PRISMA HEALTH®

2019 Community Health Needs Assessment (CHNA) Report

Our purpose:

Inspire health.
Serve with compassion.
Be the difference.

2019 Community Health Needs Assessment Report

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Mark O'Halla
Chief Executive Officer
Prisma Health

Caring for our communities

As the CEO of Prisma Health, I am pleased to share the results of the inaugural *2019 Community Health Needs Assessment (CHNA) Report* involving our new organization.

Prisma Health was formed to transform the health of South Carolinians. Currently, our state ranks #43 of 50 in national health ratings. Such transformation will not be possible, however, without the dedication of a team united as One Prisma Health in bringing our purpose to life: *Inspire health. Serve with compassion. Be the difference.* Together, our 32,000 team members are committed to making significant improvements in the health outcomes of South Carolinians.

As the state's largest not-for-profit health care organization, Prisma Health serves more than 1.2 million unique patients annually — nearly a quarter of the state's residents. In fact, our combined geography spans the Midlands to the Upstate, covering 51%, or 2.6 million, of the state's population, many of whom reside within 15 minutes of a Prisma Health facility. As such, opportunities await us to improve clinical quality, access to care and the patient experience, while addressing rising medical costs.

Three major health improvement areas rose to the top as a result of the most recent Community Health Needs Assessment. In rank order, they are:

1. Mental health
2. Obesity
3. Drug use/abuse

I am pleased to share that a number of initiatives and programs are underway that address these and other top drivers of community health status. Many of these items are noted on Pages 12–13, where we review our 2016 CHNA progress.

In tandem with these findings and by working as One Prisma Health alongside our many academic, business, legislative and community partners, I am confident that we will make progress in improving the health and well-being of our patients and our community.

Purpose and methodology

Purpose

The 2010 Patient Protection and Affordable Care Act requires tax-exempt hospitals to conduct a community health needs assessment every three years.

The assessment has two main objectives:

• Identify top health needs or issues in the community.

• Develop and implement targeted strategies to help solve these concerns.

We will use the data collected for the 2019 assessment to inform our strategies to improve the health of the communities we serve – in sum, to create a better state of health.

Results will be reported on the IRS form 990, Schedule H for tax year 2019. The CHNA document is available on the Prisma Health website at PrismaHealth.org/CHNA.

For the latest IRS language (Dec. 29, 2014) on how not-for-profit hospitals can comply with the CHNA requirement, go to www.irs.gov/charities-non-profits/community-health-needs-assessment-for-charitable-hospital-organizations-section-501r3.

Methodology

Prisma Health formed a multi-stakeholder team to carry out the 2019 Community Health Needs Assessment. Together, the team identified seven counties to focus on in collecting data for Prisma Health's 2019 CHNA. These counties are Greenville, Laurens, Lexington, Oconee, Pickens, Richland and Sumter.

A total of 5,572 surveys were completed across the seven counties. Data and information gathering used both qualitative and quantitative methods. Primary research – qualitative and quantitative – was collected through internal data sources, focus groups, community stakeholder interviews and community member surveys. Community agencies provided secondary research.

Public health experts guided the team's objectives in developing tools, analyzing data and prioritizing needs. To maximize efficiency, the qualitative and quantitative portions of the CHNA were completed simultaneously.

Data collection

### Implementation strategy development
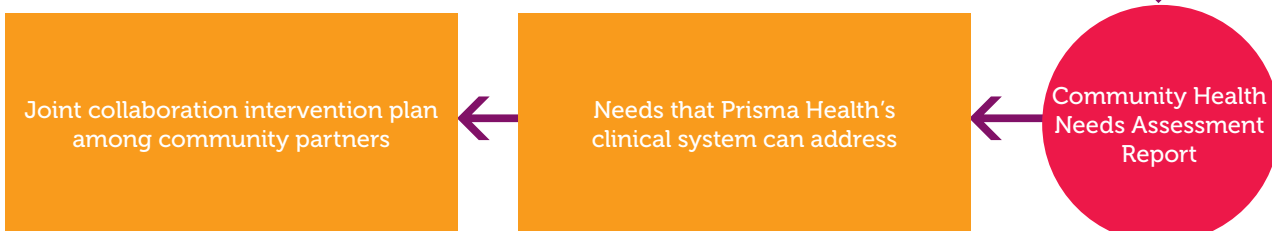
Prisma Health at a glance

- 12 hospitals

- 21-county primary and secondary service area

- Over 300 practice locations

- Nearly 3,000 licensed beds

- 14,300 babies delivered a year

- 31,000 inpatient and 67,000 outpatient surgical procedures annually

- 32,000 team members (employees, physicians and volunteers)

- 500,000+ Emergency Department visits each year

- 1.2 million unique patients treated every year

- $4+ billion total operating revenue annually

- Two affiliated medical schools; two affiliated nursing schools

- Two clinically integrated networks with 3,800 providers

Prisma Health service area

Prisma Health has more than 32,000 team members who provide high-quality care throughout our communities, including these hospitals:

- Prisma Health Baptist Easley

- Prisma Health Baptist

- Prisma Health Baptist Parkridge

- Prisma Health Greenville Memorial

- Prisma Health Greer Memorial

- Prisma Health Hillcrest

- Prisma Health Laurens County

- Prisma Health North Greenville

- Prisma Health Oconee Memorial

- Prisma Health Patewood

- Prisma Health Richland

- Prisma Health Tuomey
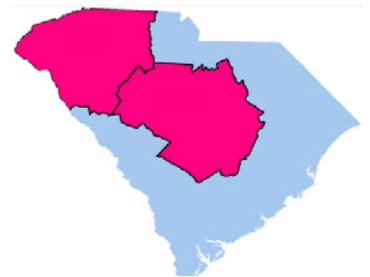
About South Carolina

Although the Palmetto State has much to offer in terms of natural resources and tourist attractions, it leaves much to be desired in terms of its population's health. According to America's Health Rankings, South Carolina is among the nation's unhealthiest states, currently ranking #43.

Consider these sobering statistics, to name just a handful:

- In the past six years, **obesity increased 11%** (34.1%, compared to the national average of 31.3%).
- South Carolina ranks **45th for low birth weight** (9.6%, compared to the national average of 8.2%).
- South Carolina ranks **46th for diabetes** (13.4%, compared to the national average of 10.5%).
- South Carolina ranks **36th for smoking** (18.8%, compared to the national average of 17.1%).
- South Carolina ranks **45th for children living in poverty** (22.6%, compared to the national average of 18.4%).

The Kaiser Family Foundation estimates that the per capita spend on health care in the state is $7,311. The 2.6 million people living within the total Prisma Health footprint (primary and secondary service areas) spend $19 billion a year on health care alone.

Much of community health status is driven by two factors: level of education and level of income. The higher these two factors, the healthier the community tends to be.

According to Claritas Demographics Data, the state's median household income in 2019 is $54,001, far below the national median of $63,174. In the seven-county target area, median income in 2019 rests between those two figures at $57,498.

The average level of education in 2019 per Claritas is almost the same for the seven-county area (31.1%) as the nation (31%) for the percent of population attaining a bachelor's degree or higher; 87.6% vs. 87.3%, respectively, have earned a high school degree (or equivalent). The state as a whole fares about 4% and 1% lower in both categories, respectively.

Social determinants of health comprise the underlying factors associated with community health outcomes. Healthy People 2020 (the federal government's prevention agenda for building a healthier nation) has identified five determinants that affect health:

1. Economic stability (includes poverty, employment, food security and housing stability)

2. Education (spans high school graduation, enrollment in higher education, language and literacy, and early childhood education and development).

3. Social and community context (covers social togetherness, civic participation, perceptions of discrimination and equity and incarceration/institutionalization).

4. Health and health care (encompasses access to health care, access to primary care and health literacy).

5. Neighborhood and built environments (includes access to healthy foods, quality of housing, crime and violence and environmental conditions).

