
**MAGNOLIA REGIONAL HEALTH CENTER
CORINTH, MISSISSIPPI**

**2013 COMMUNITY HEALTH NEEDS ASSESSMENT AND
IMPLEMENTATION PLAN**

ADOPTED BY BOARD RESOLUTION ¹



¹ Response to Schedule H (Form 990) Part V B 2



Dear Community Resident:

Magnolia Regional Health Center (MRHC) welcomes you to review this document as we strive to meet the health and medical needs in our community. All not-for-profit hospitals are required to develop this report in compliance with the Accountable Care Act.

The “2013 Community Health Needs Assessment” identifies local health and medical needs and provides a plan to indicate how MRHC will respond to such needs. This document suggests areas where other local organizations and agencies might work with us to achieve desired improvements and illustrates one way we, MRHC, are meeting our obligations to efficiently deliver medical services.

MRHC will conduct this effort at least once every three years. As you review this plan, please consider if, in your opinion, we have identified the primary needs and if our intended response should make appropriate needed improvements.

We do not have adequate resources to solve all the problems identified. We view this as a plan for how we, with other organizations and agencies, can collaborate to bring the best each has to offer to address more pressing identified needs.

The report is a response to a federal requirement of not-for-profit hospital’s to identify the community benefit it provides in responding to documented community need. Of greater importance, is the potential for this report to guide our actions and the efforts of others to make needed health and medical improvements.

Please think about how to help us improve the health and medical services our area needs. I invite your responses to this report. Magnolia Regional Health Center is dedicated to improving the health and well-being of our community by blending our passion for very good care with the use of advanced medical technology to deliver the best possible care ...*One Patient at a Time.*

Thank you



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EXECUTIVE SUMMARY

Executive Summary

Magnolia Regional Health Center (MRHC) is organized and governed as a jointly owned city-county Community Hospital. An “Authority” is a government organization, and as such, is not required to produce evidence of providing an adequate amount of “community benefit” to justify retention of their not-for-profit tax status. However, MRHC has elected to voluntarily complete a Community Health Needs Assessment to assure it is responding to the primary health needs of its residents. This study is designed to comply with standards required of a not-for-profit hospital. We assume MRHC acts as a not-for-profit hospital solely for purposes of producing this report. Tax reporting citations in this report do not apply to MRHC.

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

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

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

MRHC partnered with Quorum Health Resources (QHR) for the following:⁴

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

Brief Overview of Community Health Needs Assessment

Typically, nonprofit 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 to the less fortunate without means to pay. With the introduction of Medicare, the government met the burden of providing compensation for such care.

² Part 3 Treasury/IRS – 2011 – 52 Notice ... Community Health Needs Assessment Requirements...

³ As of the date of this report Notice of proposed rulemaking was published 6/26/2012 and available at <http://federalregister.gov/a/2012-15537>

⁴ Part 3 Treasury/IRS – 2011 – 52 Section 3.03 (2) third party disclosure notice

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:

- Emergency room open to all, regardless of ability to pay;
- Surplus funds used to improve patient care, expand facilities, train, etc.;
- Control by independent civic leaders; and
- All available and qualified physicians are privileged.

Specifically, the IRS requires:

- Effective on tax years beginning after March 23, 2012, each 501(c) (3) hospital facility is required to conduct a community health needs assessment at least once every three taxable years and adopt an implementation strategy to meet the community needs identified through such assessment;
- Assessment may be based on current information collected by a public health agency or nonprofit organization and may be conducted together with one or more other organizations, including related organizations;
- 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 ideally downloadable from the hospital web site;
- Failure to complete a community health needs assessment in any applicable three-year period results in a penalty to the organization of \$50,000, e.g., if a facility does not complete a community health needs assessment in taxable years one, two or three, it is subject to the penalty in year three. If it then fails to complete a community health needs assessment 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); and
- An organization that fails to disclose how it is meeting needs identified in the assessment is subject to existing incomplete return penalties.⁵

⁵ Section 6652

APPROACH

Approach

To complete a CHNA, the hospital must:

- Describe processes and methods used to conduct the assessment:
 - Sources of data and dates retrieved;
 - Analytical methods applied;
 - Information gaps impacting ability to assess the needs; and
 - Identify with whom the Hospital collaborated.
- Describe how the hospital gained input from community representatives:
 - When and how the organization consulted with these individuals;
 - Names, titles and organizations of these individuals; and
 - Any special knowledge or expertise in public health possessed by these individuals.
- Describe the process and criteria used in prioritizing health needs;
- Describe existing resources available to meet the community health needs; and
- Identify programs and resources the hospital facility plans to commit to meeting each identified need and the anticipated impact of those programs and resources on the health need.

QHR takes a comprehensive approach to assess community health needs. We perform several independent data analyses based on secondary source data, augment this with local survey data and resolve any data inconsistency or discrepancies from the combined opinions formed from local experts. We rely on secondary source data and most secondary sources use the county as the smallest unit of analysis. We asked our Local Experts, area residents, to note if they perceived the problems or needs, identified by secondary sources, to exist in their portion of the county.⁶

The data displays used in our analysis are presented in the Appendix. Data sources include:⁷

Web Site or Data Source	Data Element	Date Accessed	Data Date
www.countyhealthrankings.org	Assessment of health needs of Alcorn County compared to all NM counties	July 22, 2013	2002 to 2010

⁶ Response to Schedule H (Form 990) Part V B 1 i

⁷ Response to Schedule H (Form 990) Part V B 1 d

Web Site or Data Source	Data Element	Date Accessed	Data Date
www.communityhealth.hhs.gov	Assessment of health needs of Alcorn County compared to its national set of “peer counties”	July 22, 2013	1996 to 2009
Truven (formerly known as Thomson) Market Planner	Assess characteristics of the hospital’s primary service area, at a zip code level, based on classifying the population into various socio-economic groups, determining the health and medical tendencies of each group and creating an aggregate composition of the service area according to the contribution each group makes to the entire area; and, to access population size, trends and socio-economic characteristics	July 22, 2013	2012
www.capc.org and www.getpalliativecare.org	To identify the availability of Palliative Care programs and services in the area	July 22, 2013	2012
www.caringinfo.org and iweb.nhpco.org	To identify the availability of hospice programs in the county	July 22, 2013	2012
www.healthmetricsandevaluation.org	To examine the prevalence of diabetic conditions and change in life expectancy	July 22, 2013	1989 through 2009
www.dataplace.org	To determine availability of specific health resources	July 22, 2013	2005
www.cdc.gov	To examine area trends for heart disease and stroke	July 22, 2013	2007 to 2009
www.CHNA.org	To identify potential needs among a variety of resource and health need metrics	July 22, 2013	2003 to 2010
www.datawarehouse.hrsa.gov	To identify applicable manpower shortage designations	July 22, 2013	2013
www.worldlifeexpectancy.com/usa-health-rankings	To determine relative importance among 15 top causes of death	July 22, 2013	2010 published 11/29/12

- In addition, we deployed a CHNA “Round 1” survey to our local expert advisors to gain local input as to local health needs and the needs of priority populations. Local expert advisors were local individuals selected to conform to the input required by the Federal guidelines and regulations;⁸
- We received community input from 23 local expert advisors; survey responses started Tuesday, July 2, 2013 at 9:59 A.M. and ended with the last response on Wednesday, July 17, 2013 at 8:45 P.M.;
- Information analysis augmented by local opinions showed how Alcorn County relates to its peers in terms of primary and chronic needs, as well as other issues of uninsured persons, low-income persons and minority groups; respondents commented on if they believe certain population groups (or people with certain situations) need help to improve their condition and if so, who needs to do what.⁹

When the analysis was complete, we put the information and summary conclusions before our local group of experts¹⁰, who were asked to agree or disagree with the summary conclusions. They were free to augment potential conclusions with additional statements of need, and new needs did emerge from this exchange¹¹. Consultation with 21 local experts occurred again via an internet-based survey (explained below) during the period beginning Monday, July 29, 2013 at 8:49 A.M. and ending Thursday, August 8, 2013 at 6:24 P.M.

With the prior steps identifying potential community needs, the Local Experts participated in a structured communication technique called a Delphi method, originally developed as a systematic, interactive forecasting method which relies on a panel of experts who answer questionnaires in a series of rounds. We contemplated and implemented one round as referenced during the above dates. After each round, we provided an anonymous summary of the experts’ forecasts from the previous round, as well as the reasons provided for their judgments. The process encourages experts to revise their earlier answers in light of the replies of other members of their panel. Typically, this process decreases the range of answers and moves the expert opinions toward a consensus “correct” answer. The process stops when we identify the most pressing, highest priority community needs.

In the MRHC process, each local expert allocated 100 points among all identified needs, having the opportunity to introduce needs previously unidentified and to challenge conclusions developed from the data analysis. A rank order of priorities emerged, with some needs receiving none or virtually no support and other needs receiving identical point allocations.

We dichotomized the rank order into two groups: high priority (“Significant”) needs and low priority (“Other Identified”) needs. The determination of the break point, Significant as opposed to Other, was a qualitative interpretation by QHR and the MRHC executive team where a reasonable

⁸ Response to Schedule H (Form 990) Part V B 1 h

⁹ Response to Schedule H (Form 990) Part V B 1 f

¹⁰ Part response to Schedule H (Form 990) Part V B 3

¹¹ Response to Schedule H (Form 990) Part V B 1 e

break point in rank occurred, indicated by the weight amount of points each potential need received and the number of local experts allocating any points to the need. When presented to the MRHC executive team, the dichotomized need rank order identified which needs the hospital considered important to warrant development of an implementation plan.¹²

¹² Response to Schedule H (Form 990) Part V Section B 6 g, h and Part V B 1 g

FINDINGS

Findings

Definition of Area Served by the Hospital Facility¹³



Magnolia Regional Health Center, in conjunction with QHR, defines its service area as Alcorn County in Mississippi which includes the following ZIP codes:

38834 – Corinth 38846 – Glen 38865 – Rienzi

In 2011, the Hospital received 52.1% of its patients from this area.¹⁴

¹³ Responds to IRS Form 990 (h) Part V B 1 a

¹⁴ Truven MEDPAR patient origin data for the hospital; Responds to IRS Form 990 (h) Part V B 1 a

Demographic of the Community¹⁵

The 2013 population for Alcorn County is estimated to be 36,911,¹⁶ and is expected to increase at a rate of 0.1% in contrast to the 3.3% national rate of growth and the Mississippi growth rate of 1.2%. Alcorn County in 2018 anticipates a population of 36,926.

According to population estimates utilized by Truven, provided by The Neilson Company, the 2012 median age for the county is 39.6 years, older than the Mississippi median age (36.2 years) and the national median age (37.5 years). The 2013 Median Household Income for the area is \$30,511, lower than the Mississippi median income of \$36,723 and the national median income of \$49,223. Median Household Wealth value also is below the National and the Mississippi value. Median Home Values show the same pattern as Household Wealth. Alcorn's unemployment rate as of June, 2013 was 8.8%,¹⁷ which is better than the 9.7% statewide and the 7.8% national civilian unemployment rate.

The portion of the population in the county over 65 is 17%, above the Mississippi (13.7%) and the national average of 13.9%. The portion of the population of women of childbearing age is 18.3%, below the Mississippi average of 20.1% and the national rate of 19.8%.

