expenditures
11. Maternal and Infant Health
12. Mental Health and Substance Use
13. Prevention
14. Social and Economic Factors

Measurements for these categories will be displayed in the following sections.

Hospital Community Indicator

The hospital community indicator snapshots offer an at-a-glance view of how each hospital community compares to state and national benchmarks, as well as the counties that make up the community.

Each table presents the data values for selected indicators across the 14 CHNA domains, and each corresponding visual uses proportionally scaled circular markers to illustrate performance. This format is designed to quickly convey how each hospital community aligns with or diverges from broader benchmarks in key population health metrics.

Each displays four comparison points:

- **Purple** – Represents the national value for the indicator.
- **Blue** – Represents the value for the state of Arkansas.
- **Gold** – Represents the weighted average for all counties in the hospital's defined service area.
- **Gray** – Represent the values of each county assigned to that hospital community.

Where available, data for each indicator are shown for all four categories. If a value is not available or is suppressed for a contributing county, it is noted as "Not Available" in the table and excluded from the visual display. No color ranking is applied; the visuals and tables are intended to illustrate relative placement, not comparative rank.

Hospital Community: Heber Springs (Cleburne County)

Figure 1. Counties Served by Baptist Health Medical Center–Heber Springs

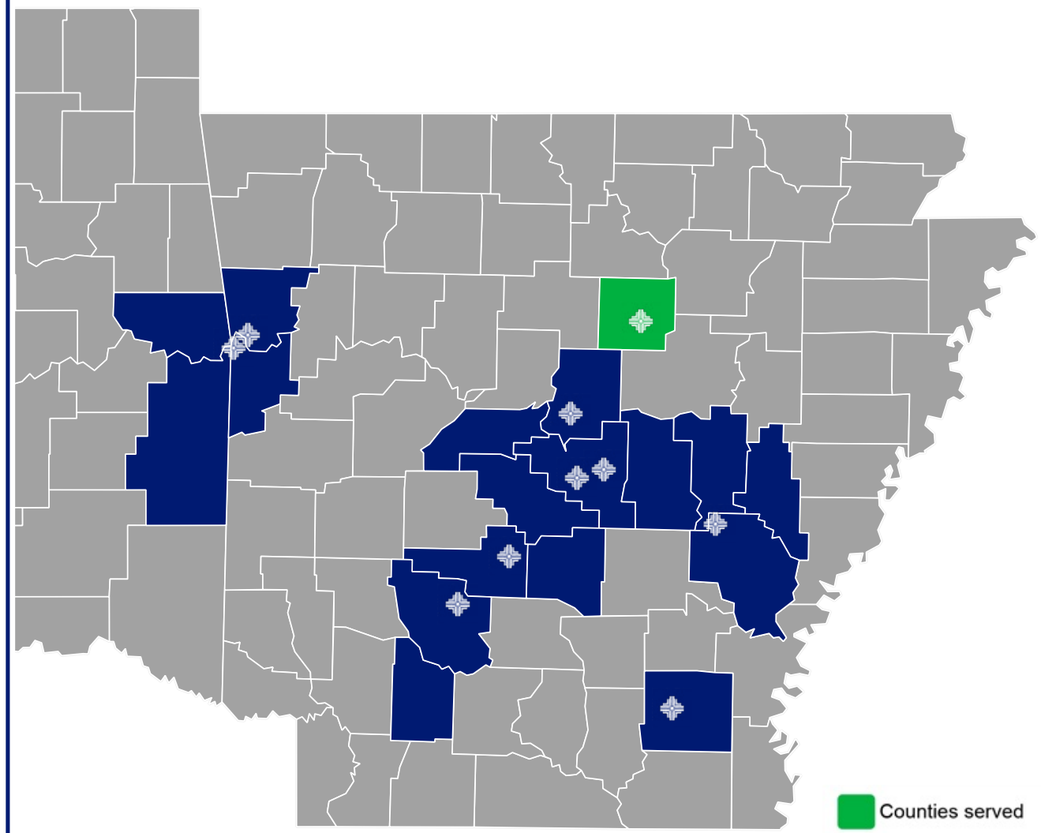


Table 1. Demographics: Age and Sex

		Cleburne County	Community Average	State	National
Total Population	*Number*	25,048	25,048	3,032,651	332,387,540
Female	*Percent*	50.04%	50.04%	50.67%	50.50%
Male	*Percent*	49.96%	49.96%	49.33%	49.50%
Ages 0-4	*Percent*	4.30%	4.30%	6.02%	5.70%
Ages 5-17	*Percent*	14.61%	14.61%	17.26%	16.46%
Ages 18-24	*Percent*	6.42%	6.42%	9.33%	9.12%
Ages 25-34	*Percent*	9.45%	9.45%	12.93%	13.69%
Ages 35-44	*Percent*	10.98%	10.98%	12.66%	13.08%
Ages 45-54	*Percent*	11.09%	11.09%	11.84%	12.29%
Ages 55-64	*Percent*	15.89%	15.89%	12.64%	12.82%
Ages 65+	*Percent*	27.26%	27.26%	17.33%	16.84%

Figure 2. Demographics: Age and Sex

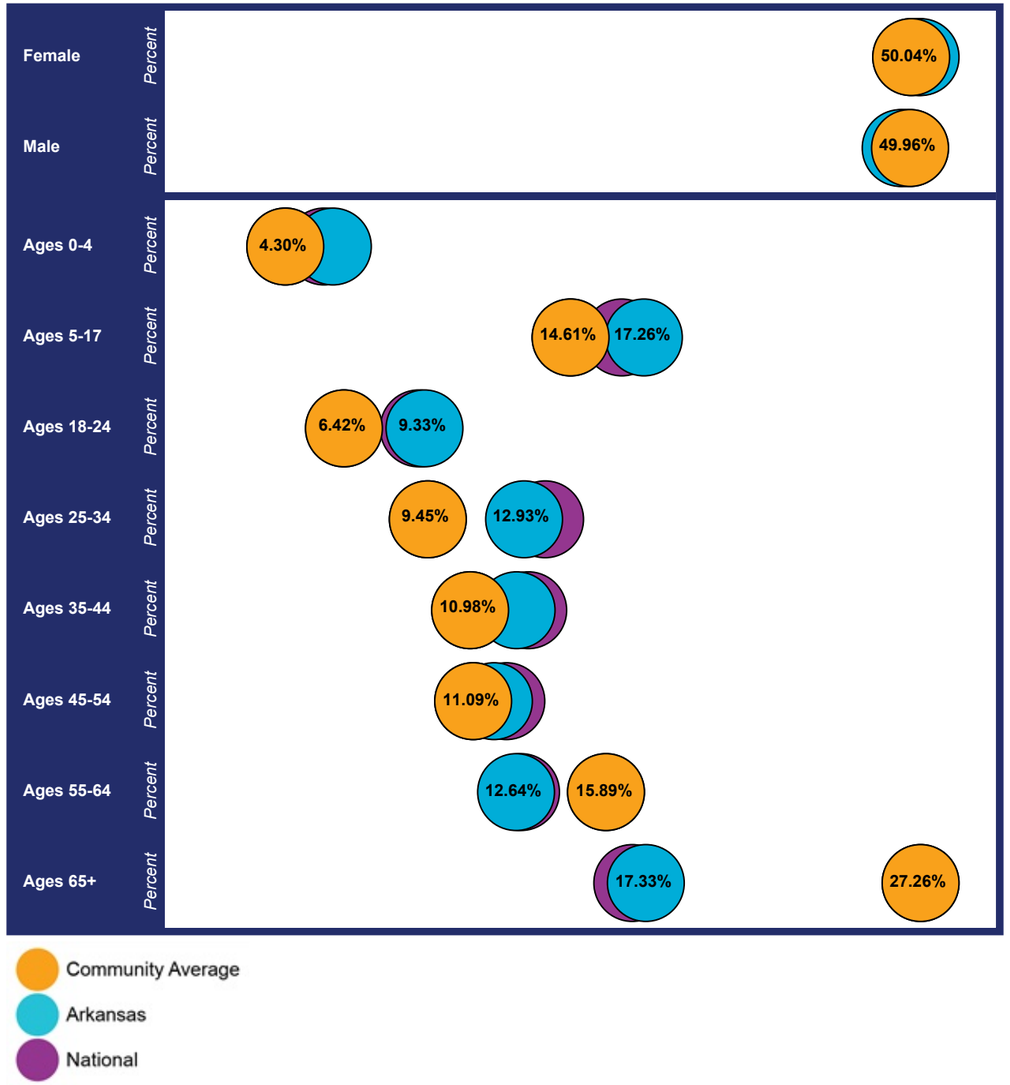


Table 2. Demographics: Race, Ethnicity, and Language

		Cleburne County	Community Average	State	National
Total Population	*Number*	25,048	25,048	3,032,651	332,387,540
Asian	*Percent*	0.20%	0.20%	1.53%	5.75%
Black or African American	*Percent*	0.36%	0.36%	14.84%	12.03%
Hispanic	*Percent*	2.85%	2.85%	8.77%	18.99%
Multiple Races	*Percent*	3.40%	3.40%	5.50%	3.87%
Native American/ Alaska Native	*Percent*	0.56%	0.56%	0.36%	0.53%
Native Hawaiian/ Pacific Islander	*Percent*	0.04%	0.04%	0.39%	0.17%
Other Races	*Percent*	0.43%	0.43%	0.26%	0.50%
White	*Percent*	92.16%	92.16%	68.36%	58.17%
Non-English Language Households	*Percent*	0.10%	0.10%	1.50%	4.20%

Figure 3. Demographics: Race, Ethnicity, and Language

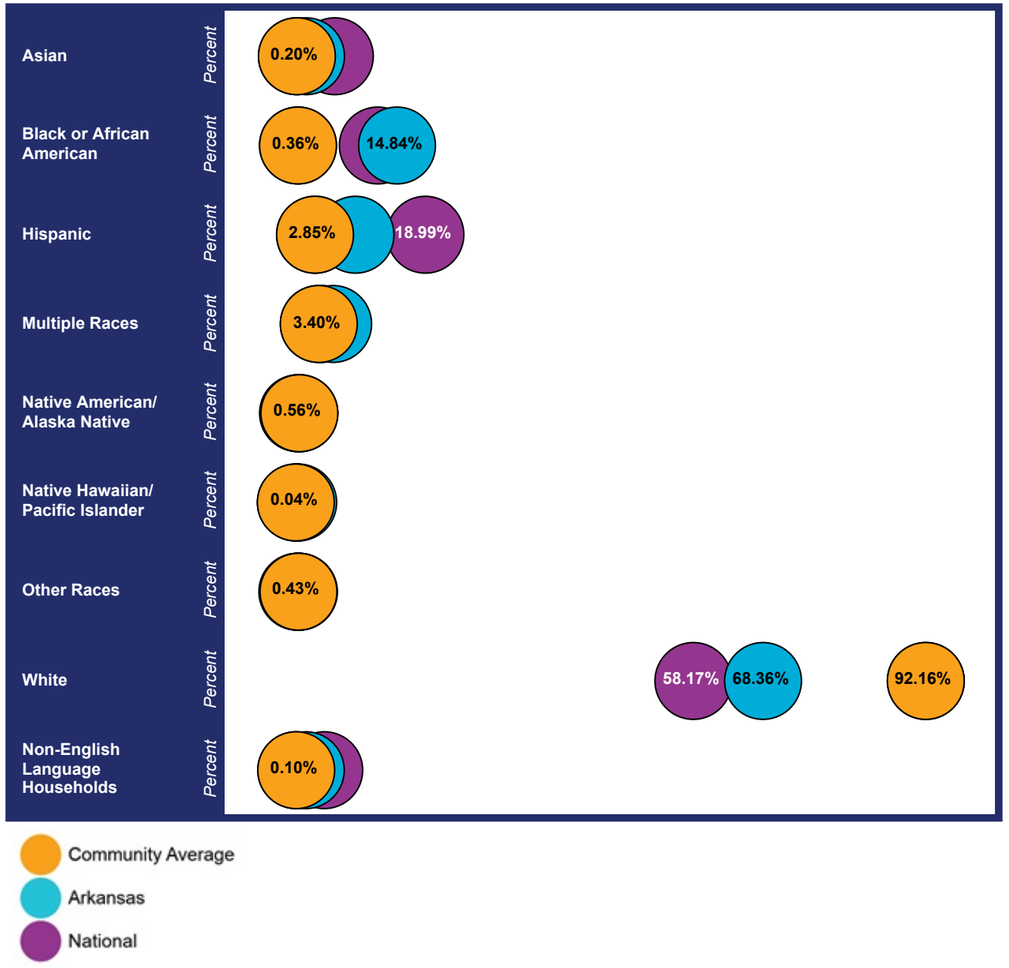


Table 3. Insurance Coverage

		Cleburne County	Community Average	State	National
Private Health Insurance Coverage	*Percentage of the total civilian non-institutionalized population for whom insurance status is determined that is covered by private health insurance*	**59.68%**	**59.68%**	**65.37%**	**73.62%**
Public Health Insurance Coverage	*Percentage of the total civilian non-institutionalized population for whom insurance status is determined that is covered by public health insurance*	**62.24%**	**62.24%**	**48.21%**	**39.70%**
Uninsured	*Percentage of adults under age 65 without health insurance coverage*	**10.00%**	**10.00%**	**10.00%**	**9.50%**

Figure 4. Insurance Coverage

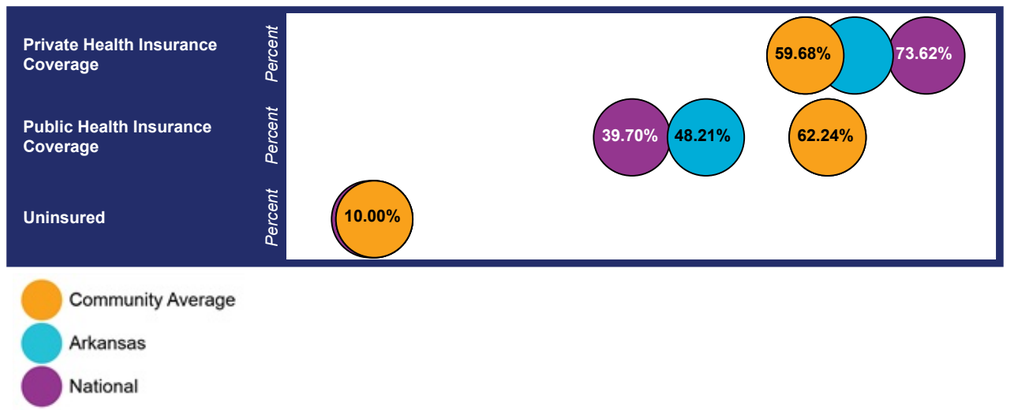


Table 4. Access to Care

		Cleburne County	Community Average	State	National
Primary Care Physicians	*Ratio of population to one primary care physician*	**1471:1**	**1471:1**	**1478:1**	**1334:1**
Mental Health Providers	*Ratio of population to one mental health provider*	**795:1**	**795:1**	**367:1**	**300:1**
Dentists	*Ratio of population to one dentist*	**2298:1**	**2298:1**	**2044:1**	**1361:1**
Active Primary Care Physicians	*Rate per 10,000 county residents of primary care physicians who provided evaluation and management services to at least two patients on the same day at least once during the year*	**18.20**	**18.20**	**9.20**	**Not Available**
Addiction or Substance Use Providers	*Rate of addiction or substance use providers per 100,000 population*	**0.00**	**0.00**	**5.98**	**29.43**
Buprenorphine Providers	*Rate of buprenorphine providers per 100,000 population*	**4.00**	**4.00**	**9.81**	**14.87**
Preventable Hospital Stays (Medicare)	*Rate of hospital stays for ambulatory care-sensitive conditions per 100,000 Medicare enrollees*	**1928.00**	**1928.00**	**3014.00**	**2666.00**
Diabetic Monitoring (Medicare)	*Percentage of Medicare enrollees aged 65 and older with diabetes who received a hemoglobin A1c (HbA1c) test within the past year.*	**90.88%**	**90.88%**	**88.47%**	**87.53%**
Mammography	*Percentage of female Medicare enrollees ages 65-74 who received an annual mammography screening*	**41.00%**	**41.00%**	**41.00%**	**44.00%**

Figure 5. Access to Care

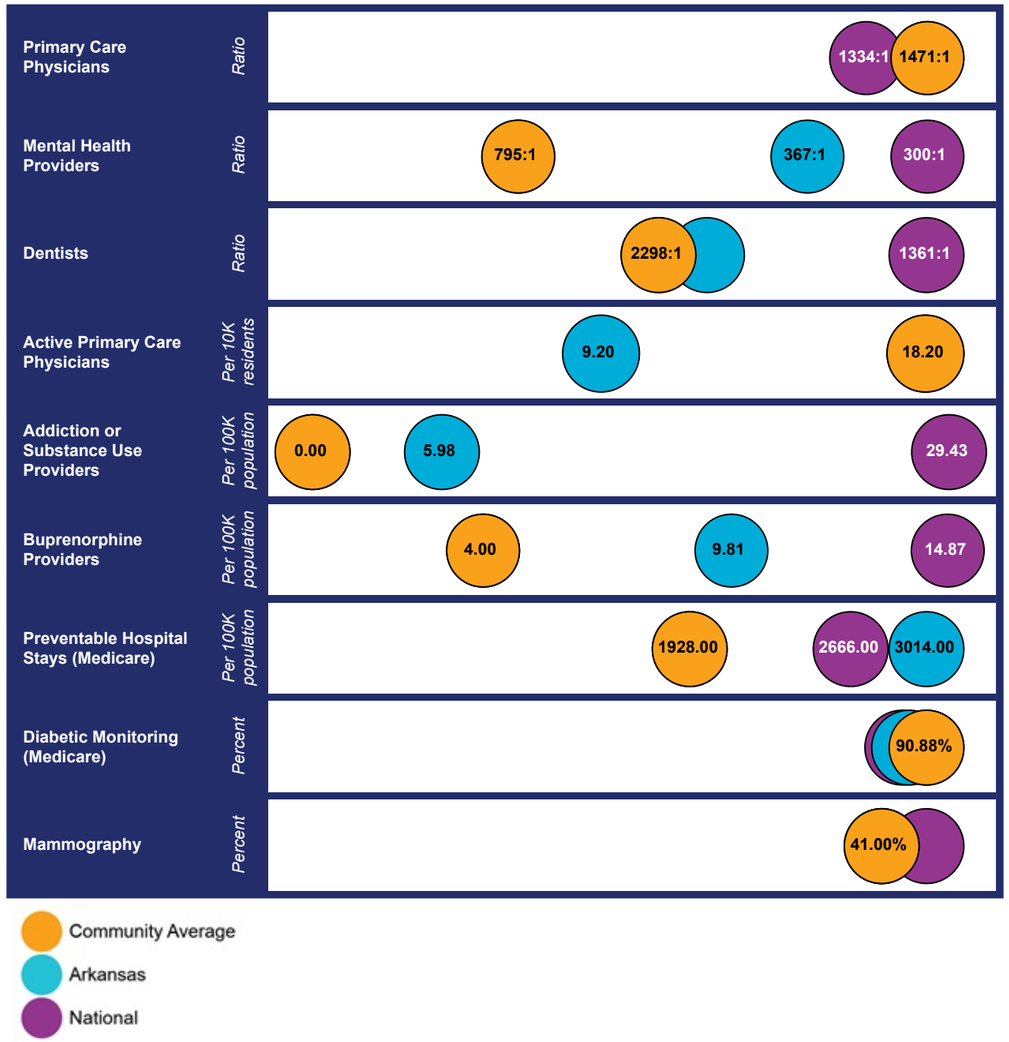


Table 5. Cause of Death

		Cleburne County	Community Average	State	National
All Causes	*Rate of deaths by all causes per 100,000 population (age-adjusted)*	943.50	943.50	1001.70	805.60
Premature Death	*Number of deaths among residents under age 75 per 100,000 population (age-adjusted)*	494.56	494.56	552.47	406.59
Heart Disease	*Rate of death due to heart disease (ICD-10 Codes I00-I09, I11, I13, I20-I151) per 100,000 population*	332.80	332.80	282.80	207.20
Cancer	*5-year average rate of death due to cancer per 100,000 population*	318.50	318.50	215.90	182.70
Unintentional Injury	*5-year average rate of death due to unintentional injury (accident) per 100,000 population*	77.20	77.20	61.90	63.30
Stroke	*5-year average rate of death due to cerebrovascular disease (stroke) per 100,000 population (age-adjusted)*	78.80	78.80	57.40	48.30
Chronic Lower Respiratory Disease	*Rate of deaths due to chronic lower respiratory disease per 100,000 population (age-adjusted)*	70.10	70.10	61.00	35.90
Diabetes Mortality	*Rate of deaths due to diabetes per 100,000 population (age-adjusted)*	33.10	33.10	34.70	23.90
Suicide Deaths	*This indicator reports the 2019-2023 five-year average rate of death due to intentional self-harm (suicide) per 100, 000 population. Figures are reported as crude rates*	19.90	19.90	19.20	14.50
Motor Vehicle Crash	*5-year average rate of death due to motor vehicle crash per 100,000 population (age-adjusted)*	25.50	25.50	20.60	12.80
Alcohol-Involved Motor Vehicle Crash	*Rate of persons killed in motor vehicle crashes involving alcohol as a rate per 100,000 population*	9.70	9.70	3.10	2.30

Figure 6. Cause of Death

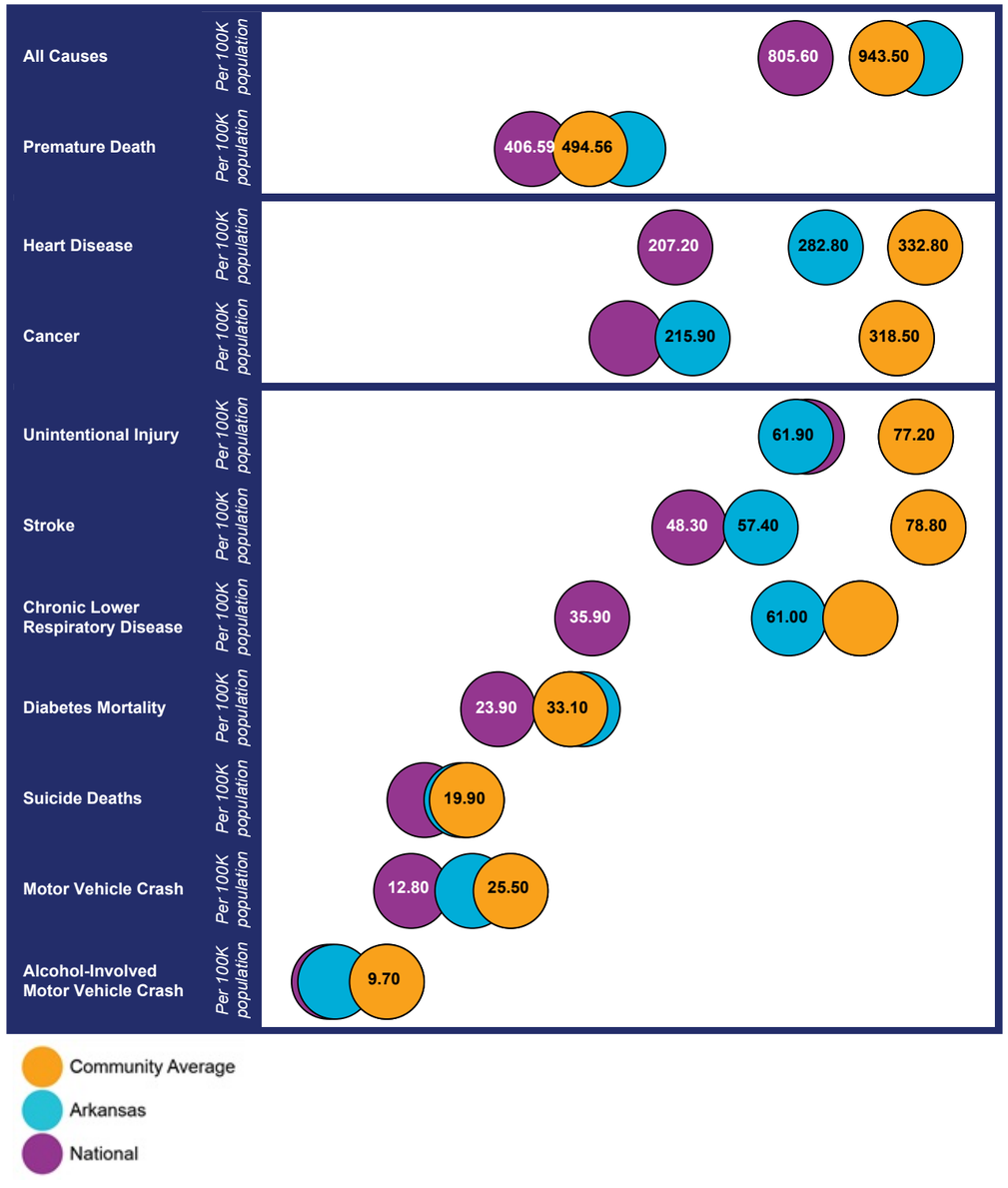


Table 6. Chronic Condtions

		Cleburne County	Community Average	State	National
Child Obesity	*Percentage of students classified as overweight to severely obese, by county location of school*	38.96%	38.96%	40.10%	Not Available
High Cholesterol	*Percentage of adults who have had their blood cholesterol checked and have been told it was high (age-adjusted)*	32.60%	32.60%	31.80%	30.40%
Adult Obesity	*Percentage of adults ages 20 and older who report a BMI higher than 30*	29.30%	29.30%	31.90%	30.10%
High Blood Pressure	*Percentage of adults who have been told they have high blood pressure (age-adjusted)*	35.10%	35.10%	36.50%	29.60%
Arthritis	*Percentage of adults ages 18 or older diagnosed with some form of arthritis*	41.80%	41.80%	32.60%	Not Available
Diabetes Prevalence	*Percentage of adults age 18 and older who report ever been told that they have diabetes other than diabetes during pregnancy (age-adjusted)*	11.70%	11.70%	12.70%	10.40%
Asthma	*Percentage of adults who have been told they currently have asthma (age-adjusted)*	11.40%	11.40%	11.00%	9.90%
Coronary Heart Disease	*Percentage of adults age 18 and older who report ever having been told by that they had angina or coronary heart disease (CHD) (age-adjusted)*	7.30%	7.30%	7.20%	5.70%

Figure 7. Chronic Conditions

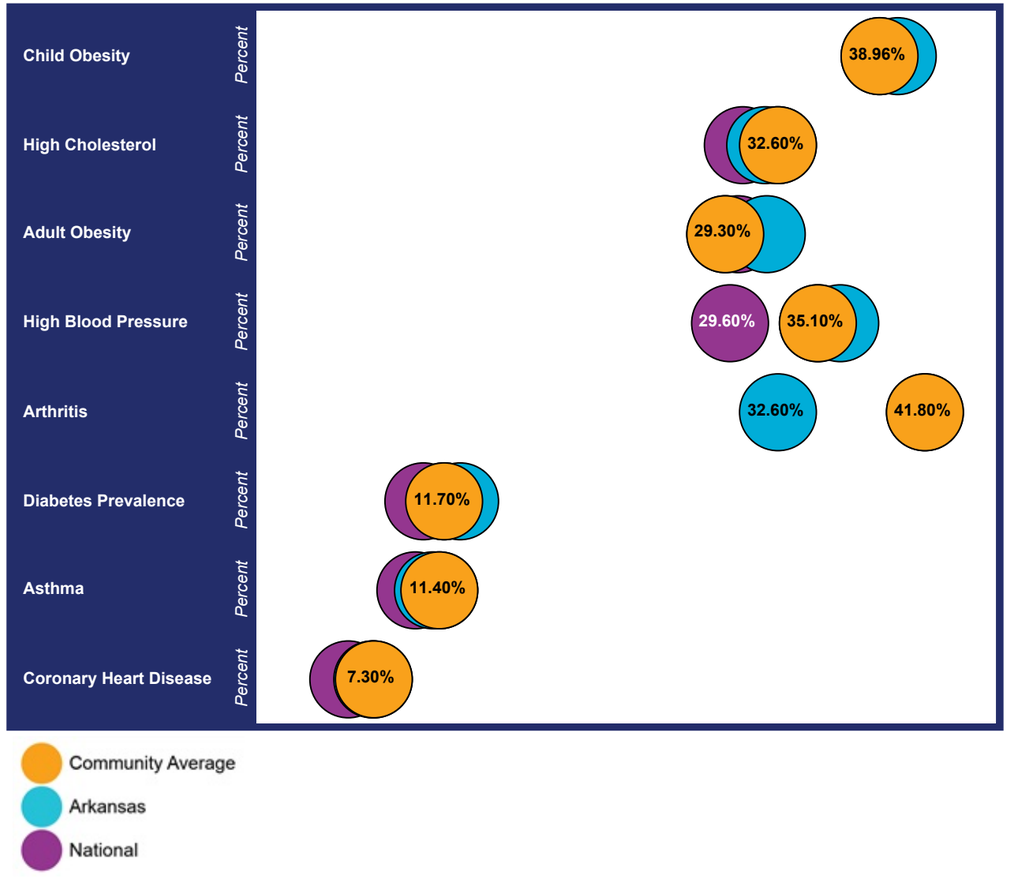


Table 7. Diagnoses at Discharge

		Cleburne County	Community Average	State
Hypertension	*Number of individuals 18 years and older discharged with a primary or secondary hypertension diagnosis as a percentage of the population 18 years and older*	8.88%	8.88%	8.70%
Hyperlipidemia	*Number of individuals 18 years and older discharged with a primary or secondary hyperlipidemia diagnosis as a percentage of the population 18 years and older*	3.34%	3.34%	3.90%
Diabetes	*Rate of individuals 18 years and older discharged with a primary or secondary diabetes diagnosis as a percentage of the population 18 years and older*	3.22%	3.22%	3.70%
Ischemic Heart Disease	*Number of individuals 18 years and older discharged with a primary or secondary ischemic heart disease diagnosis as a percentage of the population 18 years and older*	2.31%	2.31%	2.50%
Arthritis	*Rate of individuals 18 years and older discharged with a primary or secondary arthritis diagnosis as a percentage of the population 18 years and older*	1.87%	1.87%	1.90%

Figure 8. Diagnoses at Discharge

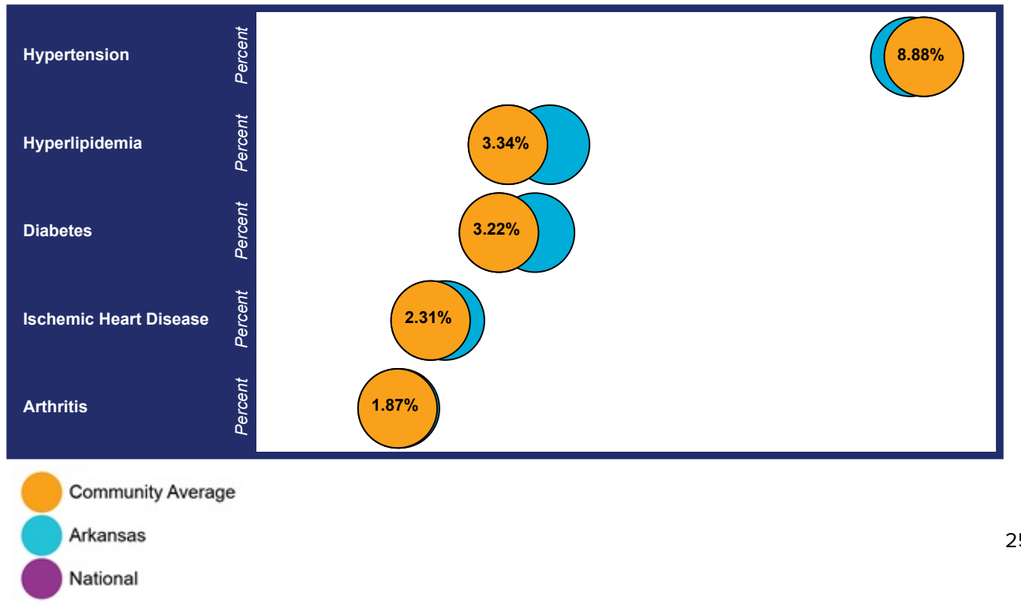


Table 8. Environment

		Cleburne County	Community Average	State	National
Food Environment Index	*Index of factors that contribute to a healthy food environment, 0 (worst) to 10 (best)*	6.70	6.70	4.40	7.40
Drinking Water Violations	*The total number of drinking water violations recorded in a two-year period*	0	0	321	16,107
Access to Exercise Opportunities	*Percentage of population with adequate access to locations for physical activity*	40.47%	40.47%	63.36%	84.45%
Broadband Access	*Percentage of population in a high-speed internet service area; access to DL speeds >= 25MBPS and UL speeds >= 3 MBPS*	98.60%	98.60%	94.04%	96.78%
Long Commute Driving Alone	*Among workers who commute in their car alone, the percentage who commute more than 30 minutes*	40.00%	40.00%	28.10%	36.50%
Severe Housing Problems	*Percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities*	9.75%	9.75%	13.23%	16.84%

Community Average
Arkansas
National

Figure 9. Environment

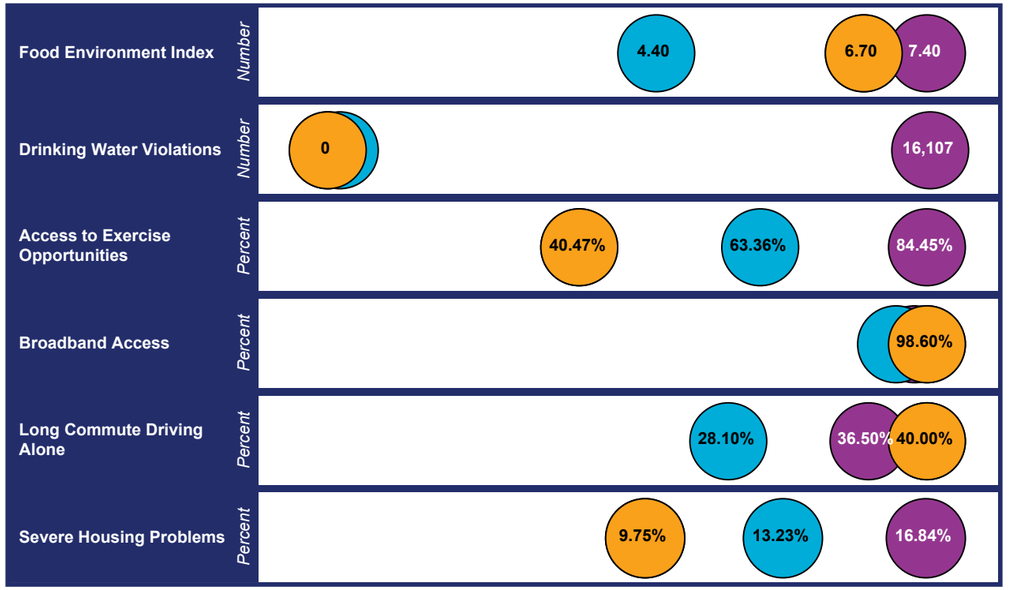


Table 9. Health Behaviors

		Cleburne County	Community Average	State	National
Physical Inactivity	*Percentage of adults aged 20 and older who self-report no leisure time for activity*	26.20%	26.20%	23.60%	19.50%
Adult Smoking	*Percentage of adults ages 18 and older who are current smokers (age-adjusted)*	21.20%	21.20%	19.20%	13.20%
Youth Vaping	*Percentage of public school students in 6th, 8th, 10th, and 12th grade who used any vape in the past 30 days*	4.70%	4.70%	8.10%	Not Available
Sexually Transmitted Infections	*Number of newly diagnosed chlamydia cases per 100,000 population*	233.30	233.30	588.30	495.00

Figure 10. Health Behaviors

Table 10. Health Outcomes

		Cleburne County	Community Average	State	National
Poor Physical Health Days	*Average number of physically unhealthy days reported in past 30 days (age-adjusted)*	5.20	5.20	5.20	3.90
Poor or Fair Health	*Percentage of adults age 18 and older who self-report their general health status as "fair" or "poor" (age-adjusted)*	22.80%	22.80%	22.60%	17.00%

Figure 11. Health Outcomes

Table 11. Healthcare Expenditures

		Cleburne County	Community Average	State	National
Average Annualized Expenditures	*Average annualized per-person spending on all covered healthcare services.*	**$10,792**	**$10,792**	**$10,116**	**Not Available**
Average Annualized Expenditures (Medical Only)	*Average annualized per-person spending on medical services, based on medical claims.*	**$7,786**	**$7,786**	**$7,252**	**Not Available**
Average Annualized Expenditures (Pharmacy Only)	*Average annualized per-person spending on prescription drugs, based on pharmacy claims.*	**$2,781**	**$2,781**	**$2,609**	**Not Available**

Figure 12. Healthcare Expenditures

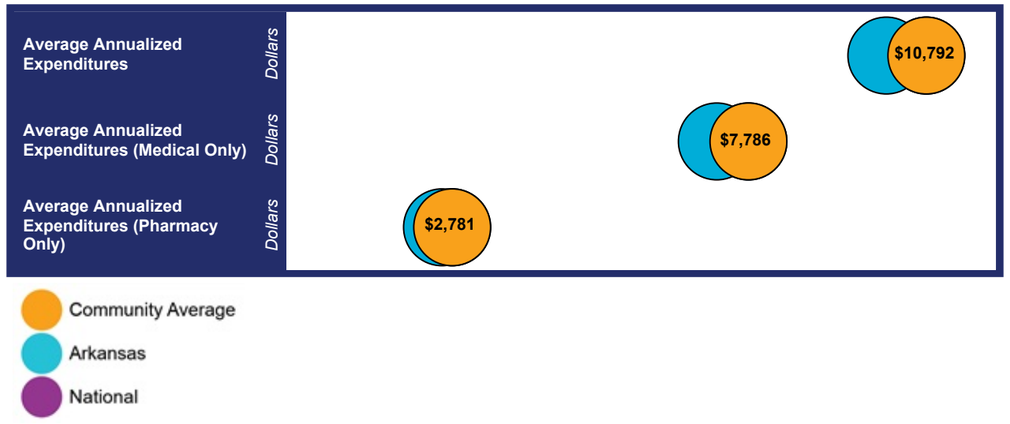


Table 12. Maternal and Infant Health

		Cleburne County	Community Average	State	National
Active Obstetrics and Gynecology Physicians	*Active OB-GYN physicians are defined as those who provided evaluation and management services to at least two female patients ages 12-55 on the same day or performed a qualifying procedure (e.g., delivery) at least once during the year.*	**1.80**	**1.80**	**3.20**	**Not Available**
Teen Births	*The seven-year average number of teen births per 1,000 female population, ages 15-19*	**32.40**	**32.40**	**27.90**	**15.50**
C-Section Rate	*Percentage of live births delivered via cesarean section among all deliveries, calculated by the mother's county of residence.*	**31.16%**	**31.16%**	**33.48%**	**Not Available**
C-Section Rate, First Birth	*Percentage of first-birth deliveries (full-term singleton pregnancies in a head-down position) delivered via cesarean section, calculated by the mother's county of residence.*	**23.47%**	**23.47%**	**27.58%**	**Not Available**
Low Birthweight	*Percentage of live births where the infant weighed less than 2, 500 grams (approximately 5 lbs., 8 oz.)*	**8.50%**	**8.50%**	**9.40%**	**8.40%**
Preterm Birth	*Percentage of live births that are preterm (<37 weeks), calculated as a three-year average.*	**10.70%**	**10.70%**	**11.90%**	**10.35%**
Median Travel Time to Delivery	*Median number of minutes Arkansas mothers traveled from their home ZIP code to the delivery facility, calculated using birth records and facility addresses. Travel time estimates include in-state and out-of-state facilities.*	**45.00**	**45.00**	**16.00**	**Not Available**

Figure 13. Maternal and Infant Health

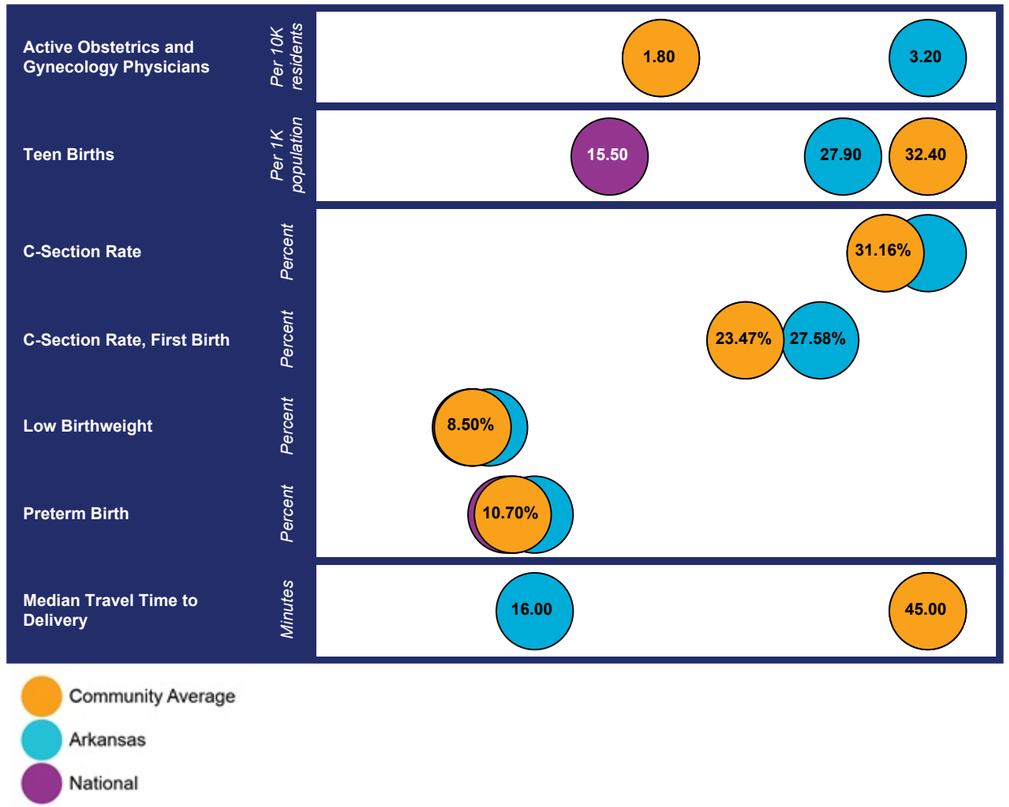


Table 13. Mental Health and Substance Use

		Cleburne County	Community Average	State	National
Adult Depression	*Percentage of adults age 18 and older who report having been told that they had depressive disorder*	30.50%	30.50%	27.50%	21.10%
Excessive Drinking	*Percentage of adults reporting binge or heavy drinking*	19.74%	19.74%	18.99%	19.35%
Poor Mental Health	*Percentage of adults age 18 or older reporting poor mental health for 14 or more days (age-adjusted)*	22.30%	22.30%	20.50%	16.40%
Youth Depression	*Percentage of public school students in 6th, 8th, 10th, and 12th grade who had feelings of depression all of the time in the past 30 days*	8.10%	8.10%	9.20%	Not Available
Drug Overdose Deaths	*Age-adjusted rate of fatal drug overdoses per 100,000 residents*	Not Available	Not Available	Not Available	Not Available
Non-Fatal Drug Overdoses	*Age-adjusted rate of non-fatal drug overdoses per 100,000 residents*	Not Available	Not Available	Not Available	Not Available

Figure 14. Mental Health and Substance Use

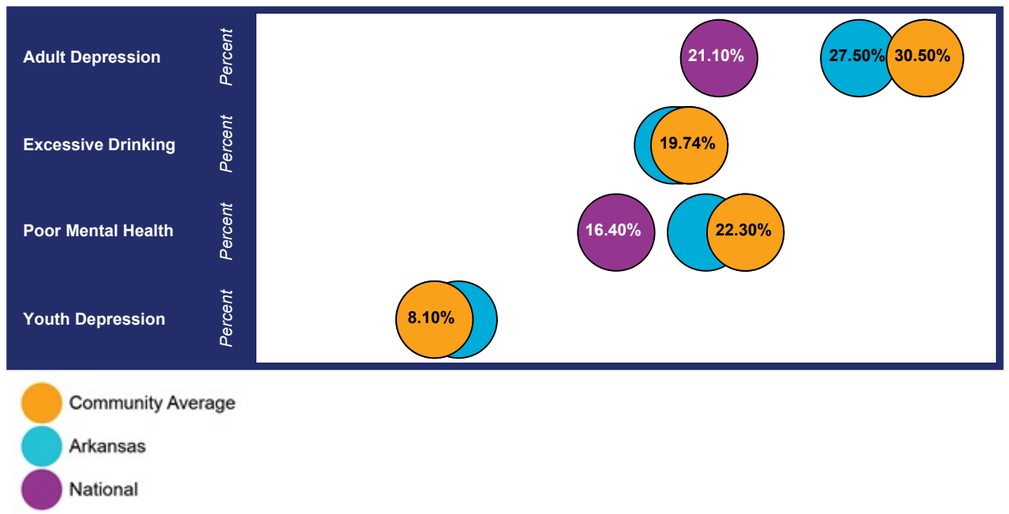


Table 14. Prevention

		Cleburne County	Community Average	State	National
Cervical Cancer Screening	*Percentage of females age 21–65 years who report having had recommended cervical cancer screening test (age-adjusted)*	80.10%	80.10%	81.20%	83.70%
Colorectal Cancer Screening	*Percentage of adults age 45-75 who have had a recent colorecal cancer screening*	68.00%	68.00%	61.60%	66.30%
Dental Care Utilization	*Dental care visit (past 1 year), age-adjusted percentage of adults age 18+ by county*	53.00%	53.00%	54.10%	63.40%
High Blood Pressure Management	*Percentage of adults age 18 and older with high blood pressure who report taking blood pressure medication (age-adjusted)*	59.70%	59.70%	61.40%	58.90%
Prevention - Seasonal Influenza Vaccine	*Percentage of adults aged 18 and older who report receiving an influenza vaccination in the past 12 months*	44.70%	44.70%	43.20%	44.80%
Annual Wellness Exam (Medicare)	*Percentage of annual wellness visits among the Medicare fee-for-service (FFS) population*	49.00%	49.00%	46.00%	44.00%
No HIV Test	*Percentage of adults ages 18 or older who have never been screened for HIV*	65.60%	65.60%	66.10%	Not Available

Figure 15. Prevention

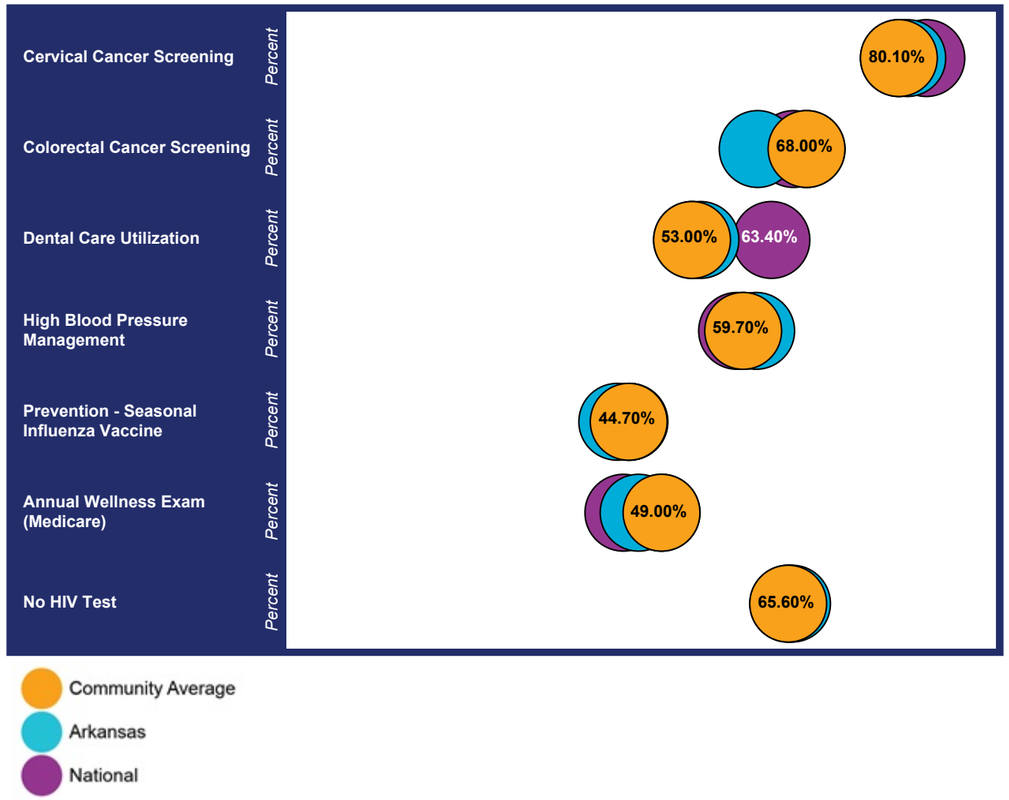
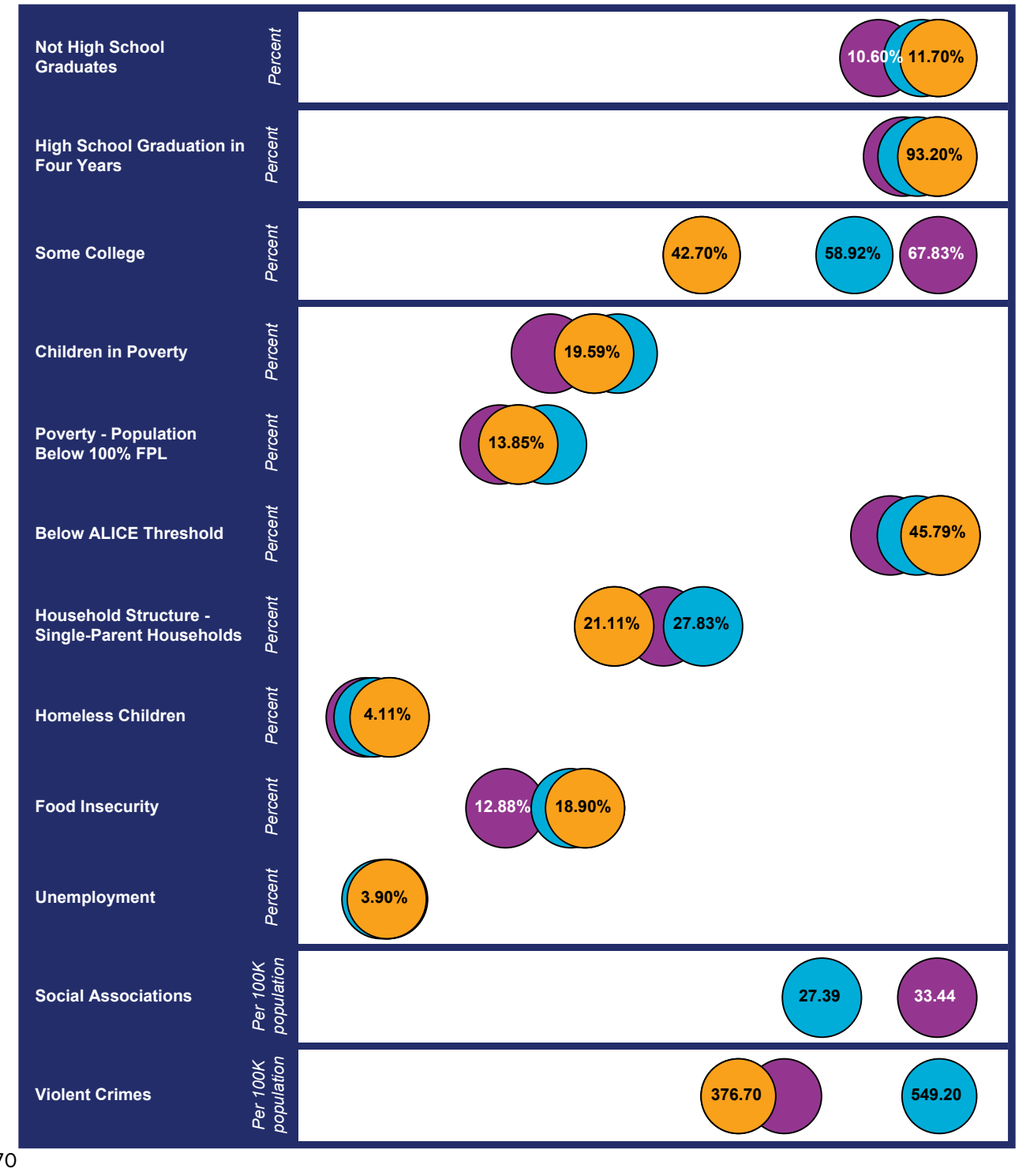


Table 15. Social and Economic Factors

		Cleburne County	Community Average	State	National
Not High School Graduates	*Percentage of adults without a high school diploma*	11.70%	11.70%	11.40%	10.60%
High School Graduation in Four Years	*Percentage of ninth-grade cohort who graduated in four years*	93.20%	93.20%	90.30%	88.20%
Some College	*Percentage of adults ages 25-44 with some post-secondary education*	42.70%	42.70%	58.92%	67.83%
Children in Poverty	*Percentage of children under age 18 below the poverty line*	19.59%	19.59%	21.37%	16.32%
Poverty - Population Below 100% FPL	*Percentage of the population living in households with income below the federal poverty level*	13.85%	13.85%	16.02%	12.44%
Below ALICE Threshold	*Percentage of households living in poverty or classified as ALICE (Asset Limited, Income Constrained, Employed)*	45.79%	45.79%	44.00%	42.00%
Household Structure - Single-Parent Households	*Percentage of children who live in households where only one parent is present*	21.11%	21.11%	27.83%	24.83%
Homeless Children	*Percentage of students experiencing homelessness enrolled in the public school system*	4.11%	4.11%	2.90%	2.31%
Food Insecurity	*Percentage of the population that experienced food insecurity in the report year*	18.90%	18.90%	17.82%	12.88%
Unemployment	*Percentage of the civilian non-institutionalized population age 16 and older that is unemployed (non-seasonally adjusted)*	3.90%	3.90%	3.50%	4.00%
Social Associations	*Establishments, rate per 100,000 population*	Not Available	Not Available	27.39	33.44
Violent Crimes	*Annual rate of reported violent crimes per 100,000 population*	376.70	376.70	549.20	416.00

Figure 16. Social and Economic Factors



IDENTIFIED NEED 1:
Increase Acces to Care and Education

GOALS/OBJECTIVE/OBJECTIVES:
Increase access to quality health care, preventive screenings, vaccinations, and community health resources for Cleburne County.

STRATEGY 1:
Expand community outreach and strengthen partnerships with local nonprofits, schools, and employers to improve access and awareness .

ACTION STEPS:

- Utilize Telehealth and the Command Center to improve access and decrease barriers to care
- Host annual free flu shot events & childhood immunization clinics
- Launch a “Wellness Meet-Up Series” open to the public, featuring monthly sessions on key wellness topics such as physical activity, mindful eating, stress management, and sleep health.
- Partner with local businesses and organizations to offer free health education and on-site screenings (e.g., blood sugar, blood pressure, BMI) and facilitate scheduling for primary care and mammogram appointments.
- Provide home monitoring devices (blood pressure/ glucose monitors primary care clinics
- Continue local and collaborations to expand access and reduce barriers to care
- Explore Resource Hub opportunities with area agencies to identify and promote community resources and social drivers of health support
- Maintain the financial assistance policy for patients who are uninsured, underinsured, ineligible for a government health care program, or otherwise unable to pay, for medically necessary or emergent care.
- Continue to evaluate the need to recruit physicians, advanced practice providers and support staff as necessary to meet community needs.
- Continue to provide education and wellness tips on news segments and social media.
- Increase access to Community-based maternal health educational programs and services
- Increase awareness and utilization of new Cancer Center

KEY PERFORMANCE METRICS:

- Provide preventive screenings, vaccinations, and related services
- Track and report the number of community outreach events hosted or attended by Baptist Health
- Measure and report the number of community members reached through health education, screenings, and outreach efforts.
- Evaluate referral and follow-up rates for individuals connected to primary or specialty care through outreach initiatives.
- Number of providers recruited will be tracked
- Charity Care will be tracked and reported

COLLABORATIONS WITH ORGANIZATIONS: Local nonprofits, faith-based organizations, community-based organizations

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS NEED: Staff time and clinical expertise, marketing and educational materials, vaccination resources, Marketing & Communications and Community Outreach

ESTIMATED COMPLETION DATE: Ongoing through 2028

PERSON(S)/DEPARTMENT RESPONSIBLE: Leadership Team, Community Outreach

IDENTIFIED NEED 1:
Increase Acces to Care and Education

GOALS/OBJECTIVE/OBJECTIVES:
To improve community health by increasing health literacy and reducing barriers to accessing healthcare through community-led, culturally appropriate education and navigation support.

STRATEGY: 2
Health Literacy & Access to Healthcare

ACTION STEPS:

- Establish a Community Health Literacy committee including patient representatives, clinical staff, and community partners) to finalize the curriculum, set implementation timelines
- Identify target populations based on data and community need
- Launch community in-person, and virtual workshops to cover topics including understanding health information, communicating with healthcare providers, navigating healthcare, self-management and preventive health, understanding prescriptions, telehealth, patient rights
- Train community-based clinical and non-clinical staff in health-literate communication (e.g., Teach-Back, plain language)

KEY PERFORMANCE METRICS:

- Curriculum identified and vetted for implementation
- Track the number of classes offered and participants
- Track pre/post test results to determine knowledge gained
- Track number of staff trained to implement the program
- Identified number of encounters using the Teach-Back method

COLLABORATIONS WITH ORGANIZATIONS: Local nonprofits, faith-based organizations, community-based organizations

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS NEED: Staff time and clinical expertise, marketing and educational materials, vaccination resources, Marketing & Communications and Community Outreach

ESTIMATED COMPLETION DATE: Ongoing through 2028

PERSON(S)/DEPARTMENT RESPONSIBLE: Leadership Team, Community Outreach

IDENTIFIED NEED 1:
Increase Acces to Care and Education

GOALS/OBJECTIVE/OBJECTIVE:
Financial Empowerment for Healthcare: The goal is to move participants from financial crisis management to proactive planning. show how sound budgeting and saving habits directly support access to care and health stability.

STRATEGY 3:
Financial Literacy & Access to Healthcare

ACTION STEPS:
- Identify a local Bank or Credit Union to partner in program delivery
- Partner with Community groups and organizations to implement class
- Incorporate Financial Literacy in Community Wellness Centers
- Incorporate Financial Literacy in Community Wellness Centers and Prenatal/Postpartum program by including the following educational topics
  - Control Your Money: Budgeting101
  - Understanding needs vs. wants, building a savings
  - Building a Savings for Emergencies and healthcare
  - Avoiding Money Traps: Debts & Credits
  - Protect Your Health: Financial Literacy
- Include information in all FoodRx bags (if applicable)
- Identify additional resources for referrals beyond classes

KEY PERFORMANCE METRICS
- Track the number of classes offered and number of participants
- Utilize pre and post test to determine knowledge gain
- Track number of community partners identified and utilized for implementation
- Track number of referrals for financial assistance

COLLABORATIONS WITH ORGANIZATIONS: Local nonprofits, local banks, cooperative extension organizations

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS NEED: Staff time and clinical expertise, marketing and educational materials, community health supplies, vaccination resources, and ongoing support from the Marketing & Communications and Community Outreach

ESTIMATED COMPLETION DATE: Ongoing through 2028

PERSON(S)/DEPARTMENT RESPONSIBLE: Leadership Team, Community Outreach

IDENTIFIED NEED 2:
The Community Mental Health Strategy: Access, Education, Acceptance

GOALS/OBJECTIVE:
Improve and increase access to mental health services, reduce stigma, and promote emotional well-being for residents of the Cleburne County

STRATEGY:
Strengthen collaboration with employers, healthcare providers, and community organizations to expand mental health education, increase access to counseling and crisis resources, and promote early intervention and resilience-building initiatives

ACTION STEPS:
- Partner with healthcare organizations, locally and statewide, to increase the capacity to provide additional mental health services
- Implementation Project to increase in-patient mental and behavioral health services.
- Provide Mental Health First Aid training to local schools, colleges, and community or faith-based organizations.
- Provide Community-based Stop the Bleed Trainings
- Participate in system-wide Mental Health Awareness Campaigns
- Integrate Mental Health Education and Awareness materials into schools and workplaces
- Utilize Telepsych for patients in need of Telemedicine services

KEY PERFORMANCE METRICS:
- Track number of patient encounters in-patient withdrawal management services
- Track number of patient encounters utilizing Telepsych services
- Report number of community partners and events for mental health services
- Track the number of mental health first aid and Stop the Bleed classes and participants
- Track the number of Mental Health First Aid trainings and attendance
- Measure campaign's reach through social media engagement, website visits, and printed material distribution.

COLLABORATIONS WITH ORGANIZATIONS: Local schools, universities and businesses, non-profits and faith-based organizations

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS NEED: Staff time and clinical expertise, marketing and educational materials, community health supplies and ongoing support from the Marketing & Communications and behavioral health, command center and Community Outreach teams

ESTIMATED COMPLETION DATE: Ongoing through 2028

PERSON(S)/DEPARTMENT RESPONSIBLE: Leadership, Behavioral Health, Community Outreach Marketing & Communications Manager, Case Management

IDENTIFIED NEED 3:
Closing the Gap: A Strategy for Healthy Communities and Nutrition Security

GOALS/OBJECTIVE:
Reduce food insecurity for inpatients and improve nutrition knowledge among in-patients and general community through education, outreach, and collaboration with local partners.

STRATEGY 1:
Expand community partnerships and implement interactive nutrition education programs that empower residents with practical skills and resources to reduce food insecurity and promote healthier eating habits.

