Highland Community Hospital

CHNA Report

CHNA Report and Implementation Plan

Approved September 23, 2025



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Executive Summary

The purpose of this Community Health Needs Assessment ("CHNA") report is to provide Highland Community Hospital ("HCH") with a functioning tool to guide the Hospital as it works to improve the health of the community it serves. Additionally, the report complies with the Internal Revenue Service's guidelines.

The results of the CHNA will guide the development of Highland Community Hospital's community health improvement initiatives and implementation strategies. This report may be used by many of the Hospital's collaborative partners in the community.

The assessment was conducted, and implementation strategies were developed by the Community Health Needs Assessment Steering Committee with assistance from HORNE. The evaluation was conducted from April through June 2025.

The primary input was provided by previous patients, employees, and community representatives. An opportunity to offer feedback was made available to the entire community through word of mouth, plus a published and publicly available survey. Additional information came from public databases, reports, and publications by state and national agencies.

The response section of this report describes how the Hospital and its collaborative partners worked together to address identified health needs in our community during the past three years. In this report, we will also discuss the health priorities that we will focus on over the next three years. The CHNA report is available on the Hospital's website www.highlandch.org or a printed copy may be obtained from the Hospital's administrative office.

James Turnage, Jr.
Administrator
Highland Community Hospital

About the Hospital

Highland Community Hospital

Highland Community Hospital, a part of the Forrest Health® System, is a 49-bed, full-service facility that serves as one of two acute-care medical facilities in Pearl River County. Highland provides a variety of medical specialties and state-of-the-art technology to our community.

Highland Community Hospital is home to a wide range of services including Radiology/Imaging and mammography, Surgical, Medical Surgical Inpatient Care, Intensive Care Unit, Laboratory, and Cardiac Services. Additional clinical programs include Respiratory Services, Physical Therapy, Hospitalist Program, Swing Bed Program, and Primary Care. Specialty Physician Clinics, such as General and Laparoscopic Surgery and Urology, Hattiesburg Clinic's Neurology, Cardiology, and Ear, Nose, and Throat, along with Southern Bone and Joint's Orthopedic Clinic, are essential components of our service offerings. Highland also offers a wide variety of Women and Children's Services, Virtual Nursery, Emergency Department and Outpatient Services that include an extensive range of infusion and injection therapies and a Wound Care Clinic.

The Emergency Department is one of the main gateways to the Hospital. Whether emergent or nonurgent, patients are seen by either a competent and caring physician or nurse practitioner to assess their specific needs and direct their personalized treatment plan. We also offer Telestroke through Servaro, as well as Telepsych services through Pine Grove, Forrest General's Behavioral Health Center. As a member of the statewide trauma system and part of the Forrest Health family, Highland can arrange for complex, specialized care in an organized and timely manner.

The Hospital has been a trusted member of greater Pearl River community for over 50 years. The citizens depend on the Hospital not only to provide for their needs when they are ill but also to turn to the Hospital as a source of health and wellness information. With its convenient, state-of-the-art facility, Highland Community Hospital is taking the lead as the catalyst for better health and living for Pearl River County.

The Community Health Needs Assessment

The Community Health Needs Assessment identifies opportunities for healthcare improvement, fosters a collaborative community environment to engage multiple change agents, and is an open and transparent process that listens to and truly understands the health needs of Pearl River County. It also provides an opportunity for the Hospital to identify valuable collaborative partners as we try to serve the community better and improve the health of our citizens.

The federal government now requires nonprofit hospitals to conduct a community health assessment. These collaborative studies enable healthcare providers to build stronger relationships with their communities, identify local needs, and allocate funding and other resources to programs that directly benefit residents.

Community Engagement and Transparency

We are pleased to share the results of our Community Health Needs Assessment with our community. The following pages provide a review of the strategic activities we undertook over the last three years in response to specific health needs identified in our community.

The report also highlights the updated key findings of the assessment. We hope you will take time to review the health needs of our community, as the findings impact on every citizen of our rural Mississippi community. Also, review our activities that were in response to the needs identified in 2022. Later in this Community Health Needs Assessment, we highlight the success achieved with our 2022 Strategic Initiatives in the Strategic Action Responses section.

The Community Health Needs Assessment, Continued

Data Collection

Primary and secondary data were gathered, reviewed, and analyzed so that the most accurate information was available in determining the community's health needs and the appropriate implementation process.

Primary Data**:** collected by the assessment team directly from the community through conversations, telephone interviews, focus groups and community forums; the most current information available.

Secondary Data**:** collected from sources outside the community and from sources other than the assessment team; information that has already been collected, collated, and analyzed; provides an accurate look at the overall status of the community.

Secondary Data Sources

- The United States Census Bureau
- U.S. Department of Health and Human Services
- Centers for Disease Control and Prevention
- American Heart Association
- Highland Community Hospital Medical Records Department
- Mississippi State Department of Health, Office of Health Data and
- ESRI Demographic Research

About The Community

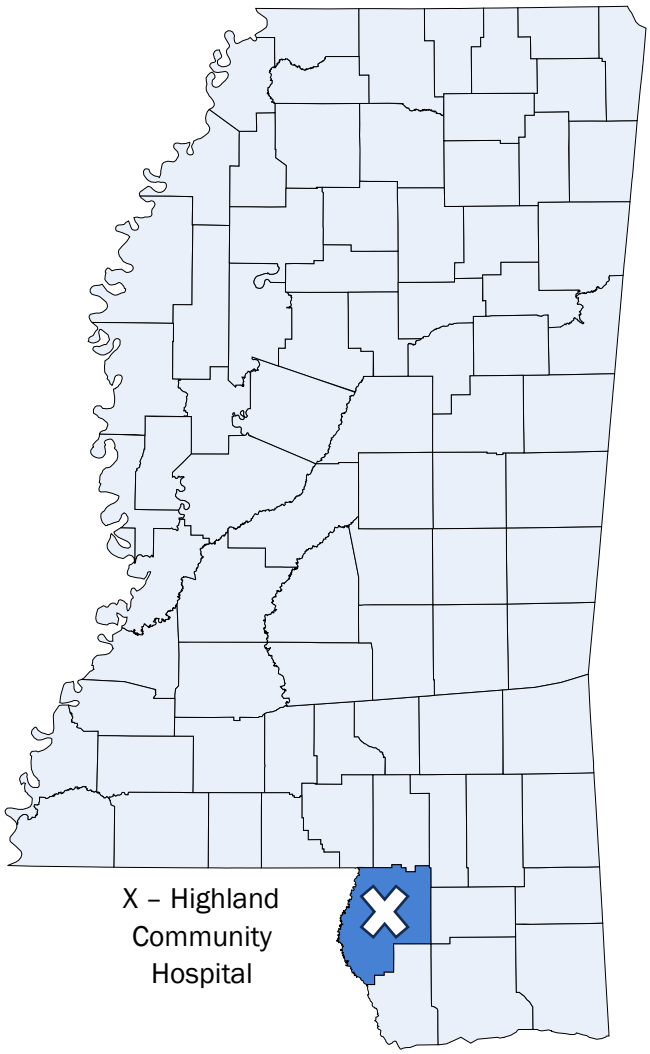
Service Area

Primary: Pearl River County

The County

Pearl River County is located in the Pine Belt region. The county was initially formed as Pearl County in 1872 from portions of Hancock and Marion Counties. Due to its low population density and small tax base, Pearl County was dissolved in 1878. Present-day Pearl River County was organized in 1890 by an act of the Mississippi Legislature utilizing the same land area as its predecessor Pearl County.

