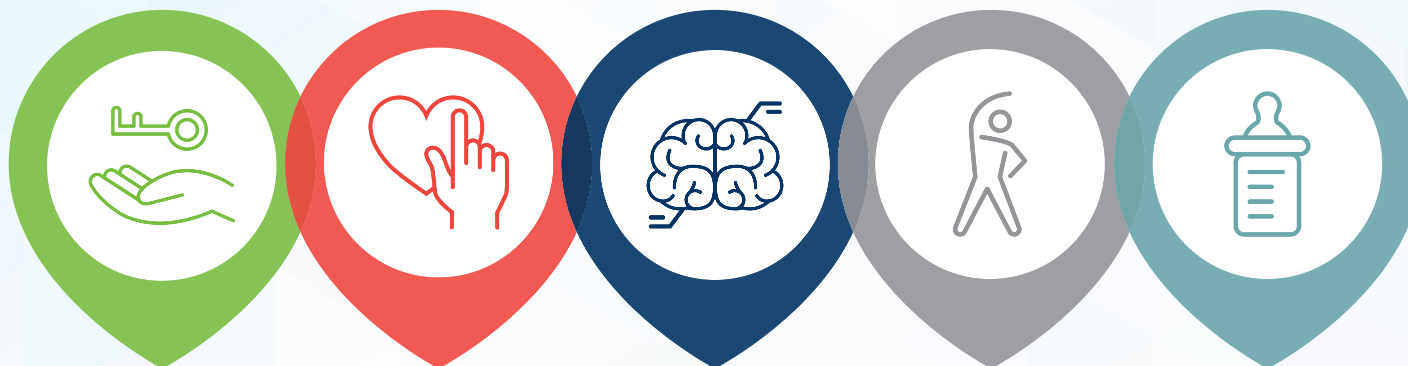
TRI-COUNTY

HEALTH LANDSCAPE

2022 Community Health Needs Assessment Report

BERKELEY | CHARLESTON | DORCHESTER



A Collaborative Effort of MUSC Health, Roper St. Francis Healthcare and Trident United Way

A Message to the Community

Beginning in 2016, MUSC Health, Roper St. Francis Healthcare and Trident United Way came together as Core Partners to create a multi-sector regional initiative known as the Healthy Tri-County Coalition (HTC). The goal of this collaboration was to improve the health outcomes of residents in Berkeley, Charleston and Dorchester counties. As part of this partnership, a Community Health Needs Assessment (CHNA) was performed in 2016 to identify the health needs of the community and address the disparities and gaps in care. When the Core Partners came together to analyze the results of the 2016 CHNA, it quickly became apparent that the HTC was only in the beginning stages of addressing the complexities of health challenges facing Tri-County residents. Thus, bringing forth the need to continually perform community health needs assessments to remain engaged in the community and monitor the evolving health needs of community residents.

In 2022, the Core Partners completed their Tri-County Community Health Needs Assessment through collective efforts with key leaders in the community such as health care, community groups, mental health leaders, faith-based communities, educational organizations, nonprofits and local governments. Together the Core Partners conducted qualitative and quantitative assessments to uncover the needs of the community. The last few years highlighted many of the economic, racial and geographic disparities our community faces. The widespread impact of COVID-19 exacerbated these disparities.

Through a collaborative effort, Healthy Tri-County remains committed to reassessing the community's priorities every three years, and will continue to promote, design and create programs and services that complement and supplement one another's efforts. As we reflect on the past years of progress and collaboration, we not only value public health as it has been, but we look to public health as what it could be.

We're committed to meeting the health needs of our community!

How to Use This Report

This report includes three sections under each of the health topic areas prioritized by the 2022 CHNA respondents:

Examining the Issue: presents national and regional data relevant to the health topic area.

Community Spotlights: showcases organizations within the Tri-County that are addressing the health topic area.

Voices from the Community: direct quotes from local community members during 2022 CHNA data collection that address the health topic area.

Healthy Tri-County Core Partners

*Want to know more about becoming a partner? Visit **www.healthytricounty.com**.*

Monitoring of 2019 CHNA Implementation Strategy

Healthy Tri-County has worked over the last three years to develop and implement strategies to address the health needs in our region. HTC workgroups tackled the problem statements outlined in the Our Health, Our Future Tri-County Health Improvement Plan 2018-2023 (TCHIP).

The monitoring process determines the effectiveness of the plan. HTC conducted self-assessments on each of the goals and strategies of the plan. The TCHIP Accomplishment Report reflects the highlights and accomplishments from HTC.

Our Health, Our Future

Tri-County Health Improvement Plan

Accomplishments Report | 2019-2021

Reporting & Monitoring Activities

The progress and outcome of activities implemented in response to the 2022 CHNA findings will be presented independently by each Core Partner and collaboratively through Healthy Tri-County. Since 2016, HTC has been committed to hosting complementary community forums that provide regional organizations and community members an opportunity to learn from leaders, network across industries and innovatively troubleshoot health barriers.

HTC workgroups continue to implement and monitor progress towards goals outlined in Our Health, Our Future. Tri-County Health Improvement Plan 2018-2023 (TCHIP). In accordance with federal requirements, Roper St. Francis Healthcare's Implementation Plans will be posted annually.

Methodology

Purpose

This report provides a snapshot of the Tri-County health landscape as captured by the 2022 Community Health Needs Assessment (CHNA) administered by MUSC Health, Roper St. Francis Healthcare and Trident United Way. This report is designed for use by various audiences and provides data for immediate application to support community health improvement efforts.

Health Topic Areas

The health topics included in the CHNA survey and referenced during qualitative data collection efforts were drawn from Healthy People 2020, a 10-year health improvement agenda developed by the US Department of Health and Human Services.

- Access to Care
- Clinical Preventive Services
- Injury & Violence
- Maternal, Infant & Child Health
- Mental Health
- Obesity, Nutrition & Physical Activity
- Oral Health
- Reproductive & Sexual Health
- Substance Misuse
- Tobacco

CHNA Data Collection Process

The CHNA process began in February 2022, and the collection of quantitative and qualitative data concluded in September 2022. HTC's Health Data Workgroup conducted focus groups and key informant interviews distributing the CHNA survey (available in English and Spanish) both electronically and in paper form to target locations within the community. Specific activities included:

- Administering 35 and 40-question paper and online surveys (40 questions for medical/ social service providers and 35 for community members) with a total of 678 respondents.
- Conducting 9 focus groups with 47 community members from different areas with various perspectives represented.
- Engaging in interviews with 10 community leaders and health care professionals.
- Hosting three virtual Community Input Sessions with 194 participants.

CHNA Data Analysis

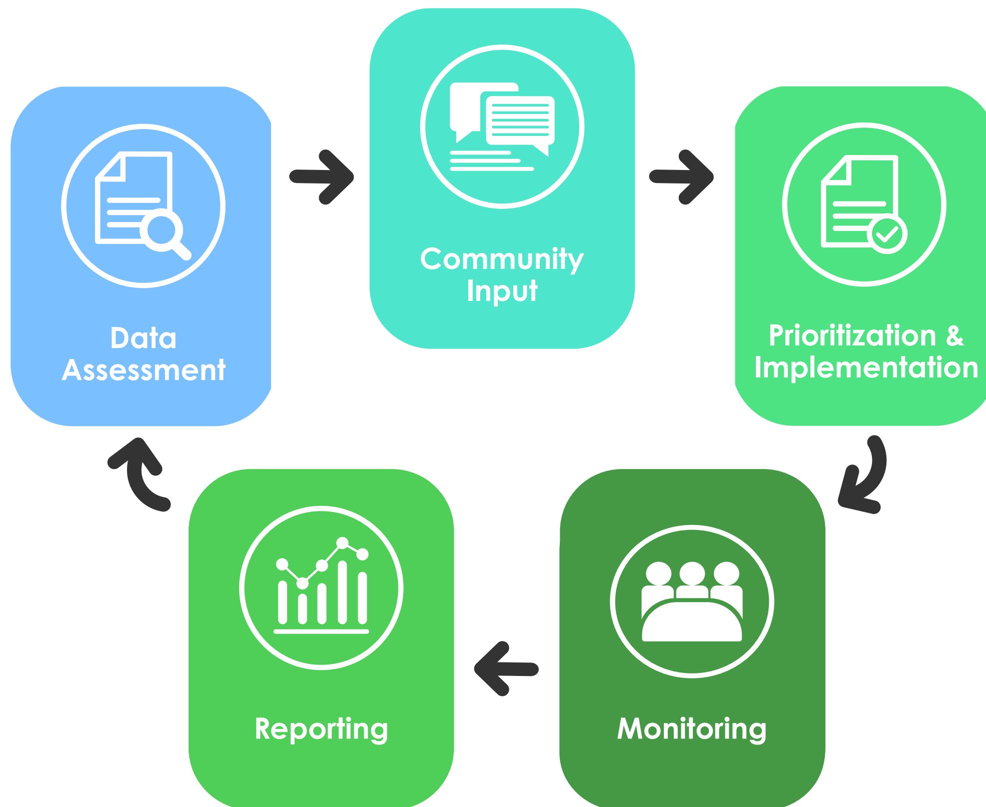
Utilizing technical assistance from SC DHEC: Division of Population Health Surveillance, the 2022 CHNA surveys were coded and analyzed to address questions about the overall health of the Tri-County area: to identify specific areas of concern for Tri-County residents and provide insight into the effects of socio-economic and racial barriers regarding differences in health outcomes and health concerns. Focus groups were conducted and the contents analyzed to gain qualitative feedback from the public on their perceptions of community health and how the health and health care of their communities has changed since 2019.

