ARKANSAS RURAL
HEALTH PARTNERSHIP

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ARKANSAS RURAL HEALTH PARTNERSHIP

Community Health Needs Assessment 2025

PREPARED FOR

White River
HEALTH

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INTRODUCTION

Every three years, White River Health conducts a Community Health Needs Assessment (CHNA) to evaluate the most pressing health issues facing the residents of Independence and Stone Counties, and surrounding counties. This process is federally mandated by the Internal Revenue Service (IRS) for all nonprofit hospitals under the Affordable Care Act—ensuring that tax-exempt hospitals demonstrate accountability to the communities they serve. Compliance with these regulations requires not only conducting a CHNA but also developing a publicly available implementation strategy to address identified needs.

Beyond regulatory requirements, White River Health views the CHNA as a vital tool for advancing its mission to improve the health and well-being of the region. The CHNA process provides an opportunity to engage community members, local leaders, health providers, and partner organizations in identifying the greatest barriers to health and the most significant opportunities for improvement. By systematically collecting and analyzing health data, listening to community perspectives, and assessing local resources, the CHNA offers a comprehensive picture of community health that goes far beyond compliance.

This assessment also plays a critical role in guiding organizational strategy and resource allocation. By identifying priority areas such as referral system processes, healthcare access and awareness, and specialty services, White River Health is able to direct its investments, programs, and partnerships toward initiatives that will have the greatest impact. Additionally, the CHNA fosters collaboration with regional partners, schools, civic groups, and state agencies—allowing for coordinated efforts that maximize resources and reduce duplication of services.

Ultimately, the CHNA process ensures that White River Health remains responsive to evolving community needs, accountable to its stakeholders, and proactive in addressing disparities in healthcare access and outcomes. Through this recurring cycle of assessment, planning, and implementation, White River Health reaffirms its commitment to improving community health in measurable and sustainable ways.

Background

The 2025 Community Health Needs Assessment (CHNA) was undertaken amid profound shifts in the healthcare landscape. Rural communities nationwide continue to contend with chronic workforce shortages, hospital financial instability, uneven access to care and an aging population beset by rising rates of chronic disease. At the same time, an uncertain economic climate—with escalating healthcare costs, shrinking reimbursements and the search for sustainable funding models—places additional strain on rural health systems.

To ensure that our response is both targeted and effective, the Arkansas Rural Health Partnership (ARHP) and White River Health collaborated closely with hospital leadership, community members and key regional stakeholders throughout the CHNA process. Together, we gathered firsthand insights, quantified the most urgent health needs, and built consensus around priority areas for action.

This assessment not only pinpoints the critical health challenges facing rural Arkansas but also establishes a strategic foundation for the years ahead. Over the next three years, our hospitals and community partners will channel resources toward strengthening rural hospital sustainability, expanding access to essential medical services and enhancing overall healthcare resilience. By embracing technological innovations, fostering new collaborative models and continually evaluating our impact, we will adapt—and thrive—despite the evolving obstacles that rural health systems confront.

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:

Arkansas Strengths
• Low prevalence of excessive drinking.
• High prevalence of fruit and vegetable consumption.
• Low percentage of households experiencing severe housing problems.
Arkansas Alarming Challenges
• 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%.
Arkansas Highlights
• 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**
Community and Family Safety			
• Homicide (Deaths per 100,000 population)	43	11.2	7.6
• Occupational Fatalities (Deaths per 100,000 workers)	39	5.5	4.2
Economic Resources			
• 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
Education			
• 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%
Social Support and Engagement			
• 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**
Air and Water Quality			
• 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%
Climate and Health			
• Climate Policies (Number out of four policies)	30	1	—

Housing and Transit			
• 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**
Access to Care			
• 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%
Preventive Clinical Services			
• 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%
Quality of Care			
• 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**
Nutrition and Physical Activity			
• 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)

Sexual Health			
• 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
Sleep Health			
• Insufficient Sleep (% of adults)	43	38.7%	35.5%
Smoking and Tobacco Use			
• 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

• 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

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%
• Cleburne County	$52,700	4.2%	14.0%
• Columbia County	$47,300	4.4%	23.0%
• Dallas County	$38,072	5.7%	11.2%
• Desha County	$31,893	4.6%	28.9%
• Drew County	$46,997	4.6%	22.7%
• Fulton County	$42,600	3.4%	15.0%
• Grant County	$55,388	4.5%	12.3%
• Independence County	$57,600	3.4%	19.6%
• Izard County	$43,900	5.2%	21.0%
• Jackson County	$43,600	5.0%	21.0%
• Jefferson County	$39,326	5.6%	20.6%
• Lawrence County	$47,300	3.6%	18.0%
• Lee County	$29,681	6.1%	27.7%
• Lincoln County	$46,596	7.4%	17.7%
• Lonoke County	$62,532	3.4%	11.1%
• 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%	20.0%
• St. Francis County	$35,348	5.6%	27.8%

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

RELEVANT DATA (Continued)

• Sevier County	$49,400	3.9%	19.6%
• Sharp County	$45,700	4.1%	20.0%
• Stone County	$41,100	4.2%	21.6%
• Union County	$44,663	4.4%	19.4%
• Van Buren County	$47,200	4.3%	20.0%
• White County	$56,900	3.5%	16.0%
• 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

• Independence and Stone Counties

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 Independence and Stone Counties, Arkansas:

GENERAL DEMOGRAPHICS			
Demographic Metric	**Independence County**	**Stone County**	**Arkansas**
• Population	37,945	12,575	3,045,637
• % Below 18 years of age	24.1%	19.6%	22.9%
• % 65 and older	18.5%	27.8%	17.8%
• % Non-Hispanic Black	2.4%	0.5%	15.3%
• % American Indian or Alaska Native	0.9%	1.1%	1.1%
• % Asian	0.9%	0.5%	1.8%
• % Native Hawaiian or Other Pacific Islander	0.4%	0.0%	0.5%
• % Hispanic/Latino	7.6%	2.1%	8.6%
• % Non-Hispanic/Latino White	86.7%	94.1%	71.0%
• % Male	49.5%	49.6%	49.4%
• % Female	50.5%	50.4%	50.6%

INCOME DEMOGRAPHICS			
Income Metric	**Independence County**	**Stone County**	**Arkansas**
• Median Household Income	$57,600	$41,100	$48,952

*Note: Data reflects figures in 2024 as reported by the *United States Census Bureau*.*

POVERTY STATISTICS				
Population Segment	**Independence County**	**Stone County**	**Arkansas**	**United States**
• All People	19.6%	21.6%	15.7%	12.5%
• Under 18 Years of Age	19.0%	29.3%	20.9%	16.0%
• 18 to 64 Years of Age	18.5%	22.5%	14.7%	11.5%
• 65 and Older	10.1%	14.1%	12.1%	11.3%

MIGRATION DEMOGRAPHICS

Migration Metric	Independence County	Stone County	Arkansas
• Moved within the Same County	4.1%	5.7%	6.0%
• Moved from a Different County, Same State	2.5%	3.3%	3.4%
• Moved from a Different State	2.5%	5.0%	2.3%
• Moved Abroad	0.1%	0.3%	0.3%

HEALTHCARE COVERAGE

Coverage Metric	Independence County	Stone County	Arkansas
• Uninsured (%)	12%	13%	11%

HEALTHCARE PROVIDER DEMOGRAPHICS

Population Segment	Independence County	Stone County	Arkansas	U.S. Top Performing Counties
• Primary Care Physicians Ratio	1,300: 1	2,080: 1	1,480:1	1,330:1
• Dentists Ratio	2,230: 1	4,190: 1	2,040:1	1,360:1
• Mental Health Providers Ratio	560: 1	660: 1	380:1	320:1
• Preventable Hospital Stays (per 100,000)	3,293	2,529	3,015	2,681
• Mammography Screening (%)	32%	29%	40%	43%
• Flu Vaccinations (%)	48%	46%	45%	47%

HEALTH STATISTICS

Health Metric	Independence County	Stone County	Arkansas	U.S. Top Performing Counties
• Adult Smoking (%)	22%	25%	22%	15%
• Adult Obesity (%)	37%	41%	39%	34%
• Food Environment Index	6.7	5.5	4.7	7.7
• Physical Inactivity (%)	30%	35%	30%	23%
• Access to Exercise Opportunities (%)	49%	50%	64%	84%
• Alcohol-Impaired Driving Deaths (%)	34%	20%	27%	26%
• Sexually Transmitted Infections (per 100,000)	408.2	160.2	592.8	495.5

*Note: Data reflects figures up to 2024 as reported by the *County Health Rankings & Roadmaps.**

Mission

The mission of White River Health is to provide quality healthcare and improve the health of our communities.

Vision

The vision of White River Health is to provide an environment where patients choose to receive care, employees desire to work, physicians want to practice, and families and visitors feel welcome.

History

White River Health (WRH), located in Batesville, Arkansas, is dedicated to providing advanced healthcare services to communities across North Central Arkansas through comprehensive inpatient and outpatient care, as well as community outreach. With two hospital campuses in Batesville and Mountain View, along with outpatient care centers and clinic offices throughout the region, WRH offers quality patient care and a healing environment close to home. Established originally as White River Medical Center, WRH is an acute care, multi-facility, not-for-profit regional referral center serving a ten-county area that includes Independence, Izard, Sharp, Stone, and portions of Cleburne, Fulton, Jackson, Lawrence, Van Buren, and White counties.

Guided by its mission to provide quality healthcare and improve the health of its communities, WRH envisions an environment where patients choose to receive care, employees desire to work, physicians want to practice, and families and visitors feel welcome. The organization's core values—Compassion, Accountability, Respect, and Excellence (C.A.R.E.)—shape its culture and daily practices. Compassion fosters empathy and concern; accountability ensures integrity and ownership of responsibilities; respect promotes dignity and collaboration; and excellence drives continuous improvement in patient care, quality, and innovation.

WRH also upholds high standards of behavior, recognizing PRIDE as *Personal Responsibility In Delivering Excellence.* These standards emphasize prompt and courteous service, respect for others, involvement and ownership in organizational success, professional demeanor, and a focus on maintaining a safe, healing, and welcoming environment. Collectively, these principles ensure that White River Health remains committed to its role as a trusted healthcare provider and community partner across North Central Arkansas.

Leadership

- Steven Webb, *Chief Executive Officer*
- Shawna Ives, *Chief Financial Officer*
- Jennifer Sandage, *Chief Nursing Officer*
- EJ Jones, MD, *Chief Medical Officer*
- Kathy Thomas, *Vice President and Chief Operating Officer, and Chief Safety Officer*
- Maggie Williams, *Vice President, Ancillary, Ambulatory, & DIO*

Organizational Chart included as Attachment D.

