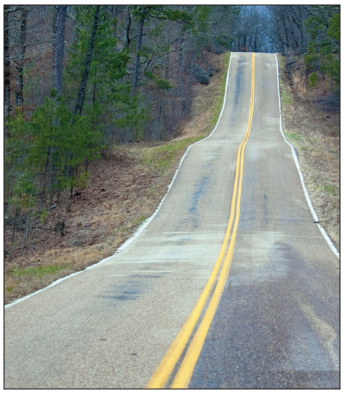
KERSHAW COUNTY

COMMUNITY HEALTH IMPROVEMENT PLAN

2019-2022



HEALTHIER TOMORROWS FOR EVERYONE

LiveWell Kershaw Coalition May 2019

LiveWell KERSHAW COALITION

Introduction & Vision

Kershaw County, South Carolina recognizes the value health plays in the future social and economic well-being of its neighborhoods, towns and communities. Improving the health of the entire county is essential to enhancing one's quality of life. LiveWell Kershaw Coalition is leading an effort to craft a detailed plan to improve the health of all residents living in Kershaw County. A destination postcard is a vivid picture from the near-term future that shows what could be possible (Heath & Heath, 2011). The cover of this report showcases what the destination postcard looks like for Kershaw County. Our vision is for all residents to be able to access healthcare, achieve optimal emotional health and to be physically active and eat healthy foods. This report outlines the three year plans our residents have co-designed in an effort to achieve our destination postcard of optimal health in Kershaw County.

Overview of the Community Health Improvement Plan

A Community Health Improvement Plan (CHIP) is a written plan that outlines key goals and objectives to support the improved health of individual residents in our community. Through a CHIP process, priorities are set, with the primary goal of aligning and coordinating resources to reach identified targets. Our CHIP is a three-year plan (June 1, 2019 - May 31, 2022) that is based on data from the 2017 Community Health Needs Assessment (see page 8 for link to the full report), which included a survey with 1,168 residents, key informant interviews, focus groups and an environmental scan of the entire county. In addition, Youth-Well Being Assessment results from 1,200 high school students were used along with Vision 2030 survey results. Other data sources included: FitnessGram data, Communities That Care data, and snapshot data sheets provided by the Department of Health and Environmental Control. Key reference documents used included: SC State Health Improvement Plan, the Rural Health Action Plan and the SC Obesity Action Plan.

Ideally, city and county government leaders, non-profits, businesses and residents will be able to clearly see how they fit into the implementation of the CHIP. It is the goal of the LiveWell Kershaw Coalition that organizations will review this three-year plan and determine what specific role they can play in supporting the improvement of health outcomes in our county. This guidance document can be used as policies are being developed and revised and also to determine what key actions and resources are needed to advance the three goals crafted in this plan. This three-year plan can be modified as conditions change.

Health is not the absence of disease but the addition of confidence, skills, knowledge and connection. But most importantly, it is simply a means to an end — which is a joyful, meaningful life.

Cristin Lind

A core set of skills known as the Community of Solutions skills, developed by the 100 Million Healthier Lives Campaign, was used throughout the planning and development of the CHIP (Stout, 2017). LiveWell Kershaw Coalition believes these skills are necessary to lead community transformation work. This framework outlines that communities must **lead from within**, **lead together**, **lead for outcomes**, **lead with equity**, and **lead for sustainability** in order to achieve a culture of health. Outcomes for a culture of health include, but are not limited to: health as a shared value; thriving cross-sector partnerships; healthy, equitable communities and improved population health; and wellbeing and equity outcomes. As a result of this framework, **the Coalition has adopted a very broad definition of health including "mental, physical, social, [and spiritual] wellbeing"** (adaptation of World Health Organization). Since the adopted definition of health is so broad, all sectors are considered key players in the advancement of improving the health of the county.

