Community Health Need:	Access to Care			Progress Update		
Topic Overview:	A person's ability to access health services has a profound effect on every aspect of his or her health, yet at the start of the decade, almost 1 in 4 Americans do not have a primary care provider (PCP) or health center where they can receive regular medical services. Approximately 1 in 5 Americans (children and adults under age 65) do not have medical insurance. People without medical insurance are more likely to lack a usual source of medical care, such as a PCP, and are more likely to skip routine medical care due to costs, increasing their risk for serious and disabling health conditions. - Healthy People 2020					
Goals:	Improve access to comprehensive, quality health care services.			*FY 20*	*FY 21*	*FY 22*
Strategy: Continued identification and enrollment of qualifying individuals into the AccessHealth Lakelands program for the uninsured with chronic medical conditions.				**Outcomes:**		
Action Step	**Accountability**	**Timeline**	**Desired Outcome**			
Will identify potential clients through multiple sources	AccessHealth Lakelands	FY 20	Increase AccessHealth Lakelands referrals			
Enroll qualified individuals	AccessHealth Lakelands	FY 20	Increase AccessHealth Lakelands enrollment			
Screen all clients for applicable insurance coverage	AccessHealth Lakelands	FY 20	Increase insurance coverage enrollment			
Strategy: Ensure the residents of the Lakelands area have access to primary and specialty care services.				**Outcomes:**		
Action Step	**Accountability**	**Timeline**	**Desired Outcome**			
Transitional Care Clinic will continue to provide short term, primary care to individuals who do not have an established medical provider	Self Regional Healthcare	Continuous	Increase volume of patients seen in the Transitional Care Clinic			
AccessHealth enrolled individuals will be established with a primary care provider	AccessHealth Lakelands	FY20	Ensure all AccessHealth Lakelands clients have established primary care providers			
SRH will continue to evaluate the healthcare needs of the community and will recruit providers to meet these needs	Self Regional Healthcare	Continuous	Increase in number of Self Regional Healthcare providers and practices (Increase access for primary and specialty care through Self Regional Healthcare			
The Transitional Care Clinic will provide hospital and emergency room follow up within the recommended time frame for individuals who have no medical home or are unable to be seen by their physician within this guideline.	Self Regional Healthcare	Continuous	Continued achievement in meeting recommended timeframe for hospital and emergency room follow up appointments.	**Outcomes:**		
Action Step	**Accountability**	**Timeline**	**Desired Outcome**			
Strategy: Self Regional Healthcare will strive to ensure adequate primary care provider availability within the communities we serve.				**Outcomes:**		
Action Step	**Accountability**	**Timeline**	**Desired Outcome**			
The Self Regional Healthcare Family Medicine Residency Program will continue to recruit and develop quality physicians while providing outstanding patient care.	Self Regional Healthcare	Continuous	Continue to graduate well trained family physicians			
SRH will continue to evaluate needs for primary care providers within our community and recruit accordingly.	Self Regional Healthcare	Continuous	Increased primary care availability within the community			
SRH will continue to monitor physician satisfaction and implement strategies for improvement.	Self Regional Healthcare	Continuous	Increased physician satisfaction			

Community Health Need:	Cancer and Screenings			Progress Update		
Topic Overview:	Continued advances in cancer research, detection, and treatment have resulted in a decline in both incidence and death rates for all cancers.1 Among people who develop cancer, more than half will be alive in 5 years, yet cancer remains a leading cause of death in the United States, second only to heart disease.2,3 The cancer objectives for Healthy People 2020 support monitoring trends in cancer incidence, mortality, and survival to better assess the progress made toward decreasing the burden of cancer in the United States. - Healthy People 2020					
Goals:	Reduce the number of new cancer cases, as well as the illness, disability, and death caused by cancer.			*FY 20*	*FY 21*	*FY 22*
Strategy: Expand use of proven cancer prevention, early detection and education				**Outcomes:**		
Action Step	**Accountability**	**Timeline**	**Desired Outcome**			
Offer at least 2 women's health screenings to uninsured/underserved women to include, pelvic exams, clinical breast exams, mammograms and women's health education.	Community Outreach Coordinator/ Breast Health Navigator	Bi-Annually	Remove/decrease barriers to healthcare for uninsured/underserved population in the GLEAMNS counties.			
Offer at least 1 Full Body Screening to community members of the GLEAMNS counties to all populations.	Community Outreach Coordinator/ Disease Coordinators	Annually	Raise awareness of Skin Cancers/Melanoma to all populations.			
Strategy: Utilize disease specific clinics to educate about cancer				**Outcomes:**		
Action Step	**Accountability**	**Timeline**	**Desired Outcome**			
Community education about Lung Nodule Clinic. Educate PCP in the community about criteria for the patients who quality/benefit from this clinic.	Physician Champion for Lung Nodule Clinic/Lung Cancer Disease Coordinator	Annually	To Maximize early detection of lung disease.			