Governance

- Randy Cross, *Chairman*
- Tyler Fowlkes, *Vice Chairman*
- Robert McIntire, *Treasurer*
- Jeff Showalter, *Secretary*
- Danny Bell, *Member*
- Steve Case, *Member*
- Beth Christian, *Member*
- Stacy Gunderman, *Member*
- Crystal Johnson, *Member*
- Lance Lamberth, *Member*
- Kathy Lanier, *Member*
- Kevin Rose, *Member*
- Jason Taylor, *Member*
- Tina Wheelis, *Member*
- Steven Webb, FACHE, *Ex Officio*
- William “Skip” Baker, MD, *Ex Officio*
- Luke Edgecombe, MD, *Ex Officio*
- Kaylan Gonugunta, MD, *Ex Officio*
- Richard Huff, *Ex Officio*
- Amanda Johnson, MD, *Ex Officio*
- Stacy Pollack, MD, *Ex Officio*
- Barry Pierce, MD, *Ex Officio*
- Roger Rich, *Ex Officio*
- Janie Starnes, *Ex Officio*

Hospital Services

WHITE RIVER HEALTH

- Cardiac & Pulmonary Rehabilitation
- Cancer Care (Diagnosis, Surgical Intervention, Chemotherapy, Immunotherapy, and Radiation Therapy)
- Emergency Room
- Health (Non-Invasive Cardiology, Cardiac Catheterization, Electrophysiology, & Interventional Cardiology)
- Inpatient Medical/Surgical Care
- Inpatient Rehabilitation
- Interventional Pain Management (Cherokee Village & Newport)
- Mental Health – (Adult Inpatient Psychiatric Care, Geriatric Psychiatric Care, Medical Detox, Outpatient therapy, MAT) Inpatient and Outpatient
- Orthopaedics
- Outpatient Audiology
- Outpatient Family Medicine
- Outpatient Neurology
- Outpatient Rheumatology
- Outpatient Therapy (PT, OT, SLP) – (Cherokee Village)
- Palliative Care
- Radiology Services
- Sleep Center
- Surgical Services (Arthroscopy, Colonoscopy, EGD, ENT, General Surgery, GYN, Orthopaedics, Urology)
- Women's & Newborn Health
- Wound Healing

STONE COUNTY MEDICAL CENTER

- Cardiac & Pulmonary Rehabilitation
- Emergency Room
- Inpatient Medical/Surgical Care
- Swing Beds
- Interventional Pain Management
- Mental Health (Outpatient)
- Orthopaedics
- Outpatient Family Medicine
- Outpatient Therapy (PT, OT, SLP)
- Palliative Care
- Radiology Services
- Sleep Center
- Surgical Services (Arthroscopy, Colonoscopy, EGD, General Surgery, Orthopedics)
- Wound Healing

Providers

PHYSICIANS (MD/DO/PhD)

- John Akins, MD, FAAOS – Orthopaedics, Hand Surgery & Sports Medicine
- Monroe Albertson, MD – Emergency Medicine
- Julia Lee Allen, MD – Family Care
- Mahesh Anantha, MD, FACC – Cardiology
- Bernice Anderson, MD – Neurology
- Jerrod Anderson, MD – Family Care
- Michael Andryka, MD – White River Medical Center
- Jeffery Angel, MD, MFin, FAAOS – Orthopaedics & Sports Medicine
- Anthony Anston, DO – Emergency Room
- Katherine Appleget, MD, ABOG – Women's Clinic
- William "Skip" Baker, MD – Emergency Room
- Ronald Bates, DO
- Michelle Bishop, MD – Family Care
- Lauren Bloch, MD – Family Care
- Hunter L. Brown, MD – Surgery Clinic – Urology
- Verona T. Brown, MD – Woodlawn Heights
- Kalyan Gonugunta, MD – White River Medical Center
- Neelima Gonugunta, MD – Internal Medicine
- Amanda Johnson, MD – White River Medical Center
- Shoaib Khan, MD – White River Medical Center
- Anil Kumar, MD – White River Medical Center
- Wyatt Lydolph, MD – White River Medical Center
- Ronald K. McCann Jr., MD – Radiology
- Charles M. McClain, III, MD – Radiology
- Carol McCourt, MD – Pain Management
- Jennifer McLaughlin, MD – Dermatology
- Cody McLeod, MD – Orthopaedics & Sports Medicine
- Christopher Melton, MD – Emergency Room
- Clint G. Melton, MD, FACOG – OB/GYN Center
- Melody Moody, MD – Pediatrics (Children's Clinic)
- Jonathan Moser, MD – Family & Specialty Care
- Patrick Mulick, Ph.D – Behavioral Health
- Devi Nair, MD – Cardiology
- Shahla Gul Naoman, MD, FACP – Pulmonology
- Sydney Neel, MD – Emergency Room
- Morgan Norton, MD – White River Medical Center
- Caleb Oster, DO – White River Medical Center
- C. Adam Pearrow, DO – Zini Medical Clinic
- Craig Pickren, MD – Wound Care
- Barry Pierce, MD – Emergency Room
- William Pittman, MD – Emergency Room
- Stacy Pollack, MD, FACOG – Women's Clinic
- John Rians, MD – Stepping Stone
- Julia Roulier, MD – UAMS North Central Family Medicine
- Todd Rumans, MD – Surgery Clinic
- Mihaela Savu, MD – Cardiology
- Edwin Sherwood, MD – Emergency Room
- Meraj Siddiqui, MD – Pain Management
- Ronald Simpson, MD – Family Care
- Amanda Smith, MD – Pediatrics (Children's Clinic)
- Thomas Soehner, MD – Urology
- Srishti Srivastava, MD – Pain Management

Providers (continued)

ADVANCED PRACTICE REGISTERED NURSES (APRNs, DNPs, FNPs, PMHNPs)

- Whitney Melton, APRN – Family Care
- Naomi Miller, APRN – Family Care
- Pamela Mize, APRN – Family Care
- Micah Moody, DNP, APRN, FNP-C – Family Care
- Robin Murphy, APRN, FNP-C – Family Care
- David Tanner Oliver, APRN – Emergency Room
- Erin Sandefur, APRN – Family Care
- Sarah “Dee” Shaw, APRN – Family Care
- Kim Moser Smith, APRN – Family Care
- Bobbi Tosh, APRN – Family Care
- Jennifer Tosh, APRN – Family Care
- Brandon Womack, APRN – Family Care
- M. Colleen Moore, APRN – Emergency Room
- Deanna Nast, APRN, ACNP-BC, CHFN – Cardiology / White River Medical Center
- Tobi Nipp, MSW – Family Care (Behavioral Health support)
- Ellen Qualls, APRN – Cardiology
- Tyler Sandlin, APRN – Pediatrics (Children’s Clinic)
- Nicole Smith, APRN, PMHNP-BC – Behavioral Health
- Michelle Snow, APRN – Surgery Clinic
- Seth Stone, APRN – White River Medical Center
- Kasey Sutterfield, APRN – Pain Management
- Charlett Watson, APRN – Family & Specialty Care
- Katie Webb, APRN – Pediatrics (Children’s Clinic)
- Sarah Wycough, APRN – Cardiology

Following the survey and community advisory board discussions, White River Health has identified three focus areas for the next three years: *Referral System Processes, Healthcare Access & Awareness, and Specialty Services.*

Priority #1: Referral System Processes

FEDERAL

Inefficient referral processes are a well-recognized nationwide issue in healthcare. According to CMS studies, it is indicated that up to 50% of patient referrals are never completed—meaning many patients never actually see the specialist to whom they were referred. This breakdown in the "referral loop" leads to delays in care, poorer health outcomes, and frustration for both patients and providers. In one survey of Medicaid enrollees, 22% reported difficulty obtaining a specialist appointment as soon as needed, reflecting widespread patient dissatisfaction with referral timeliness, according to a 2017 study published by *Agency for Healthcare Research & Quality.* Such gaps in coordination contribute to patient anxiety and no-shows, as people often give up or seek care elsewhere if a referral appointment isn't promptly secured. Overall, the national data underscore that strengthening referral system processes (for example, through better tracking and communication) is crucial to improving continuity of care.

All sources referenced (Appendix A).

ARKANSAS

Challenges with referral systems are amplified in Arkansas due to healthcare workforce shortages and rural geography. Arkansas ranks among the lowest states in physicians per capita, and more than 500,000 Arkansans live in areas federally designated as having an inadequate number of health professionals. This shortage means primary care providers often struggle to find in-state specialists for patient referrals, leading to long wait times or sending patients to distant facilities. Indeed, Arkansas is a predominantly rural state, and provider maldistribution results in many communities lacking nearby specialists. Senator John Boozman noted that Arkansas' physician shortfall is "urgent," as the state has far fewer doctors per population than the U.S. average. In practical terms, these shortages create bottlenecks in the referral process—for example, a referral from a small-town clinic might require an appointment in Little Rock or another urban center, which can delay care. The state has made efforts (such as expanding residency slots and telehealth initiatives) to improve referral networks, but bridging the gap remains a priority. Effective referral processes in Arkansas will likely require building more integrated networks and leveraging technology to connect rural providers with urban specialists.

All sources referenced (Appendix A).

INDEPENDENCE & STONE COUNTIES

In Independence and Stone Counties—the primary service area for White River Health—referral system challenges are a top concern identified in the Community Health Needs Assessment. These are rural counties (combined population around 50,000) where specialty care is limited, making referrals especially

critical for connecting patients to services not available locally. Transportation barriers exacerbate the problem: for instance, rural residents often must travel long distances for specialist care, and limited transportation options mean some patients struggle to keep referral appointments. In Stone County, nearly one-fifth of households have no vehicle available for regular use (well above urban rates), reflecting how geographic isolation and lack of transit can cause referred patients to "fall through the cracks." Moreover, before improvements were initiated, communication gaps were common—for example, local providers might refer a patient out, but never receive follow-up information, or patients might be unclear on referral instructions. Recognizing these issues, White River Health has been working on streamlining referral processes to "close the loop" on referrals. The goal is that when a patient is referred, the appointment is actually completed and the information flows back to the primary provider. Improving referral efficiency and tracking at the local level is expected to reduce wait times, prevent patients from giving up on getting specialist care, and increase trust in the system. In summary, enhancing referral system processes—ensuring timely referrals, better patient navigation, and follow-up—is a top priority federally, statewide, and acutely so in Independence and Stone Counties to connect residents with the care they need.

All sources referenced (Appendix A).

Priority #2: Access and Awareness

FEDERAL

Ensuring broad health care access and improving public health awareness are longstanding national priorities, with recent progress yet remaining gaps. On the access front, the United States has increased insurance coverage since the Affordable Care Act—the overall uninsured rate hit a historic low around 8–9% in the early 2020s, down from about 15% a decade prior. (By comparison, Arkansas' uninsured rate dropped from 24.2% before Medicaid expansion to roughly 12.5% Despite these gains, millions of Americans still lack health insurance or face other access barriers such as high out-of-pocket costs and provider shortages. Health care access is not just about insurance; it also involves having providers nearby, transportation to reach them, and the knowledge to seek appropriate care. Federal data shows how rural and low-income populations continue to have less access—for example, non-metro Americans are more likely to be uninsured and less likely to have a reliable source of care.

In terms of health awareness, nationally there is a significant deficit in health literacy and knowledge of health resources. Only about 12% of U.S. adults have proficient health literacy skills, meaning the vast majority struggle with understanding health information and navigating the system. This lack of awareness can lead to lower use of preventive services, poorer chronic disease management, and confusion about when and where to seek care. Public health agencies (like the CDC) have stressed the need for more health education as part of improving outcomes. Overall, at the federal level the focus has been on expanding coverage (e.g., through Medicaid/Marketplace) and on initiatives to boost health literacy and outreach—recognizing that coverage alone doesn't guarantee effective access or informed use of healthcare.

All sources referenced (Appendix A).

ARKANSAS

Arkansas mirrors many national challenges in health access and faces some unique hurdles. As noted, Arkansas's uninsured rate fell dramatically with the implementation of the Arkansas Health Care Independence Program (the private option Medicaid expansion — from roughly one-quarter of the population uninsured to about 12% by a few years afterward. Recent estimates put Arkansas's uninsured rate around 9–10%, close to the national average, thanks to these coverage expansions. However, insurance coverage is only one aspect; the state's rural nature means physical access to care is difficult for many residents. More than one-third of Arkansans live in a Health Professional Shortage Area (HPSA) lacking adequate primary care or mental health services. In 2020, a total of 6 Arkansas counties had only a single full-time primary care physician practicing within their borders. This shortage of local providers translates to long travel distances for routine care and even longer for specialty or hospital services — *a significant access problem.* Additionally, Arkansas struggles with poverty and transportation barriers that impede access: many communities lack public transit, and rural hospitals/clinics have closed in some areas, forcing residents to drive hours for certain medical needs.

