LiveWell KERSHAW

"Your Bridge to Better Health"

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Year One (June 2014 - May 2015)

Year Two (June 2015 - May 2016)

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LiveWell KERSHAW

Evaluation Report Quarter One

June - August 2014

LiveWell KERSHAW

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OFFICE OF PRACTICE & COMMUNITY ENGAGEMENT
ARNOLD SCHOOL OF PUBLIC HEALTH

September 4, 2014

We are pleased to share with you our 1st quarter evaluation report of the LiveWell Kershaw North Central Initiative, which is being funded by the South Carolina Department of Health and Human Services. The overall goal of our evaluation is to inform learning, decision making, and action. Our desire is that this report generates new learning and questions that will guide our collective work for Kershaw County in becoming the healthiest county in South Carolina.

For quarter one (June-August, 2014) our evaluation focused on understanding the context in which the various interventions will take place, and to make recommendations that assist in the planning and implementation of such a complex initiative. We conducted 60 key informant interviews with key stakeholders living and working in the northeastern portion of Kershaw County. Stakeholders included but were not limited to: school personnel, parents, mayors, residents of towns, clinic personnel, and pastors. Video links to interviews with members of the Core Planning Committee can be found at:

Evaluation Questions for Quarter One were:

What are the challenges and barriers of the residents in northeastern Kershaw County?
What key elements need to be in place to make this project a success?

We hope this report is of interest to you, and guides your project planning. We look forward to continuing to be active participants with you as we work together to "do small things in a great way."

Best in all you do,

Holly Hayes
Evaluator, LiveWell Kershaw

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Chester
Lancaster
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Kershaw
Jefferson
Buffalo
Mt. Pisgah
Liberty Hill
Westville
Bonetown
DeKalb
Bethune
Cassatt
Fairfield
Kershaw
County
Camden
Lugoff
Elgin


North Central Area School Routes
Distances measured from North Central High School to surrounding schools.
Kershaw
Mt Pisgah Elementary School
10.6 mi (22 min)
341
17.1 mi (24 min)
Westville
START
North Central High School
North Central Middle School
601
521
Baron DeKalb Elementary School
18.2 mi (26 min)
18.5 mi (28 min)
Bethune Elementary School
Midway Elementary School
8.1 mi (14 min)
Cassatt
Lake Wateree
1

"Word Cluster", North Central Kershaw County Interviews (June-August 2014): Photograph courtesy of PACE evaluation team

Emerging Themes from Interviews

North Central community members feel that they are perceived as the "red-headed step child" of Kershaw County and have strong identity with their town. There is a perceived lack of access to activities (specifically for children), access to technology and groceries, and jobs.

- The Chronicle only has Camden-related articles. There's nothing on Bethune unless it's bad.
- As schools consolidate and businesses close, those towns will go downhill. There is no central location in this area which is why this effort must happen at NCHS.
- Radio station 102.7 – 'Serving Lugoff, Camden, and Eglin'. We need to add Bethune – they serve us too!
- Since the high school closing in '99 we've lost 16 businesses.....we'll be a ghost town if the school closes.
- We're not North Central. We're Bethune.
- We are the best kept secret in Kershaw. Lots of diverse kids who overcome low SES and do very well on test scores despite barriers.
- We are only 2.2% of vote in Cassatt and Bethune, with only 352 people, we don't get a lot of attention from the county or the state
- Close-knit community where everybody knows everybody (can be good or bad thing), very family-oriented
- We have so many communities, and it's very isolated
- People here knew me, before I even knew myself.
- Huge population of unemployed families
- I Feel lonely here – Senior citizen

- Where IS the town? –new Cassatt resident
- Access to resources and the internet is a big need. For example, in one class, only 6 out of 24 kids at home had internet
- Very quiet town, great place to raise your family, not a lot of violence
- We don't have access to broadband; we use satellite-which is expensive ($100/month)
- No childcare in area, nursing place downtown not taking new people
- Need more activities for kids outside of school
- Visitation helps – I don't see anyone all week.
- Transportation to amenities is a barrier because North Central is so spread out) and there are "no-car" families and a lack of public transportation.
- Lot's of poverty. It's a cycle
- No normal family structure – lots of single parents and grandparents taking care of grandchildren
- There are lots of folks who are "in between" and struggle with bills. I'm lucky to have Medicaid.
- With churches, you'll get people ages 45 and up. You'll miss 2-3 generations of younger people. They're not here.
- NCHS has had 4 band directors in the past 4 years. This is a place for people to make their bones and move away. High turnover, especially with English and Math teachers.

Strong pride, regarding ability to pay for care, may influence those seeking help.

- Some people have too much pride to ask for help. I know a lot of people like that, but I am not.
- I don't have the money to run to the doctor
- I know a girl in my class that had a cold and that ended up going to the hospital and her mom is still paying the medical bills

- It will be good to have something as long as people don't abuse it, it will be fine
- People put off doing things they need, like healthcare, because it's not convenient
- Worried that folks are going to take advantage of it and will get overloaded real quick
- I always want to know, what is it going to cost me? What is this money being applied to? I'm not going to do something, if I don't have the money for it.
- "If you ain't got health, you ain't got nuth'n"
- Parents really want something for their kids, and they are going to make something for themselves.
- I don't trust the medical system. If I have cancer coming out of my ears I won't go to the doctor.
- Patient with Stage IV breast cancer- she would not make a bill that they couldn't pay for
- If you are uninsured or if you don't have money, there is no type of service.
- You don't see so much entitlement here that you see in other parts of the country
- Community spirit – we all come together in time of need

There are "small pockets" of need throughout the community.

- Large older adult population in great need, lots of people wheelchair bound
- The needs of these students travel all the way from elementary to high schools.
- Both of my children have asthma and I'm terrified that I won't be able to get to my kids fast enough
- We need someone to take care of the physical needs. We cannot afford to get to the physician. Lots of families are being raised by grandparents and have parents who can't read and still no diploma.

- Lots of students living with grandparents who “don’t know any better”

- A lot of parents are in “rut and don’t know how to get out”

- Some students have stomach aches and go to the nurse. But, as soon as you given them food they are immediately better; they are just hungry.

- Major orthodontic and dental work needs

- They don’t know what they don’t know.

- Mental health is a major concern – hardest issue to get resolved

- Pocket of kids who are constantly moving in and out, moving from trailer to trailer because of evictions

- Bring black and white communities together – still very divided, even in churches

- How to keep up with hygiene and their kid’s hygiene – fleas, ticks, lice and washing hands

- Midway has the highest Latino population in the district

- The Hispanics are small, but it’s becoming a big need. More siblings are at the elementary school than high school.

Most folks access healthcare services in Camden, Columbia, Florence and Charleston or not at all.

- Know some folks that work a mile and a half or more to go to the doctor

- The ACA is like a hole in your knitting and its unraveling

- Go to the pediatrician in Hartsville, the dentist in Sumter and the eye doctor in Hartsville

- For serious things, we go to Florence or Columbia

- Haven’t been to the doctor in years. I just rest in bed and then go back to school.

- If my grandchild is sick, it’s 19 miles from my house to the high school and then all the way to the doctor, it’s a full day

- Some kids are sick and are out for three days and never see a doctor or dentist because they can't pay for it

- For some things, instead of being out of school for 1-2 days, they are out for 5 days (wait 2 days at home, end up going to ER on day 3, and takes 2 more days to get better)

- Most folks have to take a full day off work to go to the doctor or take a child or grandchild

- Can't trust doctors in Camden. You go to Columbia or Charleston. They treat you nice

- Cassatt- Elgin and ER urgent care 45 minutes away

- Have a doctor in Columbia – takes 30-40 minutes to get there

The vision for the North Central initiative is community-centered, sustainable and bold.

- I want to impact the behavior and not just pass out prescriptions.

- We can't be afraid. We need to correct course, dream big and pray bold.

- If we prosper, our county prospers and maybe the whole state.

- I hope it will be life changingto let people know that there are options. Because a lot of people think there are no options and they're hopeless about the situation, the circumstances and the resources.

- A new project could enhance the health of the community by creating an atmosphere of community health consciousness. Education on washing hands and keep kids out (of school) when sick. Also, schools could make absence policy contingent with sickness, not just excused only when you see a doctor. It is $35 a pop to be told by a doctor, "just let it run its course."

- We do small things in a great way

- A lot of children don't know what a Nurse Practioner is. Perhaps one will want to be one?

- I've been an attendance secretary for years, having an NP on campus would help alleviate so many absences, and get them right there and right back to class instead of a full day. They are not excused for a full school day.

- We need to be cautious and don't blow our opportunity. We are dealing with very closed communities, where there is lots of suspicion and the mentality that you are here, but you are going to be gone.

- We have made it easy for folks to get to the ER, and we are not going to solve this problem overnight.

- Need to appeal to various age groups

- You must be persistent, just because it doesn't work at first, or if it's slow at first, keep at it.

- Change is something that people own

- Important to not be judgmental; easy to get caught up in "negativity"

- Bring healthcare to them (traveling healthcare, home health, kids dental)

- I feel a commitment and dedication to this community

- Need to capture the right people from the get-go

- Community Health Workers are the most important piece; they know the people and the circumstances

Stories describing some of the needs of the area.

I know a family that lives in a storage building and they have 1 child. I know of another family that the children sleep in a truck while the mama works at night. You hear a lot about power cords being shared between trailers.

Some of the students in the elementary school will tell you that their mama sells some "green stuff" in bags at the back door..they tell you everything in the elementary school

A common story I see is a single parent with two children, makes too much for Medicaid, but still doesn't have enough money from her check to get the care that she needs. Her child had a 103 degree temperature on Tuesday and mom couldn't take her to the doctor until Friday and "I can't do throat swabs". School Nurse NCHS and NCMS

Man needed to see a bone specialist, social security kicks in in December, needs $250 up front, no insurance, and can't get the after-care he needs with no insurance, and there is no open enrollment until November 1st – he is stuck in between

Pregnant woman and husband; lady works part-time at Bethune Grocery store, husband has gained 30 lbs in 3 months, $200 endoscopy, $300 for gastro, have one child and one on the way, struggling with medical bills, it's not cheap

Single dad, 3 children, didn't know if eligible for Medicaid. The School Nurse helped him get enrolled in SNAP and Medicaid and referred he and his children to physician. The dad had not been to the doctor in 6-7 years.

A lady once ran into the back of a truck with her knee. Her leg locked up and she went to EMS to see if they had an idea as to what was wrong. EMS didn't know what to tell her but offered to drive her to the hospital. Knowing they couldn't provide any medical help but that it would cost her a lot to be transported, she had a friend drive her there instead. By the time she reached the hospital, the knee/muscle unlocked so they turned around and went home.

Patient at AccessKershaw had oral cancer and had previously undergone many procedures. He needed to go to radiation weekly as well as pick up his completed lab work in order to figure out next course of action but had no way to get there. Doctors were concerned they may need to remove his jaw seeing he needed immediate attention. AccessKershaw contacted American Cancer Society who provided gas cards to go to doctor. They determined it wasn't as bad as they thought allowing him to remove the tumor and reconstruct the jaw instead of fully removing it.

Daughter was suffering from severe postpartum depression and sought help. OBGYN sent her to the mental health clinic. Clinic said they would not see her until after 6 weeks and to be seen she would need a referral from OBGYN (OBGYN referred her to the clinic in the first place).

Just today, saw a lady with a UTI and prescribed her 10 days of antibiotics. She is still sick and it's day 15. She works at the bandage dressing store in Bethune and didn't have the money to go to Camden to get the $4 prescription.

There is a young girl who needed dental care, tooth ache for several weeks, mom couldn't take her to the dentist, teacher called the dentist at Camden and got her the help she needed.

Recommendations

Overall Infrastructure

Determine decision-level authority for Director of project

Create clear job description for the role of Whitney Hinson, Project Manager, and determine if the job is at 50% or 100% effort

Solidify the larger LiveWell Kershaw initiative and the North Central Initiative, and determine who is leading the larger effort

Determine which communities should be targeted first for phase 1 of the project

Identify “low-hanging fruit” to begin working on in the next two months that will help build community buy-in and ownership of the project

Clinical/Community Health Worker

Determine representative to serve on the DHHS Community Health Worker task force to provide “in the field” voice to policies being developed

Keep in close contact with Ally Gahart to ensure that any modifications made (taking exam outside of training, etc) are approved so reimbursement will not be a barrier

Conduct site visits at high-performing sites is SC and talk with Fran Feltner at KY Homeplace (reimbursement expertise)

Provide flu shots on site at North Central High School this fall to increase trust (small step towards School-Based Health Clinic)

Provide TDAPP shots for rising 7th graders on site – 50% are not completed at the beginning of the year and are an annual need

Utilize CMC staff during phase one to work out “kinks” before transitioning to part-time or full time clinical personnel; build on CMC model based on performance improvement and patient-driven care

Recommendations

Determine role of Dr. Melissa George in mental health piece – is she focusing on adult population in community or school component, or both?

Schedule meeting to discuss project and implications with local providers in area

Community Engagement and Branding

Re-brand the initiative name so that "North Central" is not used in the name

Consider personalized branding for the individual towns

Identify potential trailer parks for outreach in addition to the churches and recruit members to serve on the Community Advisory Boards

Update website with information on project at 3rd-5th grade reading level and using recommendations from Core Planning Group
Follow all key community events and create calendar to determine when outreach can occur

School-Based Health Center

Have continued conversations with Regina Bowers (school nurse for NCHS and NCMS); what will be her role? Need to off-set fear that this will be taking her job

Consult with Laura Brey on initial steps needed to set-up SBHC and develop timeline; Brey is the Senior Training and Technical Assistance Specialist for the School-Based Health Alliance

Consider using the "Wellness Center" as the home for the SBHC; Center has undetermined purpose at moment from School Board and is not being maximized

Evaluation Plan for Next Quarter

Focus: Providing Helpful Information for Community Health Worker Launch

- Interview successful CHW sites in Kershaw County and other sites nationally
- Determine if more key informant interviews are needed in the different communities (i.e. Westville) – have a lot of info on Bethune and Cassatt, collect needed information for CHW piece
- Compile document with best practices for the CHW piece

Focus: Collecting quantitative data on communities to use as baseline

- Determine actual populations of all small communities and create tables with key demographics
- Create powerpoint presentation describing areas of focus
- Create survey for community piece (how access information, etc.)
- Pilot test survey
- Administer survey

Focus: Track accomplishments and setbacks of overall initiative & individual pillars

- Keep track of accomplishments and setbacks outlined in 5 month action plan
- Document key decisions made and implications of decisions
- Create visual graphic of project overall to share with stakeholders
- Meet monthly with Director and champions to identify questions that need to be asked
- Create Quarter Two report

Focus: Establishing infrastructure for overall evaluation work

- Create conceptual model for Phase 1 of project (community health worker piece)
- Create conceptual model for overal evaluation
- Complete NVivo training and determine how best to collaborate as group
- Create templates, protocols for how information will be stored in NVivo

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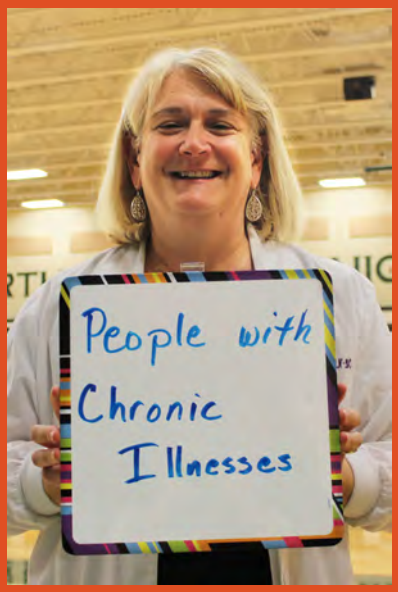
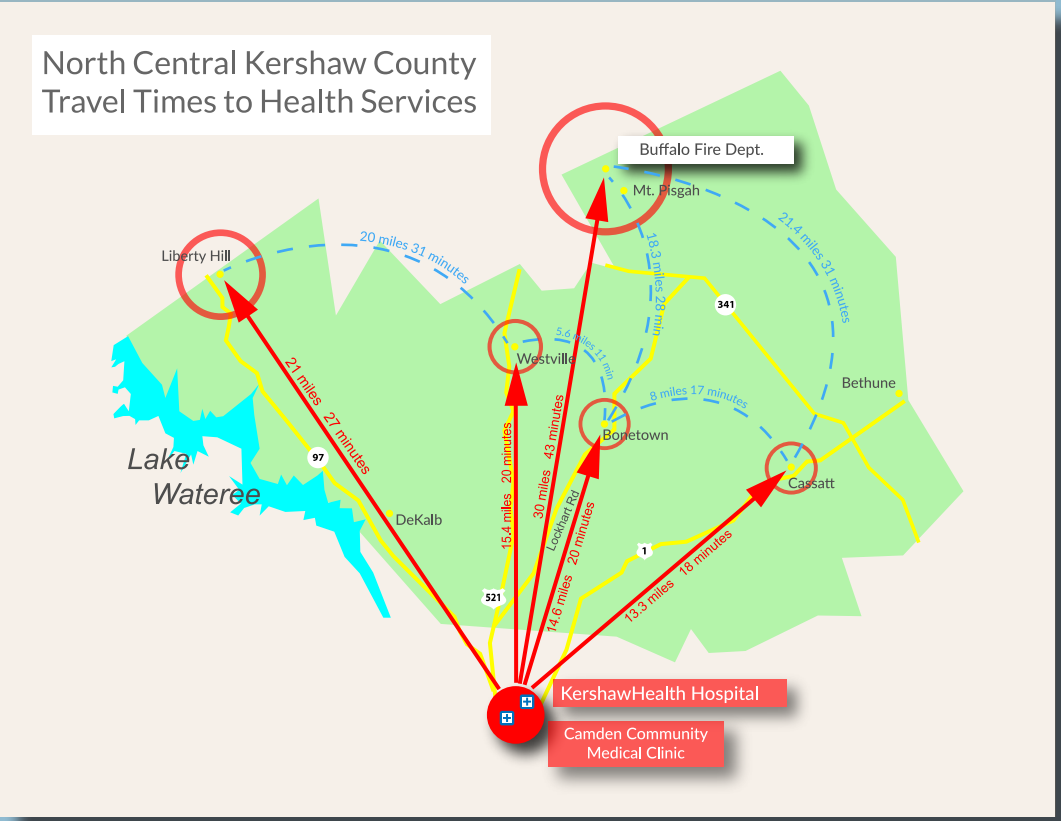


LiveWell KERSHAW

Quarter Two Report



September 1 - December 1, 2014

LiVeWell KERSHAW

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UNIVERSITY OF SOUTH CAROLINA

Office of Practice & Community Engagement
Arnold School of Public Health

December 1, 2014

We hope you enjoy Quarter Two's (September1, 2014 – December 1, 2014) evaluation report. Much time was spent this quarter in understanding one another's roles in the project and how best to maximize the skills and assets of everyone "on the bus." The North Central initiative is the agenda for LiveWell Kershaw. LiveWell Kershaw is a coalition to improve population health in Kershaw County, South Carolina.

The purpose of our developmental evaluation is to support the innovative development occurring in Kershaw County and to elucidate team discussions and data that help guide decision making. Our over-arching questions include:

- What is being learned from LiveWell Kershaw efforts?
- How can the LiveWell Kershaw efforts be improved, both during the current phase and beyond?
- What does LiveWell Kershaw want to be capable of sharing with others about its approaches?

Even though the paths and destinations are still evolving for this complex initiative; the goal is clear. We are all working to be the healthiest county in the state. And let me tell you, this group is working around the clock to make this community initiative do just that.

Best in all you do,

H
E

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Key Learnings from Quarter Two

- We are taking a community-centered and holistic approach
- Our agenda is LiveWell Kershaw
- It's important to have team members who live, worship or work from this area (it's a heart thing) and can help their neighbors
- This needs to grow organically to be sustainable
- Everyone has a stake in each team's success
- It's important to receive feedback from others
- The person is at the middle of everything we do
- There is no right or wrong, be bold, "we tried something"
- We need to have the "silver buckshot" mentality
- We are guiding this, not DHHS
- We have excellent folks and tools in the room
- On-boarding of new team members is very important
- We need to carve out time to pause and reflect
- We did a lot of "cha-cha" this quarter in clarifying and re-clarifying roles, goals and getting the right people in place

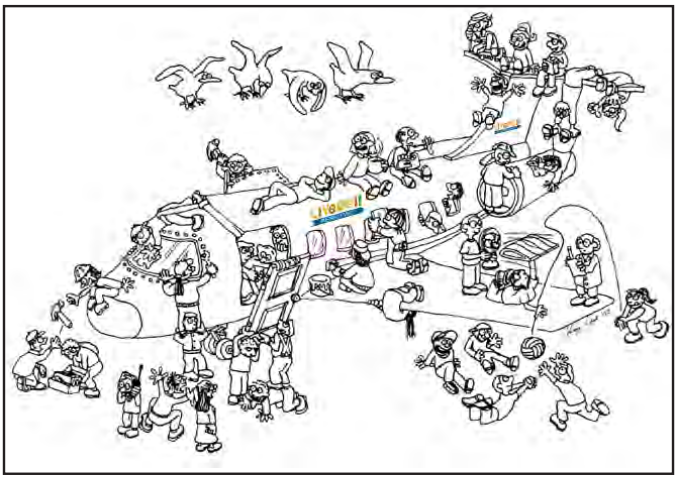
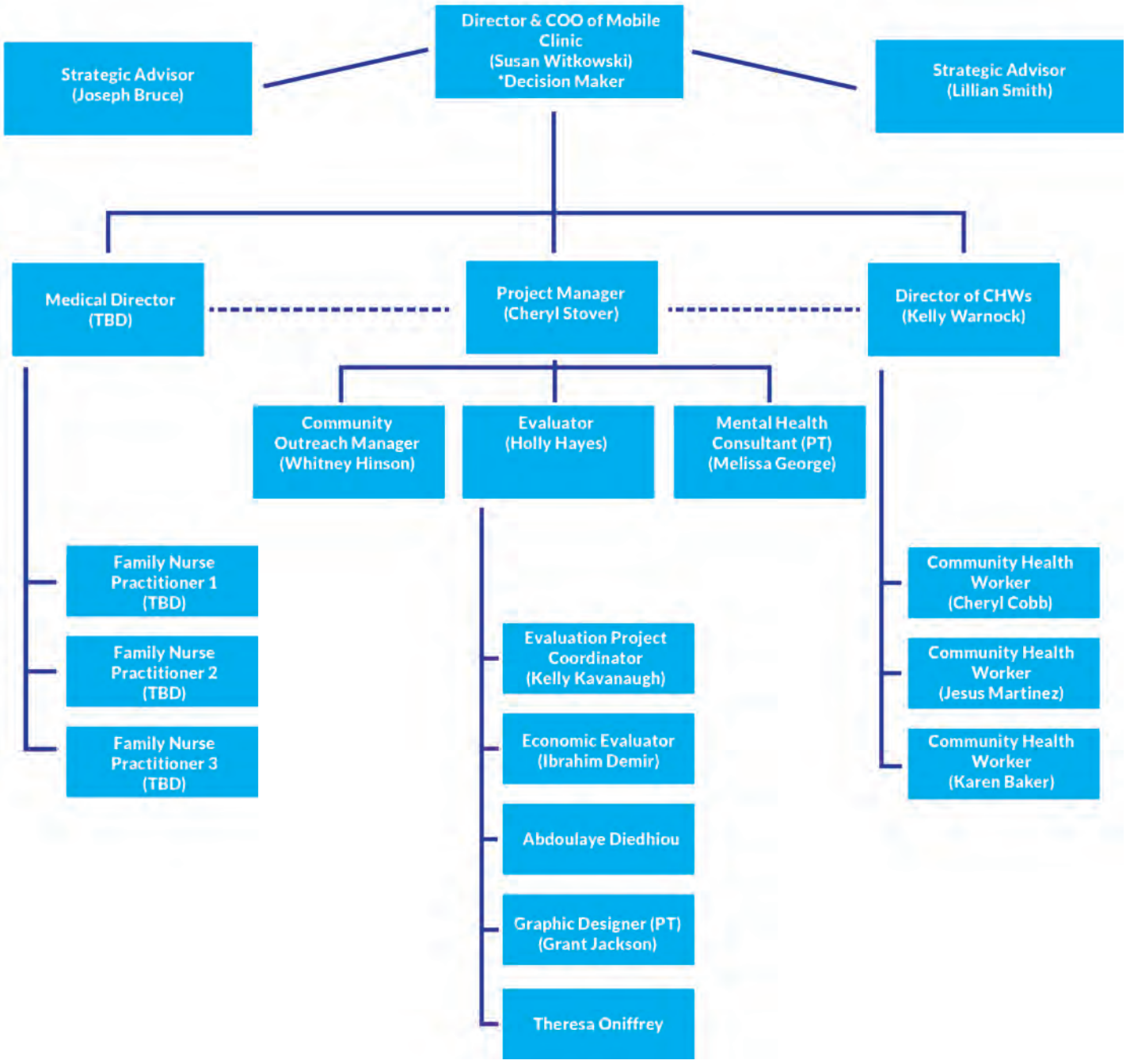


Fig. 1 "Building the plane while flying it."

Organizational Chart



Our Journey to This Point

What is the goal?

On October 17th, 2012, LiveWell Kershaw announced its ambitious plan to make Kershaw County the healthiest in South Carolina. Based on the County Health Rankings, Kershaw County is currently 10th in the state for overall population health. However, the county ranks closer to the middle of South Carolina counties in critical areas such physical inactivity, smoking, and access to healthy foods. The county also ranks relatively low in access to primary care physicians, preventable hospital stays, and access to recreational facilities.

How did this all get started? We listened…

The LiveWell Kershaw initiative began with a county-wide health assessment followed by the development of a comprehensive, long-term improvement plan (See Appendix: LiveWell Kershaw Process). In an effort to gain a deep understanding of the needs and strengths of Kershaw County, over forty community members and leaders assessed the public health system and forces impacting their community. Through the health assessment process, community members provided input though surveys (920 completed), community events and town hall meetings; focused conversations with churches, physician groups, and civic organizations; and a PhotoVoice project completed by high schoolers. Quantitative data was collected from a broad array of sources, analyzed by ASPH and then presented back to the community to determine priority areas. The working framework for LWK applies strategic thinking to select key public health issues based on community input and identify resources to address them. Using findings from the assessments, community members in Kershaw County identified poverty and health disparities as over-arching issues to be addressed across four prioritized areas:

- Nutrition/physical activity/obesity
- Access to appropriate care
- Smoking
- Sexual activity and teen health

Now that we have the assessment, what's next? We focused…

The LiveWell Kershaw Core Planning Committee (CPC) then convened a Planning Workgroup and recruited more diverse members to represent the geographical area of western Kershaw County (Bethune, Westville, Cassett, and Midway) to complement the community and agency representation already in place. The group identified North Central area as the area in most need in the county based on data collected during the community health needs assessment.

North Central High School in Kershaw County, South Carolina is located within a Medicaid adult disease cluster "hotspot" for Kershaw County (Institute for Families in Society). This area, known as North Central, includes the rural towns of Bethune, Cassatt, and Westville. Westville has the highest percentage of total uninsured persons (71%) in the county, followed by Cassatt (28%), and Bethune (25%). Together, these towns make up 14.6% of all adult Medicaid recipients in Kershaw County.

Not only have all three towns been identified as hotspots but they have also been categorized as having a "high" prevalence of cardiovascular and chronic obstructive pulmonary diseases (COPD). A "high" prevalence of chronic disease burden has been identified in both Bethune and Cassatt. Additionally, Bethune has a "high" prevalence of end-stage renal disease and hypertension while Cassatt has a "high" prevalence of diabetes behavioral health conditions.

Let's celebrate! Get to work…

On June 1, 2014, Kershaw Health received a $2.5 Million dollar contract from DHHS to develop a community-centered model that includes the coordination of school and community-based healthcare with public health strategies to improve overall population health. The LiveWell Kershaw (LWK) Core Planning team is currently working on two phases of the three year initiative, which includes hiring Community Health Workers and implementing a School Based Health Clinic at the local North Central High School. LWK has built collaborative relationships that allow the community to leverage existing resources and promote ongoing partnerships to improve overall health in the county.

The community is fully equipped to advance its mission of becoming the healthiest county in SC. While addressing the priorities identified in the assessment, the community goals of this initiative include:

1. Maximize payer source for care.
2. Maximize population in primary care or patient-centered medical homes.
3. Extend primary care into the community.
4. Measure population health and economic impact results.

What have we done so far? We have listened some more.

For quarter one (June-August, 2014), our evaluation focused on understanding the context in which the various interventions will take place, and to make recommendations that assist in the planning and implementation of such a complex initiative. We conducted 60 key informant interviews with stakeholders living and working in the northeastern portion of Kershaw County. Stakeholders included but were not limited to: school personnel, parents, mayors, residents of towns, clinic personnel, and pastors. Emerging themes from interviews included the following:

- North Central community members feel that they are perceived as the "red-headed step child" of Kershaw County and have strong identity with their town. There is a perceived lack of access to activities (specifically for children), technology, and groceries, and jobs.
- Strong pride, regarding ability to pay for care, may influence those seeking help.
- There are "small pockets" of need throughout the community.
  Folks access healthcare services in Camden, Columbia, Florence and Charleston or not at all.

Video links to interviews with members of the Core Planning Committee can be found at:
https://www.youtube.com/channel/UClm0k0YDjAC-LJKg2umSf1g

Appendix: The LiveWell Kershaw Process

A group representing communities, organizations, government, and service providers, LWK is committed to improving the overall health of Kershaw County residents through a process that engages the community and builds capacity. This process (See Figure 1) involves organizing community members and organizations, assessing the needs and assets of the community, prioritizing issues and aligning resources to address them, acting in a coordinated manner to reach collective impact, and to continuously evaluate and monitor progress and process. The process includes continuous engagement and communication through all phases and with all stakeholders. LWK identified priority areas and formulated broad goals and strategies in an improvement plan with the goal of building synergy around wellness, leveraging and aligning existing resources, and identifying gaps. LWK is currently engaged in the prioritizing and aligning phase of the process. The process is intended to be continuous, moving back and forth as needed.

Each of the priority areas is a complex social issue without easy solutions. Successfully addressing the priority areas requires a collective impact approach of multiple organizations looking at resources and innovations with a common agenda, learning through continuous feedback, and acting together. The five conditions of collective impact (http://www.collectiveimpactforum.org/) guide the organization and operations of LWK:

- Common Agenda through the vision and agreed upon priority of improving appropriate access to care for the geographic area of North Central.
- Shared Measurement through formulated broad goals and strategies with indicators for success and further refinement as the program develops.
- Mutually Reinforcing Activities coordinated through strategy management system and action plans.
- Continuous Communication through regular meetings and learning opportunities, updating IT systems, social media, and community events.
- Backbone Support through the partnership with USC Arnold School of Public Health and KershawHealth.

With the Common Agenda, LWK clearly articulated the pressing health issues of their community and crafted an initial plan of how to solve these issues. The LWK Process allows us to identify and take advantage of emerging strategies. We have structured our work to enable collective seeing, learning, and doing. This allows all of the organizations that are working together to actually learn together and adjust while doing.

Figure 1: LiveWell Kershaw Process

Community Health Workers: Hiring Process & Key Documents

Hiring Process:

LiveWell Kershaw budgeted 3 Community Health Workers (CHW) for this project. The big questions were: Who do we hire? With what qualifications? How much do we pay them? Would we find the right people? And would we make DHHS happy with the 'great flux" of CHW?

In October 2014, Kelly Warnock created a job description by using her Access Kershaw case management position and tailored it for the CHW. Kelly visited CareSouth and talked with Little River, both identified as "high performing CHW sites", during the month of October. The biggest take-aways from these discussions were that these sites were expert CHWs in a "controlled setting" and were not sure how this model would work in the wider community setting.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KERSHAW

A group of citizens, healthcare providers, businesses, churches, and schools are working together to make Kershaw County the healthiest county in South Carolina. The LiveWell Initiative will focus on the areas that serve North Central Middle and High Schools, and Baron DeKalb, Bethune, Midway and Mt.Pisgah Elementary Schools. State data has shown there is a high rate of heart disease, high blood pressure, diabetes, and behavioral health conditions.

YOU KNEW IT. WE HEARD YOU SAY IT. NOW LET'S DO SOMETHING ABOUT IT.

To improve the health in these areas, the LiveWell Initiative will use a community-centered model with **Nurse Practitioners** and **Community Health Workers (CHW).**

TO ACHIEVE THIS TOGETHER, THE FOLLOWING STRATEGIES ARE NEEDED:

- Identify and apply for services for those who qualify for Medicare, Medicaid, Welvista, and other assistance programs and enroll them.
- Seek opportunities to provide these services ongoing.
- Work with community groups, churches, and schools to find appropriate primary care homes using a case management approach.
- Provide mobile care services for adults at such locations as churches, civic organizations, and homes.
- Establish school-based health centers (SBHC)
- Create a chronic disease registry to collect data to measure changes over time in population health.
- Conduct comprehensive evaluation of entire project and measure the model's economic impact on the community.
- Realign community resources.

For more information: Whitney W. Hinson, MCHES; whinson@kershawhealth.org; (803) 424-0461

Kelly and Susan met with Ally Gayheart and Mandi Williams at DHHS and discussed how CHWs would report daily activities including travel, visits, and documentation. Kelly modified what Hospice used and is now piloting the "Daily Report" in Bethune.

Kelly and the team decided to advertise for the CHW position on the hospital (KershawHealth) website and through word of mouth. No surprise to the team, all of the candidates came through word of mouth. From a total of 25 applicants, Kelly emailed each applicant a letter of "the good, the bad, and the ugly" explaining that there was a stipend for insurance, the max pay was $14 an hour and the position could be terminated when funding cycle ended in 2017. From that letter, 15 applicants still expressed interest, including a lot of unemployed social workers. The team interviewed a total of 15 folks, but it became very evident that we had to be true to hiring folks that "work, worship or live" in the area. After interviewing a few social workers from Columbia, Kelly called the rest of the applicants back to notify them that the CHWs need to "work, worship or live" in the area.

After narrowing the applicant pool to the final five, each had a 30 minute interview with the team from AccessKershaw (Kelly, Meredith, Susan W., Sherry, and Jeana). The candidates were asked why

they were each the best fit for the job and were then given scenarios concerning the biggest healthcare challenges in the area. The interview team also pressed each candidate to address why he or she really wanted to be there, they all wanted “to give back to the community.” The team then ranked the applicants from 1-5 individually and remarkably everyone chose the same top three. Afterwards, the team discussed how the new dynamic would potentially work and agreed that the personalities would indeed mesh. Kelly called the applicants that very night and all three accepted.

Cheryl, an LPN, believes this to be part of her “mission” and lives in Cassatt.Her children attend North Central Middle and High School.

Jesus, a Bible College graduate, is fluent in Spanish and has struggled with the challenges of lack of insurance and documentation. He believes that this “is his way of giving back.”

Karen is a retired school nurse and a “whirling dervish.” She was tired of driving to Columbia for work and is the founder of the free clinic in the town of Kershaw.

Two of the new CHWs started December 1st and the third began January 1st.

Job Description:

Livewell Community Health Worker

The Livewell Community Health Workers reports to the Director of Access Kershaw. The Community Health Worker (CHW) will be responsible for helping patients and their families to navigate and access community services, other resources, and adopt healthy behaviors. The CHW supports providers and the Nurse Case Managers through an integrated approach to care management and community outreach. As a priority, their activity will promote, maintain, and improve the health of patients and their family. The CHW will provide social support and informal counseling, advocate for individuals and community health needs, and provide services such as first aid. Community outreach, such as home visits and health screenings will be required. The CHW will work within the community to identify community wellness assets and gaps. The CHW will also assist with events, staff meetings, and community service projects. The CHW will strive to utilize a holistic model of care which is patient, family, and community centered. The majority of the CHW's time will be focused in the community setting.

Key Functions/Responsibilities:

Assessment

- Conducts psycho-social assessment
- Obtains medical/surgical history, including social determinant screening
- Conducts medication assessment & reconciliation
- Assess patient's self-management components to include health beliefs, readiness to change, confidence (self-efficacy) and importance (utilize PAM tool)
- Evaluate effectiveness of care management services

Planning Care

- Develops plan of care and monitors patient's progress towards goals
- Conducts follow up and reassessments with patient at regular intervals
- Participates in interdisciplinary case conferences if necessary

Health Coaching

- Uses content from New Leaf Program for teaching clients
- Uses motivational interviewing techniques
- Utilizes patient self-management techniques
- Provides education and training for individuals and groups

Coordination of Care and Services

- Demonstrates current knowledge of community resources appropriate to setting and population.
- Assists patient with navigation of the healthcare system and community services, including SC Thrive
- Maintains effective communication with hospitals, providers, community agencies, etc.

- Oversees the patient throughou t the continuum of care

Documentation

- Documents all interactions with patients including assessment and plan of care updates.

Education Requirements:

- Must have high school diploma
- Prefer community member from the North Central Kershaw County area with strong community partnerships/connections
- Prefer RN, LPN, Social worker, or Health Educator.
- Prefer prior clinical and case management experience.

Other Requirements:

- Must successfully pass SLED and DMV check
- Must be able to complete and pass CHW training and certification within a reasonable, defined timeframe.
- Heart saver certification required within 2 months of employment
- Prefer previous experience with electronic medical records.
- Must be able to relate well with clients, co-workers, providers, hospitals, and other health and human services organizations.
- Must have strong oral and written communication skills.
- Must be able to work with minimal supervision.
- Must have access to personal vehicle. Driving within county expected daily.
- Must understand the community served-community connectedness.
- Must have proficiency with Microsoft Excel, Word, and other applicable software.
- Written and oral fluency in Spanish and English preferred.
- Additional assigned duties as required.

Physical and Mental Requirements:

- Must be in good physical condition.
- Must be able to function effectively in stressful and demanding conditions.
- Must be able to withstand many hours of sitting and standing.
- Some weekend work may be necessary
- Must be up to date on immunizations and TB testing and be in compliance with all OSHA requirements

Position reports to Director of Access Kershaw and is a non-exempt status employee. We will consider part-time and full-time options for staff.

Letter to Applicants:

October 13, 2014

Thank you for your interest in the Community Health Worker position with Access Kershaw. We will begin scheduling interviews within the next couple of weeks. In order to make sure that you have as much information about this position as possible, I am including a few bullet points that may clarify what we expect from this position. If you are still interested in pursuing this position after you review the following information, please contact Meredith at 803-272-8777 to arrange for a time to interview. We are very excited about this opportunity to make health improvements in this community!

- Position reports to Director of Access Kershaw
- We are willing to consider part-time people as well as full-time
- This is a grant position that we have funding for until at least June, 2017. We hope that these positions will continue after this date with additional funding.
- Benefits: We do not offer a medical plan at this time, but will offer a stipend to allow you to purchase your own medical insurance. We do offer several holidays and 3 weeks of vacation a year to a full time person.
- This position will be mostly located in the community. 80% of your time will be travelling in the North Central part of Kershaw County. The other 20% of the time will be located in one of our offices in Elgin or Camden.
- You must have reliable transportation and be willing to drive daily within this community. You will be reimbursed for mileage.
- Salary is negotiable, but remember that this is a grant funded position and salary with benefits will range from $25,000 to $35,000 a year. This will be a salaried position, not an hourly position so there is no opportunity for overtime.

We look forward to your interview and we are really excited about this opportunity and I want to make sure that all applicants understand the uniqueness of this position. We will be hiring 3 Community Health Workers over the next couple of months.

Kelly Warnock, FNP
Director, Access Kershaw

Elements of a Successful Community Health Worker Relationship

To aid in the development of a successful Community Health Worker (CHW) relationship, LiveWell Kershaw (LWK) staff interviewed community members about their experience accessing health services in the northern Kershaw County area. Patients who had utilized both AccessKershaw and the Healthcare Place at Bethune were identified by Healthcare place staff and asked if the LWK evaluation team could contact them for a potential interview. A convenience sample was then taken by the evaluators based on the first five participants that were successfully contacted via phone and verbally consented to participate.

Between September 9th and September 11, 2014, six persons were interviewed – four individuals and one married couple. Interviews consisted of 4 women and 2 men who were either black (4 persons) or white (2 persons). 3 interviewees lived in Bethune, 2 lived in Cassatt, and 1 lived in Camden but worked in the North Central area. Respondents ranged in age from 41 – 63 years. Interviews covered a series of pre-determined questions centered on the overarching theme of **"what are the elements of a successful Community Health Worker relationship?"** Key themes with related quotes are provided below.

Take a holistic approach to care

- Access Kershaw really helped us to find the money when we needed it to get his medicine. Not only to get his medicine, but also to show us a better way of living.
- We were able to put a plan together with AccessKershaw, the clinic, and his work to be able to figure out what works for him and his lifestyle. So what worked for Timothy was before work or after work because Timothy is not going to miss work. He's not going to be late for work, Timothy has great attendance.
- So a lot of people depend on you. And I think when we sat down and said if you weren't here today, who would start taking care of those people. And you sat down and started thinking about it. So we just took a different approach from the first time he came to the second time.

Take your time with patients

- And she took her time with me. And everyone I've worked with at AccessKershaw took their time with me. Went through, explained with me everything I need to do, helped me fill out the applications, and everything. It was just wonderful. Just wonderful.
- They always had time to talk to us. When something is wrong. I never felt rushed.
- When you go in there they treat your right, they want to know what is wrong and they take the time to find out. First, they want to know how you are doing and how they can improve.

Address patient concerns

- At first it was overwhelming to hear something and when you ask a doctor…and the doctor don't know, who you supposed to feel comfortable.
- "You've got to see it to believe it" and most people they see it, but some don't believe it. And with the mobile clinic…like I said they'd probably go, but they wouldn't really believe it. They would just think it was just a scam or anything.

Improve access and availability of care

- They were only open Monday, Tuesday, Wednesday, and Friday…half day on Fridays. But what I've been told they're going to be open on Thursdays too. The only problem with them being close on Thursdays is if you find out you need a prescription and there's no one else to get a prescription. We've ran into that several times. But I always call them at the time they open, 8:00 Friday morning, and I still pick it up that morning.
- In a general area, it would be good if people had the access to go to the clinic and didn't have to worry about going to Camden to get a shot.

Consider patients as family

- The Healthcare Place at Bethune, those Nurse Practitioners also make it a point to get to know the person. You're not just a patient to them.
- Our experience, it became like family
- Going down there is like going to my Daddy's house. Because I feel comfortable.
- It was just like a big sister that came to say "I can help you" and she put her arms around me and hugged me and said "don't worry we got you, we got you".

Serve as a beacon of hope

- They're a lifesaver. Ms. Kelly and Sheri, and all of them
- The program gives you hope. Without hope the people perish. That's why people commit suicide.
- I thank God that Melinda Kelly was in our lives because she helped us a lot. Where to go to, who to talk to. There are a lot of things that you need. And a lot of people have this condition and don't know where to go to until it is too late. As long as we have one another, we have what we need.
- When you are dealing with something, that even doctors have not heard of, it is kind of frightening. Then when you come up with, yeah, we do have something, but it is out of your reach, it is like you don't have anything. We are very thankful for the healthcare place Melinda Kelly, Kelly, and Shirlene, because they came together.

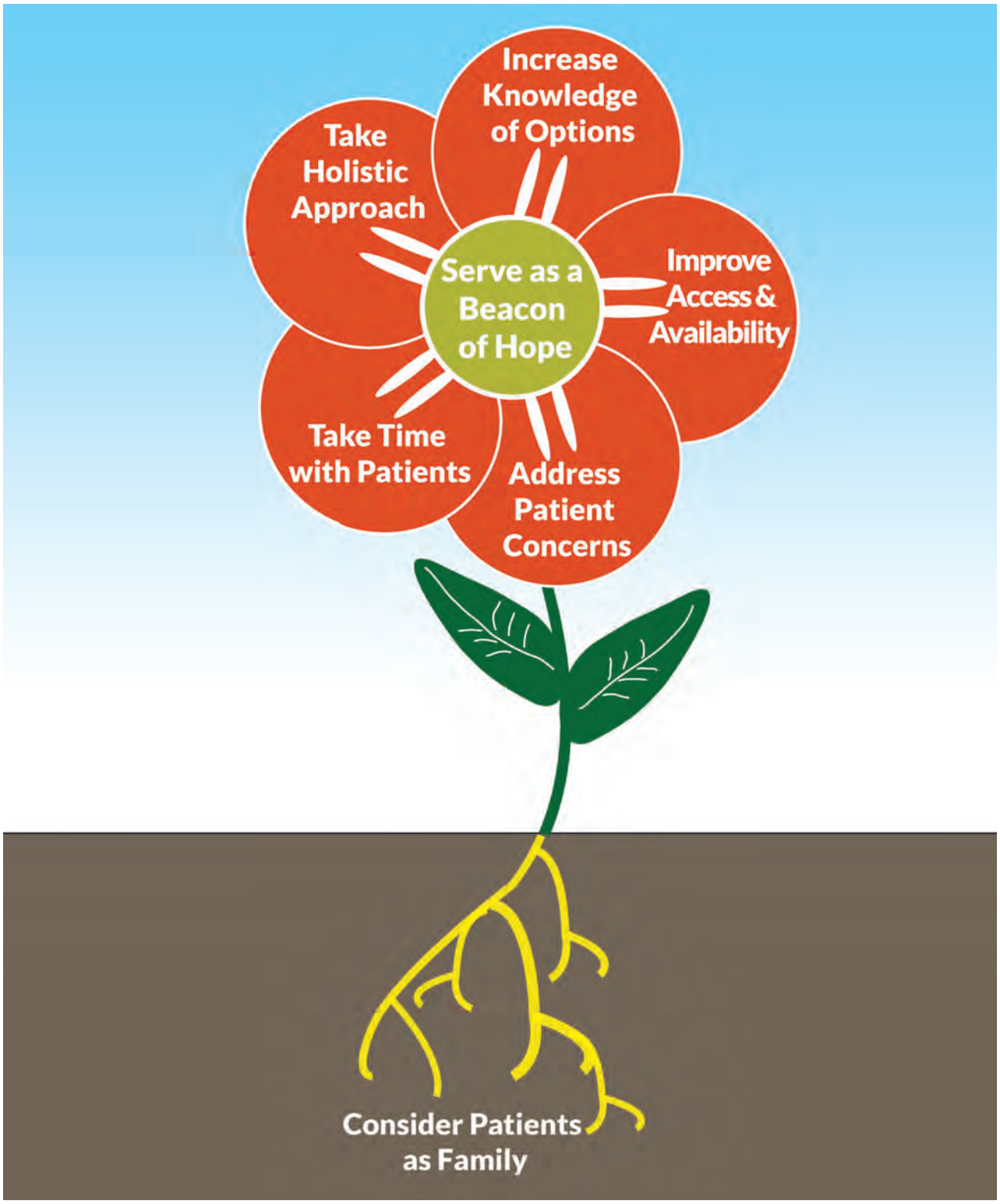
Increase knowledge regarding healthcare options

- It is easily accessed, but sometimes people don't know how to go through the channels. We made plenty of phone calls to different medical groups, doctors to find out what this is and what can we do and how did it happen.
- For us, it was not knowing there was healthcare out there. The biggest problem we faced is that really didn't know where to go
- I feel that there would be more people in this community down there now, more than it is now, because they have access to all that information.

Follow-up with patients

- I looked back in my rearview mirror and they was coming behind me and the followed me at school and talked with my principal. And let him know that he got on me and some teachers as well gett'n on me too and making sure I am doing the right thing. Making sure I'm keeping my insulin and everything straight and keeping my information down.
- If they don't hear from you, you going to be hearing from them in some kinda way. They know how to reach you. There's just a telephone call away. They the best yellow pages walking in the phone book.

Conceptual Model of a Community Health Worker



School Based Health Centers

A Qualitative Analysis of Student Health for the Development of a School-Based Health Clinic at North Central High School.

- Objective: This qualitative investigation aimed to provide essential information to the Core Planning Team regarding students' perceptions of health and needs of health services at a high school in Kershaw County, South Carolina.

- Methods: One-on-one interviews were conducted at the high school with a trained interviewer and eligible students. Parental consent was collected prior to the interview. Transcripts were analyzed using NVivo 10 software.

- Results: Data from seven students indicated a need for policy changes at the administrative level as well as health care support through the implementation of a school-based health clinic (SBHC).

- Conclusions and Implications: Due to limited sample size, researchers advise that further qualitative interviews be conducted with students, administration, and parents prior to opening the SBHC.

Introduction

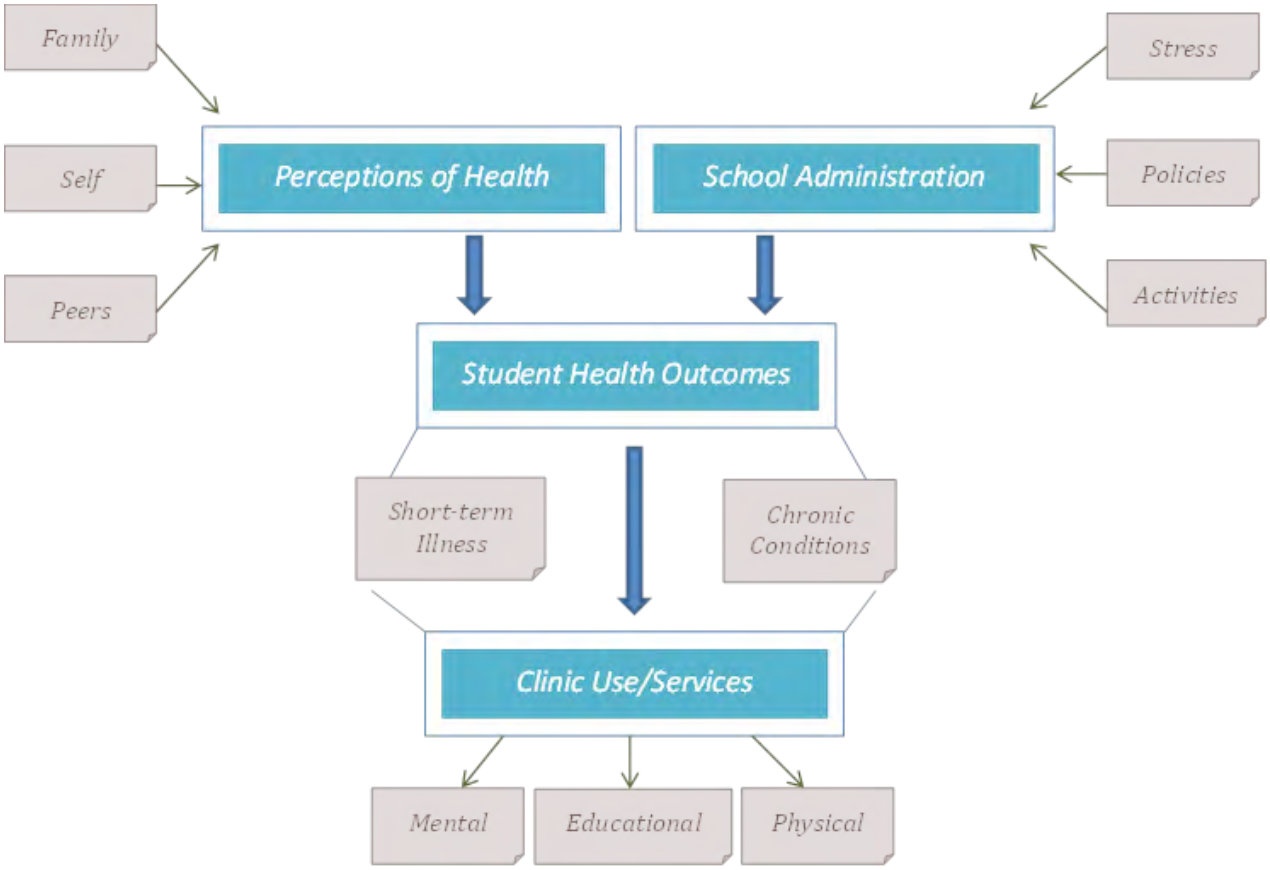
Children and adolescents spend majority of their days at school.1 School-based health centers (SBHCs) are an outlet for students to receive free or reduced health care services. Providing these services may remove several barriers to receiving health care such as transportation, while also reducing time away from school. Benefits of SBHCs range from academic benefits like reduced absenteeism, improved learning environment2, increased learning time3, reduced drop-out rates4 and grade point average (GPA)5 to personal benefits like improved physical and mental health.1,6

LiveWell Kershaw School-Based Health Clinic

In June 2014, Kershaw Health received a $2.5 million dollar contract to develop a community-centered model that includes the coordination of school and community-based health care to improve overall population health. The LiveWell Kershaw Core Planning team intends to hire Nurse Practioners and Community Health Workers to implement a School Based Health Clinic (SBHC) at North Central High School (NCHS) in rural Kershaw County, South Carolina. NCHS serves 493 students of who are mostly White (63%), followed by Black (32%) and some Hispanic (3%).

The purpose of this qualitative investigation was to provide essential information to the Core Planning Team regarding the perceptions of health and needs of health services from students in grades 9-12 at NCHS. Our research aimed to answer two primary research questions: How do students describe their individual and peer experiences with the health care system? What types of health care services are needed from the student perspective? See Figure 1 for our conceptual model.

Figure 1. LiveWell Kershaw Qualitative Student Interviews; Conceptual Model



Methods

Student buy-in is paramount for the success of SBHCs. In order to effectively provide services to the student population, in-depth interviews were conducted with students at NCHS during the school day. One page parental consent forms were reviewed and approved by the Communications Coordinator for the Kershaw County School District in advance. Participant recruitment was governed by the administration at NCHS using a purposive sampling strategy. The principal identified a group of "eligible" students based on a set of criteria established by the research team. The desired population for this study included a maximum variation sample of students from each grade 9-12 and race/ethnic groups, with an equal distribution of males and females. Eight eligible students were then provided with a copy of a child consent form to be signed by a parent/guardian. Seven consent forms were completed and returned to the administration by the deadline of October 26, 2014.

One male and one female from grades nine through twelve were included in this study, with the exception of a 10th grade female. These students were then scheduled for individual interviews with the researchers during the week of October 27, 2014. In this manuscript, participants are assigned a number 1-7 to uphold confidentiality.

Three trained interviewers conducted the individual interviews in a small, private conference room located adjacent to the main office and in a private room within the library. Students were dismissed from class to participate in an interview that lasted thirty to sixty minutes. Candy and water were offered to students upon arrival to the interview. An interview guide of seven core questions accompanied with a set of anticipated probes was used. In some cases, emergent questions and probes were developed by the interviewer on the spot. Questions covered five main categories: demographics, perceptions of individual and peer health, personal health history, barriers to health care, and input regarding the new health clinic.

Interviews were audio recorded and were either transcribed verbatim by the interviewers or sent to a transcription company and checked for reliability. Field notes were also completed immediately. Transcribed interviews were open coded using NVivo 10 software by the individuals who conducted each interview. From this open coding process, a list of codes were generated and confirmed between interviewers. The final code list was then applied across all interviews. The interviewers coded the interviews independently and then met together to discuss the main findings and themes. A summary of results focused on elements of the main research questions to assist in guiding the LiveWell Kershaw Core Planning Team with the development of the SBHC.

Results

Participant Demographics and Description of Environment

All participants (n=7) were students at NCHS and had been residents of Kershaw County since at least their freshman year. The participants all lived with at least one parent and sibling. All participants were covered under a health insurance plan and reported utilizing the health care system at least once in the previous year.

Students were asked to describe their town and school. All participants mentioned elements of the rural setting. Participant 1 described his town as, “just a little small town where everybody knows everybody.” Participants 1-4 described the majority of individuals in this area as “country” or “rednecks” and found that outdoor hobbies such as fishing, mudding, and hunting were big in this area. Despite the resounding theme of people knowing one another in the town and within the school setting, both participants 1 and 2 discussed how private the social groups were within these settings, which will come into play again when discussing clinic plans.

“You have your one group of kids that’s all friends and you have your other group that are all friends, so we kinda keep it that way. We try to mingle with some of them to get, like to get to know each other. But other than that, we kinda stick to ourselves. That way you don’t have no trouble.” – Participant 1

Overall, students seemed to enjoy attending NCHS. The teachers were described as "good" and the school "does as much as they can. Offer PE classes, weight lifting classes, and they give you good food now, or whatever, it's healthy, not saying its good or nothing, but it's healthy."

Perceptions of Individual and Peer Health

Participants were asked to identify the first three things that came to mind when prompted with the word "health". Responses are outlined in Table 1. Feedback from participants was generally consistent in terms of the importance of medicine and the role of health professionals. Three of the four participants mentioned an element of physical activity in regards to health. These findings indicate that students perceive health to be reliant on the health care system and personal investment through physical activity or healthy eating.

When asked to reflect on their individual health, participants generally considered themselves to be healthy, with a few exceptions. For those students who did not perceive themselves as "healthy", eating habits and exercising were the most common reasons indicated. Chronic conditions seemed to be a major contributor to participants' self-perceptions of health. Participant 1 had "high blood pressure, and they said, I'm probably like borderline having diabetes." Participants 2 and 4 indicated having asthma and participant 2 also divulged about a heart condition she has been dealing with since birth.

Table 1. Top three things participants identified when they heard the word "health".

Participant	Word	Explanation
1	Body condition	"You be healthy, like make sure your body is in shape."
	Eating good/in shape	"Being healthy, eating good, and being active."
	Doctors/nurses	"They also take care of you."
2	Doctors	"Well because it's usually whenever you get sick, you go to the doctor."
	Medicine	"You get medicine from the doctor."
	Heart problems	"Well I wrote that down because that's usually what I go to the doctor's for. Cause I had open heart surgery, so I have to go do a checkup every year."
3	Doctors	"That's the first thing that comes to mind with health is doctor."
	Sports medicine	"Me personally, I just always wanted to do that as a career."
	Surgeons	"Yeah, like for injuries."
4	Exercise	"You have to um exercise to keep healthy."
	Medicine	"Whenever you go to the doctor, like medicine will help you get better."
	Doctor care	"Like health care in general from like if you're older or younger, wherever you go to the doctor's office."
5	Medicine/shots	
	Care	"like the caring of people"

Participant	Word	Explanation
	Injury	
6	Eating right	“we eat lunch at like 11 something and if you play sports, if you don’t bring your own lunch, you basically go hungry.”
	Taking care of your body	“something that we’re pushed to do by our coaches and stuff, like working out, eating right, things like that”
	Maintaining a healthy lifestyle	“staying away from drugs, alcohol, things like that which a bunch of teachers around here try to help us do. Stay away from things that might hurt you”
7	Doctors/nurses/hospitals	“if you're not healthy, that's when you have to go to the doctors, to the hospital and take medication.”
	Medication	“if you're not healthy, that's when you have to go to the doctors, to the hospital and take medication.”
	Eating healthy/being active	“In order to be healthy, you have to have a good diet and exercise daily”

Regarding the health of their peers, all participants noted the presence of healthy and unhealthy individuals at NCHS:

“I don’t really hear people saying that they get really sick, or like that bad, not people that I hang out with. Like, only thing I know is that little stuff like headache or a little cough, they might think they are getting sick. But other than that, there is never a really big situation.” – Participant 1

Participant 3 and 5 associated health status with the presence or absence of injury. Participants 1, 2, and 4 distinguished unhealthy individuals as students who were coughing or sneezing frequently. Participants 6-7 described unhealthy students as those who “don’t eat right”. All participants agreed that healthy students were athletic to some degree.

“Cause whenever you’re sick it doesn’t necessarily mean, you know, that you have to throw up. Some people like I know some people, their stomach is killing them all day and they have a headache all day and they can’t do nothing about it.” – Participant 2

Furthermore, participants discussed the presence and effects of stress on themselves and classmates. Stress was a common theme among Participants 1-4. Participant 1 reflected on the impact of stress on his health outcomes, “Me, I’m stressed. It’s why, I think a lot of my problems come from. I’m stressed a lot.” Similarly, Participant 2 felt that stress was a major concern for her and her peers at NCHS.

“And the stress that comes with homework and the grades and oh my goodness. I mean, I can’t. Like I’ve looked up some facts about all the stress that homework puts on us and oh my gosh!...I know this one girl, she’s a cheerleader and sometimes, you know, practice lasts until like 6 o’clock and she’s in all honor classes. And she has homework and she does homework the next day at school. She does it during learning center or something and I know like her grades are like slowly slipping.” – Participant 2

Additional health concerns of students at NCHS were teen pregnancy, tobacco products, injuries, nutrition, exercise, vision, lab work, and mental health. Participant 2 was adamant about the fact that several students at NCHS experience chronic headaches, which she believed, "some of them need glasses but they don't have them and they're squinting to look at the board. And also because you get hunger pains and your head starts to hurt."

Personal Health History

The role of family health history was discussed in each of the interviews. Overall, students understood that there was a connection between family health history and their personal health outcomes.

"My mama and daddy both have high blood pressure. They say that some of that kinda runs in my family, but most of it really comes from me. I mean, I used to eat fried food. I stayed with my grandparents and they used, that's all my grandma used to ever cook was fried food. That's all we ever ate, that's what I was raised up. Fried home cooking food." – Participant 1

Barriers to Health Care

Due to the rural environment, we hypothesized that transportation to health services would be a barrier for most families in Kershaw County. However, our interviews were not consistent with this idea. All participants discussed the need to travel outside of their towns for medical care, typically 20-40 minutes by car. Access to transportation was not an issue for the participants, but there were several indications of employment and financial status interfering with the ability to access medical care. For instance, participant 1 worked two jobs and discussed juggling his work responsibilities with taking care of his health and how sometimes he had to call out of work for doctor's appointments. In these situations, students have to determine whether to miss school or work time to see a doctor.

"Yeah because some students come [to school] like sick and they come because you know, they may not have enough gas in the car to go to the doctors and they have to be at school and since it's so far away, you basically have to miss a whole lot of school." – Participant 2.

Related to student employment, there was an indication that parental employment affected students' access to health care at times. Participant 4 was sick during the school day but had to wait to be picked up at school until her mother's work shift ended. On the contrary, participant 1 became independent when it came to doctor's appointments.

"Me and my sister went [to the doctor's appointment]. My mama, she had to work and they [doctor's office] couldn't get me in after she got off work. So she just said to go ahead and go." – Participant 1

An unexpected barrier that was discussed during the interviews was the impact of school level policies regarding student attendance and student health. The attendance policy at NCHS may contribute to the spread of illness in the student population if students are consistently coming to school sick in order to avoid paying credit recovery fees.

"If you miss more than five days a semester, you have to pay ninety-two dollars for each class… you become paranoid that you're going to like miss a day and you don't want to pay the money, so you just have to tough it out." – Participant 2

School Based Health Clinic (SBHC)

From the interviews, we can conclude that the current school nurse's office is underutilized. Participant 1 said, "the only reason I go to her [school nurse], unless I feel like I'm running a fever, and I go to see if I'm running a fever, but that's it". Related to this, participant 2 explained that she did not go to the school nurse because, "I knew I didn't have a fever because I didn't feel hot or anything…So I was like I'm just going to be missing my [school] work if I go over there…Cause I've been to the nurse and if you don't have a fever they'll just send you back [to class]." Participant 6 stated, "I don't know if we have a nurse. I know we have a trainer". Participant 4 kept an inhaler at the school nurse's office. Mainly, students expressed that the school nurse would determine whether or not the students were ill enough to leave school.

Moving forward with the development and implementation of the SBHC, participants provided several suggestions. First, providing a clinic within the school was viewed as a positive aspect of providing services since students are already at school. Participants agreed that this would help reduce the time and costs associated with traveling to 20-40 minutes away to see a doctor. A summary of recruitment strategies is located in Table 2.

Table 2. Summary of suggested recruitment strategies to promote the SBHC:

Strategy	**Resources Needed**	**Target Population**
Print communications – fliers, posters, newsletters, calendar of events/awareness dates	Branding of the health clinic, marketing plan	Students, Staff, Parents
Intercom announcements	Script to promote the health clinic, list of upcoming events to promote	Students, Staff, Sporting spectators
Open house – allow people to come to the new facilities, meet the nurse practitioners, and ask questions	Event promotion, refreshments, staff after hours	Students, Staff, Parents, Community members
Contests/giveaways to promote student use of clinic	Promotional items	Students
School messenger (call-outs)	Approval to use school messenger, script to promote health clinic, where to go for more information	Students, Parents
School meetings – PTOs, school clubs, student assembly, parent meetings	List of PTO and club meeting schedules, information about SBHC, where to go for more information, SBHC contact info, staff after hours, information about operation and services	Students, Staff, Parents,

Services the participants suggested the SBHC offer include: administration of medications, educational events, support groups or individual counseling for specific health conditions, lab work, vaccinations, physical exams, physical therapy, routine check-ups, and health coaching for tobacco cessation, weight loss, etc.

Related to clinic services, there was an overarching theme where students expressed concern for privacy, which is important to consider when gaining the trust and buy-in of students at NCHS.

“I might add something that you should be mindful of. I feel, I feel just respect you know students and their problems, and not always like ‘why are they trying to get out of school’.” – Participant 2

Discussion

Based on the data collected through these qualitative interviews, it is evident that there is a need for a SBHC at NCHS. The most frequently used words during the interviews are displayed in Figure 2:

Figure 2. Most frequently used words among qualitative interviews related to research questions.

Participants described the overall health of NCHS as fairly split between healthy and unhealthy individuals. The most commonly discussed unhealthy conditions of students at NCHS were related to sinus infections, cold/flu, asthma, and injuries. To better assess the presence of illness and chronic conditions, future studies should be conducted to survey a greater sample of students at NCHS. Doing so would help identify which services are most needed so that resources can be allocated to reducing the high prevalence issues.

Although transportation to and from doctors’ appointments was not as prominent of an issue as expected, there was an indication of relief with having a health clinic located in the high school. By centrally locating this health clinic, barriers and burdens related to the logistics of accessing health care may be significantly reduced. Again, investigating these barriers and burdens with a larger sample size will help to identify best practices.

According to the participants, students would benefit from having the same health services received at their general health practitioner's office. Ultimately, students indicated a need for greater services than what's currently provided at the school nurse's office. This can be achieved through staffing the clinic with nurse practitioners who are qualified to provide more medical services like performing physical exams, writing prescriptions, administering medications/vaccinations, and lab work.

Findings also suggest a need for structural changes at the administrative policy level. For instance, the administration may consider re-evaluating the absenteeism policy to support a healthy school environment so that students are not motivated to come to school when ill to avoid paying credit recovery fees.

A limitation to this qualitative study was an underrepresentation of uninsured individuals in the population. Of the students interviewed, none were uninsured. North Central includes the rural towns of Bethune, Cassatt, and Westville. Together, these towns make up 14.6% of all adult Medicaid recipients in Kershaw County and have been categorized as having "high" prevalence of cardiovascular and chronic obstructive pulmonary diseases (COPD).7 Furthermore, we did not have a diverse sample of students from each grade at NCHS due to resource and time constraints. Two of the four interviewees were freshmen in their first semester at NCHS, with little exposure to the school environment, peer population, and utilization of the school nurse's office.

Implications for Future Research

In order to promote a healthy school environment conducive to learning, the school based health clinics and school administrations should work together to promote student wellness. The policies established for the health clinic should be well suited with the administrative policies of the school as well. Expanding this research to include input from parents, school administrators, school staff, and students would be beneficial in providing services at a clinic that will not be underutilized.

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Proposal to School Board:

Examining Factors Influencing Student Health at North Central High School

Background and Significance: On June 1, 2014, LiveWell Kershaw (LWK) received a $2.5 Million dollar contract to implement a School-Based Health Center (SBHC) at North Central High School (NCHS) to improve overall population health. In May of 2014, we were hired as the evaluation team to collect qualitative data that will assist in the decision making for the implementation of the SBHC. The primary audience for the findings will be the Kershaw County School District, School Board, and the LWK leadership team.

Our Research Questions:

1. What factors, positive or negative, influence the overall health of students and their families at NCHS?
2. What principles are needed to support the successful implementation of a SBHC at NCHS?

The funding for the SBHC at NCHS originated from the Department of Health and Human Services' Proviso 33.34 in 2014 (DDHS, 2014). This proviso created a plan to increase value and transparency in the current system, invest in "hot spots" of poor health, reduce per capita costs, and improve health outcomes (DHHS, 2014). NCHS in Kershaw County, SC is located within a Medicaid adult disease cluster "hotspot" for Kershaw County (Institute for Families in Society, 2012). This "hot spots" makes up 14.6% of all adult Medicaid recipients in Kershaw County (USC, 2013). In the remote part of North Central in Kershaw County, some of the students and parents travel up to 50 miles from their home to Camden, SC for care (PACE, 2014). By having a SBHC in the school, the amount of travel time and unnecessary hospital visits could be significantly reduced. SBHC services may include health education, treatment of acute illness, management of chronic illnesses, and mental health services (SBH Alliance, 2014). To date, no standardized SBHC model exists and communities across the country are implementing the clinics with great variability (Keeton et al, 2012). After talking with DHHS, we've learned that the 18 active SBHCs in SC lack any uniformity and none currently have a sustainability plan in place (M. Wise, personal communication, September 22, 2014). The LWK team is charged with creating a model that will benefit and be the most effective in their community and will also guide the development of a state-wide SBHC model.

Preliminary Data:

LWK grew organically from the community and it is imperative that our efforts remain rooted in the community. We believed it was important to obtain the student perspective on health and the integration of a clinic at NCHS. In November 2014, we conducted in-depth interviews with six high school students who were selected by the NCHS principal. From this experience, we learned that the student health is a product of the school system and their family health history. Prior to conducting these interviews, it was impossible to understand the true student perspective of health and students' experiences at NCHS. Findings from these interviews led to the development of a conceptual model which depicts how perceptions of health and school administration influence student health outcomes and potential uptake of SBHC services.

Project Description, Design and Approach

Overview:

This proposal is focused on gaining a thorough understanding of what factors influence the overall health of students and their families at NCHS. Trained staff will conduct individual interviews with students and stakeholders, focus groups with parents/guardians, and narrative analysis of essays (see Table 1). Approval will be obtained by the Kershaw County School Board and the Institutional Review Board at the University of SC. All data from this project will be de-identified to maintain confidentiality.

Design:

The design for this project strives to obtain multiple perspectives regarding factors that influence student health either directly or indirectly. We want this design to be emergent in order to be open to "rich information cases" as they arise (Patton, 2002). We will be using system theory to guide our design and analysis for this evaluation. System theory seeks to understand the entire whole in relation to all of the interdependent parts (Patton, 2001). For example, a description of a sick encounter will be viewed in relation of the student, the family, the school policies, and the community structure. The project design includes follow-up interviews with key individuals as needed, and we will interview additional stakeholders as they arise from the interviews with students and parents. We determined that focus groups would be the best method to obtain feedback from parents due to time and travel restraints. We will be compensating all students and parents for participation ($10 and $20 gift cards, respectively). The interview and focus group guides have been developed by our evaluation team and will be pilot tested with at least two students and community members (Appendix A and B). Once modifications are made, final approval will need to be gained by the Kershaw County School District before proceeding. Informed consents/child assent forms will be collected from all participating students and parents prior to participating in the study.

In addition, we will be sponsoring a writing contest for NCHS students and their families about the impact of health on their lives. Essays will be collected and one winner will be announced at the student and overall community level. An award in the form of a $100 gift card will be presented to the two winners. The essays collected will offer "translucent windows into cultural and social means" that will assist in understand the complexities of the impact of health at the student and family level (Patton, 2001,p.116). This community is extremely "private" and "keeps to themselves" (PACE, 2014). By creating different avenues to capture information (essays, interviews, and focus groups) and reinforcing confidentiality, we hope to overcome this barrier.

We will conduct at least 16 student interviews at NCHS and at least 2 focus groups of parents (ranging from 5-10 participants). Interviews and focus groups will take place at NCHS on multiple days and times within a three month period to accommodate different schedules. Based on our resources and findings, we hope to continue our qualitative work until we reach saturation of themes. Our goal is to complete all field work between January-May while school is in session and present findings to the School Board in August, 2015 (See Table 2 for Timeline).

Table 1: Evaluation Design

Key Informants	Method	Sampling Strategy
Students at NCHS (Grades 9-12)	Key Informant Interviews Essays about impact on health	Simple Random Selection with criterion sampling (gender, grade, race, Free/Reduced Lunch, quadrants of county) Convenience sampling
School administration and teachers (school nurse, principal, attendance secretary, coach, superintendent, school board member, teacher, and others identified)	Key Informant Interviews with follow-up interviews as needed	Purposeful selection – "info rich" cases
Parents of students at NCHS	Focus groups	Maximum variation sampling (gender, grade of child, race, Free/Reduced lunch, quadrants of county)
Additional Stakeholders	Key informant interviews	Emergent sampling
Family and Community Members	Essays about impact on health	Convenience sampling

Qualitative Data Analysis and Validity:

Given the proposed research questions, the analysis strategy will be taken from a holistic perspective to understand how the interdependencies and dynamics between the student, and stakeholders take place. The criteria we will use to judge the quality of our evaluation findings will be: trustworthiness, diversity of perspectives, and utility (Patton, 2001). The interviews, focus groups and the essays will not be separated and looked at individually but we will be looking at the "gestalt" to understand health as a complete picture (Patton, 2001). All of the interviews and focus groups will be transcribed verbatim and imported to NVivo 10 for analysis. We will be using open coding for this project in an effort to capture new insights and creating emic categories. The analysis will take place throughout the eight months, and detailed memos will be kept by all evaluation team members.

We have identified researcher bias and reactivity as threats to validity with this project (Maxwell, 2013). Since we, the evaluation team, are funded to do this work, we could easily become biased in supporting the clinic and ignoring negative cases. In addition, we could easily influence what information is gathered and collected by asking leading questions or ignoring key information. We will do our best to look for information that challenges any conclusions and analyze discrepant data and negative cases. We will conduct intensive interviews with stakeholders and use verbatim transcripts for all interviews and focus groups. If needed, we will follow-up with individuals to seek additional information if gaps are identified. To increase the credibility of the findings, we will be triangulating methods, interviewers (group of 3), and analysts (group of 4).We will host regular team meetings and will be documenting the entire process about decisions and changes made.

Some of the anticipated products and outcomes will include: Refined conceptual model, evaluation report, powerpoint presentations tailored for various audiences, and a website. The potential impact of this project is that information will be used to guide decision making that will lead to enhanced population health.

Table 2: Timeline

Table 1 Project Milestones and Timeline for 2015	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
Approval from Kershaw County School Board/ IRB exemption obtained								
Develop draft interview guides and develop random selection criteria, randomly select students and send off consent forms								
In-depth interviews with students								
Focus Groups with Parents								
Follow-up with select parents, in-depth interviews								
In-depth interviews with school administration								
Writing competition on the impact of health								
Analysis of data and memos throughout process								
Presentations of findings to School Board and LWK Leadership Team								

Dissemination:

The dissemination of the results of this qualitative study will first be shared with the LWK leadership team. A presentation and report will then be made to the Kershaw County School Board and the School Superintendent, Dr. Frank Morgan and NCHS principal, Mr. David Branham. After approval from the Kershaw County School District, the methodology and findings will be shared USC Graduate Student Day, the SC Rural Health Association Conference and DHHS.

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Appendix A: Student Interview Guide

Intro to Student: Hi, my name is _____ and I'm collecting information from students to be used to plan for a new project at North Central High School. Your name was randomly selected from the school database and I'm here today to get your perspective on student health. For the next 45 minutes to one hour, I would like to get your personal input on your health experiences, doctor visits and what you think we could do to start a health clinic at NCHS. There are no right or wrong answers; I am truly interested in your perspective as a student and hope to use your feedback to help with the planning. Your name will not be used in any of our reports or discussions and everything you say today will be considered confidential. Do you have any questions, before we begin?

- How would you describe North Central High School to someone like me who is not from here?
  - What is your town like?
  - How long have you lived here?
  - What are things you like to do for fun?
  - What grade are you in?
  - What types of things are you involved in at school?

- Describe your family to me.
  - Who do you live with?
  - Where do you live?
  - How close are you to your family members?
  - Who do you consider having the biggest influence on your life?

- What is the 1st word or image that comes to mind when I say the word "HEALTH"?
  - What does health mean to you?

- Tell me about the last time you were sick during the school year. This could have been this year or last school year.
  - Who took you?
  - How long were you out of school?
  - What were you sick with?
  - Did you take any medicine?
  - How often do you visit the school nurse's office?
  - What do students go to the school nurses' office for?
  - How often do you go to the doctor's office or hospital?

- In your opinion, what if any, barriers do you have related going to the doctor when you are sick? This could be related to your family or school rules or anything else.
  - Describe any experiences that you know about classmates or your family members encountering these barriers.

- What are some areas that seem to be working out really well related to your health right now? This could be physically, mentally, etc.
  Describe to me what being healthy means to you.

- What are some areas, that don't seem to be going too well for you right now related to your health?
  - How about your family? Would you consider them to be healthy?
  - What types of health issues do you or your family members have?
  - Describe to me what unhealthy means to you.

- What or who would you say is the biggest influence on your health?
  - What role do you play in regards to your health? Your family? Your school? Your community?

- On a scale of 1-10, how much control do you have over your health?

- What would need to be in place for you to feel welcome at a doctor's office? What would the ideal doctor visit look like for you?

- What would need to be in place for you to consider using a health clinic at the school? Or would you not want to use it?
  - What types of things do you think you and your classmates would go to the clinic for?
  - What student needs do you think a health clinic at school may help with?
  - What do you think is the best way to advertise to students for the new health clinic?
  - How is the best way to spread the information about the new health clinic to students?

Information we will obtain from Guidance Counselor of School on each interviewee:

Grade level, insurance, race/ethnicity, free/reduced lunch

Appendix B: Parent Focus Group Moderator Guide

Intro to Focus Group: Hi, my name is _____ and I'm collecting information from parents of students at North Central High School to understand more about the role you play with your child's health. The School District is considering opening a clinic inside NCHS and we want to take time to get your perspective. For the next 45 minutes to one hour, I would like to get your personal input on your health experiences, doctor visits and what you think we could do to start a health clinic at NCHS. There are no right or wrong answers; I am truly interested in your perspective as a parent and hope to use your feedback to help with the planning of this clinic. Your name will not be used in any of our reports or discussions and everything you say today will be considered confidential. Do you have any questions, before we begin?

- How would you describe this part of Kershaw County to someone like me who is not from here?
  - What is your town like?
  - How long have you lived here?

- Describe your family to me and your daily life. What is your role in the household?
  - Who do you live with?
  - How many children do you have going to North Central High School or Middle School? Elementary School?
  - Where do you work and how far away is it from your home?
  - What other responsibilities do you handle for your family?

- Please share with me what you do when one of your children are sick. If it helps, think back to the last time one of them was sick and share what you did, who you saw, and how long it took for your child to get well.
  - Did you miss any work to care for your child?
  - What did you do to help your child get well again?
    - Where did you take your child for health care? Doctor? Hospital? Distance?
  - How often does your child or children get sick?
  - What barriers, if any, do you encounter when your child is sick?
    - Can you elaborate on your current access to: Transportation, Finances, Insurance

- In your opinion, what if any, barriers do you face when you or your family need medical care? This could be related to your own family, school policies or anything else.
  - Describe any experiences you would be willing to share about encountering some of these specific barriers.
  - What things could be put in place that would make going to the doctor easier for you and your family?
  - What types of services would you or your children need?

- What would need to be in place for you to feel comfortable sending your child to the clinic at the school? What would the ideal doctor visit look like for your child?
  - What qualities do you look for in a good doctor or nurse practitioner relationship?

- What would need to be in place for you to consider allowing your child to use a clinic at the school? Or would you not want to use it? Or would you want your whole family to use it?
  - What types of things do you think your child would go to the clinic for?
  - What student needs do you think a health clinic at school may help with?
  - What do you think is the best way to advertise for the new health clinic to parents?
  - How is the best way to spread the information about the new health clinic to parents?

Quarter Two Activities & Metrics

LiveWell Kershaw Timeline
September – December 2014

September 2	Job Description for Community Health Worker developed, clinical workgroup met regarding action plan
September 2-3	Evaluation team develops first quarterly report
September 4	Advisory group meeting at Health Resource Center to update on project. Decision made to do large presentation at DHHS.
September 9	First 3 video interviews for DHHS presentation in North Central area (Grant, Tramaine, Kelly)
September 10	Meeting at HRC to discuss how mental health fits into phase I of the project (Melissa, Susan, Whitney, Kelly)
September 11	Last 2 video interviews for DHHS presentation in North Central area (Holly, Susan W, Grant)
September 15	DHHS presentation run-through at CMC (Susan W, Susan G, Kelly W, Kelly K, Holly, Lillian, Whitney – via call)
September 17	Year 1 Quarter 1 Evaluation completed and printed for meeting
September 17	DHHS presentation run-thru at Health Resource Center (Holly, Whitney, Joseph, Susan W, Kelly W, Kelly K, Lillian)
September 17	DHHS presentation review for lobbyists (Susan B, Robbie, Holly, Whitney, Joseph, Susan W, Kelly K, Lillian).
September 17	Lillian, Joseph, and Whitney meet to discuss Whitney's role.
September 22	DHHS presentation
September 23	CHW position posted on KershawHealth Website
October 1	Evaluation meeting at CMC (Susan W, Kelly W, Kelly K, Holly, Ibrahim, Tramaine)
October 1	Conference call with Little River Medical Center (Kelly W, Kelly K, Susan G)
October 6	Meeting with Joseph, Susan W, Mary Anne Byrd, and Frank Morgan to update

	about LWK project
October 6	Melissa and Whitney meet with NCHS and NCMS principals and school nurse
October 6	Melissa and Whitney meet with Mr. Jackson (Bethune & Mt. Pisgah principal)
October 8	Meeting with Whitney and Holly on Community Engagement team progress
October 8	Meeting with Kelly W and Holly on CHW team progress
October 8	Melissa and Whitney meet with Midway principal and nurse (same nurse as Bethune)
October 8	Melissa and Whitney meet with Kevin Rhodes to identify School District perspectives (Field placements/Social Work)
October 9	Meeting with Debbie (KershawHealth finance), Mike Bunch, and Whitney about invoicing DHHS
October 9	Melissa and Whitney meet with Baron DeKalb school nurse
October 9	Flu shot event at North Central Middle School hosted by Walgreens and CMC. Handed out outreach surveys. Present: Susan W, Kelly K, Ibrahim, Whitney, Tramaine, Joseph.
October 10	Melissa and Whitney meet with Baron DeKalb school principal
October 23	Joseph meets with Tony Keck
October 11	Melissa recruits students for Check to Connect intervention for spring semester
October 15	Advisory Board meeting – decided to name these as “team meetings”. Decided name for the NCI project will remain as just LiveWell Kershaw.
October 16	Whitney and Holly meet with Mandy and Ally at DHHS to get feedback on CHW, SBHC, and quarterly reports and deliverables
October 20	Holly and Kelly K meet with Nick to discuss NVIVO usage; server is no longer an option
October 27	CHW job description updated and re-posted
October 28	LWK becomes a Charity Tracker organization
October 29	Melissa attends teacher meeting on how to handle student needs (12 teachers, 1 counselor, 1 Asst. Principal)

October 30	Holly and Kelly K. conduct 2 student interviews each at NCHS
October 30	Tramaine's last day at PACE
October 31	Round 1 of CHW interviews completed
October 31	Student in Holly's class conducts 2 student interviews at NCHS
October 31	Melissa attends school PBIS meeting (5 teachers, 1 counselor)
October 31	Melissa meets with school personnel about USC students and Check to Connect Intervention for spring semester
November 3	Kelly W meets with Ally and Amanda at DHHS to discuss CHW piece
November 6	Cheraw CHW meeting with Kelly W, Todd Shifflet, Sharon (paramedic) Susan G, and a doctor
November 10	Tony Keck officially resigns as SCDHHS Director. Appoints Christian Soura as new Medicaid Director
November 12	Round 2 of CHW interviews
November 13	New LWK Project Manager identified (Cheryl Stover) and all 3 CHW positions accepted
November 19	NCI project team meeting (Cheryl, Holly, Susan, Kelly W., Whitney, Joseph, Lillian)
November 20	Monthly DHHS meeting (Whitney, Holly, Amanda Williams, Allie Gayheart, Maudra Brown, Megan Weis)
November 24	Kelly K. completes last student interview for quarter 2 report at North Central High School
December 1	3 New CHWs hired
December 1	New project manager, Cheryl starts

Key Metrics for Quarter 2

- **Interviews (21)**
  - With community members utilizing Access Kershaw – 5
  - With North Central High School students regarding student health needs – 7
  - With school personnel in 6 schools regarding student mental health – 8
  - With LiveWell Kershaw team members – 1

- **Meetings (74)**
  - Internal meetings – 23
  - With community members – 34
  - DHHS meetings (meetings with at least 1 DHHS person) – 5
  - Other significant project-related meetings/calls – 12

- **Events (1)**
  - Flu shot event:
    - Number of people vaccinated – 38
    - Number of surveys completed – 37

- **Hiring Process**
  - New hires – 4
    - Project Manager – 1
    - Community Health Workers (CHWs) – 3
  - CHW interviews:
    - Number of applicants – 25
    - Number of applicants who went through to Round 1 of interviews – 12
    - Number of applicants made it to Round 2 of interviews – 5

- **Additional outreach**
  - Number of community members reached – 576
  - Number of calls offering assistance with community events – 3

Economic Evaluation: Progress Report

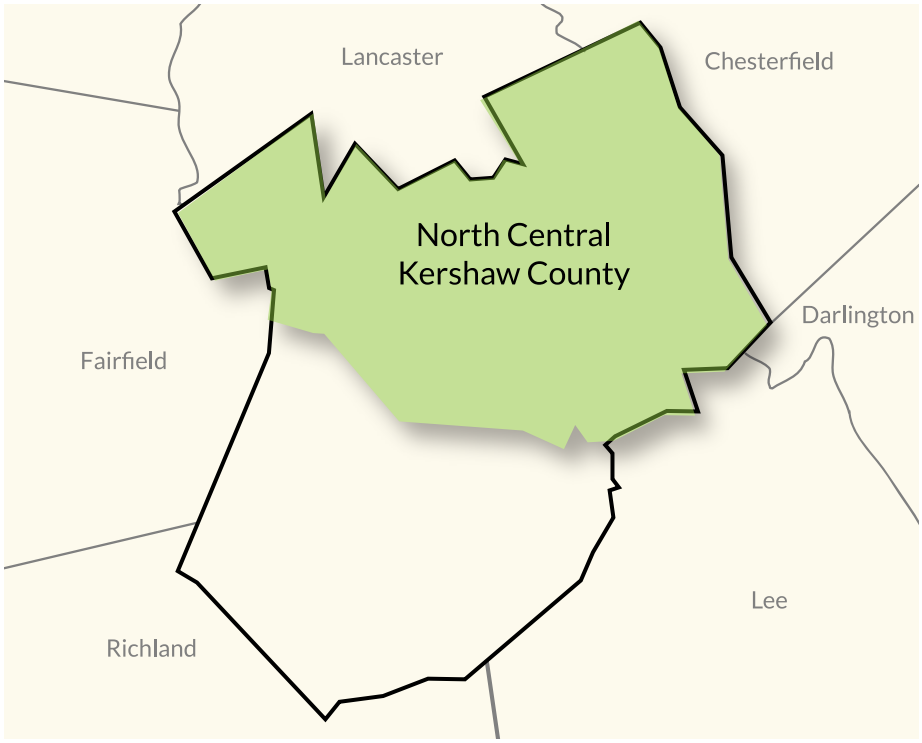
1. STATUS OF ACTIVITIES DURING THE REPORTING PERIOD

1.1. Determination of the Geographic Area of Interest and Development of Maps

While the LiveWell Kershaw Project (LWK) is a county-wide collective effort, the North Central Initiative (NCI) is aimed at improving the population health in the northern part of Kershaw County.

Specifying the geographic boundaries of the area of interest the LWK-NCI is crucial for economic evaluation purposes. Therefore, the following area map was developed in reference to the area called "North Central Kershaw" through discussions with stakeholders, clinical team, community members, and evaluation team:

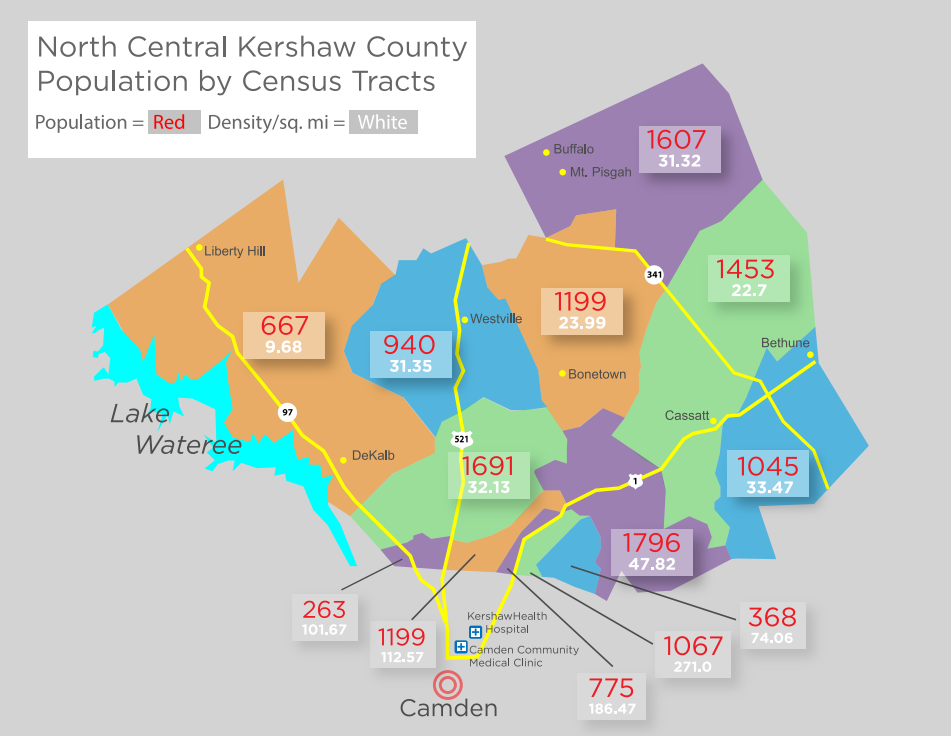
Map 1- The Area of Interest



1.2. Estimation of the Population of the Area of Interest and Development of Maps

As well as the geographic specification, the determination of the size, combination, and density of the population of the area is crucial in measuring and assessing the economic impact of interventions on area communities. Since the North Central area is a specific geographic area, the calculation of the population was done by patching the census tract data onto area maps. By doing so, the area of interest **population was estimated as 14,070** as shown in below map along with population density of census tracts:

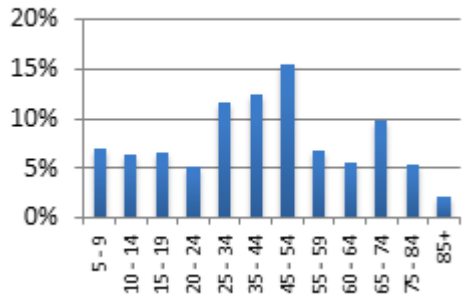
Map 2- Area of Interest Population and Density



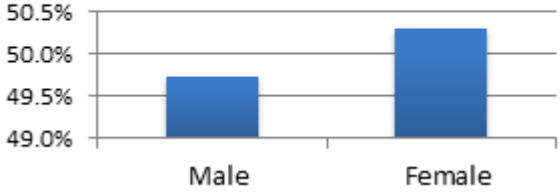
1.3. Demographics of the Area of Interest (US Census, ACS 2010, Zip Codes).

The LWK-NCI area population mostly consists of the age groups of 25-59 and 65-74; and 65% white, 31% black or African American, 3% Hispanic or Latino, and around 1% other race-ethnicity residents as shown in below charts:

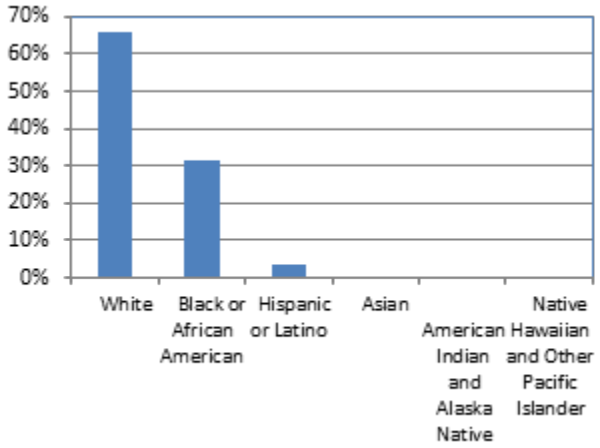
Graph 1 - Age Distribution of the Population Age Frequency (Percentage)



Graph 2 - Gender Distribution of Area Population



Graph 3 - Race Distribution of Area Population



1.4. Economic Profile of the Area

As shown in Table 1 that lists select 2008-2012 statistics, North Central Kershaw has a higher poverty rate than Kershaw County and the state of South Carolina in terms of the measures of population below poverty, households below poverty, population 200% below poverty, and population 185% below poverty. The area has similar unemployment rates with the county and state. The area shows consistent lower income patterns in terms of per capita income, average household income, and median household income relative to the county and state. The rate of households with public assistance income is more than two times higher than the county and state rates. About 7% of the households in the area had no vehicle according to 2010 figures. The average commute time in the area is around 31 minutes one-way and is 4 minutes higher than the county average of 27 minutes.

Table 1- Economic Profile of North Central Kershaw, Kershaw County, and State of South Carolina

Indicator	North Central Area*	County	State
Population Below the Poverty Level, Percent, ACS 2008-12	20.22	16.2	17.6
Households Living Below the Poverty Level, % , ACS 2008-12	18.85	16	16.5
Population Below 200% Poverty Level, Percent by Tract, ACS 2008-12	50.4	40.4	39
Population Below 185% Poverty Level, Percent by Tract, ACS 2008-12	46.63	38.1	36.1
Unemployed Workers, ACS 2008-12	11.1	11.7	11.1
Unemployed Families Receiving SNAP, ACS 2008-12	15.12	15.9	NA
Unemployment, BLS 2014 - October	NA	6.1	6.3
Per Capita Income, ACS 2008-12	$17,387	$22,351	$23,906
Average Household Income, ACS 2008-12	$43,517	$57,183	$60,416
Median Household Income, ACS 2008-12	$36,632	$44,068	$43,107
Households with Public Assistance Income, Percent of Total Households, ACS 2007-11	4.12	1.5	1.7
Households with No Vehicle, Percent by Block Group, EPA SLD 2010	7.06	NA	NA
Average Work Commute Time (Minutes), Average by County, ACS 2008-12	30.75	27	NA

* Source: Community Commons. Most of the tract data are the means of Census tract 9701, 9702, 9703, and 9706.02. NA: data are not available for the same variable and period from the same source.

1.5. Access to Care and Insurance Coverage of the Area Population

Table 2 lists select (2008-2012, mostly) access to care and insurance coverage indicators of the area population in comparison with county and state figures where available for the same indicator. The area shows lower uninsured population rates than the county and state for 0 - 17 and 18 - 64 age groups; overall population; and, worker population. The uninsured rate for the age of 65+ is slightly lower than that of the county and state rates. However, the area falls behind county and state figures in terms of the number of primary care physicians, access to primary care per 100,000 population,

access to general practice physicians per 100,000 population, and access to family practice physicians per 100,000 population, which all were 0 (zero) in 2012.

Table 2- Access to Care and Insurance Coverage

Indicator	North Central Area*	County	State
Uninsured Population, Age 0-17, Percentage, ACS 2008-12	3.95	8.1	9.6
Uninsured Population, Age 18-64, Percentage, ACS 2008-12	19.65	23	23.3
Uninsured Unemployed Workers, Percentage, ACS 2008-12	13.77	17.5	16.5
Uninsured Population, Percentage, ACS 2008-12	12.2	16.2	16.9
Uninsured Full-Time Workers, %, ACS 2008-12	9.82	14.2	14.6
Uninsured Population % Age 65+, ACS 2008-12	0	0.5	0.05
Number of Primary Care Physicians, CMS 2012	0	10	65.8**
Access to Family Practice Physicians, Rate per 100,000 Pop. by County, AHRF 2013	NA	19.3	NA
No Consistent Source of Primary Care, BRFSS 2011-12	NA	18.4	22.2
Annual Visit to Primary Care Physician, Percent of Medicare Enrollees by County, DA 2012	NA	85.2	84.3
Access to Primary Care Providers per 100,000 population (Including Nurses), CMS 2012	0	68.1	NA
Access to General Practice Physicians per 100,000 population, CMS 2012	0	1.6	NA
Access to Family Practice Physicians per 100,000 population, CMS 2012	0	21.1	NA
Physician Use Delayed by Cost, Percent of Adults Age 18+, BRFSS 2006-12	NA	14.7	16.5

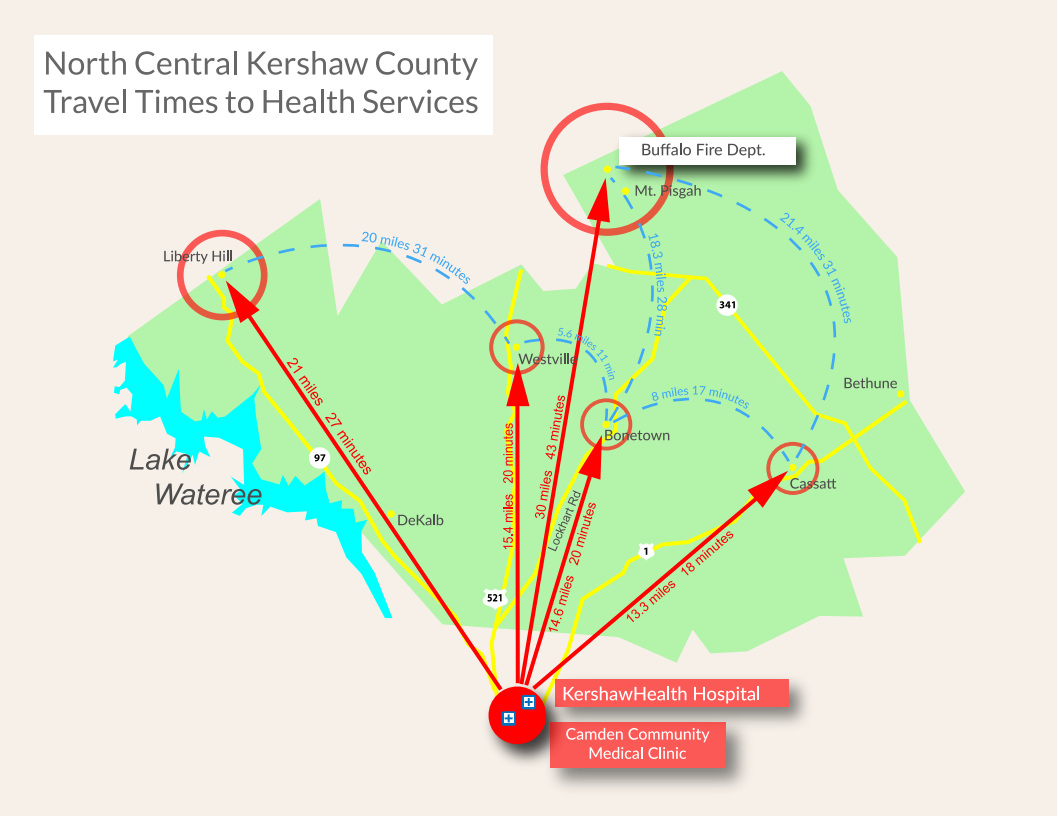
* Source: Community Commons. Most of the tract data are the means of Census tracts 9701, 9702, 9703, and 9706.02.
** 2010, HRSA.

1.6. Lay out of Interventions and Locations

1.6.1. Mobile Community Health Worker And Nurse Practitioner Units

a. The Intervention
The LWK-NCI interventions include establishing mobile community health worker (CHW) and nurse practitioner (NP) stations at **five locations: Buffalo Fire Department, Westville, Liberty Hill, Cassatt, and Bonetown.** The CHW's and NP's will be utilizing community assets such as trailers, church rooms, school rooms, and a van for blood work and similar services and screenings. The CHW's and NP's will be rotating throughout a week by being present at certain locations on certain days.

Map 3- CHW-NP Locations and Distances to Camden



One of the main justifications of the mobile CHW and NP units is the travel cost that the area population incurs. Travel cost prevents access of the lower-income area population to primary care and limits the integration of the clinical care and population health in an underserved rural area.

Considering the **mean 48 minutes and maximum 98.8 minutes of round-trip travel time** that was spent for obtaining care from the Community Medical Clinic of Kershaw (CMC) by the area population in the past two years, travel costs are confirmed to be a real economic barrier through a distance decay analysis (see section 1.9). The CHW and NP operations will be managed and executed by the CMC teams in a “spoke and hub” model fashion.

1.6.2. School-Based Health Centers

a. The Intervention
In addition to mobile CHW and NP operations, school based health centers (SBHC) will be established in some of the area schools. Which schools will have a SBHC and the scope of the intervention will be determined later.

b. Area Schools Student Population
The area schools have the following student population totaling up to 1,614 students:

Table 3- North Central Area Schools and Student Populations

Schools	Number of Students (2013)
Bethune Elementary	93
Baron Dekalb Elementary	203
Midway Elementary	394
Mt Pisgah Elementary	108
North Central Middle	346
North Central High	470
TOTAL	1614

Source: Kershaw County School District

1.7. Development of Pre and Post Economic Evaluation Indicators

The following economic and health indicators working table is developed for economic evaluation purposes:

Table 4- Economic Evaluation Effect and Impact Indicators Working Sheet

NCI Area Indicators	**Baseline Values (Fall 2014)**	**Data Year and Source**	**Post-Measures (Fall 2015 and subse-quent periods)**
SUGGESTED CMC AND KERSHAW HEALTH INDICATORS		Kershaw Health	
Reduced ER visit and ER readmission		Kershaw Health	
Reduced UTI ER visits	0		
Increased medical home placement			
Reduced missed visits (adherence)			
Reduced delay for care			
Reduced delay in diagnosis/treatment relations to blood work			
Reduced travel cost		Kershaw Health, CMC	
Increased number of folks using services (i.e. healthy checkups)			
Increased positive indicators for clinical health markers (chronic disease management)			
Nr of Children (age of 15 or below) Served by the Clinic (2 years average)	0		
HOP INDICATORS			
% successful contact with target population (successful/ successful+unseccesful)	0		
% established in medical home	0		

NCI Area Indicators	Baseline Values (Fall 2014)	Data Year and Source	Post-Measures (Fall 2015 and subsequent periods)
% of target population in Social Determinants Screening	0		
% of target population Health affordability Programs Eligibility Screening	0		
% of target population with a Patient Care Plan	0		
% Patients that have had at least one primary care encounter that includes preventive care, screenings, and interventions	0		
HOP Cost			
ED Utilization Rate			
Inpatient Utilization Rate			
Total charges per Patient			
HOP Health Metrics			
Prevalance of Targeted condition			
A1C			
Re-admissions			
Case-mix index			
Shifts in point of care			
Blood Pressure Readings			
Medication utilization/compliance			
ACCESS COVERAGE UTILIZATION			
Number of the uninsured	1,638	2008-12, Community Commons	
Delay for care (physical, mental, dental,..)			
Total Number of people served	0		
Camden CMC African American Utilization (2 years)	39.08%		
Camden CMC Hispanic Utilization Rate (2 years)	13.23%		
Camden CMC Appointment Wait Time	7-10 days		
Number of Healthy Check-ups	0		
COST SAVINGS			
Total Sick Leave Taken (past 2 years, work absenteeism)			
ED visits (general) 3yr AVG		Kershaw Health	
ED visits asthma related 3yr AVG		Kershaw Health	
ED visits diabetes mellitus related 3yr AVG		Kershaw Health	
ED visits sinusitis related 3yr AVG		Kershaw Health	
Preventable Hospital Stays		Kershaw Health	
Camden CMC Round Trip Driving Miles 1 Visit (2 years)	22,334.79	CMC	
Camden CMC Average round Trip Miles Per Visit (2-year average)	34.84	CMC	
Camden CMC Total Number of Missed Appointments (2 years)	98.00	CMC	

NCI Area Indicators	Baseline Values (Fall 2014)	Data Year and Source	Post-Measures (Fall 2015 and subse-quent periods)
Medicare Expenditures			
Medicaid Expenditures			
HEALTH STATUS			
County Health Ranking RWJ (Health Factors, 2014)	16		
County Health Ranking RWJ (Health Outcomes, 2014)	10		
EDUCATION AND ACADEMICS			
NC High School Drop-out Rate 2013	1.3		
Grades (all schools NCI)			
Average Retention Rates of Area Schools	2.133		
Average Attendance Rate of Area Schools	95.63		
NC High 4-yr Graduation Rate 2013	84.3		
NC High 5-yr Graduation Rate 2013	85.8		
Area Schools Expulsion-Suspension Rate			
NC High End of Course Tests 70+ Grade Rate 2013	74.8		
NC Middle End of Course Tests 70+ Grade Rate 2013	100		
POVERTY/DISPARITIES/EQUITY			
Number of people served in poverty	0		
Number of African Americans served	0		
Number of people served with no transportation	0		
Number of people served with no insurance	0		
Number of Hispanics/Latinos served	0		

Data Sources: Kershaw School District, RWJ Foundation, US Census.

