Tidelands Health

Tidelands Georgetown Memorial Hospital

Tidelands Waccamaw Community Hospital

2022

Community Health Needs Assessment

Approved by Board on September 27, 2022

TIDELANDS HEALTH
with MUSC Health

Table of Contents

Executive Summary

Tidelands Health (or the "Hospital") performed a Community Health Needs Assessment (CHNA) in partnership with QHR Health (“QHR”) to determine the health needs of the local community and develop an accompanying implementation plan to address the identified health needs of the community. This report includes a community assessment and implementation plan for both Tidelands Waccamaw Community Hospital and Tidelands Georgetown Memorial Hospital.

This CHNA report consists of the following information:

1) a definition of the community served by the hospital 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 solicited and considered input received from persons who represent the broad interests of the community it serves;
4) commentary on the 2019 CHNA Assessment and Implementation Strategy efforts
5) 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
6) a description of resources potentially available to address the significant health needs identified through the CHNA.

Data was gathered from multiple well-respected secondary sources to build an accurate picture of the current community and its health needs. A survey of a select group of Local Expert Advisors, as well as the general community population, was performed to review the prior CHNA and provide feedback, and to ascertain whether the previously identified needs are still a priority. Additionally, the group reviewed the data gathered from the secondary sources and determined the Significant Health Needs of the community.

The 2022 Significant Health Needs identified for Tidelands Health:

- **Access to Health Care**
- **Behavioral Health**
- **Diabetes**

In the Implementation Strategy section of the report, Tidelands Health addresses these areas through identified programs, resources, and services provided by Tidelands Health, collaboration with local organizations and provides measures to track progress.

Community Health Needs Assessment (CHNA) Overview

CHNA Purpose

A CHNA is part of the required hospital documentation of "Community Benefit" under the Affordable Care Act for 501(c)(3) hospitals. It provides comprehensive information about the community's current health status, needs, and disparities and offers a targeted action plan to address these areas, including programmatic development and partnerships.

Strategic Benefit

- Identify health disparities and social determinants to inform future outreach strategies
- Identify key service delivery gaps
- Develop an understanding of community member perceptions of health care in the region
- Target community organizations for collaborations

The CHNA Process

1 Identification of Local Experts

Develop a list of contacts representing individuals with specific knowledge of local health needs.

2 Community Survey

Launch of surveys to assess significant health needs and progression towards improvement.

3 Data Analysis

Review of relevant data resources to provide quantitative feedback on the local community.

4 Implementation Planning

Facilitation of session with CHNA team to build plans and finalize the CHNA report.

Process and Methods used to Conduct the Assessment

The methodology to conduct this assessment takes a comprehensive approach to assess community health needs, perform several independent data analyses based on secondary source data, augment this with community opinions, and resolve any data inconsistency or discrepancies by reviewing the combined opinions formed from the community respondents.

Data Collection and Analysis

The Hospital relies on secondary source data, and most secondary sources use the county as the smallest unit of analysis. Most data used in the analysis is available from public internet sources and proprietary data. Any critical data needed to address specific regulations or developed by the community members cooperating in this study are displayed in the CHNA report appendix.

Data sources are detailed in the appendix of this report and include:

- Stratasan
- www.worldlifeexpectancy.com/usa-health-rankings
- Bureau of Labor Statistics
- www.countyhealthrankings.org
- NAMI
- CDC
- Centers for Medicare & Medicaid Services: Mapping Medicare Disparities by Population
- South Carolina DHEC
- National Cancer Institute
- Kaiser Family Foundation

A standard process of gathering community input was developed. In addition to gathering data from the above sources:

- A CHNA survey was deployed to the community to gain input on local health needs and the needs of priority populations. Community input from 2,129 survey respondents was received. Survey responses were gathered between April and May 2022.

- Data Walks were conducted with the Hospital's Local Expert Advisors to analyze both the secondary data and community survey data and to identify the top health priorities in the community. 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 diverse population.

Prioritizing Significant Health Needs

The survey respondents participated in a structured communication technique called a "Wisdom of Crowds" method. The premise of this approach relies on the assumption that the collective wisdom of participants is superior to the opinion of any one individual, regardless of their professional credentials.

In the Hospital's process, each survey respondent had the opportunity to introduce needs previously unidentified. A list of all needs identified by any of the analyzed data was developed. The survey respondents then ranked the importance of addressing each health need on a scale of 1 (not important) to 5 (very important), including the opportunity to list additional needs that were not identified.

The ranked needs were divided into "Significant Needs" and "Other Identified Needs." The determination of the breakpoint — "Significant" as opposed to "Other" — was a qualitative interpretation where a reasonable break point in rank order occurred.

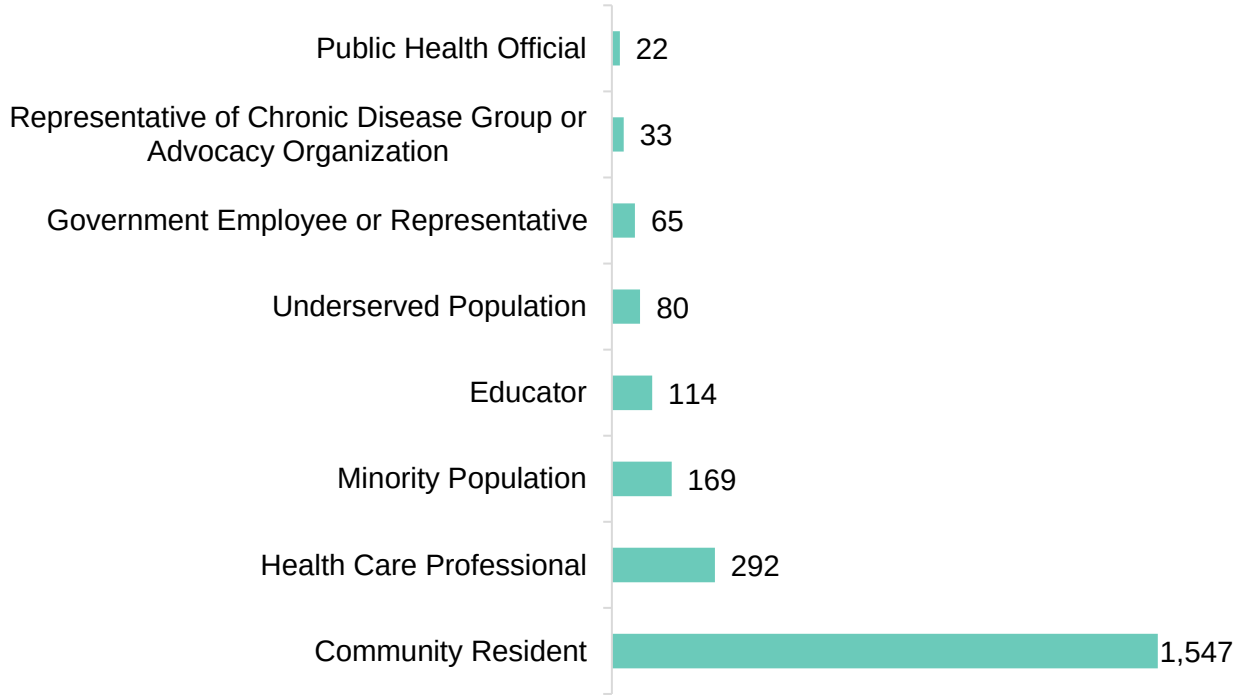
The Hospital analyzed the health issues that received the most responses and conducted Data Walks with Local Expert Advisors to select the top health priorities and establish a plan for addressing them.

