Newberry County Memorial Hospital

Newberry, South Carolina

Community Health Needs Assessment
and Implementation Strategy

Adopted by Board Resolution July 26, 2016
Dear Community Member:

At Newberry County Memorial Hospital (NCMH), we have spent more than 90 years providing high-quality compassionate healthcare to the greater Newberry community. The “2016 Community Health Needs Assessment” identifies local health and medical needs and provides a plan of how NCMH 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, NCMH, 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 of our continuing efforts to meet your health and medical needs.

NCMH 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 hospital 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 A. Baldwin
Chief Executive Officer
Newberry County Memorial Hospital
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EXECUTIVE SUMMARY
EXECUTIVE SUMMARY

Newberry County Memorial Hospital ("NCMH" or the "Hospital") 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 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 for Newberry County are:

1. Obesity/Overweight
2. Affordability
3. Cancer
4. Coronary Heart Disease
5. Diabetes
6. Alzheimer’s
7. Physical Inactivity

The Hospital has developed implementation strategies for six of the seven needs (Obesity/Overweight, Affordability, Cancer, Coronary Heart Disease, Diabetes, and Physical Inactivity) including activities to continue/pursue, community partners to work alongside, and leading and lagging indicators to track. For implementation purposes, Physical Inactivity has been combined with Obesity/Overweight. NCMH has also decided to address Mental Health & Substance Abuse because, although it was not rated a Significant Health Need, the Hospital believes it is too important to ignore.
APPROACH
**APPROACH**

Newberry County Memorial Hospital is organized as a governmental, not-for-profit hospital. A Community Health Needs Assessment (CHNA) is part of the required hospital documentation of “Community Benefit” under the Affordable Care Act (ACA), required of all not-for-profit hospitals as a condition of retaining tax-exempt status. A CHNA assures NCMH 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.¹

**Project Objectives**

NCMH partnered with Quorum Health Resources (Quorum) to:²

- Complete a CHNA report, compliant with Treasury – IRS
- Produce the information necessary for the Hospital to issue an assessment of community health needs and document its intended response

**Overview of Community Health Needs Assessment**

Typically, non-profit hospitals qualify for tax-exempt status as a Charitable Organization, described in Section 501(c)(3) of the Internal Revenue Code; however, the term ‘Charitable Organization’ is undefined. Prior to the passage of Medicare, charity was generally recognized as care provided 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:

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

Specifically, the IRS requires:

- Effective on tax years beginning after March 23, 2012, each 501(c)(3) hospital facility 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.

¹ 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
² Part 3 Treasury/IRS – 2011 – 52 Section 3.03 (2) third party disclosure notice
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 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.

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:

(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.\(^3\)

...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

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\(^3\) 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
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 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.”

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.”

Quorum takes a comprehensive approach to the solicitation of written comments. As previously cited, we obtained

4 Federal Register Op. cit. P 78966 As previously noted the Hospital collaborated and obtained assistance in conducting this CHNA from Quorum Health Resources
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 hospital facility

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

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

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

**Other** (please specify)

Quorum also takes a comprehensive approach to assess community health needs. We perform several independent data analyses based on secondary source data, augment this with Local Expert Advisor 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 local expert area residents to note if they perceived the problems or needs identified by secondary sources existed in their portion of the county.

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 Advisor individuals cooperating with us in this study are displayed in the CHNA report appendix.

Data sources include:

<table>
<thead>
<tr>
<th>Website or Data Source</th>
<th>Data Element</th>
<th>Date Accessed</th>
<th>Data Date</th>
</tr>
</thead>
<tbody>
<tr>
<td><a href="http://www.countyhealthrankings.org">www.countyhealthrankings.org</a></td>
<td>Assessment of health needs of Newberry County</td>
<td>May 20, 2016</td>
<td>2010 to 2012</td>
</tr>
<tr>
<td></td>
<td>compared to all State counties</td>
<td></td>
<td></td>
</tr>
<tr>
<td><a href="http://www.communityhealth.hhs.gov">www.communityhealth.hhs.gov</a></td>
<td>Assessment of health needs of Newberry</td>
<td>May 20, 2016</td>
<td>2005 to 2011</td>
</tr>
<tr>
<td></td>
<td>County</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

6 “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 Quorum written comment solicitation classifications, with whom the Hospital solicited to participate in the Quorum/Hospital CHNA process.

7 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
### County compared to its national set of “peer counties”

<table>
<thead>
<tr>
<th>Tool/Source</th>
<th>Description</th>
<th>Date</th>
<th>Time Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Truven (formerly known as Thompson) Market Planner</td>
<td>Assess characteristics of the hospital’s primary service area, at a zip code level, based on classifying the population into various socio-economic groups, determining the health and medical tendencies of each group and creating an aggregate composition of the service area according to the proportion of each group in the entire area; and, to access population size, trends and socio-economic characteristics</td>
<td>May 20, 2016</td>
<td>2012 to 2015</td>
</tr>
<tr>
<td><a href="http://www.capc.org">www.capc.org</a> and <a href="http://www.getpalliativecare.org">www.getpalliativecare.org</a></td>
<td>To identify the availability of Palliative Care programs and services in the area</td>
<td>May 20, 2016</td>
<td>2015</td>
</tr>
<tr>
<td><a href="http://www.caringinfo.org">www.caringinfo.org</a> and iweb.nhpco.org</td>
<td>To identify the availability of hospice programs in the county</td>
<td>May 20, 2016</td>
<td>2015</td>
</tr>
<tr>
<td><a href="http://www.healthmetricsandevaluation.org">www.healthmetricsandevaluation.org</a></td>
<td>To examine the prevalence of diabetic conditions and change in life expectancy</td>
<td>May 20, 2016</td>
<td>2000 to 2010</td>
</tr>
<tr>
<td><a href="http://www.cdc.gov">www.cdc.gov</a></td>
<td>To examine area trends for heart disease and stroke</td>
<td>May 20, 2016</td>
<td>2008 to 2010</td>
</tr>
<tr>
<td><a href="http://svi.cdc.gov">http://svi.cdc.gov</a></td>
<td>To identify the Social Vulnerability Index value</td>
<td>May 20, 2016</td>
<td>2010</td>
</tr>
<tr>
<td><a href="http://www.CHNA.org">www.CHNA.org</a></td>
<td>To identify potential needs from a variety of resources and health need metrics</td>
<td>May 20, 2016</td>
<td>2003 to 2015</td>
</tr>
<tr>
<td><a href="http://www.datawarehouse.hrsa.gov">www.datawarehouse.hrsa.gov</a></td>
<td>To identify applicable manpower shortage designations</td>
<td>May 20, 2016</td>
<td>2015</td>
</tr>
<tr>
<td><a href="http://www.worldlifeexpectancy.com/usa-health-rankings">www.worldlifeexpectancy.com/usa-health-rankings</a></td>
<td>To determine relative importance among 15 top causes of death</td>
<td>May 20, 2016</td>
<td>2015</td>
</tr>
</tbody>
</table>

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 Advisors to gain input on local health needs and the needs of priority populations. Local Expert Advisors were local individuals selected according to criteria required...
by the Federal guidelines and regulations and the Hospital’s desire to represent the region’s geographically and ethnically diverse population. We received community input from 15 Local Expert Advisors. Survey responses started May 21, 2016 and ended with the last response on June 1, 2016.

- Information analysis augmented by local opinions showed how Newberry County relates to its peers in terms of primary and chronic needs and other issues of uninsured persons, low-income persons, and minority groups. Respondents commented on whether they believe certain population groups (“Priority Populations”) need help to improve their condition, and if so, who needs to do what to improve the conditions of these groups.
- 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
  - Access to care for residents of rural areas is needed
  - The community has a disproportionately high geriatric population
  - Low-income, African American and Hispanic residents in the community have unique needs
  - High prevalence of comorbidity between substance use disorder and mental illness

When the analysis was complete, we put the information and summary conclusions before our Local Expert Advisors 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. Consultation with 12 Local Experts occurred again via an internet-based survey (explained below) beginning June 10, 2016 and ending June 24, 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, regardless of their professional credentials.

In the NCMH 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 fifty percent (50%) 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 NCMH executive team where a reasonable break point in rank order occurred.
COMMUNITY CHARACTERISTICS
Definition of Area Served by the Hospital

NCMH, in conjunction with Quorum, defines its service area as Newberry County in South Carolina, which includes the following ZIP codes:\(^8\)

- 29037 – Chappells
- 29075 – Little Mountain
- 29108 – Newberry
- 29126 – Pomaria
- 29127 – Prosperity
- 29145 – Silverstreet
- 29178 – Whitmire

In 2014, the Hospital received 84.9% of its patients from this area.\(^9\)

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\(^8\) The map above amalgamates zip code areas and does not necessarily display all county zip codes represented below

\(^9\) Truven MEDPAR patient origin data for the hospital
## Demographics of the Community

The tables below were created by Truven Market Planner, a national marketing company.

All population information, unless otherwise cited, sourced from Truven (formally Thomson) Market Planner.

