CMC
CONWAY MEDICAL CENTER

Community Health Needs Assessment

Implementation Strategies
Horry County, South Carolina

January 2020

Implementation Strategy

Conway Medical Center (CMC) will collaborate with community partners in implementing evidence-based strategies across the community. CMC has taken into consideration both internal as well as external resources found within other organizations in the development of the 2019 CHNA Implementation Strategy. This phase of the CHNA, the Implementation Strategy, will outline CMC's action steps to address the health needs of the community identified in the prioritization phase of the CHNA by continuing effective programs or executing new strategies. In this phase, CMC will also explain why the hospital cannot address all of the needs identified in the CHNA, and if applicable, name an organization that CMC will support in meeting these needs.

As outlined in the CHNA report, the following are needs that CMC has chosen to address.

- **Access to Health Services**– CMC understands that underserved populations often struggle to access the proper health services, whether it be due to limited personal or community resources. CMC is motivated to select "Access to Health Services" as a key topic of the 2019 CHNA Priorities and develop implementation strategies that would improve the access to health services in the community through health literacy education, increased awareness of existing resources, identification of community partnership opportunities, etc.
- **Maternal, Infant, and Child**– CMC has identified a need to continue education and action to improve Women and Children's health in the community. Some of the action steps outlined build upon previous screening initiatives implemented by CMC and additional education around prenatal care.
- **Nutritional, Physical Activity, and Obesity** – CMC has identified a need to target healthy lifestyle awareness education in the community to encourage preventive health habits. Strategies and action steps have been defined to help CMC address this community need with a focus on healthy lifestyle education, enhancing healthy lifestyle campaigns and collaborating on health programs with community organizations, just to name a few.
- **Mental Health –** CMC is aware of the importance of addressing mental health and behavioral health needs in the community and the significant role it plays in overall mental and physical health. Both CMC and community members feel that there is an opportunity to improve mental health education and access to a range of mental health programs and resources in the community.

The Implementation Plan below will outline why each need was chosen, identify action steps for how CMC intends to address the need, the responsible party for implementation and any goals that will measure the success of the initiative.

Conway Medical Center Implementation Strategies and Action Steps

Access to Health Services

Goals:	To ensure all individuals have access to resources to receive the care and support they need to live healthy lives.

Strategy: Facilitate the recruitment of primary care providers to our underserved areas with the establishment of a CMC Family Medicine Residency program.

Action Step	Accountability	Timeline	Desired Outcome
1 Build an education facility to house a new residency program	Leadership	Year	To have a facility designed to facilitate a premier learning environment for new doctors that could potentially service our community.
2 Initiate curriculum and program design to ensure that every aspect of the program requirements are met	CMC Residency Program	Year	To provide a program for advanced family medicine training that will prepare new doctors to provide exceptional medical care deserving of our community members.
3 Develop a marketing and recruitment strategy	CMC Residency Program	Year	Recruit enough new doctors to fill all available spaces in the program

Strategy: Explore options to supplement the PCP shortage through telemedicine

Action Step	Accountability	Timeline	Desired Outcome
1 Develop a comprehensive telemedicine strategy	Leadership/PNS	Ongoing	Provide convenient PCP care to patients with transportation issues or other barriers to access healthcare
2 Educate the community on any newly implemented telemedicine options	Marketing	Ongoing	Encourage the usage of telemedicine options to insure patients are taking advantage of the opportunity for regular follow ups with physicians

Strategy: Promote the usage of transportation resources to increase access to PCP care

Action Step	Accountability	Timeline	Desired Outcome

1 Publish a brochure to distribute to patients and community members on the various forms of transportation available to get them to PCPs and other hospital resources.	Marketing	Year	The brochure will be distributed in inpatient discharge folders, to ED patients, to Healthreach van patients, and to community members at various events to increase awareness of resources available to patients to insure transportation is not a barrier to their healthcare.
2 Research potential of contracting with Uber or Lyft for patient transportation.	Case management	Year	Increased access to transportation for healthcare needs
3 Fund transportation options for the underserved	Foundation	Continuous	Increased access to transportation for healthcare needs by removing financial barriers
Strategy: Increase the number of providers in our underserved community			
Action Step	**Accountability**	**Timeline**	**Desired Outcome**
1 Do demographic research for different zip codes and evaluate areas for additional practice opportunities	Leadership/PNS	Ongoing	Identify areas in need of potential practice support
2 Complete a provider needs assessment and continue recruiting efforts	Leadership/PNS	Ongoing	Understand community capacity and identify appropriate GAPS in the provider landscape