ACTION STEPS:
- Pilot FoodRx Program for inpatients identified as food insecure.
- Explore funding opportunities in partnership with Baptist Health Foundation to expand FoodRx Program and or Blessing box to employees
- Continue partnering with the Baptist Health Community Outreach Department, community organizations—including local school districts to provide free, engaging education on healthy eating and nutrition.
- Educate staff on food insecurity and resources within our community that can benefit our patients and fellow staff members.
- Launch a “Wellness Meet-Up Series” open to the public, featuring monthly sessions on key wellness topics such as physical activity, mindful eating, stress management, and sleep health.
- Implement a “Maintain Don’t Gain” Holiday nutrition education challenge in partnership with Community Outreach
- Provide community-based cooking and educational classes

PERFORMANCE METRICS:
- Track percentage of patients screened for food insecurity
- Track number of referrals for food resources
- Track number of educational classes and participants in nutrition education classes
- Track and report number of FoodRx bags given to patients during timeframe
- Track the amount of grant/external funding secured toward the sustainability goal

COLLABORATIONS WITH ORGANIZATIONS: Arkansas Foodbank, local non-profits, local food pantries

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS NEED: Staff time and clinical expertise, marketing and educational materials, community health supplies and ongoing support from the Marketing & Communications and Community Outreach teams.

ESTIMATED COMPLETION DATE: Ongoing through 2028

PERSON(S)/DEPARTMENT RESPONSIBLE: VP of Operations, Community Outreach Team, Marketing & Communications Manager, Case Management

BAPTIST HEALTH
Van Buren

About Us

Located in historic Van Buren, Arkansas, Baptist Health-Van Buren is a 103-bed acute care hospital and is accredited by the Joint Commission. The hospital has received Quality Improvement and Innovator awards from the Arkansas Foundation for Medical Care. We offer comprehensive medical services with an emphasis on customer service. Our goal is to provide you and your family exceptional care in a comfortable setting.

Community Health Needs Assessment 2026-2028
Baptist Health Medical Center-Van Buren

HIGHLIGHTS OF COMMUNITY HEALTH NEEDS ASSESSMENT ACCOMPLISHMENTS 2023-2025

Access to Care

- Provided 250+ Free Health Screenings: The Baptist Health Family Clinic-Van Buren offered free blood pressure screenings at the Van Buren Public Library, directly supporting preventive care for the local community
- Delivered Life-Saving Education to Youth: Collaborated with the Butterfield Trail Middle School Health Fair to provide hands-on CPR training and stroke recognition education to students and families
- Targeted Spanish-Language Outreach: Partnered with La Clínica del Pueblo and Dr. Wilson Cruz to host Spanish-language health education sessions, specifically addressing the health needs of the Hispanic community
- Developed the Future Healthcare Workforce: Sustained the MASH and Caring Teen Programs, providing experiential hospital tours to Van Buren High School students to introduce healthcare career pathways
- Ensured Consistent Care Access: Continued to operate and provide accessible Urgent Care services for all members of the community
- Bridging the gap in home monitoring: We increase access to care for patients with limited resources by providing free blood pressure machines, blood glucose machines and test strips, and scales, enabling crucial at-home health tracking

Nutrition & Food Insecurity

- Sustained Maternal Health Education: Provided free, consistent breastfeeding and nutrition classes for River Valley mothers throughout 2024 and 2025 to promote optimal infant and maternal health
- Expanded Youth Nutrition Literacy (2024-2025): Annually partnered with SNAP-Ed to deliver the impactful "Farm to You" curriculum at Cedarville Elementary, reaching hundreds of students with healthy eating education
- Encouraged students to “Re-think their Drink” with an interactive game where students at Butterfield Trail Middle School were able to guess the amount of sugar in their favorite drinks, as well as sample fruit, veggie and herb infused water samples as a sugar-free alternative
- Empowered Budget-Conscious Eating: Developed and distributed practical educational materials and low-cost recipes to community groups, directly equipping residents with strategies for healthy eating and grocery shopping on a budget
- Boosted Digital Nutrition Literacy: Strategically promoted Dietitian Education Videos across social media platforms, achieving high engagement to effectively encourage reading food labels and support community members in making immediate, healthier choices while shopping

Mental Health and Awareness

- Developed Comprehensive Behavioral Health Resource: Created a system-wide comprehensive guide highlighting all available behavioral health services
- Partnered to offer an annual ACES awareness symposium for Community members and staff with over 200 participants
- Distributed Make it Okay Mental Health Awareness materials at family clinics and urgent care clinics
- Offered the New Vision program at Baptist Health-Fort Smith and Baptist Health-Van Buren as a safe option for adults experiencing active or impending withdrawal from drugs and/or alcohol

2025 BAPTIST HEALTH COMMUNITY HEALTH NEEDS ASSESSMENT: VAN BUREN

ACHI
August 2025

Baptist Health

PREPARED BY: ACHI
INSPIRING HEALTHY ACTS

Introduction

Baptist Health engaged the Arkansas Center for Health Improvement (ACHI) to conduct the quantitative data collection and analysis for the 2025 Community Health Needs Assessment (CHNA) process. Baptist Health provided ACHI with the counties served by each of its 12 hospital communities. A total of 16 Arkansas counties and two Oklahoma counties were included.

Each report presents community-level data for a hospital community, including tables and figures for each indicator, along with comparisons to Arkansas and U.S. benchmarks. Dot graphs are provided to visualize performance across selected indicators. All reports are prepared using the same methodology to ensure consistency and comparability across Baptist Health hospital communities.

Methodology

A summary of sources, definitions, indicator criteria, and suppression rules can be found in the methods and sources document.

Community Profile Summary

To support the 2025 Community Health Needs Assessment (CHNA), ACHI compiled a comprehensive dataset of 103 health and demographic indicators for the communities served by Baptist Health's 12 hospital locations. This section provides an overview of these indicators across the full CHNA service area and offers multiple views for understanding and comparing county-level and community-level data.

Data are grouped into the following 14 categories, based on the source-defined domains outlined in the data source reference sheet:

1. Demographics
    a. Age
    b. Sex
    c. Race, Ethnicity, and Language
2. Insurance Coverage
3. Access to Care
4. Cause of Death
5. Chronic Conditions
6. Diagnoses Incidence at Discharge
7. Environment
8. Health Behaviors
9. Health Outcomes
10. Healthcare Expenditures
11. Maternal and Infant Health
12. Mental Health and Substance Use
13. Prevention
14. Social and Economic Factors

Measurements for these categories will be displayed in the following sections.

Hospital Community Indicator

The hospital community indicator snapshots offer an at-a-glance view of how each hospital community compares to state and national benchmarks, as well as the counties that make up the community.

Each table presents the data values for selected indicators across the 14 CHNA domains, and each corresponding visual uses proportionally scaled circular markers to illustrate performance. This format is designed to quickly convey how each hospital community aligns with or diverges from broader benchmarks in key population health metrics.

Each displays four comparison points:

- **Purple** – Represents the national value for the indicator.
- **Blue** – Represents the value for the state of Arkansas.
- **Gold** – Represents the weighted average for all counties in the hospital's defined service area.
- **Gray** – Represent the values of each county assigned to that hospital community.

Where available, data for each indicator are shown for all four categories. If a value is not available or is suppressed for a contributing county, it is noted as "Not Available" in the table and excluded from the visual display. No color ranking is applied; the visuals and tables are intended to illustrate relative placement, not comparative rank.

Hospital Community: Van Buren (Crawford County)

Figure 1. Counties Served by Baptist Health Medical Center–Van Buren

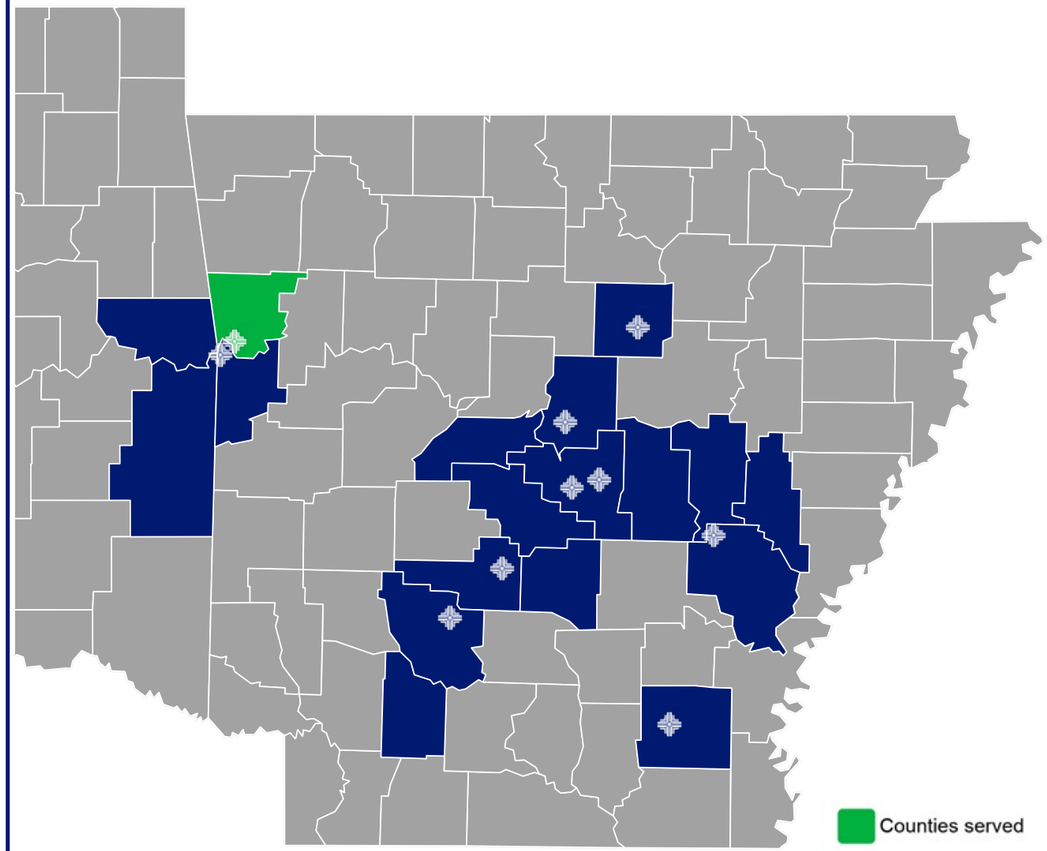


Table 1. Demographics: Age and Sex

		Crawford County	Community Average	State	National
Total Population	*Number*	60,792	60,792	3,032,651	332,387,540
Female	*Percent*	50.69%	50.69%	50.67%	50.50%
Male	*Percent*	49.31%	49.31%	49.33%	49.50%
Ages 0-4	*Percent*	6.03%	6.03%	6.02%	5.70%
Ages 5-17	*Percent*	18.11%	18.11%	17.26%	16.46%
Ages 18-24	*Percent*	7.79%	7.79%	9.33%	9.12%
Ages 25-34	*Percent*	12.58%	12.58%	12.93%	13.69%
Ages 35-44	*Percent*	12.55%	12.55%	12.66%	13.08%
Ages 45-54	*Percent*	12.01%	12.01%	11.84%	12.29%
Ages 55-64	*Percent*	13.45%	13.45%	12.64%	12.82%
Ages 65+	*Percent*	17.47%	17.47%	17.33%	16.84%

Figure 2. Demographics: Age and Sex

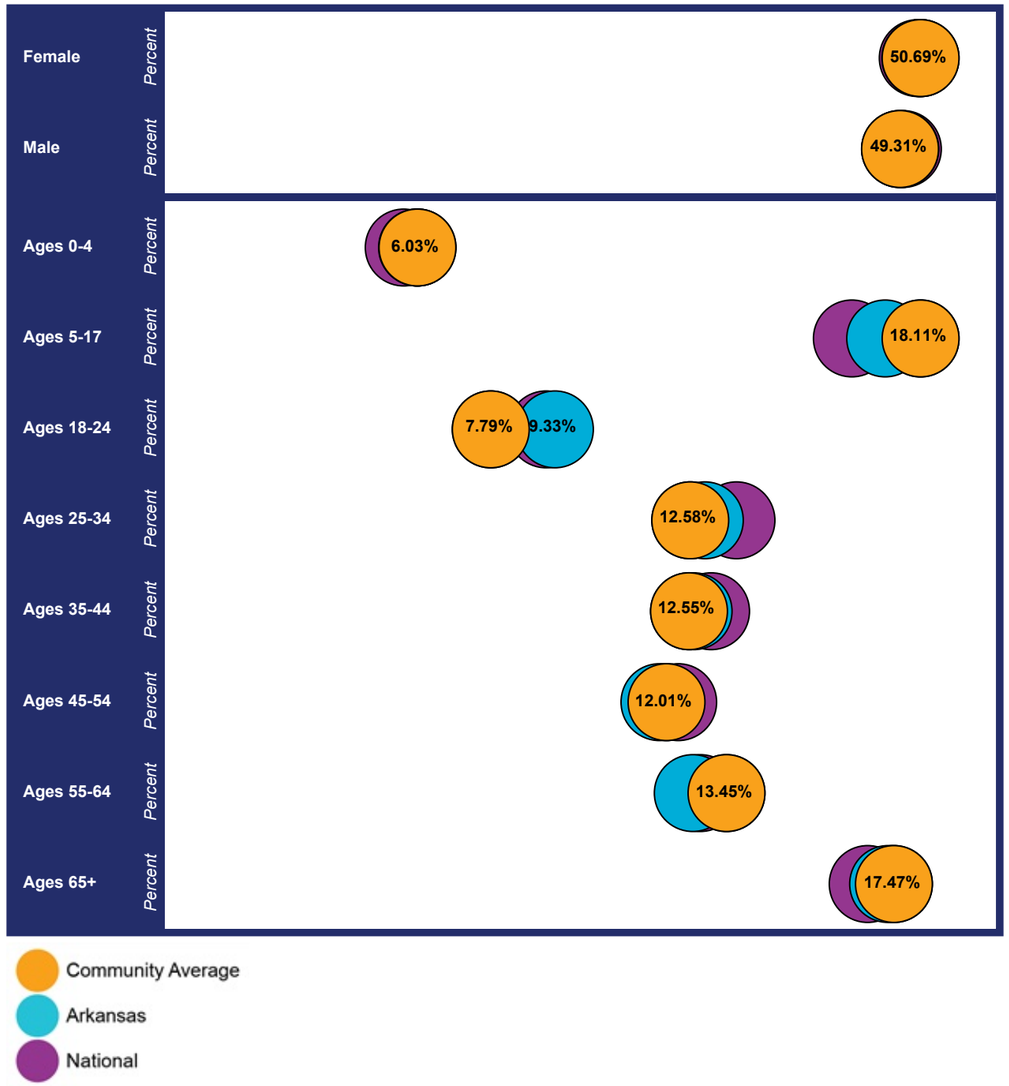


Table 2. Demographics: Race, Ethnicity, and Language

		Crawford County	Community Average	State	National
Total Population	*Number*	60,792	60,792	3,032,651	332,387,540
Asian	*Percent*	1.17%	1.17%	1.53%	5.75%
Black or African American	*Percent*	1.16%	1.16%	14.84%	12.03%
Hispanic	*Percent*	8.14%	8.14%	8.77%	18.99%
Multiple Races	*Percent*	7.40%	7.40%	5.50%	3.87%
Native American/ Alaska Native	*Percent*	1.05%	1.05%	0.36%	0.53%
Native Hawaiian/ Pacific Islander	*Percent*	0.01%	0.01%	0.39%	0.17%
Other Races	*Percent*	0.89%	0.89%	0.26%	0.50%
White	*Percent*	80.19%	80.19%	68.36%	58.17%
Non-English Language Households	*Percent*	1.00%	1.00%	1.50%	4.20%

Figure 3. Demographics: Race, Ethnicity, and Language

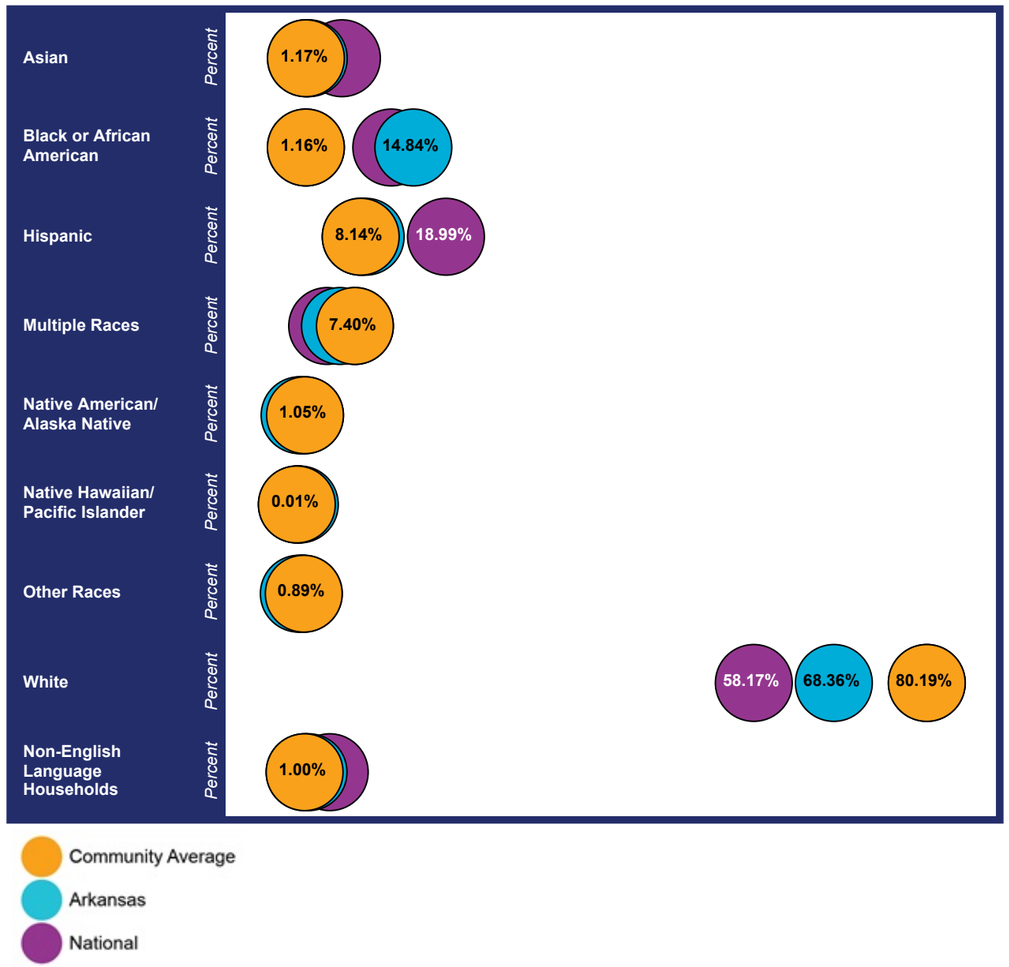


Table 3. Insurance Coverage

		Crawford County	Community Average	State	National
Private Health Insurance Coverage	*Percentage of the total civilian non-institutionalized population for whom insurance status is determined that is covered by private health insurance*	61.94%	61.94%	65.37%	73.62%
Public Health Insurance Coverage	*Percentage of the total civilian non-institutionalized population for whom insurance status is determined that is covered by public health insurance*	52.27%	52.27%	48.21%	39.70%
Uninsured	*Percentage of adults under age 65 without health insurance coverage*	9.30%	9.30%	10.00%	9.50%

Figure 4. Insurance Coverage

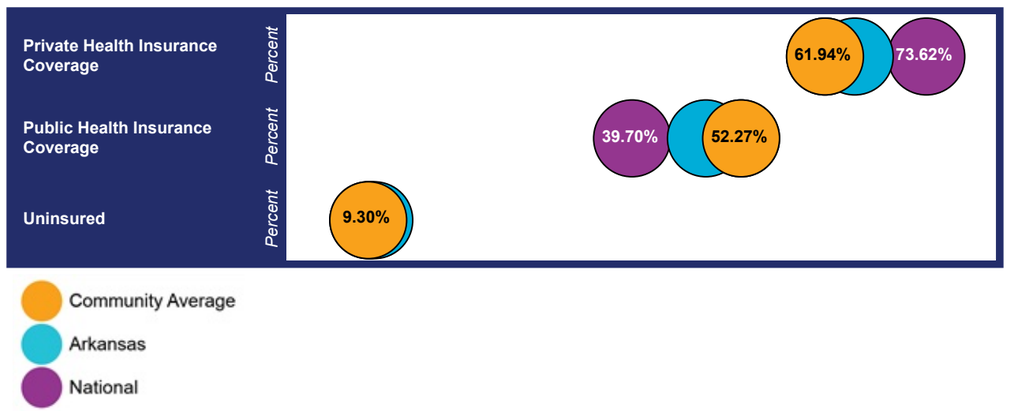


Table 4. Access to Care

		Crawford County	Community Average	State	National
Primary Care Physicians	*Ratio of population to one primary care physician*	2875:1	2875:1	1478:1	1334:1
Mental Health Providers	*Ratio of population to one mental health provider*	1473:1	1473:1	367:1	300:1
Dentists	*Ratio of population to one dentist*	4362:1	4362:1	2044:1	1361:1
Active Primary Care Physicians	*Rate per 10,000 county residents of primary care physicians who provided evaluation and management services to at least two patients on the same day at least once during the year*	11.30	11.30	9.20	Not Available
Addiction or Substance Use Providers	*Rate of addiction or substance use providers per 100,000 population*	3.33	3.33	5.98	29.43
Buprenorphine Providers	*Rate of buprenorphine providers per 100,000 population*	1.66	1.66	9.81	14.87
Preventable Hospital Stays (Medicare)	*Rate of hospital stays for ambulatory care-sensitive conditions per 100,000 Medicare enrollees*	3184.00	3184.00	3014.00	2666.00
Diabetic Monitoring (Medicare)	*Percentage of Medicare enrollees aged 65 and older with diabetes who received a hemoglobin A1c (HbA1c) test within the past year.*	87.51%	87.51%	88.47%	87.53%
Mammography	*Percentage of female Medicare enrollees ages 65-74 who received an annual mammography screening*	47.00%	47.00%	41.00%	44.00%

Figure 5. Access to Care

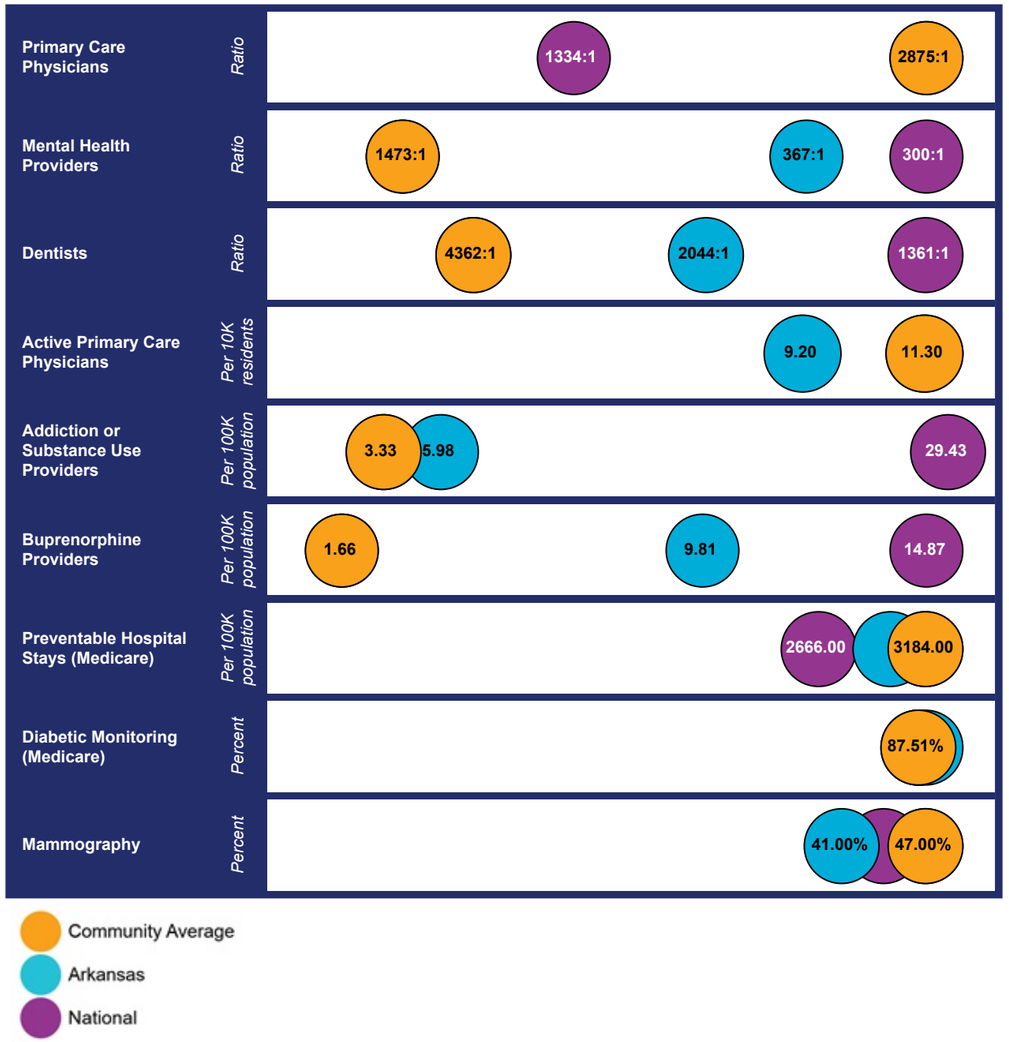


Table 5. Cause of Death

		Crawford County	Community Average	State	National
All Causes	*Rate of deaths by all causes per 100,000 population (age-adjusted)*	1034.80	1034.80	1001.70	805.60
Premature Death	*Number of deaths among residents under age 75 per 100,000 population (age-adjusted)*	572.37	572.37	552.47	406.59
Heart Disease	*Rate of death due to heart disease (ICD-10 Codes I00-I09, I11, I13, I20-I151) per 100,000 population*	307.40	307.40	282.80	207.20
Cancer	*5-year average rate of death due to cancer per 100,000 population*	231.90	231.90	215.90	182.70
Unintentional Injury	*5-year average rate of death due to unintentional injury (accident) per 100,000 population*	51.60	51.60	61.90	63.30
Stroke	*5-year average rate of death due to cerebrovascular disease (stroke) per 100,000 population (age-adjusted)*	62.30	62.30	57.40	48.30
Chronic Lower Respiratory Disease	*Rate of deaths due to chronic lower respiratory disease per 100,000 population (age-adjusted)*	70.70	70.70	61.00	35.90
Diabetes Mortality	*Rate of deaths due to diabetes per 100,000 population (age-adjusted)*	30.70	30.70	34.70	23.90
Suicide Deaths	*This indicator reports the 2019-2023 five-year average rate of death due to intentional self-harm (suicide) per 100, 000 population. Figures are reported as crude rates*	21.60	21.60	19.20	14.50
Motor Vehicle Crash	*5-year average rate of death due to motor vehicle crash per 100,000 population (age-adjusted)*	15.20	15.20	20.60	12.80
Alcohol-Involved Motor Vehicle Crash	*Rate of persons killed in motor vehicle crashes involving alcohol as a rate per 100,000 population*	4.70	4.70	3.10	2.30

Figure 6. Cause of Death

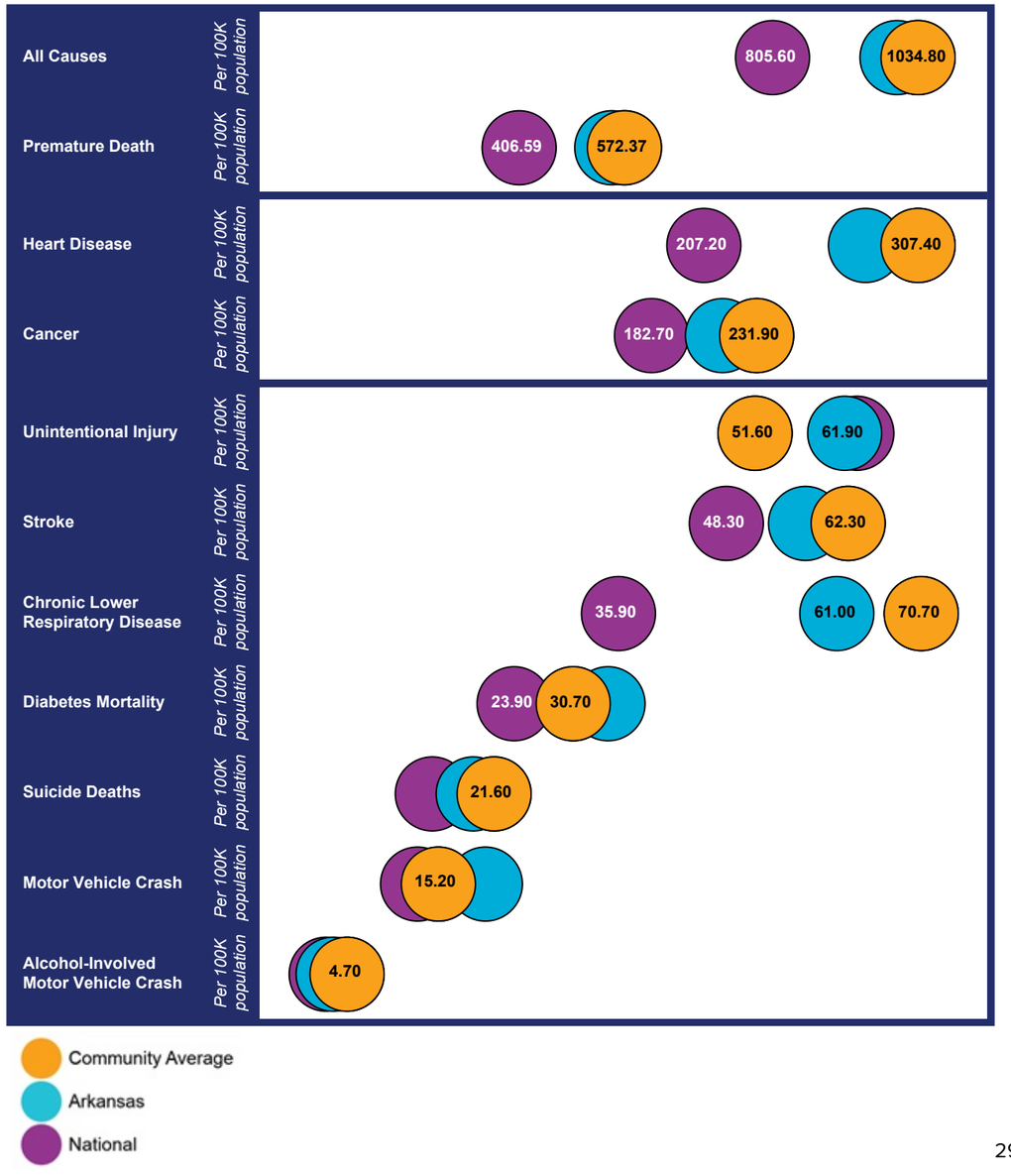


Table 6. Chronic Condtions

		Crawford County	Community Average	State	National
Child Obesity	*Percentage of students classified as overweight to severely obese, by county location of school*	37.73%	37.73%	40.10%	Not Available
High Cholesterol	*Percentage of adults who have had their blood cholesterol checked and have been told it was high (age-adjusted)*	34.30%	34.30%	31.80%	30.40%
Adult Obesity	*Percentage of adults ages 20 and older who report a BMI higher than 30*	36.20%	36.20%	31.90%	30.10%
High Blood Pressure	*Percentage of adults who have been told they have high blood pressure (age-adjusted)*	35.70%	35.70%	36.50%	29.60%
Arthritis	*Percentage of adults ages 18 or older diagnosed with some form of arthritis*	29.40%	29.40%	32.60%	Not Available
Diabetes Prevalence	*Percentage of adults age 18 and older who report ever been told that they have diabetes other than diabetes during pregnancy (age-adjusted)*	12.50%	12.50%	12.70%	10.40%
Asthma	*Percentage of adults who have been told they currently have asthma (age-adjusted)*	10.80%	10.80%	11.00%	9.90%
Coronary Heart Disease	*Percentage of adults age 18 and older who report ever having been told by that they had angina or coronary heart disease (CHD) (age-adjusted)*	7.60%	7.60%	7.20%	5.70%

Figure 7. Chronic Conditions

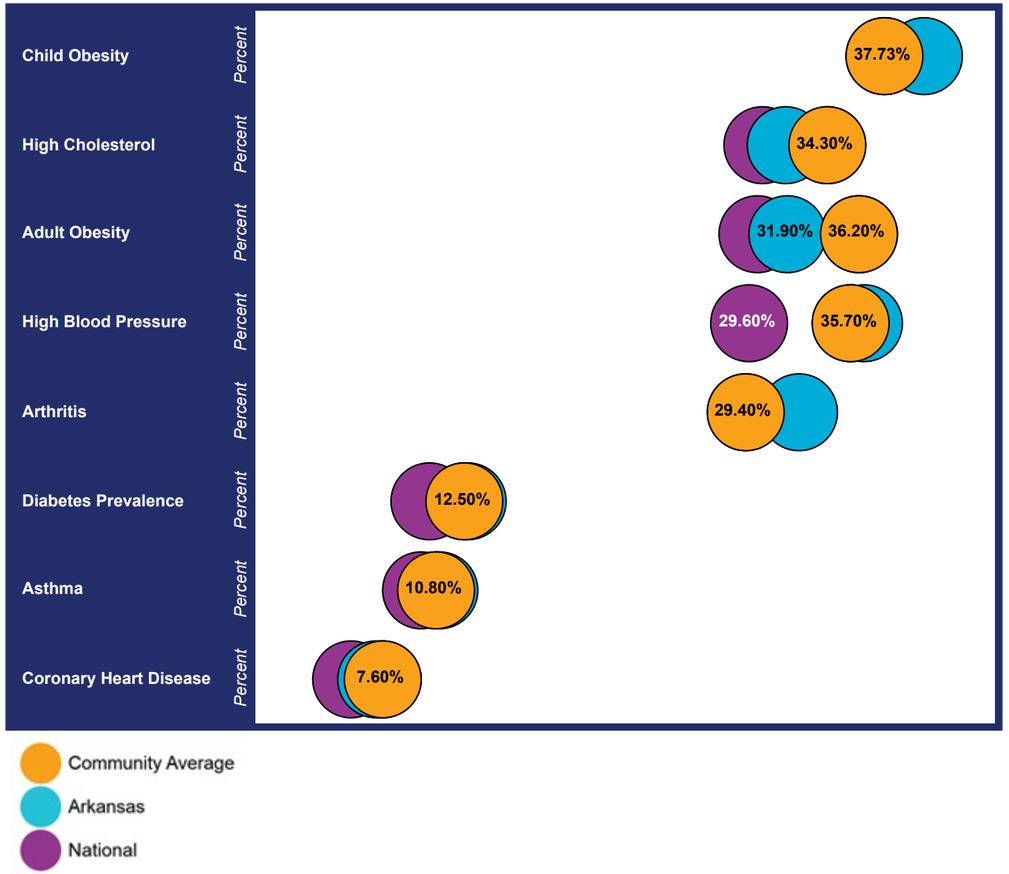


Table 7. Diagnoses at Discharge

		Crawford County	Community Average	State
Hypertension	*Number of individuals 18 years and older discharged with a primary or secondary hypertension diagnosis as a percentage of the population 18 years and older*	7.10%	7.10%	8.70%
Hyperlipidemia	*Number of individuals 18 years and older discharged with a primary or secondary hyperlipidemia diagnosis as a percentage of the population 18 years and older*	3.48%	3.48%	3.90%
Diabetes	*Rate of individuals 18 years and older discharged with a primary or secondary diabetes diagnosis as a percentage of the population 18 years and older*	3.24%	3.24%	3.70%
Ischemic Heart Disease	*Number of individuals 18 years and older discharged with a primary or secondary ischemic heart disease diagnosis as a percentage of the population 18 years and older*	2.04%	2.04%	2.50%
Arthritis	*Rate of individuals 18 years and older discharged with a primary or secondary arthritis diagnosis as a percentage of the population 18 years and older*	1.70%	1.70%	1.90%

Figure 8. Diagnoses at Discharge

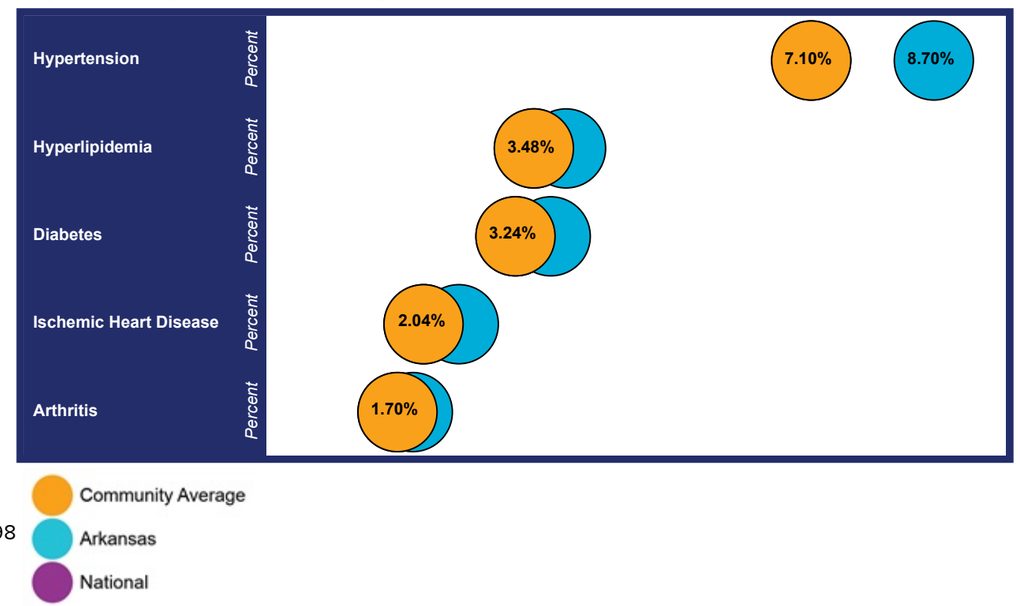


Table 8. Environment

		Crawford County	Community Average	State	National
Food Environment Index	*Index of factors that contribute to a healthy food environment, 0 (worst) to 10 (best)*	5.90	5.90	4.40	7.40
Drinking Water Violations	*The total number of drinking water violations recorded in a two-year period*	8	8	321	16,107
Access to Exercise Opportunities	*Percentage of population with adequate access to locations for physical activity*	59.54%	59.54%	63.36%	84.45%
Broadband Access	*Percentage of population in a high-speed internet service area; access to DL speeds >= 25MBPS and UL speeds >= 3 MBPS*	98.64%	98.64%	94.04%	96.78%
Long Commute Driving Alone	*Among workers who commute in their car alone, the percentage who commute more than 30 minutes*	26.90%	26.90%	28.10%	36.50%
Severe Housing Problems	*Percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities*	11.85%	11.85%	13.23%	16.84%

Community Average
Arkansas
National

Figure 9. Environment

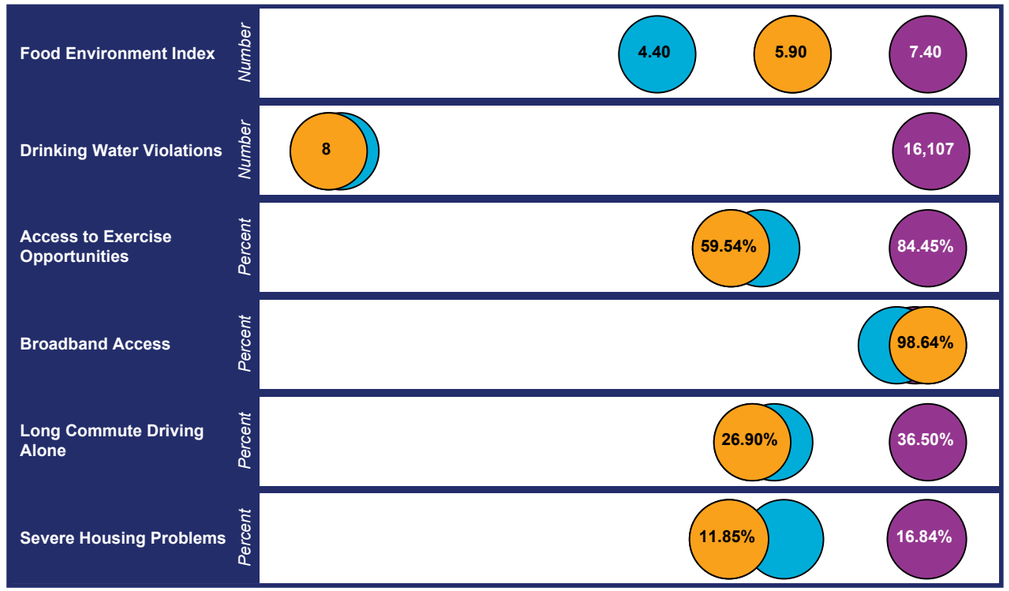


Table 9. Health Behaviors

		Crawford County	Community Average	State	National
Physical Inactivity	*Percentage of adults aged 20 and older who self-report no leisure time for activity*	24.20%	24.20%	23.60%	19.50%
Adult Smoking	*Percentage of adults ages 18 and older who are current smokers (age-adjusted)*	18.90%	18.90%	19.20%	13.20%
Youth Vaping	*Percentage of public school students in 6th, 8th, 10th, and 12th grade who used any vape in the past 30 days*	Not Available	Not Available	8.10%	Not Available
Sexually Transmitted Infections	*Number of newly diagnosed chlamydia cases per 100,000 population*	304.50	304.50	588.30	495.00

Figure 10. Health Behaviors

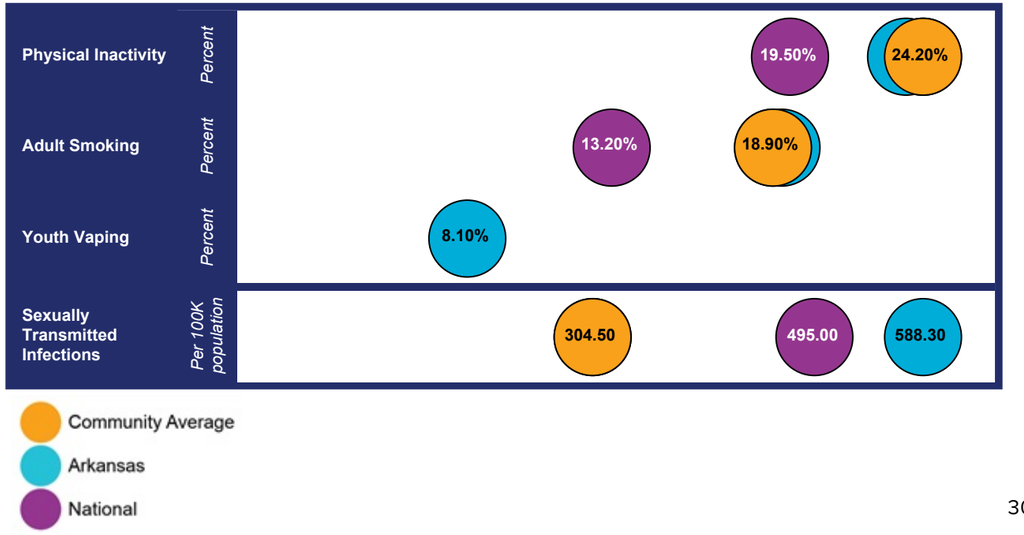


Table 10. Health Outcomes

		Crawford County	Community Average	State	National
Poor Physical Health Days	*Average number of physically unhealthy days reported in past 30 days (age-adjusted)*	5.30	5.30	5.20	3.90
Poor or Fair Health	*Percentage of adults age 18 and older who self-report their general health status as "fair" or "poor" (age-adjusted)*	23.30%	23.30%	22.60%	17.00%

Figure 11. Health Outcomes

Table 11. Healthcare Expenditures

		Crawford County	Community Average	State	National
Average Annualized Expenditures	*Average annualized per-person spending on all covered healthcare services.*	$10,289	$10,289	$10,116	Not Available
Average Annualized Expenditures (Medical Only)	*Average annualized per-person spending on medical services, based on medical claims.*	$7,275	$7,275	$7,252	Not Available
Average Annualized Expenditures (Pharmacy Only)	*Average annualized per-person spending on prescription drugs, based on pharmacy claims.*	$2,752	$2,752	$2,609	Not Available

Figure 12. Healthcare Expenditures

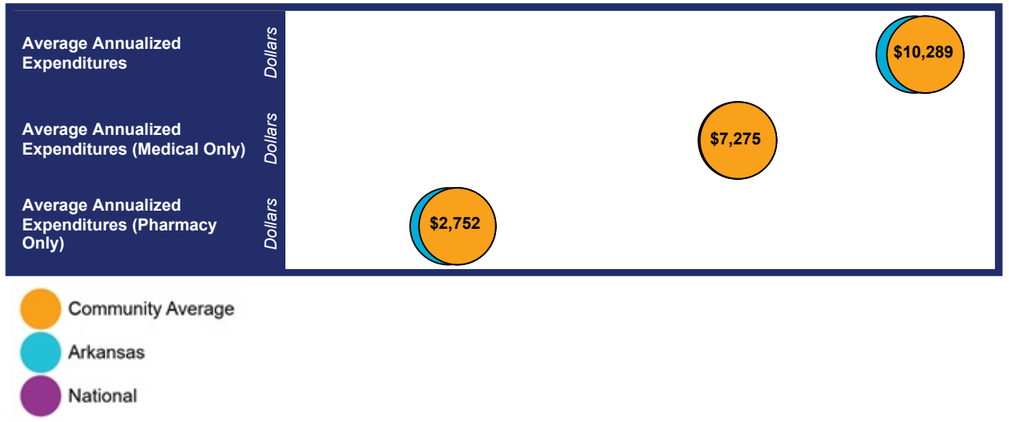


Table 12. Maternal and Infant Health

		Crawford County	Community Average	State	National
Active Obstetrics and Gynecology Physicians	*Active OB-GYN physicians are defined as those who provided evaluation and management services to at least two female patients ages 12-55 on the same day or performed a qualifying procedure (e.g., delivery) at least once during the year.*	1.20	1.20	3.20	Not Available
Teen Births	*The seven-year average number of teen births per 1,000 female population, ages 15-19*	29.40	29.40	27.90	15.50
C-Section Rate	*Percentage of live births delivered via cesarean section among all deliveries, calculated by the mother's county of residence.*	33.35%	33.35%	33.48%	Not Available
C-Section Rate, First Birth	*Percentage of first-birth deliveries (full-term singleton pregnancies in a head-down position) delivered via cesarean section, calculated by the mother's county of residence.*	28.66%	28.66%	27.58%	Not Available
Low Birthweight	*Percentage of live births where the infant weighed less than 2, 500 grams (approximately 5 lbs., 8 oz.)*	8.80%	8.80%	9.40%	8.40%
Preterm Birth	*Percentage of live births that are preterm (<37 weeks), calculated as a three-year average.*	10.90%	10.90%	11.90%	10.35%
Median Travel Time to Delivery	*Median number of minutes Arkansas mothers traveled from their home ZIP code to the delivery facility, calculated using birth records and facility addresses. Travel time estimates include in-state and out-of-state facilities.*	13.00	13.00	16.00	Not Available

Figure 13. Maternal and Infant Health

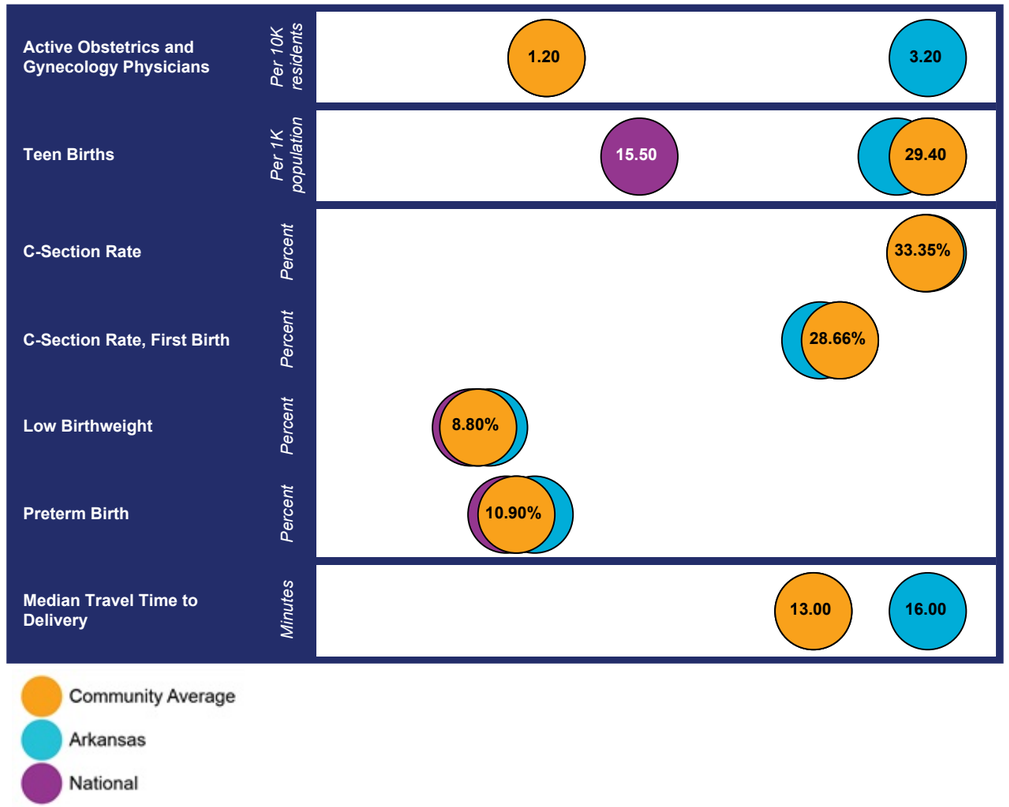


Table 13. Mental Health and Substance Use

		Crawford County	Community Average	State	National
Adult Depression	*Percentage of adults age 18 and older who report having been told that they had depressive disorder*	27.70%	27.70%	27.50%	21.10%
Excessive Drinking	*Percentage of adults reporting binge or heavy drinking*	18.16%	18.16%	18.99%	19.35%
Poor Mental Health	*Percentage of adults age 18 or older reporting poor mental health for 14 or more days (age-adjusted)*	20.30%	20.30%	20.50%	16.40%
Youth Depression	*Percentage of public school students in 6th, 8th, 10th, and 12th grade who had feelings of depression all of the time in the past 30 days*	Not Available	Not Available	9.20%	Not Available
Drug Overdose Deaths	*Age-adjusted rate of fatal drug overdoses per 100,000 residents*	Not Available	Not Available	Not Available	Not Available
Non-Fatal Drug Overdoses	*Age-adjusted rate of non-fatal drug overdoses per 100,000 residents*	35.46	35.46	Not Available	Not Available

Figure 14. Mental Health and Substance Use

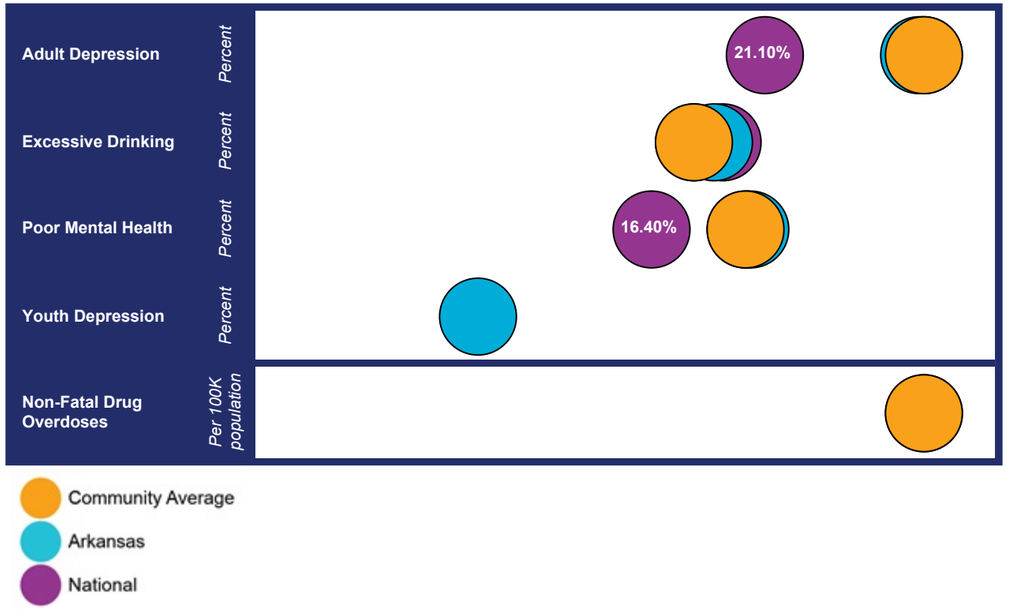


Table 14. Prevention

		Crawford County	Community Average	State	National
Cervical Cancer Screening	*Percentage of females age 21–65 years who report having had recommended cervical cancer screening test (age-adjusted)*	79.80%	79.80%	81.20%	83.70%
Colorectal Cancer Screening	*Percentage of adults age 45-75 who have had a recent colorecal cancer screening*	61.70%	61.70%	61.60%	66.30%
Dental Care Utilization	*Dental care visit (past 1 year), age-adjusted percentage of adults age 18+ by county*	54.20%	54.20%	54.10%	63.40%
High Blood Pressure Management	*Percentage of adults age 18 and older with high blood pressure who report taking blood pressure medication (age-adjusted)*	60.70%	60.70%	61.40%	58.90%
Prevention - Seasonal Influenza Vaccine	*Percentage of adults aged 18 and older who report receiving an influenza vaccination in the past 12 months*	47.50%	47.50%	43.20%	44.80%
Annual Wellness Exam (Medicare)	*Percentage of annual wellness visits among the Medicare fee-for-service (FFS) population*	47.00%	47.00%	46.00%	44.00%
No HIV Test	*Percentage of adults ages 18 or older who have never been screened for HIV*	70.00%	70.00%	66.10%	Not Available

Figure 15. Prevention

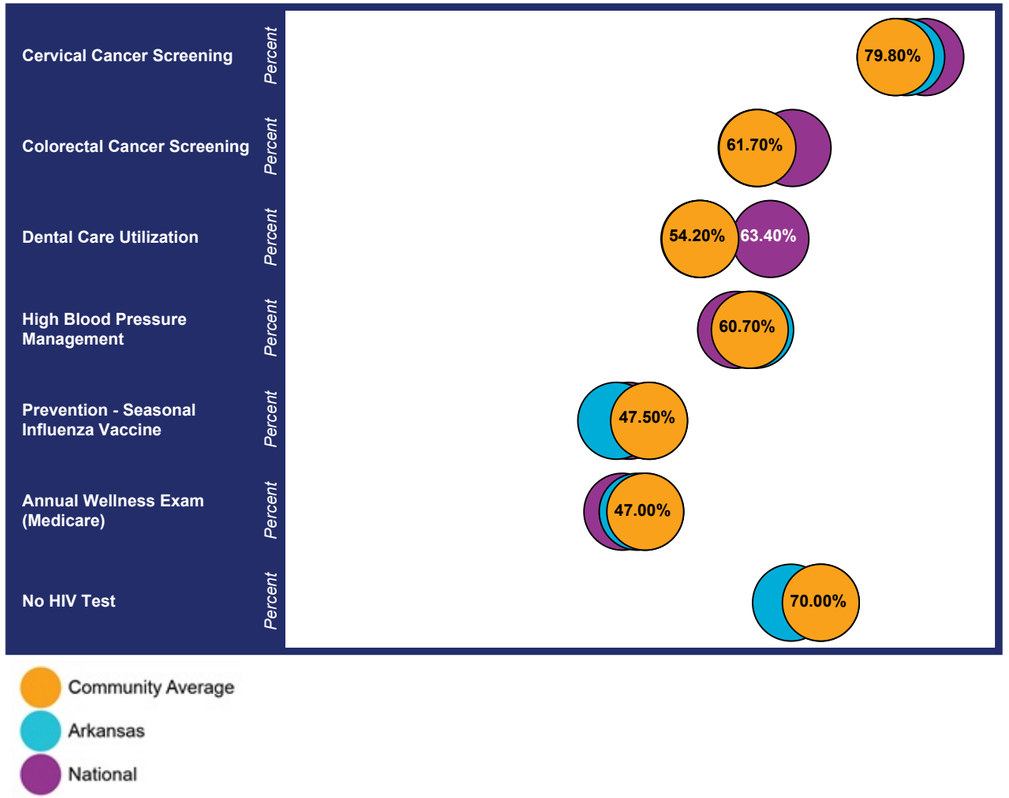
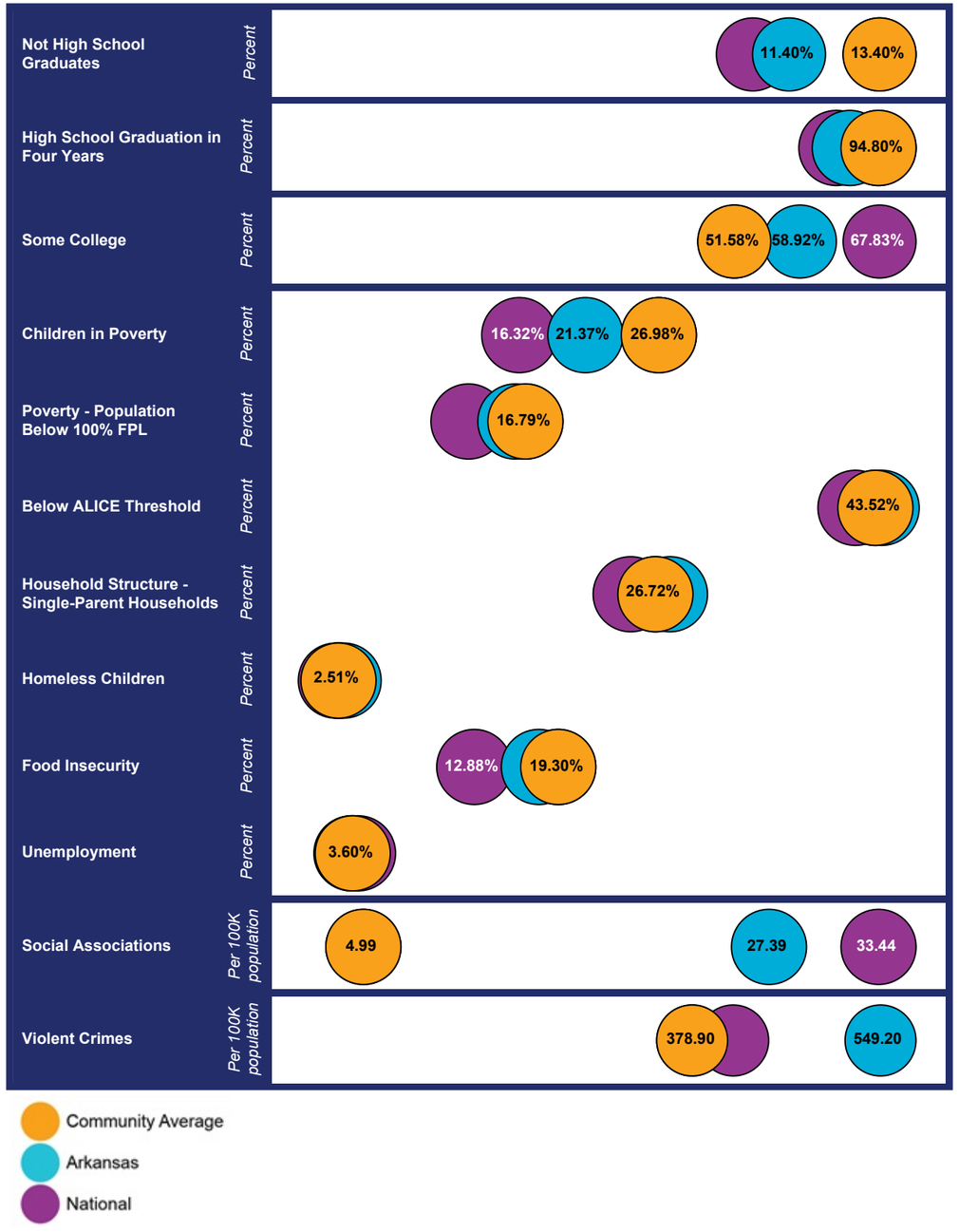


Table 15. Social and Economic Factors

		Crawford County	Community Average	State	National
Not High School Graduates	*Percentage of adults without a high school diploma*	13.40%	13.40%	11.40%	10.60%
High School Graduation in Four Years	*Percentage of ninth-grade cohort who graduated in four years*	94.80%	94.80%	90.30%	88.20%
Some College	*Percentage of adults ages 25-44 with some post-secondary education*	51.58%	51.58%	58.92%	67.83%
Children in Poverty	*Percentage of children under age 18 below the poverty line*	26.98%	26.98%	21.37%	16.32%
Poverty - Population Below 100% FPL	*Percentage of the population living in households with income below the federal poverty level*	16.79%	16.79%	16.02%	12.44%
Below ALICE Threshold	*Percentage of households living in poverty or classified as ALICE (Asset Limited, Income Constrained, Employed)*	43.52%	43.52%	44.00%	42.00%
Household Structure - Single-Parent Households	*Percentage of children who live in households where only one parent is present*	26.72%	26.72%	27.83%	24.83%
Homeless Children	*Percentage of students experiencing homelessness enrolled in the public school system*	2.51%	2.51%	2.90%	2.31%
Food Insecurity	*Percentage of the population that experienced food insecurity in the report year*	19.30%	19.30%	17.82%	12.88%
Unemployment	*Percentage of the civilian non-institutionalized population age 16 and older that is unemployed (non-seasonally adjusted)*	3.60%	3.60%	3.50%	4.00%
Social Associations	*Establishments, rate per 100,000 population*	4.99	4.99	27.39	33.44
Violent Crimes	*Annual rate of reported violent crimes per 100,000 population*	378.90	378.90	549.20	416.00

Figure 16. Social and Economic Factors



IDENTIFIED NEED 1:
Increase Access to Care and Education

GOALS/OBJECTIVE:
Increase access to quality health care, preventive screenings, vaccinations, and community health resources for residents of the River Valley.

STRATEGY:
Expand community outreach and strengthen partnerships with local nonprofits, schools, and employers to improve access and awareness.