Health awareness is another critical issue in Arkansas. Educational attainment and health literacy tend to be lower in many Arkansas counties, especially rural ones, which affects people's knowledge of healthy behaviors and available services. It is telling that nearly 88% of adults in the U.S. (and by extension, many Arkansans) have less-than-proficient health literacy, with a large portion having only "basic" comprehension of health information. In Arkansas, agencies like the Department of Health and nonprofits have rolled out health literacy programs. A great example of a community awareness program is the University of Arkansas's Cooperative Extension's "How to Talk to Your Doctor". Nevertheless, awareness of existing resources remains an issue — many Arkansans are simply not aware of all the clinics, preventive programs, or assistance options available. The Arkansas Department of Health's Hometown Health Improvement initiative is one approach aiming to engage local leaders in educating communities about health topics. In summary, while Arkansas has made strides in health access by insuring more people, the state continues to focus on bolstering the awareness and health literacy of its population to ensure those insurance cards translate into actual, effective care.

All sources referenced (Appendix A).

INDEPENDENCE & STONE COUNTIES

In Independence and Stone Counties, *health access and awareness* was identified as a top concern because many residents still encounter barriers to care and may not fully understand or utilize the health resources that do exist. Access in these counties is hindered by both economic and geographic factors. Census data show that poverty rates in parts of these counties are above state average, and a considerable share of the population is uninsured or under-insured (roughly 15% of those under 65 were uninsured in these counties in 2019, which slightly exceeded the state average). Transportation is a well-recognized local obstacle: Independence and Stone are rural, sparsely populated areas with no public transportation system. According to the Arkansas Dept. of Health profiles, a high proportion of households (on the order of

15–20%) in these counties do not have a vehicle or reliable transportation, leaving many residents isolated from health facilities. This means even if someone has health coverage, simply getting to a doctor's office or pharmacy can be a challenge. Limited transportation is a common barrier in rural areas—often forcing patients to delay or forgo care. Local healthcare leaders have noted that something as basic as arranging a ride to the clinic is a major concern for the elderly and low-income families in Stone and Independence counties.

On the awareness side, community surveys and stakeholder input in the White River Health CHNA process revealed gaps in health knowledge. Many residents are not aware of preventive services (like cancer screenings or diabetes education classes) that are available, or they lack understanding of health insurance benefits and how to use them. In these two counties, health communication can be challenging due to limited broadband internet penetration and lower health literacy. In 2024, an analysis from *American Journal of Managed Care* highlighted, rural populations often have limited internet access and higher rates of chronic disease, which can impede health communication efforts. Independence and Stone counties exemplify this: broadband coverage is spotty in some areas (making telehealth and online health information less accessible), and chronic conditions like diabetes and hypertension are common, necessitating better patient education. Local public health coalitions (including the Independence County Hometown Health Coalition and Stone County Health Improvement Coalition) have been working to increase awareness through health fairs, school programs, and social media outreach. The importance of health awareness is evident in issues like vaccination and preventative care uptake—for example, if people aren't aware of or don't understand recommendations, they tend to skip these services. Thus, the CHNA priority includes not only improving physical access (more providers, clinics, transportation services) but also boosting health awareness and literacy (through education campaigns, outreach by community health workers, etc.). By addressing both, the aim is to ensure that residents of Independence and Stone Counties can access healthcare when needed and are informed participants in their own health—ultimately improving health outcomes.

All sources referenced (Appendix A).

Priority #3: Specialty Services

FEDERAL

Gaps in specialty healthcare services are a national concern, particularly in rural and underserved areas. While urban centers often have an abundance of specialist physicians (cardiologists, oncologists, psychiatrists, etc.), many communities across the country lack local access to these specialty services. In fact, about 20% of Americans live in rural areas—but only ~9% of physicians practice in rural communities, leaving a large disparity. This imbalance is even more pronounced for specialists. The federal government and research organizations, like the *Association of American Medial Colleges,* have noted that specialty and subspecialty healthcare services are far less available in rural areas, especially high-intensity or highly specialized care. For example, a recent analysis found that over half of U.S. counties (primarily rural) do not have a local obstetrician/gynecologist, and many counties have no psychiatrists or other key specialists.

Consequently, patients in rural or small-town America often must travel long distances to metropolitan hospitals or clinics to receive specialized treatments. This travel can pose significant hardship, leading to delays in care or patients forgoing recommended specialist visits.

Another telling statistic comes from a 2019 policy brief on rural healthcare: 64% of rural health clinic staff reported difficulty finding specialist providers for patient referral. This indicates that even primary care providers working in rural settings struggle to connect their patients with specialists due to shortages. Nationally, this shortage of specialty services has prompted various responses, such as telemedicine programs (to beam specialist care remotely), incentives for specialists to practice in underserved areas, and mobile specialty clinics. Nonetheless, as of 2025, specialty care availability remains highly uneven. The issue extends beyond physician supply—it includes limited specialty facilities (like dialysis centers, cancer infusion centers, etc.) in rural regions. Federal agencies (like HRSA and the Veterans Health Administration) have identified expanding specialty care access as critical, because lacking local specialty services contributes to worse outcomes in diseases like cancer, heart disease, and mental health disorders in those communities.

All sources referenced (Appendix A).

ARKANSAS

As a largely rural state, Arkansas faces a significant challenge in providing specialty medical services to all its residents. Arkansas has only a few urban hubs (Little Rock, Jonesboro, Fort Smith, etc.) where most specialists are concentrated, and vast rural areas with very limited specialty care. The state's sole academic medical center (UAMS in Little Rock) serves as a referral center for complex cases statewide, but that means residents in outlying counties often travel hours for specialist appointments. Indeed, many smaller Arkansas counties have no practicing physicians in certain specialties. For instance, there are counties with no obstetrician, forcing pregnant women to go to another county for prenatal care and delivery. Similarly, pediatric subspecialists, oncologists, and neurologists are virtually absent in many regions outside central Arkansas. This reality aligns with the earlier point that only 9% of doctors work in rural areas—Arkansas exemplifies that, with some of the lowest physician-to-population ratios in the country. It's not just a primary care shortage; recruiting and retaining specialists in rural Arkansas has proven difficult.

The implications are serious: without local specialty services, conditions that require specialist management (like cancer, heart failure, or mental illness) may go undertreated. Arkansas has acknowledged this gap; for example, the Arkansas Department of Health and UAMS have used telehealth to extend specialty consults (such as the AR SAVES stroke program connecting neurologists to rural ERs, and telepsychiatry for mental health). Additionally, as shared in White River Health's previous Community Health Needs Assessment, state programs offer loan repayment and other incentives to lure specialists to underserved areas. Federal data identified at least 57 whole or partial counties in Arkansas as Health Professional Shortage Areas for medical specialties (primary care, dental, or mental health). In Senator Boozman's 2023 statement, he emphasized expanding residency programs in Arkansas's underserved areas to train specialists locally. This is because physicians often practice where they train, so placing residency slots

in rural hospitals could yield more specialists for those regions. In summary, Arkansas's focus at the state level is to increase specialty service capacity—through telemedicine, regional clinics, and workforce incentives—so that rural Arkansans like those in Independence/Stone Counties can access specialized care without undue burden.

All sources referenced (Appendix A).

INDEPENDENCE & STONE COUNTIES

The White River Health service area has explicitly prioritized Specialty Services in its 2025 CHNA because community members and data have highlighted a shortage of local specialty care. Independence County (home to White River Medical Center in Batesville) and neighboring Stone County (home to Stone County Medical Center in Mountain View) are rural areas where many specialized services historically have not been readily available. In past assessments, residents reported having to travel to Little Rock, Jonesboro, or out of region to see certain specialists (for example, oncologists for cancer treatment, cardiologists for advanced heart care, endocrinologists for diabetes management, etc.). This travel can be a significant hardship—it involves time off work, transportation costs, and navigating unfamiliar big-city hospitals. The CHNA findings likely showed that lack of nearby specialty providers was impacting health outcomes; for instance, delays in starting specialty treatments or skipping follow-ups due to distance.

White River Health has taken steps in recent years to address this gap. They have established specialty clinics at Stone County Medical Center so that specialists from the main hospital or visiting physicians can see patients in Mountain View on a rotating basis. As of a few years ago, WRHS started offering local cardiology, oncology, obstetrics/gynecology, and pain management clinics in Stone County. This was a direct response to community needs. Similarly, White River Medical Center in Batesville has expanded its roster of specialists and added services like chemotherapy infusion, so that Independence and Stone County residents don't always have to go to Little Rock for cancer care. Despite these improvements, there remain gaps. Certain specialties (such as advanced trauma surgery, certain pediatric subspecialties, or high-end procedures) are still only available at larger centers. Community input during the CHNA likely stressed, for instance, the need for more mental health specialists and substance abuse treatment locally—as these are specialty services in critically short supply in rural areas.

By averaging statistics of Independence and Stone Counties, one can see the scope of the issue: combined, these two counties have roughly 50,000 people but relatively few specialists among them (primary care doctors are present, but most specialties have at most one or two providers locally, if any). Both counties are designated as part of Health Professional Shortage Areas for primary care and mental health, implying specialist scarcity as well. According to a rural health policy brief, patients in areas like Independence/Stone often face significant difficulties obtaining specialist referrals—echoing the national statistics, local healthcare workers report trouble finding accepting specialists for their patients. This is precisely why improving specialty services is a top priority: it involves recruiting more specialists to practice locally, partnering with regional specialists to conduct outreach clinics, and utilizing tele-specialty care (telemedicine consultations) to bridge the gap. By expanding specialty services in Independence

and Stone Counties, White River Health aims to improve health outcomes (e.g. catching diseases earlier, managing chronic illnesses better with specialist input) and reduce the burden on patients who currently travel long distances for care. In summary, from the federal recognition of rural specialty shortages, to the state efforts to increase specialist supply, down to the local initiatives by White River Health to bring more specialty care to Batesville and Mountain View, it is clear that enhancing access to specialty services is crucial for meeting the community's health needs going forward.

All sources referenced (Appendix A).