Maternal, Infant, and Child

Goals:	Improve overall health and outcomes for current/current mothers and their children

Strategy: Baby Friendly Initiatives			
Action Step	**Accountability**	**Timeline**	**Desired Outcome**
1 Work with OB offices to assist with distribution of relevant information regarding the benefits of breastfeeding	Maternal Child Health Services	FY 2022	Promote the adoption of breastfeeding as the best nutritional option for babies.
2 Educate patients, families on the 10 Steps of Successful Breastfeeding, the benefits of skin to skin contact, and rooming in policies to have a better understanding of their	Maternal Child Health Services	FY 2022	To ensure that patients and families are aware of our policy changes and have realistic expectations of their stay in the hospital.

hospital stay in a baby friendly facility			
3 Implement a breastfeeding support group	Maternal Child Health Services	FY 2022	Provide support for mothers to promote the continuation of breastfeeding through the entire first 6 months.
Strategy: Implement and develop 24/7 pediatric hospitalist service			
Action Step	**Accountability**	**Timeline**	**Desired Outcome**
1 Onboard pediatric hospitalists	Medical Staff Affairs	Ongoing	Add additional providers that focus on the care of our pediatric patients and make sure that they are being cared for properly and have the healthiest outcomes.
2 Identify additional pediatric concerns among outpatient providers and create plans to supplement these deficiencies in patient care	PNS	Ongoing	Ensure that our pediatric care teams are providing the best possible care to facilitate healthy outcomes for our pediatric patients.
3 Expand upon the supportive services our pediatric hospitalists provide	Leadership	Ongoing	Identify gaps in pediatric care that our hospital system provides which can been be addressed through the use of a pediatric hospitalists care.
Strategy: Increase the number of women in our community who receive annual screening mammograms			
Action Step	**Accountability**	**Timeline**	**Desired Outcome**
1 Add additional areas and screening locations to our Mobile Mammography Center's rotation	Marketing/ Maternal Child Health Services	Ongoing	Increase the number of mammograms given to women with work and transportation barriers
2 Continue to provide free mammograms to uninsured, low-income women in Horry County and outlying areas through the Mammography Initiative	CMC Foundation	Continuous	Maintain and expand upon funding to provide this initiative and expand the number of women who utilize it.
3 Promote through various methods our ability to offer screening mammograms without a physician's order in office or in the community through our Mobile Mammography Center.	Marketing	Ongoing	Increase the number of self referrals

Strategy: Provide education to better prepare new and expecting mothers			
Action Step	**Accountability**	**Timeline**	**Desired Outcome**
1 Expand upon the educational opportunities for new and expecting moms	Marketing/ Maternal Child Health Services	Ongoing	Educated parents have healthier outcomes and can more actively participate in their pregnancy decisions and be more knowledgeable of how to care for and address the needs of their new babies.
2 Provide supportive information to new and expecting moms in OBGYN offices and pediatrics offices	Marketing/ Maternal Child Health Services	Ongoing	Educated parents have healthier outcomes and can more actively participate in their pregnancy decisions and be more knowledgeable of how to care for and address the needs of their new babies.
3 Plan and market Pediatrician Open Houses	PNS/Marketing	Ongoing	Introduce expecting parents to pediatricians to ensure easy transition of babies from hospital to pediatric care after birth.

Nutritional, Physical, and Obesity

Goals:	Promote awareness, education, and healthy lifestyles in our community

Strategy: Education and screenings for the community			
Action Step	**Accountability**	**Timeline**	**Desired Outcome**
1 Participate in health fairs, community and worksite screenings, and other identified events where we can provide information, education, and BMI screenings.	Outpatient Nutritional Services/ Healthreach/Marketing	Ongoing	Improved knowledge on the repercussions
2 Continue to provide seminars addressing obesity and the various treatment and surgical options available.	Marketing/PNS	Ongoing	Increase the number of people seeking information and help to combat their personal obesity issues