The county has a total area of 819 square miles, of which 811 square miles is land. It is the fourth-largest county in Mississippi by land area.



Communities

Cities and Towns in Pearl River County

- Poplarville (County Seat)
- Picayune
- Lumberton (mostly in Lamar County)

Unincorporated Communities

- Caesar
- Carriere
- McNeil
- Nicholson

About the Community, Continued

Demographics

Pearl River County 2024

Population:	57,417
Racial Mix:	
White	80.4%
African American	12.3%
Native American	0.6%
Asian	0.5%
Two or More Races	4.7%
Other	1.5%
Hispanic*	4.1%
Non-Hispanic	95.9%

Pearl River County 2022

Population:	56,145
Racial Mix:	
White	80.4%
African American	12.5%
Native American	0.7%
Asian	0.5%
Two or More Races	4.7%
Other	1.2%
Hispanic*	3.4%
Non-Hispanic	96.6%

*Hispanics may be of any race, so also are included in applicable race categories

		Pearl River County
Population:		57,417
Racial Mix:	White	46,163
	African American	7,062
	Asian	345
	American Indian	287
	2 or more	2,699
	Other	861
	Hispanic*	2,354
Median Household Income:		$53,353

*Hispanics may be of any race, so also are included in applicable race categories

About the Community, Continued

Mississippi, Pearl River County, and the United States

	Mississippi	Pearl River County	United States
Median Age	39.6	42.1	38.9
Median Household Income	$55,017	$53,353	$77,540
Poverty Level	19.4%	17.0%	11.5%

SOURCES:
U.S. Census Bureau, 2020
U.S. Census Bureau, American Community
ESRI Community Profile

Pearl River County	
Percent of residents who do not have access to broadband:	10.0%
Households receiving food stamps/SNAP:	15.8%
Households with 1+ persons with a disability:	41.7%
Households without a vehicle:	2.0%
Percent of adults who didn't finish high school:	6.0%
Percent of Unemployment as of 11/2024 ** :	4.0%
Percent living alone:	27.0%

SOURCES**
US Bureau of Labor Statistics
Source: U.S. Census Bureau, 2020
Source: U.S. Census Bureau, American Community
Source: ESRI Community Profile

About the Community, Continued

Pearl River County	
The percentage of adults who report fair to poor health	19.6%
Obesity Prevalence	40.0%
Diabetes Prevalence	10.6%
Excessive Drinking	15.2%
Smoking	19.7%
Life Expectancy	71.3
Percent of households with at least 1 – 4 housing problems (overcrowding, high costs, lack of kitchen/plumbing)	12.4%

SOURCES:
U.S. Census Bureau, American Community
University of Wisconsin Population Health Institute
County Health Rankings & Roadmaps
National Findings Report 2024

www.countyhealthrankings.org

Community Input

Community health needs were identified through the collection and analysis of data from a variety of quantitative and qualitative sources. Using multiple sources is essential to ensure the assessment reflects a comprehensive range of facts, trends, and community perspectives. This multifaceted approach helps identify the most pressing health priorities. Among these sources, one of the most valuable is direct input from the individuals and communities we serve.

To gather community input, the Hospital developed and distributed an online survey. Members of the general public were invited to participate, with the survey promoted across multiple channels to ensure broad reach. The 2025 CHNA Survey was published in the *Picayune Item* newspaper as well as on their online version with a link to click and the reader would be brought to the survey. The survey was also made available on the Highland Community Hospital Facebook page. Highland also created a table in the Hospital lobby for anyone who wishes to fill out the survey and submit it to the box provided. These options to participate in the survey were available to the public from April 23, 2025 to May 19, 2025. The responses were analyzed and used to help determine key health priorities and inform the development of new initiatives.

Comments below are from participants who expressed additional concerns on the survey:

- Number of children being born with disabilities to addicted individuals
- More education on nutrition is needed in the community
- Lack of exercise outdoors, such as public pools and walking trails
- Concerning amount of the community uninsured
- COPD, other lung issues
- Awareness of available programs



Community Input, Continued

2025 CHNA Community Survey:

Community Health Needs Survey 2025

Highland Community Hospital is committed to serving the health needs of our community. Your feedback is valuable in helping us understand and address the most pressing health concerns in Picayune and the surrounding areas. Please take a few minutes to complete this survey.

1. What is your age range?
   - 18-24
   - 25-34
   - 35-44
   - 45-54
   - 55-64
   - 65 or older
2. How long have you lived in the Picayune area?
   - 1-3 years
   - 3-5 years
   - 5-10 years
   - 10-15 years
   - 15-20 years
   - 20-30 years
   - Over 30 years
3. What do you believe are the most significant health problems facing our community? (Please select all that apply)
   - Heart disease
   - Diabetes
   - Obesity
   - Cancer
   - Mental health issues (depression, anxiety, etc.)
   - Substance abuse (alcohol, drugs)
   - Access to affordable healthcare
   - Lack of preventive care
   - other(please specify)_____
4. How satisfied are you with the availability of healthcare services in our community?
   - Very satisfied
   - Satisfied
   - Neutral
   - Dissatisfied
   - Very dissatisfied

Community Input, Continued

2025 CHNA Community Survey:

5. How easy is it for you to access primary care services?
    - Very easy
    - Easy
    - Neutral
    - Difficult
    - Very difficult
6. Are you aware of the health education and wellness programs offered in our community?
    - Yes
    - No
7. If yes, have you participated in any of these programs?
    - Yes
    - No
8. What health services do you feel are most needed in our community? (Please select all that apply)
    - Increased access to specialists
    - Mental health services
    - Substance abuse treatment
    - Preventive care screenings
    - Affordable dental care
    - Increased emergency care.
    - Transportation to medical appointments.
9. How concerned are you about the affordability of healthcare services?
    - Very concerned
    - Concerned
    - Neutral
    - Not concerned
10. Do you have adequate access to healthy food options?
    - Yes
    - No
11. Do you feel that there are enough opportunities for physical activity in our community?
    - Yes
    - No
12. How would you rate the quality of emergency services provided by Highland Community Hospital?
    - Excellent
    - Good
    - Fair
    - Poor
    - Not applicable

Community Input, Continued

2025 CHNA Community Survey:

13. What are the biggest barriers to you receiving adequate healthcare?
    - Cost.
    - Transportation.
    - Availability of doctors.
    - Insurance issues.
    - Time constraints.
    - Other (please specify)
14. Do you have any additional comments or suggestions for Highland Community Hospital regarding community health needs? _____

Thank you for your participation!