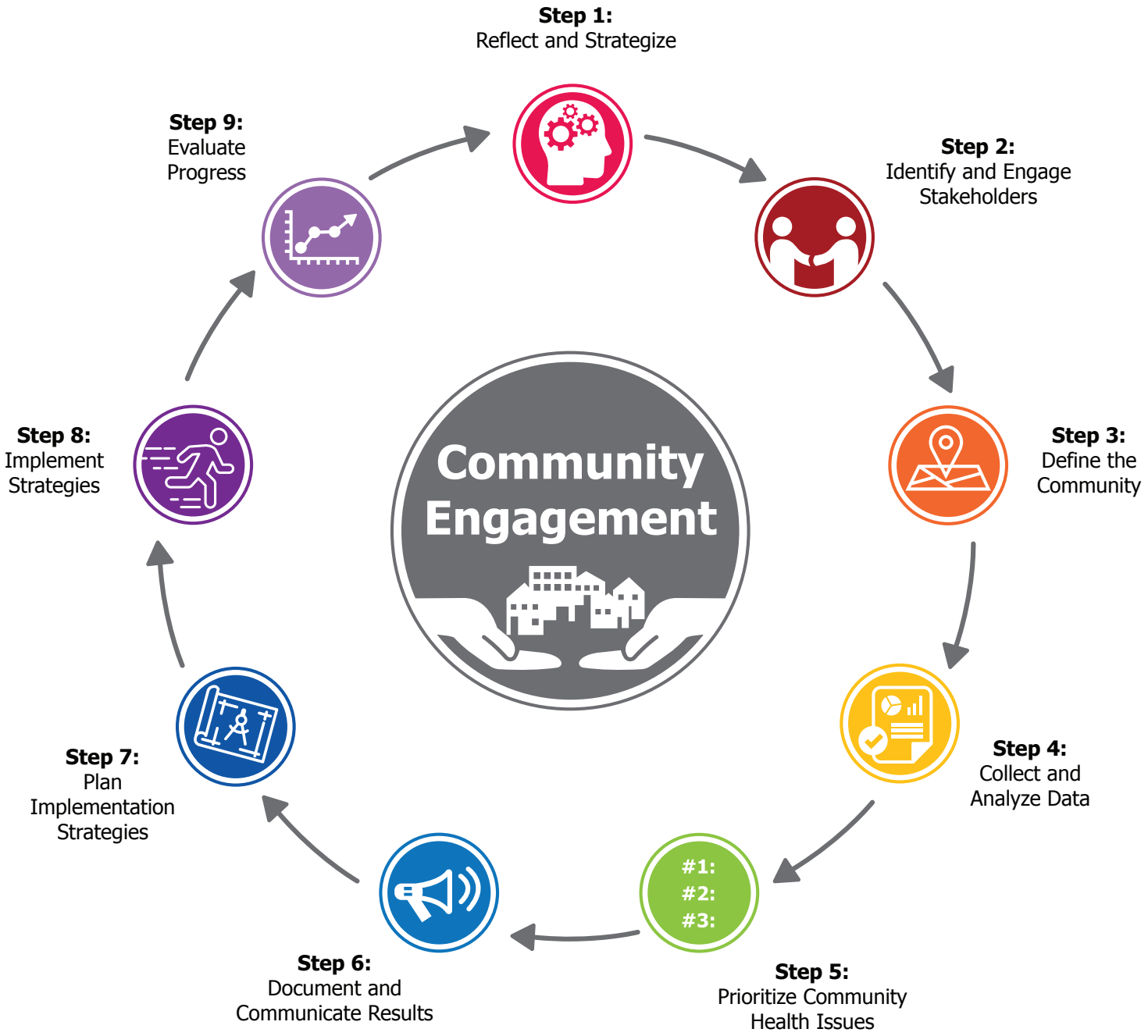
COMMUNITY HEALTH INITIATIVES

The Community Engagement division of White River Health builds partnerships that promote wellness, expand access to healthcare, and foster community involvement. The division coordinates events designed to improve healthcare access, encourage physical activity, and support interest in healthcare careers. Education partners include Batesville Public Schools, Cave City Public Schools, Cedar Ridge Public Schools, Highland Public Schools, Lyon College, Melbourne Public Schools, Midland Public Schools, Mountain View Public Schools, Newport Public Schools, Southside Public Schools, and the University of Arkansas Community College at Batesville. Community partners include the Batesville Area Chamber of Commerce, Batesville Parks and Recreation, the Children's Advocacy Center of Independence County, the Hardy Police Department, the Humane Society of Independence County, the Greers Ferry Lake Trails Council, and the Spring River Area Chamber of Commerce.

Community education and screening initiatives include programs such as the Cave City Scrub Club, Eagle Mountain Elementary Flex Friday, the Health First Women's Health Expo, and Heber Springs Athletic Physicals. Fundraising efforts have supported wellness and healthcare priorities through events such as the White River Health 5K (2022), the WRMC Highway to Health 5K (2020–2021), the Arkansas Leukemia & Lymphoma Society Woman of the Year campaign, the Batesville West Magnet Playground Project, and the Raccoon Creek Crusher. In addition, the division contributes to community service through CPR instruction, the Mom Squad of Newport, Narcan training, and Safe Sitter classes.

White River Health is also a member of the Arkansas Rural Health Partnership, an organization that serves as a crucial hub for economic growth and development across the region. ARHP's efforts are dedicated to supporting and improving existing healthcare infrastructure while strengthening healthcare delivery across rural South Arkansas—securing approximately $92 million. The Arkansas Rural Health Partnership is committed to enhancing the entire ecosystem of rural communities through transformative conversations, strategic partnerships, and impactful initiatives.

Community Engagement Process



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

CHNA Facilitation Process

The Community Health Needs Assessment (CHNA) process for White River Health was guided by the *CHNA Toolkit*—developed by the National Center for Rural Health Works at Oklahoma State University, the Center for Rural Health, and the Oklahoma Office of Rural Health. This evidence-based framework provided a structured approach that included facilitated community meetings and oversight by a dedicated steering committee, which also established and directed a Community Advisory Committee (CAC). The CAC consisted of 9 engaged community representatives who played an active role in the assessment process and contributed to the development of a strategic plan addressing the region's highest-priority health needs.

Public participation was intentionally positioned as a cornerstone of the process. The White River Health steering committee—led by Steven Webb and Stephanie Toon—collaborated with Lynn Hawkins of the Arkansas Rural Health Partnership (ARHP) to design a robust model for community engagement. Together with ARHP staff, the steering committee organized hybrid community meetings and coordinated the development of both the CHNA and the subsequent implementation plan.

To gather a wide range of perspectives, the steering committee created a Community Advisory Committee with local leaders and health professionals. This committee was key to the success of the Community Health Needs Assessment (CHNA), using their local connections and knowledge of the community to ensure a broad representation of the population. This approach made the process more efficient and ensured the CHNA was deeply rooted in the community, leading to a more accurate and comprehensive understanding of local health needs.

During CHNA meetings, staff from the Arkansas Rural Health Partnership (ARHP) presented an overview of the CHNA framework, shared local health statistics, and guided participants through the 2025 CHNA survey. Committee members then helped distribute the survey by engaging neighbors, colleagues, and local organizations. To make sure the survey was accessible to everyone, it was also made available online on the White River Health and ARHP websites, along with other community platforms.

Following the collection of survey responses, ARHP staff conducted a detailed data analysis and presented the findings during a second advisory committee meeting. During this session, participants reviewed survey results, engaged in structured discussion regarding the most pressing health issues, and collaboratively identified key community priorities. These priorities became the foundation for a comprehensive implementation plan developed by the steering committee, with the goal of generating measurable and sustainable improvements in community health.

Implementation of the strategic plan is structured over a three-year period. The White River Health steering committee will meet annually with the advisory committee to review progress, evaluate outcomes, and make necessary adjustments. This recurring evaluation cycle ensures that the implementation plan remains responsive to evolving health needs and maintains accountability to the community it serves.

Steering Committee

- Steven Webb, *Chief Executive Officer, White River Health*
- Stephanie Toon, *Interim Director of Population Health, White River Health*
- Lynn Hawkins, *Chief Operating Officer, Arkansas Rural Health Partnership*

RESULTS OVERVIEW: WHITE RIVER HEALTH'S 2025 COMMUNITY HEALTH NEEDS ASSESSMENT

There were **600** completed surveys through White River Health's 2025 Community Health Needs Assessment process. All of the results of the survey can be found in *Attachment D.*

TOP ISSUES IDENTIFIED

Referral System Processes.

Improving referral system processes emerged as a key priority, with emphasis on building a more efficient and reliable "referral loop." Strengthening this process will ensure smoother coordination and communication between providers, while also reducing delays in scheduling and accessing specialist care. By enhancing timeliness and accountability throughout the referral pathway, patients will experience more seamless transitions of care, leading to improved continuity, higher satisfaction, and better health outcomes.

Healthcare Access & Awareness.

Access to care and awareness of available resources are persistent challenges in Independence and Stone Counties. Geographic isolation, limited public transportation, and provider shortages make it difficult for many residents to reach timely and appropriate healthcare services. In addition, uninsured and underinsured populations face financial barriers that often delay or prevent care. Beyond physical access, community input revealed gaps in health literacy and awareness, with many residents lacking information about preventive services, chronic disease management programs, or how to effectively navigate the healthcare system. Strengthening healthcare access in these counties requires not only expanding provider availability and transportation options but also improving communication strategies, education efforts, and outreach programs. Enhancing both access and awareness will empower residents to take full advantage of local healthcare resources—leading to earlier interventions, better disease management, and improved overall health outcomes.

Specialty Services.

Limited availability of specialty care continues to be a significant barrier in Independence and Stone Counties. While primary care providers and local hospitals offer essential services, many residents must travel outside the region—often to Little Rock, Jonesboro, or beyond—to access specialties such as oncology, cardiology, neurology, and advanced mental health services. This creates challenges for patients who lack reliable transportation, face financial constraints, or are managing chronic conditions that require frequent follow-up. Community feedback highlighted the burden of long travel times, delayed appointments, and gaps in continuity of care caused by the scarcity of local specialists. Although White River Health has expanded some specialty clinics and introduced visiting specialists to reduce travel distances, demand still exceeds availability in several areas of care. Addressing this priority will require continued recruitment of specialty providers, partnerships with larger health systems, and expansion of telehealth services. Strengthening local access to specialty care is critical to improving early detection, chronic disease management, and treatment outcomes for rural residents.

FROM NEEDS TO ACTION: WHITE RIVER HEALTH STRATEGIC IMPLEMENTATION PLAN (2025–2028)

The 2025–2028 Strategic Implementation Plan provides a comprehensive, action-oriented framework to address the priority health needs identified in the White River Health Community Health Needs Assessment (CHNA). Developed through a collaborative partnership between the Arkansas Rural Health Partnership (ARHP) and the White River Health Board of Directors, the plan includes mechanisms for continuous monitoring, with progress reports submitted to the Internal Revenue Service in compliance with federal requirements. To ensure transparency and accessibility, hard copies of the assessment are available upon request at White River Health, and the full report is published on the White River Health website.

The Arkansas Rural Health Partnership is also expanding the scope of the strategic plan by integrating input from all member hospitals across its network. Through shared funding, coordinated resource allocation, and regional collaboration, the plan is designed to generate measurable improvements in community health throughout the Arkansas Delta. This multi-year initiative emphasizes expanding healthcare access, addressing health disparities, and building long-term sustainability for rural health systems across the region.

White River Health's Community Health Needs Assessment Strategic Plan: 2025-2028

I. REFERRAL SYSTEM PROCESSES

A. ***Goal*****.** To establish a reliable, efficient referral system that ensures timely communication and seamless transitions of care between providers.

B. Strategies & Actions.

- **a.** In **Year 1** (2025), White River Health will begin by mapping existing referral processes, identifying communication gaps, and piloting a manual referral tracking log at selected clinics. Staff will receive training on referral follow-up procedures—focusing on ensuring patients are contacted and appointments are confirmed.
- **b.** In **Year 2** (2026), a referral coordinator role or point of contact will be established to oversee follow-up and create feedback loops between primary and specialty providers. Lessons learned from the Year 1 pilot will be applied to expand manual tracking and improve coordination.
- **c.** In **Year 3** (2027), White River Health will explore integration of referral tracking into its electronic health record system and expand referral coordination to include regional partners and telehealth specialists. Evaluation will include referral timeliness, patient satisfaction, and provider engagement, with adjustments made to ensure sustainability.

C. Expected Outcomes. *A phased approach will allow White River Health to build capacity gradually, starting with low-cost, staff-driven improvements and moving toward system integration. This process will reduce missed referrals, improve provider communication, and enhance continuity of care for patients.*

WHITE RIVER HEALTH STRATEGIC IMPLEMENTATION PLAN (2025–2028) (Continued)

II. HEALTHCARE ACCESS & AWARENESS

A. ***Goal.*** To expand access to healthcare services and improve awareness of available resources in Independence and Stone Counties.

