# Our Health, Our Future

## Tri-County Health Improvement Plan 2018-2023

Berkeley | Charleston | Dorchester

# Healthy Tri-County Background

January 2017 marked the launch of the Healthy Tri-County initiative, powered by Trident United Way, in partnership with core partners MUSC Health and Roper St. Francis Healthcare. Healthy Tri-County (HTC) is a multi-sector regional initiative to improve health outcomes in Berkeley, Charleston and Dorchester counties in South Carolina. The long-term aspirational goal of HTC is to improve the health and well-being of every person and community within the Tri-County region.

Healthy Tri-County grew out of collaborative work by MUSC Health, Roper St. Francis Healthcare and Trident United Way on the 2016 Tri-County Community Health Needs Assessment. During the process, it was quickly recognized that efforts needed to extend far beyond the collection and dissemination of the report data to a partnership to help facilitate collaborative health efforts in our region. These collaborative efforts are rooted in the engagement of diverse community stakeholders using the principles of collective impact.

The development of a regional health improvement plan that outlines concrete recommendations and action steps for improving health outcomes in the region quickly emerged as the top priority for HTC. Such a plan didn't exist for our region. The Tri-County area is not a homogenous community, but a series of smaller communities within a defined geographic region. A coordinated and unified effort by local organizations focused on improving health outcomes while strengthening relationships and maximizing resources is badly needed. The South Carolina Department of Health and Environmental Control (SC DHEC) was recruited to provide technical assistance for the development of the Tri-County Health Improvement Plan (TCHIP) because of the expertise it has developed assisting similar efforts in communities throughout the state.

As of October 2018, 60 organizations have become formal HTC members, and over 600 individuals participate in network activities and utilize resources.

## Healthy Tri-County Workgroups: Opportunities to Serve

**HTC Executive Committee**
There are currently three active workgroups operating under the umbrella of HTC, all of which are governed by the HTC Executive Committee.

**TCHIP Workgroup**
implementation and monitoring of TCHIP

**Health Data Workgroup**
(1) development and implementation of the universal 2019 CHNA (2) creation of a regional health resource hub

**Tri-County Diabetes Coalition**
(1) increasing local awareness about prediabetes and diabetes. (2) Preventing new incidences of prediabetes and type 2 in the Tri-County region through the promotion of Diabetes Prevention Program (DPP)

**COLLABORATION → ACTION → IMPACT**

# Background

## What's in the Plan?

*Our Health, Our Future: Tri-County Health Improvement Plan* provides recommendations and action steps to address five prioritized health topics:

- **Access to Care**
- **Behavioral Health** – including mental health and substance use
- **Clinical Preventative Services** – including immunizations, cancer screenings and diabetes prevention
- **Maternal, Infant & Child Health**
- **Obesity, Nutrition & Physical Activity**

While there are numerous additional health issues that impact our region beyond the five listed above, community volunteers determined it is critical to address the health topics prioritized by the Tri-County community at large and to tackle issues that a cross-section of local organizations and institutions are best positioned to address through the discipline of collective impact. The five health topics have been explored with the following considerations in mind:

- Impacts of social determinants of health, which include factors such as education, income, where someone lives, etc.
- Importance of promoting equitable health outcomes in our region.

## Why Now?

Berkeley, Charleston and Dorchester counties experience favorable health outcomes when compared to other counties in the state (with all three counties ranking in the top 10),[1] however, South Carolina currently ranks 44th in the nation in overall health. No single organization or institution can tackle the health issues facing our rapidly growing region. While there are pockets of wealth and access to good health care in the region, the region also has high poverty urban and rural communities that lack access to care and have a high proportion of undiagnosed and untreated chronic conditions.

*Our Health, Our Future: Tri-County Health Improvement Plan* is the first comprehensive health improvement plan in our region, and provides concrete recommendations and action steps for improving health outcomes that can be carried out by a wide range of local organizations, groups and individuals. Many local health care institutions, social service and government organizations and nonprofit and faith-based organizations are actively working to address the health issues impacting our region. This plan can further enhance these efforts already in motion.

***Collectively, and with a clear direction, we are best positioned to make a difference.***

## How Was the TCHIP Developed?

More than 80 volunteers representing 60 organizations invested roughly 2,300 hours in the development of this regional health improvement plan. SC DHEC served as the technical assistance provider for the development of the plan, and will support the implementation of many identified recommendations and action steps moving forward.

## Report Key*

Throughout the plan, icons specify where changes are most likely to occur and where further support is needed. Use this guide to determine engagement opportunities.

**Agency** – A state agency or statewide organization

**Health Care**– Individual professionals, including physicians, social workers, etc.

**Community –** Communities at-large

**Policy**– The General Assembly OR written policies, rules, and regulations

**Funding** – State or local funders

**Adapted from 2017 South Carolina's Rural Health Action Plan: A Road Map to Healthy Rural Communities*

## What Happens Next?

The TCHIP Implementation Workgroup – which includes individuals working in social services, health care, public health and lay community members - meets monthly to support the implementation and monitoring of the recommendations and activities outlined in the plan. If you see your work or your organization's work fitting in and able to carry out some of the recommended activities – please let us know. The goal over the next five years is to document efforts towards the recommendations outlined in the plan. Progress made implementing the action steps outlined in this plan will be shared on the Healthy Tri-County website at **www.healthytricounty.com** and updated bi-annually.

A summary of this publication titled *Tri-County Health Improvement Plan: Community Action Guide*, has been developed for the broader community. It recommends activities for individuals, civic groups, businesses, schools, faith groups, etc. to implement in an effort to address the five health priorities targeted through TCHIP. Through the concerted effort of health care, public health and social service practitioners and Tri-County community members, our community will be well-positioned to achieve better health outcomes in our region!

## Who Do you Contact with Questions?

***Call (843) 740-7752 or email HTCsupport@tuw.org.***

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# Tri-County Health Improvement Plan: Process & Overview

## Formation of the TCHIP Workgroup

Development of TCHIP began in April 2017 when Trident United Way convened the first joint TCHIP workgroup meeting. TUW serves as the "backbone" of Healthy Tri-County and is responsible for convening HTC workgroups, coordinating HTC activities and providing administrative support. At the initial meeting, TCHIP workgroup volunteers committed to carrying out several key activities to support the development of the plan, including:

- Selecting a process and framework for TCHIP
- Determining topical health priorities
- Crafting recommendations and action steps that can be implemented by multiple stakeholders
- Recruiting community members and organizations to support TCHIP development and implementation

The TCHIP workgroup grew from an initial size of 21 to over 80 members and met regularly, both as an entire workgroup and in topical subcommittees. These individuals represented 60 organizations and participated in over 36 meetings to support the development of TCHIP.

## Selection of TCHIP Process

South Carolina Department of Health and Environmental Control led the TCHIP workgroup in reviewing best practices and national models in order to identify the process and framework for TCHIP. Workgroup volunteers voted to use a hybrid of the Association of State and Territorial State Health Improvement Plan Framework[2] and the Mobilizing for Action through Planning and Partnerships[3] model for the TCHIP process. After the review of both county and state level health improvement plans, the workgroup voted to model the framework of TCHIP on the Maine State Health Improvement Plan.

## Identification of Health Priorities & TCHIP Data Collection Efforts

Several data review and collection activities (outlined below) were conducted in 2017 to support the identification and selection of the five prioritized health topics included in the TCHIP and to help shape recommendations.

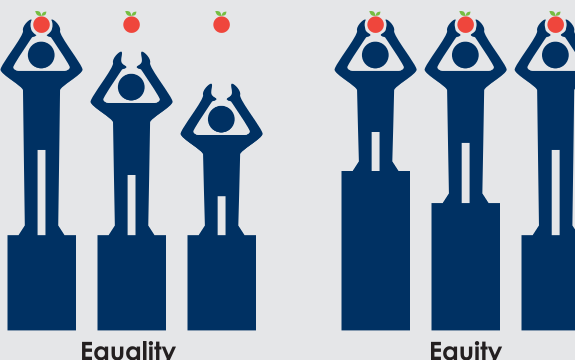
| | |
|---|---|
| **Data Walk 1**<br>April 2017 | • **Activity:** TCHIP Workgroup members reviewed data from 12 topical areas that were identified in the 2016 Tri-County Community Health Needs Assessments in a structured and interactive group discussion process.<br>• **Purpose:** Familiarize workgroup with local data and health outcomes<br>• **Participants:** Approximately 20 |
| **Priorities Survey**<br>May 2017 | • **Activity:** TUW conducted survey of TCHIP Workgroup participants<br>• **Purpose**: Prioritize the topics reviewed in the April 2017 data walk for potential focus areas of the TCHIP.<br>• **Participants:** Approximately 45 surveyed and 35 responses received<br>• *Note: The six priority areas chosen matched those identified in the 2016 CHNA, indicating consistency in the community's desire to address these topics.* |
| **Data Walk 2**<br>May 2017 | • **Activity:** TCHIP Workgroup members reviewed subsets of data from six prioritized topical areas in a structured and interactive group discussion process.<br>• **Purpose:** Review data and discuss four key questions: 1) What are the factors behind the current trends? 2) What are the results we would like see? 3) Are we likely to get those results without additional intervention? 4) What might turn the curve in our community?<br>• *Note: Discussion about key questions generated potential strategies to impact key indicators, which were provided to all topical groups for use in their meetings.* |
| **Community Conversations**<br>Oct. 2017 | • **Activity:** TUW conducted five health-focused community conversations. Focus groups were based on the Harwood Institute for Public Innovation model[4] and used an asset-based approach to gather feedback from community members on goals, assets and strategies for improvement.<br>• **Purpose:** Address available data raised by subcommittee members, specifically the input of local community members.<br>• **Participants:** 40 individuals across five sites in the Tri-County. |
| **Tri-County Provider Survey**<br>Dec. 2017 | • **Activity:** TUW developed and conducted Tri-County provider survey.<br>• **Purpose:** Address gaps in available data respective to medical and nonprofit providers already doing work in the five topical plan areas.<br>• **Participants:** Survey sent to approximately 580 individuals on the HTC email list; 88 individuals responded.<br>• *Note: Limits on data validation in certain survey fields limited TUW's ability to identify potential responses from the same organization.* |
| **2-1-1 Helpline Data Request**<br>Dec. 2017 | • **Activity:** TUW made a request to 2-1-1 Helpline for data of the taxonomy codes for agencies in 2-1-1 database prioritized by TCHIP subcommittees.<br>• **Purpose:** Provide TCHIP subcommittee members information about the services and resources relating to their health topic. Subcommittees received a full list of administrative codes for agencies listed through 2-1-1 Helpline and were asked to select codes for data.<br>• **Participants:** Approximately 40 |

# Focus on Health Equity and Social Determinants of Health

Parallel to the effort to identify health priorities, the TCHIP workgroup also looked for ways to promote equitable health outcomes in the region and to incorporate consideration of social determinants in the development of TCHIP recommendations and action steps. In August 2017 the workgroup voted to adopt the following health equity principles*:

- **Health is more than health care:** Social conditions are just as important to health as medical care.
- **Health is tied directly to the distribution of resources:** The single strongest predictor of our health is our position on the class pyramid.
- **Racism imposes an added health burden:** Ongoing discrimination in housing, jobs and education.
- **The choices we make are shaped by the choices we have:** Unhealthy behaviors are often shaped by unhealthy social and environmental factors.

