

# 5. Prioritized Health Needs



## Access to Care for At-Risk Persons

**Many barriers prevent people from accessing health care, especially those who are low-income, racial or ethnic minorities, or immigrants. Lack of insurance or underinsurance, scarcity of health care providers, and lack of transportation are all causes of poor access to care which can limit good health in our community.**

### National Perspective

Access to health care refers to comprehensive, timely, and quality health care services that result in the best health outcomes. Access to Appropriate Care is described in detail in Section 1 of this report as a Common Thread identified across the OHC region. In particular, vulnerable populations suffer from limited access due to a variety of structural and individual factors. Such barriers include



the high cost of care, lack of health insurance coverage or inadequate insurance coverage, scarce services, lack of personal transportation, and inadequate public transportation services. Those without care are not as able to obtain treatment for acute or chronic diseases, resulting in further exacerbation of the condition, increased cost of care, and at times reduction in quality of life and premature death.<sup>1</sup>

Although the Affordable Care Act granted 32 million Americans access to health insurance, rates of uninsured individuals still remain high nationwide. According to the 2014 National Health Interview Survey, the percentage of uninsured peoples of all ages

<sup>1</sup> U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. 2016. Health People 2020: Access to Health Services. <https://www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services>

in the U.S. in 2014 was at an estimated 11.5%. This represents a decrease from 16% in 2010, but the percentage of uninsured peoples remains high for those age 18-64 (16.3%) and for those age 65 and over (13.3%).<sup>2</sup>

Lack of access results in significant cost to both individuals and communities. As described previously in this report, a 2014 Kaiser Family Foundation Report sums up the impact: "In 2013, the cost of 'uncompensated care' provided to uninsured individuals was \$84.9 billion. Uncompensated care includes health care services without a direct source of payment. In addition, people who are uninsured paid an addition \$25.8 billion out-of-pocket for their care."<sup>3</sup>

Following the passage of the Affordable Care Act, Arkansas expanded Medicaid and has renewed this expansion for the upcoming year. From 2013 to 2014, an estimated 270,000 people became eligible for coverage and the rate of uninsurance dropped 49% in the state.<sup>4</sup>

## Justification for Health Issue

Through the application of the Logic Model and associated priority ranking process described in the Methodology section, health issues were compared side-by-side. In the Rogers Community, Access to Care was one of the prioritized health issues. This is the result of supporting evidence from secondary data, primary data from the hospitals, the feasibility to change the issue and the community readiness to change the issues.

## Secondary Data

Despite the overall reductions in rates of uninsured, the total uninsured population in the Rogers Community remains high at 16.4%, above both Arkansas (13.8%) and national percentages (12.0%). 20.7% of adults in the Rogers Community are uninsured, which is also higher than both the Arkansas (17.4%) and national percentages (14.3%). However, the percentage of uninsured children in the report area is 5.4%, which is below the national rate (6.2%) and only slightly above the state percentage (5.2%).<sup>5</sup>

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<sup>2</sup> CDC National Center for Health Statistics. 2016. Health Insurance Coverage. <http://www.cdc.gov/nchs/fastats/health-insurance.htm>

<sup>3</sup> Kaiser Family Foundation. 2014. Uncompensated Care for the Uninsured in 2013: A Detailed Examination. <http://kff.org/uninsured/report/uncompensated-care-for-the-uninsured-in-2013-a-detailed-examination/>

<sup>4</sup> Healthinsurance.org. 2016. Arkansas Medicaid. <https://www.healthinsurance.org/arkansas-medicaid/>

<sup>5</sup> US Census Bureau, Small Area Health Insurance Estimates. 2014.

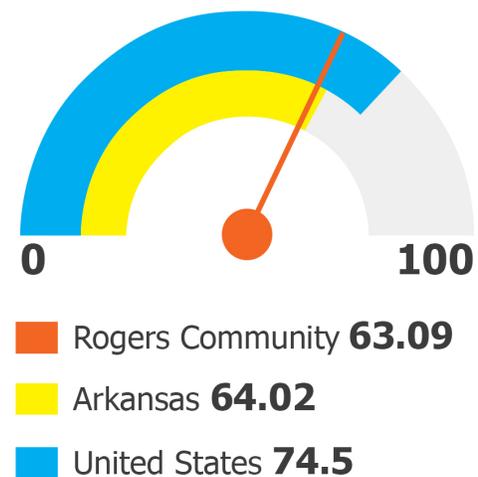
<b>Uninsured Population, 2014</b>			
<b>Report Area</b>	<b>Percent Uninsured Population under 19</b>	<b>Percent Uninsured Population 18-64</b>	<b>Percent Total Population Uninsured (under 65)</b>
Rogers Community	5.4%	20.7%	16.4%
Benton County, AR	5.6%	18.3%	14.2%
Madison County, AR	7.4%	21.4%	17.4%
Washington County, AR	6.6%	21.2%	16.9%
Adair County, OK	11.0%	32.0%	25.5%
Delaware County, OK	12.6%	26.8%	22.8%
Arkansas	5.2%	17.4%	13.8%
Oklahoma	9.1%	21.7%	17.9%
US	6.2%	14.3%	12.0%

Data Source: US Census Bureau, *Small Area Health Insurance Estimates, 2014*. Source geography: County; US Census Bureau, *Health Insurance Coverage in the United States: 2014*.

Northwest Arkansas has a relatively large population of immigrants, particularly Hispanic immigrants and migrants from the Marshall Islands. Approximately 54,000 undocumented immigrants live in Arkansas as of 2013, and 44% of these live in the Northwest Arkansas region of Benton, Washington, and Sebastian counties.<sup>6</sup> 32% of all Hispanics are uninsured<sup>7</sup> and current estimates put the uninsurance rate of Marshallese at 37%.<sup>8</sup> The legal and health status of Marshallese Islanders in Northwest Arkansas is discussed further in Part 2 of this report.

