South Carolina Maternal Health Innovation Collaborative

Strategic Plan: 2023–2028

September 29, 2025

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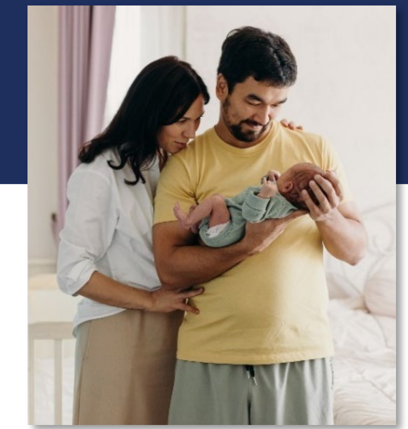
Maternal Health Innovation Collaborative Strategic Plan: 2023-2028

Executive Summary

September 29, 2025



Introduction

The South Carolina Department of Public Health (DPH) was awarded a five-year State Maternal Health Innovation (MHI) grant (2023–2028) from the Health Resources & Services Administration (HRSA) to reduce maternal mortality and severe maternal morbidity (SMM). Building on statewide initiatives such as the South Carolina Birth Outcomes Initiative (SCBOI) and South Carolina Maternal Morbidity and Mortality Review Committee (SCMMMRC), this effort expands access to high-quality care, strengthens maternal health data and surveillance, and implements innovative strategies to improve outcomes for populations most impacted.

The South Carolina Maternal Health Innovation Collaborative (SCMHIC) will bring together partners and community voices to address key drivers of poor maternal health outcomes, including workforce shortages, service gaps, limited data, and a lack of awareness of maternal warning signs. Together, these efforts aim to transform maternal health by fostering collaboration, innovation, and long-term improvements across the state.

Mission:

Innovate, Collaborate, and Elevate: Transforming Maternal Health Together

This mission seeks to inspire action and foster collaboration that addresses critical gaps in perinatal and postpartum care, data systems, policies, and practices by directing resources to solutions that address the root causes of maternal mortality and morbidity.

Vision:

Our vision is a South Carolina where every mother thrives within a unified, forward-thinking, and inclusive maternal health environment. We aspire to lead in transforming maternal health outcomes through collaborative efforts, ensuring that all South Carolinians have access to care that enables them to flourish.

Snapshot: Maternal Health in South Carolina

This snapshot highlights key maternal health indicators in South Carolina, providing context for the current conditions shaping maternal health across the state and reveal challenges in access, quality, and outcomes. The data underscore persistent gaps but also guide action — helping the SCMHIC direct resources to areas of greatest need, measure progress over time, and maximize impact to support healthier mothers, babies, and their families statewide.

Deliveries in SC

- In federal fiscal year (FFY) 2024, there were **49,755** deliveries.
- The median age of women giving birth in South Carolina was between **25 and 29** years.
- The cesarean rate was **33%** and about **1 in 9** deliveries in South Carolina were preterm (11%).

Maternal Mortality

- In 2021, South Carolina's pregnancy-related mortality ratio was **47.2 deaths per 100,000** live births.
- **Half** of these deaths occurred 7 days to 1 year after delivery.
- Across all pregnancy-related deaths, **89%** were deemed preventable.

Insurance Coverage

- In FFY 2024, nearly **60%** of deliveries were covered by Medicaid, rising to **72%** in rural areas.
- Rates of preterm birth, low birthweight, and SMM are **higher** among women whose deliveries were covered by Medicaid.

Access to Care

- **Thirteen** labor and delivery units have closed since 2011.
- **Over half** of SC counties represent medically underserved areas.
- **Many** women experience co-occurring physical and behavioral health conditions, further complicating access to appropriate care.

SCMHIC Proposed Goals and Strategies

The grant provides a clear framework to address maternal health issues in South Carolina by establishing specific, targeted objectives across four interrelated goals: service delivery, data analysis, workforce development, and empowerment and health literacy. Together, these goals create a unified and comprehensive effort to improve health outcomes. SCMHIC builds on existing statewide and community-based initiatives, including the Alliance for Innovation on Maternal Health (AIM) and the Williamsburg AIM Coalition. Thirty-eight birthing hospitals implement patient safety bundles. These AIM projects strengthen the proposed SCMHIC strategies. By focusing on these key areas, the work of SCMHIC aims to optimize resources, track progress, and promote lasting improvements in maternal and infant health. A detailed evaluation framework, provided at the end of this report, will assist in measuring the implementation and success of the strategy.

Maternal Health Service Delivery

Goal: Improve maternal health service delivery statewide by enhancing care coordination, expanding access to services, and fostering innovation and community collaboration to build a more robust and effective healthcare system.

Proposed Strategies: To achieve this goal, the initiative will strengthen maternal health care through targeted training, expand access via telehealth and mobile technologies, improve care coordination with culturally responsive support, and implement the Postpartum Alert Bracelet with provider education on emergency response.

Maternal Health Data Collection, Analysis, and Distribution

Goal: Enhance maternal health data accessibility, coordination, and utilization across South Carolina through collaboration, capacity building, and public engagement.

Proposed Strategies: Strategies focus on strengthening maternal health data efforts by supporting SCMMMRC data collection and analysis, assisting community-based initiatives with reporting, disseminating maternal health information at multiple geographic levels, and mapping existing and needed data within the data workgroup.

Maternal Health Workforce Development

Goal: Strengthening the maternal health workforce through cross-sector collaboration, capacity building, and enhanced training opportunities for healthcare providers and birth workers.

Proposed Strategies: Strategies include supporting provider education and evidence-based care, expanding simulation and low-fidelity training, scholarships to undergraduate, graduate, and health profession students to attend conferences or advance professional growth, internship, and practicum opportunities for undergraduate and graduate students, and a technical college student lunch-and-learn series to explore health profession opportunities through a virtual workforce development platform.

Maternal Health Empowerment and Literacy

Goal: Equip healthcare providers, organizations, and community members with resources that promote maternal and perinatal health literacy, empowering individuals to make informed decisions and recognize early warning signs of potential complications.

Proposed Strategies: Strategies focus on developing an online Maternal Health Resource Hub with AI support, creating a perinatal advisory council, and strengthening community partnerships to expand education, peer support, and access to local resources. Efforts also include increasing awareness of maternal health warning signs, promoting the postpartum period as critical, leveraging digital and Spanish-language tools, and expanding the use of educational materials statewide.

ACKNOWLEDGEMENTS

It takes many differing perspectives, knowledge, and contributions to improve maternal health outcomes effectively by reducing severe maternal mortality and morbidity. The development of this report would not have been possible without the collaboration and support of the members of the Maternal Health Innovation Task Force, the staff at DPH, and the partnership with the University of South Carolina (USC), Institute for Families in Society faculty and team. Also, we are grateful and acknowledge the timely input from HRSA and the technical assistance Team of the Maternal Health Innovation Program on the activities and approach in framing this strategic plan.

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SECTION 1: OVERVIEW OF MATERNAL HEALTH AND RESOURCES

The South Carolina Department of Public Health (DPH) was awarded a five-year State Maternal Health Innovation (MHI) grant as part of the third cohort of states funded by the Health Resources and Services Administration (HRSA) from September 2023 to August 2028.

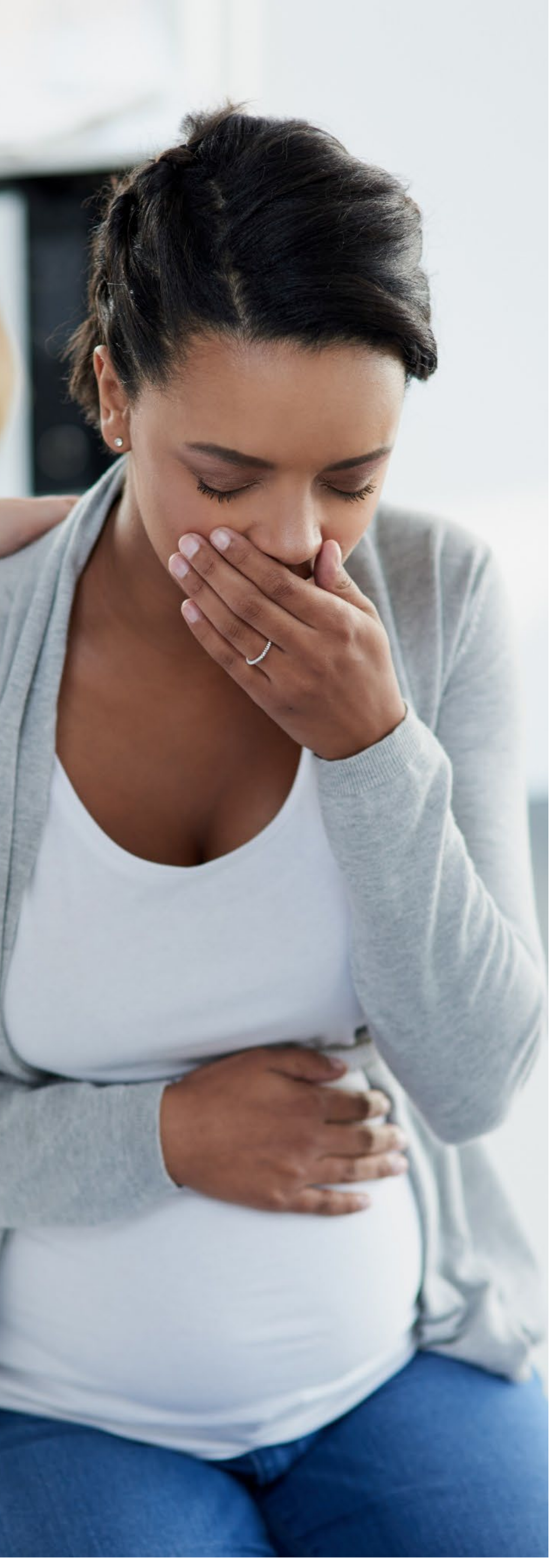
The purpose of the State MHI program is to reduce maternal mortality and severe maternal morbidity (SMM) by:

- Improving access to care, which is comprehensive, high-quality, appropriate, and ongoing throughout the preconception, prenatal, labor and delivery, and postpartum periods;
- Enhancing state maternal health surveillance and data capacity; and
- Identifying and implementing innovative interventions to improve outcomes for populations disproportionately impacted by maternal mortality and severe morbidity.

Drivers and Maternal Health Outcomes

Several quick facts on maternal health outcomes in the United States include:

- Pregnancy-related mortality has not improved over the past decade.
- Non-Hispanic Native Hawaiian and Pacific Islander, Black, and American Indian/Alaska Native women are at least two to four times as likely to die from pregnancy-related causes as non-Hispanic White women.



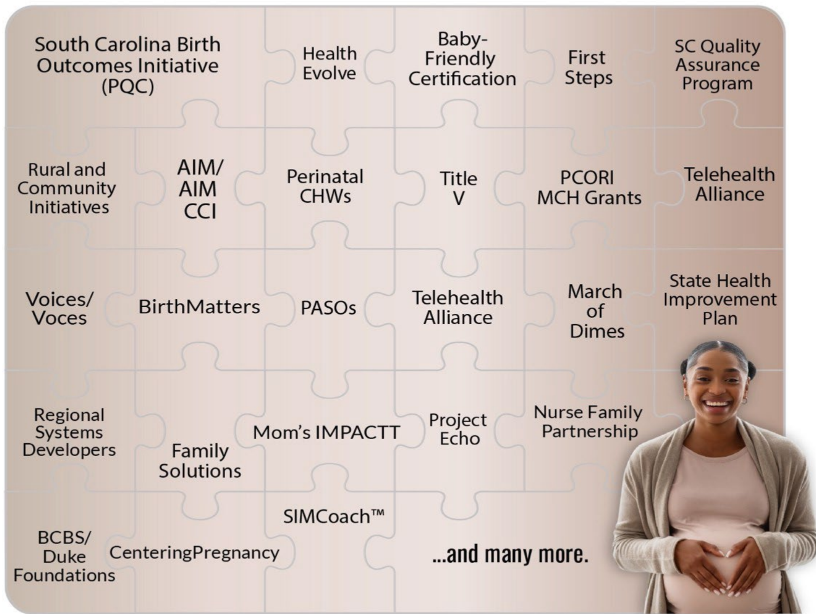
- Pregnancy-related mortality is higher in rural counties than in urban counties.
- Thirty-five percent of all U.S. counties lack hospitals or birth centers offering obstetric care, and without obstetric providers, with about 60% of these occurring in rural counties.
- Thousands of women experience unexpected outcomes of labor and delivery that result in significant short- or long-term consequences to their health.
- Four out of five pregnancy-related deaths are considered preventable.

The national and South Carolina outcomes convey a clear pattern of missed opportunities to improve maternal health outcomes. In response to these outcomes, the SCMHIC will seek to develop and implement creative and innovative solutions in collaboration with diverse partners dedicated to engagement and elevating the voices of those with lived experience.

Although this effort cannot address all the drivers of poor maternal health outcomes, it will focus on innovations that address the following drivers:

- Lack of or limited data on maternal health to leverage change at differing levels, people with lived experience, communities, county, and state levels, with stratification to better understand racial and ethnic disparities.
- Workforce shortages and the need to develop resources to enhance care coordination across a continuum of providers to deliver respectful care.
- Lack of or limited information on maternal warning signs to prevent poor maternal outcomes

and empower mothers, their families, and communities to maximize information to avert maternal complications



A key component of this effort is to leverage South Carolina's strengths in policy, state public health, and community programming, and accompanying reports and data, to shape and improve maternal health by reducing severe maternal mortality and morbidity. The South Carolina Maternal Health Innovation Collaborative (SCMHIC) is built on prior successes within the South Carolina Birth Outcomes Initiative (SCBOI) and existing strong capacity to access diverse sources of maternal health data. Being able to leverage this existing foundation brings power in partnership to **innovate, collaborate, and elevate together, transforming maternal health.**

Strengths

South Carolina has a robust, collaborative multi-sector environment that brings together stakeholders and entities across public, private, nonprofit, health care, business, and community sectors to drive improvements in maternal and infant health outcomes. The state has a strong history of fostering partnerships among these

> South Carolina has a strong history of fostering partnerships among maternal and child health programs and initiatives, creating an infrastructure that supports ongoing maternal health initiatives.

groups, creating an infrastructure that supports ongoing maternal health initiatives.

As reflected in the breadth of maternal health initiatives outlined in this plan, South Carolina is a resilient and resourceful state committed to enhancing access to, improving efficiency in, and achieving better outcomes in maternal healthcare. The state is often an early adopter of new practices and policies, exemplified by its early implementation of Medicaid coverage through 12 months postpartum in April 2022.

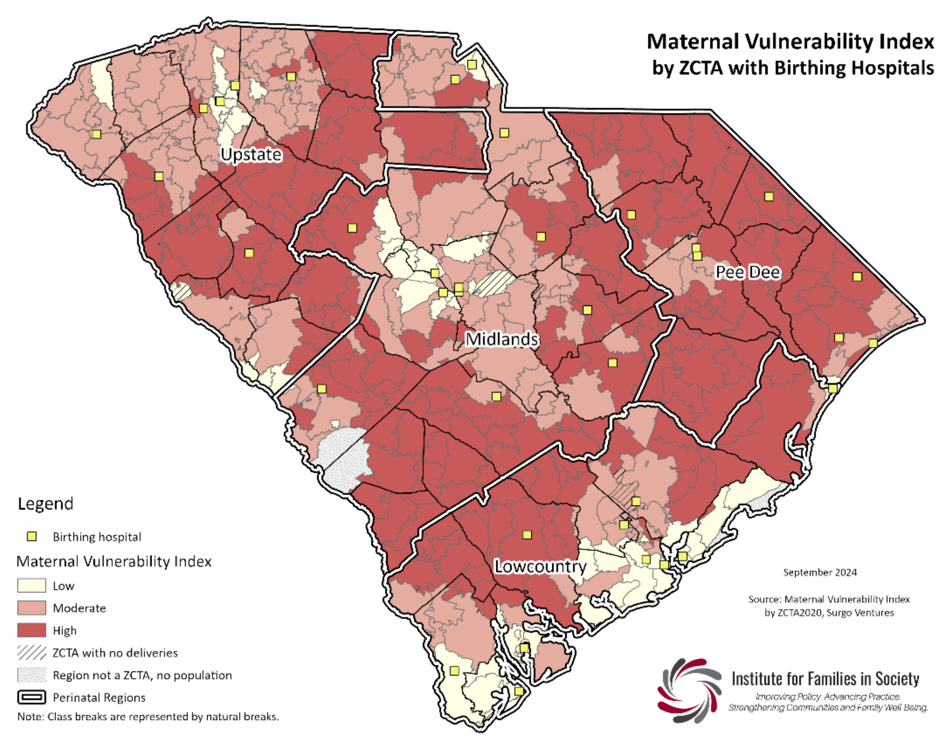
South Carolina’s regional approach to addressing public health needs further strengthens its ability to implement comprehensive maternal health strategies. These foundational strengths support the aims of the SCMHIC, including its development of the newly formed Maternal Health Task Force. The task force, composed of over 80 members, has met regularly since the grants launch to collaborate and develop strategies to achieve the initiatives outlined goals of improving access to maternal care services, identifying and addressing workforce needs, expanding data reporting capacity, and fostering maternal health literacy and empowerment through coordinated resources. This work is grounded in a commitment to engaging community partners and their individual experience to ensure that maternal health improvements are just and sustainable. Additionally, innovations such as the South Carolina Institute of Medicine and Public Health's Improving Maternal and Infant Health: Increasing Access to Care in Rural South

Carolina Task Force and Transforming Maternal Health (TMaH) Model have also begun to take shape since the start of the SCMHIC grant.

Housed within DPH, SCMHIC is well-positioned to facilitate collaboration and drive innovation. The initiative directly benefits the work of the state's Title V program and the SCMMMRC, both of which operate within DPH. Additionally, USC's Institute for Families in Society (IFS), SCMHIC's core implementation and evaluation partner, has long provided technical assistance, consultation, and evaluation expertise to statewide maternal health efforts. This partnership enables SCMHIC to support existing quality improvement initiatives, expand simulation training for non-obstetric providers, and identify gaps in maternal care services. Through these collaborative efforts, South Carolina is poised to create meaningful and lasting improvements in maternal health care systems.

Challenges

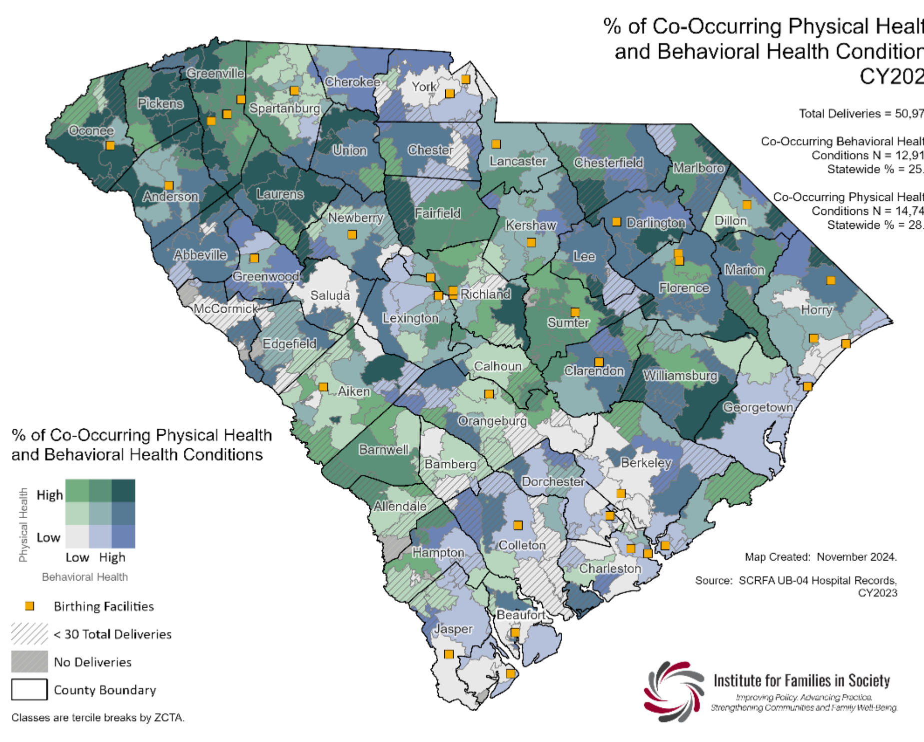
Maternal Landscape



In South Carolina, one out of every three individuals (34%) reside in a rural area compared to one out of every five (20%) nationally (U.S. Census Bureau, 2021). Over half of the counties represented medically underserved areas (MUAs), and two out of every five counties had low access to maternity care or were designated as maternity care deserts (March of Dimes, 2023).

Thirteen labor and delivery units have closed since 2011, many of which served these rural residents. Within these rural areas, in FFY 2024, 72% of deliveries were paid for by Medicaid, 1,713 babies were born prematurely, and approximately one in five experienced a perinatal mental health diagnosis. As a result, the state has one of the top five highest maternal vulnerability rates in the nation, driven by high physical health and socioeconomic status needs (Surgo Ventures, 2024).

Maternal Morbidity and Mortality



Among publicly reported states, South Carolina ranked 8th for maternal mortality (NCHS, 2024, using non-suppressed rates for 2018-2022). Based on the SCMMMRC 2025 report, pregnancy-related deaths were 2.3 times more likely among birthing individuals identifying as Black, Non-Hispanic, compared to those identifying as White, Non-Hispanic. Of deaths reviewed from 2018 to 2021, discrimination was recognized as a contributing factor in roughly 30% of cases.

