

SOUTH CAROLINA

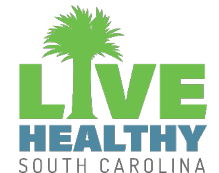
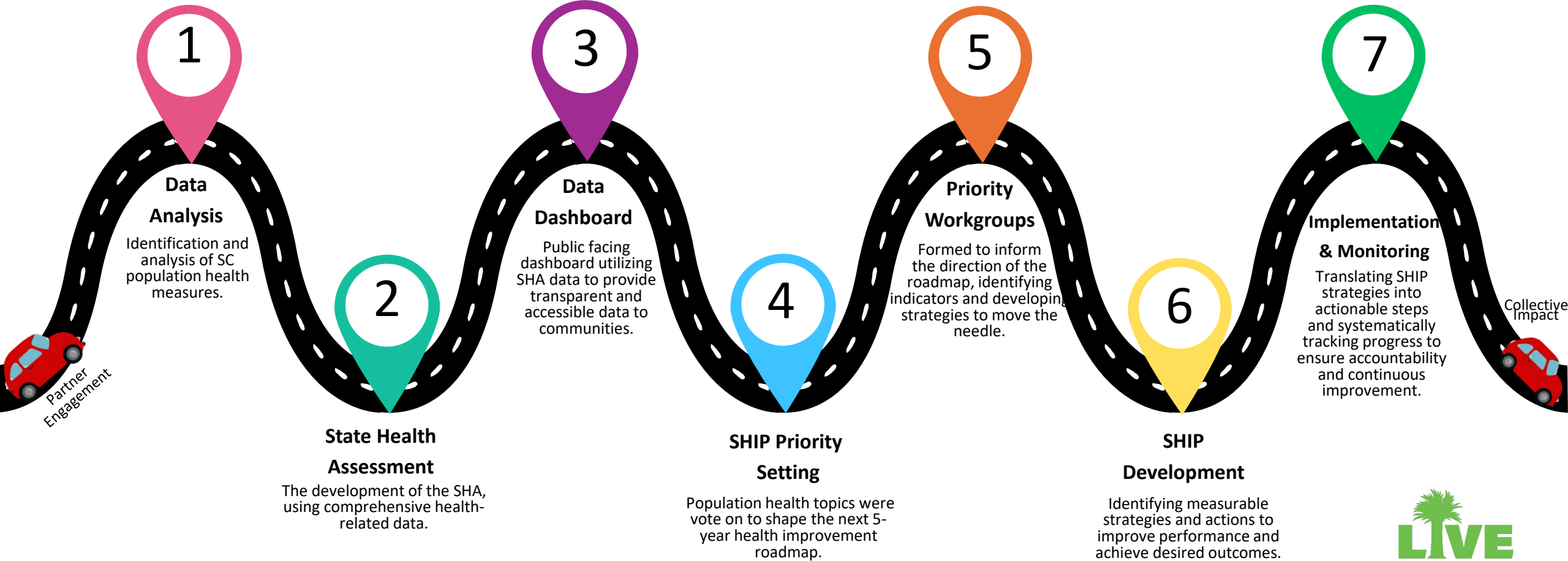
**State Health Improvement Plan**