Another barrier to Access to Care is adequate numbers of primary care physicians for a population. Doctors classified as "primary care physicians" by the AMA include Family Medicine MDs and DOs, General Practice MDs and DOs, General Internal Medicine MDs and General Pediatrics MDs. Other than Washington County, which is home to a branch of University of Arkansas for Medical Science, all counties in the Rogers Community area have a profound shortage of primary care physicians. Additionally, 27% of adults reported having no primary care doctor, higher than Arkansas (23%) and the U.S. (22%).

### Primary Care Physicians, Rate per 100,000 Pop.



<sup>6</sup> Appoid SJ, et al. 2013. A Profile of Immigrants in Arkansas: Report Summary. Little Rock, AR: Winthrop Rockefeller Foundation.

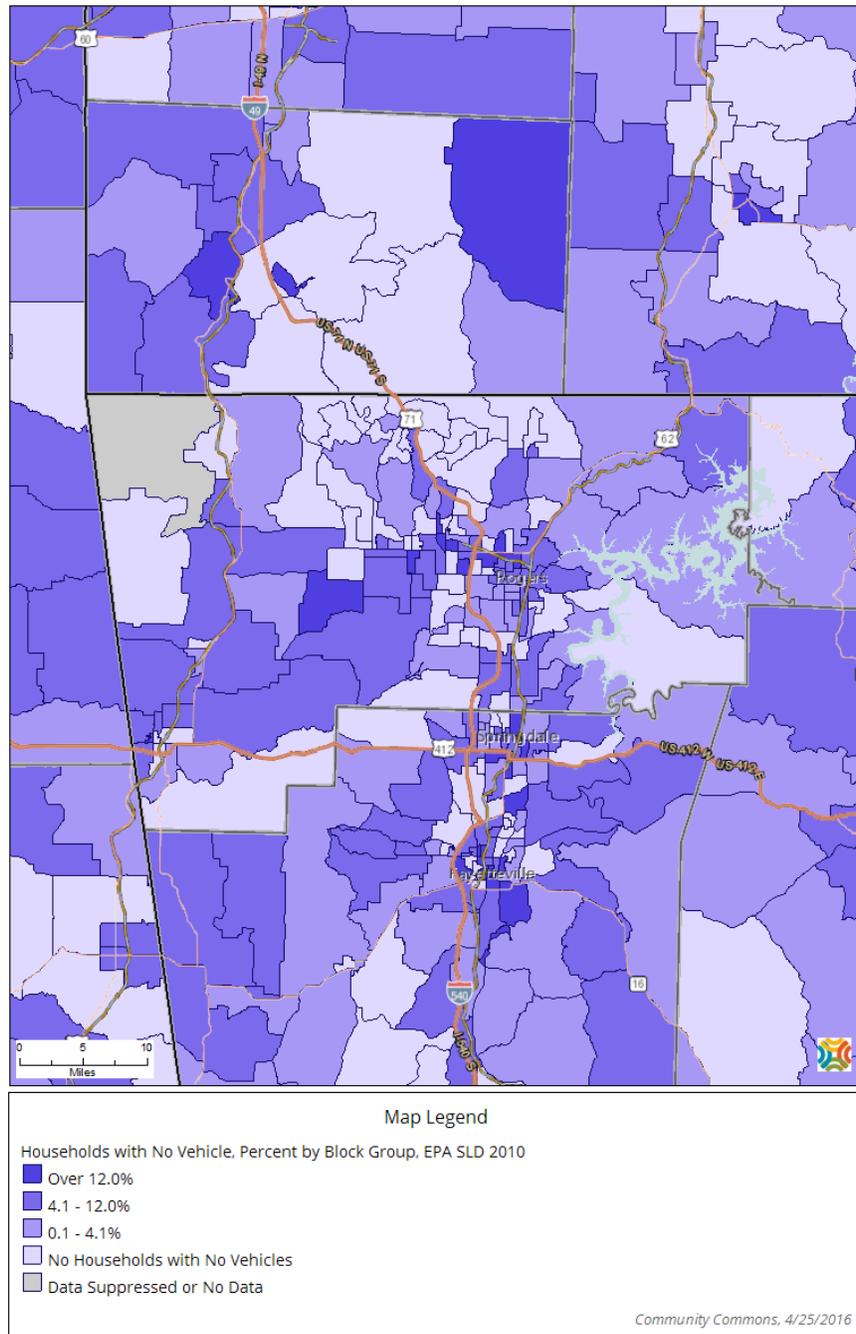
<sup>7</sup> Community Commons. 2012. Community Health Needs Assessment Secondary Data-Rogers.

<sup>8</sup> Jimeno RA. A profile of the Marshallese community in Arkansas, volume 3. Winthrop Rockefeller Foundation and University of Arkansas. 2013.

[http://www.wrfoundation.org/media/1355/immigrantstudy\\_vol3\\_resources.pdf](http://www.wrfoundation.org/media/1355/immigrantstudy_vol3_resources.pdf)

Transportation needs are high in the Northwest Arkansas and Rogers Community area, which includes many rural communities. Public transportation options are limited. An average of 4.5% of households in the Rogers Community area have no vehicle, with some census tracts exhibiting much higher rates.<sup>9</sup>

Households With No Vehicle



<sup>9</sup> Community Commons. 2014. Data Source: US Census Bureau, American Community Survey 2010-14.

