PRISMA HEALTH®

2025 Community Health Needs Assessment (CHNA) Report

Our purpose:

Inspire health.
Serve with compassion.
Be the difference.

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President and Chief Executive Officer
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Moving toward a state of better health

At Prisma Health, we're on a journey to transform the health care experience for our patients and their families by living our purpose: *Inspire health. Serve with compassion. Be the difference.*

We believe that delivering exceptional care starts with understanding the people and communities we serve. As the largest health care organization in South Carolina, we care for more than 1.4 million unique patients each year – and with that reach comes a deep responsibility.

With the size, scale and capabilities we bring to our communities, Prisma Health has played a major role in improving health status. Currently, South Carolina ranks 37th in national health ratings – our best standing in 35 years – yet still far from where we want to be. To create lasting, meaningful change, we must begin with a clear picture of the most pressing health needs affecting our neighbors, especially among underserved and vulnerable populations across South Carolina.

That's why every three years, Prisma Health conducts a comprehensive Community Health Needs Assessment. This assessment helps us identify and prioritize the health challenges facing the communities we serve. It allows us to listen, learn and take strategic, informed action that drives progress, improves outcomes, reduces disparities and advances health equity.

We are grateful to everyone who took time to participate in the 2025 survey. Three major health improvement areas rose to the top. In rank order, they are:

1. Mental health
2. Overweight and obesity
3. Diabetes

The insights in this report will guide how we focus our resources, collaborate with community partners and continue to transform the health care experience for the communities we serve.

Purpose and methodology

Purpose

The 2010 Patient Protection and Affordable Care Act requires tax-exempt hospitals to conduct a Community Health Needs Assessment (CHNA) every three years. This assessment helps evaluate the overall health of the community and identifies key challenges, strengths and available resources to guide improvement efforts. To encourage broad community involvement and collaboration, the CHNA process included the collection of both quantitative data and qualitative input. The results are summarized in this report and will also be reported on the hospital's IRS Form 990, Schedule H, for the 2025 tax year. The full CHNA report is available at **PrismaHealth.org/CHNA**. For the latest IRS language (updated August 20, 2024) on how nonprofit hospitals can comply with the CHNA requirement, click here: **www.irs.gov/charities-non-profits/community-health-needs-assessment-for-charitable-hospital-organizations-section-501r3.**

Health priorities

For this report, 19 health priorities were considered, listed below in alphabetical order. Fourteen of these were selected from the Healthy People 2030 initiative, which is led by the U.S. Department of Health and Human Services Office of Disease Prevention and Health Promotion. This national effort identifies 34 important health conditions and behaviors. The remaining five were drawn from common responses from past community health surveys.

1. Access to reliable internet
2. Alcohol use
3. Alzheimer's disease and dementia
4. Arthritis
5. Asthma
6. Cancer
7. COVID-19
8. Diabetes
9. Heart disease and stroke
10. High blood pressure
11. HIV/AIDS
12. Infant mortality
13. Injury and violence
14. Kidney disease
15. Mental health
16. Overweight obesity
17. Sexually transmitted infections
18. Substance use and abuse
19. Tobacco use

Methodology

Prisma Health engaged GOODSTOCK Consulting, LLC, an organizational development firm with expertise in strategic planning, community health needs assessments, project management, and adult education and training. This firm worked closely with Prisma Health team members, the organization's academic partners and a committee of community volunteers from various health care, nonprofit and social service agencies.

Together, these entities designed a comprehensive data collection plan of quantitative and qualitative measures across two markets that covers three counties in the Midlands (Lexington, Richland and Sumter counties) and four counties in the Upstate (Greenville, Laurens, Oconee and Pickens counties). Secondary data was gathered from numerous community sources, including the Centers for Disease Control and Prevention (CDC), S.C. Department of Public Health (SC DPH), County Health Rankings & Roadmaps, and America's Health Rankings.

GOODSTOCK Consulting, LLC, used public health experts, data scientists and researchers to develop assessment objectives, data collection protocols and instruments, and perform the data analysis. Community members, state and local officials, major employers and community-based organizations were asked to select their top health issues and share concerns on related topics, such as children's health, digital health, physical activity and nutrition.

Participating organizations included community-based organizations, state agencies, schools, free medical clinics, S.C. Department of Public Health, primary care physicians, pediatricians and schools. Diverse communities also were engaged, including adult Latinx, Generation Zers (those born 1997–2012), Millennials (those born between 1981–1996), rural residents and African-American populations. Health problems mentioned by the greater community were consistent with those discussed in one-on-one interviews and focus groups.

Quantitative data collection: Surveys

To improve data quality, the 2025 electronic survey included a validation question and instructed respondents to complete the survey only if they lived in the target counties. However, this led to significant engagement with the survey link (n = 16,367) but a large number of incomplete surveys. Approximately 1% of respondents were appropriately disqualified in the validation question (n = 201); however, approximately 46% of initial respondents abandoned the survey at the county question (n = 7,513), which is believed to be a result of the survey instruction. Even with the high non-completion rate, the response target was still met and exceeded.

8,798 Electronic surveys collected

\+ **56** Paper surveys collected

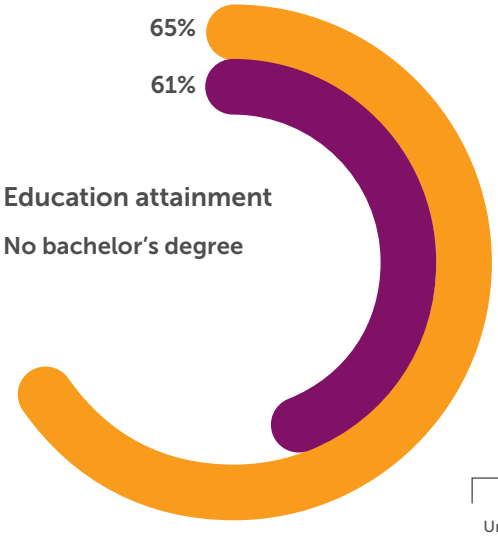
8,854 Total surveys collected

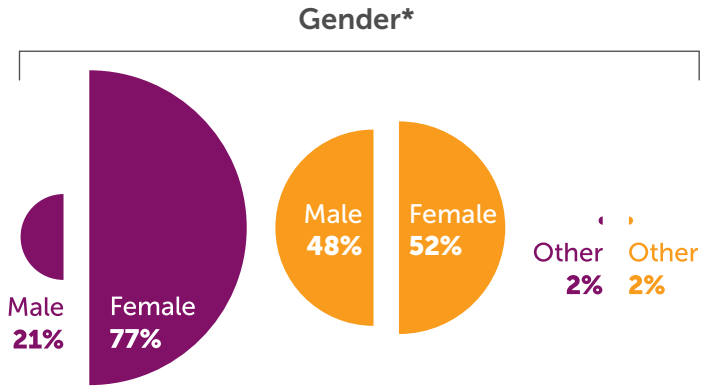
8,849 Weighted sample size

In all, **8,854** completed surveys were collected between March 31 and May 9, 2025, with the original data collection window being extended by one week (May 3-9). While most surveys were submitted electronically (99%), paper surveys also were submitted (<1%). Surveys were available in English (99% of responses) and Spanish (<1% of responses) and promoted via email and postcards with QR codes. Surveys and postcards were distributed throughout the community at satellite locations and general community gathering spots (grocery stores, schools, etc.) from March 18 to May 2, 2025.

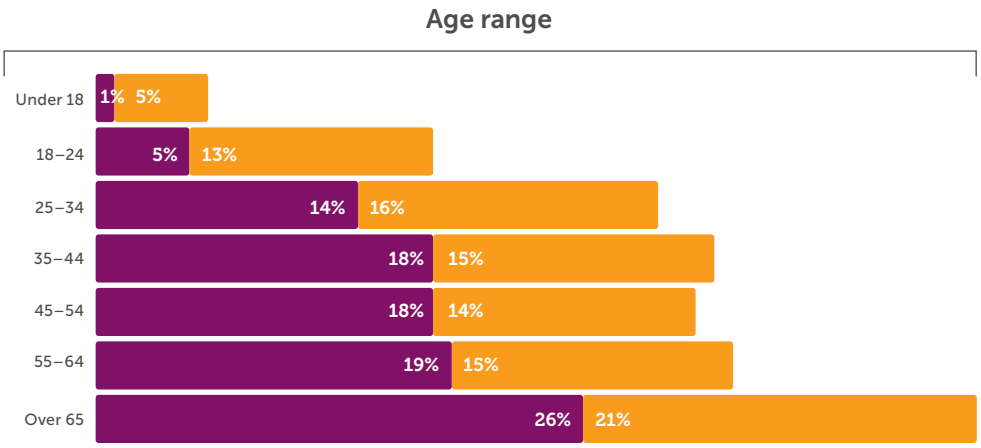
Demographic and socioeconomic summary of survey respondents

To increase the representativeness of the survey results, survey responses were weighted to better reflect the demographic and socioeconomic characteristics of the population's census data. Responses were weighted based on four factors: gender, race, age and education.



