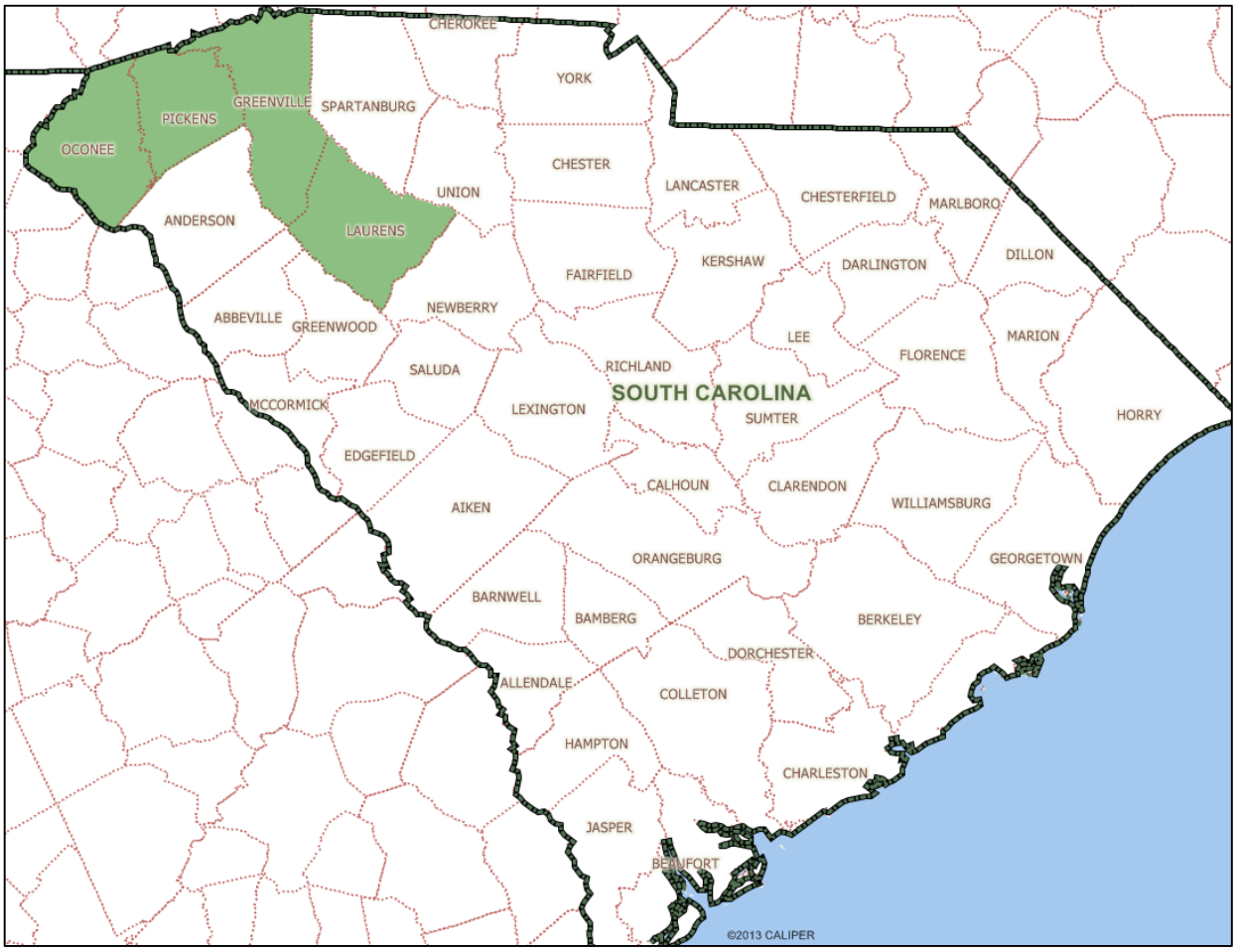
GREENVILLE HEALTH SYSTEM



Greenville Health System Health Needs Assessment: A Year in Review

Prepared: January 2015

GREENVILLE COUNTY

In September 2013, Greenville Health System (GHS) released its Community Health Needs Assessment on Greenville County, SC. Greenville County is the primary service area for 5 of GHS's Hospitals: Greenville Memorial Hospital, Greer Memorial Hospital, Hillcrest Memorial Hospital, Patewood Memorial Hospital and North Greenville Long Term Acute Care Hospital. The goal of the Community Health Needs Assessment is to reach broadly into the community to identify needs, gaps, and barriers to health and health services. After performing a quantitative and qualitative analysis, GHS was able to create a fully comprehensive community profile on Greenville County. Key health indicators were assessed and prioritized and an action plan was developed for each individual hospital to address the needs that GHS felt it could impact the most. As part of the Community Health Needs Assessment process, GHS will perform an annual review of each action plan to ensure objectives are being reached and to consider if goals or activities should be altered to improve desired outcomes.