**Adopted from the Alliance for a Healthier SC*




## Development and Review of Plan Recommendations

The development and review of TCHIP plan recommendations and action steps happened between June 2017 – June 2018. Subcommittees developed recommendations and action steps following a two-month process of extensive research on assigned topical areas by using a standardized set of questions and conducting key informant interviews.

An extensive review of the recommendations, action steps and key activities developed by subcommittees was conducted by topical experts and cross-subcommittee reviews. The Healthy Tri-County Executive Committee approved the *Our Health, Our Future: Tri-County Health Improvement Plan* in July 2018.

## Process for Implementation

The recommendations outlined in TCHIP will be actively advanced by the TCHIP workgroup subcommittees who meet monthly with the support of TUW. The goal is for partner organizations and community volunteers, both new and existing, to work together or individually to lead efforts and leverage work to address recommendations, as appropriate. While there are roughly 60 local organizations committed to supporting TCHIP implementation, subcommittees will actively seek to engage new organizations and community volunteers to help achieve the goals of the TCHIP.

## Components of Topical Health Sections

Each topical health section includes the elements outlined below:

- **Goal:** aspirational overarching statement
- **Rationale:** explanation of why each goal is important and being pursued
- **Recommendations:** concrete, time-bound statements that support the attainment of the overarching goal
- **Action Steps:** steps that need to be taken in order to achieve recommendations
- **Activities:** a list of key activities that will help advance action steps (additional activities beyond those listed are included in more detailed TCHIP implementation plans)
- **Spotlight:** a featured story of a local organization implementing high-quality services
- **Stakeholders:** key people, groups or entities that have an interest in and can support the attainment of identified goals and recommendations
- **Resources:** local, state and national resources that can be explored to learn more about each health topic
- **Community Member Quotes:** quotes from community members with 'lived' experience, captured during the October 2017 Community Conversations

***The information captured in the topical sections of this report is a high-level summary of very detailed implementation plans developed by each subcommittee based on community data, professional experience, work in progress and opportunities for quick successes and longer term impact.*** These implementation plans include outcome objectives, measures, key parties involved and deadlines for each key activity. Since the implementation plans will inevitably evolve as subcommittees tackle these tasks, the decision was made not to publish specific plans in this report.

**If you are interested in learning more about the measures being used to track the action steps captured in *Our Health, Our Future: Tri-County Health Improvement Plan*, visit your topical section of interest at www.healthytricounty.com/tri-county-health-improvement-plan.**

**To request copies of the detailed implementation plans, contact HTCsupport@tuw.org.**

# Access to Care

**GOAL** Increase access to quality health care and services (including medical, clinical preventative, behavioral health and dental) by closing the insurance coverage gap, building provider capacity and supporting the reduction of transportation barriers.

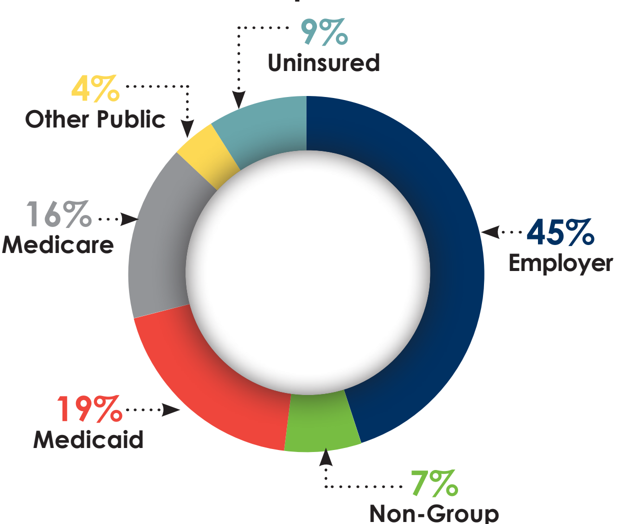
**"I think that even on top of the medical expense part, there is an intimidation factor between regular people and doctors and nurses and the whole health care industry. Maybe having some type of informal setting where doctors and medical professionals could meet and just chat over some type of a social, less intimidating environment could help." – *Community Conversations participant***

## RATIONALE

Eighty percent of community members who participated in the 2016 Community Health Needs Assessment selected access to quality health care as their top priority.

Health access may be improved by focusing on a variety of factors within targeted populations in certain geographic areas. In the Tri-County region, the goal to increase health access may be impacted, not only by closing the health insurance coverage gap, but also by activities to build provider capacity and reduce transportation barriers. Access to health care services is of critical importance to favorable health outcomes for a population. Despite some national gains in health coverage, health insurance is a primary component to the "access puzzle" within the state and the local Tri-County community. State indicators show a higher rate of uninsured in South Carolina compared to the population nationwide.

### 2016 Health Insurance Coverage of the Total Population in S.C.[5]




## RECOMMENDATION 1

***Maintain the number of Tri-County residents with health care coverage through 2023.***

*COMMUNITY INDICATOR: Number of Tri-County residents with health care coverage.*

### ACTION STEP 1

Provide technical assistance and other resources for continued health coverage outreach, education and enrollment activities to increase access to health care coverage, particularly in communities where the disparities in both access to care and health care coverage are greatest.

### Activities

- Conduct outreach meetings and provide information about health insurance coverage and health literacy within The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS standards)
- Update and maintain accurate information on Healthy Tri-County website regarding health coverage and health literacy ensuring CLAS standards

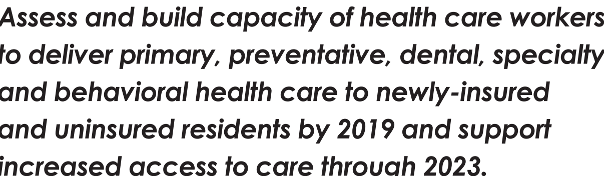
### ACTION STEP 2

Assess and expand current enrollment activities by engaging with state-affiliated organizations to leverage knowledge and experience to help increase the number of enrollment platforms and programs.

### Activities

- Monitor and report the percentage of Tri-County residents enrolled in health care coverage across all major coverage categories (i.e. Medicaid, commercial, Medicare, etc.)
- Leverage state-level affiliations to promote enrollment in health care coverage
- Facilitate enrollment activities at safety net clinics and community partners in Medicaid and the Health Insurance Marketplace, as well as make appropriate referrals into systems with content expertise

## RECOMMENDATION 2



***Assess and build capacity of health care workers to deliver primary, preventative, dental, specialty and behavioral health care to newly-insured and uninsured residents by 2019 and support increased access to care through 2023.***

*COMMUNITY INDICATOR: Demonstrate the current capacity and strength of health care workers by establishing a baseline for the number of health care services and access points within the Tri-County for primary, specialty and behavioral health, by December 2019.*

### ACTION STEP 1

Increase the capacity and strength of health care services focusing on best-practice strategies.

### Activities

- Support the recruitment, placement and retention of primary care and other providers to serve underserved communities with a focus on innovative options (telehealth/telemedicine platforms) in order to improve access to care
- Conduct an assessment of gaps and challenges in the delivery of primary, preventative, dental, specialty and behavioral health care in the Tri-County

- Develop a baseline report and support the increase of health care access points to expand availability of services for those who do not qualify for health care coverage, including but not limited to undocumented individuals

### ACTION STEP 2

Improve the quality and efficiency of the health care systems.

#### Activities

- Establish relationships with state-affiliated organizations (i.e. SC Hospital Association, SC Office of Rural Health) that provide technical assistance and other supports to providers to learn about standards/guidelines in place to evaluate the individuals who receive quality care through patient-centered medical homes
- Work with safety net providers, networks and health systems to show improved patient outcomes and evaluate formal, quality measurements and to share best practices

## RECOMMENDATION 3

***Support and expand efforts to reduce barriers to transportation by 2023.***

*COMMUNITY INDICATOR: Number of responses to transportation surveys completed and collected. Number of transportation planning/program meetings attended.*

### ACTION STEP 1

Identify organizations that have conducted, or will conduct, Tri-County transportation surveys in the last two years.

#### Activities

- Scan local transportation organizations to collect survey distribution efforts (including ride-sharing programs)
- Participate in at least five local and/or state transportation planning meetings focused on transportation access, barriers and gaps

### ACTION STEP 2

Inventory transportation programs available to Tri-County residents for health care appointments and identify evidence-based best practices that reduce transportation barriers to care.

#### Activities

- Review all regional transportation plans to determine listed health care transportation priorities
- Promote information gathered through report to community providers and organizations (especially best practices)

## SPOTLIGHT

**Palmetto Project**: Palmetto Project was founded in 1984 by leaders of the state's business community who believed that every problem we face has a solution. For the past 20 years, Palmetto Project has been a leading advocate for a more effective system of health care for South Carolinians, regardless of their financial circumstances, race or residency. During this time, the organization became a national leader in patient navigation, community-based care delivery and reducing cardiovascular disease among at-risk African-Americans. Palmetto Project's initiatives have made South Carolina a national leader in childhood immunization, health insurance enrollment and Medicaid coverage for children. Knowing that access to health care doesn't stop when someone receives an insurance card, Palmetto Project is working to improve access to health care and health outcomes in South Carolina by placing patient navigators at community food pantries, providing enrollment assistance for Medicaid, Affordable Care Act and Medicare plans and helping consumers decipher a complicated medical bill.