Community education about High Risk Breast Clinic. Educate PCP in the community about criteria for the patients who qualify/benefit from this clinic.	Medical Director of Breast Cancer Services/Breast Cancer Navigators	Annually	Raise awareness of early detection of Breast Cancer, earlier staging of Breast Cancer Diagnosis meaning better outcomes for patients.			
Strategy: Expand our education and awareness of cancer				**Outcomes:**		
Action Step	**Accountability**	**Timeline**	**Desired Outcome**			
Host Annual Focus Group consisting of patients that have been treated by SRH Cancer Center to identify what we do well as identifying areas of improvement.	Strategic Planning/Disease Coordinators	Annually	Raise awareness of advanced care locally by meeting with small cancer center population of survivors.			
Prevention/Awareness Lunch & Learns for cancer patients of the SRH Cancer Center.	Disease Coordinators	Bi-Annually	Educate Cancer Patients of healthy lifestyles, nutrition, exercise and more to reduce illness, raise awareness, & earlier staging of cancer.			
Strategy: Treat patients in need by using the most appropriate and effective measures to receive their medications				**Outcomes:**		
Action Step	**Accountability**	**Timeline**	**Desired Outcome**			
Outpatient Pharmacy and Greenwood Cancer Fund (GCF) establish partnership to help cancer patients receive medications - Patients with need for this partnership are identified (with assistance from Cancer Center and provider offices) - GCF and/or Cancer Center contact Outpatient Pharmacy to establish account for patients - Patients receive meds, as prescribed (while here for appointment normally) Outpatient Pharmacy sends invoice to GCF GCF makes payment	Outpatient Pharmacy	Ongoing	Continue to help those in our community struggling through their cancer journey (20 pts)			

Community Health Need:	Cost of Healthcare					
Topic Overview:	"The affordability of health insurance and health care continue to be key public concerns. Millions of people with low incomes get their coverage through a workplace, where there are fewer protections from high costs. People with lower incomes spend a significantly higher share of their family income towards premium contributions and out-of-pocket medical expenses. About 1 in 10 adults report that they delayed or did not get care because of its cost. Sadly, adults who are in worse health have more difficulty accessing care due to cost." - Henry J. Kaiser Family Foundation					
Goals:	Support Access to Care for the residents of Self Regional Healthcare's seven-county service area.				***FY 20***	***FY 21***	***FY 22***
Strategy: SRH will continue to support the health and well-being of our service area by distributing funds to local entities.					**Outcomes:**		
Action Step	**Accountability**	**Timeline**	**Desired Outcome**				
The Community Health Community will meet quarterly to distribute funds based on request.	Community Health Committee	Quarterly	Improve statistics on at least one area of the six focus areas for the 2019 CHNA.				
Strategy: SRH will continue to support local employers by providing preventative education and screenings.							
Action Step	**Accountability**	**Timeline**	**Desired Outcome**				
P&W/OHS will provide a monthly screening or educational topic to one employer each month.	Prevention & Wellness/Occupational Health Services	Continuous	A healthier and more productive work force.				

Community Health Need:	Diabetes					
Topic Overview:	"Diabetes Mellitus (DM) occurs when the body cannot produce or respond appropriately to insulin. Insulin is a hormone that the body needs to absorb and use glucose (sugar) as fuel for the body's cells. Without a properly functioning insulin signaling system, blood glucose levels become elevated and other metabolic abnormalities occur, leading to the development of serious, disabling complications. " - Healthy People 2020					
Goals:	Reduce the disease and economic burden of diabetes mellitus (DM) and improve the quality of life for all persons who have, or are at risk for, DM.			*FY 20*	*FY 21*	*FY 22*
Strategy: Early Identification and increase awareness of DM				**Outcomes:**		
Action Step	**Accountability**	**Timeline**	**Desired Outcome**			
Mobile Diabetes Clinic - Perform American Diabetes Association At Risk (paper) screening, if score of 5 or higher (at risk) perform A1c throughout the Self Regional Healthcare seven county service area. Distribute list of medical supply resources + literature for pre-diabetes mellitus and diabetes mellitus. Expand to McCormick and Saluda.	Diabetes Education	Ongoing	Identify undiagnosed pre-diabetes mellitus and diabetes mellitus			
Screenings at corporate health fairs	Diabetes Education	Ongoing	Identify undiagnosed pre-diabetes mellitus and diabetes mellitus.			
World Diabetes Day Event	Diabetes Education	Ongoing	Increase awareness of pre-diabetes mellitus and diabetes mellitus resources and prevent complications.			