1.8. Data Collection Activities

1.8.1. General Administrative Data

Administratively available (secondary) demographic, economic, and health data pertaining to the area population were collected from various sources that include but are not limited to US Census, Community Commons, BLS, CMS, HRSA.

1.8.2. Data from Community Medical Clinic of Kershaw

Community Medical Clinic of Kershaw (CMC) is located at 110 East Dekalb Street, Camden, SC, 29020. CMC provides free medical services to the Kershaw County population 138% below the poverty line. The data that CMC collects are highly crucial for analyzing the needs and travel behavior of the communities because of the free nature of the services to the county population 138% below the poverty level. The CMC started collecting data in a systematic way in August 2012. A two-year past visitor data set that contains diagnosis, demographics and location information was obtained from the CMC. The CMC data set contains over 850 unique visitors in 2 years between 2012 and 2014. A data use agreement was signed with CMC.

1.8.3. Data from Kershaw Health

KershawHealth (KH) is a major area hospital that is located at 1315 Roberts Street, Camden, SC 29020. One of the expected outcomes of the interventions of LWK-NCI is reduction in the emergency room (ER) visits from the area of interest population, as well as reduction in travel costs and lost work days. KH provided 3-year past physical address specifiable all visitor data with check in/check out time, demographics, insurance and payment status. A business agreement was signed with KH for data use.

1.8.4. Sick Leave Data from the Area Employers

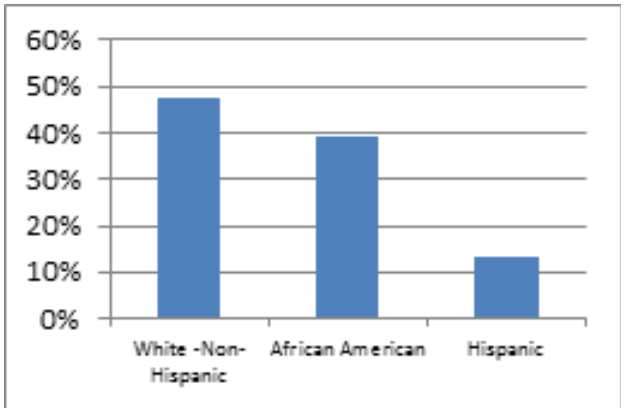
One of the objectives of the interventions of LWK is reduction in lost work days. Therefore collecting sick leave data from the area employers is crucial. Kershaw County School District, Suominen Nonwovens, Prestage Farms, and Cal-Maine Foods were identified as the major area employers based on Kershaw County Chamber of Commerce listings. A data letter was sent to these employers for the 2-year sick leave data.

1.9. CMC Data Travel Cost and Market Area Analysis

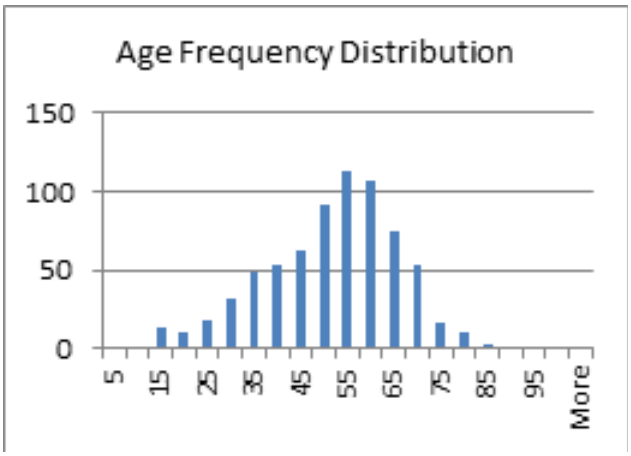
Community Medical Clinic of Kershaw (CMC) is in charge of managing the CHW and NP operations. CMC visitor profile and visitor behavioral patterns can shed light on achieving the project objectives such as increase of access to primary care, maximization of payer source, and measuring the economic impact through cost-savings and value generation to the communities live in the area.

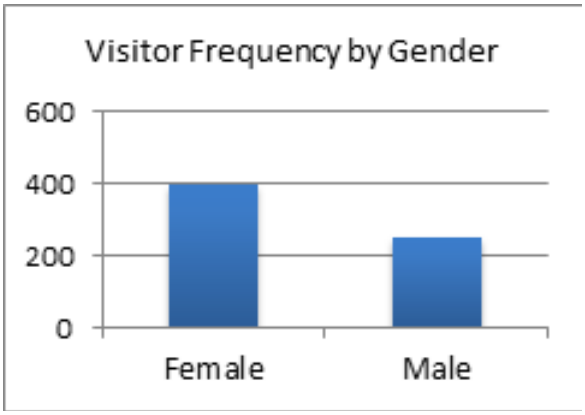
The CMC had 855 unique visitors in the past two years between Aug 2012 and Sept 2014. The visitor race, age, gender, and location distributions are as follows:

Graph 4- Race Distribution of CMC Visitors (Aug 2012-Sept 2014)



Graph 5 - Age Distribution of CMC Visitors (Aug 2012-Sept 2014)



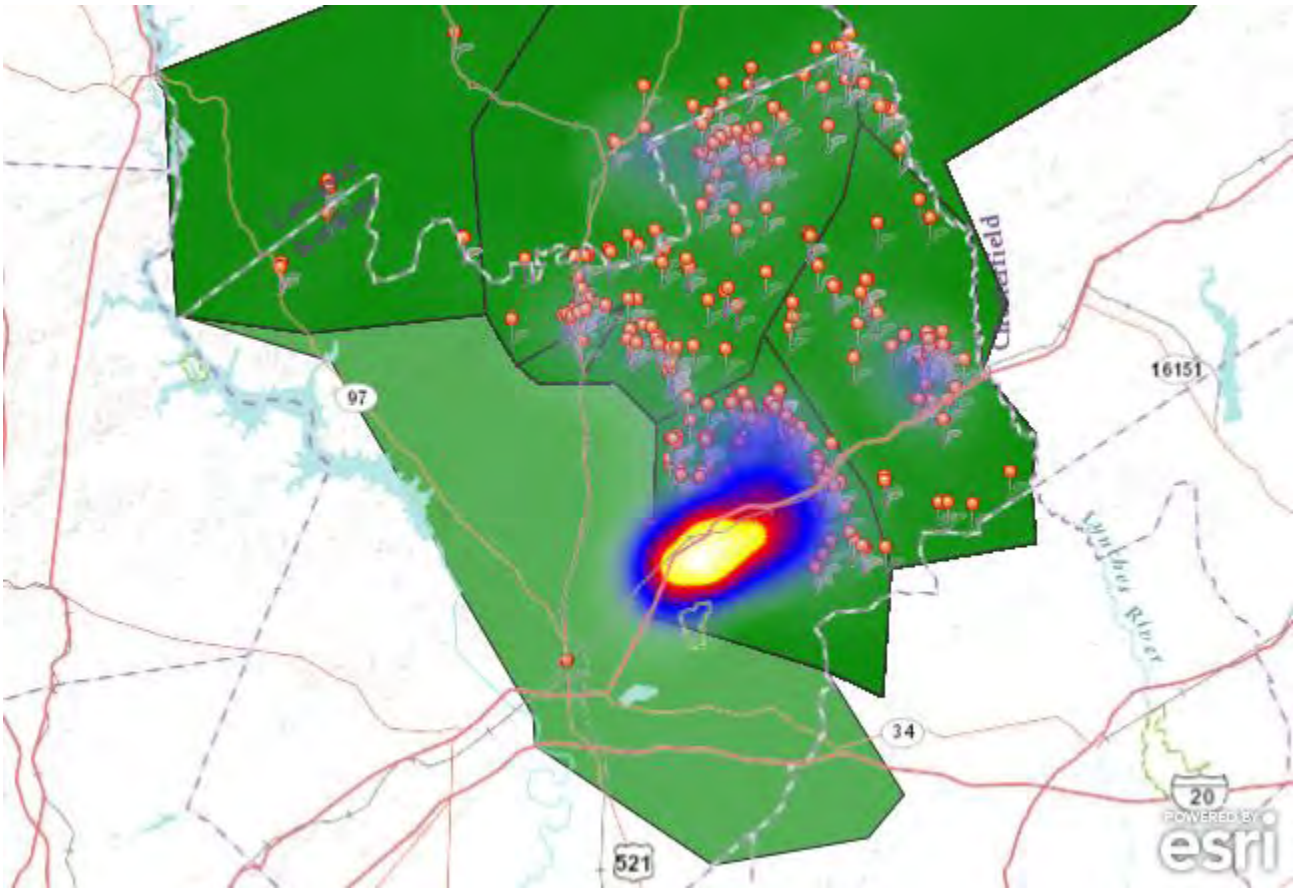


Graph 6 - Gender Distribution of CMC Visitors (Aug 2012-Sept 2014)

Graph 7 - Total Travel Time Spent by CMC Visitors (Aug 2012-Sept 2014)

The heat map below also shows the location-distribution of visitors of CMC:

Map 4- Location-distribution of the CMC Visitors (2012-2014)



As shown in the above heat map, most of the visitors are from Cassatt area. Westville, Bonetown, Bethune, and Mt. Pisgah are also other areas that visitors traveled from to Camden intensely.

Table 5- Estimated Total Travel Cost Incurred by CMC Visitors
(2 years, 3-Visit per Visitor, at IRS's $.59 per mile rate)

ZipCode	2 yr Freq.	Mean R/T Travel Miles	Total Miles Driven	Total R/T Travel Cost
29009 Bethune	103	33.5	10,351.50	$6,107.39
29020 Camden	8	8.75	210.00	$123.90
29032 Cassatt	505	16.41	24,861.15	$14,668.08
29058 Heath Springs	10	39.55	1,186.50	$700.04
29067 Kershaw	175	36.06	18,931.50	$11,169.59
29175 Westville	33	25.74	2,548.26	$1,503.47
29718 Jefferson	21	36.7	2,312.10	$1,364.14
TOTAL	**855**		**60,401.01**	**$35,636.60**
At 2014 Prices				**$36,848.24**

Assuming 3 visits per visitor per year (the available CMC data set does not allow to calculate average visit per person; however, the CMC director commented that on average visitors would pay 4 visits; here a more conservative 3-visit per year is assumed), the CMC visitors drove total of 60,401 miles and incurred total travel cost of $36,848 at 2014 prices in two years. **One of the objectives of the LWK-NCI is to reduce the travel cost for the individuals who have to travel to obtain care by having mobile units in the area.**

Assuming all full time employed visitors and **full work day loss** for each visit to obtain care, the value of the lost output for the employers (the opportunity cost of work time) would be around **$359,100** (855 visitors x 3 visits x $17.50/hr average wage rate for the area (Bureau of Labor Statistics) x 8 hours) for the CMC visitors in 2 years.

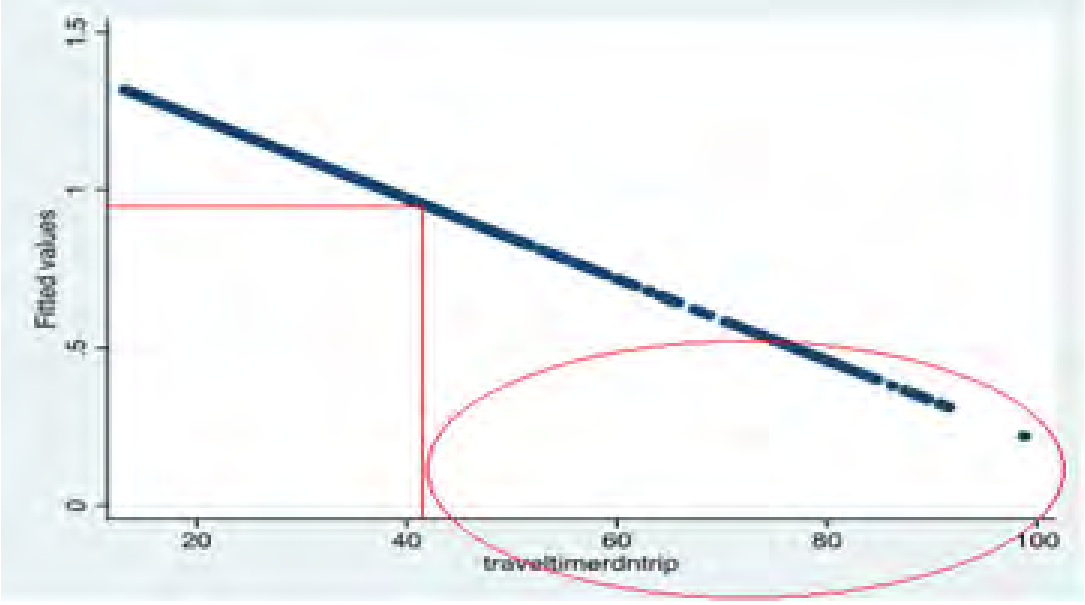
If the travel cost and lost output calculations are extended to other health care facilities in the area, such as Kershaw Health, Mental Health Clinic, and Alpha Center, travel and lost output costs would be higher. This extension will be worked on in the next quarter.

Distance Decay Estimation (Exponential)

Travel costs are barriers to obtain health care, particularly, for economically disadvantaged communities as in our area of interest. Distance decay estimation on the CMC data can explain how and to what extent the interventions will increase the access and encounter as follows:

Ln (FREQUENCY OF VISITS) =1.48 -.013 (TRAVELTIME)
(N =265, Robust std. errors; significant estimation and coefficients at 5% significance level at least).

According to the above exponential distance decay estimation based on the CMC data, **a 1-minute decrease in travel time was found to lead to a 1.3% increase in the frequency of visits** (interaction). This finding is depicted in below graph:



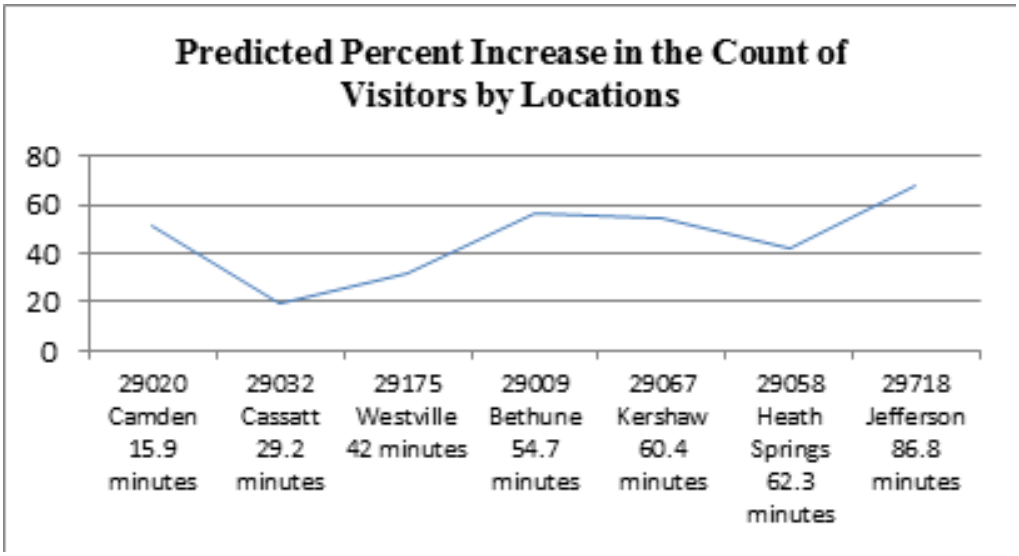
Graph 8 - Estimated Distance Decay (Exponential)

According to the above exponential distance decay estimation results, the predicted increase in the count frequency of CMC visitors due to reduced travel time would be around 40% as follows:

Table 6- Predicted Increases in Visitors Due to Reduced Round-Trip Travel Time

Location	Mean Nr. Visitors	Mean One-Way Travel Time	Mean R/T Travel Time	Predicted Increase Based on Distance Decay Estimation	Predicted Increase in the Nr. Of Visitors Based on Distance Decay Estimation
29009 Bethune	103	27.4	54.7	51	52.53
29020 Camden	8	8	15.9	19	1.52
29032 Cassatt	505	14.6	29.2	32	161.6
29058 Heath Springs	10	31.1	62.3	56	5.6
29067 Kershaw	175	30.2	60.4	54	94.5
29175 Westville	33	21	42	42	13.86
29718 Jefferson	21	43.4	86.8	68	14.28
TOTAL	855				343.89
% increase					40

Also, as shown in the graph below, it is predicted that locations with higher travel time will experience higher percentage increases in the predicted count of visitors as a general trend. The Jefferson area, which has the highest travel time, will experience the highest increase (68%) in the count of visitors.

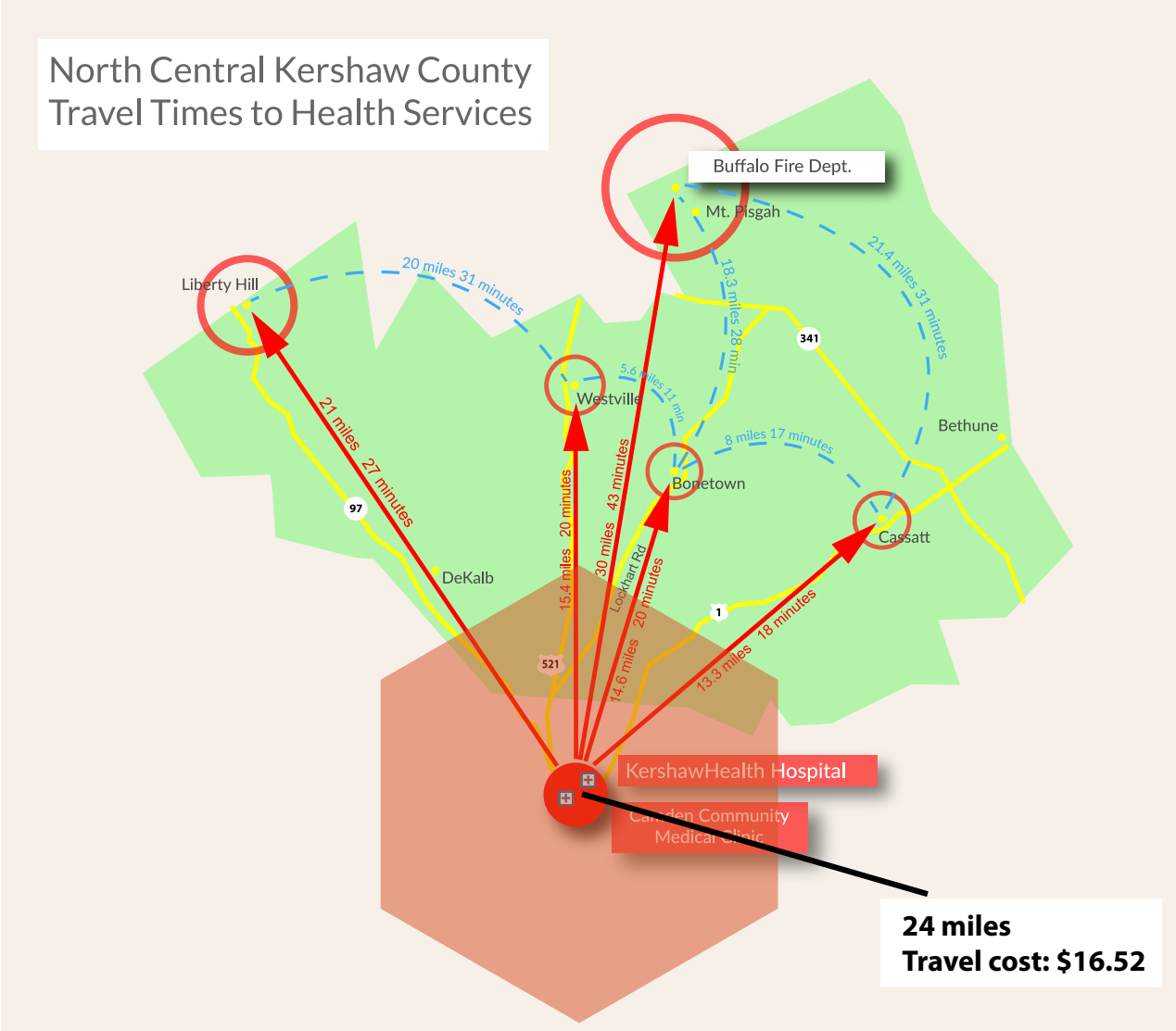


Graph 9 - Percent Increase in Predicted Count of Visitors by Locations

According to the distance decay estimation, beyond the 42-minute round trip travel time cut-off point, percentage frequency falls below its mean value. That is, the area population that lives beyond the 42-minute round trip travel time (the red circled portion) is judged to be discouraged to travel for obtaining service and become or stay underserved due to travel cost barriers.

Based on the distance decay estimation cut-off point, the maximum willingness to pay for a round trip to obtain free medical care from the CMC is calculated as $33.04 based on IRS's $.59 per mile travel cost allocation rate. That is, **beyond $33.04 round trip travel cost, the demand for the services of the CMC is assumed to drop to zero.** The maximum willingness to pay for travel and CMC service based on distance decay estimations was used to develop a hexagonal market area for the CMC that serves to the whole County.

Map 5- Market Area of CMC



LiveWell KERSHAW

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LiveWell KERSHAW

Quarter Three Report

December 1, 2014 - February 28, 2015

Our Ingredients

"We are perfecting our recipe to LIVEWELL!"

Letter from the Evaluator

Office of Research

February 28, 2015

It is hard to believe that Quarter Three (December 1, 2014 – February 28, 2015) has just finished; time has certainly flown by. This quarter can be described simply as "JUST DO IT." December of 2014 began with one newly hired Project Manager and three Community Health Workers and ended with active community health care sites at local churches and monthly mobile clinics with nurse practitioners. Theressa from Cassatt earlier this year said that "people have to see it to believe it" and the past three months have been about building tangible services and resources within ten miles of residents' homes in the towns of Cassatt, Kershaw, Bethune, Mt. Pisgah and Liberty Hill. A total of **61 new clients** were seen by Community Health Workers during the past three months with 22 follow-up visits. In addition, 14 clients were seen by a physician or nurse practitioner during one of the two mobile clinic visits in Mt. Pisgah and Cassatt. Not surprisingly, team members visited all of the schools in the area, various churches and community leaders, increasing awareness of the initiative (see the Timeline for specifics). The LiveWell Kershaw team is committed to "making Kershaw County a place where every person has an equal opportunity to health and well-being."

This report is organized into different components for the reader to understand the growth of each initiative. Please note that all of these initiatives are works in progress and team members are constantly making adjustments to better meet the needs of the clients and the population living in North Central. The Facilitation Report gives a snapshot of some of the reflections and self-assessments we do as a team to improve and sustain our efforts.

Below is a brief snapshot of the activities each team is working on:

Clinical Team – To provide clinical services to residents of North Central

- Operate 6 community healthcare sites from 9:00 am -1:00 pm each week at Cassatt, Mt. Moriah, Refuge, Abney and Sandy Level Baptist Churches
- Provide care to patients through Community Health Workers
- Provide care to patients through Nurse Practitioners at least once a month

- Community Health Workers become certified in SC and can bill for services
- Contact all self-pays using ER in North Central
- Provide tele-health capabilities for specialty care to patients

Community Outreach Team – To increase awareness and utilization of LiveWell Kershaw services

- Host community health fairs
- Attend and support local community events
- Recruit and train volunteers from each church site
- Provide dental and vision screenings to residents through Doctors Without Borders Club from Clarkson University in Potsdam, NY
- Make presentations to various groups
- Create and implement a communications plan
- Create and support an active Community Council

Evaluation Team – To systematically evaluate the LiveWell Kershaw initiative and generate learning to guide decision making

- Conduct needs assessment for school-based health center
- Collect data on mobile clinics and document process
- Assess healthcare utilization of mobile clinic visits and Return on Investment of overall project
- On-board all data collection efforts in Insight Vision
- Facilitate meetings and discussions as requested with team members
- Evaluate specific components of the initiative as requested

If you have any questions regarding this report, please do not hesitate to contact me.

Best in all you do,

Holly Hayes, MSPH
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LiveWell Kershaw At a Glance

5 Community Healthcare Sites open for business

DECEMBER 18 — First day Mobile Clinic open

JANUARY 19 — First day for Community Healthcare Sites; Mental Health facilitation also begins +

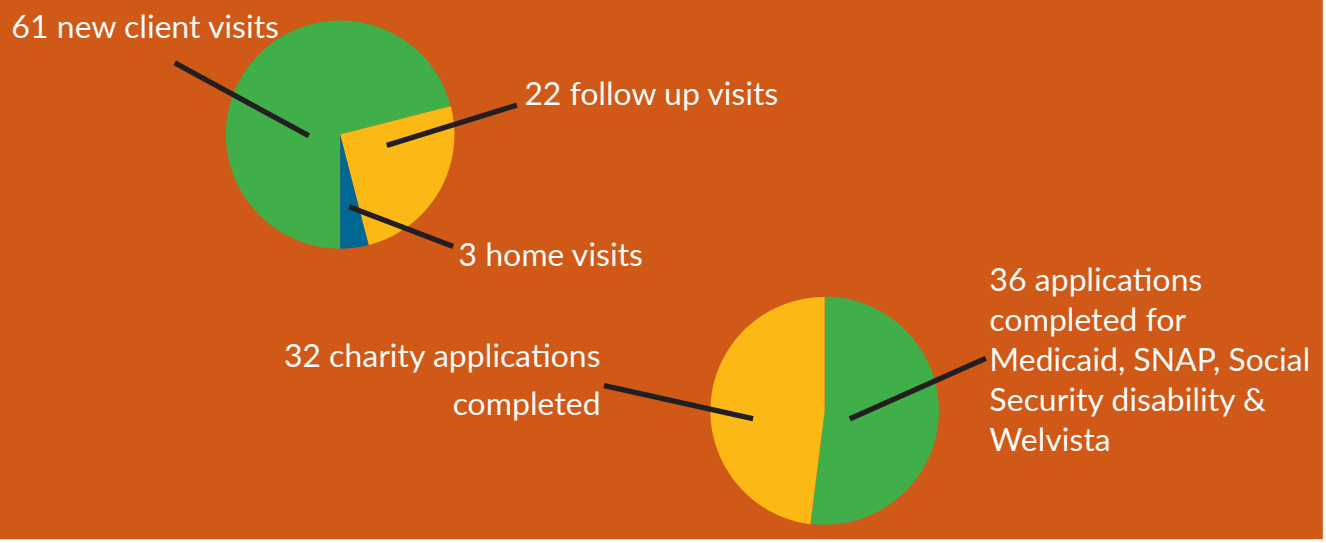
3 Community Health Workers (CHWs) hired and working

- CHWs completed 5 weeks of training
- 5 volunteers also trained

$300,000 in outstanding medical bills resolved for one client*

**CHWs achieved reconcilitation with provider (see pg. 20)*

Client Engagement



Current Issues:

Bridge on Lockhart Road (a main road) is currently closed for construction.

Connectivity issues (phone, wireless, & fax access)at the mobile sites - needed to access Electronic Medical Records.

Clarify the role of CHWs at the community healthcare sites.

+ 20% of students experience mental health concerns that impair functioning at home, school and/or in the community (see pg. 28)

Barriers

Below are barriers that have been identified by LiveWell Kershaw (LWK) for Quarter Three. The LWK team considers itself a learning organization and is constantly making adjustments and determining how methods can be improved to impact the most people living in North Central. See the Facilitations section (pg. 39) to see how the LWK team is reflecting on what is working, what is not and how best to move forward.

"The Bridge is Out"

The bridge on Lockhart Road, currently closed for construction, is the main road for Bethune, Cassatt Kershaw, and North Central Area residents to access basic services. Reconstructing the bridge due to safety issues began more than eight months ago and an end date is not in sight. Due to this bridge closure, residents are driving miles out of the way to get to churches, North Central Middle and High Schools and to the next town. With a minimum of 10 additional miles to access daily activities, there is no quick alternate route. Residents are even being charged an additional $300 for EMS services because of the bridge closure. One of our community-health care sites, Abney Baptist, is very close to the schools mentioned above, but because of the bridge closure residents have to travel many miles out of the way. This bridge closure is impacting numerous aspects of the lives of area residents in negative ways.

Providing Wrap-around Services

Two of the individuals who received care at the mobile clinic visit in February said that they most likely would not continue using the mobile clinic and would go to Camden for future visits. Currently, clients still need to drive to Camden for any lab work, X-rays or medications. If the clients are diabetic or have high cholesterol, blood work needs to be drawn every 3-6 months. The LWK team is working on enrolling clients in Well Vista for prescriptions to be mailed to them and considering the use of a mobile centrifuge for lab work on site.

Training and Reimbursement for Community Health Workers

Thus far securing dates for the Community Health Workers (CHWs) to attend training and take the certification exam has not been achieved. This greatly limits the capacity for the CHWs to work independently and move forward. We have also learned that the reimbursement for CHW services will be not approved until fall of 2015.

Technical Issues and Connectivity

The team has been troubleshooting connectivity issues related to phone, wireless printer, internet and fax access at the mobile sites. During mobile clinic days, the medical director and nurse practitioner need access to electronic medical records, x-rays, and lab data. A team is testing each site the week before to ensure that four devices can work simultaneously and troubleshooting the layout needed for wireless access within 30 feet of the internet hotspots. At both mobile clinic days, connectivity has been a major issue. As a work-around, the clinical team is bringing the face sheet (includes medications) and last visit notes for each of the clients scheduled. However, this information is often insufficient if a provider needs to review previous labs and other visit notes.

CHWs are experiencing obstacles faxing applications to organizations in order to enroll clients for much-needed services without access to a fax machine. North Central High School has declined to allow the team to use the fax machine for enrollment. As a work-around the CHWs are scanning the applications and sending them to KershawHealth Assistance and the Community Medical Clinic. For Welvista applications, faxes are required to be sent from a doctor's office; CHWs must drive to Camden weekly to fax applications. For clients seen at the Monday church site, their paperwork is not being faxed until Friday. These obstacles delay the enrollment process.

It is not possible to conduct live radio remotes in the North Central Area. We wanted to advertise at a community healthcare site during flu season and were unable to do so live. The local radio station was able to broadcast prerecorded messages every 10 minutes that appeared virtually "live."

The team is looking into installing wireless and other technology in the LWK mobile van to help with connectivity. We have already purchased four Verizon internet jet packs (wireless routers) for the CHWs and the Project Manager to use (this was not initially in the budget). AT&T does not have any service in the majority of the North Central Area. Without AT&T service, the Director for LWK and the Project Manager cannot communicate with team members in certain areas of Kershaw county.

Messaging

The LWK team is quickly moving forward with weekly community healthcare sites at five local churches and coordinating monthly mobile clinics at each of the locations. Developing a clear and consistent message for team members and residents of the area is being addressed currently through the development of a communication plan and regular team meetings. Some church members were concerned that the healthcare sites would have individuals get "naked" and "blood would be spilled on the carpet." Clearly explaining the role of the CHWs and the weekly healthcare sites will alleviate their fears and also help spread the message. The LWK team is planning "booster sessions" with team members and volunteers to ensure that everyone can articulate the same message and become a "walking advertisement" in the community. The team will be learning from Best Chance within the next two weeks to understand how they do inreach and outreach.

Timeline for Quarter Three

2014

December 1 – 3	**New CHWs and Project Manager began working on LWK** Dr. Alice Brooks officially became Medical Director of LWK
Dec 1 – Jan 31	CHWs participate in orientation training led by Kelly Warnock
December 2	Began touring North Central area to look for possible community sites; met with principal of North Central High School; visited the Bethune Clinic
December 4	LWK Team Orientation
December 5	Observed work at AccessKershaw in the morning; attended PTO Movie Night at Mt. Pisgah Elementary and spoke to approximately 25 parents about LWK
December 8	Met with the mayor of Bethune; met with the pastor of Bethany Baptist Church in Westville
December 9	Internal team meetings: community engagement (Whitney), CHWs (Kelly W.), budget and operations (Susan and Joseph)
December 10	Visited Mt. Pisgah Elementary and met with office staff about set-up for Dec. 18 clinic day
December 15	Attended PTO night at Baron DeKalb Elementary and spoke to approximately 200 people about LWK
December 16	Team met about data collection (Susan, Holly and Ibrahim)
December 17	Met with Susan and Ron at Mt. Pisgah to test internet connectivity for clinic day
December 17	North Central Initiative (NCI) team meeting (Joseph, Lillian, Andy, Cheryl, Kelly K, Kelly W, Susan, Holly, Melissa)
December 18	**Mobile Clinic in Mt. Pisgah – test run of mobile LWK**
December 19	Lillian Smith's last day at USC
December 19	Met with 3 members of Refuge Baptist Church and secured the site
December 20	Set up LWK booth at the Bethune Christmas Parade - CHWs and Kelly W. participated; met with Executive Board of Mt. Moriah Missionary Baptist Association and secured the site
December 22	Met with pastor and members of Belmont Baptist Church in Westville

2015

January 4	Met with pastor and members of Cassatt Baptist Church
January 7	Met with Susan, Dr. Morgan and Mary Anne Byrd of Kershaw County School District (KCSD); met with members of Abney Baptist Church
January 8	Attended a Women's Forum at the Elgin Outpatient Center and shared LWK with a few of the attendees
January 13	Met with principal of Midway Elementary
January 15	Meeting with DHHS (Maudra Brown, Mandy Williams, Allie Gayheart, Cheryl, Holly, Whitney)
January 19	**Official first day of community healthcare sites**
January 20	Distributed flyers at North Central High School basketball game
January 21	NCI team meeting; new six month plan developed for end of Year One
January 26	Met with members of Sandy Level Baptist Church in Bethune
January 29	Gained approval from Dr. Morgan and Mary Anne Byrd at school district on part two of evaluation plan interviewing middle school students; strategic planning session for Community Medical Clinic; team members attend crisis intervention training
January 30	Pre-kickoff meeting for InsightVision
February 4	Met with Melissa and Andy Pope to plan integration of Mental Health component
February 10	Strategic plan for EatSmart Move More Kershaw County
February 11	Met with CHWs and pastor of Bethany Baptist Church about becoming a community site (Cheryl and Melissa)
February 12	Gained approval from Dr. Morgan and Mary Anne Byrd at KCSD on part two of mental health component to provide on-site mental health support for Midway Elementary (parent education & Positive Behavioral Intervention & Support (PBIS) implementation support for school staff) and North Central Middle and High Schools (implementation of Check & Connect mentoring program for identified students in need)
February 13	USC Psychology student training for implementation of Check & Connect program
February 16	Attended Kershaw County Democratic Women's meeting and shared information about LWK

February 18	Trained volunteers at Refuge Baptist Church to assist for Mobile Clinic Day
February 20	Kelly Kavanaugh's last day with LiveWell Kershaw
February 21	Spoke to approximately 175 people about LWK at Mt. Moriah Missionary Baptist Association Black History Banquet and distributed flyers/brochures
February 23	Presentation to Alpha Delta Kappa education sorority at North Central High School; 1st leadership team meeting, "Camp David" (Susan, Cheryl, Kelly and Holly); Gained approval from principals to implement mental health component; Distributed mobile clinic brochures to Midway Elementary, North Central Middle and North Central High Schools; Distributed Check & Connect training flyers at North Central Middle & High Schools; Distributed teacher support flyers at Midway Elementary School; Began Check & Connect at North Central Middle & High Schools
February 25	**Mobile Clinic Day at Refuge Baptist Church; Team meeting with focus on Community Healthcare sites;** Began on-site mental health facilitation at Midway Elementary School
February 27	CHW Cheryl Cobb's last day with LWK
February 28	Presentation at Sandy Level Baptist Church Women's Conference

Community Health Worker Training

Kelly Warnock, Coordinator of the Community Health Workers (CHWs), provided training to our newly hired CHWs. Two began on December 1, 2014 (Cheryl Cobb and Jesus Martinez) and one began on January 29, 2015 (Karen Baker). Ms. Cobb and Mr. Martinez described the first three weeks of training in December as "a LOT of reading and understanding services that can be provided on-site."

Kelly Warnock, CHW Coordinator

The Orientation Checklist (see pg. 13) describes the materials and site visits that each CHW was responsible for completing over the five-week period. The weekly orientation plan for the CHWs shows how individual training plans were created for each CHW. Karen Baker spent two weeks training in Fhases (the case management system) and getting familiar with the paperwork process unique to AccessKershaw. Previously Karen established and operated a Free Clinic in Lancaster and was the most familiar of the CHWs with services and the process of client case management.

Each of the CHWs shadowed mentors (Sheri Baytes and Jeana Johnson from AccessKershaw) who explained how multiple systems and processes are navigated to maximize the services for each client. These mentors provided detailed answers to the new CHWs' questions. During the fourth and fifth week of training in January, the CHWs shadowed their mentors' client encounters and rotated mentors daily. This allowed for a great deal of experiential learning to take place and for the CHWs to understand and observe the intake/referral process for clients, completion of client visits, entry of information into Fhases and follow-up procedures.

Additionally, Kelly Warnock conducted "huddles" with the team to synthesize information and assess the progress of each CHW. Kelly continues to meet with the CHWs and assist them on their journey.

Access Kershaw Orientation Checklist for CHWs:

Activity	Date completed	Activity	Date completed
Review Orientation manual		Meet and introductions to PCCs at Kershaw Health	
Obtain Keys		Review options for Addictions help in KC	
Benefit Bank Training		Review transportation options in KC	
Google voice and calendar options		Review Best Chance Network Information	
Fax/Copier usage, label maker		Review housing options in Kershaw County	
Partner agency visits:		Determine options for obtaining clothing in county	
• CMC		Determine options for food assistance in county	
• Sandhills		Review utility assistance programs	
• Kershaw Health		Utilization of low-cost prescription plans in area	
• Mental Health		Competency in online PAP usage (needymeds.com)	
• DHEC		Community Vision opportunities	
• Alpha Center		Community Dental opportunities	
• Healthcare place at Bethune		Referral and Intake Process	
Introduction to Impact		Competency in completing Welvista applications	
United Way partner agencies:		Putting together client records	
• CCM		Lions club assistance application	
• Wateree Community Action		Habitat Store location and utilization	
• Family resource Center		Timesheets and how to submit	
• Midland's Women's Center		Fhases database	
• Sistercare		Review Access network and partners	
• SC voc rehab		Travel reimbursement form	
• Alston Wilkes Society		KH diabetic education	
• New Day on Mill		KH Patient education	
• DSSN		Medicaid options for families	
• DSS		ACA navigation options	
Hospital charity application Program		Healthy Outcomes Plan enrollees and potential enrollees	
Streets of Kershaw County Index		How to utilize time and mileage tracker	

Access Kershaw Orientation Checklist for CHWs cont'd:

Activity	Date completed	Activity	Date completed
Medicaid Hospital Worker-Lisa Young		Disease management tools for:	
Review volunteer packets/process		• CHF	
Review quality measures		• Hypertension	
TBB applications SNAP		• Diabetes	
• Medicaid		Competency in measuring BP	
• Financial independance		Competency in taking blood glucose	

Weekly Orientation Plan for CHWs:

Week 1	Jesus	Cheryl
Monday 12/1	**Work with Jeana this week**	**Work with Sheri this week**
	Create december schedule	Create december schedule
	Begin working on orientation checklist	Begin working on orientation checklist
	Get log in for Fhases	Get log in for Fhases
	Review use of copier and fax including speed dial	Review use of copier and fax including speed dial
	Review timesheet and how to submit	Review timesheet and how to submit
	Review KH financial assistance program and required documents	Review KH financial assistance program and required documents
Tuesday 12/2	**Work with Meredith to understand filing and front desk operations**	Review all client education material
	Review Referral and intake process	Identify any gaps in our education material and suggest options
	Practice putting together client records	Identify Medicaid options for south carolina with income limits
	Practice putting clients into Fhases	Identify Community vision opportunities
		Identify community dental opportunities
Wednesday 12/3	Review all client education material	Log into Needy Meds and see what is offered on website
	Identify any gaps in our education material and suggest options	Log into RX outreach and see what is offered on website
	Log into Needy Meds and see what is offered on website	Review Access Kershaw Partners and their roles related to Livewell
	Log into RX outreach and see what is offered on website	
2:30-4 pm	**Susan Witkowski---CMC orientation to policies and procedures**	**Susan Witkowski---CMC orientation to policies and procedures**
	Sign policy manual	Sign policy manual
	Complete CMC paperwork	Complete CMC paperwork
Thursday 12/4	**8:30-12:30: Meet in second floor conference room of Elgin Urgent Care for Livewell orientation**	**8:30-12:30: Meet in second floor conference room of Elgin Urgent Care for Livewell orientation**
1-4:30	Tour Elgin Building-Meet Elgin Primary Care and EUC staff	Tour Elgin Building-Meet Elgin Primary Care and EUC staff
	Review housing options in Kershaw County	Review housing options in Kershaw County
	Determine options for clothing assistance in KC	Determine options for clothing assistance in KC
	Identify Food assistance programs in KC	Identify Food assistance programs in KC
Friday 12/5	Review with Jeana what you have accomplished this week	**Go to Bethune with Sheri to observe**
	Continue to get comfortable with client process	Identify key personnel in Bethune
	Answer phone at front desk and direct clients as needed	Observe for barriers to care
		Go to Discount Grocery Store and meet staff

Weekly Orientation Plan for CHWs cont'd:

Week 2	Jesus	Cheryl
Monday 12/8	**Work with Sheri this week**	**Work with Meredith to understand filing and front desk operations**
	Identify Medicaid options for south carolina with income limits	Review Referral and intake process
	Identify Community vision opportunities	Practice putting together client records
	Identify community dental opportunities	Practice putting clients into Fhases
	Review Access Kershaw Partners and their roles related to Livewell	
Tuesday 12/9	**Work with Kelly at Community Clinic**	**Work with Jeana this week**
	Identify key personnel at clinic	Continue to work on check list
	Understand clinic requirements for intake	
	Participate in intake screening	
	Identify process once intake has been completed	
Wednesday 12/10	Continue to work on check list	Continue to work on check list
	If you want, SC thrive is having an open	If you want, SC thrive is having an open
	house this evening	house this evening
Thursday 12/11	Continue to work on checklist	**Work with Kelly at Community Clinic**
		Identify key personnel at clinic
		Understand clinic requirements for intake
		Participate in intake screening
		Identify process once intake has been completed
Friday 12/12	**Go to Bethune with Sheri to observe**	Review with Jeana what you have accomplished this week
	Identify key personnel in Bethune	Continue to get comfortable with client process
	Observe for barriers to care	Answer phone at front desk and direct clients as needed
	Go to Discount Grocery Store and meet staff	

Weekly Orientation Plan for CHWs cont'd:

Week 3	Jesus	Cheryl
Monday	Work with Jeana as mentor	Work with Sheri as mentor
15-Dec	Team Huddle 8-9:30	Team Huddle 8-9:30
Tuesday	Work with Jeana as mentor	Work with Sheri as mentor
16-Dec	1 pm: CMC debs retirement	1 pm: CMC debs retirement
	Work with Kelly at CMC	
Wednesday	Work with Jeana as mentor	Work with Sheri as mentor
17-Dec		
Thursday	8:30-6pm	8:30-6pm
18-Dec	Abney clinic	Abney clinic
Friday	Work with Jeana as mentor	**Go to Bethune with Sheri to observe**
19-Dec		

Week 4	Jesus	Cheryl
Monday		
22-Dec	Team Huddle 8-9:30	Team Huddle 8-9:30
Tuesday		Work with Kelly at CMC
23-Dec	1 pm Christmas Party CMC	1 pm Christmas Party CMC
Wednesday		
24-Dec		
Thursday	OFF	OFF
25-Dec		
Friday		
26-Dec		

Weekly Orientation Plan for CHWs cont'd:

January Week 1	Jesus	Cheryl
Monday		
29-Dec	Team Huddle 8-9:30	Team Huddle 8-9:30
Tuesday	Work with Jeana	Work with Sheri
30-Dec	Continue to complete orientation checklist	Continue to complete orientation checklist
Wednesday	Work with Jeana	Work with Sheri
31-Dec	Continue to complete orientation checklist	Continue to complete orientation checklist
Thursday	OFF	OFF
1-Jan		
Friday	Work with Jeana	Work with Sheri
2-Jan	Continue to complete orientation checklist	Continue to complete orientation checklist

January Week 2	Jesus	Cheryl
Monday		
5-Jan	Team Huddle 8-9:30	Team Huddle 8-9:30
Tuesday	This week interview clients and get comfortable with available programs	This week interview clients and get comfortable with available programs
6-Jan		
Wednesday	As above	As above
7-Jan		
Thursday	As above	As above
8-Jan		
Friday	As above	As above
9-Jan		

Weekly Orientation Plan for CHWs cont'd:

January Week 3	Jesus	Cheryl
Monday		
12-Jan	Team Huddle 8-9:30	Team Huddle 8-9:30
Tuesday	Benefit bank training	Benefit bank training
13-Jan		
Wednesday	Gather supplies for new office	Gather supplies for new office
14-Jan	Get familiar with PM and role	Get familiar with PM and role
Thursday	Finish orientation checklist	Finish orientation checklist
15-Jan		
Friday	Finish orientation checklist	Finish orientation checklist
16-Jan	Get ready for Monday in Cassatt	Get ready for Monday in Cassatt

Community Healthcare Sites

LiveWell Kershaw is committed to improving the health of residents in the towns of Bethune, Cassatt, Liberty Hill, Kershaw, Westville and the surrounding areas. Community healthcare sites began operating on January 19, 2015 at local churches in the area (see map on pg. 22). The healthcare sites are staffed with CHWs and volunteers to help identify services for which clients are eligible and also help clients enroll in the LiveWell Kershaw program.

Entrance to Community Healthcare Site at Cassatt Baptist Church

The goal of this program is to help the uninsured and underinsured residents of Kershaw County successfully navigate the healthcare system. CHWs assist clients with finding a doctor and affordable medication options, applying for food stamps and Medicaid/Medicare, obtaining healthy check-ups and providing support and case management services for chronic diseases such as diabetes, high blood pressure and COPD.


CHWs Karen Baker and Jesus Martinez pose with a note of thanks from "Susan."

Success Stories

A 59-year-old woman, "Susan," who lives in Cassatt, struggled with how she was going to pay a $300,000 hospital bill with her limited income. With the help of LiveWell Kershaw, Susan does not owe any money and is learning to take better care of her health. In January of this year, Susan received a letter from her child's school alerting parents that individuals from LiveWell Kershaw would be offering healthcare services at Cassatt Baptist Church. Susan visited Cassatt Baptist and met CHW Karen Baker. Susan described being overwhelmed with stress concerning how she was going to pay a bill to Palmetto Health for the removal of a tumor from her head. The hospital refused to schedule a much-needed second appointment until the debt was paid off - an impossibility for Susan.

Karen contacted KershawHealth and enrolled Susan in the Medicaid Innovation Accelerator Program (MIAP) and within 30 days the bill was resolved. Karen met with Susan again for a follow-up appointment to work with her to schedule the second appointment at the hospital and to tackle some

of her health issues. Karen spent 45 minutes with Susan and helped lift a tremendous burden off of her shoulders. There are more "Susans" living in North Central, and Karen can't wait to work with them.

This is Mr. Ricky Lee Hough. LiveWell Kershaw CHWs met him at the first Friday Community Healthcare Site event at Sandy Level Baptist Church. He was so appreciative! Mr. Hough stated:

"You all are a God-send. I'm so glad you're here!" He is a "serious" diabetic. As shown in the photo, he was given a glucometer and 50 test strips.

Community Healthcare Sites:

Abney Baptist Church
(Kershaw)

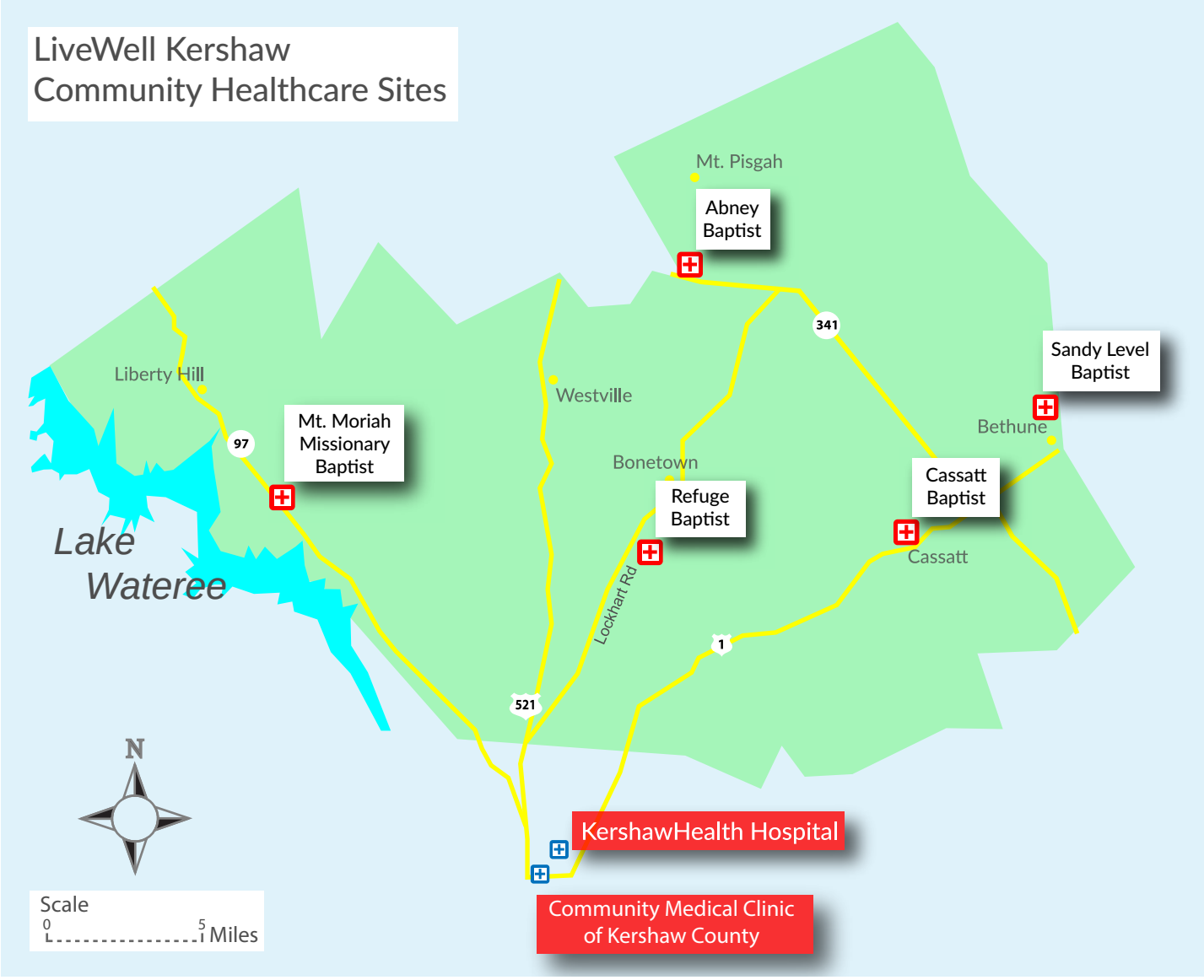
Cassatt Baptist Church
(Cassatt)

Mt. Moriah Missionary Baptist Church
(Liberty Hill)

Refuge Baptist Church
(Westville/Bonetown)

Sandy Level Baptist Church
(Bethune)

Community Healthcare Sites Map:



Weekly Schedule:

Day	Location	Address
Monday	Cassatt Baptist Church	2604 Hwy 1 North Cassatt, SC 29032
Tuesday	Mt. Moriah Missionary Baptist Association FEW Center	3045 John G. Richards Rd Liberty Hill, SC 29074
Wednesday	Refuge Baptist Church	2814 Lockhart Road Kershaw, SC 29067
Thursday	Abney Baptist Church	3705 Roberts Road Kershaw, SC 29067
Friday	Sandy Level Baptist Church	2920 Timrod Road Bethune, SC 29009

LiveWell Kershaw Report Card: Quarter 3

LiveWell Kershaw	Dec-14	Jan-15	Feb-15	YTD totals
# New client visits	15	19	27	**61**
# Follow up visits	4	7	11	**22**
# ER follow up calls		3	54	**57**
# PCP set up	2	4	4	**10**
To CMC			3	**3**
To SMF				**0**
To HCPB	2	4		**6**
To LPC				**0**
To Other			1	**1**
# Mecicaid applications	1	3	2	**6**
# SNAP applications	1	2	3	**6**
# Welvista apps	5	8	4	**17**
# SS disability	3	2	2	**7**
# Extra Help apps	1			**1**
# with Care or Caid	2			**2**
# Case Management	3			**3**
# Home Visits			3	**3**
# MD appt visits				**0**
# Medication rec	1		1	**2**
# MH Referrals				**0**
# Dental Referrals		2		**2**
# PAP applications	2			**2**
# Charity Applications	8	14	10	**32**
# HOP sessions		2		**2**
# ACA Navigations		1	1	**2**
# Lions club apps		3	1	**4**
Community Referrals	1	3	0	**4**
Housing				**0**
Utilities	1			**1**
Transportation				**0**
Food				**0**
Other		3		**3**

Mobile Clinics

The LiveWell Kershaw (LWK) Team offers mobile clinics once a month in the North Central Area to provide primary care services for residents. Team members include a Medical Director (Dr. Alice Brooks), two nurse practitioners (Susan Grumbach and Jessica Wilkes), nurses and CHWs. The mobile clinic is rotating monthly to all of the community healthcare sites at the five local churches and currently has a **100% appointment show rate for both months.** The team is reaching out to all clients to make sure that they take advantage of the new Medicaid-expanded seven month service. Please refer to the Barriers section (pg. 6) for a description of the connectivity issues with electronic medical records.

The Numbers: December – 7 Patients; January – 7 Patients

The "Smith" family visited the mobile clinic at Mount Pisgah in December 2014 at LiveWell Kershaw's first mobile clinic day. This family accumulated **32 missed appointments** last year at the Community Medical Clinic. The family all carpools to Camden; when they miss an appointment the clinic loses four visits since they all come together. They are uninsured and live in Buffalo, which is about five minutes from the mobile clinic site. "Hank" swears that if "Dr. Jessica" (nurse practitioner Jessica Wilkes) did not see him then he would be dead today. About a year ago, "Hank" had a stroke and credits Jessica for being "hard on him" and "giving it to him real." This family has one car and says it takes about 25 minutes to Camden one way. They suffer from diabetes, hypertension, hyperlipidemia, heart disease, mental health disorders, asthma, and hyperthyroidism. At the mobile clinic visit, prescriptions were refilled, diagnostic tests were ordered and follow-up visits were scheduled.

This family appreciated the fact that the mobile clinic was so close to their home. They have complex medical issues and family structure that both require great attention to detail. Dr. Alice and Jessica address their important needs in order to gain their trust and begin to target clinical needs. This family plans to continue meeting Jessica and the team at the mobile clinic sites.

A 52-year-old African American male, “John,” lives in Westville and visited the mobile clinic with his mother (lives in Westville) and sister (lives in Lancaster). John does not have insurance and has not been seen by a medical provider in three years; his last visit was to the Emergency Room. John suffers from arthritis, back pain and gout and is in significant pain. John dropped off an intake form at the Community Medical Clinic in Camden then Meredith from AccessKershaw called him and scheduled an intake in Mount Pisgah since it was much closer to his home.

Sherri, a CHW with LiveWell Kershaw, reinforced the need for the qualification paperwork, and John came prepared to the mobile clinic visit with everything the team needed. Within two hours, John was screened, received approval to be a patient at the Community Medical Clinic and was seen by a nurse practitioner. AccessKershaw reviewed eligibility programs and completed a Welvista application to arrange John’s medications.

While John was receiving care, AccessKershaw spent time with John’s mother and sister and discussed their healthcare needs, including diabetes management. One of the LWK CHWs (Cheryl) was able to give John’s sister a glucometer and fifty test strips to help her self-monitor her glucose. The glucometer allows John’s mother to be more engaged in knowing her blood sugar reading at any given time. Unfortunately, Medicare limits users to one strip a day. The CHWs also shared some diet education materials and a diabetes case management packet.

According to CHW Coordinator Kelly Warnock, “it’s about making the family healthy” regardless of what county they live in. There is no program in Lancaster. We expect that we will have more opportunities to treat families because the mobile clinic by nature has fewer walls and encourages more family interaction. Dr. Alice Brooks summed it up: “we picked up a patient today that will need our services and would not have been seen.” The mobile clinic came into his territory, which makes us vulnerable; but we left “with one more patient than we started with” and we have a lot of services to offer John.

Quotes from Clients at the Mobile Clinic

"We (the nurse practitioners) are coming into the patients' environment, and we are more vulnerable and the patients are more comfortable. Because this (the mobile clinic at Cassatt Baptist) doesn't look like a doctor's office, the patients tend to be much more honest and forthcoming. Providing emotional support to patients is just as important as working on the healthier lifestyle. At the church, I'm able to write prescriptions and review labs just like I would in the downtown clinic."

- Jessica Wilkes,
Nurse
Practitioner

"Without this clinic, I would not make it. It's very convenient to come up here. They helped me fill out papers for my husband to get lower medicine costs, took my blood pressure and listened to all of my problems (and boy, I got some problems). Without this clinic, I would die. I'm on depression pills, and without the medicines the clinic gives me, I wouldn't be here today. They open their arms to you and are good people."

- "Hattie," Cassatt
10-year patient of Community Medical Clinic

"This is a really good program and real easy for people. Some people can even walk here to go to the clinic. The doctors are good and I've been treated good. This program is awesome and I hope it continues to work for everyone who needs it."

-"Tara," Cassatt
Uninsured, former materials worker with United

"This clinic beats my last family practice doctor by a mile. They are real friendly, professional and courteous. They checked my blood pressure today and helped me control it. I've reduced my salt (intake) by not stopping at BoJangles every morning. This is an outstanding service; it really is."

-"Tim," Kershaw
Business Owner, Construction Worker

Home Visits

For individuals in the North Central Area that do not have transportation or only have transportation after 5:00 pm, LWK CHWs can visit the clients' homes. For Quarter 3, a total of **3 home visits** were conducted by the CHWs - all in Cassatt. These home visits took place in mobile homes that have open holes in the front doors, many dogs and cats, no HVAC and overall very unclean living conditions. One family used their living room only which was heated by a single space heater; they also ate one meal per day. Jesus Martinez, a LiveWell CHW from Mexico, was shocked that "people in America live like this" with all of the services available.

Karen Baker (CHW) noted that home visits allow LWK to impact not only the client but also a spouse or other relative living in the house. For Karen, home visits have h

> "My message to the client changes once I see their living environment and all they are dealing with."

Jesus Martinez (CHW) offers home visits to clients who really have no other options; he sees this as positive in that clients are much more "open" in their own environment. The CHWs are able to conduct a successful visit with the use of a mobile hotspot for internet connectivity, which allows them to assist with online applications and additional paperwork.

Susan Witkowski, COO of Clinic Operations, would like every client to ideally have a home visit at some point in their healthcare journey. Witkowski realizes that "a door just seems to be open" once you have spent that personal time with a client in their own home.

For Quarter 4, Kelly Warnock (CHW Coordinator) would like the CHWs to continue conducting home visits and to begin going with clients to doctor's appointments. She believes clients will benefit from the additional assistance navigating prescriptions and the clinical encounter, as some may not have been to a doctor in years. Home visits and physician appointments are all about meeting the client where he or she is and removing barriers - one step at a time.

Mental Health

Update and Recommendations for Spring 2015

February 5, 2015
Prepared by Melissa W. George, Ph.D., CFLE, Department of Psychology
University of South Carolina; for the Kershaw School District's Review and Feedback

Introduction

Livewell Kershaw, a community coalition to promote population health for Kershaw county, determined from a community needs assessment and resources that Kershaw residents were in need of support for promoting their mental health (among other health needs identified). The community's request was met by Livewell Kershaw with the development of a mental health component of their efforts. Given the unmatched ability for the school context to reach youth, the efforts of schools to remove barriers to student learning, similar to the importance of schools building supports for student health, strengthening mental health supports in schools has become of utmost importance across education and health research, practice and policy. Through collaboration and partnerships with community providers healthcare and mental health care are being brought to youth "where they are" -in schools.

School-based mental health care

Schools have been championed as a key context for reaching youth and families given the significant gap in youth's needs and receipt of services. For example, 20% of students experience mental health concerns that impair functioning at home, school, and/or in the community and 10% of students have more severe mental health challenges that significantly impair their daily functioning, yet fewer than 1/3 of those in need receive adequate supports for their needs. When youth with mental health problems do not receive treatment to alleviate their challenges, the costs to the individual, family, and community are tremendous. Unmet mental health needs increase the likelihood for school dropout, involvement in the juvenile justice system and incarceration, lack of employment, living in poverty, hospitalization, subsequent health and mental health problems, premature mortality, and ultimately

reduced quality of life. However, of those youth who do receive supports and services for their mental health needs the majority receive services through their school. Therefore building the capacity of schools to support students' comprehensive health and mental health needs has been a priority in the United States for the past decade.

Objectives of evidence-based, sustainable school-based mental health care

In order for schools to address the full array of student needs, it is essential to be knowledgeable of the schools' access to a wide variety of national-, state-, district-, community-, and school-based programs and resources that can begin to help address student and family needs that interfere with supporting an optimal learning environment. As such two goals of school-based mental health care are needs assessment and resource mapping of the current local mental health context. Objectives of these efforts include understanding mental health needs of students within a specific school, existing programs that schools provide onsite, community and regional resources available to the school to inform recommendations for strengthening school-community partnerships, integrating evidence-based programs and practices, and supporting schools in their processes for sustaining mental health supports for students and families.

Overview of Livewell Kershaw's Mental Health Component

To accomplish these objectives the Mental Health (MH) Component of Livewell Kershaw began in fall of 2014 by gathering and documenting information about the needs and national-, state-, community- and school-level resources of the six schools in the Northeast region of Kershaw County: North Central High School; North Central Middle School; Baron Dekalb Elementary School, Bethune Elementary School, Midway Elementary School and Mt. Pisgah Elementary School.

These efforts included the following:

- Developed flyer for schools regarding LWK MH Component (See attached, pg. 34)
- Met with principals and nurses of all six schools to discuss the mental health component and current MH needs and initiatives and began building meaningful relationships
- Identified key MH community stakeholders for schools and met with them regarding MH initiatives and relationships with schools (e.g., school district initiatives, ALPHA center services, Positive Behavioral Intervention and Support (PBIS) and Department of Mental Health presence) and gathered applicable resources for schools (e.g., PBIS assessment tools and resource guide for schools)
- In-depth interviews, meetings, and needs assessment/resource mapping with North Central Middle and High Schools. This included meeting with PBIS/RTI (Positive Behavioral

Intervention and Support / Response to Intervention) teams in the two schools to understand the context and current state of these initiatives, detailed interviews with school administrators and key informants (nurse, assistant principal, teacher, counselor) as identified by the principals (See attached Key Themes flyer, pg. 35), and observing teacher meetings about student mental health and preparing a report of the teachers' needs (See attached report, pgs 32-33)

In response to information collected above we also did the following:

- Identified national-level support from the National Center for School Mental Health at the University of Maryland, School of Medicine regarding support for school nurses and other school health providers on student mental health, assessment, and support for referral.

- Developed a school flyer for communicating with school principals and schools nurses/health providers to increase awareness of resources for mental health training appropriate for school health providers (See attached flyer, pg. 36)

- Identified university support from USC Dept of Psychology for partnering to implement a mentoring intervention: Check and Connect (C&C) is regarded as a highly effective, research-based, preventive intervention that schools can use to support students at risk for school disengagement. Gathered C&C training materials, met with C&C trainers, recruited six USC psychology students interested in implementing C&C in the spring, and developed a school flyer for outreach in schools to recruit existing school staff for training on C&C to promote sustainability of the program (See attached flyer, pg. 37)

- Identified training supports for teachers, including online training modules for understanding how students' mental health manifests in the classroom (provided free of charge by North Carolina Department of Public Instruction), identified intervention programs for teachers including classroom-wide and student-specific brief intervention strategies that support teachers' management of student mental health issues presenting barriers to learning (from the Center for Adolescent Research in Schools), and developed a flyer to be used to promote awareness of teachers selecting to engage in these trainings and implementation resources (See attached, pg. 38) to increase teacher awareness of mental health training and resources appropriate for educators.
- Developing a resource list of mental health supports for schools, youth and families for dissemination at end of the academic year

Recommendations

Based on the activities and results from fall 2014 activities of the MH component (outlined above,

with accompanying documentation) the following objectives are recommended to meet the needs of Kershaw schools and communities to strengthen mental health supports in the schools in the Northeast region of Kershaw County. Please note that the resources have already been obtained to accomplish the following activities based on the approval and recommendations of the school district and participating schools:

- **Implementation of the research-based mentoring program Check & Connect that promotes school engagement among at risk students in North Central High School (NCHS) and North Central Middle School (NCMS).** Implementation will be provided weekly by a C&C mentor from USC's psychology department for the duration of the school year and will be provided to students that NCHS and NCMS identify as being at risk and in need of the mentoring program based on disciplinary infractions and poor academic functioning.

- **Weekly, on-site school personnel MH facilitation at NCHS and NCMS to support the school nurse and teachers** as needed with training, implementation support, and resources to support their understanding and implementation of evidence-based practices and programs to support student mental health. Onsite mental health facilitation will be provided by LWK's MH facilitator one day per week and includes school mental health promotion, outreach to the school nurse and teachers, promotion of training and resources, provision of training and resources (e.g., Check & Connect, online training modules for teachers and MH-Tips training and resources for school nurse) as determined through partnership with the schools.

- **Weekly, on-site MH facilitation at Midway Elementary School to support strengthening their existing mental health initiatives.** Onsite MH facilitation will be provided by LWK's MH facilitator one day per week and includes support for: Positive Behavioral Intervention and Support (PBIS) through providing their PBIS team assessment tools and resources and direct support of teachers to implement existing PBIS practices; Parent educator programming through providing their school counselor and parent educator with training and resources; and outreach to the school nurse (who also serves Bethune and Mt. Pisgah Elementary school) with MH-Tips training and resources and implementation support as determined through partnership with the schools.

- Further information collecting from community mental health providers serving schools ' (via the above activities) to complete **resource list of mental health supports for schools, youth and families** for dissemination at end of academic year.

A Brief Report on Teacher Perspectives on Student Needs

Melissa George , Ph.D., CFLE, University of South Carolina

Although schools focus on instructional content and effective delivery to support academic achievement and student success, there has also been a growing recognition that schools must attend to non-academic barriers to student learning in order to fulfill their educational mission. Teachers are responsible for understanding and accommodating individual differences as they impact student learning making teachers aware of the links between health, mental health, and school performance (SC DOE, 2011). In recent decades teachers have become frontline mental health providers and the school setting has been championed as the best way to reach youth and families. This is because of the significant gap between youth in need and youth who actually receive effective services. For example, 20% of students experience mental health concerns that impair functioning at home, school, and/or in the community and 10% have more severe challenges that impact daily functioning, yet fewer than 1/3 of those in need receive help (Merikangas et al., 2010; 2011). Of those youth who do receive help, the majority receive services at school, so building schools' capacity to support students' comprehensive health is a central priority of research, practice and policy. Assessing and supporting teachers' perspectives on student mental health needs and their own related professional development needs are crucial components of building competencies for schools to support student success.

As Livewell Kershaw has been conducting community needs assessment and evaluation to inform the development of a school-based health clinic, understanding and informing teachers' professional development needs is at the forefront of supporting student comprehensive health. School personnel at a local school convened to discuss student strengths and weaknesses specific to recent student cohorts in order to identify the greatest needs with recommendations for supporting these student needs. Themes and recommendations are important to consider as Livewell Kershaw develops a school-based health clinic to serve residents in the North Central region of Kershaw County. A recent meeting of teachers resulted in consensus on the biggest issues facing their students including recognition that students are: (1) struggling with significant emotional issues, low motivation and apathy; (2) unprepared and lacking appropriate academic skills; (3) lacking individual responsibility for learning and (4) lacking social and behavioral skills -all of which pose a huge problem for managing classroom behavior. Teachers identified that these overlapping challenges are difficult to unravel most likely as a result of students' lack of family and community support resources. They also shared their difficulties handling these student challenges as it is nearly impossible to teach new academic and behavioral skills and

content to students who are far behind and in need of foundational skills training. Further, teachers indicated a lack of understanding when poor academic performance or behavior is associated with a mental health difficulty and an inability to know how to respond for fear of exacerbating underlying emotional issues.

Although schools must strengthen relationships with community partners to support their students' comprehensive needs, improving professional development opportunities for teachers to assess, identify, and/or refer or respond to student health and mental health needs is critically important as teachers are charged with reducing non-academic barriers to student learning. Teachers' abilities to identify student mental health needs and use evidence-based strategies for supporting positive behavior in the classroom are crucial for supporting youth and should be considered in developing a school-based health clinic to increase access to health services for youth.

References

Merikangas, K. R., He, J. P., Burstein, M., Swanson, S. A., Avenevoli, S., Cui, L., ... & Swendsen, J. (2010). Lifetime prevalence of mental disorders in US adolescents: results from the National Comorbidity Survey Replication–Adolescent Supplement (NCS-A). Journal of the American Academy of Child & Adolescent Psychiatry, 49(10), 980-989.

Merikangas, K. R., He, J. P., Burstein, M., Swendsen, J., Avenevoli, S., Case, B., ... & Olfson, M. (2011). Service utilization for lifetime mental disorders in US adolescents: results of the National Comorbidity Survey–Adolescent Supplement (NCS-A). Journal of the American Academy of Child & Adolescent Psychiatry, 50(1), 32-45.

South Carolina Department of Education (2011). South Carolina Healthy Schools Program Brochure: Working together for health and learning. Obtained from:

http://ed.sc.gov/agency/se/Instructional-Practices-and-Evaluations/documents/ HealthySchoolsBrochure2011.pdf

See Mental Health flyers on pages 34 - 38.

LiveWell KERSHAW

Strengthening Mental Health in Schools

Building effective multi-tiered systems of support involving promotion, prevention, early intervention and intervention

Helping to reduce and remove barriers to learning

Connecting to national and international initiatives on the most effective strategies for mental health in schools

Interacting with schools, families, students and community stakeholders to identify community strengths and needs

Mapping existing initiatives and identifying gaps and overlap

Supporting and helping to strengthen decision-making teams in schools

Helping school teams, school counseling, and mental health staff with data-based decision making and implementing evidence-based practices

Documenting outcomes of school mental health programs on goals that are priorities for schools, families, and communities (e.g., attendance, school behavior, grades, promotion)

Building ways for school mental health to connect with, support and strengthen other health promotion initiatives

Helping school and youth serving system leaders and stakeholders, and youth and families connect with mental health supports across SC

Providing training and implementation support to implement the best and most effective practices for serving youth and families

SC School Behavioral Health Community
Connecting Schools, Families and Mental Health

University of South Carolina School Mental Health Team

For more information: Melissa George, Ph.D, CFLE; georgemr@mailbox.sc.edu; 803.777.3838

Strengthening Mental Health Supports in Schools

LiveWell KERSHAW

Key Themes from North Central Schools

Existing strengths for supporting mental health in schools

- ⇒ Partnerships with churches are vital
- ⇒ Informal mentoring from teachers is ongoing
- ⇒ Strong sense of school community
- ⇒ School teams: Advisory student-teacher teams and PBIS & RTI teams, parent educators
- ⇒ Students are well-behaved, respectful, & cooperative; strong sense of community

Themes gathered from school district personnel, school administrators, nurses, counselors, & teachers at North Central High, North Central Middle, and Baron Dekalb, Bethune, Midway, & Mt. Pisgah Elementary Schools

Areas that need to be addressed to improve student learning

- ⇒ Adequate student nutrition, living conditions, and health care
- ⇒ Building supportive relationships between students and adults
- ⇒ Increasing school communication with families
- ⇒ Supporting families' health & well-being and their support for education
- ⇒ Increasing supports for students' mental health needs
- ⇒ Address overwhelming responsibilities & pressures on teachers
- ⇒ Finding ways to consistently get students to school & remove transportation barriers

Recommendations for strengthening students' mental health in schools

- ⇒ **Provide health & mental health programs & services for families**
  - ⇒ Provide families with free health items at athletic events
  - ⇒ Family outreach through existing events such as Annual free physicals day, Open House, and Registration
  - ⇒ Parent education programs & parenting workshops
  - ⇒ Parent small group supports during school day
- ⇒ **Provide school personnel with ways to support students**
  - ⇒ Have teachers teach student life skills, especially financial & social skills
  - ⇒ Adult mentors to check in with students regularly
  - ⇒ Teacher strategies for supporting mental health in classroom
- ⇒ **Remove barriers to students receiving mental health counseling**
  - ⇒ More mental health professionals
  - ⇒ More time from existing mental health professionals
  - ⇒ Streamline intake procedures for mental health services
  - ⇒ Provide on-site counseling and therapy supports
  - ⇒ Target students with specific needs: English language learners, families in poverty, 9th graders, student medication management, etc.
- ⇒ **Organize cultural events for community to support exposure to arts, music & theater**

For more information: Melissa George, Ph.D, CFLE; georgemr@mailbox.sc.edu; 803.777.3838

Mental Health Training Intervention for Health Providers in Schools (MH-TIPS)

LiveWell KERSHAW

What is MH-TIPS?
Online training and implementation support system for school health providers to enhance your competence in promoting student mental health and managing the needs of students with or at risk for emotional and behavioral difficulties that may interfere with learning.

What do I get from MH-TIPS?
The MH-TIPS training consists of a series of modules (12 total training hours) designed for school-based health care providers free of charge. The online training allows you to work at your own pace. You can view training modules, download materials, view video tips from experts, and explore related links, all from one central site.

How do I get started?
Register now and complete the registration survey to access the course!

The National Association of School Nurses and Center for School Mental Health are joint providers of this training.

Go to: https://mdbehavioralhealth.com/

Here's what you'll find on the MH-TIPS training site:

Training
Course information, broken down by module, including course description, learning objectives, test instructions, and CEU material.

Implementation Resources
Free downloadable materials, which can be selected by topic, and tips from trainers

University of Maryland School of Medicine | Maryland Behavioral Health | CSMH

For more information: Melissa George, Ph.D, CFLE; georgemr@mailbox.sc.edu; 803.777.3838

Check & Connect

LiveWell KERSHAW

A Comprehensive Student Engagement Intervention

What is Check & Connect?

It's a research-based mentoring program that promotes student engagement and competence in school. Mentors provide support for academic and behavioral needs through monitoring of behaviors, regular brief meetings, and problem solving with students. It is designed to:

- ↑ Increase attendance, persistence in school, accrual of credits, and school completion rates
- ↓ Decrease truancy, tardies, behavioral referrals, & dropout rates

How does it work?

- Mentors monitor student absences, grades, and behavior weekly
- Mentors meet weekly to check in with students and provide feedback on school behaviors and performance
- If needed, mentors collaborate with school staff to identify and provide additional supports for students

How much time is involved?

Training:

- One 30-45 minute initial training session.
- Ongoing, brief coaching sessions (5-10 min) for a few weeks

Mentoring: About 30 minutes per week

- 10 minutes to gather student information
- 10-15 minutes to meet with the student
- Additional time to coordinate supports for students with additional needs (for example, talk to math teacher about student using a missing assignment tracker to monitor turning in assignments)

Mentor Characteristics

- Willing to be a mentor!
- A positive and supportive perspective toward working with students to improve school behaviors
- Willing to cooperate and collaborate with school staff to find creative solutions and promote student success

For more information: Melissa George, Ph.D, CFLE; georgemr@mailbox.sc.edu; 803.777.3838

Strengthening Mental Health in Kershaw Schools

LiveWell KERSHAW

Supporting Student Mental Health: Resources for Teachers

1 in 5 students experience mental health concerns that impair functioning at school

When students experience mental health concerns it creates barriers to their learning & impacts the learning environment of others

Because of this, you probably already know….
It's important for teachers to understand & be equipped to address student's mental health concerns as they impact behavior or performance challenges in the classroom

Did you know that teachers are recognized as our frontline providers of mental health supports for youth?

What you may not know is…
there are a number of free trainings, resources and support for teachers to do this

- ⇒ **Check & Connect Mentoring Program**
- ⇒ **Online training on student mental health**
- ⇒ **Other classroom interventions:**
  - ⇒ **Routines**
  - ⇒ **Positive Interactions**
  - ⇒ **De-Escalation Strategies**
  - ⇒ **Opportunities to Respond**
  - ⇒ **Curriculum Interventions**
  - ⇒ **Accommodations**
  - ⇒ **Organizational Strategies**
  - ⇒ **Study Skills Strategies**

That's right, there are online trainings on students' mental health in the classroom designed for teachers, mentoring based programs to support student-teacher relationships, and evidence-based instructional and classroom-based interventions

If you would like to learn more about programs or receive brief trainings or resources, please email or stop by to see Melissa in the Livewell Kershaw office

Melissa George, Ph.D, CFLE; georgemr@mailbox.sc.edu; 803.777.3838

Team Orientation Report

December 4, 2014

(Team members in alphabetical order): Sheri Baytes, Joseph Bruce, Larisa Bruner, Cheryl Cobb, Ibrahim Demir, Abdulaye Diedhiou, Melissa George, Holly Hayes, Whitney Hinson, Grant Jackson, Jeana Johnson, Kelly Kavanaugh, Jesus Martinez, Meredith Oliver, Theresa Oniffery, Andy Pope, Lillian Smith, Cheryl Stover, Kelly Warnock, Susan Witkowski

LiveWell Kershaw is a coalition to improve population health in Kershaw County, South Carolina

CONTENT:

- Hopes and Expectations
- Key Nuggets from Presentations
- Questions/Clarifications
- Drafted Rules of Engagement
- Additional Information
- Evaluation Summary
- Links to Powerpoint presentations
- Contacts

Hopes & Expectations

- Build foundation to start work
- Names/skill-sets
- How Hispanic background can help with LiveWell Kershaw
- Passion for our own people; give back
- Divine calling
- What activities are planned to reach goals
- See big picture
- Get to know everyone

Key Nuggets from Presentations

- Don't be held back by low expectations – have the highest possible expectations and we will show the country how this community will transform population health.
- Best experience is when community comes to you
- Community has to drive the bus
- We serve as ambassadors in our community
- Community Health Worker – live, worship or work in the area. Needed people that lived in the community, no social workers in the area applied.
- We need decorative lab/flak jackets – want to be prepared
- Quickness doesn't always mean it's right
- 1 in 4 youth have clinically significant mental health problems
- Expectation is building the foundation; people are the rebar in the concrete
- December 18th – clinic in Mt. Pisgah and Abney Baptist
- December 29th – crisis intervention training
- Population of North Central Area is 14,070

- Estimated travel cost was around $35,000 and loss of wages totaled $400,000 for visits to Community Medical Clinic from the North Central Area over a two year period.
- We will treat everyone – we are citizens of the community

Questions/Clarifications

- Combination of paid staff and volunteer will provide services
- Consider working with alternative school
- Population = 14,070 folks. Did we reach this?
- Schools will receive findings from mental health assessment
- Treat everyone (regardless of documentation); citizens of the community
- Spanish translation
- Find places of employment

Drafted Rules of Engagement

Agreed Upon Rules:

- Trust each other
- Be bold
- Culture of learning
- Everyone respects the expertise and time of the group
- No irrelevant questions; safe place
- Respect different styles; allow thinking time
- Respect process
- Meetings to keep "wagon on the road" and not in the ditch
- Clarification of terms and language

Additional Rules for Consideration:

- To listen
- To be ready to help in any way possible
- To communicate as clearly and as openly as possible
- Lots of expertise for all people
- Responding to questions
- Be respectful/considerate of time
- Trust of each other/respect diversity
- Don't be held back
- Central place for roles and responsibilities
- Central avenue for questions
- Asset assessment of group
- Respect for individuals' skills
- Trust your peers
- Patience
- Language
- Calling on each other for support and resources
- Strong work ethics for everyone
- High expectations and accountability
- Mutual respect of each members' strengths and expertise

Additional Information: How We Can Communicate & Work Together as a Team

What are the 3 greatest challenges you have experienced in engagement and communication within the past 90 days (with this team or other teams)?

- Lack of truly being concerned about other's position
- Lack of engagement of present issue
- Lack of good/great (any) customer service
- Lack of a true desire to come to a mutually beneficial understanding
- Clarification of terms/language in clear roles and responsibilities
- Lack of a forum for communication to identify how "my piece" fits with other pieces (e.g. like we're having the opportunity to do today!)
- Uncertainty about who to connect with or follow-up with about specific questions
- Lack of knowledge of who is on the team, where we're going, how we should move forward "on the bus" together
- Respect with one another
- Understanding your title/job
- Having the information about the services that are offered out there
- Gaining trust of the community
- Establishing locations for hubs in the 5 key areas for clients/patients to come for care
- Clearly stated needs from other team members
- Delayed response to/from team
- Expressing urgency of an answer from team
- Lack of respect for members' skill-sets/expertise
- Miscommunication about members' roles in the group
- Meetings not ending on time

- Not allowing enough time for a meeting
- Rushing to prepare for a meeting
- Lack of follow-up
- Inconsistency
- Transparency
- Not being clear on each person's roles and responsibilities
- Poor communication about big decisions
- The belief that consensus is required, which delays action
- Micromanagement and/or not having the freedom to accomplish a task; I would do it, but someone dictating how it will be done
- Value diversity!

If you could go back in time, what would you change?

- The understanding would be clear on the front side of the agreement/ interaction/relationship
- All pertinent information be available and included
- How to deal with problems
- Understand how it affects/helps with the economy
- Establish timeline and stick with it
- Establish strategies followed by a clear tactical response
- Clearly communicate roles of group members
- All members would respect the expertise each person brings to the table
- What's expected of you at a meeting and time to prepare

Evaluation Summary

What worked at the team orientation:

- Group process with individual contributions
- Agenda
- Rapid presentations
- Notebook with handouts
- Setting
- Materials
- Snacks
- The organization and pace was great. The meeting moved along quickly and didn't seem as long as the actual time.
- Liked the ice breaker
- Reflection with quotes
- Group photo
- Everything
- Presentations – great
- Notebook – great
- Thanks for toys!
- Everything was great
- Introductions, knowing what people do/resources
- The format
- Time
- Content
- Good, varied format for sharing
- Good use of ice breaker/introductions for helping to practice what we preach about community engagement
- Awesome to use "Hopes and Expectations" activity
- Stayed to agenda
- Got to meet faces behind names

Changes or upgrades for future meetings:

- Need to have theory/models in short clips
- While Ibrahim's presentation was too long, it came together at the end. Need to work with researchers to represent work succinctly and meaningfully
- Need more time
- Lunch!
- None
- Wouldn't change much. Could do with less ice breaker exercise but it moved quickly and served the purpose
- Presentations were good but some people were trying to squeeze too much into a short amount of time
- Clicker for presentations in the future
- Nothing
- More time for rapid presentations
- Coffee
- Lunch or meal
- Shorter meetings
- Full day!
- Opportunities for small group discussion/"work meetings"
- Really everything was great!

Links to Powerpoint Presentations

LiveWell Kershaw History:
https://ophp.egnyte.com/dl/E2b3EmsB3O

Community Engagement:
https://ophp.egnyte.com/dl/tjWbiRdthA

Developmental Evaluation:
https://ophp.egnyte.com/dl/b3sdrEXoRu

Mental Health:
https://ophp.egnyte.com/dl/NOXJpj2AVB

Health Economics:
https://ophp.egnyte.com/dl/OSt6ItYmsw

Communications:
https://ophp.egnyte.com/dl/rV2b9nqn64

For assistance downloading please contact:
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Community Medical Clinic of Kershaw County
Strategic Planning Session

January 29, 2015

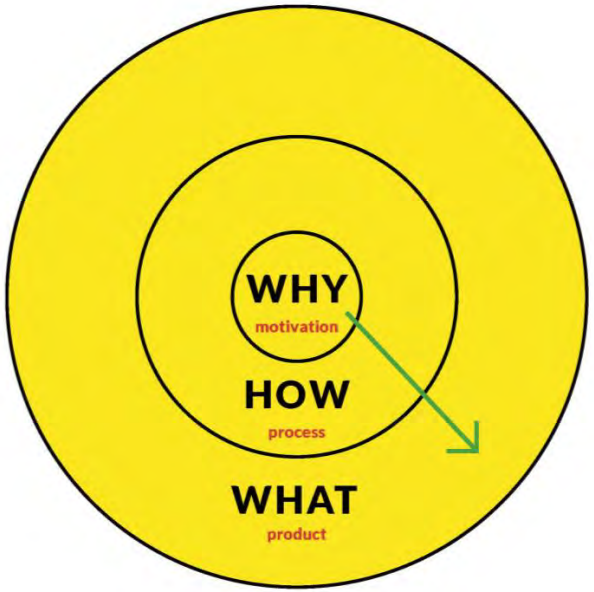
"We are committed to increasing the number of clients becoming patients at the Community Medical Clinic."

Participants: Karen Baker, Sheri Baytes, Geraldine Carter, Cheryl Cobb, Janice Coley, Susan Grombach, Gina Johnson, Jesus Martinez, Meredith Oliver, Sarah Oliver, Leigh Reed, Becky Tompkins, Kelly Warnock, Jessica Wilkes, Susan Witkowski

The following report summarizes the collective wisdom of the participants in answering:

What must we do to increase the number of patients moving from a screening visit to a medical visit?

The Golden Circle



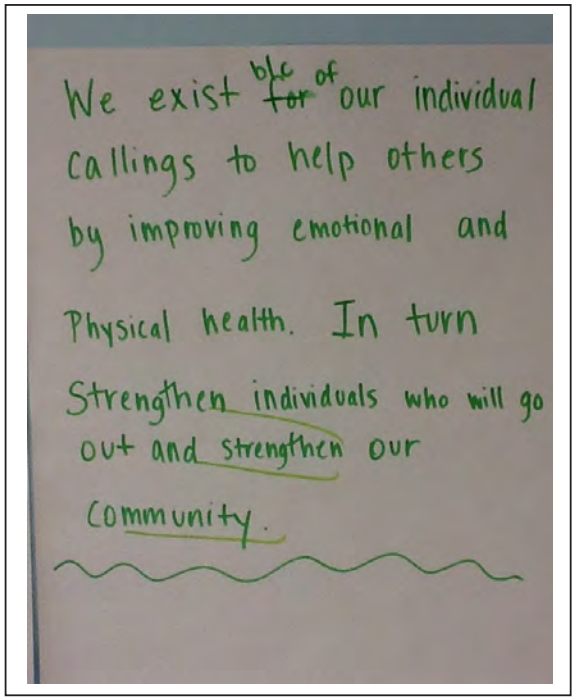
Session question: ***Why does CMC exist?***

- To receive healthcare and **be a voice** that is recognized for those in crisis and impoverished
- The clinic is here to **bridge the GAP** in healthcare among the uninsured of Kershaw County and to facilitate access to care options with the added benefit of improve overall health of the community which decreases health care costs
    - Why: Increase overall health which in turn decreases healthcare costs
- We exist because of our individual callings to help others by improving emotional and physical health. In turn, **strengthen individuals** who will go out and strengthen our community.
- To meet and unmet need and **provide hope** and improved health of Kershaw County
- To **provide HOPE and CARE** for the uninsured of Kershaw County with respect and dignity.

Looking at the "why"…

How will we express the "why" to our clients?

- Magnet/calendar with the "why" – give them something
- Take folks aside to discuss paperwork, compassionate process
- 4 mornings on site?
- Get contact information and set appointment before they leave
- Different points of access – compassionate listening
- Training with volunteers about greeting
- Personalize front desk
- Getting basic information while captive office
- Give volunteers opportunities to change – agile
- Where do you think you'll have trouble?
- Person for SS card
- Computer station (protected -> check stubs)
- Pre-printed SS card forms
- Info sheet on where to go
- Consolidating
- Who is the point of contact if lost in process?
- Proactively focus on health un-insured



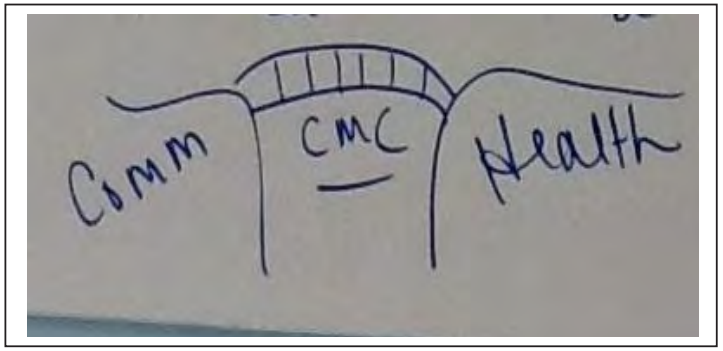
Looking at the "why"…

Which of these will give us the most momentum?

- Intake form
- Taking person to the site
- Review paperwork with person and set up first appointment
- Consolidate appointments
- Provide a point of contact

What will this mean to the community?

- If we strengthen the person, it will strengthen the community
- Whatever happens here, gets reflected in the community
- Need to also focus on healthy uninsured



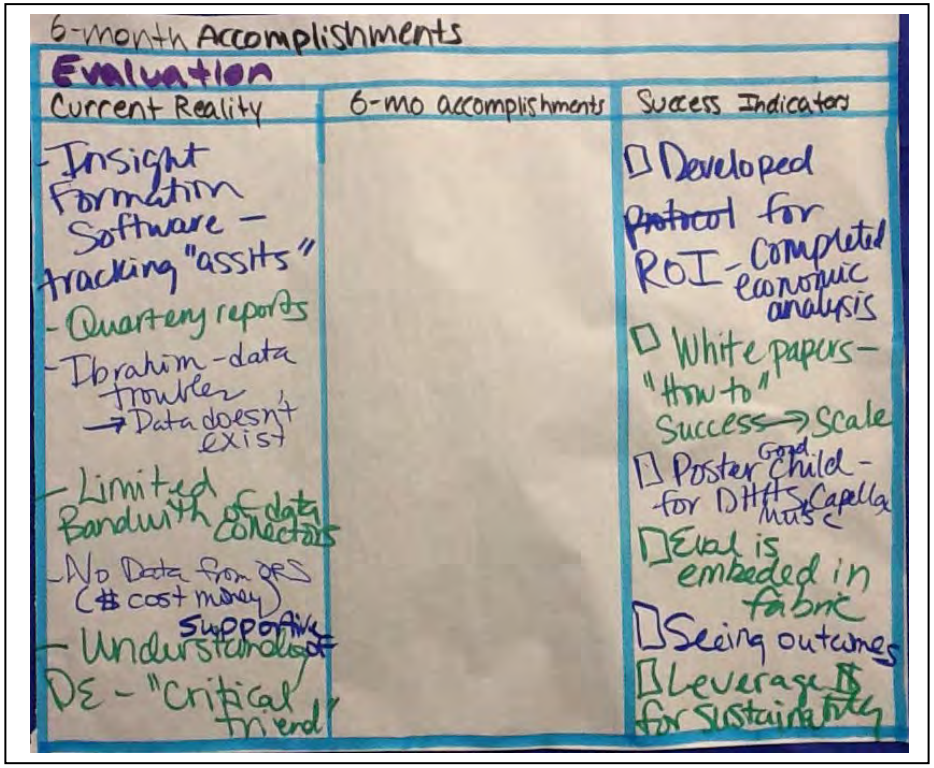
Takeaways

What are we going to do as an individual to create the shift?

- Doing a better job of letting them know where they need to go
- Explain it to them better and ask if they have any questions
- Marketing plan – needs to go way past to where it makes a difference
- Focus on the "why", not the what. How you made them feel
- Identify the hurdles they'll have trouble achieving
- Not throwing out a list of what they need to do but be more compassionate
- Becoming more humble and getting down to where they are
- Help however I can. Make people feel respected
- Explore the people you know. Figuring out a good way to help them
- If I know there is a barrier, or any up-coming changes, try to help them in process
- If someone doesn't have their SS card, go ahead and do application then and then follow-up with screening
- It's about the first impression and to carry the "why" over
- Problems with the front aren't any different than in any other place in the county. Lots of opportunities for change.
- Improving our first impression, making them feel more welcome, and consolidating as much while they're in the building
- There are other systems out there that we have no control of that affect the way we do business. We must get in touch with those people.

North Central Initiative Team
Strategic Planning Session

January 21, 2015



Participants: Joseph Bruce, Holly Hayes, Whitney Hinson, Kelly Kavanaugh, Andy Pope, Cheryl Stover, Kelly Warnock, Susan Witkowski

The following report summarizes the collective wisdom of the participants in answering:
What must we do between now and June 1st to consider Year 1 of this contract an overwhelming success?

Six-Month Accomplishments

What must we do between now and June 1st to consider Year 1 of this contract and overwhelming success?

Session question: ***What will be our specific, measurable accomplishments for the next six months?***

Strategic Direction:

COMMUNITY ENGAGEMENT (GRANT, WHITNEY, ANDY)

Current Reality	Six-Month Accomplishments	Success Indicators
* Isolation * Disparate systems * Distrust * Get naked in church * Generating hunger "we need it" * 5 community folks interested	**1. "Get to know" LWK events, presentations to clubs (naturally forming groups)** **2. Calendar of community events** **3. Local mission in backyard** **4. Advisory Board met within 30 days, not hap-hazard, 1 person representing each target area** **5. Community members visit each mobile site** **6. Communication plan is DONE** **7. Website/social media presence** **8. Meet with Ron Underwood (Baptist Association)** **9. Publicize successes at each site in positive way** **10. Client survey/site survey – interested in participating in Advisory Board**	☑ Model others > They want to share ☑ Notices, bulletins in place – HEAL ☑ Well-defined group of participants directing Community Advisory Board ☑ Life-blood of LWK is community engagement ☑ Work ourselves out of a job ☑ Diverse groups working together to provide services in systematic way (every Wed) ☑ More folks than can fill the spots

Six-Month Accomplishments

Strategic Direction: *CLINICAL (KELLY W, SUSAN)*		
Current Reality	**Six-Month Accomplishments**	**Success Indicators**
* Synergy – HOP, AK, LWK * 4 mobile sites + RHC presence * Defined group * 3 CHWs * Medical Director * NPs can deliver care * Worked out IT logistics * Shortage of referral resources (specialists)	**1. Initiated meeting with MUSC about provider rotation** **2. CHWs and NPs are certified to start billing** **3. 6 outreach sites are in place** **4. Phone calls to all self-pays using ER in NCI area, call all HOP patients weekly** **5. ID barriers/policies for eligibility** **6. Schedule created for ≥1 NP at site** **7. Re-visit SBHC info and determine which is required for compliance regulations**	☑ Clinical integration with MUSC ☑ ≥ SBHCs in place ☑ 8-10 mobile outreach sites with onsite medical ☑ Sites are part of fabric for healthcare ☑ 20% of encounters are billable ☑ Provider capacity fulfills need

Six-Month Accomplishments

Strategic Direction:

EVALUATION (HOLLY, KELLY K, IBRAHIM, THERESA)

Current Reality	Six-Month Accomplishments	Success Indicators
* Insight Formation software – tracking "assists" * Quarterly reports * Ibrahim – data troubles. Data doesn't exist * Limited bandwidth of data connectors * No data from ORS ($ cost money) * Supportive and understanding of DE – "critical friend"	**1. On-ground presence** **2. Capturing all cost data for mobile visits** **3. Kick-off for Insight-Vision with dashboard reports** **4. Data entered into Insight-Vision** **5. Determine what's really important for in-depth documentation** **6. Report in "laymans" terms that CHW/mobile clinic was a success – site specific** **7. Presentation with pastors on results (facility use agreements run out in May)** **8. Share with CE group** **9. Meeting with school board and approval** **10. Finalize indicators** **11. Process and schedule to send information to Ibrahim – Face to face meeting** **12. Monthly dashboard reports – NCI specific**	☑ Developed ROI for completed economic analysis ☑ White papers "how to" success > scale ☑ Good poster child for DHHS, Capella, MUSC ☑ Seeing outcomes ☑ Leverage $ for sustainability

Six-Month Accomplishments

Strategic Direction:

PROJECT MANAGEMENT/INTEGRATION (CHERYL)

Current Reality	Six-Month Accomplishments	Success Indicators
* Intake process established * Cheryl started 12/1 * No clear direction of mental health component * CHWs live, work, worship in area * Mobile visit schedule is in place * Monthly team meetings * Reports to DHHS * Budget is not fully maxed out	**1. Figure out centralized calendar/documentation** **2. Meeting with Mel George to set goals and expectations** **3. Standard Operating Procedure – developing materials** **4. Specific metrics complied for each quarter** **5. Tracking and monitoring meetings take place with groups to keep each other accountable** **6. Report goes to DHHS, team adjusted to increased utility** **7. Job descriptions for each team member in writing** **8. Working with Community Advisory Board to develop sustainability plan** **9. Clear evaluation/PM team**	☑ Poster child of DHHS ☑ Standardize seamless process is in place for data collection ☑ Understand everyone's role ☑ Obtain additional grant $ to expand ☑ Funds maximized to fullest ☑ Clear transition plan – community ownership, sustainability ☑ Low-turnover

Six-Month Accomplishments

Team Name: *MENTAL HEALTH COMPONENT (MEL)*		
Current Reality	**6 Month Accomplishments**	**Success Indicators**
•Supporting all 6 NCI schools is not feasible with the demands of data collection, assessment and resource mapping, let along the consultation and implementation planned for spring. Supporting 2-3 of the schools seems the max that is manageable. •MH component is operating separately although could be integrated with health efforts •Need feedback on direction of MH component to ensure success indicators •In need of formalized ways to check in regarding progress (with Cheryl, Andy, and who else?) •Uncertainty of USC-School partnership to implement C & C given need for building relationships with district/ approval •Not being in schools in formalized way is challenging and need to prioritize this	**• Implementation of mentoring program Check & Connect at NCHS & NCMS through USC partnership** **• Weekly, on-site facilitation at NCHS & NCMS for school nurse including Mental Health Training Intervention for Health Providers in Schools (MH-Tips)** **• Weekly, on-site facilitation at NCHS & NCMS for teachers including school mental health promotion, provision of training and resources (e.g., Check & Connect, online training modules)** **• Weekly, on-site facilitation, training, and resources at Midway Elem to support: Positive Behavioral Intervention and Support (PBIS), Parent educator programming, and MH-Tips for school nurse (who also serves Bethune and Mt. Pisgah Elementary)** **• Further information collecting from community mental health providers to complete resource list of mental health supports for schools, youth and families** **• Learning from Community Health Workers about their needs, through participating in "clinic days"**	• Providing Check & Connect intervention in 2 schools • Providing on-site facilitation, training and resources for school nurses and teachers, parent educators or PBIS teams for 3 schools • Developed MH Resources List for schools, youth and families • Connect with CHWs to understand impact of patient MH needs in their practice and needs for training or resources

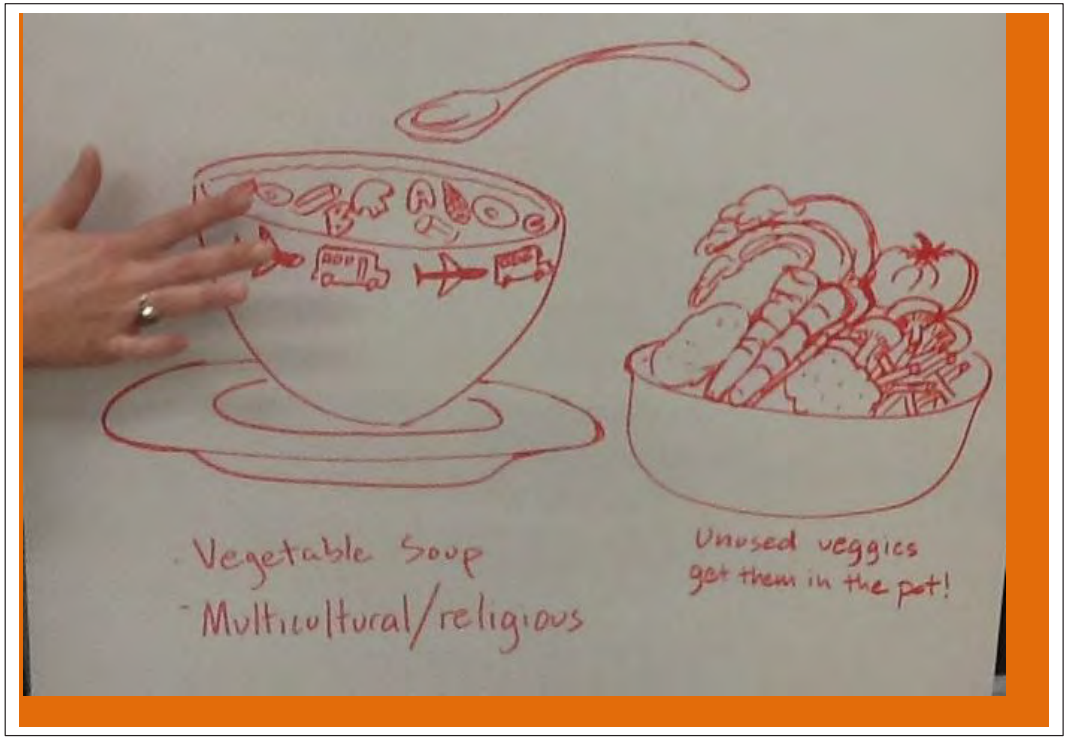
Next Steps

- Each group will develop a timeline based on 6-month accomplishments
  - Cheryl will work with Melissa to complete mental health accomplishments/timeline
- **All timelines due to Cheryl by next Wednesday, January 28th.**

De-Brief on Quarter 3 – Team Meeting

February 25, 2015, 2:00 – 4:00 PM, North Central High School

Participants: Karen Baker, Cheryl Cobb, Melissa George, Whitney Hinson, Holly Hayes, Grant Jackson, Jesus Martinez, Andy Pope, Cheryl Stover, Kelly Warnock and Susan Witkowski



Key Components to Enhance LiveWell Kershaw:

- Integration of mental health in everything
- Effective community engagement
- Utilize Community Health Workers to enhance access
- Offering Tier 1/ Tier 2 services to reduce use of Tier 3 services of appropriate use of services
- Include capacity across systems
- Empowering community members

"I'm extraordinarily confident in the role each of you play in LiveWell Kershaw and I'm so excited about what you are doing. ***Just go and do it; let it be a ripple effect to counties and communities to learn from you."***

Joseph Bruce (retiring from Kershaw Health on 3.13.2015)

Site Name –	Positives	Negatives	Specific Opportunities
Mobile Clinic (rotates monthly)	100% appointment shows, CHW working in the operations, Healthy Checkups being offered to every client, great teamwork, wonderful	Technology, fax, connectivity/internet, more marketing	Signs for clinic day (people don't believe that clinic is there)
Sandy Level (Friday)	Highest walk-ins, newest site, good location, 4.5 out of 5, people excited about us being there, great location	Smaller exam rooms, lots of storage	Have large dining area/kitchen
Cassatt (Monday)	Serve the biggest population and could have the largest ripple-effect, great interest from church goers, convenient to/off main highway, pastor has been cooperative, charitable church, community-oriented church	Church goers have disappeared, patients schedule but do not come for their appointments, cold, no volunteers, need more support from church members, not a lot of cell phone signal	Women's group is very active, Kathy (doll lady) could be strong advocate, reach more folks on the #1 Cassatt-Camden, Hard Times Café (marketing opportunity), Camden addresses can be served with this address when you look at map with their specific address
Mt. Moriah (Tuesday)	Covers large geography, accommodate large crowds, facilities has lots of potential for services	Not population-dense, it's In and out at the same time, not in center of geography, too far from the community, lots of down time	Possibly an evening site, outreach activity with women's fair, "work in progress"
Refuge (Wednesday)	Largest number of scheduled clients, large space for growth, in hot spot, volunteers, centrally located – great site, facility is good for clinical services, supportive church members, usually busy, interested parishioners, hot spot, large rooms with privacy, on main drag	More signage needed	Exercise program and classes, entrance/exits, outreach activities, kitchen for cooking classes, education
Abney (Thursday)	Helpful church goers, great facility, helpful church goers, usually busy, comfort level has been increased (originally worried about blood and clients being naked in church)	Most no shows are at this site, bridge is out which makes it not as convenient, church members are too friendly and need more privacy (glass window in room), site only passed by one vote with the deacons, two pastors have left within the last two years	Abney members are very active at North Central High, opportunity to change the perception of what clinical encounter looks like (misinformation)

Overall Operations	Great team work	Lots of down time, getting the message out, no fax	Signage (size, location of signs, getting folks in building);We need to be "walking signage"; Do qualifications, help with paperwork to become patient at the clinic; Need to determine message → free leads to no value, 8th grade reading level; Approving patients sending paperwork via email; Clean up protocol for sites;What is right number of staff per site? Need better ways to getting patients to come; Use calendar exclusively for appointments; Advertise more, more signage, advertising at locations and businesses

CRITICAL NEXT STEPS

- Move forward with CHW training
- Build the skills of the volunteers
- to spread the message
- Have every person sign up for Healthy Check Up
- Pass out flyers and talk to everyone, go back, and talk to them again (Engage Voc Rehab, county agency), provide booster sessions and training, distinguish between mobile clinic vs. community-based healthcare sites, attend church services and find out what is being currently offered, Determine what is our message and have a meeting so everyone knows what the message is

Our Fears

- We will stop or be stopped before the miracle happens
- Not reaching all 14,070 residents in North Central
- That we don't have sustainability
- People just "won't get it"
- We stop on May 31, 2017 and don't continue
- Current awareness of mental health supports does not increase
- People understand that there is not an easy quick solution to achieve healthier community, no quick fixes
- Being able to reach the people in the community who need assistance
- Working together as individuals to be a great team
- That we haven't reached everyone that can use our services
- Money to continue the project
- That we don't have full community buy-in
- That personality differences will hurt the vision and opportunity that is before us
- That we don't have a passion great enough to overcome our growing pains to evolve into what we need to become
- Community knowledge of mental health and mental health programs will not increase
- Retention of team members
- I don't have as much time to devote to LiveWell because EVERY community wants us to share with them the secrets of our success
- Going 100 mph trying to do too much
- Fear that funding and initiative from providers dries up
- Funds will no longer follow services

Additional Outreach Items

Letter to the Community:
January 13, 2015

The Community Medical Clinic (Free Clinic) in Camden, in collaboration with Access Kershaw is implementing a program called Livewell Kershaw in the North Central attendance area. Livewell Kershaw is committed to improving the health of the residents in the towns of Bethune, Cassatt, Liberty Hill, Kershaw, Westville, and the surrounding areas. A mobile medical clinic staffed with Community Health Workers and Nurse Practitioners will be available at area community centers and local churches to help identify any services for which you are eligible and also help you get enrolled into the Livewell program.

