# Abbeville Area Medical Center

*Abbeville, SC*

Community Health Needs Assessment

Adopted September 28, 2018[1]

[1]Response to Schedule H (Form 990) Part V B 4

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# EXECUTIVE SUMMARY

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Abbeville Area Medical Center ("AAMC" or the "Hospital") has performed a Community Health Needs Assessment to determine the health needs of the local community.

Data were gathered from multiple well-respected secondary sources to build an accurate picture of the current community and its health needs. A survey of a group of Local Experts was performed to review the prior CHNA and provide feedback, and to ascertain whether the previously identified needs remain a priority. A second survey was distributed to the same group that reviewed the data gathered from the secondary sources and determined the Significant Health Needs for the community.

The Significant Health Needs for Abbeville County are:

1. Obesity & Access to Healthy Food – 2015 Significant Need
2. Behavioral Health – 2015 Significant Need
3. Prevention/Wellness Education
4. Smoking – 2015 Significant Need
5. Physical Activity
6. Diabetes – 2015 Significant Need
7. Substance Use/Abuse

AAMC will develop implementation strategies for these seven needs including activities to continue/pursue, community partners to work alongside, and measures to track progress.

# APPROACH

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Abbeville Area Medical Center ("AAMC" or the "Hospital") is organized as a not-for-profit hospital. A Community Health Needs Assessment ("CHNA") is part of the required hospital documentation of "Community Benefit" under the Affordable Care Act ("ACA"), required of all not-for-profit hospitals as a condition of retaining tax-exempt status. A CHNA helps the hospital identify and respond to the primary health needs of its residents.

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designed to comply with standards required of a not-for-profit hospital.[2] Tax reporting citations in this report are superseded by the most recent Schedule H (Form 990) filings made by the hospital.

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

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

Further explanation and specific regulations are available from Health and Human Services (HHS), the Internal Revenue Service (IRS), and the U.S. Department of the Treasury.[3]

## Project Objectives

The project objectives were to:[4]

- Complete a CHNA report, compliant with Treasury – IRS
- Provide the Hospital with information required to complete the IRS – Schedule H (Form 990)
- Produce the information necessary for the Hospital to issue an assessment of community health needs and document its intended response

## Overview of Community Health Needs Assessment

Typically, non-profit hospitals qualify for tax-exempt status as a Charitable Organization, described in Section 501(c)(3) of the Internal Revenue Code; however, the term 'Charitable Organization' is undefined. Prior to the passage of Medicare, charity was generally recognized as care provided those who did not have means to pay. With the introduction of Medicare, the government met the burden of providing compensation for such care.

[2] Federal Register Vol. 79 No. 250, Wednesday December 31, 2014. Part II Department of the Treasury Internal Revenue Service 26 CFR Parts 1, 53, and 602

[3] As of the date of this report all tax questions and suggested answers relate to 2014 Draft Federal 990 Schedule H instructions i990sh—dft(2) and tax form

[4] Part 3 Treasury/IRS – 2011 – 52 Section 3.03 (2) third party disclosure notice & Schedule H (Form 990) V B 6 b

In response, IRS Revenue ruling 69-545 eliminated the Charitable Organization standard and established the Community Benefit Standard as the basis for tax-exemption. Community Benefit determines if hospitals promote the health of a broad class of individuals in the community, based on factors including:

- An Emergency Room open to all, regardless of ability to pay
- Surplus funds used to improve patient care, expand facilities, train, etc.
- A board controlled by independent civic leaders
- All available and qualified physicians granted hospital privileges

Specifically, the IRS requires:

- Effective on tax years beginning after March 23, 2012, each 501(c)(3) hospital facility must conduct a CHNA at least once every three taxable years and adopt an implementation strategy to meet the community needs identified through the assessment.
- The assessment may be based on current information collected by a public health agency or non-profit organization, and may be conducted together with one or more other organizations, including related organizations.
- The assessment process must consider input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge or expertise of public health issues.
- The hospital must disclose in its annual information report to the IRS (Form 990 and related schedules) how it is addressing the needs identified in the assessment and, if all identified needs are not addressed, the reasons why (e.g., lack of financial or human resources).
- Each hospital facility is required to make the assessment widely available and downloadable from the hospital website.
- Failure to complete a CHNA in any applicable three-year period results in an excise tax to the organization of $50,000. For example, if a facility does not complete a CHNA in taxable years one, two, or three, it is subject to the penalty in year three. If it then fails to complete a CHNA in year four, it is subject to another penalty in year four (for failing to satisfy the requirement during the three-year period beginning with taxable year two and ending with taxable year four).
- An organization that fails to disclose how it is meeting needs identified in the assessment is subject to existing incomplete return penalties.[5]

## Community Health Needs Assessment Subsequent to Initial Assessment

The Final Regulations establish a required step for a CHNA developed after the initial report. This requirement calls for considering written comments received on the prior CHNA and Implementation Strategy as a component of the development of the next CHNA and Implementation Strategy. The specific requirement is:

> *"The 2013 proposed regulations provided that, in assessing the health needs of its community, a*

[5] Section 6652

*hospital facility must take into account input received from, at a minimum, the following three sources:*

*(1) At least one state, local, tribal, or regional governmental public health department (or equivalent department or agency) with knowledge, information, or expertise relevant to the health needs of the community;*

*(2) members of medically underserved, low-income, and minority populations in the community, or individuals or organizations serving or representing the interests of such populations; and*

*(3) written comments received on the hospital facility's most recently conducted CHNA and most recently adopted implementation strategy.*[6]

*…the final regulations retain the three categories of persons representing the broad interests of the community specified in the 2013 proposed regulations but clarify that a hospital facility must ''solicit'' input from these categories and take into account the input ''received.'' The Treasury Department and the IRS expect, however, that a hospital facility claiming that it solicited, but could not obtain, input from one of the required categories of persons will be able to document that it made reasonable efforts to obtain such input, and the final regulations require the CHNA report to describe any such efforts."*

Representatives of the various diverse constituencies outlined by regulation to be active participants in this process were actively solicited to obtain their written opinion. Opinions obtained formed the introductory step in this Assessment.

To complete a CHNA:

*"… the final regulations provide that a hospital facility must document its CHNA in a CHNA report that is adopted by an authorized body of the hospital facility and includes:*

*(1) A definition of the community served by the hospital facility and a description of how the community was determined;*

*(2) a description of the process and methods used to conduct the CHNA;*

*(3) a description of how the hospital facility solicited and took into account input received from persons who represent the broad interests of the community it serves;*

*(4) a prioritized description of the significant health needs of the community identified through the CHNA, along with a description of the process and criteria used in identifying certain health needs as significant and prioritizing those significant health needs; and*

*(5) a description of resources potentially available to address the significant health needs identified through the CHNA.*

*… final regulations provide that a CHNA report will be considered to describe the process and methods*

[6] Federal Register Vol. 79 No. 250, Wednesday December 31, 2014. Part II Department of the Treasury Internal Revenue Service 26 CFR Parts 1, 53, and 602 P. 78963 and 78964

*used to conduct the CHNA if the CHNA report describes the data and other information used in the assessment, as well as the methods of collecting and analyzing this data and information, and identifies any parties with whom the hospital facility collaborated, or with whom it contracted for assistance, in conducting the CHNA."*[7]

Additionally, all CHNAs developed after the very first CHNA must consider written commentary on the prior Assessment and Implementation Strategy efforts. The Hospital must follow the Federal requirements in the solicitation of written comments by securing characteristics of individuals providing written comment but did not maintain identification data.

*"…the final regulations provide that a CHNA report does not need to name or otherwise identify any specific individual providing input on the CHNA, which would include input provided by individuals in the form of written comments."*[8]

The methodology takes a comprehensive approach to the solicitation of written comments. As previously cited, input was obtained from the required three minimum sources and expanded input to include other representative groups. The Hospital asked all participating in the written comment solicitation process to self-identify into any of the following representative classifications, which is detailed in an Appendix to this report. Written comment participants self-identified into the following classifications:

**(1) Public Health** – Persons with special knowledge of or expertise in public health

**(2) Departments and Agencies** – Federal, tribal, regional, State, or local health or other departments or agencies, with current data or other information relevant to the health needs of the community served by the hospital facility

**(3) Priority Populations** – Leaders, representatives, or members of medically underserved, low income, and minority populations, and populations with chronic disease needs in the community served by the hospital facility. Also, in other federal regulations the term Priority Populations, which include rural residents and LGBT interests, is employed and for consistency is included in this definition

**(4) Chronic Disease Groups** – Representative of or member of Chronic Disease Group or Organization, including mental and oral health

**(5) Broad Interest of the Community** – Individuals, volunteers, civic leaders, medical personnel, and others to fulfill the spirit of broad input required by the federal regulations

**(6) Other** (please specify)

The methodology also takes a comprehensive approach to assess community health needs by performing several independent data analyses based on secondary source data, augmenting this with Local Expert Advisor[9] opinions, and resolving any data inconsistencies or discrepancies by reviewing the combined opinions formed from local experts. The Hospital relies on secondary source data, and most secondary sources use the county as the smallest unit of analysis.

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[7] Federal Register Op. cit. P 78966 As previously noted the Hospital collaborated and obtained assistance in conducting this CHNA from Quorum Health Resources. Response to Schedule H (Form 990) B 6 b

[8] Federal Register Op. cit. P 78967 & Response to Schedule H (Form 990) B 3 h

[9] "Local Expert" is an advisory group of at least 15 local residents, inclusive of at least one-member self-identifying with each of the five written comment solicitation classifications, with whom the Hospital solicited to participate in the CHNA process. Response to Schedule H (Form 990) V B 3 h

Local expert area residents were asked to note if they perceived the problems or needs identified by secondary sources existing in their portion of the county.[10]

Most data used in the analysis are available from public internet sources and proprietary data. Any critical data needed to address specific regulations or developed by the Local Expert Advisor individuals participating in this study are displayed in the CHNA report appendix.

Data sources include:[11]

| Website or Data Source | Data Element | Date Accessed | Data Date |
|---|---|---|---|
| www.countyhealthrankings.org | Assessment of health needs of Abbeville County compared to all South Carolina counties | September 10, 2018 | 2012-2014 |
| IBM Watson Health (formerly known as Truven Health Analytics) | Assess characteristics of the hospital's primary service area, at a zip code level, based on classifying the population into various socio-economic groups, determining the health and medical tendencies of each group and creating an aggregate composition of the service area according to the proportion of each group in the entire area; and, to access population size, trends and socio-economic characteristics | September 10, 2018 | 2018 |
| http://svi.cdc.gov | To identify the Social Vulnerability Index value | September 11, 2018 | 2012-2016 |
| http://www.healthdata.org/us-county-profiles | To look at trends of key health metrics over time | September 12, 2018 | 1980-2014 |
| www.worldlifeexpectancy.com/usa-health-rankings | To determine relative importance among 15 top causes of death | September 12, 2018 | 2016 |

Federal regulations surrounding CHNA require local input from representatives of particular demographic sectors. For this reason, a standard process of gathering community input was developed. In addition to gathering data from the

[10] Response to Schedule H (Form 990) Part V B 3 i

[11] The final regulations clarify that a hospital facility may rely on (and the CHNA report may describe) data collected or created by others in conducting its CHNA and, in such cases, may simply cite the data sources rather than describe the ''methods of collecting'' the data. Federal Register Op. cit. P 78967 & Response to Schedule H (Form 990) Part V B 3 d

above sources:

- A CHNA "Round 1" survey was deployed to the Hospital's Local Expert Advisors to gain input on local health needs and the needs of priority populations. Local Expert Advisors were local individuals selected according to criteria required by the Federal guidelines and regulations and the Hospital's desire to represent the region's geographically and ethnically diverse population. Community input from 22 Local Expert Advisors was received. Survey responses started August 20, 2018 and ended with the last response on August 31, 2018.
- Information analysis augmented by local opinions showed how Abbeville County relates to its peers in terms of primary and chronic needs and other issues of uninsured persons, low-income persons, and minority groups. Respondents commented on whether they believe certain population groups ("Priority Populations") need help to improve their condition, and if so, who needs to do what to improve the conditions of these groups.[12]
- Local opinions of the needs of Priority Populations, while presented in its entirety in the Appendix, was abstracted in the following "take-away" bulleted populations:
  - Low income residents
  - Residents of rural areas
  - Older adults

When the analysis was complete, the information and summary conclusions were put before the Hospital's Local Expert Advisors[13] who were asked to agree or disagree with the summary conclusions. They were free to augment potential conclusions with additional comments of need.[14] Consultation with 18 Local Experts occurred again via an internet-based survey (explained below) beginning September 12, 2018 and ending September 21, 2018.

