McLeod Health

The Choice for Medical Excellence

McLeod Medical Center Dillon

Community Health Needs Assessment (CHNA) Implementation Plan Narrative

Approved by
McLeod Medical Center Dillon Board of Directors September 2016

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Letter to the Community

Dear Community Members,

Health is driven by much more than what happens in the doctor's office. What determines health begins — long before illness — in our homes, schools, and jobs. Despite our genetics playing a role, we have the opportunity to make choices that can help us all to live a healthier life, regardless of our background. People whose circumstances have made them vulnerable to poor health need our help in working towards eliminating barriers that provide everyone with the chance to live a healthy life. This work cannot happen without first making use of health data, evidenced-based research, and other facts that serve as the foundation. Health research provides indicators of health status, such as the prevalence of disease and its effect in both economic and human terms. By using the Community Health Needs Assessment, we can evaluate relevant determinants of health that gives valuable insight in guiding decisions that create a pathway for improving the health of our community.

Everyone in our community should have the opportunity to make good, healthy choices (e.g., regarding smoking, diet, substance abuse, physical activity) since this can have the largest impact on future health outcomes. Wherever possible, through programs, services, public policy or other means, emphasis needs to be placed on addressing health choices before the medical need. Research has shown that the health care system itself represents only 10-20% of determining health status, while behavioral choices account for 40% or more.

Through changes in public policy, it is possible that most people, regardless of income, could have the ability to see a doctor. Health insurance does not guarantee good health, but it does provide important access to preventative health services. It can reduce the risk of deferring needed care and the financial risk associated with receiving care. Our success in building a healthy community should be linked to collective community efforts that nurtures its families and communities. We encourage partnerships with volunteers, business, government, civic and religious institutions to join us in this work. Although we may not be able to eradicate every illness, this Community Health Needs Assessment Implementation Plan shows that there is much we can accomplish by fostering good health and addressing gaps. Health begins with healthy relationships, healthy communities, and healthy jobs, which protect us from the stress of everyday life.

Best of Health,

Joan Ervin
Administrator, McLeod Medical Center Dillon

McLeod Medical Center Dillon
The Community Health Needs Assessment (CHNA)
Implementation Plan Narrative

Introduction

McLeod Medical Center Dillon (McLeod Dillon) is a Joint Commission accredited medical center in the McLeod Health system. McLeod Dillon provides general and orthopedic surgery, women's services, emergency services, intensive care, and rehabilitative services to residents of Dillon County (South Carolina), Marlboro County (South Carolina), and Robeson County (North Carolina). McLeod Dillon has been a vital health resource in the region since 1943, and the medical center continues to find ways to provide the highest quality care to the region through investments in state-of-the-art technology.

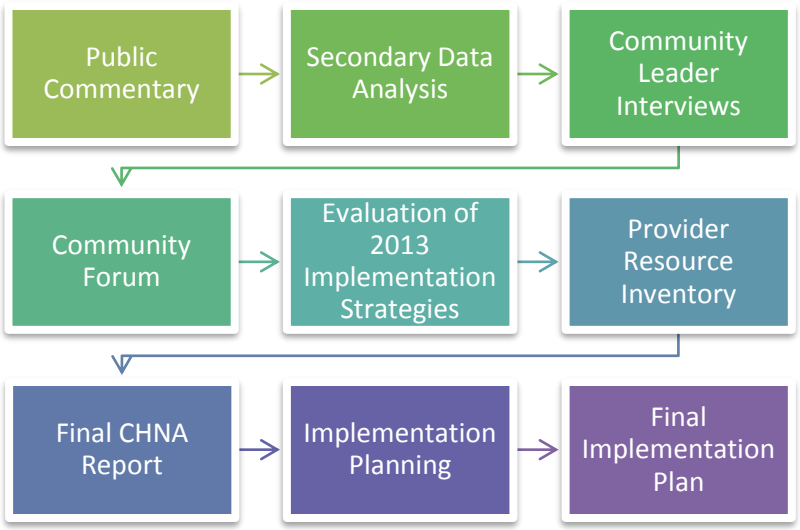
With the enactment of the Patient Protection and Affordable Care Act (PPACA) on March 23, 2010, tax-exempt hospitals are required to conduct community health needs assessments (CHNA) and to develop implementation strategies to actively improve the health of the communities they serve. To adhere to the requirements imposed by the IRS, tax-exempt hospitals and health systems must:

- Conduct a CHNA every three years.
- Adopt an implementation strategy to meet the community health needs identified through the assessment.
- Report how they are addressing the needs identified in the CHNA.

The CHNA and the CHNA Implementation Plan fulfill the IRS requirements on tax-exempt hospitals and health systems.

The comprehensive CHNA process undertaken by McLeod Dillon, with project management and consultation by Tripp Umbach, included extensive input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of public health issues, data related to underserved, vulnerable populations, and representatives of vulnerable populations served by the hospital. Tripp Umbach worked closely with leadership from McLeod Dillon and McLeod Health to oversee and accomplish the assessment with the goal of gaining a better understanding of the health needs of the region. McLeod Dillon and McLeod Health will make use of CHNA findings to address local health care concerns, as well as to function as a collaborator, working with regional agencies to help provide medical solutions to broader socioeconomic and education issues in the service area.

Figure 1. CHNA Process



The McLeod Dillon Community Health Needs Assessment (CHNA) Implementation Plan prioritizes the health needs identified in the 2016 CHNA and outlines a multi-year approach for addressing the identified needs during the 2016-2019 period. The community health needs assessment and implementation plan meet IRS requirements as delineated in the Patient Protection and Affordable Care Act (PPACA).