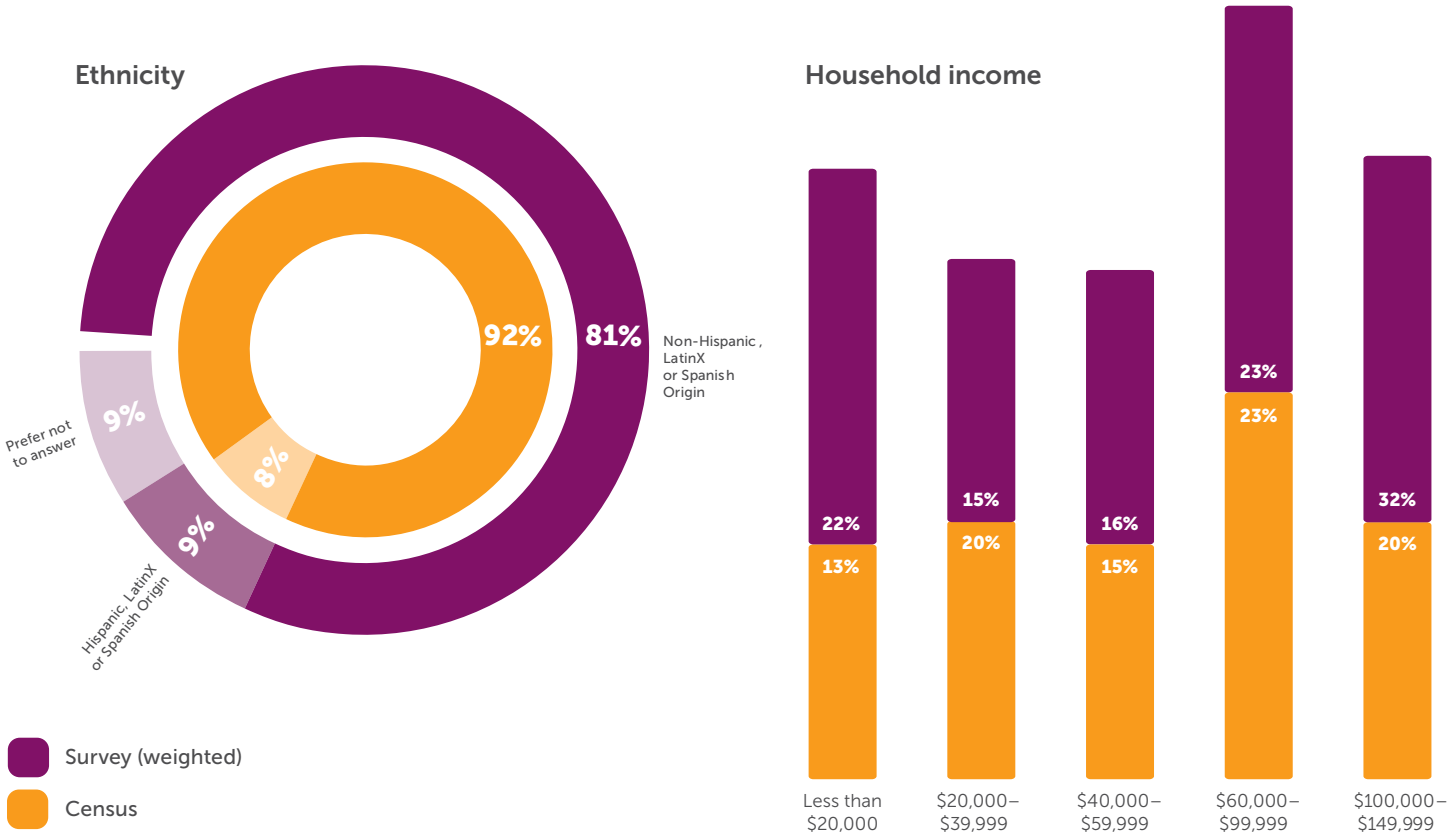


*Due to data unavailability, no weighting factor was used for "other" responses.



Survey

Census/Weighted



Qualitative data collection: Interviews and focus groups

Collection of qualitative data included interviews and focus groups facilitated between April 7 and May 9, 2025. Key informant interviews and focus groups were conducted by GOODSTOCK Consulting, LLC, to reduce potential bias imposed by the role or responsibility of hospital staff. **Thirteen** focus groups and **31** key informant interviews were conducted for this assessment. Participants were drawn from both the Midlands and Upstate markets to include community members, professional community partners, providers/clinicians, school personnel, and local and state government representatives.

All interviews and focus group sessions were recorded and transcribed for qualitative analysis. Codes for this qualitative analysis were developed both deductively and inductively. Initial inductive codes were developed from Healthy People 2030, the County Health Rankings & Roadmaps Model and GOODSTOCK Consulting, LLC. Additional deductive codes were added based on analysis of the data. All deductive codes were reviewed for consistency by the project evaluator prior to inclusion in the code book.

31 Total key informant interviews

13 Total focus groups

Prisma Health at a glance

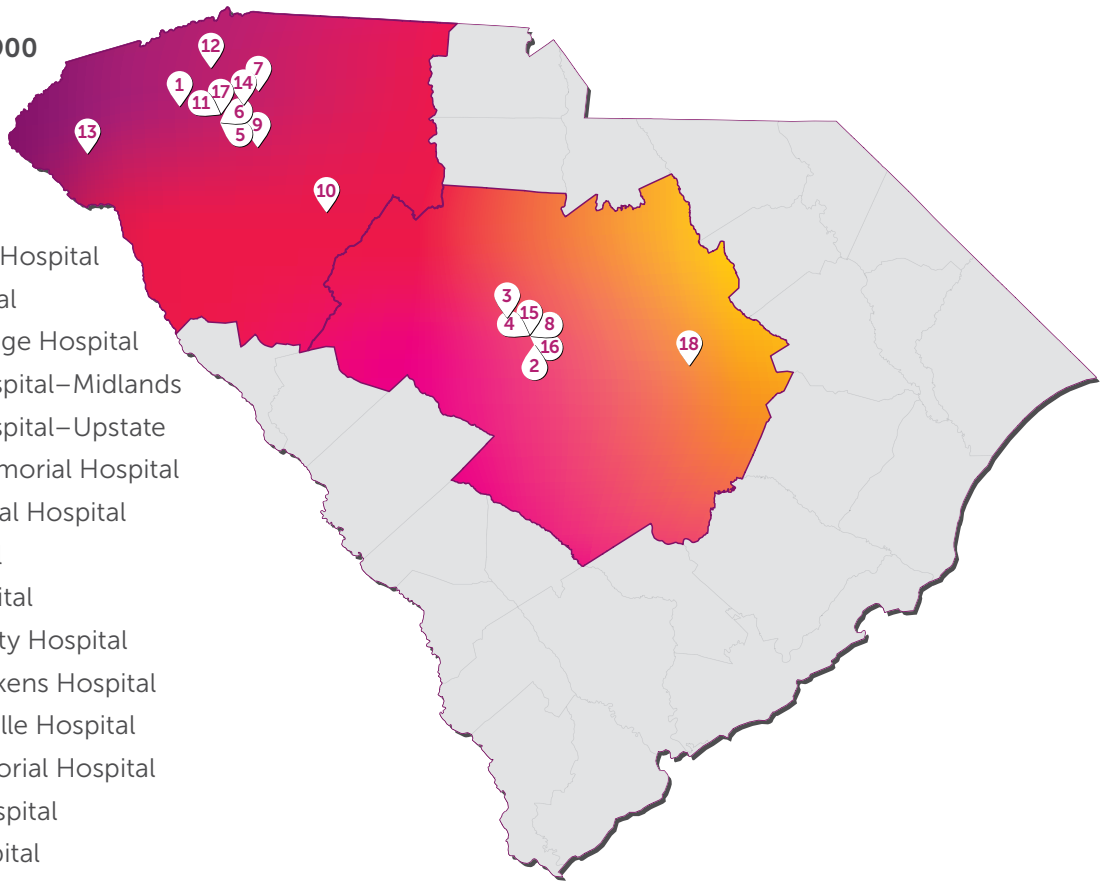
As the state's largest nonprofit health care organization, Prisma Health serves more than **1.4 million** unique patients annually across our network – nearly a quarter of the state's residents. The combined geography spans the Midlands to the Upstate, covering **51%**, or **2.7 million**, of the state's population, many of whom reside within 15 miles of a Prisma Health facility.

- **$6.4 billion** operating revenue
- More than **$1 billion** in charity care, unreimbursed medical costs and investment in community health
- **2,827** licensed beds (as of Nov. 1, 2024)
- **18** acute care and specialty hospitals in a 21-county service area
- **433** physician practices and **2,200** employed physicians
- **5,424** total doctors and other providers in its clinically integrated network
- **29,910** team members
- **123,693** hospital discharges (**18,648** pediatric)
- **27,052** inpatient and **75,359** outpatient surgeries
- **16,208** babies born
- **572,230** Emergency Department visits (**69,826** pediatric)
- **8.9 million** physician practice and outpatient visits
- **54** residency/fellowship programs with **717** residents/fellows
- **7,775** health care students educated and trained across affiliated medical, nursing pharmacy and allied health schools

Note: These are 2024 statistics and do not include Prisma Health Blount Memorial Hospital in Maryville, Tennessee.

Prisma Health service area

Prisma Health has more than **29,900** team members who provide high-quality care throughout our communities, including **13** acute-care hospitals:

