King’s Daughters Medical Center

Brookhaven, MS

Community Health Needs Assessment and Implementation Strategy

Adopted by Board Resolution August 24, 2021[1]

KING'S DAUGHTERS MEDICAL CENTER

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

Dear Community Member:

King's Daughters Medical Center's history of caring for our community dates back to 1922. Our efforts to provide exceptional healthcare to the people of the greater Lincoln region has long been in alignment with the needs of our community. The "2021 Community Health Needs Assessment" identifies local health and medical needs and provides a plan of how King's Daughters Medical Center ("KDMC") will respond to such needs. This document illustrates one way we are meeting our obligations to efficiently deliver medical services.

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

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

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

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

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

Thank You,

Alvin Hoover
Chief Executive Officer
King's Daughters Medical Center

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EXECUTIVE SUMMARY

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King's Daughters Medical Center ("KDMC" or the "Hospital") has performed a Community Health Needs Assessment to determine the health needs of the local community.

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

The 2021 Significant Health Needs identified for Lincoln County are:

In the Implementation Strategy section of the report, KDMC addresses the four areas through identified programs, resources, and services provided by KDMC, collaboration with local organizations, and provides measures to track progress.

APPROACH

APPROACH

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

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

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

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

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

Project Objectives

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

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

Overview of Community Health Needs Assessment

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

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

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

[2] Federal Register Vol. 79 No. 250, Wednesday December 31, 2014. Part II Department of the Treasury Internal Revenue Service 26 CFR Parts 1, 53, and 602
[3] As of the date of this report all tax questions and suggested answers relate to 2017 Draft Federal 990 Schedule H instructions i990sh—dft(2) and tax form
[4] Part 3 Treasury/IRS – 2011 – 52 Section 3.03 (2) third party disclosure notice & Schedule H (Form 990) V B 6 b

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

Specifically, the IRS requires:

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

Community Health Needs Assessment Subsequent to Initial Assessment

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

> *"The 2013 proposed regulations provided that, in assessing the health needs of its community, a hospital facility must take into account input received from, at a minimum, the following three sources:*
>
> *(1) At least one state, local, tribal, or regional governmental public health department (or equivalent department or agency) with knowledge, information, or expertise relevant to the health needs of the community;*
>
> *(2) members of medically underserved, low-income, and minority populations in the*

[5] Section 6652

community, or individuals or organizations serving or representing the interests of such populations; and

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

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

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

To complete a CHNA:

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

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

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

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

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

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

… final regulations provide that a CHNA report will be considered to describe the process and methods used to conduct the CHNA if the CHNA report describes the data and other information used in the assessment, as well as the methods of collecting and analyzing this data and information, and identifies any parties with whom the hospital facility collaborated, or with whom it contracted for assistance, in conducting the CHNA."[7]

Additionally, all CHNAs developed after the very first CHNA received written commentary on the prior

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

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

Assessment and Implementation Strategy efforts. The Hospital followed the Federal requirements in the solicitation of written comments by securing characteristics of individuals providing written comment but did not maintain identification data.

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

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

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

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

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

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

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

Other (please specify)

The methodology also takes a comprehensive approach to assess community health needs, perform several independent data analyses based on secondary source data, augment this with Local Expert Advisor[9] opinions, and resolve any data inconsistency or discrepancies by reviewing the combined opinions formed from Local Experts. The Hospital relies on secondary source data, and most secondary sources use the county as the smallest unit of analysis. Local Expert area residents were asked to note if they perceived the problems or needs identified by secondary sources existed in their portion of the county.[10]

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

Data sources include:[11]

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[8] Federal Register Op. cit. P 78967 & Response to Schedule H (Form 990) B 3 h
[9] "Local Expert" is an advisory group of at least 15 local residents, inclusive of at least one member self-identifying with each of the five Quorum written comment solicitation classifications, with whom the Hospital solicited to participate in the Quorum/Hospital CHNA process. Response to Schedule H (Form 990) V B 3 h
[10] Response to Schedule H (Form 990) Part V B 3 i
[11] The final regulations clarify that a hospital facility may rely on (and the CHNA report may describe) data collected or created by

Website or Data Source	Data Element	Date Accessed	Data Date
www.countyhealthrankings.org	Assessment of health needs of Lincoln County compared to all Mississippi counties	February 2021	2013-2019
IBM Watson Health (formerly known as Truven Health Analytics)	Assess characteristics of the Hospital's primary service area, at a zip code level, based on classifying the population into various socio-economic groups, determining the health and medical tendencies of each group and creating an aggregate composition of the service area according to the proportion of each group in the entire area; and, to access population size, trends and socio-economic characteristics	February 2021	2019
http://svi.cdc.gov	To identify the Social Vulnerability Index value	February 2021	2018
www.worldlifeexpectancy.com/usa-health-rankings	To determine relative importance among 15 top causes of death	February 2021	2019

A standard process of gathering community input was developed. In addition to gathering data from the above sources:

- A CHNA survey was deployed to the Hospital's Local Expert Advisors and offered to the community, through the Hospital social media and website, to gain input on local health needs and the needs of priority populations. Local Expert Advisors were local individuals selected according to criteria required by the Federal guidelines and regulations and the Hospital's desire to represent the region's geographically and ethnically diverse population. Community input from 66 Local Expert Advisors was received. Survey responses started February 22, 2021 and ended on March 17, 2021.
- Information analysis augmented by local opinions showed how Lincoln County relates to its peers in terms of primary and chronic needs and other issues of uninsured persons, low-income persons, and minority groups. Respondents commented on whether they believe certain population groups ("Priority Populations") need help to improve their condition, and if so, who needs to do what to improve the

others in conducting its CHNA and, in such cases, may simply cite the data sources rather than describe the ''methods of collecting'' the data. Federal Register Op. cit. P 78967 & Response to Schedule H (Form 990) Part V B 3 d

conditions of these groups. .[12] [13]

- Local opinions of the needs of Priority Populations, while presented in its entirety in the Appendix, was abstracted in the following “take-away” bulleted comments:
    - The top three priority populations identified by the Local Experts were low-income groups, residents of rural areas, and older adults
    - Summary of unique or pressing needs of the priority groups:
        - Access to affordable healthcare
        - Education and health programs
        - Housing and healthy food access

Having taken steps to identify potential community needs, the Local Experts then participated in a structured communication technique called a "Wisdom of Crowds" method. The premise of this approach relies on a panel of experts with the assumption that the collective wisdom of participants is superior to the opinion of any one individual, regardless of their professional credentials. [14]

In the KDMC process, the Local Experts had the opportunity to introduce needs previously unidentified and to challenge conclusions developed from the data analysis. While there were a few opinions of the data conclusions not being completely accurate, most of the comments agreed with the findings. A list of all needs identified by any of the analyzed data was developed. The Local Experts then ranked each health needs importance from not at all (1 rating) to extremely significant (5 rating). The Hospital analyzed the health issues that received the most responses and established a plan for addressing them.

The determination of the break point — “Significant” as opposed to “Other” — was a qualitative interpretation where a reasonable break point in rank order occurred. [15]

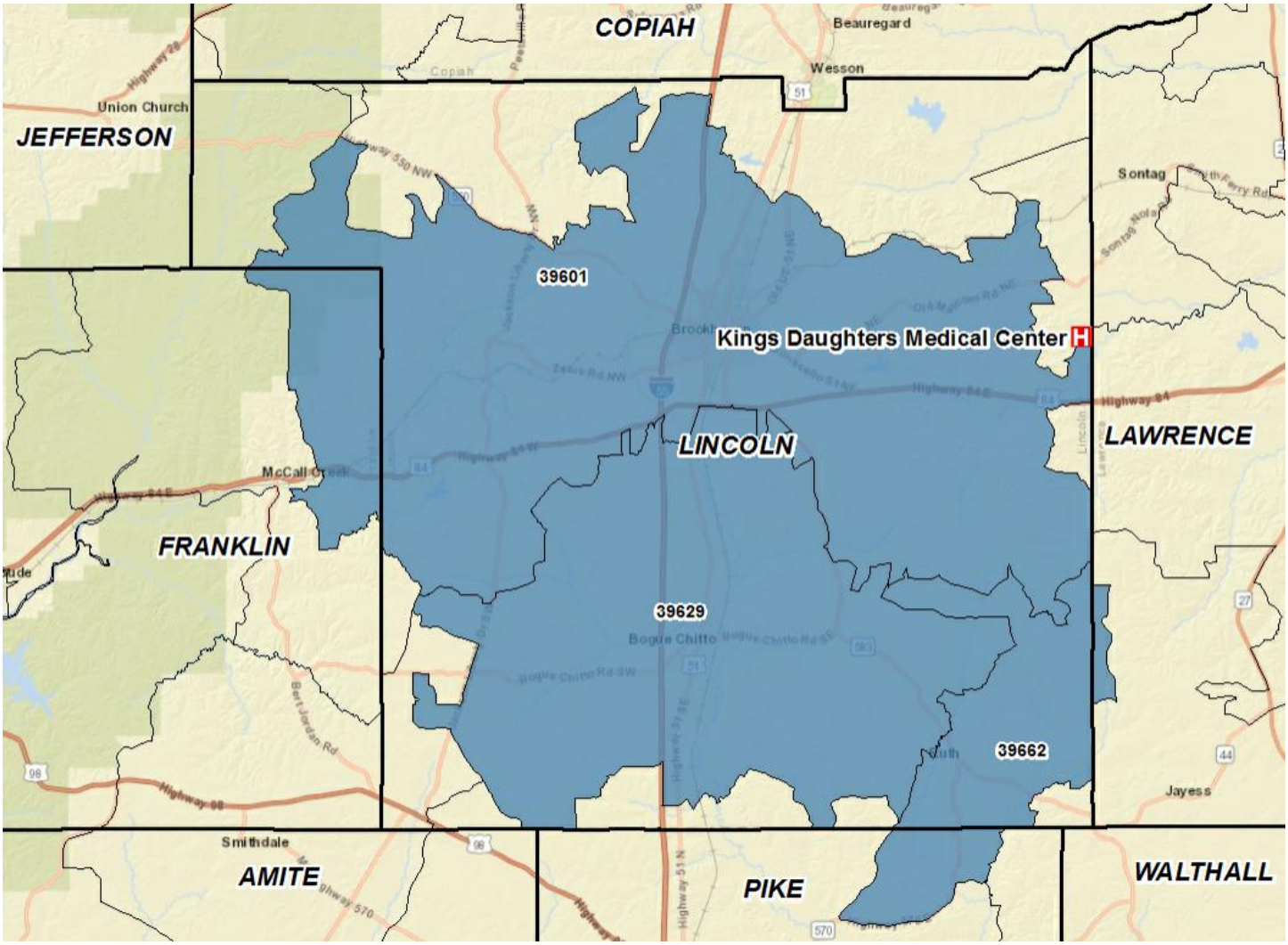
[12] Response to Schedule H (Form 990) Part V B 3 f
[13] Response to Schedule H (Form 990) Part V B 3 h
[14] Response to Schedule H (Form 990) Part V B 5
[15] Response to Schedule H (Form 990) Part V B 3 g