## Primary Data

Of participants in the Rogers Community Health Survey conducted by Mercy Hospital, 36% reported that lack of insurance makes it hard to take care of themselves or their family's health or prevents them from seeking care. Multiple responses from participants cited the high cost of care as their reason for not being able to afford doctor visits or medication. One participant stated, "I have no insurance and health insurance costs too much. I can't pay."

## What Can We Do?

Access to care is a complex issue with many components including qualifying for health insurance, having the financial ability to purchase insurance for oneself and one's family, and being able to afford premiums, deductibles, copays, medications, and other costs. It also encompasses finding a doctor to visit, securing an appointment in a timely manner, traveling to the appointment, and being able to comply with treatment plans and follow up visits.

Mercy Hospital is committed to increasing access to care for uninsured, economically poor, and vulnerable persons, as providing care to these populations is an essential part of our mission. Strategies are being planned to address barriers to access to care at multiple levels. Mercy Hospital and Mercy Clinics have been at full capacity for the past few years as the population of the area has grown faster than the health care system. Mercy has recently announced a very significant expansion plan which includes adding new primary care and specialty clinics. Construction on four new clinics will begin soon, increasing access to appointments for all Northwest Arkansas residents. Approximately 50 new providers are projected to be hired in the next five years.

Other initiatives are underway and in the planning stages. Mercy has recently begun a partnership with the Community Clinic of Northwest Arkansas to see uninsured patients in our specialty clinics for no charge to the patient or family. This program is in its early phases and will grow and expand over the next several years. Initial plans are being developed to expand access to primary care physicians for uninsured patients in the community, and specific goals and objectives for this program will be outlined in the subsequent Community Health Improvement Plan. Free flu vaccines were given to over 300 community members last fall, most of whom met the definition of at-risk persons. The flu clinics received strong support from Mercy coworkers and from the community and will be continued this year with a goal to double the number of vaccines given. Finally, a partnership with Benton County Health Department has begun this spring to

expand access to immunizations for children and adolescents, and this program will continue to be developed.



## Behavioral Health

**Behavioral health is powerfully connected to who gets sick and who stays well. It has a tremendous impact on both individuals and families. Failure to adequately address behavioral health needs results in enormous human, social, and financial costs.**

### National Perspective

According to the U.S. Department of Health and Human Services (HHS), mental (or behavioral) health may be defined as a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community. For the purposes of



this Rogers Community report, the terms mental health and behavioral health are used interchangeably. Oppositely, mental illness is described by HHS as all diagnosable mental disorders or health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning.<sup>10</sup>

Deconstructing the challenges that face our nation—as well as the Rogers Community—reveal problems that complicate addressing the behavioral health hurdles faced by many. It is impossible to separate mental and behavioral health from other health conditions, as the mind and body are physically connected and cannot operate independently. Physical illness, especially chronic disease, and mental and behavioral health diagnoses are highly associated, and a worsening of one can exacerbate the

<sup>10</sup> U.S. Department of Health and Human Services – “Mental Health: A Report of the Surgeon General,” <https://profiles.nlm.nih.gov/ps/access/NNBBHS.pdf>

other. As stated by HHS, it is estimated that only 17% of U.S. adults are considered to be in a state of optimal mental health.<sup>11</sup> Conversely, 83% of U.S. adults exist in a state that is less than optimal related to their mental health.

Another complexity lies in the fact that access to behavioral health services is limited. Even when services are accessible, often times they are costly. Mental Health Professional Shortage Areas demonstrate the great lack of access that exists throughout our nation. It is estimated that 89.3 million Americans live in one of those shortage areas.<sup>12</sup> Where access does exist, mental health treatment services are often perceived to be costly. Kaiser Family Foundation research indicates that 45% of people not receiving mental health treatment services list cost as a barrier. Each of these challenges contributes to the widespread impact of untreated mental health issues on our communities and nation.

While untreated mental and behavioral health conditions take a significant toll on individuals and their families, there is growing recognition that they also carry a significant economic and societal burden as well. A 2008 study published in the American Journal of Psychiatry found that Serious Mental Illnesses (SMIs), which impact 6% of American adults, cost the U.S. \$193.2 billion dollars in lost earnings annually.<sup>13</sup> In the same study,

**“By treating the rest in the least-restrictive settings possible, the thinking went, we would protect the civil liberties of the mentally ill and hasten their recoveries. Surely community life was better for mental health than a cold, unfeeling institution.**

**“But in the decades since, the sickest patients have begun turning up in jails and homeless shelters with a frequency that mirrors that of the late 1800s. ‘We’re protecting civil liberties at the expense of health and safety,’ says Doris A. Fuller, the executive director of the Treatment Advocacy Center, a nonprofit group that lobbies for broader involuntary commitment standards.**

**‘Deinstitutionalization has gone way too far.’”**

*(Seven Facts about America's Mental Health System--Washington Post 2012)*

<sup>11</sup> Centers for Disease Control and Prevention, <http://www.cdc.gov/mentalhealth/basics.htm>

<sup>12</sup> Kliff, Sarah, Washington Post – “Seven facts about America’s mental health-care system,” <https://www.washingtonpost.com/news/wonk/wp/2012/12/17/seven-facts-about-americas-mental-health-care-system/>

<sup>13</sup> Kessler RC; et al, American Journal of Psychiatry – “individual and Societal Effects of Mental Disorders on Earnings in the United States: Results From the National Comorbidity Survey Replication,” <http://www.ncbi.nlm.nih.gov/pubmed/18463104>

associated medical costs and disability benefits totaled \$124.4 billion dollars. Indirect costs can be substantial and difficult to quantify. These costs include reduced educational attainment, a diminished labor pool, and greater demand on the criminal justice and social welfare systems. It is estimated that 22% of those in jail have been diagnosed with a mental illness, as have one third of homeless adults.<sup>14</sup>