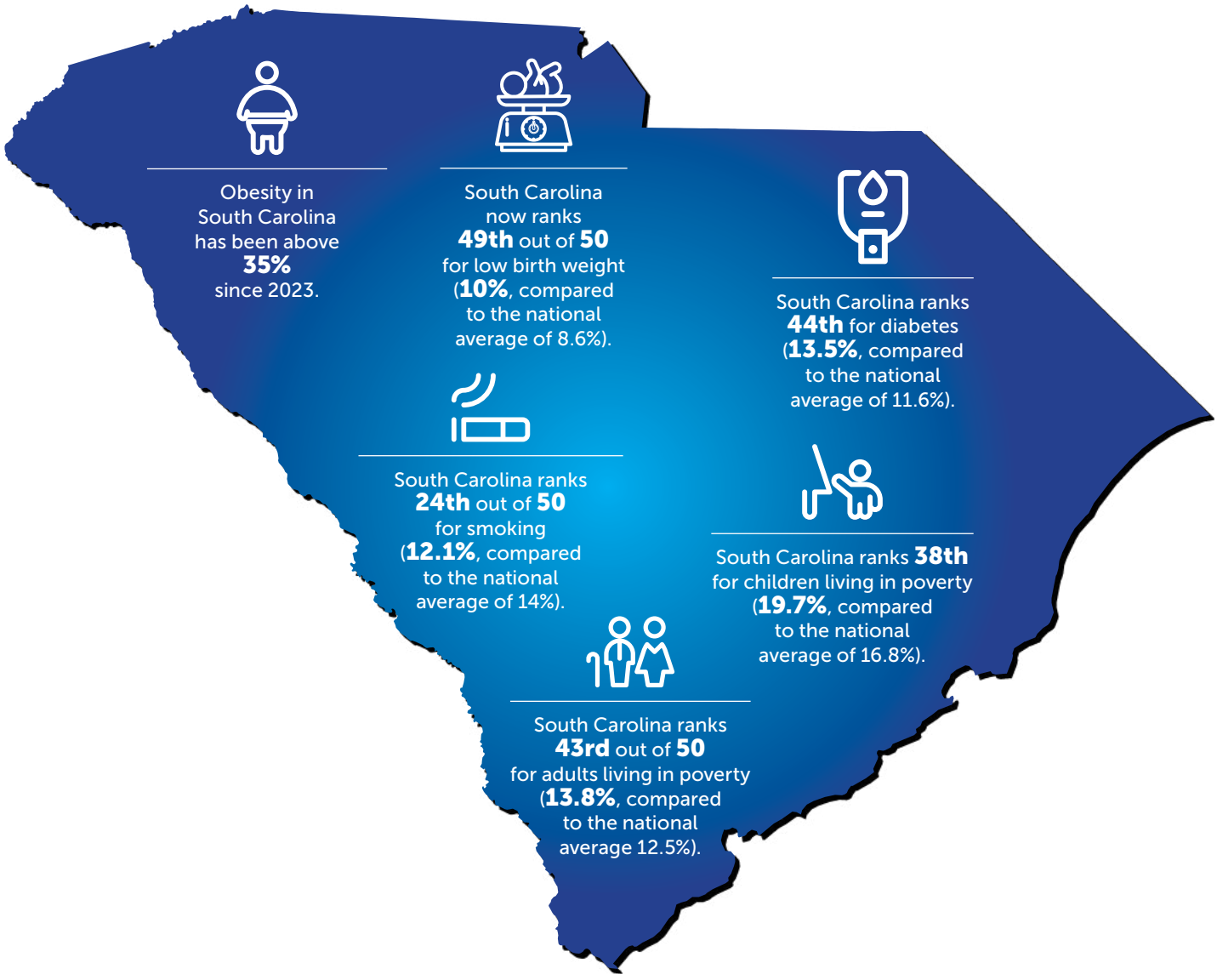


1 Prisma Health Baptist Easley Hospital
2 Prisma Health Baptist Hospital
3 Prisma Health Baptist Parkridge Hospital
4 Prisma Health Children's Hospital–Midlands
5 Prisma Health Children's Hospital–Upstate
6 Prisma Health Greenville Memorial Hospital
7 Prisma Health Greer Memorial Hospital
8 Prisma Health Heart Hospital
9 Prisma Health Hillcrest Hospital
10 Prisma Health Laurens County Hospital
11 Prisma Health Marshall I. Pickens Hospital
12 Prisma Health North Greenville Hospital
13 Prisma Health Oconee Memorial Hospital
14 Prisma Health Patewood Hospital
15 Prisma Health Richland Hospital
16 Prisma Health Richland Springs Hospital
17 Prisma Health Roger C. Peace Rehabilitation Hospital
18 Prisma Health Tuomey Hospital

About South Carolina

South Carolina has experienced significant population growth, with estimates placing its population at approximately **5.57 million**, making it the 23rd most populous state in the U.S. The state is noted as one of the fastest growing in the nation for 2024. Amid this significant growth, South Carolina continues to face ongoing health challenges. According to the 2025 America's Health Rankings Annual Report, the state ranks **37th out of 50** in overall health, indicating persistent issues in areas such as chronic disease, access to care and health behaviors.

Through the CHNA improvement plan, Prisma Health will develop interventions to address health disparities to disrupt inequities that exist in health outcomes, access to care and health equity.



Sources

- U.S. Obesity Rate (2021–2023): https://www.cdc.gov/nchs/products/databriefs/db508.htm South Carolina Obesity Rate (2021–2023): **https://www.cdc.gov/obesity/media/pdfs/2024/09/obesity-prevalence-map-race-ethnicity-2021-2023-508.pdf**
- U.S. Low Birth Weight Rate (2023): **https://www.cdc.gov/nchs/fastats/birthweight.htm**
- U.S. Smoking Rate (2022): **https://www.cdc.gov/tobacco/campaign/tips/resources/data/cigarette-smoking-in-united-states.html** South Carolina Smoking Rate (2023): South Carolina Adult Tobacco Survey
- U.S. Diabetes Prevalence (2021–2023): **https://www.cdc.gov/nchs/products/databriefs/db516.htm**
- South Carolina Diabetes Rate (2023): **https://www.cdc.gov/pcd/issues/2023/22_0199.htm**
- U.S. Maternal Mortality Rate (2023): Health E-Stat 100: Maternal Mortality Rates in the United States, 2023 South Carolina Maternal Mortality Rate (2018–2022): **https://www.cdc.gov/nchs/state-stats/states/sc.html**

Social drivers of health

At Prisma Health, our mission includes advancing health equity by addressing the needs of underserved populations and reducing health disparities in the communities we serve. We recognize that achieving true health equity means ensuring everyone has the opportunity to attain their highest level of health – regardless of race, income, education or geographic location.

Social drivers of health (SDOH) are the social and environmental conditions that shape individual and community health outcomes. These include the places where people are born, live, learn, work, play, worship and age. Factors such as education level, income, housing and access to care are just as critical to health as clinical treatment.

The U.S. Department of Health and Human Services, through Healthy People 2030, categorizes the social determinants of health into **five** key domains:

Economic stability	Education access and quality	Social and community context	Health care access and quality	Neighborhood and built environment
Employment, sufficient income, food security and housing stability	Early childhood education, high school graduation, higher education opportunities and literacy	Social cohesion, civic engagement, social capital	Access to primary care, health insurance coverage and health literacy	Access to nutritious foods, quality of housing, neighborhood safety and environmental conditions

To effectively improve health outcomes, clinical care and community interventions must take these broader social influences into account. Understanding a patient's SDOH and integrating them into care plans is essential to delivering truly person-centered care.

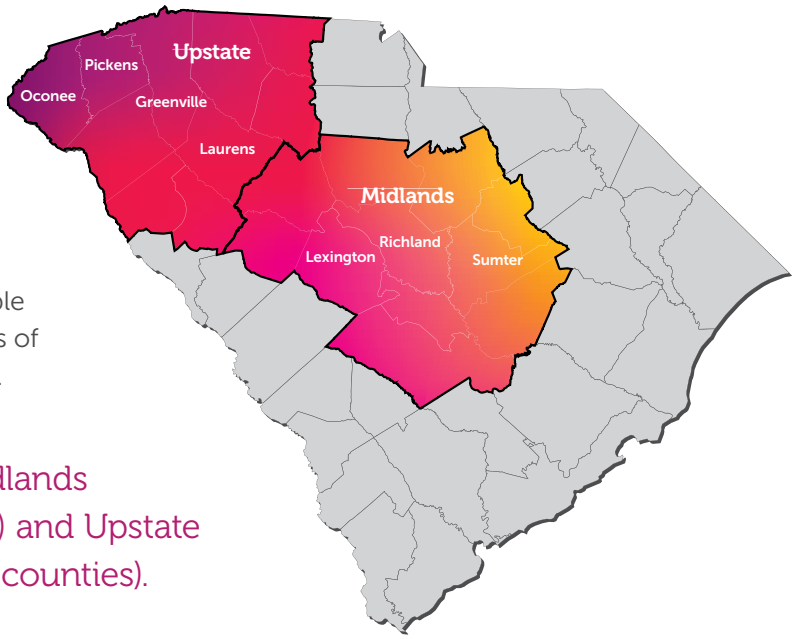
Prisma Health is committed to addressing social drivers of health through a combination of:

- Integrated clinical and care management programs
- Community-based partnerships and outreach
- Population health strategies rooted in data and equity
- Ongoing screening and referral systems for social needs

About our community

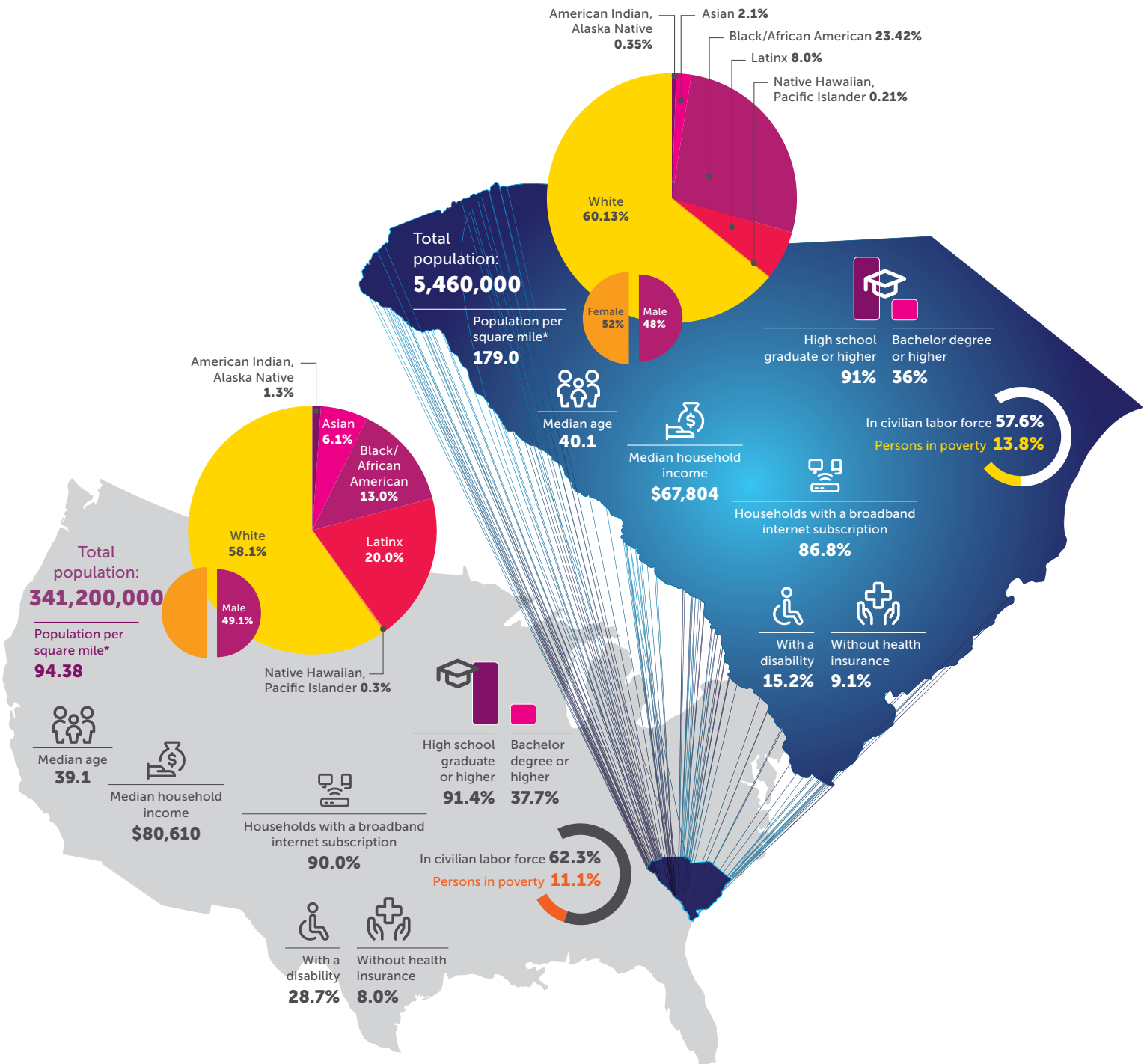
The Community Health Needs Assessment (CHNA) plays a vital role in this work by identifying local health challenges and the social drivers behind them. This report provides a data-driven baseline for understanding key health outcomes, risk behaviors and social conditions across our service areas.

