

**ARKANSAS RURAL
HEALTH PARTNERSHIP**



ARKANSAS RURAL HEALTH PARTNERSHIP



**Community
Health
Needs
Assessment
2025**

PREPARED FOR



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Jefferson Regional

Jefferson Hospital Association, Inc., operating as Jefferson Regional Medical Center (JRMC), is a 501(c)(3) not-for-profit organization incorporated in Arkansas. Its primary mission is to provide healthcare services to the citizens of Southeast Arkansas. As the only general acute care hospital in Jefferson County, JRMC is licensed for 300 acute care beds and currently operates 258. In addition, the Jefferson Regional Specialty Hospital operates 40 inpatient rehabilitation beds and 36 behavioral health beds.

The hospital serves an extensive 11-county area. Its primary service area encompasses Jefferson, Cleveland, and Lincoln counties, while its secondary service area includes Arkansas, Ashley, Bradley, Chicot, Dallas, Desha, Drew, and Grant counties. It is estimated that 65% of Jefferson Regional’s patients originate from its primary service area—with an additional 35% originating from the secondary service area.

To fulfill its mission and maintain its tax-exempt status, Jefferson Regional is dedicated to providing programs and services that intentionally assess and respond to local community health needs. These community benefits include offering health education, free community health screenings — supporting local community activities, and implementing various community health initiatives. A key component of this commitment is the Community Health Needs Assessment (CHNA), which Jefferson Regional Medical Center conducts every three years. This assessment gathers input from Jefferson County residents and hospital stakeholders throughout the surrounding region, including individuals with public health expertise. These participants form a community advisory committee, which assists hospital staff in collecting survey data to identify the most pressing health concerns in the hospital’s service area.

Following the identification of these health priorities, Jefferson Regional’s community needs assessment steering committee is tasked with creating an action plan. This plan outlines how the hospital will address selected issues using available resources. The completed CHNA report is then made available to the public.

The Jefferson Regional 2025 Community Health Needs Assessment was prepared by the leadership and staff of the Arkansas Rural Health Partnership and Jefferson Regional, in accordance with the requirements of Section 9007 of the *Patient Protection and Affordable Care Act of 2010*.



Jefferson Regional

Background

The 2025 Community Health Needs Assessment (CHNA) was prepared during a period of ongoing transformation in the healthcare landscape. Rural communities across the nation continue to face persistent challenges, including healthcare workforce shortages, hospital financial instability, disparities in healthcare access, and an aging population with increasing chronic disease burdens. The economic environment remains uncertain—with rising healthcare costs, reimbursement challenges, and the need for sustainable funding models placing additional pressure on rural health systems.

Through the CHNA process, the Arkansas Rural Health Partnership (ARHP) and Jefferson Regional have worked closely with hospital leadership, key stakeholders, and community members to assess the most pressing healthcare needs in the region. This assessment not only identifies critical health concerns but also lays the groundwork for strategic interventions to enhance healthcare delivery, strengthen rural hospital sustainability, and expand access to essential medical services. Over the next three years, healthcare service delivery and community initiatives will focus on building healthcare resilience — leveraging technological advancements, and fostering collaborative solutions to address these evolving challenges.

Key Challenges in Rural Healthcare in 2025

BEHAVIORAL HEALTH CRISIS

Rural communities are experiencing a mental health and substance use disorder epidemic, exacerbated by economic distress, social isolation, and limited access to behavioral health providers. Suicide rates, opioid overdoses, and alcohol-related health conditions have surged in rural areas — yet many counties lack inpatient psychiatric facilities, crisis intervention programs, or outpatient behavioral health services. Addressing this crisis requires expanded telepsychiatry services, recruitment incentives for behavioral health specialists, and enhanced community outreach programs to reduce stigma and improve access to care.

AGING POPULATION NEEDS

The rapidly aging population presents unique challenges for rural healthcare systems. Seniors require increased access to geriatric care, chronic disease management, long-term care facilities, and home health services. However, transportation barriers, social isolation, and financial constraints often prevent elderly individuals from receiving timely care. Expanding home-based healthcare programs, improving access to mobility and transportation services, and increasing caregiver support resources are essential to ensuring quality care for aging residents in rural communities.

HEALTHCARE WORKFORCE SHORTAGES

The rural healthcare workforce is facing a critical shortage of physicians, nurses, specialists, and support staff — which threatens the ability to provide consistent, high-quality care. Physician burnout, an aging workforce, and recruitment challenges have led to gaps in primary and specialty care services. Many rural providers have difficulty attracting and retaining healthcare professionals due to lower salaries, limited

career advancement opportunities, and fewer amenities compared to urban settings. Solutions include loan repayment programs, residency and internship partnerships with medical schools, telemedicine integration, and pipeline programs that encourage local students to pursue careers in healthcare.

RURAL HOSPITAL STABILITY

The financial viability of rural hospitals remains a pressing issue, with closures continuing at an alarming rate. Many small hospitals operate on thin margins, struggling to balance rising operational costs with declining patient volumes. Medicaid expansion, reimbursement rate adjustments, and alternative payment models such as value-based care are being explored to help rural hospitals remain financially sustainable. In addition, collaborative healthcare networks, shared services agreements, and strategic partnerships with larger healthcare systems are essential for ensuring the long-term survival of rural hospitals and maintaining local access to emergency and specialty care.

HEALTH INFRASTRUCTURE & ACCESS BARRIERS

Rural healthcare systems continue to face infrastructure deficits, including outdated medical facilities, inadequate medical equipment, and limited broadband access. Many rural hospitals struggle with transportation barriers — making it difficult for patients to reach healthcare providers. Addressing these issues requires investment in modernizing rural healthcare infrastructure, expanding broadband access to support telehealth, and developing transportation assistance programs to improve access to essential health services.

CHRONIC DISEASE MANAGEMENT

Rural populations experience higher rates of chronic diseases such as diabetes, heart disease, and obesity — often due to limited access to preventive care, healthy food options, and fitness resources. Healthcare providers must implement community-based chronic disease management programs, integrate patient education initiatives, and expand access to specialty care to help patients manage and prevent long-term health complications.

Health Care Trends & Innovation in 2025

TELEHEALTH EXPANSION

Telehealth has revolutionized rural healthcare by providing virtual access to primary care physicians, specialists, and mental health professionals. The adoption of remote patient monitoring, mobile health applications, and AI-powered diagnostics has significantly improved care coordination, chronic disease management, and mental health support. However, persistent challenges such as broadband access, insurance reimbursement, and patient digital literacy must be addressed to maximize the impact of telehealth in rural communities.

HEALTHCARE ACCESSIBILITY

Healthcare disparities remain a major concern in rural areas — where social determinants of health (SDOH) such as income, education, transportation, and food security play a significant role in healthcare access



and outcomes. Hospitals and public health agencies are increasingly focusing on initiatives that enhance healthcare availability, including community health worker programs, culturally tailored healthcare services, and policy advocacy for expanded Medicaid coverage. Strengthening partnerships between healthcare organizations, schools, and community-based organizations is critical to addressing these challenges.

ADVANCED DIAGNOSTICS & TREATMENT

Technological advancements are reshaping rural healthcare delivery. Artificial intelligence (AI) and machine learning algorithms are enhancing diagnostic accuracy, while wearable health devices enable continuous health monitoring for patients with chronic conditions. Additionally, 3D printing, precision medicine, and robotic-assisted procedures are improving patient outcomes by offering minimally invasive treatments and personalized care plans. Expanding access to these innovations in rural settings will require investment in infrastructure, workforce training, and regulatory support.

COMMUNITY-BASED HEALTHCARE MODELS

The shift toward patient-centered, community-based healthcare is gaining momentum in rural areas. Models such as mobile clinics, school-based health centers, and home healthcare services are increasing access to care, particularly for underserved populations. Federally Qualified Health Centers (FQHCs), rural health clinics, and partnerships with faith-based organizations are also playing a key role in expanding primary care services. By leveraging community resources and integrating multidisciplinary care teams, rural hospitals can enhance healthcare delivery and promote overall community well-being.

State Data: Arkansas

According to the United Health Foundation’s 2024 America’s Health Rankings Annual Report, Arkansas state health findings are as follows:

<i>Arkansas Strengths</i>
• Low prevalence of excessive drinking.
• High prevalence of fruit and vegetable consumption.
• Low percentage of households experiencing severe housing problems.
<i>Arkansas Alarming Challenges</i>
• Arkansas ranks #50 in food insecurity (% of households), with a 18.9% food insecurity per household rate.
• Arkansas ranks #48 in Adverse Childhood Experiences (% of children ages 0-17), with a rate of 21.3%.
<i>Arkansas Highlights</i>
• Smoking rate decreased by 39% — from 24.7% to 15.0% of adults between 2014 and 2023.
• The population of uninsured decreased by 25% — from 11.8% to 8.9% of the population between 2014 and 2023.
https://www.americashealthrankings.org/learn/reports/2024-annual-report/state-summaries-arkansas

Arkansas Measures

- Overall rank: 48

SOCIAL & ECONOMIC FACTORS			
Measure	State Rank	State Value	U.S. Value
<i>Community and Family Safety</i>			
• Homicide (Deaths per 100,000 population)	43	11.2	7.6
• Occupational Fatalities (Deaths per 100,000 workers)	39	5.5	4.2
<i>Economic Resources</i>			
• Economic Hardship Index (Index from 1-100)	44	82	—
• Food Insecurity (% of households)	50	18.9%	12.2%
• Income Inequality (80-20 Ratio)	34	4.77	4.87
<i>Education</i>			
• Fourth Grade Reading Proficiency (% of public school students)	38	29.7%	32.1%
• High School Completion (% of adults age 25+)	40	89.3%	89.8%
<i>Social Support and Engagement</i>			
• Adverse Childhood Experiences (% of children ages 0-17)	48	21.3%	14.5%
• High-Speed Internet (% of households)	46	91.1%	93.8%
• Volunteerism (% of population age 16+)	41	20.9%	23.2%
PHYSICAL ENVIRONMENT			
Measure	State Rank	State Value	U.S. Value
<i>Air and Water Quality</i>			
• Air Pollution (Micrograms of fine particles per cubic meter)	36	8.4	8.6
• Drinking Water Violations (Average violations per community water system)	44	3.3	2.8
• Water Fluoridation (% of population served)	18	86.8%	72.3%
<i>Climate and Health</i>			
• Climate Policies (Number out of four policies)	30	1	—

RELEVANT DATA (Continued)

<i>Housing and Transit</i>			
• Drive Alone to Work (% of workers age 16+)*	47	78.3%	69.2%
• Housing With Lead Risk (% of housing stock)	9	9.7%	16.4%
• Severe Housing Problems (% of occupied housing units)	16	13.2%	16.8%
CLINICAL CARE			
Measure	State Rank	State Value	U.S. Value
<i>Access to Care</i>			
• Avoided Care Due to Cost (% of adults)	43	13.9%	10.6%
• Dental Care Providers (Number per 100,000 population)	48	45.3	65.8
• Mental Health Providers (Number per 100,000 population)	31	289.6	344.9
• Primary Care Providers (Number per 100,000 population)	43	241.4	283.4
• Uninsured (% of population)	36	8.9%	7.9%
<i>Preventive Clinical Services</i>			
• Childhood Immunizations (% of children by age 24 months)	46	62.0%	66.9%
• Colorectal Cancer Screening (% of adults ages 45-75)	41	56.4%	61.8%
• Dental Visit (% of adults)	49	55.6%	66.0%
• Flu Vaccination (% of adults)	29	40.0%	42.9%
• HPV Vaccination (% of adolescents ages 13-17)	43	52.9%	61.4%
<i>Quality of Care</i>			
• Dedicated Health Care Provider (% of adults)	20	84.8%	84.0%
• Preventable Hospitalizations (Discharges per 100,000 Medicare beneficiaries age 18+)	41	3,058	2,665
BEHAVIORS			
Measure	State Rank	State Value	U.S. Value
<i>Nutrition and Physical Activity</i>			
• Exercise (% of adults)	39	26.8%	30.4%
• Fruit and Vegetable Consumption (% of adults)	5	10.2%	7.4%
• Physical Inactivity (% of adults)	47	32.5%	24.2%

RELEVANT DATA (Continued)

<i>Sexual Health</i>			
• Chlamydia (Cases per 100,000 population)	43	588.3	495.0
• High-Risk HIV Behaviors (% of adults)	34	6.2%	5.7%
• Teen Births (Births per 1,000 females ages 15-19)	49	24.6	13.6
<i>Sleep Health</i>			
• Insufficient Sleep (% of adults)	43	38.7%	35.5%
<i>Smoking and Tobacco Use</i>			
• E-Cigarette Use (% of adults)*	47	10.6%	7.7%
• Smoking (% of adults)	39	15.0%	12.1%
OVERALL HEALTH OUTCOMES			
Measure		Value	Rank
• Overall Health Score		-0.759	48
BEHAVIORAL HEALTH OUTCOMES			
Measure		Value	Rank
• Depression (% of adults)		26.6%	38
• Drug Deaths (per 100,000)		21.7	10
• Excessive Drinking (% of adults)		14.5%	6
• Frequent Mental Distress (% of adults)		18.9%	45
• Non-medical Drug Use (% of adults)		18.2%	34
• Suicide Rate (per 100,000)		18.0	30
MORTALITY			
Measure		Value	Rank
• Premature Death (years lost before age 75 per 100,000)		11,504	42
• Premature Death Racial Disparity (ratio)		1.3	11
PHYSICAL HEALTH			
Measure		Value	Rank
• Frequent Physical Distress (% of adults)		16.1%	46
• High Health Status (% of adults reporting good or excellent health)		41.4%	46

RELEVANT DATA (Continued)

• Low Birthweight (% of live births)	9.3%	39
• Low Birthweight Racial Disparity (ratio)	2.1	35
• Multiple Chronic Conditions (% of adults)	14.1%	44
CHRONIC DISEASES		
Measure	Value	Rank
• Arthritis (% of adults)	30.3%	42
• Asthma (% of adults)	9.9%	17
• Cancer (% of adults)	8.4%	23
• Cardiovascular Diseases (% of adults)	12.1%	46
• Chronic Kidney Disease (% of adults)	4.2%	35
• Chronic Obstructive Pulmonary Disease (% of adults)	9.0%	45
• Diabetes (% of adults)	14.5%	42
RISK FACTORS		
Measure	Value	Rank
• High Blood Pressure (% of adults)	42.5%	44
• High Cholesterol (% of adults)	40.2%	44
• Obesity (% of adults)	40.0%	46

RELEVANT DATA (Continued)

Regional Data

Region	Median Household Income	Unemployment Rate	Persons Living in Poverty
• Arkansas County	\$52,100	3.3%	14.7%
• Ashley County	\$44,744	5.3%	22.7%
• Bradley County	\$43,184	5.2%	20.1%
• Calhoun County	\$46,417	5.5%	13.3%
• Chicot County	\$34,147	6.6%	24.4%
• Columbia County	\$47,300	4.4%	23%
• Dallas County	\$38,072	5.7%	11.2%
• Desha County	\$31,893	4.6%	28.9%
• Drew County	\$46,997	4.6%	22.7%
• Grant County	\$55,388	4.5%	12.3%
• Independence County	\$57,600	3.4%	19.6%
• Jefferson County	\$39,326	5.6%	20.6%
• Lee County	\$29,681	6.1%	27.7%
• Lincoln County	\$46,596	7.4%	17.7%
• Lonoke County	\$62,532	3.4%	11.10%
• Monroe County	\$38,468	4.8%	22.2%
• Ouachita County	\$35,425	5.0%	17.9%
• Phillips County	\$29,320	5.9%	28.7%
• Polk County	\$45,300	3.7%	20%
• St. Francis County	\$35,348	5.6%	27.8%
• Sevier County	\$49,400	3.9%	19.6%
• Stone County	\$41,100	4.2%	21.6%
• Union County	\$44,663	4.4%	19.4%
• State of Arkansas	\$48,952	4.8%	15.55
• United States	\$65,712	3.8%	12.5%

*Note: Data reflects figures up to 2024 as reported by the *County Health Rankings & Roadmaps* and the US ACS 5-Year Estimates.

