Tidelands Health

Georgetown, South Carolina
Murrells Inlet, South Carolina

Community Health Needs Assessment
and Implementation Strategy

Adopted by Board Resolution August 18, 2016[1]

[1]Response to Schedule h (Form 990) Part V B 4 & Schedule h (Form 990) Part V B 9

Dear Community Member:

At Tidelands Health, we have spent 66 years providing high-quality, compassionate healthcare to the people of Georgetown and Horry counties. Tidelands Health consists of three hospitals: Tidelands Georgetown Memorial Hospital, Tidelands Waccamaw Community Hospital, and Tidelands Waccamaw Rehabilitation Hospital, as well as more than 40 outpatient locations that stretch from North Myrtle Beach to Hemingway. The "2016 Community Health Needs Assessment" identifies local health and medical needs and provides a plan of how Tidelands Health will respond to such needs. This document suggests areas where other local organizations and agencies might work with us to achieve desired improvements and illustrates one way we, Tidelands Health, are meeting our obligations to efficiently deliver medical services.

In compliance with the Affordable Care Act, all not-for-profit hospitals are now required to develop a report on the medical and health needs of the communities they serve. We welcome you to review this document not just as part of our compliance with federal law, but also as part of our continuing efforts to meet your health and medical needs.

Tidelands Health will conduct this effort at least once every three years. The report produced three years ago is also available for your review and comment. As you review this plan, please see if, in your opinion, we have identified the primary needs of the community and if you think our intended response will lead to needed improvements.

We do not have adequate resources to solve all the problems identified. Some issues are beyond the mission of the health system, and action is best suited for a response by others. Some improvements will require personal actions by individuals rather than the response of an organization. We view this as a plan for how we, along with other area organizations and agencies, can collaborate to bring the best each has to offer to support change and to address the most pressing identified needs.

The report is a response to a federal requirement of not-for-profit hospitals to identify the community benefit they provide in responding to documented community need. Footnotes are provided to answer specific tax form questions; for most purposes, they may be ignored. Most importantly, this report is intended to guide our actions and the efforts of others to make needed health and medical improvements in our area.

I invite your response to this report. As you read, please think about how to help us improve health and medical services in our area. We all live in, work in and enjoy this wonderful community together. Together, we can make our community healthier for every one of us.

Thank you,

Bruce Bailey
President and CEO
Tidelands Health

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Executive Summary

Tidelands Health has performed a community health needs assessment to determine the health needs of the local community, develop an implementation plan to outline and organize how to meet those needs, and to fulfill federal requirements.

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 experts was performed to review the prior CHNA and provide feedback and to ascertain whether the previously identified needs are still 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 are:

1. Affordability/Accessibility
2. Mental Health/Substance Abuse
3. Obesity
4. Diabetes
5. Physical Inactivity

Tidelands Health has developed implementation strategies for all five of the needs including activities to continue/pursue, community partners to work alongside and leading and lagging indicators to track.

APPROACH

APPROACH

Tidelands Health is organized as a not-for-profit health system that includes Tidelands Georgetown Memorial Hospital, Tidelands Waccamaw Community Hospital, and Tidelands Waccamaw Rehabilitation Hospital. A community health needs assessment – or CHNA -- is part of the required hospital documentation of "Community Benefit" under the Affordable Care Act, required of all not-for-profit hospitals as a condition of retaining tax-exempt status. A CHNA assures Tidelands Health identifies and responds 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 990 h filings made by the health system.

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, the Internal Revenue Service and the U.S. Department of the Treasury.[3]

Project Objectives

Tidelands Health partnered with Quorum Health Resources to:[4]

- Complete a CHNA report, compliant with Treasury – IRS
- Provide Tidelands Health with information required to complete the IRS – 990h schedule
- Produce the information necessary for Tidelands Health 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 to the less fortunate who did not have means to pay. With the introduction of Medicare, the government met the burden of providing compensation for such care.

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:

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[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

- An emergency department 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 is required to conduct a CHNA at least once every three taxable years and to adopt an implementation strategy to meet the community needs identified through such 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 take into account 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 hospital facility must take into account input received from, at a minimum, the following three sources:*

[5] Section 6652

(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 used to conduct the CHNA if the CHNA report describes the data and other information used in the

[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

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, a CHNA developed subsequent to the initial assessment must consider written commentary received regarding the prior assessment and implementation strategy efforts. We followed 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]

Tidelands Health and Quorum take a comprehensive approach to the solicitation of written comments. As previously cited, we obtained input from the required three minimum sources and expanded input to include other representative groups. We asked all participating in the written comment solicitation process to self-identify themselves 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 health system

(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 health system. 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

Other (please specify)

Tidelands Health and Quorum also take a comprehensive approach to assess community health needs. We perform several independent data analyses based on secondary source data, augment this with local expert adviser[9] opinions, and resolve any data inconsistency or discrepancies by reviewing the combined opinions formed from local experts. We rely on secondary source data, and most secondary sources use the county as the smallest unit of analysis. We asked our

[7] Federal Register Op. cit. P 78966 As previously noted, the health system collaborated and obtained assistance in conducting this CHNA from Quorum Health Resources (QHR). & 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 health system solicited to participate in the CHNA process. Response to Schedule h (Form 990) V B 3 h

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

Most data used in the analysis is available from public Internet sources and Quorum proprietary data from Truven. Any critical data needed to address specific regulations or developed by the local expert adviser individuals cooperating with us 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 Georgetown County and Horry County compared to all state counties	April 26, 2016	2010 to 2012
www.cdc.gov/communityhealth	Assessment of health needs of Georgetown County and Horry County compared to their national set of "peer counties"	April 26, 2016	2005 to 2011
Truven (formerly known as Thompson) Market Planner	Assess characteristics of Tidelands Health's primary service area, at a zip code level, based on classifying the population into various socioeconomic 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	April 26, 2016	2012 to 2015
www.capc.org and www.getpalliativecare.org	To identify the availability of palliative care programs and services in the area	April 26, 2016	2015
www.caringinfo.org and iweb.nhpco.org	To identify the availability of hospice programs in Georgetown and Horry counties	April 26, 2016	2015
www.healthmetricsandevaluation.org	To examine the prevalence of diabetic	April 26, 2016	2000 to 2010

[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

	conditions and change in life expectancy		
www.cdc.gov	To examine area trends for heart disease and stroke	April 26, 2016	2008 to 2010
http://svi.cdc.gov	To identify the Social Vulnerability Index value	April 26, 2016	2010
www.worldlifeexpectancy.com/usa-health-rankings	To determine relative importance among 15 top causes of death	April 26, 2016	2015

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

- We deployed a CHNA "Round 1" survey to our local expert advisers to gain input on local health needs and the needs of priority populations. Local expert advisers were local individuals selected according to criteria required by the federal guidelines and regulations and the health system's desire to represent the region's geographically and ethnically diverse population. We received community input from 30 local expert advisers. Survey responses started March 3, 2016, and ended with the last response on April 1, 2016.
- Information analysis augmented by local opinions showed how Georgetown and Horry counties relate to their 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 comments
  - Low-income groups are experiencing barriers to ***healthcare access***
  - Many ***older adults*** are socially isolated and do not have access to transportation
  - Nutritional education is needed to address the issues of ***obesity*** and ***diabetes*** in the community

When the analysis was complete, we put the information and summary conclusions before our local expert advisers,[13] who were asked to agree or disagree with the summary conclusions. They were free to augment potential conclusions with additional comments of need, and new needs did emerge from this exchange.[14] Consultation with 30 local experts occurred again via an Internet-based survey (explained below) beginning May 2, 2016, and ending June 20, 2016.

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,

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[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

regardless of their professional credentials.[15]

In the Tidelands Health 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, the vast majority of comments agreed with our findings. We developed a summary of all needs identified by any of the analyzed data sets. The local experts then allocated 100 points among the potential significant need candidates, including the opportunity to again present additional needs that were not identified from the data. A rank order of priorities emerged, with some needs receiving none or virtually no support and other needs receiving identical point allocations.

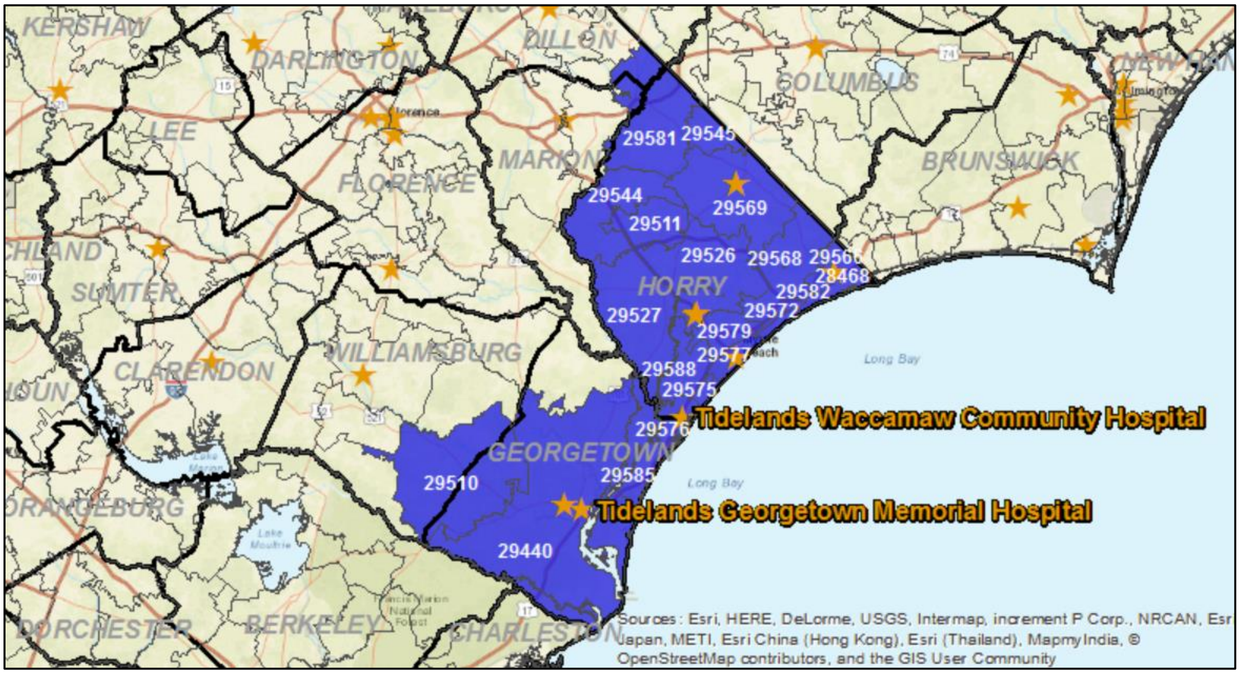
We dichotomized the rank order of prioritized needs into two groups: “significant” and “other identified needs.” Our criteria for identifying and prioritizing significant needs was based on a descending frequency rank order of the needs based on total points cast by the local experts, further ranked by a descending frequency count of the number of local experts casting any points for the need. By our definition, a significant need had to include all rank-ordered needs until at least 50 percent of all points were included and, to the extent possible, represented points allocated by a majority of voting local experts. The determination of the break point — “significant” as opposed to “other” — was a qualitative interpretation by Quorum and the Tidelands Health executive team where a reasonable break point in rank order occurred.[16]

The Tidelands Health Advisory Council was established in 2016 in response to the identified need of TCCN partner agencies to have a group of community leaders informing the strategic decision of the agencies. The council is composed of neighborhood leaders and those representing specific interest groups of people. This is a group of long-term local residents that includes pastors, a director of a HUD housing location, and respected community leaders. On June 9, 2016, the group met specifically to inform the CHNA, and discussed questions sent by Quorum. Eight people were in attendance.

[15] Response to Schedule h (Form 990) Part V B 5
[16] Response to Schedule h (Form 990) Part V B 3 g

COMMUNITY CHARACTERISTICS

Definition of Area Served by Tidelands Health[17]



Georgetown County includes the following ZIP codes:

29440 – Georgetown   29510 – Andrews   29585 – Pawleys Island

In 2014, **Tidelands Georgetown Memorial Hospital** received 77.6% of its patients from Georgetown County. **Tidelands Waccamaw Community Hospital received** 20.6% of its patients from Georgetown County. [18]

Horry County includes the following ZIP codes:

29511 – Aynor	29526 – Conway	29527 – Conway	29544 – Galivants Ferry
29545 – Green Sea	29566 – Little Rivers	29568 – Longs	29569 – Loris
29572 – Myrtle Beach	29575 – Myrtle Beach	29576 – Murrells Inlet*	29577 – Myrtle Beach
29579 – Myrtle Beach	29581 – Nichols	29582 – North Myrtle Beach	29585 – Pawleys Island
29588 – Myrtle Beach			

In 2014, **Tidelands Waccamaw Community Hospital** received 68.6% of its patients from Horry County. **Tidelands Georgetown Memorial Hospital** received 5.9% of its patients from Horry County.

**While the Murrells Inlet zip code falls in both counties, the majority of the population of Murrells Inlet falls on the Horry County side, so patients from this zip code are counted in Horry County.*

[17] Responds to IRS Schedule h (Form 990) Part V B 3 a
[18] Truven MEDPAR patient origin data for the hospital; Responds to IRS Schedule h (Form 990) Part V B 3 a

Demographics of the Community[19 20]

	Georgetown County	Horry County	State	U.S.
2016 Population[21]	**52,992**	**321,318**	**4,625,374**	**322,431,073**
% Increase/Decline	**1.9%**	**9.7%**	**5.4%**	**3.7%**
Estimated Population in 2021	**54,014**	**352,371**	**5,179,817**	**334,341,965**
% White, non-Hispanic	**59.2%**	**77.0%**	**63.6%**	**61.3%**
% Black, non-Hispanic	**35.7%**	**13.3%**	**27.0%**	**12.3%**
Median Age	**45.4**	**44.0**	**39.0**	**38.0**
Median Household Income	**$40,871**	**$42,933**	**$46,008**	**$55,072**
Unemployment Rate	**7.7%**	**6.7%**	**5.7%**	**5.0%**
% Population >65	**23.3%**	**21.1%**	**16.4%**	**15.1%**
% Women of Childbearing Age	**16.2%**	**17.6%**	**19.3%**	**19.6%**

Demographics Expert 2.7
2016 Demographic Snapshot
Area: Georgetown County
Level of Geography: ZIP Code

DEMOGRAPHIC CHARACTERISTICS

	Selected Area	USA
2010 Total Population	52,944	308,745,538
2016 Total Population	52,992	322,431,073
2021 Total Population	54,014	334,341,965
% Change 2016 - 2021	1.9%	3.7%
Average Household Income	$60,185	$77,135

	2016	2021	% Change
Total Male Population	25,200	25,724	2.1%
Total Female Population	27,792	28,290	1.8%
Females, Child Bearing Age (15-44)	8,582	8,814	2.7%

POPULATION DISTRIBUTION

	Age Distribution				
Age Group	2016	% of Total	2021	% of Total	USA 2016 % of Total
0-14	9,001	17.0%	8,618	16.0%	19.0%
15-17	2,021	3.8%	2,100	3.9%	4.0%
18-24	4,296	8.1%	4,588	8.5%	9.8%
25-34	5,257	9.9%	5,874	10.9%	13.3%
35-54	11,875	22.4%	11,034	20.4%	26.0%
55-64	8,189	15.5%	7,948	14.7%	12.8%
65+	12,353	23.3%	13,852	25.6%	15.1%
Total	52,992	100.0%	54,014	100.0%	100.0%

HOUSEHOLD INCOME DISTRIBUTION

	Income Distribution		
2016 Household Income	HH Count	% of Total	USA % of Total
<$15K	4,096	18.9%	12.3%
$15-25K	3,059	14.2%	10.4%
$25-50K	4,913	22.7%	23.4%
$50-75K	4,047	18.7%	17.6%
$75-100K	2,072	9.6%	12.0%
Over $100K	3,429	15.9%	24.3%
Total	21,616	100.0%	100.0%

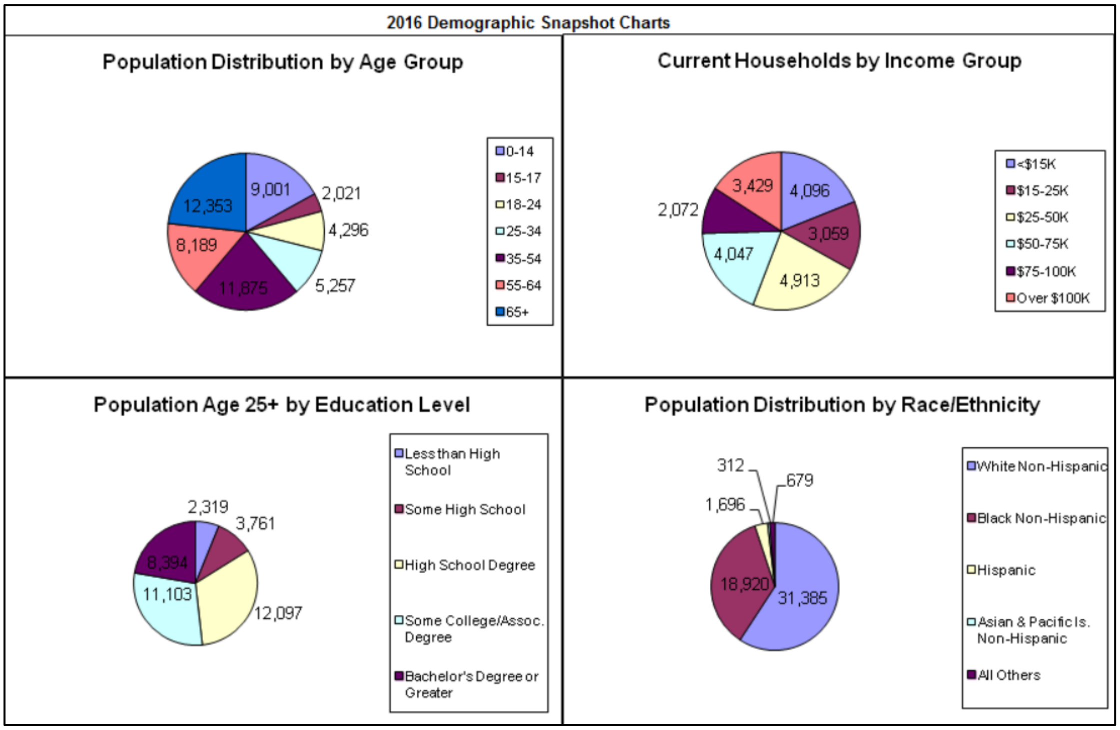
EDUCATION LEVEL

	Education Level Distribution		
2016 Adult Education Level	Pop Age 25+	% of Total	USA % of Total
Less than High School	2,319	6.2%	5.8%
Some High School	3,761	10.0%	7.8%
High School Degree	12,097	32.1%	27.9%
Some College/Assoc. Degree	11,103	29.5%	29.2%
Bachelor's Degree or Greater	8,394	22.3%	29.4%
Total	37,674	100.0%	100.0%

RACE/ETHNICITY

	Race/Ethnicity Distribution		
Race/Ethnicity	2016 Pop	% of Total	USA % of Total
White Non-Hispanic	31,385	59.2%	61.3%
Black Non-Hispanic	18,920	35.7%	12.3%
Hispanic	1,696	3.2%	17.8%
Asian & Pacific Is. Non-Hispanic	312	0.6%	5.4%
All Others	679	1.3%	3.1%
Total	52,992	100.0%	100.0%

[19] Responds to IRS Schedule h (Form 990) Part V B 3 b
[20] The tables below were created by Truven Market Planner, a national marketing company
[21] All population information, unless otherwise cited, sourced from Truven (formally Thomson) Market Planner



2016 Benchmarks
Area: Georgetown County
Level of Geography: ZIP Code

Area	2016-2021 % Population Change	Median Age	Population 65+ % of Total Population	Population 65+ % Change 2016-2021	Females 15-44 % of Total Population	Females 15-44 % Change 2016-2021	Median Household Income	Median Household Wealth	Median Home Value
USA	3.7%	38.0	15.1%	17.6%	19.6%	1.5%	$55,072	$54,224	$192,364
South Carolina	5.4%	39.0	16.4%	19.7%	19.3%	3.3%	$46,008	$52,515	$148,936
Selected Area	1.9%	45.4	23.3%	12.1%	16.2%	2.7%	$40,871	$71,612	$175,794

Demographics Expert 2.7
DEMO0003.SQP

Demographics Expert 2.7
2016 Demographic Snapshot
Area: Horry County
Level of Geography: ZIP Code

DEMOGRAPHIC CHARACTERISTICS

	Selected Area	USA
2010 Total Population	278,922	308,745,538
2016 Total Population	321,318	322,431,073
2021 Total Population	352,371	334,341,965
% Change 2016 - 2021	9.7%	3.7%
Average Household Income	$56,893	$77,135

	2016	2021	% Change
Total Male Population	156,068	171,073	9.6%
Total Female Population	165,250	181,298	9.7%
Females, Child Bearing Age (15-44)	56,623	60,692	7.2%

