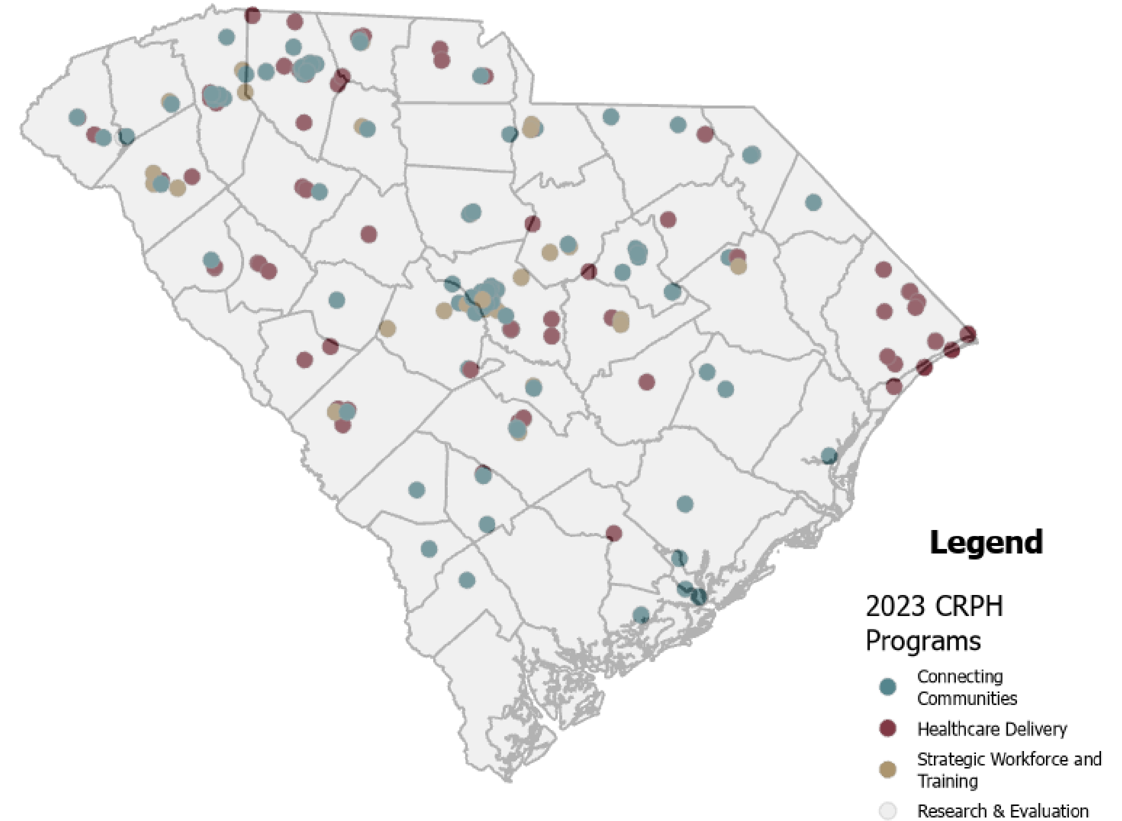
Collaborative Health
Communities

SC Center for Rural and Primary Healthcare

About Us

- Established in 2017 through a legislative proviso
- 63 actively funded programs
- Service locations in 40 counties in South Carolina
- 22,000+ patients served through CRPH programs in 2023 alone
- 1,000,000+ miles of travel saved for South Carolina's families to obtain quality specialty pediatric care