County Data

• Jefferson County

Based on the latest available data from the *2024 County Health Rankings & Roadmaps* by the Robert Wood Johnson Foundation, here is an updated overview of Jefferson County, Arkansas:

GENERAL DEMOGRAPHICS			
Demographic Metric	Jefferson County	Arkansas	
• Population	64,426	3,067,732	
• % Below 18 years of age	21.4%	23%	
• % 65 and older	19.0%	18%	
• % Non-Hispanic Black	56.9%	15.3%	
• % American Indian or Alaska Native	0.5%	1.1%	
• % Asian	1.0%	1.9%	
• % Native Hawaiian or Other Pacific Islander	0.2%	0.5%	
• % Hispanic	2.7%	9.2%	
• % Non-Hispanic White	37.7%	70.2%	
• % Male	49.8%	49.3%	
• % Female	50.2%	50.7%	
*Note: Data reflects figures up to 2024 as reported by the <i>County Health Rankings & Roadmap</i> .			
INCOME DEMOGRAPHICS			
Income Metric	Jefferson County	Arkansas	
• Median Household Income	\$39,326	\$55,500	
POVERTY STATISTICS			
Population Segment	Jefferson County	Arkansas	United States
• All Persons in Poverty	20%	16%	13%
• Under 18 years of Age	29%	22%	17%
• 18 to 64 Years of Age	13%	14%	12%
• 65 and older	13%	12%	11%
Note: Data reflects figures in the U.S. Census Data Profile.			

RELEVANT DATA (Continued)

MIGRATION DEMOGRAPHICS

Migration Metric	Jefferson County	Arkansas
• Moved From a Different State	1.3%	2.1%
• Moved Within the Same County	3.6%	6.5%
• Moved from a Different County	7.1%	3.1%
• Moved Abroad	0.4%	0.4%

HEALTHCARE COVERAGE

Coverage Metric	Jefferson County	Arkansas
• Uninsured (%)	9%	8.9%

HEALTHCARE PROVIDER DEMOGRAPHICS

Population Segment	Jefferson County	Arkansas	U.S. Top Performing Counties
• Primary Care Physicians Ratio	1,370:1	1,480:1	1,330:1
• Dentists Ratio	2,570:1	2,040:1	1,360:1
• Mental Health Providers Ratio	410:1	380:1	320:1
• Preventable Hospital Stays (per 100,000)	3,648	3,015	2,681
• Mammography Screening (%)	39%	40%	43%
• Flu Vaccinations (%)	44%	45%	46%

HEALTH STATISTICS

Health Metric	Jefferson County	Arkansas	U.S. Top Performing Counties
• Adult Smoking (%)	23%	22%	15%
• Adult Obesity (%)	43%	39%	34%
• Food Environment Index	6.7	4.7	7.7
• Physical Inactivity (%)	36%	30%	23%
• Access to Exercise Opportunities (%)	595	64%	84%
• Alcohol-Impaired Driving Deaths (%)	19%	27%	26%
• Sexually Transmitted Infections (per 100,000)	1,267.8	592.8	495.0

*Note: Data reflects figures up to 2024 as reported by the *County Health Rankings & Roadmap* and figures in the U.S. Census Data Profile.

Mission

Jefferson Regional is committed to improving health through excellence and compassion.

Vision

To be the healthcare provider and employer of choice for Southeast Arkansas

Values

Jefferson Regional, as a community-owned, not-for-profit healthcare provider, is guided by a core set of values known as “CARES” which provides direction to the organization in achieving its mission. These values are as follows:

- **Compassion** – *We show concern and understanding for others 24/7.*
- **Accountability** – *We conduct our daily activities with reliability.*
- **Respect** – *We show consideration, fairness and dignity to others.*
- **Excellence** – *We perform at a level that meets or exceeds expectations.*
- **Safety** – *We strive for zero harm for our patients and fellow employees.*

History

Jefferson Regional Medical Center’s story began in 1893, when a devoted group of Pine Bluff women launched a fundraising campaign to bring a hospital to their community. Fifteen years later — in 1908 — their vision became reality with the opening of Davis Hospital at 11th & Cherry Streets — the first hospital to serve South Arkansas. In 1960, Davis Hospital gave way to the new 255-bed Jefferson Hospital on West 42nd Avenue. As the facility’s scope and reputation grew, it adopted the name Jefferson Regional Medical Center to reflect its role as a regional referral hub. In 2008, the health system proudly celebrated a century of compassionate care for the people of South Arkansas.

Today, Jefferson Regional Medical Center is a not-for-profit, sole-community provider and Level 3 Trauma center based in Pine Bluff. Licensed for 300 acute-care beds, it employs roughly 1,500 staff members and 140 on-staff physicians — maintaining an average daily census of 120 patients. Serving a primary and secondary market of approximately 225,000 residents across 11 counties, the center offers a comprehensive range of sub-specialty services. Beyond its hospital campus, Jefferson Regional operates two Wellness Centers, an urgent care clinic, and 19 physician practice locations. Most recently, it expanded its footprint by acquiring three additional South Arkansas clinics — Monticello Medical Clinic I & II and Crossett Clinic — bringing quality care closer to even more communities.

In 2024, the Jefferson Regional Specialty Hospital opened as a state-of-the-art, 76-bed specialty hospital with 40 acute inpatient rehabilitation beds dedicated to the treatment and recovery of individuals who have experienced the debilitating effects of a severe injury or illness and a 36-bed behavioral health unit

ABOUT OUR HOSPITAL (Continued)

that offers a continuum of inpatient and outpatient behavioral health services for adults and senior citizens, including crisis stabilization for acute mental health and substance use disorders; detoxification from alcohol and drugs; and treatment for anxiety, depression, Post-Traumatic Stress Disorder and many other behavioral health concerns.

ABOUT OUR HOSPITAL (Continued)

Leadership — Jefferson Regional

- Brian Thomas, *President & Chief Executive Officer*
- Peter Austin, *Senior Vice President & Chief Operating Officer*
- Jeremy Jeffery, *Senior Vice President & Chief Financial Officer*
- Layton Anderson, *Vice President & Chief Human Resources Officer*
- Michelle Powell, RN, *Vice President & Chief Nursing Officer*

- Wendy Talbot, *Vice President & Chief Experience Officer*

Leadership — Jefferson Regional Specialty Hospital

- Mary Daggett, *Chief Executive Officer*

Governance

Jefferson Regional Medical Center: Board of Directors

- Scott Pittilo, *Chair*
- Chuck Morgan, *Vice-Chair*
- David Bridgforth, *Treasurer*

- Janice Acosta, *Secretary*
- Drew Atkinson
- David Brown
- Amy B. Cahill, MD
- Marty Casteel
- Michelle Eckert, MD
- Annette Kline
- George Makris
- Joann Mays, MD
- Tim McClure, MD
- Daniel Robinson
- Archie Sanders
- Brian Thomas, CEO
- Ford Trotter
- Steven Wright, MD

Organizational Chart included as Attachment F.

Healthcare Services

For more than 100 years, Jefferson Regional Medical Center has provided a wide range of medical services to the citizens of southeast Arkansas. These services include the following:

BREAST CENTER – MAMMOGRAPHY

- Jefferson Regional Breast Center
- Jefferson Regional Breast Center – White Hall

CARDIOLOGY

- Cardiac Rehab Program
- Jefferson Regional Cardiology Associates
- ACT Program

DIABETIC CARE

- Endocrinology

EAR, NOSE, THROAT

- Jefferson Regional Ear, Nose & Throat Associates

EMERGENCY SERVICES

- Level Three Trauma Center

GASTROENTEROLOGY

- Upper GI Endoscopy (EGD)
- Lower GI Endoscopy (Colonoscopy)
- GI Lab

HEALTH & WELLNESS PROGRAMS

- ACT Chronic Heart Failure Program
- Mammogram Assistance
- Cardiac Pulmonary Rehab
- Infant Safe Sleep

HOSPITAL MEDICINE & INTENSIVE CARE

- Hospitalist Care
- Intensive Care

IMAGING SERVICES

- Diagnostic X-Ray
- CT
- Nuclear Medicine
- PET/CT
- Low Dose CT Lung Cancer Screening
- General Ultrasound
- Vascular Ultrasound
- Mammography
- EEG/NCV
- MRI – MAGiC multi-contrast, Ready Brain, Caring Suite

JEFFERSON WELLNESS CENTERS

- Pine Bluff
- White Hall

Healthcare Services (Continued)

OCCUPATIONAL HEALTH

- Worker's Comp injuries
- DOT physicals
- Pre-employment physicals
- Hazmat physicals
- Drug screening
- Audiograms
- Labs
- Vision testing
- Vaccinations
- International immunizations
- Hazardous material exams
- Lift testing
- DOT supervisor training
- Breath alcohol testing
- Diagnostic x-rays
- Biometric screenings
- Medical Review Officer Services
- Flu shot clinics
- Wellness Education

ORTHOPEDICS & SPINE

- Sports Medicine
- Joint, Hip & Knee Replacement
- Jefferson Regional Orthopaedic Associates

PEDIATRICS

- Arkansas Children's Hospital Alliance
- Child Car Seat Safety
- Infant/Child CPR

PULMONOLOGY

- Jefferson Regional Bronchoscopy Lab
- Pulmonary Function Testing
- Jefferson Regional Pulmonology Associates

REHABILITATION & THERAPY

- Outpatient Therapy
- Wound Care Center
- Cardiac & Pulmonary Rehabilitation Program

RHEUMATOLOGY

- Jefferson Regional Rheumatology Associates

WOMEN'S HEALTH

- Obstetrics
- Breast Cancer & Mammography
- Lactation
- Gynecology
- Jefferson Regional OB/GYN Associates
- Infant Safe Sleep

JEFFERSON REGIONAL SPECIALTY HOSPITAL

- Inpatient Rehabilitation
- Behavioral Health

Providers

ANESTHESIOLOGY

- Chris Steel, MD

CARDIOLOGY

- Ayman A. Alshami, MD, FACC
- Ricki Fram, MD
- Sadeem Mahmood, MD, FACC
- Nicholas Willis, MD
- Jainil Shah, MD, FACC
- Mauro Taveras, MD

DERMATOLOGY

- Jennifer L. Jacks, MD, FADD

EMERGENCY MEDICINE

- Janet Curry, MD
- Tim McClure, MD
- George Gray, III, DO
- Samuel Turner, MD

ENDOCRINOLOGY

- Maher Alesali, MD

FAMILY MEDICINE

- Omar Alazzawi, MD
- Jared Anderson, MD
- Simmie Armstrong, Jr., MD
- Harvie Marks Attwood, MD

- Keith Gage Bennett, MD
- Jason B. Cobb, MD
- Paul Wayne Davis, MD
- Joseph Michael Fakouri, MD
- Herbert Farrell Fendley, MD
- Martha A. Flowers, MD
- Kimberly Golden, MD
- John E. Harris, MD
- Jackson Haynes, MD
- Richard Douglas Justiss, MD
- Larisa Kachowski, MD
- Patrick Mbawuike, MD
- Primus Mbawuike, MD
- Toni Lynn Middleton, MD

Providers (Continued)

- Maria Montales, MD
- Holly Handloser Morgan, MD
- Scott Richard Nichols, MD
- Julia Nicholson, MD
- Darrell R. Over, MD
- Michele A. Pashkevich, MD
- Appala Peela, MD
- Rayna Penister, MD
- Nathan Probst, MD
- Mark Anthony G. Ramiro, MD
- Timothy Chrisitan Reece, MD
- Raquel Rivera-Cruz, MD
- Hamida Saba, MD
- Waseem A. Shah, MD
- Sylvia Simon, MD
- Timothy Simon, MD
- Pavana Tirumansietti, MD
- Chizoba Usuwa, MD
- Timothee T. Wilkin, DO
- Nancy Kay Williams, MD
- Kimberly Willis, MD