The Community-based Health Centers & Mobile Clinic will begin operating on January 19, 2015. If you are looking for health care, we will be able to screen you for eligibility for the Community Medical Clinic's mobile services. Our job is to help the uninsured or underinsured residents of Kershaw County navigate through the health care system. It is a completely free service to the clients and we would love to meet with you and assist you in this process.

We are available to help you find a doctor, find affordable medication options, apply for food stamps or Medicaid, and provide support and case management services for chronic diseases such as diabetes, high blood pressure, or COPD. Please see the attached brochure for locations, days, and times that the mobile services will be in your area.

If you are in need or know of someone in need of these services, please meet us at one of the community sites listed on the brochure or call us at 803-427-5206 or 803-272-8777 and we will help you register for the program.

Cheryl S. Stover, Ed.D
LiveWell Kershaw Project Manager

Kelly Warnock, FNP
LiveWell Kershaw and Access Kershaw

Susan Witkowski, Executive Director,COO
Community Medical Clinic of Kershaw County
LiveWell Kershaw Mobile Clinic

Letter to the Parents:
January 13, 2015

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Cheryl S. Stover, Ed.D
LiveWell Kershaw Project Manager

Kelly Warnock, FNP
LiveWell Kershaw and Access Kershaw

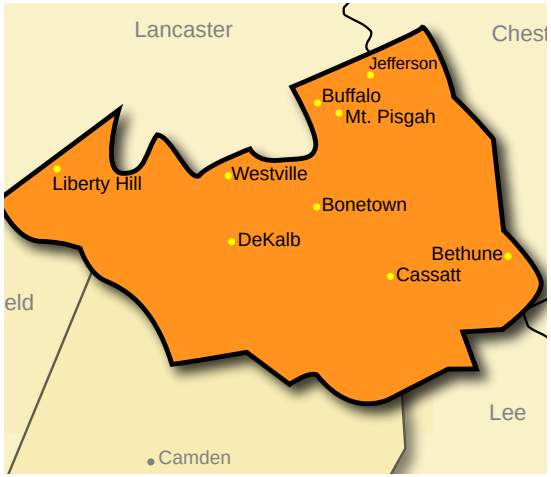
Susan Witkowski, Executive Director, COO
Community Medical Clinic of Kershaw County
LiveWell Kershaw Mobile Clinic

Weekday	**9:00 am - 1:00 pm**	**Address**
Mondays	Cassatt Baptist Church	2604 Hwy 1 North, Cassatt SC 29032
Tuesdays	Mt. Moriah Missionary Baptist Assn FEW Center	3045 John G. Richards Rd Liberty Hill SC 29074
Wednesdays	Refuge Baptist Church	2814 Lockhart Road, Kershaw SC 29067
Thursdays	Abney Baptist Church	3705 Roberts Road, Kershaw SC 29067
Fridays	By Appointment Only: 803-272-8777 Healthcare Place at Bethune	103 S. Main St. Bethune SC 29009

Volunteer Application

Today's Date:		**Birthdate:**
Printed Name: *(First, Middle, Last)*		
Address:		
Home Phone:	**Cell Phone:**	**Email:**
Special Skills:		
Job/Task Preferred: • Greeter _____ • Registrar_____ • Screener_____		**Day & Time Preferred:**
Emergency Contact Name:		**Emergency Contact Number:**
Any Health Issues:		**Retired: _____Yes _____No**
Employer:		**Work Phone:**
Signature:		

Trifold Brochure:



North Central Target Area

LiveWell Kershaw (LWK) is a coalition of healthcare providers, businesses, schools, churches, and local citizens working together to make Kershaw County the healthiest in the state. The LiveWell project will focus primarily on the North Central geographical area, identified as an "environmental hotspot" for heart disease, high blood pressure, diabetes, and behavioral health conditions.

LiveWell KERSHAW

For information:
803-272-8325

facebook.com/LiveWellKershaw

twitter.com/lwkershaw

livewellkershaw.org

LiveWell KERSHAW

"To improve population health in Kershaw County."

Community Healthcare Sites

North Central Initiative

For information:
803-272-8325

Trifold Brochure pg 2:

LiveWell Kershaw Community Healthcare Sites

- Are you uninsured? Need help with medications?
- Are you diabetic? Have high blood pressure?
- Do you need to be connected with a healthcare provider?
- Do you need to apply for Medicare, Medicaid, Welvista, or SNAP?
- Do you need assistance managing your overall health and well-being?

LiveWell Kershaw Community Healthcare Sites operate as an extension of the Community Medical Clinic of Kershaw County, Access Kershaw, and KershawHealth. Our goals include connecting individuals with ongoing healthcare services as needed, providing access and information to community members, and extending primary care into the community.

Community Health Workers (CHWs) will be at the following sites to assist you weekdays from 9:00 AM to 1:00 PM.

Day	Location	Address
Monday	Cassatt Baptist Church	2604 Hwy 1 North Cassatt, SC 29032
Tuesday	Mt. Moriah Missionary Baptist Association FEW Center	3045 John G. Richards Rd Liberty Hill, SC 29074
Wednesday	Refuge Baptist Church	2814 Lockhart Road Kershaw, SC 29067
Thursday	Abney Baptist Church	3705 Roberts Road Kershaw, SC 29067
Friday	Sandy Level Baptist Church	2920 Timrod Road Bethune, SC 29009

For information: 803-272-8325; livewellkershaw.org

access kershaw
opening doors to health

COMMUNITY MEDICAL CLINIC

KershawHealth

Confidentiality Non-Disclosure Agreement

As an extension of Community Medical Clinic of Kershaw County, the LiveWell Kershaw Project has a legal and ethical responsibility to safeguard the privacy of all patients and protect the confidentiality of information. In the course of my assignment in the LiveWell Kershaw Project, I may come into possession of confidential patient information, even though I may not be directly involved in providing patient services. I may also come into contact with non-patient confidential information.

I understand that such information must be maintained in the strictest confidence. As a condition of my assignment, I hereby agree that, unless directed by LiveWell staff, I will not at any time during or after my assignment disclose any patient or non-patient information to any person whatsoever or permit any person whatsoever to examine or make copies of any patient reports or other documents prepared by me, coming into my possession, or under my control, or use patient or non-patient information, other than as necessary in the course of my assignment.

When such information must be discussed with other healthcare practitioners in the course of my work, I will use discretion to assure that such conversations cannot be overheard by others who are not involved.

I understand that violation of this agreement may result in corrective action, up to and including discharge.

_____

Signature of Volunteer Date

_____

Print Name

Facility Use Agreement

This agreement is made this _____ day of _____, 2015 between Community Medical Clinic of Kershaw County for LiveWell Kershaw (referred to as LWK), and

_____,

concerning facility use for the purpose of establishing a community-based healthcare center, effective January 19, 2015 through May 31, 2015*.

- LWK will utilize the facility for the purpose of providing mobile health care services to eligible adults residing in the surrounding target area one day per week._____

- LWK staff will require the use of classrooms, bathrooms, running water, and electricity to provide appropriate care and assistance to persons attending the center for services.

- LWK staff will be responsible for clean-up and disposal of all waste materials resulting from the use of facility space.

- The Community Medical Clinic for LWK assumes all responsibility any loss or damage to property arising from use of the facilities.

- LWK will be solely responsible and will assume full responsibility for the actions of its employees when using the facility and providing care to patients.

- LWK will be solely responsible to provide adequate supervision of the activities conducted in the facilities for the purpose of carrying out LiveWell goals.

LWK Representative

Print Name_____

Signature_____ Date_____

Title_____

Facility Representative

Print Name_____

Signature_____ Date_____

Title_____

**Time frame reflects the remainder of Year One of three year project. Renewable upon agreement of both parties.*

Community Member Profile Sheet

Contact Information

Name: _____

Address: _____

Home Phone: _____ Work Phone: _____

Email Address: _____

Preferred Method of Contact: ☐ Mail ☐ Home Phone ☐ Work Phone ☐ Email

General Information

Profession: _____

Employer: _____

Church you attend (if any) _____

Please list any committees, clubs or organizations that you are involved in:

_____

_____

Local schools your children/grandchildren attend:

_____

_____

Radio/Newspapers/Social media you follow to receive information in the community:

_____

_____

Please list your interests/hobbies:

_____

_____

News Items

CHRONICLE-INDEPENDENT (Camden, S.C.) - MONDAY, FEBRUARY 9, 2015 - 3

LiveWell Kershaw

Partnerships are powerful, and I can think of few better examples than LiveWell Kershaw. This collaboration connects KershawHealth, the Arnold School of Public Health at the University of South Carolina, the Community Medical Clinic of Kershaw County, Access Kershaw, and a host of other local agencies in an innovative initiative to make Kershaw County the healthiest county in South Carolina, and to become a model for other communities across South Carolina and the nation. It's a huge goal, but one worthy of the pursuit.

The partnership was envisioned by Joseph Bruce, KershawHealth's vice president of marketing and community outreach, who three years ago recognized it is impossible to view healthcare in a vacuum. People's entire lives -- education, income, access to care, transportation, resources and more -- are all part of the equation. To impact overall population health, it is essential to address each of these. While there are many programs and organizations doing good and helping many people, there are few models which bring everything together and have been able to achieve measurable results. Joseph built a coalition to do just that in Kershaw County. Today, a $3 million grant from the S.C. Department of Health and Human Services is fueling LiveWell Kershaw's North Central Initiative.

It is clear there is a great deal of work to be done. Two-thirds of South Carolinians are overweight or obese; many -- particularly in rural areas -- have no access to regular medical care, healthy foods or recreational facilities; and our rates of diabetes, heart disease and smoking are higher than the national average. Obviously, impacting population health can have a profound benefit for our community. But how? The LiveWell Kershaw coalition quickly realized that community ownership of any initiative was the key to long-term results and sustainability.

Deeply rural, the area of Kershaw County centered on

North Central High School, Cassatt, and the Mt. Pisgah/Buffalo township faces many challenges. Nonetheless, it has strong ties to area churches and schools, and a proud sense of community. It was an ideal choice for LiveWell Kershaw's first initiative.

The North Central Initiative is built on a unique team concept integrating the clinical expertise of nurse practitioners working closely with community health workers who possess extensive local contacts and excellent health education and outreach skills. Given their thorough understanding of the challenges individuals in the area face and assets available, community health workers are able to conduct assessments to identify healthcare and other needs and help connect residents with local resources like primary care physicians, the Community Medical Clinic, Healthcare Place at Bethune and Access Kershaw. They can even help residents apply for Medicaid and food stamps, if appropriate. Education is equally essential. Whether it's explaining what blood pressure numbers mean or helping people learn to read food labels and choose meals wisely, education is a key aspect to improving health outcomes.

Finally, by utilizing their extensive relationships with area churches and schools, the community health workers have existing partners and infrastructure for educational and exercise activities, screenings and health demonstrations right in the neighborhood. They are working with community leaders to develop a comprehensive, coordinated plan to maximize existing programs, fill gaps in care and develop infrastructure changes to encourage healthy lifestyles. Strengthening and expanding this community network is a critical component of the initiative, and one essential for long-term success and sustainability.

Success will not come overnight, but LiveWell Kershaw is exactly the type of integrated effort with the greatest potential for actually improving the overall health of a community. It's gratifying to see such a wide range of local assets working together on a project that will not only help our neighbors become healthier, but that can put Kershaw County at the forefront of communities with innovative population health initiatives.

(KershawHealth CEO Terry Gunn is a contributing columnist to the Chronicle-Independent, Camden, S.C.)

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COMMUNITY WIDE

Camden Chronicle-Independent; Feb 9, 2015.

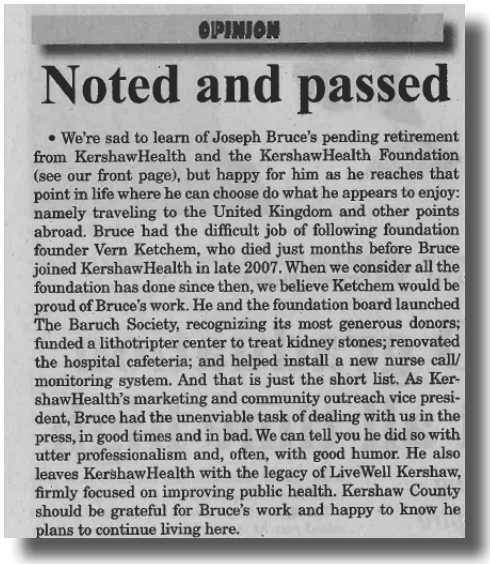
HealthCare Clinic Day at Refuge Baptist

On February 25, from 9 a.m. to 1 p.m. LiveWell Kershaw will have Nurse Practitioners and Community Health Workers on site at Refuge Baptist Church.

The church is located at 2814 Lockhart Road, Kershaw.

For more information please call Community Medical Clinic (803-713-0806), LiveWell (803-272-8325), or Access Kershaw (803-272-8777).

Kershaw News Era; February 18, 2015.



OPINION

Noted and passed

• We're sad to learn of Joseph Bruce's pending retirement from KershawHealth and the KershawHealth Foundation (see our front page), but happy for him as he reaches that point in life where he can choose do what he appears to enjoy: namely traveling to the United Kingdom and other points abroad. Bruce had the difficult job of following foundation founder Vern Ketchem, who died just months before Bruce joined KershawHealth in late 2007. When we consider all the foundation has done since then, we believe Ketchem would be proud of Bruce's work. He and the foundation board launched The Baruch Society, recognizing its most generous donors; funded a lithotripter center to treat kidney stones; renovated the hospital cafeteria; and helped install a new nurse call/monitoring system. And that is just the short list. As KershawHealth's marketing and community outreach vice president, Bruce had the unenviable task of dealing with us in the press, in good times and in bad. We can tell you he did so with utter professionalism and, often, with good humor. He also leaves KershawHealth with the legacy of LiveWell Kershaw, firmly focused on improving public health. Kershaw County should be grateful for Bruce's work and happy to know he plans to continue living here.

Camden Chronicle-Independent; Feb 23, 2015.

Bruce retiring as KHF executive director, hospital marketing VP

Joseph Bruce, executive director of the KershawHealth Foundation and KershawHealth's vice president of marketing and community development, will retire from both positions March 13. Bruce, a South Carolina native, returned to his home state in 2007 to join KershawHealth and the foundation after a career with major New York City and Washington, D.C., advertising and public relations agencies.

Bruce revitalized the foundation and created The Baruch Society to recognize its most generous donors. The annual Baruch Society Members' Dinner brought noted speakers to the community, including the executive vice president of Johns Hopkins Medicine and Bernard Baruch's grandnephew. With an expanding base of donors and significant increases in financial support, the foundation funded a variety of significant projects. They included a lithotripter center to treat kidney stones, the renovation of the medical center cafeteria and, most recently, a new nurse call/monitoring system.

"Joseph had a real vision for what the foundation could achieve and a passion that inspired members of our board," KershawHealth Foundation Board Chair Kathy Comer said. "His years in New York and Washington gave him a broader world view and a heightened sense of what was possible."

As marketing and community development vice president, Bruce guided the transition of the healthcare system's name from Kershaw County Medical Center to KershawHealth, and developed a successful marketing launch for its Urgent Care and Primary Care facility near Elgin. He was also responsible for planning the celebration of KershawHealth's centennial in 2013.

One of Bruce's chief interests has been population health and the continuing declines at the national, state, and local level despite enormous expenditures in healthcare. In response, he envisioned an initiative to use Kershaw County as a model for how

See Bruce, Page A6

Photo by Melissa Young

Joseph Bruce

Bruce

From Front Page

a community could achieve measurable improvements in the health of its population.

Under his leadership, an initiative [illegible] LiveWell Kershaw grew [illegible] collaboration among Kersh[illegible]alth, the University of South Carolina's Arnold School of Public Health, Kershaw County Community Medical Clinic and Access Kershaw. With [illegible] million grant from the S[illegible] Department of Health and Human Services, LiveWell Kershaw is now implementing an innovative community-based population health improvement plan in the North Central area of the county.

"LiveWell Kershaw will no doubt be one of Joseph's greatest legacies to our community," KershawHealth CEO Terry Gunn said. "And indeed as a model for other communities, its impact has the potential to be far-reaching in South Carolina and beyond."

Bruce reflected back on his eight years with KershawHealth and the foundation.

"I came to Camden originally with the idea of retiring. And so my time at KershawHealth was quite literally the career I never expected to have," Bruce said. "But it ended up being some of the most fulfilling years of my working life. I'm grateful for the opportunities I've had to help advance healthcare in our community and especially to launch an initiative that will successfully address the seemingly intractable challenge of improving population health.

"And now with the pound sterling hovering around $1.50, it's time for me to travel back to the UK!"

Camden Chronicle-Independent; Feb 23, 2015.

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LiveWell KERSHAW

"Your Bridge to Better Health"

Year One Quarter Four Report

"Your Bridge to Better Health"

March 1 - May 31, 2015

LiVeWell KERSHAW

Table of Contents

Cover photo: Kelly Warnock, Camden, SC

Introduction Letter

UNIVERSITY OF SOUTH CAROLINA
Arnold School of Public Health

Office of Research

May 31, 2015

As year one comes to an end for LiveWell Kershaw, we as a team have taken time to reflect on our past and recommit our collective efforts moving forward. Our ultimate goal is to make Kershaw the healthiest county in South Carolina using a holistic approach and working together with various partners.

We learned over the course of this year that achieving population health can be both challenging and rewarding. The Driver Diagram on page four describes the four primary drivers that we believe are needed to achieve our long-term outcome by building a "bridge to better health." The focus and the goals of the LWK initiative have shifted over the course of the year from the original narrative to where we are today. We believe that the driver diagram model clearly reflects our journey for years two, three and beyond after understanding the multiple dynamics involved in the community.

We hope this report provides you with a progress update and insight into our future plans. Upcoming evaluation reports will provide detailed progress based on benchmarks and concrete assessment of performance. Together, we will be "your bridge to better health."

Best in all you do,

Holly Hayes, MSPH
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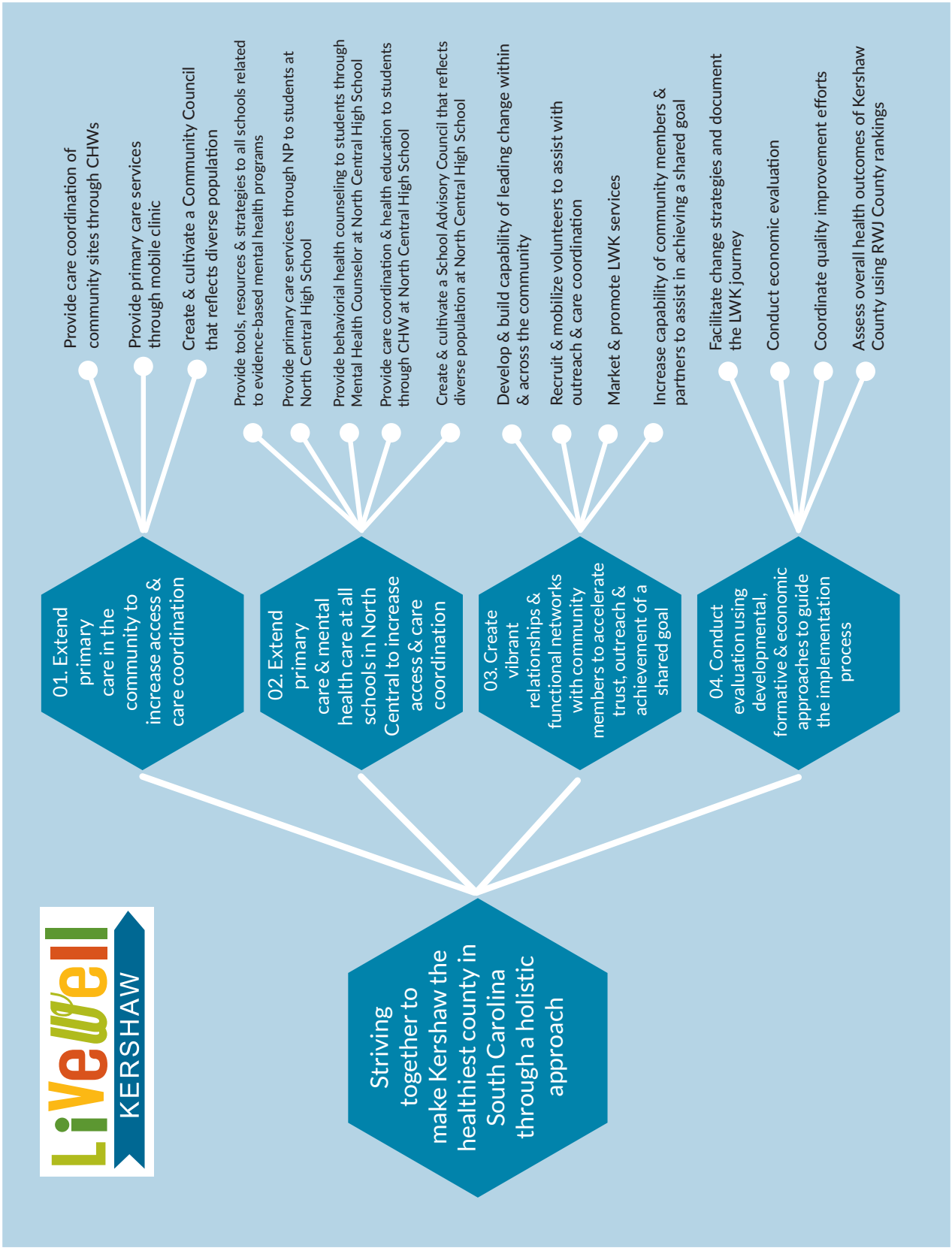
Driver Diagram



Driver 1: Extend primary care in the community to increase access and care coordination

Progress from March - May, 2015

A. Community Health Care Sites

The LWK team has continued operating five community healthcare sites at local churches that began in January of 2015. Each of the community healthcare sites (Cassatt Baptist, Mt. Moriah Missionary Baptist Association, Refuge Baptist and Sandy Level Baptist) are open from 9 AM – 1PM to provide care coordination services to residents and assist them in connecting with a medical provider. All of the church sites, with the exception of Abney Baptist, renewed their facility use agreement for an additional year (June 1, 2015 - May 31, 2016) with LiveWell Kershaw (LWK).

Map 1: LWK Community Healthcare Sites

Two Community Health Workers (CHWs), Karen Baker and Jesus Martinez, operated these community healthcare sites together over the past three months. On May 18, a new CHW, Rachael Sladek, was hired. Rachael is a long-time resident of North Central and served as an Activity Director in an assisted living facility before joining the LWK team. The newest CHW went through extensive training at AccessKershaw and the Community Medical Clinic and spent time shadowing the two CHWs as part of her training. All CHWs will begin the SC Certification training at Midlands Technical College on June 1, 2015.

Each of the CHWs and providers collected data on any encounter that occurred and tracked this in an Excel document, FASES case management system or the Electronic Health Record. Table 1 (pg 6) shows frequency counts for all months of operation and for the different activities. In both March and April, 36 new client visits occurred compared to only 11 client visits in May. The CHWs

made calls from an inpatient list provided daily by KershawHealth, which includes contact information for anyone who is uninsured or underinsured and has had any medial encounters at the Emergency Room. If a CHW is able to make successful phone contact, an appointment is scheduled at one of the community healthcare sites nearest to the client's home.

The team reported that 83% (394 of 575) of these calls were unsuccessful due to no answer, a full mailbox, message left or phone disconnected. After an initial visit, follow-up visits are made to continue care coordination for medical and social services.

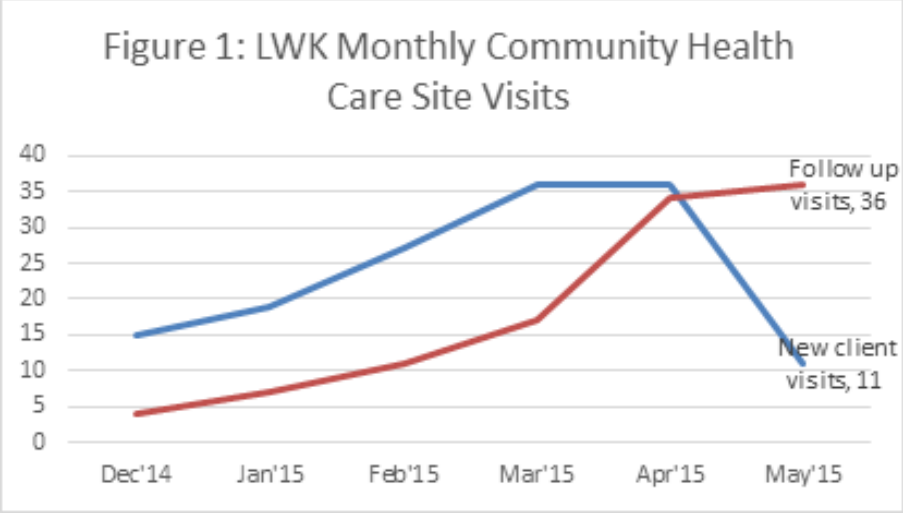


Figure 1 shows that the follow-up visits increased over the six month period from 4 to 36. This increase demonstrated progress towards further engaging with residents of the community in providing needed services. Continued follow-up services will contribute to increasing LWK's outreach goals. We also see in Figure 1 that from December to May new client visits increased, flatlined and then decreased to 11. The reason for the decrease in new client visits remains unclear.

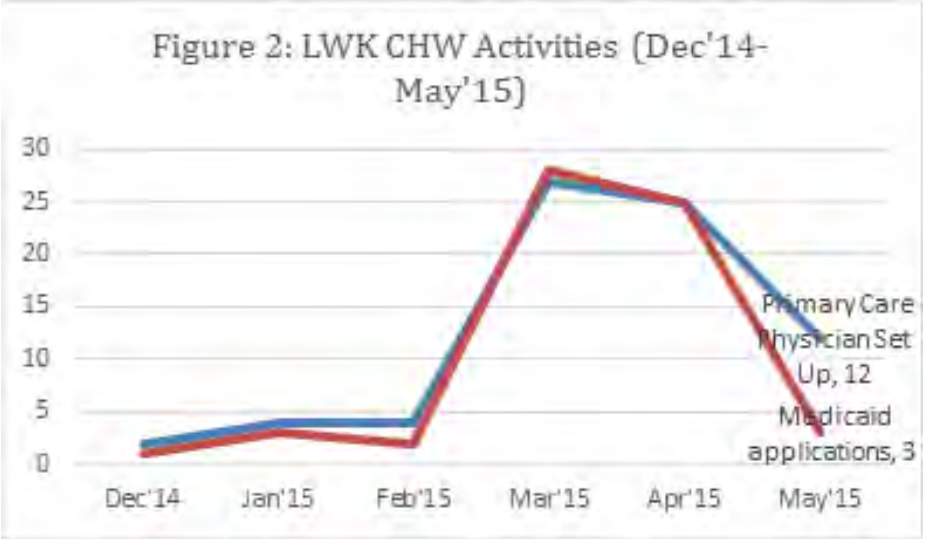


Figure 2 shows that a decline occurred in both primary care appointments and Medicaid applications taken from December to May. Eligibility for Medicaid may have played a role in the decline of applications since clients have to meet certain categorical requirements, such as family size, income, and diagnosis. When examining the data by CHW, it appears that CHW2 conducted the majority of the primary care physician appointments (55 out of 65 for Quarter 4) and Medicaid applications (47 out of 56). This variation may be due to how numbers were documented for each of the clients seen.

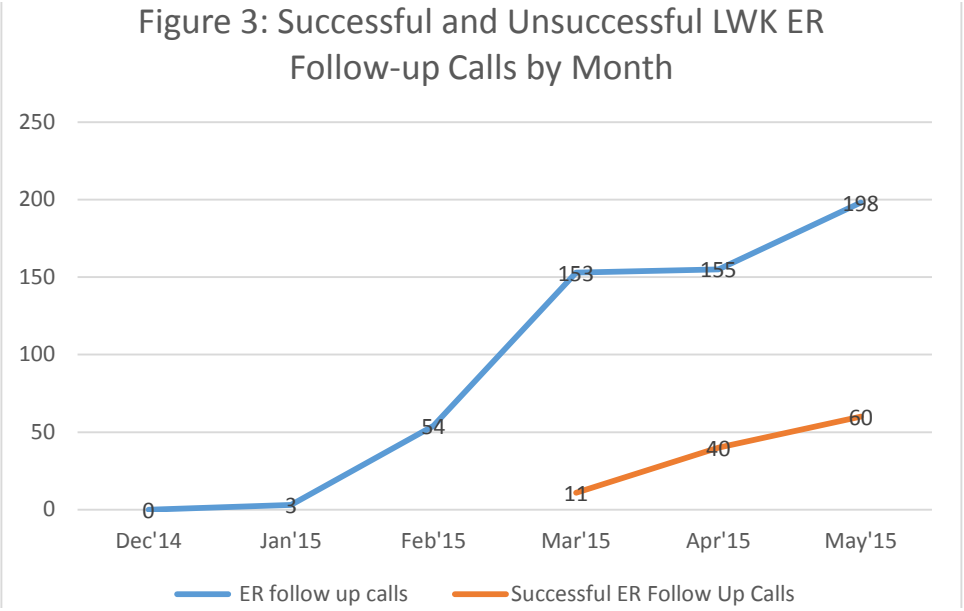


Figure 3 displays the ER follow-up calls made over the six-month period. Follow-up calls help establish relationships with clients and improve access to care. These calls steadily increased from December to May. As noted earlier, despite the positive progress made 83% of follow-up calls did not result in successful phone contact, underscoring the difficulty in reaching this population.

A confidential survey was administered to two of the CHWs on April 23rd to assess progress and to give feedback to the Project Director. Both CHWs felt that they had learned a great deal in their role, and enjoyed working with team members from the Community Medical Clinic and AccessKershaw. Both CHWs at the time of the survey did not feel that they were provided with all of the resources needed to do their job, and wanted more clarification on who their supervisor was and what their project boundaries were. As a result of this survey, the Project Director has met with both CHWs and is changing the reporting structure effective June 29th once the CHWs are certified in SC through the Midlands Tech program.

Individual data from the CHWs shows great variation in performance. The variations could be due to a wide variety of factors, and as a result a new standardized data collection process will be in place for year 2. The supervision of the CHWs is also changing in Year 2 to more closely monitor individual progress and overall goals of the initiative. As a result of this, Tamika Thomas has created performance charts broken down by CHW which will be used for quality improvement efforts. These charts will report weekly progress and Tamika will work with the team members to reach the goal of seeing 50 clients weekly.

We piloted a client satisfaction survey administered by an iPad immediately following a client visit. The nine questions asked are summarized in Table 3 (pg 10). From May 7 – May 22, the CHWs collected 15 responses with no significant variation in findings. The survey is being modified for next quarter to allow for more variation in responses. The evaluation team is working with Terri Jowers (Healthy Carolina in Columbia) to test a data instrument together that can be used for comparison data.

Table 1: LiveWell Kershaw Activities and Encounters by Month

LiveWell Kershaw	Dec'14	Jan'15	Feb'15	Mar'15	Apr'15	May'15	Total
New client visits	15	19	27	36	36	11	144
Follow up visits	4	7	11	17	34	36	109
ER follow up calls	0	3	54	153	155	198	563
PCP set up	2	4	4	27	25	12	74
Medicaid applications	1	3	2	28	25	3	62
SNAP applications	1	2	3	26	20	5	57
Welvista applications	5	8	4	28	24	11	80
SS disability	3	2	2	0	6	0	13
Extra help applications	1	0	0	1	1	12	15
With Medicare Medicaid	2	0	0	4	1	2	9
Case management	3	0	0	0	0	0	3
Home visits	0	0	3	2	3	0	8
MD appointment visits	0	0	0	1	0	0	1
Medication request	1	0	1	1	0	0	3
MH referrals	0	0	0	1	0	0	1
Dental referrals	0	2	0	2	1	0	5
PAP applications	2	0	0	0	0	0	2
Charity applications	8	14	10	33	20	15	100
HOP sessions	0	2	0	1	1	0	4
ACA navigations	0	1	1	0	0	0	2
Lions Club applications	0	3	1	3	0	0	7

Table 2 shows the breakdown of new client visits seen by each of the community healthcare sites and by each CHW. In quarter 4, the most successful site for recruiting new clients was Cassatt Baptist (n=16), followed by Abney Baptist (n=15), Refuge (n=14), and Sandy Level (n=13). The Abney site closed at the end of May, since the church did not renew the facility use agreement. The church is currently going through changes with a new pastor and struggled to find volunteers each week. The Mount Moriah Site in Liberty Hill has consistently had the fewest client encounters; this is most likely due to the low population density in the Liberty Hill area.

Table 2: New Client Visits by Site, Month and CHW

4th Quarter New Client Visits by Site, Month, and CHW				
Location	**March**	**April**	**May**	**Total**
Cassatt	CHW1: 3	CHW1: 6	CHW1: 1	10
	CHW2: 1	CHW2: 4	CHW2: 1	6
site total	4	10	2	16
Mt. Moriah	CHW1: 0	CHW1: 0	CHW1: 0	0
	CHW2: 7	CHW2: 0	CHW2: 1	8
site total	7	0	1	8
Refuge	CHW1: 2	CHW1: 2	CHW1: 1	5
	CHW2: 4	CHW2: 4	CHW2: 1	9
site total	6	6	2	14
Abney	CHW1: 1	CHW1: 3	CHW1: 0	4
	CHW2: 2	CHW2: 8	CHW2: 1	11
site total	3	11	1	15
Sandy Level	CHW1: 0	CHW1: 3	CHW1: 2	5
	CHW2: 3	CHW2: 3	CHW2: 2	8
site total	3	6	4	13
Home Visit	CHW1: 1	CHW1: 0	CHW1: 0	1
	CHW2: 0	CHW2: 0	CHW2: 0	0
site total	1	0	0	1
Hospital Visit	CHW1: 0	CHW1: 0	CHW1: 0	0
	CHW2: 0	CHW2: 2	CHW2: 0	2
site total	0	2	0	2
AccessKershaw	CHW1: 0	CHW1: 0	CHW1: 0	0
	CHW2: 0	CHW2: 1	CHW2: 0	1
site total	0	1	0	1
GRAND TOTAL	**24**	**36**	**10**	**70**

Table 3: Questions from CHW Client Satisfaction Survey

Question Topic	Not Pleased	Okay	Very Pleased	Total
Travel to the site	0.00% 0	6.67% 1	93.33% 14	15
Hours that services were available	0.00% 0	0.00% 0	100.00% 15	15
Responsiveness to your questions	0.00% 0	0.00% 0	100.00% 15	15
Kindness and respect you were given	0.00% 0	0.00% 0	100.00% 15	15
Ability to get the medical care you needed	0.00% 0	0.00% 0	100.00% 14	14
Ability to get any other help you needed (food, bills, etc)	0.00% 0	0.00% 0	100.00% 13	13
Time spent with me	0.00% 0	0.00% 0	100.00% 15	15
Follow-up with me after the visit	0.00% 0	0.00% 0	100.00% 1	1
Overall rating of LiveWell Kershaw Services	0.00% 0	0.00% 0	100.00% 15	15

B. Mobile Clinics

In addition, the CHWs worked alongside the Medical Director and nurse practitioners to offer mobile clinics from 9 AM – 1 PM at the church locations on a rotating basis. During a mobile clinic, the medical providers from the Community Medical Clinic conduct primary care visits onsite, which reduces the transportation burden for clients. Three mobile clinics occurred over the past three months at Abney, Cassatt, and Refuge (Map 2). The first mobile clinic occurred as a pilot in December at Mt. Pisgah Elementary School and was followed by a clinic at Refuge Baptist in February. Figure 4 (pg 11) shows the trend line for clinical visits by month. Table 4 describes the number of clinic encounters with a Nurse Practitioner or physician that have occurred at each of the sites. Of all of the clinical encounters from December to April of 2015, 3 finger sticks

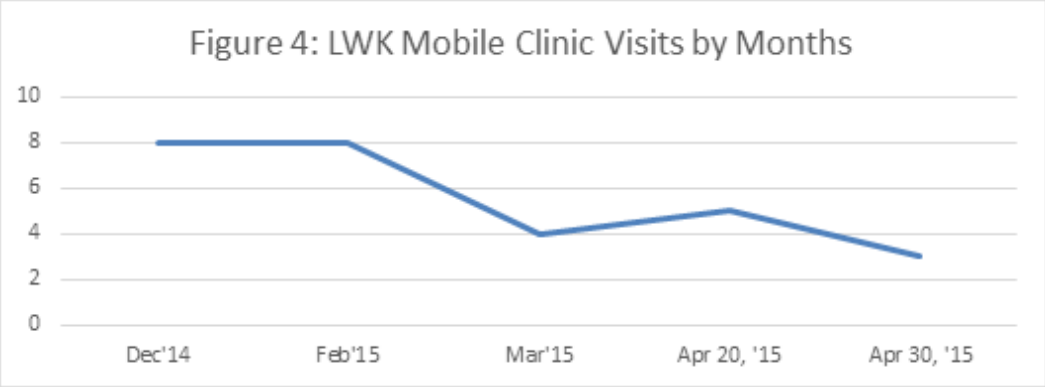
Map 2: Mobile Clinic Sites

were completed and 1 influenza vaccine was administered. Of the 28 mobile clinic visits, 15 were level 4 office visits, 10 were 15 minute outpatient visits, and there was 1 visit each for an influenza vaccine, a level 2 office visit and a 30 minute outpatient visit.

Demographically for the period December 2014 - May 2015, 23 of the patients were white, 4 were African American and 1 was American Indian; 54% of the patients were female and 46% were male. Eighty six percent of the patients seen at the mobile clinic are active patients at the Community Medical Clinic and were seen at a mobile site closer to their home. As of December 2014, the Community Medical Clinic has added three new patients that can be attributed to LWK activities.

Table 4: LWK Mobile Clinic Visitors by Month

Location	Clinical Visits
Abney Baptist	7
Cassatt Baptist	5
Mt Pisgah Elementary	8
Refuge Baptist	8



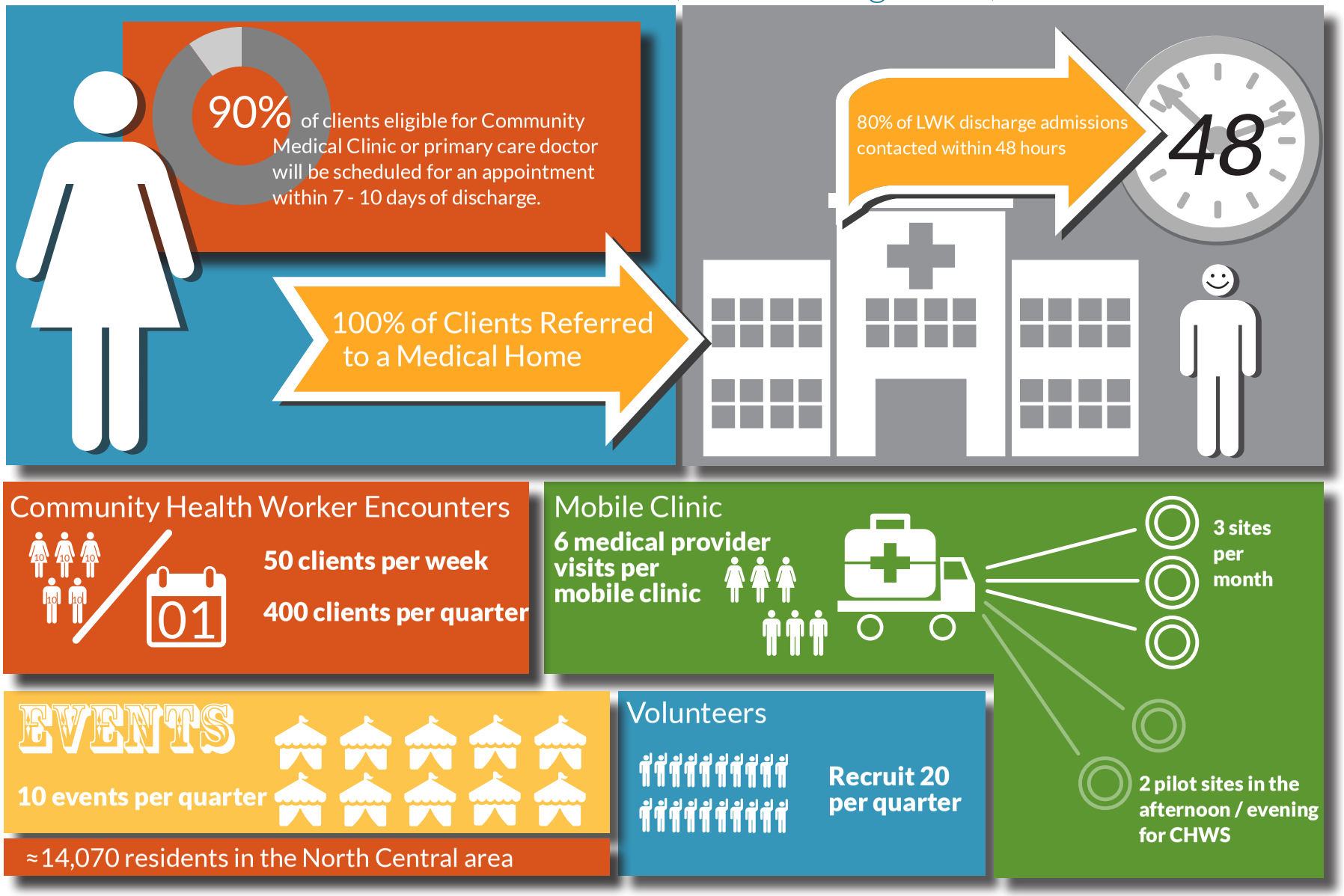
Future Plans

We realize that in order to maximize the number of individuals seen, changes need to be made. A new site, Buffalo Baptist in Kershaw, has been selected as the newest community healthcare site. This new site sits on an ER hotspot for the area. In July of this year the team will pilot afternoon and evening hours from 4 PM – 7 PM with two of the existing community healthcare sites. Karen Baker is working on establishing relationships with other churches to increase the number of sites available to residents. It appears that transportation continues to be a major barrier for residents even with the extension of primary care sites in their community. By August 2015, the team plans to have met with all of the providers in Kershaw County as well as all businesses in the area. A detailed communications/outreach plan has been developed (refer to Driver 4 section of report).

LiveWell KERSHAW

Year Two Quarter One Milestones

June 1, 2015 - August 31, 2015



The local team met at the end of this quarter, and developed metrics for Year Two Quarter One (figure 4a, pg 12). All metrics have been imported into InsightVision, a centralized database that allows progress scorecards to be created. The CHWs will enter information at least weekly into the system to allow the Director and leadership team to monitor progress towards agreed upon targets.

Redefined Role of CHW

During quarter four, the LWK team spent time defining what the CHW model would be for LWK given our needs in the community and our holistic approach. Below is a description of the model that the LWK team is striving to reach during years two and three.

CHWs are trusted and trained front line health workers that provide a range of services from patient education, outreach, advocacy, navigation and social support with an acute focus on addressing social determinants of health. Given the various CHW program models that exist, the LiveWell Kershaw leadership team believes it is important to explicitly define the role of the CHW for the LiveWell Kershaw initiative.

CHW team members (left to right): Jesus Martinez, Karen Baker & Rachael Sladek

A LWK CHW is considered part of the care delivery team and works with medical providers to provide health education and basic screening services while the medical provider conducts medical exams or any other procedures. Thus the CHW and the medical provider work together using a holistic approach to provide the patient with an integrated medical home that meets both the medical and non-medical (i.e. social determinants of health) of the patient. Basic services that are within the LWK scope of work for a CHW include: measuring blood pressure and pulse, providing first aid care, and conducting health screenings. In this role it is integral for the medical provider and CHW to maintain direct communication. To this end the CHW and the clinic medical providers have access to a shared EHR database; both CHW and medical provider can input and view patient information. The medical provider and CHW work alongside one another to serve the needs of the patient in a timely and respectful manner at mobile clinic sites.

In addition, LWK CHWs provide further care coordination outside of a mobile site visit. In this role, the LWK CHWs help patients who are having difficulty navigating the multiple healthcare and social service systems. CHWs assist with providing information on health and community resources available, coordinating transportation and making appointments for primary care and specialty services. Given the large incidence of diabetes among residents living in the North Central area, the CHWs also assist diabetic patients with developing a care management plan in collaboration with a medical provider. CHWs use tools such as food and exercise logs to assist with tracking a patient's progress. Information related to patients' self-management goals and metrics are collected in the EMR, which allows the medical provider to reinforce these goals during medical visits with patients.

In the LWK CHW role, it is important to note that the CHW does not reach beyond their scope of services. As needed, LWK triages patients to AccessKershaw for face-to-face hospital and physician visits and in-depth case management. LWK also triages patients to the Community Medical Clinic for hospital and ER visits and as a primary care medical home. For this initiative patient issues will not be viewed in isolation but will be understood using a holistic approach. Our major outcome is to provide a patient with a medical home. With that in mind, our LWK CHWs do not complete hospital charity applications on behalf of patients, but can refer individuals that need this assistance to a hospital. In addition, CHWs may visit a patient's home to provide care coordination services if transportation is not available. However, our LWK CHWs do not conduct intensive home visits or conduct environmental health and home assessments.

We recognize that garnering the trust of the residents in the community is critical for the LWK initiative to be successful. Our CHWs are responsible for visiting local restaurants, businesses, county partners and medical providers to promote the LWK initiative and to increase the number of referrals. They build relationships with key residents and recruit volunteers to assist with their efforts and become LWK ambassadors. The LWK CHW follows the volunteer model used by the Community Medical Clinic, which has been extremely successful in expanding reach and capacity in the region. The CHWs are responsible for reporting data daily into the EMR and also participate in quality improvement initiatives using the Plan, Do, Study, Act (PDSA) model. Our LWK CHWs serve as community advisors and assist in planning of key events given their depth of knowledge of the area and the residents of North Central.

Please see page 16 for an in depth look at a case study involving "Maria" from Lugoff, whom our CHWs assisted with managing much needed cancer treatment.

Evaluation Recommendations

- Secure a fax machine or e-fax capability for CHWs to be able to send needed paperwork to social service agencies.
- Develop an outreach packets for CHWs to have for replication.
- Provide the CHWs with marketing materials to have on-hand at all times to share with community members.
- Closely monitor and supervise the CHWs and create personal goals to reach related to recruitment of new clients.
- Create a checklist and standardized protocol for follow-up and outreach for CHWs.
- Create a standardized way for follow-ups to be reported in the system (discrepancy currently exists between two CHWs).
- Incorporate a "screening sheet" for CHWs to use when making initial phone calls; this sheet can better assist in gathering correct client information for providing proper assistance (i.e. Medicaid or Social Security Disability); this screening sheet can be a part of the client's file.
- Consider mailing a "follow-up contact letter" and "questionnaire" to clients who initially were unable to be reached by phone. The CHW can attempt to follow up with the patient for the next 30 business days to maintain engagement.
- With clients who were considered no-shows for visits, send a follow-up letter to the patient advising to reschedule the appointment and remind the patient of services offered.
- Assign each CHW a "territory" or specific region of the county to develop deep and trusting relationships with the businesses, schools, churches and residents. This will assist with marketing and outreach and also increase the number of volunteers.
- Separate the CHWs once they have completed the Midlands Tech Training and have them operate community healthcare sites independently.
- Pilot test evening (4 PM – 7 PM) locations to allow residents who work in the area to receive services.
- Close the Mount Moriah location in Liberty Hill due to low volume of clients seen over the past five months.
- Based on the ER usage map (see driver 5), pilot new community healthcare sites. More community sites can occur simultaneously if the CHWs are operating the sites independently.
- Secure permanent location in the North Central Region for CHWs that maximizes the most visibility for residents.
- Purchase or create large signage that is visible from the road for all of the community healthcare sites. The current signs are not visible.
- Maintain continuous communication with providers once referrals have been made.

Case Study: “Maria”

Evelyn Lugo from Best Chance Network referred Ms. “Maria” to Jesus Martinez (LWK Community Health Worker) on April 27th, so that Martinez could assist with language translation and medical care. Maria is a 35 year old Hispanic (Colombian) female and has been diagnosed with cervical cancer. A single mother of two children (age 9 and 14), she has a steady job cleaning homes. Maria has lived in Lugoff for the past 15 years.

When Maria was first referred by Evelyn, she was denied as a patient by the South Carolina Oncology because of no insurance or Medicaid. Jesus began working with Maria and connected her with the Community Medical Clinic of Kershaw County (CMCKC) so that she could have a primary care doctor and primary care home. Maria is undocumented and needed to be seen by a specialist, so Geraldine Carter, Pharmacy Manager for CMCKC, assisted her with applying for Emergency Medicaid Services. Afterwards, Jesus proceeded to get Maria to a GYN Oncologist while still trying to get her back into South Carolina Oncology. SC Oncology still would not accept Maria because she was not approved for Medicaid though she was in a pending status.

Jesus then applied for financial assistance for Maria through the hospital in Kershaw, since SC Oncology would come there to see patients. She was turned down again because the hospital did not have a specialist onsite. Jesus advised that Maria needed to see a specialist, i.e. GYN Oncologist. As an alternative Jesus tried to get her into Santee Hematology and Oncology but unfortunately they did not have a specialist onsite for her condition.

Maria’s options were running out when Jesus received an unexpected phone call from AccessKershaw case manager Sheri Baytes on Monday, June 22nd. Sheri called Jesus to request language translation for a patient with breast cancer. Jesus talked to the patient and offered translation services at her doctor’s appointment on Tuesday, June 23rd. During the visit to Camden General and Vascular Surgery, Jesus mentioned the trouble finding a specialist appointment for Maria with Dr. David Christenberry. Dr. Christenberry then made a call to Dr. (First name?) Merritt at SC Oncology, told him about Maria and asked if would he take her as his patient since she has cervical cancer and has not been receiving any treatment. Dr. Merritt agreed and Maria’s first appointment in her treatment process was scheduled for July 1st, 2015.

This success story was made possible by a group of diverse individuals and organizations working together toward the single purpose of providing Maria with a medical home and linking her with much needed specialist services for her cervical cancer. The successful outcome was catalyzed by the efforts of Jesus Martinez, a LWK Community Health Worker, who was a hub connecting Best Chance Network, AccessKershaw, the Community Medical Clinic, KershawHealth and other players in the process.

Jesus plans to stay in contact with Maria and assist her with care coordination as she continues on her journey. LiveWell will continue to be her “bridge to better health.”

Driver 2: Extend primary care and mental health at all schools in North Central to increase access and care coordination

A. Mental Health

Progress Updates: March - May 2015

Toward achieving these objectives the Livewell Kershaw's mental health team evaluated information collected in Quarters 2 & 3 and summarized our evaluation and recommendations. With school district support, we worked on our objectives to increase evidence-based mental health supports by targeting North Central High School, North Central Middle School, and Midway Elementary School. Below we share updates on activities that occurred from March to May 2015:

North Central Middle School

Activities from March - May 2015 included the following:

Meeting with North Central High School (NCHS) school personnel about Check & Connect (C&C) Mentoring Program

Meeting with North Central Middle School (NCMS) school personnel about C&C Mentoring Program

Provided NCHS personnel with student functioning data requirements for student identification for C&C program

Provided NCHS personnel with student functioning data requirements for student identification for C&C program

Identification of 10 students that could benefit from C&C Mentoring Program from school personnel at NCHS

Identification of 11 students that could benefit from C&C Mentoring Program from school personnel at NCMS

Training of 7 USC Psychology students to be C&C Mentors for the program at NCHS & NCMS

- Scheduling and logistics for implementing C&C Mentoring Program at NCHS & NCMS

- Implementation of C&C Mentoring Program at NCHS with 10 students across 3 weeks of meetings
- Implementation C&C Mentoring Program at NCMS with 8 students across 3 weeks of meetings

- Four Mental Health Facilitation meetings at Midway Elementary School

- Midway Elementary School identified 12 students and 3 teachers to conduct classroom observations and conduct meetings with who may benefit from additional MH supports

- Attended a Leadership Team meeting at Midway Elementary to promote LWK and MH Facilitation at Midway

- Met with Midway Elementary school personnel to identify a comprehensive list of all students who may benefit from additional supports provided by LWK. A total of 65 students were identified.

- Developed a communication strategy for LWK MH team to promote LWK

- Attended a Community Outreach Training Boot Camp

- Developed a community outreach plan for LWK MH team

- Trained a new LWK MH facilitation members

- Prepared and implemented transition plan for new LWK MH team members

- Prepared and co-led LWK presentation for outreach at the South Carolina Behavioral Health Community's Annual Conference in Charleston, SC

- Attended 2 School Based Health Center information and planning meetings

- Developed a decision-making tool for the School Based Health Center, including screening tools and assessments for identifying behavioral and mental health behaviors and a response plan for monitoring, referring and crisis intervention.

- Conducted a survey of school personnel at Midway Elementary School to identify perceptions of student mental health needs, beliefs about school mental health and attitudes about the benefits of Livewell Kershaw for the school, students, and families. Received responses from 15 personnel.
- Entered and analyzed findings from school personnel perceptions survey

These activities advanced our Goal and Objectives as follows:

Goal: To increase access to, and use of, evidence-based mental health programs and practices in Kershaw schools in the north east region of Kershaw County.

Objective 1. Provide a preventive evidence-based mental health mentoring program to promote school engagement for students enrolled at North Central High School and North Central Middle School.

Check & Connect (C&C) Mentoring Program

An evidence-based mentoring program was selected and implemented toward the end of the 2014-2015 school year at NCHS & NCMS. C&C is a widely-used and research supported program that promotes school engagement and reduces students' low grades, high absences, disciplinary infractions, and ultimately prevents high school dropout. This program began this spring in a trial run with C&C mentors from USC's psychology department.

School personnel at NCHS and NCMS recommended students in need of mentoring based on a data driven approach that considers a range of indicators (e.g., school attendance and class tardies, disciplinary infractions, and academic records). Seven C&C mentors were provided by USC's psychology department through partnership with the LWK mental health team, resulting in the schools being asked to recommend up to twenty-one students for the program across the middle and high schools. School personnel indicated being able to recommend more for the program if more mentors could be connected to the program. Over the course of three weeks of mentoring sessions at the end of the school year, 18 students total at NCHS and NCMS were connected with a USC C&C mentor.

The LWK mental health team plans to continue the Check & Connect program during the upcoming academic year. LWK intends to work with the students recommended for the program this past year as well as with additional students recommended by schools. USC psychology and LWK mental health team will continue to partner to provide C&C mentors and plan to recruit additional mentors from the school communities.

Objective 2. Provide on-site mental health consultation at North Central High School, North Central Middle School, and Midway Elementary to support and strengthen existing mental health initiatives through evidence-based practices and programs to support student mental health.

Mental health facilitation at Midway Elementary School –
Regular on-site services provided by LWK's mental health facilitator included learning about the existing mental health initiatives, systems, and procedures for supporting student mental health at Midway elementary school. Services included meeting with teachers and school personnel regarding their knowledge of, need for, and use of evidence-based practices including supporting the efforts of the school's Positive Behavioral Intervention and Support (PBIS) team. Ongoing facilitation also included classroom observations of student and teachers, meeting with teachers to discuss strategies used, attending leadership team meetings, and providing feedback for PBIS implementation, as well as acting as a liaison for Livewell Kershaw proving updates and information on upcoming community events.

The results of these facilitation efforts were evaluated using a survey of school personnel at Midway to help inform the continued activities of the mental health team in the next school year.

A survey was distributed by LWK's mental health facilitator in partnership with Midway personnel at the end of the school year. Fifteen responses were received and are summarized below:

School personnel believe students have mental health needs that impact student learning

- 100% of school personnel reported teaching a student in the past year who was experiencing a mental health problem that impacted the classroom environment very much

- The number of school personnel who reported each of the following problems facing their students in the past year includes:
    - 14 of 15 (93.3%) reported Disruptive behavior/acting out
    - 14 of 15 (93.3%) reported Defiant behavior
    - 11 of 15 (73.3%) reported Aggressive behavior
    - 9 of 15 (60%) reported Bullying/ Victims of bullying
    - 13 of 15 (86.7%) reported Peer problems
    - 14 of 15 (93.3%) reported Problems with inattention
    - 15 of 15 (100%) reported Hyperactivity
    - 10 of 15 (66.7%) reported Anxiety problems
    - 5 of 15 (33.3%) reported Depression
    - 15 of 15 (100%) reported Family stressors (e.g., parent death, divorce, trouble at home)

- 8 of 15 (53.3%) reported School phobia
- 7 of 15 (46.7%) reported Immigration/cultural adjustment issues
- 9 of 15 (69%)reported Medication Noncompliance

School personnel believe schools should play role in supporting students' mental health.

- 100% of school personnel agreed or strongly agreed that schools should be involved in:
  - Addressing the mental health needs of students
  - Referring students & families to school-based services
  - Referring students & families to community-based services
- 93.3% of school personnel agreed or strongly agreed that schools should be involved in:
  - Screening for students' mental health problems
  - Implementing classroom behavioral interventions
  - Teaching social-emotional lessons
  - Conducting behavioral assessments
  - Monitoring student progress

The majority of school personnel believed they could increase their knowledge, skills, and training to better address the mental health needs of their students.

- Only 1/3 of school personnel reported having the knowledge, skills, cultural knowledge & skills, and education/training on behavioral interventions to adequately meet the mental health needs of their students.

Nearly all school personnel believed they could benefit from additional mental health consultation and training to address the mental health needs of their students.

- 14 of 15 (93.3%) reported they could benefit from mental health consultation

- 14 of 15 (93.3%) reported they could benefit from learning how to recognize mental health issues in children

- 14 of 15 (93.3%) reported they could benefit from learning strategies for working with children with externalizing behavior problems

- 13 of 15 (86.7%) reported they could benefit from learning strategies for working with children with internalizing behavior problems

- 14 of 15 (93.3%) reported they could benefit from additional training in classroom management and behavioral interventions

Nearly all school personnel who worked with LWK's MH team believed there was a benefit for the school in being connected to Livewell Kershaw and having a LWK mental health facilitator.

- Two personnel reported not being aware of Livewell Kershaw or the LWK mental health activities occurring at their school

- Of the remaining 13, 11 (84.6%) reported they agreed or strongly agreed that their school benefited from being connected to Livewell Kershaw and having a mental health facilitator

Nearly all school personnel who worked with LWK's MH team indicated that Livewell Kershaw is helping to improve their school's ability to support the mental health needs of their students.

- Of the 13 personnel aware of LWK and their mental health facilitator, 11 (84.6%) reported tht they agreed or strongly agreed that Livewell Kershaw is helping to improve their school's ability to support the mental health needs of their students

Additional services proposed that may occur in the upcoming academic year include mental health facilitation for NCHS & NCMS as well as expanding efforts to include school mental health promotion, outreach to the school nurse, teachers, and other school personnel, promotion of training and resources to support students' mental health needs, and provision of training and resources (e.g., online training modules for teachers and mental health tips training, and resources for school nurse), as determined based on a collaborative partnership with the schools.

Objective 3. Provide resources to schools to promote mental health, including identifying resources that reflect mental health supports for schools, youth and families in the north east region of Kershaw County for dissemination.

Mental health newsletters have been created for dissemination for schools to use to provide information about a variety of youth mental health issues including identification, response and referral for teachers and families. These newsletters as well as an updated list of mental health in resources for children, families, and schools will be provided to schools in the upcoming year.

Future Plans for Livewell Kershaw's Mental Health Team

Based on the results of the school mental health needs assessment conducted during the 2014-2015 school year, as well as the 2014-2015 activities of the mental health component, several activities were identified to advance the goal and objectives for the upcoming 2015-2016 school year.

Foremost this includes expanding the mental health team for Livewell Kershaw in Year 2 through continued partnership with Dr. Mark Weist and the School Mental Health Team at USC. Emily Mancil, M.A., whose training is in school psychology, will serve as LiveWell Kershaw's (LWK's) mental health facilitator, continuing the efforts began by Melissa George. Abby Bode, M.A., whose training is in clinical health psychology, will also be joining the team as LWK's mental health counselor providing services as part of the School Based Health Center starting at North Central High School next academic year. This will increase the capacity of the LWK MH team to provide mental health supports and services to schools, students, and families in the Northeast region of Kershaw County.

These objectives were designed to meet the needs of Kershaw schools and communities to strengthen school mental health supports in the Northeast region of Kershaw County. It is important to note that resources have been obtained to accomplish the following based on the approval and feedback from the community, the school district and participating schools; however, the efforts of the Mental Health team are flexible in response to the needs of the community and may change accordingly:

Our goal remains to increase access to and use of evidence-based mental health programs and practices in Kershaw schools in the north east region of Kershaw County.

Objective 1. Provide a preventive evidence-based mental health mentoring program to promote school engagement for students enrolled at North Central High School and North Central Middle School.

Students identified as in need of additional supports and who may be at risk for school disengagement and dropout will be identified by school personnel to participate in a mentoring

program call Check & Connect. School personnel at NCHS and NCMS will recommend students in need of mentoring based on a data driven approach the considers student's school functioning data across range of indicators (e.g., school attendance and class tardies, disciplinary infractions, and academic records).

a. Check & Connect (C&C) Mentoring Program at NCHS & NCMS –
Based on over 20 years of research, this evidence-based mentoring program promotes school engagement and reduces students' risk for high school dropout. This program will be implemented at NCHS and NCMS with mentors meeting with students on a weekly basis. C&C mentors will include students from USC's psychology department.

b. Counseling Services at NCHS –
On-site evidence-based counseling services will be provided by LWK's mental health counselor, Abby Bode at NCHS. As part of the school-based health center, Abby will be providing direct mental health counseling services to students who have been identified by school staff as being at-risk for or experiencing emotional or behavioral difficulties. Counseling services will primarily involve providing individualized evidence-based treatment approaches to achieve treatment gains for the individuals presenting problems. For example, services may include skills-based approaches in which students learn coping strategies, problem solving, emotion regulation skills, and strategies for managing daily struggles. Services may also include involving and engaging parents in treatment sessions and goal setting for students. As needs for group counseling arises, for example if it appears as though students are facing similar struggles, group interventions may be implemented so that more students may receive intervention in a more efficient manner.

Objective 2. Mental health facilitation to support school personnel as needed with training, implementation support, and resources to support understanding and implementation of evidence-based practices and programs that promote student mental health and support student mental health needs.

Midway Elementary School

a. Check & Connect (C&C) Mentor Trainings at NCHS & NCMS -
C&C trainings will also be offered for school personnel, parents, or volunteers that are part of the school community at NCHS & NCMS who are interested in serving as a mentor. Trainings will be provided by Emily Mancil, LWK's mental health facilitator.

a. Mental health facilitation at NCHS –
Weekly on-site services provided by LWK's mental health facilitator. Services will include school mental health promotion, outreach to the school nurse, teachers, and other school

personnel, promotion of training and resources to support students' mental health needs, and provision of training and resources (e.g., C&C, online training modules for teachers and mental health tips training, and resources for school nurse), as determined based on a collaborative partnership with NCHS.

b. Mental health facilitation at Midway Elementary School –
Weekly on-site services provided by LWK's mental health facilitator. Services will include support for Positive Behavioral Intervention and Support (PBIS) through providing the PBIS team assessment tools, resources and support of teachers to implement existing PBIS practices. Additional services include, school mental health promotion, outreach to the school nurse, teachers, and other school personnel, promotion of training and resources to support students' mental health needs, and provision of training and resources (e.g., online training modules for teachers and mental health tips training, and resources for school nurse), as determined based on a collaborative partnership with Midway.
c. Mental health resources at Baron Dekalb, Bethune, and Mt. Pisgah Elementary Schools –
Resources will be provided by LWK's mental health facilitator on a monthly basis to teachers, school personnel, and parents. Resources will include information and evidence-based strategies to support positive student development, mental health, as determined based on collaborative partnership with the schools.

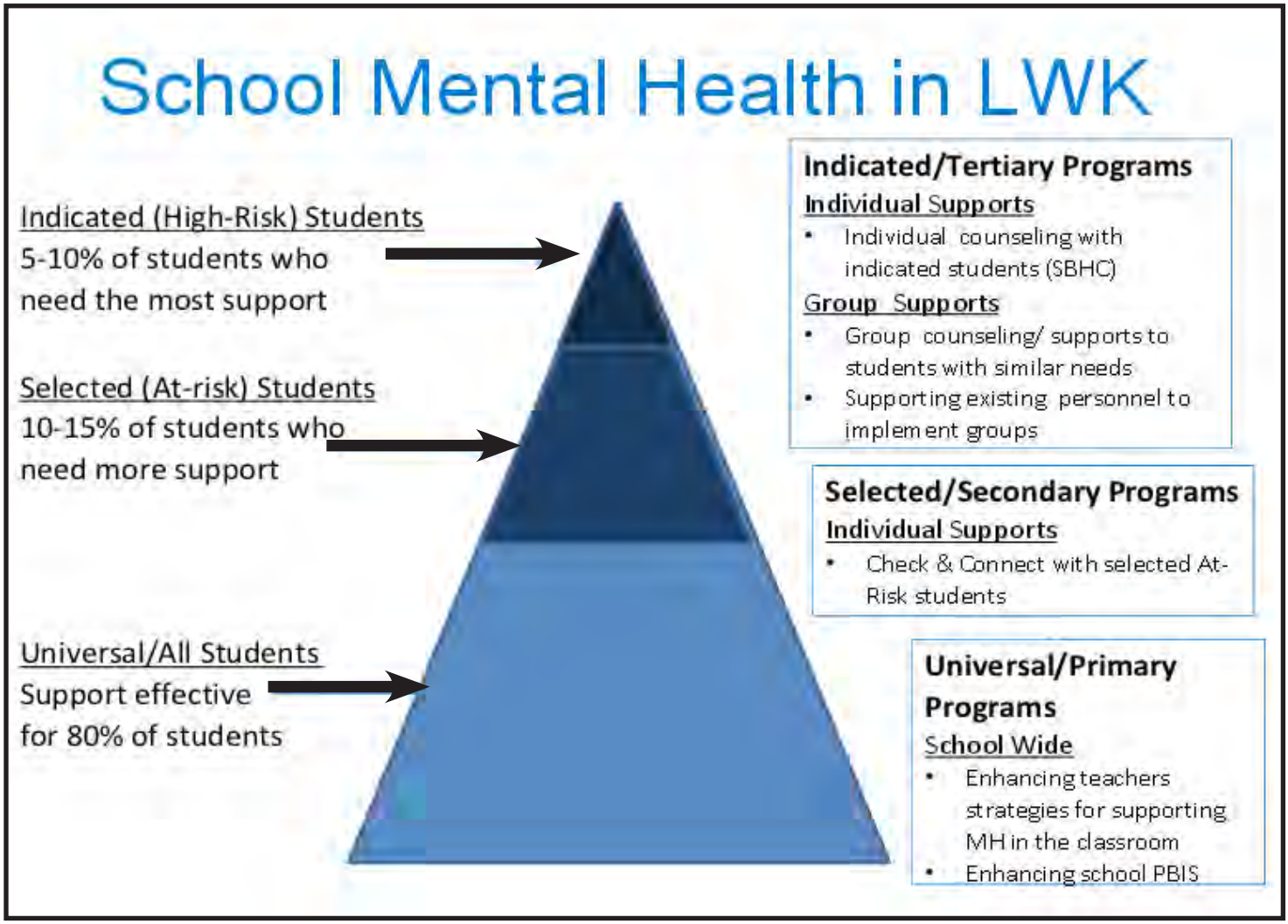
Objective 3. Provide resources to schools to promote mental health, including identifying resources that reflect mental health supports for schools, youth and families in the north east region of Kershaw County for dissemination.

a. Resource list of mental health supports for schools, youth, families –
A list of mental health supports in the school and community will be updated and disseminated to schools, youth, and families in the community.

b. Mental Health Newsletters— Mental health newsletters created in Quarter 4 will be disseminated for schools to use to provide information about a variety of youth mental health issues including identification, response and referral for teachers and families.

c. Promote parent engagement strategies— LWK's mental health facilitator will collaborate with NCHS and Midway to develop a plan to promote parent engagement and improve home-school communication.

The efforts depicted above show how we are providing programs at all levels to support all students.



Recommendations from Quarter 4

Based on the activities and evaluation of the LWK MH team component from March to May 2015 the following recommendations are made for advancing MH activities toward the Goal and Objectives

- Continue implementing the Check & Connect Mentoring Program at NCHS & NCMS through partnership with USC Psychology students serving as mentors
- Begin C&C at the beginning of the school year with students previously identified
- Request that school personnel at NCHS & NCMS identify additional students who may benefit from the C&C mentoring program
- Provide training to interested school personnel at NCHS & NCMS to expand C&C mentors pool
- Outreach & provide training to other school community volunteers, including parents to expand C&C mentors pool for NCHS & NCMS

- Promote Livewell Kershaw and the LWK MH team at school-wide teacher meetings to increase awareness of the ways in which the team can support teachers, students, and families

- Continue with mental health facilitation at Midway, NCHS and NCMS through providing teacher trainings and individual teacher meetings with evidence-based strategies taught to increase the capacity of schools to respond to students mental health needs in the classroom

- Expand mental health facilitation beyond Midway, NCHS and NCMS to include additional supports for Baron DeKalb, Bethune, and Mt. Pisgah Elementary schools through informational newsletters for school personnel and families

- Advance coordination of mental health activities with the School Based Health Center at NCHS

- Advance the partnership between the USC Psychology department and North Central High School and the Kershaw School District to develop a practicum placement for a mental health service provider at the School Based Health Center

- Advance partnerships between LWK and the MH service providers in the northeast region of Kershaw to increase school based services through connection with the School Based Health Center

B. School Based Health Center

Progress from March - May, 2015

The School Based Health Center in North Central High School is currently in the planning stages. The medical staff has selected an appropriate site within the school, and Kershaw staff are finalizing the hiring of a full time nurse practitioner. Dr. Frank Morgan, the superintendent, has been kept informed of progress being made and remains fully supportive. The team has developed a comprehensive timeline, which is a very important step in setting expectations and communicating important roles and benchmarks.

The School Based Health Center team attended a faculty meeting on May 7th, to introduce themselves and inform the faculty about the SBHC, parental consent, HIPAA and FIRPA Compliance. Sign up sheets have been drafted to be distributed to parents and students on registration day.

The SBHC will open at the school in two phases. In the first phase, SBHC staff will establish a presence in the school by offering counseling and mental health services via a school counselor. Counseling services will be coordinated with broader based mental health programming at the school. This phase will begin in the fall of 2015. Starting in January 2015, a nurse practitioner will begin offering clinical

services. The newly hired nurse practitioner is a graduate of North Central High School and has strong ties to the community.
As part of preliminary evaluation work, a brief needs survey was sent to all faculty and staff at North Central High (see Table 1 below). A needs survey will also be distributed to parents on registration day.

Findings from North Central High School Faculty and Staff Assessment Survey

In preparation for the creation of a school based health center at North Central High, LiveWell Kershaw distributed a survey to faculty and staff. The survey asked about the perceived health needs of student, and how a school based health center might address those needs. The survey was created in Survey Monkey, and distributed via email to the entire faculty and staff (N=48) at North Central High School. Thirty-seven respondents completed the survey including 26 teachers (seven of whom were also coaches) three administrators, six support staff, and one counselor.

Perceptions of health issues

Respondents were asked how rare or common certain health conditions were amongst the students that they worked with (see table 1 below). Of the 12 health issues on the list, the majority of respondents (89.2%) listed acute health issues, such as colds, sore throat, stomach aches, and headaches, as common or very common. Chronic conditions (such as asthma, allergies, and diabetes), the need for physicals (such as sports physicals), and stress and anxiety were also rated as common amongst students (86.5%, 86.1%, and 74.3%, respectively). Conversely only 5.7% of respondents rated eating disorders as common, and 26.5% rated need for vaccinations as common. Interestingly, only 36.4% of respondents rated mental health issues as common, despite it being cited as a key factor in other LiveWell Kershaw assessments for school based health.

Table 1: For students whom you work with, how rare or common are the following health issues?			
Answer Options	Very rare/Rare	Common/Very Common	Response Count
ACUTE health issues (e.g., colds, sore throat, stomach aches, headaches)	10.8%	89.2%	37
CHRONIC conditions (e.g., asthma, allergies, diabetes)	13.5%	86.5%	37
Need for PHYSICALS (such as sports physicals)	13.9%	86.1%	36
STRESS/ANXIETY	25.7%	74.3%	34
INJURIES (such as accidents and sports injuries)	36.1%	63.9%	36
DRUG/ALCOHOL/TOBACCO use	36.1%	63.9%	33
VISION problems	44.4%	55.6%	35
HUNGER	51.4%	48.6%	36
MENTAL HEALTH issues	63.6%	36.4%	35
BULLYING/SCHOOL VIOLENCE	68.6%	31.4%	35
Need for VACCINATIONS	73.5%	26.5%	36
EATING DISORDERS	94.3%	5.7%	35
Other (please specify)	Other (please specify)	Other (please specify)	1
answered question			37
skipped question			0

We also asked respondents to rate a list of potential school based health center services as being high priority, middle priority, or low priority (see table 2). Of the services listed, the majority of respondents saw acute care (70.3%) and addressing social issues (54.1%) as high priorities. Counseling and treatment for mental health was only seen as high priority by 27.0% of respondents. Addressing bullying/school violence, providing vaccinations, and counseling and treatment for eating disorders were also less likely to be seen as high priority (18.9%, 16.7% and 0.0% respectively).

Table 2: Below is a list of services a school based health center could offer. Please select those you feel are HIGH priority, those which are MIDDLE priority, and those which, while important, are LOWER priority.

Answer Options	LOWER priority	MIDDLE priority	HIGH priority	Response Count
ACUTE CARE (e.g., colds, sore throat, stomach aches, headaches)	10.8%	18.9%	70.3%	37
Addressing SOCIAL ISSUES (e.g. hunger, family problems)	2.7%	43.2%	54.1%	37
Care for INJURIES (such as accidents and sports injuries)	18.9%	32.4%	48.6%	37
Providing PHYSICAL EXAMINATIONS (such as sports physicals)	10.8%	40.5%	48.6%	37
Counseling for DRUG/ALCOHOL/TOBACCO use	13.5%	37.8%	48.6%	37
Helping students manage CHRONIC CONDITIONS (e.g., asthma, allergies, diabetes)	10.8%	59.5%	29.7%	37
Counseling and/or treatment for MENTAL HEALTH issues	21.6%	51.4%	27.0%	37
Counseling and/or treatment for STRESS/ANXIETY	8.1%	64.9%	27.0%	37
Addressing BULLYING/SCHOOL VIOLENCE	18.9%	62.2%	18.9%	37
Providing VACCINATIONS	50.0%	33.3%	16.7%	36
Counseling and/or treatment for EATING DISORDERS	52.8%	47.2%	0.0%	36
answered question				37
skipped question				0

Clinic Operations

LiveWell Kershaw also gathered perceptions of ideal hours and days of operation. When asked whether it was more beneficial to students if a school based health center were open every school day, for a few hours per day, or twice a week for the entire school day, the majority of respondents (72.2%) chose every school day.

When asked about the ideal times for operation, the most common answer was “First thing in the morning, then again in the afternoon” (45.9%), followed by “late morning to early afternoon” (35.1%) (see table 3 below).

Table 3. If a school based health clinic were open for limited hours every school day, what hours would be ideal?

Answer Options	Response Percent	Response Count
First thing in the morning, then AGAIN in the afternoon (such as 7:40am-9:10am and 1:30pm-3:00pm)	45.9%	17
Late morning to early afternoon (such as 9:45am-12:45pm)	35.1%	13
First thing in the morning (such as 7:40am-10:40am)	16.2%	6
Afternoon (such as 12:00pm-3:00pm)	2.7%	1
Do you have other suggestions for hours?		1
answered question		37
skipped question		0

When asked to choose a day of the week that the clinic “really should be open”, most respondents who chose a day chose Monday (35.1% of total). The most common answer however was “it does not matter” (45.9%).

Discussion

According to the staff surveyed by LiveWell Kershaw, it would be ideal if a School Based Health Center was well equipped to handle acute illness, and social issues. Care for injuries, physical examinations, and counseling for drug and tobacco were also seen as high priority. Though chronic conditions were seen as common, they were not seen as a high priority for a school based health center. Mental health issues were not seen as being a common health problem, nor a high priority, despite their salience in other research conducted by LiveWell Kershaw.

According to staff, the center would ideally be open every day, both in the morning at the start of the school day and again in the afternoon. Monday was an important day to be open (perhaps because students have been away from school, and thus school based health, for two days).

Future Plans

During the next quarter, the activities will focus on laying the groundwork for the SBHC including the following which relate to the overall LWK Driver diagram:

1) Create and cultivate a School Advisory Council that reflects diverse population at North Central High School
2) Provide behavioral health counseling to students at North Central High School
3) Provide care coordination and health education to students through Community Health Worker at North Central High School
4) Provide primary care services through Nurse Practitioner to students at North Central High School
    a. Finalize materials for registration, including HIPAA and FERPA forms, and introductory letters to parents; gain approval from school district
    b. Sign up students on school registration day 7/30
    c. Begin work on necessary clinic forms including sign in sheets, Medicaid forms, and billing forms
    d. Complete creation of infrastructure, including clinic space, materials, and online capabilities (i.e., text and email)
    e. Gain necessary inspection and approvals for clinic space
    f. Set operations parameters, such as hours and policies
    g. Meet with school nurse and counselors to begin coordinating activities

The evaluation for the school based health is in the planning stages but will likely contain the following components:

1) Tracking of students seen, reasons for visits, and outcomes (including referrals)
2) Tracking student visit information, such as time and day of visit, to evaluate use patterns
3) Qualitative interviews with clinic staff and some students to evaluate process
4) Surveys and interviews with students to gauge satisfaction
5) Examination of population level data (such as attendance data) to evaluate positive changes over time

Crucial to the efforts of the evaluation will be identifying the information that can be collected during students encounters, and how students can be monitored as they engage with different practitioners and resources within the school health system, such as Powerschool data and Electronic Medical Record data.

Evaluation Recommendations

- Create a SBHC Advisory Group that meets regularly to guide the group in planning and buy-in from teachers, parents and students. Consider including school health and wellness staff, such as the school nurse, guidance counselors, coaches and health class teachers.
- Appoint one person to serve as the liaison between the evaluator and the School Based Health Center team.
- Continue to have regular team meetings.
- Continue to update timeline and use project management practices to ensure successful start-up of the School Based Health Center.
- Secure North Central High School email address for all School Based Health Center team members
- Provide baseline health screenings and flu immunizations in the fall for students, parents and teachers to build buy-in.

Driver 3: Create vibrant relationships and functional networks with community members to accelerate trust, outreach and achievement of a shared goal.

Progress from March - May, 2015

During this reporting period, the inaugural Community Council meeting was held with 4 participants on March 5th at North Central High School. The LWK team presented background of the initiative and also explained the role of the council. The team was able to answer questions and the group agreed to meet monthly. As of this report, the team did not meet again and is scheduled to meet on June 16th.

Community Council attendees

On April 13, 2015, a Community Outreach 101 Bootcamp was held with all LWK team members at the Goodale State Park in Camden, SC. The purpose of this retreat was to focus on the importance of outreach and create a tagline for LWK. Evelyn Loque from the Best Chance Network shared her experiences as a community outreach worker and reinforced the importance of getting to know the people and the area to be successful. Holly Hayes gave a brief workshop on the importance of asking open ended questions with community stakeholders and how to develop focused conversations with different audiences. In addition, Grant Jackson shared with the team the role of the website and social media tools for spreading the LWK message. At the close of the retreat, the group agreed that the slogan for LWK would be "Your Bridge to Better Health." Following the bootcamp, surveys were completed by all participants using Survey Monkey. Feedback on the sessions were overall positive, with some confusion about the plans moving forward related to outreach. The group seemed to appreciate time being spent to get to know team members on a deeper level.

Over this 3 month period, LWK team members participated in 26 unique community events to share and distribute information. The Detailed Timeline on page 43 describes all of the events, locations, and outcomes. As a result of these events, the LWK team has designated Whitney Hinson as the Community Outreach Coordinator as of March 16, 2015. In this role, Whitney is responsible for creating and leading implementation of strategies and programming to facilitate community outreach efforts. Whitney works closely with diverse groups of people in community organizations throughout Kershaw County to promote a better understanding of the LiveWell Kershaw Project.

The team has also created a detailed Communication and Marketing Plan for LWK (see page 36). The team shared the first draft of the plan with DHHS on May 28, 2015. During that meeting, several outreach strategies were suggested: make a presentation to Kershaw County Council and connect

with our legislative delegation, connect with the farmers' market to get a list of nutritious foods and vendors available and create recipe cards to distribute, and use a digital tracking tool to help us determine which types of outreach events bring in the most traffic to our sites. These items have been incorporated as strategies into the Communications and Outreach Plan.

To date, a few of the strategies outlined in the revised plan (see page 36) have been implemented. Promotional materials have been designed including brochures, flyers and businesses cards. Updates are also posted regularly through Facebook and the LWK website. An ongoing weekly notice about the community healthcare site schedule appears in the Chronicle-Independent, the Kershaw County News, and Kershaw Era News. Community partnerships have also been established with Food for the Soul, the Kershaw Area Resource Exchange (KARE), Sandhills, and the SC Dept of Vocational Rehabilitation.

Future Plans

The local team plans to work on recruiting 20 volunteers over the next three months, with at least 4 per site. In addition, the team plans to visit and connect with 10 new churches in the North Central Area. In the fall, plans are being made to give presentations to local county officials. The Project Director is also considering convening the larger LWK group together regularly with the assistance of the Arnold School of Public Health.

Evaluation Recommendations

The LWK van is visible at events throughout the

- Strategically share LWK materials throughout Kershaw through CHWs, community council members, volunteers and residents.
- Newsletter needs to be distributed quarterly to all LWK stakeholders. The first newsletter was distributed in February and additional newsletters have not been distributed.
- Convene Community Council meetings monthly until numbers begin to improve and recruit diverse members of the community to serve on the Council.
    - Change meeting time for Community Council meetings from 4 PM to 6 PM to allow more community members to attend
    - Create minutes from the meeting and distribute to members not able to attend and post on the LWK website
    - Recruit families and children to attend Community Council Meetings together
    - Have each member complete a community member profile form to understand what connections and gaps exist with current membership

- Create volunteers packets and develop a standardized checklist for what needs to happen when a volunteer is recruited
    - Revitalize volunteer recruitment
- Closely monitor progress being made by individuals related to the Communications & Outreach plan
- Reconvene the LWK Collective Impact group that originally met for 18 months to plan to initial LWK strategic plan

Communication & Marketing Plan

Revised June 1, 2015
(Meeting with DHHS Communications Team – May 28, 2015)

THE LIVEWELL KERSHAW "ONE VOICE" MESSAGE:
"Your Bridge to Better Health!"
(Established April 13, 2015 – Boot Camp 101)

OVERARCHING GOALS OF THE PLAN:

GOAL ONE: To position LiveWell Kershaw as a Community Health Improvement Model to guide health investments for Kershaw County and other counties in the state.

GOAL TWO: To focus communication efforts on engaging stakeholders to develop buy-in and ownership and plan for sustainability.

GOAL THREE: To create an annual, strategic communication plan that is evaluated and revised as needed to meet the goals of LiveWell Kershaw.

CHW Karen Baker (left) assists a client at Midway Elementary

Goal One:
To position LiveWell Kershaw as a Community Health Improvement Model to guide health investments for Kershaw County and other counties in the state.

Objective One:
Develop clear, consistent messages that are delivered in "one clear voice."

Action Step	Time Frame	Responsible Persons	Success Indicator	Budget
Define & articulate the LWK theme.	On-going	All LWK Staff	All staff know and understand our "one voice message"	Printing supplies for flyers, posters, signs, reports, handouts, etc.
Develop key messages for staff, board and key communicators.	March 2015	Cheryl & Whitney	List of key messages distributed to team members	
Promote & display the LWK brand image.	On-going	All LWK Staff	Brand image is visible throughout NC, surrounding areas & Kershaw County	
Sponsor an Annual LWK Poster Contest for elementary students.	Begin Fall 2016	Whitney	Contest is held Spring 2017 Students are recognized	
Conduct booster session for staff on community outreach activities.	May – June 2015	Susan	Clear branding message. Staff can successfully demonstrate outreach/inreach activities on daily logs.	
Collect testimonial messages from clients about the services they received.	March – May 2015	Holly	Testimonial messages included in Quarterly Report	
Conduct focus groups in each target area.	Begin June 2015	Holly	Survey results show clear message in community	

Goal One Objective Two:
Develop marketing materials that emphasize LiveWell's core components and key priorities.

Action Step	Time Frame	Responsible Persons	Success Indicator	Budget
Create attractive marketing brochures.	On-going as needed	Grant & Whitney	Brochures are distributed throughout target areas	Printing supplies for brochures
Revise and update website, Twitter, Facebook.	On-going	Grant	Social media is current w/ up to date information	
Place brochures at businesses, health agencies, providers, hospitals, etc.	On-going as needed	Cheryl, Whitney, CHWs	Brochures are placed in healthcare facilities	Printing costs for signs, business cards, promotional items
Create yard signs for clients to display.	Year Two May - June 2016	Grant	Signs are available for clients to pick up when they visit the sites	
Place "permanent" signs at each community healthcare site.	June – July 2015	CHWs	Signs are visible at each site	
Create uniform business cards for all LWK staff.	March-April 2015	Whitney & Grant	All staff have cards to distribute	
Develop and distribute promotional paraphernalia, such as canvas bags, refrigerator magnets, pens, stickers, etc.	Year Two May - June 2016	Cheryl, Whitney & Grant, CHWs	Promotional items are distributed at community events	
Create promotional video clips, blogs, podcasts and/or other digital presentations.	Year Two May - June 2016	Grant & Whitney	Presentations are posted appropriately for public view	
Create Healthy Recipe Cards to be distributed at local grocery stores, farmers' markets, community events, etc. Include ingredients list for local food stores/markets.	Year Two May - June 2016	Cheryl, Whitney, CHWs	Cards are distributed throughout target areas & other relevant areas of the county	

Goal two:
To focus communication efforts on engaging stakeholders to develop buy-in and ownership & plan for sustainability.

Objective One:
Establish regular communication with key stakeholders, community members, and the public.

Action Step	Time Frame	Responsible Persons	Success Indicator	Budget
Provide regular updates for stakeholders and target area residents.	Quarterly	Whitney & Grant	A newsletter is distributed electronically and hard copies are mailed & provided at community sites	
Inform public of LWK activities and events via local newspapers & community publications.	On-going as needed	Whitney	Events are printed in "free" sections of local publications	
Use local radio to deliver information on a regular basis.	On-going as needed	Whitney	LWK activities are announced on local stations	
Present LWK information and services to civic groups, faith-based organizations, parents, & local political groups, including County Council.	On-going as appropriate	Cheryl & Whitney	Scheduled presentations listed on Google calendar	
Initiate regular communication with local clergy.	On-going	Whitney & CHWs	Log of meetings & contacts with local pastors/ministers	
Use current sites to connect with other churches.	On-going as needed	Cheryl & CHWs	2 additional sites by December 2015	

Goal Two Objective Two:
Establish a LWK Community Council.

Action Step	Time Frame	Responsible Persons	Success Indicator	Budget
Identify influential parents, community and business leaders, including minority leaders.	February-March 2015	Cheryl & Whitney	A directory of potential council members is created	Funds for snacks & supplies for meetings
Meet with Community Council at least once each quarter.	Beginning March 2015	Cheryl & Whitney	Agenda, roster & meeting minutes	
Invite council members to visit each community site.	2015 June – December	Cheryl & CHWs	Documentation of site visits	
Keep members informed between meetings via newsletters and emails.	Beginning March 2015	Whitney	Newsletters & emails are disseminated to members	
Establish a hotline or direct contact for key communicators to clarify information or head off rumors.	On-going	Whitney	Members are provided with a direct contact number for questions	

Goal Two Objective Three:
Continue to develop and implement community engagement/outreach strategies.

Action Step	Time Frame	Responsible Persons	Success Indicator	Budget
Hold town halls or forums in each target area.	Year Two June-Aug	Whitney, CHWs, Cheryl	One event is held in each area.	Supplies & materials needed for workshops, forums
Sponsor workshops or study circles on "hot topics" related to good health, wellness, and nutrition & meal preparation.	Year Two June-May	Whitney & CHWs	Workshop flyer, agenda, pictures	
Offer safety, CPR, and/or first-aid trainings at community sites.	Begin Year Two	Whitney, Cheryl, Susan	Record of number of attendees/ certifications	
Provide opportunities for public input that don't require attendance at a meeting.	On-going as needed	Whitney, Holly, Grant	Surveys developed for public input	
Develop collaborative partnerships with other county agencies/entities.	On-going	Susan, Whitney, Cheryl & CHW's	Directory of partnerships, i.e. KARE, Food for the Soul, Farmers' Market, McCaskill & McLeod Farms, local churches	
Participate in community outreach programs to distribute information and gain feedback.	On-going as appropriate	Cheryl, Whitney & CHWs	Events listed on shared Google calendar	

Goal three:
To create an annual strategic communication plan that is evaluated and revised as needed to meet the goals of LiveWell Kershaw.

Objective One:
Develop communication goals designed to improve and integrate effective communication with stakeholders and the public.

Action Step	Time Frame	Responsible Persons	Success Indicator	Budget
Involve the LWK Community Council in developing specific communication goals and action steps.	December –February 2016	Whitney	Community Council gives input during the review process	
Use interviews, opinion polls, and/ or surveys to regularly evaluate communication efforts.	Bi-annually	Whitney	Results are used during review process	
Establish a process to review and update the plan on a regular basis.	Bi-annually	Cheryl	LWK Team, Community Council and others are notified of the date of the plan review	

ON-GOING STRATEGIES TO ADDRESS ALL GOALS:

- Use web tracking tools to see if events/activities, etc. show corresponding increase in web traffic; survey clients and visitors to the sites to measure increase in site traffic.
- Connect with elected county officials to establish relationships and develop support for sustainability, county-wide presence, and future implementation: Funderburk, Sheheen, Burns, Matthews, etc.
- Implement current communication and marketing goals, objectives and strategies to promote SBHC services.

COMMUNITY HEALTHCARE SITES SCHEDULE - Begins July 6, 2015 (Proposed)		
MONDAYS:	CASSATT	9:00 a.m. – 1:00 p.m.
TUESDAYS:	SANDY LEVEL FREEDOM OUTREACH*	9:00 a.m. – 1:00 p.m. 4:00 p.m. – 7:00 p.m.
WEDNESDAYS	REFUGE BAPTIST CHURCH	9:00 a.m. – 1:00 p.m.
THURSDAYS	BUFFALO BAPTIST CHURCH* DEKALB BAPTIST CHURCH*	9:00 a.m. – 1:00 p.m. 4:00 p.m. – 7:00 p.m.
FRIDAYS	MT. MORIAH CENTER	9:00 a.m. – 1:00 p.m.+

*+ (2nd & 4th Fridays), * Unconfirmed*

Timeline of Community Events in Quarter 4

DATE	STAFF	DESCRIPTION	LOCATION	OUTCOME
March 5	LWK Team	Community Council Meeting	North Central High School	5 community members attended; LWK Team presented background on the project and the role of the Council
March 9	Cheryl	KC Democratic Women Mtg	Camden SC	Presented information on LWK & distributed brochures
March 10	Holly, Cheryl, Susan, Whitney	Eat Smart, Move More Meeting	Camden SC	Holly facilitated; ESMM goals/activities interconnect with LWK
March 16	Cheryl, Karen, Jesus	Bethune Elementary PTO	Bethune SC	Presented information & brochures to approximately 40 parents & school staff
March 16	Cheryl	KARE (Outreach Partner)	Kershaw SC	Picked up medical supplies for sites & clients
March 18	LWK & Access Kershaw	IMPACT Meeting	Camden SC	Presented LWK to attendees from various county agencies & organizations
March 20	Cheryl	KARE Collaboration Luncheon	Kershaw SC	Presented LWK to attendees from various agencies in Lancaster County
March 21	Kelly, Karen, Jesus	Sandy Grove Church Life Choice Awareness Day	Kershaw SC	Presented LWK to approximately 20 attendees in the Mt. Pisgah area
March 21	Cheryl, Whitney	Midway Elementary Rodeo	Cassatt SC	Distributed LWK materials; Easter Basket give-away; presented information to families; took pictures of some attendees
March 22	Cheryl	Believer's Temple Church	Cassatt SC	Presented information to approximately 30 attendees
March 24	LWK Team	Mini Health Fair @ Mt. Moriah	Liberty Hill SC	Presented LWK; offered free screenings; distributed materials, promotional give-aways; networked with other vendors
March 27	Cheryl	Jackson Elementary Career Fair	Camden SC	Spoke to students about LWK & healthy living practices
March 31	Cheryl	Food for the Soul (Outreach Partner)	Camden SC	Met with Director Fred Ogburn to discuss opportunity for community sites to serve as "soup kitchens"

DATE	STAFF	DESCRIPTION	LOCATION	OUTCOME
April 2	Cheryl, Holly	Camden Rotary Club Meeting	Camden SC	Presented LWK information to Rotary members; PPT on North Central area and targeted activities
April 4	Cheryl	Sandy Level Community Egg Hunt	Bethune SC	Distributed LWK newsletters; spoke to approximately 100 adults & children; promotional give-aways; acquired names and numbers of potential clients
April 13	LWK Team	Boot Camp – Staff Training	Camden SC	Team & Staff participated in communications, media, and outreach workshop sessions; facilitated by Holly, Grant, & Cheryl. Special session presented by Evelyn Loque, Hispanic Community Outreach Worker for state of SC
April 14	Cheryl	SC Thrive Training	Columbia SC	Certification as a TBB counselor
April 18	Cheryl & Whitney	Clinic Classic – CMC Annual Fundraiser	Camden SC	Booth display; presented information, newsletters, promotional give-aways; discussed healthy eating habits with attendees
April 20	LWK Team, NP, MD	Clinic Day @ Cassatt	Cassatt SC	The mobile clinic provided primary care to scheduled patients and enrolled new patients.
April 22	LWK Team	InsightVision Kick-Off Training	Camden SC	Consultants presented the software program to LWK Team & 5 community members
April 23	LWK Team	InsightVision Training-Day 2	Camden SC	Consultants continued training & team members practiced using the program online
April 28	Whitney, Kelly, Karen	Kershaw Baptist Association Block Party	Westville SC	Took LWK van; distributed promotional give-aways, informational materials; offered free screenings
April 28	Cheryl, Whitney, Mel, Mark, NP, Susan, MD	SBHC Planning Meeting	Camden SC	Team & staff heard presentation from Laura Brey, National School Based Health Alliance; participated in Q&A; preliminary planning for SBHC at North Central
April 29	Holly, Cheryl, Whitney	DHHS Quarterly Meeting	Columbia SC	Presented Quarter 3 Report

DATE	STAFF	DESCRIPTION	LOCATION	OUTCOME
April 30	LWK Team, NP, MD	Clinic Day @ Abney	Kershaw SC	The mobile clinic provided primary care to scheduled patients and enrolled new patients.
May 7	Cheryl, Whitney, Holly, Mark, Mel, NP, MD	North Central High School Faculty Meeting	Kershaw SC	Met with school staff and presented information on plans for the School Based Health Center
May 7	Access Kershaw Staff	SC Workforce Development		Distributed LWK brochures @ Job Fair
May 9	Whitney, Karen, Jesus	Kershaw Spring-a-Thon	Kershaw SC	Took LWK van; distributed promotional give-aways, informational materials; offered free screenings
May 13	LWK & Access Kershaw Staff	CMC Board Meeting	Camden SC	Presented PPT on project updates, strategies & evaluation
May 15	Kelly & Whitney	Santee Wateree Mental Health Fair & Walk		Offered free BP / Glucose screenings; counseled visitors on health maintenance; discussed LWK services
May 18	CHWs	Hispanic Parenting Class @ Midway Elementary	Cassatt SC	Karen presented a session on the importance of good general health. Jesus translated as needed
May 18	Cheryl	BDK PTO Family Night	Camden SC	Distributed information, newsletters, promotional give-aways; informed attendees about LWK
May 21	Cheryl	Food for the Soul Meeting	Kershaw SC	Food kitchen Chair & Board member met with representatives from healthcare sites
May 22	Cheryl, Whitney	BDK Field Day	Camden SC	Took LWK van; distributed promotional give-aways, informational materials; offered free screenings; display
May 27	Cheryl, CHWs, Interns	IGA Foodliner	Kershaw SC	Offered free BP / Glucose screenings; counseled visitors on health maintenance; discussed LWK services
May 28	Cheryl, Whitney, Grant	DHHS – Communication Plan Review	Columbia SC	Discussed the contents of the plan and strategies for moving forward
May 29	Cheryl	BDK Elementary	Camden SC	Speaker for 5th Grade Promotion; interacted w/parents & informed them about LWK – gave out business cards

Driver 4: Conduct evaluation using developmental, formative and economic approaches to guide the implementation process.

