McLeod Health Clarendon

2019 Community Health Needs Assessment

Approved by McLeod Health Clarendon Community Board on 08/21/2019

McLeod Health
The Choice for Medical Excellence

Introduction

Health begins —long before illness—in our homes, schools and jobs. Through meaningful collaboration, we have the opportunity to make choices that can help us all to live a healthy life, regardless of income, education or ethnic background. This *Community Health Needs Assessment* and *Action Plan* presents an opportunity for improving health status.

People whose circumstances have made them vulnerable to poor health need our help in working towards eliminating barriers that provide everyone with the chance to live a healthy life. This work can't happen without first making use of the facts that serve as the foundation. Health research provides indicators of health status, such as the prevalence of disease or health issue and its effect in both economic and human terms. As health improvement initiatives are introduced, it can reflect the effectiveness of an approach or intervention. By using the *Community Health Needs Assessment*, we can evaluate relevant determinants of health that provides valuable insight in guiding decisions that create a pathway for improving the health of our community. As you read the *Community Health Needs Assessment*, it can change the way you think about health.

After reviewing the report, it is important to begin where health starts. Everyone in our community should have the opportunity to make good healthy choices (e.g., regarding smoking, diet, alcohol use, physical activity) since this has the largest impact on future health outcomes. Wherever possible, through programs, services, public policy or other means, emphasis needs to be placed on addressing health choices and prevention before there is a medical need. Research has shown that the health care system represents only 10-20% of determining health status, while our individual health behaviors we choose account for 40% or more.

Through changes in public policy, it is possible that most people, regardless of income, could have the ability to see a doctor. Health insurance does not guarantee good health, but it does provide important access to preventative health services. It can reduce the risk of deferring needed care and the financial risk associated with receiving care. Those most vulnerable to poor health often have the weakest voice when it comes to health policy. Our efforts should prioritize

our resources to address the most pressing needs, disparities, and inequalities where we may be impactful.

Our success should be linked to collaboration where our collective efforts can build a healthy community that nurtures its families and communities. McLeod Health encourages partnerships with volunteers, business, government, civic and religious institutions to join us in this work. Although we will not be able to eradicate every illness, there is much we can accomplish by education, fostering good health and addressing community health gaps. Health begins with healthy relationships, healthy communities, and healthy jobs, which can protect us from the stress of everyday life.

Input was solicited and taken into account from the following sources in identifying and prioritizing significant health needs and in identifying resources potentially available to address those health needs:

- At least one state, local, or regional governmental public health department (or equivalent department or agency), or State Office of Rural Health with knowledge, information, or expertise relevant to the health needs of the community
- Members of medically underserved, low-income, and minority populations in the community served by the hospital facility or individuals or organizations serving or representing the interests of these populations
- Solicitation of comments received on the hospital facility's most recently conducted CHNA and most recently adopted implementation strategy

One-on-one interviews, questionnaires, and forums were conducted in Spring 2019 as a means to gather input.

Top Health Concerns Reported Among Community Members

- Access to Primary Care
- Cancer
- Diabetes

- Family Planning/Teen Pregnancy
- Healthy Environment

Source: McLeod Health 2019 Survey

Top Health Concerns Reported Among Health Professionals

Most frequent health concerns:

- Heart Disease/Stroke
- Access to Primary Care
- Diabetes
- Addressing Mental Health
- Obesity

Source: McLeod Health 2019 Survey

Primary Diagnosis Admitted to Emergency Department

Most frequent health needs presenting to McLeod Health Clarendon Emergency Department October 2017 – September 2018:

- Urinary Tract Infection
- Streptococcal Pharyngitis
- Acute Upper Respiratory Infection
- Chest Pain
- Non-infective Gastroenteritis and Colitis
- Headache
- Acute Pharyngitis
- Viral Infection
- Influenza

Source: McLeod Health Clinical Outcomes

Primary Inpatient Diagnosis

Most frequent health needs presenting to McLeod Health Clarendon October 2017 – September 2018:

- Labor and Deliver, Vaginal and Cesarean Section
- Sepsis
- Post-Term Pregnancy
- Hypertension, Heat Disease with Heart Failure
- Chronic Obstructive Pulmonary Disease with Heart Failure
- Acute Kidney Failure
- Pneumonitis

Source: McLeod Health Clinical Outcomes

Opportunities & Plan Priorities

McLeod Health Clarendon will collaborate with community partners to provide community health initiatives that are focused on areas listed below and further described within the Implementation Plan. Evidence-based practices will be instituted to address the following key areas by McLeod Clarendon:

- Access to Care
- Diabetes
- Heart Disease and Stroke
- Lung Disease

About McLeod Health Clarendon

Established in 1951, McLeod Health Clarendon has served the residents of Clarendon County for 67 years. In 2013, the hospital completed a $22 million, 47,000 square foot expansion

and renovation, encompassing new operating rooms, an emergency department, same-day surgery center and larger patient rooms.

Services available at McLeod Health Clarendon include: labor and delivery, infusion therapy, cardiac rehabilitation, outpatient rehabilitation, diagnostic imaging, home health and hospice. The hospital has nearly 30 physicians representing medical specialties ranging from family medicine, OB/GYN and orthopedics to plastic surgery and urology.

OVERVIEW

This Community Health Needs Assessment serves as a tool to evaluate the overall health status, behaviors and needs of Clarendon County. The March 2010 passage of the Patient Protection and Affordable Care Act (ACA) introduced reporting requirements for private, not-for-profit hospitals. To meet these new federal requirements, the information gathered in this assessment is used to guide the strategic planning process in addressing health disparities.

A Community Health Needs Assessment gives information to health care providers to make decisions and commit resources to areas of greatest need, making the greatest impact on community health status.

This assessment incorporates data from within the community, such as individuals served and health organizations, as well as vital statistics and other existing health-related data to develop a tailored plan which targets the needs of the county. The Community Health Needs Assessment includes:

METHODS

An assessment team comprised of McLeod Health's Community Health and Communication and Public Information staff reviewed literature, data and publications from public sources. Members of the assessment team represented each of the seven acute care hospital facilities within McLeod Health and were assigned to collect data that represented indicators of community health status or its socioeconomic determinants. Therefore, focus was placed on identifying locally-appropriate indicators, benchmarks, and pertinent health issues.

Pre-existing databases containing local, state and national health and behavior data were used for comparisons when possible. Sources of this data are listed at the end of this document.

Data collection was limited to the most recent publicly available resources and some primary data from qualitative and quantitative investigation. As a result, this document portrays a partial picture of the health status of the community served.

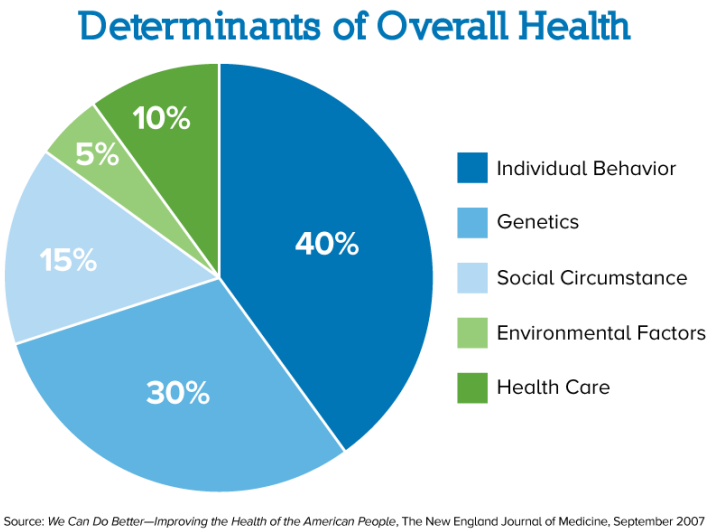
Data analysis included demographic, socioeconomic and health determinant measures. When possible, data also was analyzed according to age, gender and/or race to offer insight into health disparities that may affect specific subgroups in the community.

A summary of county data is reflected as a comparison to state and national data when available to indicate community health concerns.

HEALTH DETERMINANTS AND DISPARITIES

What are the determinants of health?

Health behaviors had the majority overall impact on future health outcomes (i.e., smoking, diet, drug & alcohol use, physical activity, other lifestyle behaviors) and account for 40% of causes for premature death. Genetic predisposition is responsible for 30%, Social circumstances 15%, and Health care for only 10% (i.e., access to physician and other health services) of health risk for premature death.



Behavioral Determinants (40%)

Examples:

- Diet
- Physical activity

- Alcohol, cigarette, and other drug use
- Hand washing

Genetic Determinants (30%)

Examples:

- Age
- Sex
- HIV status
- Inherited conditions, such as sickle-cell anemia, hemophilia, and cystic fibrosis
- Carrying the BRCA1 or BRCA2 gene, which increases risk for breast and ovarian cancer
- Family history of heart disease, cancer, etc.

Social Determinants (15%)

Examples:

- Availability of resources to meet daily needs, such as educational and job opportunities, living wages, or healthful foods
- Social norms and attitudes, such as discrimination
- Exposure to crime, violence, and social disorder, such as the presence of trash
- Social support and social interactions
- Socioeconomic conditions, such as concentrated poverty
- Quality schools
- Transportation options
- Public safety

Health Care Determinants (10%)

Examples:

- Quality, affordability, and availability of services
- Lack of insurance coverage
- Limited language access

Environmental Determinants (5%)

Examples:

- Quality of food, water, and air
- Worksites, schools, and recreational settings
- Housing, homes, and neighborhoods
- Exposure to toxic substances and other physical hazards
- Physical barriers, especially for people with disabilities

What are health disparities?

"Health disparity" refers to a higher burden of illness, injury, disability, or mortality experienced by one population group relative to another group. Health disparities can involve the medical care differences between groups in health insurance coverage, access to care, and quality of care. While disparities are commonly viewed through the lens of race and ethnicity, they occur across many dimensions, including socioeconomic status, age, location, gender, and disability status. Poor health status is often linked with people without health insurance, those who have poor access of care (i.e., limited transportation), lower socioeconomic status, lower education obtainment, and those among racial minority groups. Beyond the provision of health care services, eliminating health disparities will necessitate behavioral, environmental, and

social-level approaches to address issues such as insufficient education, inadequate housing, exposure to violence, and limited opportunities to earn a livable wage.

Health disparities have persisted across the nation and have been documented for many decades and, despite overall improvements in population health over time, many disparities have persisted and, in some cases, widened. Moreover, economic downturns contributed to a further widening of disparities.

The Community Health Needs Assessment attempts to identify and quantify the health disparities within a defined county population that are at disproportionately higher in incidence of disease, disability, or at risk of experiencing worse health outcomes. Within these identified disparities and availability of health resources, gaps can be identified and prioritized based on need so that health resources can be targeted. Planning initiatives to address community health needs take in consideration the existing initiatives, the available resources that we are aware of, and where future improvements can be anticipated to make meaningful impact on improving community health.

What are Key Initiatives to reduce disparities?

In 2010, the U.S. Department of Health and Human Services (HHS) established a vision of, "a nation free of disparities in health and health care," and set out a series of priorities, strategies, actions, and goals to achieve this vision. States, local communities, private organizations, and providers also are engaged in efforts to reduce health disparities.

Federal, state, and local agencies and programs work along with local hospitals, often in cooperation, to provide access to needed health care services. Within constraints of limited resources, each of these entities generally target populations with specific services offered within the county. This study attempts to incorporate their input into determining the priorities among health disparities and look for opportunities for collaboration.

Preventative Care

Preventative care includes medical services such as screenings, immunizations, counseling, and preventative medications intended to prevent illness or detect diseases early before symptoms are developed. With early detection, diseases can be treated more effectively, reducing potential complications of disease or even death. Regular preventative care can improve individual health and the overall health of a community.

Various preventative care guidelines and recommendations are published by different professional organizations, but most health care professionals refer to the recommendations published by the United States Preventative Services Task Force (USPSTF) as a reliable, widely accepted, and evidence-based guide. The USPSTF is an independent, volunteer panel of national experts in prevention and evidence-based medicine. Their recommendations are based on a rigorous review of existing peer-reviewed data. The USPSTF assigns a letter grade (A, B, C, D, or I) to each recommendation based on the strength of evidence and the balance of benefits and potential harms of the preventative service. Grade A and Grade B preventative services are recommended because the USPSTF has determined a high or moderate certainty that the net benefit is moderate or substantial.[1]

USPSTF preventative care recommendations apply to people who have no signs or symptoms of a specific disease or condition. USPSTF recommendations are evidence-based guidelines that help physicians identify appropriate preventative services for certain patient populations, but preventative care should be tailored for each patient depending on individual circumstances. Determining appropriate preventative services for an individual patient requires a one-on-one discussion between the physician and patient.

A complete list of USPSTF preventive care guidelines, including A and B grade recommendations, can be found at www.uspreventiveservicestaskforce.org. The table below highlights USPSTF grade A and B preventative care recommendations pertaining to community health priority areas including heart disease and stroke, diabetes, cancer, and oral health.

USPSTF Grade A and B Preventative Service Recommendations Associated with Identified Key Priority Areas

Topic	Recommendation	Grade
Blood Pressure Screening: Adults	The USPSTF recommends screening for high blood pressure in adults aged 18 years or older. The USPSTF recommends obtaining measurements outside of the clinical setting for diagnostic confirmation before starting treatment.	A
Breast Cancer Screening	The USPSTF recommends biennial screening mammography for women aged 50 to 74 years.	B
Cervical Cancer Screening	The USPSTF recommends screening for cervical cancer every 3 years with cervical cytology alone in women aged 21 to 29 years. For women aged 30 to 65 years, the USPSTF recommends screening every 3 years with cervical cytology alone, every 5 years with high-risk human papillomavirus (hrHPV) testing alone, or every 5 years with hrHPV testing in combination with cytology (cotesting).	A
Colorectal Cancer Screening	The USPSTF recommends screening for colorectal cancer starting at age 50 years and continuing until age 75 years.	A
Dental Caries Prevention: Infants and children up to age 5 years	The USPSTF recommends the application of fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption in primary care practices. The USPSTF recommends primary care clinicians prescribe oral fluoride supplementation starting at age 6 months for children whose water supply is fluoride deficient.	B

Diabetes Screening	The USPSTF recommends screening for abnormal blood glucose as part of cardiovascular risk assessment in adults aged 40 to 70 years who are overweight or obese. Clinicians should offer or refer patients with abnormal blood glucose to intensive behavioral counseling interventions to promote a healthful diet and physical activity.	B
Lung Cancer Screening	The USPSTF recommends annual screening for lung cancer with low-dose computed tomography in adults ages 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.	B
Obesity Screening and Counseling: Adults	The USPSTF recommends that clinicians offer or refer adults with a body mass index of 30 or higher (calculated as weight in kilograms divided by height in meters squared) to intensive, multicomponent behavioral interventions.	B
Obesity Screening: Children and Adolescents	The USPSTF recommends that clinicians screen for obesity in children and adolescents 6 years and older and offer or refer them to comprehensive, intensive behavioral interventions to promote improvements in weight status.	B
Skin Cancer Behavioral Counseling	The USPSTF recommends counseling young adults, adolescents, children, and parents of young children about minimizing exposure to ultraviolet (UV) radiation for persons	B

	aged 6 months to 24 years with fair skin types to reduce their risk of skin cancer.	
Tobacco Use Counseling and Interventions: Non-Pregnant Adults	The USPSTF recommends that clinicians ask all adults about tobacco use, advise them to stop using tobacco, and provide behavioral interventions and U.S. Food and Drug Administration (FDA)–approved pharmacotherapy for cessation to adults who use tobacco.	A
Tobacco Use Counseling: Pregnant Women	The USPSTF recommends that clinicians ask all pregnant women about tobacco use, advise them to stop using tobacco, and provide behavioral interventions for cessation to pregnant women who use tobacco.	A
Tobacco Use Interventions: Children and Adolescents	The USPSTF recommends that clinicians provide interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents.	B

USPSTF A and B Recommendations by Date. U.S. Preventive Services Task Force. June 2019.

https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations-by-date/

COMMUNITY DEFINED FOR THIS ASSESSMENT

The community was defined based on the geographic origins of McLeod Clarendon inpatient and outpatient hospital data, the study area for this assessment is defined as Clarendon County which represents the majority of patients served, to include the zip codes shown in Table 1.

Table 1. McLeod Clarendon Primary Service Area ZIP Codes

ZIP Code	City	County
29001	Alcolu	Clarendon
29051	Gable	Clarendon

29056	Greeleyville	Williamsburg
29102	Manning	Clarendon
29111	New Zion	Clarendon
29125	Pinewood	Sumter
29148	Summerton	Clarendon
29556	Kingstree	Williamsburg
29590	Salters	Williamsburg

Demographics

Current population demographics and changes in demographic composition over time play a determining role in the types of health and social services needed by communities.

The following information represents indicators of health status. The gauge displays, where available, compare local data to state and national data. A green needle on the gauge indicates the county is performing above the state and national data. A red needle indicates the county is performing below the state and national data.

Total Population

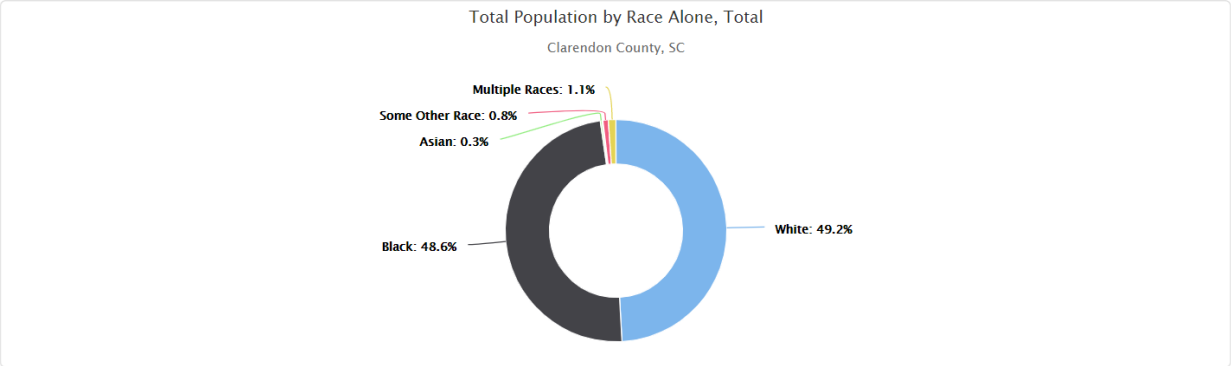
A total of 34,156 people live in the 606.94 square mile report area defined for this assessment according to the U.S. Census Bureau American Community Survey 2013-17 5-year estimates. The population density for this area, estimated at 56.28 persons per square mile, is less than the national average population density of 90.88 persons per square mile.

