McLeod Health

The Choice for Medical Excellence

McLeod Regional Medical Center and McLeod Darlington

Community Health Needs Assessment (CHNA) Implementation Plan Narrative

Approved by
McLeod Regional Medical Center Board of Directors September 2016

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Letter to the Community

Dear Community Members,

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

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

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

Best of Health,

Marie Saleeby
Senior Vice President and Administrator, McLeod Regional Medical Center

McLeod Regional Medical Center and McLeod Darlington
The Community Health Needs Assessment (CHNA)
Implementation Plan Narrative

Introduction

The McLeod Regional Medical Center (MRMC) is a 453-licensed bed and 40 Neonatal Intensive Care bed hospital located in Florence, South Carolina. McLeod Medical Center Darlington (McLeod Darlington), formerly Wilson Hospital, is a vital health resource to Darlington County and surrounding communities, providing outpatient and inpatient acute care to the region.

MRMC and McLeod Darlington are members of McLeod Health, a not-for-profit health care system dedicated to improving the health of the communities it serves in 15 counties throughout South Carolina and North Carolina.

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

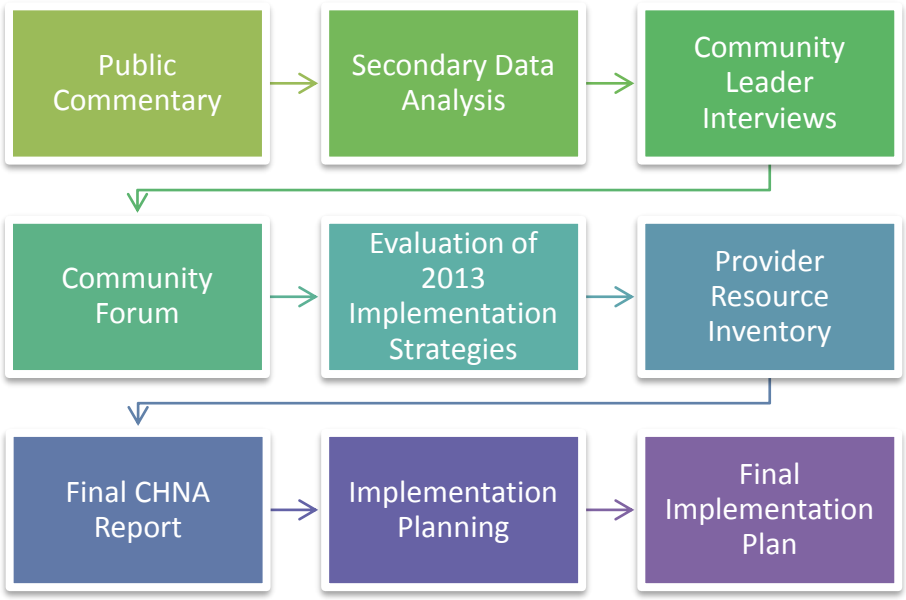
- Conduct a CHNA every three years.
- Adopt an implementation strategy to meet the community health needs identified through the assessment.
- Report how they are addressing the needs identified in the CHNA.

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

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

regional agencies to help provide medical solutions to broader socioeconomic and education issues in the service area.

Figure 1. CHNA and Implementation Planning Process



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

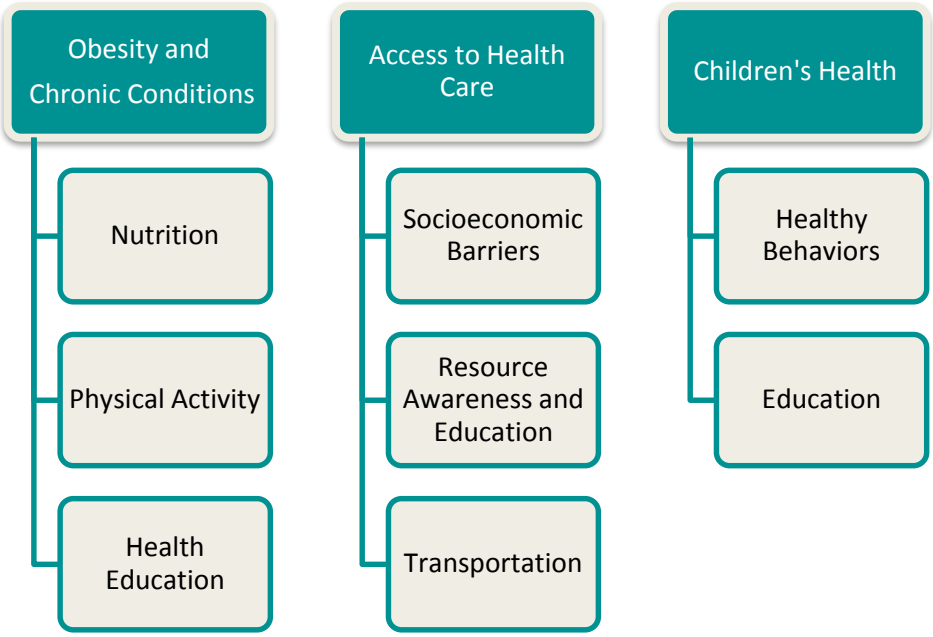
Health care organizations and systems strive to improve the health of the community they serve through collaboration with local, state, and national partners as delineated in the CHNA Implementation Plan, which will be conducted over a three-year period from 2016 through 2019. During this time, MRMC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