As we move forward, this assessment will guide Prisma Health's efforts to implement targeted, equitable and sustainable strategies that address the root causes of poor health across both rural and urban communities.



The market identified for this CHNA is Midlands (Richland, Lexington and Sumter counties) and Upstate (Greenville, Laurens, Oconee and Pickens counties).

Demographic summary by market



Sources

- U.S. Census Bureau QuickFacts: United States https://www.census.gov/quickfacts/
- https://nces.ed.gov/programs/coe/indicator/coi
- Census Bureau Tables https://data.census.gov/table?q=median+age

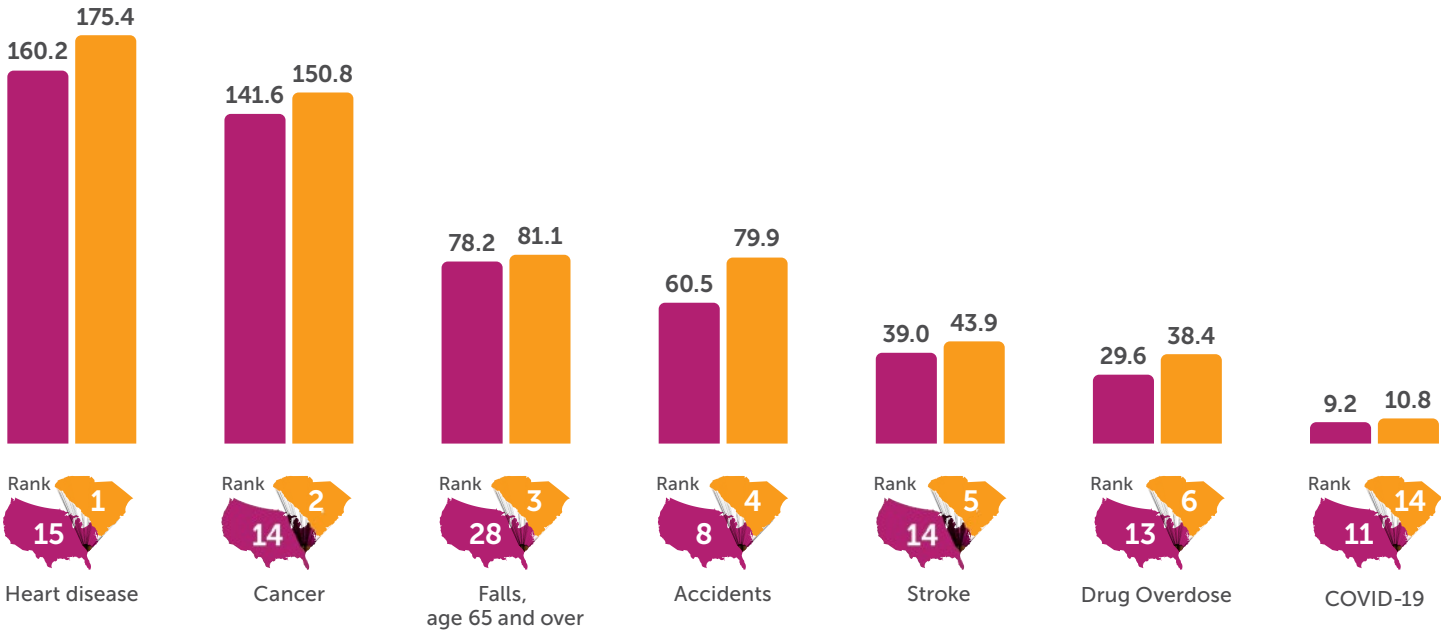
COVID-19

While the acute phase of COVID-19 has passed, the pandemic's influence on the health care landscape endures. Prisma Health remains vigilant – monitoring case trends, supporting access to testing and vaccination, and applying lessons learned to strengthen long-term emergency preparedness. Investments made during the pandemic continue to shape the way care is delivered today. Expanded virtual care platforms, enhanced infection prevention protocols and a renewed emphasis on public health infrastructure are helping to build a more resilient system. Notably, the impact of telehealth expansion is reflected in community sentiment: **70%** of survey respondents now say they feel comfortable using the internet to talk to their doctor – nearly double the **37%** reported just three years ago.

Leading causes of death

In South Carolina, the top causes of death closely mirror national trends but often occur at higher rates. Heart disease remains the leading cause, with **175.4** deaths per 100,000 – above the national average of **160.2**. Cancer follows, also higher than the U.S. rate of **141.6**. Falls among adults 65 and older rank third in South Carolina, with a rate of **81.1**, compared to the U.S. rate of **78.2**. Accidents, strokes and drug overdoses are also major concerns, each ranking among the top six causes of death. While COVID-19 now ranks 14th, its death rate in South Carolina (**10.8**) still slightly exceeds the national figure (**9.2**), underscoring ongoing health challenges.

Leading causes of death per 100,000 deaths



Sources

- Quarterly Provisional Mortality Estimates
- South Carolina Population 2025
- State Summaries South Carolina | 2024 Annual Report | AHR

Prisma Health: Advancing community health and wellness

At Prisma Health, our purpose – *Inspire health. Serve with compassion. Be the difference.* – guides every step in our journey to improve the well-being of the communities we serve. Understanding the most pressing health issues facing our residents, particularly among underserved and vulnerable populations, is essential to making a meaningful impact.

This Community Health Needs Assessment (CHNA) serves as a vital tool to identify and prioritize the most urgent health needs across the Prisma Health service areas. The report is informed by diverse community perspectives gathered through mail and online surveys, focus groups and interviews with local leaders. These insights, combined with robust data analysis and in compliance with IRS regulations under the 2010 Affordable Care Act, have helped shape our direction for the next three years.

Prisma Health has identified the following top health priorities – consistent across both the Midlands and Upstate regions:

1. Mental health
2. Overweight and obesity
3. Diabetes

In the months ahead, Prisma Health will evaluate current strategies and develop new, targeted interventions to address these key areas. By fostering collaboration among patients, families, health care professionals, community leaders, advocates, academic institutions, businesses and policy makers, we aim to create healthier, more resilient communities.

Voices from the community

Mental health is one of those issues, those health related issues that is really hard to address on a holistic level. I think that is one of the greatest barriers that I see with the families we serve.

We already have three behavioral health facilities, and they're all full. What would it look like to have a mobile team with a psychiatrist if we had other options, but the ED is the only option. And then I'm taking them to a facility where they're not insured.

To be able to access a psychologist who can treat you without having to wait so long or who you can pay without having to stop shopping for the week or the month, well, it is a challenge.

Finding a good psychiatrist is a big one. We have one right now, but again, it's that two to three minute conversation: "Hey, how's the medicine working? Oh, it's working good. Cool. Let's refill it." You know, we wanted it to be more in depth just a little bit, kind of get to know him, make it more personable.

Examining the issue

Mental health

Mental health remains a critical concern nationwide. According to the Centers for Disease Control and Prevention (CDC), nearly half of all Americans will experience a mental health disorder during their lifetime, yet only about half of those individuals receive appropriate care. Conditions such as anxiety and depression – two of the most common diagnoses – can significantly impact a person's ability to engage in healthy daily behaviors and maintain overall well-being.

In this survey, more than **30%** of respondents reported having been diagnosed with depression or anxiety. Encouragingly, perceptions of access to care have improved: While 25% of respondents in a previous assessment believed they could not easily access treatment for mental health or substance use disorders, that figure dropped to just 14% in this year's survey.

Despite this progress, barriers to accessing mental health care persist. The top three challenges identified by community members include:

1. Cost of care or lack of insurance
2. Long wait times for appointments
3. Stigma associated with seeking behavioral health support

Addressing these barriers is essential to improving mental health outcomes across our communities and ensuring equitable access to care.

Mental Health America of Greenville County

Life's challenges can be difficult, and many people face crises related to mental health struggles, emotional distress, or substance misuse without the necessary support. Mental Health America of Greenville County (MHAGC), home of South Carolina's 988 Suicide & Crisis Lifeline, is dedicated to addressing urgent mental health challenges across our state. The 988 Suicide & Crisis Lifeline offers a free, confidential resource available 24/7/365, connecting anyone in need to a caring, nonjudgmental counselor by phone, text, video or computer chat.

MHAGC strengthens and saves lives through this and other services that positively impact mental health. The organization's vision is a world where everyone can live with hope – where care is accessible, stigma and suicide are erased, and positive mental health is a reality for all.

MHAGC is deeply engaged in the community, teaching basic mental health coping skills and suicide protective factors to both children and adults.

In 2024, MHAGC's volunteer coordinator/trainer spoke to the Upstate Department of Pediatrics about the 988 Suicide and Crisis Lifeline, and the organization regularly meets with pediatric and med-peds residents during their Community Child Health & Advocacy rotation to discuss their work, including their aim to eliminate mental health stigma.

Voices from the community

I would say obesity in spite of food insecurity. It continues to baffle me to see so many of our patients who really struggle with food and are extremely obese now. They're eating horrible food. I mean, cheap boxed, canned, processed, fast food.

And sometimes we tend to eat the wrong things, which causes us to have weight issues. And as a result of weight issues, a lot of high blood pressure.

And then those of us who are affected by obesity, that's another layer of stigma that gets added to finding our health care.

There's quite a bit of obesity in the Midlands, and some of that is southern in nature with fried foods and so forth.

The rate of obesity, the lack of ability to purchase healthy foods ... I think we're gonna see that exacerbated in our current environment as prices are going up especially around imported produce and fruits and vegetables.

Examining the issue

Overweight and obesity

Maintaining a healthy body weight through balanced nutrition is fundamental to overall wellness and disease prevention. Poor dietary habits and excess weight are major contributors to many of the most common and serious health conditions, including high blood pressure, Type 2 diabetes, heart disease, stroke and certain types of cancer.

Obesity continues to be a widespread concern both nationally and locally. From 2021 to 2023, **40.3%** of adults in the United States were classified as obese. In South Carolina, the rate was **32.6%**, reflecting a significant portion of the population at elevated risk for chronic disease. In this survey, **35%** of respondents indicated a health care provider diagnosis of being obese or overweight.

These trends highlight the urgent need for community-wide strategies that promote healthier lifestyles through increased access to nutritious foods, opportunities for physical activity and education about sustainable weight management.