An analysis conducted by IFS in 2023 of calendar year 2023 data found that nearly one in four birthing individuals in South Carolina had a co-occurring behavioral health condition, and almost one in three had a co-occurring physical health condition during the 12 months preceding, at the time of, or in the 12 months following childbirth. This elevated disease burden may contribute to higher rates of maternal morbidity and mortality across the state.

> Maternal and child health in South Carolina faces significant challenges due to its largely rural and medically underserved landscape, where many women experience co-occurring behavioral and physical health conditions that complicate care.

Emergency Department Use

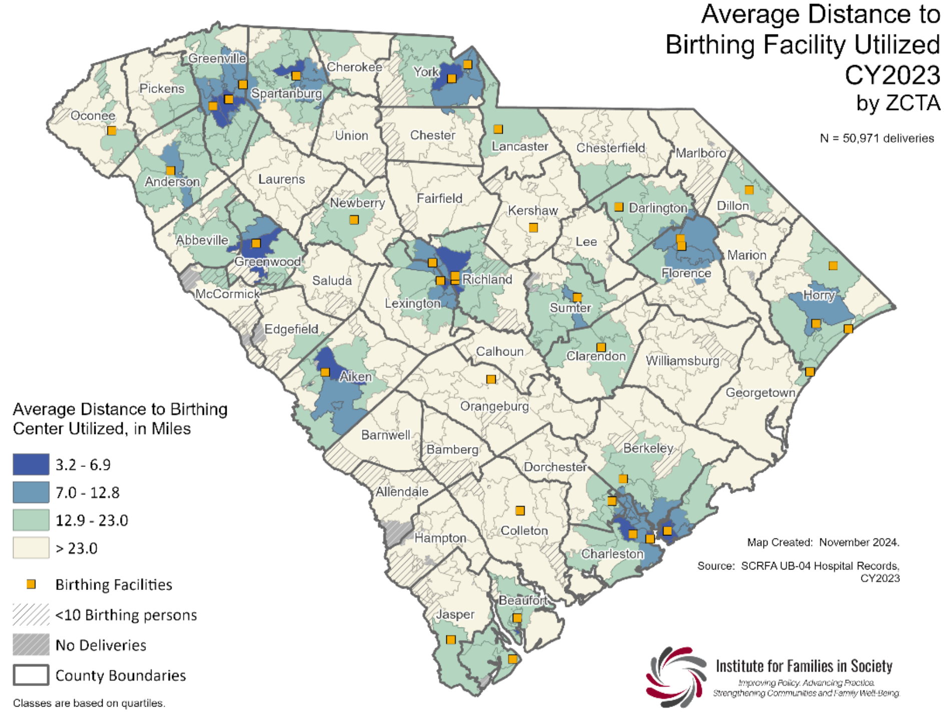
The analysis also revealed significant gaps in South Carolina's maternity care infrastructure. Nearly one in four hospitals in the state lacked a labor and delivery unit, potentially increasing reliance on emergency departments (EDs) for obstetric care and underscoring the need for targeted maternal health training for ED staff. Among hospitals that do provide delivery services, nearly half of all births occurred at Perinatal Level II facilities. Although fewer in number, Perinatal Level III and IV facilities cared for a disproportionately high share of obstetric patients, many of whom had co-occurring conditions and experienced severe maternal morbidity (SMM). Among these patients, 55% of births were preterm, and 58% were classified as low birthweight. These findings suggest that high-risk or complex deliveries are frequently transferred or admitted to higher-level facilities, reinforcing the need to adopt

ACOG's maternal levels of care framework to support risk-appropriate, coordinated care statewide.

Additionally, approximately 1 in 14 delivery patients visited an ED in the week before delivery, and about 1 in 25 returned in the week following the delivery. Common non-obstetric diagnoses behind the ED visits included hypertension, mental health, and cardiovascular conditions. Most of these visits occurred at birthing facilities, highlighting the importance of ensuring that ED providers are adequately equipped to recognize maternal early warning signs and communicate effectively with obstetric providers to ensure a timely response and treatment. Results of a recent South Carolina Alliance for Innovation on Maternal Health (AIM) survey administered by IFS with the support of the South Carolina Department of Health and Human Services (SCDHHS), in which 66% of birthing facilities responded (launched April 2025), indicated that lack of ED provider training, low staffing, and poor communication between the ED and obstetric providers were barriers to care.

Access to Maternal Care

The analysis also identified significant access barriers, particularly for rural residents. Individuals giving birth in rural areas traveled approximately 1.7 times farther, both distance and time, than their urban counterparts.



Those traveling the most distances to reach a birthing facility were more likely to be Medicaid beneficiaries, have co-occurring physical and behavioral health conditions, reside in rural areas, and live in communities with high Maternal Vulnerability Index (MVI) scores. Notably, nearly two in five birthing individuals delivered outside of their county of residence, further underscoring the limited availability of local maternity care across South Carolina.

Gaps

The newly formed South Carolina Maternal Health Task Force (SCMHTF) has identified gaps in maternal health care in the state. These include the need to:

- Develop tailored training on recognition and readiness for obstetric emergencies spanning across all obstetric and non-obstetric specialties.
- Enhance the accessibility and sustainability of maternal health services in South Carolina by expanding partnerships with existing community organizations, implementing innovative care models, and ensuring continuity of care.
- Create pathways to improve communication and collaboration among community-based maternal health professionals, birth workers, clinical providers, and health systems.

- Increase opportunities and efforts to recruit and retain the maternal health care workforce.
- Promote maternal health literacy and empowerment across the perinatal period with a focus on providing education on prenatal and postpartum visit attendance and urgent warning signs.
- Expand access to maternal health and mortality data, including both existing data and new data that can drive community-engaged local action.

Existing South Carolina Maternal Health Initiatives

Although being a smaller rural state presents specific challenges, it also brings much strength, allowing for robust cross-state collaboration and innovation with engagement across all spheres of influence from clinical to community.

For instance, national conversations about perinatal regionalization began in 1976, but the South Carolina Board of Health and Environment approved a regionalization plan as early as 1974.[1] To date, this system facilitates timely transport to higher-level birthing facilities and provides workforce training support from obstetric educators and Regional Systems Developers.

Further cross-state collaboration has been demonstrated by the state's thriving **Perinatal Quality Collaborative, the South Carolina Birth Outcomes Initiative (SCBOI)**, which was founded in 2011 with the initial goal of improving the state's infant mortality rate. Across its founding initiatives, a common thread emerged of using innovative public-private payment strategies to support quality improvement, which would both improve maternal and newborn outcomes and reduce costs. Uniquely housed within the SCDHHS Healthy Connections Medicaid program, these efforts have connected managed care organizations,

[1] Smith, M. G.(2016). Examining Infant Health Outcomes Impacted By South Carolina's Regionalized System of Perinatal Care. (Doctoral dissertation). Retrieved from https://scholarcommons.sc.edu/etd/3521

the South Carolina Hospital Association, state agencies, Healthy Start and home visiting programs, community organizations, and academic centers, totaling more than 100 partners.

South Carolina demonstrates strong cross-state collaboration with clinical and community partners to improve maternal and child health, having been a pioneer in halting payment for medically elective early inductions at 37–38 weeks and in developing a robust data warehouse to support informed decision-making.

Through SCBOI, South Carolina's Medicaid program became the first to stop payment for medically elective early inductions at 37-38 weeks of gestation and to separate payment for the long-acting reversible contraception methods at the time of delivery from the global maternity payment. Other strategies included offering payment incentives to encourage group prenatal care through CenteringPregnancy®; becoming a designated breastfeeding Baby-Friendly® hospital; and assessing behavioral health needs through the Screening, Brief Intervention, and Referral to Treatment (SBIRT) approach. As SCBOI continued and the national landscape focused on the high rate of maternal mortality in the United States, focus broadened to quality improvement efforts to reduce potentially avoidable Cesareans (Supporting Vaginal Birth), severe maternal morbidity (via South Carolina AIM maternal safety bundles), and low rates of postpartum care (South Carolina Postpartum Learning Collaborative). A particular strength of these initiatives is that they share a common goal of engaging every birth facility in South Carolina at some level.

Following the implementation of the Children with Special Health Care Needs Title V programming, South Carolina also became one of the first states to develop a robust data warehouse, currently housed at the South Carolina Revenue

and Fiscal Affairs Office. To this day, this integrated data system, which spans state, private, and federal data sources, facilitates cross-data linkages that many states do not have access to. This system has fostered the development of an interactive maternal health dashboard developed by IFS and funded by SCDHHS, which links data across Medicaid, birth, and hospital records.

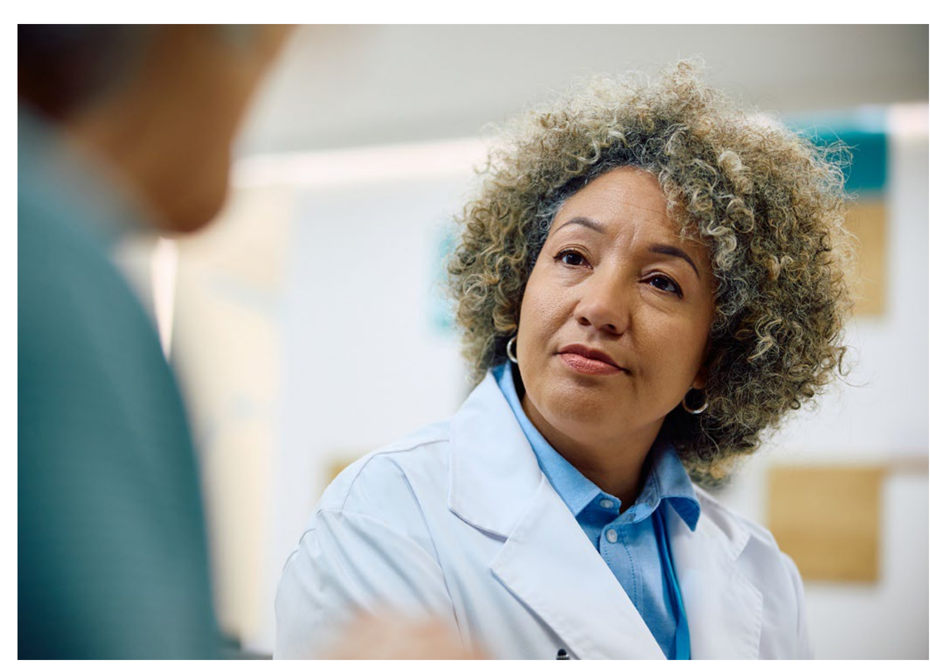
South Carolina Title V funding has supported the integration of family interviews into the multidisciplinary efforts of the SCMMMRC (See Appendix 1), as well as DPH initiatives to collaborate with partners to address chronic conditions, mental health, and substance use disorders during preconception, postpartum, and intrapartum periods. The program has expanded its efforts to increase well-woman visits by promoting perinatal community health workers, supporting pregnancy prevention, and engaging in outreach efforts that highlight maternal warning signs.

Through funding to the Williamsburg County Community Coalition (WC3), South Carolina was one of the first states to participate in the AIM – Community Care Initiative. With this funding, WC3 began implementing the Community Care for Postpartum Safety and Wellness bundle to ensure that all pregnant and postpartum individuals receive the care and support they need to recover from childbirth, acclimate to motherhood, and transition to well-woman care. Williamsburg County experiences high MVI and is considered a March of Dimes maternity care desert, with 86% of pregnant people qualifying for Medicaid at delivery and 99% residing in a rural area. Post-grant, WC3 plans to continue community-

There are numerous community-based maternal and child health initiatives in the state focused on improving access to care and addressing maternal vulnerability through education. Members of these initiatives, both clinical and community, play key roles in the broader SCMHIC maternal health taskforce.

engaged efforts focused on increasing breastfeeding uptake, care coordination for chronic conditions, and education on maternal warning signs, utilizing maternal monologues as one tool to facilitate this work.

Additional well-known maternal health community-based programs in South Carolina include BirthMatters, which provides community doula services to young expectant people at no charge to them; Family Solutions, a Healthy Start program of the South Carolina Office of Rural Health (SCORH) that is dedicated to improving health outcomes for pregnant women and their families through case management, home visiting, and community-based doula care. Nurse-Family Partnership, a home visiting program whose mission is to empower women having their first baby, and PASOs, which provides Spanish-speaking community health workers connecting clients to community resources.



This is not an exhaustive description of all the maternal health initiatives currently underway in South Carolina. The SCMHIC Maternal Health Task Force (MHTF) represents a broad coalition of stakeholders, including healthcare providers, policymakers, and community organizations, that work on various programs aimed at improving maternal health

outcomes. In addition to the efforts described here, numerous other initiatives in the state are focused on addressing these critical issues. A more comprehensive list of some of these programs is provided in Appendix 2.

While our shared goal is to improve maternal health outcomes, these different funding streams are sometimes perceived as competing for resources rather than collaborating. Through the development of comprehensive aims, SCMHIC has identified ways to enhance existing initiatives without duplicating them. This process guided our selection of partners for our initial MHTF, emphasizing authentic collaboration and mutual trust. For a more comprehensive examination of alignment with the SC Maternal Mortality and Morbidity Committee and Title V Needs Assessment, see Appendices 1 and 3.

> The data snapshots support the need to increase data capacity, with a commitment to enhancing data and integrating multiple data sources, e.g., opportunities to incorporate data from EHRs and nonclinical data sources, identification of telehealth services for prenatal and postpartum care, regional strengths and needs, and the impact of how care coordination and patient navigation impacts SMM across differing units of geography in South Carolina.

Alignment With Most Recent Maternal Health Data

The work of SCMHIC directly aligns with addressing the needs of our birthing population, with a focus on decreasing severe maternal morbidity among communities, and with the opportunity to address maternal mortality. The following South Carolina maternal health data snapshot, reflecting the linkage of birth, UB, and Medicaid records, describes characteristics associated with severe maternal morbidity and mortality. [2]

The data snapshots support the need to increase data capacity, with a commitment to enhancing data and integrating multiple data sources, e.g., opportunities to incorporate

[2] Institute for Families in Society. South Carolina Birth Outcomes Initiatives About the Data. https://boi.ifsreports.com/resources/documents/HowToUseTheDashboard.pdf

data from EHRs and nonclinical data sources, identification of telehealth services for prenatal and postpartum care, regional strengths and needs, and the impact of how care coordination and patient navigation impacts SMM across differing units of geography in South Carolina.

Maternity Delivery Characteristics Overview

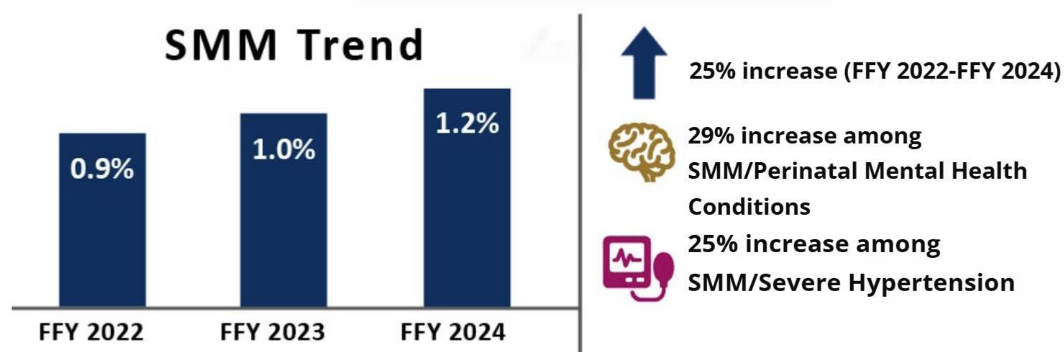
The South Carolina maternal delivery profile for federal fiscal year 2024 (FFY 2024) reflects a highly varied population experiencing risk of low birthweight and prematurity (particularly among Medicaid beneficiaries and those self-identifying as Black, Non-Hispanic) and facing community/contextual factors that influence health outcomes, such as socioeconomic status needs, inadequate prenatal care, and lower educational attainment.

FFY 2024 South Carolina Quick Facts

- 3 out of every 5 deliveries were paid for by Medicaid
- 1 in 5 pregnant/postpartum persons received inadequate prenatal care
- Approximately 1 in 10 pregnant/postpartum persons delivered a premature or had a low birthweight baby
- Roughly 1 in 4 had a potentially avoidable cesarean
- Nearly 1 in 5 were ages 35 or older

Severe Maternal Mortality and Morbidity (SMM) AIM Safety Bundle Analysis

The Alliance for Innovation on Maternal Health (AIM) SMM patient safety bundles are a set of evidence-based practices designed to prevent SMM and mortality. This next section provides an example of efforts to increase data capacity across multiple stakeholders, aligning data-driven decisions and fostering action and collaboration.



From FFY 2022 to FFY 2024, there was a 25% relative increase in SMM in South Carolina, driven by statistically significant increases among those with perinatal mental health conditions (+29%) and severe hypertension (+25%) using the Cochran–Armitage test. Deliveries with SMM were three times more costly than non-SMM deliveries. They were seen at a higher rate among those self-identifying as Black, Non-Hispanic, age 35 and older, receiving Medicaid benefits, and experiencing co-occurring physical and behavioral health conditions.

Among SMM Deliveries

About **2 in 3** had **non-hereditary anemia.**

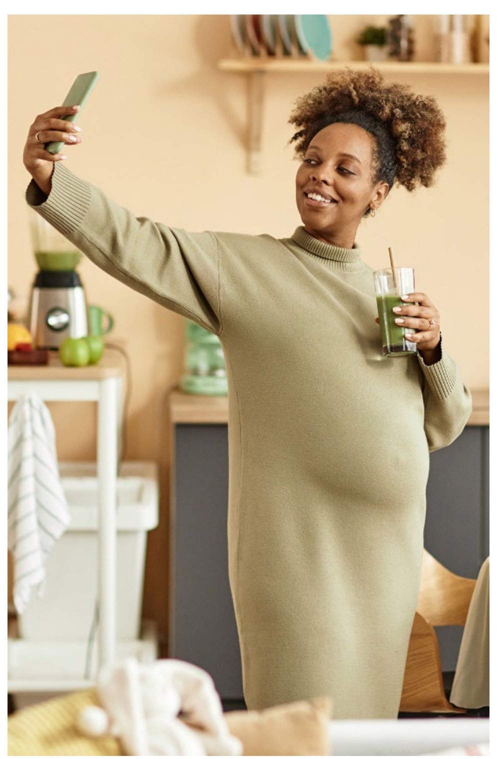
Nearly **1 in 2** had **cardiovascular disease**.

About **1 in 3** had **obesity or a mental health condition**.

About **1 in 5** had **substance use disorder**.

About **1 in 10** had **diabetes**.

Among those with SMM, two-thirds had a diagnosis of non-hereditary anemia, which is a preventable condition. Nearly half had cardiovascular disease, and approximately one-third had obesity or a mental health diagnosis. These diagnoses occurred in the year before through a year after delivery in an ED or inpatient setting, as recorded on hospital billing or birth records.

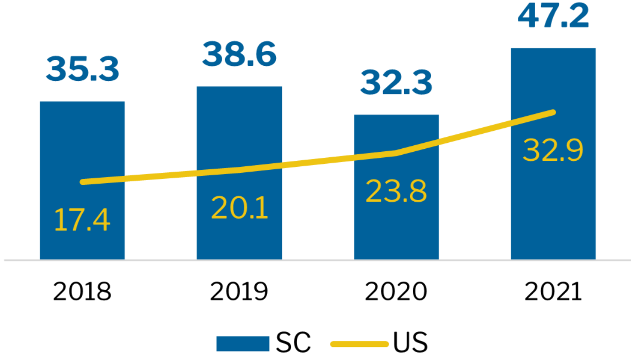


Although the FFY 2024 statewide SMM rate was 1%, rates were higher among individuals with cardiovascular disease (5%), diabetes (4%), and anemia (2%).

Addressing co-occurring chronic conditions is an SCMHIC data-driven priority given their significant role in postpartum complications and preventable maternal morbidity. The grant supports this by aiming to train non-obstetric providers, raise awareness of early warning signs, and strengthen coordination between community and clinical providers during critical care transitions.