Overview of COVID-19 Survey Results:

- As an addition to the survey, KDMC gathered input from Local Experts on the impacts COVID-19 has had on their community. Below you will find and overview of their feedback; See the appendix for full survey responses:
    - **Overall impact of COVID-19:** It is clear from the survey results that the community was impacted by COVID-19 personally or in their household; 44% of the surveyors reported being noticeably impacted by the pandemic and 23% reported significant daily disruption with reduced access to healthcare services or severe daily disruption, immediate needs unmet
    - **Social Determinants of Health:** Social determinants of health have been shown to have a considerable effect on COVID-19 outcomes. The top areas respondents reported as negatively impacted by the pandemic include education, social support systems, employment, access to healthcare services, and childcare. As a result of this, mental health issues have increased throughout the community.
    - **Delay in Healthcare Services:** As a result of COVID-19, 26% of surveyors reported delayed elective care, 24% reported delaying primary care and specialty care.
    - **Community Support:** There are several ways that healthcare providers, like KDMC, can support the community through these pressing times. Examples include serving as a trusted source of information and education, offering alternatives to in-person healthcare visits, connecting with patients through digital communication channels, and posting enhanced safety measures and process changes to prepare for upcoming appointments.
    - **Pressing Healthcare Services/Programs:** The healthcare services/programs identified by respondents as being most important to supporting community health throughout the pandemic are mental health, primary care, elder/senior care and emergency care.
    - **Alternative Care Options:** Establishing alternative options to in-person care will continue to be a critical piece of the COVID response. Survey respondents believe telephone and video visits with healthcare providers, patient portal, and smartphone apps would be most beneficial to the local community

COMMUNITY CHARACTERISTICS

Definition of Area Served by the Hospital[16]



For the purposes of this study, King's Daughters Medical Center defines its service area as Lincoln County in Mississippi, which includes the following ZIP codes:[17]

39601 – Brookhaven 39629 – Bogue Chitto 39662 – Ruth

During 2019, the Hospital received 60.3% of its Medicare inpatients from this area. [18]

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

Demographics of the Community [19] [20]

Variable	Lincoln County 2021	Lincoln County 2026	Lincoln County %Change	Mississippi 2021	Mississippi 2026	Mississippi %Change	United States 2021	United States 2026	United States %Change
DEMOGRAPHIC CHARACTERISTICS									
Total Population	30,366	30,134	-0.8%	2,985,367	2,994,155	0.3%	330,342,293	341,132,645	3.3%
Total Male Population	14,417	14,337	-0.6%	1,449,284	1,455,838	0.5%	162,698,834	168,065,523	3.3%
Total Female Population	15,949	15,797	-1.0%	1,536,083	1,538,317	0.1%	167,643,459	173,067,122	3.2%
Females, Child Bearing Age (15-44)	5,792	5,648	-2.5%	590,615	585,757	-0.8%	64,355,395	65,121,999	1.2%
Average Household Income	$60,872			$65,411			$93,706		
POPULATION DISTRIBUTION									
Age Distribution									
0-14	5,895	5,584	-5.3%	575,205	553,879	-3.7%	61,004,273	61,243,083	0.4%
15-17	1,281	1,327	3.6%	123,673	124,385	0.6%	12,813,132	13,256,890	3.5%
18-24	2,570	2,695	4.9%	302,626	310,779	2.7%	31,228,330	32,158,942	3.0%
25-34	3,601	3,513	-2.4%	389,386	378,964	-2.7%	44,634,051	43,444,871	-2.7%
35-54	7,587	7,186	-5.3%	724,827	712,073	-1.8%	83,213,897	84,462,100	1.5%
55-64	3,932	3,736	-5.0%	376,416	357,913	-4.9%	42,483,870	42,775,689	0.7%
65+	5,500	6,093	10.8%	493,234	556,162	12.8%	54,964,740	63,791,070	16.1%
HOUSEHOLD INCOME DISTRIBUTION									
Total Households	11,648	11,577	-0.6%	1,129,960	1,136,166	0.5%	125,475,973	129,798,935	3.4%
2021 Household Income									
<$15K	1,995			180,273			12,506,722		
$15-25K	1,710			137,432			10,771,922		
$25-50K	2,981			279,270			26,014,485		
$50-75K	1,517			189,071			20,994,518		
$75-100K	1,177			127,953			15,613,467		
Over $100K	2,268			215,961			39,574,859		
EDUCATION LEVEL									
Pop Age 25+	20,620			1,983,863			225,296,558		
2021 Adult Education Level Distribution									
Less than High School	703			98,936			11,743,386		
Some High School	1,911			214,912			15,852,334		
High School Degree	7,650			606,837			61,254,638		
Some College/Assoc. Degree	7,205			633,288			65,195,238		
Bachelor's Degree or Greater	3,151			429,890			71,250,962		
RACE/ETHNICITY									
2021 Race/Ethnicity Distribution									
White Non-Hispanic	19,972			1,674,151			195,988,231		
Black Non-Hispanic	9,519			1,118,364			40,865,574		
Hispanic	353			103,456			62,877,742		
Asian & Pacific Is. Non-Hispanic	130			34,351			19,739,190		
All Others	392			55,045			10,871,556		

[19] Responds to IRS Schedule H (Form 990) Part V B 3 b
[20] Claritas (accessed through IBM Watson Health)

Consumer Health Service Behavior[21]

Key health services topics for the service area population are presented in the table below. In the second column of the chart, the national average is 100%, so the 'Demand as % of National' shows a community's likelihood of exhibiting a certain health behavior more or less than the national average. The next column shows the percentage of the population that is likely to exhibit those behaviors.

Where the KDMC Service Area varies more than 5% above or below the national average (that is, less than 95% or greater than 105%), it is considered noteworthy. Items in the table with **green text** are viewed as **adverse** findings. Items with **blue text** are viewed as **beneficial** findings. Items with black text are neither a favorable nor unfavorable finding.

Health Service Topic	Demand as % of National	% of Population Affected	Health Service Topic	Demand as % of National	% of Population Affected
Weight / Lifestyle			**Cancer**		
BMI: Morbid/Obese	118.9%	36.3%	Cancer Screen: Skin 2 yr	72.1%	7.7%
Vigorous Exercise	92.0%	52.5%	Cancer Screen: Colorectal 2 yr	90.2%	18.5%
Chronic Diabetes	107.1%	16.8%	Cancer Screen: Pap/Cerv Test 2 yr	85.0%	40.9%
Healthy Eating Habits	89.0%	20.7%	Routine Screen: Prostate 2 yr	80.8%	22.9%
Ate Breakfast Yesterday	93.6%	74.0%	**Orthopedic**		
Slept Less Than 6 Hours	124.2%	16.9%	Chronic Lower Back Pain	114.9%	35.5%
Consumed Alcohol in the Past 30 Days	76.2%	41.0%	Chronic Osteoporosis	132.1%	13.4%
Consumed 3+ Drinks Per Session	112.6%	31.7%	**Routine Services**		
Behavior			FP/GP: 1+ Visit	100.8%	82.0%
Search for Pricing Info	83.8%	22.5%	NP/PA Last 6 Months	102.7%	42.6%
I am Responsible for My Health	100.2%	90.5%	OB/Gyn 1+ Visit	90.1%	34.6%
I Follow Treatment Recommendations	100.0%	76.9%	Medication: Received Prescription	105.2%	61.2%
Pulmonary			**Internet Usage**		
Chronic COPD	130.0%	7.0%	Use Internet to Look for Provider Info	79.5%	31.8%
Chronic Asthma	111.0%	13.1%	Facebook Opinions	96.0%	9.7%
Heart			Looked for Provider Rating	76.7%	18.0%
Chronic High Cholesterol	104.2%	25.5%	**Emergency Services**		
Routine Cholesterol Screening	91.4%	40.5%	Emergency Room Use	111.4%	38.7%
Chronic Heart Failure	147.0%	6.0%	Urgent Care Use	94.1%	31.0%

Conclusions from Demographic Analysis Compared to National Averages

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

- 6% less likely to **Eat Breakfast**, affecting 74%
- 8% less likely to **Vigorously Exercise**, affecting 52%
- 9% less likely to receive **Routine Cholesterol Screenings**, affecting 40%

[21] Claritas (accessed through IBM Watson Health)

- 15% less likely to receive **Cervical Cancer Screenings Every 2 Years**, affecting 40%
- 11% more likely to **Visit Emergency Room for Non-Emergent Needs**, affecting 38%
- 18% more likely to have a **BMI: Morbid/Obese**, affecting 36%
- 14% more likely to have **Chronic Lower Back Pain**, affecting 35%
- 10% less likely to have **Routine OB/Gyn Visit**, affecting 34%
- 13% more likely to **Consume 3+ Drinks per Session**, affecting 31%

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

- 24% less likely to have **Consumed Alcohol in the Past 30 Days**, affecting 41%

Leading Causes of Death[22]

The Leading Causes of Death are determined by official Centers for Disease Control and Prevention (CDC) final death total. Mississippi's Top 15 Leading Causes of Death are listed in the tables below in KDMC's rank order. Lincoln County was compared to all other Mississippi counties, Mississippi state average and whether the death rate was higher, lower or as expected compared to the U.S. average.

Cause of Death			Rank among all counties in MS (#1 rank = worst in state)	Rate of Death per 100,000 age adjusted		Observation (Lincoln County Compared to U.S.)
MS Rank	Lincoln Rank	Condition		MS	Lincoln	
1	1	Heart Disease	55 of 82	222.1	263.2	***Higher than expected***
2	2	Cancer	33 of 82	179.7	207.6	***Higher than expected***
3	3	Lung	4 of 82	59.9	73.5	***Higher than expected***
4	4	Stroke	26 of 82	51.7	60.9	***Higher than expected***
5	5	Accidents	62 of 82	54.3	57.8	***Higher than expected***
7	6	Diabetes	15 of 82	30.5	47.4	***Higher than expected***
8	7	Flu - Pneumonia	6 of 82	26.0	34.0	***Higher than expected***
9	8	Kidney	16 of 82	22.2	28.8	***Higher than expected***
10	9	Hypertension	10 of 82	15.8	25.7	***Higher than expected***
6	10	Alzheimer's	57 of 82	45.9	24.3	***Lower than expected***
11	11	Blood Poisoning	56 of 82	14.1	15.2	***Higher than expected***
14	12	Homicide	35 of 82	13.4	11.6	***Higher than expected***
13	13	Suicide	51 of 82	13.7	11.5	***As expected***
15	14	Parkinson's	7 of 82	8.7	8.3	***As expected***
12	15	Liver	73 of 82	12.0	6.6	***As expected***

**County Death Rate Observation: Higher than expected = 5 or more deaths per 100,000 compared to the US; Lower than expect = 5 or more less deaths per 100,000 compared to the US*

[22] www.worldlifeexpectancy.com/usa-health-rankings

Priority Populations[23]

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

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

A specific question was asked to the Hospital's Local Expert Advisors about unique needs of Priority Populations, and their responses were reviewed to identify if there were any trends in the service area. Accordingly, the Hospital places great importance on the commentary received from the Local Expert Advisors to identify unique population needs to which the Hospital should respond. Specific opinions from the Local Expert Advisors are summarized below:[24]