GASTROENTEROLOGY

- Ian Gaillard, MD
- Ioannis Papayannis, MD
- Cyrus P. Tamboli, MD

GENERAL SURGERY

- Roger Blake, MD
- Michelle Eckert, MD, FACS
- Lee A. Forestiere, MD, FACS
- Heather LeBlanc, MD, FACS
- Charles D. Mabry, MD, FACS
- J.R. Taylor III, MD, FACS
- Madison Lim, MD, M.P.H.
- Leigh Anna Robinson, MD

HEMATOLOGY

- Brian Campbell, MD
- Asif Masood, MD

INTERNAL MEDICINE

- Apolinar “Ben” Bordador, MD
- James Steven Cash, MD
- Mistie Charlemagne, MD
- John D. Dedman, MD
- Chinedu Ede, MD
- Jemeca D. Edwards, MD
- Naznin T. Jamal, MD
- Olabode Olumufin, MD, MPH
- Arafat Shabbir, MD
- Ivan Quintanar Smith, MD
- Ramakrishna Thotakura, MD
- Nauman Yunus, MD, FACP

NEPHROLOGY

- James A. Campbell, Jr., MD
- M. Ahmer Kashif, MD
- Syed Shah, MD
- Brandi Wright, MD
- Steven H. Wright, MD

NEUROLOGY

- Jacquelyn Sue Frigon, MD
- Ghulam M Khaleel, MD

OBSTETRICS & GYNECOLOGY

- Amy L. Cahill, MD
- Joseph E. Browning, MD, FACOG
- Kenneth J. Lambert, MD
- Reid G. Pierce, MD, FACOG

OPHTHALMOLOGY

- David T. Nixon, MD

ORTHOPEDECS

- Gordon Troy Birk, MD
- Roy Burrell, MD
- J. Alan Pollard, MD

OTOLARYNGOLOGY

- Christine Mirabal, MD
- Stephen D. Shorts, MD

PAIN MANAGEMENT

- Navdeep Dogra, MD

PATHOLOGY

- Kari Hooper, MD
- Julie Harris, MD

PEDIATRICS

- Sade Francois, MD
- Christopher Riley, MD

PSYCHIATRY

- Stephen A. Broughton, MD
- Abeer Washington, MD

PULMONOLOGY

- Ali Alnashif, MD
- Sarenthia Epps, MD
- Rachael Idowu, MD
- Nabeel Siddiqui, MD

RADIATION ONCOLOGY

- Shahid Hameed, MD

RADIOLOGY

- Albert S. Alexander, MD
- Edward Angtuaco, MD
- Jodi Barboza, MD
- Benjamin J. Bartnicke, MD
- Blake Becker, MD
- Logan Benoist, MD
- William Borrer, MD
- Eric Bready, MD
- Charles William Deaton, MD
- Steven A. Dunnagan, MD
- Douglas E. Elliott, MD



Providers (Continued)

- Jonathan F. Fravel, MD
- Robert Gaines Fricke, MD
- Micah Fritsche, MD
- Saima Ghori, MD
- Aaron L. Janos, MD
- Brandon Kelly, MD
- Don L. Kusenberger, MD
- Paolo Lim, MD
- Wilma Jean Matchett, MD
- Ryan McAllister, MD
- John N. Meadors, MD
- Rogerich T. Paylor, MD
- Barbara Rodrigues, MD
- Daniel Roubain, MD
- John P. Scurlock, MD

- Kathleen M. Sitarik, MD
- Aaron M. Spann, MD
- David E. Tamas, MD
- Shannon R. Turner, MD

RHEUMATOLOGY

- Maaman Bashir, MD
- Snigdha Gadireddy, MD

SLEEP MEDICINE

- Keith Schluterman, MD
- Timothy Freyaldenhoven, MD

UROLOGY

- Nathan Green, MD
- Jordan Hanberry, MD
- Nickolas Scherzer, MD

At the conclusion of the Jefferson Regional survey and community advisory board processes, there were three priorities that were targeted for the hospital to address over the next three years: Accessibility to Healthcare Services, Mental Health, and Chronic Disease. The following data highlights the issues around these topics at the federal, state, and local levels.

Accessibility to Healthcare Services

FEDERAL

Access to care remains a significant challenge across the United States, particularly in rural areas. As of 2024, more than 76 million Americans live in designated Health Professional Shortage Areas (HPSAs), with an estimated 13,273 additional practitioners needed to eliminate these shortages. While the national uninsured rate reached a historic low of 7.7% as of early 2023, cost barriers continue to impact care-seeking behaviors. According to a study conducted by the United States Federal Reserve in 2023, 27% of American adults skipped some form of medical treatment because they couldn't afford it.

ARKANSAS

Arkansas experiences significant healthcare access disparities — particularly in rural regions. The state ranks 38th nationally in its supply of primary care physicians — with only 82.3 physicians per 100,000 residents, well below the national average (Arkansas Center for Health Improvement, 2024). While access to primary care remains a concern, Arkansas had 104 primary care clinicians per 100,000 people in 2022, matching the national average. This total includes physicians, physician assistants, and nurse practitioners. Notably, Arkansas had 40 nurse practitioners per 100,000 people, compared to 26 nationally. In areas with higher social deprivation, defined as communities ranking above the median on the Social Deprivation Index (SDI), the density of nurse practitioners was even higher at 48 per 100,000 people (Arkansas Center for Health Improvement, 2024).

Arkansas has also made progress in community-based and rural-focused training of primary care residents. In 2022, 28% of medical residents in the state received training in community-based settings, which are primarily located outside of hospitals and large academic centers. This rate is significantly higher than the 16% national average. Additionally, 60% of Arkansas' primary care residents were trained in rural or medically underserved areas, exceeding the national rate of 54%. Despite these efforts, the state continues to face critical shortages in key areas of its healthcare workforce. The number of primary care physicians per 100,000 people in Arkansas was only 58, compared to 67 nationally. Physician assistants were particularly underrepresented, with only 5 per 100,000 people in Arkansas — compared to 10 per 100,000 nationally, highlighting the continued workforce shortage in primary care (Arkansas Center for Health Improvement, 2024).

Further exacerbating the issue, Arkansas saw declines in the percentage of clinicians working in primary care between 2021 and 2022 — mirroring national trends. The percentage of nurse practitioners working in primary care fell by nearly 10%, from 41% to 37% — while the percentage of physician assistants in primary care dropped by 25% — from 36% to 27%. The overall percentage of clinicians in primary care declined by

TOPIC SPECIFIC DATA: PRIORITIES (Continued)

6% — from 33% to 31% — reflecting a growing shift of these professionals into specialty care, likely influenced by financial incentives and increased workload pressures in the primary care sector (Arkansas Center for Health Improvement, 2024). In addition to this workforce shift, the pipeline of new physicians entering primary care is shrinking. Nationally, only 24% of new physicians entered primary care in 2022, or 20% of hospitalists (physicians working exclusively in hospitals) are excluded. Arkansas mirrored this national trend — with 33% of new physicians entering primary care in 2022, but when excluding hospitalists, this number dropped to 20%. Between 2021 and 2022, the number of new physicians entering primary care in Arkansas declined by 6%, a trend that may have long-term consequences for access to care, particularly as current providers retire or leave practice (Arkansas Center for Health Improvement, 2024).

The ongoing primary care workforce shortages are compounded by structural and systemic challenges that make accessing primary care difficult for many Arkansas residents. One of the biggest barriers is the chronic underfunding of primary care services and limitations in fee-for-service payment models, which restrict providers' ability to meet patient needs. The declining workforce means patients frequently experience long wait times for primary care appointments due to a lack of available clinicians. Funding for graduate medical education (GME) has also failed to keep pace with the state's needs — as residency training programs remain concentrated in hospitals rather than in community-based primary care settings. The increasing administrative burden created by electronic health records and insurance documentation requirements further limits the time providers can dedicate to direct patient care. Additionally, insufficient funding for primary care research has hindered the ability to implement evidence-based improvements that could enhance service delivery (Arkansas Center for Health Improvement, 2024).

The Arkansas Center for Health Improvement has published a workforce report and dashboard profiling the state's primary care workforce, detailing the number of active primary care physicians, their levels of activity, demographic trends, and payer mix. Additional analyses of graduate medical education (GME) trends indicate that the number of first-year residency slots in Arkansas has not kept pace with the number of medical graduates, though recent efforts have helped narrow this gap (Arkansas Center for Health Improvement, 2024). These findings underscore the urgent need for sustained investment in primary care workforce development to ensure adequate provider availability for Arkansas residents.

Sustaining and expanding the state's primary care workforce remains a challenge, especially given the concentration of healthcare services in urban centers. Arkansas faces a shortage of local healthcare facilities — with 21 of its 75 counties lacking a hospital — which exacerbates accessibility challenges for rural residents (Arkansas Department of Health, 2024). The disparity in healthcare provider density is also significant; rural Arkansans have nearly half the provider availability of urban residents, forcing many individuals to travel long distances for routine and specialty care (Arkansas Center for Health Improvement, 2024). While the state's uninsured rate has declined in recent years, it remains slightly above the national average at 9.2% (Kaiser Family Foundation, 2025). Given these ongoing challenges, efforts to recruit, train, and retain healthcare providers in rural Arkansas must remain a priority in order to improve healthcare access across the state.

TOPIC SPECIFIC DATA: PRIORITIES (Continued)

JEFFERSON COUNTY

Jefferson County, AR, residents face significant barriers to obtaining timely, affordable care—rooted in geography, economics and system-level constraints:

- **Geographic barriers.** Many communities beyond Pine Bluff lie 20 miles or more from primary care clinics or hospital services — limited public transit and ride-share options make even routine appointments difficult to keep.
- **Provider shortages & hospital vulnerability.** Jefferson Regional Medical Center has operated on thin margins since the pandemic, with dwindling cash reserves forcing service reductions that disproportionately affect older adults and those with chronic conditions.
- **Economic constraints.** With roughly one in four children living in poverty, families often delay preventive visits or treatment to cover basic needs — out-of-pocket costs and low reimbursement rates discourage providers from expanding services for low-income and uninsured residents.
- **Maternal-care deserts.** Many expectant mothers travel 40+ miles for prenatal check-ups, leading to delayed first visits and heightened risks during pregnancy.
- **Chronic-disease disparities.** A substantial percentage — 45% of the population — experiences higher rates of obesity, diabetes and hypertension — limited access to specialists drives preventable hospitalizations and exacerbates poor health outcomes.
- **Emerging solutions.** Local efforts — expanding Community Health Worker (CHW) programs, deploying mobile clinics and scaling telehealth — are beginning to close gaps. Still, sustained investment in transportation, workforce incentives and facility upgrades is critical to ensure every Jefferson County resident can access the care they need.

All sources referenced (Appendix A).

Mental Health

FEDERAL

At the federal level, the United States is confronting a profound and multifaceted mental health crisis. Roughly one in five adults experiences a mental illness each year, and nearly 60 million Americans — or more than 23% of adults — met the criteria for a mental health condition in the past year, with nearly 6% enduring a severe illness. Anxiety disorders remain the most common concern, but the situation is deteriorating most rapidly among young people: in 2024, 43% of adults reported greater anxiety than the year before, and among adolescents aged 12–17, diagnosed mental or behavioral health conditions have surged by over 35 percent since 2016. Between 2016 and 2023, adolescent anxiety diagnoses jumped from ten to more than sixteen percent, and depression rose from 5.8 to 8.4 percent; in 2023 alone, four in ten high school students reported persistent feelings of sadness or hopelessness, and one in five seriously considered suicide. Suicide now claims nearly 50,000 lives annually, ranking as the second or third leading cause of death for those aged ten through thirty-four, and its age-adjusted rate has climbed by more than a third since 2000.

TOPIC SPECIFIC DATA: PRIORITIES (Continued)

Yet despite these alarming trends, access to care remains woefully inadequate. Over 28% million adults with mental illness receive no treatment, and more than half of those who do seek help encounter barriers such as provider shortages, cost, inadequate insurance coverage, and stigma. Adolescents face growing obstacles, too: in 2023, six in ten young people needing counseling or treatment struggled to obtain it. Sparse insurance reimbursement further discourages providers from participating in mental health networks.

All sources referenced (Appendix A).

ARKANSAS

Arkansas is facing a significant mental health crisis, characterized by a high prevalence of mental illness, substantial barriers to accessing care, and a severe shortage of mental health professionals, particularly in rural areas. Experts and recent data paint a concerning picture of the state's mental health landscape, impacting adults, adolescents, and specific demographic groups.

Approximately one in five Arkansans experiences some form of mental illness. Statistics indicate that a significant portion of these individuals, especially those with mild to moderate conditions, do not receive necessary treatment. For instance, reports suggest that about 65.5% of residents with mild mental illness, 39% with moderate mental illness, and over 33% with severe mental illness go untreated.

A critical factor exacerbating the crisis is the severe shortage of mental health professionals. Across Arkansas, 73 out of 75 counties are designated as Mental Health Professional Shortage Areas (HPSAs). This includes a lack of psychiatrists, psychologists, licensed therapists, and social workers. The scarcity is particularly acute in rural communities — making it incredibly difficult for residents in these areas to find local treatment options..

Access to behavioral health services in Arkansas is undermined by financial, social, and geographic obstacles. Many residents cannot afford the out-of-pocket costs of treatment, and gaps in insurance coverage leave them unable to initiate or sustain care. At the same time, the stigma surrounding mental illness — fueled by fear of judgment and discrimination — discourages individuals from seeking help even when services are available. These barriers are compounded by the state's rural geography: with providers clustered in urban centers, many Arkansans must travel great distances — often without reliable transportation — to reach the nearest clinic or specialist.

Youth mental health in particular has emerged as a critical concern. Between 2016 and 2020, Arkansas recorded the third-highest rise in childhood anxiety and depression nationwide, and an annual average of 15.3% of adolescents aged 12–17 reported experiencing at least one major depressive episode in the years leading up to 2019. This surge in emotional distress among students places extraordinary demands on schools, families, and community support.

TOPIC SPECIFIC DATA: PRIORITIES (Continued)

The mental health crisis in Arkansas is closely intertwined with substance use disorders. Rising rates of opioid addiction and alcohol dependency frequently overlap with untreated depression, anxiety, and trauma—creating a dual challenge for overburdened treatment systems. Without sustained investment in prevention, early intervention, and a strengthened behavioral-health workforce, Arkansas risks deepening the mental health epidemic—particularly in its most rural communities.