SC Medical Association  
April 2026





# Live Healthy South Carolina Process



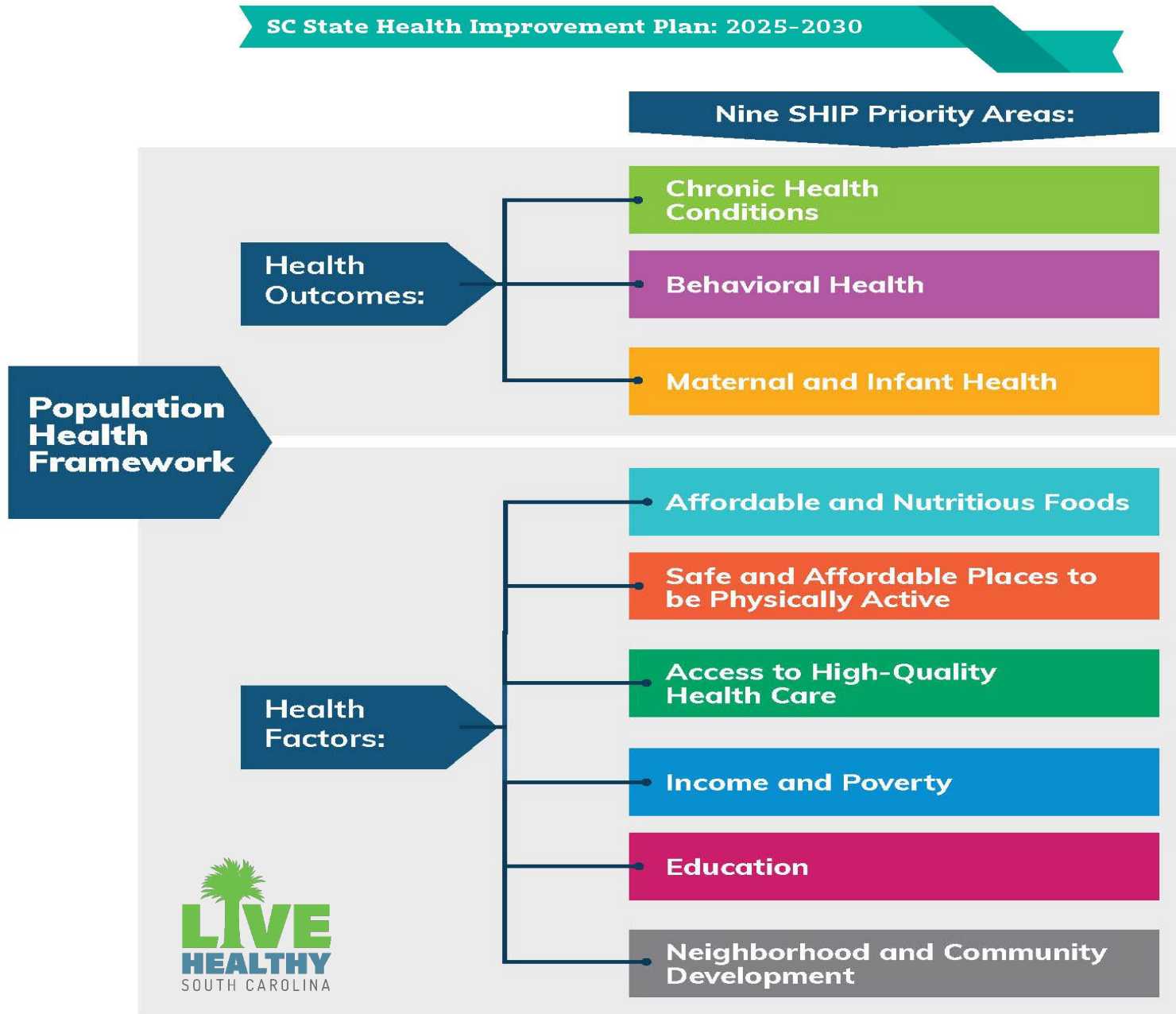
# SHIP Frameworks & Foundation

## Grounded in Proven Models:

- **Population Health Model:**  
Focuses on community-wide health determinants
- **Results-Based Accountability™ (RBA):**  
Ensures measurable results and continuous improvement
- Aligned with **Healthy People 2030** and **Public Health 3.0**



Scan the QR Code for the full SHIP report and details on all nine priority areas.



**Priority Area 1:**  
**Chronic Health Conditions**

Intended Result

All people in South Carolina achieve optimal health by preventing and managing chronic health conditions through systems that provide accessible opportunities and resources.

Why is This Important?

Chronic health conditions are a major driver of poor health outcomes in South Carolina, especially in communities where access to care and essential resources is limited. Achieving optimal health means building systems that support prevention and management of chronic health conditions through consistent access to care, healthy environments, and the resources people need in their daily lives.

Headline Indicators

► **Multiple Chronic Conditions**

Percentage of adults living with two or more chronic health conditions.

► **Diabetes**

Percentage of adults living with diabetes.

► **Social Vulnerability**

Percentage of the population living in areas with medium-high to high social vulnerability.

Strategies & Opportunities for Collaborative Action

**1.1** Allocate resources and services to underserved communities living with or at greater risk of developing multiple chronic conditions.