Pregnancy-Related Mortality Ratio

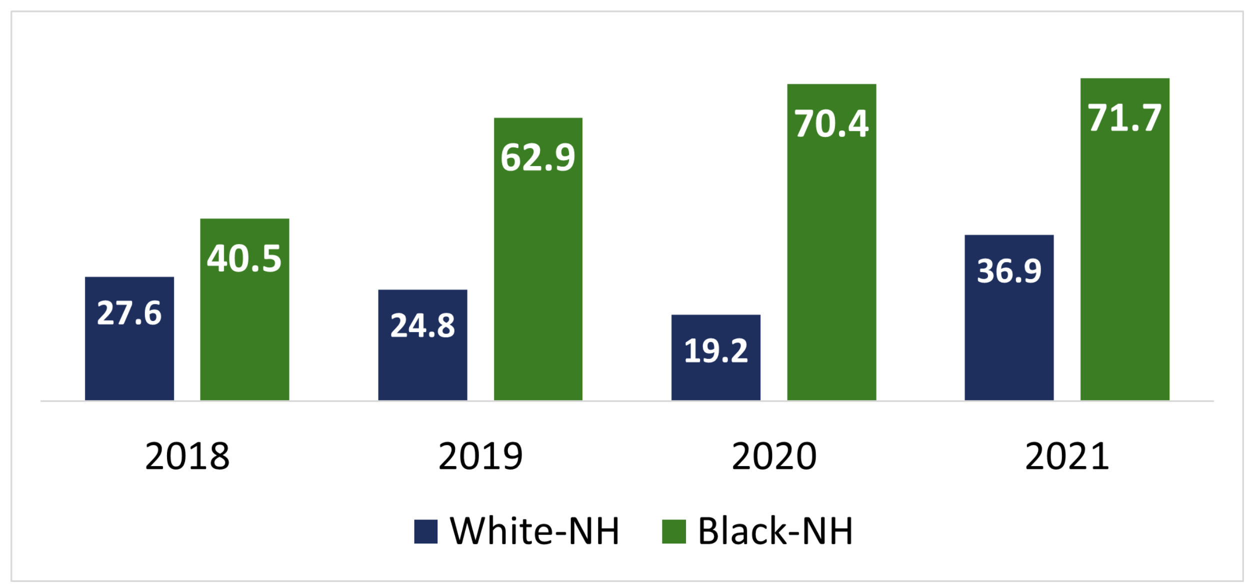
As of the most recent data available in 2021, the pregnancy-related mortality ratio (PRMR), which reflects the number of pregnancy-related deaths per 100,000 live births, was 47.2, compared to 32.9 nationally.[3] When examining this by race, the results are striking, with a PRMR of 71.1 for those self-identifying as Black, Non-Hispanic, compared to 36.9 for those identifying as White, Non-Hispanic.



From 2018 to 2021, the leading causes of death for individuals identifying as Black, Non-Hispanic were infections, embolism, and heart conditions. For persons identifying as White, Non-Hispanic, the leading causes of death were infections, mental health conditions, and hemorrhage.

[3] South Carolina Maternal Mortality and Review Committee. 2025 Legislative Brief. https://www.scstatehouse.gov/reports/DeptofPublicHealth/SCMMMRC%20Legislative%20Report%202025.pdf

Pregnancy Related Mortality Ratio by Race, Ethnicity, South Carolina 2018-2021

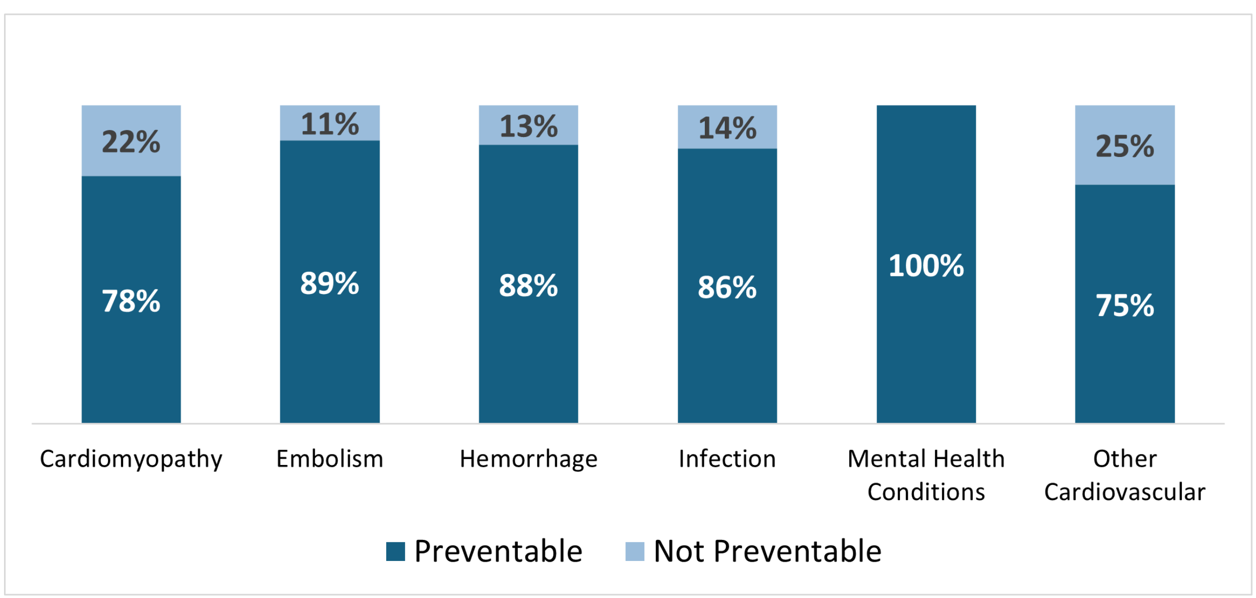


Over half of the deaths occurred 7 days to 1 year after, with about two-thirds occurring during the 2021 period. Across all pregnancy-related deaths in 2021, 89% were deemed preventable. This varied by cause of death, with 100% of mental-health-related deaths being preventable and 75% of those related to cardiovascular conditions. Among mental health conditions from 2018 to 2021, approximately two out of every three cases were identified as substance use disorder.

Leading Causes of Death by Race Ethnicity, South Carolina 2019–2021

Top 3 Leading Causes of Death	White-NH	Black-NH
	1.) Infections 2.) Mental Health Conditions 3.) Hemorrhage	1.) Infections 2.) Embolism 3.) Heart Conditions

Preventability by Cause of Death, South Carolina 2018-2021



In summary, the overview of South Carolina's maternal health provides compelling evidence for Alignment With Title V Needs Assessment and State Action Plan to reduce the drivers associated with SMM and overall poor maternal health outcomes.

Title V Alignment

DPH collaborated with the USC's Center for Applied Research and Evaluation (CARE) to identify community needs and desired outcomes for maternal and child health (MCH) populations, as well as the existing capacity of programs and organizations across the state to address the identified areas of need. The goals of the needs assessment were to determine priority needs, develop an action plan, and inform the allocation of funds and resources to promote the health of women, children, and adolescents, including those with special healthcare needs, as well as their families.

A mixed-method systems approach was used for this process, wherein programs, policies, and statewide organizations were considered as parts of a whole MCH serving

system. The needs assessment is viewed as a continuous process that will continue to engage stakeholders in and beyond the data gathering and prioritization process, in accordance with HRSA's Title V Needs Assessment Framework, with annual stakeholder engagement. The HRSA framework guided this needs assessment process, which included the following six steps: engaging stakeholders, assessing needs, examining needs and capacity, selecting priorities, setting measures, and developing the state action plan.

Both quantitative and qualitative MCH data were gathered and synthesized from multiple sources, then shared with Advisory Committee members to support their work during three in-person meetings. These meetings included facilitated exercises that led to the development of a prioritized list of needs and recommended actions. Priority setting took place within each domain workgroup during the final in-person meeting. Alignment with the SCMHIC was a key factor within the Women/Maternal and Perinatal/Infant population health domain-specific workgroups throughout the process. DPH was intentional about not overburdening those MHTF members who also serve as key Title V stakeholders and partners, while ensuring that their voices were included and considered within these two Needs Assessment workgroups. This was accomplished by including an SCMHIC Leadership Team member within the workgroups.

The DPH Title V program then conducted a series of internal meetings, organized by population health domain, to develop a draft Title V State Action Plan. These meetings included MCH Leadership and subject matter experts within the MCH Bureau pertinent to each

domain and consisted of a review of the quantitative and qualitative data, to include needs/gaps and resources/assets; the Advisory Council's needs and prioritization for each domain; and then a critical examination of the 2021-2025 State Action Plan. At least one overarching priority need was finalized for each domain, with several highlighted below aligned with the SCMHIC's work and Strategic Plan:

1) Improve utilization of healthcare visits to promote health before, during, and after pregnancy

2) Strengthen implementation of evidence-based practices that keep infants safe, healthy, and prevent mortality

3) Enhance partnerships that address community health factors

Alignment between the Title V State Action Plan and the SCMHIC Strategic Plan is a priority of DPH's Maternal and Child Health Bureau, which will be ensured throughout the SCMHIC implementation process.

SSDI Alignment

The SCMHIC Principal Investigator also serves as the SSDI Project Director and works very closely with the MCH Epidemiology Team to support state MCH programs and maternal health initiatives, including the SCMHIC and Maternal Health Strategic Plan.

The DPH MCH Epidemiology Team has access to a variety of datasets, enabling them to effectively analyze and disseminate key findings that measure progress towards meeting state MCH Title V performance and outcome measures, informing

programmatic activities aimed at improving maternal and perinatal health. DPH will leverage its SSDI capacity to support activities related to this effort.

The next section of the strategic plan details the development of the South Carolina Maternal Health Innovation Task Force (MHTF) and outlines the vision and mission guiding this effort. It is a living document subject to change to achieve the goal of reducing SMM in South Carolina.

SECTION 2: MATERNAL HEALTH INNOVATION TASK FORCE

Mission:

Innovate, Collaborate, and Elevate: Transforming Maternal Health Together

This mission seeks to inspire action and foster collaboration that addresses critical gaps in perinatal and postpartum care, data systems, policies, and practices by directing resources to solutions that address the root causes of maternal mortality and morbidity.

Vision:

Our vision is a South Carolina where every mother thrives within a unified, forward-thinking, and inclusive maternal health environment. We aspire to lead in transforming maternal health outcomes through collaborative efforts, ensuring that all South Carolinians have access to care that enables them to flourish.

Values and Guiding Principles:

- Decision informed by data and best practices to inform strategic planning efforts.
- Intentional and constructive collaboration
- Respect for different perspectives and approaches to meeting the needs of pregnant women during the prenatal and postpartum periods.
- Administrative, technical, and instrumental support to carry out the activities.

Drivers and Maternal Health Outcomes

National Maternal Health Quick Facts

- The U.S. maternal mortality rate (18.6 deaths per 100,000 live births; 2023) is the highest among high-income countries.[4]
- Non-Hispanic Black women are almost three times as likely to die from pregnancy-related causes compared to non-Hispanic White women.[1]
- Pregnancy-related mortality is higher in rural counties than in urban counties. [2]
- Four out of five pregnancy-related deaths are considered preventable.[2]
- Thirty-five percent of all US counties lack hospitals or birth centers offering obstetric care, and without obstetric providers, with about 60% of these occurring in rural counties.[5]
- National rates for SMM, low birthweight, and infant mortality have increased over time.[6]

The national and South Carolina outcomes convey a clear pattern of missed opportunities to improve maternal health outcomes. In response to these outcomes, the SCMHIC will seek to develop and implement creative and innovative solutions in collaboration with diverse partners dedicated to engagement and elevating the voices of those with personal experience.

Although this effort cannot address all the drivers of poor maternal health outcomes, it will focus on innovations that target the following:

- Lack of or limited data on maternal health to leverage change at differing levels, people with individual experience,

[4] https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2023/Estat-maternal-mortality.pdf
[5] https://www.hrsa.gov/maternal-health
[6] https://www.americashealthrankings.org/learn/reports/maternal-and-infant-health-disparities-data-brief/key-findings-health-outcomes

communities, county, and state levels, with stratification to better understand differences across communities.

- Lack of access to medical and human services information at differing levels of geography and the funding to empower local communities to address gaps.
- Workforce shortages and the need to develop resources to enhance care coordination across a continuum of providers to deliver respectful care.
- Lack of or limited information on maternal warning signs to prevent poor maternal outcomes and empower mothers, their families, and communities to maximize information to avert maternal complications and death.

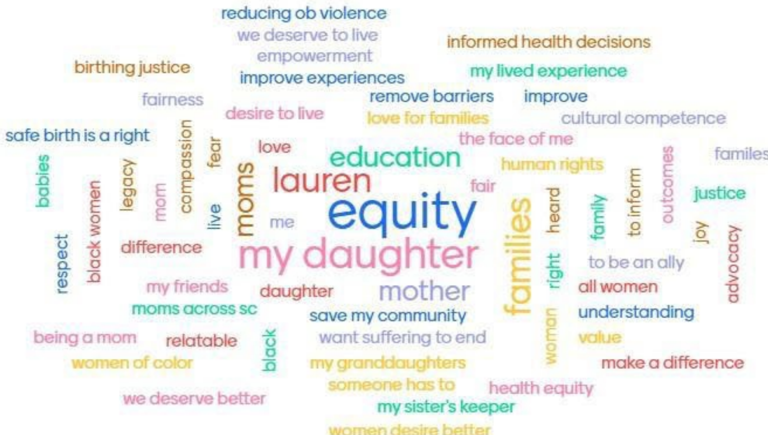
Aim:

The SCMHIC MHTF aims to bring together diverse perspectives from various sectors to encourage innovation in maternal health initiatives and address critical drivers preventing optimal maternal and child outcomes.

Mentimeter

Reflections: What is your why for improving maternal health outcomes?

82 responses



(Figure reflects the results of a Mentimeter word cloud activity conducted at the SCMHIC MHTF launch meeting, August 22, 2024.)

Membership by Organization

In building the MHITF, we are keenly aware of the various initiatives across South Carolina that support the improvement of maternal health outcomes and the reduction of severe maternal mortality and morbidity.

SCMHIC MHTF—Current Members as of September 2025		
Member Name	**Organization**	**Role**
Clinical/Provider Organizations and Partners		
Michelle Flanagan	Prisma Health Quality & Patient Safety	Clinical Consultant, OB Outreach Educator
Connie Guille	Medical University of SC (MUSC)	Women's Reproductive Behavioral Health Division Director
Nita Thapa	Cooperative Health-FQHC	Director of OB/GYN
Kacey Eichelberger	Prisma Health University of South Carolina	Chair, Dept. OB/GYN Professor, Maternal Fetal Medicine
Amy Crockett	Prisma Health Upstate	Maternal Fetal Medicine Physician
Cheryl Neuner	McLeod Health	Regional Systems Developer
Kathy Ray	MUSC	Regional Systems Developer
Renee Washington	Prisma Health Midlands	Regional Systems Developer
Faith Knowles	Prisma Health Upstate	Regional Systems Developer
Aunyika Moonan	SC Hospital Association CaroNova	VP of Innovations, SC Director of Implementation
Dom Francis	SC Hospital Association	Manager, Community Health and Social Drivers of Health
TK Curtis-Pugh	SC Nurses Association	Executive Director
Jewel Scott	Columbia Black Nurses Association	Member
Randy Branham	Prisma Health Midlands	Director of Simulation and Clinical Skills
Kelly Bockelmann	Humana	Senior Quality Compliance RN

Jennifer Desai	McLeod Health	OB Outreach Educator
Susan Cheek-Williams	Prisma Health	Midwifery Division Director
Keisha Lockhart	After Birth LLC	Founder and Provider
Jeffery Hall	University of South Carolina Prisma Health	Clinical Professor of Family and Preventive Medicine Family Medicine Provider
Patricia Witherspoon	Prisma Health–Columbia	Family Medicine Physician and Medical Consultant
Community Organizations and Partners		
Tanya Ambrose	Scrub Life Cares	Founder CEO
Sarah Covington-Kolb	Center for Community Health Alignment	Program Impact Manager
Angela Johnson	Trident United Way	Director of Health
Kim Alston	Healthy Start Midlands	Director
Jaiden Branch	SC First Steps	Evaluation Coordinator
Kerry Cordan	SC First Steps	Health Program Manager
Amy Holbert	Family Connection	Chief Executive Officer
Symon'e Johnson	Pamoja Partnership	CEO, Holistic Doula
Paris Mebane	Clemson Extension, Williamsburg Community Care Coalition (WC3), an Alliance for Innovation on Maternal Health-Community Care Initiative (AIM CCI) Grantee	Co-chair Extension Associate, Rural Health & Nutrition Program Team
Regina Nesmith-Dimery	WC3 DPH	Co-chair Community Engagement Manager, Community Systems Team
Amber Pendergraph	BirthMatters	Executive Director
Cortni Jones	SC First Steps	Local Partnerships Health Program Assistant
Kelssy Ambrosio Soto	PASOs	Evaluation and Quality Control Coordinator
Lamikka Samuels	Family Solutions	Senior Director

Rhonda Sims	MoMMA's Voices Columbia Black Maternal Health Week	Founder
Kim Smith	Health Evolve	CEO
Shaterica Neal	Good Hands Political Advocacy & Co.	CEO
Rachel Grater	Project ECHO	Program Manager
Tiffany Townsend	De La Flor Midwifery	Senior Midwife
Quantrilla Ard	Health Evolve	Director of Research and Strategic Partnerships
Stormi Harmon	Live 2 Serve	Founder & Owner
Sydney Estes	Hope Feeds Families and Feeding Families Education and Consulting	IBCLC
Ladrea Williams-Briggs	#NotUsSC	Executive Director
Julie Greer	Spartanburg Academic Movement	Prenatal to Three Coordinator
Educational Entities and Research Partners		
Amelia Clinkscales	Clemson University, College of Behavioral, Social, and Health Sciences	Senior Lecturer, Women's Health Researcher
Ashley Knowell	SC State University Health Equity Research & Training Center	Associate Professor Co-Director
Jihong Liu	University of South Carolina, School of Public Health	Division Director of Epidemiology
Kerry Sease	Furman University Institute for the Advancement of Community Health	Executive Director
Rachel Mayo	Clemson University, Dept of Public Health	Professor
Deborah Billings	University of South Carolina	Professor, Maternal Health Researcher
Berry Campbell	Prisma Health, University of South Carolina Medical School	Maternal Fetal Medicine Specialist Director of Maternal Fetal Medicine
Tisha Felder	University of South Carolina College of Nursing Black Breastfeeding Study	Associate Professor Researcher

Curisa Tucker	USC, College of Nursing	Assistant Professor
Hope Lima	Winthrop University, Department of Human Nutrition	Department Chair Associate Professor
Deborah Hopla	Francis Marion University	Director of Nursing Programs
Karen Warren	University of South Carolina College of Nursing	Assistant Professor
Jennifer Baumstark	University of South Carolina Nurse-Midwifery Program	Program Director/Associate Professor
Individual Experience/Perinatal Advisory Council*		
Saheigh Leveque	Community Member	Community Member/ Parent Educator
Public Health Organizations and Maternal and Child Health (MCH) Initiatives		
Eric Bellamy	Children's Trust of SC	Chief Partner Engagement Officer
Brie Hunt	SC Institute of Medicine and Public Health	Senior Director of Policy
Zeporia Tucker	SC Dept. of Health & Human Services (SCDHHS)	Maternal and Fetal Health Program Manager
Tangee Summers	SC DHHS	TMaH
Megan Weis	SC Center for Rural and Primary Care	Director, Connecting Communities
Kristine Hobbs	SC Birth Outcomes Initiative	Director of Community Initiatives
Tameca Wilson	March of Dimes	Director, SC Maternal Infant Health Initiatives
Christine Williams	DPH	Community Engagement Coordinator
Marie Bass	DPH	MCH Program Manager
Elizabeth Biddle	DPH	MCH Outreach Coordinator
Keisha Moore	DPH	Perinatal Regionalization Program Manager
Danielle Wingo	DPH	Bureau Director
Kim Jenkins	SCMMMRC	Clinical Manager
Alicia Paige	SC Commission on Minority Affairs	Statistical Analyst
Jimmell Felder	Self Regional	Medical Consultant
Beverly Brockington	DPH	Assistant Director
Amber Woodward	Aiken County Emergency Medical	Captain

	Services	
Ashely Lidow	Women’s Rights & Empowerment Network (WREN)	Senior Director of Policy and Government Relations
Paige Jones	DPH	Epidemiologist
Jordyn Livingston	DPH	MCH Research and Planning Administrator
Ann Lefebvre	MUSC, SC AHEC	Executive Director
Media and Information Groups		
Salandra Bowman	SC ETV	Chief Learning Officer
Ashley Locklear	Elsevier	Clinical Editor

***Note:** Additional people with individual experience will be recruited in collaboration with the University of South Carolina Patient Engagement Studio as part of Year 3 cohorts, where they will serve as members of the Perinatal Advisory Council. This list will be updated iteratively as new members are fully onboarded.*

SCMHIC MHTF Member Composition

The structure of the MHTF was intentionally designed to reflect the full range of life experiences that influence maternal and perinatal health across South Carolina. Membership includes representatives from fatherhood programs, rural health organizations, immigrant and Latino-serving groups such as PASOs, Medicaid, the Black Mamas Matter Alliance, and other trusted community-based partners. This intentional approach broadens the understanding of who is impacted during the perinatal period — extending beyond birthing people to include partners, infants, adolescents, and others in the family network. The initiative prioritizes grassroots outreach, especially in rural and hard-to-reach areas, and emphasizes transparency, relationship-building, and consistency as key elements of trust. Community partners are engaged early, compensated fairly, and regarded as essential voices in shaping meaningful and sustainable change.

Clinical/Provider Organizations and Partners are institutions, entities, or individuals dedicated to delivering medical and health-related services to individuals. These entities are typically involved in the direct delivery of clinical care and may include hospitals, clinics, private practices, or specialty centers. These may also include organizations that provide support to those working in clinical environments, such as local nurses' associations and initiatives focused on patient safety and quality improvement.

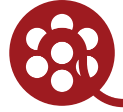
Community Organizations and Partners are groups, entities, or individuals working within a specific group or area to address local needs, enhance well-being, and foster collective action. These groups or individuals focus on social, economic, or environmental issues affecting a specific social group or geographical region. These may include nonprofits, advocacy groups, cooperatives, and other grassroots initiatives that operate to provide a service or assistance to improve their community. Their representation in the MHTF ensures authenticity in our work on community involvement and engagement.