The process to develop the CHIP began in February, 2019 and ended in May, 2019. LiveWell Kershaw Coalition intentionally made the planning process as short as possible, in an effort to focus more attention on the implementation plan that follows the CHIP. A kick-off meeting was held on March 27, 2019 with 47 participants representing various sectors and zip codes of the county. At the kick-off meeting, participants reviewed the 2017 Community Health Needs Assessment and examined the following issues in-depth: access to care, built environment, diabetes, hypertension, mental health, obesity, and substance abuse. Following the data walk and data table discussions, participants voted using PollEverywhere. Criteria for ranking the priorities were based on impact and feasibility to tackle in the next three years. The kick-off meeting ended with three priorities emerging from the original list of seven topics: **access to care** (27%), **obesity** (23%) and **mental health** (20%).

Participants then signed up for workgroups based on the three priorities. During the month of April, the workgroups met three times to develop goal statements, objectives, tactics and outcome metrics. The workgroups ranged from five participants to twelve participants. The mental health workgroup decided to change their name to the emotional health workgroup in an effort to reduce stigma. The draft outline of a plan was then presented on May 3, 2019 with 27 participants, where workgroup members shared their initial thoughts and participants then gave feedback on the initial drafted plan and offered recommendations to strengthen particular elements. Based on the feedback, a complete plan was created and disseminated to members on May 15, 2019. Implementation of the plan will begin by June 1, 2019.

Let him who would be moved to convince others, be first moved to convince himself.

Thomas Carlyle

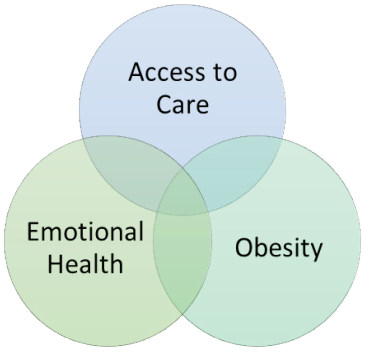
What Are the Priorities?

What are the Priorities?

1. Access to Care
2. Obesity
3. Emotional Health

*Community members recognize that there is overlap with all three of these issues.

Complete tables for all priorities are found on pages 9-11.



What Are Next Steps?

The three priority areas are broad and can feel overwhelming. The goal of this plan is to shrink the change and begin tackling our priorities one piece at a time. This three-year plan will move one step at a time to gain ground before moving to other tasks. We acknowledge that change is difficult. Through strategic action and implementation, we will see indicators of progress as we tackle a strategy at a time. Moving forward, we can expect to follow this outlined process:

1. CHIP report will be disseminated to community organizations and residents
2. Access to Care, Obesity and Emotional Health implementation teams will prioritize action items
3. Teams will finalize their respective metrics and develop a work plan including baseline metrics, strategy leads, and target completion dates for specified activities

"Being fit and healthy begins in childhood and carries over into adulthood. I started lifting weights at 11 years old, when my mom bought me a pair of 15-pound dumbbells and a jump rope. I was on a mission from then on to get fit for life. My passion is to teach others how to be fit and healthy. If I did it, others can, too!"

Chris Conde´
Lugoff, SC

Strategic Elements of the CHIP

OBESITY

GOAL Statement

Increase healthy lifestyles among families* countywide in order to decrease the obesity epidemic.

* Families includes ALL adults, children and elderly (everyone).

Outcome Metrics

Obesity rates among adults and children (decrease) & students ranking in top 25% of FitnessGram data for the nation

Objective One

Strengthen existing collaborations.

1. Supporting other groups' current obesity efforts

Objective Two

Implement evidence-based interventions.

1. HEAL (Healthy Eating, Active Living) Champions in schools, faith-based organizations, worksites and local communities
2. School Campaigns ("5-2-1-0" and "Say Yes! to Water)
3. FAN (Faith, Activity and Nutrition) Program for churches
4. Worksite wellness programs
5. Policy changes to decrease obesity
6. Public infrastructure that supports physical activity (outdoor fitness parks, walking trails, community parks)

Objective Three

Conduct an awareness campaign.