Community Input, Continued

Community Health Needs Assessment Steering Committee



HOSPITAL STEERING COMMITTEE

Name	Title	Affiliation
Amy Alfonso	DON	Highland Community Hospital
Bre Butler	Director of Clinical Outcomes	Highland Community Hospital
Todd Carroll	Regional Radiology Manager	Highland Community Hospital
Leslie Dauzat	Director of Acute Care Services	Highland Community Hospital
Kevin Galloway	DO (OB/GYN) Physician	Highland Community Hospital
Rachel Garcia	Social Worker	Highland Community Hospital
Jordyn Holston	Pharmacy Operations Coordinator	Highland Community Hospital
Monica Jahn	Executive Secretary	Highland Community Hospital
Sally Mitchell	Director of Outpatient Services	Highland Community Hospital
Jerel Myers	Supply Chain Manager	Highland Community Hospital
Carrier Olson	Director of Labor & Delivery	Highland Community Hospital
Allen Smith	Director of Emergency Services	Highland Community Hospital
Abbie Turnage	Regional Mammography Coordinator	Highland Community Hospital
Derek Turnage	Pearl River County Coroner	Pearl River County
James Turnage Jr.	Administrator	Highland Community Hospital
Ashleigh Ward	Registration Manager	Highland Community Hospital
Kari Weatherly	Director of Clinics	Highland Community Hospital

Community Input, Continued

Community Focus Group

Name	Title	Affiliation
Amy Alfonso	DON	Highland Community Hospital
David Alisson	Sheriff	Pearl River County Sheriff
Joseph Anderson	Psychiatric Mental Health Nurse Practitioner	Highland Family Medicine Clinic
Angel Austin	Mental Health	Highland Family Medicine Clinic
Beverly Bilbo	Lab Team Lead	Pearl River County Hospital
Jennifer Boehm	Executive Director	Hope Haven -Children's Advocacy Center
Melinda Bowman	Chancery Clerk	Pearl River County
Deena Branum	DON	Pearl River County Hospital
Caitlyn "Bre" Butler	Director of Clinical Outcomes	Highland Community Hospital
Todd Carroll	Regional Radiology Manager	Highland Community Hospital
Leslie Dauzat	Director of Acute Care Services	Highland Community Hospital
Cheryl Doyle	Nurse Lead	Mississippi Department of Health
Sara Duncan	Nurse Practitioner	Pearl River Family Clinic
Kevin Hedgepeth	Administrator	Pearl River County Hospital
Jessica James Henry	Public Health & Nonviolence Educator	Gulf Coast Center for Nonviolence
Jennifer Hines	Executive Secretary	Pearl River County Hospital
Jordyn Holston	Pharmacy Operations Coordinator	Highland Community Hospital
Alexander Huff, MD	Physician	Pearl River Family Clinic
Monica Jahn	Executive Secretary	Highland Community Hospital
Jameye Martin	Director	Manna Ministries
Kay Miller	Director	Exodus 21 Project
Sally Mitchell	Director of Outpatient Services	Highland Community Hospital
Jerel Myers	Supply Chain Manager	Highland Community Hospital
Carrie Olson	Director of Labor & Delivery	Highland Community Hospital
Stachia Peterson	Director Special Services	Poplarville School District
Steve Reid	Business Development	Forrest Health
Jimmy Richardson	Pastor	New Providence Baptist Church
James "Allen" Smith	Director of Emergency Services	Highland Community Hospital
Lori Stines	Education/Trauma	Pearl River County Hospital
Janet Teague	General Manager	Christian Care Ministries
Elizabeth Treadway	Director	Pearly River County SPCA
Abbie Turnage	Regional Mammography Coordinator	Highland Community Hospital
Derek Turnage	Pearl River County Coroner	Pearl River County
James Turnage Jr.	Administrator	Highland Community Hospital
Lindsey Ward	Director of Economic Development	Pearl River County
Sugar Whitten	Director of Respiratory	Pearl River County Hospital
Carol Williams	Director	Backpack Buddies -Poplarville
Dr. Andrew Wilson	Associate Pastor	Picayune First Baptist Church

Community Input, Continued

Participants in the Community Focus Group

On April 17, 2025, Highland Community Hospital and Pearl River County Hospital hosted a joint focus group meeting at the McNeill Community Center in Carrier, MS. Since both hospitals serve the same county, this was an excellent opportunity for the leaders of the community to sit down with leaders from both of the local hospitals.







Social Determinants of Health

Social Determinants of Health: Definition and Impact

The concept of social determinants of health ("SDOH") refers to the broad range of nonmedical factors that significantly influence individual and community health outcomes. According to the World Health Organization, SDOH are "the conditions in which people are born, grow, live, work and age," encompassing a vast array of influences that extend well beyond clinical care. These determinants are typically grouped into six domains:

- **Economic Stability**: Employment, income, expenses, medical bills, and financial support.
- **Neighborhood and Physical Environment**: Housing, transportation, safety, parks, playgrounds, walkability, and geography.
- **Education**: Literacy, language, early childhood education, vocational training, and higher education.
- **Nutrition**: Hunger and access to healthy food options.
- **Community and Social Context**: Social integration, support systems, community engagement, discrimination, and stress.
- **Health Care Access**: Health coverage, provider availability, cultural competency, and quality of care.

These social determinants have a measurable impact on both medical outcomes and the total cost of care. For example, food insecurity alone is associated with approximately $155 billion in annual healthcare costs in the U.S., and nearly 80 percent of emergency department visits by homeless patients are preventable with reliable access to primary care. Research indicates that 60 percent of a patient's overall health is shaped by SDOH and individual behavior, compared to 30 percent by genetics and only 10 percent by the care they receive.

The Role of Highland Community Hospital: Convener and Organizer

Hospitals are uniquely positioned to serve as conveners and organizers of community-wide efforts to address SDOH. While addressing these determinants often extends beyond the traditional scope of medical care, hospitals encounter the consequences of unaddressed social needs daily. As such, they have both a vested interest and a responsibility to lead collaborative initiatives that drive meaningful change.

Social Determinants of Health, Continued

Five Critical Steps for Hospital-Led SDOH Initiatives:

1. **Articulate the Hospital's Unique Role**

   Highland will clearly define its role in collaboratively tackling SDOH. This involves understanding their "impact advantage," the specific resources, relationships, and expertise that position them to drive change—and communicating this role to partners and stakeholders.

2. **Leverage Community Partnerships**

   Effective SDOH interventions require collaboration with a diverse range of stakeholders, including community-based organizations, public health agencies, payers, and local government. Highland will act as a convener, bringing these groups together to align efforts, share data, and coordinate resources.

3. **Address Root Causes, Not Just Symptoms**

   Successful strategies go beyond addressing the immediate consequences of social needs (such as providing transportation or food) and instead target the underlying causes, like poverty, housing instability, and systemic inequities. This requires engaging directly with affected populations to understand their lived experiences and priorities.

4. **Prioritize Trust-Building with Patients and Communities**

   There is often deep mistrust between marginalized populations and the healthcare system, rooted in historical discrimination and inequity. Highland will prioritize earning trust by involving patients in program design, ensuring cultural competence, and demonstrating sustained commitment to community well-being.

5. **Integrate SDOH Efforts Across the Organization**

   Addressing SDOH is not solely the responsibility of community outreach teams; it must be embedded from the C-suite to the front lines. Hospital leadership will champion SDOH as a strategic priority, while clinical and nonclinical staff are empowered to identify social needs and connect patients with appropriate resources.

Overview of Social Determinants of Health for Highland's Population

The social determinants of health ("SDOH") are the nonmedical factors that influence health outcomes. For Highland Community Hospital's service area, which includes Pearl River and surrounding counties in Mississippi, recent community health needs assessment ("CHNA") survey data and demographic profiles reveal several key SDOH impacting the population.

Social Determinants of Health, Continued

Key Types of Social Determinants Identified

Economic Stability

- **Cost as a Barrier:** 39 percent of respondents (12 out of 31) cited cost as a barrier to care, underscoring its significant role in limiting healthcare access.
- **Affordability Concerns:** 77 percent (24 out of 31) reported being either very concerned or concerned about the affordability of healthcare services, with no respondents saying they were "not concerned."