**1.2** Invest efforts in reducing the lifelong risk of diabetes and closing gaps in health outcomes.

**1.3** Allocate funds and resources to counties experiencing high social vulnerability.



**Priority Area 6:**  
**Access to High-Quality Health Care**

Intended Result

All people in South Carolina receive patient-centered, timely, and high-quality health care.

Why is This Important?

Access to high-quality health care is fundamental to individual and community well-being. High-quality health care is effective, efficient, patient-centered, safe, and timely, all of which are critical for preventing disease, managing chronic conditions, and reducing avoidable disability and premature death. However, gaps in access, particularly for low-income, rural, and underserved populations, drive gaps in health outcomes, lead to delayed diagnoses, and increase preventable hospitalizations, disease complications, and health care costs.

Headline Indicators

► **Delayed Medical Care**

Percentage of adults reporting delaying medical care due to cost.

► **Avoidable Emergency Department Utilization**

Rate of avoidable emergency department visits per 100,000 population.

► **Health Insurance Coverage**

Percentage of adults with health insurance coverage.

► **Medically Underserved Areas**

Rate of primary care providers per 100,000 population.

Strategies & Opportunities for Collaborative Action

**6.1** Reduce structural and economic barriers within the healthcare system.

**6.2** Strengthen access to and navigation of the healthcare system.

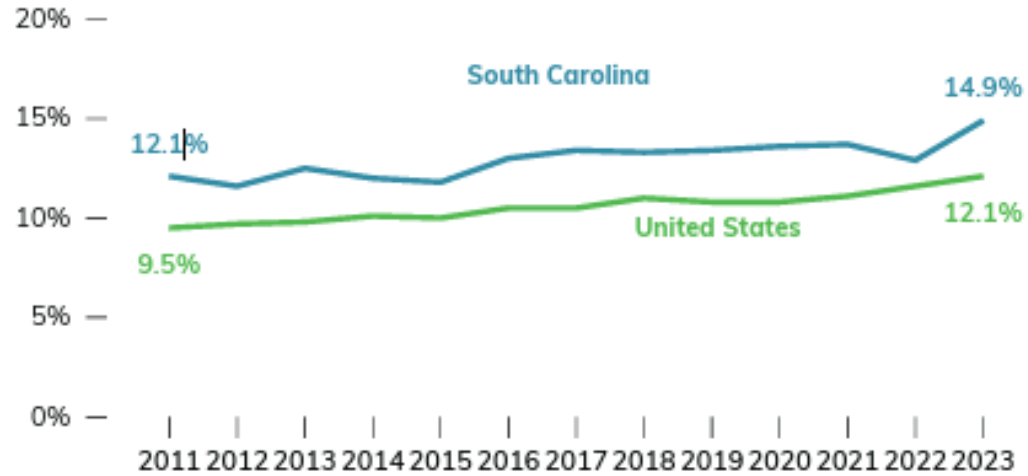
**6.3** Advance healthcare policies to close coverage gaps across populations.