All sources referenced (Appendix A).

JEFFERSON COUNTY

Jefferson County is fighting with significant mental health challenges, mirroring a broader crisis across Arkansas. These issues are characterized by limited access to care and a shortage of mental health professionals, impacting residents' ability to obtain necessary services. A key aspect of the mental health situation in Jefferson County is its designation as a Mental Health Professional Shortage Area (HPSA) by the Health Resources and Services Administration (HRSA), as of April 20, 2023. The county has received a HPSA score of 18 (out of a maximum of 25), indicating a significant shortage of mental health providers relative to the population. This shortage is a critical barrier to accessing timely and adequate mental healthcare.

While specific, current statistics on the prevalence of mental illness solely within Jefferson County are not readily available in detailed public reports, the county is part of a state where approximately 1 in 5 individuals experience mental illness, and a substantial portion do not receive treatment. Statewide issues like financial barriers, social stigma, and geographic limitations in rural areas further compound difficulties in accessing care, and these are likely reflected in Jefferson County.

A 2017 qualitative study conducted in Jefferson County — as noted in a Substance Abuse and Mental Health Services Administration (SAMHSA) report — identified various local determinants and barriers to mental wellness, underscoring long-standing concerns in the area.

All sources referenced (Appendix A).

Chronic Disease

FEDERAL

The United States is grappling with a widespread and increasing prevalence of chronic diseases, which are long-term conditions that significantly impact health, daily life, and longevity. These factors include: 1) *High Incidence*: A substantial majority of Americans — approximately 6 out of 10 — live with at least one chronic illness, and 4 out of 10 manage two or more. This includes conditions like heart disease, cancer, diabetes, and obesity, all of which have become more common over the last two decades; 2) *Leading Cause of Death*: Chronic diseases are responsible for 8 of the top 10 causes of death in the US, with heart disease and cancer being particularly deadly; 3) *Massive Financial Strain*: These conditions are the primary drivers of healthcare spending in the U.S. — accounting for roughly 90% of the nation's annual healthcare expenditures, which total around \$4.5 trillion. This also leads to significant productivity losses.

TOPIC SPECIFIC DATA: PRIORITIES (Continued)

4) *Preventable Risk Factors*: Many chronic diseases are linked to common, modifiable behaviors such as smoking, unhealthy diets, lack of physical activity, and excessive alcohol consumption; and 5) *Access Concerns*: There are ongoing challenges in ensuring sufficient access to primary care — which is vital for early detection and management.

All sources referenced (Appendix A).

ARKANSAS

Arkansas contends with one of the nation’s highest burdens of chronic disease. In 2023, more than four in ten adults — 42.5% — reported a diagnosis of hypertension — well above the national rate of 34.0%. Hyperlipidemia is similarly widespread: 40.2% of Arkansans have been told their cholesterol is high — compared to 36.9% nationwide. Coronary heart disease and related cardiovascular conditions affect roughly 12.1% of adults — placing Arkansas among the bottom five states for CVD prevalence. Meanwhile, 14.5% of adults live with diabetes — well above the U.S. average of 11.5%. These chronic conditions drive Arkansas’s poor overall health standing: the state ranks 48th nationally in America’s Health Rankings — a composite of outcome and determinant measures.

The persistent high prevalence of these diseases translates to elevated rates of hospitalization, long-term disability, and premature death, imposing substantial strain on Medicaid budgets, rural health systems, and the broader economy. Without targeted, strategic action — broadening preventive screenings, reinforcing primary care in rural communities, and rolling out community-driven, evidence-based programs — chronic disease will persistently fuel Arkansas’s high morbidity and mortality and impose a steep economic burden on the state.

All sources referenced (Appendix A).

JEFFERSON COUNTY

Jefferson County, Arkansas, bears a disproportionate burden of chronic illness — exceeding national and state averages in both prevalence and severity. A substantial proportion of adults here contend with multiple chronic conditions — ranging from arthritis, asthma, and chronic kidney disease to COPD, cardiovascular disease, cancer, depression, and diabetes. In fact, the county’s rate of residents living with three or more chronic diseases surpasses the U.S. average.

Premature death in Jefferson County mirrors statewide patterns — with heart disease and cancer leading the toll. Yet locally, these conditions exact an even heavier price, reflecting deeper socioeconomic and demographic pressures. Nearly 40% of adults are classified as obese, and almost a third report no leisure-time physical activity — both key drivers of chronic illness. Compounding these risks, significant levels of poverty and food insecurity limit many families’ ability to afford nutritious food and preventive care, further fueling the cycle of chronic disease.

All sources referenced (Appendix A).

COMMUNITY HEALTH INITIATIVES

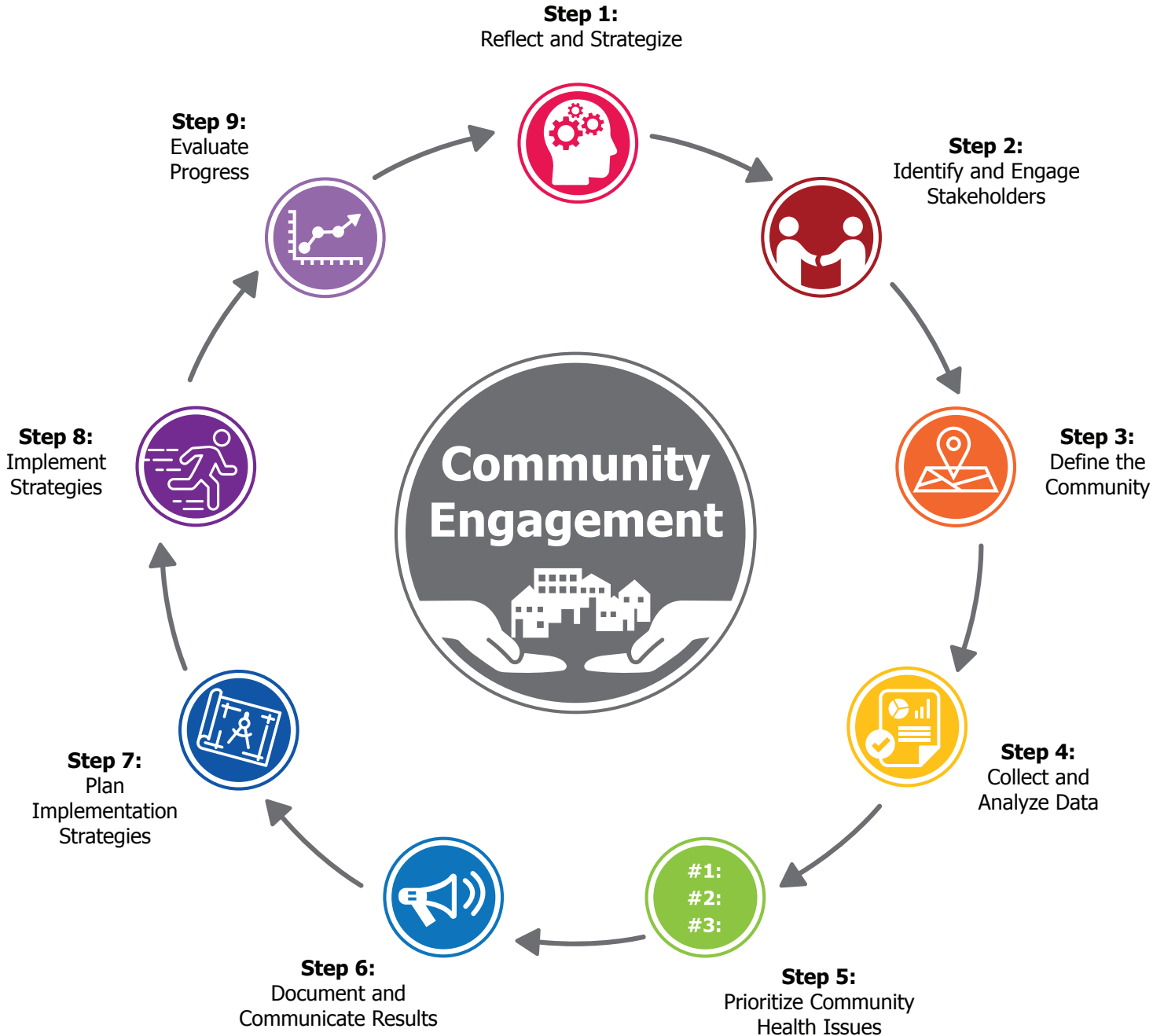


Jefferson Regional Medical Center (JRMC) actively promotes wellness across Jefferson County and its neighboring communities by sponsoring health fairs, offering health education programs, providing free screenings, and hosting a variety of other outreach events.

Communities throughout Arkansas — particularly in the Southeast region — confront deep socioeconomic challenges that directly affect health outcomes. Jefferson Regional Medical Center aligns its initiatives with its mission, vision, and values by targeting the root causes of poor health — from limited access to services to economic instability. By addressing the various dimensions of these root causes, we not only improve individual well-being but also build broader economic resilience and growth in our communities.

Additionally, Jefferson Regional Medical Center currently participates in several health outreach efforts through its affiliation with the Arkansas Rural Health Partnership (ARHP). The Arkansas Rural Health Partnership (ARHP) is a non-profit horizontal hospital and economic development organization composed of 19 Arkansas rural hospitals, 4 Federally Qualified Health Centers (FQHCs), and 3 teaching medical institutions. This unique network is the largest healthcare service provider in the area and serves as a hub for economic growth and development across the region. ARHP efforts aim to support and improve existing healthcare infrastructure, while strengthening healthcare delivery across rural South Arkansas. The Arkansas Rural Health Partnership is committed to strengthening the ecosystem of rural communities across South Arkansas by engaging in transformative conversations, partnerships, and initiatives.

Community Engagement Process



<http://www.healthycommunities.org/Education/toolkit/files/community-engagement.shtml#.XEnj7bLru70>

CHNA Facilitation Process

The Community Health Needs Assessment (CHNA) Toolkit — developed by the National Center for Rural Health Works at Oklahoma State University and the Center for Rural Health in collaboration with the Oklahoma Office of Rural Health — guided the CHNA facilitation process (National . This structured approach involved two community meetings coordinated by a facilitator and a steering committee responsible for establishing and overseeing a Community Advisory Committee (CAC). The CAC comprised approximately 30–40 community members who participated actively throughout the assessment to formulate a strategic plan addressing the community’s health priorities.

Public participation is a cornerstone of the CHNA process. Initially, the Jefferson Regional staff steering committee met with Arkansas Rural Health Partnership (ARHP) representative Lynn Hawkins, to strategize community involvement. Key members of the Jefferson Regional steering committee included Brian Thomas, Peter Austin, and Wendy Talbot. Together with ARHP staff, they facilitated the organization of hybrid community meetings and collaborated closely on developing both the community health needs assessment and the subsequent strategic implementation plan.

Given the extensive size of the service area, the steering committee chose to utilize a focused group comprising community leaders and professionals from health-related sectors. The Jefferson Regional staff steering committee identified and invited approximately 30 community members to serve on this Community Advisory Committee. All invited participants attended the initial advisory committee meeting — where ARHP staff delivered an educational presentation outlining the CHNA process. During this initial gathering, participants reviewed health statistics pertinent to the service area and individually completed the 2025 Community Health Needs Assessment survey.

Advisory committee members actively assisted in distributing surveys, reaching out to neighbors, colleagues, and friends — thus ensuring broad community engagement. Additionally, electronic surveys were available through the Jefferson Regional and ARHP websites, as well as various local community platforms.

Once survey responses were gathered, the ARHP team analyzed the data to facilitate the presentation of key findings during the committee’s second meeting. At this follow-up session, committee members reviewed survey results, engaged in group discussions regarding critical health issues identified, and collaboratively prioritized community health concerns. These priorities formed the foundation of a comprehensive implementation plan developed by the staff steering committee to generate measurable community benefits.

Implementation of these strategic action plans will occur over a three-year period, with the hospital steering committee convening annually with the advisory committee to monitor progress and make necessary adjustments.

2025 COMMUNITY HEALTH NEEDS ASSESSMENT

(Continued)

Steering Committee

- Brian Thomas, *President & Chief Executive Officer, Jefferson Regional*
- Peter Austin, *Senior Vice President & Chief Operating Officer, Jefferson Regional*
- Wendy Talbot, *Vice President & Chief Experience Officer, Jefferson Regional*
- Mellie Boagni, *President & Chief Executive Officer, Arkansas Rural Health Partnership*
- Lynn Hawkins, *Chief Operating Officer, Arkansas Rural Health Partnership*
- Camille Watson, *Chief Program Officer, Arkansas Rural Health Partnership*

Community Advisory Committee

Pat Tate	Neighbor to Neighbor	n2nptate@gmail.com
Sandra Brown	Jefferson Comprehensive Care System	sbrown@jccsi.org
Cheryl Smith	EASI	csmith@easimedics.com
John Proctor	SEARK	jproctor@seark.edu
Rosemary White	Pine Bluff Specialty Hospital	rosemary.white@jeffersonrsh.com
Allison Thompson	Jefferson County Alliance	allison@jeffersoncountyalliance.com
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Roosevelt Brown	Family Church of Pine Bluff	rbrown@familychurch.ws
Dianne Wood	Pursuit Church	diannewood4548@gmail.com
Ellen Horton	Jefferson Regional (Urgent Care)	hortonel@jrmc.org
Regina Quarles	Jefferson Regional (Director of Clinic Operations)	quarlesr@jrmc.org
Kim West	Pine Bluff School District	kimberley.west@pinebluffschoools.org
Chris Hart	Central Moloney	chart@centralmoloneyinc.com
Dr. Celeste Alexander	Arts & Science Center for Southeast Arkansas	calexander@artx3.org
Kevin Crumpton	Group Violence Intervention Program	kevin.crumpton@cityofpinebluff-ar.gov
Emily Rushing	Jefferson Regional (Social Worker)	emily.mcallister@jrmc.org
Melissa Koonce	Jefferson Regional Jones-Dunklin Cancer Center APRN	koonceme@jrmc.org
Leanne Carter	Jefferson Regional (Primary Care)	carterl@jrmc.org
Melissa Robertson	ARCare	Melisa.Robertson@arcare.net
Mary Daggett	Jefferson Regional Specialty Hospital	mary.daggett@jeffersonrsh.com

2025 COMMUNITY HEALTH NEEDS ASSESSMENT

(Continued)

Community Advisory Committee (Continued)

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Brian Thomas	Jefferson Regional (CEO & CHNA Steering Committee)	thomasb@jrnc.org
Wendy Talbot	Jefferson Regional (CXO & CHNA Steering Committee)	talbotw@jrnc.org
Lynn Hawkins	Arkansas Rural Health Partnership (CHNA Steering Committee)	lynnhawkins@arruralhealth.org
Michelle Powell	Jefferson Regional	powellmi@jrnc.org
Peter Austin	Jefferson Regional	austinp@jrnc.org
Jeremy Jeffery	Jefferson Regional	jefferyj@jrnc.org
Layton Anderson	Jefferson Regional	andersonla@jrnc.org
Karen Blevins	Jefferson County OEM	karenblevins@jeffersoncounty911.com
Lawrence Fikes	Pine Bluff Community Foundation	pinebluffarea@arcf.org

RESULTS OVERVIEW: 2025 COMMUNITY HEALTH NEEDS ASSESSMENT

There were **291** completed surveys through Jefferson Regional’s 2025 Community Health Needs Assessment process. All of the results of the survey can be found in *Attachment D*.