1. Mass and small media, social media
2. Local resolutions

Key Partners

American Heart Association, Chamber of Commerce, Dollar General stores, EatSmart MoveMore Kershaw County, elementary schools, grocery stores, SC Hospital Association, LiveWell Kershaw Coalition, local churches, local providers, media outlets, parents, school district, school newspapers/ newsletters/broadcast, and Trails Committee

Key Indicators to Watch

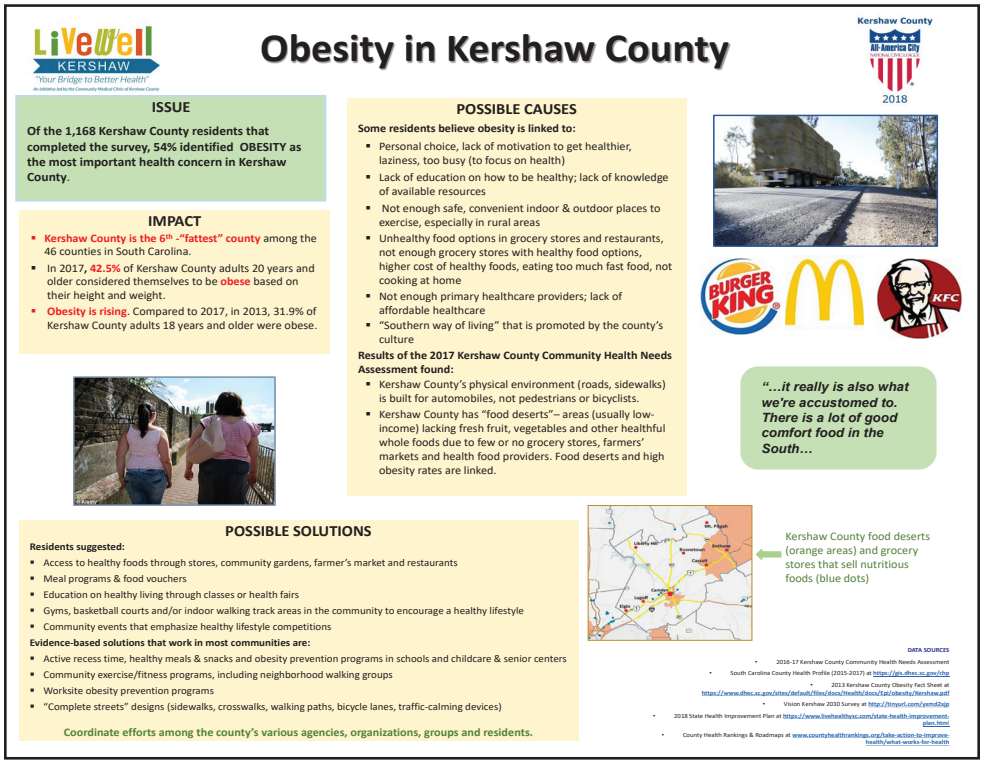
Personal stories of transformation, number of local residents participating in local health events and using trails, decrease in screen time, decrease in sugar-sweetened beverages, number of policy changes/types, percentage of participating churches, number of students leading health initiatives, number of participating schools, number of functional trails, number of media presentations/articles

BRIGHT SPOT of a Current Local Effort to Reduce Obesity

Active Living Made Easier with Trails and Complete Streets

With a Healthy South Carolina Initiative grant in 2012, Kershaw County agencies and organizations began to lay the groundwork—literally—to enhance the county's physical environment to make it easier and safer for residents to be physically active. The Kershaw County Bicycle, Pedestrian and Greenways Plan was developed to set the course for building an on- and off-street bikeway, walkway, and trails network. It includes "complete streets" designs to promote safer travel for pedestrians, cyclists and drivers, as well as recommended policies and programs to encourage usage of the bikeway, walkway, and trail network, and to promote safe bicycling, walking, and driving practices. County and City councils adopted the plan and incorporated it into their respective comprehensive plans. The greenways plan efforts are ongoing. EatSmart MoveMore Coalition Kershaw County supported and led these efforts. Some of the enhancements to the physical environment thus far include:

- the one-half mile, 10 foot wide, paved Sweet Gum Connector Trail that connects Woodward Park to Scott Park in Camden
- marked and signed pedestrian crosswalks on Broad Street in downtown Camden
- fifty "share the road" signs throughout the county to alert drivers and bicyclists to safely share the roads.