ACTION STEPS:

- Host annual free flu shot and vaccination events in collaboration with Community Outreach and local partners.
- Launch a six-month "Wellness Meet-Up Series" open to the public, featuring monthly sessions on key wellness topics such as physical activity, mindful eating, stress management, and sleep health.
- Partner with local businesses and organizations to offer free health education and on-site screenings (e.g., blood sugar, blood pressure, BMI) and facilitate scheduling for primary care and mammogram appointments.
- Collaborate with area schools to promote healthy, active lifestyles and early preventive habits among youth. When applicable include providers from Baptist Health La Clinica del Pueblo to reduce language barriers.
- Coordinate with Baptist Health Urgent Care Clinics to enhance accessibility and convenience for patients seeking acute or after-hours care, as well as referrals to additional imaging and specialty care.

KEY PERFORMANCE METRICS:

- Provide preventive screenings, vaccinations, education and related services to at least 500 community members annually.
- Track and report the number of community outreach events hosted or attended by Baptist Health–Van Buren.
- Measure and report the number of community members reached through health education, screenings, and outreach efforts.
- Evaluate referral and follow-up rates for individuals connected to primary or specialty care through outreach initiatives.

COLLABORATIONS WITH ORGANIZATIONS: Van Buren Chamber of Commerce, leaders of municipalities, school districts and employers across Crawford County County.

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS NEED: Staff time and clinical expertise, marketing and educational materials, community health supplies, vaccination resources, and ongoing support from the Marketing & Communications and Community Outreach teams.

ESTIMATED COMPLETION DATE: Ongoing through 2028

PERSON(S)/DEPARTMENT RESPONSIBLE: Marketing & Communications Manager, Community Outreach Director.

IDENTIFIED NEED 2:
The Community Mental Health Strategy: Access, Education, Acceptance

GOALS/OBJECTIVE:
Improve access to mental health services, reduce stigma, and promote emotional well-being for residents of the River Valley, with a focus on improving early identification, access to care, and community support for adults ages 55 and older experiencing memory loss, cognitive decline, or early signs of dementia.

STRATEGY:
Strengthen collaboration with employers, healthcare providers, and community organizations to expand mental health education, increase access to counseling and crisis resources, and promote early intervention and resilience-building initiatives.

ACTION STEPS:

- Continue to offer and promote the New Vision program at Baptist Health-Van Buren as a safe option for adults experiencing active or impending withdrawal from drugs and/or alcohol.
- Collaborate with primary care providers and hospital staff to expand screening opportunities, increase awareness of early dementia symptoms, and connect individuals and caregivers to education, counseling, and local support resources.
- Continue to partner with the Center for Psychiatric Trauma and Mental Health to participate in the annual ACE/Trauma Symposium.
- Launch a six-month "Wellness Meet-Up Series" open to the public, featuring monthly sessions on key wellness topics such as physical activity, mindful eating, stress management, and sleep health.
- Develop a public awareness campaign to reduce stigma surrounding mental health, dementia and encourage early conversations about mental health and memory changes.

KEY PERFORMANCE METRICS:

- Track the number of primary care implementing routine cognitive or mental health screenings for adults ages 55+.
- Record the number of community outreach events attended by Baptist Health-Van Buren and New Vision.
- Track number of patients referred to New Vision program
- Monitor attendance numbers, participant satisfaction surveys, and self-reported behavior changes following the six-month series.
- Measure campaign's reach through social media engagement, website visits, and printed material distribution.

COLLABORATIONS WITH ORGANIZATIONS: New Vision, Center for Psychiatric Trauma and Mental Health

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS NEED: Staff time and clinical expertise, marketing and educational materials, community health supplies and ongoing support from the Marketing & Communications and Community Outreach teams.

ESTIMATED COMPLETION DATE: Ongoing through 2028

PERSON(S)/DEPARTMENT RESPONSIBLE: Marketing & Communications Manager, Community Outreach Director, Director of Behavioral Health, New Vision program director.

IDENTIFIED NEED 3:
Closing the Gap: A Strategy for Healthy Communities and Nutrition Security

GOALS/OBJECTIVE:
Reduce food insecurity and improve nutrition knowledge among residents of the River Valley through education, outreach, and collaboration with local partners.

STRATEGY:
Expand community partnerships and implement interactive nutrition education programs that empower residents with practical skills and resources to reduce food insecurity and promote healthier eating habits.

ACTION STEPS:

- Explore funding opportunities in partnership with Baptist Health Foundation to expand FoodRx Program to employees and contractors of Baptist Health-Fort Smith, Van Buren and surrounding clinics, also in need of food and nutrition support
- Continue partnering with the Baptist Health Nutrition Counseling Center and community organizations—including local school districts, the Crawford County Cooperative Extension Service, local employers and nonprofits—to provide free, engaging education on healthy eating and nutrition. Each session will feature interactive activities and practical, actionable steps participants can take to make healthier food choices in their daily lives.
- Education staff on food insecurity and resources within our community that can benefit our patients and fellow staff members.
- Launch a six-month “Wellness Meet-Up Series” open to the public, featuring monthly sessions on key wellness topics such as physical activity, mindful eating, stress management, and sleep health.

PERFORMANCE METRICS:

- Track and report number of patients identified as food insecure during screening
- Record the number of community outreach events attended

COLLABORATIONS WITH ORGANIZATIONS: Crawford County Cooperative Extension Service, local school districts such as Van Buren and Cedarville, and Van Buren Chamber of Commerce.

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS NEED: Staff time and clinical expertise, marketing and educational materials, community health supplies and ongoing support from the Marketing & Communications and Community Outreach teams.

ESTIMATED COMPLETION DATE: Ongoing through 2028

PERSON(S)/DEPARTMENT RESPONSIBLE: Marketing & Communications Manager, Community Outreach Director, Outpatient Dietitian

BAPTIST HEALTH
Rehabilitation Institute-Little Rock

About Us

Open since 1974, Baptist Health Rehabilitation Institute-Little Rock is Arkansas' largest and most comprehensive physical medicine and rehabilitation hospital. Located on the Baptist Health Medical Center-Little Rock campus, the Rehab Institute allows convenient, 24-hour access to specialized services such as laboratory and pharmacy. In addition to specially-trained physical medicine and rehabilitation physicians, there are staff physicians in-house to respond to medical emergencies every weeknight from 5 pm to 8 am, and 24 hours a day on the weekends. This continual availability of specialized services and medical staff ensures timeliness of results reporting and responsiveness to orders.

The types of conditions that require rehabilitation are sometimes tragic and life-changing. Even the less complex rehabilitation issues can significantly impact one's day-to-day living. Baptist Health Rehabilitation Institute-Little Rock's team of physicians and therapists works with patients and their family members to achieve the GOALS/ OBJECTIVE that restore them to their highest level of function.

Community Health Needs Assessment 2026-2028

Baptist Health-Rehabilitation Institute Little Rock

HIGHLIGHTS OF COMMUNITY HEALTH NEEDS ASSESSMENT ACCOMPLISHMENTS 2023-2025

Access to Care:

- The BHRI-Little Rock location is noted as the only facility in Arkansas certified in Brain Injury Specialty Program, Spinal Cord Injury Specialty Program and Amputee Specialty Program
- First CARF--accredited stroke program in Arkansas.
- Recognized as a Top Performer for outstanding clinical outcomes, placing it in the top 10 percent of rehabilitation hospitals in the nation for clinical outcomes for ten consecutive years
- Coordinate monthly Stroke support groups
- Provided first responder training on Spinal support education for patient potential spinal injuries
- Provided home equipment assistance and loaner programs
- Provided community education with local schools
- Continued focus on a collaborative, interdisciplinary team approach to ensure all patients can return home and achieve their highest level of independence
- Continued to offer access to fully-equipped kitchens, bedrooms, and bathrooms with movable fixtures to simulate the patient's home environment, ensuring training is practical for their eventual discharge
- Offered a peer mentorship program for patients
- Offered access to a certified Lymphedema specialist
- Provided Fall Risk education and assessments with Community Outreach
- Offer access to the Baptist Heath Fitness Center through the Buddy System to encourage access to the Exercise Prescription Program

Mental Health Awareness:

- Provided Social Determinants of Health Screenings and referrals
- Offered support group services for stroke patients and brain injury patients
- Education and resources designed to reduce the stress of returning home through assessments, assistance and education
- Provide extensive patient follow-up initiatives and resource assistance
- Partnered with Community Outreach to offer Mental Health First Aid Trainings
- Partnered with Community Outreach to offer “Stop the Bleed” Trauma training
- Provided mental health screenings
- Partnered with Community Outreach to office 6-month virtual wellness meet-ups
- A system-wide Behavioral Health Vice President was hired to establish a system-wide comprehensive plan to address and expand mental health services
- Utilized ‘David’s Village” on-site community simulation center with a mock restaurant, grocery store, gas pump, and home entry, designed to help patients practice real-life skills in a safe environment for a successful return home after brain injury or spinal cord injury

Food Insecurity:

- Provided nutrition education and safe cooking education and instruction
- Screened patients for food insecurity
- In partnership with Community Outreach offered community cooking and nutrition classes
- Provided access to the FoodRx program and food locker system for patients and employees

2025 BAPTIST HEALTH COMMUNITY HEALTH NEEDS ASSESSMENT: BAPTIST HEALTH REHABILITATION INSTITUTE

ACHI
August 2025

Baptist Health

PREPARED BY:
ACHI
INSPIRING HEALTHY ACTS

Introduction

Baptist Health engaged the Arkansas Center for Health Improvement (ACHI) to conduct the quantitative data collection and analysis for the 2025 Community Health Needs Assessment (CHNA) process. Baptist Health provided ACHI with the counties served by each of its 12 hospital communities. A total of 16 Arkansas counties and two Oklahoma counties were included.

Each report presents community-level data for a hospital community, including tables and figures for each indicator, along with comparisons to Arkansas and U.S. benchmarks. Dot graphs are provided to visualize performance across selected indicators. All reports are prepared using the same methodology to ensure consistency and comparability across Baptist Health hospital communities.

Methodology

A summary of sources, definitions, indicator criteria, and suppression rules can be found in the methods and sources document.

Community Profile Summary

To support the 2025 Community Health Needs Assessment (CHNA), ACHI compiled a comprehensive dataset of 103 health and demographic indicators for the communities served by Baptist Health's 12 hospital locations. This section provides an overview of these indicators across the full CHNA service area and offers multiple views for understanding and comparing county-level and community-level data.

Data are grouped into the following 14 categories, based on the source-defined domains outlined in the data source reference sheet:

1. Demographics
    a. Age
    b. Sex
    c. Race, Ethnicity, and Language
2. Insurance Coverage
3. Access to Care
4. Cause of Death
5. Chronic Conditions
6. Diagnoses Incidence at Discharge
7. Environment
8. Health Behaviors
9. Health Outcomes
10. Healthcare Expenditures
11. Maternal and Infant Health
12. Mental Health and Substance Use
13. Prevention
14. Social and Economic Factors

Measurements for these categories will be displayed in the following sections.

Hospital Community Indicator

The hospital community indicator snapshots offer an at-a-glance view of how each hospital community compares to state and national benchmarks, as well as the counties that make up the community.

Each table presents the data values for selected indicators across the 14 CHNA domains, and each corresponding visual uses proportionally scaled circular markers to illustrate performance. This format is designed to quickly convey how each hospital community aligns with or diverges from broader benchmarks in key population health metrics.

Each displays four comparison points:

- **Purple** – Represents the national value for the indicator.
- **Blue** – Represents the value for the state of Arkansas.
- **Gold** – Represents the weighted average for all counties in the hospital's defined service area.
- **Gray** – Represent the values of each county assigned to that hospital community.

Where available, data for each indicator are shown for all four categories. If a value is not available or is suppressed for a contributing county, it is noted as "Not Available" in the table and excluded from the visual display. No color ranking is applied; the visuals and tables are intended to illustrate relative placement, not comparative rank.

Hospital Community: Baptist Health Rehabilitation Institute (Grant, Pulaski, and Saline Counties)

Figure 1. Counties Served by Baptist Health Medical Center–BHRI

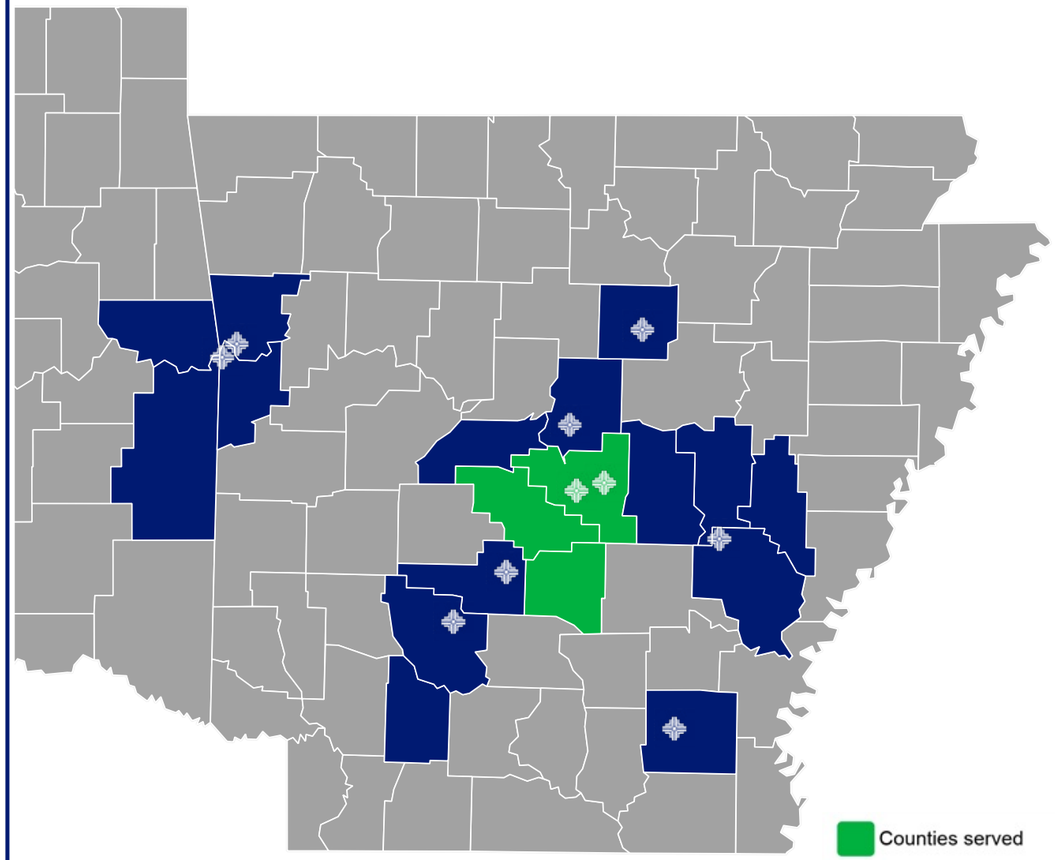


Table 1. Demographics: Age and Sex

		Grant County	Saline County	Pulaski County	Community Average	State	National
Total Population	*Number*	18,111	125,724	398,949	542,784	3,032,651	332,387,540
Female	*Percent*	49.66%	51.03%	52.15%	51.81%	50.67%	50.50%
Male	*Percent*	50.34%	48.97%	47.85%	48.19%	49.33%	49.50%
Ages 0-4	*Percent*	5.33%	5.59%	6.34%	6.13%	6.02%	5.70%
Ages 5-17	*Percent*	16.03%	17.78%	17.08%	17.21%	17.26%	16.46%
Ages 18-24	*Percent*	8.39%	7.34%	8.77%	8.43%	9.33%	9.12%
Ages 25-34	*Percent*	12.71%	12.16%	14.42%	13.84%	12.93%	13.69%
Ages 35-44	*Percent*	12.31%	13.93%	13.05%	13.23%	12.66%	13.08%
Ages 45-54	*Percent*	12.91%	12.53%	11.73%	11.95%	11.84%	12.29%
Ages 55-64	*Percent*	14.17%	12.51%	12.35%	12.45%	12.64%	12.82%
Ages 65+	*Percent*	18.15%	18.16%	16.25%	16.76%	17.33%	16.84%

Figure 2. Demographics: Age and Sex

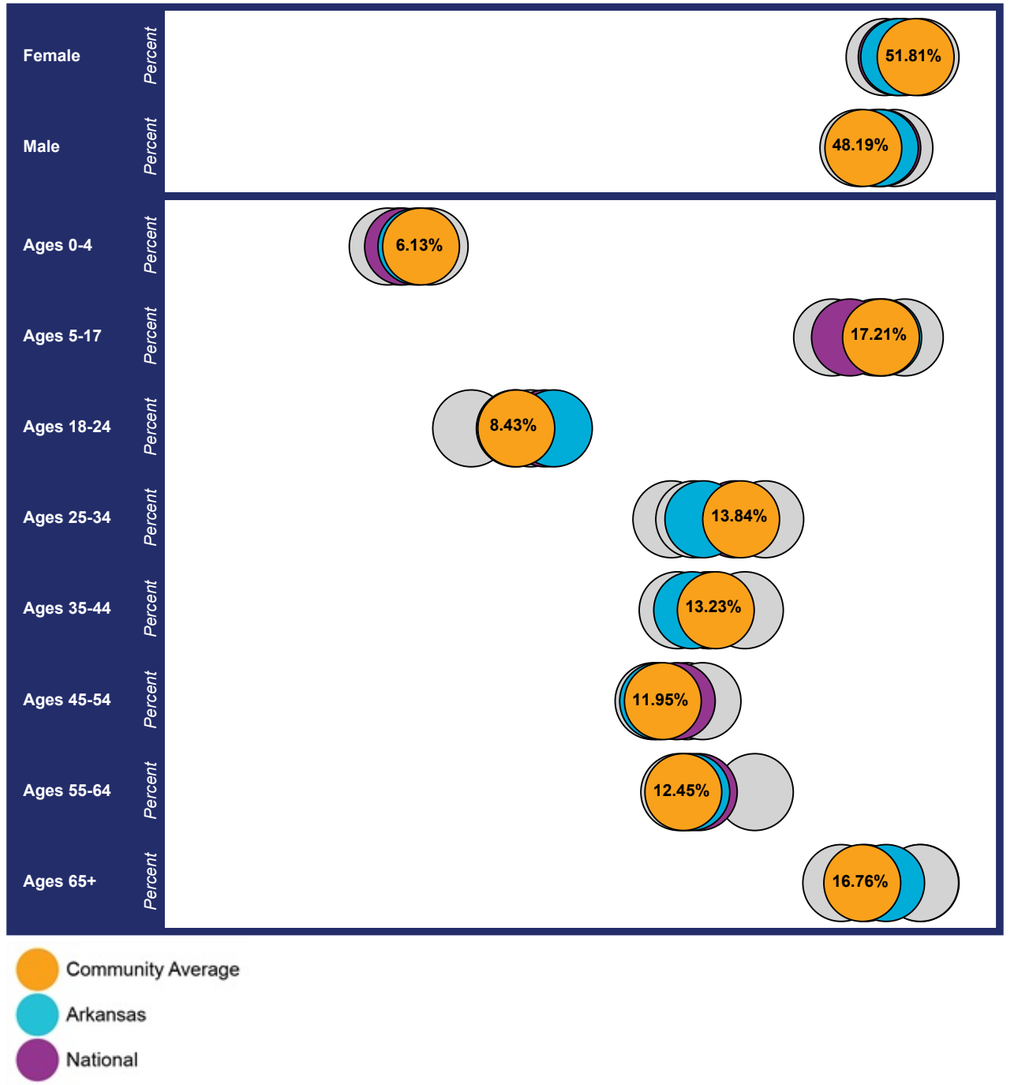


Table 2. Demographics: Race, Ethnicity, and Language

		Grant County	Saline County	Pulaski County	Community Average	State	National
Total Population	*Number*	18,111	125,724	398,949	542,784	3,032,651	332,387,540
Asian	*Percent*	0.36%	1.03%	2.13%	1.82%	1.53%	5.75%
Black or African American	*Percent*	2.59%	8.25%	36.72%	28.99%	14.84%	12.03%
Hispanic	*Percent*	2.71%	6.98%	8.20%	7.73%	8.77%	18.99%
Multiple Races	*Percent*	2.14%	3.70%	3.69%	3.64%	5.50%	3.87%
Native American/ Alaska Native	*Percent*	0.11%	0.19%	0.21%	0.20%	0.36%	0.53%
Native Hawaiian/ Pacific Islander	*Percent*	0.19%	0.00%	0.04%	0.04%	0.39%	0.17%
Other Races	*Percent*	0.48%	0.49%	0.30%	0.35%	0.26%	0.50%
White	*Percent*	91.43%	79.36%	48.70%	57.23%	68.36%	58.17%
Non-English Language Households	*Percent*	0.20%	2.10%	1.80%	1.82%	1.50%	4.20%

Figure 3. Demographics: Race, Ethnicity, and Language

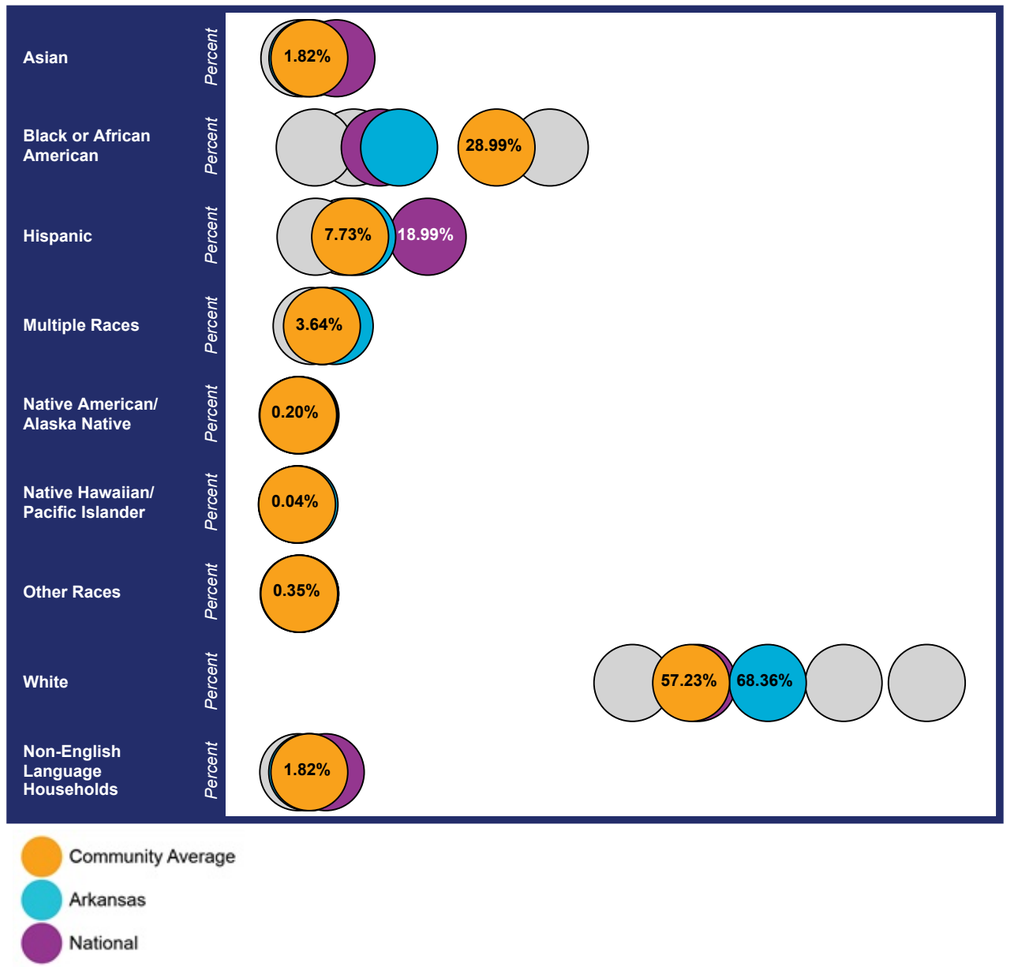


Table 3. Insurance Coverage

		Grant County	Saline County	Pulaski County	Community Average	State	National
Private Health Insurance Coverage	*Percentage of the total civilian non-institutionalized population for whom insurance status is determined that is covered by private health insurance*	**71.02%**	**75.34%**	**68.22%**	**69.96%**	**65.37%**	**73.62%**
Public Health Insurance Coverage	*Percentage of the total civilian non-institutionalized population for whom insurance status is determined that is covered by public health insurance*	**47.46%**	**39.32%**	**45.65%**	**44.24%**	**48.21%**	**39.70%**
Uninsured	*Percentage of adults under age 65 without health insurance coverage*	**7.10%**	**8.20%**	**9.00%**	**8.75%**	**10.00%**	**9.50%**

Figure 4. Insurance Coverage

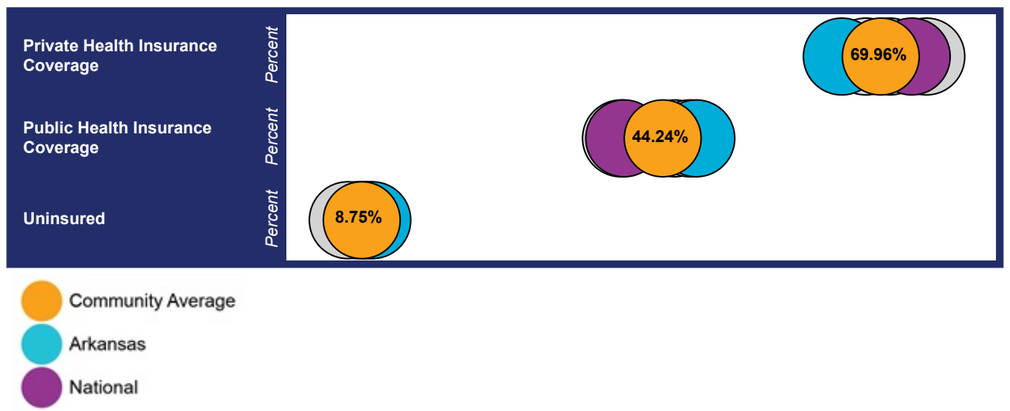


Table 4. Access to Care

		Grant County	Saline County	Pulaski County	Community Average	State	National
Primary Care Physicians	*Ratio of population to one primary care physician*	9045:1	2555:1	848:1	1517:1	1478:1	1334:1
Mental Health Providers	*Ratio of population to one mental health provider*	765:1	617:1	189:1	232:1	367:1	300:1
Dentists	*Ratio of population to one dentist*	2594:1	2961:1	1300:1	1523:1	2044:1	1361:1
Active Primary Care Physicians	*Rate per 10,000 county residents of primary care physicians who provided evaluation and management services to at least two patients on the same day at least once during the year*	4.50	9.20	27.60	22.57	9.20	Not Available
Addiction or Substance Use Providers	*Rate of addiction or substance use providers per 100,000 population*	5.57	1.62	10.52	8.29	5.98	29.43
Buprenorphine Providers	*Rate of buprenorphine providers per 100,000 population*	5.52	2.39	19.35	14.96	9.81	14.87
Preventable Hospital Stays (Medicare)	*Rate of hospital stays for ambulatory care-sensitive conditions per 100,000 Medicare enrollees*	2813.00	3492.00	2682.00	2873.99	3014.00	2666.00
Diabetic Monitoring (Medicare)	*Percentage of Medicare enrollees aged 65 and older with diabetes who received a hemoglobin A1c (HbA1c) test within the past year.*	87.91%	88.80%	88.61%	88.63%	88.47%	87.53%
Mammography	*Percentage of female Medicare enrollees ages 65-74 who received an annual mammography screening*	39.00%	36.00%	45.00%	42.72%	41.00%	44.00%

Figure 5. Access to Care

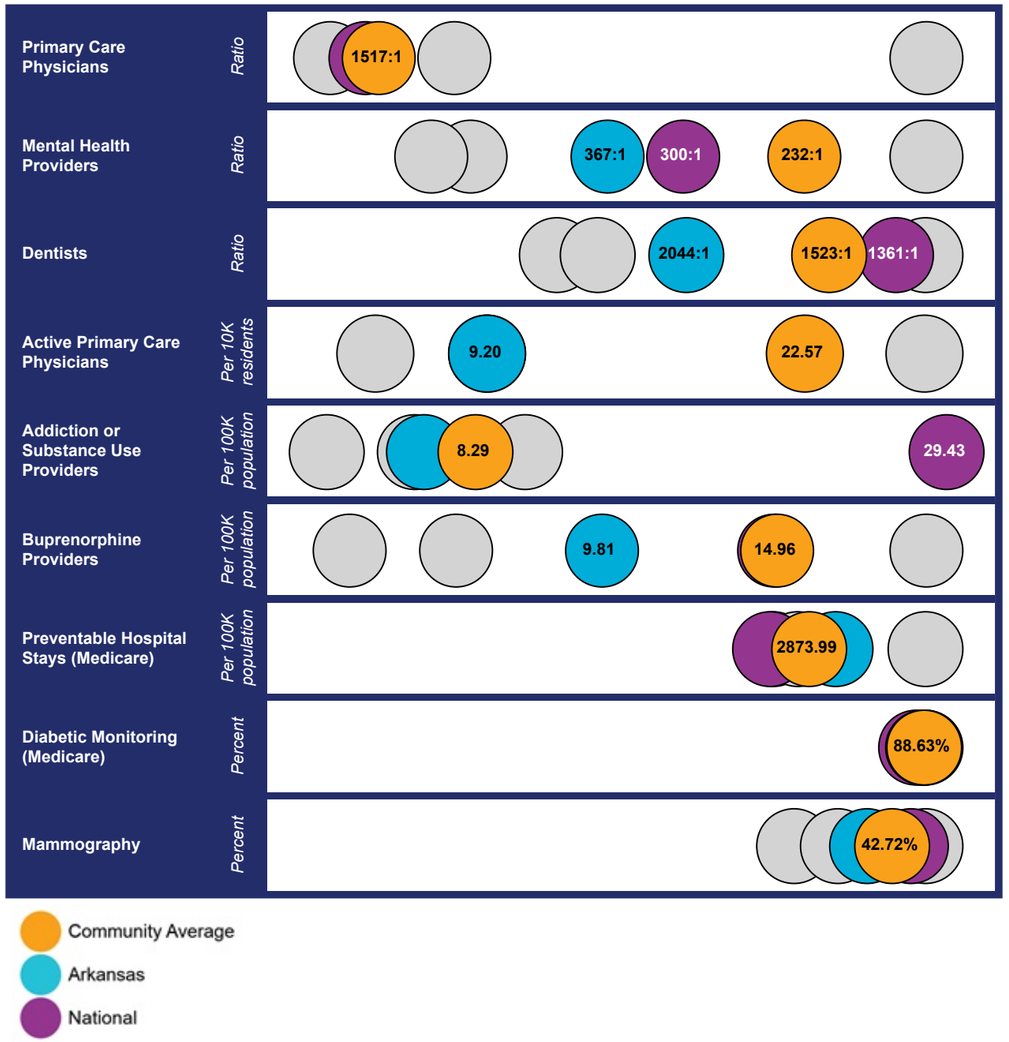


Table 5. Cause of Death

		Grant County	Saline County	Pulaski County	Community Average	State	National
All Causes	*Rate of deaths by all causes per 100,000 population (age-adjusted)*	1060.40	910.90	955.20	948.45	1001.70	805.60
Premature Death	*Number of deaths among residents under age 75 per 100,000 population (age-adjusted)*	562.31	468.31	545.57	528.23	552.47	406.59
Heart Disease	*Rate of death due to heart disease (ICD-10 Codes I00-I09, I11, I13, I20-I151) per 100,000 population*	306.50	235.30	222.80	228.49	282.80	207.20
Cancer	*5-year average rate of death due to cancer per 100,000 population*	241.90	199.20	188.90	193.05	215.90	182.70
Unintentional Injury	*5-year average rate of death due to unintentional injury (accident) per 100,000 population*	72.30	67.30	69.90	69.38	61.90	63.30
Stroke	*5-year average rate of death due to cerebrovascular disease (stroke) per 100,000 population (age-adjusted)*	43.80	46.80	53.50	51.62	57.40	48.30
Chronic Lower Respiratory Disease	*Rate of deaths due to chronic lower respiratory disease per 100,000 population (age-adjusted)*	76.50	51.10	41.70	45.04	61.00	35.90
Diabetes Mortality	*Rate of deaths due to diabetes per 100,000 population (age-adjusted)*	24.50	32.10	40.80	38.24	34.70	23.90
Suicide Deaths	*This indicator reports the 2019-2023 five-year average rate of death due to intentional self-harm (suicide) per 100, 000 population. Figures are reported as crude rates*	25.20	22.60	16.10	17.91	19.20	14.50
Motor Vehicle Crash	*5-year average rate of death due to motor vehicle crash per 100,000 population (age-adjusted)*	31.80	15.40	20.80	19.92	20.60	12.80
Alcohol-Involved Motor Vehicle Crash	*Rate of persons killed in motor vehicle crashes involving alcohol as a rate per 100,000 population*	0.00	2.10	3.80	3.28	3.10	2.30

Figure 6. Cause of Death

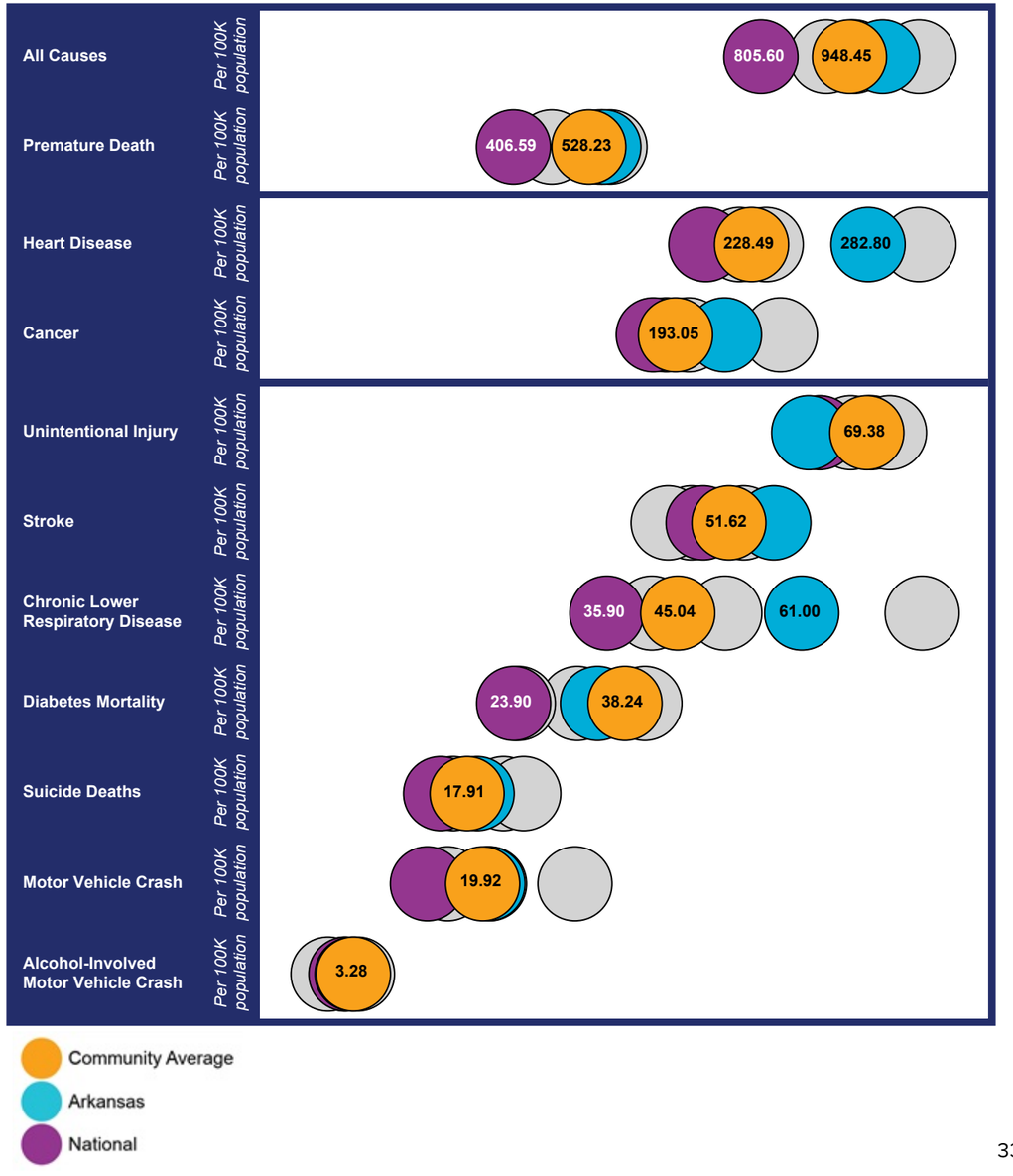


Table 6. Chronic Condtions

		Grant County	Saline County	Pulaski County	Community Average	State	National
Child Obesity	*Percentage of students classified as overweight to severely obese, by county location of school*	**35.00%**	**38.71%**	**38.89%**	**38.72%**	**40.10%**	**Not Available**
High Cholesterol	*Percentage of adults who have had their blood cholesterol checked and have been told it was high (age-adjusted)*	**32.00%**	**31.60%**	**30.10%**	**30.51%**	**31.80%**	**30.40%**
Adult Obesity	*Percentage of adults ages 20 and older who report a BMI higher than 30*	**33.90%**	**33.20%**	**34.90%**	**34.47%**	**31.90%**	**30.10%**
High Blood Pressure	*Percentage of adults who have been told they have high blood pressure (age-adjusted)*	**34.50%**	**34.70%**	**38.00%**	**37.12%**	**36.50%**	**29.60%**
Arthritis	*Percentage of adults ages 18 or older diagnosed with some form of arthritis*	**30.40%**	**30.20%**	**28.00%**	**28.59%**	**32.60%**	**Not Available**
Diabetes Prevalence	*Percentage of adults age 18 and older who report ever been told that they have diabetes other than diabetes during pregnancy (age-adjusted)*	**11.00%**	**10.60%**	**12.70%**	**12.16%**	**12.70%**	**10.40%**
Asthma	*Percentage of adults who have been told they currently have asthma (age-adjusted)*	**10.90%**	**10.10%**	**10.80%**	**10.64%**	**11.00%**	**9.90%**
Coronary Heart Disease	*Percentage of adults age 18 and older who report ever having been told by that they had angina or coronary heart disease (CHD) (age-adjusted)*	**6.90%**	**6.20%**	**6.60%**	**6.52%**	**7.20%**	**5.70%**

Figure 7. Chronic Conditions

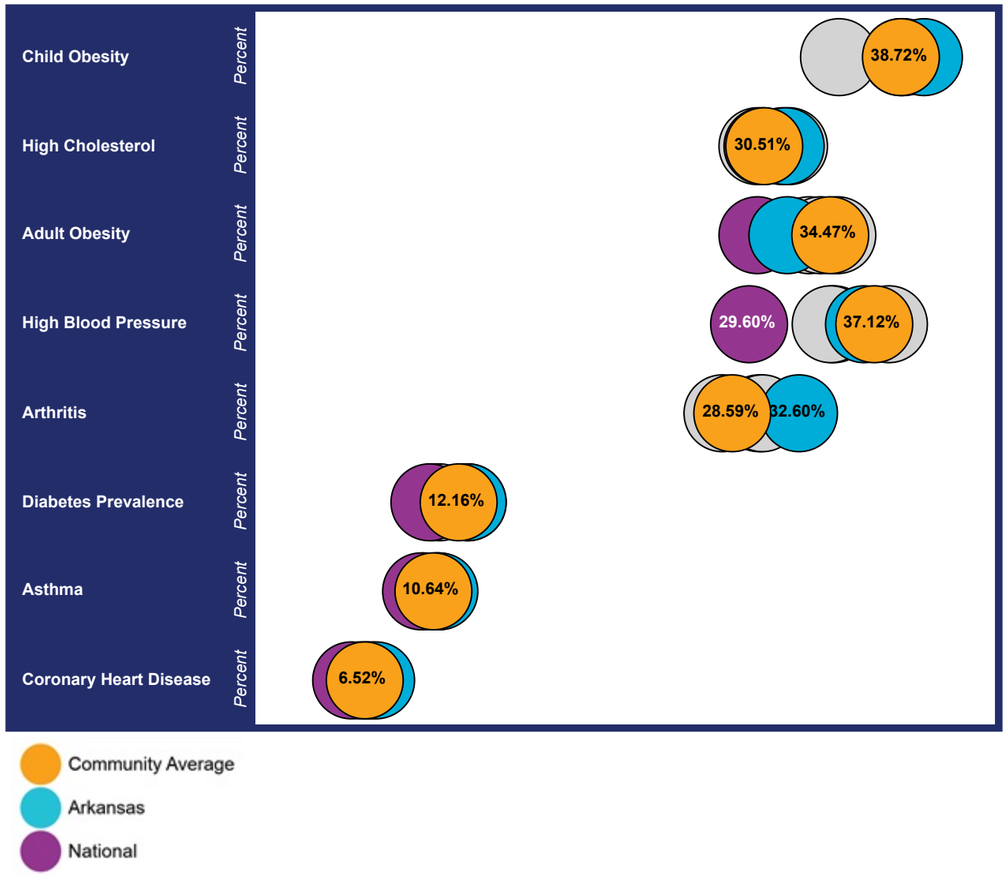


Table 7. Diagnoses at Discharge

		Grant County	Saline County	Pulaski County	Community Average	State
Hypertension	*Number of individuals 18 years and older discharged with a primary or secondary hypertension diagnosis as a percentage of the population 18 years and older*	7.86%	8.19%	8.12%	8.13%	8.70%
Hyperlipidemia	*Number of individuals 18 years and older discharged with a primary or secondary hyperlipidemia diagnosis as a percentage of the population 18 years and older*	3.08%	3.32%	2.77%	2.91%	3.90%
Diabetes	*Rate of individuals 18 years and older discharged with a primary or secondary diabetes diagnosis as a percentage of the population 18 years and older*	3.07%	2.77%	3.13%	3.04%	3.70%
Ischemic Heart Disease	*Number of individuals 18 years and older discharged with a primary or secondary ischemic heart disease diagnosis as a percentage of the population 18 years and older*	2.65%	2.44%	1.54%	1.79%	2.50%
Arthritis	*Rate of individuals 18 years and older discharged with a primary or secondary arthritis diagnosis as a percentage of the population 18 years and older*	1.44%	1.52%	1.42%	1.44%	1.90%

Figure 8. Diagnoses at Discharge

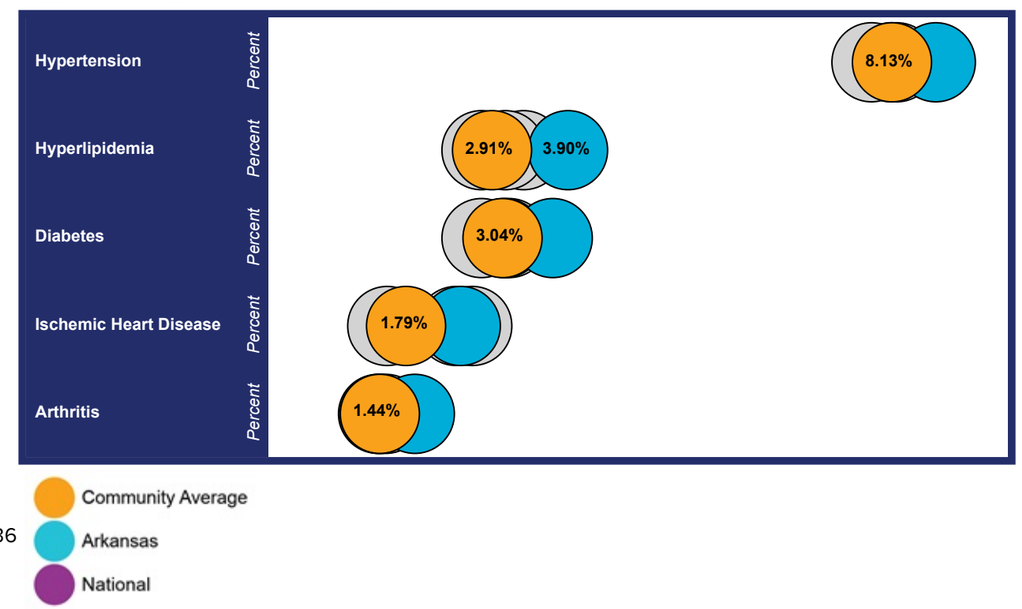


Table 8. Environment

		Grant County	Saline County	Pulaski County	Community Average	State	National
Food Environment Index	*Index of factors that contribute to a healthy food environment, 0 (worst) to 10 (best)*	6.40	7.40	6.60	6.78	4.40	7.40
Drinking Water Violations	*The total number of drinking water violations recorded in a two-year period*	0	0	0	0	321	16,107
Access to Exercise Opportunities	*Percentage of population with adequate access to locations for physical activity*	35.10%	51.50%	84.98%	75.56%	63.36%	84.45%
Broadband Access	*Percentage of population in a high-speed internet service area; access to DL speeds >= 25MBPS and UL speeds >= 3 MBPS*	95.54%	97.75%	99.09%	98.66%	94.04%	96.78%
Long Commute Driving Alone	*Among workers who commute in their car alone, the percentage who commute more than 30 minutes*	54.80%	42.60%	20.80%	26.98%	28.10%	36.50%
Severe Housing Problems	*Percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities*	9.27%	10.07%	16.37%	14.67%	13.23%	16.84%

Figure 9. Environment

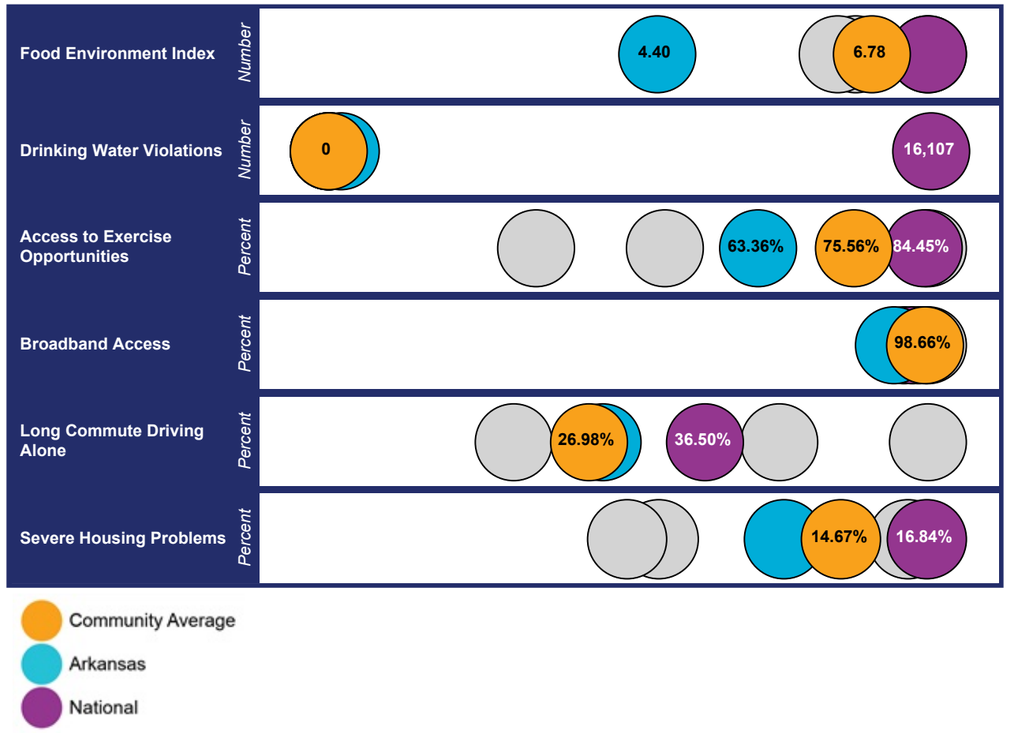


Table 9. Health Behaviors

		Grant County	Saline County	Pulaski County	Community Average	State	National
Physical Inactivity	*Percentage of adults aged 20 and older who self-report no leisure time for activity*	22.00%	21.60%	22.80%	22.50%	23.60%	19.50%
Adult Smoking	*Percentage of adults ages 18 and older who are current smokers (age-adjusted)*	20.40%	15.00%	16.70%	16.43%	19.20%	13.20%
Youth Vaping	*Percentage of public school students in 6th, 8th, 10th, and 12th grade who used any vape in the past 30 days*	10.00%	6.40%	6.90%	6.89%	8.10%	Not Available
Sexually Transmitted Infections	*Number of newly diagnosed chlamydia cases per 100,000 population*	357.90	363.50	969.80	808.95	588.30	495.00

Figure 10. Health Behaviors

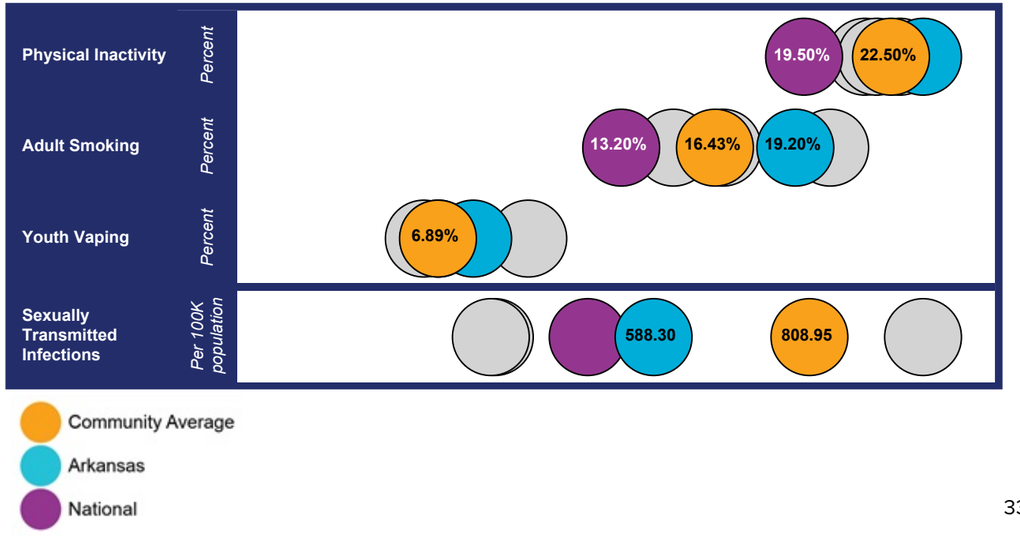


Table 10. Health Outcomes

		Grant County	Saline County	Pulaski County	Community Average	State	National
Poor Physical Health Days	*Average number of physically unhealthy days reported in past 30 days (age-adjusted)*	4.80	4.40	4.70	4.63	5.20	3.90
Poor or Fair Health	*Percentage of adults age 18 and older who self-report their general health status as "fair" or "poor" (age-adjusted)*	20.80%	17.20%	20.20%	19.53%	22.60%	17.00%

Figure 11. Health Outcomes

Table 11. Healthcare Expenditures

		Grant County	Saline County	Pulaski County	Community Average	State	National
Average Annualized Expenditures	*Average annualized per-person spending on all covered healthcare services.*	$10,931	$10,903	$10,003	$10,242	$10,116	Not Available
Average Annualized Expenditures (Medical Only)	*Average annualized per-person spending on medical services, based on medical claims.*	$7,599	$7,750	$7,131	$7,289	$7,252	Not Available
Average Annualized Expenditures (Pharmacy Only)	*Average annualized per-person spending on prescription drugs, based on pharmacy claims.*	$3,073	$2,842	$2,579	$2,656	$2,609	Not Available

Figure 12. Healthcare Expenditures

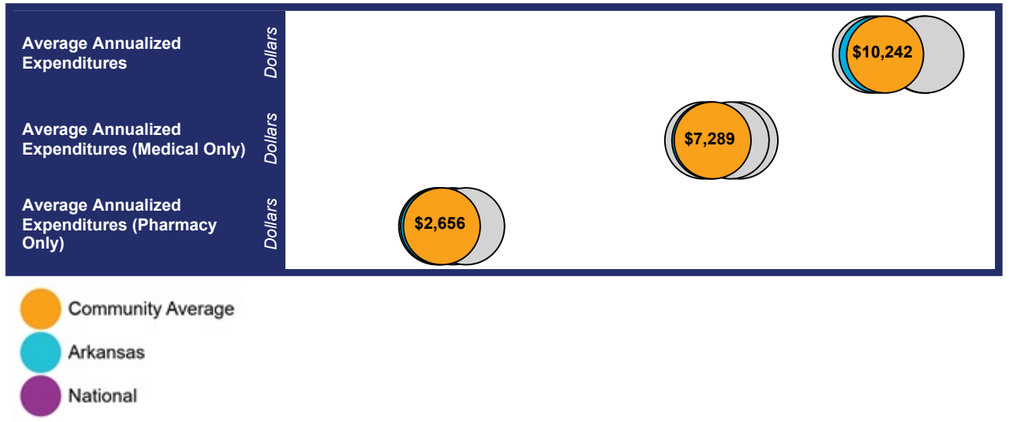


Table 12. Maternal and Infant Health

		Grant County	Saline County	Pulaski County	Community Average	State	National
Active Obstetrics and Gynecology Physicians	*Active OB-GYN physicians are defined as those who provided evaluation and management services to at least two female patients ages 12-55 on the same day or performed a qualifying procedure (e.g., delivery) at least once during the year.*	2.00	3.20	8.20	6.83	3.20	Not Available
Teen Births	*The seven-year average number of teen births per 1,000 female population, ages 15-19*	23.50	17.70	26.50	24.36	27.90	15.50
C-Section Rate	*Percentage of live births delivered via cesarean section among all deliveries, calculated by the mother's county of residence.*	33.99%	33.62%	33.87%	33.82%	33.48%	Not Available
C-Section Rate, First Birth	*Percentage of first-birth deliveries (full-term singleton pregnancies in a head-down position) delivered via cesarean section, calculated by the mother's county of residence.*	21.99%	27.87%	29.11%	28.58%	27.58%	Not Available
Low Birthweight	*Percentage of live births where the infant weighed less than 2, 500 grams (approximately 5 lbs., 8 oz.)*	10.30%	8.30%	11.70%	10.87%	9.40%	8.40%
Preterm Birth	*Percentage of live births that are preterm (<37 weeks), calculated as a three-year average.*	13.90%	11.80%	13.60%	13.19%	11.90%	10.35%
Median Travel Time to Delivery	*Median number of minutes Arkansas mothers traveled from their home ZIP code to the delivery facility, calculated using birth records and facility addresses. Travel time estimates include in-state and out-of-state facilities.*	41.00	21.00	13.00	15.79	16.00	Not Available

Figure 13. Maternal and Infant Health

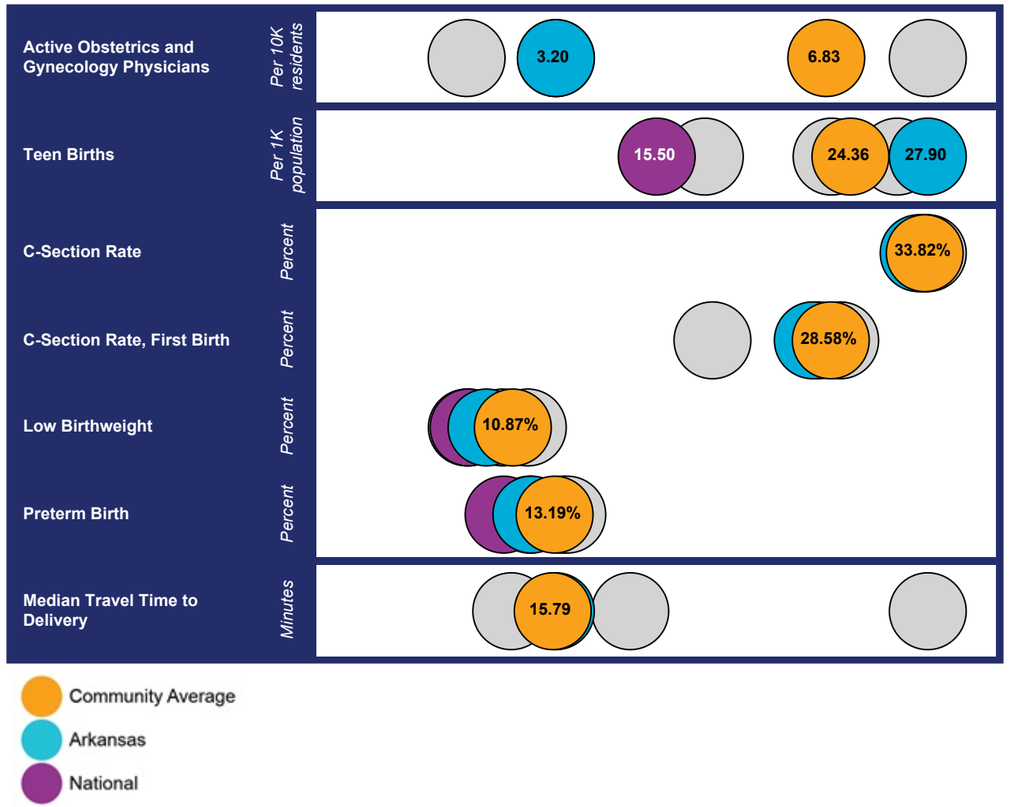


Table 13. Mental Health and Substance Use

		Grant County	Saline County	Pulaski County	Community Average	State	National
Adult Depression	*Percentage of adults age 18 and older who report having been told that they had depressive disorder*	28.90%	27.10%	25.80%	26.20%	27.50%	21.10%
Excessive Drinking	*Percentage of adults reporting binge or heavy drinking*	20.58%	19.85%	19.60%	19.69%	18.99%	19.35%
Poor Mental Health	*Percentage of adults age 18 or older reporting poor mental health for 14 or more days (age-adjusted)*	21.30%	19.30%	19.30%	19.37%	20.50%	16.40%
Youth Depression	*Percentage of public school students in 6th, 8th, 10th, and 12th grade who had feelings of depression all of the time in the past 30 days*	9.90%	5.90%	11.00%	9.78%	9.20%	Not Available
Drug Overdose Deaths	*Age-adjusted rate of fatal drug overdoses per 100,000 residents*	Not Available	Not Available	20.56	20.56	Not Available	Not Available
Non-Fatal Drug Overdoses	*Age-adjusted rate of non-fatal drug overdoses per 100,000 residents*	Not Available	18.72	29.43	26.86	Not Available	Not Available

Figure 14. Mental Health and Substance Use

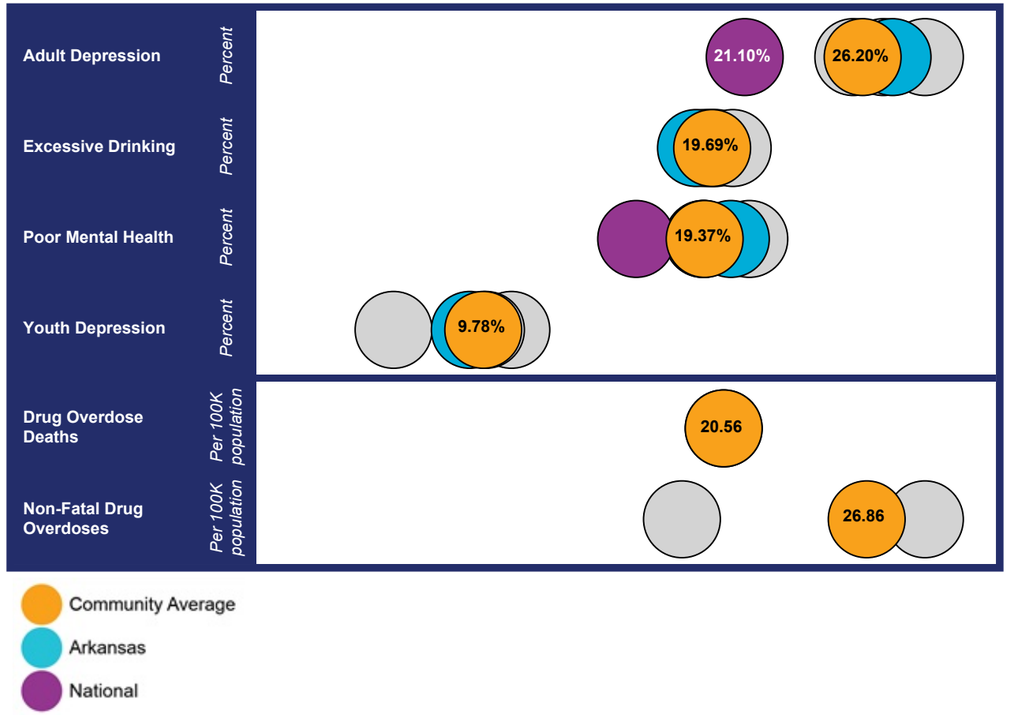


Table 14. Prevention

		Grant County	Saline County	Pulaski County	Community Average	State	National
Cervical Cancer Screening	*Percentage of females age 21–65 years who report having had recommended cervical cancer screening test (age-adjusted)*	81.90%	83.10%	83.90%	83.65%	81.20%	83.70%
Colorectal Cancer Screening	*Percentage of adults age 45-75 who have had a recent colorecal cancer screening*	63.40%	60.90%	64.40%	63.56%	61.60%	66.30%
Dental Care Utilization	*Dental care visit (past 1 year), age-adjusted percentage of adults age 18+ by county*	53.90%	62.40%	58.40%	59.18%	54.10%	63.40%
High Blood Pressure Management	*Percentage of adults age 18 and older with high blood pressure who report taking blood pressure medication (age-adjusted)*	60.00%	59.70%	61.50%	61.03%	61.40%	58.90%
Prevention - Seasonal Influenza Vaccine	*Percentage of adults aged 18 and older who report receiving an influenza vaccination in the past 12 months*	44.70%	47.10%	51.50%	50.25%	43.20%	44.80%
Annual Wellness Exam (Medicare)	*Percentage of annual wellness visits among the Medicare fee-for-service (FFS) population*	47.00%	47.00%	47.00%	47.00%	46.00%	44.00%
No HIV Test	*Percentage of adults ages 18 or older who have never been screened for HIV*	63.10%	63.40%	60.80%	61.48%	66.10%	Not Available

Figure 15. Prevention

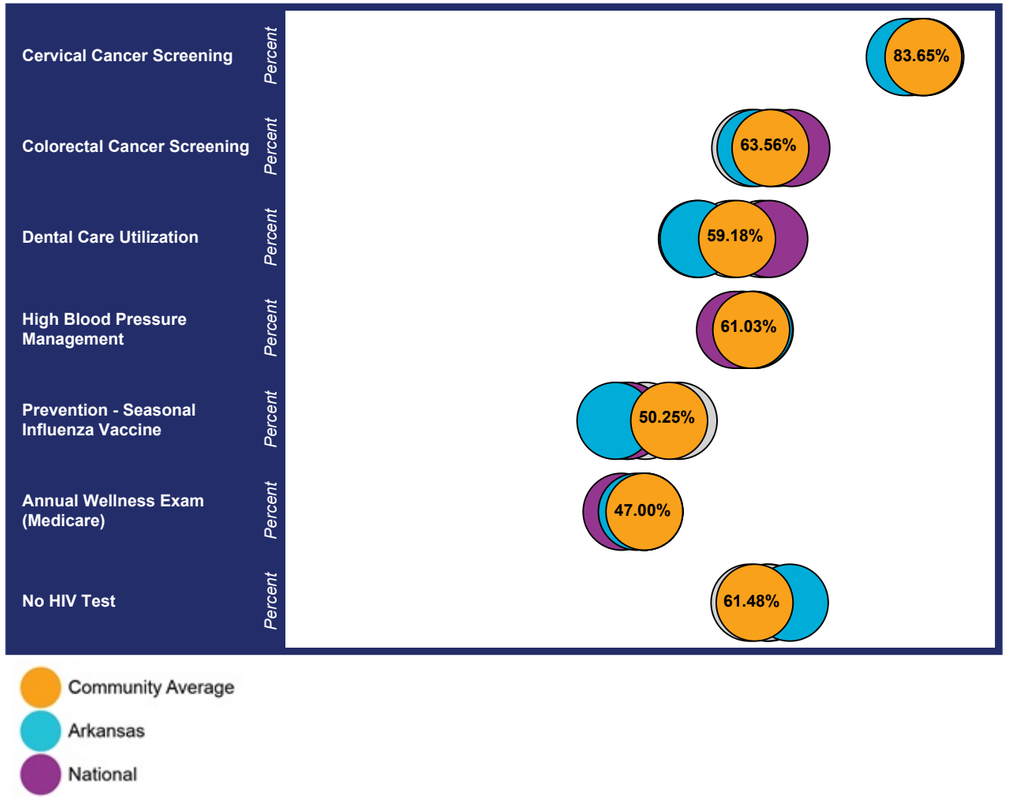
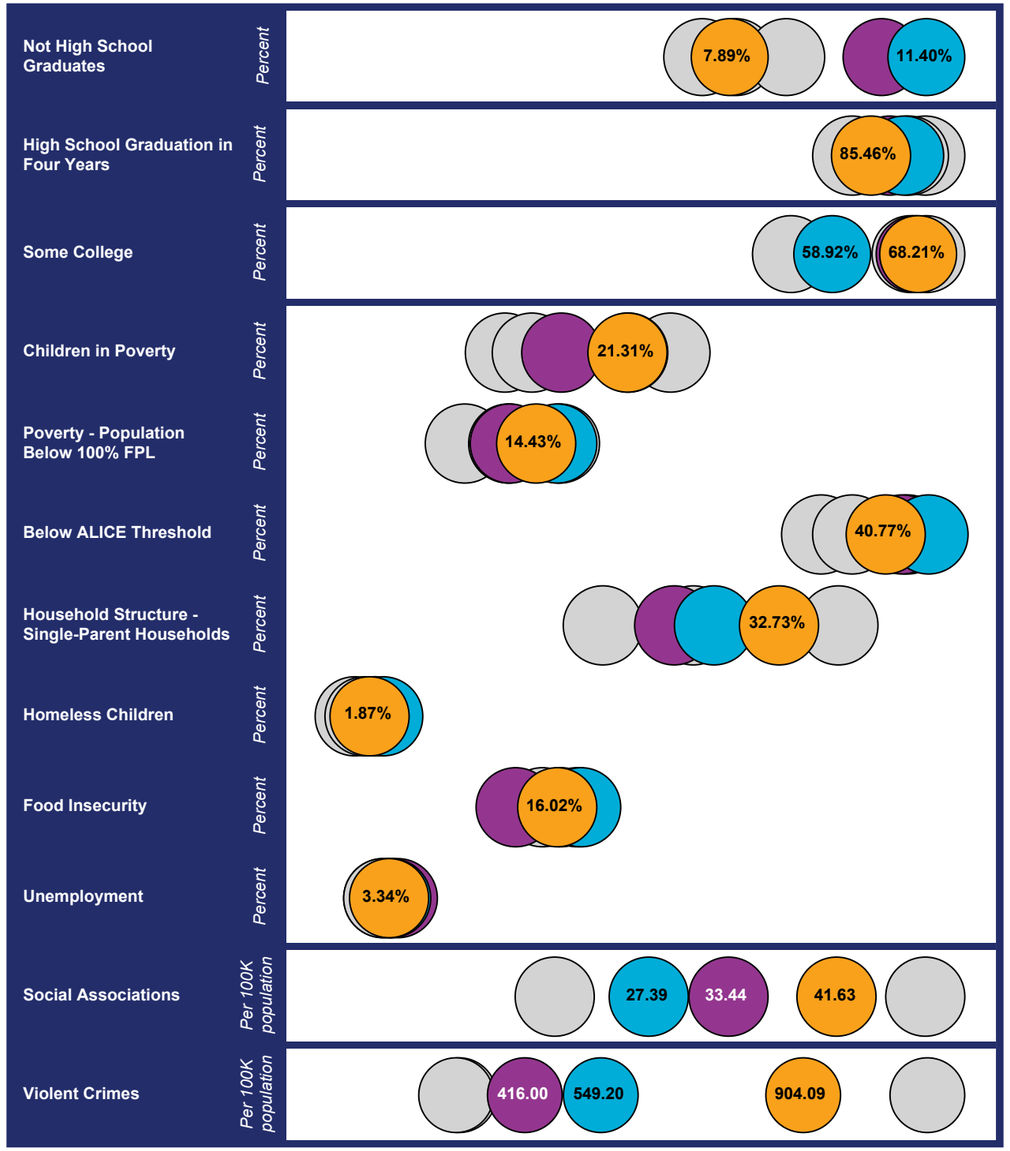


Table 15. Social and Economic Factors

		Grant County	Saline County	Pulaski County	Community Average	State	National
Not High School Graduates	*Percentage of adults without a high school diploma*	8.90%	7.40%	8.00%	7.89%	11.40%	10.60%
High School Graduation in Four Years	*Percentage of ninth-grade cohort who graduated in four years*	91.00%	93.40%	82.70%	85.46%	90.30%	88.20%
Some College	*Percentage of adults ages 25-44 with some post-secondary education*	54.45%	67.38%	69.10%	68.21%	58.92%	67.83%
Children in Poverty	*Percentage of children under age 18 below the poverty line*	14.10%	12.07%	24.55%	21.31%	21.37%	16.32%
Poverty - Population Below 100% FPL	*Percentage of the population living in households with income below the federal poverty level*	12.32%	9.05%	16.22%	14.43%	16.02%	12.44%
Below ALICE Threshold	*Percentage of households living in poverty or classified as ALICE (Asset Limited, Income Constrained, Employed)*	38.25%	35.91%	42.42%	40.77%	44.00%	42.00%
Household Structure - Single-Parent Households	*Percentage of children who live in households where only one parent is present*	26.27%	19.45%	37.21%	32.73%	27.83%	24.83%
Homeless Children	*Percentage of students experiencing homelessness enrolled in the public school system*	1.49%	0.75%	2.24%	1.87%	2.90%	2.31%
Food Insecurity	*Percentage of the population that experienced food insecurity in the report year*	17.50%	14.90%	16.30%	16.02%	17.82%	12.88%
Unemployment	*Percentage of the civilian non-institutionalized population age 16 and older that is unemployed (non-seasonally adjusted)*	2.90%	2.90%	3.50%	3.34%	3.50%	4.00%
Social Associations	*Establishments, rate per 100,000 population*	Not Available	20.26	48.36	41.63	27.39	33.44

Figure 16. Social and Economic Factors



IDENTIFIED NEED 1:
Increase Access to Care and Education

GOALS/OBJECTIVE/OBJECTIVES:
Increase Access to Quality Health Care through Education and Community Resources.