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

Prioritized Community Health Needs

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

Figure 2. Prioritized Community Health Needs for MRMC 2016 CHNA



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

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

Addressing the Community Health Priorities

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

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

OBESITY

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

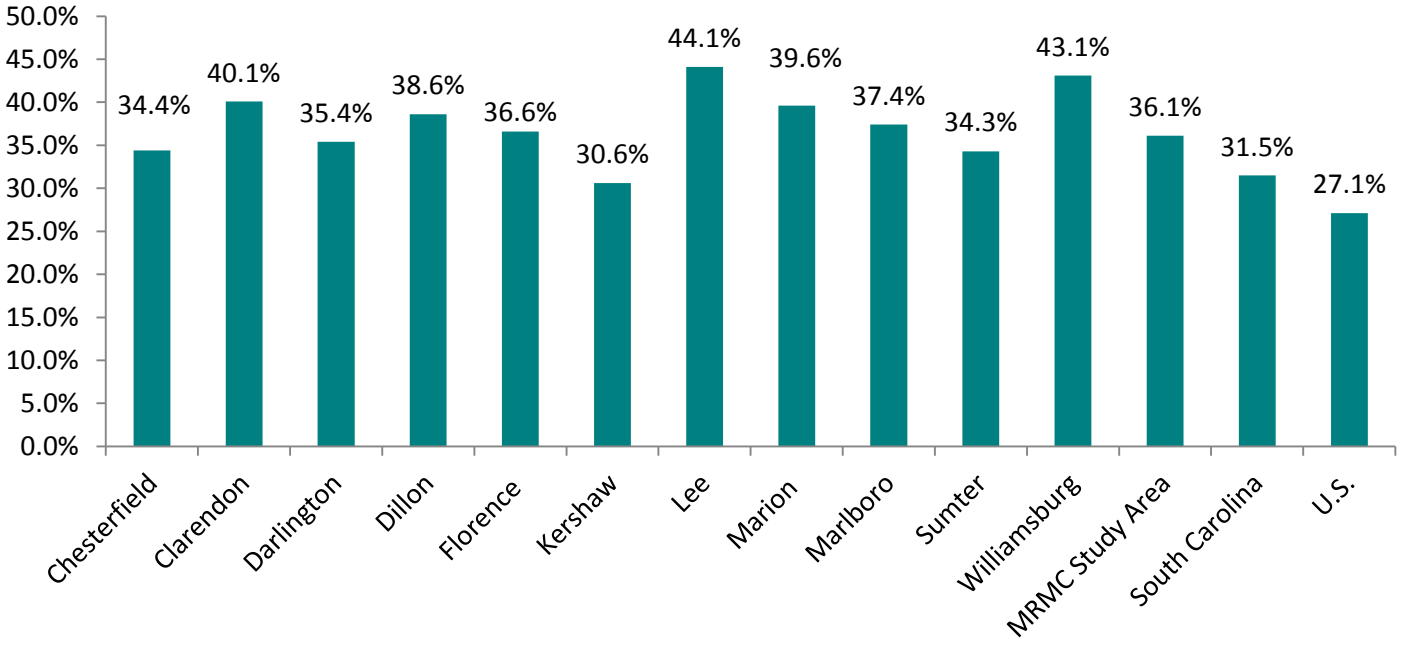
Environmental, economic, and cultural conditions greatly influence health behaviors such as diet and physical activity and contribute to the rise in obesity rates. Obesity rates are higher among low-income adults and children and among American Indians/Alaska native, black, and Hispanic individuals.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

Obesity is particularly prevalent across southern states and South Carolina had the 10th highest obesity rate in the nation in 2014.[4] 66.9 percent of adults were overweight, with a Body Mass Index (BMI) of 25 or greater and 31.5 percent of adults were obese, with a Body Mass Index (BMI) of 30 or greater. Among the youth in South Carolina, 15 percent were overweight (≥ 85th percentile for age and sex) and 16.7 percent were obese (≥ 95th percentile for age and sex).[5] In the MRMC study area, 36.1 percent of residents are obese (See Chart 1).[6]

[1] Begley, Sharon. "Fat and getting fatter: U.S. obesity rates to soar by 2030." *Reuters.* September 18, 2012.
[2] "Overweight & Obesity – Data & Statistics." Centers for Disease Control and Prevention. September 24, 2015. https://www.cdc.gov/obesity/data/index.html.
[3] "Physical Activity – Data & Statistics." Centers for Disease Control and Prevention. March 27, 2015. https://www.cdc.gov/physicalactivity/data/index.html.
[4] "The State of Obesity in South Carolina." The State of Obesity. http://stateofobesity.org/states/sc/. 2015.
[5] Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 2012 via Community Commons.
[6] Ibid.