- The top three priority populations identified by the Local Experts were low-income groups, residents of rural areas, and older adults
- Summary of unique or pressing needs of the priority groups:
    - Access to affordable healthcare
    - Education and health programs
    - Housing and healthy food access

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

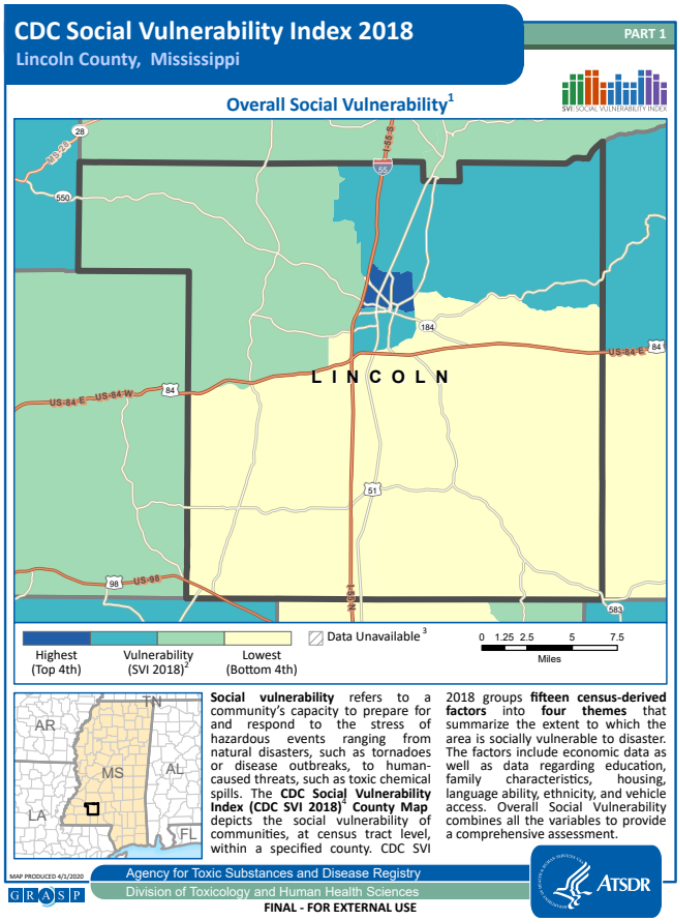
Social Vulnerability[25]

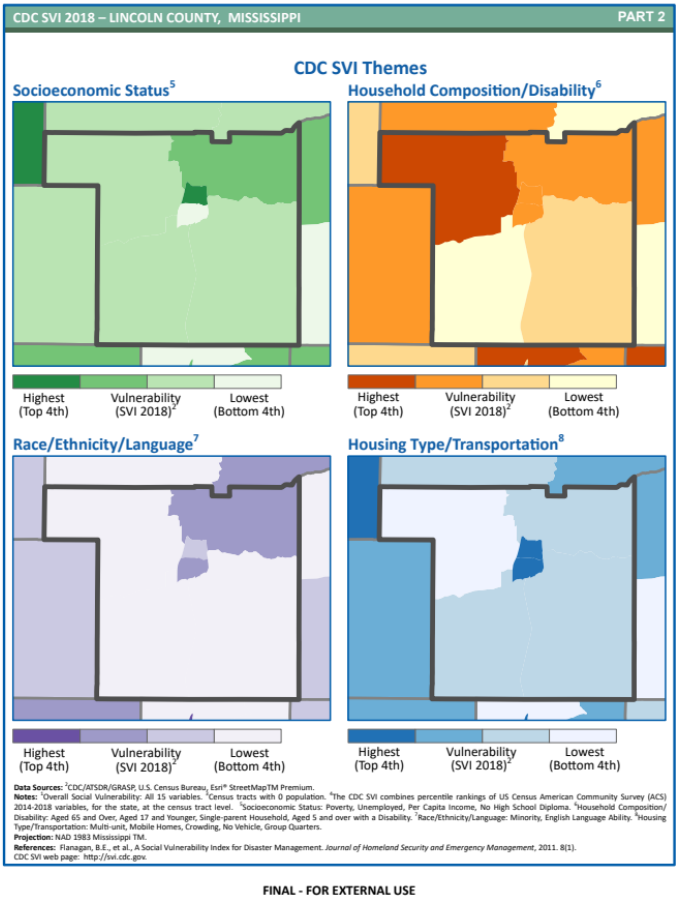
Social vulnerability refers to the resilience of communities when confronted by external stresses on human health, stresses such as natural or human-caused disasters, or disease outbreaks. Reducing social vulnerability can decrease both human suffering and economic loss. The Social Vulnerability Index uses U.S. census variables at tract level to help local officials identify communities that may need support in preparing for hazards, or recovering from disaster.

Social Vulnerability ranks an area's ability to prepare for and respond to disasters. Measures of socioeconomic status, household composition, race/ethnicity/language, and housing/transportation are layered to determine an area's overall vulnerability.

Based on the overall social vulnerability, Lincoln County falls into all four quartiles of social vulnerability. The lower half region has the lowest vulnerability, while the central and upper right region are considered to have higher social vulnerability.

Link to Lincoln, MS SVI Map





[25] http://svi.cdc.gov

Comparison to Other State Counties[26]

To better understand the community, Lincoln County has been compared to all 82 counties in the state of Mississippi across six areas: Length of Life, Quality of Life, Health Behaviors, Clinical Care, Social & Economic Factors, and Physical Environment. The last four areas are all Health Factors that ultimately affect the Health Outcomes of Length (Mortality) and Quality of Life (Morbidity).

In the chart below, each county's rank compared to all counties is listed along with any measures in each area compared to state average and U.S. median.

	Lincoln	Mississippi	U.S. Median	Top U.S. Performers
Length of Life				
Overall Rank *(best being #1)*	***32/82***			
- Premature Death*	**10,700**	10,400	8,200	5,500
Quality of Life				
Overall Rank *(best being #1)*	***22/82***			
- Poor or Fair Health	**22%**	24%	17%	12%
- Poor Physical Health Days	**4.4**	4.8	3.9	3.1
- Poor Mental Health Days	**4.6**	5.0	4.2	3.4
- Low Birthweight	**11%**	12%	8%	6%
Health Behaviors				
Overall Rank *(best being #1)*	***41/82***			
- Adult Smoking	**20%**	22%	17%	14%
- Adult Obesity	**39%**	37%	33%	26%
- Physical Inactivity	**33%**	32%	27%	20%
- Access to Exercise Opportunities	**54%**	54%	66%	91%
- Excessive Drinking	**14%**	14%	18%	13%
- Alcohol-Impaired Driving Deaths	**21%**	20%	28%	11%
- Sexually Transmitted Infections*	**559.0**	708.7	327.4	161.4
- Teen Births *(per 1,000 female population ages*	**36**	36	28	13
Clinical Care				
Overall Rank *(best being #1)*	***18/82***			
- Uninsured	**15%**	14%	11%	6%
- Population to Primary Care Provider Ratio	**2,150:1**	1,890:1	2,070:1	1,030:1
- Population to Dentist Ratio	**2,630:1**	2,120:1	2,410:1	1,240:1
- Population to Mental Health Provider Ratio	**1,630:1**	630:1	890:1	290:1
- Preventable Hospital Stays	**5,061**	6,085	4,710	2,761
- Mammography Screening	**34%**	39%	41%	50%
- Flu vaccinations	**50%**	41%	43%	53%
Social & Economic Factors				
Overall Rank *(best being #1)*	***21/82***			
- High school graduation	**81%**	83%	90%	96%
- Unemployment	**4.7%**	4.8%	3.9%	2.6%
- Children in Poverty	**25%**	28%	20%	11%
- Income inequality**	**6.0**	5.3	4.4	3.7
- Children in Single-Parent Households	**39%**	44%	32%	20%
- Violent Crime*	**108**	279	205	63
- Injury Deaths*	**95**	86	84	58
- Median household income	**$43,500**	$44,700	$50,600	$69,000
- Disconnected youth	**19%**	9%	8%	4%
- Suicides *(measure not included in overall*	**13**	14	17	11
Physical Environment				
Overall Rank *(best being #1)*	***25/82***			
- Air Pollution - Particulate Matter	**9.5 µg/m³**	9.9 µg/m³	9.4 µg/m³	6.1 µg/m³
- Severe Housing Problems***	**12%**	16%	14%	9%
- Driving to work alone	**91%**	85%	81%	72%
- Long commute - driving alone	**36%**	32%	31%	16%

Key (Legend)
- Better than MS and US
- Similar to MS and US
- Worse than US
- Worse than MS and US

Per 100,000 Population
****Ratio of household income at the 80th percentile to income at the 20th percentile***
*****Overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities***

[26] www.countyhealthrankings.org

IMPLEMENTATION STRATEGY

Significant Health Needs

KDMC used the priority ranking of the area health needs by the Local Expert Advisors as the primary input to develop the response and implementation plans for the community health needs.[27] The following list:

- Identifies goals established by the KDMC Admin Team in response to the identified health issues in the community
- Identifies current efforts responding to the needs
- Establishes the implementation strategy programs and resources KDMC will devote to attempt to achieve improvements
- Presents key measures tailored to the identified health needs that KDMC will use to track progress
- Identifies any potential partnerships with local organizations and presents locally available resources believed to be currently available to respond to this need.

[27] Response to IRS Schedule H (Form 990) Part V B 3 e

CHNA Implementation Plan Overview

The Hospital has determined that the action plan to address the health needs identified in the health needs survey will be worked through the following subgroups. Additional disease specific details are further described in the full report.