<table>
<thead>
<tr>
<th>Demographic Category</th>
<th>County</th>
<th>State</th>
<th>U.S.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2016 Population</strong></td>
<td>39,639</td>
<td>4,625,374</td>
<td>322,431,073</td>
</tr>
<tr>
<td><strong>% Increase/Decline</strong></td>
<td>2.8%</td>
<td>5.4%</td>
<td>3.7%</td>
</tr>
<tr>
<td><strong>Estimated Population in 2021</strong></td>
<td>40,743</td>
<td>5,179,817</td>
<td>334,341,965</td>
</tr>
<tr>
<td><strong>% White, non-Hispanic</strong></td>
<td>60.7%</td>
<td>63.6%</td>
<td>61.3%</td>
</tr>
<tr>
<td><strong>% Black, non-Hispanic</strong></td>
<td>29.3%</td>
<td>27.0%</td>
<td>12.3%</td>
</tr>
<tr>
<td><strong>Median Age</strong></td>
<td>41.4</td>
<td>39.0</td>
<td>38.0</td>
</tr>
<tr>
<td><strong>Median Household Income</strong></td>
<td>$43,104</td>
<td>$46,008</td>
<td>$55,072</td>
</tr>
<tr>
<td><strong>Unemployment Rate</strong></td>
<td>5.6%</td>
<td>5.7%</td>
<td>5.0%</td>
</tr>
<tr>
<td><strong>% Population &gt;65</strong></td>
<td>18.7%</td>
<td>16.4%</td>
<td>15.1%</td>
</tr>
<tr>
<td><strong>% Women of Childbearing Age</strong></td>
<td>17.6%</td>
<td>19.3%</td>
<td>19.6%</td>
</tr>
</tbody>
</table>
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%. Where Newberry County varies more than 5% above or below that norm (that is, less than 95% or greater than 105%), 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 Newberry County area. Items with blue text are viewed as statistically important potential beneficial findings—in other words, these are areas in which Newberry County is 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.
<table>
<thead>
<tr>
<th>Health Service Topic</th>
<th>Demand as % of National</th>
<th>% of Population Affected</th>
<th>Health Service Topic</th>
<th>Demand as % of National</th>
<th>% of Population Affected</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Weight / Lifestyle</strong></td>
<td></td>
<td></td>
<td><strong>Cancer</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BMI: Morbid/Obese</td>
<td>107.5%</td>
<td>32.5%</td>
<td>Mammography in Past Yr</td>
<td>98.6%</td>
<td>45.0%</td>
</tr>
<tr>
<td>Vigorous Exercise</td>
<td>97.5%</td>
<td>55.3%</td>
<td>Cancer Screen: Colorectal 2 yr</td>
<td>99.3%</td>
<td>25.3%</td>
</tr>
<tr>
<td>Chronic Diabetes</td>
<td>134.5%</td>
<td>16.5%</td>
<td>Cancer Screen: Pap/Cerv Test 2 yr</td>
<td>89.4%</td>
<td>53.6%</td>
</tr>
<tr>
<td>Healthy Eating Habits</td>
<td>91.7%</td>
<td>27.2%</td>
<td>Routine Screen: Prostate 2 yr</td>
<td>99.9%</td>
<td>32.0%</td>
</tr>
<tr>
<td>Ate Breakfast Yesterday</td>
<td>102.8%</td>
<td>69.3%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Slept Less Than 6 Hours</td>
<td>109.7%</td>
<td>17.1%</td>
<td>Chronic Lower Back Pain</td>
<td>126.3%</td>
<td>29.6%</td>
</tr>
<tr>
<td>Consumed Alcohol in the Past 30 Days</td>
<td>79.4%</td>
<td>43.3%</td>
<td>Chronic Osteoporosis</td>
<td>124.4%</td>
<td>12.2%</td>
</tr>
<tr>
<td>Consumed 3+ Drinks Per Session</td>
<td>104.9%</td>
<td>28.7%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Behavior</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I Will Travel to Obtain Medical Care</td>
<td>94.5%</td>
<td>22.2%</td>
<td>FP/GP: 1+ Visit</td>
<td>103.3%</td>
<td>91.2%</td>
</tr>
<tr>
<td>I am Responsible for My Health</td>
<td>94.4%</td>
<td>61.7%</td>
<td>Used Midlevel in last 6 Months</td>
<td>104.5%</td>
<td>43.3%</td>
</tr>
<tr>
<td>I Follow Treatment Recommendations</td>
<td>92.4%</td>
<td>47.9%</td>
<td>OB/Gyn 1+ Visit</td>
<td>83.2%</td>
<td>38.5%</td>
</tr>
<tr>
<td><strong>Pulmonary</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic COPD</td>
<td>132.5%</td>
<td>5.3%</td>
<td>Use Internet to Talk to MD</td>
<td>68.6%</td>
<td>8.5%</td>
</tr>
<tr>
<td>Tobacco Use: Cigarettes</td>
<td>118.1%</td>
<td>30.1%</td>
<td>Facebook Opinions</td>
<td>87.3%</td>
<td>9.0%</td>
</tr>
<tr>
<td><strong>Heart</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic High Cholesterol</td>
<td>125.2%</td>
<td>27.5%</td>
<td>Looked for Provider Rating</td>
<td>86.1%</td>
<td>12.3%</td>
</tr>
<tr>
<td>Routine Cholesterol Screening</td>
<td>91.5%</td>
<td>46.5%</td>
<td>Emergency Room Use</td>
<td>104.2%</td>
<td>35.3%</td>
</tr>
<tr>
<td>Chronic Heart Failure</td>
<td>142.8%</td>
<td>6.2%</td>
<td>Urgent Care Use</td>
<td>91.1%</td>
<td>21.2%</td>
</tr>
<tr>
<td><strong>Routine Services</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Orthopedic</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Internet Usage</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Emergency Service</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Leading Causes of Death

<table>
<thead>
<tr>
<th>Newberry Rank</th>
<th>SC Rank</th>
<th>Condition</th>
<th>Rank among all counties in SC (#1 rank = worst in state)</th>
<th>Rate of Death per 100,000 age adjusted</th>
<th>Observation (County compared to U.S.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>Heart Disease</td>
<td>26 of 46</td>
<td>180.0</td>
<td>218.7</td>
</tr>
<tr>
<td>2</td>
<td>1</td>
<td>Cancer</td>
<td>28 of 46</td>
<td>174.0</td>
<td>195.3</td>
</tr>
<tr>
<td>3</td>
<td>4</td>
<td>Stroke</td>
<td>29 of 46</td>
<td>47.6</td>
<td>58.0</td>
</tr>
<tr>
<td>4</td>
<td>5</td>
<td>Accidents</td>
<td>32 of 46</td>
<td>46.6</td>
<td>50.5</td>
</tr>
<tr>
<td>5</td>
<td>3</td>
<td>Lung</td>
<td>22 of 46</td>
<td>50.8</td>
<td>47.6</td>
</tr>
<tr>
<td>6</td>
<td>6</td>
<td>Alzheimer's</td>
<td>4 of 46</td>
<td>32.4</td>
<td>42.9</td>
</tr>
<tr>
<td>7</td>
<td>7</td>
<td>Diabetes</td>
<td>11 of 46</td>
<td>22.6</td>
<td>33.7</td>
</tr>
<tr>
<td>8</td>
<td>9</td>
<td>Flu – Pneumonia</td>
<td>27 of 46</td>
<td>14.2</td>
<td>18.8</td>
</tr>
<tr>
<td>9</td>
<td>8</td>
<td>Kidney</td>
<td>30 of 46</td>
<td>16.0</td>
<td>18.0</td>
</tr>
<tr>
<td>10</td>
<td>10</td>
<td>Blood Poisoning</td>
<td>27 of 46</td>
<td>13.6</td>
<td>14.2</td>
</tr>
<tr>
<td>11</td>
<td>11</td>
<td>Suicide</td>
<td>9 of 46</td>
<td>14.0</td>
<td>14.1</td>
</tr>
<tr>
<td>12</td>
<td>12</td>
<td>Liver</td>
<td>18 of 46</td>
<td>12.1</td>
<td>11.9</td>
</tr>
<tr>
<td>13</td>
<td>13</td>
<td>Hypertension</td>
<td>20 of 46</td>
<td>8.0</td>
<td>11.2</td>
</tr>
<tr>
<td>14</td>
<td>14</td>
<td>Parkinson’s</td>
<td>6 of 46</td>
<td>7.7</td>
<td>7.6</td>
</tr>
<tr>
<td>15</td>
<td>15</td>
<td>Homicide</td>
<td>43 of 46</td>
<td>6.8</td>
<td>5.0</td>
</tr>
</tbody>
</table>
Priority Populations

Information about Priority Populations in the service area of the Hospital 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 (QDR), which are annual reports to Congress mandated in the Healthcare Research and Quality Act of 1999 (P.L. 106-129). These reports provide a comprehensive overview of the quality of healthcare received by the general U.S. population and disparities in care experienced by different racial, ethnic, and socioeconomic groups. The purpose of the reports is to assess the performance of 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 complete report is provided in Appendix C.

We asked a specific question to our Local Expert Advisors 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 Advisors to identify unique population needs to which we should respond. Specific opinions from the Local Expert Advisors are summarized below:

- Access to care for residents of rural areas is needed
- The community has a disproportionately high geriatric population
- Low-income, African American and Hispanic residents in the community have unique needs
- High prevalence of comorbidity between substance use disorder and mental illness

13 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.