HEALTH PRIORITIES IDENTIFIED

The following Health Indicators were chosen to focus on within Greenville County:

- Cancer – the objective was to increase the number of men receiving preventive prostate screenings and increase the number of women receiving preventive breast screenings.
- Nutrition, Physical Activity, and Obesity – the objective was to increase the number of individuals screened and educated on their BMI and to provide an educational platform for healthy food choices.
- Maternal & Infant Health – the objective was to identify vulnerable first-time moms and provide support for them to have a healthy pregnancy and to increase capacity to effectively respond to the reproductive health needs of Latinas and their babies.
- Heart Health – the objective was to increase the number of individuals receiving health screenings for Blood Pressure and Cholesterol and provide education on heart health.
- Aging Population – the objective was to increase the number of caregivers receiving education on how to best support their loved ones suffering from Alzheimer's disease and related disorders (ADRD).
- Influenza and Pneumonia – the objective was to increase the number of individuals receiving the flu vaccination.

GREENVILLE MEMORIAL HOSPITAL

With the majority of women in Greenville County delivering their babies at Greenville Memorial Hospital (GMH), equipped with a Level III Perinatal Unit, GHS felt that this hospital could have the most influence on matters of maternal infant health. Below are four of the programs that were developed to address the health priority of Maternal & Infant Health:

- Journey to become a baby-friendly hospital – throughout 2013 and 2014, GMH positioned itself to apply for designation as a Baby-Friendly Hospital. The Baby-Friendly Hospital Initiative (BFHI) is a global initiative of the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF). The initiative's goal is to improve health outcomes for mothers and babies through breastfeeding and immediate skin-to-skin bonding. The effects of breastfeeding can significantly improve infant health by decreasing the chance of ear infections, asthma, obesity, and sudden infant death syndrome (SIDS). It also has positive effects on maternal health by decreasing blood loss, reducing the risk for postpartum depression, heart disease, Type 2 diabetes, and ovarian and breast cancer. GMH did qualify and receive official designation as a Baby-Friendly Hospital in 2014. In fact, the program was so successful, it is now being implemented in other GHS facilities like Greer Memorial and Baptist Easley Hospital. The year one CHNA goals for this program were to:
    - Achieve an overall breastfeeding rate of 80% or better. This is the rate for any mother who initiates breastfeeding while in the hospital. GMH achieved this rate with an average of 85%.
    - The second goal was to achieve an exclusive breastfeeding rate of 90% or better. This is the rate of babies who receive no formula while in the hospital. While GMH did not achieve 90%, it still achieved a high average rate of 81%.
- Centering Pregnancy – Centering Pregnancy is a model of prenatal care that brings women with similar due dates to their appointments together in groups. While each of them receives their own medical care, there is also time for group discussion, support, and education with the same group of approximately a dozen women. Scientific studies have shown that families who participate in this initiative have higher rates of satisfaction with their prenatal care. The year one CHNA goals for the program were to:
    - Enroll a total of 433 participants. The program was so popular, there were a total of 503 participants in FY14.
    - Achieve a rate of 68% of participants who were breastfeeding at the time of discharge. The Centering program actually far surpassed this goal in 2014, with an average of 87% of participants' breastfeeding at the time of discharge.
- Nurse-Family Partnership – The Nurse-Family Partnership is an evidence-based community health program that fosters long-term family improvements in health, education, and economic self-sufficiency. Through ongoing home visits from registered nurses, low-income, first-time moms receive the care and support they need to have a healthy pregnancy, provide responsible and competent care for their children, and become more economically self-sufficient. The year one CHNA goals for the program were to:
    - Maintain a low birth weight rate of under 14% among participants. The Nurse-Family Partnership was able to surpass this goal with a rate of 11.9% low-weight births among participants of the program.

- Increase the high school/GED completion rate among participants to at least a 61% completion rate. The program had close to 66% of its participants' complete high school or obtain their GED in 2014.