Healthcare Disparities	**Education Prevention**
Goal: *Offer accessible and supportive services to achieve health equity, eliminate disparities, and improve the health of all groups.*	Goal: *Improve the health status of residents in the Hospital service area by engaging the community in screenings and educational events that promote healthier lifestyles and better self-management of health and chronic conditions.*
Current Resources: • Several off-site health clinics available for access • Telehealth capabilities established during COVID • KDMC's participation in an Accountable Care Organization (ACO)(Myriad) • COVID vaccines provided • Maternal outcomes and breast-feeding rates monitored by race • Health Insurance Exchange Program and Financial Assistance Program available • KDMC Standard of Behavior practiced and reviewed annually	Current Resources: • Healthy Heart Screening • Diabetes Support Group and education classes • Mommy University for moms-to-be; Baby Café • Community flu vaccines, COVID-19 vaccines • Smoking Cessation Classes • Community Blood Pressure Checks • Weight Loss Classes (TOPS) provided free of charge • Wellness Works for Occupational Health • Sports Physicals provided to schools • KDMC Fitness & Performance Centers provided for community use; Walking trail along KDMC's campus • KDMC's Participation in an Accountable Care Organization (ACO) • Bi-Annual Wellness Magazine published • KDMC designated as a Lung Cancer Screening Center • Medication Management Services
Future Plans: • Remote patient monitoring • Health fairs in community locations • Develop tool to show patient outcomes by race and socioeconomic status	Future Plans: • Interactive kiosks/health education library • Interactive TVs in patient rooms • Lunch and learn • Involvement in community education and events
Drug/Substance Abuse	**Behavioral Health/Suicide**
Goal: *Increase access to substance abuse related health services and resources.*	Goal: *Increase access to quality mental and behavioral health treatment.*
Current Resources: • Established Prescription Drug Drop-Off Location at KDMC • Smoking Cessation Classes offered • Participation in the Opioid Prescription Drug Program • Designed workflow to require review of prescription monitoring program • EHR alerts sent to providers to review Controlled Rx Report • Screening for tobacco use performed in KDMC clinics and hospital • Tele psych offered in Behavioral Wellness Center	Current Resources: • Behavioral Wellness Center (1 psychiatrist & 2 Nurse Practitioners) • Collaboration with local mental health center (Region 8) • Identify suicide/self-harm risks in the hospital and clinics • Upon request, Wellness Works utilizes an approved questionnaire to identify Behavioral Health concerns for local employers • Individual and group therapy services available
Future Plans: • Pursue partnerships with local community organizations	Future Plans: • ED psych consults

1. Healthcare Disparities

Goal:

- *Offer accessible and supportive services to achieve health equity, eliminate disparities, and improve the health of all groups.*

KDMC services, programs, and resources available to respond to this need include: [28]

- Several off-site health clinics available for access
- Some telehealth capabilities established during COVID to continue providing safe healthcare access to patients during the pandemic
- KDMC's participation in the Myriad ACO
- COVID vaccines are provided to community
- Offered Rapid and PCR COVID-19 testing at the Medical Clinic
- Identified as a COVID Center of Excellence by the Mississippi State Department of Health due to KDMC's commitment to COVID-19 prevention and treatment
- Maternal outcomes and breast-feeding rates are monitored by race with efforts to improve breastfeeding practices. KDMC is a Baby Friendly hospital.
- KDMC Standards of Behavior are practiced and reviewed annual by employees to ensure fair and equitable treatment of all employees and patients

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

- Continue the above services, programs and resources
- Implementing remote patient monitoring to enable monitoring of patients outside of the conventional clinical setting to increase access to care and decrease health delivery costs
- Participate in local health fairs providing education and preventative information to industries, businesses, and churches
    - Offering body fat, cholesterol, bone density screenings, blood pressure checks, etc.
    - Appointment scheduling available
- Continue to monitor and track ED and programs for appropriate use of ED
- Research options for implementing a patient outcomes measurement tool that will assist in the identification of the disparities that need addressing
- Continue offering financial assistance
- Explore opportunity to track ED volumes by race and socioeconomic status to guide patients to appropriate care setting

Identified measures and metrics to track progress

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

- Track inpatient, outpatient, ED, and clinic visits
- Telehealth visits
- Financial assistance measures

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

Organization	Contact Name	Contact Information
Local off-site health clinics	N/A	N/A
TRIAD	Charles Smith	Lincoln County Sheriff Department

Anticipated results from KDMC Implementation Strategy

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

2. Education and Prevention

Goal:

- *Improve the health status of residents in the Hospital service area by engaging the community in screenings and educational events that promote healthier lifestyles and better self-management of health and chronic conditions.*

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

- Healthy Heart Program is available to the community that offers screening exams with consultation at a flat rate
- Accredited Diabetes Education program by the American Association of Diabetes Educators that provides the community with access to critical diabetes education services
- Mommy University offers one-on-one education for moms-to-be that includes conversation about birthing plans and individual needs of the patient, offering a more convenient and personalized learning environment. KDMC is certified as a Baby Friendly hospital.
- Community flu vaccines and COVID-19 vaccines offered to the community
- Smoking Cessation Classes offered to the community to assist in maintaining a smoke-free lifestyle
- KDMC participates in community health fairs that provides various health measurements
- Community Blood Pressure Checks available to connect at-risk patients to medical care for high blood pressure
- Weight Loss Classes (TOPS) provided free of charge to promote successful, affordable weight management with “a hands-on pounds-off approach to weight loss”
- Wellness Works collaborates with local employers to provide easy access to healthcare services (i.e. blood pressure & glucose checks, bone density scans, BMI checks, 7-lead EKGs conducted)
- Sports Physicals provided to local school students
- Offers a range of wellness and fitness options to meet the community’s needs including a premier center for athletic training and conditioning, community education classes for all ages, a beautiful fitness center to improve overall health, and programs for employers to promote their employees' health and well-being
- Walking trail along KDMC’s campus
- Several health clinics available in the community
- KDMC participation in the Myriad ACO
- Bi-Annual Wellness Views Magazine published that focuses on different aspects of physical and mental wellbeing
- KDMC designated as a Lung Cancer Screening Center (2019)
- Partnership with local civic clubs giving health information presentations at club meetings.
- Baby Café--free resource for pregnant and breastfeeding mothers to get support from specifically-trained staff and to share experiences with other moms

- Medication management services available in the specialty clinic

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

- Continue the above services, programs and resources
- Reimplement interactive kiosks/health education library throughout the community. The interactive health education kiosks are self-served to deliver health education directly to patients for free.
- Research implementing interactive TVs in patient rooms that will deliver educational materials to patients in their rooms. Educational videos customized to the patient's condition and assigned to their room as part of the treatment intervention.
- Explore options to host lunch and learns on a variety of health topics to the community
- Exploration of additional community programming such as health fairs and screenings to promote prevention and early detection of chronic diseases

Identified measures and metrics to track progress

- Interactive kiosks/health education library usage (usage rate and content)
- Participation in education programs and community events
- Number of screenings completed (blood pressure, A1C, BMI, bone density)
- Death rate associated with chronic diseases
- Participation in Wellness Works program

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

Organization	Contact Name	Contact Information
Faith Based Organizations	N/A	N/A
Civic Clubs	N/A	N/A
Wellness Works	N/A	N/A

Anticipated results from KDMC Implementation Strategy

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

3. Drug/Substance Abuse

Goal:

- *Increase access to substance abuse related health services and resources.*

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

- Established a Behavioral Wellness Center that provides outpatient services (1 Psychiatrist & 2 Nurse Practitioners)
- Collaboration with local mental health center (Region 8 Mental Health) to offer alcohol and drug treatment services, including an IOP intensive outpatient program and a residential treatment program
- Established Prescription Drug Drop-Off Location at KDMC
- Smoking Cessation Classes offered to the community to assist in maintaining a smoke-free lifestyle
- Participation in the Opioid Prescription Drug Program
- Designed workflow to require review of prescription monitoring program
- Monthly EHR alerts sent to providers to review Controlled Rx Report
- Screening for tobacco use performed in KDMC clinics
- Technology tool that allows EMS with access to patient medication history up to six months
- Telepsychiatry available to assist patients in the behavioral health clinic

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

- Continue the above services, programs and resources
- Pursue partnerships with local community organizations to provide additional access and education to substance abuse services
- Offering ED psych consults summer 2021

Identified measures and metrics to track progress

- Smoking Cessation Participation
- Opioid Drug Prescription
- Tobacco screening rate
- Successful detox program completion
- Drug overdose deaths
- Detox relapse rate
- Opioid prescribing rate

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

Organization	Contact Name	Contact Information
Region 8 Mental Health	N/A	601-823-2345 http://region8mhs.org/

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

- Local AA and NA

Anticipated results from KDMC Implementation Strategy

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

4. Behavioral Health/Suicide

Goal:

- *Increase access to quality mental and behavioral health treatment.*

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

- Established a Behavioral Wellness Center that provides outpatient services (1 Psychiatrist & 2 Nurse Practitioners)
- Collaboration with local mental health center (Region 8 Mental Health) to provide access to mental health treatment, case management, education and consultation
- Established a method of identifying suicide/self-harm risks in the ER
- Upon request, Wellness Works utilizes an approved questionnaire to identify Behavioral Health concerns for local employers
- PHQ9 depression screenings are administered at Behavioral Health visits and Medicare Annual Wellness visits

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

- Continue the above services, programs and resources
- Pursue partnerships with local community organizations to provide additional access and education to behavioral health services
- Offering ED psych consults summer 2021

Identified measures and metrics to track progress

- Behavioral Wellness Center visits
- Behavioral Health questionnaire tracked results
- Suicide death rate
- ED Behavioral Health visits

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

Organization	Contact Name	Contact Information
Region 8 Mental Health	N/A	601-823-2345 http://region8mhs.org/

Anticipated results from KDMC Implementation Strategy

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

Overall Community Need Statement and Priority Ranking Score

Significant needs where hospital has implementation responsibility[29]

1. Healthcare Disparities
2. Education and Prevention (includes Heart Disease and Diabetes)
3. Drug/Substance Abuse
4. Behavioral Health/Suicide

Significant needs where hospital did not develop implementation strategy[30]

1. None

Other needs where hospital developed implementation strategy

1. N/A

Other needs where hospital did not develop implementation strategy

1. N/A

[29] Responds to Schedule h (Form 990) Part V B 8
[30] Responds to Schedule h (Form 990) Part V Section B 8

APPENDIX

Appendix A – Written Commentary on Prior CHNA (Local Expert Survey)

Hospital solicited written comments about its 2018 CHNA.[31] 66 individuals responded to the request for comments. The following presents the information received in response to the solicitation efforts by the hospital. No unsolicited comments have been received.

1. Please indicate which (if any) of the following characteristics apply to you. If none of the following choices apply to you, please give a description of your role in the community.[32]

	Yes (Applies to Me)	No (Does Not Apply to Me)	Response Count
1) **Public Health Expertise**	16	40	56
2) **Departments and Agencies** with relevant data/information regarding health needs of the community served by the hospital	7	49	56
3) **Priority Populations**	14	43	57
4) Representative/Member of **Chronic Disease Group** or Organization	9	46	55
5) Represents the **Broad Interest of the Community**	51	12	63
Other			7

Congress defines "Priority Populations" to include:

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

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

- *Diet and exercise education to prevent future disease due to obesity.*
- *Housing and medical care for uninsured*
- *Diabetes and Heart*
- *Health disparities*

[31] Responds to IRS Schedule H (Form 990) Part V B 5
[32] Responds to IRS Schedule H (Form 990) Part V B 3 g

- *Health Assessments and education*
- *Access to affordable health care.*
- *Our state, County and community is made up of all of these groups. We have many elderly, low-income, residents with co-morbidities. The LGBTQ population is trending upward, but the stigma is so strong that many are still afraid to "come out". We also have had an increase in our Hispanic (documented and undocumented) populations. Working in the school system, I see the poverty that many of our children are living in, as well as living in homes of family members/friends and not parents because of drug addiction and incarceration.*
- *Low-income individuals who are out of work through natural occurring events out of their control or lack of work. Most of their issues are a result of poor education or lack of training, mental health problems, drug dependency, lack of work, dysfunctional families*
- *Homeless shelter and shelter for domestic abuse. There is also a need for food pantry.*
- *Many of these people are caught in the gap of working but can't afford insurance and making too much to qualify for Medicaid. Because of this, they do not see physicians as they should.*
- *We were very concerned during the ice storm that there were those in the community without power, mainly heat and some without water. We had no way to help, being unable to drive on the iced over roads. We did manage to get food to one gentleman and put another in a motel.*
- *Housing or assisted living for the severely mentally ill.*
- *Education, low wages, no access to health insurance*
- *Potential issues with access to healthcare by some.*
- *All children's welfare, including safety, security, and basic needs should be monitored and investigated promptly.*
- *Access to medical and financial needs are lacking to minorities in our community.*

