**Introduction**

The following 2016 Community Health Needs Assessment serves to fulfill the CHNA requirements for Edgefield County Hospital. The CHNA utilized population demographic data, medical utilization trends, and socio-economic influences specific to the Edgefield community. The purpose of the CHNA was to identify disease trends among the highest at risk and vulnerable groups with the objective of reinforcing preventative care, set up a medical home, reduce emergency department utilization, and provide therapeutic interventions as necessary. The CHNA allowed Edgefield County Hospital to identify three high risk categories, diabetes, heart disease, and behavioral health.

The Healthy Outcomes Plan (HOP) along with the interventions as provided by Edgefield County Hospital’s rural health clinic, Peachtree Medical Center, serves as the implementation strategy for the CHNA.

**Edgefield County Hospital’s mission and values**

The mission and values of Edgefield County Hospital is to provide quality and appropriate care to all people.

**Description of the health needs for which we are adopting action plans**

**Diabetes (from SCDHEC.gov)**

**People with Diabetes**

• South Carolina had the 7th highest prevalence of diabetes among adults in the nation in 2014. One in

Eight adults have diabetes.

• Approximately one in six African-Americans has diabetes, compared to one in nine white adults.

• One in four over the age of 65 has diabetes in South Carolina. Additionally, one in six has prediabetes in this growing age group.

• One in five adults with less than a $15,000 annual household income has diabetes.

**Diabetes Death**

• Diabetes is the 7th leading cause of death in South Carolina. In 2014, 1,234 people died from diabetes, or three deaths every day. African-Americans had more than two times a higher death rate compared to whites.

**Hospitalization and Cost of Diabetes**

• In 2014, approximately 25,000 hospitalization and Emergency Department visits occurred in South Carolina for diabetes, costing more than $404 million.

• The cost of care for all South Carolinians with diabetes is estimated to exceed three billion dollars in 2015 and projected to be more than four billion dollars by 2020. Less than one quarter (23.7 percent) of this cost has been paid by private insurance. The public portion will exceed three billion dollars in 2020 (Source: CDC Cost Calculator).

**Diabetes Risk and Complications**

• Four out of five people with diabetes in South Carolina are overweight or obese

• Seven out of 10 people with diabetes have hypertension

• Two out of three people with diabetes have high cholesterol

• Cases of end-stage renal disease attributable to diabetes have increased by 50 percent in the last 10 years

• Two out of five people with diabetes have not taken a diabetes self-management class

**Heart Disease (from SCDHEC.gov)**

**High Blood Pressure in South Carolina**

About **1 in 3 South Carolinians** have been told by a doctor that they have high blood pressure, also called hypertension. Thousands more South Carolinians have high blood pressure and don’t know it.

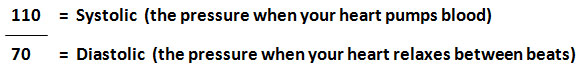
**The Silent Killer**

High blood pressure is a major risk factor for [heart disease](http://www.scdhec.gov/Health/DiseasesandConditions/HeartDiseaseStroke/HeartDisease/) and [stroke](http://www.scdhec.gov/Health/DiseasesandConditions/HeartDiseaseStroke/Stroke/). It’s a condition where the pressure of the blood in your arteries is too high.

Because there are usually no symptoms, high blood pressure is often called the “silent killer.” The best way to find out if you have high blood pressure is to get it checked regularly.

**Know Your Numbers**

Blood pressure is the force of your blood pushing against the walls of your arteries. Blood pressure is measured with two numbers, and is written with one number on top of the other:



**Behavioral Health (from Healthy People 2020)**

Mental disorders are among the most common causes of disability. The resulting disease burden of mental illness is among the highest of all diseases. In any given year, an estimated 18.1% (43.6 million) of U.S. adults ages 18 years or older suffered from any mental illness and 4.2% (9.8 million) suffered from a seriously debilitating mental illness.[**1**](https://www.healthypeople.gov/2020/topics-objectives/topic/mental-health-and-mental-disorders#1) Neuropsychiatric disorders are the leading cause of disability in the United States, accounting for 18.7% of all years of life lost to disability and premature mortality.[**2**](https://www.healthypeople.gov/2020/topics-objectives/topic/mental-health-and-mental-disorders#2) Moreover, suicide is the 10th leading cause of death in the United States, accounting for the deaths of approximately 43,000 Americans in 2014

Mental health and physical health are closely connected. Mental health plays a major role in people’s ability to maintain good physical health. Mental illnesses, such as depression and anxiety, affect people’s ability to participate in health-promoting behaviors. In turn, problems with physical health, such as chronic diseases, can have a serious impact on mental health and decrease a person’s ability to participate in treatment and recoveryta sources: SC BRFSS, SC Vital Records, SC Revenue and Fiscal Affairs Office

Prepared by: Division

**Action steps in response to the adopted health needs**

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| **Action** | **Anticipated impact** | **Metric for future evaluation** | **Resources planning to commit** | **Any planned collaboration with other facilities or organizations** | **Health needs addressed** |
| Patients that are seen in the ED or admitted to the hospital that are diagnosed with HBP, DM, or behavioral health issues that are uninsured and who do not have a medical home are referred to PTMC Healthy Outcomes program | To establish a medical home for the patient to help them with treatment of the chronic medical condition | Decrease numbers in the ED and admissions | ECH staff and PTMC staff | Patients will be enrolled in Welvista and the 340B program for pharmacy needs | HBP, DM, behavioral health |
| Diabetic Training | Improved diabetes prevention and management | Lower A1C values and routine 3 month check ups  Participation rates | PTMC staff to schedule the patients for this service. ECH to provide a place for the training | Drug companies that offer diabetic training at no cost | DM |
| Screening patients for insurance availability | Provide patients the resources to become insured if qualified | Patients who enrolled successfully into Medicaid or the health affordability programs | RHC staff will work with the patient to obtain the required documentation needed to try to enroll | SC Thrive | Social Determinants |
| Establishing patients with a Behavioral Health Therapist | Provide patients that have a behavioral health issue the ability to see a LSW | Appointments kept with the LSW | RHC staff will schedule patients with our local LSW (LSW sees patient’s at ECH until the RHC moves into their new building) | Lakeland’s Access and SCDMH | Behavioral Health |
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NOTE: The Healthy Outcomes Plan was implemented in 2013, and became an integral part of the Implementation strategy for the CHNA. The implementation strategy in turn has been in effect since 2013, with behavioral health added in 2016. The 2016 CHNA implementation strategy was is approval status by the Board of Trustees by February 2017.