Educational Entities and Research Partners are organizations or individuals involved in providing or supporting education. Examples include schools, colleges, vocational institutes, and online platforms. Many universities in South Carolina have specialized institutes dedicated to community or family health. These centers often conduct research, collect and analyze data, and lead initiatives in maternal health. Their staff are deeply involved in supporting community-based organizations, developing and implementing health programs, and contributing valuable expertise in maternal health policy and intervention.

The Individual Experience/Perinatal Advisory Council represents those who are pregnant, giving birth, or have been pregnant. Their real-world experiences are not just powerful but essential to creating solutions that reflect the realities and needs of the people they are meant to serve. Recruitment for the Perinatal Advisory Council is currently ongoing in collaboration with the University of South Carolina Patient Engagement Studio.

Public Health Organizations and Maternal and Child Health (MCH) Initiatives, both governmental and privately funded, are responsible for collecting vital health data, advising on public health policy, and addressing the needs of specific populations. These organizations may also manage

federally funded programs, such as WIC, and oversee Medicaid through agencies like the Department of Health and Human Services (DHHS).



Media and Information Groups, including the SC Public Broadcasting Station and Elsevier Publishing, are responsible for disseminating knowledge and information through public broadcasts or scientific publications.

Overview of Meeting Frequency and Planned Activities

SCMHIC MHTF Meetings

The inaugural meeting of the SCMHIC MHTF was held on Thursday, August 22, 2024, at the S.C. Archives and History Building. The first meeting was collaborative and energizing, with a focus on providing background information, building partnerships, reviewing data-driven needs, identifying strategies, and planning next steps.

Subsequent meetings will be held quarterly, alternating between in-person gatherings and virtual sessions via Microsoft Teams. The workgroups within the task force meet between scheduled quarterly meetings to explore implementation, data findings, and factors that may require adjustments to the strategies and approach to address the changing maternal health landscape in South Carolina.

MHTF Activities

In Year 2 of the project, the MHTF focused on drafting the maternal health strategic plan, refining implementation strategies, and establishing key avenues for moving forward. This included building relationships with stakeholders, identifying potential partners, and addressing the financial and logistical aspects, such as securing subawards and finalizing contracts. The strategic priorities outlined in this plan are high-level and must be accompanied by specific work plans that detail actions, partners, and a timeline. As the work proceeds over the funding periods, a vital part of the process includes revisiting the annual implementation and evaluation efforts. This requires task group members and innovation partners to work together to support the implementation plan, to network, and ensure the engagement of those involved in similar efforts across organizations and communities.

The MHTF also laid the groundwork for **Year 3**, when the focus will shift to actively implementing the strategies outlined in the plan. This will involve continued collaboration with partners, further development of resources, and the initiation of programs aimed at improving maternal health outcomes across the state. The groundwork laid in Year 2 will ensure a smooth transition into the implementation phase, with a solid foundation for success.

In **Years 4 and 5** of the projects, the MHTF will focus on the ongoing implementation of the strategies outlined in the Maternal Health Innovation Strategic Plan. This phase will involve monitoring the progress of various initiatives, refining them as necessary, and ensuring that they are effectively addressing the needs of communities across the state. The sustainability of this work is critical. To sustain these efforts, partner organizations and stakeholders will explore existing and future funding sources across all strategic priorities where evaluation efforts indicate the effectiveness of the activities.

SECTION 3: SC MHI PROGRAM GOALS AND STRATEGIC PLAN

This section outlines the MHTF's goals, strategies, collaborating partners, objectives, and evaluation measures that guide these activities. The goals align with those of the HRSA MHI Program, as reflected throughout the work plan. The SC Maternal Health Innovation (MHI) has several overarching goals in partnership and collaboration across the state to:

- Reduce the Severe Maternal Morbidity rate by 10% from the 2021 baseline rate of 77.2 cases per 100,000 deliveries by September 29, 2029.
- Reduce the Severe Maternal Mortality rate by 10% from the baseline value of 47.2 deaths per 100,000 births.

The MHTF has broad and ambitious goals that will require careful planning and thoughtful implementation across all sectors and communities. At the same time, the task force members acknowledge that achieving these goals will require multiple years and create the drivers for achieving progress and uniting stakeholders under a shared vision.

The evaluation framework includes maternal health measures at the state level to address factors associated with severe maternal mortality and morbidity. As such, the goals and strategies are consistently designed to address global measures and are tailored to the specific intervention. The statewide measures include the total number of live births, the total number of pregnancy-related deaths, the percentage of live births among mothers with health insurance, the rate of low-risk cesarean births, the percentage of women who received a postpartum visit, and the percentage of women screened for postpartum depression (See Appendix 4 for the definitions).

The following tables reflect both the statewide measures and those specific to the strategies. To support this Strategic Plan, workgroups will continue to help refine the strategic priorities. To ensure sustainability and avoid duplication, collaboration among state and community organizations will be a priority in implementing this plan. A key

factor in the success of the implementation is the continuous engagement of the task force participants and the patient advisory group, ensuring they have a voice through meetings, surveys, and discussion groups.

Maternal Health Data Collection, Analysis, and Distribution

Goal: Enhance maternal health data accessibility, coordination, and utilization across South Carolina through collaboration, capacity building, and public engagement.

<table>
<tr><th>Strategy</th><th>Related Activity</th><th>Objective</th><th>Measurement Evaluating Goal</th></tr>
<tr><td>Support and expand capacity for SCMMMRC data collection & analysis</td><td>DPH funding for an additional position</td><td>By December 2025, SCMMMRC's data abstraction capacity will be enhanced through the hiring of one additional nurse abstractor, funded by DPH, to improve the timeliness and completeness of maternal mortality case reviews. This initiative seeks to reduce the time from death to review completion by 25% compared to the 2024 baseline</td><td rowspan="3">Total number of live births
Total number of pregnancy-related deaths
Percent of live births where the mother had health insurance
Rate of low-risk cesarean birth
Percent of women with a recent live birth who received a postpartum visit
Percent of women with a recent live birth screened for postpartum depression
Percent of women screened for depression or anxiety following a live birth
Percent of women with a diagnosis of diabetes with an ED visit related to the medical condition</td></tr>
<tr><td>Support the data collection and reporting efforts of community-based initiatives</td><td>IFS Subaward: Data support for AIM CCI
DPH data support for Prisma Health Project ECHO Subaward</td><td>By September 2025, provide technical assistance and coordination support to AIM CCI and Project ECHO to streamline maternal health data collection, analysis, and reporting processes, with documented improvements in reporting workflows and submission of at least two complete data summaries per partner</td></tr>
<tr><td>Develop and disseminate maternal health information at different geographical levels</td><td>IFS Subaward: Empower Portal</td><td>By November 2025, launch the MHI Data Hub, featuring maternal health indicators visualized by ZIP code, county, and region, with key indicators available and accompanied by a user guide for community and clinical partners</td></tr>
</table>

Strategy	Related Activity	Objective	Measurement Evaluating Goal
Map out existing and needed maternal health data within the data workgroup	MHTF Data Workgroup Data Mapping Activity & Summary Report	By September 2025, conduct a comprehensive maternal health data mapping activity through the Data Workgroup to identify existing data sources, data ownership, and key gaps, including equity-related gaps, and present findings in a summary report to the Maternal Health Force	Percent of women with a diagnosis of hypertension with an ED Visit related to the medical question Number of requests for data and integration into other efforts supporting initiatives centered on improving maternal outcomes

Maternal Health Service Delivery

Goal: Improve maternal health service delivery statewide by enhancing care coordination, expanding access to services, and fostering innovation and community collaboration to build a more robust and effective healthcare system.

<table>
<tr><th>Strategy</th><th>Related Activity</th><th>Objective</th><th>Measurement Evaluating Goal</th></tr>
<tr><td>Develop a low-fidelity curriculum focused on obstetric emergencies and maternal health care</td><td>Prisma Health Clinical Champion Subaward: Low-fidelity Curriculum</td><td>By December 2025, develop and deliver a low-fidelity, evidence-based obstetric emergency training curriculum through a train-the-trainer model, preparing clinical champions and reaching providers—especially in rural and underserved areas—via in-person and virtual sessions statewide</td><td rowspan="3">Survey and follow-up with practitioners and participants
Logs of activities and event evaluation
Total number of pregnancy-related deaths
Percent of live births where the mother had health insurance
Rate of low-risk cesarean birth
Percent of women with a recent live birth who received a postpartum visit
Percent of women with a recent live birth screened for postpartum depression
Percent of women screened for depression or anxiety following a live birth</td></tr>
<tr><td>Expand maternal health services through telehealth, mobile, or other technology-based initiatives</td><td>SCSU Subaward: Digital Collaboration Platform</td><td>By September 2025, implement and evaluate a digital care coordination app at community-based Mom's Café events by finalizing a care coordination protocol, training staff, integrating the app at 60% of events, and analyzing referral and feedback data to inform future improvements</td></tr>
<tr><td>Enhance care coordination and expand access to culturally responsive perinatal support</td><td>Perinatal Community Health Worker Workshop</td><td>By January 2026, implement the quarterly Perinatal Community Health Worker Workshops to train 60–80 CHWs and community leaders annually in core perinatal health competencies</td></tr>
</table>

Strategy	Related Activity	Objective	Measurement Evaluating Goal
Support statewide implementation of the Postpartum Alert Bracelet, including provider education on evidence-based response to obstetric emergencies	Postpartum Alert Bracelet	By October 2025, develop, pilot, and expand a standardized PALMETTO-BIRTH band (Palmetto Awareness to eLevate Maternal Emergencies To sTrengthen Outcomes—Bracelets Identifying Risks To Her), providing educational materials, staff training, and bracelets to postpartum patients in pilot counties; analyzing implementation data; and scaling statewide to ensure all birthing facilities adopt the protocol by 2028	Percent of women with a diagnosis of diabetes with an ED visit related to the medical condition Percent of women with a diagnosis of hypertension with an ED Visit related to the medical question

Maternal Health Workforce Development

Goal: Strengthening the maternal health workforce through cross-sector collaboration, capacity building, and enhanced training opportunities for healthcare providers and birth workers.

Strategy	Activity	Objectives	Measurement Evaluating Goal
Support provider education and the adoption of evidence-based care that enhances clinical and community-based collaboration with practical applications	Project ECHO Collaborating Partnerships: • IFS/DPH	By September 2025, support Prisma Health's Project ECHO: SC Pregnancy Wellness in its efforts to host one-hour, biweekly virtual learning sessions using the ECHO model to build clinical and community provider knowledge of evidence-based best practices and community-based strategies to improve maternal health outcomes By February 2026, expand the capacity of Project ECHO: SC Pregnancy Wellness's website to house session recordings, provider resources, and a digital collaboration space to strengthen communication between clinical and community-based providers By May 2026, provide case studies in support of the learning objectives associated with Project ECHO, enhancing the application of learning sessions By May 2026, provide training with an emphasis on respectful care using the Voices/Voces Training Curriculum	Logs and participant evaluation survey Total number of pregnancy-related deaths Percent of live births where the mother had health insurance Rate of low-risk cesarean birth Percent of women with a recent live birth who received a postpartum visit Percent of women with a recent live birth screened for postpartum depression Percent of women screened for depression or anxiety following a live birth

<table>
<tr><th>Strategy</th><th>Activity</th><th>Objectives</th><th>Measurement Evaluating Goal</th></tr>
<tr><td>Enhance and expand simulation-based training on OB emergencies</td><td>SimCoach™</td><td>Evaluate the effectiveness and scalability of the SimCoach™ training program to determine its potential for expansion into rural and community-based settings

Expand the SimCoach™ program to strengthen obstetric emergency preparedness in hospitals, emergency departments, family medicine settings, and community organizations providing direct clinical services to pregnant women</td><td rowspan="2">Percent of women with a diagnosis of diabetes with an ED visit related to the medical condition

Percent of women with a diagnosis of hypertension with an ED Visit related to the medical question

Log of attendance and participant evaluation

Annual survey of participants with geographical measures of pre- and post-statistics at the geographical unit of the sites

Percent of facilities that adopt and indicate the use of low-fidelity training

Total number of pregnancy-related deaths</td></tr>
<tr><td>Enhance the opportunities for low-fidelity training.</td><td>Collaborating Partnership:

• Prisma/DPH/IFS</td><td>Provide low-fidelity training materials addressing OB emergencies to ED hospitals, family medicine settings, emergency medical services, and community-based organizations to increase the knowledge base and opportunities for consultation on OB protocols

Provide a virtual simulation of key OB emergencies based on the SimCoach™ curriculum to key stakeholders with an accompanying tool for assessing learning</td></tr>
</table>

Strategy	Related Activity	Objective	Measurement Evaluating Goal
Provide learning opportunities and scholarships to support undergraduate students (with two-year and four-year degrees) in the health professions across various disciplines, increasing their knowledge and promoting professional development and respect for the maternal health profession	DPH/IFS **Collaborating Partnership**: • Technical colleges offering health professions training(Associate level) • Colleges offering undergraduate training in health professions • USC and MUSC Medical School (2nd and 3rd year students)	By October 2026, MCH Internships will have a focus on health policy and services By December 2026, provide a web platform for technical college and undergraduate students to explore differing health professionals available through the SC educational entities By December 2026, provide a comprehensive resource platform engaging health professionals to explore training opportunities and legislation governing practice in these professions By January 2026, provide a virtual symposium and a lunch-and-learn series on the work of the MHI, highlighting work opportunities and internships for non-public health students By March 2026, provide ongoing support for engineering and related technical fields associated with application development, designed to meet the needs of pregnant women and stakeholders who need resources and information By June 2026, provide five annual scholarships to attend a professional conference in the health profession field, with an emphasis on maternal health, that offers exposure to and new learning opportunities for improving maternal health outcomes	Logs of attendance, visits to web and resource tools, and awarded scholarships Percent of students who participate in an internship or virtual learning report an increased awareness of available healthcare professions and enter or select a continuation of education in the field Percent of individuals who complete the online resource evaluation and report increased knowledge of available options in the health care profession

Maternal Health Empowerment and Literacy

Goal: Equip healthcare providers, organizations, and community members with resources that promote maternal and perinatal health literacy, empowering individuals to make informed decisions and recognize early warning signs of potential complications.

Strategy	Related Activity	Objective	Measurement Evaluating Goal
Develop and disseminate an online Maternal Health Resource Hub with AI Chatbot Integration	EMPOWER Resource Hub	By November 2025, develop and launch a Maternal Health Resource Hub with AI chatbot integration, providing easy access to maternal health education, local resources, and peer support. Quarterly update of the resources and expansion to address identified needs	Log of use and participant evaluation documenting use, engagement, and reporting satisfaction with the available resources across differing groups in South Carolina

<table>
<tr><th>Strategy</th><th>Related Activity</th><th>Objective</th><th>Measurement Evaluating Goal</th></tr>
<tr><td>Create a perinatal advisory council</td><td>Perinatal Advisory Council</td><td>By October 2025, expand the reach and use of culturally relevant maternal health education materials by equipping clinical and community-based organizations across South Carolina with tools and guidance to incorporate them into outreach, support groups, and events, in collaboration with trusted campaigns and partners</td><td rowspan="4">Report of engagement at the meetings and contributions to the review of the materials and activities of the task force

Evaluation of proposed versus actual implementation of efforts and documentation of impact

Attendance logs and evaluation of the impact of activities on increasing learning and commitment to community action to improve maternal outcomes and reduce severe maternal mortality and morbidity

Logs of dissemination and evaluation of the impact of activities on increasing learning and commitment to community action to improve maternal outcomes and reduce severe maternal mortality and morbidity

Logs of dissemination, incorporation of the Postpartum Alert Bracelet into the hospital, and care coordination reported protocols

Pilot areas measurements of the percent of women with a recent live birth who received a postpartum visit

Percent of women with a recent live birth screened for postpartum depression

Percent of women screened for depression or anxiety following a live birth</td></tr>
<tr><td>Support community partnerships that improve maternal health knowledge and early health literacy</td><td>Small Grants</td><td>By September 2027, we will support three community-based organizations across South Carolina through the Small Grants Project, enhancing access to maternal health education, peer support, and local resources for individuals experiencing perinatal health issues. The awards will be a minimum of $20,000 annually for two years</td></tr>
<tr><td>Improve access to maternal health education, peer support, and local resources through community-based organizations</td><td>Mom’s Cafe</td><td>By September 2025, implement the Mommy’s Café initiative across all South Carolina regions, partnering with community-based organizations to host 30 pop-up events that deliver maternal health education, peer support, and resource navigation</td></tr>
<tr><td>Support and expand the use of maternal health education materials across partnerships and community organizations</td><td>Maternal health education distribution partnerships (SCDPH, CDC Hear Her, March of Dimes, etc.)</td><td>By June 2026, expand the reach and use of culturally relevant maternal health education materials by equipping at least 35 clinical and community-based organizations across South Carolina with tools and guidance to incorporate them into outreach, support groups, and events, in collaboration with trusted campaigns and partners</td></tr>
</table>

<table>
<tr><th>Strategy</th><th>Related Activity</th><th>Objective</th><th>Measurement Evaluating Goal</th></tr>
<tr><td>Increase statewide awareness of maternal health warning signs and promote greater recognition of the postpartum period as a critical phase of care</td><td>Postpartum Alert Bracelet</td><td>By September 2028, develop and pilot a comprehensive education and expansion plan for the PALMETTO-BIRTH band (Palmetto Awareness to eLevate Maternal Emergencies To sTrengthen Outcomes—Bracelets Identifying Risks To Her) by creating accessible materials, equipping at least five community and healthcare partners in pilot counties, and laying the groundwork for statewide awareness, to reach at least 75% of communities in pilot and expansion counties</td><td rowspan="2">Percent of women with a diagnosis of diabetes with an ED visit related to the medical condition

Percent of women with a diagnosis of hypertension with an ED Visit related to the medical question

Logs of dissemination and reported use across different stakeholders

Percent of individuals who participate in Train the Trainer Modules by organization type

Web statistics indicating the use and download of materials

Adoption and continued use of respectful care modules across the identified targeted efforts of the MHI activities</td></tr>
<tr><td>Leverage digital media to improve maternal health literacy and community awareness</td><td>IFS Subaward: Voice/Voces Initiative</td><td>By September 2027, develop and implement a comprehensive communications plan that leverages the Voices/Voces Initiative to promote and disseminate information about key MHI initiatives, including the Post-Birth Alert Orange Bracelet Program, MHI Resource Hub, Maternal Health Data Hub, Mom’s Café, and Project ECHO</td></tr>
<tr><td>Improve access to Spanish-language maternal health materials, services, and digital tools across South Carolina</td><td>Spanish materials
Spanish resource hub</td><td>By September 2027, ensure the availability of Spanish-language maternal health education materials by translating key MHI resources, supporting partners in offering materials in Spanish, and integrating Spanish-language functionality into the Maternal Health Resource Hub</td><td>Percent of users who access the available information in Spanish

Percent of Spanish language users who report satisfaction with the tool, resources, ease of use, and the content</td></tr>
</table>

Appendix 1:
South Carolina Maternal Morbidity and Mortality Review Committee Legislative Brief

South Carolina Maternal Morbidity and Mortality Review Committee

2025 LEGISLATIVE BRIEF

South Carolina Maternal Morbidity and Mortality Review Committee Co-Chairs:
Naida Rutherford, APRN-BC
Ashley Jones, MD

The South Carolina Maternal Morbidity and Mortality Review Committee (SCMMMRC) was established under Act 42 of 2016 (South Carolina Statute Section 44-1-310) and, in accordance with the Act, the Committee must review all maternal deaths that occur during pregnancy or within 365 days after the pregnancy ends, regardless of the cause death and compile and distribute an annual report of their findings by March 1st. Each death is examined using a standardized approach, which involves investigating the underlying causes of death, the pregnancy-relatedness, preventability, and any circumstances or contributing factors surrounding the death.

Goals

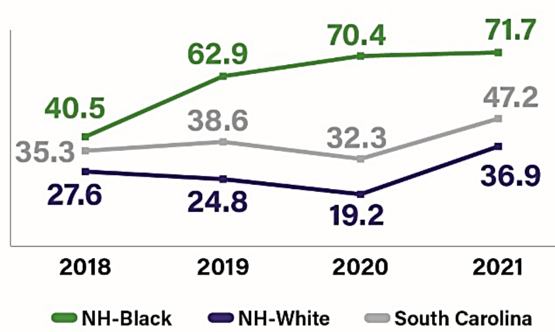
Determine the annual number of pregnancy-associated deaths that are pregnancy-related.

Identify trends and risk factors among preventable pregnancy-related deaths in SC.

Develop actionable recommendations for prevention and intervention.

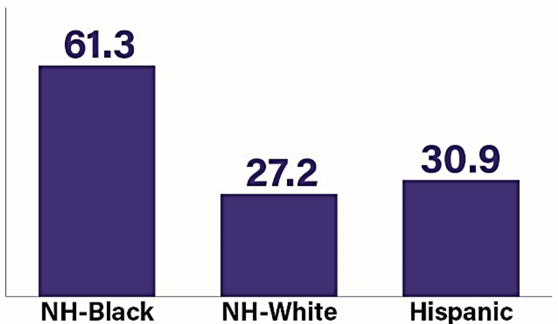
Trend in Pregnancy-Related Mortality Rate, by Race and Ethnicity

Rate per 100,000 live births



Pregnancy-Related Mortality Rate, by Race and Ethnicity

Rate per 100,000 live births, 2018-2021



In 2024, the SCMMMRC completed the review of 88 deaths occurring in 2021; 27 of the deaths were determined to be Pregnancy-Related (PR). A PR death occurs when a woman dies from a pregnancy complication, a chain of events initiated by the pregnancy, or a condition made worse by the pregnancy.