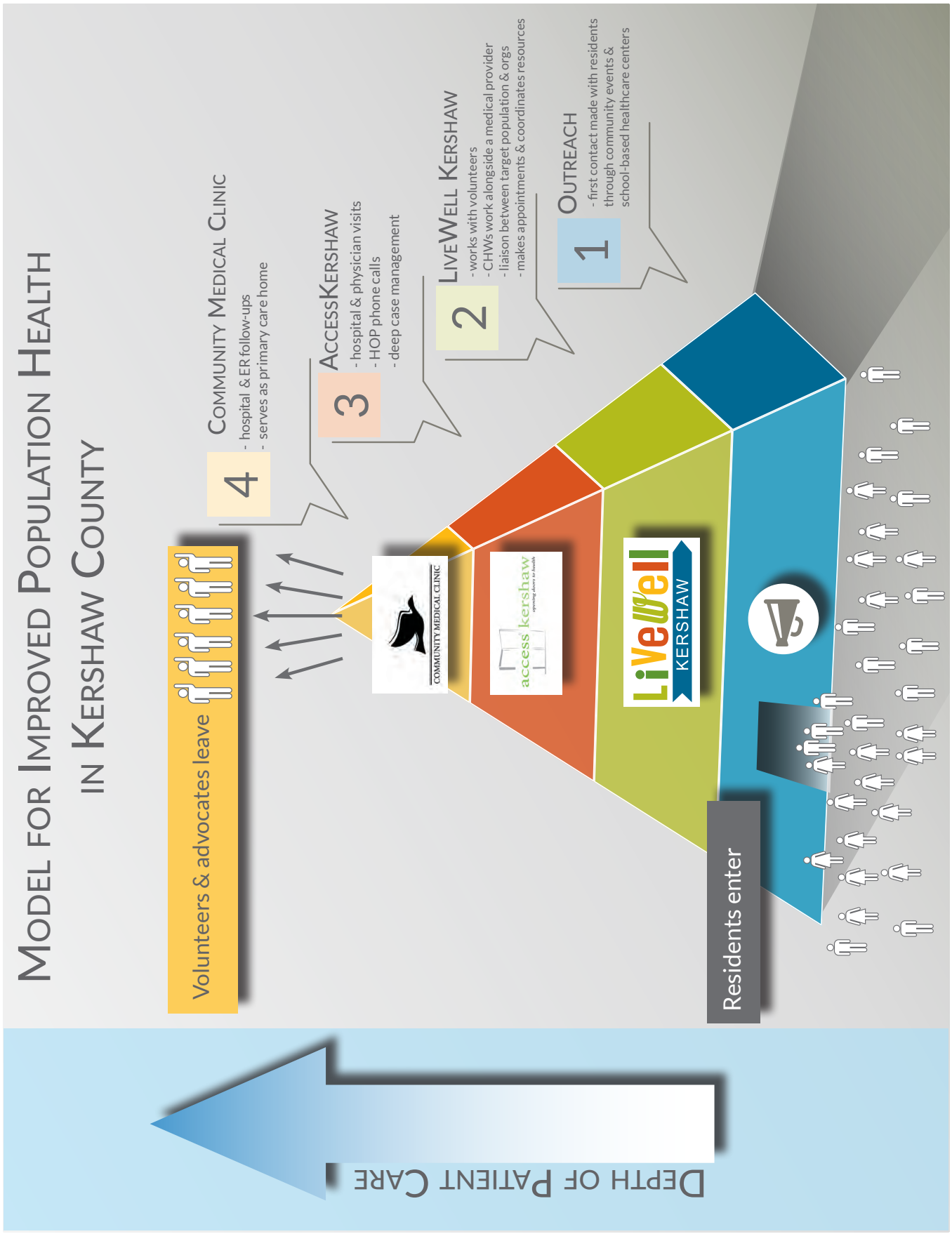
Progress from March - May, 2015

Lead evaluator Holly Hayes worked closely with the Project Director this quarter to bring greater clarity to the question "What is LWK?" by re-framing the roles of the CHWs, AccessKershaw and the Community Medical Clinic (see Figure 1 pg 47). The lead evaluator attended all key meetings and met regularly with various team members at least weekly. Surveys were administrated and interviews were conducted based on the needs of the project and information that was needed to guide decisions. It became very apparent that a strong quality improvement component was needed as the mobile clinics and community healthcare sites became fully operational.

The theme for quarter four was course-correcting. We often say that we are building the plane as we are flying it; quick responses to data are essential for the model we are using. After observations and pilot data were gathered on a specific topic, the Project Director and Lead Evaluator met and developed recommendations and potential changes. Throughout the past three months, changes were made to how the CHWs were monitored, the roles of individuals at mobile clinics, the integration and role of LWK partners, and frequency of meetings with key players was increased. Modifications were also made in data collection, decision making and sharing with others, information sharing through a Google business platform, and how volunteers are used to increase the capacity of the LWK initiative. The Project Director intentionally included CHWs and others at key meetings to develop performance metrics for the next year and to discuss the importance of reaching as many people as possible in the North Central Area. By the end of quarter four, the LWK team has a clear picture of what LWK is and how the different roles integrate and complement one another. The team also clearly understands expectations and goals for the upcoming year, and will continue to follow this course-correcting journey during year two.

Tamika Thomas joined the evaluation team on May 18th. Tamika has 6 years of experience working as a patient navigator at two community hospitals. In this new role, Tamika will spend three days a week in the field primarily assisting with testing and scaling small changes related to the community healthcare sites and mobile clinics.

Figure 1


Model for Improved Population Health
in Kershaw County
Volunteers & advocates leave
4
Community Medical Clinic
- hospital & ER follow-ups
- serves as primary care home
3
AccessKershaw
- hospital & physician visits
- HOP phone calls
- deep case management
2
LiveWell Kershaw
- works with volunteers
- CHWs work alongside a medical provider
- liaison between target population & orgs
- makes appointments & coordinates resources
1
Outreach
- first contact made with residents
through community events &
school-based healthcare centers
COMMUNITY MEDICAL CLINIC
access kershaw
LiveWell
KERSHAW
Residents enter
Depth of Patient Care

Dr. Mark Macauda joined our evaluation team this quarter to conduct a formative evaluation on the development of a School Based Health Center (SBHC). Dr. Macauda is an anthropologist and has 6 years of experience working with program evaluation and 9 years of experience working in qualitative and quantitative health research. In this role, Mark is responsible for designing and implementing the process and outcome evaluation components of the SBHC. The SBHC is currently in the planning stages, with operations scheduled to beginn in the fall of 2015.

This quarter Dr. Ibrahim Demir continues to conduct an economic evaluation for LWK. He has direct access to data from KershawHealth and the Community Medical Clinic. Dr. Demir has been able to render all Community Medical Clinic and KershawHealth visits, including ER visits, that originated from the North Central area for the past 3 years (baseline/before) of the LWK Project by utilizing GIS applications. Total unique visitors to both CMC and KershawHealth constitute 68% of the area population. He will contrast the "baseline/before" metrics to "after" metrics every six months starting from January 2015. He calculated the market areas for each healthcare site, established data collection tables with CHWs, and established a cost-accounting schedule with the project manager for the costing of the project. His current challenges include blockage of data flow from data sources, low data coverage of the area population, and lack of health information about residents in the target area population who received healthcare services from providers other than Community Medical Clinic of Kershaw and KershawHealth. Dr. Demir will submit biannual economic evaluation reports every September and February.

Future Plans

The evaluation team will continue to work closely with LWK during year two including expanding evaluation activities to the School Based Health Center initiative. The evaluation team also hopes to provide data that can be used to apply for grants through the Robert Wood Johnson Foundation and other funding sources, and to conduct evaluation workshops with the LWK team to share key skills that will enhance greater sustainability. Collectively we hope to use data to inform action and next steps in a productive way to improve population health.

Evaluation Recommendations

- Continue to request data from DHHS for economic evaluation (original requests began in 2013)
- Host a Quality Improvement workshop for the team and introduce the use of Plan, Do, Study, Act cycles
- Move evaluation efforts from developmental to formative for the community healthcare sites and mobile clinics
- Provide data-guided feedback to the CHWs and clinical teams related to service utilization marketing and costs of the operations so that the necessary re-allocations can be made.
- Utilize an improved Excel template to record and streamline data for analysis for the community healthcare site reporting

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LiveWell KERSHAW

"Your Bridge to Better Health"

Year Two

Quarter One Report

June 1 - August 31, 2015

LiVeWell KERSHAW

"Your Bridge to Better Health"

Table of Contents

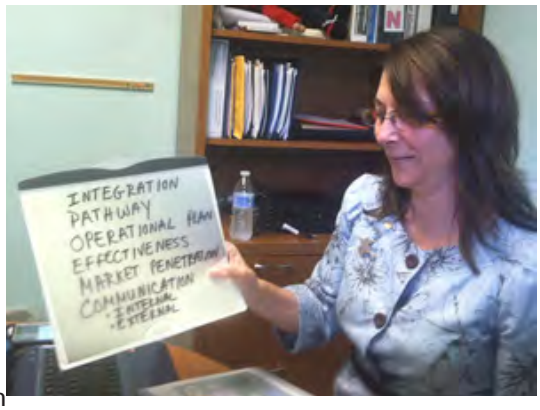
cover photo: *Highway 1 Bridge, Bethune, SC (listed in the Guinness Book of World Records as the only bridge to span the same river three times.)*

Introduction Letter

UNIVERSITY OF SOUTH CAROLINA
Arnold School of Public Health

Office of Research

September 1, 2015



Year two quarter two can be defined as "iteration after iteration" to ensure that we are a "bridge to better health" for the residents of Kershaw County. In an effort to integrate LiveWell Kershaw, the Community Medical Clinic and AccessKershaw, Susan Witkowski presented a new team-based structure on June 29, 2015 (see page 4). This team-based framework is the first attempt at integrating three unique initiatives all working together to promote and achieve patient-centered and family-centered care. As a result of this iteration, Whitney Hinson changed roles within the team to lead and support the care coordination and outreach team. Emily Mancil and Abby Albright from the University of South Carolina's Department of Psychology began to play a much larger role in relation to the launching of the School-Based Health Center team. A new team emerged this quarter based on insights from Dr. Rick Foster and others known as the "Pathway" team which is working to develop clear pathways to serve all patients and ensure smooth care transitions. This unique team includes case managers, Nurse Practitioners, and team members from AccessKershaw and the Community Medical Clinic. All teams are now meeting at least monthly discuss progress being made, and more importantly what activities need to be conducted to meet their goals. Data is being shared and examined at all meetings to track progress to date.

The driver diagram (see page 5) is still being used as our most current theory of change. We believe that by working on the four drivers listed below, that Kershaw will be the healthiest county in SC through a holistic approach. We are constantly asking ourselves, Is this change making an improvement? And if not, what change do we need to make?

Our Primary Drivers include:

- Extend primary care in the community to increase access and care coordination
- Extend primary care and mental health care at all schools in North Central to increase access and care coordination
- Create vibrant relationships and functional networks with community members to accelerate trust, outreach and achievement of a shared goal
- Conduct evaluation using developmental, formative, and economic approaches to guide the implementation process

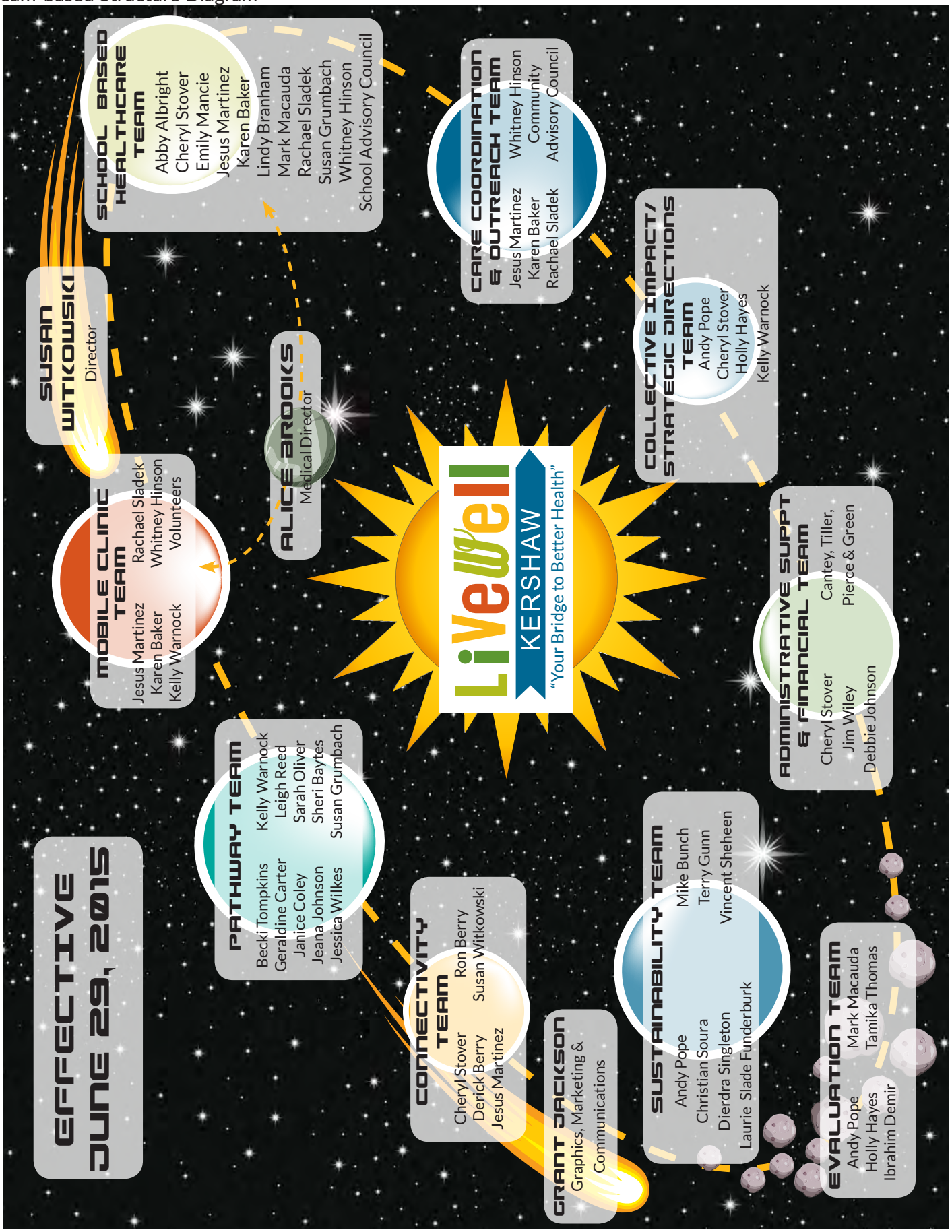
We invite you to read our progress and lessons learned this quarter. As we delve deeper into this work, we are committed to building results, relationships and processes to build a "bridge to better health."

Best in all you do,

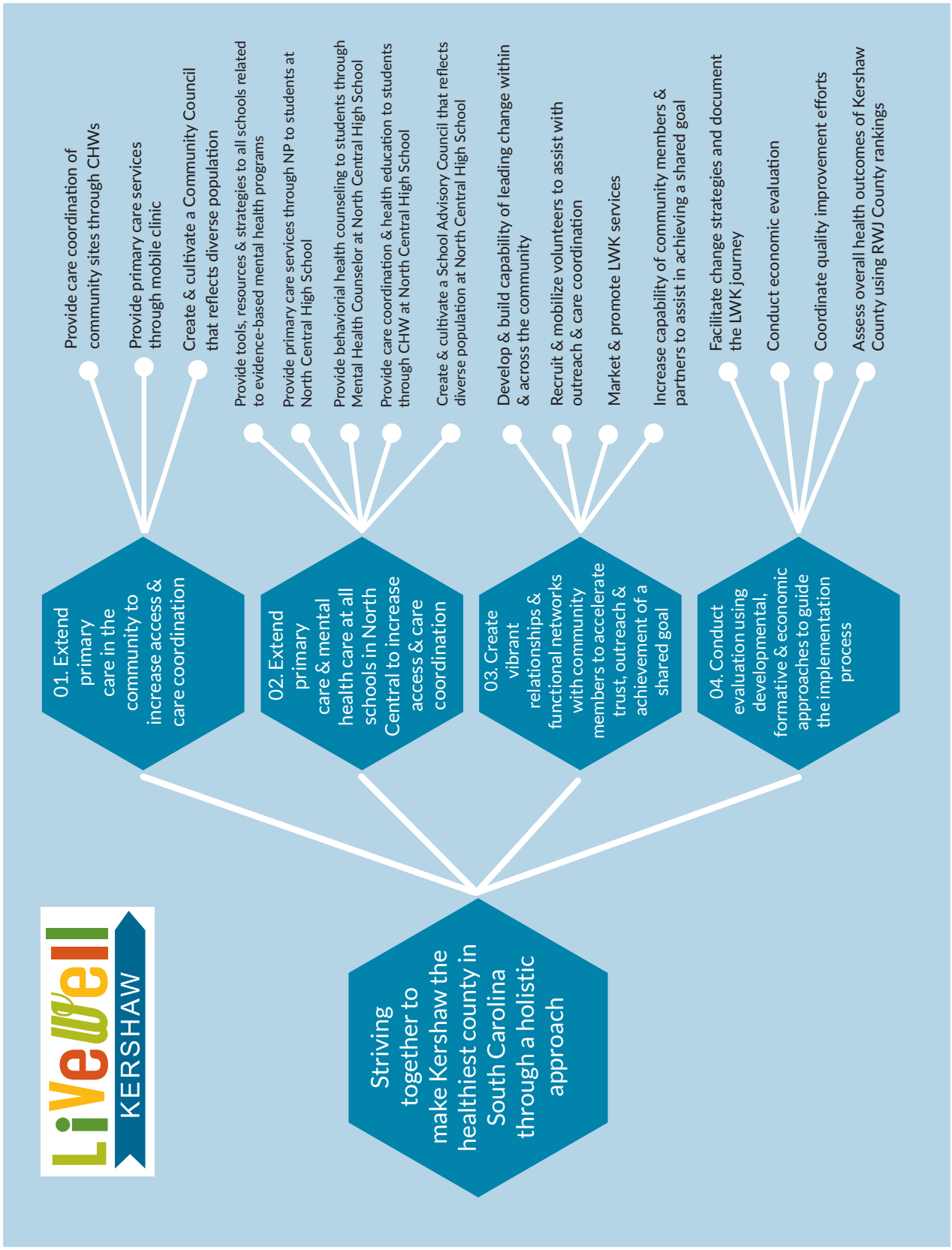
Holly Hayes
Evaluator, LiveWell Kershaw

Susan Witkowski
Director, Community Medical Clinic

Team-based Structure Diagram



Driver Diagram



DRIVER 1

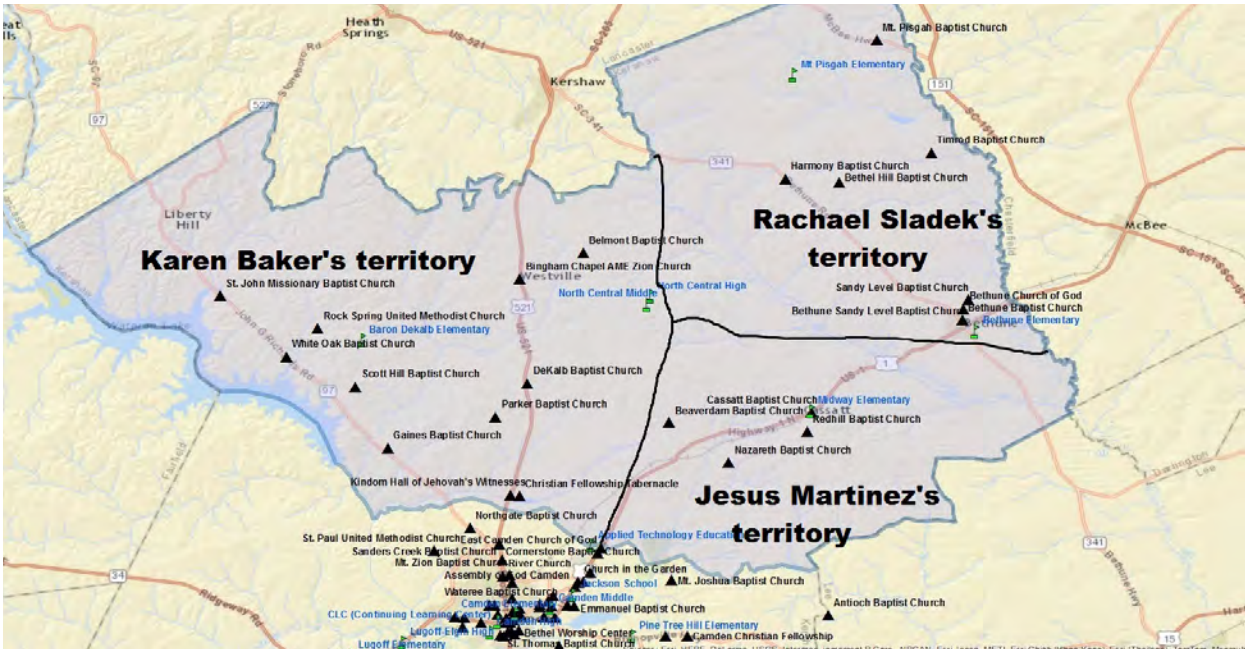
Extend primary care in the community to increase access and care coordination

Progress from June-August, 2015

A. Community Healthcare Sites

The care coordination team focused on addressing the majority of evaluation recommendations to ensure the successful extension of primary care in the community. The CHWs successfully completed the state certification training through Midlands Technical College from June 1- June 29 and participated in clinical trainings in July at the Community Medical Clinic (See pages 14 - 20 for more details). The site at Mt. Moriah Missionary Baptist Association, which is available every 2nd and 4th Friday, was closed in July due to low volume of client encounters. The team adjusted the hours of the community healthcare sites to increase client volume. Clients can be seen on Monday, Tuesday, Wednesday, and Thursday mornings from 9am to 1pm and again on Monday and Tuesday evenings from 5pm to 7pm. The team opened three new satellite sites this quarter, including Buffalo Baptist, Freedom Outreach Baptist, and DeKalb Baptist. The team worked closely with Tamika Thomas, the evaluation coordinator, to monitor certain metrics weekly to determine if sites' hours needed to be adjusted to maximize client volume.

On June 29th, Whitney Hinson became the Community Engagement and Outreach Manager, supervising the CHWs and all activity related to drivers one and three. This includes satellite clinics, Community Council meetings, community events, and School-Based Health Center advisory Committee. Karen Baker became the lead CHW after the Director realized that more local oversight was needed. Whitney Hinson created a detailed schedule which is divided by territory per CHW and includes time blocks specifically for clinics,
businesses, and churches. This was needed after CHWs became certificated and could operate independently. In August, two of the CHWs began to rotate hours at the SBHC at North Central High. All the CHWs and Ms. Hinson completed an online New Leaf Training which allows the CHWs to do health



CHW Territories Map

coaching related to healthy living, including nutrition and physical activity. The CHWs completed a group session with Leigh Reed from the Community Medical Clinic to see how coaching can be modeled with patients. The team plans to begin using the training manual in their clinical encounters at the satellite clinics.

In an effort to increase the number of clients enrolled at the Community Medical Clinic, the CHWs and Whitney Hinson attended training with Geraldine Carter at the Community Medical Clinic. The goal of the training was to ensure that all the CHWs could approve and screen clients on sites for enrollment into the Community Medical Clinic. The team now has binders with necessary paperwork and directions. According to Rachael Sladek, "this has changed my work" and increased efficiency. Patients no longer have to visit the clinic two or three times to complete the necessary paperwork for approval. According to Ms. Hinson "this process has allowed us to be more patient centered" and eliminate unnecessary trips to the clinic.

Large LiveWell Kershaw signs are now in front of the church sites for easy visibility from the road. Based on recommendations, the CHWs were assigned unique territories (split into three) that encompass the entire North Central region (Refer to map on pg 6). Jesus Martinez is responsible for seeing clients at the Cassatt Baptist Church site and at the Refuge Baptist Church site on Mondays and Wednesdays. Rachael Sladek is responsible for seeing clients at the Sandy

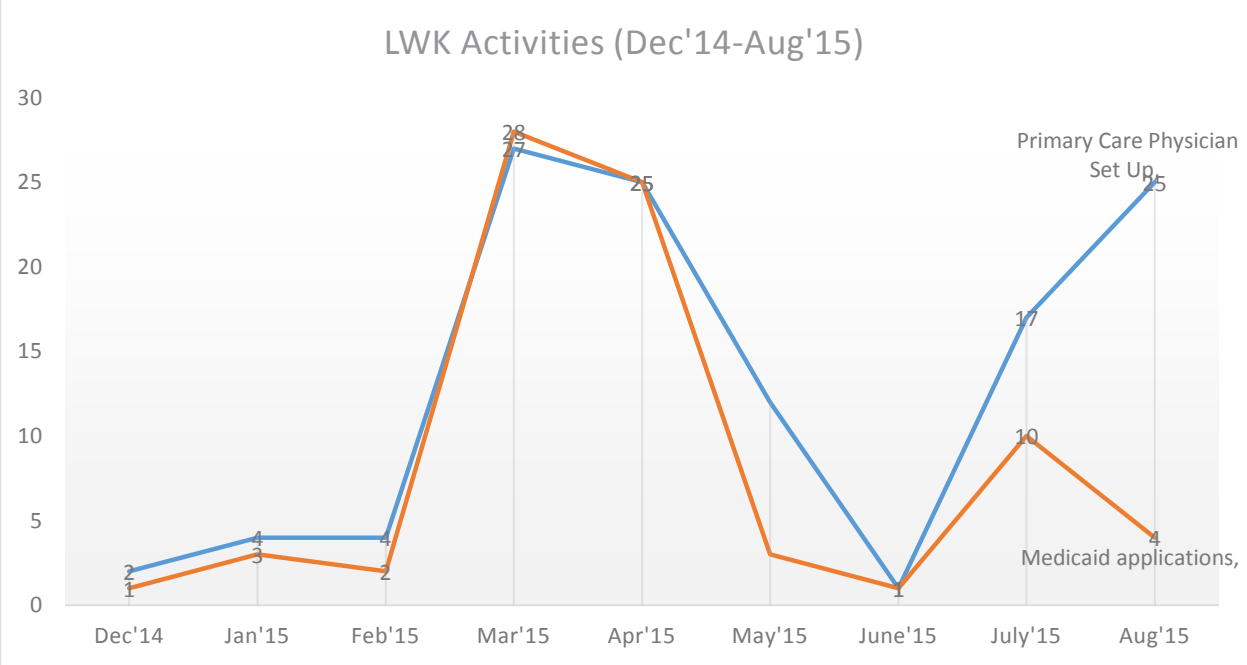
Level Baptist Church site and at the Buffalo Baptist Church on Tuesdays and Thursdays. Ms. Sladek is also responsible for the site at DeKalb Baptist Church on Monday evenings, while Jesus is responsible for the site at Freedom Baptist Outreach on Tuesday evenings. Karen Baker is focusing on outreach activities by phone, mail, and setting up medical and social service appointments for clients after a back injury. As a result, she has been able to provide more assistance to clients with the Affordable Care Act (ACA navigations), as indicated in table 4 on pg 12.

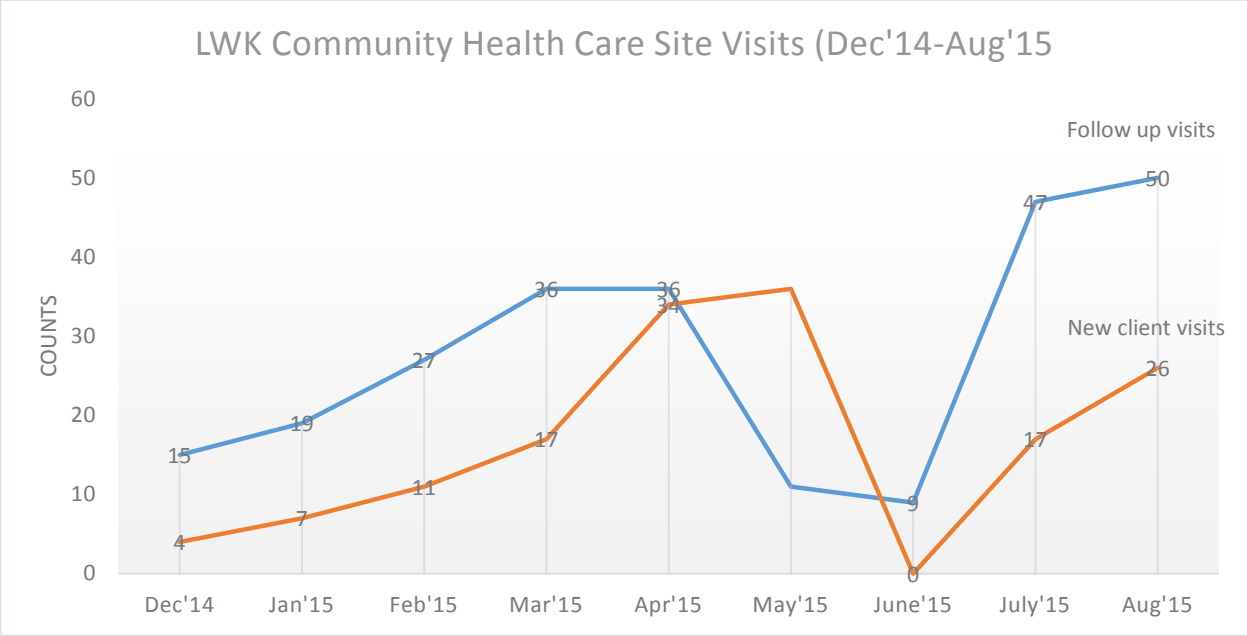
Table 1 shows the productivity of the CHWs for this quarter. The numbers for June were low due to the CHW training that occurred in June, and part of July was spent completing the required two week clinical rotation at the Community Medical Clinic.

Table 1: CHW Productivity for Quarter 1 in Year Two

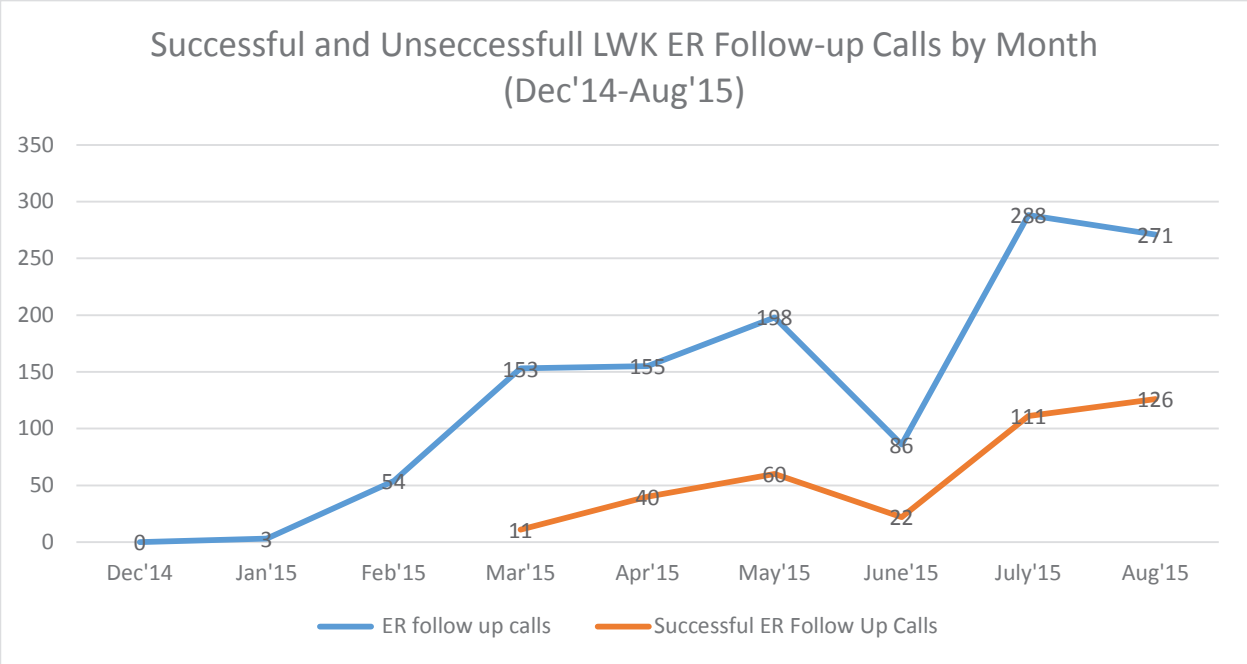
CHW	June			July			August		
	New Client Visits	Follow-Up Visits	No-Shows	New Client Visits	Follow-Up Visits	No-Shows	New Client Visits	Follow-Up Visits	No-Shows
CHW 1	2	0	0	11	0	14	4	4	0
CHW 2	1	0	0	2	2	0	7	4	7
CHW 3	1	0	0	26	11	1	10	14	2
Totals	4	0	0	39	13	15	21	22	9

The trend charts below show activities from December to August related to work for care coordination across North Central.





Trend charts continued.

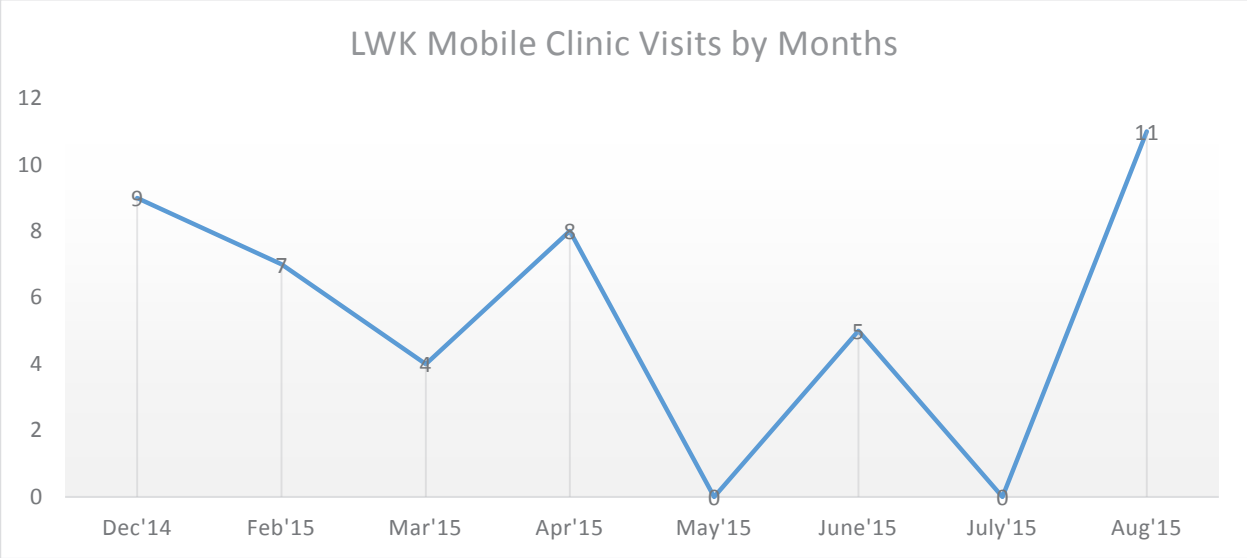


B. Mobile Clinics

The mobile clinics continued to serve clients by a Nurse Practitioner or Medical Director at the satellite church sites. There are currently four mobile clinics operating from 9 am to 1 pm each month on a rotating basis. A mobile clinic was held on June 24th at Refuge Baptist Church and the second on June 29th at Cassatt Baptist Church. There were three patients and four clients (walk-ins) seen at Refuge and two at Cassatt. No mobile clinics occurred in July due to CHW training. On August 3rd at Cassatt, the CHWs served four clients and the Nurse Practitioner served three patients and administered five sports physicals for North Central High School Students. This mobile clinic has been the most successful to date. The care coordination team attributes the success of the mobile clinic to successful outreach at school registration events the previous week. On August 19th at Refuge, the Nurse Practitioner served one patient. On August 27th, Buffalo Baptist Church had its first mobile clinic where the CHWs cared for two clients, and the Nurse Practitioner served one patient. Two volunteers helped with urine collection and the registration desk. On August 31st at Cassatt, the Nurse Practitioner served one patient.

Table 2: Mobile Clinic Patient Visits

Location (Mobile Clinic)	Patient Visits
Cassatt Baptist	6
Sandy Level Baptist	0
Refuge Baptist	4
Buffalo Baptist	1
Sports Physicals	16



C. Follow-Up Phone Calls

The CHWs continued to call residents living in the North Central area who went to the Emergency Room. The CHWs made phone contact with more clients (47%) compared to last quarter (17%). The team attributes the increased number of phone contacts to changing their phone number to an unblocked number. Rachael Sladek noted that "not having a blocked number has been incredible for our work." In addition, the Community Engagement and Outreach Manager began to closely monitor the CHW activities and created an expectation of timely feedback for all persons on the hospital referral lists that is emailed daily.

Table 3: Successful Calls made in 1st Quarter

	June	July	August
Successful Calls	64	111	126
Total Calls Made	86	288	271

D. Continuous Quality Improvement

In the continuing effort to serve the North Central region, the care coordination team is making significant improvements to ensure success. The Google phone service is operating effectively so that the CHWs can make and receive calls to work better with clients and maintain consistent communication. The CHWs have e-fax capability so that paperwork to social service agencies is processed quickly. Outreach packets that include marketing materials, such as a LiveWell Kershaw Newsletter, a postcard, and a pen are being used to give to clients to share with family, friends, and church members. This outreach helps CHWs reach individuals who need healthcare assistance and health screenings but have not been to visit one of the sites.

The CHWs streamlined the tracking of client encounters. On July 20, 2015, the CHWs began using a new paper-based client satisfaction survey and a new Microsoft Excel spreadsheet to keep track of all client encounters on a weekly basis. The spreadsheet is serving as a checklist and standardized protocol for follow-up and outreach. It is emailed to Whitney Hinson and Tamika Thomas at the end of each week. In addition to the spreadsheet, the CHWs still place data into Fases, a case management system, which gives the Community Medical Clinic an overall picture of staff productivity. Insight Vision, which will be discussed in a later section, is another standardized way that data is being reviewed for quality improvement. The online data dashboard provides trend analyses to show progress on a weekly, monthly, and quarterly basis. The CHWs, Whitney Hinson and Tamika Thomas meet every Thursday to touch base on client activity and recruitment during the week, and to provide action plans for the week going forward. Each CHW prepares a weekly action plan based on their specific territory, including specific businesses, schools and churches. The care coordination team is working on recruiting and retaining volunteers to maximize their efforts. The team realizes that they cannot reach their client goal of 50 per week without outreach support from volunteers. The team only used two volunteers for this entire quarter.

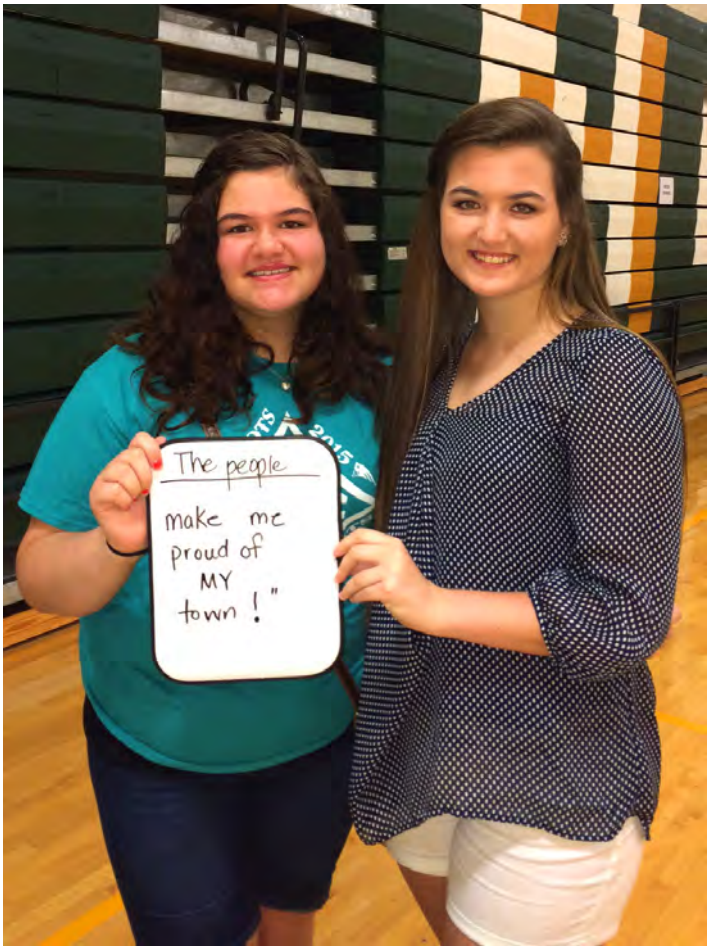


Table 4: Live Well Kershaw Activities

LiveWell Kershaw Activities	June	July	August	Total
New Client visits	9	47	50	106
Follow up visits	9	17	26	52
ER follow up calls	86	288	271	645
PCP set up	0	17	25	42
Medicaid applications	1	10	4	15
SNAP applications	1	8	7	16
Welvista applications	0	4	6	10
SS Disability	0	1	0	1
Extra Help application	0	2	1	3
With Medicare or Medicaid	0	6	1	7
Case Management Referrals	0	2	0	2
Home Visits	0	3	4	7
MD appointments visits	0	0	0	0
MH referrals	0	0	0	0
Dental referrals	3	9	4	16
PAP applications	1	9	3	13
Charity applications	2	3	3	8
HOP sessions	0	0	0	0
ACA navigations	2	3	46	51

LiveWell Kershaw staff with the LiveWell van.

Future Plans

- CHWs are now certified and are able to work independently of one another, thus increasing capacity.
- CHWs will integrate what they learned through New Leaf Program training into their daily practice and improve their health coaching skills to enable clients to make better choices for healthy living. This will include food assessments, health eating, physical activity, diabetes prevention and management, bone health assessment, smoking, and stress and depression.
- Once targets are met consistently, more satellite sites can occur simultaneously.
- The group is planning to purchase a mobile unit that will be placed on the grounds of North Central High School and will become a physical space for the CHWs to have face to face client encounters and a space for administrative work.

Evaluation Recommendations

- Ensure that CHWs are using the New Leaf training materials with client encounters as needed for health coaching in a consistent manner.
- Provide numbers of clients with missed appointments to evaluation team. Have the evaluation team call clients to determine why they are missing their appointments.
- Ensure that CHWs or volunteers are attending key community events in their assigned territory to continue to increase awareness of services.
- Determine if additional strategies need to be developed to target the Hispanic population in North Central.
- Follow-up with all volunteers recruited from School Registration day and create a plan to communicate and engage volunteers regularly to enhance retention.
- Determine if the recommendation made by Community Council members can be implemented and engage members to execute recommendations as appropriate.
- Produce detailed minutes for Community Council meetings.
- Utilize the PDSA worksheet and conduct quick tests on a weekly basis.
- Conduct PDSA workshop in collaboration with evaluation team to focus on enhancing performance of CHWs.
- Continue to closely monitor performance of CHWs.
- Continue weekly meetings to problem solve and plan for weekly activities based on data shared by Evaluation Coordinator.
- Ensure that all CHWs consistently distribute satisfaction surveys for every face to face client encounter. Change the process to ensure that clients are completing the survey in privacy.

Case Study: “Jerry Cabin”

“Jerry Cabin”, 59, is a resident of Bethune, SC. In 2009, he could no longer perform his job duties because of gout and high blood pressure (180/140). Jerry heard about LiveWell Kershaw through church members of Sandy Level Baptist Church, one of the satellite clinic sites supported by the Community Medical Clinic. He first visited Sandy Level in April, 2015. Karen Baker, a Community Health Worker, checked his blood pressure and encouraged him to record his blood pressure weekly. Karen is helping him navigate the healthcare system in Bethune and other surrounding areas and is meeting with him regularly.

Jerry could not find his car keys on the day of his scheduled appointment at the Healthcare Place in Bethune. In an effort to not be late for his appointment, Jerry decided to walk the three miles from his home to the clinic. After this incident, he began to walk every day to improve his health. Jerry's walking initiative has motivated his family, neighbors and friends. Over time, ten Bethune residents, including Reverend Jerry Henry from Believer's Baptist Church in Cassatt, saw Jerry walking and have now joined him as he walks at least one hour daily. Jerry believes that his walking has created a small movement in the town of Bethune. Since LiveWell Kershaw materials have been distributed throughout town, he believes that many people are aware of the program and he is promoting the services everywhere he visits.

In an effort to meet his health goals, Jerry drinks a gallon of water per day and visits the Nurse Practitioner weekly at the Healthcare Place in Bethune. He eats smaller portions and has changed his diet to include more fruits and vegetables. His blood pressure is now consistently within the normal range. Since March, 2014, Jerry has lost 43 pounds and is working to reaching his goal weight of 180 pounds this year. He no longer experiences pain in his joints, has better concentration, and is sleeping better. Overall, Jerry's initiative to change his health is not only motivating him, but also others in Bethune person by person and block by block. LiveWell Kershaw and the Healthcare Place and Bethune are working together to amplify their efforts to "be your bridge to better health."

LiveWell staffers attending CHW training

Evaluation of the Community Health Worker Training through Midlands Technical College (June-July, 2015)

After attending the Community Health Worker Training in Columbia, taught by Beverly Pittman, at Midlands Technical College, four individuals from LiveWell Kershaw became certified. They include Karen Baker, Jesus Martinez, Rachael Sladek and Beckie Thompkins. The students have not received their certificates or pins from Midlands Technical College.

The Arnold School of Public Health's evaluation team from the University of South Carolina conducted a focus group with the CHW participants and administered a comprehensive survey on July 21, 2015 at Sandy Level Baptist Church in Bethune, SC. Cheryl Stover, Project Manager, observed two sessions of the training and shared observations. In the focus group, the moderator asked participants to evaluate the training by considering if the training was effective in promoting the 11 core CHW competencies and what worked and didn't work. Some of the activities that occurred during the training included:

- Discussing biases and assessment of individuals and communities to learn how to talk with clients;
- Watching music videos to look for positive and negative messages, and how these messages may affect a certain group or individual;
- Watching the movies *John Q* and *Philadelphia* to understand the difficulties of not having health insurance and how to navigate the healthcare system;

- An assignment to photograph healthy vs. non-healthy things in the community in order to explain how unhealthy choices are too easily made;
- Learning of a free clinic in Columbia that offers vision, dental and pediatric care through a guest speaker

Overall, the participants agree that the training was beneficial and that the textbook and resource guide will be helpful on the job.

There were four major themes that emerged from the focus group discussion: poor instruction, cultural humility, role playing, and racial undertones.
The moderator asked a variety of questions to the participants that involved objective, reflective, interpretive, and decisional thinking.

In assessing the effectiveness of the course instructor, the participants overall agreed that she was very knowledgeable in the course material and that the course assignments were valuable, but that the teaching delivery and style were poor. The instructor did not give the participants a class syllabus, although it was requested. The participants described the instructor as inconsistent in teaching methods, unmotivated, and late for class on a regular basis. All of the participants mentioned "excessive use of reading Powerpoint slides." According to participant 4, the instructor would show up 10-15 minutes late to class on a regular basis. Participant 2 stated "sometimes we would leave at 3 or 3:30 (2 to 3 times a week)" though class was until 4 pm. The observer did confirm the student's comments from the two days that she was in the class.

Overall the participants gave the instructor an average rating of 2.5 on a scale of 1 to 5, with 1 being horrible and 5 being excellent. If another CHW training option was available, all the participants stated they would choose that option. In contrast, the participants agreed that they gained applicable knowledge related to the 11 core competencies and that the textbook and reference guide were the most valuable tools in the CHW training.

CHWs Rachael Sladek & Jesus Martinez celebrate completion of their training

Of all the concepts learned, cultural humility came up most often as an important and highly applicable competency for the CHW. Cultural humility is the "understanding that the client is the expert on their culture, their situation, their beliefs, and that [itself] is going to make a big impact for how they are going to change their behaviors, with using their resources and knowledge." Supporting this concept even further, Participant 1 referenced that since "I am a talker…I have learned to sit back and listen…and with the motivational interviewing/open-ended questions, I have to let the client verbalize so they can understand they are the one who's in charge of their behavioral change(s)…telling the client they need to do this or that is not going to work…you're just going to get a wall. It was a refresher on asking the right interview questions."

Role playing was a helpful learning tool used in training. Example scenarios were in the textbook addressing client experiences of applying for food stamps and other services.

The participants were surprised by the racial undertones given by the instructor. The instructor spoke daily about race and racial discrimination. The instructor was African-American and the participants were either Caucasian or Hispanic. The participants

felt the Instructor did not need to overtly make references to black or white people, although they appreciated understanding the perspective of African-Americans.

Participant 4 stated, "That last day she started talking about the shootings in Charleston and then she laid out on the table books about Malcolm X., Martin Luther King, and the whole nine yards. It's like she was preaching to the choir. We were taught, all of us were taught, that we respect each other and we love each other and we might not love what people do but we love each other. We don't treat people like how she thought people were treated (mean). It was like she was trying to push it at us and we don't live like that… you saw the black people come in and I hugged them and you saw the white people come in and I hugged them. We all equal. She had to preach to us about it. It was everyday."

Participants 1 and 2 however appreciated understanding the perspective of African-Americans. Participant 1 stated, "Her perspective was infused in her teachings by her feelings and experiences." Participant 2 stated "It was necessary (the talks about race)….we're not black so we did not know how they feel. It didn't need to be every single day though. To me it was necessary to hear their point of view. It was important to hear how she feels."

Overall, the participants felt that the "racial undertones" did not create a comfortable and conducive learning environment. Participants acknowledge the importance of discussing racial inequities, but also wanted more attention placed on broader issues related to CHWs. It is important to note that the observer for the two days of the class, did not mention any racial undertones in her written observations.

Overall, the participants agreed that the instructor was highly knowledgeable about CHW concepts and how those concepts are applied in the field, working with clients. Role playing was something that the CHWs enjoyed along with outside class assignments, as both gave practical experience of the type of work they are already doing. Though racial undertones weighed heavily in the class, the participants did overall agree that they all learned something and it has helped them to be better in their roles and scope of practice.

Paper Survey Summary

After the Community Health Worker training, the participants completed a paper survey which included questions related to the training overall and a retrospective pre-post test related to the 11 core CHW competencies. All of the CHWs reported a positive improvement in knowledge related to all of the competencies.

All but one CHW thought the class was a joy to attend and that the objectives of the training were clear. All but one CHW agreed that the quality of the trainer and guest speakers were excellent, as well as, the pace of the training fitting individual learning needs. All of the CHWs agreed that the level of detail presented was a good fit for their learning needs, and the detail also incorporated the right mix of presentations, discussions, and exercises, with the textbook being extremely helpful. One of the CHWs disagreed that the audio/visual was good quality, while one CHW remained neutral. For the five remaining questions, all of the CHWs agreed that the content and strategies of the CHW training was relevant to their work, found conducting clinicals at the Community Medical Clinic to be productive and beneficial, and being able to apply what they have learned into their community roles.

Table X: Retrospective Pre/Post Test for each CHW

CHW	Item	Before	After	Change
A	1. I understand outreach methods and strategies including how to "meet people where they are" and working with underserved populations.	4	5	+
A	2. I have a good understanding of how to make on-going efforts to identify community and individual needs, concerns and assets including doing a community assessment. .	3	5	+
A	3. I feel that I communicate effectively with clients about individual needs and concerns.	4	5	+
A	4. I believe that I speak clearly and effectively, demonstrating a respectful attitude and a deep cultural knowledge in all aspects of their work with individuals, their families, community members and colleagues.	4	5	+
A	5. I feel confident in my ability to assist individuals and their families in achieving desired behavioral changes.	3	5	+
A	6. I understand how to assist patients in navigating the health care system, improving patients' health knowledge, understanding their health condition(s), and developing strategies to help them improve their overall health and well-being.	3	4	+
A	7. I am very familiar with how to advocate for and coordinate care for my clients.	3	5	+
A	8. I see how my work fits in as one part of the broader context of public health practice.	4	5	+
A	9. I believe that one of my roles as a CHW is to play a critical role in increasing the ability of the communities to care for themselves.	4	5	+
A	10. I feel confident in my ability to write and prepare clear reports about my clients, my activities, and my assessments of individual and community needs.	3	4	+
A	11. I believe that as a CHW, I am a frontline health worker who is seen as a trusted member of the community that I serve.	4	5	+
CHW	Item	Before	After	Change
B	1. I understand outreach methods and strategies including how to "meet people where they are" and working with underserved populations.	1	5	+
B	2. I have a good understanding of how to make on-going efforts to identify community and individual needs, concerns and assets including doing a community assessment. .	2	5	+
B	3. I feel that I communicate effectively with clients about individual needs and concerns.	5	5	no change

Retrospective continued

B	4. I believe that I speak clearly and effectively, demonstrating a respectful attitude and a deep cultural knowledge in all aspects of their work with individuals, their families, community members and colleagues.	4	5	+
B	5. I feel confident in my ability to assist individuals and their families in achieving desired behavioral changes.	2	5	+
B	6. I understand how to assist patients in navigating the health care system, improving patients' health knowledge, understanding their health condition(s), and developing strategies to help them improve their overall health and well-being.	4	5	+
B	7. I am very familiar with how to advocate for and coordinate care for my clients.	4	5	+
B	8. I see how my work fits in as one part of the broader context of public health practice.	5	5	no change
B	9. I believe that one of my roles as a CHW is to play a critical role in increasing the ability of the communities to care for themselves.	5	5	no change
B	10. I feel confident in my ability to write and prepare clear reports about my clients, my activities, and my assessments of individual and community needs.	3	5	+
B	11. I believe that as a CHW, I am a frontline health worker who is seen as a trusted member of the community that I serve.	5	5	no change
CHW	Item	Before	After	Change
C	1. I understand outreach methods and strategies including how to "meet people where they are" and working with underserved populations.	3	4	+
C	2. I have a good understanding of how to make on-going efforts to identify community and individual needs, concerns and assets including doing a community assessment. .	4	5	+
C	3. I feel that I communicate effectively with clients about individual needs and concerns.	4	5	+
C	4. I believe that I speak clearly and effectively, demonstrating a respectful attitude and a deep cultural knowledge in all aspects of their work with individuals, their families, community members and colleagues .	4	5	+
C	5. I feel confident in my ability to assist individuals and their families in achieving desired behavioral changes.	4	5	+
C	6. I understand how to assist patients in navigating the health care system, improving patients' health knowledge, understanding their health condition(s), and developing strategies to help them improve their overall health and well-being.	4	5	+
C	7. I am very familiar with how to advocate for and coordinate care for my clients.	5	5	no change

Retrospective continued

C	8. I see how my work fits in as one part of the broader context of public health practice.	3	5	+
C	9. I believe that one of my roles as a CHW is to play a critical role in increasing the ability of the communities to care for themselves.	4	4	no change
C	10. I feel confident in my ability to write and prepare clear reports about my clients, my activities, and my assessments of individual and community needs.	4	5	+
C	11. I believe that as a CHW, I am a frontline health worker who is seen as a trusted member of the community that I serve.	4	5	+
CHW	Item	Before	After	Change
D	1. I understand outreach methods and strategies including how to "meet people where they are" and working with underserved populations.	4	5	+
D	2. I have a good understanding of how to make on-going efforts to identify community and individual needs, concerns and assets including doing a community assessment. .	3	5	+
D	3. I feel that I communicate effectively with clients about individual needs and concerns.	4	5	+
D	4. I believe that I speak clearly and effectively, demonstrating a respectful attitude and a deep cultural knowledge in all aspects of their work with individuals, their families, community members and colleagues.	4	5	+
D	5. I feel confident in my ability to assist individuals and their families in achieving desired behavioral changes.	4	5	+
D	6. I understand how to assist patients in navigating the health care system, improving patients' health knowledge, understanding their health condition(s), and developing strategies to help them improve their overall health and well-being.	4	5	+
D	7. I am very familiar with how to advocate for and coordinate care for my clients.	4	5	+
D	8. I see how my work fits in as one part of the broader context of public health practice.	3	5	+
D	9. I believe that one of my roles as a CHW is to play a critical role in increasing the ability of the communities to care for themselves.	4	5	+
D	10. I feel confident in my ability to write and prepare clear reports about my clients, my activities, and my assessments of individual and community needs.	4	5	+
D	11. I believe that as a CHW, I am a frontline health worker who is seen as a trusted member of the community that I serve.	4	5	+

Recommendations

- Add community engagement and outreach, and public health assessments components to the curriculum. The Director for LiveWell felt the importance of "connecting at the local level" was not emphasized in the training, and that this is a core component of a CHW's scope of work. In addition to discussing social determinants of health, the CHWs need to be educated in marketing, customer service, and time management to increase productivity and efficiency.
- Include diverse case studies, and guest speakers demonstrating different CHW models.
- Evaluate Midlands Technical College as the provider for CHW training in relation to customer service, and overall training effectiveness.
- Ensure that the instructor is engaged, motivated, and excited about teaching CHW competencies and concepts, and make sure training time is used for the full allotted time for class instruction.
- Incorporate diverse learning styles for all learners (hands-on application, more discussion/critical thinking opportunities, more role-playing scenarios) and provide a syllabus to all students on the first day of class.

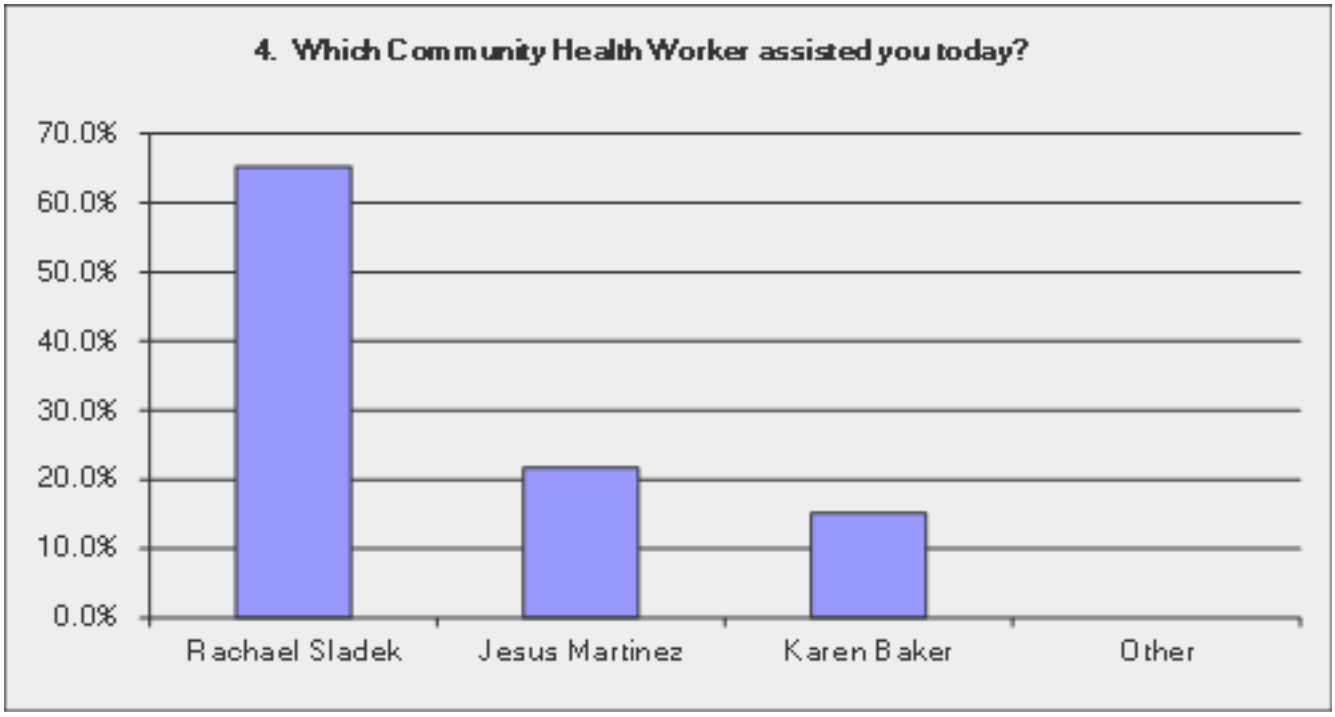
Community Health Worker Client Satisfaction Survey

As of July 20th, the CHWs distributed a revised client satisfaction survey (paper-based) to all clients. A copy of the survey instrument can be found on pages 28 & 29. The iPad is no longer used after each client encounter since the team found paper surveys to be more effective. Each CHW asks clients to fill out the survey after each face to face visit, and then the clients place the survey in a storage container to maintain confidentiality. Tamika Thomas, Evaluation Coordinator, collects all surveys weekly and analyzes the data. A total of 46 clients completed the survey compared to only 15 from the previous quarter. Approximately 63% of all client encounters were collected from the survey for the quarter. The less than 100% response rate is attributed to CHWs not passing out the survey consistently to all clients. No client, to date, has declined completing the survey. The evaluation team is working to ensure that CHWs make this a standardized process. The summary of the survey findings are on the following six pages.

1. What community health site did you visit today?		
Answer Options	**Response Percent**	**Response Count**
Cassatt	17.4%	8
Sandy Level	43.5%	20
Refuge	4.3%	2
Buffalo	21.7%	10
Dekalb	0.0%	0
Freedom Outreach	13.0%	6
Other	0.0%	0
answered question		**46**
skipped question		**0**

2. Was the community health site location convenient for you to travel to?		
Answer Options	**Response Percent**	**Response Count**
Yes	97.8%	45
Somewhat	2.2%	1
No	0.0%	0
answered question		**46**
skipped question		**0**

3. Were the hours for the site location convenient for you?		
Answer Options	**Response Percent**	**Response Count**
Yes	97.8%	45
Somewhat	2.2%	1
No	0.0%	0
answered question		**46**
skipped question		**0**



5. Was it easy to talk with the Community Health Worker?

Answer Options	Response Percent	Response Count
Yes	100.0%	46
Somewhat	0.0%	0
No	0.0%	0
answered question		46
skipped question		0

6. Did you receive kindness and respect during your visit?

Answer Options	Response Percent	Response Count
Yes	100.0%	46
Somewhat	0.0%	0
No	0.0%	0
answered question		46
skipped question		0

7. Was the Community Health Worker knowledgeable about the reason for your visit?		
Answer Options	**Response Percent**	**Response Count**
Yes	97.8%	45
Somewhat	2.2%	1
No	0.0%	0
answered question		**46**
skipped question		**0**

8. Was the health information clearly communicated to you by the Community Health Worker?		
Answer Options	**Response Percent**	**Response Count**
Yes	93.5%	43
Somewhat	0.0%	0
No	0.0%	0
Not Applicable	6.5%	3
answered question		**46**
skipped question		**0**

9. During your visit was enough time spent with you?		
Answer Options	**Response Percent**	**Response Count**
Yes	100.0%	46
Somewhat	0.0%	0
No	0.0%	0
answered question		**46**
skipped question		**0**

10. What service(s) did you receive today, for your visit?

Answer Options	Response Percent	Response Count
Referral to Primary Care Physician/Home	40.9%	18
Medicaid Application	9.1%	4
SNAP (Foodstamps)	20.5%	9
Pharmacy Assistance	11.4%	5
Social Security Disability	2.3%	1
Case Management	0.0%	0
Mental Health Referral	0.0%	0
Dental Referral	15.9%	7
Vision Referral	15.9%	7
Affordable Care Act Navigations	2.3%	1
Utilities Assistance	6.8%	3
Transportation Assistance	2.3%	1
Christian Community Ministry	2.3%	1
Housing Assistance	0.0%	0
Medical Bills Assistance	6.8%	3
Clothing Assistance	0.0%	0
Health Education	0.0%	0
Blood Pressure Taken	20.5%	9
Finger Stick (Blood sugar)	0.0%	0
Other service (please specify)		3
answered question		44
skipped question		2

11. How satisfied are you with your visit today?

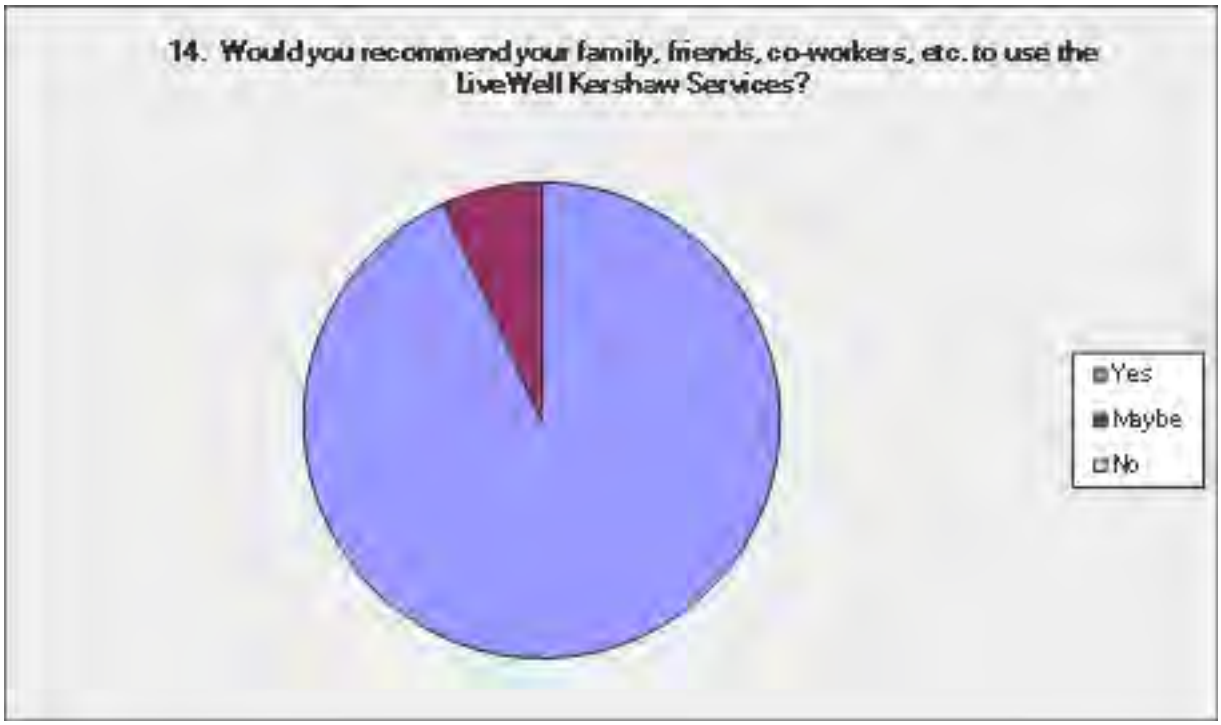
Answer Options	Response Percent	Response Count
Very Satisfied	93.0%	40
Satisfied	7.0%	3
Neither Satisfied nor Dissatisfied	0.0%	0
Dissatisfied	0.0%	0
Very Dissatisfied	0.0%	0
answered question		43
skipped question		3

12. [Answer ONLY if you were dissatisfied with the service(s) you received today.] Which service(s) were you dissatisfied with?

Answer Options	Response Percent	Response Count
Referral to Primary Care Physician/Home	0.0%	0
Medicaid Application	0.0%	0
SNAP (Foodstamps)	0.0%	0
Pharmacy Assistance	0.0%	0
Social Security Disability	0.0%	0
Case Management	0.0%	0
Mental Health Referral	0.0%	0
Dental Referral	0.0%	0
Vision Referral	0.0%	0
Affordable Care Act Navigations	0.0%	0
Utilities Assistance	0.0%	0
Transportation Assistance	0.0%	0
Christian Community Ministry	0.0%	0
Housing Assistance	0.0%	0
Medical Bills Assistance	0.0%	0
Clothing Assistance	0.0%	0
Health Education	0.0%	0
Blood Pressure Taken	0.0%	0
Finger Stick (Blood sugar)	0.0%	0
Other service (please specify)		0
answered question		**0**
skipped question		**46**

13. [Answer ONLY if you answered question #12.] In a few words explain why you were dissatisfied with the service(s)

Answer Options	Response Count
	0
answered question	**0**
skipped question	**46**


14. Would you recommend your family, friends, co-workers, etc. to use the LiveWell Kershaw Services?
Yes
Maybe
No


SANDY LEVEL BAPTIST CHURCH
CHURCHREV 19AT5PM REV MCFARLAND
THRU24A7PM SPEAKER REVS.LADSON
JULY2015
SUNDAY SCHOOL 9:30 AM
WORSHIP SERVICE 10:30 AM
LiVeWell
KERSHAW
HEALTHCARE SITE
TUESDAYS
9:00 - 1:00
803-272-8325

LiveWell KERSHAW
"Your Bridge to Better Health"

Community Health Worker Satisfaction Survey

Instructions: Please make selection with a check mark ☑
Responses are anonymous

1. Which community health site did you visit today?

- ☐ Buffalo
- ☐ Cassatt
- ☐ DeKalb
- ☐ Freedom Outreach
- ☐ Refuge
- ☐ Sandy Level
- ☐ Other

2. Was the community health site location convenient for you to travel to?

☐ Yes ☐ Somewhat ☐ No

3. Were the hours for the site location convenient for you?

☐ Yes ☐ Somewhat ☐ No

4. Which Community Health Worker assisted you today?

- ☐ Rachael Sladek
- ☐ Jesus Martinez
- ☐ Karen Baker
- ☐ Other

5. Was it easy to talk with the Community Health Worker?

☐ Yes ☐ Somewhat ☐ No

6. Did you receive kindness and respect during your visit?

☐ Yes ☐ Somewhat ☐ No

7. Was the Community Health Worker knowledgeable about the reason for your visit?

☐ Yes ☐ Somewhat ☐ No

8. Was the health information clearly communicated to you by the Community Health Worker?

☐ Yes ☐ Somewhat ☐ No

☐ Not Applicable

9. During your visit was enough time spent with you?

☐ Yes ☐ Somewhat ☐ No

10. What service(s) did you receive today for your visit?

- ☐ Referral to Primary Care Physician/Home
- ☐ Medicaid Application
- ☐ SNAP (Foodstamps)
- ☐ Pharmacy Assistance
- ☐ Social Security Disability
- ☐ Case Management
- ☐ Mental Health Referral
- ☐ Dental Referral
- ☐ Vision Referral
- ☐ Affordable Care Act Navigations
- ☐ Utilities Assistance
- ☐ Transportation Assistance
- ☐ Christian Community Ministry
- ☐ Housing Assistance
- ☐ Medical Bills Assistance
- ☐ Clothing Assistance
- ☐ Health Education
- ☐ Blood Pressure Taken
- ☐ Finger Stick (Blood sugar)

Other service (please specify):

Thank you for taking this survey! Your responses are greatly appreciated.

PO Box 142 Cassatt, SC 29032
tythomas@mailbox.sc.edu

11. How satisfied are you with your visit today?

- ☐ Very Satisfied
- ☐ Satisfied
- ☐ Neither Satisfied nor Dissatisfied
- ☐ Dissatisfied
- ☐ Very Dissatisfied

*** 12. [Answer ONLY if you were dissatisfied with the service(s) you received today.] Which service(s) were you dissatisfied with?**

- ☐ Referral to Primary Care Physician/Home
- ☐ Medicaid Application
- ☐ SNAP (Foodstamps)
- ☐ Pharmacy Assistance
- ☐ Social Security Disability
- ☐ Case Management
- ☐ Mental Health Referral
- ☐ Dental Referral
- ☐ Vision Referral
- ☐ Affordable Care Act Navigations
- ☐ Utilities Assistance
- ☐ Transportation Assistance
- ☐ Christian Community Ministry
- ☐ Housing Assistance
- ☐ Medical Bills Assistance
- ☐ Clothing Assistance
- ☐ Health Education
- ☐ Blood Pressure Taken
- ☐ Finger Stick (Blood sugar)

Other service (please specify):

***13. [Answer ONLY if you answered question #12.] In a few words explain why you were dissatisfied with the service(s) you received.**

14. Would you recommend your family, friends, co-workers, etc. to use the LiveWell Kershaw Services?

- ☐ Yes
- ☐ Maybe
- ☐ No

Thank you for taking this survey! Your responses are greatly appreciated.

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tythomas@mailbox.sc.edu

DRIVER 2

Extend primary care and mental health at all schools in North Central to increase access and care coordination

Progress from June-August, 2015

The School Based Health Center (SBHC) team met their stated goals for the quarter. During this quarter, the SBHC team focused on setting up the processes and space needed to implement the School Based Health Center as well as registering students. These steps are in line with the overall timeline of providing behavioral health services from August to December, and then starting clinical physical health services in January, when a new Nurse Practitioner will begin at the school.

During June and July, the team created and finalized visit, HIPAA, and registration forms and met with school administration. The team was granted space at the school for the SBHC and set up the space for mental/behavioral health services in the SBHC (renovations to the space to set up for clinical services will begin in the next quarter). They created basic policies and procedures for the referral and service provision of students who could benefit from mental/ behavioral health services.

A school based health center advisory council was also created which met August 6th. The Advisory council's purpose is to help guide the development of the school based health center and to give stakeholders a voice through a collaborative relationship with SBHC staff. The council includes the school Nurse Practitioner, a faculty member, two parents, a school administrator, and the medical staff of the school based health center. They plan to meet at least quarterly.

SBHC Health and Wellness staff and a Community Health Worker were in place and ready to provide services to referred students during the first week of school (week of August 17th).

School Based Healthcare Center at North Central High School

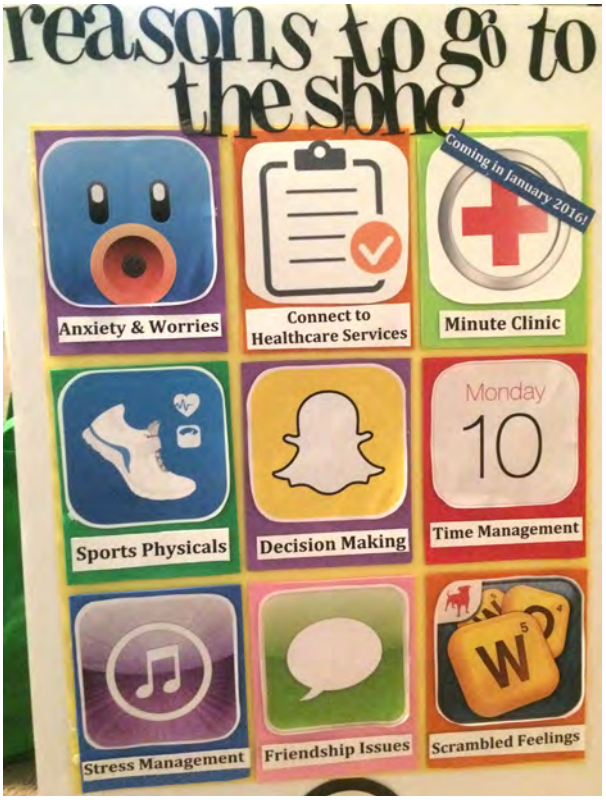
Outreach

School Registration

SBHC staff sent out information packets and registration forms to parents and guardians of all NCHS students (total enrollment=505) with instructions to return them to school for registration day. Registration for Kershaw County Schools occurred on July 30th and 31st. SBHC staff (including wellness facilitator, Emily Mancil, and wellness coach, Abby Bode) was present to sign up students, answer questions, and pass out informational flyers about the SBHC and the behavioral health and wellness services available. While only two registration forms were mailed into SBHC staff before the registration day, several parents and guardians brought completed forms and necessary identification with them. Individuals were also able to register during school registration day. In total, 54 students were registered with the SBHC at the conclusion of school registration, and another 84 provided contact information for follow up. Approximately 10% of students enrolled at North Central High School were registered for the SBHC. The overall goal is to have 75% of students enrolled in the first year.

North Central High School open house
North Central High School hosted an open house on August 31st. Members of the SBHC team were present, as well as a Community Health Worker Jesus Martinez. They set up a table in front of the main entrance with registration materials and offered refreshments. The SBHC team received support from school administration, who encouraged parents to register. Out of about 50 attending parents, 10 took home forms to be returned. One completed the registration during the event.

Follow- ups with parents
Community Health Worker Jesus Martinez had been following up with interested parents and guardians who provided contact information (mainly at school registration) but did not complete registration, as well as students with incomplete enrollment applications. As of August 31st, he completed 33 follow up calls, which has netted three more enrollees. Many phone calls, however, have gone directly to voicemail, making it difficult to engage with parents directly.



Poster in the School Based Healthcare Center

School Operations

On August 14th Abby Bode, Emily Mancil, and Jesus Martinez spoke at a NCHS teacher meeting prior to the first day of school to discuss SBHC services and distribute information that provided guidance on identification of students who might benefit from mental/behavioral health services. They gave instructions regarding how to refer students for coaching/wellness services. The Check & Connect Mentoring program was described and 13 teachers volunteered to be trained as mentors and to meet weekly with identified students. Emily Mancil also attended a teacher meeting at NCMS, where 19 teachers volunteered to be trained mentors. Overall, faculty at North Central High School have been supportive, proactive and engaged with encouraging students to complete SBHC registration forms so that they can be referred for wellness programs.

There have been 51 students enrolled in the school based health center with complete registration materials (approximately 10% of the total population, which is 505), with an additional 73 who have begun registration but are missing key pieces of information in their registration packet. Common registration issues were missing signatures, proper identification, and insurance paperwork.

Physicals were also offered at the SBHC for NCHS students on August 30th. About 20 students received sports related physical examinations. Coaches required students to bring completed forms to register for the SBHC to their physical exam. Over half of these students need additional information to complete the registration process.

Physical health services will begin in January, when a newly hired full time Nurse Practitioner will start work at North Central High School. A flu clinic is being planned for October, and vaccines have been ordered. Until then the SBHC team will focus on improving mental/behavioral health for students in north central area schools. The Wellness Coach, Abby Bode is available for one-on-one counseling Mondays from 7:30 to 3:00 and Wednesday mornings from 8:00 to 10:00 am.
The Wellness Facilitator, Emily Mancil, is available Wednesdays from 9:30 am to 4:00 pm at NCHS and Thursdays between 9:30 am and 4:00 pm, split

between NCMS and NCHS.

As of August 31st, five students experiencing emotional/behavioral difficulties had been referred to and seen by Abby Bode for guidance and coaching. Beginning in October, the SBHC's Wellness Facilitator will present the nationally recognized Check & Connect Mentoring Program at NCMS and NCHS. At the end of August, thirteen students had already been referred. Additionally, the Wellness Facilitator will be on-site weekly at NCHS and NCMS and available for teacher consultation to promote the use of evidence-based classroom strategies to address student mental/behavioral health difficulties. Wellness newsletters highlighting tips to promote mental/behavioral health will be distributed quarterly to teachers, school mental health professionals, and parents of students in north-central area schools.

A mental health advisory board (which includes NCHS school administrators and SBHC mental health/wellness staff) was created in order to increase collaboration and communication among SBHC staff and NCHS to assist with student referrals. The first mental health advisory board meeting was held on August 6th. During this initial meeting administrators provided feedback on plans and procedures for initiating mental health/wellness services at the school and ensured that all services were in line with school policies and procedures. Administrators also provided the suggestion that instead of referring to these services as "mental health," SBHC staff could consider referring to the as "wellness," as this terminology they explained is less stigmatizing and they believed students would be more likely to use the services. The board plans to meet on a monthly basis.

Evaluation

Evaluation staff, Mark Macauda and Tamika Thomas, attended all team planning meetings, and began reviewing the information that will be collected from students during SBHC visits, as well as the Electronic Medical Record System that will be used to record student health data. The Evaluation team will coordinate with medical staff and project leaders during the next reporting period to solidify data collection, management, and reporting requirements. This will ensure that the evaluation team has the data that is necessary to measure progress to the stated SBHC goals for student enrollment and outcomes.

Moving forward, the evaluation team will request updates from SBHC staff weekly concerning progress towards project goals. This will help capture the successes and issues that are faced by the SBHC team that might not be evident in metrics, such as numbers of students seen or Electronic Medical Records of patient outcomes. Weekly updates will also promote cohesion and engagement among team members as well as ensure that the evaluation team remains engaged and aware of process issues.

In preparation for student registration and the provision of behavioral health/wellness services, the evaluation team also designed a survey that was distributed to parents and guardians. The survey asked some general information about child medical visits, as well as gauged interest in the SBHC initiative.

Results of the School Based Health Center Parent Survey

Eighty-four parents of students at North Central High School completed the survey. Of these, most had either one (39%) or two (44%) children. In addition to having a child at North Central High School, 25% of respondents had a child at North Central Middle School, and 17% had a child at Midway Elementary. Less than 5% reported a child at the other district schools.

Eighty-one percent reported that they or someone else in their household had taken a child to see a healthcare provider in the last year. The most common reasons for the visit was for a well visit or checkup (75%), a child's illness (63%), and vaccinations (27%).

Table 1: Reasons Children have been taken to a Healthcare Provider

If yes, select all of the reasons you, or another adult in your household, have taken a child to see a health care provider.		
Reason for Visit	Number	Percent
Well Visit or check up	51	75%
Routine Chronic Care	11	16%
To see a specialist	17	25%
Child was sick	43	63%
Child was injured	13	19%
Child needed surgery	10	15%
Child has a learning disability	6	9%
Child needed mental health counseling	6	9%
Vaccinations	18	27%
Other	1	2%

When asked where respondents had taken a child to obtain health care in the last year, the most common answer was a pediatrician's office (76%), followed by urgent care (21%), and emergency rooms (16%). The least selected answers were mental health professional (13%), hospital (12%), and other (10%). The most common answer for "other", when given, was a non-pediatric general practice physician. Forty six percent of the respondents reported that they, or another adult in their household, had to take time from work in the last year to take a child to see a healthcare provider. Of those that reported missing work, 33% reported missing a few hours, and about the same reported missing one to two days of work. Fifteen percent reported missing seven days or more, and the same percentage reported missing three to four days. The least common answer was five to six days (3%.)

Support for an SBHC was high with 98% of respondents agreeing that it would be helpful to have a clinic in their child's school that could act as a doctor's office. Please note that the parents who completed the survey already expressed an interest in the SBHC. Our sample was not representative of all NCHS parents. When asked what types of services they think they might use a clinic for, the highest percentage was for "If a child were sick" (89%), followed by "if a child were injured" (72%).

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Table 2: Types of Services

What types of services do you think you would use such a clinic for? (select all that apply)		
	Number	Percent
I am not interested in a school based clinic	3	4%
For mental health wellness or counseling	23	28%
For child check-ups	36	43%
To manage my child's chronic illness	17	21%
If my child(ren) were sick	74	89%
If my Child(ren) were injured	60	72%
For child vaccinations	27	33%
Other	2	2%

Future Plans

During the next quarter, the SBHC team will focus on finalizing data collection procedures, continue provision of mental wellness services, and begin preparations for the beginning of physical health services. Due to the high number of referrals, the SBHC has already received for wellness coaching and mentoring, SBHC wellness staff will also work to solidify policies and procedures regarding case load and waitlist procedures for students who cannot be seen immediately. Further, the SBHC wellness team will consider initiating a "gatekeeper" at NCHS to help filter and direct some of the referrals received.

Data Collection Procedures

- Complete review of EMR system to determine what student health and outcome data can be accommodated within the system
- Design additional electronic data record databases for student information that cannot be recorded within the EMR
- Map out reporting procedures and intervals

Provision of Mental Wellness Services

- Continue provision of one on one counseling
- Train volunteer teacher mentors and USC undergraduate mentors
- Begin implementation of Check and Connect programs at NCMS and NCHS
- Conduct fidelity checks once per month on implementation of Check and Connect
- Provide booster training sessions as needed for teacher and USC undergraduate mentors for Check and Connect
- Create policies for waitlists for students who cannot be seen immediately

Provision of Physical Health Services

- Hold October Flu vaccine clinic
- Offer winter sports physicals

Preparation for Physical Health Clinic

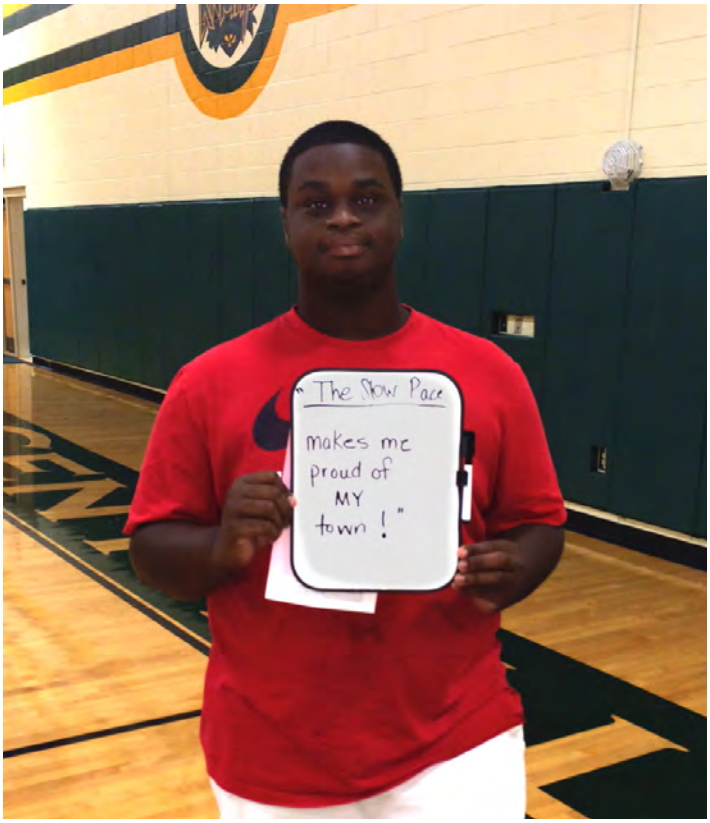
- Begin renovations of clinic space

Advisory Councils

- Hold at least one meeting of the SBHC advisory council
- Hold monthly meetings of the mental health advisory board

Evaluation Recommendations

Progress in the SCBHS Initiative has been excellent so most recommendations are geared towards ensuring continued success. The evaluation team considers the school based health center the most successful driver to achieving health throughout the county during this quarter. The integration of the USC School of Psychology and the Community Medical Clinical has been remarkable.



- Continue documenting the story: Continue to documenting processes involved in introducing the SBHC at NCHS, including documentation of facilitators and barriers to implementation which will help to inform initiation of future SBHC programs at other north central area schools in the future.

- Solidify current leadership structure: Progress towards goals has been very good; however, operations would be strengthened by a more defined leadership structure. As services ramp up, and there are greater interactions with students and faculty, it will be important to have one person who observes the big picture and is ultimately responsible for the running of operations.

- Continue Communication with School: It is important to make sure that communication between the members of the SBHC team and school stakeholders remains active and collaborative. Regular feedback from school administrators and school personnel regarding SBHC procedures for referrals are also important for continuing to increase buy-in of school staff and to ensure policies and procedures are consistent with school procedures.

- Continue to review activities and timeline goals: It is important that the team continue to not only set achievable and concrete milestones and deadlines, but also evaluate the purpose behind activities, assess whether activities and deadlines are appropriate going forward, and that adjustments are made accordingly.

- Implement the recruitment plan: Ten percent of students at NCHS registered for the SBHC is a very good start, however, if the SBHC want to reach stated goals of 75% enrollment by the end of the school year, more comprehensive recruitment plans will need to be developed.

- Increase communications between evaluation and team: In order to ensure good information flow between the implementation and the evaluation teams, the evaluator, Mark Macauda, should check in weekly with all SBHC team members individually, to get insight onto progress and barriers.

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North Central Middle School Wellness Implementation Timeline

AUGUST

Goals: 1- Begin at NCMS
2- Learn about Policies, Procedures, & Resources at School

- Finalize implementation plan in collaboration with principals and counselors
- Meet teachers/staff
- Distribute information in school about wellness services available and how to refer students (i.e., C&C* program & classroom facilitation services)
- Learn about school policies, procedures, resources, and current systems in place for addressing wellness/behavior concerns
- Learn about CLC program, MH needs, and transition services available for these students

*** = Check & Connect Mentoring Program*

SEPTEMBER

Goals: 1- Begin Recruiting Mentors for C&C
2- Begin Receiving Referrals for C&C Students

- Begin receiving referrals for wellness services & gathering data for referred students
- Recruit teacher & community mentors for C&C program
- Identify 6 students for mentoring (or more depending on number of mentors recruited)
- Begin C&C mentor trainings
- Continue to Learn about school policies, school resources, and current systems in place for addressing wellness/behavior concerns
- Provide teacher facilitation services as needed
- Survey teachers about wellness training needs for parent/teacher newsletters

OCTOBER

Goal: Begin C&C Implementation

- Begin C&C program
- Progress monitoring & continued evaluation and adaptation of all wellness services in place
- Continue to recruit mentors for C&C mentoring program
- Continue C&C mentor trainings as needed
- Teacher facilitation services as needed

NOVEMBER

Goal: Continued Implementation, Progress Monitoring & Evaluation of Interventions

- Progress monitoring & continued evaluation and adaptation of all wellness services in place
- Continued implementation of C&C mentoring program
- Continue to recruit mentors for C&C mentoring program
- Continue C&C mentor trainings as needed
- Provide teacher facilitation services as needed

DECEMBER

Goal: Continued Implementation & Evaluation of C&C

- Progress monitoring & continued evaluation and adaptation of C&C
- Plan for break for C&C mentoring when university semester ends
- Continue to recruit mentors for C&C program
- Continue C&C mentor trainings
- Teacher facilitation services as needed
- In collaboration with NCMS counselors and administrators, discuss strengths & areas of improvement of C&C program implementation and develop plans for addressing wellness services in the spring (e.g., continued implementation of C&C program, revisions to implementation of program, and discussion of other wellness resources that may be available)

Newsletters/wellness strategies will be distributed to teachers and parents on an ongoing basis.

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North Central High School Wellness Implementation Timeline

AUGUST

Goal: 1- Begin at NCHS

- Finalize implementation plan in collaboration with principals and counselors
- Meet teachers and staff
- Distribute information in school about wellness services available through the SBHC* and how to refer students
- Learn about school policies, procedures, resources, and current systems in place for addressing wellness/behavior concerns
- Learn more about CLC & QUEST to determine students' wellness needs & develop a plan in collaboration with NCHS staff

** SBHC= School-Based Health Center*

SEPTEMBER

Goals: 1- Begin Counseling
2- Recruit Mentors for C&C+

- Begin receiving referrals for wellness services & gathering data for referred students
- Begin individual counseling as referrals come in: identify 8 students for individual counseling & 6 for mentoring
- Recruit teacher & community mentors for C&C mentoring
- Begin C&C mentor trainings
- Continue to learn about school policies, school resources, and current systems in place for addressing wellness/behavior concerns
- Provide teacher facilitation services as needed
- Survey teachers about wellness training needs for parent/teacher newsletters
- In collaboration with NCHS staff, develop plan for addressing wellness needs of QUEST students

+Check & Connect Mentoring Program

OCTOBER

Goal: Begin C&C Mentoring

- Progress monitoring & continued evaluation and adaptation of all wellness services in place
- Begin C&C program
- Continue individual counseling
- Continue to recruit mentors for C&C mentoring program
- Continue C&C mentor trainings as needed
- Teacher facilitation services as needed

NOVEMBER

Goal: 1- Continued Implementation, Progress Monitoring & Evaluation of Interventions

- Progress monitoring & continued evaluation and adaptation of all wellness services in place
- Continue counseling and C&C mentoring program
- Continue to recruit mentors for C&C mentoring program
- Continue C&C mentor trainings as needed
- Provide teacher facilitation services as needed

DECEMBER

Goals: 1- Continued Implementation & Evaluation of Interventions
2- In Collaboration with School Identify Training/Resource Areas of Need & Plan for Addressing

- Progress monitoring & continued evaluation and adaptation of all wellness services in place
- Continued individual counseling
- Plan for break for C&C mentoring at end of university semester
- Continue to recruit mentors for C&C program
- Continue C&C mentor trainings
- Teacher facilitation services as needed
- Based on information gathered develop plan for sharing resources with school, in collaboration with principals and counselors.

Newsletters/wellness strategies will be distributed to teachers and parents on an ongoing basis.

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LiveWell KERSHAW

"Your Bridge to Better Health"

Check & Connect:

A Comprehensive Student Engagement Intervention

What is Check & Connect?

Check & Connect is a research-based mentoring program that promotes student engagement and competence in school. Mentors provide support for academic and behavioral needs through monitoring of behaviors, regular brief meetings and problem solving with students. It is designed to:

- **Increase attendance, persistence in school, accrual of credits, and school completion rates**
- **Decrease truancy, tardies, behavioral referrals, & dropout rates**

Now Recruiting Mentors!*

Are you interested in being a Check & Connect mentor? We're looking for candidates who:

- Have a positive and supportive perspective toward working with students to improve school behaviors
- Are willing to cooperate and collaborate with school staff to find creative solutions and promote student success

How does it work?

- Mentors monitor student absences, grades, and behavior weekly
- Mentors meet weekly to check in with students and provide feedback on school behaviors & performance
- If needed, mentors collaborate with school staff to identify & provide additional supports for students

How much time is involved?

Training:

- One 30-45 minute initial training session
- Ongoing, brief coaching sessions (5-10 min) for a few weeks

Mentoring takes about 30 minutes per week:

- 10 minutes to gather student information
- 10 - 15 minutes to meet with the student
- Additional time to coordinate supports for students with additional needs (such as talking to a math teacher about allowing a student to use a missing assignment tracker)

*If you are interested in becoming a mentor or would like more information please contact Emily Mancil (emily.mancil@gmail.com) or stop by the NCHS School Based Health Center on Mondays, Wednesdays or Thursdays.

LiveWell Kershaw is a group of healthcare providers, businesses, schools, churches, and local citizens working together to make Kershaw County the healthiest county in South Carolina. Our partners include AccessKershaw, KershawHealth, Community Medical Clinic of Kershaw County, and the Arnold School of Public Health, USC.

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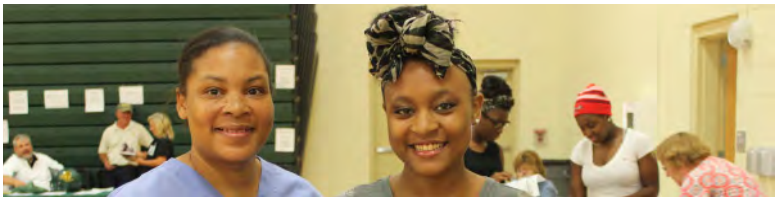

Strengthening Wellness in Schools

Building effective, multi-tiered systems of support involving promotion, prevention, early intervention and intervention

Helping to reduce and remove barriers to learning

Connecting to national and international initiatives on the most effective strategies for wellness in schools

Emily Mancil
Wellness facilitator for North Central area schools

Abby Bode
Wellness Coach for the School Based Health Center at North Central High School

Wellness services provided in the upcoming school year include:

Coaching Services

- Research-based treatment approaches that are tailored to students' unique behavioral health and wellness needs.
- For example, services may include skills-based approaches in which students learn coping strategies, problem solving skills, emotion regulation, and strategies for managing daily struggles.

Check & Connect Mentoring Program

- Nationally recognized program, based on 20+ years of research (see http://www.checkandconnect.umn.edu/ for more information).
- Promotes student engagement and prevents dropout.
- On a weekly basis, students "check" in and "connect" with a school-based mentor, who helps them to develop and work towards meeting specific academic and/or behavioral goals.
- Mentors will include a combination of USC students, volunteers in the community, and teachers/staff at NCHS.

Wellness Facilitation

- Promote the use of research-based wellness strategies that promote wellness for all students.
- Facilitation of research-based training, resources, and programs to support students' wellness and behavioral health needs.
- Consultation services for teachers supporting the use of evidence-based strategies in the classroom to promote positive behavioral health and wellness for students.

Wellness Newsletters

- Newsletters provided for schools and families.
- Topics will cover a variety of youth wellness issues, including how to identify health concerns, strategies for addressing these concerns and resources available in the Kershaw community.

University of South Carolina School Mental Health Team

For more information please contact: emily.mancil@gmail.com or abbya@email.sc.edu
We are located in the NCHS School Based Health Center on Mondays, Wednesdays and Thursdays.

LiveWell Kershaw is a group of healthcare providers, businesses, schools, churches, and local citizens working together to make Kershaw County the healthiest county in South Carolina. Our partners include AccessKershaw, KershawHealth, Community Medical Clinic of Kershaw County, and the Arnold School of Public Health, USC.

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Wellness Brief: Back to School

Fall 2015
Teacher's Edition

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The **School Based Healthcare Center (SBHC)** is similar to a "minute clinic" and delivers convenient healthcare for students. The SBHC is now open at North Central High School and is providing health screenings, such as sports physicals, and wellness and counseling services including coaching/behavioral skills and the nationally-recognized Check & Connect Mentoring Program. Each quarter the SBHC will be sending you newsletters with tips and strategies to promote wellness.

Getting Back on Track

Summer is over and the school year has begun. This is an exciting time for the entire school community. Students are happy to reunite with their friends and are eager to learn. Teachers and school staff are excited about seeing both new and familiar faces. Despite all the excitement, it can be difficult to get back into a regular routine. Some tips for making a smooth transition into the new school year are outlined below.

1. **Create a "time budget"**. List everything you do in a day and how much time it takes you to do it. If the total time is more than 24 hours then reexamine your budget.

2. **Make a schedule**. You can write this in your daily planner or use your phone's calendar app. It doesn't matter what you use as long as you have a tangible way to keep track of what you have to do and when you need to do it.

3. **Don't neglect the little things**. It's easy to skip breakfast or forget to take your vitamins. People tend to be so focused on all of the "important" things that need to get done that they forget about the "little" things which can make a big difference in their lives.

4. **Avoid overextending yourself**. Taking on more tasks than you can handle can be stressful. If you feel like you've bitten off more than you can chew, prioritize and/or ask for help.

5. **Fit in some personal time**. With a million things to do each day we often put ourselves on the back burner. For a better, healthier, happier you, allow yourself at least an hour a day to do something that you enjoy.

Motivating Students from the Beginning

The first few weeks of school set the tone for the entire school year. Motivating students from the beginning will pique their interest and make for an exciting year of learning.

1. **Show your enthusiasm**. When students see that you have a genuine interest in what you teach, your energy and passion may motivate them.

2. **Vary your teaching style**. To keep your class interesting, explore different teaching methods.

3. **Emphasize mastery**. Testing and grading provide educators with a way of assessing how well students are learning. Although this is an essential part of school it can also encourage students to simply memorize class material without fully understanding the content. Try giving tests and assignments which require students to combine ideas and think critically.

4. **Engage students in active learning**. Try using innovative exercises and activities which actively engage students in learning, for example class debates or role playing.

5. **Recognize students for their good work**. Rewarding students for working hard is sure to keep them interested in learning. It is not necessary to do or say anything extravagant. A simple comment such as "That's a good point" shows students that you are impressed by their effort. It is also good practice to avoid embarrassing students or making negative comments, as this often decreases their motivation.

Eight Instant Stress Busters

Below are some tips to help you deal with stress throughout the school year:

1. **Practice letting go** the next time you find yourself becoming annoyed or angry with something trivial. Making a conscious choice not to become angry is a great way to keep the stress level down.

2. **Breathe slowly and deeply**. Before reacting to a stressful situation, take three deep breaths and release them slowly. Try a relaxation technique if you have the time.

3. **Practice speaking more slowly than usual** whenever you feel overwhelmed by stress. You'll find that you think more clearly and react more reasonably to stressful situations. You'll also appear less anxious and more in control of any situation.

4. **Jump-start an effective time management strategy**. Choose one simple thing you have been putting off and do it immediately. Just taking care of one nagging responsibility can be energizing and can improve your attitude.

5. **Get outdoors for a brief break.** Getting a breath of fresh air can be invigorating. Don't be deterred by foul weather or a full schedule. Even taking a five minute walk outside can energize you.

6. **Drink plenty of water and eat small, nutritious snacks**. Hunger and dehydration, even before you're aware of them, can provoke aggressiveness and exacerbate feelings of anxiety and stress.

7. **Do a quick posture check**. Hold your head and shoulders upright and avoid stooping or slumping. Bad posture can lead to muscle tension, pain, and increased stress.

8. **Plan something rewarding for the end of your stressful day**, even if only a relaxing bath or a half hour with a good book. Put aside work, housekeeping or family concerns for a brief period before bedtime and allow yourself to fully relax. Remember that you need time to recharge and energize yourself. You'll be much better prepared to face another stressful day.

Tips adapted from http://www.medicinenet.com/script/main/art.asp?articlekey=59875.

" You can teach a student a lesson for a day; but if you can teach him to learn by creating curiosity, he will continue the learning process as long as he lives."
-Clay P. Bedford

Resources:

Check out the following websites for great, free resources made just for teachers and school staff:

http:// www.teachers.net
http://www.teachertube.com
http://www.midgefrazel.net/middle.html

For more information contact:
Emily Mancil,
Wellness Facilitator for
North Central Area Schools
emily.mancil@gmail.com

References:

Vanderbilt Center for Teaching (2007). Motivating students. Retrieved August 28, 2007 from: http://www.vanderbilt.edu/cft/resources/teaching_resources/interactions/motivating.htm#strategies

Center for Excellence in Teaching (2000). Motivating your students. Retrieved August 28, 2007 from: http://www.usc.edu/programs/cet/private/pdfs/teaching_nuggets/motivating.PDF

This newsletter was originally created by the Center for School Mental Health (CSMH).

LiveWell Kershaw is a group of healthcare providers, businesses, schools, churches, and local citizens working together to make Kershaw County the healthiest county in South Carolina. LiveWell Kershaw focuses on health issues impacting the North Central area: heart disease, high blood pressure, diabetes and behavioral health conditions. Our partners include AccessKershaw, KershawHealth, Community Medical Clinic of Kershaw County, and the Arnold School of Public Health, USC.

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Wellness Brief: Back to School

Fall 2015
School Mental Health Professional's Edition

facebook.com/LiveWellKershaw
twitter.com/lwkershaw

The **School Based Healthcare Center (SBHC)** is similar to a "minute clinic" and delivers convenient healthcare for students. The SBHC is now open at North Central High School and is providing health screenings, such as sports physicals, and wellness and counseling services including coaching/behavioral skills and the nationally-recognized Check & Connect Mentoring Program. Each quarter the SBHC will be sending you newsletters with tips and strategies to promote wellness.

Shoot for the Moon, Settle for the Stars

The wellness literature highlights the relationship between expectancy & outcomes (Kawada, 2004). By contrasting a desired future with a less ideal present, one develops a deeper commitment to one's goals. On the other hand, low expectations make it much more difficult for individuals to persevere. This month we outline steps for effective and meaningful goal-setting:

1. **Develop your desire.** Think about the importance of wellness and how it relates to your role as a clinician. How does your health influence your ability to help students? Do you provide better counseling services when you are healthy and happy?

2. **Write it down**. It sounds simple enough, but most people never get to this stage. Don't worry about prioritizing; write what comes to mind when you think about wellness. Be clear and concise since you can always redefine your goals later.

3. **Benefits and obstacles.** Before starting on the path to wellness, assess your current situation. Ask yourself how you may benefit from being healthier at home, at work and in other social contexts. More importantly, though, consider what stands in your way to wellness: time, money, patience, etc. Knowing what you are up against allows you to prepare ahead of time for potential roadblocks.

Fewer than 3% of adults have written goals and plans that they work on every single day. When you sit down and write out your goals, you move yourself in to the top 3%.

4. **List possible resources.** As a clinician working in one of the north central area schools associated with the LiveWell Kershaw project, you enjoy access to a variety of personnel and information support that can provide you with wellness literature and guide you in the process of clearly articulating your goals. Please contact Emily Mancil (emily.mancil@gmail.com) for more information on available resources.

5. **Make a plan.** Be specific about how and when you will attain your wellness goals. Remember that effective goals walk a fine line between being too difficult and too simple. Often it takes time to learn how to challenge yourself without setting yourself up for failure.

We hope these tips point you in a positive and productive direction.

Source: Kawada, Christie L. K. (2004). Self-regulatory thought in goal-setting: Perceptual and cognitive processes. Dissertation Abstracts International: Section B: The Sciences & Engineering, 64 (12B), 6377.

Seven Ways to Wellness

1. **Maintain healthy relationships.** Communicate honestly and treat every person with respect. Surround yourself with those who bring out your best.

2. **Maintain a fit body.** Balance food intake with exercise routine. Avoid addictions to the fullest extent possible. Remain mindful of your body's limits.

3. **Maintain a positive self-concept.** Recognize your feelings and realize your limitations as an individual. Learn to express a full range of emotions in an appropriate, adult manner.

4. **Maintain a meaningful work community.** Listen to others' ideas and continue developing marketable job skills. Find work that benefits you and those around you most.

5. **Maintain an understanding of yourself.** Don't be afraid to ask tough questions of yourself or society. Save time for self-reflection and critical thinking; take time to stop and smell the roses.

6. **Maintain a sustainable environment.** Learn to live in harmony with your natural surroundings. Take responsibility for protecting the air, water and soil.

7. **Maintain a consistent purpose in life.** Recognize the multiple paths to happiness and choose one that best suits your belief system.