Report Area	Total Population	Total Land Area (Square Miles)	Population Density (Per Square Mile)
Clarendon County, SC	34,156	606.94	56.28
South Carolina	4,893,444	30,062.97	162.77
United States	321,004,407	3,532,315.66	90.88

Data Source: US Census Bureau, American Community Survey. 2013-17. Source geography: Tract ➞ Show more details

Total Population by Race Alone, Total

Report Area	White	Black	Asian	Native American / Alaska Native	Native Hawaiian / Pacific Islander	Some Other Race	Multiple Races
Clarendon County, SC	16,792	16,591	86	32	9	270	376
South Carolina	3,292,598	1,332,110	71,994	14,992	3,015	74,328	104,407
United States	234,370,202	40,610,815	17,186,320	2,632,102	570,116	15,553,808	10,081,044

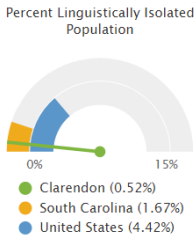


Population in Limited English Households

This indicator reports the percentage of the population aged 5 and older living in Limited English speaking households. A “Limited English speaking household” is one in which no member 14 years old and over (1) speaks only English at home or (2) speaks a language other than English at home and speaks English “Very well.” This indicator is significant as it identifies households and populations that may need English-language assistance.

Report Area	Total Population Age 5+	Linguistically Isolated Population	Percent Linguistically Isolated Population
Clarendon County, SC	32,479	168	0.52%
South Carolina	4,603,480	76,656	1.67%
United States	301,150,892	13,323,495	4.42%

Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2013-17. Source geography: Tract ➞ Show more details



Social & Economic Factors

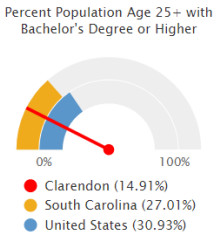
Economic and social insecurity often are associated with poor health. Poverty, unemployment, and lack of educational achievement affect access to care and a community's ability to engage in healthy behaviors. Without a network of support and a safe community, families cannot thrive. Ensuring access to social and economic resources provides a foundation for a healthy community.

Education - Bachelor's Degree or Higher

14.91% of the population aged 25 and older, or 3,572 have obtained an Bachelor's level degree or higher. This indicator is relevant because educational attainment has been linked to positive health outcomes.

Report Area	Total Population Age 25+	Population Age 25+ with Bachelor's Degree or Higher	Percent Population Age 25+ with Bachelor's Degree or Higher
Clarendon County, SC	23,956	3,572	14.91%
South Carolina	3,325,601	898,081	27.01%
United States	216,271,644	66,887,603	30.93%

Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2013-17. Source geography: Tract → Show more details



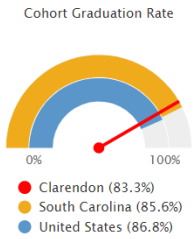
Education - High School Graduation Rate

Within the report area 83.3% of students are receiving their high school diploma within four years. Data represents the 2016-17 school year.

This indicator is relevant because research suggests education is one the strongest predictors of health (Freudenberg & Ruglis, 2007).

Report Area	Total Student Cohort	Estimated Number of Diplomas Issued	Cohort Graduation Rate
Clarendon County, SC	354	295	83.3%
South Carolina	49,427	42,320	85.6%
United States	3,095,906	2,688,701	86.8%

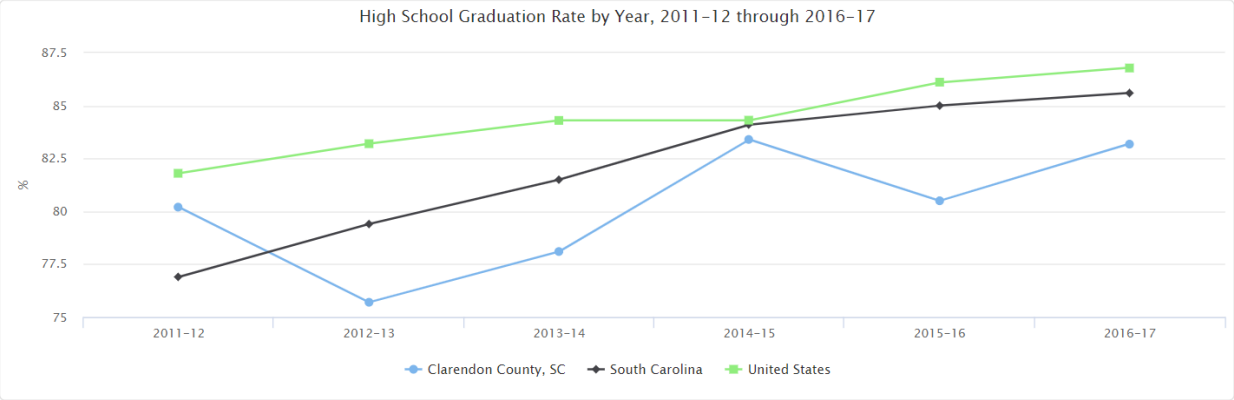
Note: This indicator is compared to the state average.
Data Source: US Department of Education, EDFacts. Accessed via DATA.GOV. Additional data analysis by CARES. 2016-17. Source geography: School District → Show more details



High School Graduation Rate by Year, 2011-12 through 2016-17

The table below shows local, state, and National trends in cohort graduation rates.
Note: Data for some states are omitted each year when they fail to meet federal reporting standards or deadlines. Use caution when comparing national trends as the "universe" population may differ over time.

Report Area	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17
Clarendon County, SC	80.2%	75.7%	78.1%	83.4%	80.5%	83.2%
South Carolina	76.9%	79.4%	81.5%	84.1%	85%	85.6%
United States	81.8%	83.2%	84.3%	84.3%	86.1%	86.8%

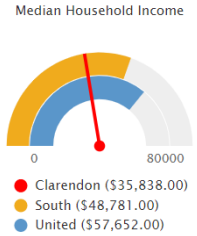


Income - Median Household Income

This indicator reports median household income based on the latest 5-year American Community Survey estimates. This includes the income of the householder and all other individuals 15 years old and over in the household, whether they are related to the householder or not. Because many households consist of only one person, average household income is usually less than average family income.

Report Area	Total Households	Average Household Income	Median Household Income
Clarendon County, SC	13,573	$51,417.00	$35,838.00
South Carolina	1,871,307	$66,759.00	$48,781.00
United States	118,825,921	$81,283.00	$57,652.00

Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2013-17. Source geography: Tract → Show more details



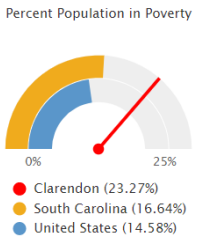
Poverty - Population Below 100% FPL

Poverty is considered a *key driver* of health status.

Within the report area 23.27% or 7,551 individuals are living in households with income below the Federal Poverty Level (FPL). This indicator is relevant because poverty creates barriers to access including health services, healthy food, and other necessities that contribute to poor health status.

Report Area	Total Population	Population in Poverty	Percent Population in Poverty
Clarendon County, SC	32,455	7,551	23.27%
South Carolina	4,751,345	790,657	16.64%
United States	313,048,563	45,650,345	14.58%

Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2013-17. Source geography: Tract → Show more details



Clarendon County, SC

Physical Environment

A community's health also is affected by the physical environment. A safe, clean environment that provides access to healthy food and recreational opportunities is important to maintaining and improving community health.

Air Quality - Respiratory Hazard Index

This indicator reports the non-cancer respiratory hazard index score. This score represents the potential for non-cancer adverse health effects, where scores less than 1.0 indicate adverse health effects are unlikely, and scores of 1.0 or more indicate a potential for adverse health effects.

Report Area	Total Population	Respiratory Hazard Index Score
Clarendon County, SC	34,971	1.48
South Carolina	4,625,357	1.63
United States	312,576,287	1.83

Data Source: EPA National Air Toxics Assessment. → Show more details

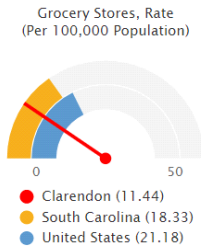
Food Environment - Grocery Stores

This indicator reports the number of grocery stores per 100,000 population. Grocery stores are defined as supermarkets and smaller grocery stores primarily engaged in retailing a general line of food, such as canned and frozen foods; fresh fruits and vegetables; and fresh and prepared meats, fish, and poultry. Included are delicatessen-type establishments. Convenience stores and large general merchandise stores that also retail food, such as supercenters and warehouse club stores are excluded. This indicator is relevant because it provides a measure of healthy food access and environmental influences on dietary behaviors.

Report Area	Total Population	Number of Establishments	Establishments, Rate per 100,000 Population
Clarendon County, SC	34,971	4	11.44
South Carolina	4,625,364	848	18.33
United States	308,745,538	65,399	21.18

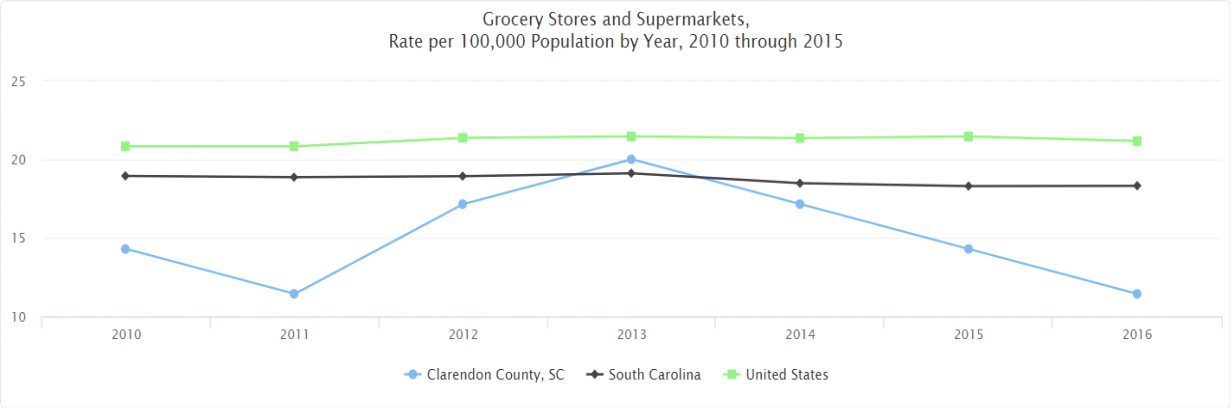
Note: This indicator is compared to the state average.

Data Source: US Census Bureau, County Business Patterns. Additional data analysis by CARES. 2016. Source geography: ZCTA → Show more details



Grocery Stores and Supermarkets, Rate per 100,000 Population by Year, 2010 through 2015

Report Area	2010	2011	2012	2013	2014	2015	2016
Clarendon County, SC	14.3	11.44	17.16	20.02	17.16	14.3	11.44
South Carolina	18.96	18.87	18.94	19.13	18.49	18.31	18.33
United States	20.85	20.85	21.39	21.47	21.37	21.47	21.18



Food Environment - SNAP-Authorized Food Stores

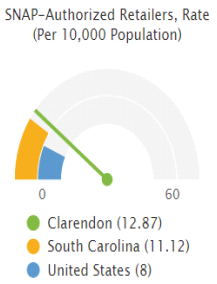
This indicator reports the number of SNAP-authorized food stores as a rate per 10,000 population. SNAP-authorized stores include grocery stores as well as supercenters, specialty food stores, and convenience stores that are authorized to accept SNAP (Supplemental Nutrition Assistance Program) benefits.

Report Area	Total Population	Total SNAP-Authorized Retailers	SNAP-Authorized Retailers, Rate per 10,000 Population
Clarendon County, SC	34,971	45	12.87
South Carolina	4,625,364	5,145	11.12
United States	312,383,875	250,022	8

Note: This indicator is compared to the state average.

Data Source: US Department of Agriculture, Food and Nutrition Service, USDA - SNAP Retailer Locator. Additional data analysis by CARES. 2019. Source geography: Tract

→ Show more details



Clinical Care

A lack of access to care presents barriers to good health. The supply and accessibility of facilities and physicians, the rate of uninsured, financial hardship, transportation barriers, cultural competency, and coverage limitations affect access.

Rates of morbidity, mortality, and emergency hospitalizations can be reduced if community residents access services such as health screenings, routine tests, and vaccinations. Prevention indicators can call attention to a lack of access or knowledge regarding one or more health issues and can inform program interventions.

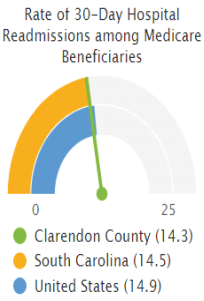
30-Day Hospital Readmissions

This indicator reports the percentage of Medicare fee-for-service beneficiaries readmitted to a hospital within 30 days of an initial hospitalization discharge.

Report Area	Medicare Part A and B Beneficiaries	Rate of 30-Day Hospital Readmissions among Medicare Beneficiaries
Clarendon County, SC	481	14.3
South Carolina	52,069	14.5
United States	2,885,032	14.9

Note: This indicator is compared to the state average.

Data Source: Dartmouth College Institute for Health Policy & Clinical Practice, Dartmouth Atlas of Health Care. → Show more details



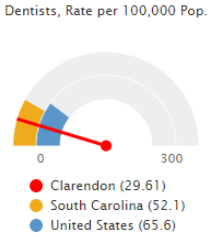
Access to Dentists

This indicator reports the number of dentists per 100,000 population. This indicator includes all dentists - qualified as having a doctorate in dental surgery (D.D.S.) or dental medicine (D.M.D.), who are licensed by the state to practice dentistry and who are practicing within the scope of that license.

Report Area	Total Population, 2015	Dentists, 2015	Dentists, Rate per 100,000 Pop.
Clarendon County, SC	33,775	10	29.61
South Carolina	4,896,146	2,549	52.1
United States	321,418,820	210,832	65.6

Note: This indicator is compared to the state average.

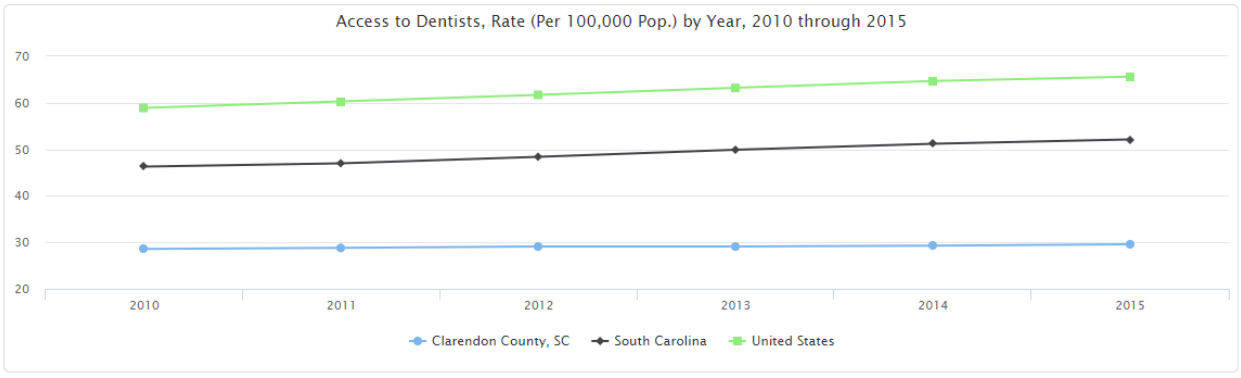
Data Source: US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File. 2015. Source geography: County → Show more details



Access to Dentists, Rate (Per 100,000 Pop.) by Year, 2010 through 2015

This indicator reports the rate of dentists per 100,000 population by year.

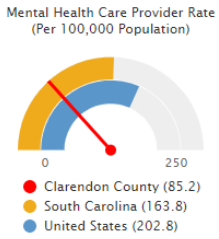
Report Area	2010	2011	2012	2013	2014	2015
Clarendon County, SC	28.6	28.8	29.1	29.1	29.3	29.6
South Carolina	46.3	47	48.4	49.9	51.2	52.1
United States	58.9	60.3	61.7	63.2	64.7	65.6



Access to Mental Health Providers

This indicator reports the rate of the county population to the number of mental health providers including psychiatrists, psychologists, clinical social workers, and counsellors that specialize in mental health care.

Report Area	Estimated Population	Number of Mental Health Providers	Ratio of Mental Health Providers to Population (1 Provider per x Persons)	Mental Health Care Provider Rate (Per 100,000 Population)
Clarendon County, SC	34,057	29	1,174.4	85.2
South Carolina	5,024,369	8,231	610.4	163.8
United States	317,105,555	643,219	493	202.8

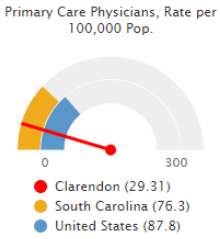


Note: This indicator is compared to the state average.
Data Source: University of Wisconsin Population Health Institute, County Health Rankings. 2017. Source geography: County ➞ Show more details

Access to Primary Care

This indicator reports the number of primary care physicians per 100,000 population. Doctors classified as "primary care physicians" by the AMA include: General Family Medicine MDs and DOs, General Practice MDs and DOs, General Internal Medicine MDs and General Pediatrics MDs. Physicians age 75 and over and physicians practicing sub-specialties within the listed specialties are excluded. This indicator is relevant because a shortage of health professionals contributes to access and health status issues.