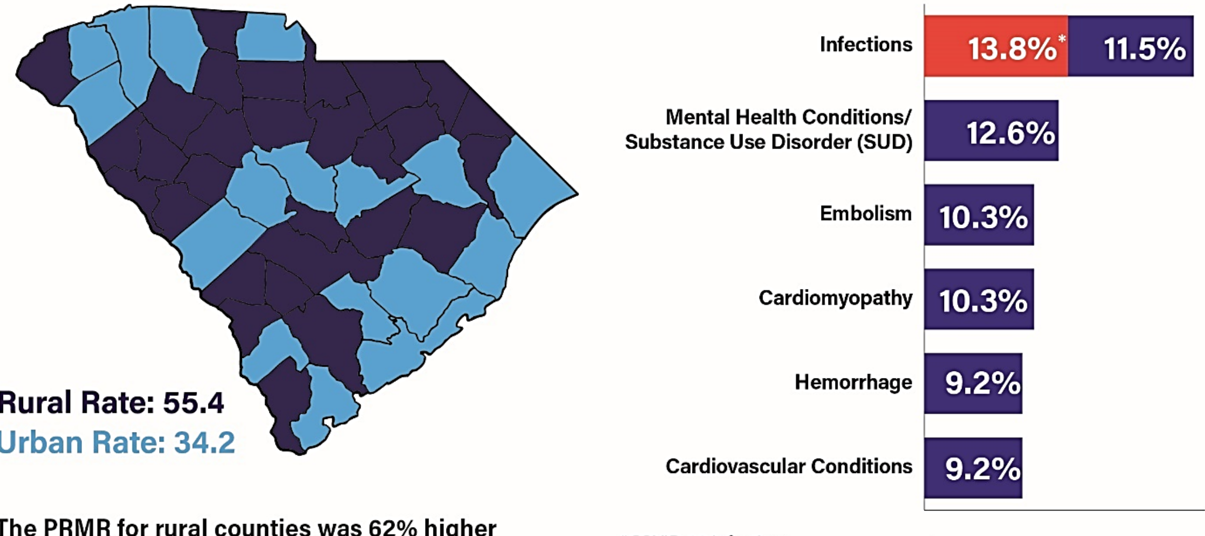
In 2021, the SC Pregnancy-Related Mortality Rate (PRMR) was 47.2 PR deaths per 100,000 live births, a 46.2% increase from 32.3 in 2020. Black women were nearly twice as likely to die than White women. During the years 2018 to 2021, the overall PR death rate differed by race and ethnicity **(61.3 for non-Hispanic Black, 27.2 non-Hispanic White, and 30.9 for Hispanic mothers)**.

Pregnancy-Related Mortality Rate, by Urban and Rural Designation

Rate per 100,000 live births, 2018-2021

Leading Causes of Pregnancy-Related Deaths

Percent of pregnancy-related deaths, 2018-2021



The PRMR for rural counties was 62% higher than the PRMR for urban counties[1] (55.4 and 34.2, respectively).

Pregnancy-Related Deaths

- **The cause of PR death refers to the specific underlying medical condition or event that directly led to the individual's death. This is typically determined through clinical records, autopsy reports, and death certificates.**
- **Over half of all PR infection deaths were attributed to COVID-19. COVID-19 accounted for 13.8% of all PR deaths during 2018-2021.**
- **In 2021, there were fewer PR deaths due to mental health conditions/substance use disorder (SUD), embolism and hemorrhage than in 2020. PR deaths due to mental health conditions/ SUD decreased by 53.4% from 2020 to 2021.**

The top three leading causes of death varied by race, from 2018-2021:

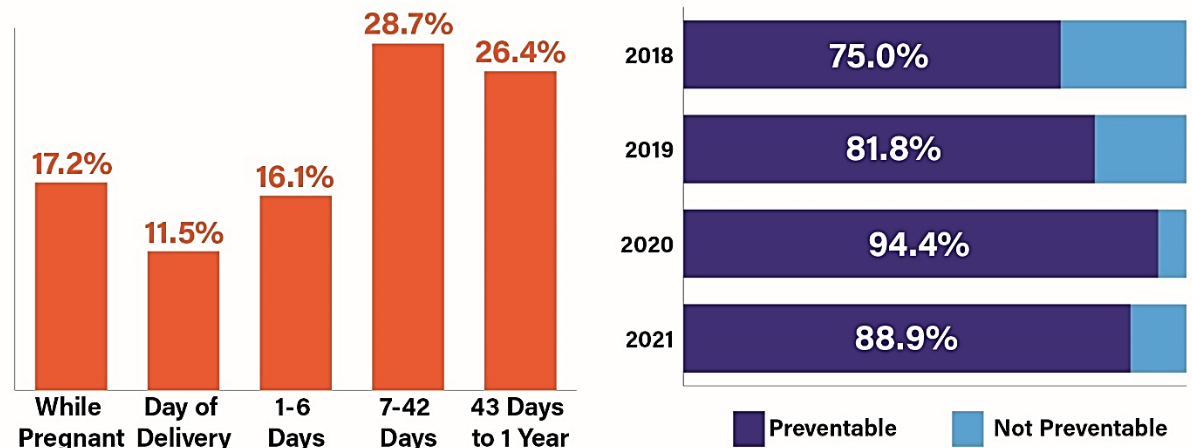
Non-Hispanic White Women	Non-Hispanic Black Women
• Infections	• Infections
• Mental Health Conditions/SUD	• Embolism
• Hemorrhage	• Heart Conditions

Timing of Pregnancy-Related Deaths

Percent of pregnancy-related deaths, 2018-2021

Preventability of Pregnancy-Related Deaths

Percent of pregnancy-related deaths, 2018-2021

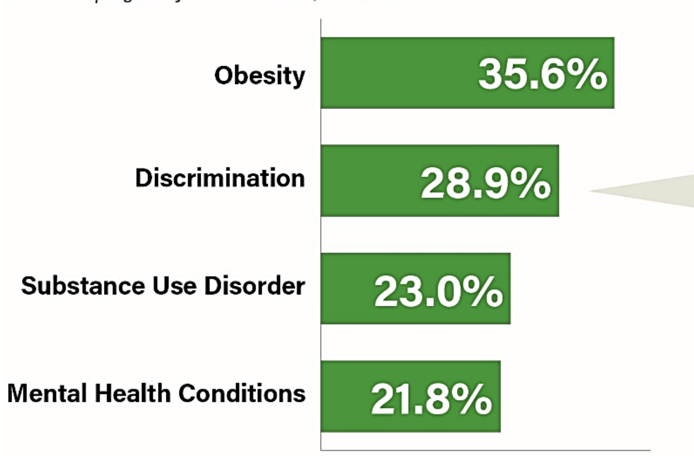


Among pregnancy-related deaths, 55.1% occurred 7 to 365 days post-partum. SC has seen an increase in pregnancy-related deaths in the late post-partum period (7-365 days), from 1 in 5 deaths in 2018 to about 2 in 3 deaths in 2021. The top three leading causes of death during the late post-partum period were infections, mental health conditions/SUD, and cardiomyopathy.

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. These changes may occur at the patient/family, provider, facility, system, or community levels and may be associated with various contributing factors.[2] **The causes of death determined most likely to be preventable were mental health conditions/SUD (100%), embolism (89%), and infection (86%).**

Circumstances of Pregnancy-Related Deaths

Percent of pregnancy-related deaths, 2018-2021



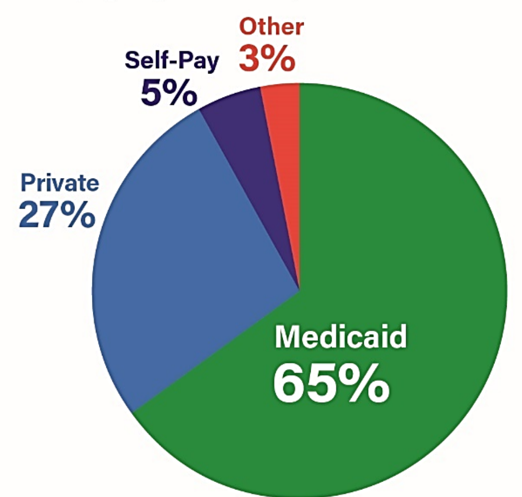
Discrimination

The possibility of discrimination is described as treating someone less or more favorably based on the group, class, or category they belong to resulting from biases, prejudices, and stereotyping. It can manifest as differences in care, clinical communication, and shared decision-making.[3]

Circumstance of PR death refers to the broader social, behavioral, or systemic factors that contributed to the death. These circumstances help provide additional context of contributing factors related to the death. Obesity was recognized as a contributing factor in a little over one third of PR deaths from 2018 to 2021. Discrimination was recognized as a contributing factor in a little over one quarter of the PR deaths.

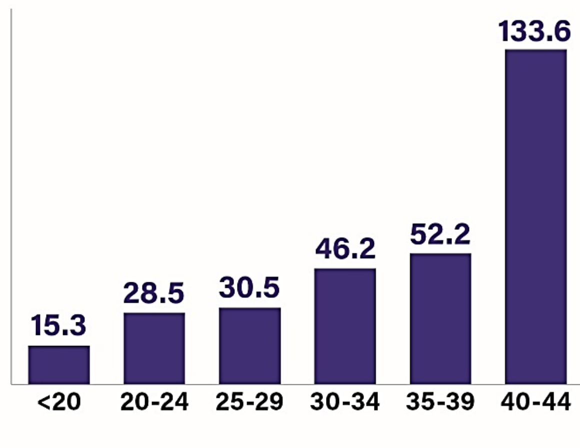
Pregnancy-Related Deaths, by Payor Source

Percent of pregnancy-related deaths, 2018-2021



Pregnancy-Related Mortality Rate, by Age

Rate per 100,000 live births, 2018-2021



All data presented through 2021 reflect Medicaid coverage that ended at 60 days post-partum. With the 2022 extension of Medicaid benefits through 365 days post-partum, an increase in utilization of services is anticipated during this time, which may impact the PR deaths among this population.

Key Takeaways

Pregnancy-related deaths increased among NH-White and NH-Black mothers with NH-Black mothers twice as likely to die.

Infection (and in particular, COVID-19 infection) was the leading cause of PR deaths from 2018-2021, followed by mental health conditions/SUD, and embolism.

The PRMR was 62% higher in rural counties than in urban counties in 2018-2021.

Citations:

1. https://www.census.gov/programs-surveys/geography/guidance/geo-areas/urban-rural.html
2. Pregnancy Related Death: Data from Maternal Mortality Revie Committees in 36 States, 2017-2019. Retrieved from https://www.cdc.gov/maternal-mortality/php/data-research/mmrc-2017-2019.html
3. Institute of Medicine (US) Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care. Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. Smedley BD, Stith AY, Nelson AR, editors. Washington (DC): National Academies Press (US); 2003. PMID: 25032386.

Recommendations from the SCMMMRC are strategies to improve maternal outcomes.

System Level: All women should have access to maternity care regardless of where they live and their ability to pay for care. All pregnant and post-partum women should receive healthcare that is respectful, non-judgmental, and non-biased and considers their cultural differences. SC should adopt an access to treatment model versus a punitive model for pregnant women who have a substance use disorder. SC should promote fair treatment of women with substance use disorder; it should be de-stigmatized and given the same consideration as a medical diagnosis. Case management and nurse navigators should be utilized for care coordination to assist pregnant women with complex medical conditions, including mental health conditions and substance use disorder.

Facility Level: Facilities should implement maternal safety bundles and use these tools to adopt standards of care. Drug and alcohol screenings should be required at facilities for women who received no prenatal care or have a history of substance use disorder. Additionally, facilities should require Emergency Room physicians and personnel to participate in training on the appropriate care of pregnant and post-partum women.

Provider Level: Providers should advise pregnant and post-partum women on the benefits and risks of the COVID-19 and all recommended vaccines. For pregnant women with moderate to severe COVID-19 infection, providers should consider the administration of monoclonal antibodies. Providers should screen and refer pregnant & post-partum women who screen positive for substance use or mental health conditions to the appropriate services for treatment.

Community Level: South Carolina communities should provide community outreach to include education about Urgent Maternal Warning Signs. South Carolina should have community-wide education, resources and information about substance use disorder available to pregnant and post-partum women and their families.

Patient and Family Level: Pregnant women should follow the American College of Obstetricians and Gynecologists and Society for Fetal Medicine recommendation that the COVID-19 vaccine is safe in any trimester.

Summary:

The SCMMMRC has identified several disproportionately affected populations that experienced a pregnancy-related death during 2018-2021, including non-Hispanic Black women, rural county residents, and women of advanced maternal age. Further, infections were the leading cause of PR deaths, and over half of these were attributed to COVID-19. The SCMMMRC is committed to improving maternal health outcomes and eliminating preventable deaths. The 2022 extension of SC Medicaid coverage provides continued benefits for post-partum women beyond the standard 6-week Ob/Gyn visit. This is an opportunity to establish a primary care provider and address key health care needs such as obesity, hypertension, mental health conditions and substance use disorder.

Committee Wins:

The Centers for Disease Control and Prevention (CDC) awarded funds for a five-year period to support the SCMMMRC. The funds will be utilized to increase timeliness and standardization of surveillance activities, data reporting, and to facilitate community engagement. The SCMMMRC is committed to eliminating pregnancy-related deaths.

APPENDIX 2:
MATERNAL HEALTH INITIATIVES IN SOUTH CAROLINA

Below is a comprehensive list of maternal health initiatives in South Carolina, in addition to those listed in the respective subheading under *Section I: Overview of Maternal Health and Resources*. These are additional resources identified through a December 2024 SCMHTF survey.

- **Access Health** is a network of community-based programs across South Carolina that provide coordinated healthcare services to uninsured and underinsured individuals.
- Pilot doula programs at Prisma Health funded by the TD Charitable Foundation (i.e., "**Black Doula Project**") and another funded by The Duke Endowment in Columbia serving Medicaid-insured, uninsured, teen, and Black mothers to offset the cost of doula services.
- Based in rural Hartville, South Carolina, **Carolina Pines Regional Medical Center –Midwifery** offers comprehensive maternity services, including a laborist model with continuous, 24-hour coverage of the labor and delivery unit.
- **Center for Community Health Alignment** perinatal community health worker initiatives addressing the social determinants of health.
- Mobile health clinics and library programs funded by the **Center for Rural and Primary Healthcare** addressing chronic care and women's health services.
- **Choose Well** is the largest statewide contraceptive access initiative in the Southeast, aiming to reduce unintended pregnancies by providing comprehensive family planning services. The program collaborates with various healthcare providers to offer education, resources, and access to a wide range of contraceptive
- **Emmanuel Family Clinic** in Newberry assists women in affording and receiving prenatal care, ensuring that expectant mothers have access to necessary medical services. The clinic is currently expanding its reach to serve additional counties, aiming to improve maternal health outcomes in underserved areas.

- **Family Connects** is a universal home visiting program implemented in hospitals in Spartanburg through the Hello Family initiative and in Greenville through Greenville County First Steps and Pickens County First Steps. The program begins with a nurse visit to the mother and newborn in the hospital and continues with home visits to provide support and resources.
- **Guided Beginnings** is a program at Self Regional Healthcare, funded by the Center for Rural and Primary Healthcare (CRPH), designed to support high-risk pregnant mothers and their infants. This Collaborative Health Community (CHC) includes a dedicated Perinatal Community Health Worker (CHW) program that offers personalized assistance, education, and resources to ensure healthy pregnancies and improve birth outcomes.
- **H.O.P.E. (Healthy Opportunities for Perinatal Equity) Program of La Clinica Gratis** provides comprehensive support and services to uninsured and underinsured pregnant mothers and their babies in the Lakelands communities of South Carolina.
- **Magdalene Clinic at Prisma Health** specializes in assisting pregnant women who are dealing with substance use disorders in Greenville and Seneca, South Carolina. The clinic offers integrated care that addresses both prenatal health and substance use treatment, aiming to support the health of both mother and child through a multidisciplinary approach.
- **Management of Maternal (MOMs) Diabetes Program** at MUSC Women's Health and Prisma Health Greenville and Midlands.
- The **Maternal and Child Health (MCH) CATALYST Program** at the University of South Carolina focuses on promoting education and research in maternal and child health. Funded by the Health Resources and Services Administration (HRSA), the program informs policy, trains future leaders, and works to expand the maternal and child health workforce, aiming to improve health outcomes through academic and community collaboration.
- The HRSA-funded University of South Carolina **Maternal and Child Health and Leadership, Education, and Advancement in Undergraduate Pathways (LEAP)** program led by Dr. Jihong Liu, which provides MCH-related mentorship and training to students from underserved or racially and ethnically under-represented backgrounds.
- **Moms in Control at Prisma Health** is a diabetes management program at Prisma Health which offers specialized care and education for pregnant women managing diabetes, aiming to ensure healthy pregnancies and reduce

complications associated with gestational diabetes. This model of care was established and funded in partnership with Diabetes Free SC and BlueCross BlueShield of South Carolina Foundation and through their Management of Maternal Diabetes (MOMs) program which launched in 2020.

- **Mom's IMPACTT** is a mental health and substance use disorder resource and referral program tailored for pregnant or postpartum individuals. Offering telehealth services, the program provides accessible support and connects individuals to necessary treatment and resources, addressing critical behavioral health needs during and after pregnancy.
- Telemedicine and telehealth initiatives funded through the **Patient-Centered Outcomes Research Institute (PCORI)** and housed at the Medical University of South Carolina with Dr. Connie Guille supporting mental health care and postpartum screening and care coordination (**Project DREAM**). PCORI is also funding grants in South Carolina centered on breastfeeding and improving postpartum outcomes through doula care (**H.E.A.R 4 Mamas**).
- **Power In Changing's Prenatal Power Program** distributes vitamins and essential baby kits to expectant mothers. This initiative supports maternal and infant health by providing necessary prenatal supplements and newborn care items to mothers in need.
- Clinical training offered through **Project ECHO South Carolina Pregnancy Wellness**, which is a network of obstetric providers working to support provider capacity and improve maternal health care and outcomes in the state.
- The **Rural Health Collaborative** brings together members who work collectively to achieve excellence in rural healthcare to address unique challenges faced by rural communities, including access to maternal health services, by fostering partnerships and implementing innovative solutions.
- **SCDHHS Hospital Quality Achievement Program** is working to reduce elective deliveries and decrease preterm and low birthweight births through incentivized payments.
- **SEEDS (Supportive Engagement for Every Dimension of Substance Use in Postpartum People) Program** is an intensive care management initiative funded by The Duke Endowment, serving pregnant and postpartum individuals with substance use disorders in Greenville. The program aims to reduce postpartum relapse and mortality by providing comprehensive support, including counseling, medical care, and connection to community resources.

- **SimCoach™** is a fully equipped mobile simulation training center led by Prisma Health-University of South Carolina School of Medicine Simulation Center.
- **South Carolina Institute for Medicine & Public Health (IMPH) task force** focused on rural access to care for improving maternal and infant health in counties without an obstetrician and/or birthing center.
- The **South Carolina Rural Provider Incentive Program**, the **SCDHHS Rural & Medically Underserved Area Grant,** and the **SCORH Revolving Loan Fund** provide financial resources to shore up rural access to care.
- Training for clinical and community providers focused on implicit bias and respectful care offered through both the South Carolina March of Dimes and IFS **Voices/Voces Initiative**.

Appendix 3

Title V Needs Assessment Summary and 2026-2030 State Action Plan

1. Process Description

The SC Department of Public Health's (SC DPH) Bureau of Maternal and Child Health (MCH) collaborated with the University of South Carolina's Center for Applied Research and Evaluation (CARE) to identify community needs and desired outcomes for maternal and child health (MCH) populations as well as the existing capacity of programs and organizations across the state to address the identified areas of need. The goals of the needs assessment were to determine priority needs, develop an action plan, and inform allocation of funds and resources to promote the health of women; children and adolescents, with and without special healthcare needs; and their families.

A mixed-method systems approach was used for this process, wherein programs, policies and statewide organizations were considered as parts of a whole MCH serving system. The needs assessment is viewed as a continuous process that will continue to engage stakeholders into and beyond the data gathering and prioritization process, in accordance with HRSA's Title V Needs Assessment Framework, with annual stakeholder engagement. The HRSA framework guided this needs assessment process, and the summary will describe SC's first six steps: engaging stakeholders, assessing needs, examining needs and capacity, selecting priorities, setting measures, and developing the state action plan.

Engaging Stakeholders

The Title V Advisory Committee was formed in the Summer of 2024. The committee included 45 stakeholders and partners representing various organizations, including DPH and other state agencies, community-based organizations, social services, nurses, physicians, non-profit organizations, and academia. The roles of these individuals within their organization ranged from direct service providers to senior-level executives.

Individuals with lived experience were also identified through our Title V Family Partner, Family Connection of SC, and Healthy Start of the Midlands; these individuals were asked and agreed to participate in the needs assessment process as part of the Advisory Committee and attended a one-hour virtual orientation sessions prior to joining the group.

The MCH Leadership Team made a concerted effort to ensure active stakeholder participation of the Advisory Committee by facilitating a Kick-Off Meeting in September 2024, in which the purpose, goals, and timeline of the needs assessment process were outlined along with the role and expectations of the Committee members. The members were assigned to a population health domain or the cross-cutting domain and asked to sit with their domains to form workgroups to complete the afternoon activity, which included a guided exercise to determine key issues or concerns within their domains and identify contacts and groups to engage through key informant interviews and community listening sessions.