Access to Health Care

- **Barriers Identified:** Cost (39 percent), availability of doctors (32 percent), insurance issues (19 percent), transportation (16 percent), and time constraints (23 percent) were all reported as barriers to receiving adequate care.
- **Difficulty Accessing Primary Care:** 90 percent (28 out of 31) described access as "easy" or "very easy," while only one respondent (3 percent) found it challenging.
- **Satisfaction with Services**: A majority were positive—52 percent satisfied and 39 percent neutral—with only 6 percent dissatisfied or very dissatisfied.

Social and Community Context

- **Health Challenges Identified:** Obesity (74 percent) was the most reported issue, followed by mental health (65 percent), substance abuse (65 percent), heart disease (61 percent), diabetes (52 percent), and cancer (16 percent).
- **Community Improvements Desired:** Increased mental health services (58 percent) and substance abuse treatment (55 percent) were the top requests, followed by access to specialists (48 percent) and transportation support (48 percent). Preventive screenings (26 percent) and affordable dental care (26 percent) were also noted.
- **Awareness Gap:** 70 percent of respondents were unaware of existing health education or wellness programs, indicating a need for improved outreach and communication.

Transportation and Infrastructure

- **Transportation as a Barrier:** Although only 16 percent (5 out of 31) reported transportation as a direct barrier, nearly half (48 percent) of respondents identified transportation services to medical appointments as a critical community need.

Preventive Health

- **Low Program Participation:** Only 13 percent (4 out of 31) had participated in community health education or wellness programs, even among the 30 percent who knew such programs existed.
- **Screenings and Preventive Care:** Just 26 percent (8 out of 31) highlighted preventive screenings as a priority, suggesting that while preventive services are needed, they are not seen as urgently as behavioral health or specialty access.
- **Opportunity:** The large awareness gap indicates that with stronger promotion, preventive health engagement could rise significantly.

Social Determinants of Health, Continued

Key Types of Social Determinants Identified

Emergency and Acute Care

- **Emergency Services Ratings:** 74 percent rated Hospital emergency services as excellent (26 percent) or good (48 percent), while only one respondent rated them poor.
- **Strength of Acute Care:** The Hospital is viewed positively for urgent and emergency care delivery, representing a community strength compared to gaps in longer-term and preventive services.
- **Perception vs. Need:** While ER services are strong, demand is shifting toward behavioral health, affordability, and transportation—indicating the Hospital's reputation for emergency care could be leveraged to build trust in new service areas. Community Perspective

Community Perspective

- The community benefits from strong foundations in housing (97 percent reported having a secure place to live), safety (93 percent feel safe in their neighborhood), and food access (74 percent reported adequate, healthy food access).
- However, respondents consistently emphasized the need for expanded mental health and substance abuse services, improved access to specialists, and relief from financial barriers to care.
- Overall, the results suggest that behavioral health, affordability, and specialty care access are the most pressing community health priorities.

Social Determinants of Health, Continued

Summary Table: Key SDOH for Highland's Population

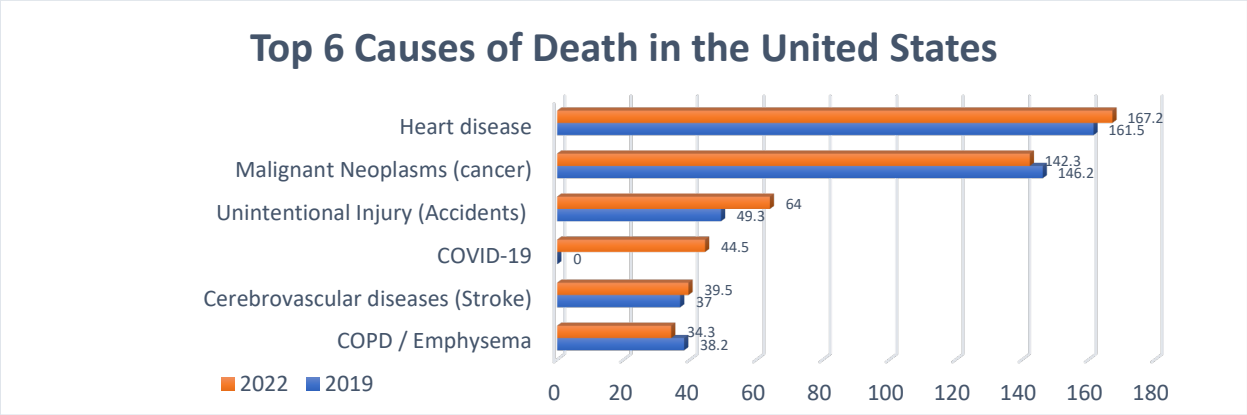
Determinant Type	Main Issues Identified	Impact on Health Outcomes
Economic Stability	Cost, insurance, income disparities, employment	Delayed care, chronic disease management issues
Access to Health Care	Provider shortages, long wait times, transportation	Reduced preventive care, delayed treatment
Neighborhood/Environment	Rurality, lack of exercise facilities	Lower physical activity, higher chronic disease
Education/Health Literacy	Low health education, limited awareness	Poor self-management, late disease detection
Social/Community Context	Caregiver support, cultural/language barriers	Navigation challenges, disparities in care
Health Behaviors	Diet, physical inactivity, tobacco/alcohol use	Elevated chronic disease rates