STRATEGY: 1:
Improve health outcomes through patient education and partnerships with patients and families

ACTION STEPS:

- Offer Stroke Prevention Education and Support group for patients and community members
- Partner with First Responders on training staff transporting potential spinal injury patients
- Continued to offer access to fully-equipped kitchens, bedrooms, and bathrooms with movable fixtures to simulate the patient's home environment, ensuring training is practical for their eventual discharge
- Increase access to education on traumatic brain injuries,
- Partner with Community Outreach and Health Management Center to Increase access to Diabetes complication prevention services and self-management resources including Diabetes Support Group.
- Partner with Community Outreach to Increase access to Stroke complication prevention services and self-management resources including Stroke Support Group
- Partner with MEMS to provide blood pressure equipment individuals with hypertension
- Continue to offer specialty programs focusing on Specialty Program, Spinal Cord Injury Specialty Program and Amputee Specialty Program

KEY PERFORMANCE METRICS:

- Track Number of Community Education and Screenings
- Track Support Group participation
- Track the number of classes offered and participants
- Track number of blood pressure monitors provided through the MEMS initiative

COLLABORATIONS WITH ORGANIZATIONS: Local nonprofits, Coalitions, First Responders

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS NEED: Staff time and clinical expertise, marketing and educational materials, vaccination resources, Marketing & Communications and Community Outreach

ESTIMATED COMPLETION DATE: Ongoing through 2028

PERSON(S)/DEPARTMENT RESPONSIBLE: Leadership Team, Community Outreach

IDENTIFIED NEED 1:
Increase Access to Care and Education

GOALS/OBJECTIVE/OBJECTIVES:
To improve community health by increasing health literacy and reducing barriers to accessing healthcare through community-led, culturally appropriate education and navigation support.

STRATEGY: 2
Health Literacy & Access to Healthcare

ACTION STEPS:

- In partnership with Community Outreach Establish a Community Health Literacy committee including patient representatives, clinical staff, and community partners) to finalize the curriculum, set implementation timelines
- Identify target populations based on data and community need
- Launch community in-person, and virtual workshops to cover topics including understanding health Information, communicating with healthcare providers, navigating healthcare, self-management and preventive health, understanding prescriptions, telehealth, patient rights
- Train community-based clinical and non-clinical staff in health-literate communication (e.g., Teach-Back, plain language)

KEY PERFORMANCE METRICS:

- Curriculum identified and vetted for implementation
- Track the number of classes offered and participants
- Track pre/post test results to determine knowledge gained
- Track number of staff trained to implement the program
- Identified number of encounters using the Teach-Back method

COLLABORATIONS WITH ORGANIZATIONS: Local nonprofits, faith-based organizations, community-based organizations

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS NEED:
Staff time and clinical expertise, marketing and educational materials, vaccination resources, Marketing & Communications and Community Outreach

ESTIMATED COMPLETION DATE: Ongoing through 2028

PERSON(S)/DEPARTMENT RESPONSIBLE: Leadership Team, Community Outreach

IDENTIFIED NEED 1:
Increase Access to Care and Education

GOALS/OBJECTIVE/OBJECTIVE:
Financial Empowerment for Healthcare: The goal is to move participants from financial crisis management to proactive planning. show how sound budgeting and saving habits directly support access to care and health stability.

STRATEGY: 3
Financial Literacy & Access to Healthcare

ACTION STEPS:
- Partner with Community groups and organizations to implement class
- Incorporate Financial Literacy in Community Wellness Centers
- Incorporate Financial Literacy in Community Wellness Centers and Prenatal/Postpartum program by including the following educational topics
  - Control Your Money: Budgeting101
  - Understanding needs vs. wants, building a savings
  - Building a Savings for Emergencies and healthcare
  - Avoiding Money Traps: Debts & Credits
  - Protect Your Health: Financial Literacy
- Identify additional resources for referrals beyond classes

KEY PERFORMANCE METRICS
- Track the number of classes offered and number of participants
- Utilize pre and post test to determine knowledge gain
- Track number of community partners identified and utilized for implementation
- Track number of referrals for financial assistance

COLLABORATIONS WITH ORGANIZATIONS: Local nonprofits, local banks, cooperative extension organizations

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS NEED: Staff time and clinical expertise, marketing and educational materials, community health supplies, vaccination resources, and ongoing support from the Marketing & Communications and Community Outreach

ESTIMATED COMPLETION DATE: Ongoing through 2028

PERSON(S)/DEPARTMENT RESPONSIBLE: Leadership Team, Community Outreach

IDENTIFIED NEED 2:
The Community Mental Health Strategy: Access, Education, Acceptance

GOALS/OBJECTIVE:
Improve and increase access to mental health services, reduce stigma, and promote emotional well-being for residents of the Pulaski, Saline & Grant counties.

STRATEGY:
Strengthen collaboration with employers, healthcare providers, and community organizations to expand mental health education, increase access to counseling and crisis resources, and promote early intervention and resilience-building initiatives.

ACTION STEPS:
- Partner with healthcare organizations, locally and statewide, to increase the capacity to provide additional mental health services.
- Implementation Project to increase in-patient mental and behavioral health services.
- Provide Mental Health First Aid training to local schools, colleges, and community or faith-based organizations.
- Provide Community-based Stop the Bleed Trainings
- Participate in system-wide Mental Health Awareness Campaigns
- Integrate Mental Health Education and Awareness materials into Schools and Workplaces
- Utilize Telepsych for patients in need of Telemedicine services

KEY PERFORMANCE METRICS:
- Track number of patient encounters in-patient withdrawal management services
- Track number of patient encounters utilizing Telepsych services
- Report number of Community partners and events for mental health services
- Track the number of mental health first aid and Stop the Bleed classes and participants
- Track the number of Mental Health First Aid trainings and attendance
- Measure campaign's reach through social media engagement, website visits, and printed material distribution.

COLLABORATIONS WITH ORGANIZATIONS: Local schools, universities and businesses, non-profits and faith-based organizations

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS NEED: Staff time and clinical expertise, marketing and educational materials, community health supplies and ongoing support from the Marketing & Communications and behavioral health, command center and Community Outreach teams.

ESTIMATED COMPLETION DATE: Ongoing through 2028

PERSON(S)/DEPARTMENT RESPONSIBLE: Leadership, Behavioral Health, Community Outreach Marketing & Communications Manager, Case Management

IDENTIFIED NEED 3:
Closing the Gap: A Strategy for Healthy Communities and Nutrition Security

GOALS/OBJECTIVE/OBJECTIVE:
Provide food directly to patients and/or employees to meet the needs of those with demonstrated food insecurity.

STRATEGY:
Participate in the System FoodRx initiative to provide healthy, nutritious food choices to food insecure patients and/or employees.

ACTION STEPS:

- Utilize the Epic System to screening for Food Insecurity for inpatients visits and refer to Community Outreach FoodRx program
- Promote the Arkansas Fruit and Vegetable Prescription Program with Community Outreach and the Arkansas Hunger Relief Alliance to distribute fresh produce to food-insecure patients with a diet-related chronic health condition.
- Continue utilization of David's village to educate patients on cooking healthy meals and shopping with ease
- Promote Community-based nutrition education and cooking classes
- Provide education to families and caregivers nutritional needs based on oral problems, height and weight, weight change, nutrition problems (altered taste, hunger, uneaten meals), approaches to nutritional care (nutrition support, and therapeutic diets), and food intake

KEY PERFORMANCE METRICS

- Track and report the number of individuals served by the FoodRx program.
- Track and report the number of bags distributed
- Track and report the total number of pounds or "meals" of food distributed.
- Track and report the number of participants in the Arkansas Fruit and Vegetable program.
- Track number of participants in community nutrition education and cooking classes

COLLABORATIONS WITH ORGANIZATIONS: Local nonprofits, foodbank, Arkansas Hunger Relief Alliance

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS NEED: Staff time and clinical expertise, marketing and educational materials, community health supplies, vaccination resources, and ongoing support from the Marketing & Communications and Community Outreach

ESTIMATED COMPLETION DATE: Ongoing through 2028

PERSON(S)/DEPARTMENT RESPONSIBLE: Leadership Team, Case Coordination, Community Outreach

BAPTIST HEALTH MEDICAL CENTER-
Hot Spring County

About Us

Baptist Health Medical Center-Hot Spring County is a 72-bed community hospital with a long tradition of providing great patient care since it opened in 1923. The hospital joined Baptist Health on Jan. 1, 2014, making it the eighth hospital in the system.

Baptist Health Medical Center-Hot Spring County built a walking trail to give our employees, volunteers and community a safe place to walk. In partnership with our hospital Auxiliary, we were able to construct a path that spans 1,056 feet on part of our campus. So five loops around and you have one mile! Join the community walking program today!

Awards & Recognitions

- American Heart Association's
  Get with the Guidelines Stroke Silver Award
- Top 100 Hospitals by Fortune/
  IBM Watson Health

Community Health Needs Assessment 2026-2028

Baptist Health Medical Center-Hot Spring County

HIGHLIGHTS OF COMMUNITY HEALTH NEEDS ASSESSMENT ACCOMPLISHMENTS 2023-2025

Access to Care

- Provided CPR training for Community-based first responders
- Partnered with Community Outreach to offer childhood immunizations
- Utilized the Baptist Health Command Center to increase access and decrease barriers to care
- Sustained Commitment to Preventative Health: Demonstrated a three-year commitment to community wellness by consistently offering the Maintain, Don't Gain program annually from 2023 through 2025, supporting participants in long-term weight management during critical times.
- Provided various community-based organizations information and educational training on stroke awareness/prevention
- Partnered with locals schools to assist with vision, height and weight of students of multiple grades
- Mental Health Awareness
- Provided mental health information and education at the ASU community fair
- Provided mental health resources during childhood immunization initiative
- Offered Telepsych services for community members
- Maintained Level IV Trauma Center recognition
- Continued to provide mental health treatment via Hospital base

Food and Nutrition

- Conducted two hands-on grocery store tours at Walmart using the Cooking Matters curriculum, directly empowering seven participants with practical skills in budgeting and making healthy food selections
- Delivered five "Cooking Matters" educational classes at Center X, generating 40 participant encounters focused on enhancing culinary skills and promoting improved nutrition
- In partnership with Community Outreach Successfully launched and managed two system-wide, 6-week holiday virtual wellness programs, achieving a robust 525 participant encounters and promoting employee health during a high-stress period
- In partnership with Community outreach Delivered three system-wide virtual cooking classes, expanding access to hands-on nutritional education across the organization

2025 BAPTIST HEALTH COMMUNITY HEALTH NEEDS ASSESSMENT: HOT SPRING COUNTY

ACHI
August 2025

Baptist Health

PREPARED BY:
ACHI
INSPIRING HEALTHY ACTS

Introduction

Baptist Health engaged the Arkansas Center for Health Improvement (ACHI) to conduct the quantitative data collection and analysis for the 2025 Community Health Needs Assessment (CHNA) process. Baptist Health provided ACHI with the counties served by each of its 12 hospital communities. A total of 16 Arkansas counties and two Oklahoma counties were included.

Each report presents community-level data for a hospital community, including tables and figures for each indicator, along with comparisons to Arkansas and U.S. benchmarks. Dot graphs are provided to visualize performance across selected indicators. All reports are prepared using the same methodology to ensure consistency and comparability across Baptist Health hospital communities.

Methodology

A summary of sources, definitions, indicator criteria, and suppression rules can be found in the methods and sources document.

Community Profile Summary

To support the 2025 Community Health Needs Assessment (CHNA), ACHI compiled a comprehensive dataset of 103 health and demographic indicators for the communities served by Baptist Health's 12 hospital locations. This section provides an overview of these indicators across the full CHNA service area and offers multiple views for understanding and comparing county-level and community-level data.

Data are grouped into the following 14 categories, based on the source-defined domains outlined in the data source reference sheet:

1. Demographics
    a. Age
    b. Sex
    c. Race, Ethnicity, and Language
2. Insurance Coverage
3. Access to Care
4. Cause of Death
5. Chronic Conditions
6. Diagnoses Incidence at Discharge
7. Environment
8. Health Behaviors
9. Health Outcomes
10. Healthcare Expenditures
11. Maternal and Infant Health
12. Mental Health and Substance Use
13. Prevention
14. Social and Economic Factors

Measurements for these categories will be displayed in the following sections.

Hospital Community Indicator

The hospital community indicator snapshots offer an at-a-glance view of how each hospital community compares to state and national benchmarks, as well as the counties that make up the community.

Each table presents the data values for selected indicators across the 14 CHNA domains, and each corresponding visual uses proportionally scaled circular markers to illustrate performance. This format is designed to quickly convey how each hospital community aligns with or diverges from broader benchmarks in key population health metrics.

Each displays four comparison points:

- **Purple** – Represents the national value for the indicator.
- **Blue** – Represents the value for the state of Arkansas.
- **Gold** – Represents the weighted average for all counties in the hospital's defined service area.
- **Gray** – Represent the values of each county assigned to that hospital community.

Where available, data for each indicator are shown for all four categories. If a value is not available or is suppressed for a contributing county, it is noted as "Not Available" in the table and excluded from the visual display. No color ranking is applied; the visuals and tables are intended to illustrate relative placement, not comparative rank.

Hospital Community: Hot Spring County

Figure 1. Counties Served by Baptist Health Medical Center–Hot Spring County

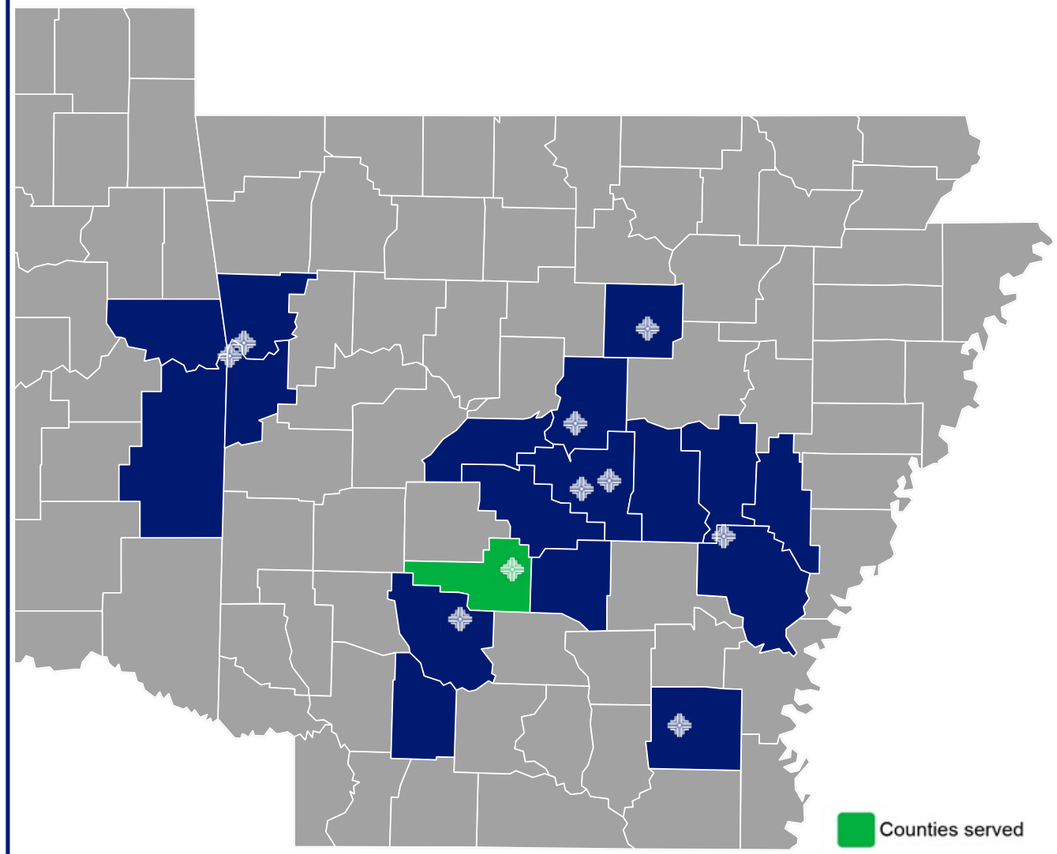


Table 1. Demographics: Age and Sex

		Hot Spring County	Community Average	State	National
Total Population	*Number*	33,142	33,142	3,032,651	332,387,540
Female	*Percent*	47.71%	47.71%	50.67%	50.50%
Male	*Percent*	52.29%	52.29%	49.33%	49.50%
Ages 0-4	*Percent*	4.70%	4.70%	6.02%	5.70%
Ages 5-17	*Percent*	14.91%	14.91%	17.26%	16.46%
Ages 18-24	*Percent*	8.00%	8.00%	9.33%	9.12%
Ages 25-34	*Percent*	13.02%	13.02%	12.93%	13.69%
Ages 35-44	*Percent*	12.60%	12.60%	12.66%	13.08%
Ages 45-54	*Percent*	13.40%	13.40%	11.84%	12.29%
Ages 55-64	*Percent*	13.64%	13.64%	12.64%	12.82%
Ages 65+	*Percent*	19.74%	19.74%	17.33%	16.84%

Figure 2. Demographics: Age and Sex

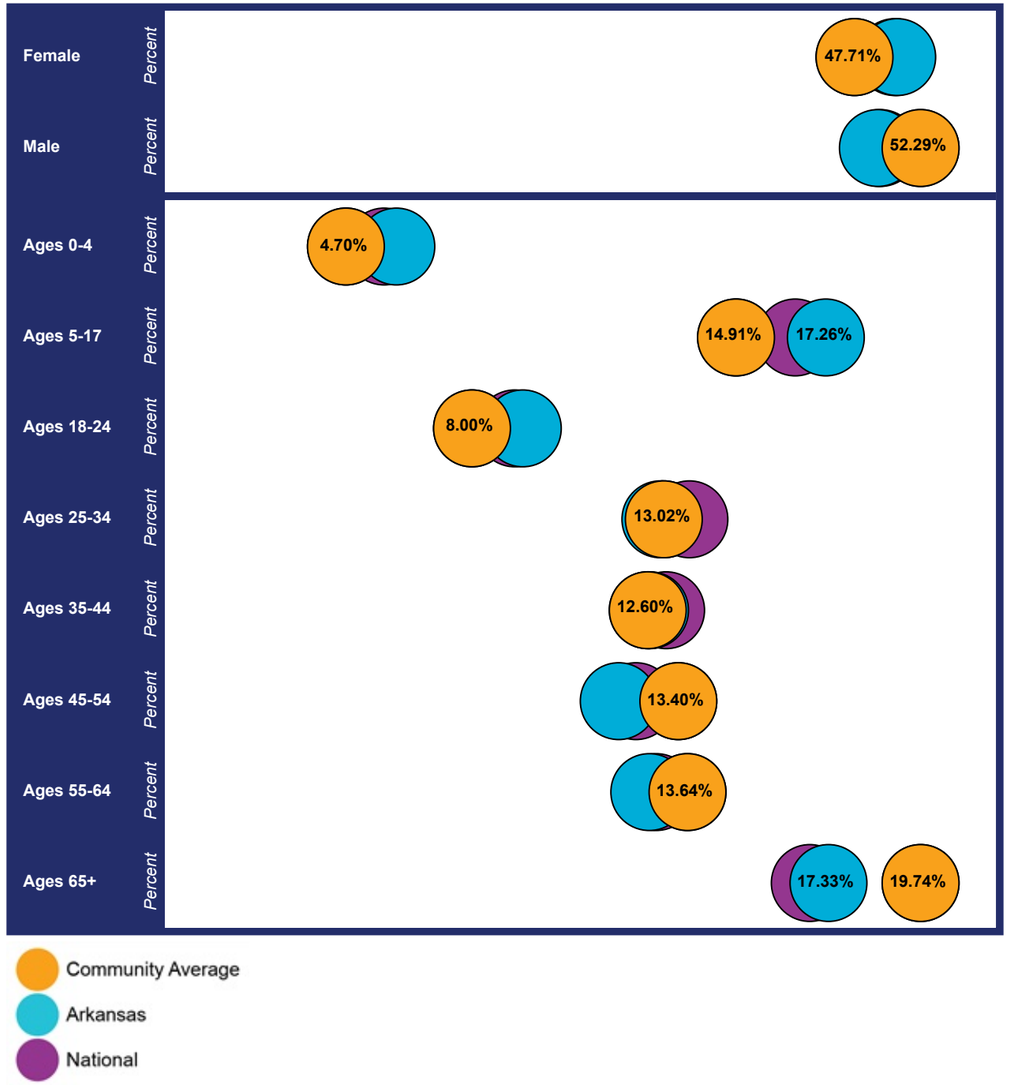


Table 2. Demographics: Race, Ethnicity, and Language

		Hot Spring County	Community Average	State	National
Total Population	*Number*	33,142	33,142	3,032,651	332,387,540
Asian	*Percent*	0.03%	0.03%	1.53%	5.75%
Black or African American	*Percent*	11.46%	11.46%	14.84%	12.03%
Hispanic	*Percent*	3.99%	3.99%	8.77%	18.99%
Multiple Races	*Percent*	3.09%	3.09%	5.50%	3.87%
Native American/ Alaska Native	*Percent*	0.24%	0.24%	0.36%	0.53%
Native Hawaiian/ Pacific Islander	*Percent*	0.00%	0.00%	0.39%	0.17%
Other Races	*Percent*	0.05%	0.05%	0.26%	0.50%
White	*Percent*	81.14%	81.14%	68.36%	58.17%
Non-English Language Households	*Percent*	0.10%	0.10%	1.50%	4.20%

Figure 3. Demographics: Race, Ethnicity, and Language

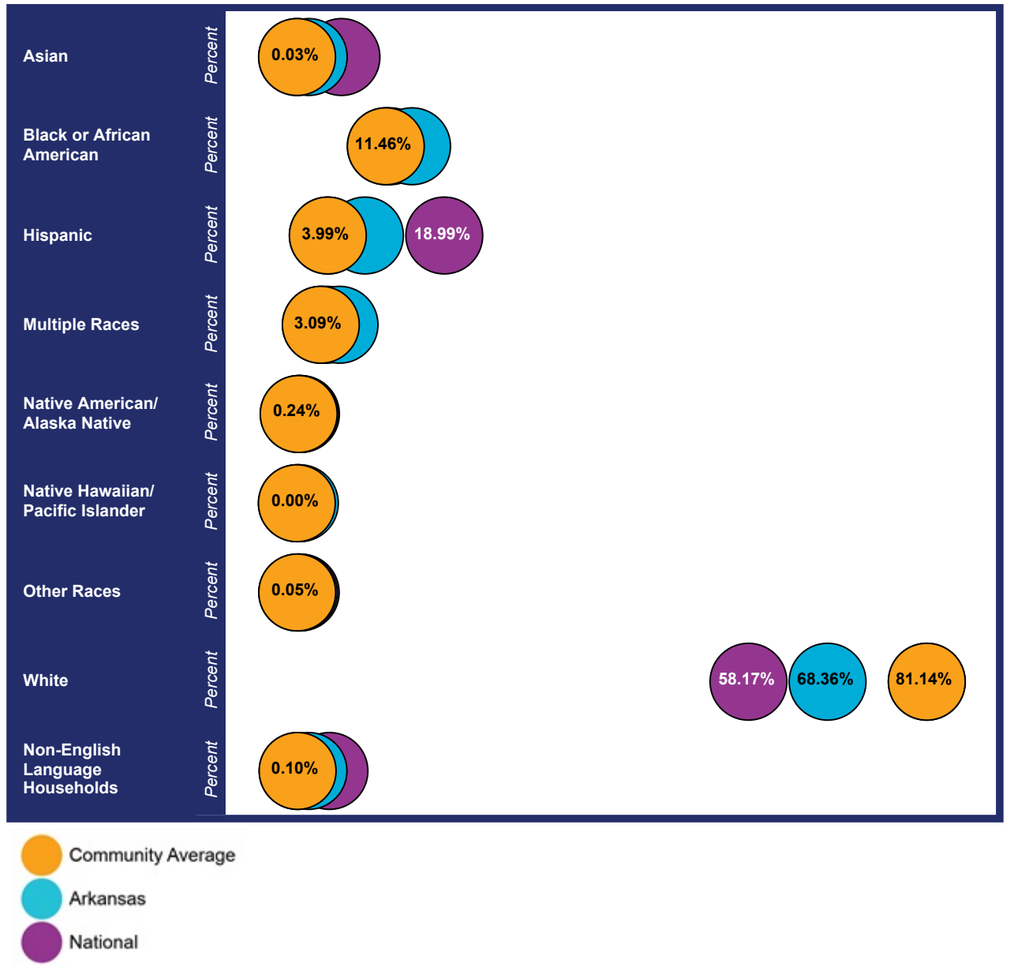


Table 3. Insurance Coverage

		Hot Spring County	Community Average	State	National
Private Health Insurance Coverage	*Percentage of the total civilian non-institutionalized population for whom insurance status is determined that is covered by private health insurance*	60.24%	60.24%	65.37%	73.62%
Public Health Insurance Coverage	*Percentage of the total civilian non-institutionalized population for whom insurance status is determined that is covered by public health insurance*	52.90%	52.90%	48.21%	39.70%
Uninsured	*Percentage of adults under age 65 without health insurance coverage*	8.40%	8.40%	10.00%	9.50%

Figure 4. Insurance Coverage

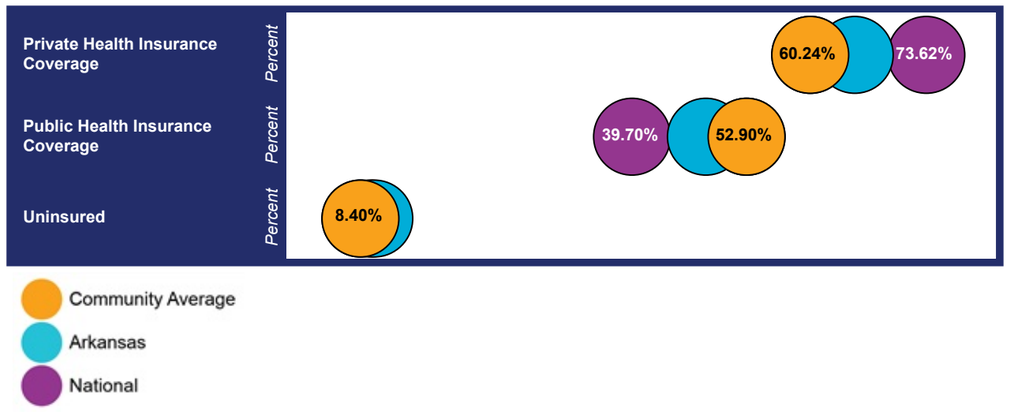


Table 4. Access to Care

		Hot Spring County	Community Average	State	National
Primary Care Physicians	*Ratio of population to one primary care physician*	4143:1	4143:1	1478:1	1334:1
Mental Health Providers	*Ratio of population to one mental health provider*	405:1	405:1	367:1	300:1
Dentists	*Ratio of population to one dentist*	3689:1	3689:1	2044:1	1361:1
Active Primary Care Physicians	*Rate per 10,000 county residents of primary care physicians who provided evaluation and management services to at least two patients on the same day at least once during the year*	13.60	13.60	9.20	Not Available
Addiction or Substance Use Providers	*Rate of addiction or substance use providers per 100,000 population*	6.05	6.05	5.98	29.43
Buprenorphine Providers	*Rate of buprenorphine providers per 100,000 population*	9.07	9.07	9.81	14.87
Preventable Hospital Stays (Medicare)	*Rate of hospital stays for ambulatory care-sensitive conditions per 100,000 Medicare enrollees*	2601.00	2601.00	3014.00	2666.00
Diabetic Monitoring (Medicare)	*Percentage of Medicare enrollees aged 65 and older with diabetes who received a hemoglobin A1c (HbA1c) test within the past year.*	89.55%	89.55%	88.47%	87.53%
Mammography	*Percentage of female Medicare enrollees ages 65-74 who received an annual mammography screening*	39.00%	39.00%	41.00%	44.00%

Figure 5. Access to Care

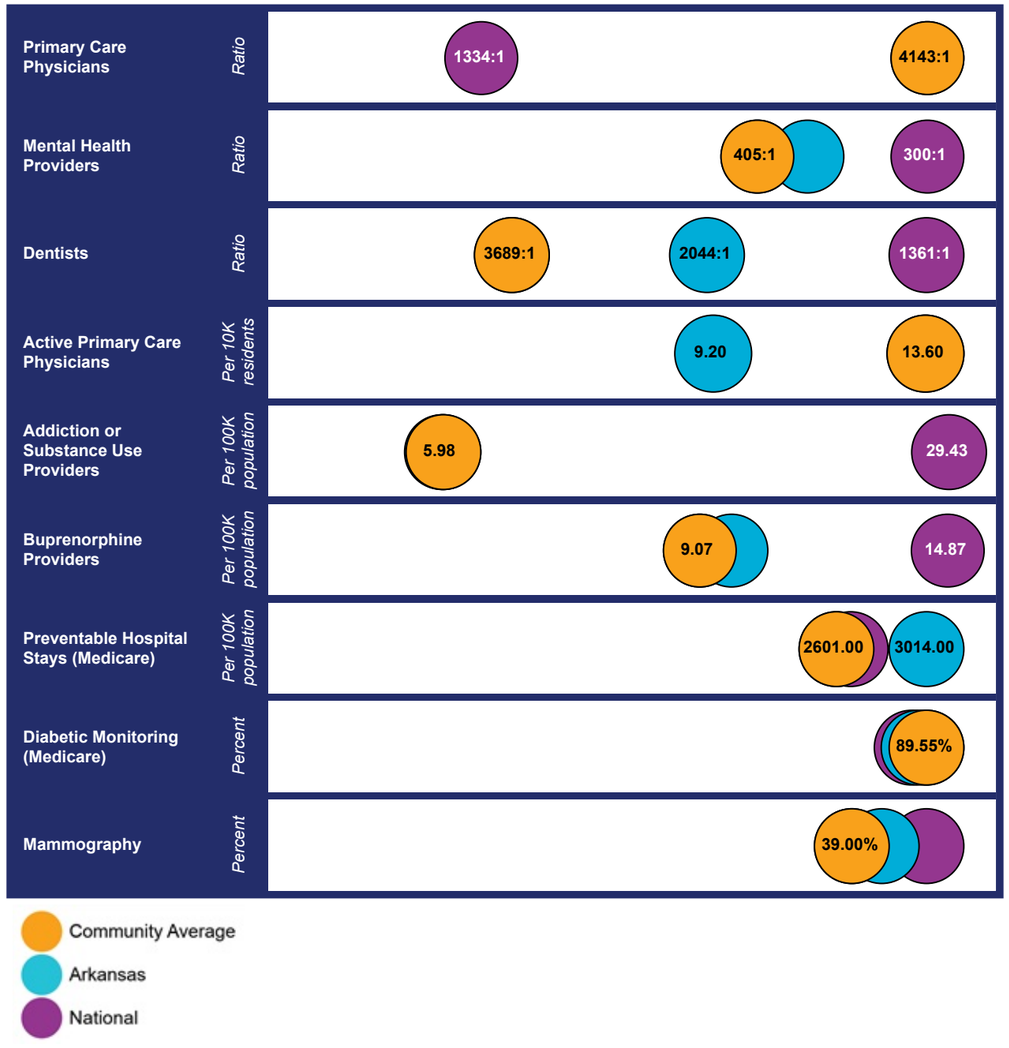


Table 5. Cause of Death

		Hot Spring County	Community Average	State	National
All Causes	*Rate of deaths by all causes per 100,000 population (age-adjusted)*	1122.50	1122.50	1001.70	805.60
Premature Death	*Number of deaths among residents under age 75 per 100,000 population (age-adjusted)*	628.72	628.72	552.47	406.59
Heart Disease	*Rate of death due to heart disease (ICD-10 Codes I00-I09, I11, I13, I20-I151) per 100,000 population*	352.30	352.30	282.80	207.20
Cancer	*5-year average rate of death due to cancer per 100,000 population*	246.50	246.50	215.90	182.70
Unintentional Injury	*5-year average rate of death due to unintentional injury (accident) per 100,000 population*	71.80	71.80	61.90	63.30
Stroke	*5-year average rate of death due to cerebrovascular disease (stroke) per 100,000 population (age-adjusted)*	63.40	63.40	57.40	48.30
Chronic Lower Respiratory Disease	*Rate of deaths due to chronic lower respiratory disease per 100,000 population (age-adjusted)*	71.70	71.70	61.00	35.90
Diabetes Mortality	*Rate of deaths due to diabetes per 100,000 population (age-adjusted)*	23.90	23.90	34.70	23.90
Suicide Deaths	*This indicator reports the 2019-2023 five-year average rate of death due to intentional self-harm (suicide) per 100,000 population. Figures are reported as crude rates*	30.50	30.50	19.20	14.50
Motor Vehicle Crash	*5-year average rate of death due to motor vehicle crash per 100,000 population (age-adjusted)*	22.10	22.10	20.60	12.80
Alcohol-Involved Motor Vehicle Crash	*Rate of persons killed in motor vehicle crashes involving alcohol as a rate per 100,000 population*	5.40	5.40	3.10	2.30

Figure 6. Cause of Death

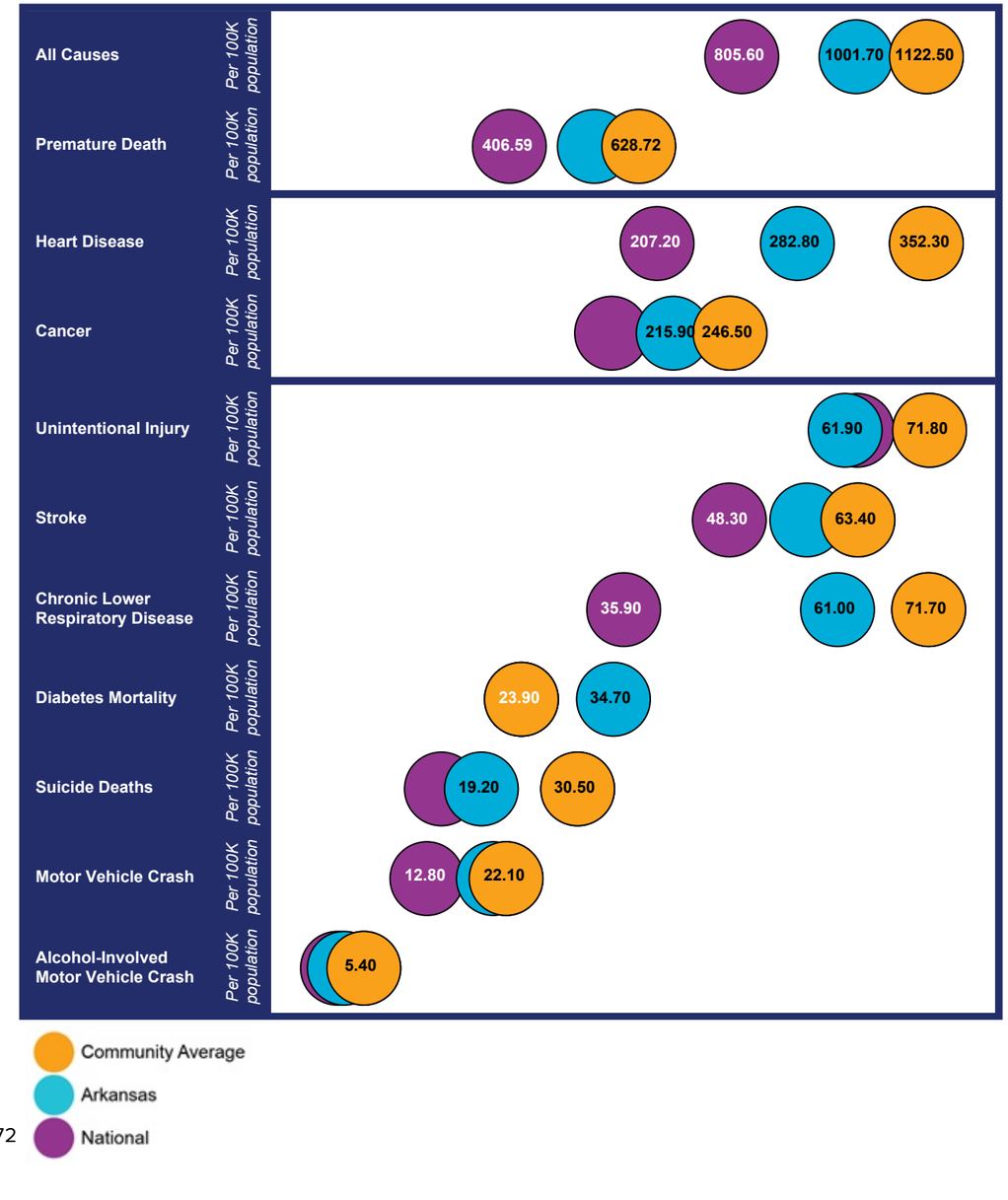


Table 6. Chronic Condtions

		Hot Spring County	Community Average	State	National
Child Obesity	*Percentage of students classified as overweight to severely obese, by county location of school*	44.55%	44.55%	40.10%	Not Available
High Cholesterol	*Percentage of adults who have had their blood cholesterol checked and have been told it was high (age-adjusted)*	32.90%	32.90%	31.80%	30.40%
Adult Obesity	*Percentage of adults ages 20 and older who report a BMI higher than 30*	25.80%	25.80%	31.90%	30.10%
High Blood Pressure	*Percentage of adults who have been told they have high blood pressure (age-adjusted)*	36.80%	36.80%	36.50%	29.60%
Arthritis	*Percentage of adults ages 18 or older diagnosed with some form of arthritis*	34.40%	34.40%	32.60%	Not Available
Diabetes Prevalence	*Percentage of adults age 18 and older who report ever been told that they have diabetes other than diabetes during pregnancy (age-adjusted)*	13.00%	13.00%	12.70%	10.40%
Asthma	*Percentage of adults who have been told they currently have asthma (age-adjusted)*	10.80%	10.80%	11.00%	9.90%
Coronary Heart Disease	*Percentage of adults age 18 and older who report ever having been told by that they had angina or coronary heart disease (CHD) (age-adjusted)*	7.60%	7.60%	7.20%	5.70%

Figure 7. Chronic Conditions

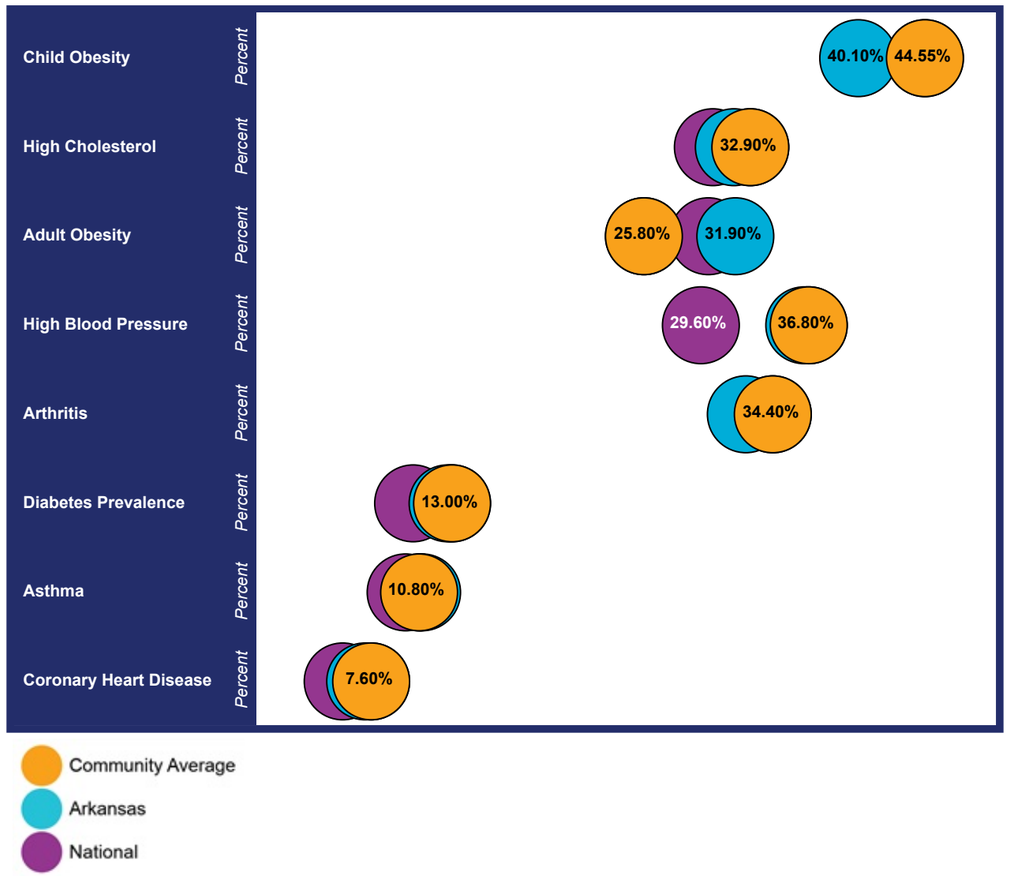


Table 7. Diagnoses at Discharge

		Hot Spring County	Community Average	State
Hypertension	*Number of individuals 18 years and older discharged with a primary or secondary hypertension diagnosis as a percentage of the population 18 years and older*	9.23%	9.23%	8.70%
Hyperlipidemia	*Number of individuals 18 years and older discharged with a primary or secondary hyperlipidemia diagnosis as a percentage of the population 18 years and older*	4.19%	4.19%	3.90%
Diabetes	*Rate of individuals 18 years and older discharged with a primary or secondary diabetes diagnosis as a percentage of the population 18 years and older*	3.71%	3.71%	3.70%
Ischemic Heart Disease	*Number of individuals 18 years and older discharged with a primary or secondary ischemic heart disease diagnosis as a percentage of the population 18 years and older*	2.89%	2.89%	2.50%
Arthritis	*Rate of individuals 18 years and older discharged with a primary or secondary arthritis diagnosis as a percentage of the population 18 years and older*	2.16%	2.16%	1.90%

Figure 8. Diagnoses at Discharge

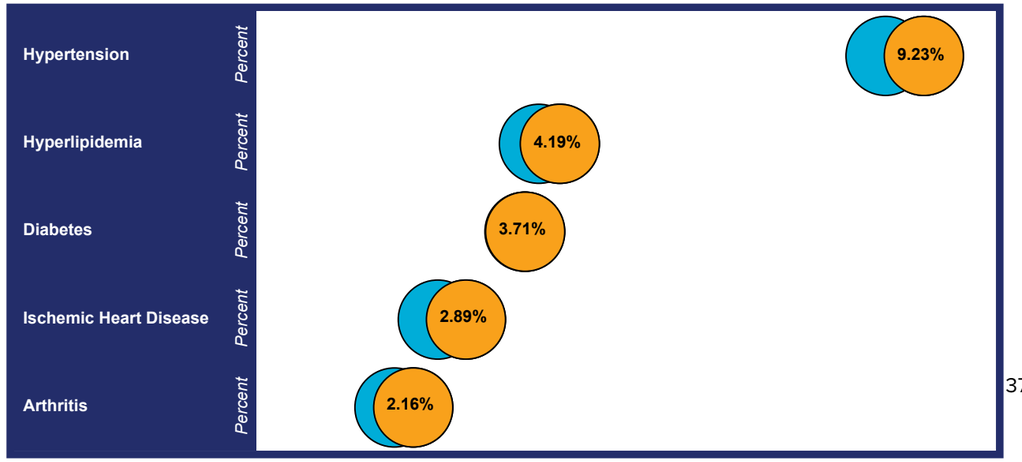


Table 8. Environment

		Hot Spring County	Community Average	State	National
Food Environment Index	*Index of factors that contribute to a healthy food environment, 0 (worst) to 10 (best)*	5.80	5.80	4.40	7.40
Drinking Water Violations	*The total number of drinking water violations recorded in a two-year period*	0	0	321	16,107
Access to Exercise Opportunities	*Percentage of population with adequate access to locations for physical activity*	19.72%	19.72%	63.36%	84.45%
Broadband Access	*Percentage of population in a high-speed internet service area; access to DL speeds >= 25MBPS and UL speeds >= 3 MBPS*	98.00%	98.00%	94.04%	96.78%
Long Commute Driving Alone	*Among workers who commute in their car alone, the percentage who commute more than 30 minutes*	46.20%	46.20%	28.10%	36.50%
Severe Housing Problems	*Percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities*	12.55%	12.55%	13.23%	16.84%

Figure 9. Environment

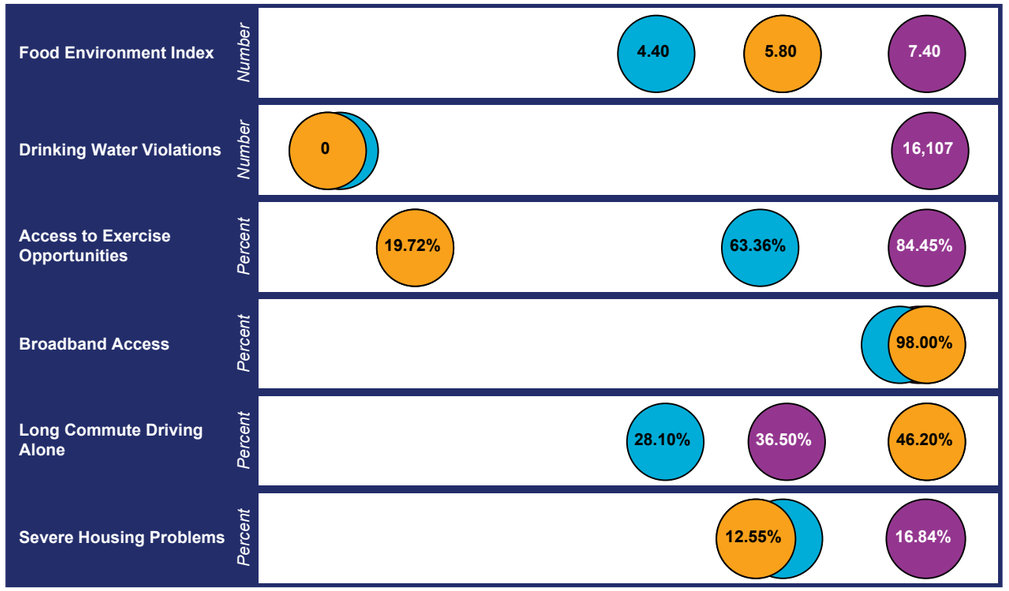


Table 9. Health Behaviors

		Hot Spring County	Community Average	State	National
Physical Inactivity	*Percentage of adults aged 20 and older who self-report no leisure time for activity*	21.60%	21.60%	23.60%	19.50%
Adult Smoking	*Percentage of adults ages 18 and older who are current smokers (age-adjusted)*	21.80%	21.80%	19.20%	13.20%
Youth Vaping	*Percentage of public school students in 6th, 8th, 10th, and 12th grade who used any vape in the past 30 days*	8.40%	8.40%	8.10%	Not Available
Sexually Transmitted Infections	*Number of newly diagnosed chlamydia cases per 100,000 population*	466.80	466.80	588.30	495.00

Figure 10. Health Behaviors

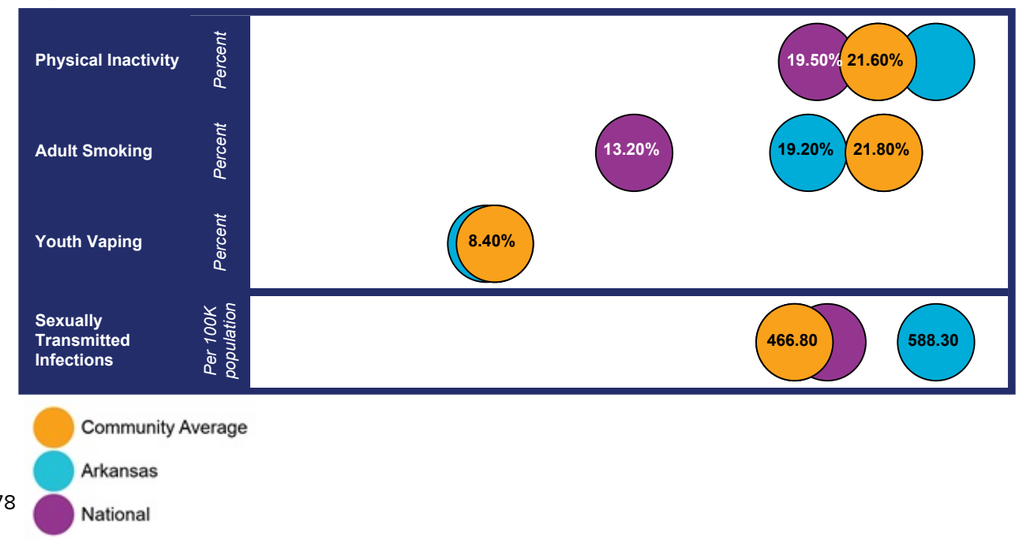


Table 10. Health Outcomes

		Hot Spring County	Community Average	State	National
Poor Physical Health Days	*Average number of physically unhealthy days reported in past 30 days (age-adjusted)*	5.40	5.40	5.20	3.90
Poor or Fair Health	*Percentage of adults age 18 and older who self-report their general health status as "fair" or "poor" (age-adjusted)*	24.00%	24.00%	22.60%	17.00%

Figure 11. Health Outcomes

Table 11. Healthcare Expenditures

		Hot Spring County	Community Average	State	National
Average Annualized Expenditures	*Average annualized per-person spending on all covered healthcare services.*	**$11,038**	**$11,038**	**$10,116**	**Not Available**
Average Annualized Expenditures (Medical Only)	*Average annualized per-person spending on medical services, based on medical claims.*	**$7,826**	**$7,826**	**$7,252**	**Not Available**
Average Annualized Expenditures (Pharmacy Only)	*Average annualized per-person spending on prescription drugs, based on pharmacy claims.*	**$2,983**	**$2,983**	**$2,609**	**Not Available**

Figure 12. Healthcare Expenditures

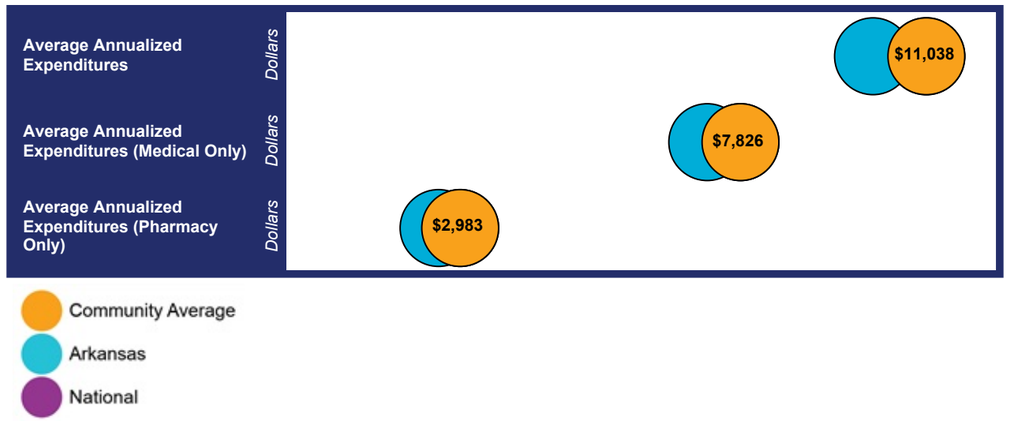


Table 12. Maternal and Infant Health

		Hot Spring County	Community Average	State	National
Active Obstetrics and Gynecology Physicians	*Active OB-GYN physicians are defined as those who provided evaluation and management services to at least two female patients ages 12-55 on the same day or performed a qualifying procedure (e.g., delivery) at least once during the year.*	**3.50**	**3.50**	**3.20**	**Not Available**
Teen Births	*The seven-year average number of teen births per 1,000 female population, ages 15-19*	**32.00**	**32.00**	**27.90**	**15.50**
C-Section Rate	*Percentage of live births delivered via cesarean section among all deliveries, calculated by the mother's county of residence.*	**33.40%**	**33.40%**	**33.48%**	**Not Available**
C-Section Rate, First Birth	*Percentage of first-birth deliveries (full-term singleton pregnancies in a head-down position) delivered via cesarean section, calculated by the mother's county of residence.*	**22.34%**	**22.34%**	**27.58%**	**Not Available**
Low Birthweight	*Percentage of live births where the infant weighed less than 2, 500 grams (approximately 5 lbs., 8 oz.)*	**9.10%**	**9.10%**	**9.40%**	**8.40%**
Preterm Birth	*Percentage of live births that are preterm (<37 weeks), calculated as a three-year average.*	**12.90%**	**12.90%**	**11.90%**	**10.35%**
Median Travel Time to Delivery	*Median number of minutes Arkansas mothers traveled from their home ZIP code to the delivery facility, calculated using birth records and*	**27.00**	**27.00**	**16.00**	**Not Available**