Report Area	Total Population, 2014	Primary Care Physicians, 2014	Primary Care Physicians, Rate per 100,000 Pop.
Clarendon County, SC	34,113	10	29.31
South Carolina	4,832,482	3,689	76.3
United States	318,857,056	279,871	87.8

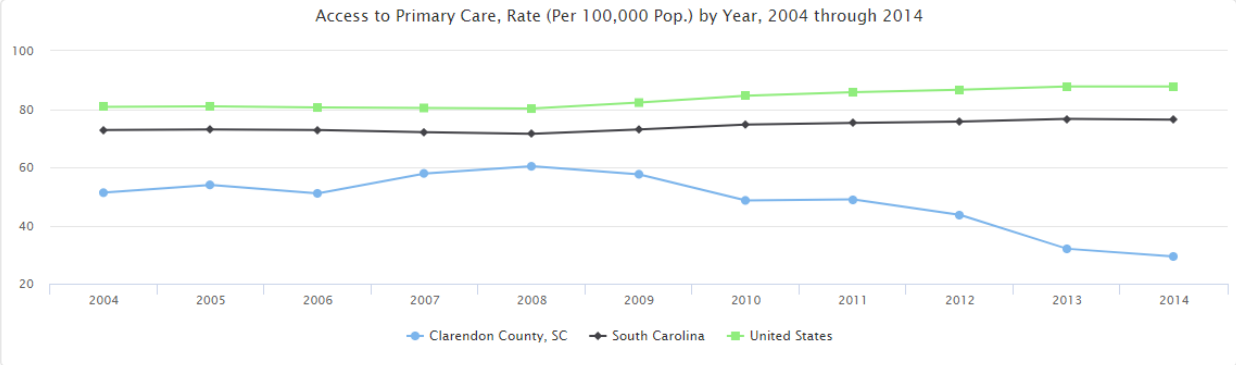


Note: This indicator is compared to the state average.
Data Source: US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File. 2014. Source geography: County ➞ Show more details

Access to Primary Care, Rate (Per 100,000 Pop.) by Year, 2004 through 2014

This indicator reports the rate of primary care physicians per 100,000 population by year.

Report Area	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Clarendon County, SC	51.27	53.95	50.99	57.89	60.33	57.6	48.61	48.95	43.66	32.02	29.31
South Carolina	72.8	73.02	72.83	72.03	71.48	72.98	74.7	75.2	75.66	76.63	76.34
United States	80.76	80.94	80.54	80.38	80.16	82.22	84.57	85.83	86.66	87.76	87.77

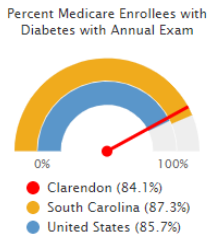


Diabetes Management - Hemoglobin A1c Test

This indicator reports the percentage of diabetic Medicare patients who have had a hemoglobin A1c (hA1c) test, a blood test which measures blood sugar levels, administered by a health care professional in the past year. In the report area, 517 Medicare enrollees with diabetes have had an annual exam out of 615 Medicare enrollees in the report area with diabetes, or 84.1%. This indicator is relevant because engaging in preventive behaviors allows for early detection and treatment of health problems. This indicator can also highlight a lack of access to preventive care, a lack of health knowledge, insufficient provider outreach, and/or social barriers preventing utilization of services.

Report Area	Total Medicare Enrollees	Medicare Enrollees with Diabetes	Medicare Enrollees with Diabetes with Annual Exam	Percent Medicare Enrollees with Diabetes with Annual Exam
Clarendon County, SC	4,479	615	517	84.1%
South Carolina	550,660	70,300	61,388	87.3%
United States	26,937,083	2,919,457	2,501,671	85.7%

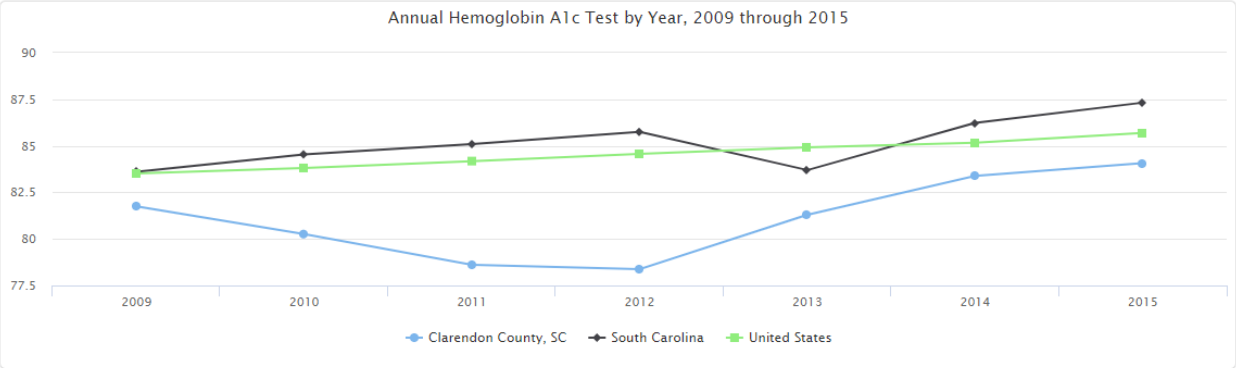
Note: *This indicator is compared to the state average.*
Data Source: *Dartmouth College Institute for Health Policy & Clinical Practice, Dartmouth Atlas of Health Care. 2015. Source geography: County → Show more details*



Annual Hemoglobin A1c Test by Year, 2009 through 2015

Percent of Medicare Beneficiaries with Diabetes with Annual Hemoglobin A1c Test

Report Area	2009	2010	2011	2012	2013	2014	2015
Clarendon County, SC	81.75	80.26	78.61	78.37	81.30	83.38	84.07
South Carolina	83.61	84.54	85.09	85.75	83.70	86.23	87.32
United States	83.52	83.81	84.18	84.57	84.92	85.16	85.69



Federally Qualified Health Centers

This indicator reports the number of Federally Qualified Health Centers (FQHCs) in the community. This indicator is relevant because FQHCs are community assets that provide health care to vulnerable populations; they receive extra funding from the federal government to promote access to ambulatory care in areas designated as medically underserved.

Report Area	Total Population	Number of Federally Qualified Health Centers	Rate of Federally Qualified Health Centers per 100,000 Population
Clarendon County, SC	34,971	3	8.58
South Carolina	4,625,364	187	4.04
United States	312,471,327	8,768	2.81

Health Professional Shortage Areas

This indicator reports the number and location of health care facilities designated as "Health Professional Shortage Areas" (HPSAs), defined as having shortages of primary medical care, dental or mental health providers. This indicator is relevant because a shortage of health professionals contributes to access and health status issues.

Report Area	Primary Care Facilities	Mental Health Care Facilities	Dental Health Care Facilities	Total HPSA Facility Designations
Clarendon County, SC	1	1	1	3
South Carolina	49	48	47	144
United States	3,599	3,171	3,071	9,836

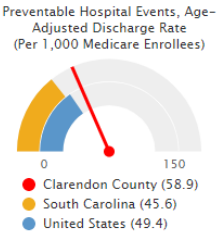
Data Source: US Department of Health & Human Services, Health Resources and Services Administration, Health Resources and Services Administration. February 2019. Source geography: Address → Show more details

Preventable Hospital Visits

This indicator reports the discharge rate (per 1,000 Medicare enrollees) for conditions that are ambulatory care sensitive (ACS). ACS conditions include pneumonia, dehydration, asthma, diabetes, and other conditions which could have been prevented if adequate primary care resources were available and accessed by those patients. This indicator is relevant because analysis of ACS discharges allows demonstrating a possible "return on investment" from interventions that reduce admissions (for example, for uninsured or Medicaid patients) through better access to primary care resources.

Report Area	Total Medicare Part A Enrollees	Ambulatory Care Sensitive Condition Hospital Discharges	Ambulatory Care Sensitive Condition Discharge Rate
Clarendon County, SC	3,450	203	58.9
South Carolina	434,703	19,801	45.6
United States	22,488,201	1,112,019	49.4

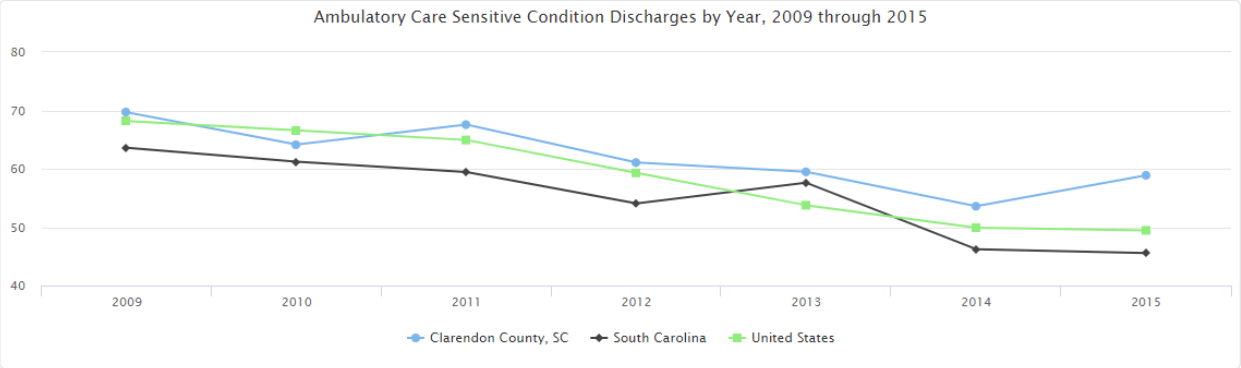
Note: This indicator is compared to the state average.
Data Source: Dartmouth College Institute for Health Policy & Clinical Practice, Dartmouth Atlas of Health Care. 2015. Source geography: County → Show more details



Ambulatory Care Sensitive Condition Discharges by Year, 2009 through 2015

Rate of Ambulatory Care Sensitive Condition Discharges (per 1,000 Medicare Part A Beneficiaries)

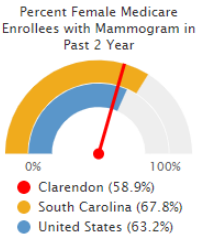
Report Area	2009	2010	2011	2012	2013	2014	2015
Clarendon County, SC	69.66	64.17	67.56	61.07	59.47	53.58	58.86
South Carolina	63.62	61.20	59.44	54.08	57.60	46.23	45.55
United States	68.16	66.58	64.93	59.29	53.76	49.90	49.45



Prevention - Mammogram

This indicator reports the percentage of female Medicare enrollees, age 67-69, who have received one or more mammograms in the past two years. This indicator is relevant because engaging in preventive behaviors allows for early detection and treatment of health problems. This indicator can also highlight a lack of access to preventive care, a lack of health knowledge, insufficient provider outreach, and/or social barriers preventing utilization of services.

Report Area	Total Medicare Enrollees	Female Medicare Enrollees Age 67-69	Female Medicare Enrollees with Mammogram in Past 2 Years	Percent Female Medicare Enrollees with Mammogram in Past 2 Year
Clarendon County, SC	4,479	472	278	58.9%
South Carolina	550,660	58,753	39,850	67.8%
United States	26,937,083	2,544,732	1,607,329	63.2%



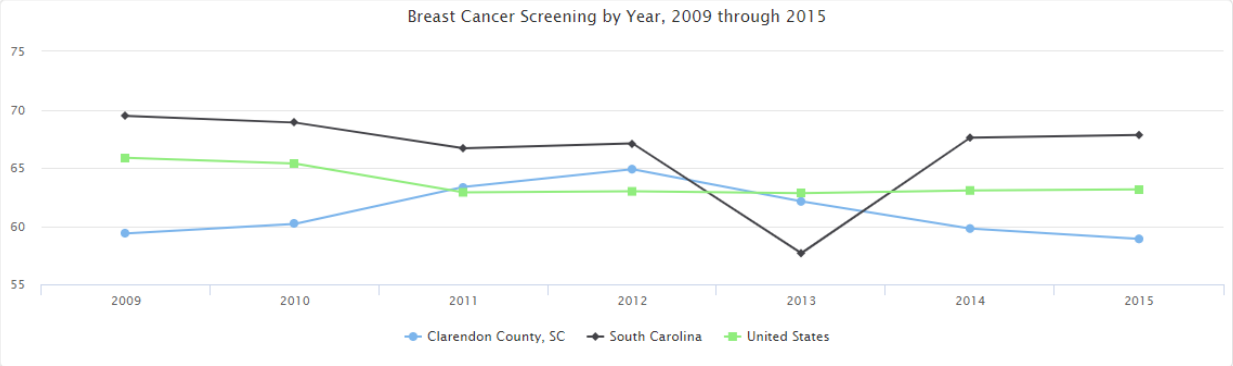
Note: This indicator is compared to the state average.

Data Source: Dartmouth College Institute for Health Policy & Clinical Practice, Dartmouth Atlas of Health Care. 2015. Source geography: County → Show more details

Breast Cancer Screening by Year, 2009 through 2015

Percent of Female Medicare Beneficiaries Age 67-69 with Mammogram trend

Report Area	2009	2010	2011	2012	2013	2014	2015
Clarendon County, SC	59.38	60.19	63.36	64.89	62.12	59.79	58.90
South Carolina	69.46	68.89	66.69	67.10	57.67	67.59	67.83
United States	65.87	65.37	62.90	62.98	62.82	63.06	63.16



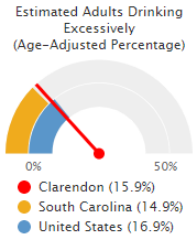
Health Behaviors

Health behaviors such as poor diet, a lack of exercise, and substance abuse contribute to poor health status.

Alcohol Consumption

This indicator reports the percentage of adults aged 18 and older who self-report heavy alcohol consumption (defined as more than two drinks per day on average for men and one drink per day on average for women). This indicator is relevant because current behaviors are determinants of future health and this indicator may illustrate a cause of significant health issues, such as cirrhosis, cancers, and untreated mental and behavioral health needs.

Report Area	Total Population Age 18+	Estimated Adults Drinking Excessively	Estimated Adults Drinking Excessively (Crude Percentage)	Estimated Adults Drinking Excessively (Age-Adjusted Percentage)
Clarendon County, SC	26,874	3,413	12.7%	15.9%
South Carolina	3,500,728	500,604	14.3%	14.9%
United States	232,556,016	38,248,349	16.4%	16.9%



Note: This indicator is compared to the state average.

Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health & Human Services, Health Indicators Warehouse. 2006-12. Source geography: County → Show more details

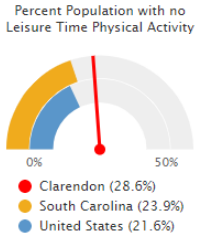
Physical Inactivity

Within the report area, 7,887 or 28.6% of adults aged 20 and older self-report no leisure time for activity, based on the question: "During the past month, other than your regular job, did you participate in any physical activities or exercises such as running, calisthenics, golf, gardening,

or walking for exercise?". This indicator is relevant because current behaviors are determinants of future health and this indicator may illustrate a cause of significant health issues, such as obesity and poor cardiovascular health.

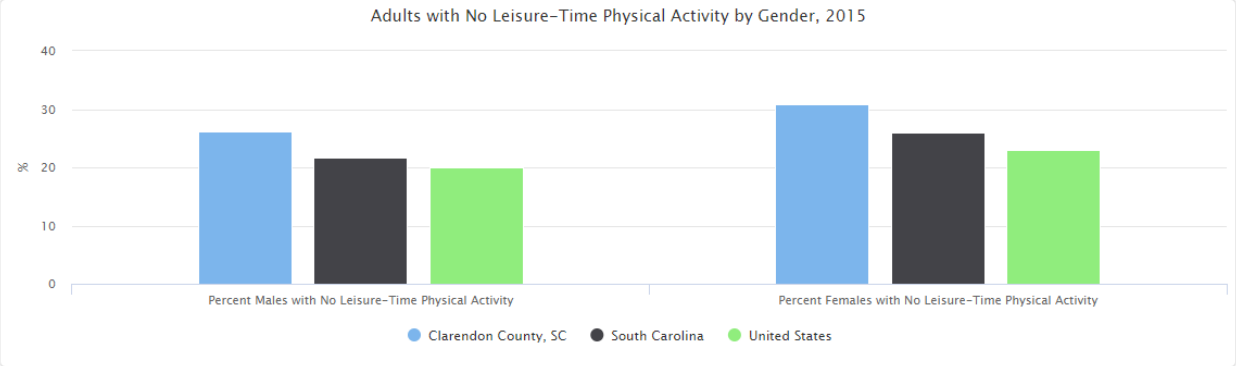
Report Area	Total Population Age 20+	Population with no Leisure Time Physical Activity	Percent Population with no Leisure Time Physical Activity
Clarendon County, SC	26,115	7,887	28.6%
South Carolina	3,674,036	907,850	23.9%
United States	238,798,321	52,960,511	21.6%

Note: This indicator is compared to the state average.
Data Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2015. Source geography: County ➞
Show more details



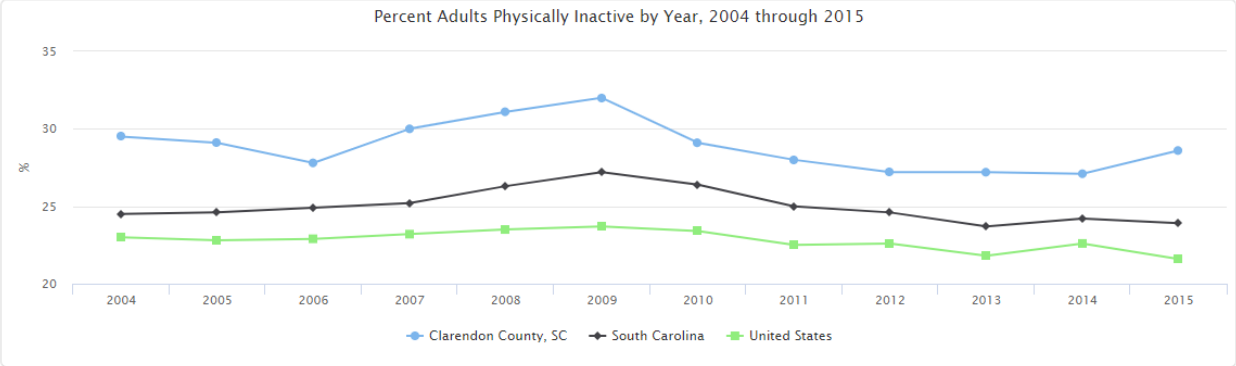
Adults with No Leisure-Time Physical Activity by Gender, 2015

Report Area	Total Males with No Leisure-Time Physical Activity	Percent Males with No Leisure-Time Physical Activity	Total Females with No Leisure-Time Physical Activity	Percent Females with No Leisure-Time Physical Activity
Clarendon County, SC	3,432	26.2%	4,456	30.9%
South Carolina	389,165	21.7%	518,684	25.9%
United States	23,655,542	20%	29,304,977	23%



Percent Adults Physically Inactive by Year, 2004 through 2015

Report Area	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Clarendon County, SC	29.5%	29.1%	27.8%	30%	31.1%	32%	29.1%	28%	27.2%	27.2%	27.1%	28.6%
South Carolina	24.5%	24.6%	24.9%	25.2%	26.3%	27.2%	26.4%	25%	24.6%	23.7%	24.2%	23.9%
United States	23%	22.8%	22.9%	23.2%	23.5%	23.7%	23.4%	22.5%	22.6%	21.8%	22.6%	21.6%

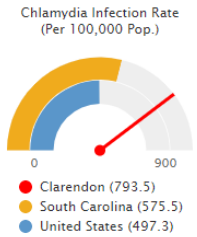


STI - Chlamydia Incidence

This indicator reports incidence rate of chlamydia cases per 100,000 population. This indicator is relevant because it is a measure of poor health status and indicates the prevalence of unsafe sex practices.