Challenges and Improvements to Data Collection

Based on lessons learned from the 2016 and 2019 CHNA process, the HTC's Health Data Workgroup initiated the 2022 CHNA planning process engaging specific community groups and organizations to reach previously underrepresented groups. We participated in a statewide pilot project for CHNA survey tool development, data collection and analysis led by SC DHEC and SCHA. We worked closely with partners to engage more members from African American, LGBTQIA+, Latinx, low socioeconomic and rural communities. Looking forward, we see opportunities to reach even more rural and Spanish-speaking communities through targeted outreach and by building onto our existing resource network within these groups. As in previous years, a recommendation from the Health Data Workgroup is a more concerted effort to engage other groups like LGBTQIA+, veterans and people living with disabilities when scheduling focus groups and tailoring questions specifically for those groups to better understand their health issues.

Community Health Needs Assessment & Engagement

The Tri-County Community Health Needs Assessment & Engagement Strategy is a cyclical process composed of five steps. The three HTC Core Partner organizations work collaboratively to assess data and gather community input. Then, given different missions, goals and government requirements, the teams will split up to strategically prioritize health needs and implement supporting programs. The HTC Core Partners and its partner organizations will annually report the monitoring of the health improvement plans and evaluate the process and outcomes.



What You Can Do:

- Share data findings from the 2022 CHNA with local elected officials, community leaders and within your social networks.
- Use data from the *Examining the Issue* sections to guide specific actions you or your organization can take.
- Email HTCsupport@tuw.org to request the 2022 CHNA data file to further analyze and inform community health strategies and programming.
- Seek additional input from community members and engage them in developing culturally appropriate materials and programs.
- Join Healthy Tri-County as an organization by submitting a commitment pledge from the most senior member of your company or institution.
- Join Healthy Tri-County as an individual by visiting https://www.healthytricounty.com/become-member for details and complete the member interest form.

Community Engagement in Action

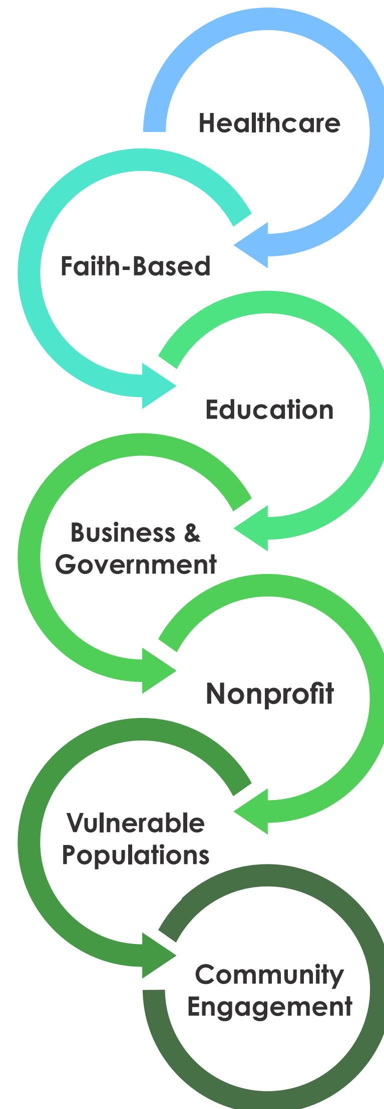
The intention of our 2022 CHNA is to build upon previous assessment efforts, to refine existing health priority areas and to identify new areas of concern for the community.

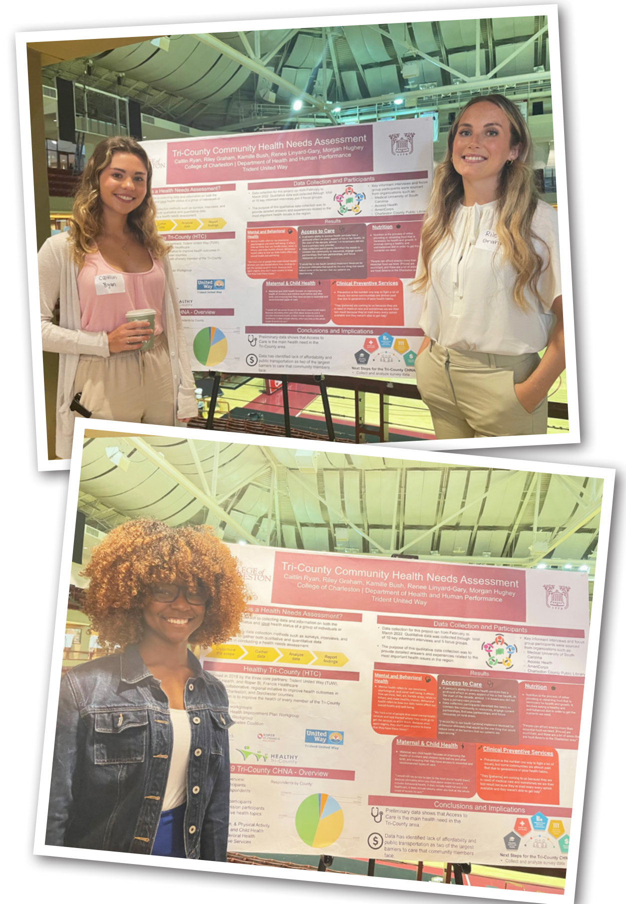
This year, Healthy Tri-County placed a relentless focus on actions required to improve health and quality of life for residents. Focus groups and community interviews drew similarities consistent with the survey results of top community needs.

Focus Group and Interview: Common Barriers and Challenges

- Bias and Stigma Surrounding Mental Health
- Health Literacy
- Poverty
- Lack of Transportation
- Economy and Inflation
- Differences in Demographics/ Regions
- Lack of Access to Healthcare
- Access to Mental Health, Behavioral Health
- Homelessness
- Food Insecurity

Healthy Tri-County fosters multi-sector community stakeholder engagement to advance health equity.

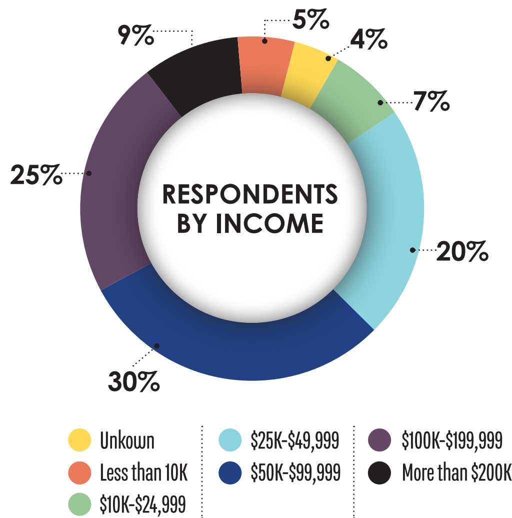


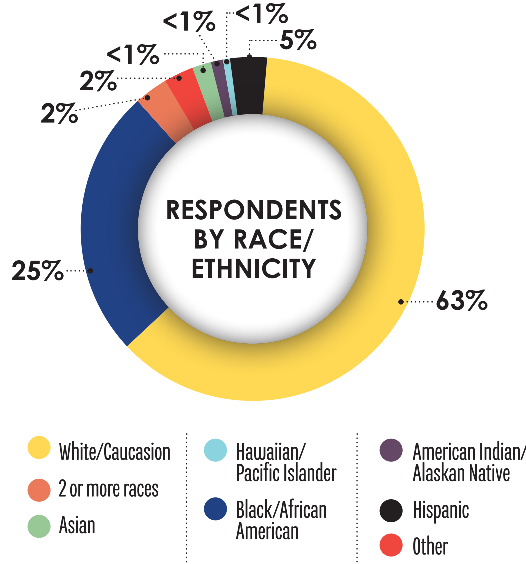


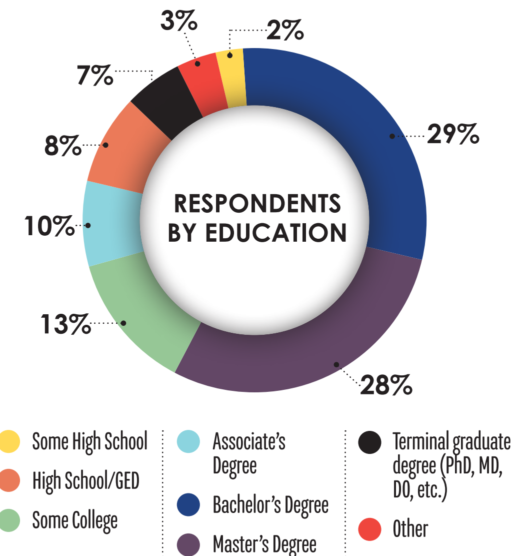
Three public health students at the College of Charleston presented results from the interviews and focus groups as a part of the 2022 Community Health Needs Assessment at the 2022 College of Charleston EXPO, a celebration of student research. The event was held in April in TD Arena. Students included Caitlin Ryan (class of 2022), Riley Graham (class of 2022), and Kamille Bush.

CHNA Data & Demographics

Featured Demographics Represent The Participants (Medical And Non-Medical Service Providers) Of The 2022 CHNA.







Health Topic Rankings

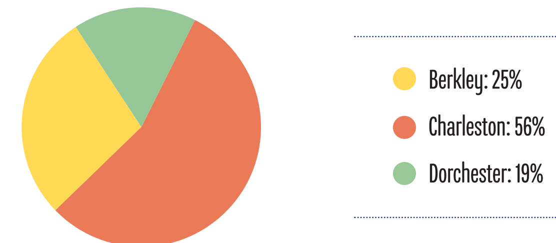
The 2022 CHNA survey respondents were asked to rank the top 10 health topic areas from Healthy People 2020 that impact the communities where they live and/or work from 1 (most concerning) to 10 (least concerning). While the top six health topics prioritized by the community include oral (#3) and sexual health (#6), these health issues are currently identified within other health priority areas in the TCHIP. Oral and sexual health, respectively, are addressed in strategies under access to care (#1) and maternal, infant and child health (#7). Understanding the intersection of these health issues, the five prioritized health topics featured in this report will align with TCHIP.