**6.4** Adopt and expand programs that improve geographical access to care.



# Chronic Health Conditions

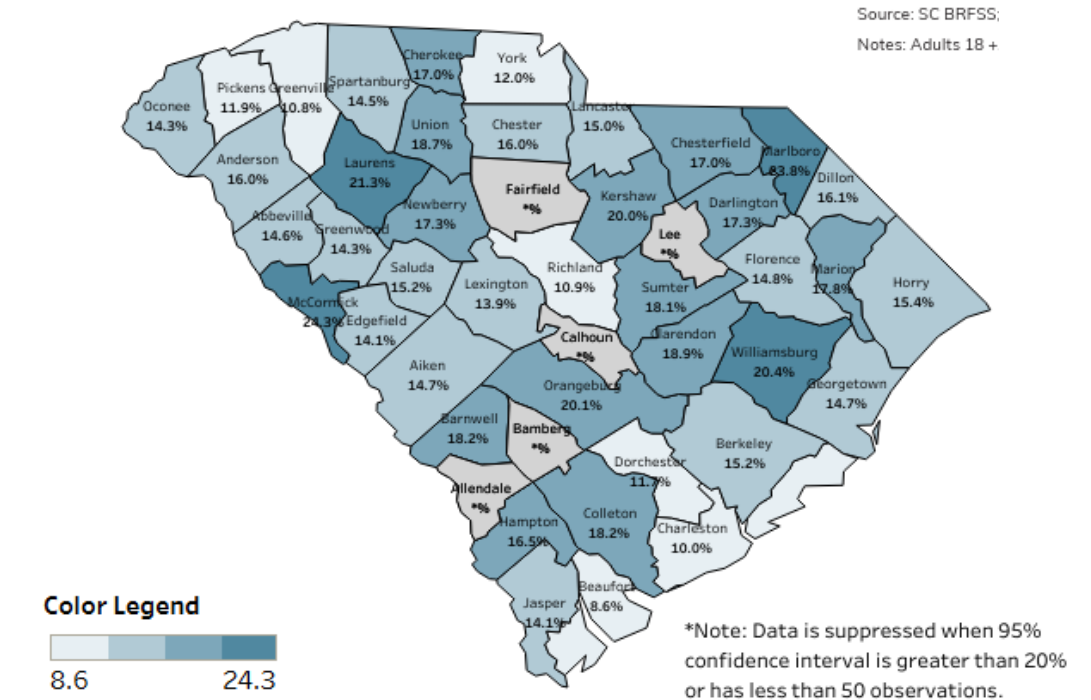
Prevalence of Diabetes  
Percent



Source: SC BRFSS; Centers for Disease Control and Prevention (CDC) BRFSS.

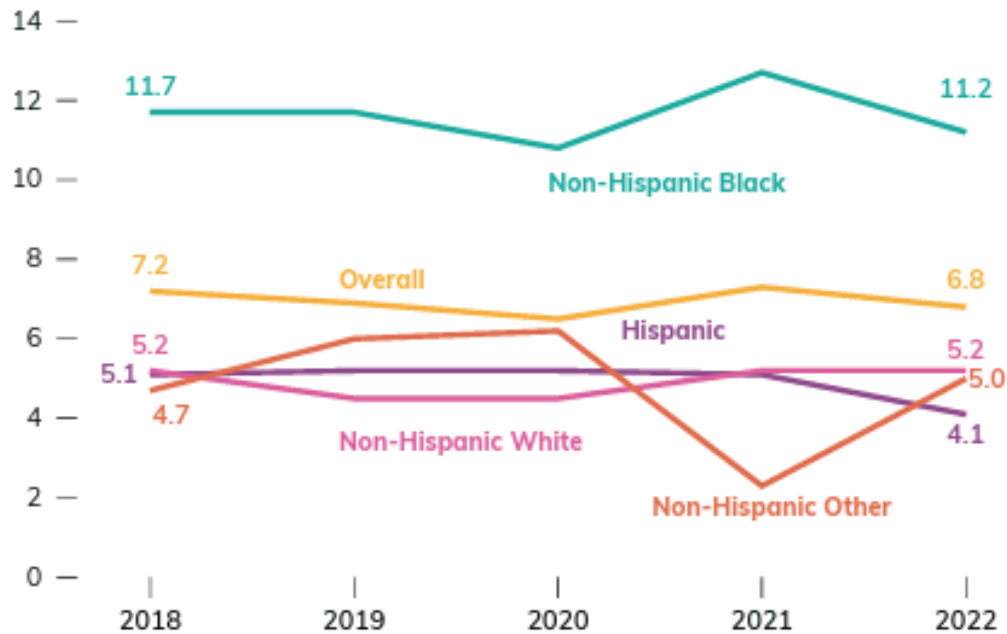
Notes: Adults 18 +.