It should come as no surprise that the state's top health issues – smoking, diabetes and obesity – reflect the environmental circumstances and behavioral choices of South Carolinians. These issues also registered among the 2019 Community Health Needs Assessment survey participants in our seven target counties – Greenville, Laurens, Lexington, Oconee, Pickens, Richland and Sumter – but they are not the same trio of priorities identified for our geographic area. Also noteworthy is that Prisma Health continues to address social determinants affecting health outcomes through community programs, population health and case management.
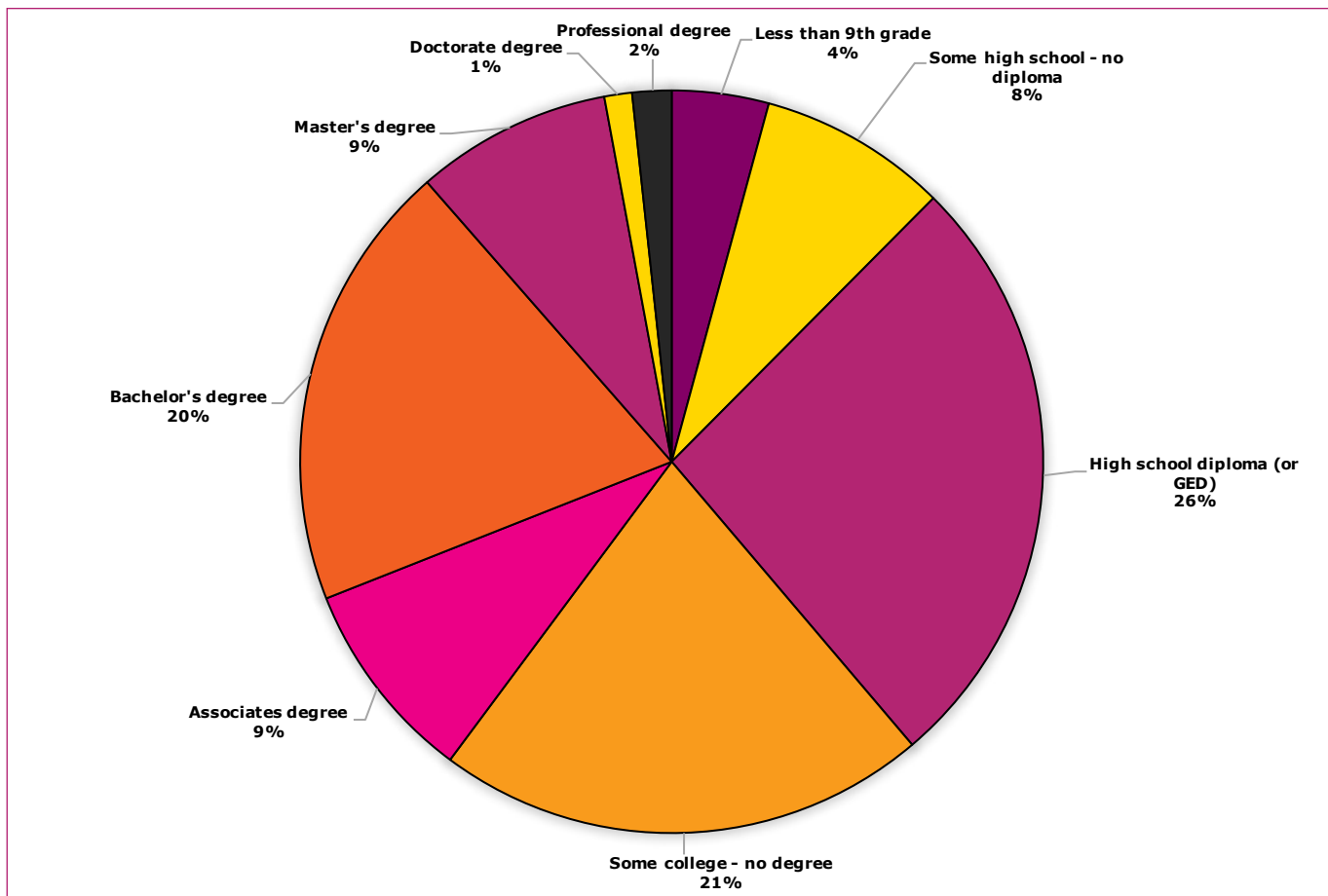
Demographics

2019 South Carolina population breakdown	
Female	51%
Male	49%
Median age	40
Average household income	$74,564
Median household income	$54,001
Population	5,117,956

County	2019 population
Greenville	518,904
Laurens	67,061
Lexington	296,997
Oconee	78,200
Pickens	124,709
Richland	416,671
Sumter	106,515
Total 7-county	**1,609,057**

2019 7-county population breakdown	
Female	51%
Male	49%
Median age	38
Average household income	$77,763
Median household income	$57,498
Population	1,609,057

7-county education breakdown

Educational attainment	7-county focus	South Carolina total	United States total
High school equivalent or higher	87.6%	86.5%	87.3%
Bachelor's degree or higher	31.1%	27%	31%

Source: Claritas Demographic Data

At its core, Prisma Health was formed to address issues of community health – especially the poor health status of South Carolinians and significant costs borne by society for this poor health. The CHNA is an important tool for prioritizing and addressing the drivers of health and health status in our area.

The bar graphs that follow provide both a statewide and seven-county baseline of health outcomes, social determinants of health and unhealthy behaviors.

Health outcomes: Diabetes and adult obesity

When it comes to two of South Carolina's top health concerns – diabetes and adult obesity – Prisma Health's primary service area largely mirrors the state's outcomes. This chart indicates definite opportunities for improvement exist in raising the population's overall health status.

Source: South Carolina Department of Health and Environmental Control

Social determinants of health: High-priority focus areas

■ Access to exercise opportunities ■ Uninsured ■ Unemployment ■ Food insecurity

	Access to exercise opportunities	Uninsured	Unemployment	Food insecurity
South Carolina	69%	12%	4%	14%
Greenville	83%	12%	4%	14%
Laurens	58%	12%	4%	15%
Lexington	65%	11%	4%	10%
Oconee	71%	14%	4%	11%
Pickens	72%	13%	4%	12%
Richland	76%	9%	4%	17%
Sumter	75%	12%	5%	18%

By focusing on social determinants of health, we can address the foundations of our community's poor health status. (Because of multiple responses, totals may not equal 100%.)

Source: South Carolina Department of Health and Environmental Control

Unhealthy behavior trends: Drivers of poor health

	Adult smoking	Physical inactivity	Excessive drinking	Limited access to healthy foods
South Carolina	20%	25%	18%	9%
Greenville	17%	21%	18%	13%
Laurens	20%	31%	16%	13%
Lexington	16%	23%	22%	8%
Oconee	18%	23%	16%	7%
Pickens	18%	21%	19%	12%
Richland	14%	22%	19%	11%
Sumter	20%	28%	16%	11%

Smoking, lack of exercise, alcohol abuse and access to healthy foods all rank high among unhealthy trends, despite percentage variations among counties. (Because of multiple responses, totals may not equal 100%.)

Source: South Carolina Department of Health and Environmental Control

2016 CHNA progress review

In 2016, both Greenville Health System and Palmetto Health (now Prisma Health) used similar, though not identical, methodologies and processes to assess community health needs. Focus areas and results were considered priorities when establishing the 2019 CHNA. Many of these activities will continue on to support 2019 CHNA priorities.

What follows is a compilation of top results from the targeted strategic health initiatives that were put in place for each organization. (More information is available at PrismaHealth.org/CHNA.)

Prisma Health–Midlands (then known as Palmetto Health)

Access to care
Increase focus on telehealth as an anytime, anywhere, any place source of access to consumers; improve access to health care

- Increased SmartExam registrations by 91% and use/visits by over 100%.
- Found that 49% of patients would have traveled to urgent care or an emergency department if SmartExam had not been available.
- Expanded access to students by creating a school-based telehealth program that provides services to three counties and 15 school sites.

Overweight/Obesity
Launch and expand educational and intervention programs; Healthy eating, active living and food insecurity

- Began evidence-based youth program on obesity prevention and reduction at five elementary schools in Lower Richland and Sumter; 94% of students in the program reported learning how to prepare a healthy snack at home.
- Supported the FoodShare program, which includes healthy cooking classes and fresh foods, along with identification of food deserts.
- Initiated 12–week YFIT health education behavior change program serving 171 adults at two locations in Sumter; 70% of participants reported weight loss.

Hypertension
Launch or expand educational and intervention programs

- Launched four Check.Change.Control cohorts and Strongheart programs in partnership with the American Heart Association, resulting in a total average of 5 mmHg decrease in systolic blood pressure and 4.4 mmHg decrease in diastolic blood pressure among participants; 20% of participants reported improved health; 40% reported improved hypertension knowledge; and 35% reported increased self-monitoring.
- Started Holy Strokes and held 12 events, screening 289 participants at churches.
- Expanded screening services to include blood pressure checks and referrals to intervention programs.

Prisma Health–Upstate (then known as Greenville Health System)

Access to health care

- Launched the Mobile Health Clinic, which visits 11 community sites monthly and has received over 500 Emergency Department follow-up referrals.

- Received more than 7,200 referrals to AccessHealth and enrolled 3,232 low-income, uninsured patients into medical homes with care coordination.

- Debuted the Dispensary of Hope (DOH) medication assistance program for low-income, uninsured residents.

- Recruited two volunteer dentists for the dental clinic.

- Created educational materials for patients and providers, and developed a health insurance literacy guide.

Social determinants of health

- Implemented Healthy Planet, an Epic care management platform, to house an organization-wide screening questionnaire that informs a plan of care.

- Implemented NowPow, an innovative SDOH referral system that better connects patients with community services.

Mental and behavioral health

- Added adult mental health providers to Centralized Online Resource Database.

- Established Greenville County Behavioral Health Coalition with United Way.

- Offered tele-psychiatry consulting daily at satellite EDs and five days a week to inpatient floors/ICUs in satellite hospitals.

- Expanded psychiatry programs through academic offerings such as a Child Psychiatry fellowship and Psychiatry residency program in Greer.

- Certified the Accountable Communities team in Mental Health First Aid.

- Conducted depression screenings on 87% of primary care patients.

Healthy eating, active living, food insecurity

- Partnered with FoodShare to provide fresh, healthy produce.

- Participated in two community coalitions for healthy eating and active living; developed action plans with multiple groups to drive healthy eating and active living initiatives.