In the 2018 CHNA, there were five health needs identified as "significant" or most important:

1. Physical Activity
2. Mental Illness
3. Access to Care/Prevention
4. Substance Abuse

3. Please share comments or observations about the actions KDMC has taken to address Physical Activity.

- *I do not think past actions in this area have resulted in measurable benefits to the community.*
- *I have not witness anything that KDMC has been doing in regard to physical activity. I do know they work very hard to provide the best care environment possible.*
- *Great partner for schools - support, education, awareness*

- *There is a walking trail around KDMC for public use. There has been an increase in bike lanes in town.*
- *KDMC provides facilities to address physical activity through the use of the KDMC Fitness Center and the KDMC Performance Center.*
- *Fitness center for the one that can afford it*
- *Positive progress in providing education to further enhance our community in taking action into their health and wellness plan.*
- *I am unaware of most of the planned actions taken but the Kiosks seem to be effective and user friendly. Staff to address obesity should be helpful.*
- *They provide a wonderful Fitness center and Performance center for area athletes.*
- *Very good*
- *Fitness center*
- *Performance center, social media posts*
- *KDMC actively advertises walks and other events they are sponsoring.*
- *I haven't seen any free 5Ks even before the pandemic*
- *KDMC operates a fitness center with classes for all age groups.*
- *Internally they have encouraged participation in programs that are aimed at education, exercise, and incentives. KDMC does extensive community Ed, and sponsors numerous physical activity events, races, teams.*
- *Sponsor 5k Races, Donate to the local school's athletic programs, employee enrollment to KDMC fitness gym*
- *Health fair*
- *There are classes and community get togethers.*
- *KDMC owns a gym with qualified people in charge*
- *The plan of action sounds good. I don't know how much was actually implemented, I can't speak to that. I would love to see some sort of hands-on action to deal with the increase in obesity/type II diabetes and lack of physical activity many of our children in lower elementary school experience. It would need to be comprehensive and FUN, in order to get these children to participate.*
- *Health educators to help in the fight of obesity.*
- *All good. Since KDMC has a fitness center, a program to specifically outreach to obese patients, perhaps a discount correlating to weight loss, would motivate lower income individuals,*
- *KDMC sponsors high school football, tennis tournaments, golf tournaments and 5 k walks*
- *As a member of the gym, I have seen a good bit of response to the program that offers free membership to those attending the diabetes classes.*
- *They operate an excellent gym that if utilized provides community activities.*

- *KDMC runs a very effective physical fitness building that accommodates many Lincoln countians.*
- *Fitness center*
- *I have noticed an abundance of local 5ks throughout our community. Additionally, KDMC does a great job relaying healthy tips and information to local schools.*
- *KDMC has taken the appropriate actions to address the physical needs of our community with collaboration with local organizations.*
- *We have a Fitness Center and Walking Trail for hospital employees...and we have a Performance Center for some in the Community....but I do feel we need more things for youth and children to do in the area to promote physical activity.*

4. Please share comments or observations about the actions KDMC has taken to address Mental Illness.

- *There is now a Behavioral Wellness clinic, which is a tremendous help to the community. The Pandemic has been particularly trying and the clinic has been very beneficial to the community.*
- *KDMC has established KDMC Behavioral Wellness Clinic.*
- *I think there is a mental health clinic in the area, but I don't know if KDMC is associated with it.*
- *Cooperation with Region 8 is a definite asset to help address the mental health issues.*
- *Recently added Mental Health to their offerings, and hopefully will expand due to the great demand.*
- *A great step forward in a state which has turned its back on mental health needs*
- *Has a mental health clinic*
- *Behavioral health department*
- *Improving. Needs concerted effort with partners outside the KDMC team.*
- *KDMC addressed this with the opening of KDMC Behavioral Wellness Center.*
- *KDMC routinely works with Region 8. Internally, employees have access to counseling and assistance if needed*
- *Opened up a Behavioral Wellness Center two years ago.*
- *Works with the local Regions 8 office to provide services and awareness.*
- *KDMC has hired a psychiatrist along with nurse practitioners operating in a clinic*
- *Working well with Region 8. There needs to be more help for the uninsured.*
- *New mental health provider and clinic.*
- *Untreated mental illness worsens with those who are lower income/no insurance. Programs that target this population, and increasing availability of mental health programs, can only improve community wellbeing as a whole.*
- *Brought in Dr Richardson and 2 nurse practitioners and opened a Behavioral Wellness center*

- *The opening of the mental health clinic was a huge step. After working in the school system for several years, I see the downfalls with Region 8. Having a local mental health clinic is a definite plus for our community.*
- *Provide limited resources like Region 8, which desperately needs to expand. Long term mental health facilities are desperately needed for people who are unable to care for themselves and to reduce community crime.*
- *KDMC does an excellent job using Region 8 and local speakers to reach out to teens in the community concerning numerous mental illnesses while also providing resources to help any struggling children.*
- *KDMC has taken appropriate actions to help the needs of mental illness in our community with collaboration with other facilities. Shortage of mental health providers. Need mental health personnel placed within each school building*
- *We now have a Behavioral Clinic open that is available to help those with mental illness.*

5. Please share comments or observations about the actions KDMC has taken to address Access to Care/Prevention.

- *Support, education, awareness*
- *There are multiple classes available to the public through KDMC....smoking cessation, diabetes information, weight loss to name a few.*
- *In addition to the facilities listed above KDMC also addresses Access to Care/Prevention through the KDMC Medical Clinic, the KDMC Specialty Clinic, the KDMC Magazine, the KDMC Newsletter, as well as their website, social media, and radio announcements.*
- *Always sharing and providing access to the options available to the public.*
- *Diabetic education is vital to community. Expansion of clinics and their hours is also a good service to our community.*
- *KDMC has opened several off-site clinics to reach more in the community*
- *Has multiple clinics in our area*
- *Telehealth*
- *KDMC took a big role in vaccination in our community.*
- *I haven't noticed.*
- *We are a part of an ACO to help patients manage their chronic health issues.*
- *KDMC currently is weekly providing our community with Covid vaccines as they are available through the state. Regular community events and education occur.*
- *1. Initiated an Accountable Care Organization for the Medicare population in the community. 2. Opened a COVID testing site for the community during a pandemic. 3. Opened a respiratory clinic at the Medical Clinic for patients with COVID symptoms. 4. Provided COVID vaccinations on a weekly basis to those patients that are eligible. 5. Hosts diabetic support groups and teaching.*

- *Provides the local schools in the county to free physicals in the school setting. KDMC works with the local school athletics in caring for athletes during games and teaching them proper conditioning. Provide a Health Fair for the local school's employees*
- *Health fair*
- *My seniors that come to the center tell me they have information luncheons and classes.*
- *Need to make those financial assistance to the uninsured programs more widely known.*
- *Recruitment of quality doctors and NP.*
- *All good. Discounted medications, health fairs, and education are key.*
- *Advertising through paper, tv, radio about the care options KDMC has. Began telemedicine for patients not able to get to doctor's office*
- *Again, I see several patients who benefit from the diabetes educational program. KDMC coming into the schools and providing the flu shots for our staff is also a big help and greatly appreciated.*
- *Provide care for low-income needs*
- *KDMC installed triages or kiosks in several places in the county to provide help and information.*
- *Classes for care and prevention*
- *I can personally attest that any doctor my family has seen through KDMC has always prescribed the generic versions of medications. Also, during the pandemic, the rapid testing site at KDMC was invaluable to almost every member of our community.*
- *KDMC has taken the appropriate actions to address the access to care/prevention of our community. Collaboration with other organizations should be extended the surrounding areas of our community.*
- *I'm not aware of anything we've done to address this. I do feel this is an issue, especially for those in rural areas. There is a "Five County" van that can help, but I think more help is needed in this area.*

6. Please share comments or observations about the actions KDMC has taken to address Substance Abuse.

- *Medical personnel provides information to schools, patients, and the community as a whole about all forms of substance abuse.*
- *I don't have any knowledge regarding these services.*
- *Continued education is always essential in solving the problem of substance abuse.*
- *I don't have any knowledge as to if they do or don't*
- *Behavioral health department*
- *Other that Opioid abuse posters at clinics not much else has been done.*
- *Hosts smoking cessation classes free of charge.*
- *Provide the local schools with guest speakers and seminars*

- *Better advertising on medication drop off locations.*
- *Provide education on substance abuse.*
- *Good. I would like to see KDH collaboration with local substance abuse partners, like Alcoholics Anonymous, or a referral system to substance abuse programs. I am not aware of any local programs like that.*
- *We have had health educators come into the schools and give presentations on vaping and other drugs. These are very helpful and greatly appreciated*
- *More long-term dependency counseling is needed which may prevent deterioration of community values.*
- *I have served as a member on the Mississippi Tobacco-Free Coalition and there is always at least one representative from the hospital in attendance. I also think KDMC does an excellent job getting information to the schools and holding informative health fairs.*
- *KDMC has taken the appropriate actions to address the needs of substance abuse.*
- *I am not aware of what has been done to address this.*

Appendix B – Identification & Prioritization of Community Needs (Local Expert Survey)

Survey question: Please rate each item's importance on a scale of 1 (Not at all) to 5 (Extremely) = 2018 Identified Significant Health Needs*

Health Need	Local Expert Votes Extremely Significant *Rated 5*	Significant *Rated 4*	Combined *5+4 Ratings*
Access to Healthcare*	64%	13%	***78%***
Obesity/Overweight*	60%	16%	***76%***
Drug/Substance Abuse*	55%	23%	***77%***
Behavioral Health/Suicide*	52%	23%	***75%***
Education/Prevention	48%	30%	***77%***
Heart Disease	48%	20%	***68%***
Cancer	43%	32%	***75%***
Diabetes*	43%	32%	***75%***
Affordability	43%	30%	***73%***
Hypertension	36%	30%	66%
Women's Health	30%	23%	52%
Accidents	28%	19%	47%
Social Factors	27%	27%	55%
Lung Disease	26%	23%	49%
Dental	25%	23%	48%
Stroke	23%	43%	66%
Kidney Disease	23%	32%	55%
Alzheimer's	16%	39%	55%
Liver Disease	16%	18%	34%

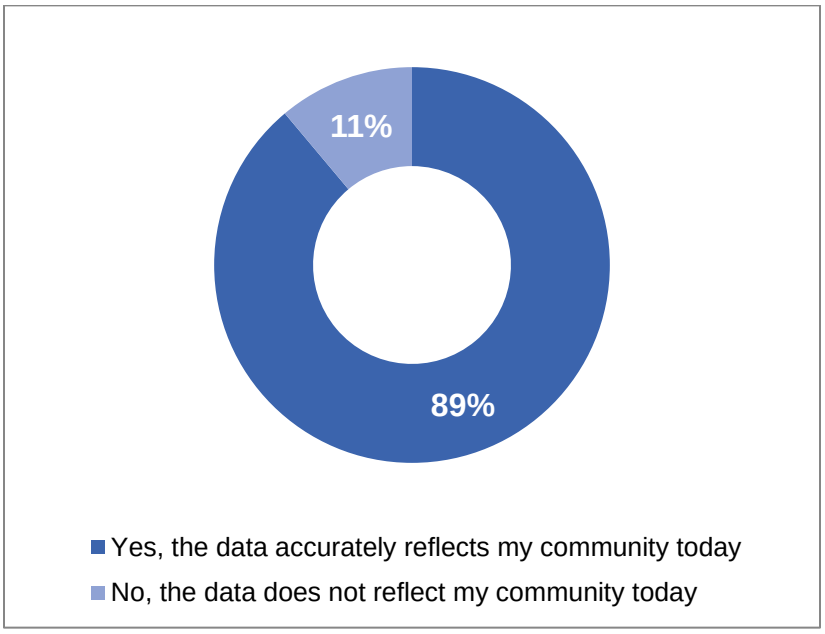
* = 2018 Signifcant Need

Survey question: Of the issues listed above for Lincoln County, which 3 do you think are most important within the community?