Figure 13. Maternal and Infant Health

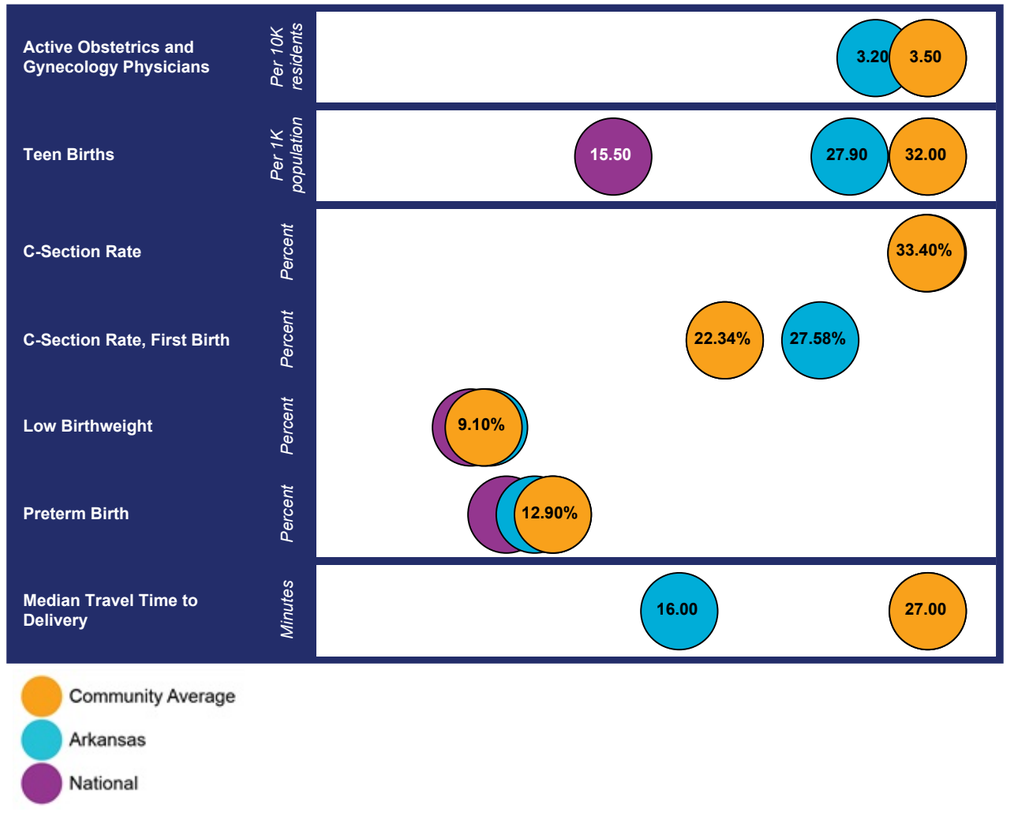


Table 13. Mental Health and Substance Use

		Hot Spring County	Community Average	State	National
Adult Depression	*Percentage of adults age 18 and older who report having been told that they had depressive disorder*	27.30%	27.30%	27.50%	21.10%
Excessive Drinking	*Percentage of adults reporting binge or heavy drinking*	18.30%	18.30%	18.99%	19.35%
Poor Mental Health	*Percentage of adults age 18 or older reporting poor mental health for 14 or more days (age-adjusted)*	20.80%	20.80%	20.50%	16.40%
Youth Depression	*Percentage of public school students in 6th, 8th, 10th, and 12th grade who had feelings of depression all of the time in the past 30 days*	10.70%	10.70%	9.20%	Not Available
Drug Overdose Deaths	*Age-adjusted rate of fatal drug overdoses per 100,000 residents*	Not Available	Not Available	Not Available	Not Available
Non-Fatal Drug Overdoses	*Age-adjusted rate of non-fatal drug overdoses per 100,000 residents*	53.66	53.66	Not Available	Not Available

Figure 14. Mental Health and Substance Use

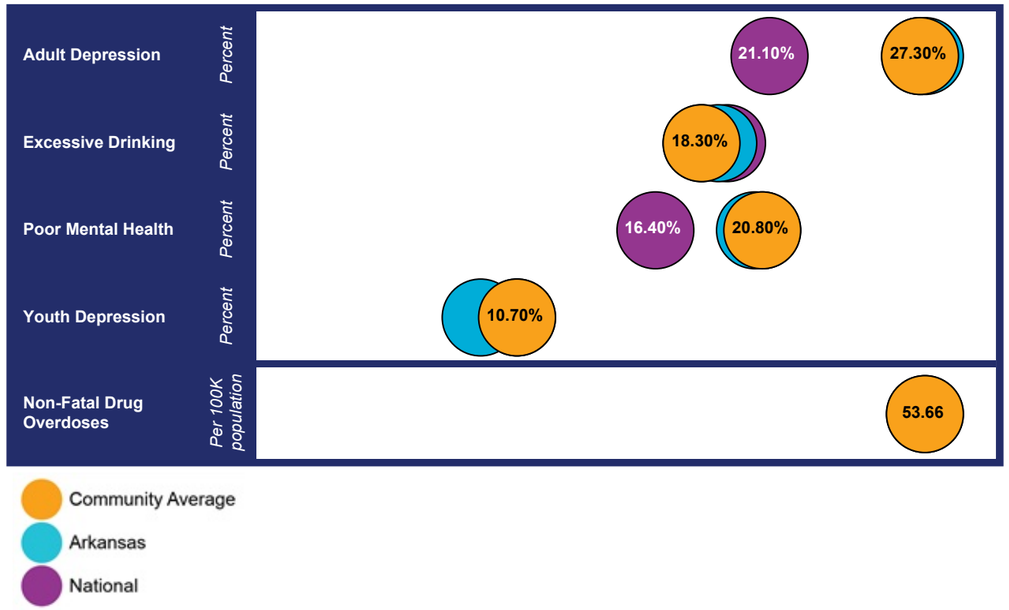


Table 14. Prevention

		Hot Spring County	Community Average	State	National
Cervical Cancer Screening	*Percentage of females age 21–65 years who report having had recommended cervical cancer screening test (age-adjusted)*	80.50%	80.50%	81.20%	83.70%
Colorectal Cancer Screening	*Percentage of adults age 45-75 who have had a recent colorecal cancer screening*	61.70%	61.70%	61.60%	66.30%
Dental Care Utilization	*Dental care visit (past 1 year), age-adjusted percentage of adults age 18+ by county*	51.20%	51.20%	54.10%	63.40%
High Blood Pressure Management	*Percentage of adults age 18 and older with high blood pressure who report taking blood pressure medication (age-adjusted)*	61.20%	61.20%	61.40%	58.90%
Prevention - Seasonal Influenza Vaccine	*Percentage of adults aged 18 and older who report receiving an influenza vaccination in the past 12 months*	40.50%	40.50%	43.20%	44.80%
Annual Wellness Exam (Medicare)	*Percentage of annual wellness visits among the Medicare fee-for-service (FFS) population*	52.00%	52.00%	46.00%	44.00%
No HIV Test	*Percentage of adults ages 18 or older who have never been screened for HIV*	70.80%	70.80%	66.10%	Not Available

Figure 15. Prevention

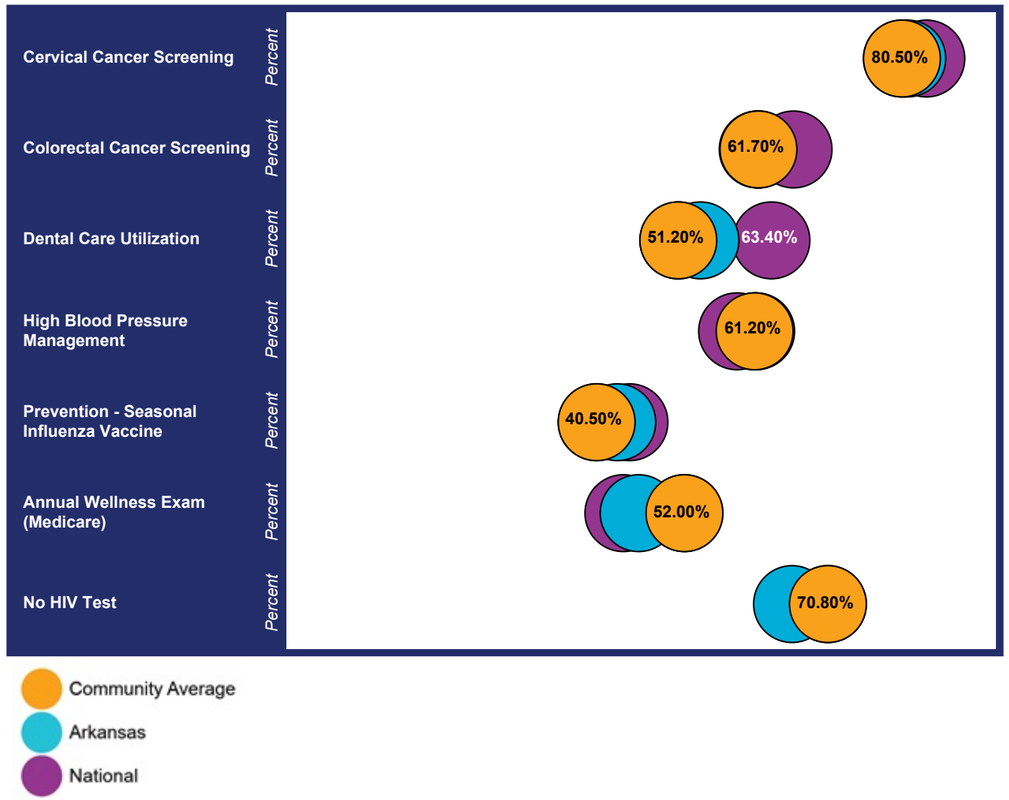
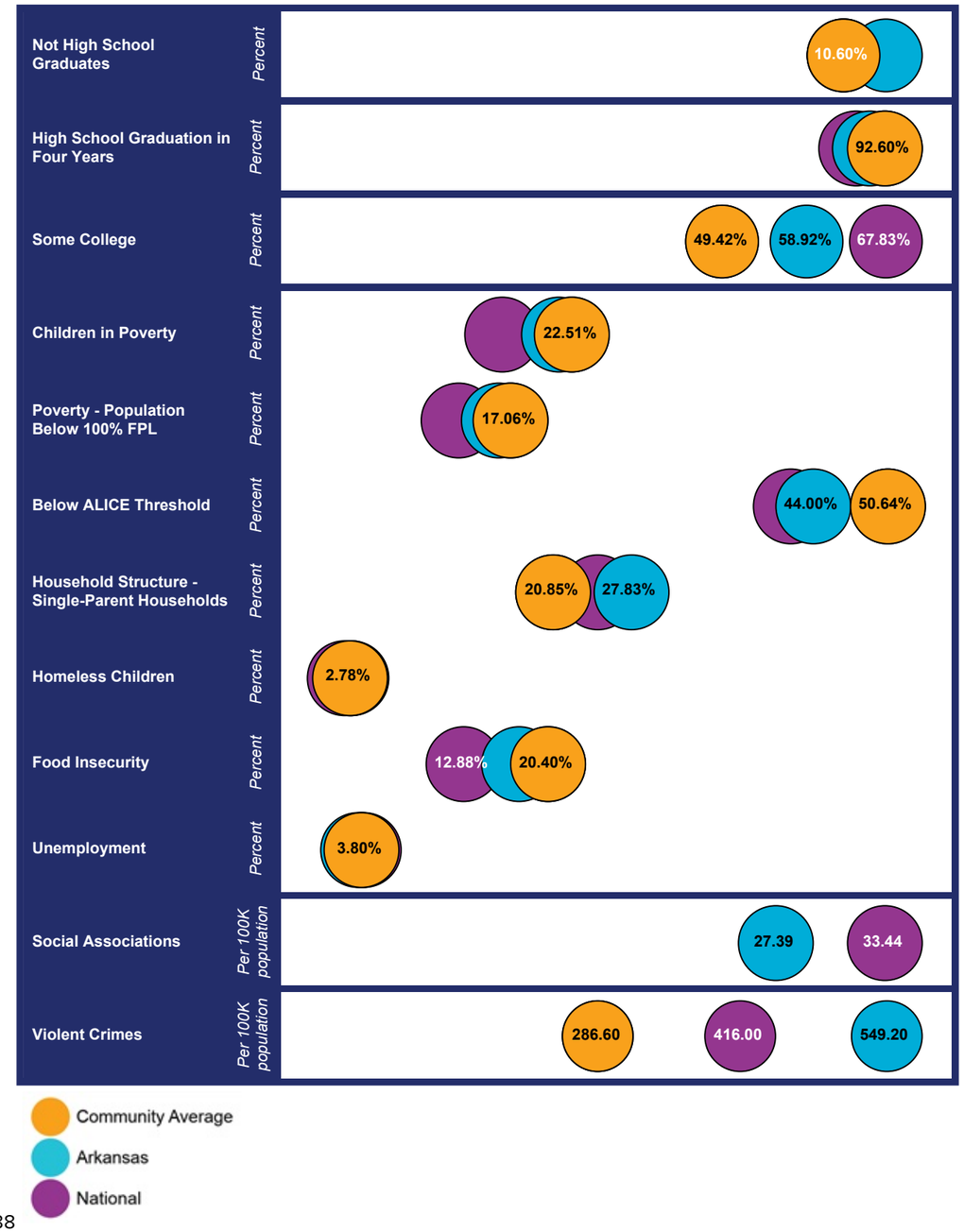


Table 15. Social and Economic Factors

		Hot Spring County	Community Average	State	National
Not High School Graduates	*Percentage of adults without a high school diploma*	**10.60%**	**10.60%**	**11.40%**	**10.60%**
High School Graduation in Four Years	*Percentage of ninth-grade cohort who graduated in four years*	**92.60%**	**92.60%**	**90.30%**	**88.20%**
Some College	*Percentage of adults ages 25-44 with some post-secondary education*	**49.42%**	**49.42%**	**58.92%**	**67.83%**
Children in Poverty	*Percentage of children under age 18 below the poverty line*	**22.51%**	**22.51%**	**21.37%**	**16.32%**
Poverty - Population Below 100% FPL	*Percentage of the population living in households with income below the federal poverty level*	**17.06%**	**17.06%**	**16.02%**	**12.44%**
Below ALICE Threshold	*Percentage of households living in poverty or classified as ALICE (Asset Limited, Income Constrained, Employed)*	**50.64%**	**50.64%**	**44.00%**	**42.00%**
Household Structure - Single-Parent Households	*Percentage of children who live in households where only one parent is present*	**20.85%**	**20.85%**	**27.83%**	**24.83%**
Homeless Children	*Percentage of students experiencing homelessness enrolled in the public school system*	**2.78%**	**2.78%**	**2.90%**	**2.31%**
Food Insecurity	*Percentage of the population that experienced food insecurity in the report year*	**20.40%**	**20.40%**	**17.82%**	**12.88%**
Unemployment	*Percentage of the civilian non-institutionalized population age 16 and older that is unemployed (non-seasonally adjusted)*	**3.80%**	**3.80%**	**3.50%**	**4.00%**
Social Associations	*Establishments, rate per 100,000 population*	**Not Available**	**Not Available**	**27.39**	**33.44**
Violent Crimes	*Annual rate of reported violent crimes per 100,000 population*	**286.60**	**286.60**	**549.20**	**416.00**

Figure 16. Social and Economic Factors



IDENTIFIED NEED 1:
Increase Access to Care and Education

GOALS/OBJECTIVE/OBJECTIVES:
Increase access to quality health care, preventive screenings, vaccinations, and community health resources for Hot Spring County.

STRATEGY 1:
Expand community outreach and strengthen partnerships with local nonprofits, schools, and employers to improve access and awareness .

ACTION STEPS:

- Utilize Telehealth and the Command Center to improve access and decrease barriers to care
- Host annual free flu shot events & childhood immunization clinics
- Launch a six-month “Wellness Meet-Up Series” open to the public, featuring monthly sessions on key wellness topics such as physical activity, mindful eating, stress management, and sleep health.
- Partner with local businesses and organizations to offer free health education and on-site screenings (e.g., blood sugar, blood pressure, BMI) and facilitate scheduling for primary care and mammogram appointments.
- Provide home monitoring devices (blood pressure/ glucose monitors primary care clinics
- Continue local and collaborations to expand access and reduce barriers to care
- Explore Resource Hub opportunities with area agencies to identify and promote community resources and social drivers of health support
- Maintain the financial assistance policy for patients who are uninsured, underinsured, ineligible for a government health care program, or otherwise unable to pay, for medically necessary or emergent care.
- Continue to evaluate the need to recruit physicians, advanced practice providers and support staff as necessary to meet community needs.
- Continue to provide education and wellness tips on news segments and social media.
- Increase access to Community-based maternal health educational programs and services

KEY PERFORMANCE METRICS:

- Provide preventive screenings, vaccinations, and related services to at least 200 community members
- Track and report the number of community outreach events hosted or attended by Baptist Health
- Measure and report the number of community members reached through health education, screenings, and outreach efforts.
- Evaluate referral and follow-up rates for individuals connected to primary or specialty care through outreach initiatives.
- Number of providers recruited will be tracked
- Charity Care will be tracked and reported

COLLABORATIONS WITH ORGANIZATIONS: Local nonprofits, faith-based organizations, community-based organizations

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS NEED: Staff time and clinical expertise, marketing and educational materials, community health supplies, vaccination resources, and ongoing support from the Marketing & Communications and Community Outreach

ESTIMATED COMPLETION DATE: Ongoing through 2028

PERSON(S)/DEPARTMENT RESPONSIBLE: Vice-President of Operations, Pharmacy, Administration, Community Outreach

IDENTIFIED NEED 1:
Increase Access to Care and Education

GOALS/OBJECTIVE/OBJECTIVES:
To improve community health by increasing health literacy and reducing barriers to accessing healthcare through community-led, culturally appropriate education and navigation support.

STRATEGY 2:
Health Literacy & Access to Healthcare

ACTION STEPS:
- Establish a Community Health Literacy committee including patient representatives, clinical staff, and community partners) to finalize the curriculum, set implementation timelines
- Identify target populations based on data and community need
- Launch community in-person, and virtual workshops to cover topics including understanding health information, communicating with healthcare providers, navigating healthcare, self-management and preventive health, understanding prescriptions, telehealth, patient rights
- Train community-based clinical and non-clinical staff in health-literate communication (e.g., Teach-Back, plain language)

KEY PERFORMANCE METRICS:
- Curriculum identified and vetted for implementation
- Track the number of classes offered and participants
- Track pre/post test results to determine knowledge gained
- Track number of staff trained to implement the program
- Identified number of encounters using the Teach-Back method

COLLABORATIONS WITH ORGANIZATIONS: Local nonprofits, faith-based organizations, community-based organizations

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS NEED: Staff time and clinical expertise, marketing and educational materials, community health supplies, vaccination resources, and ongoing support from the Marketing & Communications and Community Outreach

ESTIMATED COMPLETION DATE: Ongoing through 2028

PERSON(S)/DEPARTMENT RESPONSIBLE: Vice-President of Operations, Pharmacy, Administration, Community Outreach

IDENTIFIED NEED 1:
Increase Access to Care and Education

GOALS/OBJECTIVE/OBJECTIVE:
Financial Empowerment for Healthcare: The goal is to move participants from financial crisis management to proactive planning. show how sound budgeting and saving habits directly support access to care and health stability.

STRATEGY 3:
Financial Literacy & Access to Healthcare

ACTION STEPS:
- Identify a local Bank or Credit Union to partner in program delivery
- Partner with Community groups and organizations to implement class
- Incorporate Financial Literacy in Community Wellness Centers
- Incorporate Financial Literacy in Community Wellness Centers and Prenatal/Postpartum program by including the following educational topics
  - Control Your Money: Budgeting101
  - Understanding needs vs. wants, building a savings
  - Building a Savings for Emergencies and healthcare
  - Avoiding Money Traps: Debts & Credits
  - Protect Your Health: Financial Literacy
- Include information in all FoodRx bags (if applicable)
- Identify additional resources for referrals beyond classes

KEY PERFORMANCE METRICS
- Track the number of classes offered and number of participants
- Utilize pre and post test to determine knowledge gain
- Track number of community partners identified and utilized for implementation
- Track number of referrals for financial assistance

COLLABORATIONS WITH ORGANIZATIONS: Local nonprofits, local banks, cooperative extension organizations

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS NEED:
Staff time and clinical expertise, marketing and educational materials, community health supplies, vaccination resources, and ongoing support from the Marketing & Communications and Community Outreach

ESTIMATED COMPLETION DATE: Ongoing through 2028

PERSON(S)/DEPARTMENT RESPONSIBLE: Vice-President of Operations, Community Outreach

IDENTIFIED NEED 2:
The Community Mental Health Strategy: Access, Education, Acceptance

GOALS/OBJECTIVE/OBJECTIVES:
Improve and increase access to mental health services, reduce stigma, and promote emotional well-being for residents of the Pulaski County

STRATEGY:
Strengthen collaboration with employers, healthcare providers, and community organizations to expand mental health education, increase access to counseling and crisis resources, and promote early intervention and resilience-building initiatives.

ACTION STEPS:
- Partner with healthcare organizations, locally and statewide, to increase the capacity to provide additional mental health services.
- Implementation Project to increase in-patient mental and behavioral health services.
- Provide Mental Health First Aid training to local schools, colleges, and community or faith-based organizations.
- Provide Community-based Stop the Bleed Trainings
- Participate in System-wide Mental Health Awareness Campaigns
- Partner with local schools and colleges to increase mental health awareness
- Integrate Mental Health Education and Awareness materials into Schools and Workplaces
- Utilize Telepsych for patients in need of Telemedicine services

KEY PERFORMANCE METRICS:
- Track number of patient encounters in-patient withdrawal management services
- Track number of patient encounters utilizing Telepsych services
- Report number of Community partners and events for mental health services
- Track the number of mental health first aid and Stop the Bleed classes and participants
- Track the number of Mental Health First Aid trainings and attendance
- Measure campaign's reach through social media engagement, website visits, and printed material distribution.

COLLABORATIONS WITH ORGANIZATIONS: Local schools, universities and businesses, non-profits and faith-based organizations.

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS NEED: Staff time and clinical expertise, marketing and educational materials, community health supplies and ongoing support from the Marketing & Communications and behavioral health, command center and Community Outreach teams.

ESTIMATED COMPLETION DATE: Ongoing through 2028.

PERSON(S)/DEPARTMENT RESPONSIBLE: VP of Operations, Behavioral Health, Community Outreach Director Marketing & Communications Manager, Case Management.

IDENTIFIED NEED 3:
Closing the Gap: A Strategy for Healthy Communities and Nutrition Security

GOALS/OBJECTIVE:
Reduce food insecurity for inpatients and improve nutrition knowledge among in-patients and general community through education, outreach, and collaboration with local partners.

STRATEGY:
Expand community partnerships and implement interactive nutrition education programs that empower residents with practical skills and resources to reduce food insecurity and promote healthier eating habits.

ACTION STEPS:
- Pilot FoodRx Program for inpatients identified as food insecure.
- Explore funding opportunities in partnership with Baptist Health Foundation to expand FoodRx Program and or Blessing box to employees
- Continue partnering with the Baptist Health Community Outreach Department, community organizations—including local school districts to provide free, engaging education on healthy eating and nutrition.
- Educate staff on food insecurity and resources within our community that can benefit our patients and fellow staff members.
- Launch a "Wellness Meet-Up Series" open to the public, featuring monthly sessions on key wellness topics such as physical activity, mindful eating, stress management, and sleep health.
- Implement a "Maintain Don't Gain" Holiday nutrition education challenge in partnership with Community Outreach

KEY PERFORMANCE METRICS:
- Track percentage of patients screened for food insecurity
- Track and report number of patients identified as food insecure during screening
- Track number of referrals for food resources
- Track and report number of FoodRx bags given to patients during timeframe
- Track and report number of FoodRx bags given to employees (if funding is secured to expand program)
- Track the amount of grant/external funding secured toward the sustainability goal

COLLABORATIONS WITH ORGANIZATIONS: Arkansas Foodbank, local non-profits, local food pantries

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS NEED: Staff time and clinical expertise, marketing and educational materials, community health supplies and ongoing support from the Marketing & Communications and Community Outreach teams.

ESTIMATED COMPLETION DATE: Ongoing through 2028

PERSON(S)/DEPARTMENT RESPONSIBLE: VP of Operations, Community Outreach Team, Marketing & Communications Manager, Case Management

BAPTIST HEALTH MEDICAL CENTER-
North Little Rock

About Us

Baptist Health Medical Center-North Little Rock became part of Baptist Health in 1962. The medical center offers comprehensive services delivered in an inviting, less institutionalized setting. The design was based on community research with a focus on patient-centered care. There are 225 patient beds ensuring timely admissions to the hospital. Two medical office buildings are located on the campus, allowing doctors and patients convenient access to the hospital.

The Emergency Department at Baptist Health Medical Center-North Little Rock provides emergency care for adult and pediatric patients 24 hours per day, seven days per week, supported by our full-service hospital. Our experienced physicians are dedicated to providing high-quality, patient-centered care for emergency medical conditions including heart attack, stroke, injuries, major illness and more. We employ APRNs in triage areas for faster screening and easier access, and we have Level III trauma services, providing prompt assessment, resuscitation, surgery, intensive care and stabilization of injured patients and emergency operations.

This facility also offers Invenia ABUS 2.0 (Automated Breast Ultrasound System) technology for breast cancer detection in women with dense breast tissue. This ultrasound procedure is the only ultrasound technology of its kind approved by the FDA and when used in addition to your mammogram, will provide a more complete evaluation of dense breast tissue.

Community Health Needs Assessment 2026-2028
Baptist Health Medical Center-North Little Rock

HIGHLIGHTS OF COMMUNITY HEALTH NEEDS ASSESSMENT ACCOMPLISHMENTS 2023-2025

Access to Care

- Baptist Health in partnership with the City of North Little Rock and supports the area, which is experiencing growth with new homes and factories, by providing necessary infrastructure, including reliable local healthcare
- Coordinated Heaven's Loft, an incentive-based program that drives utilization of prenatal and well-baby care among low-income mothers by rewarding attendance with coupons redeemable for essential baby supplies (e.g., car seats, diapers). More than 600 patient encounters.
- Conducted health screenings and vaccinations at more than 75 special events, with more than 1,800 patient encounters. Vaccinations for influenza, COVID-19 (2023) and childhood immunizations totaled more than 1,100.
- Community Wellness Centers had just over 4,000 patient encounters with preventative screenings and vaccinations.
- The Community Clinic in Rose City opened September 2024. The clinic distributed 30 glucose monitors, 16 blood pressure machines and 21 food bags for patients during its first year of operation.

Mental Health Awareness

- Expanded Behavioral Health Treatment Capacity increasing the number of beds available for adults (ages 18-65) needing intensive psychiatric care for conditions like depression, anxiety, grief, and psychosis.
- Developed Specialized Mental Health Infrastructure including a new inpatient unit, an outpatient behavioral health clinic and a memory care clinic.
- Launched a Psychiatry Residency Training Program in North Little Rock is a long-term strategy to ensure a robust supply of mental health professionals.

Food Insecurity/Nutition

- Distributed 2,071 bags of food, providing approximately 43,000 meals of essential, shelf-stable nutrition to the community.
- Conducted three Grocery Store Tours using the Cooking Matters curriculum, directly teaching nine participants practical skills in budgeting and healthy food selection.
- Successfully delivered a comprehensive 8-week "Weight Wise" series, engaging 19 participants in long-term health and weight management education.
- Led four "Eat Smart Live Strong" classes, resulting in 48 participant encounters focused on improving nutrition for older adults.
- Successfully launched the Healthy Active Youth and Families Program, transforming it into a holistic, nine-week family-centric model that pairs one-on-one health coaching with experiential learning (e.g., garden tours, fitness challenges) to improve mental health, nutrition, and physical activity; notably, this initiative pioneered the use of the "Veggie Meter" technology for objective, non-invasive measurement of fruit and vegetable consumption.

2025 BAPTIST HEALTH COMMUNITY HEALTH NEEDS ASSESSMENT: NORTH LITTLE ROCK

ACHI
August 2025

Baptist Health

PREPARED BY:
ACHI
INSPIRING HEALTHY ACTS

Introduction

Baptist Health engaged the Arkansas Center for Health Improvement (ACHI) to conduct the quantitative data collection and analysis for the 2025 Community Health Needs Assessment (CHNA) process. Baptist Health provided ACHI with the counties served by each of its 12 hospital communities. A total of 16 Arkansas counties and two Oklahoma counties were included.

Each report presents community-level data for a hospital community, including tables and figures for each indicator, along with comparisons to Arkansas and U.S. benchmarks. Dot graphs are provided to visualize performance across selected indicators. All reports are prepared using the same methodology to ensure consistency and comparability across Baptist Health hospital communities.

Methodology

A summary of sources, definitions, indicator criteria, and suppression rules can be found in the methods and sources document.

Community Profile Summary

To support the 2025 Community Health Needs Assessment (CHNA), ACHI compiled a comprehensive dataset of 103 health and demographic indicators for the communities served by Baptist Health's 12 hospital locations. This section provides an overview of these indicators across the full CHNA service area and offers multiple views for understanding and comparing county-level and community-level data.

Data are grouped into the following 14 categories, based on the source-defined domains outlined in the data source reference sheet:

1. Demographics
    a. Age
    b. Sex
    c. Race, Ethnicity, and Language
2. Insurance Coverage
3. Access to Care
4. Cause of Death
5. Chronic Conditions
6. Diagnoses Incidence at Discharge
7. Environment
8. Health Behaviors
9. Health Outcomes
10. Healthcare Expenditures
11. Maternal and Infant Health
12. Mental Health and Substance Use
13. Prevention
14. Social and Economic Factors

Measurements for these categories will be displayed in the following sections.

Hospital Community Indicator

The hospital community indicator snapshots offer an at-a-glance view of how each hospital community compares to state and national benchmarks, as well as the counties that make up the community.

Each table presents the data values for selected indicators across the 14 CHNA domains, and each corresponding visual uses proportionally scaled circular markers to illustrate performance. This format is designed to quickly convey how each hospital community aligns with or diverges from broader benchmarks in key population health metrics.

Each displays four comparison points:

- **Purple** – Represents the national value for the indicator.
- **Blue** – Represents the value for the state of Arkansas.
- **Gold** – Represents the weighted average for all counties in the hospital's defined service area.
- **Gray** – Represent the values of each county assigned to that hospital community.

Where available, data for each indicator are shown for all four categories. If a value is not available or is suppressed for a contributing county, it is noted as "Not Available" in the table and excluded from the visual display. No color ranking is applied; the visuals and tables are intended to illustrate relative placement, not comparative rank.

Hospital Community: North Little Rock (Lonoke and Pulaski Counties)

Figure 1. Counties Served by Baptist Health Medical Center–North Little Rock

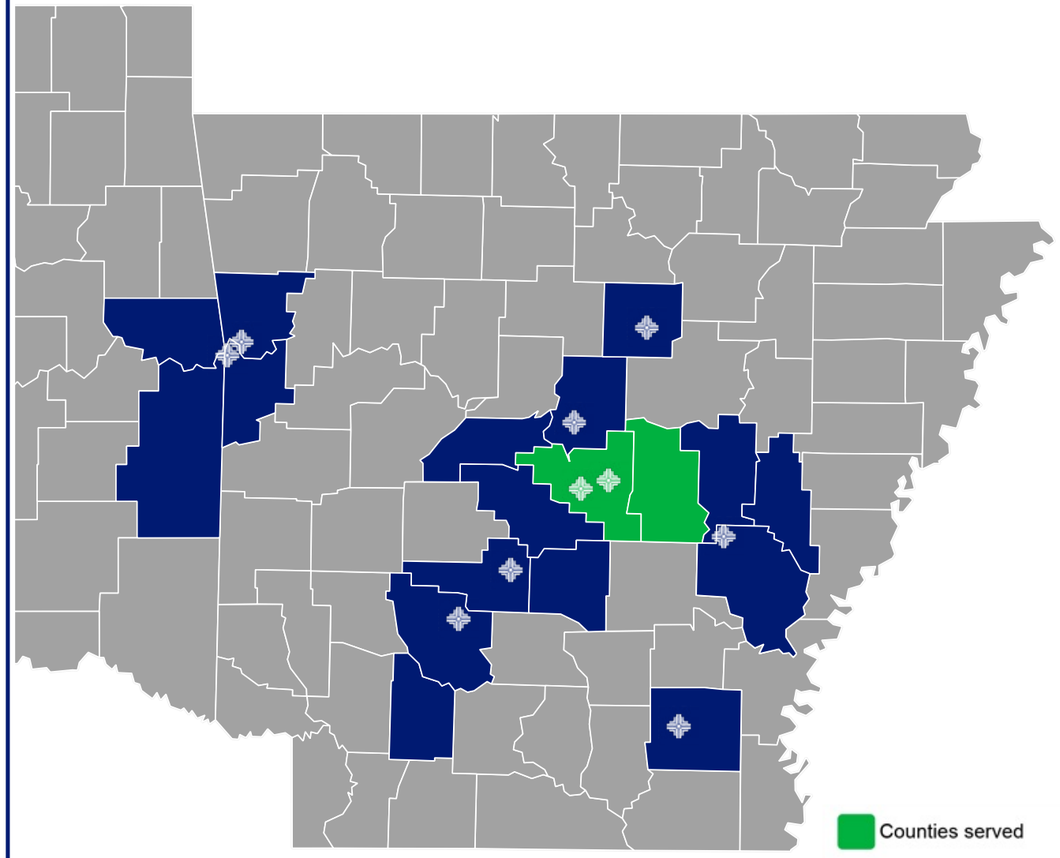


Table 1. Demographics: Age and Sex

		Lonoke County	Pulaski County	Community Average	State	National
Total Population	*Number*	74,747	398,949	473,696	3,032,651	332,387,540
Female	*Percent*	50.57%	52.15%	51.90%	50.67%	50.50%
Male	*Percent*	49.43%	47.85%	48.10%	49.33%	49.50%
Ages 0-4	*Percent*	6.11%	6.34%	6.30%	6.02%	5.70%
Ages 5-17	*Percent*	18.88%	17.08%	17.36%	17.26%	16.46%
Ages 18-24	*Percent*	7.75%	8.77%	8.61%	9.33%	9.12%
Ages 25-34	*Percent*	13.93%	14.42%	14.34%	12.93%	13.69%
Ages 35-44	*Percent*	14.08%	13.05%	13.21%	12.66%	13.08%
Ages 45-54	*Percent*	12.63%	11.73%	11.87%	11.84%	12.29%
Ages 55-64	*Percent*	12.24%	12.35%	12.33%	12.64%	12.82%
Ages 65+	*Percent*	14.39%	16.25%	15.96%	17.33%	16.84%

Figure 2. Demographics: Age and Sex

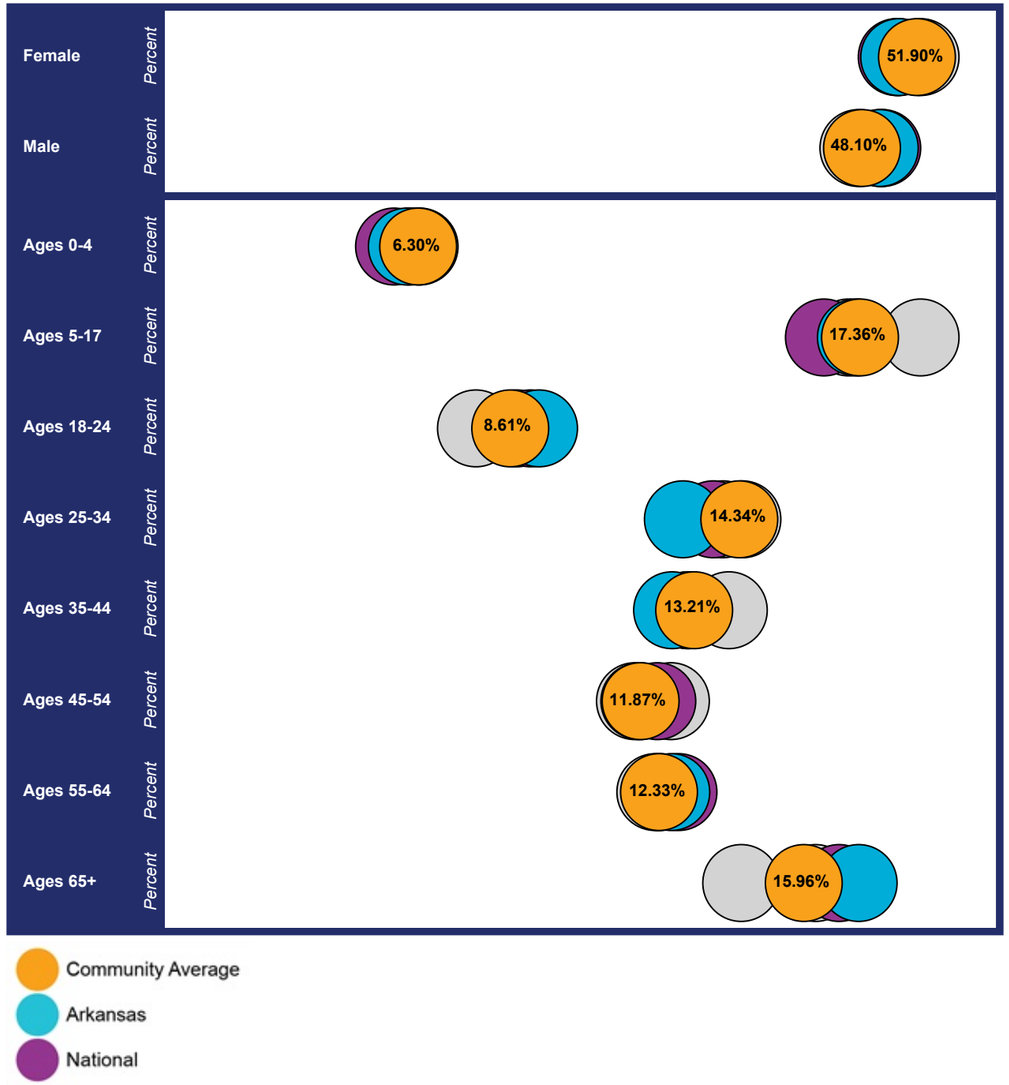


Table 2. Demographics: Race, Ethnicity, and Language

		Lonoke County	Pulaski County	Community Average	State	National
Total Population	*Number*	74,747	398,949	473,696	3,032,651	332,387,540
Asian	*Percent*	1.09%	2.13%	1.97%	1.53%	5.75%
Black or African American	*Percent*	5.50%	36.72%	31.79%	14.84%	12.03%
Hispanic	*Percent*	5.18%	8.20%	7.72%	8.77%	18.99%
Multiple Races	*Percent*	4.23%	3.69%	3.78%	5.50%	3.87%
Native American/ Alaska Native	*Percent*	0.08%	0.21%	0.19%	0.36%	0.53%
Native Hawaiian/ Pacific Islander	*Percent*	0.16%	0.04%	0.06%	0.39%	0.17%
Other Races	*Percent*	0.16%	0.30%	0.28%	0.26%	0.50%
White	*Percent*	83.60%	48.70%	54.21%	68.36%	58.17%
Non-English Language Households	*Percent*	0.70%	1.80%	1.63%	1.50%	4.20%

Figure 3. Demographics: Race, Ethnicity, and Language

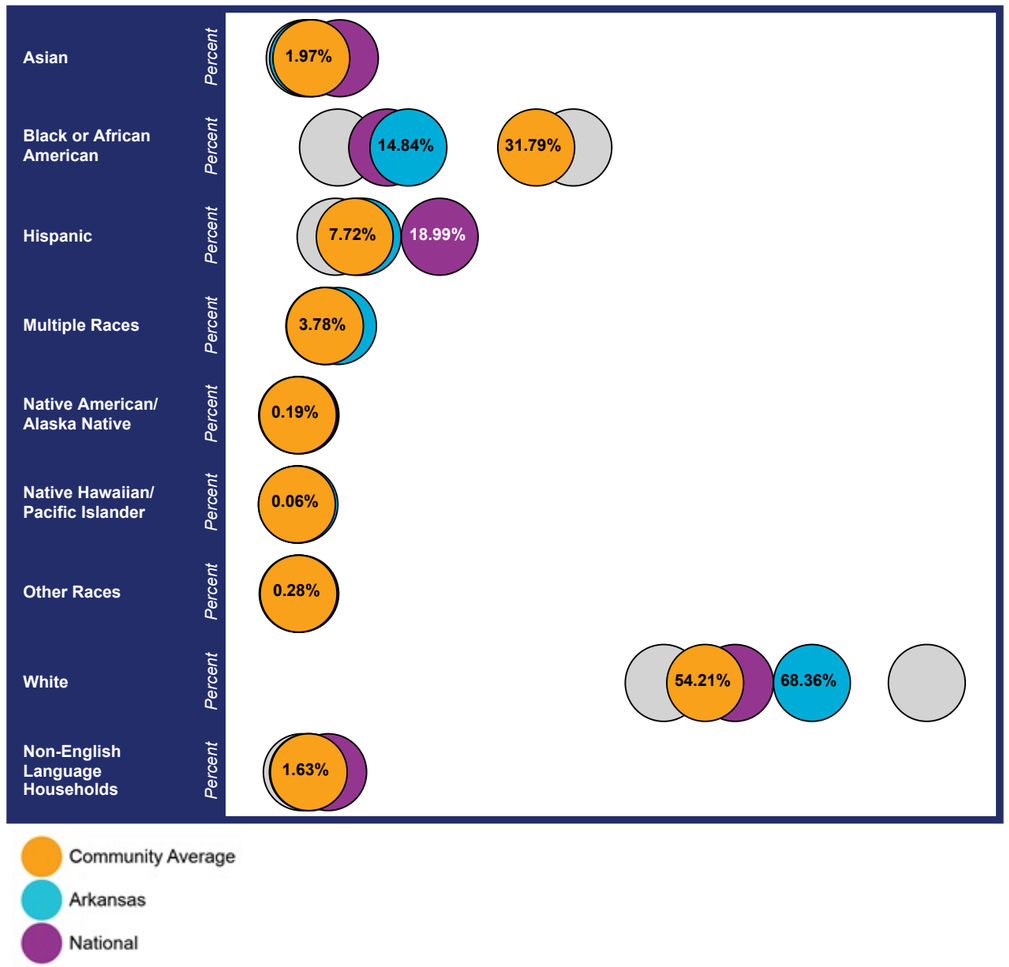


Table 3. Insurance Coverage

		Lonoke County	Pulaski County	Community Average	State	National
Private Health Insurance Coverage	*Percentage of the total civilian non-institutionalized population for whom insurance status is determined that is covered by private health insurance*	74.53%	68.22%	69.22%	65.37%	73.62%
Public Health Insurance Coverage	*Percentage of the total civilian non-institutionalized population for whom insurance status is determined that is covered by public health insurance*	40.40%	45.65%	44.82%	48.21%	39.70%
Uninsured	*Percentage of adults under age 65 without health insurance coverage*	8.60%	9.00%	8.94%	10.00%	9.50%

Figure 4. Insurance Coverage

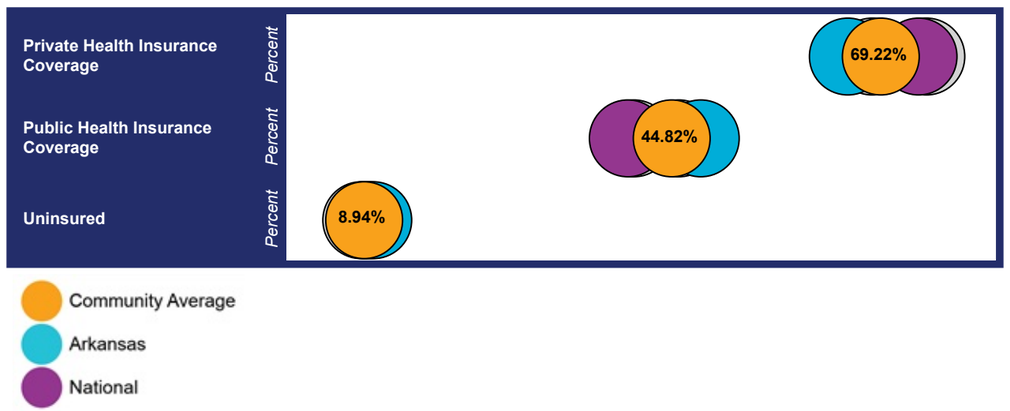


Table 4. Access to Care

		Lonoke County	Pulaski County	Community Average	State	National
Primary Care Physicians	*Ratio of population to one primary care physician*	6792:1	848:1	1786:1	1478:1	1334:1
Mental Health Providers	*Ratio of population to one mental health provider*	904:1	189:1	216:1	367:1	300:1
Dentists	*Ratio of population to one dentist*	3419:1	1300:1	1441:1	2044:1	1361:1
Active Primary Care Physicians	*Rate per 10,000 county residents of primary care physicians who provided evaluation and management services to at least two patients on the same day at least once during the year*	6.60	27.60	24.29	9.20	Not Available
Addiction or Substance Use Providers	*Rate of addiction or substance use providers per 100,000 population*	0.00	10.52	8.86	5.98	29.43
Buprenorphine Providers	*Rate of buprenorphine providers per 100,000 population*	1.34	19.35	16.51	9.81	14.87
Preventable Hospital Stays (Medicare)	*Rate of hospital stays for ambulatory care-sensitive conditions per 100,000 Medicare enrollees*	2812.00	2682.00	2702.51	3014.00	2666.00
Diabetic Monitoring (Medicare)	*Percentage of Medicare enrollees aged 65 and older with diabetes who received a hemoglobin A1c (HbA1c) test within the past year.*	90.76%	88.61%	88.95%	88.47%	87.53%
Mammography	*Percentage of female Medicare enrollees ages 65-74 who received an annual mammography screening*	42.00%	45.00%	44.53%	41.00%	44.00%

Figure 5. Access to Care

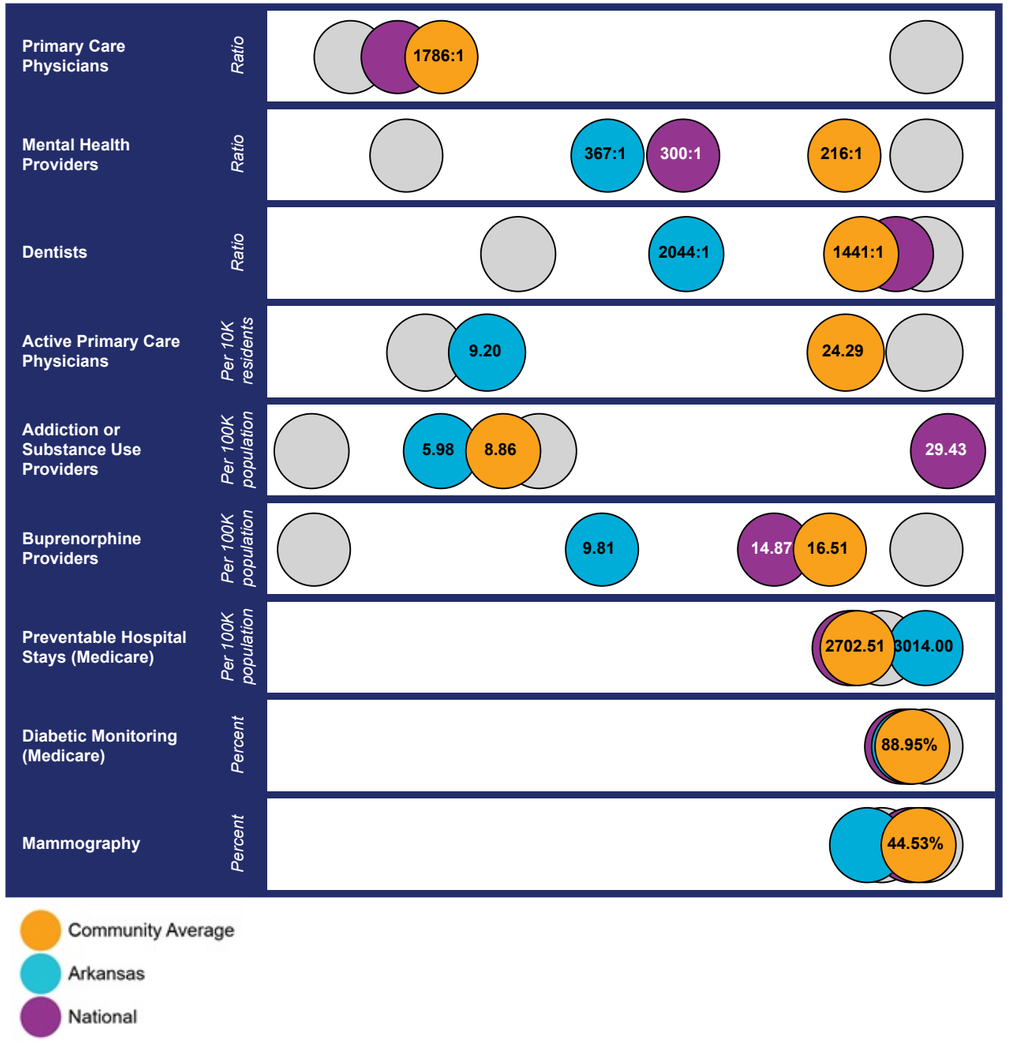


Table 5. Cause of Death

		Lonoke County	Pulaski County	Community Average	State	National
All Causes	*Rate of deaths by all causes per 100,000 population (age-adjusted)*	1036.40	955.20	968.01	1001.70	805.60
Premature Death	*Number of deaths among residents under age 75 per 100,000 population (age-adjusted)*	507.06	545.57	539.49	552.47	406.59
Heart Disease	*Rate of death due to heart disease (ICD-10 Codes I00-I09, I11, I13, I20-I151) per 100,000 population*	222.70	222.80	222.78	282.80	207.20
Cancer	*5-year average rate of death due to cancer per 100,000 population*	190.80	188.90	189.20	215.90	182.70
Unintentional Injury	*5-year average rate of death due to unintentional injury (accident) per 100,000 population*	54.70	69.90	67.50	61.90	63.30
Stroke	*5-year average rate of death due to cerebrovascular disease (stroke) per 100,000 population (age-adjusted)*	59.20	53.50	54.40	57.40	48.30
Chronic Lower Respiratory Disease	*Rate of deaths due to chronic lower respiratory disease per 100,000 population (age-adjusted)*	62.00	41.70	44.90	61.00	35.90
Diabetes Mortality	*Rate of deaths due to diabetes per 100,000 population (age-adjusted)*	61.80	40.80	44.11	34.70	23.90
Suicide Deaths	*This indicator reports the 2019-2023 five-year average rate of death due to intentional self-harm (suicide) per 100, 000 population. Figures are reported as crude rates*	15.80	16.10	16.05	19.20	14.50
Motor Vehicle Crash	*5-year average rate of death due to motor vehicle crash per 100,000 population (age-adjusted)*	19.80	20.80	20.64	20.60	12.80
Alcohol-Involved Motor Vehicle Crash	*Rate of persons killed in motor vehicle crashes involving alcohol as a rate per 100,000 population*	2.70	3.80	3.63	3.10	2.30

Figure 6. Cause of Death

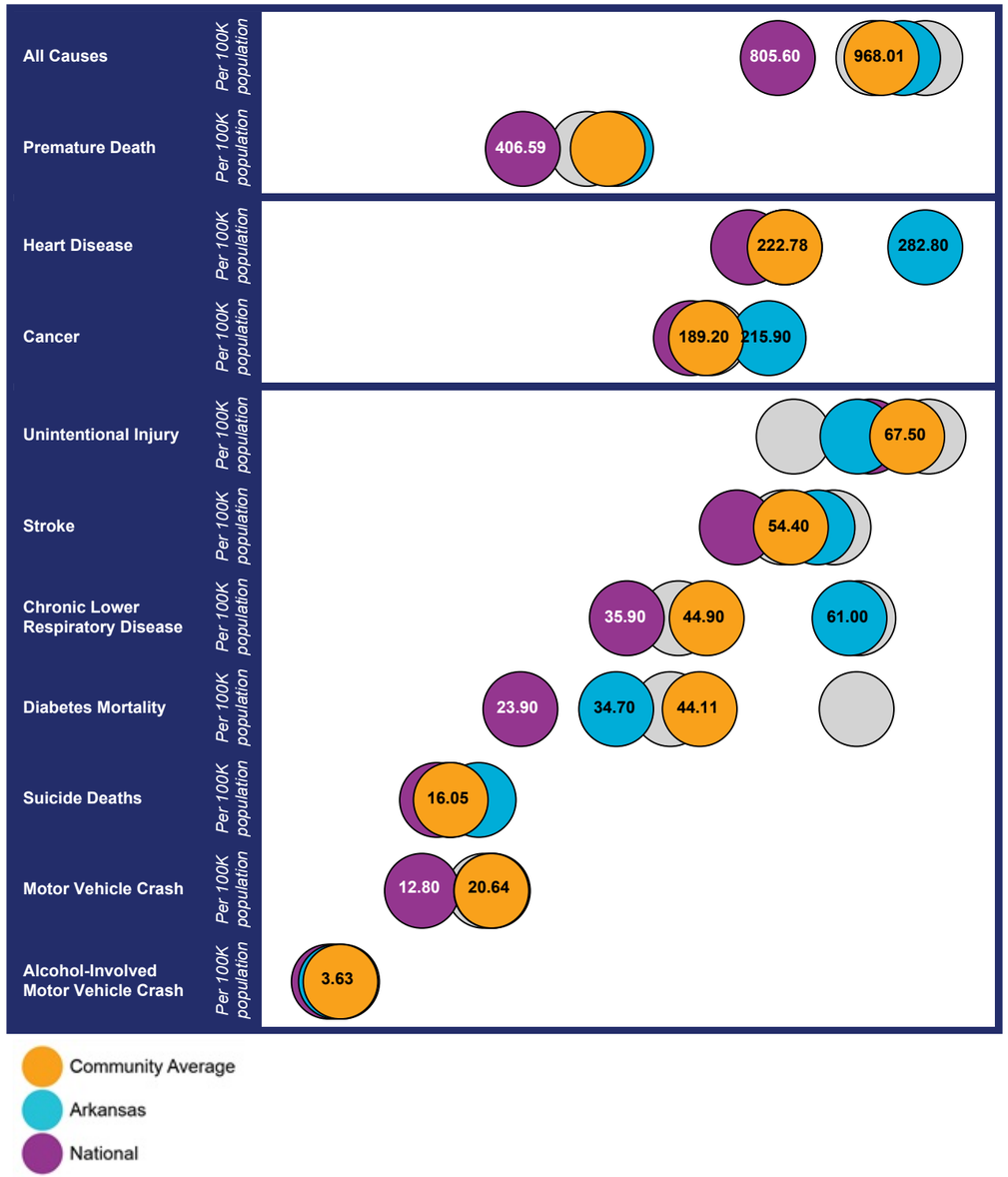


Table 6. Chronic Condtions

		Lonoke County	Pulaski County	Community Average	State	National
Child Obesity	*Percentage of students classified as overweight to severely obese, by county location of school*	36.86%	38.89%	38.57%	40.10%	Not Available
High Cholesterol	*Percentage of adults who have had their blood cholesterol checked and have been told it was high (age-adjusted)*	32.10%	30.10%	30.42%	31.80%	30.40%
Adult Obesity	*Percentage of adults ages 20 and older who report a BMI higher than 30*	32.50%	34.90%	34.52%	31.90%	30.10%
High Blood Pressure	*Percentage of adults who have been told they have high blood pressure (age-adjusted)*	35.50%	38.00%	37.61%	36.50%	29.60%
Arthritis	*Percentage of adults ages 18 or older diagnosed with some form of arthritis*	28.60%	28.00%	28.09%	32.60%	Not Available
Diabetes Prevalence	*Percentage of adults age 18 and older who report ever been told that they have diabetes other than diabetes during pregnancy (age-adjusted)*	11.80%	12.70%	12.56%	12.70%	10.40%
Asthma	*Percentage of adults who have been told they currently have asthma (age-adjusted)*	10.90%	10.80%	10.82%	11.00%	9.90%
Coronary Heart Disease	*Percentage of adults age 18 and older who report ever having been told by that they had angina or coronary heart disease (CHD) (age-adjusted)*	7.00%	6.60%	6.66%	7.20%	5.70%

Figure 7. Chronic Conditions

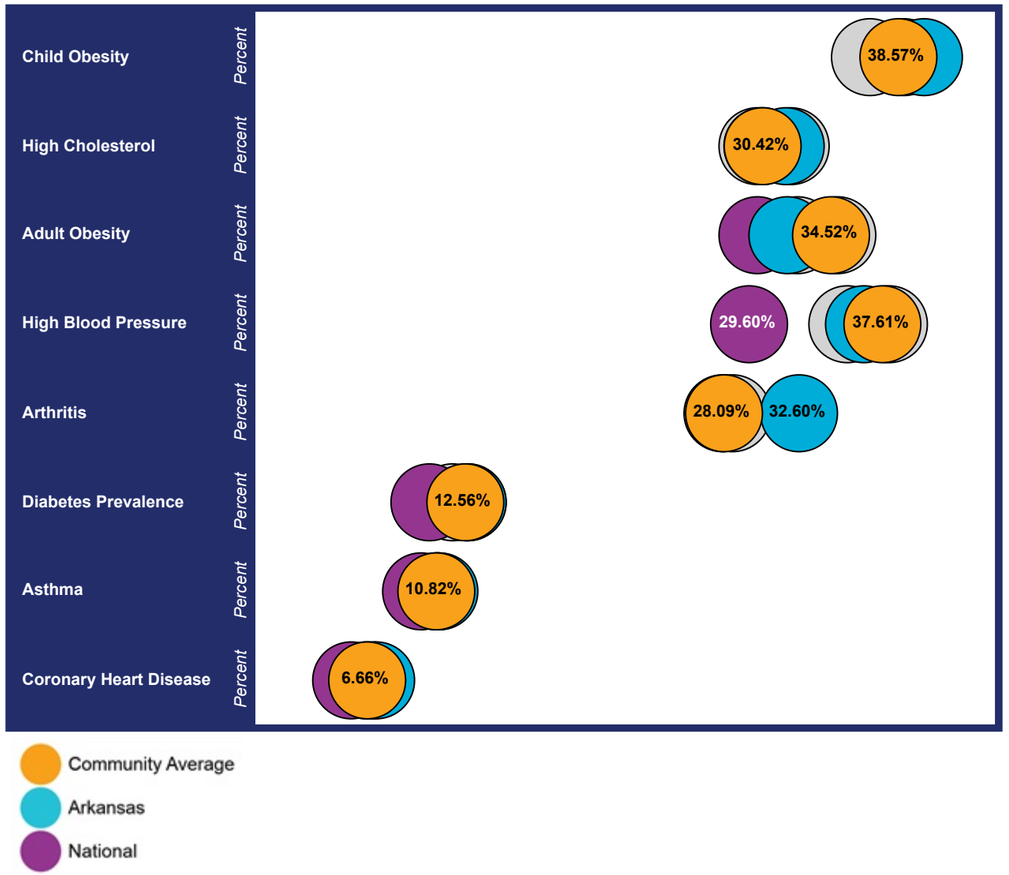


Table 7. Diagnoses at Discharge

		Lonoke County	Pulaski County	Community Average	State
Hypertension	*Number of individuals 18 years and older discharged with a primary or secondary hypertension diagnosis as a percentage of the population 18 years and older*	6.66%	8.12%	7.89%	8.70%
Hyperlipidemia	*Number of individuals 18 years and older discharged with a primary or secondary hyperlipidemia diagnosis as a percentage of the population 18 years and older*	2.60%	2.77%	2.74%	3.90%
Diabetes	*Rate of individuals 18 years and older discharged with a primary or secondary diabetes diagnosis as a percentage of the population 18 years and older*	2.72%	3.13%	3.07%	3.70%
Ischemic Heart Disease	*Number of individuals 18 years and older discharged with a primary or secondary ischemic heart disease diagnosis as a percentage of the population 18 years and older*	1.62%	1.54%	1.55%	2.50%
Arthritis	*Rate of individuals 18 years and older discharged with a primary or secondary arthritis diagnosis as a percentage of the population 18 years and older*	1.33%	1.42%	1.41%	1.90%

Figure 8. Diagnoses at Discharge

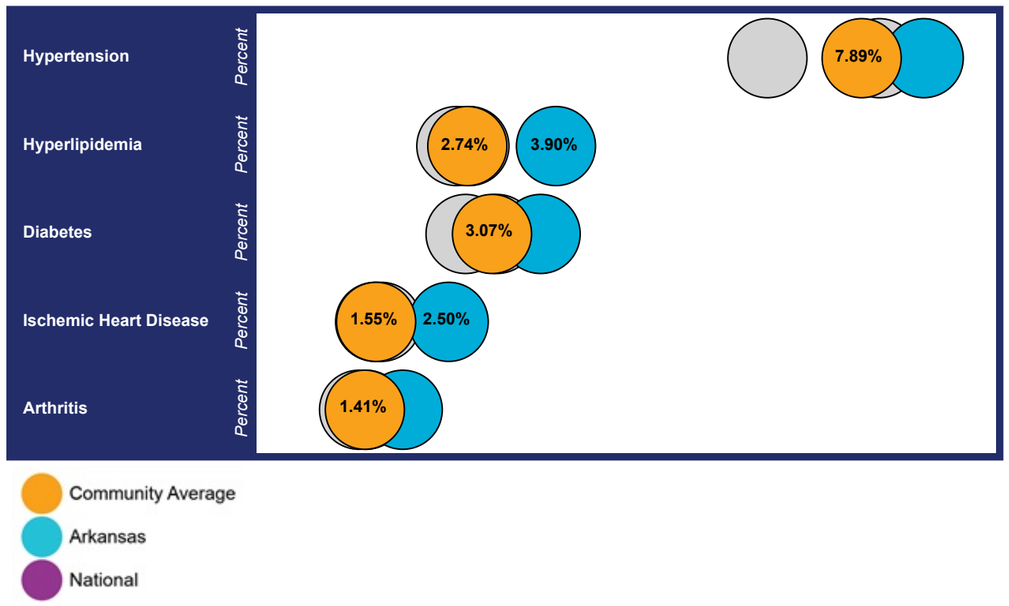


Table 8. Environment

		Lonoke County	Pulaski County	Community Average	State	National
Food Environment Index	*Index of factors that contribute to a healthy food environment, 0 (worst) to 10 (best)*	7.40	6.60	6.73	4.40	7.40
Drinking Water Violations	*The total number of drinking water violations recorded in a two-year period*	4	0	0	321	16,107
Access to Exercise Opportunities	*Percentage of population with adequate access to locations for physical activity*	46.95%	84.98%	78.98%	63.36%	84.45%
Broadband Access	*Percentage of population in a high-speed internet service area; access to DL speeds >= 25MBPS and UL speeds >= 3 MBPS*	99.80%	99.09%	99.20%	94.04%	96.78%
Long Commute Driving Alone	*Among workers who commute in their car alone, the percentage who commute more than 30 minutes*	47.90%	20.80%	25.08%	28.10%	36.50%
Severe Housing Problems	*Percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities*	10.14%	16.37%	15.39%	13.23%	16.84%