Assessment of Needs and Examination of Strengths

Quantitative data were used to assess the current burden and disparities among key MCH indicators. Data were collected and analyzed from a wide range of existing sources, including the National Survey of Children's Health (NSCH), Behavioral Risk Factor Surveillance Systems (BRFSS), Pregnancy Risk Assessment Monitoring System (PRAMS), American Community Survey (ACS), National Immunization Survey, SC Vital Statistics, SC hospitalization data, KIDS COUNT and various MCH-related programs to inform Title V Outcome and Performance Measures, community health factors, and other MCH indicators for each population health domain. High-level data by population health domain were shared with the Advisory Committee at the 2nd in-person meeting on January 30, 2025, and a deep-dive data presentation was provided separately to each domain workgroup table.

Qualitative data were collected through Key Informant Interviews and used to illuminate the barriers and challenges that have led to the identified burdens and disparities. The interviews were conducted with individuals representing health care providers, public health professionals, school personnel, and community and non-profit organizations. A semi-structured interview guide was designed to

gather stakeholder's perspectives on strengths of the programs, policies, and organizations that serve MCH populations, as well as challenges, barriers, and needs to continue serving MCH populations and improve their health and wellbeing. A thorough summary of the interview findings was also shared with the Committee on January 30, 2025.

Domain-specific workgroups were then challenged to reflect on the information shared and work through a *Making Sense of the Data* exercise in which each workgroup reported to the Committee the top three to four (1) greatest needs in SC to improve MCH and (2) what assets should be leveraged to address those needs.

Community Listening Sessions yielded qualitative data from a variety of MCH populations, including those being served by Family Solutions, Midlands Fatherhood Coalition, Family Connection of SC, and representatives for Latino and Immigrant groups. Discussion guides were developed to obtain information around concerns and challenges faced in accessing needed support, services and resources. The CARE team conducted 6 community listening sessions with the following priority groups:

- English speaking Women, in partnership with Family Solutions
- Spanish speaking Women, in partnership with PASOs
- Teenagers, in partnership with Columbia Housing Authority
- English speaking Parents of Children and Youth with Special Healthcare Needs, in partnership with Family Connection of SC
- Spanish speaking Parents of Children and Youth with Special Healthcare Needs, in partnership with Family Connection of SC
- Fathers, in partnership with A Father's Place (a part of the SC Center for Fathers and Families)

Data were also collected through an extensive community concerns survey to identify domain-specific needs and administered using a convenience sampling approach to gather information on all Title V population health domains. Two hundred fifteen participants completed the online survey in English and Spanish, and they identified as:

- Public health professionals (33.0%), parents, guardians, and grandparents (32.1%), healthcare providers (11.6%); an additional 13.5% selected "Other" which included roles such as educators, Community Health Workers (CHWs) and non-profit organization representatives; and 9.8% identified as a community member
- 36.3% identified as White, 28.4% as Black or African American; smaller percentages identified as Hispanic/Latino (1.4%), Asian (0.9%), more than one race (2.3%), or "Other" (2.8%). Notably, 27.9% of respondents did not provide race information.

Each respondent rated the perceived level of improvement needed for a range of issues for each domain using the following 4-point scale: needs no improvement, needs some improvement, needs a lot of improvement, not sure/ no opinion. Additionally, participants were asked to select the top five (5) priority issues among those they rated as needs a lot of improvement.

These final qualitative data results were presented to the Advisory Committee at the 3rd in-person meeting in April 2025. Domain-specific workgroups completed a final exercise in which all data, including Advisory Committee Recommendations thus far, were compiled and formatted into easily referenced at-a-glance documents for each domain workgroup to discuss and prioritize needs and identify recommended actions.

Priority Setting & Development of State Action Plan

Each step of this needs assessment was designed to build on the previous results and step. The Advisory Committee recommendations informed the Key Informant Interviews. Those results helped to shape the Community Listening Sessions, and the Community Concerns Survey was developed to gather input from communities on those identified needs. And the synthesis of all data led to robust discussions and prioritization of needs and recommended actions—priority setting occurred within each of the domain workgroups at the final in-person Advisory Committee Meeting, with one member of the MCH Leadership Team included.

The MCH Leadership Team conducted a series of internal meetings by domain to develop a draft Title V State Action Plan. These meetings included MCH Leadership and subject matter experts within the MCH Bureau pertinent to each

domain and consisted of a review of the quantitative and qualitative data, to include needs/gaps and resources/assets; the Advisory Council's needs and prioritization for each domain; and then a critical examination of the 2021-2025 State Action Plan. At least one overarching priority need was finalized for each domain; most of the new priority needs were tweaked from the previous cycle, with a few retained as is, and the cross-cutting priority need was newly developed. The next steps included selection of at least one National Performance Measure (NPM) and the key strategy or strategies that the Title V team would focus on over the next five years. Evidence-based Strategy Measures were then developed to measure progress on advancing the strategy and impacting the NPM.

A final virtual Advisory Committee meeting was held on June 26, 2025 with all members, including the community individuals with lived expertise in which the 2026-2030 Title V State Action Plan was presented with a solicitation of feedback to follow. All information received was positive, and there were a few suggestions provided for consideration on how best to implement a strategy.

Allocation of Resources

As the new State Action Plan was developed, MCH Leadership documented several action items that would fall under each strategy. These action items are to be refined during the last quarter of FFY2025 with input from the bureau experts and the Deputy Area of Health Promotion Services leaders. Funding allocations and shifting of resources across the bureau along with execution of new or continued subawards with partners will be decided upon and tied to the specific actions identified under each strategy for effective implementation.

Monitor Progress and Reporting Back to Partners

Moving forward, the MCH Leadership Team plans to engage with the Advisory Committee members twice annually to discuss progress and obtain feedback from our key partners.

2. Findings: MCH Population Health & Wellbeing

Women/Maternal Health Domain

Health Status Overview:

Women's health and maternal health are both central to the success of individuals and families throughout the life course. An analysis of quantitative data for selected NPMs and other key indicators showed:

- Annual preventive health visits among reproductive aged women decreased from 73.8% in 2018 to 70.1% in 2022.
- The percentage of pregnant women with a preventive dental visit was between 40-45% during this time frame but varied by demographic characteristics.
- However, the percentage of women who received a postpartum checkup increased from 90.3% in 2018 to 92.3% in 2022.
- The percentage of unintended pregnancies has decreased in SC from 35.8% in 2018 to 24.0% in 2022.
- Pre-pregnancy obesity (BMI=30+) has increased from 28.0% in 2018 to 36.2% in 2022.
- Pre-pregnancy hypertension has remained stable over the past 5 years: 7.8% of new mothers reported having HBP prior to conception in 2022.
- The 2020 Pregnancy-Related Mortality Rate was 32.3 deaths per 100,000 live births, a 16.3% decrease from 38.6 in 2019.
- In 2020, black women were 4.2 times more likely to die than white women. SC ranks 8th highest for maternal mortality when compared to other states.
- Geographic disparities exist as well. PRMRs in rural counties were nearly twice as high as those in urban counties (55.7 compared to 28.9, respectively).
- During 2018-2020, the top 3 leading causes of PR deaths were: mental health conditions/SUD, thrombotic embolism, and cardiomyopathy, but this varied by race/ethnicity:
  - Among non-Hispanic White—top 3 causes were mental health condition, hemorrhage, and infections

    - Among non-Hispanic Black—top 3 cases were thrombotic embolism, cardiomyopathy, and hemorrhage.
- Preventability is determined by “some chance of the death being averted by one or more reasonable changes.”
- Causes of death determined most likely to be preventable were mental health conditions/substance use disorder (100%) and thrombotic embolism (88%).

Qualitative Results—Key Themes
NEEDS:

- More Mental Health Services and Supports Needed
- Lack of access to high quality healthcare (particularly prenatal care and postpartum services)
- Better connection to existing resources
- More empathetic, culturally informed care needed in healthcare and social services delivery
- Health education on topics such as reproductive health, substance use and healthy living

ASSETS:

- Community-based providers (CHWs, Doulas)
- Project IMPACTT (Dr. Guille)
- Project Lauren
- Existing initiatives focused on improving maternal health

Advisory Committee Recommendations:

- Consolidated health resources system: including a 1-stop shop for new SC moms
- Increased education on maternal warning signs for providers and health professionals
- Increased education on maternal warning signs for moms and families/support systems
- Expand mental health awareness and resources

Perinatal/Infant Health Domain

Health Status Overview:

Unaddressed perinatal and infant health issues may lead to short- and long-term health risks for mothers and their babies. An analysis of quantitative data on selected NPMs and other key indicators showed:

- SC experienced a higher infant mortality rate from 2017 to 2021 compared to the US average, which peaked at 7.3 per 1,000 live births in 2021.
- IMR in 2022 was 6.8; disparities remain.
- Very low birthweight infants (<1,500 g) experienced the highest infant mortality rate (204 per 1,000) followed by low birthweight (1,500-2499 g; 13.6 per
- 1,000), then normal birthweight (2,500+ g; 2.4 per 1,000).
- Mothers with a college degree place their infant on their back to sleep at the highest frequence (78.5%) compared to all other education groups.
- In 2022, babies were placed on their back to sleep 11.2% less in SC compared to the US average.
- Compared to non-Hispanic White infants, non-Hispanic Black infants are 3 times more likely to be very low birthweight (<1500 g) and 2 times more likely to be moderately low birthweight (1500-2499 g).
- Trends in birthweight remained stable from 2017 to 2021, around 8% from 2017- 2021.
- Breastfeeding initiation in SC decreased from 83.1% in 2016 to 78.7% in 2020.
- Exclusive breastfeeding to 6 months remained stable from 22.8% in 2016 to 27.9% in 2020; however, in 2020, SC surpassed the national average of 25.4%.

Qualitative Results—Key Themes

NEEDS:

- More mental health services and supports needed
- Lack of access to high quality healthcare
- Better connection to existing resources

- More empathetic, culturally informed care needed in healthcare and social services delivery (providers recognizing biases)
- More access to high quality childcare

ASSETS:

- The SC Birth Outcomes Initiative is an incredible asset and credited with many MCH successes
- Available Trainings and Technical Assistance providers & Evidence-Based Practices that can be scaled up
- Help Me Grow SC and the SC Infant Mental Health Association
- Local communities are the asset, including community-based providers (doulas, CHWs)

Advisory Council Recommendations:

- Payment models that incentivize parent/health education
- Parenting education for high school health education
- More public service announcements focused on specific health topics and available resources

Child Health Domain

Health Status Overview:

The skills developed in childhood have the potential to affect them for the rest of their lives, and good physical and emotional health early on lends to a strong foundation for good behaviors and practices in adulthood. Quantitative data for selected NPMs and other key indicators shows:

- Over 1/3 of children 6-11 are overweight or obese (39% in 21-22 and 36% in 22- 23).
- Only 25% of children 6-11 exercise at least daily.
- Less than half of children 9-35 months received developmental screening in the past year, and disparities exist by demographic characteristics.
- The percent of children who had a preventive dental visit in the last year decreased during COVID-19.
- The percent of children 1-11 who have decayed teeth or cavities is increasing over time.

Qualitative Results—Key Themes
NEEDS:

- Universal Developmental Screening
- Funding for infant and young child mental health needs
- Lack of access to high quality healthcare
  - Shortage of providers (higher reimbursement rates/incentives needed for medical, mental, and dental providers)
  - Transportation barriers; long distances to travel
- Support for early childhood providers, especially to prevent expulsions/suspensions
- Better connection to existing resources
- More empathetic, culturally informed care needed in healthcare and social services delivery
- Support for bullying—no standardized approach or protocol for intervention

ASSETS:

- SCIMHA & Help Me Grow (HMG) SC
- Department of Health and Human Services (DHHS), the state's Medicaid Agency; and insurance carriers
- Department of Education (DPH School Health Nurse Consultant)
- First Steps

Advisory Committees Recommendations:

- Identify and promote awareness of resources, specifically among service providers and professionals
- Strengthen the child health workforce
- Integrate developmental screening partners into the development of a statewide registry
- Explore funding opportunities for full saturation of programs throughout the state

Adolescent Health Domain

Health Status Overview:

According to the U.S. Department of Health and Human Services, the five essentials for healthy adolescents include positive connections with supportive people; safe and secure places to live, learn, and play; access to high-quality, teen-friendly healthcare; opportunities for teens to engage; and coordinated, adolescent- and family-centered services. Quantitative data for selected NPMs and other key indicators shows:

- Bullying is linked to many negative outcomes and impacts mental health, substance use, and suicide.
- 23% of high school students experience bullying, with 16.1% experiencing at school.
  - Higher among non-Hispanic White and Asian students and females.
- Less than half (46.2%) of adolescents who needed mental health treatment, received it & decreasing since 2016.
- Almost 20% of high schoolers reported alcohol use in past month.
- About 15% of HS students reported marijuana use in past month.
- Adolescent suicide rate in SC has been increasing.
  - Suicide attempts are higher than the national average among males & non-Hispanic Black teens.
- Teen birth rate decreased from 2018-2022, but higher than US average.
  - Highest among non-Hispanic Black and Hispanic teens.

Qualitative Results—Key Themes

NEEDS:

- Organized systems improvement (state-level approach for implementation of programs)
- Better access to mental health resources & (timely) services
- Educational improvements for optimal health (SC Comprehensive Health Education Act standards, but no accountability)
- Increased cultural sensitivity
- Support for bullying—no standardized approach or protocol for intervention
- PRESENT parents and good role models (more connection, less phones)

ASSETS:

- RIZE Prevention Program

- DPH PREP Program
- Parks and Rec, such as YMCA
- 46 mental health centers via DMH
- Mental health access in schools
- DMH YAP-P Initiative
- SC Youth Advocate Program (YAP), Youth Advisory Council

Advisory Committee Recommendations:

- A safe space where adolescents can ask questions to professionals and receive mentoring, like a Connection Hub
- Venues where parents and their children can connect and trainings on difficult conversations can be offered
- Increased awareness of the signs for mental health issues and how to intervene (possibly introducing coping mechanisms for stress)
- Increase and/or link to community advocates – assist with reducing risky behaviors (teen pregnancy, mental health issues, etc.)

CYSHCN

Health Status Overview:

Generally, CYSHCN require health and related services of a type or amount beyond that required by children without special health care needs. An analysis of quantitative data for selected NPMs and other key indicators shows:

- 40.7% of CSHCN (0-17 years) had a medical home in 2022.
- 13.7% of CSHCN (0-17 years) received care in a well-functioning system in 2022.
- 58.2% of CSHCN (3-17 years) with a mental/behavioral condition received needed treatment or counseling in 2021.
- 21.5% of CSHCN (12-17 years) received services to help transition to adult care in 2022.
- 4.9% of CSHCN (0-17 years) were unable to obtain needed care.
- 31.7% had inadequate insurance or a gap in insurance in 2021.

Qualitative Results—Key Themes

NEEDS:

- Care Coordination is Essential for CYSHCN Families, including Case Management & Assistance with Navigation
- Medical Home
- The Emotional and Mental Health Needs of Children and Parents; Families Need Respite and Supports for Caregiving
- Insurance and Financial Challenges
- Need To Focus on Transition Times
- Childcare and Educational System Challenges
- Long Wait Times for Therapy Services

ASSETS:

- DPH CYSHCN Program
- Family Connection of SC
- Early Intervention Services, BabyNet
- Education and Employment Pathways for Children/Youth
- Medicaid/TEFRA & MCO Care Coordination

Advisory Committee Recommendations:

- Find ways to support families who are over-burdened through paid parent caregiving, respite care and recreation for those with special needs
- SC aims to ensure that families of CYSHCN can more easily navigate the system through coordinated care that integrates physicians, social workers, early intervention and therapy services in co-located accessible settings
- Improving awareness and engagement with services for CYSHCN by organizing resources to enhance utilization, streamline application processes, and clarify eligibility criteria
- Enhance the transition from adolescent to adult health care by offering incentives and identifying adult care providers to ensure a smoother, more coordinated process

Cross-Cutting Domain

A synthesis of the key themes and ideas that emerged around systems-building and addressing community health factors is shown below:

MORE MENTAL HEALTH SERVICES AND SUPPORTS ARE NEEDED

- Individuals of all ages need connections to affordable mental health support and services. Participants also discussed the need for more awareness about mental health to reduce stigma.

LACK OF ACCESS TO HIGH QUALITY HEALTHCARE IS A KEY CHALLENGE

- Not all communities across the state have adequate health care providers due to provider shortages, rural hospital closures, and lack of individual health insurance.

SOCIAL DETERMINANTS OF HEALTH MUST BE ADDRESSED

- Participants discussed the need for support finding higher paying jobs, affordable housing, high quality affordable childcare, safe schools and neighborhoods, social connections, and daily necessities (including food, clothing, and hygiene supplies).

CONNECTING TO EXISTING RESOURCES IS A CHALLENGE

- While resources in communities exist, people are not always sure how to find them. There is a need for education on what resources exist and how to access them. Care coordination, case management, and community navigation are essential to help people connect to existing resources.

SYSTEMS COORDINATION IS NEEDED

- Families need to have single points of entry to connect to resources, as well as support to help them transition from different stages and seasons of life.

MORE EMPATHETIC, CULTURALLY INFORMED CARE IS NEEDED IN DELIVERY OF HEALTHCARE AND SOCIAL SERVICES

- Participants expressed that they want to feel heard with empathy and respect, regardless of their cultural background.

HEALTH EDUCATION IS NEEDED FOR ADULTS AND YOUTH

- Adults and teens described the need for health education on topics including reproductive health, substance use, and healthy living.

BUILDING PARENTING SKILLS AND FAMILY CONNECTIONS

- Preschool suspensions and expulsions are a challenge for families and childcare providers. Some participants described the need for parenting skills development to help parents address behavioral challenges early on. In addition, fathers explained the need for positive family dynamics where they are viewed equally with mothers.

NEEDS	ASSETS
Increase for integrated models of care (medial dental MH)	FQHCs great models for integrated care (good co-location of services
Increase services to address SDOH (trans, food,	Telehealth
Build social supports for community network and social connections (we keep seeing issues of social isolation, we're more connected than ever....but not really—we need human contact)	Faith based institutions and community programs
Workforce development (all areas, CHWs, providers, specialist, etc.)	CHW programs/PASOs
SC specific data deficits	School systems (school nurses, social workers)
Is there a biggest bang for your buck strategy and at what life stage?	Telehealth

Advisory Committee Recommendations:

- Increase access/education around behavioral health resources
- Build integrated systems of care across public health and Title V domains
- Implement empathetic culturally informed care webinars/trainings for Title V partners, cross-sector
- Community Health Worker Model expansion to address community health factors and the non-medical drivers of health

3. Program Capacity

3a. Impact of Organizational Structure

The Title V Maternal and Child Health (MCH) and Children and Youth with Special Health Care Needs (CYSHCN) programs in South Carolina are housed within the MCH Bureau at the state's public health agency, the Department of Public Health (DPH). DPH was established on July 1, 2024, following the restructuring of the former Department of Health and Environmental Control (DHEC). Previously, DHEC operated under a Board of Directors composed of eight members representing each congressional district and a statewide chairperson, all appointed by the Governor.Under the new structure, DPH is now a cabinet-level agency within the Governor's administration, currently led by Governor Henry McMaster. As a cabinet agency, DPH falls under the broader Health policy area, with its Director appointed by the Governor and confirmed by the State Legislature. Like other cabinet agencies, DPH functions under the direct authority of the Governor, implementing laws, delivering public health services, and regularly reporting to ensure alignment with the Governor's strategic priorities.

Dr. Edward Simmer, who previously served as Director of DHEC, now serves as the Interim Director of DPH. He is expected to undergo the legislative confirmation process during the 2026 session. Dr. Simmer brings a wealth of experience and leadership to the role, having guided the state through significant public health challenges, including the COVID-19 pandemic. A board-certified psychiatrist and retired U.S. Navy Captain, Dr. Simmer has over three decades of experience in health care leadership, policy development, and systems transformation. His background in clinical care, public health administration, and military medicine positions him well to lead the newly formed agency as it works to improve population health outcomes and strengthen health infrastructure across South Carolina.

DPH is comprised of seven operational areas: Human Resources, Finance and Operations, Healthcare Quality, General Counsel, Information Technology, Health Strategy & External Affairs, and Health Promotion and Services (HPS). HPS, under the direction of Dr. Brannon Traxler, the Chief Medical Officer,

consists of 3 branches— Regional Operations & Community Engagement (ROCE), Health Collaboration, and Health Programs. Dr. Linda Bell serves as the Director of Health Programs and oversees all of the public health bureaus, including the MCH Bureau. All Title V MCH and CYSHCN programs are housed within the MCH Bureau, led by Danielle Wingo, the SC Title V Director.

The MCH Bureau administers all Title V Block Grant programs through the Children's Health & Perinatal Services Section, directed by Dr. Michelle Myer; the Children and Youth with Special Health Care Needs Section, directed by Malerie Hartsell; the Population Health Surveillance (PHS) Section, led by Dr. Nick Resciniti in an interim capacity; and in the area of the Deputy Director, Kristen Shealy, who also serves as the SSDI Principal Investigator. The MCH Bureau is responsible for the supervision and delivery of programs carried out with allotments under rehabilitation services, medical equipment for CYSHCN, Camp Burnt Gin, childhood lead screening surveillance and intervention, perinatal regionalization, postpartum newborn home visiting, and SC's Maternal Morbidity and Mortality Review Committee, among other efforts. Data analysis and epidemiological support are carried out by the MCH Epidemiology Team, led by Carlos Avalos within the PHS Section and in close collaboration with the Deputy Director, Ms. Shealy.