Having taken steps to identify potential community needs, the Local Experts then participated in a structured communication technique called a "Wisdom of Crowds" method. The premise of this approach relies on a panel of experts with the assumption that the collective wisdom of participants is superior to the opinion of any one individual, regardless of their professional credentials.[15]

In AAMC's process, each Local Expert had the opportunity to introduce needs previously unidentified and to challenge conclusions developed from the data analysis. While there were a few opinions of the data conclusions not being completely accurate, most of the comments agreed with the findings. A list of all needs identified by any of the analyzed data was developed. The Local Experts then allocated 100 points among the list of health needs, including the opportunity to list additional needs that were not identified from the data.

The ranked needs were divided into two groups: "Significant" and "Other Identified Needs." The Significant Needs were prioritized based on total points cast by the Local Experts in descending order, further ranked by the number of local experts casting any points for the need. By definition, a Significant Need had to include all rank ordered needs until at least fifty percent (50%) of all points were included and to the extent possible, represented points allocated by a

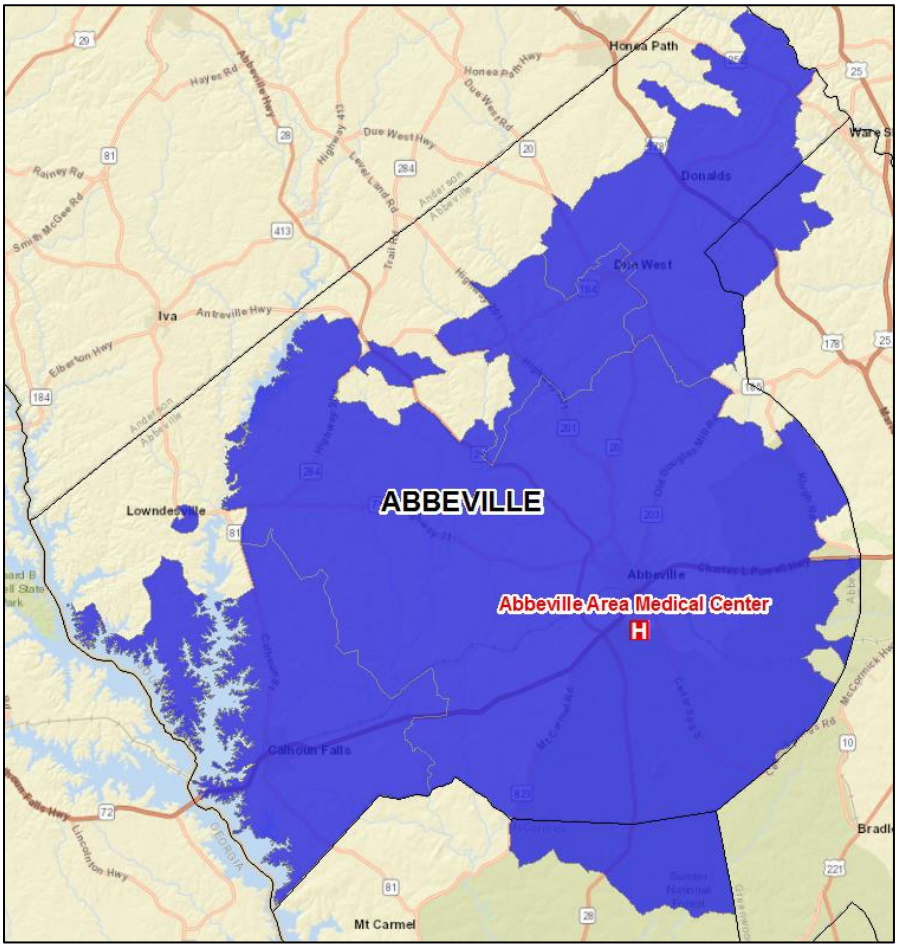
[12] Response to Schedule H (Form 990) Part V B 3 f
[13] Response to Schedule H (Form 990) Part V B 3 h
[14] Response to Schedule H (Form 990) Part V B 3 h
[15] Response to Schedule H (Form 990) Part V B 5

majority of voting local experts. The determination of the break point — “Significant” as opposed to “Other” — was a qualitative interpretation where a reasonable break point in rank order occurred.[16]

[16] Response to Schedule H (Form 990) Part V B 3 g

# COMMUNITY CHARACTERISTICS

## Definition of Area Served by the Hospital[17]




For the purposes of this study, Abbeville Area Medical Center defines its service area as Abbeville County in South Carolina, which includes the following ZIP codes:[18]

29620 – Abbeville 29628 – Calhoun Falls 29638 – Donalds 29639 – Due West

29659 – Lowndesville

From 10/1/2016 – 9/30/2017, the Hospital received 63.0% of its inpatients from this service area.[19]

[17] Responds to IRS Schedule H (Form 990) Part V B 3 a
[18] The map above amalgamates zip code areas and does not necessarily display all county zip codes represented below
[19] IBM Watson Health MEDPAR patient origin data for the hospital; Responds to IRS Schedule H (Form 990) Part V B 3 a

## Demographics of the Community[20] [21]

| | Abbeville County | South Carolina | U.S. |
|---|---|---|---|
| 2018 Population[22] | **19,998** | **5,053,046** | **326,533,070** |
| % Increase/Decline | **1.2%** | **5.8%** | **3.5%** |
| Estimated Population in 2023 | **20,223** | **5,347,475** | **337,947,912** |
| Median Age | **42.9** | **39.5** | **38.3** |
| Median Household Income | **$37,053** | **$51,157** | **$59,039** |
| % Population over age 65 | **21.2%** | **17.4%** | **15.9%** |
| % Women of Childbearing Age | **17.7%** | **19.2%** | **19.6%** |
| % White, non-Hispanic | **64.4%** | **63.6%** | **60.4%** |
| % Hispanic | **1.7%** | **5.8%** | **18.3%** |
| Unemployment Rate | **4.6%** | **4.4%** | **4.1%** |

**2018 Benchmarks**
**Area: Abbeville County, SC**
**Level of Geography: ZIP Code**

| Area | 2018-2023 % Population Change | Median Age | Population 65+ % of Total Population | Population 65+ % Change 2018-2023 | Females 15-44 % of Total Population | Females 15-44 % Change 2018-2023 | Median Household Income |
|---|---|---|---|---|---|---|---|
| **USA** | **3.5%** | **38.3** | **15.9%** | **17.0%** | **19.6%** | **1.4%** | **$60,315** |
| **South Carolina** | **5.8%** | **39.5** | **17.4%** | **19.6%** | **19.2%** | **4.0%** | **$51,157** |
| **Selected Area** | **1.2%** | **42.9** | **21.2%** | **11.8%** | **17.7%** | **1.0%** | **$37,053** |

[20] Responds to IRS Schedule H (Form 990) Part V B 3 b
[21] The tables below were created by IBM Watson Health
[22] All population information, unless otherwise cited, sourced from IBM Watson Health (formally Truven Health Analytics)

**Demographics Expert 2.7**
**2018 Demographic Snapshot**
**Area: Abbeville County, SC**
**Level of Geography: ZIP Code**

## DEMOGRAPHIC CHARACTERISTICS

| | Selected Area | USA |
|---|---|---|
| 2010 Total Population | 20,497 | 308,745,538 |
| 2018 Total Population | 19,988 | 326,533,070 |
| 2023 Total Population | 20,223 | 337,947,861 |
| % Change 2018 - 2023 | 1.2% | 3.5% |
| Average Household Income | $49,764 | $86,278 |

| | 2018 | 2023 | % Change |
|---|---|---|---|
| Total Male Population | 9,660 | 9,788 | 1.3% |
| Total Female Population | 10,328 | 10,435 | 1.0% |
| Females, Child Bearing Age (15-44) | 3,539 | 3,575 | 1.0% |

## POPULATION DISTRIBUTION

Age Distribution

| Age Group | 2018 | % of Total | 2023 | % of Total | USA 2018 % of Total |
|---|---|---|---|---|---|
| 0-14 | 3,376 | 16.9% | 3,267 | 16.2% | 18.7% |
| 15-17 | 776 | 3.9% | 792 | 3.9% | 3.9% |
| 18-24 | 2,106 | 10.5% | 2,204 | 10.9% | 9.7% |
| 25-34 | 2,081 | 10.4% | 2,164 | 10.7% | 13.4% |
| 35-54 | 4,531 | 22.7% | 4,270 | 21.1% | 25.5% |
| 55-64 | 2,874 | 14.4% | 2,783 | 13.8% | 12.9% |
| 65+ | 4,244 | 21.2% | 4,743 | 23.5% | 15.9% |
| **Total** | **19,988** | **100.0%** | **20,223** | **100.0%** | **100.0%** |

## HOUSEHOLD INCOME DISTRIBUTION

Income Distribution

| 2018 Household Income | HH Count | % of Total | USA % of Total |
|---|---|---|---|
| <$15K | 1,422 | 18.0% | 10.9% |
| $15-25K | 1,340 | 16.9% | 9.5% |
| $25-50K | 2,249 | 28.4% | 22.1% |
| $50-75K | 1,277 | 16.1% | 17.1% |
| $75-100K | 770 | 9.7% | 12.3% |
| Over $100K | 855 | 10.8% | 28.2% |
| **Total** | **7,913** | **100.0%** | **100.0%** |

## EDUCATION LEVEL

Education Level Distribution

| 2018 Adult Education Level | Pop Age 25+ | % of Total | USA % of Total |
|---|---|---|---|
| Less than High School | 932 | 6.8% | 5.6% |
| Some High School | 1,946 | 14.2% | 7.4% |
| High School Degree | 5,107 | 37.2% | 27.6% |
| Some College/Assoc. Degree | 4,001 | 29.1% | 29.1% |
| Bachelor's Degree or Greater | 1,744 | 12.7% | 30.3% |
| **Total** | **13,730** | **100.0%** | **100.0%** |

## RACE/ETHNICITY

Race/Ethnicity Distribution

| Race/Ethnicity | 2018 Pop | % of Total | USA % of Total |
|---|---|---|---|
| White Non-Hispanic | 12,869 | 64.4% | 60.4% |
| Black Non-Hispanic | 6,326 | 31.6% | 12.4% |
| Hispanic | 330 | 1.7% | 18.2% |
| Asian & Pacific Is. Non-Hispanic | 93 | 0.5% | 5.8% |
| All Others | 370 | 1.9% | 3.2% |
| **Total** | **19,988** | **100.0%** | **100.0%** |

