



**Conway Medical Center
Community Needs Assessment
Implementation Plan
Horry County
February 2026**



Our Mission

Conway Medical Center will improve the overall health of our communities by being a leader in health care.

About Conway Medical Center

Conway Medical Center is a trusted leader in healthcare and has served the medical needs of Horry County and the surrounding communities for nearly a century. The roots of this nonprofit medical center run deep in Horry County. In the 1920s, a group of local physicians recognized the need for a hospital in the area, and an application for a charter for Conway Hospital was filed with the South Carolina Secretary of State on November 7, 1928. At the time, the hospital operated on Elm Street in the old Burroughs Hospital.

They soon outgrew that location. As demand grew, that location quickly became insufficient. Work began on constructing and furnishing a new building on 9th Avenue with accommodations for 31 patients in single rooms and multi-bed wards on three floors. An open house for the facility was held on May 30, 1930.

Then in 1982, Conway Hospital moved to its current location on Singleton Ridge Road. However, the growth did not stop. In 2001, the hospital expanded the Emergency Department, Obstetrical Department, and added a three-story medical office building. A new Patient Bed Tower opened in 2009, adding 71,000 square feet and 64 patient rooms including critical and surgical care.

Conway Medical Center has significantly expanded its footprint and clinical offerings in the past few years, particularly by adding new specialties and establishing integrated offsite facilities to improve community access to care. New service lines and locations include the addition of specific medical specialties such as Oncology, Rheumatology, dermatology, infectious diseases, orthopedics, and pain management, along with the introduction of advanced technologies like robotic surgery.

A key component of CMC's recent growth has been the development of integrated medical plazas, most notably at its Health Plaza South campus in Socastee and a planned facility at Highway 90 and 22, which combine 24/7 emergency departments, ambulatory surgery centers, and comprehensive imaging services in a unified "one-stop-shop" model. These expansions, supported by a strategic partnership with Novant Health, aim to meet the growing healthcare needs of Horry County and the surrounding region.

Today, Conway Medical Center has 222 inpatient beds and is one of the county's largest employers with more than 2,500 team members. We are excited about the growth that continues at Conway Medical Center as we work to improve the overall health of our communities by being a leader in healthcare.



Implementation Plan

Conway Medical Center will engage key community partners in implementing evidence-based strategies across the service area. Acknowledging the many organizations and resources in place to address the health needs of our communities, Conway Medical Center has strategically integrated both internal and external resources. The Implementation Plan will explain how Conway will address health needs identified in the CHNA through existing programs and services and implementing new strategies.

Health Priorities

As outlined in the CHNA report, the following section outlines the needs Conway Medical Center has chosen to address. It will also describe why we chose to address this need, how we will address the need, who the responsible party will be, and any goals that will be set forth from the beginning, as well as timeframe for achieving those goals.

Prioritization was developed Conway community health leadership and presented to the board for approval. Criteria included importance to the service area, relevance of the health issues to the population served, and the ability of Conway to effectively impact and improve the identified health need.

The following five categories were identified as community health priorities in the county by Conway.

- Mental/Behavior Health
- Financial Barriers / Insurance
- Access to Healthcare
- Chronic Disease
- Health Education

Each of the community health needs identified above are interconnected. For instance, the lack of proper health education could impact access to health care services affecting the timeliness of preventive care or screenings necessary to properly diagnose and treat current and emerging diseases. This Implementation Plan will be executed in collaboration with community partners and health issue experts over the next three years.

The following key elements were used to develop Conway's implementation strategies:

- Identify what other local organization are doing to address the health priority
- Develop support and participation for these approaches to address the health need
- Develop specific and measurable goals so that the effectiveness of these approaches can be measured
- Develop detailed work plans
- Communicate with the assessment team and ensure appropriate coordination with other efforts currently underway to address the issue



Mental / Behavioral Health – Implementation Strategy

Objective: Improve mental and behavioral health outcomes for Horry County residents by expanding early identification, screening, referral, and access to evidence-based behavioral health services—particularly for uninsured, underinsured, postpartum, and other vulnerable populations—through coordinated clinical workflows and community partnerships.