- Perinatal Awareness for Successful Outcomes Program (PASOs) - South Carolina is home to a fast-growing Latino population that is young, generally healthy, and has a high birth rate. Research has shown however, that the longer Latinos live in this country, the worse their maternal and child health outcomes are if support is not provided. In our state, Latina women may have many challenges accessing prenatal care because of language and cultural barriers, and they have higher rates of birth defects and pregnancy complications arising from a lack of nutritional education. The goal of the PASOs program is to improve prenatal care and health for Hispanic women, so that patients experience fewer preterm deliveries and complications, and a reduced rate of infant mortality. The year one CHNA goals for the program were to:
  - Increase the number of Hispanic mothers receiving folic acid and vitamins. Through increased outreach efforts and interaction with Hispanic women, it was discovered that the majority of the Latina women had stated that they had their tubes tied or did not plan on having more children and were using a method of birth control. This caused a reassessment of the CHNA goals to be altered to meet the needs of this specific community. The need for folic acid and vitamins as an early intervention was no longer the focus of this initiative; instead the focus was changed to provide general health education.
  - Increase the number of encounters to provide education, support and referrals. In 2014, there were 325 individual encounters. This again did not meet our original goal, as that goal was focused on early pregnancy interventions. The PASOs program, instead, decided to develop a dynamic approach to community education by delivering culturally appropriate health education through a series of radio campaigns.

Since the incidence of Prostate and Breast cancer has been increasing over the past few years, GHS wanted to make access to screenings a priority. Therefore, screening events were included in the action plans of four of our five hospitals in Greenville County. The year one CHNA goal for GMH was to:

- Provide at least 120 screenings for women receiving clinical breast exams and men receiving prostate exams. At an event held in the fall, 122 screenings were provided to members of the community.

GREER MEMORIAL HOSPITAL

Greer Memorial's action plan focused on expanding access to vital screenings and flu vaccinations. Below are the year one CHNA goals for Greer Memorial:

- Expand access to the number of men receiving prostate screenings by providing at least 60 free prostate cancer screenings. Greer came very close to meeting this goal with a total of 52 free screenings provided in 2014.
- Provide community outreach and access to important preventive screenings and provide education and guidance to individuals at risk for heart disease. The goal for 2014 was to provide at least 370 free screenings for blood pressure, body mass index, and glucose finger sticks. Again, Greer Memorial came very close to this goal with a total of 360 free screenings provided in the community.
- Provide community outreach and access to flu shots, targeting elderly, but open to anyone with a goal of providing 500 free flu vaccinations. Greer Memorial far surpassed this goal by providing a total of over 2,000 flu shots.

HILLCREST MEMORIAL HOSPITAL

Hillcrest Memorial's action plan focused on expanding access to vital screenings. Below are the year one CHNA goals for Hillcrest Memorial:

- Expand access to the number of men receiving prostate screenings by providing at least 60 free prostate cancer screenings. Hillcrest provided 40 free prostate screenings in 2014.
- Provide community outreach and access to important preventive screenings and provide education and guidance to individuals at risk for heart disease. The goal for 2014 was to provide at least 1000 free screenings for blood pressure, and body mass index. Hillcrest Memorial exceeded this goal with a total of 1336 free screenings provided in the community.

NORTH GREENVILLE LONG TERM ACUTE CARE HOSPITAL

North Greenville Long Term Acute Care Hospital's (NGLTACH) action plan focused on expanding access to vital screenings. Below are the year one CHNA goals for NGLTACH:

- Expand access to the number of men receiving prostate screenings and women receiving mammograms by providing at least 42 free cancer screenings. NGLTACH provided 49 free cancer screenings in 2014.
- Provide community outreach and education sessions to low-income individuals in the community, educating them on how to make healthy meal choices on a limited budget. The original goal for 2014 was to hold two sessions throughout the year with at least 16 participants. In 2014, the program held 7 sessions with 76 participants.

PATEWOOD MEMORIAL HOSPITAL

The Patewood Memorial Campus is the home for the GHS Center for Success in Aging so GHS found it appropriate that their action plan include a goal to address the growing aging population in Greenville County. Below are the year one CHNA goals for the Patewood Campus:

- Caregiving 101 - Educational classes were held with helpful information to those caring for loved ones affected by memory health conditions. These Caregiving 101 classes were designed to increase caregivers' knowledge of maintaining their love one's independence. The goal for year one of the CHNA was to have at least 120 participants attended these classes. Approximately 192 participants attend these sessions in 2014. In addition to the Caregiving 101 classes, a virtual experience was created for caregivers to better understand the effects of dementia. The Virtual Dementia Tour is not a class, but an experience for those interested in knowing more about dementia and what patients might be going through.

