Palmetto Health made a commitment in 1998 to return to the community a tithe of 10 percent from the annual bottom line. In the past 19 years, Palmetto Health has provided more than $53 million for programs and services for the uninsured and medically underserved population.

In 2016, as required by the passing of the Affordable Care Act, Palmetto Health and partnering organizations created the Community Health Needs Assessment (CHNA), and interviewed, surveyed and researched people in Richland and Lexington counties on their top health needs. Those results can be reviewed in the 2016 CHNA Report at PalmettoHealth.org/CHNA.

Palmetto Health currently provides services that address these areas and have identified additional opportunities for action along with community partners.

<table>
<thead>
<tr>
<th>Priority area</th>
<th>Current state</th>
<th>2013-2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to care</td>
<td>Palmetto AccessHealth (formerly Richland Care)</td>
<td>27,862 participants</td>
</tr>
<tr>
<td>Overweight/Obesity</td>
<td>Weight/BMI measurements</td>
<td>2,048 measurements</td>
</tr>
<tr>
<td>Overweight/Obesity</td>
<td>Healthy lifestyle sessions</td>
<td>247 sessions</td>
</tr>
<tr>
<td>Hypertension</td>
<td>Blood pressure checks</td>
<td>2,155 checks</td>
</tr>
</tbody>
</table>
Methodology

The 2016 CHNA action planning team is a multi-stakeholder group including public health experts, various Palmetto Health department leaders, other hospitals and local leaders (a list of participants is included on the website, PalmettoHealth.org/CHNA). A catalog was developed of current stakeholder activity. Hotspotting, which involves utilizing geographic data to identify the highest need areas within Richland and Lexington counties, and the collective impact framework were utilized as the most efficient and applicable tools in priority areas. A list of strategies was suggested and the team selected the top two areas of focus within access to care, overweight/obesity and hypertension.

Timeline

The 2016 CHNA report was completed in September 2016. Action planning teams met and finalized strategies in early 2017. Work will begin in 2017 and continue through September 2019 (Palmetto Health FY 2019). Some action items will begin immediately while others may not be implemented until later or as appropriate. Milestones and successful initiatives will be captured throughout the process. All actions will be completed by the end of FY 2019 (Sept. 30, 2019).

Health needs

Please see back page for the CHNA action plan for each of the health needs identified.

Access to care

Increasing access to care is an ongoing effort and key to Palmetto Health's strategy associated with community and population health. Because South Carolina did not expand Medicaid, access is considered critical for many community members. Access to care is a large and systemic issue that will require long-term investments and multiple strategies to be successful, such as clinical standardization, service redesign and expansion of alternative services (e.g., Palmetto Health Mobile Clinic and online health visits).

Themes and goals

- **Insurance**: Preferred physicians may be out of network or patients don't understand their plans
- **Costs**: Many people cannot afford co-pays or other costs associated with health care
- **Navigation**: Patients do not understand what care is available, or care is difficult to schedule and not available outside of normal business hours

Collaborating partners

- Palmetto Project
- Providence Health
- Richland Library
- United Way of the Midlands
- South Carolina Hospital Association
- SC TeleHealth Alliance
- SC Thrive
- University of South Carolina
Overweight/Obesity
America's Health Rankings, a leading publication in defining healthy states, ranks South Carolina 42, one of the nation's unhealthiest states. Adult and childhood obesity are increasingly common in Lexington and Richland counties, where more than 30 percent of their population were rated as obese. Before the 2016 CHNA results were finalized, Palmetto Health already identified obesity as a priority area. Palmetto Health invests in health and wellness physician leaders who are focused on leading transformational change within the health system. An internal taskforce has been developed and, in the next three to five years, Palmetto Health will direct extensive resources toward health and wellness.

Themes and goals
- **Safe neighborhoods:** Stray dogs and lack of sidewalks
- **Access and availability of healthy foods:** Cost, preparation and knowledge
- **Behavior and culture:** Obesity stigma, nutrition and physical activity perceptions

Collaborating partners
- Carolina's Cooking
- FoodShare SC
- Scale Down
- SC Department of Health and Environmental Control
- Providence Health

Hypertension
Comorbidities, such as hypertension, have overweight/obesity as a root cause. Blood pressure checks are important in controlling hypertension. There are resources available in the community for blood pressure checks and measurements. However, an extended opportunity could be health education and understanding of blood pressure levels. These programs can be established or grown to help manage hypertension.

Themes and goals
- **Large health problem in the community:** Common health issue
- **Related to other issues:** People diagnosed with hypertension also often have diabetes, high cholesterol and heart disease
- **Behavior and culture:** Lifestyle choices, exercise and diet

Collaborating partners
- American Heart Association
- Eat Smart Move More SC
- Palmetto Project
- Scale Down
- SC Department of Health and Environmental Control
- SC Pharmacy Association
- United Way of the Midlands

Please see back page for the CHNA action plan for each of the health needs identified.