Source: School of Health Promotion and Human Development: University of Wisconsin-Stevens Point (2004). Are you balancing the 7 dimensions of wellness?. Retrieved March 8, 2004 from http://www.uwsp.edu/HPHD/empwell/wellQuiz/

Goal-setting begins by knowing where you are now; only then can you say you know where you want to go.

Staying Motivated

It is difficult at times to stay motivated and it can be easy to lose sight of your goals. Here are some ways for clinicians to stay motivated and to motivate their clients:

1. **Make a commitment to stay motivated**.

2. **Define a motive** . Decide what matters most and focus on it by writing an action plan with clear goals.

3. **Find a passion.** Discover the force that drives you and use it to fuel your efforts at work.

4. **Cultivate an awareness**. Listen to every success story you hear and learn from it.

5. **Center on others**. Gravitate toward positive, productive people, and you, too, will be one.

This newsletter was originally created by the Center for School Mental Health (CSMH), at the University of Maryland School of Medicine and was modified by the Center for Adolescent Research in Schools (CARS).

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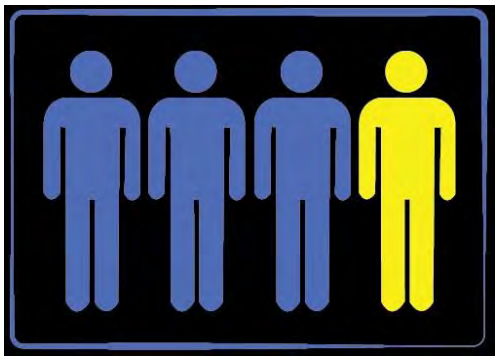

1 in 4 youth

experience mental health difficulties each year

Know the signs:

Withdrawing from friends, teachers, and family
- Spending more time alone
- Not communicating as much as before

A drop in school work
- Sudden decline in grades
- Decline in completion of school or homework

Decreased motivation or concentration
- Not engaging in usual activities
- Difficulties focusing

Changes in sleep
- Disrupted sleep patterns
- Not sleeping as much as usual

Change in mood or demeanor
- Moodiness when usually a cheerful student
- Lethargy, appearing disconnected
- Visible sadness or anger
- Excessive worry or anxiety
- Negative self-talk (questioning ability or self-worth)

Refer a student:

1. **Pick up a referral packet** from Mrs. Ham or the School-Based Health Center (SBHC) in the Gymnasium building.

2. **Complete and return** the packet to Mrs. Ham.

3. Within a week, the **wellness staff at the SBHC will follow up with you** to schedule an interview and collect any additional data.

4. The wellness staff, in collaboration with the School Advisory Board, will discuss treatment options using a data-based decision making process.

The wellness staff at the SBHC are available to discuss student wellness with teachers and staff:
- Identification of symptoms/signs
- Consultation regarding classroom strategies
- Facilitation of intervention implementation
- Individualized treatment opportunities for students (e.g., one-on-one wellness coaching, mentoring)

Emily & Abby welcome drop-ins when they are on-site at the SBHC (Mondays, Wednesdays, and Thursdays). Teachers may also set up an appointment to to discuss student wellness via email (emily.mancil@gmail.com).

LiveWell KERSHAW

Mental/Behavioral Health Resources Available in Kershaw County

The Alpha Center
709 Mill St.
Camden, SC 29020
Phone: 803.432.6902
Fax: 803.432.6890
http://www.thealphacentersc.org
The ALPHA behavioral Health provides group, individual and family counseling to those in need. They also provide youth and adolescent counseling to help with academic, emotional and behavioral issues. They accept Medicaid and some private insurance. If you have private insurance, please call them and ensure they will work with your insurance provider.

Family Resource Center
1111 Broad St
Camden, SC 29020
Phone: 803.425.4357
Toll Free: 1.800.585.4455
Fax: 803.425.5769
http://thefamilyresourcecenter.org
The Family Resource Center provides free and confidential services to help victims of abuse and their families. The Family Resource Center supports victims throughout the recovery process with counseling and support and offers guidance through medical and legal aspects of abuse, along with other services. The Family Resource Center is staffed by counselors and trained volunteers 24 hours a day, 7 days a week.

Santee-Wateree Department of Mental Health
Kershaw County Clinic
2611 Liberty Hill Rd
Camden, SC 29020
Phone: 803.432.5323
Fax: 803.713.3978
24hr Emergency Contact: 803.775.9364
http://www.state.sc.us/dmh/santee_wateree/SWInternet/main1.asp
The S.C. Department of Mental Health provides individual, family and group counseling to adults and children with emotional and/or behavioral issues. If necessary, they also offer psychiatric appointments for medication management. They accept Medicaid and some private insurance. If you have private insurance, please call them and ensure they will work with your insurance provider.

Midlands Area Pastoral Counseling Services
Camden, SC
Phone: 803.432.1111
Fax: 803.425.1111
Midlands Area Pastoral Counseling is a faith based organization that provides individual counseling, family counseling and marriage counseling. They also have educational seminars on grief, stress and marital issues.

Community Medical Clinic of Kershaw County
110 C East DeKalb Street
Camden, SC 29020
Phone: 803-713-0806
Fax: 803-713-0526
http://www.cmcofkc.org/
The Community Medical Clinic of Kershaw County is a non-profit authorized charitable organization. They are a family practice medical clinic that provides healthcare to the uninsured residents of Kershaw County at or below 150% Federal Poverty level. Provides case management services including short term mental health and support groups. Can provide free meds through pharmacy programs with exception of narcotics and psychiatry-related drugs.

AccessKershaw
2478 Main Street
Elgin, SC 29045
803.272.8777
http://www.accesskershaw.org/
AccessKershaw connects Kershaw County residents with appropriate healthcare providers, such as Sandhills Medical Clinic, the Free Medical Clinic, doctor's office and Kershaw Medical Center. While they specifically target uninsured residents at or below 150% of poverty, the organization will help connect any resident with needed services in the area.

Sandhills Medical Foundation, Inc.
1165 Highway 1 South
Lugoff, SC, 29078-8966
803-408-3262
http://sandhillsmedical.org/about/history/
(Other Sandhills offices providing behavioral health outside of Kershaw County: McBee, Kershaw, Jefferson, Sumter.)
Sandhills Medical Foundation is a Federally qualified community health center (FQHC) serving residents of Chesterfield, Kershaw, Lancaster, and Sumter Counties. It is a community-based and patient-directed organization that serve populations with limited access to health care. These include low income populations, the uninsured, those with limited English proficiency, migrant and seasonal farmworkers, individuals and families experiencing homelessness, and those living in public housing. Sandhills provides primary care, behavioral health care, onsite pharmacy, and lab services.

South Carolina Vocational Rehabilitation Department
15 Battleship Road Extension
Camden, SC 29020
803-432-1068
http://scvrd.net/centers/camden.php
The SCVRD Camden Work Training Center provides an individualized array of services to help people with disabilities find employment. The department also provides specialized services in substance abuse and dependence treatment.

Mental Health America – Kershaw County
PO Box 586
Camden, SC 29020
803-432-7955
Mental Health America is the oldest mental health advocacy organization in the nation. It is a grassroots, volunteer organization which educates civic groups, churches, the media, elected officials and the public about mental illness. The organization has a Representative Payee Program where staff serve as financial conservator for mental health clients and others who cannot manage their own finances. They also conduct depression screenings

Kershaw County Psychiatry
2171 Highway 1 South
Elgin, SC 29045
803-438-0455
Kershaw County Psychiatry conducts medical management and therapy. They do not take Medicaid or provide a sliding scale but they do take Medicare and insurance from the following: BCBS, Cigna, Magellan, and United Healthcare. While they do not initially work with TriCare they can work with you to get authorization for this.

R&B Counseling Services
612 Lafayette Avenue
Camden, SC 29020
803-425-1007
R&B Counseling Services is a private counseling company in Camden.

The Counseling Center at Horsepower Midlands
1645 Etters Lane
Cassatt, SC 29032
803-425-7178
Offers Equine Assisted, and traditional counseling services for adults, adolescents and children. Treatment is available for individuals, couples and families including premarital, marriage and relationship counseling. They specialize in relationship issues, parenting problems, and troubled teens. Treatment issues include substance abuse, impulse control, anger management, depression, and the day to day challenges life presents. They accept Medicare and most private insurances, and also offer a sliding payment scale.

Karen Taylor at Kairos Counseling
2439 Main St
Elgin, SC 29045
803-463-6861
Kairos Counseling is a private, independent, Christian counseling practice serving NE Richland and Kershaw Counties in South Carolina. They specialize in individual, couples, family, marriage, adult and adolescent therapy. They take clients ages 10 and up. They do not take insurance but does offer a sliding scale for payment.

Terry Hager , MSW LISW-CP
803-432-0988
222 Welsh Street
Columbia, SC 29020
Distance Counseling by Phone or Skype, or in her Office. Energy Psychotherapy, Anxiety, Panic Attacks, Phobias, Grief, Medical Issues, LGBT Issues, Weight Loss.

Additional Resources:
NAMI (South Carolina's Voice on Mental Health) help line: 800.788.5131

DRIVER 3

Create vibrant relationships and functional networks with community members to accelerate trust, outreach and achievement of a shared goal.

Progress from June-August, 2015

The LiveWell Kershaw team participated in numerous community events this quarter to increase awareness and engagement within the LiveWell Kershaw initiative (see detailed timeline on page 53). The team is committed to increasing awareness and also recruiting and retaining volunteers to assist with improving population health. The LiveWell Kershaw team distributed a newsletter to all stakeholders (paper and email). A community council meeting was held on June 7th at North Central High School expressing the need for volunteers and giving an update on the services provided. An additional community council meeting was held on August 15th. At this meeting, members brainstormed additional ways to increase exposure including hosting area pastors for a breakfast and involving students from the School Based Health Center to promote LiveWell Kershaw to their parents. For the August meeting, the time was changed to 6 PM to increase attendance. However, the attendance has remained the same for both meetings.

The CHWs were charged with posting LiveWell Kershaw materials at all businesses, churches, and organizations within their assigned territories. The CHWs visit these locations weekly to replenish materials and also re-connect with local stakeholders. Tamika Thomas, evaluation coordinator, conducted spot checks on certain businesses and organizations in all three territories during this quarter. She noted that the majority of the marketing materials are posted in Bethune (Rachael's territory) and less in Cassatt and Kershaw. Tamika Thomas is coaching the team on the importance of checking sites regularly to replenish materials. The CHWs do not attribute any phone calls to this particular activity to date.

In an effort to develop and build capacity within the organization, the Pathways team met three times during this quarter. The management meetings began in August and occur bi-weekly. During these meetings, staff from the Community Medical Clinic and AccessKershaw discuss individual cases that require intense collaboration across sectors. As a result, the team now has a new contract for medication and a new gynecologist referral. They are currently working on a urology referral. The team plans to include CHWs from LiveWell Kershaw in future meetings to begin to integrate the hub and pathway model. Susan Witkowski noted the following: "Through this collaboration, the patient is able to get to the outcome they need much quicker by the case managers and Nurse Practitioners working together." Susan also has noted an increase in staff morale and an increase in the number of phone calls and text managers between the case managers and Nurse Practitioners. The Pathways team will continue to use the Model for Improvement and PDSA cycles to increase positive results for all patients.

Summary of Outreach Activities during School Registration held on July 29-30, 2015

In the mission to improve population health in Kershaw County's North Central Region, team members participated in the county's school registration in an effort to promote and increase access to health services. The team wanted to (1) increase parent and teacher awareness of LWK activities; (2) make appointments for adults in need of CHW or Nurse Practitioner services; (3) recruit volunteers; and (4) enroll students to the school-based health center at North Central High School. Team members who assisted in the effort were from LiveWell Kershaw, Access Kershaw, the Community Medical Clinic of Kershaw County, the Arnold School of Public Health, and the Department of Psychology at the University of South Carolina.

Registration for Baron-Dekalb Elementary School, Mt. Pisgah Elementary School, Midway Elementary School, Bethune Elementary School, and North Central Middle School took place on Wednesday, July 29, 2015 from 9 am to 1 pm and 3 pm to 6 pm. Registration for North Central High School took place on Wednesday, July 29th and Thursday, July 30, 2015, from 9 am to 1 pm and 3 pm to 6 pm. Overall, the outreach event proved to be extremely successful in increasing awareness and signing up volunteers and residents for services. Below is a description of what took place at each school with the team members unidentified. These descriptions will guide the LWK team next year during their planning efforts.

Elementary Schools

At Baron-Dekalb Elementary School, registration took place in the cafeteria with a rotation of tables, with the LiveWell Kershaw table in the middle and the Kershaw County Mental Health table on one side. Principal Betty Turner and a few teachers stopped by the LiveWell Kershaw table since they are former colleagues of team member #1. Baron-Dekalb Elementary School is very small, less than 200 students, yet the flow of parents and students was very steady, facilitating the introduction of services of LiveWell Kershaw in the North Central region. Team member #1 mentioned that most people who stopped at the table were already familiar with LiveWell

Kershaw and that only a few were unaware of the available services. The team member introduced the School Based Health Center to some parents since they have children who attend the middle or high schools. Approximately 65 parents were reached no new clients signed up for LiveWell Kershaw services and no new volunteers were recruited during the registration. Overall, having LiveWell Kershaw present at the school registration was successful.

Bethune Elementary School registration took place in the cafeteria, in a counterclockwise table rotation with the LiveWell Kershaw table in the middle. Susan Carmichael, the registration coordinator, and Estelle Benson, the principal, greeted team member #2 and showed her where to sit. Four teachers, the bus supervisor, and the cafeteria manager assisted with registration and directed parents over to the LiveWell Kershaw table. The flow for both morning and afternoon registration was steady, with the team member approaching parents since some were hesitant to come to the table. Many parents were interested in the services available. The registration staff knew about LiveWell Kershaw and felt comfortable directing the parents to receive information. There was one mother with two children who had never heard about LiveWell Kershaw. Team member #2 explained its origin and the services provided. Though her insured children already have a pediatrician, the mother stated that she would definitely keep LiveWell Kershaw in consideration. The mother was told about the mobile clinics and its availability in the North Central

region. She took some newsletters to give to family and friends. A mother with one child had heard about LiveWell Kershaw from her grandmother who attends Sandy Level Baptist Church, one of the community healthcare sites. She took a newsletter and a card and said that she will be sure to get her grandfather to visit to take advantage of the services. Another parent stated, "I see LiveWell Kershaw advertised everywhere [in Bethune] and received information in the mail." She said she will visit one of the sites. She took plenty of newsletters to give to family and friends. All together there was one referred client and three volunteers recruited. Approximately 44 parents were reached.

During registration at Mt. Pisgah Elementary School, all the parents were very receptive and took time to listen to the description of LiveWell Kershaw by team member #3. Registration took place in the library though team member #3 was stationed outside in the hallway beside the bus route table for more visibility. The staff was very accommodating and assisted parents in receiving information. Principal Estelle Benson had met the other team member Bethune Elementary School. She believes that LiveWell Kershaw is very beneficial to families. Approximately half of the parents and school staff were aware of LiveWell Kershaw. Everyone picked up either a newsletter, a card with the site locations, or pencils for more information. A few of the parents were patients of the Community Medical Clinic of Kershaw County. Team member #3 went directly to the parents to explain about LiveWell Kershaw and gave pencils to the children for an opening to speak with parents. No clients signed up for LiveWell Kershaw Services or volunteers recruited.

Midway Elementary School registration was held in the cafeteria where there was a table rotation, with the LiveWell Kershaw table in between The Boys' and Girls' Club table and the dance studio table. Team member #4 described the afternoon registration environment as slow until 4:30 when the pace picked up. The afternoon crowd appeared less interested in receiving any additional information. Newsletters, cards, and pencils were given out to partners while waiting in the line. Principal Dell Brabham, stopped by the table and remarked of how LiveWell Kershaw serves the community to help improve health. Though the School Based Health Center will not be implemented on the elementary school level at this time, the team member did share with teachers about the possibility of on-site services for the elementary school students in the future.

North Central Middle School

North Central Middle School registration took place in the media center with the LiveWell Kershaw table second in the clockwise rotation. Attendance was low. The parents and students appreciated receiving information on LiveWell Kershaw when they came to the table. Parents were receptive. Team member #5 went over to Principal Burchell Richardson and the librarian, Mrs. Cynthia Sparks, and to all the tables to talk about LiveWell Kershaw. The team member stated, "The bus drivers, Susan and Jack, were very

engaged about LiveWell Kershaw since they like to engage the students on their bus route. Having the LWK pencils on hand to give to the students is something the bus drivers take pride in to help spread the word about LiveWell Kershaw." The team member spoke with the coach about LiveWell Kershaw and he thought the services were very helpful for flu shots and screenings. Team member #5 also provided a few details about the School Based Health Center and its location at the high school. Many teachers from the middle school repeatedly stated, "We need that, especially Mental Health." No new clients who signed up for LiveWell Kershaw services or no new volunteer signed up.

North Central High School

The purpose of the registration at the high school was two-fold: (1) to increase awareness about the LiveWell Kershaw services, and (2) to sign students up for the school based health center and answer questions. A total of twelve team members were present on at least one of the two registration days. Principal David Branham and some faculty stopped by the tables to engage in the effort. Registration was held in the gymnasium in a counterclockwise table rotation, from left to right. The tables for the School Based Health Center and LiveWell Kershaw were at the end of the rotation as the last stop for parents and students. At least two team members were manning each table, while other team members were mingling with school staff, parents, and students. On day one, registration was for 9th and 10th grade students, while 11th and 12th grade students registered on day two. Team member #7 pointed out, after hearing from others, that the pace was slightly slower on day two than day one, possibly because there were more students (grades 9-10) to register.

The School Based Health Center table team members included a Nurse Practitioner and clinical team members from USC's Department of Psychology. Team member #7 stated "it was more about the logistics of how the center would work," and understanding outstanding questions from parents. For instance, parents wanted to know if the School Based Health Center would be communicating with their doctor(s) and have access to their medical records. Team members informed parents that the School Based health center would act as an additional health service provider for students. Team member #8 shared that the team members did an excellent job explaining the School Based Health Center, using the analogy of a minute clinic, with the availability of services such as vaccinations and mental health services. The descriptions of the school-based health center were consistent and accurate. Some visitors had questions about insurance and reimbursement, which at this time is in development. Team members #6 and #7 handled most of the initial registration, taking school-based health center applications and parent surveys and making copies of social security and picture identification cards. Team member #9 was able to provide more detailed information about nurse practitioner services and operations in response to more specific questions about insurance. Team members #1, #10, and #11 also assisted with the School Based Health Center when needed. The parent survey for the School Based Health Center is an evaluation of services that may be needed by students while in school. The survey was handed out consistently to parents during the registration process. Refer to page 32 for the findings of this survey.

The LiveWell Kershaw table shared information with parents and students related to available services and the ability to provide greater assistance to the uninsured and underinsured. Team members #1, #10 and #11 were key staff all day at North Central High School in this effort. LiveWell Kershaw newsletters and postcards with dates and times of healthcare community sites and mobile clinics were distributed. Team member #5 stated, "The cool pencils were a hit as well. Who doesn't need a mood pencil in their favorite color?" Team member #5 also enlisted and inspired a 15 year-old student and the school's Key Club to do their community service hours and help out at events. For those that expressed interest in medical careers, team member #5 spoke for longer periods of time and encouraged them to get involved with LiveWell Kershaw and explore potential opportunities.

Team members assisted with an evaluation and marketing project asking parents and students to write down something that made them happy about their community. Pictures were taken with residents holding a white board in front of them with a word or phrase written on it. Some of the themes that emerged from the photos included "closeness," "summer on the lake," "quiet and peaceful," "really nice people," "love our school," "family," and "my church." This white board project is a way for people of North Central to tell us what is important to them and to better serve the area in our holistic approach in improving health and referral services.

There are several recommendations to consider for next year's implementation. As the team member #2 notes that having LiveWell Kershaw information bags available is important so parents can read the information later and share it with others. Team member #5 notes that volunteers can help man the tables, offer snacks, and mingle with school employees. Team member #7 suggests continuing outreach registration each year and creating a sign-up link for LiveWell Kershaw and the School Based Health Center on the website for each school. Team member #8 highly recommends obtaining a secured storage for copies of personal information for sign-ups for LiveWell Kershaw and the School Based Health Center. Being included in school events is essential to the success of each of these units, as a part of the North Central Initiative.

The school registration events were very effective in increasing awareness of services, enrolling clients for needed services and recruiting volunteers. Live Well Kershaw and School-Based Health Center team members interacted very well with each other and actively engaged in the promotion of services with parents, teachers and students. **A total of 29 LiveWell Kershaw client applications, 21 LiveWell Kershaw volunteer applications, and 52 School-Based Health Center applications were received. There were 78 School-Based Health Center follow-up requests.**

Evaluation Recommendations

- Observe and closely monitor how each CHW is interacting with community businesses and see if the approach is effective or needs to be modified (great variability in distribution of materials across territories).
- Begin implementing strategies proposed by the Community Council Members.
- Make contact with pastors and providers in the area to ensure that key community leaders are aware of community efforts.
- Continue to generously post and distribute LiveWell Kershaw schedules, newsletters, and marketing materials.
- Personally call Community Council members and determine if time, location, etc. may need to change and if community council meetings should be divided by the CHW's territories (some members are driving over 45 minutes to attend the meeting).
- Engage Pastor Dave Lowe at Buffalo Baptist Church who appears to be a champion, and give him a specific assignment.
- Create a call to action for Community Council members.
- Create a plan to engage volunteers on a regular basis.
- Expand the monthly case management meetings to include CHWs, continue to center dialogue on patient and family centered needs and resources, and document case studies.

Timeline of Community Events in Quarter 1

DATE	STAFF	DESCRIPTION	LOCATION	OUTCOME
June 1	Susan, Cheryl, Whitney, Kelly, Andy, Mel, Abby, Ibrahim, Tamika	Mental Health Presentation	Camden, SC	Mel George, former MH facilitator, shared some common myths about MH; presented the language of MH and mental illness and issues surrounding the terminology; and discussed the 3-tiered approach to implementation of the LWK MH component in the North Central area schools
June 1-19	Karen, Rachael, Jesus	CHW Training	Columbia, SC	CHWs attended training at MTC to acquire certification
June 10	Cheryl	Meeting with Pastor Lowe, Buffalo Baptist Church	Kershaw, SC	Discussed Buffalo Baptist as a community healthcare site
June 12	Cheryl	Meeting with Pastor Henry, Believer's Temple	Cassatt, SC	Discussed how his church could help increase awareness of LWK in the Cassatt area
June 13	Whitney	Haile Gold Mine yard sale	Kershaw, SC	Whitney spoke with residents about LWK and provided KARE supplies to them
June 16	Susan W., Cheryl, Whitney, Mark W., Emily, Abby	Meeting with Dr. Morgan, Superintendent KCSD	Camden, SC	Introduced Emily and Abby as they began to transition into the MH component; presented their proposal to continue the work Mel started and to expand services
June 16	Cheryl, Whitney, Karen	Community Council Meeting	Kershaw, SC	7 attendees; we presented an update on healthcare sites, movile clinics and SBHC; discussed partnership with Food for the Soul; expressed the need for volunteers
June 17-18	Cheryl	CHW Training	Columbia, SC	Observed the CHW class; focused on instructional techniques, CHW interactions and class performance, assignments and activities
June 20	Cheryl	Community Cook-Out at St. John Baptist	Liberty Hill, SC	Distributed flyers; about 12 blood pressure checks
June 24	Cheryl, Whitney, Dr. Brooks, CHWs, Tamika, 1 volunteer	Mobile Clinic at Refuge Baptist	Kershaw, SC	3 appointments (1 medical); 4 walk-ins received services
June 24	Whitney, Racheel, Karen	Buffalo Baptist	Kershaw, SC	speaking engagement

DATE	STAFF	DESCRIPTION	LOCATION	OUTCOME
June 27	3 CHWs	Westville Fire Dept BBQ	Westville, SC	Blood pressure and glucose taken; LWK materials given out to attendees
June 29	Susan, Cheryl, Whitney, Dr. Brooks, CHWs	Mobile Clinic at Cassatt Baptist	Cassatt, SC	2 appointments (medical)
June 29	CMC, LWK, AK, and USC	Joint Staff Meeting	Camden, SC	Reviewed project milestones and set goals for Year 2; Created priority action plans for Quarter 1
July 6	Susan W. Holly, Cheryl, Whitney	Phone conference with Dr. Rick Foster	Camden, SC	Discussed the Pathways Model of providing access to care; requested that he conduct a session with full staff
July 7	Susan W. Cheryl, Susan G., Whitney	Meeting with Dr. Morgan, Mary Anne Byrd, David Branham-NCHS Principal	Camden, SC	Addressed questions and concerns related to SBHC; documents created to inform parents; Center enrollment forms
July 9	Susan W., Cheryl, Whitney, Holly	Meeting with DHHS	Columbia, SC	Reviewed Quarter 4 - Year 1 Report
July 13	Cheryl; Volunteers	SBHC Enrollment Forms mailed	Kershaw, SC	NCHS Grades 10-12: Approximately 360 letter mailed NCMS Grade 8 (rising grade 9): Approximately 145 mailed
July 15	CMC, AK, LWK	IMPACT Meeting	Camden, SC	Informed attendees about new sites schedule; distributed spring newsletter
July 19	Karen, Rachael, Cheryl	Buffalo Baptist Church VBS Kick-Off	Kershaw, SC	Distributed materials; spoke to attendees about LWK services
July 29-30	CMC, LWK, AK, and USC	Elementary, Middle and High Schools registration	North Central Area Schools	Team members were assigned to each school to have a table display and distribute materials, recruit volunteers, enroll potential LWK clients, and enroll NCHS students for the SBHC; over 20 volunteers recruited; over 50 students enrolled, 80 requested follow-up calls
August 1	Whitney	Belk Kids Fest	Camden, SC	Back to School
August 3	CHWs, Dr. Brooks, Whitney, Cheryl	Mobile Clinic at Cassatt Baptist	Cassatt, SC	2 appointments; 5 sports physicals for NCHS students; 1 walk-in medical; 4 client encounters
August 4	CMC, LWK, AK, and USC	Joint Staff Meeting	Camden, SC	Dr. Rick Foster presented the Pathway Model for providing community healthcare; CHWs were recognized for mastering exam and receiving certification
August 6	Whitney	SBHC Advisor Council Meeting	Kershaw, SC	Meeting for SBHC intiatives and services

DATE	STAFF	DESCRIPTION	LOCATION	OUTCOME
August 8	Rachael, Jesus	Bethune Discount Grocery Store	Bethune, SC	Booth set-up; CHWs took blood pressures and handed out LWK information
August 10	Cheryl	KC Democratic Women	Camden, SC	Updated attendees on new schedule; SBHC
August 13	Cheryl	Community Council Meeting	Kershaw, SC	5 attendees; brainstormed ideas for increasing exposure, encouraging interest in LWK, hosting area pastors and ministers for a breakfast or lunch to gain their support; involving students from the SBHC to promote LWK through the SBHC
August 13	Jesus	Midway Elementary		Back to School
August 13	Rachael	Mt. Pisgah		Back to School
August 14	Rachael	Bethune Elementary	Bethune, SC	Back to School
August 15	Jesus, Rachael	Back to School Bash at Sandy Level	Bethune, SC	18 bp, ~50
August 18	Emily, Abby	First day at SBHC	Kershaw, SC	Ninth graders toured school and SBHC; Emily and Abby discussed their services and encouraged students to enroll
August 19	Jesus, Dr. Brooks	Mobile Clinic at Refuge Baptist	Kershaw, SC	1 medical but had Medicare
August 26	Rachael, Karen, Jesus, Whitney, Dr. Brooks, Lindy	NCHS	Kershaw, SC	11 sports physicals, 6 SBHC new students
August 27	Rachael	Recreation Center	Bethune, SC	Visionkershaw 20/30 Town Council
August 27	Whitney, Dr. Brooks, Jesus, Rachael	Mobile Clinic at Buffalo Baptist	Kershaw, SC	1 medical, 2 walk-ins, 2 volunteers
August 28	Jesus	NCHS	Kershaw, SC	football game bp, info, SBHC forms

LiveWell KERSHAW
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NEWSLETTER

PO Box 142 Cassatt, SC 29032
livewellkershaw.org

SUMMER 2015
Contact: cstover@livewellkershaw.org 803.427.5206

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REGISTRATION DAY AT NORTH CENTRAL AREA SCHOOLS

Staff members from the Community Medical Clinic, LiveWell Kershaw, Access Kershaw and USC's Arnold School of Public Health joined forces to participate in registration at all six North Central area schools on July 29 & 30. Staff talked with parents & students about LWK services, recruited volunteers, distributed flyers, postcards & pencils, and enrolled more than 50 students for the new School Based Health Center at North Central High School. An additional 80 students requested follow-up calls.

LWK Project Manager Cheryl Stover with students from Baron DeKalb Elementary

SCHOOL BASED HEALTHCARE CENTER (SBHC) NOW OPEN

The SBHC began operations on August 17, the first day of classes at North Central High School. The SBHC is now offering counseling services & health screenings, including sports physicals, which have proven to be a very popular item with more than 20 sports physicals performed since the center opened. NCHS cross country coach Emily Fenton had this to say: "Having LiveWellKershaw complete sports physicals saved me a lot of time and headaches about my runners having the proper paper work needed to compete for me. The accessibility and the timely manner in which the physicals were done was phenomenal and I hope LiveWell can help other sports teams in the future!"

North Central High School in Kershaw County

Emily Mancil, Wellness Facilitator for all North Central area schools, is excited about getting to know North Central's students, "We hope that these services will be a great resource for the North Central area schools! We look forward to connecting teachers and parents to evidence-based strategies and referral information to identify and address mental/behavioral health concerns of students." Services currently offered at the SBHC also include wellness coaching & counseling, behavioral skills consultation services, and the nationally recognized Check & Connect Mentoring Program.

The wellness coach is available Monday 7:30am - 3:30pm and Wednesday 8:00 - 11:00am. The wellness facilitator coordinates the mentoring program and is available Wednesday 9:30am - 4:00pm and Thursday 1:00 - 4:00pm. Community Health Workers will be available on various days and times to connect students and families to basic healthcare services. In 2016 the LWK nurse practioner will begin providing some primary care services Monday through Thursday. For more information contact Whitney Hinson: 803.900.5598; whinson@livewellkershaw.org.

TWO NEW AFTERNOON COMMUNITY HEALTHCARE SITES NOW OPEN

In August, new sites were opened to accomodate North Central residents in need of healthcare services after the 9 to 5 workday. DeKalb Baptist Church (2034 DeKalb School Rd, Camden) is open Monday 5 - 7pm, and Freedom Outreach Baptist (1113 Hwy 1 North, Cassatt) is open Tuesday 5 - 7pm.

These sites offer the same services as the other LWK Healthcare Sites, including blood pressure and glucose screenings, assistance with medications and health insurance, applying for Medicare, Medicaid, SNAP and Welvista, and assistance managing overall health and well-being.

Services available at Community Healthcare Sites include diabetes testing materials.

Community Council & SBHC Advisory Board Meetings

The LWK Community Council met on August 13 at Refuge Baptist Church in Kershaw. Attendees were excited to learn more about plans for the SBHC at NCHS and ways to promote student involvement. The group also discussed raising awareness about the Community Healthcare Sites and Mobile Clinics with North Central area clergy leaders.

The SBHC Advisory Board met on August 6 and discussed student enrollment at the center, providing a clear listing of services for parents, and coordinating the SBHC activities with the school nurse at NCHS.

Would you like to attend one of our meetings? Upcoming Community Council meetings will be held at 6 pm at Refuge Baptist on September 10 & October 8. For more information contact Whitney Hinson: 803.900.5598; whinson@livewellkershaw.org.

LWK staff members Emily Mancil, Jesus Martinez and Abby Bode

NCHS Open House

LWK staffers visited Open House at North Central High School on August 31 to share information about the new SBHC. School staff welcomed LWK and are encouraging parents to enroll their students at the center. Many parents took enrollment materials to be returned later.

Community Healthcare Site Schedule	
MONDAY 9am - 1pm	Cassatt Baptist Church 2604 Hwy 1 North Cassatt, SC 29032
MONDAY 5 - 7pm	DeKalb Baptist Church 2034 DeKa lb School Rd Camden 29020
TUESDAY 9am - 1pm	Sandy Level Baptist Church 2920 Timrod Road Bethune, SC 29009
TUESDAY 5 - 7pm	Freedom Outreach Baptist Church 1113 Hwy 1 North, Cassatt 29032
WEDNESDAY 9am - 1pm	Refuge Baptist Church 2814 Lockhart Road Kershaw, SC 29067
THURSDAY 9am - 1pm	Buffalo Baptist Church 6390 Lockhart Rd Kershaw, SC 29067

Upcoming Mobile Clinic Dates

September 8	Sandy Level Baptist
September 16	Refuge Baptist Church
September 24	Buffalo Baptist Church
September 28	Cassatt Baptist Church
October 6	Sandy Level Baptist
October 14	Refuge Baptist Church
October 22	Buffalo Baptist Church
October 26	Cassatt Baptist Church

The mobile clinic offers many of the same primary care services available in a doctor's office or a clinic such as diagnosis & treatment and prescriptions-many at little or no cost.

For more information and to schedule a mobile clinic visit please call 803.272.8325. Clinic hours are 9 am - 1 pm. Please visit our website to find out more.

CHWs Complete Training with High Marks

LiveWell Kershaw's Community Healthcare Workers (CHWs) completed a rigorous training program at Midlands Technical College in Columbia this summer. The program provides CHWs with a better understanding of healthcare infrastucture, including medical billing procedures, which will enable them to better serve clients in navigating all points in their healthcare journey.

Dr. Rick Foster Addresses LiveWell Kershaw

Dr. Rick Foster, Executive Director for Catalyst for Health, a new enterprise within the South Carolina Hospital Association, was the guest speaker at the August all staff meeting for LiveWell Kershaw. Catalyst for Health is focused on guiding and supporting collective efforts to improve health and healthcare at the population level across South Carolina. Dr. Foster presented many inspirational ideas to the LWK team, including this:

"It's what you do <u>with</u> a community, not to or for the community."

A full video of Dr. Foster's presentation can be found at:
https://youtu.be/m_0WyNfDCHE

LiveWell Kershaw is a group of healthcare providers, businesses, schools, churches, and local citizens working together to make Kershaw County the healthiest county in South Carolina. LiveWell Kershaw focuses on health issues impacting the North Central area: heart disease, high blood pressure, diabetes and behavioral health conditions. Our partners include AccessKershaw, KershawHealth, Community Medical Clinic of Kershaw County, and the Arnold School of Public Health, USC.

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Community Healthcare Sites & Mobile Clinic

What is a Community Healthcare Site?

Community Healthcare Sites are local churches and community centers that have partnered with us by opening their doors to help our Community Health Workers & Nurse Practitioners provide basic healthcare services to area residents. These sites provide health screenings, help applicants with insurance, Medicare/Medicaid, SNAP & Welvista and offer other assistance to manage overall health and well-being.

What is a Mobile Clinic?

The mobile clinic offers many of the same primary care services available in a doctor's office or a clinic such as diagnostics, treatment and prescriptions. **The mobile clinic will be visiting Cassatt Baptist Church on Monday, June 29 from 9:00 am - 1:00 pm.**

Volunteers Are Needed

We have many opportunities available for you to get involved, including helping at one of our community healthcare sites and representing LiveWell Kershaw at events throughout the community. For more information about how you can get involved, please contact:

Whitney W. Hinson
803.900.5598
whinson@livewellkershaw.org

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Community Healthcare Site Schedule

MON 9:00 am - 1:00 pm
Cassatt Baptist Church
2604 Hwy 1 North
Cassatt, SC 29032

TUES 9:00 am - 1:00pm +
Sandy Level Baptist Church
2920 Timrod Road
Bethune, SC 29009
+ *beginning July 7th*

WED 9:00 am - 1:00 pm
Refuge Baptist Church
2814 Lockhart Road
Kershaw, SC 29067

THURS 9:00 am - 1:00 pm ++
Buffalo Baptist Church
6390 Lockhart Rd
Kershaw, SC 29067
++ *beginning July 9th*

FRI 9:00 am - 1:00 pm *
Mt. Moriah Missionary Baptist Church
3045 John G. Richards Rd
Liberty Hill, SC 29074
* *2nd & 4th Friday/month*

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PO Box 142 Cassatt, SC 29032

LiveWell KERSHAW

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Mobile Clinic

What Is a Mobile Clinic?

The mobile clinic offers many of the same primary care services available in a doctor's office or a clinic. LiveWell Kershaw's nurse pracitioner is qualified to diagnose & treat illness and prescribe some medications. The mobile clinic is currently available once per month and rotates among the Community Healthcare Sites. Appointments are not necessary but are suggested.

Upcoming Mobile Clinic Dates

The mobile clinic will be visiting the following sites this month:

Wednesday, June 24
9:00 am - 1:00 pm
Refuge Baptist Church
2814 Lockhart Road
Kershaw, SC 29067

Monday, June 29
9:00 am - 1:00 pm
Cassatt Baptist Church
2604 Hwy 1 North
Cassatt, SC 29032

Community Health Workers will also be available to connect visitors with a regular healthcare provider, help applicants with insurance, Medicare, Medicaid, SNAP & Welvista and offer other assistance to manage overall health and well-being.

For more information please contact:
Whitney W. Hinson
803.230.8108. whinson@livewellkershaw.org

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Appointment Card with Updated Evening Hours

Front

LiveWell KERSHAW
"Your Bridge to Better Health"

_____

has an appointment on:

☐ MON ☐ TUE ☐ WED ☐ THU ☐ FRI

Date: _____ at _____a.m. / p.m.

Location:_____

Notes: _____

_____
Staff signature

PLEASE SEE REVERSE FOR LOCATION ADDRESS

Questions? Please contact:
803.272.8325 whinson@livewellkershaw.org

Back

LiveWell KERSHAW
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Community Healthcare Site Locations

Day/Time	Location	Address
MON 9 am - 1 pm	Cassatt Baptist Church	2604 Hwy 1 North Cassatt 29032
MON 5 - 7 pm	DeKalb Baptist Church	2034 DeKalb School Rd Camden 29020
TUES 9 am - 1 pm	Sandy Level Baptist Church	2920 Timrod Rd Bethune 29009
TUES 5 - 7 pm	Freedom Outreach Baptist	1113 Hwy 1 North Cassatt 29032
WED 9 am - 1 pm	Refuge Baptist Church	2814 Lockhart Rd Kershaw 29067
THURS 9 am - 1 pm	Buffalo Baptist Church	6390 Lockhart Rd Kershaw 29067
FRI 9 am - 1 pm *2nd & 4th Fridays of mo*	Mt. Moriah Missionary Baptist Association	3045 John G. Richards Rd Liberty Hill 29074

803.272.8325 livewellkershaw.org P.O. Box 142 Cassatt, SC 29032

DRIVER 4

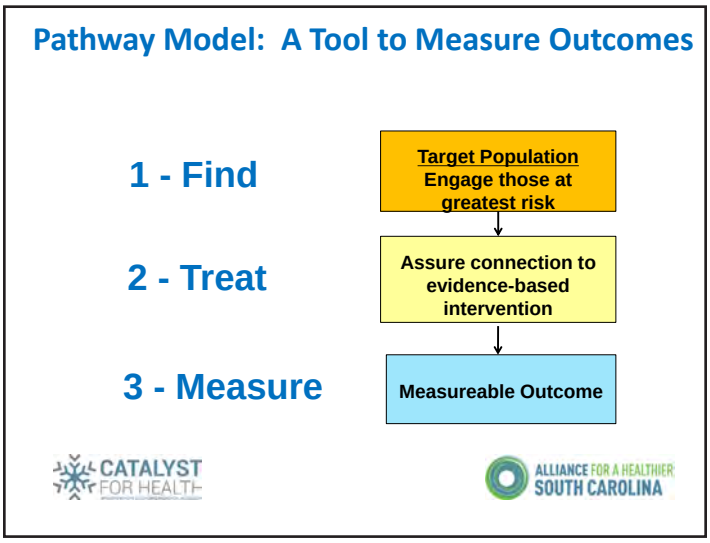
Conduct evaluation using developmental, formative and economic approaches to guide the implementation process.

Progress from June-August, 2015

The evaluation team (Holly Hayes, Tamika Thomas, Mark Macauda, and Ibrahim Demir) continued to work closely with the implementation team of LiveWell Kershaw. Tamika Thomas spends three days a week in Kershaw serving as a quality improvement coach for the community care coordination team. Mark Macauda is leading the efforts to evaluate the school-based health center, and Ibrahim Demir is conducting the economic evaluation. Evaluation has become part of the fabric of the project and is integrated into LiveWell Kershaw initiatives. The Director, Susan Witkowski, and leaders within LiveWell Kershaw, review data regularly to guide needed course corrections and acknowledge team members excelling in meeting their goals.

During this quarter, the evaluation team linked the LiveWell Kershaw team with Dr. Rick Foster and Ana Gallego, who are part of Catalyst for Health with the SC Hospital Association. Dr. Foster gave a presentation to the entire staff on August 4, 2015 entitled "Improving health at the population level- the community HUB model." The leadership and evaluation team is working on how to reframe the LiveWell Kershaw initiative within the hub and

pathway framework which is a tool to measure outcomes. Ana Gallego shared strategies to engage with community with the CHWs. Holly Hayes reached out to the developers of this model, and the team is currently working on focusing on 2-3 pathways and developing action steps for each pathway. In addition, Ms. Hayes and Dr. Foster co-facilitated a meeting with board members of the Community Medical Clinic to discuss the best ways to integrate the clinic, AccessKershaw and LiveWell Kershaw. The team recognizes that LiveWell Kershaw is "not an entity" as stated often by the Project Director, Susan Witkowski. Based on initial discussions, the leadership views the DHHS contract as an extension of the mission and vision of the clinic with the clinic serving as a hub (central point for coordinating efforts). Ms. Hayes will be examining the integration process as it unfolds and what impacts this has related to short term and long term outcomes.



The evaluation team assisted LiveWell Kershaw in applying to be part of the Institute for Healthcare Improvement's SCALE (Spreading Community Accelerators through Learning and Evaluation) initiative. As of August 1st, LiveWell Kershaw became part of the national "Pathways to Pacesetters" cohort which is funded by Robert Wood Johnson. The purpose of this project is assist communities in the United States to substantially accelerate their health improvement journey. Holly Hayes is currently a coach for this project and is able to share tools, materials, and exercises with LiveWell Kershaw to unlock their potential and achieve significant results. During this quarter, the Medical Director, Community Health Workers, Community Outreach Manager, and Project Director along with the evaluation team participated in their first webinar addressing health equity. In the next quarter, the team will begin to work closely with the Model for Improvement which includes PDSA (Plan, Do, Study, Act) cycles and how to use data to guide implementation.

Insight Vision

Insight Vision, performance management software by InsightFormation, assists in strategy management and collective impact, and provides a way to report and present data for trends, analysis, and evaluation. This is a web-based software that allows team members to log into the system to see dashboards specific to their project and also to examine trends. Initial training with Insight Vision began in the early summer of 2015 with instruction from InsightFormation consultants, Mark Specht and Amanda Mancuso. Team members Holly Hayes, Mark Macauda, and Tamika Thomas, from the Office of Research at the University of South Carolina's Arnold School of Public Health, took part in the training in hopes of then training team members from LiveWell Kershaw.

For analysis purposes, the actual data is entered into Insight Vision to verify if targets, agreed to by the team, are being reached. Targets are coded as red, yellow and green to identify priorities and areas where quality improvement efforts may need to be focused. The data is entered on a weekly, monthly, and/or quarterly basis depending on the metric. On July 22nd, Tamika Thomas initially trained Whitney Hinson, the Community Engagement and Outreach Manager, and Cheryl Stover, the Project Manager, on entering community health worker and school-based health center data, respectively. Continued training with Insight Vision is provided as needed as team members work through making sense of the data.

For the school-based health center data, evaluation recommendations are based on the following measures:

- % enrollees with signed HIPPA and FERPA (per month)
- % of student body signed up with SBHC (per month)
- % of students in need in school medical home
- Average number of visits to SBHC per year per enrollee
- % of total identified students in need who enroll in clinic (per year)
- # of active members (per year)
- # of meetings per year (per year)

For the community health worker data which is directly tied to the care coordination driver, evaluation recommendations are based on the following measures:

- # of new clients seen (per week)
- # of new clients seen (per quarter)
- # referrals to case management (per month)
- # of contacts made within 48 hours (per week)
- # of contacts made over 48 hours (per week)
- # of scheduled appointments made at Community Medical Clinics within 7-10 days of discharge (per quarter)
- # of scheduled appointments made at a primary care doctor within 7-10 days of discharge (per quarter)
- # of “unreachables” addicted to ER Black hole clients (per quarter)
- # of clients referred to a medical home (per month)
- # of new volunteers (per quarter)
- # of hours contributing (per quarter)
- # churches visited (per quarter)
- # of provider visits (per month)
- # of patient visits at mobile clinic (per month)
- # of mobile clinic sites (per month)
- # of clients seen at each site (per month)
- # of events (per quarter)

Future Plans

The evaluation team will continue to work closely with the LiveWell Kershaw team. By linking the team to national resources, we hope to integrate quality improvement into the daily fabric of LiveWell Kersahw. Holly Hayes will work closely with the Director, Susan Witkowski, as a new organizational chart, operations plan, and strategic plan are developed. Ms. Hayes will also examine bright spots occurring among all of the work and share these with the leaders to see how the bright spots can spread among staff, territories and initiatives. Tamika Thomas will be working closely with Whitney Hinson, Outreach Manager, this quarter to increase the skill level among the Community Health Workers using the Model for Improvement and other quality improvement tools.

Evaluation Recommendations

- Continue to evaluate Insight Vision and determine if it is needed.
- Continue to attend all key LiveWell Kershaw meetings and meet regularly with team members, volunteers, and community members to support evaluation efforts and learnings throughout the quarter.
- Closely track progress made during all driver meetings, and remind team members of recommendations, if needed.
- Conduct fidelity monitoring related to the Green Leaf health coaching material.
- Review the economic evaluation report that will be published this month, and determine if milestones or additional indicators need to be tracked to reach LiveWell Kershaw's overall goal.
- Integrate the work from Dr. Ibrahim Demir into the overall implementation and evaluation work.
- Work closely with Susan Witkowski and Whitney Hinson to integrate the Model for Improvement and PDSA cycle into daily work.
- Have Holly Hayes participate in upcoming strategic retreat in November, 2015 for the Community Medical Clinic.
- Assist leadership team in developing a revised conceptual model using the hub and pathway framework.

INSIGHTVISION

Scorecard

Extend Primary Care via CHW & Mobile Clinics

Operational Measures

Name	Prior Period	Current Value	Change	Target Value	Most Recent Period
CHW & Mobile: CHW Successfully Conduct Client Encounters From 9am to 1pm at Church Sites					
# of new clients seen per week	17	15	1	50	Yr2 W13
# of new clients seen per quarter	N/A	106	0	400	Y2 QTR1
CHW & Mobile: Provide Chronic Disease Case Management to Clients (Referral System)					
# referred to case management	0	0	2	0	Aug 15
CHW & Mobile: Initiate Contact with LWK Discharge Admissions within 48 Hours					
# of phone contacts made within 48 hours per week	40	58	3	0	Yr2 W13
# of phone contacts made over 48 hours per week	0	0	12	0	Yr2 W13
CHW & Mobile: Schedule an Apt at the Community Medical Clinic w/n 7-10 days of LWK Discharge if Client Qualifies					
# of scheduled appointments made at Community Medical Clinics within 7-10 days of discharge (per quarter)	N/A	23	0	0	Y2 QTR1
CHW & Mobile: Schedule an Appointment with a Primary Care Doctor w/n 7-10 days of LWK Discharge					

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# of scheduled appointments made at a primary care doctor within 7-10 days of discharge (per quarter)	N/A	19	0	0	Y2 QTR1
CHW & Mobile: Track the Number of "Unreachables" in LWK					
# of "unreachables" - addicted to ER "Black hole" clients (per quarter)	N/A	100	0	0	Y2 QTR1
CHW & Mobile: Refer Clients to a Medical Home with Scheduled Appointment					
# of clients referred to a medical home (per month)	13	26	2	0	Aug 15
CHW & Mobile: Recruit Volunteers / LWK Ambassadors					
# of new volunteers (per quarter)	N/A	26	0	20	Y2 QTR1
# of hours contributing (per quarter)	N/A	N/A	N/A	N/A	N/A
CHW & Mobile: Visit Churches in North Central and on the Bordering Counties					
# of churches visited (per quarter)	N/A	6	0	0	Y2 QTR1
CHW & Mobile: Contact all Providers in Area, Provide Info on LWK, Follow-Up as Needed					
# of provider visits per month	N/A	N/A	N/A	N/A	N/A
CHW & Mobile: Medical Provider Conducts Client Visit at Mobile Clinic					
# of patient visits at mobile clinic per month	0	5	1	24	Aug 15
CHW & Mobile: Operate 3 Mobile Clinics per Month					
# of mobile clinic sites per month	2	4	1	4	Aug 15

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# of clients seen at each site per month	56	50	1	0	Aug 15
CHW & Mobile: Participate in Community Events and Share LWK Info					
# of events per quarter	N/A	24	0	10	Y2 QTR1
# of participants reached	N/A	N/A	N/A	N/A	N/A

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Extend Primary Care via School Based Health Center

Operational Measures

Name	Prior Period	Current Value	Change	Target Value	Most Recent Period
EPC-SBHC: Distribute HIPPA and FERPA Forms to Guardians					
% enrollees with signed HIPPA and FERPA	N/A	75%	0	100%	Aug 15
EPC-SBHC: Sign Students up for SBHC					
% of student body signed up with SBHC	N/A	11%	0	70%	Aug 15
EPC-SBHC: Place Students in Medical Home					
% of students in need in school medical home	N/A	N/A	N/A	N/A	N/A
EPC-SBHC: See Patients at Medical Clinic					
Average number of visits to SBHC per year per enrollee	N/A	N/A	N/A	N/A	N/A
EPC-SBHC: Provide Healthcare Access to those who Would Otherwise Not Have Access					
% of total identified students in need who enroll in clinic	N/A	100%	0	75%	Y2
EPC-SBHC: Establish Advisory Council					

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# of active members	N/A	12	0	12	Y2
EPC-SBHC: Hold Advisory Council Meetings					
# of meeting per year	N/A	1	0	4	Y2

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"Your Bridge to Better Health"

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LiveWell KERSHAW

"Your Bridge to Better Health"

Year Two
Quarter Two Report
September 1 - November 30, 2015

LiveWell KERSHAW

"Your Bridge to Better Health"

Table of Contents

Cover photo: *Bobby T. Jones Bridge, Kershaw County by Jeremy Williams*

Introduction Letter

UNIVERSITY OF SOUTH CAROLINA
Arnold School of Public Health

Office of Research

December 1, 2015


Strategic Planning Retreat, November 23,

As this year draws to a close, we reflect on this past year of LiveWell Kershaw. We are amazed of the great strides that have taken place to be a "bridge to better health" for the residents of North Central in Kershaw County. Our group has moved from looking at hospital and clinic data to working models and revised organizational charts. We are now moving to re-engineering the Community Medical Clinic to serve as the backbone for population health in Kershaw County and are excited about being in "pioneering territory" as Dr. Rick Foster often says. See page 4 for a visual of our transition over the past two years during this journey. We are committed to working together with individuals, organizations, and local, state and national leaders to refine and expand our patient and family centered model to achieve optimal patient outcomes.

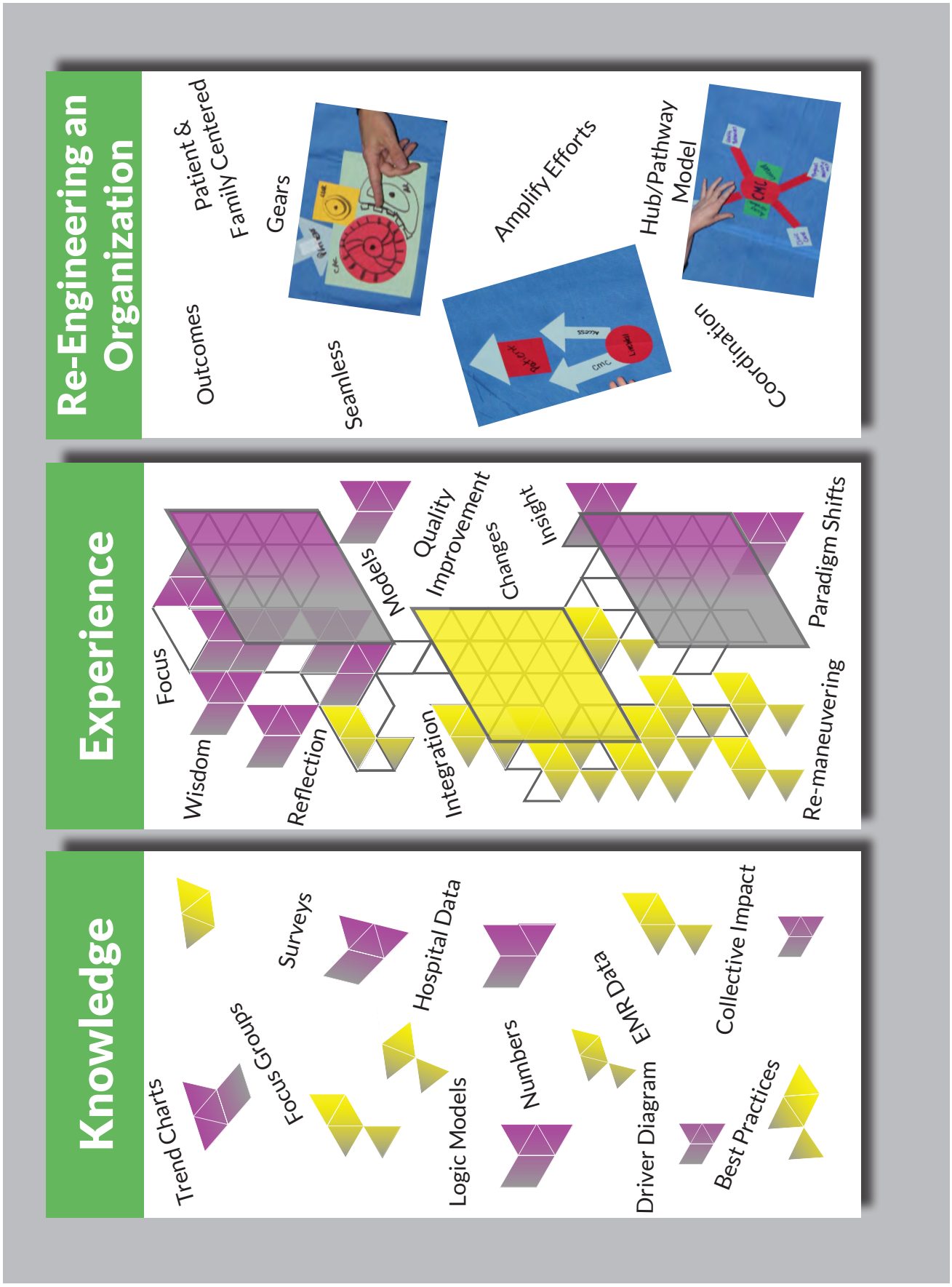
This quarterly report shares just a snapshot of the work that has been accomplished over the past three months. Local businesses and providers recognize "LiveWell Kershaw" in the community and are now encouraging residents to call Community Health Workers for care coordination. Vice Principals and teachers at North Central High school are working closely with our mental health counselors and referring students in need to the School Based Health Center next to the gym. Construction is actively underway for renovations being made at North Central High for a "minute clinic" led by a Nurse Practitioner. Over ten residents of North Central meet monthly at Refuge Baptist Church to discuss how to increase awareness of the program and involve more than 60 of the churches in the area. The Community Medical Clinic Board of Directors and staff of LiveWell Kershaw, Access Kershaw, and the Community Medical Clinic just spent two days together crafting a three year strategic plan. The leadership team, staff, and the evaluation team are working together to create an integrated model that will best serve the patients and families of the County.

We continue to move forward in these efforts, even if sometimes we are "failing forward." We hope you enjoy reading about our journey and look forward to sharing our progress with you as we work together to "lead a collaborative effort to provide the resources needed for improved health of the underserved, while always respecting the dignity, integrity, and diversity of those we serve" (revised Mission statement of the Community Medical Clinic).

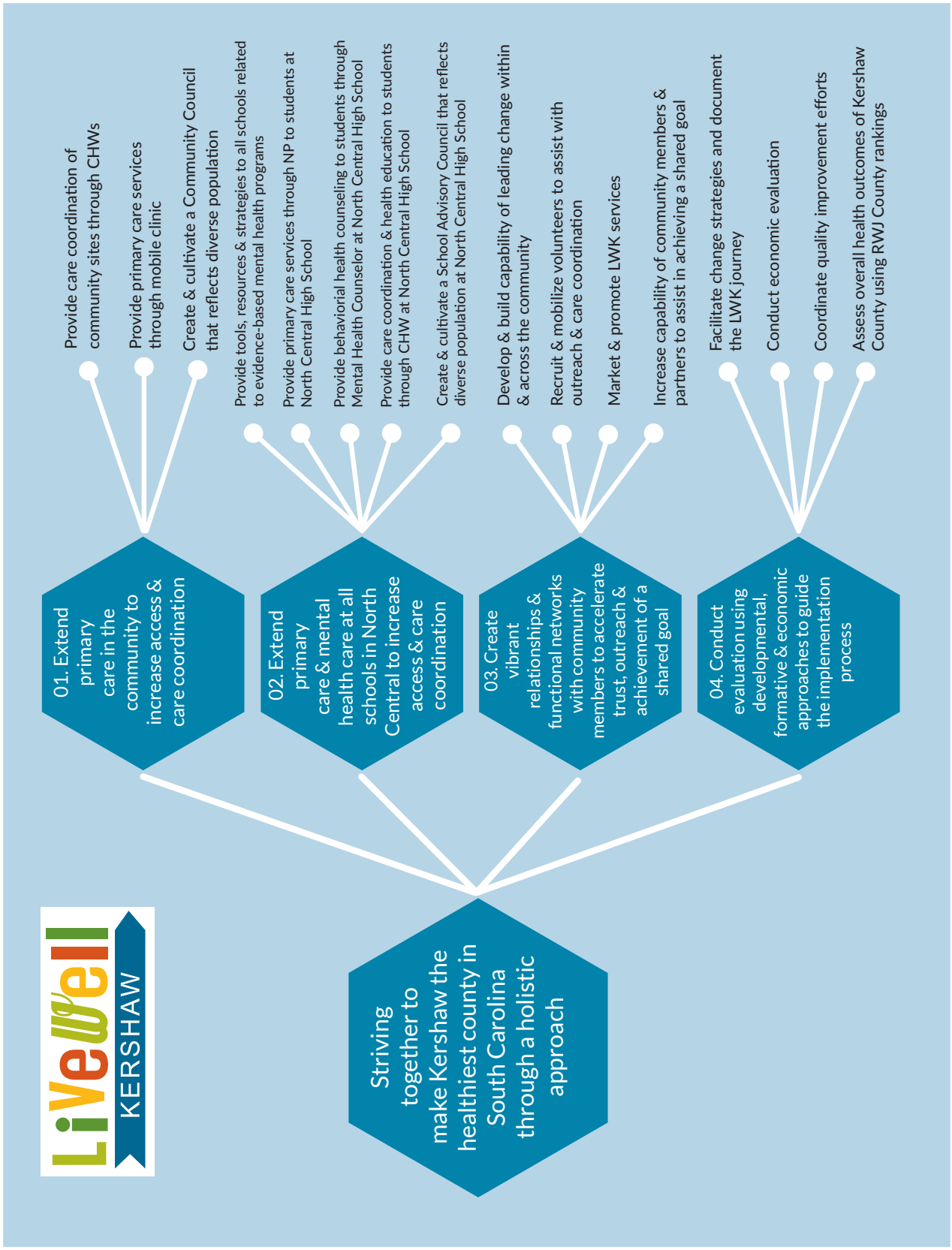
Best in all you do,

Holly Hayes
Evaluator, LiveWell Kershaw

Susan Witkowski
Director, Community Medical Clinic


Re-Engineering an Organization
Outcomes
Patient & Family Centered
Gears
Seamless
Amplify Efforts
Hub/Pathway Model
Coordination
Experience
Focus
Wisdom
Reflection
Models
Quality Improvement
Changes
Integration
Insight
Paradigm Shifts
Re-maneuvering
Knowledge
Trend Charts
Focus Groups
Surveys
Hospital Data
Logic Models
Numbers
EMR Data
Driver Diagram
Collective Impact
Best Practices

Driver Diagram



DRIVER 1

Extend primary care in the community to increase access and care coordination

A. Satellite Care Coordination Sites

During the course of the second quarter, the care coordination team continued to serve the North Central region with community outreach and services. The satellite sites are continuing to improve and make changes to accommodate residents living in North Central. The Freedom Baptist Church satellite site closed on October 1st due to low client volume and connectivity issues. The DeKalb Baptist Church satellite site still remains open with new hours from 3 p.m. to 7 p.m. (effective October 12th). This decision was supported by the Kershaw Hospital ER Usage Report, which showed that residents in this area are using the ER the most. The remaining sites -Cassatt Baptist Church, Sandy Level Baptist Church, Refuge Baptist Church, and Buffalo Baptist Church- still operate weekly. LiveWell Kershaw (LWK) volunteers at the Refuge and Buffalo satellite sites support on site Community Health Workers (CHWs). Figure 1 shows all the churches in North Central, and Table 1 shows Productivity per site. Dr. Demir updated the map on November 3rd to reflect how the CHWs have been continuing with outreach in their respective market areas.

Figure 1: 109 Churches in Area

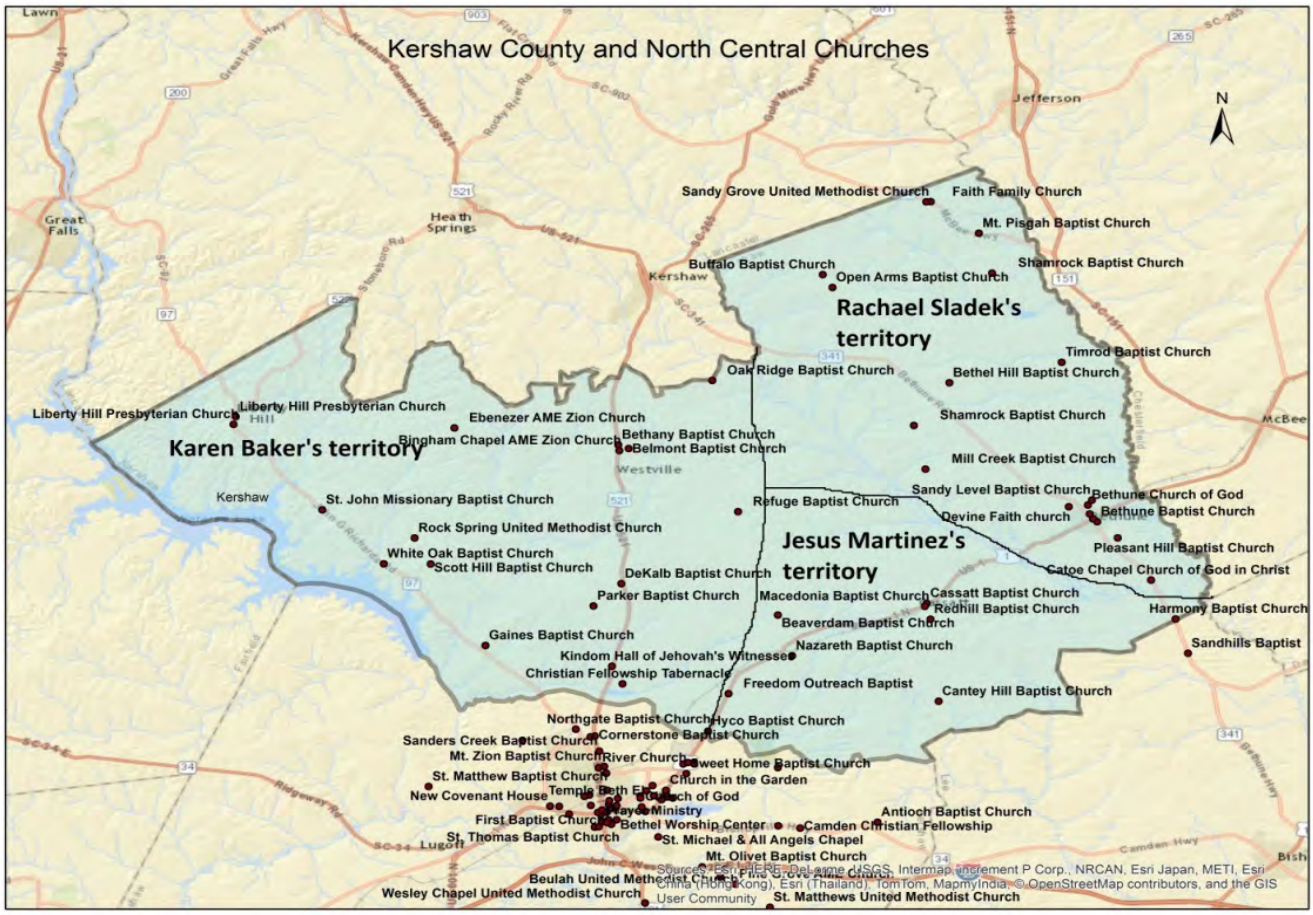


Table 1: Productivity of Satellite Sites

Satellite Sites	September			October			November		
	New Client Visits	Follow-Up Visits	No-Shows	New Client Visits	Follow-Up Visits	No-Shows	New Client Visits	Follow-Up Visits	No-Shows
Cassatt (9a-1p)	7	0	0	4	3	0	1	0	0
Sandy Level (9a-1p)	2	16	1	0	3	0	10	11	0
Refuge (9a-1p)	4	5	0	5	2	0	4	7	0
Buffalo (9a-1p)	4	1	0	4	6	0	5	0	0
DeKalb (5p-7p) & (3p-7p)	0	0	0	1	0	0	1	0	0
Freedom (5p-7p)	2	0	0	closed	closed	closed	closed	closed	closed
Other Locations (NC High School, KARE, Home Visit, Bethune Discount Food Store, Bethune Elementary, Access Kershaw, Bethune Discount Meat Market)	2	0	2	17	4	0	13	4	2
Total	**21**	**22**	**3**	**31**	**18**	**0**	**34**	**22**	**2**

Clients receive donations at the Refuge satellite

The CHWs' roles continue to evolve; they served clients at schools and businesses in addition to the satellite sites. The CHWs screened clients either in person or by phone using a Client In-Take form. Based on the client's responses, the CHWs provided the appropriate assistance, such as help with the Supplemental Nutrition Assistance Program (SNAP), Medicaid/Social Security Disability, and Dental and Vision assistance. If the client was screened in person, CHWs completed the paperwork on site and submitted applications through the respective portal for faster processing. If a client was screened by phone, CHWs scheduled a time and site location most convenient for the client to complete and submit paperwork.

Operations of CHW Unit

Several staff changes occurred during this quarter. Beckie Tompkins, who is the current Healthy Outcomes Plan (HOP) Coordinator at Access Kershaw, will transition into a CHW role with LiveWell Kershaw beginning in January. Karen Baker will transition out of her current CHW role with LiveWell Kershaw and into Beckie's current role. Both Beckie and Karen are currently cross-training. Whitney Hinson, the Community Engagement and Outreach Manager, took on another supervisory role effective September 8th. In addition to supervising the CHWs, she is the new supervisor for Access Kershaw. Kelly Warnock is now working at Sandhills Medical in Camden. Also during September, the LWK project manager position, formerly held by Cheryl Stover, phased out due to reorganization and realignment of CMC. CHW Jesus Martinez, who served the Cassatt and Freedom satellite sites, resigned on November 6th.

The work schedule of the CHWs falls into "blocks" with time dedicated at the satellite sites, schools, businesses, clinics and medical offices through the week. A general schedule includes:

	Mon am	Mon aft	Mon Evening	Tues am	Tues aft	Tues Evening	Wed am	Wed aft	Thur am	Thur aft	thurs 2-3 pm	Thurs Evening	Fri am	fri aft
Rachael	SBHC	schools		Sandy	clinics		churches	SBHC	Buffalo	towns	Staff		f/u	f/u
Jesus	Cassatt	SBHC		schools	towns	Freedom	SBHC	churches	clinics	SBHC	Staff		f/u	f/u
Karen	schools	towns	DeKalb	clinics	KARE		Refuge	churches	towns	towns	Staff		f/u	f/u
	8:30-1	1p-5p	5p-7p	8:30-1	1p-5p	5p-7p	8:30-1	1p-5p	8:30-1	1p-5p		5p-7p	8:30-1	1p -5p

CHWs goals for this quarter included:

- Continually increasing the number of new client and follow-up visits weekly (conducting outreach using PDSA cycles and attending more events)
- Reduce the amount of no-shows on missed appointments or cancellations (following up by phone, mail, and/or home visits)
- Offering healthcare navigation services (i.e. Primary Care Physician referrals and Medicaid application assistance) to increase outreach efforts in North Central

Beginning in September, Tamika Thomas implemented a monthly "snapshot" of CHW productivity for coaching and continuous quality improvement. The snapshot is an Excel spreadsheet broken down by weeks in the current month to show the number of new client visits, follow-up visits, and no-shows at satellite sites. The "snapshots" are emailed to the CHWs and leadership at the midpoint and at end of each month.

The CHWs, Tamika Thomas, and Whitney Hinson continue to meet regularly to discuss individual progress as well as team progress. CHW team meetings this quarter have been on Thursdays or Fridays, with Lead CHW Karen Baker and Whitney Hinson additionally meeting on Friday mornings. The CHWs and Tamika meet on Fridays for individual coaching using The Model for Improvement (PDSA), which is discussed in a later section. This quarter, all three CHWs applied the health coaching curriculum from the New Leaf Program. The New

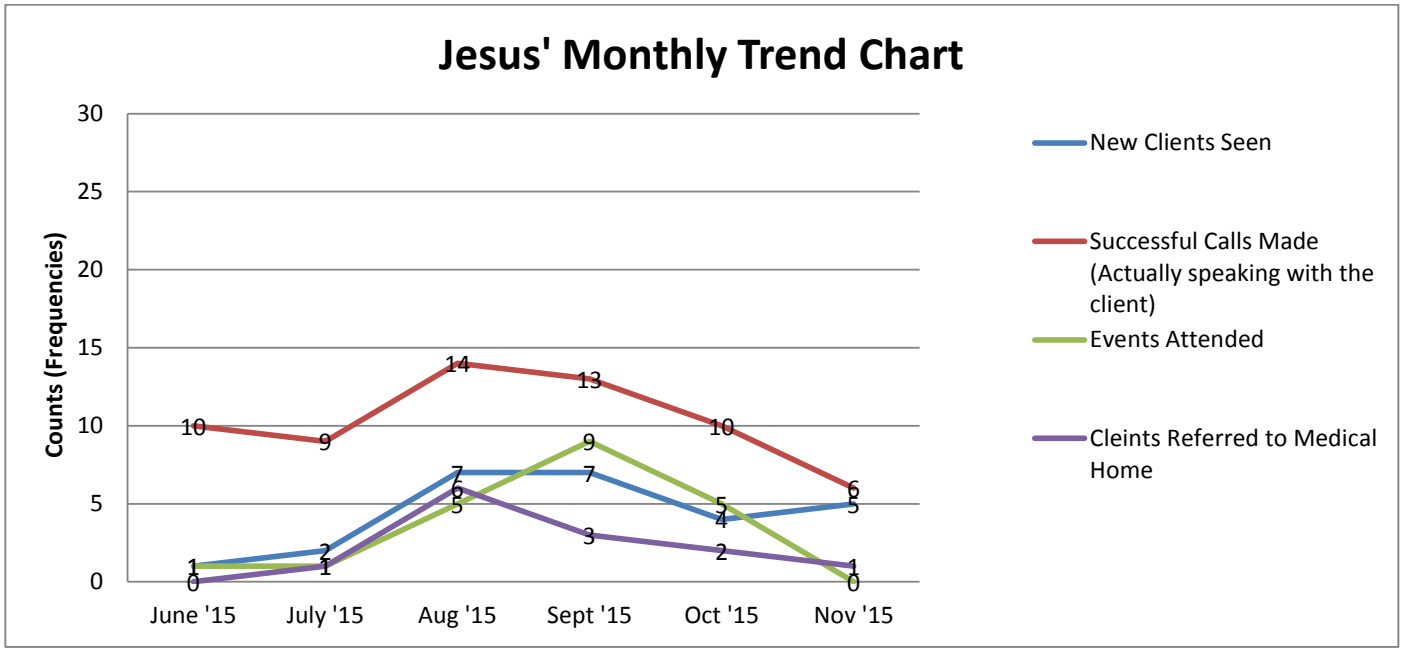
Leaf Program encourages practicing healthy eating behaviors, increasing physical activity, and improving blood pressure or controlling hypertension.

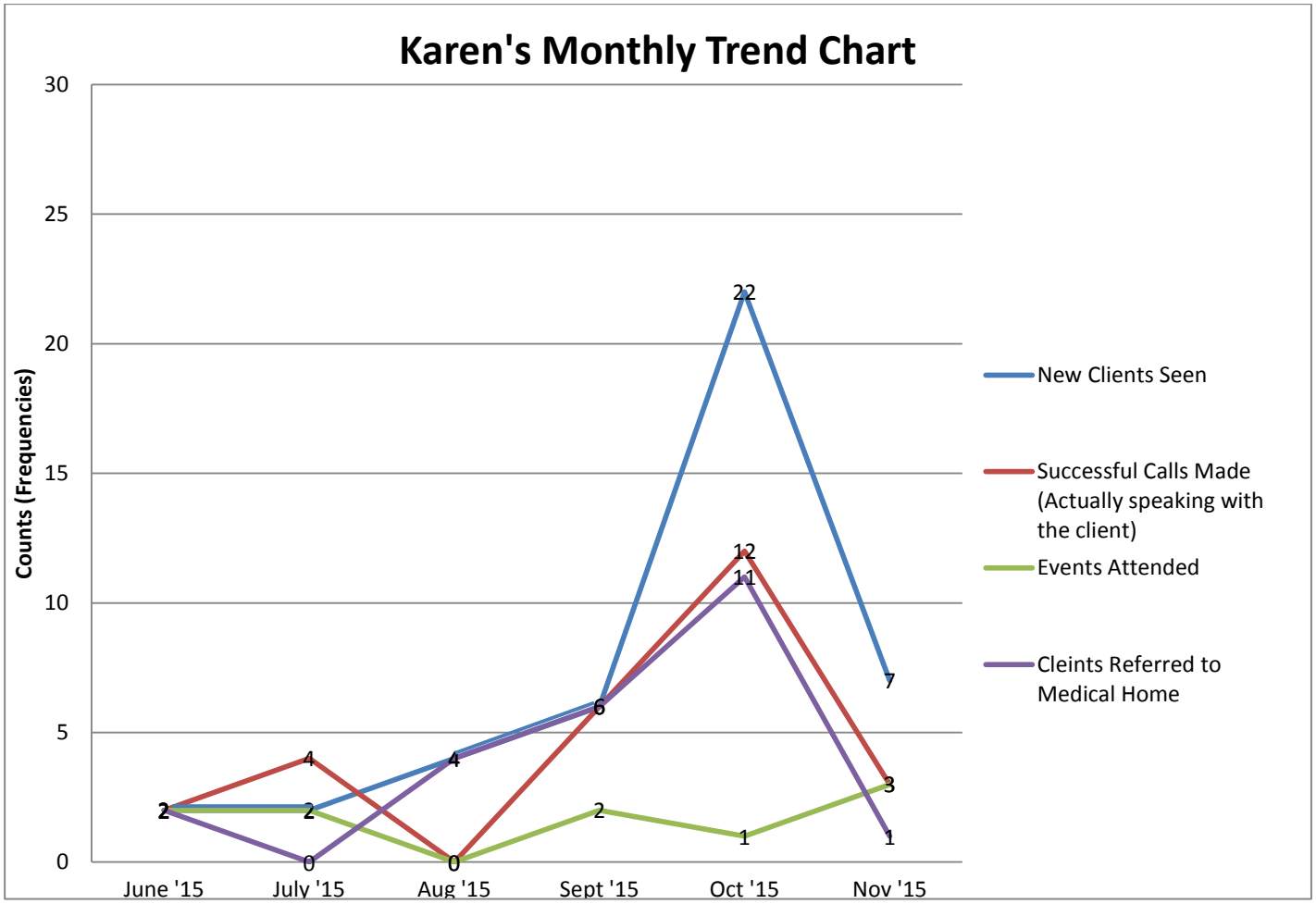
On October 13th at Midway Elementary School, CHWs Jesus Martinez and Karen Baker addressed a group of Hispanic parents on healthy eating as well as the dangers of an unhealthy diet. Afterwards, Karen performed blood sugar and blood pressure screenings. On November 13th at Bethune Elementary School's Fall Festival, CHW Rachael Sladek introduced the New Leaf Program by creating a "My Plate" game for the children and adults to learn about healthy eating.

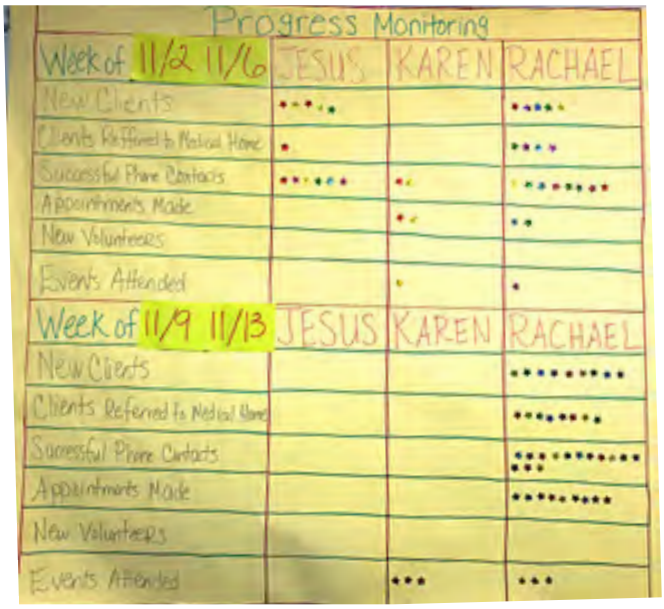
Table 2 documents client encounters by each CHW. For September, all three CHWs performed relatively the same with "New Client Visits." However Rachael Sladek had the most "Follow-Up Visits" in September due to previous clients needing additional help. A new client is defined as a person who visits a satellite site (or a satellite clinic) for the first time. In October there was a spike in "New Client Visits" for Karen Baker. She attributes this success to visiting Kershaw Area Resource Exchange (KARE) regularly, and mailing out contact letters. Rachael attributes her spike in "New Client Visits" for November to using the ER call sheets and having successful phone calls. There was an overall decrease in the new client visits from the previous quarter (from 106 new clients to 86 new clients).

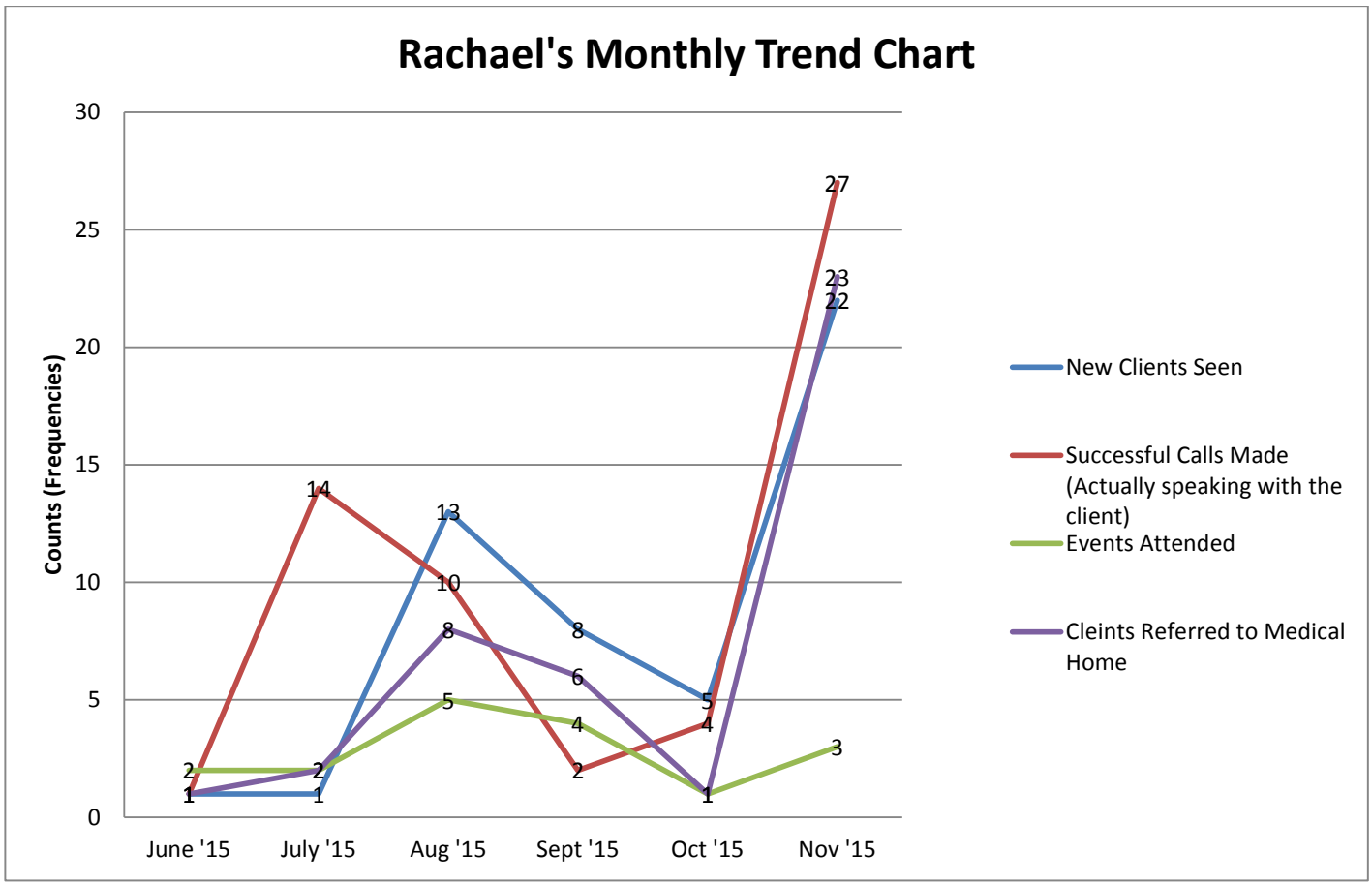
Table 2: CHW Productivity

CHW Productivity: 2nd Quarter									
CHW	**September**			**October**			**November**		
	New Client Visits	Follow-Up Visits	No-Shows	New Client Visits	Follow-Up Visits	No-Shows	New Client Visits	Follow-Up Visits	No-Shows
Jesus	7	0	0	4	4	0	5	1	0
Karen	6	5	0	22	6	0	7	7	0
Rachael	8	17	3	5	8	0	22	14	2
Totals	**21**	**22**	**3**	**31**	**18**	**0**	**34**	**22**	**2**




Karen's Monthly Trend Chart
Counts (Frequencies)
30
25
20
15
10
5
0
June '15
July '15
Aug '15
Sept '15
Oct '15
Nov '15
22
12
11
7
6
4
4
3
2
2
2
1
1
0
0
New Clients Seen
Successful Calls Made (Actually speaking with the client)
Events Attended
Cleints Referred to Medical Home


Progress Monitoring
Week of 11/2 11/6
JESUS
KAREN
RACHAEL
New Clients
Clients Referred to Medical Home
Successful Phone Contacts
Appointments Made
New Volunteers
Events Attended
Week of 11/9 11/13
JESUS
KAREN
RACHAEL
New Clients
Clients Referred to Medical Home
Successful Phone Contacts
Appointments Made
New Volunteers
Events Attended



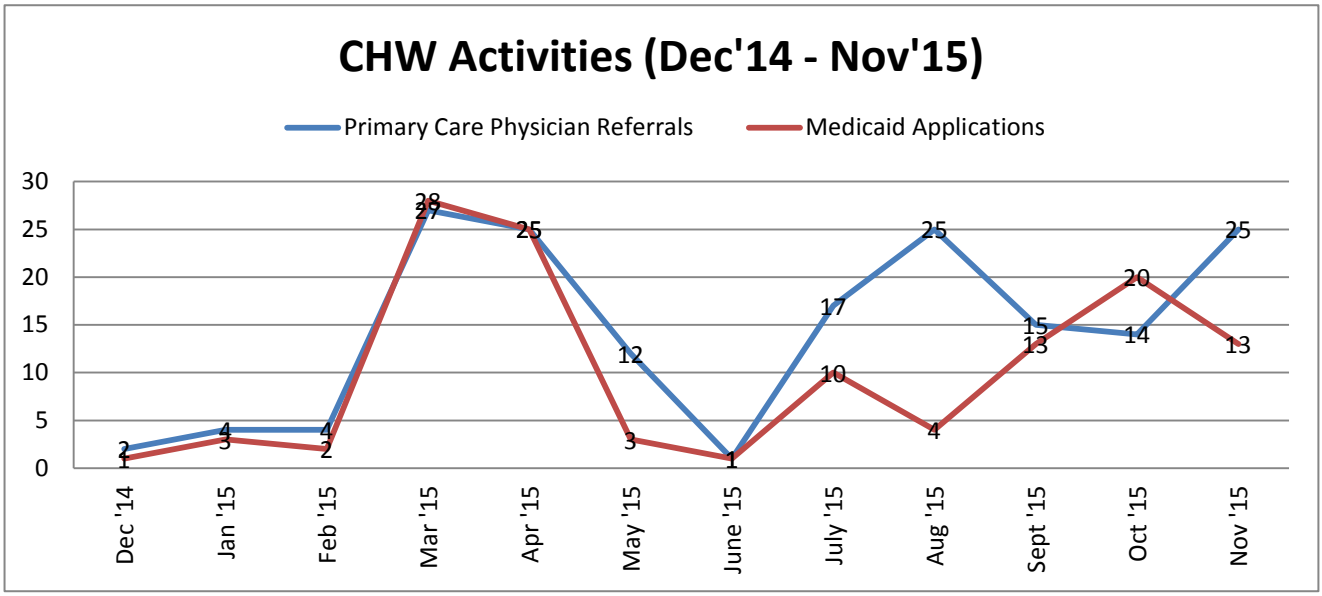
Tamika researched the reasons 19 individuals missed appointments from June – November 2015. (see table below)

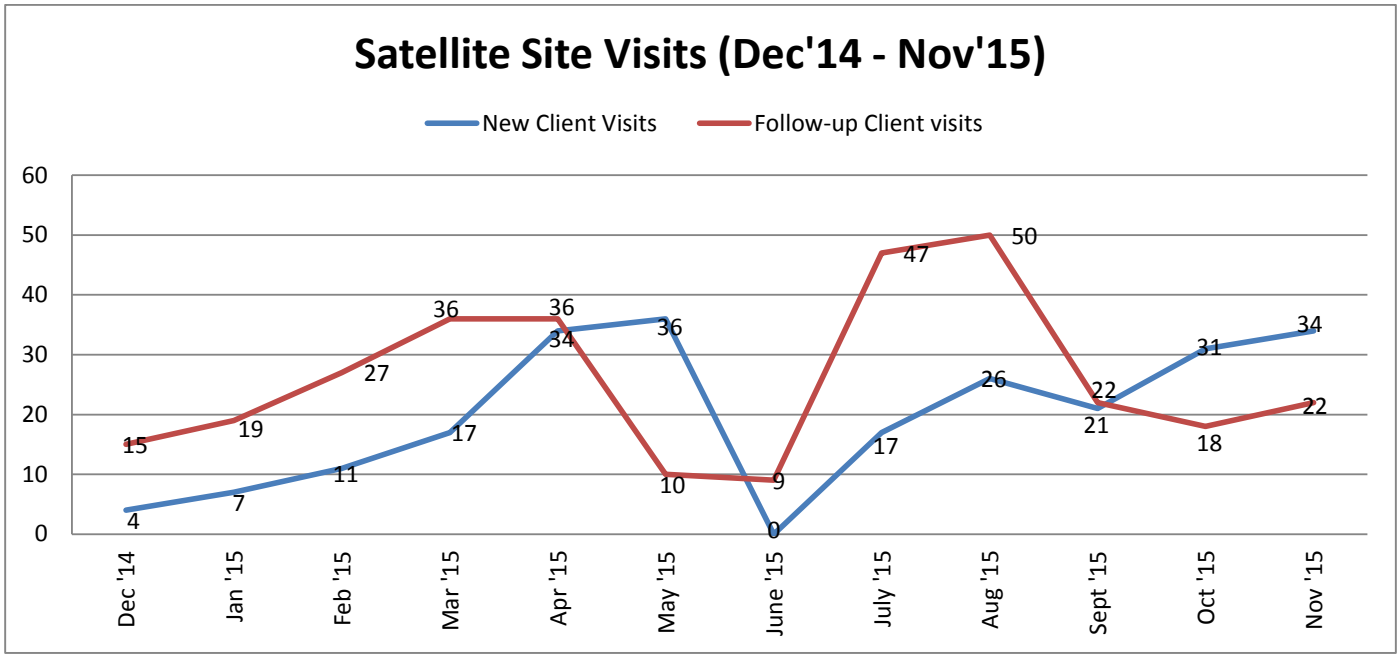
Frequency	Reason for missed appointment and/or unable to contact client
1	Had to be at work
4	Not home; Message left for a callback
4	No answer, Unable to leave a message(voicemail not set-up)
1	Already has insurance
1	Unreliable transportation
1	Wrong number
4	Phone number disconnected
1	Did not want assistance
1	Rescheduled due to something coming up
1	Has Primary Care Physician

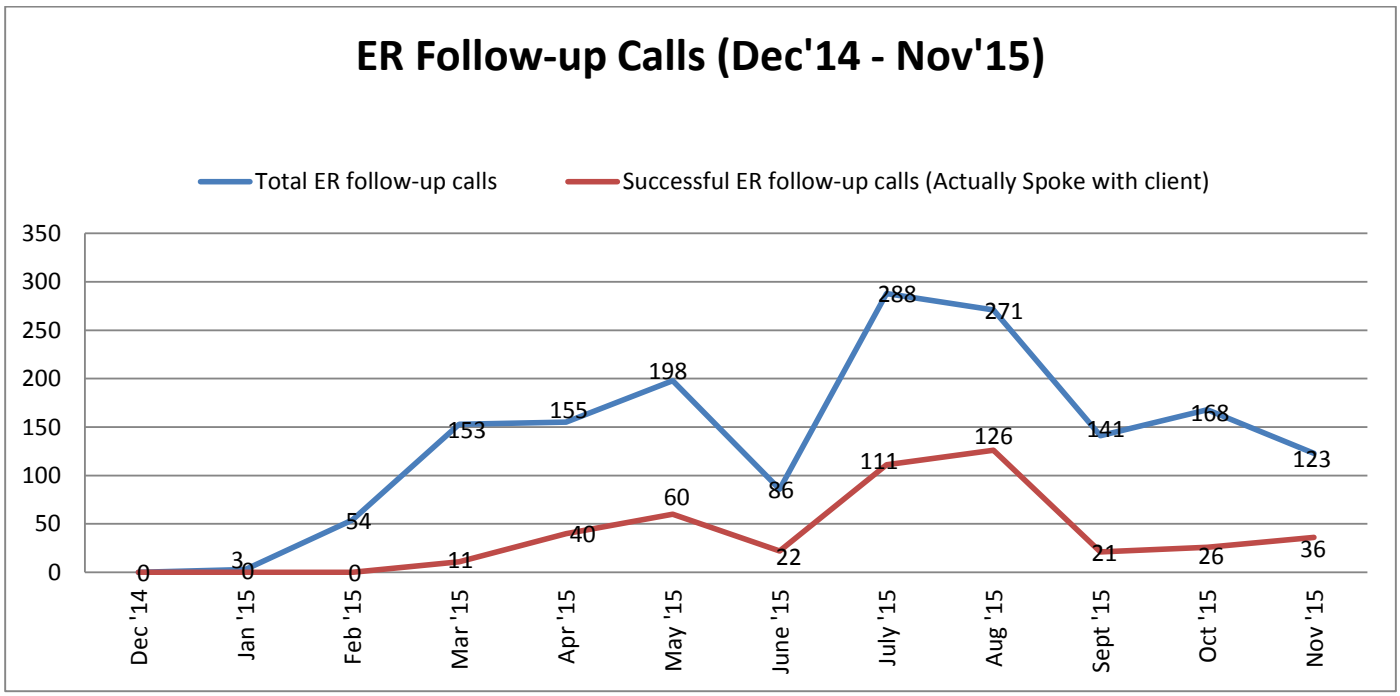
Table 3 lists the outreach and services provided during the 2nd quarter. In particular, Primary Care Physician (PCP) referrals increased by 18%, which is also an overall increase from the previous quarter (from 42 to 54). Medicaid applications increased by 15% in October but decreased in November, not meeting eligibility requirements. Medicaid applications increased in this quarter to 46 from 15 in the previous quarter.

Table 3: Services Provided to Clients

CHW Activities	September	October	November	Total
ER follow up calls	141	168	123	432
Primary Care Physician Referral	15	14	25	54
Medicaid applications	13	20	13	46
SNAP applications	10	15	6	31
Welvista applications	7	7	11	25
SS Disability	5	2	5	12
Extra Help application	5	4	8	17
With Medicare Medicaid	8	7	10	25
Case Management	0	0	3	3
Home Visits	0	2	5	7
MD appointments made	23	22	31	76
MH referrals	0	0	0	0
Dental referrals	3	1	2	6
PAP applications	0	4	1	5
Charity applications	3	6	2	11
HOP sessions	0	0	0	0
ACA navigations	0	0	1	1




Satellite Site Visits (Dec'14 - Nov'15)
New Client Visits
Follow-up Client visits
60
50
40
30
20
10
0
15
19
27
36
36
10
9
47
50
22
18
22
4
7
11
17
34
36
0
17
26
21
31
34
Dec '14
Jan '15
Feb '15
Mar '15
Apr '15
May '15
June '15
July '15
Aug '15
Sept '15
Oct '15
Nov '15


ER Follow-up Calls (Dec'14 - Nov'15)
Total ER follow-up calls
Successful ER follow-up calls (Actually Spoke with client)
350
300
250
200
150
100
50
0
0
3
54
153
155
198
86
288
271
141
168
123
0
0
11
40
60
22
111
126
21
26
36
Dec '14
Jan '15
Feb '15
Mar '15
Apr '15
May '15
June '15
July '15
Aug '15
Sept '15
Oct '15
Nov '15

On October 29th a “trunk checklist” was designed to ensure that each CHW has LiveWell Kershaw materials well stocked in their vehicle. An evaluator is checking trunks at least once a quarter to ensure that CHWs are adequately prepared for outreach and care coordination.

CMC Community Engagement and Outreach Manager Whitney Hinson addresses the Bethune Women’s Club.

A paper-based satisfaction survey was administered to 106 clients from September through November. The purpose of the survey is to determine how receptive clients are to the services provided by the CHWs. Some services include pharmacy assistance, dental referrals, and vision referrals. Each CHW asks clients to fill out the survey after each face-to-face visit. The clients returned the completed surveys to a sealed storage container to maintain confidentiality. Tamika Thomas collects the surveys weekly to analyze the data. The summary of the survey findings are found on the following five pages.

Second Quarter Client Satisfaction Survey Responses

1. What community health site did you visit today?

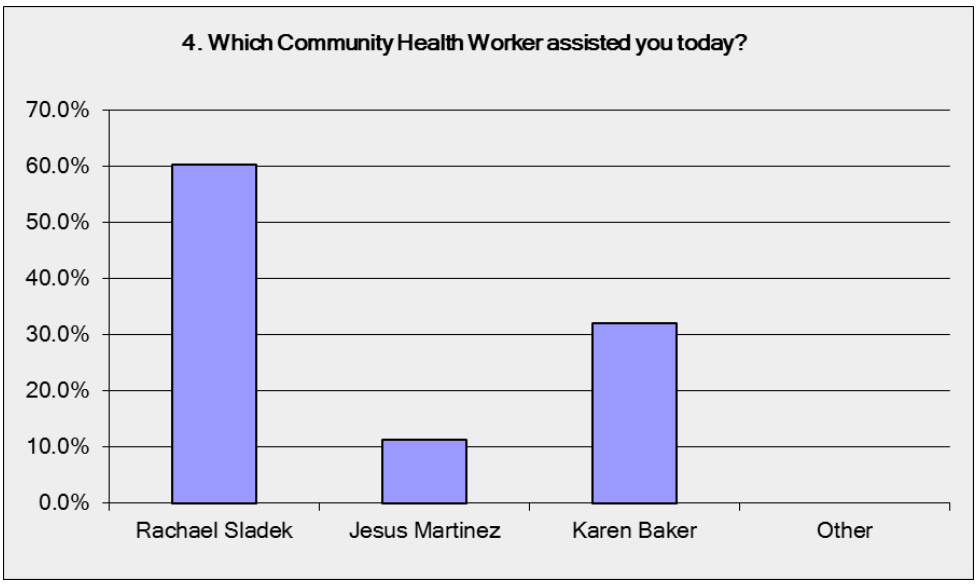
Answer Options	Response Percent	Response Count
Cassatt	9.4%	10
Sandy Level	37.7%	40
Refuge	17.0%	18
Buffalo	14.2%	15
DeKalb	3.8%	4
Freedom Outreach	0.9%	1
Other	17.0%	18
answered question		106
skipped question		0

2. Was the community health site location convenient for you to travel to?

Answer Options	Response Percent	Response Count
Yes	99.1%	105
Somewhat	0.9%	1
No	0.0%	0
answered question		106
skipped question		0

3. Were the hours for the site location convenient for you?

Answer Options	Response Percent	Response Count
Yes	100.0%	104
Somewhat	0.0%	0
No	0.0%	0
answered question		104
skipped question		2



5. Was it easy to talk with the Community Health Worker?		
Answer Options	Response Percent	Response Count
Yes	99.0%	104
Somewhat	1.0%	1
No	0.0%	0
answered question		105
skipped question		1

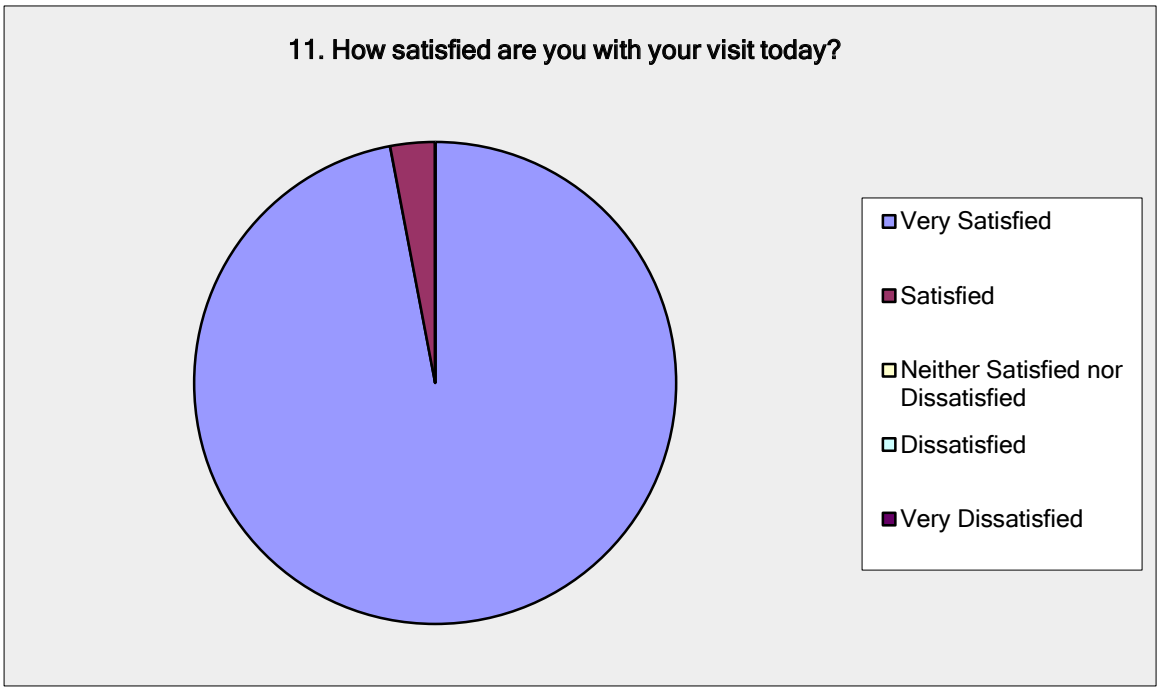
6. Did you receive kindness and respect during your visit?		
Answer Options	Response Percent	Response Count
Yes	100.0%	106
Somewhat	0.0%	0
No	0.0%	0
answered question		106
skipped question		0

7. Was the Community Health Worker knowledgeable about the reason for your visit?		
Answer Options	Response Percent	Response Count
Yes	96.2%	100
Somewhat	3.8%	4
No	0.0%	0
answered question		104
skipped question		2

8. Was the health information clearly communicated to you by the Community Health Worker?		
Answer Options	**Response Percent**	**Response Count**
Yes	94.3%	99
Somewhat	0.0%	0
No	0.0%	0
Not Applicable	5.7%	6
answered question		105
skipped question		1

9. During your visit was enough time spent with you?		
Answer Options	**Response Percent**	**Response Count**
Yes	100.0%	106
Somewhat	0.0%	0
No	0.0%	0
answered question		106
skipped question		0

10. What service(s) did you receive today, for your visit?		
Answer Options	**Response Percent**	**Response Count**
Referral to Primary Care Physician/Home	40.0%	40
Medicaid Application	20.0%	20
SNAP (Foodstamps)	14.0%	14
Pharmacy Assistance	19.0%	19
Social Security Disability	11.0%	11
Case Management	0.0%	0
Mental Health Referral	3.0%	3
Dental Referral	13.0%	13
Vision Referral	10.0%	10
Affordable Care Act Navigations	1.0%	1
Utilities Assistance	0.0%	0
Transportation Assistance	1.0%	1
Christian Community Ministry	1.0%	1
Housing Assistance	0.0%	0
Medical Bills Assistance	5.0%	5
Clothing Assistance	2.0%	2
Health Education	0.0%	0
Blood Pressure Taken	3.0%	3
Finger Stick (Blood sugar)	0.0%	0
Other service (please specify)		12
answered question		100
skipped question		6



Medical Director Dr. Alice Brooks administers care to a client at the Refuge satellite site.

13. [Answer ONLY if you answered question #12.] In a few words explain why you were dissatisfied with the service(s) you received.	
Answer Options	**Response Count**
	0
answered question	**0**
skipped question	**106**

14. Would you recommend your family, friends, co-workers, etc. to use the LiveWell Kershaw Services?		
Answer Options	**Response Percent**	**Response Count**
Yes	100.0%	102
Maybe	0.0%	0
No	0.0%	0
answered question		**102**
skipped question		**4**

Bethune Case Study

Mr. G. Johnson, 52 years old and a longtime resident of Bethune, SC, began visiting the Sandy Level Baptist Church satellite site in March 2015. He heard about LWK by 'word of mouth' from Kershaw Hospital. The initial reason for his visit was acid reflux. Mr. Johnson stated that CHW Karen Baker initially assisted him by directing him to community services, and CHW Rachael Sladek continued to help him on his follow-up visits at Sandy Level. As Rachael followed up to help Mr. Johnson navigate the healthcare system, he needed to get his identification (ID) card to be able to attend his disability hearing. At the time the only piece of identification he had was his social security card.