## Customer Segmentation[23]

Claritas Prizm uses Census data, sources of demographic and consumer information, and 30 years of annual consumer surveys to classify all U.S. households into 68 demographically and behaviorally distinct groups. These segments represent clusters of at least 250 households that have comparable characteristics and exhibit similar behaviors. The top segments in Abbeville County are:

| Claritas Prizm Segments | Characteristics | |
|---|---|---|
| **Segment 1 (46.8%)** | • Urbanicity: Rural<br>• Income: Downscale<br>• Household Technology: Lowest<br>• Income Producing Assets: Low<br>• Age Ranges: Age 55+ | • Presence of Kids: Mostly without Kids<br>• Homeownership: Mostly Owners<br>• Employment Levels: Mostly Retired<br>• Education Levels: High School |
| **Segment 2 (22.7%)** | • Urbanicity: Rural<br>• Income: Upper Mid-Scale<br>• Household Technology: Average<br>• Income Producing Assets: Above Avg<br>• Age Ranges: Age 35-54 | • Presence of Kids: Mostly w/ Kids<br>• Homeownership: Mostly Owners<br>• Employment Levels: Management and Professional<br>• Education Levels: College Graduate |
| **Segment 3 (15.6%)** | • Urbanicity: Suburban<br>• Income: Wealthy<br>• Household Technology: Highest<br>• Income Producing Assets: Millionaires<br>• Age Ranges: Age 35-54 | • Presence of Kids: Mostly w/ Kids<br>• Homeownership: Mostly Owners<br>• Employment Levels: Management and Professional<br>• Education Levels: College Plus |
| **Segment 4 (8.3%)** | • Urbanicity: Town<br>• Income: Mid-Scale<br>• Household Technology: Average<br>• Income Producing Assets: Low<br>• Age Ranges: Age 25-44 | • Presence of Kids: Mostly w/ Kids<br>• Homeownership: Mix<br>• Employment Levels: Service Mix<br>• Education Levels: College Graduate |
| **Segment 5 (6.6%)** | • Urbanicity: Town<br>• Income: Upscale<br>• Household Technology: Above Avg<br>• Income Producing Assets: High<br>• Age Ranges: Age 25-44 | • Presence of Kids: Mostly w/ Kids<br>• Homeownership: Mostly Owners<br>• Employment Levels: Management and Professional<br>• Education Levels: College Graduate |

[23] IBM Watson Health Household Targeter

Each of the 68 Claritas Prizm segments exhibits prevalence toward specific health behaviors. In the second column of the chart below, the national average is 100%, so the 'Demand as % of National' shows a community's likelihood of exhibiting a certain health behavior more or less than the national average. The next column shows the percentage of the population that is likely to exhibit those behaviors.

Where Abbeville County varies more than 5% above or below the national average (that is, less than 95% or greater than 105%), it is considered noteworthy. Items in the table with **red text** are viewed as **adverse** findings. Items with **blue text** are viewed as **beneficial** findings. Items with **black text** are neither a favorable nor unfavorable finding.

| Health Service Topic | Demand as % of National | % of Population Affected |
|---|---|---|
| **Weight / Lifestyle** | | |
| BMI: Morbid/Obese | 121% | 36.9% |
| Vigorous Exercise | 89.5% | 51.1% |
| Chronic Diabetes | 124.9% | 19.6% |
| Healthy Eating Habits | 99.2% | 23.1% |
| Ate Breakfast Yesterday | 96.0% | 75.9% |
| Slept Less Than 6 Hours | 129.3% | 17.6% |
| Consumed Alcohol in the Past 30 Days | 66.7% | 35.8% |
| Consumed 3+ Drinks Per Session | 126.3% | 35.6% |
| **Behavior** | | |
| Search for Pricing Info | 87.9% | 23.6% |
| I am Responsible for My Health | 99.1% | 89.8% |
| I Follow Treatment Recommendations | 100.8% | 77.7% |
| **Pulmonary** | | |
| Chronic COPD | 142.2% | 7.7% |
| Chronic Asthma | 99.6% | 11.8% |
| **Heart** | | |
| Chronic High Cholesterol | 113.5% | 27.7% |
| Routine Cholesterol Screening | 88.2% | 39.1% |
| Chronic Heart Failure | 172.9% | 7.0% |

| Health Service Topic | Demand as % of National | % of Population Affected |
|---|---|---|
| **Cancer** | | |
| Cancer Screen: Skin 2 yr | 84.3% | 9.0% |
| Cancer Screen: Colorectal 2 yr | 94.8% | 19.5% |
| Cancer Screen: Pap/Cerv Test 2 yr | 80.6% | 38.8% |
| Routine Screen: Prostate 2 yr | 89.5% | 25.4% |
| **Orthopedic** | | |
| Chronic Lower Back Pain | 109.5% | 33.8% |
| Chronic Osteoporosis | 142.8% | 14.4% |
| **Routine Services** | | |
| FP/GP: 1+ Visit | 101.6% | 82.6% |
| NP/PA Last 6 Months | 104.6% | 43.4% |
| OB/Gyn 1+ Visit | 75.2% | 28.9% |
| Medication: Received Prescription | 103.1% | 62.5% |
| **Internet Usage** | | |
| Use Internet to Look for Provider Info | 69.8% | 27.9% |
| Facebook Opinions | 85.3% | 8.6% |
| Looked for Provider Rating | 66.7% | 15.7% |
| **Emergency Services** | | |
| Emergency Room Use | 107.6% | 37.4% |
| Urgent Care Use | 91.0% | 30.0% |

## Leading Causes of Death[24]

The Leading Causes of Death are determined by the official Centers for Disease Control and Prevention (CDC) final death total. South Carolina's Top 15 Leading Causes of Death are listed in the table below in Abbeville County's rank order. Abbeville County was compared to all other South Carolina counties, South Carolina state average, and whether the death rate was higher, lower or as expected compared to the U.S. average.

| Cause of Death | | | Rank among all counties in SC (#1 rank = worst in state) | Rate of Death per 100,000 age adjusted | | Observation (Compared to U.S.) |
|---|---|---|---|---|---|---|
| SC Rank | Abbeville Rank | Condition | | SC | Abbeville | |
| 2 | 1 | Heart Disease | 38 of 46 | 173.8 | 196.4 | Higher than expected |
| 1 | 2 | Cancer | 29 of 46 | 167.7 | 188.9 | Higher than expected |
| 5 | 3 | Stroke | 20 of 46 | 45.5 | 59.8 | Lower than expected |
| 4 | 4 | Lung | 25 of 46 | 47.5 | 46.1 | Higher than expected |
| 3 | 5 | Accidents | 41 of 46 | 58.9 | 44.9 | As expected |
| 6 | 6 | Alzheimer's | 30 of 46 | 45.3 | 27.5 | As expected |
| 7 | 7 | Diabetes | 39 of 46 | 22.3 | 18.7 | As expected |
| 8 | 8 | Kidney | 39 of 46 | 15.3 | 15.8 | As expected |
| 12 | 9 | Flu - Pneumonia | 35 of 46 | 12.0 | 15.4 | As expected |
| 9 | 10 | Blood Poisoning | 36 of 46 | 14.8 | 12.8 | As expected |
| 10 | 11 | Suicide | 21 of 46 | 15.7 | 12.3 | As expected |
| 11 | 12 | Liver | 33 of 46 | 12.4 | 9.8 | As expected |
| 15 | 13 | Homicide | 25 of 46 | 9.0 | 8.0 | As expected |
| 14 | 14 | Parkinson's | 19 of 46 | 7.7 | 6.4 | As expected |
| 13 | 15 | Hypertension | 43 of 46 | 8.2 | 6.3 | As expected |

[24] www.worldlifeexpectancy.com/usa-health-rankings

## Priority Populations[25]

Information about Priority Populations in the service area of the Hospital is difficult to encounter if it exists. The Hospital's approach is to understand the general trends of issues impacting Priority Populations and to interact with the Local Experts to discern if local conditions exhibit any similar or contrary trends. The following discussion examines findings about Priority Populations from a national perspective.

Begin by analyzing the National Healthcare Quality and Disparities Reports (QDR), which are annual reports to Congress mandated in the Healthcare Research and Quality Act of 1999 (P.L. 106-129). These reports provide a comprehensive overview of the quality of healthcare received by the general U.S. population and disparities in care experienced by different racial, ethnic, and socioeconomic groups. The purpose of the reports is to assess the performance of the Hospital's health system and to identify areas of strengths and weaknesses in the healthcare system along three main axes: **access to healthcare**, **quality of healthcare**, and **priorities of the National Quality Strategy** (NQS). The report's key findings are provided in Appendix C.

A specific question was asked to the Hospital's Local Expert Advisors about unique needs of Priority Populations, and their responses were reviewed to identify if there were any report trends in the service area. Accordingly, the Hospital places a great reliance on the commentary received from the Hospital's Local Expert Advisors to identify unique population needs to which the Hospital should respond. Specific opinions from the Local Expert Advisors are summarized below:[26]

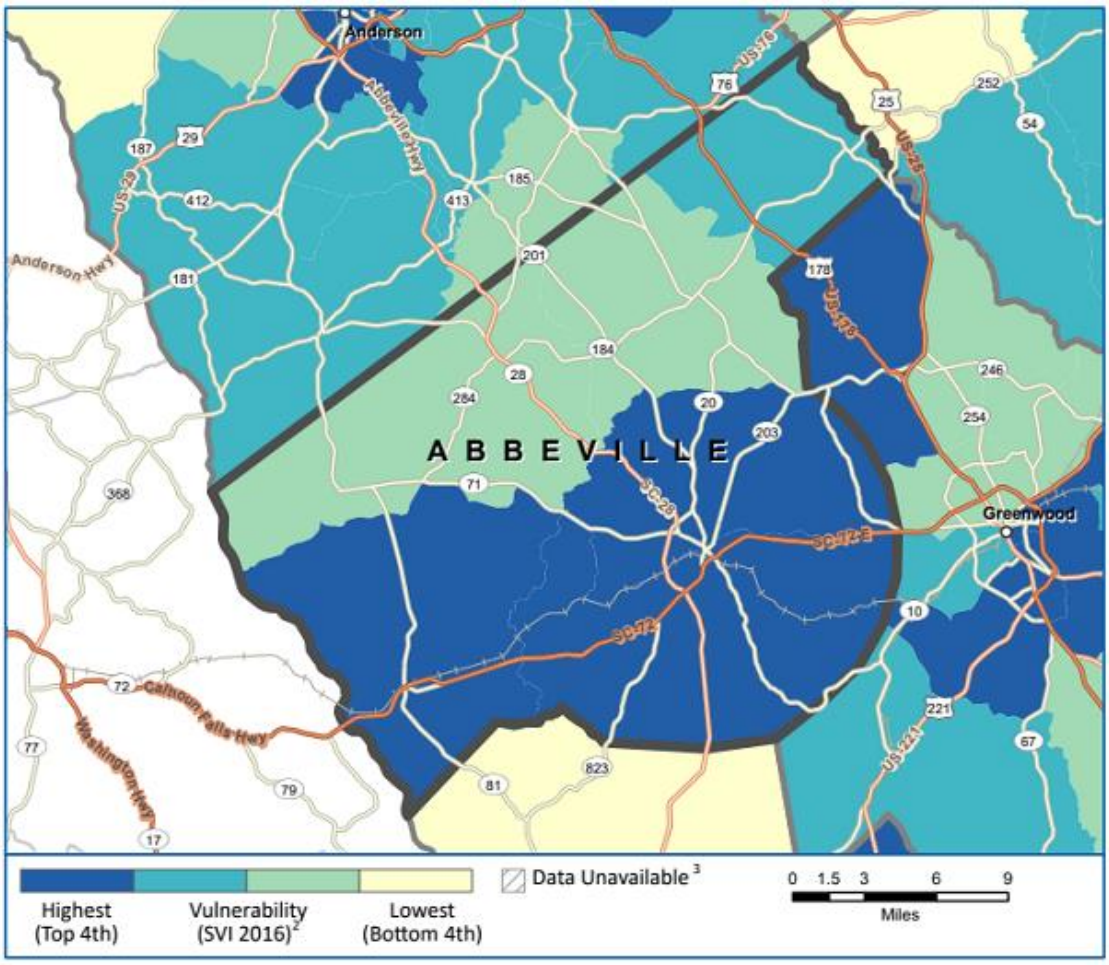
- Lower income residents
- Residents of rural areas
- Older adults

[25] http://www.ahrq.gov/research/findings/nhqrdr/nhqdr14/index.html Responds to IRS Schedule H (Form 990) Part V B 3 i
[26] All comments and the analytical framework behind developing this summary appear in Appendix A

## Social Vulnerability[27]

Social vulnerability refers to the resilience of communities when confronted by external stresses on human health, such as natural or human-caused disasters, or disease outbreaks.