To help continue our work in 2022-2023, HTC will utilize Healthy People 2020 topic areas to remain consistent with the current five-year health improvement plan. We will reference the Healthy People 2030 equivalents for future implementation plans. Healthy People 2030 has a strong focus on eliminating health disparities and creating equitable opportunities for people to live healthy lives. We will work to advance health equity, increase health literacy and address social determinants of health in the region.

Top 10 Health Topics

1. ***Access to Care***
2. ***Clinical Preventive Services***
3. ***Oral Health***
4. ***Mental Health***
5. ***Obesity, Nutrition and Physical Activity***
6. Sexual Health
7. Maternal, Infant and Child Health
8. Injury and Violence
9. Substance Misuse
10. Tobacco Use

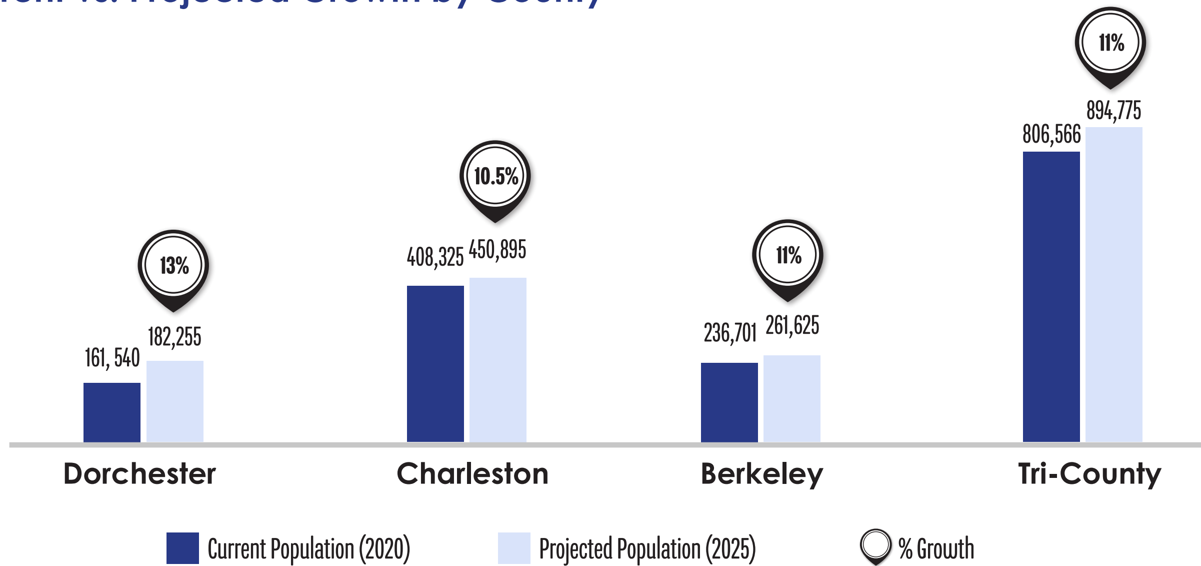
Respondents by County



Source: SC DHEC

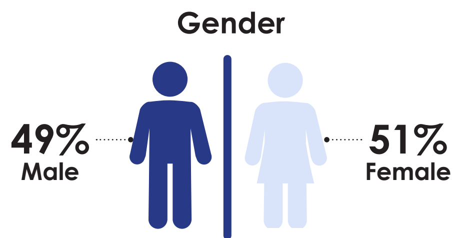
Community at a Glance

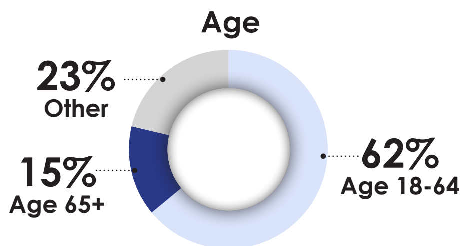
Current vs. Projected Growth by County

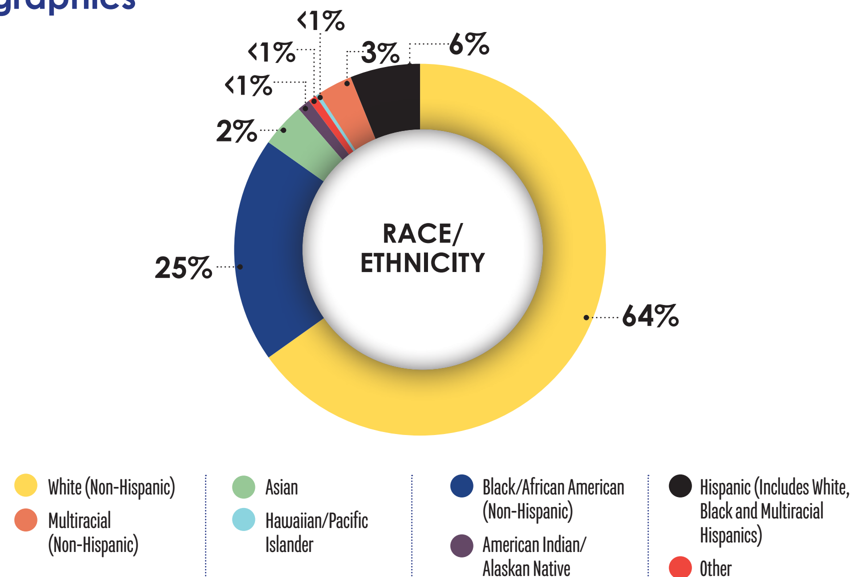


Source: US Census Quick Facts, 2020

Tri-County Population Demographics







US Census Quick Facts, 2020

National and County Health Rankings

The United Health Foundation releases annual health rankings that measure the overall health of each state. In 2021, South Carolina ranked 43rd of 50 states, positioned only above Kentucky, Alabama, Oklahoma, West Virginia, Mississippi and Louisiana. South Carolina continues to face challenges such as high premature death rates, high prevalence of multiple chronic conditions, as well as high incidence of sexually transmitted infections.

Between 2016 – 2018 obesity increased from 32.3% to 36.2% of adults. Insufficient sleep decreased 10% from 37.4% to 33.7 % of adults between 2018-2020. Annual dental visits increased 10% from 61.8% of adults to 71.8% of adults between 2018-2020.

Despite the United Health Foundation ranking, Berkeley, Charleston and Dorchester Counties each rank within the top 10 of overall health compared to the other 46 counties in South Carolina.

2022 County Health Rankings 46 Counties in SC

Health Outcomes (length and quality of life)

Berkeley County 7th
Charleston County 4th
Dorchester County 6th

Health Factors (health behaviors, clinical care, social, economic and physical environment)

Berkeley County 9th
Charleston County 3rd
Dorchester County 10th

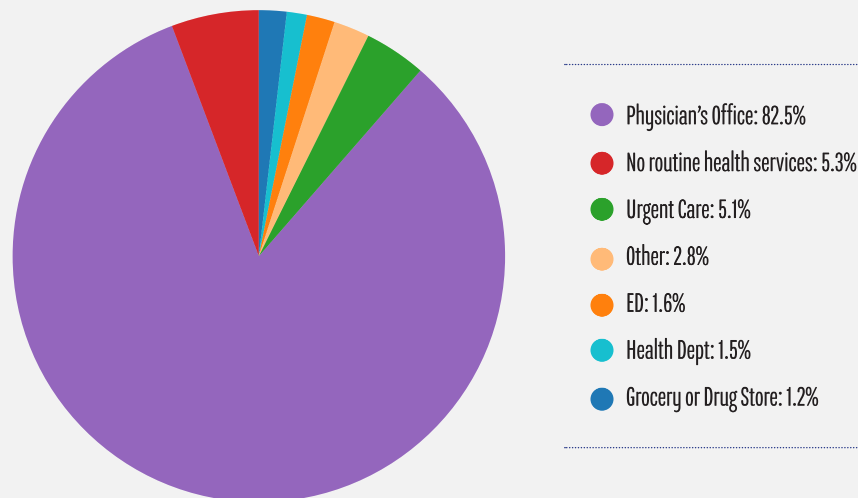
Access to Care

Examining the Issue

In order to achieve the best health outcomes, a person must have access to timely health care without barriers to preventing access health services. Many Tri-County residents have an issue with accessing the care they need. Reasons range from lack of knowledge to lack of transportation access to a lack of personable connections with physicians. Continuously struggling through various parts of the social determinants of health are part of the problem. While the evidence shows that the populations are not all affected by the same need, they are all affected in some way.

45.9% of all respondents listed **Access to Care** as their **#1** health priority

Respondent Choices For Routine Health Care Services Providers



COMMUNITY SPOTLIGHT

Dee Norton Child Advocacy Center

Dee Norton understands the need to provide services to all referred children and their families in order to reduce the negative impacts of abuse and the related long-term suffering (individual, familial and societal) associated with childhood exposure to trauma. Therefore, all individuals referred who are in need of services, regardless of their ability to pay, receive the treatment services they need at no cost to the family. Children are referred to Dee Norton by child protective services, law enforcement, medical professionals, schools and families. Comprehensive medical exams are performed on-site to document any physical signs of abuse and assure the child's overall health. Dee Norton therapists deliver an impressive menu of evidence-based treatments, which have been proven to reduce psychiatric disorders, such as PTSD, depression, anxiety and conduct problems.

Voices from the Community

"Transportation was a barrier, especially for those out in rural areas. In Charleston if you go certain places like Moncks Corner, there's no public transportation. Evenin Dorchester County, the bus does not come throughout Summerville. Transportation has always been an issue (in the Tri-County)."