Conclusion/Next Steps
The 2016 CHNA report was completed in September 2016 and action planning teams met and finalized strategies in early 2017. Work on the community health strategies will continue through September 2019 (Palmetto Health FY 2019). Some action plans will begin immediately, while others may not be implemented until later or as appropriate. For each area, the action planning team developed goals, objectives and metrics for tracking and measurement. Through this collective approach, partnering organizations can evaluate how each organization will contribute to the goal.

The action planning team will meet quarterly to monitor and review the implementation process and identify areas for process improvement. Palmetto Health's community health improvement team is committed to facilitate measurable improvements. All action plans will be completed by the end of FY 2019 and the next Community Health Needs Assessment will be conducted in 2019 to re-address the health needs of the community.
## Health need Goals

### Access to care

- Increase access to primary care services
  - Determine areas of highest need for Palmetto Health’s Mobile Clinic
  - Expand online health visit (e.g., SmartExam) referrals and usage
- Expansion of access through usage of a non-traditional, low-cost service (meeting patients where they are)

### Overweight/Obesity

- Enhance healthy lifestyle education offerings in the community
  - Work with community partners to offer customized interventions, particularly in areas of highest need
  - Increase healthy lifestyle education offerings in a variety of community settings
  - Increase use of technology to reach underserved populations
- Increased knowledge of healthy eating options and strategies
  - Improved measurements and increased knowledge in cohort of participants
  - Expand reach of team through use of solutions

### Hypertension

- Improve hypertension management
  - Establish new programs where necessary or expand partnerships
  - Enhance identification of hypertensive patients
  - Develop community educational materials
  - Improved management of hypertension for cohorts of patients
  - Expanded identification of high blood pressure
  - At-home reference guide to improve understanding of signs, symptoms and treatment

### Hypertension

- Enhance healthy lifestyle education offerings in the community
  - Include hypertension prevention and/or management in nutrition education classes and other community activities
  - Increased knowledge of hypertension options and strategies

<table>
<thead>
<tr>
<th>Health need</th>
<th>Goals</th>
<th>Actions</th>
<th>Anticipated impact</th>
<th>Evaluation</th>
</tr>
</thead>
</table>
| Access to care | Increase access to primary care services  | - Determine areas of highest need for Palmetto Health’s Mobile Clinic | - Expansion of access through usage of a non-traditional, low-cost service (meeting patients where they are) | 1. ED utilization  
2. Patients served  
3. Patient activity |
|                |                                            | - Expand online health visit (e.g., SmartExam) referrals and usage    | 1. ED utilization  
2. Patient survey results  
3. “Vouchers” or additional options for access |
|                |                                            | - Expansion of access through usage of a non-traditional, low-cost service (meeting patients where they are) | 1. ED utilization  
2. Patients served  
3. Patient survey results  
3. “Vouchers” or additional options for access |
| Overweight/Obesity | Enhance healthy lifestyle education offerings in the community | - Work with community partners to offer customized interventions, particularly in areas of highest need  
- Increase healthy lifestyle education offerings in a variety of community settings  
- Increase use of technology to reach underserved populations | - Increased knowledge of healthy eating options and strategies  
- Improved measurements and increased knowledge in cohort of participants  
- Expand reach of team through use of solutions | 1. Percent increase/ 
2. Change in behavior/ 
3. Increased knowledge |
|                |                                            |                                                                       | 1. Sessions  
2. Attendees  
3. Quality of session |
|                |                                            |                                                                       | 1. Enrollees  
2. Events  
3. Trained staff |
| Increase access/ availability of healthy foods to the community | Increase access/use of farmers markets  
Increase awareness of the South Carolina farmers and roadside markets  
Increase usage of affordable vegetable outlets | - Enhanced usage of available farmers markets  
- Improved understanding of available options  
- Enhanced usage of expanded solutions offering healthy foods | 1. Farmer’s market access points  
2. Materials developed for increased awareness |
| Hypertension   | Improve hypertension management           | - Establish new programs where necessary or expand partnerships  
- Enhance identification of hypertensive patients  
- Develop community educational materials | - Improved management of hypertension for cohorts of patients  
- Expanded identification of high blood pressure  
- At-home reference guide to improve understanding of signs, symptoms and treatment | 1. Percent improvement in blood pressure management (cohorts)  
2. Blood pressure checks  
3. Educational materials |
|                |                                            |                                                                       | 1. Sessions  
2. Quality of sessions |