## **Developmental Disabilities**

Developmental disabilities affect approximately 15% of children between the ages of 3 and 17 years. Developmental disorders can include:

- Attention Deficit Hyperactivity Disorder (ADHD)
- Autism spectrum disorder
- Cerebral palsy
- Intellectual disability
- Learning disability
- Other developmental delays.<sup>15</sup>

## **Substance Abuse**

It is estimated that 18% of Americans over the age of 18 have experienced a mental illness, and in the past year more than 8% of people have experienced a substance abuse disorder. SAMHSA states that substance abuse disorders occur when the recurrent use of alcohol and/or drugs causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home.<sup>16</sup>

Prescription drug misuse is a growing trend throughout the country. Opioid drug sales have increased four-fold from 1999 through 2010. During that same time, overdose deaths and substance abuse treatment admissions have increased six-fold.<sup>17</sup> Health systems in the OHC Region have experienced a similar trend and have treated many patients with these types of disorders. More information is needed to fully understand the causes and the impact of this trend in our population. Also needed are more treatment facilities and other resources to help address the situation and begin to reverse the trend.

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<sup>14</sup> Insel TR, American Journal of Psychiatry – “Assessing the Economic Costs of Serious Mental Illness,” – <http://www.ncbi.nlm.nih.gov/pubmed/18519528>

<sup>15</sup> Centers for Disease Control and Prevention, <http://www.cdc.gov/ncbddd/developmentaldisabilities/facts.html>

<sup>16</sup> Substance Abuse and Mental Health Services Administration, <http://www.samhsa.gov/disorders>

<sup>17</sup> Substance Abuse and Mental Health Services Administration, <http://www.samhsa.gov/prescription-drug-misuse-abuse>

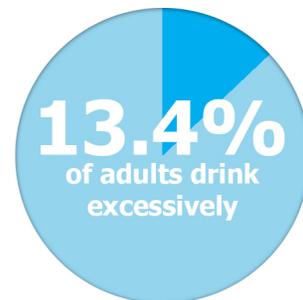
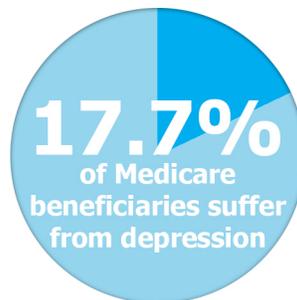
## Justification for Health Issue

Through the application of the Logic Model and associated priority ranking process, described in the Methodology section, health issues were compared side-by-side. In the Rogers Community, Behavioral Health was one of the prioritized health issues. This is the result of supporting evidence from secondary data, primary data from the hospitals, the feasibility to change the issue and the community readiness to change the issues.

### Secondary Data

This assessment provides a limited amount of data related to behavioral health and mental health for the Rogers Community.

The data for prevalence was obtained from Medicare fee-for-service population with depression. The data for mortality was from suicide rates. The source of data was Centers for Disease Control and Prevention, National Vital Statistics System.



As in all communities of the OHC Region, shortages of mental health professionals and facilities are significant. Four of five counties in the Rogers Community reporting area have mental health care facilities designated as Health Professions Shortage Areas.<sup>18</sup> Please refer to the table in section 2-10 for details.

Additional secondary data included in the Rogers Community assessment from the University of Arkansas 2015 Point-In-Time Homeless Report indicated that mental health is a significant problem among the approximately 2,500 homeless persons in the area. Of those, 63% have a history of mental illness in their lifetime, 62% are currently taking medication for mental illness, and 58% have been hospitalized for a mental illness.<sup>19</sup>

<sup>18</sup> US Department of Health & Human Services, Health Resources and Service Administration. Health Professional Shortage Areas. March 2015

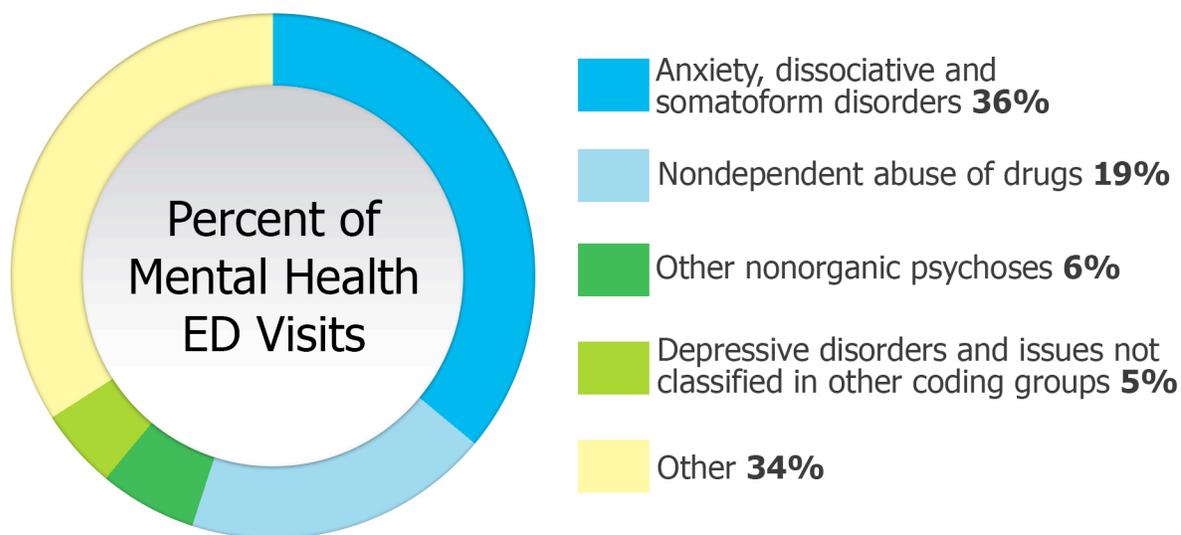
<sup>19</sup> Fitzpatrick FM, Collier S, O'Connor G. 2015 *Northwest Arkansas Homeless Report*. Community and Family Institute, University of Arkansas, 2015.