ACCESS TO CARE

Goal Statement

Increase and improve ways to access affordable healthcare and transportation services among rural and underserved residents.*

*With dignity and empowerment embedded throughout framework.

Outcome Metrics

Decreased uninsured rate, decrease in avoidable ER visits and readmission rates, and reduction in missed follow-up appointments due to transportation

Objective One

Connect every community member to timely and quality care

1. Workplace wellness (Workplace Health Index, worksite clinic, Doc in a Box, policy change)
2. Telehealth opportunities (existing and new; Alexa homebased solution)
3. Transportation backbone (Rides to Wellness, LYFT, transportation consortium, billboards at bus stops and churches)
4. Mobile clinic (Sullivan Center Model, community paramedicine)

Objective Two

Advocate for meaningful and trusting relationships with community residents.

1. Trainings to Promote Dignity and Empowerment – certification, hot line (incentivize those with lived experience, implicit bias, patient advocates, how to navigate, motivational interviewing)
2. Organizational Policy Revisions (addressing "gatekeepers" and partner engagement)
3. Community Champion Identification (influencers in each community), Identify and address barriers

Key Partners

Census, Chamber of Commerce, community paramedics, Human Affairs Commission, KershawHealth, local churches, local providers, local technical college, network of Human Resource Directors/Committee of 100/Economic Development, patient advocates, "real" communities (race/nationality/geographic location/occupation), school district, school service providers, transportation committee/RTA, and United Way

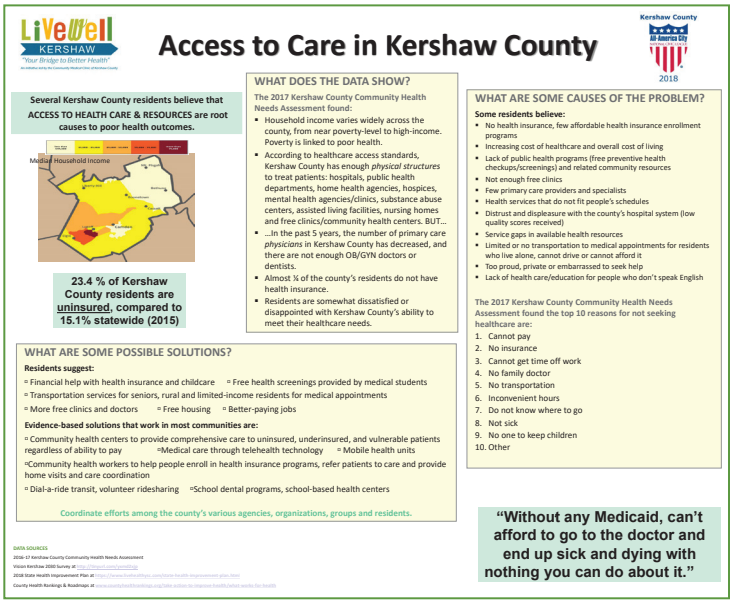
Key Indicators to Watch

Increase in access to healthcare for those who live west of the river, number of providers accepting Medicare/Medicaid (increase), number of missed follow-up appointments due to transportation (decrease), healthcare visits (NP, PA, Walmart clinic, school wellness centers, telehealth) in nontraditional locations (increase), HR directors sharing reasons employees missing work, attitudes and perceptions (change over time) related to healthcare (more confidence in availability), number of local policy changes or procedures/type (residency, incentives, time off to see doctors, breaks for telehealth visits)

"I moved here from Egypt and was left alone with my kids. I had no one to help me with finding a job, transportation, or medical care. I now have freedom to work, drive my car, and see the doctor because of a navigator.