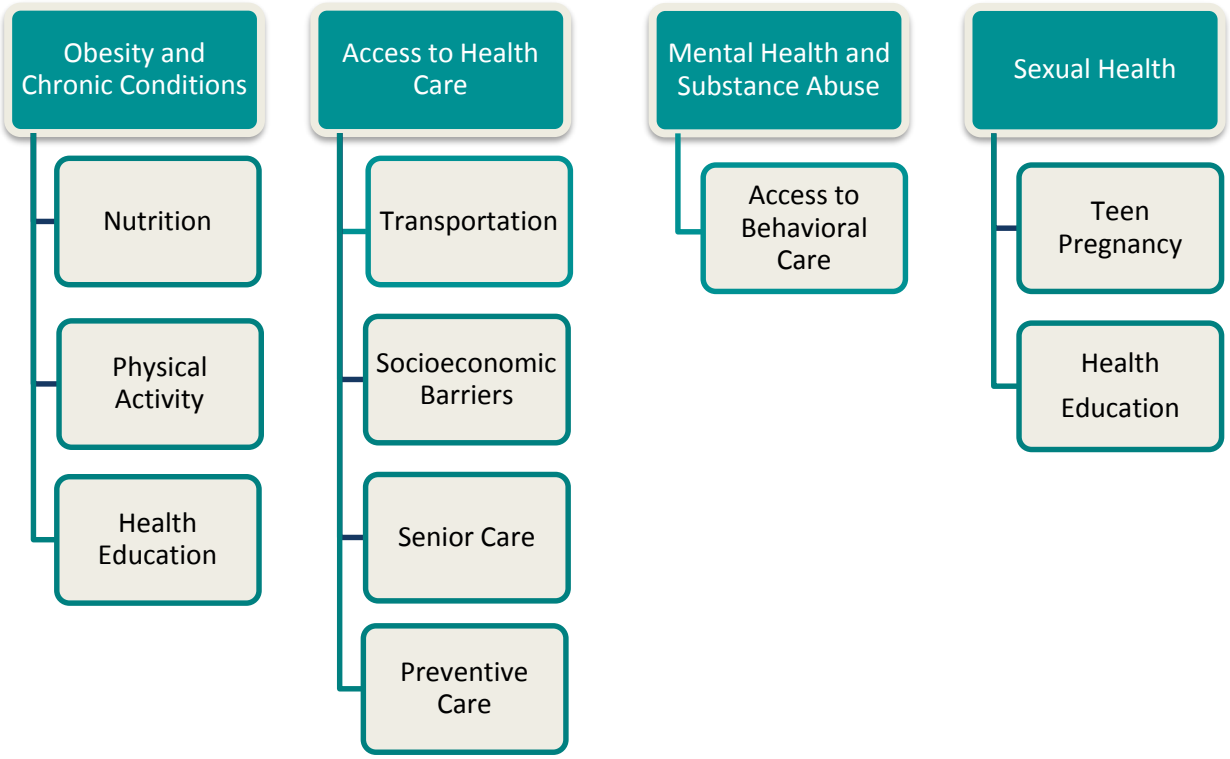
Health care organizations and systems strive to improve the health of the community they serve through collaboration with local, state and national partners as delineated in the CHNA Implementation Plan which will be conducted over a three-year period from 2016 through 2019. During this time, McLeod Dillon will continue its coordinated approach and engagement with community partners to maximize health improvement efforts. Through collaboration with community partners, the community health events, programs, initiatives are better aligned with available resources and organizational goals.

With a history of leadership in community health development and outreach, McLeod Dillon will advance efforts to ensure a sustainable impact on improving the health of the communities they serve by pursuing evidence based practices, participating in state led health initiatives and increasing availability of providers/services in the region.

Prioritized Community Health Needs

The community needs are based on qualitative and quantitative data, particularly from community forum feedback. Figure 2 (below) details the three prioritized need areas and key factors and considerations of each need.

Figure 2. McLeod Dillon Prioritized Community Health Needs 2016 CHNA



A broad range of social, economic, and other environmental factors affect the health of individuals and communities. The social and economic conditions where people live, work, learn, and play are called social determinants of health. Social determinants can have a profound influence on the choices that people have in their daily lives that promote or inhibit health. Within each of the community health need areas, multiple factors must be considered. Health behaviors, education, and socioeconomic/environmental conditions greatly affect an individual's health status and ability to overcome health issues in the region.

The McLeod Dillon CHNA noted a plethora of community health issues as well as health disparities across the study area. It is critical for health providers and community-based organizations to understand not only the regional health issues, but to be aware of where disparities occur to pinpoint what services and improvements are most needed.

Addressing the Community Health Priorities

The goals and strategic actions delineated in this CHNA Implementation Plan Narrative are developed to address each of the identified priority areas and to ensure a patient centered and community engagement approach.

Priority 1: Obesity and Chronic Conditions (Nutrition, Physical Activity, and Health Education)

OBESITY

Obesity is an epidemic in the U.S. and contributes to several leading causes of death, including heart disease, diabetes, stroke, and some cancers. If present trends continue, by 2030, 86 percent of adults will be overweight; 51 percent will be obese; and nearly a third of all children will be overweight according to the Centers for Disease Control and Prevention (2012). Total health care costs attributable to obesity/overweight are predicted to double each decade.[1]