B. Strategies & Actions.

- **a.** In **Year 1** (2025), a community awareness campaign will be launched to highlight available services, preventive care options, and chronic disease management programs. White River Health will partner with schools, churches, and civic organizations to distribute resource guides and work with local transit providers to identify transportation solutions.
- **b.** In **Year 2** (2026), Community Health Workers (CHWs) will be engaged to provide outreach, navigation, and education services. Health literacy workshops such as "How to Talk to Your Doctor" will be offered in schools and community centers. A partnership with a transportation assistance program for medical visits will be established.
- **c.** In **Year 3** (2027), telehealth expansion will be prioritized for primary and preventive care. Improvements in preventive screening rates, chronic disease management participation, and community awareness of services will be measured—with outreach strategies refined based on findings.

C. Expected Outcomes. *Enhanced access and awareness will increase preventive care utilization, improve chronic disease management, reduce transportation barriers, and promote greater health "wealth" across the service area.*

III. SPECIALTY SERVICES.

A. ***Goal.*** To expand the availability and accessibility of specialty care within Independence and Stone Counties.

B. Strategies & Actions.

- **a.** In **Year 1** (2025), White River Health will conduct an assessment of specialty service gaps and prioritize high-need areas. As part of this process, the organization will evaluate the recruitment model for visiting specialists, determine opportunities to expand existing specialty clinics, and formalize referral agreements with regional tertiary centers to strengthen continuity of care.
- **b.** In **Year 2** (2026), tele-specialty services such as tele-oncology and tele-psychiatry will be introduced. Partnerships will be developed with regional providers to host rotating specialty clinics. Additionally, financial and workforce incentives will be assessed— potentially to recruit specialists to rural practice settings.
- **c.** In **Year 3** (2027), utilization trends, patient outcomes, and satisfaction with specialty services will be evaluated. Successful models will be scaled to additional White River Health sites, and long-term funding streams will be secured to sustain outreach and telehealth initiatives.

C. Expected Outcomes. *Expanded specialty services will reduce travel distances and wait times, increase access to advanced treatments, and improve early detection and chronic disease management for rural residents.*

White River Health CHNA Strategic Implementation Plan: 2025-2028

I. LEADERSHIP & COLLABORATION.

A. Oversight will be provided jointly by the White River Health Board of Directors and the Arkansas Rural Health Partnership.

II. MONITORING & EVALUATION.

A. Annual reviews will be conducted with the Community Advisory Committee, and progress updates will be submitted to the Internal Revenue Service in accordance with federal CHNA requirements.

B. Evaluation metrics will include referral completion rates, preventive screening uptake, transportation assistance utilization, specialty clinic attendance, patient satisfaction, and overall improvements in community health indicators.

White River Health Community Health Sustainability: 2028 & Beyond

A. ***Goal.*** The goal is to ensure long-term sustainability of the strategic implementation plan through workforce development, resource alignment, and financial stability.

B. **Strategies & Actions.**

a. Workforce sustainability will be advanced by investing in training and retaining qualified healthcare professionals, including expanding pipeline programs in partnership with local schools, colleges, and residency programs. White River Health will also strengthen the role of Community Health Workers (CHWs) and referral coordinators to ensure continuity of services.

b. Financial sustainability will be supported by leveraging shared funding opportunities through the Arkansas Rural Health Partnership, pursuing federal and state grant opportunities, and reinvesting operational savings from improved care coordination and reduced duplication of services.

c. System sustainability will be addressed through partnerships with regional health systems, telehealth providers, and community-based organizations to maximize resources and reduce gaps in care. Annual evaluations will track measurable outcomes such as improved access, patient satisfaction, and health indicators to demonstrate value and attract ongoing investment.

C. **Expected Outcomes.** *By embedding workforce, financial, and system sustainability strategies into implementation efforts, White River Health will strengthen its capacity to address community health needs beyond the 2025–2028 cycle—ensuring improved access, continuity of care, and better health outcomes across Independence and Stone Counties.*

QUALIFICATIONS OF THE REPORT PREPARER

The Arkansas Rural Health Partnership (ARHP) was established by a coalition of rural hospital leaders who recognized the vital role that home, community, and locally based healthcare play in sustaining rural life. From the outset, ARHP members understood that advancing the health and wellness of their communities required a collaborative approach—working in close partnership with local leaders, healthcare providers, state and federal agencies, and community members themselves. This commitment to collective action has positioned ARHP as both a trusted resource and a model of rural health innovation and collaboration across Arkansas and nationally. Today, ARHP remains dedicated to creating pathways for rural communities to unite in strengthening healthcare delivery and improving outcomes throughout South Arkansas and beyond.

To support White River Health's 2025 Community Health Needs Assessment, Lynn Hawkins, Chief Operations Officer, and Camille Watson, Chief Programs Officer, were designated as project leads. Their expertise in rural healthcare, combined with extensive experience in data collection, analysis, and evaluation, provided the foundation for facilitating an inclusive and evidence-based assessment process.

ABOUT THE ARKANSAS RURAL HEALTH PARTNERSHIP

The Arkansas Rural Health Partnership (ARHP) is a non-profit collaborative network of 22 rural hospitals, 5 Federally Qualified Health Centers (FQHCs), the FQHC Primary Care Association for Arkansas, and 3 teaching medical institutions. As the largest healthcare service provider in the region, ARHP functions not only as a healthcare network but also as a catalyst for economic growth and regional development. Its efforts focus on strengthening rural healthcare delivery, expanding access to care, and enhancing existing infrastructure to ensure that Arkansas's rural communities have the resources needed to thrive.

DOCUMENTATION

The following documentation of White River Health'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 and 2025 White River Health Survey Results PowerPoint Presentation.
- **Attachment B.** Community Advisory Committee Meeting Agenda.
- **Attachment C.** Community Advisory Attendance Roster.
- **Attachment D.** Organizational Chart
- **Attachment E.** *2022 Progress Updates (NOTE: Information for this section to be provided at a later date.)*

White River Health

COMMUNITY HEALTH NEEDS ASSESSMENT

2025

MEETING AGENDA

01 **Introductions**

02 **The CHNA Process**

03 **Survey Results**

04 **Discussion/Plans**

05 **Questions**

WHY DO WE DO A COMMUNITY HEALTH NEEDS ASSESSMENT?

White River Health 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 form federal, state, and local governments.

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 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**
- **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.**

COMMUNITY ENGAGEMENT IS CENTRAL . . . .

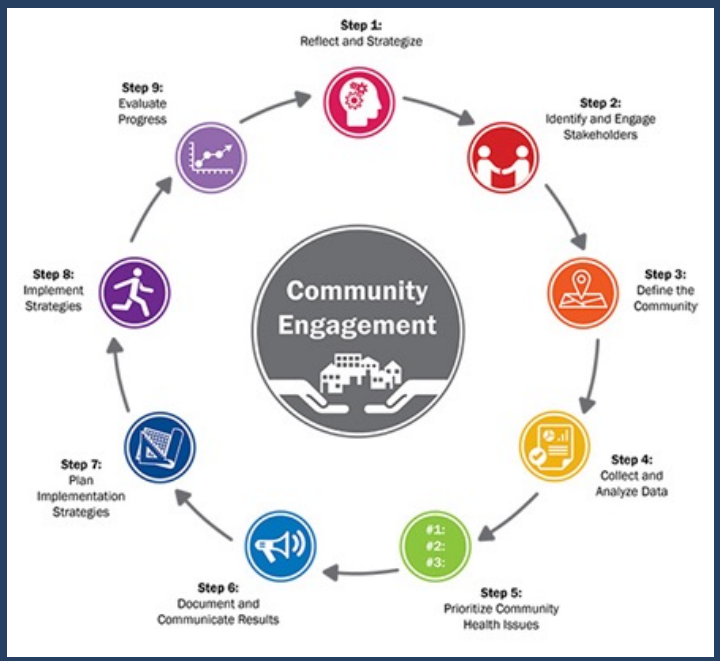
Benefits for Your Hospital:

- **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.**

THE CHNA PROCESS



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

DATA ANALYSIS

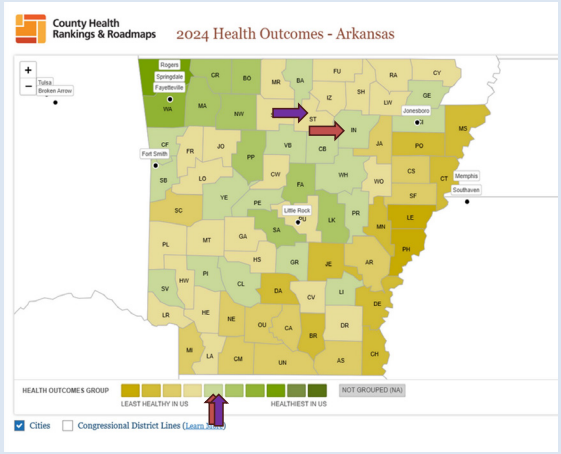
- **Survey responses (N=600) were analyzed to assess community health priorities–focusing on representation across key demographic groups, including gender, age, and race.**
- **The analysis ensured that results accurately reflected the community's perspectives; however, demographic comparisons revealed certain gaps–highlighting opportunities for more targeted outreach to improve representation among specific populations.**

COLLECT & ANALYZE DATA | STEP FOUR

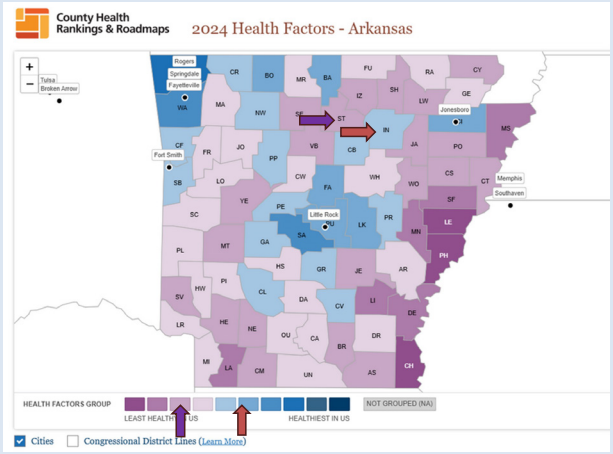
INDEPENDENCE & STONE COUNTY, ARKANSAS

Based on the 2024 County Health Rankings by the University of Wisconsin Population Health Institute, Independence and Stone Counties, while performing slightly better than the average county in Arkansas for both Population Health and Well-being and Community Conditions, is performing slightly worse than the national average in both areas.

Health Outcomes

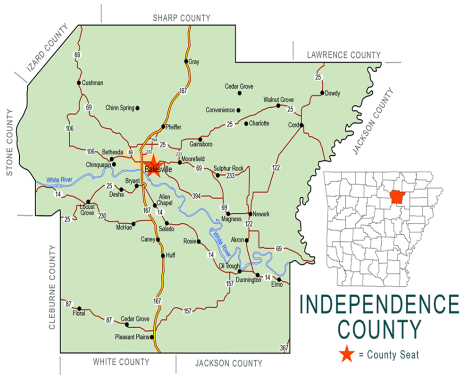


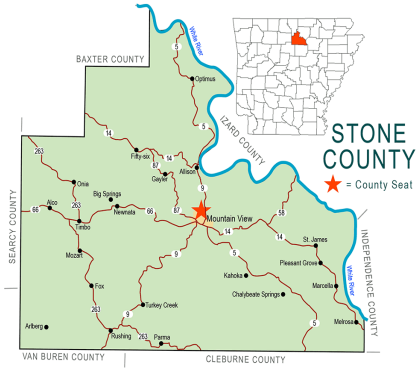
Health Factors



DEFINE THE COMMUNITY | STEP THREE

While White River Health serves patients primarily from Independence County. At its Stone County Medical Center location, it serves primarily Stone County residents. They both provide service in neighboring counties.