## Stakeholders

- AccessHealth Tri-County Network
- Berkeley-Charleston-Dorchester Council of Governments
- Berkeley Community Mental Health
- Charleston Regional Transportation Authority
- Charleston Center/SC Department of Alcohol and Other Drug Abuse Services
- Charleston Dorchester Mental Health
- East Cooper Medical Center
- Fetter Health Care Network
- Free Clinic Partners
- Free Medical Clinics within the Tri-County
- Healthy Tri-County
- Medical University of South Carolina
- Palmetto Project
- Roper St. Francis Healthcare
- St. James Santee Family Health Center
- Trident Health System
- Welvista

## Resources

- AccessHealth South Carolina, *www.scha.org/members/member-initiatives/accesshealth-sc*
- Alliance for a Healthier South Carolina, *www.healthiersc.org*
- Blue Cross Blue Shield of South Carolina Foundation, *www.bcbsscfoundation.org*
- Charleston Regional Transportation Authority, *www.ridecarta.com*
- Charleston Center/SC Department of Alcohol and Other Drug Abuse Services, *cc.charlestoncounty.org*
- Federally Qualified Health Centers
  - Fetter Health Care Network, *fetterhealthcare.org*
  - St. James Santee Family Health Center, *www.stjamessanteefhc.com*
- First Choice by SelectHealth of SC, *www.selecthealthofsc.com/index.aspx*
- Palmetto Project, *palmettoproject.org*
- SC Community Health Workers Association, *scchwa.org*
- SC Dental Association, *www.scda.org*
- SC Department of Health and Human Services, *www.scdhhs.gov*
- SC Department of Mental Health, *scdmh.net*
- SC Department of Transportation, *www.dot.state.sc.us*
- SC Free Medical Clinics, *www.scfreeclinics.org*
- SC Hospital Association, *www.scha.org*
- SC Office of Rural Health, *scorh.net*
- SC Primary Health Care Association, *www.scphca.org*
- Welvista, *www.welvista.org*

# Behavioral Health

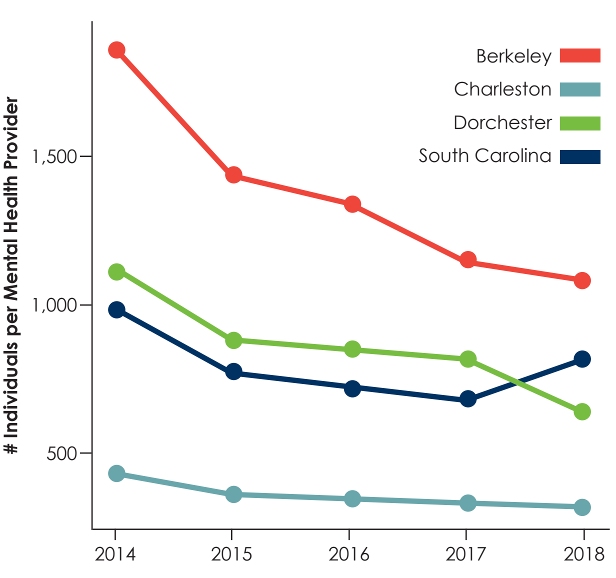
"I think there are a good bit of mental health resources out there. So you have to let people know that it's okay to come for it, with whatever issue it is you are dealing with, and there is hope out there for you." – *Community Conversations participant*

**GOAL 1** Increase the Tri-County's knowledge about behavioral health issues and services/resources in order to reduce stigma and increase service utilization.

## RATIONALE

Nearly one in five adults experiences a significant behavioral health problem (including mental health and substance use) each year.[6] Similarly, one in four youth experiences a diagnosable behavioral health disorder each year.[7] These national prevalence rates suggest that over 160,000 citizens in the Tri-County experience a behavioral health disorder requiring treatment in any given year. However, more than half of these individuals likely do not receive the necessary treatment for these conditions.[8] Service utilization for African-Americans and Latinos is consistently reported to be even lower than that of Caucasians.[10] The underutilization of behavioral health treatments can largely be attributed to a lack of awareness of the symptoms of behavioral health conditions, a lack of knowledge of local treatment resources and stigmas about such diagnoses.[11] It is essential that we reduce health inequities and increase skills that enable our citizens to recognize and manage their total health, including behavioral health. To achieve this, we need to conduct regional awareness campaigns as well as targeted outreach and engagement to underserved populations within our community.

### Mental Health Services by County[9]




## RECOMMENDATION

***Assess public awareness of:***
***1) knowledge of behavioral health resources***
***2) public awareness of behavioral health conditions as treatable, as measured by provider and community surveys, and increase awareness by 10% by 2023.***

*COMMUNITY INDICATOR: Number or percentage of survey responses indicating: 1) knowledge of resources 2) awareness of behavioral health issues as treatable conditions*

### ACTION STEP 1

Gather Tri-County baseline data of behavioral health awareness.

#### Activities

- Define behavioral health topics to be included in the provider surveys and identify a pre-existing survey that meet the criteria
- Complete provider awareness surveys to assess awareness of behavioral health resources and referral processes
- Include questions in Community Health Needs Assessment to assess community members' knowledge of resources and awareness of behavioral health issues as treatable conditions

### ACTION STEP 2

Develop and implement an education plan for increasing public awareness of behavioral health conditions (e.g. trauma, opioid misuse, drug/alcohol misuse, depression, anxiety and suicidality).

#### Activities

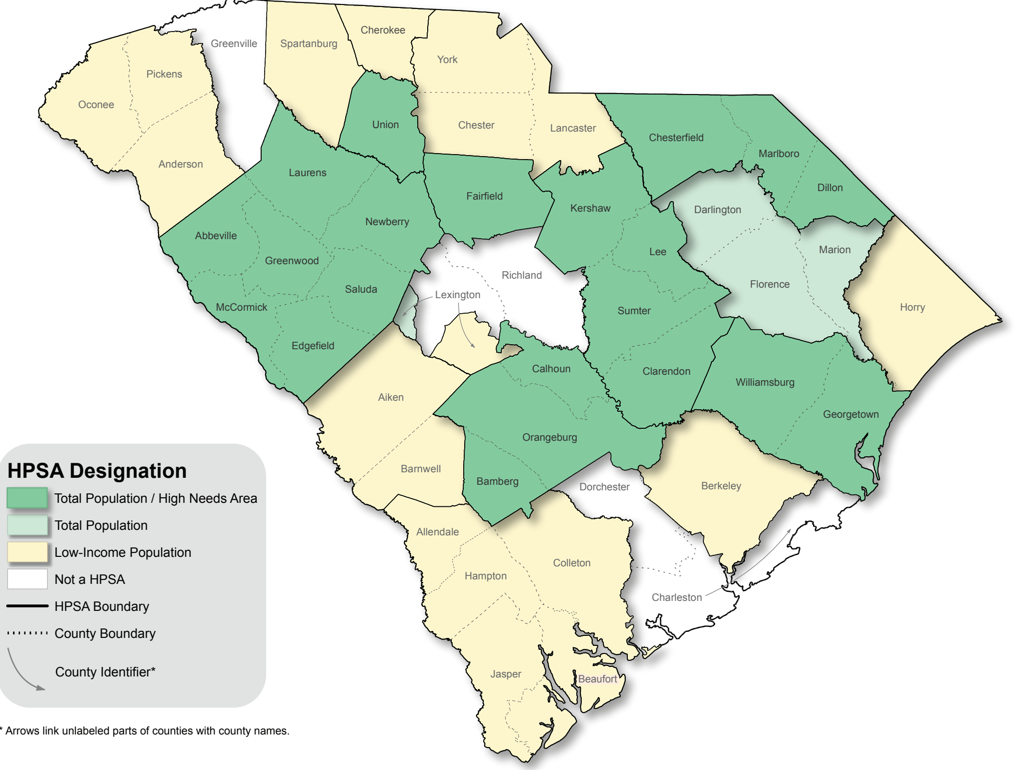
- Create collaborative brochure, flyer or mobile app to distribute to providers (for distribution to patients) regarding behavioral services available in the Tri-County
- Create outreach and education plan for safety net providers (referral processes, services available) that increase understanding of behavioral health conditions and local resources
- Identify target groups for awareness campaign (e.g., schools, law enforcement, medical providers, first responders)
- Conduct community awareness activities in alignment with and support of current/planned activities (e.g. social media, media, billboards, multimedia, ads, PSAs, community, parenting programs, PTA meetings, expos, faith-based events)

**GOAL 2** Improve access to and utilization of behavioral health services for all citizens of the Tri-County.

## RATIONALE

While there is a high concentration of behavioral health providers in Charleston County and an adequate number in Dorchester County, Berkeley County has been identified as a Health Professional Shortage Area for behavioral health care services for low-income individuals.[12] Even within regions with adequate provider coverage, many do not access these intervention services. Barriers to accessing services include a lack of both adequate insurance coverage and parity in coverage, clinic hours conflicting with employment schedules and transportation difficulties.[13] Behavioral health service providers in the Tri-County should collaborate to reduce these barriers through creative solutions that include co-locating providers in primary health clinics (which are accessed at a higher rate than behavioral health) and providing services via telehealth to reduce barriers associated with travel to the clinic.[14] Furthermore, primary insurers of Tri-County citizens need to work to ensure that policies include adequate behavioral health coverage, including reimbursement for behavioral health treatments via telehealth provided by licensed master's and doctorate-level clinicians.

### Mental Health Care Health Professional Shortage Areas in South Carolina, June 2017[15]




## Stakeholders

- Berkeley Community Mental Health Center
- Charleston Center (Charleston County Department of Alcohol and Other Drug Abuse Services, DAODAS)
- Charleston Dorchester Mental Health Center
- Dee Norton Child Advocacy Center
- Dorchester Children's Advocacy Center
- Ernest E. Kennedy Center
- Franklin C. Fetter Family Health Center
- Medical University of South Carolina (Center for Telehealth, Department of Psychiatry)
- Palmetto Lowcountry Behavioral Health
- Ralph H. Johnson Veterans Affairs Medical Center
- Trident Medical Center

## Resources

- Adverse childhood experiences (ACEs), *www.cdc.gov/violenceprevention/acestudy/index.html* *www.samhsa.gov/capt/practicing-effective-prevention/prevention-behavioral-health/adverse-childhood-experiences*
- Berkeley Community Mental Health Center, *www.berkeleymentalhealth.org*
- Charleston Center, *cc.charlestoncounty.org*
- Charleston Dorchester Mental Health Center, *www.charlestondorchestermhc.org*
- Dee Norton Child Advocacy Center, *deenortoncenter.org*
- Ernest E. Kennedy Center, *www.ekcenter.org*
- MUSC Center for Telehealth, *www.muschealth.org/telehealth*
- MUSC Department of Psychiatry, *www.musc.edu/psychiatry*
- National Alliance on Mental Illness – Charleston Area Chapter, *namicharlestonarea.org*
- National Center for PTSD, *www.ptsd.va.gov*
- National Child Traumatic Stress Network, *www.nctsn.org*
- Project BEST, *academicdepartments.musc.edu/projectbest*
- South Carolina County Health Rankings, *www.countyhealthrankings.org/app/south-carolina/2018/measure/factors/62/data?sort=sc*
- Substance Abuse and Mental Health Services Administration, *www.samhsa.gov*

## RECOMMENDATION 2

***Identify and reduce barriers (e.g. lack of coverage, outdated legislation and provider recruitment, training and education) to accessing behavioral health services, and expand where necessary, resulting in increased utilization of current and new behavioral health services by December 2023.***

*COMMUNITY INDICATOR: Number or percentage of survey responses of Tri-County emergency departments visits with a level one diagnosis for a behavioral health issue*

### ACTION STEP 1

Identify unknown barriers to accessing mental health services.