– Interview Respondent

"The logistical challenges of navigating a complicated healthcare system based on one's financial status, social status or zip code is a challenge for many of our patients."

– Interview Respondent

Clinical Preventive Services

Examining the Issue

Getting preventive care reduces the risk for diseases, disabilities and death — yet millions of people in the United States do not get the recommended preventive health care services. Services like screenings, dental check-ups and vaccinations are key to keeping people of all ages healthy. Barriers to receiving this care include cost, not having a primary care provider, living too far from providers and lack of awareness about recommended preventive services.

Healthy Tri-County's (HTC) three-year relationship with the Duke Endowment began in 2018. Healthy People, Healthy Carolinas (HPHC) is an initiative designed to help communities in North Carolina and South Carolina address chronic health issues such as obesity, diabetes and heart disease.

The figure on the right, provided by HPHC, reports the "Footprints" of the Tri-County Diabetes Prevention Programs.

Source: HPHC, 2022

Healthy People
Healthy Carolinas

COMMUNITY SPOTLIGHT

AccessHealth Tri-County Network (AHTN)

The Diabetes Prevention Project Expansion at AHTN began in 2019. Their mission is to meet the community where they are; to empower and equip with the tools that are needed to change the course of their health through education in diabetes prevention.

AHTN serves as the HUB of Diabetes Prevention Programs in Berkeley, Charleston and Dorchester counties. No matter where an individual lives or works within the tri-County area, AHTN is committed to connecting them with the program that best fits their needs!

Voices from the Community

"Sometimes you get more information discussing (a patient's) preventative care. You find out the stuff that they're really struggling with when you're doing the clinical assessments. (It helps to) get a rough area of how the person is doing."

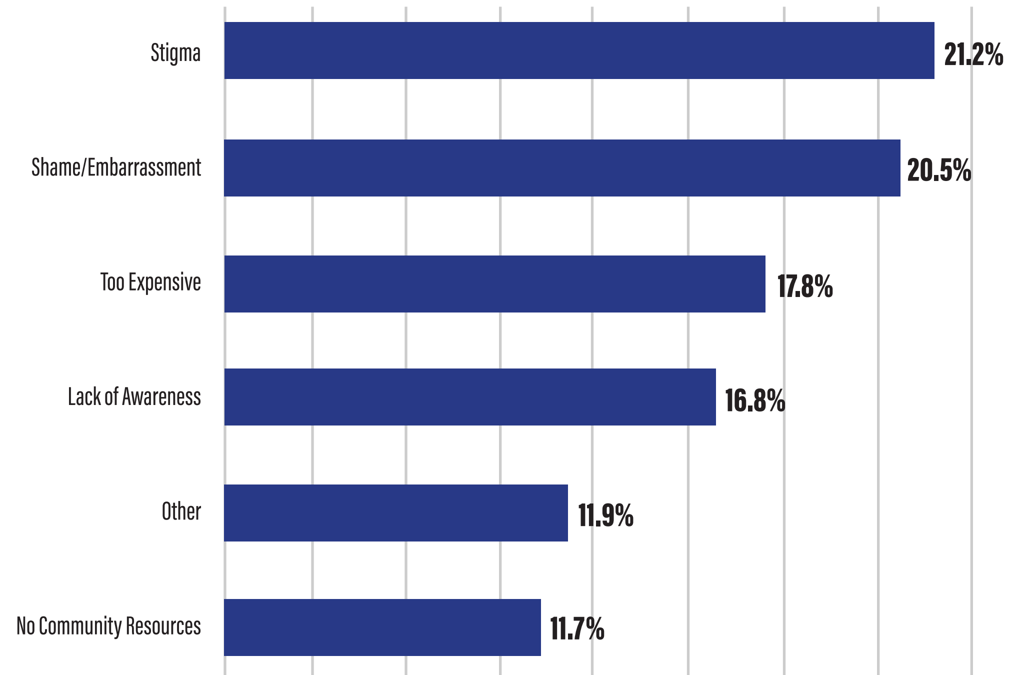
– Focus Group Respondent

Behavioral Health

Examining the Issue

According to the Centers for Medicare & Medicaid Services, behavioral health is sometimes called mental health and often includes substance use. Behavioral health is the emotions and behaviors that impact an individual's overall well-being. The increasing number of adults with a behavioral health disorder across South Carolina is alarming under any circumstance; however, as a result COVID-19 pandemic, the number of people suffering from serios mental illness and substance use disorders continues to increase due to various contribution factors (isolation, uncertainty, stress and financial insecurity). A global survey published in the journal Progress in Neuro-Psychopharmacology and Biological Psychiatry in 2020 reported that younger people are more vulnerable to stress, depression and anxiety symptoms associated with COVID-19.

Factors Negatively Impacting Behavioral Health Outcomes



Source: 2022 CHNA Respondents

COMMUNITY SPOTLIGHT

Dorchester County Community Outreach

The organization, Dorchester County Community Outreach (DCCO),which operates the men's shelter, Home of Hope and the women's shelter, Hope's House, provides support to guests who are looking to move out of homelessness. DCCO assists the men and women and women in Dorchester County and surrounding counties in recognizing what led them to homelessness and providing the contacts and resources to help them to reach self-sufficiency. The DCCO's primary area of need is mental health assistance, which can be difficult for the guests to obtain without guidance and accessibility. Both behavioral health and access to care are needs the organization is striving to impact. In addition, DCCO provides available resources and expects guests with alcohol and drug dependency participate in local programs for their addictions.

Voices from the Community

"When it comes to mental health or seeing a doctor, if you're already in crisis mode and you have to wait to see a professional, that doesn't help anything. The waiting period is detrimental to a lot of people."

– Focus Group Respondent

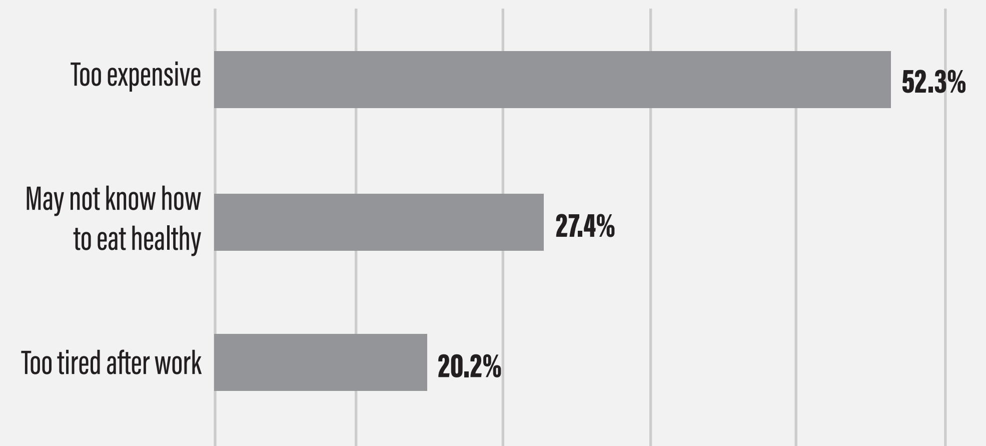
"We have a lot of people who need mental health services, but lack (the resources) to get them. And because of stigma, they don't want anyone to know that they have these issues."

– Interview Respondent

Obesity, Nutrition & Physical Activity

Examining the Issue

Having a healthy diet consisting of proteins, fruits and vegetables is necessary for a community to decrease their health risks as well as increase long-term health goals. Eating a healthy diet and maintaining an active lifestyle are among some of the recommendations for maintaining a healthy weight by the Center for Disease Control and Prevention. Berkeley, Charleston and Dorchester are all considered rural counties; however, some areas within the Tri-County do not have the same access to healthy food options. Learning to reduce weight, becoming more active and eating balanced meals are all topics of need expressed by the community.



COMMUNITY SPOTLIGHT

Green Heart Project

Green Heart's programs serve students at Title I schools, including the elementary and middle school Farm to School programs and the high-school Youth Internship Program. Farm to School Programs involve school garden education, farm field trips & garden workdays and fresh produce distribution. Farm to School programs bring green space to urban schools to promote outdoor learning, physical activity and hands-on food and nutritioneducation. This improves healthy eating behaviors and provides access to thousands of pounds of fresh, healthy produce for school communities. By improving access to healthy food and offering nutritional education in schools, Farm to School programs can change the narrative for some of the most vulnerable young people in communities across Charleston.

2021-2022

- **Number of schools served: 16**
- **Students served: 3,983**
- **Number of lessons taught: 507**
- **Pounds of produce grown & distributed: 5,477**

Voices from the Community

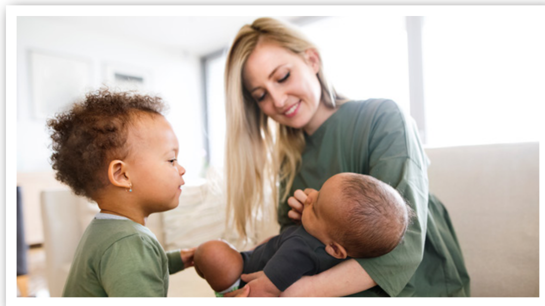
"I don't think all communities in the Tri-County have places where people can be physically active. You don't see community centers or YMCA's where people can walk around a track or do some type of circuit training or play basketball. I don't think there's enough of that in the Charleston area."