POPULATION DISTRIBUTION

	Age Distribution				
Age Group	2016	% of Total	2021	% of Total	USA 2016 % of Total
0-14	51,692	16.1%	55,222	15.7%	19.0%
15-17	10,580	3.3%	12,148	3.4%	4.0%
18-24	25,708	8.0%	26,661	7.6%	9.8%
25-34	39,506	12.3%	41,978	11.9%	13.3%
35-54	78,639	24.5%	83,091	23.6%	26.0%
55-64	47,286	14.7%	49,795	14.1%	12.8%
65+	67,907	21.1%	83,476	23.7%	15.1%
Total	321,318	100.0%	352,371	100.0%	100.0%

HOUSEHOLD INCOME DISTRIBUTION

	Income Distribution		
2016 Household Income	HH Count	% of Total	USA % of Total
<$15K	19,424	14.4%	12.3%
$15-25K	17,922	13.3%	10.4%
$25-50K	40,069	29.8%	23.4%
$50-75K	26,626	19.8%	17.6%
$75-100K	13,032	9.7%	12.0%
Over $100K	17,436	13.0%	24.3%
Total	134,509	100.0%	100.0%

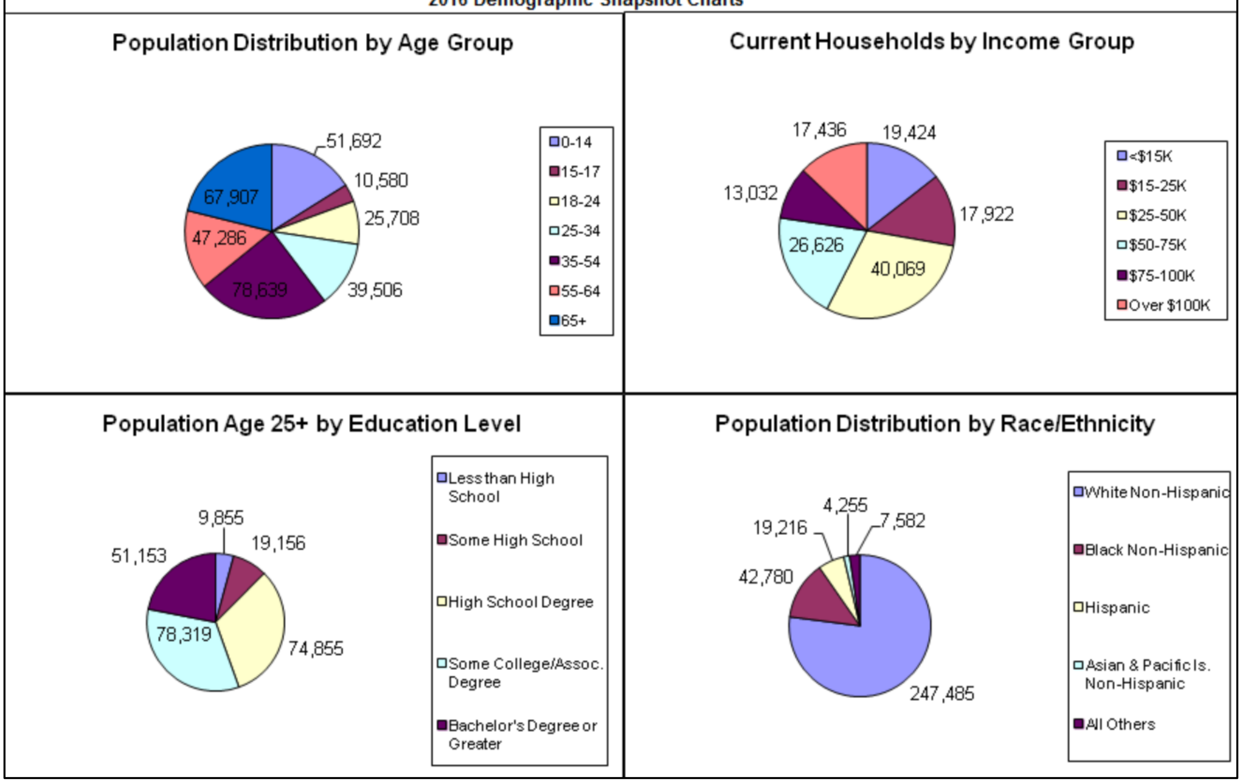
EDUCATION LEVEL

	Education Level Distribution		
2016 Adult Education Level	Pop Age 25+	% of Total	USA % of Total
Less than High School	9,855	4.2%	5.8%
Some High School	19,156	8.2%	7.8%
High School Degree	74,855	32.1%	27.9%
Some College/Assoc. Degree	78,319	33.6%	29.2%
Bachelor's Degree or Greater	51,153	21.9%	29.4%
Total	233,338	100.0%	100.0%

RACE/ETHNICITY

	Race/Ethnicity Distribution		
Race/Ethnicity	2016 Pop	% of Total	USA % of Total
White Non-Hispanic	247,485	77.0%	61.3%
Black Non-Hispanic	42,780	13.3%	12.3%
Hispanic	19,216	6.0%	17.8%
Asian & Pacific Is. Non-Hispanic	4,255	1.3%	5.4%
All Others	7,582	2.4%	3.1%
Total	321,318	100.0%	100.0%

2016 Demographic Snapshot Charts



2016 Benchmarks									
Area: Horry County									
Level of Geography: ZIP Code									
			Population 65+		Females 15-44				
Area	2016-2021 % Population Change	Median Age	% of Total Population	% Change 2016-2021	% of Total Population	% Change 2016-2021	Median Household Income	Median Household Wealth	Median Home Value
USA	3.7%	38.0	15.1%	17.6%	19.6%	1.5%	$55,072	$54,224	$192,364
South Carolina	5.4%	39.0	16.4%	19.7%	19.3%	3.3%	$46,008	$52,515	$148,936
Selected Area	9.7%	44.0	21.1%	22.9%	17.6%	7.2%	$42,933	$53,991	$164,191

Demographics Expert 2.7
DEMO0003.SQP

Customer Segmentation

The population was also examined according to characteristics presented in the Claritas Prizm customer segmentation data. This system segments the population into 66 demographically and behaviorally distinct groups. Each group, based on annual survey data, is documented as exhibiting specific health behaviors.

The makeup of the service area, according to the mix of Prizm segments and its characteristics, is contrasted to the national population averages to determine probable lifestyle and medical conditions present in the population. The national average, or norm, is represented as 100 percent. Where Georgetown County and Horry County vary more than 5 percent from the norm (that is, less than 95 percent or greater than 105 percent), it is considered significant.

Items in the table with red text are viewed as statistically important adverse potential findings—in other words, these are health areas that need improvement in the Georgetown County and Horry County areas. Items with blue text are viewed as statistically important potential beneficial findings—in other words, these are areas in which Georgetown County and Horry County are doing better than other parts of the country. Items with black text are viewed as either not statistically different from the national norm or neither a favorable nor unfavorable finding—in other words more or less on par with national trends.

Georgetown County

Health Service Topic	Demand as % of National	% of Population Affected
Weight / Lifestyle		
BMI: Morbid/Obese	100.7%	30.7%
Vigorous Exercise	95.0%	54.2%
Chronic Diabetes	125.6%	15.5%
Healthy Eating Habits	97.0%	28.8%
Ate Breakfast Yesterday	102.8%	75.0%
Slept Less Than 6 Hours	102.0%	15.1%
Consumed Alcohol in the Past 30 Days	83.8%	45.4%
Consumed 3+ Drinks Per Session	102.1%	28.4%
Behavior		
I Will Travel to Obtain Medical Care	95.4%	22.1%
I am Responsible for My Health	95.9%	62.6%
I Follow Treatment Recommendations	94.3%	48.9%
Pulmonary		
Chronic COPD	138.4%	5.5%
Tobacco Use: Cigarettes	108.5%	27.6%
Heart		
Chronic High Cholesterol	127.0%	27.8%
Routine Cholesterol Screening	94.4%	47.9%
Chronic Heart Failure	149.6%	6.2%

Health Service Topic	Demand as % of National	% of Population Affected
Cancer		
Mammography in Past Yr	104.1%	47.5%
Cancer Screen: Colorectal 2 yr	106.3%	27.1%
Cancer Screen: Pap/Cerv Test 2 yr	88.4%	53.0%
Routine Screen: Prostate 2 yr	106.0%	34.0%
Orthopedic		
Chronic Lower Back Pain	117.0%	27.5%
Chronic Osteoporosis	133.3%	13.1%
Routine Services		
FP/GP: 1+ Visit	103.5%	91.4%
Used Midlevel in last 6 Months	104.0%	43.1%
OB/Gyn 1+ Visit	81.2%	37.5%
Medication: Received Prescription	103.9%	60.5%
Internet Usage		
Use Internet to Talk to MD	67.1%	8.3%
Facebook Opinions	83.6%	8.6%
Looked for Provider Rating	85.3%	12.1%
Emergency Service		
Emergency Room Use	101.2%	34.3%
Urgent Care Use	88.6%	20.6%

Horry County

Health Service Topic	Demand as % of National	% of Population Affected	Health Service Topic	Demand as % of National	% of Population Affected
Weight / Lifestyle			**Cancer**		
BMI: Morbid/Obese	108.6%	33.0%	Mammography in Past Yr	97.5%	44.4%
Vigorous Exercise	94.4%	53.7%	Cancer Screen: Colorectal 2 yr	94.8%	24.2%
Chronic Diabetes	131.2%	16.2%	Cancer Screen: Pap/Cerv Test 2 yr	89.5%	53.7%
Healthy Eating Habits	93.6%	27.8%	Routine Screen: Prostate 2 yr	97.0%	31.1%
Ate Breakfast Yesterday	101.0%	71.3%	**Orthopedic**		
Slept Less Than 6 Hours	112.0%	16.8%	Chronic Lower Back Pain	123.3%	29.0%
Consumed Alcohol in the Past 30 Days	86.4%	46.9%	Chronic Osteoporosis	126.1%	12.4%
Consumed 3+ Drinks Per Session	106.7%	29.5%	**Routine Services**		
Behavior			FP/GP: 1+ Visit	102.5%	90.5%
I Will Travel to Obtain Medical Care	94.8%	22.0%	Used Midlevel in last 6 Months	103.4%	42.8%
I am Responsible for My Health	94.8%	61.9%	OB/Gyn 1+ Visit	87.3%	40.4%
I Follow Treatment Recommendations	92.9%	48.2%	Medication: Received Prescription	101.8%	58.5%
Pulmonary			**Internet Usage**		
Chronic COPD	130.8%	5.2%	Use Internet to Talk to MD	71.4%	8.8%
Tobacco Use: Cigarettes	113.8%	29.0%	Facebook Opinions	94.6%	9.7%
Heart			Looked for Provider Rating	85.3%	12.1%
Chronic High Cholesterol	119.6%	26.2%	**Emergency Service**		
Routine Cholesterol Screening	94.2%	47.8%	Emergency Room Use	104.4%	35.4%
Chronic Heart Failure	134.6%	5.7%	Urgent Care Use	98.0%	22.8%

Leading Causes of Death

Cause of Death			Rank among all counties in SC (#1 rank = worst in state)	Rate of Death per 100,000 age adjusted		Observation
Georgetown Rank	SC Rank	Condition		SC	Georgetown	
1	2	Heart Disease	38 of 46	181.1	198.1	Lower than expected
2	1	Cancer	36 of 46	171.4	185.7	As expected
3	5	Accidents	15 of 46	48.2	60.4	Higher than expected
4	4	Stroke	29 of 46	44.2	57.0	Higher than expected
5	3	Lung	37 of 46	48.2	40.8	As expected
6	6	Alzheimer's	25 of 46	37.4	28.4	Higher than expected
7	7	Diabetes	37 of 46	21.8	19.8	Lower than expected
8	8	Kidney	42 of 46	15.1	13.8	As expected
9	12	Blood Poisoning	33 of 46	14.4	13.4	Higher than expected
10	10	Liver	6 of 46	11.8	13.3	Higher than expected
11	13	Hypertension	10 of 46	8.6	13.0	Higher than expected
12	9	Flu - Pneumonia	43 of 46	13.9	12.5	Lower than expected
13	11	Suicide	41 of 46	15.2	9.1	As expected
14	15	Parkinson's	18 of 46	7.6	6.6	As expected
15	14	Homicide	35 of 46	7.6	6.6	Higher than expected

Cause of Death			Rank among all counties in SC (#1 rank = worst in state)	Rate of Death per 100,000 age adjusted		Observation
Horry Rank	SC Rank	Condition		SC	Horry	
1	2	Heart Disease	30 of 46	181.1	207.2	As expected
2	1	Cancer	34 of 46	171.4	186.7	As expected
3	4	Stroke	33 of 46	44.2	54.1	As expected
4	5	Accidents	28 of 46	48.2	53.0	As expected
5	3	Lung	18 of 46	48.2	49.2	As expected
6	6	Alzheimer's	12 of 46	37.4	33.5	Higher than expected
7	7	Diabetes	41 of 46	21.8	17.8	Lower than expected
8	8	Kidney	38 of 46	15.1	16.0	As expected
9	9	Flu - Pneumonia	39 of 46	13.9	15.0	Lower than expected
10	11	Suicide	8 of 46	15.2	14.5	Higher than expected
11	10	Liver	6 of 46	11.8	14.1	Higher than expected
12	12	Blood Poisoning	33 of 46	14.4	12.1	As expected
13	14	Homicide	31 of 46	7.6	7.4	Higher than expected
14	13	Hypertension	39 of 46	8.6	7.1	As expected
15	15	Parkinson's	21 of 46	7.6	6.0	As expected

Priority Populations[22]

Information about priority populations in the service area of Tidelands Health is difficult to encounter if it exists. Our approach is to understand the general trends of issues impacting priority populations and to interact with our 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.

We begin by analyzing the National Healthcare Quality and Disparities Reports, 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 our 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. The complete report is provided in Appendix D.

We asked a specific question to our local expert advisers about unique needs of priority populations. We reviewed their responses to identify if any of the above trends were obvious in the service area. Accordingly, we place great reliance on the commentary received from our local expert advisers to identify unique population needs to which we should respond. Specific opinions from the local expert advisers are summarized below:[23]

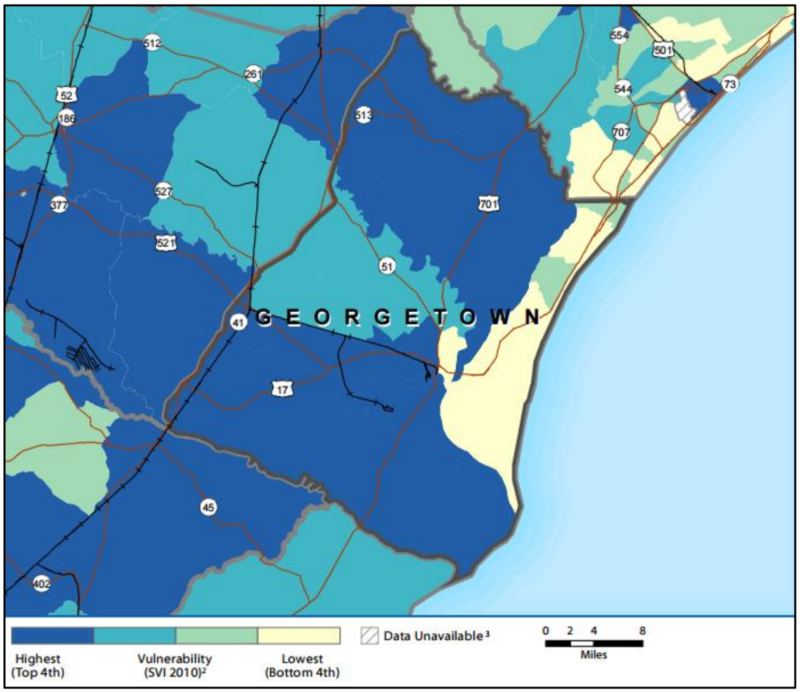
- Low-income groups are experiencing barriers to ***healthcare access***
- Many ***older adults*** are socially isolated and do not have access to transportation
- Nutritional education is needed to address the issues of ***obesity*** and ***diabetes*** in the community

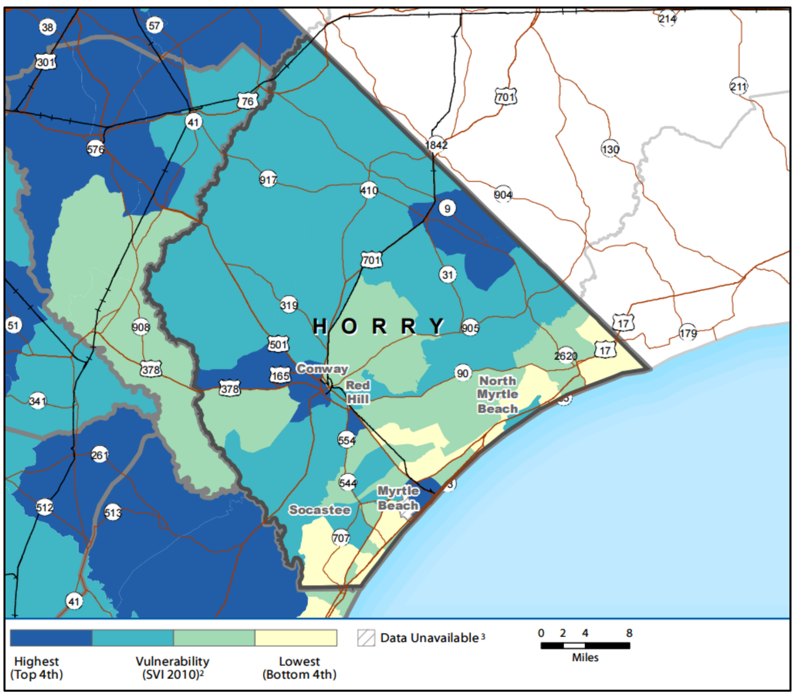
[22] http://www.ahrq.gov/research/findings/nhqrdr/nhqdr14/index.html Responds to IRS Schedule h (Form 990) Part V B 3 i
[23] All comments and the analytical framework behind developing this summary appear in Appendix A

Social Vulnerability

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

All four quartiles of social vulnerability are represented throughout Georgetown County and Horry County zip codes. However, the northwestern and southern portions of Georgetown County are noted as being in the highest quartile of vulnerability.





Consideration of Written Comments from Prior CHNA

A group of 30 individuals provided written comment in regard to the 2013 CHNA. Our summary of this commentary produced the following points, which were introduced in subsequent considerations of this CHNA.

Commenter characteristics:

Local Experts Offering Solicited Written Comments on 2013 Priorities and Implementation Strategy	Yes (Applies to Me)	No (Does Not Apply to Me)	Response Count
1) Public Health Expertise	6	19	25
2) Departments and Agencies with relevant data/information regarding health needs of the community served by the health system	13	15	28
3) Priority Populations	11	13	24
4) Representative/Member of Chronic Disease Group or Organization	8	16	24
5) Represents the Broad Interest of the Community	22	4	26
Other			
Answered Question			29
Skipped Question			1

Priorities from the last assessment where the health system intended to seek improvement were:

- Affordability
- Diabetes
- Obesity
- High Blood Pressure
- Primary Care

Tidelands Health received the following **verbatim** responses to the question: **"Comments or observations about this set of needs as being the most appropriate for the hospital to take on in seeking improvements?"**

- Should the hospital continue to consider each need identified as most important in the 2013 CHNA report as the most important set of health needs currently confronting residents in the county?