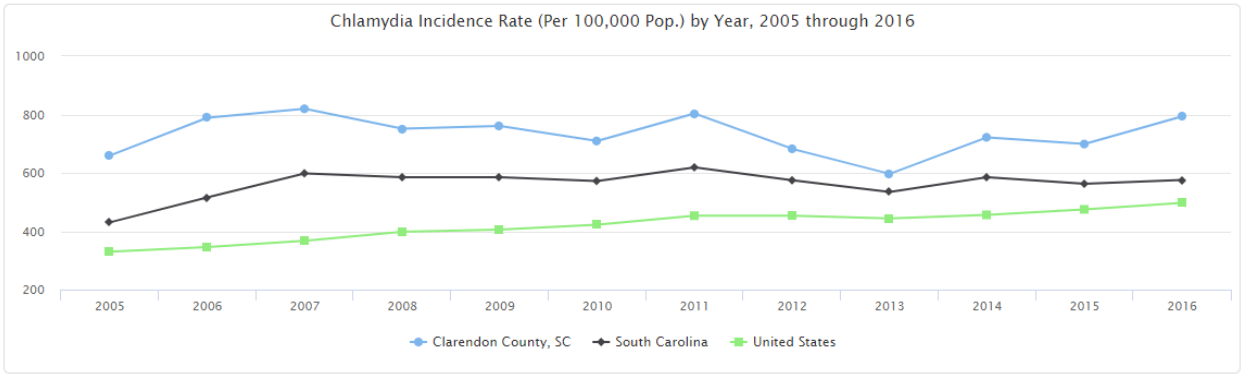
Report Area	Total Population	Total Chlamydia Infections	Chlamydia Infections, Rate (Per 100,000 Pop.)
Clarendon County, SC	33,775	268	793.5
South Carolina	4,896,146	28,179	575.5
United States	321,418,820	1,598,354	497.3

Note: This indicator is compared to the state average.
Data Source: US Department of Health & Human Services, Health Indicators Warehouse. Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2016. Source geography: County → Show more details



Chlamydia Incidence Rate (Per 100,000 Pop.) by Year, 2005 through 2016

Report Area	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Clarendon County, SC	659.41	788.87	819.57	751.15	760.88	709.16	803.43	682.49	596.71	721.87	698.74	793.49
South Carolina	430.39	515.7	598.38	585.25	585.25	572.11	619.06	574.77	534.8	585.5	562.44	575.53
United States	330.3	345.4	367.7	398	405.7	422.8	453.4	453.4	443.5	456.1	474.97	497.28



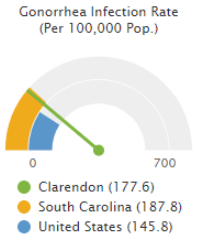
STI - Gonorrhea Incidence

This indicator reports incidence rate of Gonorrhea cases per 100,000 population. This indicator is relevant because it is a measure of poor health status and indicates the prevalence of unsafe sex practices.

Report Area	Total Population	Total Gonorrhea Infections	Gonorrhea Infections, Rate (Per 100,000 Pop.)
Clarendon County, SC	33,775	60	177.6
South Carolina	4,896,146	9,194	187.8
United States	321,418,820	468,514	145.8

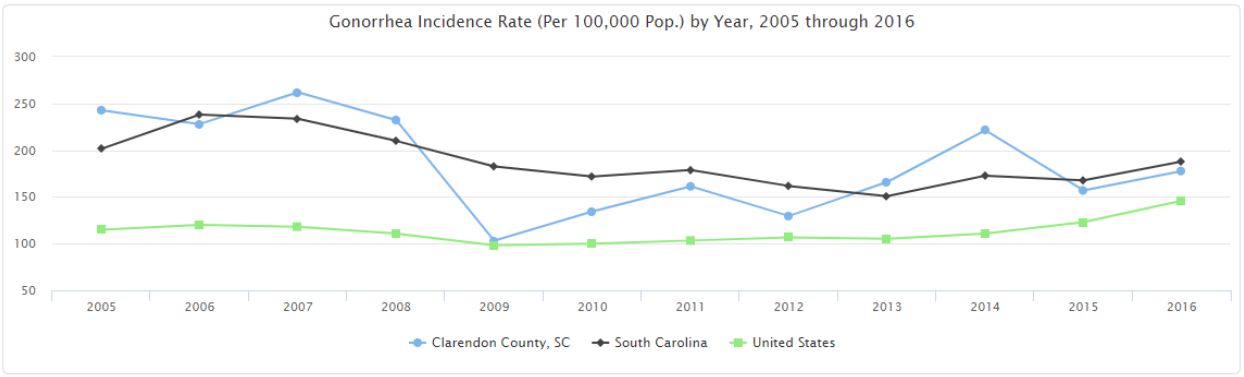
Note: This indicator is compared to the state average.

Data Source: US Department of Health & Human Services, Health Indicators Warehouse. Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2016. Source geography: County → Show more details



Gonorrhea Incidence Rate (Per 100,000 Pop.) by Year, 2005 through 2016

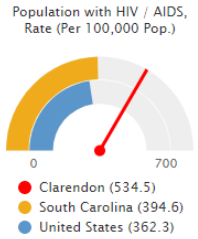
Report Area	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Clarendon County, SC	242.78	227.96	262.02	232.28	103.07	134.4	161.26	129.59	165.91	221.22	156.92	177.65
South Carolina	201.39	238.11	233.78	209.93	182.64	171.9	178.67	161.7	150.7	172.8	167.6	187.78
United States	114.9	120.1	118.1	110.7	98.2	100	103.3	106.7	105.3	110.7	122.96	145.76



STI - HIV Prevalence

This indicator reports prevalence rate of HIV per 100,000 population. This indicator is relevant because HIV is a life-threatening communicable disease that disproportionately affects minority populations and may also indicate the prevalence of unsafe sex practices.

Report Area	Population Age 13+	Population with HIV / AIDS	Population with HIV / AIDS, Rate (Per 100,000 Pop.)
Clarendon County, SC	29,000	155	534.5
South Carolina	4,111,529	16,224	394.6
United States	268,159,414	971,524	362.3

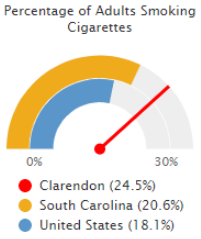


Note: This indicator is compared to the state average.
Data Source: US Department of Health & Human Services, Health Indicators Warehouse. Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2015. Source geography: County ➞ Show more details

Tobacco Usage - Current Smokers

In the report area an estimated 5,885, or 21.9% of adults age 18 or older self-report currently smoking cigarettes some days or every day. This indicator is relevant because tobacco use is linked to leading causes of death such as cancer and cardiovascular disease.

Report Area	Total Population Age 18+	Total Adults Regularly Smoking Cigarettes	Percent Population Smoking Cigarettes (Crude)	Percent Population Smoking Cigarettes (Age-Adjusted)
Clarendon County, SC	26,874	5,885	21.9%	24.5%
South Carolina	3,500,728	710,648	20.3%	20.6%
United States	232,556,016	41,491,223	17.8%	18.1%



Note: This indicator is compared to the state average.
Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health & Human Services, Health Indicators Warehouse. 2006-12. Source geography: County ➞ Show more details

Health Outcomes

Measuring morbidity and mortality rates allows assessing linkages between social determinants of health and outcomes. By comparing, for example, the prevalence of certain chronic diseases to indicators in other categories (e.g., poor diet and exercise) with outcomes (e.g., high rates of obesity and diabetes), various causal relationship may emerge, allowing a better understanding of how certain community health needs may be addressed.

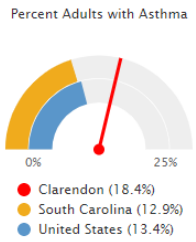
Asthma Prevalence

This indicator reports the percentage of adults aged 18 and older who self-report that they have ever been told by a doctor, nurse, or other health professional that they had asthma. This

indicator is relevant because asthma is a prevalent problem in the U.S. that is often exacerbated by poor environmental conditions.

Report Area	Survey Population (Adults Age 18+)	Total Adults with Asthma	Percent Adults with Asthma
Clarendon County, SC	24,219	4,463	18.4%
South Carolina	3,526,734	456,596	12.9%
United States	237,197,465	31,697,608	13.4%

Note: This indicator is compared to the state average.
Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES. 2011-12. Source geography: County ➞ Show more details

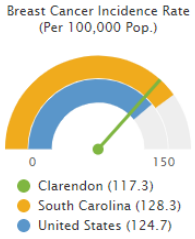


Cancer Incidence - All Sites

This indicator reports the age adjusted incidence rate (cases per 100,000 population per year) of females with breast cancer adjusted to 2000 U.S. standard population age groups (Under Age 1, 1-4, 5-9, ..., 80-84, 85 and older). This indicator is relevant because cancer is a leading cause of death and it is important to identify cancers separately to better target interventions.

Report Area	Estimated Total Population (Female)	New Cases (Annual Average)	Cancer Incidence Rate (Per 100,000 Pop.)
Clarendon County, SC	2,472	29	117.3
South Carolina	299,688	3,845	128.3
United States	18,800,721	234,445	124.7

Note: This indicator is compared to the state average.
Data Source: State Cancer Profiles. 2011-15. Source geography: County ➞ Show more details



Cancer Incidence - All Sites

This indicator reports the age adjusted incidence rate (cases per 100,000 population per year) of females with breast cancer adjusted to 2000 U.S. standard population age groups (Under Age 1, 1-4, 5-9, ..., 80-84, 85 and older). This indicator is relevant because cancer is a leading cause of death and it is important to identify cancers separately to better target interventions.

Report Area	Estimated Total Population (Female)	New Cases (Annual Average)	Cancer Incidence Rate (Per 100,000 Pop.)
Clarendon County, SC	2,472	29	117.3
South Carolina	299,688	3,845	128.3
United States	18,800,721	234,445	124.7

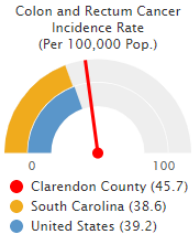
Note: This indicator is compared to the state average.
Data Source: State Cancer Profiles. 2011-15. Source geography: County ➞ Show more details

Cancer Incidence - Colon and Rectum

This indicator reports the age adjusted incidence rate (cases per 100,000 population per year) of colon and rectum cancer adjusted to 2000 U.S. standard population age groups (Under age 1, 1-4, 5-9, ..., 80-84, 85 and older). This indicator is relevant because cancer is a leading cause of death and it is important to identify cancers separately to better target interventions.

Report Area	Estimated Total Population	New Cases (Annual Average)	Cancer Incidence Rate (Per 100,000 Pop.)
Clarendon County, SC	4,595	21	45.7
South Carolina	561,398	2,167	38.6
United States	35,701,530	139,950	39.2

Note: This indicator is compared to the state average.
Data Source: State Cancer Profiles. 2011-15. Source geography: County → Show more details

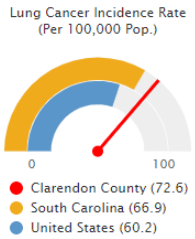


Cancer Incidence - Lung

This indicator reports the age adjusted incidence rate (cases per 100,000 population per year) of colon and rectum cancer adjusted to 2000 U.S. standard population age groups (Under age 1, 1-4, 5-9, ..., 80-84, 85 and older). This indicator is relevant because cancer is a leading cause of death and it is important to identify cancers separately to better target interventions.

Report Area	Estimated Total Population	New Cases (Annual Average)	Cancer Incidence Rate (Per 100,000 Pop.)
Clarendon County, SC	5,234	38	72.6
South Carolina	582,212	3,895	66.9
United States	36,137,043	217,545	60.2

Note: This indicator is compared to the state average.
Data Source: State Cancer Profiles. 2011-15. Source geography: County → Show more details



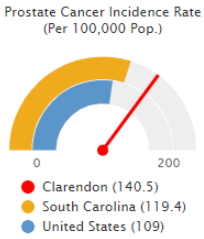
Cancer Incidence - Prostate

This indicator reports the age adjusted incidence rate (cases per 100,000 population per year) of males with prostate cancer adjusted to 2000 U.S. standard population age groups (Under age 1, 1-4, 5-9, ..., 80-84, 85 and older). This indicator is relevant because cancer is a leading cause of death and it is important to identify cancers separately to better target interventions.

Report Area	Estimated Total Population (Male)	New Cases (Annual Average)	Cancer Incidence Rate (Per 100,000 Pop.)
Clarendon County, SC	2,419	34	140.5
South Carolina	281,658	3,363	119.4
United States	17,489,816	190,639	109

Note: This indicator is compared to the state average.

Data Source: State Cancer Profiles. 2011-15. Source geography: County → Show more details



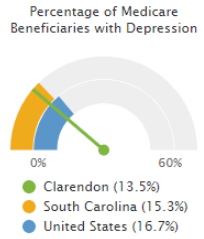
Depression (Medicare Population)

This indicator reports the percentage of the Medicare fee-for-service population with depression.

Report Area	Total Medicare Fee-for-Service Beneficiaries	Beneficiaries with Depression	Percent with Depression
Clarendon County, SC	5,610	758	13.5%
South Carolina	691,524	105,719	15.3%
United States	34,118,227	5,695,629	16.7%

Note: This indicator is compared to the state average.

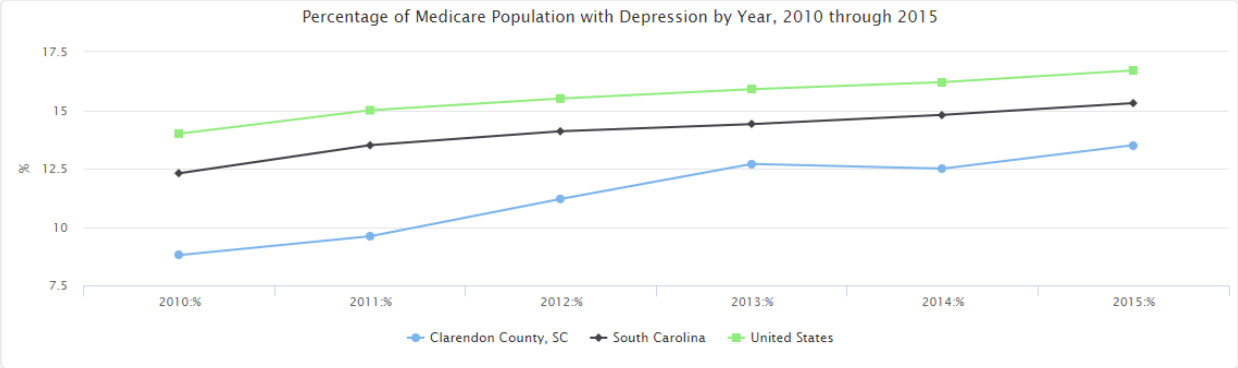
Data Source: Centers for Medicare and Medicaid Services. 2015. Source geography: County → Show more details



Percentage of Medicare Population with Depression by Year, 2010 through 2015

This indicator reports the percentage trend of the Medicare fee-for-service population with depression over time.

Report Area	2010	2011	2012	2013	2014	2015
Clarendon County, SC	8.8%	9.6%	11.2%	12.7%	12.5%	13.5%
South Carolina	12.3%	13.5%	14.1%	14.4%	14.8%	15.3%
United States	14%	15%	15.5%	15.9%	16.2%	16.7%

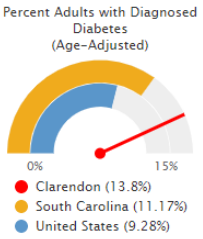


Diabetes (Adult)

This indicator reports the percentage of adults aged 20 and older who have ever been told by a doctor that they have diabetes. This indicator is relevant because diabetes is a prevalent problem in the U.S.; it may indicate an unhealthy lifestyle and puts individuals at risk for further health issues.