– Focus Group Respondent

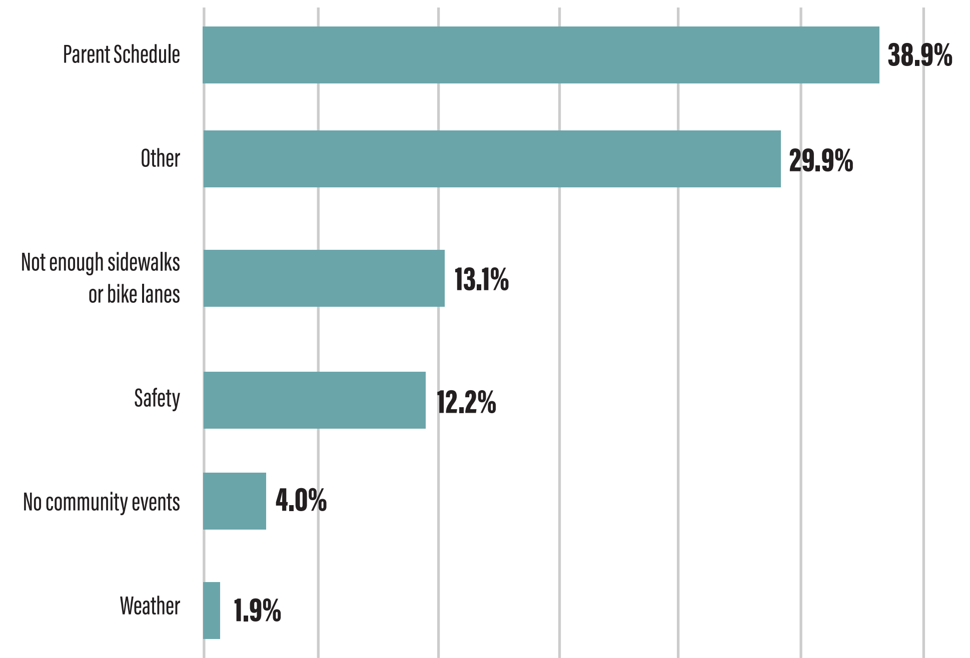
Maternal, Infant & Child Health

Examining the Issue

Women in the United States are more likely to die from childbirth than women living in other developed countries. Healthy People 2020 focuses on preventing pregnancy complications and maternal deaths and helping women stay healthy before, during and after pregnancy. COVID-19 pandemic has brought a new focus to health disparities, including the longstanding inequities in maternal and infant health among people of color. Despite advancements in medical care, disparities in maternal and infant health continue in communities of color throughout the Tri-County regions, and laws surrounding reproductive health may widen the existing disparities in maternal, infant and child health for generations to come.



The Main Reason that Prevents Children in my community from being physically active is:



Source: 2022 CHNA Respondents

COMMUNITY SPOTLIGHT

Florence Crittenton

For more than 120 years, Florence Crittenton has provided residential services and support programs to ensure at-risk, pregnant, and parenting teens have a healthy start to life. In addition to providing a safe home environment, we provide pregnant and parenting teens with an education, career development support, life skills classes, prenatal and postpartum care, and parenting education. The Pregnant and Parenting Program's goal is to seek healthy pregnancies and the prevention of child abuse. The Florence Crittenton Nurse primarily coordinates the medical care for pregnant and parenting clients, including administering medications and daily vitamins; scheduling prenatal, postpartum, and well-baby appointments; and overseeing weekly meal planning to ensure the nutritional needs of the mother and infant are met.

Voices from the Community

"(It's important to find) doctors and physicians that listen to what a mom needs and not brushing it off or making her feel as if she is exaggerating or overestimating what her health concerns are. Especially for something like childbirth. That's as close to death as some of us will ever experience, when we give birth to a child."

– Interview Respondent

Acknowledgements

CHNA Advisory Workgroup

This report is based on the collaboration of numerous organizations. The Core Partners of Healthy Tri-County are pleased to extend a special thanks to all staff and community partners who actively served on the Community Health Needs Assessment Advisory Workgroup.

Roper St. Francis Healthcare

- Mark Campbell Dickson*, Mission
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- Troy Powell, Continuing Care
- Nichole Stephens, Marketing
- Tiquita Stewart*, Diversity, Inclusion & Health Equity

Medical University of South Carolina

- Kim Balaguer, LMSW, Community Outreach
- Willette Burnham-Williams*, PhD, Office of Equity
- Shawn Gathers, DHA, Community Outreach
- Quenton Tompkins*, Community & Government Affairs

Trident United Way

- Joseph Current*, Community Impact
- Amanda Lawrence, Community Impact
- Debbie Mann, Community Impact

Supporting Community Partners

- AccessHealth Tri-County Network
- Alliance for a Healthier SC
- Art Pot
- Barrier Island Free Medical Clinic
- Charleston Promised Neighborhood
- City of Charleston
- College of Charleston
- Ernest E. Kennedy Center
- Palmetto Community Care
- SC Hospital Association
- SC Department of Environmental Control
- St. James Health and Wellness

Healthy Tri-County Health Data Workgroup

Several staff and organizations dedicated additional time and resources to gather qualitative and quantitative data throughout
the data collection process.

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- Stacy Varvel
- Kathleen Williams
- Nancy Wilson

This Community Health Needs Assessment Report for fiscal year 2022 was approved by the Roper St. Francis Healthcare Board of Directors at its meeting held on **December 8, 2022**.

**Core Planning Committee*

End Notes

- US Census Bureau. (2021). Quickfacts
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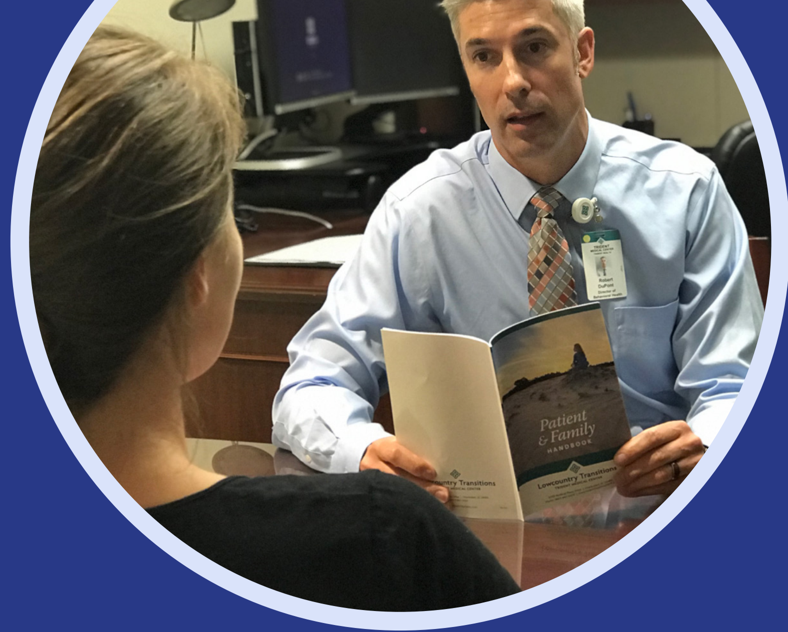

HEALTHY
Tri-County

Appendix

2022 Community Health Needs Assessment - Roper St. Francis Healthcare (RSFH)

Adopted by the Roper St. Francis Board of Directors, December 8, 2022
(Includes Roper Hospital, Bon Secours St. Francis Hospital, Roper St. Francis Mount Pleasant Hospital and Roper St. Francis Berkeley Hospital)

There isn't any one reason why Roper St. Francis Healthcare is the first choice for care among Lowcountry families. It's because of everything we are. We've been trusted with our neighbor's health and wellness for generations. As our community grows, we continue to expand our services and open our arms to provide care to our friends who need it most.

Roper St. Francis Healthcare have four flagship hospitals strategically placed across the region: Roper Hospital on the Charleston Peninsula, Bon Secours St. Francis Hospital in West Ashley, Roper St. Francis Mount Pleasant Hospital in Mount Pleasant and Roper St. Francis Berkeley Hospital in Carnes Crossroads in Berkeley County. In an emergency, we have six strategically placed ERs. With almost 6,000 teammates, we're the Lowcountry's second-largest private employer. We have nearly 1,000 doctors representing almost every medical specialty. Our 657-bed system consists of 117+ facilities and services across five counties, predominately serving residents of Berkeley, Charleston and Dorchester counties and surrounding areas.

Every three years we evaluate those needs through a comprehensive Community Health Needs Assessment (CHNA) process. The most recent assessments, completed by MUSC Health, Roper St. Francis Healthcare and Trident United Way and community leaders, include quantitative and qualitative data that guide both our community benefit and strategic planning.

The Tri-County Health Landscape 2022 Community Health Needs Assessment Report document is the detailed CHNA adopted for Roper St. Francis Healthcare, including Roper Hospital, Bon Secours St. Francis Hospital, Roper St. Francis Mount Pleasant Hospital and Roper St. Francis Berkeley Hospital. As a system, Roper St. Francis Healthcare lives our mission of healing all people with compassion, faith and excellence. As the area's only private not-for-profit healthcare system, we choose purpose over profits by putting our extra money back into our system to help meet the health needs of our community.

Roper St. Francis Healthcare also provide millions of dollars in charitable services and care for our community through patient financial assistance, community-based programs and the incredible dedication and volunteerism of our teammates.

Through collaborative efforts such Healthy Tri-County, Roper St. Francis Healthcare remains committed to reassessing the community's priorities every three years, and will continue to promote, design and create programs and services that complement and supplement our partners' efforts.

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No written comments were received on the most recently conducted CHNA. Written comments regarding the health needs that have been identified in the current CHNA should be directed to Roper St. Francis Healthcare, email community@rsfh.com.

Joint CHNA

This is a joint CHNA report, within the meaning of Treas. Reg. §1.501(r)-3(b)(6)(v), by and for Roper St. Francis Healthcare (Includes Roper Hospital, Bon Secours St. Francis Hospital, Roper St. Francis Mount Pleasant Hospital and Roper St. Francis Berkeley Hospital). This report reflects the hospitals' collaborative efforts to assess the health needs of the community they serve. Each of the hospitals included in this joint CHNA report define its community to be the same as the other included hospitals. The assessment included is seeking and receiving input from that community.