Stats

- The top challenges to eating healthfully are healthy foods are too expensive, some do not know how to eat healthfully, and being too tired after work.
- The top challenges to physical activity include personal choice, not enough sidewalks or bike lanes, and safety of the community.
- More than **1 in 10 parents** reported their children have been diagnosed as overweight.
- Similar to adults, the top challenges to eating healthfully for children are healthy foods are too expensive, and some do not know how to eat healthfully.
- **44%** of parents indicated that their children eat fast food at least once a week.
- Access to physical activity for children is limited by parent schedule, not enough sidewalks or bike lanes, and safety of the community.

County	Adult obesity
Greenville	30%
Laurens	41%
Oconee	32%
Pickens	37%
Lexington	39%
Richland	34%
Sumter	41%

Source: **https://www.countyhealthrankings.org**

FoodShare South Carolina

Many communities in South Carolina do not have access or financial resources to eat healthfully every day. Barriers include where people live, age, income and whether reliable transportation exists. Without healthy options, health risks increase. Bringing fresh produce into the community is a form of food equity and is part of the mission of FoodShare South Carolina. The goal is to enhance the quality of life in diverse communities by increasing access to fresh, affordable produce and providing quality cooking skills education.

"I was introduced to the VeggieRX program that helped transform my life," said a program participant. "This program helped me to lose 40 pounds by implementing healthy eating habits. I will be forever grateful for this program."

FoodShare South Carolina's mission is to increase access to, knowledge of and consumption of vegetables and fruit through community-led projects. All of FoodShare's work is guided by strong beliefs that reflect the commitment to food security and food justice. In early April 2025, FoodShare South Carolina launched their first community cooking class in their new kitchen. FoodShare collaborates with Finlay House, a senior residence community in Columbia, on a three-part series for residents who receive the Fresh Food Box.

"These are great lessons on food insecurity and ways to combat that with patients [and] excellent opportunities to collaborate with peers," said one class participant.

The classes focus on strategies for safe food storage, cooking for one, cooking with limited equipment and/or in a small space and managing chronic disease through food choices.

Voices from the community

We are not as aggressive in eating healthy and exercise to try to prevent hypertension, diabetes until it happens. And then we get extremely aggressive about taking care of those issues after the horse has gotten outta the gate.

I give away free glucometers every day. We have a lot of diabetes educators and we have a lot of resources, but I'm not sure they always get to the right place.

My community seemed to be plagued with diabetes and hypertension, which, as you well know, lead to other complications. A lot of high amputees come from hypertension and diabetes.

I'm going there because I have problems with my legs, and I have diabetes, so I'm learning how to handle that. And I'm also reaching out and teaching people where to go and what to do and how to help themselves.

Examining the issue

Diabetes

Diabetes affects over **13%** of adults in South Carolina, with an additional **34%** estimated to have prediabetes, placing the state among those with the highest prevalence in the nation. Within the Prisma Health service area, CHNA research revealed that **25%** of respondents reported a recent diagnosis of diabetes or prediabetes. The disease disproportionately impacts older adults, low-income populations and Black communities. Among those affected, serious complications such as kidney failure, heart disease and amputations are common. To curb this trend, health professionals emphasize early detection, lifestyle changes (including diet, exercise and weight loss), and structured diabetes education – strategies shown to reduce risk by up to **58%**.

Stats

- Fasting blood glucose or A1c screenings are routine for **37%** of respondents.
- The top challenges to eating healthfully are healthy foods are too expensive, some do not know how to eat healthfully, and being too tired after work.
- The top challenges to physical activity include personal choice, not enough sidewalks or bike lanes, and safety of the community.

County	Diabetes prevalence (adults 18+)
Greenville	9%
Laurens	12%
Oconee	10%
Pickens	10%
Lexington	10%
Richland	12%
Sumter	13%

Source: https://www.countyhealthrankings.org

Sources

- https://diabetes.org/
- https://www.diabetesfreesc.org/resources/professional-resources
- https://dph.sc.gov/sites/scdph/files/Library/CR-013028.pdf

LiveWell Greenville

Since 2017, coalitions across South Carolina have been working alongside Prisma Health as part of Healthy People, Healthy Carolinas, an initiative launched by The Duke Endowment. Over the past eight years, these coalitions have expanded their reach, supporting communities within Prisma Health's service area, including Greenville, Laurens and Richland counties.

One such coalition, LiveWell Greenville, plays a vital role in addressing social and environmental factors that influence health outcomes. For nearly 15 years, LiveWell has served as a trusted community convener, working to increase access to healthy foods and opportunities for physical activity. The organization focuses on creating lasting policy, systems and environmental change.

"LiveWell Greenville's more than **250** partners are working to tackle huge, systemic problems that contribute to health outcomes. No one organization can shift the system alone. It takes many of us working together to address the social drivers of health like food security and active living opportunities," said Sally Wills, LiveWell Greenville executive director.

A recent example of LiveWell's impact is the action taken after a road safety audit near a local school. In response to identified hazards, LiveWell partnered with the Department of Transportation to develop a plan, advocate for improvements and secure funding. These infrastructure upgrades will be in place by fall 2025, creating safer routes to school and improving daily health and safety of local children.

This collaborative, community-driven approach reflects Prisma Health's ongoing commitment to addressing the broader factors that shape health and well-being across the region.

Anthony Jackson

Senior Vice President, Service Lines and Chief Community Officer

Prisma Health

Final thoughts and next steps

To all the community members and residents who took time to fill out the surveys, thank you. We hear you and will continue to provide opportunities to understand your top health concerns. We appreciate the time and support from our stakeholders, focus groups and community leaders to provide their input for strategies and opportunities for growth and improvement.

We believe that the Community Health Needs Assessment is an opportunity for Prisma Health to hear the voices of the community as we identify health priorities, foster collaborations and develop strategies to improve health for all South Carolinians. The CHNA allows us to:

- **Develop strategies uniquely designed to meet the needs of our local communities.** We recognize that each county presents its own unique challenges, assets and opportunities. We will work closely with community leaders and organizations to understand the best way to develop strategies that address health disparities and support programs that improve health.
- **Collaborate with civic and community leaders.** Prisma Health has a unique opportunity to work collaboratively to improve the health outcomes. As the state's largest nonprofit health care provider, we can think of creative and innovative ways to enhance or expand community health services, especially for chronic conditions that impact the entire state, including the top three priorities – mental health, overweight and obesity, and diabetes.
- **Explore opportunities for authentic communication and community engagement.** We look forward to community forums to introduce Prisma Health staff and services to community members, and share communication on the programs and services we develop to improve access to care, mental health services, and to promote health and wellness to curb overweight and obesity, and diabetes.
- **Be innovative with non-traditional partnerships.** Overweight and obesity are the second highest priority of both markets. Through discussions with key stakeholders, Prisma Health could begin to lead changes that affect not just healthier eating but also influence a way to promote lifestyle changes. Prisma Health will begin an implementation plan of the 2025 CHNA priorities and report progress at **PrismaHealth.org/CHNA**.

Prisma Health will begin an implementation plan of the 2025 CHNA priorities by February 2026.

Acknowledgments

This 2025 Community Health Needs Assessment (CHNA) Report is based on the collaboration of several organizations. Prisma Health would like to extend special thanks to all members of GOODSTOCK, LLC, for their consulting work, the CHNA internal planning team and the advisory team.

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This Community Health Needs Assessment Report for fiscal year 2025 was adopted by the Prisma Health Board of Directors at its meeting held on September 3, 2025.

Appendix 1

CHNA Survey

Dear community member,

During the next several months, Prisma Health will conduct a community health needs assessment (CHNA) to identify ways we can collaborate with community organizations and leaders to help improve the overall health and wellness of individuals living in our hospital service areas. Your answers to this CHNA Survey will help us understand what is important and how we can better serve the residents of our community.

The CHNA is designed to identify health and social needs such as food, transportation, housing, and resources, and strategies to address the health needs of underserved communities. This CHNA, required with the passage of the Affordable Care Act, will include interviews with state and local elected officials, major employers, community members and community organizations that provide health services. Along with the interviews, our team also will conduct surveys, through prepaid mailings, in-person, online and at local organizations, agencies, businesses, and community events.

Once the assessment is completed, we will work with our partners to analyze the results, determine gaps in services and decide how the hospital system may be able to collaborate to meet high priority community needs.

The surveys are anonymous. Collected information will not be attributed to any specific source. Once all data is compiled, we will share the results of the completed report on PrismaHealth.org/CHNA. Previous reports and information about the CHNA also are provided on this website.

Sincerely,

Anthony Jackson
Vice President, Accountable Communities and Community Health
Prisma Health

PRISMA HEALTH

2025 Community Health Needs Assessment Survey

If you already completed the 2025 Community Health Needs Assessment Survey, please do not complete it again. Thank you.

PART 1: Your Information and Community

1. What county do you live in? (If your county is not listed, you do not need to complete this survey.)
   - ❑ Greenville
   - ❑ Laurens
   - ❑ Lexington
   - ❑ Oconee
   - ❑ Pickens
   - ❑ Richland
   - ❑ Sumter

2. My home ZIP code is: _____

3. How many people live in your home (including yourself): _____

4. What is your age? **Please choose only one.**
   - ❑ Under 18
   - ❑ 18-24
   - ❑ 25-34
   - ❑ 35-44
   - ❑ 45-54
   - ❑ 55-64
   - ❑ 65+

5. How do you describe your gender identity? **Please choose only one.**
   - ❑ Female
   - ❑ Male
   - ❑ Non-binary
   - ❑ Transgender (female to male)
   - ❑ Transgender (male to female)
   - ❑ Prefer to not answer
   - ❑ Prefer to self-identify: _____

6. Which race and ethnicity category do you most identify with? Check all that apply.
   - ❑ American Indian or Alaska Native
   - ❑ Asian
   - ❑ Black or African American
   - ❑ Native Hawaiian or other Pacific Islander
   - ❑ White
   - ❑ More than one race
   - ❑ Prefer not to answer
   - ❑ Other: _____

7. Which ethnic category do you most identify with? **Please choose only one.**
   - ❑ Hispanic, Latinx or Spanish origin
   - ❑ Non-Hispanic, Non-Latinx or Non-Spanish origin
   - ❑ Prefer not to answer

8. What is your living situation? Check all that apply.
   - ❑ I own my home.
   - ❑ I rent my home.
   - ❑ I live with family or friends.
   - ❑ I live in temporary housing (such as shelter, hotel, motel, transitional housing).
   - ❑ I am homeless.
   - ❑ Prefer not to answer.
   - ❑ Other: _____

9. What is your current employment status? Check all that apply.
   - ❑ Full-time work
   - ❑ Part-time work
   - ❑ Self-employed
   - ❑ Out of work and not currently looking for work
   - ❑ Out of work and looking for work
   - ❑ A homemaker
   - ❑ Student
   - ❑ Retired
   - ❑ Unable to work

Continued next page

❑ Disabled ❑ Seasonal or migrant work ❑ Other:_____

10. Have you served on active duty in the United States armed forces? **Please choose only one.**

❑ Yes ❑ No ❑ Currently enlisted

11. What was your total family income last year before taxes? **Please choose only one.**

❑ Less than $10,000 ❑ $10,001-$20,000 ❑ $20,001-$30,000

❑ $30,001-$40,000 ❑ $40,001-$50,000 ❑ $50,001-$60,000

❑ $60,001-$70,000 ❑ $70,001-$80,000 ❑ $80,001-$90,000

❑ $90,001-$100,000 ❑ $100,000+

12. What is the highest level of school, college or vocational training you finished? **Please choose only one.**

❑ Less than a high school diploma ❑ High school diploma (or GED) ❑ Some college, no degree

❑ Associate degree ❑ Bachelor's degree ❑ Graduate degree (master's, doctorate)

❑ Other:_____

13. Please rank the top THREE health concerns in your community. Write a **1** for your top ranked concern, **2** for your second ranked concern and **3** for your third ranked concern.