	Yes	No	No Opinion
Affordability	23	2	0
Diabetes	22	3	0
Obesity	22	3	0
High Blood Pressure	21	4	0
Primary Care	24	1	0

- **Specific comments or observations about <u>affordability</u> as being among the most significant needs for the health system to work on to seek improvements:**
  - *People think that they can not access care if they do not have money. More education is needed.*
  - *I hope that this was addressed by Obamacare.*
  - *Affordability has not improved under Obamacare. Even insured patients have a heavy financial burden. People without insurance are usually that way because they can't afford it. If they can't afford insurance, then they certainly cannot afford basic healthcare costs. Also, since many cannot afford to pay the costs of healthcare, that puts the onus on those who can afford to do so (insurance companies and insured patients); inevitably, that pushes costs onto those who are paying.*
  - *Small group care/programs can help reduce cost. There are evidence based medical programs which focus on many of the abocelisted chronic diseases.*
  - *Doctors care is still out of reach for many residents because unemployment is very high and transportation is often a problem. I think affordability is definitely still a priority.*
  - *There is no easy answer to this problem. The hospital does a great job of providing charity care and other forms of assistance to combat the cost of healthcare. People simply cannot afford it.*
  - *Being uninsured means falling within a gap. A gap is b/c of earning enough to be above medicaid yet not enough to afford medical coverage. Therefore, affordability is a step the hospital can make to alleviate the costs to those uninsured.*
  - *Most important. If people are scared of costs they are going to incur if they go to doctor and avoid until a problemm becomes much worse and thus more expensive. Focusing your efforts on preventative care seems like a no brainer.*
  - *This is critical because a large portion of our County residents forsake care because of other bills.*
  - *The hospital is doing a good job in this area.*
  - *Everyone should have some form of access to Medicaid or some type of medical insurance. Affordability is very important because if the poor cannot purchase meds or see a physician they will continue to die an early death due to no medical insurance. Chances are if they don't have medical insurance they don't have life insurance, which is then a burden on the family that is already living in poverty.*
  - *None.*
  - *By providing medical care to the uninsured, you are enabling them to break the LAW. Thank you President Obama.*
  - *Access to care remains a high priority area; access in the right place at the right time can often prevent further deterioration of a condition and can actually result in lower costs to the individual and the health system. Access to care is also necessary to promote wellness or the ability of the individual to participate in their care needs; these factors can impact their ability to support themselves/family.*
- **Specific comments or observations about <u>diabetes</u> as being among the most significant needs for the health system to work on to seek improvements:**

- *The work being done is good.*
- *As long as our society is in the midst of an obesity epidemic, then diabetes will remain a critical need. So many of the costs of healthcare are related to diabetes complications.*
- *Similar to answer from 2 questions above. [Small group care/programs can help reduce cost. There are evidence based medical programs which focus on many of the abocelisted chronic diseases.]*
- *People are still being diagnosed every day with diabetes due to lack of education in the rural communities.*
- *the faith based community needs to be informed that they can play a significant role in educating people about Diabetes.*
- *Again, think focus should be on the causes not the symptoms.*
- *One way to help people who are suffering with diabetes is to keep them educated. The North Santee community center use to have a nurse come out once a month and speak the community on how to eat, exercise and take care of their bodies while living as a diabetic. I heard great things about this program but it no longer exists. Education is the best tool.*
- *None.*
- *Again, life choices about what you put in your mouth. This needs to be addressed from birth forward.*
- *Management diabetes and the prevention of diabetes can impact many lagging indicators of health with significant cost and quality of life concerns.*

- **Specific comments or observations about obesity as being among the most significant needs for the health system to work on to seek improvements:**
  - *This is a major problem that seems to be part of the culture. I am not sure what can be done to change this.*
  - *I believe this to be the number one need that must be addresses. An enormous percentage of the overall costs of healthcare can be traced to complications arising from obesity.*
  - *This issue is complex. Regional attitudes and beliefs around nutrition and physical activity exacerbate the problem. Access, education and income disparity are problematic. It is difficult to provide quick healthy meals when your basic needs are unmet.*
  - *Obesity is still a big problem in the rural communities especially among teens and young adults. Obesity is a problem with adults and seniors as well, partly because they don't know the right foods to buy, they can't afford the right foods due to unemployment and other financial concerns and they often can't read the labels on foods.*
  - *If you look at the root cause of diabetes and high blood pressure, it is often lifestyle related--and is often manifested as diabetes. Helping to create a culture of health in the county*
  - *Continue to educate the public.*
  - *Again, think focus should be on the causes not the symptoms.*

- *Obesity is a growing problem in our community. In my own opinion people who can afford healthy food eat healthy. Those who can't afford to eat healthy eat what they can afford. WIC gives out vouchers for the farmers market but may people are not aware that they have this in place. Getting the word out and once again educating people will help with obesity in our community.*
- *None.*
- *Again, you are what you eat. Move more, eat less. How about having people take ownership for what they eat. Partner with gyms or other organizations to offer incentives for weight loss.*
- *Obesity contributes to the development of many other health conditions; obesity can impact many lagging indicators of health with significant cost and quality of life concerns.*

- **Specific comments or observations about high blood pressure as being among the most significant needs for the health system to work on to seek improvements:**
  - *All these problems are related and rooted in culture and social circumstances.*
  - *See comments on Diabetes / obesity. Even High Blood Pressure issues would diminish with an attendant decline in obesity.*
  - *The hospital is great at diagnosing, however treating through nutrition and exercise should be physicians goal versus medication. PARTNERS can provide programs and need direct referrals.*
  - *High blood pressure is still killing folks in the rural community. High blood pressure, obesity, strokes and heart attacks are on the rise.*
  - *Partnering with other community groups to educate public. Maybe install hbp machines in schools and encourage employers to do the same.*
  - *Again, think focus should be on the causes not the symptoms.*
  - *Need more health fairs.*
  - *Blacks develop high blood pressure more often, and at an earlier age, than whites and Hispanics do. More black women than men have high blood pressure. High blood pressure increases your risk for dangerous health conditions. Kidney disease is also a major risk factor for high blood pressure.*
  - *None.*
  - *No comment.*
  - *High blood pressure contributes to the development of many other health conditions which can impact many lagging indicators of health with significant cost and quality of life concerns.*

- **Specific comments or observations about primary care as being among the most significant needs for the health system to work on to seek improvements:**
  - *Primary Care access seems to have improved. Locations are convenient. I think the expansion of services is good and needs to continue.*
  - *If the hospital could be proactive at a local clinic level, then patients could be provided with resources that may prevent the identified issues of obesity, diabetes, and high blood pressure.*

- *There are far too few doctors who are accessible in the rural communities. People still have to travel a good distance to see a primary care doctor. If a specialist is needed, most people have to travel to Charleston for care.*
- *It is a significant need to educate people about the background of the employees that are*
- *Again, access and preventative medicine are my themes here, so this seems like a very important investment by the community. Would love to see Tidelands take on Williamsburg County also. Know that is a huge leap but the problems are so great and Tidelands is such a leader that could very well help to make a HUGE difference in our counties. Having to literally wait months and months for an appointment that the doctor spends 5 minutes with you is RIDICULOUS. No wonder the medical practice field is the butt of so much angst and anger and cynicism. Also the loss of time for appointments that are directed to Charleston and other larger cities makes them almost impossible for the working class. I think having access to good doctors who have the time and don;t make you wait an hour or more for a scheduled appointment is vital in helping people want to go to the doctor instead of dreading nad avoiding it.*
- *Primary care is the cornerstone of health care that is effective and efficient and meets the needs of patients, families, and communities.*
- *None.*
- *Not only more doctors, but quality doctors that people actually want to go and see.*
- *Primary care should be the medical home for many of our community; this is an opportunity to identify risk and provide care pathways to improve health outcomes. This is an area the hospital has some influence over and should be an area of focus.*

Conclusions from Public Input

Our group of 30 local expert advisers participated in an online survey to offer opinions about their perceptions of community health needs and the potential needs of unique populations. Complete *verbatim* written comments appear in the Appendix to this report.

Tidelands Health received the following responses to the question: **"Should the hospital continue to consider each need identified as most important in the 2013 CHNA report as the most important set of health needs currently confronting residents in the county? Please add any additional information you would like us to understand."**

- *Targeting the aging population related to each of these needs should be a focus.*
- *PREVENTION! education, taxes, incentivize*
- *Arthritis and asthma have become priorities in health care here in Georgetown County as well as those already identified.*
- *Older adults need to have access to communities and human interactions to fight the deteriorating affects of isolation.*
- *Isn't nuitrition the basis for diabetes, obesity and high blood pressure. Why isn't the focus on the cause instead of the symptoms? From an outreach aspect seems as though the hospital could do more on that end to lead the county in thoughtful eating habits. Working with schools, foodbanks, restaurants, churches, civic clubs, etc. on what poor nuitrition is doing to our population. Internally from a medical standpoint we know the cures of all of the diseases listed. So tying in medical solutions to stablize and follow up like nurse/family partnerships for the chronic disease management for nuitrition and education on healthy living.*
- *As a case manager working in an outreach ministry I do believe that people in the Georgetown county area need an advocate. Most of the people that fall under the above categories are most likely, uneducated on their illness. We need education classes so people can understand the importance of exercise, eating healthy, keeping up with appointments and maintaining a good relationship with their doctors. Some people get intimidated by the white coats and don't ask questions. People need to feel comfortable with addressing all issues to their primary care physician. So yes, the hospital should consider each need as the most important issues confronting residents in the Georgetown County area.*
- *Diabetes, obesity and high blood pressure are most likely due to life choices. You need to reach the population at childhood to transform the way they think about food. The current SNAP benfit does not limit one to healthy food. It encourages bad eating habits by supporting junk food. Until the mindset of eating is changed, you can keep dumping money in for these issues with little impact.*
- *I think if you are addressing diabetes and obesity you are also essentially addressing high blood pressure within those needs. It might not need to be a separate need depending on resources available.*

Summary of Observations: Comparison of Georgetown to Other SC Counties

Health Outcomes

In a health status classification termed “Health Outcomes," Georgetown ranks 22 among the 46 ranked South Carolina counties (best being #1). Premature death (deaths prior to age 75) presents worse values (shorter survivability) than the average for the US and South Carolina.

Health Factors

In another health status classification “Health Factors," Georgetown ranks number 15 among the 46 ranked South Carolina counties. The following indicators compared to SC average and to national top 10 percent performance present such poor values it warrants investigating how to improve:

- Adult Obesity – Georgetown 34% of residents compared to SC 32% and US best of 25%
- Physical Inactivity – Georgetown 27% of residents compared to SC 25% and US best of 20%
- Teen Births – Georgetown 51 births per 1,000 (age 15 to 19) compared to SC 43 and US best of 19
- Access to Exercise Opportunities – Georgetown 65% compared to SC 71% and US best of 91%

Clinical Care

In the “Clinical Care” classification, Georgetown County ranks 22 among the 46 ranked South Carolina counties. The following indicators compared to SC average and to national top 10 percent performance present such poor values it warrants investigating how to improve:

- Uninsured – Georgetown 22% of residents compared to SC 19% and US best of 11%
- Population to Primary Care Physician – Georgetown 1,730:1 which is worse than the SC average of 1,500:1 and US best of 1,040:1
- Population to Dentist – Georgetown 2,100:1 which is worse than the SC average of 1,950:1 and US best of 1,340:1
- Population to Mental Health Provider – Georgetown 1,320:1 which is worse than the SC average of 650:1 and US best of 370:1

Social and Economic Factors

In the “Social and Economic Factors” classification, Georgetown ranks number 18 among the 46 ranked South Carolina counties. The following indicators compared to SC average and to national top 10% performance present such poor values it warrants investigating how to improve:

- Children in Poverty – Georgetown 32% of children compared to SC 26% and US best of 13%
- Children in Single-Parent Households – Georgetown 49% of children compared to SC 40% and US best of 21%
- Unemployment – Georgetown 8.3% compared to SC 6.4% and US best of 3.5%
- Injury Deaths – Georgetown 75 deaths per 100,000 compared to SC 71 and US best of 51
- Some College – Georgetown 50% compared to SC 61% and US best of 72%

Comparison of Horry to Other SC Counties

Health Outcomes

In a health status classification termed “Health Outcomes," Horry ranks 18 among the 46 ranked South Carolina counties (best being #1). Premature death (deaths prior to age 75) presents worse values (shorter survivability) than the average for the US and South Carolina.

Health Factors

In another health status classification “Health Factors," Horry ranks number 22 among the 46 ranked South Carolina counties. The following indicators compared to SC average and to national top 10% performance present such poor values it warrants investigating how to improve:

- Excessive Drinking – Horry 17% of residents compared to SC 16% and US best of 12%

Clinical Care

In the “Clinical Care” classification, Horry County ranks 31 among the 46 ranked South Carolina counties. The following indicators compared to SC average and to national top 10 percent performance present such poor values it warrants investigating how to improve:

- Uninsured – Horry 24% of residents compared to SC 19% and US best of 11%
- Population to Primary Care Physician – Horry 1,630:1 which is worse than the SC average of 1,500:1 and US best of 1,040:1
- Population to Dentist – Horry 2,510:1 which is worse than the SC average of 1,950:1 and US best of 1,340:1
- Population to Mental Health Provider – Horry 710:1 which is worse than the SC average of 650:1 and US best of 370:1
- Mammography Screening – Horry 66% compared to SC 67% and US best of 71%
- Preventable Hospital Stays – Horry is at 55, which is higher than SC 50 and US best of 38

Social and Economic Factors

In the “Social and Economic Factors” classification, Horry ranks number 19 among the 46 ranked South Carolina counties. The following indicators compared to SC average and to national top 10 percent performance present such poor values it warrants investigating how to improve:

- Children in Poverty – Horry 30% of children compared to SC 26% and US best of 13%
- Unemployment – Horry 7.3% compared to SC 6.4% and US best of 3.5%
- Injury Deaths – Horry 72 deaths per 100,000 compared to SC 71 and US best of 51
- Violent Crime – Horry 658 offenses compared to SC 577 and US best of 59
- Some College – Horry 59% compared to SC 61% and US best of 72%

Summary of Observations: Peer Comparisons of Georgetown County

The Federal Government administers a process to allocate all counties into "peer" groups. County "peer" groups have similar social, economic, and demographic characteristics. Health and wellness observations when Georgetown County is compared to its national set of peer counties and compared to national rates result in the following:

Mortality

- *Better*
  - Nothing
- *Worse*
  - Female Life Expectancy – 78.9 years; 3rd worst among 40 peer counties; US avg. 79.8
  - Male Life Expectancy – 72.9 years; 2nd worst among 40 peer counties; US avg. 75.0
  - Motor Vehicle Deaths – 31.4 deaths per 100,000; 2nd worst among 33 peer counties; US avg. 19.2
  - Stroke Deaths – 55.2 deaths per 100,000; 2nd worst among 38 peer counties; US avg. 46.0
  - Unintentional Injury – 66.3 deaths per 100,000; 3rd worst among 38 peer counties; US avg. 50.8

Morbidity

- *Better*
  - Older Adult Depression
- *Worse*
  - Adult Diabetes – 8.7% of adults; 9th worst among 38 peer counties; US avg. 8.1%
  - Adult Obesity – 35.4% of adults; 5th worst among 38 peer counties; US avg. 30.4%
  - Gonorrhea – 135.0 rate per 100,000; worst among 40 peer counties; US avg. 30.5
  - HIV – 382.4 rate per 100,000; worst among 31 peer counties; US avg. 105.5
  - Preterm Births – 14.3% of births; 4th worst among 39 peer counties; US avg. 12.1%
  - Syphilis – 5.0 rate per 100,000; worst among 40 peer counties; US avg. 0.0

Healthcare Access and Quality

- *Better*
  - Nothing
- *Worse*
  - Uninsured – 21.4% of the population; 7th worst among 40 peer counties; US avg. 17.7%

Health Behaviors

- *Better*
  - Nothing
- *Worse*
  - Adult Physical Inactivity – 24.8% of adults; 9th worst among 38 peer counties; US avg. 25.9
  - Teen Births – 52.6 rate per 1,000; 7th worst among 38 peer counties; US avg. 42.1

Social Factors

- *Better*
  - Nothing
- *Worse*
  - Children in Single-Parent Households – 44.6% of children; 2nd worst among 40 peer counties; US avg. 30.8
  - High Housing Costs – 35.9% of individuals; 9th worst among 40 peer counties; US avg. 27.3%
  - Inadequate Social Support – 24.1% of adults; 3rd worst among 34 peer counties; US avg. 19.6%
  - Poverty – 19.8% of individuals; 7th worst among 40 peer counties; US avg. 16.3%
  - Violent Crime – 568.4 rate per 100,000; worst among 40 peer counties; US avg. 199.2

Summary of Observations: Peer Comparisons of Horry County

The Federal Government administers a process to allocate all counties into "peer" groups. County "peer" groups have similar social, economic, and demographic characteristics. Health and wellness observations when Horry County is compared to its national set of peer counties and compared to national rates result in the following:

Mortality

- *Better*
  - Nothing
- *Worse*
  - Chronic Kidney Disease Deaths – 16.8 deaths per 100,000; 4th worst among 32 peer counties; US avg. 17.5
  - Alzheimer's Disease Deaths – 38.7 deaths per 100,000; 6th worst among 32 peer counties; US avg. 27.3
  - Male Life Expectancy – 73.8 years; 3rd worst among 33 peer counties; US avg. 75.0
  - Motor Vehicle Deaths – 21.9 deaths per 100,000; 2nd worst among 32 peer counties; US avg. 19.2
  - Stroke Deaths – 50.0 deaths per 100,000; 2nd worst among 33 peer counties; US avg. 46.0
  - Unintentional Injury – 53.4 deaths per 100,000; 7th worst among 32 peer counties; US avg. 50.8

Morbidity

- *Better*
  - Older Adult Depression; Older Adult Asthma; Alzheimer's Diseases/Dementia
- *Worse*
  - Adult Diabetes – 9.0% of adults; 3th worst among 33 peer counties; US avg. 8.1%
  - Gonorrhea – 132.4 rate per 100,000; 2ndworst among 33 peer counties; US avg. 30.5
  - HIV – 296.5 rate per 100,000; 5th worst among 33 peer counties; US avg. 105.5
  - Preterm Births – 15.3% of births; worst among 33 peer counties; US avg. 12.1%
  - Syphilis – 3.3 rate per 100,000; 5th worst among 33 peer counties; US avg. 0.0

Healthcare Access and Quality

- *Better*
  - Nothing
- *Worse*
  - Uninsured – 26.2% of the population; worst among 33 peer counties; US avg. 17.7%

- Cost Barrier to Care – 19.2% of adults; 6th worst among 33 peer counties; US avg. 15.6%
- Primary Care Provider Access – 64.1 rate per 100,000; 7th worst among 33 peer counties; US avg. 48.0

Health Behaviors

- *Better*
  - Nothing
- *Worse*
  - Adult Physical Inactivity – 23.3% of adults; 7th worst among 33 peer counties; US avg. 25.9%
  - Adult Smoking – 26.0% of adults; 3rd worst among 33 peer counties; US avg. 27.1%
  - Teen Births – 43.9 rate per 1,000; 6th worst among 33 peer counties; US avg. 42.1

Social Factors

- *Better*
  - Nothing
- *Worse*
  - Children in Single-Parent Households – 39.3% of children; 2nd worst among 33 peer counties; US avg. 30.8
  - Poverty – 19.6% of individuals; 3th worst among 33 peer counties; US avg. 16.3%
  - Violent Crime – 658.1 rate per 100,000; 2nd worst among 33 peer counties; US avg. 199.2

Conclusions from Demographic Analysis Compared to National Averages – Georgetown

According to 2016 Truven Health Analytics data, the current population for Georgetown County is estimated to be 52,992 and is expected to increase at a rate of 1.9 percent through 2021. This is lower than South Carolina's 5.4 percent growth rate and the national average of 3.7 percent. In 2021, Georgetown County anticipates a population of 54,014.

Population estimates indicate the 2016 median age for the county is 45.4 years, older than the South Carolina average (39.0 years) and the national median age of 38.0. The 2016 median household income for the area is $40,871, lower than the South Carolina median income of $46,008 and the national median income of $55,072. Median household wealth value is higher than both the national and the South Carolina value. Median home value ($175,794) for Georgetown is higher than the South Carolina median of $149,936 but lower than the national median of $192,364. Georgetown's unemployment rate as of March 2016 is 7.7 percent, which is higher than the 5.7 percent statewide and the 5.0 percent national civilian unemployment rate.

The portion of the population in the county over 65 is 23.3 percent, compared to South Carolina (16.4 percent) and the national average (15.1 percent). The portion of the population of women of childbearing age is 16.2 percent, lower than the South Carolina average of 19.3 percent and the national rate of 19.6 percent. A total of 59.2 percent of the population is white non-Hispanic. The largest minority is the black non-Hispanic population, which comprises 35.7 percent of the total.

The following areas were identified from a comparison of the county to national averages. Metrics impacting more than 30 percent of the population and statistically significantly different from the national average include the following. All are considered adverse:

- **Vigorous Exercise** is 5.0% below average, impacting 54.2% of the population
- **I Follow Treatment Recommendations** is 5.7% below average, impacting 48.9% of the population
- **Routine Cholesterol Screening** is 5.6% below average, impacting 47.9% of the population
- **Cervical Cancer Screening** in past two years is 11.6% below average, impacting 53.0% of the population
- **OB/GYN Visit** is 18.8% below average, impacting 37.5% of the population

Metrics impacting more than 30 percent of the population and statistically significantly different from the national average include the following. All are considered beneficial:

- **Consumed Alcohol in the Past 30 Days** is 16.2% below average, impacting 45.4% of the population
- **Prostate Cancer Screening** is 6.0% above average, impacting 34.0% of the population

Conclusions from Demographic Analysis Compared to National Averages – Horry

According to 2016 Truven Health Analytics data, the current population for Horry County is estimated to be 321,318 and is expected to increase at a rate of 9.7 percent through 2021. This is significantly higher than South Carolina's 5.4 percent growth rate and the national average of 3.7 percent. In 2021, Horry County anticipates a population of 352,371.

Population estimates indicate the 2016 median age for the county is 44.0 years, older than the South Carolina average (39.0 years) and the national median age of 38.0. The 2016 median household income for the area is $42,933, lower than the South Carolina median income of $46,008 and the national median income of $55,072. Median household wealth value is higher than the South Carolina value but lower than the national average. Median home value ($164,191) for Horry is higher than the South Carolina median of $149,936 but lower than the national median of $192,364. Horry's unemployment rate as of March 2016 is 6.7 percent, which is higher than the 5.7 percent statewide and the 5.0 percent national civilian unemployment rate.