- Established a diabetes task force for Laurens County; Hispanic Alliance Health Team, led by Prisma Health team members, offered cooking classes for Spanish speakers with diabetes.

- Formed a partnership with Laurens County Hospital and a local church to plant a community garden and build a walking path at a middle school.

- Identified food deserts (areas without ready access to fresh, healthy, affordable food) and worked with various partners to improve access to such foods.

2019 CHNA findings

Prisma Health's commitment to transforming community health and wellness is driven by our purpose: *Inspire health. Serve with compassion. Be the difference.* To effectively and efficiently transform health, we must first be aware of the top health issues facing our residents, especially the health of underserved and vulnerable populations.

A Community Health Needs Assessment is an invaluable tool for identifying and prioritizing a community's health needs, in this case, the areas served by Prisma Health. This report includes input from individuals representing the broad interests of the community through a randomized mail survey in our service area counties, online surveys, community focus groups and in-person interviews with community leaders.

With this input, along with support from community stakeholders and a thorough analysis of relevant data (and in accordance with regulations put forth by the Internal Revenue Service pursuant to the 2010 Patient Protection and Affordable Care Act), Prisma Health has identified three health priorities (listed in rank order) to focus on over the next three years:

1. Mental health
2. Obesity
3. Drug use/abuse

These needs were identified using three key measures: **health access needs, health status and barriers to care.**

Results were then grouped into priorities of health needs using a six-step process:
1. Incidence and prevalence
2. Presence and degree of disparities
3. Alignment with health system and state priorities
4. Potential for measurable, achievable outcomes
5. Support from the community
6. Existing community partnerships, programs and resources

Over the coming months, we will craft strategies to address these prioritized needs through 2022, with an end goal of improving community health. Through concerted efforts and strong engagement with our patients, guests and families; area leaders; health care advocates and goodwill ambassadors; academic, business, legislative and community partners; and team members acting as One Prisma Health, our communities can become stronger and healthier – both physically and emotionally. Our *2019 Community Health Needs Assessment Report* will help guide this transformation.

2019 CHNA data overview

Data collection

The information contained in this assessment consists of primary and secondary data. Primary data (both quantitative and qualitative) was collected through surveys, interviews and focus groups conducted in Greenville, Laurens, Lexington, Oconee, Pickens, Richland and Sumter counties. Secondary data was gathered from numerous community sources, such as the S.C. Department of Health and Environmental Control, County Health Rankings and America's Health Rankings. Public health experts, data scientists and researchers developed assessment objectives, data collection protocols and instruments, and performed data analysis. Data collection and analysis took place December 2018 to July 2019.

Note: Unlike 2016, which had a separate data collection process and implementation plan for Palmetto Health and for Greenville Health System, 2019 marks the first unified set of data and forthcoming implementation plans as Prisma Health.

Surveys

Community members from the seven counties listed above made up the primary target audiences. Survey responses were distributed by mail, at events and online. Team members and volunteers visited local events, community meetings and businesses to obtain survey responses. Organizations such as the United Way and other community partners helped gather the responses. Completed surveys were collectively entered into the same system, coded and tabulated at the conclusion of the survey period.
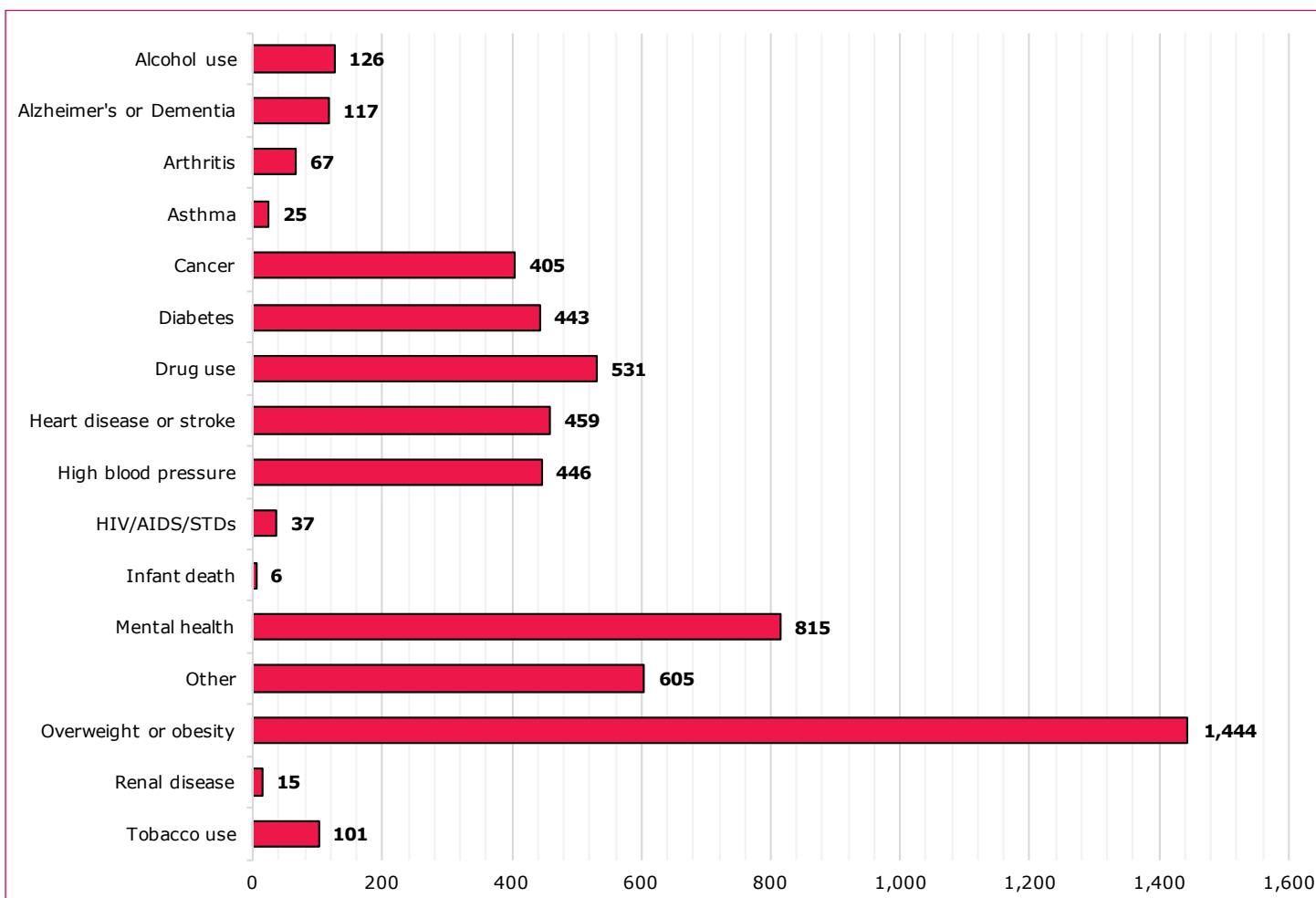
Community members were asked to select their top health issues and share concerns on related topics, such as children's health, digital health, physical activity and nutrition. Health problems mentioned by the community were consistent with those discussed in one-on-one interviews and focus groups.

Survey collection

County	Goal	Actual
Total surveys	**5,000**	**5,572**
Greenville	1,583	1,607
Laurens	215	224
Lexington	910	844
Oconee	245	587
Pickens	392	442
Richland	1,307	1,342
Sumter	347	706

Top 4 health concerns (from surveys, in rank order)
Overweight or obesity
Mental health
Drug use/abuse
High blood pressure

Most important health concern (as identified through surveys)

Health concern	Value
Alcohol use	126
Alzheimer's or Dementia	117
Arthritis	67
Asthma	25
Cancer	405
Diabetes	443
Drug use	531
Heart disease or stroke	459
High blood pressure	446
HIV/AIDS/STDs	37
Infant death	6
Mental health	815
Other	605
Overweight or obesity	1,444
Renal disease	15
Tobacco use	101

Focus groups

Prisma Health team members and volunteers conducted 19 focus groups. Survey data helped inform recommended participants for these groups. Under-representation from males, people under 25 and Latinos led to specialized recruitment in focus groups to reach those populations. Focus groups also included physicians and nurses to ensure a varied perspective on community health conditions. Team members from Prisma Health's Care Coordination Institute® devised a consistent process for coding, data entry and analysis of focus group responses.