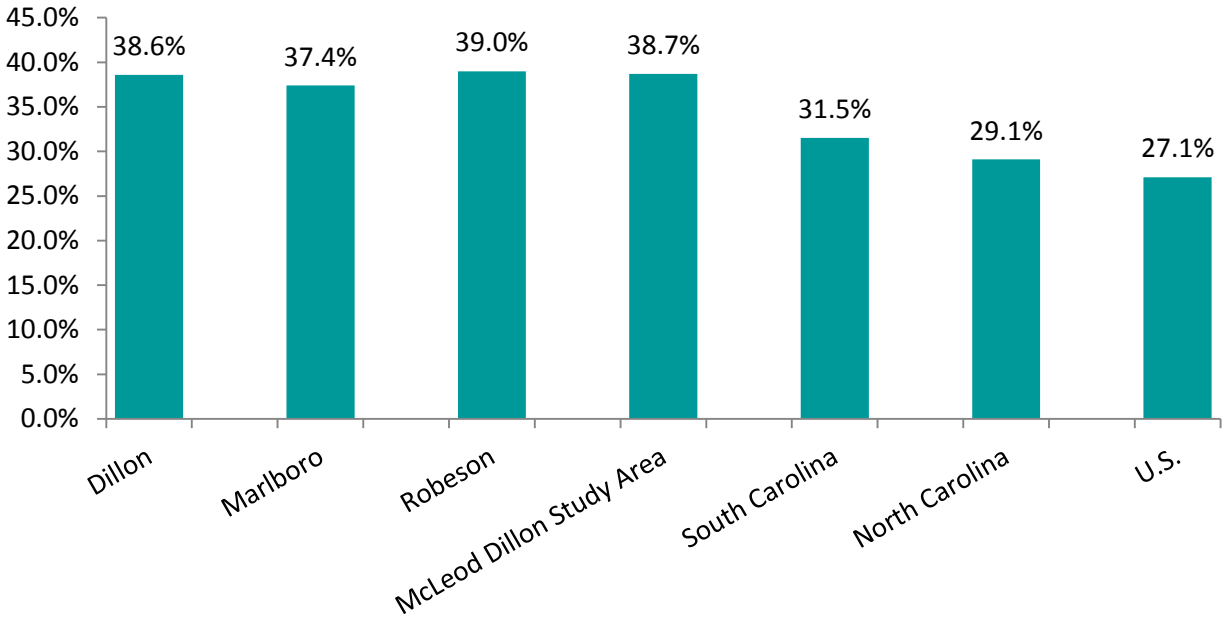
Environmental, economic, and cultural conditions greatly influence health behaviors such as diet and physical activity and contribute to the rise in obesity rates. Obesity rates are higher among low-income adults and children and among American Indians/Alaska native, black, and Hispanic individuals. Children living in disadvantaged communities and neighborhoods are more likely to be obese.[2] Most adults in the U.S. do not meet the Physical Activity Guidelines for Americans. [3]

Obesity is particularly prevalent across states in the southern part of the U.S. The state of South Carolina is plagued by high rates of obesity, as the state had the 10th highest obesity rate in the nation in 2014. North Carolina had the 24th highest obesity rate in 2014.

[1] Begley, Sharon. "Fat and getting fatter: U.S. obesity rates to soar by 2030." *Reuters.* September 18, 2012.
[2] "Overweight & Obesity – Data & Statistics." Centers for Disease Control and Prevention. September 24, 2015. https://www.cdc.gov/obesity/data/index.html.
[3] "Physical Activity – Data & Statistics." Centers for Disease Control and Prevention. March 27, 2015. https://www.cdc.gov/physicalactivity/data/index.html.

High obesity rates are of particular concern across the McLeod Dillon study area; obesity was cited as the top health issue in the region among community leaders both in stakeholder interviews and at the community forum public input session. Obesity also was cited as a top community health concern among health professionals in McLeod Dillon's 2013 CHNA. The study area overall has a higher percent of adults who are obese than the states and nation, with 38.7 percent of residents in the study area being obese. The percentage of obese adults is highest in Robeson County as 39.0 percent of residents are obese (See Chart 1). [4]

Chart 1. Percent Obese Adults



CHRONIC CONDITIONS

Obesity is a key factor in preventing chronic diseases such as hypertension, heart disease, diabetes and stroke. Adults who are overweight are more likely to have hypertension and high cholesterol, both of which can lead the major health issues like heart disease and stroke. Obesity and chronic diseases have a negative effect on a person's general health and overall well-being. It is noted that the counties that experience the highest rates of obesity and chronic conditions also report higher percentages of residents with poor or fair health.

[4] Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 2012 via Community Commons.

Heart Disease and Hypertension

Chronic conditions that stem from obesity are prominent in South Carolina, North Carolina, and the study area. South Carolina has the eighth highest hypertension rate in the U.S.[5] North Carolina has the 11th highest hypertension rate in the nation. While both South Carolina and North Carolina have high rates of chronic diseases, a number of chronic diseases are even more prevalent in the study area.

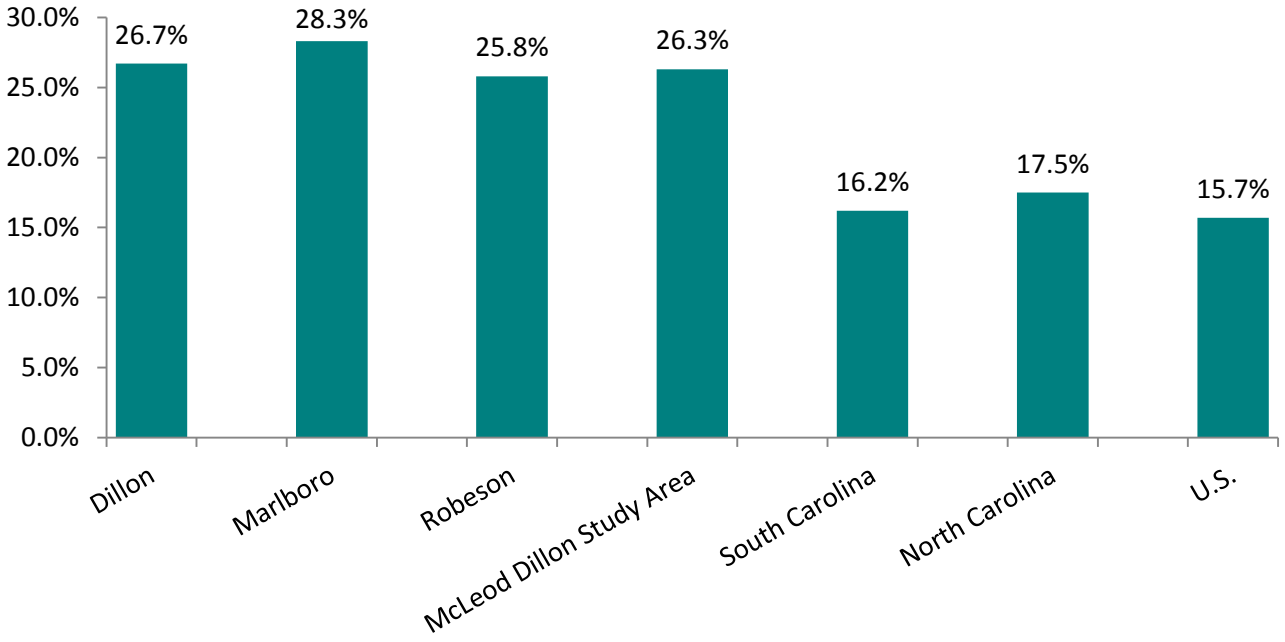
5.7 percent of residents in the study area have heart disease. This percentage is higher than the states (4.6 percent – South Carolina and 4.4 percent – North Carolina) and nation (4.4 percent).[6] 36.5 percent of residents in the study area have high blood pressure, which is higher that the percentages in the states (31.6 percent – South Carolina and 29.7 percent – North Carolina) and nation (28.2 percent).