The portion of the population in the county over 65 is 21.1 percent, compared to South Carolina (16.4 percent) and the national average (15.1 percent). The portion of the population of women of childbearing age is 17.6 percent, lower than the South Carolina average of 19.3 percent and the national rate of 19.6 percent. A total of 77.0 percent of the population is white non-Hispanic. The largest minority is the black non-Hispanic population, which comprises 13.3 percent of the total.

The following areas were identified from a comparison of the county to national averages. Metrics impacting more than 30 percent of the population and statistically significantly different from the national average include the following. All are considered adverse:

- **Vigorous Exercise** is 5.6% below average, impacting 53.7% of the population
- **BMI: Morbid/Obese** is 8.6% above average, impacting 33.0% of the population
- **I Am Responsible for My Health** is 5.2% above average, impacting 61.9% of the population
- **I Follow Treatment Recommendations** is 7.1% below average, impacting 48.2% of the population
- **Routine Cholesterol Screening** is 5.8% below average, impacting 47.8% of the population
- **Cervical Cancer Screening** in past two years is 10.5% below average, impacting 53.7% of the population
- **OB/GYN Visit** is 12.7% below average, impacting 40.4% of the population

Metrics impacting more than 30 percent of the population and statistically significantly different from the national average include the following. All are considered beneficial:

- **Consumed Alcohol in the Past 30 Days** is 13.6% below average, impacting 46.9% of the population

Conclusions from Other Statistical Data – Georgetown

Among the Top 15 causes of death in the U.S., five of the 15 occurred at expected rates in Georgetown County. However, **accidents, stroke, Alzheimer's, blood poisoning, liver disease, hypertension** and **homicide** occurred at higher rates than expected, and **heart disease, diabetes** and **flu/pneumonia** occurred at lower rates. The Top 10 causes of death in Georgetown County are:

1. **Heart Disease** with Georgetown ranking #38 among 46 SC counties (where #1 is worst in state)
2. **Cancer** ranking #36 in SC
3. **Accidents** ranking #15 in SC
4. **Stroke** ranking #29 in SC
5. **Lung Disease** ranking #37 in SC
6. **Alzheimer's** ranking #25 in SC
7. **Diabetes** ranking #37 in SC
8. **Kidney Disease** ranking #27 in SC
9. **Blood Poisoning** ranking #30 in SC
10. **Liver Disease** ranking #27 in SC

The Institute for Health Metrics and Evaluation at the University of Washington analyzed all 3,143 US counties or equivalents applying small area estimation techniques to the most recent county information.

Unfavorable Georgetown County measures that are *worse than* the US average *and* had an *unfavorable change*:

- **Male Heavy Drinking** – As of 2012, 11.5% of males are heavy drinkers; value increased 1.9 percentage points since 2005
- **Male Binge Drinking** – As of 2012, 24.7% of males are binge drinkers; value increased 0.2 percentage points since 2002
- **Female Obesity** – As of 2011, 42.9% of females are obese; value increased 10.3 percentage points since 2001
- **Male Obesity** – As of 2011, 35.6% of males are obese; value increased 6.2 percentage points since 2001

Unfavorable Georgetown County measures that are *worse than* the US average *but* had a *favorable change*:

- **Female Life Expectancy** – As of 2013, female life expectancy is at 79.3 years; value increased 3.2 years since 1985

- **Male Life Expectancy** – As of 2013, male life expectancy is at 73.1 years; value increased 5.2 years since 1985
- **Female Smoking** – As of 2012, female smoking is at 18.4%; value decreased 3.4 percentage points since 1996
- **Male Smoking** – As of 2012, male smoking is at 24.6%; value decreased 5.8 percentage points since 1996
- **Female Physical Activity** – As of 2011, physical activity for females is at 51.6%; value increased 8.5 percentage points since 2001

Desirable Georgetown County measures *better than* the US average *but* had an *unfavorable change*:

- **Female Heavy Drinking** – As of 2012, 5.6% of females are heavy drinkers; value increased 1.2 percentage points since 2005
- **Female Binge Drinking** – As of 2012, 9.1% of females are binge drinkers; value increased 0.3 percentage points since 2002
- **Male Physical Activity** – As of 2011, physical activity for males is at 58.8%; value decreased 1.3 percentage points since 2001

Desirable Georgetown County measures *better than* the US average *and* had a *favorable change*:

- **None**

Conclusions from Other Statistical Data – Horry

Among the Top 15 causes of death in the U.S., 9 of the 15 occurred at expected rates in Horry County. However, **Alzheimer's, suicide, liver disease,** and **homicide** occurred at higher rates than expected, and **diabetes** and **flu/pneumonia** occurred at lower rates. The Top 10 causes of death in Horry County are:

1. **Heart Disease** with Horry ranking #30 among 46 SC counties (where #1 is worst in state)
2. **Cancer** ranking #34 in SC
3. **Accidents** ranking #28 in SC
4. **Stroke** ranking #33 in SC
5. **Lung Disease** ranking #18 in SC
6. **Alzheimer's** ranking #12 in SC
7. **Diabetes** ranking #41 in SC
8. **Kidney Disease** ranking #38 in SC
9. **Flu/Pneumonia** ranking #39 in SC
10. **Suicide** ranking #8 in SC

The Institute for Health Metrics and Evaluation at the University of Washington analyzed all 3,143 US counties or equivalents applying small area estimation techniques to the most recent county information.

Unfavorable Horry County measures that are *worse than* the US average *and* had an *unfavorable change*:

- **Male Heavy Drinking** – As of 2012, 10.7% of males are heavy drinkers; value increased 0.2 percentage points since 2005
- **Female Heavy Drinking** – As of 2012, 7.2% of females are heavy drinkers; value increased 0.9 percentage points since 2005
- **Female Obesity** – As of 2011, 36.7% of females are obese; value increased 7.9 percentage points since 2001
- **Male Obesity** – As of 2011, 36.6% of males are obese; value increased 8.8 percentage points since 2001

Unfavorable Horry County measures that are *worse than* the US average *but* had a *favorable change*:

- **Female Life Expectancy** – As of 2013, female life expectancy is at 79.9 years; value increased 1.6 years since 1985
- **Male Life Expectancy** – As of 2013, male life expectancy is at 74.5 years; value increased 4 years since 1985

- **Female Smoking** – As of 2012, female smoking is at 23.2%; value decreased 3.2 percentage points since 1996
- **Male Smoking** – As of 2012, male smoking is at 27.0%; value decreased 3.5 percentage points since 1996
- **Female Binge Drinking** – As of 2012, 12.7% of females are binge drinkers; value decreased 0.3 percentage points since 2002
- **Male Binge Drinking** – As of 2012, 24.9% of males are binge drinkers; value decreased 1.2 percentage points since 2002

Desirable Horry County measures *better than* the US average *but* had an *unfavorable change*:

- **Male Physical Activity** – As of 2011, physical activity for males is at 59.2%; value decreased 0.3 percentage points since 2001

Desirable Horry County measures *better than* the US average *and* had a *favorable change*:

- **Female Physical Activity** – As of 2011, physical activity for males is at 55.1%; value increased 8.0 percentage points since 2001

Conclusions from Prior CHNA Implementation Activities

Worksheet 4 of Form 990 h can be used to report the net cost of community health improvement services and community benefit operations.

> *"Community health improvement services" means activities or programs, subsidized by the health care organization, carried out or supported for the express purpose of improving community health. Such services do not generate inpatient or outpatient revenue, although there may be a nominal patient fee or sliding scale fee for these services.*
>
> *"Community benefit operations" means:*
>
> - *activities associated with community health needs assessments, administration, and*
> - *the organization's activities associated with fundraising or grant-writing for community benefit programs.*

Activities or programs cannot be reported if they are provided primarily for marketing purposes or if they are more beneficial to the organization than to the community. For example, the activity or program may not be reported if it is designed primarily to increase referrals of patients with third-party coverage, required for licensure or accreditation, or restricted to individuals affiliated with the organization (employees and physicians of the organization).

To be reported, community need for the activity or program must be established. Community need can be demonstrated through the following:

- A CHNA conducted or accessed by the organization.
- Documentation that demonstrated community need or a request from a public health agency or community group was the basis for initiating or continuing the activity or program.
- The involvement of unrelated, collaborative tax-exempt or government organizations as partners in the activity or program carried out for the express purpose of improving community health.

Community benefit activities or programs also seek to achieve a community benefit objective, including improving access to health services, enhancing public health, advancing increased general knowledge, and relief of a government burden to improve health. This includes activities or programs that do the following:

- Are available broadly to the public and serve low-income consumers.
- Reduce geographic, financial, or cultural barriers to accessing health services, and if they ceased would result in access problems (for example, longer wait times or increased travel distances).
- Address federal, state, or local public health priorities such as eliminating disparities in access to healthcare services or disparities in health status among different populations.
- Leverage or enhance public health department activities such as childhood immunization efforts.
- Otherwise would become the responsibility of government or another tax-exempt organization.
- Advance increased general knowledge through education or research that benefits the public.

Activities reported by Tidelands Health in its implementation efforts and/or its prior year tax reporting included:

- Community Benefit = $1,503,730

Other aid and contributions:

- Financial Assistance at Cost = $8,399,888
- Medicaid = $1,619,642
- Health professions education = $325,346
- Cash and in-kind contributions for community benefit = $422,886
- Workforce Development = $1,143,283
- Charity Care = $6,546,562
- Medicare: $15,893,392

EXISTING HEALTHCARE FACILITIES, RESOURCES, AND IMPLEMENTATION STRATEGY

Significant Health Needs

We used the priority ranking of area health needs by the local expert advisers to organize the search for locally available resources as well as the response to the needs by Tidelands Health.[24] The following list:

- Identifies the rank order of each identified significant need
- Presents the factors considered in developing the ranking
- Establishes a problem statement to specify the problem indicated by use of the significant need term
- Identifies Tidelands Health current efforts responding to the need including any written comments received regarding prior Tidelands Health implementation actions
- Establishes the implementation strategy programs and resources Tidelands Health will devote to attempt to achieve improvements
- Documents the leading Indicators Tidelands Health will use to measure progress
- Presents the lagging Indicators Tidelands Health believes the leading indicators will influence in a positive fashion, and
- Presents the locally available resources noted during the development of this report as believed to be currently available to respond to this need.

Tidelands Georgetown Memorial Hospital is a 131-bed acute care medical facility located in Georgetown, South Carolina. The next closest facilities are outside the service area and include:

- Conway Medical Center in Conway, SC, 41 miles (52 minutes)
- Grand Strand Regional Medical Center in Myrtle Beach, SC, 41 miles (65 minutes)
- Clarendon Memorial Hospital in Manning, SC, 65 miles (72 minutes)

Tidelands Waccamaw Community Hospital is a 124-bed acute care, 43-bed rehab medical facility located in Murrells Inlet, South Carolina. The next closest facilities are outside the service area and include:

- Conway Medical Center in Conway, SC, 18 miles (32 minutes)
- Grand Strand Regional Medical Center in Myrtle Beach, SC, 20 miles (32 minutes)
- McLeod Hospital in Loris, SC, 46 miles (62 minutes)

All data items analyzed to determine significant needs are “lagging indicators,” measures presenting results after a period of time, characterizing historical performance. Lagging indicators tell you nothing about how the outcomes were achieved. In contrast, the Tidelands Health implementation strategy uses “leading indicators.” Leading Indicators anticipate change in the lagging indicator. Leading Indicators focus on short-term performance, and if accurately selected, anticipate the broader achievement of desired change in the Lagging Indicator. In the Quorum application, leading indicators also must be within the ability of the health system to influence and measure.

[24] Response to IRS Schedule h (Form 990) Part V B 3 e

1. **AFFORDABILITY/ACCESSIBILITY** – 2013 Significant Need; Local Expert concern; lack of transportation cited as a concern; uninsured rate higher than US and SC average; uninsured 7th worst among peer counties; population to primary care physician ratio worse than US and SC

Public comments received on previously adopted implementation strategy:

- *The hospital system can reallocate resources to clinics that can treat minor illnesses with less cost and greater effectiveness than the ER.*
- *Partnerships. Will be important. Need to Identify funding sources, space, outreach methods.*
- *If the Hospital could somehow provide transportation to the facility, I think more people would be helped. DHEC provides transportation to Charleston, but not to Georgetown and it quite often is a whole-day affair when patients have to go to Charleston.*
- *A more inclusive population of people are needed to represent all areas of the community. Inform the community about statistics for the area in which they live.*
- *It seems to me that if people were not scared about what an xray or a visit to a doctor or a blood test would cost there might be more access by the low income population. Heck, the well insured are fearful too! Better communication prior to procedures about costs and how a person can pay for it in a reasonable manner, better use of free and reduced services to areas that are lacking medical services on a more regular basis, more effort to be sought for a consolidaiton of resources or abuse of expensive resources like emergency rooms and high end medications. Better grasp of alternative medical choices. And the most important a focus on preventative and healthy living life styles.*
- *The actions of the hospital need to be structured and consistent. The hospital has to make sure they are aware of the financial difficulties within the community.*
- *None.*
- *Figure out a way to insure them through the hospital.*
- *Affordability of care can impact access to care in the right place at the right time; as stated in access this can often prevent further deterioration of a condition and can actually result in lower costs to the individual and the health system and can impact their ability to support themselves/family.*

Tidelands Health services, programs, and resources available to respond to this need include:[25]

- Tidelands Community Care Network – physician partnership agreements
- TCCN health screening initiative – coordinated community access to health screenings
- TCCN dental initiative – coordinated community planning for dental care
- Hospital financial assistance policy; charity care provided
- Welvista – medication access
- Partnering with FQHC, St James Santee, for physician recruitment/diabetes care initiative

[25] This section in each need for which the hospital plans an implementation strategy responds to Schedule h (Form 990) Part V Section B 3 c

- Tidelands Health makes scholarships available for local gym memberships
- Tidelands Health makes flu shots available to the community
- Tidelands Health makes available school physicals and sports injury clinics for athletes
- Sponsorship and participation at local health fairs
- Tidelands Health Foundation "Breast Care Fund," provides transportation and medication support
- Blood pressure monitoring; test strips, blood monitoring pumps, and scales provided to residents
- Mental health counseling appointments available to Healthy Outcomes Plan participants
- Community physician lectures provided on a regular basis

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

- Continue above activities
- Developing family medicine residence program
- Increase utilization of telemedicine
- Improve transportation to increase medical access
- Improve education provided to community on resources available to the community
- Introduce health awareness messaging through media channels
- Provide heart scans, cardiac calcium scoring, and lung cancer screening
- Increase specialty services through recruitment of medical staff members

Tidelands Health evaluation of impact of actions taken since the immediately preceding CHNA:

- Teleneurology specialist added to staff

Anticipated results from Tidelands Health implementation strategy

Community Benefit Attribute Element	Yes, Implementation Strategy Addresses	Implementation Strategy Does Not Address
1. Available to public and serves low income consumers	X	
2. Reduces barriers to access services (or, if ceased, would result in access problems)	X	
3. Addresses disparities in health status among different populations	X	
4. Enhances public health activities	X	
5. Improves ability to withstand public health emergency	X	
6. Otherwise would become responsibility of government or another tax-exempt organization		X

Community Benefit Attribute Element	Yes, Implementation Strategy Addresses	Implementation Strategy Does Not Address
7. Increases knowledge; then benefits the public	X	

The strategy to evaluate Tidelands Health intended actions is to monitor change in the following leading indicator:

- Number of persons provided with access to care = 1,234 (2015)

The change in the leading indicator anticipates appropriate change in the following lagging indicator:

- Preventable hospital stays
  - Georgetown County = 44
  - Horry County = 55

Tidelands Health anticipates collaborating with the following other facilities and organizations to address this significant need:

Organization	Contact Name	Contact Information
Tidelands Community Care Network	Linda Bonesteel	(843) 520-8586 www.tidelandshealth.org/community-wellness/tidelands-community-care-network
Youth Collaboratives of Georgetown County	Sheryn Waterman	(843) 237-1222 www.youthcollabgtown.org sherynwaterman@gmail.com
Early Childhood Physician Advisory Council	Carla Wham	(843) 520-8579 cwham@tidelandshealth.org
Helping Hands Extraction Clinic	Tracy Jones	(843) 527-3424 www.helpinghandsofgeorgetown.org acct.hhands@gmail.com
St. James Santee, FQHC	Sandra Gilliard	(843) 887-3274 www.stjamessanteefhc.com sgilliard@stjamessanteefhc.com
Horry Georgetown Tech Dental Program	Noelle Witaker	(843) 347-3186 http://www.hgtc.edu/community/dental_clinic.html Noelle.whittaker@hgtc.edu

Welvista	Cathy Martin	(803) 933-9183 cmartin@welvista.org
YMCA	Shane Riffle	(843) 545-9622 www.coastalcarolinaymca.org/georgetown ShaneR@coastalcarolinaymca.org

2. MENTAL HEALTH/SUBSTANCE ABUSE – Local expert concern; population to mental health provider ratio worse than US and SC average

Public comments received on previously adopted implementation strategy:

- While this was a significant need in 2013, an implementation strategy was not developed at that time, so no comments were solicited

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

- Access to telepsych services at many Tidelands Health Group locations
- Partnership with Georgetown County Alcohol and Drug Commission; prevention work provided to schools and support groups
- Provide educational materials in emergency department describing patients' rights
- Early Childhood Physician Committee – large conference to bring community leaders together to address childhood behavior and mental health
- Online health library with risk assessment materials (depression/alcohol abuse) provided
- Provide risk management education for mental health certification

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

- Developing plan to assess community need and make recommendations for mental health
- Recruiting a behavioral health specialist and looking into a shared cost mental health professional in emergency department
- Expanding telepsych services available to the community through Tidelands Health Group
- Developing comprehensive pain management protocol/program that includes education on opioid addiction and non-opiate alternatives

Anticipated results from Tidelands Health implementation strategy

Community Benefit Attribute Element	Yes, Implementation Strategy Addresses	Implementation Strategy Does Not Address
1. Available to public and serves low income consumers	X	
2. Reduces barriers to access services (or, if ceased, would result in access problems)	X	
3. Addresses disparities in health status among different populations	X	
4. Enhances public health activities	X	
5. Improves ability to withstand public health emergency		X

Community Benefit Attribute Element	Yes, Implementation Strategy Addresses	Implementation Strategy Does Not Address
6. Otherwise would become responsibility of government or another tax-exempt organization	X	
7. Increases knowledge; then benefits the public	X	

The strategy to evaluate Tidelands Health intended actions is to monitor change in the following leading indicator:

- Number of mental health referrals through Tidelands Community Care Network = 66

The change in the Leading Indicator anticipates appropriate change in the following lagging indicator:

- Number of poor mental health days reported in past 30 days
  - Georgetown County = 4.1
  - Horry County = 4.3

Tidelands Health anticipates collaborating with the following other facilities and organizations to address this significant need:

Organization	Contact Name	Contact Information
Tidelands Community Care Network	Linda Bonesteel	(843) 520-8586 www.tidelandshealth.org/community-wellness/tidelands-community-care-network
Georgetown County Alcohol and Drug Abuse Commission	Raphael Carr	(843) 527-3125 rcarr@gcadac.org
Waccamaw Center for Mental Health	Doris Smith	(843) 546-6107 (Georgetown Clinic) (843) 347-4888 (Horry Clinic) www.waccamawmentalhealth.org Beverly.smith@scdmh.org
Shoreline Behavioral Health	John Coffin	(843) 365-8884 www.shorelinebhs.com john@shorelinebhs.org
South Carolina Hospital Association	Melanie Matney	(803) 796-3080 www.scha.org mmatney@scha.org

Other local resources identified during the CHNA process that are believed available to respond to this need: [26]

Organization	Contact Name	Contact Information
Lighthouse Care Center		(843) 347-8871 www.lighthousecarecenterofconway.com
Local AA/NA/NAMI Chapters		(843) 655-7674 (Alcoholics Anonymous) www.area62.org/intergroup/grandstrand.php
Smith Medical Clinic	Anne Faul	(843) 237-2672 www.smithfreeclinic.org
Georgetown County public schools	Dr. Randall Dozier	(843) 436-7000 www.gcsd.k12.sc.us
Horry County public schools		(843) 488-6700 www.horrycountyschools.net

[26] This section in each need for which the hospital plans an implementation strategy responds to Schedule h (Form 990) Part V Section B 3 c and Schedule h (Form 990) Part V Section B 11

3. **OBESITY** – 2013 significant need; adult obesity above US and SC average; adult obesity 5th worst among peers; male and female obesity worse than US average

Public comments received on previously adopted implementation strategy:

- *I have not seen the hospital's involvement in reducing obesity out in the community. I would like to see the hospital undertake programs to get people moving more. The hospital should be a leader in this effort.*
- *There should be some form of obesity intervention whenever the hospital encounters a patient who is obese or approaching obesity. There must be a strong message about the health risks of obesity. The hospital should bend over backwards to help any obese person who truly wants to change their condition.*
- *Same as diabetes question [Small group behavior change programs are proven effective.]*
- *Education is the key! Not everyone will make the necessary changes in their eating habits, but they tend to tell family members and friends about what they are learning.*
- *the hospital can be very influential in helping to create a culture of health in the county*
- *I believe the children and other non profits should be given incentives to incorporate this initiative into their strategic plans.*
- *Use of non-profits and health providers and schools, combining their resources around what the hospital is leading throughout its departments on every level. Helping have a collaborative approach to preventative medicine while dealing with chronic issues.*
- *Following a healthy lifestyle can help you prevent overweight and obesity. Many lifestyle habits begin during childhood. Thus, parents and families should encourage their children to make healthy choices, such as following a healthy diet and being physically active.*
- *None.*
- *No comment.*
- *Obesity contributes to the development of many other health conditions; obesity can impact many lagging indicators of health with significant cost and quality of life concerns.*