The MCH Bureau collaborates extensively with various programs and offices across HPS to address the needs of the maternal and child health population. Key partnerships include the Community Engagement Office within ROCE; the Vital Statistics Bureau Emergency Preparedness Bureau, and the Public Health Laboratory (e.g., Newborn Screening Follow-up) under Health Collaboration. The MCH Bureau also works with the additional public health bureaus within Health Programs to include: Community Nutrition Services (e.g., WIC and childhood physical activity initiatives); Chronic Disease (oral health and childhood injury prevention, such as car seats and gun locks); Clinical Services (Title X and women's health services); and Communicable Disease (e.g., immunizations, STIs).

3b. Impact of Agency Capacity

SC DPH is a centralized state public health agency. The agency has at least one public health clinic in each of SC's 46 counties, for a total of 60 facilities across the state's four regions: Upstate, Midlands, Lowcountry, and Pee Dee. As a centralized public health system, the programmatic activities in these regions, counties, and clinics are coordinated by the agency's central office, located in Columbia, SC. This structure allows DPH to have the capacity to promote and protect the health of all SC mothers and children, including CYSHCN.

Women/Maternal Health:

During the recent restructuring of the agency, a reorganization occurred within the public health sector to form the new Health Programs and Services Deputy Area and the new Health Programs Branch. One change that directly affected the MCH Bureau was the creation of the new Clinical Services Bureau. The previous Women's Health Division under MCH, which administers the Title X/Family Planning Program, was moved into the new bureau. Two other programs that fell in Women's Health, the Rape and Sexual Assault Prevention & Education Program (RPE) and the Personal Responsibility Education Program (PREP) were moved into the MCH Bureau with the Deputy Director and Child Health & Perinatal Services Section, respectively. While a Women's Health Division no longer exists within the MCH Bureau, financial support to fund nurses offering family planning and immunization services remains one of several initiatives to promote the health of women in the preconception, prenatal and postpartum periods. Additional partnerships and collaborations include the administration of the State Maternal Health Innovation Grant; the SC Maternal Morbidity and Mortality Review Committee, Pregnancy Risk Assessment Monitoring System data collection, analysis, and dissemination efforts; and the RPE & PREP programs.

Perinatal/Infant Health:

The MCH Bureau administers the First Sound and Postpartum Newborn Home Visiting programs. Each public health region has an MCH Program Manager to oversee responsibilities associated with these and other programs within the DPH clinics around the state. The MCH Bureau also oversees the SC Perinatal Regionalization System (PRS). PRS manages a series of contracts with Perinatal

Centers to assure risk- appropriate care is received for high-risk pregnancies, deliveries, and neonates regardless of demographic characteristics, rurality of residence, or ability to pay. While no longer under the organizational leadership of the MCH Bureau and Title V Director, the statewide Newborn Blood Spot Screening and Follow up Program, housed within the Public Health Lab, collaborate heavily with the MCH team and remains funded through Title V.

The WIC Program, housed within the Bureau of Community Nutrition Services, provides educational classes, nutrition, counseling, and vouchers for healthy food to pregnant, breastfeeding, and postpartum women and to infants and children. WIC also partners with hospitals around the state to integrate WIC breastfeeding peer counselors and breast pump distribution with in-hospital breastfeeding support.

The Population Health Surveillance Section, housed within the MCH Bureau, manages the SC Birth Defects Program. The Birth Defects Program conducts active data collection from medical records from all delivering hospitals in SC for nearly 50 different congenital anomalies.

Child Health:

The school nursing consultant, housed within the MCH Bureau's Section of Children's Health and Perinatal Services, provides education for and coordination of school nursing activities across SC through a contract with the Department of Education. In addition, this Section houses the postpartum newborn home visit program, newborn hearing screening, and childhood lead poison prevention program.

The Oral Health Section within DPH Bureau of Chronic Disease Prevention includes a School-Based Oral Health Program, in which oral health providers conduct screenings within schools across SC, and a Fluoridation Program, in which DPH's Bureau of Water and municipalities across SC provide data and consultation for implementing community water fluoridation programs. Currently, 94% of SC's public water systems are fluoridated.

Adolescent Health:

The MCH Bureau includes the SC State Adolescent Health Coordinator. This role helps to ensure that programs such as the Title X program and the Personal Responsibility and Education Program (PREP) are providing services that meet the needs of adolescents in SC. Some of these initiatives include technical assistance training geared towards adolescents for clinics in different areas of the state and collaborating with the SC Campaign to Prevent Teen Pregnancy to select PREP educational offerings and oversee the implementation of PREP activities.

Children and Youth with Special Health Care Needs:

Key CYSHCN programmatic activities include care coordination, services for individuals with hemophilia, special formula, hearing assistance, support for craniofacial and sickle cell clinics, support for sickle cell foundations, Camp Burnt Gin, and Children's Rehabilitative Services (CRS). A parent-to-parent mentor program is facilitated through a contract with Family Connections of SC.

The CYSHCN Program has financial assistance programs for orthodontia, special formula, hearing devices, CRS, and hemophilia and has contracts with three healthcare systems throughout the state to fund services to CYSHCN with severe craniofacial disorders. Additionally, the CYSHCN Program maintains contracts to provide support to four sickle cell organizations that provide services to individuals and families affected by the disease. This program also provides payment for office visits, durable medical equipment, prescriptions, and other needs under CRS for SC residents from birth through 18 years of age with a qualifying diagnosis.

Cross-Cutting/Life Course:

The MCH Bureau is actively collaborating with key partners across the state to increase access to needed services and resources and address community health factors that affect the health of all Title V populations. Key partnerships with organizations such as Father's and Families, PASOs, and DHHS ensure that support can be provided across all MCH domains.

3c. Title V Workforce Capacity

A skilled workforce is essential to advancing MCH in a rapidly changing public health system. Qualitative data from the needs assessment suggest provider shortages and the need to build more community-based support workers are key issues. It was noted that newer members of the workforce may not have the experience necessary to address the complex needs of families or the pay is too low to attract qualified experienced professionals. Resources, such as training, education and increased funding are required to recruit qualified experienced people into the MCH workforce.

DPH is partnering with several agencies across SC to addresses these issues, including the Center of Community Health Alignment and the Home Visiting Consortium. The MCH Bureau offered its collaborating support for the Division of MCH Workforce Development's MCH Public Health Catalyst Program. This program trains masters and doctorial graduates on MCH competencies, focusing on family- and community-based approaches. Seeking to build SC's MCH workforce pipeline, this partnership will provide practicum opportunities for students enrolled in the MCH Certificate Program working closely with the Univ. of SC's Arnold School Public Health's Office of Practice and Workforce Development.

Stakeholders also explained the need for more leadership and infrastructure to promote collaboration and coordination for MCH across the state. Increased funding to support MCH initiatives and discouraging silos for increased interagency connections could be very beneficial. DPH continues to participate in several interagency collaborations, such as the Department of Health and Human Services' Birth Outcomes Initiative, SC's perinatal quality collaborative, and the Department of Mental Health's Youth Access to Psychiatry Program. DPH recognizes that improvements cannot be achieved in silos and encourages collaboration and coordination with its partners.

Additionally, data and evaluation are areas for improvement. As mentioned elsewhere, the MCH team have received technical assistance on enhancing data metric and performance measures. Moreover, through the MCH Dashboard, informatics has now been introduced when evaluating both programmatic and

Title V measures. The MCH Leadership Team continues to collaborate with the State Data Team, Arnold School of Public Health, and Revenue and Fiscal Affairs on data and evaluation projects and is committed to making data-driven programmatic decisions focused on increasing transparency and accountability.

The experience brought by the MCH Bureau's Leadership is fitting for the current needs across the MCH Bureau and DPH as shown below:

Danielle Wingo has served as the MCH Bureau Director since 2023 and is the former Upstate Region Lead Operations Director and Upstate Quality Improvement Director for DPH, overseeing local health department services, emergency response, and QI activities in 11 of the state's 46 counties. Ms. Wingo received her degree in Nutrition/ Dietetics from Clemson University and has worked in public health for over 17 years.

Malerie Hartsell, MPH, CHES, APM, has served as the Director of the Children and Youth with Special Health Care Needs (CYSHCN) Section since August 2024, following her service as Interim Director beginning in May 2024. Since joining the program in 2016, she has played a pivotal role in the development and coordination of state plans, policies, and protocols aimed at supporting children and youth with special health care needs. Her contributions include the coordination and expansion of the blood disorders program, leadership in the development of the South Carolina Sickle Cell State Health Plan and SC Sickle Cell Disease Registry, and oversight of program contract management. Ms. Hartsell is a 2021–2022 Fellow of the Region IV Public Health Leadership Institute and a graduate of the Department of Public Health's inaugural *Leading the Way* Leadership Program, through which she earned her Associate Public Manager (APM) certification. She brings extensive expertise in stakeholder engagement, coalition and partnership building, public health program administration, and continuous quality improvement to inform program planning and policy development.

Michelle Myer, DNP, RN, APRN, CPNP, is the current director for the Children's Health and Perinatal Services (CHPS) Section. Dr. Myer has worked directly in the MCH field for 29 years of her 40-year Public Health career. In that time, her work has ranged from providing well-baby (EPSDT) and newborn home visits,

and newborn (bloodspot) screening; to childcare health consultation, developmental screening and qualification for early childhood education; to state-level nursing consultation, policy development, and monitoring for children's health programs. Her 11 years of MCH-adjacent work in epidemiology included development of school and childcare exclusion lists and responding to outbreaks of communicable diseases in childcare and schools. She has directed the CHPS Section for over three years, providing guidance and supporting policy development and programmatic monitoring for regional perinatal coordination, newborn bloodspot and hearing screening, newborn and postpartum home visiting, childhood lead poisoning prevention, school health, adolescent health, and family engagement and outreach.

Kristen Shealy, MSPH, is the MCH Bureau Deputy Director and also serves as the Principal Investigator for Title V's discretionary State Systems Development Initiative (SSDI), the Pregnancy Risk Assessment Monitoring System, and the State Maternal Health Innovation Grant. As an epidemiologist by training and having served in the field of MCH for over 20 years, she has extensive experience working with state health departments to promote the utilization of data to inform program planning and evaluation and policy development.

Within the Deputy Director's area, Elizabeth Biddle, MPH, MCHES®, serves as the MCH Bureau Outreach Coordinator. She joined DPH in 2022 and brings a background in health promotion and education. In this role, Elizabeth works with MCH and other DPH sections to update and create educational materials and social media campaigns related to MCH programs and services. Additionally, Elizabeth works closely with DPH Communications to assist with drafting press releases, responding to media inquiries,and developing advertising plans for mass communications like radio and television. She is also dedicated to identifying and establishing connections with community-based organizations that could serve as valuable partners, fostering direct links to the community and frequently participates in community baby showers distributing providing health education and resources for expectant and new parents.

Dedicated MCH data and analytic support has been fundamental in supporting the work of not only the Maternal and Child Health (MCH) Bureau but other areas across the agency and stakeholders throughout the state. Since 2022, the MCH

Bureau has housed the Population Health Surveillance (PHS) Section. This addition greatly improved the MCH Bureau's ability to conduct, produce, and disseminate analytics in various capacities, including presentations, research, infographics, and dashboards.

Dr. Nick Resciniti is currently the Interim Section Director for Population Health Surveillance. Dr. Resciniti has worked for SC DPH for over 5 years, serving in different roles, but has worked directly in the field of MCH for over 2 years of those. He works closely with or oversees several population health programs, such as the Maternal Mortality Review Committee, Pregnancy Risk Assessment Monitoring System, and Muscular Dystrophy Surveillance. His background is in epidemiology, data analytics, data to action, and data visualization.

The PHS Section consists of twenty-eight positions dedicated to Title V and other MCH program areas. Under the leadership and guidance of the Interim Division Director, Dr. Nick Resciniti, this unit includes an Interim Senior MCH Epidemiologist, Carlos Avalos, who provides and oversees dedicated data and analytic support for Title V and develops robust MCH data analysis plans, prioritizing underutilized data for greater program planning and evaluation. Other epidemiologists, nurse abstractors, data managers and MCH program managers within the division focus on the data collection, data management, analysis and/or dissemination efforts for PRAMS, BRFSS, Birth Defects, Childhood Lead, MD STARnet, Maternal Morbidity and Mortality Review, and Fetal and Infant Mortality Review Programs. The MCH epidemiologists also support the SSDI grant, looking for innovative ways to increase data capacity and explore opportunities for additional data linkages.

Epidemiological expertise within PHS consists of data analytics, research, data visualization, decision-making tool development and coordinating with diverse partners on the development of large-scale projects. Additionally, MCH epidemiologists are supported by informatics specialists who serve to evaluate data and analytic processes for increased efficiency; this cross-collaboration ultimately enhances the validity and consistency of repetitive analyses and findings.

3d. State Systems Development Initiative (SSDI)

The SSDI funding is administered within the MCH Bureau with Deputy Director, Kristen Shealy, currently serving as the PI. Ms. Shealy works closely with Dr. Nick Resciniti and Dr. Carlos Avalos in the Population Health Surveillance (PHS) Division, and they collaborate to ensure the SSDI activities are carried out in the new 5-year grant cycle.

The MCH Epi team, with support from leadership, has the experience and capacity to work with partners to achieve the goals and objectives of SSDI. The team continues to work closely with MCH programs to ensure that data needs are met. SSDI staff work closely with the budget analyst assigned to the project to accurately document and submit time spent on the project into the agency's Personnel Cost and Accountability System (PCAS).

A new workplan was developed for the 2022-2027 SSDI grant cycle, and progress to date is highlighted for each of the project goals:

Goal 1*: Strengthen capacity to collect, analyze, and use reliable data for the Title V MCH Block Grant to assure data-driven programming.*

Within the MCH Bureau, the South Carolina Department of Public Health (SC DPH) has expanded the data analytics and epidemiological capacity by hiring highly trained full- time staff and graduate students. The Senior Epidemiologist was hired with a PhD and postdoctoral training that helps the department with analytical, methodological, and scientific needs. He supervises 7 MCH staff members, of which, two MCH Epidemiologist IIs are BRFSS and PRAMS coordinators and to support the department with MCH needs. To better support our staff and department, we have provided the necessary equipment and training. This was accomplished through high-performance laptops set up to conduct powerful statistical analyses, equipping staff with appropriate software (e.g., SAS and R), and trainings on MCH and epidemiological topics.

Additionally, we supported our staff in attending local and national conferences, such as SC PHA, CityMatCH, AMCHP, MMRIA, and BRFSS. Staff attending these conferences were able to gain valuable insight into emerging MCH topics

and epidemiological tools, while also connecting and networking with other members of the MCH community throughout the country. Five staff members participated in the 2024 Data Science Team Training by CSTE to help increase the data science capacity of the public health workforce. Lastly, one staff member attended the 2025 CityMatch Maternal and Child Health Epidemiology Training Course in Denver, CO.

Goal 2*: Strengthen access to, and linkage of, key MCH datasets to inform MCH Block Grant programming and policy development, and assure and strengthen information exchange and data interoperability.*

The MCH Epi team has worked extensively to secure access to new data sources as well as enhance existing sources through linkages. Agency-wide Data Sharing Agreement processes continue to be evaluated and enhanced. Members of the MCH Epidemiology team sit on a variety of external data committees where they work collaboratively with partners to overcome data linkage and access barriers. Data linkages now exist within the Birth Defects program, PRAMS, Lead, SET-NET, FIMR and MMMRC. These linkages have allowed for more efficient and effective use of currently available data. Most recently, the MCH Epi team has worked in establishing two separate data sharing agreements with our Bureau of Vital Statistics to have access to better contact information to enhance SC PRAMS data as well as very low birth weight data to create quarterly reports.

Goal 3*: Enhance the development, integration, and tracking of community health factors to inform Title V programming.*

Throughout the MCH Bureau, a strong emphasis is placed on tracking and understanding community health factors. South Carolina PRAMS contains an additional module that is focused on community health factors and these data will be collected over the course of the current phase of data collection. This module includes information related to education, healthcare access, and housing. Additionally, we produce an annual provider scorecard back to providers reporting blood lead data that is then used to help improve data quality. One facet of this scorecard is understanding the percentage of data missing by race and within each racial group, which is then shared back with the providers. There

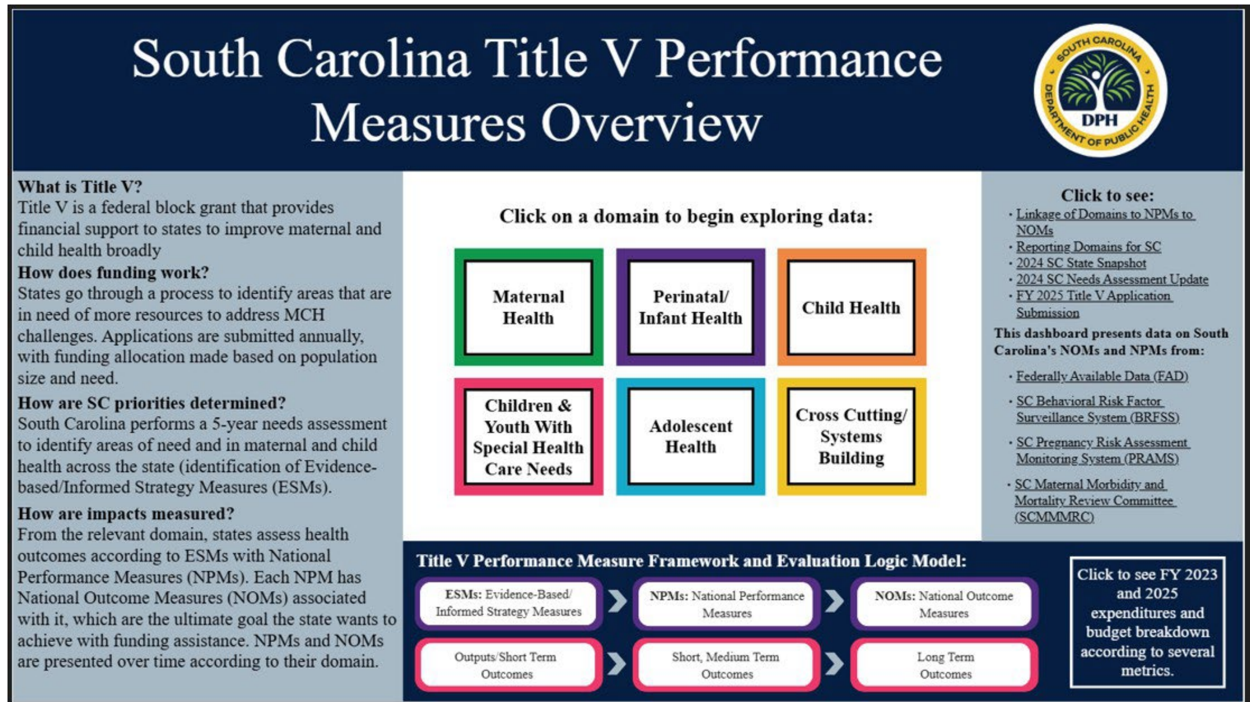
are additional resources provided throughout the year for staff to gain additional training and knowledge of community health factors, including webinars, conferences, and trainings. Staff attended AMCHP and CityMatCH, both of which had sessions focused on community health factors. Specifically, staff were able to attend sessions related to metrics and analyses on community supports.

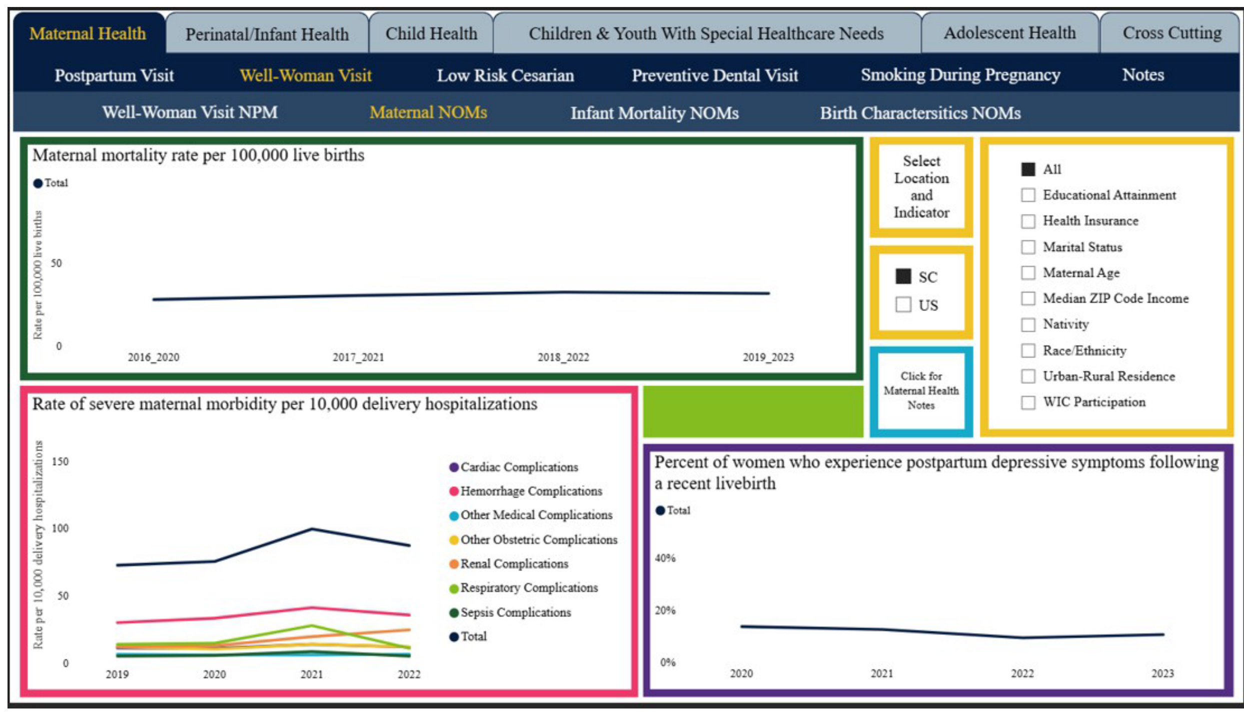
Our Maternal Mortality Review Committee developed training related to community health factors and incorporated an analysis of discrimination related to maternal deaths.