Action Step	Accountability	Timeline	Desired Outcome
Depression Screening in Physician Offices			
Expand PHQ-9 screening to additional care settings.	PNS	Ongoing	Increased early identification and timely referral of patients experiencing depression across Horry County through standardized PHQ-9 screening in expanded clinical care settings, resulting in improved access to behavioral health evaluation, reduced untreated depression, and improved continuity of care for insured, underinsured, and uninsured populations.
Implement follow-up protocols to ensure continuity of care.	PNS	Ongoing	Reduce missed follow-up rates among patients with moderate-to-severe PHQ-9 scores through protocolized care navigation (including community resource guides and Access Health Horry pathways), leading to increased engagement in counseling or treatment and improved continuity of care across outpatient, maternal, and ancillary settings.
Strengthen partnerships with community organizations to broaden resource availability.	Leadership/ Foundation	Ongoing	Formalize and strengthen partnerships with community-based organizations that provide behavioral health, social support, and financial assistance services.
Postpartum Social Determinants of Health (SDOH) Screening			
Expand SDOH screening to additional maternal care settings.	Maternal Team/ PNS	Ongoing	Achieve a measurable increase in documented SDOH screenings and completed referrals for postpartum and perinatal patients, reducing unmet social and behavioral health needs that contribute to adverse maternal and infant outcomes.



Implement standardized follow-up protocols for postpartum behavioral health needs.	Maternal Team/ PNS	Ongoing	Implement standardized postpartum behavioral health follow-up protocols to ensure timely reassessment, referral, and care coordination for women with identified behavioral health or social needs, improving continuity of care and access to appropriate services during the postpartum period.
Strengthen partnerships with community organizations to broaden resource availability for mothers and families.	Foundation	Ongoing	Strengthen partnerships with community-based organizations to expand behavioral health and social support resources for mothers and families, increasing successful referrals and reducing access barriers for pregnant and postpartum patients with identified social or behavioral health needs.
Existing Community Investments and Capacity <i>Screening and referral workflows will include identification of substance use risks and linkage to community SUD services (e.g., counseling, MAT, overdose prevention), leveraging Access Health Horry and United Way partners for uninsured and underinsured patients.</i>			
Maintain grant-funded partnerships that expand community-based behavioral health services	Foundation	Ongoing	Sustained access to no-cost or low-cost behavioral health services for uninsured and underinsured residents.
Collaborate with Access Health Horry to support behavioral health referrals for uninsured patients	Leadership/ Foundation	Ongoing	Reduced access barriers and improved continuity of behavioral health care for vulnerable populations.



Financial Barriers / Insurance – Implementation Strategy

Objective: Address the financial barriers and lack of insurance, which play a major role in Horry County resident’s ability to access healthcare. Although medical services may be available throughout the county, high unemployment, lower incomes, and a lack of insurance may prohibit people from accessing or using these resources. People who have a low or fixed income are more vulnerable to competing financial priorities. These barriers must be addressed as county and hospital resources are expended to meet the community need.

Action Step	Accountability	Timeline	Desired Outcome
Increase Foundation donations to expand community outreach abilities			
Increase CMC employee donors via "Foundation Fridays" (jeans with qualifying donation)	Foundation	Year	Increase employee donations to support outreach
Grow annual events: Tree Auction, Golf Classic, Tennis Classic, Lights of Love, and PINK events	Foundation	Ongoing	Host successful events that generate visibility and donations
Promote Annual Giving Campaign for payroll-deducted employee donations	Foundation	Ongoing	Increase employee giving to fund initiatives, programs, endowments
Collaborate with community colleges/universities to expand skills training			
Maintain agreements with higher education institutions for clinical rotations and internships; maintain family medicine education via Campbell University affiliation	Leadership	Ongoing	Educate next-generation clinicians and serve rural/underserved communities
Open CMC College of Health and Human Performance at Coastal Carolina University	Leadership	Year	Produce career-ready individuals with immediate positive impact; align academic programs with community needs
Collaborate with community colleges/universities to expand skills training			
Provide support/resources for Horry County Schools Scholars Academy	Leadership	Ongoing	Increase access to STEAM education for youth
Allocate Foundation funding for employee scholarships to advance medical careers	Foundation	Ongoing	Expand scholarships for CMC employees/recruits pursuing healthcare degrees
Provide education/information about public assistance and CMC pricing			