Both community leaders and stakeholders cited obesity as a top health concern during the previous 2013 CHNA process. Among the counties, adult obesity is highest in Lee County with 44.1 percent of residents being obese. Williamsburg County is second highest at 43.1 percent of obese residents in the county.[7]

Chart 1. Percent Obese Adults



CHRONIC CONDITIONS

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

Heart Disease and Hypertension

South Carolina has the eighth highest rate of hypertension in the nation.[8] Florence County has the highest rate of hypertension among Medicare patients for the state and the second-highest

[7] Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 2012 via Community Commons.
[8] "The State of Obesity in South Carolina." The State of Obesity. http://stateofobesity.org/states/sc/. 2015.

rate in the nation.[9] Across the CHNA study area, the correlation between obesity and chronic conditions is evident. Lee and Williamsburg counties have the highest percent of obese adults in the study area. Lee County has the highest rate of mortality due to stroke in the study area with a rate of 71.6 per 100,000 population, while Williamsburg County has the highest rates of diabetes, high cholesterol, and mortality due to heart disease in the study area.[10]

In addition to the rates of obesity and chronic conditions in Lee and Williamsburg counties, Dillon County reports the highest percentage of residents in the study area with high blood pressure at 41.6 percent. Lee, Williamsburg, and Dillon counties report some of the highest percentages of residents with poor or fair general health for the study area. It is noted that Kershaw County has the lowest percentage of obese adults among counties assessed at 30.6 percent and the lowest percentage of adults with poor or fair general health at 15.0 percent.[11]

Diabetes

Nationwide, it is estimated that nearly 26 million people have diabetes—including over a quarter with the condition undiagnosed—and that 79 million people are pre-diabetic, with blood glucose levels that increase the risk of developing diabetes. The prevalence of diabetes increases with age, and nearly 27 percent of those over age 65 have diabetes. Among racial and ethnic groups, diabetes prevalence is highest among African Americans.[12]

The rise in diabetes prevalence corresponds with the rise in obesity rates, and children are increasingly affected by both obesity and diabetes. It is documented among diabetes educators that many patients are generally unaware of the seriousness of diabetes. They also note that people who are newly diagnosed are often overwhelmed, confronted with misinformation, or feel they are powerless to make positive changes to control the disease.

South Carolina has the seventh highest diabetes rate in the U.S., and 13.4 percent of residents in the MRMC study area have diabetes. Williamsburg County, which has the highest obesity rate in the MRMC study area, has the highest rate of diabetes in the study area. In addition, Williamsburg County has one of the lowest average household income levels for the MRMC region. Residents who are living in poverty and are uninsured oftentimes face challenges accessing care for health conditions associated with diabetes due to the cost of care, which can result in higher rates of hospitalizations due to diabetes complications. A majority of community leaders who were

[9] CMS/Office of Enterprise Data and Analytics. Medicare Chronic Conditions Dashboard. June 2015.
[10] Centers for Disease Control and Prevention. Behavioral Risk Factor Surveillance System. Accessed via Community Commons.
[11] Centers for Disease Control and Prevention. Behavioral Risk Factor Surveillance System. Accessed via Community Commons.
[12] "Diabetes – Data & Statistics." Centers for Disease Control and Prevention. December 1, 2015. https://www.cdc.gov/diabetes/data/index.html.

interviewed and participated in the forum as part of the CHNA identified access to health care as the top health need for the populations they served.

In the Pee Dee region of South Carolina, which includes Florence County (location of MRMC) and Darlington County (location of McLeod Darlington), chronic conditions such as diabetes, diseases of the heart, chronic lower respiratory disease, and chronic liver disease, account for the 10 leading causes of death in the region.[13] Many deaths that are attributed to chronic disease are considered to be premature—before age 75—because of behaviors like smoking, poor diet, lack of physical activity, and substance abuse, as well as social and environmental factors. In the U.S., people with lower incomes are more likely to die prematurely than those with higher incomes. Life expectancy at birth is the number of years a newborn can expect to live if the current age-specific death rates stay the same for his or her life. In South Carolina, life expectancy is 76.5 years.[14]

Nutrition. Many adults and children do not eat the recommended servings of fruits and vegetables as the foods that are associated with healthy diets often cost more than unhealthy foods and are unaffordable for many low income and uninsured families. In 2015, 45.2 percent of surveyed adults reported consuming fruit less than one time daily, while 26.8 percent of adults reported consuming vegetables less than one time daily.[15]

Physical Activity. Among South Carolina adults, 49.1 percent achieved at least 150 minutes a week of aerobic physical activity. 26.9 percent of South Carolina's adults reported that during the past month, they had not participated in any physical activity according to the Centers for Disease Control and Prevention (CDC) 2015.