The study area has higher rates of mortality due to heart disease compared to the states and U.S. The mortality rate due to heart disease in the study area is 252.0 per 100,000 population. The heart disease mortality rate is particularly high in Marlboro County (354.8 per 100,000 population).[7]

Obesity and chronic conditions have a negative effect on a person's general health and overall well-being. As the study area has higher percentages of the population with certain chronic diseases in comparison to the states and nation, a higher percentage of residents in the study area also report having poor or fair health than those in the state and nation. Approximately 26.3 percent of the population in the study area reports having poor or fair general health (See Chart 2).

[5] "The State of Obesity in South Carolina." The State of Obesity. http://stateofobesity.org/states/sc/. 2015.
[6] Centers for Disease Control and Prevention. Behavioral Risk Factor Surveillance System. 2011-2012. Accessed via Community Commons.
[7] Centers for Disease Control and Prevention. Behavioral Risk Factor Surveillance System. Accessed via Community Commons.

Chart 2. Percent Adults with Poor or Fair General Health



Diabetes

Nationwide, it is estimated that nearly 26 million people have diabetes—including over a quarter with the condition undiagnosed—and that 79 million people are pre-diabetic, with blood glucose levels that increase the risk of developing diabetes. The prevalence of diabetes increases with age, and nearly 27 percent of those over age 65 have diabetes. Among racial and ethnic groups, diabetes prevalence is highest among African Americans.[8]

McLeod Dillon Health Fair

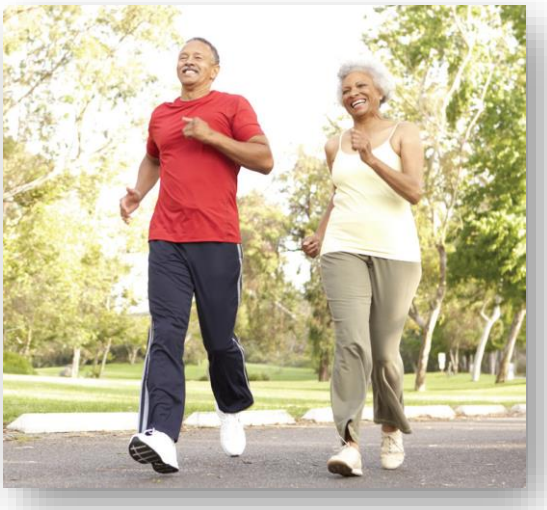
The prevalence of diabetes has risen with the rise in obesity rates, and children are increasingly affected by both obesity and diabetes. It is documented among diabetes educators that many patients are generally unaware of the seriousness of diabetes. They also note that people who are newly diagnosed

[8] "Diabetes – Data & Statistics." Centers for Disease Control and Prevention. December 1, 2015. https://www.cdc.gov/diabetes/data/index.html.

are often overwhelmed, confronted with misinformation, or feel they are powerless to make positive changes to control the disease.

South Carolina has the seventh highest diabetes rate in the U.S. 15.0 percent of the population in the McLeod Dillon study area has diabetes, while 11.2 percent of the population in South Carolina, 10.2 percent in North Carolina, and 9.1 percent in the U.S. has diabetes.[9]

Nutrition. Many adults and children do not eat the recommended servings of fruits and vegetables as the foods that are associated with healthy diets often cost more than unhealthy foods and are unaffordable for many low income and uninsured families. In 2015, 45.2 percent of surveyed adults reported consuming fruit less than one time daily, while 26.8 percent of adults reported consuming vegetables less than one time daily.[10] 85.4 percent of residents in the study area do not consume an adequate amount of fruits and vegetables. This percentage is higher than the percent of adults with inadequate fruit and vegetable consumption in South Carolina, North Carolina, and U.S.[11]



Physical Activity. In addition to a healthy diet, physical activity also is important to leading a healthy lifestyle and obesity and chronic disease prevention. Physical inactivity is responsible for one in 10 deaths among U.S. adults.[12] Among the states in the U.S., South Carolina is the 13th most physically inactive state, while North Carolina falls in the middle as the 25th most physically inactive state.[13]

In the McLeod Dillon study area, physical activity is not a priority for residents. The overall study area has a higher percentage of residents who fail to engage in any type of leisure time physical activity when compared to the states and nation; 33.5 percent of study area residents do not

[9] Centers for Disease Control and Prevention. 2012. Accessed via Community Commons.
[10] Centers for Disease Control and Prevention. "South Carolina State Obesity, Nutrition, and Physical Activity Report." 2015.
[11] Centers for Disease Control and Prevention. Behavioral Risk Factor Surveillance System. 2005-2009 . Accessed via Community Commons .
[12] Danaei G, Ding EL, Mozaffarian D, et al. The Preventable Causes of Death in the United States: Comparative Risk Assessment of Dietary, Lifestyle, and Metabolic Risk Factors. PLoS Med 6(4): e1000058. doi:10.1371/journal.pmed.1000058, 2009. Accessed via http://stateofobesity.org/physical-inactivity.
[13] "Physical Inactivity in the United States." The State of Obesity." http://stateofobesity.org/physical-inactivity/. 2014.

engage in leisure time fitness, while 24.6 percent in South Carolina, 24.5 percent in North Carolina, and 22.6 percent in the nation do not engage in leisure time physical activity.