The western portion of Newberry County falls into the second highest quartile of social vulnerability, and the eastern portion falls into the lowest two quartiles. However, the central portion is noted as being in the highest quartile of vulnerability.
Consideration of Written Comments from Prior CHNA

A group of 15 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:

<table>
<thead>
<tr>
<th>Local Experts Offering Solicited Written Comments on 2013 Priorities and Implementation Strategy</th>
<th>Yes (Applies to Me)</th>
<th>No (Does Not Apply to Me)</th>
<th>Response Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Public Health Expertise</td>
<td>8</td>
<td>4</td>
<td>12</td>
</tr>
<tr>
<td>2) Departments and Agencies with relevant data/information regarding health needs of the community served by the hospital</td>
<td>5</td>
<td>7</td>
<td>12</td>
</tr>
<tr>
<td>3) Priority Populations</td>
<td>6</td>
<td>4</td>
<td>10</td>
</tr>
<tr>
<td>4) Representative/Member of Chronic Disease Group or Organization</td>
<td>3</td>
<td>8</td>
<td>11</td>
</tr>
<tr>
<td>5) Represents the Broad Interest of the Community</td>
<td>10</td>
<td>4</td>
<td>14</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Answered Question</td>
<td></td>
<td></td>
<td>15</td>
</tr>
<tr>
<td>Skipped Question</td>
<td></td>
<td></td>
<td>0</td>
</tr>
</tbody>
</table>

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

- Affordability
- Cancer
- Coronary Heart Disease
- Obesity/Overweight
- Maternal/Child Health
- Diabetes
- Predisposing Conditions
- Alcohol Abuse

NCMH 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?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>No Opinion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Affordability</td>
<td>10</td>
<td>0</td>
</tr>
<tr>
<td>Cancer</td>
<td>10</td>
<td>1</td>
</tr>
<tr>
<td>Coronary Heart Disease</td>
<td>11</td>
<td>1</td>
</tr>
<tr>
<td>Obesity/Overweight</td>
<td>12</td>
<td>0</td>
</tr>
<tr>
<td>Maternal/Child Health</td>
<td>11</td>
<td>1</td>
</tr>
<tr>
<td>Diabetes</td>
<td>12</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>---------------------</td>
<td>-----</td>
<td>----</td>
</tr>
<tr>
<td>Predisposing Conditions</td>
<td>10</td>
<td>0</td>
</tr>
<tr>
<td>Alcohol Abuse</td>
<td>11</td>
<td>0</td>
</tr>
</tbody>
</table>

- Specific comments or observations about **Affordability** as being among the most significant needs for the Hospital to work on to seek improvements?
  - *If people do not have access to affordable healthcare, some will be deterred from seeking the care they need.*
  - *This should remain*
  - *will always be an area of concern*
  - *Affordability will always be an issue*
  - *HOP usage at both the hospital and at WBHS shows that many local residents cannot afford care and are under- or uninsured.*

- Specific comments or observations about **Cancer** as being among the most significant needs for the Hospital to work on to seek improvements?
  - *Education about the tests to detect early stages as well as affordability should help in this area.*
  - *Yes should remain*
  - *Yes, especially since some our initial equipment costs have since decreased leaving us in a position of a higher return on our investment and already having the staff and equipment to support both chemo and radiation*

- Specific comments or observations about **Coronary Heart Disease** as being among the most significant needs for the Hospital to work on to seek improvements?
  - *Being the #1 cause of death, this area is a no-brainer. This issue is also larger than just eating better foods; there is the high cost of healthier foods that is always a barrier. It is also far too easy to pick up unhealthy foods than prepare healthier versions.*
  - *Yes....early detection would benefit. Ongoing community involvement of the risk factors. Reduced cost for carotid screening and/or sonography.*
  - *Continuing education efforts and supporting the local physicians*

- Specific comments or observations about **Obesity/Overweight** as being among the most significant needs for the Hospital to work on to seek improvements?
  - *This issue is larger than just eating better foods; there is the high cost of healthier foods that is always a barrier. It is also far too easy to pick up unhealthy foods than prepare healthier versions.*
  - *Yes.....*
  - *One of the main underlying health problems in this area - predisposing to DM, HTN, CAD, CVD, etc*

- Specific comments or observations about **Maternal/Child Health** as being among the most significant needs for the Hospital to work on to seek improvements?
• Healthier moms lead to healthier babies who have a better chance in life.

• Yes

• Specific comments or observations about Diabetes as being among the most significant needs for the Hospital to work on to seek improvements?
  ▪ Circling back to health care and diet that been addressed in #s 6, 10, and 12.
  ▪ Yes

• Specific comments or observations about Predisposing Conditions as being among the most significant needs for the Hospital to work on to seek improvements?
  ▪ We have a long way to go with this one. I would like to see more mentoring between adults and children to try to overcome some of the conditions. Currently looking into grants for this purpose.

• Specific comments or observations about Alcohol Abuse as being among the most significant needs for the Hospital to work on to seek improvements?
  ▪ Outside of addressing the underage aspect, I almost feel as though we are limited in what we can do about addiction as a community. Having resources and support systems for people who realize their addictions is important. This may be the least likely issue to be able to alter.
  ▪ Yes
  ▪ Substance abuse is a priority health need for the Newberry County.
Summary of Observations: Comparison to Other Counties

Health Outcomes
In a health status classification termed “Health Outcomes,” Newberry County ranks 23 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,” Newberry County ranks number 11 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:

- Adult Obesity – Newberry 33% of residents compared to SC 32% and US best of 25%
- Physical Inactivity – Newberry 26% of residents compared to SC 25% and US best of 20%
- Sexually Transmitted Infection – Newberry 598.8 cases per 100,000 compared to SC 541.8 and US best of 134.1
- Teen Births – Newberry 51 births per 1,000 (age 15 to 19) compared to SC 43 and US best of 19
- Access to Exercise Opportunities – Newberry 59% which is worse than the SC average of 71% and US best of 91%

Clinical Care
In the “Clinical Care” classification, Newberry County ranks 17th 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:

- Uninsured – Newberry 20% of residents compared to SC 19% and US best of 11%
- Population to Dentist – Newberry 3,780:1 which is worse than the SC average of 1,950:1 and US best of 1,340:1
- Population to Mental Health Provider – Newberry 1,640:1 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, Newberry County ranks number 13 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 – Newberry 30% of children compared to SC 26% and US best of 13%
- Children in Single-Parent Households – Newberry 45% of children compared to SC 40% and US best of 21%
- Some College – Newberry 50% compared to SC 61% and US best of 72%
Summary of Observations: Peer Comparisons

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 Newberry County is compared to its national set of Peer Counties and compared to national rates result in the following:

Mortality

- **Better**
  - Coronary Heart Disease Deaths

- **Worse**
  - Female Life Expectancy – 78.5 years; 12\(^{th}\) worst among 70 peer counties; US avg. 79.8
  - Diabetes Deaths – 32.0 deaths per 100,000; 12\(^{th}\) worst among 69 peer counties; US avg. 24.7
  - Male Life Expectancy – 72.3 years; 7\(^{th}\) worst among 70 peer counties; US avg. 75.0
  - Alzheimer’s Disease Deaths – 52.1 deaths per 100,000; 4\(^{th}\) worst among 69 peer counties; US avg. 27.3

Morbidity

- **Better**
  - Cancer

- **Worse**
  - Adult Diabetes – 9.8% of adults; 17\(^{th}\) worst among 69 peer counties; US avg. 8.1%
  - Gonorrhea – 90.1 rate per 100,000; 10\(^{th}\) worst among 70 peer counties; US avg. 30.5%
  - HIV – 264.5 rate per 100,000; worst among 64 peer counties; US avg. 105.5
  - Syphilis – 10.6 rate per 100,000; worst among 70 peer counties; US avg. 0.0
  - Preterm Births – 17.0% of births; worst among 70 peer counties; US avg. 12.1%

Healthcare Access and Quality

- **Better**
  - Nothing

- **Worse**
  - Uninsured – 19.2% of the population; 12\(^{th}\) worst among 70 peer counties; US avg. 17.7%

Health Behaviors

- **Better**
  - Nothing

- **Worse**
  - Teen Births – 55.8 rate per 1,000; 9\(^{th}\) worst among 70 peer counties; US avg. 42.1
Social Factors

- **Better**
  - Nothing

- **Worse**
  - Inadequate Social Support – 21.2% of adults; 16th worst among 63 peer counties; US avg. 19.6%
  - On Time High School Graduation – 76% graduation rate; 3rd worst among 62 peer counties; US avg. 83.8%
  - Children in Single-Parent Households – 41.2% of children; 3rd worst among 70 peer counties; US avg. 30.8%
  - Violent Crime – 383.1 rate per 100,000; 11th worst among 66 peer counties; US avg. 199.2
Conclusions from Demographic Analysis Compared to National Averages

According to 2016 Truven Health Analytics data, the current population for Newberry County is estimated to be 39,639 and expected to increase at a rate of 2.8% through 2021. This is lower than South Carolina's 5.4% growth rate and the national average of 3.7%. In 2021, Newberry County anticipates a population of 40,743.