TOP ISSUES IDENTIFIED

Accessibility to Healthcare Services.

Respondents identified multiple barriers limiting access to healthcare, including high costs, provider shortages, lack of insurance, language barriers, and, notably, transportation challenges. Addressing these barriers comprehensively, especially transportation issues, will significantly improve community health outcomes.

Mental Health Services.

The survey findings underscored mental health as a critical area of concern — emphasizing the dual needs for improved access to services and greater community awareness of available resources.

Chronic Disease.

Respondents expressed significant concern over the impact of chronic diseases on individual well-being and the overall health of the community. These combined factors underscore the urgent need for targeted interventions in prevention, early detection, and effective management of chronic conditions.

2025-2028: JEFFERSON REGIONAL CHNA STRATEGIC IMPLEMENTATION PLAN

The 2025–2028 Strategic Implementation Plan serves as an action-driven framework to address the priority health issues identified in the Jefferson Regional Community Health Needs Assessment (CHNA). This plan is currently being developed through a collaborative effort between Arkansas Rural Health Partnership (ARHP) and the Jefferson Regional Board of Directors, with ongoing progress reports submitted to the Internal Revenue Service in compliance with federal regulations. As part of this initiative, hard copies of the assessment are available upon request at Jefferson Regional, and the full report is also accessible online via the Jefferson Regional website. Additionally, Arkansas Rural Health Partnership is in the process of expanding this strategic plan to incorporate input from all ARHP member hospitals. Through shared funding, resource allocation, and regional collaboration, the implementation plan is expected to drive significant community health improvements across the Arkansas Delta region. This multi-year strategic initiative remains in progress — with an emphasis on enhancing healthcare access, addressing disparities, and fostering long-term sustainability for rural health systems throughout the regions.

Priority 1. Access to Healthcare.

OBJECTIVE 1. IMPROVING ACCESSIBILITY TO HEALTHCARE SERVICES.

- Recruit specialty and primary care providers based on identified service gaps.
- Strengthen partnerships with local clinics and health systems to expand primary care options.
- Promote awareness of available healthcare services, facilities, and support programs through community outreach, printed materials, and digital platforms.

OBJECTIVE 2. ADDRESS NON-CLINICAL BARRIERS TO ACCESS.

- Complete the Warrior Lodge, a housing facility for cancer patients receiving long-term care at Jefferson Regional.
- Advocate at the state and national levels for the continued support of the 340B Drug Pricing Program, which provides essential access to medication for underserved patients.
- Deploy Arkansas Rural Health Partnership (ARHP)'s Community Health Workers (CHWs) to support care coordination, resource navigation, and follow-up.
- Increase education and visibility of local transportation options to healthcare appointments.
- Share information about after-hours and weekend care options available within the region

2025-2028: JEFFERSON REGIONAL CHNA STRATEGIC IMPLEMENTATION PLAN (Continued)

Priority 2. Mental Health.

OBJECTIVE 1. EXPAND MENTAL & BEHAVIORAL HEALTH SERVICES.

- Continue the development and capacity expansion of Jefferson Regional Specialty Hospital to address regional gaps in behavioral health services.
- Invest in mental health workforce development, including hiring and training to increase patient access and reduce wait times.

OBJECTIVE 2. BUILD & STRENGTHEN COMMUNITY PARTNERSHIPS.

- Collaborate with local and statewide mental health service providers to expand regional offerings.
- Actively participate in the ARHP Mental/Behavioral Health Task Force to align on strategies and share resources.
- Offer Mental Health First Aid (MHFA) training in schools, colleges, and community organizations through ARHP to build awareness, reduce stigma, and promote early intervention.

2025-2028: JEFFERSON REGIONAL CHNA STRATEGIC IMPLEMENTATION PLAN (Continued)

Priority 3. Chronic Disease.

OBJECTIVE 1. IMPROVE ACCESS TO CHRONIC DISEASE MANAGEMENT & PREVENTION.

- Continue robust chronic disease case management through population health teams.
- Increase public education campaigns around preventive screenings for hypertension, diabetes, and cancer, and ensure availability across the region.
- Host community-wide health fairs and mobile screening events in collaboration with partners.
- Expand diabetes education services and integrate community-level interventions.
- Launch the ARHP Food Pharmacy in Jefferson County to provide nutritious food to patients managing chronic illnesses.
- Utilize social media and digital platforms to share “Healthy Tips” videos and physician-led educational content.

OBJECTIVE 2. PROVIDE NAVIGATION & FOLLOW-UP SUPPORT.

- Expand patient navigation services using ARHP Community Health Workers for chronic disease follow-up and education.
- Implement systematic follow-up phone calls for patients discharged from acute care settings to ensure follow-up appointments and continuity of care.
- Provide real-time support for hospitalized patients flagged for chronic conditions, ensuring discharge planning includes connections to long-term resources.

Monitoring & Evaluation

Jefferson Regional Medical Center will: 1) Track measurable outcomes tied to each objective (e.g., provider recruitment numbers, patient navigation touchpoints, MHFA sessions held); 2) Regularly review and revise the implementation plan based on community feedback and health outcome data; and 3) Publish annual updates on progress to promote transparency and maintain community trust.

QUALIFICATIONS OF THE REPORT PREPARER

Arkansas Rural Health Partnership (ARHP) was founded by a handful of rural hospital leaders who knew the significance and stabilizing force of home, community, and local healthcare. ARHP members recognized early on that if they wanted to continue to shape the health, wellness, and lives of their communities, they had to work together — hand-in-hand with local leaders, other rural healthcare providers, state and federal partners, and community members themselves — to truly address the needs of rural south Arkansas residents. Since its inception, ARHP has become a reference point and model for rural health innovation and collaboration across the state and nation. As an organization, ARHP is committed to paving the road for rural communities to come together and turn the tide for rural healthcare — across rural south Arkansas and beyond.

Lynn Hawkins, Chief Operations Officer; Caleb Cox, Senior Program Evaluation Specialist; and Camille Watson, Chief Projects Officer, were designated to serve as leads on Jefferson Regional’s 2025 Community Health Needs Assessments due to their expertise in rural healthcare, as well as data collection, analysis, and evaluation.

ABOUT THE ARKANSAS RURAL HEALTH PARTNERSHIP

The Arkansas Rural Health Partnership (ARHP) is a non-profit horizontal hospital and economic development organization composed of 19 Arkansas rural hospitals, 4 Federally Qualified Health Centers (FQHCs), and 3 teaching medical institutions. This unique network is the largest healthcare service provider in the area and serves as a hub for economic growth and development across the region. ARHP efforts aim to support and improve existing healthcare infrastructure while strengthening healthcare delivery across rural Arkansas.

The following documentation of Jefferson Regional’s 2025 Community Health Needs Assessment presentations, agendas, attendance, and survey results is included in the following attachments, which can be found at the end of this report:

- **Attachment A.** Community Advisory Committee Education PowerPoint Presentation.
- **Attachment B.** Community Advisory Committee Meeting Agenda.
- **Attachment C.** Community Advisory Attendance Roster.
- **Attachment D.** Community Advisory Committee Meeting PowerPoint Presentation & 2025 Jefferson Regional Survey Results.
- **Attachment E.** 2025 CHNA Implementation Plan
- **Attachment F.** Organizational Chart

Jefferson Regional

COMMUNITY HEALTH NEEDS ASSESSMENTS 2025

Advisory Committee
Informational
Meeting

MEETING AGENDA

- ❖ Introductions
- ❖ Overview of the Community Health Needs Assessment (CHNA)
 - Why do we do it?
 - What is it?
- ❖ The Community Health Needs Assessment Process
- ❖ Next Steps
- ❖ Questions

Jefferson Regional is a not for profit private 501(c) 3 organization because:

- Allows the hospital to be eligible to participate in the Special Medicaid Assessment Program which increases Medicaid reimbursements.
- Allows fewer regulations than a public organization.
- Receives a variety of tax exemptions from federal, state, and local governments.

**WHY DO WE DO A
COMMUNITY HEALTH
NEEDS ASSESSMENT?**



In return, the Internal Revenue Service (IRS) mandates that, like other non-profit organizations benefiting from this status, community benefit must be center to the mission of a non-profit hospital.

COMMUNITY BENEFIT MEANS . . .

According to the Internal Revenue Service (IRS) community benefit means programs and services are designed to address identified needs and improve community health and must meet at least one of the following criteria:

- Improve access to healthcare services;
- Enhance health of the community;
- Advance medical or health knowledge; or
- Relieve/reduce the burden of other community efforts.

THEREFORE, ALL NON-PROFIT HOSPITALS MUST . . .

- Conduct a formal community health needs assessment every three years.
- Widely publicize these assessment results by the end of the fiscal year.
- Adopt an implementation strategy to meet needs identified by the assessment.
- Provide the Secretary of the Treasury with an annual report of how the organization is addressing the needs identified in each community health needs assessment.

Failure to meet the new requirements in any taxable year will result in a \$50,000 excise tax as well as possible revocation of the tax-exempt status.

THE CHNA PROCESS



<http://www.healthycommunities.org/Education/toolkit/files/community-engagement.shtml#.XEnj7bLru70>

COMMUNITY ENGAGEMENT IS CENTRAL . . .

Benefits for Your Hospital

- A clearer understanding of the community (health issues, availability of resources).
- Strengthened bonds between community and hospital; increased collaboration.
- Greater community buy-in and a sense of shared commitment to community health.
- Stronger relationships with individuals/organizations that are assets for improving community health.
- Healthier communities where individuals have access to care; potentially leading to lower costs for the hospital.

Benefits for Your Community

- A different perspective of the community and the hospital's role in health promotion.
- Improved communication between community and hospital.
- Potential community coalitions/collaborative improvement efforts.
- The ability to apply knowledge and experiences to improve the health of the community.
- The opportunity for leadership development and capacity-building.
- The potential for a healthier community.

Everyone that was invited was deliberately chosen to participate in this process.

- ❖ Others may be identified prior to the next meeting.

We are looking for community members who:

- ❖ Represent different community interests and sectors.
- ❖ Bring different strengths and/or resources to support the process.
- ❖ Are energetic, committed and willing to collaborate.

IDENTIFY & ENGAGE STAKEHOLDERS | STEP ONE

While Jefferson Regional serves patients primarily from Jefferson County, patients served by the hospital include residents from neighboring Arkansas counties.

DEFINE THE COMMUNITY | STEP TWO

ATTACHMENT A. Community Advisory Committee Education PowerPoint Presentation (Continued)

- ❖ Surveys include sections about overall health, you & your family's health, you & your community, and demographic questions about the respondent.
- ❖ Advisory Committee will be instrumental in gathering data through surveys.
- ❖ Surveys will be available on Jefferson Regional website and Facebook page. Also available by text & email. Surveys are confidential & open now.
- ❖ All data will be compiled & presented at next meeting on Monday, May 19, 2025.

COLLECT & ANALYZE DATA

STEP THREE

NEXT STEPS . . .

- ❖ Complete the survey (If you provided your email address, we will email you the link to the survey.)
- ❖ Talk to your friends and family about the survey and ask them to complete it.
- ❖ Talk to your friends and family about their health care concerns for the community.
- ❖ Attend meeting #2 on May 19, 2025 at 12:00 p.m.
- ❖ At next meeting we will 1) Review data collected; 2) Identify key health concerns to address; and 3) Outline a plan to address concerns over the next 3 years.

THANK YOU!

Arkansas Rural Health
Partnership

MEETING AGENDA

- ❖ Introductions
- ❖ Overview of the Community Health Needs Assessment (CHNA)
 - Why do we do it?
 - What is it?
- ❖ The Community Health Needs Assessment Process
- ❖ Next Steps
- ❖ Questions

ATTACHMENT C.