Goal 1: Reinforce importance of physical activity among youth and adults in the community.

- **Strategy 1:** Coordinate Run/Walk in Dillon as part of McLeod Health Series.

In 2016, McLeod Dillon hosted a Fitness Challenge 5K Run/Walk and 1-Mile Fun Run in recognition of the McLeod Health 110 year celebration. McLeod Dillon has set forth the strategy to continue the 5K Run/Walk annually as part of an ongoing health series, striving to have at least 100 participants each year.

2016 McLeod Dillon Fitness Challenge

Goal 2: Promote and raise awareness of healthy behaviors among youth and adults in the community.

- **Strategy 1**: Partner with City of Dillon Wellness Center.

- **Actions/Tactics**

  - ✓ Promote free inside/outside walking tracks to potential cardiac rehab patients.
  - ✓ Place mile markers on indoor/outdoor tracks.
  - ✓ Post health tips at stations along track (ex. stretching).
  - ✓ Investigate interest of City of Dillon to host a community weight loss event and partner in their efforts.

To address the high rates of obesity and lack of physical activity noted in the CHNA, McLeod Dillon will partner with the Dillon Wellness Center to provide programs and services that enable community residents, employees, and their families to lead healthier lifestyles. These programs will raise awareness and promote wellness through health education with a focus on the importance of walking as a means of physical fitness, weight management, good nutrition, and other healthy behaviors that build healthy lifestyles for adults and children.

Goal 3: Improve healthy eating behaviors among youth and adults in the community.

- **Strategy 1:** Support Dillon's Francis Marion University Rural Area Leadership Institute (RALI) in undertaking Blue Cross Blue Shield grant funding in partnership with the SC Office of Rural Health

  - **Actions/Tactics**

    - ✓ Increase physical activity among youth.
    - ✓ Increase availability of fresh foods and markets.

The leadership of McLeod Dillon has brought together RALI, the SC Office of Rural Health, and the Blue Cross Blue Shield Foundation to develop a grant designed to build initiatives that improve healthy eating, increase access to fresh fruits and vegetables, and impact healthy lifestyles among adults and children across Dillon County.

Goal 4: Offer Cardiac Rehabilitation exercise regime and education to improve healthy eating and physical activity behaviors among at- risk and post heart event patients.

- **Strategy 1:** Apply for grant funding to offer scholarships to those in need of Cardiac Rehabilitation that have limited resources.

It is noted that some at-risk and post cardiac event patients have limited access to the cardiac rehab services due to a lack of insurance or low income. By securing financial support to provide scholarships, at-risk patients will have access to these vital services and will receive essential health education on healthy eating and physical activity. Making resources and programs such as Cardiac Rehab available to the uninsured and underinsured is critical in helping them to manage their health and recovery.

Goal 5: Re-Design cafeteria to offer visitors/employees a more informed decision for adults and youth.

- **Strategy 1:** Implement McLeod Dillon Cafeteria Improvements.
- **Strategy 2:** Achieve CDM Certification of two nutrition services leaders (Director and Supervisor).
- **Strategy 3:** Educate employees through health system intranet and newsletters.

The health center cafeteria is accessed by employees, patient families, and the public and serves as a good setting for enhancing awareness and education on healthier eating. Through the posting of dietary and nutritional information such as portion control, serving size, calorie count, and food options, appropriate decision on healthy eating can be made and learned.

Certification of dietary staff and health education through the intranet has great potential for impacting the broader community with health education and healthy behaviors. Employees and their families are "the community," and efforts to address their health can be very beneficial in improving the overall health status of the community.

Priority 2: Access to Health Care (Socioeconomic Barriers – Affordable Care, Transportation, and Preventive Care)

ACCESS TO HEALTH CARE

The slow national and local economy since 2008 has left many across the nation without employer-sponsored health insurance and many sense an insecurity regarding their financial wellbeing. Prior to the Affordable Care Act (ACA), low income, uninsured and underinsured individuals and families struggled to gain access to health care when needed. Many individuals and families delayed seeking care because they lacked health insurance and were unable to pay out of pocket health care costs. As a result, low income and uninsured populations often seek

care in the emergency room rather than through regular primary care office visits. Lack of health insurance leads many to defer or delay preventive care and early intervention with chronic conditions.

Socioeconomic Barriers. As documented by the CHNA, barriers to care and treatment are noted as uninsured and low income residents experience financial and medical challenges that prevent and limit access to health care. Basic necessities like food and housing become more important than receiving care. The inability to afford health insurance also plays a major role in residents choosing not to schedule medical appointments and not taking preventive care measures.

Affordable Care. Access issues are prominent in South Carolina and North Carolina. SC ranks 41st in the U.S. in terms of access and affordability of care, while NC ranks 30th according to the Commonwealth Fund of State Health System Performance in 2015.[14] Health care access issues also are evident in the study area. Dillon and Marlboro counties rank in the lowest ten percent (unfavorable) in the state of SC in terms of clinical care according to the 2016 County Health Rankings report, with rankings of 41 and 46 out of a total 46 counties. Robeson County has the worst clinical care ranking in North Carolina.

Lack of health insurance coverage is a key factor as people without insurance are more likely to lack a health care medical home and are at increased risk for serious health conditions. The study area overall has a higher percentage of uninsured residents at 18.0 percent than South Carolina (15.9), North Carolina (15.5 percent), and U.S. (14.2 percent). Dillon County, in particular, has the highest uninsured percentage in the study area at 21.5 percent (See Chart 3).[15] With a lack of access to care and health conditions being diagnosed at later stages, the uninsured and low income residents often have higher mortality rates.