Input from Persons Who Represent the Broad Interests of the Community

The input was obtained from the required three minimum sources and expanded to include other representative groups. The Hospital asked all those participating in the written comment solicitation process to self-identify themselves into any of the following representative classifications, which are detailed in an appendix to this report. Participants self-identified into the following classifications:

1) **Public Health Official**
2) **Government Employee or Representative**
3) **Minority Population**
4) **Underserved Population**
5) **Chronic Disease Groups**
6) **Community Resident**
7) **Educator**
8) **Health Care Professional**
9) **Other** (please specify)

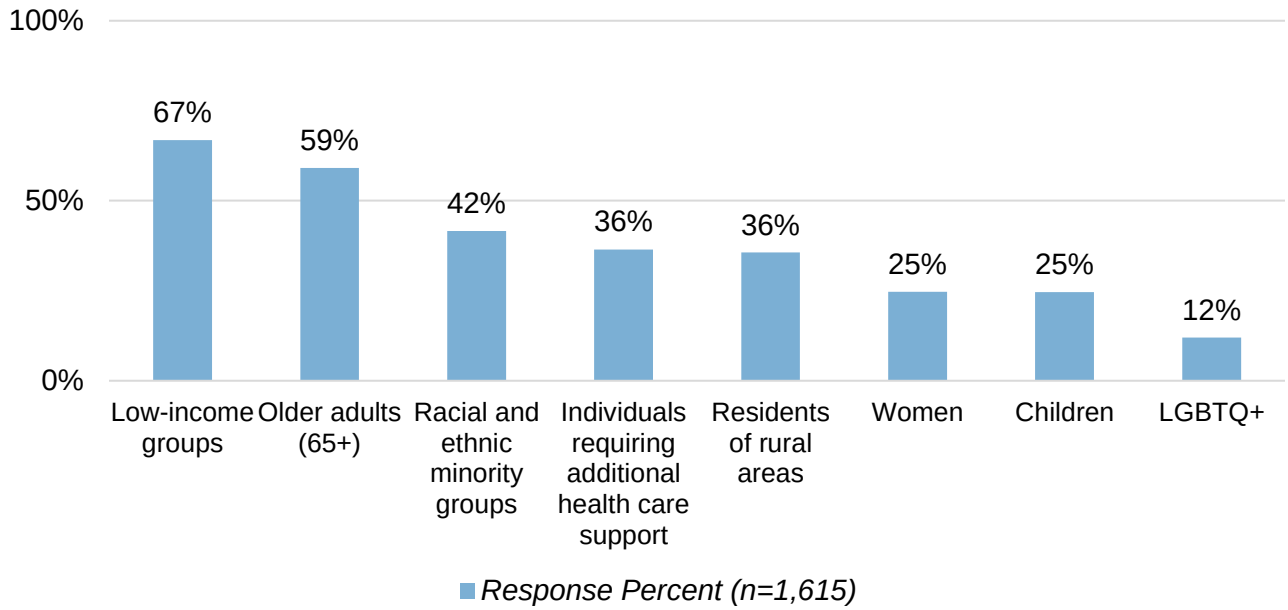
Survey Question: Please select all roles that apply to you (n=1,774)



Input on Priority Populations

Information analysis augmented by local opinions showed how the Tidelands Health Service area 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, what needs to be done to improve the conditions of these groups.

Survey Question: Which of these populations are prevalent/most common in your community?

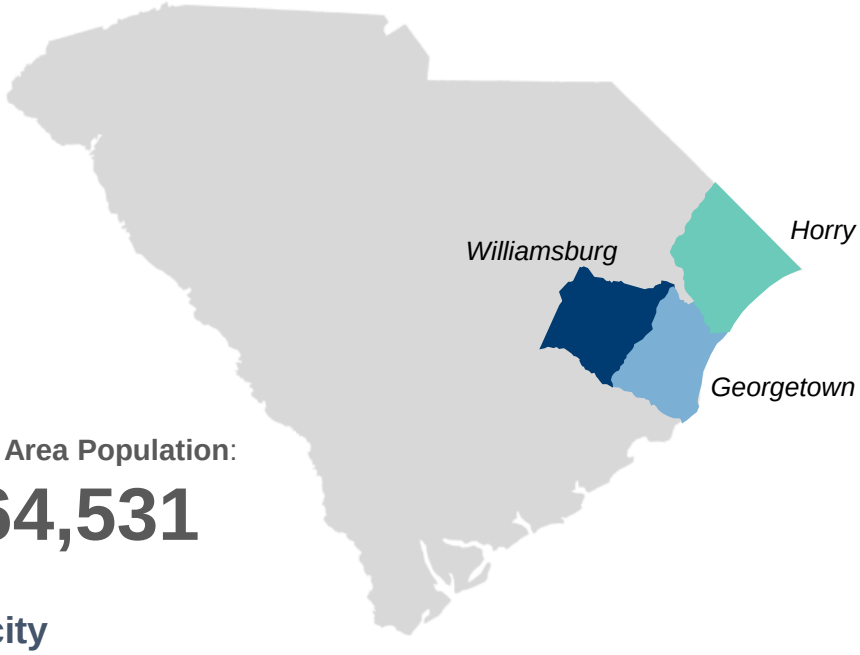


- Local opinions of the needs of Priority Populations, while presented in their entirety in the appendix, were abstracted in the following "take-away" bulleted comments:
  - The top three priority populations identified by the survey respondents were low-income groups, older adults, and racial and ethnic minority groups.
  - Summary of unique or pressing needs of the priority groups identified by the surveyors:
    - Affordable health care
    - Access to health care services
    - Preventative care
    - Aging needs/geriatric care

Community Served

For the purpose of this study, Tidelands Health defines its service area as Williamsburg, Georgetown, and Horry Counties in South Carolina. In 2021, Tidelands Health received 94% of its Medicare inpatients from this area.

Service Area Demographics



Service Area Population:

464,531

Race/Ethnicity

	Georgetown County	Horry County	Williamsburg County	South Carolina
White	*67.7%*	*75.6%*	*33.3%*	*66.0%*
Black	*28.6%*	*15.3%*	*62.9%*	*26.3%*
Asian and Pacific Islander	*0.5%*	*1.9%*	*1.1%*	*2.0%*
Other	*3.2%*	*7.2%*	*2.7%*	*5.8%*
Hispanic*	*3.2%*	*7.5%*	*2.1%*	*6.2%*

*Ethnicity is calculated separately from Race

Source: Stratasan, ESRI

Age

	Georgetown County	Horry County	Williamsburg County	South Carolina
0 – 17	*18.4%*	*18.4%*	*20.3%*	*21.3%*
18 – 44	*27.0%*	*33.3%*	*33.0%*	*35.0%*
45 – 64	*27.6%*	*25.7%*	*26.1%*	*25.3%*
65 +	*27.0%*	*22.6%*	*20.5%*	*18.4%*

Education and Income

	Georgetown County	Horry County	Williamsburg County	South Carolina
Median Household Income	*$52,994*	*$53,694*	*$34,309*	*$55,711*
Some High School or Less	*11.6%*	*9.4%*	*18.8%*	*11.4%*
High School Diploma/GED	*27.6%*	*31.2%*	*41.3%*	*28.0%*
Some College/ Associate's Degree	*31.1%*	*33.6%*	*26.6%*	*30.3%*
Bachelor's Degree or Greater	*29.8%*	*25.8%*	*13.3%*	*30.4%*

Source: Stratasan, ESRI

Tidelands Health Locations

Community Health Characteristics

The data below shows an overview of Williamsburg, Georgetown, and Horry Counties' strengths and weaknesses regarding health behaviors, quality of life, socioeconomic factors, access to health, and physical environment - all of which influence the health of the entire community. These statistics were used in our community and local expert survey to help prioritize the health needs of the community. For descriptions of each measure and dates of when the data was obtained, please visit: https://www.countyhealthrankings.org.

