CHRONIC HEALTH CONDITIONS

Strategies to prevent and manage chronic conditions, reduce barriers, and improve health outcomes in SC.

INDICATORS

MULTIPLE CHRONIC CONDITIONS

DIABETES

SOCIAL VULNERABILITY

PARTNER STRATEGIES

Care Coordination & Integrated Care: Organizations are implementing interdisciplinary care teams, care coordination models, transitional care services, and integrated healthcare approaches that improve continuity of care for individuals managing multiple chronic conditions.

Community Health Workers & Navigation: Many strategies leverage Community Health Workers, patient navigators, and community-based outreach to improve health literacy, strengthen patient engagement, and connect individuals to healthcare and support services.

Chronic Disease Prevention & Self-Management: Submissions emphasize disease prevention, self-management education, medication adherence, self-monitoring, and lifestyle interventions that help individuals better manage chronic conditions and reduce complications.

Access to Care & Telehealth: Efforts expand access to healthcare through telehealth, home-based care, specialty services, and innovative care delivery models that reduce geographic, transportation, and mobility barriers.

Social Determinants of Health (SDOH) & Community Supports: Strategies address food access, housing stability, transportation, childcare, and other social factors that influence chronic disease outcomes and overall well-being.

Data, Quality Improvement & Population Health Management: Organizations are utilizing EHRs, dashboards, quality improvement initiatives, and population health data to identify care gaps, monitor outcomes, and reduce disparities among high-risk populations.

Community Partnerships & Coalition Building: Stakeholders are building coalitions and strengthening partnerships among healthcare providers, public health agencies, community organizations, and residents to advance chronic disease prevention and management efforts.

Policy, Systems & Environmental Change: Several initiatives support policy, systems, and environmental changes that create healthier communities and strengthen long-term chronic disease prevention and management infrastructure.

Specialized & Vulnerable Population Supports: Efforts target populations with unique health needs, including individuals with disabilities, rural residents, pregnant women, and those with complex or rare chronic conditions.

Care Coordination & Integrated Care: Organizations are implementing interdisciplinary care teams, care coordination models, transitional care services, and integrated healthcare approaches that improve continuity of care for individuals managing multiple chronic conditions.

Diabetes Prevention Programs: Organizations are implementing evidence-based prevention programs, obesity prevention initiatives, and healthy lifestyle interventions designed to reduce the incidence of type 2 diabetes.

Diabetes Self-Management & Education: Strategies provide diabetes education, coaching, lifestyle support, and self-management resources that help individuals successfully manage their condition and improve health outcomes.

Clinical Care & Disease Management: Submissions highlight coordinated, team-based approaches to diabetes care that strengthen screening, treatment, monitoring, and disease management across healthcare settings.

Access to Medications & Treatment: Many organizations are working to reduce barriers to diabetes treatment by providing medication assistance, improving access to insulin and other therapies, and supporting medication adherence.

Community Health Workers & Peer Support: Stakeholders are utilizing CHWs, peer support networks, faith-based programs, and community partnerships to increase engagement and reinforce diabetes prevention and management efforts.

Access to Care & Telehealth: Efforts expand diabetes care through telehealth, home-based services, rural outreach, and strategies that improve access for underserved populations.

Screening, Monitoring & Early Detection: Organizations are increasing diabetes screening, risk assessment, monitoring, and use of population health tools to identify individuals at risk and improve disease management.

Social Determinants & Resource Supports: Strategies connect individuals to food assistance, transportation, healthcare navigation, and other resources that address barriers affecting diabetes outcomes.

Workforce Development & Provider Capacity: Submissions emphasize provider education, CHW training, workforce development, and quality improvement activities that strengthen diabetes prevention and care delivery.

Community Partnerships & Systems Change: Collaborative efforts bring together healthcare, public health, community organizations, and payers to advance coordinated and sustainable approaches to diabetes prevention and management.

Social Determinants of Health & Resource Navigation: Organizations are helping individuals access food, housing, transportation, financial assistance, and other essential resources that influence health outcomes and quality of life.

Access to Healthcare Services: Strategies improve access to primary care, preventive services, insurance coverage, and treatment options for populations facing financial, geographic, or systemic barriers.

Care Coordination & Community Support Services: Many initiatives provide care coordination, outreach, navigation, and follow-up services that help individuals access healthcare and community-based supports.

Community Partnerships & Referral Networks: Stakeholders are strengthening referral systems and building partnerships across healthcare, public health, and community organizations to better address unmet social needs.

Health Equity & Vulnerable Population Initiatives: Efforts prioritize populations disproportionately affected by social, economic, and health inequities through targeted services and culturally responsive approaches.

Community Engagement & Empowerment: Organizations are engaging residents, caregivers, and community leaders in planning, peer support, advocacy, and community-driven decision-making processes.

Data, Screening & Population Targeting: Strategies use data, vulnerability assessments, and geographic targeting to identify priority populations and direct resources where they are most needed.

Health Literacy & Education: Submissions include educational initiatives, outreach campaigns, and culturally responsive communication strategies that help individuals better understand and navigate health information and services.

Access Through Alternative Delivery Models: Many organizations are utilizing telehealth, mobile services, home-based care, and other innovative approaches to expand access to care.

Systems Change & Infrastructure Development: Efforts strengthen workforce capacity, referral systems, technology, and cross-sector infrastructure needed to address social vulnerability and improve health outcomes over time.

Care Coordination & Integrated Care: Organizations are implementing interdisciplinary care teams, care coordination models, transitional care services, and integrated healthcare approaches that improve continuity of care for individuals managing multiple chronic conditions.

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

LIVE HEALTHY SOUTH CAROLINA