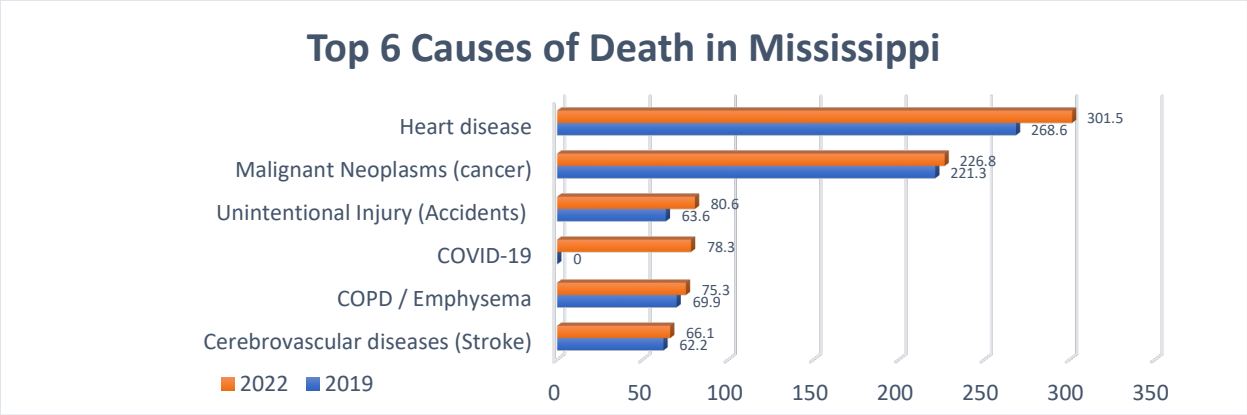
Conclusion

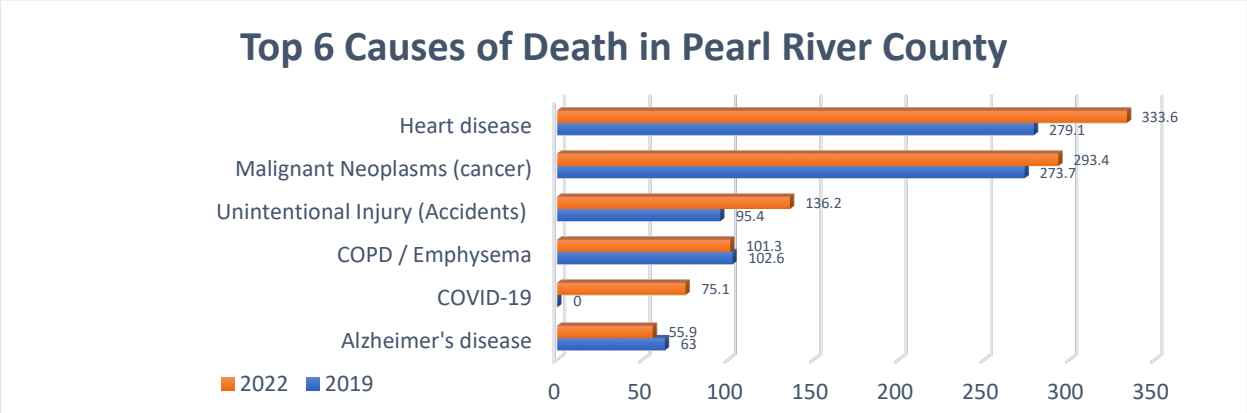
Highland's population faces a combination of economic, access, educational, and environmental barriers that shape health outcomes. Addressing these SDOH—especially affordability, provider access, transportation, and health education—will be critical to improving overall community health and reducing health disparities in the region.

Causes of Death Analytics

Cause of Death Comparison (based on per 100,000)





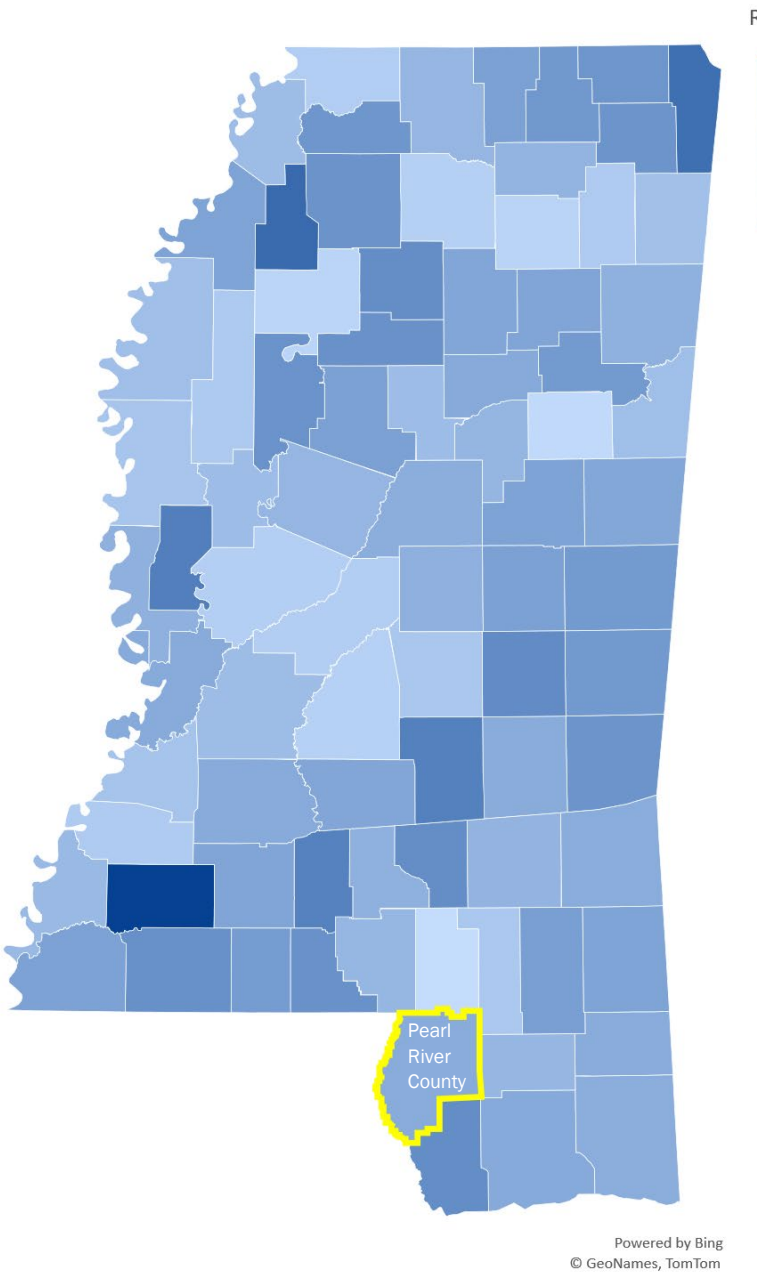


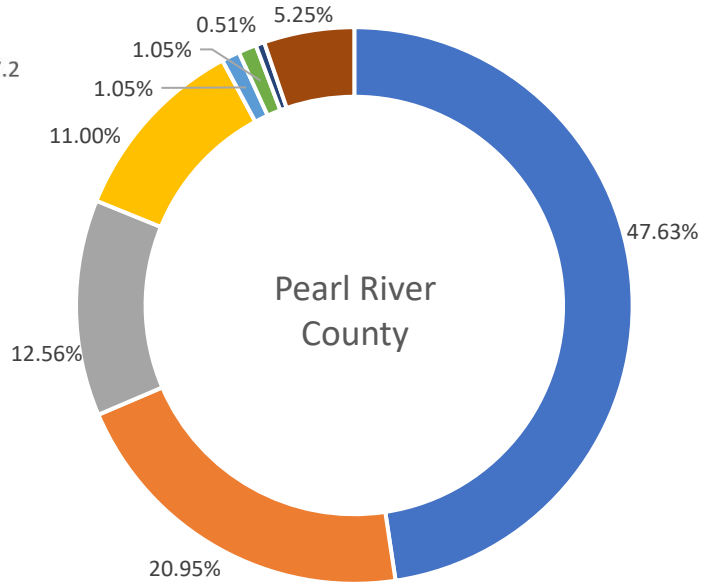
Causes of Death Analytics, Continued

Heart Disease Death Analytics (based on per 100,000)

Below is a heat map showing heart disease-related deaths across Mississippi by county, with darker shades indicating higher death counts. HORNE conducted a focused review of the specific types of heart disease contributing to deaths in Pearl River County to identify key trends and areas for targeted intervention.