Georgetown County Health Status Indicators

Health Behaviors

Teen Births per 1,000	Adult Smoking	Physical Inactivity	Adult Obesity	Driving Deaths Involving Alcohol	Excessive Drinking
24	**19%**	**28%**	**37%**	**17%**	**18%**
SC: 23	*SC: 18%*	*SC: 29%*	*SC: 36%*	*SC: 33%*	*SC: 22%*

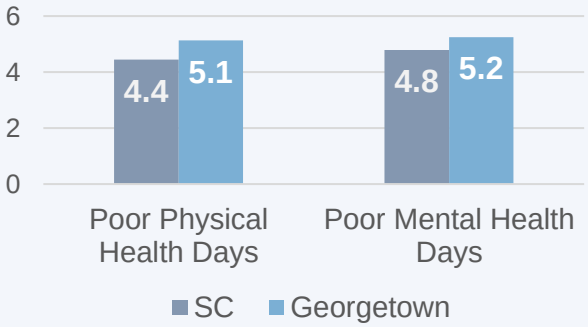
Quality of Life

Suicide Rate: 10.6
Compared to 16.3 in SC
Per 100,000

Poor or Fair Health: 20%
Compared to 18 in SC

Low Birthweight: 11%
Compared to 10% in SC

Average number of physically and mentally unhealthy days in the past 30 days



Source: County Health Rankings 2022 Report, worldlifeexpectancy.com

Socioeconomic Factors

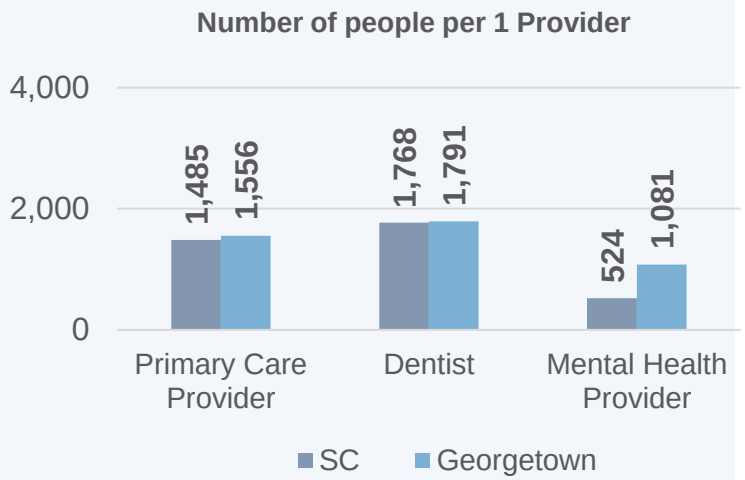
Income Inequality*	Unemployment	Children in Single Parent Households	Children in Poverty	Violent Crime *per 100,000*	Injury Deaths *per 100,000*
5.3	**4.8%**	**43%**	**31%**	**477**	**103**
SC: 4.8	*SC: 4.0%*	*SC: 31%*	*SC: 19%*	*SC: 500*	*SC: 94*

Access to Health

Uninsured: 10.2%
Compared to 10.4%

Preventable Hospital Stays: 3,950
Compared to 3,797 in SC
Per 100,000

Access to Exercise Opportunities: 69%
Compared to 65% in SC



Physical Environment

Air Pollution (µg/m³)	Severe Housing Problems**	Driving to Work Alone	Broadband Access
7.7	**15%**	**81%**	**77%**
SC: 8.0	*SC: 14%*	*SC: 82%*	*SC: 81%*

Source: County Health Rankings 2022 Report, Bureau of Labor Statistics
*Notes: *Ratio of household income at the 80th percentile to income at the 20th percentile*
***Overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities*

Horry County Health Status Indicators

Health Behaviors

Teen Births per 1,000	Adult Smoking	Physical Inactivity	Adult Obesity	Driving Deaths Involving Alcohol	Excessive Drinking
23	**23%**	**29%**	**32%**	**26%**	**24%**
SC: 23	*SC: 18%*	*SC: 29%*	*SC: 36%*	*SC: 33%*	*SC: 22%*

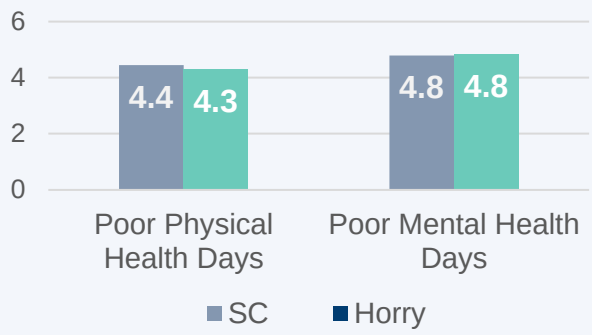
Quality of Life

Suicide Rate: 14.9
Compared to 16.3 in SC
Per 100,000

Poor or Fair Health: 20%
Compared to 18 in SC

Low Birthweight: 9%
Compared to 10% in SC

Average number of physically and mentally unhealthy days in the past 30 days



Source: County Health Rankings 2022 Report, worldlifeexpectancy.com

Socioeconomic Factors

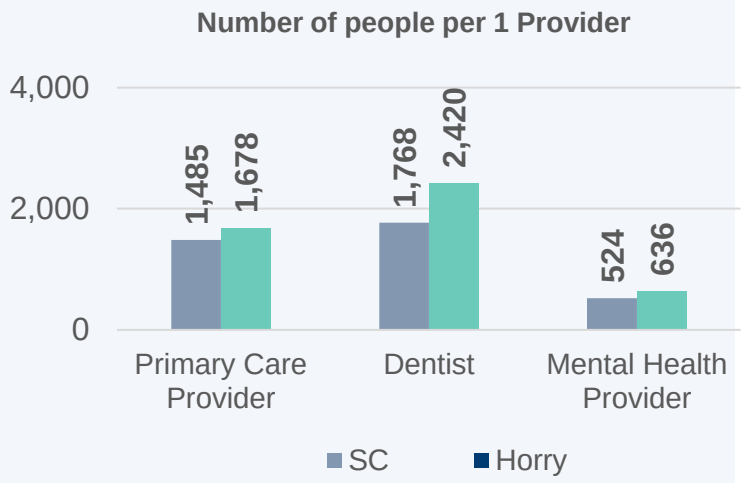
Income Inequality*	Unemployment	Children in Single Parent Households	Children in Poverty	Violent Crime *per 100,000*	Injury Deaths *per 100,000*
5.1	**4.8%**	**20%**	**20%**	**569**	**104**
SC: 4.8	*SC: 4.0%*	*SC: 31%*	*SC: 19%*	*SC: 500*	*SC: 94*

Access to Health

Uninsured: 14.1%
Compared to 10.4%

Preventable Hospital Stays: 3,945
Compared to 3,797 in SC
Per 100,000

Access to Exercise Opportunities: 81%
Compared to 65% in SC



Physical Environment

Air Pollution (µg/m³)	Severe Housing Problems**	Driving to Work Alone	Broadband Access
6.9	**15%**	**82%**	**87%**
SC: 8.0	*SC: 14%*	*SC: 82%*	*SC: 81%*

Source: County Health Rankings 2022 Report, Bureau of Labor Statistics
*Notes: *Ratio of household income at the 80th percentile to income at the 20th percentile*
***Overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities*