Focus groups

Goal	Number completed
5–10	19

Top health concerns (from focus groups, in rank order)	
Community group concerns	Clinician group concerns
Diabetes	Diabetes
Hypertension	Obesity
Obesity	Hypertension

Community focus group health concerns (in rank order)

Top tier	Second tier	Third tier
• Diabetes • Hypertension	• Obesity • Substance abuse • Cancer • Insurance	• Arthritis • Cholesterol • Heart disease • STDs • Access • Allergies • Flu • Food poisoning • Lack of education • Mental health • Nutrition • Strep throat • Alcohol usage • Asthma • Clinic resources • Cost • Dementia • Dental • Preventive care • Speeding in cars

Clinician focus group health concerns (in rank order)

Top tier	Second tier	Third tier
• Diabetes	• Obesity • Hypertension • Nutrition	• Mental health • Opioid dependence • Substance abuse • Access • Cost • Cancer • Hepatitis C • Kidney disease • Insomnia • Isolation • Lack of education • Screen time

Interviews

To ensure service area representation, team members and volunteers conducted 90 interviews of community leaders. With the exception of drug use/abuse, those interviewed expressed consistent health concerns across counties.
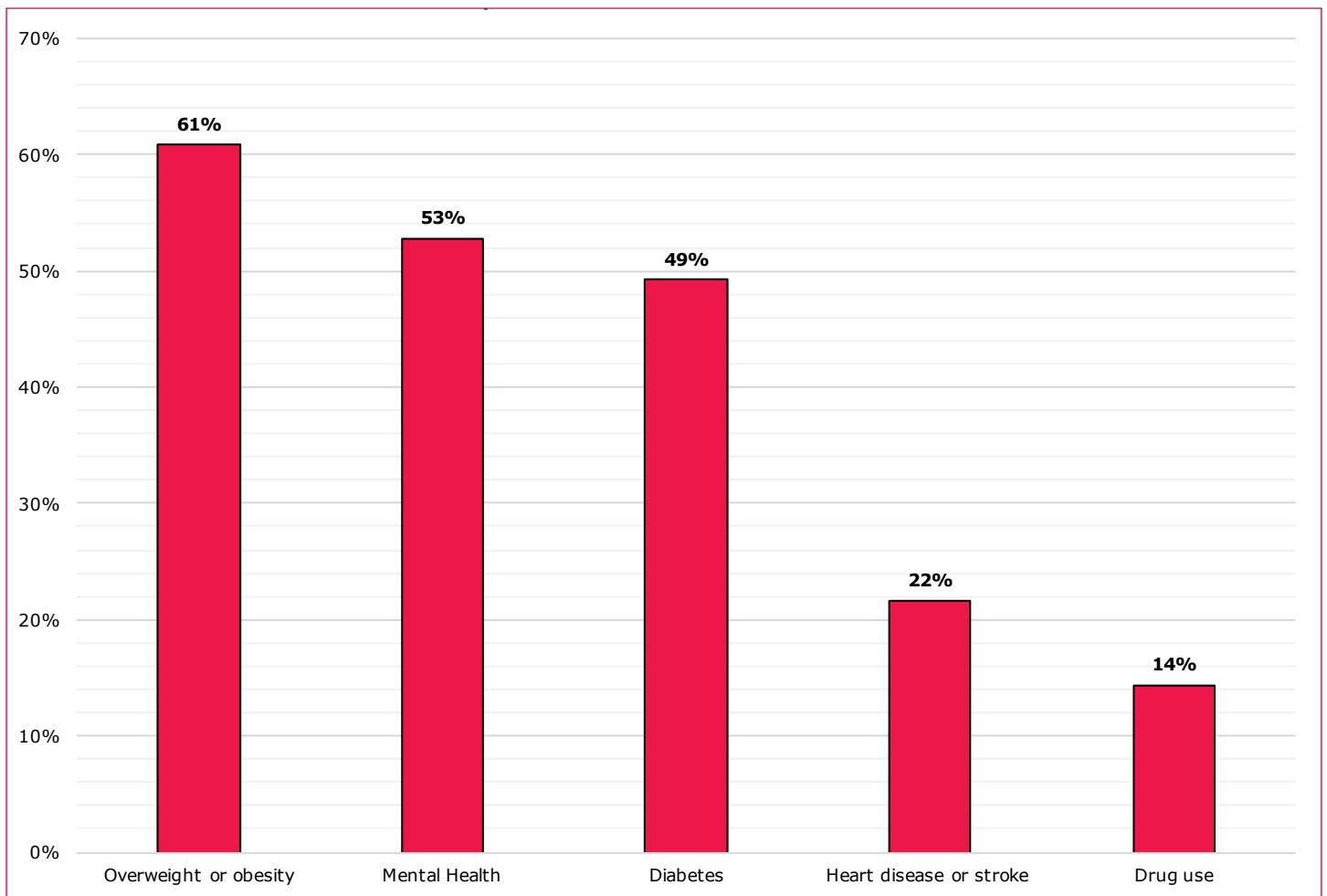
Interviews

Goal	Number completed
25–50	90

Top 5 health concerns (from interviews, in rank order)
Overweight or obesity
Mental health
Diabetes
Heart disease or stroke
Drug use/abuse

Top health concerns

Community priorities

Process

The top three health needs were identified from interviews, focus groups and surveys. Not surprisingly, overlap occurred across these three mediums with regard to health concerns. Here are the top eight health topics mentioned (in alphabetical order):

- Access to health care
- Cancer
- Diabetes
- Drug use/abuse
- Heart disease and stroke
- High blood pressure
- Mental health
- Overweight/Obesity

In conjunction with the S.C. Department of Health and Environmental Control, S.C. Hospital Association and Prisma Health's Care Coordination Institute team members, Prisma Health CHNA project leadership developed a priority process whereby health organization and community leaders were invited to "score" each health need based on criteria feedback from the team's research and steering committee.

Survey criteria
- Incidence and prevalence
- Presence and degree of disparities
- Alignment with health organization or state priorities
- Potential for measurable, achievable outcomes
- Support from the community
- Existing community partnerships, programs and resources

Priorities for 2019 CHNA

With the priority process in place and with participation from over 30 stakeholders, 90 interviews, 19 focus groups and 5,572 surveys, the top three health needs (in rank order) were identified for Greenville, Laurens, Lexington, Oconee, Pickens, Richland and Sumter counties:

1. Mental health
2. Obesity
3. Drug use/abuse

Next steps

Over the coming months, we will craft strategies to address these prioritized needs through 2022, with an end goal of improving community health. Our *2019 Community Health Needs Assessment Report* will help guide this transformation.

Through concerted efforts and strong engagement with our patients, guests and families; area leaders; health care advocates and goodwill ambassadors; academic, business, legislative and community partners; and team members acting as One Prisma Health, our communities can become stronger and healthier – both physically and emotionally.

Appendix 1

Community survey

Dear community member,

During the next several months, Prisma Health (Greenville Health System and Palmetto Health recently joined together to become Prisma Health) plans to conduct a Community Health Needs Assessment (CHNA) in order to understand the health care needs of citizens in the Midlands and Upstate so that we may better respond to them.
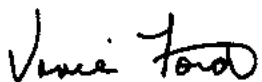
Community Health Needs Assessments are designed to help improve the overall health and wellness of communities by identifying community needs and use of local health resources, and action needed to address health care delivery in a defined area. This assessment will include interviews with state and local elected officials, major employers, community members and community organizations that provide health services. Along with the interviews, our team also will conduct surveys, through prepaid mailings, door-to-door, online and at local organizations/agencies and community events.

Once completed, we will work with our partners to analyze the results, determine gaps in the provision of services and decide how the hospital system may be able to collaborate to meet high priority community needs. The project also will help determine where additional resources may be needed or how cost savings may be achieved.

The surveys are anonymous. We cannot tell who has completed one. Collected information will not be attributed to any specific source. Your answers will help us understand what is important and how we can better serve the residents of our community. Once all data is compiled, we will share the results of the completed report on prismahealth.org/chna.

The survey is included with this letter. Please fill it out and return it in the pre-stamped and addressed envelope. Thank you for your time.

Sincerely,

Vince Ford
Senior Vice President, Community Health Services, Prisma Health

Community Health Needs Assessment

2019 Survey

Have you completed this survey in 2019? ☐ Yes ☐ No
If yes or not sure, please stop the survey here. Thank you for your time.

PART 1: Your community

1. What county do you live in?
☐ Greenville ☐ Laurens ☐ Sumter
☐ Pickens ☐ Richland ☐ Other: _____
☐ Oconee ☐ Lexington

2. My home ZIP code is: _____.

3. What is the main reason that prevents people in your community from receiving preventive care (mammograms, cancer screenings, flu shots, etc.)? Please select one.
☐ Lack of knowledge ☐ Cost
☐ Access to facilities ☐ Other: _____
☐ Fear

4. Which reasons prevent people from being physically active in your community? Check all that apply.
☐ Safety of community ☐ Weather
☐ Not enough sidewalks or bike lanes ☐ Personal choice
☐ No community events ☐ Other: _____

5. What types of health services are most important to keep you healthy? Check all that apply.
☐ Hypertension/high blood pressure ☐ Cancer care
☐ Fall prevention for the elderly ☐ Colorectal care/screening
☐ HIV/AIDS/STD ☐ Heart disease care
☐ Diabetes care ☐ Quitting smoking/tobacco products
☐ Drug and alcohol misuse ☐ Suicide prevention
☐ Alzheimer's/dementia care ☐ Disease outbreak prevention
☐ Emergency preparedness ☐ Mental health/depression care
☐ Routine wellness checkups ☐ Weight loss support
(mammogram, cholesterol, immunization, well child) ☐ Other: _____
☐ Nutrition for prenatal care