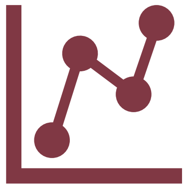


Accountable Health Communities

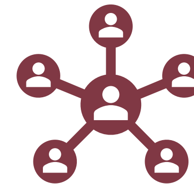
Nationally developed and tested model

Shared goals and collaborative leadership

Universal standardized screening

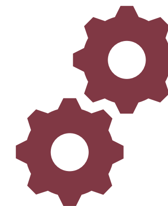


Data-driven decisions and meaningful outcomes



Intentional navigation, coordination, and support

Accountability and alignment across partners



Strengthening network capacity and infrastructure

Collaborative Health Communities

Rural Health Transformation Pilot

Guiding Principles	
Capacity Building - evolving the existing systems and infrastructures to better serve their community	**Community Driven** - Communities are the primary decision-makers of what services are needed and how it happens
Accountability - all agencies have an obligation to the health and wellbeing of their community	**Accessible** - access to services and support that match patient and community needs
Sustainable - recognition that systems need to be built and flexible to evolving payment models	**Multisector Collaboration -** adaptable and collaborative partners that include healthcare systems, community-based organizations, and local human service agencies that provide a seamless system of services for communities
Evidence Informed Action – emphasizing data-driven decision making and leveraging evidence-informed practices and strategies while adapting through continuous quality improvement	**Equitable** - services that respect and value the differences of community members by actively identifying and removing barriers, including structural barriers, to ensure that historically marginalized groups have the same opportunity to optimize health

