Maternal Mortality: Statewide Efforts to Reduce Adverse Outcomes of Pregnancy and Childbirth

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S.C. Summit on Early Childhood

Public Health Session

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Disclosures

Chair of the SC Maternal Mortality and Morbidity Review Committee (MMMRC)

SC ACOG Section Chair

Thanks to Dave Goodman, CDC and to Amy Crockett, SC BOI Clinical Lead

Key Definitions

A pregnancy-associated death is the death of a woman (during pregnancy or within one year of pregnancy) that is temporally related to pregnancy.

A pregnancy-related death is a subset of pregnancy-associated deaths that is related to or are aggravated by pregnancy.

Building U.S. Capacity to Review and Prevent Maternal Deaths. (2018) Report from nine maternal mortality review committees.

The Maternal Mortality Rate[1] is reported as

of maternal deaths per 100,000 live births

The Pregnancy-Related Mortality Ratio[2] is reported as

of pregnancy-related deaths per 100,000 live births

MMRIA MATERNAL MORTALITY REVIEW INFORMATION APP

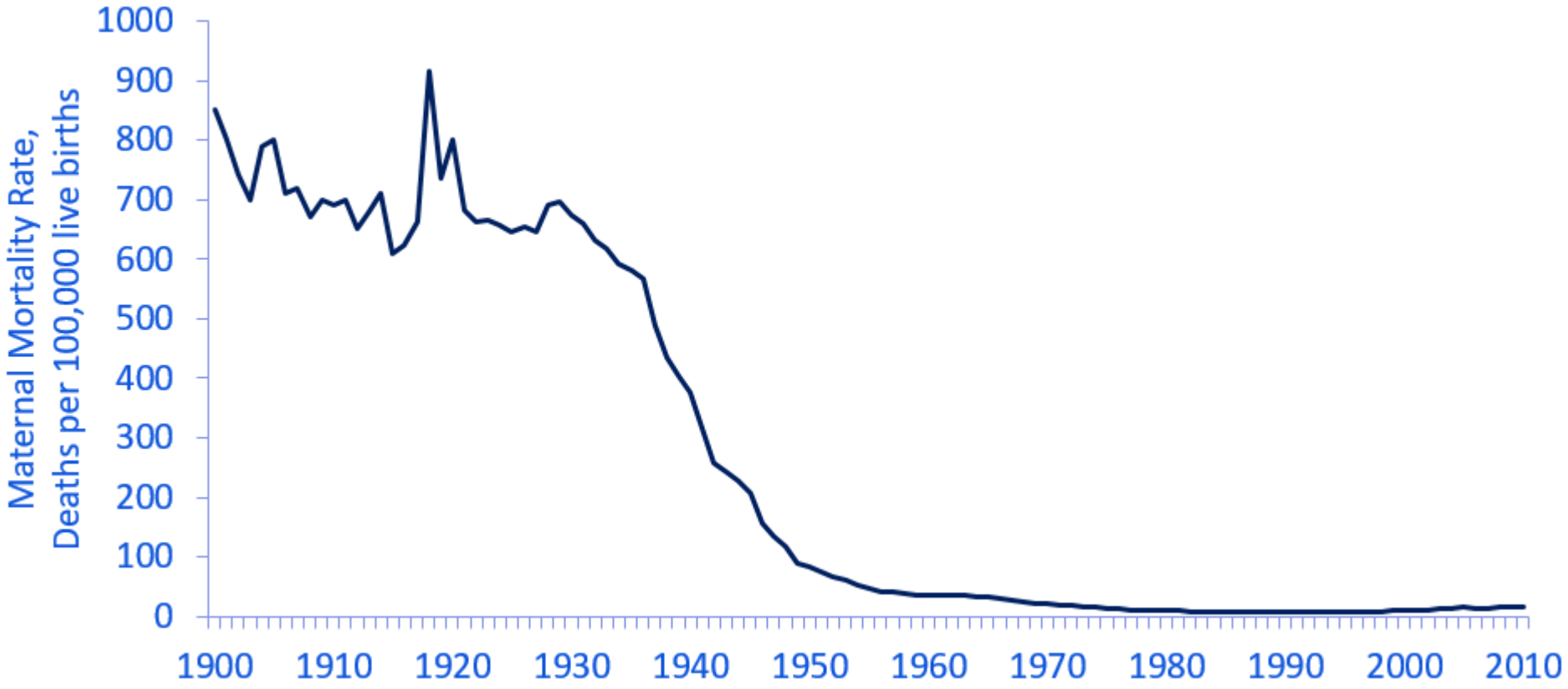
ERASE MM

REVIEW to ACTION WORKING TOGETHER TO PREVENT MATERNAL MORTALITY

[1]Deaths occurring during pregnancy or within 42 days of delivery. Maternal deaths are identified by ICD-10 codes as listed on the death certificate.

[2] Deaths occurring during pregnancy or within one year of pregnancy. Pregnancy-related deaths are identified by the pregnancy checkbox and/or death certificate linked to fetal deaths or birth certificate.

Measuring Maternal Deaths



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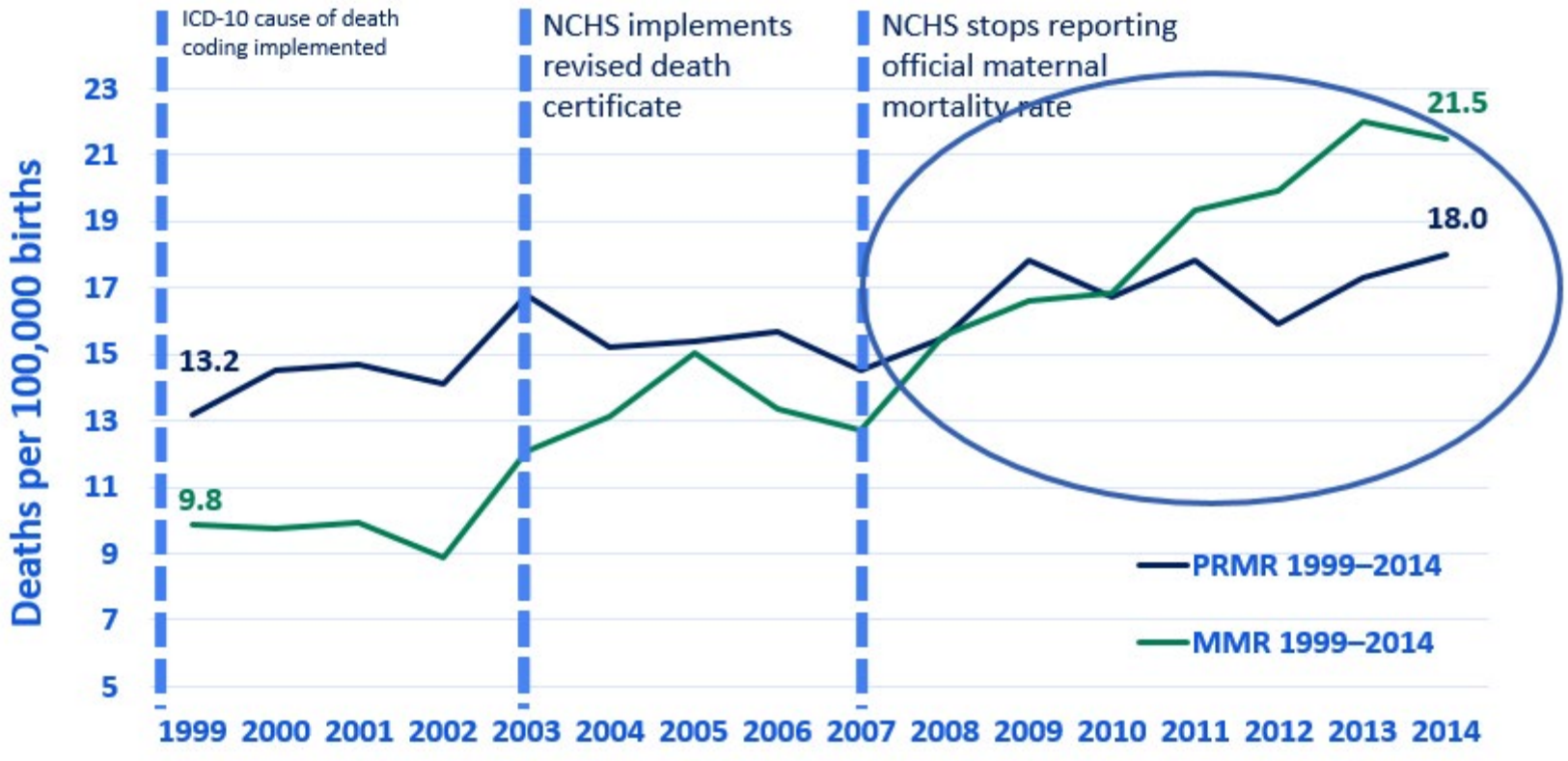
Measuring Maternal Deaths: NCHS & PMSS



PRMR: Pregnancy-related mortality ratio
MMR: Maternal mortality rate
http://www.cdc.gov/reproductivehealth/maternalinfanthealth/pmss.html

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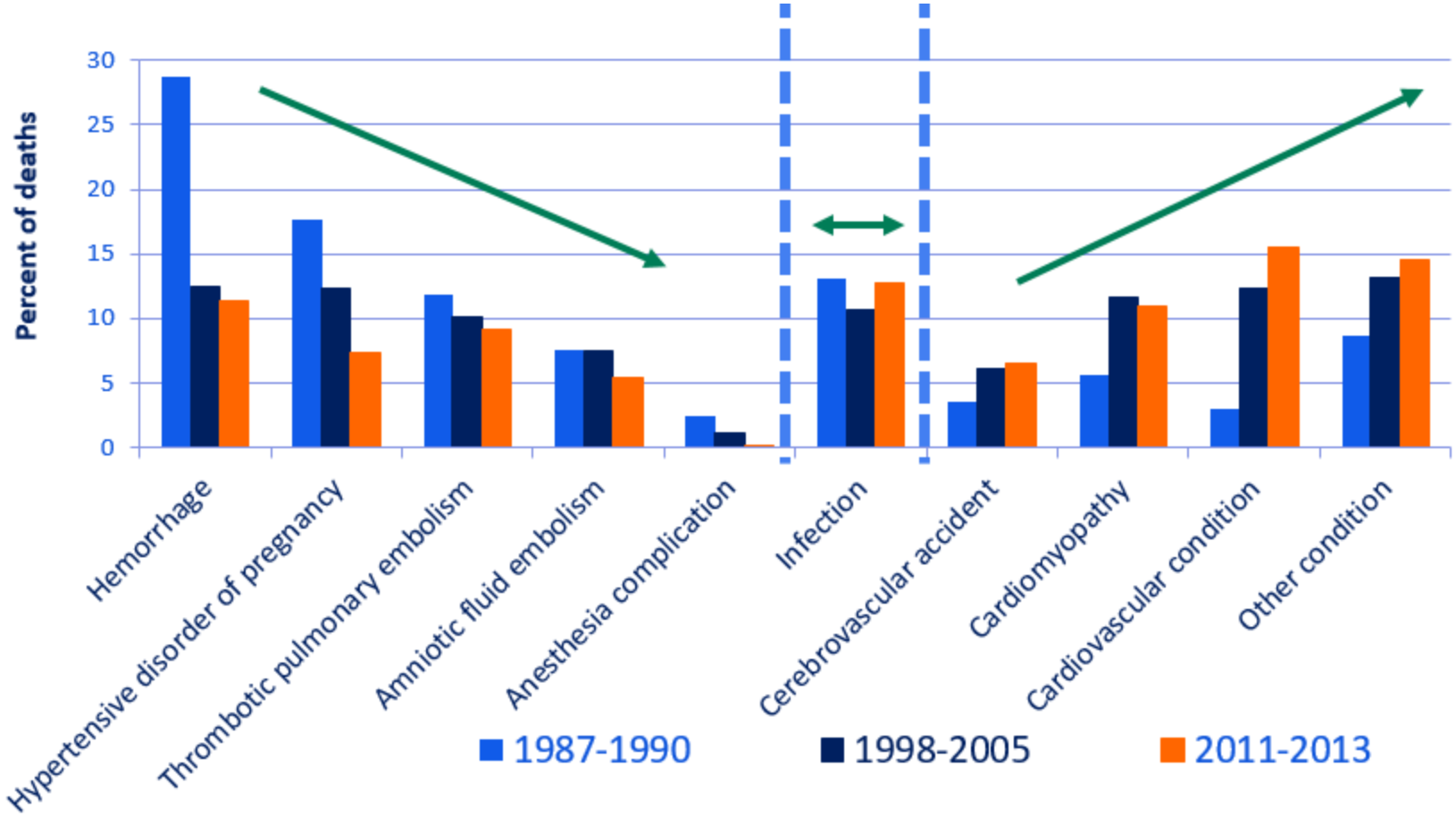
PMSS: Causes of Pregnancy-related Death



Creanga AA, et al. Obstet Gynecol 2015;125:5-12.