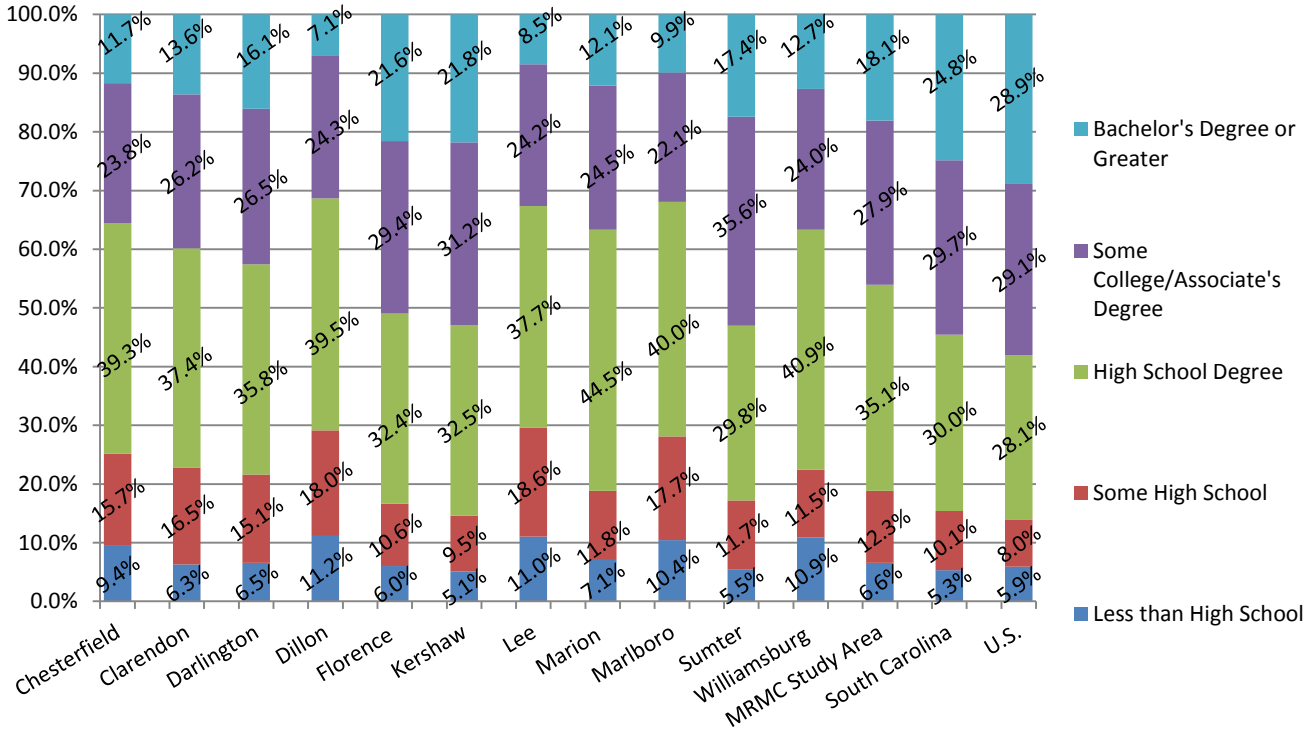
Health Education. Both in the 2013 and the 2016 CHNAs, nearly every community leader interviewed responded that residents do not make healthy eating and living a priority because

[13] "Leading Causes of Death." South Carolina Department of Health and Environmental Control. 2014.
[14] "Lifespans in U.S.A. States Ranked From Longest to Shortest." ABC13 News. http://abc13.com/health/which-states-citizens-live-the-longest-or-shortest/151639/.
[15] Centers for Disease Control and Prevention. "South Carolina State Obesity, Nutrition, and Physical Activity Report." 2015.

they lack the education to understand how important these steps are to preventing chronic conditions, especially obesity and living a longer and healthier life.

Where lower education levels exist in the study area, rates of obesity and chronic conditions are higher. Lee and Dillon counties have the highest percentages of individuals without a high school degree in the study area at 29.6 percent and 29.2 percent, respectively. These counties also have some of the highest rates of obesity, chronic conditions related to obesity, and residents with poor general health. At the same time, Kershaw and Florence counties have the highest percentages of residents with a bachelor's degree or higher, while also having some of the lowest rates of obesity and chronic conditions in the MRMC study area (See Chart 2).[16]

Chart 2. Educational Attainment



[16] Truven Health Analytics. 2015.

Goal 1: Prevention of chronic disease such as heart disease, hypertension, and diabetes.