Strategy: Community diabetes education				**Outcomes:**		
Action Step	**Accountability**	**Timeline**	**Desired Outcome**			
Sit and Be Fit classes	Diabetes Education	Ongoing	Increase attendance with marketing			
Diabetes community class education	Diabetes Education	Ongoing	Improve attendance and reinforce diabetes management knowledge			
Strategy: Improve accessibility for DSMT/S (Diabetes Self Management Training/Support) to rural areas lacking diabetes educators/programs.				**Outcomes:**		
Action Step	**Accountability**	**Timeline**	**Desired Outcome**			
Market Self Regional Healthcare Diabetes Self Management Training and Support services to Self Medical Group and other sharing benefits of sending their patients to an Accredited Diabetes Program, including Current Procedural Terminology.	Diabetes Education	Ongoing	Increase referrals to center to help more patients achieve diabetes mellitus goals. Providers will have a better knowledge of our program/improve program exposure to medical doctors			
Expand DSMES to areas that have high no show rates due to transportation issues. Newberry, Ware Shoals locations.	Diabetes Education	Ongoing	Increase diabetes education program completion in rural areas with transportation issues.			
Increase public's awareness of Medicare benefit for diabetes education.	Diabetes Education	Ongoing	Increased referrals to clinic, decreased diabetes mellitus education gaps			
Market program to corporations in town health fairs, Diabetes Prevention Program, diabetes mellitus classes at their facility	Diabetes Education	Ongoing	Make education more accessible and timely for patients and corporations.			
Start MDPP (Medicare Diabetes Prevention Program)	Diabetes Education	Ongoing	Bridge gap in services and provide pre-diabetes education based on the CDC DPP program for qualified Medicare patients to prevent diabetes.			
Continue to partner with Vocational Rehab for those without or non-covered insurance for Diabetes Self Management Training and Support	Diabetes Education	Ongoing	Those who need education will get education regardless of ability to pay for services during their time of need.			
Strategy: Educate children with diabetes on blood glucose/monitoring/devices/physical activity/and proper nutrition while improving quality of life for those children				**Outcomes:**		
Action Step	**Accountability**	**Timeline**	**Desired Outcome**			
Diabetes Youth Day Camp	Diabetes Education	Ongoing	Educate children with diabetes on blood glucose, monitoring devices, physical activity, insulin and proper nutrition while improving the quality of life for those children who have diabetes			

Community Health Need:	High Blood Pressure			Progress Update		
Topic Overview:	Heart disease is the leading cause of death in the United States.1 Stroke is the third leading cause of death in the United States. Together, heart disease and stroke are among the most widespread and costly health problems facing the Nation today, accounting for more than $500 billion in health care expenditures and related expenses in 2010 alone.2 Fortunately, they are also among the most preventable - Healthy People 2020					
Goals:	Improve cardiovascular health and quality of life through prevention, detection, and treatment of risk factors for heart attack and stroke; early identification and treatment of heart attacks and strokes; and prevention of repeat cardiovascular events.			*FY 20*	*FY 21*	*FY 22*
Strategy: Utilize the Health Express for hypertension screenings and education in each Lakeland county to promote hypertension prevention.				**Outcomes:**		
Action Step	**Accountability**	**Timeline**	**Desired Outcome**			
Conduct hypertension screenings in the seven counties of the Lakelands area.	Prevention & Wellness Services	Continuous	Conduct hypertension screenings in each county of the Lakelands area			
Identify at least one church in each of the seven counties to promote hypertension prevention among parishioners.	Prevention & Wellness Services	Continuous	Conduct hypertension screenings in each county of the Lakelands area			
Strategy: Increase cholesterol screenings and education in each Lakeland county to promote cardiovascular health.				**Outcomes:**		
Action Step	**Accountability**	**Timeline**	**Desired Outcome**			
Conduct monthly cholesterol screenings through churches, community events, or businesses/industries.	Prevention & Wellness Services	Continuous	Increase community cholesterol screenings to at least 12 per year			
Strategy: Increase education of the community about the importance of screenings for early detection of hypertension.				**Outcomes:**		
Action Step	**Accountability**	**Timeline**	**Desired Outcome**			
Build rapport with community leaders to increase trust and cooperation of community members (i.e. government officials, non-profit organizations, etc.).	Prevention & Wellness Services	Continuous	Increased community events in each county of the Lakelands area			
Identify at least one business/industry in each county to promote hypertension prevention.	Prevention & Wellness Services	Continuous	Reach at least one business/industry per county			

Community Health Need:	Obesity			Progress Update		
Topic Overview:	The Nutrition and Weight Status objectives for Healthy People 2020 reflect strong science supporting the health benefits of eating a healthful diet and maintaining a healthy body weight. The objectives also emphasize that efforts to change diet and weight should address individual behaviors, as well as the policies and environments that support these behaviors in settings such as schools, worksites, health care organizations, and communities- Healthy People 2020					
Goals:	Promote health and reduce chronic disease risk through the consumption of healthful diets and achievement and maintenance of healthy body weights.			*FY 20*	*FY 21*	*FY 22*
Strategy: Increase education and awareness of obesity prevention and wellness among adults in all seven Lakeland counties.				**Outcomes:**		
Action Step	**Accountability**	**Timeline**	**Desired Outcome**			
Identify at least one business/industry in each of the seven counties and implement wellness programs to serve the adult population	Prevention & Wellness/Occupational Health Services	Continuous	Conduct obesity prevention programs at one business/industry in each county of the Lakelands			
Identify at least one church in each of the seven counties and educate parishioners on obesity prevention and wellness	Prevention & Wellness Services	Continuous	Provide obesity prevention education to at least one church in each county of the Lakelands			
Build rapport with community leaders to increase trust and cooperation of community members (i.e. government officials, non-profit organizations, etc.)	Prevention & Wellness Services	Continuous	Increased rapport and trust with community leaders/members			
Strategy: Increase education and awareness of childhood obesity prevention and wellness among children and their caregivers in all seven Lakeland counties.				**Outcomes:**		
Action Step	**Accountability**	**Timeline**	**Desired Outcome**			
Safe Kids Lakelands will promote obesity education and awareness concerning childhood obesity through all car seat services.	Prevention & Wellness Services	Continuous	Provide obesity prevention education to all parents in the seven county service area through child passenger safety checks.			