_____Accidents/Injury/Violence	_____Alcohol use	_____Alzheimer's/Dementia
_____Arthritis	_____Asthma	_____Cancer
_____Care for individuals with special health care needs	_____COVID-19	_____Diabetes
_____Drug use	_____Healthy pregnancies and childbirth	_____Heart disease/stroke
_____High blood pressure	_____HIV/AIDS	_____Immunizations (vaccines)
_____Infant death	_____Infectious diseases	_____Kidney disease
_____Mental health (anxiety, depression, etc.)	_____Nutrition	_____Overweight/Obesity
_____STI/STD (Sexually Transmitted Infection/Disease)	_____Tobacco use	_____Other:_____

14. What types of health services are most important to keep you healthy? Check all that apply.

❑ Alzheimer's/dementia care	❑ Cancer care	❑ Colorectal care/screening
❑ Dental care	❑ Diabetes care	❑ Disease outbreak prevention
❑ Drug and alcohol misuse	❑ Emergency preparedness	❑ Fall prevention for the elderly
❑ Heart disease care	❑ HIV/AIDS	❑ Hypertension/high blood pressure services
❑ Maternal/infant services	❑ Mental health/depression care	❑ Nutrition
❑ Quitting smoking/tobacco products	❑ Routine wellness checkups (mammogram, cholesterol, immunization, well child)	❑ STI/STD (Sexually Transmitted Infection/ Disease) care
❑ Suicide prevention	❑ Telehealth	❑ Vision care
❑ Weight loss support	❑ Other: _____	

Continued next page

15. What is the main reason that prevents you from receiving preventive care (mammograms, cancer screenings, flu shots, etc.)? **Please choose only one.**

❑ Access to facilities	❑ Cost	❑ Discrimination
❑ Fear (medical bias, diagnosis, etc.)	❑ Lack of health knowledge	❑ Other:_____
❑ I do not experience significant barriers to receiving preventive care		

16. Which of the following are challenges in your community to eating healthy? Check all that apply.

❑ Don't cook at home	❑ Eat fast food regularly	❑ May not know how to eat healthy
❑ No community gardens	❑ No farmers market	❑ No grocery store nearby
❑ Stores don't accept SNAP/EBT/WIC	❑ Stores don't have quality fruits and vegetables	❑ Too tired after work
❑ Too expensive	❑ Other:_____	

17. Which reasons prevent people from being physically active in your community? Check all that apply.

❑ Access to community centers or facilities	❑ Access to parks	❑ Lack of community events
❑ Not enough sidewalks or bike lanes	❑ Personal choice	❑ Safety of community (streetlights, crime, etc.)
❑ Other:_____		

18. Below is a list of potential barriers to behavioral health services. Indicate your level of agreement for YOUR COMMUNITY.

Cost of behavioral health care/ No insurance	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Not sure
Lack of behavioral health resources	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Not sure
Lack of trained behavioral health staff	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Not sure
Transportation to and from services	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Not sure
Limited hours of operation	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Not sure
Long waiting lists to access care	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Not sure
Stigma of seeking help for behavioral issues	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Not sure

Continued next page

Discrimination	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Not sure
Religious/cultural differences	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Not sure
Language barriers	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Not sure
Lack of cultural competence	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Not sure
Sexual orientation barriers	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Not sure

PART 2: Children's Health

Please answer the following about the children in your community.

19. Which reasons prevent children in your community from being physically active? Check all that apply.

- ❑ Access to facilities
- ❑ No community or organized events
- ❑ Not enough physical activity at school
- ❑ Not enough sidewalks or bike lanes
- ❑ Parent schedule
- ❑ Safety of community

20. Which of the following are reasons that prevent children in your community from eating healthy foods? Check all that apply.

- ❑ Eat fast food regularly
- ❑ No community gardens
- ❑ No farmers market
- ❑ No grocery store nearby
- ❑ Marketing of over processed foods to children
- ❑ May not know how to eat healthy
- ❑ Meal options at school
- ❑ Parents don't cook at home
- ❑ Parents too tired after work
- ❑ Stores don't accept SNAP/EBT/WIC
- ❑ Stores don't have quality fruits and vegetables
- ❑ Too expensive for parents
- ❑ Other:_____

20. How old is/are the child/children living in your home?

- ❑ Under one year
- ❑ 5-11
- ❑ 12-14
- ❑ 15-18
- ❑ No children live in my home **(<u>SKIP TO PART 3, Your Health</u>)**

21. Does **your child** receive free or reduced lunch? **Please choose only one.**

- ❑ Yes
- ❑ No
- ❑ Not sure

22. Check all the health issues children in your home have faced. Check all that apply.

- ❑ Allergies
- ❑ Asthma
- ❑ Autism
- ❑ Bullying
- ❑ Behavioral health/Mental health
- ❑ Birth-related (such as low birthweight, prematurity, prenatal and others)
- ❑ Child abuse/Child neglect
- ❑ Children overweight
- ❑ Children underweight

Continued next page

- ❑ Crime/community violence
- ❑ Dental problems (such as cavities, root canals, extractions, surgery and others)
- ❑ Diabetes/Pre-diabetes/High blood sugar
- ❑ Educational needs
- ❑ Sexually transmitted disease
- ❑ Teen pregnancy
- ❑ Unintentional injuries or accidents that required immediate medical care (such as a concussion from playing sports)
- ❑ Using drugs or alcohol
- ❑ Using tobacco, e-cigarettes or vaping
- ❑ My children have not faced any health issues.
- ❑ Other:_____

23. Do any children in your home…? Check all that apply.

Eat at least 3 servings of fresh fruits and vegetables every day	❑ Yes	❑ No	❑ Not sure
Eat home cooked meals	❑ Yes	❑ No	❑ Not sure
Exercise at least 60 minutes every day	❑ Yes	❑ No	❑ Not sure
Get at least 8 hours of sleep every night	❑ Yes	❑ No	❑ Not sure
Have access to firearms in the home	❑ Yes	❑ No	❑ Not sure
Know how to swim	❑ Yes	❑ No	❑ Not sure
Receive all shots to prevent disease	❑ Yes	❑ No	❑ Not sure
Stay home from school five or more days a year because of health	❑ Yes	❑ No	❑ Not sure
Use a car/booster seat (under 4 feet, 9 inches)	❑ Yes	❑ No	❑ Not sure
Use sunscreen	❑ Yes	❑ No	❑ Not sure
Wear a bike helmet	❑ Yes	❑ No	❑ Not sure
Wear a seatbelt at all times	❑ Yes	❑ No	❑ Not sure

24. During the past 12 months, where did you usually take your child/children for routine medical care? **Please choose only one.**

- ❑ Doctor's office
- ❑ Emergency room
- ❑ Retail clinic (i.e. CVS)
- ❑ School-based health center
- ❑ Urgent care
- ❑ Other:_____

25. Was there a time in the PAST 12 MONTHS when children in your home needed health care but did NOT get the care they needed?

- ❑ My child(ren) did not receive the **medical care** they needed at least once in the last 12 months.
  ANSWER QUESTION 26
- ❑ My child(ren) did not receive **dental care** they needed at least once in the last 12 months.
  ANSWER QUESTION 27
- ❑ My child(ren) did not receive the **mental health care** they needed at least once in the last 12 months.
  ANSWER QUESTION 28
- ❑ My child(ren) did need any healthcare in the last 12 months.
  SKIP TO PART 3
- ❑ My child(ren) received all the healthcare they needed in the last 12 months.
  SKIP TO PART 3
- ❑ Not sure
  SKIP TO PART 3

26. What is the MAIN reason they didn't get the **<u>medical care</u>** they needed? **Please choose only one.**

- ❑ Can't afford it/Costs too much
- ❑ I had transportation problems
- ❑ I don't have a doctor

Continued next page

- ❑ I don't know where to go
- ❑ I had trouble getting an appointment
- ❑ I don't have health insurance
- ❑ Other: _____

27. What is the MAIN reason they didn't get the **dental care** they needed? **Please choose only one.**

- ❑ Can't afford it/Costs too much
- ❑ I had transportation problems
- ❑ I don't have a dentist
- ❑ I don't know where to go
- ❑ I had trouble getting an appointment
- ❑ I don't have dental insurance
- ❑ Other: _____

28. What is the MAIN reason they didn't get the **mental health care** they needed? **Please choose only one.**

- ❑ Can't afford it/Costs too much
- ❑ I had transportation problems
- ❑ I don't have a doctor/counselor
- ❑ I don't know where to go
- ❑ I had trouble getting an appointment
- ❑ I don't have health insurance
- ❑ Other: _____

PART 3: Your Health

31. How do you pay for most of your health care? **Please choose only one.**

- ❑ Cash (no insurance)
- ❑ Commercial or employer-provided health insurance (HMO, PPO)
- ❑ Credit Card (no insurance)
- ❑ Indian Health Services
- ❑ Medicaid or Medicaid HMO
- ❑ Medicare or Medicare HMO
- ❑ TRICARE
- ❑ Veterans Administration
- ❑ Other: (describe) _____

32. Do you have one person you think of as your personal doctor or health care provider? **Please choose only one.**

- ❑ Yes
- ❑ No
- ❑ Not sure

33. Which of the following tests/screenings/procedures are routine in your personal health? Check all that apply.

- ❑ A1c or fasting blood glucose
- ❑ Annual physical or well check
- ❑ Blood pressure check
- ❑ Cholesterol screening
- ❑ Colonoscopy
- ❑ Dental cleaning/X-rays
- ❑ Flu shot
- ❑ Mammogram
- ❑ Pap smear
- ❑ Vision screening
- ❑ None of the above

34. Please rate the following statement: **I am comfortable using the Internet to talk with my doctor (video visit, online chat, other online options). Please choose only one.**

- ❑ Strongly agree
- ❑ Agree
- ❑ Neutral
- ❑ Disagree
- ❑ Strongly disagree
- ❑ Not sure
- ❑ No reliable internet

35. Has a doctor, nurse or other health care provider told you that you have the following? Check all that apply.

- ❑ Alcohol use or substance use disorder
- ❑ Depression/anxiety
- ❑ High cholesterol
- ❑ High blood sugar (pre-diabetes, diabetes)
- ❑ High blood pressure
- ❑ Overweight/obesity
- ❑ None of the above

PART 4: Your Social and Behavioral Health

Continued next page

36. In the last 12 months, have you or any family member you live with been unable to get any of the following when it was really needed?