Population estimates indicate the 2016 median age for the county is 41.4 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 $43,104, 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 ($122,294) for Newberry is lower than the South Carolina median of $149,936 and the national median of $192,364. Newberry's unemployment rate as of March 2016 is 5.6%, which is lower than the 5.7% statewide but higher than the 5.0% national civilian unemployment rate.

The portion of the population in the county over 65 is 18.7%, compared to South Carolina (16.4%) and the national average (15.1%). The portion of the population of women of childbearing age is 17.6%, lower than the South Carolina average of 19.3% and the national rate of 19.6%. 60.7% of the population is White non-Hispanic. The largest minority is the Black non-Hispanic population which comprises 29.3% of the total.

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

- BMI: Morbid/Obese is 7.5% above average, impacting 32.5% of the population
- I Am Responsible for My Health is 5.6% below average, impacting 61.7% of the population
- I Follow Treatment Recommendations is 7.6% below average, impacting 47.9% of the population
- Tobacco Use: Cigarettes is 18.1% above average, impacting 30.1% of the population
- Routine Cholesterol Screening is 8.5% below average, impacting 46.5% of the population
- Cervical Cancer Screening in past two years is 10.6% below average, impacting 53.6% of the population
- OB/GYN Visit is 16.8% below average, impacting 38.5% of the population

Metrics impacting more than 30% 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 20.6% below average, impacting 43.3% of the population
Conclusions from Other Statistical Data

Among the Top 15 Causes of Death in the U.S., 6 of the 15 occurred at expected rates in Newberry County. However, Stroke, Diabetes, Alzheimer's, Kidney Disease, Blood Poisoning, Suicide, Liver Disease, Hypertension, and Parkinson's occurred at higher rates than expected. The Top 10 Causes of Death in Newberry County are:

1. Heart Disease with Newberry ranking #26 among 46 SC counties (where #1 is worst in state)
2. Cancer ranking #28 in SC
3. Stroke ranking #29 in SC
4. Accidents ranking #32 in SC
5. Lung Disease ranking #22 in SC
6. Alzheimer's ranking #4 in SC
7. Diabetes ranking #11 in SC
8. Flu/Pneumonia ranking #27 in SC
9. Kidney Disease ranking #30 in SC
10. Blood Poisoning 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 Newberry County measures which are worse than the US average and had an unfavorable change:

- **Male Heavy Drinking** – As of 2012, 12.1% of males are heavy drinkers; value increased 2.5 percentage points since 2005
- **Male Binge Drinking** – As of 2012, 26.3% of males are binge drinkers; value increased 2 percentage points since 2002
- **Female Obesity** – As of 2011, 45.4% of females are obese; value increased 9.1 percentage points since 2001
- **Male Obesity** – As of 2011, 41.1% of males are obese; value increased 8.8 percentage points since 2001
- **Male Physical Activity** – As of 2011, physical activity for males is at 49.4%; value decreased -3.7 percentage points since 2001

Unfavorable Newberry County measures which are worse than the US average but had a favorable change:

- **Female Life Expectancy** – As of 2013, female life expectancy is at 78.4 years; value increased 1 years since 1985
- **Male Life Expectancy** – As of 2013, male life expectancy is at 73.9 years; value increased 6.6 years since 1985
- **Female Smoking** – As of 2012, female smoking is at 22.6%; value decreased -1.3 percentage points since 1996
- **Male Smoking** – As of 2012, male smoking is at 28.6%; value decreased -3.5 percentage points since 1996

- **Female Physical Activity** – As of 2011, physical activity for females is at 41.9%; value increased 6 percentage points since 2001

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

- **Female Heavy Drinking** – As of 2012, 5.1% of females are heavy drinkers; value increased 1.4 percentage points since 2005

- **Female Binge Drinking** – As of 2012, 8.6% of females are binge drinkers; value increased 1.2 percentage points since 2002

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

- None
Conclusions from Prior CHNA Implementation Activities

“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 the Hospital in its implementation efforts included:

- $5,857,564
EXISTING HEALTHCARE FACILITIES, RESOURCES, & IMPLEMENTATION STRATEGY
Significant Health Needs

We used the priority ranking of area health needs by the Local Expert Advisors to organize the search for locally available resources as well as the response to the needs by NCMH. 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 NCMH current efforts responding to the need including any written comments received regarding prior NCMH implementation actions
- Establishes the Implementation Strategy programs and resources NCMH will devote to attempt to achieve improvements
- Documents the Leading Indicators NCMH will use to measure progress
- Presents the Lagging Indicators NCMH 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.

In general, NCMH is the major hospital in the service area. Newberry County Memorial Hospital is a licensed 90-bed general medical and surgical facility with 52 beds in service located in Newberry, South Carolina. The next closest facilities are outside the service area and include:

- GHS Laurens County Memorial Hospital in Clinton, SC, 30 miles (33 minutes)
- Palmetto Health Baptist Parkridge in Columbia, SC, 31 miles (40 minutes)
- Wallace Thomson Hospital in in Union, SC, 36 miles (41 minutes)
- Self Regional Healthcare in Greenwood, SC, 38 miles (52 minutes)

All of the data that was analyzed to determine the significant needs are “Lagging Indicators,” which are measures presented after a period of time, showing historical performance. Lagging Indicators tell you nothing about how the outcomes were achieved. In contrast, the NCMH 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 must be within the ability of the hospital to influence and measure.
1. **OBESITY/OVERWEIGHT** – 2013 Significant Need; adult obesity worse than SC and US average; BMI: Morbid/Obese 7.5% above average; male and female obesity worse than US average

7. **PHYSICAL INACTIVITY** – above SC and US average; access to exercise opportunities below SC and US average; male and female physical activity worse than US average

(For the purposes of the implementation plan, the #1 and #7 needs have been combined.)

**Public comments received on previously adopted implementation strategy:**

- *Battle of the Bulge seems to go over well. Offering a walking track free to the public is an asset to the community.*
- *Adequate to the community involvement. Need greater participation*
- *The more we can do the better. The Wellness Center is a good resource for implementing more in this area*

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

- Eat Smart, Move More – Newberry County; community collaboration; help write grant; encourages healthy eating/wellness; supports local farmer’s market
- Healthy Hearts/Healthy Habits; diabetic educator providing healthy lifestyle education
- Provide meeting space to weight watchers program
- Battle of the Bulge program (weekly meetings/5k race); discounted rates for wellness program; 200 people (2014)
- Diabetic educator on staff; provides diet education (cooking classes)
- Wellness program with fitness center on-site including classes and trained staff to help educate on exercise; provides initial assessment; open to public; includes discounted rates for employees and family members
- Provide a walking track open to the public
- Post articles on social media and website on health and wellness; success stories from wellness program in local newspaper
- Participating in 7 local health fairs and industrial health fairs; blood pressure checks/glucose checks/orthotics for diabetics
- Speaking engagements at local churches/civic clubs/Chamber of Commerce on a variety of health care topics
- Rehab staff went to local private school to teach physical education class

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

- Researching federal grant program to help encourage wellness and healthy lifestyles; include schools/senior centers/physician programs
- Looking into venture with YMCA to help expand wellness program
- Explore partnership with local college to promote healthy lifestyle
- Look at collaborating with Boys Farm to combine annual half marathon with existing 5k run walk
• Initiating process and training for recognizing sleep issues before patients leave to send them home with sleep study materials to prevent readmissions

Anticipated results from NCMH Implementation Strategy

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</table>

The strategy to evaluate NCMH intended actions is to monitor change in the following Leading Indicator:

• Number of participants in wellness program = 266 (2015)

The change in the Leading Indicator anticipates appropriate change in the following Lagging Indicator:

• Adult Obesity rate = 33% (SC 32%, and US best 25%) (2016)

NCMH anticipates collaborating with the following other facilities and organizations to address this Significant Need:

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<td>Newberry College</td>
<td>Athletic trainer</td>
<td><a href="http://www.newberry.edu">www.newberry.edu</a></td>
</tr>
<tr>
<td>Eat Smart, Move More</td>
<td></td>
<td><a href="http://www.eatsmartmovemore.org">www.eatsmartmovemore.org</a></td>
</tr>
<tr>
<td>Newberry Public School System</td>
<td></td>
<td><a href="http://www.newberry.k12.sc.us">www.newberry.k12.sc.us</a> (803) 321-2600</td>
</tr>
<tr>
<td>Organization</td>
<td>Contact Name</td>
<td>Contact Information</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>----------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>Boys Farm</td>
<td>André Jennings</td>
<td><a href="http://www.boysfarm.org">www.boysfarm.org</a> (803) 276-5910</td>
</tr>
<tr>
<td>Newberry Academy</td>
<td></td>
<td><a href="http://www.newberryacademy.com">www.newberryacademy.com</a> (803) 276-2760</td>
</tr>
<tr>
<td>Newberry Free Clinic</td>
<td>Pam Branton</td>
<td><a href="http://www.newberryclinic.org">www.newberryclinic.org</a> (803) 276-6665</td>
</tr>
<tr>
<td>Local industries</td>
<td></td>
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</tbody>
</table>