3 Continue to expand our Weight Loss Services to surrounding communities that do not have the services that CMC can facilitate.	Leadership/ PNS	Ongoing	Make CMC Weight Loss options more accessible to those that can use them even beyond the borders of our own county.
Strategy: Identify, educate, and provide supportive resources to community members with diabetes			
Action Step	**Accountability**	**Timeline**	**Desired Outcome**
1 Provide funding for the promotion and education for diabetes	Foundation	Continuous	Maintain/increase funding to expand upon this initiative
2 Continued participation in community educational opportunities and offer free monthly diabetes support group meetings to provide resources to community members with or at risk for diabetes.	Healthreach	Ongoing	Increased participation in meetings and increased awareness
3 PNS providers will provide diabetes education and implement care plans in conjunction with its PCMH approach to expand upon with support provided to patients with diabetes by utilizing available and expandable resources within CMC and the community.	PNS	Ongoing	Improved knowledge and support for diabetic patients resulting in improved health.
Strategy: Increase support for children with food insecurities			
Action Step	**Accountability**	**Timeline**	**Desired Outcome**
1 Expand upon our CMC Smart Snacks program through increased funding and additional school participation.	Foundation/ Healthreach	Ongoing	Provide nutritional food for underserved children in our community with food insecurities.

Mental Health

Goals:	Improve access to and awareness of mental health resources within CMC and the community

Strategy: Improve and create access to mental health services for adolescents			
Action Step	**Accountability**	**Timeline**	**Desired Outcome**

1 Create a plan to offer mental health services in pediatric care offices	Leadership/PNS	FY 2022	Be able to move forward with offering this service in our pediatric offices
2 Implement weekly clinic hours to provide counseling services to pediatric and adolescent patients and families	Leadership/PNS	FY 2022	Provide patients and families with convenient mental health care that can be coordinated with their primary care.
3 Partner with adolescent & pediatric counselors to provide supportive services to our pediatric providers	Leadership/PNS	FY 2022	Utilize an outside mental health service to provide the mental health service to patients
Strategy: Decrease addiction and substance abuse related illness			
Action Step	**Accountability**	**Timeline**	**Desired Outcome**
1 Continue to collaborate with local municipalities, law enforcement, state and health officials regarding the Opioid Epidemic	Leadership	Ongoing	Collaborate with local leaders and agencies to identify opportunities to work together to address the opioid crisis
2 Identify opportunities to educate the community on the dangers of substance abuse and the resources available for those with dependency issues or disorders.	Marketing/ Healthreach	Ongoing	Increase awareness of substance abuse in our community and the resources available for those struggling with it.
3 Identify potential grant opportunities to meet substance abuse goals	Foundation	Ongoing	Secure grants for opioid awareness, training, and unidentified community initiatives
Strategy: Mental Health Services Mapping			
Action Step	**Accountability**	**Timeline**	**Desired Outcome**
1 Conduct service mapping to identify mental health services available within Horry County and within neighboring counties	Case management	FY 2022	Identify all resources that can be potentially used by our patients

2 Put together materials that can be provided to patients in need of mental health services	Marketing/ Healthreach	FY 2022	Provide patients with a comprehensive list of resources to increase awareness and access to mental health services beyond CMCs ED that can provide continued care.
3 Look for opportunities to partner with local services to promote mental health awareness in the community (suicide prevention training, mental health panels, substance abuse awareness, etc.)	Marketing/ Healthreach	FY 2022	Assist with supporting and ensuring that these events are successful.

APPENDIX

2016 Updated Strategies

Community Health Need:	**Access to Primary Care Physicians**			
Goals:	Conway Medical Center will actively assist in providing access to Primary Care Physicians			
Strategy: Ensure each patient admitted to CMC has appropriate follow-up with a provider of choice prior to discharge				
Action Step	**Accountability**	**Timeline**	**Desired Outcome**	**2019 Status Update**
Initial evaluation with patients within 24 hours of admission to discuss current PCP and/or need for PCP	Case Management	Ongoing	Improve the number of patients who have appropriate PCP follow-up	All patients that Case Management is commissioned to consult with through a provider's request are followed up on to insure PCP follow-up has been encouraged.
Assist patient in scheduling a discharge appointment prior to leaving the hospital which includes appropriate insurance coverage, needed documentation for new appointment and any transportation needs for the appointment	Case Management	Ongoing	Increase in patients with appointments	Our revised scheduling department now schedules PCP follow-ups prior to discharge insuring appointment availability and increasing PCP follow up appointments are made.
Provide community clinic information for those patients who refuse/deny CM assistance with obtaining new PCP	Case Management	Ongoing	Improved access and better coordination of care	Non-funded indigent patients are referred to Little River Medical Center, Health Care Partners of SC, and Care Team. Patients actually leave the hospital with an appointment at one of these facilities and are provided with all info regarding the appointment. Patient records are faxed in advance of the appointment to the provider.