Tidelands Health and community partner agency services, programs, and resources available to respond to this need include:

- Teach My People – after-school program focusing on healthy lifestyles
- Baby Friendly Hospital Certification – program focusing on breastfeeding
- Well Excel – Tidelands Health employee incentive program
- Partnership with YMCA to provide gym scholarships
- GCOST – after-school provider collaborative (nutritional and physical activity core program components)
- Stronger Through Movement at Tidelands HealthPoint Center for Health and Fitness – physician-referred medical fitness program available to those living with a chronic condition and/or physically inactive
- Stronger At Work – medical fitness program offered to local industries

- Lunch and learns for community members
- Grocery store tours and nutritional education provided by Tidelands Health
- Cyclovia-Myrtle Beach – day-long outdoor event to get the community moving; sponsorship; fitness classes and clinicians on site providing nutritional education
- Sponsorship of local fitness events; primary organizer of In the Pink breast cancer walk and sponsor of several local 5Ks and road races
- Mitney Project – healthy eating activities with after-school kids
- Identified walking paths on hospital campuses
- Weight management courses through Tidelands Health nutrition department
- Funded initiative to place self-directed exercise stations in East Bay Park in Georgetown

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

- Initiating health and wellness council for the public school system
- Bike the Neck program – promoting alternative transportation options
- Developing plan on both campuses for structured walking paths – access to safe and free exercise

Anticipated results from Tidelands Health implementation strategy

Community Benefit Attribute Element	Yes, Implementation Strategy Addresses	Implementation Strategy Does Not Address
1. Available to public and serves low income consumers	X	
2. Reduces barriers to access services (or, if ceased, would result in access problems)	X	
3. Addresses disparities in health status among different populations		X
4. Enhances public health activities	X	
5. Improves ability to withstand public health emergency		X
6. Otherwise would become responsibility of government or another tax-exempt organization		X
7. Increases knowledge; then benefits the public	X	

The strategy to evaluate Tidelands Health intended actions is to monitor change in the following leading indicator:

- Number of BMI screenings/educational encounters provided = 1,051 (2015)

The change in the leading indicator anticipates appropriate change in the following lagging indicator:

- Obesity rate

- Georgetown County = 34%
- Horry County = 29%

Tidelands Health anticipates collaborating with the following other facilities and organizations to address this significant need:

Organization	Contact Name	Contact Information
Tidelands Community Care Network	Linda Bonesteel	(843) 520-8586 www.tidelandshealth.org/community-wellness/tidelands-community-care-network
Low County Food Bank		(843) 747-8146 www.lowcountryfoodbank.org
YMCA	Shane Riffle	(843) 545-9622 www.coastalcarolinaymca.org/georgetown ShaneR@coastalcarolinaymca.org
Relay for Life	Dr. Randall Dozier	(843) 436-7000 www.relayforlife.org
Healthy Learners	Rebecca Lammonds	(843) 436-7020, (843) 436-7006 www.healthylearners.com/georgetown

4. DIABETES – 2013 significant need; #7 leading cause of death; adult diabetes 9th worst among peer counties

Public comments received on previously adopted implementation strategy:

- *Expand the outreach.*
- *Diabetes prevention and treatment must be addressed in conjunction with obesity-related health issues.*
- *Small group behavior change programs are proven effective.*
- *The Hospital needs to hire outreach workers to come into the communities to get first hand knowledge of the situation instead of trying to assess needs from behind a desk. It has been proven in the past that outreach workers who genuinely care about rural needs have made a difference in the community.*
- *Children can be involved in educating adults. Invest in the future of the children. Work with the schools*
- *Use of non-profits and health providers and schools, combining their resources around what the hospital is leading throughout its departments on every level. Helping have a collaborative approach to preventative medicine while dealing with chronic issues.*
- *I'm encouraged that the hospital intends to make diabetes a community-wide effort and look forward to seeing as many partners as possible engaged in this work.*
- *Patients need to learn how to watch their weight, eat healthy, Choose lean meats and lots of fresh veggies and cutting down on fats, starches, and sugary foods can help you stay on track. A dietitian can help put a meal plan together. Some people with diabetes think they won't ever be able to enjoy their favorite foods, but that's not true.*
- *None.*
- *Be more involved with what the schools are preparing for lunch and the education about how we are what we eat. This may bring some issues as most of the Southern Traditional diet is unhealthy.*
- *Management diabetes and the prevention of diabetes can impact many lagging indicators of health with significant cost and quality of life concerns.*

Tidelands Health and community partner agency services, programs, and resources available to respond to this need include:

- Predictive modeling in identifying people at risk for pre-diabetes and diabetes; targeting education and directing them to Stronger Through Movement medical fitness program
- Cooking Matters program
- Grocery store tours and nutritional education provided by Tidelands Health
- Working with Diabetes Stat (statewide diabetes prevention program)
- Collaboration with local industries for Wellness Works (pre-diabetes prevention program); provides A1C screenings
- Population Health Readiness Assessment in partnership with Community Care of North Carolina
- Community health education – grant screening initiative and diabetic educator on staff

- A1Cs taken at Tidelands Health-sponsored community screenings
- Medication therapy management – focused on diabetes; clinical pharmacist participating with patients with diabetes; hoping to optimize medication therapy; coding for Medicare patients
- Working with Helping Hands to purchase refrigeration to hand out milk and eggs at food pantries
- Press releases promoting healthy food options available in cafeterias (alternatives to soda/junk food)
- Both Tidelands Georgetown Memorial Hospital and Tidelands Waccamaw Community Hospital are Baby Friendly designated facilities – program focusing on optimal nutrition through breastfeeding
- Welvista – medication access
- Partnering with FQHC, St. James Santee, for physician recruitment/diabetes care initiative
- Diabetes support group at Tidelands Waccamaw Community Hospital

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

- Expanding diabetes certification model; looking into adding at least four certified diabetes educators to staff
- Expanding MTM program (pharmacy expansion)
- Collaboration between TCCN and Smith Medical Clinic as it relates to chronic disease management
- Mobile kitchen/Cooking Matters/hypertension program with YMCA
- Expanding healthy food bag model

Tidelands Health evaluation of impact of actions taken since the immediately preceding CHNA:

- Development of NuMed program – physician-led weight loss program directing people to counseling, supplements, and surgery, as appropriate
- Development of Stronger Through Movement medical fitness program

Anticipated results from Tidelands Health implementation strategy

Community Benefit Attribute Element	Yes, Implementation Strategy Addresses	Implementation Strategy Does Not Address
1. Available to public and serves low income consumers	X	
2. Reduces barriers to access services (or, if ceased, would result in access problems)	X	
3. Addresses disparities in health status among different populations	X	
4. Enhances public health activities	X	
5. Improves ability to withstand public health emergency		X
6. Otherwise would become responsibility of government or another tax-exempt organization	X	

Community Benefit Attribute Element	Yes, Implementation Strategy Addresses	Implementation Strategy Does Not Address
7. Increases knowledge; then benefits the public	X	

The strategy to evaluate Tidelands Health intended actions is to monitor change in the following leading indicator:

- Number of diabetes screenings and education = 861 (2015)

The change in the leading indicator anticipates appropriate change in the following lagging indicator:

- Diabetes rate
  - Georgetown County = 8.7%
  - Horry County = 9.0%

Tidelands Health anticipates collaborating with the following other facilities and organizations to address this significant need:

Organization	Contact Name	Contact Information
American Diabetes Association	Carla Wham	(843) 520-8579 www.diabetes.org
YMCA	Shane Riffle	(843) 545-9622 www.coastalcarolinaymca.org/georgetown ShaneR@coastalcarolinaymca.org
Welvista	Cathy Martin	(803) 933-9183 cmartin@welvista.org
Smith Medical Clinic	Anne Faul	(843) 237-2672 www.smithfreeclinic.org
Little River Medical Center	Celeste Bondurant-Bell	(843) 663-8000 www.lrmcenter.com cbell@lrmcenter.com
Georgetown County Schools nutrition services department	Dr. Marthena Morant	teemorant@frontier.com

Other local resources identified during the CHNA process that are believed available to respond to this need:

Organization	Contact Name	Contact Information
Baskervill Food Pantry	Linda Ducharme Carl Harmon	(843) 215-6656 (843) 237-3459

5. **PHYSICAL INACTIVITY** – Local expert concern; above the US and SC average; adult physical inactivity 9th worst among peers; access to exercise opportunities below US and SC average; vigorous exercise is 5.0% below average; female physical activity worse than US average

Public comments received on previously adopted implementation strategy:

- This was not a significant need identified in 2013 so no written public comments about this need were solicited

Tidelands Health and community partner agency services, programs, and resources available to respond to this need include:

- Well Excel – Tidelands Health employee incentive program
- Partnership with YMCA and Tidelands HealthPoint to provide gym scholarships
- Stronger Through Movement at Tidelands HealthPoint – physician-referred medical fitness program for those with a chronic condition and/or physically inactive
- Stronger At Work – medical fitness program offered to local industries
- Cyclovia-Myrtle Beach – day-long outdoor event to get the community moving; sponsorship; fitness classes and clinicians on site providing nutritional education
- Sponsor of local fitness events; primary organizer of In the Pink breast cancer walk and sponsor of numerous community 5Ks and road races
- Identified walking paths on hospital campuses
- Funded initiative to place self-directed exercise stations in East Bay Park in Georgetown

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

- Bike the Neck program – promoting alternative transportation options
- Developing plan on both campuses for structured walking paths – access to safe and free exercise

Anticipated results from Tidelands Health implementation strategy

Community Benefit Attribute Element	Yes, Implementation Strategy Addresses	Implementation Strategy Does Not Address
1. Available to public and serves low income consumers	X	
2. Reduces barriers to access services (or, if ceased, would result in access problems)	X	
3. Addresses disparities in health status among different populations	X	
4. Enhances public health activities	X	
5. Improves ability to withstand public health emergency		X

Community Benefit Attribute Element	Yes, Implementation Strategy Addresses	Implementation Strategy Does Not Address
6. Otherwise would become responsibility of government or another tax-exempt organization	X	
7. Increases knowledge; then benefits the public	X	

The strategy to evaluate Tidelands Health intended actions is to monitor change in the following leading indicator:

- Number of gym scholarships/passes for physical activity = 45 in 2015

The change in the leading indicator anticipates appropriate change in the following lagging indicator:

- Physical inactivity rate
    - Georgetown County = 27%
    - Horry County = 23%

Tidelands Health anticipates collaborating with the following other facilities and organizations to address this significant need:

Organization	Contact Name	Contact Information
Tidelands Community Care Network	Linda Bonesteel	(843) 520-8586 www.tidelandshealth.org/community-wellness/tidelands-community-care-network
YMCA	Shane Riffle	(843) 545-9622 www.coastalcarolinaymca.org/georgetown ShaneR@coastalcarolinaymca.org
Relay for Life	Dr. Randall Dozier	(843) 436-7000 www.relayforlife.org

Other Needs Identified During CHNA Process

6. **EDUCATION/PREVENTION**
7. **HIGH BLOOD PRESSURE** – 2013 significant need
8. **COMPLIANCE BEHAVIOR**
9. **SUBSTANCE ABUSE**
10. **DENTAL**
11. **SMOKING**
12. **ALZHEIMER'S**
13. **ACCIDENTS**
14. **CANCER**
15. **SEXUALLY TRANSMITTED INFECTION**
16. **LIVER DISEASE**
17. **HEART DISEASE**
18. **MATERNAL MEASURES**
19. **KIDNEY DISEASE**
20. **STROKE**
21. **SOCIAL VULNERABILITY**
22. **PALLIATIVE CARE**
23. **PREDISPOSING CONDITIONS**
24. **CHOLESTEROL**
25. **LUNG DISEASE**
26. **BLOOD POISONING**
27. **LIFE EXPECTANCY**

Overall Community Need Statement and Priority Ranking Score

Significant needs where hospital has implementation responsibility[27]

1. Affordability/accessibility
2. Mental health/substance abuse
3. Obesity
4. Diabetes
5. Physical inactivity

Significant needs where hospital did not develop implementation strategy[28]

None

Other needs where hospital developed implementation strategy

None

Other needs where hospital did not develop implementation strategy

6. Education/prevention
7. High blood pressure
8. Compliance behavior
9. Substance abuse
10. Dental
11. Smoking
12. Alzheimer's
13. Accidents
14. Cancer
15. Sexually transmitted infection
16. Liver disease
17. Heart disease

[27] Responds to Schedule h (Form 990) Part V B 8
[28] Responds to Schedule h (Form 990) Part V Section B 8

18. Maternal measures
19. Kidney disease
20. Stroke
21. Social vulnerability
22. Palliative care
23. Predisposing conditions
24. Cholesterol
25. Lung disease
26. Blood poisoning
27. Life expectancy

APPENDIX

Appendix A – Written Commentary on Prior CHNA

Health system solicited written comments about its 2013 CHNA.[29] Thirty 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, skip the indication and please continue to the next question.**

Local Experts Offering Solicited Written Comments on 2013 Priorities and Implementation Strategy	Yes (Applies to Me)	No (Does Not Apply to Me)	Response Count
1) Public Health Expertise	6	19	25
2) Departments and Agencies with relevant data/information regarding health needs of the community served by the hospital	13	15	28
3) Priority Populations	11	13	24
4) Representative/Member of Chronic Disease Group or Organization	8	16	24
5) Represents the Broad Interest of the Community	22	4	26
Other			
Answered Question			29
Skipped Question			1

- **Within the county, do you perceive the local priority populations to have any unique needs, as well as potential unique health issues needing attention? If you believe any situation as described exists, please also indicate who you think needs to do what.**
  - *There are many priority populations including an aging community that is moving into the area as well as members of the local community who are unaware of available services for healthcare and other support needs. The service providers need to find ways to share this information with the members of this community.*
  - *I perceive a dire need to address the problem of morbid obesity in our society in general and in our community in particular. Many of the "Priority Populations" are at increased risk for health problems related to poor diets (especially the poor, African-American, the rural poor, and children). Health care providers are the first line to be able to confront the obesity epidemic. Also, the poor (probably weighted more heavily toward the ethnic minority population) do not have access to preventive health care services and basic internal medicine. There is a need for facilities other than the ER to receive marginally sick people and treat them, in order to take some of the tremendous cost of ER treatments off the shoulders of the hospital.*
  - *Many of the health issues we see are diet/exersize related. A comprehensive education program in place starting in elementary school all the way through high school is needed. In addition programs such as "Cooking Matters" should be taught in all non-profits, churches and community organizations.*
  - *Low income- access and broad education: health as defined broadly to include nutrition and physical*

[29] Responds to IRS Schedule h (Form 990) Part V B 5

activity. Start with youth through schools, YMCA, camps and after school programs. Access to fitness 'sites', i.e. Cycling/commuting trails, walking paths, parks, gyms (include public transport). Then behavior modification programs to support medical care providers for sustainable change. Need to define partnerships and health pathways and find funding.

- *The residents in our rural locations have many needs: housing, financial, job training, health care. Diabetes is very prevalent in our area as well as high blood pressure, eye care, asthma, arthritis and weight control. Federal funding in the rural communities is the number one issue. Those who are already in the health field need to be more present in the community.*
- *low-income, uninsured - access to care beyond normal working hours. costly for individuals to access care when they might normally be working. hospitals and community health centers should offer mobile units to provide primary care. racial and ethnic minority groups - hospitals and community health centers should collaborate more with these groups in order to break down cultural and language barriers to care. all priority populations need assistance obtaining diagnostic testing (due to financial barriers) and dental care (with the exception of children and a few well-insured) there is little to no dental assistance, particularly for oral surgery, root canals and dentures..*
- *Drug and alcohol addiction Mental health issues*
- *Older adults deteriorate physically, mentally, and emotionally when isolated. With such a lack of transportation options for aging residents, this unique need is amplified with record numbers of retirees coming to Horry and Georgetown counties.*
- *disabled individuals, and pregnant woman, children and the elderly.*
- *Yes, lack of education of resources available, use of ACA, and understanding of preventative measures and followup to health concWhile the resources seem plentiful, access from the Priority populations seems minimal. How to connect one to the other? I guess that is the million dollar question. While continued partnerships with the healthcare providers is essenhetial another piece is gaining input from the populations trying to be reached. Intense focus groups, workign with human service organizations and faith based partners may help shed light on barriers, and a fresh look from Priority Population perspectives on how to build a bridge. Knowing very clearly that lack of education, fear of medical services and mental health way heavily into the process and continue to make this a challenge. Stepping out of the box and thinking of new ways to engage are incredibly important.*
- *As pertains to low-income groups, it is my opinion more services are needed in respect to health care.*
- *Because diabetes is so prevalent in our community, many people assume that it is inevitable - just a part of growing up and/or growing older. There is an educational component that we are missing but also a cultural one that needs to be addressed as well so that children grow up realizing that they are empowered (and expected) to adopt a lifestyle that prevents or lowers the risk of developing this horrible disease.*
- *There is a great need for the African American group concerning mental illness. Most are middle aged, living in rural areas, no transportation and can't afford medication. I believe that these people need some type of social worker who can make home visits bi-weekly in order to insure they are not a threat*

to themselves or others around them. Or maybe have a family member contact to insure they have their meds and are making it to their doctor appointments.

- *Yes. Older adults need access to people and communities to prevent the devastating effects of being isolated.*
- *An adopted opinion from my field is the priority populations have a higher incidence of substance use disorders and are more at risk to for the development of the disorder.*
- *Transportation is number one barrier for the majority of the priority populations. The SCDOT and local communities should assume responsibility for public transportation from the rural areas coming to the populated areas. Why build wonderful recreation centers if the population that needs them the most cannot get to them. Come up with means to transport then build places to take them.*
- *Yes. It's important to consider a few things to improve the health and well-being of the community: Know what affects health (40% socioeconomic factors; 30% health behaviors; 20% clinical care; 10% physical environment); Focus on areas of greatest need (zip codes are important!); Collaborate with others to maximize efforts; Use a balance of interventions for greatest impact.*
- *I think needs fall within the minority group to include the elderly and middle age persons. There are some groups other than minority that include the uninsured and umderinsured population.*
- *needs public education on hypertension, diabetes, healthy diets, exercise options within their own environment*
- *Within the counties of Horry and the Waccamaw Neck of Georgetown, the unique needs of older adults is accessing transportation. Additionally, senior isolation, which is a unique health issue for this population, needs more attention b/c of its detrimental effects.*

2. In the last process, several data sets were examined and a group of local people were involved in advising the hospital. While multiple needs emerged, the hospital had to determine what issues were of high priority and where it would be a valuable resource to assist in obtaining improvements.

Priorities from the last assessment where the hospital intended to seek improvement were:

- **Affordability**
- **Diabetes**
- **Obesity**
- **High blood pressure**
- **Primary care**

Comments or observations about this set of needs being the most appropriate for the hospital to take on in seeking improvements:

- **Should the hospital continue to consider each need identified as most important in the 2013 CHNA report as**

the most important set of health needs currently confronted residents in the county?