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

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<tbody>
<tr>
<td>Local fitness centers</td>
<td></td>
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</tbody>
</table>
2. **AFFORDABILITY** – 2013 Significant Need; uninsured rate higher than SC and US average; uninsured 12th worst among peer counties

Public comments received on previously adopted implementation strategy:

- *I am not aware of the hospital's actions to address*
- *Effective to the extent possible*
- *can we do things more cost effectively than can be done at bigger hospitals? that would be a big advantage if the quality is good as well*
- *The hospital should continue to use its charitable care and work closely, as it has in the past, with the free clinic. We haven't seen much of an increase in patients at the hospital presenting a government plan under the ACA, so the only solution at this point is to continue to utilize these methods.*

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

- Adopted new financial assistance policies, including sliding fee scale; expanded eligibility for charity care
- Adopted policy for discount for self-pay patients for up-front payers (discount is average of all payers)
- Working with Healthy Outcomes Program (HOP) collaborative with local agencies (DHEC, Health Department, Free Clinic) to identify low-income/high-needs populations to target for services (includes mental health professional)
- Staff members in ER available (including certified Navigators) to help patients apply for Medicaid or access Charity Care; help patients provide medical homes at clinics or local physician offices
- ED provides emergent/urgent care regardless of ability to pay
- Hospital provides ancillary services like X-rays, surgeries, etc., to Newberry Free Clinic
- Work with drug companies to find replacement drugs for Oncology patients who can’t afford medications
- Continuous recruitment of primary care physicians to improve access and decrease use of ER
- Case Management team works closely with patients to coordinate care and find resources
- Provide tele-stroke program in collaboration with Greenville Health Systems; joint venture for Oncology that provides chemo locally; local Pediatric Rehab program; visiting Cardiologists, Nephrologists, Sleep Study, Orthotics; Wound Care program with two hyperbaric chambers for diabetes patients (reduces transportation needs)
- Provide free screenings at local health fairs and industrial health fairs; blood pressure checks/glucose checks/orthotics for diabetics

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

- As part of ACO, staff members will become certified to provide care management/coordination
- Continuous recruitment of primary care physicians to improve access and decrease use of ER
- Continue expanding HOP
- Continue above activities
NCMH evaluation of impact of actions taken since the immediately preceding CHNA:

- Added mid-levels in the ED and in family practice clinics

**Anticipated results from NCMH Implementation Strategy**

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</tbody>
</table>

The strategy to evaluate NCMH intended actions is to monitor change in the following Leading Indicator:

- Medicaid applications = 670 (2015)

The change in the Leading Indicator anticipates appropriate change in the following Lagging Indicator:

- Uninsured Rate = 20% (SC 19%, US best 11%) (2016)

NCMH anticipates collaborating with the following other facilities and organizations to address this Significant Need:

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<tr>
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<tbody>
<tr>
<td>Healthy Outcomes Program (HOP)</td>
<td>Kevin Bonds</td>
<td><a href="https://msp.scdhhs.gov/proviso/site-page/healthy-outcomes-plan-0">https://msp.scdhhs.gov/proviso/site-page/healthy-outcomes-plan-0</a></td>
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<td>Newberry Free Clinic</td>
<td>Pam Branton</td>
<td><a href="http://www.newberryclinic.org">www.newberryclinic.org</a> (803) 276-6665</td>
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<tr>
<td>Resource Corporation of America (Medicaid eligibility assistance)</td>
<td>Elizabeth Turner</td>
<td><a href="http://www.resource-corp.com">www.resource-corp.com</a></td>
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Other local resources identified during the CHNA process that are believed available to respond to this need:

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<tr>
<td>Local Home Health, DMEs</td>
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</table>
3. **CANCER** – 2013 Significant Need; #2 leading cause of death; cervical cancer screening 10.6% below average

**Public comments received on previously adopted implementation strategy:**
- *I am not aware of the hospital’s actions to address*
- *Adequate...inclusion of early detection/screening would be of benefit*

**NCMH services, programs, and resources available to respond to this need include:**
- Work with drug companies to find replacement drugs for Oncology patients who can’t afford medications
- Joint venture with local oncologists/radiation therapist to provide chemo and radiation locally
- IV Infusion Center offered in the hospital, including some free services for those who can’t afford
- Mammography technicians present at local health fairs educating on benefits of screenings and self-exams
- Breast Cancer Awareness campaign in August including some free screenings
- Coordinate with Newberry Free Clinic for colonoscopies
- Sponsor for local Relay for Life

**Additionally, NCMH plans to take the following steps to address this need:**
- Research offering reduced-rate mammograms
- Look at promoting February as Colon Cancer Awareness Month and have providers educate on need for colonoscopies

**Anticipated results from NCMH Implementation Strategy**

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The strategy to evaluate NCMH intended actions is to monitor change in the following Leading Indicator:

- Number of colonoscopies performed = 874 (2015)
- Number of mammograms performed = 3,000 (2015)

The change in the Leading Indicator anticipates appropriate change in the following Lagging Indicator:

- Cancer rate = 419.5 per 100,000 (age adjusted cancer incidence rate) (2016)

NCMH anticipates collaborating with the following other facilities and organizations to address this Significant Need:

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<tr>
<td>Newberry Free Clinic</td>
<td>Pam Branton</td>
<td><a href="http://www.newberryclinic.org">www.newberryclinic.org</a> (803) 276-6665</td>
</tr>
<tr>
<td>Newberry Oncology</td>
<td></td>
<td>298 Commerce Dr, Newberry, SC 29108 (803) 321-3232</td>
</tr>
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Other local resources identified during the CHNA process that are believed available to respond to this need:

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<td>Local physicians</td>
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4. **CORONARY HEART DISEASE** – 2013 Significant Need; #1 leading cause of death; routine cholesterol screening 8.5% below average

Public comments received on previously adopted implementation strategy:

- *I am not aware of the hospital's actions to address*
- *Diminished due to expense*

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

- **Eat Smart, Move More** – Newberry County; community collaboration; help write grant; encourages healthy eating/wellness; supports local farmer’s market
- **Provide meeting space to weight watchers program**
- **Battle of the Bulge program (weekly meetings/5k race); discounted rates for wellness program; 200 people (2014)**
- **Diabetic educator on staff; provides diet education (cooking classes)**
- **Wellness program with fitness center on-site including classes and trained staff to help educate on exercise; provides initial assessment; open to public; includes discounted rates for employees and family members**
- **Provide a walking track open to the public**
- **Post articles on social media and website on health and wellness; success stories from wellness program in local newspaper**
- **Participating in local and industrial health fairs; blood pressure checks/glucose checks/orthotics for diabetics**
- **Speaking engagements at local churches/civic clubs/Chamber of Commerce on a variety of health care topics**
- **Certified Cardiac Rehab program (Levels I, II, and III)**
- **Offer cardiac stress testing**
- **Visiting Cardiologist two days each week**
- **STEMI (ST elevation myocardial infarction) training and protocol for early recognition to reduce heart damage**
- **Hospital manages local EMS services, which improves communication and reduces barriers, particularly in situations of cardiovascular events**

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

- Continue above activities

**NCMH evaluation of impact of actions taken since the immediately preceding CHNA:**

- Collaborate with local home health agency to provide home heart disease monitoring
### Anticipated results from NCMH Implementation Strategy

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**The strategy to evaluate NCMH intended actions is to monitor change in the following Leading Indicator:**

- Number of Phase II Cardiac Rehabilitation Visits = 184 patients with 1,456 sessions (2015)

**The change in the Leading Indicator anticipates appropriate change in the following Lagging Indicator:**

- Heart Disease Deaths = 83.3 per 100,000 (2016)

**NCMH anticipates collaborating with the following other facilities and organizations to address this Significant Need:**

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<tr>
<th>Organization</th>
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<tbody>
<tr>
<td>Columbia Cardiology</td>
<td></td>
<td>2601 Laurel St #260, Columbia, SC 29204</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(803) 744-4900</td>
</tr>
<tr>
<td>Eat Smart, Move More</td>
<td></td>
<td><a href="http://www.eatsmartmovemoresc.org">www.eatsmartmovemoresc.org</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>184 Commerce Drive, Newberry, SC 29108</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(803) 276-9359</td>
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Other local resources identified during the CHNA process that are believed available to respond to this need:

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<th>Organization</th>
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<tr>
<td>Local physicians</td>
<td></td>
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<tr>
<td>American Heart Association (local Jump Rope for Heart program)</td>
<td></td>
<td><a href="http://www.heart.org/HEARTORG/Giving/ForSchools/JumpRopeforHeartEvent/Jump-Rope-for-Heart-Event_UCM_315609_Sub">http://www.heart.org/HEARTORG/Giving/ForSchools/JumpRopeforHeartEvent/Jump-Rope-for-Heart-Event_UCM_315609_Sub</a> HomePage.jsp</td>
</tr>
</tbody>
</table>
5. **DIABETES** – 2013 Significant Need; diabetes deaths 12th worst among peer counties

**Public comments received on previously adopted implementation strategy:**

- *I am not aware of the hospital’s actions to address*
- *More health fairs for screening*