Mississippi's Death Rate from Heart Disease



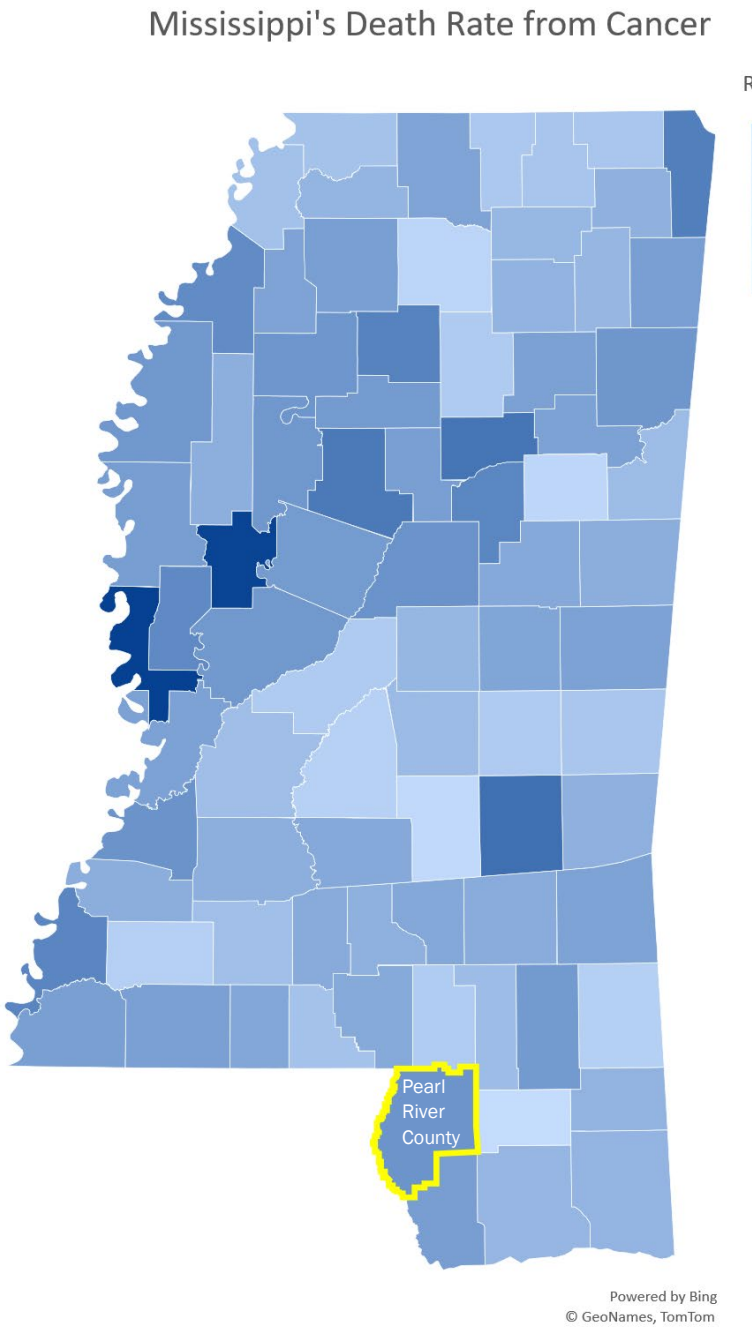


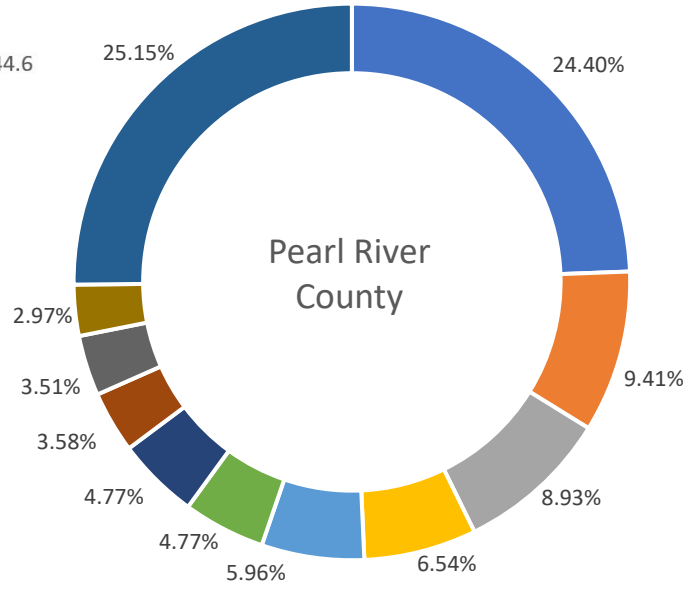
Type of Heart Disease	Percentage
Ischemic Heart Disease	47.63%
Heart Failure	20.95%
Cardiac Dysrhythmias	12.56%
Hypertensive Heart Disease with or without Renal Disease	11.00%
Diseases of Pulmonary Circulation	1.05%
Ill-Defined Heart Diseases	1.05%
Rheumatic Heart Disease	0.51%
All Other Heart Diseases	5.25%

Causes of Death Analytics, Continued

Cancer Death Analytics (based on per 100,000)

Below is a heat map showing cancer-related deaths across Mississippi by county, with darker shades indicating higher death counts. HORNE conducted a focused review of the specific types of cancer contributing to deaths in Pearl River County to identify key trends and areas for targeted intervention.