Health Need	1	2	3	Total
Obesity	14%	20%	10%	44%
Access to Healthcare	26%	7%	5%	38%
Drug/Substance Abuse	10%	12%	15%	36%
Education/Prevention	2%	12%	20%	34%
Heart Disease	10%	12%	10%	31%
Behavioral Health/ Suicide	17%	5%	7%	29%
Affordability	7%	12%	7%	27%
Cancer	0%	15%	2%	17%
Diabetes	5%	0%	5%	10%
Women's Health	0%	2%	5%	7%
Alzheimer's	2%	0%	2%	5%
Stroke	2%	0%	2%	4%
Accidents	0%	0%	2%	2%
Chronic kidney disease	0%	2%	0%	2%
DM	0%	0%	2%	2%
EDS	0%	0%	2%	2%
Social factors	0%	0%	2%	2%
No dementia unit	2%	0%	0%	2%
Pregnancy	2%	0%	0%	2%

Advice Received from Local Expert Advisors

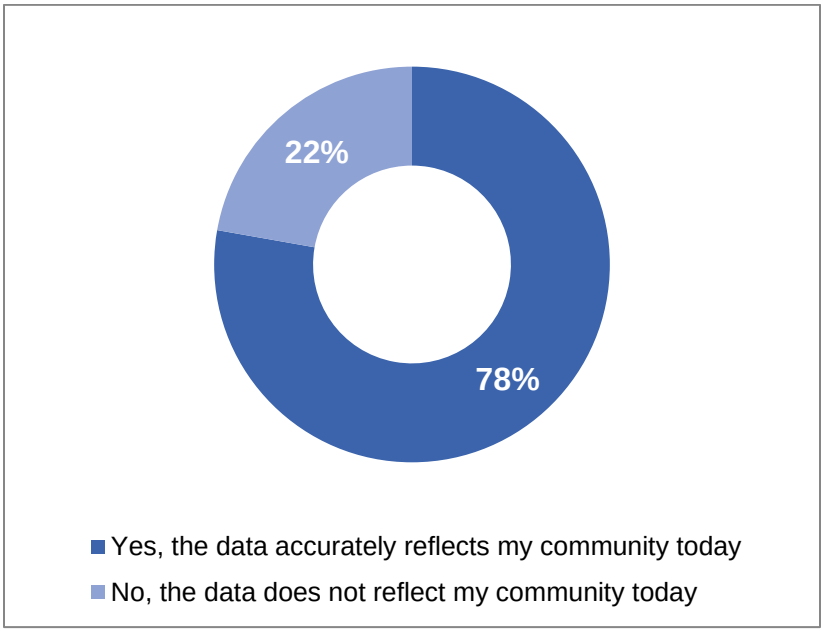
Question: Do you agree with the comparison of Lincoln County compared to Mississippi and the US?



Comments:

- *The statistics are disturbing. I have no reason to question them, but obviously our county has much room for improvement in many areas.*
- *Mental health is a bigger concern than is listed.*
- *Of course, there is always room for improvement however I believe we are in touch with the needs of our community and striving to meet these needs.*
- *Cannot believe the numbers are that bad in Lincoln county.*
- *Obvious disparities with the rest of the country and state*
- *I don't have enough information to comment on this. I have no reason to believe that the information/data is not reflective of this community.*
- *Our community has a lot of issues to address. Funding and income are major disadvantages to improvement to the statistics. Our hospital does a good job trying to improve our community but it's going to take the entire community to make a real difference. Unfortunately, a lot of rural hospitals are spending a tremendous amount of time trying to stay open with the reduction in reimbursements.*

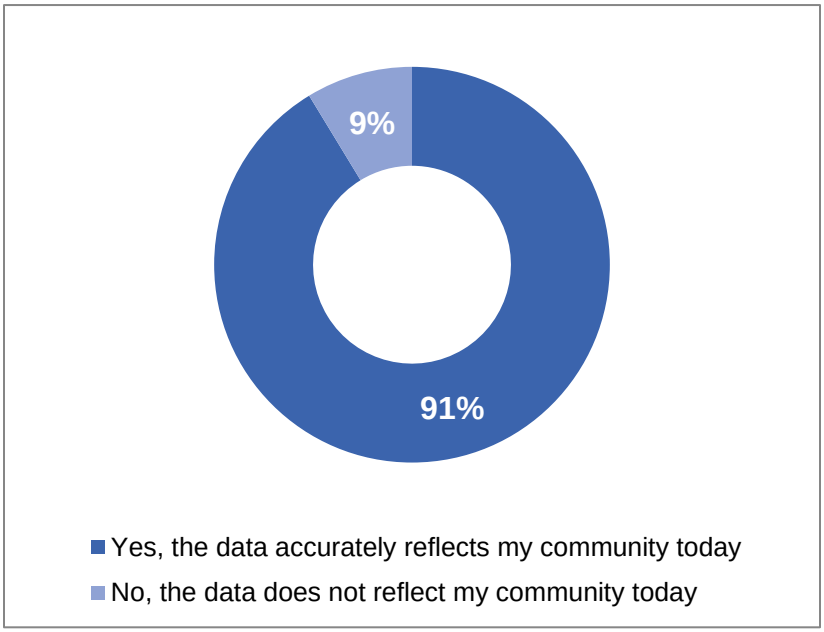
Question: Do you agree with the demographics and common health behaviors of KDMC's Service Area?



Comments:

- *Need to work on these areas to improve our health and health care practices.*
- *Didn't realize how bad/unhealthy Lincoln county is.*
- *More than 36% obese, more than 31% drinking. Not sure where the people who exercise are.*
- *Statistics probably too high. Unhealthier than indicated*
- *"We have a population who uses the ER as a PCP.,*
- *We have a problem with Obesity, and many get little or no exercise. This also applies to children."*
- *Ties back to poverty and low access to health care.*
- *Think the vigorously exercise is far below this number. With that being said would think the morbid/obese BMI is far above. The 3+ drinks per session would depend on if there is a holiday. There are several days that we have people in ER that you can smell ETOH on them but say that they have not had a drink in several days. The visit for ER non-emergent needs should be much higher than this. Just this past week when the snow was on the ground, we had people coming in because they was home alone.*
- *Most of the people I know practice good health habits, regular doctors' visits, exercise, non-drinkers. I know there are other groups in the community that need help with those good health practices.*

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



Comments:

- *Some of these percentages and numbers could be brought down by education and better health practices. We are definitely in the "higher than expected" range in most categories.*
- *COVID has taken lives this past year and continues to do so.*
- *I imagine the pandemic has exacerbated everything.*
- *Very disheartening numbers that reflect how important access to health insurance and Medicaid expansion is to our county and state. People will continue to suffer a higher death rate until healthcare is addressed at the legislative level.*

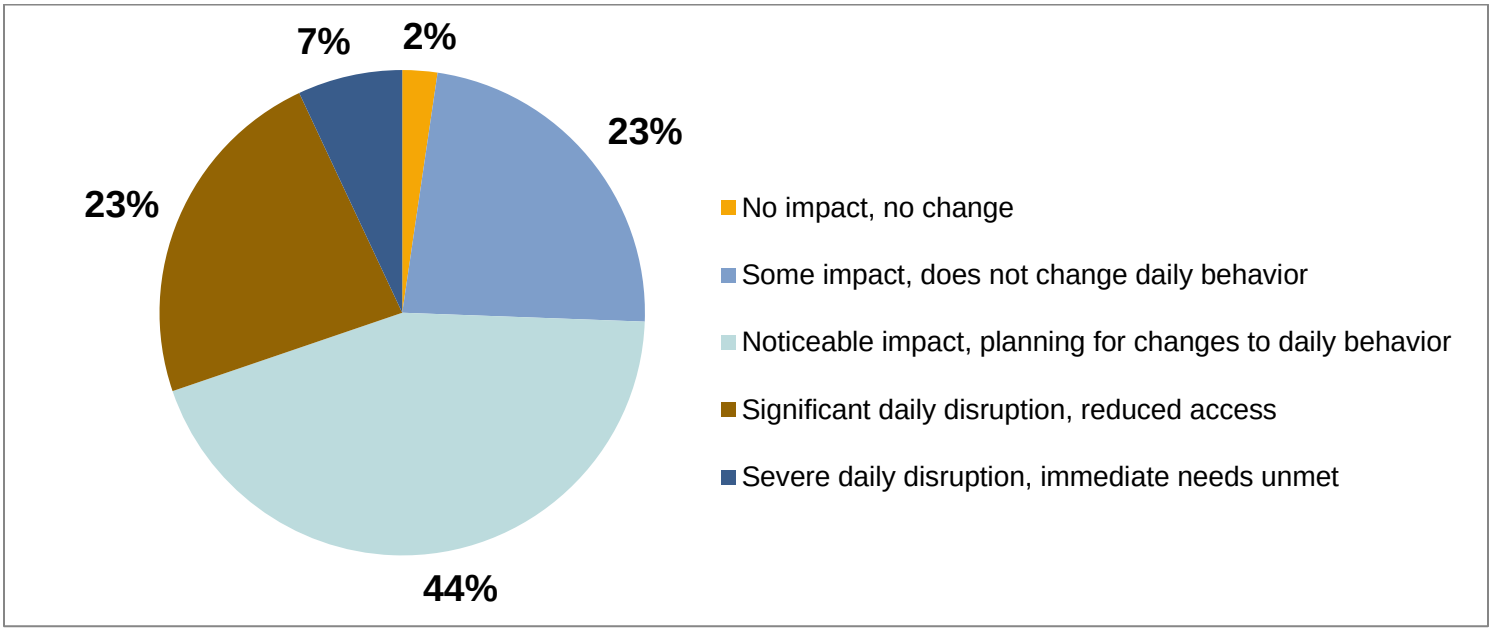
Question: Please add any additional information you would like us to understand.