Access to care is important. Everyone needs help."

Elham Hamad
Elgin, SC



BRIGHT SPOT of a Current Local Effort to Address Access to Care:

Gatekeepers stand at the entry point of every system, health included. The Community Medical Clinic of Kershaw County identified areas for improvement within their own organization in relation to patients' ability to access health care and feel empowered throughout the process. After undergoing Implicit Bias Training and an Image Shift Workshop, the team agreed to change organizational policy by providing patients with medical attention prior to undergoing the eligibility process to receive services. Staff members recognized that the in-depth eligibility process can be a barrier to creating trust between medical provider and patient. As a result, the organization has shifted to an intake model that is patient-centered.

EMOTIONAL HEALTH

Goal Statement

Improve the Emotional Well-Being of Kershaw County residents by increasing the quality, availability, and effectiveness of Community Health Programs.

Outcome Metrics

Suicide rate (decrease), drug overdose death rate (decrease), overall well-being (increase)

Objective One

Identify and assess the impact of our local mental health programs and initiatives.

1. Assessment and Evaluation
2. Continuous Quality Improvement

Objective Two

Provide Training and Resources to Prevent Mental Health Crisis.

1. Mental Health First Aid
2. Family Foundations Program
3. GROW model
4. Mindfulness practices
5. Reduce "screen time"

Objective Three

Provide safety-net crisis intervention resources and provide children and youth access to adequate and timely School-Based Behavioral Health Services

1. Community Crisis Response and Intervention
2. Roads of Independence (ROI)
3. Mental Health Counselors at High Schools
4. Creating Lasting Family Connections Programs
5. Health Clubs at High Schools

Key Partners

ALPHA Center, Department of Mental Health, EMS, Family Resource Center, Fire Department, Food for the Soul, Kershaw County Mental Health Task Force, KershawHealth, Law Enforcement, local providers, Mental Health America, Probate Judge, School District/Schools, United Way, and Worksites/employee assistance programs

Key Indicators to Watch

Utilization of the hospital for mental health, When Programs Reach Capacity, Number of Trainings, Support Groups & Manuals Distributed, Inventory Complete of Identification and Assessment of Programs, Impact of interventions (referrals, testimonials)

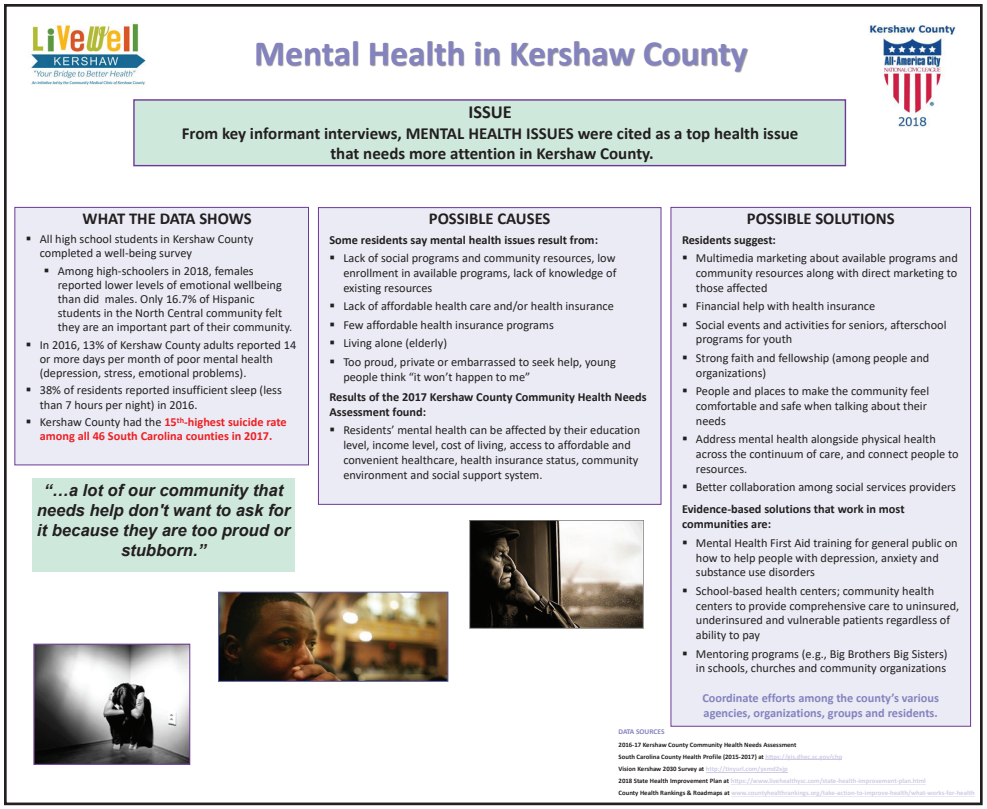
"Mental health impacts every aspect of a person's life. I've seen how it impacted my family growing up and am now fighting to ensure that my family and children get the support they need to live a full life. We have to start talking about this issue."