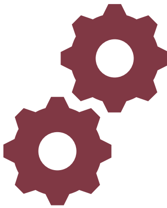
Collaborative Health Communities

Rural Health Transformation Pilot

Collaborative priorities

Shared investment and shared accountability

Structured coordination and alignment



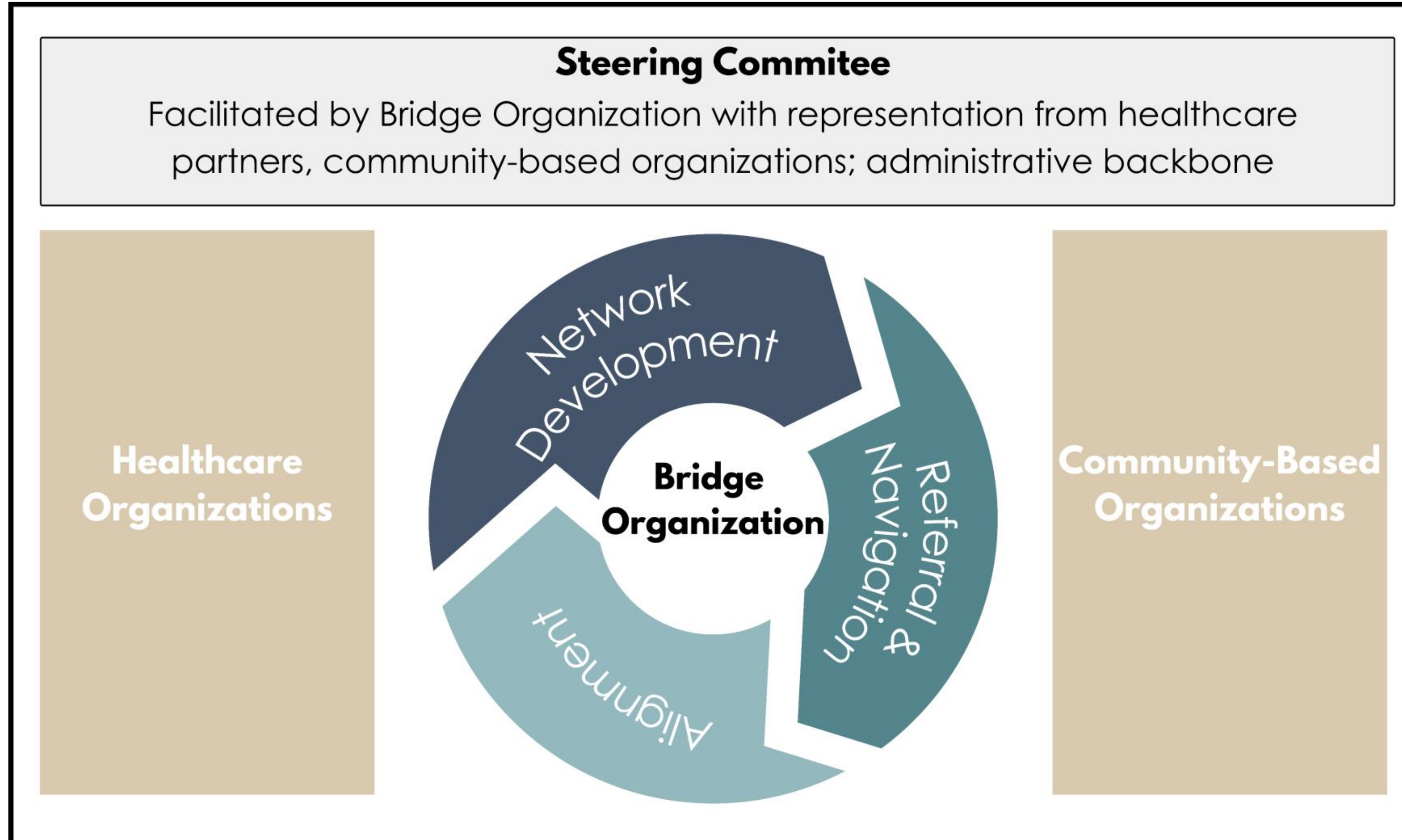
Meaningful capacity building

Built locally

Continuous shared learning

Collaborative Health Communities

Creating a Stronger System of Care

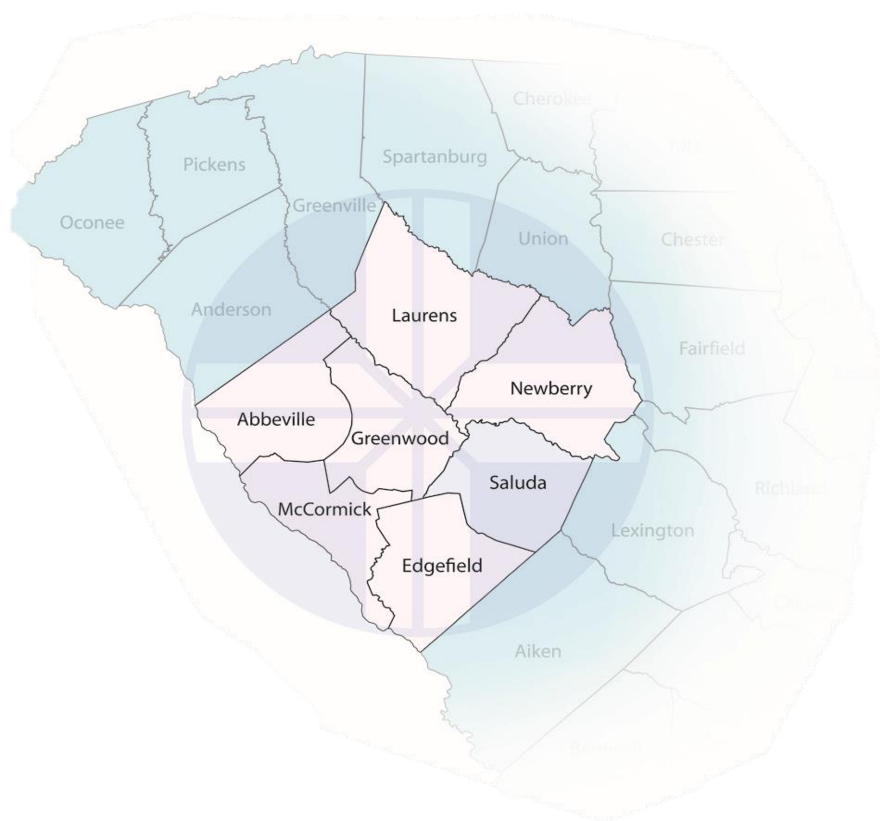


Collaborative Health Communities

In Action

Guided Beginnings

Navigating Health and Hope for Mothers and Babies



Oconee
Pickens
Greenville
Spartanburg
Cherokee
Union
Chester
Anderson
Laurens
Fairfield
Newberry
Abbeville
Greenwood
Saluda
McCormick
Lexington
Edgefield
Aiken