Comments:

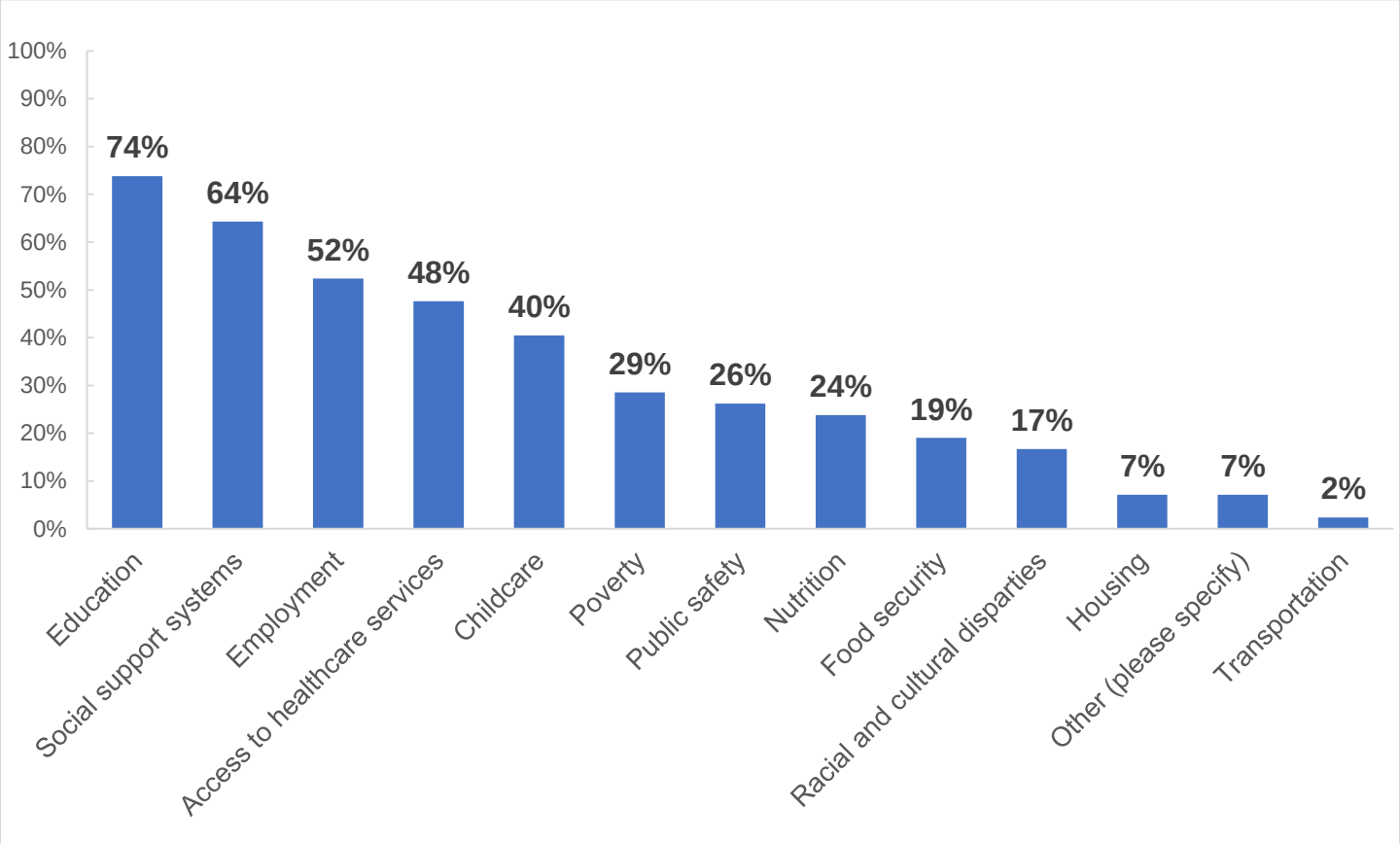
- *Obesity leads to a lot of the other problems such as diabetes, hypertension, and heart trouble.*
- *There are treatments for ailments that present as needing attention, but the circumstances that cause them need treatment before detrimental conditions are a reality.*
- *No swing beds that are separate unit from nursing home beds. Also, no dementia units.*
- *If people's behavior improves - the other categories would improve.*
- *Homeless patients*

Local Expert COVID-19 Impacts

Question: Overall, how much has the COVID-19 pandemic affected you and your household?



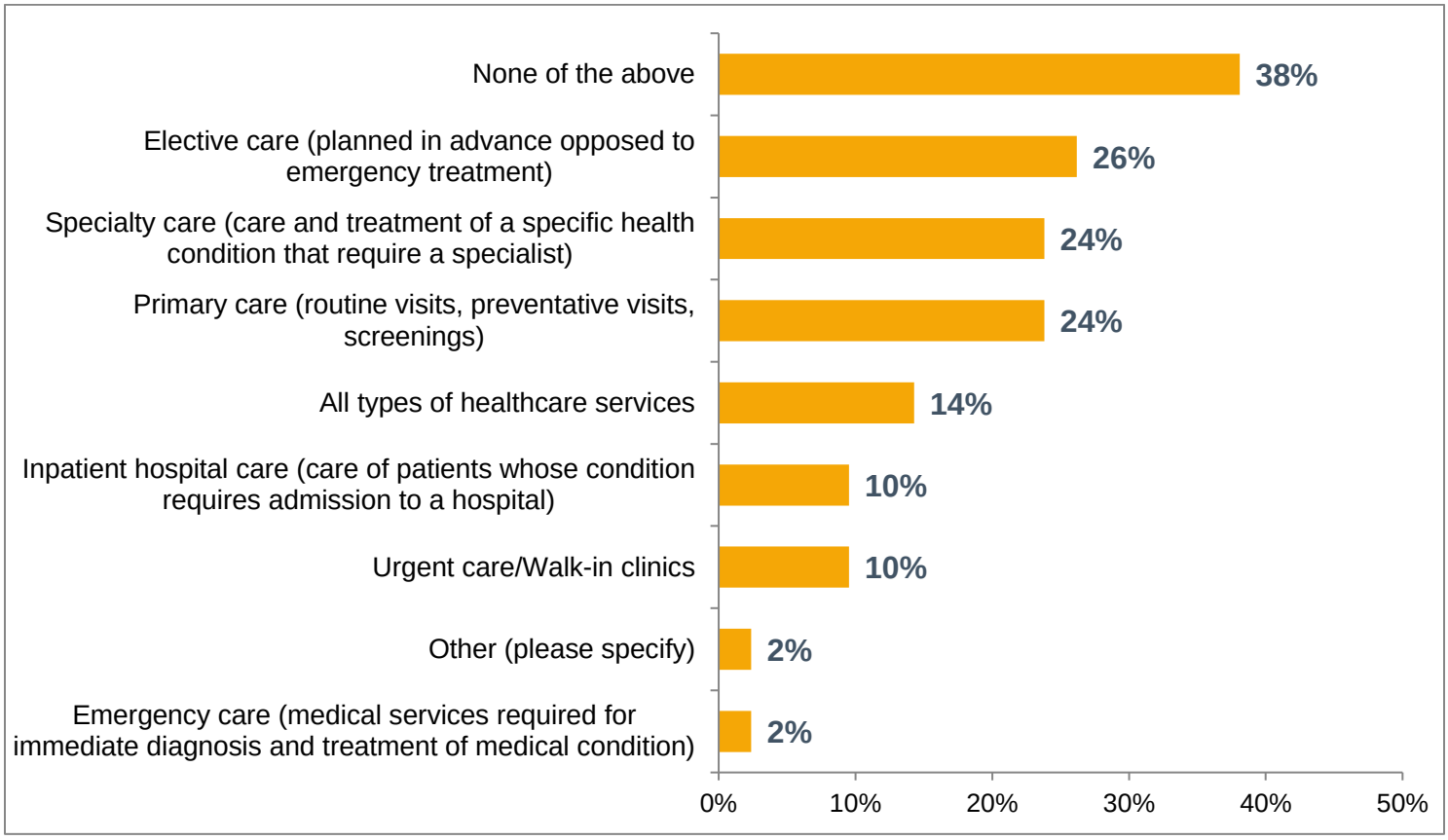
Question: Social determinants of health are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes. Please select the key social determinants that have been negatively impacted by the COVID-19 pandemic in your community (please select all that apply):



Comments:

- *Socialization of children*
- *Church*
- *Reduced income due to covid tends to affect everything*

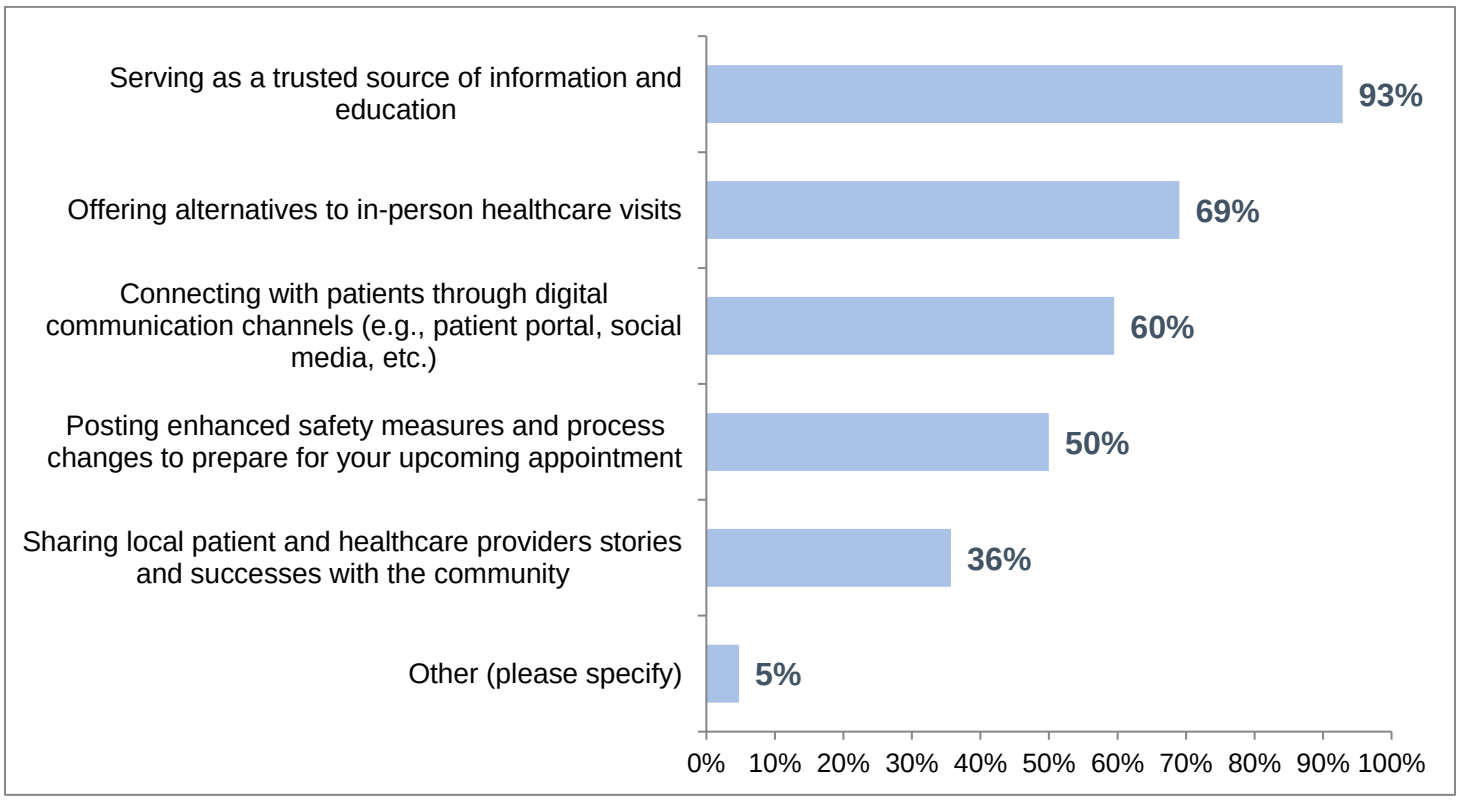
Question: During the COVID-19 pandemic, what healthcare services, if any, have you or your family delayed accessing? (please select all that apply)