[14] Health System Data Center. The Commonwealth Fund. http://datacenter.commonwealthfund.org/scorecard/state/42/south-carolina/.2015.
[15] U.S. Census Bureau. American Community Survey. 2010-2014.

Chart 3. Total Uninsured Population

Transportation. Transportation plays a vital role in accessing care and services. Residents who do not have their own means of transportation are dependent on the public transportation system. Transportation barriers can lead to missed health appointments and the delay of health care services making health management difficult for the individual and for the health provider. Further, the lack of transportation impacts an individual's ability to purchase food, maintain employment, access care, and meet the needs of everyday life.

The lack of public transportation across the McLeod Dillon study area served as a top discussion point during community leader interviews and community forum input sessions. Community leaders view the public transportation system as a barrier to accessing health care. Residents cannot depend on public transportation in the region as a means to travel to their appointments. The region has no mass transit system, and the bus system is underfunded. The lack of transportation prevents residents from managing their health issues because they cannot always receive the care they need if it is not available in their local community. The study area has fewer providers when compared to provider rates across the state and nation. With a lower rate of providers, residents must travel in order to receive care, especially specialty care services; however, the lack of dependable public transportation makes doing so difficult.

Preventive Care. Study area data indicates that residents in the McLeod Dillon region may not be fully utilizing preventive care measures, which may account for high rates of mortality due to chronic disease. A number of indicators demonstrate residents failing to take preventive care measures. The study area has a smaller percentage of residents taking preventive care measures, such as receiving cancer screenings, immunizations, and diabetes management tests, compared to the states and nation.

Goal 1: Improve education and access as well as remove transportation and financial barriers for underserved expecting/new moms.

- **Strategy 1:** Expand McLeod Nurse Family Partnership Program from 25 to 30 enrolled in the program at a given time.

The Nurse-Family Partnership (NFP) is an evidenced based program that provides nurse home visits to pregnant women with no previous live births. Most of the women served are low-income, unmarried, and teenagers. The nurses visit the women approximately once per month during their pregnancy and the first two years of their children's lives. The nurses teach positive health related behaviors, competent care of children, and strengthen maternal personal development through family planning, educational achievement, and participation in the workforce.

Among the significant outcomes documented are reductions in measures of child abuse and neglect, reductions in mothers' subsequent births during their late teens and early twenties, and decreases in prenatal smoking among mothers. Most importantly, the NFP program has resulted in improvement in cognitive and academic outcomes for the children born to mothers with low psychological resources (i.e., intelligence, mental health, self-confidence).

Goal 2: Remove socioeconomic barriers and connect individuals (both adult and youth) to a Primary Care Provider (PCP).

- **Strategy 1:** Provide support to CareSouth (FQHC) clinics and mobile unit.
- **Strategy 2:** Provide location for Healthy Learners (Dillon Site).
- **Strategy 3:** Support Free Medical Clinic.
    - **<u>Actions/Tactics</u>**

✓ Provide comprehensive diagnostic testing.

Goal 3: Expand specialty providers to rural area for both adult and youth populations.

- **Strategy 1:** Pursue grant funding for telehealth.

Telehealth, or the electronic exchange of telemedicine, allows for patients to receive medical advice, care, and referrals with added convenience and cost efficiency. Telehealth will allow for a greater number of residents in the more rural areas of the McLeod Dillon study area to be able to access specialty care in a time efficient manner, without transportation serving as a barrier.

McLeod Dillon will be working with Palmetto Care Connections, a telehealth provider in South Carolina, to help with providing this service in the community.

Goal 4: Remove barriers to learning for youth.

- **Strategy 1:** Provide Sponsorship for Healthy Learners program.
- **Strategy 2:** Engage Physicians as partner providers to Healthy Learners program.

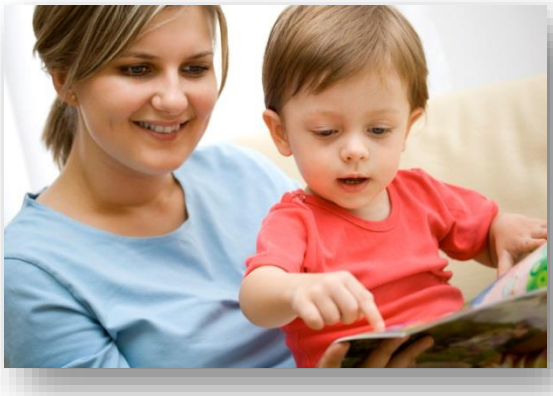
Believing that children learn better when they are healthy, the Healthy Learners program was established in 1992 to help alleviate health related barriers to learning for children who are without resources and in need. Currently, Healthy Learners programs serve 145 schools in ten school districts across South Carolina.

The Healthy Learners program connects children to care so that poor health is not an obstacle to doing well in school. The program provides assistance with Medicaid application process, referrals for clinical counseling, coordination of health care, dental care, hearing evaluations and care, medications, transportation to appointments, treatment for medical needs and vision care. The Healthy Learners program documents health status improvement, increased self-esteem, and improved ability to perform academically in school.

Priority 3: Mental Health (Access to Behavioral Care)

BEHAVIORAL HEALTH

Behavioral health is a major concern across the nation and is a top health priority in the CHNA study area. The issues affect not only the mental well-being of an individual; but also spiritual, emotional and physical health. Unmanaged mental illnesses increase the likelihood of adverse health outcomes, chronic disease, and substance abuse partly due to a decrease in accessing medical care. Patients often deal with lengthy waiting periods, traveling long distances, and being unable to secure appointments when it comes to receiving behavioral health services.