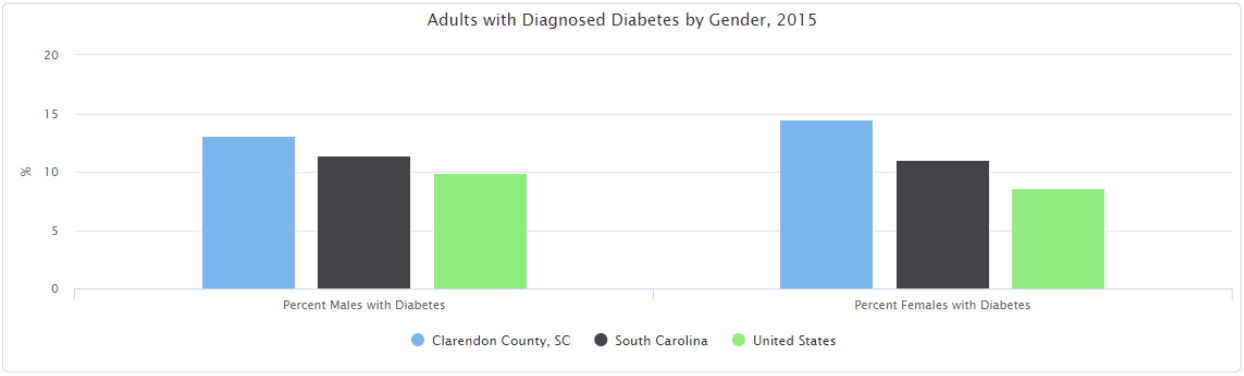
Report Area	Total Population Age 20+	Population with Diagnosed Diabetes	Population with Diagnosed Diabetes, Age-Adjusted Rate
Clarendon County, SC	26,130	4,416	13.8%
South Carolina	3,675,498	463,200	11.17%
United States	241,492,750	24,722,757	9.28%

Note: This indicator is compared to the state average.
Data Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2015. Source geography: County →
Show more details



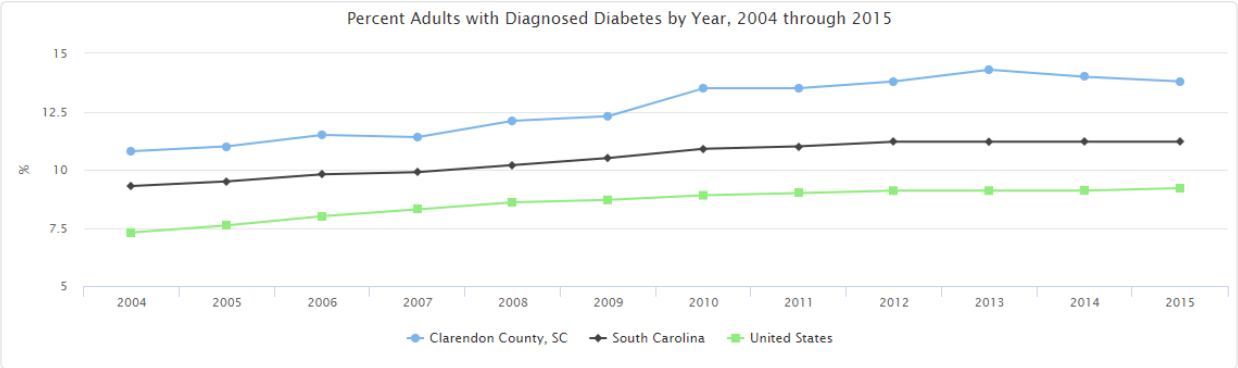
Adults with Diagnosed Diabetes by Gender, 2015

Report Area	Total Males with Diabetes	Percent Males with Diabetes	Total Females with Diabetes	Percent Females with Diabetes
Clarendon County, SC	1,971	13.1%	2,446	14.5%
South Carolina	221,906	11.4%	241,297	11%
United States	12,333,249	9.9%	11,950,019	8.6%



Percent Adults with Diagnosed Diabetes by Year, 2004 through 2015

Report Area	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Clarendon County, SC	10.8%	11%	11.5%	11.4%	12.1%	12.3%	13.5%	13.5%	13.8%	14.3%	14%	13.8%
South Carolina	9.3%	9.5%	9.8%	9.9%	10.2%	10.5%	10.9%	11%	11.2%	11.2%	11.2%	11.2%
United States	7.3%	7.6%	8%	8.3%	8.6%	8.7%	8.9%	9%	9.1%	9.1%	9.1%	9.2%

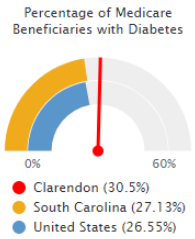


Diabetes (Medicare Population)

This indicator reports the percentage of the Medicare fee-for-service population with diabetes.

Report Area	Total Medicare Fee-for-Service Beneficiaries	Beneficiaries with Diabetes	Percent with Diabetes
Clarendon County, SC	5,610	1,711	30.5%
South Carolina	691,524	187,643	27.13%
United States	34,118,227	9,057,809	26.55%

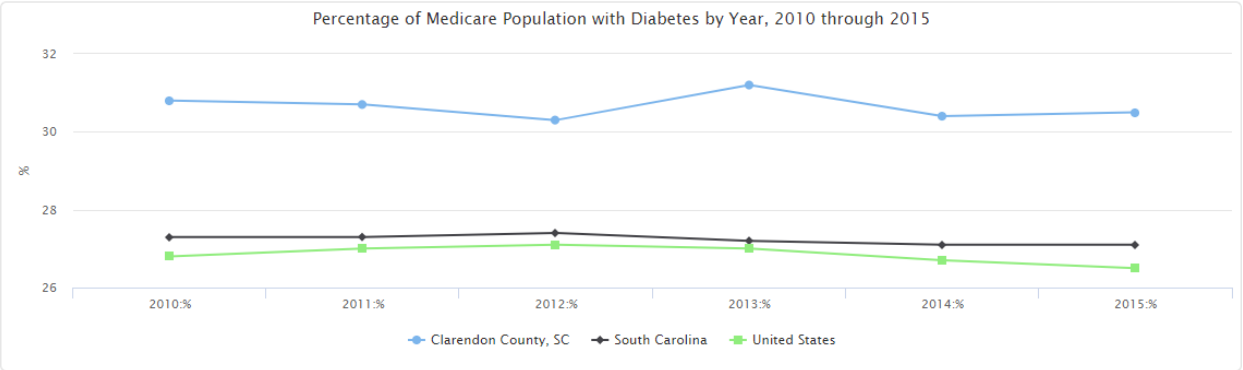
Note: *This indicator is compared to the state average.*
Data Source: Centers for Medicare and Medicaid Services. 2015. Source geography: County → Show more details



Percentage of Medicare Population with Diabetes by Year, 2010 through 2015

This indicator reports the percentage trend of the Medicare fee-for-service population with diabetes over time.

Report Area	2010	2011	2012	2013	2014	2015
Clarendon County, SC	30.8%	30.7%	30.3%	31.2%	30.4%	30.5%
South Carolina	27.3%	27.3%	27.4%	27.2%	27.1%	27.1%
United States	26.8%	27%	27.1%	27%	26.7%	26.5%

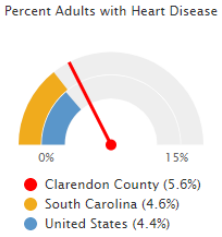


Heart Disease (Adult)

1,327, or 5.6% of adults aged 18 and older have ever been told by a doctor that they have coronary heart disease or angina. This indicator is relevant because coronary heart disease is a leading cause of death in the U.S. and is also related to high blood pressure, high cholesterol, and heart attacks.

Report Area	Survey Population (Adults Age 18+)	Total Adults with Heart Disease	Percent Adults with Heart Disease
Clarendon County, SC	23,815	1,327	5.6%
South Carolina	3,509,878	163,079	4.6%
United States	236,406,904	10,407,185	4.4%

Note: This indicator is compared to the state average.
Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES. 2011-12. Source geography: County → Show more details

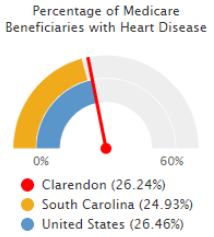


Heart Disease (Medicare Population)

This indicator reports the percentage of the Medicare fee-for-service population with ischaemic heart disease.

Report Area	Total Medicare Fee-for-Service Beneficiaries	Beneficiaries with Heart Disease	Percent with Heart Disease
Clarendon County, SC	5,610	1,472	26.24%
South Carolina	691,524	172,428	24.93%
United States	34,118,227	9,028,604	26.46%

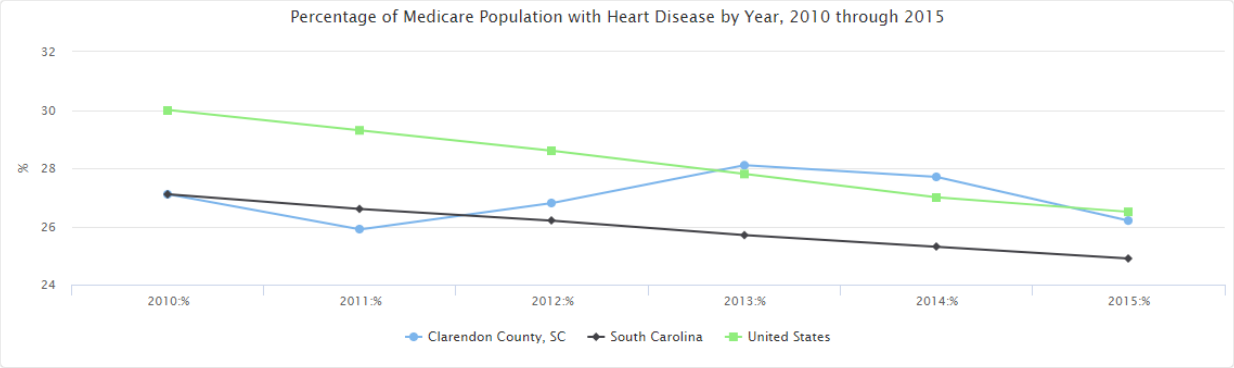
Note: This indicator is compared to the state average.
Data Source: Centers for Medicare and Medicaid Services. 2015. Source geography: County → Show more details



Percentage of Medicare Population with Heart Disease by Year, 2010 through 2015

This indicator reports the percentage trend of the Medicare fee-for-service population with ischaemic heart disease over time.

Report Area	2010	2011	2012	2013	2014	2015
Clarendon County, SC	27.1%	25.9%	26.8%	28.1%	27.7%	26.2%
South Carolina	27.1%	26.6%	26.2%	25.7%	25.3%	24.9%
United States	30%	29.3%	28.6%	27.8%	27%	26.5%

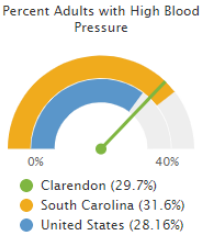


High Blood Pressure (Adult)

7,982, or 29.7% of adults aged 18 and older have ever been told by a doctor that they have high blood pressure or hypertension.

Report Area	Total Population (Age 18+)	Total Adults with High Blood Pressure	Percent Adults with High Blood Pressure
Clarendon County, SC	26,874	7,982	29.7%
South Carolina	3,500,728	1,106,230	31.6%
United States	232,556,016	65,476,522	28.16%

Note: *This indicator is compared to the state average.*
Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health & Human Services, Health Indicators Warehouse. 2006-12. Source geography: County ➞ Show more details

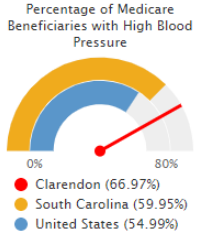


High Blood Pressure (Medicare Population)

This indicator reports the percentage of the Medicare fee-for-service population with hypertension (high blood pressure).

Report Area	Total Medicare Fee-for-Service Beneficiaries	Beneficiaries with High Blood Pressure	Percent with High Blood Pressure
Clarendon County, SC	5,610	3,757	66.97%
South Carolina	691,524	414,573	59.95%
United States	34,118,227	18,761,681	54.99%

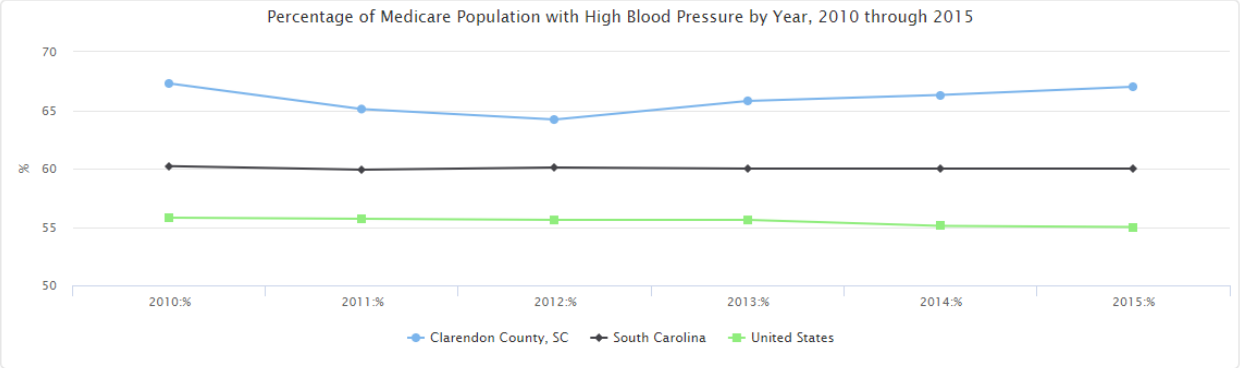
Note: *This indicator is compared to the state average.*
Data Source: Centers for Medicare and Medicaid Services. 2015. Source geography: County ➞ Show more details



Percentage of Medicare Population with High Blood Pressure by Year, 2010 through 2015

This indicator reports the percentage trend of the Medicare fee-for-service population with ischaemic heart disease over time.

Report Area	2010	2011	2012	2013	2014	2015
Clarendon County, SC	67.3%	65.1%	64.2%	65.8%	66.3%	67%
South Carolina	60.2%	59.9%	60.1%	60%	60%	60%
United States	55.8%	55.7%	55.6%	55.6%	55.1%	55%

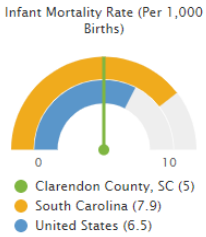


Infant Mortality

This indicator reports the rate of deaths to infants less than one year of age per 1,000 births. This indicator is relevant because high rates of infant mortality indicate the existence of broader issues pertaining to access to care and maternal and child health.

Report Area	Total Births	Total Infant Deaths	Infant Mortality Rate (Per 1,000 Births)
Clarendon County, SC	1,995	10	5
South Carolina	302,210	2,387	7.9
United States	20,913,535	136,369	6.5

Note: This indicator is compared to the state average.
Data Source: US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File. 2006-10. Source geography: County
→ Show more details

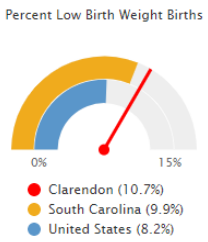


Low Birth Weight

This indicator reports the percentage of total births that are low birth weight (Under 2500g). This indicator is relevant because low birth weight infants are at high risk for health problems. This indicator can also highlight the existence of health disparities.

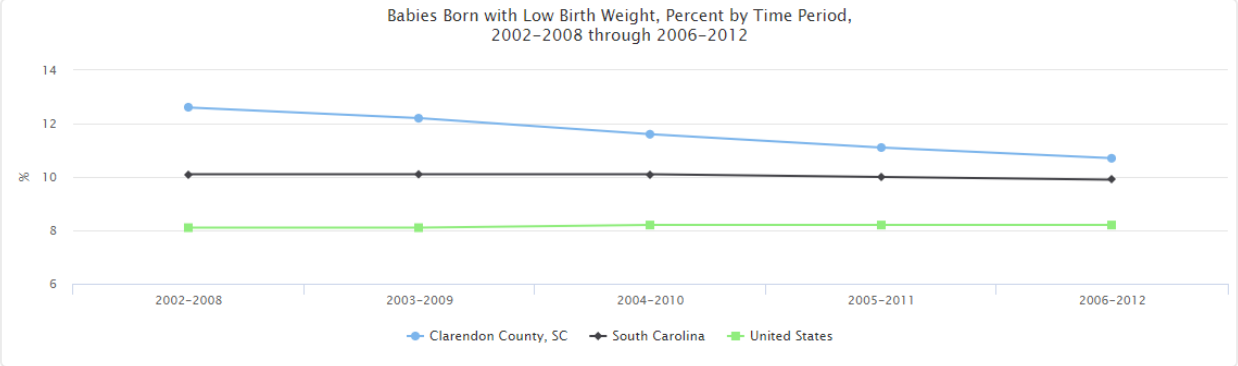
Report Area	Total Live Births	Low Weight Births (Under 2500g)	Low Weight Births, Percent of Total
Clarendon County, SC	2,849	305	10.7%
South Carolina	418,684	41,450	9.9%
United States	29,300,495	2,402,641	8.2%

Note: This indicator is compared to the state average.
Data Source: US Department of Health & Human Services, Health Indicators Warehouse. Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. 2006-12. Source geography: County → Show more details



Babies Born with Low Birth Weight, Percent by Time Period, 2002-2008 through 2006-2012

Report Area	2002-2008	2003-2009	2004-2010	2005-2011	2006-2012
Clarendon County, SC	12.6%	12.2%	11.6%	11.1%	10.7%
South Carolina	10.1%	10.1%	10.1%	10%	9.9%
United States	8.1%	8.1%	8.2%	8.2%	8.2%

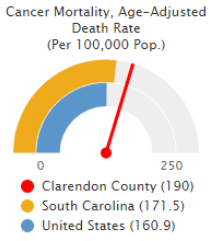


Mortality - Cancer

This indicator reports the rate of death due to malignant neoplasm (cancer) per 100,000 population. Figures are reported as crude rates, and as rates age-adjusted to year 2000 standard. Rates are re-summarized for report areas from county level data, only where data is available. This indicator is relevant because cancer is a leading cause of death in the United States.