OCONEE MEMORIAL HOSPITAL

Oconee Memorial Hospital performed its Community Health Needs Assessment on Oconee and Pickens Counties. As a result of the prioritization process, 11 needs were identified to be addressed:

- Primary Care Physician Need – Improve access to comprehensive, quality health services. OMH's strategies included:
  - Enhancing patient access to primary care in the community. OMH set the following goals to enhance access to primary care:
    - Hire 3 primary care physicians over the next year. Although OMH did not meet this goal during year one, it hired one family medicine physician and lost an internal medicine physician. In the meantime, they are utilizing a walk-in clinic to bridge the gap in access and are still actively recruiting 3 primary care physicians.
    - Provide access and provider information in the work place. OMH has had significant growth achieved in industry-based Wellness programs, RN and FNP clinics in 2014.
    - Coordinate better post hospital care to reduce readmissions. OMH established a mid-level walk-in clinic designed specifically to see patients post-discharge that do not have a primary care physician.
  - Improving patient education and quality of care by increasing the use of mid-level providers. OMH's goals for accomplishing this strategy were:

        - Recruitment and efforts to increase mid-levels and care navigators in the current Oconee Physician Practices with the goal of having at least one midlevel in each primary care office. OMH achieved this goal in 2014, although they did lose one mid-level but are recruiting for a replacement.
        - Pursue Patient Centered Medical Home recognition. OMH is in the process of the PCMH application process and is planning for submission in March 2015.
        - Increase patient wellness education and compliance during office visits through the use of care navigators. The goal is to increase patient compliance and achieve better core metrics. OMH will be able to achieve this goal once it receives PCMH status. Then it can explore the next steps associated with care navigators.
    - Enhance the hospital's position related to the ongoing care of the uninsured. OMH set the following goals to achieve this strategy:
        - Increase awareness and access to care using Mountain Lakes Community Care. The desired outcome is to reduce overutilization of the ED and bridge patient access to a PCP office. OMH has three mid-level providers that cover this primary care practice 6 days week, 12 hours a day. They are getting ready to look at a proposal to add one more provider due to the growth with this facility.
        - Increase the availability of Residents to see more of the uninsured. This goal has been achieved and it will be ongoing.
        - Seek additional avenues to see the uninsured patients other than in the Emergency Room. OMH set out to seek grant opportunities to align patient care with the right location. Access Health to determine possible funding and treatment paths for uninsured patients. They also use the residents where possible.
        - Identify patients that would be good candidates for participating in Mountain Lakes Access Health. This is an ongoing program that makes healthcare available to patients to help get them back into the workforce.
        - Pursue additional physician partners in the community and with Mountain Lakes Access Health. OMH's goal is to increase the number of patients that can be assisted and improve health outcomes. OMH UMG offices are 100% supportive of Access Health and are partnering to address the needs of the patients of this program.

- Clinical Preventive Services – Improve access to clinical preventive services. OMH's strategies included:
    - Provide free prostate cancer screenings. OMH completed offering these screenings in September.
    - Provide free breast health exams. OMH completed offering these screenings in October.
    - Provide a community wellness day. Free community health screenings were cut from the budget in 2013. However, OMH does offer screenings annually to 10 corporations in the community.
    - Provide seminars by physicians on various medical topics. This is an ongoing program that was completed in 2014 and will be ongoing by providing free seminars by physicians throughout the year.
- Unintentional Injury Deaths – Reduce the number of preventable injuries to children birth to 19 through Safe Kids Upstate/Oconee County. OMH's strategies included:
    - Increase parental/caregiver education regarding safe transport of children. OMH has accomplished this goal by increased the number of care seat inspections by 50%. They are also piloting a program in a middle school and high school in the fall to increase safe driving awareness in order to reduce teenage driving incidents.
    - Decrease the number of children on Lake Keowee without flotation devices. This goal has been accomplished through a Life Jacket Loaner board established at Chau Ram Park in Westminster. It is fully stocked with life jackets.
- Maternal and Child Health – Provide pre-natal care to low-income, uninsured women. OMH's strategies included:
    - Partner with Clemson University's Sullivan Center, an interdisciplinary health Center. The goal of this program is to provide pre-natal healthcare to low-income uninsured women in Walhalla, SC in partnership with Clemson University's Sullivan Center. This is an ongoing program that will continue.
    - Partner with Anderson, Oconee, Pickens Mental Health Department (AOP) to fund a Behavioral Health Clinician to assist in evaluation, placement, and discharge planning. OMH completed this strategy by providing medical residents to deliver pre-natal healthcare to low-income, uninsured women in Walhalla, SC in partnership with Clemson University's Sullivan Center.
    - Provide free childbirth classes. This program is completed and will be ongoing to improve birth outcomes by providing free childbirth classes to low income, uninsured parents.
- Mental Health – Improve access to acute-care mental health services. OMH's strategy included:

- Collaborate with other upstate hospitals and share physician resources.
  - One of the goals was a collaborative with AnMed, Baptist Baptist, Cannon Memorial Hospital, and OMH to fund the salary of an additional psychiatrist to open 15 additional beds at Patrick Harris Hospital. The goal was to decrease the holding period for patients waiting to be admitted to Patrick B. Harris Psychiatric Hospital. In 2014, The 15 beds were opened and have provided relief for OMH. This program will be ongoing.
- Partner with AOP to fund a Behavioral Health Clinician to assist in evaluation, placement and discharge planning. The goal of this strategy was to increase access to care with appropriate discharge follow up. This goal was completed in 2014.

- Nutritional/Physical Activity – Improve access to education about good nutrition; improve access to physical activity facilities. OMH's strategies included:
  - Donation of acreage to YMCA.
    - OMH's goal to accomplish this strategy is to transfer 22 acres of land on the hospital campus to county government for use, in partnership with the YMCA, to build an aquatic center. Although the county has not yet formally requested the land, it has expressed intent to do so.
    - Partner with AOP to fund a Behavioral Health Clinician to assist in evaluation, placement and discharge planning. This goal is to provide financial support for the construction of YMCA/aquatic center. This goal was completed in 2014.
  - Educate community providers on importance of diabetes self-management education (DSME)
    - Send brochures to all Oconee Physician Practices (OPP) offices and referral forms for DSME in an effort to increase the number of referrals. OMH has accomplished this goal by increasing the number of referrals by 40% since 2013.
    - Offer Lunch and Learns to OPP staff on diabetes education. OMH accomplished this goal by offering numerous Lunch and Learns in 2014 on a variety of health related topics to all OMH staff.
- Transportation – Improve transportation options for those in need of transportation assistance. OMH's strategy included:
  - Establishing and operating an electric bus. OMH's strategy included donating property to the City of Seneca for a bus stop and electric bus recharging station. The goal is to provide free bus transportation for low-income adults and children; access to healthcare services. This project has been completed; the bus stop and charging station are in operation.

- Chronic Disease – Improve the well-being of people living with chronic disease. OMH's strategies included:
    - Provide diabetes education classes to all diabetics, regardless of ability to pay. OMH accomplished this goal by providing free diabetes education to patients from Mountain Lakes AccessHealth (14 patients last year). A few were seen from the Rosa Clark and Clemson Free Clinic as well.
    - Provide palliative care services to patients with chronic conditions to improve the well-being of patients with chronic conditions through education and support. This program was complete, the inpatient and outpatient palliative care program is up and running.
    - Launch Congestive Heart Failure Clinic to improve health outcomes for patients with congestive heart failure by offering outpatient services and frequent checks of health status. This goal was accomplished in 2014.
    - Provide a medical home to low-income, uninsured patients through Mountain Lakes Access Health to improve health outcomes. This program was accomplished with 156 new patients and a total of 242 total patients in 2014.
- Dental Health – Reduce the number of dental–related emergencies in the Emergency Department by providing accessible services in a community dental clinic. OMH's strategy included:
    - Develop an accessible dental extraction clinic located in Oconee County.
        - Develop procedures, train and staff a community dental clinic providing extractions, cleanings and education to low-income, uninsured adults in order to reduce dental-related ED visits. The dental clinic was opened and is operational. OMH is on track to see a 15% reduction in ED visits for the first year of operation.
        - Partner with AOP to fund a Behavioral Health Clinician to assist in evaluation, placement and discharge planning with the goal to treat over 800 dental emergencies treated in clinic. Through this partnership, more than 250 extractions were performed since June 2014.
- Smoking Cessation – Improve access to smoking cessation education and support services. OMH's strategies included:
    - Provide classes with goals:
        - Have two certified Smoking Cessation Educators in order to increase the frequency of classes offered. This goal was accomplished with the addition of 2 educators certified and offering classes for employees, industries and the community members.
        - Partner with AOP to fund a Behavioral Health Clinician to assist in evaluation, placement and discharge planning in order to

increase participation rates in smoking cessation classes. This goal has been completed in 2014.