SELF REGIONAL HEALTHCARE
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SELF REGIONAL HEALTHCARE
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EDGEFIELD COUNTY HOSPITAL

Guided Beginnings Program Overview

Guided Beginnings is a Collaborative Health Community (CHC) with a dedicated perinatal program designed to support high-risk pregnant mothers and their babies through the baby's first year. Operating in Greenwood and Abbeville Counties (for now), our team of perinatal-trained Community Health Workers (CHWs) and social workers are committed to providing comprehensive care that addresses both clinical and social needs through the CHC network.

Key Components of the Program:

Clinical Navigation

Social Support

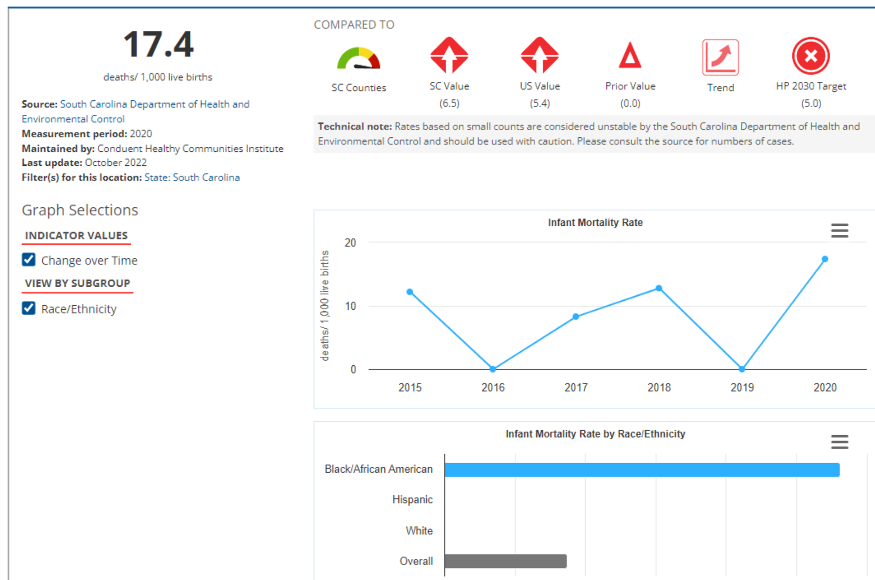
Education

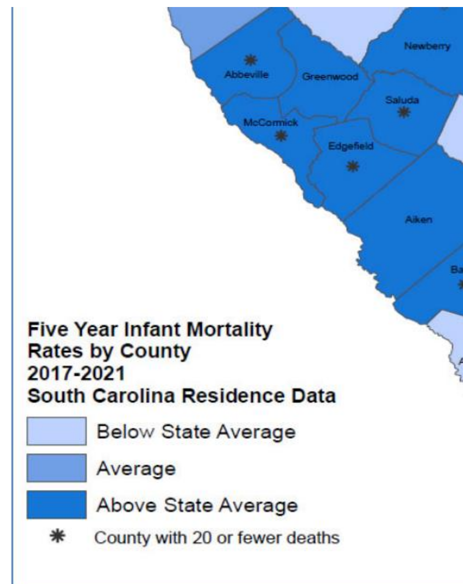
Collaborative Health Communities Steering Committee