Supporting Community Partners

Organization providing input	Nature and extent of input	Medically under-served, low-income or minority populations represented by organization
AccessHealth Tri-County Network	Survey collection, focus group, CHNA/CHIP planning meetings	Community/all populations
Alliance for a Healthier SC	CHNA/CHIP planning meetings	Many populations
AmeriCorps	Survey collection and focus group	Community/all populations
Art Pot	Survey collection and key informant interviews	All populations/Hispanic/minority health
Barrier Island Free Medical Clinic	Survey collection	Community/all populations
Charleston Promised Neighborhood	Survey collection	Community/all populations
City of Charleston	Survey collection, focus group, CHNA/CHIP planning meetings	Community/all populations
College of Charleston	Survey collection, focus group, CHNA/CHIP planning meetings	Academics/students
Ernest E. Kennedy Center	Survey collection, CHNA/CHIP planning meetings	Mental health/substance abuse, recovery
Palmetto Community Care	Key Informant interviews	Community/Sexual Health

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Ryan White Wellness Center	Survey collection	Sexual Health/LGBTQIA+ community
SC Hospital Association	CHNA/CHIP planning meetings	Community/all populations
SC Department of Environmental Control	Survey collection, CHNA/CHIP planning meetings	Community/all populations
St. James Health and Wellness	Survey collection, key informant interview	Community/all populations

Community Served by the Hospital

Roper St. Francis Healthcare participated alongside MUSC Health and Trident United Way and regional partners to develop the 2022 Community Health Needs Assessment (CHNA). Hospital members of the CHNA Advisory Group joined the collaboration which resulted in a robust portrait of the larger Lowcountry region. The regional report covers Berkeley, Charleston and Dorchester counties.

Significant and Prioritized Health Needs

After analyzing the qualitative and quantitative feedback from the community engagement process, the following five significant health needs were identified and prioritized as the 2022 health needs.

1. Access to Care (Includes Oral Health)
2. Clinical Preventive Services
3. Mental Health (Behavioral Health)
4. Obesity, Nutrition and Physical Activity
5. Maternal, Infant and Child Health (Includes Sexual/Reproductive Health)

Resources Available

The regional CHNA process highlighted existing assets and concrete strategies to address health and social service care delivery challenges. Assets included established agencies and organizations with expertise in a priority area, and models or best practices that community members agree would address prioritized needs if implemented. The list is limited to the perceptions and ideas of those who were engaged in the CHNA community engagement and CHIP planning activities.

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Roper St. Francis Healthcare (Includes Roper Hospital, Bon Secours St. Francis Hospital, Roper St. Francis Mount Pleasant Hospital and Roper St. Francis Berkeley Hospital) is committed to addressing the prioritized needs identified in our 2022 Community Health Needs Assessment process and to making a measurable impact on community health across the Lowcountry. True collective impact comes when strategic partnerships are formed, and when collaborations are built that can achieve greater results. Roper St. Francis partners or collaborates with over ninety (90) organizations across the Berkeley, Charleston and Dorchester counties and surrounding areas to help patients connect to community support outside of the acute or outpatient setting. Outlined within Our Health, Our Future Tri-County Health Improvement Plan (TCHIP) 2018-2023 are the organizations, programs and strategies identified within the CHNA process as regional assets which link the CHNA to concrete action steps to address prioritized needs (Visit https://www.rsfh.com/upload/docs/About%20Us/Mission/OurHealthOurFuture-TCHIP-2018-2023.pdf for additional information).

The TCHIP Accomplishments Report highlights the collaborations already in process in areas that impact our prioritized health needs (See https://issuu.com/tridentunitedway/docs/2021_healthy_tri-county_tchip_accomplishments_repo for full report).

The list below provides a representative but not exhaustive list of existing resources that collaborate with or support Roper St. Francis Healthcare hospitals and their patients. While each prioritized need below is currently being addressed to some capacity, there remains an inadequacy of services to meet the needs of the community completely.

Access to Care: RSFH's Ryan White Wellness Center was founded in 2000 to care for the region's uninsured patients living with HIV. For two decades, the Ryan White Wellness Center has sustained a legacy of compassionate, state-of-the-art care. The Center empowers patients and the community to take charge of their sexual health while championing overall wellness. It is the only one-stop-shop sexual health center in the Tri-County, offering more than 20 different onsite services.

Clinical Preventive Services: The Diabetes Prevention Project Expansion at RSFH's AccessHealth Tri-County Network began in 2019. Their mission is to meet the community where they are; to empower and equip with the tools that are needed to change the course of their health through education in diabetes prevention. AHTN serves as the HUB of Diabetes Prevention Programs in Berkeley, Charleston and Dorchester counties.

Behavioral Health: RSFH's Greer Transitions Clinic closes this gap for unfunded or underfunded patients who do not have a medical home. The Clinic is helping improve care coordination as a one-stop shop for approximately 2,500 patients annually and on average 96% reduction rate in ED utilization. Patients can visit board-certified physicians, learn preventive care and health literacy, connect with social services and find a primary medical home. The Clinic continues to expand and make a dramatic impact meeting the medical needs and addressing the social determinants of health and wellness which includes behavioral health and counseling services.

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Obesity, Nutrition and Physical Activity: The Lowcountry Senior Center and Waring Senior Center are welcoming places for adults 50 and older to learn, exercise and socialize. The Centers promote the whole person's health - spirit, mind and body. The Lowcountry Senior Center and Waring Senior Center are owned by the City of Charleston and managed by Roper St. Francis Healthcare. Both locations offer hundreds of programs a month ranging from strength training and exercise to support groups and painting lessons.

Maternal, Infant and Child Health: Since 2011, Roper St. Francis Maternal Fetal Medicine department has partnered with Our Lady of Mercy Community Outreach to provide free OBGYN Care to the women who lack insurance or the ability to pay.

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2019 - 2021 IMPLEMENTATION PLANS STRATEGIES AND OUTCOMES

of the 2019 Community Health Needs Assessment

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After examining the range of services currently available, significance, impact ability, relevance to the population served, and needs already being addressed by community partners, Roper St. Francis chose the following priorities to address:

- Access to Care
- Obesity, Nutrition, and Physical Activity
- Maternal, Infant, Child Health
- Mental and Behavioral Health
- Clinical Preventive Services

Fortunately, the priorities identified for 2019 directly complement the strategies and services initiated in both 2013 and 2016. This will allow Roper St. Francis teammates to continue successful efforts to address the identified priorities. In addition, it allows administrative staff an opportunity to explore these health topics in more detail, allowing opportunities for innovation and creativity.

Roper St. Francis will engage system leaders and essential community partners to implement evidence-based strategies to address each health priority identified in the 2019 Community Health Needs Assessment (CHNA) process. We will:

- Identify local organizations and agencies that address each health priority, and provide support;
- Develop specific and measurable goals;
- Develop detailed work plans across internal departments and external local partners;
- Ensure coordination of related priorities and efforts; and
- Communicate regularly with the assessment team.

This plan will be used and assessed each year for three years. Strategies are clearly defined, and applicable hospital campuses are identified. The team will also develop a monitoring method at the conclusion of the implementation planning process to provide status updates to community partners, stakeholders, and the community-at-large. As such, the community benefit planning is integrated into the system's annual planning and budgeting process.

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IMPLEMENTATION PLAN AT-A-GLANCE

Roper St. Francis Healthcare Sites: Roper Hospital (RH); Bon Secours St. Francis Hospital (BSSF); RSF Mount Pleasant Hospital (MPH); RSF Physician Partners (PP); RSF Berkeley Hospital (BH)

Health Priority	Strategy	RH	BSSF	MPH	PP	BH
Access to Care Ability to reach and receive regular medical/dental care from a primary care provider or health center	Navigate high users of emergency departments to primary care medical homes.	*	*	*	*	*
	Connect underinsured and uninsured patients to medical homes.	*	*	*	*	*
	Coordinate and collaborate with safety-net partners for delivery of services, including area Federally Qualified Health Centers (FQHCs), free clinics, and homeless shelters.	*	*	*		*
Clinical Preventive Services Routine physical exams, cancer screenings and immunizations	Provide routine, primary care for low-income, uninsured adults that live or work on the sea islands of Charleston County.	*	*	*		*
	Provide early intervention services for patients diagnosed with HIV/AIDS.	*	*	*	*	*
	Provide evidence-based outpatient care for diabetic patients.	*	*	*	*	*
	Expand access to free annual breast health screenings for all women, particularly African-American women.	*	*	*	*	*
Mental Health Emotional, psychological and behavioral services, programs, and providers	Coordinate services between Emergency Departments and regional mental health agencies.	*	*	*		*
	Expand mental health services within central outpatient clinic.	*	*	*	*	*
Obesity/Nutrition/Physical Activity Diet, exercise and weight management to control health and wellness	Increase opportunities for comprehensive wellness for older adults.	*	*	*	*	*
	Collaborate with local partners to increase healthy food options in underprivileged communities.	*	*	*		*
	Host evidence-based health and wellness community programs for older adults.	*	*	*	*	*
Maternal, Infant & Child Health Adequate prenatal care and birth outcomes	Offer specialized services for high-risk pregnancies.		*	*		*
	Provide prenatal care for uninsured patients that are not eligible for Medicaid.		*	*	*	*
	Host expectant parent education classes and tours, and Safe Sitter ® classes.		*	*		*

Roper Hospital, Inc. no longer offers labor and delivery services at its hospital facility and will not directly address this identified significant health need. While this need is not a direct focus for the hospital, Roper Hospital will support the strategies of the Roper St. Francis sites and other local organizations specifically designed and better prepared both through resources and experience to respond to this need.