WHO IS INDEPENDENCE AND STONE COUNTY?

Key insights per the CHNA survey

600 SURVEY RESPONSES WERE RECEIVED.

51.8% of the respondents were from Independence County. Additional responses were received from Stone (12.5%), Izard (8.7%), Sharp (8.5%), Cleburne (3.5%), several responses stated the USA rather than a county (3.8%), one from out of state. Other counties with representation were Arkansas, Craighead, Fulton, Greene, Jackson, Lawrence, Lonoke, Newton, Washington and White.

77.7% of respondents were female, 20% male, and 2.3% of respondents chose not to disclose.

AGES 26 TO 65 The four largest respondent age groups were 46-55 (23.3%), 56-65 (21.8%), 36-45 (19.3%), and 26-35 (16%). However, responses were also received from the remaining age groups: 18-25, 66-75, 76-85 and 86+.

93% of the respondents, the largest group was Caucasian, with the second largest response being those who preferred not to say, at 4%. Other groups making up a smaller % of participants reported as follows: Hispanic/Latino, White: Native American/American Indian, White: Hispanic/Latino, Black/African American, Native American/American Indian, Asian/Pacific Islander, White: Black/African American, and Native American/American Indian.

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 May 7th to June 27th.

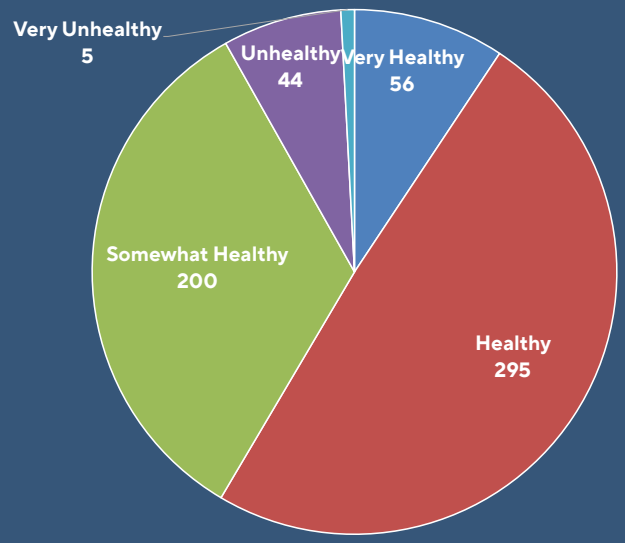
COLLECT & ANALYZE DATA | **STEP FOUR**

DATA ANALYSIS

- Survey responses (N=600) 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.
- All data represents surveys completed for White River Health, which includes Stone County Medical Center located in Mountain View, Arkansas.

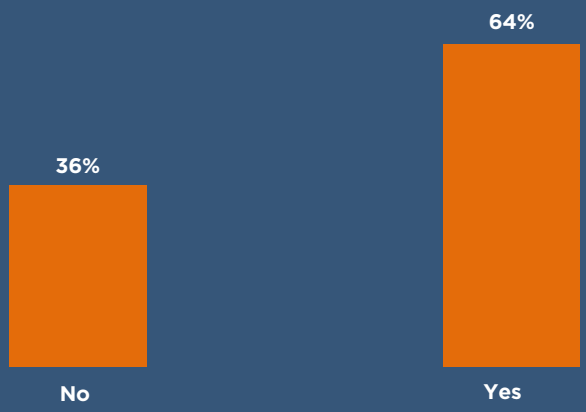
COLLECT & ANALYZE DATA **STEP FOUR**

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



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

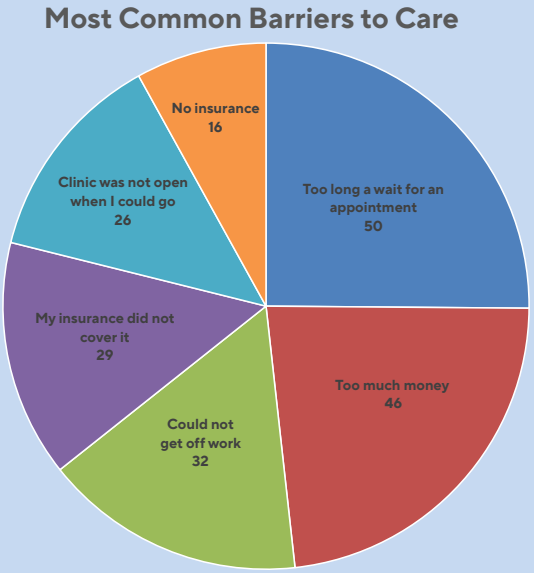
DID YOU OR SOMEONE IN YOUR HOUSEHOLD GO WITHOUT HEALTHCARE OR DELAYED RECEIVING HEALTHCARE IN THE PAST THREE YEARS?



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

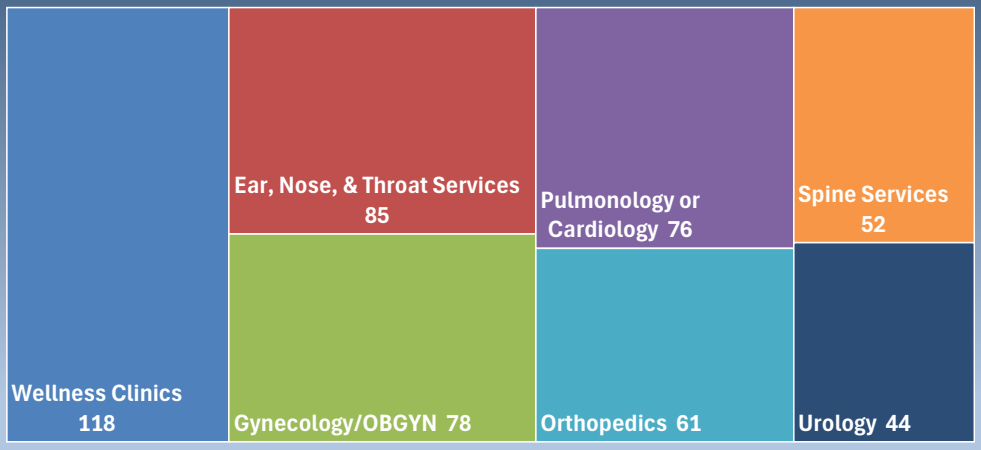
Key Insight: The overwhelming response of "I was not prevented from receiving healthcare services" (90 times) indicates that a significant portion of respondents did not experience barriers to care, providing important context to the frequency of the issues listed above.

However, Most Common Barriers to Care and Other Notable Barriers Mentioned are noted below.



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

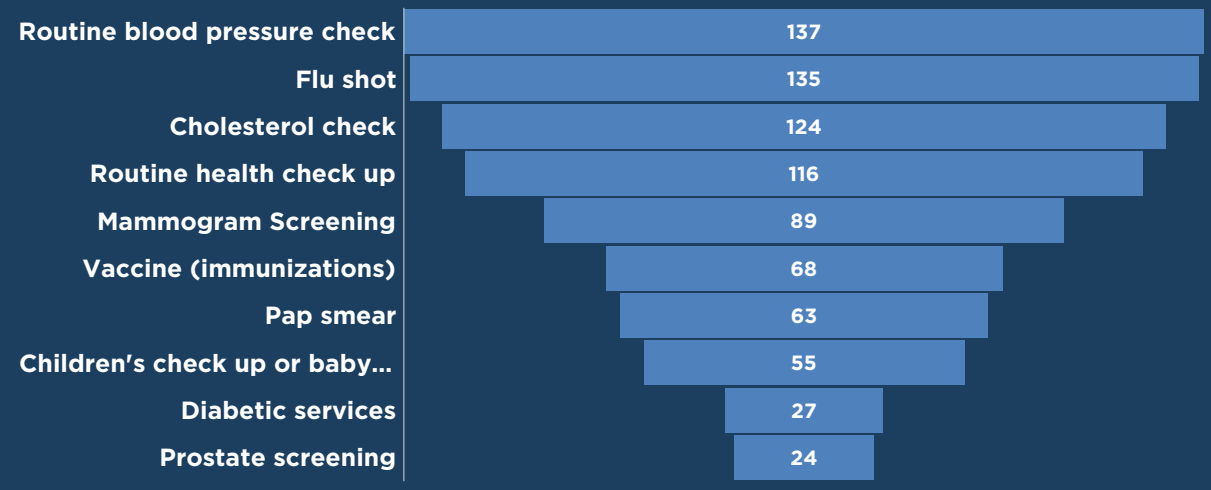
The most frequently requested services are reflected in the diagram below.



Key Insights: The most desired healthcare services, based on the survey respondents' selections, are listed in the order of the most chosen to least chosen: Wellness Clinics, Ear, Nose, & Throat, Gynecology/OBGYN, Pulmonology or Cardiology, Orthopedics, and Urology. Other services were noted, but they were far less frequent.

USE OF PREVENTATIVE HEALTH SERVICES:

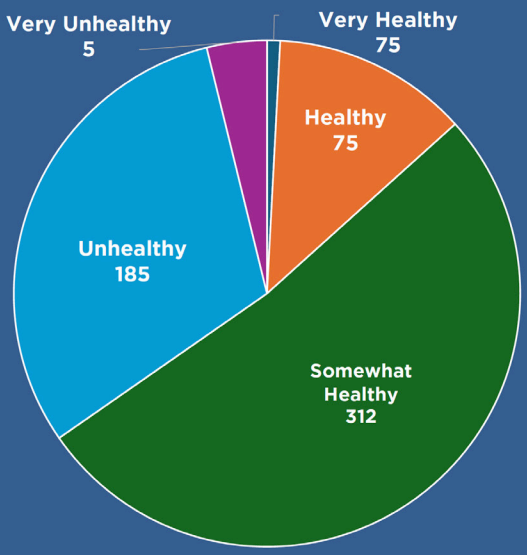
Preventative testing and services help to prolong the length of living and can lead to early diagnosis of serious health problems. Which of the following services have you used in the past year?



Key Insight: While most respondents actively engage in some form of preventive healthcare services, a small portion did not choose any preventive services.