#### Activity

- Develop and include questions in 2019 Tri-County Community Health Needs Assessment to assess barriers

### ACTION STEP 2

Increase known barriers and support an increased use of telehealth.

#### Activity

- Gain approval for Medicaid reimbursement for behavioral health services by licensed behavioral health providers (masters, & doctorate-level)

### ACTION STEP 3

Address known barriers and increase available behavioral health treatment facilities (inpatient and outpatient).

#### Activities

- Increase behavioral health services offered at primary care locations
- Increase co-location of behavioral health providers in schools (office-based, telehealth and mobile unit)
- Increase the number of psychiatric, inpatient beds available to individuals experiencing acute behavioral health problems
- Expand the use of drug courts and the presence of counselors in law enforcement facilities

### ACTION STEP 4

Identify and increase current utilization of community health workers, including but not limited to, public health workers, care coordinators/navigators, nurse navigators and patient advocates as referral sources for behavioral health providers and to ensure behavioral health patient engagement.

#### Activities

- Identify current processes for behavioral health follow-up and engagement completed by providers and patients
- Identify possible improvements to existing processes for behavioral health follow-up and engagement

## SPOTLIGHT

## MUSC Health Center for Telehealth

The Medical University of South Carolina for Telehealth was recognized as one of only two national Telehealth Centers of Excellence in the United States in Fall 2017. This designation supports MUSC in providing telehealth services at more than 200 locations statewide, leading and modeling the way for health care delivery through advanced technology. One area of growth within telehealth is the provision of mental health services. MUSC's Department of Psychiatry is providing evidence-based trauma treatment to youth across the state who are unable to access this treatment through traditional office-based care. One Latino teen who experienced abuse and had a diagnosis of post-traumatic stress disorder received trauma-focused cognitive behavioral therapy through MUSC's School-Based Telehealth program because there was not a Spanish-speaking therapist in her community and she lived too far from the clinic. Because of telehealth services she was able to heal from her abuse and is at lower risk for future behavioral health problems.

"I think a lot of people just need information. They don't even know what the first step to take is, in terms of 'I'm sick, now what do I do?' Just having some type of a flow chart or some type of information where people would even know what to do first would be helpful." – *Community Conversations participant*

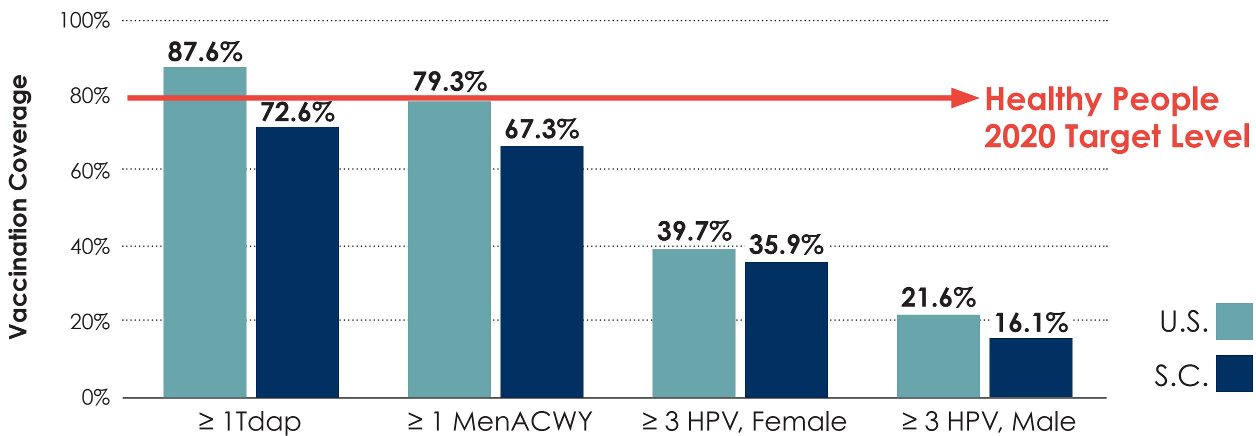
# Clinical Preventative Services

**GOAL 1** Increase immunization rates across the lifespan of Tri-County residents by 2023.

## RATIONALE

As the Tri-County population continues to grow, our goal is to reduce the occurrence of vaccine-preventable diseases through timely vaccination. Vaccination is critical in protecting all members of our community from infants to the elderly. There is a continuing need to assure that all children receive the standard group of recommended vaccines, and that adults receive boosters as needed. A particular focus is needed on human papillomavirus (HPV) and pneumococcal immunizations as South Carolina is ranked one of the lowest states in the nation for completion of these immunizations. The HPV vaccination is critical to preventing cervical cancer, while pneumococcal immunizations are recommended across the lifespan, making it a good indicator of other immunization compliance.[16] Significant gaps exist between the number of babies and adults who are recommended to receive the pneumococcal vaccination and those who actually receive them. The national average death rate is 13% for flu and pneumonia, but death rates for counties in South Carolina range from 10% to 63%.[17] There were 7,800 reported cases of vaccine-preventable diseases in the Palmetto State in 2016.[18] Increasing immunization rates is an area of preventive care necessary for improving health outcomes of all Tri-County residents.

***NOTE: Recommendations 1-3 of this goal have similar action steps and activities. Therefore, these action steps and activities are listed below only once, but are applicable across all three recommendations.***




## Stakeholders

- American Academy of Pediatrics
- American Cancer Society
- Fetter Health Care Network
- Liberty Doctors
- Medical University of South Carolina
- Palmetto Primary Care
- Pfizer
- Roper St. Francis Healthcare
- Sweetgrass Pediatrics
- SC Department of Health & Environmental Control
- SC Immunization Coalition
- SC Primary Health Care Association
- St. James Santee Family Health Center
- Trident United Way

## Resources

- American Academy of Pediatrics, Bright Futures, *https://brightfutures.aap.org/Pages/default.aspx*
- Center for Disease Control – National Center for Immunization & Respiratory Diseases, *https://www.cdc.gov/ncird/index.html*
- Flu FIT, *http://flufit.org/*
- Immunization Action Coalition, *http://immunize.org/*
- Local Pharmacies (varied)
- Personal Health Insurance Plans (varied)
- Pfizer vaccines & other varied pharmaceutical vaccine companies, *https://www.pfizer.com/*
- SC Department of Health & Environmental Control, *http://www.scdhec.gov/*

# Clinical Preventative Services

## RECOMMENDATION 1

***Increase the percentage of children who have completed the series of pneumococcal vaccines (Prevnar) by two years of age in the Tri-County region to 90% by 2023. This aligns with the Centers for Disease Control and Prevention and Healthy People 2020 goals.***

*COMMUNITY INDICATOR: Discharges per 1,000 among children ages 0-5 for respiratory infections recorded in hospitals in Berkeley, Charleston and Dorchester - through both inpatient and emergency departments*

## RECOMMENDATION 2

***Increase the percentage of adolescents/ young adults ages 10-23 who complete the HPV vaccine series by 10% in the Tri-County region by 2023.***

*COMMUNITY INDICATOR: Annual percentage of HPV vaccinations [any or ≥ 3]; five-year smoothed average of individuals ages 10 - 23 receiving HPV vaccinations [any or ≥ 3]*

## RECOMMENDATION 3

***Increase the percentage of adults, ages 65+, who complete the recommended pneumococcal vaccine series in the Tri-County region to 90% to align with the CDC recommendation and Healthy People 2020 goal by 2023.***

*COMMUNITY INDICATOR: Incidence per 100,000 among adults ages 65+ of respiratory infections in hospitals in Berkeley, Charleston and Dorchester - through both inpatient and emergency departments; mortality per 100,000 for seniors ages 65+*

### ACTION STEP 1

Track the number of children, adolescents and adults who have either initiated or completed their respective immunizations.

**Activities**

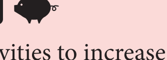
- Generate baseline data reports to track number of children, adolescents and adults who have either initiated or completed their respective immunizations
- Develop process and identify parties responsible for monitoring and tracking

### ACTION STEP 2

Conduct public education campaign to dispel myths specific to key childhood, adolescent and adult vaccines and increase awareness about local immunization resources.

**Activities**

- Develop a regional education campaign focused on debunking myths around vaccinations that includes traditional and social media components
- Implement outreach campaign activities
- Track and monitor education campaign

### ACTION STEP 3 

Conduct provider education activities to increase effective communication with patients and parents that will result in higher awareness and vaccination rates.

**Activities**

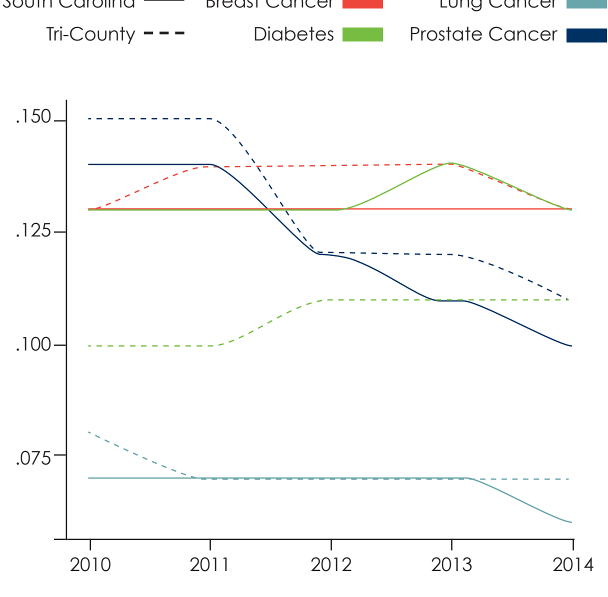
- Inventory provider education efforts already underway to identify gaps and opportunities
- Establish and strengthen connections between key stakeholders with the capacity to deliver provider education activities and other care providers (including local school districts and faith-based institutions)
- Develop process to monitor and track the number of provider education activities conducted

## GOAL 2 Increase the awareness of cancer risks (breast, cervical, colorectal, lung and prostate) for all Tri-County residents through early detection, prevention and education efforts by 2023.

