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 Sumter County on their top health needs. Those results can be reviewed in the 2016 CHNA Report at PalmettoHealth.org/CHNA.

**Top health needs in Sumter County**

- Access to care
- Overweight/Obesity
- Hypertension
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 Sumter County, 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.

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).

Access to care
Increasing access to care is an ongoing effort and key to Palmetto Health Tuomey’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: Many patients do not have transportation access to primary care physicians

Collaborating partners
- SC Department of Health and Environmental Control
- Sumter Public Schools
- United Way of the Midlands
- United Ministries
- YMCA
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 Sumter County, where more than 36 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

• SC Department of Health and Environmental Control
• Sumter Public Schools
• United Ministries
• United Way of the Midlands
• YMCA

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

• SC Department of Health and Environmental Control
• Sumter Public Schools
• United Ministries
• United Way of the Midlands
• YMCA

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 Tuomey’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.
<table>
<thead>
<tr>
<th>Health need</th>
<th>Goals</th>
<th>Actions</th>
<th>Anticipated impact</th>
<th>Evaluation</th>
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</thead>
</table>
| Access to care      | Increase access to primary care services | • Expand online health visit (e.g., SmartExam) referrals and usage  
• Collaborate with prospective social service partners to examine issues (e.g., transportation) affecting primary care access | • Increase access through usage of a non-traditional, low-cost service (meeting patients where they are) 
• Enhance community’s access to primary care services by reducing barriers | 1. Number of patients served (via SmartExam)  
2. Patient survey results  
1. Number of partnerships reducing primary care service barriers (e.g., transportation for medical services) |
|                     | Engage stakeholders to improve policy-related efforts to increase access | • Expand partnerships and enhance marketing between physicians, community organizations and other partners  
• Develop and share materials regarding health care offerings | • Promote stakeholder engagement and collaboration respective to issues affecting access to primary care  
• Improve patients’ access to services from local providers | 1. Number of partnerships/collaborative efforts  
2. Number of stakeholder meetings regarding access to care  
3. Percent increase in primary care visits after baseline established  
1. Number of marketing materials distributed |
| Overweight/Obesity  | Improve weight management within defined populations | • Identify cohort of patients  
• Implement evidence-based interventions with cohort | • Improve weight management within defined populations  
• Allow specific interventions relative to weight management to be implemented; participants see consistent improvement in BMI (Body Mass Index) | 1. Number of program participants  
1. Track participant progress related to BMI  
2. Change in behavior/increased knowledge |
|                     | Enhance healthy lifestyle awareness and education offerings in the community | • Increase healthy lifestyle education sessions and walking programs with participation interventions in various community settings  
• Increase use of technology to reach underserved populations (e.g., GoNoodle community usage)  
• Expand collaborative partnerships and enhance marketing among partner medical facilities and social service partners | • Enhance knowledge of participation in healthy lifestyle choices and behaviors  
• Expand of access opportunities through partner access points (Hope Centers, library, Council of Government programs)  
• Reduce duplication of effort to reach participants; enhance availability of and exposure to information related to nutrition and physical activity within community | 1. Number of sessions  
2. Quality of sessions (attendee survey)  
3. Number of walking programs present within community  
4. Quality of health programs (attendee survey)  
1. Number of collaborative partnerships formed  
2. Number of educational materials distributed |
| Hypertension        | Enhance healthy lifestyle education offerings in the community | • Provide information pertaining to hypertension prevention and management during health education classes | • Enhance community knowledge regarding hypertension, options for treatment and existing community programs | 1. Number of informational materials distributed  
2. Number of health education classes |
|                     | Improve hypertension management | • Enhance identification of hypertensive patients | • Expand identification of high blood pressure; promote efforts to evaluate need for further interventions related to hypertension | 1. Number of blood pressure checks/screenings  
2. Number of hypertensive patients within service area identified |