Adults with Diabetes by County, 2018-2022  
Percent



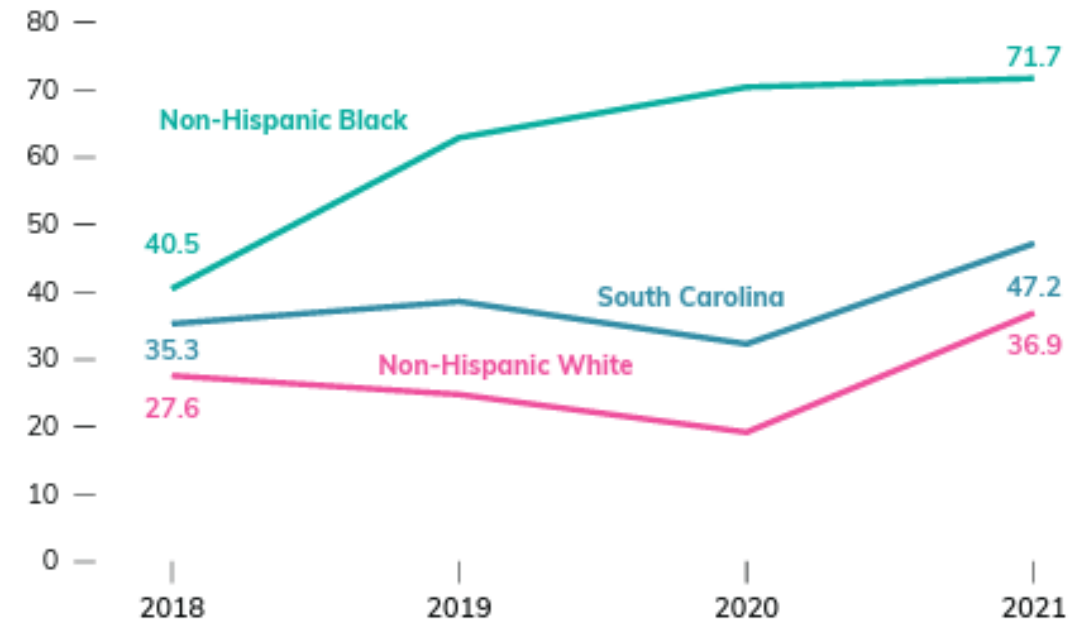
# Maternal & Infant Health

Infant Mortality Rate, by Race and Hispanic Origin of Mother  
Rate per 1,000 Live Births



Source: SC DPH Vital Statistics.

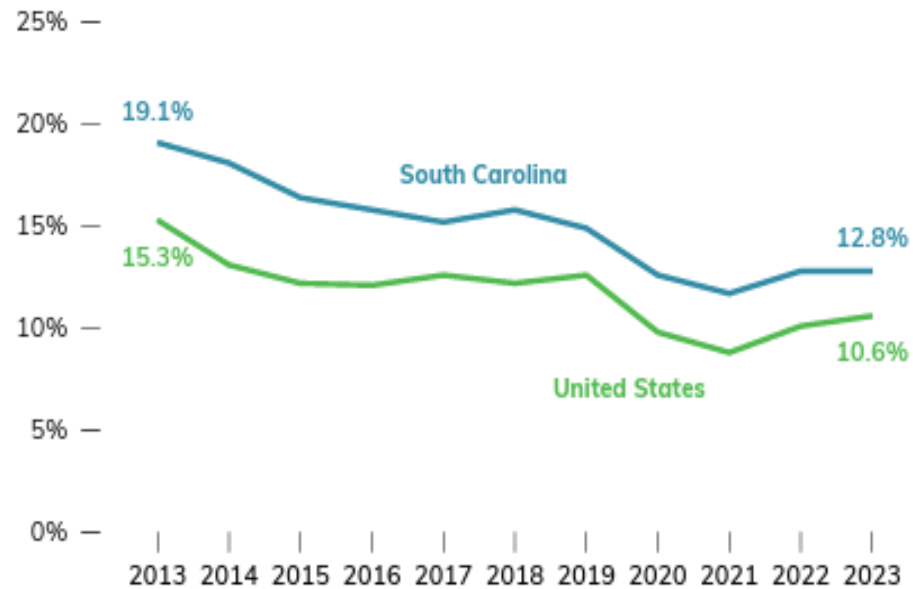
Pregnancy Related Mortality Rate, by Race/Ethnicity  
Rate per 100,000 Live Births



Source: SC Maternal Morbidity and Mortality Review Committee (SCMMMRC) Legislative Brief, 2025.