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Maintain Pricing Transparency and Cost Estimator on CMC website	Marketing / Patient Accounting	Ongoing	Provide transparency and help patients understand potential out-of-pocket costs
Add website links to Medicaid and other public program resources	Marketing	Year	Connect low-income patients with assistance for medical bills and prescriptions
Secure grant funding for serious illness care (social worker + financial counselor)	Foundation	Year	Educate patients on care plans and available resources to address health and wellbeing
Partner with community-based organizations for low-income/uninsured care			
Provide overhead support for Friendship Medical Clinic (rent, utilities, hospital services)	Foundation	Ongoing	Offset operating costs for South Carolina's oldest free medical clinic
Support AccessHealth Horry to link uninsured/underinsured patients to care and medications	Foundation	Ongoing	Expand community network of care for low-income patients
Partner with Best Chance Network (SC Breast & Cervical Cancer Early Detection Program)	Foundation / Mobile Mammography	Ongoing	Refer qualifying patients for no-cost breast/cervical screening
Provide free healthcare services			
Colon Cancer Screening Initiative: pay for screening colonoscopy for uninsured (referrals via Friendship Clinic)	HealthReach	Year	Increase screening access for uninsured who meet clinical guidelines
Secure grants for mobile mammograms for uninsured/underinsured patients	Foundation	Ongoing	Provide free mammograms and related services
Secure grants for HealthReach van/team to deliver community services	Foundation	Ongoing	Reach individuals lacking insurance/family physician; identify conditions and educate on treatment



Access to Healthcare – Implementation Strategy

Objective: Provide better access points to healthcare in this community, to enhance the quality of life for Horry County citizens. The resources that the community and Conway Medical Center provide can have a significant impact on population health outcomes. If more resources are available in the community, the social and physical environments within the community will help to promote good health for all. For Horry County, the promotion of health education, increased provider access, and insurance literacy will help to improve the overall health of the community.

Action Step	Accountability	Timeline	Desired Outcome
Explore telemedicine options to supplement PCP shortage			
Continue building comprehensive telemedicine strategy	Leadership / PNS	Ongoing	Provide convenient PCP care to patients with barriers (e.g., transportation)
Educate community on newly implemented telemedicine options	Marketing	Ongoing	Encourage usage to enable regular physician follow-ups
Secure telehealth grant through the Duke Endowment	Foundation	Ongoing	Provide rural, low-income patients with access to provider/specialty services via telehealth
Promote usage of transportation resources			
Publish website information on available transportation resources	Marketing	Ongoing	Help patients find transportation to PCPs and hospital resources
Fund transportation options for underserved patients	Foundation	Ongoing	Facilitate transportation to CMC facilities for low-income patients
Coordinate transportation for patients lacking other means (taxi, vouchers, rural bus, Greyhound, non-emergent medical transport)	Case Management	Ongoing	Arrange transportation for low-income patients
Increase number of providers in underserved areas			
Conduct demographic research by ZIP code to evaluate practice opportunities	Leadership / PNS	Ongoing	Identify areas needing practice support
Complete provider needs assessment and continue recruiting efforts	Leadership / PNS	Ongoing	Understand capacity and address gaps in provider landscape
Expand new service lines (Dermatology, Orthopedics,	Leadership / PNS	Ongoing	Increase access to specialty care in Horry County



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Rheumatology, Pain Management, Cancer Care, Interventional Cardiology, Weight Loss, Infectious Diseases, Otolaryngology)			
Bring services to underserved communities via school/mobile clinics			
Operate mobile mammography van with adequate coverage (sites, days/times)	Foundation / Mobile Mammography	Ongoing	Provide free mammograms for eligible individuals aged 40–47 who are uninsured and do not qualify for assistance
Provide sports physicals at Carolina Forest High School; expand to additional Horry County schools; provide physicals to CCU student-athletes	PNS	Ongoing	Ensure student-athletes are fit to safely participate
Optimize EHR integration for Outreach van/mobile clinics	Information Technology	Ongoing	Facilitate seamless patient care for those without transportation
Expand CMC physical footprint			
Open/expand clinic locations (Health Plaza South, West Conway, Del Webb)	Leadership	Year	Increase access points within the CMC network
Go live with Embrace Home Hospice	Leadership	Year	Provide hospice care in patients' homes
Advance planning for new hospital at Carolina Forest (shift 50 underutilized beds; services include ED, labor/delivery, cancer care, surgery, imaging)	Leadership	Ongoing	Improve access to comprehensive hospital services



Chronic Disease – Implementation Strategy

Objective: Take actions to promote healthy lifestyles and environments that prevent chronic conditions.