MRMC and McLeod Darlington will address the rise in obesity and lack of physical inactivity resulting in a significant prevalence of chronic diseases such as heart disease, hypertension, and diabetes among both adults and children through the following goals and strategies:

MRMC Go Red Heart Luncheon

- **Strategy 1**: Place emphasis on managing diabetes and managing weight through "Healthier You" – an Employee Health initiative for employees and spouses.
    - <u>Action/Task</u>
    - ✓ Use the South Carolina Hospital Association's Working Well Initiative as an example of implementing healthier practices among hospital employees.
- **Strategy 2**: Provide public information regarding the signs and symptoms of diabetes through media sources.
- **Strategy 3**: Publish nutritional information through the local paper, *Morning News*, which focuses on healthy eating, diabetes prevention, and hypertension prevention.
- **Strategy 4**: Support recovery from heart attacks by providing scholarships for cardiac rehabilitation among the underinsured and uninsured.
- **Strategy 5**: Emphasize walking as a form of exercise anyone can do, at any place.

Despite the wealth of knowledge and resources available through the health system, many residents are often unaware and do not always know where to turn for help. In a region with overall lower education levels compared to state and national rates, residents do not know what services they need to manage their health issues. At the same time, providers are not always aware of where to refer patients for specialty health care and treatment.

In collaboration with local health and human service agencies and the media, a focus on the health of employees, their families, and community residents is continued. Programs such as "Healthier You" and a plethora of monthly and quarterly media publications have proven to be very effective and serve to educate the public and reinforce the need for good nutrition, exercise,

and healthy behaviors. Making resources and programs such as cardiac rehab available to the uninsured and underinsured is critical in helping them to manage their health and recovery.

Evidence shows that strong media outreach also serves to provide residents with the tools and information needed to recognize the signs and symptoms of chronic diseases and empowers them to become partners in better managing as well as preventing hypertension and diabetes.

Goal 2: Improving the health of youth in the community.

- **Strategy 1**: Recruit and employ a Pediatric Endocrinologist.

- **Strategy 2**: Expand the "Biggest Loser" Program to include children.
- **Strategy 3**: Utilize the sports medicine trainer program in high schools to identify young people with hypertension.

According to the 2015 Centers for Disease Control and Prevention Report on Obesity, Nutrition, and Physical Activity in South Carolina, 76.2 percent of adolescents were not physically active for a total of at least 60 minutes per day on each of the seven days prior to the survey. 19.6 percent of adolescents did not participate in at least 60 minutes of physical activity on at least one day during the seven days before the survey. The report further noted that 33.3 percent of adolescents watched television for three or more hours per day on an average school day.

Expanding the "Biggest Loser" to include youth and making evidenced-based sports medicine practices available in high schools will serve to screen for and prevent hypertension. More importantly, these programs will encourage the youth to eat healthy, to better understand the value of physical activity, and to lead a healthy lifestyle.

Due to poor diets, childhood obesity, and hereditary factors, many youths today are being diagnosed with Type 2 Diabetes. A pediatric endocrinologist will serve to address the incidence of Type 2 Diabetes and its complications among younger populations.

Priority 2: Access to Health Care (Socioeconomic Barriers to Health Care, Specialty Care, Dental Care, and Transportation)

ACCESS TO HEALTH CARE

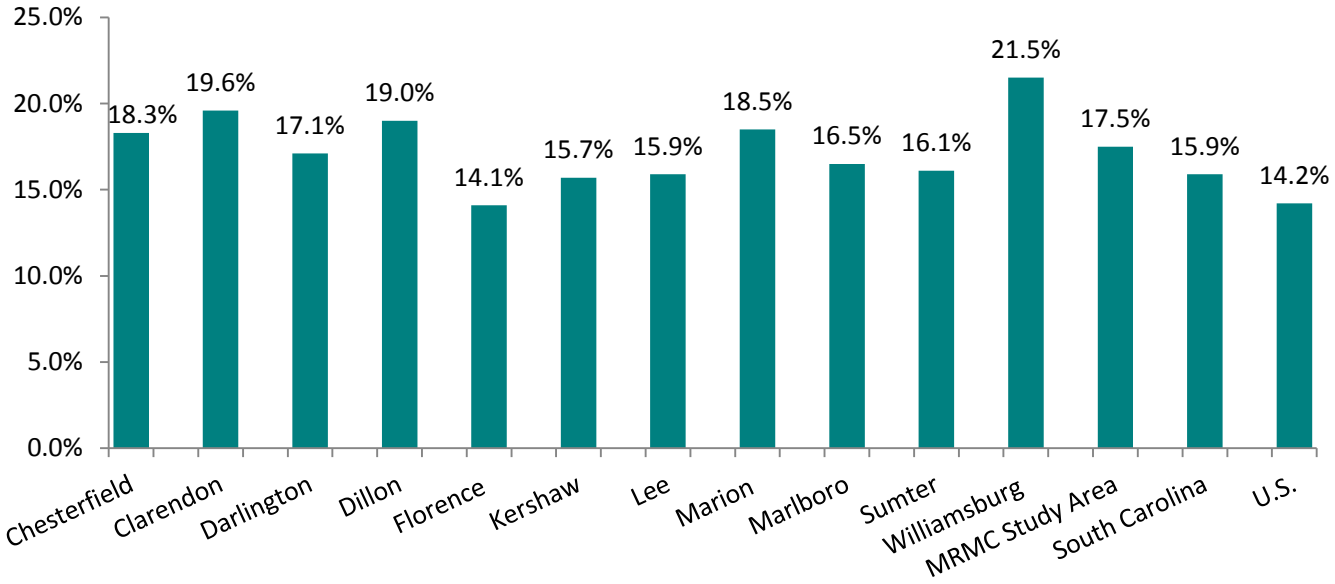
The slow national and local economic growth since 2008 has left many across the nation without employer-sponsored health insurance and many sense an insecurity regarding their financial well-being. Prior to the Affordable Care Act (ACA), low income, uninsured and underinsured individuals and families struggled to gain access to health care when needed. Many individuals and families delayed seeking care because they lacked health insurance and were unable to pay out of pocket health care costs. As a result, low income and uninsured populations often seek care in the emergency room rather than through regular primary care office visits. Lack of health insurance leads many to defer or delay preventive care and early intervention with chronic conditions.