Access to reliable internet	❑ Yes	❑ No	❑ Not sure
Childcare	❑ Yes	❑ No	❑ Not sure
Clothing	❑ Yes	❑ No	❑ Not sure
Food	❑ Yes	❑ No	❑ Not sure
Housing	❑ Yes	❑ No	❑ Not sure
Medicine or any health care	❑ Yes	❑ No	❑ Not sure
Phone	❑ Yes	❑ No	❑ Not sure
Utilities	❑ Yes	❑ No	❑ Not sure
Other (describe):			

37. Has lack of transportation kept you from any of the following:

Medical appointments	❑ Yes	❑ No	❑ Not sure
Meetings or work	❑ Yes	❑ No	❑ Not sure
Getting the things you need for daily living (e.g., food, clothes, prescriptions, etc.)	❑ Yes	❑ No	❑ Not sure

38. What is your main form of general transportation? **Please choose only one.**

❑ Family/friend
❑ Personal automobile (e.g., car, truck, motorcycle)
❑ Public transportation (e.g., bus)
❑ Taxi/ride-share company (e.g., Uber, Lyft)
❑ Walk/bicycle
❑ Other:_____

39. How often do you see or talk to people you care about and feel close to (such as talking to friends on the phone, visiting with family or friends, going to church or club meetings)? **Please choose only one.**

❑ Less than once per week
❑ 1 to 2 times per week
❑ 3 to 5 times per week
❑ 5 or more times per week

40. In the last 12 months, how often were you worried that your food would run out before you got money to buy more? **Please choose only one.**

❑ Often
❑ Sometimes
❑ Never

41. In the last 12 months, how often did your food run out and you did not have money to get more? **Please choose only one.**

❑ Often
❑ Sometimes
❑ Never

42. Do you feel physically and emotionally safe where you currently live? **Please choose only one.**

❑ Yes
❑ No
❑ Unsure

43. Please rate your level of agreement with the following statement: **I could easily obtain treatment for a mental health illness or substance abuse disorder. Please choose only one.**

❑ Strongly agree
❑ Agree
❑ Neutral
❑ Disagree
❑ Strongly disagree
❑ Not sure

44. Whether it was diagnosed or not, do you believe YOU or SOMEONE IN YOUR HOUSEHOLD has experienced the following: Check all that apply.

Alcohol use disorder	❑ Yes	❑ No	❑ Not sure

Anxiety disorder	❑ Yes	❑ No	❑ Not sure
Depression	❑ Yes	❑ No	❑ Not sure
Opioid use disorder	❑ Yes	❑ No	❑ Not sure
Other mental health condition	❑ Yes	❑ No	❑ Not sure
Other substance use disorder	❑ Yes	❑ No	❑ Not sure

Thank you for your time in completing this survey. Your answers will help us create a healthier community. If you prefer to complete this survey online, please visit PrismaHealth.org/CHNA. Your identity will remain anonymous for all survey responses.

If you would like to be entered in a drawing to win a $100 Visa gift card, please enter your information here: (All survey response will remain anonymous)

Name:
Email:
Phone/Cell:

Appendix 2

Interview Guide

1. How would you describe the overall health of your community?
   PROBE: What do you consider to be your community's greatest strength?
2. How has the health of the community changed in last 3 years?
   PROBE: What has contributed to this change?
3. What do you think are the three MOST important health issues in your community? (Choose only three.)
   PROBE: What makes these the most important for your community?
   PROBE: Which segments of your community are experiencing these issues the most/least?
   - Access to reliable Internet
   - Alcohol use
   - Alzheimer's/Dementia
   - Arthritis
   - Asthma
   - Cancer
   - COVID-19
   - Diabetes
   - Drug use
   - Heart disease/Stroke
   - High blood pressure
   - HIV/AIDS
   - Infant death
   - Injury/Violence
   - Kidney disease
   - Mental health (anxiety, depression, etc.)
   - Overweight/Obesity
   - STI/STD (Sexually transmitted infection/disease)
   - Tobacco use
   - Other
4. Are there adequate resources in your community to address these issues? Yes – Please explain: No – Please explain:
5. How do you view your organization's role in working to improve these (health) issues?
   PROBE: What are your current strategies to improve these issues?
6. What other organizations are working to improve these issues?
   PROBE: How are organizations collaborating to address these issues?
7. What are the biggest client barriers you have encountered while trying to improve the health of the residents in your service area?
   - Lack of insurance
   - Having insurance but not being able to afford the co-pays or deductibles
   - Lack of knowledge of health care and insurance options
   - Lack of transportation
   - Cultural issues
   - Language issues
   - Not trusting doctors or medical professionals
   - Fear or uncertainty around seeking health care
   - My clients typically do not have barriers to access
   - Other
8. What community resources or services have you noticed as being most helpful for your clients to maximize their health?
9. What are the top three strengths or resources in [Greenville, Laurens, Lexington, Oconee, Pickens, Richland, and Sumter counties] that can be used to improve health? (Clarify which county is being discussed)
   PROBE: How would you use these resources to address health in your community?
   - Government support
   - Community coalitions and collaboration
   - Funding opportunities
   - Health system support
   - Local colleges and universities
   - Community infrastructure
   - Other
10. How do these strengths help improve the health in your community?
11. How can these strengths be built upon or enhanced to further address health in your community?
12. What is Prisma Health's unique role in addressing community health needs?
13. What additional comments do you have regarding health in Greenville, Laurens, Lexington, Oconee, Pickens, Richland and Sumter Counties (clarify which county is being discussed)?

Appendix 3a

Community Focus Group Guide

- **Welcome and Introductions** – 10 minutes
  Goal: Create a sense of common purpose.
  Process: Explain that the purpose of this focus group is to determine if there are any community health areas of need that should be focused on. This will be determined by the clinicians identifying any clinical outliers.
- **Leading Questions** (55 minutes)
  Goal: Generate conversation and feedback
  Process: Ask participants questions listed below.
- **Conclusion** (5-10 minutes)
  Goal: Summarize meeting key notes and allow participants to share reflections
  Process:
  - Facilitator shares 2-3 key themes that emerged during conversation
  - Ask 2-3 participants to share their final thoughts and/or reflection on the discussion overall
  - Provide information on next steps regarding the CHNA (results will be analyzed in June and July, with a report prepared and approved by Sept. 30, 2025 and posted on PrismaHealth.org/CHNA

Tips

- All thoughts and opinions are welcomed. We're not trying to achieve consensus; we're gathering information.
- Move up or move back. Don't hesitate to offer your opinion but respect the group by sharing the floor.
- To help ensure anonymity, please do not discuss the perspectives shared by your fellow community members/ colleagues during this focus group.
- Remind participants that the conversation will be recorded for transcription purposes only, and that their responses will remain anonymous. Those who are not comfortable being recorded are welcome to leave. State: by participating in this focus group, you are providing consent to be recorded.
- Ask participants if they have any questions.
- Press record

Engagement Questions:

1. What are the main strengths or assets of your community?
   a. PROBE: How do these assets help people live a healthy life?
   b. PROBE: Are there individuals in your community who do not have access to these assets? Why or why not?

Health Care Access Exploration Questions:

1. What are the main health issues in your community?
   a. PROBE: What contributes to these health issues?
   b. PROBE: What is Prisma Health's unique role in addressing community health needs?
2. Where do you go when you need health care services for yourself?
   a. PROBE: How about for other members of your family?
   b. PROBE: What helped you decide to go to your current doctor/provider for health care for you/ your family?
   c. PROBE: What are the main reasons you go to the doctor?
3. What is the hardest part of getting care in your area?
4. What is the easiest part of getting care in your area?
5. What, if any, services do you wish you had easier access to?
   a. PROBE: What would make accessing this service easier?
6. If you have children, what, if any, services do you wish you had easier access to?
   a. PROBE: What would make accessing these services easier?
7. What is the level of awareness of health care services in your community?
   a. PROBE: What are the reasons people in your community might not seek care even when needed?

Exit Questions:

1. Is there anything else you would like to add in regard to health care in your community?

Appendix 3b

Clinician Focus Group Guide

- **Welcome and Introductions** – 10 minutes
  Goal: Create a sense of common purpose.
  Process: Explain that the purpose of this focus group is to determine if there are any community health areas of need that should be focused on. This will be determined by the clinicians identifying any clinical outliers.
- **Leading Questions** (55 minutes)
  Goal: Generate conversation and feedback
  Process: Ask participants questions listed below.
- **Conclusion** (5-10 minutes)
  Goal: Summarize meeting key notes and allow participants to share reflections
  Process:
  - Facilitator shares 2-3 key themes that emerged during conversation
  - Ask 2-3 participants to share their final thoughts and/or reflection on the discussion overall
- Provide information on next steps regarding the CHNA (results will be analyzed in May, June and July, with a report prepared and approved by Sept. 30, 2022 and posted on PrismaHealth.org/CHNA

Engagement Questions:

1. Briefly describe your current practice setting.

Exploration Questions

1. What are the most common clinical encounters you see in your practice?
2. What specific clinical encounters have you seen increase or decrease over the past 1-3 years?
   a. PROBE: What do you think is contributing to this increase or decrease?
   b. PROBE: To what degree does this cause you concern?
3. Focusing on specific health issues, what would you say are the biggest health problems in our community?
   a. PROBE: What is contributing to this issue?
4. Focusing on specific health issues, what would you say are the biggest health successes in the community?
   a. PROBE: What is contributing to these successes?
5. What or who are the underserved populations in our community?
   a. PROBE: In what ways are they underserved?
   b. PROBE: How can we improve access to care for the populations you identified?
6. What is Prisma Health's unique role in addressing community health needs?
7. How aware are people in the community of the health care services/options available to them?
   a. PROBE: What contributes to this awareness/lack of awareness?
8. What are the most pressing health issues children in your community or practice face?
   a. PROBE: What is contributing to these issues for children?
   b. PROBE: What assets/resources are in your community to help address these issues for children?