Action Step	Accountability	Timeline	Desired Outcome
Increase Medicaid Annual Wellness Visits (AWV) for eligible patients			
Identify method to notify clinics of patients with overdue AWV	Information Technology / PNS / Payer Strategy	Year	Identify due patients; enable physician assessment/reporting of risk-adjusted diagnoses
Enable automated reminders to patients due for AWV	Information Technology / Marketing	Year	Increase AWV compliance via reminders
Publish information about medical benefits of AWV (Facebook posts/website article)	Marketing	Year	Raise awareness of AWV benefits
Host seminars to help manage chronic disease			
Host "Freedom from Smoking" classes	Foundation	Ongoing	Provide evidence-based techniques to support smoking cessation
Offer CMC Diabetes Self-Management Training (individual/group classes upon physician order)	Foundation	Ongoing	Teach self-management to prevent diabetes complications
Host online Weight Loss Surgery Seminars and non-surgical options	PNS	Ongoing	Support patients in achieving healthy weight
Lead Horry County Health Coalition			
Secure Duke Endowment grant to lead "Healthy People, Healthy Carolinas"	Foundation	Year	Collaborate with partners to reduce barriers and improve access
Organize meetings; take lead to ensure effective coalition	Leadership	Ongoing	Promote behavior changes (physical activity, nutrition) to reduce unhealthy weight, heart disease, diabetes
Support/implement coalition strategies (e.g., reduce hypertension under SC Quality Achievement Program)	Leadership	Ongoing	Share best practices; implement evidence-based programs
Expand primary care locations to support prevention			



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Open West Conway location (primary care + specialty services)	Leadership	Year	Improve chronic disease prevention via expanded access
Open CCU clinic for employees and dependents (potential expansion to HGTC)	Leadership	Year	Convenient access for CCU population; prevention opportunities
Open Del Webb location	Leadership	FY2024	Provide primary care and prevention for Grand Dunes residents
Raise awareness regarding chronic disease prevention			
Host annual Tennis Tournament to support Cancer Initiatives	Foundation	Ongoing	Use 100% of proceeds to fund lifesaving screenings and support patients
Keep CMC website updated with healthy recipes and exercise plans	Marketing	Ongoing	Provide resources for nutritious meals and physical activity
Continue/expand Smart Snacks Program for elementary-aged children (Waccamaw, Homewood, Midland, Conway)	Foundation	Ongoing	Deliver weekend nutritious snacks during school year



Health Education – Implementation Strategy

Objective: Create a more knowledgeable community that can successfully find and access care, prevent certain health conditions, make informed decisions, and effectively manage the health issues that arise.

Action Step	Accountability	Timeline	Desired Outcome
Partner with local/regional organizations and government agencies			
Increase networking/collaboration among corporate partners, community organizations, and health systems	Leadership	Ongoing	Improve resource sharing and coordination to enhance health education
Provide education via HealthReach to HGTC and local schools	Foundation	Ongoing	Empower patients with knowledge to better manage health
Partner with CCU on orthopedic/physical therapy service lines to support and educate student-athletes	PNS	Ongoing	Provide injury prevention and related health education
Identify, educate, and provide supportive resources to community members			
Fund promotion and education for diabetes, including support group	Foundation	Ongoing	Deliver diabetes education and support (assessment, consultation, group classes, nutrition therapy, monthly support group)
PNS providers to deliver diabetes education and care plans under PCMH approach	PNS	Ongoing	Improve knowledge and support for diabetic patients
Retain CMC Wellness Coordinator (The Wellness Connection)	Leadership	Ongoing	Promote health/safety for employees; support healthier habits
Host seminars and other health events			
Provide seminars addressing obesity and treatment/surgical options	Marketing / PNS	Ongoing	Increase number of people seeking help to address obesity
Participate in health fairs, community/worksite screenings, and other events	HealthReach / Marketing	Ongoing	Provide information, education, and screenings to improve health management
Host seminars at corporate partner sites	Marketing / Leadership	Ongoing	Offer onsite seminars convenient for working community members
Engage trusted community leaders to spread messages			
Promote CMC Heart to Heart Challenge (with Grand Strand Water, CCU)	Marketing	Ongoing	Encourage community members to become heart healthy
Participate in CCU Wellness Week (Kickoff, CMC Health Information Fair)	Leadership	Ongoing	Promote wellness and provide health information at CCU campus events
Expand CMC Employee Wellness Program			



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Continue financial incentive for employee completion of program	CMC Wellness	Ongoing	Maximize participation via incentives for actions that improve health
Build robust program (fitness, emotional wellness, nutrition, screenings)	CMC Wellness	Ongoing	Maintain integrated, comprehensive plan to support healthier lives
Improve care gap for employees with diabetes (increase compliance with recommended lab work)	CMC Wellness	Ongoing	Ensure effective diabetes management for employees



Appendix A — CHNA → Implementation Strategy Crosswalk

This appendix is a reference tool that summarizes how actions described in the Implementation Plan align with the priority needs identified in the 2025 Community Health Needs Assessment (CHNA). It does not replace or supersede the detailed strategies, timelines, or accountability outlined in the Implementation Plan.