Community Advisory Attendance Roster

NAME	OCCUPATION	EMAIL	MEETING #1	MEETING #2
Pat Tate	Neighbor to Neighbor	n2nptate@gmail.com	Yes	Yes
Sandra Brown	Jefferson Comprehensive Care System	sbrown@jccsi.org	Yes	
Cheryl Smith	EASI	csmith@easimedics.com	Yes	
John Proctor	SEARK	jproctor@seark.edu	Yes	Yes
Rosemary White	Pine Bluff Specialty Hospital	rosemary.white@jeffersonrsh.com	Yes	
Allison Thompson	Jefferson County Alliance	allison@jeffersoncountyalliance.com	Yes	Yes
Rhonda Hall	Jefferson County Health Department	rhonda.hall@arkansas.gov		Yes
Jaimie Wright	University of Arkansas at Pine Bluff	wrightjd@uapb.edu	Yes	Yes
John Lawson	Express Employment	John.Lawson@expresspros.com	Yes	
Lauren Bland	Area Agency on Aging	lbland@aaasea.org		Yes
Letetia Jenkins	Jefferson Regional (Nursing Director)	jenkinsl@jrnc.org	Yes	Yes
Beverly Gray	Arkansas Blue Cross Blue Shield	bygray@arkbluecross.com	Yes	Yes
Tavante Calhoun	Boys & Girls Club	tcalhoun@boysgirlsclubjc.org		Yes
Roosevelt Brown	Family Church of Pine Bluff	rbrown@familychurch.ws	Yes	Yes
Dianne Wood	Pursuit Church	diannewood4548@gmail.com	Yes	Yes
Ellen Horton	Jefferson Regional (Urgent Care)	hortonel@jrnc.org	Yes	Yes
Regina Quarles	Jefferson Regional (Director of Clinic Operations)	quarlesr@jrnc.org	Yes	
Kim West	Pine Bluff School District	kimberley.west@pinebluffschoools.org	Yes	
Chris Hart	Central Moloney	chart@centralmoloneyinc.com	Yes	
Dr. Celeste Alexander	Arts & Science Center for Southeast Arkansas	calexander@artx3.org	Yes	Yes
Kevin Crumpton	Group Violence Intervention Program	kevin.crumpton@cityofpinebluff-ar.gov		Yes
Emily Rushing	Jefferson Regional (Social Worker)	emily.mcallister@jrnc.org	Yes	Yes
Melissa Koonce	Jefferson Regional Jones-Dunklin Cancer Center APRN	koonceme@jrnc.org	Yes	
Leanne Carter	Jefferson Regional (Primary Care)	carterl@jrnc.org	Yes	Yes
Melissa Robertson	ArCare	Melisa.Robertson@arcare.net	Yes	Yes

ATTACHMENT C.

Community Advisory Attendance Roster (Continued)

NAME	OCCUPATION	EMAIL	MEETING #1	MEETING #2
Mary Daggett	Jefferson Regional Specialty Hospital	mary.daggett@jeffersonrsh.com	Yes	Yes
Shantonio Elliott	Archwell Health	shantonio.elliott@archwellhealth.com	Yes	Yes
Brian Thomas	Jefferson Regional (CEO & CHNA Steering Committee)	thomasb@jrmc.org	Yes	Yes
Wendy Talbot	Jefferson Regional (CXO & CHNA Steering Committee)	talbotw@jrmc.org	Yes	Yes
Lynn Hawkins	Arkansas Rural Health Partnership (CHNA Steering Committee)	lynnhawkins@arruralhealth.org	Yes	Yes
Michelle Powell	Jefferson Regional (CNO)	powellmi@jrmc.org	Yes	
Peter Austin	Jefferson Regional	austinp@jrmc.org	Yes	Yes
Jeremy Jeffery	Jefferson Regional	jefferyj@jrmc.org	Yes	
Layton Anderson	Jefferson Regional	andersonla@jrmc.org	Yes	
Karen Blevins	Jefferson County OEM	karenblevins@jeffersoncounty911.com	Yes	Yes
Lawrence Fikes	Pine Bluff Community Foundation	pinebluffarea@arcf.org		Yes

Jefferson Regional COMMUNITY HEALTH NEEDS ASSESSMENT

2025

MEETING AGENDA

01

Introductions

02

The CHNA Process

03

Survey Results

04

Discussion/Plans

05

Questions



THE CHNA PROCESS



<http://www.healthycommunities.org/Education/toolkit/files/community-engagement.shtml#.XEnj7bLru70>

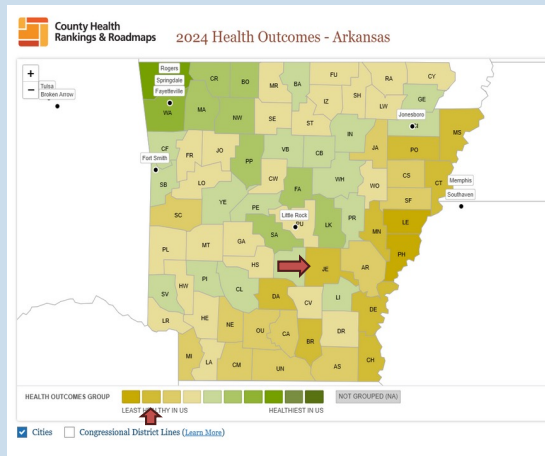
While Jefferson Regional serves patients primarily from Jefferson County, patients served by the hospital include residents from neighboring Arkansas counties.

DEFINE THE COMMUNITY | STEP THREE

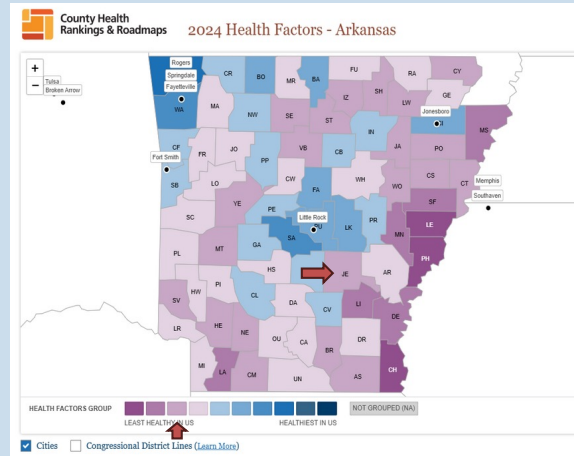
JEFFERSON COUNTY, ARKANSAS

Based on the County Health Rankings by the University of Wisconsin Population Health Institute, Jefferson County, located in Arkansas' Delta region, consistently ranks low in overall health outcomes. This aligns with a trend of poorer health seen across the Delta due to factors like higher chronic disease rates, unhealthy behaviors, and socioeconomic challenges such as poverty. Jefferson County's low health rankings and concerning data on obesity, inactivity, and poverty exemplify this pattern of poorer health in the Delta

HEALTH OUTCOMES



HEALTH FACTORS



WHO IS JEFFERSON COUNTY?

Key insights per the CHNA Survey

291 SURVEY RESPONSES

66%

of the respondents were from Jefferson County. Additional responses were received from Arkansas, Ashley, Bradley, Chicot, Cleveland, Dallas, Desha, Drew, Garland, Grant, Lincoln, Lonoke, Saline, Pulaski, St. Francis, Stone, and unspecified counties were also represented.

75.9%

of respondents were female. Male (21.6%) and undisclosed respondents (2.4%) accounted for remaining survey completions.

Ages 46-75

The 3 largest respondent age groups were 46- 55 (23.7%), 56- 65 (23.4%), and 66-75 (24.1%). However, there were responses received from the remaining age groups, 36 to 45 (12.7%) 18-25 (3.1%), 26-35 (5.8%), and 76-85 (7.2%)

61.2%

The largest racial group represented was White (61.2%). Black/African American (30.6%), Hispanic or Latino (.03%) and undisclosed respondents (7.9%) made up a smaller portion of participants.

- *Black/African American representation in the survey was notably lower than expected given the county's demographic makeup, thus, limiting the validity of survey responses. Additionally, it may also indicate a gap in engagement that may reflect broader barriers to participation in healthcare discussions.*

DATA COLLECTION PROCESS

The assessment was conducted through multiple methods to maximize engagement and ensure broad representation:

- digital outreach via social media platforms
- traditional word-of-mouth methods
- direct interactions with healthcare providers
- online surveys
- community events
- local businesses

Surveys were made available from April 9th to May 6th.

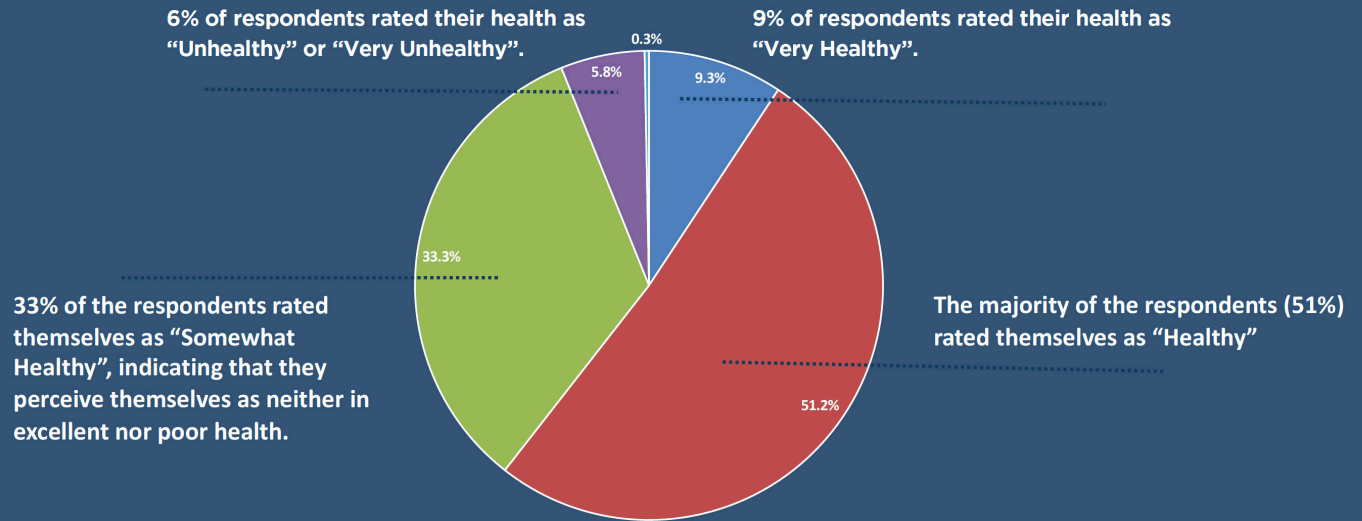
COLLECT & ANALYZE DATA | **STEP FOUR**

DATA ANALYSIS

- **Survey responses (N=291) were analyzed to assess community health priorities—focusing on representation across key demographic groups, including gender, age, and race.**
- **The analysis ensured that results accurately reflected the community's perspectives; however, demographic comparisons revealed certain gaps—highlighting opportunities for more targeted outreach to improve representation among specific populations.**

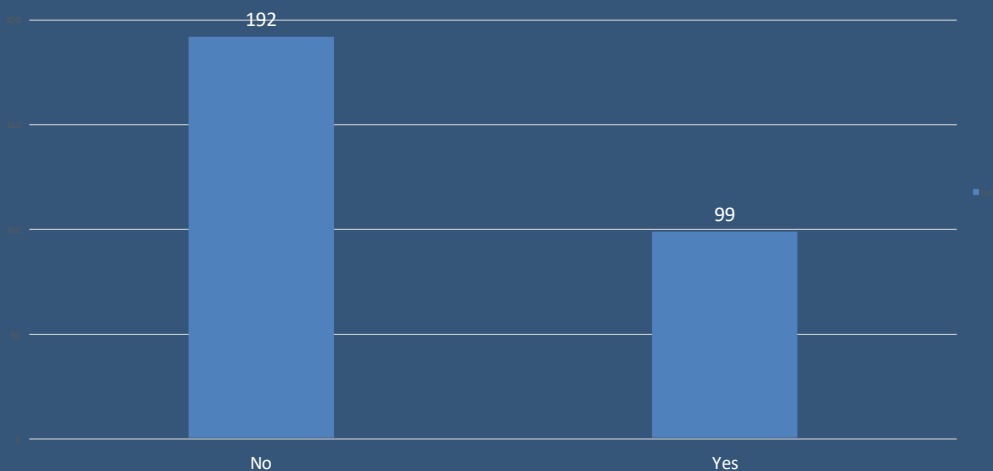
COLLECT & ANALYZE DATA | **STEP FOUR**

**PERSONAL HEALTH PERCEPTION:
OVERALL, HOW WOULD YOU RATE YOUR PERSONAL HEALTH?**



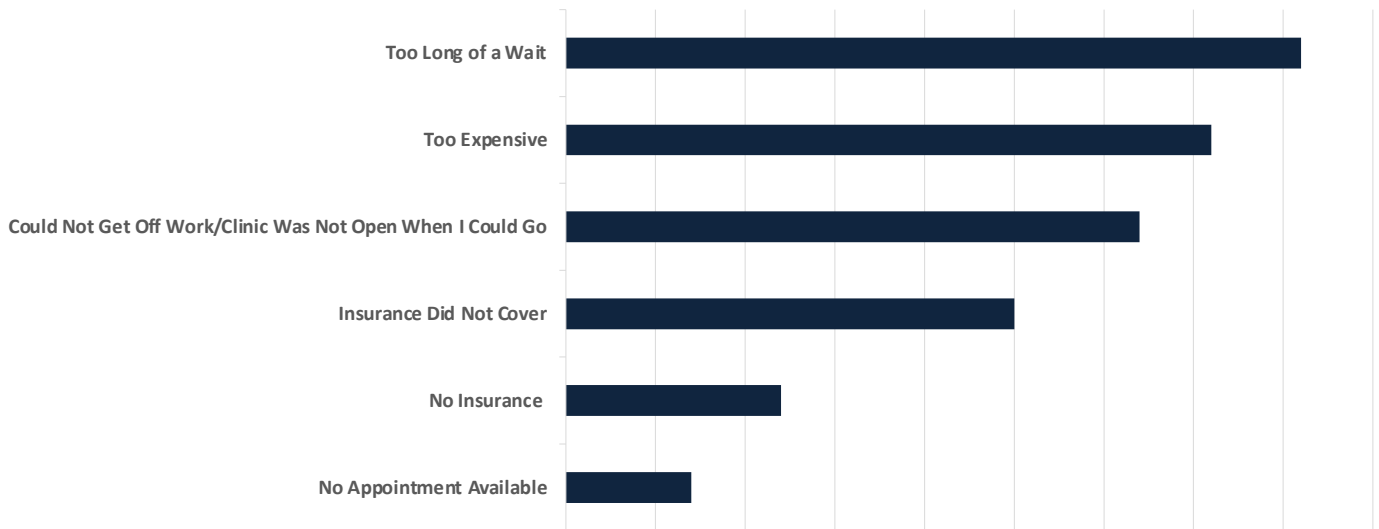
Key Insight: The majority perceive themselves as very healthy or somewhat healthy.

