Live Healthy SC: The Blueprint for Achieving Health and Racial Equity across South Carolina
“THE TEST OF OUR PROGRESS IS NOT WHETHER WE ADD MORE TO THE ABUNDANCE OF THOSE WHO HAVE MUCH, IT IS WHETHER WE PROVIDE ENOUGH FOR THOSE WHO HAVE LITTLE.”

FRANKLIN D. ROOSEVELT
SC Health and Racial Equity Blueprint
Key Populations

• Racial and rural gaps in maternal/child care access and health outcomes
• Children living in poverty that experience major gaps in social support, educational performance and academic advancement opportunities
• Racial and rural gaps in access to preventive care screening and chronic disease rates
• Equity gaps in access to non-emergent behavioral healthcare services for low income populations
• Higher rates of suicide in adolescents/young adults who suffer from discrimination and social isolation
The Neighborhood and The Need

The 5.6 square mile area of CPN is marked by under-education, teenage pregnancy, poor healthcare, violent crime, unemployment, and intergenerational poverty.

We aim to break that cycle.

Note: 2016 Federal Poverty Line for a family of 4 (200% FPL) = $48,500

Area Comparison
Mt. Pleasant, Charleston County, CPN Neighborhood

The 5.6 square mile area of CPN is marked by under-education, teenage pregnancy, poor healthcare, violent crime, unemployment, and intergenerational poverty. We aim to break that cycle.
Specific Equity-Based Health Disparities

FIGURE 5.7
Low Birthweight, by Race/Ethnicity

Percent

- non-Hispanic White: 7.5%
- non-Hispanic Black: 14.6%
- non-Hispanic Other: 9.2%
- Hispanic/Latino: 6.8%

South Carolina Pregnancy-Related Death by Race, 2013-2017

Rate per 100,000 live births

- South Carolina: 24.7
- White: 13.7
- Black and Other: 46.3
- Healthy People 2020 Goal: 11.4

Nonfatal Child Maltreatment, by Race

Rate per 1,000

Note: Ages less than 18.
Specific Equity-Based Health Disparities

South Carolina Graduation Rate, by Demographics

Demographic Characteristic

<table>
<thead>
<tr>
<th>Demographic Characteristic</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>84.3%</td>
</tr>
<tr>
<td>Black</td>
<td>76.5%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>79.5%</td>
</tr>
<tr>
<td>Male</td>
<td>75.3%</td>
</tr>
<tr>
<td>Female</td>
<td>87.4%</td>
</tr>
<tr>
<td>Economically Disadvantaged</td>
<td>78.7%</td>
</tr>
<tr>
<td>Noneconomically Disadvantaged</td>
<td>94.2%</td>
</tr>
</tbody>
</table>

Specific Equity-Based Health Disparities

Stroke Deaths, by Race/Ethnicity and Sex
Rate per 100,000 population

Note: Age-adjusted.
• Mission: Coordinating action on shared goals to improve the health of ALL people in South Carolina.

- **Healthy Babies**
  - Improve the health of moms and babies from preconception through the first year of life.

- **Healthy Children**
  - Improve the health and educational outcomes of children.

- **Healthy Bodies**
  - Improve physical health through good nutrition, physical activity, and increased access to high quality primary care.

- **Healthy Aging**
  - Improve the environment and opportunity to live a long and healthy life.

- **Healthy Minds**
  - Improve access to appropriate behavioral health services and other necessary critical and support services.

- **Health Equity Commitment**
  - For all people in SC
  - Strive to attain the highest level of health for all people, independent of gender, race, sexual orientation, neighborhood, disability, ethnicity, education level, or socioeconomic status.

- **At a lower per-capita cost**
  - Reduce the cost of care for every individual in the state.
SOCIAL DETERMINANTS AND SOCIAL NEEDS: MOVING BEYOND MIDSTREAM

COMMUNITY IMPACT
- STRATEGIES: Improve Community Conditions
- TACTICS: Laws, policies, and regulations that create community conditions supporting health for all people.

INDIVIDUAL IMPACT
- STRATEGIES: Addressing Individuals' Social Needs
- TACTICS: Include patient screening questions about social factors like housing and food access; use data to inform care and provide referrals.

LIVE HEALTHY SOUTH CAROLINA

downstream
- Providing Clinical Care
- Social workers, community health workers, and/or community-based organizations providing direct support/assistance to meet patients' social needs
- Medical interventions
Live Healthy SC

Behavioral Health Improvement

Obesity & Chronic Disease Prevention

Maternal & Child Health and Wellbeing

Health System Transformation  Focus on Social Determinants of Health

Health Equity
South Carolina State Health Improvement Plan

OBJECTIVES for 2023:

1. Decrease the rate of nonfatal child maltreatment to 14.2 per 1,000 children
   - 2016: 15.8 per 1,000
   - 2017: 15.5 per 1,000

2. Increase the high school graduation rate to 88.8%
   - 2017: 84.6%
   - 2019: 81.1%

3. Decrease the percent of adults ages 20 years or older who are obese to 31.5%
   - 2016: 33.2%
   - 2018: 35.2%

4. Decrease the percent of adults who smoke to 18.5%
   - 2016: 20.6%
   - 2018: 18.6%

5. Decrease the stroke death rate to 43.1 per 100,000
   - 2016: 45.4 per 100,000
   - 2018: 45.5 per 100,000

6. Decrease the suicide rate from 14.9 per 100,000
   - 2016: 15.7 per 100,000
   - 2018: 15.4 per 100,000

7. Decrease the rate of drug overdose deaths to 17.1 per 100,000
   - 2016: 18.0 per 100,000
   - 2018: 22.2 per 100,000

LiveHealthySC.com
Blueprint for Health and Racial Equity in SC

• A call to action focused on achieving health and racial equity across all SC communities:

• Built on 4 collective action categories:
  ➢ Cultural awareness and humility
  ➢ Health equity in all policies
  ➢ Equity targeted improvement programs/practices
  ➢ Investments in upstream SDOH solutions

• Focus on specific areas with the greatest equity gaps:
  ➢ Maternal/child health
  ➢ Obesity and chronic disease prevention
  ➢ Access to behavioral health services
Achieving Health Equity as our Primary Goal

• Create a “safe space” for candid dialogue about the root causes of health and racial inequities

• Build the capacity for cultural humility and the capability to counter the implicit biases that most contribute to inequity

• Ensure that all key population and community health data indicators are equity-stratified and geo-mapped

• Target collective policy and programmatic actions to the major equity-driven gaps in healthcare access and health outcomes

• Give an active voice to those who are most impacted by health and social inequities—realizing the “power of with”