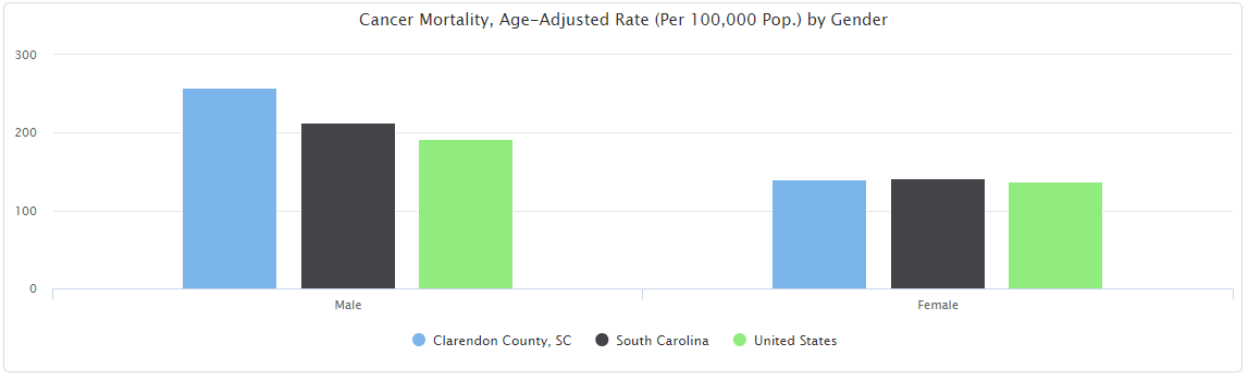
Report Area	Total Population	Average Annual Deaths, 2012-2016	Crude Death Rate (Per 100,000 Pop.)	Age-Adjusted Death Rate (Per 100,000 Pop.)
Clarendon County, SC	34,110	91	267.4	190
South Carolina	4,837,662	9,942	205.51	171.5
United States	318,689,254	590,634	185.3	160.9

Note: This indicator is compared to the state average.
Data Source: Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. 2012-16. Source geography: County → Show more details



Cancer Mortality, Age-Adjusted Rate (Per 100,000 Pop.) by Gender

Report Area	Male	Female
Clarendon County, SC	257.38	140.29
South Carolina	213.27	141.41
United States	192.58	137.85



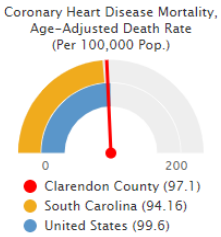
Mortality - Coronary Heart Disease

Within the report area the rate of death due to coronary heart disease (ICD10 Codes I20-I25) per 100,000 population is 97.1. This rate is less than the Healthy People 2020 target of less than or equal to 103.4. Figures are reported as crude rates, and as rates age-adjusted to year 2000 standard. Rates are re-summarized for report areas from county level data, only where data is available. This indicator is relevant because heart disease is a leading cause of death in the United States.

Report Area	Total Population	Average Annual Deaths, 2012-2016	Crude Death Rate (Per 100,000 Pop.)	Age-Adjusted Death Rate (Per 100,000 Pop.)
Clarendon County, SC	34,110	45	131.3	97.1
South Carolina	4,837,662	5,270	108.94	94.16
United States	318,689,254	367,306	115.3	99.6

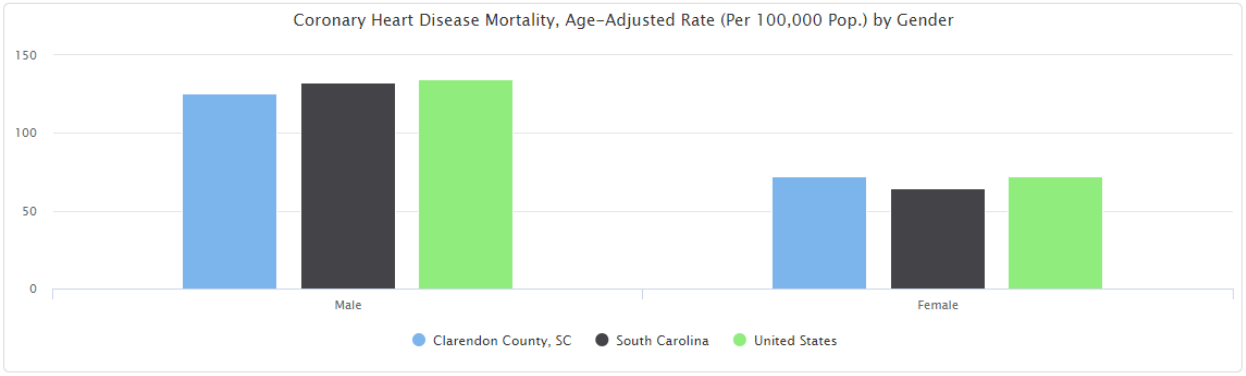
Note: This indicator is compared to the state average.

Data Source: Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. 2012-16. Source geography: County → Show more details



Coronary Heart Disease Mortality, Age-Adjusted Rate (Per 100,000 Pop.) by Gender

Report Area	Male	Female
Clarendon County, SC	125.26	72.48
South Carolina	132.26	64.66
United States	134.28	72.41



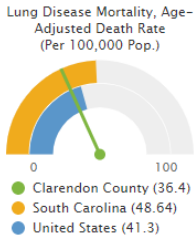
Mortality - Lung Disease

This indicator reports the rate of death due to chronic lower respiratory disease per 100,000 population. Figures are reported as crude rates, and as rates age-adjusted to year 2000 standard. Rates are re-summarized for report areas from county level data, only where data is available. This indicator is relevant because lung disease is a leading cause of death in the United States.

Report Area	Total Population	Average Annual Deaths, 2012-2016	Crude Death Rate (Per 100,000 Pop.)	Age-Adjusted Death Rate (Per 100,000 Pop.)
Clarendon County, SC	34,110	17	49.8	36.4
South Carolina	4,837,662	2,743	56.71	48.64
United States	318,689,254	149,886	47	41.3

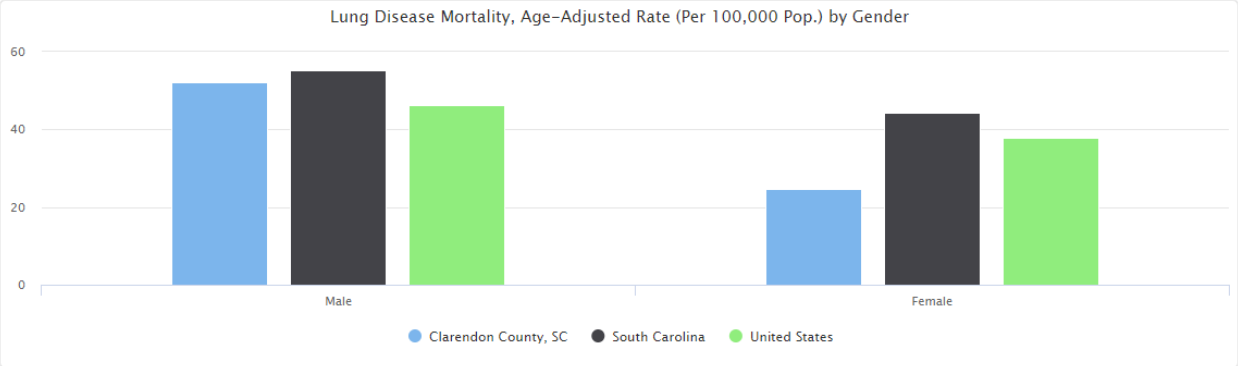
Note: This indicator is compared to the state average.

Data Source: Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. 2012-16. Source geography: County → Show more details



Lung Disease Mortality, Age-Adjusted Rate (Per 100,000 Pop.) by Gender

Report Area	Male	Female
Clarendon County, SC	52.17	24.71
South Carolina	55.35	44.2
United States	46.19	37.88

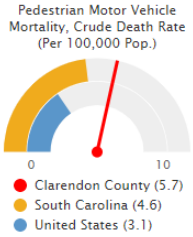


Mortality - Pedestrian Motor Vehicle Crash

This indicator reports the crude rate of pedestrians killed by motor vehicles per 100,000 population. This indicator is relevant because pedestrian-motor vehicle crash deaths are preventable and they are a cause of premature death.

Report Area	Total Population (2010)	Total Pedestrian Deaths, 2011-2015	Average Annual Deaths, Rate per 100,000 Pop.
Clarendon County, SC	34,971	6	5.7
South Carolina	4,625,364	645	4.6
United States	312,732,537	28,832	3.1

Note: *This indicator is compared to the state average.*
Data Source: *US Department of Transportation, National Highway Traffic Safety Administration, Fatality Analysis Reporting System. 2011-2015. Source geography: County* ➞ Show more details

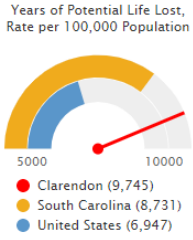


Mortality - Premature Death

This indicator reports Years of Potential Life Lost (YPLL) before age 75 per 100,000 population for all causes of death, age-adjusted to the 2000 standard. YPLL measures premature death and is calculated by subtracting the age of death from the 75-year benchmark. This indicator is relevant because a measure of premature death can provide a unique and comprehensive look at overall health status.

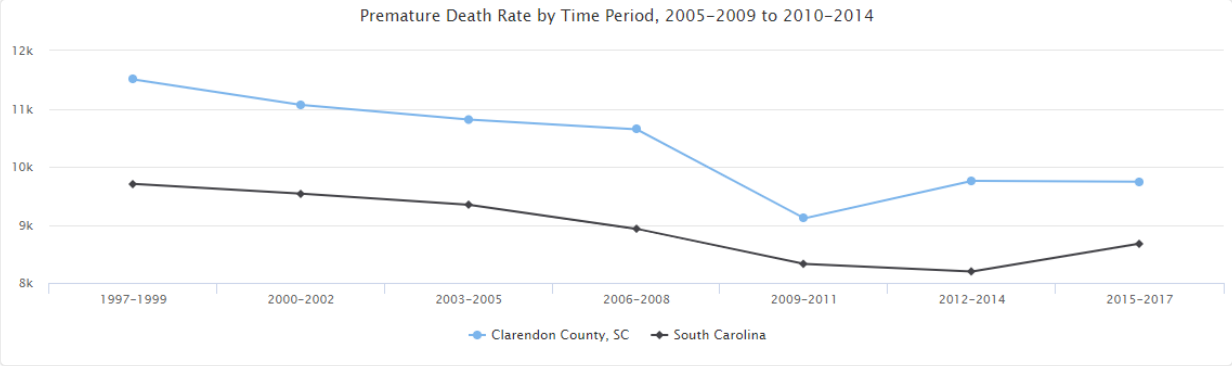
Report Area	Total Population	Total Premature Death, 2013-2017	Total Years of Potential Life Lost, 2013-2017 Average	Years of Potential Life Lost, Rate per 100,000 Population
Clarendon County, SC	93,324	649	9,094	9,745
South Carolina	13,928,349	73,733	1,216,076	8,731
United States	908,082,355	3,744,894	63,087,358	6,947

Note: *This indicator is compared to the state average.*
Data Source: *University of Wisconsin Population Health Institute, County Health Rankings. 2015-17. Source geography: County* ➞ Show more details



Premature Death Rate by Time Period, 2005-2009 to 2010-2014

Report Area	1997-1999	2000-2002	2003-2005	2006-2008	2009-2011	2012-2014	2015-2017
Clarendon County, SC	11,506.6	11,063.4	10,812.4	10,646.68	9,113.6	9,756.2	9,744.87
South Carolina	9,707.6	9,538.1	9,347.9	8,932.05	8,328	8,197.4	8,678.14



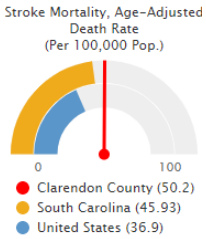
Mortality - Stroke

Within the report area there are an estimated 50.2 deaths due to cerebrovascular disease (stroke) per 100,000 population. This is greater than the Healthy People 2020 target of less than or equal to 33.8. Figures are reported as crude rates, and as rates age-adjusted to year 2000 standard. Rates are re-summarized for report areas from county level data, only where data is available. This indicator is relevant because stroke is a leading cause of death in the United States.

Report Area	Total Population	Average Annual Deaths, 2012-2016	Crude Death Rate (Per 100,000 Pop.)	Age-Adjusted Death Rate (Per 100,000 Pop.)
Clarendon County, SC	34,110	23	67.4	50.2
South Carolina	4,837,662	2,495	51.58	45.93
United States	318,689,254	134,618	42.2	36.9

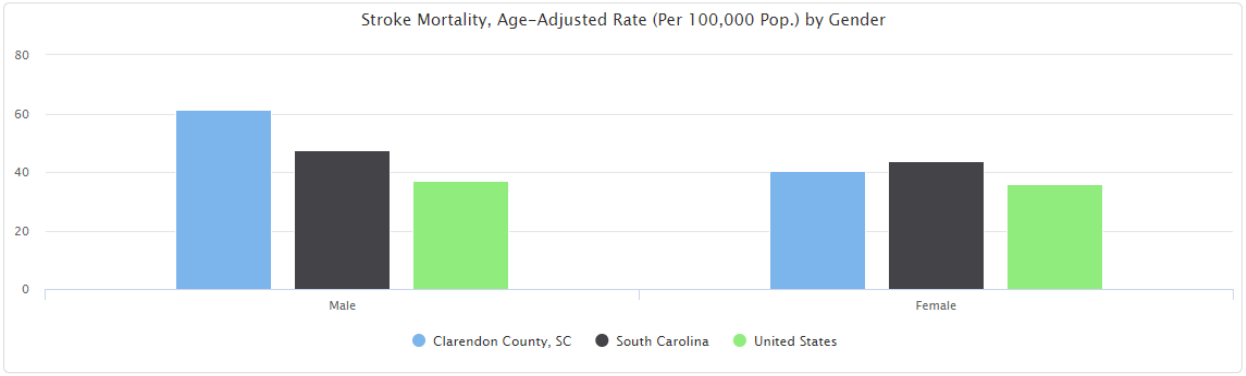
Note: This indicator is compared to the state average.

Data Source: Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. 2012-16. Source geography: County → Show more details



Stroke Mortality, Age-Adjusted Rate (Per 100,000 Pop.) by Gender

Report Area	Male	Female
Clarendon County, SC	61.19	40.49
South Carolina	47.41	43.91
United States	37.18	36.04



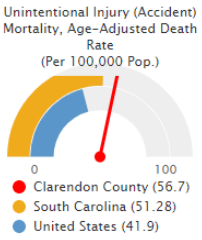
Mortality - Unintentional Injury

This indicator reports the rate of death due to unintentional injury (accident) per 100,000 population. Figures are reported as crude rates, and as rates age-adjusted to year 2000 standard. Rates are re-summarized for report areas from county level data, only where data is available. This indicator is relevant because accidents are a leading cause of death in the U.S.

Report Area	Total Population	Average Annual Deaths, 2012-2016	Crude Death Rate (Per 100,000 Pop.)	Age-Adjusted Death Rate (Per 100,000 Pop.)
Clarendon County, SC	34,110	22	63.3	56.7
South Carolina	4,837,662	2,562	52.95	51.28
United States	318,689,254	140,444	44.1	41.9

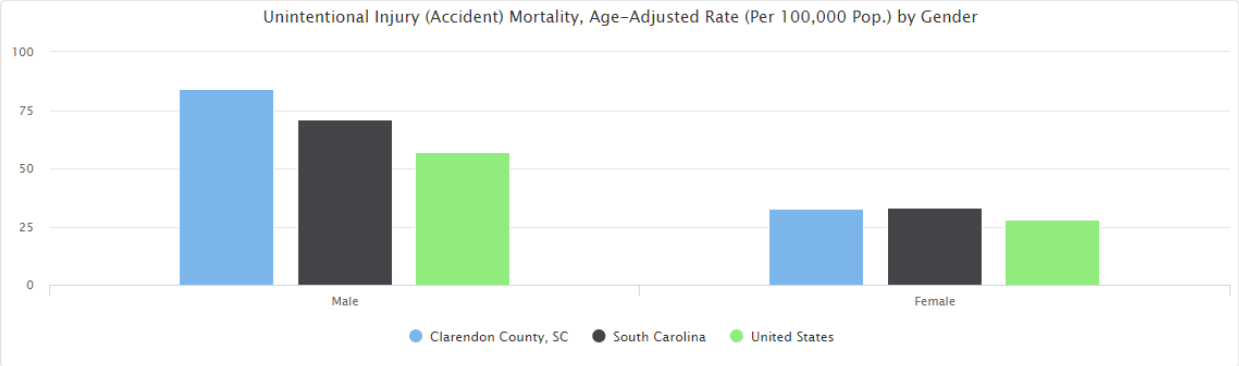
Note: This indicator is compared to the state average.

Data Source: Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. 2012-16. Source geography: County → Show more details



Unintentional Injury (Accident) Mortality, Age-Adjusted Rate (Per 100,000 Pop.) by Gender

Report Area	Male	Female
Clarendon County, SC	84.2	32.88
South Carolina	71.15	33.19
United States	56.87	27.98

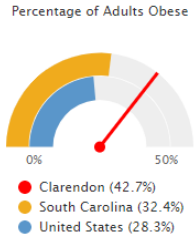


Obesity

42.7% of adults aged 20 and older self-report that they have a Body Mass Index (BMI) greater than 30.0 (obese) in the report area. Excess weight may indicate an unhealthy lifestyle and puts individuals at risk for further health issues.