Williamsburg County Health Status Indicators

Health Behaviors

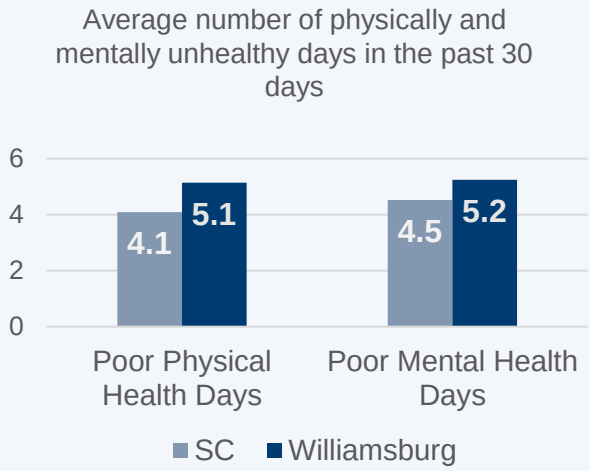
Teen Births per 1,000	Adult Smoking	Physical Inactivity	Adult Obesity	Driving Deaths Involving Alcohol	Excessive Drinking
30	**25%**	**36%**	**46%**	**38%**	**18%**
SC: 23	*SC: 18%*	*SC: 29%*	*SC: 36%*	*SC: 33%*	*SC: 22%*

Quality of Life

Suicide Rate: 7.0
Compared to 16.3 in SC
Per 100,000

Poor or Fair Health: 28%
Compared to 18 in SC

Low Birthweight: 13%
Compared to 10% in SC



Source: County Health Rankings 2022 Report, worldlifeexpectancy.com

Socioeconomic Factors

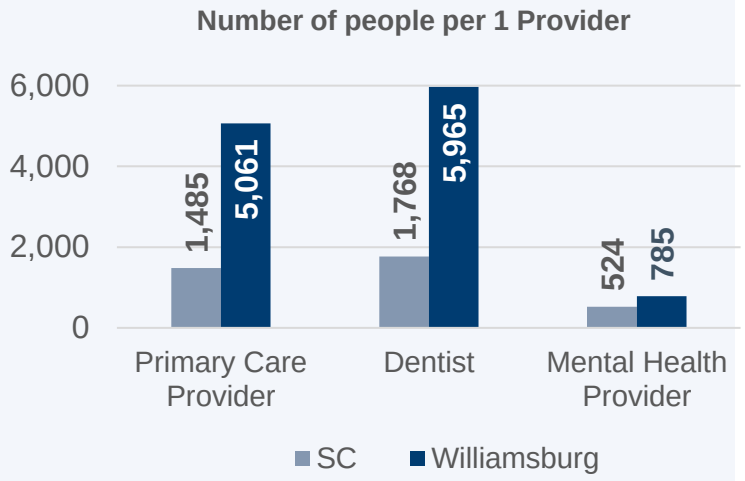
Income Inequality*	Unemployment	Children in Single Parent Households	Children in Poverty	Violent Crime *per 100,000*	Injury Deaths *per 100,000*
7.3	**6.1%**	**44%**	**35%**	**531**	**127**
SC: 4.8	*SC: 4.0%*	*SC: 31%*	*SC: 19%*	*SC: 500*	*SC: 94*

Access to Health

Uninsured: 10.0%
Compared to 10.4%

Preventable Hospital Stays: 4,988
Compared to 3,797 in SC
Per 100,000

Access to Exercise Opportunities: 37%
Compared to 65% in SC



Physical Environment

Air Pollution (µg/m³)	Severe Housing Problems**	Driving to Work Alone	Broadband Access
7.4	**17%**	**86%**	**60%**
SC: 8.0	*SC: 14%*	*SC: 82%*	*SC: 81%*

Source: County Health Rankings 2022 Report, Bureau of Labor Statistics
*Notes: *Ratio of household income at the 80th percentile to income at the 20th percentile*
***Overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities*

Methods of Identifying Health Needs

Collect and Analyze

Analyze existing data and collect new data

737 indicators collected from data sources

2,129 surveys completed by community members

50 local stakeholders participated in Data Walks

Evaluate

Evaluate indicators based on the following factors:

- Worse than benchmark
- Identified by the community
- Impact on health disparities
- Feasibility of being addressed

Select

Select priority health needs for implementation plan

Community Survey Data

When identifying the health needs of a community, health factors, community factors, and personal factors should all be evaluated, as they all impact the overall health and health outcomes of a community.

Health factors include chronic diseases, health conditions, and the physical health of the population. Community factors are the external social determinants that influence community health, while personal factors are the individual decisions that affect health outcomes.

In our community survey, each broad factor was broken out with components of each, and respondents rated the importance of addressing each component in the community on a scale of 1 to 5. Results of the health priorities rankings are outlined below:

Survey Question: Please rate the importance of addressing each health factor on a scale of 1 (Not at all) to 5 (Extremely).

Answer Choices	Weighted Average of Votes (out of 5)
Cancer	**4.54**
Heart Disease	**4.51**
Mental Health	**4.45**
Diabetes	**4.43**
Children's Health	**4.41**
Women's Health	**4.41**
Stroke	**4.38**
Obesity	**4.31**
Alzheimer's and Dementia	**4.28**
Lung Disease	**4.28**
Kidney Disease	**4.27**
Liver Disease	**4.16**
Dental	**4.08**
Other (please specify)	See appendix

Survey Question: Please rate the importance of addressing each community factor on a scale of 1 (Not at all) to 5 (Extremely).

Answer Choices	Weighted Average of Votes (out of 5)
Access to Childcare	**4.13**
Access to Exercise/Recreation	**4.05**
Access to Healthy Food	**4.27**
Access to Senior Services	**4.29**
Affordable Housing	**4.24**
Community Safety	**4.37**
Education System	**4.38**
Employment and Income	**4.30**
Health Care Services: Affordability	**4.60**
Health Care Services: Nearby Location	**4.46**
Health Care Services: Prevention	**4.39**
Safe Housing	**4.27**
Social Connections	**3.86**
Social Support	**3.93**
Transportation	**4.14**
Other (please specify)	See appendix

Survey Question: Please rate the importance of addressing each individual factor on a scale of 1 (Not at all) to 5 (Extremely).

Answer Choices	Weighted Average of Votes (out of 5)
Diet	**4.26**
Drug/Substance Abuse	**4.21**
Employment	**4.11**
Excess Drinking	**3.97**
Livable Wage	**4.28**
Physical Inactivity	**4.11**
Risky Sexual Behavior	**3.81**
Smoking/Vaping/Tobacco Use	**3.95**
Other (please specify)	See appendix

Overall health priority ranking

Answer Choices	Weighted Average of Votes (out of 5)
Health Care Services: Affordability	**4.60**
Cancer	**4.54**
Heart Disease	**4.51**
Health Care Services: Nearby Location	**4.46**
Mental Health	**4.45**
Diabetes	**4.43**
Women's Health	**4.41**
Children's Health	**4.41**
Health Care Services: Prevention	**4.39**
Stroke	**4.38**
Education System	**4.38**
Community Safety	**4.37**
Obesity	**4.31**
Employment and Income	**4.30**
Access to Senior Services	**4.29**
Alzheimer's and Dementia	**4.28**
Lung Disease	**4.28**
Livable Wage	**4.28**
Kidney Disease	**4.27**
Access to Healthy Food	**4.27**
Safe Housing	**4.27**
Diet	**4.26**
Affordable Housing	**4.24**
Drug/Substance Abuse	**4.21**
Liver Disease	**4.16**
Transportation	**4.14**
Access to Childcare	**4.13**
Employment	**4.11**
Physical Inactivity	**4.11**
Dental	**4.08**
Access to Exercise/Recreation	**4.05**
Excess Drinking	**3.97**
Smoking/Vaping/Tobacco Use	**3.95**
Social Support	**3.93**
Social Connections	**3.86**
Risky Sexual Behavior	**3.81**