MENTAL HEALTH

The majority of adults with mental illness received no mental health treatment in the last year, indicating a nationwide issue with

individuals being able to receive proper mental health services and treatment. There is a lack of mental health providers available to United States citizens. Close to 91 million adults live in areas where there is a shortage of mental health professionals. The primary data received from residents, health professionals and community leaders across the CHNA study area showed the need for attention to mental health services.[16]

There are approximately 90.1 mental health providers per 100,000 population in the study area. This rate is lower than the rate of mental health providers in South Carolina (97.6 per 100,000 population), North Carolina (140.0 per 100,000 population), and nation (134.1 per 100,000 population). Dillon County, in particular, has a low rate of mental health providers with 40.8 per 100,000 population.[17]

The primary focus of the following goals and strategies address mental health and behavioral health needs for adults and youth.

Goal 1: Increase access to behavioral health services for adults and youth.

- **Strategy 1:** Place a counselor in McLeod OB/GYN Dillon Office (Substance Dependence) and McLeod Pediatrics Dillon Office (ADD/ADHD).
- **Strategy 2:** Utilize CareSouth's Master Prepared Behavioral Health Counselor at Dillon, Latta, and Lake View offices.

Goal 2: Gain access to specialty providers to rural areas for both adult and youth populations.

- **Strategy 1:** Use Tele-Psychiatry in the ED.

The need for more behavioral health care providers was strongly emphasized by community leaders during the McLeod Dillon CHNA study as mental illness and substance abuse become increasingly prevalent in the region. Treatment of mental health is often reactive in the form of crisis intervention through hospital emergency rooms rather than proactive practices. Additional barriers to mental health services include out-of-pocket costs/insurance coverage, negative social stigmas and lack of health education. Many residents who have mental health issues tend also to have multiple behavioral diagnoses, making it even more essential for those in need to have access to and receive continuous treatment.

[16] "Mental Health by the Numbers" National Alliance on Mental Illness. 2016.
[17] Mental health providers are defined as psychiatrists, psychologists, clinical social workers, and counselors that specialize in mental health care. University of Wisconsin Population Health Institute. County Health Rankings. 2014.

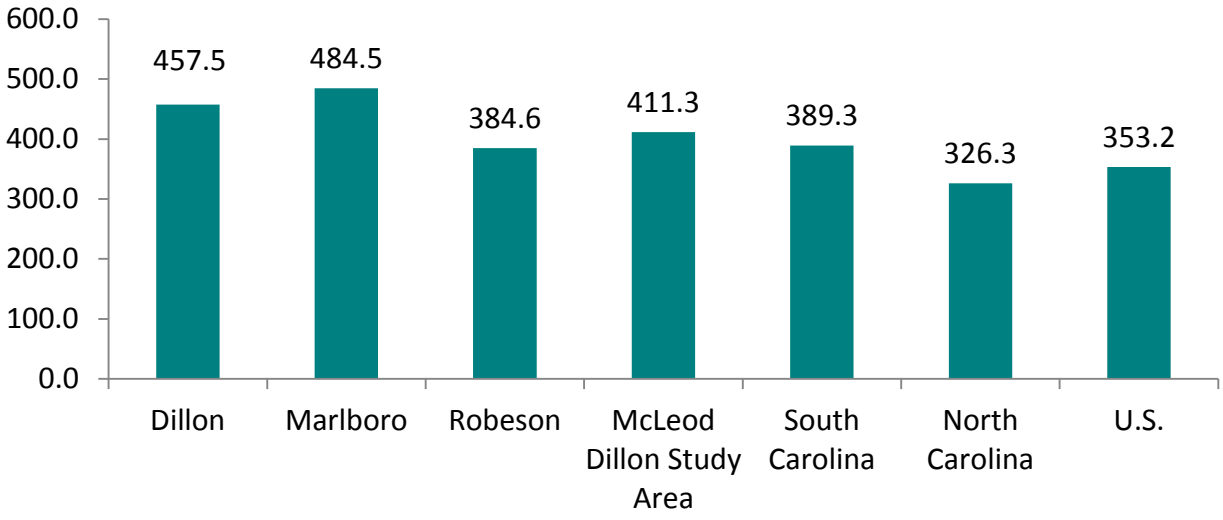
McLeod Dillon will take a proactive approach by placing a counselor in the McLeod OB/GYN Dillon Office to address substance dependence and within the pediatric office to meet needs of youth diagnosed with ADD/ADHD. Having the mental health professionals on site will enhance continuity in services and integration of mental and physical health. This approach allows the professional to address patient needs while they are on site.

The use of tele-psychiatry services has greatly enhanced access to specialty providers for rural adults and youth. In the absence of a readily available specialist and providers, tele-psychiatry can be an effective tool for patient evaluation and facilitating access to care within a rural setting. This initiative will be part of the Alliance for a Healthier South Carolina's Healthy Minds initiative.

Priority 4: Sexual Health (Birth Outcomes, STDs, Teen Pregnancy and Education)

STD diagnoses occur most frequently among young people between the ages of 15 to 24 and many go undiagnosed. One in five people with human immunodeficiency virus (HIV) do not know that they have HIV. Rates of sexually transmitted diseases are high in the McLeod Dillon study area and a lower percentage of residents who have not received an HIV screening or tests is documented (See Chart 4).[18]

Chart 4. HIV Rates per 100,000 Population



[18] "Reproductive and Sexual Health." Healthy People 2020. https://www.healthypeople.gov/2020/leading-health-indicators/2020-lhi-topics/Reproductive-and-Sexual-Health. 2014.

Early intervention in promoting healthy behaviors and health education is key in helping today's youth lead healthier lives in the future, as well as help to reduce high risk behaviors, teen pregnancy and STDs. The state of South Carolina ranks 42nd out of 51 in terms of child well-being as of 2015, while North Carolina ranks 35th; this measure takes into account numerous education, economic, health, and family/community measures.[19] Community leaders across the study area understand the significance of focusing on the health and well-being of children for a healthier future.