## Primary Data

Of all emergency department (ED) visits in the past year at Mercy Hospital Northwest Arkansas, mental disorders accounted for 2% of visits across all age cohorts. This percentage increased within the age 18-64 cohort to 2.6%. Mental and behavioral disorders were also common secondary diagnoses for ED visits.

This assessment process has revealed a number of limiting factors to truly understanding the mental health challenges in the Rogers Community. For example, a striking discussion among healthcare provider partners early in the data collection process determined that the path forward to assess data revealed discrepancies in data collection and tracking methods among providers. This is not unique to the OHC Region. Evaluation of mental and behavioral health needs in provider settings varies greatly according to the facility and the individual providing care.

However, the participating healthcare provider did determine a data set useful in evaluating the documented need for this assessment. For Mercy Hospital ED visits in which behavioral health was the principal diagnosis, the chart below outlines the top coded diagnoses. Participants in the Rogers focus group identified access to mental and behavioral health services as a major area of concern and an area in which further resources ought to be dedicated.



## What can we do

More information is definitely needed on the prevalence of mental health disorders and the gaps in behavioral health services in the Rogers Community and the entire OHC Region. Mercy is continuing to expand outpatient services in psychiatry, psychology, and outpatient therapy with a focus on those in greatest need in Northwest Arkansas. Mercy is also completing a grant-supported school-based research study called Join the Solution to identify mental/behavioral, physical, and basic needs of children in Northwest Arkansas and to improve access to services. Addressing mental and behavioral health needs will be a key component to improving health of our community in the future.

## Homelessness

**Homelessness is a real and significant problem in the community. It is caused by wide income disparities, poverty, and relatively high housing costs in our community.**

### National Perspective

The National Health Care for the Homeless Council defines a homeless individual as one who does not have a stable housing situation. Many living situations qualify as homelessness, including living in temporary shelters, transitional housing, on the street or in a car, or with a series of friends or extended family members.<sup>20</sup> Approximately 578,424 people experienced homelessness in the United States in 2014.<sup>21</sup> The 2015 Annual Homeless Assessment



<sup>20</sup> National Health Care for the Homeless Council. 2016. Definition of Homelessness. <https://www.nhchc.org/faq/official-definition-homelessness/>

<sup>21</sup> National Alliance to End Homelessness. 2015. The State of Homelessness in America 2015. [www.endhomelessness.org/library/entry/the-state-of-homelessness-in-america-2015](http://www.endhomelessness.org/library/entry/the-state-of-homelessness-in-america-2015)

Report to Congress (AHAR) estimated that 25% of these were children under age 18.<sup>22</sup> The racial makeup of people experiencing homeless was 49% white, 40% African-American, and 20% Hispanic.

The 2015 AHAR also distinguished between homelessness and chronic homelessness. Chronic homelessness is defined as experiencing continuous homelessness for a year or more or having had at least four episodes of homelessness in the past three years. The 2015 AHAR estimates that about 96,000 people were chronically homeless in January 2015.

Nationwide, homelessness has declined 2% between 2014 and 2015 and has decreased by 11% since 2007. Similarly, homelessness has decreased across multiple subpopulations since 2007, including individuals, families, and veterans. This decline was due in part to increased federal funding focused on permanent housing solutions, which included supportive permanent housing and rapid re-housing programs. A 2014 study conducted at the University of North Carolina-Charlotte found that providing housing for individuals who have experienced homelessness reduced emergency room visits by 81% and time spent in the hospital by 62%.<sup>23</sup> These reductions saved the Charlotte taxpayers \$2.4 million over two years. Similar studies in Florida and Colorado have produced analogous outcomes, suggesting that directly addressing the problem of homelessness improves health outcomes and is cost effective for the community.

Multiple factors, both structural and individual, contribute to homelessness. Some structural causes include low wages, unemployment, and lack of affordable housing. Individual causes include mental illness, substance abuse, relationship issues, and/or lack of social support. Those experiencing homelessness also suffer significantly from a variety of health concerns due to their disproportionate inability to receive and pay for care. Other causes of poor health among the homeless include the lack of consistent access to adequate daily hygiene, basic nutrition, and first aid. In addition, those who spend much of their time unsheltered are at high risk for exposure-related problems such as frostbite or hypothermia, which make them more susceptible to infections. Some common health concerns include mental illness, substance abuse, bronchitis, and

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<sup>22</sup> U.S. Department of Housing and Urban Development. 2015. The 2015 Annual Homeless Assessment Report (AHAR) to Congress. <https://www.hudexchange.info/resources/documents/2015-AHAR-Part-1.pdf>

<sup>23</sup> University of North Carolina-Charlotte School of Social Work. 2015. UNCC Social Work Report: Homeless Housing Program Works. <http://socialwork.uncc.edu/uncc-social-work-report-homeless-housing-program-works>

pneumonia.<sup>24</sup> Environmental and social factors exacerbate the poor health of those who are experiencing homelessness.

## Justification for Health Issue

Through the application of the Logic Model and associated priority ranking process, described in the Methodology section, health issues were compared side-by-side. In the Rogers Community, Homelessness was one of the prioritized health issues. This is the result of supporting evidence from secondary data, primary data from the hospitals, the feasibility to change the issue and the community readiness to change the issues.