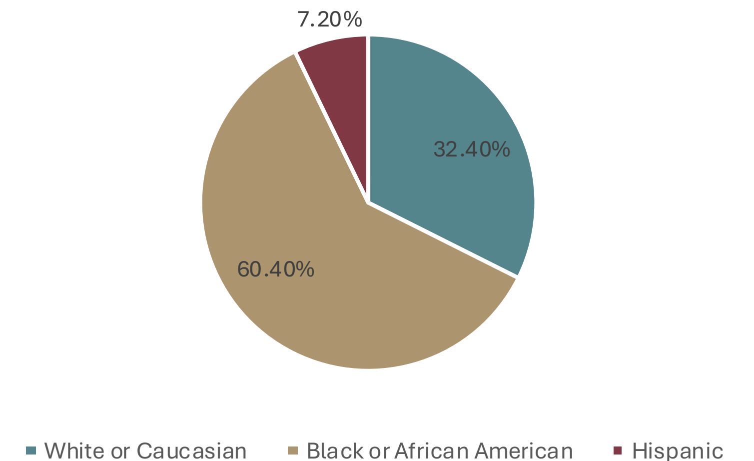
Data Driven Decisions

Latest South Carolina Infant, Maternal Mortality Reports Reveal Alarming Trends

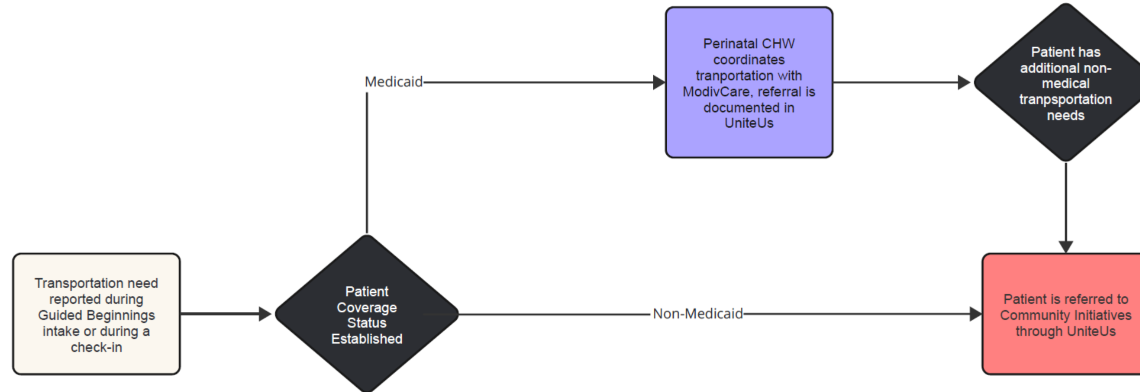
SCDHEC
APR 26, 2023

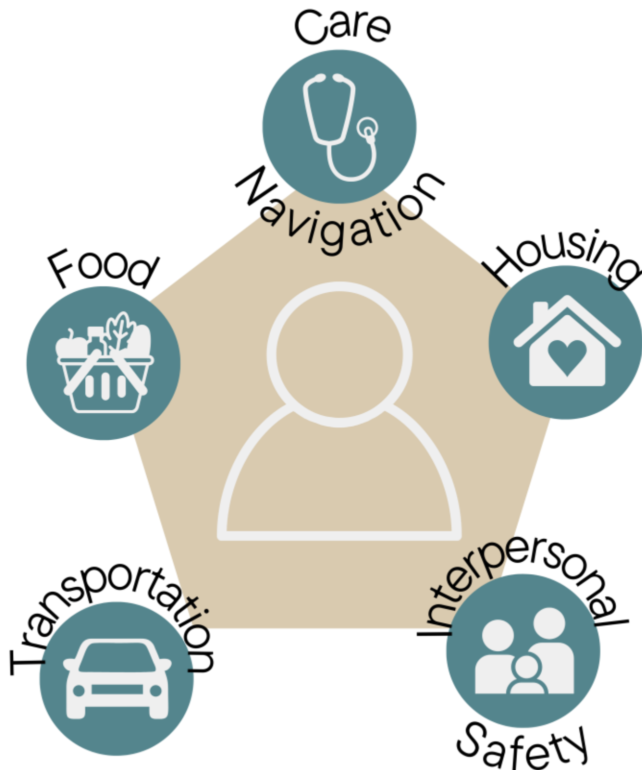






Shared Coordination





Collaborative Health Communities – Lakelands
Health-Related Social Needs Screening Tool Draft