Comments:

- *Thankfully, we do not need extra medical care*

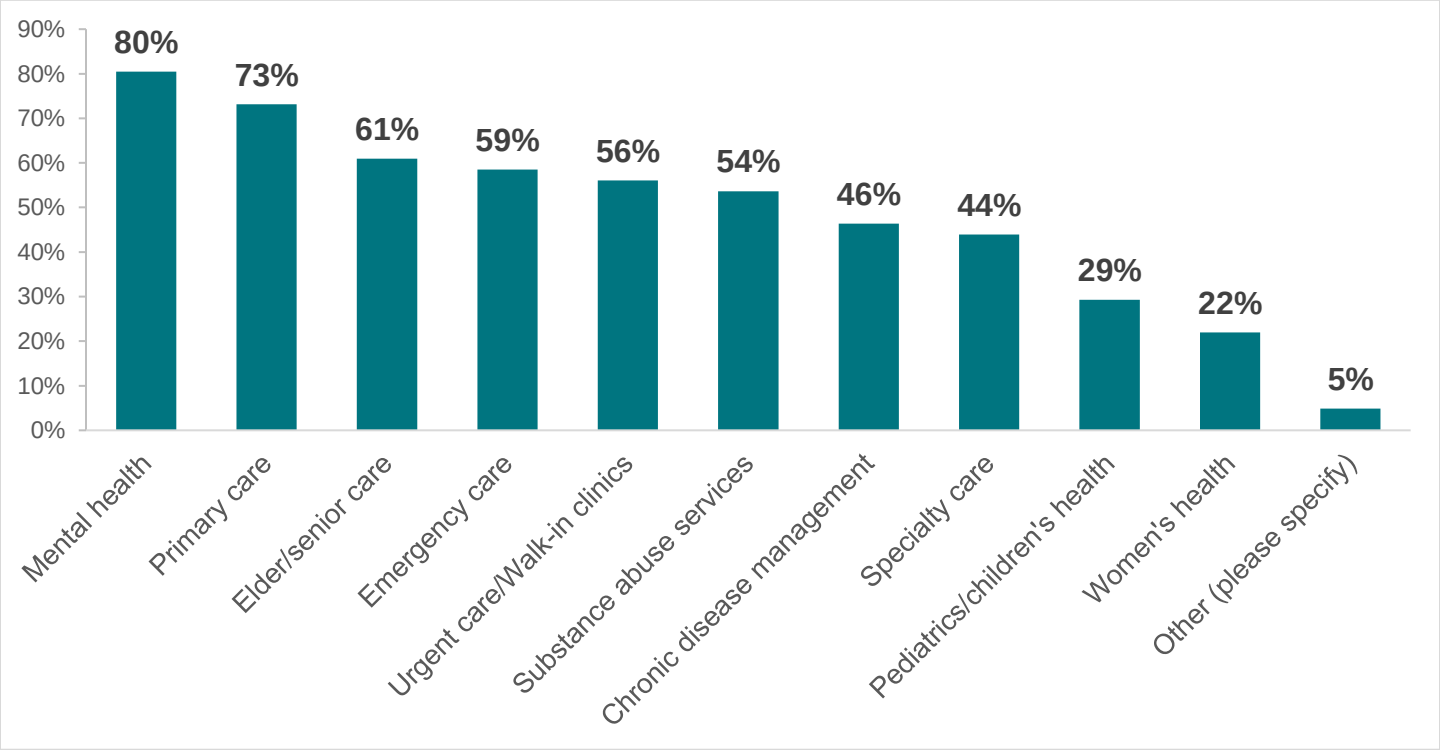
Question: How can healthcare providers, including King's Daughters Medical Center, continue to support the community through the challenges of COVID-19? (please select all that apply)



Comments:

- *Making sure not to dismiss other illnesses because the person has covid symptoms. If covid test is negative or positive, there still could be other issues causing the symptoms that should not be overlooked.*
- *Have given several 1 and 2 Covid Shots*

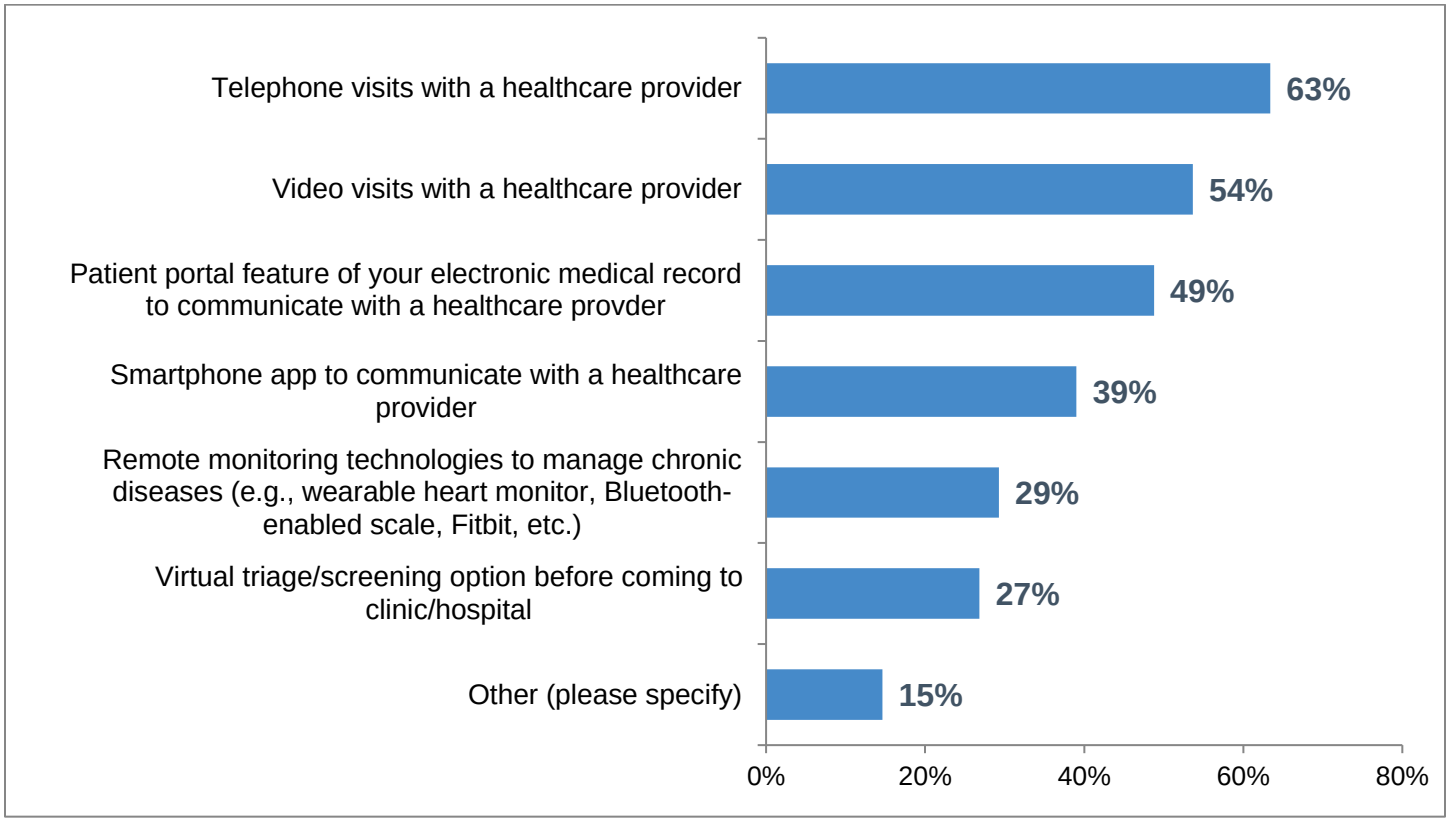
Question: What healthcare services/programs will be most important to supporting community health as the pandemic continues to unfold? (please select all that apply)



Comments:

- *Preventive care and education*
- *Obviously, all are important, but I feel these areas will be needed more and more during this pandemic.*

Question: COVID-19 has led to an increase in virtual and at-home healthcare options, including telemedicine, telephone visits, remote monitoring, etc. What alternative care options do you believe would benefit the community most? (please select all that apply)



Comments:

- *Many who need care are not tech savvy or do not have devices other than a phone.*
- *Many do not have internet.*
- *We need internet access for any of these measures to work. Even cell phone reception is spotty 2 miles out of city limits.*
- *Patient portal feature has not been reliable. I have had very poor luck in retrieving my information.*
- *Being able to speak to a person in the area, instead of someone answering the phone in TEXAS!*
- *Tel Med and blue tooth is not always good for elderly*

Question: Please share resources and solutions that would help you and community get through the COVID-19 crisis.

Comments:

- *Improvement of Electronic Medical records, portability, common systems between clinic and hospitals. More consistent detail on provider visits.*
- *Being able to get lab drawn without having to check in at KDMC outpatient as if you are having major surgery or something. Just make it seamless and quick. As it's set up now, it takes far too long for a simple lab draw. Just set something quicker and easier up or more and more people will seek out a "lab ore type place "to get labs drawn.*
- *Continued availability of vaccines*
- *We should all understand that we are responsible for our own health.*
- *Information, vaccination, education on available devices. The rest is the responsibility of the individual.*
- *Trusted data.*
- *Home health services for elderly adults to assist in their medical care and with their social isolation*
- *Working people all get frontline pay*
- *Keep leading vaccination efforts and pushing for stricter measures/precautions*
- *We need more telehealth options. More attention to the elderly that are dealing with dementia and those battling chronic health issues.*
- *Continue to practice safe distancing, wash your hands regularly and wear your mask.*
- *Please stop having the phones answered by people in other states during regular business hours! They are not helpful and do not understand anything about our town or our healthcare system.*
- *Up to date communications concerning COVID symptoms and access to more vaccine doses.*
- *Education for people not technologically minded, because we are uploading documents via email and online. Some just don't know how to do.*
- *Continual prayers for health and safety*
- *Start making Covid vaccines for less than 65-year-old.*
- *Diversity Planning Committee*