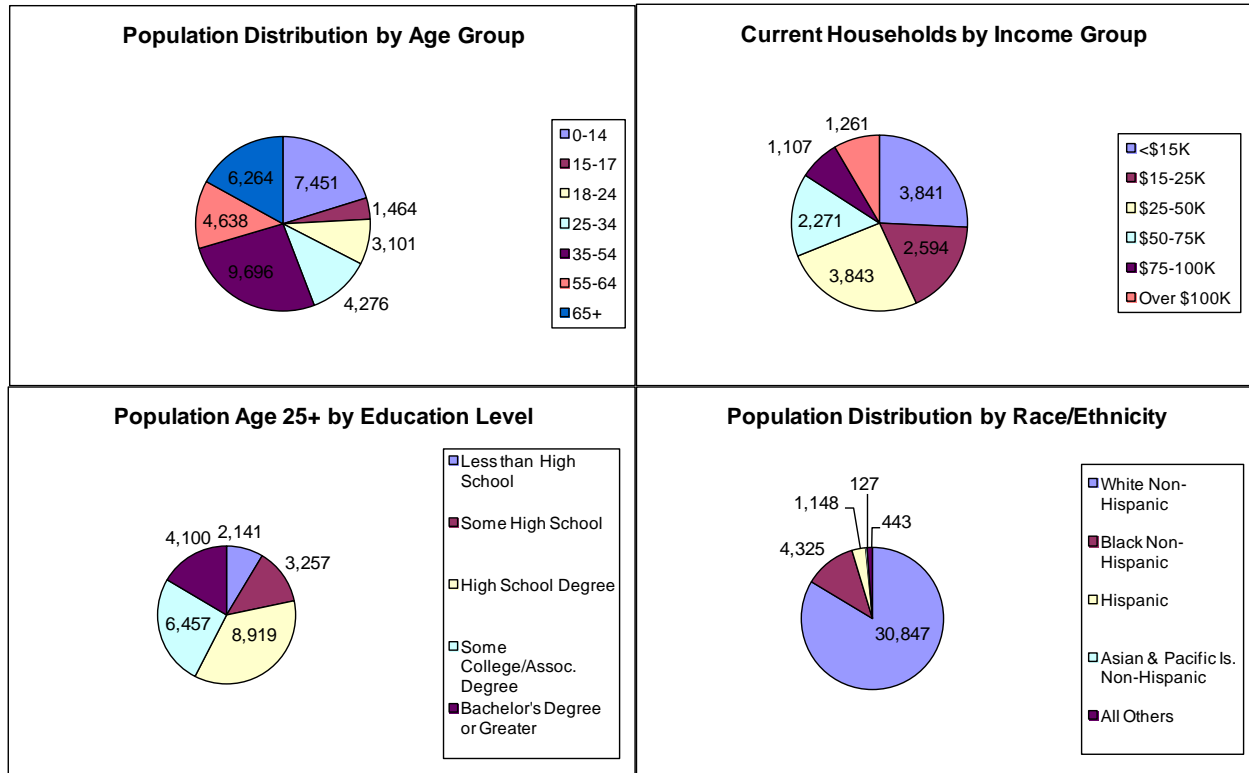
Demographics Expert 2.7											
2013 Demographic Snapshot											
Area: Alcorn MS											
Level of Geography: ZIP Code											
DEMOGRAPHIC CHARACTERISTICS											
			Selected Area	USA					2013	2018	% Change
2010 Total Population			36,911	308,745,538							
2013 Total Population			36,890	314,861,807					18,038	18,063	0.1%
2018 Total Population			36,926	325,322,277							
% Change 2013 - 2018			0.1%	3.3%							
Average Household Income			\$43,333	\$69,637							
POPULATION DISTRIBUTION						HOUSEHOLD INCOME DISTRIBUTION					
Age Distribution						Income Distribution					
Age Group	2013	% of Total	2018	% of Total	USA 2013 % of Total	2013 Household Income	HH Count	% of Total	USA % of Total		
0-14	7,451	20.2%	7,458	20.2%	19.6%	<\$15K	3,841	25.7%	13.8%		
15-17	1,464	4.0%	1,444	3.9%	4.1%	\$15-25K	2,594	17.4%	11.6%		
18-24	3,101	8.4%	3,244	8.8%	10.0%	\$25-50K	3,843	25.8%	25.3%		
25-34	4,276	11.6%	4,158	11.3%	13.1%	\$50-75K	2,271	15.2%	18.1%		
35-54	9,696	26.3%	9,132	24.7%	26.9%	\$75-100K	1,107	7.4%	11.7%		
55-64	4,638	12.6%	4,673	12.7%	12.4%	Over \$100K	1,261	8.5%	19.5%		
65+	6,264	17.0%	6,817	18.5%	13.9%						
Total	36,890	100.0%	36,926	100.0%	100.0%	Total	14,917	100.0%	100.0%		
EDUCATION LEVEL						RACE/ETHNICITY					
Education Level Distribution						Race/Ethnicity Distribution					
USA						USA					
2013 Adult Education Level	Pop Age 25+	% of Total	% of Total			Race/Ethnicity	2013 Pop	% of Total	% of Total		
Less than High School	2,141	8.6%	6.2%			White Non-Hispanic	30,847	83.6%	62.3%		
Some High School	3,257	13.1%	8.4%			Black Non-Hispanic	4,325	11.7%	12.3%		
High School Degree	8,919	35.9%	28.4%			Hispanic	1,148	3.1%	17.3%		
Some College/Assoc. Degree	6,457	26.0%	28.9%			Asian & Pacific Is. Non-Hispanic	127	0.3%	5.1%		
Bachelor's Degree or Greater	4,100	16.5%	28.1%			All Others	443	1.2%	2.9%		
Total	24,874	100.0%	100.0%			Total	36,890	100.0%	100.0%		

© 2013 The Nielsen Company, © 2013 Truven Health Analytics Inc.

¹⁵ Responds to IRS Form 990 (h) Part V B 1 b

¹⁶ All population information, unless otherwise cited, sourced from Truven (formally Thomson) Market Planner

¹⁷ <http://research.stlouisfed.org/fred2/series/MSALURN>; <http://research.stlouisfed.org/fred2/series/MSURN>; <http://research.stlouisfed.org/fred2/series/UNRATENSA>



2013 Benchmarks
 Area: Alcorn MS
 Level of Geography: ZIP Code

Area	2013-2018		Population 65+		Females 15-44		Median	Median	Median
	% Population Change	Median Age	% of Total Population	% Change 2013-2018	% of Total Population	% Change 2013-2018	Household Income	Household Wealth	Home Value
USA	3.3%	37.5	13.9%	16.3%	19.8%	-0.1%	\$49,233	\$54,682	\$169,011
Mississippi	1.2%	36.2	13.7%	13.1%	20.1%	-1.5%	\$36,723	\$46,692	\$96,867
Selected Area	0.1%	39.6	17.0%	8.8%	18.3%	-3.2%	\$30,511	\$42,143	\$87,146

Demographics Expert 2.7
 DEMO0003.SQP
 © 2013 The Nielsen Company, © 2013 Truven Health Analytics Inc.

The population was examined according to characteristics presented in the Claritas Prizm customer segmentation data. This system segments the population into 66 demographically and behaviorally distinct groups. Each group, based on annual survey data, is documented as exhibiting specific health behaviors. The makeup of the service area, according to the mix of Prizm segments and its characteristics, is contrasted to the national population averages to discern the following table of probable lifestyle and medical conditions present in the population. Items with red text are viewed as statistically important adverse potential findings. Items with blue text are viewed as statistically important potential beneficial findings. Items with black text are viewed as either not statistically different from the national normal situation or not being a favorable or unfavorable consideration in our use of the information.

Health Service Topic	Demand as % of National	% of Population Affected	Health Service Topic	Demand as % of National	% of Population Affected
Weight / Lifestyle			Heart		
BMI: Morbid/Obese	112.5%	28.7%	Routine Screen: Cardiac Stress 2yr	89.2%	13.9%
Vigorous Exercise	94.3%	47.8%	Chronic High Cholesterol	104.6%	23.4%
Chronic Diabetes	129.5%	13.4%	Routine Cholesterol Screening	87.1%	44.3%
Healthy Eating Habits	85.1%	25.2%	Chronic High Blood Pressure	123.4%	32.4%
Very Unhealthy Eating Habits	138.6%	3.8%	Chronic Heart Disease	128.0%	10.7%
Behavior			Routine Services		
I Will Travel to Obtain Medical Care	96.0%	28.5%	FP/GP: 1+ Visit	103.1%	91.1%
I Follow Treatment Recommendations	82.6%	33.3%	Used Midlevel in last 6 Months	106.4%	44.4%
I am Responsible for My Health	90.7%	58.6%	OB/Gyn 1+ Visit	85.2%	40.0%
Pulmonary			Ambulatory Surgery last 12 Months	101.7%	19.6%
Chronic COPD	127.0%	5.8%	Internet Usage		
Tobacco Use: Cigarettes	129.0%	33.4%	Use Internet to Talk to MD	75.1%	10.9%
Chronic Allergies	109.0%	24.6%	Facebook Opinions	81.7%	8.4%
Cancer			Looked for Provider Rating	87.3%	12.7%
Mammography in Past Yr	92.5%	41.9%	Misc		
Cancer Screen: Colorectal 2 yr	89.0%	22.4%	Charitable Contrib: Hosp/Hosp Sys	88.1%	21.1%
Cancer Screen: Pap/Cerv Test 2 yr	82.1%	49.5%	Charitable Contrib: Other Health Org	80.1%	31.2%
Routine Screen: Prostate 2 yr	91.6%	29.2%	HSA/FSA: Employer Offers	95.7%	49.3%
Orthopedic			Emergency Service		
Chronic Lower Back Pain	127.1%	28.6%	Emergency Room Use	110.3%	37.5%
Chronic Osteoporosis	132.1%	12.8%	Urgent Care Use	93.9%	22.2%

Leading Causes of Death

Cause of Death			Rank among all counties in MS (#1 rank = worst in state)	Rate of Death per 100,000 age adjusted		Observation
MS Rank	Alcorn County Rank	Condition		MS	Alcorn County	
1	1	Heart Disease	56 of 82	266.0	272.1	Higher than expected
2,11,14,15,18,26,29,30,31,33,36,37,38,41	2	Cancer	30 of 82	200.0	215.1	Higher than expected
4	3	Stroke	15 of 82	52.9	73.1	Higher than expected
3	4	Lung	8 of 82	47.4	68.9	Higher than expected
10,19,22	5	Accidents	39 of 82	61.7	65.9	Higher than expected
6	6	Alzheimer's	13 of 80	26.5	36.3	Higher than expected
12	7	Flu - Pneumonia	42 of 82	18.3	20.6	As expected
13	8	Blood Poisoning	41 of 81	18.3	17.6	Higher than expected
9	9	Kidney	74 of 82	23.9	16.5	As expected
16	10	Suicide	16 of 81	13.7	16.3	Higher than expected
5	11	Hypertension	48 of 82	14.5	9.7	Higher than expected
8	12	Diabetes	80 of 82	21.8	8.7	Lower than expected
21	13	Liver	64 of 80	8.8	6.0	Lower than expected
25	14	Homicide	66 of 81	9.9	5.2	As expected
28	15	Parkinson's	53 of 76	5.0	2.9	Lower than expected

Primary and Chronic Disease Needs and Health Issues of Uninsured Persons, Low-Income Persons and Minority Groups

Some information is available to describe the size and composition of various uninsured persons, low income persons, minority groups and other vulnerable population segments. Studies identifying specific group needs, distinct from the general population at a county unit of analysis, are not readily available from secondary sources.