	Yes	No	No Opinion
Affordability	23	2	0
Diabetes	22	3	0
Obesity	22	3	0
High Blood Pressure	21	4	0
Primary Care	24	1	0

- **Specific comments or observations about affordability as being among the most significant needs for the hospital to work on to seek improvements:**
  - *People think that they can not access care if they do not have money. More education is needed.*
  - *I hope that this was addressed by Obamacare.*
  - *Affordability has not improved under Obamacare. Even insured patients have a heavy financial burden. People without insurance are usually that way because they can't afford it. If they can't afford insurance, then they certainly cannot afford basic healthcare costs. Also, since many cannot afford to pay the costs of healthcare, that puts the onus on those who can afford to do so (insurance companies and insured patients); inevitably, that pushes costs onto those who are paying.*
  - *Small group care/programs can help reduce cost. There are evidence based medical programs which focus on many of the abocelisted chronic diseases.*
  - *Doctors care is still out of reach for many residents because unemployment is very high and transportation is often a problem. I think affordability is definitely still a priority.*
  - *There is no easy answer to this problem. The hospital does a great job of providing charity care and other forms of assistance to combat the cost of healthcare. People simply cannot afford it.*
  - *Being uninsured means falling within a gap. A gap is b/c of earning enough to be above medicaid yet not enough to afford medical coverage. Therefore, affordability is a step the hospital can make to alleviate the costs to those uninsured.*
  - *Most important. If people are scared of costs they are going to incur if they go to doctor and avoid until a problemm becomes much worse and thus more expensive. Focusing your efforts on preventative care seems like a no brainer.*
  - *This is critical because a large portion of our County residents forsake care because of other bills.*
  - *The hospital is doing a good job in this area.*
  - *Everyone should have some form of access to Medicaid or some type of medical insurance. Affordability is very important because if the poor cannot purchase meds or see a physician they will continue to die an early death due to no medical insurance. Chances are if they don't have medical insurance they don't have life insurance, which is then a burden on the family that is already living in poverty.*
  - *None.*

- *By providing medical care to the uninsured, you are enabling them to break the LAW. Thank you President Obama.*
- *Access to care remains a high priority area; access in the right place at the right time can often prevent further deterioration of a condition and can actually result in lower costs to the individual and the health system. Access to care is also necessary to promote wellness or the ability of the individual to participate in their care needs; these factors can impact their ability to support themselves/family.*

- **Specific comments or observations about diabetes as being among the most significant needs for the hospital to work on to seek improvements:**
    - *The work being done is good.*
    - *As long as our society is in the midst of an obesity epidemic, then diabetes will remain a critical need. So many of the costs of healthcare are related to diabetes complications.*
    - *Similar to answer from 2 questions above. [Small group care/programs can help reduce cost. There are evidence based medical programs which focus on many of the abocelisted chronic diseases.]*
    - *People are still being diagnosed every day with diabetes due to lack of education in the rural communities.*
    - *the faith based community needs to be informed that they can play a significant role in educating people about Diabetes.*
    - *Again, think focus should be on the causes not the symptoms.*
    - *One way to help people who are suffering with diabetes is to keep them educated. The North Santee community center use to have a nurse come out once a month and speak the community on how to eat, exercise and take care of their bodies while living as a diabetic. I heard great things about this program but it no longer exists. Education is the best tool.*
    - *None.*
    - *Again, life choices about what you put in your mouth. This needs to be addressed from birth forward.*
    - *Management diabetes and the prevention of diabetes can impact many lagging indicators of health with significant cost and quality of life concerns.*
- **Specific comments or observations about obesity as being among the most significant needs for the Hospital to work on to seek improvements:**
    - *This is a major problem that seems to be part of the culture. I am not sure what can be done to change this.*
    - *I believe this to be the number one need that must be addresses. An enormous percentage of the overall costs of healthcare can be traced to complications arising from obesity.*
    - *This issue is complex. Regional attitudes and beliefs around nutrition and physical activity exacerbate the problem. Access, education and income disparity are problematic. It is difficult to provide quick healthy meals when your basic needs are unmet.*
    - *Obesity is still a big problem in the rural communities especially among teens and young adults. Obesity*

is a problem with adults and seniors as well, partly because they don't know the right foods to buy, they can't afford the right foods due to unemployment and other financial concerns and they often can't read the labels on foods.

  - *If you look at the root cause of diabetes and high blood pressure, it is often lifestyle related--and is often manifested as diabetes. Helping to create a culture of health in the county*
  - *Continue to educate the public.*
  - *Again, think focus should be on the causes not the symptoms.*
  - *Obesity is a growing problem in our community. In my own opinion people who can afford healthy food eat healthy. Those who can't afford to eat healthy eat what they can afford. WIC gives out vouchers for the farmers market but may people are not aware that they have this in place. Getting the word out and once again educating people will help with obesity in our community.*
  - *None.*
  - *Again, you are what you eat. Move more, eat less. How about having people take ownership for what they eat. Partner with gyms or other organizations to offer incentives for weight loss.*
  - *Obesity contributes to the development of many other health conditions; obesity can impact many lagging indicators of health with significant cost and quality of life concerns.*

- **Specific comments or observations about <u>high blood pressure</u> as being among the most significant needs for the hospital to work on to seek improvements:**
  - *All these problems are related and rooted in culture and social circumstances.*
  - *See comments on Diabetes / obesity. Even High Blood Pressure issues would diminish with an attendant decline in obesity.*
  - *The hospital is great at diagnosing, however treating through nutrition and exercise should be physicians goal versus medication. PARTNERS can provide programs and need direct referrals.*
  - *High blood pressure is still killing folks in the rural community. High blood pressure, obesity, strokes and heart attacks are on the rise.*
  - *Partnering with other community groups to educate public. Maybe install hbp machines in schools and encourage employers to do the same.*
  - *Again, think focus should be on the causes not the symptoms.*
  - *Need more health fairs.*
  - *Blacks develop high blood pressure more often, and at an earlier age, than whites and Hispanics do. More black women than men have high blood pressure. High blood pressure increases your risk for dangerous health conditions. Kidney disease is also a major risk factor for high blood pressure.*
  - *None.*
  - *No comment.*
  - *High blood pressure contributes to the development of many other health conditions which can impact*

many lagging indicators of health with significant cost and quality of life concerns.

- **Specific comments or observations about <u>primary care</u> as being among the most significant needs for the hospital to work on to seek improvements:**
  - *Primary Care access seems to have improved. Locations are convenient. I think the expansion of services is good and needs to continue.*
  - *If the hospital could be proactive at a local clinic level, then patients could be provided with resources that may prevent the identified issues of obesity, diabetes, and high blood pressure.*
  - *There are far too few doctors who are accessible in the rural communities. People still have to travel a good distance to see a primary care doctor. If a specialist is needed, most people have to travel to Charleston for care.*
  - *It is a significant need to educate people about the background of the employees that are*
  - *Again, access and preventative medicine are my themes here, so this seems like a very important investment by the community. Would love to see Tidelands take on Williamsburg County also. Know that is a huge leap but the problems are so great and Tidelands is such a leader that could very well help to make a HUGE difference in our counties. Having to literally wait months and months for an appointment that the doctor spends 5 minutes with you is RIDICULOUS. No wonder the medical practice field is the butt of so much angst and anger and cynicism. Also the loss of time for appointments that are directed to Charleston and other larger cities makes them almost impossible for the working class. I think having access to good doctors who have the time and don;t make you wait an hour or more for a scheduled appointment is vital in helping people want to go to the doctor instead of dreading nad avoiding it.*
  - *Primary care is the cornerstone of health care that is effective and efficient and meets the needs of patients, families, and communities.*
  - *None.*
  - *Not only more doctors, but quality doctors that people actually want to go and see.*
  - *Primary care should be the medical home for many of our community; this is an opportunity to identify risk and provide care pathways to improve health outcomes. This is an area the hospital has some influence over and should be an area of focus.*

3. **Comments and observations about the implementation actions of the hospital to seek health status improvement:**

- **Should the hospital continue to allocate resources to assist improving the needs?**

	Yes	No	No Opinion
Affordability	24	1	0
Diabetes	25	0	0
Obesity	24	1	0
High Blood Pressure	24	1	0
Primary Care	24	1	0

- **Specific comments and observations about the implementation actions of the hospital seeking improvement in affordability:**
    - *The hospital system can reallocate resources to clinics that can treat minor illnesses with less cost and greater effectiveness than the ER.*
    - *Partnerships. Will be important. Need to Identify funding sources, space, outreach methods.*
    - *If the Hospital could somehow provide transportation to the facility, I think more people would be helped. DHEC provides transportation to Charleston, but not to Georgetown and it quite often is a whole-day affair when patients have to go to Charleston.*
    - *A more inclusive population of people are needed to represent all areas of the community. Inform the community about statistics for the area in which they live.*
    - *It seems to me that if people were not scared about what an xray or a visit to a doctor or a blood test would cost there might be more access by the low income population. Heck, the well insured are fearful too! Better communication prior to procedures about costs and how a person can pay for it in a reasonable manner, better use of free and reduced services to areas that are lacking medical services on a more regular basis, more effort to be sought for a consolidaiton of resources or abuse of expensive resources like emergency rooms and high end medications. Better grasp of alternative medical choices. And the most important a focus on preventative and healthy living life styles.*
    - *The actions of the hospital need to be structured and consistent. The hospital has to make sure they are aware of the financial difficulties within the community.*
    - *None.*
    - *Figure out a way to insure them through the hospital.*
    - *Affordability of care can impact access to care in the right place at the right time; as stated in access this can often prevent further deterioration of a condition and can actually result in lower costs to the individual and the health system and can impact their ability to support themselves/family.*
- **Specific comments and observations about the implementation actions of the hospital seeking improvement in diabetes:**
    - *Expand the outreach.*
    - *Diabetes prevention and treatment must be addressed in conjunction with obesity-related health issues.*
    - *Small group behavior change programs are proven effective.*
    - *The Hospital needs to hire outreach workers to come into the communities to get first hand knowledge of the situation instead of trying to assess needs from behind a desk. It has been proven in the past that outreach workers who genuinely care about rural needs have made a difference in the community.*
    - *Children can be involved in educating adults. Invest in the future of the children. Work with the schools*
    - *Use of non-profits and health providers and schools, combining their resources around what the hospital is leading throughout its departments on every level. Helping have a collaborative approach to*

- *preventative medicine while dealing with chronic issues.*
  - *I'm encouraged that the hospital intends to make diabetes a community-wide effort and look forward to seeing as many partners as possible engaged in this work.*
  - *Patients need to learn how to watch their weight, eat healthy, Choose lean meats and lots of fresh veggies and cutting down on fats, starches, and sugary foods can help you stay on track. A dietitian can help put a meal plan together. Some people with diabetes think they won't ever be able to enjoy their favorite foods, but that's not true.*
  - *None.*
  - *Be more involved with what the schools are preparing for lunch and the education about how we are what we eat. This may bring some issues as most of the Southern Traditional diet is unhealthy.*
  - *Management diabetes and the prevention of diabetes can impact many lagging indicators of health with significant cost and quality of life concerns.*
- **Specific comments and observations about the implementation actions of the hospital seeking improvement in obesity:**
  - *I have not seen the hospital's involvement in reducing obesity out in the community. I would like to see the hospital undertake programs to get people moving more. The hospital should be a leader in this effort.*
  - *There should be some form of obesity intervention whenever the hospital encounters a patient who is obese or approaching obesity. There must be a strong message about the health risks of obesity. The hospital should bend over backwards to help any obese person who truly wants to change their condition.*
  - *Same as diabetes question [Small group behavior change programs are proven effective.]*
  - *Education is the key! Not everyone will make the necessary changes in their eating habits, but they tend to tell family members and friends about what they are learning.*
  - *the hospital can be very influential in helping to create a culture of health in the county*
  - *I believe the children and other non profits should be given incentives to incorporate this initiative into their strategic plans.*
  - *Use of non-profits and health providers and schools, combining their resources around what the hospital is leading throughout its departments on every level. Helping have a collaborative approach to preventative medicine while dealing with chronic issues.*
  - *Following a healthy lifestyle can help you prevent overweight and obesity. Many lifestyle habits begin during childhood. Thus, parents and families should encourage their children to make healthy choices, such as following a healthy diet and being physically active.*
  - *None.*
  - *No comment.*
  - *Obesity contributes to the development of many other health conditions; obesity can impact many*

lagging indicators of health with significant cost and quality of life concerns.

- **Specific comments and observations about the implementation actions of the hospital seeking improvement in <u>high blood pressure</u>:**
    - *Continuing outreach and programs like the Diabetes Core Group and other community centered programs are having an impact and need to be continued.*
    - *Health pathway with partners!*
    - *Again - Education regarding nutrition and exercise is the key.*
    - *Use of non-profits and health providers and schools, combining their resources around what the hospital is leading throughout its departments on every level. Helping have a collaborative approach to preventative medicine while dealing with chronic issues.*
    - *An unhealthy lifestyle will raise your blood pressure over time and the higher your blood pressure becomes, the higher your risk of having a stroke or heart attack in the future. Patients need to eat less salt and more fruits and veggies.*
    - *None.*
    - *No comment.*
    - *High blood pressure contributes to the development of many other health conditions which can impact many lagging indicators of health with significant cost and quality of life concerns.*
- **Specific comments and observations about the implementation actions of the hospital seeking improvement in <u>primary care</u>:**
    - *Doctors are being turned into clerks. The amount of time they are spending with patients is negatively impacted by the need to use electronic records. There has got to be a better way to get health information into the system than having highly educated and trained medical professionals spending hours a day typing.*
    - *Especially for the high-risk populations that have been identified, community health centers are vital. Not only would primary care be provided, but also a host of preventive services could be offered at low cost (certainly lower than when people use the ER as a walk-in clinic).*
    - *More satellite clinics like the Choppee Health Complex would be very helpful as a first stop for residents needing care.*
    - *In agreement with recruiting a higher quality of physicians for the area. Too many fears about being serviced at the Georgetwon site.*
    - *Not aware of this.*
    - *Care coordination, getting patients involved and educating patients will help improve doctors primary care.*
    - *None.*
    - *No comment.*

- *Primary care should be the medical home for many of our community; this is an opportunity to identify risk and provide care pathways to improve health outcomes. This is an area the hospital has some influence over and should be an area of focus.*

- **Do you have opinions about new or additional implementation efforts or community needs the hospital should pursue?**
  - *As noted previously, the needs of the aging population in each of these areas needs attention.*
  - *Mental health care providers are too few. The care of sickle cell disease, especially in young adults, needs greater priority than it has received in the past.*
  - *I believe the establishment of community health centers in areas that are underserved would be a more efficient way to treat minor sicknesses than using the ER as primary care alternative (which I perceive that many of the uninsured poor do).*
  - *Mental health Smoking*
  - *I feel like the Hospital should be more visible in the community and offer nutritional classes and other classes in the rural community to help residents with their health issues.*
  - *Create mobile health opportunities which can help overcome transportation barriers and improve access to care. Expand service hours of primary care as well.*
  - *Older adults need to have access to communities and human interactions to fight the deteriorating affects of isolation.*
  - *Outreach to rural communities*
  - *Not familiar with all the outreach efforts. Leading the community in health related matters whether related to the hospital or not seems to be a necessary priority. Our community needs to be educated on every level and understnad why the poor health of 30%+ of our population affects us all. I'd love to know best practices for reaching the priority populations and how we can make those work in our county.*
  - *More outreach information around the County on a quarterly basis.*
  - *I think the hospital has done a great job of addressing community needs.*
  - *I believe that Waccamaw Mental Health needs some improvement in our community. I also believe that we should somehow find a way to collaborate with the local recreation centers. Hopefully there can be some way to allow needy families to exercise with the use of exercising machines at a low cost or no cost.*
  - *No, not at this time.*
  - *The area needs a means of public transportation. This means regular bus/van route throughout the county. It is embarrassing that this county knows it is an issue, but no long term solutions are provided. It is not that difficult, many other progressive communities have a bus/van service. Even the service in Williamsburg County through their on demand services make Georgetown look like they are stuck in another century or even the ice age.*
  - *What efforts have been made to lower the Aids statistics?*

- **Finally, after thinking about our questions and the information we seek, is there any anything else you think important as we review and revise our thinking about significant health needs within the county?**
  - *Again, I think the important thing to think about is the aging population. Although Medicare is available, meny people still are unaware of the services that are available.*
  - *The transportation situation in this county is pitiful. I can't imagine how some people ever get to the doctor's office or the hospital without an ambulance.*
  - *I feel that arthritis and asthma, heart attack and stroke are on the rise and need to be addressed with education. Pancreatic cancer is another area that is not talked about very often and many times is not diagnosed until it is too late for effective treatment.*
  - *I think Tidelands does an outstanding job at providing care and access to all residents of Georgetown County. Please continue to be the innovative and caring hospital that you are.*
  - *Older adults need to have access to communities and human interactions to fight the deteriorating affects of isolation.*
  - *Educate the doctors and employees about the service population in the area. They should know who they are serving.*
  - *Mental Health and Drug and ALcohol treatments should be prioritized. Tiem after tiem after time I hear from different health partners, police officiers, school officials that our services in these two areas are severly lacking and need great attentionto help ease soem of the other chronic issues we are facing. And then scoping down to what are the root causes of so much mental health and drug and alcohol addiction in our area and working with community partners outside the health fields to address. Addressing symptoms will never cure the causes.*
  - *Access and affordability.*
  - *I think that we need to stay the course. The needs that have been identified require long term attention and solutions.*
  - *Improving health care for the poor and minorities will make a significant change in the lives of the residents in Georgetown County. When you focus on the poor and the minority one thing that you have to consider is that people who live in poverty sometimes need a change of heart and mind. knowledge is power. Some people with health care issues need to be educated*
  - *No, not at this time.*
  - *There are many communities with functioning public transportation. Besides providing the service, please consider the overall well being of the community and make it a priority.*
  - *Education of the appropriate usage of Emergency Department resources.*

Appendix B – Identification and Prioritization of Community Needs

Need Topic	Total Votes	Number of Local Experts Voting for Needs	Percent of Votes	Cumulative Votes	Need Determination
Affordability - 2013 Significant Need	306	16	14.57%	14.57%	Significant Needs
Mental Health	214	14	10.19%	24.76%	
Obesity - 2013 Significant Need	186	16	8.86%	33.62%	
Diabetes - 2013 Significant Need	177	17	8.43%	42.05%	
Physical Inactivity	174	10	8.29%	50.33%	
Primary Care - 2013 Significant Need	173	15	8.24%	58.57%	
Education/Prevention	166	14	7.90%	66.48%	Other Identified Needs
High Blood Pressure - 2013 Significant Need	131	14	6.24%	72.71%	
Compliance Behavior	98	10	4.67%	77.38%	
Substance Abuse	65	9	3.10%	80.48%	
Dental	53	8	2.52%	83.00%	
Smoking	52	6	2.48%	85.48%	
Alzheimer's	36	7	1.71%	87.19%	
Accidents	35	6	1.67%	88.86%	
Cancer	33	7	1.57%	90.43%	
Sexually Transmitted Infection	31	6	1.48%	91.90%	
Liver Disease	26	6	1.24%	93.14%	
Heart Disease	22	5	1.05%	94.19%	
Maternal Measures	21	6	1.00%	95.19%	
Kidney Disease	17	5	0.81%	96.00%	
Stroke	16	5	0.76%	96.76%	
Social Vulnerability	15	5	0.71%	97.48%	
Palliative Care	11	5	0.52%	98.00%	
Predisposing Conditions	10	5	0.48%	98.48%	
Cholesterol	8	4	0.38%	98.86%	
Unallocated Points	8	1	0.38%	99.24%	
Lung Disease	6	4	0.29%	99.52%	
Blood Poisoning	5	4	0.24%	99.76%	
Life Expectancy	5	4	0.24%	100.00%	
Total	2100		100.00%		

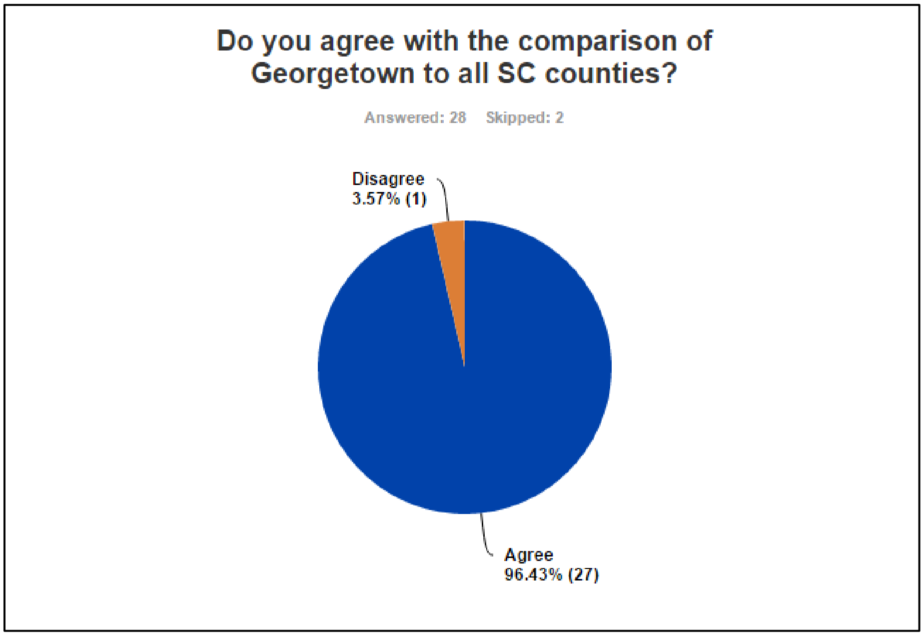
Individuals Participating as Local Expert Advisers[30]

Local Experts Offering Solicited Written Comments on 2013 Priorities and Implementation Strategy	Yes (Applies to Me)	No (Does Not Apply to Me)	Response Count
1) Public Health Expertise	7	12	19
2) Departments and Agencies with relevant data/information regarding health needs of the community served by the hospital	10	14	24
3) Priority Populations	8	12	20
4) Representative/Member of Chronic Disease Group or Organization	3	16	19
5) Represents the Broad Interest of the Community	19	5	24
Other			
Answered Question			30
Skipped Question			0