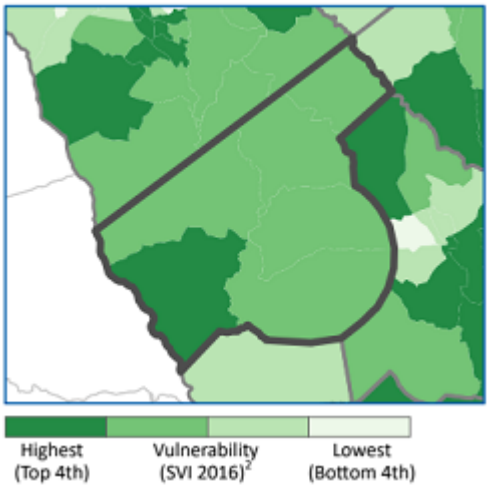
While regions of Abbeville County fall into the top three quartiles, more than half of the county is in the top two quartiles of vulnerability, making its vulnerability index higher in those regions.




[27] http://svi.cdc.gov

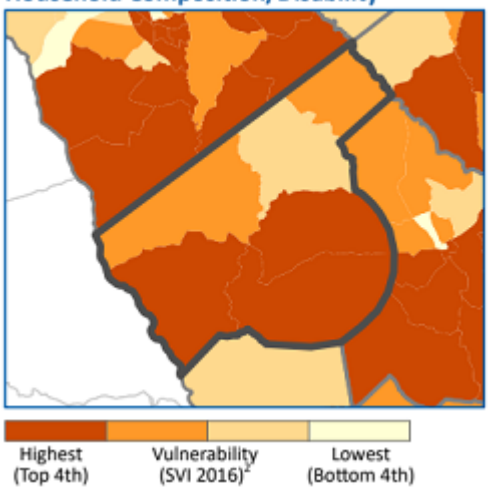
## SVI Themes

### Socioeconomic Status



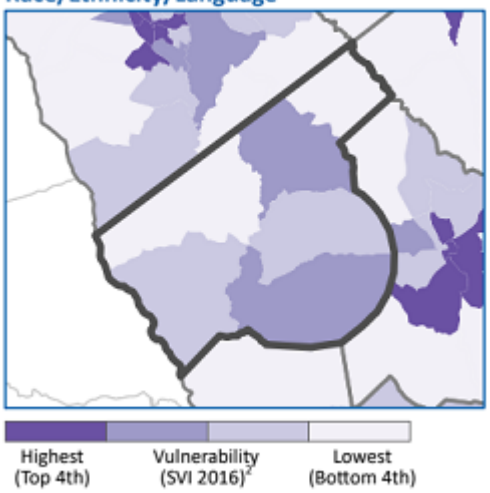
Highest (Top 4th) | Vulnerability (SVI 2016) | Lowest (Bottom 4th)

### Household Composition/Disability



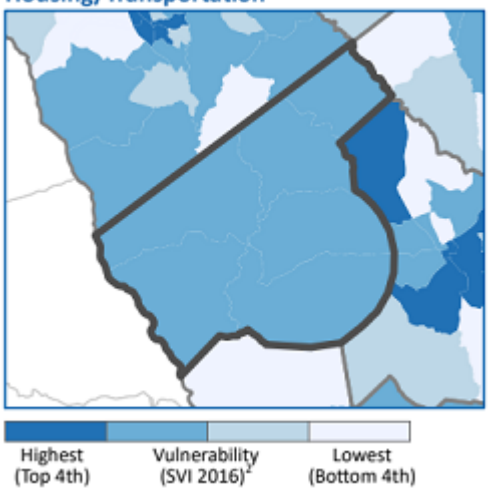
Highest (Top 4th) | Vulnerability (SVI 2016) | Lowest (Bottom 4th)

### Race/Ethnicity/Language



Highest (Top 4th) | Vulnerability (SVI 2016) | Lowest (Bottom 4th)

### Housing/Transportation



Highest (Top 4th) | Vulnerability (SVI 2016) | Lowest (Bottom 4th)

## Summary of Survey Results on Prior CHNA

In the Round 1 survey, a group of 22 individuals provided feedback on the 2015 CHNA. Complete results, including *verbatim* written comments, can be found in Appendix A.

Commenter characteristics:

| | Yes (Applies to Me) | No (Does Not Apply to Me) | Response Count |
|---|---|---|---|
| 1) **Public Health Expertise** | 7 | 7 | 14 |
| 2) **Departments and Agencies** with relevant data/information regarding health needs of the community served by the hospital | 7 | 9 | 16 |
| 3) **Priority Populations** | 9 | 8 | 17 |
| 4) Representative/Member of **Chronic Disease Group** or Organization | 2 | 12 | 14 |
| 5) Represents the **Broad Interest of the Community** | 17 | 4 | 21 |
| Other | | | |
| Answered Question | | | 22 |
| Skipped Question | | | 0 |

Priorities from the last assessment where the Hospital intended to seek improvement:

- Low-income groups
- Residents of rural areas
- Older adults

AAMC received the following responses to the question: **"Should the hospital continue to consider the 2015 Significant Health Needs as the most important health needs currently confronting residents in the county?**

| | Yes | No | Response Count |
|---|---|---|---|
| Obesity & Access to Healthy Food | 20 | 0 | 20 |
| Behavioral Health | 20 | 0 | 20 |
| Smoking | 16 | 2 | 18 |
| Diabetes | 19 | 0 | 19 |
| Access to Primary Care | 16 | 4 | 20 |

AAMC received the following responses to the question: **"Should the Hospital continue to allocate resources to help improve the needs identified in the 2015 CHNA?"**

| | Yes | No | Response Count |
|---|---|---|---|
| Obesity & Access to Healthy Food | 19 | 0 | 19 |
| Behavioral Health | 20 | 0 | 20 |
| Smoking | 13 | 4 | 17 |
| Diabetes | 19 | 0 | 19 |
| Access to Primary Care | 14 | 4 | 18 |

## Comparison to Other State Counties[28]

To better understand the community, Abbeville County has been compared to all 46 counties in the state of South Carolina across five areas: Health Outcomes, Health Behaviors, Clinical Care, Social & Economic Factors, and Physical Environment. The last four areas are all Health Factors that ultimately affect the Health Outcomes of Length (Mortality) and Quality of Life (Morbidity).

In the chart below, the county's rank compared to all counties is listed along with any measures in each area that are ***worse than*** the state average and U.S. Best (90th percentile).

| | Abbeville County | South Carolina | U.S. Best |
|---|---|---|---|
| **Health Outcomes** | | | |
| Overall Rank *(best being #1)* | 22/46 | | |
| Premature Deaths* | 9,500 | 8,300 | 5,300 |
| Poor or Fair Mental Health | 21% | 19% | 12% |
| Poor Mental Health Days *(reported in the last 30 days)* | 4.6 | 4.4 | 3.1 |
| **Health Behaviors** | | | |
| Overall Rank *(best being #1)* | 21/46 | | |
| Adult Obesity | 38% | 32% | 26% |
| Physical Inactivity | 32% | 25% | 20% |
| Access to Exercise Opportunities | 27% | 54% | 91% |
| Alcohol-impaired Driving Deaths | 48% | 37% | 13% |
| Teen Births *(Per 1,000 female population ages 15-19)* | 34 | 33 | 15 |
| **Clinical Care** | | | |
| Overall Rank *(best being #1)* | 20/46 | | |
| Population to Primary Care Provider | 2,080:1 | 1,480:1 | 1,280:1 |
| Population to Dentist | 8,290:1 | 1,890:1 | 330:1 |
| Population to Mental Health Provider | 1,660:1 | 640:1 | 330:1 |
| Diabetes Monitoring | 85% | 86% | 91% |
| **Social & Economic Factors** | | | |

[28] www.countyhealthrankings.org

| | Abbeville County | South Carolina | U.S. Best |
|---|---|---|---|
| Overall Rank *(best being #1)* | 16/46 | | |
| Unemployment | 5.3% | 4.8% | 3.2% |
| Some College | 49% | 62% | 72% |
| Children in Poverty | 25% | 23% | 12% |
| **Physical Environment** | | | |
| Overall Rank *(best being #1)* | 43/46 | | |
| Air Pollution (PM2.5 concentration) | 10.0 | 9.7 | 6.7 |
| Long commute – driving alone | 46% | 33% | 15% |

***Per 100,000***

## Comparison to Peer Counties[29]

The Federal Government administers a process to allocate all 3,143 U.S. counties into "Peer" groups. County "Peer" groups have similar social, economic, and demographic characteristics. The counties are ranked across six health and wellness categories and divided into quartiles: Better (top quartile), Moderate (middle two quartiles), and Worse (bottom quartile).