Appendix

IMPLEMENTATION PLAN

Roper St. Francis Healthcare's four full-service member hospitals are the heart of the extensive regional healthcare network. For nearly two centuries, **Roper Hospital (RH)** and **Bon Secours St. Francis Hospital (BSSF)** have been medical anchors for the residents of Charleston. In the last decade, the system added **Roper St. Francis Mount Pleasant Hospital (MTP)** and **Roper St. Francis Berkeley Hospital (BH)** to create a vast system that stretches throughout Berkeley, Charleston and Dorchester counties. The 668-bed system also includes more than 90 facilities and doctor offices (**Physician Partners (PP)**).

The implementation strategies for each campus are provided below by priority area. Often, more than one campus will contribute to a strategy to ensure system-wide synergy and community health improvements.

PRIORITY: ACCESS TO CARE

More than 20% of the Tri-county residents are without health insurance at any given time. Nearly 16% of adults do not have a regular doctor and approximately 14% of hospital discharges are designated as due to ambulatory care sensitive conditions, conditions that could have been prevented if adequate primary care resources were available and accessed by patients.

STRATEGY: Navigate high users of emergency departments to primary care medical homes.			
Lead Agency: Roper St. Francis Healthcare (system-wide)			
Action Step	**Lead RSF Department**	**2019, 2020 & 2021 Outcome**	**2022 Action**
Collaborate with local healthcare systems to identify Emergency Department "super utilizers".	Care Coordination	The four local hospital systems actively participate in AccessHealth Tri-County Network.	Sustain support and participation with AccessHealth.
Navigate uninsured Emergency Department "super utilizers" to AccessHealth and/or the Transitions Clinic.	AccessHealth Transitions Clinic/RSFPP	AccessHealth 2019: 3,411 patients (1,042 new patients) 2020: 2,728 patients (690 new patients)	Continue to coordinate with AccessHealth and Transitions.

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		2021: 2,113 patients (668 new patients) Transitions 2019: 6,155 visits by 1,321 patients (406 new patients) resulting in a 61% reduction in ED visits 2020: 1,313 patients (350 new patients) resulting in an 83% reduction in ED visits	
Develop a team-based program to create a comprehensive, patient-centered care plan for Emergency Department "super utilizers," engaging both RSF and community resources.	ED U-Turn Program	BSSF 2019: Enrolled 45 patients in the program. Roper 2019: Enrolled 25 patients in the program. Systemwide 2021: Enrolled 69 patients in the program.	Seek opportunities to expand program to other facilities. Continue efforts to identify patients and enroll in program.

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STRATEGY: Connect underinsured and uninsured patients to medical homes.			
Lead Agency: Roper St. Francis Healthcare (system-wide)			
Action Step	**Lead RSF Department**	**2019, 2020 & 2021 Outcome**	**2022 Action**
Refer underinsured and uninsured RSF patients to AccessHealth and/or the Transitions Clinic.	AccessHealth Transitions Clinic Care Coordination	AccessHealth 2019: 3,411 patients (1,042 new patients) 2020: 2,728 patients (690 new patients) 2021: 2,113 patients (668 new patients) Transitions 2019: 6,155 visits by 1,321 patients (406 new patients) resulting in a 61% reduction in ED visits 2020: 1,313 patients (350 new patients) resulting in an 83% reduction in ED visits	Continue to coordinate with AccessHealth and Transitions.

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STRATEGY: Coordinate and collaborate with safety-net partners for delivery of services, including area Federally Qualified Health Centers (FQHC), free clinics, and homeless shelters. Lead Agency: Roper St. Francis Healthcare (system-wide)			
Action Step	**Lead RSF Department**	**2019, 2020 & 2021 Outcome**	**2022 Action**
Provide lab work, free supplies, and ancillaries to partner medical clinics and supportive service agencies: Barrier Islands Free Medical Clinic, Our Lady of Mercy Outreach, East Cooper Community Outreach, Dream Center, One80 Place Medical Ministries	Mission	Signed contracts to continue partnerships. Systemwide 2021: Provided $2,211,126 of in-kind services to partnered clinics.	Continue providing in-kind services.
Manage care coordination for eligible patients referred from local partners through the shared care navigation hub managed by AccessHealth.	Care Coordination AccessHealth	AccessHealth 2019: 3,411 patients (1,042 new patients) 2020: 2,728 patients (690 new patients) 2021: 2,113 patients (668 new patients)	Continue to coordinate with local partners.

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STRATEGY: Provide in-home care to patients with limited mobility through Home Health and Hospice Care.			
Lead Agency: Roper St. Francis Healthcare (system-wide)			
Action Step	**Lead RSF Department**	**2019, 2020 & 2021 Outcome**	**2022 Action**
Provide high quality care for patients with transportation or mobility issues or those with end-of-life needs through in- home or inpatient Hospice or Home Health services.	Home Health	Home Health 2019: 5,525 patients 2020: 6,027 patients 2021: 6,986 patients In-home Hospice 2019: 561 patients 2020: 613 patients 2021: 636 patients Inpatient Hospice 2019: 562 patients 2020: 460 patients 2021: 437 patients	Continue providing Home Health and Hospice services. Increase community awareness of Hospice Cottage option

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PRIORITY: CLINICAL PREVENTIVE SERVICES
Routine physical exams, disease screenings and immunizations have been highlighted as critical preventive services to reduce premature death and disability. Yet, thousands of South Carolinians forgo preventive services due to a list of antecedents. Fortunately, the Tri-county has been ranked as three of the healthiest counties (of 46) in South Carolina.

STRATEGY: Provide routine, primary care for low-income, uninsured adults that live or work on the Sea Islands of Charleston County.			
Lead Agency: Roper St. Francis Healthcare (system-wide)			
Action Step	**Lead RSF Department**	**2019, 2020 & 2021 Outcome**	**2022 Action**
Provide lab work, free supplies, and ancillaries to partner medical clinics and supportive service agencies: Barrier Islands Free Medical Clinic, Our Lady of Mercy Outreach, East Cooper Community Outreach, Dream Center, One80 Place Medical Ministries	Mission	Signed contracts to continue partnerships.	Continue providing in-kind services.
Provide financial support for clinical staff and infrastructure at Our Lady of Mercy Outreach.	Mission	Signed contracts to continue partnerships. Systemwide 2021: Provided $2,211,126 of in-kind services to partnered clinics and $307,984 of financial support for clinical staff and infrastructure at Our Lad of Mercy Outreach.	Continue financial support and promote services of the agency.

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STRATEGY: Provide early intervention services for patients diagnosed with HIV/AIDS.			
Lead Agency: Roper St. Francis Healthcare (system-wide)			
Action Step	**Lead RSF Department**	**2019, 2020 & 2021 Outcome**	**2022 Action**
Enroll HIV positive patients into federally funded Ryan White program.	Ryan White Wellness Center	Ryan White Wellness Center provided comprehensive HIV and primary care for 2019: 869 HIV positive patients 2020: 836 HIV positive patients 2021: 802 HIV positive patients	Continue to provide comprehensive HIV care
Ensure continued health insurance coverage for HIV positive adults using federal and employer insurance programs.	Ryan White Wellness Center	Ryan White Wellness Center maintains health insurance coverage for 2019: 267 patients 2020: 308 patients 2021: 325 patients	Continue to enroll patients in federal insurance program and assist with employer-based plans.
Seek grant funding to expand primary prevention services for high risk HIV negative adults, and prevent the rate of transmission for HIV positive patients.	Ryan White Wellness Center	Ryan White Wellness Center (2019) invested over $105,000 in transportation assistance to reduce barriers to accessing services. RWWC provided HIV prevention (PrEP) to 2019: 123 HIV negative patients 2020: 144 HIV negative patients 2021: 112 HIV negative patients	Continue to promote HIV awareness and prevention.

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Provide free HIV testing at community events and in-clinic	Ryan White Wellness Center	Community events: 2019: 44 HIV tests 2020 - 2021: Due COVID, testing not performed events attended Clinic testing: 2019: 311 HIV tests 2020: 453 HIV tests	Continue to promote HIV testing, awareness, and prevention.
STRATEGY: Provide evidence-based outpatient care for diabetic patients.			
Lead Agency: Roper St. Francis Physician Partners			
Action Step	**Lead RSF Department**	**2019, 2020 & 2021 Outcome**	**2022 Action**
Track percentage of patients who receive evidence-based outpatient care for diabetes.	RSF Physician Partners	2019: 92.6% of all RSFPP patients with a diagnosis of diabetes received A1c testing. 2020: 90.75% of all RSFPP patients of diabetes received A1c testing. 2021: 70.3% of RSFH's patients were considered to have controlled diabetes with the goal of reaching 78% of diabetes patients with controlled diabetes.	Continue assessments via the RSF Physician Partners. RSFH continues to hire additional diabetes educators to help improve scores

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STRATEGY: Expand access to free annual breast health screenings for all women, particularly African American women.			
Lead Agency: Roper St. Francis Physician Partners			
Action Step	**Lead RSF Department**	**2019, 2020 & 2021 Outcome**	**2022 Action**
Host annual “Family Wellness Night” (formerly Ladies’ Night Out) and other screening events for underserved men and women to get breast and colorectal screenings.	Oncology Services	2019: 79 clinical breast exams with 72 referrals for additional testing and 55 colorectal screenings with no referrals for positive FIT test 2020: 48 clinical breast exams with 42 referrals for additional testing and 200 home colorectal screenings due to COVID-19. 2021: 15 clinical breast exams with 11 same day mammograms and 22 colorectal screenings and 5 completed colonoscopies.	Continue hosting events and encouraging participation.
Host annual skin cancer screening	Oncology Services	2019: 119 skin cancer screenings with 31 referred for biopsy	

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PRIORITY: MENTAL HEALTH
Research has proven that adults and children with undiagnosed and untreated mental health issues are at higher risk for unhealthy and unsafe behaviors. Behaviors like alcohol or drug abuse, violent or self-destructive behavior, and suicide have been noted as measurable indicators of a community's mental health. County Health Rankings identifies a shortage of mental health providers in the Tri-county area.