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

- **Eat Smart, Move More** – Newberry County; community collaboration; help write grant; encourages healthy eating/wellness; supports local farmer’s market
- Provide meeting space to local Weight Watchers group
- Battle of the Bulge program (weekly meetings/5k race); discounted rates for wellness program; 200 members (2014)
- Diabetic educator on staff; provides diet education (cooking classes), counseling for inpatients and outpatients, and encourages having a ‘cheerleader’ to also be educated and work alongside patient
  - Pharmacist and nurses provide specific education on diabetes medications and how to administer them properly
- Free glucometers and strips available for those who don’t qualify for Medicaid, but need assistance
- Wellness program with fitness center on site, including classes and trained staff to help educate on exercise; provides initial assessment; open to public; includes discounted rates for employees and family members
- Provide a walking track open to the public
- Post articles on social media and website on health and wellness; success stories from wellness program in local newspaper
- Participating in local and industrial health fairs; blood pressure checks/glucose checks/orthotics for diabetics/A1C screenings
- Speaking engagements at local churches/civic clubs/Chamber of Commerce on a variety of healthcare topics
- Case Management team works closely with patients to coordinate care and find resources
- Work with Healthy Outcomes Program (HOP) collaborative with local agencies (DHEC, Health Department, Free Clinic) to identify low-income/high-needs populations to target for services (includes mental health professional)
- Collaborate with RCA to help diabetes patients (in particular) get enrolled in Medicaid

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

- Continue above activities
Anticipated results from NCMH Implementation Strategy

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</table>

The strategy to evaluate NCMH intended actions is to monitor change in the following Leading Indicator:

- Number of glucose checks provides at health fairs = 61
- Number of A1C screens provided at health fairs = 30

The change in the Leading Indicator anticipates appropriate change in the following Lagging Indicator:

- Diabetes Deaths = 32 deaths per 100,000 (12th worst among 69 peer counties; US avg. 24.7) (2016)

NCMH anticipates collaborating with the following other facilities and organizations to address this Significant Need:

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<th>Organization</th>
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<tr>
<td>Eat Smart, Move More</td>
<td></td>
<td><a href="http://www.eatsmartmovemoresc.org">www.eatsmartmovemoresc.org</a></td>
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<tr>
<td>Healthy Outcomes Program (HOP)</td>
<td>Kevin Bonds</td>
<td><a href="https://msp.scdhhs.gov/proviso/site-page/healthy-outcomes-plan-0">https://msp.scdhhs.gov/proviso/site-page/healthy-outcomes-plan-0</a></td>
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<tr>
<td>Resource Corporation of America (Medicaid eligibility assistance)</td>
<td>Elizabeth Turner</td>
<td><a href="http://www.resource-corp.com">www.resource-corp.com</a></td>
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<td>(803) 276-9359</td>
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Other local resources identified during the CHNA process that are believed available to respond to this need:

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</table>
6. **ALZHEIMER’S** – #6 leading cause of death; 4\(^{th}\) worst among peer counties

**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

**NCMH does not intend to develop an implementation strategy for this Significant Need**
- We are choosing not to respond to this need at this time. We feel we can have a greater impact by putting attention and resources toward other significant needs for which we are better qualified to serve.

<table>
<thead>
<tr>
<th>Federal classification of reasons why a hospital may cite for not developing an Implementation Strategy for a defined Significant Need</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Resource Constraints</td>
<td>X</td>
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<tr>
<td>2. Relative lack of expertise or competency to effectively address the need</td>
<td>X</td>
</tr>
<tr>
<td>3. A relatively low priority assigned to the need</td>
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<tr>
<td>4. A lack of identified effective interventions to address the need</td>
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<tr>
<td>5. Need is addressed by other facilities or organizations in the community</td>
<td>X</td>
</tr>
<tr>
<td>6. Other</td>
<td></td>
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11. **MENTAL HEALTH & SUBSTANCE ABUSE** – Not a 2016 Significant Need, but the Hospital is choosing to address because of the importance of this issue

Suicide is the #11 leading cause of death; Newberry County is ranked #9 of 46 SC counties; 14.1 suicide deaths per 100,000, which is higher than SC and the US;

**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

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

- PET Team – contract with Palmetto Health to help with diagnosis and placement of patients presenting with mental health issues
- Behavioral Health department – physician and two social workers who provide limited counseling and group therapy sessions (primarily targeted at seniors)
- ED physicians very conservative in providing narcotics

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

- Research providing education sessions to local schools on substance abuse/suicide/mental health
- Look at need for additional hours for psychiatrist
- Research space and options for providing inpatient mental health services
- Look at coalition with other mental health/behavioral health agencies to improve collaboration and coordination

**Anticipated results from NCMH Implementation Strategy**

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<tbody>
<tr>
<td>1. Available to public and serves low income consumers</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>2. Reduces barriers to access services (or, if ceased, would result in access problems)</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>3. Addresses disparities in health status among different populations</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>4. Enhances public health activities</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>5. Improves ability to withstand public health emergency</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>6. Otherwise would become responsibility of government or another tax-exempt organization</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>7. Increases knowledge; then benefits the public</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>
The strategy to evaluate NCMH intended actions is to monitor change in the following Leading Indicator:

- Number of PET Team evaluations = 300 (2015)

The change in the Leading Indicator anticipates appropriate change in the following Lagging Indicator:

- Frequent Mental Distress – Percentage of adults reporting more than 14 days of poor mental health per month = 12% (SC = 14%, U.S. best 9%)

NCMH anticipates collaborating with the following other facilities and organizations to address this Significant Need:

<table>
<thead>
<tr>
<th>Organization</th>
<th>Contact Name</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Palmetto Health</td>
<td></td>
<td><a href="http://www.palmettohealth.org">www.palmettohealth.org</a> (803) 296-CARE</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Organization</th>
<th>Contact Name</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Department of Mental Health</td>
<td></td>
<td><a href="http://www.beckmancenter.com">www.beckmancenter.com</a> (864) 229-7120</td>
</tr>
<tr>
<td>Westview Behavioral Health</td>
<td></td>
<td><a href="http://www.westviewbehavioral.org">www.westviewbehavioral.org</a> (803) 276-5690</td>
</tr>
<tr>
<td>Three Rivers Behavioral Health</td>
<td></td>
<td><a href="http://www.threeriversbehavioral.org">www.threeriversbehavioral.org</a> (803) 796-9911</td>
</tr>
<tr>
<td>South Carolina Suicide Prevention Coalition</td>
<td></td>
<td><a href="http://www.preventingsuicides.org/index.php">www.preventingsuicides.org/index.php</a></td>
</tr>
</tbody>
</table>
Other Needs Identified During CHNA Process

8. FLU/PNEUMONIA
9. MATERNAL/CHILD HEALTH – 2013 Significant Need
10. ALCOHOL ABUSE – 2013 Significant Need
12. STROKE
13. PREDISPOSING CONDITIONS – 2013 Significant Need
14. LIFE EXPECTANCY
15. EDUCATION/PREVENTION
16. SEXUALLY TRANSMITTED INFECTION
17. LUNG DISEASE
18. SMOKING
19. DIABETES
20. KIDNEY DISEASE
21. DENTAL
22. BLOOD POISONING
23. ACCIDENTS
24. PHYSICIAN
25. COMPLIANCE BEHAVIOR
Overall Community Need Statement and Priority Ranking Score

**Significant needs where hospital has implementation responsibility**

1. Obesity/Overweight
2. Affordability
3. Cancer
4. Coronary Heart Disease
5. Diabetes
6. Physical Inactivity

**Significant needs where hospital did not develop implementation strategy**

6. Alzheimer’s

**Other needs where hospital developed implementation strategy**

11. Mental Health & Substance Abuse

**Other needs where hospital did not develop implementation strategy**

8. Flu/Pneumonia
9. Maternal/Child Health
10. Alcohol Abuse
12. Stroke
13. Predisposing Conditions
14. Life Expectancy
15. Education/Prevention
16. Sexually Transmitted Infection
17. Lung Disease
18. Smoking
19. Diabetes
20. Kidney Disease
21. Dental
22. Blood Poisoning
23. Accidents
24. Physician
25. Compliance Behavior
APPENDIX
Appendix A – Written Commentary on Prior CHNA

Hospital solicited written comments about its 2013 CHNA. 15 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.