In the below chart, Abbeville County is compared to its peer counties and the U.S. average, but only areas where the county is Better or Worse than it's peer counties are listed. The list and number of peer counties used in each ranking may differ.

| | Abbeville County | Peer Ranking | U.S. Best |
|---|---|---|---|
| **BETTER** | | | |
| **Health Outcomes** | | | |
| Premature death | 9,500 | 7 of 35 | 5,300 |
| **Health Behaviors** | | | |
| Adult smoking | 6% | 2 of 33 | 14% |
| Teen births *(per 1,000 population ages 15-19)* | 34 | 4 of 35 | 15 |
| **Clinical Care** | | | |
| Preventable hospital stays | 41 | 1 of 35 | 35 |
| Mammography screening | 69% | 1 of 36 | 71% |
| **Social and Economic Factors** | | | |
| N/A | | | |
| **Physical Environment** | | | |
| N/A | | | |
| **WORSE** | | | |
| **Health Behaviors** | | | |
| Adult Obesity | 38% | 31 of 35 | 20% |
| Access to exercise opportunities | 27% | 30 of 36 | 91% |
| Excessive drinking | 16% | 28 of 29 | 13% |
| Alcohol-impared driving deaths | 48% | 33 of 36 | 13% |
| **Clinical Care** | | | |
| Population to dentist ratio | 8,290:1 | 31 of 36 | 1,280:1 |
| **Social and Economic Factors** | | | |
| Unemployment | 5.3% | 5 of 36 | 3.2% |
| Children in poverty | 25% | 4 of 33 | 12% |
| Injury deaths | 76 | 5 of 35 | 55 |
| **Physical Environment** | | | |
| Air pollution - particulate matter | 10.0 | 28 of 34 | 6.7 |
| Long commute - driving alone | 46% | 27 of 35 | 15% |

[29] www.cdc.gov/communityhealth

## Conclusions from Demographic Analysis Compared to National Averages

The following areas were identified from a comparison of the county to national averages. **Adverse** metrics impacting more than 30% of the population and statistically significantly different from the national average include:

- 21.0% more likely to have a **BMI of Morbid/Obese,** affecting 36.9%
- 10.5% less likely to **Vigorously Exercise**, affecting 51.1%
- 26.3% more likely to **Consumed 3+ Drinks per Session**, affecting 35.6%
- 11.8% less likely to receive **Routine Cholesterol Screening**, affecting 39.1%
- 19.4% less likely to receive **Cervical Cancer Screening every 2 years**, affecting 38.8%
- 9.5% more likely to have **Chronic Lower Back Pain**, affecting 33.8%
- 7.6% more likely to have **Emergency Room Use**, affecting 37.4%

**Beneficial** metrics impacting more than 30% of the population and statistically significantly different from the national average include:

- 33.3% less likely to **Consumed Alcohol in the Past 30 Days**, affecting 35.8%

## Conclusions from Other Statistical Data[30]

The Institute for Health Metrics and Evaluation at the University of Washington analyzed all 3,143 U.S. counties or equivalents applying small area estimation techniques to the most recent county information. The below chart compares Abbeville County statistics to the U.S. average, and lists the change since the last date of measurement.

| | Current Statistics (2014) | Percent Change (1980-2014) |
|---|---|---|
| **UNFAVORABLE Abbeville county measures that are WORSE than the U.S. average and had an UNFAVORABLE change** | | |
| Female Tracheal, Bronchus, and Lung Cancer | 48.6 | 107.1% |
| Female Skin Cancer | 2.0 | 7.9% |
| Male Skin Cancer | 4.7 | 48.2% |
| Female Diabetes, Urogenital, Blood, and Endocrine Deaths | 50.3 | 28.6% |
| Male Diabetes, Urogenital, Blood, and Endocrine Deaths | 66.6 | 31.5% |
| Female Mental and Substance Use Disorder Deaths | 8.3 | 351.2% |
| Female Cirrhosis and Other Liver Disease Deaths | 12.1 | 7.3% |
| Male Cirrhosis and Other Liver Disease Deaths | 29.3 | 25.2% |
| **UNFAVORABLE Abbeville county measures that are WORSE than the U.S. average and had a FAVORABLE change** | | |
| Male Heart Disease | 202.7 | -55.6% |
| Female Stroke | 56.1 | -37.2% |
| Male Stroke | 59.9 | -52.8% |
| Male Tracheal, Bronchus, and Lung Cancer | 96.0 | -16.8% |
| Female Breast Cancer | 26.1 | -16.0% |
| Male Breast Cancer | 0.4 | -12.0% |
| Female Self-Harm and Interpersonal Violence Deaths | 11.3 | -13.0% |

[30] http://www.healthdata.org/us-county-profiles

| | Current Statistics (2014) | Percent Change (1980-2014) |
|---|---|---|
| Male Self-Harm and Interpersonal Violence Deaths | 33.7 | -18.7% |
| **DESIRABLE Abbeville county measures that are BETTER than the U.S. average and had an UNFAVORABLE change** | | |
| Male Mental and Substance Use Disorder Deaths | 14.2 | 78.7% |
| **DESIRABLE Abbeville county measures that are BETTER than the U.S. average and had a FAVORABLE change** | | |
| Female Heart Disease | 107.9 | -49.4% |

## Top Significant Needs Identified During CHNA Process

1. **Obesity & Access to Healthy Food – 2015 Significant Need**
2. **Behavioral Health – 2015 Significant Need**
3. **Prevention/Wellness Education**
4. **Smoking – 2015 Significant Need**
5. **Physical Activity**
6. **Diabetes – 2015 Significant Need**
7. **Substance Use/Abuse**

## Other Needs Identified During CHNA Process

8. **Chronic Pain Management**
9. **Access to Primary Care – 2015 Significant Need**
10. **Hypertension**
11. **Suicide**
12. **Affordability**
13. **Alcohol Use**
14. **Alzheimer's**
15. **Stroke**
16. **Accidents**
17. **Women's Health**
18. **Heart Disease**
19. **Lung Disease**
20. **Kidney Disease**
21. **Liver Disease**
22. **Flu/Pneumonia**

# APPENDIX

## Appendix A – Written Commentary on Prior CHNA (Round 1)

Hospital solicited written comments about its 2015 CHNA.[31] 22 individuals responded to the request for comments. The following presents the information received in response to the solicitation efforts by the Hospital. No unsolicited comments have been received.

1. **Please indicate which (if any) of the following characteristics apply to you. If none of the following choices apply to you, please give a description of your role in the community.**

| | Yes (Applies to Me) | No (Does Not Apply to Me) | Response Count |
|---|---|---|---|
| 1) **Public Health Expertise** | 7 | 7 | 14 |
| 2) **Departments and Agencies** with relevant data/information regarding health needs of the community served by the hospital | 7 | 9 | 16 |
| 3) **Priority Populations** | 9 | 8 | 17 |
| 4) Representative/Member of **Chronic Disease Group** or Organization | 2 | 12 | 14 |
| 5) Represents the **Broad Interest of the Community** | 17 | 4 | 21 |
| Other | | | |
| Answered Question | | | 22 |
| Skipped Question | | | 0 |

**Congress defines "Priority Populations" to include:**

- **Racial and ethnic minority groups**
- **Low-income groups**
- **Women**
- **Children**
- **Older Adults**
- **Residents of rural areas**
- **Individuals with special needs including those with disabilities, in need of chronic care, or in need of end-of-life care**
- **Lesbian Gay Bisexual Transsexual (LGBT)**
- **People with major comorbidity and complications**

2. **Do any of these populations exist in your community, and if so, do they have any unique needs that should be addressed?**

- *Prevalence of high blood pressure and diabetes.*
- *Lack of affordable health insurance; lack of transportation to and from appointments; expense of healthy/fresh foods*
- *Getting supplies and DME not covered by insurance or transportation to appointments*
- *Access to care, health equity, lack of resources to groups identified, need for coordination of care for chronic*

[31] Responds to IRS Schedule H (Form 990) Part V B 5

*groups, need for health coaches or medical care coordinators for specific groups especially older adults and children, health literacy, transportation, poor living conditions*

- *Access to affordable health care*
- *Transportation for several of the above selected groups – for medical, for many resources in a timely manner. Mindset, education opportunities, and change (in habits) in general to influence the above selected groups can be a challenge.*
- *I don't can't speak with data regarding LGBT*
- *Low-income groups – not having health insurance*

**In the 2015 CHNA, there were five health needs identified as "significant" or most important:**

1. **Obesity & Access to Healthy Foods**
2. **Behavioral Health**
3. **Smoking**
4. **Diabetes**
5. **Access to Primary Care**

**3. Should the hospital continue to consider the 2015 Significant Health Needs the most important health needs currently confronting residents in the county?**

| | Yes | No | Response Count |
|---|---|---|---|
| Obesity & Access to Healthy Food | 20 | 0 | 20 |
| Behavioral Health | 20 | 0 | 20 |
| Smoking | 16 | 2 | 18 |
| Diabetes | 19 | 0 | 19 |
| Access to Primary Care | 16 | 4 | 20 |

Comments:

- *These, in conjunction with the 2019 HEDIS measures should be reviewed.*
- *Counseling for substance abuse would be useful; Feel that there is adequate access to primary care in the county due to interval changes*
- *Access to PCP specific the uninsured or under insured*

**4. Should the Hospital continue to allocate resources to help improve the needs identified in the 2015 CHNA?**

| | Yes | No | Response Count |
|---|---|---|---|
| Obesity & Access to Healthy Food | 19 | 0 | 19 |
| Behavioral Health | 20 | 0 | 20 |
| Smoking | 13 | 4 | 17 |
| Diabetes | 19 | 0 | 19 |
| Access to Primary Care | 14 | 4 | 18 |

Comments:

- *These, in conjunction with the 2019 HEDIS measures should be reviewed.*
- *Yes, continue to allocate resources, but evaluate services and the way services are offered and community is served. Change to make major differences in community such as raising awareness to those in control of community funds and spending. We need to push for policies and programs that can address needs in the communities around us.*

5. **Are there any new or additional health needs the Hospital should address? Are there any new or additional implementation efforts the Hospital should take? Please describe.**
   - *Prenatal care; teaching young children about vegetable gardening, farmers market access, hypertension*
   - *Abbeville SC also has important health needs in physical inactivity, access to exercise opportunities, excessive drinking and driving, sexually transmitted infections and teen births. We do not have enough mental health providers. 25% of the children live in poverty and 39% of households are in single-parent households. Serving community means outside our walls and learning to embed ourselves out in community with other entities to serve those who are medically underserved and unhealthy, we have many rural areas in our communities where medical and health assistance could be valuable to the people living there if it were available. There are also pockets of population who need special care and programs, women, parenting, teens and school aged children, we could develop specific programs in primary care to focus in these areas.*
   - *Drug addiction*
   - *Substance Abuse and Chronic Pain Management*
   - *A Telehealth venue beyond psychiatry. The challenge again is that data shows Abbeville county is a best 50% accessible to the internet. Consider a placing a telehealth site somewhere in the community for PCP. The logistic will be challenging but not impossible.*
   - *At health screenings, I have seen a high number of individuals with high blood pressure and high cholesterol numbers. I believe more education/programs in these areas would be beneficial.*
6. **Please share comments or observations about keeping <u>Obesity & Access to Healthy Food</u> among the most significant needs for the Hospital to address.**
   - *Nutrition is key to person's physical and mental health.*
   - *I think obesity and access to healthy food should remain a priority area.*
   - *Definitely a need in the community; with low income levels, fast food is less expensive than fresh fruits and vegetables; not much education in the community re: eating right and exercising;*
   - *Our population could benefit from a focus of resources on obesity. Obesity drives so many other chronic diseases, such as diabetes, heart disease, stroke, bone and joint disease, and some types of cancer. Obesity is a serious health concern that reduces quality of life. Obesity is also associated with moving to little. Obesity is a disease that needs many resources in order for it to improve. Access to Healthy Food is just one cause of obesity in our population and we need to concentrate on all causes with the help of others.*
   - *Yes. Very important. This is imperative to good health*
   - *Ready access to dietary counseling and healthy food choices*

- *Expansion of health fairs to civic groups and industries should be a priority.*
- *Need to "clean up" the list to see what has been done and what still needs to be done, but should remain an area for the hospital to address*
- *We continue to see individuals who are obese which compounds and contributes to other medical factors. If obesity were better managed, some of these comorbidities would be reduced or eliminated.*
- *AAMC does not model good behavior as we have too many obese workers who do not eat healthy. We need to have more emphasis on exercise and healthy living with our staff and to model this behavior starting with senior and other leaders.*
- *It stays and data speaks to why.*