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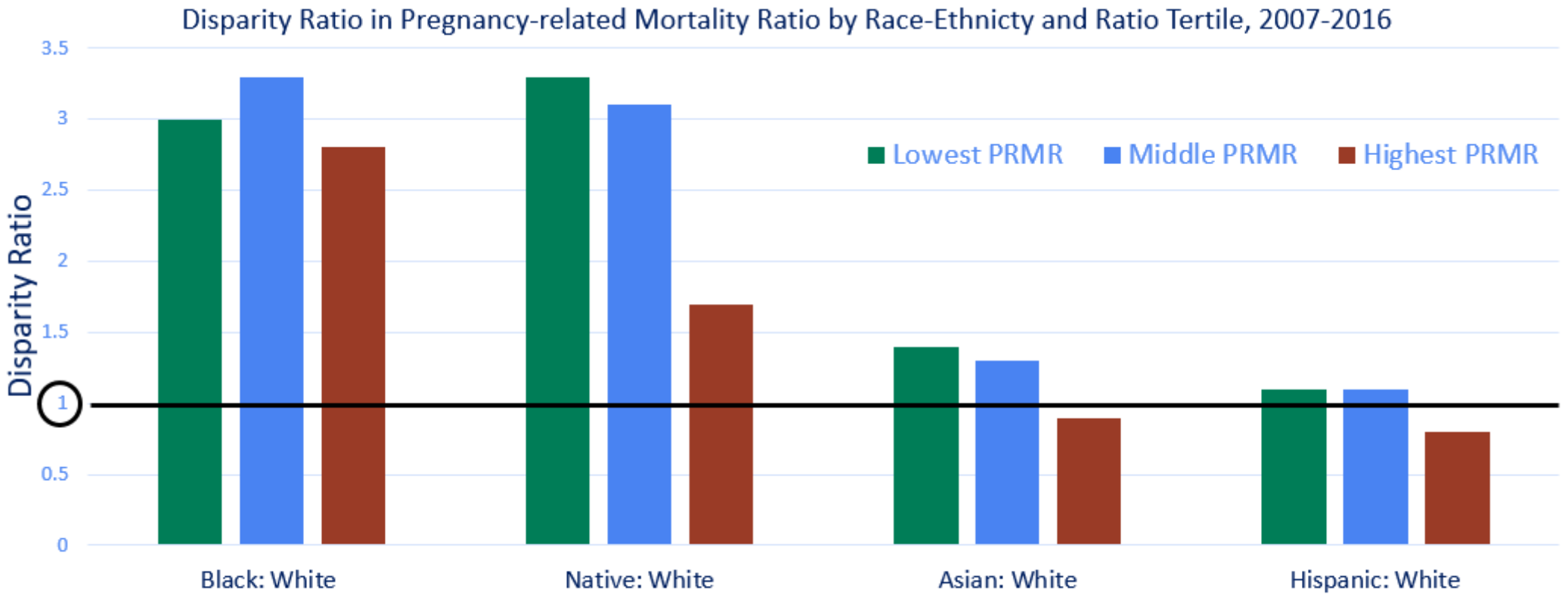
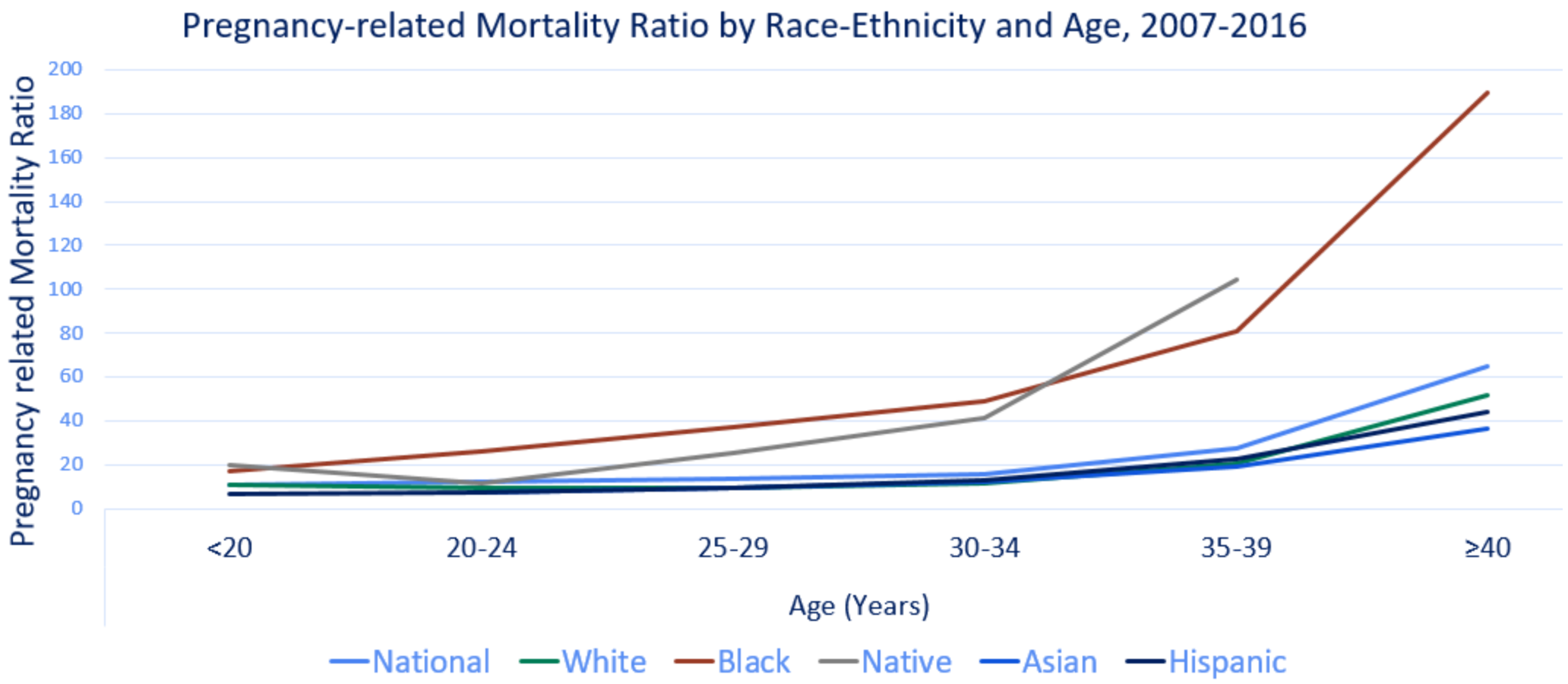
Disparity implies inequality often where a greater equality might be reasonably expected

PMSS: Disparity Ratio



Petersen EE, Davis NL, Goodman D, et al. Racial/Ethnic Disparities in Pregnancy-Related Deaths — United States, 2007–2016. MMWR Morb Mortal Wkly Rep 2019;68:762–765

PMSS: by Age Grouping



Petersen EE, Davis NL, Goodman D, et al. Racial/Ethnic Disparities in Pregnancy-Related Deaths — United States, 2007–2016. MMWR Morb Mortal Wkly Rep 2019;68:762–765

Preventing Maternal Deaths:
Maternal Mortality Review Committees (MMRCs)

Preventing Maternal Deaths: Maternal Mortality Review Committees (MMRCs)

MMRCs have 3 components that the other systems (NCHS and PMSS) don't have:

1. Robust **DATA** system dedicated to maternal mortality with multi-level data from multiple sources (including non-traditional sources)

2. A multidisciplinary committee of **EXPERTS** to review each death, through clinical and non-clinical lens, with a focus on prevention (population level)

3. PH **STAFF (**usually a state department of public health team) to gather and manage the data, establish and guide the committee, communicate with stakeholders, and conduct and disseminate research and surveillance. (AKA, put it all together)

MMRIA MATERNAL MORTALITY REVIEW INFORMATION APP

ERASE MM Enhancing Reviews and Surveillance to Eliminate Maternal Mortality

REVIEW to ACTION WORKING TOGETHER TO PREVENT MATERNAL MORTALITY

Preventing Maternal Deaths Committee reporting forms MMRIA

MMRIA

MATERNAL MORTALITY REVIEW COMMITTEE DECISIONS FORM v14

REVIEW DATE

RECORD ID #

PREGNANCY-RELATEDNESS: SELECT ONE

- ☐ **PREGNANCY-RELATED**
  The death of a woman during pregnancy or within one year of the end of pregnancy from a pregnancy complication, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition by the physiologic effects of pregnancy
- ☐ **PREGNANCY-ASSOCIATED, BUT NOT -RELATED**
  The death of a woman during pregnancy or within one year of the end of pregnancy from a cause that is not related to pregnancy
- ☐ **UNABLE TO DETERMINE IF PREGNANCY-RELATED OR PREGNANCY-ASSOCIATED, BUT NOT -RELATED**
- ☐ **NOT PREGNANCY-RELATED OR -ASSOCIATED**
  (i.e. false positive, woman was not pregnant within one year of her death)

ESTIMATE THE DEGREE OF RELEVANT INFORMATION (RECORDS) AVAILABLE FOR THIS CASE:

- ☐ **COMPLETE**
  All records necessary for adequate review of the case were available
- ☐ **MOSTLY COMPLETE**
  Minor gaps (i.e. information that would have been beneficial but was not essential to the review of the case)
- ☐ **SOMEWHAT COMPLETE**
  Major gaps (i.e. information that would have been crucial to the review of the case)
- ☐ **NOT COMPLETE**
  Minimal records available for review (i.e. death certificate and no additional records)
- ☐ **N/A**

DOES THE COMMITTEE AGREE WITH THE UNDERLYING CAUSE OF DEATH LISTED ON DEATH CERTIFICATE? ☐ YES ☐ NO

COMMITTEE DETERMINATION OF CAUSE(S) OF DEATH

TYPE	CAUSE (DESCRIPTIVE)
IMMEDIATE	
CONTRIBUTING	
UNDERLYING	
OTHER SIGNIFICANT	

IF PREGNANCY-RELATED, COMMITTEE DETERMINATION OF UNDERLYING CAUSE OF DEATH
Refer to page 3 for PMSS-MM cause of death list. If more than one is selected, list in order of importance beginning with the most compelling (1-2; no more than 2 may be selected in the system).

DID **OBESITY** CONTRIBUTE TO THE DEATH?	☐ YES	☐ PROBABLY	☐ NO	☐ UNKNOWN
DID **MENTAL HEALTH CONDITIONS** CONTRIBUTE TO THE DEATH?	☐ YES	☐ PROBABLY	☐ NO	☐ UNKNOWN
DID **SUBSTANCE USE DISORDER** CONTRIBUTE TO THE DEATH?	☐ YES	☐ PROBABLY	☐ NO	☐ UNKNOWN
WAS THIS DEATH A **SUICIDE**?	☐ YES	☐ PROBABLY	☐ NO	☐ UNKNOWN
WAS THIS DEATH A **HOMICIDE**?	☐ YES	☐ PROBABLY	☐ NO	☐ UNKNOWN

IF HOMICIDE, SUICIDE, OR ACCIDENTAL DEATH, LIST THE **MEANS OF FATAL INJURY**

- ☐ FIREARM
- ☐ SHARP INSTRUMENT
- ☐ BLUNT INSTRUMENT
- ☐ POISONING/ OVERDOSE
- ☐ HANGING/ STRANGULATION/ SUFFOCATION
- ☐ FALL
- ☐ PUNCHING/ KICKING/BEATING
- ☐ EXPLOSIVE
- ☐ DROWNING
- ☐ FIRE OR BURNS
- ☐ MOTOR VEHICLE
- ☐ INTENTIONAL NEGLECT
- ☐ OTHER, SPECIFY:
- ☐ UNKNOWN
- ☐ NOT APPLICABLE

IF HOMICIDE, WHAT WAS THE **RELATIONSHIP OF THE PERPETRATOR TO THE DECEDENT**?

- ☐ NO RELATIONSHIP
- ☐ PARTNER
- ☐ EX-PARTNER
- ☐ OTHER RELATIVE
- ☐ OTHER ACQUAINTANCE
- ☐ OTHER, SPECIFY:
- ☐ UNKNOWN
- ☐ NOT APPLICABLE

PRISMA HEALTH

COMMITTEE DETERMINATION OF PREVENTABILITY

A death is considered preventable if the committee determines that there was at least some chance of the death being averted by one or more reasonable changes to patient, family, provider, facility, system and/or community factors.

WAS THIS DEATH PREVENTABLE? ☐ YES ☐ NO

CHANCE TO ALTER OUTCOME? ☐ GOOD CHANCE ☐ SOME CHANCE ☐ NO CHANCE ☐ UNABLE TO DETERMINE

CONTRIBUTING FACTORS WORKSHEET

What were the factors that contributed to this death? Multiple contributing factors may be present at each level.

CONTRIBUTING FACTOR LEVEL	CONTRIBUTING FACTOR AND DESCRIPTION OF ISSUE
PATIENT/FAMILY	
PROVIDER	
FACILITY	
SYSTEM	
COMMUNITY	

RECOMMENDATIONS OF THE COMMITTEE

If there was at least some chance that the death could have been averted, what were the specific and feasible actions that, if implemented or altered, might have changed the course of events?

RECOMMENDATIONS OF THE COMMITTEE	LEVEL OF PREVENTION (SEE BELOW)	LEVEL OF IMPACT (SEE BELOW)

CONTRIBUTING FACTOR KEY (DESCRIPTIONS ON PAGE 4)

- Delay
- Adherence
- Knowledge
- Cultural/religious
- Environmental
- Violence
- Mental health conditions
- Substance use disorder – alcohol, illicit/prescription drugs
- Tobacco use
- Chronic disease
- Childhood abuse/ trauma
- Access/financial
- Unstable housing
- Social support/ isolation
- Equipment/ technology
- Policies/procedures
- Communication
- Continuity of care/ care coordination
- Clinical skill/ quality of care
- Outreach
- Enforcement
- Referral
- Assessment
- Legal
- Other

PREVENTION LEVEL

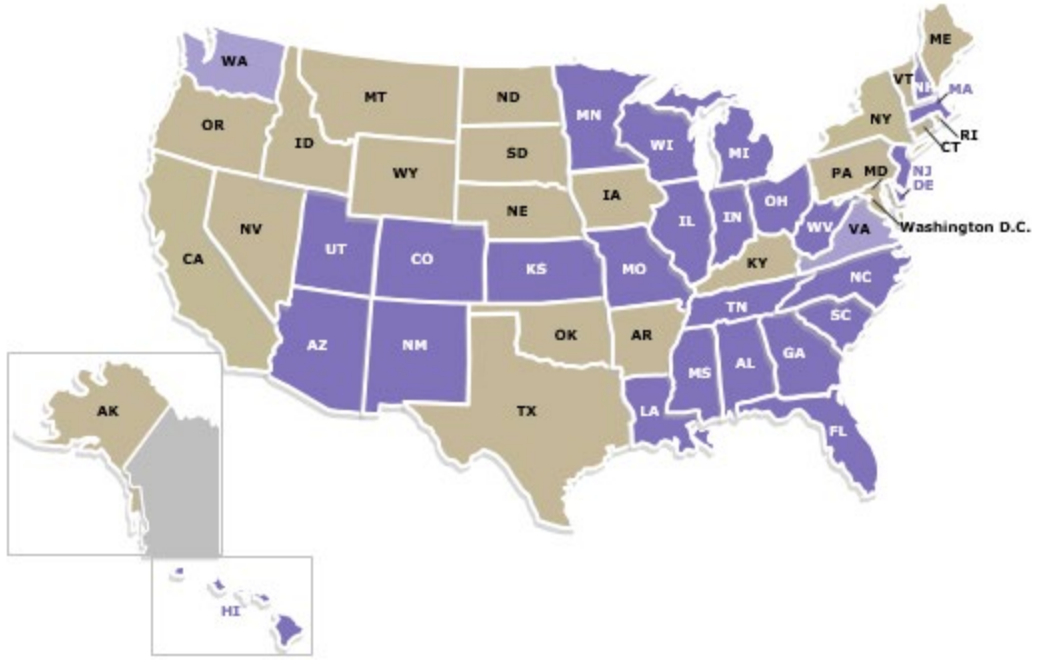
- **PRIMARY:** Prevents the contributing factor before it ever occurs
- **SECONDARY:** Reduces the impact of the contributing factor once it has occurred (i.e. treatment)
- **TERTIARY:** Reduces the impact or progression of an ongoing contributing factor once it has occurred (i.e. management of complications)

EXPECTED IMPACT LEVEL

- **SMALL:** Education/counseling (community- and/or provider-based health promotion and education activities)
- **MEDIUM:** Clinical intervention and coordination of care across continuum of well-woman visits through obstetrics (protocols, prescriptions)
- **LARGE:** Long-lasting protective intervention (improve readiness, recognition and response to obstetric emergencies/LARC)
- **EXTRA LARGE:** Change in context (promote environments that support healthy living/ensure available and accessible services)
- **GIANT:** Address social determinants of health (poverty, inequality, etc.)

Maternal Mortality Review Information Application (MMRIA)

A common language for reviews to work together



MMRIA MATERNAL MORTALITY REVIEW INFORMATION APP

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REVIEW to ACTION WORKING TOGETHER TO PREVENT MATERNAL MORTALITY

MMRCs: Equity Framework

Understanding community contributing factors requires a shift in thinking

1. We can link MMRIA data to community context
2. Assigning contributing role of community in individual cases is challenging
3. Community factors may be more evident in aggregate data
4. Adaptation, implementation, and evaluation of a *Health Equity Toolkit* in process(!)