Lack of health care access is significant across the state of South Carolina. The state ranks 41st in the U.S. in terms of access and affordability of care according to the Commonwealth Fund of State Health System Performance in 2015. Across the 2016 CHNA study area, eight (8) out of eleven (11) counties rank within the lowest ten percent (unfavorable rankings) in the state in terms of clinical care according to the 2016 County Health Rankings report.

Lack of health insurance coverage is a key indicator for access to health care. People without insurance are more likely to lack a health care medical home and are at increased risk for serious health conditions. The MRMC study area overall has a higher percentage of uninsured at 17.5 percent than the state at 15.9 percent and U.S. at 14.2 percent and especially higher among Clarendon, Dillon, Marion, and Williamsburg counties. With a lack of access to care and health conditions being diagnosed at later stages, the uninsured and low income residents often have higher mortality rates (See Chart 3).[17]

[17] U.S. Census Bureau, American Community Survey. 2010-2014.

Chart 3. Total Uninsured Population[18]



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

Specialty Care. The PCP provider rate also paints a picture of the disparities in the study area. Florence County has the highest PCP rate by far in the study area at 94.2 PCPs per 100,000 population. Lee County on the other hand has the lowest PCP rate with only 10.7 per 100,000 population, followed closely by Williamsburg County with 14.9 PCPs per 100,000 population. A lack of mental health providers also is noted as there are 76.7 mental health providers per 100,000 population in the study area, which is lower than the state rate of 97.6 and the U.S. rate of 134.1 per 100,000 population.[19]

Dental Care. Access to dental care is a challenge as well, particularly for uninsured adults. The biggest barrier to dental care and preventive dental services is most frequently reported through community health needs assessments as financial barriers or cost. Many Americans cannot get

[18] The uninsured numbers above reflect data collected from 2010 to 2014. Uninsured percentages for 2015 and 2016 may be lower than those in the figure above due to the Affordable Care Act. South Carolina, however, has not adopted Medicaid expansion as part of the Affordable Care Act.

[19] U.S. Department of Health & Human Services. Health Resources and Services Administration. 2012. Accessed via Community Commons.

the dental care that they need, resulting in a detrimental effect on their overall health and productivity.

The MRMC study area also has a lower rate of dentists as compared to state and national rates. The MRMC study area has a total of 34.3 dentists per 100,000 population, while the state rate is 49.9 and national rate is 63.2 per 100,000 population. The rate of dentists in Florence County is significantly higher than the other counties in the MRMC study area at 58.6 dentists per 100,000 population. Lee County has the lowest rate of dentists in the study area at 10.9 per 100,000 population, followed closely by Williamsburg County with 12.1 dentists per 100,000 population.[20]

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

The region has no mass transit system and the bus system is underfunded. Almost every community leader stated that the lack of transportation in the region is a major challenge for residents as it prevents residents from managing their health issues.

To address access to health care, MRMC and McLeod Darlington will focus on socioeconomic barriers, specialty care, dental care, and transportation through the following goals and strategies:

Goal 1: Address access to care barriers.

- **Strategy 1:** Partner with Hope Health FQHC, a member of the Coastal Plain Rural Health Network, to expand primary care services in Florence County.
- **Strategy 2:** Move into second year of development of the AccessHealth Program for Florence, Marion, Darlington, and Dillon counties to provide access to care coordination for uninsured.
    - **Actions/Tasks:**
    - ✓ Obtain Duke Endowment Grant.