The National Healthcare Disparities Report results from a Congressional directive to the Agency for Healthcare Research and Quality (AHRQ). This production is an annual report to track disparities related to "racial factors and socioeconomic factors in priority populations." The emphasis is on disparities related to race, ethnicity and socioeconomic status and includes a charge to examine disparities in "priority populations," which are groups with unique health care needs or issues that require special attention.¹⁸

Nationally, this report observes the following trends:

- Measures for which Blacks were worse than Whites and are getting better:
 - Diabetes – Hospital admissions for short-term complications of diabetes per 100,000 population;
 - HIV and AIDS – New AIDS cases per 100,000 population age 13 and over; and
 - Functional Status Preservation and Rehabilitation – Female Medicare beneficiaries age 65 and over who reported ever being screened for osteoporosis with a bone mass or bone density measurement.
- Measures for which Blacks were worse than Whites and staying the same:
 - Cancer – Breast cancer diagnosed at advanced stage per 100,000 women age 40 and over ; breast cancer deaths per 100,000 female population per year; adults age 50 and over who ever received colorectal cancer screening; colorectal cancer diagnosed at advanced stage per 100,000 population age 50 and over; colorectal cancer deaths per 100,000 population per year;
 - Diabetes – Hospital admissions for lower extremity amputations per 1,000 population age 18 and over with diabetes;
 - Maternal and Child Health – Children ages 2-17 who had a dental visit in the calendar year; Children ages 19-35 months who received all recommended vaccines;
 - Mental Health and Substance Abuse – Adults with a major depressive episode in the last 12 months who received treatment for depression in the last 12 months; people age 12 and over treated for substance abuse who completed treatment course;

¹⁸ <http://www.ahrq.gov/qual/nhdr10/Chap10.htm> 2010

- Respiratory Diseases – Adults age 65 and over who ever received pneumococcal vaccination; hospital patients with pneumonia who received recommended hospital care;
- Supportive and Palliative Care – High-risk long-stay nursing home residents with pressure sores; short-stay nursing home residents with pressure sores; adult home health care patients who were admitted to the hospital; hospice patients who received the right amount of medicine for pain;
- Timeliness – Adults who needed care right away for an illness, injury or condition in the last 12 months who got care as soon as wanted; emergency department visits where patients left without being seen; and
- Access – People with a usual primary care provider; people with a specific source of ongoing care.
- Measures for which Asians were worse than Whites and getting better:
 - Cancer – Adults age 50 and over who ever received colorectal cancer screening; and
 - Patient Safety – Adult surgery patients who received appropriate timing of antibiotics.
- Measures for which Asians were worse than Whites and staying the same:
 - Respiratory Diseases – Adults age 65 and over who ever received pneumococcal vaccination; hospital patients with pneumonia who received recommended hospital care; and
 - Access – People with a usual primary care provider.
- Measures for which American Indians and Alaska Natives were worse than Whites for most recent year and staying the same:
 - Heart Disease – Hospital patients with heart failure who received recommended hospital care;
 - HIV and AIDS – New AIDS cases per 100,000 population age 13 and over;
 - Respiratory Diseases – Hospital patients with pneumonia who received recommended hospital care;
 - Functional Status Preservation and Rehabilitation – Female Medicare beneficiaries age 65 and over who reported ever being screened for osteoporosis with a bone mass or bone density measurement;
 - Supportive and Palliative Care – Hospice patients who received the right amount of medicine for pain; high-risk, long-stay nursing home residents with pressure sores; adult home health care patients who were admitted to the hospital; and
 - Access – People under age 65 with health insurance.

- Measures for which American Indians and Alaska Natives were worse than Whites for most recent year and getting worse:
 - Cancer – Adults age 50 and over who ever received colorectal cancer screening; and
 - Patient safety – Adult surgery patients who received appropriate timing of antibiotics.
- Measures for which Hispanics were worse than non-Hispanic Whites for most recent year and getting better:
 - Maternal and Child Health – Children ages 2-17 who had a dental visit in the calendar year;
 - Lifestyle Modification – Adult current smokers with a checkup in the last 12 months who received advice to quit smoking; adults with obesity who ever received advice from a health provider about healthy eating; and
 - Functional Status Preservation and Rehabilitation – Female Medicare beneficiaries age 65 and over who reported ever being screened for osteoporosis with a bone mass or bone density measurement.
- Measures for which Hispanics were worse than non-Hispanic Whites for most recent year and staying the same:
 - Cancer – Women age 40 and over who received a mammogram in the last 2 years; adults age 50 and over who ever received colorectal cancer screening;
 - Diabetes – Adults age 40 and over with diagnosed diabetes who received all three recommended services for diabetes in the calendar year;
 - Heart Disease – Hospital patients with heart attack and left ventricular systolic dysfunction who were prescribed angiotensin-converting enzyme inhibitor or angiotensin receptor blocker at discharge; hospital patients with heart failure who received recommended hospital care;
 - HIV and AIDS – New AIDS cases per 100,000 population age 13 and over;
 - Mental Health and Substance Abuse – Adults with a major depressive episode in the last 12 months who received treatment for depression in the last 12 months;
 - Respiratory Disease – Adults age 65 and over who ever received pneumococcal vaccination; hospital patients with pneumonia who received recommended hospital care;
 - Lifestyle Modification – Adults with obesity who ever received advice from a health provider to exercise more;
 - Supportive and Palliative Care – Long-stay nursing home residents with physical restraints; high-risk, long-stay nursing home residents with pressure sores; short-stay

- nursing home residents with pressure sores; adult home health care patients who were admitted to the hospital; hospice patients who received the right amount of medicine for pain;
- Patient Safety – Adult surgery patients who received appropriate timing of antibiotics;
- Timeliness – Adults who needed care right away for an illness, injury or condition in the last 12 months who got care as soon as wanted;
- Patient Centeredness – Adults with ambulatory visits who reported poor communication with health providers; children with ambulatory visits who reported poor communication with health providers; and
- Access – People under age 65 with health insurance; people under age 65 who were uninsured all year; people with a specific source of ongoing care; people with a usual primary care provider; people unable to get or delayed in getting needed care due to financial or insurance reasons
- Measures for which Hispanics were worse than non-Hispanic Whites for most recent year and getting worse:
 - Maternal and Child Health – Children ages 3-6 who ever had their vision checked by a health provider.

We asked a specific question to our Local Expert Advisors about unique needs of priority populations. We reviewed their response to identify if any of the above trends were obvious in the service area. Accordingly, we place great reliance on the commentary received to identify unique population needs to which we should respond. Specific opinions from the Local Expert Advisors are summarized as follows¹⁹:

- Primary and chronic disease untreated due to uninsured or low-income
- Access is not perceived the problem but education "as to need for control of risk factors" and "Continued promotion of healthier life style"
- Uninsured aging/elderly and children were noted as the primary populations at risk

¹⁹ All comments and the analytical framework behind developing this summary appear in Appendix A.

Statistical information about special populations:

Access to Care: Alcorn County, MS

In addition to use of services, access to care may be characterized by medical care coverage and service availability

Uninsured individuals (age under 65)¹	6,015
Medicare beneficiaries²	
Elderly (Age 65+)	5,355
Disabled	2,527
Medicaid beneficiaries²	9,640
Primary care physicians per 100,000 pop²	47.7
Dentists per 100,000 pop²	44.9
Community/Migrant Health Centers³	Yes
Health Professional Shortage Area³	No

nda No data available.

¹The Census Bureau. *Small Area Health Insurance Estimates Program, 2006.*

²HRSA. *Area Resource File, 2008.*

³HRSA. *Geospatial Data Warehouse, 2009.*

Vulnerable Populations: Alcorn County, MS

Vulnerable populations may face unique health risks and barriers to care, requiring enhanced services and targeted strategies for outreach and case management.

Vulnerable Populations Include People Who¹

Have no high school diploma (among adults age 25 and older)	7,832
Are unemployed	1,232
Are severely work disabled	1,813
Have major depression	1,858
Are recent drug users (within past month)	2,013

nda No data available.

¹The most current estimates of prevalence, obtained from various sources (see the *Data Sources, Definitions, and Notes for details*), were applied to 2008 mid-year county population figures.

Findings

Upon completion of the CHNA, QHR identified several issues within the Magnolia Regional Health Center community:

Conclusions from Public Input to Community Health Needs Assessment

Our group of 23 Local Expert Advisors participated in an on-line survey to offer opinions about their perceptions of community health needs and potential needs of unique populations.

Responses were first obtained to the question: “What do you believe to be the most important health or medical issue confronting the residents of your County?” In summary, we receive the following commentary regarding the more important health or medical issues:

- Leading concern cite Diabetes and Obesity
- Heart / cardiovascular concerns also present
- The next highest frequency mentions "Self management of chronic disease", concerns due to lack of awareness and/or timely access to treatment
- A lower order of mentions concern mental health, drug/alcohol treatment needs and not enough primary care doctors

Responses were then obtained to the question: “Do you perceive there are any primary and/or chronic disease needs, as well as potential health issues, of uninsured persons, low-income persons, minority groups and/or other population groups (i.e. people with certain situations) which need help or assistance in order to improve? If you believe any situation as described exists, please also indicate who you think needs to do what?” In summary, we received the following commentary regarding the more important health or medical issues:

- Primary and chronic disease untreated due to uninsured or low-income
- Access is not perceived the problem but education "as to need for control of risk factors" and "Continued promotion of healthier life style"
- Uninsured aging/elderly and children were noted as the primary populations at risk

Summary of Observations from Alcorn County Compared to All Other Mississippi Counties, in Terms of Community Health Needs

In general, Alcorn County residents are about average health for Mississippi residents.

In a health status classification termed "Health Outcomes", Alcorn ranks number 36 among the 81 Mississippi ranked counties (best being #1). Typifying the problem, Premature Death (deaths prior to age 75) Alcorn has seen increasing rates while MS rates have declines so it is now higher than average for Mississippi and Mississippi is about 20% worse than the national benchmark.

Clinical conditions warranting investigation because of adverse values include the following:

Adult Smoking – 23% of adults smoke, which statistically is the same as the Mississippi average, but is significantly above the national benchmark standard of 13%

Obesity – 32% of adults with an increasing trend, in line with the last ten year increasing values for MS and US. Alcorn's obesity rate is lower than the average rate for MS but higher than the average US rate.; Physically inactivity is a related problem, 35% of residents are inactive, a rate now higher than average in MS, and significantly exceeds US benchmark standard of 21%.

Excessive drinking, motor vehicle crash deaths and sexually transmitted disease are all well below average for MS and do not appear as areas of concern.

Preventable Hospital Stays – 133 hospital admissions per 1,000 Medicare enrollees which is significantly higher than the MS average of 91 or the US national benchmark rate of 47, and, the Alcorn rate has remained virtually unchanged for the last seven years while MS and US rates declined. Typically this indicates a shortage of physicians.