Kramer MR, Strahan AE, Preslar J, Zaharatos J, ST. Pierre A, Grant J, Davis NL, Goodman D, Callaghan W, Changing the conversation: Applying a health equity framework to maternal mortality reviews, *American Journal of Obstetrics and Gynecology* (2019), doi: https://doi.org/10.1016/j.ajog.2019.08.057

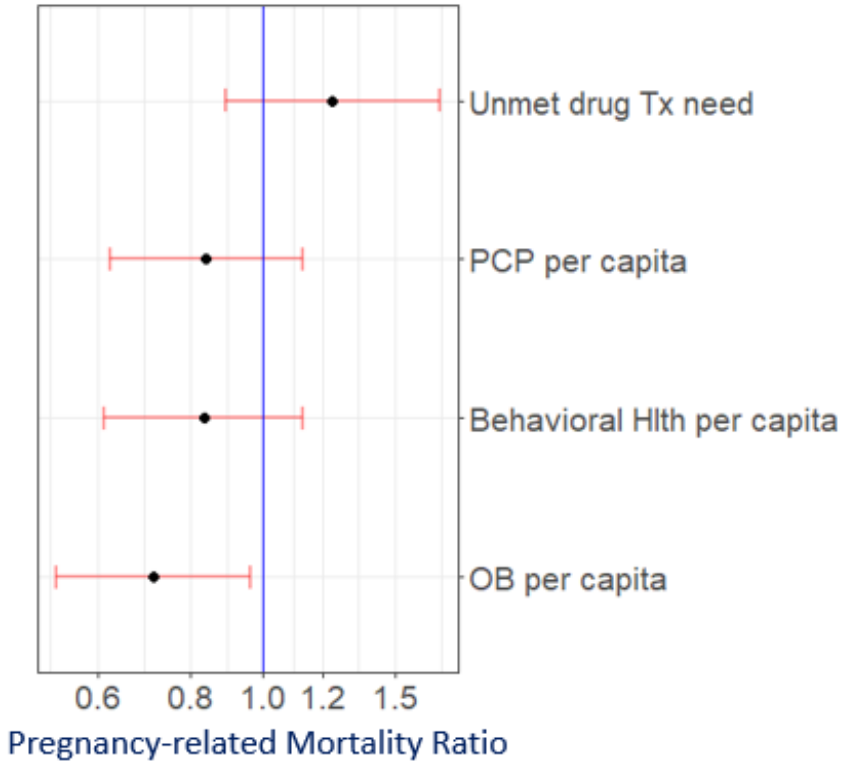
MMRCs Equity Framework

EQUALITY

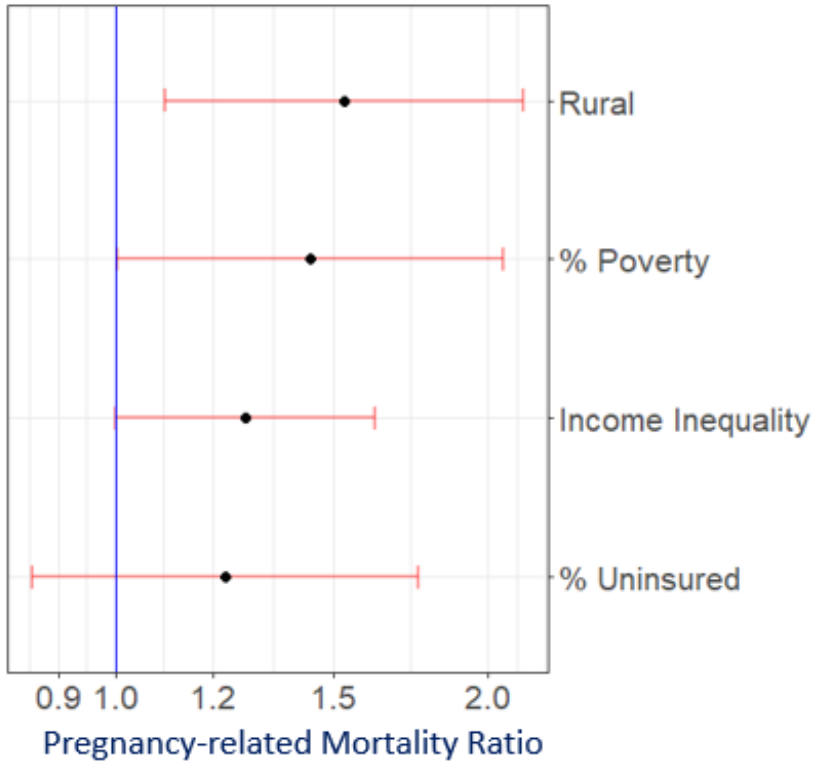
EQUITY

MMRCs: Equity Framework

Health Care Service Environ



Social Environ



MMRIA MATERNAL MORTALITY REVIEW INFORMATION APP

ERASE MM

REVIEW to ACTION WORKING TOGETHER TO PREVENT MATERNAL MORTALITY

PRISMA HEALTH

MMRIA: Preventability

Definition
A death is considered preventable if the committee determines there was at least some chance of the death being averted by one or more reasonable changes to patient, family, provider, facility, system and/or community factors.

Why
MMRCs determine preventability to prioritize interventions with the greatest opportunity for impact.

Committee established by statute – 2016

Meets quarterly

Voluntary reporting

Annual report to the legislature

https://www.scstatehouse.gov/reports/DHEC/MMMR%202019%20Legislative%20Brief%20-%20Revised%2003182019.pdf

SC Maternal Morbidity and Mortality Review Committee (MMMRC)

Multidisciplinary

Actively practicing

Based on ACOG and CDC recommendations

Three- to four-year terms

75% attendance requirements

Renewable once

SC Maternal Morbidity and Mortality Review Committee (MMMRC)

3 YEARS

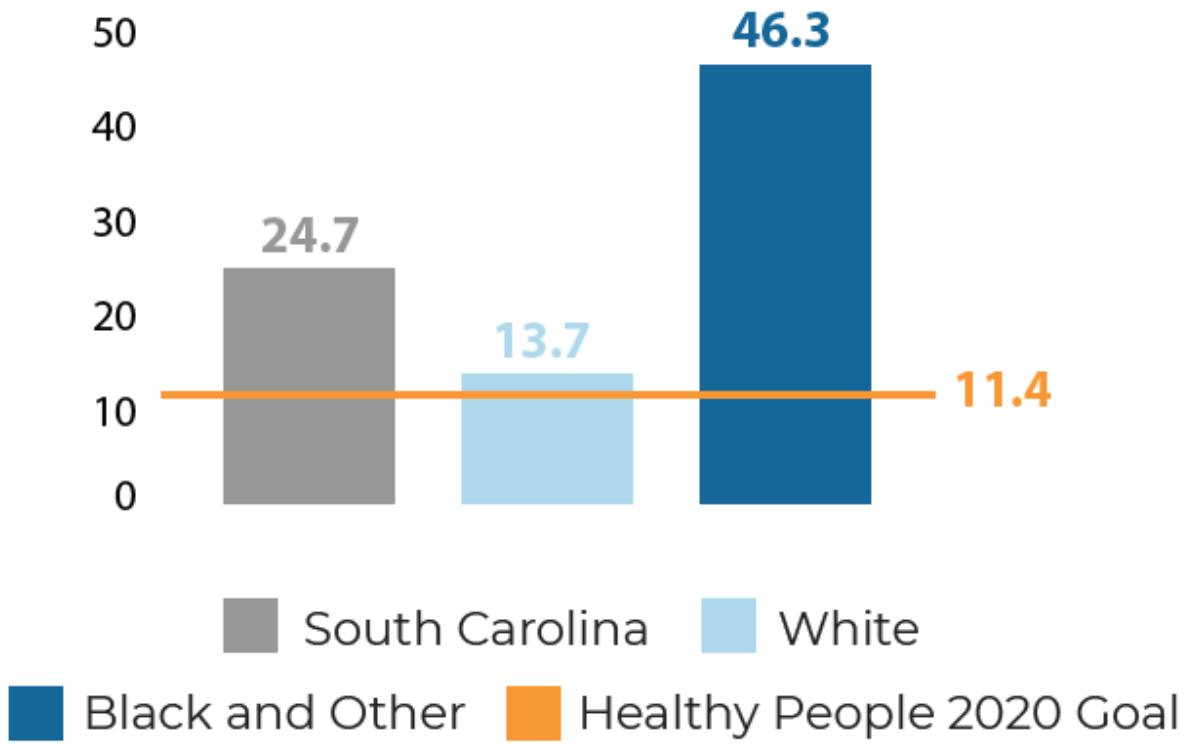
- ACOG
- MRM/OB each Regional Perinatal Center (RPC)
- SC Perinatal Association
- Coroner
- SC Hospital Association
- SC Department of Health and Human Services (DHHS)
- OB MD FQHC
- OB MD Level II hospital

4 YEARS

- OB Anesthesia
- Cardiology
- Domestic Violence
- Midwife
- Law Enforcement
- Alcohol and Drug Abuse
- Regional Systems Developers (RSDs)
- Family Medicine
- Psychiatry/Behavioral Medicine

South Carolina Pregnancy-Related Death by Race, 2013-2017[2]

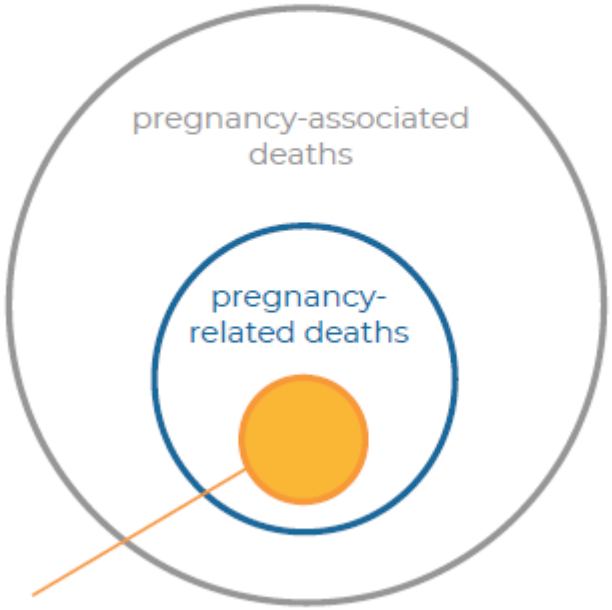
Rate per 100,000 live births



https://www.scstatehouse.gov/reports/DHEC/MMMR%202019%20Legislative%20Brief%20-%20Revised%2003182019.pdf

SC Maternal Morbidity and Mortality Review Committee (MMMRC)

Scope of Case Review



Primary Focus
preventable pregnancy-related deaths

MMMR Committee Findings

During the 2016-2018 review period, 13 of the 15 maternal deaths reviewed in South Carolina were determined to be pregnancy-related. One death was determined to be pregnancy-associated but not related to pregnancy, and the other could not be determined. Among the 13 pregnancy-related deaths, 54% were determined to be preventable.

54%

As reported nationally[3], the findings from South Carolina's MMMR Committee show that the common causes of maternal death include cardiovascular and coronary conditions, hemorrhage, infection, and embolism.

https://www.scstatehouse.gov/reports/DHEC/MMMR%202019%20Legislative%20Brief%20-%20Revised%2003182019.pdf

SC Maternal Morbidity and Mortality Review Committee (MMMRC)

SC MMMRC ACCOMPLISHMENTS

SC uses the **MMRIA** reporting format

CDC-developed
Assist with identifying social determinants
Includes **community factors**

SC Maternal Morbidity and Mortality Review Committee (MMMRC)

SC MMMRC ACCOMPLISHMENTS

Annual Report to the South Carolina Birth Outcomes Initiative (SC BOI) each Spring

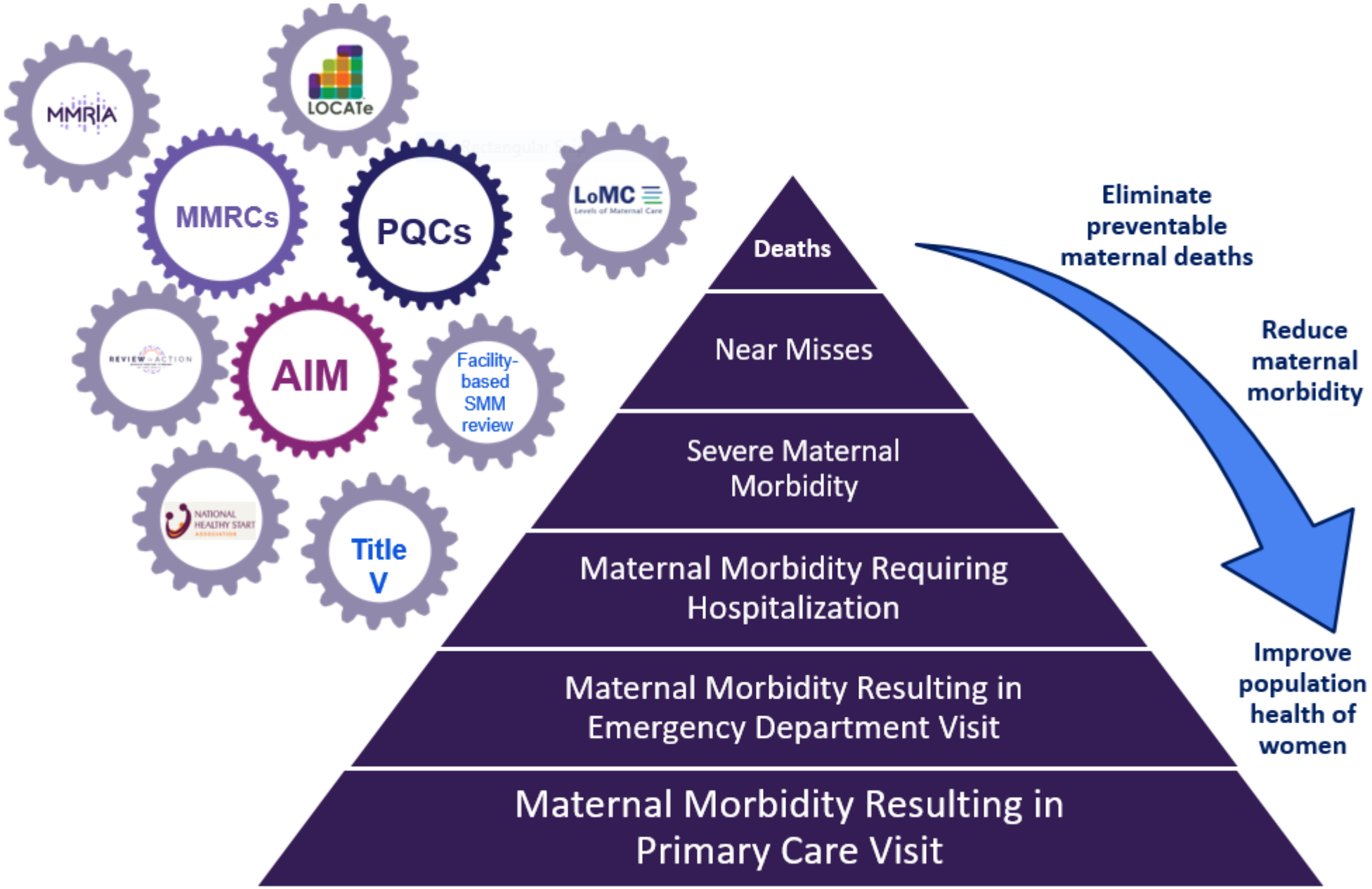
Annual Report to the SC General Assembly

https://www.scstatehouse.gov/reports/DHEC/MMMR%202019%20Legislative%20Brief%20-%20Revised%2003182019.pdf

Moving from Thought to Action: State Level
South Carolina SimCoach

Moving from Thought to Action: Local Level
GHS Postpartum Hemorrhage Cart

A standardized PPH cart that contains all equipment needed for any staff in any setting within the Women's Hospital.