**7. Please share comments or observations about the implementation actions the Hospital has taken to address <u>Obesity & Access to Healthy Food</u>.**

- *Partnered with EMS to provide community garden for Free clinic and underserved patients. Successful first year, subsequent years less successful. Lack of interest all parties.*
- *There may be a way to market the ""Play 60"" program or 60 minutes of physical activity per day to Abbeville schools/youth populations."*
- *I haven't seen much activity in this area with the exception of the Direct Health program promotion of information to employers about healthy diet and exercise; at one time AAMC's dietitian was working with UCMAC??? and hosting a cooking class that was well received - unsure if this class has continued.*
- *Direct health has provided an avenue for employees in Abbeville to connect to AAMC as a healthcare provider. This has been a great start to connect community to us. TV material in the waiting rooms on healthy eating is helpful to those receiving care or visiting us. We did provide ""Produce Patch"" Farm Boxes to employees, but many did not like not having a choice in what was received, and the freshness of the vegetables was not good.*
- *AAMC needs to assign this project to someone, in 2015 this was not done and a plan was not developed. There are many good resources available to work on this topic. By setting an example, our employee population could have a focus on obesity. Providing more healthier options in the cafeteria and labeled calories on each item could help raise awareness. Healthy eating and a focus on exercise in the schools is a key to building a culture of healthy living, don't forget play. Children need play to be happy and start young with early care education. and working with faith-based organizations on healthy eating and exercise has proven to be a benefit in community. Raising awareness and getting community groups to serve healthy options should be a focus. Utilization of the community room at the practices for more community functions involving how to shop and buy healthy options and demonstrating healthy cooking. Involve local grocery stores in assisting in educating and displaying health choices. Need to promote more community exercise programs, walking groups, yoga on the square, 5 K's, bicycle groups, walking trails, etc. working with other entities in the community to accomplish. Connecting with Greenwood Parks and Trails, providing places where children can play, working with districts to open up playgrounds during specific hours.*
- *Great start but needs to continue*
- *Collaborative efforts with school district's culinary arts program is key for reduction in obesity.*

- *If some of this has been done, then it may not be well-known in the area*
- *At times the hospital has included nutritional information on the cafeteria board (although not consistently). The dietician on staff currently appears to be very knowledgeable and is vocal for patients; however, I think we could plug her more into the community to prevent issues rather than address.*
- *The community garden*
- *Increased access to PCP but getting the DE's out into the community.*

8. **Please share comments or observations about keeping <u>Behavioral Health</u> among the most significant needs for the Hospital to address.**
   - *Mental health support is core issue for those struggling with mental and addictive issues. Affects total well-being.*
   - *Among the population that I serve/work with, behavioral/mental health is highly stigmatized and rarely discussed openly. I think it should definitely remain a priority and that focus should be placed on awareness, education, stigma reduction in addition to treatment.*
   - *Continues to be an area of need across the country; being in a rural area there are limited resources*
   - *Behavioral health needs to be provided for the needs of the community. Understanding what behavioral health the community needs should be explored. Where is it in the community that behavioral health would be most utilized. Having primary care perform mental health screening up front on patients in a more detailed fashion would assist in identifying more needs and referring to behavioral health.*
   - *Our rural areas do not have enough access to behavioral health professionals*
   - *Great strides in the AAHC with 2 behavioral therapists and a psychiatrist*
   - *House behavioral health specialists in new medical office building is detrimental for dealing with the increase in mental health patients.*
   - *Needs to be more interaction on the pediatric end (with schools and Abbeville Mental Health)*
   - *We continue to see a large amount of behavioral health patients that have either not been identified or are not being served by a provider. This falls to having the medical staff attempt to assist without a valuable piece of the puzzle.*
   - *This is not just a hospital problem, but we do need more emphasis on how we manage this within the hospital We have no programs to help with behavioral health within the hospital except our behavior health telemedicine but nothing within the hospital.*
   - *Data speaks to the need*

9. **Please share comments or observations about the implementation actions the Hospital has taken to address <u>Behavioral Health</u>.**
   - *Thank you for having a psychiatrist and counselors on our team at AAHC.*
   - *I would like to see the hospital offer workshops such as the ""Youth Mental Health First Aid"" course on an ongoing basis (monthly, quarterly). As it relates to opioid epidemic/substance abuse, which I believe falls under mental/behavioral health, AAMC might consider conducting addiction screenings as well as training programs*

*around safe use, storage, and disposal of prescribed medications, etc...*

- *Having the Behavioral Health service line at AAHC is a much needed resource for patients. I have been impressed with the care given by these providers.*
- *Addition of tele-psych to the ED; addition of Behavioral Health service line at new Healthcare Center to include two therapists and a psychiatrist that comes weekly*
- *Just because we have behavioral health specialists doesn't mean that they are being utilized, Study what is happening in the program, feed information back to the providers. Study successful programs and what they are doing to build and sustain the program. Also, Behavioral Health can be offered outside of the physician's office, connect up other behavioral health entities in our community by building a coalition and focus on a goal to improve access.*
- *We have added great professionals to our staff!*
- *See above*
- *Collaboration with school district counselors and medical community to provide psychological support to patients with mental illnesses such as depression, bipolar type 1, schizophrenia, and other forms of psychosis.*
- *Improved access to counseling services and part-time psychiatrist has helped increase access*
- *Tele-psych*
- *Behavioral health counselors within AAHC and behavioral health telemedicine within the emergency department only.*
- *Added two LISW's full time and a part time Psychiatrist to AAHC.*

**10. Please share comments or observations about keeping <u>Smoking</u> among the most significant needs for the Hospital to address.**

- *If we are going to continue this topic moving forward a plan and concerted effort need to be laid out.*
- *Not sure what the hospital has done*
- *Still needs work*
- *More collaboration of the hospital with schools to prevent smoking among youth.*
- *Need to continue working on smoking cessation classes*
- *I think we have done a good job in this area. We provide information at both the hospital, physician's offices, and health fairs. The information and resources are there; however, interest on the patient's part isn't always.*
- *AAMC continues to have a portion of employees that smoke and the negative reinforcement to stop like greatly increased health benefit cost, is minimal*
- *Abbeville is a smoker county as well as the other counties served.*

**11. Please share comments or observations about the implementation actions the Hospital has taken to address <u>Smoking</u>.**

- *Smoking Cessation offered to industry via Direct Health program*

- *We did very little to raise awareness around smoking in the community last year. We have no program or plan in place. We need someone who is certified in smoking cessation to work specifically with those who want to quit.*
- *Please see above comment*
- *"Freedom from Smoking" from the American Lung Association - classes for community is extremely important and should be expanded.*
- *Some success with smoking cessation classes*
- *Health fair information and programs for smoking cessation*
- *Brochures on not smoking and offered during visits throughout the organization.*
- *B2B sessions*

**12. Please share comments or observations about keeping <u>Diabetes</u> among the most significant needs for the Hospital to address.**

- *Diabetes affects all systems of the body*
- *Diabetes is somewhat prevalent among the population I serve (church congregation). Since meals are a frequent part of church gatherings, having reminders of healthy eating habits on hand may be helpful. Even flyers in the foyers and fellowship halls of church buildings would be helpful.*
- *Large diabetic population in the area; definite need to serve community*
- *Many of our patients have diabetes, but it is but one cause of chronic care which is where we need to be concentrating our efforts and resources.*
- *Diabetes management and prevention helps to keep a lot of other illness from happening.*
- *Great diabetic education program with motivated educators*
- *It is critical factor in our community.*
- *Increasing prevalence and a lot of factors that will continue to lead to increasing prevalence*
- *Diabetes continues to be a prevalent diagnosis we deal with (almost daily). Addressing DM and appropriate treatment would continue to reduce hospitalizations and unnecessary medical costs for when it is uncontrolled.*
- *There are many diabetics in the community and many that come to the hospital for healthcare related to diabetes*

**13. Please share comments or observations about the implementation actions the Hospital has taken to address <u>Diabetes</u>.**

- *Continue Diabetic Education at Abbeville Area Health Care Center*
- *Thank you for having a diabetic educator at AAHC. It helps the clinic run smoothly when I see a diabetic patient and need some teaching/instruction on injections and can ask them to help.*
- *Target youth and younger populations for diabetes prevention (educate on risk factors etc...) in addition to the treatment efforts and support groups that are being provided.*

- *Hopefully with the addition of Athena, we will be able to better monitor and produce measurable outcomes from our Diabetes Care program.*
- *Active Diabetic Education program that has free support groups*
- *While we did build the primary practice and incorporate the diabetes program, but very little or no reporting on how the program is doing has been reported. Having a table at a wellness fair is not enough, need to get these educators out into the work places and areas that need assistance, The Mennonite community has many issues with diabetes because of the way they cook and eat. Focus on life long lifestyle changes has not been accomplished. No plan was ever developed or shared and no specific person was assigned this effort. There are new recommendations around Diabetes and support from SCHA with a statewide group working on diabetes and am not sure or not if our educators are involved or advocating for these new standards. Evaluate the program and the staff. Use a solid successful model and look for opportunities to improve. Assign program to someone who has passion about seeing something change and provide physician oversight. I feel that we have sufficient resources assigned to this program, just little oversight.*
- *Great start but need to continue*
- *Continue with the expansion of health fairs to civic groups and industries.*
- *Need to offer more community offerings and strengthen our diabetic education program*
- *Diabetic education is offered and ordered on newly identified patients.*
- *Education in the ED and inpatient areas.*
- *increased access. participated in pilot Diabetic Program home monitoring.*

**14. Please share comments or observations about keeping <u>Primary Care</u> among the most significant needs for the Hospital to address.**

- *I agree that this should remain a significant priority due to the rural, low income demographic*
- *Physician shortages are occurring*
- *Access to Primary care has greatly improved, we now need to move out to the rural areas that are undeserved with additional access. We need a plan to bring the primary care market business back from Greenwood and Anderson. We need to coordinate care for patients currently in the practices, then grow our market by using that success. We need to talk about quality and quality ratings successes with both practices to demonstrate to citizens (70-80 % of them who seek services outside our market) to come home for their care.*
- *Need to do more telehealth*
- *AAHC is a state-of-the-art facility with providers second to none in the area*
- *Explore possible expanded hours of clinic for many people who need evening and weekend assistance.*
- *Feel that access to primary care is adequate at this time*
- *Branching out into the surrounding areas to continue to provide primary care close to home for our community continues to be a desire and part of the mission of the hospital.*
- *This is getting much better as hours have improved and access to the healthcare center has improved with*

*initiatives to reduce waiting times and the wait list.*

- *First it's the future path of survival for the hospital and second key to diabetes, behavioral health and smoking treatment.*

**15. Please share comments or observations about the implementation actions the Hospital has taken to address <u>Primary Care</u>.**

- *Opening and operation of Abbeville Area Healthcare Center - increased access to care.*
- *Build on home care programs already in existence. Maybe consider mobile clinics, partnering with churches/schools to operate on site community clinics in the future. etc...*
- *Construction of a new primary care practice and recruitment of several new providers*
- *Physician offices are offering before and after hours for the community, but expansion is needed outside the two offices for access.*
- *Need more in the rural parts*
- *Continue to hire providers to staff new medical office building.*
- *Feel that there is adequate access for patients with insurance; there continues to be issues for the uninsured*
- *Built new facility and partnered with Due West Family medicine to make this more accessible.*
- *Increased hours at the healthcare center has helped. Walk ins welcome has helped with quicker access.*
- *Expanded hours and walk in welcome program.*
- *Creating the new office building was a big step regarding access to primary care, along with the expanded hours. Also, community outreach by doing onsite health screenings and connecting new patients with a primary care doctor has helped with this area.*