# Access to High Quality Care

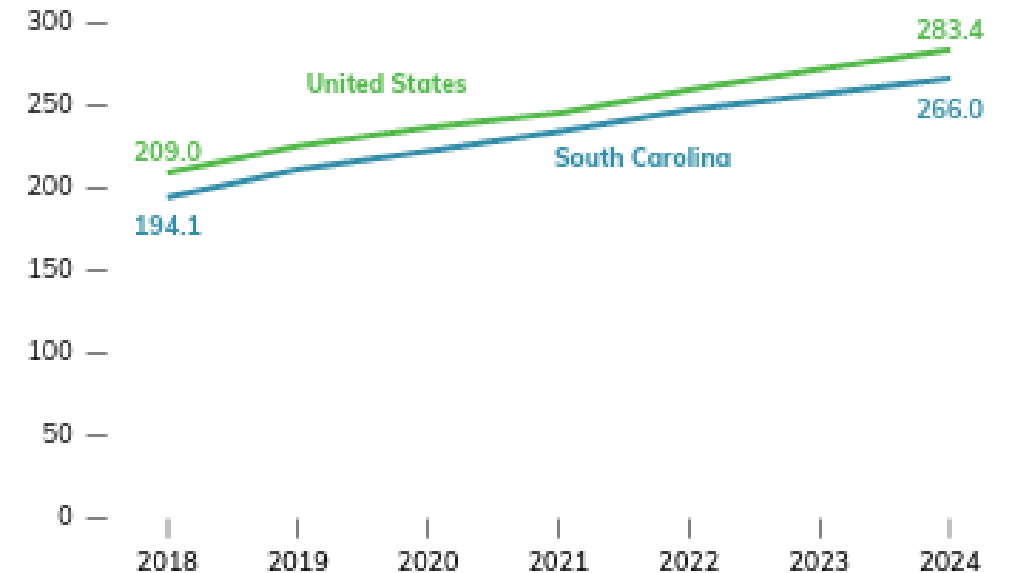
Delayed Medical Care due to Cost  
Percent



Sources: SC BRFSS.

Notes: Adults 18 +.

Primary Care Providers  
Rate per 100,000 population



Source: America's Health Rankings.

Note: Data was collected in September. Number of active primary care providers (including general practice, family practice, obstetrics and gynecology, pediatrics, geriatrics and internal medicine physicians, as well as physician assistants and nurse practitioners).

# Connecting Clinical Focus Areas to Population Health Outcomes

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- High-Impact Areas
  - Chronic Disease Management
    - Proactive care coordination and patient engagement improve long-term health outcomes.
  - Behavioral Health Integration
    - Embedding behavioral support within primary care improves patient compliance and holistic outcomes.
  - Maternal and Infant Health
    - Comprehensive prenatal and postnatal oversight reduces complications and supports healthy development.
  - Continuity and Access to Care
    - Strengthening the patient-physician relationship improves adherence to care plans and reduces fragmented care.
  - Addressing Social Drivers of Health
    - Screening for and addressing non-clinical barriers (food, housing, transportation) empowers patients to follow treatment recommendations.

# Relevant Strategies within the SHIP

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## Chronic Health Conditions

- Allocate resources and services to underserved communities living with or at greater risk of developing MCCs.
- Invest efforts in reducing the lifelong risk of diabetes and closing gaps in health outcomes.
- Allocate funds and resources to counties experiencing high social vulnerability.

## Behavioral Health

- Integrate alcohol misuse prevention, intervention, treatment, and recovery services into the public health and healthcare systems.
- Promote overdose education, risk reduction efforts, and evidence-based treatment and prevention services.
- Improve suicide prevention and postvention initiatives.
- Integrate behavioral health care into primary and specialty medical care.

## Maternal and Infant Health

- Develop the healthcare workforce through enhanced training and partnerships.
- Increase mobile health care maternity services in rural areas.
- Address social determinants of health through culturally competent service delivery.
- Improve reimbursement for maternal and pediatric health care with emphasis on preventive care.
- Improve awareness and education about safe sleep practices.

## Nutritious Foods

- Increase the reach of nutrition supports.
- Expand access to Food is Medicine (FiM) interventions.

## Physical Activity

- Promote community mobility and opportunities for active transportation.
- Improve early care and education environments.

## Access to High-Quality Care

- Reduce structural and economic barriers within the healthcare system.
- Strengthen access to and navigation of the healthcare system.
- Advance healthcare policies to close coverage gaps across populations.
- Adopt and expand programs that improve geographical access to care.

## Income & Poverty

- Expand collaborative and preventive approaches to address housing insecurity and homelessness.

## Education

- Improve access to post-secondary educational opportunities.