## RATIONALE

The American Cancer Society estimates 27,980 new cases of cancer were diagnosed in South Carolina in 2016, with 10,330 SC residents dying from cancer that same year.[20] The four most common cancers diagnosed in South Carolina are breast (female), prostate, lung and colorectal.[21] In the Tri-County region, breast cancer rates in women have increased by 14% from 2005-2015, which could be due to early detection from increased awareness, financial assistance and better technology.[22] African-Americans have higher death rates than all other groups for many cancer types and are more likely to die from breast cancer, and two times more likely to die from stomach and prostate cancer.[23] Therefore, targeted education and prevention campaigns are needed to address the health disparity in at-risk populations.

### Percent of community diagnosed with diseases each year[24]




***NOTE: Recommendations 1-4 of this goal have similar action steps and activities. Therefore, these action steps and activities are listed below only once, but are applicable across all four recommendations.***

## RECOMMENDATION 1

***Increase breast cancer screenings among women ages 40 and above by 2% in the Tri-County region by 2023. (Primary form of screenings will be mammography.)***

*COMMUNITY INDICATOR: Rates of identified breast cancers in women 40+*
*POSSIBLE SECONDARY INDICATOR: Women ages 50-74 who have had a mammography in the last two years*

## RECOMMENDATION 2

***Increase rate of Pap tests among women ages 21-65 by 2% in the Tri-County region by 2023.***

*COMMUNITY INDICATOR: Incidence per 100,000 Pap tests*

## RECOMMENDATION 3

***Increase the rate of colon cancer screening by 2% in the Tri-County region by 2023.***

*COMMUNITY INDICATOR: Incidence of colon cancer by county*

## RECOMMENDATION 4

***Increase awareness about lung cancer risks and prevention through outreach and education activities in the Tri-County area by 2023.***

*COMMUNITY INDICATOR: Change in incidence of lung cancer 2018 - 2023*

### ACTION STEP 1

Conduct outreach events to increase public awareness of recommended breast cancer screenings for women.

### ACTION STEP 2

Promote equitable breast cancer screening rates between African-American, Caucasian and Hispanic women.

### ACTION STEP 3

Create resource list for clinicians to refer patients who require follow-up after screening.

### ACTION STEP 4

Initiate print and social media campaign to increase the public's knowledge about low-dose computed tomography for lung cancer screening and smoking cessation programs.

## Stakeholders

- American Cancer Society
- American Society of Clinical Oncology
- American College of Obstetricians & Gynecologists
- Center for Disease Control – Division of Cancer Prevention and Control
- Foundation for Women's Cancers
- Mayo Clinic
- National Breast Cancer Foundation
- SC Cancer Alliance
- SC Tobacco Quitline

## Resources

- American Cancer Society
- American Lung Association
- Best Chance Network
- East Cooper Medical Center
- Fetter Health Care Network
- Local free clinics
- Medical University of South Carolina
- One80 Place
- Quitline (DHEC)
- Roper St. Francis Healthcare
- SC Cancer Alliance
- SC Department of Health & Environmental Control
- Smokefree Lowcountry
- Trident Health Medical Center

**GOAL 3** Reduce rates of type 2 diabetes among Tri-County residents through screening, education and awareness efforts by 2023.

## RATIONALE

More than one-third of residents in the Tri-County region are likely living with prediabetes, and 90% are unaware they have it.[25] With this in mind, it is highly concerning that the Center for Disease Controls' (CDC) Behavioral Risk Factor Surveillance System found only 1% of people in South Carolina have been diagnosed as having prediabetes.[26] These individuals have blood sugar levels that are elevated but not high enough to be classified as type 2 diabetes. It is estimated that without lifestyle change, 25% of these individuals could develop diabetes within five years. Diagnosed diabetes costs an estimated $5.9 billion in South Carolina each year.[27] Compared to national levels, the Tri-County experiences higher rates of obesity, high blood pressure, poverty and food assistance while also experiencing lower per capita income levels and access to health care, all indicators of type 2 diabetes.

## RECOMMENDATION 1

***Conduct a two-year Diabetes Prevention Program (DPP) expansion effort with at least 500 high-risk participants by 2021.***

*COMMUNITY INDICATOR: Rate of type 2 diabetes within defined geographic area and within counties.*

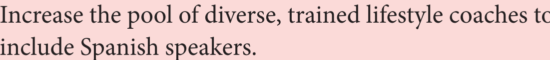
### ACTION STEP 1

Increase regional DPP implementer organizations from six to a minimum of 10 by the end of the program at workplaces, faith-based facilities or in clinical settings.

### Activities

- Identify and secure sites to implement DPP
- Support sites in obtaining official CDC recognition as a DPP site through the submission of participant data during the expansion timeframe (six-month data for 60-75% of the project's 500 participants and 12-month data for 40% of participants to the CDC - based on average completion rates)

### ACTION STEP 2



Increase the pool of diverse, trained lifestyle coaches to include Spanish speakers.

### Activities

- Develop process and timeline for recruiting and training new pool of trainers
- Identify and train one or two individuals who can be certified as DPP Master Trainers
- Disseminate educational materials about DPP training opportunities in targeted communities

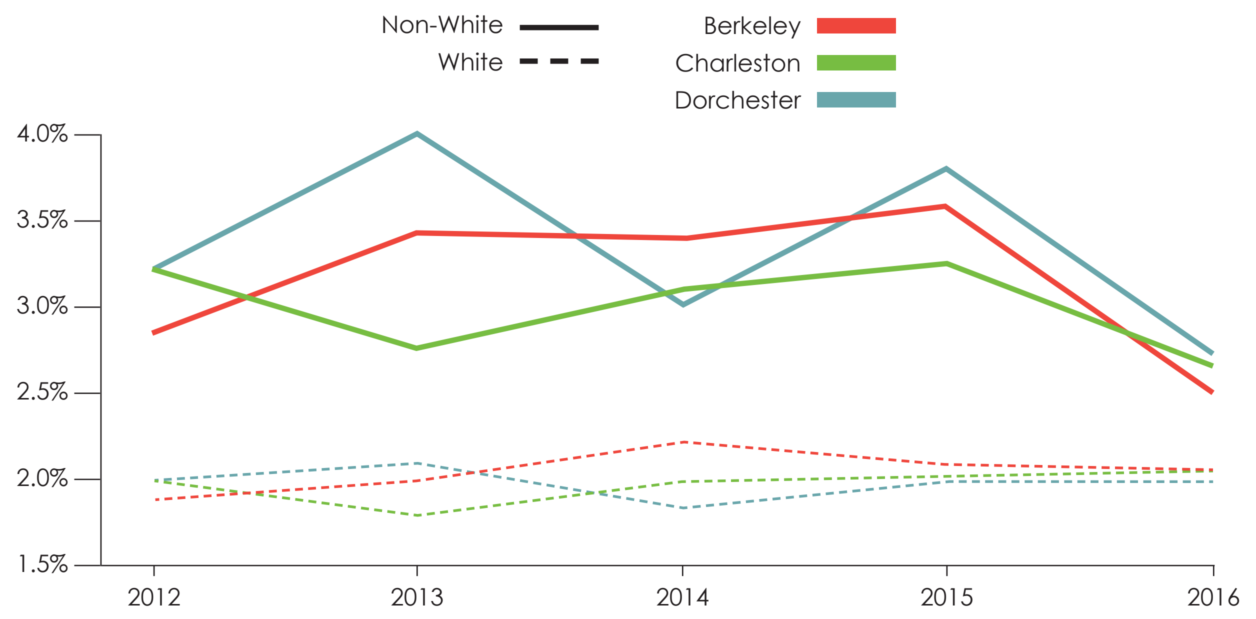
### ACTION STEP 3

Develop a process for Tri-County implementation organizations to problem solve and exchange best practices and resources.

### Activities

- Question current DPP providers to get their input about the best process for cross-site exchange

### Percentage of Hospital Discharges Due to Diabetes[28]



## RECOMMENDATION 2

***Increase rates of prediabetes screening among Tri-County residents through implementation of awareness campaign and targeted screening events in identified hot spot areas by 2023.***

*COMMUNITY INDICATOR: Rate of type 2 diabetes within defined geographic area*

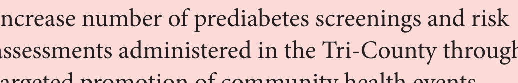
### ACTION STEP 1

Implement comprehensive awareness campaign targeting identified hot spots of high type 2 diabetes incidence rates in the Tri-County.

### Activities

- Secure stakeholders to support the development of the campaign
- Review and assess readily available prediabetes prevention resources (CDC, American Medical Association, American Diabetes Association (ADA))
- Target non-traditional partners, including local barber shops, libraries, etc. for campaign implementation
- Conduct key informant interviews and focus groups in identified Tri-County diabetes hot spots (six prioritized zip codes) to determine best access points and methods of dissemination of campaign materials
- Develop a communications plan to support campaign rollout and implementation

### ACTION STEP 2



Increase number of prediabetes screenings and risk assessments administered in the Tri-County through targeted promotion of community health events.