<table>
<thead>
<tr>
<th>Local Experts Offering Solicited Written Comments on 2013 Priorities and Implementation Strategy</th>
<th>Yes (Applies to Me)</th>
<th>No (Does Not Apply to Me)</th>
<th>Response Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Public Health Expertise</td>
<td>8</td>
<td>4</td>
<td>12</td>
</tr>
<tr>
<td>2) Departments and Agencies with relevant data/information regarding health needs of the community served by the hospital</td>
<td>5</td>
<td>7</td>
<td>12</td>
</tr>
<tr>
<td>3) Priority Populations</td>
<td>6</td>
<td>4</td>
<td>10</td>
</tr>
<tr>
<td>4) Representative/Member of Chronic Disease Group or Organization</td>
<td>3</td>
<td>8</td>
<td>11</td>
</tr>
<tr>
<td>5) Represents the Broad Interest of the Community</td>
<td>10</td>
<td>4</td>
<td>14</td>
</tr>
<tr>
<td>Other</td>
<td>Answered Question</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Skipped Question</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

- 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.
  - Yes. All have specific needs, and it is important that people be considered “people first.” All should be respected and communicated with so that they understand their healthcare and that their issues are heard.
  - Older adults and individuals with special needs
  - Yes
  - Yes
  - Low income, African-American, Hispanic populations. My area of expertise is with older adults, and we have a high percentage in this area
  - We have been Able To sectionalize Our Community To Receive Block Grants To Improve Sewer System Ans Improve Available Potable Water.
  - Yes, We have a mostly rural community that has factions of extreme poverty and, what seems to be a undocumented Hispanic population. We also have a disproportionately high geriatric population. I think access to a physician would be a common need to all these groups. Education as to major health risks as they pertain to each group.
  - Yes and yes
• Yes, trauma informed care for women. Access to care for residents of rural areas. High prevalence of comorbidity between substance use disorder and mental illness
• Yes, ............and they do have special needs
• Obesity- children and adults;

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
• Cancer
• Coronary Heart Disease
• Obesity/Overweight
• Maternal/Child Health
• Diabetes
• Predisposing Conditions
• Alcohol Abuse

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?

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>No Opinion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Affordability</td>
<td>10</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Cancer</td>
<td>10</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Coronary Heart Disease</td>
<td>11</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Obesity/Overweight</td>
<td>12</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Maternal/Child Health</td>
<td>11</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Diabetes</td>
<td>12</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Predisposing Conditions</td>
<td>10</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Alcohol Abuse</td>
<td>11</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

• Specific comments or observations about Affordability as being among the most significant needs for the Hospital to work on to seek improvements?

  ▪ If people do not have access to affordable healthcare, some will be deterred from seeking the care they need.
  ▪ This should remain
▪ **will always be an area of concern**

▪ **Affordability will always be an issue**

▪ **HOP usage at both the hospital and at WBHS shows that many local residents cannot afford care and are under- or uninsured.** [Health Outcomes Provisio][Westview Behavioral Health Service]

- Specific comments or observations about **Cancer** as being among the most significant needs for the Hospital to work on to seek improvements?
  - *Education about the tests to detect early stages as well as affordability should help in this area.*
  - *Yes should remain*
  - *Yes, especially since some our initial equipment costs have since decreased leaving us in a position of a higher return on our investment and already having the staff and equipment to support both chemo and radiation*

- Specific comments or observations about **Coronary Heart Disease** as being among the most significant needs for the Hospital to work on to seek improvements?
  - *Being the #1 cause of death, this area is a no-brainer. This issue is also larger than just eating better foods; there is the high cost of healthier foods that is always a barrier. It is also far too easy to pick up unhealthy foods than prepare healthier versions.*
  - *Yes...early detection would benefit. Ongoing community involvement of the risk factors. Reduced cost for carotid screening and/or sonography.*
  - *Continuing education efforts and supporting the local physicians*

- Specific comments or observations about **Obesity/Overweight** as being among the most significant needs for the Hospital to work on to seek improvements?
  - *This issue is larger than just eating better foods; there is the high cost of healthier foods that is always a barrier. It is also far too easy to pick up unhealthy foods than prepare healthier versions.*
  - *Yes.....*
  - *One of the main underlying health problems in this area - predisposing to DM, HTN, CAD, CVD, etc [Diabetes Mellitus, Hypertension, Coronary Artery Disease, Cardiovascular Disease]*

- Specific comments or observations about **Maternal/Child Health** as being among the most significant needs for the Hospital to work on to seek improvements?
  - *Healthier moms lead to healthier babies who have a better chance in life.*
  - *Yes*

- Specific comments or observations about **Diabetes** as being among the most significant needs for the Hospital to work on to seek improvements?
  - *Circling back to health care and diet that been addressed in #s 6, 10, and 12.*
  - *Yes*
• Specific comments or observations about Predisposing Conditions as being among the most significant needs for the Hospital to work on to seek improvements?
  ▪ We have a long way to go with this one. I would like to see more mentoring between adults and children to try to overcome some of the conditions. Currently looking into grants for this purpose.

• Specific comments or observations about Alcohol Abuse as being among the most significant needs for the Hospital to work on to seek improvements?
  ▪ Outside of addressing the underage aspect, I almost feel as though we are limited in what we can do about addiction as a community. Having resources and support systems for people who realize their addictions is important. This may be the least likely issue to be able to alter.
  ▪ Yes
  ▪ Substance abuse is a priority health need for the Newberry County.

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?

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
<th>No Opinion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Affordability</td>
<td>9</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Cancer</td>
<td>10</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Coronary Heart Disease</td>
<td>12</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Obesity/Overweight</td>
<td>12</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Maternal/Child Health</td>
<td>11</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Diabetes</td>
<td>12</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Predisposing Conditions</td>
<td>8</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Alcohol Abuse</td>
<td>9</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

• Specific comments and observations about the implementation actions of the Hospital seeking improvement in Affordability?
  ▪ I am not aware of the hospital’s actions to address
  ▪ Effective to the extent possible
  ▪ can we do things more cost effectively than can be done at bigger hospitals? that would be a big advantage if the quality is good as well
  ▪ The hospital should continue to use it’s charitable care and work closely, as it has in the past, with the free clinic. We haven’t seen much of an increase in patients at the hospital presenting a government plan under the ACA, so the only solution at this point is to continue to utilize these methods.

• Specific comments and observations about the implementation actions of the Hospital seeking improvement in Cancer?
  ▪ I am not aware of the hospital’s actions to address
  ▪ Adequate...inclusion of early detection/screening would be of benefit
• Specific comments and observations about the implementation actions of the Hospital seeking improvement in Coronary Heart Disease?
  ▪ I am not aware of the hospital's actions to address
  ▪ Diminished due to expense

• Specific comments and observations about the implementation actions of the Hospital seeking improvement in Obesity/Overweight?
  ▪ Battle of the Bulge seems to go over well. Offering a walking track free to the public is an asset to the community.
  ▪ Adequate to the community involvement. Need greater participation
  ▪ The more we can do the better. The Wellness Center is a good resource for implementing more in this area

• Specific comments and observations about the implementation actions of the Hospital seeking improvement in Maternal/Child Health?
  ▪ I am not aware of the hospital's actions to address this need. Free classes, in partnership with other organizations, would be beneficial.
  ▪ More of an "open door" policy for those with poor prenatal care

• Specific comments and observations about the implementation actions of the Hospital seeking improvement in Diabetes?
  ▪ I am not aware of the hospital's actions to address
  ▪ More health fairs for screening

• Specific comments and observations about the implementation actions of the Hospital seeking improvement in Predisposing Conditions?
  ▪ I am not aware of the hospital's actions to address

• Specific comments and observations about the implementation actions of the Hospital seeking improvement in Alcohol Abuse?
  ▪ I am not aware of the hospital's actions to address this issue. The Newberry County Coalition on Underage Drinking can be a great resource for this issue (at least on the underage aspect).
  ▪ Possibly intergrate work with schools and communities of interest.
  ▪ Westview Behavioral Health Services is the county authority for prevention and treatment of substance abuse. NCMH is duplicating services by providing services. Work more closely with Westview.

• Do you have opinions about new or additional implementation efforts or community needs the Hospital should pursue?
  ▪ If not already doing so, partner with groups who are also working towards the improvement in these areas.
  ▪ No
- Preventative health measures. Nutrition and healthy lifestyle

- Recruitment and retention of Gp's and internist should be our number one goal. Expanding our current physician groups would be key in allowing the community access. Most physician in the county have all the patients they can handle. Members of these "at risk" groups either have to seek help outside of the county or simply go without being seen.

- No

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

- The Free Medical Clinic is a valuable resource. My Utopian society has all groups and organizations sharing their resources and knowledge with one another for a greater good.

- None

- I found this survey to not be very beneficial in assessing our needs. All of these are important concerns and ranking such would depend more on the financial viability, infrastructure and staff to provide or continue to provide care in these areas. The monetary considerations could only be assessed through some type of pro forma to determine the viability of each concern.