After a few weeks of making phone calls and working with the documentation that Mr. Johnson had, Rachael was able to help him secure his birth certificate and obtain his state-issued ID. He was finally able to attend his disability hearing where he was approved for Supplemental Security Income (SSI) in October. Since then, he has received Medicaid and visits his doctor regularly. He also received a mobile phone from Safelink to stay in better contact with his doctor(s) and lawyer. Mr. Johnson stated that "Rachael is his angel." She never gave up working with him to get what he needed to take better care of himself. Mr. Johnson continues to work on his self-management goals in collaboration with his doctors and the CHWs. He plans to get his vision checked in the next two weeks.

Applying Quality Improvement to Accelerate Efforts

During this quarter, Tamika Thomas worked individually with the CHWs on using PDSA cycles for continuous quality improvement. Initially a Model for Improvement workshop was conducted on September 1st at the All-Staff meeting facilitated by Holly Hayes. The PDSA cycle is a rapid way of testing a change by developing a plan to test the change (Plan), carrying out the test (Do), observing and learning from the outcomes (Study), and determining what changes should be made to the test (Act). On October 1st the CHWs initially began constructing their tests in their territories to increase outreach and the number of new client encounters. The tests are done weekly or bi-weekly, depending on if changes (positive or negative) were happening. The following is a summary of progress in this area.

CHW	PDSA tests from October 2015 – November 2015
Karen	- Karen conducted PDSA tests on changing the Monday evening hours of DeKalb Baptist Church from 5p.m.-7p.m. to 3p.m.-7p.m. to establish DeKalb as a successful site - Karen's goal is to steadily increase number of client encounters because it is challenging to reach the target of 50 new clients in the North Central region. - The initial PDSA began on Monday, October 12th with the new hours 3pm-7pm, to see if this would get people to stop by during earlier hours - Since this test began, there has only been two visits to the site, which occurred on Monday, October 26th and Monday, November 27th - Director Susan Witkowski feels DeKalb is still the right place to be for a satellite site in the area, with supporting data showing ER usage in that area; CHW provided with a "Need for Healthcare" map showing ER usage - Karen has received feedback from residents living near/around DeKalb Baptist Church, that possibly Ebenezer Baptist Church and/or Ebenezer Community Center would be good site locations to set up for more people to visit; Karen says residents say that people probably do not come to DeKalb because of perception (socio-economic status of people in that area) - Karen is continuing to work with her assigned schools (in addition to satellite sites) for getting permission to put LWK postcards into the "sacks of love" bag, that is sent home with students every Friday
Rachael	- Rachael conducted PDSA tests on changing her "Wednesday" schedule (morning and/or afternoon) to set-up somewhere in her territory to check blood pressures and give out LWK information; this is done in an effort to get more clients, versus at the satellite sites. - Rachael's goal is to steadily increase number of client encounters because it is challenging to reach the target of 50 new clients in the North Central region. - Received permission from business owners to set up a LWK table to reach out to residents - The initial PDSA began on Wednesday, November 11th ; CHW provided with a "Need for Healthcare" map showing ER usage - Since this test began, there have only four additional clients from the community, which occurred on Friday, November 13th and Wednesday, November 18th - Rachael began setting up at businesses; this helps with client encounters and community outreach as opposed to being at satellite sites and the school-based health center with set hours - In addition to changing "Wednesday" schedule, Rachael is conducting a PDSA on the School Improvement Council at Mt. Pisgah (since she is already a business partner with the Bethune Student Improvement Council)

Jesus	- Jesus conducted PDSA tests on changing from being at the School Based Health Center to spending more time in the town(s) and at town events, in order to increase number of client encounters - Jesus' goal was to steadily increase number of client encounters because it is challenging to reach the target of 50 new clients in the North Central region. - Because Jesus was working to get permission to set a LWK table, his goal was to begin by the 2nd week in November at the Country Store in Cassatt; CHW provided with a "Need for Healthcare" map showing ER usage - Jesus suggested, setting up a LWK table at the Country Store will help with getting more client encounters

The following is the PDSA Instrument used by the CHWs weekly:

PDSA Worksheet: Testing Ideas for Change **Team Name:** **Date:** **Cycle**

What are you testing?

What do you hope to achieve with this test?

Big Aim Context:

Plan

Describe your first (or next) test of change (Every goal will require multiple tests of change)	**Person Responsible**	**When to be done**	**Where to be done**

List the tasks needed to set up this test of change (include getting ready to measure)	**Person Responsible**	**When to be done**	**Where to be done**

Predict what will happen when the test is carried out (e.g., if we do "x", "y" will happen)	**Measures to determine if prediction succeeds**
2.	**2.**

Mobile Clinic sign at the Refuge Baptist satellite site.

Kershaw Case Study

Last April, "Susan" received assistance in getting a primary care doctor from CHW Karen Baker (see previous case study). Susan, who is continuing her journey to better health, previously had a blockage in her brain. She is no longer able to work, and filed for disability in February. She has been consistent in her follow-up with Karen at the Refuge Baptist Church satellite site. After receiving prior assistance from Karen, Susan needed to have a special test done on her brain. Because she was still waiting for Social Security, Disability and Medicaid, Susan postponed the test until a better time. With Karen diligently working on Susan's behalf, supplying requested documentation to the Social Security and Medicaid offices, Susan was approved for SSI benefits including Medicaid in July. Once she received the news of her approval, Susan had her cerebral angiogram test done in October and received favorable results back. With Susan's continued trust in LWK and Karen, she was able to receive more help than she ever imagined. She's expressed to Karen just how important LWK is and how it has changed her life.

Evaluation Recommendations for Satellite Sites

- Consistently pass out outreach packets to all clients to share with friends and family
- Determine if the DeKalb evening satellite site should continue to operate.
- Determine other churches that could serve as better satellite sites in assisting more clients in North Central.
- Continue to build trust with the North Central Hispanic population. Whitney has been engaging with Guadalupe Vincent in Camden for support with the Hispanic population. Guadalupe teaches at Vocational Rehabilitation and teaches an ESL (English as Second Language) class at Camden First Baptist Church.
- Continue to follow up with clients who missed appointments to get them rescheduled.
- Schedule site visit with CareSouth to see how mobile van is being used in Chesterfield county.
- Focus efforts to increase buy-in at local businesses for on-site CHW visits
- Create plans for how the New Leaf training will be systematically integrated into CHW activities.

Nurse Practitioner Kelly Warnock meets with a client at the Buffalo Baptist satellite site.

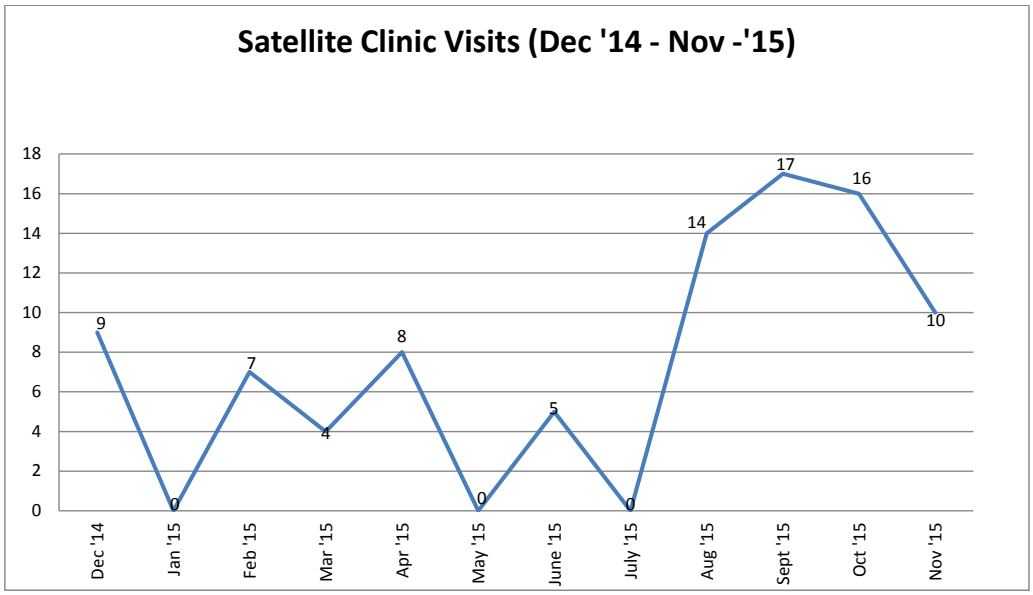
B. Satellite Clinics

The satellite clinics continue to serve North Central residents by the Medical Director or Nurse Practitioner, along with CHWs. The Medical Director or Nurse Practitioner provides primary care services to patients who are unable to be seen at a regular doctor's office or who have transportation challenges. These services include but are not limited to: sick visit, primary care visit/check-up, prescription visit, chronic disease management, urinalysis, and health education. The goal for this quarter was to operate four satellite clinics per month with at least six patients scheduled for each satellite clinic (total of 72 patients). The satellite clinic sites (Cassatt, Sandy Level, Refuge, and Buffalo) are still operating from 9am to 1pm on a rotating basis. A total of 11 satellite clinics were held during the 2nd quarter, with the Sandy Level satellite clinic closed during October, due to flooding. A total of 43 patients were seen. To date, the Buffalo satellite clinic has served the most patients with 23 and the Refuge satellite clinic has had two volunteers assist regularly. The satellite clinics generally operated smoothly with CHWs Rachael Sladek and Jesus Martinez conducting patient in-take and seeing LWK clients; CHW and nurse Karen Baker triaging patients, and Dr. Alice Brooks or Nurse Practitioner Kelly Warnock administering care to patients. Table 4 shows the breakdown of the satellite clinic visits and Figure 2 shows the trend since December 2014.

Table 4: Satellite Clinic Visits

Satellite Clinic Visits				
Location	**September**	**October**	**November**	**Total**
Cassatt	3	1	4	8
Sandy Level	1	Cancelled due to flooding	2	3
Refuge	4	4	1	9
Buffalo	9	11	3	23
Total	**17**	**16**	**10**	**43**

Figure 2



On October 22nd the first satellite clinic satisfaction surveys were administered. The purpose of the survey is to determine how receptive patients are to the services, since many do not have means to receive primary care anywhere else. Out of the 18 patients who completed the survey, 61% were seen at the Buffalo site, since it was more convenient for them to travel there, with 50% traveling five minutes or less. 83% of the visits were scheduled for primary care or a check-up and 50% of the visits were scheduled for new or re-fill prescription medication. All the patients rated the services of the satellite clinic as excellent and would recommend family and friends who need primary care to visit the satellite clinics. Figure 3 shows the breakdown of the satellite clinic responses and Figure 4 shows the actual satellite clinic satisfaction survey.

Figure 3

1. Which satellite clinic site did you visit today?

Answer Options	Response Percent	Response Count
Buffalo	61.1%	11
Refuge	5.6%	1
Cassatt	22.2%	4
Sandy Level	11.1%	2
Other (please specify)		0
answered question		**18**
skipped question		**0**

2. How close do you live to this site?

Answer Options	Response Percent	Response Count
Less than 5 minutes	50.0%	9
5-10 minutes	38.9%	7
10-20 minutes	11.1%	2
More than 20 minutes	0.0%	0
answered question		**18**
skipped question		**0**

3. How easy did you find it to schedule this appointment?		
Answer Options	**Response Percent**	**Response Count**
Extremely easy	100.0%	18
Quite easy	0.0%	0
Moderately easy	0.0%	0
Slightly easy	0.0%	0
Not at all easy	0.0%	0
answered question		18
skipped question		0

4. How long did you wait to be seen today by the medical provider (medical doctor or nurse practitioner)?		
Answer Options	**Response Percent**	**Response Count**
No Wait	66.7%	12
Less than 5 minutes	5.6%	1
5-10 minutes	16.7%	3
10-20 minutes	5.6%	1
More than 20 minutes	5.6%	1
answered question		18
skipped question		0

5. Was it easy to talk with the medical provider?

Answer Options	Response Percent	Response Count
Yes	100.0%	18
Somewhat	0.0%	0
No	0.0%	0
answered question		**18**
skipped question		**0**

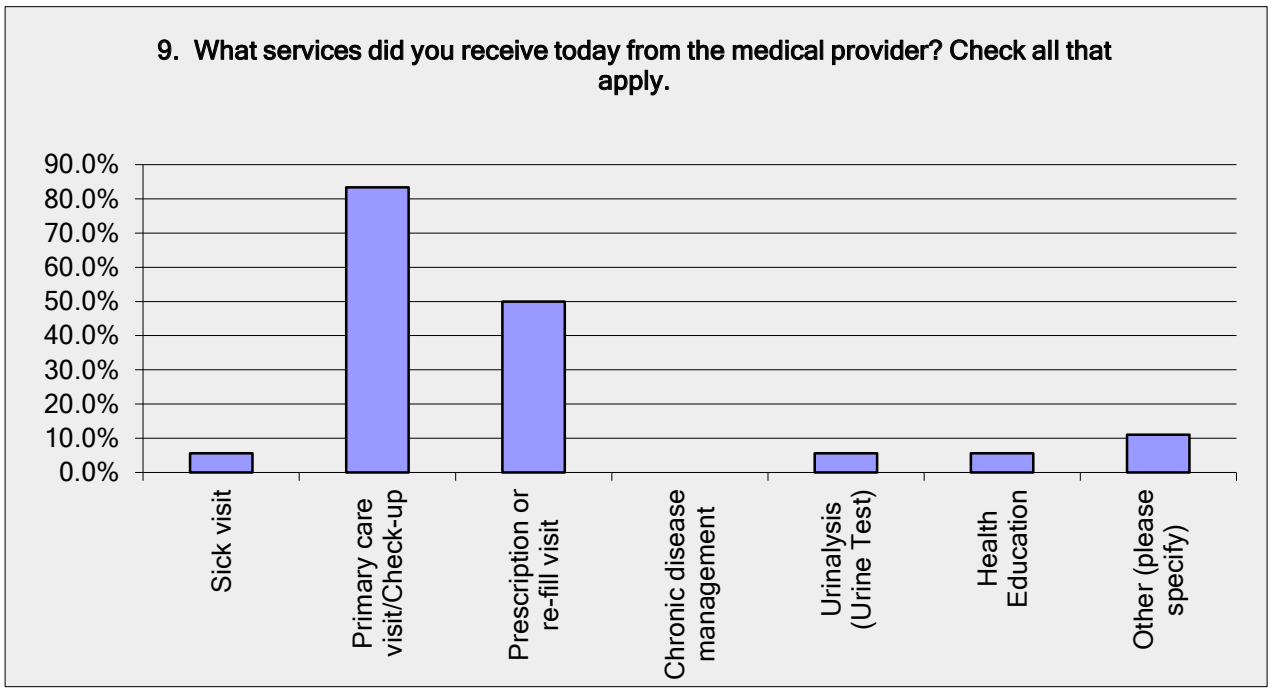
6. Please rate how you were treated by the medical provider today.

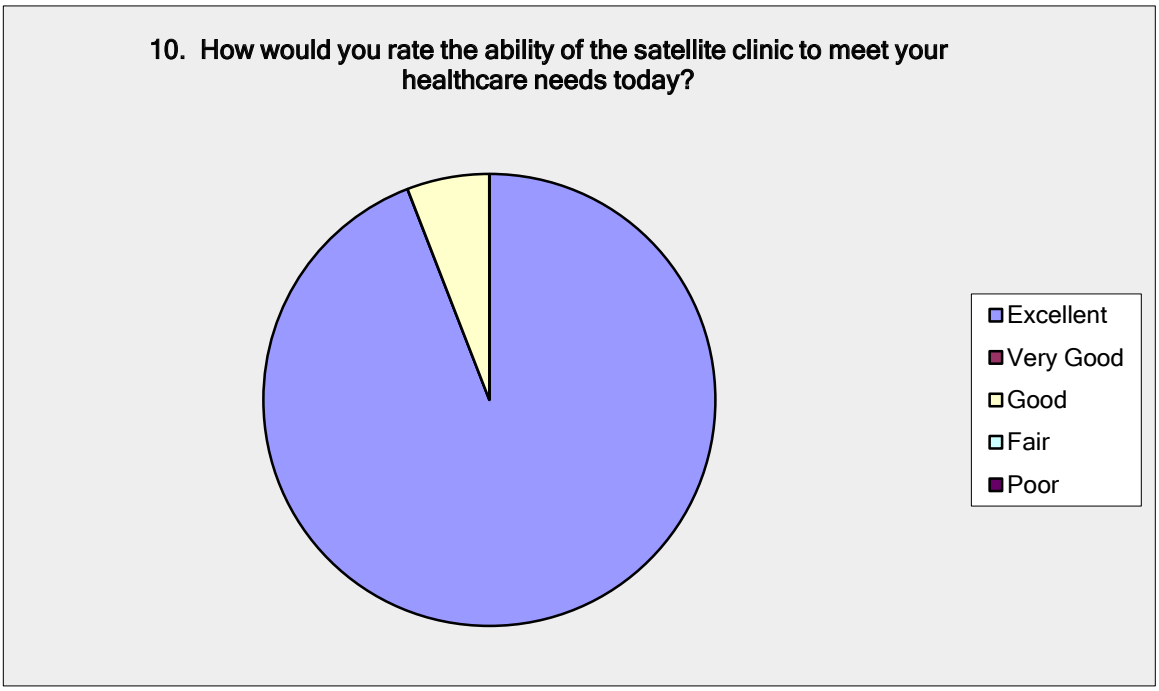
Answer Options	Response Percent	Response Count
Excellent	100.0%	18
Very good	0.0%	0
Good	0.0%	0
Fair	0.0%	0
Poor	0.0%	0
answered question		**18**
skipped question		**0**

7. Was the health information clearly communicated to you by the medical provider?

Answer Options	Response Percent	Response Count
Yes	100.0%	18
Somewhat	0.0%	0
No	0.0%	0
Does Not Apply	0.0%	0
answered question		**18**

8. Was enough time spent with you during your appointment?		
Answer Options	Response Percent	Response Count
Yes	100.0%	18
Somewhat	0.0%	0
No	0.0%	0
answered question		18
skipped question		0





11. Would you recommend your family, friends, co-workers, etc. to use the satellite clinic services?		
Answer Options	**Response Percent**	**Response Count**
Yes	100.0%	18
Maybe	0.0%	0
NO	0.0%	0
answered question		**18**
skipped question		**0**

Figure 4

LiveWell KERSHAW
"Your Bridge to Better Health"

Satellite Clinic Satisfaction Survey

Instructions: Please make selection with a check mark ☑
Responses are anonymous

1. Which satellite clinic site did you visit today?

☐ Buffalo ☐ Cassatt
☐ Refuge ☐ Sandy Level
☐ Other (please specify):

2. How close do you live to this site?

☐ Less than 5 minutes ☐ 5-10 minutes
☐ 10-20 minutes ☐ More than 20 minutes

3. How easy did you find it to schedule this appointment?

☐ Extremely easy ☐ Quite easy
☐ Moderately easy ☐ Slightly easy
☐ Not at all easy

4. How long did you wait to be seen today by the medical provider (medical doctor or nurse practitioner)?

☐ No Wait ☐ Less than 5 minutes
☐ 5-10 minutes ☐ 10-20 minutes
☐ More than 20 minutes

5. Was it easy to talk with the medical provider?

☐ Yes ☐ Somewhat ☐ No

6. Please rate how you were treated by the medical provider today.

☐ Excellent ☐ Very good
☐ Good ☐ Fair
☐ Poor

7. Was the health information clearly communicated to you by the medical provider?

☐ Yes ☐ Somewhat
☐ No ☐ Does not apply

8. Was enough time spent with you during your appointment?

☐ Yes ☐ Somewhat ☐ No

9. What services did you receive today from the medical provider? Check all that apply.

☐ Sick visit
☐ Primary care visit/Check-up
☐ Prescription or refill visit
☐ Chronic disease management
☐ Urinalysis (Urine test)
☐ Health Education
☐ Other services (please specify):

10. How would you rate the ability of the satellite clinic to meet your healthcare needs today?

☐ Excellent ☐ Very Good
☐ Good ☐ Fair
☐ Poor

11. Would you recommend your family, friends, co-workers, etc. to use the satellite clinic services?

☐ Yes ☐ No ☐ Maybe

Thank you for taking this survey! Your responses are greatly appreciated.

PO Box 142 Cassatt, SC 29032
tythomas@mailbox.sc.edu

Evaluation Recommendations for Satellite Clinics

- Continue to operate 4 satellite clinics per month
- Continue to ensure connectivity issues are optimal to scan labs and/or paperwork for patients
- Create a Menu of Services to station somewhere at satellite clinics so that patients can know what services are offered
- Meet regularly with local medical providers to increase the number of referrals to the satellite clinic

CMC Director Susan Witkowski trains volunteers at the Community Medical Center in Camden.

Newspaper clippings from this quarter

The Kershaw County Current. September 30, 2015

www.facebook.com/TheKCCurrent © 2015 Aerographics

LiveWell Kershaw Mobile Clinics

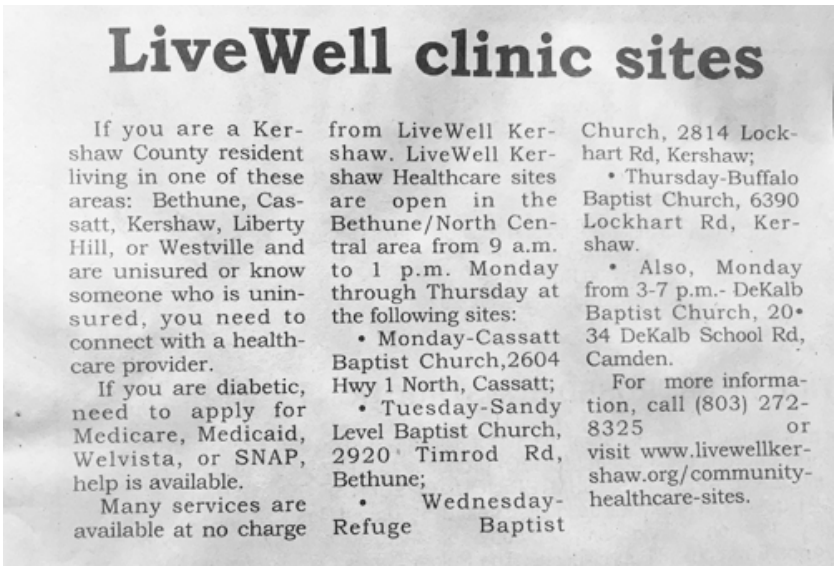
LiveWell Kershaw mobile clinics offer many of the same primary care services available in a doctor's office such as diagnostics, treatment, and prescriptions - many at little or no cost. For more information and to schedule a mobile clinic visit please call 803.272.8325. Clinic hours are 9am-1pm. Please visit *livewellkershaw.org* to find out more.

Dates remaining in 2015 are: **Oct 6** Sandy Level Baptist Church; **Oct 14** Refuge Baptist Church; **Oct 22** Buffalo Baptist Church; **Oct 26** Cassatt Baptist Church; **Nov 3** Sandy Level Baptist Church; **Nov 11** Refuge Baptist Church; **Nov 19** Buffalo Baptist Church; **Nov 30** Cassatt Baptist Church; **Dec 8** Sandy Level Baptist Church; **Dec 16** Refuge Baptist Church; **Dec 17** Buffalo Baptist Church

The Chronicle-Independent (Camden, SC). Oct 6, 2015

ONGOING -- LIVEWELL KERSHAW COMMUNITY HEALTHCARE SITES, are now open in the North Central area from 9 a.m. to 1 p.m. Monday through Thursday at the following sites: Monday - Cassatt Baptist Church, 2604 Hwy. 1 North, Cassatt; Tuedsay - Sandy Level Baptist Church, 2920 Timrod Road, Bethune; Wednesday - Refuge Baptist Church, 2814 Lockhart Road, Kershaw; Thursday - Buffalo Baptist Church, 6390 Lockhart Road, Kershaw. Also from 5 to 7 p.m. Monday and Tuesday at the following sites: Monday - DeKalb Baptist Church, 2034 DeKalb School Road, Camden; and Tuesday - Freedom Outreach Baptist Church, 1113 Hwy. 1 North, Cassatt. For more information, call (803) 272-8325 visit www.livewellkershaw.org/communi ty-healthcare-sites.

Kershaw News-Era. Dec. 9, 2015



LiveWell clinic sites

If you are a Kershaw County resident living in one of these areas: Bethune, Cassatt, Kershaw, Liberty Hill, or Westville and are unisured or know someone who is uninsured, you need to connect with a healthcare provider.

If you are diabetic, need to apply for Medicare, Medicaid, Welvista, or SNAP, help is available.

Many services are available at no charge from LiveWell Kershaw. LiveWell Kershaw Healthcare sites are open in the Bethune/North Central area from 9 a.m. to 1 p.m. Monday through Thursday at the following sites:

- Monday-Cassatt Baptist Church,2604 Hwy 1 North, Cassatt;
- Tuesday-Sandy Level Baptist Church, 2920 Timrod Rd, Bethune;
- Wednesday-Refuge Baptist Church, 2814 Lockhart Rd, Kershaw;
- Thursday-Buffalo Baptist Church, 6390 Lockhart Rd, Kershaw.
- Also, Monday from 3-7 p.m.- DeKalb Baptist Church, 2034 DeKalb School Rd, Camden.

For more information, call (803) 272-8325 or visit www.livewellkershaw.org/community-healthcare-sites.

INSIGHTVISION

Scorecards

Extend Primary Care via CHW & Mobile Clinics

Operational Measures

Name	Prior Period	Current Value	Change	Target Value	Most Recent Period
CHW & Mobile: CHW Successfully Conduct Client Encounters From 9am to 1pm at Church Sites					
# of new clients seen per week	12	1	1	50	Yr2 W26
# of new clients seen per quarter	106	86	1	400	Y2 QTR2
CHW & Mobile: Provide Chronic Disease Case Management to Clients (Referral System)					
# referred to case management	0	3	1	0	Nov 15
CHW & Mobile: Initiate Contact with LWK Discharge Admissions within 48 Hours					
# of phone contacts made within 48 hours per week	25	21	1	0	Yr2 W26
# of phone contacts made over 48 hours per week	19	0	2	0	Yr2 W26
CHW & Mobile: Schedule an Apt at the Community Medical Clinic w/n 7-10 days of LWK Discharge if Client Qualifies					
# of scheduled appointments made at Community Medical Clinics within 7-10 days of discharge (per quarter)	23	54	1	0	Y2 QTR2
CHW & Mobile: Schedule an Appointment with a Primary Care Doctor w/n 7-10 days of LWK Discharge					

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# of scheduled appointments made at a primary care doctor within 7-10 days of discharge (per quarter)	19	32	1	0	Y2 QTR2
CHW & Mobile: Track the Number of "Unreachables" in LWK					
# of "unreachables" - addicted to ER "Black hole" clients (per quarter)	100	67	1	0	Y2 QTR2
CHW & Mobile: Refer Clients to a Medical Home with Scheduled Appointment					
# of clients referred to a medical home (per month)	14	25	1	0	Nov 15
CHW & Mobile: Recruit Volunteers / LWK Ambassadors					
# of new volunteers (per quarter)	26	1	1	20	Y2 QTR2
# of hours contributing (per quarter)	N/A	N/A	N/A	N/A	N/A
CHW & Mobile: Visit Churches in North Central and on the Bordering Counties					
# of churches visited (per quarter)	6	10	1	0	Y2 QTR2
CHW & Mobile: Contact all Providers in Area, Provide Info on LWK, Follow-Up as Needed					
# of provider visits per month	N/A	8	0	0	Nov 15
CHW & Mobile: Medical Provider Conducts Client Visit at Mobile Clinic					
# of patient visits at mobile clinic per month	16	10	2	24	Nov 15
CHW & Mobile: Operate 4 Mobile Clinics per Month					
# of clients seen at each site per month (new and follow-up)	49	56	2	0	Nov 15

# of mobile clinic sites per month	3	4	1	4	Nov 15
CHW & Mobile: Participate in Community Events and Share LWK Info					
# of events per quarter	24	21	1	10	Y2 QTR2
# of participants reached	2,408	1,634	1	0	Y2 QTR2

DRIVER 2

Extend primary care and mental health at all schools in North Central to increase access and care coordination

Progress from September – December, 2015

SBHC Operations

Mental Health and Wellness

This quarter saw major strides in the implementation of the mental health and wellness component of the School Based Health Center. During the last quarter, Abby Bode, who serves as the one-on-one wellness counselor enrolled 10 students, 8 of which were actively receiving counseling as of December 21, 2015. There have been 17 total referrals. She has conducted 81 individual sessions with students, 16 sessions via telephone, 1 session with a parent, and 7 sessions with concerned teachers. Currently she is at capacity for students.

Emily Mancil, who directs mentoring services at North Central High School and North Central Middle School has also begun program implementation. At North Central High School, Emily has trained 11 active mentors (10 faculty/staff members and 1 university undergraduate), had 25 student referrals, and had 17 students actively in mentoring. At North Central Middle School, Emily has trained 17 active mentors (including 15 faculty and staff and 2 university undergraduates), had 27 student referrals, and had 24 students in active mentoring. The school administration has been extremely happy with the efforts of the health and wellness team, and feels as though they are "part of the school".

Along with the implementation of services, the wellness team distributed a mental health newsletter to faculty, staff, students, and parents at NCMS and NCHS. They also presented at the "Parent University Event" at Midway elementary, began collecting baseline health and wellness data for all students (with parental permission), and began planning for student and teacher satisfaction surveys, which will be deployed in the spring semester.

CHW Karen Baker administers influenza vaccine.

Plans are moving forward to integrate the health and wellness services into the Community Medical Clinic Electronic Medical Records. Susan Witkowski has met with Abby, Emily, and Cameron, and trained them on the Electronic Medical Records system. A laptop computer should be present at the school for EMR entry by the end of December.

As implementation has progressed, the referral process for students has been refined, with the school administration taking a very active role in helping students access services. The SBHC wellness team is one of a few options available to students with mental health and wellness needs. In addition to the wellness services from the SBHC, there is a staff psychologist from the state Department of Mental Health assigned to the school district, and a student from the University of South Carolina College of Social Work who operates a mentoring program similar to the Check and Connect program used by the SBHC team.

Originally, teachers desiring to refer students to the SBHC team would contact Abby or Emily directly. However, school administration discovered that some students were already referred to other mental health services. In order to reduce duplication, and maximize mental health resources, the school principal and administration members now receive all

referrals to mental health and wellness services, and in consultation with the mental health practitioners at the school, decide where students should be directed. This practice has streamlined the referral process. Emily and Abby meet with the two vice principals and the principal monthly to review caseloads and procedures and also obtain feedback related to services. In addition, Abby meets regularly with Mrs. Rose Montgomery, vice principal, to stay informed on school events and anything related to academic functioning.

Clinical Services

During this quarter an influenza clinic was conducted at North Central High School on November 4-6th and then on November 11th- 13th. It was staffed by one of the LiveWell Kershaw community health workers (Karen Baker). In total, 13 students received flu shots during the clinic. The low turnout may have been due to a $10.00 copay charged to students for receiving vaccinations at the school. Many students may have had less expensive alternatives.

Clinical services are due to begin in January, with a temporary nurse practitioner. Originally, a permanent nurse practitioner was to start in January, but the new hire will not complete her degree until May. During the November SBHC meeting, the team discussed whether it would be more prudent to wait to begin clinical services with a permanent hire, so that she could build rapport with students, staff, and faculty; or whether it would be preferable to start with a temporary practitioner, in order to begin services at the promised time. The team decided that it was more important to begin clinical services on time. The LWK team is looking for an adequate temporary practitioner for the start of 2016.

In anticipation of the beginning of clinical services, the LWK space at NCHS is undergoing renovation. Construction is moving forward and will begin over the winter break. The renovations will include a waiting room with a reception area, a private exam room, and an ADA compliant bathroom. The new facility is slated to open on January 25th. The LWK team plans to hold an open house at the new space on January 21st, and attend the spring NCHS open house on January 25th to inform rising freshmen about the SBHC and LiveWell Kershaw.

While excellent progress has been made in the implementation of clinical services, there have been some roadblocks. The medical director for the community clinic, Dr. Alice Brooks, resigned from her position in November (last day will be in March 2016). This poses a challenge for the SBHC since a nurse practitioner must operate under the umbrella of a physician's license. The Clinic Director, Susan Witkowski, is currently attempting to find an alternate solution so that the nurse practitioner can start in January.

School Based Health Community Advisory Council

The Advisory Council for the School Based Health Center met on Tuesday, December 8th, 2015. The assistant principal, a parent representative, the school nurse, members of the SBHC team, a representative from the United Way, and the SBHC evaluator were present.

The United Way representative talked about programs to feed school age children and young adults, especially those on free and reduced lunch, at times when school is not in session (such as the summer months). She was interested in expanding the program into the North Central area, and wanted to brainstorm possible locations.

The group then discussed the upcoming renovation to the SBHC space, and asked for an update, and whether the nurse practitioner would still be starting in January. It was confirmed that the nurse practitioner would be starting in late January, and the space should be ready by that time. Much of the renovation will take place over Christmas break when students are not

CHW Karen Baker administers influenza vaccine.

present in the building.
The group also discussed referral procedures between the nurse practitioner and the current school nurse. It was clarified that when the School Nurse is present, she would see all ill students first, then refer to the Nurse Practitioner as needed.

The evaluator, Mark Macauda, then gave an overview of the results of the parent survey (see previous quarter report) and took questions. Emily Mancil also discussed the possibility of having a USC student volunteer conduct grief counseling sessions at the school.

Construction of the SBHC space at North Central High School.

Future Plans

The renovations to the clinic space should be completed by the end of January, when the nurse practitioner is due to start. The permanent nurse practitioner will not be finished with her education until later in the semester, so a temporary practitioner will fill in for the beginning of the year. The temporary practitioner will likely be "on loan" from a local clinic or physicians office.

The mental health team will see some changes and new initiatives in the next quarter. Abby Bode, the current wellness counselor will be leaving her position later in the school year. Cameron Massey, a PhD student at the USC Department of Psychology, will be taking over for Abby Bode.

Due to positive feedback from administrators, two to three USC undergraduate volunteers will continue to work at North Central as mentors and assistants for administrative work.

Starting in the spring semester, Alex Golden, a practicum student in the doctoral clinical/community psychology program at USC, will begin to hold grief counseling sessions weekly, which can accommodate 10-16 students. She may, if time permits, also see one or two students for individual counseling. This will extend the reach of the SBHC wellness services. The involvement of USC students is part of a larger effort to form a stronger partnership with USC. This partnership would allow an expansion of services at North Central High, provide opportunities for practicums for graduate students, and experience for undergraduate students.

Evaluation

During Quarter 2 Evaluation staff attended all driver meetings, collected and reported data on number of students seen and registered for the School Based Health Center, continued to identify variables in EMR records that may be used for evaluation, attended the community council meeting, and performed a site visit at North Central High.

Overall, the School Based Health Center initiative has been very successful, largely due to the efforts of Emily Mancil and Abby Bode. Abby and Emily have created a strong relationship with the school administration, who have been overwhelmingly supportive and collaborative with SBHC efforts (as evidenced by the willingness on the part of the administration to oversee student referrals, and administration's eagerness to support expansion of programs). We have heard from multiple sources that Abby and Emily are considered "part of the school" by many faculty and staff. They are also "at capacity" for student counseling sessions, thus there is clearly a need for greater capacity for wellness services.

In personal communications with the wellness team, it has become evident that many at the school are unaware of the larger SHBC initiative, or the beginning of clinical services. The health and wellness components have tapped into a need at the school, but more needs to be done for faculty, staff, and students to see the mental health and wellness component as part of the SBHC.

The success of wellness programs had necessitated extra hours on the part of both Abby and Emily, who are both full time doctoral students. This is a situation that should be monitored very closely in the future. While high quality programs are often the result of dedication and high levels of effort, it is important that the project be successful within the stated time commitments of the staff involved. This is important for the health and wellbeing of staff (especially those who are full time students) and for sustainability and replicability, since staff working extra hours cannot be "built in" to an implementation plan.

The evaluation team recommends the following for Quarter 1, 2016:

1. Continue management meetings with Abby, Cameron, and Emily. It is important that lines of communication stay open between the health and wellness team and administrative staff of LiveWell Kershaw. In order to ensure that communication stays open the team should continue to hold regular meetings between LWK administration and the SBHC health and wellness staff. These meetings should be in addition to the "driver meetings" which bring together the entire SBHC staff, and often have very full agendas.

2. Campaign to help associate the work of the wellness team with the SBHC. The majority of faculty and staff at the school know the wellness team, but may not associate them with LiveWell or the larger SBHC initiative. An information campaign should be initiated to remind faculty, staff, and students that the health and wellness services are part of a larger program. The connection may become more evident when the nurse practitioner begins in January, but it would be advisable to solidify the connection between the wellness programs and the SBHC program as a whole, especially since the wellness team is so trusted and welcomed by the school.

3. Examine ways to involve parents. The health and wellness efforts generally involve the students, faculty, and staff. According to the health and wellness team, the SBHC should reach out to parents so that they can both work with their children on wellness issues, and also gain a access to services they may themselves need through the community clinic and CHWs. This will strengthen the support network for students and their families.

4. Review protocols, and preparation plan for nurse practitioner. Since the renovations are planned to be completed in January, it would be advantageous to review the plans for the opening of the clinic (supplies, protocols, policies and procedures) to ensure that the clinic is ready. Planning is especially crucial at this point, given the current absence of a medical director.

5. Conduct focus group with teachers to evaluate the utilization and perception of mental health services. In order to gain an in-depth understanding of the view of mental health services amongst the faculty at NCHS, the evaluation team recommends that six to eight teachers be recruited for a focus group. Topics could include perception of mental health issues at the school, understanding of the mental services offered by the SBHC, and recommendations for further services.

CHW Rachael Sladek shares information about the SBHC at Bethune Elementary School.

SBHC Team December to February 2016 Timeline

DATE	TASK
December 2015-February 2016	Continue provision of one-on-one counseling services to students at NCHS
December 2015-February 2016	Continue training of teacher mentors on Check and Connect as needed
December 2015-February 2016	Continue monitoring and quality checks on Check and Connect as needed
December 2015	Planning for spring semester services
January 2016	Cameron begins counseling at NCHS
January 2016	Wellness newsletters will be distributed at NCHS, NCMS, & Midway
January 15, 2016	SBHC Staff to attend NCHS teacher work day
January 21, 2016	Renovations completed for SBHC clinic space
January 21, 2016	Open house for rising freshmen at NCHS-SBHC staff present to talk about role of SBHC
Janurary 21, 2016	Nurse practitioner begins
January 25, 2016	SBHC begins clinic operations
February 2016	New USC undergraduate mentors will be trained & begin mentoring at NCMS/NCHS

Extend Primary Care via School Based Health Center

Operational Measures

Name	Prior Period	Current Value	Change	Target Value	Most Recent Period
EPC-SBHC: Distribute HIPPA and FERPA Forms to Guardians					
% enrollees with signed HIPPA and FERPA	N/A	75%	0	100%	Aug 15
EPC-SBHC: Sign Students up for SBHC					
% of student body signed up with SBHC	N/A	11%	0	70%	Aug 15
EPC-SBHC: See Patients at Medical Clinic					
Average number of visits to SBHC per year per enrollee	N/A	N/A	N/A	N/A	N/A
EPC-SBHC: Provide Healthcare Access to those who Would Otherwise Not Have Access					
% of total identified students in need who enroll in clinic	N/A	100%	0	75%	Y2
EPC-SBHC: Establish Advisory Council					
# of active members	N/A	10	0	10	Y2
EPC-SBHC: Hold Advisory Council Meetings					

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# of meeting per year	N/A	2	0	4	Y2

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DRIVER 3

Create vibrant relationships and functional networks with community members to accelerate trust, outreach and achievement of a shared goal.

Progress from June-August, 2015

The LiveWell Kershaw team participated in numerous community events this quarter to increase awareness and engagement within the LiveWell Kershaw initiative (see detailed timeline on pages 45 - 47). CHWs were actively involved in sharing health information and checking blood sugars and blood pressures at Bethune Discount Meat Market, KARE (Kershaw Area Resource Exchange) Day, Burke's store, Bethune Women's Club and several open houses and fall festivals at local elementary, middle and high schools. In addition, all of the CHWs are now mentoring one student each at North Central High School to continue to develop strong relationships with the students (whose families may need services) and also the teachers. The team is committed to increasing awareness and also recruiting and retaining volunteers to assist with the population health efforts.

The Community Medical Clinic hired several new positions this quarter that will also assist with the integration of LiveWell Kershaw within the clinic. The Volunteer and Special Events Manger working in partnership with Executive Director is responsible for organizing the volunteers and executing special events supporting our strategic efforts to accelerate revenue growth and increase resources by maximizing fundraising net revenue growth and cultivate relationships. They will be working with the Community Outreach Manager to build relationships within the community including community outreach to local businesses and corporations. They will also be responsible for managing volunteers in placement areas, including on boarding, on-going maintenance and retention of volunteers for services that promote the mission.

CASE STUDY: SYLVIE

"Sylvie," 53, benefits from joint Case Management Meetings at the Community Medical Clinic
Sylvie became a patient with the Community Medical Clinic on June 5, 2013. Over the past three years, she has worked with numerous medical providers and volunteers to help manage her comorbidities. In addition, Sylvie also visited case managers at Access Kershaw for continued care coordination. Diagnoses for Sylvie include: hypertension, leiomyoma of uterus, embolism and thrombosis of the arteries of the lower extremities, iron deficiency, GERD, cardiac murmur and obesity. Sylvie is a portrait of a medically complex patient.

In June of 2016, Sylvie arrived at the Emergency Room of KershawHealth in immense pain. A pelvic MRI revealed she needed to have a hysterectomy soon. However, with a blood clot, the needed surgery could not be scheduled immediately. After being discharged from the hospital, Sylvie followed up with medical providers at the Community Medical Clinic and also visited a specialist in Columbia. After much discussion, the Community Medical Clinic medical team decided that Lovenox

Case study continued.

would be the best medication for Sylvie, despite not being on the preferred list for the Prescription Assistance Program. The Executive Director decided to use $2,000 from the medication fund to pay for Lovenox. In September, Sylvie successfully recovered from her hysterectomy and now continues to receive follow up care with the medical team at the Community Medical Clinic and Access Kershaw.

Today, Sylvie feels "100% better" and speaks very highly of the team at the Community Medical Clinic and Access Kershaw. She shared that "everybody has a smile on their face" and is extremely friendly. Sylvie now advocates for others like her, in pain and suffering from health issues, to visit the Community Medical Clinic. Unlike some other places, Sylvie noted that "they really, really help you."

Behind the scenes, the Executive Director convened three case management meetings over the summer to make sure that Sylvie was getting the best coordinated care possible. Joint face-to-face meetings were held with the entire medical team of the Community Medical Clinic as well as the nurse case managers of Access Kershaw to discuss Sylvie's medical situation and to make sure all appropriate follow-up was being taken. Leigh Reed, LPN, believes that there are many more "Sylvies" in Kershaw County with diverse and complicated medical needs that require a team based approach. Jeana Johnson with Access Kershaw found the joint case management meetings to be invaluable and notes that this "really helps with continuity of care and improving outcomes for the patient." The Executive Director will continue to have monthly joint case management meetings to discuss the individual needs of their patient population and has expanded the group to include LiveWell Kershaw Community Health Workers. By working and talking together about each patient, improved patient outcomes will become a reality for the uninsured and underinsured residents of Kershaw County.

The November Community Council meeting was held at Refuge Baptist

Community Council Meetings

Community Council meetings were held on September 10th (10 attendees) and November 12th (10 attendees) in Kershaw, SC. At the September 10th meeting, Susan Witkowski shared information about the Community Medical Clinic and the vision for LiveWell Kershaw moving forward. Some of the council members were not aware of the Community Medical Clinic in Camden and brainstormed ways to better inform the residents of North Central of available services in the area. At the November 12th meeting, Holly Hayes facilitated an action plan with the council members to determine what each member could commit to do within the next few months. The council members agreed to give presentations, pass out materials and their local church, and personally spread the word door to door to local residents. The Council strongly believes that once a variety of churches are actively supportive of LiveWell Kershaw, that the majority of the residents will be reached and begin to utilize the services.

Volunteer Training

On October 8, 2015, a volunteer training for LiveWell Kershaw was conducted at the Community Medical Clinic. A total of 30 volunteers were invited but only five showed up for the training. This training is the fourth volunteer training for LiveWell Kershaw. The session was from 6-7pm, with Susan Witkowski training and instructing the volunteers of responsibilities in their new roles at the clinic, satellite church sites, and in the community. Susan opened the training with

introductions and then talked about what a volunteer is and why it is essential to have volunteers. Susan conducted a tour of the clinic, discussing services and demonstrating how duties are handled within the clinic setting. The volunteers also received a welcome packet put together by Whitney, Karen, Rachael, and Jesus. The packet included a community medical clinic volunteer application, volunteer/employee/ student confidentiality non-disclosure agreement, proper lifting techniques, OSHA safety and compliance continuing education exam and participant application, a community newsletter, a school-based health center newsletter, a postcard with site locations and times, and a pen. The volunteers were appreciative of the training and completed a brief survey. The volunteers liked having a tour of the of the facility and believe that volunteering "presents opportunities for ministry." Some of the volunteers appreciated being informed of the services that LiveWell Kershaw provided and how they can better share this with others. The group was disappointed that more volunteers did not show up and want to do a better job of "getting the word out."

Annual Volunteer Appreciation Dinner

On November 10th, an annual volunteer appreciation dinner took place from 6:30 pm - 8:30 pm at the Roberts Mill Courthouse in Camden. The dinner was held to show appreciation to all the Community Medical Clinic (CMC) and LiveWell Kershaw volunteers, for their continued dedication and service to the Kershaw community. There were 92 volunteers who attended the dinner with four being from the LWK satellite sites. CMC and LWK Director Susan Witkowski, talked about the vision and the mission of the clinic, the integration of CMC, LiveWell Kershaw, and Access Kershaw, and the importance of volunteers throughout the community. CMC Volunteer Coordinator, Cynthia Nelson, stated "it was good meeting volunteers who started with the clinic in the beginning and being reacquainted with some volunteers from previous work experience." Lead Community Health Worker Karen Baker, "stated she enjoyed the wonderful atmosphere and that the food was delicious!"

Students at the Bethune Fall Festival learned about healthy eating by playing the My Plate game.

Evaluation Recommendations

- Amplify efforts reaching residents of North Central in the local businesses where there is high traffic
- Create a volunteer recruitment and retention plan for LiveWell Kershaw in collaboration with the Volunteer Coordinator at the Community Medical Clinic
- Work with community council members and volunteers to create a comprehensive community event calendar and begin planning what council members and volunteers can assist at events
- Systematically track what churches have been contacted related to LiveWell Kerahsw and current outreach efforts (database should include name, contact, what activity has been taken) and assign each Council Member up to three churches; database will need to be updated regularly
- Create two Community Councils – one for western part of county (including the towns of Liberty Hill, Kershaw, and Westville) and one for the eastern

part of the county (including towns of Buffalo, Mount Pisgah). No one from the eastern part of the county is attending the current Community Council Members – takes 45 minutes one way to travel.

- Create agendas for Community Council meetings that have a consistent structure and maximize the full allotted one hour.
    - o Share monthly data with Community Council members to assist with continuous quality improvement
    - o Share a success story each month (members need new stories that they can share with others)
    - o Have a volunteer speak on how working with the LiveWell Kershaw efforts is changing the area from their personal perspective
    - o Need a specific call to action at each meeting with a follow up as part of the agenda
    - o Need to assign specific roles for Council Members to assist with meeting (i.e. someone responsible for calling members, someone facilitating a certain component of agenda, helping set up refreshments)
    - o Consider proving a capacity building workshop with the Council Members related to community engagement and empowerment

Timeline of Community Events In Quarter 2

DATE	STAFF	DESCRIPTION	LOCATION	OUTCOME
Sept 1	Karen, Emily	NCMS Open House	Kershaw	Approximately 300 attended, LKW booth, bp
Sept 3	Jesus	NCHS Volleyball game	Kershaw	50 attended, LWK booth, spoke to students and parents about signing up for the SBHC
Sept 4	Jesus	NCHS ROTC class	Kershaw	Spoke to ROTC about LWK SBHC
Sept 5	Rachael	Bethune Discount Meat Mkt & More	Bethune	2 client encounters and 43 bps
Sept 8	CHWs, Dr. Brooks, Whitney	Sandy Level Baptist	Bethune	1 appt, 1 client encounter
Sept 9	Jesus	NCHS Volleyball	Kershaw	LWK table
Sept 10	CHWs, Whitney	Community Council at Refuge Baptist	Kershaw	
Sept 12	Karen	KARE Day	Kershaw	LWK table, bp
Sept 14	Whitney, Rachael, Jesus	Burke's	Camden	BCA table, 10 bps
Sept 15	Emily, Jesus	NCHS Math class	Kershaw	Spoke to students about the SBHC
Sept 15	Whitney, Jesus	Malvern Hill Senior Festival	Camden	LWK table, 15 bp
Sept 16	CHWs, Dr. Brooks, Whitney	Mobile Clinic at Refuge Baptist	Kershaw	5 appts, 3 client encounters
Sept 19	Jesus	NCHS Volleyball Tournament	Kershaw	LWK table

Timeline continued

DATE	STAFF	DESCRIPTION	LOCATION	OUTCOME
Sept 24	CHWs, Whitney, Dr. Brooks	Mobile Clinic at Buffalo	Kershaw	7 appts
Sept 25	Karen, Whitney	Burke's	Camden	BCA table, 19 bps
Sept 28	CHWs, Dr. Brooks, Whitney	Mobile Clinic at Cassatt Baptist	Cassatt	3 appts
Sept 28	Rachael	Bethune Elem.	Bethune	PTO meeting
Oct 1	Jesus	NCHS Volleyball	Kershaw	LWK table, 2 bp
Oct 2	Jesus	NCHS Football game	Kershaw	LWK table, 4 bp
Oct 8	CHWs, Whitney	Volunteer Training at the Community Medical Clinic of Kershaw County	Camden	5 volunteers were informed on LWK and trained on mobile clinic procedures
Oct 13	Jesus, Karen	Midway Elem Hispanic Parents	Cassatt	Used New Leaf curric, 6 attended, 6 bp and glucose
Oct 14	CHWs, Dr. Brooks, Whitney	Mobile Clinic at Refuge Baptist	Kershaw	4 appts
Oct 22	Jesus	Midway Fall Carnival	Cassatt	LWK table, 2 client encounters
Oct 22	CHWs, Dr. Brooks, Whitney	Mobile Clinic at Buffalo Baptist	Kershaw	11 appts
Oct 26	CHWs, Dr. Brooks, Whitney	Mobile Clinic at Cassatt	Cassatt	1 appt
Oct 26	Rachael	Bethune Elem	Bethune	SIC meeting, 15 attendees, LWK info put in school newsletter and website
Oct 29	Whitney, Holly, Ibrahim	DHHS meeting	Columbia	Reviewed Year 2 Quarter 2 and 6mo economic analysis
Oct 29	Jesus, Karen, Rachael, Dr. Brooks	NCHS	Kershaw	Sports Physicals
Nov 2	Rachael	Mt Pisgah Elem	Mt. Pisgah	SIC meeting
Nov 3	CHWs, Dr. Brooks, Whitney	Mobile Clinic at Sandy Level Baptist	Bethune	2 appts, 2 client encounters
Nov 10	Whitney, Emily	Midway Elem Parent University	Cassatt	shared powerpoint, 12 bps and glucose
Nov 11	CHWs, Dr. Brooks, Whitney	Mobile Clinic at Refuge Baptist	Kershaw	2 appts, 2 encounters
Nov 11	Whitney, Rachael	Bethune Woman's Club	Bethune	Spoke to Club about LWK, 20 attendance, 10 bp
Nov 12	CHWs, Whitney	Community Council	Kershaw	Holly led us in a 6mo action planning. All council members left with agreed responsibilities.

Timeline continued

DATE	STAFF	DESCRIPTION	LOCATION	OUTCOME
Nov 12	CHWs, Whitney, Tamika, Beckie	Focus Group with the Care Coordination Team	Kershaw	Our goal for partner agencies and clients to have an easy single access to all services in Kershaw County. Issues and action items discussed.
Nov 13	Rachael	Bethune Elem Fall Festival	Bethune	150 attendance, 60 played My Plate game, 4 client encounters, gave out water bottles and Frisbees
Nov 18	Rachael	IMPACT meeting	Camden	AGAPE speaker discussed senior care and hospice even for children. Learned about disaster relief including DSNAP
Nov 19	CHWs, Dr. Brooks, Whitney	Mobile Clinic at Buffalo Baptist	Kershaw	3 appts
Nov 24	Rachael	BES SIC meeting	Bethune	Spoke to SIC about LWK
Nov 23	CHWs, Whitney, Emily, Tamika, Dr. Brooks, CMC staff, CMC board	Strategic Planninng	Camden	Holly and Dr. Foster led the group in a strategic planning.
Nov 30	CHWs, Dr. Brooks, Whitney	Mobile Clinic at Cassatt Baptist	Cassatt	4 appts

LiveWell sign created by an employee of Bethune Discount Foods. CHW Rachael Sladek offered free blood pressure screenings inside the store on September 5th.

LiveWell KERSHAW "Your Bridge to Better Health"

Wellness Brief: Back to School

Fall 2015
Parents' Edition

PO Box 142 Cassatt, SC 29032
whinson@livewellkershaw.org 803.272.8325

facebook.com/LiveWellKershaw
twitter.com/lwkershaw

LiveWell Kershaw is an organization whose goal is to make Kershaw county the healthiest county in the state of South Carolina. In August, LiveWell Kershaw opened a **School Based Health Center** (SBHC) at North Central High School that is providing health screenings, such as sports physicals, wellness and counseling services including coaching/behavioral skills, and the nationally recognized Check & Connect Mentoring Program. In January, the SBHC will welcome a Nurse Practitioner to their staff, who will deliver "minute clinic" type healthcare that is convenient for students. Although the SBHC is housed primarily at North Central High, the SBHC staff have goals of improving wellness at other North Central area schools. Each quarter the SBHC will be sending you newsletters with tips and strategies to promote wellness.

Identifying Wellness Concerns

Parents and teachers play a crucial role in the intellectual and emotional development of children. It is often easy to forget that they also play an important role in children's mental health. If not addressed, mental health disorders can hinder the learning of children and adolescents.

Up to 15% of children in the United States experience mental health problems[1], yet only a small percentage (i.e., 0.6%-16%) of these children are ever identified by teachers or pediatricians.[2] Of those children in need of services, less than 1 in every 5 children actually receive help or mental health services.[3]

Teachers and parents are in an excellent position to observe a child's behavior and identify when help is needed from the school's mental health personnel, such as the guidance counselor, school psychologist, interventionist, or social worker. Below are some warning signs teachers and parents should look out for in recognizing mental health concerns.

Warning Signs

Some warning signs for young children include:

- Change in school performance
- Poor grades despite strong efforts
- Excessive worry or anxiety
- Hyperactivity
- Persistent disobedience or aggression
- Frequent temper tantrums

Some warning for older children and adolescents include:

- Defiance of authority
- Truancy
- Theft and/or vandalism
- Prolonged negative mood
- Frequent outbursts of anger
- Intense fear of weight gain

If you observe these or similar behaviors, take the time to talk with a mental health professional.

These tips were developed by the Maryland School Mental Health Alliance.

Every adult in a child's life can make a difference. Parents and teachers are at the frontline and are natural role models for students.
"If we are to save our children then we must become people they will look up to. Children need heroes now more than ever..."

*-Geoffrey Canada**

**(First Stick Knife Fun, 1995, pg. 178)*

[1] (Roberts, Attkisson, & Rosenblatt, 1998)
[2] (Briggs-Gowan, Horwitz, Schwab-Stone, Leventhal, & Leaf, 2000)
[3] (Costello, Mustillo, Erkanli, Keeler, & Angold, 2003)

livewellkershaw.org

The Myth of the "Bad Kid"

Six-year-old Jimmy is having trouble in school. As a first grader, he already has a reputation among the teachers as a "bad kid." He spends most of his school day sitting in the corner or the principal's office. With 30 other children in his class, the teacher has little time for Jimmy. He isn't learning anything in the classroom, and he has trouble making friends.

We all have memories of the "bad kid" in our class - the child who was always in trouble and often alone. We tend to blame this kind of behavior on a lack of discipline or a bad home. We say the child was spoiled, abused, or "just trying to get attention." But these labels are often misguided. Many of these children suffer from serious emotional problems that are not the fault of their caregivers or themselves.

Myths about children's behavior make it easy to play the "blame game" instead of trying to help children like Jimmy. Often, in making assumptions, we "write off" some children. However, with understanding, attention and appropriate mental health services, many children can succeed - they can have friends, join in activities and grow up to lead productive lives. To help children with emotional problems realize their potential, we must first learn the facts about the "bad kid."

- **Children do not misbehave or fail in school just to get attention.** Behavior problems can be symptoms of emotional, behavioral or mental disorders, rather than merely attention seeking devices. These children can succeed in school with understanding, attention and appropriate mental health services.

While between 20 - 38% of youth have a diagnosable mental health disorder, less than one third of these youth will receive any treatment.

- (Lever & Weist, 2006).

- **Behavioral problems in children can be due to a combination of factors.** Research shows that many factors contribute to children's emotional problems including genetics, trauma and stress. While these problems are sometimes due to inconsistent parenting practices or abuse, parents and family are more often a child's greatest source of emotional support.
- **Children's emotional, behavioral and mental disorders affect millions of American families.** An estimated 14-20 percent of all children have some type of mental health problem. Jimmy and the many others mislabeled as "bad kids" can be influenced by the positive support of their communities and schools

For more information on children's emotional and behavioral problems, call the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, one of the Public Health Service agencies in the U.S. Department of Health and Human Services at 1-800-789-2647.

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This newsletter was originally created by the Center for School Mental Health (CSMH), at the University of Maryland School of Medicine.

For more information contact:
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LiveWell Kershaw is a group of healthcare providers, businesses, schools, churches, and local citizens working together to make Kershaw County the healthiest county in South Carolina. LiveWell Kershaw focuses on health issues impacting the North Central area: heart disease, high blood pressure, diabetes and behavioral health conditions. Our partners include AccessKershaw, KershawHealth, Community Medical Clinic of Kershaw County, and the Arnold School of Public Health, USC.

PO Box 142 Cassatt, SC 29032 803.272.8325
livewellkershaw.org

Ad for Bethune Elementary School newsletter

Uninsured? Need help with medications?
Diabetic? High blood pressure?
Need to apply for Medicare, Medicaid, Welvista, or SNAP?
Need to connect with a healthcare provider?

Do you or someone you know need these services?
Many are available at no charge.

Community Health Workers Are at these Locations to Assist You:

Day & Time	Location
MON 9am - 1pm	Cassatt Baptist Church 2604 Hwy 1 North Cassatt 29032
MON 3pm - 7pm	DeKalb Baptist Church 2034 DeKalb School Rd Camden 29020
TUES 9am - 1pm	Sandy Level Baptist Church 2920 Timrod Rd Bethune 29009
WED 9am - 1pm	Refuge Baptist Church 2814 Lockhart Rd Kershaw 29067
THURS 9am - 1pm	Buffalo Baptist Church 6390 Lockhart Rd Kershaw 29067

LiVeWell KERSHAW
"Your Bridge to Better Health"
PO Box 142 Cassatt, SC 29032

Walk-ins welcome!
To make an appointment:
803.272.8325
whinson@livewellkershaw.org

Are you uninsured?
Do you need help with getting medications?
Are you diabetic or have high blood pressure?
Do you need to connect with a healthcare provider?

Healthcare for the Community

Community Healthcare Sites include local churches, businesses and community centers that have partnered with us by opening their doors to help our Community Health Workers & Nurse Practitioners provide basic healthcare services to area residents. Our goals include connecting individuals with ongoing healthcare services as needed, providing access and information to community members, and extending primary care into the community.

Services Include:

- Health screenings including blood pressure and blood glucose
- Diabetes supplies including test strips
- Assistance with applying for health insurance
- Assistance with Medicare/Medicaid, SNAP & Welvista
- Other assistance to manage overall health and well-being.

A LiveWell Kershaw Community Health Worker will be serving area residents at this location soon. See the bottom of this flyer for details.*

LiveWell KERSHAW
"Your Bridge to Better Health"

LiveWell Kershaw is a group of healthcare providers, businesses, schools, churches, and local citizens working together to make Kershaw County the healthiest county in South Carolina. LiveWell Kershaw focuses on health issues impacting the North Central area: heart disease, high blood pressure, diabetes and behavioral health conditions. Our partners include AccessKershaw, KershawHealth, Community Medical Clinic of Kershaw County, and the Arnold School of Public Health, USC.

*A LiveWell Kershaw Community Health Worker will be visiting:

_____

DATE: _____TIME: _____

Handout with updated satellite healthcare site information

FRONT:

LiveWell KERSHAW

"Your Bridge to Better Health"

Community Health Workers Are On-site to Assist You

Day/Time	Location	Address
MON 9 am - 1 pm	Cassatt Baptist Church	2604 Hwy 1 North Cassatt 29032
MON 3 - 7 pm	DeKalb Baptist Church	2034 DeKalb School Rd Camden 29020
TUES 9 am - 1 pm	Sandy Level Baptist Church	2920 Timrod Rd Bethune 29009
WED 9 am - 1 pm	Refuge Baptist Church	2814 Lockhart Rd Kershaw 29067
THURS 9 am - 1 pm	Buffalo Baptist Church	6390 Lockhart Rd Kershaw 29067

Walk-ins welcome or call to make an appointment: 803.272.8325
livewellkershaw.org

BACK:

Are you a Kershaw County resident living in one of these areas: Bethune, Cassatt, Kershaw, Liberty Hill, or Westville?

Uninsured? Need help with medications?
Diabetic? High blood pressure?
Need to connect with a healthcare provider?
Need to apply for Medicare, Medicaid, Welvista, or SNAP?
Need help with your overall health & well-being?

Do you or someone you know need these services?
Many are available at no charge.
Please share this information with a friend!

LiveWell KERSHAW

"Your Bridge to Better Health"

PO Box 142 Cassatt, SC 29032
803.272.8325 livewellkershaw.org

OUR PARTNERS:

AccessKershaw
Arnold School of Public Health, USC
Community Medical Clinic of Kershaw County
KershawHealth

Mailing for clients

LiveWell KERSHAW
"Your Bridge to Better Health"

DATE: _____

Dear _____

We have been trying to contact you by phone but were unable to reach you. If you would be interested in our services or would like more information please give us a call or stop by one of our Community Healthcare Sites.

Sincerely,

_____

Community Healthcare Site Locations

Day/Time	Location	Address
MON 9 am - 1 pm	Cassatt Baptist Church	2604 Hwy 1 North Cassatt 29032
MON 3 - 7 pm	DeKalb Baptist Church	2034 DeKalb School Rd Camden 29020
TUES 9 am - 1 pm	Sandy Level Baptist Church	2920 Timrod Rd Bethune 29009
WED 9 am - 1 pm	Refuge Baptist Church	2814 Lockhart Rd Kershaw 29067
THURS 9 am - 1 pm	Buffalo Baptist Church	6390 Lockhart Rd Kershaw 29067

Are you a Kershaw County resident living in one of these areas:
Bethune, Cassatt, Kershaw, Liberty Hill, or Westville?

Uninsured? Need help with medications?
Diabetic? High blood pressure?
Need to connect with a healthcare provider?
Need to apply for Medicare, Medicaid, Welvista, or SNAP?
Need help with your overall health & well-being?

Do you or someone you know need these services? Many are available at no charge.
Please share this information with a friend!
Please call (803) 272-8325 for additional information. Thank you!
PO Box 142 Cassatt, SC 29032
livewellkershaw.org

DRIVER 4

Conduct evaluation using developmental, formative and economic approaches to guide the implementation process.

Progress from September -December, 2015

The evaluation team continued to work closely with the implementation team to collect data, reflect on progress and determine next steps in becoming a "bridge to better health" for the residents of Kershaw. The Director, Susan Witkowski, and leaders within LiveWell Kershaw review data regularly to guide needed course corrections and acknowledge team members excelling in meeting their goals. The evaluation team actively participated or observed in all key meetings (Community Health Workers, School Based Health Center and the Community Council). The lessons learned template was shared with the team to begin using after events and key milestones are met (See page 69). The evaluation team emphasized the importance of focusing on "bright spots" in their work and learn how to grow the bright spots across locations and within the team. See page 70 for a Bright Spot Bulletin related to the Community Health Workers. In addition, Holly Hayes facilitated a focus group (see page 66) with the care coordination team to reflect on the past quarter and to determine what changes can be made to increase efficiency and better serve the residents in Kershaw.

Over the past six months, the LiveWell Kershaw team has been working to determine how best to integrate LiveWell Kershaw and AccessKershaw within the Community Medical Clinic. During this quarter, Holly Hayes and Dr. Rick Foster with Catalyst for Health (SC Hospital Association) worked closely with Susan Witkowski and planned a two day strategic planning retreat that was held on November 23rd and 24th of 2015. The over arching question for the retreat was: What must we do to ensure improved health outcomes and health care access for uninsured and underinsured populations in Kershaw County? In preparation for the retreat, a survey was administered November 17th – 21st to all board members assessing the current strengths, weaknesses, opportunities and threats of the organization. In addition, 15 staff members from the Community Medical Clinic, AccessKershaw and LiveWell Kershaw completed two staff surveys on November 19th-20th also assessing organizational strengths and weaknesses as well as an assessment of internal leadership, communication and patient outcomes. The summary of the report can be found on pages 58 - 65. Holly Hayes will be meeting with the staff on January 19th to create a detailed implementation plan based on the six vision elements.

Community Medical Clinic Board members at the Strategic planning retreat

The Community Medical Clinic Board wanted the vision and mission of the organization to reflect the clinic as BOTH a provider of primary care services for the uninsured and underinsured AND the backbone for collective population health efforts in Kershaw County.

The updated vision and mission are:

Vision: A healthier Kershaw County, where individuals and communities are empowered to take charge of their own health and well-being.

Mission: We will lead a collaborative effort to provide the resources needed for improved health of the underserved, while always respecting the dignity, integrity, and diversity of those we serve.

The evaluation team continues to work collaboratively with LiveWell Kershaw and also serve as a link to other efforts with similar visions. Holly Hayes represents Kershaw at HEART meetings and also at collective impact meetings coordinated by the Alliance for a Healthier South Carolina and will begin to attend the statewide Community Health Worker Association meetings.

Future Plans

The evaluation team will continue to work closely with the LiveWell Kershaw team. In the upcoming quarter, the evaluation team will be very involved at North Central High School as the primary care component of the School Based Health Center is launched. In addition, the team will work with the care coordination leaders on beginning to track key clinical outcomes for patients receiving health coaching and accelerating health promotion activities at local businesses and events. The team will also work closely with the Director, Board of Directors and staff in facilitating meetings and key informant interviews as the strategic plan begins to be implemented.

Evaluation Recommendations

- Create an implementation plan for the 3 year strategic plan for the Community Medical Clinic.
- Link to national and regional experts as needed related to the School Based Health Center implementation.
- Continue to participate in the Pathway to Pacesetter webinars and link the team with resources and tools.
- Create a detailed evaluation plan for the volunteer component of LiveWell Kershaw.
- Continue to attend all key LiveWell Kershaw meetings and meet regularly with team members, volunteers, and community members to support evaluation efforts and learnings throughout the quarter.
- Closely track progress made during all driver meetings, and remind team members of recommendations, if needed.
- Assist leadership team in developing a revised conceptual model using the hub and pathway framework.

COMMUNITY MEDICAL CLINIC

STRATEGIC PLAN

November 23 - 24, 2015

Goodale State Park

Participants: Karen Baker, Sheri Baytes, Keri Boyce, Alice Brooks, Joseph Bruce, Geraldine Carter, Mary Clark, William Cox, Roy Fakoury, Susan Grumbach, Holly Hayes, Mary Hill, Whitney Hinson, Jeana Johnson, Emily Mancil, Cynthia Nelson, Sarah Oliver, Alicia Pendergrass, Robbie Powers, Leigh Reed, Tommy Rose, Rachael Sladek, Jerry Stokes, Tamika Thomas, Beckie Tompkins, Jim Wiley, Susan Witkowski

Facilitators: Dr. Rick Foster and Holly Hayes

The following report summarizes the collective wisdom of the participants in answering:

"What must we do to ensure improved health outcomes and health care access for the uninsured and underinsured populations in Kershaw County?"

The core values of the organization include:

- Patient and community centered
- Value all human and financial resources and use them wisely
- Compassion
- Acting with Integrity and Honesty
- Dignity and Respect
- Diversity
- Quality
- Accountability and Transparency
- Continuity of care
- Empowerment
- Overall well-being
- Innovation

Based on these values, the group developed a revised mission and vision statement for the organization. A vision says where you want to be in the next three years while the mission states how you will achieve the vision. It was important to the Board that both the vision and the mission reflected the expanded model of the clinic, which includes CMC as BOTH a provider of primary care services for the uninsured and underinsured AND the backbone for collective population health efforts in Kershaw County.

Vision:

A healthier Kershaw County where individuals and communities are empowered to take charge of their own health and well-being.

Mission:

We will lead a collaborative effort to provide the resources needed for improved health of the underserved, while always respecting the dignity, integrity, and diversity of those we serve and who serve.

Six Strategic Direction Tables Based on Vision

Strategy A: **Access to Needed Services**

Potential components could include: transportation for patients, medical Uber, satellite clinics throughout the county, school-based clinics in all middle and high schools in county, and clinics in remote areas.

Current Reality	Key Actions	Success Indicators
• AccessKershaw and LiveWell Kershaw are based at West Wateree and Community Medical Clinic is based on Dekalb Street • 1 School-Based health center at North Central High School • 4 satellite church sites in operation • Not providing patient transportation	• Board to assess whether they are interested in using the Health Resource Center as a home base for clinic • Pay insurance for 3 volunteer drivers ($3,000) • Get Capella to include CMC in expanded Elgin facility ($150,000) • Ensure success in North Central and report results to school board	• Operating satellite clinics • School-based Health Center in place with schools with high concentration of underserved (including Elgin and Jackson Elementary school) • Volunteers providing transportation throughout county (decreasing no-shows) • Permanent site in Elgin

THREE YEAR TIMELINE

YEAR ONE	YEAR TWO	YEAR THREE

Strategy B: **Community Outreach and Engagement**

Potential elements: Everyone in Kershaw county is aware of our mission. County Council has made population health a priority. More community involvement/awareness, more bilingual staff, partnership with churches, and increase volunteers in north central area.

Current Reality	Key Actions	Success Indicators
• Work has begun educating key leaders on population health (County Council, Rotary Club, State Representatives) • 85% of volunteers and donors from Camden • The geography of the county creates division and separate communities	• Increase awareness of mission and vision • Identify and cultivate multiple relationships with community champions throughout the county (Board of Visitors, County Council) • Create a vibrant website and social media campaign ($50,000) • Effective direct mail to build awareness – donors and patients ($5,000) • Get on speaking circuit • Focus on recruiting more translators. Consider certifying translators (medical terminology, body parts, cultural norms) • Outreach to Pastor's Association and Baptist Association	• Population health is a County Council priority • Increased number of volunteers, patients and donors from Elgin and West Wateree area and across the county • Increased number of volunteers • Increased number of bilingual translators

THREE YEAR TIMELINE

YEAR ONE	YEAR TWO	YEAR THREE

Strategy C: **Financial Sustainability**

Potential elements: $3.5 million in Endowment, financial sustainability, increase funding, successful fundraising events, $500,000 from big sponsors and donors, "How-To" book on creating a healthy community, professional development Director/sustainability.

Current Reality	Key Actions	Success Indicators
• 85% of money comes from Camden • Susan is handling day-to-day operations as well as development operations	• Approach Carolina Cup/Racing Association • Obtain money from Hospital Foundation - $2 million • Create a process to uncover new grant opportunities • Hire full-time professional development director within 90 days ($60,000 annually) • Finish feasibility study on major donors • Launch major donor program AND legacy program • Annual campaign by a proven process	• $2.5 million in endowment • Major donors and legacy (including grants) will exceed $750,000 annually

THREE YEAR TIMELINE

YEAR ONE	YEAR TWO	YEAR THREE

Strategy D: **Effective Data Management**

Potential elements: Fully integrated system for patient tracking (between CMC, LiveWell and Access), efficient EMR that connects all entities, access to database of patients' medical coverage, common database with reliable connectivity.

Current Reality	Key Actions	Success Indicators
• Poor connectivity (phone, internet, fax) within clinic and at satellite sites • Hospital and CMC Electronic Medical Records are not integrated	• Purchase, implement and train team on new Electronic Health Record ($100,000) • Connect with DHHS database to verify Medicaid coverage • Obtain data on admissions from area hospitals and nearby free clinics • Obtain ER visits from hospital and Access; review for accuracy • Update and verify connectivity to ensure we are with best available ($1,000)	*Indicators will be added that directly apply to these measures at implementation retreat • Reduced unnecessary ER visits • Measurable improvement in specific health metrics (i.e. asthma, diabetes) • Increased satisfaction among providers • Lower hospital readmission rates • Streamlined data entry and reporting across all three product lines

THREE YEAR TIMELINE

YEAR ONE	YEAR TWO	YEAR THREE

Strategy E: **Expand Diversity And Scope Of Clinical Services**

Potential elements: Increase capacity in both services and numbers served, expand community based services, Diabetes Center of Excellence, mental health program for non-psychotic disorders, preventative dental program, preventative and acute dental care, need more doctors (specialists), dispensing pharmacy, expand referrals to specialists, create partnerships with specialists (dental, ortho, vison, opto, endo)

Current Reality	Key Actions	Success Indicators
• Cannot do insulin pumps • No endocrinologists • No ophthalmologists • Initial conversations around telemedicine	• Develop a program to train volunteers (CHW extenders) to be healthy living coaches ($10,000) • Partner with the school district and school nurses to expand our preventative healthcare initiatives within schools • Hire a Health Program Coordinator to support LiveWell's efforts ($50,000 annually) • Expand existing diabetes education program ($60,000 annually) • Provide dental and mental health services • Become a dispensing pharmacy • Negotiate telemedicine agreement	• Dental program in place • Dispensing pharmacy is in place • Telemedicine agreement in place with MUSC

THREE YEAR TIMELINE

YEAR ONE	YEAR TWO	YEAR THREE

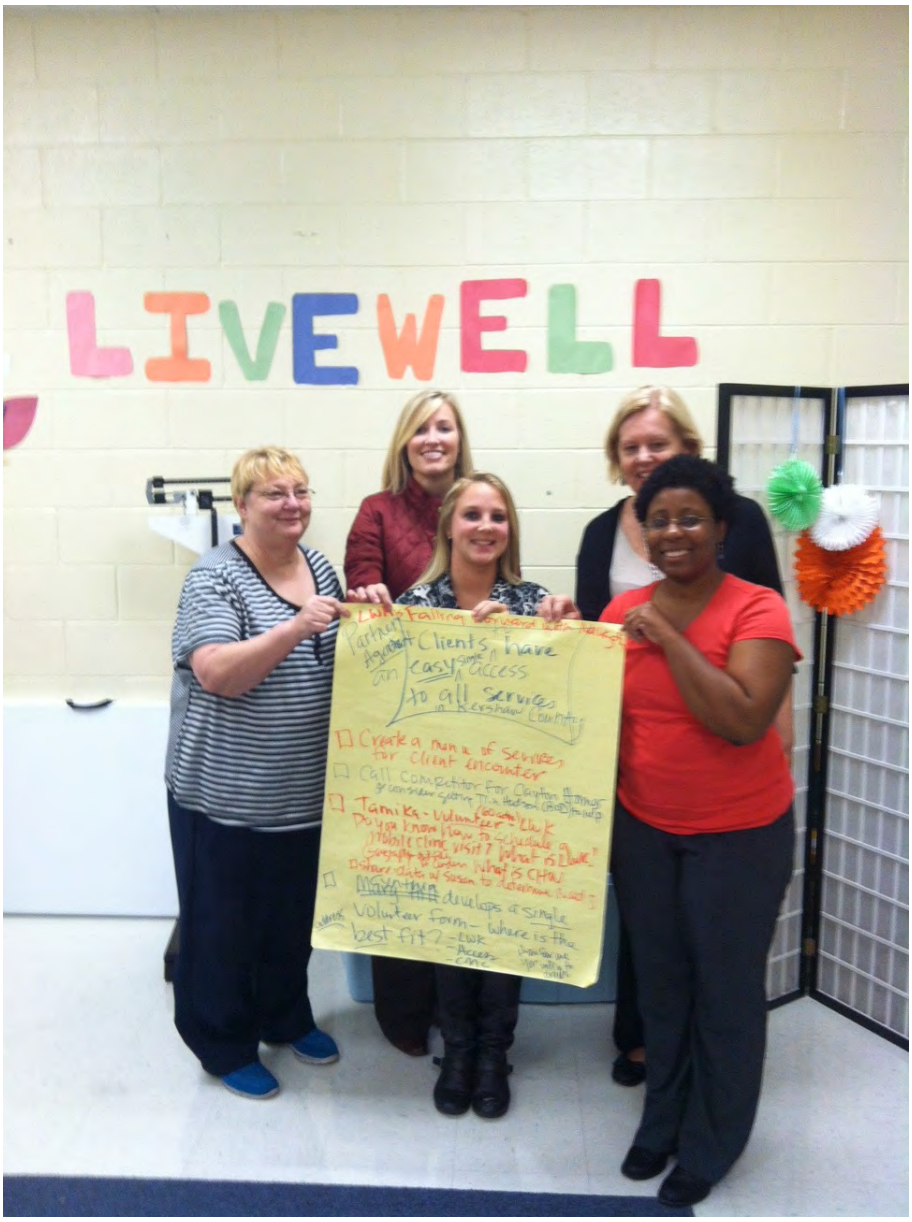
Strategy F: **Provide Preventative Activities to Promote and Support Population Health throughout the county**

Potential elements: Preventative healthcare initiative in schools, health/life coach, smoking cessation programs, increase patient exercise, classes on wellness (exercise/financial management/budget)

Current Reality	Key Actions	Success Indicators
• Providing health coaching at CMC • CHWs have completed online health coach training	• Consider partnering with USC and MUSC with a test site related to diabetes • Develop a program to train volunteers to be healthy living coaches ($10,000) • Partner with the school district and school nurses to expand our preventative healthcare initiatives within schools • Begin specific wellness programs (These points will be clarified and expanded.)	• Reduced rate of diabetes among patients • Improved quality of life for chronic disease patients • Preventative healthcare initiative in place at the schools • Select indicators improving based on classes and health coaching

THREE YEAR TIMELINE		
YEAR ONE	**YEAR TWO**	**YEAR THREE**

Focus Group with the LiveWell Kershaw Care Coordination Team



Participants:

Karen Baker, Whitney Hinson, Rachael Sladek,

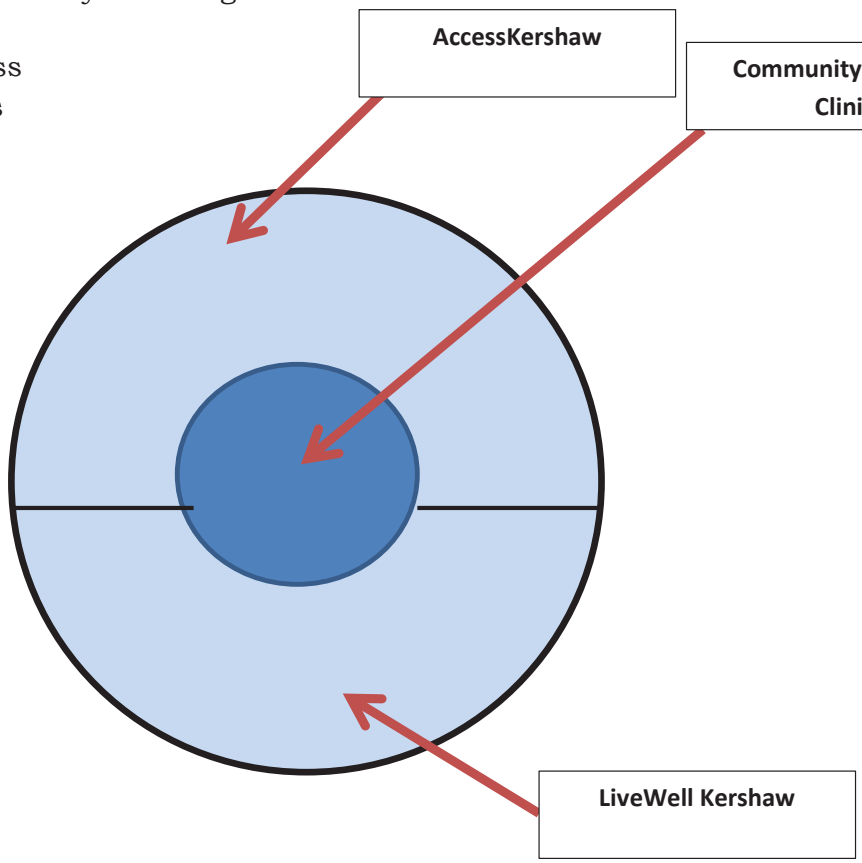
Tamika Thomas, Beckie Thompkins

LiveWell Kershaw is Failing Forward with Navigation

Our goal is for partner agencies and clients to have an easy single access to all services in Kershaw County

- Create a menu of services for client encounters
- Call competitor for Clayton Homes
  - Consider getting Tim Hudson (BOD) to help
- Tamika – Conduct a survey with current Volunteers (60 active) –
  - Do you know how to schedule a mobile clinic visit?
  - What is LWK?
- Cynthia develops a single volunteer form
  - Where is the best fit?
  - How far are you willing to drive?
  - LWK
  - Address
  - Access
  - CMC

There are not 3 concentric circles there are only 2 circles. The difference between Access and LiveWell is largely based on "territories."



ACCESS/CMC ISSUES

- Volunteers not fully understanding LWK (phone call triage)
- No building – people have to "see it" to "believe it"
- Outreach is difficult
- Patient needs are growing – need a lot more services, can take up to 2 hours
- Patients not knowing what they need
- Access needs more LWK materials. Access staff are seeing patients in North Central. Don't know what follow up occurs after phone calls.
- Recruited volunteers at school registration and by phone – what next?
- Google phone is not efficient
- "Trust" issue with LWK/Access
    - I'm going to get it done
    - Jeana calling patients of Karen
- Information overload
- Becky/Karen transition (32 hours, M-TH) - what is the plan?
    - Tamika didn't know about transition
- Can't schedule for LWK from Access

ACTION ITEMS

- PDSA "test" on Becky/Sarah triaging all calls for CMS/LMK/Access
    - Focus on new patients
    - Sarah will schedule in Fhases
- Address volunteers at strategic plan
- Consider two Community Council meetings for the two regions (i.e."Bethune North Central")
- Make sure everyone, including Access, has lots of LWK materials
- Include LWK in case management meetings
- Create a detailed training and implementation plan for the Karen/Becky transition
- Whitney remind and enforce that everyone schedules in Fhases

LESSONS LEARNED

Project Name:_____ CHW Name:_____

Facilitator:_____ Date: ____/_____/_____

Required Attendees:

What went right during this phase?

People	Process	Outcome

What could have been done differently during this phase?

People	Process	Outcome

What did we learn during this phase?

People	Process	Outcome

Bright Spot Bulletin for CHWs – Rachael

The Recipe for Bright Spots

1. Gather data on the issue.
2. Study the data to find the bright spots (the unusually positive performers).
3. Make sure you understand the "normal way" things are done.
4. Next, study the bright spot to see what they're doing differently.
5. Make sure none of those practices are "exceptional" in some way.
6. Find a way to reproduce the practices of the bright spots among other people.

Key Domains	What is Rachael doing as a CHW that is working well?
Community	- Keeps a box of info with her at all times in her trunk including volunteer forms, client forms, pens, pencils, postcards, and newsletters - Builds key relationships with business owners and workers – Sarah at the Exxon is distributing cards to anyone she hears that may need LWK help, Chris at the Dollar General is giving them to families in need at the cash register - Visits the businesses anytime there is free time in schedule, at least twice a week – "the postcards are going somewhere" – "The key is building relationships in the community" - Asked by the Discount store to set up a table once a week - Talked with lady from Women's club for 45 minutes and now has speaking engagement - Spoke with county council woman and getting signage at the front of Bethune and speaking at Lion's club
Schools	- Attends PTO meetings and meets with President of PTO and key members - Attends School Improvement Council meetings (elected as Business partner) - Distributes LWK materials in Saks for Love - Planning to attend Fall Festival at both schools - Planning to attend Pastries for Pastors at both schools - Meets weekly with the Principal, secretary, and teachers
Churches	- Promotes LiveWell Kershaw at Vacation Bible School - Placed a "What is LWK" flyer on every door of her 17 churches each week with materials - Gives volunteer packets to the pastors - Buffalo Baptist shares LWK during church service and includes info in church bulletin

Doctor's offices	- Drives each week to Sandhills in McBee, Healthcare place at Bethune, and CareSouth in Bishopville - Talk to receptionists and drop off materials - Has list of doctors and dentists that take Medicaid to help with patient referrals (received from AccessKersahw) - Working with Christ Central Institute to get vision and dental services needed for clients
Administrative work	- Stays caught up on all data collection - Before she calls a person on the ER list she always checks Fhases and IMS - She keeps Fhases open during the phone call, immediately documents outcome, and then inserts the Fhases number into the worksheet
Screening of New CMC patients	- Complete applications based on instructions and give to Geraldine - Learned how to complete the form and already turned in 3 applications that were completed on-site
CHW Satisfaction Survey	- Give to all clients immediately after visit - Reads questions to clients that have trouble reading

What's working well and how do we clone it?
Let's look at successes FIRST and not to problems.

Contact Information

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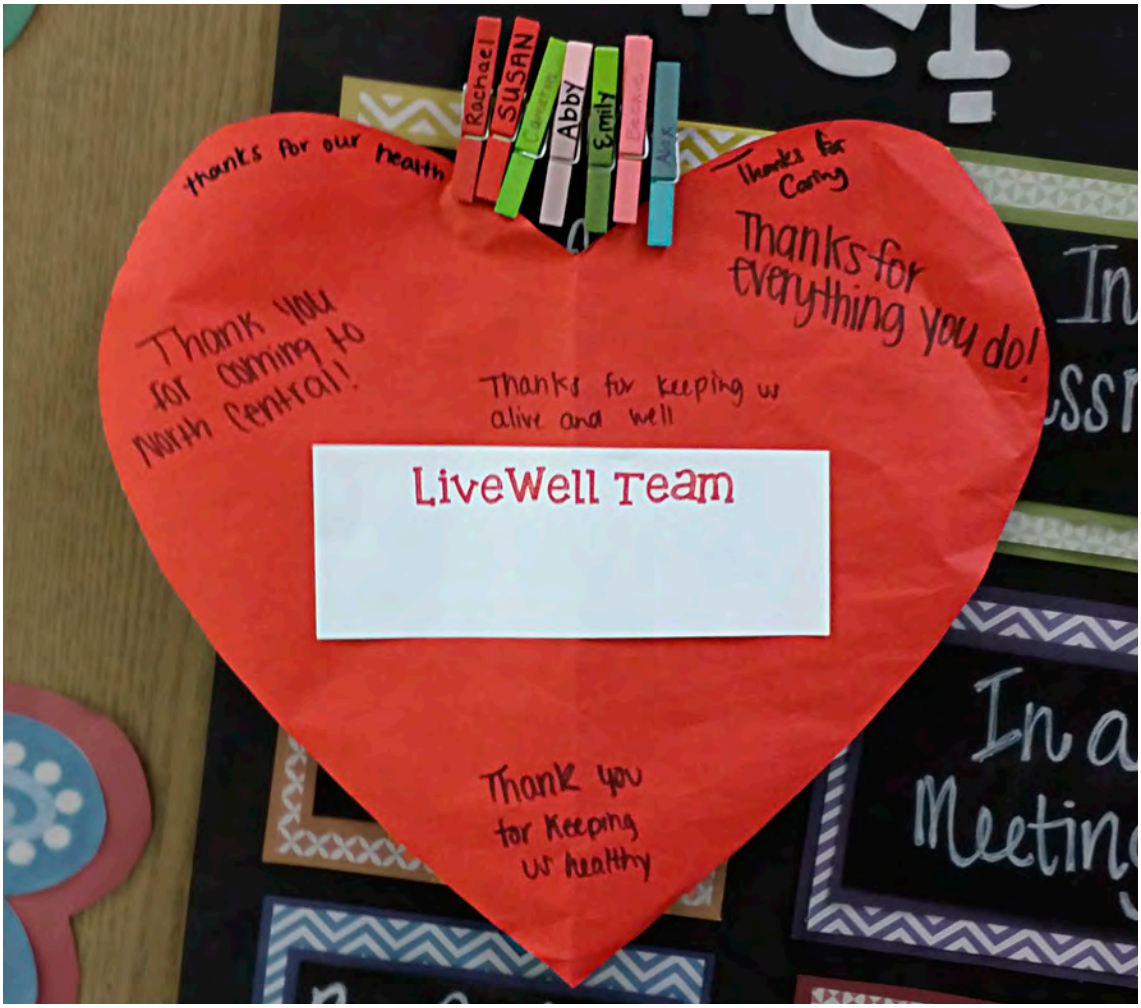
LiveWell KERSHAW

"Your Bridge to Better Health"

Quarterly Report

Year Two Quarter Three



December 1, 2015 - February 29, 2016

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Introduction

March 1, 2016

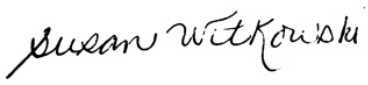
One of my favorite inspirational children's books is entitled "I Knew You Could! A book for all the stops in your life" by Craig Dorfman. To us, one passage sums up our accomplishments this quarter which include launching phase two (primary care component) of the School Based Health Center at North Central High School while also expanding phase one (mental health counseling, group sessions, and mentoring) at the same time.

I knew you could! And you knew it too –
That you'd come out on top after all you've been though.
And from here you'll go farther and see brand-new sights.
You'll face brand-new hills that rise to new heights.
I wish I could show you the stops that you'll visit,
But that isn't my choice to make for you, is it?
Instead, I can tell you some lessons and some tales
That I've learned and relearned in my time on the rails.

This quarter, we celebrate! We celebrate our successes and we celebrate all of the individual and collective efforts of our team. Our team is mighty and includes Community Medical Clinic employees, volunteers, board members, Community Council Advisory members, School Based Health Center Advisory committee members, school administration, local and state leaders, students, and our patients. Dr. Frank Morgan, Superintendent of Kershaw County schools, said that "this has surpassed (his) expectations" and he is so happy that North Central students now have access to much needed services in such a rural part of the county.

Best in all you do,

Holly Hayes,
Evaluator



Susan Witkowski,
Director

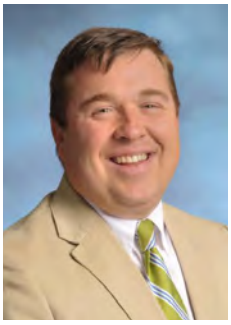
In case you want to read the book:
Dorfman, C. 2003. I Knew You Could! A book for all the stops in your life. NY, NY: Penguin Group.

We Appreciate You

Thank you for helping make the School-Based Health Center at North Central High School such a success!

Abby Bode

Regina Bowers



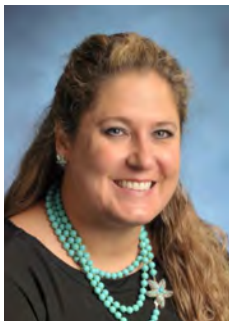
David Branham

Roy Fakoury

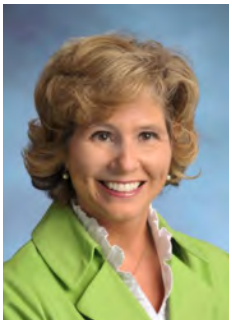
Susan Grumbach

Emily Mancil

Frank Morgan



Rose Montgomery



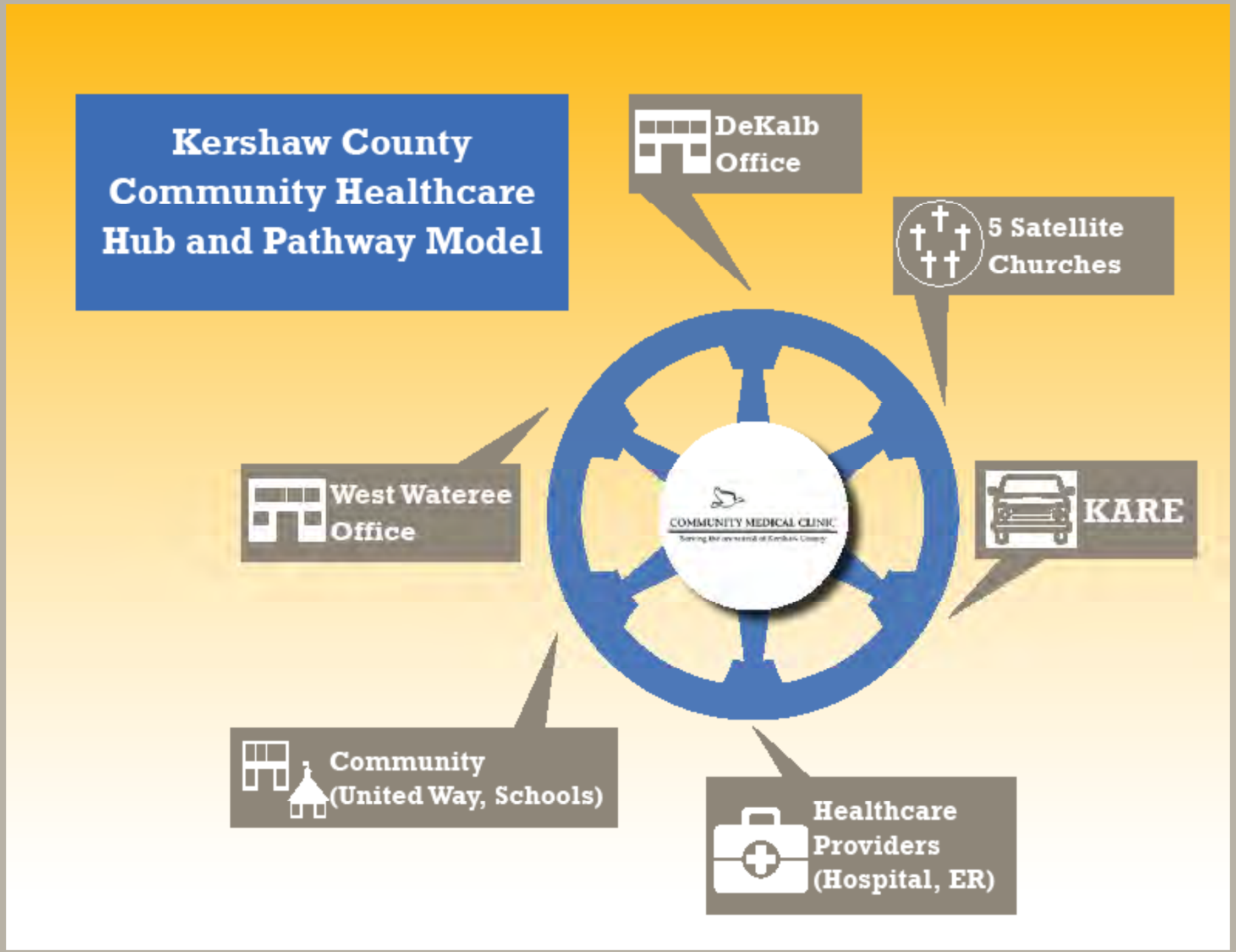
Lori Pate

Rachael Sladek

Beckie Tompkins

Success is the sum of small efforts repeated day in and day out.

-Robert Collier


Kershaw County Community Healthcare Hub and Pathway Model
DeKalb Office
5 Satellite Churches
West Wateree Office
COMMUNITY MEDICAL CLINIC
KARE
Community (United Way, Schools)
Healthcare Providers (Hospital, ER)

School Based Health Center

Primary Care Services

Renovations to the clinic space were completed in late January. The space, which was originally one open room, has been transformed and now includes a waiting area with a reception desk, workspace for Community Health Workers and support staff, a large examination room, and a large lavatory.

SBHC Open House

On January 25, 2016, North Central High School conducted an open house for incoming freshman and their parents to welcome them to the school and to discuss topics such as electives and scheduling. Representatives of LiveWell Kershaw, and specifically the School Based Health Center (SBHC), were invited to attend. LiveWell staff set up two tables outside the auditorium; one containing information about the SBHC and one containing information about Community Health Workers (CHWs) and their role both at the SBHC and in the larger community. One table was also set up outside the main office with similar information.

Susan Witkowski, the director for the Community Medical Clinic, gave a brief presentation about the SBHC as well as the current mental health services being offered by LiveWell Kershaw at NCHS. She stressed that the SBHC is staffed by Nurse Practitioners, and serves as a "minute clinic", a concept that seemed to resonate with the attendees. During the presentation, the school administration, as well as parents and teachers who serve on the SBHC advisory committee, expressed their support for the SBHC and encouraged parents to enroll their children. During the meeting, it became evident that the NCHS parent portal is a main communication outlet for parents. In response, the SBHC team plans to place information about the SBHC on the parent portal.

l to r: Grief Counselor Alex Golden, Mental Health Counselors Abby Bode & Emily Mancil, & CHW Rachael Sladek

In total, 108 people attended the presentation on the SBHC. Overall 12 students were enrolled in the SBHC, and several parents indicated that they would complete the forms and return them to the school at a later date. In addition to the SBHC enrollments, one client signed up for services with the community clinic, and one individual registered to become a volunteer.

In summation, the Community Medical Clinic Director, Susan Witkowski had this to say:

"THANK YOU all for working long hours today to make the NCHS event a success. This was pretty close to letter perfect. It is evident from the parents on the advisory group and teachers comments that the SBHC is making a difference. They had many positive comments."

Launch of SBHC Clinical Services and Assessment of Progress

Phase Two of the SBHC began operations on February 2 with primary care services being provided Monday with hours from 8:00 am to noon. The regular hours are Mondays and Thursdays from 8:00 am to noon. Primary staff currently include Susan Grumbach serving as Nurse Practitioner, and CHW Becky Thompkins assisting. The current staffing plan is for all the Nurse Practitioners at the Community Medical Clinic to rotate through the SBHC. Due to provider shortages, Susan Grumbach has currently been the only Nurse Practitioner at the school.

So far there are 26 students enrolled with complete registration and 67 students with partial registrations. Three students have come in for acute treatment between February 8th and February 29th, 2016 (see details on pg. 15). Two of the three referrals were from the School Nurse. One of the students was sent home with a medical excuse and the two other students returned to class. In addition, from August to February, the Nurse Practitioner completed 29 physicals for sports eligibility. One of the students receiving medical care said "this is awesome." A presentation of the progress to-date was made to Dr. Frank Morgan, the superintendent, and Mr. David Branham, the principal.

The exam room in the new SBHC facility.

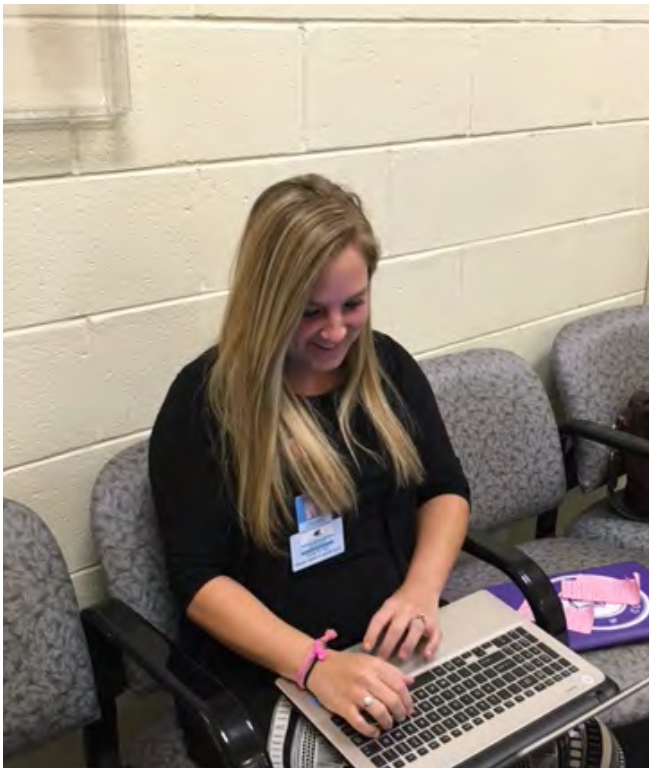
Susan Grumbach, the SBHC Nurse Practitioner recounted to the SBHC Advisory Committee the treating of one student, that underscores the potential impact of the SBHC. This student was ill and had a previous prescription from his general practitioner for an antibiotic. The student was sent to the school nurse, who then referred him to the SBHC. Susan Grumbach was able to see the student and prescribe a new antibiotic. She also judged that the student was too ill to remain in school and sent him home. She then called the student's general practitioner to inform them of the treatment. Next, she followed up with the student's mother, who expressed that she was only able to get a much later appointment with the general practitioner. The student, therefore, was treated much earlier than would have been possible. The student's mother worked 2nd shift and did not have to miss work to take the child to the doctor. Susan was also able to write three excused absences for the student. This ability to excuse absences can help students avoid penalties for carrying more than five unexcused absences in a school year. The coordination between the student, mother, school nurse, attendance secretary and the primary care physician, took only one hour.

The issue of excused absences and "seat time" for each of the four blocks in a school day is of great importance to the administration at North Central High School. Each student can have up to five excuses per block.

According to Assistant Principal Rose Montgomery, state law requires that students have a certain number of minutes of instruction. Unexcused absences can lead to failure of a grade as well as a monetary penalty. At North Central High School, approximately 85% of students passed their grade. Eight percent failed due to unexcused absences. The inability for parents to get their sick children to a doctor (for treatment and also to excuse the absences), can put those children at risk for failure. The ability of the nurse practitioner to

excuse absences alleviates this concern. According to Ms. Montgomery, since the overall population of the school is small (about 500 students total), the failure of a few students can have a significant effect. As an example, she mentioned that the school recently earned a Palmetto Awards Gold Status. She stated that the difference between earning Gold Status versus a lesser status came down to the record of one student. This example underscores that the health and wellbeing of each student is both intrinsically important and also affects the success of the school as a whole. More generally, the need for an unexcused absence note necessitated by the rule for excused absences has negatively impacted the primary care providers. The need to obtain a note has created a capacity issue for general practitioners, who must deal with walk-ins in need of a note. In some cases, the need for a note has then spilled over to unnecessary ER visits. The SBHC can provide an alternative solution to this issue.

One of the services provided by the SBHC is administering sports physicals, which are an essential eligibility requirement for any student who would like to be involved in athletics. According to athletics director Louis Clyburn, there has been a "good marriage" between athletics and the School Based Health Center. Mr. Clyburn explained that it may be difficult for some students in North Central to have access to sports physicals, either from their doctor, or from a clinic such as those in Walmart (which cost $25.00). Often there is an issue with transportation, or cost is a barrier. The SBHC can remove this significant barrier to participation. Mr. Clyburn recounted the case of a student who had been unable to participate in sports for three years due to the inability to get a physical. She was able to get seen at the SBHC and be cleared to participate during her senior year. In addition to clearing students to play, sports physicals have discovered hidden health issues with students that could have made athletic participation dangerous. Students from North Central Middle are also beginning to be seen at the High School to play Junior Varsity sports.