Community Average
Arkansas
National

Figure 9. Environment

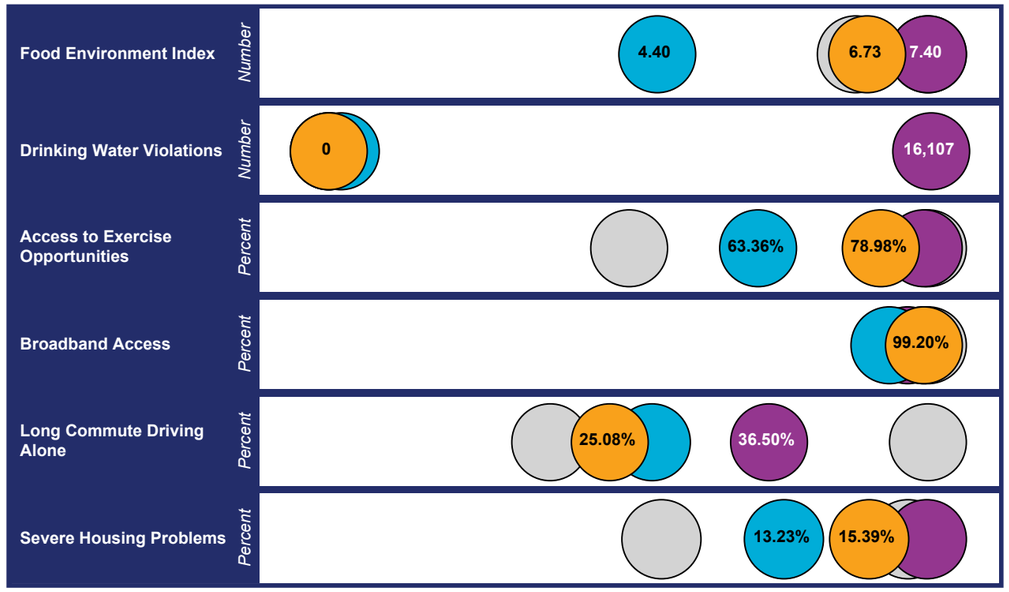


Table 9. Health Behaviors

		Lonoke County	Pulaski County	Community Average	State	National
Physical Inactivity	*Percentage of adults aged 20 and older who self-report no leisure time for activity*	24.50%	22.80%	23.07%	23.60%	19.50%
Adult Smoking	*Percentage of adults ages 18 and older who are current smokers (age-adjusted)*	18.00%	16.70%	16.91%	19.20%	13.20%
Youth Vaping	*Percentage of public school students in 6th, 8th, 10th, and 12th grade who used any vape in the past 30 days*	7.70%	6.90%	7.03%	8.10%	Not Available
Sexually Transmitted Infections	*Number of newly diagnosed chlamydia cases per 100,000 population*	329.70	969.80	868.80	588.30	495.00

Figure 10. Health Behaviors

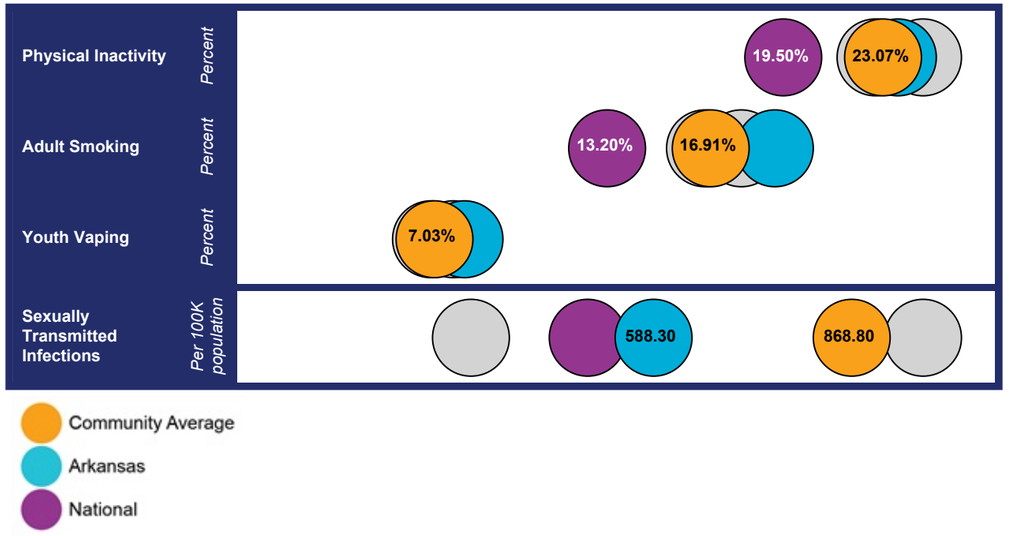


Table 10. Health Outcomes

		Lonoke County	Pulaski County	Community Average	State	National
Poor Physical Health Days	*Average number of physically unhealthy days reported in past 30 days (age-adjusted)*	4.90	4.70	4.73	5.20	3.90
Poor or Fair Health	*Percentage of adults age 18 and older who self-report their general health status as "fair" or "poor" (age-adjusted)*	19.70%	20.20%	20.12%	22.60%	17.00%

Figure 11. Health Outcomes

Table 11. Healthcare Expenditures

		Lonoke County	Pulaski County	Community Average	State	National
Average Annualized Expenditures	*Average annualized per-person spending on all covered healthcare services.*	$10,291	$10,003	$10,048	$10,116	Not Available
Average Annualized Expenditures (Medical Only)	*Average annualized per-person spending on medical services, based on medical claims.*	$7,382	$7,131	$7,170	$7,252	Not Available
Average Annualized Expenditures (Pharmacy Only)	*Average annualized per-person spending on prescription drugs, based on pharmacy claims.*	$2,633	$2,579	$2,587	$2,609	Not Available

Figure 12. Healthcare Expenditures

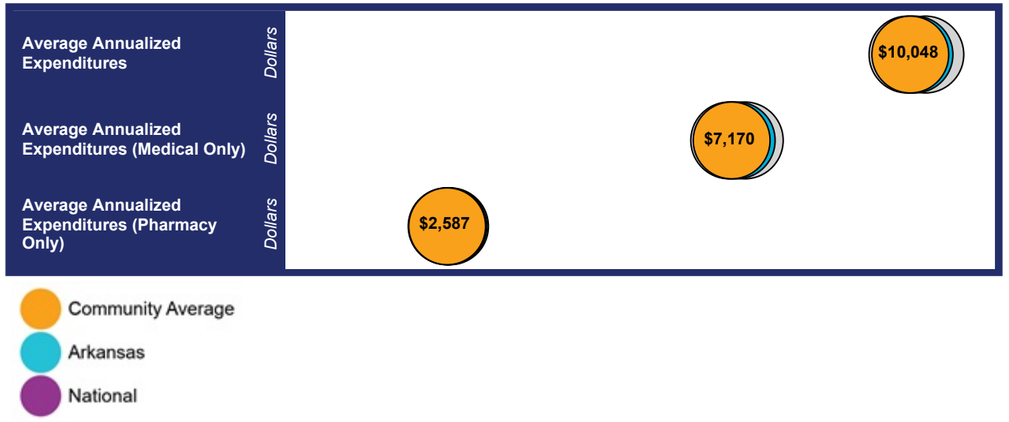


Table 12. Maternal and Infant Health

		Lonoke County	Pulaski County	Community Average	State	National
Active Obstetrics and Gynecology Physicians	*Active OB-GYN physicians are defined as those who provided evaluation and management services to at least two female patients ages 12-55 on the same day or performed a qualifying procedure (e.g., delivery) at least once during the year.*	0.90	8.20	7.05	3.20	Not Available
Teen Births	*The seven-year average number of teen births per 1,000 female population, ages 15-19*	21.80	26.50	25.76	27.90	15.50
C-Section Rate	*Percentage of live births delivered via cesarean section among all deliveries, calculated by the mother's county of residence.*	35.40%	33.87%	34.12%	33.48%	Not Available
C-Section Rate, First Birth	*Percentage of first-birth deliveries (full-term singleton pregnancies in a head-down position) delivered via cesarean section, calculated by the mother's county of residence.*	28.43%	29.11%	29.00%	27.58%	Not Available
Low Birthweight	*Percentage of live births where the infant weighed less than 2, 500 grams (approximately 5 lbs., 8 oz.)*	8.30%	11.70%	11.16%	9.40%	8.40%
Preterm Birth	*Percentage of live births that are preterm (<37 weeks), calculated as a three-year average.*	12.40%	13.60%	13.41%	11.90%	10.35%
Median Travel Time to Delivery	*Median number of minutes Arkansas mothers traveled from their home ZIP code to the delivery facility, calculated using birth records and facility addresses. Travel time estimates include in-state and out-of-state facilities.*	31.00	13.00	15.84	16.00	Not Available

Figure 13. Maternal and Infant Health

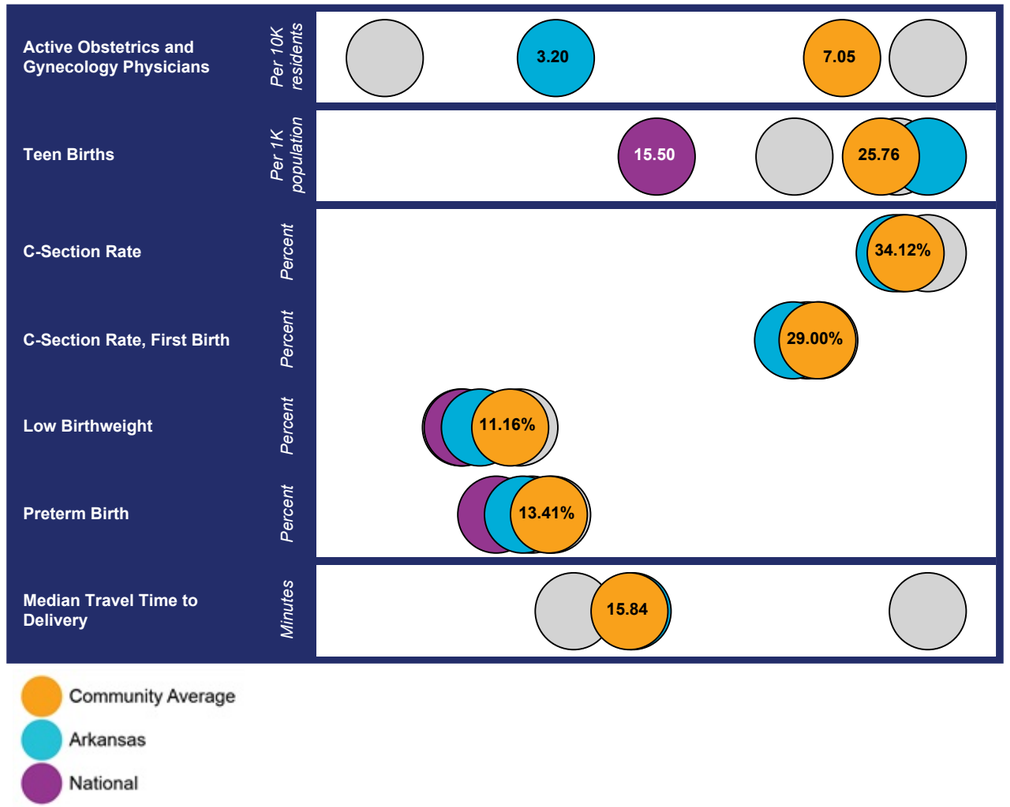


Table 13. Mental Health and Substance Use

		Lonoke County	Pulaski County	Community Average	State	National
Adult Depression	*Percentage of adults age 18 and older who report having been told that they had depressive disorder*	28.10%	25.80%	26.16%	27.50%	21.10%
Excessive Drinking	*Percentage of adults reporting binge or heavy drinking*	18.40%	19.60%	19.41%	18.99%	19.35%
Poor Mental Health	*Percentage of adults age 18 or older reporting poor mental health for 14 or more days (age-adjusted)*	20.40%	19.30%	19.47%	20.50%	16.40%
Youth Depression	*Percentage of public school students in 6th, 8th, 10th, and 12th grade who had feelings of depression all of the time in the past 30 days*	6.50%	11.00%	10.29%	9.20%	Not Available
Drug Overdose Deaths	*Age-adjusted rate of fatal drug overdoses per 100,000 residents*	Not Available	20.56	20.56	Not Available	Not Available
Non-Fatal Drug Overdoses	*Age-adjusted rate of non-fatal drug overdoses per 100,000 residents*	17.83	29.43	27.60	Not Available	Not Available

Figure 14. Mental Health and Substance Use

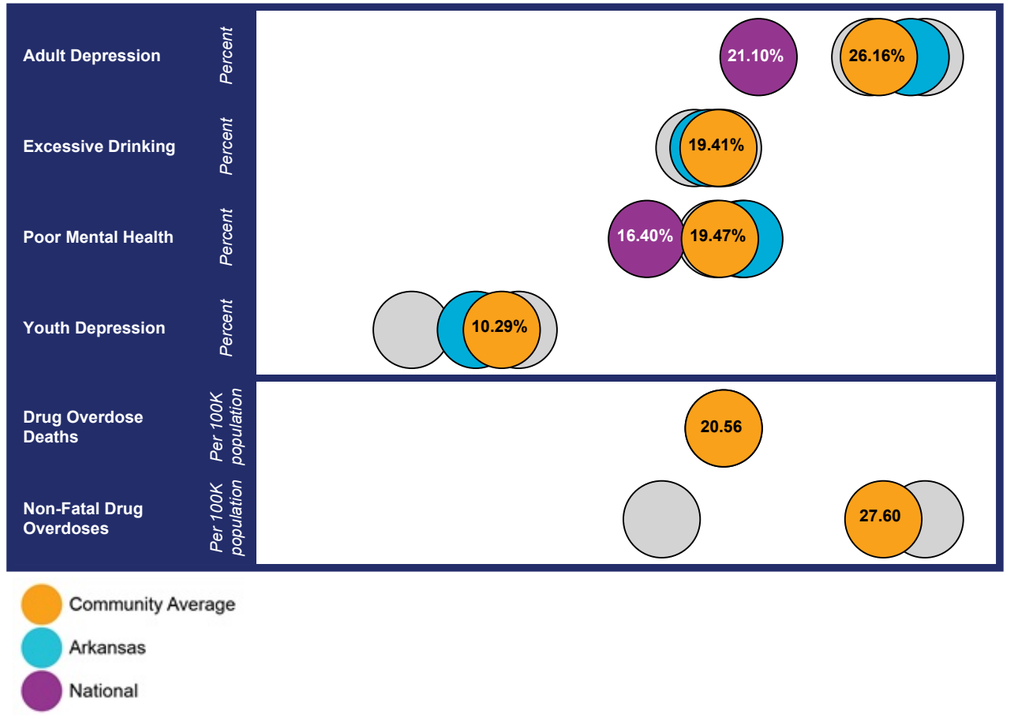


Table 14. Prevention

		Lonoke County	Pulaski County	Community Average	State	National
Cervical Cancer Screening	*Percentage of females age 21–65 years who report having had recommended cervical cancer screening test (age-adjusted)*	81.30%	83.90%	83.49%	81.20%	83.70%
Colorectal Cancer Screening	*Percentage of adults age 45-75 who have had a recent colorecal cancer screening*	63.30%	64.40%	64.23%	61.60%	66.30%
Dental Care Utilization	*Dental care visit (past 1 year), age-adjusted percentage of adults age 18+ by county*	57.20%	58.40%	58.21%	54.10%	63.40%
High Blood Pressure Management	*Percentage of adults age 18 and older with high blood pressure who report taking blood pressure medication (age-adjusted)*	60.60%	61.50%	61.36%	61.40%	58.90%
Prevention - Seasonal Influenza Vaccine	*Percentage of adults aged 18 and older who report receiving an influenza vaccination in the past 12 months*	38.80%	51.50%	49.50%	43.20%	44.80%
Annual Wellness Exam (Medicare)	*Percentage of annual wellness visits among the Medicare fee-for-service (FFS) population*	44.00%	47.00%	46.53%	46.00%	44.00%
No HIV Test	*Percentage of adults ages 18 or older who have never been screened for HIV*	59.80%	60.80%	60.64%	66.10%	Not Available

Figure 15. Prevention

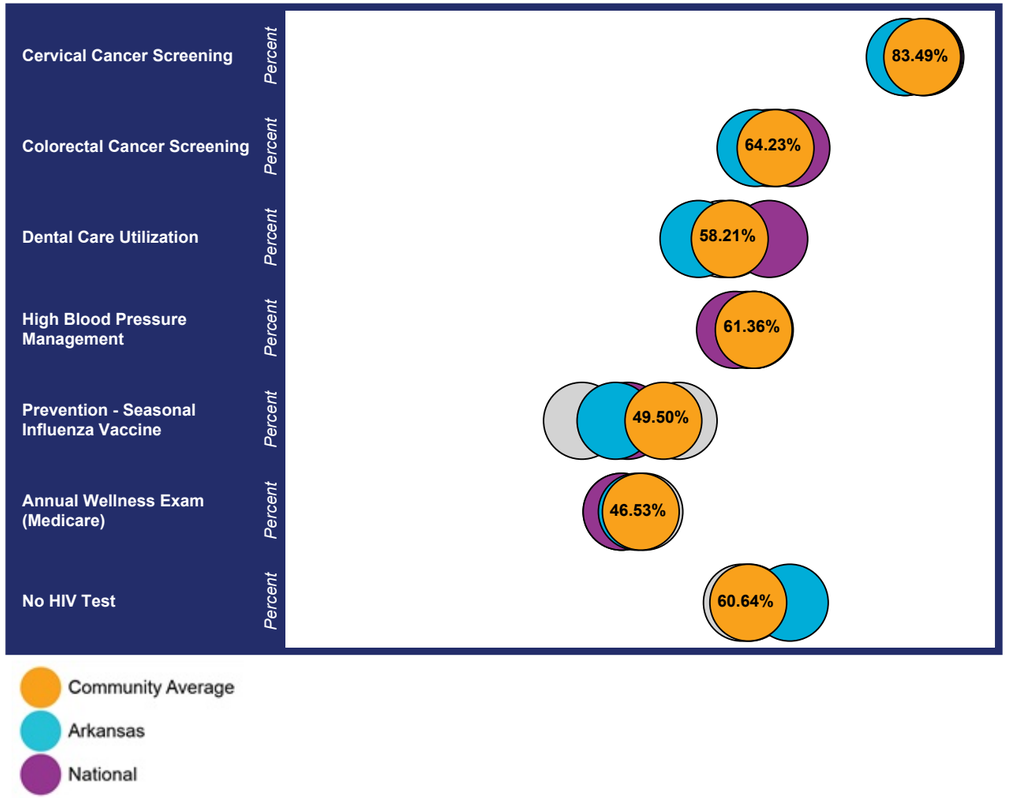
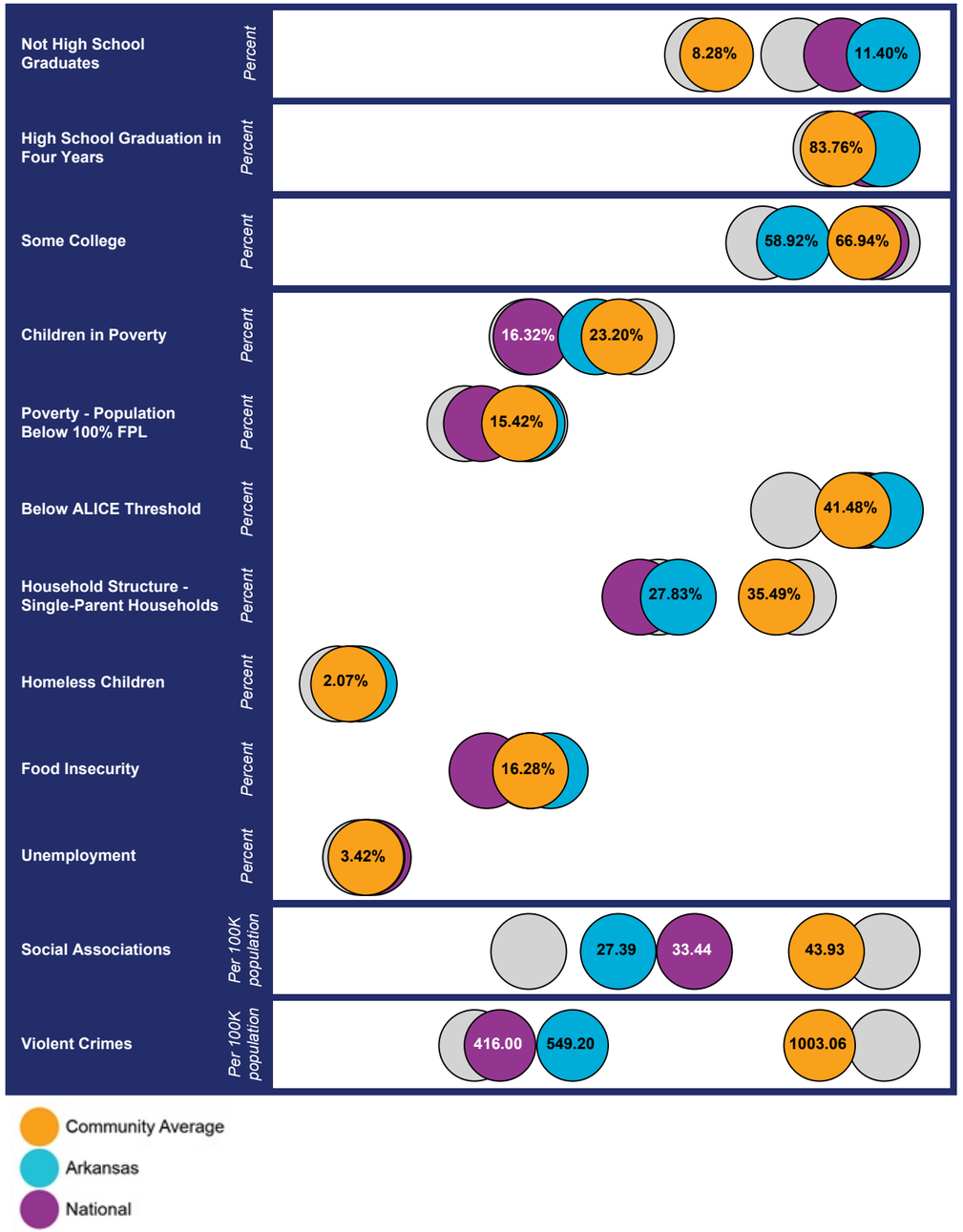


Table 15. Social and Economic Factors

		Lonoke County	Pulaski County	Community Average	State	National
Not High School Graduates	*Percentage of adults without a high school diploma*	9.80%	8.00%	8.28%	11.40%	10.60%
High School Graduation in Four Years	*Percentage of ninth-grade cohort who graduated in four years*	89.40%	82.70%	83.76%	90.30%	88.20%
Some College	*Percentage of adults ages 25-44 with some post-secondary education*	55.43%	69.10%	66.94%	58.92%	67.83%
Children in Poverty	*Percentage of children under age 18 below the poverty line*	16.01%	24.55%	23.20%	21.37%	16.32%
Poverty - Population Below 100% FPL	*Percentage of the population living in households with income below the federal poverty level*	11.15%	16.22%	15.42%	16.02%	12.44%
Below ALICE Threshold	*Percentage of households living in poverty or classified as ALICE (Asset Limited, Income Constrained, Employed)*	36.44%	42.42%	41.48%	44.00%	42.00%
Household Structure - Single-Parent Households	*Percentage of children who live in households where only one parent is present*	26.28%	37.21%	35.49%	27.83%	24.83%
Homeless Children	*Percentage of students experiencing homelessness enrolled in the public school system*	1.18%	2.24%	2.07%	2.90%	2.31%
Food Insecurity	*Percentage of the population that experienced food insecurity in the report year*	16.20%	16.30%	16.28%	17.82%	12.88%
Unemployment	*Percentage of the civilian non-institutionalized population age 16 and older that is unemployed (non-seasonally adjusted)*	3.00%	3.50%	3.42%	3.50%	4.00%
Social Associations	*Establishments, rate per 100,000 population*	20.27	48.36	43.93	27.39	33.44
Violent Crimes	*Annual rate of reported violent crimes per 100,000 population*	369.30	1121.80	1003.06	549.20	416.00

Figure 16. Social and Economic Factors



IDENTIFIED NEED 1:
Increase Access to Care and Education

GOALS/OBJECTIVE/OBJECTIVES:
Increase access to quality health care, preventive screenings, vaccinations, and community health resources for Pulaski County.

STRATEGY 1:
Expand community outreach and strengthen partnerships with local nonprofits, schools, and employers to improve access and awareness.

ACTION STEPS:

- Host annual free flu shot events & childhood immunization clinics
- Partner with local businesses and organizations to offer free health education and on-site screenings (e.g., blood sugar, blood pressure, BMI) and facilitate scheduling for primary care and mammogram appointments.
- Continue local and regional partnerships and collaborations to expand access to care and reduce barriers to care
- Explore Resource Hub opportunities with area agencies to identify and promote community resources and social drivers of health support
- Maintain the financial assistance policy for patients who are uninsured, underinsured, ineligible for a government health care program, or otherwise unable to pay, for medically necessary or emergent care.
- Continue to evaluate the need to recruit physicians, advanced practice providers and support staff as necessary to meet community needs.
- Continue to provide education and wellness tips on news segments and social media.
- Expand Maternal Health Initiatives including ARHOME and a New Prenatal Clinic
- Increase and Expand Prenatal Wellness Center program and utilization of Hello Pregnancy app and women's clinics
- Prioritize utilizing the Mobile Health Unit to provide preventative health screening education and referrals to counties with a A.L.I.C.E. threshold of 50% or greater.
- Continue preventative health screening and referrals at Community Wellness Centers

KEY PERFORMANCE METRICS:

- Provide preventive screenings, vaccinations, and related services to at least 200 community members
- Track and report the number of community outreach events hosted or attended by Baptist Health–North Little Rock.
- Measure and report the number of community members reached through health education, screenings, and outreach efforts.
- Evaluate referral and follow-up rates for individuals connected to primary or specialty care through outreach initiatives.
- Track maternal health program progress and growth
- Track Mobile Health unit utilization and referral data

COLLABORATIONS WITH ORGANIZATIONS: Local nonprofits, faith-based organizations, community organizations

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS NEED: Staff time and clinical expertise, marketing and educational materials, community health supplies, vaccination resources, and ongoing support from the Marketing & Communications and Community Outreach

ESTIMATED COMPLETION DATE: Ongoing through 2028

PERSON(S)/DEPARTMENT RESPONSIBLE: Community Outreach, Pregnancy Clinic Team, ARHOME Team, Marketing and Communications

IDENTIFIED NEED 1:
Increase Access to Care and Education

GOALS/OBJECTIVE/OBJECTIVE:
Increase equitable access to specialized NICU and pediatric care for families facing geographic, financial, and emotional barriers through the Ronald McDonald House on the Little Rock campus.

STRATEGY 2:
Refer families who can benefit to BH Little Rock for access to the Ronald McDonald House (RMH) to provide essential supportive services on the Baptist Health campus that enable family presence and participation in care, thereby improving health outcomes and reducing disparities.

ACTION STEPS:
- Formalize Partnership and Referral Pathways: Establish a formal agreement with RMH to streamline the referral process for NICU and pediatric families in need of lodging and support.
- Educate Healthcare Staff and Families: Develop and disseminate educational materials for hospital staff and families about the benefits and services offered by RMH, emphasizing its role in supporting family-centered care.
- Integrate RMH Support into Discharge Planning: Incorporate RMH resources into discharge planning for NICU and pediatric patients, ensuring families are prepared for post-discharge care and have access to ongoing support.
- Collaborate on Ancillary Service Provision: Work with RMH to connect families with additional wraparound services such as meals, transportation, support groups, and sibling care, reducing family stress and allowing greater focus on patient care.

KEY PERFORMANCE METRICS:
- Number of families housed by RMH Annually
- Average length of stay at RMH: Monitor the average duration families reside at RMH, correlating with the length of hospital stay.
- Average Distance from home Annually
- Community Awareness Campaigns: Track coverage, printed and social media
- Capital Funding Secured: Track and report percentage of funding secured for implementation
- Reduction in NICU readmission rates tracked annually.

COLLABORATIONS WITH ORGANIZATIONS: Ronald McDonald House Charities of Arkansas & North Louisianal Baptist Health-Little Rock

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS NEED: Staff time and clinical expertise, marketing and educational materials, ongoing support from the Marketing & Communications

ESTIMATED COMPLETION DATE: Ongoing

PERSON(S)/DEPARTMENT RESPONSIBLE: Baptist Health Leadership

IDENTIFIED NEED 1:
Increase Access to Care and Education

GOALS/OBJECTIVE/OBJECTIVE:
To improve community health by increasing health literacy and reducing barriers to accessing healthcare through community-led, culturally appropriate education and navigation support.

STRATEGY 3:
Health Literacy & Access to Healthcare

ACTION STEPS:
- Establish a Community Health Literacy committee to plan implementation and collaboration opportunities
- Equip internal staff and community leaders to train utilizing an evidence based curriculum for delivery.
- Identify target populations based on data and community need
- Launch community in-person, and virtual workshops to cover topics including understanding health information, communicating with healthcare providers, navigating healthcare, self-management and preventive health, understanding prescriptions, telehealth, patient rights
- Train community-based clinical and non-clinical staff in health-literate communication (e.g., Teach-Back, plain language)
- Evaluate impact and build sustainability plan

KEY PERFORMANCE METRICS:
- Curriculum identified and vetted for implementation
- Track the number of classes offered and participants
- Track pre/post test results to determine knowledge gained
- Track number of staff trained to implement the program
- Identified number of encounters using the Teach-Back method

COLLABORATIONS WITH ORGANIZATIONS: Cooperative Extension services, faith-based community leaders, local non-profit organizations

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS NEED: Staff time and clinical expertise, marketing and educational materials, ongoing support from the Marketing & Communications

ESTIMATED COMPLETION DATE: Ongoing

PERSON(S)/DEPARTMENT RESPONSIBLE: Community Outreach, Marketing & Communications

IDENTIFIED NEED 1:
Increase Access to Care and Education

GOAL:
Financial Empowerment for Healthcare: The goal is to move participants from financial crisis management to proactive planning. Show how sound budgeting and saving habits directly support access to care and health stability.

STRATEGY 4:
Financial Literacy & Access to Healthcare

ACTION STEPS:

- Identify a local Bank or Credit Union to partner in program delivery
- Partner with Community groups and organizations to implement class
- Incorporate Financial Literacy in Community Wellness Centers
- Incorporate Financial Literacy in Community Wellness Centers and Prenatal/Postpartum program by including the following educational topics
  - Control Your Money: Budgeting101
  - Understanding needs vs. wants, building a savings
  - Building a Savings for Emergencies
  - Avoiding Money Traps: Debts & Credits
  - Protect Your Health: Financial Literacy
- Include information in all FoodRx bags (if applicable)
- Identify additional resources for referrals beyond classes

KEY PERFORMANCE METRICS

- Track the number of classes offered and number of participants
- Utilize pre and post test to determine knowledge gain
- Track number of community partners identified and utilized for implementation
- Track number of referrals for financial assistance

COLLABORATIONS WITH ORGANIZATIONS: Local Bank, Baptist Health Foundation, faith-based community leaders, local non-profit organizations

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS NEED: Staff time and clinical expertise, marketing and educational materials, ongoing support from the Marketing & Communications

ESTIMATED COMPLETION DATE: Ongoing

PERSON(S)/DEPARTMENT RESPONSIBLE: Community Outreach, Marketing & Communications

IDENTIFIED NEED 2:
The Community Mental Health Strategy: Access, Education, Acceptance

GOALS/OBJECTIVE:
Improve and increase access to mental health services, reduce stigma, and promote emotional well-being for residents of the Pulaski County

STRATEGY:
Strengthen collaboration with employers, healthcare providers, and community organizations to expand mental health education, increase access to counseling and crisis resources, and promote early intervention and resilience-building initiatives.

ACTION STEPS:

- Partner with healthcare organizations, locally and statewide, to increase the capacity to provide additional mental health services.
- Implementation Project to increase in-patient mental and behavioral health services.
- Provide Mental Health First Aid training to local schools, colleges, and community or faith-based organizations.
- Provide Community-based Stop the Bleed Trainings
- Participate in System-wide Mental Health Awareness Campaigns
- Integrate Mental Health Education and Awareness materials into Schools and Workplaces
- Utilize Telepsych for patients in need of Telemedicine services
- Utilize GME program to increase number of providers for the state of Arkansas
- Utilize Command Center to increase access and reduce barriers to mental health care in a timely manner
- Continue to screen for depression at Community Wellness Centers and maternal health programs

KEY PERFORMANCE METRICS:

- Track number of patient encounters in-patient withdrawal management services
- Track number of patient encounters utilizing Telepsych services
- Report number of Community partners and events for mental health services
- Track the number of mental health first aid and Stop the Bleed classes and participants
- Track the number of Mental Health First Aid trainings and attendance
- Measure campaign's reach through social media engagement, website visits, and printed material distribution.

COLLABORATIONS WITH ORGANIZATIONS: Local schools, universities and businesses, non-profits and faith-based organizations

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS NEED: Staff time and clinical expertise, marketing and educational materials, community health supplies and ongoing support from the Marketing & Communications and behavioral health, command center and Community Outreach teams.

ESTIMATED COMPLETION DATE: Ongoing through 2028

PERSON(S)/DEPARTMENT RESPONSIBLE: Leadership, Behavioral Health, Community Outreach Marketing & Communications Manager, Case Management, Command Center

IDENTIFIED NEED 3:
Closing the Gap: A Strategy for Healthy Communities and Nutrition Security

GOAL:
Increase knowledge of healthful food choices education and increasing access to food through the FoodRx initiative.

STRATEGY 1:
Increase access to nutrition education for community members.

ACTION STEPS:

- Implement Cooking with Community Outreach classes to empower participants to build cooking skills, cook more healthy meals, reduce food waste, and make healthier selections at the grocery store.
- Implement Maintain, Don't Gain holiday challenge program for adult community members that encourages using stress management strategies, physical activity, and healthful food choices during the holiday season to maintain one's physical and mental health and avoid holiday weight gain.
- Implement Wellness Meetups, a monthly wellness program that focuses on nutrition, physical activity, mental health, or other wellness areas.
- Implement nutrition education for pregnant and postpartum mothers to also empower healthier food choices for mom, baby and family.
- Implement the Healthy Active Youth and Families (HAYF) nutrition and physical activity program.
- Utilize the FoodRx program for Employees, AHG Clinics, PACE program, and Community Wellness Centers to provide food.
- Implement Arkansas Fruit and Vegetable Prescription Program with the Arkansas Hunger Relief Alliance to distribute fresh produce to food-insecure patients with a diet-related chronic health condition.

KEY PERFORMANCE METRICS

- Implementation of two Cooking With Community Outreach classes per year.
- Track number of program participants, programs and food distributions.
- Offer three nutrition or diet-related Wellness Meetup programs each year.
- Track participants of "mom and tot" hands on cooking classes.
- Track number of participants for lactation support classes for nursing mothers.
- Track number of HAYF program series offered and number of participants.
- Measure skin carotenoid levels using Veggie Meter before and after HAYF program implementation.

COLLABORATIONS WITH ORGANIZATIONS: Arkansas Foodbank, Arkansas Hunger Relief Alliance

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS NEED: Staff time and clinical expertise, marketing and educational materials, ongoing support from the Marketing & Communications

ESTIMATED COMPLETION DATE: Ongoing

PERSON(S)/DEPARTMENT RESPONSIBLE: Community Outreach, Marketing & Communications

IDENTIFIED NEED 3:
Closing the Gap: A Strategy for Healthy Communities and Nutrition Security

STRATEGY 2:
Mobile Health Unit (MHU) "Food as Medicine" Initiative (MHU)
To improve the health and nutritional well-being of underserved community members by utilizing the Mobile Health Unit to proactively identify individuals experiencing food insecurity, provide immediate relief through nutritious food access, and ensure sustainable connectivity to community food resources.

ACTION STEPS:

- Utilize the Standardized Food Insecurity Screening Protocol to screen all patients/individuals at pre-determined locations
- Develop and deploy food boxes in cooperation with the Arkansas Foodbank
- Identify and schedule high-need service locations. Using Arkansas Foodbank data and existing CHNA data (low-income census tracts, areas with high chronic disease rates, or known food deserts) to create a quarterly MHU route schedule.
- Identify key preventative screenings to be offered at each distribution event
- Promote the schedule through local channels (churches, community centers, public libraries) using clear, accessible flyers and social media to maximize attendance for free health screenings.
- Implement a short-term follow-up mechanism to measure the impact of referrals.

KEY PERFORMANCE METRICS:

- Number of scheduled MHU visits that occurred in high need areas
- Track and report the number of bags and pounds of food distributed
- Track and report health outcomes for the population being screened
- Percentage of food-insecure clients who confirm they utilized at least one resource on the provided local pantry list during the 30-day follow-up call.
- Track other social determinants of health identified and referrals

COLLABORATIONS WITH ORGANIZATIONS: Arkansas Foodbank, Arkansas Hunger Relief Alliance

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS NEED: Staff time and clinical expertise, marketing and educational materials, ongoing support from the Marketing & Communications

ESTIMATED COMPLETION DATE: Ongoing

PERSON(S)/DEPARTMENT RESPONSIBLE: Community Outreach, Marketing & Communications

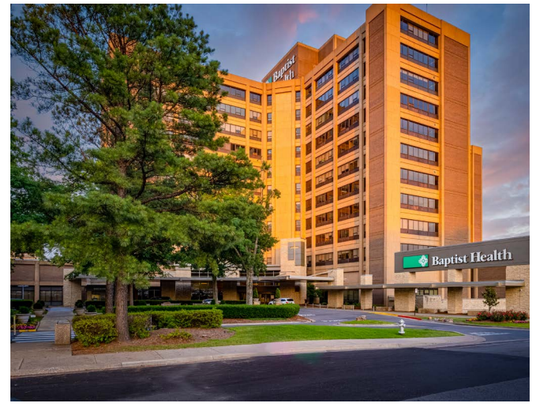
BAPTIST HEALTH
Extended Care Hospital

About Us

Baptist Health Extended Care Hospital, a state-of-the-art facility located on the campus of Baptist Health Medical Center-Little Rock, provides long-term acute care to patients with complex medical conditions.

We offer a caring atmosphere where family involvement is supported and visitation is encouraged. With a dedicated staff of professionals, we provide interdisciplinary care for unique needs.

Our interdisciplinary team works with the patient, their family, and community providers to develop a discharge plan that enables each patient's return to daily living at the highest possible capacity.



Community Health Needs Assessment 2026-2028
Baptist Health Extended Care Hospital

HIGHLIGHTS OF COMMUNITY HEALTH NEEDS ASSESSMENT ACCOMPLISHMENTS 2023-2025

Access to Care

- Offered Med to Bed Access for patients who could utilize the program
- Provided information/ education to patients and caregivers for additional services resources needed upon discharge
- Partnered with Community Outreach to provide provide Education and Information on Fall Prevention at Southwest and Dunbar Community Centers
- Partnered with Community Outreach to develop and promote information Safety in the home for Community Events and Wellness Centers

MENTAL HEALTH:

- Educated patients and care-givers on the 24-hour behavioral health-line available to staff and patients
- Provided educational materials for patients and care-givers on stress management, depression, self-care during Mental Health Awareness Month
- Offered Mental health activities that promote self-care, relaxation, and mindfulness including information on yoga, journaling, spending time in nature, art therapy, and music therapy at Community and recruitment events.

FOOD INSECURITY:

- Provide education on the relationship between nutrition and pressure sores to caregivers
- Provide education to families and caregivers nutritional needs based on oral problems, height and weight, weight change, nutrition problems (altered taste, hunger, uneaten meals), approaches to nutritional care (nutrition support, mechanically altered food, therapeutic diets), and food intake.
- Partner with Community Outreach to provide presentations to Community Wellness Centers on relationships between food and Chronic Disease Management
- Promoted Community Outreach's FoodRx Program for individuals with Food Insecurity including employees

2025 BAPTIST HEALTH COMMUNITY HEALTH NEEDS ASSESSMENT: BAPTIST HEALTH EXTENDED CARE HOSPITAL

ACHI
August 2025

Baptist Health

PREPARED BY:
ACHI
INSPIRING HEALTHY ACTS

Introduction

Baptist Health engaged the Arkansas Center for Health Improvement (ACHI) to conduct the quantitative data collection and analysis for the 2025 Community Health Needs Assessment (CHNA) process. Baptist Health provided ACHI with the counties served by each of its 12 hospital communities. A total of 16 Arkansas counties and two Oklahoma counties were included.

Each report presents community-level data for a hospital community, including tables and figures for each indicator, along with comparisons to Arkansas and U.S. benchmarks. Dot graphs are provided to visualize performance across selected indicators. All reports are prepared using the same methodology to ensure consistency and comparability across Baptist Health hospital communities.

Methodology

A summary of sources, definitions, indicator criteria, and suppression rules can be found in the methods and sources document.

Community Profile Summary

To support the 2025 Community Health Needs Assessment (CHNA), ACHI compiled a comprehensive dataset of 103 health and demographic indicators for the communities served by Baptist Health's 12 hospital locations. This section provides an overview of these indicators across the full CHNA service area and offers multiple views for understanding and comparing county-level and community-level data.

Data are grouped into the following 14 categories, based on the source-defined domains outlined in the data source reference sheet:

1. Demographics
    a. Age
    b. Sex
    c. Race, Ethnicity, and Language
2. Insurance Coverage
3. Access to Care
4. Cause of Death
5. Chronic Conditions
6. Diagnoses Incidence at Discharge
7. Environment
8. Health Behaviors
9. Health Outcomes
10. Healthcare Expenditures
11. Maternal and Infant Health
12. Mental Health and Substance Use
13. Prevention
14. Social and Economic Factors

Measurements for these categories will be displayed in the following sections.

Hospital Community Indicator

The hospital community indicator snapshots offer an at-a-glance view of how each hospital community compares to state and national benchmarks, as well as the counties that make up the community.

Each table presents the data values for selected indicators across the 14 CHNA domains, and each corresponding visual uses proportionally scaled circular markers to illustrate performance. This format is designed to quickly convey how each hospital community aligns with or diverges from broader benchmarks in key population health metrics.

Each displays four comparison points:

- **Purple** – Represents the national value for the indicator.
- **Blue** – Represents the value for the state of Arkansas.
- **Gold** – Represents the weighted average for all counties in the hospital's defined service area.
- **Gray** – Represent the values of each county assigned to that hospital community.

Where available, data for each indicator are shown for all four categories. If a value is not available or is suppressed for a contributing county, it is noted as "Not Available" in the table and excluded from the visual display. No color ranking is applied; the visuals and tables are intended to illustrate relative placement, not comparative rank.

Hospital Community: Baptist Health Extended Care Hospital (Grant, Pulaski, and Saline Counties)

Figure 1. Counties Served by Baptist Health Medical Center–BHECH

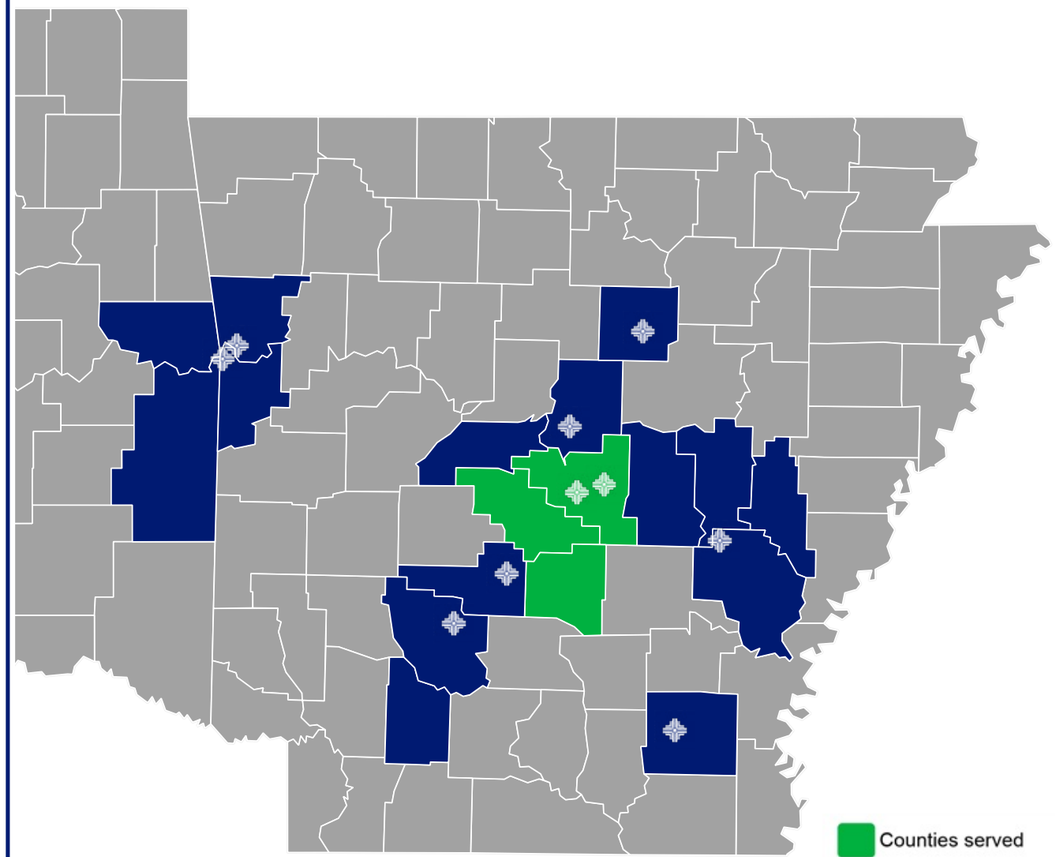


Table 1. Demographics: Age and Sex

		Grant County	Saline County	Pulaski County	Community Average	State	National
Total Population	*Number*	18,111	125,724	398,949	542,784	3,032,651	332,387,540
Female	*Percent*	49.66%	51.03%	52.15%	51.81%	50.67%	50.50%
Male	*Percent*	50.34%	48.97%	47.85%	48.19%	49.33%	49.50%
Ages 0-4	*Percent*	5.33%	5.59%	6.34%	6.13%	6.02%	5.70%
Ages 5-17	*Percent*	16.03%	17.78%	17.08%	17.21%	17.26%	16.46%
Ages 18-24	*Percent*	8.39%	7.34%	8.77%	8.43%	9.33%	9.12%
Ages 25-34	*Percent*	12.71%	12.16%	14.42%	13.84%	12.93%	13.69%
Ages 35-44	*Percent*	12.31%	13.93%	13.05%	13.23%	12.66%	13.08%
Ages 45-54	*Percent*	12.91%	12.53%	11.73%	11.95%	11.84%	12.29%
Ages 55-64	*Percent*	14.17%	12.51%	12.35%	12.45%	12.64%	12.82%
Ages 65+	*Percent*	18.15%	18.16%	16.25%	16.76%	17.33%	16.84%

Figure 2. Demographics: Age and Sex

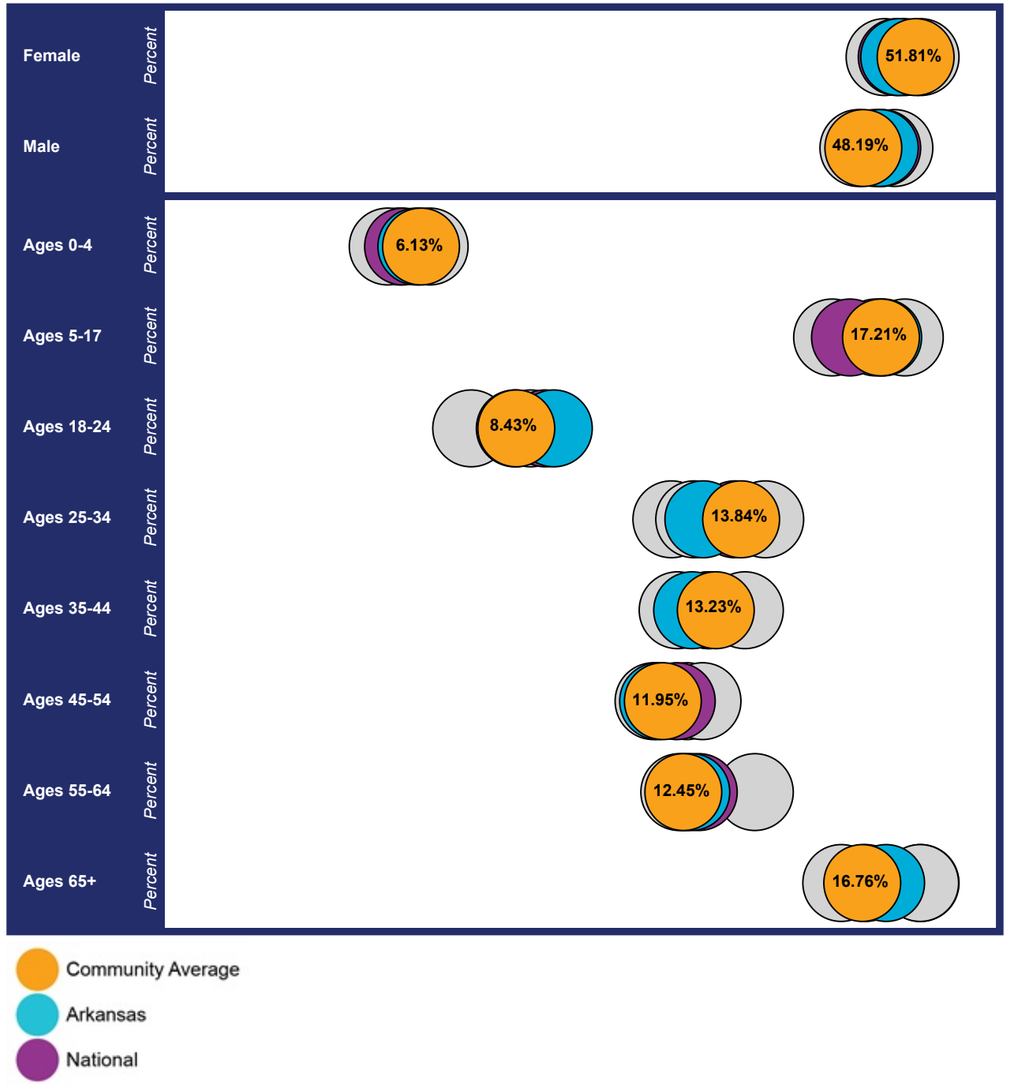


Table 2. Demographics: Race, Ethnicity, and Language

		Grant County	Saline County	Pulaski County	Community Average	State	National
Total Population	*Number*	18,111	125,724	398,949	542,784	3,032,651	332,387,540
Asian	*Percent*	0.36%	1.03%	2.13%	1.82%	1.53%	5.75%
Black or African American	*Percent*	2.59%	8.25%	36.72%	28.99%	14.84%	12.03%
Hispanic	*Percent*	2.71%	6.98%	8.20%	7.73%	8.77%	18.99%
Multiple Races	*Percent*	2.14%	3.70%	3.69%	3.64%	5.50%	3.87%
Native American/ Alaska Native	*Percent*	0.11%	0.19%	0.21%	0.20%	0.36%	0.53%
Native Hawaiian/ Pacific Islander	*Percent*	0.19%	0.00%	0.04%	0.04%	0.39%	0.17%
Other Races	*Percent*	0.48%	0.49%	0.30%	0.35%	0.26%	0.50%
White	*Percent*	91.43%	79.36%	48.70%	57.23%	68.36%	58.17%
Non-English Language Households	*Percent*	0.20%	2.10%	1.80%	1.82%	1.50%	4.20%

Figure 3. Demographics: Race, Ethnicity, and Language

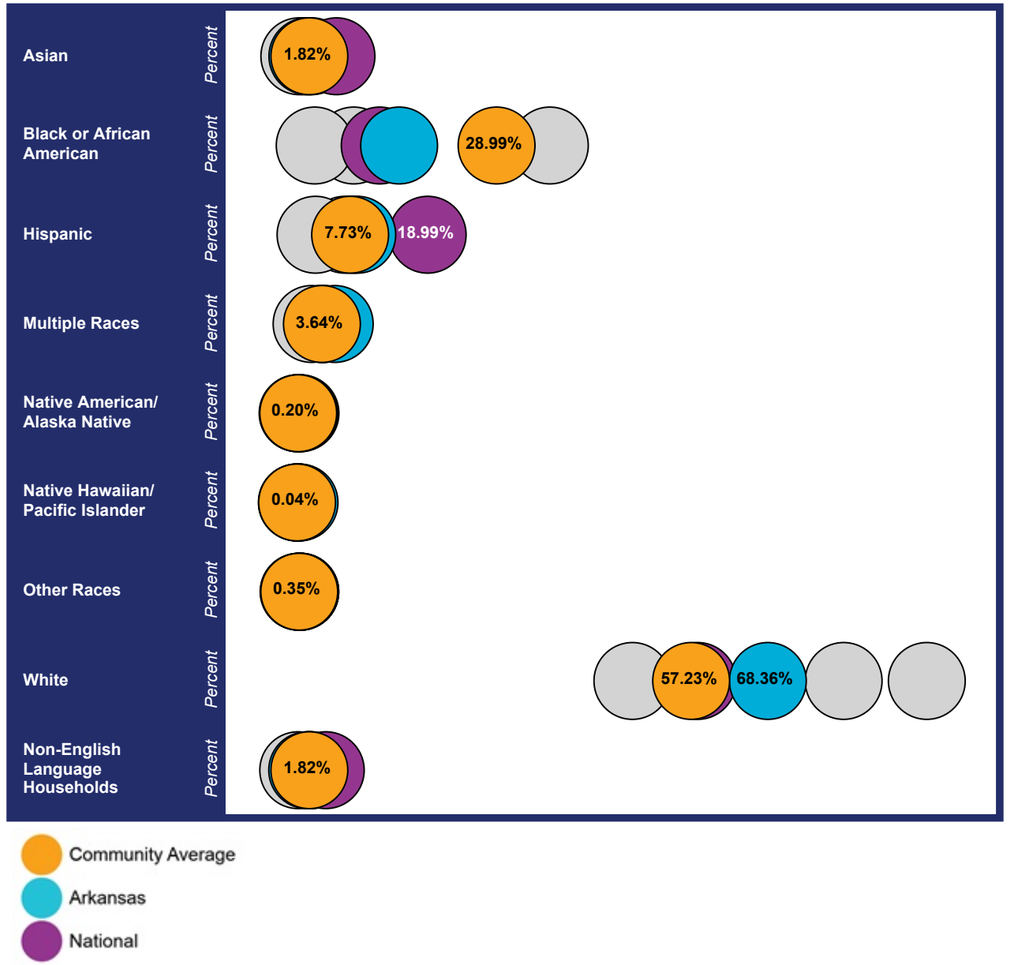


Table 3. Insurance Coverage

		Grant County	Saline County	Pulaski County	Community Average	State	National
Private Health Insurance Coverage	*Percentage of the total civilian non-institutionalized population for whom insurance status is determined that is covered by private health insurance*	71.02%	75.34%	68.22%	69.96%	65.37%	73.62%
Public Health Insurance Coverage	*Percentage of the total civilian non-institutionalized population for whom insurance status is determined that is covered by public health insurance*	47.46%	39.32%	45.65%	44.24%	48.21%	39.70%
Uninsured	*Percentage of adults under age 65 without health insurance coverage*	7.10%	8.20%	9.00%	8.75%	10.00%	9.50%

Figure 4. Insurance Coverage

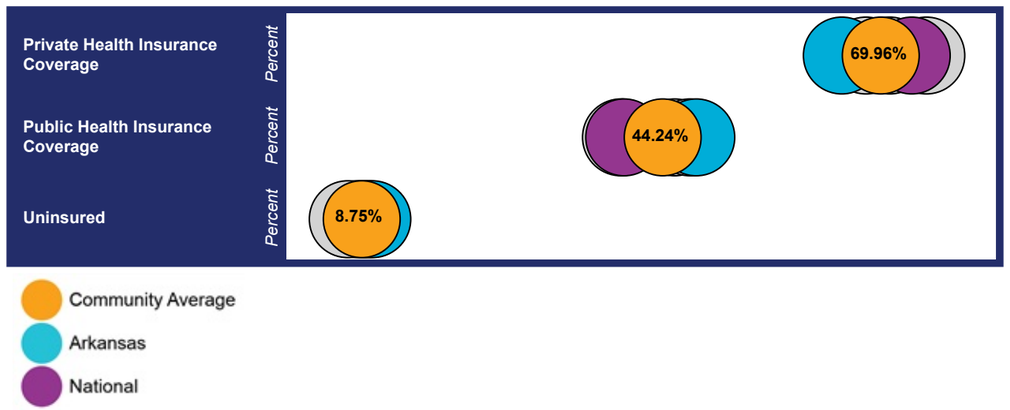


Table 4. Access to Care

		Grant County	Saline County	Pulaski County	Community Average	State	National
Primary Care Physicians	*Ratio of population to one primary care physician*	9045:1	2555:1	848:1	1517:1	1478:1	1334:1
Mental Health Providers	*Ratio of population to one mental health provider*	765:1	617:1	189:1	232:1	367:1	300:1
Dentists	*Ratio of population to one dentist*	2594:1	2961:1	1300:1	1523:1	2044:1	1361:1
Active Primary Care Physicians	*Rate per 10,000 county residents of primary care physicians who provided evaluation and management services to at least two patients on the same day at least once during the year*	4.50	9.20	27.60	22.57	9.20	Not Available
Addiction or Substance Use Providers	*Rate of addiction or substance use providers per 100,000 population*	5.57	1.62	10.52	8.29	5.98	29.43
Buprenorphine Providers	*Rate of buprenorphine providers per 100,000 population*	5.52	2.39	19.35	14.96	9.81	14.87
Preventable Hospital Stays (Medicare)	*Rate of hospital stays for ambulatory care-sensitive conditions per 100,000 Medicare enrollees*	2813.00	3492.00	2682.00	2873.99	3014.00	2666.00
Diabetic Monitoring (Medicare)	*Percentage of Medicare enrollees aged 65 and older with diabetes who received a hemoglobin A1c (HbA1c) test within the past year.*	87.91%	88.80%	88.61%	88.63%	88.47%	87.53%
Mammography	*Percentage of female Medicare enrollees ages 65-74 who received an annual mammography screening*	39.00%	36.00%	45.00%	42.72%	41.00%	44.00%

Figure 5. Access to Care

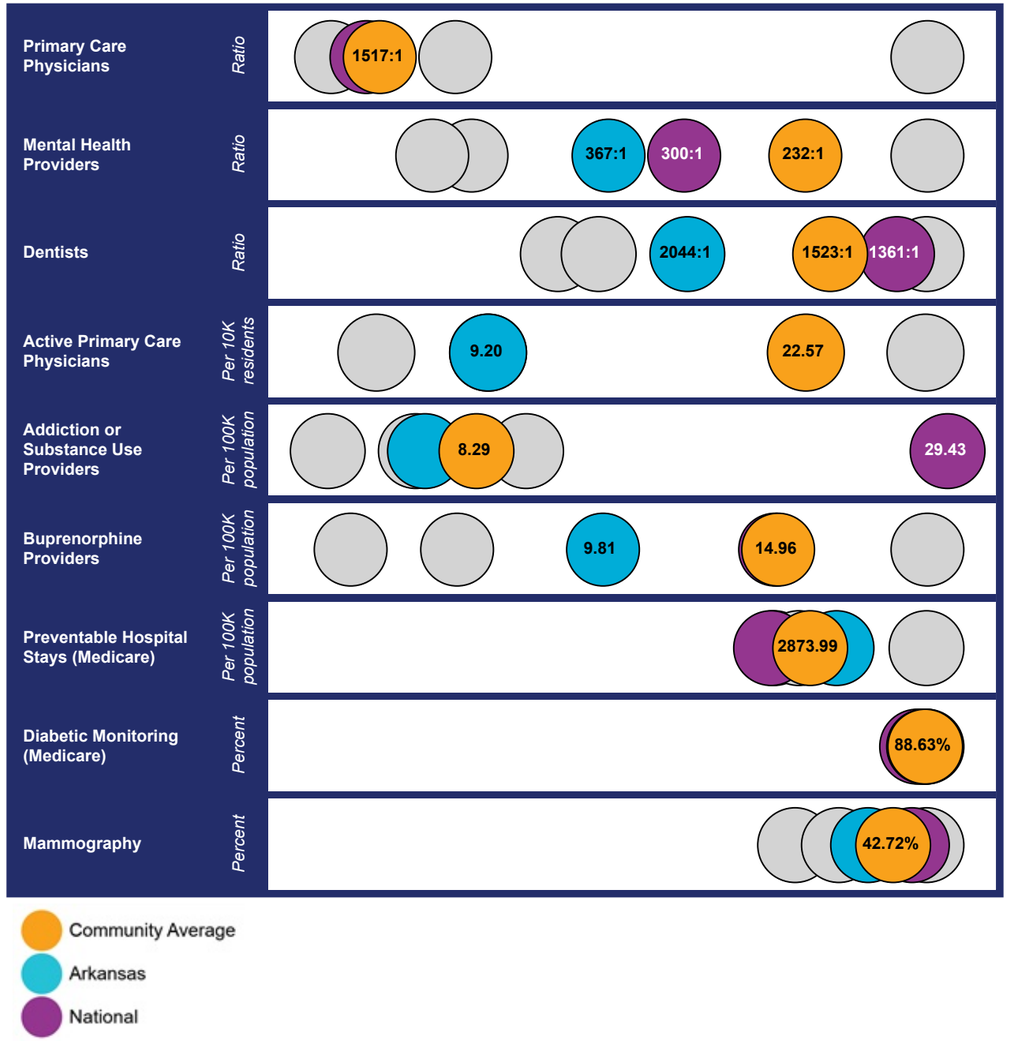


Table 5. Cause of Death

		Grant County	Saline County	Pulaski County	Community Average	State	National
All Causes	*Rate of deaths by all causes per 100,000 population (age-adjusted)*	1060.40	910.90	955.20	948.45	1001.70	805.60
Premature Death	*Number of deaths among residents under age 75 per 100,000 population (age-adjusted)*	562.31	468.31	545.57	528.23	552.47	406.59
Heart Disease	*Rate of death due to heart disease (ICD-10 Codes I00-I09, I11, I13, I20-I151) per 100,000 population*	306.50	235.30	222.80	228.49	282.80	207.20
Cancer	*5-year average rate of death due to cancer per 100,000 population*	241.90	199.20	188.90	193.05	215.90	182.70
Unintentional Injury	*5-year average rate of death due to unintentional injury (accident) per 100,000 population*	72.30	67.30	69.90	69.38	61.90	63.30
Stroke	*5-year average rate of death due to cerebrovascular disease (stroke) per 100,000 population (age-adjusted)*	43.80	46.80	53.50	51.62	57.40	48.30
Chronic Lower Respiratory Disease	*Rate of deaths due to chronic lower respiratory disease per 100,000 population (age-adjusted)*	76.50	51.10	41.70	45.04	61.00	35.90
Diabetes Mortality	*Rate of deaths due to diabetes per 100,000 population (age-adjusted)*	24.50	32.10	40.80	38.24	34.70	23.90
Suicide Deaths	*This indicator reports the 2019-2023 five-year average rate of death due to intentional self-harm (suicide) per 100, 000 population. Figures are reported as crude rates*	25.20	22.60	16.10	17.91	19.20	14.50
Motor Vehicle Crash	*5-year average rate of death due to motor vehicle crash per 100,000 population (age-adjusted)*	31.80	15.40	20.80	19.92	20.60	12.80
Alcohol-Involved Motor Vehicle Crash	*Rate of persons killed in motor vehicle crashes involving alcohol as a rate per 100,000 population*	0.00	2.10	3.80	3.28	3.10	2.30