MMRIA
LOCATe
MMRCs
PQCs
LoMC
Levels of Maternal Care
REVIEW to ACTION
AIM
Facility-based SMM review
NATIONAL HEALTHY START ASSOCIATION
Title V
Deaths
Near Misses
Severe Maternal Morbidity
Maternal Morbidity Requiring Hospitalization
Maternal Morbidity Resulting in Emergency Department Visit
Maternal Morbidity Resulting in Primary Care Visit
Eliminate preventable maternal deaths
Reduce maternal morbidity
Improve population health of women

Thanks

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RURAL & MINORITY Health Research Center

Maternal and Child Health in Rural Communities

Elizabeth Crouch, PhD, Deputy Director

Rural and Minority Health Research Center

University of South Carolina Arnold School of Public Health

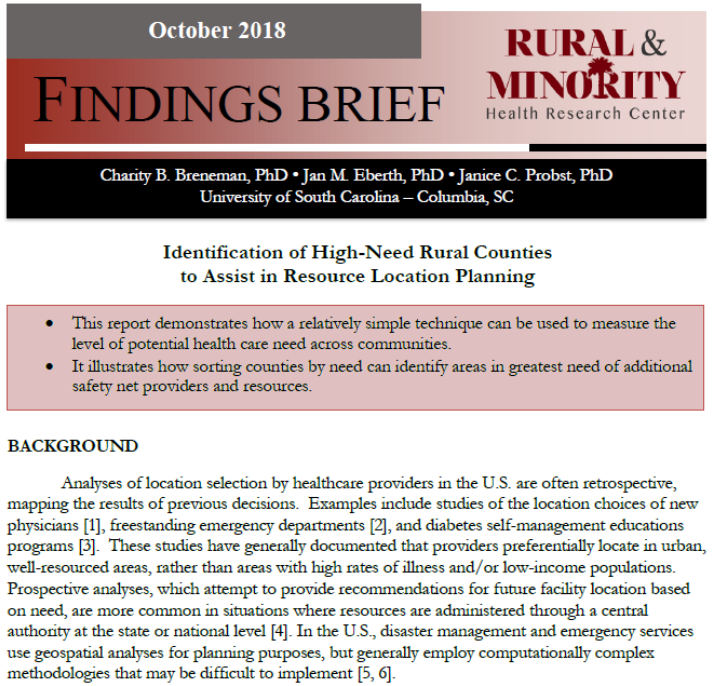
RURAL & MINORITY Health Research Center

Our center's mission

To illuminate and address the problems experienced by rural and minority populations in order to guide research, policy, and related advocacy.

Director: Jan M. Eberth, PhD

Deputy Director: Elizabeth Crouch, PhD



October 2018

FINDINGS BRIEF

RURAL & MINORITY Health Research Center

Charity B. Breneman, PhD • Jan M. Eberth, PhD • Janice C. Probst, PhD
University of South Carolina – Columbia, SC

Identification of High-Need Rural Counties to Assist in Resource Location Planning

- This report demonstrates how a relatively simple technique can be used to measure the level of potential health care need across communities.
- It illustrates how sorting counties by need can identify areas in greatest need of additional safety net providers and resources.

BACKGROUND

Analyses of location selection by healthcare providers in the U.S. are often retrospective, mapping the results of previous decisions. Examples include studies of the location choices of new physicians [1], freestanding emergency departments [2], and diabetes self-management educations programs [3]. These studies have generally documented that providers preferentially locate in urban, well-resourced areas, rather than areas with high rates of illness and/or low-income populations. Prospective analyses, which attempt to provide recommendations for future facility location based on need, are more common in situations where resources are administered through a central authority at the state or national level [4]. In the U.S., disaster management and emergency services use geospatial analyses for planning purposes, but generally employ computationally complex methodologies that may be difficult to implement [5, 6].

Findings briefs are produced 2-3 times/year on a variety of topics related to rural health and healthcare. Briefs are available at www.ruralhealthresearch.org.

Unique issues facing rural communities

DISPARITIES IN HEALTH

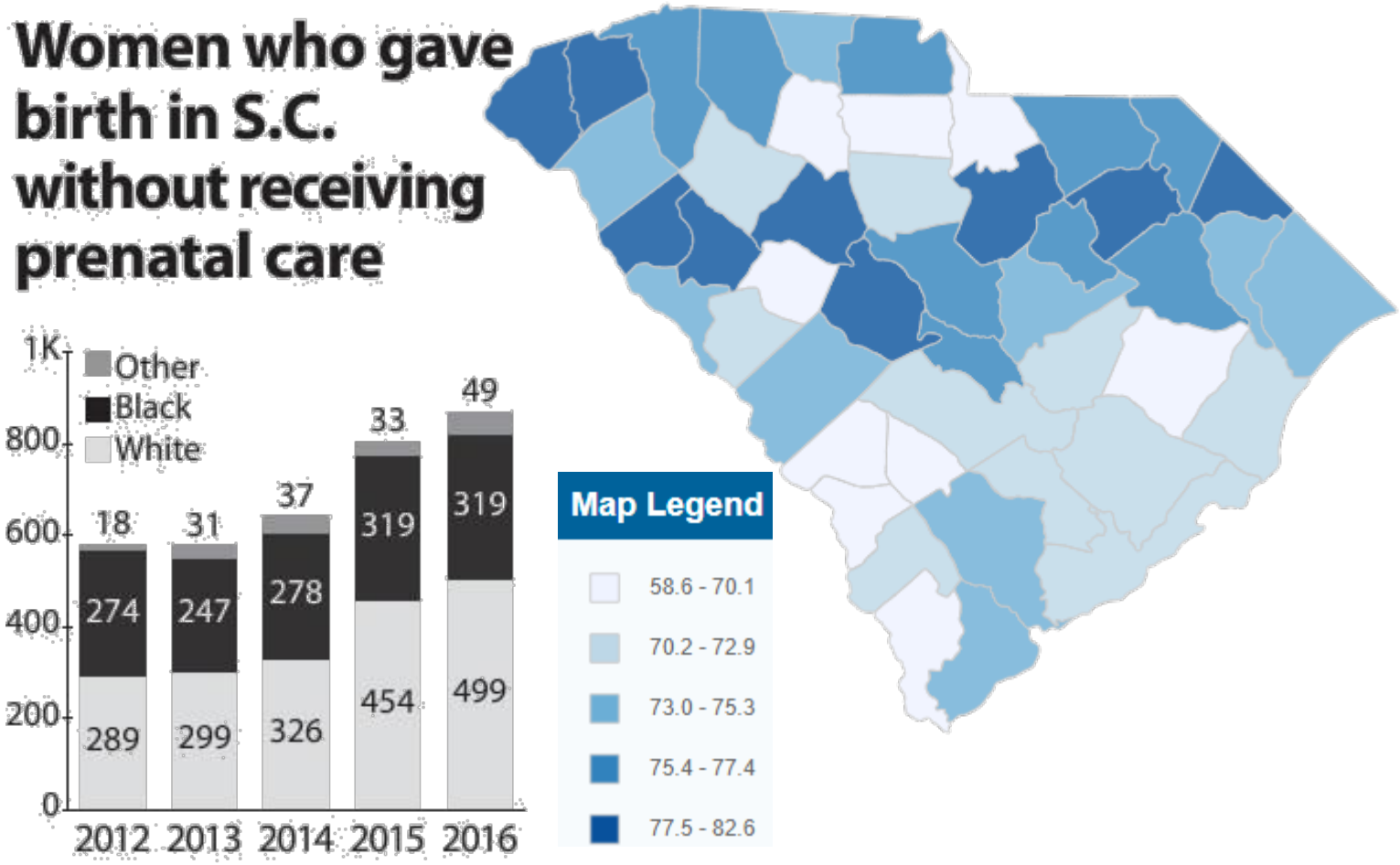
- Increased mortality rates
- Lower life expectancies
- Higher % of overweight adults
- Higher rates of pain and suffering
- Higher rate of teen births
- Higher rate of children hospitalized for unintentional injuries

DISPARITIES IN HEALTH CARE

- Geographic isolation
- Lower socio-economic status
- Higher rates of health risk behaviors
- Limited job opportunities
- Lack of health care coverage
- Higher % of adults who delay seeing a doctor due to cost
- Lower % of screening for cervical, breast, and colorectal cancers

Gaps to be addressed…
Prenatal Care

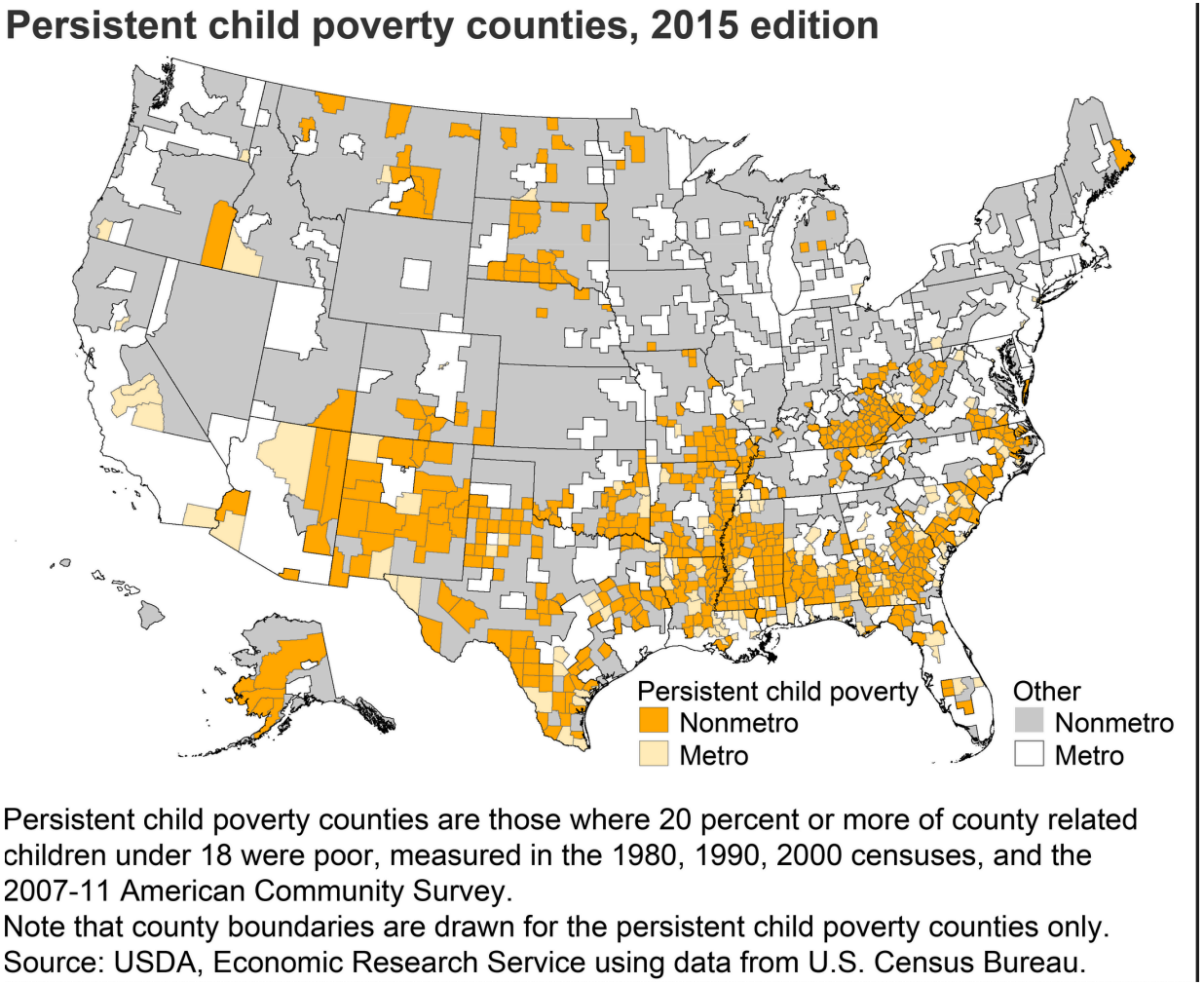
"More than **860** pregnant women gave birth in South Carolina last year having received no prenatal care — the highest number in more than 20 years"



Source: S.C. Department of Health and Environmental Control.
https://gis.dhec.sc.gov/chp/

There are 708 persistent child poverty counties.

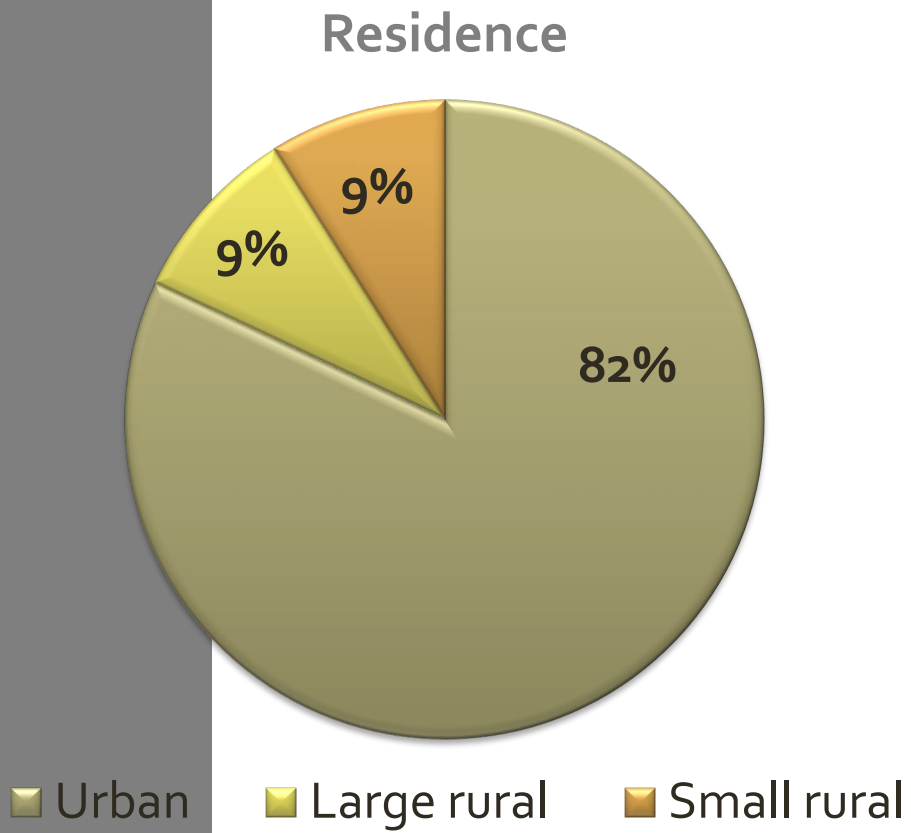
558 of them are rural.