- No
### Appendix B – Identification & Prioritization of Community Needs

<table>
<thead>
<tr>
<th>Need Topic</th>
<th>Total Votes</th>
<th>Number of Local Experts Voting for Needs</th>
<th>Percent of Votes</th>
<th>Cumulative Votes</th>
<th>Need Determination</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obesity/Overweight - 2013 Significant Need</td>
<td>111</td>
<td>9</td>
<td>12.53%</td>
<td>12.53%</td>
<td>Significant Needs</td>
</tr>
<tr>
<td>Affordability - 2013 Significant Need</td>
<td>92</td>
<td>7</td>
<td>10.38%</td>
<td>22.91%</td>
<td></td>
</tr>
<tr>
<td>Cancer - 2013 Significant Need</td>
<td>65</td>
<td>8</td>
<td>7.34%</td>
<td>30.25%</td>
<td></td>
</tr>
<tr>
<td>Coronary Heart Disease - 2013 Significant Need</td>
<td>61</td>
<td>8</td>
<td>6.88%</td>
<td>37.13%</td>
<td></td>
</tr>
<tr>
<td>Diabetes - 2013 Significant Need</td>
<td>61</td>
<td>9</td>
<td>6.88%</td>
<td>44.02%</td>
<td></td>
</tr>
<tr>
<td>Alzheimer's</td>
<td>55</td>
<td>7</td>
<td>6.21%</td>
<td>50.23%</td>
<td></td>
</tr>
<tr>
<td>Physical Inactivity</td>
<td>51</td>
<td>7</td>
<td>5.76%</td>
<td>55.98%</td>
<td></td>
</tr>
<tr>
<td>Flu/Pneumonia</td>
<td>37</td>
<td>7</td>
<td>4.18%</td>
<td>60.16%</td>
<td></td>
</tr>
<tr>
<td>Maternal/Child Health - 2013 Significant Need</td>
<td>36</td>
<td>7</td>
<td>4.06%</td>
<td>64.22%</td>
<td></td>
</tr>
<tr>
<td>Alcohol Abuse - 2013 Significant Need</td>
<td>32</td>
<td>8</td>
<td>3.61%</td>
<td>67.83%</td>
<td></td>
</tr>
<tr>
<td>Mental Health</td>
<td>32</td>
<td>7</td>
<td>3.61%</td>
<td>71.44%</td>
<td></td>
</tr>
<tr>
<td>Stroke</td>
<td>30</td>
<td>7</td>
<td>3.39%</td>
<td>74.83%</td>
<td></td>
</tr>
<tr>
<td>Predisposing Conditions - 2013 Significant Need</td>
<td>26</td>
<td>7</td>
<td>2.93%</td>
<td>77.77%</td>
<td></td>
</tr>
<tr>
<td>Life Expectancy</td>
<td>25</td>
<td>7</td>
<td>2.82%</td>
<td>80.59%</td>
<td></td>
</tr>
<tr>
<td>Education/Prevention</td>
<td>20</td>
<td>6</td>
<td>2.26%</td>
<td>82.84%</td>
<td></td>
</tr>
<tr>
<td>Sexually Transmitted Infection</td>
<td>20</td>
<td>6</td>
<td>2.26%</td>
<td>85.10%</td>
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<tr>
<td>Lung Disease</td>
<td>19</td>
<td>6</td>
<td>2.14%</td>
<td>87.25%</td>
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</tr>
<tr>
<td>Smoking</td>
<td>19</td>
<td>6</td>
<td>2.14%</td>
<td>89.39%</td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td>18</td>
<td>6</td>
<td>2.03%</td>
<td>91.42%</td>
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</tr>
<tr>
<td>Kidney Disease</td>
<td>17</td>
<td>6</td>
<td>1.92%</td>
<td>93.34%</td>
<td></td>
</tr>
<tr>
<td>Dental</td>
<td>15</td>
<td>5</td>
<td>1.69%</td>
<td>95.03%</td>
<td></td>
</tr>
<tr>
<td>Blood Poisoning</td>
<td>14</td>
<td>6</td>
<td>1.58%</td>
<td>96.61%</td>
<td></td>
</tr>
<tr>
<td>Accidents</td>
<td>12</td>
<td>5</td>
<td>1.35%</td>
<td>97.97%</td>
<td></td>
</tr>
<tr>
<td>Physician</td>
<td>10</td>
<td>1</td>
<td>1.13%</td>
<td>99.10%</td>
<td></td>
</tr>
<tr>
<td>Compliance Behavior</td>
<td>8</td>
<td>5</td>
<td>0.90%</td>
<td>100.00%</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>886</strong></td>
<td></td>
<td><strong>100.00%</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Individuals Participating as Local Expert Advisors

<table>
<thead>
<tr>
<th>Local Experts Offering Solicited Written Comments on 2013 Priorities and Implementation Strategy</th>
<th>Yes (Applies to Me)</th>
<th>No (Does Not Apply to Me)</th>
<th>Response Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Public Health Expertise</td>
<td>6</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>2) Departments and Agencies with relevant data/information regarding health needs of the community served by the hospital</td>
<td>3</td>
<td>5</td>
<td>8</td>
</tr>
<tr>
<td>3) Priority Populations</td>
<td>2</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>4) Representative/Member of Chronic Disease Group or Organization</td>
<td>1</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>5) Represents the Broad Interest of the Community</td>
<td>10</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Answered Question</td>
<td></td>
<td></td>
<td>12</td>
</tr>
<tr>
<td>Skipped Question</td>
<td></td>
<td></td>
<td>0</td>
</tr>
</tbody>
</table>
Advice Received from Local Expert Advisors

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

Comments:

- "Children in Poverty" and "children in single-parent households" data are supported by multiple sources like KidsCount, etc. Eat Smart Move More has done a survey of healthy eating/activity survey. Rates of substance abuse remain high.
Question: Do you agree with the observations formed about the comparison of Newberry County to its peer counties?

Comments:

- These figures seem harsher than others I've seen. We generally are below average in such categories but not worse. I've not seen the HIV rating as worse before, for example. For violent crime, we have a low crime rate in the county so it surprises me that we're 11th worse. In general, I'm not seen this negative of a portrayal of the county in other studies.

- I would be surprised if HIV and syphilis rates are that high in Newberry County
Question: Do you agree with the observations formed about the population characteristics of Newberry County?

Comments:

- Under Social Vulnerability Newberry County the western part is mostly agriculture the other 2/3rds of the county 1/3rd is made up of national forest land while most of the population resides in the lower part of the county. Economic factors and population density need consideration in those areas.

- Current unemployment rate is 4.6%
Question: Do you agree with the observations formed from the national ranking and leading causes of death?

Comments:

- Binge drinking is a significant concern, especially among the college population. Marijuana use has been noted in more of our diagnoses than alcohol use, however.
Question: Do you agree with the written comments received on the 2013 CHNA?

Comments:

- The Affordable Health Care Act has had a lot of effect on people NOT having insurance. Companies have cut back due to cost and the Affordable Care Act is NOT affordable for the younger population. It is better for them to pay the penalty.

- Empower local independent physician practices through recruitment and retention - these are the ones who are most committed to serve the community - employed physicians can easily pack up and leave

- Dire need to recruit primary care physicians and simplify reimbursement and medicine coverage through the insurance companies. Patients are unable to afford medicines due to high deductibles and insurance companies using "prior authorizations" as a stall tactic to delay paying for medications.

- Collaborate with Westview to find ways to better serve substance abusers
Question: Do you agree with the additional written comments received on the 2013 CHNA?

Comments:

Appendix C – National Healthcare Quality and Disparities Reports

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, 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.

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.

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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15 In this report, racial groups such as Blacks and Whites are non-Hispanic, and Hispanics include all races.
• 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.

• In 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-diptheria-acellular pertussis vaccine*
- *Adolescents ages 13-15 years who received 1 or more doses of tetanus-diptheria-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.


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.\(^1\)

- 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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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; tetanus-diphtheria-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. ¹⁸
- 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:

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 D – Required Information Checklist

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?
   
   Suggested Answer – 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
   
   Suggested Answer – 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. If “Yes,” indicate what the CHNA report describes.
   
   a. A definition of the community served by the hospital facility
      
      Suggested Answer – See page 11
   
   b. Demographics of the community
      
      Suggested Answer – See page 12
   
   c. Existing health care facilities and resources within the community that are available to respond to the health needs of the community
      
      Suggested Answer – See pages 30 and 32
   
   d. How data was obtained
      
      Suggested Answer – See page 7
   
   e. The significant health needs of the community
      
      Suggested Answer – See page 29
   
   f. Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups
      
      Suggested Answer – See page 9
   
   g. The process for identifying and prioritizing community health needs and services to meet the community health needs
      
      Suggested Answer – See page 57
   
   h. The process for consulting with persons representing the community's interests
      
      Suggested Answer – See page 7
   
   i. Information gaps that limit the hospital facility's ability to assess the community's health needs
      
      Suggested Answer – See pages 7, 9, and 16
4. Indicate the tax year the hospital facility last conducted a CHNA: 20__
   Suggested Answer – 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
   Suggested Answer – Yes; see pages 7 and 51

6. a. Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities
   Suggested Answer – No

   b. Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If “Yes,” list the other organizations
   Suggested Answer – Yes; see pages 4 and 7

7. Did the hospital facility make its CHNA report widely available to the public?
   Suggested Answer – Yes

   If “Yes,” indicate how the CHNA report was made widely available (check all that apply):
   
   a. Hospital facility's website (list URL)
      Suggested Answer – http://www.newberryhospital.org/

   b. Other website (list URL)
      Suggested Answer – No other website

   c. Made a paper copy available for public inspection without charge at the hospital facility
      Suggested Answer – Yes

   d. Other (describe in Section C)
      Suggested Answer – 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 question 11.
   Suggested Answer – Yes; see page 50

9. Indicate the tax year the hospital facility last adopted an implementation strategy: 20__
   Suggested Answer – 2013
10. Is the hospital facility’s most recently adopted implementation strategy posted on a website?
   a. If “Yes,” (list url):
      
      *Suggested Answer – Yes; http://www.newberryhospital.org/*
   b. If “No,” is the hospital facility’s most recently adopted implementation strategy attached to this return?

11. Describe 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

   *Suggested Answer – See page 34*