### Activities

- Facilitate cross-partner promotion of health events which include diabetes screening
- Promote ADA's risk assessment as a viable screening tool and precursor to finger stick testing
- Generate list of referral sites and resources, and update on a determined schedule, for individuals who are identified as prediabetes and individuals who test positive for type 2 diabetes

## Stakeholders

- American Diabetes Association
- Diabetes Advisory Council of SC
- Diabetes Initiative South Carolina
- Eat Smart Move More Charleston Tri-County
- Healthy Plate Cooking
- MUSC Health
- Roper St. Francis Healthcare
- Tri-County Diabetes Coalition
- Trident Medical Center
- Wellness Beyond Fifty
- YMCA Summerville

## Resources

- American Diabetes Association, *http://www.diabetes.org*
- Center for Disease Control, Division of Diabetes Translation, *https://www.cdc.gov/diabetes/home/index.html*
- National Institute of Diabetes and Digestive and Kidney Diseases, *https://www.niddk.nih.gov/health-information/diabetes*
- National Diabetes Prevention Program, *https://www.cdc.gov/diabetes/prevention/index.html*
- National Institutes of Health, *https://www.nih.gov/about-nih/what-we-do/nih-turning-discovery-into-health/diabetes*

## SPOTLIGHT

## Fetter Health Care Network

Fetter Health Care Network is the longest operating Federally Qualified Health Center in South Carolina, having opened in Charleston in 1967. Fifty years later, it operates 21 total sites throughout four counties in the Lowcountry; including eight medical sites, a community dental center, migrant health camp and several school-based service sites. Fetter accepts patients with all insurance types and provides care on a sliding fee scale to ensure greater accessibility to patients of low socio-economic groups. In addition to assisting with case management, Fetter also provides a range of primary care services including pediatric, geriatric, women's health (OB/GYN) and behavioral health. To facilitate timely access to care, Fetter offers in-house laboratories at each standing site and reduced prescription costs at the Charleston and Cross sites. Clinical preventative services Fetter offers include immunizations (pediatric, adolescent and adult immunizations), cervical, breast, colon, and prostate cancer screening and diabetes education.

# Maternal, Infant & Child Health

"There are a lot of single mothers who might not have time to go into some place to take a class. I think we should probably make a nurse available that they can call in and ask questions that wouldn't judge them or couldn't punish them for something they may be doing that they should be doing differently."
***– Community Conversations participant***

## GOAL 1 Improve the reproductive health of families in the Tri-County area.

### RATIONALE

Unintended or unplanned pregnancies negatively affect the health of women worldwide and contribute to adverse outcomes in maternal, neonatal and economic health. These consequences are especially pronounced for minorities and economically disadvantaged women, who suffer these effects as well as an increased risk of maternal and infant mortality.[29] Additionally, mothers who have mistimed pregnancies or have short inter-pregnancy intervals (<18 months between pregnancies) are at an elevated risk for adverse birth outcomes.[30] Nearly one half of all pregnancies in South Carolina are unintended.[31] Many of these unplanned births are publicly funded (78.6% in SC compared to 68% nationally)[32] leading to a cost of $443 per woman between the ages of 15 and 44 years of age for unplanned pregnancies in South Carolina. Reducing the rate of unintended pregnancies is part of the U.S. Department of Health and Human Services' ongoing Healthy People 2020 initiative. Meaningful access to reproductive health services and education to reduce discontinuation of contraceptives due to side effects, has been shown to increase women's confidence in the effectiveness of contraceptives, contributing to positive health outcomes for mothers and babies.

### RECOMMENDATION

***Support efforts to reduce unintended pregnancy by 30% in the Tri-County area by 2023.***

*COMMUNITY INDICATOR: Number of unintended pregnancies*

#### ACTION STEP 1

Increase community awareness of reproductive health and family planning options, resources and information.

**Activities**

- Promote community awareness on reproductive health and family planning through work with identified Choose Well partners and the promotion of the Choose Well "No Drama" campaign
- Establish strategic partnerships with community organizations such as Fetter Health Care Network and PASOs to disseminate information and culturally-tailored education on contraceptive care in the Tri-County area
- Identify gaps in reproductive health services in vulnerable communities, and increase awareness of options for contraceptive care by working with partner community agencies who address these needs
- Promote the CDC/Association of State & Territorial Health Officials (ASTHO) postpartum Long Acting Reversible Contraceptive (LARC) learning community

#### ACTION STEP 2

Increase health care providers' knowledge about research and best practices for contraception, including the implant and intrauterine device.

**Activities**

- Promote the CDC/ASTHO postpartum LARC learning community to the general public
- Establish a baseline for provider knowledge on best practices for contraception

#### ACTION STEP 3

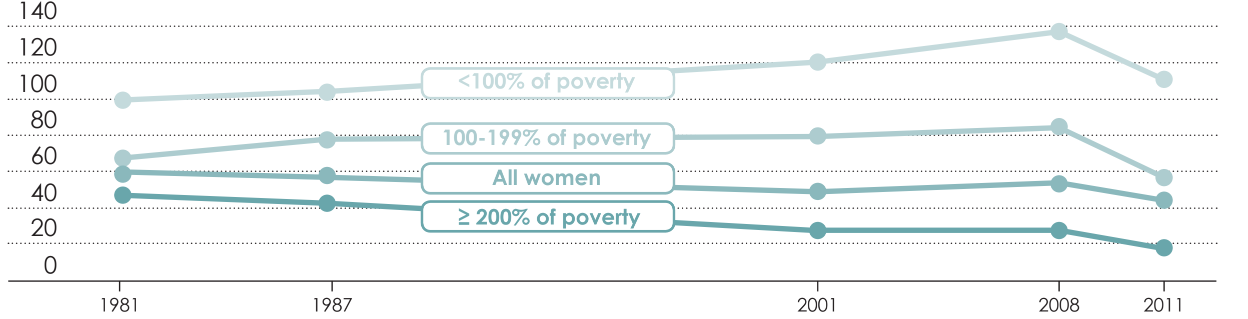
Increase LARC use in the Tri-County Area.

**Activities**

- Promote the use of the South Carolina Postpartum LARC Toolkit by providers in the Tri-County area
- Promote patient access to LARCs through existing partnerships in the Choose Well initiative
- Promote increased provider awareness of Medicaid billing standards for LARC insertion

### Unintended Pregnancy Rates[33]

**Rates (per 1,000 women aged 15-44)**

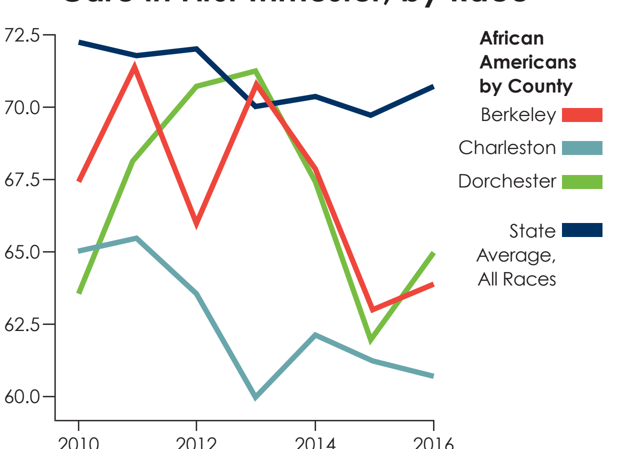


**GOAL 2** Safeguard maternal health to lower maternal mortality and morbidity in the Tri-County area and in South Carolina.

## RATIONALE

In South Carolina, maternal mortality rates of African-American women represent more than 30% of the Tri-County population have spiked by 300% in recent years.[34] The U.S. has the worst maternal morbidity and mortality rate of any wealthy nation and even many less affluent countries. According to the Centers for Disease Control and World Health Organization, 60% of maternal deaths in the U.S. are preventable.[35] Nationwide, women at the highest risk of maternal mortality and morbidity are African-American, low income and living in rural areas, due in part to gaps in access to quality health care. Increased rates of mortality and morbidity are due to the emergence of cardiovascular disease and diabetes, as well as mental health illnesses. The stresses of systemic racism are also a factor. There is a groundswell of effort statewide and nationwide to address maternal mortality and morbidity as a multi-factorial problem, including the statewide Birth Outcomes Initiative, South Carolina Maternal Morbidity/ Mortality Review Committee and nationwide Alliance for Innovation on Maternal Initiative. These organizations promote consistent and safe maternity care and support interventions to reduce the incidence. Engaging community partners is key to achieving goals in the Tri-County area.

### Percent Women Receiving Prenatal Care in First Trimester, by Race[36]




## RECOMMENDATION 1

***Raise maternal mortality by a relative improvement rate of 5% and maternal morbidity by a relative improvement rate of 10% by 2023.***

*COMMUNITY INDICATOR: Percent of birthing hospitals in the Tri-County area receiving its own hospital statistics on maternal mortality and morbidity to elevate its sense of urgency and prioritization for concrete actions*

### ACTION STEP 1

Increase awareness from birthing hospitals about maternal mortality and morbidity across the Tri-County area.

### Activities

- Disseminate data to all hospital CEOs, quality points of contact and perinatal managers
- Elevate the status of maternal mortality and morbidity outcomes by appointing a regional DHEC perinatal manager for provider/hospital education in the Tri-County, as well as throughout the state

### ACTION STEP 2

Increase collaborative partnerships that support maternal health issues.

### Activities

- Endorse research-based, state and national partnerships for data-driven public and private initiatives already underway in-state (Alliance for Innovation on Maternal Health Birth Outcomes Collaborative and others) – and in sync with those nationwide – focused on safeguarding maternal, prenatal, obstetric and postnatal health

### ACTION STEP 3

Identify South Carolina groups that will be able to prioritize maternal health and intervene with maternal morbidity and mortality issues.

### Activities

- Support the South Carolina's Maternal Morbidity and Mortality Review Committee in identifying problems contributing to deaths and to support interventions to lower the incidence, both clinical and non-clinical.

## RECOMMENDATION 2

***Reduce the racial disparity between African-American women and women of other races in rates of maternal mortality and morbidity in the Tri-County area by a relative improvement rate of 10% by 2023.***

*COMMUNITY INDICATOR: Rate of maternal mortality and morbidity (by racial groups)*

### ACTION STEP 1

Support efforts by partnering organizations to increase awareness of the racial disparity gap in maternal mortality and morbidity in the Tri-County community.

### Activities

- Enhance public awareness of maternal mortality and morbidity among African-Americans in the Tri-County area
- Identify funding organizations with best practices for maternal health that could assist the Tri-County area with its racial disparity gap

### ACTION STEP 2

Increase the percentage of women receiving prenatal/ postnatal care in the Tri-County area as one means of improving maternal health.