6. Which of the following are reasons that prevent people in your community from eating healthy foods? Check all that apply.
☐ Don't cook at home ☐ No grocery store near by
☐ Eat fast food regularly ☐ May not know how to eat healthy
☐ No community gardens ☐ Stores don't accept SNAP/EBT/WIC
☐ Too expensive ☐ Stores don't have quality fruits and vegetables
☐ Too tired after work ☐ Other: _____
☐ No farmers market

7. What is the most important health concern in your community. Choose only one.
☐ Alcohol use ☐ Infant death
☐ Alzheimer's/Dementia ☐ Mental health (anxiety, depression, etc.)
☐ Arthritis ☐ Overweight/obesity
☐ Asthma ☐ Tobacco use
☐ Cancer ☐ Other: _____
☐ Diabetes
☐ Drug use
☐ Heart disease/stroke
☐ High blood pressure
☐ Renal disease
☐ HIV/AIDS/STDs

	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
8. My community is a safe place to live because:					
*There is **safe housing**.*	☐	☐	☐	☐	☐
*There are safe places to **play**.*	☐	☐	☐	☐	☐
*There are safe places to **work**.*	☐	☐	☐	☐	☐
*There are safe **schools**.*	☐	☐	☐	☐	☐
*There is good **street lighting**.*	☐	☐	☐	☐	☐
*There are safe **roads and sidewalks**.*	☐	☐	☐	☐	☐
*There are safe ways to get to where I need to go **(transportation)**.*	☐	☐	☐	☐	☐
*There are good **fire/safety/emergency services**.*	☐	☐	☐	☐	☐
There is a strong faith-based community.	☐	☐	☐	☐	☐
9. My community is strong in providing:					
*Good **housing** options*	☐	☐	☐	☐	☐
*Good **education***	☐	☐	☐	☐	☐
***Transportation** services*	☐	☐	☐	☐	☐
***Child care** options*	☐	☐	☐	☐	☐
***Jobs** with fair wages*	☐	☐	☐	☐	☐

10. I would rate the overall health of my community as:
☐ Poor
☐ Fair
☐ Average
☐ Good
☐ Excellent

11. Over the past 12 months, how often did you eat fruits and vegetables?
☐ Never
☐ 1 time per month
☐ 2-3 times per month
☐ 1 time per week
☐ 2 times per week
☐ 3-4 times per week
☐ 5-6 times per week
☐ 1 time per day
☐ 2 or more times per day

12. Over the past 12 months, how many times were you physically active or exercised for 60 or more minutes?
☐ Never
☐ 1-2 times in the last week
☐ 3-4 times in the last week
☐ 5 or more times in the last week

PART 2: Children's health

13. What is the main reason that prevents children in your community from being physically active? Please select one.
☐ Safety of community
☐ Not enough sidewalks or bike lanes
☐ No community events
☐ Weather
☐ Parent schedule
☐ Other: _____

14. Which of the following are reasons that prevent children in your community from eating healthy foods? Check all that apply.
☐ Parents don't cook at home
☐ No community gardens
☐ Eat fast food regularly
☐ Too expensive for parents
☐ Parents too tired after work
☐ No farmers market
☐ No grocery store nearby
☐ May not know how to eat healthy
☐ Stores don't accept SNAP/EBT/WIC
☐ Stores don't have quality produce
☐ Other: _____

15. Do you have children?
☐ Yes - Go to question 16
☐ No - Skip to part 3: My Information

16. What is the age range of your child(ren)? _____

17. Does your child eat the following meals at school? Check all that apply.
- ☐ Breakfast
- ☐ Lunch
- ☐ Dinner
- ☐ None

18. How often does your child receive 60 minutes or more of activity each day (organized sports, outside play, dance, gym class, video games requiring movement)?
- ☐ None
- ☐ 1-2 times in the last week
- ☐ 3-4 times in the last week
- ☐ 5 or more times in the last week
- ☐ I don't know

19. Over the past 12 months, how often did your child eat fruits and vegetables?
- ☐ Never
- ☐ 1 time per month
- ☐ 2-3 times per month
- ☐ 1 time per week
- ☐ 2 times per week
- ☐ 3-4 times per week
- ☐ 1 time per day
- ☐ 2 or more times per day

PART 3: My information

20. What is your age?
- ☐ Under 18
- ☐ 18-24
- ☐ 25-34
- ☐ 35-44
- ☐ 45-54
- ☐ 55-64
- ☐ 65+
- ☐ Prefer not to answer

21. How do you describe your gender identity?
- ☐ Male
- ☐ Female
- ☐ Transgender
- ☐ If you identify as a gender other than those listed here, please specify: _____
- ☐ Prefer not to answer

22. Which race category do you most identify with? Choose only one.
- ☐ White or Caucasian
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Native Hawaiian or Pacific Islander
- ☐ Asian
- ☐ More than one race
- ☐ Some other race

23. Are you of Hispanic, Latino or Spanish origin?
- ☐ Yes
- ☐ No

24. What is your current employment status? Choose all that apply.
- ☐ Employed for wages
- ☐ Self-employed
- ☐ Out of work and not currently looking for work
- ☐ Out of work and looking for work
- ☐ A homemaker
- ☐ Student
- ☐ Military
- ☐ Retired
- ☐ Unable to work
- ☐ Other: _____

25. What was your total family income last year before taxes? Choose only one.
- ☐ Less than $10,000
- ☐ $10,000–$25,000
- ☐ $25,001–$50,000
- ☐ $50,001–$100,000
- ☐ $100,001–$200,000
- ☐ $200,001 or over

26. What is the highest level of school, college or vocational training you finished? Choose only one.
- ☐ No schooling completed
- ☐ High school diploma (or GED)
- ☐ Some college credit, less than one year
- ☐ One or more years of college credit, no degree
- ☐ Associates degree
- ☐ Bachelor's degree
- ☐ Master's degree
- ☐ Professional degree beyond a bachelor's degree
- ☐ Doctorate degree
- ☐ Other: _____

27. I have the following types of health insurance: Check all that apply.
- ☐ Self-pay
- ☐ Medicare
- ☐ Medicaid
- ☐ Commercial insurance
- ☐ Workers compensation
- ☐ Indigent/charitable organization
- ☐ Other government (Champus, state, county)
- ☐ HMO (Health Maintenance Organization)
- ☐ Medicaid family planning only
- ☐ Not stated

28. Do you have a primary care provider?
- ☐ Yes
- ☐ No

29. Have you had any of the following preventive procedures in the past year? Check all that apply.
- ☐ Flu shot
- ☐ Cholesterol screening
- ☐ Dental cleaning/X-rays
- ☐ Vision screening
- ☐ Blood pressure check
- ☐ Yearly check up
- ☐ None of the above

30. Technology has made it easier to use computers, mobile phones and tablets to safely talk face-to-face with your doctor without a visit to the office.

Please indicate if you would be OK with talking face-to-face with your doctor using the Internet (video visits, online chat, other online options).
- ☐ Strongly agree
- ☐ Agree
- ☐ Neutral
- ☐ Disagree
- ☐ Strongly disagree

31. A doctor, nurse or other health care provider has told you that you have the following: Check all that apply.
- ☐ High blood pressure
- ☐ High blood sugar (pre-diabetes, diabetes)
- ☐ Overweight/obesity
- ☐ High cholesterol
- ☐ Depression/anxiety
- ☐ None of the above

32. Your main form of transportation is: Choose one.
- ☐ Walk/bicycle
- ☐ Public transportation (i.e. bus)
- ☐ Personal automobile (i.e. car, truck, motorcycle)
- ☐ Taxi/ride share company (i.e. Uber, Lyft)
- ☐ Family/friends
- ☐ Other: _____

33. Is your transportation reliable when you have a health-related appointment? If no, please explain.
- ☐ Yes
- ☐ No _____

Thank you for your time in completing this survey. Your answers will help us as we work with you to make a healthier community.

If you prefer to complete this survey online, please visit PrismaHealth.org/CHNA.

Appendix 2

Organization/Stakeholder interview guide

Interviewee's name:
Title:
Name of organization:
Primary health-related focus:
Description of services offered:
Description of target population:
Size of organization:
Type of organization: ❐ Private   ❐   Nonprofit ❐   Public
Other pertinent information about the organization:

Counties: ❐ Greenville ❐ Laurens ❐ Lexington
❐Oconee ❐ Pickens ❐ Richland ❐   Sumter
Sex: ❐ Mostly male   ❐   Mostly female   ❐Same
Insurance status: ❐   Privately insured ❐ Medicare
❐Medicaid ❐Uninsured
Age range:❐ 0-18 ❐ 18-34 ❐ 35-54 ❐55+

1.   How has the health of the community changed in last 3–5 years?

2.   What do you think are the three MOST important health issues in your community? (Choose only three.)
   - ❐ Alcohol use
   - ❐ Alzheimer's/Dementia
   - ❐ Arthritis
   - ❐ Cancer
   - ❐ Tobacco use
   - ❐ High blood pressure
   - ❐ HIV/AIDS/STD
   - ❐ Infant death
   - ❐ Mental health
   - ❐ Other _____
   - ❐ Diabetes
   - ❐ Drug use
   - ❐ Heart disease and stroke
   - ❐ Overweight/Obesity

3.   Are there adequate resources in your community to address these issues?
   - ❐ Yes   ❐ No – Please explain: _____

4.   How do you view your organization's role in working to improve these issues?
   - a.   What are your current strategies to improve these issues?