Evaluation Process

Worse than Benchmark Measure

Health needs were deemed “worse than the benchmark” if the supported county data was worse than the state and/or US averages

Identified by the Community

Health needs expressed in the online survey and/or mentioned frequently by community members

Feasibility of Being Addressed

Growing health needs where interventions by the hospital are feasible and could make an impact

Impact on Health Disparities

Health needs that disproportionately affect vulnerable populations and can impact health equity by being addressed

Tidelands Health - Health Need Evaluation

	Worse than Benchmark	Identified by the Community	Feasibility	Impact on Health Disparities
Health Care Services: Affordability	✓	✓	✓	✓
Cancer	✓	✓	✓	✓
Heart Disease	✓	✓	✓	✓
Health Care Services: Nearby Location	✓	✓	✓	✓
Mental Health	✓	✓	✓	✓
Diabetes	✓	✓	✓	✓
Women's Health		✓	✓	✓

Overview of Top Health Priorities

Health Care Services: Affordability

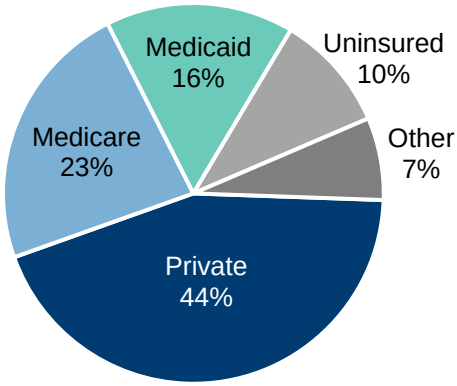
Affordability of health care services was the #1 survey identified health need in the community with 74.3% of respondents ranking it as extremely important to be addressed. Affordability was not identified as a top priority in 2019 but was identified as a top priority in both the 2016 and 2013 CHNA reports.

Williamsburg, Georgetown, and Horry Counties all fare worse than the state average when it comes to the unemployment rate, children in poverty, and median household income. Williamsburg and Georgetown Counties have similar uninsured rates as the state average whereas Horry County's uninsured rate is about 4% higher. Additionally, low-income populations were identified as the top priority population in the community, making affordability of health care services a pressing need.

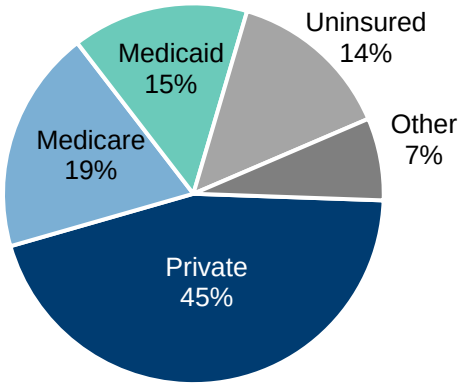
	Georgetown County	Horry County	Williamsburg County	South Carolina
Uninsured	10.2%	14.1%	10.0%	10.4%
Unemployment	4.8%	5.1%	6.1%	4.0%
Children in poverty	31%	20%	35%	19%
Median household income	$52,994	$53,694	$34,309	$55,711
Delayed seeing a doctor in past year due to cost	15.4%	18.9%	14.9%	15.6%

Source: County Health Rankings 2020, Bureau of Labor Statistics 2021, Stratasan, ESRI 2021, South Carolina DHEC 2016-2018

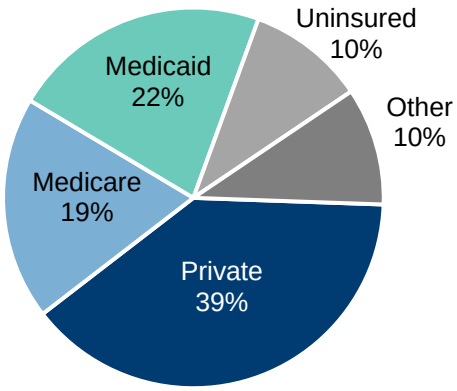
Georgetown County
Insurance Coverage



Horry County
Insurance Coverage



Williamsburg County
Insurance Coverage



Source: Stratasan, ESRI 2021

Cancer

Cancer was identified as the #2 health priority in the community survey with 72.3% of respondents rating it as extremely important to be addressed in the community. Cancer was identified as a top health priority in the 2019 CHNA report.

Cancer is the second leading cause of death in all three service area counties. Additionally, priority populations such as racial and ethnic minority groups, women, low-income communities, and residents of rural communities suffer more from cancer and its effects (NIH).

	Georgetown County	Horry County	Williamsburg County	South Carolina
Cancer incidence – all sites (*per 100,000*)	468	433	471	450
Cancer mortality – all sites (*per 100,000*)	159	171	192	165

Note: Rate based on a 5-year average from 2014-2018
Source: South Carolina DHEC

Cancer Incidence by Four Most Common Cancers

	Georgetown County	Horry County	Williamsburg County
Breast	138	116	131
Prostate	116	95	186
Lung	59	67	68
Colon	38	37	58

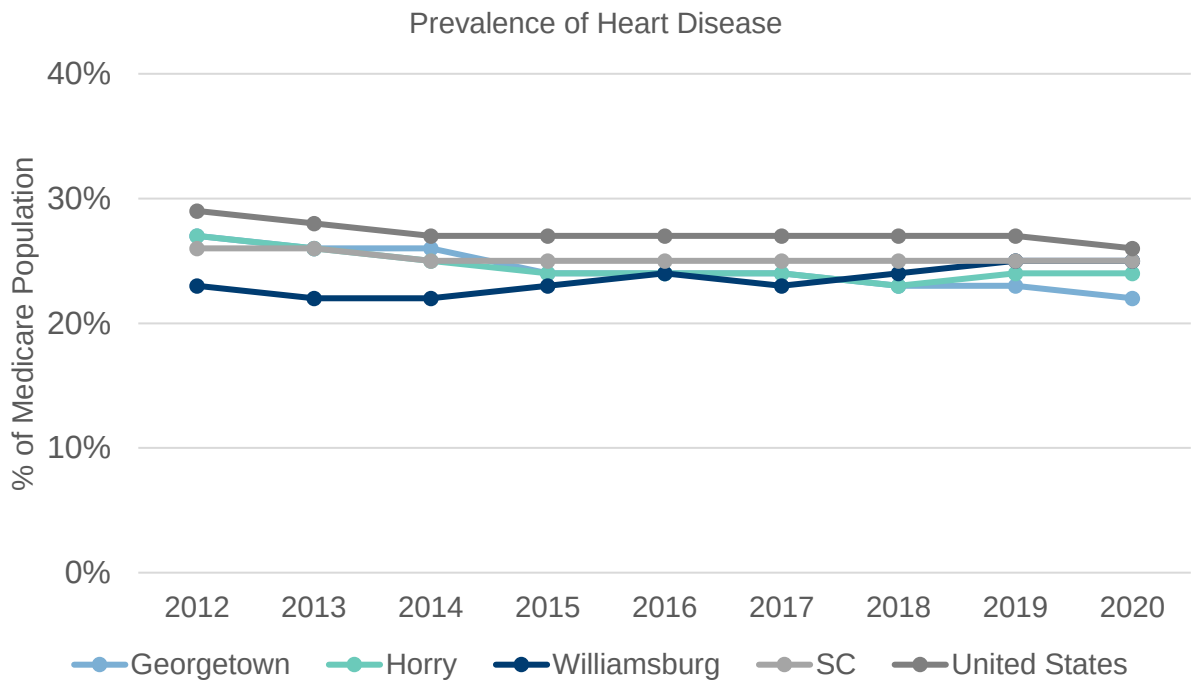
Note: Rate is per 100,000 and based on a 5-year average from 2014-2018
Source: South Carolina DHEC

Heart Disease

In the community survey, heart disease was identified as the #3 health priority with 68.8% of respondents rating it as extremely important to address. Heart disease is the leading cause of death in all three service area counties. When it comes to health disparities, racial and ethnic minority groups are more likely to die of heart disease than their white counterparts (CDC).