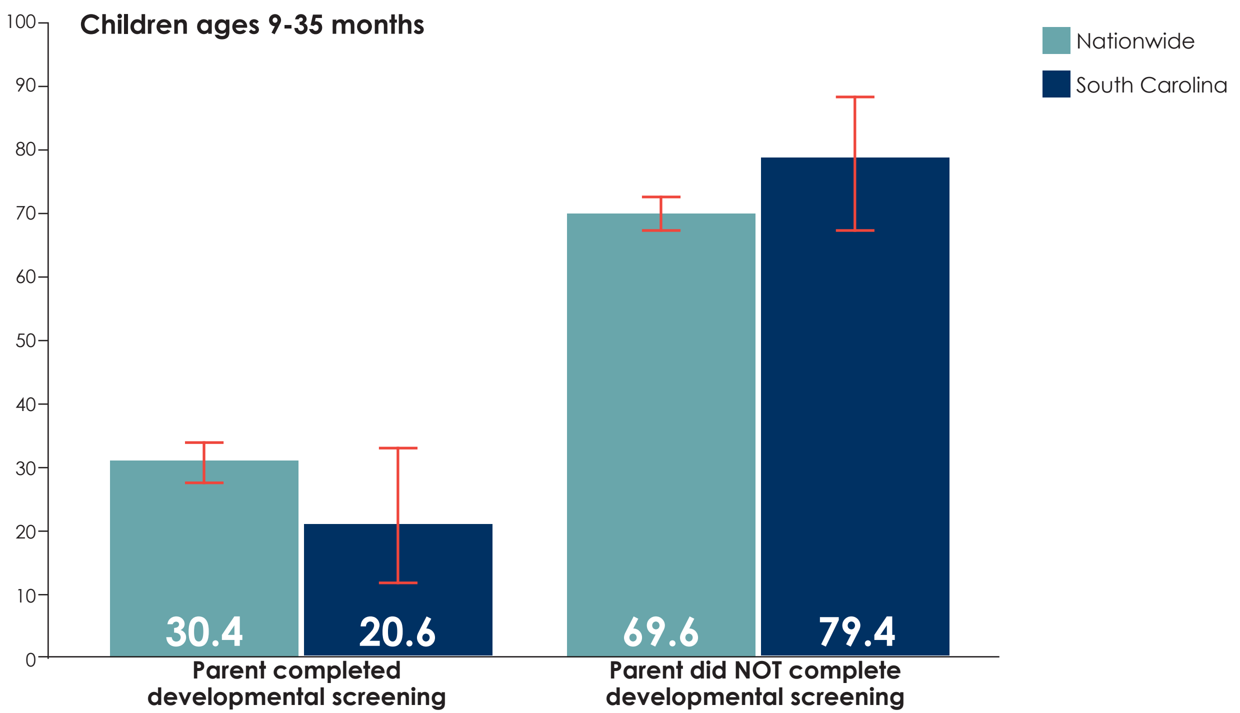
### Activities

- Collaborate with statewide organizations that help coordinate or facilitate prenatal care visits to the Tri-County area regardless of means to pay for services

**GOAL 3** Increase the number of children ages 9-35 months who receive a developmental screening using a standardized, parent-completed screening tool.

## RATIONALE

While the percentage of children with a developmental or behavioral disorder has been increasing, screening rates remain low. With as many as one in four children (ages 0-5) at risk for developmental delay, universal screening is critical to ensure early detection of delays and connection to services. Pediatric health care providers are in a unique position to identify children at risk for developmental or behavioral problems because they have near-universal access to young children during their first five years of life. The American Academy of Pediatrics recommends the following: developmental screening using a formal, validated tool at nine, 18, and 24 or 30 months, autism screening at 18 and 24 months and social-emotional screening at regular intervals.[37] Unfortunately, approximately 40% of pediatricians do not consistently screen for developmental delays,[38] and only 20.6% of South Carolina parents reported completing a standardized developmental screening through their child's health care provider.[39]




## RECOMMENDATION 1

***Increase the number of children who received a developmental screening to 50% by 2023.****

**Note: State data; Tri-County level data currently unavailable.*

*COMMUNITY INDICATOR: Percent of children (9-35 months) who receive a developmental screening using a standardized, parent-completed screening tool*

### ACTION STEP 1

Increase child health providers' knowledge of the benefits of developmental screening and monitoring.

### Activities

- Increase awareness of child health providers on the importance of conducting systematic surveillance and screening of young children and referrals/connection to services
- Promote family engagement and developmental screening through clinic-appointed health champions and community partnerships
- Embed developmental monitoring tools and resources in child health provider settings using the CDC's "Learn the Signs. Act Early." program materials that promote screening

### ACTION STEP 2

Increase community awareness of the benefits of developmental screening and monitoring.

### Activity

- Promote awareness among parents and child care providers about the importance of developmental screening through community partnerships with child care training organizations

## SPOTLIGHT

# Help Me Grow South Carolina

Help Me Grow South Carolina is a systems-model that promotes the healthy development of children prenatal to age five, and is designed to help communities leverage existing resources to ensure they identify vulnerable children, link families to community-based services and equip them to support their children's healthy development. Help Me Grow collaborates with multiple partners in developing strategies to ensure identification of vulnerable children, early detection and linkage to services. Families access Help Me Grow through a centralized access point staffed by child development specialists who help to assess a child's needs and connect them to services. An online developmental screening portal provides parents with the opportunity to assess their child's development, determine any areas needing further evaluation and learn ways they can support their child's healthy development. Since its launch in 2012, Help Me Grow SC has assisted 4,443 families and made 6,518 referrals to community programs and services.

## Stakeholders

- Alliance for Innovation on Maternal Health
- BabyNet
- Barrier Islands Free Medical Clinic
- Berkeley County First Steps
- Charleston County First Steps
- Dorchester County First Steps
- Faith-based communities in Tri-County
- Fetter Health Care Network
- Help Me Grow SC
- Medical University of South Carolina
- PASOs
- Roper St. Francis Healthcare
- Shifa Free Clinic
- SC Hospital Association
- SC Department of Health and Environmental Control
- SC Department of Health and Human Services

## Resources

- American Academy of Pediatrics, *www.aap.org/en-us/Pages/Default.aspx*
- Bedsider, *www.bedsider.org*
- Birth to 5: Watch Me Thrive!, *www.acf.hhs.gov/ecd/child-health-development/watch-me-thrive*
- CDC Learn the Signs. Act Early, *www.cdc.gov/ncbddd/actearly/index.html*
- Choose Well- No Drama Campaign, *www.nodrama.org*
- Council on Patient Safety in Women's Health Care, *www.safehealthcareforeverywoman.org*
- Healthy People - US Office of Disease Prevention and Health Promotion, *www.healthypeople.gov/2020/topics-objectives/topic/family-planning*
- Help Me Grow SC, *helpmegrowsc.org*
- Integrated Health & Policy Research, South Carolina Institute for Families in Society, *ifs.sc.edu*
- Medical University of South Carolina (MUSC), *academicdepartments.musc.edu/nursing/initiatives/centers*
- PASOs, *www.scpasos.org*
- Planned Parenthood, *www.plannedparenthood.org/learn/birth- control*
- Roper St. Francis Healthcare, *www.rsfh.com/community*
- SC Campaign to Prevent Teen Pregnancy, *www.teenpregnancysc.org*
- SC Department of Health and Environmental Control, *www.scdhec.gov*
- SC Department of Health and Human Services, *www.scdhhs.gov*
- SC First Steps to School Readiness, *scfirststeps.com*

# Obesity, Nutrition & Physical Activity

**GOAL** Reduce obesity in children and adults in the Tri-County by creating environments that promote healthful nutrition and regular physical activity.

**"I think it would be helpful to have centers that not only have recreational facilities, you know, equipment, swimming pools, all of these organized things available, but educational classes. There are a lot of churches in the area that do things individually, you know, a class here or there, but formal classes are needed on an ongoing basis about various topics."**
***– Community Conversations participant***

## RATIONALE

Across the United States, more than one in three adults are obese.[41] Obesity, physical inactivity and poor diet are found to be major causes of chronic disease and premature death. Surgeon General David Satcher reported that obesity "has reached epidemic proportions in the U.S." Locally, adult and childhood obesity rates in Berkeley, Charleston, Dorchester counties are similar to the United States overall.[42 43] The nutritional and physical environment has a strong influence on people's healthy habits. Creating environments with easy, equitable access to both fruits and vegetables and safe physical activity can have profound effects on obesity rates. Lack of access to healthy food choices is commonly associated with higher rates of obesity. The Behavioral Risk Factor Survey states that the majority of people in South Carolina consume far fewer than the recommended number of servings of fruit and vegetables.[44] Likewise, there is a strong correlation between lack of physical activity and obesity. Survey data reports an overwhelming lack of physical activity and limited access to exercise opportunities in South Carolina.[45]

## RECOMMENDATION 1

***Increase affordable fruit and vegetable access for all adults and children by 10% by 2023.***

*COMMUNITY INDICATOR: Percent of Tri-County population with low food access*

### ACTION STEP 1

Identify community access points.

### Activities

- Identify farmers markets, roadside stands, community supported agriculture and wholesale distributors
- Identify who will accept Supplemental Nutrition Assistance Program (SNAP) funds, Women, Infants and Children (WIC) vouchers, senior vouchers etc.
- Link agency maps and SNAP, WIC & senior voucher distribution sites
- Conduct gap analysis of fruit and vegetable access points and develop recommendations for closing identified gaps

### ACTION STEP 2

Promote community fruit and vegetable access points.

### Activities

- Coordinate and develop a common language resource for fruit and vegetable access points, appropriate across all sectors in Tri-County region for the consumer
- Widely share these resources with consumers

### ACTION STEP 3

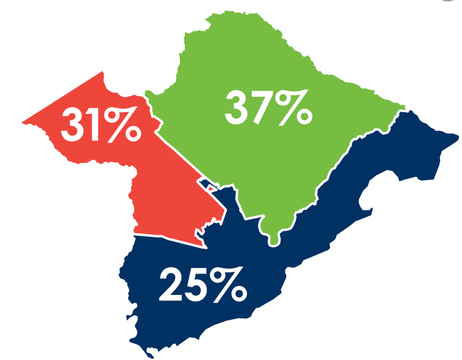
Conduct education activities to promote higher fruit and vegetable consumption.

### Activities

- Incorporate nutrition education for adults and children into workplaces, faith-based and community organizations
- Incorporate nutrition education into schools through gardens, school cafeteria, classrooms, morning announcements, after school activities, etc. (Team Nutrition Toolkit)
- Convene a networking meeting with key stakeholders doing nutrition education in the community; utilize various assessments to identify areas of need, e.g. Healthy Eating Active Living
- Identify funding, availability, access and/or resources to educate adults on fruit and vegetable consumption

**More than one-third of U.S. adults are obese as are 17% of children and adolescents aged 2–19 years.[46]**

**32% of adults** in South Carolina are considered obese.[47]




Charleston (25%) and Dorchester (31%) counties fared slightly better, but Berkeley exceeded the state average at 37%.[48]

### ACTION STEP 4

Increase access to fresh fruits and vegetables in local public schools (pre-k through 12th grade).