Yolanda Roary
Lugoff, SC

BRIGHT SPOT of a Current Local Initiative to Improve Emotional Health

Mental Health Counselors in High Schools

In the 2018-2019 school year, teachers and administrators referred students to Life Coaches (doctoral students) at North Central High School, North Central Middle School, Camden High School and Lugoff-Elgin High School through a partnership with the University of South Carolina's Community Psychology Program. A total of 81 students were served with most receiving more than five visits and reporting reaching at least half of their goals set by the student and life coach. Students frequently report feeling appreciative that they "have someone to talk to." Students identified problems including feeling overwhelmed, difficulty focusing, feeling sad, trouble sleeping and eating, trouble communicating with others, trouble with family, low grades, and academic difficulties. Related goals included decreasing anxiety, being less overwhelmed, gaining self-confidence, not getting stuck on negative thoughts, being assertive, and learning study skills. Funding and support were made possible by the Community Medical Clinic of Kershaw County, Kershaw County School District and the Health Services District of Kershaw County.



Funding and Project Staff

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LiveWell KERSHAW COALITION

CHIP process and report supported by Iron Sharpens Iron Consulting Group led by Holly Hayes.

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ACCESS TO CARE

Goal and Outcome Metrics	Objectives	Tactics	Potential Indicators to Watch	Partners
Increase and improve ways to access affordable healthcare and transportation services among rural and underserved residents.* (*With dignity and empowerment embedded throughout framework). Outcome metrics: Decreased uninsured rate, decrease in avoidable ER visits and readmission rates, and reduction in missed follow-up appointments due to transportation	Connect every community member to timely and quality care	Workplace Wellness (Workplace Health Index, Worksite Clinic, Doc in a Box, policy change)	• Increase in access to healthcare for those who live west of the river • Number of providers accepting Medicare/Medicaid (increase), • Number of Missed follow up appts due to transportation (decrease), • Visits (NP, PA, Walmart clinic, school wellness centers, telehealth) in nontraditional locations (increase), • HR directors sharing reasons employees missing work, • Attitudes and perceptions (change over time) related to healthcare (more confidence in availability), • Number of local policy changes or procedures/type (residency, incentives, time off to see doctors, breaks for telehealth visits)	• Census • Chamber of Commerce • Community paramedics • Human Affairs Commission • KershawHealth • Local churches • Local providers • Local technical college • Network of Human Resource Directors/ Committee of 100/Economic Development • Patient advocates • "Real" communities (race/nationality/geographic location/occupation) • School district • School service providers • Transportation committee/RTA • United Way
		Telehealth opportunities (Existing and new; Alexa homebased solution)		
		Transportation Backbone (Rides to Wellness, LYFT, transportation consortium, billboards at bus stops and churches)		
		Mobile Clinic (Sullivan Center Model, Community paramedicine)		
	Advocate for meaningful and trusting relationships with community residents.	Trainings to Promote Dignity and Empowerment – certification, hot line (Incentivize those with lived experience, Implicit bias, patient advocates, how to navigate, motivational interviewing)		
		Organizational Policy Revisions (Addressing "gatekeepers" and partner engagement)		
		Community Champion Identification (Influencers in each community), Identify and address barriers		