Primary Care Physicians to population ratio is above the MS average and almost double the US average (indicating physician shortage).

- Dentist to population ratio is better (more dentists) than average for MS but is 55% above the US average (indicating dentist shortage)

Summary of Observations from Alcorn County Peer Comparisons

The federal government administers a process to allocate all counties into "Peer" groups. County "Peer" groups have similar social, economic and demographic characteristics. Health and wellness observations when Alcorn County is compared to its national set of Peer Counties and compared to national rates include:

UNFAVORABLE observations occurring at rates worse than national AND worse than among Peers

- BIRTHS TO WOMEN UNDER 18
- LOW BIRTH WEIGHT (less than 2.5g)
- PREMATURE BIRTHS (<37wks)
- INFANT MORTALITY
- NEONATAL INFANT MORTALITY
- BLACK NON HISPANIC INFANT MORTALITY
- POST-NEONATAL INFANT MORTALITY
- LUNG CANCER
- COLON CANCER

- STROKE
- MOTOR VEHICLE INJURIES

SOMEWHAT A CONCERN observations because occurrence is EITHER above national average or above Peer group average

- SUICIDE
- WHITE NON HISPANIC INFANT MORTALITY
- BIRTHS TO WOMEN AGE 40 to 54
- BIRTHS TO UNMARRIED WOMEN
- BREAST CANCER
- CORONARY HEART DISEASE
- UNINTENTIONAL INJURY
- BETTER Performance than Peers and National rates:
- VERY LOW BIRTH WEIGHT (<1.5g)

Conclusions from the Demographic Analysis Comparing Alcorn County to National Averages

Alcorn County in 2013 comprises 36,890 residents. It is projected to increase by 36 residents in the next five years, 0.1%. This is considerably slower than the Mississippi growth rate of 1.2% or the US growth rate average of 3.3%. The population is 83.6% non-Hispanic White. Asian & Pacific Island non-Hispanics constitute 0.3% of the population. Hispanics comprise 3.1% of the population. Black non-Hispanics comprise 11.7% and are the largest minority population.

17% of the population is age 65 or older. This is a larger population segment than the elderly comprise elsewhere in Mississippi (13.7%) or in comparison to the national average (13.9%). 18.3% of the women are in the childbirth population segment. This segment is smaller than as elsewhere in Mississippi (20.1%) or in comparison to the national average (19.8%). The median income, median home value and household wealth are below the Mississippi and national averages.

The following areas were identified from a comparison of the county to national averages:

Metrics impacting more than 25% of the population and statistically significantly different from the national average include the following. All are considered adverse findings unless otherwise noted and this list is more extensive than typically encountered:

- I am responsible for my health 9% below average impacting 59% of the population
- Obtained a Pap/Cervix test in last 2 years 18% below average impacting 50% of the population

- Engage in vigorous exercise is 6% below average impacting 48% of the population
- Obtain routine cholesterol screening is 13% below average impacting 44% of the population
- Obtain Mammogram in past 2 years is 8% below average impacting 42% of the population
- Obtained a visit to an OB/GYN in last year 15% below average impacting 40% of the population
- Used an Emergency Room in last 2 years 10% above average impacting 37% of population
- Tobacco Use 29% above average impacting 33% of the population
- Follow treatment recommendations 17% below average impacting 33% of the population
- Chronic high blood pressure 23% above normal impacting 32% of the population
- Routing Screen: Prostate in last 2 yr 8% below average impacting 29% of population
- BMI: Morbid obese is 8% below average impacting 29% of the population, a beneficial finding
- Chronic Lower Back Pain 27% above average impacting 29% of population
- Healthy eating habits 15% below average impacting 25% of population
- Chronic Allergies 9% above average impacting 25% of the population

Situations and Conditions statistically significantly different from the national average but impacting less than 25% of the population include the following. All are considered adverse findings unless otherwise noted:

- Colorectal screening in last 2 years 11% below average impacting 24% of the population
- Obtain routine Cardiac Stress Test in last 2 years 11% below average impacting 14% of the population
- Chronic Diabetes 30% above average impacting 13% of the population
- Chronic Osteoporosis 32% above average impacting 13% of the population
- Chronic Heart Disease 28% above average impacting 11% of the population
- Chronic COPD 27% above average impacting 6% of the population
- Very Unhealthy Eating Habits 39% above average impacting 4% of the population

Key Conclusions from Consideration of Other Statistical Data Examinations

- Palliative Care (programs relieving serious illness symptoms pain and stress) do not exist in the County. Hospice Care (programs providing comfort care during terminal disease); do exist and 4 other surrounding area programs serve Alcorn.

- 3 of the top 15 causes of death in Alcorn have lower than expected rates of occurrence (Diabetes, Liver and Parkinson's). 9 top causes of death are higher than expected rates (Heart Disease, Cancer, Stroke, Lung, Accidents, Alzheimer's, Blood Poisoning, Suicide and Hypertension). Ranking death causes finds (in descending order):
 1. Heart Disease death rate per 100,000, 272.1, ranks Alcorn #56 among 82 MS Co (#1 = worst), rate above MS average
 2. Cancer 215.1 per 100,000 ranks Alcorn #30 among MS Co - above MS average
 3. Stroke 73.1 per 100,000 ranks #15 among MS Co – above MS average
 4. Lung 68.9 per 100,000 ranks #8 among MS Co – above MS average
 5. Accidents 65.9 per 100,000 ranks #39 among MS Co – above MS average
 6. Alzheimer's 36.3 per 100,000 ranks #13 among MS Co – above MS average
 7. Flu / Pneumonia 20.6 per 100,000 ranks #42 among MS Co - above MS average
 8. Blood Poisoning 17.6 per 100,000 ranks #41 among MS Co – below MS average
 9. Kidney 16.5 per 100,000 ranks #74 among MS Co – below MS average
 10. Suicide 16.3 per 100,000 ranks #16 among MS Co – above MS average
- The CDC cites, Heart Disease above MS and US avg. Deaths among Black's are below the MS rate but 19% above the US rate. The Heart Disease hospitalization rate is above US and MS average for all races but for Blacks it is 7% above MS average; among White it is 33% above the MS average
- The incident of Stroke deaths different by race. Among Black's, the death rate is 97% of the MS average, but 16% above the US rate. Among White's, the death rate is 28% above MS average and 48% above US rate
- The Institute for Health Metrics and Evaluation notes Diabetes prevalence among adults is about the national avg. However, more severe among men than among women. Life expectancy for males in 1989 was 69.8 years, 11.8 years behind the best rates, improving in 2009 to 71.6 years, 10 years behind the best rates. Life expectancy for females in 1989 was 78.2 years, 7.6 years behind the best international rates, and declined in 2009 to 77.9 years, 7.9 years behind the longest living females. Life expectancy improvement for males is typical but the female decline is the first noted in more than 30 QHR CHNA studies.
- The Health Resources and Services Administration designated Alcorn a primary medical care shortage area, a dental shortage area and a mental health shortage area. Alcorn is designated a medically underserved area.
- Community Commons data presents several Alcorn indicators differing from MS or US average:

- Medicaid population is 25.2% compared to 22.5% on average in MS and US average of 19.9%
- Fast Food restaurant rate per 100,000 is 75.56 above average for MS and the US. Grocery store access is below MS and US average
- Liquor Store rate per 100,000 is 0 and Alcohol consumption is below average, both beneficial findings.
- 40% of adults last year did not have a dental exam, slightly better than the MS but worse than the US average
- Access to primary care providers is below the MS and US average (adverse finding) but a higher than average population percentage has a consistent source of medical care (positive finding).

EXISTING HEALTH CARE FACILITIES, RESOURCES AND MRHC IMPLEMENTATION PLAN

Significant Needs

We used the priority ranking of area health needs by the local expert advisors to organize the search for locally available resources as well as the response to the needs by Magnolia Regional Health Center.²⁰ The following list:

- Identifies the rank order of each identified Significant Need;
- Presents the factors considered in developing the ranking;
- Establishes a Problem Statement to specify the problem indicated by use of the Significant Need term;
- Identifies Magnolia Regional Health Center current efforts responding to the need;
- Establishes the Implementation Plan programs and resources Magnolia Regional Health Center will devote to attempt to achieve improvements;
- Documents the Leading Indicators Magnolia Regional Health Center will use to measure progress;
- Presents the Lagging Indicators Magnolia Regional Health Center believes the Leading Indicators will influence in a positive fashion, and;
- Presents the locally available resources noted during the development of this report as believed to be currently available to respond to this need.

In general, MRHC is the major hospital in the service area. MRHC is a 200 bed acute care medical facility located in Corinth, MS. The next closest facilities are outside the service area and include:

- North Mississippi Medical Center, a 48 bed acute care facility located in Iuka, MS (24 miles, 30 minutes from Corinth, MS)
- Baptist Memorial Hospital, a 66 bed acute care facility located in Booneville, MS (20.24 miles, 26 minutes from Corinth, MS)
- Tippah County Hospital, a 110 bed acute and skilled care facility located in Ripley, MS (36 miles, 43 minutes from Corinth, MS)
- McNairy Regional Hospital, a 28 bed acute care facility located in Selmer, TN (18.7 miles, 23 minutes from Corinth, MS)

²⁰ Response to IRS Form 990 h Part V B 1 c

Definitions of Significant Needs Listed in Highest to Lowest Rank Order of Need

1. **OBESITY/OVERWEIGHT** –

One of Local Expert leading concern; Obesity – 32% and increasing, lower than MS average but above US rate; 35% Physically inactivity above MS average, and above US 21% average; Vigorous exercise 6% below average impacts 48% of pop; Morbid obese 8% below average impacts 29% of pop, beneficial finding; Healthy eating habits 15% below average impacts 25% of pop; fast food restaurants above MS and US average; Grocery store access below MS and US average

Issue to be addressed: Increase education of healthy eating and physical activity among 4th grade students.

Magnolia Regional Health Center (MRHC) current services available to respond to this need include:

- www.MRHC.org
- MRHC Owned Clinics
- Annual Women’s Health Conference Education

Magnolia Regional Health Center believes it has a high responsibility to respond to this need. Our Implementation Plan’s intended response includes:²¹

Continue to pursue the above mentioned tactics; and

- Address at 2014 Women’s Health Conference, February, 2014, Crossroads Arena, 2800 South Harper Road
- Continuance of the Kids Get Fit program in the 4th grade City of Corinth & Alcorn County, Mississippi schools. Linley Brawner, Program Coordinator, linleybrawner@bellsouth.net
- Plans for a Community Health Fair, late spring, 2014

Magnolia Regional Health Center anticipates the results from the implementation of this plan will:

- Help decrease the number of obese residents through educating elementary students.