## Secondary Data

In contrast to the nationwide decline of homelessness over the last few years, homelessness has significantly increased in the Rogers Community area. According to the University of Arkansas Community and Family Institute's 2015 Northwest Arkansas Homeless Report, there are an estimated 2,462 people experiencing homelessness in the region.<sup>25</sup> All of the following data and charts are drawn from this point-in-time survey and report, a detailed summary of which is included in the Appendices.

Of the 2,462 homeless persons identified in the report, 1,334 were youth under 18. There has been a 116% increase in the population of those experiencing homelessness in the area since 2007. This increase was made up predominately of children. 52% of all homeless persons in Benton and Washington counties are less than 18 years old, and almost 90% of homeless youth report that they double up with friends or relatives for shelter. The remainder of these children live in hotels or shelters. The Rogers Community area has limited housing available for women alone or women with children, representing a significant gap in service delivery to this population.

28% of homeless persons living in Northwest Arkansas are considered chronically homeless. The median time spent homeless was 12 months. Many of those experiencing homelessness reported that personal relationships and job loss/income issues were the main reasons for their homelessness. The median income was about \$600 per month and 36% reported that their main source of income was from some form of full or part time work. However, the main reason cited for not doing any paid work in the past week was poor health, followed by lack of available work and lack of transportation.

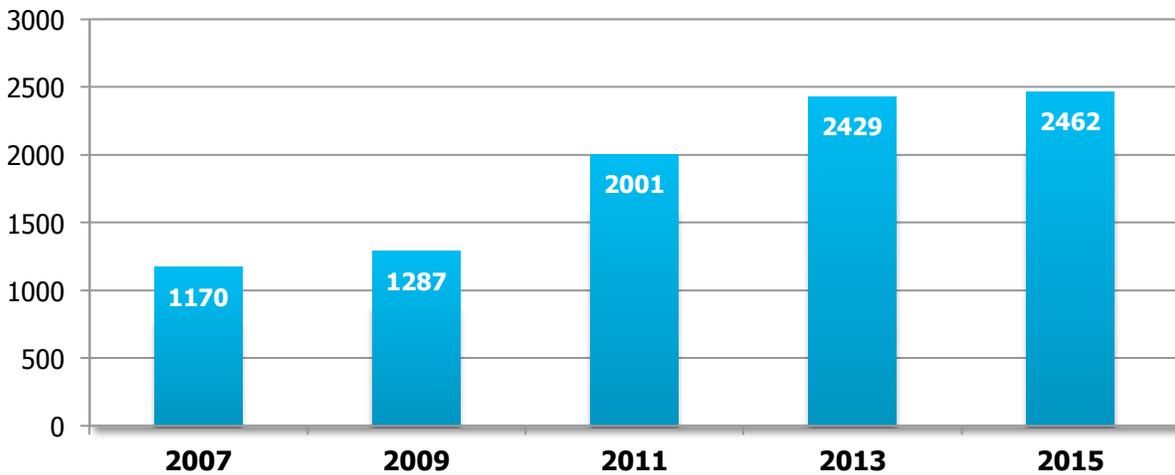
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<sup>24</sup> National Institutes of Health. 2016. Homeless Health Concerns. <https://www.nlm.nih.gov/medlineplus/homeleshealthconcerns.html>

<sup>25</sup> Fitzpatrick FM, Collier S, O'Connor G. 2015 *Northwest Arkansas Homeless Report*. Community and Family Institute, University of Arkansas, 2015

A majority of homeless persons in the area reported fair or poor health. Because of lack of finances and transportation, 41% say they have been unable to reach a doctor during times when they needed one. 70% of those in the area report living with at least one disability, while more than 50% report one or more chronic disability. 67% are overweight, while 63% have a history of mental illness. In addition to high instances of substance abuse, mental health disorders, physical and sexual abuse, and violence, environmental risk factors related to homelessness worsen already existing health problems.

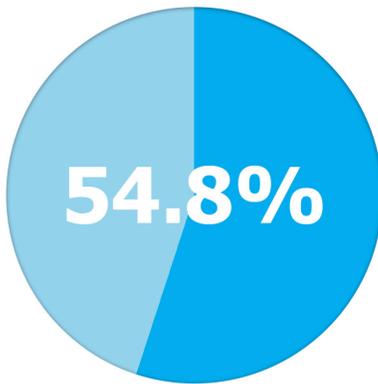
**NWA Point-In-Time  
Estimate of Homeless Persons 2007-2015**



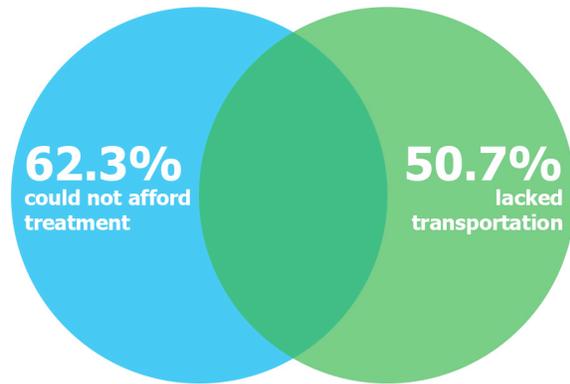
<b>Point-In-Time Total Persons Counted</b>	
<b>Data Source</b>	<b>2015</b>
<b>Survey Responses: Homeless Adults and Accompanying Youth</b>	
Adults (18 years and over, responded to survey)	512
Youth under 6 living with respondents, not present for survey	139
<b>School-Age Youth and Parents/Guardians</b>	
School-age youth reported by school districts	1,195
Parents/guardians of youth attending schools*	563
<b>Estimate of Invisible Homeless**</b>	<b>53</b>
<b>TOTAL NUMBER OF HOMELESS (counted + estimated)</b>	<b>2,462</b>
Notes:	
* Projection of adults accompanying youth enrolled in local schools who reported "doubling up" with friends or relatives	
** Projection based on survey respondents who reported staying with friends and family.	