5.   What are the biggest client barriers you have encountered while trying to improve the health of the residents i your service area?
   - ❐ Being uninsured
   - ❐ Having insurance but not being able to afford the co-pays or deductibles
   - ❐ Lack of knowledge of health care and insurance options
   - ❐ Lack of transportation
   - ❐ Cultural issues
   - ❐ Not trusting doctors or medical professionals
   - ❐ My clients typically do not have barriers to access
   - ❐ Other: _____

6.   What are the top three strengths in Greenville, Laurens, Lexington, Oconee, Pickens, Richland and Sumter counties that can be used to improve the health of these counties?
   - ❐ Government support
   - ❐ Community coalitions and collaboration
   - ❐ Funding opportunities
   - ❐ Health system support
   - ❐ Local colleges and universities
   - ❐ Community infrastructure
   - ❐ Other: _____

7.   What additional comments do you have regarding health in Greenville, Laurens, Lexington, Oconee, Pickens, Richland and Sumter counties?

Appendix 3

Focus group guide

Objectives

- To collect feedback from community members and community clinicians for the CHNA from Greenville, Pickens, Oconee, Laurens, Richland, Lexington and Sumter counties.
- Feedback will be combined with other data to help determine community priorities.

Time

45-60 minutes

Materials/Leaders

- Leaders: Facilitator and note taker
- Materials: Paper surveys, pens/pencils, snacks/drinks (incentives), notes

Preparation

- Review focus group questions in **orange** and become very familiar with them in case discussion bounces around.
- Allocate time for plan and outcomes discussion between note taker and facilitator before and after the focus group

Facilitators tips

- Arrive early enough for preparation and to greet participants as they arrive.
- Be neutral and engaging when facilitating the content (facilitator is not the subject matter expert).
- The goal of the session is to get community feedback and we desire a variety of opinions.
- Establish group rules/agreements and refer to them as needed. This will help participants feel more connected to the group and keep the conversation on task.
- Recording should be used for personal notes only and must be disclosed to the group.

Community member's focus group guide

Suggested agenda

Welcome and introductions — 10 minutes

- *Goal:* Create a sense of common purpose
  Before group starts: Welcome participants and ensure each person completes the survey.
  To begin focus group: Welcome to today's focus group. My name is _____ and this is (<u>name of note taker</u>) and we are volunteers with Prisma Health. Our goal is to gather your feedback s members of the community. The information you share in today's focus group will not be associated with any single person but instead will be used to combine with other data and develop priority areas to focus community-based work on. After the 2016 assessment, we developed several new programs and services to address areas of concern for the community. There are no wrong answers and we want a variety of opinions. My role is to help us stick to our 1-hour time so at times, I may need to move us along.

Leading questions — 40 minutes

- *Goal:* Generate conversation and feedback
  Facilitator tips
  - Begin by asking questions in orange below
  - For the engagement question, be sure to ask this question of each individual present.
    Engagement question:
    1. Where do you go when you need health care services?

- The exploration questions are meant to be open ended dialogue.

  Exploration questions:

  2. What are the main reasons you go to the doctor?

  3. Why do you choose to go to your current doctor?

  4. What is the hardest part of getting care in your area?

  5. What are the main health issues in your community?

  6. Do you feel like the people in your community are aware of all the health care options that are available to them?

  7. What are the reasons people in your community might not seek care even when needed?

  8. Are there services you wish you had easier access to?

      a. If you have children, are there services you wish you had easier access to?

- Facilitator should discuss and review notes at the end of the session.
- Use training tips to engage quiet participants and manage disruptive participants
- Allow time for feedback from participants (embrace silence to encourage participation)
- Be conscience of time and ensure you allow a minimum of five minutes for the conclusion

Conclusion — 10 minutes

- *Goal:* Summarize meeting pearls

  Thank the team for participation and ask exit questions of each participant

  Exit question:

  9. Is there anything else you would like to add in regards to health care in your community?

- Share that the completed CHNA will be posted online by Sept. 15, 2019 at www.PrismaHealth.org/CHNA.
- Facilitator should discuss and review notes at the end of the session.

Clinician member's focus group guide

Each clinician focus group participant must complete.

Participant's name:

Title:

Name of organization:

Primary health-related focus:

Description of services offered:

Description of target population:

Size of organization:

Type of organization: ❑ Private ❑ Nonprofit ❑ Public

Other pertinent information about the organization:

Suggested agenda

Welcome and introductions — 10 minutes

- *Goal:* Create a sense of common purpose

  Before group starts: Welcome participants and ensure each person completes the survey.

  To begin focus group: Welcome to today's focus group. My name is _____ and this is (<u>name of note taker</u>) and we are volunteers with Prisma Health. Our goal is to gather your feedback s members of the community. The information you share in today's focus group will not be associated with any single person but instead will be used to combine with other data and develop priority areas to focus community-based work on. After the 2016 assessment, we developed several new programs and services to address areas of concern for the community. There are no wrong answers and we want a variety of opinions. My role is to help us stick to our 1-hour time so at times, I may need to move us along.

Leading questions – 40 minutes

- *Goal:* Generate conversation and feedback
  Facilitator tips
  - Begin by asking questions in orange below
  - For the engagement question, be sure to ask this question of each individual present.
    Engagement question:
    1. Briefly describe your current practice setting.
  - The exploration questions are meant to be open ended dialogue.
    Exploration questions:
    2. What are the most common clinical encounters you see in your practice.
    3. Have you seen an increase in a specific clinical encounter over the past 1-3 years that causes you concern?
    4. Focusing on specific health issues, what would you say are the biggest health problems in the community?
    5. What are the underserved population in your community?
    6. How can we improve access to care for the populations you listed?
    7. Do you feel that people in the community are fully aware of the health care services/options that are available to them? Why or why not?
    8. What are the most pressing health issues children in your community or practice face?

  - Use training tips to engage quiet participants and manage disruptive participants.
  - Allow time for feedback from participants (embrace silence to encourage participation).
  - Summarize main themes and topics after each question for your note taker.
  - Be conscience of time and ensure you allow a minimum of five minutes for the conclusion.

Conclusion – 10 minutes

- *Goal:* Summarize meeting pearls
  Thank the team for participation and ask exit questions of each participant
  Exit question:
  9. Is there anything else you would like to add about the health in the community you serve?
- Share that the completed CHNA will be posted online by Sept. 15, 2019 at www.PrismaHealth.org/CHNA.
- Facilitator should discuss and review notes at the end of the session.

Appendix 4

County health rankings: Greenville County

2019 rankings	Greenville County	Error margin	Top U.S. performers	South Carolina	Rank (of 46)
Health outcomes					**5**
Length of life					**5**
Premature death	7,400	7,200-7,700	5,400	8,700	
Quality of life					**7**
Poor or fair health**	17%	16-17%	12%	19%	
Poor physical health days**	4.2	4.1-4.3	3.0	4.2	
Poor mental health days**	4.2	4.1-4.3	3.1	4.4	
Low birthweight	8%	8-9%	6%	10%	
Health factors					**2**
Health behaviors					**2**
Adult smoking**	17%	16-17%	14%	20%	
Adult obesity	28%	26-30%	26%	32%	
Food environment index	7.6		8.7	6.3	
Physical inactivity	21%	19-23%	19%	25%	
Access to exercise opportunities	83%		91%	69%	
Excessive drinking**	18%	17-18%	13%	18%	
Alcohol-impaired driving deaths	35%	32-37%	13%	35%	
Sexually transmitted infections	379.2		152.8	575.5	
Teen births	26	25-27	14	30	
Clinical care					**3**
Uninsured	12%	11-13%	6%	12%	
Primary care physicians	950:1		1,050:1	1,490:1	
Dentists	1,560:1		1,260:1	1,840:1	
Mental health providers	470:1		310:1	610:1	
Preventable hospital stays	3,102		2,765	4,520	
Mammography screening	47%		49%	45%	
Flu vaccinations	52%		52%	45%	
Social and economic factors					**4**
High school graduation	87%		96%	84%	
Some college	67%	66-69%	73%	62%	
Unemployment	3.7%		2.9%	4.3%	
Children in poverty	18%	15-20%	11%	22%	
Income inequality	4.7	4.5-4.8	3.7	4.8	
Children in single-parent households	31%	29-33%	20%	39%	
Social associations	12.4		21.9	11.7	
Violent crime	533		63	500	
Injury deaths	82	78-86	57	81	
Median household income	$56,300	$53,400-$59,200	$67,100	$50,700	
Children eligible for free or reduced price lunch	53%		32%	67%	
Residential segregation, black/white	40		23	46	
Residential segregation, non-white/white	34		15	42	
Homicides	7	6-7	2	8	
Firearm fatalities	14	13-16	7	17	

County health rankings: Greenville County (continued)