	Yes	No
Food		
1. Within the past 12 months, did you worry that your food would run out before you got money to buy more?		
2. Within the past 12 months, did the food you bought just not last and you didn't have money to get more?		
Housing/ Utilities		
3. Within the past 12 months, have you ever stayed: outside, in a car, in a tent, in an overnight shelter, or temporarily in someone else's home (i.e. couch-surfing)?		
4. Are you worried about losing your housing?		
5. Do you have any concerns about the current conditions or safety of your housing?		
6. Within the past 12 months, have you been unable to get utilities (heat, electricity) when it was really needed?		
Transportation		
7. Within the past 12 months, has a lack of transportation kept you from medical appointments or from doing things needed for daily living?		
Interpersonal Safety		

Clinical Integration

First Trimester

	Week 6	Week 7	Week 8	Week 9	Week 10	Week 11	Week 12	Week 13
Visits	Initial visit: Medical history, LMP established, family history, physical exam, labs						Prenatal Visit	
Milestones	Establishing care, confirming pregnancy	Ultrasound, nuchal translucency scan, non-invasive prenatal screening						
Hypertension	Baseline labs: comprehensive metabolic panel, PC ratio, CBC; medication management; early dating; start RPM; preeclampsia risks and education; kick counts							
Diabetes	Baseline labs: check for risk of superimposed preeclampsia							
Guided Beginnings	Initial referral, risk stratification, HRSN screening and referrals, in-person home visit, “what to expect” resource sharing/visit map							

Second Trimester

	Week 14	Week 15	Week 16	Week 17	Week 18	Week 19	Week 20
Visits			Prenatal Visit				Prenatal Visit
Milestones							Anatomy scan ultrasound
Hypertension							Anatomy scan – potentially MFM
Diabetes							
Guided Beginnings		Check In				Check In	

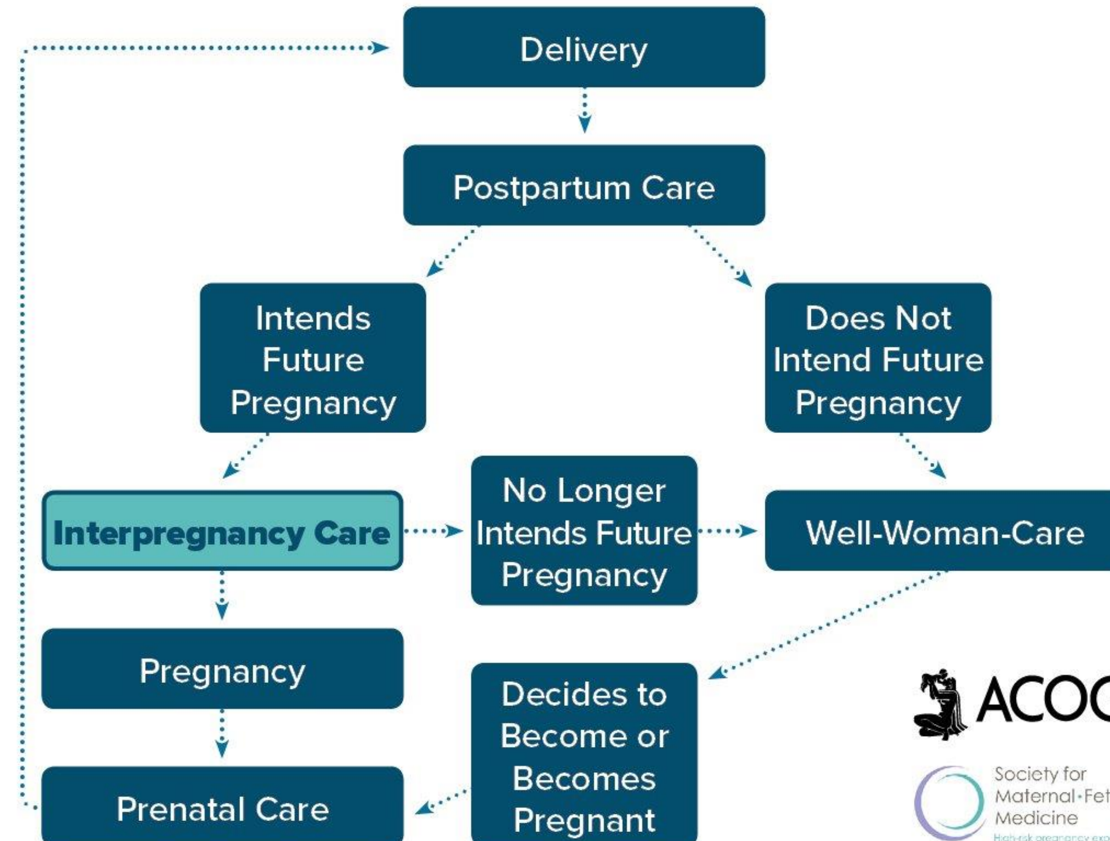
	Week 21	Week 22	Week 23	Week 24	Week 25	Week 26	Week 27
Visits				Prenatal Visit			
Milestones				Glucose Challenge Test and follow-up 3 hour Glucose Tolerance Test if needed (aim for 26-28 weeks)			
Hypertension							
Diabetes							
Guided Beginnings				Check in around GCT/GTT dates and process			