<b>Point-in-Time Chronic &amp; Disabling Conditions</b>		
<b>Type of Condition</b>	<b>N</b>	<b>%</b>
Substance Abuse (alcohol or drug)	203	39.6%
Physical Disability or Long-Term Illness	153	29.90%
Mental Illness	225	43.9%
Domestic Violence	90	17.6%
Developmental Disability	37	7.2%
HIV/AIDS	1	0.2%

**54.8% are currently being treated for a medical problem**



**41.3% say there have been times when they needed a doctor but could not go to one**



### Primary Data

Five percent of participants in the Rogers Community Health Survey conducted by Mercy Hospital Northwest Arkansas reported that housing makes it difficult to care for their health and/or prevents them from obtaining health care.

Northwest Arkansas has a relatively large population of immigrants, particularly Hispanic immigrants and migrants from the Marshall Islands. The area has large income disparities, relatively high housing costs, and a comparative lack of low-income housing. All of these factors contribute to the problem, surprising to many, of homelessness in the area.

### What Can We Do?

Although homelessness is not a traditional focus for acute care hospitals, strong interest exists at Mercy and in the Rogers Community to explore ways to address this issue. A community collaborative has been formed and outreach projects have begun to assist

homeless residents living at a local motel. From these efforts, further initiatives are being considered and programs developed in cooperation with local nonprofit organizations and churches. Homelessness is a strong social determinant of health status, and Mercy will continue to explore possible strategies and plans aimed at addressing this significant community need.



## Diabetes

**Diabetes is a common chronic illness, affecting almost one out of ten residents of the Rogers Community. Addressing diabetes and its causes can go a long way to improving overall health of the community.**

### National Perspective

Diabetes mellitus is a disease in which blood glucose or blood sugar levels are too high. There are two types of diabetes, type 1 and type 2. Type 1 diabetes can occur at any age, although it is commonly diagnosed in children or young adults. Type 1 diabetes occurs when a person's body does not make enough insulin, a hormone that is



necessary to move glucose into the cells in order to give cells energy. Type 2 diabetes, formerly known as adult-onset diabetes, is often diagnosed in middle-aged or older adults, but is increasingly being diagnosed in children. Type 2 diabetes is the more common type and occurs when a person's body does not make or use insulin well. Without insulin, too much glucose can accumulate in the blood, which can lead to other serious health problems. Those with type 2 diabetes are at a higher risk for developing serious health complications such as heart disease, kidney failure, stroke, blindness, and loss of toes, feet or legs.

Type 2 diabetes has multiple risk factors including family history, obesity, and physical inactivity. NIH-funded research has shown that type 2 diabetes can be delayed or prevented through behavioral modifications. Basic lifestyle interventions – modest weight loss and regular exercise – cut type 2 diabetes risk by 58% over 3 years in

people with prediabetes.<sup>26</sup> However, type 2 diabetes still accounts for 90% of diabetes cases nationwide and is increasing at an alarming rate due to the rise in obesity in the United States.<sup>27</sup> Although behavioral adjustments help improve the lives of some people living with type 2 diabetes, others must rely on medication to control their blood sugar levels.

In the United States, 29 million people, or one out of 11, have diabetes.<sup>28</sup> The National Institutes of Health estimates that one third of those with diabetes still do not know they have it.<sup>29</sup> Additionally, 86 million people, or one in 3 adults, have prediabetes, 9 out of 10 do not know they have it, and of these, 15-30% will develop type 2 diabetes within 5 years.<sup>30</sup> In this population, diabetes can be prevented with weight loss and moderate physical activity.

Diabetes and its effects impact far more people than those just living with the disease. Substantial direct and indirect costs to society are incurred for diabetes, including lost productivity resulting from diabetes-related morbidity and premature mortality. According to a 2012 study by the American Diabetes Association, the total estimated cost of diagnosed diabetes in 2012 is \$245 billion, including \$176 billion in direct medical costs and \$69 billion in reduced productivity.<sup>31</sup> Medical costs for people with diabetes are twice as high as for people without diabetes.

## Justification for Health Issue

Through the application of the Logic Model and associated priority ranking process, described in the Methodology section, health issues were compared side-by-side. In the Rogers Community, Diabetes was one of the prioritized health issues. This is the result of supporting evidence from secondary data, primary data from the hospitals, the feasibility to change the issue and the community readiness to change the issues.

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<sup>26</sup> National Institutes of Health. 2014. Diabetes. <http://www.nih.gov/about-nih/what-we-do/nih-turning-discovery-into-health/diabetes>.

<sup>27</sup> National Institutes of Health. 2014. Diabetes. <http://www.nih.gov/about-nih/what-we-do/nih-turning-discovery-into-health/diabetes>.

<sup>28</sup> Centers for Disease Control and Prevention. Diabetes in the United States. <http://www.cdc.gov/diabetes/pubs/statsreport14/diabetes-infographic.pdf>.