CHW Rachael Sladek

Since the SBHC has begun administering the physicals, participation in sports has increased. According to assistant coach Jill White, about 5 students per athletic team are ineligible to play due to lack of physical. She stressed that athletics can be very important to students in building self-esteem and confidence, and she is happy that more students can have the opportunity to participate. To date, the SBHC has completed 29 physicals of students, and is planning to begin another round for spring athletics in the coming months.

The SBHC clinical services component has been a well received addition to the School. The School Nurse for North Central High School, Regina Bowers, reported that the coordination between the nurse's office and the SBHC has gone very smoothly and communication has been excellent between her office and LiveWell staff. The nurse practitioners at the SBHC use the same form used at the nurse's office to document patient information and vitals, so that information can be consistent between offices. Ms. Bowers underscored that her role is very different than that at the SBHC, and she is happy that the SBHC can prescribe medications to students. She

School Based Healthcare Center Advisory members discuss progress being made in the library at North Central High School.

also mentioned that the difference between the nurse's office and the SBHC may not be apparent to teachers because the referral process for an ill student is the same. Ms. Bowers is showing her support for the SBHC initiative by reaching out to students that she knows need primary care attention, and providing them with the SBHC enrollment forms.

The Superintendent, Dr. Frank Morgan, is very supportive of the efforts of both phase one and phase two of the SBHC. For an evaluation perspective, he is interested in tracking the following for each student receiving services: grades, attendance, discipline referrals, and student engagement (participation in sports, clubs). Susan Witkowski and Holly Hayes will give a presentation to the school board in May and also share their plans for future SBHCs. Dr. Morgan had this to say about the initiative:

"This is why I've advocated so hard for a School-Based Health Center in North Central. Those children have the least services in the area, and I knew this would benefit them and holds the potential to address absenteeism. This has exceeded my expectations."

Plans for expansion

As the SBHC continues with mental health services and primary care services, it is being looked to as a model for a wider implementation across Kershaw County. The Community Medical Clinic of Kershaw County, which is the backbone organization for LiveWell Kershaw is advocating a philosophical change in how health care is delivered in the county: moving to a systems-wide approach that focuses on community intervention, disease prevention, and access to services. Roy Fakoury, Chairman of the board of directors for the Community Medical Clinic explained the vision:

"One of my goals is ... Whether you have insurance, or you don't have insurance. Whether you are under served or whatever the issue is. That there's a system that works for everybody."

As part of this, there are plans to have school based health centers in every high School and middle school in Kershaw.

Athletic Director Louis Clyburn

Mental Health and Wellness

The Mental Health and Wellness team has continued its successful interventions, both in mentoring at the middle and high schools and in counseling at the high school. During this quarter, 16 teachers at the middle school and six teachers at the high school were actively mentoring students, though only two were implementing with full program integrity. In addition, two undergraduate students from USC are mentoring students at the middle school, and one USC undergraduate student is mentoring students at the high school. The middle school had 20 students enrolled in mentoring, and the high school had ten students enrolled. With respect to wellness counseling, Abby Bode worked with eight students and conducted 46 individual sessions. In March, Abby Bode will be leaving her position as wellness counselor, and PhD student Cameron Massey will be taking over the program. Cameron will continue with five students regularly, and will check-in with remaining students.

Abby sat for an exit interview and provided some insight into the direction of counseling services at the high school. One of the major issues is one of capacity. Abby's capacity was eight students, and Cameron's will be five at the outset. The school administration, as well as the SBHC team are well aware that the need for services is far greater. One possible solution is to increase the number of practicum students from USC psychology, and move Cameron into a supervisory role. Barriers to this approach mainly center around travel time and reimbursement for students. Cameron and Emily will be speaking to the USC program director, Dr. Mark Weist, about the feasibility of expansion plans.

Abby also expressed that many mental health issues have been precipitated by family issues (which was also a major issue identified by teachers and staff during focus groups-see below). This indicates a need for counseling that would involve the family in addition to the student.

Susan Witkowski gave Abby Bode flowers for her incredible work with teachers and students.

New this quarter was the implementation of grief counseling services. According to school administration, NCHS has a high rate of students who have lost one or both parents. This was brought to the attention of the administration by a new faculty member who recently transferred from another district. A PhD student, Alex Golden from USC School of Psychology, is running the grief counseling groups. Thus far, three groups have been started to serve 20 students who have been identified as needing counseling. The goal is to have weekly hour-long sessions over a period of 10 weeks. The attendance secretary is very sensitive to loss of relatives and is referring students to grief counseling. For example, a student recently received a text from her father informing her that that her grandmother had passed away, and was crying in the attendance secretary's office. Alex Golden was able to counsel her immediately following the attendance secretary bringing her over.

Focus Groups with Mentors

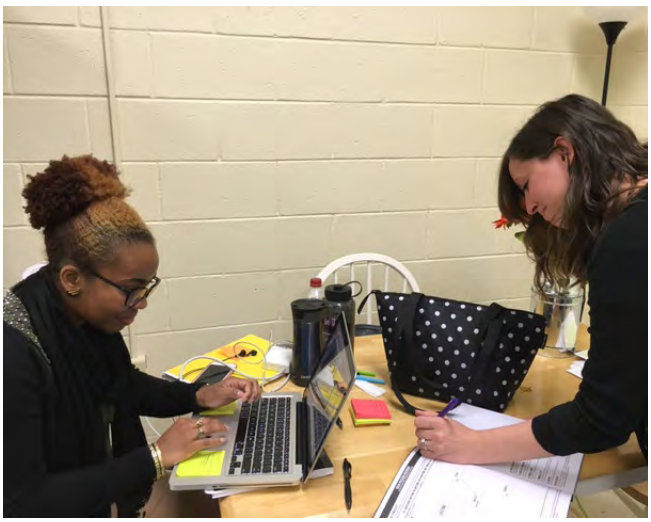
As part of the evaluation of the mental health component, the evaluation team conducted interviews with teachers and staff at North Central Middle School and North Central High

School. Overall five interviews with 10 teachers were conducted at the middle school and three interviews with eight teachers were conducted at the high school. Participants were asked about their general impressions of mental health issues at their schools, their involvement with the mental health mentoring programs conducted by LiveWell, and their impression of the impact of health and wellness programs.

Impression of mental health issues

The school administration has been very supportive of the activities at the School Based Health Center, especially the mental health component. School administration at North Central Middle School described the impact as follows:

"[The] greater need that we have here that we can't fulfill with the staff that we have. For you guys, through USC and LiveWell, to come in and do that has been a blessing. Our students are getting a lot more attention that they need, that we can't provide, so it's been awesome."



Alex Golden & Abby Bode at the SBHC.

Respondents in the middle school felt as though family issues were often at the heart of mental health issues of students. Family issues took the form of divorced parents or "broken homes" as this respondent from the middle school explains:

"A lot of the kids come from broken homes. To me, that's where it starts, because if the family's breaking down, the child doesn't have that stability at home. Then, it's like a spiral effect."

This was also seen in the high school, in addition to having students who have lost parents:

"We have a lot of kids that either have, live with or grew up with their grandparents and their grandparents died, or both grandparents have died, or a mom has died or a dad, I feel like that's where most of, a lot of issues at home stem from. With these kids, anxiety, and not being able to achieve things, is because they're dealing with so much grief and they don't know how to deal with it."

In addition there is a perception that some parents are not fulfilling their role, which is negatively impacting students, as this middle school respondent explains:

"We've got a kid that has been sent to court, because she can't get to school. She can't get to school, because her Dad won't get up in time and leaves it up to that kid to get herself up as a seventh grader, get herself ready for school, get herself fed and catch the bus, because he can't go to bed before 3:00 am drinking beer all night. Doesn't work, doesn't do anything."

According to respondents these issues lead to anxiety, depression and poor school performance.

In addition to issues at home, some high school respondents talked about a lack of social skills which leads to disruptive behavior problems:

"We get more and more students every year. They do not know how to handle themselves and interact in social situations and we don't know if it's because of everything in social media, because they're on a computer or an iPad or whatever. But we see more and more and they just don't know how to act in a public situation or a social situation whether its a classroom or a hallway, an assembly, the library."

Teacher Role in Mental Health

All of the respondents had some role in mental health and wellness, mainly through mentoring students. Some had referred students to other services as well. Perspectives on the mentoring program were generally positive, and that they see sometimes small but steady improvement in the students that they mentor:

"He's doing pretty good, he's got better in some areas over the course of the year. Some of it's not ... I mean, he has times where he goes back, but most of it, he's gotten better, I think."

Student improvement was at the heart of some respondents' satisfaction with their involvement with the program, as this middle school respondent explains:

"To me, if I wasn't getting anywhere with the child, it would be a burden, because I would feel like I was wasting my time. This kid doesn't give a rip. He doesn't care. I'm wasting my time.... If we're making small strides, then I feel like I'm not wasting my time."

While the overall impression of the program was positive, and mentors were positive about their roles, they did feel that there were some barriers. Some teachers felt as though they were ill equipped to deal with some of the more severe problems of students:

"I have a girl that's in sixth grade that I do not teach. She actually has a really good ability, is actually a gifted type of student. But I feel like a lot of her issues are a lot deeper probably then I'm able to handle, so Emily has given me some great suggestions and we try to do a lot of things with her as far as motivation."

Interestingly, several respondents mentioned that mentoring could be beneficial because it reminded them about the struggles some students in this rural area face. This was especially true for respondents who did not grow up in this area:

Wellness Counselor Emily Mancil

"What these kids have been through is so different then anything I've been through in my life that its just been kind of a good reminder that so many of the things they experience at home, do impact what they do here, so I think from that perspective, its a good reminder. We all know that. That's something we all know, that what happens at home, impacts them here but I think when you talk to them one-on-one you really hear that story, its a good reminder about it."

Two respondents from the high school said they sometimes act as advocates for students who are having trouble:

"Yeah, that's probably the best way to describe it, we find ways to make teachers more favorable to help them out somehow you know? Give them a break in some cases and we help them to go around and be more responsible about their assignments and things."

Overall, communications with the SBHC team, especially Emily Mancil, who directs the mentoring program, have been positive, and to the satisfaction of the respondents:

"Her coming to the school is sufficient, but she is always available for us to e-mail, which is awesome."

"Emily has certainly been good about following up with me and seeing if I'm needing anything, trying to give suggestions."

In an effort to expand the reach of mental health and wellness services, the SBHC team had discussed holding workshops during teacher in-service days. We asked middle school respondents what would be topics of interest. During two of the interviews, respondents mentioned combatting student apathy and motivation as important topics, as well as combatting student depression.

Challenges

Some respondents, in both the middle and high school felt that access to records and additional paperwork were a barrier to effective mentoring. As these respondents explain:

"I struggle with the paperwork and forms because as the special ed teacher I have so much paperwork and you all do too. I have so much paperwork and so many forms that filling out these forms, it really it adds that much more to my plate."

"having to go around and find out how many assignments did they miss that week, because I don't have access to see what her grade book looks like. I go on around having to find that information out was extremely difficult."

Similarly, the lack of feedback on students who have been referred was a source of criticism, especially from some of the high school respondents:

"I think it fulfills a need. I just don't have any feedback on ... It would be nice in a faculty meeting or an e-mail as to what the students feedback is, how it's been used."

"I don't know if it's allowed, but having maybe a list sent out of which students are being mentored or are being seen for the mental health stuff makes the teachers more aware of what's going on. I would like to know if I had students that were being helped."

Athletic Director Louis Clyburn and Coach Jill White

Summary

According to faculty and staff at the school, the mental health and wellness team has been a very welcome addition to the middle and high schools. The students at the school can sometimes face difficult situations at home (divorce, death of a parent or care giver, parents that may lack knowledge or support to provide all that is necessary for their child's development). The need for the additional services provided by the LiveWell team is clear. The teachers also spoke of some challenges. Teachers are often very busy themselves, and additional paperwork (for referrals) was seen as a barrier. Similarly, some mentors felt that they did not have easy access to the academic records that are needed to monitor progress of their mentees. At the high school, some respondents felt as if there was not enough feedback about student progress once the teacher referred a student to mental health services.

In addition, some mentors felt that they were not prepared to handle some of the complex problems of students.

Despite these concerns, many said that they would mentor again, and they felt as though the LiveWell team was responsive and supportive of faculty in mentoring roles. It appears from the interviews that the middle and high schools would benefit from an increased level of services from the LiveWell team.

Challenges and Solutions

One of the challenges for the SBHC is recruiting students. Ideally 75% of students would be enrolled in the SBHC, which would mean 375 students vs. 93 currently. The team hopes that the high visibility of sports physicals will help with enrollment. Mr. David Branham is aware of this issue and is making it a priority to increase enrollment. In addition, over the next few months, the SBHC team plans to have a CHW visit classrooms and tell students about the services offered. As an added measure, the School Improvement Council has offered to assist in supporting enrollment in the SBHC. CHW Becky Thompson will follow up with them. In the fall, the SBHC will be offering TDAPP shots for incoming freshman, which is a requirement for high school. This will greatly assist with helping parents who struggle with getting their children's needed immunization. During this fall, Mr. David Branham, reported that one freshman was out of school for an entire two weeks because he did not have the required TDAPP vaccine.

As services have been implemented, incomplete paperwork on the part of enrollees has hampered delivery of services. For example: the grief counseling sessions have only been able to complete student introductions, since many of the students have not returned registration paperwork. Commonly missing are copies of parent IDs and student social security cards. This paperwork is needed because of HIPAA and FERPA guidelines. Assistant Principal Rose Montgomery expressed that this is a problem generally at the school: paperwork sent home with students, often is not seen by parents. While there is a web portal for parents, not all parents have internet access. She suggested that creating a deadline for paperwork might motivate completion. She also offered that the school may be able to provide some of the missing information from their records.

As mentoring services have grown at the middle school and high school, wellness coordinator Emily Mancil has found that mentoring services have been more successful in the middle school setting, both with numbers of students and teachers participating, and in the consistency of meetings and interactions between students and mentors. The reasons for this are unknown, but could be related to additional stigma related to mental health issues at the high school, or higher teacher turnover. Emily is planning to meet with Rose Montgomery to discuss the issue during the next quarter.

North Central Middle School (top), North Central High School (bottom).

Recommendations:

- Focus on SBHC recruitment, including engagement with School Improvement Council and CHW visits to classroom
- Contact students and parents to collect outstanding paperwork
- Include the mental health counselor/graduate student at the student's IEP meeting
- Provide teachers that are mentoring with progress reports for the students they are mentoring (to eliminate time spent requesting student information)
- Consider creating criteria for mentoring to include: same gender, teacher that have had in past but not currently
- Provide email feedback to teacher that made initial referral and let them know if student is/ is not receiving counseling (just as fyi, no details needed)
- Plan on capacity level for mental health counseling could be expanded for Fall, 2016
- Have middle school vice principal and teachers share success of mentoring program to encourage high school teachers to participate

The Impact of a Visit

Visiting the School Based Health Center, even once, can have significant benefits over alternatives.

Consider the following:

- More than 5 unexcused absences can cause a student to lose credit for a semester. Charges for making up hours are $72.00 per day missed.
- The average visit to a General Practitioner costs $150.00
- A trip from North Central High School to Camden for a doctor visit would likely take two hours including travel time and visit time.

Three Current Cases at the SBHC:

Concussion:

- A student was referred to the SBHC from the emergency room with a concussion
- There were two visits with the SBHC, which were free
- Since the student was seen at school, his mother was able to remain at work, rather than taking time off over two separate days, which could have resulted in lost wages
- The student was able to be treated without any absences from school
- The student teachers could be notified to monitor in-class performance and grades, a benefit difficult to achieve with a general practitioner outside the school system

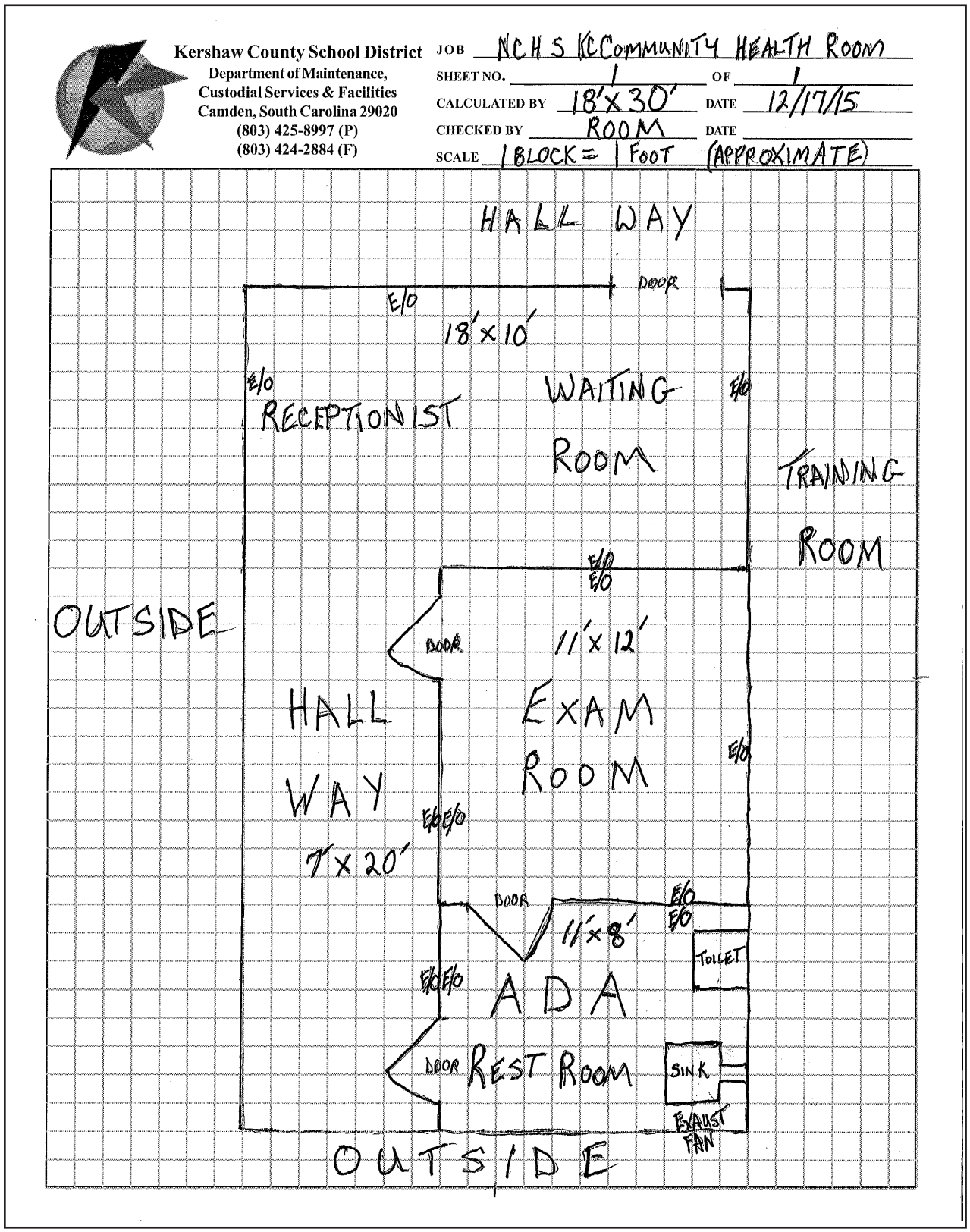
Acute Illness:

- A student was ill with a bacterial infection, and was treated at the SBHC
- Student needed to be sent home, but the Nurse Practitioner was able to write excused absence, avoiding potential penalties for unexcused absences
- Student's mother works third shift, and did not have to miss work to make an afternoon appointment with a general practitioner
- A Letter was sent to Primary Care Practitioner to inform and coordinate care

Acute Illness:

- An ill student was sent to the SBHC
- Student avoided trip to Primary Care Physician, thus saving the cost of a visit
- Student was able to go back to class, avoiding absences
- Student's mother was able to remain at work, avoiding lost wages

Floor plan for SBHC.



Prioritizing Our Patients Through the Hub & Pathway Model

Embracing Integration and Models

This quarter, the leadership continued to focus on integrating programs and initiatives and embracing a shared model for care coordination. This builds on our work for the past year and half as we are building a sustainable model to provide high quality services to vulnerable populations. Taking a systems-level approach and re-designing a free clinic model to serve as the backbone for population health in the county has taken an enormous amount of time and resources. However, we believe that the model and the progress described below will move us in the right direction and guide all of our activity in the future at a much more accelerated pace. We understand that this system change will impact the delivery of healthcare not only for North Central, but for the entire county as well.

The culture of continuous quality improvement continues to be embraced by leadership, by the board of directors, and by a majority of the staff. Holly Hayes worked very closely with Susan Witkowski in defining what care coordination will look like for the Community Medical Clinic moving forward and next steps. The activities that took place this quarter will influence the evaluation plan and measures selected moving forward with the DHHS contract. The Board of Directors is fully supportive of the efforts that have taken place. Susan Witkowski is actively moving forward with implementing decisions with the entire staff of 17. Over the next quarter, the leadership will assess each initiative and its corresponding evaluation data from the last year and determine what needs to be removed, modified, expanded or replicated moving forward.

Vision:
A healthier Kershaw where individuals and communities are empowered to take charge of their own health and well-being.

Mission:
We will lead a collaborative effort to provide the resources for improved health of the underserved, while always respecting the dignity, integrity and diversity of those we serve and those who serve.

Strategic Plan Part Two

On January 19, 2016, Holly Hayes facilitated part two of the strategic planning retreat with all of the staff of the Community Medical Clinic. The purpose of this retreat was to review the updated mission and vision statement developed by the board in November 2016 and to gain staff buy-in. The staff agreed and were excited about the updated mission and vision statements (see above).

The team also participated in a Marshmallow Challenge during the retreat based on the TED talk by Tom Wujec entitled “Build a Tower, Build a Team.” From this exercise, there was much discussion about what the “marshmallow” was for each of the goals developed from the strategic plan (see pages 26 - 29). One take-away from the exercise was the importance of identifying

assumptions early in any project and to test them early and often. Prototyping matters. If the group is going to be successful, we must continually prototype and refine throughout the process.

The group developed three-year goal statements and formed six initial sub-committees for each goal (See summary report, page 26 along with a six month timeline). The next steps in this process are to develop aims for each goal and measures (outcome, process, and balancing) for each of the goal statements and an accountability structure to monitor progress.

Rebranding of LiveWell Kershaw

After discussion with the Board of Directors, staff members, the Executive Director and two marketing experts, it was decided that the name "LiveWell Kershaw" would undergo a branding transition and become part of the "Community Medical Clinic." Previously, patients being seen at the satellite clinic sites by a Nurse Practitioner, were surprised to see them and thought that the Nurse Practitioners had changed jobs. The patients had no idea that LiveWell Kershaw is part of the Community Medical Clinic; all of the LiveWell Kershaw team members are employees of the Community Medical Clinic. In addition, some of the donors of the Community Medical Clinic were confused about all of the initiatives and what was taking place. The group currently has three logos and three branding statements that at times got very confusing for the volunteers, staff, board members and even patients. AccessKershaw's logo is an open door and is a grant funded by the Duke Endowment. LiveWell Kershaw is an initiative funded by a contract with DHHS and uses a multicolored logo. The Community Medical Clinic, an entity established 16 years ago, incorporates a dove in its logo.

As a result of these discussions the new logo for all entities, including LiveWell Kershaw, was created. The new logo is entitled the "Community Medical Clinic" with the branding statement "Outreach. Access. Medical Home." This encompasses all three arms of the mission of the Community Medical Clinic. Plans for the rebranding include The development of a roll out plan by the communications/marketing team. The new logo below will be incorporated into all our materials. Brochures are currently being developed to define services that will integrate the new Pathways Community HUB model as care coordination. Specific strategies are being put into place to phase out the LiveWell logo.

COMMUNITY MEDICAL CLINIC

Outreach. Access. Medical Home.

Site Visits to Determine a Best Working Model

In an effort to determine a best working model for the Community Medical Clinic, the Executive Director of the Community Medical Clinic and The Director of the AccessKershaw grant visited two Access sites in order to identify bright spots and direct application to the Kershaw site.

Tidelands Access

On January 18, 2016, Susan Witkowski and Whitney Hinson traveled to Georgetown, SC, to visit Linda Bonesteel, Director, and Carla Wham, RN Director, of Community Health Education at Tidelands Community Care Network, which is a part of Tidelands.

The Tidelands Community Care Network helps those that are age 19 or older with no health insurance. Like Access Kershaw, they can help individuals find a medical doctor that they can afford, get low-cost or free medications, work with a nurse to learn more about their medical condition, get rides to their medical appointments and see if they qualify for the health insurance exchange or Medicaid Healthy connections

Checkup.
They are an active part of the Tidelands Health Transitional Care Team. They are trying to do their part in prioritizing population health i.e. stratify, engage, manage. They also assign and direct interventions for the greatest impact to their hospital group including the Tidelands Community Care Network which encompasses the Access Health Program, Human Services Collaborative, Healthy Outcomes Program (HOP), and community health education and case management. Their health education is broken down into Prenatal/new born, children/youth, and adults/seniors. Tidelands Community Care Network also has an office visit form for the client to keep that identifies which provider the client is qualified to see.

Their staff structure consists of a Director, Intake Coordinator (2 CHW's, AmeriCorps Vista, and Welvista Liaison), Population Health Liaison (2 OB Education/Lactation consultants, Health Navigator, and a Wellness Works), Integrated Care Managers (2 CHE, 7 Care Coordinators, 2 Transitional Care Coordinators, Pharmacy Tech and RN) and a Program Grant Manager.

Application/Take-Aways: Linda Bonesteel shared their risk stratification model. We were able to take this model and adapt it to our community care coordination plan. We are able to build upon this by adding our resources that would support each category and redesign work flow and job descriptions. This became the basis for our staff development training session that was held on February 17th. The application of the Tidelands charity care program was unique. It was a tiered system and approach that was more cost effective than the KershawHealth plan, which has inherent steps that create unnecessary costs. Susan Witkowski will be sharing this with the KershawHealth executives in our partnership meetings.

Visual of an Integrated State shared at the January team meeting

Access Lakelands

On Feb 8, 2016, Susan Witkowski and Whitney Hinson traveled to Greenwood, SC, to visit Cyndi New, Director of Access Lakelands and Transition Care Clinic, and Dr. Ishenhowser, the Medical Director. Access Lakelands includes 7 counties- Laurens, Newberry, Abbeville, Greenwood, McCormick, Saluda, and Edgefield. They are part of Self Regional Hospital which is a clinically integrated Accountable Care Organization called My Health First Network. They have access to 38 Primary and Specialty care doctors. Their doctors have to see at least 10 Access Lakelands patients per year and 20 specialty care patients per year.

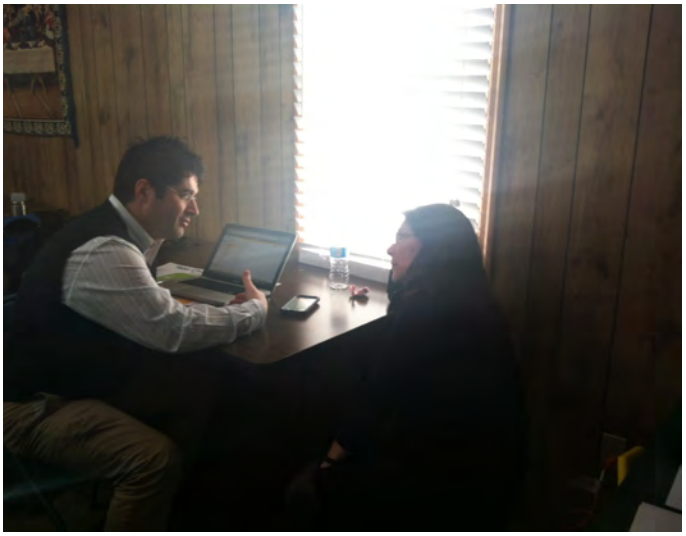
Their staff is made up of 3 CHWs, eligibility specialists, and an RN Care Coordinator. Certified CHWs go to at least the 1st medical appointments, work through the patients' social determinants, help find PCP, check on patients in hospital, advocate and are flexible on a daily basis. An eligibility specialist helps with the application process, referrals and calls so the CHWs can be more hands-on. The RN Care Coordinator handles

the care plans and is a medical resource for the high risk. She does a lot of following up to make sure it gets done. Dr. Ishenhowser plays a big role, he's their champion. He has contacts and relationships within the hospital.

Access Lakelands uses All Scripts and works with charity care specialists every day. They are interested in risk stratification. Currently they have 540 cases; 200-250 for each CHW. They use HOP funds to pay for specialty care at the Medicaid rate. They keep patients that find a payer source. Access Lakelands also works closely with their quality, readmissions team and inpatient case managers plus Welvista representative. In addition, the majority of their patients come from hospital enrollment.

They aren't a revenue generating hospital but they control cost and keep the cost down for the hospital. Four percent of hospital profit goes to their Community Health Committee to help pay for doctor's office, behavioral health, transportation (gas cards), and dentists at the Medicaid rate.

Cyndi attends practice manager meetings. Sometimes she has to advocate for her patients to be treated the same if not better.



Economist Ibrahim Demir and CMC Director Susan Witkowski discuss ER utilization.

Application/Take-Ways: Dr. Eisenhower's statement regarding private physicians' role in the delivery system was an eye opener. He said, "if we can make the physician's visit more meaningful we can impact the patient's outcome." By having the CHW's go with patients that were discharged from the hospital with a reconciled medication list and a summary of care, we will take the guess work out of the rushed 10 minute office visit. We are emphasizing in the first phase of the Care coordination model when we have CHW's attend these visits and measure the MD office visit with the patient.

Defining the Pathways Community HUB Model

As a result of the site visits, and discussions with Dr. Rick Foster of the SC Hospital Association and Laura Brennen of Communities Joined in Action, and communities participating in the Institute for Healthcare Improvement's Pathway to Pacesetter Program, the Community Medical Clinic has selected the HUB and Pathway model as our model for the care coordination of patients (Community Care Coordination Learning Network, 2010; Improving Health Outcomes with Pathways, 2012; Pathways: Building a Community Outcome Production Model, 2010; Redding et al., 2014; Zeigler, Redding, Leath, & Carter, 2014). The purpose of having a Community HUB is to coordinate the delivery of healthcare and social services for specific vulnerable and at risk populations. The Pathways model is a visual, logical work management tool that facilitates actions to resolve specific problem areas for at risk patients and measure associated health and socioeconomic outcomes. The HUB relies on community care coordinators - community health workers, nurses, social workers, and others to identify at-risk individuals. Once an at-risk individual is engaged, a comprehensive assessment of health, social, behavioral health, economic, and other issues that place the individual at increased risk is given. Each identified risk factor is tracked as a Pathway that confirms risk and is addressed through connection to evidence-based and best practice interventions.

The primary goal of the Pathways Community HUB model is to ensure timely provision of appropriate, high quality, cost-effective healthcare and social services that will have a meaningful impact on the health status and outcomes of those served. We can achieve this goal by focusing on those patients at greatest risk and those populations with the most significant disparities in health status and outcomes. In order to prioritize our patients along the Pathways Community HUB model we will use the following steps: stratifying the patient based on risk level, identifying appropriate pathways as needed, determining who is most responsible for the pathway, and achieving the most appropriate outcome and closing the pathway.

On February 17, 2016, a three and a half hour training was held with all of the Community Medical Clinic employees at Refuge Baptist Church. The objectives of the training included that at the end of the session participants would be able to do the following: 1.) Stratify patient based on risk level; 2.) Identify appropriate pathways needed for person based on case scenario; 3.) Determine who is most appropriate to be responsible for pathway; 4.) Understand the importance of outcomes and closed pathways. See page 5 for a visual of the Community Medical Clinic model and page 42 for the pathways identified that the entire team will focus on in the coming months. For each of these objectives, real scenarios were shared with the group and participants were walked through the model. Participants worked in groups to go through exercises and scenarios of how the Pathways Community HUB would be implemented. Group discussion emphasized the importance of stratification of risk, as well as understanding the different pathways and the importance of following through to ensure if outcomes were or were not reached for individual pathways. An audio CD of the training and manual was made for all of the participants and the training was also videotaped. Phase one of the Pathways Community HUB model will begin on April 18th. This phase will include: A strong emphasis on transitional care pathway (See pathways on page 42), working with the hospital discharge planners/case managers to reconcile medications, and attending physician follow up visits. Checklists and policies will be created for this pathway.

A summary of the evaluation of the training as well as recommendations for phase 1 are included on pages 23 - 25.

Roy Fakoury

Tying All of this Together

Roy Fakoury serves as the Chairman of the Community Medical Clinic and also serves as Chairman for Kershaw Health (part of the Capella/ MUSC Health network). Roy is passionate about improving population health in Kershaw County and credits the Community Medical Clinic board for being bold and willing to expand their mission and vision to something that is much broader. He noted that the board has embraced the selected model and is moving forward with a systems-based approach.

One of the critical pieces that has made the Community Medical Clinic so successful up to this point and will be important in moving forward with the re-branding, implementation of the strategic plan, as well as the execution of the Pathways Community HUB model are volunteers.

Mr. Fakoury shared the following with Holly Hayes:

"There is no way to determine a direct dollar or human impact for the volunteer network that supports the clinic. The volunteers are the foundation of the clinic, and I believe they are necessary as we move forward with increasing access to care and population health. It's absolutely clear to me that there is no other organization in Kershaw County that can do that but the Community Medical Clinic."

While the Clinic operates a school based health center at North Central High School, the Board of Directors would like to see health centers in every middle and high school in Kershaw County and possibly elementary schools within the next three years. When reflecting on this, Mr. Fakoury said this would "just be incredible." With the involvement of the parent and student organizations, teachers, and administrators, we will literally have "thousands of volunteers." Mr. Fakoury noted that when this happens, "you will have a population taking care of a population in a cost effective way." The board is embracing a long-term view of population health and executing strategies that will have profoundly positive health outcomes for Kershaw County.

Team members work through identifying the needed pathways for a case study.

Evaluation Survey Summary of February 17, 2016 Training

There were 12 participants that completed the survey. However, not all 12 responded to every question.

The majority of participants felt that they fully understood all the topics that were covered at the meeting. In addition, most of the respondents felt that implementing The Hub and Pathways Model would improve outcomes for our patients. There was only one respondent that felt the model would not improve outcomes.

When asked what was most pleasing about the session, participants had the following responses:

- Beginning to understand the "whole" picture better.
- Teamwork, giving examples, lunch, and setting.
- Topics.
- The cases we were assigned helped illustrate day to day situations that everyone will have to encounter. Very helpful.
- I really liked the mix between big group time and smaller group discussions. It helped me better understand the material to have that type of interaction.
- Setting was more relaxed than meeting at clinic.
- The topics and small group discussion.
- The tag team approach, between Susan and Holly, was very enjoyable.
- I thought breaking into small groups to learn each step was a good teaching method. The interaction between the groups was beneficial to processing the material.
- I think overall everything was great. I think this model and new structuring will be great for us and better for patients.

When asked for recommendations for future meetings that could enhance the learning experience respondents had the following responses:

- I think our meeting was great.
- None.
- I was ok with the last learning session.
- More marshmallow activities. I like having small elements of team building as well.
- It would be nice if we could meet at some of the areas that we serve.
- I felt like it was great the way it was. Everyone who put the meeting together did a fantastic job.

The majority of participants found Susan's presentation, the small group work, and group reflection to be enjoyable. Only one person did not enjoy the group work.

When asked for additional comments about the meeting, the following responses were collected:

- We could have used a little more time on a couple of the group activities.
- Holly's facilitation was key to the learning process. An organized packet of materials.
- I like it all. I am so glad to be a part of this organization and family. Together we can achieve new heights.

When asked what three things need to be in place for Phase I of The Hub and Pathway model to launch on March 14, 2016, participants had these responses:

1:

a. Job descriptions/duties
b. A clear understanding of what I will need to do/should anything be done differently?
c. Have an Access Case worker at CMC every day
d. A clear understanding of role
e. Better understanding of newly defined roles
f. Every employee understands his/her role in a client health
g. Direction from leadership on where to record stratification level, assigned pathways, who is responsible, progress on pathway, etc.
h. Job descriptions
i. Roles and responsibilities need to be clearly laid out of who is responsible

2:

a. Trust
b. IMS for all facilities
c. Understanding that we might get it wrong before we get it right
d. Be ready to do what your job requires
e. More clarification from leadership, as to who will be handling what, within scope of practice
f. Clear roles for working in each risk category
g. Paperwork needs to be synonymous in all parts of our organization

3:

a. Communication
b. Everyone to get along!
c. We need patience and guidance from our leaders as we move forward, as well as feeling supported and valued
d. Everyone to work hard to improve a great outcome for the patients
e. How will tasks be communicated, documented, etc., i.e. a team member from another site sees a patient but the patient's need does not require their particular scope of practice and can be handled by another team member, how will these requests be communicated?
f. Staff development
g. A meeting together to establish these things

References

Community Care Coordination Learning Network. Connecting those at risk to care: a guide to building a community "HUB" to promote a system of collaboration, accountability, and improved outcomes. Rockville, MD: Agency for Healthcare Research and Quality (AHRQ); September 2010. AHRQ Publication No. 09(10)-0088.

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COMMUNITY MEDICAL CLINIC

Serving the uninsured of Kershaw County

Proposed Strategic Plan approved by full board on 2.3.16
Updated Mission and Vision Statements

Vision:

A healthier Kershaw where individuals and communities are empowered to take charge of their own health and well-being.

Mission:

We will lead a collaborative effort to provide the resources for improved health of the underserved, while always respecting the dignity, integrity and diversity of those we serve and those who serve.

Core Values:

- Patient and community centered
- Value all human and financial resources and use them wisely
- Compassion
- Acting with integrity and honesty
- Innovation
- Dignity and respect
- Diversity
- Quality
- Accountability and transparency
- Continuity of care
- Empowerment
- Overall well-being

Three-Year Goal Statements and Initial Sub-Committees for Each Strategy

Strategy: Facilitate Improved Access to Needed Services
Goal: Provide resources and knowledge to access needed health and social services.
Sub-Comm.: Geraldine, Jeana and Karen

Strategy: Community Outreach and Engagement
Goal: Be the recognized leader in improving population health in Kershaw County.
Sub-Comm.: Cynthia, Keri, Whitney, Beckie, and Sheri

Strategy: Expand Diversity and Scope of Services
Goal: Provide client-centered holistic care to meet an individual's and a family's needs.
Sub-Comm: Susan G, Susan W, Leigh, Mary

Strategy: Provide Preventative Activities to Promote/Support Population Helth
Goal: Provide ongoing community wellness and fitness education promoting healthy lifestyles.
Sub-Comm.: Rachael, Sarah

Strategy: Ensure Effective Data Management Systems
Goal: Achieve integrated internal systems and 100% connectivity; achieve effective data interchange with healthcare partners
Sub-Comm.: Susan W, Ron, Susan G

Strategy: Diversify and grow revenue sources to ensure sustainability of clinic
Goal: 100% Sustainability by Year 3 plus Substantial Endowment Fund
Sub-Comm.: Roy, Jim, Susan W

	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec
PROVIDE RESOURCES AND KNOWLEDGE TO ACCESS NEEDED HEALTH AND SOCIAL SERVICES	Ibrahim conducts scatter map scan for ER visits		Send out communica-tion to all volunteers about needing drivers	**Secure insurance for volunteers to drive personal vehicles**	Get a driver czar	Actively recruit driver volunteers Explore repurposing LWK van	Partner with Grocery van to see if CMC could be a permanent stop Partner with pastors of churches to be drivers/use church vans	Create communica-tion materials	Launch volunteer uber partnership Request labs to be done on-site in Bethune	Begin discussion about planning more sites within 10 miles of home Explore getting access a site in Elgin/Lugoff and in between Bethune		
BE THE RECOGNIZED LEADER IN IMPROVING POPULATION HEALTH IN KERSHAW COUNTY		Follow up meeting with discharg e planners **Re-Brand**	Launch one website Conduct focus groups in Lugoff and Elgin Create internal communica-tion plan		Target patients and voluntee rs in Lugoff and Elgin to tell their personal stories with CMC		Create external communic ation plan					
TARGET PATIENTS AND VOLUNTEERS IN LUGOFF AND ELGIN TO TELL THEIR PERSONAL STORIES WITH CMC	Recruit volunteer leader champion in Lugoff and Elgin	**Baseline needs assessm ent for specialty care**	Plan in place for health coaching for diabetics Evaluation of case management sessions and outcomes Develop new agreements with all specialists			Recruit volunteer leader champion in Lugoff and Elgin	Explore dental componen t				Begin telehealth discussion s	Explore becoming a dispensing pharmacy

	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec
PROVIDE ONGOING COMMUNITY WELLNESS AND FITNESS EDUCATION PROMOTING HEALTHY LIFESTYLES						**Needs assessment of current fitness and wellness activities in county**		Hire a health program coordinator Create our healthcare initiative	Partner with schools to expand health care initiatives		Create a pilot of healthcare initiative in North Central churches	Create virtual library of health resources
EFFECTIVE DATA MANAGEMENT SYSTEMS			Explore landline internet access for mobile sites to be included in facility use agreements	Explore data sharing with Access partners		Verify with FoxMeadow if case managment can be done. Review fhases.						Standardize training Standard policy and procedures for entering and collecting data
DIVERSIFY AND GROW REVENUE SOURCES TO ENSURE SUSTAINABILITY OF CLINIC	Engage consultant in feasibility and major donor campaign Research and submit grants	Contracted Donor Path to assist with general fund raising campaigns	Present major donor feasibility study Clinic Classic	Implement Major Donor Plan Conduct general fundraising campaign Hire Development Director				Conduct general fundraising campaign	Attic Sale	Discuss options for endowment	O&BBQ	Conduct Annual campaign

Care Coordination

Extend primary care in the community to increase access and care coordination

CHWs Beckie Tompkins and Rachael Sladek

A. Satellite Care Coordination Sites

The care coordination team continues to serve the North Central area with community outreach and care coordination services. Beckie Tompkins has transitioned fully as a Community Health Worker at 32 hours a week. Karen Baker continues to serve as a Community Health Worker for the KARE site and is now assisting with case management. Rachael Sladek continues to primarily serve the western part of the North Central area.

Continuous Quality Improvement is being applied in order to improve the productivity of each site. DeKalb Baptist Church's hours were changed to the 1st and 3rd Tuesday of every month from 9 AM – 1 PM to coincide with the church food bank's hours. Beckie Tompkins is still hopeful about the potential for this site, given that on any Sunday there could be up to 300 individuals in attendance. Beckie is conducting multiple PDSA cycles and is working on ways to best engage the residents who live near DeKalb Baptist Church. In addition, the entire care coordination team participated in a New Leaf training this quarter and will begin applying the general health coaching curriculum with clients.

The system for entering data into Fhases, the case management system for the care coordination team, is being modified. A single process for entering data is being created through written policies. In addition, a formal training of Fhases is planned for March 2016 with the care coordination team.

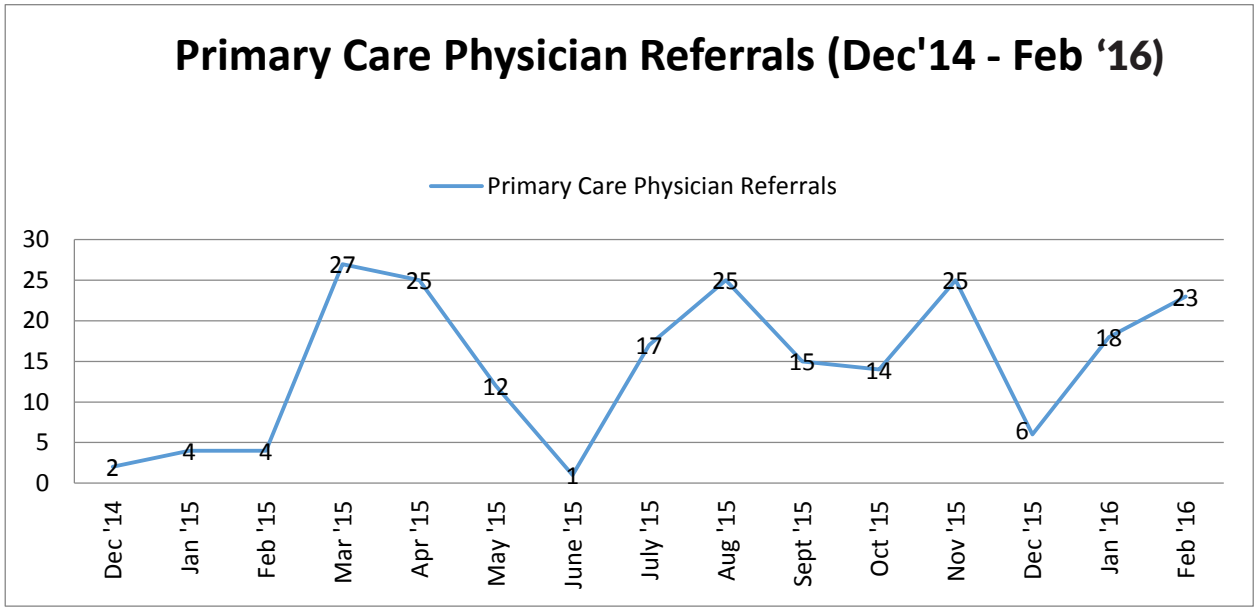
Future plans include the following:

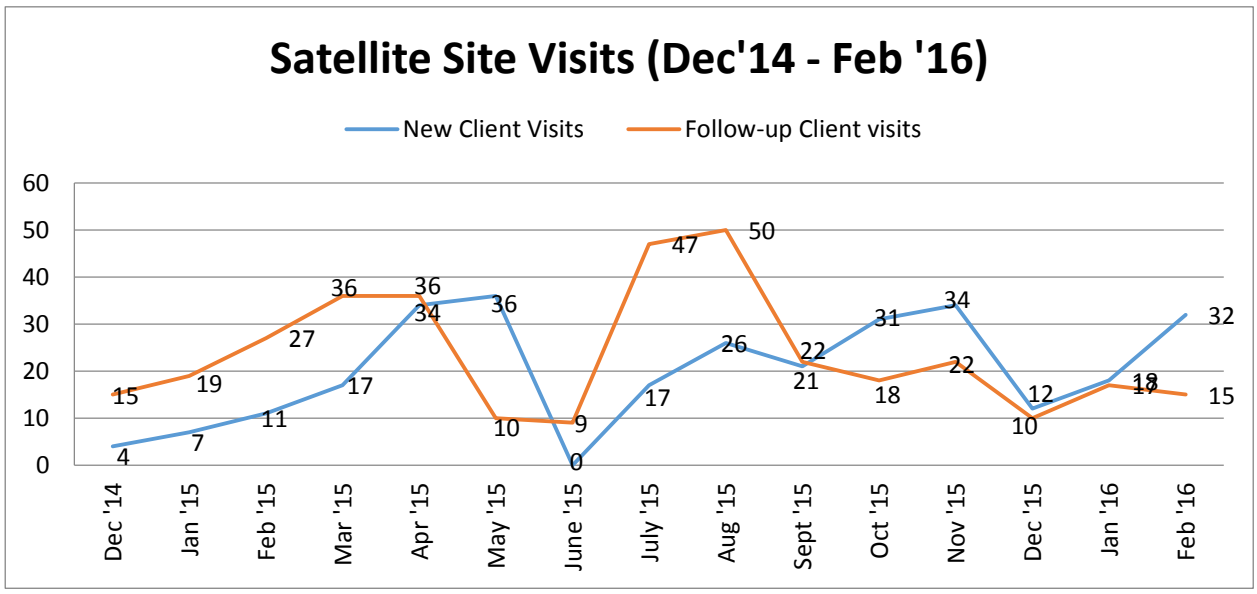
- Reach out to CareSouth to learn about mobile van outreach in Chesterfield
- Schedule our first New Leaf, CPR, and Nutrition class
- Grow DeKalb First Baptist satellite site by visiting on food bank days
- Check CHW documentation in Fhases weekly
- Create two Community Councils

Satellite Sites Productivity: 3rd Quarter

Satellite Sites	December			January			February		
	New Client Visits	Follow-Up Visits	No-Shows	New Client Visits	Follow-Up Visits	No-Shows	New Client Visits	Follow-Up Visits	No-Shows
Cassatt	2	0	0	4	3	0	3	2	1
Sandy Level	2	5	0	1	5	0	2	3	0
Refuge	4	3	0	7	6	0	6	1	0
Buffalo	3	0	0	3	1	0	8	1	0
KARE	0	0	0	1	2	0	1	4	0
DeKalb	2	2	0	1	0	0	2	0	0
Home Visit	0	2	0	0	0	0	0	0	0
Total	13	12	0	17	17	0	22	11	1

CHW Activities	December	January	February	Total
ER Calls	141	160	66	367
Primary Care Physician Referrals	8	18	23	49
SNAP Applications	5	11	5	21
Welvista Applications	9	15	11	35
SS Disability Assistance	2	3	4	9
Extra Help Application	1	4	3	8
With Medicare Medicaid	3	1	1	5
Case Management	0	0	1	1
Home Visits	0	0	1	1
Mental Health Referrals	0	0	1	1
Dental Referrals	1	2	1	4
PAP Applications	0	0	1	1
Charity Assistance	2	1	4	7
Vision Referrals	1	0	0	1
HOP Sessions	0	2	1	3
ACA Navigations	0	0	0	0


Primary Care Physician Referrals (Dec'14 - Feb '16)
Primary Care Physician Referrals
30
25
20
15
10
5
0
2
4
4
27
25
12
1
17
25
15
14
25
6
18
23
Dec '14
Jan '15
Feb '15
Mar '15
Apr '15
May '15
June '15
July '15
Aug '15
Sept '15
Oct '15
Nov '15
Dec '15
Jan '16
Feb '16


Satellite Site Visits (Dec'14 - Feb '16)
New Client Visits
Follow-up Client visits
60
50
40
30
20
10
0
4
7
11
17
34
36
0
17
26
21
31
34
12
18
32
15
15
19
27
36
36
10
9
47
50
22
18
22
10
17
18
Dec '14
Jan '15
Feb '15
Mar '15
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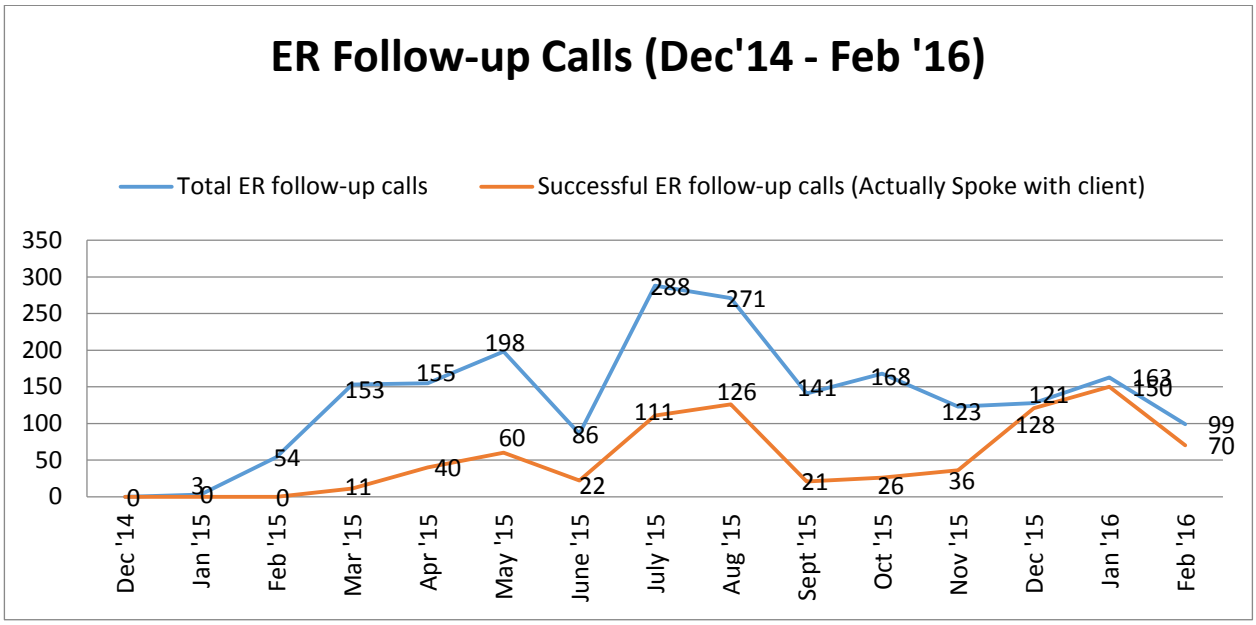
July '15
Aug '15
Sept '15
Oct '15
Nov '15
Dec '15
Jan '16
Feb '16



Third Quarter Client Satisfaction Survey Summary

A paper-based satisfaction survey was administered to clients from December through February. The purpose of this survey is to determine how receptive clients are to the services provided by the CHWs. After each face to face visit, clients are asked to complete the survey. 61 out of 75 clients completed the survey. The clients then returned the completed surveys to a sealed container to maintain confidentiality. Kathryn Johnson collects the surveys weekly to analyze the data. The summary of the survey findings are as follows:

Which community health site did you visit today?		
Answer Options	**Response Percent**	**Response Count**
Buffalo	13.1%	8
Cassatt	23.0%	14
DeKalb	4.9%	3
Refuge	31.1%	19
Sandy Level	21.3%	13
Other	6.6%	4
	answered question	61
	skipped question	0

From the respondents of the survey, we were able to determine that an overwhelming majority of our clients found that our health site locations and hours provided were convenient. Our Community Health Workers, Rachel Sladek and Karen Baker, each served similar amounts of clients. Rachel served nearly 56% of survey respondents while Karen served 44%. Beckie Tompkins joined us as one of our new CHWs near the end of February and served 3% of clients. Of the clients that were served, all felt that they could easily

talk with the CHW, that they received kindness and respect during their visit, that health information was clearly communicated by the CHW, and that enough time was spent with them during their visit. All of the respondents felt that the CHWs were either very or somewhat knowledgeable about the reason for their visit.

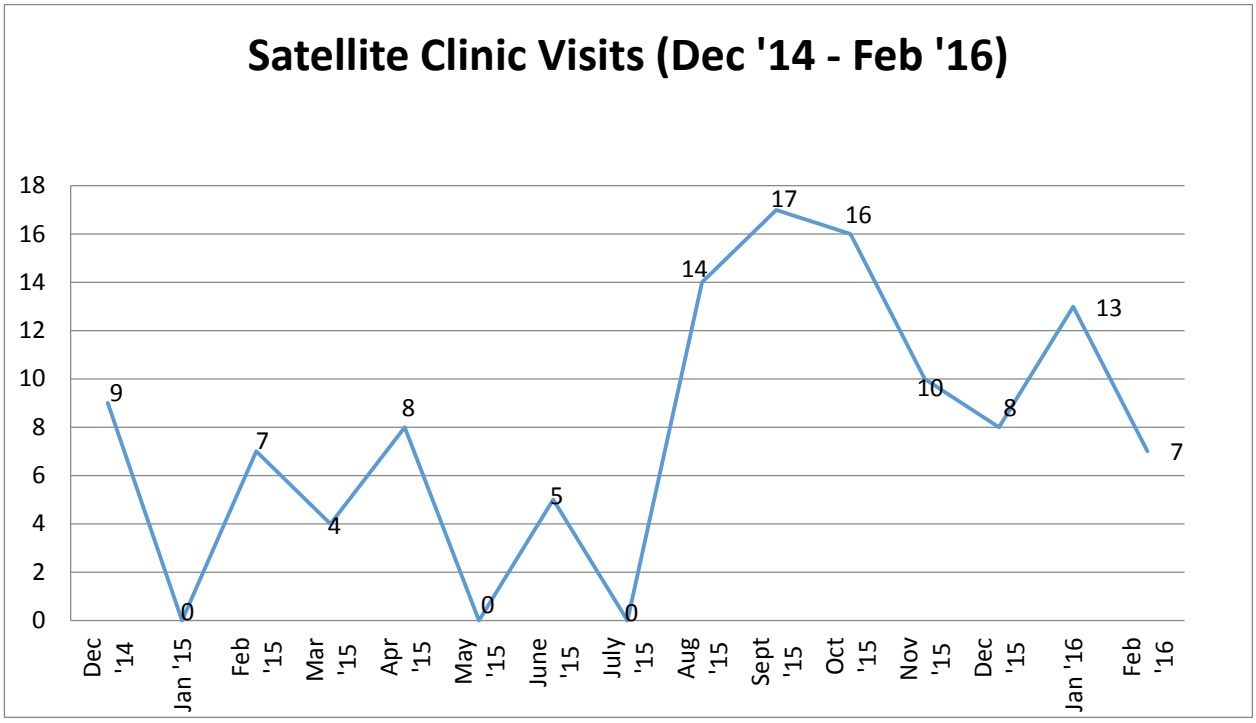
The most common services received by clients are referrals to Primary Care Physicians (53%), help with Medicaid applications (44%), and assistance with applying for SNAP (37%). Other services utilized by clients include: Pharmacy Assistance, Social Security Disability, Mental Health referral, Dental referral, Vision referral, Utilities Assistance, Transportation Assistance, Medical Bills Assistance, Blood Pressure taken, Blood Sugar test, and other services.

From the responses collected, all respondents noted that they were either very satisfied or satisfied with their visit. In addition, an overwhelming majority of clients indicated that they would recommend LiveWell Kershaw services to family, friends, and co-workers.

B. Satellite Clinics

The satellite clinics continue to serve North Central residents via a Nurse Practitioner along with a Community Health Worker and volunteers. The Nurse Practitioner providers primary care services to patients who are unable to be seen at a regular doctor's office or who have transportation challenges. The services include but are not limited to: sick visit, primary care visit/check-up, prescription visit, chronic disease management, urinalysis, and health education. Due to one Nurse Practitioner on maternity leave, and one Nurse Practitioner who left the clinic to take a different job, the Community Medical Clinic had a shortage of Nurse Practitioners to serve the satellite clinic and the main clinic office in Camden. The satellite clinic sites (Cassatt, Sandy Level, Refuge, and Buffalo) are still operating from 9 am – 1pm on a rotating basis.

Satellite Clinic Productivity				
Location	**December**	**January**	**February**	**Total**
Cassatt	No satellite clinic scheduled	Rescheduled patients to another site due to Provider capacity	Rescheduled patients to another site due to Provider capacity	0
Sandy Level	No satellite clinic scheduled	6	3	9
Refuge	8	3	4	15
Buffalo	No satellite clinic scheduled	4	Rescheduled patients to another site due to Provider capacity	4
Total	**8**	**13**	**7**	**28**



Third Quarter Satellite Clinic Satisfaction Survey Summary

The purpose of the survey is to determine how receptive patients are to the services, since many do not have means to receive primary care anywhere else. Surveys were completed for all 28 satellite clinic visits. Of the 28 surveys, we were able to determine that the majority of our clients served were seeking care from the Refuge location, followed by the Sandy Level location. Other sites included Buffalo, and Cassatt. The survey results also indicate a nearly even split among how long it takes clients to reach the satellite clinic locations. According to results it takes clients less than 5 minutes, 5-10 minutes, or 10-20 minutes to reach the satellite clinic for their appointment. In regards to appointment wait time, 50% of clients reported no wait. While other clients did experience some wait time. Length of wait time experienced is outlined in the following chart.

How long did you wait to be seen today by the medical provider (medical doctor or nurse practitioner)?		
Answer Options	**Response Percent**	**Response Count**
No wait	50.0%	14
Less than 5 minutes	3.6%	1
5-10 minutes	25.0%	7
10-20 minutes	10.7%	3
More than 20 minutes	10.7%	3
	answered question	28
	skipped question	0

Of the responses provided, nearly all clients felt that it was easy to make an appointment and easy to talk with the medical provider. An overwhelming majority of clients felt that they were treated in an excellent manner by the medical provider, that health information was communicated clearly by the provider, and that enough time was spent with them during the appointment. In regards to type of services received, 71% visited the clinic for a Primary Care visit or check-up while 50% visited for a prescription or refill. Other services that were received included sick visits, health education and lab work reviews.

Clients rated the services that they received as either excellent or very good. In addition, all indicated that they would recommend LiveWell Kershaw satellite clinic services to family, friends, and coworkers.

CHW Karen Baker discusses some possible options for healthcare with a client at Refuge Baptist Church.

Flyer sent to parents by Kershaw County School District email server.

Are you a Kershaw County resident living in one of these areas: Bethune, Buffalo, Cassatt, DeKalb, Kershaw, Liberty Hill, Mt. Pisgah or Westville?

No health insurance and need a doctor?
Can't afford your medicine?
Need to apply for Medicare, Medicaid, or SNAP "food stamps"?
Need help with managing your diabetes or high blood pressure?

Do you or someone you know need these services? Many are available at no charge. Call (803) 272-8325 for more information and to schedule an appointment at one of our Satellite Sites.

Satellite Sites

Day/Time	Location
MON 9 am - 1 pm	Cassatt Baptist Church 2604 Hwy 1 North Cassatt 29032
TUES 9 am- 1 pm *	DeKalb Baptist Church 2034 DeKalb School Rd Camden 29020
TUES 9 am - 1 pm	Sandy Level Baptist Church 2920 Timrod Rd Bethune 29009
WED 9 am - 1 pm	Refuge Baptist Church 2814 Lockhart Rd Kershaw 29067
THURS 9 am - 1 pm	Buffalo Baptist Church 6390 Lockhart Rd Kershaw 29067

**1st and 3rd Tuesday each month.*

LiVeWell KERSHAW
"Your Bridge to Better Health"

110 C East DeKalb Street Camden, SC 29020
803.272.8325 livewellkershaw.org

LiveWell Kershaw, an initiative of Community Medical Clinic of Kershaw County, is working to make Kershaw county the healthiest county in the state of South Carolina. LiveWell Kershaw focuses on health issues impacting the North Central area: heart disease, high blood pressure, diabetes and behavioral health conditions. Our partners include AccessKershaw, KershawHealth, Community Medical Clinic of Kershaw County, and the Arnold School of Public Health, USC.

Community Engagement & Outreach

Create vibrant relationships and functional networks with community members to accelerate trust, outreach and achievement of a shared goal.

Progress from December – February, 2016

The Community Medical Clinic team participated in various community events this quarter to increase awareness of the care coordination services provided through the contract (see detailed timeline on pages 40 - 42). Presentations were made at Kershaw County Vocational Rehabilitation Center, Elgin Primary Care, the Lion's Club, United Way Health Care Council, and Elementary, Middle, and High School Student Improvement Councils. Community Health Workers amplified their efforts by working with local businesses and consistently meeting with managers and workers on a weekly basis in order to increase awareness of the initiative in the North Central Area. In addition, Community Health Workers also passed out post cards that included the church schedule.

During this quarter, one volunteer was recruited and trained to work in the North Central Area. The volunteer is assisting Community Health Worker Beckie Thompkins twice a week at Refuge Baptist and at Dekalb Baptist. A volunteer training was held on January 15, 2016, at the Community Medical Clinic in Camden with 29 participants. Volunteers serve as the backbone of the clinic and provide over 10,000 hours of service annually. Whitney Hinson gave a brief presentation about LiveWell Kershaw and encouraged volunteers to consider volunteering at the local churches in the North Central Area. The Volunteers/Special Events Manager, Cynthia Nelson, is working on developing a modified training that will take place in North Central. She will also invite volunteers to begin working at one of the local churches. During the

Volunteers/Special Events Manager Cynthia Nelson

months of June through August, there is a strategic initiative to actively recruit both volunteers and volunteer nurses.

Susan Witkowski and the entire care coordination team visited KershawHealth on January 19, 2016. They met with seven discharge planners and provided lunch. Susan Witkowski presented information regarding the Community Medical Clinic's satellite clinics and church sites in the North Central Area. All of the discharge planners received packets that outlined the services that are available. The discharge planners were excited about receiving the information and having support for transitional care for North Central residents. The biggest barrier voiced by the discharge planners was finding medication for patients that cannot afford to have prescriptions filled. Follow-up meetings are scheduled to continue the development of a referral process for those discharged from the hospital.

Flu shots were also made available to high school and middle school students and also for church residents at Cassatt, Sandy Level and Refuge

Baptist Churches on December 17-18 and 21-23. Only one person received a flu shot during these five days. The flu shots were given at no charge.

Members of the community council advisory committee continue to meet monthly and guide the Community Health Workers on their efforts. A master calendar is shared with members in order to discuss upcoming events and who can assist with outreach. In addition, a church database containing the names of all of the churches in North Central was shared with members of the Council. Individual members are charged with connecting with a pastor or church member regarding the satellite clinic sites and available care coordination services. In April, two Community Councils will be formed to reduce the travel time for residents living on the other side of the county. Beckie Thompkins will lead the western part of the county (this Council is established) and Rachael Sladek will lead the eastern part of the county.

Plans for the next quarter include:

- Work with NCHS Student Improvement Council to reach NCHS parents in need at school activities
- Attend Eat Smart Move More meetings to network and learn of resources for our clients
- Continue volunteer recruitment
- Continue working with Guadalupe Vincent at Vocational Rehabilitation to build trust with North Central Hispanic population
- Partner with the Community Friendship Fiesta on April 9, hosted by the ALPHA Center & Sen. Vincent Sheheen

Timeline of Events for this Quarter

DATE	STAFF	DESCRIPTION	LOCATION	OUTCOME
Dec 1	Whitney	LWK Presentation to Voc Rehab	Camden	8 attended, spoke to staff
Dec 4	Whitney	Elgin Primary Care	Elgin	Spoke to Dr. Varughese, Keisler, Wideman, Harleston and staff
Dec 7	Rachael & Whitney	LWK presentation at Lion's Club Meeting	Bethune	30 attended. Signed up a volunteer.
Dec 7	Rachael	SIC	Mt. Pisgah	10 attended, assisted DHEC with Healthy Food demo. Discussed a walking program for students and parents
Dec 8	Rachael, Whitney	SBHC NCHS Advisory Board	Kershaw	8 attended, SBHC update, discussed procedures
Dec 9	Whitney	United Way Health Care Council	Camden	6 attended, discussed fund allocation for community health partners
Dec 10	Rachael, Beckie, Karen, Whitney	Community Council	Kershaw	12 attended, discussed outreach ideas & plans
Dec 17, 18, 21- 23	CHWs	Flu Shots available	NCHS, NCMS, Cassatt, Sandy Level, Refuge	1 attended
Dec 28	Karen	KARE Mobile Food Van, Jefferson Bapt.	Jefferson	58 attended, checked bp
Dec 29	Karen	KARE Mobile Food Van DeKalb Baptist	Camden	4 attended, checked bp

DATE	STAFF	DESCRIPTION	LOCATION	OUTCOME
Jan 14	Rachael, Beckie, Karen, Whitney	Community Council	Kershaw	9 attended, discussed quarterly data, community master calendar
Jan 19	LWK staff	Discharge Planners Meeting at KershawHealth	Camden	Quick intro & information session with a follow up with them giving more time for discussion.
Jan 22-23	Karen	Benefit lunch & dinner at Refuge Baptist	Kershaw	150 attended, 100 bps done, 52 glucose check
Jan 25	Karen, Beckie, Holly, Susan W., Whitney, Rachael	NCHS Open House & 9th Grade Orientation	Kershaw	Presentation, Enrolled students into the SBHC
Feb 1	Rachael	SIC, Bethune Elem	Bethune	10 attended, Assisted DHEC with Food demo. Presented Family Fitness Bingo Game and walking club for teachers.
Feb 1	Beckie, Susan G.	NCHS SBHC Mental health component continues & Phase 2 begins	Kershaw	Mondays and Thursdays students can be seen by the NP.
Feb 8	Rachael	SIC, Mt. Pisgah Elem.	Mt. Pisgah	10 attended, Presented Family Fitness Bingo and Teacher Mileage Club, discussed LWK and gave out postcards
Feb 11	Beckie, Rachael, Karen, Whitney	Community Council	Kershaw	10 attended. Guest speaker on Community Nutrition Programs, Church Database discussion and responsibilities

DATE	STAFF	DESCRIPTION	LOCATION	OUTCOME
Feb 16	Beckie	DeKalb Harvest Hope Food Delivery	DeKalb Baptist	Met with congregation volunteers and some partici- pants (approximately 25) offering info on LWK.
Feb 23	Susan W, Susan G. Whitney, Rachel, Beckie	NCHS SBHC Advisory Council	NCHS	Review efforts at SBHC with school staff

LiveWell KERSHAW
"Your Bridge to Better Health"

Newsletter

PO Box 142 Cassatt, SC 29032
livewellkershaw.org

Fall 2015

Contact: whinson@livewellkershaw.org 803.900.5598

facebook.com/LiveWellKershaw
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Bethune Fall Festival

Community Health Worker Rachael Sladek attended The Fall Festival at Bethune Elementary on November 13. Rachel shared the game "My Plate" with Bethune students, parents, and Bethune town council members. My Plate is designed to educate children about the five food groups that make up a healthy diet.

"It was exciting to see how much the children enjoyed playing the My Plate game. They had fun, while learning at the same time," said Rachael. "Many of the children came back multiple times to play because they enjoyed it so much!"

Students at the Bethune Fall Festival learned about healthy eating by playing the My Plate game.

Flu Shots at School Based Healthcare Center

The SBHC at North Central High School offered flu vaccinations for students in November. Karen Baker, LPN, CHW and Leigh Reed, LPN at the Community Medical Clinic, partnered to administer the vaccinations during the students' lunch period and after school.

"The SBHC is a huge asset to the administration, teachers and students," said Rose Montgomery, NCHS Assistant Principal.

Flu shots will also be offered at the community healthcare sites on December 21 - 23. Cassatt Baptist, Sandy Level Baptist, and Refuge Baptist will offer vaccinations during regular hours (9am - 1pm); they will also be available on December 28 at Jefferson First Baptist Church (11:30 am - 12:30 pm) and on December 29 at DeKalb Baptist Church (11:30 am - 12:30 pm). The cost is $10 per vaccination.

The SBHC also offers counseling services for students. In 2016, a nurse practitioner will begin administering expanded services including some diagnostic care and prescriptions.

Volunteer with Us!

The Community Medical Clinic of Kershaw County hosted LiveWell Kershaw's volunteer training on October 8. The one hour session was facilitated by Community Medical Clinic Director Susan Witkowski with help from the CHWs and the Outreach & Evaluation team.

Volunteering is a great way to learn more about the community and its health challenges. Find out how you can help in the clinic, at our Community Based Healthcare Sites, and at community events. For more information contact Cynthia Nelson: (cnelson@cmcofkc.org, 803.713.0806).

CMC Director Susan Witkowski (center) trains new volunteers about diabetes care.

Welcome Beckie Tompkins!

Beckie Tompkins, former Healthy Outcomes Plan (HOP) coordinator with Access Kershaw, will be joining LiveWell Kershaw as the newest Community Health Worker. Look for Beckie at all of our community healthcare sites located throughout the Bethune and North Central area!

Community Council Meeting in January

Are you interested in helping make the Bethune and North Central community a healthier place to live, work, and play? Join us January 14 from 6 - 7pm at Refuge Baptist Church (2814 Lockhart Rd Kershaw 29067). Meetings are the second Thursday of the month at Refuge. We hope to see you there!

Upcoming Mobile Clinic Dates

December 16	Refuge Baptist Church
January 12	Sandy Level Baptist
January 20	Refuge Baptist Church
January 28	Buffalo Baptist Church

The mobile clinic offers many of the same primary care services available in a doctor's office or a clinic . To schedule a mobile clinic visit please call 803.272.8325.

Clinic hours are 9 am - 1 pm. Please visit our website to find out more.

Community Healthcare Site Schedule	
MONDAY 9am - 1pm	Cassatt Baptist Church 2604 Hwy 1 North Cassatt, SC 29032
MONDAY 3pm - 7pm	DeKalb Baptist Church 2034 DeKa lb School Rd Camden 29020
TUESDAY 9am - 1pm	Sandy Level Baptist Church 2920 Timrod Road Bethune, SC 29009
WEDNESDAY 9am - 1pm	Refuge Baptist Church 2814 Lockhart Road Kershaw, SC 29067
THURSDAY 9am - 1pm	Buffalo Baptist Church 6390 Lockhart Rd Kershaw, SC 29067

A Success Story Continues

Last spring we reported the story of "Susan," a Cassatt woman who has been unable to work since a blockage was discovered in her brain. Susan had no insurance or disability coverage and continually postponed her needed tests. She also faced paying $300,000 in outstanding medical bills.

With the help of CHW Karen Baker, Susan enrolled in the Medicaid Innovation Accelerator Program (MIAP) and her bills were resolved within 30 days. Karen continued to work on Susan's behalf, supplying requested documentation to the Social Security and Medicaid offices. In July, Susan received approval for Social Security benefits including Medicaid.

Susan underwent her needed cerebral angiogram test in October and received promising results. Karen and LWK have been life changing for Susan; she has continued her follow-up appointments at the Refuge Baptist Church community healthcare site and continues to recover her health.

Connect with us online!

facebook.com/LiveWellKershaw

@lwkershaw

LiveWell Kershaw is a group of healthcare providers, businesses, schools, churches, and local citizens working together to make Kershaw County the healthiest county in South Carolina. LiveWell Kershaw focuses on health issues impacting the North Central area: heart disease, high blood pressure, diabetes and behavioral health conditions. Our partners include AccessKershaw, KershawHealth, Community Medical Clinic of Kershaw County, and the Arnold School of Public Health, USC.

PO Box 142 Cassatt, SC 29032
livewellkershaw.org

LiveWell Client Check-In Form.

Instructions: Please make selections with a check mark.
Responses are anonymous.

Do you have health insurance?

☐ Yes ☐ No

What may we assist you with today (check all that apply):

☐ Finding a Doctor
☐ Finding Affordable Medication
☐ Applying for Food Stamps
☐ Applying for Medicaid/Medicare
☐ Applying for Social Security Disability
☐ Shelter, Food, Glasses or Clothing Assistance
☐ General Health Education
☐ Other medical care: _____

_____

_____

Thank you!

110 C East DeKalb Street Camden, SC 29020
livewellkershaw.org 803.272.8325

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LiVeWell KERSHAW

"Your Bridge to Better Health"

Quarterly Report

Year Two Quarter Four

We will lead a collaborative effort to provide the resources for improved health of the underserved, while always respecting the dignity, integrity and diversity of those we serve and those who serve.

March 1 - May 31, 2016

Table of Contents

Introduction

June 1, 2016

As year two comes to a close, we are excited about what we have collectively accomplished as a community and realize that our mission in Kershaw County is not yet fulfilled. Despite our successes in creating a School-Based Health Center at North Central High School, establishing mobile sites for care coordination at churches, integrating mental health and primary care in the clinic setting and establishing a culture of continuous quality improvement, more is needed.

This past month we said farewell to Abby Bode and Emily Mancil, doctoral students in USC's Department of Psychology, who continued incredible work with one-on-one counseling, grief sessions, and teacher and student mentoring at North Central Middle and High Schools. In April, we expanded our team to include Mariana Martinez, a bilingual Certified Nursing Assistant, who has been volunteering at the Community Medical Clinic for the past 7 ½ years. She is now assisting the Nurse Practitioners with the School Based Health Center as well as the church mobile sites. Christie Derrick also joined the team as a licensed family and marriage counselor and is providing mental health counseling through an integrative medicine model to Community Medical Clinic patients.

We continue to have team meetings for training, sharing of lessons learned and co-designing the next phase of LiveWell Kershaw. We continue to struggle with connectivity at our rural sites in North Central, but are now working to install permanent internet lines at all sites and also encouraging our legislators to make this an advocacy issue. We have incorporated an online project management platform, known as "Quip," into our daily operations in order to stay abreast of all activities and outputs from the various components of LiveWell Kershaw. Many of our staff are remote and may not see team members face to face except once a month. Continual communication, meaningful relationships and collaboration are critical pieces that have accelerated our work.

The Robert Wood Johnson Foundation's County Health Rankings report was released this past month, and Kershaw County is now ranked 14th in 2016 for health outcomes as opposed to 10th in 2013. We realize that different factors and weights are being used in the latest algorithm of county health. We still need to continue to press on. As we move forward, we continually ask ourselves these questions to drive our collective work together:

- Who isn't thriving in terms of their health and well being? What will it take for that to change?
- Whose lives got better because we were here? How will we know it?
- Regardless of our role, what can we do to facilitate real transformation in the health and well being of people, systems and communities?
- How can we engage and partner with stakeholders, including those uninsured and underinsured, to build a community of solutions?

We invite you to read our latest quarterly report, and to actively look for areas where strategies, relationships, and platforms are being built to answer these questions. We cannot do this alone, and invite you to join our journey towards "a healthier Kershaw County where individuals and communities are empowered to take charge of their own health and well-being."

Best in all you do,

Holly Hayes Susan Witkowski

Highlights

Kershaw County Wellness Riders Bus Tour

On Friday, April 8, 2016, the Community Medical Clinic (CMC) of Kershaw County's staff and board members, along with members of the USC Arnold School of Public Health evaluation team and the USC Department of Psychology's mental health team, took a three hour bus tour of the HOP area of North Central Kershaw County. The route included visits to Cassatt, Bethune, Mt. Pisgah, Bone Town, Kershaw and Lancaster. Participants visited all five church sites that are part of the initiative and also toured the School-Based Health Center at North Central High School.

After 18 months of focused effort, CMC staff and board members felt that it was time to take a closer look at the lasting impact that has been made in these communities. CMC Director Susan Witkowksi and USC Lead Evaluator Holly Hayes led the tour.

"The ride was designed to shift our thinking of how care is provided for community members in this area," stated Witkowski. "Hopefully seeing the day-to-day challenges that this community faces will help us to question ourselves about how to design an effective care coordination model for this area." As the clinic implements the Community HUB Pathway Model it was important to visit all clinical sites used to provide care for the underserved of Kershaw County.

Questions now being asked include:

- How does our medical home successfully fit into this care coordination model for success, if clinical care impacts only 20% of the health outcomes?

The Wellness Riders group poses for a picture before the tour.

- How can our outreach efforts impact health behaviors, which are 30% of the health outcomes? (i.e. How can we focus our efforts on upstream factors?)

- What does our community HUB Pathway model look like now that we've seen communities struggling with financial and social supports?

The North Central area of Kershaw County covers 431 square miles (approximately 58% of the county's land area). Since 2014, South Carolina DHHS has funded the Community Medical Clinic through Livewell Kershaw, an initiative specifically aimed at improving population health in the North Central area. The work of Livewell Kershaw has been manifested by Community Health Workers

Mobile homes are typical housing in the North Central area.

and Nurse Practitioners addressing the needs of the population where they live: through satellite health sites and mobile clinics in community churches and a successful School Based Health Center (SBHC) established at North Central High School.

"Livewell staff have set up the process for administrators and teachers to refer students to the SBHC and it's all gone very well. I'm very pleased –they have an A+ in my book," stated David Branham, principal of North Central High School.

Population health is the distribution of health outcomes across a geographically-defined group which results from the interaction between individual biology and behaviors; the social, familial, cultural, economic and physical environments that support or hinder wellbeing; and the effectiveness of the public health and healthcare systems. A committed team of volunteers, staff, board members, visionaries and partners are working together to make improved population health a reality for all residents of Kershaw County.

True commitment requires the full engagement of the head, heart, and hands. The bus tour allowed participants to engage all three in a meaningful way as the team works together to create integrated care coordination teams.

Clinic staff meeting about the transitional care team.

Admin day at the Community Medical Clinic.

Other Highlights

- New business cards
- Translational research sessions with medical providers
- Two in-service trainings
- Updated policies and procedures
- New online project management software (Quip)

Follow up series of email messages sent to Wellness Riders.

Hello Wellness Riders,

Our bus tour Friday started a great conversation about the challenges that face us to realize our vision of a healthier Kershaw County. In the spirit of keeping this dialogue open, I'm sending a series of emails to facilitate deeper thoughts and discussion for opportunities to empower individuals and communities to improve their health and well-being.

Each email will have three sections: focus, reflect and act. If a particular section resonates with you, please hit reply and let me know.

Go forward and do good.
Susan Witkowski

DAY 1

FOCUS
Making Kershaw County the healthiest county is our ultimate goal. In order to succeed we must: BE PROACTIVE. Look for solutions not problems. We had an opportunity to look through different lenses at each of the towns along the way on the bus tour Friday.

30% of health outcomes are driven by health behaviors (tobacco use, diet and exercise, alcohol use and unsafe sex); 20% by clinical care (access to care and quality of care); 40% by social and economic factors (education, employment, income, family and social support and community safety).

What lenses do we use to impact change to improve the healthcare delivery system?

REFLECT
How did Kershaw County look when asked to view it only through a certain lens? On our tour the call for glasses went out as we traveled through different communities. Were you able to see through the glasses you had? How hard was it to make the shift?

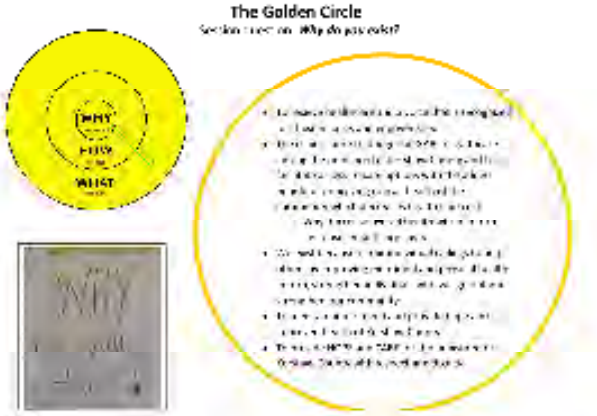
Abraham Maslow said in 1966, "I suppose it is tempting, if the only tool you have is a hammer, to treat everything as if it were a nail."

ACT
Be conscious of the lens you use and the lens that is needed to design the pathway for our patients/clients. Try to see the pathway through abundance. Be mindful of the resources that are available when designing the pathway for our patients/clients.

DAY 2

FOCUS
Making Kershaw County the healthiest county in SC is our ultimate goal. In order to succeed we must: BEGIN WITH THE END IN MIND. Why do we exist? As a mission centered organization, changes can be made through a foundation of strength. Our mission and shared vision and values are our compass. Let that compass direct your actions, conversations, and priorities.

REFLECT
On January 29, 2015 we agreed that the statements in The Golden Circle were why we exist. The common theme in this circle is helping people. The what and how are important but the motivation, the heart of our organization is in this circle.



ACT
Use this golden circle as a filter in your decision making. As we move forward with stratifying patients based on risk level, identifying pathways and most importantly tracking the outcomes of these pathways, reminding yourself of the why is paramount. The appropriate pathways will empower the patient/client to see changes more clearly, and hold us accountable to documenting their journey and outcomes along their pathways. Using real-time data will make implementation possible and meaningful. Quality improvement is about making changes for the long haul.

DAY 3

FOCUS
Making Kershaw County the healthiest county in SC is our ultimate goal. In order to succeed we must: PUT FIRST THINGS FIRST. This would be you. Designing the community hub and pathway model will be ineffective if we do not develop our team and implement a process that will guide the patient on the pathway. We hope that having personnel working at the top of their skill set will create greater job satisfaction and personal meaning to their daily activities.

REFLECT
What does it feel like to move from a "lone ranger" model to a team approach? Do you see hope within this model? In this model, a patient is not surrounded by just one person, but a team of individuals. For our team, this will include: A Nurse Practitioner, a care coordinator, a Community Health Worker and a mental health specialist. I am encouraged that we will be able to secure resources within our community and patient centered medical home with the right persons in the right place within our integrated care teams.

ACT
For things to change, somebody somewhere has to start acting differently. Let it be you! Creating the team for transitional care is our first step to building our community hub pathway model. Be aware of the positive behaviors that are needed as we design the process and start to cultivate these in your conversations and actions. Full commitment requires our hands, head and our heart.

DAY 4

FOCUS
Making Kershaw County the healthiest county in SC is our ultimate goal. In order to succeed we must: WIN/WIN. Look for solutions through all lenses. Making changes to the healthcare delivery system that will ultimately empower individuals and communities is achieved when a we see the problem from the other points of view. Principles, accountability and outcomes are front and center.

REFLECT
Aligning our systems to reflect our mission will result in accelerating the desired outcomes we hope to achieve. Systems thinking requires us to take a "hard look" at reality and be willing to make changes to systems that have been in place for a month or even ten years. It's important to constantly remind ourselves of the why (the golden circle) when re-designing systems. How does our work culture reflect this? The PDSA (Plan Do Study Act) cycle, also known as the Model for Improvement, is the model we use for CQI (continuous quality improvement). This model is all about making "tests" and seeing what happens, and then building on these cycles each time. How do you apply this to keep focus on outcomes?

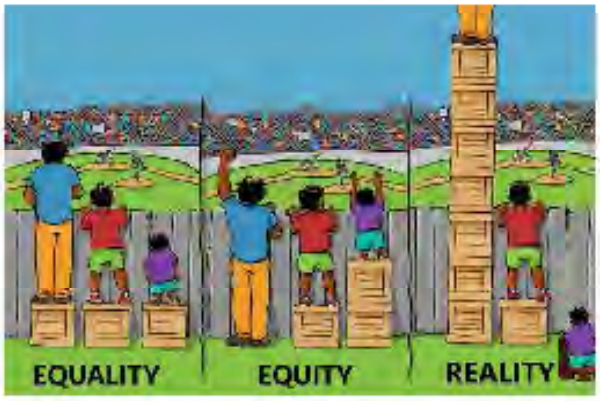
ACT
Design our community hub and pathway model that supports a solution focused team. We all need to be iterative learners. We all teach and we all learn. Supportive systems are needed for both the team and the patient/client to achieve the desired outcomes. Fail forward. Fail forward quickly. Fail forward often. Fail forward and document and learn during the process.

DAY 5

FOCUS
Making Kershaw County the healthiest county in SC is our ultimate goal. In order to succeed we must: SEEK FIRST TO UNDERSTAND THEN TO BE UNDERSTOOD. Our tour of the county gave us an opportunity to experience how we access our resources to meet our basic needs for food, clothing and healthcare. To improve the healthcare delivery system we need to understand what impacts change. Community health is a complex challenge and not a technical challenge. There is no "cake recipe" for this. This requires all of us to listen more, adapt to new information, use PDSA cycles, and emerge with new processes given each situation.

REFLECT
As we drove through the countryside of Kershaw County, I paused: what impact have we really had after two years of LiveWell efforts? Have we been able to give our patients/clients a hand up; a bus to stand on? The image above demonstrates that we need to provide resources, according to need and NOT equally. Our care coordination team will strive to provide the RIGHT bus within the system we have. If we are not able to provide needed buses, we can refer patients to other agencies, while circling back to track the outcomes of that referral. What efforts would

we need if the picture was different? What if there was NO FENCE! How many boxes would we need then? I see this fence and am reminded in 1989 President Reagan challenged the President of Russia with these six words "Mr. Gorbachev tear down this wall!"



This picture is powerful. We take for granted everyday what we have. How many people are standing in a hole?

ACT
Be mindful of the resources that are available. Construct the pathways with your care coordination team to empower the change through the understanding of the patient/client and not how we best think it should be. Also begin to shift your thinking on ways to tear down the fence!

DAY 6

FOCUS
Making Kershaw County the healthiest county in SC is our ultimate goal. In order to succeed we must: SYNERGIZE. Collective impact occurs when one plus one equals three or more; when the whole is greater than the sum of its parts.

REFLECT
How did this three hour, 90 mile ride shift your thinking of how we provide care? Clinical care only impacts 30% of the health outcomes. Where does our medical home fit in this model for success? How can our outreach efforts impact health behaviors, which is 30% of the health outcomes? What does our access model look like now seeing communities struggling with financial and social supports?

ACT
Create goals that have measurable outcomes in these three areas will result in positive changes for a healthier community.

DAY 7

FOCUS
Making Kershaw County the healthiest county in SC is our ultimate goal. In order to succeed we must: SHARPEN THE SAW. Working together is success. Team building is paramount as we construct our hub and pathway model. An effective team exhibits: trust, conflict resolution, commitment, accountability and is results oriented.

REFLECT
Healthcare is a complex system and takes an enormous amount of energy to affect positive outcomes. Think back on how the room looked before. How can we develop effective teams to move our mission forward? Do you take time for self-renewal, self-improvement, self-care and self-respect?

Maze of "Sylvie"

Work better

ACT
Make a commitment to excellence and focus on the big picture. Develop effective teams based on trust by being vulnerable. Embrace conflict. Hold people accountable for their behaviors.

DAY 8

FOCUS
Making Kershaw County the healthiest county in SC is our ultimate goal. In order to succeed: WE ARE ALL IN THIS TOGETHER. We are in uncharted territory. We are taking risks. Failing forward. We are change agents for Kershaw County.

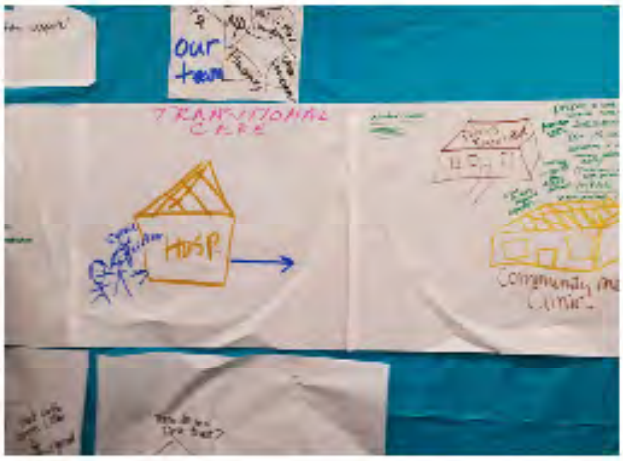
REFLECT
The words on our white board: Stay engaged. Be courageous. Be curious. Speak your truth. It is in our differences we arrive at the solution. How do we apply this throughout our work day? How do we interact with patients/clients and each other?

ACT
Commit to excellence. Respect all ideas. Make a decision. Move forward as one. The standards we walk past are the standards we accept.

DAY 9

FOCUS
Making Kershaw County the healthiest county in SC is our ultimate goal. In order to succeed we must: SWITCH. Chip and Dan Heath are authors of Switch. They have defined how to change things when change is hard. Apply these three principles: Logic, motivation and a clear path.

REFLECT
How can we apply these principles to design the transitional care pathway? What is the ultimate goal? Why is this pathway important to change? How do we shape the path?



ACT
Take time to view the link below to find out more about Switch:
https://www.youtube.com/watch?v=qaoowWxVx5ow

DAY 10

FOCUS
Making Kershaw County the healthiest county in SC is our ultimate goal. In order to succeed we must: LOOK UPSTREAM. Health begins where we live. Understanding the whole person is part of our organization's culture.

REFLECT
Recall the story of the three friends that come upon a river to find a man drowning. Now think about the interactions you have throughout your day. Which friend are you? Depending on the situation do you change how you help? Is it important to have all three friends in our organization?

Here is a four minute video clip of the river if you would like to review more:
http://www.ihi.org/education/IHIOpenSchool/resources/Pages/AudioandVideos/Rishi-WhatIsAnUpstreamist.aspx

ACT
Set aside 20 minutes to listen to this inspiring TED talk from a physician on what makes us get sick:

https://www.ted.com/talks/rishi_manchanda_what_makes_us_get_sick_look_upstream?language=en#t-58479

School Based Health Center

Extend primary care and mental health at all schools in North Central to increase access and care coordination

School Based Health Center

For the entire academic school year 2015-2016, mental health counseling was available. Acute care services were made available on January 26, 2016. In addition, the SBHC's newly renovated space next to the gym is working out very well. The LWK team also has access to a phone and remotes into CMC to update Electronic Medical Records. Principal David Branham is extremely pleased with the program and feels that "everyone is part of the family." He says that having the SBHC has been such a "blessing" to the students, teachers and administration. A total of 72 students were seen by a mental health counselor or a Nurse Practitioner this academic year. The Mental Health Counselors and Nurse Practitioners work side by side and are integrating their approach to care for the whole student.

Some of the metrics that we will continue to track for intermediate and long-term outcomes include:

- Attendance rates and/or tardiness
- Graduation rate
- Disciplinary referrals
- GPA and test scores
- School climate or learning environment as reported by students and parents
- Emergency Room utilization rates
- Student reported quality of life (SBHC students vs non-SBHC students)

The administration of NCHS has enlisted the help of the SBHC in their initiative to cut down on truancy among students. If a student misses five blocks of any class, he or she is then considered to be truant. There were 85 students who met this criteria during this academic school year. The Community Health

NCHS Principal David Branham talks about the benefits of the SBHC.

Workers and the Attendance Secretary worked with border-line students to prevent any more students from being added to the truancy list. Each Friday, the attendance secretary sent a SBHC packet to all absent students.

SBHC Data

Demographics:
There were 69 participants from grades 9-12 (mean grade: 10.2) and ages 14-19 (mean age: 16.4). Forty-seven (68.1%) were male and 22 (31.9%) were female. Forty were white (58%), 22 were black (31.9%), 4 were Hispanic (5.8%), 2 were mixed race (2.9%), and 1 was B/I (1.4%). The majority of participants received physicals (N=40, 58%), followed by mentoring (N=9, 13%), acute care (N=7, 10.1%) and counseling (N=7, 10.1%), grief group (N=5, 7.2%), and one participant received both acute care and counseling (1.4%).

Absences:
There was a significant average difference between excused absences in 2014-2015 and 2015-2016 ($t68 = -2.279$, $p<0.05$) for students who received services from the SBHC (acute care, counseling, mentoring, grief group, and physicals). On average, there were 0.67 more excused absences per child during the 2015-2016 school year. The average

difference between unexcused absences in the 2014-2015 and 2015-2016 school years was not significant (p=0.208). There was a significant difference between total absences in 2014-2015 and 2015-2016 ($t_{63} = -2.423$, $p<0.05$). On average, there were 1.22 more total absences in the 2015-2016 school year than 2014-2015.

Physicals and extracurricular:
Of the 40 students who received physicals, 17 (42.5%) did not participate in extracurricular activities, whereas 23 (57.5%) did participate in extracurricular activities.

NCHS student and Susan Grumbach.

Brief Literature Review on the Value of Integrative Medicine in the School Setting

According to the Health Resources and Services Administration (HRSA), the number of adult patients receiving behavioral health services has increased 21% since 2010. This trend suggests a similar need in children (Behavioral Health 2014). In the coming years, we can expect these numbers to rise. Many times, children that need mental health care services are unable to access them for various reasons. These barriers to access might include lack of providers, perceived stigma, or even lack of education regarding available resources (Behavioral Health 2014; California School-Based Health Alliance 2014; Mental Health 2016; Rural School-Based Health Centers 2009). However, many organizations have shown positive outcomes through the integration of mental health services into primary care settings within School Based Health Centers (SBHC) (Mental Health 2016). Those that have integrated these health services believe that this type of coordination places an emphasis on treatment of the "whole child" (Rural School-Based Health Centers 2009).

SUCCESS STORY: ADAM

Adam, a 10th grader at NCHS, was referred to the School Based Health Center by the school nurse. Adam was not feeling well and presented with symptoms of abdominal pain. Susan G. brought him in for examination and concluded that he may be experiencing increased gas production as a result of habitual consumption of acidic drinks. The Nurse Practitioner then coordinated plans with his grandmother to send Adam home and to treat the problem with over the counter medication and reducted consumption of orange juice. Susan G. also informed the front office staff (Ms. Ham, Ms. Bowers, and Ms. Helms) that Adam would be going home and that his absence would be medically excused. The efforts of the SBHC helped Adam finish his day in a more comfortable state.

SUCCESS STORY: MARQUIS

Marquis, a 16-year-old student, at North Central High School visited the SBHC on a Thursday morning for a sports physical. When he arrived, Marquis told Susan G. that he had not been able to start football practice with pads on Monday because he had not yet had a physical exam. After having his physical completed by Susan G., Marquis said that going to the School Based Health Center is "way easier" than trying to get an appointment with his doctor. He said that he would not have been able to get a physical from his doctor until June 2nd, and football practice started on May 9th. Marquis is also a part of the Quest program -the step before being sent to the Department for Juvenile Justice. Therefore having the ability to play the sport that he loves may keep Marquis on the right track and out of the juvenile justice system. Marquis had his physical completed within thirty minutes of his arrival. After he left, Susan G. informed Coach NAME HERE that Marquis was ready for practice.

When considering the integration of mental health and primary care health, it is important to note how this coordination of care will create better access for students that need these issues addressed. 1 out of 5 children in the United States experiences a mental disorder during a given year (Behavioral Health 2014). This statistic alone describes the need for mental health care within SBHCs. Furthermore, the School-based Health Alliance discovered that through the integration of mental health and primary care into School Based Health Centers, many children that would not have access to mental health care are now able to utilize the care they need. In addition, research has suggested that adolescents are much more likely to access mental health care services through a SBHC rather than seeking this type of care through a primary care provider. The reasoning provided for this explanation points to the fact that those students accessing mental health services through a SBHC are not identified. When students visit a SBHC they are not labeled by their peers for accessing mental health care because the reason for their SBHC utilization is unknown. Confidentiality is noted as a reason why SBHCs work so well in integrating mental health care with primary care. In the SBHC setting, the mental health care providers are able to do interventional therapy that can improve academic performance and dropout rates while also working with families of the affected student (Behavioral Health 2014). Additionally, these mental health services are able to address conflict management, depression, and stress management.

North Central Middle School students will be able to enroll in the SBHC next year.

The need for mental health care services in SBHCs in rural areas is critical. The Colorado Association for School-Based Health Care presented "A Framework for Success" in regards to Rural School-Based Health Centers. This report highlighted that those involved in School-based Health Centers recognized the need for behavioral health because it is intertwined in the primary care of a child. Furthermore, the group believes that providing both primary care and mental health services is

instrumental in caring for the "whole child" (Rural School-Based Health Centers, 2009). Placed in rural areas, the SBHCs recognized that having access to mental health care services was one of the main issues that residents were facing. Within Colorado, there are currently 46 SBHCs that are providing integrated primary care and mental health services (Rural School-Based Health Centers, 2009). Because of how rural the area is, mental health care services are limited. Therefore, the SBHCs that have integrated mental health services into their primary care set-up are fulfilling a need for the community. In fact, within one SBHC all the rooms were remodeled to feature connecting doors that allow for discussion between primary care, mental health, and the school nurse. This is beneficial to the center because students are often using both primary care and mental health services at the same time (Rural School-Based Health Centers, 2009).

Currently, 75% of SBHCs in California have a mental health provider (California School-Based Health Alliance 2014). According to a national survey of SBHCs, mental health counseling services provided to students include crisis intervention, mental health assessment, grief and loss therapy, substance abuse therapy, meditation, etc. In addition, where there would be perceived barriers by the students in traditional mental health settings, these barriers are overcome in school-based centers. While many SBHCs have already put mental health services into place, some have not. However, these SBHCs have recognized the need to integrate mental health services into their current structure. As a part of the California School-Based Health Alliance's strategic framework for 2016, mental health care integration has been targeted for expansion. In fact, mental health care is the number one priority for 2016 because it is an identified area of need for school districts. In order to address this priority, the Alliance will utilize various tools and trainings to strengthen schools' capacity to provide mental health care services. In addition, there are plans in place to develop a policy related to financing the delivery of mental health services (California School-Based Health Alliance 2014). According to the School-Based Health Alliance (SBHA), SBHCs are the ideal location for adolescents to access an integration of primary care and mental health through the collaboration of healthcare providers. In addition, the SBHA believes that the close proximity of the healthcare providers in SBHCs to adolescents allows the providers to deliver mental health care in a safe and confidential environment while also developing relationships that will support positive behavioral changes.

Many times, adolescents that need mental health services cannot access them due to various barriers. SBHCs that have integrated mental health services into primary care have seen improvement in outcomes of the children that are served (Behavioral Health 2014; California School-Based Health Alliance 2014; Mental Health 2016; Rural School-Based Health Center 2009). As SBHCs are created in South Carolina, it is paramount that this integration begins during the initial planning and implementation stages.

North Central High School teachers and staff enjoy a luncheon sponsored by LiveWell.

Enrolling Students in the SBHC: PDSA Summary

A variety of recruitment methods were used in order to enroll 85% of the student body into the SBHC. We initially visited classrooms, spoke with students, handed out applications and urged them to return a completed packet. This effort was not as successful as we would have liked. We then

decided to reach out to parents directly at the NCHS car riders circle. We spoke to parents and handed out applications for 2 mornings from 7 to 8 a.m. in the circle. This effort, however, produced only a few completed applications. We reached out to the athletic staff, who were training for spring football and volleyball practice, and asked them to pass out and collect completed SBHC applications. Once again, we were let down by our efforts. The SBHC team met and began to ask key questions in order to determine what could be done differently. On the last day of school, 114 students were enrolled in the SBHC. Some of these questions included: Could it be a timing issue, as we were doing these things towards the end of the year? Did the students give the applications to their parents? Are the parents not interested? Are we asking for too much information?

In the upcoming 2016-2017 academic school year, the following plan is in place to enroll as many students as possible:

- SBHC application will be 1 page instead of 3
- Application will be avaiable online with the school registration forms
- Parents can check "yes" if they would like to enroll their child or check "no" if not
- Reducing documentation requirements needed for the application

Cameron Massey, counselor for the SBHC

By applying a Continuous Quality Improvement framework, the team has changed their approach for next school year. This would not have been possible without the close relationship with the principal and the superintendent. The team is "failing forward" and will continue to conduct PDSA cycles until the aim of 85% of students at NCHS are enrolled in the SBHC.

Acute Care Services

Acute Care services were offered by the SBHC two days a week, Mondays and Thursdays from 8:00 a.m. to noon beginning in January 2016. Susan Grumbach, a Nurse Practitioner who has served the patients of CMC for the past 16 years, is now the Nurse Practitioner for the SBHC. One of the main goals of the SBHC is to see students in less than 30 minutes -ideally 20 minutes. The more time that passes, the more likely a student may be marked absent for a block of class. Susan Grumbach notes that: "This is what makes or breaks a clinic- what is the value for a student missing a whole block- 1 ½ hours? That's a whole class." Susan describes the SBHC as a "minute clinic" in the school and works very closely with the school nurse, Regina Bowers, to ensure a smooth transition during the referral process.

Running a SBHC requires great attention to detail, strong relationships with school personnel, and a lot of time. During the five months that acute services have been offered, Susan has determined that, on average, one hour of coordination is needed for every acute care visit. This coordination time includes: a referral, calling a parent, informing the attendance secretary and the front office staff if the child is going home, and data entry into the Electronic Medical Record.

Every physical exam requires at least 20 minutes of data coordination. This includes obtaining a copy of a parent's ID, an application, tracking down needed IDs from the school safe, and performing the physical itself. Susan tries to perform physicals during students' lunch period if possible, so they do not miss any class time.

In March of this year, Susan realized that she needed additional support for the SBHC to reach its goal of seeing students in a timely manner. One Tuesday, Susan was alone in the clinic at 10 a.m. when two sick students and three students needing physicals all arrived at the same time. To make matters worse, Susan could not get the online satisfaction survey to work and was "scrambling to get everything done." To avoid this in the future, a Certified Nursing Assistant (CNA) was added to the team to assist at the school and monthly mobile clinics. On April 18, 2016, Mariana Martinez joined the SBHC team and now supports Susan Grumbach with clinical care for both students seen at NCHS and adults seen at the local church sites. Mariana has 7 ½ years of experience as a volunteer at CMC and also worked as a doula at Lexington Medical Center. She also provides much needed Spanish Translation services at all of the CMC sites (Camden, Lugoff, and North Central area).