Leading Indicators MRHC will use to identify improvement:

- Number of students participating in “Kids Get Fit program”
 - 2012 = 319 kids

Lagging Indicator MRHC will use to identify improvement:

- **Percent of Alcorn County Population with BMI greater than 30**

²¹ This section in each need description responds to IRS 990 Schedule H (form 990) Part V B 6 a and 6 b

- **2009 (most recent data) = 32.8%**
<http://assessment.communitycommons.org/CHNA/Report.aspx?page=6&id=603>

Other Local Resources:

Corinth Sportsplex, 1911 Webster Street, Corinth, MS 38834
Shiloh Ridge Athletic Club, 3303 Shiloh Ridge Road, Corinth, MS 38834
Weight Watchers, 2025 Highway 72 East, Corinth, MS 38834
Curves, 1901 South Harper Road E, Corinth, MS 38834
Corinth Advanced Weight Loss, 209 North Harper Road, Corinth, MS 38834

2. Cancer

2nd cause of death, Alcorn ranks #30 (1st = worst) higher than expected, above MS average; death rate worst than US and among Peers for Lung Cancer, Colon Cancer; Rate exceeds US or peer average for Breast Cancer; obtained Pap/Cervix test 18% below average impacts 50% of pop; obtain Mammogram 8% below average impacts 42% of pop; Prostate screening 8% below average impacts 29% of population

Issue to be addressed: Enhance resident involvement in early disease detection.

Magnolia Regional Health Center (MRHC) services currently available to respond to this need include:

- MRHC reduced price mammography screenings for the month of October each year
- Magnolia Cancer Center providing radiation and medical oncology
- Screening cards to employer groups through the MRHC Corporate Health Department
- Annual Women's Health Conference and screening
- Physician's Talk Time to educate employer and community about cancer topics
- Prostate screening services through the Magnolia Cancer Center

Magnolia Regional Health Center believes it has a high responsibility to respond to this need. Our Implementation Plan's intended response:

- MRHC will continue its current efforts
- Urology recruitment will increase prostate examinations
- New equipment will increase examinations

Magnolia Regional Health Center anticipates the results from the implementation of this plan will:

Early detection will initially increase disease incident but with treatment commencing at an earlier stage of the disease, survivability should increase

Leading Indicators MRHC will use to identify improvement:

MRHC provision of mammography

- o Number of patients procedures in 2012 = 4,229

Lagging Indicator MRHC will use to identify improvement:

State of Mississippi Cancer Death rate 215.1per 100,000 residents

Other Local Resources:

West Clinic, Magnolia Cancer Center, 2001 State Drive, Corinth, MS 38834

3. PHYSICIANS including prevention clinic focus on screening and education

Lower but important Local Expert concern for not enough primary care doctors; Preventable Hospital Stays (indicator of primary care shortage) significantly above MS and US average; Primary Care Physicians to population ratio above MS average and double US average (indicates need); OB/GYN visit 15% below average impacts 40% of pop; Used ER 10% above average impacts 37% of pop; federal designation primary physician shortage area and medically underserved; primary care providers access below MS and US average (adverse finding) but above average have consistent source of medical care (positive finding)

Issue to be addressed: Access and availability of primary care physician services needs to increase.

Magnolia Regional Health Center (MRHC) services currently available to respond to this need include:

- MRHC GME Internal medicine residency program
- MRHC Stipend training support program
- Magnolia Community Care Clinic to provide primary care to indigent patients
- Nurse Practitioners IPA and Physician IPA
- MRHC Physician recruitment
- Walk in Magnolia Medistat Clinic

Magnolia Regional Health Center believes it has a high responsibility to respond to this need. Our Implementation Plan's intended response:

- Continue existing efforts
- Recruit and retain existing practitioners
- Periodically updating the physician recruitment and need plan

Magnolia Regional Health Center anticipates the results from the implementation of this plan will:

- A reduction in patients reporting problems in obtaining physicians services

Leading Indicators MRHC will use to identify improvement:

- Number of emergency room level one procedures
 - 2012 = 1,407 or 4.1% of total visits

Lagging Indicator MRHC will use to identify improvement:

- Primary Care Provider availability per 100,000
 - 2011 = 48.57 (below MS 57.6 and US 84.7 average) (source www.chna.org)

Other Local Resources:

Primary care physicians as listing on hospital web site www.MRHC.org

4. CORONARY HEART DISEASE

1st cause of death, Alcorn ranks #56 (1st = worst) higher than expected, above MS average; Local Expert additional concern; death rate exceeds US or peer average; Heart Disease above state and US average; Heart Disease hospitalization rate above US and MS average Blacks 7% above Whites 33% above MS average

Issue to be addressed: The incident rate for health disease should be lowered and utilization of diagnostic screening services should increase.

Magnolia Regional Health Center (MRHC) services currently available to respond to this need include:

- MRHC offers annual Women’s Health Conference
- MRHC GME Cardiology Fellowship training program
- Comprehensive delivery of diagnostic, treatment and rehabilitation services at the Magnolia Heart & Vascular Center
- MRHC Corporate Health Program exams, employee health fair include blood pressure and cholesterol exams

Magnolia Regional Health Center believes it has a high responsibility to respond to this need. Our Implementation Plan’s intended response:

- MRHC will continue the above services
- Adding providers to the MRHC GME Interventional Cardiology Fellowship
- Implement a cardiac MRI service

Magnolia Regional Health Center anticipates the results from the implementation of this plan will:

- Reduce coronary deaths

Leading Indicators MRHC will use to identify improvement:

- Noninvasive cardiac screenings performed
 - 2012 = 2,453 GXT & 2,787 Cardiac Echos

Lagging Indicator MRHC will use to identify improvement:

- Coronary Heart Disease death rate in Alcorn County as reported by the State of MS change from 272.1 per 100,000 residents

Other Local Resources:

Mississippi State Department of Health web site: <http://www.msdh.state.ms.us/>

American Heart Association web site: <http://www.heart.org/HEARTORG/>

5. STROKE

Stroke 3rd cause of death, Alcorn ranks #15 (1st = worst) higher than expected, above MS average; Death rate worse than US and Peers for Stroke; Stroke deaths differ by race. Black deaths 97% of MS average but 16% above US Black rate. White deaths 28% above MS average and 48% above US rate

Issue to be addressed: Reduce the incident of death from stroke.

Magnolia Regional Health Center (MRHC) services currently available to respond to this need include:

- Board certified neurologist
- Participation in State of MS Statewide Stroke Network
- Participate in CMS Stroke Process of Care
- Vascular surgery services

Magnolia Regional Health Center believes it has a high responsibility to respond to this need. Our Implementation Plan's intended response:

- Continue above initiatives

Magnolia Regional Health Center anticipates the results from the implementation of this plan will:

- Increase public awareness of signs and symptoms of stroke

Leading Indicators MRHC will use to identify improvement:

- CMS process of care measure composite score

- 2012 = 99.7%

Lagging Indicator MRHC will use to identify improvement:

- Alcorn resident rate of death from Stroke reduced from 73.1 deaths per 100,000

Other Local Resources:

Mississippi State Department of Health web site: <http://www.msdh.state.ms.us/>

American Heart Association web site: <http://www.heart.org/HEARTORG/>

6. COMPLIANCE BEHAVIOR / PREDESPOSING CONDITIONS

Local experts cite "Self management of chronic disease", concerns due to lack of awareness and/or timely access to treatment; Local Expert priority population concern access is not perceived to be the problem but education "as to need for control of risk factors" and "Continued promotion of healthier life style"; I am responsible for my health 9% below average impacts 59% of pop; Follow treatments 17% below average impacts 33% of pop

Issue to be addressed: Increase the number of residents engaged in treatment and compliant with treatment efforts.

MRHC SERVICES AVAILABLE TO RESPOND TO THIS NEED INCLUDE:

- MRHC Home Health Program
- Indigent Medication education and access to pharmaceutical program through the Magnolia Community Care Clinic
- Inpatient discharge planning education efforts

MRHC IMPLEMENTATION PLAN PROGRAMMATIC INITIATIVES:

- Community partner network to coordinate post-acute care – Community Resource Guide

ANTICIPATED RESULTS FROM MRHC IMPLEMENTATION PLAN

- Increased treatment compliance

LEADING INDICATOR MRHC WILL USE TO MEASURE PROGRESS:

- Percent of patients who reported that YES, they were given information about what to do during their recovery at home.

- 2012 results = 89.7%

LAGGING INDICATOR MRCC WILL USE TO IDENTIFY IMPROVEMENT

- Percent 65+ receiving pneumonia vaccination and Flu vaccination
 - 2011 results (most recent available) = 74.1% <http://assessment.communitycommons.org>

Other Local Resources identified during the CHNA process which are believed available to respond to this need include the following:		
Primary care physicians listed on www.MRHC.org web site	611 Alcorn Drive, Corinth, MS 38834	662.293.1000
Mississippi State Department of Health web site: http://www.msdh.state.ms.us/	570 East Woodrow Wilson Drive, Jackson, MS 39216	866-HLTHY4U

7. CHOLESTEROL (high)

Routine cholesterol screen 13% below average impacts 44% of pop

Issue to be addressed: Increase awareness resident cholesterol values.

Magnolia Regional Health Center Corporation (MRHC) services currently available to respond to this need include:

- Corporate Health Program and Employee wellness fair screening
- Outpatient and inpatient nutrition education

Magnolia Regional Health Center believes it has a high responsibility to respond to this need. Our Implementation Plan’s intended response:

- Continue current efforts

Magnolia Regional Health Center anticipates the results from the implementation of this plan will:

- Increased awareness of cholesterol values

Leading Indicators MRHC will use to identify improvement:

- Number of Corporate Health cholesterol screenings
 - 2012 = 5,222

Lagging Indicator MRHC will use to identify improvement:

- Percent of Mississippi Adults who have had their blood cholesterol checked and have been told it was high
 - 2011 = greater than 41% (highest national classification) Source CDC.gov brfss maps

Other Local Resources:
Primary care physicians as listing on hospital web site, www.MRHC.org

8. BLOOD PRESSURE (high)

8th cause of death, Alcorn ranks #41 (1st = worst) higher than expected, below MS average

Issue to be addressed: Reduce deaths caused by high blood pressure

Magnolia Regional Health Center (MRHC) services currently available to respond to this need include:

- Corporate Health Program and Employee wellness fair screening
- Continuity Care clinic for indigent patients
- Urgent care clinic

Magnolia Regional Health Center believes it has a high responsibility to respond to this need. Our Implementation Plan's intended response:

- Continue above efforts
- Establish a community health fair in partnership with foundation

Magnolia Regional Health Center anticipates the results from the implementation of this plan will:

- Increase public awareness of blood pressure

Leading Indicators MRHC will use to identify improvement:

- Number of held community health fairs
 - 2012 = 0

Lagging Indicator MRHC will use to identify improvement:

- State of Mississippi cause of death from hypertension per 100,000
 - 2012 = 9.7

Other Local Resources:
Primary care physicians as listing on hospital web site
Planned MRHC Community Health Fair, late spring, 2014

Other Identified Needs

9. LUNG

4th cause of death, Alcorn ranks #8 (1st = worst) higher than expected, above MS average;

Chronic Allergies 9% above average impacts 25% of pop

Other Local Resources during the CHNA development process:

No community resources were specifically identified during the CHNA process.

10. DIABETES

Lower than expected death rate, one of Local Expert leading concern; Adult Diabetes at US average but more severe among men

Other Local Resources during the CHNA development process:

No community resources were specifically identified during the CHNA process.

11. MENTAL HEALTH / SUICIDE

Suicide 10th cause of death, Alcorn ranks #16 (1st = worst) higher than expected, above MS average; Lower but important Local Expert concern for mental health; Rate exceeds US or peer average for Suicide; federal designation mental health professional shortage area.

Other Local Resources during the CHNA development process:

No community resources were specifically identified during the CHNA process.