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

- **52% of respondents believe their community is *"Somewhat Healthy"*, 31% for *"Unhealthy", and .04% "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 (98% rated themselves as "Healthy"), compared to their perceptions of their community's health.**



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

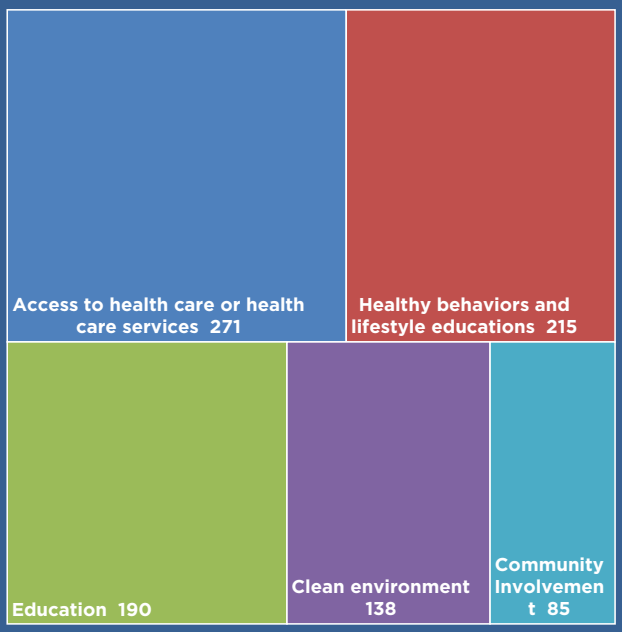
KEY FACTORS FOR A HEALTHY COMMUNITY: SELECT THE MOST IMPORTANT FOR CREATING A HEALTHY COMMUNITY

Respondents identified the most important elements for a healthy community as identified below:

- Access to Healthcare or Healthcare Services was considered the most important factor for creating a healthy community, with 271 survey respondent selections. *This strongly emphasizes the perceived significance of accessible healthcare.*

- Healthy Behaviors and Lifestyle Education was the second most important factor, selected 215 times by survey 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.*

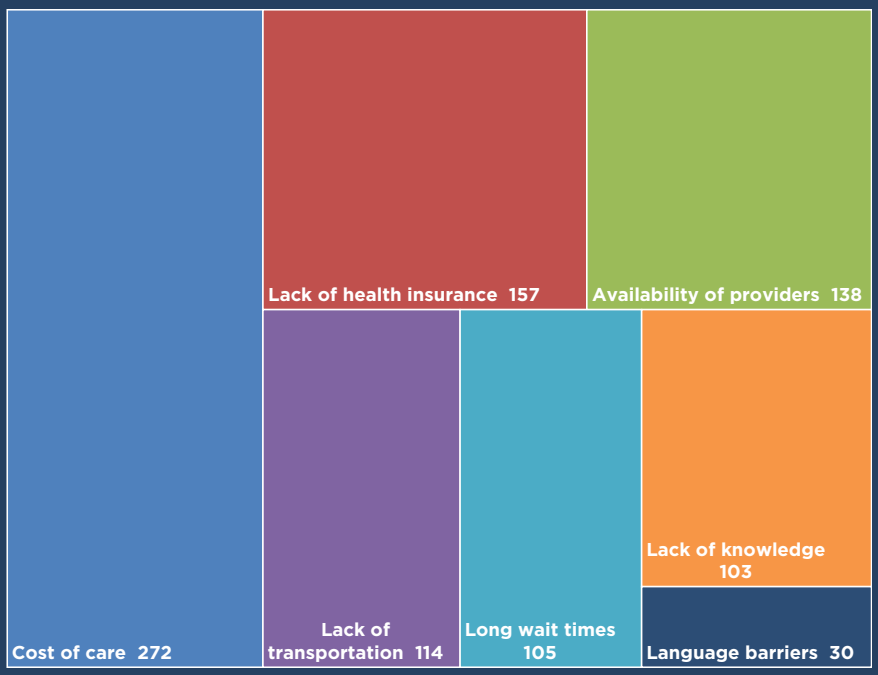
- Other factors selected were: General Education (190), Clean Environment (138), and Community Involvement (85). These were considered essential but received lower ratings from survey respondents.
  - *This indicates these factors are seen as having a moderate level of importance in creating a healthy community.*



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

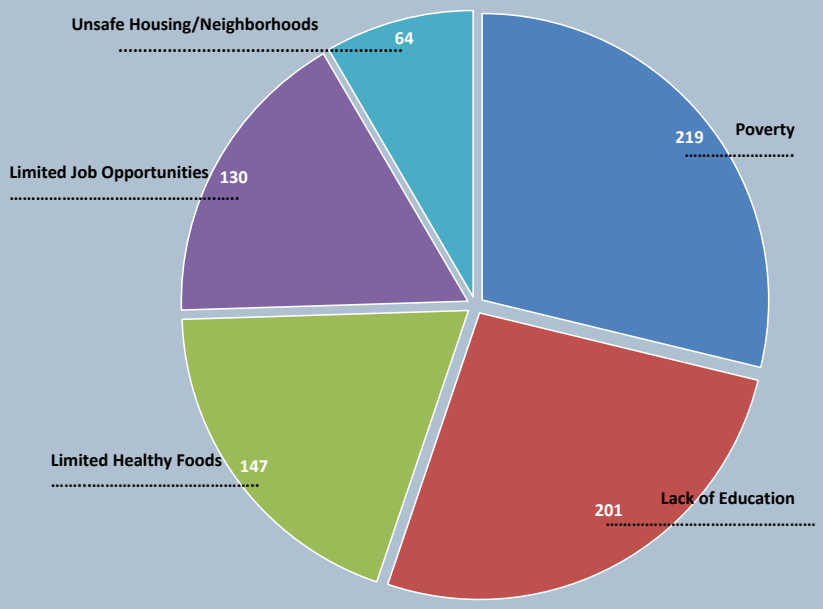
Key Insights: Responses indicate primary challenges to healthcare access in the community are:

- ***Financial*** *(cost of care and lack of insurance)*
- ***Logistical*** *(availability of providers, lack of transportation, and long wait times)*
- ***Less widespread but still noted:*** *Lack of Knowledge and Language barriers.*

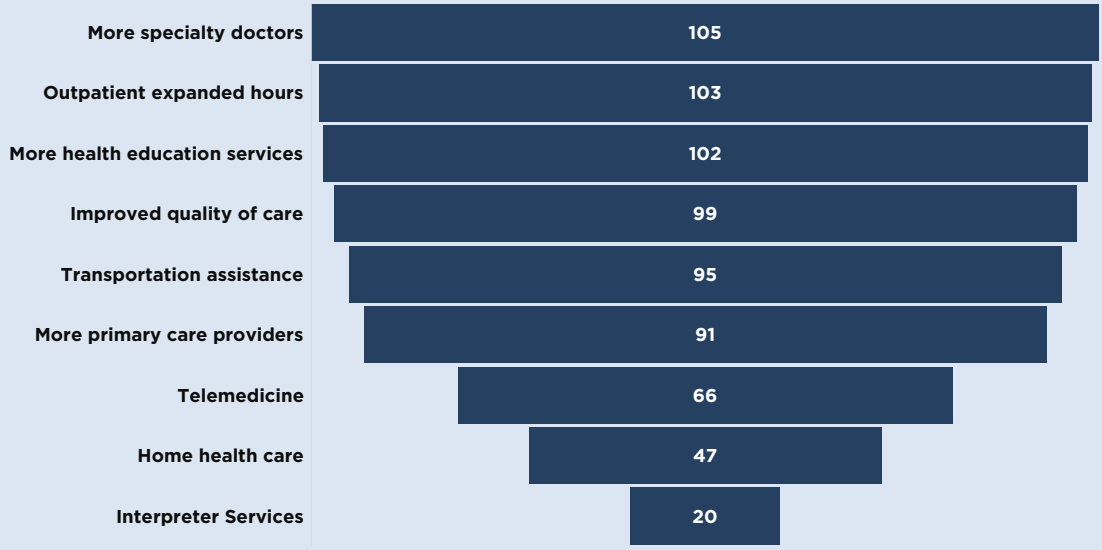


PERSPECTIVE ON FACTORS THAT CONTRIBUTE MOST TO HEALTH CONCERNS IN THE COMMUNITY

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 **limited job opportunities** are also considered important contributing factors, while **unsafe housing/neighborhoods** 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: results noted below:



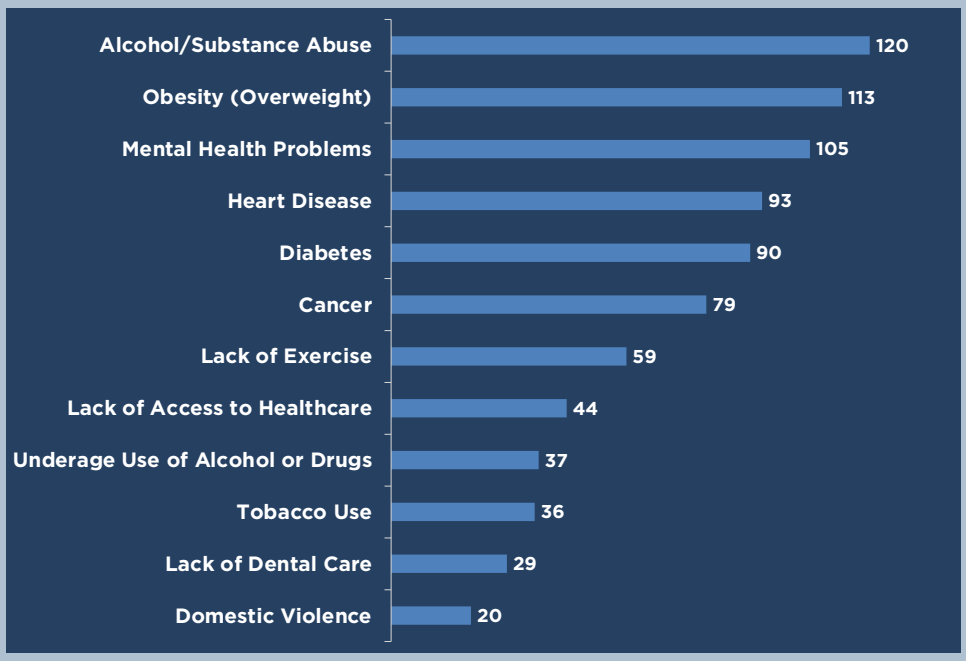
Key Insights: *The community clearly identified its top priorities for improving access to healthcare.* ***Increasing the number of specialty doctors, expanding outpatient hours, and enhancing health education*** *are seen as the most crucial steps. While these three areas are the clear frontrunners, the community also highlighted other significant factors. The fourth priority was a close call, with* ***improving the quality of care, providing transportation assistance, and increasing the number of primary care providers*** *all seen as highly important. Less significant, but still noted, were* ***telemedicine, home healthcare services, and interpreter services.***

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?

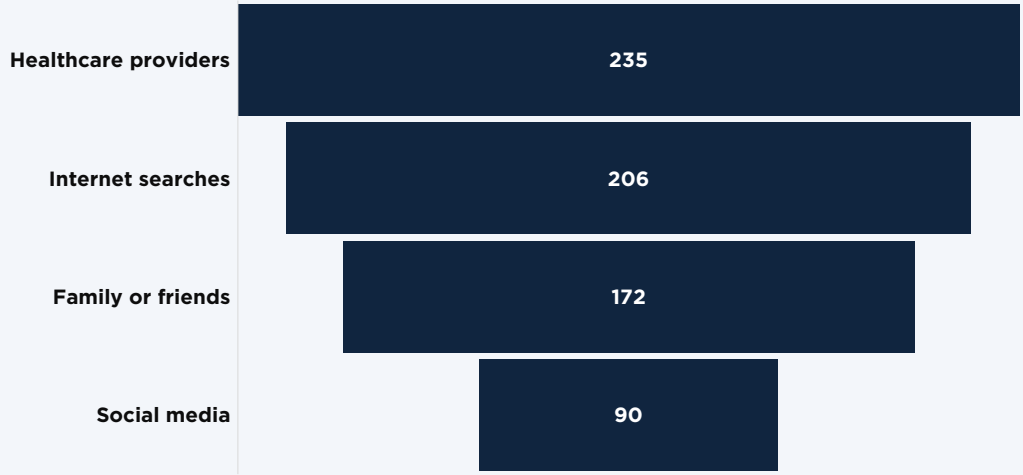
Key Insight: *The community perceives substance abuse, obesity, and mental health issues as their most pressing health challenges, closely followed by major chronic diseases.*

Lifestyle factors appear to play a significant role in many of these concerns, and access to care is also an issue.

Other concerns were noted, but with less frequency.