Goal 4*: Develop and enhance capacity for timely MCH data collection, analysis, reporting, and visualization to inform rapid state program and policy action related to emergencies and emerging issues/threats, such as COVID-19.*

The MCH Epidemiology team continues to work to enhance data capacity for timely MCH data. Key informant interviews have been held with MCH programmatic staff to assess data needs. This information has been used to develop an MCH Data Dashboard in Tableau and a PRAMS opioid use in pregnancy dashboard in Power BI. With the lessons learned through the development of these dashboards, the MCH Epi team developed a comprehensive Title V dashboard that highlights all aspects of Title V data in our state, allowing for enhanced programmatic decision making. These experiences have also allowed us to start creating a Maternal and Child Health Dashboard, which will integrate PRAMS, BRFSS, FIMR, MMRC, medical claims data, and other data sources to provide access and interoperability to many data sources at one time. Additionally, the MCH Epidemiology team has secured access to the state syndromic surveillance system which makes chief complaints available for more than 4 out 5 Emergency Department visits in SC within a 24-hour period. Staff are working with internal and external partners to pilot early alert systems for MCH populations across the state. A CSTE Applied Epidemiology Fellowship (AEF) will spearhead these efforts.

Snapshots of the Title V Dashboard are shown below:





3e. Other Data Capacity

The state's MCH data infrastructure supports planning, monitoring, and evaluation of Title V program activities through a wide range of epidemiological and data enhancement efforts. In addition to SSDI-funded work, state dollars and other federal grant opportunities allow for in-kind epidemiological and statistical support to Title V.

MCH epidemiologists collaborate closely with other public health programs to enhance data use. For example, partnerships with WIC support analysis of breastfeeding trends and effects of supplemental nutrition on maternal and child health. Data from the Bureaus of Chronic Disease and Injury Prevention and Communicable disease Prevention also contribute to MCH analytic priorities by providing insight into suicide and homicide, substance and tobacco use, immunizations, and sexually transmitted infections, including HIV.

Within the MCH Bureau, federal funding enables use of data related to birth defects, childhood lead exposure, newborn screening, family planning, and teen pregnancy prevention. These data sources are used to support critical review committees such as the Maternal Mortality and Mortality Review and Fetal and Infant Mortality Review Committees, which rely on timely, high-quality data to guide recommendations and interventions.

MCH's Population Health Surveillance Division enhances data access and capacity through a data sharing agreement with the South Carolina Office of Revenue and Fiscal Affairs, which maintains hospitalization data and serves as the data warehouse for state agencies. These data have been used to analyze trends in birthing charges, shaken baby syndrome, gestational diabetes, COVID-19 and pregnancy, childhood lead exposure, and emergency visits related to rare diseases like muscular dystrophy.

Vital statistics are another essential source of data that informs on the health of mothers and infants. Access to this data is available by an interactive web-based query system and by special requests for de-identified datasets. Data sharing

agreements allow for these aggregate data to be analyzed with more flexibility and for special projects.

Despite advances in data integration and sharing, the program continues to face challenges in maintaining sufficient analytic workforce capacity. Continued investments in the analytical workforce as well as continued cross-collaboration between internal and external partners will be essential to advancing data-driven decision-making in MCH.

4. Title V Program Partnerships, Collaboration, and Coordination

Collaboration is essential to moving the needle on MCH issues. As part of the statewide MCH Needs Assessment, qualitative data collected through key informant interviews and community listening sessions highlighted several examples of successful collaborations across the state.

Leadership among agencies that collaborate and partner with DPH, including the Department of Behavioral Health and Developmental Disabilities (BHDD), the Department of Education (DOE), and the Department of Social Services (DSS) were described as key resources. The Department of Health and Human Services (DHHS) was noted for their role in administering Medicaid and other support programs like the SC Birth Outcomes Initiative, SC Perinatal Quality Collaborative, and BabyNet. The BHDD Office of Mental Health was also noted as an asset, specifically for their county- based mental health services, but stakeholders emphasized more funding and support are needed.

Family Solutions, a program of the SC Office of Rural Health, houses Healthy Start and Nurse-Family Partnership in Orangeburg, SC and the surrounding areas. Family Solutions' Family Resource Center, doula program and home visiting program were highly praised from interview participants. The Family Resource Center is especially beneficial as they provide connections to breastfeeding support, SC Works, WIC, and childcare. One participant stated *"I don't know where I'd be [without Family Solutions]. I'd be a hot mess. When I was first pregnant. And I was like, "I don't know what I'm getting myself into. I'm*

pregnant and then when they came to the home, they just made it seem so easy and [I was] relieved."

Another key collaboration noted as a strength include Family Connection of SC, an organization that works to empower families of children and youth with special health care needs (CYSHCN) with education, support, and resources. Overall, case management, navigation, and care coordination were selected as the highest priority from parents of CYSHCN including understanding what resources are available.

Systems of care for families of CYSHCN are complex and confusing, especially when parents are overwhelmed with a new diagnosis. Participants said that parents often receive handfuls of pamphlets and paperwork without having it explained to them, which can be bewildering. One participant shared their own experience, "*the school says you need to do this test, but they don't give me any more information on where to do the test or how to do the test."* Moreover, parents expressed that there is "*sometimes a lack of enough case management and knowledge to support parents."*

An array of other DPH partners and collaborators was cited as key assets for MCH. Among those mentioned include the Children's Trust of SC, SC First Steps, PASOs, BabyNet, Help Me Grow, the SC Hospital Association, the SC Office of Rural Health, and Sexual Trauma Services of the Midlands. Other specific programs mentioned as an asset include the Choose Well's contraceptive access program, United Way's Youth in Transition program (for homeless youth), the SC Center for Fathers and Families, A Father's Place, Columbia Housing Authority, and the March of Dimes. Other organizations, including Boys and Girls Clubs, SC First 5 (a resource portal), local libraries, and faith-based organizations were suggested as assets for the support they provide to communities across the state, especially for adolescents. The SC Youth Advocacy Program was also praised for their work to provide a range of programs and services to children and families dealing with serious emotional, behavioral, psychological and/or development issues. However, it was noted that there are some promising programs, strategies and initiatives across the state that can be built upon. Among these are school-based mental health clinics across the state, telehealth and integration of mental health services into primary

care. The Youth Access to Psychiatry Program (YAP-P) is a new free pediatric mental health access offering a provider-to- provider consultation line, clinical trainings, and behavioral health resources to pediatric primary care providers in SC. YAP-P and youth mental health services were mentioned during community listening sessions as a high priority, especially for adolescent females. Some participants discussed that some parents "*don't believe in mental health*" and female participants shared that "*more check ins*" are needed with trustworthy adults and supportive people.

DPH provides valuable education, outreach, and health care services. The Bureau of Maternal and Child Health works closely with other DPH programs to promote comprehensive health for the MCH population. These services include but are not limited to the Women, Infants, and Children (WIC) nutrition program, postpartum newborn home visiting program, safe sleep programs, Baby & Me Tobacco Free, injury prevention, oral health, vital health records, and immunizations. Additionally, MCH works closely with the Bureau of Community Engagement and Community Health Workers program to assist with promoting MCH programs across the state.

Stakeholders suggested that DPH's role to lead statewide coordination for MCH issues is essential and should continue. Further, some noted their appreciation for DPH investing in focus groups and related activities to ensure the voices of families and communities are heard. DPH's Newborn Screening Program was noted as a strong, effective program to identify diseases or conditions early on and connect families with appropriate referrals. The value of various home visiting programs across the state was noted, and in particular, "*DPH's postpartum newborn home visits are* [an asset]…*they head off issues by checking in on mom and baby, but many families need continued visits.*

5. Family & Community Partnerships

SC DPH's MCH Bureau continues to maintain its partnership with Family Connection of South Carolina (FCSC), the state's designated Family-to-Family Health Information Center and an affiliate of Family Voices. FCSC provides a centralized source of peer support, education, training, and evidence-based

resources for families and children with special health care needs. As a recognized Parent Center, FCSC prioritizes the family perspective and delivers services through a diverse team of experienced parents, including bilingual and bicultural staff members with lived experience. Through this collaboration, DPH refers families and individuals to FCSC and they make family referrals to DPH for CYSHCN services and care coordination. DPH and FCSC work in tandem to address the needs of children and youth with special health care needs by providing information and community resources, connecting families with peer support, especially for families of newly diagnosed children, assuring families have access to support and related services through education, information, training and technical assistance.

CYSHCN serves as a member of FCSC’s established Parent Advisory Council (PAC) to gather valuable feedback and recommendations from the PAC’s trained parent leaders which help direct and inform changes to CYSHCN services. FCSC’s PAC helps to highlight the voice of the parent to help better understand the challenges and barriers families face when accessing and obtaining needed CYSHCN services.

Through DPH’s CYSHCN Section existing partnership with community organizations, CYSHCN continues to serve as a community resource and ally, ensuring information and resources are shared through bridged connections to reach as many families as possible in SC. The CYSHCN Director serves on both the Developmental Disabilities Council (DDC) and the Advisory Council for Education Students with Disabilities (ACESD) to provide feedback on recommendations impacting families and students living with disabilities in the state. CYSHCN continues to work extensively with the sickle cell community-based organizations to disseminate information to families served, and also support the expansion of resources, services, and educational opportunities available in the state related to sickle cell disease. Through our partnership with the Bleeding Disorders Association of South Carolina (BDASC), CYSHCN presents on current programs and services offered to those living with a bleeding disorder, and ensures families receive information and education about the programs available.

The MCH Bureau also collaborates with other community partners across the maternal, infant, child, and adolescent health domains to address the priorities that have been identified through the recent needs assessment and development of the 2026-2030 State Action Plan. Several of these partnerships have been solidified through a contracting mechanism in which Title V funds support community-based efforts and initiatives across the state such as PASOs, an organization that supports the Latino MCH population, Help Me Grow for developmental screening and referral to follow-up services, the SC Center for Fathers and Families which supports positive parenting and healthy relationships between parents, Family Solutions to administer the HealthySteps program, the Institute for Child Success to administer the Hello Family Initiative. Community partners are vital to successful implementation of SC's 2026-2030 State Action Plan.

6. Identification of Priority Needs and Linking to Performance Measures

As outlined in the process summary, data were gathered and synthesized from multiple sources, then shared with Advisory Committee members to support their work during three in-person meetings. These meetings included facilitated exercises that led to the development of a prioritized list of needs and recommended actions. Priority setting took place within each domain workgroup during the final in-person meeting, with a member of the MCH Leadership Team participating in each group.

The MCH Leadership Team then conducted a series of internal meetings by domain to develop a draft Title V State Action Plan. These meetings included MCH Leadership and subject matter experts within the MCH Bureau pertinent to each domain and consisted of a review of the quantitative and qualitative data, to include needs/gaps and resources/assets; the Advisory Council's needs and prioritization for each domain; and then a critical examination of the 2021-2025 State Action Plan. At least one overarching priority need was finalized for each domain; most of the new priority needs were tweaked from the previous cycle, with a few retained as is, and the cross-cutting priority need was newly developed.

The final State Action Plan Table includes 7 Priority Needs, listed below along with a summary of changes from the previous 5-year cycle:

1. Improve utilization of healthcare visits to promote health before, during, and after pregnancy. The intent of this priority need did not change; however, the word "preventive" was dropped to prevent any internal confusion with the Title X health department services. The focus is still on utilization of health care visits to improve women's health throughout the life course, before pregnancy to ensure the woman is healthy prior to conception and manage chronic conditions; early in the pregnancy for appropriate monitoring, screenings and education; and postpartum to ensure mom is recovering from delivery and any risks can be identified and managed (e.g., maternal mortality, postpartum depression).

2. Strengthen implementation of evidence-based practices that keep infants safe, healthy and prevent mortality. This priority need remains unchanged from the previous cycle and includes one strategy, and it's associated NPM to address safe sleep as a best practice in the first year of life. There was a second priority need in the previous plan within the Perinatal/Infant Health Domain focused on Perinatal Regionalization; however, this priority need was dropped as it clearly falls under this overarching need as a best practice (the associated NPM was retained with a strategy and ESM focused on this work).

3. Increase access to coordinated and comprehensive health promotion efforts for children. This priority need was retained with a minor change in wording to highlight access as a challenge. There was a second priority need in the previous plan within the Child Health Domain focused on developmental screening; however, this priority need was dropped as it clearly falls under this overarching need as a critical health promotion effort and best practice (an associated strategy and ESM focused on this work is included in the new plan).

4. Increase access to coordinated and comprehensive health promotion efforts for adolescents. This priority need was retained with a minor change in wording to highlight access as a challenge. The focus of efforts within the Adolescent Health Domain is related to needed mental health treatment or counseling, which is a key component of coordinated and comprehensive care in this population.

5. Improve care coordination for CYSHCN. Care Coordination was identified as a continued need and has been retained from the last cycle. Retaining this priority will allow the CYSHCN team to continue to build on the great work that has already taken place regarding care coordination.

6. Promote the advancement of transition health care services for CYSHCN clients from pediatric to adult providers. Transition from pediatric/adolescent care to adult care for CYSHCN is also an area that remains a priority from the last cycle. The wording was tweaked slightly as new efforts will not focus on telehealth as outlined in the previous action plan but more on activities within the Title V CYSHCN program.

7. Enhance partnerships that address community health factors. This needs assessment process yielded findings that underscore the need across all population health domains for focused efforts that address community health factors. The SC Title V program relies heavily on community partners and organizations that utilize our support to carryout initiatives that increase access to needed and culturally appropriate services and resources for improved health outcomes across the life course. This priority need is new and highlights valued and effective Title V partnerships and collaborations.

The SC State Action Plan Table is located at the end of this Strategic Plan.

Appendix 4:
Measurement Definitions

- The total number of live births refers to the total number of babies born alive in a specific population during a given time, typically expressed as a rate per 1,000.
- Total number of pregnancy-related deaths refers to a death during or within one year 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[i]
- The percent of live births where the mother had health insurance refers to the source of insurance in the delivery record classified as private, public, or not self-pay or other.
- Rate of low-risk cesarean delivery refers to a cesarean delivery among nulliparous (no prior births), term (37 or more completed weeks based on obstetric estimate), singleton (not a multiple birth), and cephalic or vertex (head-first) births [iv]. Also referred to as NTSV (nulliparous, term, singleton, vertex) births.
- The percent of women with a recent live birth who received a postpartum visit refers to the percent of women who reported receiving a postpartum checkup or documented through a claim record.
- The percent of women with a recent live birth screened for postpartum depression refers to the number of women who were asked during a postpartum checkup if they were feeling down or depressed, or as measured through a billable claim record.
- The percent of women screened for depression or anxiety following a live birth refers to the number of women who report being screened for depression or anxiety following a live birth or a measure of a billable claim record.
- The percent of women with a recent live birth diagnosis of diabetes with an ED visit related to the medical condition refers to the number of women who have a confirmed diagnosis of diabetes and an emergency department visit after a recent birth, using claims records.

Appendix 5: SC Title V Needs Assessment and Action Plan State Action Plan Table

South Carolina		State Action Plan Table		2026 Application/2024 Annual Report	
Priority Needs	**Five-Year Objectives**	**Strategies**	**Evidence-Based or –Informed Strategy Measures (ESM)**	**National and State Performance Measures (NPM)**	**National and State Outcome Measures (NOM)**
Women/Maternal Health					
Improve utilization of healthcare visits to promote health before, during, and after pregnancy.	Increase the percentage of women who received a post-partum check up to 90% by 2030.	Implement a mobile maternal health initiative to provide prenatal and postpartum care in areas of greatest need across the state. Collaborate with partners to increase awareness and knowledge of urgent maternal warning signs. Support initiatives that address access to mental health services for women.	ESM PPV.1 - Percent of women, 18-44 years, who report having a personal doctor or healthcare provider. ESM PPV.2 - Percent of women, 18-44 years, who report having a routine healthcare visit within the past 2 years.	NPM - Postpartum Visit (PPV)	**Linked NOMs:** Maternal Mortality Neonatal Abstinence Syndrome Women's Health Status Postpartum Depression Postpartum Anxiety
Perinatal/Infant Health					
Strengthen implementation of evidence-based practices that keep infants safe, healthy, and prevent mortality.	Increase the percent of VLBW infants born in a hospital with a Level III+ NICU to 80% by 2030.	Maintain a high level of collaboration between Regional Systems Developers and DPH staff to strengthen the Perinatal Regionalization System through perinatal activities and initiatives.	ESM RAC.1 - Percent of Level I and Level II hospitals that complete the VLBW Self-Monitoring Tool	NPM - Risk-Appropriate Perinatal Care (RAC)	**Linked NOMs:** Stillbirth Perinatal Mortality Infant Mortality Neonatal Mortality Postneonatal Mortality Preterm-Related Mortality

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures (ESM)	National and State Performance Measures (NPM)	National and State Outcome Measures (NOM)
Strengthen implementation of evidence-based practices that keep infants safe, healthy, and prevent mortality.	Increase the percent of infants placed to sleep on their backs to 80% by 2030.	Promote safe sleep education and activities through the implementation of a Safe Sleep Coalition.	ESM SS.1 - Percent of infant deaths due to unsafe sleep accidents	NPM - Safe Sleep (SS)	**Linked NOMs:** Infant Mortality Postneonatal Mortality SUID Mortality
Child Health					
Increase access to coordinated and comprehensive health promotion efforts for children.	Increase the percent of all SC children who have a medical home to 60% by 2030.	Collaborate with partners to increase developmental screenings and referral to early intervention services for children through utilization of a new statewide registry. Establish interagency partnerships to improve coordination between oral health services and well child visits. Increase physical activity among children, working with internal partners and school districts.	ESM MH.1 - Percent of children, 9-35 months, who received a developmental screening using a parent-completed screening tool in the past year ESM MH.2 - Percent of children, ages 1-17, who had a preventive dental visit in the past year ESM MH.3 - Percent of school districts participating in professional development	NPM - Medical Home (MH)	**Linked NOMs:** Children's Health Status CSHCN Systems of Care Flourishing - Young Child Flourishing - Child Adolescent - CSHCN Flourishing - Child Adolescent - All

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures (ESM)	National and State Performance Measures (NPM)	National and State Outcome Measures (NOM)
			opportunities that include methods to provide at least 30 minutes daily physical activity opportunities for all students before, during, and after the school day		
Adolescent Health					
Increase access to coordinated and comprehensive health promotion efforts for adolescents.	Increase the percent of adolescents who receive needed mental health treatment or counseling to 85% by 2030.	Collaborate with partners to support and promote initiatives that provide health education and prevention services to youth across SC.	ESM MHT.1 - Number of Youth Access to Psychiatry Program (YAP-P) consults	NPM - Mental Health Treatment (MHT)	**Linked NOMs:** Adolescent Mortality Adolescent Suicide Adolescent Firearm Death Adolescent Injury Hospitalization Children's Health Status Adolescent Depression/Anxiety CSHCN Systems of Care Flourishing - Child Adolescent - CSHCN Flourishing - Child Adolescent - All

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures (ESM)	National (NPM) and State Performance Measures (SPM)	National and State Outcome Measures (NOM)
Children with Special Health Care Needs					
Improve care coordination for children and youth with special health care needs.	Increase percent of children and youth with special healthcare needs who have a medical home to 60% by 2030.	Assure children with special health care needs receive coordinated, ongoing, comprehensive care within a medical home.	ESM MH.4 - Percent of CYSHCN who receive needed care coordination	NPM - Medical Home (MH)	**Linked NOMs:** Children's Health Status CSHCN Systems of Care Flourishing - Young Child Flourishing - Child Adolescent - CSHCN Flourishing - Child Adolescent - All
Promote the advancement of transition in health care services for CYSHCN clients from adolescent to adult providers.	Increase the percent of children and youth with special healthcare needs who received services to prepare for transition to adult care to 35%.	Ensure all DPH CYSHCN clients 16-21 have a valid transition care plan.	ESM TAHC.1 - Percentage of DPH CYSHCN clients ages 16-21 who have a valid transition care plan in place	NPM - Transition to Adult Health Care (TAHC)	**Linked NOMs:** CSHCN Systems of Care
Cross-Cutting/Systems Building					
Enhance partnerships that address community health factors across Title V population health domains	Increase the number of Title V-funded partnerships or MOUs that align with the 2026-2030 State Action Plan for SC.	Develop new and strengthen current partnerships with external organizations to improve systems of care and social supports within communities across Title V population health domains.	No ESMs were created by the State. ESMs are optional for this measure.	SPM 1: Number of formal partnerships that address community health factors across Title V population health domains	