Figure 6. Cause of Death

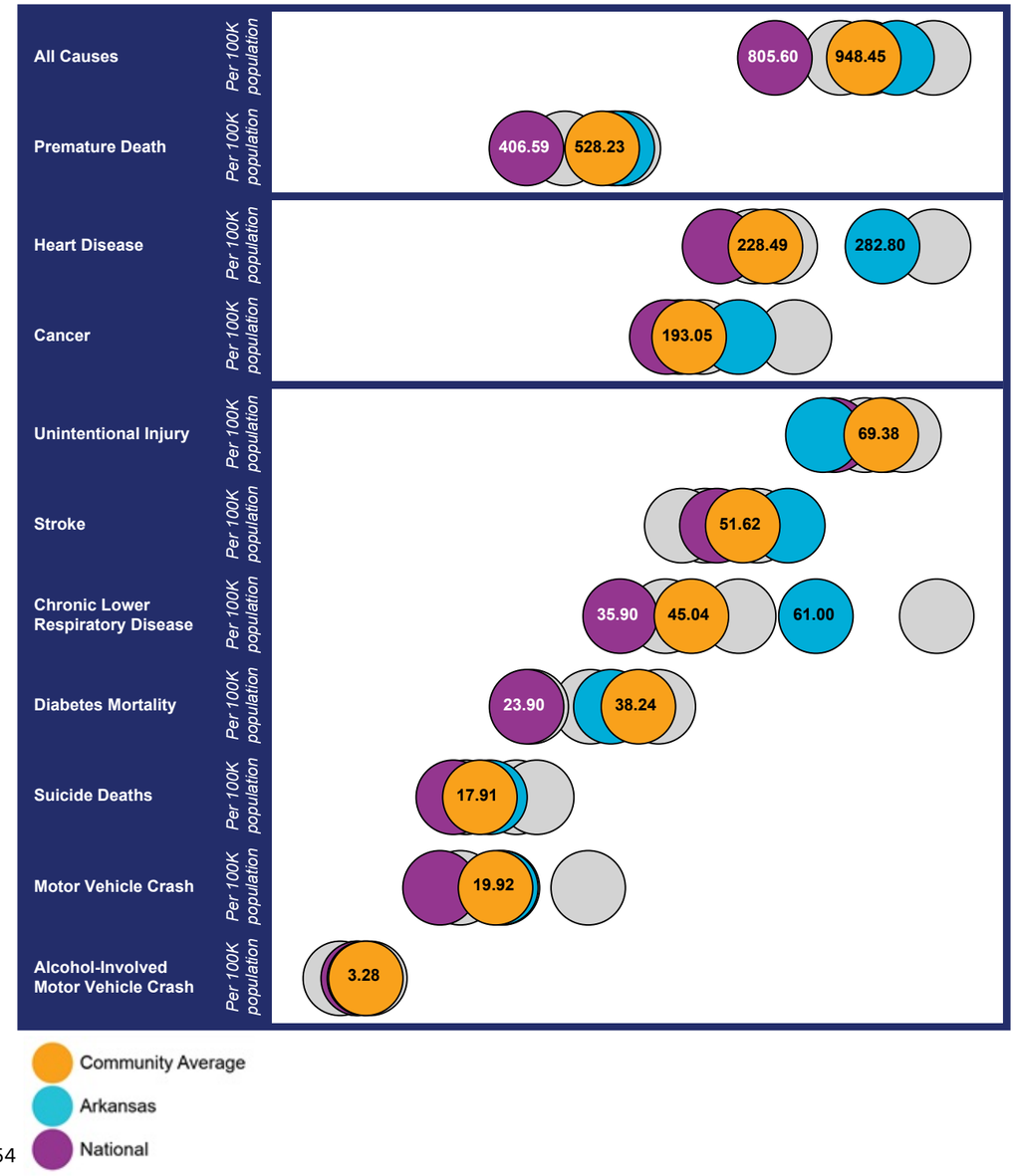


Table 6. Chronic Condtions

		Grant County	Saline County	Pulaski County	Community Average	State	National
Child Obesity	*Percentage of students classified as overweight to severely obese, by county location of school*	35.00%	38.71%	38.89%	38.72%	40.10%	Not Available
High Cholesterol	*Percentage of adults who have had their blood cholesterol checked and have been told it was high (age-adjusted)*	32.00%	31.60%	30.10%	30.51%	31.80%	30.40%
Adult Obesity	*Percentage of adults ages 20 and older who report a BMI higher than 30*	33.90%	33.20%	34.90%	34.47%	31.90%	30.10%
High Blood Pressure	*Percentage of adults who have been told they have high blood pressure (age-adjusted)*	34.50%	34.70%	38.00%	37.12%	36.50%	29.60%
Arthritis	*Percentage of adults ages 18 or older diagnosed with some form of arthritis*	30.40%	30.20%	28.00%	28.59%	32.60%	Not Available
Diabetes Prevalence	*Percentage of adults age 18 and older who report ever been told that they have diabetes other than diabetes during pregnancy (age-adjusted)*	11.00%	10.60%	12.70%	12.16%	12.70%	10.40%
Asthma	*Percentage of adults who have been told they currently have asthma (age-adjusted)*	10.90%	10.10%	10.80%	10.64%	11.00%	9.90%
Coronary Heart Disease	*Percentage of adults age 18 and older who report ever having been told by that they had angina or coronary heart disease (CHD) (age-adjusted)*	6.90%	6.20%	6.60%	6.52%	7.20%	5.70%

Figure 7. Chronic Conditions

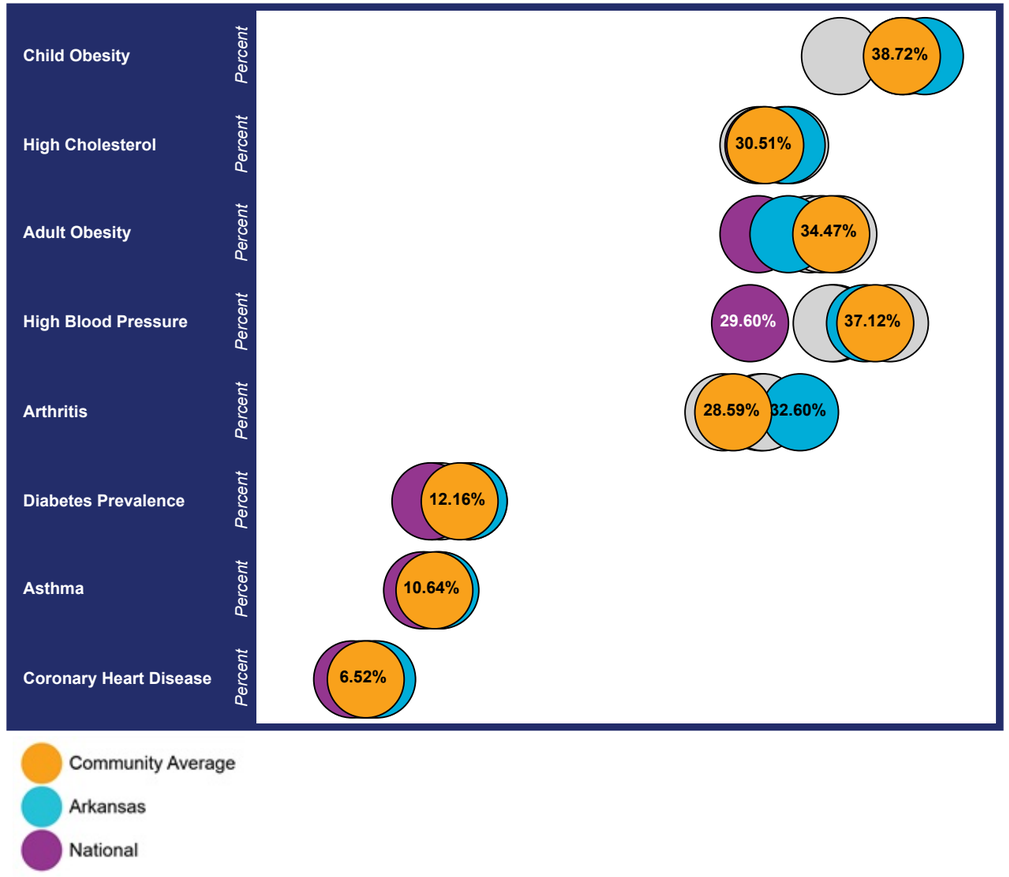


Table 7. Diagnoses at Discharge

		Grant County	Saline County	Pulaski County	Community Average	State
Hypertension	*Number of individuals 18 years and older discharged with a primary or secondary hypertension diagnosis as a percentage of the population 18 years and older*	7.86%	8.19%	8.12%	8.13%	8.70%
Hyperlipidemia	*Number of individuals 18 years and older discharged with a primary or secondary hyperlipidemia diagnosis as a percentage of the population 18 years and older*	3.08%	3.32%	2.77%	2.91%	3.90%
Diabetes	*Rate of individuals 18 years and older discharged with a primary or secondary diabetes diagnosis as a percentage of the population 18 years and older*	3.07%	2.77%	3.13%	3.04%	3.70%
Ischemic Heart Disease	*Number of individuals 18 years and older discharged with a primary or secondary ischemic heart disease diagnosis as a percentage of the population 18 years and older*	2.65%	2.44%	1.54%	1.79%	2.50%
Arthritis	*Rate of individuals 18 years and older discharged with a primary or secondary arthritis diagnosis as a percentage of the population 18 years and older*	1.44%	1.52%	1.42%	1.44%	1.90%

Figure 8. Diagnoses at Discharge

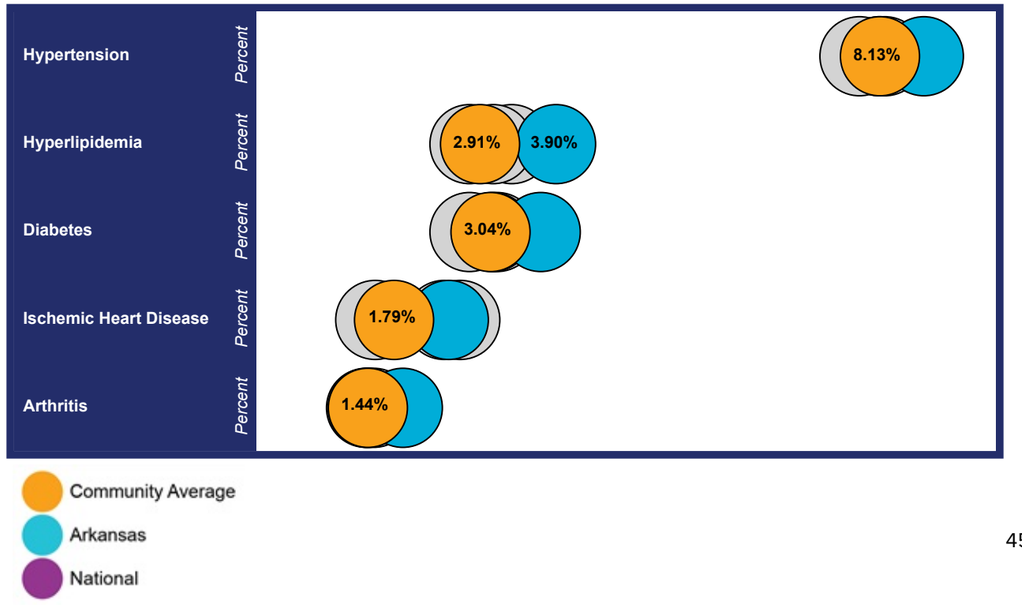


Table 8. Environment

		Grant County	Saline County	Pulaski County	Community Average	State	National
Food Environment Index	*Index of factors that contribute to a healthy food environment, 0 (worst) to 10 (best)*	6.40	7.40	6.60	6.78	4.40	7.40
Drinking Water Violations	*The total number of drinking water violations recorded in a two-year period*	0	0	0	0	321	16,107
Access to Exercise Opportunities	*Percentage of population with adequate access to locations for physical activity*	35.10%	51.50%	84.98%	75.56%	63.36%	84.45%
Broadband Access	*Percentage of population in a high-speed internet service area; access to DL speeds >= 25MBPS and UL speeds >= 3 MBPS*	95.54%	97.75%	99.09%	98.66%	94.04%	96.78%
Long Commute Driving Alone	*Among workers who commute in their car alone, the percentage who commute more than 30 minutes*	54.80%	42.60%	20.80%	26.98%	28.10%	36.50%
Severe Housing Problems	*Percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities*	9.27%	10.07%	16.37%	14.67%	13.23%	16.84%

Figure 9. Environment

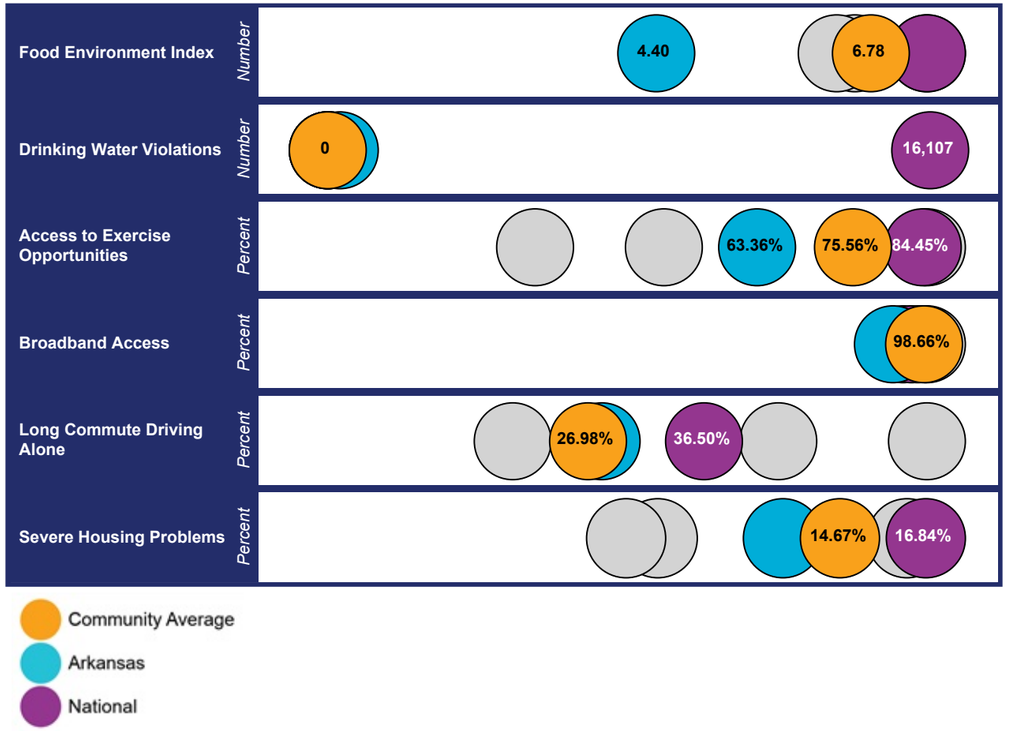


Table 9. Health Behaviors

		Grant County	Saline County	Pulaski County	Community Average	State	National
Physical Inactivity	*Percentage of adults aged 20 and older who self-report no leisure time for activity*	22.00%	21.60%	22.80%	22.50%	23.60%	19.50%
Adult Smoking	*Percentage of adults ages 18 and older who are current smokers (age-adjusted)*	20.40%	15.00%	16.70%	16.43%	19.20%	13.20%
Youth Vaping	*Percentage of public school students in 6th, 8th, 10th, and 12th grade who used any vape in the past 30 days*	10.00%	6.40%	6.90%	6.89%	8.10%	Not Available
Sexually Transmitted Infections	*Number of newly diagnosed chlamydia cases per 100,000 population*	357.90	363.50	969.80	808.95	588.30	495.00

Figure 10. Health Behaviors

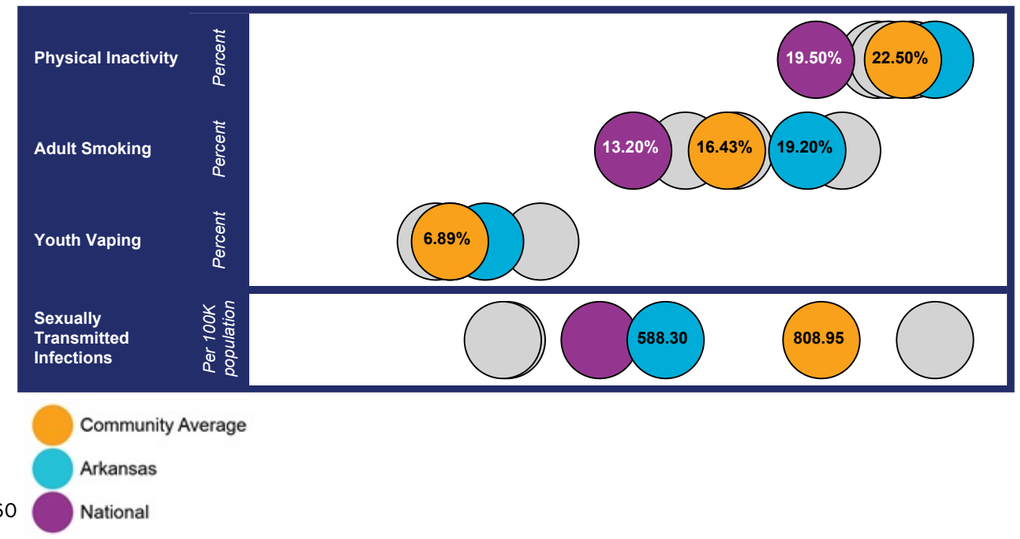


Table 10. Health Outcomes

		Grant County	Saline County	Pulaski County	Community Average	State	National
Poor Physical Health Days	*Average number of physically unhealthy days reported in past 30 days (age-adjusted)*	4.80	4.40	4.70	4.63	5.20	3.90
Poor or Fair Health	*Percentage of adults age 18 and older who self-report their general health status as "fair" or "poor" (age-adjusted)*	20.80%	17.20%	20.20%	19.53%	22.60%	17.00%

Figure 11. Health Outcomes

Table 11. Healthcare Expenditures

		Grant County	Saline County	Pulaski County	Community Average	State	National
Average Annualized Expenditures	*Average annualized per-person spending on all covered healthcare services.*	$10,931	$10,903	$10,003	$10,242	$10,116	Not Available
Average Annualized Expenditures (Medical Only)	*Average annualized per-person spending on medical services, based on medical claims.*	$7,599	$7,750	$7,131	$7,289	$7,252	Not Available
Average Annualized Expenditures (Pharmacy Only)	*Average annualized per-person spending on prescription drugs, based on pharmacy claims.*	$3,073	$2,842	$2,579	$2,656	$2,609	Not Available

Figure 12. Healthcare Expenditures

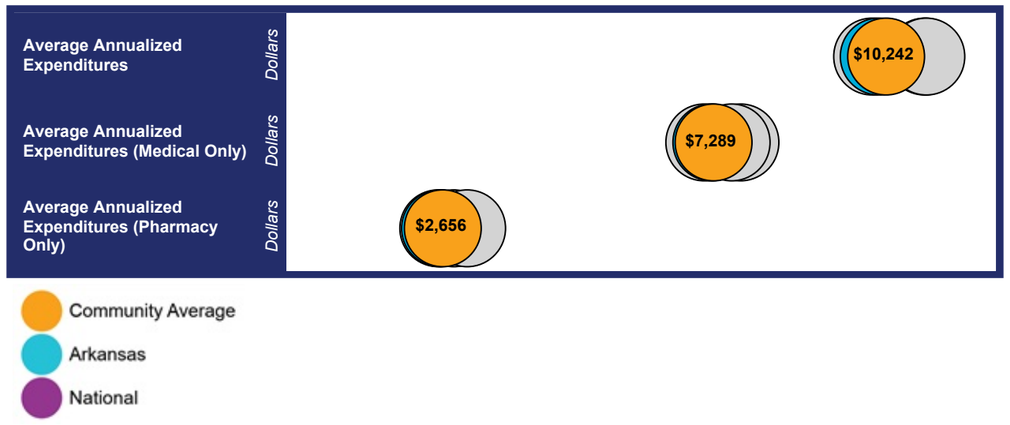


Table 12. Maternal and Infant Health

		Grant County	Saline County	Pulaski County	Community Average	State	National
Active Obstetrics and Gynecology Physicians	*Active OB-GYN physicians are defined as those who provided evaluation and management services to at least two female patients ages 12-55 on the same day or performed a qualifying procedure (e.g., delivery) at least once during the year.*	2.00	3.20	8.20	6.83	3.20	Not Available
Teen Births	*The seven-year average number of teen births per 1,000 female population, ages 15-19*	23.50	17.70	26.50	24.36	27.90	15.50
C-Section Rate	*Percentage of live births delivered via cesarean section among all deliveries, calculated by the mother's county of residence.*	33.99%	33.62%	33.87%	33.82%	33.48%	Not Available
C-Section Rate, First Birth	*Percentage of first-birth deliveries (full-term singleton pregnancies in a head-down position) delivered via cesarean section, calculated by the mother's county of residence.*	21.99%	27.87%	29.11%	28.58%	27.58%	Not Available
Low Birthweight	*Percentage of live births where the infant weighed less than 2, 500 grams (approximately 5 lbs., 8 oz.)*	10.30%	8.30%	11.70%	10.87%	9.40%	8.40%
Preterm Birth	*Percentage of live births that are preterm (<37 weeks), calculated as a three-year average.*	13.90%	11.80%	13.60%	13.19%	11.90%	10.35%
Median Travel Time to Delivery	*Median number of minutes Arkansas mothers traveled from their home ZIP code to the delivery facility, calculated using birth records and facility addresses. Travel time estimates include in-state and out-of-state facilities.*	41.00	21.00	13.00	15.79	16.00	Not Available

Figure 13. Maternal and Infant Health

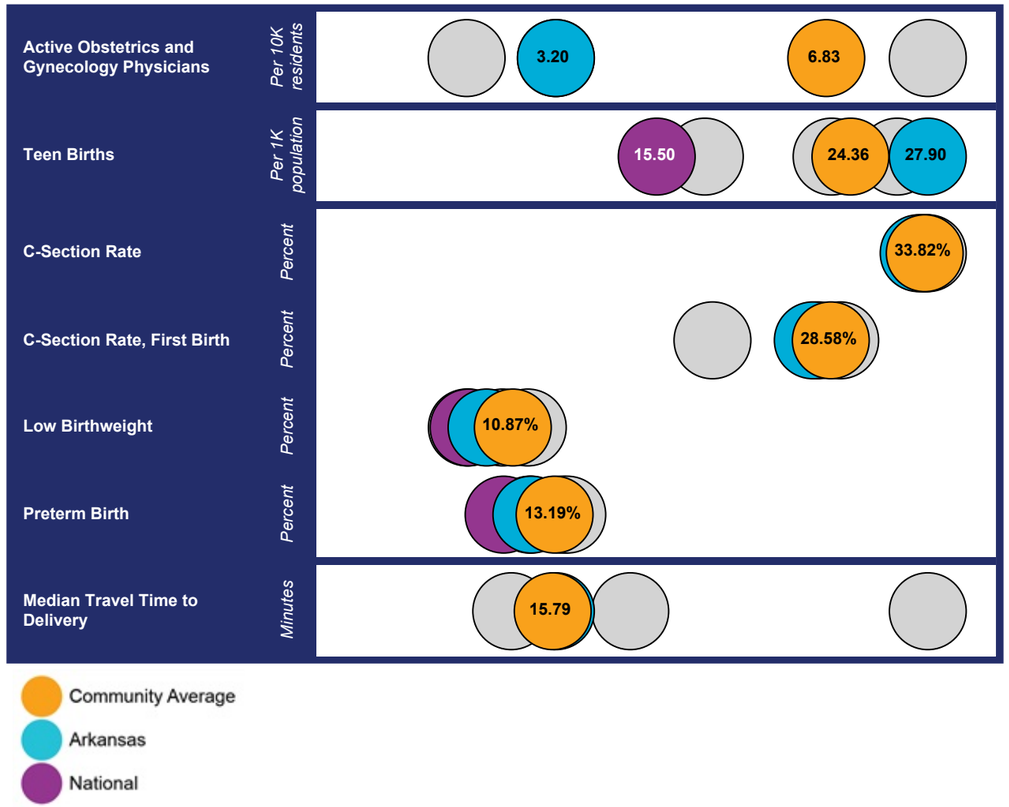


Table 13. Mental Health and Substance Use

		Grant County	Saline County	Pulaski County	Community Average	State	National
Adult Depression	*Percentage of adults age 18 and older who report having been told that they had depressive disorder*	28.90%	27.10%	25.80%	26.20%	27.50%	21.10%
Excessive Drinking	*Percentage of adults reporting binge or heavy drinking*	20.58%	19.85%	19.60%	19.69%	18.99%	19.35%
Poor Mental Health	*Percentage of adults age 18 or older reporting poor mental health for 14 or more days (age-adjusted)*	21.30%	19.30%	19.30%	19.37%	20.50%	16.40%
Youth Depression	*Percentage of public school students in 6th, 8th, 10th, and 12th grade who had feelings of depression all of the time in the past 30 days*	9.90%	5.90%	11.00%	9.78%	9.20%	Not Available
Drug Overdose Deaths	*Age-adjusted rate of fatal drug overdoses per 100,000 residents*	Not Available	Not Available	20.56	20.56	Not Available	Not Available
Non-Fatal Drug Overdoses	*Age-adjusted rate of non-fatal drug overdoses per 100,000 residents*	Not Available	18.72	29.43	26.86	Not Available	Not Available

Figure 14. Mental Health and Substance Use

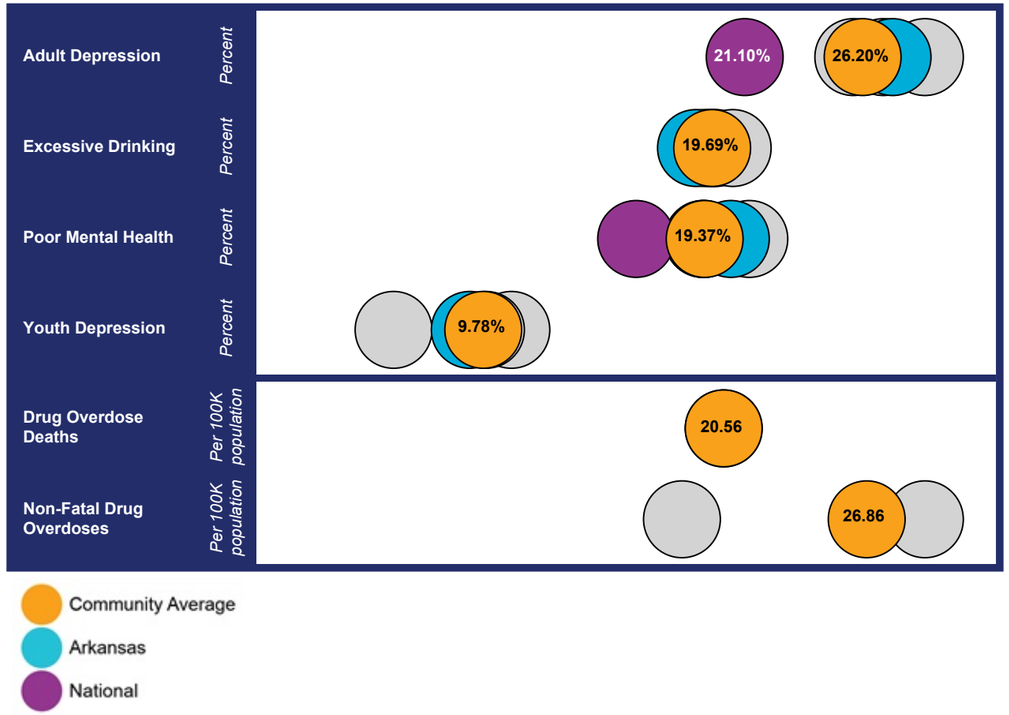


Table 14. Prevention

		Grant County	Saline County	Pulaski County	Community Average	State	National
Cervical Cancer Screening	*Percentage of females age 21–65 years who report having had recommended cervical cancer screening test (age-adjusted)*	81.90%	83.10%	83.90%	83.65%	81.20%	83.70%
Colorectal Cancer Screening	*Percentage of adults age 45-75 who have had a recent colorecal cancer screening*	63.40%	60.90%	64.40%	63.56%	61.60%	66.30%
Dental Care Utilization	*Dental care visit (past 1 year), age-adjusted percentage of adults age 18+ by county*	53.90%	62.40%	58.40%	59.18%	54.10%	63.40%
High Blood Pressure Management	*Percentage of adults age 18 and older with high blood pressure who report taking blood pressure medication (age-adjusted)*	60.00%	59.70%	61.50%	61.03%	61.40%	58.90%
Prevention - Seasonal Influenza Vaccine	*Percentage of adults aged 18 and older who report receiving an influenza vaccination in the past 12 months*	44.70%	47.10%	51.50%	50.25%	43.20%	44.80%
Annual Wellness Exam (Medicare)	*Percentage of annual wellness visits among the Medicare fee-for-service (FFS) population*	47.00%	47.00%	47.00%	47.00%	46.00%	44.00%
No HIV Test	*Percentage of adults ages 18 or older who have never been screened for HIV*	63.10%	63.40%	60.80%	61.48%	66.10%	Not Available

Figure 15. Prevention

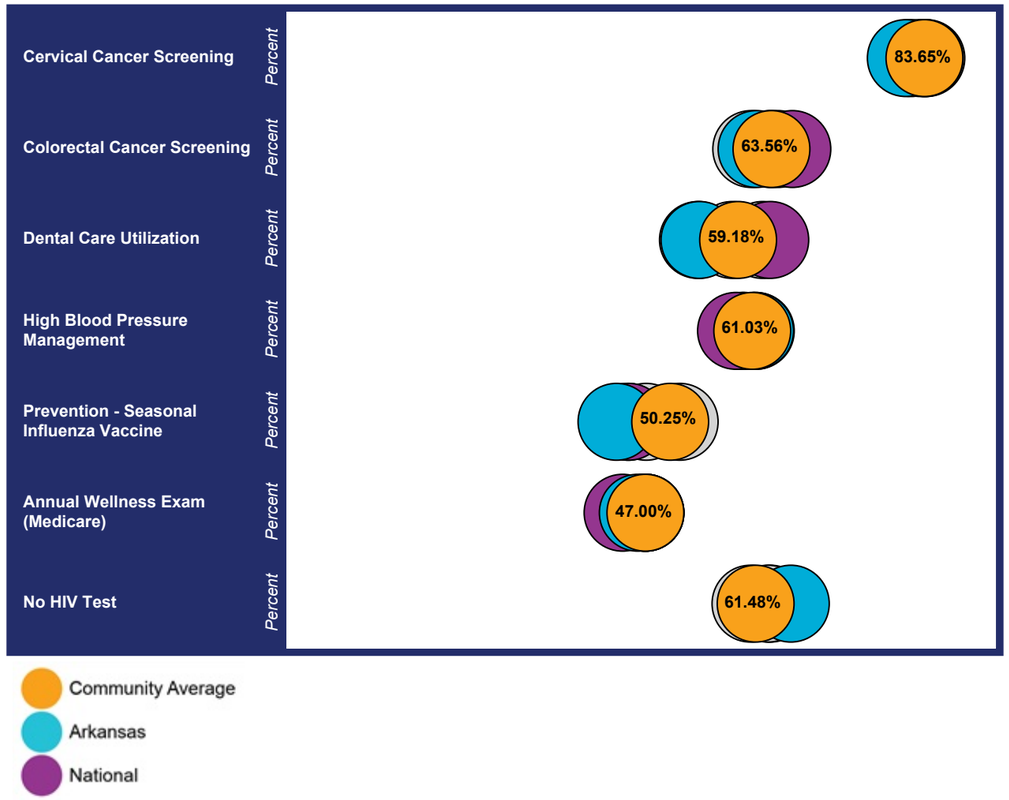
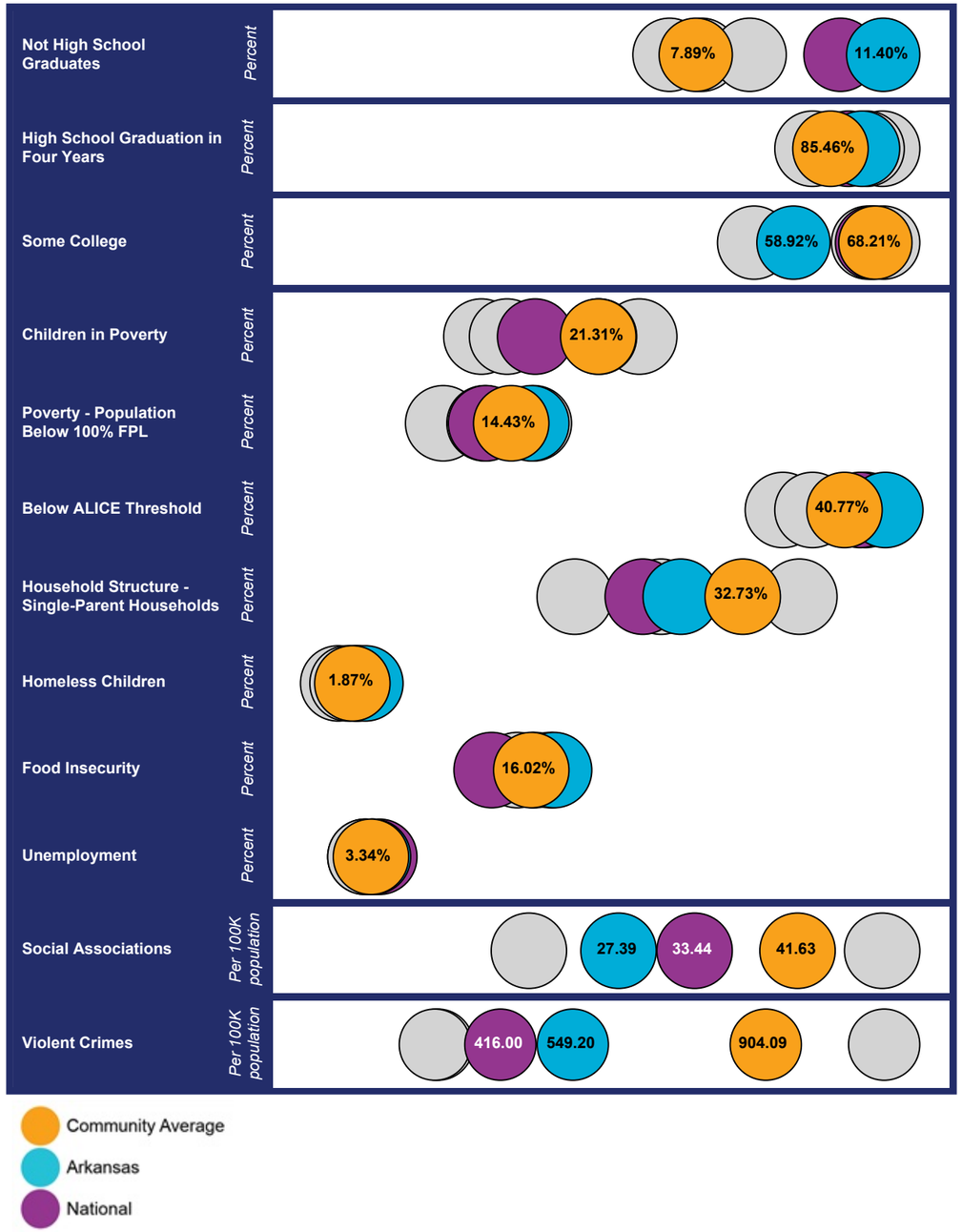


Table 15. Social and Economic Factors

		Grant County	Saline County	Pulaski County	Community Average	State	National
Not High School Graduates	*Percentage of adults without a high school diploma*	8.90%	7.40%	8.00%	7.89%	11.40%	10.60%
High School Graduation in Four Years	*Percentage of ninth-grade cohort who graduated in four years*	91.00%	93.40%	82.70%	85.46%	90.30%	88.20%
Some College	*Percentage of adults ages 25-44 with some post-secondary education*	54.45%	67.38%	69.10%	68.21%	58.92%	67.83%
Children in Poverty	*Percentage of children under age 18 below the poverty line*	14.10%	12.07%	24.55%	21.31%	21.37%	16.32%
Poverty - Population Below 100% FPL	*Percentage of the population living in households with income below the federal poverty level*	12.32%	9.05%	16.22%	14.43%	16.02%	12.44%
Below ALICE Threshold	*Percentage of households living in poverty or classified as ALICE (Asset Limited, Income Constrained, Employed)*	38.25%	35.91%	42.42%	40.77%	44.00%	42.00%
Household Structure - Single-Parent Households	*Percentage of children who live in households where only one parent is present*	26.27%	19.45%	37.21%	32.73%	27.83%	24.83%
Homeless Children	*Percentage of students experiencing homelessness enrolled in the public school system*	1.49%	0.75%	2.24%	1.87%	2.90%	2.31%
Food Insecurity	*Percentage of the population that experienced food insecurity in the report year*	17.50%	14.90%	16.30%	16.02%	17.82%	12.88 %
Unemployment	*Percentage of the civilian non-institutionalized population age 16 and older that is unemployed (non-seasonally adjusted)*	2.90%	2.90%	3.50%	3.34%	3.50%	4.00%
Social Associations	*Establishments, rate per 100,000 population*	Not Available	20.26	48.36	41.63	27.39	33.44
Violent Crimes	*Annual rate of reported violent crimes per 100,000 population*	295.50	300.90	1121.80	904.09	549.20	416.00

Figure 16. Social and Economic Factors



IDENTIFIED NEED 1:
Increase Access to Care and Education

GOALS/OBJECTIVE/OBJECTIVES:
Increase Access to Quality Health Care through Education and Community Resources.

STRATEGY: 1:
Improve health outcomes through patient education and partnerships with patients and families

ACTION STEPS:

- Offer Stroke Prevention Education and Support group for patients and community members
- Provide Fall Risk prevention education for community groups and community wellness centers
- Partner with Community Outreach and Health Management Center to Increase access to Diabetes complication prevention services and self-management resources including Diabetes Support Group.
- Partner with Community Outreach to Increase access to Stroke complication prevention services and self-management resources including Stroke Support Group

KEY PERFORMANCE METRICS:

- Track Number of Community Education and Screenings
- Track Support Group participation
- Track the number of classes offered and participants
- Track number of blood pressure monitors provided through the MEMS initiative

COLLABORATIONS WITH ORGANIZATIONS: Local nonprofits, Coalitions, First Responders

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS NEED: Staff time and clinical expertise, marketing and educational materials, vaccination resources, Marketing & Communications and Community Outreach

ESTIMATED COMPLETION DATE: Ongoing through 2028

PERSON(S)/DEPARTMENT RESPONSIBLE: Leadership Team, Community Outreach

IDENTIFIED NEED 1:
Increase Access to Care and Education

GOALS/OBJECTIVE/OBJECTIVES:
To improve community health by increasing health literacy and reducing barriers to accessing healthcare through community-led, culturally appropriate education and navigation support.

STRATEGY 2:
Health Literacy & Access to Healthcare

ACTION STEPS:
- Identify target populations based on data and community need
- Launch community in-person, and virtual workshops to cover topics including understanding health information, communicating with healthcare providers, navigating healthcare, self-management and preventive health, understanding prescriptions, telehealth, patient rights
- Train community-based clinical and non-clinical staff in health-literate communication (e.g., Teach-Back, plain language)

KEY PERFORMANCE METRICS:
- Curriculum identified and vetted for implementation
- Track the number of classes offered and participants
- Track pre/post test results to determine knowledge gained
- Track number of staff trained to implement the program
- Identified number of encounters using the Teach-Back method

COLLABORATIONS WITH ORGANIZATIONS: Local nonprofits, faith-based organizations, community-based organizations

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS NEED: Staff time and clinical expertise, marketing and educational materials, vaccination resources, Marketing & Communications and Community Outreach

ESTIMATED COMPLETION DATE: Ongoing through 2028

PERSON(S)/DEPARTMENT RESPONSIBLE: Leadership Team, Community Outreach

IDENTIFIED NEED 2:
The Community Mental Health Strategy: Access, Education, Acceptance

GOALS/OBJECTIVE/OBJECTIVE:
In partnership with Community Outreach Improve and increase access to mental health services, reduce stigma, and promote emotional well-being for residents of the Pulaski County

STRATEGY 1:
Strengthen collaboration with employers, healthcare providers, and community organizations to expand mental health education, increase access to counseling and crisis resources, and promote early intervention and resilience-building initiatives.

ACTION STEPS:
- Partner with healthcare organizations, locally and statewide, to increase the capacity to provide additional mental health services.
- Implementation Project to increase in-patient mental and behavioral health services.
- Provide Mental Health First Aid training to local schools, colleges, and community or faith-based organizations.
- Provide Community-based Stop the Bleed Trainings
- Participate in System-wide Mental Health Awareness Campaigns
- Integrate Mental Health Education and Awareness materials into Schools and Workplaces
- Utilize Telepsych for patients in need of Telemedicine services

KEY PERFORMANCE METRICS:
- Track number of patient encounters in-patient withdrawal management services
- Track number of patient encounters utilizing Telepsych services
- Report number of Community partners and events for mental health services
- Track the number of mental health first aid and Stop the Bleed classes and participants
- Track the number of Mental Health First Aid trainings and attendance
- Measure campaign's reach through social media engagement, website visits, and printed material distribution.

COLLABORATIONS WITH ORGANIZATIONS: Local schools, universities and businesses, non-profits and faith-based organizations

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS NEED: Staff time and clinical expertise, marketing and educational materials, community health supplies and ongoing support from the Marketing & Communications and behavioral health, command center and Community Outreach teams.

ESTIMATED COMPLETION DATE: Ongoing through 2028

PERSON(S)/DEPARTMENT RESPONSIBLE: Leadership, Behavioral Health, Community Outreach Marketing & Communications Manager, Case Management

IDENTIFIED NEED 3:
Closing the Gap: A Strategy for Healthy Communities and Nutrition Security

GOALS/OBJECTIVE/OBJECTIVE:
Provide food directly to patients, family members and/or employees to meet the needs of those with demonstrated food insecurity.

STRATEGY:
Participate in the System FoodRx initiative to provide healthy, nutritious food choices to food insecure patients, families and employees.

ACTION STEPS:

- Utilize the Epic System to screening for Food Insecurity for inpatients visits and refer to Community Outreach FoodRx program
- Promote the Arkansas Fruit and Vegetable Prescription Program with Community Outreach and the Arkansas Hunger Relief Alliance to distribute fresh produce to food-insecure patients with a diet-related chronic health condition.
- Continue utilization of David's village to educate patients on cooking healthy meals and shopping with ease
- Promote Community-based nutrition education and cooking classes
- Provide education to families and caregivers nutritional needs based on oral problems, height and weight, weight change, nutrition problems (altered taste, hunger, uneaten meals), approaches to nutritional care (nutrition support, and therapeutic diets), and food intake

KEY PERFORMANCE METRICS

- Track and report the number of individuals served by the FoodRx program.
- Track and report the number of bags distributed
- Track and report the total number of pounds or "meals" of food distributed.
- Track and report the number of participants in the Arkansas Fruit and Vegetable program.
- Track number of participants in community nutrition education and cooking classes

COLLABORATIONS WITH ORGANIZATIONS: Local nonprofits, foodbank, Arkansas Hunger Relief Alliance

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS NEED: Staff time and clinical expertise, marketing and educational materials, community health supplies, vaccination resources, and ongoing support from the Marketing & Communications and Community Outreach

ESTIMATED COMPLETION DATE: Ongoing through 2028

PERSON(S)/DEPARTMENT RESPONSIBLE: Leadership Team, Case Coordination, Community Outreach

BAPTIST HEALTH
Fort Smith

About Us

Baptist Health-Fort Smith was the first hospital built in Arkansas in 1887. It is currently a 492- bed medical center accredited by The Joint Commission. In addition to operating one of the busiest emergency departments in the state, the hospital offers providers who specialize in areas such as cardiology, cardiovascular and thoracic surgery, interventional radiology and stroke care, orthopedics, general and trauma surgery, labor and delivery, pediatrics, and many more.

From screenings to expert treatment to surgical procedures, we provide advanced, state-of-the-art services to ensure you get the best possible results from your care including the minimally-invasive da Vinci surgical system.

In addition, we offer Aquablation therapy— an advanced, minimally invasive treatment of lower urinary tract symptoms (LUTS) due to benign prostatic hyperplasia (BPH).

Another unique attribute is the hospital's gym, Marvin Altman Fitness Center, which features a junior Olympic-size indoor pool, indoor rubberized track, yoga studios, massage therapy, and cardiac rehabilitation services.

Awards & Recognitions

- American Heart Association's Get with the Guidelines Stroke Gold Plus with Honor Roll Achievement Award.

- Baptist Health-Fort Smith received the American Heart Association's Gold Plus and Target Type 2 Diabetes Honor Roll Get With The Guidelines award for their commitment to ensuring stroke patients receive the most appropriate treatment according to nationally recognized research-based guidelines. Learn more about the providers at Baptist Health Neuroscience Center-Fort Smith.
- Baptist Health-Fort Smith has demonstrated sustained achievement in the Chest Pain MI Registry for four consecutive quarters during 2020 and performed with distinction in specific performance measures to receive this 2021 award.
- Baptist Health-Fort Smith was also recognized by the American Heart Association for its commitment to safety and quality care for patients with heart failure. Learn more about our cardiologists at Baptist Health Cardiology Center-Fort Smith.

Community Health Needs Assessment 2026-2028
Baptist Health Extended Care Hospital

HIGHLIGHTS OF COMMUNITY HEALTH NEEDS ASSESSMENT ACCOMPLISHMENTS 2023-2025

ACCESS TO CARE

- Expanded Clinical Expertise in the River Valley: Added seven new providers across Primary Care, Surgery, and Women's Health.
- Significantly Grew Specialized Provider Base: Added providers in nine critical areas including Nephrology, Cardiothoracic and Vascular Surgery, Internal Medicine, Oncology, Women's Health, Surgery, and Pulmonology.
- Enhanced Maternal Care Team: Added two certified nurse midwives to the care team to positively impact maternal health outcomes.
- Invested in Future Healthcare Professionals: Partnered with Fort Smith Public Schools and Darby Middle School to open the Darby Health Sciences Academy at Baptist Health Medical Plaza, fostering the next generation of caregivers.
- Strengthened Health Outreach in Latin Community: Partnered with La Clinica del Pueblo to host and attend events in honor of Cinco de Mayo, Hispanic Heritage Month and Breast Cancer Awareness Month where free health education and screenings were provided to the community in Spanish..
- Partnered with the National Association for the Advancement of Colored People (NAACP) to host an annual health fair at St. James Baptist Church in Fort Smith.
- Priorities Corporate Wellness and Safety: Participated in Pernod Ricard's safety day and employee health fair, providing vital education on heart attack and stroke signs and risk factors.
- Cultivated Healthcare Career Interest: Successfully hosted MASH and Caring Teen Programs during the summer to expose high school students to careers in healthcare.
- Encouraged multi-agency collaboration with local students during county-wide emergency disaster drill held at Baptist Health-Fort Smith.
- Supported Local Collegiate Athletics: Provided physical examinations for University of Arkansas Fort Smith student athletes.
- Advanced Breast Cancer Screening Technology: Added the Invenia Automated Breast
- Ultrasound System (ABUS), a crucial screening option for women with dense breast tissue, at the Baptist Health Breast Center-Fort Smith.
- Bridging the gap in home monitoring: We increase access to care for patients with limited resources by providing free blood pressure machines, blood glucose machines and test strips, and scales, enabling crucial at-home health tracking.
- Executed Major Capital Investment: Baptist Health-Fort Smith invested in new, state-of-the-art equipment including imaging technology, CT machines, Ion Robotic Bronchoscopy, and the latest da Vinci 5 robotic surgical system.
- Provided Ongoing Stroke Support: Hosted Monthly Stroke Support Groups at Baptist Health-Fort Smith.
- Championed Community Stroke Education: The stroke education team delivered education at more than 20 community events and meetings annually, including multiple sessions at public schools.
- Partnered with the Good Samaritan clinic to provide health care services for the under-served and uninsured populations.
- Distributed Findhelp resource cards throughout the hospital service areas and in FoodRx distribution bags.
- Invested in Precision Cancer Treatment: Baptist Health Radiation Oncology-Fort Smith invested in Surface Guided Radiation Therapy (SGRT) for more precise cancer treatment for River Valley patients.
- Expanded Critical Care Capacity: Baptist Health-Fort Smith began offering Extracorporeal Membrane Oxygenation (ECMO), a high-level life support service.
- Maximized Preventative Care Access: Actively participated with numerous community groups and employers to provide access to preventative health screenings and referrals.
- Hosted Targeted Health Education: Both Dr. Kyle Basham and Dr. John Terrell of Baptist Health Urology Clinic-Fort Smith hosted multiple webinars and in-person sessions to address both men's health and women's health, with a focus on sexual health and urologic health.
- Provided Essential Public Health Services: Successfully offered community-based Flu clinics.
- Increased virtual care Access: Delivered 30,000 system-wide outpatient virtual care encounters.
- Enhanced remote Patient Monitoring: Provided nearly 40,000 system-wide remote patient encounters for cardiac care.
- Increased Mammogram Accessibility: The Baptist Health Breast Center-Fort Smith offered special Saturday appointments for mammograms, ABUS, and other screenings.
- Improved Lung Cancer Screening Access: The Baptist Health Imaging Center-Fort Smith offered special Saturday appointments for LDCT screenings for lung cancer.
- Promoted Maternal and Infant Health by offering free breastfeeding classes to local moms-to-be and their partners.
- Expanded community outreach to expectant mothers by participating in annual virtual baby showers.

MENTAL HEALTH

- Provided Access to Mental Health Services including counseling, depression treatment,anxiety relief, conflict management, ADHD testing psychiatric evaluations along with other services through the Baptist Health Behavioral Services Clinic.
- Expanded Tele-Psychiatry Services: Successfully offered vPsych Consults across multiple campuses.
- Integrated Mental Health Screening (MENTAL HEALTH): Implemented and utilized Depression screening tools within the EPIC systems.
- Promoted Holistic Wellness: Partnered with the Marvin Altman Fitness Center to implement a dance marathon promoting both mental and physical health.
- Provided Neuro-Cognitive Health Education: Partnered with the Alzheimer's Association to offer community health education on "Health Living for the Brain and Body."
- Increased Geriatric Mental Health Awareness: Actively participated in various community events to promote geripsych services and awareness.
- Educated on Nutrition's Mental Health Impact: Provided promotions and education on how nutrition affects mental health to various groups, including ArcBest, senior care alliances, and the City of Fort Smith.
- Developed Comprehensive Behavioral Health Resource: Created a system-wide comprehensive guide highlighting all available behavioral health services.
- Partnered to offer an annual ACES awareness symposium for Community members and staff with over 200 participants.
- Offered the New Vision program at Baptist Health-Fort Smith and Baptist Health-Van Buren as a safe option for adults experiencing active or impending withdrawal from drugs and/or alcohol.

NUTRITION AND FOOD INSECURITY

- Integrated Mental Health Screening (Nutrition and Food Insecurity): Successfully utilized Food Insecurity screenings tools within the EPIC systems.
- Fostered Employee and Patient Sustainability: Developed and maintained a rooftop garden run by hospital employees and community volunteers.
- Successfully implemented FoodRx program to provide fresh produce and shelf-stable groceries to patients who identified as food insecure upon discharge. Roughly 200 bags are distributed annually.
- Offered Community-based educational programs on nutrition and healthy eating
- Partnered with agencies to prepare and provide healthy meals to low-income and un-housed community members.
- In partnership with Community Outreach offered a virtual “Maintain Don’t Gain” nutrition and education program open statewide.
- Utilized EPIC to screen patients for Food Insecurity Needs. Provided food for those screening positive, provided Findhelp resource car for additional social determinants of health needs.
- Increased access to breast milk milk for high-risk infants by opening UAMS Milk Depot inside Expressly for You-Fort Smith, an outpatient lactation clinic and boutique.

2025 BAPTIST HEALTH COMMUNITY HEALTH NEEDS ASSESSMENT: FORT SMITH

ACHI
August 2025

Baptist Health

PREPARED BY:
ACHI
INSPIRING HEALTHY ACTS

Introduction

Baptist Health engaged the Arkansas Center for Health Improvement (ACHI) to conduct the quantitative data collection and analysis for the 2025 Community Health Needs Assessment (CHNA) process. Baptist Health provided ACHI with the counties served by each of its 12 hospital communities. A total of 16 Arkansas counties and two Oklahoma counties were included.

Each report presents community-level data for a hospital community, including tables and figures for each indicator, along with comparisons to Arkansas and U.S. benchmarks. Dot graphs are provided to visualize performance across selected indicators. All reports are prepared using the same methodology to ensure consistency and comparability across Baptist Health hospital communities.

Methodology

A summary of sources, definitions, indicator criteria, and suppression rules can be found in the methods and sources document.

Community Profile Summary

To support the 2025 Community Health Needs Assessment (CHNA), ACHI compiled a comprehensive dataset of 103 health and demographic indicators for the communities served by Baptist Health's 12 hospital locations. This section provides an overview of these indicators across the full CHNA service area and offers multiple views for understanding and comparing county-level and community-level data.

Data are grouped into the following 14 categories, based on the source-defined domains outlined in the data source reference sheet:

1. Demographics
    a. Age
    b. Sex
    c. Race, Ethnicity, and Language
2. Insurance Coverage
3. Access to Care
4. Cause of Death
5. Chronic Conditions
6. Diagnoses Incidence at Discharge
7. Environment
8. Health Behaviors
9. Health Outcomes
10. Healthcare Expenditures
11. Maternal and Infant Health
12. Mental Health and Substance Use
13. Prevention
14. Social and Economic Factors

Measurements for these categories will be displayed in the following sections.

Hospital Community Indicator

The hospital community indicator snapshots offer an at-a-glance view of how each hospital community compares to state and national benchmarks, as well as the counties that make up the community.

Each table presents the data values for selected indicators across the 14 CHNA domains, and each corresponding visual uses proportionally scaled circular markers to illustrate performance. This format is designed to quickly convey how each hospital community aligns with or diverges from broader benchmarks in key population health metrics.

Each displays four comparison points:

- **Purple** – Represents the national value for the indicator.
- **Blue** – Represents the value for the state of Arkansas.
- **Gold** – Represents the weighted average for all counties in the hospital's defined service area.
- **Gray** – Represent the values of each county assigned to that hospital community.

Where available, data for each indicator are shown for all four categories. If a value is not available or is suppressed for a contributing county, it is noted as "Not Available" in the table and excluded from the visual display. No color ranking is applied; the visuals and tables are intended to illustrate relative placement, not comparative rank.