12. ALZHEIMER'S

6th cause of death, Alcorn ranks #13 (1st = worst) higher than expected, above MS average

Other Local Resources during the CHNA development process:

No community resources were specifically identified during the CHNA process.

13. SMOKING / TOBACCO USE

23% of adults smoke, at MS average but above US 13%; Tobacco Use 29% above average impacts 33% of pop

Other Local Resources during the CHNA development process:

No community resources were specifically identified during the CHNA process.

14. AFFORDABILITY

Local Expert concern of primary and chronic disease untreated due to uninsured or low-income

Other Local Resources during the CHNA development process:

No community resources were specifically identified during the CHNA process.

15. ALCOHOL / SUBSTANCE ABUSE

Important but less priority Local Expert concern for drug/alcohol treatment; Excessive drinking well below MS average; Alcohol consumption below average a beneficial findings

Other Local Resources during the CHNA development process:

No community resources were specifically identified during the CHNA process.

16. KIDNEY DISEASE

9th cause of death, Alcorn ranks #74 (1st = worst) as expected and below MS average

Other Local Resources during the CHNA development process:

No community resources were specifically identified during the CHNA process.

17. PRIORITY POPULATIONS

Uninsured aging/elderly and children were noted as the primary populations at risk; Heart death rate among the Blacks below MS rate but 19% above US Black death rate; 25.2% of pop receive Medicaid above MS and US average

Other Local Resources during the CHNA development process:

No community resources were specifically identified during the CHNA process.

18. MATERNAL AND INFANT MEASURES

Rates worse than US and Peers for Births to Women under 18, Low Birth Weight births, Premature Births, Infant Mortality, Neonatal Infant Mortality, Black Non Hispanic Infant Mortality, Post Neonatal Infant Mortality; Rate exceeds US or peer average for White Non Hispanic Infant Mortality, Births to Women age 40 to 54, Births to Unmarried Women; Rates better than US and Peer for Very Low Birth Weight

Other Local Resources during the CHNA development process:

No community resources were specifically identified during the CHNA process.

19. ACCIDENTS

5th cause of death, Alcorn ranks #39 (1st = worst) higher than expected, above MS average; Motor vehicle crash deaths well below MS average; Rates worse than US and Peers for Motor Vehicle Injury; Rate exceeds US or peer average for Unintentional Injury

Other Local Resources during the CHNA development process:

No community resources were specifically identified during the CHNA process.

20. LOW BACK PAIN (Chronic)

Chronic Lower Back Pain 27% above average impacts 29% of pop

Other Local Resources during the CHNA development process:

No community resources were specifically identified during the CHNA process.

21. LIFE EXPECTANCY / PREMATURE DEATH

Alcorn residents about average health "Health Outcomes" ranks # 36 of 81 MS counties (best being #1). Premature Death increasing rates while MS rates declined, about 20% worse than US; Life expectancy for males improved females unexpectedly and unusually declined

Other Local Resources during the CHNA development process:

No community resources were specifically identified during the CHNA process.

22. FLUE-PNEUMONIA

7th cause of death, Alcorn ranks #42 (1st = worst) at expected rate, above MS average

Other Local Resources during the CHNA development process:

No community resources were specifically identified during the CHNA process.

23. BLOOD POISONING

8th cause of death, Alcorn ranks #41 (1st = worst) higher than expected, below MS average

Other Local Resources during the CHNA development process:

No community resources were specifically identified during the CHNA process.

24. DENTAL

More Dentist than MS average but below US average; federal designation dental physician shortage area; 40% adults have no dental exam, better than MS but worse than US average

Other Local Resources during the CHNA development process:

No community resources were specifically identified during the CHNA process.

25. PALLIATIVE CARE & HOSPICE

Palliative care do not exist in the Co; Hospice Care do exist and other programs service from surrounding areas

Other Local Resources during the CHNA development process:

No community resources were specifically identified during the CHNA process.

26. COMMUNICABLE DISEASE

Sexually transmitted disease well below MS average

Other Local Resources during the CHNA development process:

No community resources were specifically identified during the CHNA process.

27. PARKINSON'S

Lower than expected death rate

Other Local Resources during the CHNA development process:

No community resources were specifically identified during the CHNA process.

28. LIVER DISEASE

Lower than expected death rate

Other Local Resources during the CHNA development process:

No community resources were specifically identified during the CHNA process.

Overall Community Need Statement and Priority Ranking Score:

Significant Needs with MRHC Implementation Plan

1. OBESITY/OVERWEIGHT

2. CANCER
3. PHYSICIANS including prevention clinic focus on screening & education
4. CORONARY HEART DISEASE
5. STROKE
6. COMPLIANCE BEHAVIOR / PREDESPOSING CONDITIONS
7. CHOLESTEROL (HIGH)
8. BLOOD PRESSURE (High)

Significant Needs where MRHC does not have an Implementation Plan²²

(None)

Other Needs where MRHC has an Implementation Plan

(None)

Other Needs where MRHC does not have an Implementation Plan

9. LUNG
10. DIABETES
11. MENTAL HEALTH / SUICIDE
12. ALZHEIMER'S
13. SMOKING / TOBACCO USE
14. AFFORDABILITY
15. ALCOHOL / SUBSTANCE ABUSE
16. KIDNEY DISEASE
17. PRIORITY POPULATIONS
18. MATERNAL AND INFANT MEASURES
19. ACCIDENTS
20. LOW BACK PAIN (Chronic)
21. LIFE EXPECTANCY / PREMATURE DEATH
22. FLU-PNEUMONIA
23. BLOOD POISONING
24. DENTAL

²² Reference Schedule H (Form 990) Part V Section B 7

- 25. PALLIATIVE CARE & HOSPICE
- 26. COMMUNICABLE DISEASE
- 27. PARKINSON'S
- 28. LIVER DISEASE

APPENDIX

(schedule appointments and receive written reports in a timely manner) for our clients, both adults and children.

- As a small business owner, I believe many citizens and other businesses are very concerned about the potential effects of the implantation of Obama care. There are so many unknowns in regards to the effects it will have not only to individuals but also to healthcare in general.
- **CARDIOVASCULAR DISEASE**
- Health services for indigent patients
- I believe it is what I'll call "health awareness" or the lack thereof. Our community suffers from a lack of emphasis on physical fitness and nutrition. As a result, obesity, diabetes and heart disease are serious problems.
- I believe some of the biggest medical issues of our county are obesity and knowledge deficit. Heart problems and diabetes are a big problem in our community, the majority of these issues stem from obesity. Childhood obesity is also a very concerning problem in our area. I do not think that parent's understand the impact that being obese as a child can have on the child's future health. It can affect almost every body organ, the child's grades, and his/her self-esteem and peer relationships. The majority of parent's do not even recognize a problem and if they do, they do not know how to remedy it.
- I believe the most important health / medical issue in Alcorn County would be diabetes or heart trouble. It seems to me that there is an abundance of people that have trouble with these issues.
- I believe the most important health/medical issue confronting our community is the use of tobacco. Tobacco use and secondhand smoke are the leading preventable cause of premature death and disease in our nation. Tobacco effects everyone its touches through heart attacks, stroke, cancers, asthma in children, cognitive defects in our children, etc.
- I believe this to be costs associated with health care which would include all aspects of medical care as well as costs of health insurance.
- I feel there are two main issues: 1. Cancer 2. Heart disease It seems like most of the families in our county are affected by either one of these or both. Over the years, it seems like our area has had a high rate of cancer in comparison to other counties in our state.
- **OBESITY**
- Obesity (childhood and adult)
- Obesity and drug abuse.
- Our community has many citizens that are combating high cholesterol, high blood pressure, and diabetes. These factors are contributing to another health issue, heart disease. In younger children and adolescents, our community is seeing more obesity and diabetes.

- Our population is aging, and our education level is not as high as we would like it to be. Therefore, many of our people are not aware of how much they, themselves, can affect their own health and wellness by their own personal actions, or inactions. If we can teach our people how to take better care of themselves (and not through legislation) we can improve health issues locally. I'm not just talking about eating too much or not balancing calorie intake with calorie burn, but even things like taking your medication.
- Pro-Active Health needs assessment in home. Visits to homes of a defined population to determine proper usage of medication and medication availability. Examine safety, Environment, Mental Health Issues, Support Personnel to include family members. Explore dietary needs and availability.
- Self management of chronic disease processes- specifically, diabetes, hypertension, COPD, obesity, medication management.
- The most critical health issue confronting the residents of Alcorn County is obesity and the many medical problems that are associated with this issue.
- The most important health or medical issue confronting my patient population, independent of a specific disease process such as diabetes, hypertension, or a complication there of, is simply their ability to be seen, evaluated, and treated in a timely manner. Whether the barrier to care is financial, logistical, cultural, spiritual, or educational, the patient still is in need of services and doesn't possess the ability to maneuver through the "system" to gain access. Beyond access, even when these barriers are removed, the ability to comply with treatment plans, afford medications, travel to and from referrals, etc is beyond the reach of many. So often, we "put a Band-Aid" on a hemorrhaging wound and hope for the best.
- The MOST important health or medical issue is hard to narrow down. The main issues that commonly go untreated are mental health disorders, high blood pressure, diabetes, and thyroid disorders. The commonalities of all the patients that experience these diseases or disorders are lack of recourses. Most of these patients have no insurance, lacking financially, and have no support systems.
- The most important medical issue confronting the residents of Alcorn County is cancer with heart conditions following.

Our second question to the Local Experts was “Do you perceive there are any primary and/or chronic disease needs, as well as potential health issues, of uninsured persons, low-income persons, minority groups and/or other population groups (i.e. people with certain situations) which need help or assistance in order to improve? If you believe any situation as described exists, please also indicate who you think needs to do what.”

The responses generated the following image:

regret that many, many (most) medical conditions seem to result from poor choices made by the individual. This is an education process and, unfortunately, will take more than one generation to solve!! I wish we could address that!

- I believe that we face a growing population of illegal aliens. Hospitals will continue to have to treat patients with the potential of not being able to collect for billable services. I believe these issues and policies should be reviewed by hospital boards and community leaders.
- I believe the issues of hypertension, heart disease, and diabetes need to be addressed with un-insured and lower income groups. The hospital needs to plan activities to help these individuals address these issues and work with them through the schools and community organizations to provide education and assistance.
- I do not believe that there are any chronic disease needs that get over looked. However, people with no insurance or Medicaid patients may be more limited to their physician choice. Several offices require co-pays up front, so a person with no insurance would be required to pay the full amount of an office visit before being seen. A person with no insurance or Medicaid could go to the ER if needed and cannot be turned away. Adults in our community can also be referred to the Resident clinic that is less expensive than a regular MD office. I do think that often children's needs get over looked. Not chronically ill children, but average children that do not get taken to the routine health checkups. The school that I am employed at does a great job at screening children's vision and hearing but all the school can do is make referrals and/or recommendations it is up to the parent's to take the child to an MD to have the issue addressed. The school also does EPST screens on children that qualify, but again if any issue is found it is still up to the parent's to take the child to the MD. Lots of times the child does not get taken to the MD or there is a long period before the child is taken. Most Medicaid plans will pay for children to have a well-child checkup, eye exam, and dental exam every year. It is my opinion that parents should be required to take their children to these yearly visits or the child's Medicaid could be suspended until these yearly requirements are met.
- I feel that anyone that has heart or cancer condition, as well as kidney dialysis, can have a very difficult time obtaining the medication and/or care that they need. This is even more emphasized due to the growing unemployment rate in our area. In addition, transportation can also be an issue. Furthermore, since we are primarily a retirement community, this is very prevalent in the senior citizens in our county. I think that increased public transportation funded by the federal government would be optimal to help with the transportation issue. In addition, I think the health care costs should be better controlled by the federal government since they control immigration, health aid, etc. As far as primary care for minority groups, it is hard for Hispanics in our area to receive care from health care providers that can speak in their language. There seem to be very few clinics, doctors, hospital employees, etc. that can communicate well with these groups.