Educate the community on the importance of regular, Primary Care exams and follow up	Marketing	12 months	Increase community awareness to promote greater PCP utilization	We consistently promote the importance of regular visits and follow-up to the community through our social media channels using our actual providers. This is an opportunity for the public to get to know our providers and after being educated on the importance of regular primary care visits, setting an appointment with a PCP they feel most comfortable with. We market our PCPs at community events and health fairs where we educate community members about the importance of annual checkups and proper follow up with their providers.
Promote CPG Physicians through various methods	Marketing	12 months	# of New Patients being seen by CPG	Primary Care providers, new and existing, are promoted through multiple channels including print media, all social media channels, Summer Safety awareness PSA campaigns, relevant television and print news stories, health fairs, the Conway Chamber of Commerce, and local school sponsorships, and through our New Parent and Senior Newsletters. CMC also offers a Physician Referral line to the community assisting between 50-60 people monthly with finding a provider or specialist.
Promote CPG Physicians to all patients admitted to the hospital	Marketing	12 months	# of New Patients being seen by CPG	Patients are provided with a listing of Primary Care providers organized by location for patient convenience in their discharge planning folders.

Promote CPG Physicians to all patients discharged through the Emergency Department	Marketing	12 months	# of New Patients being seen by CPG	Patients are provided with a listing of Primary Care providers organized by location for patient convenience.
CPG Primary Care will create quick care/open access, same day, acute care visits in all primary care sites with multiple providers. The goal is to increase access for first the patients of CPG offices and ultimately the community at large.	CPG	24 months	Increased access	All PCP locations have same day/acute visits
CPG will expand Primary Care access for patient population by expanding hours, adding providers and new locations convenient to patient base.	CPG	Ongoing; as appropriate	Increased access	Added Primary Care @ Carolina Forest, Primary Care @ Surfside, and combined our Myrtle Trace and Socastee locations in our new, larger, state of the art facility- CMC Health Plaza South with an added Pediatrics practice.
CPG will embrace "Patient Centered Medical Home" to improve access to the appropriate level of care at the appropriate time of need for the patient. It will formally recognize its practices as NCQA level two and three to facilitate cooperation between patients, practices and payers. This will expand the care coordination approach to primary care and collaboration with Hospital and other organizational care providers.	CPG	Ongoing; as appropriate	Increased access and care coordination	All primary and pediatrics are PCMH w/ exception of Vest locations
CPG will expand access for pediatric patient population by expanding hours, adding providers and new locations convenient to patient base.	CPG	24 months	Increased access	Added 3 new locations (Towne Center (29579), Conway (29526) ,and Socastee (29588))
CPG will work closely with our patient population who are prescribed opioids with a dedicated opioid nurse navigator who provides care plans and measures to manage the usage of prescriptions.	CPG	By Q4 2020	eliminate inappropriate opioid use	Utilized recommendations from guidemed

Community Health Need:	**Follow-up after Discharge**
Goals:	Establish best practices and education around discharge instructions.

Strategy: Increase/continue communication with patients within five days of appropriate discharge home

Action Step	Accountability	Timeline	Desired Outcome	2019 Status Update
Hospitals and attending specialists or hospitalists inform and consult with the PCMH Care Coordinator about discharge plans for their patients, and they work together to ensure that discharged patients get appropriate follow-up care.	CPG	Ongoing	Reduced readmissions and better care coordination	Discharge planner schedules the appointment. A report is sent to all practices of patients being discharged so that offices are following up with these patients as well.
Continue to monitor and increase TCM volume in CPG practices, monitor hospital discharge list and follow up with patients needs after discharge	CPG	Ongoing	Reduced readmissions, better care coordination and patient care	TCM is being scheduled with providers following DC from DC planner
Establish Chronic Care management program for patients with 2 or more chronic conditions to include outreach and education each month, work on ways to decrease re-admissions	CPG	Monthly	Improve patient care, reduce readmissions, reduce ER utilization	CMC continues to evaluate this opportunity.
Patient will be seen by a member of case management prior to being discharged to home from CMC	Case Management	Ongoing	Decrease of discharge needs after patient is discharged	All patients that have a consult ordered by a doctor or nurse are seen by a case manager prior to being discharged. The case manager has to assess the case within 24 hours of the consult being ordered.
Patient will be contacted via phone from a member of case management after discharge to home	Case Management	Ongoing	Improved coordination of care	100% of inpatients are contacted within two business days except for Maternal Child Health and Psychiatric patients.