2019 rankings	Greenville County	Error margin	Top U.S. performers	South Carolina	Rank (of 46)
Health factors					**2**
Physical environment					**1**
Air pollution/particulate matter**	9.5		6.1	10.2	
Drinking water violations	No				
Severe housing problems	14%	13-14%	9%	15%	
Driving alone to work	83%	83-84%	72%	83%	
Long commute/driving alone	28%	27-29%	15%	34%	
Additional physical environment (not included in overall ranking)					
Homeownership	65%	63-66%	80%	69%	
Severe housing cost burden	14%	13-16%	7%	13%	
**Data should not be compared with prior years. *Note: Blank values reflect unreliable or missing data.* *Data provided by: S.C. DHEC*					

County health rankings: Laurens County

2019 rankings	Laurens County	Error margin	Top U.S. performers	South Carolina	Rank (of 46)
Health outcomes					**27**
Length of life					**28**
Premature death	10,800	9,900-11,700	5,400	8,700	
Quality of life					**27**
Poor or fair health**	22%	21-22%	12%	19%	
Poor physical health days**	4.8	4.6-4.9	30	4.2	
Poor mental health days**	4.8	4.6-5.0	3.1	4.4	
Low birthweight	10%	9-11%	6%	10%	
Health factors					**27**
Health behaviors					**30**
Adult smoking**	20%	19-21%	14%	20%	
Adult obesity	38%	34-42%	26%	32%	
Food environment index	7.0		8.7	6.3	
Physical inactivity	31%	28-34%	19%	25%	
Access to exercise opportunities	58%		91%	69%	
Excessive drinking**	16%	15-16%	13%	18%	
Alcohol-impaired driving deaths	36%	31-40%	13%	35%	
Sexually transmitted infections	477.3		152.8	575.5	
Teen births	41	38-44	14	30	
Clinical care					**23**
Uninsured	12%	10-14%	6%	12%	
Primary care physicians	1,850:1		1,050:1	1,490:1	
Dentists	3,520:1		1,260:1	1,840:1	
Mental health providers	1,490:1		310:1	610:1	
Preventable hospital stays	4,526		2,765	4,520	
Mammography screening	39%		49%	45%	
Flu vaccinations	42%		52%	45%	
Social and economic factors					**28**
High school graduation	81%		96%	84%	
Some college	52%	48-56%	73%	62%	
Unemployment	4.4%		2.9%	4.3%	
Children in poverty	29%	23-36%	11%	22%	
Income inequality	4.4	4.0-4.7	3.7	4.8	
Children in single-parent households	47%	42-53%	20%	39%	
Social associations	13.6		21.9	11.7	
Violent crime	551		63	500	
Injury deaths	99	88-110	57	81	
Physical environment					**19**
Air pollution/particulate matter**	10.6		6.1	10.2	
Drinking water violations	No				
Severe housing problems	13%	11-15%	9%	15%	
Driving alone to work	82%	80-84%	72%	83%	
Long commute/driving alone	36%	33-40%	15%	34%	
Additional physical environment (not included in overall ranking)					
Homeownership	65%	63-66%	80%	69%	
Severe housing cost burden	14%	13-16%	7%	13%	

County health rankings: Laurens County (continued)

2019 rankings	Laurens County	Error margin	Top U.S. performers	South Carolina	Rank (of 46)

**Data should not be compared with prior years.
Note: Blank values reflect unreliable or missing data.

Data provided by: S.C. DHEC

2019 rankings		Laurens County	Error margin	Top U.S. performers	South Carolina	Rank (of 46)

County health rankings: Lexington County

2019 rankings	Lexington County	Error margin	Top U.S. performers	South Carolina	Rank (of 46)
Health outcomes					**6**
Length of life					**9**
Premature death	7,700	7,300–8,100	5,400	8,700	
Quality of life					**4**
Poor or fair health**	16%	16-17%	12%	19%	
Poor physical health days**	3.9	3.8-4.1	3.0	4.2	
Poor mental health days**	4.2	4.1-4.4	3.1	4.4	
Low birthweight	9%	8-9%	6%	10%	
Health factors					**4**
Health behaviors					**9**
Adult smoking**	16%	15-16%	14%	20%	
Adult obesity	32%	29-35%	26%	32%	
Food environment index	8.2		8.7	6.3	
Physical inactivity	23%	21-25%	19%	25%	
Access to exercise opportunities	65%		91%	69%	
Excessive drinking**	22%	21-22%	13%	18%	
Alcohol-impaired driving deaths	48%	45-51%	13%	35%	
Sexually transmitted infections	554.6		152.8	575.5	
Teen births	27	26-28	14	30	
Clinical care					**4**
Uninsured	11%	10-12%	6%	12%	
Primary care physicians	1,630:1		1,050:1	1,490:1	
Dentists	2,190:1		1,260:1	1,840:1	
Mental health providers	660:1		310:1	610:1	
Preventable hospital stays	3,837		2,765	4,520	
Mammography screening	46%		49%	45%	
Flu vaccinations	48%		52%	45%	
Social and economic factors					**2**
High school graduation	86%		96%	84%	
Some college	65%	62-67%	73%	62%	
Unemployment	3.6%		2.9%	4.3%	
Children in poverty	17%	14-21%	11%	22%	
Income inequality	4.1	3.9-4.3	3.7	4.8	
Children in single-parent households	32%	29-35%	20%	39%	
Social associations	11.2		21.9	11.7	
Violent crime	346		63	500	
Injury deaths	76	71-81	57	81	
Residential segregation, black/white	40		23	46	
Residential segregation, non-white/white	33		15	42	
Homicides	6	5-7	2	8	
Firearm fatalities	15	13-17	7	17	

County health rankings: Lexington County (continued)

2019 rankings	Lexington County	Error margin	Top U.S. performers	South Carolina	Rank (of 46)
Health factors					**4**
Physical environment					**6**
Air pollution/particulate matter**	10.0		6.1	10.2	
Drinking water violations	No				
Severe housing problems	13%	12-14%	9%	15%	
Driving alone to work	84%	83-85%	72%	83%	
Long commute/driving alone	37%	35-38%	15%	34%	
Additional physical environment (not included in overall ranking)					
Homeownership	65%	63-66%	80%	69%	
Severe housing cost burden	14%	13-16%	7%	13%	

**Data should not be compared with prior years.
Note: Blank values reflect unreliable or missing data.

Data provided by: S.C. DHEC

County health rankings: Oconee County

2019 rankings	Oconee County	Error margin	Top U.S. performers	South Carolina	Rank (of 46)
Health outcomes					**11**
Length of life					**15**
Premature death	9,200	8,400-10,000	5,400	8,700	
Quality of life					**6**
Poor or fair health**	15%	15-16%	12%	19%	
Poor physical health days**	4.1	3.9-4.2	3.0	4.2	
Poor mental health days**	4.4	4.2-4.6%	3.1	4.4	
Low birthweight	8%	8-9%	6%	10%	
Health factors					**11**
Health behaviors					**12**
Adult smoking**	18%	17-19%	14%	20%	
Adult obesity	30%	26-34%	26%	32%	
Food environment index	8.0		8.7	6.3	
Physical inactivity	23%	20-26%	19%	25%	
Access to exercise opportunities	71%		91%	69%	
Excessive drinking**	16%	15-16%	13%	18%	
Alcohol-impaired driving deaths	34%	28-41%	13%	35%	
Sexually transmitted infections	361.9		152.8	575.5	
Teen births	43	39-46	14	30	
Clinical care					**11**
Uninsured	14%	13-16%	6%	12%	
Primary care physicians	1,820:1		1,050:1	1,490:1	
Dentists	1,930:1		1,260:1	1,840:1	
Mental health providers	1,250:1		310:1	610:1	
Preventable hospital stays	4,114		2,765	4,520	
Mammography screening	59%		49%	45%	
Flu vaccinations	48%		52%	45%	
Social and economic factors					**14**
High school graduation	86%		96%	84%	
Some college	55%	50-59%	73%	62%	
Unemployment	4.4%		2.9%	4.3%	
Children in poverty	23%	18-28%	11%	22%	
Income inequality	4.7	4.2-5.2	3.7	4.8	
Children in single-parent households	38%	32-44%	20%	39%	
Social associations	15.5		21.9	11.7	
Violent crime	370		63	500	
Injury deaths	100	90-110	57	81	
Residential segregation, black/white	49		23	46	
Residential segregation, non-white/white	42		15	42	
Homicides	5	3-7	2	8	
Firearm fatalities	18	14-23	7	17	

County health rankings: Oconee County (continued)

2019 rankings	Oconee County	Error margin	Top U.S. performers	South Carolina	Rank (of 46)
Health factors					**11**
Physical environment					**14**
Air pollution/particulate matter**	10.2		6.1	10.2	
Drinking water violations	No				
Severe housing problems	15%	13-17%	9%	15%	
Driving alone to work	84%	82-86%	72%	83%	
Long commute/driving alone	29%	26-32%	15%	34%	
Additional physical environment (not included in overall ranking)					
Homeownership	65%	63-66%	80%	69%	
Severe housing cost burden	14%	13-16%	7%	13%	