Exit Questions

1. Is there anything else you would like to add about the health in the community you serve?

Appendix 4

County Health Rankings

Greenville County

Population Health and Well being	
Length of life	
Premature Death	9,100
Quality of life	
Poor Physical Health Days	3.6
Low Birth Weight	9%
Poor Mental Health Days	5.2
Poor or Fair Health	13%
Community Conditions	
Health infrastructure	
Flu Vaccinations	54%
Access to Exercise Opportunities	85%
Food Environment Index	7.9
Primary Care Physicians	900:01:00
Mental Health Providers	320:01:00
Dentists	1,470:1
Preventable Hospital Stays	1,961
Mammography Screening	52%
Uninsured	10%
Physical environment	
Severe Housing Problems	13%
Driving Alone to Work	76%
Long Commute Driving Alone	31%
Air Pollution: Particulate Matter	8.1
Drinking Water Violations	No
Broadband Access	91%
Library Access	2
Social and economic factors	
Some College	71%
High School Completion	90%
Unemployment	2.60%
Income Inequality	4.4
Children in Poverty	15%
Injury Deaths	109
Social Associations	12
Child Care Cost Burden	28%

Laurens County

Population Health and Well being	
Length of life	
Premature Death	13,900
Quality of life	
Poor Physical Health Days	4.5
Low Birth Weight	10%
Poor Mental Health Days	6.1
Poor or Fair Health	19%
Community Conditions	
Health infrastructure	
Flu Vaccinations	44%
Access to Exercise Opportunities	52%
Food Environment Index	7.5
Primary Care Physicians	1,990:1
Mental Health Providers	1,150:1
Dentists	3,580:1
Preventable Hospital Stays	3,021
Mammography Screening	52%
Uninsured	13%
Physical environment	
Severe Housing Problems	15%
Driving Alone to Work	80%
Long Commute Driving Alone	41%
Air Pollution: Particulate Matter	8.3
Drinking Water Violations	No
Broadband Access	84%
Library Access	<1
Social and economic factors	
Some College	49%
High School Completion	84%
Unemployment	3.20%
Income Inequality	4.6
Children in Poverty	24%
Injury Deaths	131
Social Associations	12.4
Child Care Cost Burden	24%

County Health Rankings

Lexington County

Population Health and Well being	
Length of life	
Premature Death	8,900
Quality of life	
Poor Physical Health Days	3.8
Low Birth Weight	9%
Poor Mental Health Days	5.4
Poor or Fair Health	15%
Community Conditions	
Health infrastructure	
Flu Vaccinations	52%
Access to Exercise Opportunities	69%
Food Environment Index	8.1
Primary Care Physicians	1,590:1
Mental Health Providers	470:01:00
Dentists	1,990:1
Preventable Hospital Stays	2,065
Mammography Screening	49%
Uninsured	10%
Physical environment	
Severe Housing Problems	12%
Driving Alone to Work	79%
Long Commute Driving Alone	37%
Air Pollution: Particulate Matter	7.8
Drinking Water Violations	Yes
Broadband Access	91%
Library Access	2
Social and economic factors	
Some College	68%
High School Completion	92%
Unemployment	2.50%
Income Inequality	4.2
Children in Poverty	14%
Injury Deaths	100
Social Associations	11.1
Child Care Cost Burden	27%

Oconee County

Population Health and Well being	
Length of life	
Premature Death	10,500
Quality of life	
Poor Physical Health Days	4.2
Low Birth Weight	9%
Poor Mental Health Days	5.7
Poor or Fair Health	16%
Community Conditions	
Health infrastructure	
Flu Vaccinations	49%
Access to Exercise Opportunities	51%
Food Environment Index	7.1
Primary Care Physicians	1,930:1
Mental Health Providers	830:01:00
Dentists	1,780:1
Preventable Hospital Stays	2,500
Mammography Screening	60%
Uninsured	13%
Physical environment	
Severe Housing Problems	12%
Driving Alone to Work	78%
Long Commute Driving Alone	29%
Air Pollution: Particulate Matter	8.2
Drinking Water Violations	No
Broadband Access	83%
Library Access	2
Social and economic factors	
Some College	64%
High School Completion	87%
Unemployment	2.80%
Income Inequality	4.8
Children in Poverty	20%
Injury Deaths	118
Social Associations	14.5
Child Care Cost Burden	20%

County Health Rankings

Pickens County

Population Health and Well being	
Length of life	
Premature Death	10,300
Quality of life	
Poor Physical Health Days	4.2
Low Birth Weight	8%
Poor Mental Health Days	5.8
Poor or Fair Health	18%
Community Conditions	
Health infrastructure	
Flu Vaccinations	54%
Access to Exercise Opportunities	73%
Food Environment Index	6.8
Primary Care Physicians	1,700:1
Mental Health Providers	680:01:00
Dentists	1,960:1
Preventable Hospital Stays	2,358
Mammography Screening	52%
Uninsured	12%
Physical environment	
Severe Housing Problems	16%
Driving Alone to Work	78%
Long Commute Driving Alone	40%
Air Pollution: Particulate Matter	8.2
Drinking Water Violations	Yes
Broadband Access	85%
Library Access	2
Social and economic factors	
Some College	62%
High School Completion	87%
Unemployment	2.90%
Income Inequality	5
Children in Poverty	18%
Injury Deaths	115
Social Associations	11.5
Child Care Cost Burden	36%

Richland County

Population Health and Well being	
Length of life	
Premature Death	9,500
Quality of life	
Poor Physical Health Days	3.9
Low Birth Weight	11%
Poor Mental Health Days	5.3
Poor or Fair Health	17%
Community Conditions	
Health infrastructure	
Flu Vaccinations	52%
Access to Exercise Opportunities	74%
Food Environment Index	7.2
Primary Care Physicians	1,210:1
Mental Health Providers	240:01:00
Dentists	1,050:1
Preventable Hospital Stays	2,044
Mammography Screening	52%
Uninsured	10%
Physical environment	
Severe Housing Problems	19%
Driving Alone to Work	72%
Long Commute Driving Alone	30%
Air Pollution: Particulate Matter	6.9
Drinking Water Violations	No
Broadband Access	89%
Library Access	2
Social and economic factors	
Some College	74%
High School Completion	92%
Unemployment	3.00%
Income Inequality	5.1
Children in Poverty	20%
Injury Deaths	84
Social Associations	11.4
Child Care Cost Burden	34%

County Health Rankings

Sumter County

Population Health and Well being	
Length of life	
Premature Death	13,400
Quality of life	
Poor Physical Health Days	4.4
Low Birth Weight	11%
Poor Mental Health Days	5.5
Poor or Fair Health	19%
Community Conditions	
Health infrastructure	
Flu Vaccinations	50%
Access to Exercise Opportunities	79%
Food Environment Index	8.1
Primary Care Physicians	1,870:1
Mental Health Providers	550:01:00
Dentists	1,760:1
Preventable Hospital Stays	2,773
Mammography Screening	45%
Uninsured	11%
Physical environment	
Severe Housing Problems	15%
Driving Alone to Work	85%
Long Commute Driving Alone	25%
Air Pollution: Particulate Matter	7.7
Drinking Water Violations	No
Broadband Access	84%
Library Access	<1
Social and economic factors	
Some College	64%
High School Completion	89%
Unemployment	3.80%
Income Inequality	5.2
Children in Poverty	24%
Injury Deaths	111
Social Associations	10.1
Child Care Cost Burden	38%

Additional social and economic factors	
High School Graduation	78%
Reading Scores	2.6
Math Scores	2.6
School Segregation	0.05
Children Eligible for Free or Reduced Price Lunch	99%
Gender Pay Gap	0.79
Median Household Income	$55,500
Living Wage	$44.17
Child Care Centers	6
Residential Segregation Black/White	37
Homicides	13
Motor Vehicle Crash Deaths	25
Firearm Fatalities	22
Disconnected Youth	6%
Lack of Social and Emotional Support	32%

Demographics

	Greenville	Laurens	Lexington	Oconee	Pickens	Richland	Sumter
County population	558,036	68,873	309,528	81,221	135,495	425,138	104,165
18 years or younger	22.8%	21.7%	22.9%	18.8%	18.4%	21.4%	23.6%
19-64 years	60.1%	59.1%	59.5%	55.8%	64.0%	64.1%	41.7%
65 + years	17.1%	19.2%	17.6%	25.4%	17.6%	14.5%	18.1%
Male	48.5%	48.6%	48.7%	49.4%	49.9%	48.0%	48.1%
Female	51.5%	51.4%	51.3%	50.6%	50.1%	52.0%	51.9%
American Indian	0.6%	0.5%	0.6%	0.5%	0.3%	0.4%	0.5%
Native Hawaiian	0.1%	0.2%	0.1%	0.0%	0.1%	0.1%	0.2%
Asian	2.8%	0.6%	2.5%	0.9%	2.0%	3.1%	1.4%
White	66.2%	67.0%	70.9%	83.8%	83.8%	39.7%	44.1%
African American	17.1%	23.5%	16.1%	7.0%	6.8%	48.2%	47.3%
Hispanic	11.7%	6.9%	8.1%	6.3%	5.5%	6.5%	4.5%
Single-parent houshold	22.0%	37.0%	23.0%	30.0%	21.0%	37.0%	39.0%
Rural population	11.9%	64.0%	25.2%	63.7%	37.6%	8.6%	34.8%

Source: County Health Rankngs (2025)

Through concerted efforts and strong engagement with our patients, guests and families; area leaders; health care advocates and goodwill ambassadors; academic, business, legislative and community partners; and team members acting as one Prisma Health, our communities can become stronger and healthier – both physically and emotionally.

PRISMA HEALTH®

Prisma Health Foundation, a 501(c)(3) nonprofit organization, engages community partners to enhance health care for patients and families served by Prisma Health. Gifts to the foundation will allow the hospital to continue to offer an ever increasing array of services targeted to meet specific community needs. Private support is essential to maintain a level of excellence with new programs, services and equipment. Find out more at PrismaHealthFoundation.org.

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