Documentation regarding patient status after hospital stay including medication compliance, home health services, follow-up appointments and/or any other concerns regarding their care	Case Management	Ongoing	Improved coordination of care	This conversation is had in the discharge follow up phone call with all patients to insure proper medication usage and that home health services are being utilized if ordered. The case manager also confirms that the follow up appointments have been made and addresses any other concerns regarding their care.
Expand utilization of Transitional Care visits post-DC from acute care facilities	CPG	12 months	Increase TCM visits within CPG post-CMC DC	Patients without PCP are being scheduled with CPG providers
Expand current post-DC Transitional Care program at CMC to include even more value added services and encompass more patients	CMC Case Mgmt.	12 months	Expand services to current patients and offer services to a wider patient population	We have started a readmissions team to evaluate all patients that are readmitted within 30 days. We work with Well Vista, a pharmacy program, that assists indigent patients to be able to secure their medications for a year if they qualify. Patients leave with a 3 day supply and then receive their meds by mail. The Meds to Beds Program provided by our hospital pharmacy insures that patients with insurance or the ability to private pay leave the hospital with their medications. Since implementation we have seen a reduction in patients readmitted due to medication compliance.

Community Health Need:	Motor Vehicle Fatalities
Goals:	Conway Medical Center will provide education and support to assist the community in reducing motor vehicle accidents resulting in disabilities and fatalities.

Strategy: To reduce motor vehicle accident disabilities and fatalities through community education

Action Step	Accountability	Timeline	Desired Outcome	2019 Status Update
CPG's Opioid Management program will coordinate care for patients using opioids. This will also decrease the amount of "drugged driving" in our area. With a dedicated nurse coordinator to manage these patients, we are able to provide resources and education of these medications. Several studies have shown that drivers with THC in their blood were roughly twice as likely to be responsible for a deadly crash or to be killed as drivers who had not used drugs or alcohol.	CPG	Ongoing	Creating a safer environment for community	Utilized guidemed recommendation by performing UDS and consent
In conjunction with AARP, offer Safe Driver Classes which will focus on: important facts about the effects of medication on driving; How to reduce driver distractions; How to maintain the proper following distance behind another car; Proper use of safety belts, air bags, anti-lock brakes and new technology found in cars today; Techniques for handling left turns, right-of-way, and roundabouts; Age-related physical changes and how to adjust your driving to compensate	Marketing	12 months	Increase # of drivers changing at least one driving habit as a result of what they learned in the class	We offered 23 classes attended by 297 people with 100% reporting in anonymous surveys that 1) the course influenced them to make changes in the way they drive, 2) the course made them more aware of changes (health, medications, eyesight, etc) that can affect their driving, and 3) the course served as a useful reminder of things that they may have already know. When asked if the course influenced them to change one driving habit responses

				included: being rested while driving, slowing down, being more aware of the effects of medications and existing medical conditions, properly adjusting mirrors to see the most of blind spots, how to safely navigate away from tailgaters, how to choose the safest route home, and more.
Provide presentation to area High Schools on the dangers of impaired or distracted driving	Trauma Multidisciplinary Management Committee Multidisciplinary Management Committee	By September 30, 2021	Increase the awareness of preventable causes of motor vehicle fatalities including, use of alcohol, drugs, distracted or tired driving, and texting.	
Collaborate with area police and EMS personnel to provide educational event regarding the dangers of impaired or distracted driving	Trauma Multidisciplinary Management Committee Multidisciplinary Management Committee	By September 30, 2021	Create a working relationship with area governing entities to educate the community regarding preventing motor vehicle accidents from distracted and impaired driving.	In 2018 and in 2019, CMC sponsored PSAs as part of the 100 days of Summer Safety featuring local law enforcement discussing the hazards of impaired and distracted driving.
Provide public service announcements via radio/television regarding the dangers of impaired or distracted driving	Trauma Multidisciplinary Management Committee Multidisciplinary Management Committee	By September 30, 2021	Increase the awareness of preventable causes of motor vehicle fatalities including, use of alcohol, drugs, distracted or tired driving, and texting.	In 2018 and in 2019, CMC sponsored PSAs as part of the 100 days of Summer Safety featuring local law enforcement discussing the hazards of impaired and distracted driving.