Participate in children's camps, programs or events in each county in the Lakelands area to promote education and awareness of childhood obesity	Prevention & Wellness Services	Continuous	Provide obesity prevention education at one camp, event or program per county			
Identify at least one school in each county to educate caregivers on childhood obesity prevention	Prevention & Wellness Services	Continuous	Provide obesity prevention education to caregivers at one school in each county			
Strategy: Promote the use of local Healthy Food via Uptown Farmers Market				**Outcomes:**		
Action Step	**Accountability**	**Timeline**	**Desired Outcome**			
Every other Wednesday in the Spring & Fall provide a healthy recipes & samples of locally grown food featured @ the Uptown Market	Food & Nutrition Services	2-3x/month, April/May Sept/Oct	Public participants will be able to taste, purchase & prepare locally-grown food using the recipes provided.			
Strategy: Provide healthy meals to community facilities to support Health & Nutrition guidelines				**Outcomes:**		
Action Step	**Accountability**	**Timeline**	**Desired Outcome**			
Offer the Senior Center one healthy meal every day Monday - Friday.	Food & Nutrition Services	Initiated and ongoing	The participants will be able to enjoy a nutritious meal provided to support a healthy diet.			
Offer Hospice a health meal 3x/day every day - 365 days/year.	Food & Nutrition Services	Initiated and ongoing	The participants will be able to have a nutritious meal provided to support their intake during this time.			
Strategy: Participate in the Local Food Policy Council Development Program to make the food system more equitable and accessible for low-income populations.				**Outcomes:**		
Action Step	**Accountability**	**Timeline**	**Desired Outcome**			
Participate in the local Food Policy Gatherings to discuss the challenges and potential solutions and develop recommendations focused on changing policy and systems for our community needs and environment.	Food & Nutrition Services	Initiated and ongoing: 1st gathering 03/28/2020.	To plan & implement thru partnerships, easier access to food and resources to meet our community needs.			
Strategy: Promote affordable healthy options to employees & the public who dine @ Self Regional Retail locations to combat obesity.				**Outcomes:**		
Action Step	**Accountability**	**Timeline**	**Desired Outcome**			
Provide a "Chef Cares" or "Self Select" meal which emphasizes an overall calorie level <700, ≤35%cals Fat, 0 trans fats, and < 650 mg. of sodium at a reduced price; to encourage more healthy purchases.	Food & Nutrition Services	Initiated & ongoing	Employees and the public can eat healthier options in the retail services at affordable prices.			
Strategy: Provide nutrition education to families that enroll in the Lifestyle Clinic 2020, if program continued.				**Outcomes:**		
Action Step	**Accountability**	**Timeline**	**Desired Outcome**			
The clinic will serve families from community/medical practices that have a need/show interest in participating, counseling service, nutrition education & behavior modification, as well to instruct participants in healthy eating for weight loss/healthy weight maintenance.	Dietitian	TBD	To instill healthy eating for weight loss/healthy weight maintenance for children and their families.			
Strategy: Provide nutrition education to clients of the Transitional Rehab. program at the Optimum Life Center				**Outcomes:**		
Action Step	**Accountability**	**Timeline**	**Desired Outcome**			
Provide nutrition education classes to clients of the Transitional Wellness program at the Optimum Life Center with obesity patients wanting or needing to lose weight before they can have their surgery, also cancer patients or others with unique nutritional needs.	Dietitian	Initiated & ongoing	To educate and support healthy eating for weight loss/cancer patients and unique needs clients.			