<sup>29</sup> National Institutes of Health. 2006. One-Third of Adults with Diabetes Still Don't Know They Have It. <http://www.nih.gov/news-events/news-releases/one-third-adults-diabetes-still-dont-know-they-have-it>

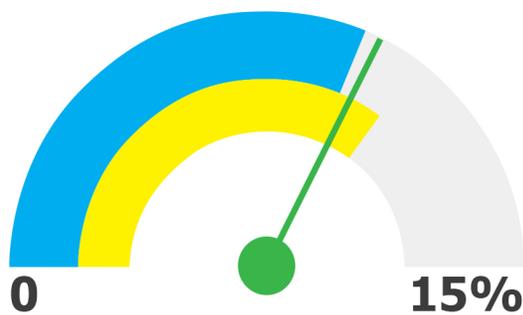
<sup>30</sup> Centers for Disease Control and Prevention. Diabetes in the United States. <http://www.cdc.gov/diabetes/pubs/statsreport14/diabetes-infographic.pdf>.

<sup>31</sup> American Diabetes Association. 2013. Economic Costs of Diabetes in the U.S. in 2012. <http://care.diabetesjournals.org/content/36/4/1033.full>

## Secondary Data

In the OHC region, the rate of adults age 20 and older who have ever been told by a doctor they have diabetes is 9.9%. In the Rogers Community, the rate is 9.7%, which is lower than the OHC region and Arkansas (10.8%), but higher than the U.S. (9.1%) and is slowly increasing. In addition, the percentage of diabetic Medicare patients who have had a hemoglobin A1c (HbA1c) test in the past year in the Rogers community is 77%, which is lower than both the percentage in Arkansas (83%) and the U.S. (85%). Testing for HbA1c is essential for early detection and monitoring of diabetes and its associated complications.

### Percent Adults with Diagnosed Diabetes (Age-Adjusted)

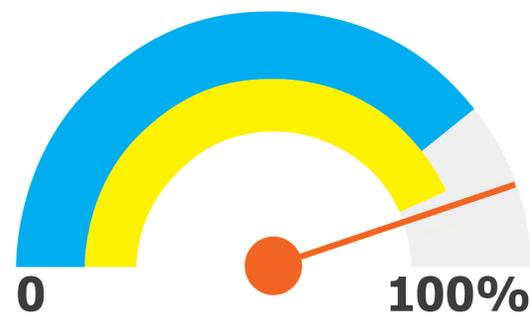


**Rogers Community 9.7%**

**Oklahoma 10.8%**

**United States 9.1%**

### Percent Medicare Enrollees with Diabetes with Annual Exam



**Rogers Community 77.0%**

**Arkansas 83.0%**

**United States 84.6%**

Making matters worse, Arkansas is the most obese state in the U.S., and although the prevalence of adult obesity in the Rogers Community is less than that of Arkansas, it is still worse than the national average. This data is important to note as obesity significantly increases a person's risk of developing diabetes. For death rates due to diabetes, the state of Arkansas has one of the highest death rates, ranking 11<sup>th</sup> in the U.S.<sup>32</sup>

<sup>32</sup> Centers for Disease Control and Prevention: Stats of the State of Arkansas, 2014. [http://www.cdc.gov/nchs/pressroom/states/AR\\_2014.pdf](http://www.cdc.gov/nchs/pressroom/states/AR_2014.pdf).

In addition, secondary data from the University of Arkansas 2015 Point-In-Time Homeless Report indicated that diabetes and related risk factors are a significant health problem for the approximately 2,500 people experiencing homelessness in the Rogers Community area. According to their self-reported Body Mass Indexes, 67% of homeless persons are overweight or obese. Of that same group, 46% have high blood pressure, and 17% report living with diabetes.<sup>33</sup>

## Primary Data

Of all emergency department (ED) visits in the past year at Mercy Hospital Northwest Arkansas, endocrine, metabolic, and immunological related concerns accounted for 1.7% of all visits across all age cohorts. This percentage increased to 1.9% within the age 18-64 cohort and then to 2.4% within the age 65 and older cohort.

As noted elsewhere in this report, Mercy Hospital increasingly serves Marshallese migrant patients, a community in which type 2 diabetes is epidemic. In 2012, the rate of Marshallese adults with diabetes in Arkansas was 46.5%, while the pre-diabetes rate was 21.4%.<sup>34</sup> Of all ED visits in the past year at Mercy from patients listing their race as Pacific Islander, 3% were due to endocrine, metabolic, or immunological related health concerns.

Participants in the Rogers community health survey identified diabetes as the third most prominent area of concern in terms of health. One participant noted, "diabetes strips and supplies, I can't afford, so I don't check my blood." This statement represents a common sentiment expressed by other survey participants - finances are a major barrier to preventative and primary health care.

## What Can We Do?

Making significant strides in the fight against diabetes mellitus will require more than treating patients who have already been diagnosed with the disease. The epidemic of diabetes in the United States, which does not spare the Ozarks Health Commission region or the Rogers Community area, is closely tied to the national obesity epidemic. Risk factors for diabetes, namely obesity, nutrition, and physical activity, must be addressed. Mercy Hospital is exploring several initiatives to encourage physical activity in the community, increase healthier food options for employees in the cafeteria,

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<sup>33</sup> Fitzpatrick FM, Collier S, O'Connor G. 2015 *Northwest Arkansas Homeless Report*. Community and Family Institute, University of Arkansas, 2015

<sup>34</sup> Hallgren, E.A, McElfish, P.A., Rubon-Chutaro, J. 2014. *Barriers and Opportunities: A Community-Based Participatory Research Study of Health Beliefs Related to Diabetes in a US Marshallese Community*. <https://northwestcampus.uams.edu/files/2015/06/DOC37664948-Barriers-Article.pdf>

educate families about maintaining their health, and expand access to diabetes prevention programs for at-risk patients.

## **Implementation Strategy and Evaluation Plan**

An Implementation Strategy (or Community Health Improvement Plan – CHIP) will be developed to address each of the four prioritized health needs described in this assessment and will be published separately. The CHIP will include plans for evaluating outcomes of the strategies and programs developed to address the prioritized needs.