	Georgetown County	Horry County	Williamsburg County	South Carolina
Heart Disease Death Rate (*per 100,000*)	169.3	171.5	166.9	167.6
Hospitalization Rate (*per 1,000*)	54.4	50.8	46.5	44.3

Note: Hospitalization rate based on Medicare beneficiaries
Source: CDC 2017-2019



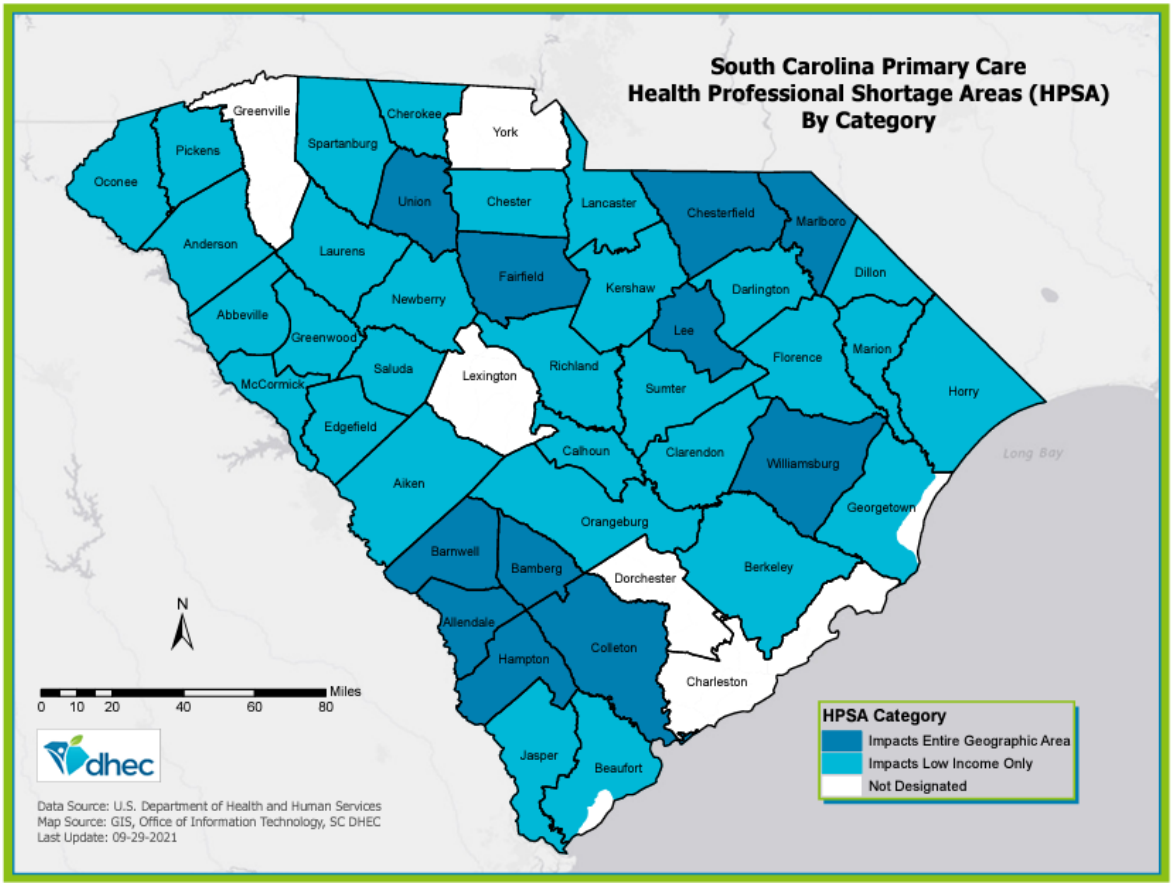
Source: Centers for Medicare & Medicaid Services: Mapping Medicare Disparities by Population

Health Care Services: Nearby Location

Nearby location for health care services was identified as the #4 health priority with 65.2% of survey respondents rating it as extremely important to address. Williamsburg, Georgetown, and Horry County all have larger ratios of population per primary care provider and per dentist compared to the state of South Carolina.

	Georgetown County	Horry County	Williamsburg County	South Carolina
Primary care physician ratio	1,556:1	1,678:1	5,061:1	1,485:1
Dentist ratio	1,791:1	2,420:1	5,965:1	1,768:1

Source: County Health Rankings 2019, 2020



Source: South Carolina DHEC 2021

Behavioral Health

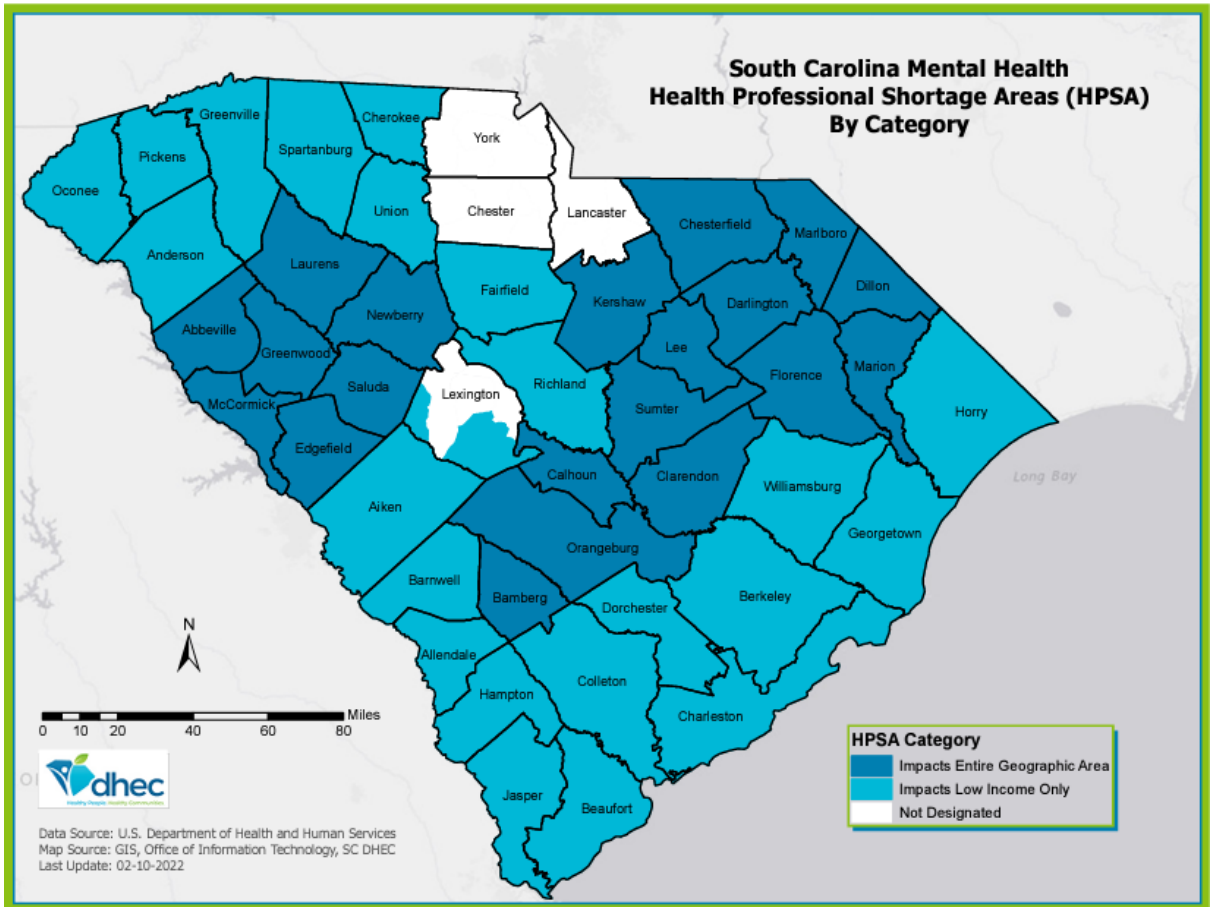
Mental health was the #5 community-identified health priority with 68% of survey respondents ranking it as extremely important to be addressed in the community. For cohesion among Tidelands Health terminology, mental health is referred to as behavioral health for the implementation plan portion of this report. Suicide is the 15th leading cause of death in Williamsburg County, 14th leading cause of death in Georgetown County, and 11th leading cause of death in Horry County. Mental health was identified as a top health priority in the 2019 and 2016 CHNA reports.