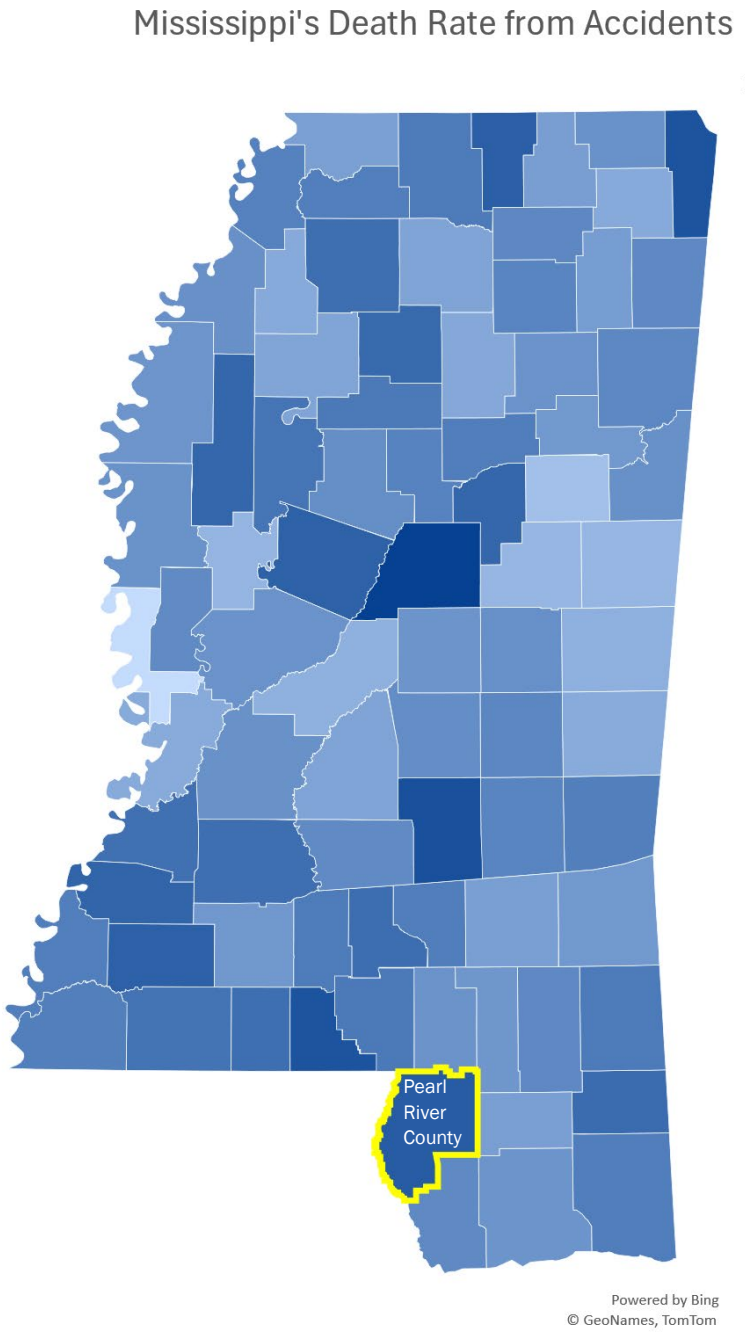


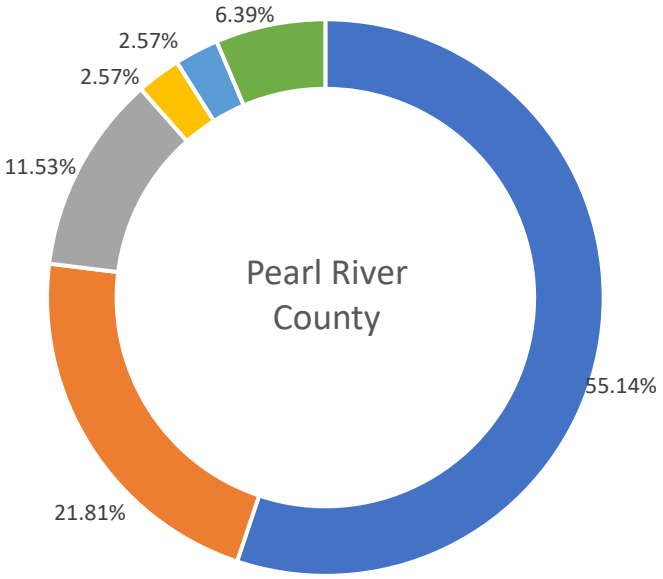
Type of Cancer	Percentage
Trachea, Bronchus, and Lung	24.40%
Female Breast	9.41%
Pancreas	8.93%
Colorectal	6.54%
Liver and Intrahepatic Bile Ducts	5.96%
Prostate	4.77%
Bladder	4.77%
Brain	3.58%
Cervix Uteri	3.51%
Lip, Oral Cavity, and Pharynx	2.97%
All Other Cancers	25.15%

Causes of Death Analytics, Continued

Accidental Death Analytics (based on per 100,000)

Below is a heat map showing accident-related deaths across Mississippi by county, with darker shades indicating higher death counts. HORNE conducted a focused review of the specific types of accidents contributing to deaths in Pearl County to identify key trends and areas for targeted intervention.





Type of Accident	Percentage
Poisoning-Drugs	55.14%
Motor Vehicle	21.81%
Falls	11.53%
Poisoning-solids, Liquids & Gases	2.57%
Fires, Flames and Smoke	2.57%
All Other Unintentional Injuries	6.39%

Our Response to the 2022 Needs

Summary of Impact of the 2022 CHNA Implementation Plan and Strategic Actions

An essential element of the three-year Community Health Needs Assessment ("CHNA") cycle is revisiting the progress made on the priority needs identified in the previous assessment. By reviewing the actions taken to address the needs identified by our communities and prioritized by the CHNA Steering Committee, it is better to target resources and efforts during the upcoming CHNA cycle. This review also provides the collaborative partners with the affirmation that the joint efforts to improve the overall health of our community have been successful.

Prioritization

The information gathered from the community was uniform and consistent with the quantitative data. The most common needs mentioned by the community members were related to chronic diseases, health education, lifestyle improvement, and access to care.

Being aware of this lifestyle disparity, the Steering Committee was diligent in addressing these chronic illnesses, which led to a disproportionate number of deaths. Additionally, the quality of life in our state is negatively impacted by these conditions that deprive our citizens of the opportunity to maintain good health on a daily basis.

Hypertension, heart disease, diabetes, weight loss/obesity, and nutrition were all health needs identified by both the community members and healthcare professionals. In addition, deaths from female breast cancer and trachea, bronchus, and lung cancer were identified as disproportionate for the county. Community members saw a need for increased education and preventive care to eliminate the path to chronic disease and cancer.

Prevention can be more cost-effective than the costly treatment required when a chronic disease goes unmanaged and causes serious health issues. Emphasis was placed on education related to nutrition due to the connection between obesity and various chronic health conditions. Other community health needs identified included a demand for increased health literacy and a reduction in health disparities among different socioeconomic and racial groups.

Community Health Improvement Plan

Based on the communities' input and the knowledge of the patient population we serve, the CHNA Steering Committee prioritized these needs. It has developed a Community Health Improvement Plan (CHIP) to address them. The Strategic Actions and activities aimed at improving the health and well-being of our community, along with their positive impacts, are detailed on the following pages.

Our Response to the 2022 Needs, Continued

2022 Strategic Action Response:

Awareness and Prevention of Heart Attack and Cardiovascular Death

- **October 2022, 2023** - Sponsored and participated in the 1st Annual Racing for Y'unity 5K and 1 Mile Run hosted by Fit Focused Community PRC. The event was held on Saturday, October 8th, at Crosby Commons. Displayed and distributed Hospital promotional materials and highlighted the importance of maintaining an active lifestyle to prevent heart disease. Proceeds from this event were donated to the Juvenile Diabetes Foundation.
- **January 2023, 2024, and 2025** - Sponsored and participated in the Annual Pearl River Community College Women's Health Symposium. Displayed and distributed information regarding various health-related topics. Also provided supplies for attendees to get their cholesterol and glucose checked. Provided handouts on how to reduce cholesterol. Conducted Bone Density Screening and report for attendees of the symposium.

Cancer Awareness and Prevention

- **October 2022, 2023, 2024, and upcoming October 2025** - Sponsored and participated in the Annual *Puttin' on the Pink* Gala. This nonprofit organization provides free mammograms to women in the community who are uninsured or have no other means of getting a mammogram.
- **June 2023, 2024, and 2025** - Sponsored the Picayune Police Department's Annual Summer Camp program, where kids were educated on the effects of drugs, alcohol, and smoking/vaping.
- **October 2022, 2023, 2024, and upcoming October 2025** - Sponsored and participated in the Annual *Puttin' for the Pink* Golf Tournament hosted by the Greater Picayune Area Chamber of Commerce. We had a booth set up to distribute health information regarding breast and lung cancer. The proceeds from this event were donated to the Puttin on the Pink Foundation, which provides free mammograms to women in the community who are uninsured or have no other means of accessing a mammogram.

Community Focus-Diversity

- **March 2025** -Sponsored and attended The ARC Glow Run, which will support special needs individuals and families in Pearl River County.