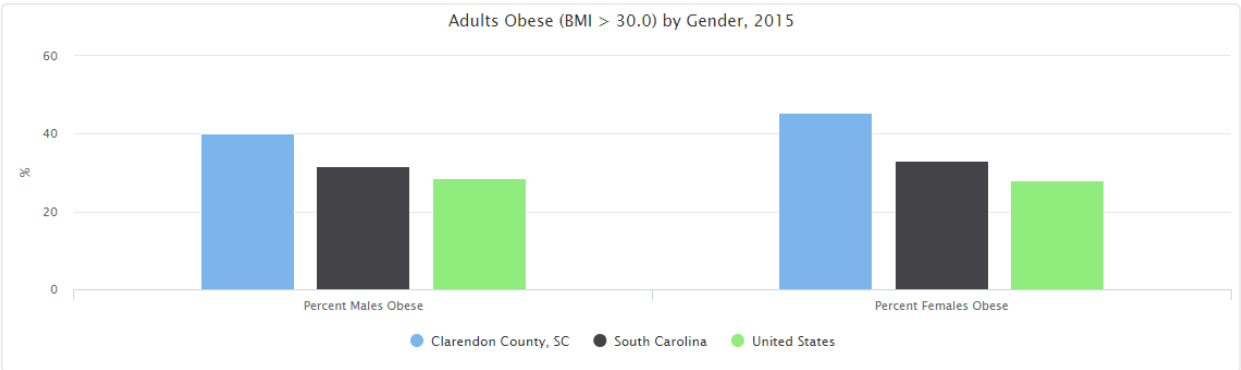
Report Area	Total Population Age 20+	Adults with BMI > 30.0 (Obese)	Percent Adults with BMI > 30.0 (Obese)
Clarendon County, SC	26,092	11,037	42.7%
South Carolina	3,674,444	1,190,573	32.4%
United States	238,842,519	67,983,276	28.3%

Note: This indicator is compared to the state average.
Data Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2015. Source geography: County →
Show more details



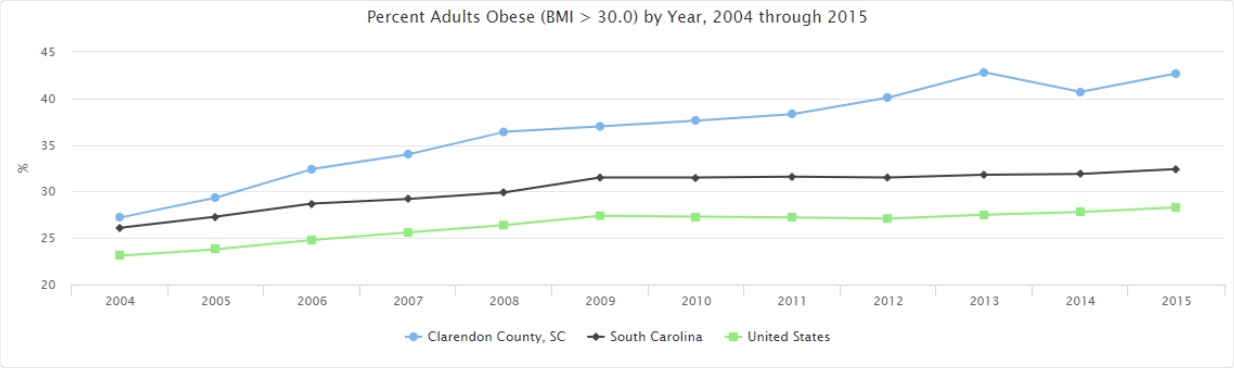
Adults Obese (BMI > 30.0) by Gender, 2015

Report Area	Total Males Obese	Percent Males Obese	Total Females Obese	Percent Females Obese
Clarendon County, SC	4,993	40%	6,043	45.3%
South Carolina	556,571	31.7%	634,001	33.2%
United States	33,600,782	28.7%	34,382,509	27.9%



Percent Adults Obese (BMI > 30.0) by Year, 2004 through 2015

Report Area	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Clarendon County, SC	27.2%	29.35%	32.4%	34%	36.4%	37%	37.6%	38.3%	40.1%	42.8%	40.7%	42.7%
South Carolina	26.1%	27.3%	28.7%	29.2%	29.9%	31.5%	31.5%	31.6%	31.5%	31.8%	31.9%	32.4%
United States	23.1%	23.8%	24.8%	25.6%	26.4%	27.4%	27.3%	27.2%	27.1%	27.5%	27.8%	28.3%



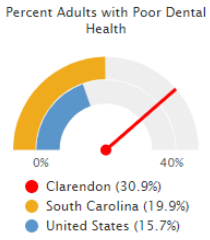
Poor Dental Health

This indicator reports the percentage of adults age 18 and older who self-report that six or more of their permanent teeth have been removed due to tooth decay, gum disease, or infection. This indicator is relevant because it indicates lack of access to dental care and/or social barriers to utilization of dental services.

Report Area	Total Population (Age 18+)	Total Adults with Poor Dental Health	Percent Adults with Poor Dental Health
Clarendon County, SC	26,616	8,229	30.9%
South Carolina	3,500,728	697,720	19.9%
United States	235,375,690	36,842,620	15.7%

Note: This indicator is compared to the state average.

Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES. 2006-10. Source geography: County → Show more details



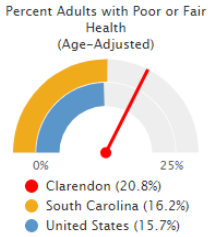
Poor General Health

Within the report area 24.8% of adults age 18 and older self-report having poor or fair health in response to the question "would you say that in general your health is excellent, very good, good, fair, or poor?". This indicator is relevant because it is a measure of general poor health status.

Report Area	Total Population Age 18+	Estimated Population with Poor or Fair Health	Crude Percentage	Age-Adjusted Percentage
Clarendon County, SC	26,874	6,665	24.8%	20.8%
South Carolina	3,500,728	598,624	17.1%	16.2%
United States	232,556,016	37,766,703	16.2%	15.7%

Note: This indicator is compared to the state average.

Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health & Human Services, Health Indicators Warehouse. 2006-12. Source geography: County → Show more details



Clarendon County Health Rankings 2016 vs. 2019

To evaluate the impact of any actions that were taken to address the significant health needs identified in the 2016 CHNA the following is a comparison of health outcomes and behaviors in 2016 and in 2019.

	Clarendon 2016 Ranking	**Progress**	**Clarendon 2019 Ranking**
Health Outcomes	25		25
Length of Life	20		24
Premature Death	8,800	Getting Worse	9,700
Quality of Life	32		26
Poor or Fair Health	25%		22%
Poor Physical Health Days	4.6		4.5
Poor Mental Health Days	4.3		4.8
Low Birthweight	11%		10%
Health Factors	32		36
Health Behaviors	26		37
Adult Smoking	21%		20%
Adult Obesity	40%	Getting Worse	42%
Food Environment Index	6.3		7
Physical Inactivity	28%	Getting Worse	30%
Access to Exercise Opportunities	48%		43%
Excessive Drinking	12%		15%
Alcohol-Impaired Driving Deaths	25%		28%
Sexually Transmitted Infections	596.7	Getting Worse	793.4
Teen Births	49	Improving	34
Clinical Care	40		37
Uninsured	21%	Improving	14%
Primary Care Physicians	3,120:1		3,090:1

Dentists	3,410:1		3,780:1
Mental Health Providers	1,220:1		1,170:1
Preventable Hospital Stays	59		5,297
Diabetes Monitoring	81%		
Mammography Screening	62%	Getting Worse	39%
Social & Economic Factors	37		36
High School Graduation	76%		81%
Some College	47%		50%
Unemployment	8.50%	Improving	6.00%
Children in Poverty	39%	Improving	35%
Income Inequality	5.3		5.1
Children in Single-Parent Households	50%		49%
Social Associations	13.4		13
Violent Crime	588	Improving	455
Injury Deaths	90		86
Physical Environment	23		9
Air Pollution – Particulate Matter	12.4	Improving	10.1
Drinking Water Violations	Yes		No
Severe Housing Problems	15%		14%
Driving Alone to Work	79%		82%
Long Commute – Driving Alone	40%		41%

Data Source: https://www.countyhealthrankings.org/app/south-carolina/2016/compare/snapshot?counties=45_027

Priority Issues and Implementation Plan

McLeod Health utilizes resources such as U.S. Department of Health and South Carolina State Health Improvement Plan which serves to guide health promotion and disease prevention efforts. The South Carolina State Health Improvement Plan (SHIP) lays out the foundation for giving everyone a chance to live a healthy life. It is a call to action for South Carolinians to take data-driven, evidence-based steps to advance the health and well-being of all South Carolinians. The plan highlights goals and strategies on which communities can focus so the state can make measurable health improvement by 2023. Attention is focused on determinants that affect the

public's health that contribute to health disparities by addressing identified needs through education, prevention, targeted initiatives validated through research, and the delivery of health services. Cross-sector collaboration is now widely considered as essential for having meaningful impacts on building healthier communities. Through collaboration with public health agencies, health care organizations and providers, community leaders, and input from across business sectors and others in the community, McLeod Health can better serve its mission.

In prioritization of needs, consideration was given to the following:

- Based on importance to community
- Capacity to address change
- Alignment to McLeod Health Mission, Vision and Values
- Collaboration with existing organizations
- Magnitude/Severity of problem
- Need among vulnerable populations
- Willingness to act on issue
- Ability to have meaningful impact
- Availability of hospital resources

Plan Priorities

McLeod Health Clarendon has selected the following areas which to collaborate with community partners for improving community health in Clarendon County.

- Access to Care
- Diabetes
- Heart Disease and Stroke
- Lung Disease

Implementation Plan

Priority issues were determined from the community input gathered for the CHNA. The priority issues, or “goal”, are listed as Strategies, Metrics on how to measure those strategies, Community Partners and Timeframe.

Through successful partnerships and collaborations with public health agencies, health care organizations and providers, community leaders, and input from across business sectors and other in our community, McLeod Health can more effectively satisfy its long standing mission dedicated to improving the health and well-being in our region through excellence in health care.

CHNA Need #1: Access to Care (Primary Care Physicians, Telehealth, Food, Transportation, Oral Health)				
Goal	**Strategies**	**Metrics/What we are measuring**	**Community Partners**	**Timeframe**
Goal #1: Reduce socioeconomic barriers to healthcare	**Strategy 1:** Sustainment of a system to make home visits using paramedic who visits chronic disease populations at risk for non-compliance due to transportation challenges on an established time cadence as evidence shows community paramedic approaches are effective (Community Guide recommendation)	• Numbers of referrals and/or participants, Case Study Outcomes	• Duke Endowment • EMS • Physicians • Council on Aging • Home Health • Behavioral Health • Mental Health	Ongoing
	Strategy 2: Collaborate with community partners to offer a Community Garden and/or items collected from Community Garden to underserved groups	• # of crop distributions per year	• United Ministries • Council on Aging • City of Manning • Clemson University Extension • Master Gardner's • Manning High School • Manning Junior High School •	Ongoing
	Strategy 3: Remove financial barriers to accessing care for cancer patients through access to the HOPE Fund from McLeod Health Foundation.	• # of patients that receive funding	• McLeod Health Foundation • McLeod Cancer Center	Ongoing
	Strategy 4: Expansion of McLeod Nurse Family Partnership to meet the needs in the area.	• # of participants annually	• Nurse Family Partnership • McLeod Health Foundation • Alliance for a healthier South Carolina/Initiative Health Babies	Establishment within 12 Months
	Strategy 5: Work with local agencies to establish to establish a coordinating council as evidence shows community wide approaches are effective. (Community Guide recommendation)	• Program establishment	• Health and Social Services Organizations •	6 Months

	Strategy 6: Continued Partnership with Hope Health FQHC to provide access to care coordination for uninsured patients to a medical home (Access Health)	• Number of enrolled patients • Number of ER visits among target population.	• Hope Health FQHC • Rural Health Network	Ongoing
Goal #2: Improve access to specialty care.	**Strategy 1:** Expand local specialty availability by utilizing space on the McLeod Health Clarendon campus for part-time clinics in Clarendon and Sumter counties. As evidence shows health screening intervention and behavioral counseling are effective. (Community Guide Recommendation)	• New or increased access for specialists	• South Carolina Office of Rural Health	Ongoing
	Strategy 2: Recruit primary care and specialty physicians to underserved areas.	• # of provider recruits to the area • Pursuit of Family Medicine Rural Residency Track	• South Carolina Office of Rural Health	12-36 Months
	Strategy 3: Develop partnerships to offer telemedicine services and expansion of current telehealth services. (Telestroke, Telecardiology, Telepsychiatry, Televascular, Teleneurology and Telepulmonology.)	• # Telehealth services offered • # of telehealth visits	• State of South Carolina • South Carolina REACH Network • Palmetto Care Connections	12-36 Months
	Strategy 4: Add Dialysis Access Center Service line to provide local interventional care to dialysis patients.	• Establishment of Service • # of patients served	• Local Dialysis Centers • Area Nephrologist	12 Months
	Strategy 5: Addition of Oral Health Services through McLeod Family Residence Program and Community Partners	• Managed through McLeod Family Medicine Program and Community Partners	• Duke Endowment • Hope Health FQHC Dental Services offered in Williamsburg County • Smiles Dental Clinic (School based program in Clarendon)	12 Months

CHNA Need #2: Diabetes				
Goal	**Strategies**	**Metrics/What we are measuring**	**Community Partners**	**Timeframe**
Goal #1: Improve diabetes management	**Strategy 1:** Offer Telediabetes services lead by certified diabetic educator.	• # of participants	• McLeod Diabetes Center	Ongoing
	Strategy 2: Place emphasis on managing diabetes and managing weight through "Healthier You" – an Employee Health initiative for employees and spouses. Evidence shows employer health promotion programs are effective (Healthy People 2020). • Use the South Carolina Hospital Association's Working Well Initiative as an example of implementing healthier practices among hospital employees.	• # of participants	• McLeod Employee Health • McLeod Healthier You	Ongoing
	Strategy 3: Provide public information regarding the signs and symptoms of diabetes through media sources and community outreach opportunities, as evidence shows health communication and social marketing are effective (Healthy People 2020).	• Educational activities	• Health and Social Service Organizations • Faith Based Organizations • Media Outlets • Community and Civic organizations	Ongoing

CHNA Need #3: Heart Disease and Stroke				
Goal	**Strategies**	**Metrics/What we are measuring**	**Community Partners**	**Timeframe**
Goal #1: Prevention and management of Heart Disease	**Strategy 1:** Ongoing support recovery from heart attacks by providing cardiac rehab program. Actions/Tactics: Offer scholarships to those that are uninsured and need to continue cardiac rehab program.	• # of participants	• McLeod Health Foundation	Ongoing
	Strategy 2: McLeod Health Healthier You Program for employees and their spouses to help them live healthier lifestyles. Educational information from this program is widely available to all employees through various distribution methods. Evidence shows employer health promotion programs are effective (Healthy People 2020).	• # of participants	• McLeod Employee Health	Ongoing
	Strategy 3: Promotion of Health and Fitness Center membership and activities as means to a healthy lifestyle	• # of members	• McLeod Health Clarendon Health and Fitness Center	Ongoing
	Strategy 4: Support of City's Exercise program. (Let's Move Manning) as evidence shows increasing physical activities in communities by social support interventions. (Healthy People 2020)	• Participation in and other demonstrations of support	• City of Manning • Community Wellness Groups • McLeod Health Clarendon Health and Fitness Center	Ongoing
	Strategy 5: Promote Healthy options in the cafeteria.	• Continued offering of healthy options	• Food and Nutrition Services Provider • School/DHEC (Public Schools)	Ongoing

	Strategy 6: Provide plants and seeds through a community garden for individual and community groups. Explore opportunities to participate in health and nutrition education	• # of crop/seed distributions per year	• United Ministries • Council on Aging • City of Manning • Clemson University Extension • Master Gardner's • Manning High School • Manning Junior High School	Ongoing
	Strategy 6: Stroke Certification (statewide system of stroke care established under the guidance of The Stroke Advisory Council)	• Achievement and maintenance of Stroke Certification evidenced by DNV accrediting agency	• American Heart Association • County EMS • SC REACH Stroke Network • South Carolina State Health Improvement Plan 2023 Objective: Decrease the stroke death rate from 45.4 per 100,000 to 43.1 per 100,000	Achievement in Year One then sustainment
Goal #2: Provide health education through various mediums to promote healthy life styles through disease management	**Strategy 1:** Provide health education on cardiovascular disease prevention and management and screenings through health fairs and other community events as evidence shows screenings are very effective (Healthy People 2020).	• Support of or participation in events	• American Heart Association • Faith Based Organizations • Health and Social Service Organizations • Local health care providers • South Carolina State Health Improvement Plan 2023 Objective: Decrease percent of adults age 20 or older who are obese from 33.2 to 31.5 percent	Ongoing
	Strategy 2: Provide public health information through media outlets and speaker opportunities that focus on educating the community on chronic diseases and prevention, as evidence shows health communication and social marketing are effective (Healthy People 2020).	• Media outlets and speaker activity	• American Heart Association • Local physicians • South Carolina State Health Improvement Plan 2023 Objective: Decrease percent of adults age 20 or older who are obese from 33.2 to 31.5 percent	Ongoing

	Strategy 3: Participate in the American Heart Association STEMI National Initiative. This includes collaborating with first responders and hospitals to implement best practice guidelines to expedite care to cath lab.	• # of patients presenting with myocardial infarction	• American Heart Association • County EMS • McLeod Regional Medical Center	Ongoing

CHNA Need #4: Lung Disease (COPD, Lung Cancer, Pulmonary Fibrosis, Asthma)				
Goal	**Strategies**	**Metrics/What we are measuring**	**Community Partners**	**Timeframe**
Goal #1: Promote health education through various mediums to promote healthy life styles through disease management, diet and nutrition, physical activity, smoking cessation and disease prevention	**Strategy 1:** McLeod Health Healthier You Program for employees and their spouses to help them live healthier lifestyles. Educate employees about smoking cessation program through communications. Evidence shows employer health promotion programs are effective (Healthy People 2020) Action/Tactic: • Offer financial incentive on benefits program for non-smoking employees as evidence shows policies and programs to reduce tobacco users' out-of-pocket costs approaches are effective (Community Guide recommendation)	• # of participants	• McLeod Employee Health • SCHA - Working Well Initiative • South Carolina State Health Improvement Plan 2023 Objective: Decrease percent of adults who smoke from 20.6 to 18.5 percent	Annually
	Strategy 2: Provide public information through media sources, as evidence shows health communication and social marketing are effective. (Healthy People 2020)	• Media outlet and outreach activities	• American Cancer Society • Faith Based Organizations • Health and Social Service Organizations • Local health care providers	Ongoing

	Strategy 3: Improve the continuum of care for patients through collaborative primary care provider and hospital inpatient setting in an effort to reduce readmissions or ED visits for respiratory disease exacerbations under the guidance of AHRQ's evidence-based Project Red Toolkit Remove financial barriers to accessing care for cancer patients through access to the HOPE Fund from McLeod Health Foundation.	• Readmission Outcomes for Respiratory-Related Illnesses • Integrated EMR	• McLeod Health Foundation • Community Paramedic Program • Duke Endowment • McLeod Home Health • County EMS	Annually
	Strategy 4: Explore inpatient telepulmonology services.	• Establishment of service • # of telehealth visits	• McLeod Physician Network	36 Months
Goal #2: Promote low dose lung cancer screening	**Strategy 1:** Provide public information through media sources about low dose lung cancer screening.	• Determination of Feasibility of Service • Media outlet and outreach activities	• American Cancer Society • McLeod Health Foundation • Faith Based Organizations • Health and Social Service Organizations • Local health care providers	24 Months

Sources

Total Population, Data Source: US Census Bureau, *American Community Survey*. 2013-17. *Source geography:* Tract

Population in Limited English Households, Data Source: US Census Bureau, *American Community Survey.* 2013-17. *Source geography:* Tract

Education – Bachelor's Degree or Higher, Data Source: US Census Bureau, *American Community Survey.* 2013-17. *Source geography:* Tract

Education – High School Graduation Rate, Data Source, US Department of Education, EDFacts. Accessed via DATA.GOV. Additional data analysis by CARES. 2016-17. *Source geography:* School District

Income – Median Household Income, Data Source: US Census Bureau, *American Community Survey.* 2013-17. *Source geography:* Tract

Poverty – Population Below 100% FPL, Data Source: US Census Bureau, *American Community Survey.* 2013-17. *Source geography:* Tract

Air Quality – Respiratory Hazard Index, Data Source: EPA National Air Toxics Assessment.