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



Key Insight: Survey respondents reflected a multi-faceted approach to information dissemination, with **healthcare providers being the most influential source, followed by online resources, personal networks, and social media.** Traditional media and community groups also contribute to how people learn about available health services, but with a much less common response in the survey.

Community Insights: A Qualitative Perspective

Overall insights from survey respondents:

The responses highlight significant concerns regarding access, affordability, and quality of healthcare services in the community. There's a clear demand for more specialized care, improved hospital reputation, and better support systems for vulnerable populations.

A few comments from respondents:

- "As all are aware insurance and health care cost continue to increase and are to a state where the lower middle class cannot afford. There must be additional efforts to control cost and make health care affordable."
- "Even being employed by a health care provider, the wages are low, and the health insurance provider for corporate benefits including dental and vision are disappointing. The poor level of coverage is a huge barrier to me and my family attaining the medical care and health services we would normally use."
- "Dental access is extremely limited and very expensive. A lot of people are unable to afford dental work, and the dentist that are in the area have extremely long wait times to get in to be seen."
- "Our elderly people need assistance for transportation. A lot of these people do not the access to transportation. E.G they don't have Medicaid, and family that is not available to assist with transportation."
- "Batesville needs an endocrinologist desperately. "

White River Health 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 Community Health Needs Assessment.

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

IMPLEMENT STRATEGIES & NEXT STEPS | STEP EIGHT

- Arkansas Rural Health Partnership will provide White River Health with the Community Health Needs Assessment Report by August 11, 2025.
- ARHP and White River Health Steering Committee will draft the implementation plan and communicate back to the advisory committee.
- Conduct annual progress assessment with the advisory committee.

THANK YOU!

Arkansas Rural Health Partnership

Lynn Hawkins
Chief Operations Officer
lynnhawkins@arruralhealth.org

ATTACHMENT B.
Community Advisory Committee Meeting Agenda

MEETING AGENDA

01 **Introductions**

02 **The CHNA Process**

03 **Survey Results**

04 **Discussion/Plans**

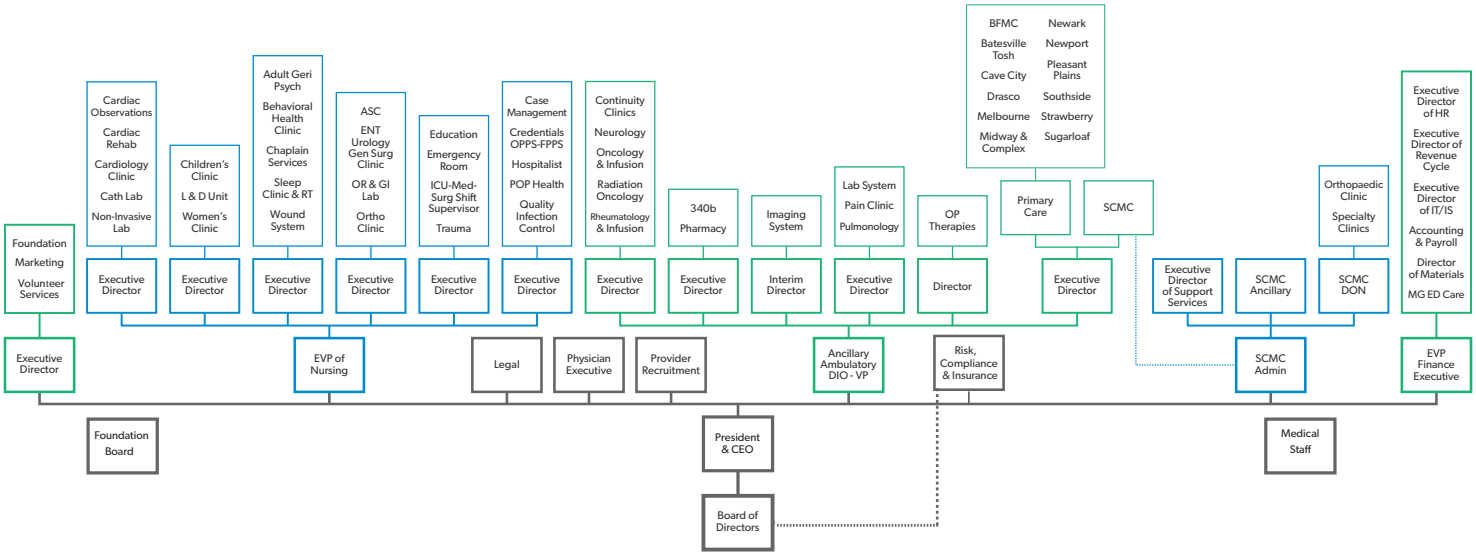
05 **Questions**

ATTACHMENT C.
Community Advisory Attendance Roster

FIRST NAME	LAST NAME	ORGANIZATION
William "Skip"	Baker, MD	WRH Emergency Medicine
Micah	Beard	The Citizens Bank
Danny	Bell	Lifeplus
Steve	Case	Future Fuel Chemical Company
Beth	Christian	White River Health Foundation
Randy	Cross	Edward Jones Financial Advisor
Tyler	Fowlkes	Sylamore Investments
Kyle	Gaither	Future Fuel Chemical Company
Stacy	Gunderman	Future Fuel Chemical Company
Ted	Hall	White River Area Agency on Aging
Crystal	Johnson	Batesville Area Chamber of Commerce
EJ	Jones, MD	WRH Chief Medical Officer
Lance	Lamberth	Atlas Ashphalt
Scott	Lancaster	Lifeplus
Kathy	Lanier	Vital Link
Sheila	Mace	WRH Public Relatioins & Foundation Development
Robert	McIntire	Bad Boy Mowers
Chris	Poole	WRH Quality Manager
Kevin	Rose	Centennial Bank
Hayden	Sowers	White River Eye Care
Jason	Taylor	First Community Bank
Stephanie	Toon	WRH Interim Director of Population Health
Jeff	Walter	
Steven	Webb	White River Heatlh CEO
Tina	Wheelis	Ozarka College
Clint	Wiles	FNBC Bank
Jackie	Crain	Former Director of Populaiton Health
Kathy	Thomas	VP & COO, Chief Safety Officer Stone County Medical Center
Stephanie	Welch	Executive Director of Quality
Ashtin	Rogers	Associate Chief Nursing Officer

ATTACHMENT D.
Organizational Chart

White River HEALTH



ORGANIZATIONAL CHART | SEPTEMBER 2025

ATTACHMENT E.
2022 Progress Updates

NOTE: Information for this section to be provided at a later date.

APPENDIX A. *References*

Agency for Healthcare Research and Quality. (2013). *Strategy 6E: Rapid referral programs.* **https://www.ahrq.gov/sites/default/files/wysiwyg/cahps/quality-improvement/improvement-guide/6-strategies-for-improving/access/cahps-strategy-6e.pdf**

Arkansas Advocate. (2023, August 29). *Arkansas' uninsured rate has plummeted since Medicaid expansion.* **https://arkansasadvocate.com/2025/06/18/arkansas-troubled-health-landscape-could-worsen-under-proposed-federal-cuts-advocacy-group-warns/**

Arkansas Center for Health Improvement. (2023). *Profile of the primary care physician workforce in Arkansas.* **https://achi.net/wp-content/uploads/2023/12/230712B-HRSA-Report_UPDATE.pdf**

Arkansas Center for Health Improvement. (2024). *Arkansas healthcare workforce.* **https://achi.net/arkansas-healthcare-workforce/**

Arkansas Center for Health Improvement. (2024). *Attacks on healthcare workers more common than you might think.* **https://achi.net/newsroom/attacks-on-healthcare-workers-more-common-than-you-might-think/**

Arkansas Center for Health Improvement. (2024). *Healthcare transparency initiative.* **https://achi.net/healthcare-transparency-initiative/**

Arkansas Center for Health Improvement. (2024). *Regional view: Northwest Arkansas.* **https://achi.net/regional-view/**

Arkansas Center for Health Improvement. (2024). *Report on primary care in Arkansas reveals mixed outcomes.* **https://achi.net/newsroom/report-on-primary-care-in-arkansas-reveals-mixed-outcomes/**

Arkansas Center for Health Improvement. (2024). *Report on the state of primary care has mixed findings for Arkansas.* **https://achi.net/newsroom/report-on-the-state-of-primary-care-has-mixed-findings-for-arkansas/**

Arkansas Center for Health Improvement. (2024). *Urgent care centers: A growing component of the healthcare system.* **https://achi.net/wp-content/uploads/2024/02/240221B_Urgent-Care-Centers.pdf**

Arkansas Department of Health. (2019). *County health fact sheets: Independence County; Stone County.* **https://www.healthy.arkansas.gov/programs-services/topics/county-health-fact-sheets**

Arkansas Department of Health. (2022). *Arkansas health professions manpower statistics 2022.* **https://healthy.arkansas.gov/wp-content/uploads/Manpower-Report-2022.pdf#:~:text=CALHOUN%202%200%200%200,0%201%200%200%2014**

APPENDIX A. *References* (Continued)

Arkansas Department of Health. (2024). *Health professional shortages and rural healthcare access report.* **https://www.healthy.arkansas.gov**

Arkansas Economic Development Institute. (2024). *Broadband access in rural Arkansas.* **https://www.youraedi.com**

Arkansas Literacy Councils. (2024). *Health literacy and education gaps in Arkansas.* **https://www.arkansasliteracy.org**

Centers for Medicare & Medicaid Services. (2019). *Closing the referral loop: Lessons learned from the CMS Innovation Center.* **https://www.cms.gov/priorities/innovation/files/x/tcpi-san-pp-loop.pdf**

County Health Rankings & Roadmaps. (2024). *Independence County health data.* **https://www.countyhealthrankings.org**

County Health Rankings & Roadmaps. (2024). *Stone County health data.* **https://www.countyhealthrankings.org**

GlobalData Plc. (2024). The complexities of physician supply and demand: Projections from 2021 to 2036. Washington, DC: *American Association of Medical Colleges.* **https://www.aamc.org/media/75236/download?attachment.**

Health Resources & Services Administration. (2024). *Primary care and specialty shortages in the U.S.* **https://data.hrsa.gov**

Office of Senator John Boozman. (2023). *Boozman introduces bills to combat Arkansas physician shortage [Press release].* **https://www.boozman.senate.gov/public/index.cfm/2023/3/boozman-introduces-bills-to-combat-arkansas-physician-shortage**

Rural Health Information Hub. (2023). *Healthcare access in rural communities.* **https://www.ruralhealthinfo.org/topics/healthcare-access**

Siegel, Daniel. (2025). Recruitment challenges, solutions, and outlooks for the rural doc shortage. *National Rural Health Assocation.* **https://www.ruralhealth.us/blogs/2025/07/recruitment-challenges,-solutions,-and-outlooks-for-the-rural-doc-shortage#:~:text=Advanced%20practice%20providers:%20To%20mitigate,fill%20critical%20gaps%20in%20care**

U.S. Department of Health and Human Services. (2008). *America's health literacy: Why we need accessible health information.* **https://www.ahrq.gov/sites/default/files/wysiwyg/health-literacy/dhhs-2008-issue-brief.pdf**

APPENDIX A. *References* (Continued)

U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. (2010). *National action plan to improve health literacy.* **https://odphp.health.gov/sites/default/files/2019-09/Health_Literacy_Action_Plan.pdf**

West Health–Gallup. (2024). *Tracking healthcare affordability and value: The west health–gallup healthcare affordability index and healthcare value index. West Health.* **https://westhealthmosaic.com/articles/tracking-healthcare-affordibility-and-value**

White River Health. (2025). *About Us.* **https://whiteriverhealth.org/about-us#about**

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