- Partner with Access Health:
  - Enroll all Mountain Lakes Access Health participants identified as tobacco users into the free smoking cessation classes. Require all three classes for continued care. The goal of the program was to have MLAH clients that use tobacco complete the program. All MLAH tobacco-users were referred to a group program. MLAH participants were seen for one-on-one tobacco use counseling.
  - Have informational brochures regarding smoking cessation classes in MLAH offices. Make referral for class at the time when a tobacco user is identified to increase awareness of smoking cessation. MLAH has class flyers and refers regularly.

- Access for the Uninsured and Underinsured – Improve the health and well-being of low-income, uninsured adults by providing access to timely, comprehensive services. OMH's strategies included:
  - Provide medical home and case management through Mountain Lakes Access Health
    - Recruit clinical providers for the MLAH network to ensure all MLAH patients have access to a medical home and (if applicable) specialists for comprehensive care. The goal is for 100% of active MLAH clients to have a medical home. This goal was accomplished.
    - Partner with AOP to fund a Behavioral Health Clinician to assist in evaluation, placement and discharge planning to reduce IP admissions and costs among MLAH participants. OMH was able to complete this goal in 2014.
    - Provide intensive case management services (including social supports and health education) to equip clients with tools to improve their overall well-being. OMH accomplished this goal by reducing IP discharges by 61.54% and a 25% reduction in ED discharges.
    - Ensure that Mountain Lakes Access Health is sustainable and able to continue providing services through maintaining donations or grant funding to MLAH. OMH continues to support MLAH.
  - Support Rosa Clark Free Clinic
    - Provide $150,000 in funding to Rosa Clark Free Clinic by providing medical services to the indigent by supporting the operations of Rosa Clark Free Clinic. This goal has been completed in 2014.

        - Provide free laboratory testing, radiology exams and other services to the patients of Rosa Clark Free Clinic by providing medical services to the indigent by supporting the operations of Rosa Clark Free Clinic. This goal has been accomplished in 2014.
    - Partner with the Sullivan Center by providing quarterly stipend to improve access to care in order to increase the number of clients seen at center. OMH continues to support the center.

LAURENS COUNTY MEMORIAL HOSPITAL

Laurens County Memorial Hospital (LCMH) performed its Community Health Needs Assessment on Laurens County. As a result of the prioritization process, 4 needs were identified to be addressed:

- Access to Services – through collaboration with Carolina Health Centers, LCMH created LC4 to connect frequent users of emergency services to a primary care medical home. It is a federally qualified health center, designed to improve accessibility and affordability of primary care and reduce non-emergent care in the Emergency Department. LCMH set a goal of having 150 patients referred from the ER to LC4 in 2014. LCMH exceeded its goal by referring 350 from the Hospital ER to the LC4 Community Health Center.
- Heart Health Access – LCMH developed programs and services to provide community outreach and access for preventative screenings and offer education and guidance to individuals at risk for heart disease. The goal of this program was to increase the number of individuals who receive heart-related preventive screenings (blood pressure and BMI). The goal for 2014 was to provide 150 screenings in the community. LCMH exceeded its goal set in FY14 by providing 175 health screenings in the community.
- Cancer Support – LCMH partnered with the Laurens County Cancer Association to create Wings of Hope Cancer Support Group. The group provides education, community resource education, access to services, care and spiritual/emotional support to patients and survivors of all types of cancer. The goal for FY14 was to have 35 participants within the group. LCMH far surpassed their goal for this program with 90 individuals participating in the program in FY14.
- Maternal & Infant Health – LCMH developed a program called Pregnancy Partners to combat premature and low birth weight babies. The program is designed to assist moms through their entire pregnancy journey, at no additional cost to the patient. The goal for 2014 was to have 25% of new moms delivering at LCMH participating in the program. LCMH was successful in meeting this goal with 27% of new moms participating in the program.