**16. Finally, after thinking about our questions and the information we seek, is there anything else you think is important as we review and revise our thinking about significant health needs in the county?**

- *It would be important to involve as many community partners as possible (i.e. nursing homes, assisted living facilities, urgent cares, school districts, pharmacies, CONNECT transit, etc.) in this assessment to get a good picture of the needs.*
- *Continue to reach out to community to participate in overall health of Abbeville county. It's not a one size fits all and one entity is not responsible for everything. Continue to reach across the aisles and keep communication open.*
- *Dental and vision care come to mind, particularly for children. I am not even sure about the feasibility of having these as options (monthly, weekly, etc.) within AAHC, but they came to mind as I was reading through the survey. I also wonder if cardio/vascular ultrasound within AAHC would be beneficial to patients due to ease of accessibility at the practice level. Just my thoughts...*
- *Abbeville has many resources at work, but they are working in silos. A comprehensive approach needs to be built in order for many individuals to work towards any given goal. It takes many resources working together to bring a community together for success.*

- *Prevention is the key. Continue all efforts to allow people to stay healthy.*
- *The hospital as part of its mission needs to be the champion for these efforts and engage the community in accomplishing these items. The hospital does not have to be the sole owner, but often times will need to be the driver*
- *My biggest concern is in the area of behavioral health for the patients in the hospital. We do have a program for outpatient; however, during the hospitalization these people will need care specific to them. We could also benefit from a palliative care team. This is an area we broach often; however, we don't have a team approach to handling these conversations with the families at this time.*
- *There needs to be a greater emphasis on mid-level providers as this is more cost efficient and there are many folks entering the field. Predictions are that 50% of nurses under 36 years old will be seeking further education as mid-level providers. The emergency department needs to utilize this resource as well.*
- *ASK THE COMMUNITY FIRST. We assume we know but have vet this with patient and the community.*
- *Based upon what I have seen at various community health events, I think the focus definitely needs to remain on obesity and diabetes. Also adding in a focus on high blood pressure and cholesterol would serve a large population in our area. More smoking cessation classes could definitely be utilized also. In the realm of behavior health, if there is a way to provide education on stress management, I believe this is something that is needed also.*

# Appendix B – Identification & Prioritization of Community Needs (Round 2)

| Need Topic | Total Votes | Number of Local Experts Voting for Needs | Percent of Votes | Cumulative Votes | Need Determination |
|---|---|---|---|---|---|
| Obesity & Access to Healthy Food – 2015 Significant Need | 242 | 15 | 16.13% | 16.13% | Significant Needs |
| Behavioral Health – 2015 Significant Need | 154 | 13 | 10.27% | 26.40% | |
| Prevention/Wellness Education | 145 | 13 | 9.67% | 36.07% | |
| Smoking - 2015 Significant Need | 121 | 13 | 8.07% | 44.13% | |
| Physical Activity | 114 | 13 | 7.60% | 51.73% | |
| Diabetes - 2015 Significant Need | 88 | 12 | 5.87% | 57.60% | |
| Substance Use/Abuse | 88 | 12 | 5.87% | 63.47% | |
| Chronic Pain Management | 68 | 10 | 4.53% | 68.00% | Other Identified Needs |
| Access to Primary Care - 2015 Significant Need | 66 | 10 | 4.40% | 72.40% | |
| Hypertension | 58 | 9 | 3.87% | 76.27% | |
| Suicide | 47 | 11 | 3.13% | 79.40% | |
| Affordability | 43 | 9 | 2.87% | 82.27% | |
| Alcohol Use | 43 | 9 | 2.87% | 85.13% | |
| Alzheimer's | 42 | 8 | 2.80% | 87.93% | |
| Stroke | 31 | 8 | 2.07% | 90.00% | |
| Accidents | 30 | 7 | 2.00% | 92.00% | |
| Women's Health | 27 | 9 | 1.80% | 93.80% | |
| Heart Disease | 24 | 7 | 1.60% | 95.40% | |
| Lung Disease | 22 | 6 | 1.47% | 96.87% | |
| Kidney Disease | 17 | 6 | 1.13% | 98.00% | |
| Liver Disease | 17 | 6 | 1.13% | 99.13% | |
| Flu/Pneumonia | 13 | 7 | 0.87% | 100.00% | |
| Points reserved for NEW health needs | 0 | 0 | 0.00% | 100.00% | |
| Total | 1,500 | | 100.00% | | |

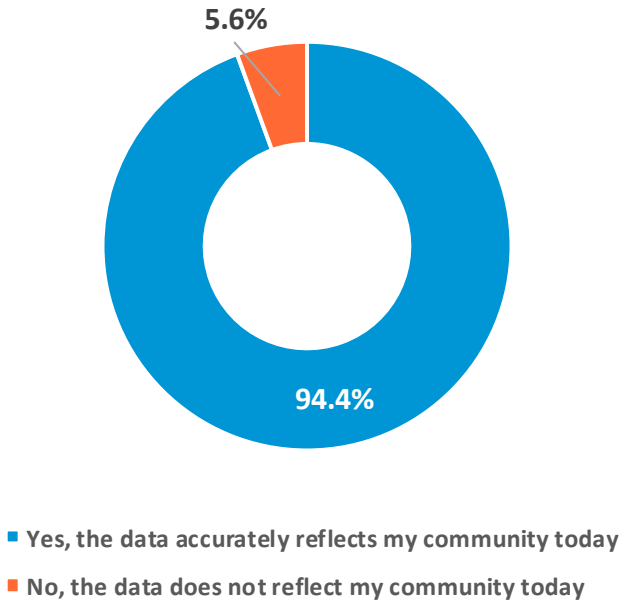
**Individuals Participating as Local Expert Advisors**[32]

| | Yes (Applies to Me) | No (Does Not Apply to Me) | Response Count |
|---|---|---|---|
| 1) **Public Health Expertise** | 7 | 9 | 16 |
| 2) **Departments and Agencies** with relevant data/information regarding health needs of the community served by the hospital | 7 | 8 | 15 |
| 3) **Priority Populations** | 7 | 9 | 16 |
| 4) Representative/Member of **Chronic Disease Group** or Organization | 1 | 14 | 15 |
| 5) Represents the **Broad Interest of the Community** | 13 | 2 | 15 |
| Other | | | |
| Answered Question | | | 18 |
| Skipped Question | | | 0 |

[32] Responds to IRS Schedule H (Form 990) Part V B 3 g

**Advice Received from Local Expert Advisors**

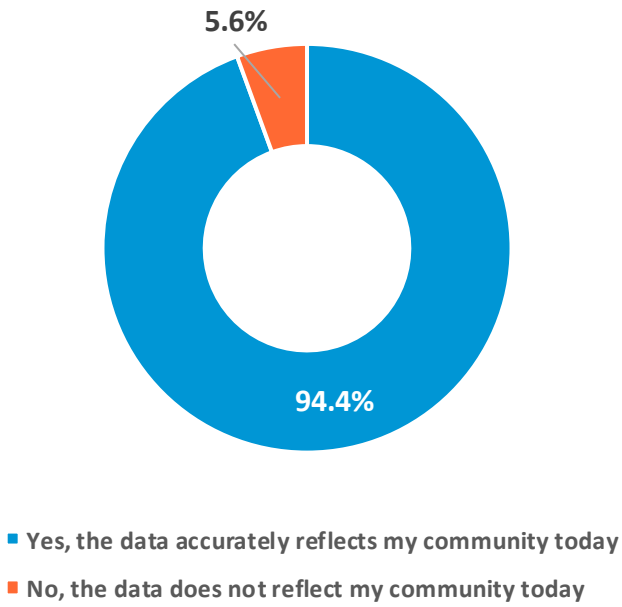
**Question: Do you agree with the comparison of Abbeville County to peer counties?**




Comments:

- *From other sources I can verify the following: Adult smoking: even though it is at 6%, data shows more deaths and more health care costs are associated with smoking; Adult obesity: obesity in children and adults is the largest negative health behavior in our state, it effects so much more than health. Access to exercise opportunities; Excessive drinking: leads to much more - violence upon women and children, we have very week laws to deal with those that sell to underage or already drunk individuals; alcohol-impaired driving deaths: while they were high over the past 2 years, have improved in 2016; Population to dentist ratio: this is true to Abbeville; Unemployment has gotten better; Children in poverty - this is the most appalling statistic on this whole page; Injury deaths- at our emergency room, we see many injuries, especially with children; Air pollution- although this is true we have many agencies that deal with this effectively; Long commute because folks leave county to work elsewhere.*
- *Yes, we still have issues with unemployment, and child poverty*
- *One that surprises me is the section that we were ranked poorly in Air Pollution. Also, I was surprised to see that we had a good rating for adult smoking. It may just be the population that I work with, but I see several smokers in the community.*

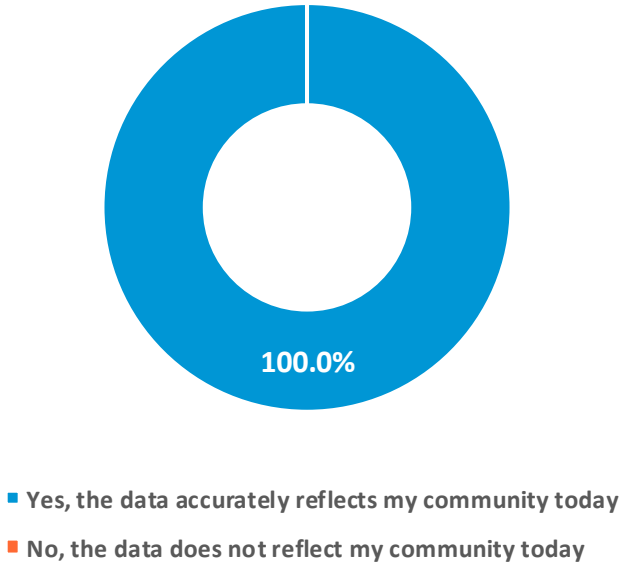
**Question: Do you agree with the demographics and common health behaviors of Abbeville County?**




Comments:

- *Abbeville has very little growth overall in our population and very little growth in Hispanic population despite those counties around us, Abbeville is not a very diverse community mainly made up of Caucasian and African American. The median household income is a diversity issue because most Caucasian people earn much more than their minority counter parts.*
- *If the data is correct. We need to focus on obesity.*

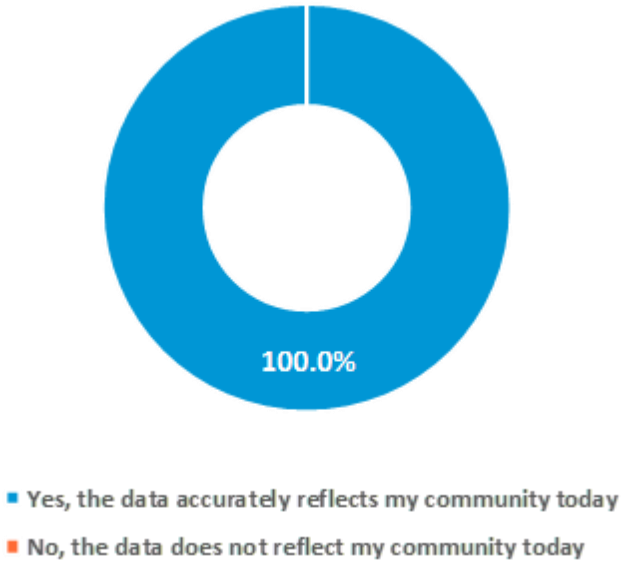
**Question: Do you agree with the overall social vulnerability index for Abbeville County?**