Persistent child poverty counties are those where 20 percent or more of county related children under 18 were poor, measured in the 1980, 1990, 2000 censuses, and the 2007-11 American Community Survey.
Note that county boundaries are drawn for the persistent child poverty counties only.
Source: USDA, Economic Research Service using data from U.S. Census Bureau.

https://www.ers.usda.gov/data-products/county-typology-codes/descriptions-and-maps.aspx#pcpov

Nationwide:
Children by rural/urban residence



Urban: 58.9 million children
Large rural: 6.5 million children
Small rural: 6.4 million children

Children in rural areas

- Compared to urban children, rural children are:
  - less likely to be breastfed
  - more likely to be overweight or obese
  - more likely to live with someone who smokes
    - less likely to have preventative health & dental care
    - more likely to travel far for specialized care
    - more likely to require hospital readmissions
  - more **likely to die**, largely due to unintentional injury

Lots of bad news

- Infant Death Rates Are Higher in Rural America - but Not for All Causes
- Eroding Access and Quality of Childbirth Care in Rural US Counties
- Delivering rural babies: Maternity Care Shortages in Rural America
- A Shrinking Number of Rural Texas Hospitals Still Deliver Babies
- Rural Maternity Care Losses Lead to Childbirth Risks
- Diminishing Access to Rural Maternity Care and Associated Changes in Birth Location and Outcomes

Maternal and Child Health Collaborations

- Children's Trust Maternal, Infant, and Early Childhood Home Visiting Evaluation
- Community Support for Young Parents Evaluation
- Fact Forward

Maternal Infant and Early Childhood Visiting Program

ng

MIECHV was created under the 2010 *Affordable Care Act*

***Home visits** by a nurse, social worker, early childhood educator, or other trained personnel during early parenting improve the lives of children and families.*

RURAL & MINORITY Health Research Center

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Legislatively mandated benchmark measures

1. Improve maternal, newborn, and child health
2. Prevent child maltreatment & injury-related ER visits
3. Improve school readiness
4. Reduce crime and domestic violence
5. Improve family economic self-sufficiency
6. Improve coordination of community resources

Maternal Infant, and Early Childhood Home Visiting Program (MIECHV)

Aimed at breaking intergenerational patterns related to poverty, neglect, and poor health outcomes

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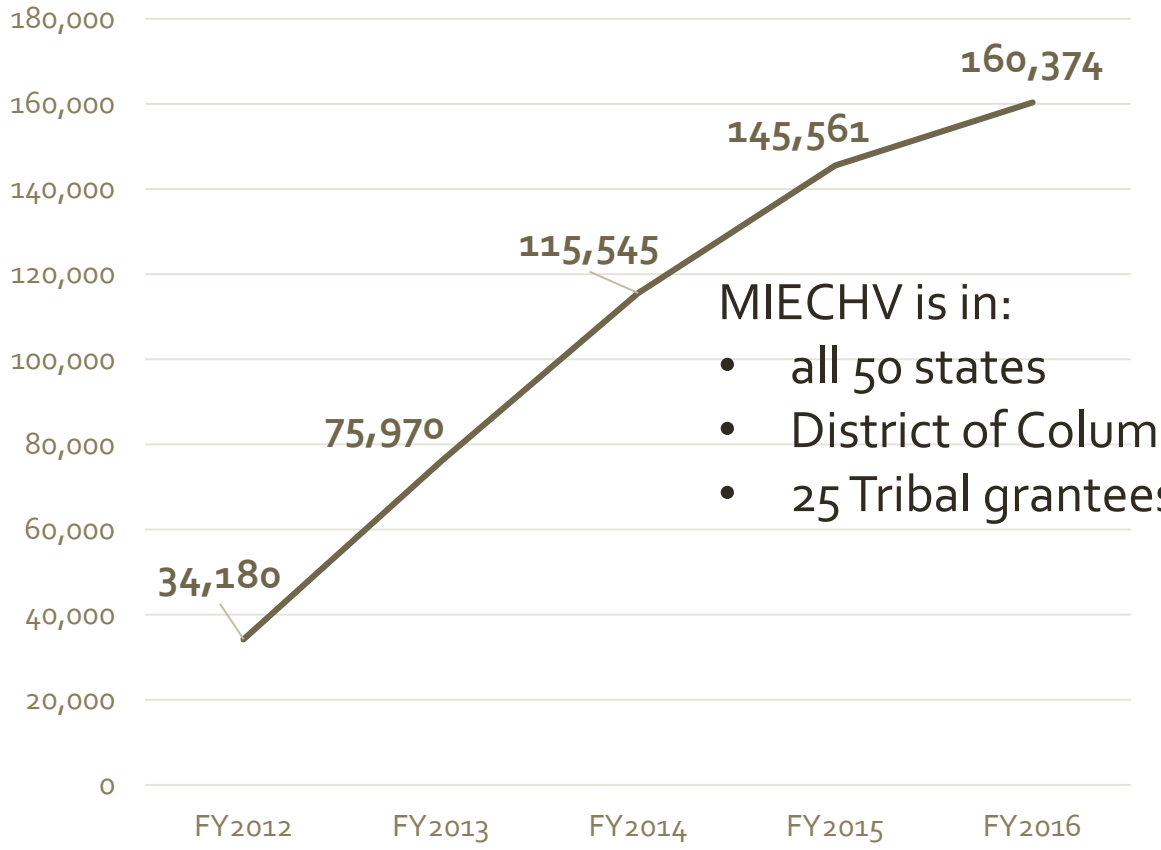
Number of children & parents served by MIECHV grantees, 2012-2016

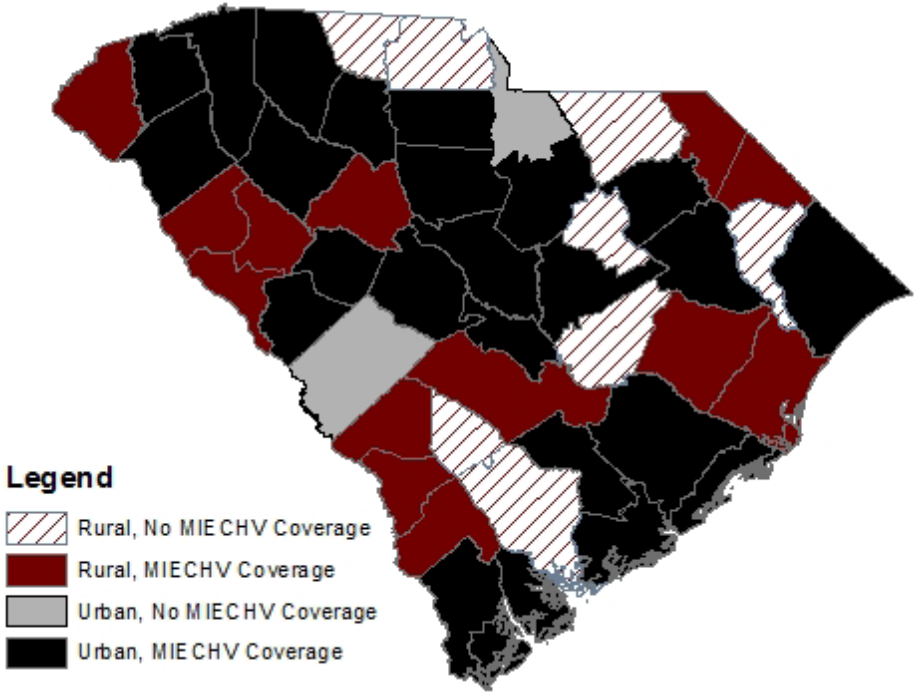


MIECHV is in:

- all 50 states
- District of Columbia
- 25 Tribal grantees

3.3 million home visits made in 2012-2016

HRSA, Maternal, Infant, and Early Childhood Home Visiting Program: Partnering with Parents to Help Children Succeed. (2017)



SC MIECHV: rural vs. urban coverage

2015

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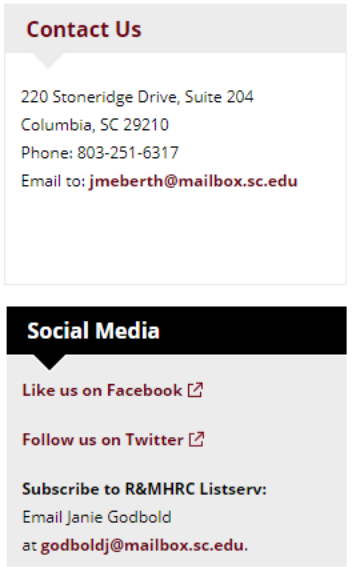
Questions and contact information

- The Rural and Minority Health Research Center receives funding from a variety of federal, state, and local grants and contracts including a cooperative agreement with the **Federal Office of Rural Health Policy**.



Contact Us

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RURAL & MINORITY Health Research Center

UNIVERSITY OF SOUTH CAROLINA

Live Healthy SC: The Blueprint for Achieving Health and Racial Equity across South Carolina




LIVE HEALTHY SOUTH CAROLINA

ALLIANCE FOR A HEALTHIER SOUTH CAROLINA

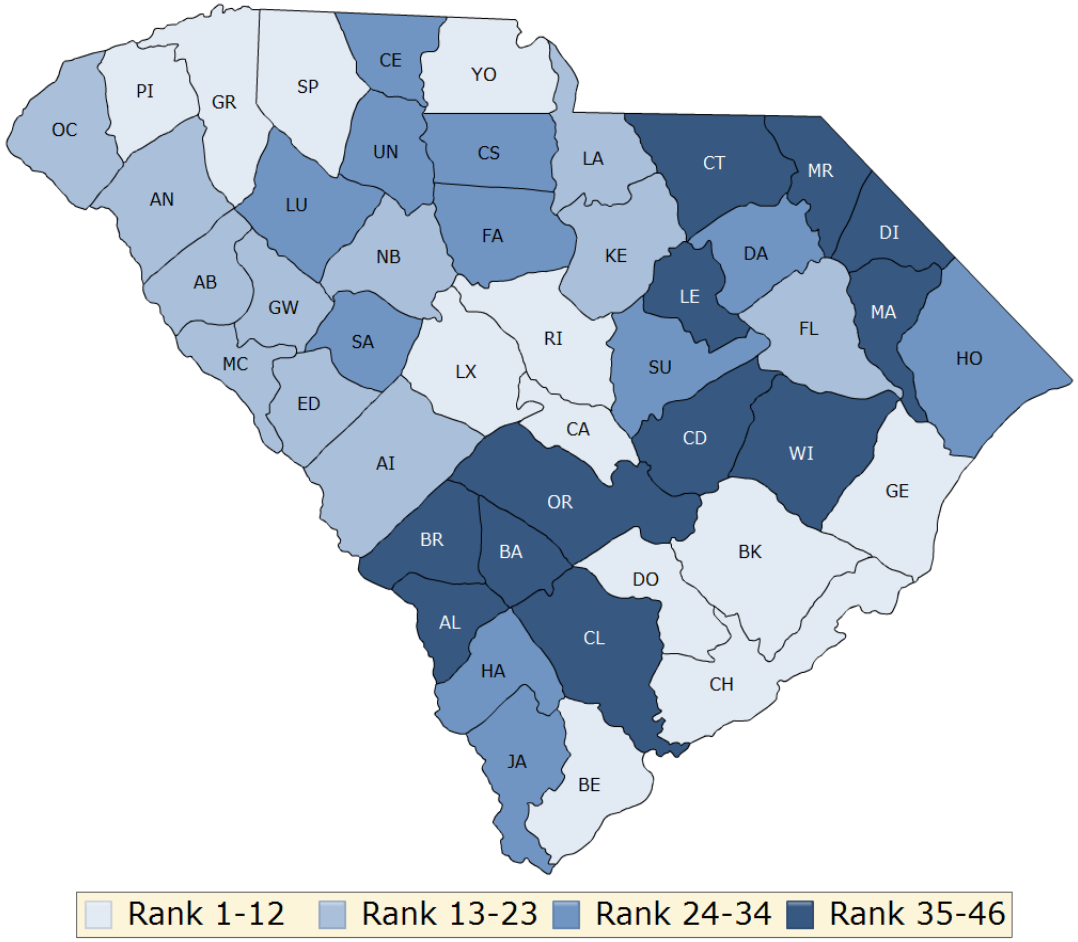
“THE TEST OF OUR PROGRESS IS NOT WHETHER WE ADD MORE TO THE ABUNDANCE OF THOSE WHO HAVE MUCH, IT IS WHETHER WE PROVIDE ENOUGH FOR THOSE WHO HAVE LITTLE.”