SEXUAL HEALTH AND EDUCATION

Children and teens who are not focused on school or extracurricular work and activities are more likely to engage in risky behaviors. While unsafe sex practices can result in HIV and STDs, such practices also attribute to unplanned pregnancies. In the study area, community leaders discussed teen pregnancy as a sexual health concern. Teen birth rates have dropped across the U.S. in recent years. As of 2014, a total of 249,078 were born to women between the ages of 15 and 19; this rate is down 9.0 percent from 2013.[20] In the study area, teen birth rates also have declined in recent years, however, teen births still remain a concern in the region as rates are much higher than those in the states and nation (See Table 1).

Table 1. Teen Birth Rates

Year	McLeod Dillon Study Area	South Carolina	North Carolina	U.S.
2002-2008	79.7	50.6	47.9	41.0
2003-2009	77.7	50.0	46.9	40.3
2004-2010	76.4	49.0	45.6	39.3
2005-2011	74.0	47.5	43.8	38.0
2006-2012	71.3	45.9	41.7	36.6

[19] KIDS Count Data Center, 2015.
[20] "About Teen Pregnancy." Centers for Disease Control and Prevention.

Parents, educators, and health providers together must instill in our youth at an early age the importance of healthy behaviors and education necessary to play a positive role in their growth and development. Working to create an educated, healthier generation of youth today will benefit the community for the future.

The following goals and strategies are designed to provide an early impact on the sexual health of young and adult women and to emphasize the importance of healthy behaviors and education.

Goal 1: Improve birth outcomes through education to expecting moms.

- **Strategy 1:** Centering Care in McLeod OB/GYN Dillon practice – to improve outcomes and reduce preterm birth.
    - **<u>Actions/Tactics</u>**
    - ✓ Promote benefits of full-term delivery through new Centering program, as well as OB packets distributed to expecting moms at McLeod OB/GYN Dillon.
    - ✓ Childbirth preparation offerings.
- **Strategy 2:** Utilize the March of Dimes 39+ Weeks Quality Improvement Initiative and Baby Friendly educational pieces with expecting moms.

McLeod Dillon was recognized among 100 hospitals nationwide and selected to receive the March of Dimes Quality Improvement Service Package. This noted designation instructs the hospital in creating and implementing policies to reduce medically unnecessary elective inductions and cesarean deliveries scheduled before 39 weeks of pregnancy. The pursuit of "Baby Friendly" designation at McLeod Dillon will teach and enable moms and families to raise a healthier generation.

Goal 2: Increase education, increase condom access, and improve parent/child communication.

- **Strategy 1:** Continue county wide teen pregnancy task force to plan and guide collaborative action to reduce teen pregnancy.

- **Actions/Tactics**

✓ Provide Evidence Based Practices and Programming to emphasize abstinence first, then contraception, condom access.

✓ Increase awareness and understanding of STD risks and prevention.

With higher teen pregnancy rates than the region and the state, McLeod Dillon implemented a community wide, interagency Task Force and leads efforts among many health and human service agencies to address teen pregnancy. Education classes designed to increase awareness and understanding of STD risks and prevention will emphasize "abstinence first" then contraception and condom usage.

Goal 3: Reach underserved and uninsured women and improve sexual health outcomes.

- **Strategy 1:** Expand Free Medical Clinic to include Women's Services.

The Free Clinic will be expanded to include women's services with a purpose of improving the sexual health of underserved and uninsured women.

Implementation Next Steps

The McLeod Dillon CHNA Implementation Plan defines our commitment to the community, documents how the identified community needs will be met, and ensures that results and impact on the health of the community will be reported and communicated.

Efforts to measurably impact the health of the community are on-going as 2016-2019 Community Health Needs Assessment implementation strategies are aligned with the system's strategic focus and organizational goals.

Communication and continuous planning efforts are vital throughout the next few years. Information regarding the CHNA findings and implementation plan deployment will be important to residents, community groups, leaders and other organizations that seek to better understand the health needs of the communities across the study area and how to best serve those needs. Evaluation and progress on the implementation of community initiatives will be reported at least annually and will be included in community benefit reporting.

APPENDIX A: Community Definition

In 2016, nine ZIP code areas were analyzed for McLeod Dillon. The nine ZIP codes represent the community served by McLeod Dillon as the hospital's primary service area, or where approximately 80% of the hospital's inpatient population resides. The nine ZIP codes fall into three counties in South Carolina and North Carolina – Dillon, SC; Marlboro, SC; and Robeson, NC (See Table 2).

Table 2. McLeod Dillon Primary Study Area ZIP Codes

ZIP Code	City	County
29536	Dillon	Dillon
29543	Fork	Dillon
29547	Hamer	Dillon
29563	Lake View	Dillon
29567	Little Rock	Dillon
29525	Clio	Marlboro
28340	Fairmont	Robeson
28369	Orrum	Robeson
28383	Rowland	Robeson

The following map depicts the primary service area and the locations of the nine ZIP codes as described in Table 1.

Map 1: McLeod Dillon – 2016 Study Area Map

Source: Truven Health Analytics 2015

APPENDIX B: Community Partners

The following is a list of community organizations and agencies that will serve as important partners and resources as McLeod Dillon works to employ the implementation strategies and reach target metrics and goals (in alphabetical order):

- Alliance for a Healthier South Carolina
- Blue Cross Blue Shield
- Boys and Girls Youth Center
- Care South (FQHC)
- Chamber of Commerce – Dillon
- City of Dillon
- Dillon Co. Rural Leadership Institute (RALI)
- First Steps
- Free Medical Clinic
- Healthy Learners
- McLeod Health Foundation
- McLeod Nurse Family Partnership
- McLeod OB/GYN Dillon
- Palmetto Care Connections
- Pee Dee Coalition
- South Carolina Campaign to Prevent Teen Pregnancy
- South Carolina Eat Smart, Move More
- South Carolina Office of Rural Health
- Tricounty/Trinity Mental Health
- United Way