[30] Responds to IRS Schedule h (Form 990) Part V B 3 g

Advice Received from Local Expert Advisers

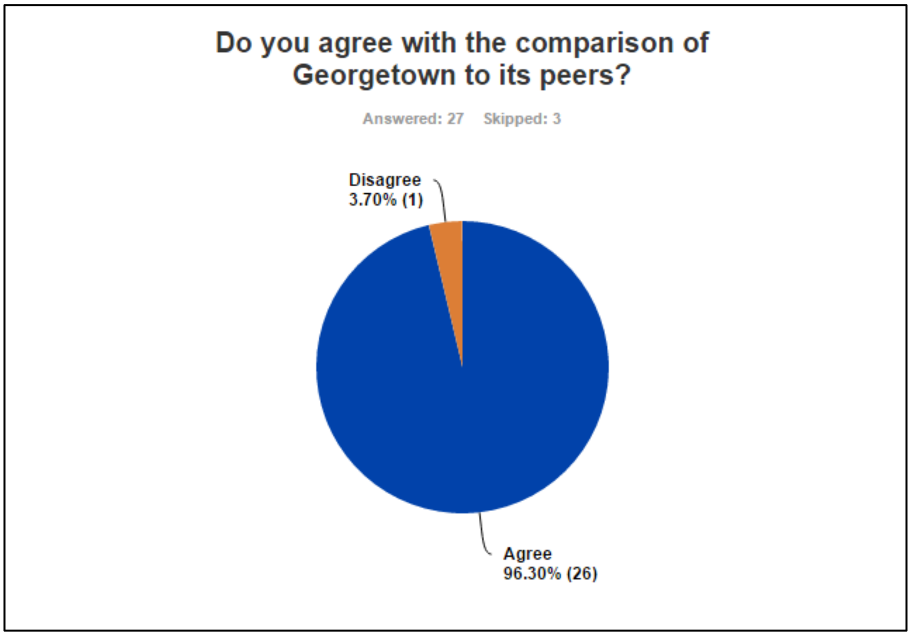
Question: **Do you agree with the observations formed about the comparison of Georgetown County to all other South Carolina counties?**



Comments:

- *AS A MEDICAL SOCIAL WORKER WHO HAS LIVED AND WORKED IN MICHIGAN AND DENVER, COLORADO, SOUTH CAROLINA IS A THIRD WORLD COUNTRY.THE RESOURCES FOR THE MINORITIES IN WILLIAMSBURG COUNTY IS ALMOST NON EXISTANT UNLESS YOU RECEIVE MEDICAID .*
- *I strongly agree with the "Clinical Care" outcomes because I work with this population on a daily basis.*
- *These figures would all be significantly different if the Waccamaw Neck were analyzed separate from the rest of the county.*

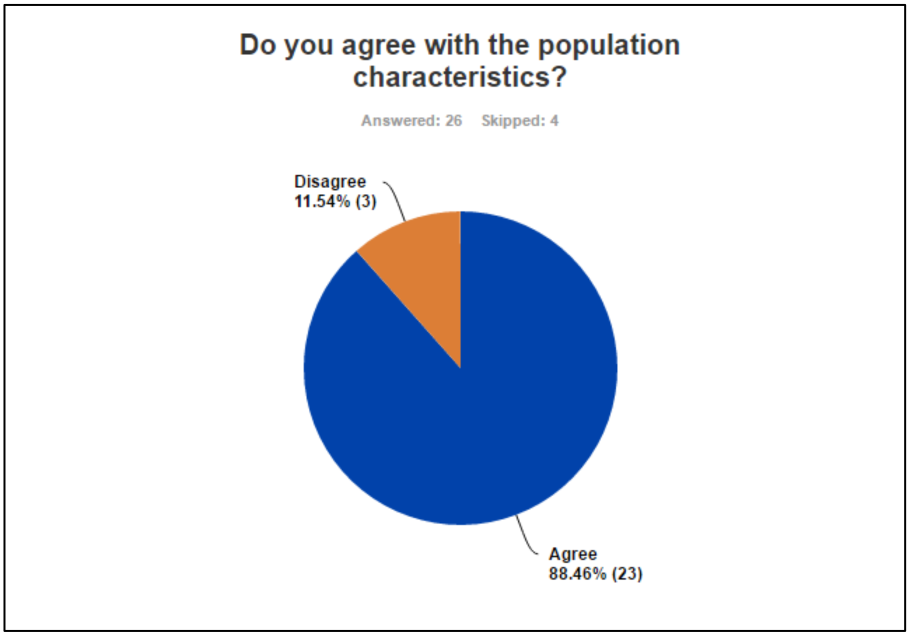
Question: **Do you agree with the observations formed about the comparison of Georgetown County to its peer counties?**



Comments:

- *TRANSPORTATION IS A HUGH ISSUE FOR ALL THE ABOVE. IF THERE WERE JOBS , THERE IS NO TRANSPORTATION.*
- *The lack of employment opportunities in G'town County result in a higher level of poverty, food instability, and crime. This is the Trifecta for poor health*
- *I was surprised by the violent crime rate in the county.*

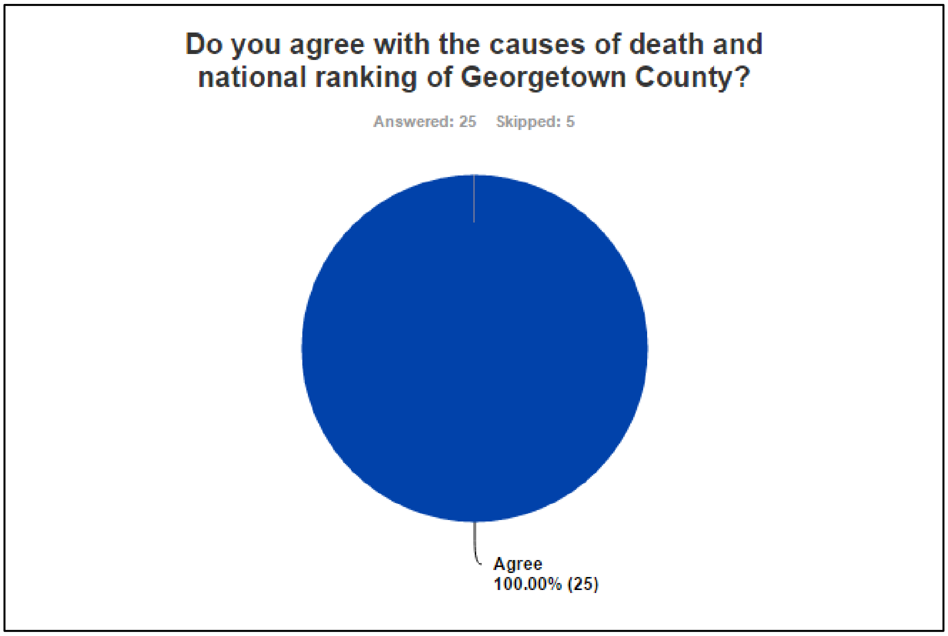
Question: **Do you agree with the observations formed about the population characteristics of Georgetown County?**



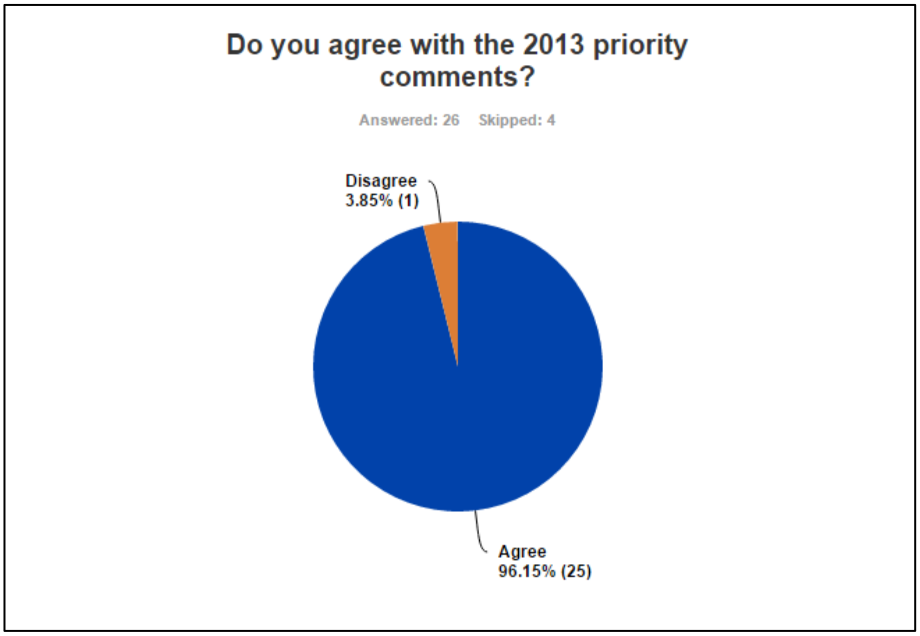
Comments:

- *THE GEORGETOWN AREA HAS VERY FEW PARKS TO TAKE KIDS, NO BIKE PATHS, NO SIDEWALKS , NO STREET LIGHTS, AND NO TRANSPORTATION, JOBS OR MANY OTHER NECESSITIES OF HEALTHY LIVING.*
- *I am a little surprised at the low alcohol consumption and a higher than average prostate screening. Otherwise I agree with all of the statements.*
- *I think it is important to include information/analysis of Horry County as well; the service area for Tidelands Health includes a growing presence in Horry County.*
- *question population growth projections for county - anticipate continued growth on the "neck" as well as growth from the south (Charleston area)*
- *Our patients do not get cervical cancer screening on a regular basis, despite knowing that we offer this service. Many of our patients do not adhere to treatment plans. Most of our patients do not exercise and tell me that they do not have access to exercise (cant afford a gym, no transportation, do not live in a safe enough place to walk outside)*

Question: **Do you agree with the observations formed from the national ranking and leading causes of death?**



Question: **Do you agree with the written comments received on the 2013 CHNA?**



Comments:

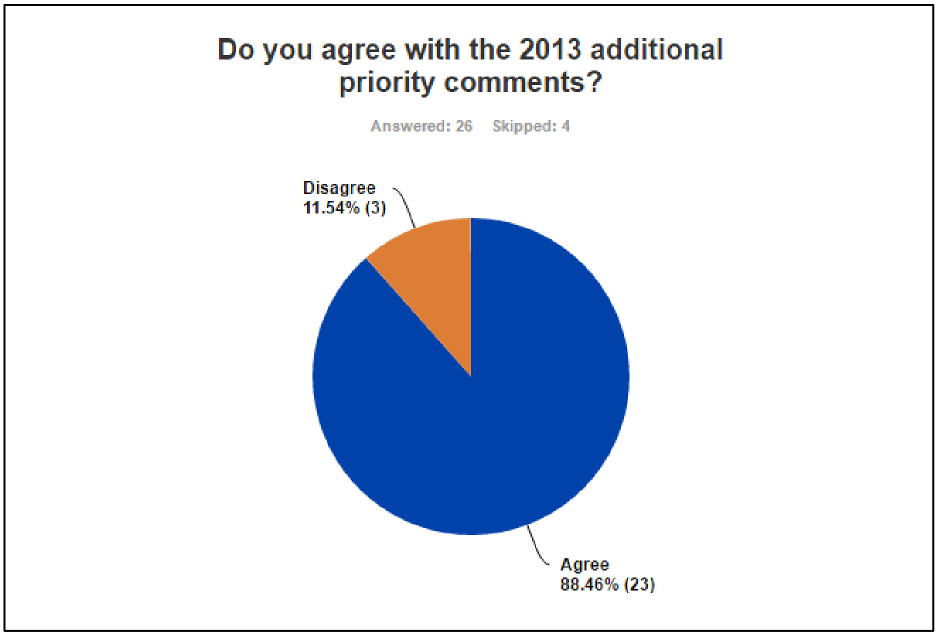
- *Georgetown has to take some bold steps to challenge the system to change outcomes. This will involve creating new opportunities for disadvantaged youth that prevent them from falling into the destructive cycles of their community. Creating a physical literacy and active culture with youth can positively impact education, health, and future income potential. This needs to be understood and made a priority of all local leadership that control the resources and interacts with the citizens. Health=>Community Devlopment=>Economic Prosperity. But Tidelands has to take the lead. Treating the symptoms of the communities health issues is unsustainable on the path Georgetown Co. is following and everyone will suffer it we don't make changes.*

- *All issues mentioned above are important items of need. In order as I see these items. 1. Mental Health 2. Care of the elderly 3. Community outreach services 4. I am not sure about offering public transportation; our county is wide with road problems plus other dilemmas.*

- *I believe that the hospital is doing a great job. I also agree that Waccamaw mental needs some improvements with their clients.*

- *I believe there should be a greater effort made in bringing awareness to heath care, in particular having a physician.*

Question: **Do you agree with the additional written comments received on the 2013 CHNA?**



Comments:

- *I feel that all areas mentioned above need equal attention.*
- *Behavioral/Mental Health should be included communities priorities.*

Appendix C – Additional Comments from Community Meetings

Question: What is going on in the community? What are you proud of?

Comments:

- *Medicare can cover most needs if a person knows about and can afford a supplemental plan*
- *The diabetes educator of a local FQHC recently taught gardening to a 48-apartment senior HUD housing complex. This has been a huge asset and people are now growing their own vegetables.*
- *Food pantries in many food deserts (although they have only canned/boxed food items). Vegetable gardens are becoming more common in Pawleys Island, and a local food pantry has a vegetable garden. Many food pantries, especially in Georgetown County.*
- *A large church in Pawleys island has a playground, and whole families often use this as a safe active space.*
- *Resources for food, clothes, hot meals, help with utility bills. Donations from local grocery stores are delivered to people's homes (but is mostly unhealthy food, mostly breads and cakes).*

Question: What do you see as the biggest health challenge facing the community?

Comments:

- *Health education regarding diet and general health literacy is lacking in the elderly. This is compounded by the tendency for individuals who are elderly to be resistant to changing habits.*
- *Young people (20's/30's) stay on the periphery of society due to past or present substance abuse issues. Need greater access to and awareness of services for low-income young people for substance abuse.*
- *Young people (20's/30's) usually don't have health insurance, even if they are working. Need greater access to and awareness of affordable healthcare for low-income young people.*
- *There is a large group of community members who are no longer working, but who are not old enough for Medicare. These individuals fall through the cracks and may not have income or health insurance.*
- *Insurance is expensive, as are the co-pays. Many services that are needed are not covered by insurance (like Marketplace plans).*
- *Transportation is the biggest challenge facing the community's health. The Bureau of Aging ran out of funding for transportation.*
- *No access to neurology in the area*
- *Housing for seniors and low-income individuals/families (senior HUD housing here has 71 people on the waitlist for a 48-apartment organization.*
- *No services for special needs adults who don't quite fit into independent living. Need skills training for this group.*
- *Adult day care used to be offered in the community, but isn't any longer. This is now an area of need.*
- *There used to be a free community pool in the Pawleys Island area (the closest YMCA is at least 25 minutes away by car), but the pool has been closed for quite some time. Community children no longer have a space to play,*

which decreases the access to exercise.

- *Many food deserts in Georgetown and Horry county. Limited food pantries in some areas.*
- *Many travelers/snow birds come to Myrtle Beach and get stuck. Homelessness is on the rise. There are not many resources for a person who is transient. (Can't cook the food from the food pantry, nowhere to stay other than their car, if they have one, no emergency housing.) For residents, they often stay with friends or family, but are unable to contribute to the household needs and must move on. Supplying rent money is too risky for many area agencies.*
- *Mental health services: lacking throughout both counties. There are no services at all on the Waccamaw Neck (Pawleys Island and surrounding area). Services are in Georgetown or Conway.*
- *Many people (insured or not) do not go to the doctor because they do not think they're sick.*
- *People on fixed income (elderly and disabled) cannot pay for medications because money runs out*
- *Not much in the community to keep the youth active (pick-up sports and places to do this)*
- *Food bank food is not healthy food*
- *Affordable insurance is greatest need, and insurance that covers specialized treatments (like infusions for rheumatoid arthritis when nothing else has helped)*
- *Education to young people (20's) for programs that they may be eligible for.*
- *Promote health education: you can't do better if you don't know better.*
- *For senior citizens, teaching new skills like crocheting. Use those blankets and clothing for foster kids, which would give the elderly a purpose. Find younger senior citizens to transport older senior citizens. Need more senior activities, as many elderly people are isolated in their homes. Make them needed.*
- *Young people are using the emergency room for non-emergencies because they can't get into the PCP. Educate people about programs and opportunities. Educate on basic medical practices (for example: when you get a prescription, take it to the pharmacy). African Americans may not ask anyone who is white questions about what to do with a script. They may be less likely to confess that they are illiterate because they may feel judged. Cultural competency training to use each culture's lingo and language.*
- *Educational posters can be made by children and posted in the community churches.*
- *Specifically for the Hispanic community:*
- *Transportation less of a barrier*
- *Language is the main barrier.*
- *In the case where there are mental health problems, a person cannot communicate to their psychiatrist, and using an interpreter is difficult for such a private and complex topic.*
- *Prescription labels are printed in English*
- *Due to immigration status, people cannot get insurance*
- *Many places in the community do not accept the ID's that people have from their countries and require state*

ID's. This is a barrier at pharmacies (specifically Wal-Mart). People must take a friend with a US ID to get prescriptions.

- *Regardless of socioeconomic status, many people are lacking skills to navigate a system in order for them to get their needs met. Education could be increased in local skills on how to do "adult" tasks. How to write a check at the bank, how to get a prescription filled, how to make a doctor's appointment, when to make a follow-up appointment, what to take to the appointment. Smaller community could equal big change. People avoid these tasks due to fear of the unknown.*
- *Thought: how do we educate policy makers and health systems on the best way to spend their money?*
- *Education on aging, and what the options are when a person can no longer take care of themselves. Education could be done in churches and schools, and is appropriate for all socioeconomic levels.*
- *Affordable housing, emergency housing, transportation, mental health services, affordable insurance (these themes were repeated at the end as "main areas of need")*

Question: Over the last five years, would you say the health of this community has improved or declined? Can you give me some examples?

Comments:

- *Improved: new senior center (which needs to be utilized more). People are starting to work together.*
- *Declined: people are getting older and don't have the resources to deal with this. (specifically in the Hispanic community)*
- *Declined: people have given up because there were no resources.*
- *No change: church health fairs have helped to educate people. But there are no follow-through programs. An event is not as impactful as a series would be.*
- *Improved: Smith Medical Clinic has had a great effect in the community on education people how to take responsibility for their health.*
- *Improved*
- *Improved: increased education in churches*
- *No change*
- *No change: the quality of food in schools has drastically increased and serves much healthier options. But the food is not being eaten, and is thrown away. People culturally do not want it. Policy has improved, but habits have not. And now kids are coming home hungry. Be mindful of culture.*
- *Healthcare and school nutrition have become political issues, which is standing in the way of improvement.*

Question: Do you believe community members take responsibility for their own wellness and health? Please give examples.

Comments:

- *Only if it's an emergency*
- *By the time a person realizes that they should have taken care of themselves, they are dying*
- *Hispanic representative: No. diet is a big factor, and a lot of food is fried and corn. This is the culture of their community.*
- *Only when it's a crisis and a matter of survival. It's easy to think about other things (healthier eating) when a person is not in crisis, but they are not interested at that time.*
- *No: parents particularly struggle with this because they are so busy*
- *No. The youth especially do not, as they wait until they are in crisis mode and depend on other people to pay for services.*

Question: How do people get their health knowledge?

Comments:

- *From neighbors/friends*
- *A local food pantry (Baskervill) that gives out vegetables*

Additional comments from community meetings:

- *Missing specialists (example, Neurologists) within the Community.*
    - *The system is big enough that we should always have one*
    - *Have a back-up plan already in place (ex., provide transportation to next town)*
- *Transportation*
    - *Volunteers just don't work – have an "uber" situation*
    - *Tidelands has busses for community – or work with the present bus system*
- *Education*
    - *Work with Dr. Dozier in the school system to provide knowledge, "life program"*
    - *There are now 4 senior centers in the county run by Parks & Rec- join up with them*
    - *Teach about SC Thrive and have available in centers*
- *Mental Health*
    - *Have awareness drives – put it out there – "shove" it down our throats*

- *Tidelands and all pharmacies work together*
- *Create “safe” places to go for help – joint with Sheriff, Fire and hospitals/clinics*

- *Financial Resources*
  - *Make sure poor are not forgotten*
  - *Billing doesn’t drive them crazy with threats and phone calls*
  - *Make sure all billing is correct and insurance/resources are used to maximum*

Appendix D – National Healthcare Quality and Disparities Report

The National Healthcare Quality and Disparities Reports (QDR) 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 our 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 reports are based on more than 250 measures of quality and disparities covering a broad array of healthcare services and settings. Data is generally available through 2012, although rates of un-insurance have been tracked through the first half of 2014. The reports are produced with the help of an Interagency Work Group led by the Agency for Healthcare Research and Quality (AHRQ) and submitted on behalf of the Secretary of Health and Human Services (HHS).

Beginning with this 2014 report, findings on healthcare quality and healthcare disparities are integrated into a single document. This new National Healthcare Quality and Disparities Report (QDR) highlights the importance of examining quality and disparities together to gain a complete picture of healthcare. This document is also shorter and focuses on summarizing information over the many measures that are tracked; information on individual measures will still be available through chartbooks posted on the Web (www.ahrq.gov/research/findings/nhqrdr/2014chartbooks/).

The key findings of the 2014 QDR are organized around three axes: access to healthcare, quality of healthcare, and NQS priorities.