**PERSONAL HEALTH :
DID YOU OR SOMEONE IN YOUR HOUSEHOLD GO WITHOUT HEALTHCARE OR DELAYED RECEIVING HEALTHCARE IN THE PAST THREE YEARS. ?**

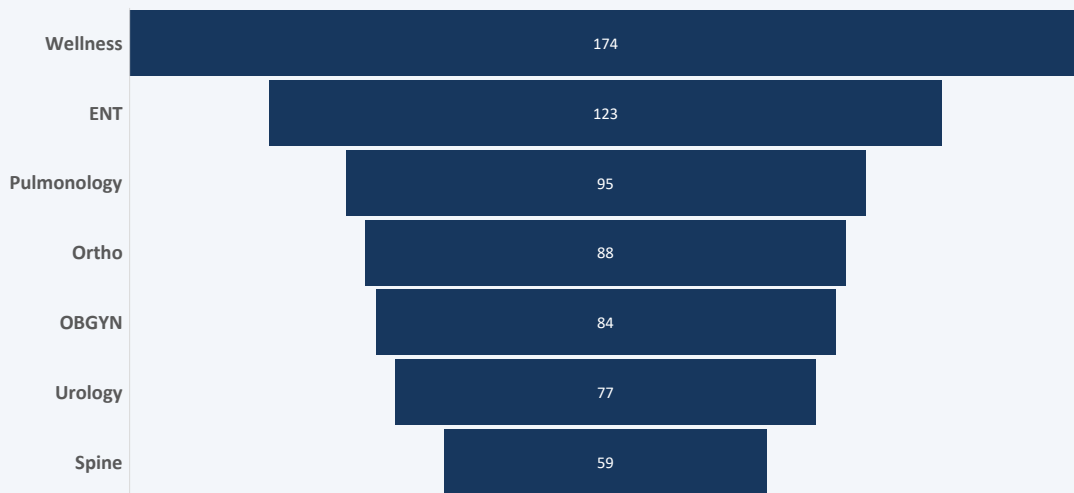




WHEN ASKED WHY HEALTHCARE WAS NOT RECEIVED, THE MOST NOTABLE RESPONSES ARE IDENTIFIED BELOW

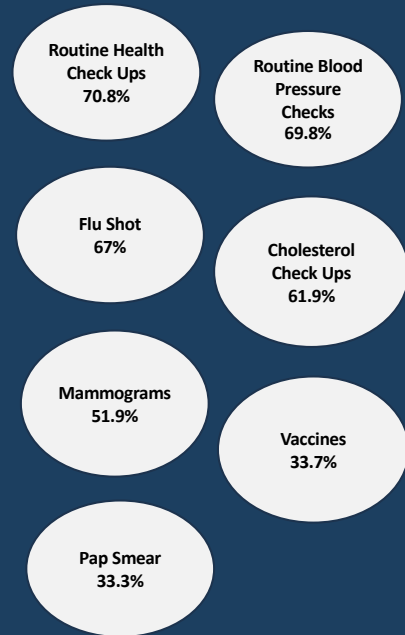


**MOST NEEDED HEALTHCARE SERVICES:
WHAT HEALTHCARE SERVICES WOULD YOU USE IF THEY WERE AVAILABLE?**



• Respondents were asked which healthcare services they would use if they were more accessible. The most frequently requested services are reflected in the funnel chart above.

USE OF PREVENTATIVE HEALTH SERVICES:
Preventative testing and services help to prolong the length of living and can lead to early diagnosis of serious health problems. Which of the following services have you used in the past year?

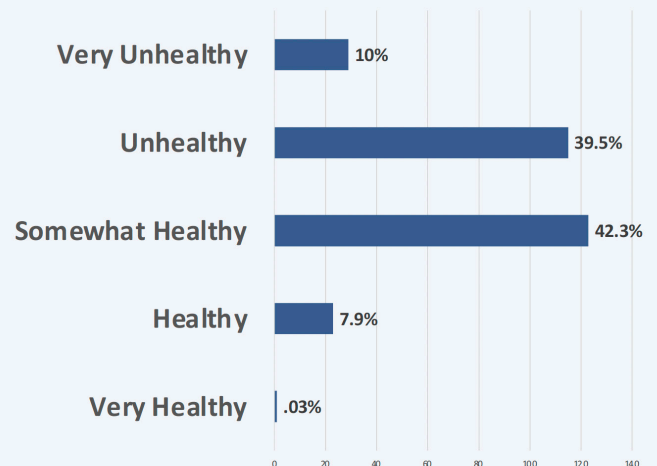


Key Insight: While most respondents actively engage in preventive healthcare of some sort, only 3.1% do not use any preventive services, which increases the risk of undiagnosed conditions.

**PERCEPTION OF COMMUNITY HEALTH:
HOW WOULD YOU RATE THE GENERAL HEALTH OF YOUR COMMUNITY?**

When asked to rate the general health of their community:

- 42.3% of respondents believe their community is "Somewhat Healthy", 39.5% for "Unhealthy", and 10% "Very Unhealthy", aligning with concerns about healthcare access and chronic conditions.
- This highlights a notable contradiction between respondents' views of their personal health, previously noted (51% rated themselves "Healthy" and 9% "Very Healthy"), compared to their perceptions of their community's health.

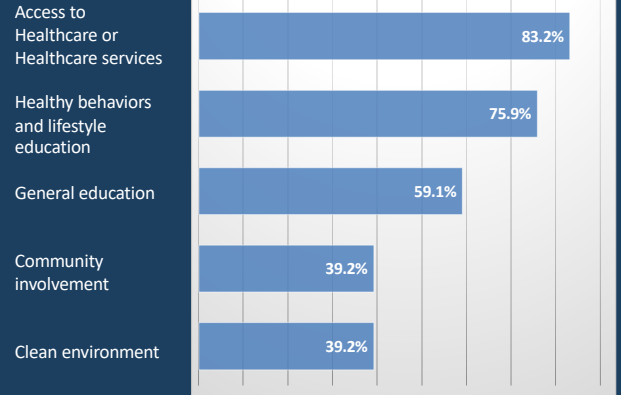


Key Insight: This discrepancy suggests that while individuals feel they manage their personal health effectively, they recognize broader systemic health issues impacting their community.

KEY FACTORS FOR A HEALTHY COMMUNITY: SELECT THE MOST IMPORTANT FOR CREATING A HEALTHY COMMUNITY.

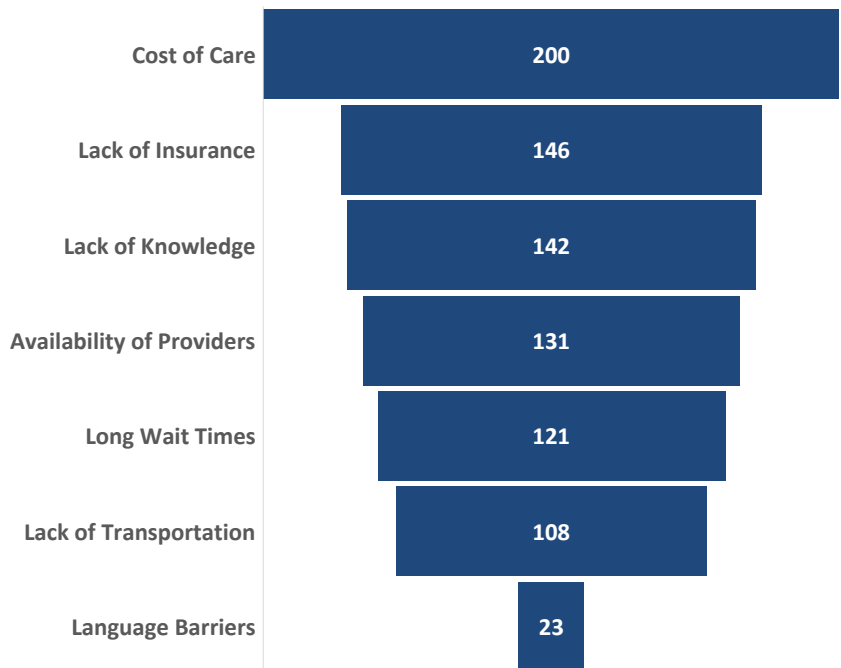
Respondents identified the most important elements for a healthy community:

- Access to Healthcare or Healthcare Services was considered the most important factor for creating a healthy community by the largest percentage of respondents (83.2%).
 - *This strongly emphasizes the perceived significance of accessible healthcare.*
- Healthy Behaviors and Lifestyle Education was the second most important factor, selected by 75.9% of respondents.
 - *This highlights the community's recognition of the role of education, healthy food choices, and a safe environment for physical activity in promoting health. While "access to healthy food" was selected at only 1.5% by the respondents, this could likely be addressed here.*
- General Education (51.9%), Community Involvement (39.2%), and Clean Environment (39.2%) were considered essential but had a lower response rate.
 - *This indicates these factors are seen as having a moderate level of importance in creating a healthy community.*



BARRIERS TO HEALTHCARE ACCESS: WHAT ARE THE BIGGEST CHALLENGES TO ACCESSING HEALTHCARE IN YOUR COMMUNITY?

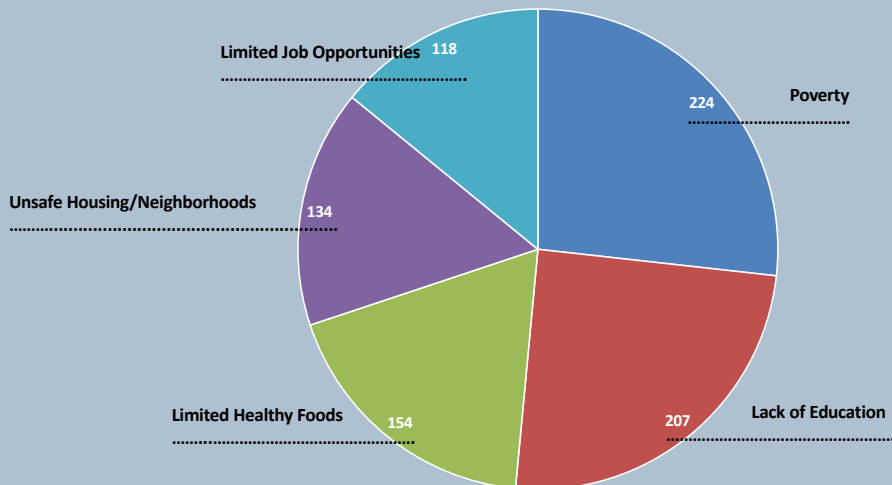
• **Key Insight:** Responses indicate primary challenges to healthcare access in the community are financial (cost of care and lack of insurance), informational (lack of knowledge), and logistical (availability of providers, long wait times, and lack of transportation). Language barriers appear to be a less widespread issue compared to the other factors.



ATTACHMENT D. Community Advisory Committee Meeting PowerPoint Presentation & 2025 Jefferson Regional Survey Results (Continued)

PERSPECTIVE ON FACTORS THAT CONTRIBUTE MOST TO HEALTH CONCERNS IN THE COMMUNITY

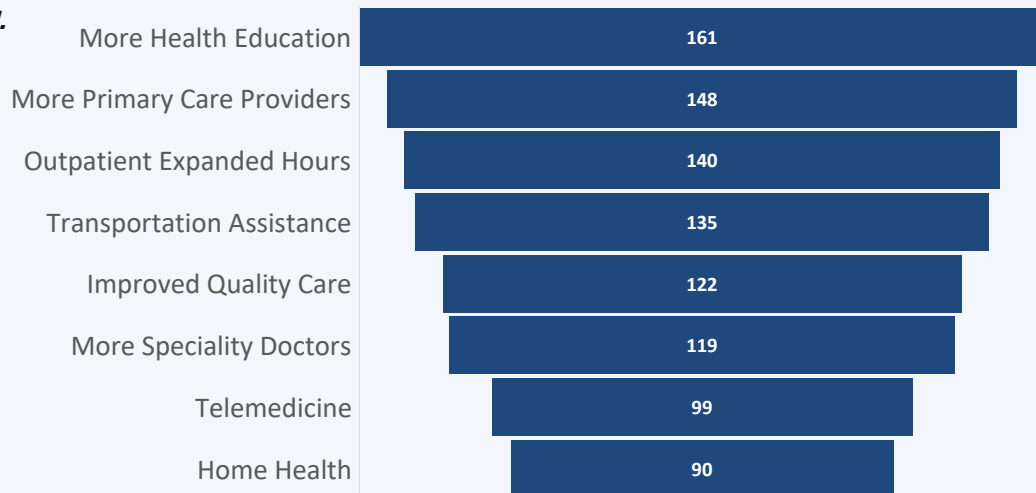
Respondents identified the health concerns below as the most that contribute:



Key Insight: Respondents viewed poverty as the most substantial driver of health concerns in the community, followed by lack of education. Limited access to healthy foods and unsafe housing/neighborhoods are also considered important contributing factors, while limited job opportunities are perceived as having a less direct impact on overall community health compared to the other factors listed.

Community Perspective on how to improve the community's access to health care.

When asked about what would improve the community's access to health care the following results were provided.

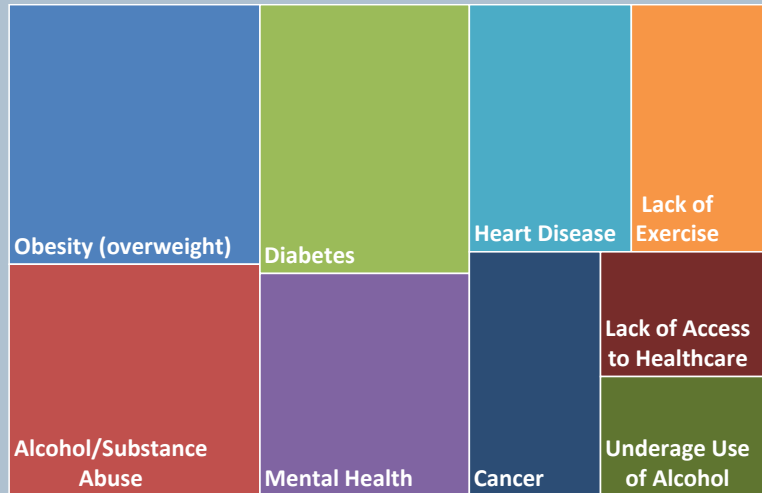


Key Insight: The community perceives that increasing health education, the availability of primary care, expanded hours and providing transportation assistance would most significantly improve their access to healthcare.