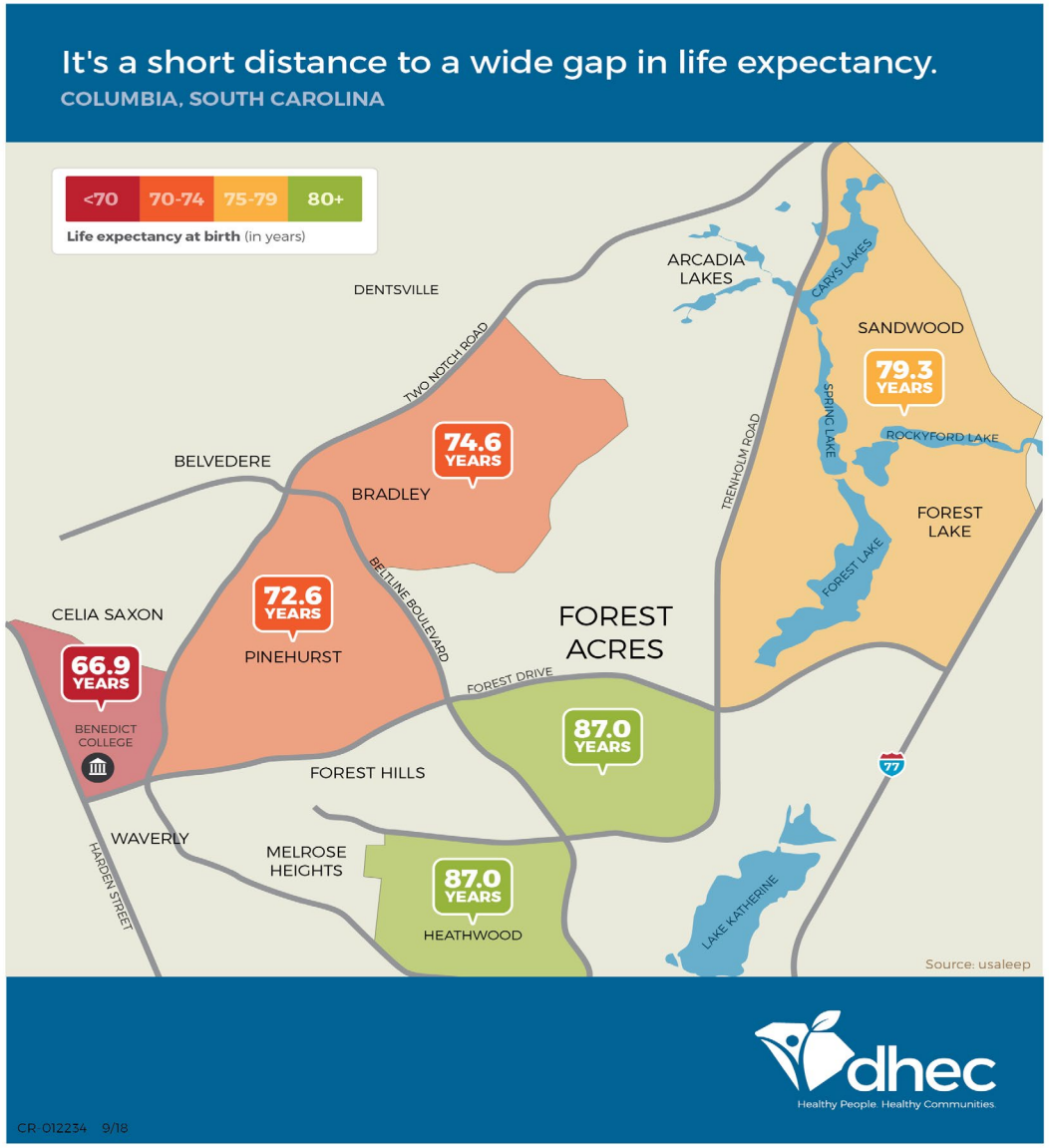
FRANKLIN D. ROOSEVELT

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**

- Health Outcomes Map

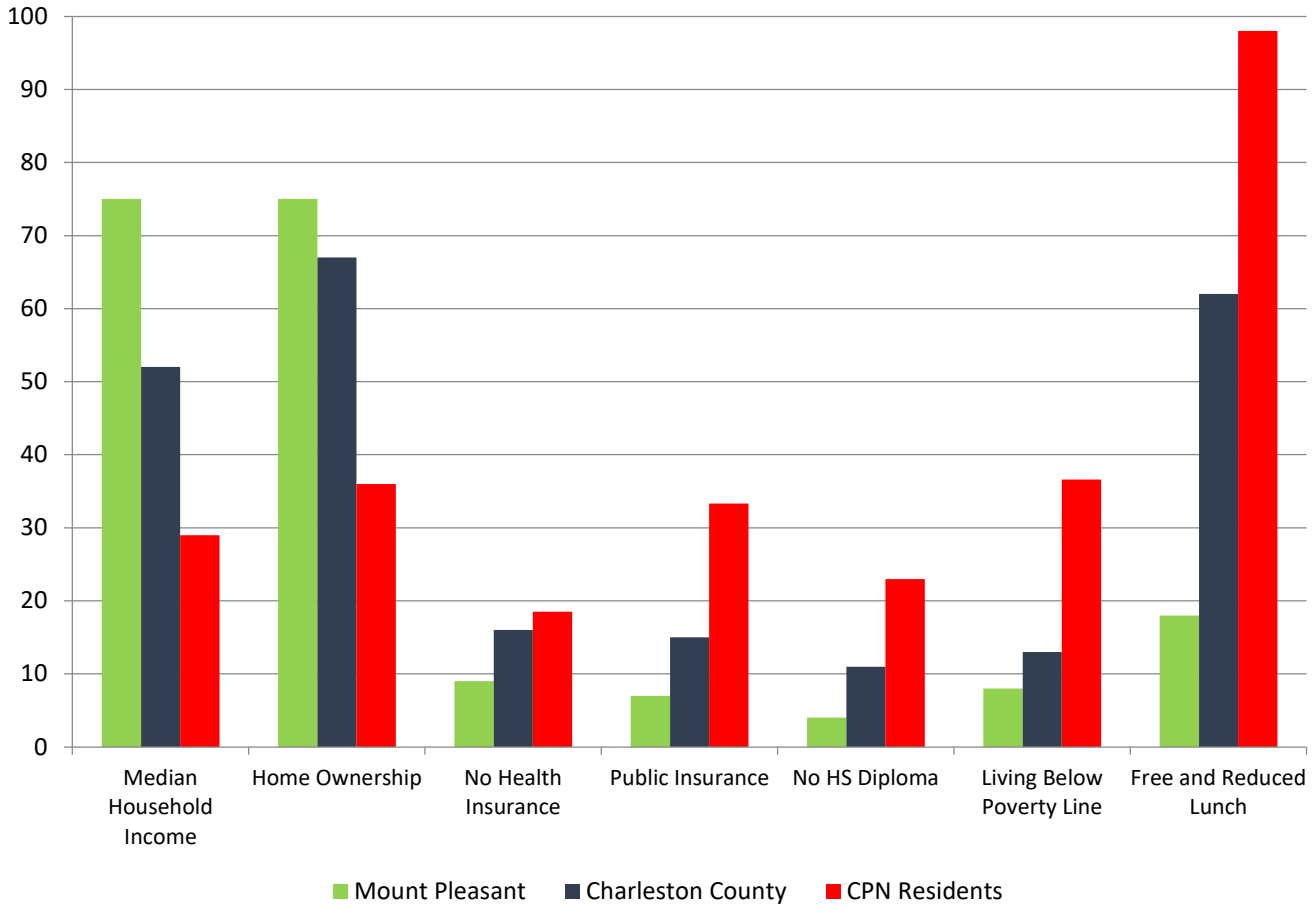




The Neighborhood and The Need

Area Comparison

Mt. Pleasant, Charleston County, CPN Neighborhood



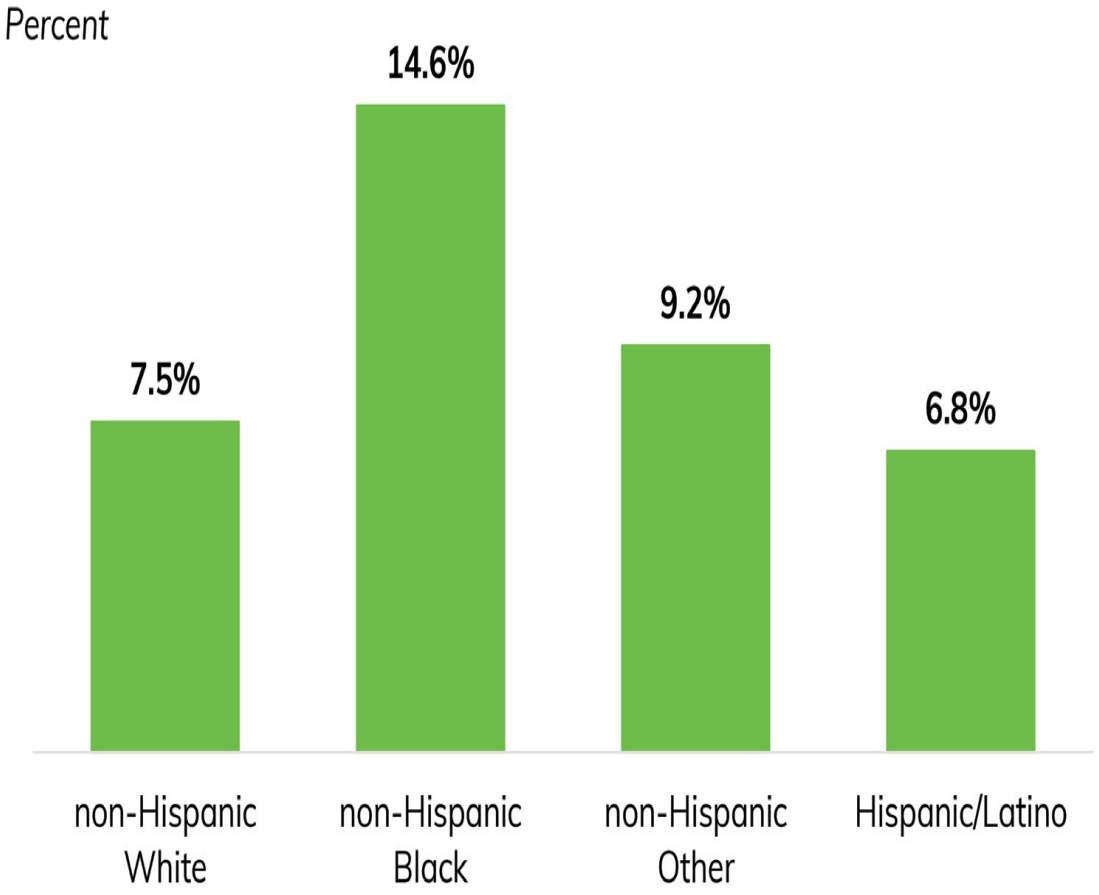
The 5.6 square mile area of CPN is marked by under-education, teenage pregnancy, poor healthcare, violent crime, unemployment, and intergenerational poverty. ***We aim to break that cycle.***

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

Specific Equity-Based Health Disparities

FIGURE 5.7

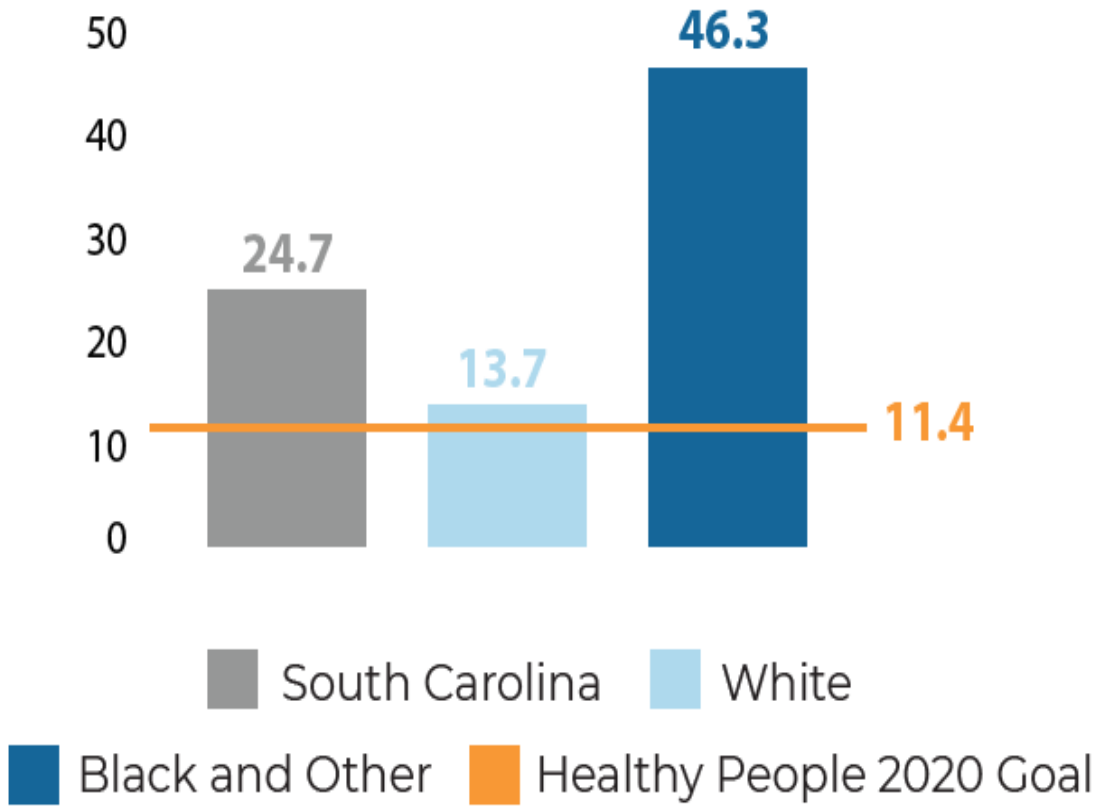
Low Birthweight, by Race/Ethnicity



Source: SC DHEC Vital Statistics, 2016.

South Carolina Pregnancy-Related Death by Race, 2013-2017[2]

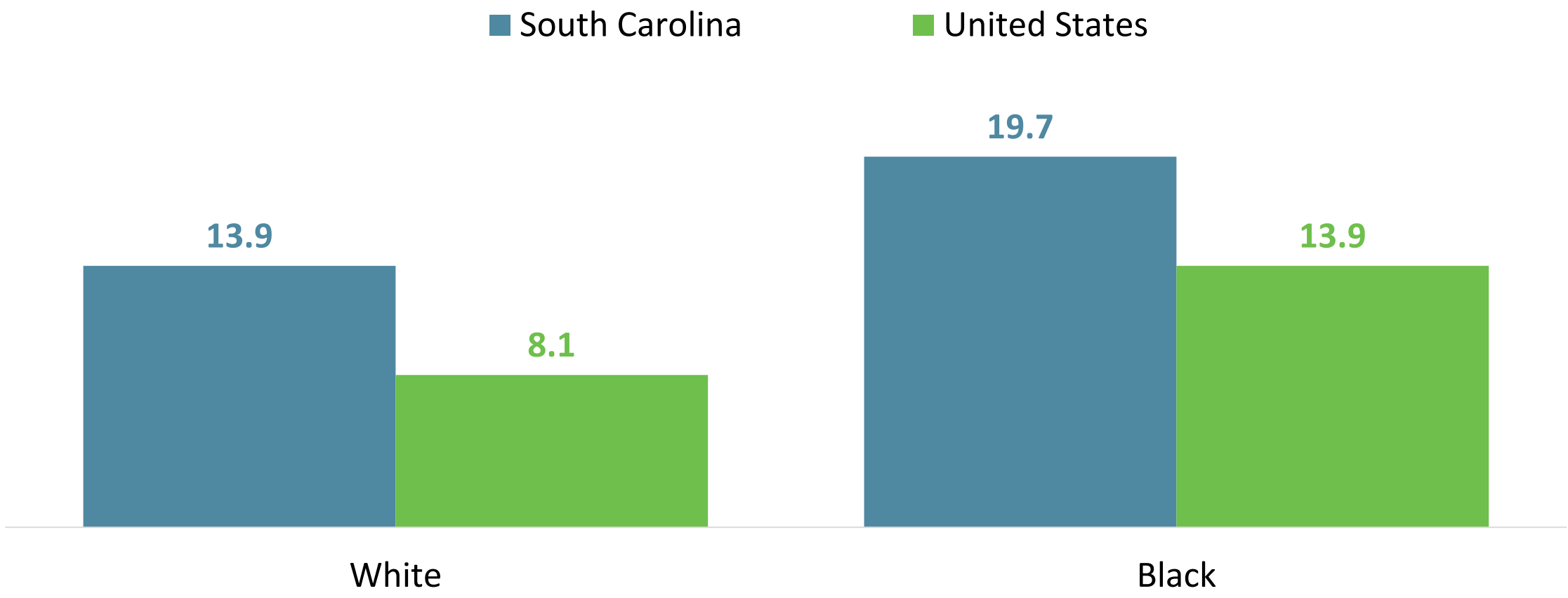
Rate per 100,000 live births



Specific Equity-Based Health Disparities

Nonfatal Child Maltreatment, by Race

Rate per 1,000

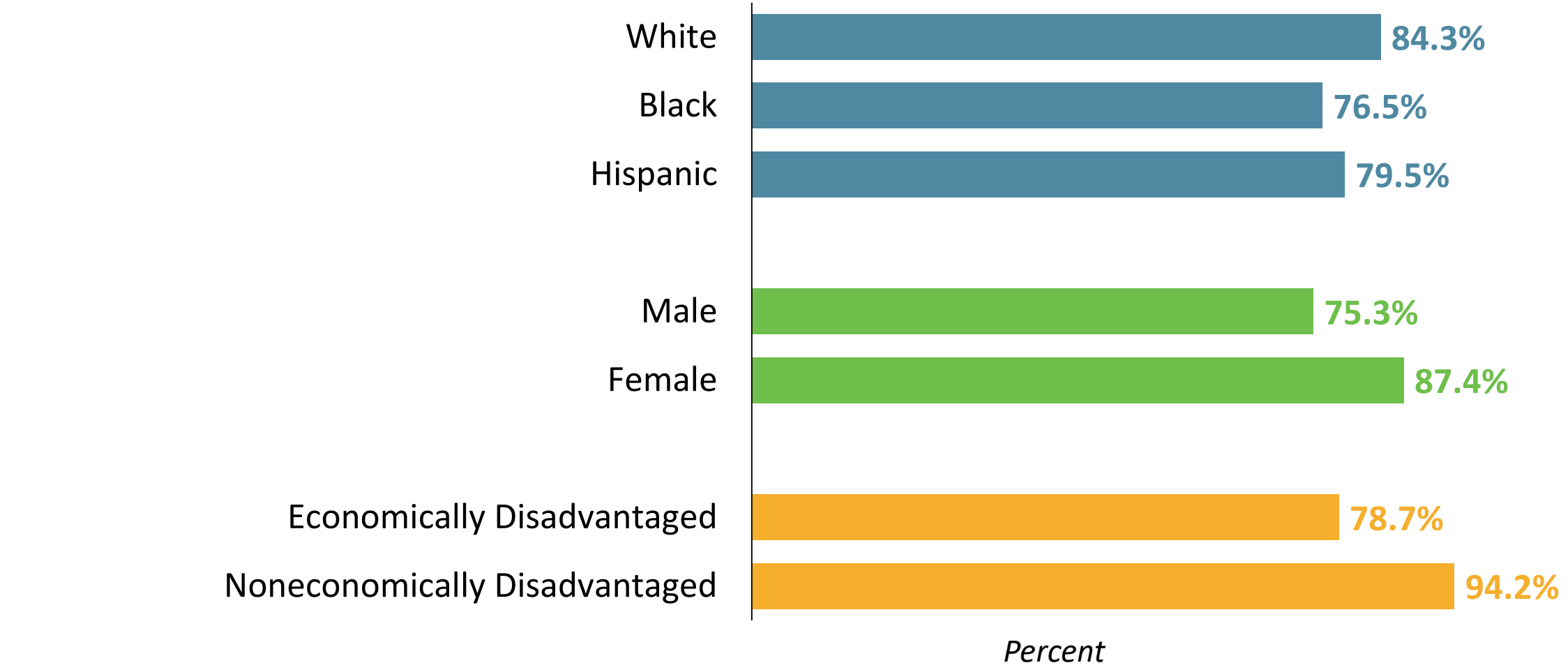


Source: National Child Abuse and Neglect Data System, 2017.
Note: Ages less than 18.