- I think there are people that need help or assistance with the above issues; however, I believe very strongly that if a person can't pass a drug test she/he should not receive any help.
- I'M SURE THERE ARE MANY WHO ARE UNABLE TO PURCHASE MEDICAL COVERAGE BECAUSE THEY CANNOT AFFORD.WHEN INCOME IS LOW,PEOPLE USALLY CHOOSE THE BASIC FIRST(FOOD,BILL PAYING).I HAVE SEEN THIS IN ALL RACES IN THE COMMUNITY.
- It is my opinion: a community based health and wellness clinic would benefit the aforementioned group if such a clinic provided screenings, teaching and early intervention free of charge to prevent the need for ER visits and acute hospitalizations. This group of people generally use the emergency room for their primary care because they cannot or will not bear the expense of a visit to a fee for service clinic or physician. When these individuals present to the ER or are discharge from an Acute care facility, a referral should be made the clinic for follow-up.
- Low-income, uninsured and educationally deprived persons need instruction and guidance in the importance of education and nutrition.
- Mississippi, in general, is an obese, inactive hotbed for diabetes, hypertension, and heart disease. The risk of these goes up substantially as the poverty level increases. As health care providers, we need to all focus more on preventive health issues, healthy weights, exercise/active lifestyles, etc. This has to be a community wide interventions that begins in the schools, churches, community centers, medical offices, local businesses, etc. to re-educate and help change behaviors. Diabetes educations is much needed in the community. Both as initial education for the newly diagnosed, continuing education for the currently diagnosed and general education for family/friend. We so very much need an endocrinologist and diabetes center.
- No.
- Statistics show that tobacco companies prey on the low-income, low-education, poverty, and minority groups in our communities. As mentioned before, tobacco use leads to many health related issues for the user and the many innocent bystanders (majority of which are children). I believe that our hospital should offer some sort of Tobacco Cessation program to its patients. By getting to the cause of the many complications that tobacco can lead to, we save not only many lives, but also the money that is being spent in health related costs for the above mentioned people groups.
- Uninsured aging/elderly population who need medications but must chose not to have them filled in order to meet basic needs. Mental health acute care treatment for indigent patients.
- We have the necessary means to treat the problems of heart disease and diabetes however what we do not have adequate methods of prevention. Prevention will be a might task taking significant public awareness campaigns. It will not happen quickly.

- Yes there are needs and issues in our area that needs improvement. We seem to have some of our elderly in the community that have needs that their insurance and/or Medicaid/Medicare doesn't cover and they can't afford to pay the amounts owed out of their monthly income.
- Yes. Patients with Medicaid, Medicare end up seeing NP instead of MD because there are simply not enough medical doctors for the demand of patients. Both in general/primary care and also sub specialties. The patients many times are more complicated and have more issues needing higher trained physicians, yet get put on NPs. The MDs are overloaded by demand. Patients many times will have to go out of town even for primary care due to MDs already heavy patient load.

Appendix B – Process to Identify and Prioritize Community Need²⁴

Community Health Need Topic	Total Points Allocated	Number of Local Experts Allocating Points	Cumulative Percentage of Points	Break Point From Higher Need	Need Determination
1. OBESITY/OVERWEIGHT	164	15	10.25%	14	Significant Needs
2. CANCER	150	14	19.63%	4	
3. PHYSICIANS inc prevention clinic focus on screening & education	119	12	27.06%	31	
4. CORONARY HEART DISEASE	115	13	34.25%	4	
5. STROKE	98	14	40.38%	17	
6. COMPLIANCE BEHAVIOR / PREDISPOSING CONDITIONS	86	12	45.75%	12	
7. CHOLESTEROL (HIGH)	81	13	50.81%	5	
8. BLOOD PRESSURE (High)	78	13	55.69%	3	
9. LUNG	62	13	59.56%	16	Other Identified Needs
10. DIABETES	61	12	63.38%	1	
11. MENTAL HEALTH / SUICIDE	58	12	67.00%	3	
12. ALZHEIMER'S	56	14	70.50%	2	
13. SMOKING / TOBACCO USE	53	12	73.81%	3	
14. AFFORDABILITY	48	10	76.81%	5	
15. ALCOHOL / SUBSTANCE ABUSE	42	12	79.44%	6	
16. KIDNEY DISEASE	42	11	82.06%	0	
17. PRIORITY POPULATIONS	39	11	84.50%	3	
18. MATERNAL AND INFANT MEASURES	38	11	86.88%	1	
19. ACCIDENTS	35	10	89.06%	3	
20. LOW BACK PAIN (Chronic)	27	9	90.75%	8	
21. LIFE EXPECTANCY / PREMATURE DEATH	21	10	92.06%	6	
22. FLU-PNEUMONIA	21	9	93.38%	0	
23. BLOOD POISONING	20	9	94.63%	1	
24. DENTAL	20	8	95.88%	0	
25. PALLIATIVE CARE & HOSPICE	19	10	97.06%	1	
26. COMMUNICABLE DISEASE	19	8	98.25%	0	
27. PARKINSON'S	17	10	99.31%	2	
28. LIVER DISEASE	11	9	100.00%	6	
Total	1600	16			

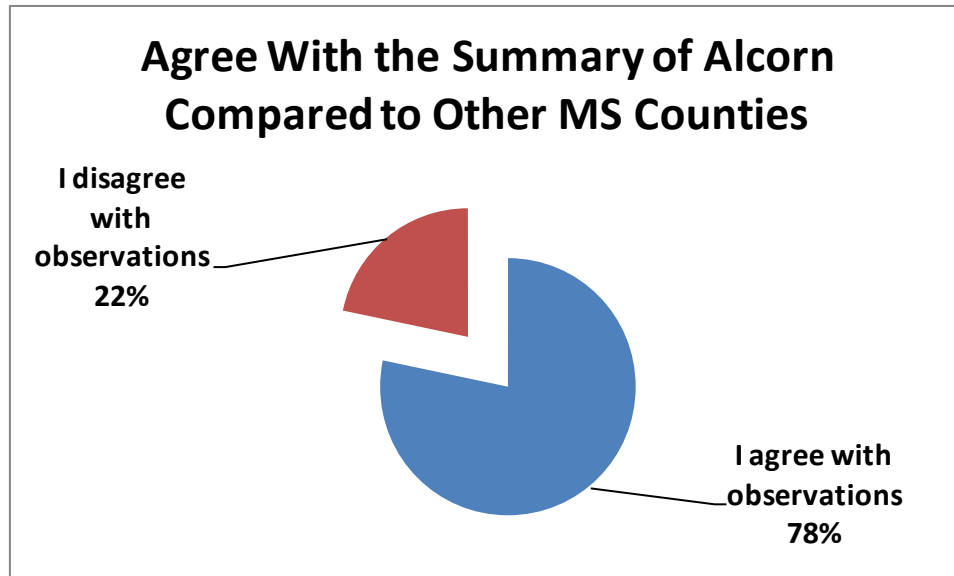
Individuals Participating as Local Expert Advisors

Organization	Title	Area of Expertise
Alcorn County	Supervisor, 1st District	Rep and long term area resident
Alcorn County	Supervisor	Elected official
Alcorn County Department of Human Services	Area Social Work Supervisor	Social worker with the Division of Family and Children's Services, investigating child abuse/neglect and providing for the medical and mental health needs of children in state custody.
Alcorn County Sheriff's Dept.	Investigator	Investigations
Alcorn School District	Superintendent	education
Capitol Resources, LLC	Lobbyist	area resident
Caterpillar, Inc.	Facility Manager	Manufacturing Operations Leadership
City of Corinth	Alderman	City board member
CITY OF CORINTH, MS	MAYOR	MAYOR-FORMER INDUSTRY EX.
Coca-Cola Bottling Works	President	Long term area resident; Physical Fitness/Preventive advocate
Corinth Elementary School	School Nurse	Pediatrics
Corinth School District	Superintendent	Representative of K-12 educational community
Corinth School District	Principal	Mostly High School Age Students
Magnolia Regional Health Center	Director of Home Health and Hospice	Home and Community Based Health and End of Life Care
Mississippi State Department of Health	Public Health Nurse	Public Health
Mississippi Tobacco-Free Coalition of Alcorn & Tippah Counties	Project Director	Public Health, organize and facilitate tobacco education and cessation activities, long term area resident as well.
MRCCC	ATTENDING	CLINIC PHYSICIAN
MRHC	General Peditrician	pediatrics
MSU Extension Service - Alcorn County	Extension Agent IV/Coordinator	agricultural consultant/educator
Region IV Mental Health Services	Executive Director	mental health
The Alliance	President	Chamber of Commerce/Economic Development Representative
The Wright Solution	CEO Retired	Geriatric Management
Trinity Health Clinic	FNP-BC	18 year experience locally practicing FNP
Trustmark National Bank	AVP	Banking & Finance

²⁴ Responds to IRS Schedule H (990) Part V B 1. g. and V B 1. h.

Advice Received from Local Experts

Q. Do you agree with observations formed about the comparison of Alcorn County to all other Mississippi counties?

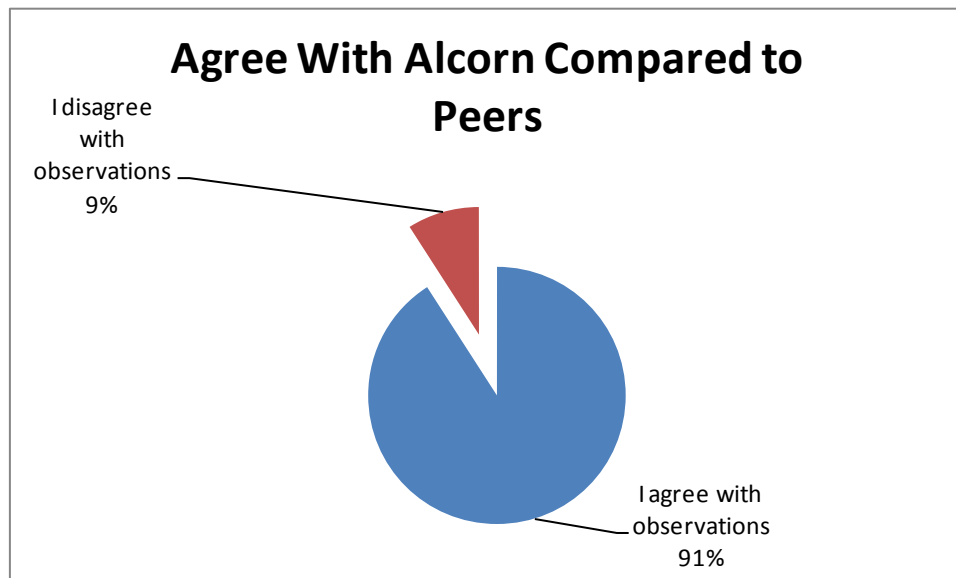


Clarifying Comments:

- I think one of the reason our death rate may be out of balance is we are recognized as a retirement community. The average age of all citizens could play a part in this.
- In the past, I believe physician shortage may have been an issue, but this seems to have improved over the last several years.
- It also seems like there is a large amount of heart disease in the community contributing to hospital visits, health problems. etc.
- I believe the rates for obesity and inactivity are both low
- 1. Proactive home visits to vulnerable adults might have an impact on preventable admissions. 2. Lack of medical coverage omits office visits and increase emergency visits.
- In the last 10 years Corinth has become much more of a regional medical community, including increased number of medical specialties. It's surprising that the numbers above reflect a pronounced physician shortage. We must continue to aggressively recruit physicians.
- It's well known that our population is older and less educated. This, in turn negatively affects our medical situation. Good health is a function of education and age, as well as medical care. We must (continue) to improve the whole issue in order to improve our medical situation."