Comments:

- *The areas located on the map that indicate vulnerability also reflect where the most concentrated areas of unemployment, low income, worse housing, and single parent household. These populations have a more difficult time following directions, doing what is desired for the whole, and communicating with in crisis.*

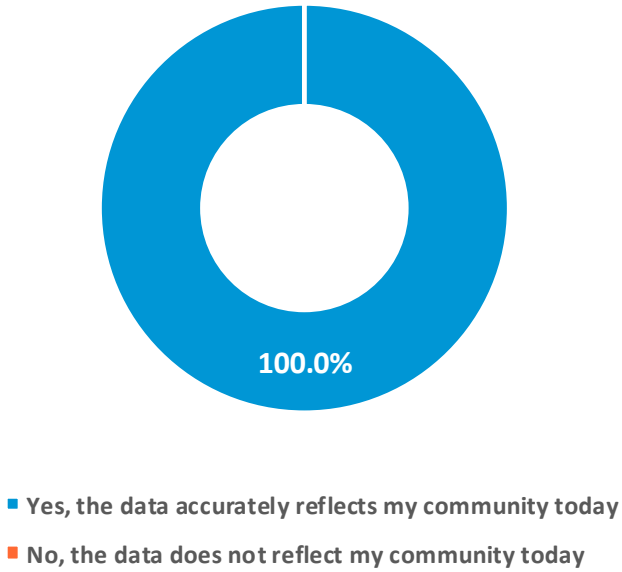
**Question: Do you agree with the national rankings and leading causes of death?**




Comments:

- *Higher rates of Heart Disease, Cancer, and Lung Disease occur because of our high obesity and smoking rates.*
- *Things like obesity and cancer can be treated. We need to focus next on these needs*

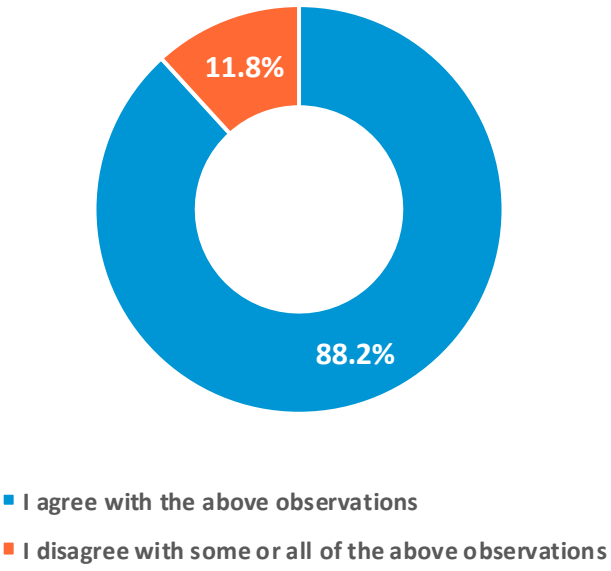
**Question: Do you agree with the health trends in Abbeville County?**




Comments:

- *Disease changes are usually fairly accurate in Abbeville due to many sources of data in our state. Cancer, Diabetes, and failure to eat healthy due to no availability of fresh foods are hugely associated with causes of Endocrine Disease deaths*

**Question: Do you agree with the written comments received on the 2015 CHNA?**




Comments:

- *I agree with most of the above, but could debate some of those issues.*
- *I think as a healthcare industry it is our responsibility to educate our community. I am currently helping to get coaches from Abbeville Youth Association to Mentor at Westwood Elementary (due to behavior issues). I think we need a way to tie all this together with the Recreation dept. (they reach many children and parents), schools, after school programs (Youth Center), healthcare providers, etc. I was also in the Abbeville Woman's Club for 7 years. The group has dissolved. but I think a civic organization such as this (or even a Junior Woman's Club) would offer teens and pre-teens the ability to learn how to serve in their community. Education levels in our community mimic the poverty level (in my opinion). During a recent clinical trial (which included telehealth) (at AAMC through MUSC) I started to notice a trend during the testing of most of the patients. The chosen patients had memory loss (and had to meet other criteria) but had not been diagnosed with Dementia or Alzheimer's. During testing, the patient's symptoms were being mistaken as Dementia, all the while it was their education level that was skewing the numbers on the test. They simply could not complete the testing in the correct manner. As far as the Telehealth site… could we not go out into the homes. Some type of community liaison for these folks? I think in our community, we are going to have to get outside the box to reach people. I think there are so many here that don't even know they need to be helped. There are so many things they don't understand such as their health insurance (benefits), some elderly do not know how to choose correct RX or healthcare plans, middle age people that are retiring early (and need insurance until Medicare starts), preventive medicine (when they should start Colonoscopy, Screenings, Complete Physical's, etc. I have a passion for the youth, middle age and elderly, especially in our community. Training people that it is ok to receive help is going to be a hard task. There is a lot of work to be done and I would love to be part of the solution."*
- *Community networking, partnerships and leadership to support larger projects, staff, volunteers, etc. may be considered as a resource to provide programs, outreach and education to the populations at need (county wide). Networking faith-based organizations to host events, events at social groups, agencies/orgs that have*

*"memberships" and gatherings may also be a resource to tap into for education and understanding in attempts to create changed behaviors through education. Transforming by opportunity, hands on learning, and other means of awareness are also routes to help the greater community get on board for better health. Living and working in a small community, with economic constraints, the work of fewer hands becomes greater when partnered together to make a larger impact. Grant resources to fund positions that aid in community health, awareness, organization, networking, assessments, etc. may be a short-term solution to long term behavior changes.*

## Appendix C – National Healthcare Quality and Disparities Report[33]

The National Healthcare Quality and Disparities Reports (QDR; annual reports to Congress mandated in the Healthcare Research and Quality Act of 1999 (P.L. 106-129)) are based on more than 300 healthcare process, outcome, and access measures, covering a wide variety of conditions and settings. Data years vary across measures; most trend analyses include data points from 2000-2002 to 2012-2015. An exception is rates of uninsurance, which we are able to track through 2017. The reports are produced with the support of an HHS Interagency Work Group (IWG) and guided by input from AHRQ's National Advisory Council and the Institute of Medicine (IOM), now known as the Health and Medicine Division of the National Academies of Sciences, Medicine, and Engineering.

For the 15th year in a row, the Agency for Healthcare Research and Quality (AHRQ) has reported on progress and opportunities for improving healthcare quality and reducing healthcare disparities. As mandated by the U.S. Congress, the report focuses on "national trends in the quality of health care provided to the American people" (42 U.S.C. 299b-2(b)(2)) and "prevailing disparities in health care delivery as it relates to racial factors and socioeconomic factors in priority populations" (42 U.S.C. 299a-1(a)(6)).

The 2017 report and chartbooks are organized around the concepts of access to care, quality of care, disparities in care, and six priority areas—including patient safety, person-centered care, care coordination, effective treatment, healthy living, and care affordability. Summaries of the status of access, quality, and disparities can be found in the report.

The report presents information on trends, disparities, and changes in disparities over time, as well as federal initiatives to improve quality and reduce disparities. It includes the following:

- **Overview of Quality and Access in the U.S. Healthcare System** that describes the healthcare systems, encounters, and workers; disease burden; and healthcare costs.
- **Variation in Health Care Quality and Disparities** that presents state differences in quality and disparities.
- **Access and Disparities in Access to Healthcare** that tracks progress on making healthcare available to all Americans.
- **Trends in Quality of Healthcare** that tracks progress on ensuring that all Americans receive appropriate services.
- **Trends in Disparities** that tracks progress in closing the gap between minority racial and ethnic groups and Whites, as well as income and geographic location gaps (e.g., rural/suburban disparities).
- **Looking Forward** that summarizes future directions for healthcare quality initiatives.

**Key Findings**

**Access:** An estimated 43% of access measures showed improvement (2000-2016), 43% did not show improvement, and 14% showed worsening. For example, from 2000 to 2017, there were significant gains in the percentage of people who reported having health insurance.

[33] http://www.ahrq.gov/research/findings/nhqrdr/nhqdr14/index.html Responds to IRS Schedule H (Form 990) Part V B 3 i

**Quality:** Quality of healthcare improved overall from 2000 through 2014-2015, but the pace of improvement varied by priority area:

- Person-Centered Care: Almost 70% of person-centered care measures were improving overall.
- Patient Safety: More than two-thirds of patient safety measures were improving overall.
- Healthy Living: More than half of healthy living measures were improving overall.
- Effective Treatment: More than half of effective treatment measures were improving overall.
- Care Coordination: Half of care coordination measures were improving overall.
- Care Affordability: Eighty percent of care affordability measures *did not* change overall.

**Disparities:** Overall, some disparities were getting smaller from 2000 through 2014-2015; but disparities persist, especially for poor and uninsured populations in all priority areas.

**Trends**

- Trends show that about 55% percent of quality measures are improving overall for Blacks.[34] However, most recent data in 2014-2015 show that about 40% of quality measures were worse for Blacks compared with Whites.
- Trends show that about 60% of quality measures are improving overall for Asians. However, most recent data in 2014-2015 show that 20% of quality measures were worse for Asians compared with Whites.
- Trends show that almost 35% of quality measures are improving overall for American Indians/Alaska Natives (AI/ANs). However, most recent data in 2014-2015 show that about 30% of quality measures were worse for AI/ANs compared with Whites.
- Trends show that approximately 25% of quality measures are improving overall for Native Hawaiians/Pacific Islanders (NHPIs). However, most recent data in 2014-2015 show that nearly 33% of quality measures were worse for NHPIs compared with Whites.
- Trends show that about 60% of quality measures are improving overall for Hispanics, but in 2014-2015, nearly 33% of quality measures were worse for Hispanics compared with non-Hispanic Whites.
- Variation in care persisted across the urban-rural continuum in 2014-2016, especially in access to care and care coordination.

**Looking Forward**

The National Healthcare Quality and Disparities Report (QDR) continues to track the nation's performance on healthcare access, quality, and disparities. The QDR data demonstrate significant progress in some areas and identify other areas that merit more attention where wide variations persist. The number of measures in each priority area varies, and some measures carry more significance than others as they affect more people or have more significant consequences. The summary charts are a way to quantify and illustrate progress toward achieving accessible, high-quality, and affordable

[34] Throughout this report and its appendixes, "Blacks" refers to Blacks or African Americans, and "Hispanics" refers to Hispanics or Latinos. More information is available in the Reporting Conventions section of the Introduction and Methods.

care at the national level using available nationally representative data. The summary charts are accessible via the link below.

This report shows that while performance for most access measures did not change significantly over time (2000-2014), insurance coverage rates did improve (2000-2016). Quality of healthcare improved in most areas but some disparities persist, especially for poor and low-income households and those without health insurance.

U.S. Department of Health and Human Services (HHS) agencies are working on research and conducting programs in many of the priority areas—most notably opioid misuse, patient safety, effective treatment, and health disparities.

**Link to the full report:**

https://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/nhqrdr/2017qdr.pdf