Priority 1: Mental / Behavioral Health

1. CHNA Finding:

Elevated adult depression prevalence; provider shortages; uninsured barriers.

Implementation Action:

Expand PHQ-9 screening to additional care settings (specialty, maternal, outreach/mobile).

Accountability:

PNS / Clinic Operations / IT (EHR).

Desired Outcome (Concise):

Earlier identification and referral across more settings.

Core Tracking Metrics:

Annual screening volume increase; ≥85% eligible screened at added sites; documented referrals to behavioral health/community partners.

2. CHNA Finding:

Postpartum mental health risks; social needs affecting recovery.

Implementation Action:

Expand SDOH screening in maternal settings (prenatal, postpartum follow-ups).

Accountability:

Nursing / Care Management / Women's Services.

Desired Outcome (Concise):

Earlier identification of social/behavioral risks for mothers.

Core Tracking Metrics:

≥85% SDOH screen coverage; referrals initiated and completed; time-to-referral.

3. CHNA Finding:

Care gaps after positive screens.

Implementation Action:

Implement standardized follow-up protocols (PHQ-9 and postpartum behavioral health).

Accountability:

Care Management / Behavioral Health / PNS.

Desired Outcome (Concise):

Timely reassessment, referral, and continuity of care.

Core Tracking Metrics:

≥85% documented follow-ups; referrals within 7–14 days; service engagement rates.



4. CHNA Finding:

Community access barriers to behavioral health/substance use disorder services.

Implementation Action:

Strengthen partnerships (Access Health Horry, United Way-supported programs, etc.).

Accountability:

Foundation / Community Partnerships.

Desired Outcome (Concise):

Broaden low/no-cost resource availability and navigation.

Core Tracking Metrics:

3–5 active referral agreements; successful referrals increased; utilization of partner services.

Priority 2: Financial Barriers / Insurance

1. CHNA Finding:

Higher uninsured rate; delayed or foregone care due to cost.

Implementation Action:

Provide insurance literacy and navigation referrals (Medicaid, Marketplace, renewals); publish plain-language links on CMC website.

Accountability:

Marketing / Patient Accounting / Foundation.

Desired Outcome (Concise):

Increased successful insurance enrollment and renewals.

Core Tracking Metrics:

Referral count and completion; web page views; navigator handoffs.

2. CHNA Finding:

Affordability barriers to preventive services.

Implementation Action:

Deliver no-cost screenings (screening colonoscopy, mobile mammography) and HealthReach outreach.

Accountability:

HealthReach / Foundation.

Desired Outcome (Concise):

Increased preventive screening among uninsured/underinsured.

Core Tracking Metrics:

Screening volume; abnormal results follow-up; diagnostic completion.

3. CHNA Finding:

Limited awareness of assistance programs.

Implementation Action:

Maintain pricing transparency and cost estimator; link to Medicaid and other public program resources.

Accountability:

Marketing / Patient Accounting.

Desired Outcome (Concise):

Improved patient understanding of potential costs and available aid.

Core Tracking Metrics:

Estimator usage; calls to financial counseling; assistance applications.



Priority 3: Access to Healthcare

1. CHNA Finding:

Transportation and distance barriers; growth corridors.

Implementation Action:

Continue building telemedicine strategy and patient education; fund and coordinate transportation options.

Accountability:

Leadership / PNS / Marketing / Case Management.

Desired Outcome (Concise):

Convenient access to care and reduced missed appointments.

Core Tracking Metrics:

Telehealth activations and completed visits; completed rides; no-show reduction.

2. CHNA Finding:

Underserved ZIP codes; long travel times to ED/specialty care.

Implementation Action:

Develop freestanding EDs (Socastee; Hwy 90/22) and advance planning for new hospital services.

Accountability:

Leadership.