To obtain high-quality care, Americans must first gain entry into the healthcare system. Measures of access to care tracked in the QDR include having health insurance, having a usual source of care, encountering difficulties when seeking care, and receiving care as soon as wanted. Historically, Americans have experienced variable access to care based on race, ethnicity, socioeconomic status, age, sex, disability status, sexual orientation, and residence location.

ACCESS: After years without improvement, the rate of un-insurance among adults ages 18-64 decreased substantially during the first half of 2014.

The Affordable Care Act is the most far-reaching effort to improve access to care since the enactment of Medicare and Medicaid in 1965. Provisions to increase health insurance options for young adults, early retirees, and Americans with pre-existing conditions were implemented in 2010. Open enrollment in health insurance marketplaces began in October 2013 and coverage began in January 2014. Expanded access to Medicaid in many states began in January 2014, although a few had opted to expand Medicaid earlier.

Trends

- From 2000 to 2010, the percentage of adults ages 18-64 who reported they were without health insurance coverage at the time of interview increased from 18.7% to 22.3%.
- From 2010 to 2013, the percentage without health insurance decreased from 22.3% to 20.4%.
- During the first half of 2014, the percentage without health insurance decreased to 15.6%.

- Data from the Gallup-Healthways Well-Being Index indicate that the percentage of adults without health insurance continued to decrease through the end of 2014,[31] consistent with these trends.

ACCESS: Between 2002 and 2012, access to health care improved for children but was unchanged or significantly worse for adults.

Trends

- From 2002 to 2012, the percentage of people who were able to get care and appointments as soon as wanted improved for children but did not improve for adults ages 18-64.

Disparities

- Children with only Medicaid or CHIP coverage were less likely to get care as soon as wanted compared with children with any private insurance in almost all years.
- Adults ages 18-64 who were uninsured or had only Medicaid coverage were less likely to get care as soon as wanted compared with adults with any private insurance in all years.

Trends

- Through 2012, most access measures improved for children. The median change was 5% per year.
- Few access measures improved substantially among adults. The median change was zero.

ACCESS DISPARITIES: During the first half of 2014, declines in rates of un-insurance were larger among Black and Hispanic adults ages 18-64 than among Whites, but racial differences in rates remained.

Trends

- Historically, Blacks and Hispanics have had higher rates of un-insurance than Whites.[32]

Disparities

- During the first half of 2014, the percentage of adults ages 18-64 without health insurance decreased more quickly among Blacks and Hispanics than Whites, but differences in un-insurance rates between groups remained.
- Data from the Urban Institute's Health Reform Monitoring System indicate that between September 2013 and September 2014, the percentage of Hispanic and non-White non-Hispanic adults ages 18-64 without health insurance decreased to a larger degree in states that expanded Medicaid under the Affordable Care Act than in states that did not expand Medicaid.[33]

ACCESS DISPARITIES: In 2012, disparities were observed across a broad spectrum of access measures. People in poor households experienced the largest number of disparities, followed by Hispanics and Blacks.

Disparities

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[31] Levy J. In U.S., Uninsured Rate Sinks to 12.9%. http://www.gallup.com/poll/180425/uninsured-rate-sinks. aspx.
[32] In this report, racial groups such as Blacks and Whites are non-Hispanic, and Hispanics include all races.
[33] Long SK, Karpman M, Shartzer A, et al. Taking Stock: Health Insurance Coverage under the ACA as of September 2014. http://hrms.urban.org/briefs/Health-Insurance-Coverage-under-the-ACA-as-of- September-2014.html

- In 2012, people in poor households had worse access to care than people in high-income households on all access measures (green).
- Blacks had worse access to care than Whites for about half of access measures.
- Hispanics had worse access to care than Whites for two-thirds of access measures.
- Asians and American Indians and Alaska Natives had worse access to care than Whites for about one-third of access measures.

ACCESS DISPARITIES: Through 2012, across a broad spectrum of access measures, some disparities were reduced but most did not improve.

Disparity Trends

- Through 2012, most disparities in access to care related to race, ethnicity, or income showed no significant change (blue), neither getting smaller nor larger.
- I n four of the five comparisons shown above, the number of disparities that were improving (black) exceeded the number of disparities that were getting worse (green).

QUALITY: Quality of health care improved generally through 2012, but the pace of improvement varied by measure.

Trends

- Through 2012, across a broad spectrum of measures of health care quality, 60% showed improvement (black).
- Almost all measures of Person-Centered Care improved.
- About half of measures of Effective Treatment, Healthy Living, and Patient Safety improved.
- There are insufficient numbers of reliable measures of Care Coordination and Care Affordability to summarize in this way.

QUALITY: Through 2012, the pace of improvement varied across NQS priorities.

Trends

- Through 2012, quality of health care improved steadily but the median pace of change varied across NQS priorities:
  - Median change in quality was 3.6% per year among measures of Patient Safety.
  - Median improvement in quality was 2.9% per year among measures of Person-Centered Care.
  - Median improvement in quality was 1.7% per year among measures of Effective Treatment.
  - Median improvement in quality was 1.1% per year among measures of Healthy Living.
  - There were insufficient data to assess Care Coordination and Care Affordability.

QUALITY: Publicly reported CMS measures were much more likely than measures reported by other sources to achieve high levels of performance.

Achieved Success

Eleven quality measures achieved an overall performance level of 95% or better this year. At this level, additional improvement is limited, so these measures are no longer reported in the QDR. Of measures that achieved an overall performance level of 95% or better this year, seven were publicly reported by CMS on the Hospital Compare website (italic).

- *Hospital patients with heart attack given percutaneous coronary intervention within 90 minutes*
- Adults with HIV and CD4 cell count of 350 or less who received highly active antiretroviral therapy during the year
- *Hospital patients with pneumonia who had blood cultures before antibiotics were administered*
- *Hospital patients age 65+ with pneumonia who received pneumococcal screening or vaccination*
- *Hospital patients age 50+ with pneumonia who received influenza screening or vaccination*
- *Hospital patients with heart failure and left ventricular systolic dysfunction who were prescribed angiotensin-converting enzyme or angiotensin receptor blocker at discharge*
- *Hospital patients with pneumonia who received the initial antibiotic dose consistent with current recommendations*
- *Hospital patients with pneumonia who received the initial antibiotic dose within 6 hours of arrival*
- Adults with HIV and CD4 cell counts of 200 or less who received Pneumocystis pneumonia prophylaxis during the year
- People with a usual source of care for whom health care providers explained and provided all treatment options
- Hospice patients who received the right amount of medicine for pain management

Last year, 14 of 16 quality measures that achieved an overall performance level of 95% or better were publicly reported by CMS. Measures that reach 95% and are no longer reported in the QDR continue to be monitored when data is available to ensure that they do not fall below 95%.

Improving Quickly

Through 2012, a number of measures showed rapid improvement, defined as an average annual rate of change greater than 10% per year. Of these measures that improved quickly, four are adolescent vaccination measures (italic).

- *Adolescents ages 16-17 years who received 1 or more doses of tetanus-diphtheria-acellular pertussis vaccine*
- *Adolescents ages 13-15 years who received 1 or more doses of tetanus-diphtheria-acellular pertussis vaccine*
- Hospital patients with heart failure who were given complete written discharge instructions
- *Adolescents ages 16-17 years who received 1 or more doses of meningococcal conjugate vaccine*
- *Adolescents ages 13-15 years who received 1 or more doses of meningococcal conjugate vaccine*
- Patients with colon cancer who received surgical resection that included 12+ lymph nodes pathologically examined
- Central line-associated bloodstream infection per 1,000 medical and surgical discharges, age 18+ or obstetric admissions

- Women with Stage I-IIb breast cancer who received axillary node dissection or sentinel lymph node biopsy at time of surgery

Worsening

Through 2012, a number of measures showed worsening quality. Of these measures that showed declines in quality, three track chronic diseases (italic). Note that these declines occurred prior to implementation of most of the health insurance expansions included in the Affordable Care Act.

- Maternal deaths per 100,000 live births
- Children ages 19-35 months who received 3 or more doses of Haemophilus influenzae type b vaccine
- People who indicate a financial or insurance reason for not having a usual source of care
- Suicide deaths per 100,000 population
- Women ages 21-65 who received a Pap smear in the last 3 years
- *Admissions with diabetes with short-term complications per 100,000 population, age 18+*
- *Adults age 40+ with diagnosed diabetes who had their feet checked for sores or irritation in the calendar year*
- Women ages 50-74 who received a mammogram in the last 2 years
- Postoperative physiologic and metabolic derangements per 1,000 elective-surgery admissions, age 18+
- *People with current asthma who are now taking preventive medicine daily or almost daily*
- People unable to get or delayed in getting needed medical care, dental care, or prescription medicines due to financial or insurance reasons

QUALITY DISPARITIES: Disparities remained prevalent across a broad spectrum of quality measures. People in poor households experienced the largest number of disparities, followed by Blacks and Hispanics.

Disparities

- People in poor households received worse care than people in high-income households on more than half of quality measures (green).
- Blacks received worse care than Whites for about one-third of quality measures.
- Hispanics, American Indians and Alaska Natives, and Asians received worse care than Whites for some quality measures and better care for some measures.
- For each group, disparities in quality of care are similar to disparities in access to care, although access problems are more common than quality problems.

QUALITY DISPARITIES: Through 2012, some disparities were getting smaller but most were not improving across a broad spectrum of quality measures.

Disparity Trends

- Through 2012, most disparities in quality of care related to race, ethnicity, or income showed no significant change (blue), neither getting smaller nor larger.

- When changes in disparities occurred, measures of disparities were more likely to show improvement (black) than decline (green). However, for people in poor households, more measures showed worsening disparities than improvement.

QUALITY DISPARITIES: Through 2012, few disparities in quality of care were eliminated while a small number became larger.

Disparities Trends

- Through 2012, several disparities were eliminated.
    - One disparity in vaccination rates was eliminated for Blacks (measles-mumps-rubella), Asians (influenza), American Indians and Alaska Natives (hepatitis B), and people in poor households (human papillomavirus).
    - Four disparities related to hospital adverse events were eliminated for Blacks.
    - Three disparities related to chronic diseases and two disparities related to communication with providers were eliminated for Asians.
    - On the other hand, a few disparities grew larger because improvements in quality for Whites did not extend uniformly to other groups.
    - At least one disparity related to hospice care grew larger for Blacks, American Indians and Alaska Natives, and Hispanics.
    - People in poor households experienced worsening disparities related to chronic diseases.

QUALITY DISPARITIES: Overall quality and racial/ethnic disparities varied widely across states and often not in the same direction.

Geographic Disparities

- There was significant variation in quality among states. There was also significant variation in disparities.
- States in the New England, Middle Atlantic, West North Central, and Mountain census divisions tended to have higher overall quality while states in the South census region tended to have lower quality.
- States in the South Atlantic, West South Central, and Mountain census divisions tended to have fewer racial/ethnic disparities while states in the Middle Atlantic, West North Central, and Pacific census divisions tended to have more disparities.
- The variation in state performance on quality and disparities may point to differential strategies for improvement.

National Quality Strategy: Measures of Patient Safety improved, led by a 17% reduction in hospital-acquired conditions.

Hospital-acquired conditions have been targeted for improvement by the CMS Partnership for Patients initiative, a major public-private partnership working to improve the quality, safety, and affordability of health care for all Americans. As a result of this and other federal efforts, such as Medicare's Quality Improvement Organizations and the HHS National Action Plan to Prevent Health Care-Associated Infections, as well as the dedication of practitioners, the general trend in patient safety is one of improvement.

Trends

- From 2010 to 2013, the overall rate of hospital-acquired conditions declined from 145 to 121 per 1,000 hospital discharges.
- This decline is estimated to correspond to 1.3 million fewer hospital-acquired conditions, 50,000 fewer inpatient deaths, and $12 billion savings in health care costs.[34]
- Large declines were observed in rates of adverse drug events, healthcare-associated infections, and pressure ulcers.
- About half of all Patient Safety measures tracked in the QDR improved.
- One measure, admissions with central line-associated bloodstream infections, improved quickly, at an average annual rate of change above 10% per year.
- One measure, postoperative physiologic and metabolic derangements during elective-surgery admissions, got worse over time.

Disparities Trends

- Black-White differences in four Patient Safety measures were eliminated.
- Asian-White differences in admissions with iatrogenic pneumothorax grew larger.

National Quality Strategy: Measures of Person-Centered Care improved steadily, especially for children.

Trends

- From 2002 to 2012, the percentage of children whose parents reported poor communication significantly decreased overall and among all racial/ethnic and income groups.
- Almost all Person-Centered Care measures tracked in the QDR improved; no measure got worse.

Disparities

In almost all years, the percentage of children whose parents reported poor communication with their health providers was:

- Higher for Hispanics and Blacks compared with Whites.
- Higher for poor, low-income, and middle-income families compared with high-income families.

Disparities Trends

- Asian-White differences in two measures related to communication were eliminated.
- Four Person-Centered Care disparities related to hospice care grew larger.

National Quality Strategy: Measures of Care Coordination improved as providers enhanced discharge processes and adopted health information technologies.

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[34] Agency for Healthcare Research and Quality. Interim Update on 2013 Annual Hospital-Acquired Condition Rate and Estimates of Cost Savings and Deaths Averted From 2010 to 2013. http://www.ahrq.gov/professionals/quality-patient-safety/pfp/interimhacrate2013.html

Trends

- From 2005 to 2012, the percentage of hospital patients with heart failure who were given complete written discharge instructions increased overall, for both sexes, and for all racial/ethnic groups.
- There are few measures to assess trends in Care Coordination.

Disparities

- In all years, the percentage of hospital patients with heart failure who were given complete written discharge instructions was lower among American Indians and Alaska Natives compared with Whites.

National Quality Strategy: Many measures of Effective Treatment achieved high levels of performance, led by measures publicly reported by CMS on Hospital Compare.

Trends

- From 2005 to 2012, the percentage of hospital patients with heart attack given percutaneous coronary intervention within 90 minutes of arrival increased overall, for both sexes, and for all racial/ethnic groups.
- In 2012, the overall rate exceeded 95%; the measure will no longer be reported in the QDR.
- Eight other Effective Treatment measures achieved overall performance levels of 95% or better this year, including five measures of pneumonia care and two measures of HIV care.
- About half of all Effective Treatment measures tracked in the QDR improved.
- Two measures, both related to cancer treatment, improved quickly, at an average annual rate of change above 10% per year.
- Three measures related to management of chronic diseases got worse over time.

Disparities

- As rates topped out, absolute differences between groups became smaller. Hence, disparities often disappeared as measures achieved high levels of performance.

Disparities Trends

- Asian-White differences in three chronic disease management measures were eliminated but income-related disparities in two measures related to diabetes and joint symptoms grew larger.

National Quality Strategy: Healthy Living improved in about half of the measures followed, led by selected adolescent vaccines from 2008 to 2012.

Trends

- From 2008 to 2012, the percentage of adolescents ages 16-17 years who received 1 or more doses of meningococcal conjugate vaccine increased overall, for residents of both metropolitan and nonmetropolitan areas, and for all income groups.
- About half of all Healthy Living measures tracked in the QDR improved.

- Four measures, all related to adolescent immunizations, improved quickly, at an average annual rate of change above 10% per year (meningococcal vaccine ages 13-15 and ages 16-17; tetanusdiphteria-acellular pertussis vaccine ages 13-15 and ages 16-17).
- Two measures related to cancer screening got worse over time.

Disparities

- Adolescents ages 16-17 in nonmetropolitan areas were less likely to receive meningococcal conjugate vaccine than adolescents in metropolitan areas in all years.
- Adolescents in poor, low-income, and middle-income households were less likely to receive meningococcal conjugate vaccine than adolescents in high-income households in almost all years.

Disparities Trends

- Four disparities related to child and adult immunizations were eliminated.
- Black-White differences in two Healthy Living measures grew larger.

National Quality Strategy: Measures of Care Affordability worsened from 2002 to 2010 and then leveled off.

From 2002 to 2010, prior to the Affordable Care Act, care affordability was worsening. Since 2010, the Affordable Care Act has made health insurance accessible to many Americans with limited financial resources.

Trends

- From 2002 to 2010, the overall percentage of people unable to get or delayed in getting needed medical care, dental care, or prescription medicines and who indicated a financial or insurance reason rose from 61.2% to 71.4%.
- From 2002 to 2010, the rate worsened among people with any private insurance and among people from high- and middle-income families; changes were not statistically significant among other groups.
- After 2010, the rate leveled off, overall and for most insurance and income groups.
- Data from the Commonwealth Fund Biennial Health Insurance Survey indicate that cost-related problems getting needed care fell from 2012 to 2014 among adults.[35]
- Another Care Affordability measure, people without a usual source of care who indicate a financial or insurance reason for not having a source of care, also worsened from 2002 to 2010 and then leveled off.
- There are few measures to assess trends in Care Affordability.

Disparities

- In all years, the percentage of people unable to get or delayed in getting needed medical care, dental care, or prescription medicines who indicated a financial or insurance reason for the problem was:

[35] Collins SR, Rasmussen PW, Doty MM, et al. The Rise in Health Care Coverage and Affordability Since Health Reform Took Effect: Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2014. http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2015/jan/1800_collins_biennial_survey_brief.pdf?la=en

- Higher among uninsured people and people with public insurance compared with people with any private insurance.
- Higher among poor, low-income, and middle-income families compared with high-income families.

CONCLUSION

The 2014 Quality and Disparities Reports demonstrate that access to care improved. After years of stagnation, rates of un-insurance among adults decreased in the first half of 2014 as a result of Affordable Care Act insurance expansion. However, disparities in access to care, while diminishing, remained.

Quality of healthcare continued to improve, although wide variation across populations and parts of the country remained. Among the NQS priorities, measures of Person-Centered Care improved broadly. Most measures of Patient Safety, Effective Treatment, and Healthy Living also improved, but some measures of chronic disease management and cancer screening lagged behind and may benefit from additional attention. Data to assess Care Coordination and Affordable Care were limited and measurement of these priorities should be expanded.

Appendix E – Illustrative Schedule h (Form 990) Part V B Potential Response

Illustrative IRS Schedule h Part V Section B (Form 990)[36]

Community Health Need Assessment Illustrative Answers

1. **Was the hospital facility first licensed, registered, or similarly recognized by a State as a hospital facility in the current tax year or the immediately preceding tax year?**

   No

2. **Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C**

   No

3. **During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12. If "Yes," indicate what the CHNA report describes (check all that apply)**

   a. **A definition of the community served by the hospital facility**

      See footnotes 17 and 18 on page 13

   b. **Demographics of the community**

      See footnote 19 on page 14

   c. **Existing health care facilities and resources within the community that are available to respond to the health needs of the community**

      See footnote 25 on page 46 and footnote 26 on page 52

   d. **How data was obtained**

      See footnote 11 on page 9

   e. **The significant health needs of the community**

      See footnote 24 on page 45

   f. **Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups**

      See footnote 12 on page 10

   g. **The process for identifying and prioritizing community health needs and services to meet the community health needs**

      See footnote 30 on page 78

   h. **The process for consulting with persons representing the community's interests**

      See footnotes 8 and 9 on page 8

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[36] Questions are drawn from 2014 Federal 990 schedule h.pdf and may change when the hospital is to make its 990 h filing

i. **Information gaps that limit the hospital facility's ability to assess the community's health needs**

See footnote 10 on page 9, footnotes 13 and 14 on page 10, and footnote 22 on page 22

j. **Other (describe in Section C)**

N/A

4. **Indicate the tax year the hospital facility last conducted a CHNA: 20__**

2013

5. **In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted**

Yes; see footnote 15 on page 11 and footnote 29 on page 66

6. **a. Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C**

Yes; Tidelands Health consists of Tidelands Georgetown Memorial Hospital and Tidelands Waccamaw Community Hospital

b. Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C

Yes; see footnote 4 on page 5 and footnote 7 on page 8

7. **Did the hospital facility make its CHNA report widely available to the public?**

Yes

If "Yes," indicate how the CHNA report was made widely available (check all that apply):

a. **Hospital facility's website (list URL)**

https://www.tidelandshealth.org/app/files/public/287/Tidelands-Georgetown-Needs-Assesment.pdf

https://www.tidelandshealth.org/app/files/public/286/Tidelands-Waccamaw-Needs-Assesment.pdf

b. **Other website (list URL)**

No other website

c. **Made a paper copy available for public inspection without charge at the hospital facility**

Yes

d. **Other (describe in Section C)**

No other efforts

8. **Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11**

   Yes; see footnotes 27 and 28 on page 63

9. **Indicate the tax year the hospital facility last adopted an implementation strategy: 20__**

   2013

10. **Is the hospital facility's most recently adopted implementation strategy posted on a website?**

    a. **If "Yes," (list url):**

       https://www.tidelandshealth.org/app/files/public/287/Tidelands-Georgetown-Needs-Assesment.pdf

       https://www.tidelandshealth.org/app/files/public/286/Tidelands-Waccamaw-Needs-Assesment.pdf

    b. **If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?**

11. **Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed**

    See footnote 25 on page 46

12. **a. Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r) (3)?**

    None incurred

    b. If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax?

    Nothing to report

    c. If "Yes" to line 12b, what is the total amount of section 4959 excise tax the organization reported on Form4720 for all of its hospital facilities?

    Nothing to report