Food Environment – Grocery Stores, Data Source: US Census Bureau, *County Business Patterns.* Additional data analysis by CARES. 2016. Source geography: ZCTA

Food Environment – SNAP-Authorized Food Stores, Data Source: *US Department of Agriculture, Food and Nutrition Service,* USDA – SNAP Retailer Locator. Additional data analysis by CARES. 2019. Source geography: Tract

30-Day Hospital Readmissions, Data Source: *Dartmouth College Institute for Health Policy & Clinical Practice, Dartmouth Atlas of Health Care.*

Access to Dentists, Data Source: *US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File.* 2015. Source geography: County

Access to Mental Health Providers, Data Source, *University of Wisconsin Population Health Institute, County Health Rankings.* 2017. Source geography: County

Access to Primary Care, Data Source: *US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File.* 2014. Source geography: County

Diabetes Management – Hemoglobin A1c Test, Data Source: Dartmouth College Institute for Health Policy & Clinical Practice, *Dartmouth Atlas of Health Care.* 2015. Source geography: County

Federally Qualified Health Centers, Data Source: *US Department of Health & Human Services, Center for Medicare & Medicaid Services, Provider of Services Files.* December 2018. Source geography: Address

Health Professional Shortage Areas, Data Source: *US Department of Health & Human Services, Health Resources and Services Administration, Health Resources and Services Administration.* February 2019. Source geography: Address

Lack of Prenatal Care, Data Source: Centers for Disease Control and Prevention, *National Vital Statistics System.* Accessed via *CDC WONDER. Centers for Disease Control and Prevention, Wide-Ranging Online Data for Epidemiologic Research.* 2007-10. Source geography: County

Preventable Hospital Visits, Data Source: Dartmouth College Institute for Health Policy & Clinical Practice, *Dartmouth Atlas of Health Care.* 2015. Source geography: County

Prevention – Mammogram, Data Source, Dartmouth College Institute for Health Policy & Clinical Practice, *Dartmouth Atlas of Health Care.* 2015. Source geography: County

Alcohol Consumption, Data Sources: Centers for Disease Control and Prevention, *Behavioral Risk Factor Surveillance System.* Accessed via the *Health Indicators Warehouse.* US Department of Health & Human Services, *Health Indicators Warehouse.* 2006-12. Source geography: County

Physical Inactivity, Data Source: *Center for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion.* 2015. Source geography: County

STI – Chlamydia Incidence, Data Source: US Department of Health & Human Services, *Health Indicators Warehouse.* Centers for Disease Control and Prevention, *National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.* 2016. Source geography: County

STI- Gonorrhea Incidence, US Department of Health & Human Services, *Health Indicators Warehouse.* Centers for Disease Control and Prevention, *National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.* 2016. Source geography: County

STI – HIV Prevalence, US Department of Health & Human Services, *Health Indicators Warehouse.* Centers for Disease Control and Prevention, *National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.* 2015. Source geography: County

Tobacco Usage – Current Smokers, Data Source: Centers for Disease Control and Prevention, *Behavioral Risk Factor Surveillance System.* Accessed via the *Health Indicators Warehouse. US Department of Health & Human Services, Health Indicators Warehouse.* 2006-12. Source geography: County

Asthma Prevalence, Data Source: *Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System.* Additional data analysis by CARES. 2011-12. Source geography: County

Cancer Incidence – All Sites, Data Source: State Cancer Profiles. 2011-15. Source geography: County

Cancer Incidence – Colon and Rectum, Data Source: State Cancer Profiles. 2011-15. Source geography: County

Cancer Incidence – Lung, Data Source: State Cancer Profiles. 2011-15. Source geography: County

Cancer Incidence – Prostate, Data Source: State Cancer Profiles. 2011-15. Source geography: County

Depression (Medicare Population), Data Source: *Centers for Medicare and Medicaid Services.* 2015. Source geography: County

Diabetes (Adult), Data Source: Centers for Disease Control and Prevention, *National Center for Chronic Disease Prevention and Health Promotion.* 2015. Source geography: County

Diabetes (Medicare Population), Data Source: *Centers for Medicare and Medicaid Services.* 2015. Source geography: County

Heart Disease (Adult), Data Source: Centers for Disease Control and Prevention, *Behavioral Risk Factor Surveillance System.* Additional data analysis by *CARES.* 2011-12. Source geography: County

Heart Disease (Medicare Population), *Note: This indicator is compared to the state average.* Data Source: *Centers for Medicare and Medicaid Services.* 2015. Source geography: County

High Blood Pressure (Adult), *Note: This indicator is compared to the state average.* Data Source: Centers for Disease and Prevention, *Behavioral Risk Factor Surveillance System.* Accessed via the *Health Indicators Warehouse.* US Department of Health & Human Services, *Health Indicators Warehouse.* 2006-12. Source geography: County

High Blood Pressure (Medicare Population), *Note: This indicator is compared to the state average.* Data Source: *Centers for Medicare and Medicaid Services.* 2015. Source geography: County

Infant Mortality, *Note: This indicator is compared to the state average.* Data Source: *US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File.* 2006-10. Source geography: County

Low Birth Weight, *Note: This indicator is compared to the state average.* Data Source: *US Department of Health & Human Services, Health Indicators Warehouse.* Centers for Disease Control and Prevention, *National Vital Statistics System.* Accessed via CDC WONDER. 2006-12. Source geography: County

Mortality – Cancer, *Note: This indicator is compared to the state average.* Data Source: Centers for Disease Control and Prevention, *National Vital Statistics System.* Accessed via CDC WONDER. 2012-16. Source geography: County

Mortality – Coronary Heart Disease, *Note: This indicator is compared to the state average.* Data Source: Centers for Disease Control and Prevention, *National Vital Statistics System.* Accessed via CDC WONDER. 2012-16. Source geography: County

Mortality – Lung Disease, *Note: This indicator is compared to the state average.* Data Source: Centers for Disease Control and Prevention, *National Vital Statistics System.* Accessed via CDC WONDER. 2012-16. Source geography: County

Mortality – Pedestrian Motor Vehicle Crash, *Note: This indicator is compared to the state average.* Data Source: *US Department of Transportation, National Highway Traffic Safety Administration, Fatality Analysis Reporting System.* 2011-2015. Source geography: County

Mortality – Premature Death, *Note: This indicator is compared to the state average.* Data Source: *University of Wisconsin Population Health Institute, County Health Rankings.* 2015-17. Source geography: County

Mortality – Stroke, *Note: This indicator is compared to the state average.* Data Source: Centers for Disease Control and Prevention, *National Vital Statistics System.* Accessed via CDC WONDER. 2012-16. Source geography: County

Mortality – Suicide, *Note: This indicator is compared to the state average.* Data Source: Centers for Disease Control and Prevention, *National Vital Statistics System.* Accessed via CDC Wonder. 2012-16. Source geography: County

Mortality – Unintentional Injury, *Note: This indicator is compared to the state average.* Data Source: Center for Disease Control and Prevention, *National Vital Statistics System.* Accessed via CDC WONDER. 2012-16. Source geography: County

Obesity, *Note: This indicator is compared to the state average.* Data Source: Centers for Disease Control and Prevention, *National Center for Chronic Disease Prevention and Health Promotion.* 2015. Source geography: County

Poor Dental Health, *Note: This indicator is compared to the state average.* Data Source: Centers for Disease Control and Prevention, *Behavioral Risk Factor Surveillance System.* Additional data analysis by CARES. 2006-10. Source geography: County

Poor General Health, *Note: This indicator is compared to the state average.* Data Source: Centers for Disease Control and Prevention, *Behavioral Risk Factor Surveillance System.* Accessed via the *Health Indicators Warehouse.* US Department of Health & Human Services, *Health Indicators Warehouse.* 2006-12. Source geography: County

Clarendon County Health Rankings, Data Source: https://www.countyhealthrankings.org/app/south-carolina/2016/compare/snapshot?counties=45_027

USPSTF Grade A and B Preventative Service Recommendations Associated with Identified Key Priority Areas, Data Source: *USPSTF A and B Recommendations by Date.* U.S. Preventive Services Task Force. June 2019. https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations-by-date/

Appendix A

List of civic groups, providers, and organizations surveyed:

- McLeod Health Clarendon EMS
- Eagerton Family Practice
- McLeod Health Clarendon Hospitalist
- Colonial Family Practice
- Clarendon County Chamber of Commerce
- South Carolina Department of Health & Environmental Control

Appendix B

Below is supplemental information to the Health Outcomes data found in this report.

Clarendon County Health Profile[6]

INDICATOR	MEASURE	COUNT	VALUE	RANK[1]	STATE
Births[2]	Births with expected payor Medicaid (percent of all live births; 2015-2017)	706	73.1	NA	50.1
	Breastfeeding initiation (percent of all live births; 2015-2017)	621	64.3	26	76.5
	Low birthweight births (<2,500 grams; percent of all live births; 2015-2017)	89	9.2	12	9.6
	Mothers receiving adequate prenatal care (percent of all live births; 2015-2017)	682	70.6	37	75.2
	Mothers who smoked during pregnancy (percent of all live births; 2015-2017)	102	10.6	25	9.1
	Preterm births (<37 weeks gestation; percent of all live births; 2015-2017)	103	10.6	11	11.2
	Teen live births (rate per 1,000 female population aged 15-19; 2015-2017)	79	28.6	21	23.8
Infant Mortality[2]	Infant mortality (rate per 1,000 live births; 2015-2017)	9	9.3	33	6.8
Chronic Diseases, Risk Factors, and Health Behaviors[3]	Coronary heart disease (percent; 2015-2017)	NA	6.3	33	4.6
	Stroke (percent; 2015-2017)	NA	6.3	38	3.8
	Heart attack (percent; 2015-2017)	NA	6.5	28	4.9
	Hypertension (percent; 2015-2017)	NA	42.3	20	38.4
	Diabetes (percent; 2015-2017)	NA	14.1	20	12.8
	Current asthma (percent; 2015-2017)	NA	8.2	15	8.7
	Current smoking (percent; 2015-2017)	NA	21.9	29	19.5
	Adults categorized as obese, aged 20+ (BMI ≥30; percent; 2015-2017)	NA	38.7	33	33.2
	Reported leisure time physical activity in the past 30 days (percent; 2015-2017)	NA	67.4	30	72.7
	Received a flu vaccine in the last year, aged 65+ (percent; 2015-2017)	NA	68.7	3	62.4
	Received a pneumococcal vaccine ever, aged 65+ (percent; 2015-2017)	NA	75.3	13	73.4
Mortality[2]	Accidental drug overdose (age-adjusted rate per 100,000 population; 2015-2017)		7.5	12	16.7
	Alzheimer's disease (age-adjusted rate per 100,000 population; 2015-2017)		27.0	6	45.4
	Cancer (malignant neoplasms only; age-adjusted rate per 100,000 population; 2015-2017)		172.5	21	165.5
	Cerebrovascular disease (age-adjusted rate per 100,000 population; 2015-2017)		51.2	27	45.6
	Chronic lower respiratory disease (age-adjusted rate per 100,000 population; 2015-2017)		44.0	13	48.4
	Diabetes (age-adjusted rate per 100,000 population; 2015-2017)		19.4	13	23.4
	Diseases of the heart (age-adjusted rate per 100,000 population; 2015-2017)		183.4	24	174.0
	Motor vehicle accident (age-adjusted rate per 100,000 population; 2015-2017)		27.8	27	20.5
	Suicide (age-adjusted rate per 100,000 population; 2015-2017)		8.9	5	15.6
	All causes (age-adjusted rate per 1,000 population; 2015-2017)		8.5	18	8.3
Population Demographics[4]	Families below the poverty level (percent; 2013-2017)	NA	18.5	NA	12.3
	Population Non-Hispanic white (percent; 2017)	NA	47.9	NA	64.6
	Population Non-Hispanic black (percent; 2017)	NA	47.8	NA	27.5
	Population Non-Hispanic other (percent; 2017)	NA	1.1	NA	2.3
	Population Hispanic/Latino (percent; 2017)	NA	3.2	NA	5.7
Health Care Access	Delayed seeing a doctor in the last year due to cost (percent; 2015-2017)[3]	NA	13.9	9	15.8
	Has at least one person considered a personal doctor or health care provider (percent; 2015-2017)[3]	NA	79.9	31	78.0
	Population insured by Medicaid (percent; 2013-2017)[4]	NA	53.5	NA	65.2
	Population insured by private health insurance (percent; 2013-2017)[4]	NA	10.8	NA	5.3
	Population without health insurance (percent; 2013-2017)[4]	NA	12.3	NA	12.1
Home and Environmental Hazards	Elevated (≥5 mcg/dL) blood lead tests in children <6 years of age (percent of all tests; 2017)[5]	NA	0.7	5	1.9
	Homes built prior to 1980 (percent; 2013-2017)[4]	NA	35.0	NA	38.7

1 - Ranking based on VALUE column, Regardless of the INDICATOR a ranking of 1 is always better, NA - Not Applicable.
2 - Source: Division of Biostatistics, DHEC
3 - Source: Behavioral Risk Factor Surveillance System, DHEC
4 - Source: 2013-2017 American Community Survey 5-Year Estimates, US Census Bureau, US Department of Commerce
5 - Source: Lead Surveillance, DHEC
6 - Estimates for counties with low populations contain more error.
Source: South Carolina Department of Health and Environmental Control, County Profile, Accessed June 6, 2019.

Created: 01-2019

Appendix C

McLeod Health Clarendon completed an inventory of community resources available within the service area. These resources include but are not limited to organizations, facilities, and programs in the community that are potentially available to address health needs.

Organizations are listed by county under the following headings:

- Alcoholics Anonymous
- Behavioral Health Service
- County Council on Aging
- Department of Disabilities and Special Needs
- Department of Social Services
- DHHS – Community Long Term Care
- Health Department
- Pee Dee Coalition Against Domestic & Sexual Assault
- Santee Wateree Community Mental Health Center
- Specialists
- United Ministries
- United Way
- Veterans Affairs
- Welvista (Prescription Drug Assistance)

Community Resources

Guide Book to Getting the Help You Need After You Leave the Hospital

McLeod Health
Clarendon

12/2017

provided by
McLeod Health
Clarendon

About This Guide

McLeod Health Clarendon is concerned about your health and well being after you leave our hospital.

The purpose of this guide is to provide you with information on services available in the region. The guide is not all-inclusive of the services provided; it was put together to provide you with a starting point.

In this guide are a variety of resources that may offer additional care and services to you.

Specialists

McLeod Women's Care Clarendon
Julie A. Mullins, DO
50 East Hospital Street, Suite 4A, Manning
(803) 433-0797

McLeod Women's Care Clarendon
Steven B. Tollison, MD
50 East Hospital Street, Suite 4A, Manning
(803) 433-0797

Specialists

McLeod Cardiology Associates
Ryan C. Garbalosa, DO
540 Physicians Lane, Sumter
(803) 883-5171

McLeod Cardiology Associates
Dennis Lang, DO
540 Physicians Lane, Sumter
(803) 883-5171

McLeod Cardiology Associates
Prabal Guha, MD
540 Physicians Lane, Sumter
(803) 883-5171

Manning Clinic:
21 East Hospital Street, Manning • (803) 883-5171

McLeod Nephrology Associates
M. Adnan Alsaka, MD
409 Mill Street, Manning
(843) 777-7290

McLeod Orthopaedics Clarendon
Lawrence L. Conley, DO
50 East Hospital Street, Suite 6, Manning
(803) 433-3065

McLeod Orthopaedics Sumter
David M. Woodbury, MD
540 Physicians Lane, Sumter
(843) 433-5633

McLeod Urology Associates Sumter
Christopher S. Fukuda, MD
540 Physicians Lane, Sumter
(843) 777-7555

McLeod Surgery Clarendon
Devonne D. Barrineau, MD
15 East Hospital Street, Manning
(803) 435-2822

Sumter Clinic:
540 Physicians Lane, Sumter • (803) 883-5171

South Carolina
(Clarendon and Sumter Counties)

Clarendon County Resources

Clarendon Behavioral Health Service	**803-435-2121**
Clarendon County Council on Aging	**803-435-8593**
Department of Disabilities and Special Needs	**803-435-2330**
Dept of Social Services	**803-435-4303**
DHHS - Community Long Term Care	**803-435-3447**
Health Department	**803-435-8178**
Pee Dee Coalition Against Domestic & Sexual Assault	**803-773-4357**
Santee Wateree Community Mental Health Center	**803-435-2124**
United Ministries	**803-435-9086**
United Way	**803-773-7935**
Veterans Affairs	**803-435-2527**
Welvista (Prescription Drug Assistance)	**800-763-0059**

The 2019 McLeod Health Clarendon Community Health Needs Assessment is located on the website of McLeod Health at ***www.McLeodHealth.org*.**

A copy can also be obtained by contacting the hospital administration office.