Additionally, lack of access to mental health services perpetuates disparities in priority populations like racial and ethnic minority groups, residents of rural areas, and LGBTQ+ communities because of a lack of providers and an inclusive behavioral health workforce (NAMI).

While it's difficult to measure the true rate of mental illness in the community, the following data points give insight into the health priority:

	Georgetown County	Horry County	Williamsburg County	South Carolina
Mental health provider ratio	1,060:1	640:1	780:1	520:1
Average number of mentally unhealthy days (past 30 days)	4.8	4.8	5.2	4.5
Suicide death rate (*per 100,000*)	10.6	14.9	7.0	16.3
Depression diagnosis	19.1%	21.1%	18.9%	--

Source: County Health Rankings 2019, 2021, worldlifeexpectancy.com 2020, CDC 2019



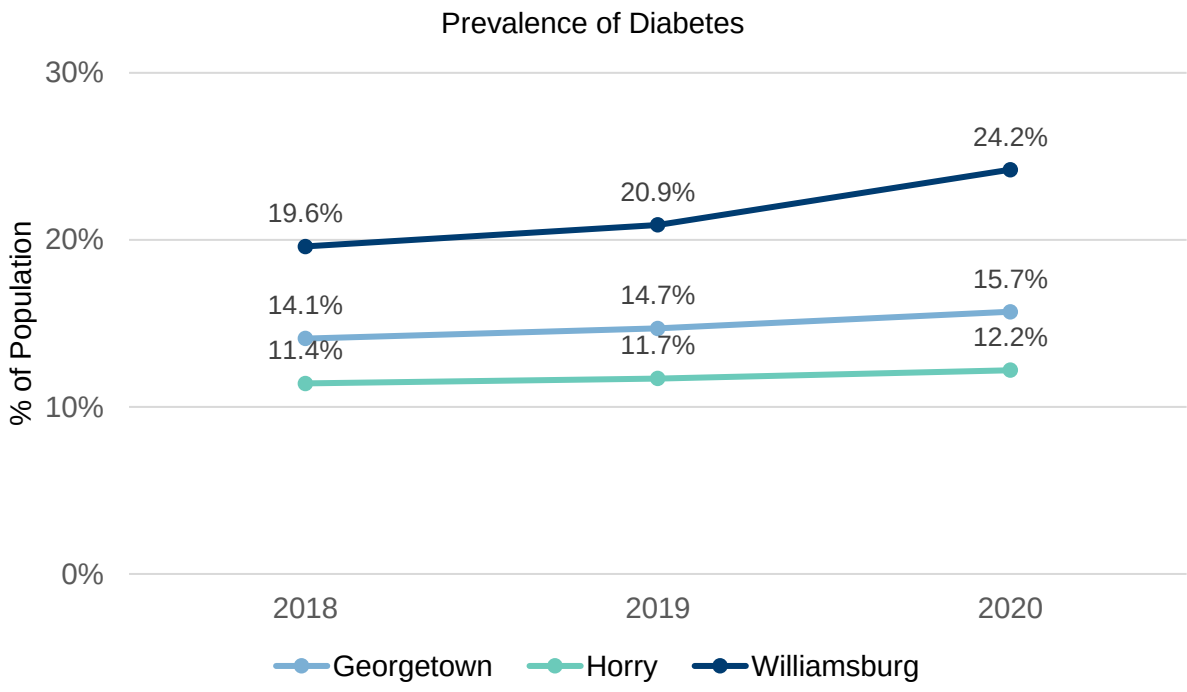
Source: South Carolina DHEC 2022

Diabetes

Diabetes was identified as the #6 health priority in the community survey with 63% of respondents rating it as extremely important to address. Diabetes is the 6th leading cause of death in Williamsburg County and the 8th leading cause of death in both Georgetown and Horry Counties. The prevalence of diabetes has been increasing in all 3 counties in recent years. Diabetes was identified as a top health priority in the 2019, 2016, and 2013 CHNA reports.

	Georgetown County	Horry County	Williamsburg County	South Carolina
Adult Obesity	37%	32%	46%	36%
Physical Inactivity	28%	29%	36%	29%
Access to Exercise Opportunities	69%	81%	37%	65%
Diabetes Mortality (*per 100,000*)	19.7	16.5	49.2	28.5

Source: County Health Rankings 2019, 2021, worldlifeexpectancy.com 2020



Source: County Health Rankings

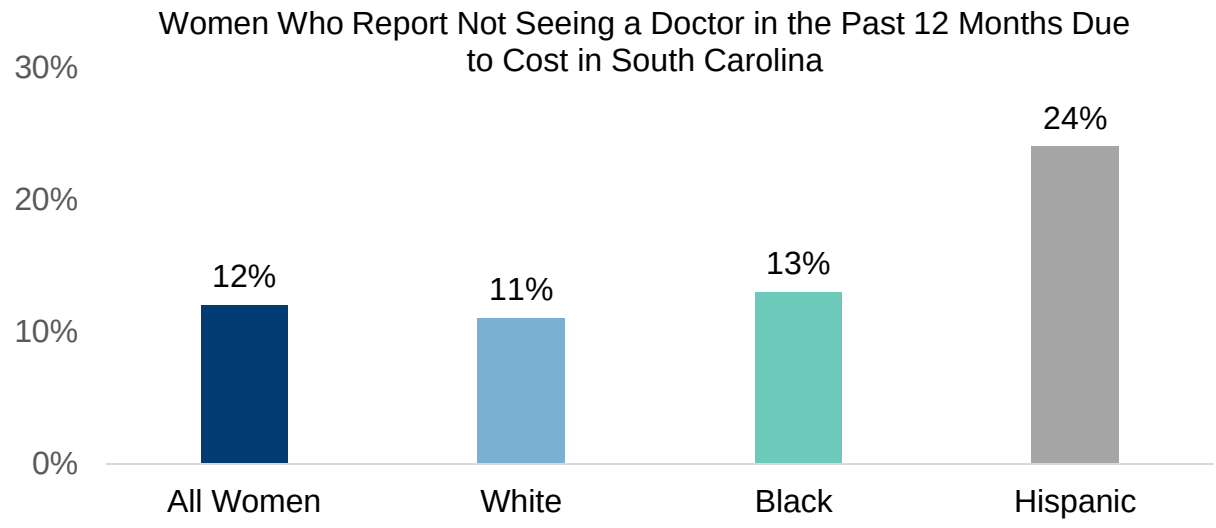
Women's Health

Women's health was identified as the #7 priority with 62.4% of survey respondents identifying it as being extremely important to address in the community. Women's health was not identified as a top health priority in any of the previous CHNA reports.