Third Trimester

	Week 28	Week 29	Week 30	Week 31	Week 32	Week 33	Week 34
Visits	Prenatal Visit		Prenatal Visit		Prenatal Visit		Prenatal Visit
Milestones	Tdap, hemoglobin						
Hypertension	Check in labs				NST and biophysical profile, Ultrasound	NST and biophysical profile	NST and biophysical profile
Diabetes	Check in labs				NST and biophysical profile, Ultrasound	NST and biophysical profile	NST and biophysical profile
Guided Beginnings	Check in					Check in, pediatrician prep	

	Week 35	Week 36	Week 37	Week 38	Week 39	Week 40	Week 40+
Visits		Prenatal Visit	Prenatal Visit	Prenatal Visit	Prenatal Visit	Prenatal Visit	Prenatal Visit
Milestones		GBS Test	Early Term Birth	Early Term Birth	Full Term Birth, Potential induction based on risk	Full Term Birth	Late Term Birth, Weekly ultrasound and NTS, Potential induction
Hypertension	NST and biophysical profile	NST and biophysical profile, Ultrasound	Typical Induction				
Diabetes	NST and biophysical profile	NST and biophysical profile, Ultrasound	NST and biophysical profile, Ultrasound, Engage with MFM if diabetes is poorly controlled	Typical Induction			
Guided Beginnings	Check in						

Transition to Medical Home



Interpregnancy care. ACOG. (2021). https://www.acog.org/clinical/clinical-guidance/obstetric-care-consensus/articles/2019/01/interpregnancy-care

Data Collection and Measures

Outcome Measures	Process Measures
Prenatal	**Program Referrals and Enrollment**
Early and adequate prenatal care (Kotelchuck/APNCU Index) (HEDIS)	Number of referrals to bridge organization
Birth	**Care Management**
Preterm births (QAP)	Number of patient encounters
Low birth weight (QAP)	**Health-Related Social Needs**
Postpartum	Number of screenings (QAP)
Maternal morbidity	Number of patients with needs identified (QAP)
Maternal mortality	
Infant mortality	
Health-Related Social Needs	
Food and nutrition security	
Quality of Care	
Perception of Respectful Maternity Care	

Program Outcomes

Improve	Enhance	Empower
Improve Maternal and Infant Health Outcomes: By providing integrated clinical and social support, we aim to reduce preterm births, low birth weight, and maternal and infant mortality rates.	Enhance Access to Care: Ensuring that high-risk pregnant women have access to comprehensive healthcare services and social support.	Empower Families: Empowering mothers with the knowledge and resources they need to care for their babies and themselves.

Contact

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