[20] U.S .Department of Health & Human Services,. Health Resources and Services Administration. Area Health Resource File. 2013 via Community Commons.

- ✓ Collaborate with ministers to inform underserved communities of resources available through AccessHealth.
- ✓ Attempt to secure dental services for uninsured dental needs.

- **Strategy 3**: Provide transportation to low income and uninsured to medical appointments by obtaining grants for transportation vouchers.
- **Strategy 4:** Continue to provide support to Darlington Free Clinic and Mercy Medicine Free Clinics to provide free care to residents.
- **Strategy 5:** Support South Carolina Dental Access Days (DAD), a three-day event that provides free dental care to underserved residents in Florence and surrounding counties, through volunteerism.

Collaboration and care coordination among health care providers, local health clinics, nurses, social workers, and care managers are essential to improve access to care for uninsured patients and their families. Care coordination helps patients navigate a complex health care delivery system. Through follow-up contact and phone calls, patient needs are identified and connections to available services and resources are made.

Forming strong bonds and a partnership between the health system and the Hope Health FQHC expands access and strengthens care to the uninsured in Florence County. The Hope Health FQHC provides primary health care and mental health services to the medically uninsured residents and those with incomes under 200 percent of the federal poverty level. The Hope Health FQHC also sponsors the SC Dental Access Days, helping to provide dental care to thousands of underserved residents in Florence and surrounding counties.

Partnerships to expand access further aim to meet the need for laboratory, radiology, and other essential services to uninsured residents.

Priority 3: Children's Health (Healthy Behaviors and Education)

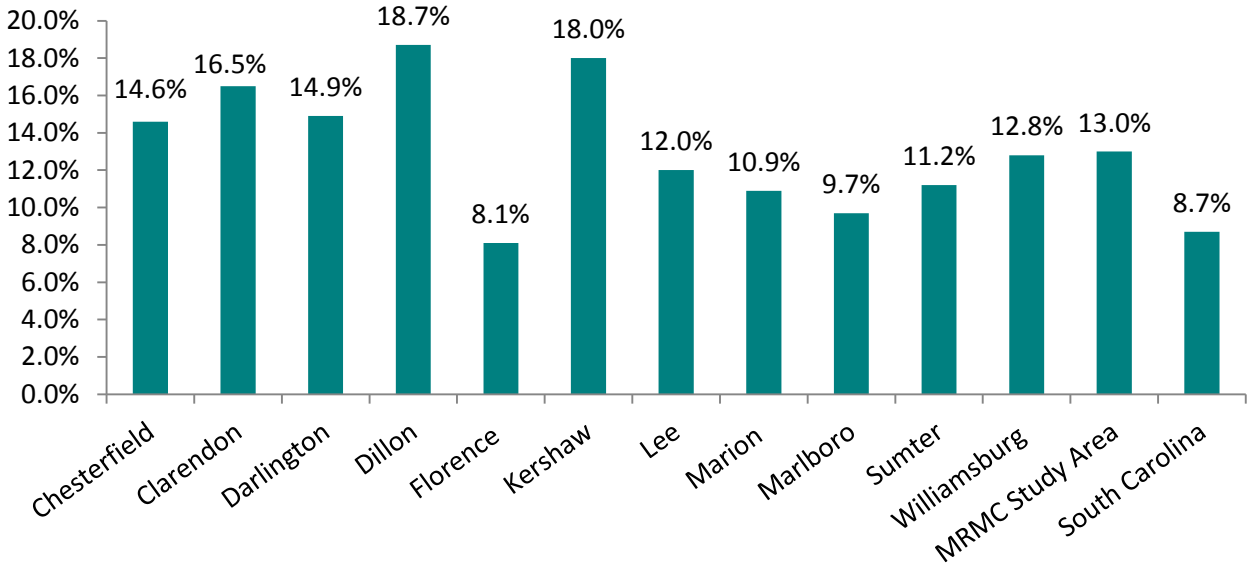
Early intervention in promoting healthy behaviors and health education is key in helping today's children lead healthier lives in the future, as well as helping to reduce chronic issues and health disparities. The state of South Carolina ranks 42nd out of 51 (including the District of Columbia) in terms of child well-being as of 2015; this measure takes into account numerous education,

economic, health, and family/community measures.[21] Community leaders in the MRMC study area understand the significance of focusing on the health and well-being of children for a healthier future.

HEALTHY BEHAVIORS AND EDUCATION

Children and teens who are not focused on school or extracurricular work and activities are more likely to engage in risky behaviors. In Dillon County, the data shows a higher percentage of teens who are not pursuing education or work opportunities. At the same time, Dillon County has the highest teen birth rate in the study area at 76.7 teen births out of 100,000 population.[22]

Chart 4. Teens Age 16-19 Not Attending School and Not Working



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

The following goals and strategies are designed to provide an early impact on the health of children and to emphasize the importance of healthy behaviors and education:

[21] "Well-Being of South Carolina's Children." Children's Trust of South Carolina. http://www.scchildren.org/advocacy_and_media/kids_count_south_carolina/well-being_of_south_carolinas_children/. 2016.
[22] KIDS COUNT Data Center. 2015.