#### Activities

- Increase Farm to School initiatives (school gardens, taste testing, providing/promoting locally-grown foods, farm field trips, school-based farmers markets)
- Increase participation in the USDA Fresh Fruit and Vegetable Program
- Increase participation in the Smarter Lunchroom Movement

### ACTION STEP 5

Increase access to fruits and vegetables in food assistance programs.

#### Activity

- Expand access to fruits and vegetables for adults and children at school, workplace, faith-based and community organization sites

## RECOMMENDATION 2

***Increase access to safe and affordable opportunities for all adults and children to participate in regular physical activity by 10% by 2023.***

*COMMUNITY INDICATOR: Percent of population with reliable, safe access to locations for physical activity*

### ACTION STEP 1

Increase the number of open community use facilities (school outdoor facilities).

#### Activities

- Assess and identify current open community use practices and policies for school outdoor facilities
- Educate school district boards, staff and PTAs on the benefits and implementation of open community use practices and policies

### ACTION STEP 2

Advocate for safer active living routes and opportunities.

#### Activities

- Convene a networking meeting with key stakeholders in the community to develop recommendations for expanding bicycle/pedestrian trails and other safe active living opportunities
- Increase participation in SC Safe Routes to School initiative
- Engage developers, businesses, law enforcement, county planners, Council of Governments and other community members

### ACTION STEP 3

Educate public on the active living opportunities in the community.

#### Activities

- Support the Healthy Eating Active Living Assessment compiled by University of South Carolina to determine gaps
- Link agency physical activity maps (Eat Smart Move More, Let's Go, SC trails, Berkeley Charleston Dorchester Council of Government walk/bike plan, Charleston County Parks and Recreation Peoples 2 Parks)

## Stakeholders

- Berkeley County School Districts
- Breen Consulting
- Charleston County Park and Recreation Commission
- Dorchester School District Two
- Eat Smart Move More Charleston Tri-County
- Healthy Plate Cooking
- Lowcountry Food Bank
- Lowcountry Local First
- Measure of Success
- MUSC Boeing Center for Children's Wellness
- MUSC Children's Health
- Safe Kids Charleston Coalition (MUSC)
- SC Department Health and Environmental Control - Lowcountry Region
- YMCA Summerville

## Resources

- Centers for Disease Control and Prevention
  - Obesity, *www.cdc.gov/obesity*
  - Weight Management, *www.cdc.gov/healthyweight*
  - Nutrition, *www.cdc.gov/nutrition*
  - Physical Activity, *www.cdc.gov/physicalactivity*
  - Breastfeeding, *www.cdc.gov/breastfeeding*
- Charleston Moves, *www.facebook.com/pg/charlestonmoves/events/?ref=page_internal*
- Choose My Plate, *www.choosemyplate.gov*
- Health.gov, *health.gov/dietaryguidelines*
- Healthy Kids Eat Well, Get Active, *www.healthykids.nsw.gov.au*
- Let's Go! SC, *www.letsgosc.org*
- Let's Move, *letsmove.obamawhitehouse.archives.gov*
- TrailLink SC, *www.traillink.com/statelist/?state=sc*

## RECOMMENDATION 3

***Promote water intake for adults and children; increase marketing of water intake by 5% by 2023.***

*COMMUNITY INDICATOR: Increase in promotion materials and media coverage / campaign viewership metric*

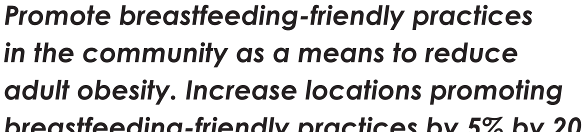
### ACTION STEP 1

Promote water intake in the community.

### Activities

- Promote water intake in community sectors
- Encourage schools to have water drinking campaigns and water drinking policies

## RECOMMENDATION 4



***Promote breastfeeding-friendly practices in the community as a means to reduce adult obesity. Increase locations promoting breastfeeding-friendly practices by 5% by 2023***

*COMMUNITY INDICATOR: Number of organizations with formal breastfeeding policies*

### ACTION STEP 1

Promote breastfeeding-friendly practices in the community.

### Activities

- Convene a networking meeting with key stakeholders in the community who are promoting breastfeeding (hospitals, DHEC, South Carolina Program for Infant/ Toddler Care, La Leche League, State Breastfeeding Coalition, WIC)
- Promote and support breastfeeding-friendly locations and policies, such as on-site breastfeeding in childcare settings, schools and in the workplace

### ACTION STEP 2

Promote education for existing breastfeeding support providers regarding connection between breastfeeding and adult obesity.

### Activities

- Identify when and where education is happening and potential gaps in local breastfeeding education
- Advocate for the inclusion of obesity connection in materials/curriculum

## SPOTLIGHT

## MUSC Boeing Center for Children's Wellness

MUSC Boeing Center for Children's Wellness works to instill a culture of wellness and prevent obesity such that each child is healthy, succeeds in school and thrives in life.

MUSC BCCW reaches young children and their teachers through the South Carolina Program for Infant/Toddler Care, the Breastfeeding Friendly Child Care designation and conferences and the Infant – Early Childhood Mental Health Initiative. It reaches school-aged children and their teachers with the Docs Adopt School Health Initiative©.

MUSC BCCW K-12 efforts in Charleston, Berkeley and Dorchester Two school districts have reached over 150 schools, assisting in the creation of culture and wellness through resources to encourage changes to policies, environments and systems that improve nutrition and increase physical activity. Participating schools receive a monetary award of up to $1,000 to make wellness changes. Schools have established gardens, installed refillable water stations, purchased kinesthetic desks, provided additional physical education equipment and more.

# Call to Action

*Our Health, Our Future: Tri-County Health Improvement Plan* contains goals and recommendations that have more than one intended audience. To achieve these, it is necessary for a wide range of community groups and organizations, health care partners and local government agencies to invest time, talent and treasure to help build a healthier Tri-County. No single organization, no matter how well-resourced or powerful, can tackle these issues alone.

With *Our Health, Our Future Tri-County: Health Improvement Plan* we have a clear path to helping build healthier individuals, families and communities, which in turn will help strengthen our regional economy. Healthy Tri-County strongly believes that in order to improve health outcomes in our region we must directly address the needs of our local communities experiencing the highest rates of health disparities. By investing resources and time in communities that are experiencing the greatest need, our community will realize the saying "a rising tide raises all boats" in our region. Throughout the five-year process of achieving the goals outlined in the plan, we will modify plan action steps and activities as needed to ensure capitalization on emerging opportunities, achievement of quick successes and prevention of loss of momentum.

**Through collective action we can and will make a difference.**

***Individually we are a drop. Together we are an ocean.***
– Ryunosuke Satoro

## Next Steps that Everyone Can Take:

- **Join Healthy Tri-County, either as a formal member organization or as an individual participant in one of the three HTC workgroups.** Formal organizational membership requires the submission of a signed commitment pledge. Individual membership requires participation in both an online webinar and in-person orientation .
- **Make sure that people in your network are aware of TCHIP.** Help promote the document through your social media platforms.
- **Organizations and Institutions: Review TCHIP to determine which areas of the plan align with the efforts of your organization.** Think creatively about how you can use this plan, not only to achieve the outlined goals and recommendations, but also to forge new relationships across different sectors.
- **Challenge organizations or groups that you're a part of to address one of the five health areas of TCHIP.** Set goals for how you will support TCHIP, and recommit to them over the next five years!
- **Take the next step to becoming more informed about the health topics** included in TCHIP by reviewing the resources provided in the document.
- **Keep Healthy Tri-County informed of your actions and progress.** Our hope is to capture and document all efforts towards the goals of TCHIP, and to ensure that groups are recognized for their efforts.

***To learn more about Healthy Tri-County, visit www.healthytricounty.com. To get engaged with the TCHIP, contact (843) 740-7752 or HTCsupport@tuw.org.***

# Acknowledgements

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# Healthy Tri-County Core Partners

MUSC Health is the clinical enterprise of the Medical University of South Carolina (MUSC), comprised of a 700-bed medical center, the MUSC College of Medicine and the physician's practice plan. It serves patients across South Carolina and beyond through four hospital facilities in Charleston and more than 100 outreach sites. Among these are the Hollings Cancer Center, the only National Cancer Institute-designated center in the state, a nationally recognized children's hospital, the Center for Telehealth and the state's only transplant center. The Medical University was founded in 1824 and has become a premiere academic health sciences center at the forefront of the latest advances in medicine, with world-class physicians, scientists and groundbreaking research and technology that is often the first of its kind in the world. MUSC educates and trains more than 3,000 students and residents, and has nearly 13,000 employees, including approximately 1,500 faculty members in six colleges (Dental Medicine, Graduate Studies, Health Professions, Medicine, Nursing and Pharmacy).

***www.musc.edu***

Roper St. Francis Healthcare is Charleston's only private, not-for-profit hospital system with a specific focus on community outreach, maintaining a mission of healing all people with compassion, faith and excellence. The healthcare system has three hospitals strategically located across the region: Roper Hospital on the Charleston peninsula, Bon Secours St. Francis Hospital in West Ashley and Roper St. Francis Mount Pleasant Hospital in Mount Pleasant. The system is building a fourth flagship hospital in the Carnes Crossroads section of Berkeley County. Roper St. Francis Healthcare is one of the Lowcountry's largest private employers with more than 5,500 employees. The healthcare system has a robust, active medical staff of more than 900 doctors representing every medical specialty and provides services in more than 125 locations in seven counties.

***www.rsfh.org***

Trident United Way

The mission of Trident United Way is to be a catalyst for measurable community transformation through collective impact in education, financial stability and health.

Trident United Way brings organizations and people together to improve educational outcomes for all students, improve the opportunity for all people to enjoy a quality standard of living and improve the health of all individuals. Trident United Way unites expertise, resources and passion by fulfilling its roles and responsibilities in our community as a community connector, a strategic partner, volunteer engager and investor.

When you invest your time, talent and treasure with Trident United Way, you join a movement of people and organizations working together to create bold change. We know that working together is the most efficient way to solve complex community-level issues.

***www.tuw.org***