# Example Activities within the SHIP

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## Chronic Health Conditions

- Increase access to preventive screenings for chronic conditions



## Behavioral Health

- Increase utilization of brief alcohol screening and intervention in primary care



## Nutritious Foods

- Increase the implementation, reach, and sustainability of FiM interventions across the state

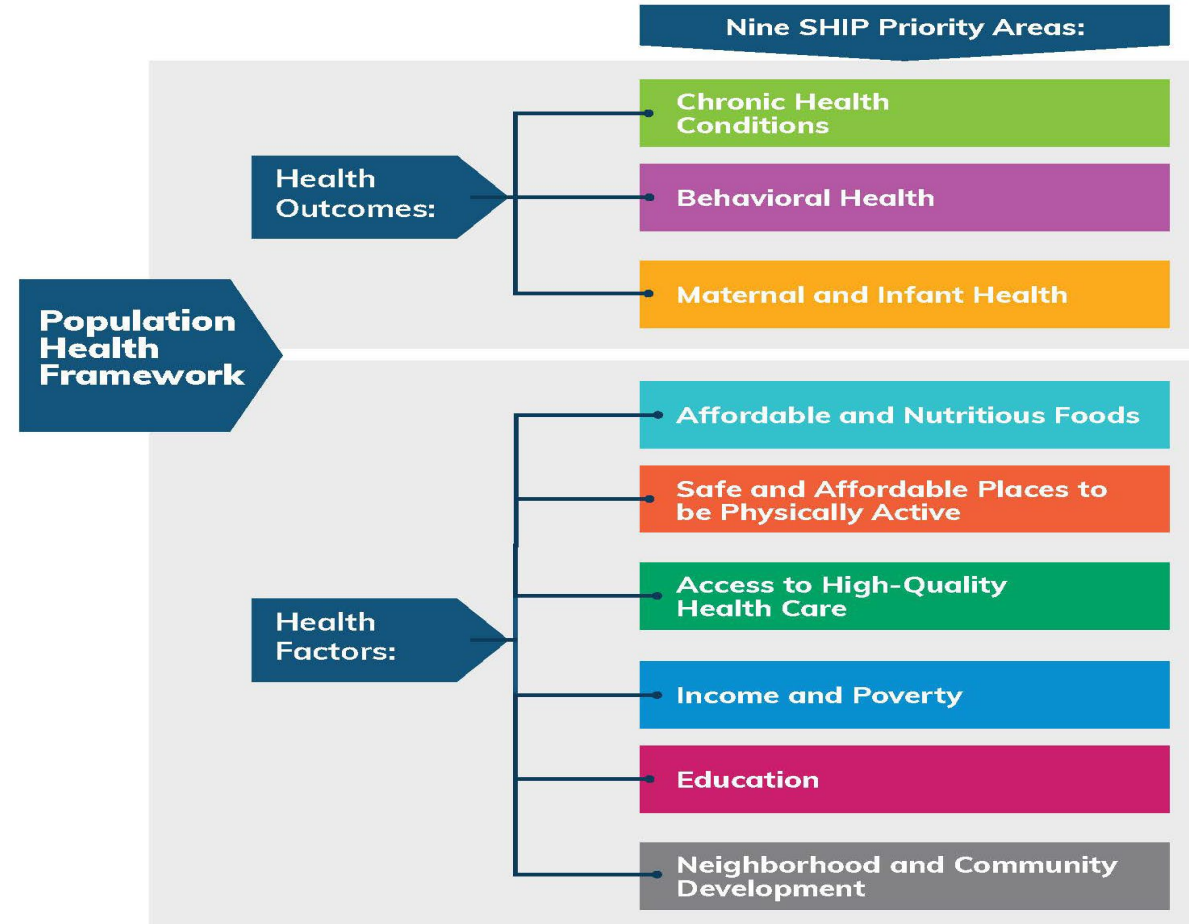


## Access to High Quality Care

- Maximize full utilization of healthcare professionals within the scope of their education and licensure
- Invest in rural health centers, federally qualified health centers (FQHCs), and free clinics

# SCMA's Role in SHIP Implementation

- How does the work of the SHIP relate to your “why”?
- Which SHIP priorities/strategies align most with your work?
- Where do you see the greatest opportunity for involvement or influence?



# The Opportunity in Front of Us

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Align efforts across  
systems



Scale what works



Leverage new funding  
and partnerships

# Connect with Us

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Scan the QR Code to  
get involved in one of  
the priority area  
workgroups!