Goal 1: Continue to provide primary children's care in the Florence community.

- **Strategy 1:** Continue the Nurse Family Partnership in rural areas to support the first two years of life in children born at risk.
    - **Action/Task:**
    - ✓ Seek grant funding to support the Nurse Family Partnership.
- **Strategy 2:** Expand the Neonatal Intensive Care Unit.
- **Strategy 3:** Develop a breast milk bank to support breast feeding in neonates.
    - **Action/Task:**
    - ✓ Encourage breast feeding in the community.
- **Strategy 4:** Engage in a community campaign regarding Safe Infant Sleeping.
- **Strategy 5:** Encourage reading in children to promote literacy improvement through the Reach Out and Read initiative.

Nurse Family Partnership

The Nurse-Family Partnership (NFP) is an evidenced-based program that provides nurse home visits to pregnant women with no previous live births. Most of the women served are low-income, unmarried, and teenagers. Nurses visit the women approximately once per month during their

pregnancy and the first two years of their children's lives. The nurses teach positive health related behaviors, competent care of children, and strengthen maternal personal development through family planning, educational achievement, and participation in the workforce.

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

Expanding neonatal bed capacity and services, such as the breast feeding program and the national Safe Infant Sleeping initiatives, serve to improve the health of children at an early age and ensure healthy development and growth.

The Safe Infant Sleeping (1998) initiative helps parents and caregivers reduce the risk of sleep-related infant death by following the American Association of Pediatrics (AAP) safe sleep guidelines and assures that infants age 0 to 12 months do not get into a position that could cause injury or even death.

Poor health and poor literacy can be major obstacles to doing well in school. Improving literacy by providing books to children removes related barriers to learning, especially among children who are without resources and are in need. As an outcome, improving health literacy among children improves their self-esteem and improves their ability to perform academically in school. Improving literacy enables future generations to lift themselves and their communities to a better life.

Implementation Next Steps

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

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

Communication and continuous planning efforts are vital throughout the next few years. Information regarding the CHNA findings and implementation plan deployment will be important to residents, community groups, leaders, and other organizations that seek to better understand the health needs of the communities in the MRMC study area and how to best serve those needs.

Evaluation and progress on the implementation of community initiatives will be reported at least annually and will be included in community benefit reporting.

APPENDIX A: Community Definition

In 2016, 29 ZIP code areas were analyzed for McLeod Regional Medical Center (MRMC). The 29 ZIP codes represent the community served by MRMC as the hospital's primary service area, or where approximately 80 percent of the hospital's inpatient population resides. The 29 ZIP codes fall into 11 counties in South Carolina – Chesterfield, Clarendon, Darlington, Dillon, Florence, Kershaw, Lee, Marion, Marlboro, Sumter, and Williamsburg (See Table 1).

Table 1. MRMC Primary Study Area ZIP Codes

ZIP Code	City	County
29009	Bethune	Kershaw
29010	Bishopville	Lee
29046	Elliott	Lee
29069	Lamar	Darlington
29080	Lynchburg	Lee
29101	Mc Bee	Chesterfield
29104	Mayesville	Sumter
29114	Olanta	Florence
29161	Timmonsville	Florence
29162	Turbeville	Clarendon
29501	Florence	Florence
29505	Florence	Florence
29506	Florence	Florence
29516	Blenheim	Marlboro
29518	Cades	Williamsburg
29530	Coward	Florence
29532	Darlington	Darlington
29540	Darlington	Darlington
29541	Effingham	Florence
29550	Hartsville	Darlington
29555	Johnsonville	Florence
29560	Lake City	Florence
29565	Latta	Dillon
29571	Marion	Marion
29574	Mullins	Marion
29583	Pamplico	Florence
29591	Scranton	Florence
29592	Sellers	Marion
29593	Society Hill	Darlington

The following map depicts the primary service area for MRMC as described in Table 1 (See Map 1).

Map 1: MRMC Primary Service Area – 2016 Study Area Map

Source: Truven Health Analytics 2015

The McLeod Darlington study area encompasses all of Darlington County.

APPENDIX B: Community Partners

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

- American Heart Association
- Darlington Free Clinic
- Florence School District
- Hope Health
- Let's Go! SC
- Local Churches/Ministers
- Local media – *Morning News, She Magazine*
- Mercy Medicine Free Clinics
- Pee Dee Regional Transport Authority (PDRTA)
- Rural Health Network (Costal Plain Rural Health Network)
- South Carolina Department of Health and Environmental Control
- South Carolina Hospital Association