Our Response to the 2022 Needs, Continued

2022 Strategic Action Response:

Drug Overdoses and Drug Education for the Youth

- **March 2025** -Colorectal Cancer Awareness on social media sites.
- **March 2023** - Designed and sold addiction awareness t-shirts with proceeds being donated to the Exodus Project 21 organization. This organization helps individuals dealing with drug/alcohol abuse.
- **April 2023, 2024, and 2025** - Sponsored and participated in Kids Day at the Commons. Set up a booth with a coloring station where coloring books educating kids on saying no to drugs, etc., were given out.
- **May 2025** -Sponsored and will attend the Exodus Project 21 Health Fair & Expo. Will hand out health-related brochures and talk about staying healthy and giving encouragement to those in recovery.
- **June 2024, 2025** -Sponsored and attended Annual Cops Night Out to help bridge the gap between the community and the Picayune Police Department.
- **October 2022** - Provided information to local schools regarding a free educational seminar hosted by MHA on the Opioid crisis in relation to middle/high school-aged kids.
- **October 2022, 2023, 2024, and April 2025** - Participated in National Drug Take Back Day. Provided a safe drop-off location at the Hospital for those wanting to get rid of medications they no longer need.
- **November 2022, 2023, and 2024** - Sponsored a Drug & Safety Program facilitated by Community Partners Group and the Picayune Police Department. This program distributes publications to school-age children, focusing on drug education and other safety topics.
- **November 2023, upcoming in December 2025** - Sponsored and attended the Exodus Project 21 fundraising gala to support the organization in their efforts to help individuals with drug/alcohol addiction.

Prioritizing Our Needs for 2025

Southern Rural Health at a Disadvantage

According to research conducted by the National Institutes of Health, some rural areas of America experience better health outcomes compared to people residing in urban areas. Individuals living in rural areas in the Northeast, and some parts of the Midwest and West in the US, tend to have lower rates of death and disease compared to both the US in general and to their urban counterparts.

However, those living in the rural South, especially in Appalachia and the Mississippi Delta region, have the lowest life expectancy in the country, and the highest mortality rates due to heart, lung, blood, and sleep disorders; stroke; and cancer. Individuals residing in the rural South experience higher mortality rates compared to both their urban counterparts and other populations living in different rural regions across the US. The disparity in mortality rates between rural regions is stark, with people living in rural communities in the East South Central Region (Kentucky, Tennessee, Mississippi, and Alabama) experiencing more than 1,000 deaths per 100,000 from 2013 to 2015, compared to 850 deaths per 100,000 in all other rural areas of the US.

Prioritizing Future Efforts for Healthier Rural Communities

The traditional Southern lifestyle is significantly influenced by a diet that is less than healthy — characterized by fried foods, organ meats, processed meats, eggs and egg dishes, sugar-sweetened beverages, and bread products. Poor diet, along with a lack of consistent aerobic activity, and the widespread use of tobacco products, are major contributing lifestyle factors that can explain the prevalence of chronic conditions like high blood pressure, obesity, diabetes, and some cancers.

The awareness of the Southern rural health disadvantage, along with the mortality statistics for the population of our service area, made establishing our need for healthy changes a priority for the next three years. In addition to education for a healthier lifestyle for our residents, we will focus many of our strategic actions around reducing the prevalence of cancer, heart disease, stroke, and substance abuse.

Community Health Implementation Plan 2025

Highland Community Hospital's leadership, in collaboration with the CHNA Steering Committee and a diverse group of collaborative partners, analyzed various data indicators for Pearl River County, along with state and national health comparisons and community input, to identify the health and social needs in Pearl River County. Following the completion of the Community Health Needs Assessment (CHNA), Highland Community Hospital selected a subset of the research findings as the prioritized needs around which the Hospital has developed a Community Health Implementation Plan (CHIP), a three-year implementation plan and strategy. Although the Hospital may respond to many needs, the prioritized needs will be at the center of a formal CHNA implementation plan and corresponding tracking and reporting.

2025 Strategic Initiatives

Initiative 1: Awareness and Prevention of Heart Attack and Cardiovascular Death

Heart disease is the number one leading cause of death among Pearl River County residents. We recognize a need to enhance education for our residents and offer an opportunity to participate in a healthy heart initiative.

Target Population

Community residents who are in the age group that is most affected by heart disease, as well as those who need to learn healthier habits to decrease their risk of developing heart disease at a later age.

Goals/Desired Outcome

The goal is to educate the community about early detection of heart disease and to prevent death caused by heart disease.

Process/Time Frame/Location

The plan is to host or attend a Heart Walk and promote heart health awareness through social media.

Measure of Success

The goal is to reduce the number of deaths from heart disease in Pearl River County.

Collaborating Partners

- Manna Ministries
- American Heart Association
- Picayune Item Newspaper
- WRJW/Swap Shop News

2025 Strategic Initiatives, Continued

Initiative 2: Cancer Awareness and Prevention

Cancer is the second leading cause of death in Pearl River County, with lung cancer causing the most deaths, followed by breast cancer. Highland Community Hospital, in an effort to improve access to breast health education and care, will partner with *Puttin' on the Pink* Foundation. The *Puttin' on the Pink* Foundation's Community Collaboration to Battle Breast Cancer, also known as the Mammogram Voucher Program (MVP) will be continued during this report period.

Target Population

Those residents at the most significant risk of developing lung cancer are low-income, medically underserved, uninsured women and men in Pearl River County.

Goals/Desired Outcome

To decrease the instances of death due to lung cancer. Also, through the MVP, provide free breast screenings to members of the community. The goal is to increase this by 10 percent annually over the next three years. The initiative will also address ways to resolve the transportation challenges faced by underserved populations attending screenings.

Process/Time Frame/Location

We plan to provide high-quality, culturally competent outreach, education, screenings, and navigation services. Cancer education will be shared at events such as the annual Senior Health Fair, *Puttin' on the Pink* annual event, and *Putt'n for the Pink* yearly golf tournament. Also, plan to host fundraising events for programs related to these cancers.

Measures of Success

A 10 percent increase in those served annually. Through educational events, reach more than 350 community members annually.

Collaborative Partners:

- *Puttin' on the Pink* Breast Cancer Foundation
- Greater Picayune Area Chamber of Commerce
- WRJW/Swap Shop News
- Picayune Chamber of Commerce
- Manna Ministers

2025 Strategic Initiatives, Continued

Initiative 3: Drug Overdoses and Drug Education to the Youth

By focusing on prevention and education, this initiative seeks to protect Pearl River County youth from the dangers of drug abuse and empower them to make safer, healthier decisions as they transition into adulthood.

Target Population:

Youth who attend Pearl River County schools, as well as those at risk for possible drug overdose.

Goals and Desired Outcomes:

Our goal is to increase awareness of the dangers of drug abuse in the school-age population so that they make better choices as they grow into adulthood

Process/Time Frame/Location

Collaborate with the school district's Resource Officers and School Nurses to support educational events that promote awareness.

Measures of Impact:

It will be measured through positive feedback from schools and community members. The second measure will be whether the number of drug overdoses decreases over the next three years.

Collaborative Partners:

- Community Partners Group (Publications to School-Aged Children)
- Mississippi Department of Health
- Pearl River County School District
- Local Pharmacies
- Pearl River County Coroner

Thank You

This comprehensive assessment helps us better understand the needs and concerns of our community. Highland Community Hospital, part of the Forrest Health System, believes in being "our brother's keeper." We're honored to work with our community partners to provide outstanding healthcare and create a healthier world for residents of Pearl River County and surrounding areas.

We extend our sincere thanks to everyone who participated in this process. We're especially grateful to the Forrest General Board of Trustees and the health system's leadership for their guidance, which allows us to continue our mission in our wonderful, rural Mississippi community.

A special thanks goes to our CHNA Steering Committee members and all who participated in our Community Focus Group, whether by attending the Forum or through conversations. Your time, support, and invaluable insight have been crucial.

And finally, but most importantly, to the general public—your voices truly matter. Thank you for completing our Community Health Survey, reading our latest Community Health Needs Assessment, and for supporting our mission of care in Pearl River County.

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