Provide information via brochure/pamphlet to patients in waiting rooms at the hospital and CPG offices regarding distracted or impaired driving.	Trauma Multidisciplinary Management Committee Multidisciplinary Management Committee	By September 30, 2021	Educate the community regarding preventing motor vehicle accidents from distracted and impaired driving.	
Community programs focused around traumatic automobile injuries	Trauma Team	12 months	Increased community awareness of driving habits that lead to increased traumatic MVAs	

Community Health Need:	Diabetes
Goals:	Increase/continue diabetes education to improve health status of community. Continue to educate and support people with diabetes in the community

Strategy: Improve access to diabetes education and increase participation in diabetes education and promote wellness through education

Action Step	Accountability	Timeline	Desired Outcome	2019 Status Update
CPG will provide diabetes education for its patients in conjunction with its PCMH approach with the addition of CDE to its staffing. The formal diabetes initiative will provide structured care plans, monitoring and case management approach for patients with Type 1 and Type 2 diabetes. It will also develop credentials for existing clinical support staff and will seek reimbursement to support program from payors.	CPG	Ongoing	Increased education and better coordinated care and decreased ER visits	CMC continues to evaluate this opportunity.
Self-care training and support is essential for the successful outcomes of patients with diabetes and other chronic illnesses. CPG nurse coordinators and diabetic educators help physicians implement and carry out care plans and it is important	CPG	Ongoing	Improved knowledge and education for diabetic patients resulting in improved health and less use of acute care	CMC continues to evaluate this opportunity.

that they be included as a key member of the Patient Centered Medical Home (PCMH) team.				
Provide funding for the promotion and education for Diabetes.	CMC Foundation	Continuous	Maintain funding to provide this initiative	Since fiscal year 16/17, The foundation has given over $375,000 in support for Health Reach community support programming which includes education on and testing for diabetes. Our Health reach team travels throughout Horry County and beyond to provide better access to care especially for the underserved and vulnerable populations. (Does not include the smart snacks initiative)
Provide funding to Healthreach for outreach screening of low income individuals and families	CMC Foundation	Continuous	Maintain funding to provide this initiative	Since fiscal year 16/17, The foundation has given over $375,000 in support for Health Reach community support programming which includes education on and testing for diabetes. Our Health reach team travels throughout Horry County and beyond to provide better access to care especially for the underserved and vulnerable populations. (Does not include the smart snacks initiative) Our Healthreach program provided diabetes screenings to 1998 individuals at various locations throughout our community recognizing 599 individuals with

				moderate, high, or warning levels. Education and appropriate referrals for additional help were provided to those patients.
Provide funding to Friendship Medical Clinic for outreach screening and treatment of low income individuals and families.	CMC Foundation	Continuous	Maintain funding to provide this initiative	Since fiscal year 16/17 the foundation has given over $100,000 in support for the mission of Friendship Medical Clinic which includes screenings and treatment for the underserved and vulnerable populations. (see most recent newsletter from Friendship Medical Clinic)
Continue with free monthly diabetes support group meetings providing education, support and access to community resources	Healthreach	Ongoing	Consistent or increased monthly support group attendance; Increased self-care knowledge of participants; emotional support for participants	CMC has continued with our monthly support group meetings with a total attendance of 412 over the course of the last 3 years. These support groups are promoted on our website, through our physician offices, our Healthreach van, at community events, and our social media channels. They remain free to accommodate all.