Hospital Community: Fort Smith (Sebastian, Le Flore and Sequoyah Counties)

Figure 1. Counties Served by Baptist Health Medical Center–Fort Smith

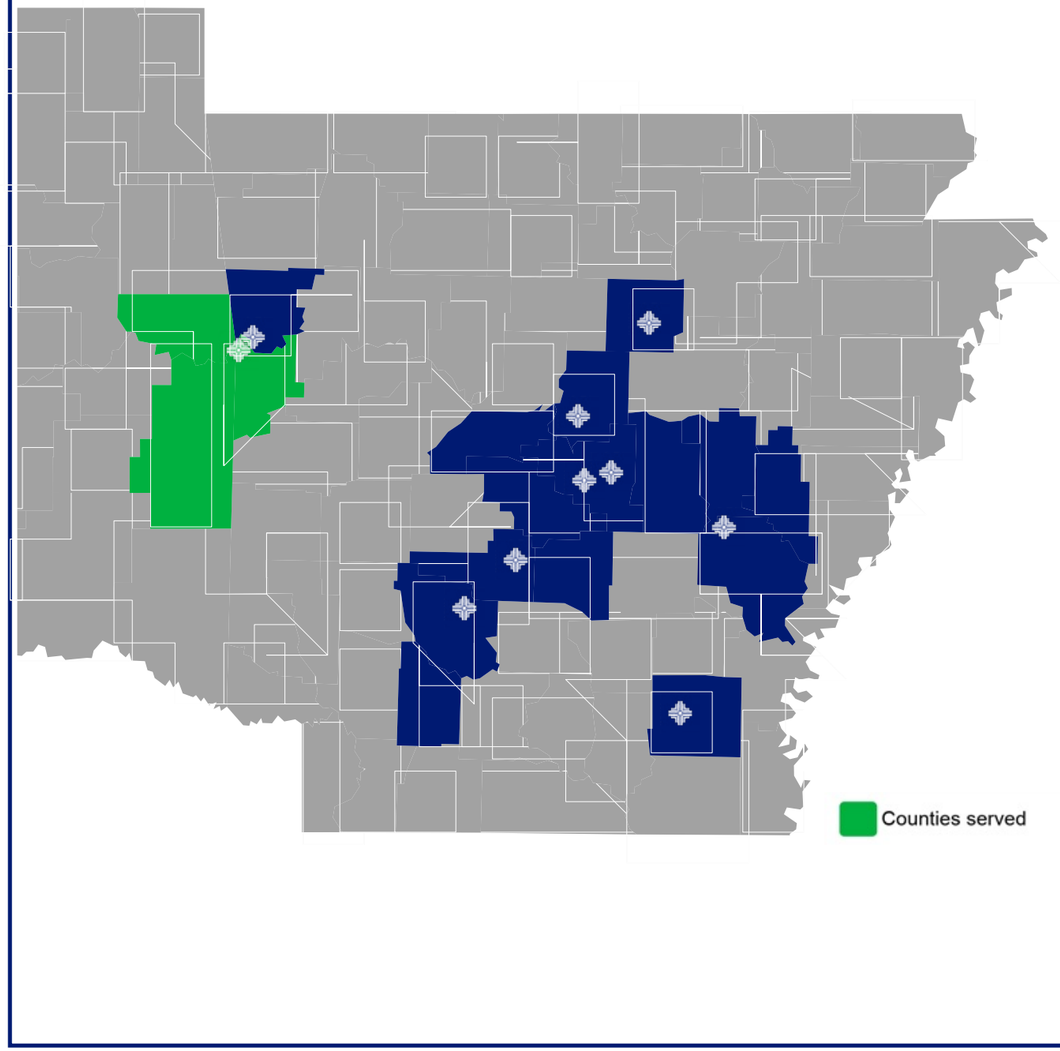


Table 1. Demographics: Age and Sex

		Sequoyah County (OK)	Le Flore County (OK)	Sebastian County	Community Average	State	National
Total Population	*Number*	39,676	48,728	128,448	128,448	3,032,651	332,387,540
Female	*Percent*	50.44%	49.55%	50.85%	50.85%	50.67%	50.50%
Male	*Percent*	49.56%	50.45%	49.15%	49.15%	49.33%	49.50%
Ages 0-4	*Percent*	6.34%	6.30%	6.34%	6.34%	6.02%	5.70%
Ages 5-17	*Percent*	17.56%	18.07%	17.57%	17.57%	17.26%	16.46%
Ages 18-24	*Percent*	8.01%	8.47%	8.80%	8.80%	9.33%	9.12%
Ages 25-34	*Percent*	11.89%	12.17%	13.41%	13.41%	12.93%	13.69%
Ages 35-44	*Percent*	11.36%	12.37%	12.36%	12.36%	12.66%	13.08%
Ages 45-54	*Percent*	12.72%	11.85%	12.03%	12.03%	11.84%	12.29%
Ages 55-64	*Percent*	13.61%	12.97%	12.75%	12.75%	12.64%	12.82%
Ages 65+	*Percent*	18.52%	17.81%	16.74%	16.74%	17.33%	16.84%

Figure 2. Demographics: Age and Sex

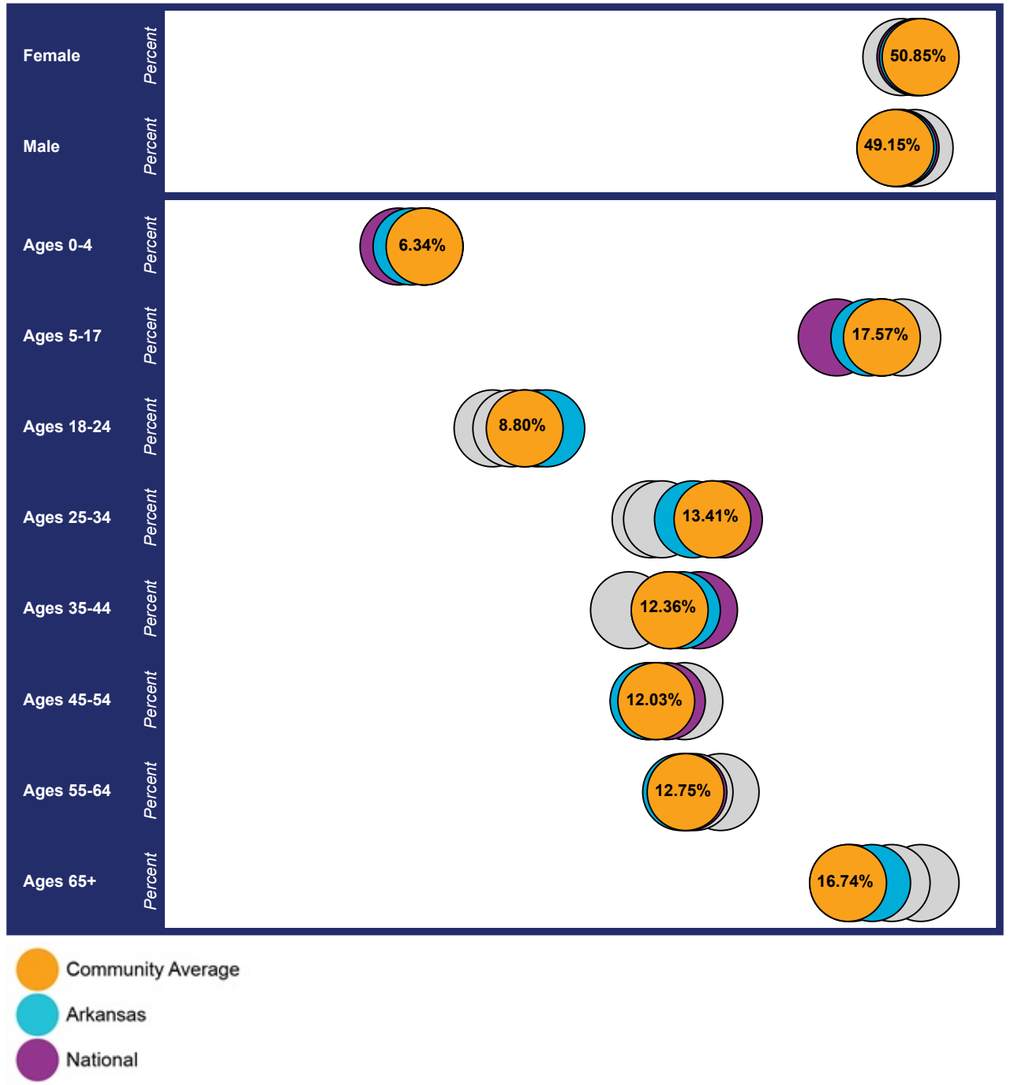


Table 2. Demographics: Race, Ethnicity, and Language

		Sequoyah County (OK)	Le Flore County (OK)	Sebastian County	Community Average	State	National
Total Population	*Number*	39,676	48,728	128,448	128,448	3,032,651	332,387,540
Asian	*Percent*	0.69%	0.83%	4.19%	4.19%	1.53%	5.75%
Black or African American	*Percent*	1.94%	1.83%	5.72%	5.72%	14.84%	12.03%
Hispanic	*Percent*	4.85%	7.76%	15.59%	15.59%	8.77%	18.99%
Multiple Races	*Percent*	12.25%	9.23%	6.71%	6.71%	5.50%	3.87%
Native American/ Alaska Native	*Percent*	19.21%	11.31%	0.69%	0.69%	0.36%	0.53%
Native Hawaiian/ Pacific Islander	*Percent*	0.08%	0.03%	0.12%	0.12%	0.39%	0.17%
Other Races	*Percent*	0.14%	0.10%	0.17%	0.17%	0.26%	0.50%
White	*Percent*	60.83%	68.90%	66.80%	66.80%	68.36%	58.17%
Non-English Language Households	*Percent*	0.50%	1.20%	3.30%	3.30%	1.50%	4.20%

Figure 3. Demographics: Race, Ethnicity, and Language

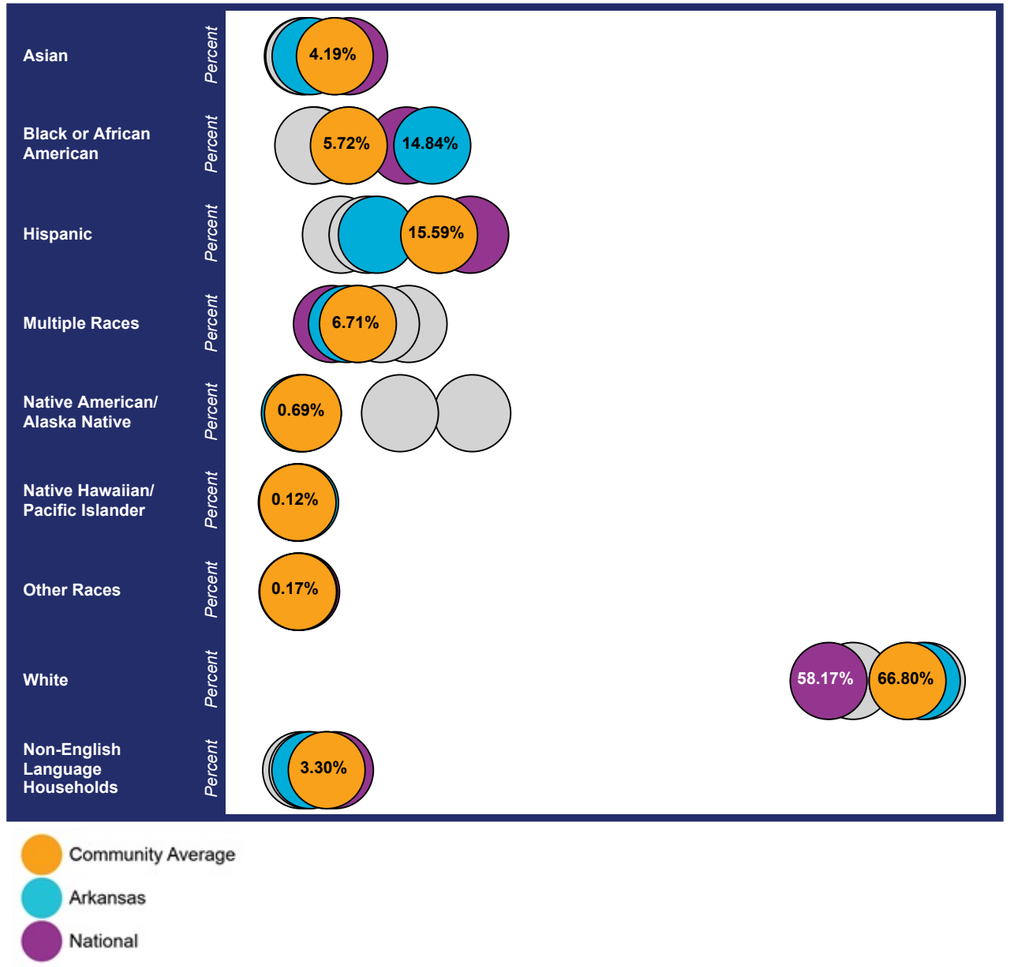


Table 3. Insurance Coverage

		Sequoyah County (OK)	Le Flore County (OK)	Sebastian County	Community Average	State	National
Private Health Insurance Coverage	*Percentage of the total civilian non-institutionalized population for whom insurance status is determined that is covered by private health insurance*	55.58%	57.38%	65.05%	65.05%	65.37%	73.62%
Public Health Insurance Coverage	*Percentage of the total civilian non-institutionalized population for whom insurance status is determined that is covered by public health insurance*	57.71%	55.42%	48.07%	48.07%	48.21%	39.70%
Uninsured	*Percentage of adults under age 65 without health insurance coverage*	16.50%	19.10%	11.40%	11.40%	10.00%	9.50%

Figure 4. Insurance Coverage

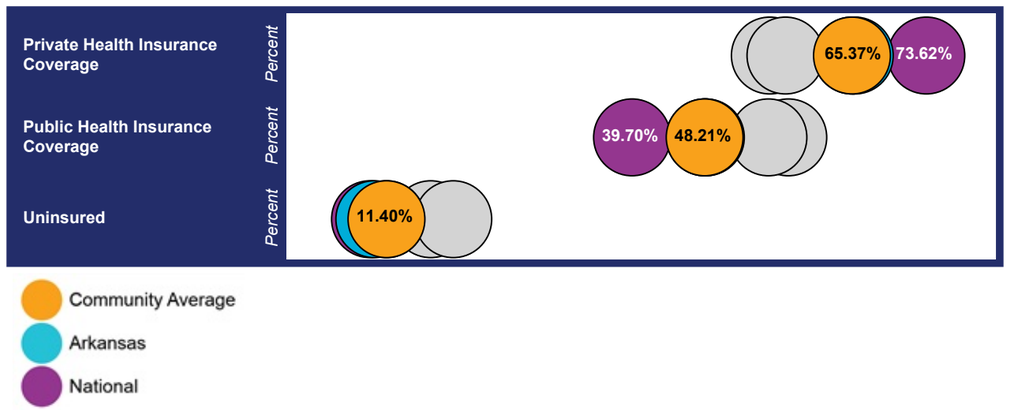


Table 4. Access to Care

		Sequoyah County (OK)	Le Flore County (OK)	Sebastian County	Community Average	State	National
Primary Care Physicians	*Ratio of population to one primary care physician*	2822:1	3462:1	764:1	764:1	1478:1	1334:1
Mental Health Providers	*Ratio of population to one mental health provider*	319:1	298:1	255:1	255:1	367:1	300:1
Dentists	*Ratio of population to one dentist*	2479:1	3493:1	1265:1	1265:1	2044:1	1361:1
Active Primary Care Physicians	*Rate per 10,000 county residents of primary care physicians who provided evaluation and management services to at least two patients on the same day at least once during the year*	Not Available	Not Available	19.00	19.00	9.20	Not Available
Addiction or Substance Use Providers	*Rate of addiction or substance use providers per 100,000 population*	40.73	18.70	18.78	18.78	5.98	29.43
Buprenorphine Providers	*Rate of buprenorphine providers per 100,000 population*	12.66	8.23	17.16	17.16	9.81	14.87
Preventable Hospital Stays (Medicare)	*Rate of hospital stays for ambulatory care-sensitive conditions per 100,000 Medicare enrollees*	4205.00	4292.00	3224.00	3224.00	3014.00	2666.00
Diabetic Monitoring (Medicare)	*Percentage of Medicare enrollees aged 65 and older with diabetes who received a hemoglobin A1c (HbA1c) test within the past year.*	67.73%	73.72%	87.65%	87.65%	88.47%	87.53%
Mammography	*Percentage of female Medicare enrollees ages 65-74 who received an annual mammography screening*	38.00%	39.00%	47.00%	47.00%	41.00%	44.00%

Figure 5. Access to Care

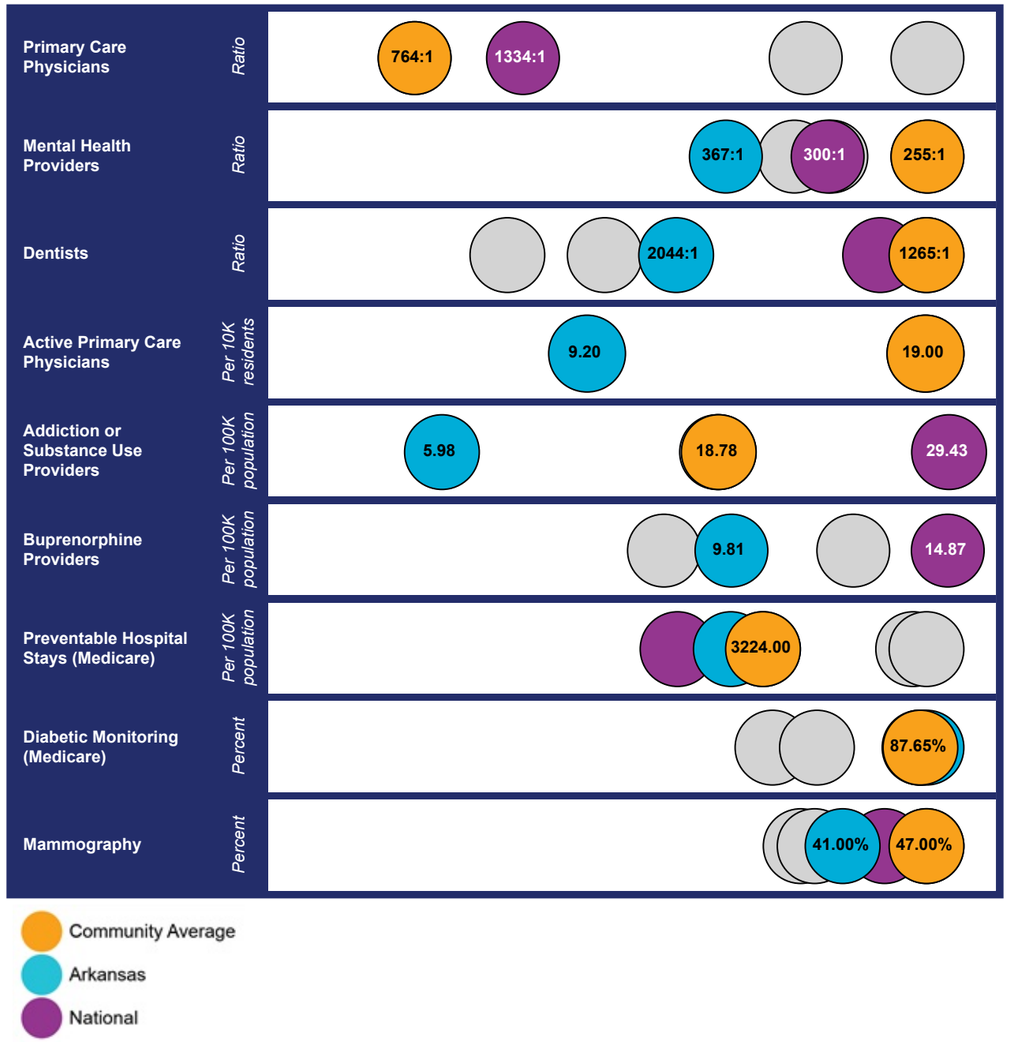


Table 5. Cause of Death

		Sequoyah County (OK)	Le Flore County (OK)	Sebastian County	Community Average	State	National
All Causes	*Rate of deaths by all causes per 100,000 population (age-adjusted)*	1227.30	1221.20	1004.70	1004.70	1001.70	805.60
Premature Death	*Number of deaths among residents under age 75 per 100,000 population (age-adjusted)*	718.72	692.42	571.65	571.65	552.47	406.59
Heart Disease	*Rate of death due to heart disease (ICD-10 Codes I00-I09, I11, I13, I20-I151) per 100,000 population*	418.10	400.40	263.60	263.60	282.80	207.20
Cancer	*5-year average rate of death due to cancer per 100,000 population*	307.50	261.80	203.40	203.40	215.90	182.70
Unintentional Injury	*5-year average rate of death due to unintentional injury (accident) per 100,000 population*	83.90	72.90	57.60	57.60	61.90	63.30
Stroke	*5-year average rate of death due to cerebrovascular disease (stroke) per 100,000 population (age-adjusted)*	62.70	60.40	62.30	62.30	57.40	48.30
Chronic Lower Respiratory Disease	*Rate of deaths due to chronic lower respiratory disease per 100,000 population (age-adjusted)*	72.80	96.10	65.10	65.10	61.00	35.90
Diabetes Mortality	*Rate of deaths due to diabetes per 100,000 population (age-adjusted)*	38.10	36.80	38.90	38.90	34.70	23.90
Suicide Deaths	*This indicator reports the 2019-2023 five-year average rate of death due to intentional self-harm (suicide) per 100, 000 population. Figures are reported as crude rates*	20.20	21.50	20.40	20.40	19.20	14.50
Motor Vehicle Crash	*5-year average rate of death due to motor vehicle crash per 100,000 population (age-adjusted)*	25.70	27.10	14.50	14.50	20.60	12.80
Alcohol-Involved Motor Vehicle Crash	*Rate of persons killed in motor vehicle crashes involving alcohol as a rate per 100,000 population*	1.50	3.70	1.90	1.90	3.10	2.30

Figure 6. Cause of Death

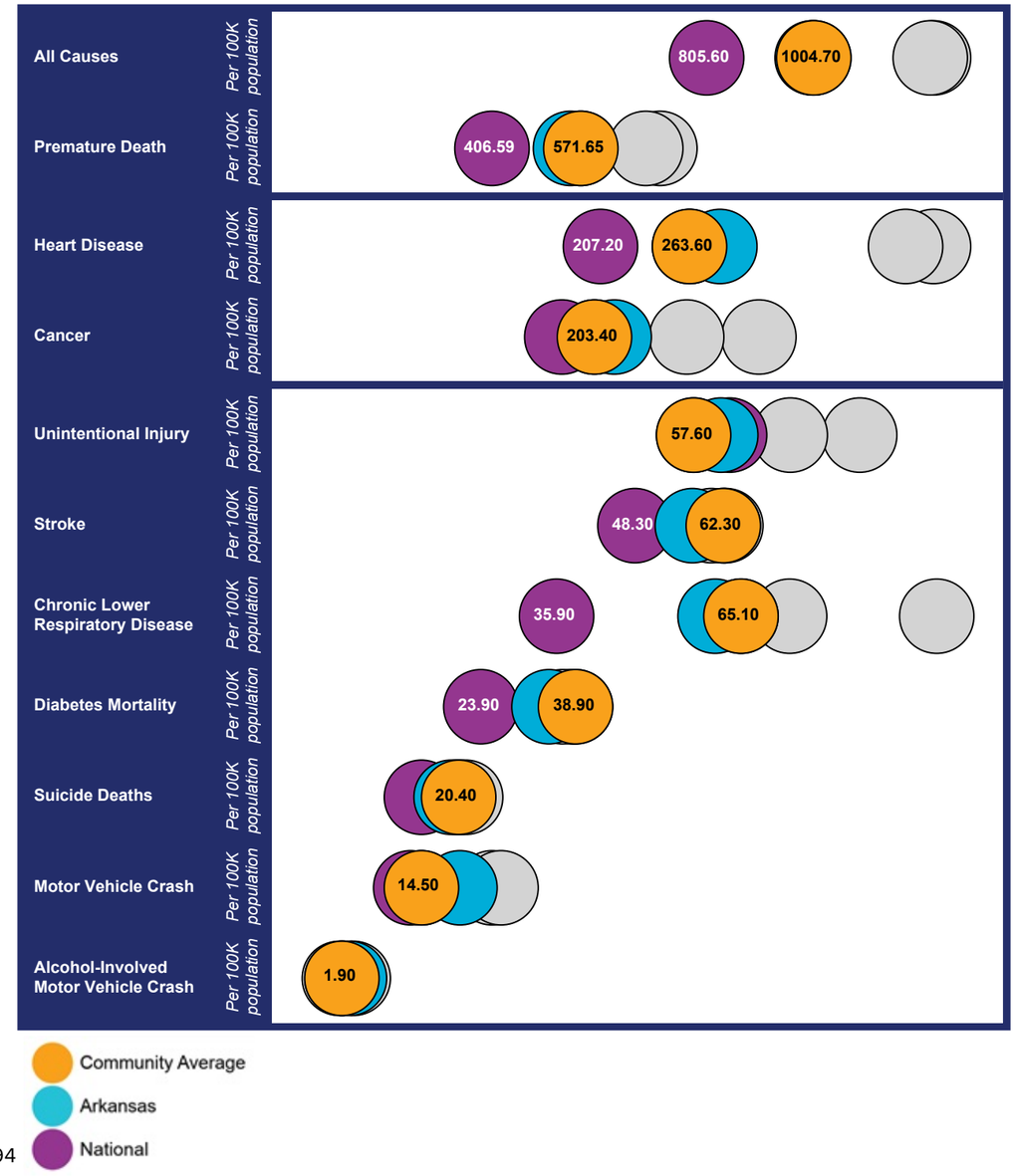


Table 6. Chronic Condtions

		Sequoyah County (OK)	Le Flore County (OK)	Sebastian County	Community Average	State	National
Child Obesity	*Percentage of students classified as overweight to severely obese, by county location of school*	**Not Available**	**Not Available**	**40.55%**	**40.55%**	**40.10%**	**Not Available**
High Cholesterol	*Percentage of adults who have had their blood cholesterol checked and have been told it was high (age-adjusted)*	**32.80%**	**32.80%**	**31.60%**	**31.60%**	**31.80%**	**30.40%**
Adult Obesity	*Percentage of adults ages 20 and older who report a BMI higher than 30*	**33.40%**	**38.10%**	**34.20%**	**34.20%**	**31.90%**	**30.10%**
High Blood Pressure	*Percentage of adults who have been told they have high blood pressure (age-adjusted)*	**39.30%**	**38.40%**	**36.00%**	**36.00%**	**36.50%**	**29.60%**
Arthritis	*Percentage of adults ages 18 or older diagnosed with some form of arthritis*	**Not Available**	**Not Available**	**31.30%**	**31.30%**	**32.60%**	**Not Available**
Diabetes Prevalence	*Percentage of adults age 18 and older who report ever been told that they have diabetes other than diabetes during pregnancy (age-adjusted)*	**14.10%**	**13.50%**	**13.20%**	**13.20%**	**12.70%**	**10.40%**
Asthma	*Percentage of adults who have been told they currently have asthma (age-adjusted)*	**13.60%**	**13.20%**	**11.50%**	**11.50%**	**11.00%**	**9.90%**
Coronary Heart Disease	*Percentage of adults age 18 and older who report ever having been told by that they had angina or coronary heart disease (CHD) (age-adjusted)*	**8.70%**	**8.30%**	**7.80%**	**7.80%**	**7.20%**	**5.70%**

Figure 7. Chronic Conditions

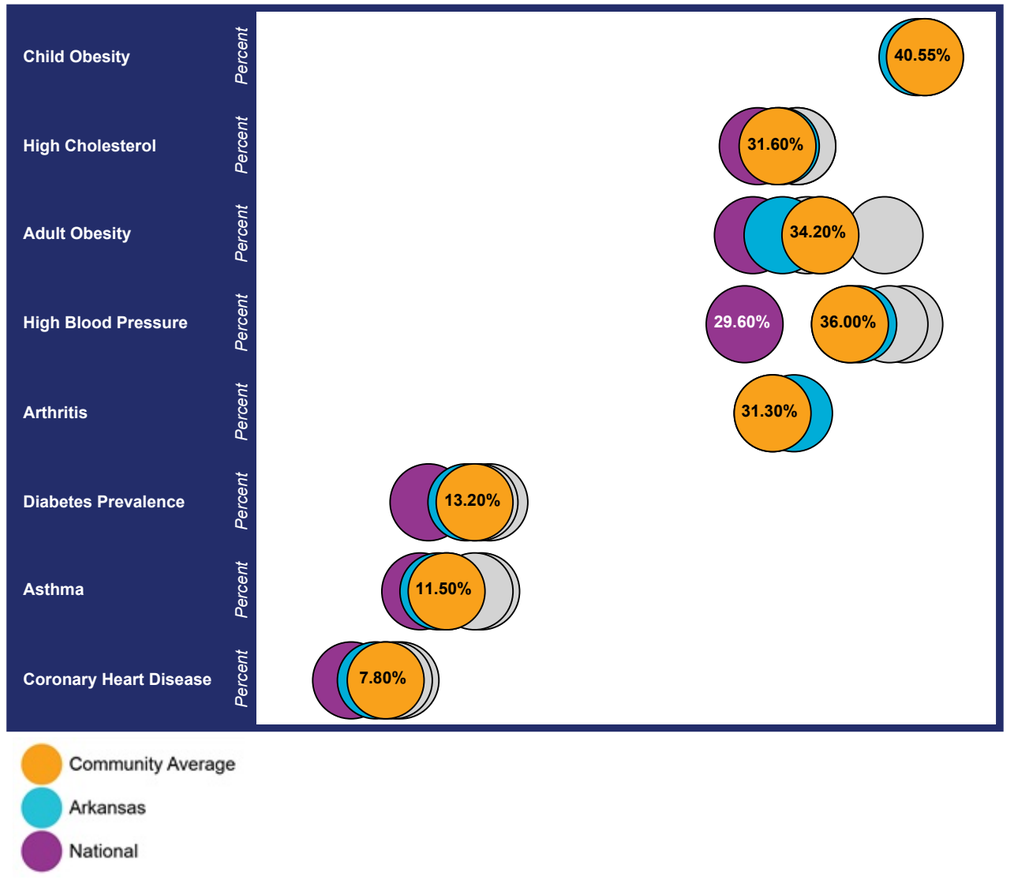


Table 7. Diagnoses at Discharge

		Sebastian County	Community Average	State
Hypertension	*Number of individuals 18 years and older discharged with a primary or secondary hypertension diagnosis as a percentage of the population 18 years and older*	**7.49%**	**7.49%**	**8.70%**
Hyperlipidemia	*Number of individuals 18 years and older discharged with a primary or secondary hyperlipidemia diagnosis as a percentage of the population 18 years and older*	**3.82%**	**3.82%**	**3.90%**
Diabetes	*Rate of individuals 18 years and older discharged with a primary or secondary diabetes diagnosis as a percentage of the population 18 years and older*	**3.45%**	**3.45%**	**3.70%**
Ischemic Heart Disease	*Number of individuals 18 years and older discharged with a primary or secondary ischemic heart disease diagnosis as a percentage of the population 18 years and older*	**2.00%**	**2.00%**	**2.50%**
Arthritis	*Rate of individuals 18 years and older discharged with a primary or secondary arthritis diagnosis as a percentage of the population 18 years and older*	**1.95%**	**1.95%**	**1.90%**

Figure 8. Diagnoses at Discharge

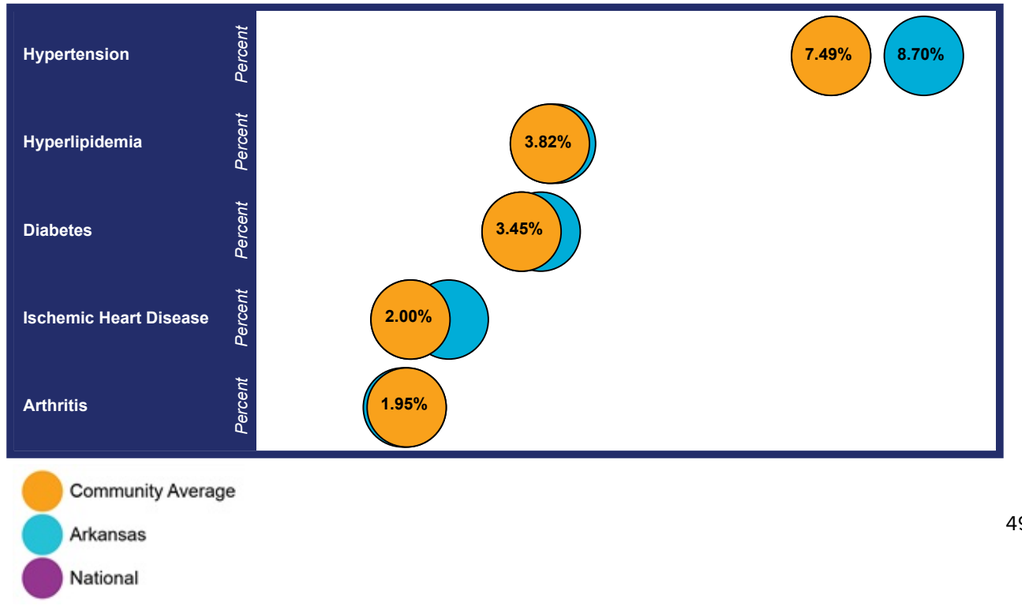


Table 8. Environment

		Sequoyah County (OK)	Le Flore County (OK)	Sebastian County	Community Average	State	National
Food Environment Index	*Index of factors that contribute to a healthy food environment, 0 (worst) to 10 (best)*	6.30	6.30	6.60	6.60	4.40	7.40
Drinking Water Violations	*The total number of drinking water violations recorded in a two-year period*	2	136	19	19	321	16,107
Access to Exercise Opportunities	*Percentage of population with adequate access to locations for physical activity*	40.15%	32.03%	64.50%	64.50%	63.36%	84.45%
Broadband Access	*Percentage of population in a high-speed internet service area; access to DL speeds >= 25MBPS and UL speeds >= 3 MBPS*	99.58%	86.85%	99.52%	99.52%	94.04%	96.78%
Long Commute Driving Alone	*Among workers who commute in their car alone, the percentage who commute more than 30 minutes*	37.80%	31.40%	17.90%	17.90%	28.10%	36.50%
Severe Housing Problems	*Percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities*	12.79%	11.86%	13.51%	13.51%	13.23%	16.84%

Community Average
Arkansas
National

Figure 9. Environment

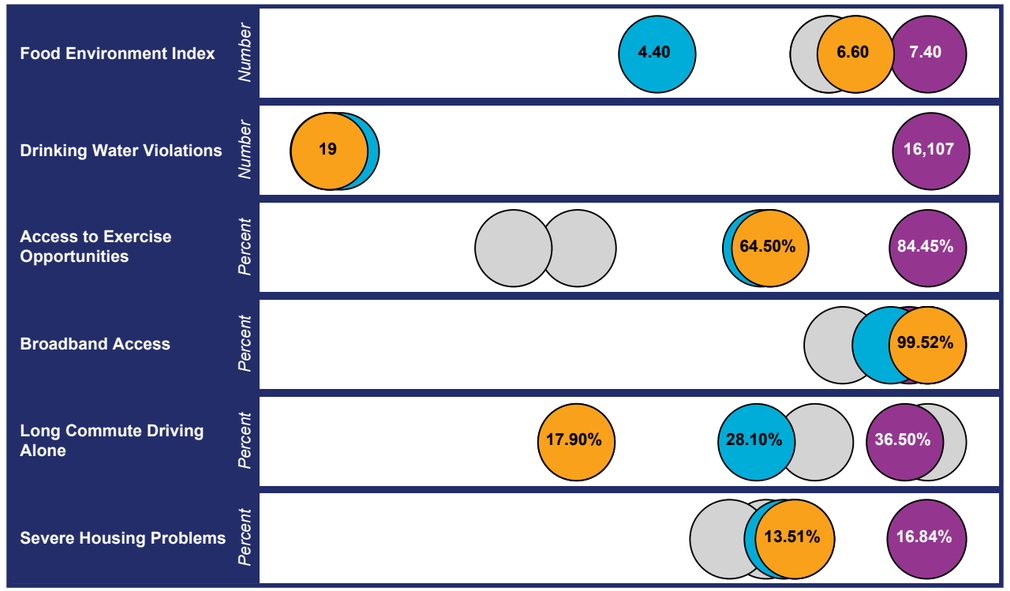


Table 9. Health Behaviors

		Sequoyah County (OK)	Le Flore County (OK)	Sebastian County	Community Average	State	National
Physical Inactivity	*Percentage of adults aged 20 and older who self-report no leisure time for activity*	27.80%	27.30%	25.70%	25.70%	23.60%	19.50%
Adult Smoking	*Percentage of adults ages 18 and older who are current smokers (age-adjusted)*	23.20%	23.00%	19.10%	19.10%	19.20%	13.20%
Youth Vaping	*Percentage of public school students in 6th, 8th, 10th, and 12th grade who used any vape in the past 30 days*	Not Available	Not Available	9.00%	9.00%	8.10%	Not Available
Sexually Transmitted Infections	*Number of newly diagnosed chlamydia cases per 100,000 population*	405.90	357.80	519.90	519.90	588.30	495.00

Figure 10. Health Behaviors

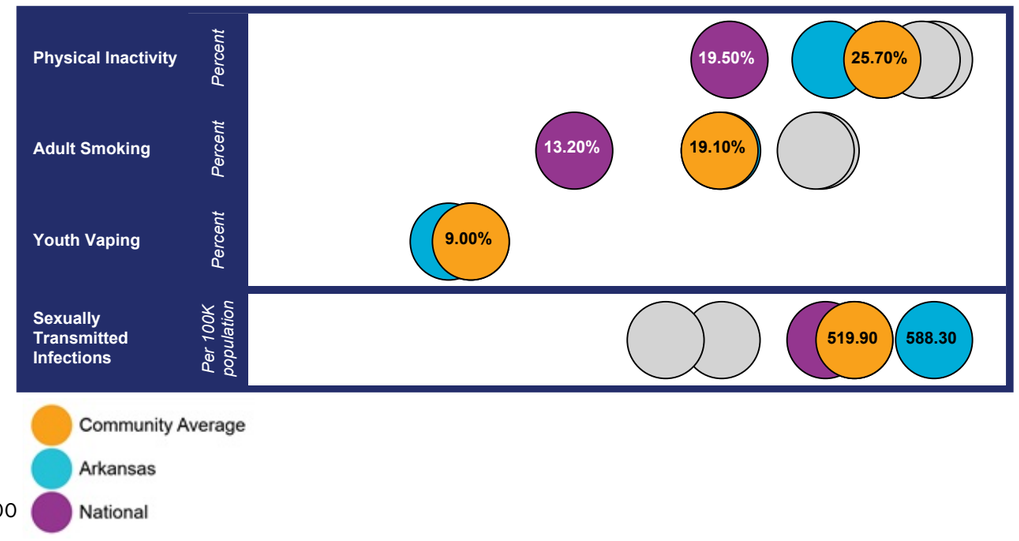


Table 10. Health Outcomes

		Sequoyah County (OK)	Le Flore County (OK)	Sebastian County	Community Average	State	National
Poor Physical Health Days	*Average number of physically unhealthy days reported in past 30 days (age-adjusted)*	5.50	5.20	5.30	5.30	5.20	3.90
Poor or Fair Health	*Percentage of adults age 18 and older who self-report their general health status as "fair" or "poor" (age-adjusted)*	26.60%	25.60%	24.70%	24.70%	22.60%	17.00%

Figure 11. Health Outcomes

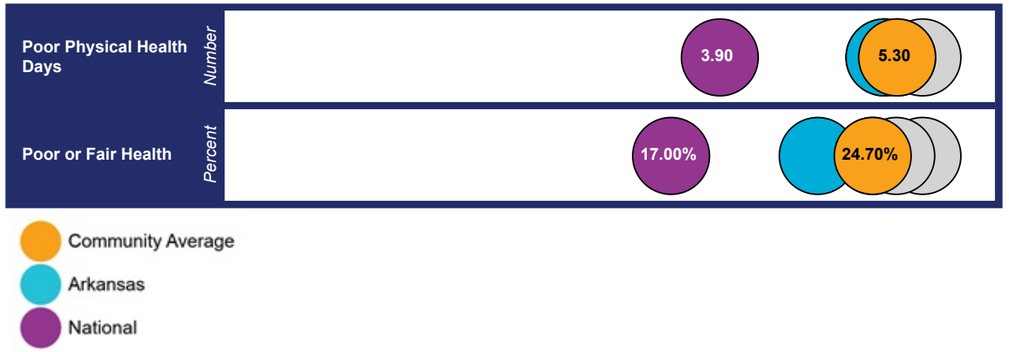


Table 11. Healthcare Expenditures

		Le Flore County (OK)	Sequoyah County (OK)	Sebastian County	Community Average	State	National
Average Annualized Expenditures	*Average annualized per-person spending on all covered healthcare services.*	**Not Available**	**Not Available**	**$9,974**	**$9,974**	**$10,116**	**Not Available**
Average Annualized Expenditures (Medical Only)	*Average annualized per-person spending on medical services, based on medical claims.*	**Not Available**	**Not Available**	**$7,249**	**$7,249**	**$7,252**	**Not Available**
Average Annualized Expenditures (Pharmacy Only)	*Average annualized per-person spending on prescription drugs, based on pharmacy claims.*	**Not Available**	**Not Available**	**$2,477**	**$2,477**	**$2,609**	**Not Available**

Figure 12. Healthcare Expenditures

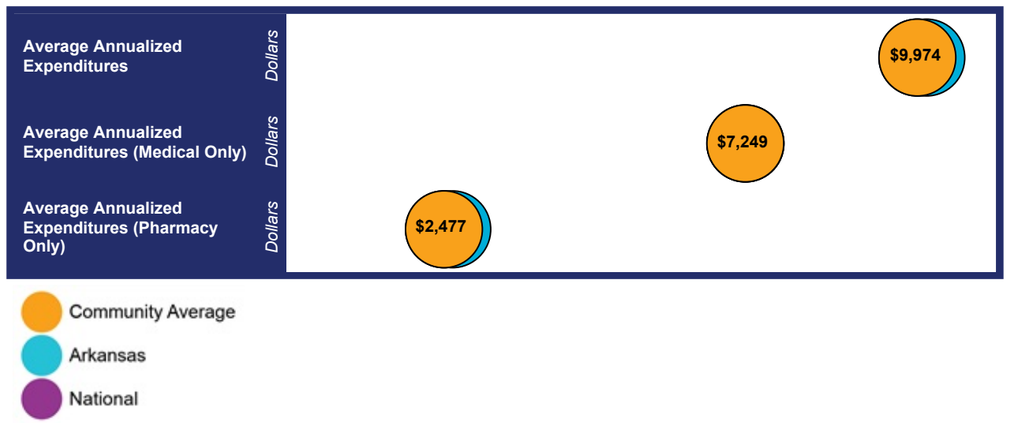


Table 12. Maternal and Infant Health

		Sequoyah County (OK)	Le Flore County (OK)	Sebastian County	Community Average	State	National
Active Obstetrics and Gynecology Physicians	*Active OB-GYN physicians are defined as those who provided evaluation and management services to at least two female patients ages 12-55 on the same day or performed a qualifying procedure (e.g., delivery) at least once during the year.*	**Not Available**	**Not Available**	**11.50**	**11.50**	**3.20**	**Not Available**
Teen Births	*The seven-year average number of teen births per 1,000 female population, ages 15-19*	**39.50**	**34.70**	**29.60**	**29.60**	**27.90**	**15.50**
C-Section Rate	*Percentage of live births delivered via cesarean section among all deliveries, calculated by the mother's county of residence.*	**Not Available**	**Not Available**	**34.46%**	**34.46%**	**33.48%**	**Not Available**
C-Section Rate, First Birth	*Percentage of first-birth deliveries (full-term singleton pregnancies in a head-down position) delivered via cesarean section, calculated by the mother's county of residence.*	**Not Available**	**Not Available**	**29.33%**	**29.33%**	**27.58%**	**Not Available**
Low Birthweight	*Percentage of live births where the infant weighed less than 2, 500 grams (approximately 5 lbs., 8 oz.)*	**8.40%**	**8.90%**	**8.50%**	**8.50%**	**9.40%**	**8.40%**
Preterm Birth	*Percentage of live births that are preterm (<37 weeks), calculated as a three-year average.*	**10.30%**	**11.50%**	**10.10%**	**10.10%**	**11.90%**	**10.35%**
Median Travel Time to Delivery	*Median number of minutes Arkansas mothers traveled from their home ZIP code to the delivery facility, calculated using birth records and facility addresses. Travel time estimates include in-state and out-of-state facilities.*	**Not Available**	**Not Available**	**11.00**	**11.00**	**16.00**	**Not Available**

Figure 13. Maternal and Infant Health

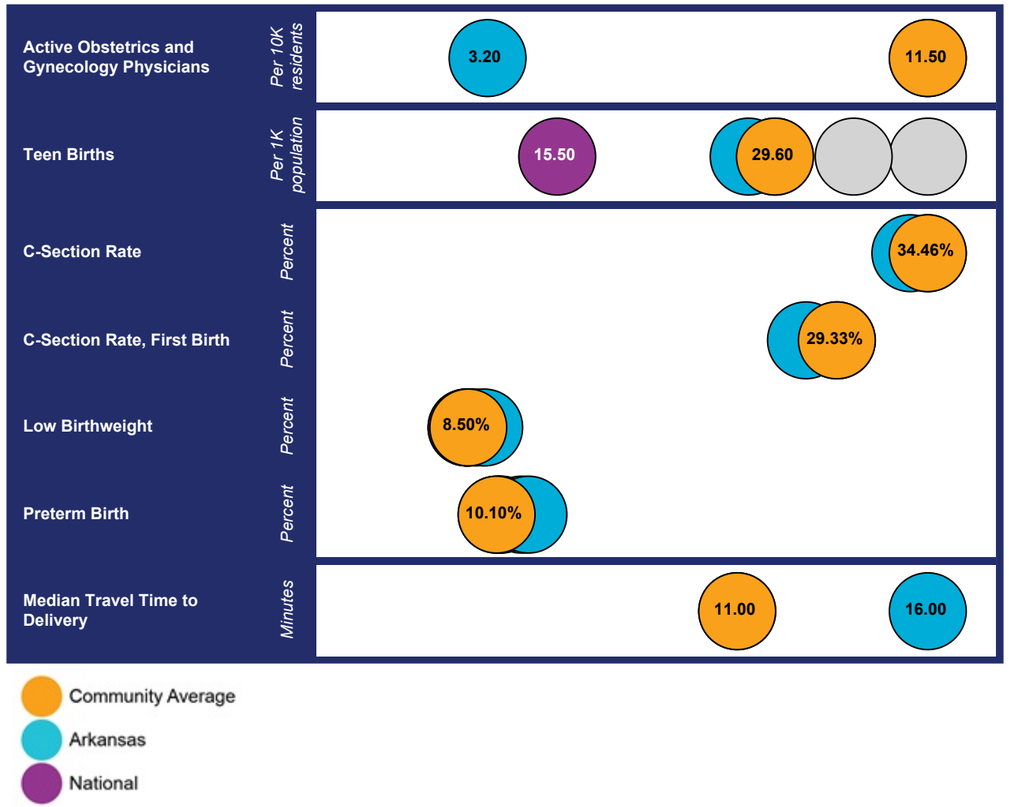


Table 13. Mental Health and Substance Use

		Sequoyah County (OK)	Le Flore County (OK)	Sebastian County	Community Average	State	National
Adult Depression	*Percentage of adults age 18 and older who report having been told that they had depressive disorder*	30.50%	29.20%	30.30%	30.30%	27.50%	21.10%
Excessive Drinking	*Percentage of adults reporting binge or heavy drinking*	15.09%	14.21%	16.80%	16.80%	18.99%	19.35%
Poor Mental Health	*Percentage of adults age 18 or older reporting poor mental health for 14 or more days (age-adjusted)*	22.60%	22.30%	21.00%	21.00%	20.50%	16.40%
Youth Depression	*Percentage of public school students in 6th, 8th, 10th, and 12th grade who had feelings of depression all of the time in the past 30 days*	Not Available	Not Available	8.30%	8.30%	9.20%	Not Available
Drug Overdose Deaths	*Age-adjusted rate of fatal drug overdoses per 100,000 residents*	Not Available	Not Available	15.82	15.82	Not Available	Not Available
Non-Fatal Drug Overdoses	*Age-adjusted rate of non-fatal drug overdoses per 100,000 residents*	Not Available	Not Available	38.40	38.40	Not Available	Not Available

Figure 14. Mental Health and Substance Use

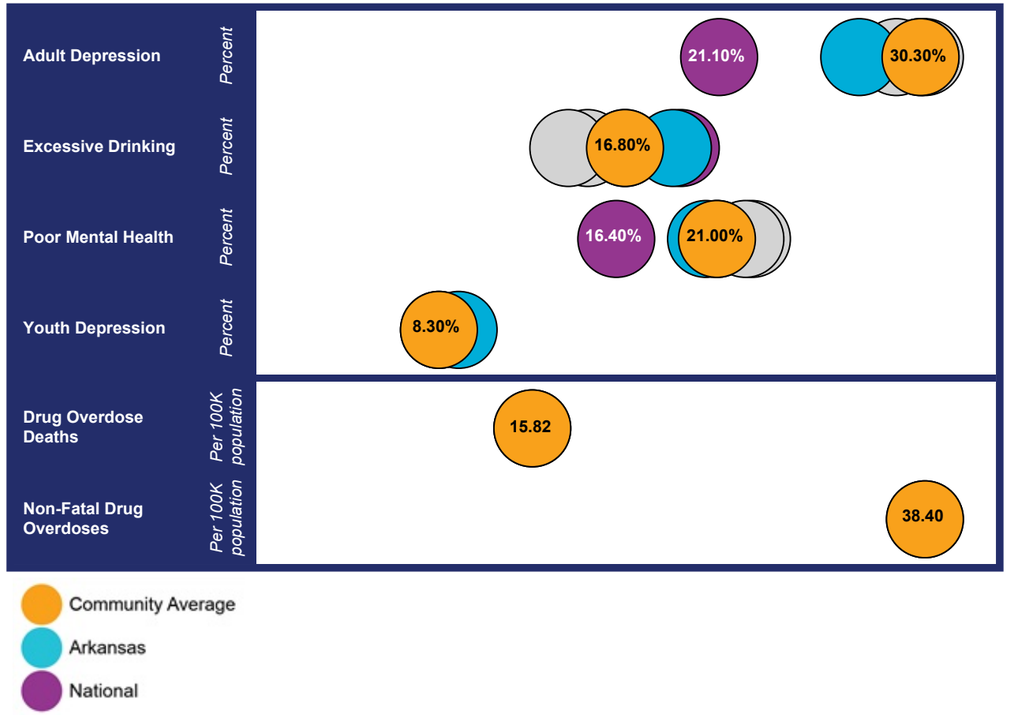


Table 14. Prevention

		Sequoyah County (OK)	Le Flore County (OK)	Sebastian County	Community Average	State	National
Cervical Cancer Screening	*Percentage of females age 21–65 years who report having had recommended cervical cancer screening test (age-adjusted)*	78.10%	78.60%	79.30%	79.30%	81.20%	83.70%
Colorectal Cancer Screening	*Percentage of adults age 45-75 who have had a recent colorecal cancer screening*	57.50%	55.60%	60.90%	60.90%	61.60%	66.30%
Dental Care Utilization	*Dental care visit (past 1 year), age-adjusted percentage of adults age 18+ by county*	48.60%	48.10%	52.50%	52.50%	54.10%	63.40%
High Blood Pressure Management	*Percentage of adults age 18 and older with high blood pressure who report taking blood pressure medication (age-adjusted)*	60.50%	61.80%	60.40%	60.40%	61.40%	58.90%
Prevention - Seasonal Influenza Vaccine	*Percentage of adults aged 18 and older who report receiving an influenza vaccination in the past 12 months*	35.90%	34.50%	44.20%	44.20%	43.20%	44.80%
Annual Wellness Exam (Medicare)	*Percentage of annual wellness visits among the Medicare fee-for-service (FFS) population*	38.00%	31.00%	46.00%	46.00%	46.00%	44.00%
No HIV Test	*Percentage of adults ages 18 or older who have never been screened for HIV*	Not Available	Not Available	68.30%	68.30%	66.10%	Not Available

Figure 15. Prevention

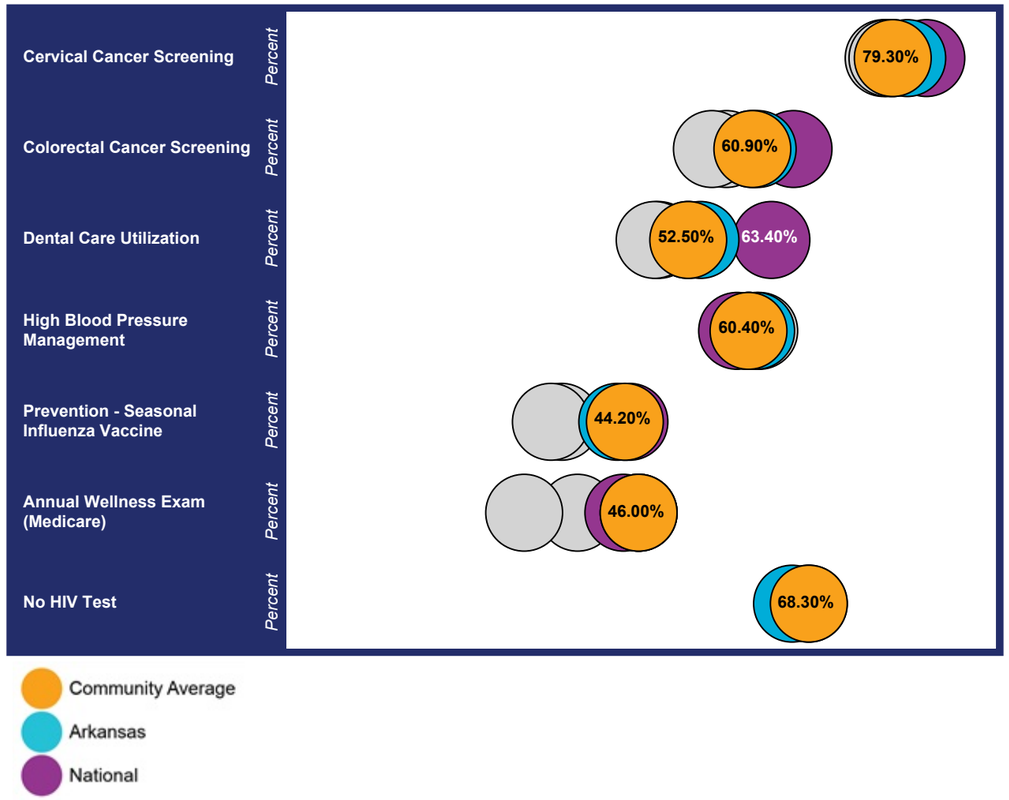
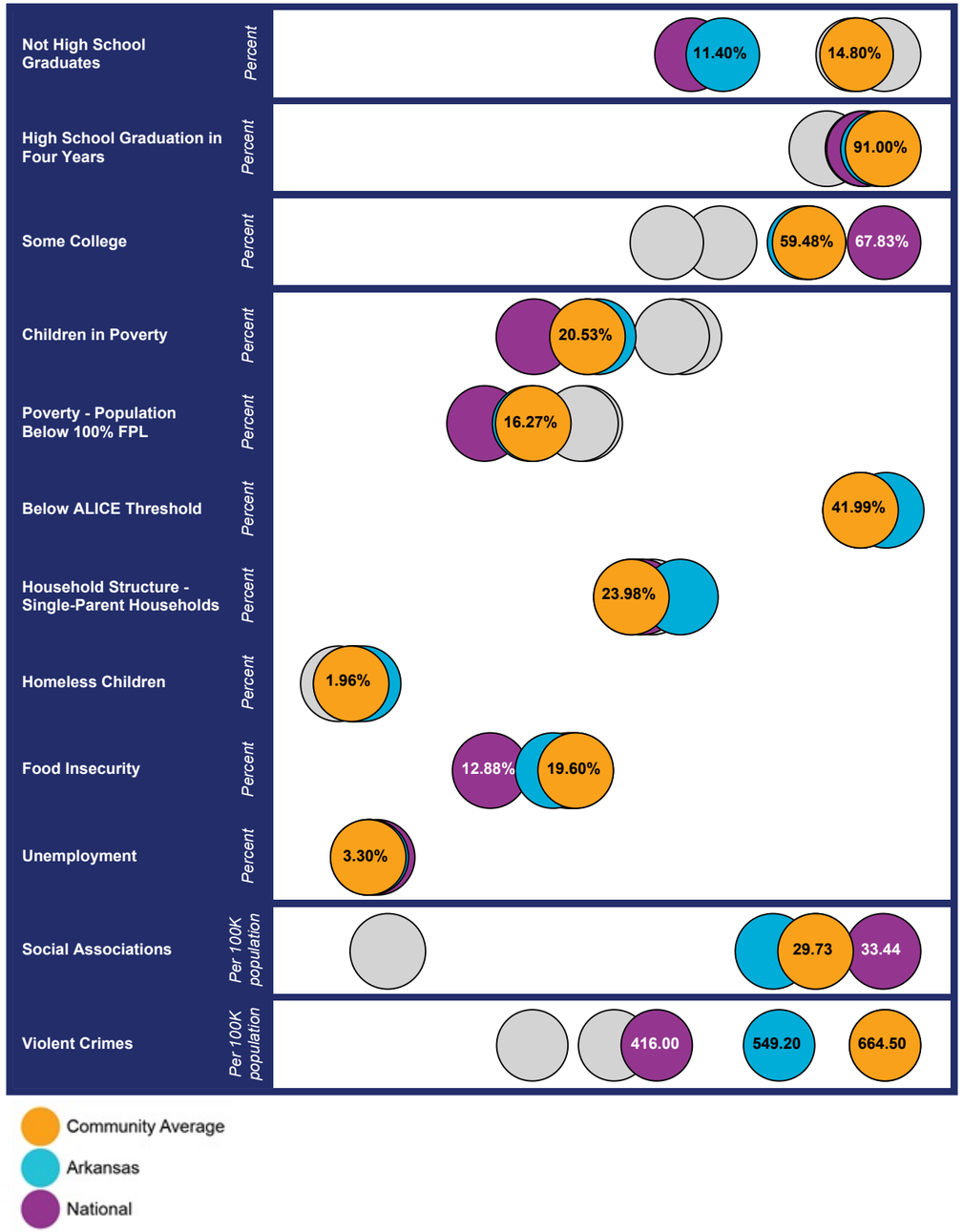


Table 15. Social and Economic Factors

		Sequoyah County (OK)	Le Flore County (OK)	Sebastian County	Community Average	State	National
Not High School Graduates	*Percentage of adults without a high school diploma*	15.50%	14.70%	14.80%	14.80%	11.40%	10.60%
High School Graduation in Four Years	*Percentage of ninth-grade cohort who graduated in four years*	82.60%	88.00%	91.00%	91.00%	90.30%	88.20%
Some College	*Percentage of adults ages 25-44 with some post-secondary education*	49.58%	43.65%	59.48%	59.48%	58.92%	67.83%
Children in Poverty	*Percentage of children under age 18 below the poverty line*	28.10%	27.14%	20.53%	20.53%	21.37%	16.32%
Poverty - Population Below 100% FPL	*Percentage of the population living in households with income below the federal poverty level*	20.31%	19.98%	16.27%	16.27%	16.02%	12.44%
Below ALICE Threshold	*Percentage of households living in poverty or classified as ALICE (Asset Limited, Income Constrained, Employed)*	Not Available	Not Available	41.99%	41.99%	44.00%	42.00%
Household Structure - Single-Parent Households	*Percentage of children who live in households where only one parent is present*	25.60%	24.53%	23.98%	23.98%	27.83%	24.83%
Homeless Children	*Percentage of students experiencing homelessness enrolled in the public school system*	0.95%	2.42%	1.96%	1.96%	2.90%	2.31%
Food Insecurity	*Percentage of the population that experienced food insecurity in the report year*	19.00%	19.20%	19.60%	19.60%	17.82%	12.88%
Unemployment	*Percentage of the civilian non-institutionalized population age 16 and older that is unemployed (non-seasonally adjusted)*	3.40%	3.40%	3.30%	3.30%	3.50%	4.00%
Social Associations	*Establishments, rate per 100,000 population*	Not Available	6.23	29.73	29.73	27.39	33.44
Violent Crimes	*Annual rate of reported violent crimes per 100,000 population*	369.60	280.60	664.50	664.50	549.20	416.00

Figure 16. Social and Economic Factors



IDENTIFIED NEED 1:
Increase Access to Care and Education

GOALS/OBJECTIVE:
Increase access to quality health care, preventive screenings, vaccinations, and community health resources for residents of the River Valley.

STRATEGY:
Expand community outreach and strengthen partnerships with local nonprofits, schools, and employers to improve access and awareness.

ACTION STEPS:

- Host annual free flu shot and vaccination events in collaboration with Community Outreach and local partners.
- Launch a “Wellness Meet-Up Series” open to the public, featuring monthly sessions on key wellness topics such as physical activity, mindful eating, stress management, and sleep health.
- Partner with local businesses and organizations to offer free health education and on-site screenings (e.g., blood sugar, blood pressure, BMI) and facilitate scheduling for primary care and mammogram appointments.
- Collaborate with area schools to promote healthy, active lifestyles and early preventive habits among youth.
- Continue operating La Clínica del Pueblo to reduce language and cultural barriers and improve access to care for Hispanic residents.
- Coordinate with Baptist Health Urgent Care Clinics to enhance accessibility and convenience for patients seeking acute or after-hours care, as well as referrals to additional imaging and specialty care.

KEY PERFORMANCE METRICS:

- Provide preventive screenings, vaccinations, education and related services to at least 500 community members annually.
- Track and report the number of community outreach events hosted or attended by Baptist Health–Fort Smith.
- Measure and report the number of community members reached through health education, screenings, and outreach efforts.
- Evaluate referral and follow-up rates for individuals connected to primary or specialty care through outreach initiatives.

COLLABORATIONS WITH ORGANIZATIONS: Local nonprofits such as Good Samaritan Clinic, Donald W. Reynolds Cancer Support House and the National Association for the Advancement of Colored People (NAACP), as well as school districts and employers across Sebastian County.

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS NEED: Staff time and clinical expertise, marketing and educational materials, community health supplies, vaccination resources, and ongoing support from the Marketing & Communications and Community Outreach teams.

ESTIMATED COMPLETION DATE: Ongoing through 2028

PERSON(S)/DEPARTMENT RESPONSIBLE: Marketing & Communications Manager, Community Outreach Director.

IDENTIFIED NEED 2:
The Community Mental Health Strategy: Access, Education, Acceptance

GOALS/OBJECTIVE/OBJECTIVE:
Improve access to mental health services, reduce stigma, and promote emotional well-being for residents of the River Valley, with a focus on improving early identification, access to care, and community support for adults ages 55 and older experiencing memory loss, cognitive decline, or early signs of dementia.

STRATEGY:
Strengthen collaboration with employers, healthcare providers, and community organizations to expand mental health education, increase access to counseling and crisis resources, and promote early intervention and resilience-building initiatives.

ACTION STEPS:
- Collaborate with primary care providers, neurologists, and hospital staff to expand screening opportunities, increase awareness of early dementia symptoms, and connect individuals and caregivers to education, counseling, and local support resources.
- Continue partnership with Center for Psychiatric Trauma and Mental Health to participate in annual ACE/Trauma Symposium
- Baptist Health Senior Care Behavioral Health at Baptist Health-Fort Smith will continue to participate in community events and partner with organizations like the Senior Care Alliance for outreach opportunities.
- Launch a “Wellness Meet-Up Series” open to the public, featuring monthly sessions on key wellness topics such as physical activity, mindful eating, stress management, and sleep health.
- Develop a public awareness campaign to reduce stigma surrounding mental health, dementia and encourage early conversations about mental health and memory changes.

KEY PERFORMANCE METRICS:
- Track the number of primary care and neurology clinics implementing routine cognitive or mental health screenings for adults ages 55+.
- Record the number of community outreach events attended by Baptist Health Senior Care Behavioral Health and the estimated number of residents reached.
- Track ongoing partnerships and collaborative events held with organizations such as the Senior Care Alliance.
- Monitor attendance numbers, participant satisfaction surveys, and self-reported behavior changes following the six-month series.
- Measure campaign’s reach through social media engagement, website visits, and printed material distribution.

COLLABORATIONS WITH ORGANIZATIONS: Senior Care Alliance, Alzheimer's Association, Center for Psychiatric Trauma and Mental Health, ArcBest, Fort Smith Public Schools, City of Fort Smith

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS NEED: Staff time and clinical expertise, marketing and educational materials, community health supplies and ongoing support from the Marketing & Communications and Community Outreach teams.

ESTIMATED COMPLETION DATE: Ongoing through 2028

PERSON(S)/DEPARTMENT RESPONSIBLE: Marketing & Communications Manager, Community Outreach Director, Director of Behavioral Health.

IDENTIFIED NEED 3:
Closing the Gap: A Strategy for Healthy Communities and Nutrition Security

GOALS/OBJECTIVE/OBJECTIVE:
Reduce food insecurity and improve nutrition knowledge among residents of the River Valley through education, outreach, and collaboration with local partners.

STRATEGY:
Expand community partnerships and implement interactive nutrition education programs that empower residents with practical skills and resources to reduce food insecurity and promote healthier eating habits.

ACTION STEPS:

- Continue FoodRx Program for inpatients identified as food insecure.
- Explore funding opportunities in partnership with Baptist Health Foundation to expand FoodRx Program to employees and contractors of Baptist Health-Fort Smith, Van Buren and surrounding clinics, also in need of food and nutrition support
- Continue Rooftop Garden to supplement the FoodRx program with fresh produce. Excess produce will be shared with employees as it becomes available.
- Continue to partner with River Valley Regional Food Bank to host an annual employee food drive during Hunger Action Month (September).
- Continue partnering with the Baptist Health Nutrition Counseling Center and community organizations—including local school districts, the Sebastian County Cooperative Extension Service, local employers and nonprofits—to provide free, engaging education on healthy eating and nutrition. Each session will feature interactive activities and practical, actionable steps participants can take to make healthier food choices in their daily lives.
- Educate staff on food insecurity and resources within our community that can benefit our patients and fellow staff members.
- Launch a “Wellness Meet-Up Series” open to the public, featuring monthly sessions on key wellness topics such as physical activity, mindful eating, stress management, and sleep health.

KEY PERFORMANCE METRICS:

- Track and report number of patients identified as food insecure during screening
- Track and report number of FoodRx bags given to patients during timeframe
- Track and report number of FoodRx bags given to employees (if funding is secured to expand program)
- Track and report progress of Rooftop Garden

COLLABORATIONS WITH ORGANIZATIONS: Sebastian County Cooperative Extension Service, local school districts, employers such as Hytrol and the City of Fort Smith, River Valley Master Gardeners.

RESOURCES HOSPITAL PLANS TO COMMIT TO ADDRESS NEED: Staff time and clinical expertise, marketing and educational materials, community health supplies and ongoing support from the Marketing & Communications and Community Outreach teams.

ESTIMATED COMPLETION DATE: Ongoing through 2028

PERSON(S)/DEPARTMENT RESPONSIBLE: Marketing & Communications Manager, Community Outreach Director, Outpatient Dietitian, Volunteer Services Manager, Chaplain, Case Management


Baptist
Health