STRATEGY: Coordinate services between Emergency Departments and regional mental health agencies.			
Lead Agency: Roper St. Francis Healthcare (system-wide)			
Action Step	**Lead RSF Department**	**2019, 2020 & 2021 Outcome**	**2022 Action**
Participate in the Charleston/Dorchester Mental Health Department's community task force.	Emergency Services	Ongoing participation and collaboration	Continue participation in regularly scheduled meetings.
Coordinate care of behavioral health patients, using local agencies and resources for support.	Care Coordination	Ongoing coordination and collaboration	Continue coordination using community resources.
Collaborate with mental health providers to engage community members in highest need areas to direct to appropriate services	Farmacy Program	2019: Over 2,000 bags of fresh produce distributed to families in need	Continue partnership with Charleston Police Department, MUSC,
		Added Charleston County Public Library to the list of collaborators 2020: 1,064 bags of fresh produce were distributed to families in need. RSFH also held voter registration drive	Lowcountry Food Bank, and CDMHC. Coordinate with other agencies to broaden the scope of the project

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		and utility assistance drive in the community 2021: In partnership with Lowcountry Food Bank, RSFH distributed 1,962 nutritious, prepared meals for home-bound seniors in Charleston County. Additionally, RSFH distributed approximately 1,715 bags of fresh produce through Farmacy.	
STRATEGY: Provide services and education to combat the opioid epidemic.			
Lead Agency: Roper St. Francis Healthcare (system-wide)			
Action Step	**Lead RSF Department**	**2019, 2020 & 2021 Outcome**	**2022 Action**
Develop partnerships with local law enforcement to create an alliance for holding Drug Take Back events	Pharmacy, Mission	Expanded initiative and created relationships with North Charleston Police Dept and Berkeley County Sheriff's Dept	Continue current partnerships and build new ones throughout the area.

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Organize Drug Take Back events throughout the Tri-County	Pharmacy, Mission	Successfully applied for two grants to increase the reach of take back events with education and awareness around the opioid epidemic 2019: Held 11 take back events and collected 755 pounds of drugs. 2020: Held 10 take back events and collected 591 pounds of drugs. 2021: Held 8 take back events and collected 238.6 pounds of drugs	Hold at least 10 Take Back events in the area.

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STRATEGY: Provide mental health screenings at wellness and postpartum OB/GYN visits.			
Lead Agency: Roper St. Francis Healthcare (system-wide)			
Action Step	**Lead RSF Department**	**2019, 2020 & 2021 Outcome**	**2022 Action**
Incorporate depression screenings at primary care wellness visits and postpartum OB/GYN patient visits.	RSF Physician Partners	2019: 79.8% of all patients received a depression screening during primary care wellness checks; 90.6% of all patients received a depression screening during follow-up postpartum visit. 2020: 78.4% of all patients received a depression screening during primary care wellness checks; 93.7% of all patients received a depression screening during follow-up postpartum visit. 2021: 81.0% of all patients received a depression screening during primary care	Continue tracking and promoting mental health screenings as part of routine primary care and postpartum medical exams.

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		wellness checks; 95.1% of all patients received a depression screening during follow-up postpartum visit.	

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PRIORITY: OBESITY, NUTRITION, AND PHYSICAL ACTIVITY
Diet, exercise and weight management are the foundations of health and wellness. A healthy balance of each greatly contributes to better long-term health outcomes and decreased health risks. USDA data shows a number of food deserts in the Tri-county area, a common measure synonymous with high poverty areas. Charleston County contains 12 urban census tracts that have a significant number of people with low access to a grocery store. Berkeley and Dorchester counties contain rural census tract food deserts, which means a significant amount of people are more than 10 miles from a healthy food outlet.

STRATEGY: Increase opportunities for comprehensive wellness.			
Lead Agency: Roper St. Francis Healthcare (system-wide)			
Action Step	**Lead RSF Department**	**2019, 2020 & 2021 Outcome**	**2020 Action**
Require annual primary care screening for each RSF employee.	Human Resources Employee Health RSF Physician Partners	2019: 3,463 teammates had PCP visits 2020: 88 % of teammates had PCP visits 2021: 3,914 teammates had PCP visits	Continue to implement Wellness Works incentives to increase employee participation.
Promote employee participation in disease-specific events to increase health awareness and advocacy.	Mission	2019: 7,859 hours of staff time supporting initiatives, serving 19,373 community residents. 2020: 3,033 hours of staff time supporting initiatives, serving 9,753 community	Continue to encourage participation in community-based health events.

		residents. 2021: 3,478 hours of staff time supporting initiatives, serving 9,972 community residents.	
Host informative and interactive tables/booths during local community and agency health fairs/screenings.	Mission	2019: Participated in over 100 community health fairs, screenings and events. 2020: Due to COVID-19, community events paused. 2021: Participated in over 44 community health fairs, screenings and events.	Continue to encourage participation in health fairs/events.

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STRATEGY: Collaborate with local partners to increase healthy food options in underprivileged communities.			
Lead Agency: Roper St. Francis Healthcare (system-wide)			
Action Step	**Lead RSF Department**	**2019, 2020 & 2021 Outcome**	**2022 Action**
Engage community members in highest need areas to promote wellness and nutrition	Farmacy Project	2019: Over 2,000 bags of fresh produce distributed to families in need. 2020: 1,064 bags of fresh produce were distributed to families in need. 2021: 1,715 bags of fresh produce were distributed to families in need.	Continue partnership with Charleston Police Department, MUSC, Lowcountry Food Bank, and CDMHC
Collaborate with the Lowcountry Food Bank and East Cooper Meals on Wheels to provide home-delivered meals in low-income communities.	Mission	2019 – 2020: Assisted in providing over 3,000 meals to 400 homebound residents in Charleston County each year	Continue financial support and promote services of the agency.

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STRATEGY: Host evidence-based health and wellness community programs for older adults.			
Lead Agency: Roper St. Francis Healthcare (system-wide)			
Action Step	**Lead RSF Department**	**2019, 2020 & 2021 Outcome**	**2022 Action**
Offer physical wellness classes specifically targeting older adults.	Senior Services	2019: 1,789 2020: 766 2021: 895 seniors were enrolled as members at Lowcountry Senior Center 2019: 76,882 2020: 41,373 2021: 47,290 visits to fitness and exercise activities, including exercising in our fitness centers 2019: 1,619 2020: 888 2021:1055 seniors were enrolled as members at Waring Senior Center.	Continue providing programs & classes throughout the Tri-County.

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PRIORITY: MATERNAL, INFANT, AND CHILD HEALTH

The health of a community's women and children are essential to growth and will predict the future's public health strengths and challenges. The Healthy People 2020 recognizes adequate prenatal care and birth outcomes as two strong indicators of infant death and disability. Charleston County has the lowest infant mortality rate in state (4.8 per 1,000 live births), and Berkeley County has one of the highest (7.2 per 1,000 live births). However, prenatal care and birth weight rates are comparable between the counties and with the state.

STRATEGY: Offer specialized services for high-risk pregnancies.			
Lead Agency: Bon Secours St. Francis Hospital			
Action Step	**Lead RSF Department**	**2019, 2020 & 2021 Outcome**	**2022 Action**
Continue specialized care teams for high-risk pregnant women to include a board-certified maternal fetal medicine specialist.	Women, Infant, and Children	Accomplished	Continue coordinating care teams.
Support a Maternal Fetal Medicine program that includes medical management, counseling, biophysical profiles, diagnosis and management of birth defects, and other highly specialized services.	Women, Infant, and Children	2019: 5,761 patient visits; 1,930 total patients served 2020: 5,299 patient visits; 1,402 total patients served 2021: 5,166 patient visits; 1,504 total patients served	Continue MFM services.

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STRATEGY: Provide prenatal care for uninsured patients that are not eligible for Medicaid. Lead Agency: Bon Secours St. Francis Hospital			
Action Step	**Lead RSF Department**	**2019, 2020 & 2021 Outcome**	**2022 Action**
Support prenatal care for eligible uninsured and immigrant patients of Our Lady of Mercy Outreach, a local rural healthcare clinic.	Women, Infant and Children	2019: Provided 103 annual exams, 25 deliveries, and 60 total GYN patients 2020: Provided 46 annual exams, 8 deliveries, and 46 total GYN patients	Continue support and promote services of the agency.
Provide routine lab work, radiology services, prenatal education classes, and Maternal Fetal Medicine services for Spanish-speaking patients.	Women, Infant and Children	Signed contracts to continue partnerships	Continue support and promote services of the agency.

STRATEGY: Host expectant parent education classes and tours, and Safe Sitter ® classes. Lead Agency: Bon Secours St. Francis Hospital, Roper St. Francis Mt. Pleasant Hospital			
Action Step	**Lead RSF Department**	**2019, 2020 & 2021 Outcome**	**2022 Action**
Facilitate regularly scheduled expectant parent education classes and hospital tours as well as Safe Sitter ® classes.	Women, Infant and Children	2019: Facilitated 251 total classes (including 134 free classes) with 2,582 participants. Expanded classes to now include Berkeley Hospital campus.	Continue to offer onsite and online options for convenience.

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		2020: Facilitated 161 total classes (including 35 free classes) with 1,250 participants. 2021: Facilitated 122 total classes with 694 participants.	

The 2020 Implementation Plan was approved by the Roper St. Francis Healthcare Board of Directors on October 22, 2020.