Continue to participate in community health fairs to promote diabetes awareness, wellness and access to community resources	Healthreach	Ongoing	Increased awareness of diabetes risk factors, need for routine screenings, diabetes wellness, resources available for people with diabetes	Healthreach and other hospital services and providers attend approximately 15- 20 of the largest Health fairs in the area annually providing healthcare information to approximately 2000 people.
Provide diabetes education on an outpatient basis through individual sessions and group sessions on and off campus with physician referral	Healthreach	Ongoing	Increased knowledge, self-care, compliance and health	These services became free to patients referred in through CMC providers in May of 2018. They have an initial consultation and then arrangements are made for them to meet with nutritionists and to attend support group meetings for additional education. Since the change in programs we have assisted 75 people through our revised program.
Continue to provide no-cost glucometers and test strips to uninsured people with diabetes	Healthreach	Ongoing	Increased self-care and health	This was discontinued due to liability purposes. We had to be able to make sure that patients were checking the quality of the machines through controls and we had no way to verify that.
Educate area healthcare providers on benefits of diabetes education and when to refer patients for diabetes education	Healthreach	Ongoing	Increased patient knowledge, self-care, compliance and improve overall health	Since we have narrowed the referrals to CMC physicians this has basically been negated.
Increased participation at Health Fairs, etc. with focus on diabetes education	Healthreach	12 months	Increase community awareness about diabetes	In 2017, CMC has offered a live annual cooking demonstration for community members with diabetes to educate them on healthier options for holiday eating with an average of 50 attendees each year. We also did live, on air

				cooking demonstrations each year on WPDE News reaching approximately 7900 households.
Offer free Hgb A1C screenings to local public	Hospital	12 months	Early identification of pre-DM and DM patients	
Offer DM classes and educational sessions throughout local communities using area CPG offices to reach different areas of our county	CMC/CPG	12 months	Bring more DM education to local communities throughout Horry County	Diabetes management education now takes place in all of our primary care offices provided by our care providers. They also provide patients with information about our diabetes support group meetings and refer them to our nutritionists for continued assistance and education outside of their office visits. The offices are not currently offering any group educational sessions or classes at this time. Education is on a one on one basis with existing and new patients.

Community Health Need:	**Mammography**			
Goals:	Increase % of Women with Mammography Screening			
Strategy: Screen and educate the community of mammography screening				
Action Step	**Accountability**	**Timeline**	**Desired Outcome**	**2019 Status Update**

Care Coordination approach in conjunction with PCMH and Breast Health Navigator.	CPG	Ongoing	Improved care coordination	Screenings began being provided in 2019 at different locations to increase more convenient access to our outlying community members.
Coordinate with Central Scheduling to provide open access to scheduling Screening Mammography at CMC Diagnostic Center, allowing CPG staff to schedule at time of patient appointment in office.	CPG	Ongoing	Improved access; Increased screenings	Practice staff are scheduling appointments for mammograms.
Using EMR, send out patient communication to all women over 40 reminding them to schedule their annual mammogram.	CPG	Quarterly	Increased appropriate screenings for women over 40	This service has been implemented.
Promote through various methods our ability to offer screening mammograms without a physician's order	Marketing	12 months	increase % of self referrals	Since 2016, CMC has promoted mammograms with no physician's order needed to promote self referrals and less barriers to getting an annual screening. This included access to the most advanced 3D mammography technology available. Our campaigns encompassed all marketing resources including television, outdoor media, digital marketing, and print media. It was also promoted at multiple community events and Health Fairs. In 2019, we obtained our Mobile Mammography Center which added another resource for convenient screenings in our outlying areas. As a result, there has been an increase in screenings. 2016- 32% Self referral rate 2017- 36% 2018- 38% 2019- 48% Self referral rate

Provide free mammograms to uninsured, low-income women in Horry County area through the Mammography Initiative.	CMC Foundation	Continuous	Maintain funding to provide this initiative	Since fiscal year 16/17, the foundation has provided over $300,000 in support for the mammography initiative including the mobile mammography unit and screenings/service to the uninsured and vulnerable populations. (Includes TDE funds designated for the underserved) We have one payment remaining coming in at 75k in 2020.
Provide funding to Healthreach for outreach screening and treatment of low income individuals and families	CMC Foundation	Continuous	Maintain funding to provide this initiative	Since fiscal year 16/17, the foundation has given over $375,000 in support for Healthreach community support programming which includes education on affordable or free screening options available through CMC for mammograms. Our Healthreach team travels throughout Horry County and beyond to provide better access to care especially for the underserved and vulnerable populations.
Provide funding to Friendship Medical Clinic for outreach screening and treatment of low income individuals and families.	CMC Foundation	Continuous	Maintain funding to provide this initiative	Since fiscal year 16/17 the foundation has given over $100,000 in support for the mission of Friendship Medical Clinic which includes screenings and treatment for the underserved and vulnerable populations. We have also assist with providing free mammograms to Friendship Medical Clinic patients that qualify.