Specific Equity-Based Health Disparities

South Carolina Graduation Rate, by Demographics

Demographic Characteristic

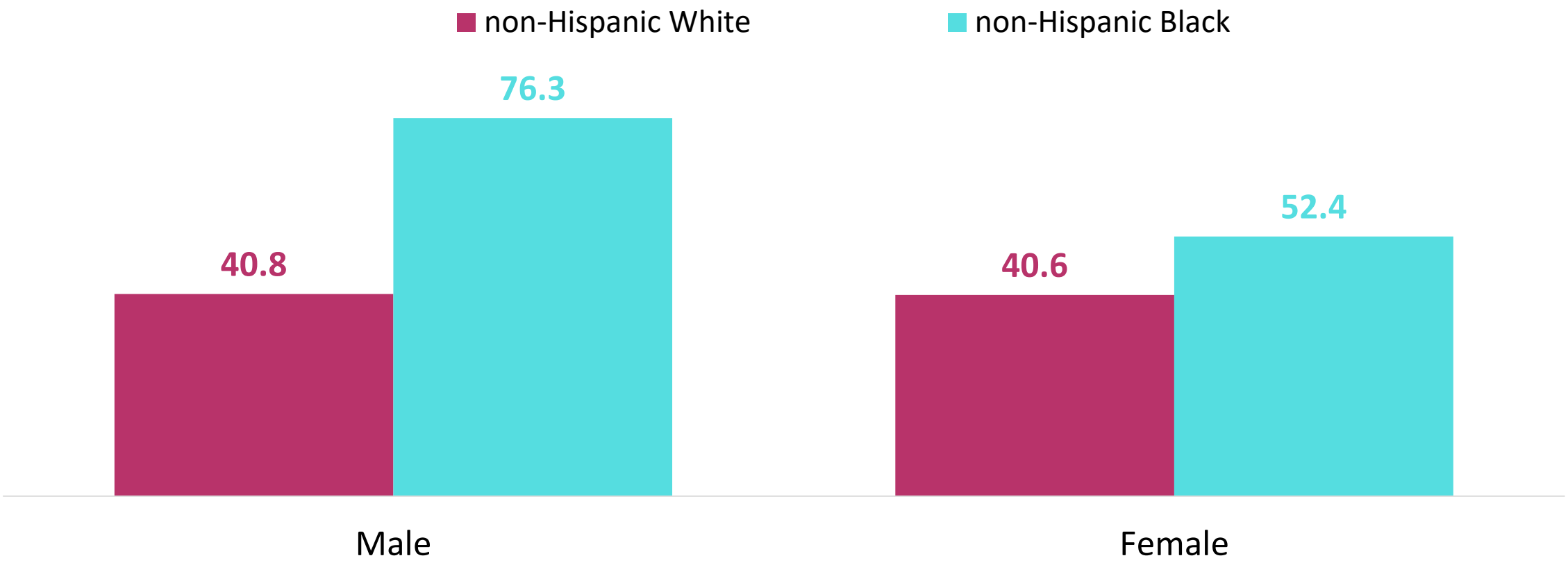


Source: SC Department of Education, 2019.

Specific Equity-Based Health Disparities

Stroke Deaths, by Race/Ethnicity and Sex

Rate per 100,000 population



Source: SC DHEC Vital Statistics, 2018.
Note: Age-adjusted.

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dhec
Healthy People. Healthy Communities.

LIVE HEALTHY SOUTH CAROLINA

ALLIANCE FOR A HEALTHIER SOUTH CAROLINA

SHARED PRIORITIES

- **Mission:**
  - Coordinating action on shared goals to improve the health of ALL people in South Carolina.

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

Healthy Babies

Improve the health of moms and babies from preconception through the first year of life

Healthy Minds

Improve access to appropriate behavioral health services and other necessary critical and support services

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

At a lower per-capita cost

Reduce the cost of care for every individual in the state

LIVE HEALTHY SOUTH CAROLINA

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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 to 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

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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”**


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#thisispublichealth

The Impact of Adverse Childhood Experiences in South Carolina

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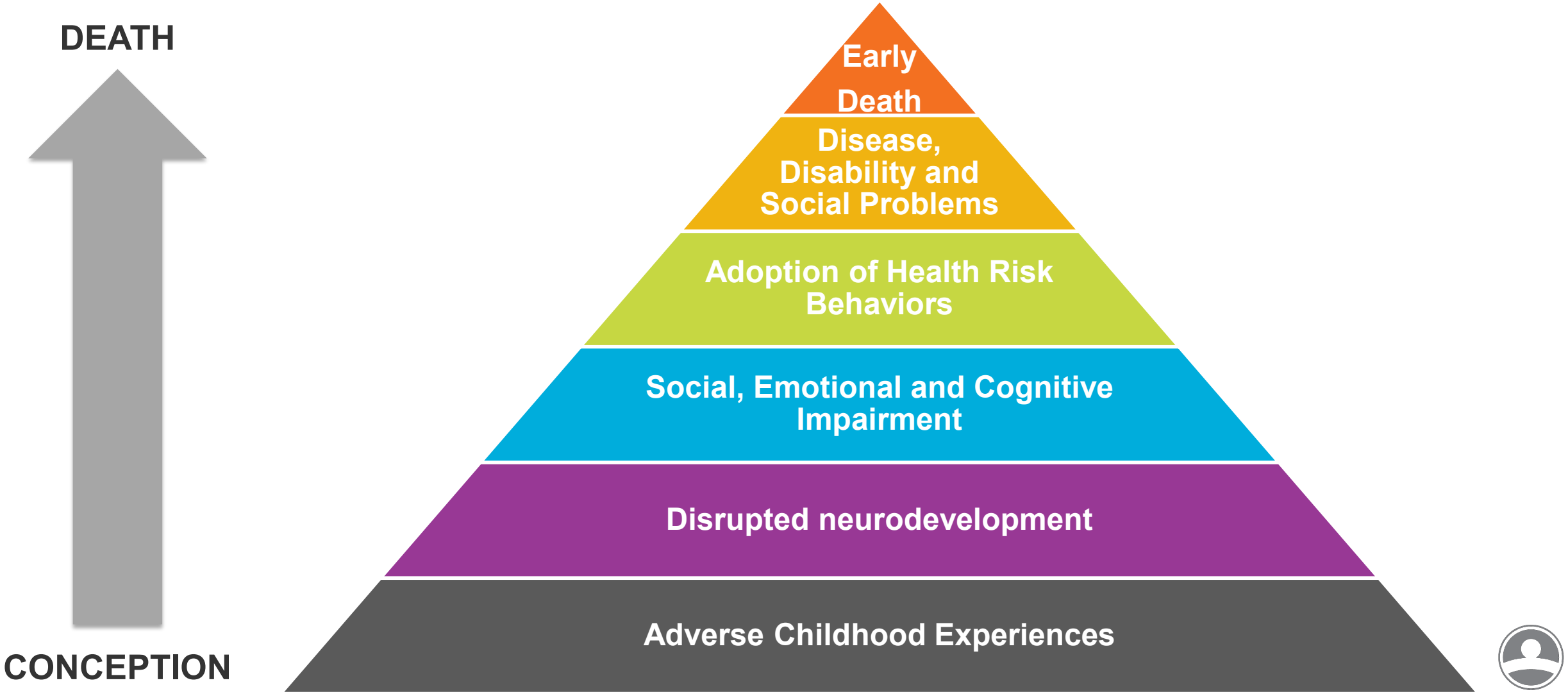
Children's Trust
OF SOUTH CAROLINA

U.S. Department of Health and Human Services. (2014). *Healthy People 2020*. Retrieved from http://www.healthypeople.gov/

The Original ACE Study



Adverse Childhood Experiences

Household Dysfunction

- Domestic violence
- Incarceration of a parent
- Mental illness in the household
- Substance use in the household
- Parent divorce/separation

Abuse

- Physical
- Emotional
- Sexual

Neglect

- Emotional
- Physical

ACE Score = Number of Yes's to Questions

Did you live with anyone who was depressed, mentally ill, or suicidal?

Did you live with anyone who was a problem drinker or alcoholic?

Did you live with anyone who used illegal street drugs or who abused prescription medications?

Did you live with anyone who served time or was sentenced to serve time in a prison, jail, or other correctional facility?

Were your parents separated or divorced?

Did your parents or adults in your home ever slap, hit, kick, punch, or beat each other up?

Did a parent or adult in your home ever hit, beat, kick, or physically hurt you in any way?

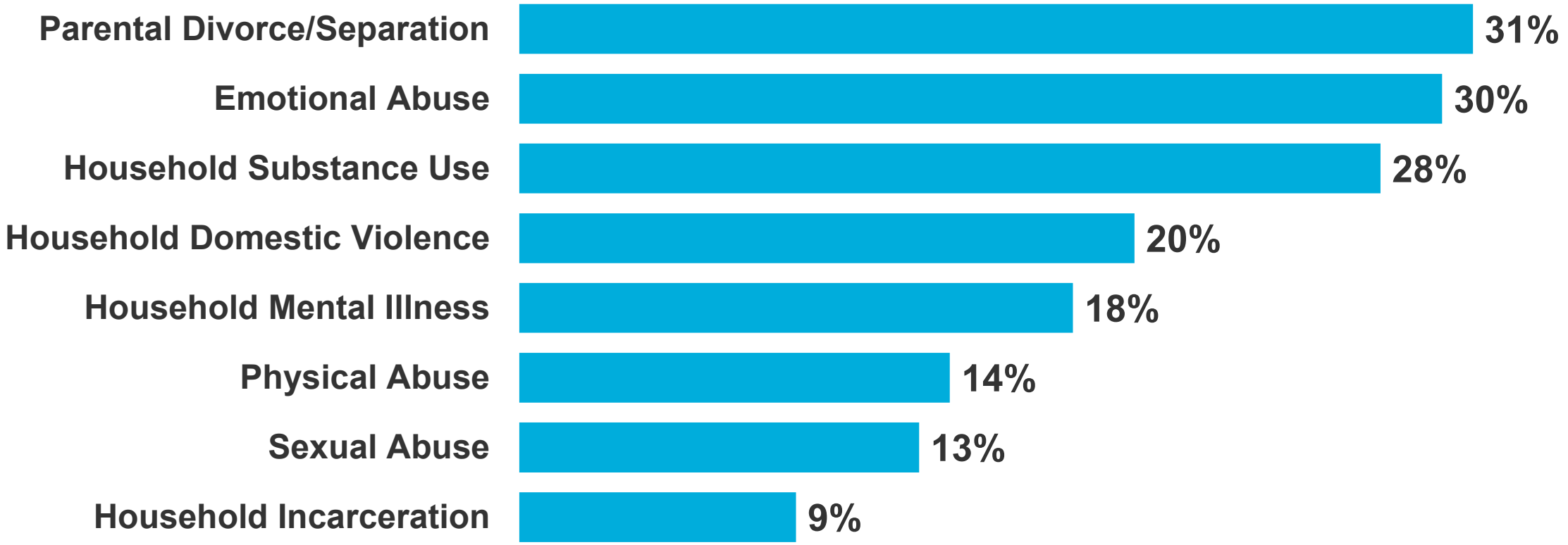
Key Findings of The CDC-Kaiser ACE Study

- ACEs are common (63%)
- ACEs are interrelated (87%)
- ACEs have a dose-response relationship with health and social outcomes

South Carolina ACE Data

Three in five South Carolinians report ACEs

ACEs are common in South Carolina

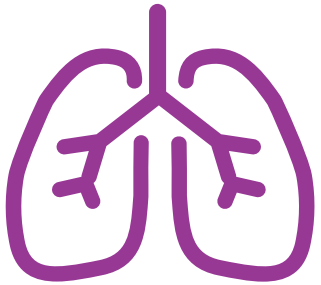


Lower income is associated with higher ACEs

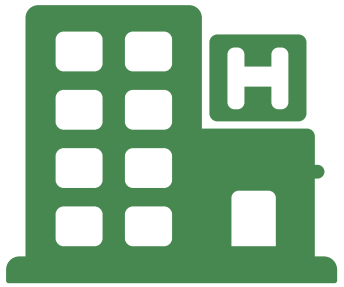
To understand the impact of ACEs, we can examine their links to:

Risk Behaviors

Mental Health



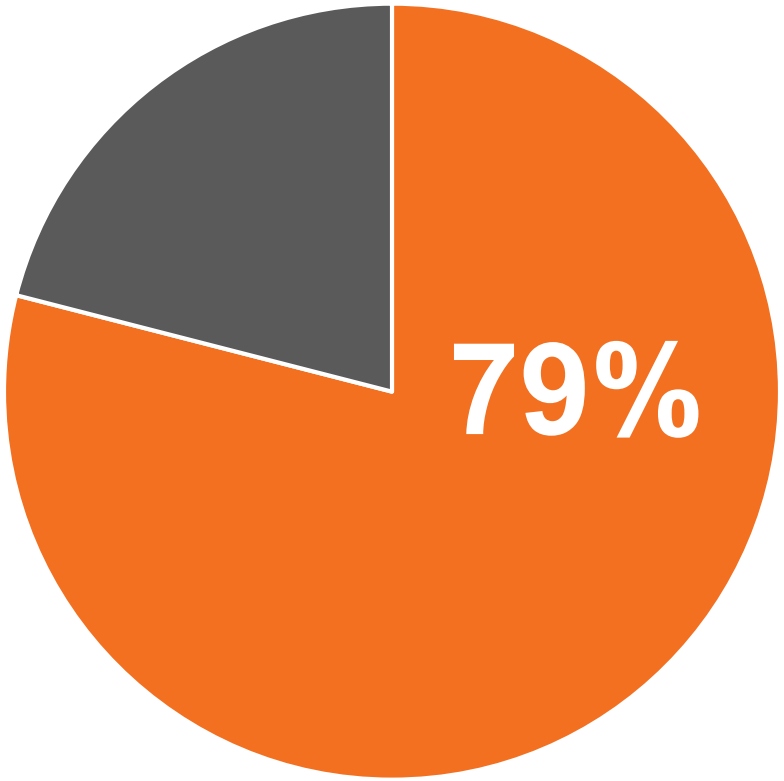
Chronic Disease



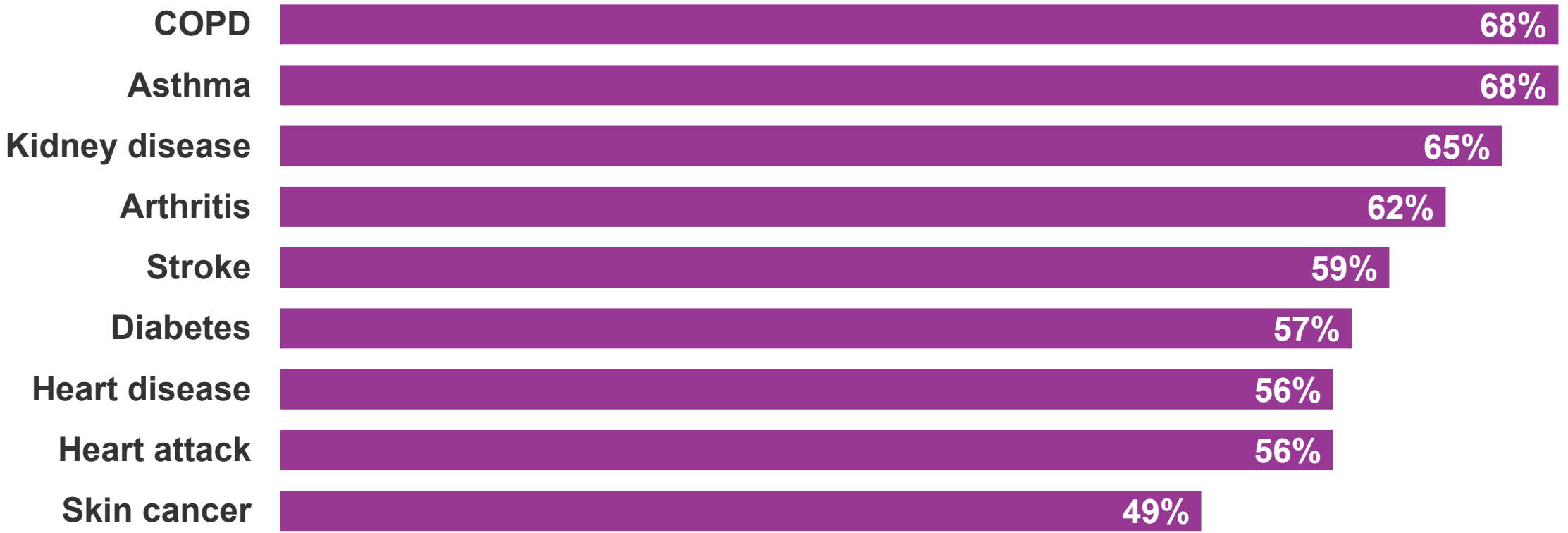
Healthcare Access

South Carolinians who engage in risky behaviors also report hi gh rates of ACEs

More than a majority of South Carolinians who report depressive disorder also report ACEs.



South Carolinians who report chronic physical health conditions also report high rates of ACEs



South Carolinians who report lack of access to healthcare also report high rates of ACEs.

Of the South Carolinians who reported ACEs, 88% reported more than one ACE.

ACEs are common, interrelated, powerful

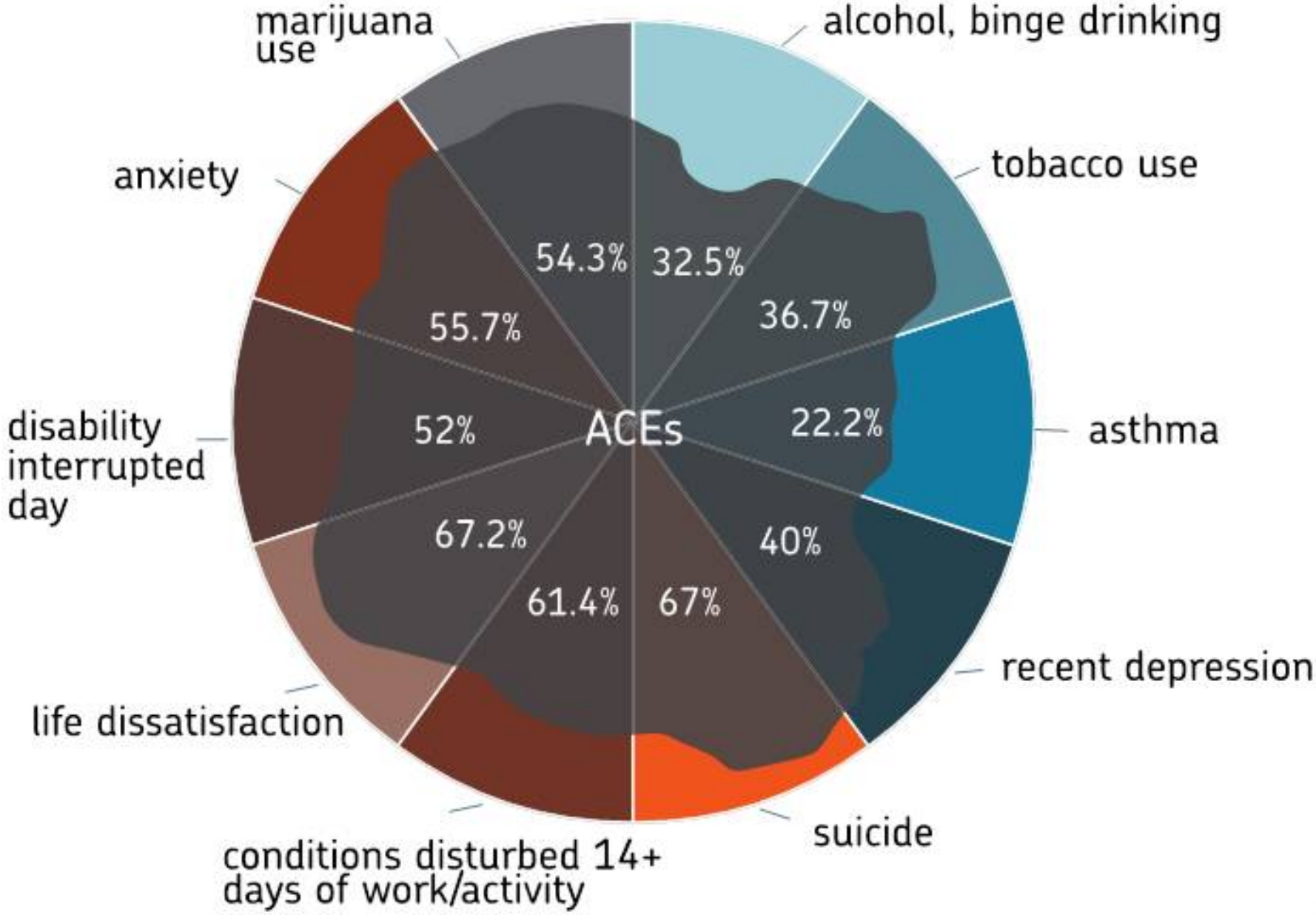
High ACE scores in population

Increased risk of multiple health and social problems

Opportunity for prevention

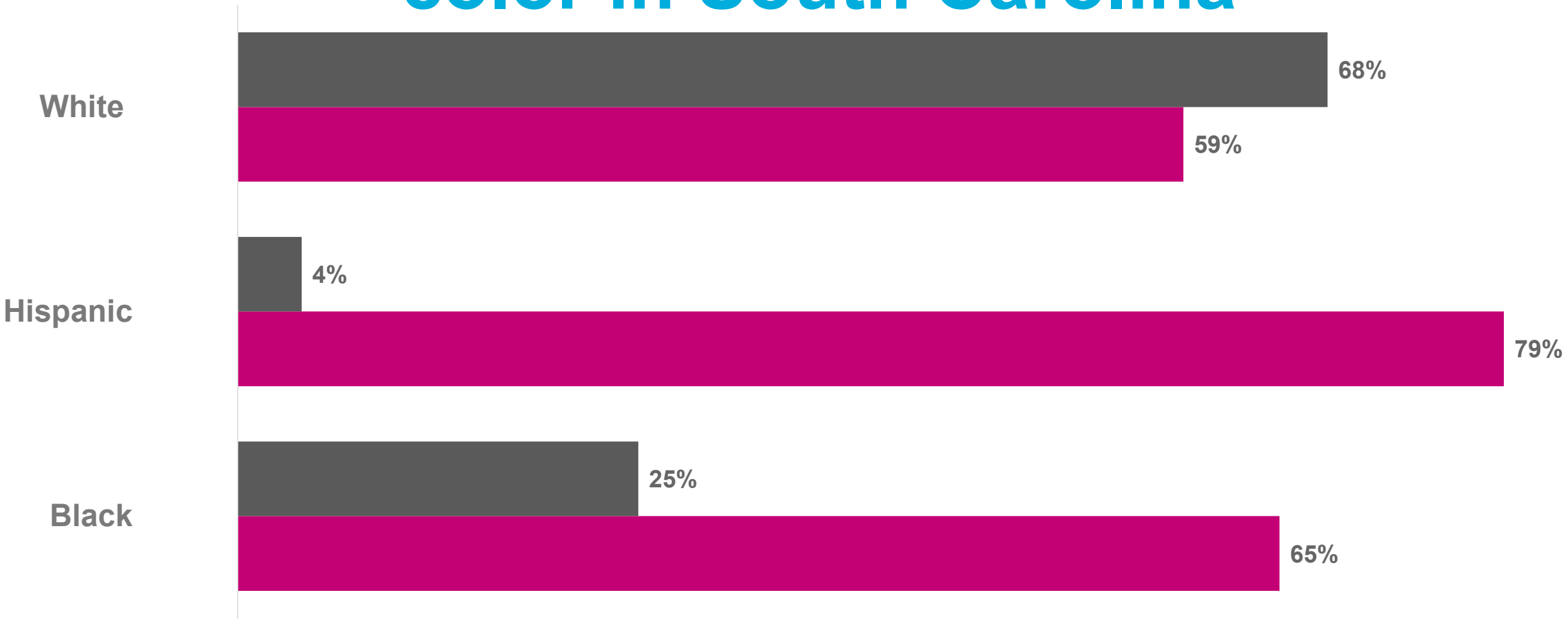
Impact of ACEs in South Carolina: Equity & Impact

Population Attributable Risk



Controls: gender, age, income, education, race-ethnicity

ACEs are more common among people of color in South Carolina



ACEs are Experienced Differently By People of Color in South Carolina

34%

of Hispanic adults report domestic violence in childhood

14%

of Black adults reported a parent being incarcerated in childhood

10%

Higher prevalence of health consequences associated with ACEs

DEATH

CONCEPTION

ACEs = Adverse Community Experiences?

Household Dysfunction

- Domestic violence
- Incarceration of a parent
- Mental illness in the household
- Substance use in the household
- Parent divorce/separation

Abuse

- Physical
- Emotional
- Sexual

Neglect

- Emotional
- Physical

Community Disadvantage

- Neighborhood violence
- Discrimination
- Lack of economic mobility
- Poverty

Three Keys to Resilience

Positive Self-view

Safe, stable, nurturing Relationships

Supportive, Equitable Community


RESILIENT COMMUNITY
Equitable Opportunity
• Adequate living wages
• Local wealth
• Quality education
People
• Strong social networks
• Trust
• Willingness to act for the common good
• Norms/culture that support health and safety
Place
• Safe parks and open spaces
• Arts and cultural expression
• Perceptions of safety
• Availability of healthy products
• Availability of quality housing
Increased well-being for individuals, families and communities


“Nothing that is worth doing can be achieved in our lifetime; therefore we must be saved by hope.”
-Reinhold Neibuhr

Thank you!

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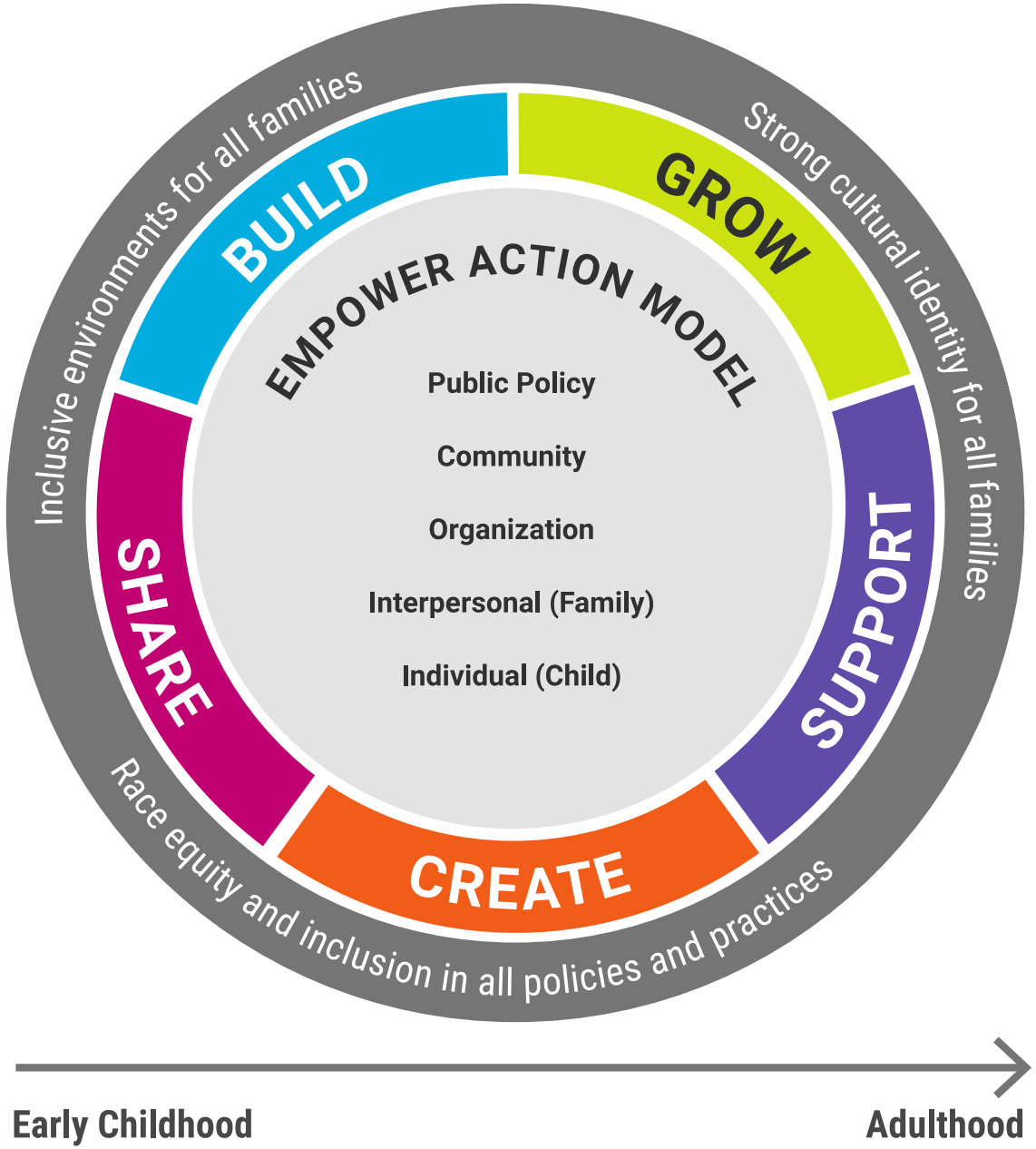

Empower Action Model™