ATTACHMENT D. Community Advisory Committee Meeting PowerPoint Presentation & 2025 Jefferson Regional Survey Results (Continued)

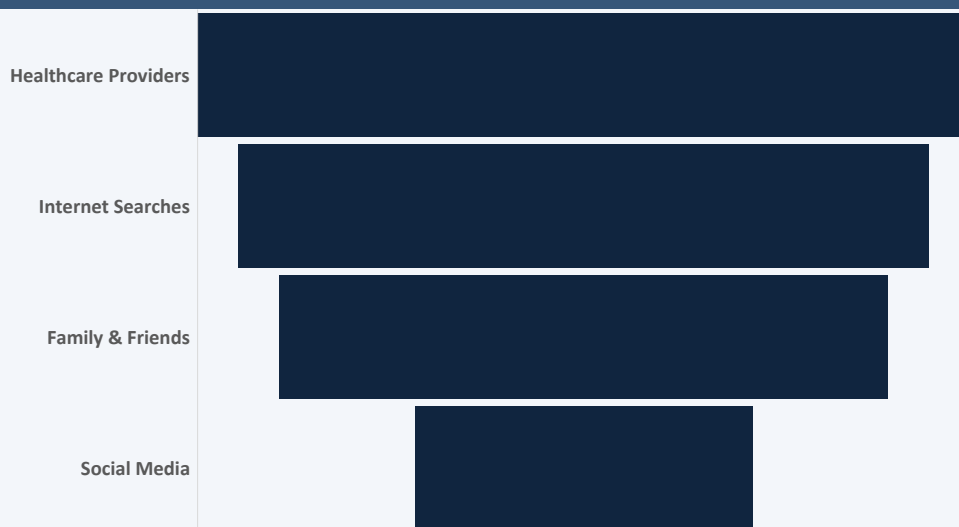
PERSPECTIVE ON MAJOR HEALTH CONCERNS IN THE COMMUNITY:
 IN THE FOLLOWING LIST, WHAT DO YOU THINK ARE THE THREE MOST SERIOUS HEALTH CONCERNS IN YOUR COMMUNITY?

Respondents identified the most serious health concerns affecting their community:



Key Insight: Chronic diseases such as diabetes, obesity, and alcohol/substance abuse, and mental health are perceived as the primary health threats. Obesity and diabetes are typically preventable through diet, exercise, and early intervention. Alcohol/substance abuse and mental health are a complex set of problems that need to be addressed. Additionally, significant concerns about heart disease, cancer, underage use of alcohol, and limited healthcare access point to a broader need for comprehensive, community-driven health initiatives addressing both physical and behavioral health.

When asked how the respondents typically receive information regarding available health services, the replies were



In summary, the slide highlights a multi-faceted approach to information dissemination, with **healthcare providers being the most influential source, followed by online resources and personal networks**. Traditional media and community groups also contribute to how people learn about available health services, but this was a less common response in the survey.

Community Insights: A Qualitative Perspective

LACK OF ACCESS TO MENTAL HEALTH SERVICES

Mental Health is a major problem in our area.
....services need to be easily accessible, where to get these services should be common knowledge

TRANSPORTATION BARRIERS TO HEALTHCARE

Needs to be access to transportation other than SEAT
The majority of the population are not “well off” financially and have difficulty with transportation.

EDUCATION ON HEALTHCARE AND HEALTHY LIFESTYLES RESOURCES

Pine Bluff needs more outreach into the poor families to get people to the doctor
Education on healthy lifestyles seems very important
People just don't eat right
Little desire to improve lifestyles and eating habits.

• Improve Accessibility to Healthcare Services

- Respondents identified multiple barriers limiting access to healthcare, including high costs, provider shortages, lack of insurance, language barriers, lack of knowledge on available services (especially specialty services), transportation challenges. Addressing these barriers comprehensively will significantly improve community health outcomes.

• Mental Health

- The survey highlighted a perceived gap in the accessibility and availability of mental health services, suggesting the needs to prioritize this need. Addressing mental wellness is therefore crucial to improving overall community health outcomes.

• Chronic Disease

- Respondents identified chronic diseases such as obesity, diabetes, and heart disease as major health challenges in the community. Focusing on education, prevention, and treatment compliance will greatly impact the community's health.

PRIORITIZE COMMUNITY HEALTH ISSUES | STEP FIVE

- **Jefferson Regional must adopt an implementation strategy before the 15th day of the fifth month after the end of the taxable year in which the hospital finishes conducting the CHNA.**

<https://www.irs.gov/charities-non-profits/community-health-needs-assessment-for-charitable-hospital-organizations-section-501r3>

DOCUMENT & COMMUNICATE RESULTS | **STEP SIX**

THIS IS AN ONGOING PROCESS

- **Develop work groups**
- **Create measurable action plan recommendations based upon key themes identified (15 minutes)**
- **Consider potential barriers for implementation.**
 - **SWOT Analysis, etc.**

PLAN IMPLEMENTATION STRATEGIES | **STEP SEVEN**

- **Arkansas Rural Health Partnership will provide Jefferson Regional with the Community Health Needs Assessment Report by June 16, 2025.**
- **ARHP and Jefferson Regional Steering Committee will draft the implementation plan and communicate back to the advisory committee.**
- **Conduct annual progress assessment with the advisory committee.**

**IMPLEMENT STRATEGIES &
NEXT STEPS**

STEP EIGHT

THANK YOU!

Arkansas Rural Health
Partnership

Jefferson Regional COMMUNITY HEALTH NEEDS ASSESSMENT

2025

- **Jefferson Regional must adopt an implementation strategy before the 15th day of the fifth month after the end of the taxable year in which the hospital finishes conducting the CHNA.**

<https://www.irs.gov/charities-non-profits/community-health-needs-assessment-for-charitable-hospital-organizations-section-501r3>

DOCUMENT & COMMUNICATE
RESULTS | **STEP SIX**

Community Health Needs Assessment 2025

- CHNA 2025 identified the following needs and ranked them by priority:
 - Access to Healthcare
 - Mental Health
 - Chronic Disease
 - Alcohol & Substance Abuse
 - Health Education
 - Transportation
- Implementation strategies were developed collaboratively between Jefferson Regional & the Arkansas Rural Health Partnership.

Community Health Needs Assessment 2025 Prioritized Need: Access to Healthcare

Objective 1: Expand Provider Access and Community Awareness

- Recruit specialty and primary care providers based on identified service gaps.
- Strengthen partnerships with local clinics and health systems to expand primary care options.
- Promote awareness of available healthcare services, facilities, and support programs through community outreach, printed materials, and digital platforms.

Community Health Needs Assessment 2025 Prioritized Need: Access to Healthcare

Objective 2: Address Non-Clinical Barriers to Access

- Complete the **Warrior Lodge**, a housing facility for cancer patients receiving long-term care at Jefferson Regional.
- Advocate at the state and national levels for the continued support of the 340B Drug Pricing Program, which provides essential access to medication for underserved patients.
- Deploy **ARHP Community Health Workers (CHWs)** to support care coordination, resource navigation, and follow-up.
- Increase education and visibility of **local transportation options** to healthcare appointments.

Community Health Needs Assessment 2025 Prioritized Need: Mental Health

Objective 1: Expand Mental and Behavioral Health Services

- Continue the development and capacity expansion of **Jefferson Regional Specialty Hospital** to address regional gaps in behavioral health services.
- Invest in **mental health workforce development**, including hiring and training to increase patient access and reduce wait times.

Community Health Needs Assessment 2025 Prioritized Need: Mental Health

Objective 2: Build and Strengthen Community Partnerships

- Collaborate with local and statewide mental health service providers to expand regional offerings.
- Actively participate in the **ARHP Mental/Behavioral Health Task Force** to align on strategies and share resources.
- Offer **Mental Health First Aid (MHFA)** training in schools, colleges, and community organizations through ARHP to build awareness, reduce stigma, and promote early intervention.

Community Health Needs Assessment 2025 Prioritized Need: Chronic Disease

Objective 1: Improve Access to Chronic Disease Management and Prevention

- Continue robust **chronic disease case management** through population health teams.
- Increase public education campaigns around **preventive screenings** for hypertension, diabetes, and cancer, and ensure availability across the region.
- Host **community-wide health fairs and mobile screening events** in collaboration with partners.
- Expand **diabetes education services** and integrate community-level interventions.
- Launch the **ARHP Food Pharmacy** in Jefferson County to provide nutritious food to patients managing chronic illnesses.
- Utilize **social media and digital platforms** to share “Healthy Tips” videos and physician-led educational content.

Community Health Needs Assessment 2025 Prioritized Need: Chronic Disease

Objective 2: Provide Navigation and Follow-Up Support

- Expand **patient navigation services** using ARHP Community Health Workers for chronic disease follow-up and education.
- Implement systematic **follow-up phone calls** for patients discharged from acute care settings to ensure follow-up appointments and continuity of care.
- Provide **real-time support** for hospitalized patients flagged for chronic conditions, ensuring discharge planning includes connections to long-term resources.

Community Health Needs Assessment 2025 Monitoring & Evaluation

Jefferson Regional will:

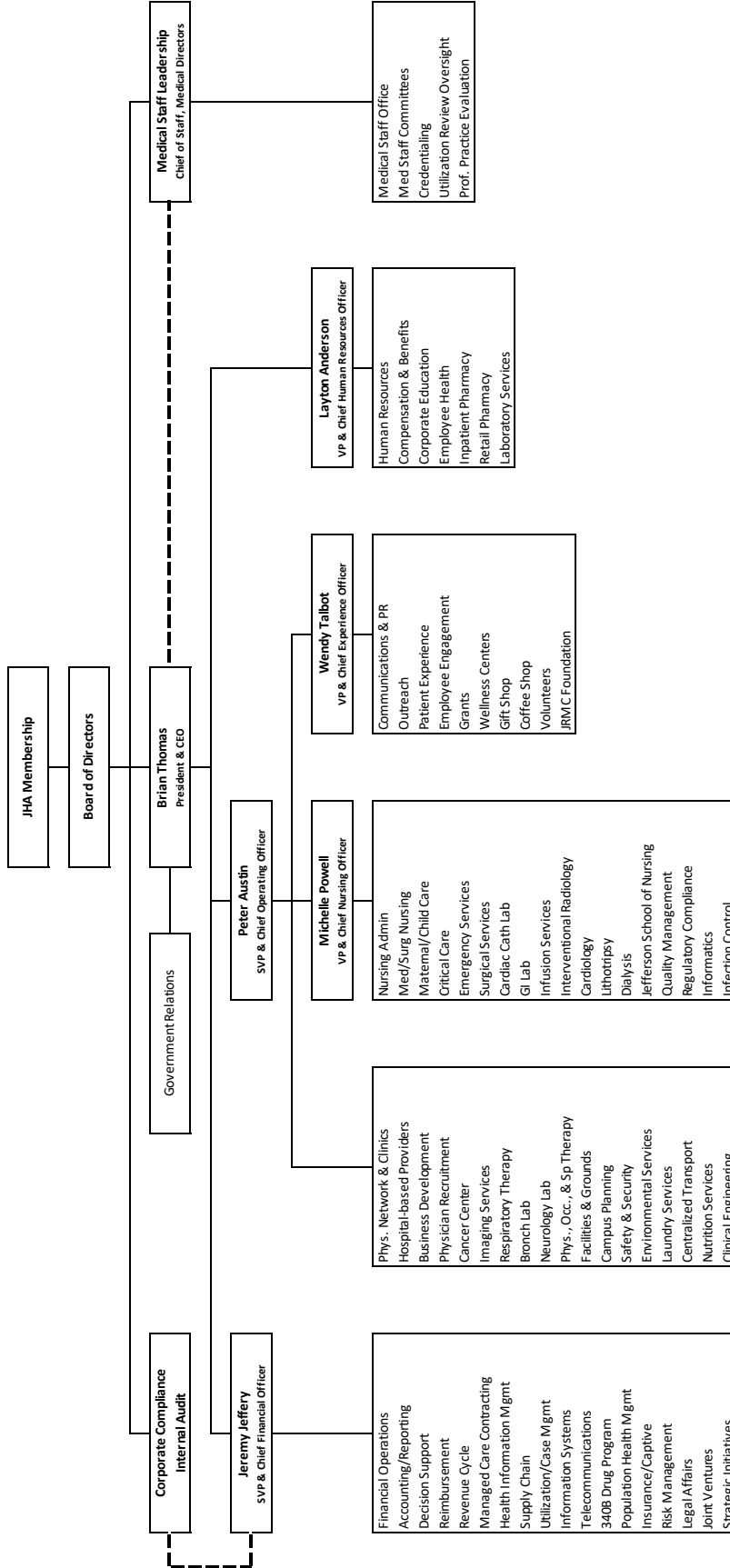
- Track measurable outcomes tied to each objective (e.g., provider recruitment numbers, patient navigation touchpoints, MHFA sessions held).
- Regularly review and revise the implementation plan based on community feedback and health outcome data.
- Publish annual updates on progress to promote transparency and maintain community trust.

Community Health Needs Assessment 2025 Conclusion

This Strategic Implementation Plan reflects Jefferson Regional’s commitment to addressing the region’s most pressing health needs through sustainable, collaborative, and community-focused initiatives. Through continued partnership with ARHP and other stakeholders, Jefferson Regional will work to ensure improved access, healthier outcomes, and a stronger support system for the communities it serves.

ATTACHMENT F. Organizational Chart

Jefferson Hospital Association, Inc. d/b/a Jefferson Regional Organization Chart



Revised: April 1, 2024

APPENDIX A. References

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APPENDIX A. References (Continued)

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**April 2026: Information was added in the following sections to include additional information about the Jefferson Regional Specialty Hospital – Introduction, About, Leadership and Healthcare Services.*

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