**Data should not be compared with prior years.
Note: Blank values reflect unreliable or missing data.

Data provided by: S.C. DHEC

County health rankings: Pickens County

2019 rankings	Pickens County	Error margin	Top U.S. performers	South Carolina	Rank (of 46)
Health outcomes					**9**
Length of life					**11**
Premature death	8,400	7,800-9,000	5,400	8,700	
Quality of life					**9**
Poor or fair health**	17%	17-18%	12%	19%	
Poor physical health days**	4.1	3.9-4.3	3.0	4.2	
Poor mental health days**	4.4	4.2-4.6%	3.1	4.4	
Low birthweight	8%	8-9%	6%	10%	
Health factors					**9**
Health behaviors					**13**
Adult smoking**	18%	17-19%	14%	20%	
Adult obesity	32%	28-37%	26%	32%	
Food environment index	7.5		8.7	6.3	
Physical inactivity	21.%	18-25%	19%	25%	
Access to exercise opportunities	72%		91%	69%	
Excessive drinking**	19%	18-20%	13%	18%	
Alcohol-impaired driving deaths	32%	26-37%	13%	35%	
Sexually transmitted infections	359.9		152.8	575.5	
Teen births	22	21-24	14	30	
Clinical care					**7**
Uninsured	13%	11-14%	6%	12%	
Primary care physicians	1,620:1		1,050:1	1,490:1	
Dentists	1,960:1		1,260:1	1,840:1	
Mental health providers	980:1		310:1	610:1	
Preventable hospital stays	3,570		2,765	4,520	
Mammography screening	50%		49%	45%	
Flu vaccinations	49%		52%	45%	
Social and economic factors					**9**
High school graduation	84%		96%	84%	
Some college	60%	57-64%	73%	62%	
Unemployment	4.1%		2.9%	4.3%	
Children in poverty	16%	11-20%	11%	22%	
Income inequality	4.9	4.6-5.3	3.7	4.8	
Children in single-parent households	32%	28-36%	20%	39%	
Social associations	13.6		21.9	11.7	
Violent crime	342		63	500	
Injury deaths	93	71-81	57	81	
Residential segregation, black/white	42		23	46	
Residential segregation, non-white/white	36		15	42	
Homicides	5	4-7	2	8	
Firearm fatalities	18	15-22	7	17	

County Health Rankings: Pickens County (continued)

2019 rankings	Pickens County	Error margin	Top U.S. performers	South Carolina	Rank (of 46)
Health factors					**9**
Physical environment					**37**
Air pollution/particulate matter**	10.4		6.1	10.2	
Drinking water violations	No				
Severe housing problems	17%	15-18%	9%	15%	
Driving alone to work	85%	83-86%	72%	83%	
Long commute/driving alone	38%	36-41%	15%	34%	
Additional physical environment (not included in overall ranking)					
Homeownership	65%	63-66%	80%	69%	
Severe housing cost burden	14%	13-16%	7%	13%	

**Data should not be compared with prior years.
Note: Blank values reflect unreliable or missing data.

Data provided by: S.C. DHEC

County health rankings: Richland County

2019 rankings	Richland County	Error margin	Top U.S. performers	South Carolina	Rank (of 46)
Health outcomes					**12**
Length of life					**10**
Premature death	8,000	7,700–8,300	5,400	8,700	
Quality of life					**17**
Poor or fair health**	15%	15-15%	12%	19%	
Poor physical health days**	3.9	3.8-4.0	3.0	4.2	
Poor mental health days**	4.4	4.3-4.5	3.1	4.4	
Low birthweight	11%	10-11%	6%	10%	
Health factors					**8**
Health behaviors					**6**
Adult smoking**	14%	14-15%	14%	20%	
Adult obesity	32%	30-34%	26%	32%	
Food environment index	6.7		8.7	6.3	
Physical inactivity	22%	20-24%	19%	25%	
Access to exercise opportunities	76%		91%	69%	
Excessive drinking**	19%	18-19%	13%	18%	
Alcohol-impaired driving deaths	41%	39-44%	13%	35%	
Sexually transmitted infections	871.4		152.8	575.5	
Teen births	19	18-20	14	30	
Clinical care					**1**
Uninsured	9%	9-10%	6%	12%	
Primary care physicians	1,190:1		1,050:1	1,490:1	
Dentists	1,150:1		1,260:1	1,840:1	
Mental health providers	330:1		310:1	610:1	
Preventable hospital stays	3,888		2,765	4,520	
Mammography screening	47%		49%	45%	
Flu vaccinations	44%		52%	45%	
Social and economic factors					**19**
High school graduation	70%		96%	84%	
Some college	72%	69-74%	73%	62%	
Unemployment	4.3%		2.9%	4.3%	
Children in poverty	20%	16-24%	11%	22%	
Income inequality	4.7	4.5-4.9	3.7	4.8	
Children in single-parent households	43%	40-46%	20%	39%	
Social associations	12.1		21.9	11.7	
Violent crime	796		63	500	
Injury deaths	68	65-72	57	81	
Residential segregation, black/white	44		23	46	
Residential segregation, non-white/white	42		15	42	
Homicides	10	8-11	2	8	
Firearm fatalities	17	15-19	7	17	

County health rankings: Richland County (continued)

2019 rankings	Richland County	Error margin	Top U.S. performers	South Carolina	Rank (of 46)
Health factors					**8**
Physical environment					**34**
Air pollution/particulate matter**	9.8		6.1	10.2	
Drinking water violations	Yes				
Severe housing problems	18%	17-19%	9%	15%	
Driving alone to work	78%	77-79%	72%	83%	
Long commute/driving alone	29%	27-30%	15%	34%	
Additional physical environment (not included in overall ranking)					
Homeownership	65%	63-66%	80%	69%	
Severe housing cost burden	14%	13-16%	7%	13%	

**Data should not be compared with prior years.
Note: Blank values reflect unreliable or missing data.

Data provided by: S.C. DHEC

County health rankings: Sumter County

2019 rankings	Sumter County	Error margin	Top U.S. performers	South Carolina	Rank (of 46)
Health outcomes					**21**
Length of life					**22**
Premature death	9,600	8,900-10,200	5,400	8,700	
Quality of life					**24**
Poor or fair health**	23%	22-23%	12%	19%	
Poor physical health days**	4.5	4.3-4.6	3.0	4.2	
Poor mental health days**	4.4	4.3-4.6	3.1	4.4	
Low birthweight	11%	10-11%	6%	10%	
Health factors					**26**
Health behaviors					**31**
Adult smoking**	20%	19-20%	14%	20%	
Adult obesity	36%	33-39%	26%	32%	
Food environment index	6.4		8.7	6.3	
Physical inactivity	28%	25-31%	19%	25%	
Access to exercise opportunities	75%		91%	69%	
Excessive drinking**	16%	16-17%	13%	18%	
Alcohol-impaired driving deaths	47%	42-51%	13%	35%	
Sexually transmitted infections	776.0		152.8	575.5	
Teen births	36	33-38	14	30	
Clinical care					**24**
Uninsured	12%	11-13%	6%	12%	
Primary care physicians	1,920:1		1,050:1	1,490:1	
Dentists	2,180:1		1,260:1	1,840:1	
Mental health providers	790:1		310:1	610:1	
Preventable hospital stays	5,919		2,765	4,520	
Mammography screening	45%		49%	45%	
Flu vaccinations	45%		52%	45%	
Social and economic factors					**26**
High school graduation	84%		96%	84%	
Some college	60%	56-64%	73%	62%	
Unemployment	5.3%		2.9%	4.3%	
Children in poverty	29%	22-35%	11%	22%	
Income inequality	4.7	4.4-5.0	3.7	4.8	
Children in single-parent households	46%	42-51%	20%	39%	
Social associations	11.5		21.9	11.7	
Violent crime	621		63	500	
Injury deaths	67	60-74	57	81	
Residential segregation, black/white	31		23	46	
Residential segregation, non-white/white	29		15	42	
Homicides	9	7-12	2	8	
Firearm fatalities	15	12-18	7	17	

County health rankings: Sumter County (continued)

2019 rankings	Sumter County	Error margin	Top U.S. performers	South Carolina	Rank (of 46)
Health factors					**26**
Physical environment					**24**
Air pollution/particulate matter**	10.5		6.1	10.2	
Drinking water violations	No				
Severe housing problems	15%	13-16%	9%	15%	
Driving alone to work	85%	83-86%	72%	83%	
Long commute/driving alone	24%	22-27%	15%	34%	
Additional physical environment (not included in overall ranking)					
Homeownership	65%	63-66%	80%	69%	
Severe housing cost burden	14%	13-16%	7%	13%	

**Data should not be compared with prior years.
Note: Blank values reflect unreliable or missing data.

Data provided by: S.C. DHEC

Appendix 5

References

- America's Health Rankings.
- Catholic Health System: Assessing and Addressing Community Health Needs.
- Center for Rural Health: Checklist for Community Health Needs Assessment Written Report and
    Implementation Strategy.
- Claritas Demographics Data.
- Common Core: Retrieved from http://www.chna.org.
- Dignity Health: Community Need Index.
- Healthy People 2020.
- Kaiser Family Foundation.
- Kaiser Permanente: Community Health Needs Assessment Tool.
- National Research Corporation.
- S.C. Department of Health and Environmental Control: County Health Rankings.
- S.C. Department of Health and Human Services.

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