Desired Outcome (Concise):

Improved timely emergency/specialty access in high-growth areas.

Core Tracking Metrics:

ED visits served locally; travel time proxy; ZIP-code coverage.

3. CHNA Finding:

Limited access points for prevention and early detection.

Implementation Action:

Operate mobile/outreach clinics and school-based services; optimize EHR integration for Outreach van/mobile clinics.

Accountability:

Foundation / IT / PNS.

Desired Outcome (Concise):

Bring services to where patients are to increase preventive care.

Core Tracking Metrics:

Outreach encounters; EHR integration success; referrals generated.



Priority 4: Chronic Disease

1. CHNA Finding:

High prevalence of diabetes, obesity, cardiovascular disease.

Implementation Action:

Identify and notify clinics of patients due for Medicaid Annual Wellness Visits; enable automated patient reminders.

Accountability:

IT / PNS / Payer Strategy / Marketing.

Desired Outcome (Concise):

Higher AWV completion and better risk capture.

Core Tracking Metrics:

AWV completion rate; documented risk-adjusted diagnoses (process measure).

2. CHNA Finding:

Tobacco use above state averages.

Implementation Action:

Host evidence-based “Freedom from Smoking” classes.

Accountability:

Foundation.

Desired Outcome (Concise):

Increased quit attempts and program completion.

Core Tracking Metrics:

Enrollment and completion; 3–6-month quit status (self-report).

3. CHNA Finding:

Diabetes self-management gaps.

Implementation Action:

Offer Diabetes Self-Management Training (individual/group upon physician order).

Accountability:

Foundation / PNS.

Desired Outcome (Concise):

Improved self-management and reduced complications risk.

Core Tracking Metrics:

Class completion; A1c trend or care-plan adherence (process measure).

4. CHNA Finding:

Weight management needs in adult population.

Implementation Action:

Host online Weight Loss Surgery Seminars and non-surgical options.

Accountability:

PNS.

Desired Outcome (Concise):

Increased engagement in evidence-based weight management.

Core Tracking Metrics:

Attendance; referrals scheduled; program enrollment.



5. CHNA Finding:

Countywide need for coordinated prevention strategies.

Implementation Action:

Lead Horry County Health Coalition under Healthy People, Healthy Carolinas grant.

Accountability:

Leadership / Foundation.

Desired Outcome (Concise):

Coordinated interventions and reduced barriers.

Core Tracking Metrics:

Coalition participation; interventions implemented; partner reports.

6. CHNA Finding:

Access expansion supports prevention and early detection.

Implementation Action:

Expand primary care locations (West Conway, CCU clinic, Del Webb).

Accountability:

Leadership.

Desired Outcome (Concise):

More preventive visits and screenings delivered locally.

Core Tracking Metrics:

New patient panels; preventive visit/screening counts.

Priority 5: Health Education

1. CHNA Finding:

Health literacy and navigation gaps among high-need populations.

Implementation Action:

Provide community seminars, health fairs, screenings, and CORE/HealthReach education.

Accountability:

HealthReach / Marketing.

Desired Outcome (Concise):

Improved care navigation and preventive engagement.

Core Tracking Metrics:

Attendance; screenings delivered; abnormal follow-up; referrals.

2. CHNA Finding:

Need for trusted messengers to amplify prevention messages.

Implementation Action:

Engage trusted community leaders (Heart to Heart Challenge; CCU Wellness Week).

Accountability:

Marketing / Leadership.

Desired Outcome (Concise):

Increased participation and awareness.

Core Tracking Metrics:

Campaign participation; social engagement; partner feedback.



3. CHNA Finding:

Employee wellness context (secondary to community education).

Implementation Action:

Expand CMC Employee Wellness Program (fitness, emotional wellness, nutrition, screenings).

Accountability:

CMC Wellness.

Desired Outcome (Concise):

Support healthier habits for employees; reported separately from community metrics.

Core Tracking Metrics:

Program completion; screenings; care-gap closure (e.g., diabetes labs).

Cross-Cutting Notes

- Geography & Equity Focus: Activities prioritize underserved ZIP codes and high-need populations identified in the CHNA (e.g., Bucksport, Green Sea Floyds, Loris; uninsured/underinsured; seniors; maternal/postpartum).
- Measurement Approach: Where clinical outcomes are not immediately feasible, process and uptake metrics (screening rates, referrals, engagement, completion) will be used, with quarterly review.