All three service area counties have similar mammogram screening rates and cervical cancer screening rates as the national average. Additionally, in South Carolina, there are disparities between Race/Ethnicity in the affordability of health care among women (KFF).

	Georgetown County	Horry County	Williamsburg County	U.S.
Mammogram screening rate	72.1%	73.2%	78.1%	74.8%
Cervical cancer screening rate	84.7%	84.2%	83.6%	84.%
Receive adequate prenatal care	75.0%	75.0%	70.9%	--

Source: CDC 2018, South Carolina DHEC 2016-2018
Note: mammograph rate based on women aged 50-74, cervical screening rate based on women aged 21-65



Source: KFF: State Health Facts 2020

Health Priority Selection

Around 50 local health care professionals, community partners, and other local stakeholders participated in Data Walks to further prioritize the 7 health needs identified in the community survey. In these Data Walks, the local experts evaluated the secondary data and identified hospital resources for each of the health priorities. The top 3 health priorities for 2022 identified from these sessions are:

- **Access to Health Care**
- **Behavioral Health**
- **Diabetes**

Tidelands Health recognizes the importance of the remaining 4 health priorities identified in the community survey, however, feels that the Hospital and other community organizations currently have strong programs and resources to address these needs. Tidelands Health believes that it can have a greater impact by putting attention and resources toward the 3 selected top health priorities through future programming and partnerships.

The key feedback taken from the Data Walks is as follows:

Access to Health Care

- **Bright Spots:**
  - Telehealth
  - Mobile units
  - Free clinics
- **Opportunities:**
  - Cost high despite insurance
  - Industry Screenings
  - Partner with faith-based organizations
  - Access to services and funding
  - Transportation
  - Broaden network of hospitals
  - Partner with blood drives
  - Pop Up clinics w/ nutritionist services

Behavioral Health

- **Bright Spots:**
  - Community-based programs
  - Youth workshops
  - Telehealth
  - Awareness
  - Gun safety program
- **Opportunities:**
  - System and support for adolescents
  - Transportation
  - Prevention programs
  - Increase the number of providers
  - Access to community counseling support
  - Counselors and social workers in schools
  - Drug treatment programs

Diabetes

- **Bright Spots:**
  - Health fairs
  - Free clinics
  - Telehealth
- **Opportunities:**
  - Focus on educating racial and ethnic minority groups
  - Leverage relationships with faith-based organizations
  - Telehealth accessibility
  - Mobile food pantries
  - Increase patient navigators
  - Increase focus on rural areas
  - Educate patients with high-risk factors
  - Cost of insulin

Implementation Plan Strategy

Access to Health Care

Hospital services, programs, and resources available to respond to this need include:

- Livewell Georgetown County Coalition.
- Behavioral Health Collaborative.
- Tidelands Health Financial Assistance.
    - Self-pay patients are screened for eligibility for the financial assistance program and TCCN.
- Tidelands Community Care Network – or TCCN.
- Tidelands Clinical Navigation.
- Tidelands Community Palliative Care.
- Tidelands Community Wellness Programming.
- Healthy Outcomes Plan – or HOP.
- Telehealth/Televisits offered system-wide.
- Transportation program for eligible patients who are up to 200% of the federal poverty line.
- Discounted prescription program.
- Pop-up clinics opened for COVID-19 testing and vaccinations.
- Tidelands Health participates in multiple community programs/events.
- Tidelands Works.

Additionally, the Hospital plans to take the following steps to address this need:

- Increase awareness of telehealth service offerings.
- Work with local churches to provide screening opportunities.
    - Leverage opportunities with current Tidelands Health employees who are members of local churches.
- Improve awareness of financial assistance programs.
    - Increase community awareness of on financial assistance programs and eligibility.
- Implement mobile unit.
- Evaluate additional opportunities for transportation.
    - Group services/rideshare.
- Complete analysis of cancellations/no-show appointments.
- Make improvements in call center/communication with patients.

Identified goals and metrics to track progress:

All metrics will be evaluated for potential disparities through REGI.

- Increase the number of patients in charity programming that are also enrolled in TCCN programming each year.
- Decrease no-show rates in primary care each year.
- Maintain readmission rate.

Partnership Organizations:

See appendix.

Behavioral Health

Hospital services, programs, and resources available to respond to this need include:

- Telehealth access to mental health services.
- Depression screening tools in the pediatric clinic.
- Triple P – in-school education on mental health.
- Referrals to additional behavioral health services and programs.
- Postpartum depression screenings.

Impact of actions taken since the immediately preceding CHNA:

- The employee wellness office now provides mental health first aid training.
- Increased community initiatives through coalitions and discussions.
- Medication-assisted treatment – or MAT, SBIRT – programs in emergency departments – or ED.
- Providers are now available to prescribe suboxone.
- MAT and SBIRT dashboard started in the ED.

Additionally, the Hospital plans to take the following steps to address this need:

- Adapt a behavioral health integration model in primary care with the goal of also integrating with specialty care.
- Standardize depression screenings across clinics.
- Improve referral pathways to treatment programs.
- Increase focus on funding for behavioral health services.
- Work with community partners to address the social determinants of health that influence negative mental health outcomes.

Identified goals and metrics to track progress:

All metrics will be evaluated for potential disparities through REGI.

- Increase the number of brief interventions in the ED through SBIRT/MAT program.
- Increase the number of patients linked to behavioral health treatment.

Partnership Organizations:

See appendix.

Diabetes

Hospital services, programs, and resources available to respond to this need include:

- Diabetes Prevention Program – or DPP.
- Livewell Georgetown County collaborative.
  - Healthy recipes provided in food boxes.
  - Educational classes.
- Food Pantry.
- Smith Medical DME is required during primary care visits.
- Community education.
- Tidelands Health Personal Health Navigation.
- Tidelands Clinical Navigation.

Impact of actions taken since the immediately preceding CHNA:

- Tidelands Health conducts screening at an array of community events.
- Increased programming through Livewell Georgetown County.
- Increased outreach and education in the community.
- Implemented walking prescriptions with Brookgreen Gardens to promote exercise and healthy habits.
- Received a grant to implement a food prescription program.

Additionally, the Hospital plans to take the following steps to address this need:

- Implement a food prescription program to improve the health outcomes of patients with diet-related health risks or conditions.
- Provide healthy recipes for diabetic patients.
- Improve resources to catch patients before they are diagnosed with diabetes.
- Expand education and awareness of DPP to increase enrollment in the program.
- Connect community programs, food pantries, and diabetic patients to create sustainable resources for patients.
- Implement mobile unit for educational opportunities.
- Work with local recreational centers and park districts on programs to increase activity.
- Create employee champions for community wellness to help educate all employees on what services Tidelands Health has to offer.
- Track trends in A1C among patients to monitor local rates.
- Increase education around smoking and how it relates to Diabetes.

Identified goals and metrics to track progress:

All metrics will be evaluated for potential disparities through REGI.

- Increase the number of diabetic and pre-diabetic referrals to the DPP program.
- Increase the number of the diabetic and pre-diabetic adult population of Tideland's Health Group with A1Cs taken in the past year.

Partnership Organizations:

See appendix.

Appendix

The appendix can be found here:
https://www.tidelandshealth.org/discover/community-health-needs-assessment/