OBESITY

Goal and Outcome Metrics	Objectives	Tactics	Potential Indicators to Watch	Partners
Increase healthy lifestyles among families* countywide in order to decrease the obesity epidemic. *Families include ALL adults, children and elderly (everyone). Outcome metrics: Obesity rates among adults and children (decrease) & students ranking in top 25% of FitnessGram data for the nation	Strengthen existing collaborations	Supporting other groups' current obesity efforts	• Personal stories of transformation • Number of local residents participating in local health events and using trails (increase) • Decrease in screen time • Decrease in sugar-sweetened beverages • Number of policy changes/types (increase) • Percentage of participating churches • Number of students leading health initiatives • Number of participating schools • Number of functional trails • Number of media presentations/articles	• American Heart Association • Chamber of Commerce • Dollar Generals • Eat Smart Move More Kershaw County • Elementary schools • Grocery stores • Hospital Association • LiveWell Kershaw Coalition • Local churches • Local providers • Media outlets • Parents • School district • School Media (newsletters, broadcast) • Trails Committee
	Implement evidence-based interventions	HEAL (Healthy Eating, Active Living) Champions in schools, faith-based organizations, worksites and local communities		
		School Campaigns ("5-2-1-0" and "Say Yes! to Water)		
		FAN (Faith, Activity and Nutrition) Program for churches		
		Worksite wellness programs		
		Policy changes to decrease obesity		
		Public infrastructure that supports physical activity (outdoor fitness parks, walking trails, community parks)		
	Conduct an awareness campaign	Mass and small media, social media		
		Local resolutions		

EMOTIONAL HEALTH

Goal and Outcome Metrics	Objectives	Tactics	Potential Indicators to Watch	Partners
Improve the Emotional Well-Being of Kershaw County Residents by Increasing the quality, availability, and effectiveness of Community Health Programs. Outcome metrics: Suicide rate (decrease), drug overdose death rate (decrease), overall well-being (increase)	Identify and assess the impact of our local mental health programs and initiatives	Assessment and evaluation	• Utilization of the hospital for mental health • When Programs Reach Capacity • Utilization of local programs • Number of Trainings and support groups • Manuals Distributed • Inventory Complete of Identification and Assessment of Programs • Impact of interventions (referrals, testimonials)	• ALPHA Center • Department of Mental Health • EMS • Family Resource Center • Fire Department • Food for the Soul • Kershaw County Mental Health Task Force • KershawHealth • Law Enforcement • Local providers • Mental Health America • Probate Judge • School District/Schools • United Way • Worksites/employee assistance programs
		Continuous Quality Improvement		
	Provide Training and Resources to Prevent Mental Health Crisis.	Mental Health First Aid		
		Family Foundations Program		
		GROW Model		
		Mindfulness Practice		
		Strategies to reduce “screen time”		
	Provide safety-net crisis Intervention resources & provide children and youth access to adequate and timely School-Based Behavioral Health Services	Community Crisis Response and Intervention		
		Roads of Independence (ROI)		
		Mental Health Counselors in High Schools		
		Creating Lasting Family Connections Programs		
		Health Clubs at High Schools		

Participants

Thank you to all our LiveWell Kershaw Coalition members for making our mission possible. LWK Coalition members are individuals of organizations across community sectors willing to give time, energy and effort to the advancement of population health in Kershaw County.

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Dana Corporation
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April Wach
KershawHealth
Liz Walsh
SC Thrive
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Sandhills Medical Foundation
Susan Witkowski
Community Medical Clinic of Kershaw County

References

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