- Disagree with excessive drinking. Believe there is a higher percentage but gathering data is challenging due to lack of willingness to be honest with most collection tools.
- The adult smoking rate is consistent with our coalition findings. In reference to the preventable hospital stays, many patients lack a regular physician and choose to visit the emergency room for their primary care. Also, there is a physician shortage in relation to our population in Alcorn County. But many of the health problems could be eliminated if the Adult smoking and obesity issues were addressed more readily.

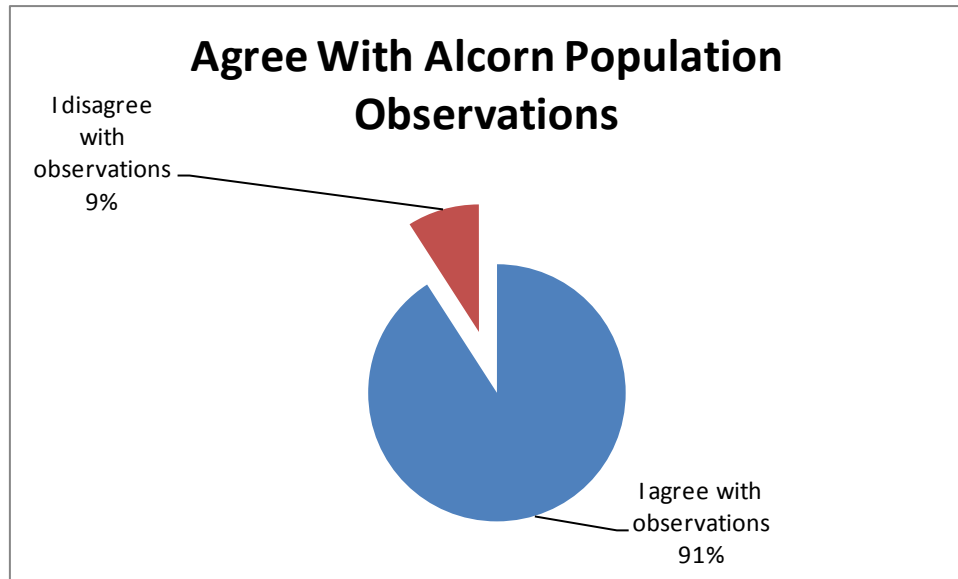
Q. Do you agree with observations formed about the comparison of Alcorn County to its Peer counties?



Clarifying Comments:

- I know that we do have a higher incident rate of cancer and coronary heart disease but as far as the others are concerned, I don't know that we are being compared correctly. During my years in the community, I have not observed a lot of the infant mortality and other neonatal issues listed above.
- Coronary Heart Disease rates here are very ,very high
- Basically, I can't argue with this. Again, our population is basically poor, older and less educated. We must deal with all the issues to show the most improvement.
- Alcorn County has a high rate of teen births and also a large Hispanic population.

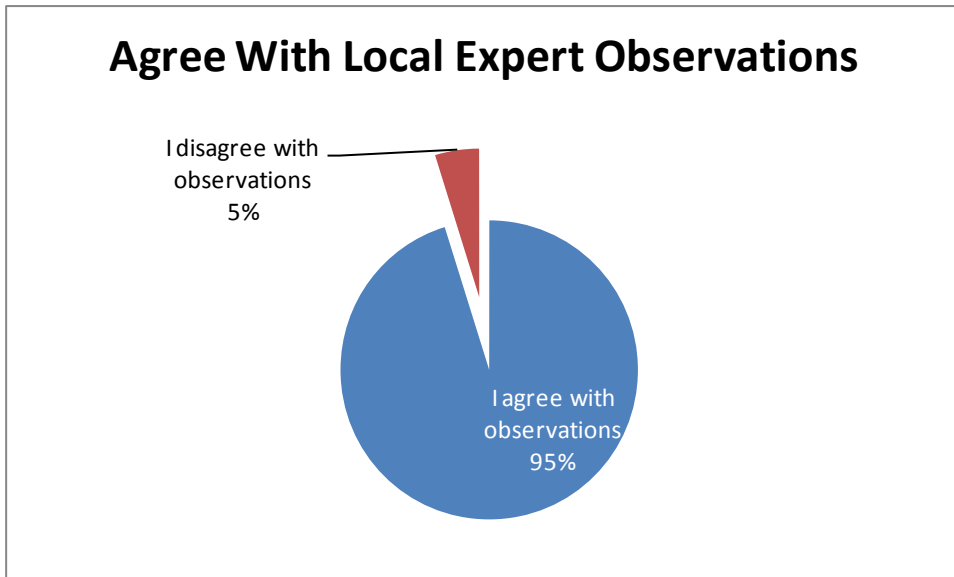
Q. Do you agree with observations formed about population characteristics of Alcorn County?



Clarifying Comments:

- I think because of the hospital's presence in the county and their BCA program, we would have a better rate of mammograms. Also, I am not in agreement with the "following treatment recommendations". People in our community are very money conscious and don't seem to go to the doctor unless necessary and would want to carry through on his/her recommendation. Several of these issues, such as high blood pressure, health eating habits, etc. seem to be prevalent due to the current economic situation. I do agree with the allergy assessment, we do have a largely agricultural area that probably impacts this a great deal.
- Most of these percentages are probably low
- The demographics of our population tend to support this data. Again, we are composed of generations of poor, rural, under-educated, older people. It's a continuing problem and education must be a huge part of the solution. We need to stress adult education regarding health and wellness, and ways to improve one's personal health, as well as the need for the various medical tests that many of us consider routine.
- Many patients do not follow their treatment recommendations because they are poorly educated or the questions they have are not answered in a timely manner. This is also attributed to the physician shortage and lack of personal time spent with patients while in a doctor's care. Many of the chronic problems listed above are due to the effects of unhealthy eating habits as well as tobacco use, etc.

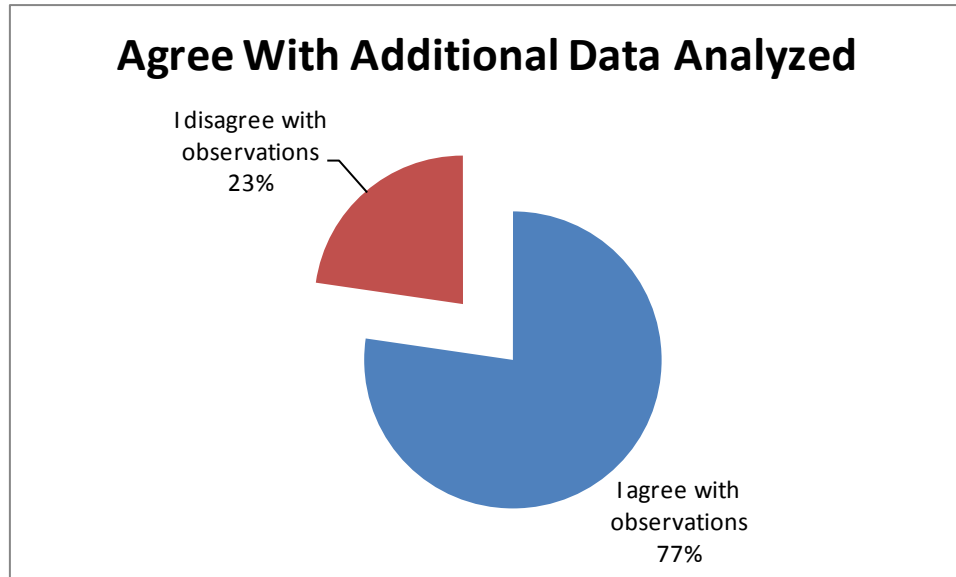
Q. Do you agree with observations formed about the opinions from local residents?



Clarifying Comments:

- “I continue to believe that many of our healthcare problems surround life style issues of our residents. I am also convinced that 'lack of understanding'", brought on by lack of education (both normal children's education AND adult education) contributes heavily. I don't think our population basically understands that their actions, whether doing something that they shouldn't OR failing to do something that they should, has a direct result! An example is how untreated high blood pressure increases the chances for stroke and death.
- Our population has been less educated and poor for generations. All of the health problems associated with those issues remain. We must provide good medical care while at the same time trying to educate the children AND the adults about the importance of good health."
- The response did not include who needs to do what. The medical community (hospital and other providers), should partner with community agencies and organizations to address these concerns. I contend that access is a problem in that the emergency room is not an appropriate access site for chronic disease management.

Q. Do you agree with observations formed about additional data analyzed about Alcorn County?



Clarifying Comments:

- "The liquor Store rate is inaccurate as we now have several since recent laws have been passed. Also, as we stated earlier, we are a retirement community and I believe our age rate impacts these death rates listed."
- It is important to consider that Diabetes and Obesity are intimately associated along with BP, Cholesterol and Dyslipemia in the development -- as well as inactivity (life style) in the development of Coronary Heart disease. With our increasing business and industrial outlook, when added to all of the above, will need to consider that we are a referral center --MRHC- and our need for Primary Care AND Cardiology will only increase. This may skew some of the lists
- "The statistics viewed in this survey are many and technical. While I would have difficulty arguing with many of them, my firm belief is that:
 - ** Healthcare in Alcorn County is basically GOOD!
 - ** Healthcare in Alcorn County is far BETTER than it was 15 years ago
 - ** Affordable healthcare is available for ANYONE in Alcorn County who seeks it
 - ** We are on the right track to improve healthcare for all, but it's going to be a long, process.
 - ** In order to do this, we must continue to educate both our children and adults on the importance of taking care of their own health."
- Does there need to be a note that the City of Corinth passed referendum and there now are liquor stores

- The incident of Stroke: Among Black's, the death rate is 97% of the MS average - don't fully understand this statistic. The fact that the heart disease hospitalization rate is above US and MS average for all races but for Blacks it is only 7% above MS average; when it is 33% above the MS average for whites might cause one to ask the question access to care again- why is the hospitalization rate for Black so low? It would be interesting to know how deaths heart disease related deaths among Black compare to that of whites.
- We now have multiple liquor stores however I believe that regardless of whether or not liquor stores are present, liquor has always been available and will continue to be available whether legal or not. IRRELEVANT
- Many of these health issues are due to stress and poor lifestyle choices. If we could address the stress issues people face and their poor lifestyle choices many of these health issues could be eliminated.