Both Susan and Mariana agree that working together has helped their ability to treat students, as well as allowing the CHWs to be in the community more and not in the school. In the past, one of the CHWs tried to be at the school during the two days of the clinic. Mariana noted that she "loves working with Susan and receives constant feedback." Mariana has also been instrumental in communicating with Spanish-only students and their parents. In one case a student needed a sports physical but could not provide a picture ID.

SBHC staff Mariana Hernandez and Susan Grumbach

Mariana called the guardian of the student and explained that the only purpose of the photo ID was for parent/child identification. Additionally, both Susan and Mariana believe that having two people in the clinic gives credibility to the SBHC. The office now looks more professional with Mariana taking vitals and Susan seeing students. Oftentimes, Mariana is able to take a student's vitals so they ready to be seen by the time Susan arrives in the morning. This integrated team is working together to see all students as quickly as possible, so they can get back in class if they are able.

As of June 2016, the School Based Health Center (SBHC) has had 16 clients complete patient satisfaction surveys. When asked to rate their visit with the Nurse Practitioner, 81% (13 students) said their visit was "great," while only 19% (3 students) said their visit was "okay." No students said that their visit was "horrible."

When asked if they would recommend the SBHC to a sick student or friend, 94% of students said that they would recommend, while 6% (1 student) said they would not recommend the SBHC.

Mental Health and Wellness

Alexandra Golden, a doctoral student at USC's Department of Clinical/Community Psychology's program, provided grief groups to students who had lost a parent or relative in the past two years. The attendance secretary and principal recognized this as a growing issue at NCHS and NCMS since many of the students are being raised by their grandparents and lack the coping strategies to deal with such great loss in their lives. As a result of this need, Alex facilitated five group sessions with three 6th grade students at the middle school. Unfortunately, there were scheduling conflicts for ten 7th and 8th grade students that had lost a parent or grandparent, and they were not able to participate in a support group. At the high school, three support groups initially began and two groups continued with a total of nine sessions. Of the 20 students that were referred only five students attended regularly. Many of the students

that suffered a loss were not ready to address their grief. In the future, it will be important to offer these students individual therapy as an option. It may also be that some stigma was associated with "grief groups." Next year, the counselor would like to use the term "support groups." It will also

Emily Mancil, Wellness Facilitator for the SBHC.

be critical to work with the guidance counselor to help schedule support groups for various ages.

Emily Mancil continued the mentoring program at both the high school and middle school. In the spring, the middle school had 20 students in active mentoring and 19 teachers; the high school had 9 students in active mentoring and 11 teachers. For the total academic year there were 23 students mentored at the high school and 26 students mentored at the middle school. There were also 8 students participating in the Check and Connect program. There was a total of 31.7 hours of mentoring and 7.3 hours of consultation at the high school, and 73.5 hours of active mentoring and 16.6 hours of counseling at the middle school. The mentoring program continued to grow in the middle school due to highly engaged teachers.

Data was collected from a total of 46 students at the high school (N=25) and middle school (N=21) during the fall and/or spring semesters. Among students with data in the following areas, there were no significant differences between fall and spring semesters: Behav Ref (N=15), tardiness (N=15), detention (N=16), ISS (N=16), OSS (N=15); and grades in English (N=11), Math (N=9), Social Studies (N=11), or "Other" (N=7). There was a significant difference in absences (N=16) between the fall and spring semesters ($t15 = -2.675$, $p<0.05$). On average, there were 12.75 more absences per student in the spring semester. There was also a significant difference in Science grades between the fall and spring semesters ($t9 = 2.586$, $p<0.05$). On average, students scored nearly a full letter grade lower in the spring semester.

It is important to note that due to the very small sample size and not all sample sizes matching up (i.e. some students took Social Studies for only one semester), the sample is not normally distributed. When the data are examined by looking at the difference in the means, ALL of the behavioral components (tardies, Behavioral Referrals, OSS, etc.) showed a decrease. While only Absences were "significant," the rest of the indicators show a trend of improvement over the year. The grades variables all showed slight decreases in performance (with only Science being "significant" just barely), but that could probably be best interpreted as school demands increasing over the course of the year. Also it is actually expected that the data would show more significant drops for students that have pre-existing learning problems from fall to spring semester.

At NCHS, students reported that they liked having someone keeping them on track with their schoolwork and how much the service helped them. In the future, students would like to have mentoring meetings more than once a week.

At NCMS, students that received mentoring services reported that they liked being able to check over grades and talk about what is going on at school. Most students enjoyed the mentoring program, while only one student did not. Some middle school students did not like how many questions were asked during the session. When asked what they would change about the mentoring program, most students said that they wouldn't change anything or that they did not know what they would change.

The SBHC has well equipped exam facilities.

Future Plans

The SBHC will be open for the 2016-2017 academic school year every Monday-Thursday from 8:00 a.m. to noon. The SBHC will provide services to both middle and high school students. Middle school students needing services will be transported in one of the driver's education vehicles. Susan Witkowski will also be giving a presentation to the School Board on August 2nd to share updates of the great strides made this year and the vision for the SBHC in the future. The SBHC Advisory Council is also meeting during the summer to gain additional insight into messaging and increasing SBHC enrollment.

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SUCCESS STORY: BOBBY JOE

Bobby Joe is an 11th grader at North Central High School and plays several different sports including basketball and soccer. On a Friday evening, Bobby Joe was playing in a basketball game when she suffered a concussion after being hit in the head. She had a CT scan at an urgent care center and was evaluated. However, she was not cleared to play in her soccer game the following week unless medically released by a healthcare professional. Bobby Joe stopped by the SBHC and was seen by Susan G. who was able to release her to play in her soccer game. When asked if she liked the SBHC Bobby Joe said, "I love it, just knowing that I have people to come to if something happened to me. I wish I had this place in the 7th grade when I sliced my hand open dissecting a chicken wing in class. My mom had to get off work to come get me."

REDUCING UNNECESSARY HEALTHCARE EXPENDITURES THROUGH SBHC UTILIZATION: A CASE STUDY ON "HENRY"

One Thursday morning, Susan G. received a call from the school nurse who reported that she was bringing "Henry" down to the SBHC in a wheelchair. He had reportedly dropped 180 lbs of weight onto his chest after another student dared him to lift that much in the weight room.

Susan G. recalled a similar situation happening with Henry not too long ago. Several weeks earlier, Henry had dropped 90 lbs on his leg and was brought to the SBHC. Because he was not enrolled at the time, he needed several documents completed, as well as a parent ID. Henry's mother came but had no form of identification, and became very upset at the situation. Susan G. told the mother, "We are just here to help you, I know you are under a lot of stress." Henry has also been identified as a truant student (a student becomes truant after missing five blocks of any class). Susan G. is able to identify whether or not a student truly needs to miss school due to a health issue, which can help reduce truancy.

Henry entered the SBHC looking sweaty and shaken from his experience. After taking Henry into the exam room, the school nurse asked Susan G., "Do I need to call EMS?" After examining Henry and speaking with school administrators, Susan G. determined that Henry was physically fine and only shaken from an adrenaline rush, so EMS was not needed. Henry thought he might need to leave school to have X-rays taken but the Nurse Practitioner assured both Henry and his mother, after she arrived, that he was fine and only experiencing some tenderness. In the end his mother took Henry home, but Susan G. was able to prevent unnecessary medical costs associated with an ambulance ride and ER visit.

This situation involved several individuals: the school nurse, Susan G., Mariana H., three administrators, a stressed mom, and Henry. Susan G. was able to work with all persons in this scenario and determine the best course of action. On this particular day the nurse had to leave Henry at the SBHC in order to treat a diabetic student at the middle school. Susan G. was able to take the lead and handle this situation without the need for emergency services. In addition, Henry would have been able to stay in school for the remainder of the day if his mother had not decided to take him home. The SBHC played a role in reducing unnecessary healthcare costs and made a brave attempt to prevent truancy at North Central High School.

LiVeWell KERSHAW
"Your Bridge to Better Health"

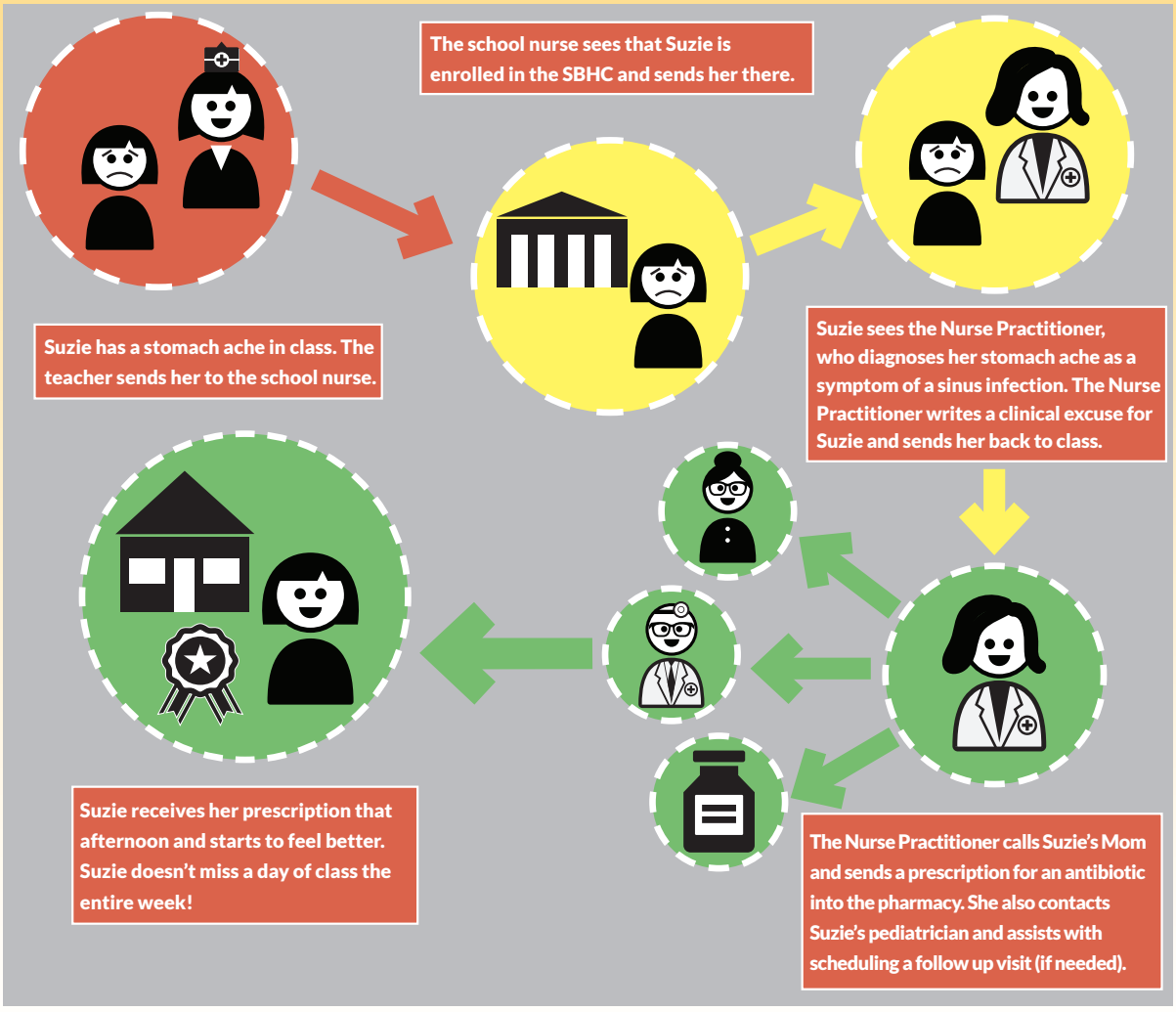
School Based Healthcare Center at North Central High School

110 C East DeKalb Street Camden, SC 29020
803.272.8325

facebook.com/LiveWellKershaw
twitter.com/lwkershaw

North Central now has its own School Based Healthcare Center (SBHC). It's like a minute clinic in the school! The school nurse can refer students to the SBHC where they will see the Nurse Practitioner, who will diagnose and treat common illnesses, care for minor wounds, and write prescriptions. The SBHC also provides sports physicals, vaccinations, and routine lab tests.

The Nurse Practitioner is available **Monday through Friday from 8:00 am - noon.** We are located in the new gym next to the training room. Most SBHC services are available at no cost to North Central families.



To learn how your student can enroll in the SBHC contact the school nurse (Ms. Bowers) or the office (Ms. Ham).

livewellkershaw.org

LiveWell KERSHAW
"Your Bridge to Better Health"

SBHC Enters Phase 2 for 2016: Welcome Our Nurse Practitioners

110 C East DeKalb Street Camden, SC 29020
803.272.8325

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twitter.com/lwkershaw

This February the School Based Healthcare Center (SBHC) has added two nurse practitioners -Susan Grumbach, NP, and Mary Lee Addis, NP -specializing in family health care. Much like a family doctor/physician, nurse practitioners are able to diagnose and treat illnesses, prescribe medications, and help manage patients' overall care.

The nurse practitioners join our community health workers Beckie Tompkins and Rachael Sladek, along with mental health providers Abby Bode, Emily Mancil, and Cameron Massey.

The nurse practitioner will be available on Monday and Thursday 8:00 am to 12:00 noon. We are located in the new gym next to the training room.

Care from Experienced Nurse Practitioners

Our practitioners can:

- Diagnose, treat and write prescriptions for common family illnesses such as strep throat, bladder infections, pink eye, and infections of the ear, nose and throat
- Provide common vaccinations for flu
- Treat minor wounds, abrasions, joint sprains and skin conditions such as poison ivy, ringworm, lice and acne
- Offer routine lab tests, instant results and education for those with diabetes, high cholesterol or high blood pressure
- Share records with a primary care provider (with patient permission)

Patients with the following should not seek care at the SBHC:

- Severe chest pain
- Severe shortness of breath or difficulty breathing
- Suspected poisoning
- Children with temperatures of 104 degrees Fahrenheit or more
- Conditions that require our practitioners to prescribe controlled substances

Patients with conditions or health needs outside of our clinical scope will be directed to other community health care providers.

Disclaimer: *If you have a medical emergency or require immediate assistance due to an accident or injury please call 911.*

How to Enroll in the SBHC

We provide care for students who are enrolled in the SBHC with a referral from the school nurse.

- To enroll please obtain an application form from the school nurse (Ms. Bowers) or the office (Ms. Ham).
- A student's enrollment application must be signed by a parent or legal guardian.
- The student must have an ID and Social Security card.
- The student should have a health insurance card.

livewellkershaw.org

Flyer sent to Kershaw County School District for distribution through Peachjar portal.

Are you a Kershaw County resident living in one of these areas: Bethune, Buffalo, Cassatt, DeKalb, Kershaw, Liberty Hill, Mt. Pisgah or Westville?

No health insurance and need a doctor?
Can't afford your medicine?
Need to apply for Medicare, Medicaid, or SNAP "food stamps"?
Need help with managing your diabetes or high blood pressure?

Do you or someone you know need these services? Many are available at no charge. Call (803) 272-8325 for more information and to schedule an appointment at one of our Satellite Sites.

Satellite Sites

Day/Time	Location
MON 9 am - 1 pm	Cassatt Baptist Church 2604 Hwy 1 North Cassatt 29032
TUES 9 am- 1 pm *	DeKalb Baptist Church 2034 DeKalb School Rd Camden 29020
TUES 9 am - 1 pm	Sandy Level Baptist Church 2920 Timrod Rd Bethune 29009
WED 9 am - 1 pm	Refuge Baptist Church 2814 Lockhart Rd Kershaw 29067
THURS 9 am - 1 pm	Buffalo Baptist Church 6390 Lockhart Rd Kershaw 29067

**1st and 3rd Tuesday each month.*

LiveWell KERSHAW
"Your Bridge to Better Health"

110 C East DeKalb Street Camden, SC 29020
803.272.8325 livewellkershaw.org

LiveWell Kershaw, an initiative of Community Medical Clinic of Kershaw County, is working to make Kershaw county the healthiest county in the state of South Carolina. LiveWell Kershaw focuses on health issues impacting the North Central area: heart disease, high blood pressure, diabetes and behavioral health conditions. Our partners include AccessKershaw, KershawHealth, Community Medical Clinic of Kershaw County, and the Arnold School of Public Health, USC.

Care Coordination (Hub & Pathway Model)

Extend primary care in the community to increase access and care coordination

Satellite Care Coordination Sites

The care coordination team continues to serve the North Central area with community outreach and care coordination services. Both Beckie Tompkins and Rachael Sladek continue to serve as Community Health Workers throughout Kershaw County. Karen Baker continues to serve as a Community Health Worker for the KARE site and is now assisting with case management. Rachael Sladek continues to primarily serve the eastern part of the North Central area while Beckie Tompkins serves the western part of the county.

The care coordination team has been applying the Model for Improvement and conducting various PDSA cycles this quarter. The purpose of the CMC eligibility PDSA plan was to allow CHWs to approve CMC enrollment applications. In allowing this we hoped to reduce the time for a new patient to be seen by a provider. As a result, two patients were approved by a CHW the same day as screening, which allowed them to be seen by a provider on the same day. The time from initial intake to approval ranged from two days up to two weeks due to the Memorial Day holiday and patients' availability of transportation to the closest healthcare site. Another obstacle to being able to approve enrollment was the patients' lack of access to their Medicaid denial letter from DSS. In order to move the process forward the CMC pharmacy manager got permission to have an authorization form from DSS which allowed us to obtain a Medicaid denial letter on behalf of the patient if necessary.

The Transitional Care PDSA focused on working to reduce the time a patient is admitted to the hospital and to decrease the time between admissions.

Hub & Pathway meeting, March 24th.

The CHW and Community Care Coordinator will work together for transitional care of established CMC patients before moving on to self-pay patients. The admissions list is pulled daily and checked for CMC patients. The Community Care Coordinator calls the Nurse Case Manager on floor. Then consent forms are signed by the patient to begin case management and to schedule an appointment with CMC before the patient leaves the hospital. The CHW will attend the patient's CMC visit if the patient is classified at-risk or complex. Two CMC patients have been seen in the hospital and are receiving case management. The CHW has also attended doctor visits to ensure medication compliance.

Future plans include the following:

- Hiring another Community Health Worker to increase outreach across the North Central area as well as access and care coordination for the residents.
- Adding a new volunteer, Lynn Blizzard with Goodwill Financial Stability Center, and an SC Thrive representative at mobile clinics to help with intake and walk-ins.
- Ordering exam tables to diagnose certain conditions that can't be done sitting in a chair (saving patients a trip to Camden).

	CHW Activities	March	April	May	Total
1	**ER Calls**	41	51	54	146
2	**Primary Care Physician Referrals**	24	12	16	52
3	**Medicaid Applications**	7	2	2	11
4	**SNAP Applications**	4	5	4	13
5	**Welvista Applications**	15	8	7	30
6	**SS Disability Assistance**	4	3	2	9
7	**Extra Help Application**	1	0	0	1
8	**With Medicare Medicaid**	3	3	0	6
9	**Case Management**	2	0	1	3
10	**Mental Health Referrals**	4	0	1	5
11	**Dental Referrals**	1	1	0	2
12	**PAP Applications**	3	0	5	8
13	**Charity Assistance**	8	5	2	15
14	**Vision Referrals**	2	1	0	3
15	**HOP Sessions**	0	0	1	1
16	**ACA Navigations**	0	0	0	0

Third Quarter Client Satisfaction Survey Summary

A paper-based satisfaction survey was administered to clients from December through February. The purpose of this survey is to determine how receptive clients are to the services provided by the CHWs. After each face-to-face visit, clients are asked to complete the survey; 61 out of 117 clients completed the survey. The clients then returned the completed surveys to a sealed container to maintain confidentiality. Kathryn Johnson collects the surveys weekly to analyze the data. The summary of the survey findings are as follows:

	Which community health site did you visit today?		
1	**Answer Options**	**Response Percent**	**Response Count**
2	Buffalo	13.10%	8
3	Cassatt	23%	14
4	DeKalb	4.90%	3
5	Refuge	31.10%	19
6	Sandy Level	21.30%	13
7	Other	6.60%	4
8	*answered question*	61	
9	*skipped question*	0	

JODI

Patients know they will receive quality medical care at a Mobile Clinic. When "Jodi" needed to be seen for a medical issue, she contacted the Community Medical Clinic (CMC) for an appointment. However, she was told that she would be seen more quickly at the Sandy Level Mobile Clinic. Jodi had no hesitation about the Mobile Clinic because she knew she would receive the same level of care provided by the CMC. As a result, Jodi has been coming to Sandy Level since September 2015. When it comes to solving her medical issues, Jodi says, "they don't let grass grow under their feet!" The mobile clinic staff does not waste any time when it comes to solving her medical issues. As a result, Jodi expects to undergo a much needed surgery arranged with help from LiveWell Kershaw.

VOLUNTEER SPOTLIGHT

Dianne Roberts is a 70-year-old resident of Westville, SC, where she lives with her 79-year-old husband. Dianne has remained active in her community by serving as a volunteer for the mobile clinic and care coordination visits at Refuge Baptist Church. She enjoys her role as a volunteer because it allows her to get out of the house and take a break from caring for her aging husband, while also serving the community that she was raised in. Because Dianne has attended Refuge Baptist Church since birth, she is an asset to Beckie, the CHW for this area. Dianne currently serves as a greeter for mobile clinic days and assists in anyway needed. While most of the folks that she greets for the mobile clinic don't attend Refuge Baptist, they do attend other churches in the community. Through her role in LiveWell Kershaw, Dianne has been able to assist her two sisters in obtaining medical care. She hopes that others will visit the church and access the available services as well. Dianne's sister, Vivian, is also a loyal volunteer every Wednesday at the church on her day off from work. The two sisters have been critical to LiveWell's success at Refuge Baptist Church.

From the respondents of the survey, we were able to determine that an overwhelming majority of our clients found that our health site locations and hours provided were convenient. Our Community Health Workers, Rachael Sladek and Beckie Tompkins, have provided excellent service to our clients this quarter. Rachael served nearly 70% of survey respondents while Beckie served around 30% of clients. Beckie joined the LiveWell Kershaw team this past February. Of the clients that were served, all felt that they could easily talk with the CHW, that they received kindness and respect during their visit, that health information was clearly communicated by the CHW, and that enough time was spent with them during their visit. All of the respondents felt that the CHWs were either very or somewhat knowledgeable about the reason for their visit.

The most common services received by clients are referrals to Primary Care Physicians (26%) and Pharmacy Assistance (17%). Other services utilized by clients include: assistance with Medicaid applications, applying for SNAP benefits, Social Security Disability, Mental Health referral, Dental referral, Vision referral, Utilities Assistance, Transportation Assistance, Medical Bills Assistance, Blood Pressure taken, Blood Sugar test, and other services.

From the responses collected, all respondents noted that they were either satisfied or very satisfied with their visit. In addition, all clients indicated that they would recommend LiveWell Kershaw services to family, friends, and co-workers.

CHW Beckie Tompkins performs health screenings on Main Street in Bethune.

Satellite Clinics

The satellite clinics continue to serve North Central residents via a Nurse Practitioner, along with a Community Health Worker and volunteers. The Nurse Practitioner provides primary care services to patients who are unable to be seen at a regular doctor's office or who have transportation challenges. These services include but are not limited to: sick visit, primary care visit/check-up, prescription visit, chronic disease management, urinalysis, and health education. The Community Medical Clinic had a shortage of Nurse Practitioners to serve the satellite clinic and the main

clinic office in Camden (one Nurse Practitioner was out on maternity leave and another left the clinic to take a different job), The satellite clinic sites (Cassatt, Sandy Level, Refuge, and Buffalo) are still operating from 9:00 a.m. to 1:00 p.m. on a rotating basis.

Satellite Clinic Productivity

	Satellite Clinic Productivity: 4th Qtr				
1	**Location**	**March**	**April**	**May**	**Total**
2	**Cassatt**	No satellite clinic scheduled	0	2	2
3	**Sandy Level**	5	5	1	11
4	**Refuge**	4	7	6	17
5	**Buffalo**	4	1	1	6
6	**Total**	13	13	10	36

Third Quarter Satellite Clinic Satisfaction Survey Summary

The purpose of the survey is to determine how receptive patients are to the services since many do not have means to receive primary care anywhere else. Out of 36 clients served, 29 clients from this quarter completed the survey. Of the 29 survey respondents, we were able to determine that the majority of our clients served were seeking care from the Refuge location, followed by the Sandy Level location; other sites included Buffalo and Cassatt.

The survey results also indicate a nearly even split for travel time to the satellite clinic locations. According to results it takes clients less than 5 minutes, 5-10 minutes, or 10-20 minutes to reach the satellite clinic for their appointment. In regards to appointment wait time, 48% of clients reported no wait. While other clients did experience some wait time. Length of wait time experienced is outlined in the following chart:

	How long did you wait to be seen today by the medical provider (medical doctor or nurse practitioner)?		
1	**Answer Options**	**Response Percent**	**Response Count**
2	No wait	48.30%	14
3	Less than 5 minutes	17.20%	5
4	5-10 minutes	20.70%	6
5	10-20 minutes	10.30%	3
6	More than 20 minutes	3.40%	1
7	*answered question*	29	

"MR. AND MRS. JONES"

Mr. and Mrs. "Jones" meet with a Nurse Practitioner on a monthly basis during mobile clinic days at Refuge Baptist. They have lived in Bonetown since 2009; Mr. Jones is employed by the Camden Walmart. Rachael Sladek, CHW, recently assisted Mr. Jones in applying for Welvista benefits. In order to apply, Mr. Jones needed to submit check stubs. Since Walmart posts check payments online he needed to create an online account in order to get a hard copy of these payments.

Rachael spent 4 hours working with Mr. Jones to set up an account to verify his Walmart employment. Thanks to Rachael's efforts, Mr. Jones now receives his medications mailed to his home through Welvista. He is very appreciative of Rahael's efforts.

Mr. Jones now has a primary care home thanks to Beckie Tompkins, CHW, who guided him through the CMC enrollment process. Beckie continues to help him through the lengthy application process to obtain catheters at no charge.

Of the responses provided, all clients felt that it was either extremely easy or quite easy to make an appointment and easy to talk with the medical provider. An overwhelming majority of clients felt that they were treated in an excellent manner by the medical provider, that health information was communicated clearly by the provider, and that enough time was spent with them during the appointment. In regards to type of services received, 90% visited the clinic for a primary care visit or check-up, while 45% visited for a prescription or refill. Other services that were received included sick visits and lab results.

The majority of clients rated the services that they received as excellent or very good, while all indicated that they would recommend LiveWell Kershaw satellite clinic services to family, friends, and co-workers.

CMC Nurse Leigh Reed presents a Health Coaching session.

No-Shows

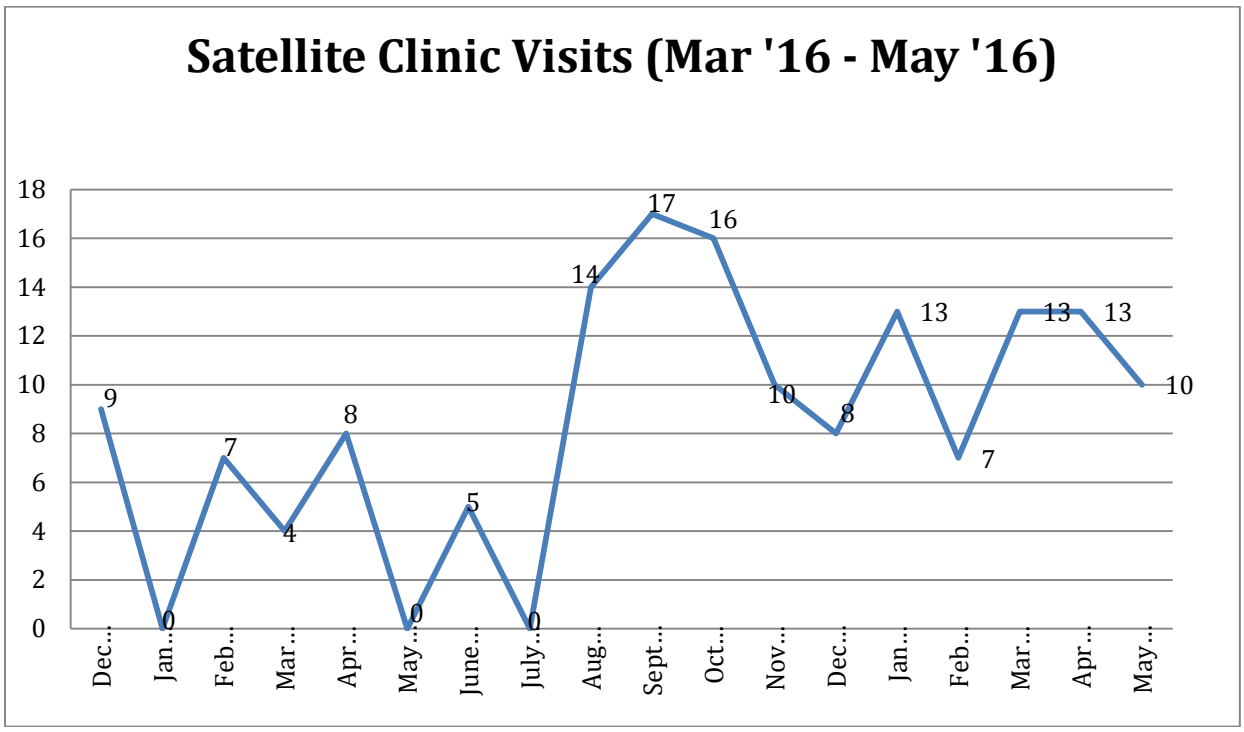
Of the 8 patients that were identified as "No-Shows" for missing their scheduled appointments, five were reached for comment regarding why they missed their appointment. When asked if there were extenuating circumstances that kept them from their appointments, patients had a variety of responses: some patients had transportation issues, while others could not afford to leave work and therefore lose income. Additionally, other patients were either out of town at the time or had not completed the paperwork necessary to begin the next steps at the Community Medical Clinic.

"CALEB"

"Caleb" is a trained painter from Asheville, NC, who moved back to Westville, SC, to care for his aging parents. After suffering a heart attack and an arm injury he has been unable to find work. Beckie Tompkins called him after leaving the hospital and shared with him about the LiveWell Kershaw program. "Caleb" has since been working with the CHWs and Nurse Practitioners to obtain his necessary medication and lab work. "Caleb" really believes in the program and that the best way to share with others in the community is through word of mouth.

"RONNY"

Convenience plays a large role in whether or not a patient will seek medical care. "Ronny", a patient at the Sandy Level Mobile Clinic in Bethune, has been receiving care at this location for over 2 years. Ronny heard about this Mobile Clinic from a few of his friends and decided to stop by since it is within a few miles of his home. His sister drove him to his appointment today. When asked how he feels about this clinic, Ronny says, "I love coming here! It works out great!"


Satellite Clinic Visits (Mar '16 - May '16)
18
16
14
12
10
8
6
4
2
0
9
0
7
4
8
0
5
0
14
17
16
10
8
13
7
13
13
10
Dec...
Jan...
Feb...
Mar...
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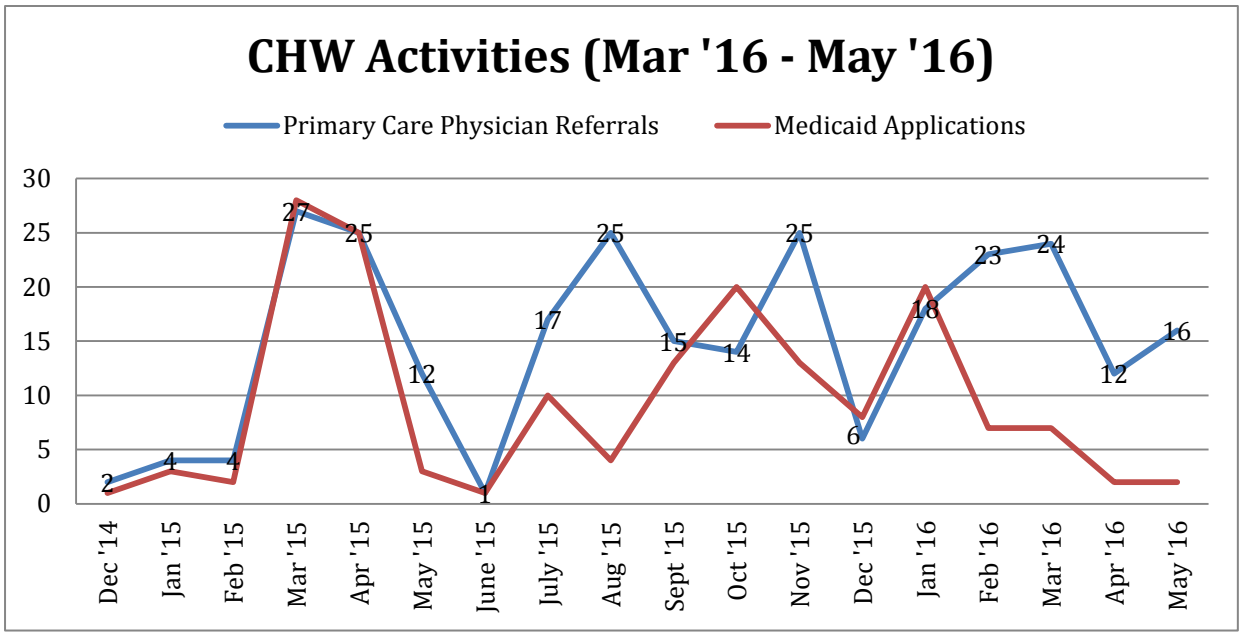
CHW Activities (Mar '16 - May '16)
Primary Care Physician Referrals
Medicaid Applications
30
25
20
15
10
5
0
2
4
4
27
25
12
1
17
25
15
14
25
6
18
23
24
12
16
Dec '14
Jan '15
Feb '15
Mar '15
Apr '15
May '15
June '15
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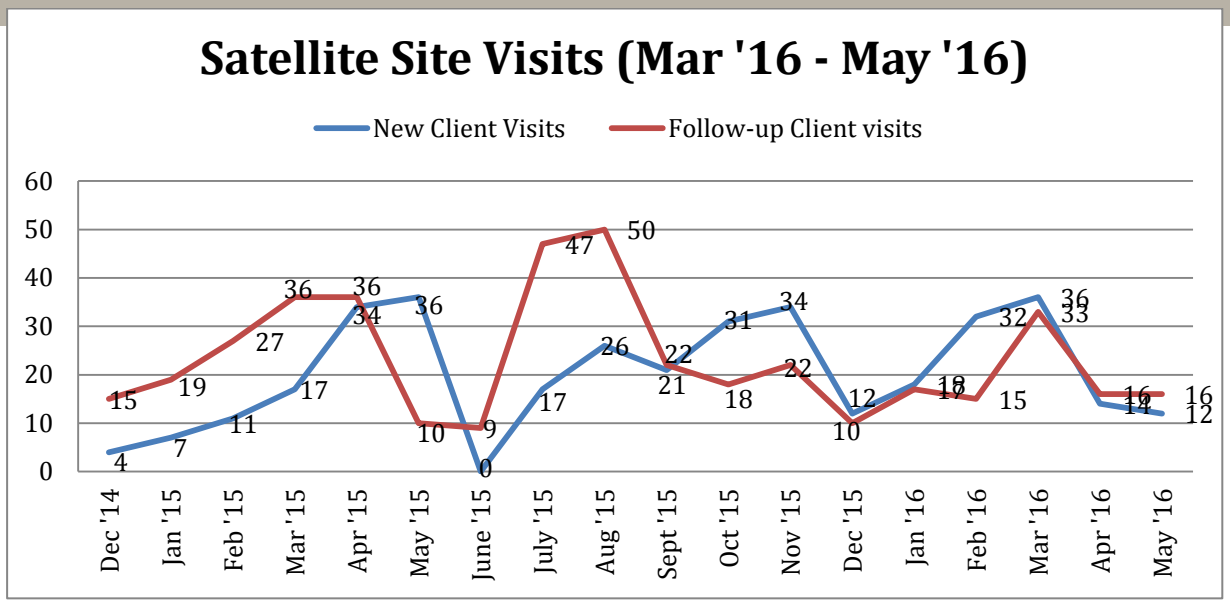
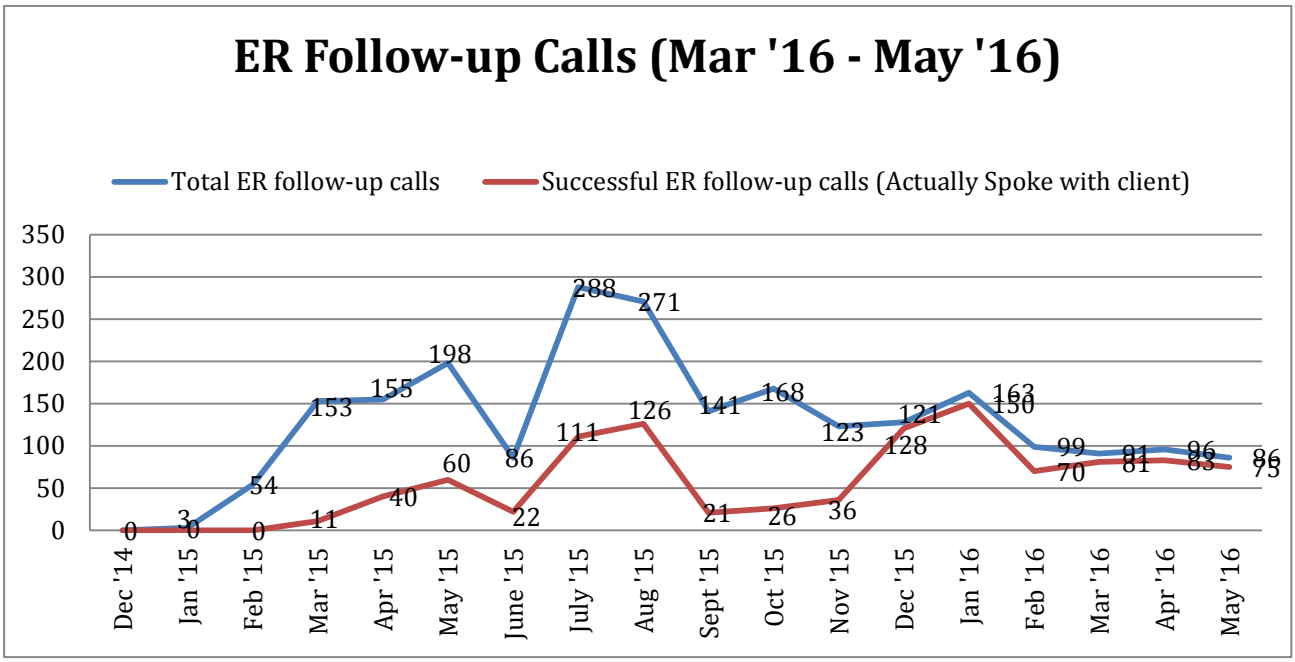
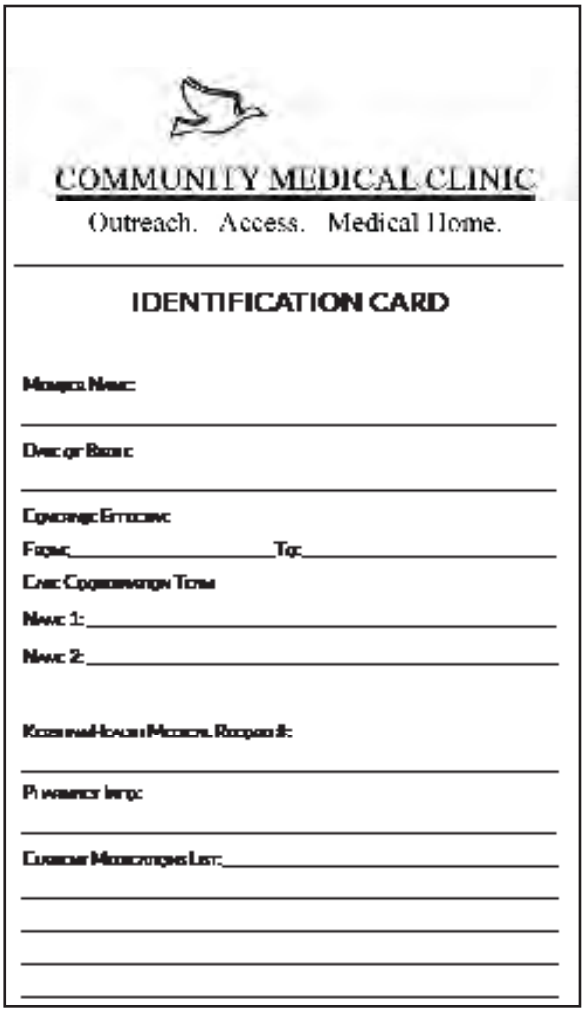
Dec '15
Jan '16
Feb '16
Mar '16
Apr '16
May '16


Satellite Site Visits (Mar '16 - May '16)
New Client Visits
Follow-up Client visits
60
50
40
30
20
10
0
Dec '14
Jan '15
Feb '15
Mar '15
Apr '15
May '15
June '15
July '15
Aug '15
Sept '15
Oct '15
Nov '15
Dec '15
Jan '16
Feb '16
Mar '16
Apr '16
May '16


ER Follow-up Calls (Mar '16 - May '16)
Total ER follow-up calls
Successful ER follow-up calls (Actually Spoke with client)
350
300
250
200
150
100
50
0
Dec '14
Jan '15
Feb '15
Mar '15
Apr '15
May '15
June '15
July '15
Aug '15
Sept '15
Oct '15
Nov '15
Dec '15
Jan '16
Feb '16
Mar '16
Apr '16
May '16

New Clinic ID card for all sites.

Front



COMMUNITY MEDICAL CLINIC

Outreach. Access. Medical Home.

IDENTIFICATION CARD

Member Name:

Date of Birth:

Coverage Effective:

From:_____ To:_____

Care Coordinator Team

Name 1:_____

Name 2:_____

Referral/Health Medical Record #:

Pharmacy Info:

Current Medications List:_____

Back

PRIMARY CARE OFFICE:

CMC Congaree Office • 110 C Engr DgKrug Sr, Congaree, SC 29030
803.713.0806

CMC Lugoff Office • 1165 US-1, Lugoff, SC 29078
803.408.0500

Borough Berwyn Clinic • 6390 Lugoff Rd, Kingsburg, SC 29067
803.713.0806

Copper Berwyn Clinic • 2604 US-1, Copper, SC 29022
803.713.0806

Kingsburg Berwyn Clinic • 2834 Lugoff Rd, Kingsburg, SC 29032
803.713.0806

Swamp Legs Berwyn Clinic • 2920 Tharpe Rd, Elgin, SC 29009
803.713.0806

Please carry this card in your wallet or purse. The information in this card may help you to quickly find the correct medical care, saving time and possibly costs.

- Call 24 hours in advance for written prescriptions.
- Give 48 hours notice to have orders written.

Bring all medications with you to every appointment, including medicines prescribed by other doctors and over the counter remedies, such as Goody powder.

CONTACTS:

Pharmacy Assistance Programs (PAP) • 803.713.0806 ext. 404

CMC • 803.713.0806 fax 803.713.0526

Care Coordinator Team • 803.408.0500 fax 803.408.0502

Outreach Team • 803.272.8325 fax 803.408.0502

cmcsc.org

Please present this card for all healthcare appointments.

COMMUNITY MEDICAL CLINIC
Outreach. Access. Medical Home.

Transitional Care Intake Form

Date: _____ Room No. _____

Patient Information

Patient Name: _____ DOB: _____

Address: _____ Phone: (___) _____

City: _____ State: _____ ZIP: _____

Admitting Dx: _____ PCP: _____

Hospitalist: _____

Family Member Contact: _____ Phone: _____

Support Person Contact: _____ Phone: _____

Medical History

Brief Medical History/Problem List: _____

_____

_____

Admitting Medications (if available): _____

_____

Welvista (circle one): Yes No

Transportation: _____

Barriers Identified: _____

Independent in self care: Yes No

Psychosocial: _____

_____

110 East DeKalb St Camden, SC 29020
803.272.8325

Additional Information

Comments/Concerns: _____

_____

_____

_____

Progress Notes: _____

_____

_____

_____

_____

_____

Team Members: _____

_____

_____

Signatures of Team:

Signature 1:_____Date: _____

Signature 2:_____Date: _____

Signature 3:_____Date: _____

Signature 4:_____Date: _____

110 East DeKalb St Camden, SC 29020
803.272.8325

Community Engagement & Outreach

Create vibrant relationships and functional networks with community members to accelerate trust, outreach and achievement of a shared goal.

Progress from March-May, 2016

The Community Medical Clinic team participated in various community events this quarter to increase awareness of the care coordination services provided through the contract (see detailed timeline on pages 34 - 37). Some of the highlights included actively participating in Student Improvement Councils, Teacher Appreciation Days and Fitness Days at the local schools, sending 430 materials about LiveWell Kershaw through the Sacks of Love program, sharing success stories in a WPUB radio spot event, and integrating with the Baron DeKalb Baptist Food truck. CMC is also designing new business cards to share with community members that include a short tag line about each person's role within the Clinic.

Leigh Williams launched an initiative to have community events at a local park. On a Saturday morning one patient, two volunteers, and three staff made mandalas. Leigh walked with a patient in the park for two Saturdays during fitness at the park.

Community council advisory meeting at Refuge satellite site.

Finish line at the Clinic Classic.

The group plans to continue to engage patients and staff in fitness and mindfulness exercises to reinforce what is taught during health coaching and client encounters.

Whitney Hinson began attending Eat Smart Move More Kershaw County meetings on a regular basis to network and learn about resources for our clients. These meetings are held at the United Way of Kershaw County on the second Wednesday of each month. The coalition is basically comprised of dedicated residents that are passionate about making Kershaw County a healthier place to eat, live, work, and play.

During this quarter, two volunteers were recruited and trained to work in the North Central Area. The volunteer recruiter/event planner's time was spent coordinating the Clinic Classic 5K fundraiser and the Volunteer appreciation/Memorial Garden dedication. Specific plans for this upcoming quarter include: recruiting 10 volunteers to work at the six county schools in the North Central Area during the week of school registration, conduct a new volunteer training, and visiting all of the churches served by CMC in the North Central Area by September 1, 2016.

Members of the community council advisory committee continue to meet monthly and guide the Community Health Workers on their efforts. In

Volunteers at the Memorial Garden dedication.

March, Beckie Tompkins and Rachael Sladek shared success stories about the number of clients seen at each of the church sites. The team brainstormed ideas for outreach, including speaking with churches on Wednesday evenings, and getting volunteers to talk with community members who can share our efforts by word of mouth.

In May, Whitney Hinson introduced the transitional care model that is beginning to take place, and Rachael Sladek gave an update on the School Based Health Center.

Special Outreach Events

CMC celebrated volunteer appreciation day and the dedication of a new Volunteer Memorial Garden on April 14th. The slogan for the event, which honored deceased and living volunteers of the clinic was "Volunteers Are the Roots of Strong Communities." A special presentation was given for each family representing a deceased loved one and all enjoyed an outdoor reception.

On April 30, 2016, CMC held its 9th Annual Clinic Classic 5K Walk/Run, which is the primary fundraiser for the clinic. Over 400 walkers and runners participated in this event supporting and advancing the mission of the Community Medical Clinic. Radio station WPUB was also on-site and interviewed patients, volunteers, and LiveWell Kershaw team members to spotlight the work taking place throughout the county. Board chairman Roy Fakoury said he loves running this 5K course and is proud to sponsor an event that supports a mission for the underserved. The Classic Challenge, encourages the 11 county elementary schools to participate in a healthy community wide event. The school with the most participants wins $750 to be used at the discretion of the school's principal. This year 6 schools and 153 students participated throughout the county. And 40 community members trained for 11 weeks prior to the 5K, including North Central High's very own vice principal, Ms. Rose Montgomery. The event this year was considered to be the most successful yet.

To build off the Clinic classic, this year launched the inaugural Biggest Loser Challenge. The competition included 74 participants from Lugoff-Elgin, Camden and North Central. Each area had a coach that worked with local participants and donated time and space for working out.

Plans for the next quarter include:

- North Central area School Registration July 27-28 (6 schools)
- Belk Kids Fest July 30
- Community Resource Fair July 31
- Camden City Council Health Awareness Aug. 23
- County Council July 26
- School Board
- Elgin Town Council Aug. 2
- Access Collaboration Group Aug. 8
- Engage local churches and volunteers

Pathway in the Memorial Garden.

Timeline of Community Events in Quarter 4

DATE	STAFF	DESCRIPTION	LOCATION	OUTCOME
March 3	Whitney, Susan, Holly	SC Free Clinic Awareness Day	Columbia, SC	Spoke to legislators and shared information about LiveWell Kershaw (LWK) and Community Medical Clinic of Kershaw County (CMC).
March 8	Rachael	Mt P Elem	Mt. Pisgah	Planned for Fitness Day at School Improvement Council (SIC)
March 10	Beckie, Rachael, Karen, Whitney, Sheri	Community Council at Refuge Baptist Church	Kershaw	10 Attended.
March 15	Beckie	DeKalb Food Truck	Camden	Interacted with approximately 30 people
March 15	Rachael, Karen	Mobile clinic at Sandy Level Baptist	Bethune	5 appts, 1 client encounters
March 21	Whitney	Mt P Elem Family Fitness Day	Mt. Pisgah	100 attended. 10 BP. Giveaways
March 21	Rachael	Bethune Elem	Bethune	Student Improvement Council
March 21	Beckie	Baron DeK Elem Talent Show	Camden	Spoke to 25 parents
March 22	Beckie	KC Baptist Assoc	Camden	Send promo material through 430 Sacks of Love program
March 23	Rachael, Beckie, Karen	Mobile Clinic at Refuge Baptist	Kershaw	4 appts, 3 client encounters
March 24	Rachael, Whitney	KC School District Transition Fair at Rhame Arena	Camden	100 attended, LWK booth
March 30	Beckie	CMC WPUB Event	Camden	Live radio with brief overview of LWK efforts
March 31	Rachael, Beckie, Karen	Mobile Clinic at Buffalo Baptist	Buffalo	4 appts, 2 client encounters
April 4	Rachael	Bethune Elem	Bethune	Student Improvement Council

DATE	STAFF	DESCRIPTION	LOCATION	OUTCOME
April 4	Rachael, Beckie, Karen, Leigh Pate	Mobile Clinic at Cassatt Baptist	Cassatt	0 appts, 2 client encounters
April 5	Beckie	Baron DeKalb Baptist Men's Group	Camden	Outreach, 5 attended
April 8	LWK, CMC (including board members) and USC staff	Satellite Site Bus Tour	Kershaw County	Road a bus to every CMC satellite site
April 12	Beckie, Rachael, Karen	Mobile Clinic at Sandy Level Baptist	Bethune	5 appts, 2 client encounters
April 14	Rachael, Karen, Whitney, Beckie, Holly, Susan	CMC Volunteer Appreciation Day and Memorial Garden Dedication	Camden	LWK Volunteers Recognized
April 18	Rachael	Bethune Elem Family Walk Day	Bethune	100 attended. 21 BP, 14 glucose, and 1 client encounter
April 19	Beckie	Baron DeKalb Baptist Food Truck	Camden	3 food truck applications submitted
April 19	Beckie	NCHS	Kershaw	SIC monthly meeting. 3 attended, Discussed outreach efforts for SBHC and overall LWK program
April 20	Beckie, Rachael, Karen	Mobile Clinic at Refuge Baptist	Kershaw	7 appts, 3 client encounters
April 21	Susan W	HOP Meeting	Columbia, SC	100 attended, Gave presentation on LWK and use of the Switch principles
April 25	Beckie	Midway Elem	Cassatt	Overview of Services to SIC-5 attendees at 3PM. PTO-6 attendees at 6 PM
April 25	Rachael	Mt P Elem	Mt. Pisgah	Student Improvement Council
April 27	Beckie	NCHS	Kershaw	Provide Mrs. Jirel SBHC application and LWK promo for Peach Jar social media
April 28	Beckie, Rachael, Karen, Mary Lee Addis	Mobile Clinic at Buffalo Baptist	Kershaw	1 appts, 0 client encounters

DATE	STAFF	DESCRIPTION	LOCATION	OUTCOME
April 30	Rachael, Whitney, Sheri, Holly, Susan	CMC Clinic Classic 5K	Camden	Outreach and Biggest Loser Contest
May 2	Beckie, Emily, Whitney, Rachael, Susan W., Susan G., Mariana, Alex, Cameron, Grant	NCHS Teacher Appreciation lunch	Kershaw	Outreach
May 2	Beckie, Rachael, Karen	Mobile Clinic at Cassatt Baptist	Cassatt	2 appts, 2 client encounters
May 5	Emily, Whitney, Rachael, Beckie, Susan G., Mariana	NCMS Teacher Appreciation lunch	Kershaw	Outreach. Announcement of SBHC for NCMS students.
May 5 & 6	Beckie, Rachael	NCHS	Kershaw	32 SBHC applications distributed in car rider line
May 6	Beckie, Rachael, Whitney	NCHS Athletic Event Day	Kershaw	12 SBHC applications distributed plus 50 apples and waters
May 9	Rachael	Bethune Elem	Bethune	Student Improvement Council
May 10	Rachael, Beckie, Karen	Mobile Clinic at Sandy Level Baptist	Bethune	1 appts, 1 client encounters
May 11	Beckie, Rachael, Whitney	Rabbit's Convenient Store	Kershaw	Outreach, 52 promo, waters and apples distributed
May 12	Beckie, Rachael, Karen, Whitney, Sheri	Community Council at Refuge Baptist Church	Kershaw	7 Attended
May 18	Rachael, Beckie, Karen	Mobile Clinic at Refuge Baptist	Kershaw	6 appts, 8 client encounters
May 20	Rachael, Beckie, Emily	NCHS Field Day	Kershaw	Distributed applications and assisted Athletic Director with concessions
May 23	Rachael	Mt P Elem	Mt. Pisgah	Student Improvement Council
May 23	Susan W	Kershaw County Health Services District Board Meeting	Camden	13 attended, presentation on LWK and accomplishments
May 26	Beckie, Rachael, Karen	Mobile Clinic at Buffalo Baptist	Kershaw	1 appts, 0 client encounters

DATE	STAFF	DESCRIPTION	LOCATION	OUTCOME
May 26	Susan W	Rotary	Camden	65 attended, presentation on LWK and plan for future
May 27	Rachael, Whitney	Healthy Schools Spring Workshop at NCHS	Kershaw	Beth Barry with Alliance for a Healthier Generation allowed schools to celebrate and share experiences
May 31	Beckie, Rachael	Bethune Discount Store	Bethune	Outreach with 4 blood pressure checks and interactions with approximately 15 people

Clinic Classic participants shared their healthy living goals.

Local residents stopped by the clinic and shared their stories on-air during the radio remote on March 30.

Kershaw County School District Health Fair, March 24.

LiveWell KERSHAW
"Your Bridge to Better Health"

May 2016

Spring Newsletter

110 C East DeKalb Street Camden, SC 29020
803.272.8325 livewellkershaw.org
facebook.com/LiveWellKershaw
twitter.com/lwkershaw

Outreach News

The Biggest Loser Challenge

This spring the Community Medical Clinic of Kershaw County sponsored the Biggest Loser Challenge, which began with an initial weigh-in February 27 for residents of Lugoff, Elgin, Camden, and the North Central area, and ended April 30 at the Community Medical Clinic's 9th Annual Clinic Classic 5K Run/Walk. North Central Middle School teacher and track coach Katie Elliott was one of several successful participants.

"I was so happy to find out about and join the Biggest Loser challenge," said Ms. Elliott. "I began changing my eating habits and became more active back in January, and this competition arrived just in time to keep me motivated during a lull in my weight loss!"

Katie's story is truly an example of building a bridge to better health. Congratulations Katie!

Upcoming Events

- Cooking Matters! Class at Food for the Soul. Mondays, June 6 - July 18; 11 am - 1 pm. Call 432-4771 to register.
- Community Council Meetings. June 9 & July 14; 6 pm. Refuge Baptist Church (2814 Lockhart Road)
- School registration for NCHS (July 27 & 28) and NCMS (July 27). LiveWell Kershaw will be enrolling students in the SBHC.

School Based Health Center Update

Healthcare for NCMS Students

Beginning this August North Central Middle School students will have access to the NCHS School Based Health Center (SBHC) for the 2016 - 17 school year. The new hours for the SBHC will be Monday - Friday from 8:00 am - noon.

A nurse practitioner will work with the school nurse, Ms. Bowers, to provide diagnostic care and will write some prescriptions. To enroll a student please pick up an application at the front office of NCMS or NCHS, the Community Medical Clinic of Kershaw County, or one of our community satellite sites. Forms can also be found at our website (livewellkershaw.org), at the KCSD Peachjar website or requested by phone (803.272.8325).

This program is not income based. Students MUST be enrolled to receive services. SBHC services are FREE for all enrolled students.

Get Involved!

There are many volunteer opportunities available, from helping with the Community Medical Clinic in Camden to working at our community satellite sites. For more information contact Cynthia Nelson: 803.713.0806 or cnelson@cmcofkc.org

NCMS teachers and staff enjoy a luncheon hosted by the SBHC during Teacher Appreciation Week.

Upcoming Mobile Clinics

Cassatt Baptist Church.....June 6
Sandy Level Baptist Church.....June 14, July 12
Refuge Baptist Church.....June 22, July 20
Buffalo Baptist Church.....June 30, July 28

The mobile clinic offers many of the same services available in a doctor's office for the uninsured. To schedule an appointment please call 803.272.8325. Clinic hours are 9 am -1 pm.

Wellness Update: Avoiding Burnout*

The school year is almost over and many of us are counting down the days to vacation. For some of us, vacation could not come soon enough. If you feel this way it is possible that you may be experiencing burnout, a physical and psychological symptom that often involves exhaustion, decreased productivity, and just not feeling like yourself.

Burnout results from a number of difficulties in life, including stress. While some stress is a normal part of life, it is important to address stressful feelings early, rather than waiting until it leads to psychological and physical burnout. Building strategies that promote wellness into your work and home life now will help to keep daily life stressors at bay, prevent burnout, and improve wellness for your whole family.

- Seek out helpful supervision at work or school.
- Stay active outside of work and prioritize time for yourself and your physical and psychological health. Making time to prioritize your own health shows your children how to prioritize wellness and develop healthy strategies in their own lives.
- Personalize your work environment with items that make you feel good.
- Manage your time at work and at home: delegate tasks, take more frequent breaks, and schedule time to relax and recuperate.
- Establish a peer support group with colleagues. Talking about issues with peers can be a healthy way to get things off of your chest and can be helpful in talking through potential solutions to the problem with others who understand the situation.
- After venting to others about what is bringing you down, come up with a plan to work through the problem.
- Set daily, weekly, or monthly goals to help you prioritize and stay focused on larger goals.
- Find relaxation strategies that work for you (such as some of the tips outlined below) and use them regularly to maintain wellness and prevent burnout.

Even if you are already experiencing burnout, there is still hope! By making efforts like those listed above, you can help to relieve the stress in your day-to-day life. Remember to make your own well being a priority.

Learning to Relax*

A variety of techniques can be used to encourage relaxation, not only during times of stress, but throughout every day. Here are a few suggestions from the University of Maryland Medical Center:

Toe Tensing: This technique is designed to draw tension away from your body. Lie on your back, eyes closed. Tense your toes. Pull all ten toes back towards your face, and count to 10. Then, relax them and count to 10. Repeat the cycle 10 times.

Deep Breathing: Concentrating on breathing is a great way to relax and synchronize the entire body. Lie on your back in a relaxed position. Slowly inhale, filling your lower and then upper chest with air. Hold your breath for a second or two before slowly letting the air out. Wait a few seconds and repeat.

Guided Imagery: This process involves picturing yourself in a peaceful setting. Imagine that you are at your favorite place (such as the beach, the mountains, or a field). Practice picturing the sensations you would feel if you were actually there—the smells, the sounds, the scenery, and the emotions.

Quiet Ears: This activity is meant to try right before you go to sleep. Lie on your back, eyes closed, and hands behind

your head. Relax your hands, and place your thumbs in your ears, blocking the ear canals. You will hear a high-pitched rushing sound. Listen to the sound for 10 to 15 minutes, then relax your arms at your sides and go to sleep.

These are just examples of strategies that research shows work for many people. But relaxation strategies differ for everyone and you should use what works for you, whether it be spending time alone in a quiet place, listening to music, or getting out of the house and going for a walk.

** Adapted from the Center for Adolescent Research in Schools (CARS) newsletter for December 2011.*

LiveWell Kershaw, an initiative of the Community Medical Clinic of Kershaw County, is working to make Kershaw county the healthiest county in the state of South Carolina. In 2015, LiveWell Kershaw opened a School Based Health Center (SBHC) at North Central High School that provides health screenings and wellness services including coaching/behavioral skills. For more information contact Emily Mancil, Wellness Facilitator for North Central Area Schools (803.900.5598).

Finalized Strategic Plan

3 Year Strategic Plan for the Community Medical Clinic 2016-2018

Updated Mission and Vision Statements

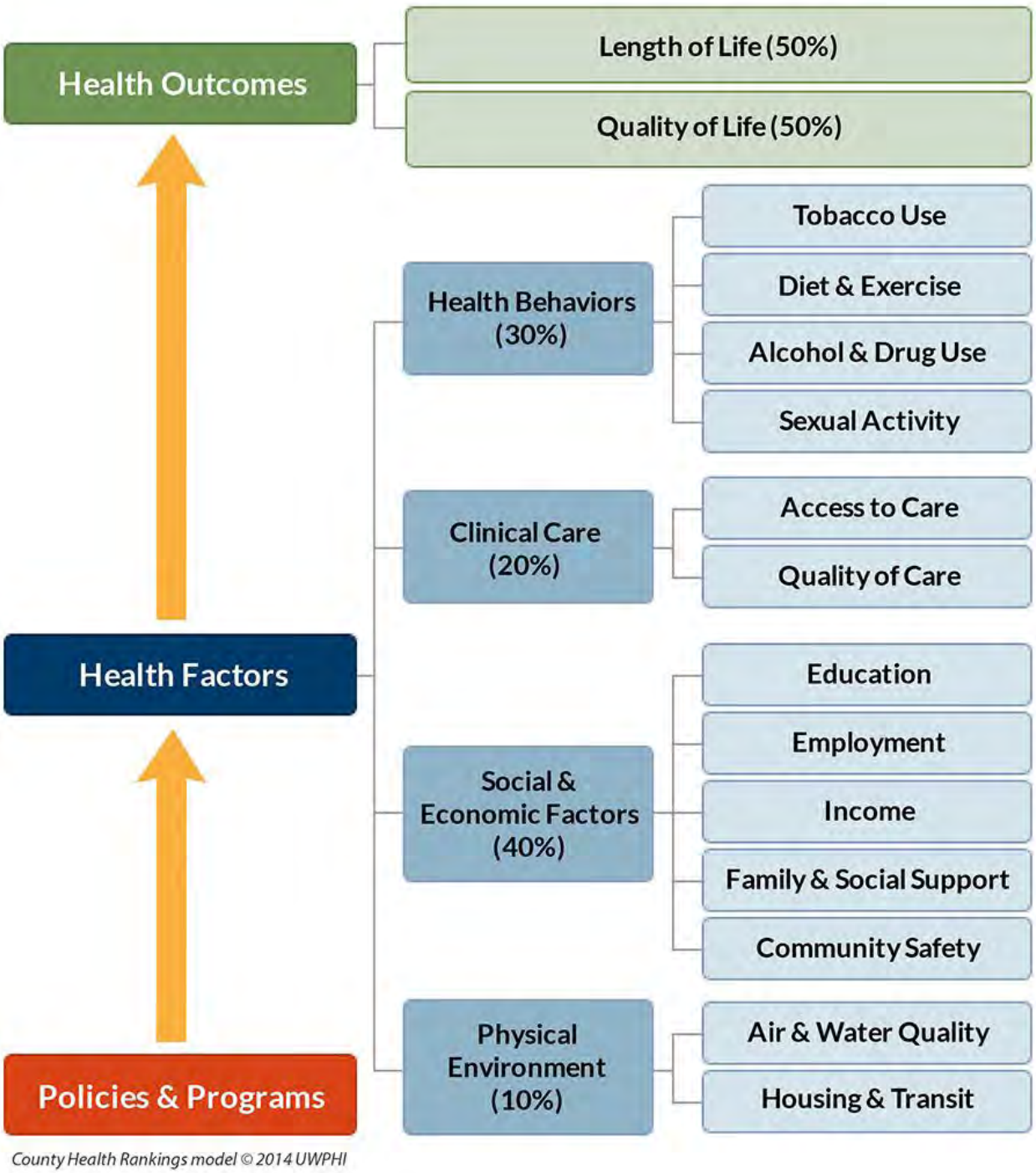
Vision:
A healthier Kershaw county where individuals and communities are empowered to take charge of their own health and well-being.

Mission:
We will lead a collaborative effort to provide the resources for improved health of the underserved, while always respecting the dignity, integrity and diversity of those we serve and those who serve.

Core Values:

- Patient and community centered
- Value all human and financial resources and use them wisely
- Compassion
- Acting with integrity and honesty
- Innovation
- Dignity and respect
- Diversity
- Quality
- Accountability and transparency
- Continuity of care
- Empowerment
- Overall well-being

RWJ County Health Rankings Model



A Objective : Diversify and grow revenue services to ensure sustainability of the clinic **Core Team Members:** Joseph, Cathy, Jim and TBN Development Director	
Strategies	**Benchmarks and Metrics**
Hire Development director	• Job description made • Job posted • Date of hire
Conduct general fundraising campaign	• $720,000 raised annually • Special events hosted (Clinic Classic, Oyster BBQ) • Major donors at each financial level • More effective Annual Campaign
Implement donor-centric model	Survey donors
Create an endowment	• Develop and pursue a Legacy Program • Secure $3 Million in the endowment
Increase awareness of clinic in charity evaluation websites	• Secure Platinum status through GuideStar • Secure premium status through Charity Navigator
Re-apply for the legislative proviso to continue and expand LiveWell Kershaw contract	• Meet with key legislative leaders • Showcase LWK efforts • Submit proposal and budget request

B Objective: Ensure effective data management systems **Core Team Members:** Lawanda, Susan W, TBN Board Member, and Keri	
Strategies	**Benchmarks and Metrics**
Integrate internal systems for patient health records	• Adoption of one Electronic Health Record or multiple systems if users can easily access all needed information • Date when Care Coordination Team goes paperless • Date when providers are able to read case management notes • Determination of whether Fhases will be kept or abandoned • Hire IT consultant • Develop and execute data management plan for reports and Quality Improvement
Ensure internet, phone and fax connectivity at all mobile sites	• Landline access for mobile sites • # of updated facility use agreements in place • Explore cloud-based platform • Lobbying for Verizon coverage in North Central
Achieve effective data interchange with healthcare partners	• Obtain access for patient Medicaid and Medicare status to determine eligibility • Explore SCHIEx partnership • Contribute data to the SC Free Clinic Association database
Standardize training , policy and procedures for volunteers and staff	• Online training in place for volunteers and staff

C Objective : Be the recognized leader in population health in Kershaw County through Community Outreach & Engagement **Core Team Members:** Cynthia, Keri, Whitney, Jim, Joseph, and Cathy	
Strategies	**Benchmarks and Metrics**
Launch one website	• Development of content for a merged website • Date of new merged website launch • Google analytics (hits, length of time on page, etc)
Re-brand of Community Medical Clinic	• New logo developed • New branding statement developed; new elevator speech developed • New business cards; new patient ID card • Focus groups conducted in Lugoff and Elgin to guide branding • Stories, photos, and videos collected • Speaking engagements and presentations
Create internal communication plan	• Development and implementation of plan
Create external communication plan	• Development and implementation of plan

D Objective : Provide client-centered holistic care to meet an individual's and family's needs **Core Team Members:** Susan G, Susan W, Leigh, Mary, Beckie, Sheri and Dr. Jansen	
Strategies	**Benchmarks and Metrics**
Expand diversity of specialty care	• Completed baseline needs assessment for specialty care • New and renewed agreements with specialists in place • All patients using specialty services needed
Expand dental services to include prevention	• Meet with Development Director in 2017 to develop funding strategy in 2017
Implement tele-health	• MOUs in place with College of Nursing and MUSC
Explore becoming a dispensing pharmacy	• Research Pharmacy Act to ensure community members needs are met • Make decision regarding becoming a dispensing pharmacy
Implement the Community Hub and Pathway Model	• Conduct training with all staff • Form and launch transitional care teams • Continue to provide health coaching using NewLeaf • Create integrated healthcare teams that include mental health counselor

E Objective : Provide resources and knowledge to access needed health and social services **Core Team Members:** Geraldine, Jeana, and Karen, Kevin and Dr. Jansen	
Strategies	**Benchmarks and Metrics**
Launch volunteer "Uber" partnership	• Insurance secured for volunteers to drive personal vehicle • Driver czar secured • Volunteer drivers recruited • Churches involved in partnership • All patients that need transportation use the medical uber
Become a permanent stop with the Grocery Van	• Formal MOA in place • # of patients using Grocery van to visit clinic
Conduct on-site labs in Bethune	• Secure KershawHealth phlebotomist
Establish site at Elgin Urgent Care	• Establish MOU with KershawHealth • Secure Nurse Practitioner
Explore hiring a Nurse Practitioner at Lugoff site	• Date for Nurse Practitioner services to begin • Promote this service in Lugoff and West Wateree
Re-evaluate mobile and satellite sites	• County-wide Scatter maps produced for ER visits • New sites opened • Non-productive sites closed
Expand School-Based Health Center to include 3 high schools and 4 middle schools	• Students enrolled in clinic • Students receiving services by NP or MH counselor • Teachers and family members seen at clinic

F Objective : Facilitate activities to support healthy behaviors **Core Team Members:** Rachael and Sarah	
Strategies	**Benchmarks and Metrics**
Provide ongoing education and activities for tobacco use, diet and exercise, drug and alcohol use and sexual activity	• Completed asset map of what's available • Completed needs assessment • Health program coordinator hired • Partners engaged • 50% of patients participate in needed activities • Volunteers and staff that lead or co-lead activities • Events offered, type of event
Create a wellness and fitness pilot initiative in North Central area	• Identified partner and location • Data initiative was launched • Participation and outcomes from initiative
Support the development of a virtual library of health resources	• Content collected • Date of virtual library launch

Contact Information

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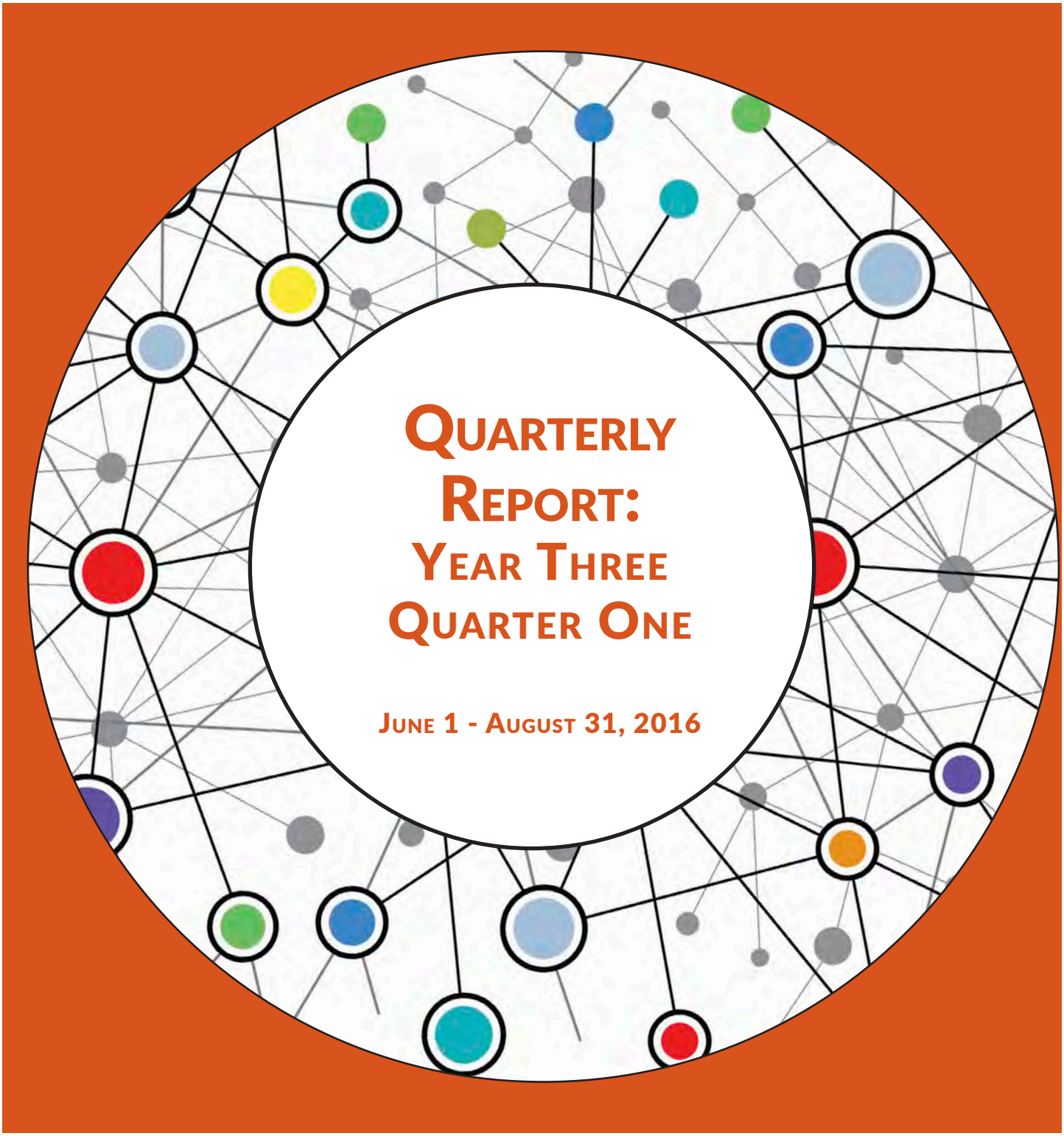
LiveWell KERSHAW

"Your Bridge to Better Health"



Quarterly Report: Year Three Quarter One

June 1 - August 31, 2016

Table of Contents

INTRODUCTION

September 1, 2016

The LiveWell Kershaw team at the Community Medical Clinic has been busy this summer advancing strategies, specific goals, and our message to community members and partners. Our ongoing efforts to use Continuous Quality Improvement as a lens for our work has allowed us to see areas that are working really well and also areas for improvement. We have also added additional team members to keep up with our fast-paced expansion of services and geographical area while also fulfilling the six strategies outlined in our three-year strategic plan.

Based on conversations with board members, staff members, community members, and partners, we recognize the increasing importance of connecting the dots. Ken Blanchard, a management expert and author, once said: "**Connect the dots between individual roles and the goals of the organization. When people see that connection, they get a lot of energy out of work. They feel the importance, dignity, and meaning in their job."** This summer, we have been working on connecting the dots between team members, policies, and procedures, terminology, approaches, funding and models. With various presentations given this summer to community organizations, we have been able to crystalize our message further and connect even more dots between what's occurring at the Community Medical Clinic and local community efforts. We will continue to strive to make time for these connections to take place, before advancing too quickly ahead. Without the connections, information and assumptions become tangled and difficult to navigate. Clarity of message and connection to the bigger picture is essential and cannot be underestimated.

We are excited to hear good news and positive reports coming from our partners at KershawHealth, our patients, school administration, and even our employees. Be sure to read the stories of Pamela, Craig, Felipe, Sally, and Manuel in this quarterly report. We are streamlining quantitative data collection at all of our sites to give an accurate depiction of patients reached and more importantly, the outcomes that our patients are meeting during their journey to improved health.

Please join us in our efforts for a "healthier Kershaw County where individuals and communities are empowered to take charge of their own health and well-being."

Best in all you do,

Holly Hayes
Evaluator

Susan Witkowski
Chief Executive Officer

Expansion of CMC

Expansion of Community Medical Clinic

With the expanded vision of the Community Medical Clinic approved by the Board of Directors in the strategic plan, the leadership has decided to add several new team members to support our population health efforts. In an effort to better tell our story, photos of all Community Medical Clinic team members from our Camden, Lugoff, and satellite locations as well as our academic partners at the University of South Carolina can be found on pages 5 - 8.

New Team Members

We have added a Nurse Practitioner, one Community Health Worker, and two Community Care Coordinators to the care coordination team. All of the new team members live in Kershaw County and have a significant amount of expertise in clinical care, social determinants, and also the community that they serve.

Debbie Davis joined the CMC team on July 11th as a Community Care Coordinator and is housed at the Lugoff satellite. She graduated with her nursing degree from the University of South Carolina. She has over 30 years of nursing experience in many specialty areas including Pediatrics, OB, GI, and Oncology. She has been married for 29 years to her husband, Gregg and lives in the Baron Dekalb area of Kershaw County. She is looking forward to helping others take charge of their health.

Brandi Thompson joined the CMC team on August 22nd as a Community Care Coordinator and is also housed at the Lugoff satellite. She graduated from Francis Marion University and Florence-Darlington Technical College with her nursing degree. She has over 19 years of nursing experience in many specialty areas including, but not limited to GI, Med-Surg, ER and Pediatrics. Additionally, she served as a Professional Community Healthcare Liaison in Kershaw County. Brandi is

CMC team members examine monthly data reports during administrative day.

happily married to Benjy Thompson and they are the proud parents of two amazing children that attend Lugoff area schools. Brandi is passionate about helping others and is excited about giving back to her community.

Jodi Rodgers, a Community Health Worker, began on August 22nd and is housed at satellites in the North Central Area. She graduated with a counseling degree from Marshall University. More recently, Jodi served as an area sales manager at Belk in Camden connecting local non-profits and also worked with the Department of Social Services in the food stamps division. She is very active with PTO's and is excited to work with the Community Care Coordination team. She will be working with the other Community Health Workers to serve as an extender to the Nurse Practitioner and will be providing resources to residents in need. Jodi is married to Coach Jamie Rogers at North Central High School and has two children that attend Midway Elementary School.

Vicky Craig, a Family Nurse Practitioner, was welcomed to the team on September 6th, 2016 as the Satellite Operations Director. She will oversee the clinical operations of the School Based Health Center and satellites, as well as see patients. She attended the University of South Carolina and the University of Massachusetts-Boston. After joining the nursing field in 2005, she worked extensively in the ICU and CCU. Her name may sound familiar as she has previously worked at the Healthcare Place at Bethune. Her husband and 15 year old son have lived in the Bethune area since 1998. Vickie is very excited to join the Community Medical Clinic of Kershaw and to begin inspiring others to become involved in their own healthcare in hopes of improving their health outcomes.

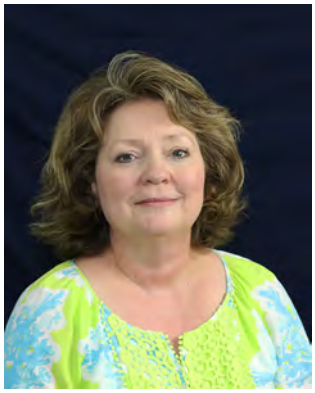
Community Medical Clinic Team 2016

Mary Lee Addis, FNP-BC
Nurse Practitioner
“Provide compassionate care to help patients live healthier lives.”

Sheri Baytes, RN
Community Care Coordinator
“I will empower you to take charge of your health.”

Keri Boyce
Communications/Marketing
"Storyteller connecting compassionate people, vital resources and medical care."

Geraldine Carter
Pharmacy Manager
“Compassionate, resourceful advocate to assist you with prescriptions to achieve and maintain a healthier lifestyle.”



Vicky Craig, FNP
Satellite Operations Director
"Individualized holistic care to improve the health within our community."

Debbie Davis, RN, BSN
Community Care Coordinator
“Helping you take charge of your health.”

Christie Derrick
Counselor
“Helping you feel happier and healthier.”

Holly Hayes
Facilitator and Evaluator
“Braiding voice and strategy into action.”

Mary Hill
Office Manager
“Connecting all office functions to meet your healthcare needs.”

Grant Jackson
Designer/Media Resource Consulant
"Effectively presenting useful data for all."

Jeana Johnson
Community Care Coordinator
“Care coordinator to help you improve your overall health using a holistic approach.”

Kathryn Johnson
Graduate Assistant
“Synthesizing data and stories to inform actions.”

Mariana Martinez, CNA
Bilingual Nursing Assistant
“Bridge to better health by caring,educating and providing a healing touch to all our patients.”

Cameron Massey
Wellness Counselor
"Supporting students and teachers to achieve their goals."

LaWanda Miller, MBA
Compliance/Policy & Procedure Specialist
“Ensuring that we provide Quality Healthcare for our patients through Compliance, Effective Training & Innovated systems.”

Cynthia Nelson
Volunteer/Special Events Manager
“Innovative leader creating change so you can live a healthy lifestyle”

Alicia Pendergrass, FNP
Nurse Practitioner
"Empowering patients to improve quality of life through support and education."

Jodi Rodgers
Community Health Worker
“Helping you connect the dots to better health.”

Rachael Sladek
Community Health Worker
"If you have a healthcare need, I can help get you on the right path."

Brandi Thompson, RN
Community Care Coordinator
"I will empower you to take charge of your health."

Beckie Tompkins
Community Health Worker
"An advocate for connecting people with resources to enhance their health and overall wellbeing."

Jessica Wilkes, DNP
Nurse Practitioner
"Your partner for better health."

Susan Witkowski, CHCQM
Chief Executive Officer
"An innovative leader creating change in the healthcare system to support a healthy lifestyle."

Care Coordination Team Using the Hub and Pathway Model

Snowflake Leadership Model

The Care Coordination team for the Community Medical Clinic is led by a Nurse Practitioner (NP) and is supported by at least six individuals that work together to serve the needs of the patient (see Figure 1. Snowflake Leadership Model). This team includes a Community Care Coordinator, Mental Health Counselor, Community Health Worker (CHW), Certified Nursing Assistant (CNA) or License Practical Nurse (LPN) , Pharmacy Assistant and Volunteer. The Nurse Practitioner in this model is supported by the CEO of the Community Medical Clinic as well as the Medical Director. Eventually, all team members within the Community Medical Clinic will transition to the snowflake leadership model which will empower team leads to make decisions in a collaborative environment.

Each team member has a unique and complementary scope of practice which allows them to support each other and more importantly, the patient. Patients can

Team members examined quarterly data at the Lugoff satellite in August.

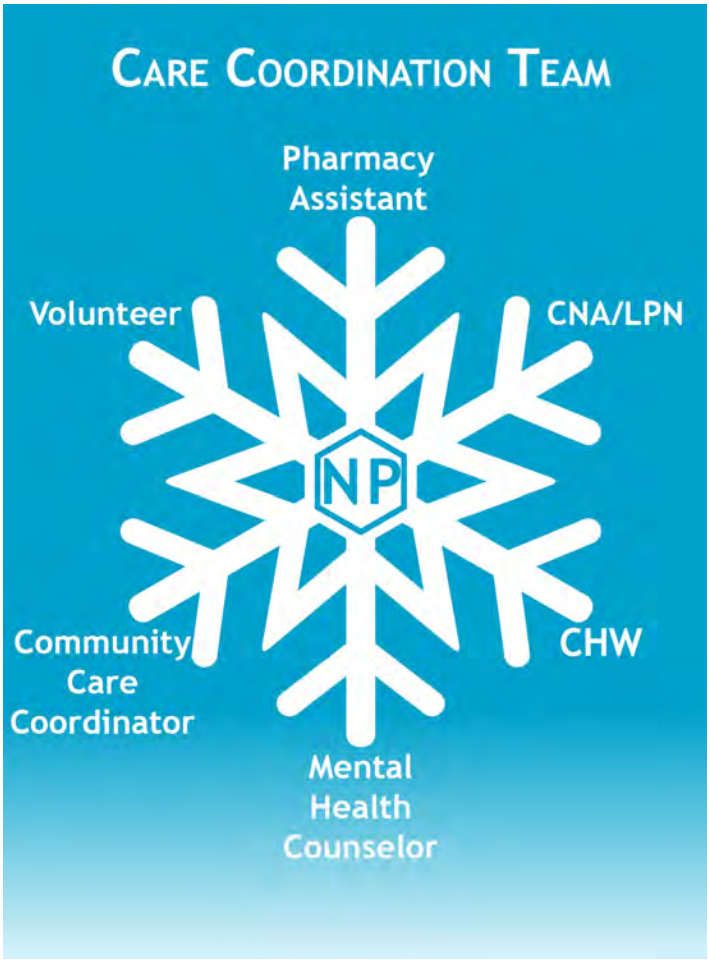
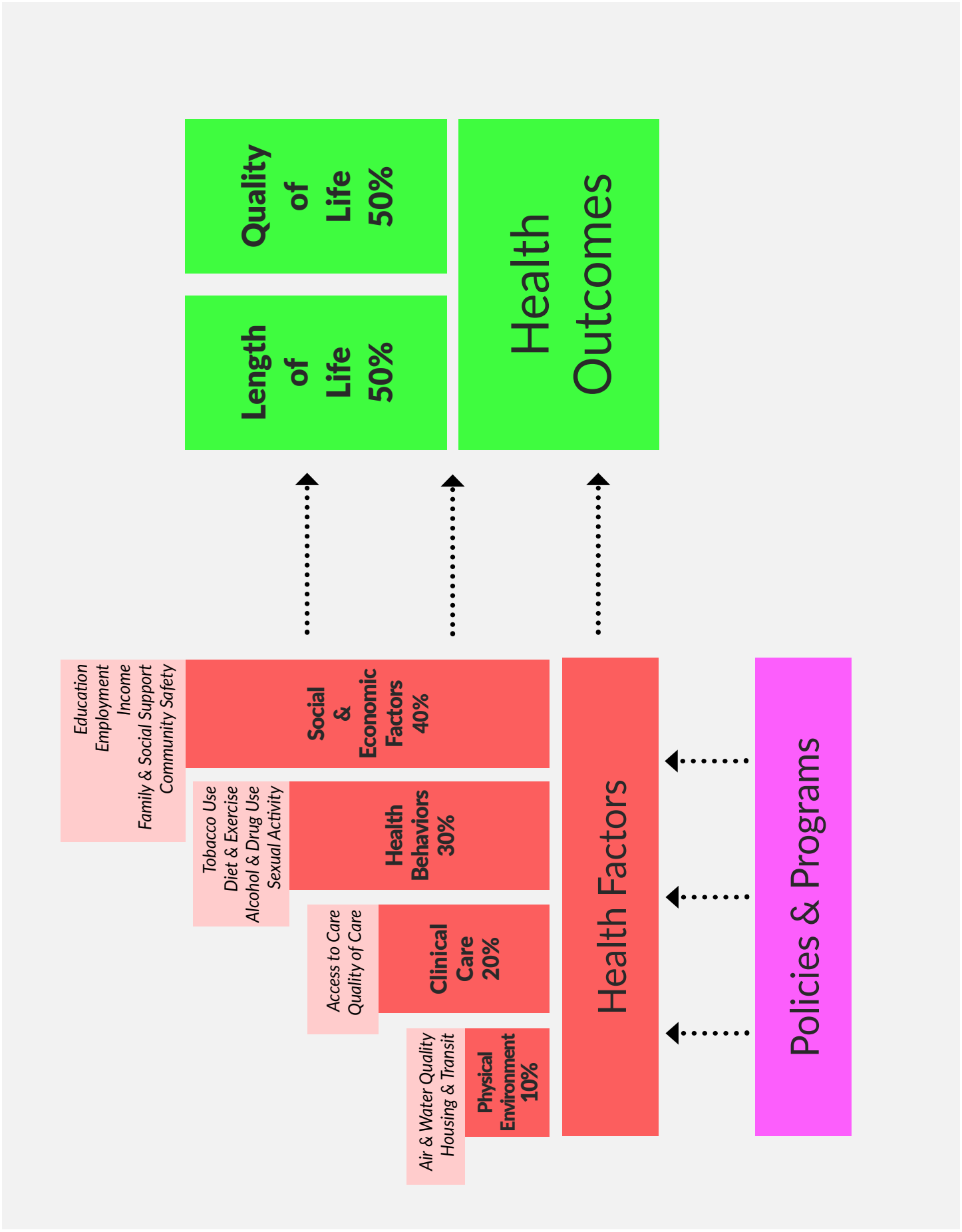


Figure 1.

be seen by anyone on the team at the Camden office, the Lugoff office or any of the satellites (formerly called church mobile clinics and care coordination sites). The two patient primary outcomes are to increase a patient's length of life and quality of life. Based on the health factors, care coordination team members focus on specific drivers related to a patient's health outcomes (Figure 2 on page 10). The Community Health Workers are primarily focused on social and economic factors, while the Community Care Coordinators (CCC) are primarily focused on health behaviors. Clinical care is provided by the Nurse Practitioner, Certified Nursing Assistant, and the Mental Health Counselor. The Pharmacy Assistant assists with clinical and the social and economic factors. Detailed descriptions of each of the team members are below.

Figure 2. Robert Wood Johnson County Health Rankings Model



Review of Data

The CMC team reviewed data for the past eight months and reviewed the productivity of each satellite and CHW. Based on these discussions grounded in the formative evaluation data, the following decisions were made:

Data from Dec. 2015 - May 2016	Actions decided by the Implementation team on 8.3.2016	Updates as of 8.31.2016 based on decisions made
The population around Sandy Level is 340 people. There have been 15 new client visits and a total of 31 follow-up visits with CHWs. There have been a total of 27 patients seen by a Nurse Practitioner from Dec-July.	Close Sandy Level Baptist church as a satellite. Relocate the patients/clients to the Healthcare Place at Bethune or another satellite.	The Sandy Level Baptist Church site officially closed on August 29, 2016. All of the patients who were being seen at this satellite are now being directed to Cassatt Baptist Church, the closest satellite.
The population of Cassatt is 4,445 and a large percentage of ER users are coming from the town of Cassatt. The largest Hispanic population is in the Cassatt community. There have been 22 new client visits and 8 follow-up visits in Cassatt with CHWs. There have been 5 patients seen by a Nurse Practitioner during 3 clinic sessions from Dec-July.	Adding an additional satellite site in Cassatt to test a non-church setting to reach the ER users in Cassatt. Group will explore Cassatt Water and Black River Cooperative. Susan Witkowski will also work with the priest at Our Lady of the Perpetual Help	The Community Health Workers met with leaders from both Cassatt Water and Black River Cooperative, and the meetings were not promising. The CHWs will continue to look at other non-church venues to see clients. Susan Witkowski plans to work with the priest at Our Lady of Perpetual Help Church to reach Hispanics in the North Central area.
We have only tested satellites at Baptist churches. We know that nationally, CHWs have successfully partnered with local EMS and fire stations to engage diverse populations.	Explore adding satellites at local EMS/Fire stations.	Susan Witkowski plans to investigate this further in the upcoming month.
Calls to residents who have been discharged from the ER have gradually declined over the past six months. In January there were 163 calls made and in May there were 86 calls made. The CHWs have not had time to make phone calls.	CHWs will prioritize phone calls and spent approximately 30% of effort on this a week. Making phone calls from the ER sheets, are beyond the scope of practice for Volunteers.	The CHWs have not been able to prioritize phone calls as of yet. Job descriptions have been changed to reflect this. Jodi Rodgers has been receiving training from the two CHWs which has taken time away from phone calls temporarily.
No clients have resulted from visiting businesses and the post cards distributed at the local business sites. CHWS have been spending 3-5 hours a week visiting businesses.	CHWs will not make weekly business visits. The residents at the businesses are often busy and typically with children and are not focused on the message that the CHW is sharing. The CHWs will build synergy and "drag" off existing community events with large participation from the community.	As of August 3, the CHWs are no longer visiting businesses weekly. The CHWs are focused on large community outreach events where they see synergy between their efforts and the community efforts.

Data from Dec. 2015 - May 2016	Actions decided by the Implementation team on 8.3.2016	Updates as of 8.31.2016 based on decisions made
Patient satisfaction has been assessed regularly for the past two years. The results consistently show that patients and clients are satisfied or very satisfied with services provided and the location of the satellites.	Stop evaluating patient satisfaction at the satellites. CHW will modify the patient intake form to include a question about where the patient/client heard about the satellites.	As of August 3rd, the care coordination team is no longer passing out paper satisfaction surveys. The intake form has been modified and is currently being used. The Evaluation team plans to host rotating focus groups with patients/ clients to elicit their feedback on the quality of services being provided at all satellites.
Community council meetings have occurred quarterly for the past two years at Refuge Baptist Church. Attendance has been declining and the same participants are attending each time. Due to the vast geography, a single community council is not informative in developing and sustaining satellites throughout the North Central area.	Suspend hosting all community council meetings. Begin having quarterly focus groups that rotate locations.	The evaluation team is planning to host the first focus group in October 2016.

Transitioning from Tracking Outputs to Tracking Outcomes

The Care Coordination team realizes that to fully implement and adapt the Community HUB and Pathway model, data must be readily available and outputs and outcomes need to be linked. Within the model, it's important to know at any time how many open and closed pathways a client has in order to ensure that these pathways are closed in a timely manner. As a result, the Community Care Coordinators reviewed all of their paper charts for the past year, which included approximately 2,100 patients. Each case was reviewed to determine if the case was still open or not. If open, each patient was stratified by risk level (healthy, at risk, rising risk or complex) and then assigned a Community Care Coordinator. There are currently 400 active cases.

Each of the Community Care Coordinators currently have a case load of about 90 clients with 80% of the clients being classified as rising risk or complex. All of the Community Care Coordinators and Community Health Workers are being trained in Fhases, the electronic case management system, which will now be solely used for all open and new cases. An IT consultant hired by the Community Medical Clinic is working with Fhases to ensure that all appropriate pathways and the outcomes of the pathways are entered into the system. In addition, a SQL database is being developed to begin to report meaningful data from the Community Hub and Pathway model. Data from both the Electronic Health Record (IMS) and the case management system (Fhases) will be exported daily and integrated together to produce reports that can be used for our CQI efforts as well as evaluation and grant reporting.

Job Descriptions

Nurse Practitioner

Nurse Practitioners play an integral role in team-based and patient-centered models of care. The Nurse Practitioner provides medical diagnosis and treatment of patients. The Community Medical Clinic's Nurse Practitioner has coded over 76% of their patient visits as a level three or level four visit, which demonstrates the complexity of the patients they are serving (See Figure 2). The Nurse Practitioner also serves as the lead for the Care Coordination team and oversees the activities of care coordination team members in relation to the patient and their needs.

CPT CODE	Description	Percent Visits
99203	New Office Visit Patient Level 3	1.5%
99204	New Office Visit Patient Level 4	6 %
99211	Established Office Visit Level 1	2%
99212	Established Office Visit Level 2	1%
99213	Established Office Visit Level 3	39%
99214	Established Office Visit Level 4	30%
99215	Established Office Visit Level 5	<1%

Figure 2. *Data from June 2015 through May 2016 at the Community Medical Clinic*

Mental Health Counselor

The Mental Health Counselor identifies patients' strengths and options for treatment related to mental health. The Counselor is responsible for completing a full assessment of each patient referred in order to understand potential services and begin regular counseling sessions as needed. The Counselor communicates and works closely with the Nurse Practitioner for medications and possible specialty referrals.

Community Care Coordinator (CCC)

The Community Care Coordinator (CCC) coordinates care and services for the low income, uninsured population of Kershaw County and is responsible for assessment and management of clients with an emphasis on psycho-social wellness, medication assessment and reconciliation, planning care, as well as health coaching and patient self-management techniques. A typical day for a CCC entails spending half of the day conducting one on one extended patient meetings (approximately 30-45 minutes per visit). The other half of the day is spent on follow-up with patients, family/caregivers, providers, and community resources via secure email, phone calls and other communications. The CCC works in collaboration and continuous partnership with chronically ill or "high risk" patients and their family/caregiver(s), clinic/hospital/specialty providers and staff, and community resources in a team approach. Some of their daily activities include the following:

Community Care Coordinators worked to examine clients' medical records and identify risk stratification levels.

- Promote timely access to appropriate care
- Increase utilization of preventative care
- Reduce emergency room utilization and hospital readmissions
- Increase comprehension through culturally and linguistically appropriate education
- Create and promote adherence to a care plan, developed in coordination with the patient, primary care provider and family/caregiver(s)
- Increase continuity of care by managing relationships with tertiary care providers, transitions-in-care, and referrals
- Increase patients' ability for self-management and shared decision-making
- Provide medication reconciliation
- Connect patients to relevant community resources, with the goal of enhancing patient health and well-being
- Increase patient satisfaction
- Reduce health care costs

Success in the CCC's daily activities will lead to improved health for the patient and reduced health care costs for the managed population of patients.

Community Health Worker (CHW)

In 2009, the Department of Labor Bureau of Labor and Statistics created an occupation code for CHWs. Then in January of 2014, the Affordable Care Act included specific provisions for CHWs that are changing how healthcare providers and CHWs interface. There are many different CHW models that are being tested nationally and internationally. The CHW at the Community Medical Clinic is considered an "extender" for the Nurse Practitioner, the patient and the community. **In a typical week, time spent by a CHW includes care coordination visits (40%), phone calls (30%), transitional care follow-up visits (20%) and community outreach events (10%).** Community outreach events include participating in school improvement councils and meeting with local physicians to increase referrals to the Community Medical Clinic. The CHW is responsible for helping patients and their families navigate and access community services, other resources, and adopt healthy behaviors. The CHW supports providers and the Community Care Coordinators through an integrated approach to care management and community outreach. Transitional Care such as hospital visits, doctor appointments and home visits are part of the CHW duties, including conducting health screenings during community outreach. The CHW works within the community to identify community wellness assets and gaps. The CHW also assists with events, staff meetings, and community service projects. The CHW strives to utilize a holistic model of care which is patient, family, and community centered.

This new wall decal welcomes patients at the Lugoff satellite.

Certified Nursing Assistant or Licensed Practical Nurse

The Certified Nursing Assistant or Licensed Practical Nurse assures patients' chief complaints are documented and communicated to the Nurse Practitioner. The Nursing Assistant assists with assuring that appropriate referrals and medications are reconciled. The Nursing Assistants at the Community Medical Clinic are trained in *New Leaf* and provide health education to patients as needed using motivational interviewing methods.

Pharmacy Assistant

The Pharmacy Assistant is responsible for screening all new patients to ensure that they are eligible for services at the Community Medical Clinic. In addition, the Pharmacy Assistant is responsible for overseeing all incoming and outgoing medical records for new and outgoing patients while also assisting with specialty referrals. The Pharmacy Assistant assists with all prescription applications for the Community Medical Clinic's patients including WellVista and the Prescription Assistance Program.

Care Coordination Data

Our Pivot in How Data is Collected and Presented

After a joint presentation to the board and staff of the Community Medical Clinic on August 9, 2016, the leadership and evaluation team recognized that the data being collected was not a complete depiction of the efforts being made in the northeastern part of Kershaw County, traditionally referred to as "North Central." In the evaluation reports up to this point, data has only been presented related to Nurse Practitioners, Community Health Workers, and mental health providers providing services at the school based health-center and one of the five churches in the area. However, Nurse Practitioners, community care coordinators, and even Community Health Workers were seeing patients who live in the North Central area at the Camden and Lugoff locations. A portion of the efforts at each of these satellites is being funded through LiveWell Kershaw and should be reported in all LiveWell Kershaw reports.

Typically, residents of North Central travel to Lugoff, Elgin or Camden to visit family, do their shopping, go to the pharmacy, and other typical consumer activities. Residents from the North Central area can and are being seen at various satellites (shown in the map on page 16) based on their preferences and needs. Our goal is to provide high quality care to the patient and reduce any barriers that can be resolved within the scope of the Community Medical Clinic. **From this point forward, data will be presented including North Central encounters from all satellites.**

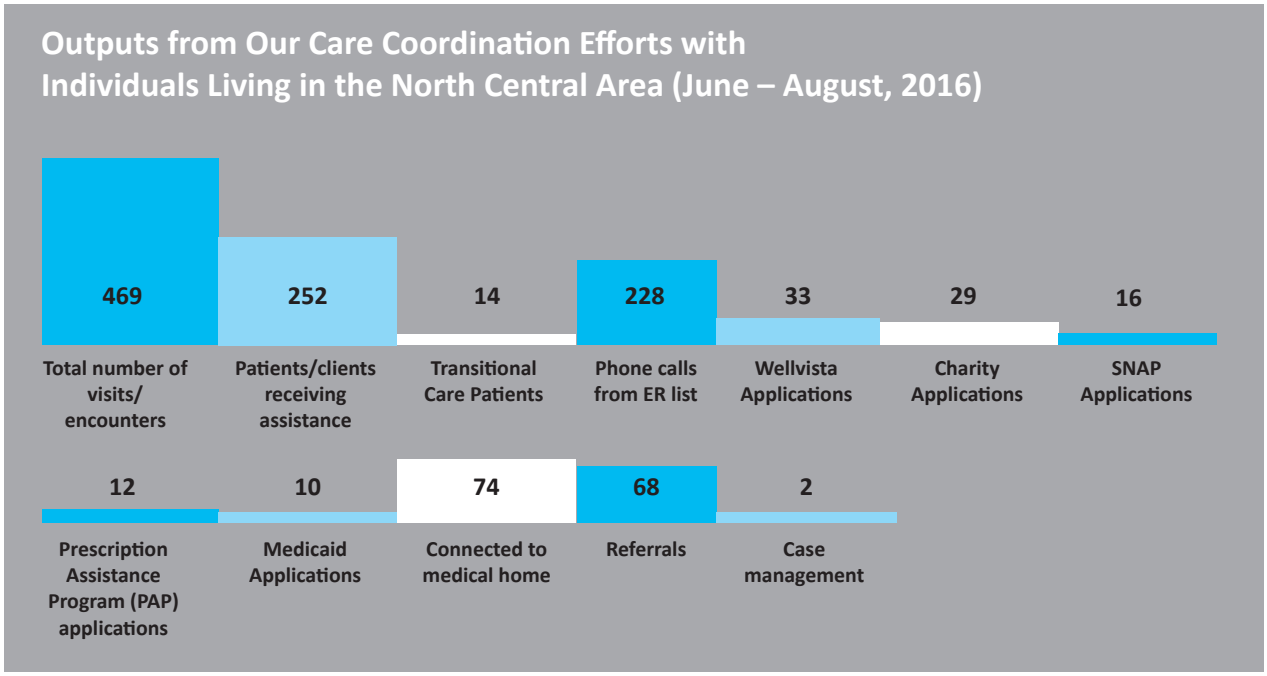
What zipcodes are included in our data?

Cassatt – 29032
Heath springs – 29058
Jefferson – 29718
Kershaw – 29067
Liberty Hill – 29074
Westville – 29175
Bethune – 29009

Our Data

The infographic below summarizes our outputs for this quarter. **The Care Coordination team served 252 unduplicated patients in the North Central area, including 469 encounters.** Patients may have received services from a Nurse Practitioner, Community Health Worker, Community Care Coordinator, or a mental health counselor. With our integrative medicine approach, some patients were seen by multiple team members on the care coordination team, possibly during the course of one visit. **Of the encounters made by a Nurse Practitioner, 43% were coded as level four visits and 53% were coded as level three visits.** These CPT codes demonstrate the complexity of the visit.

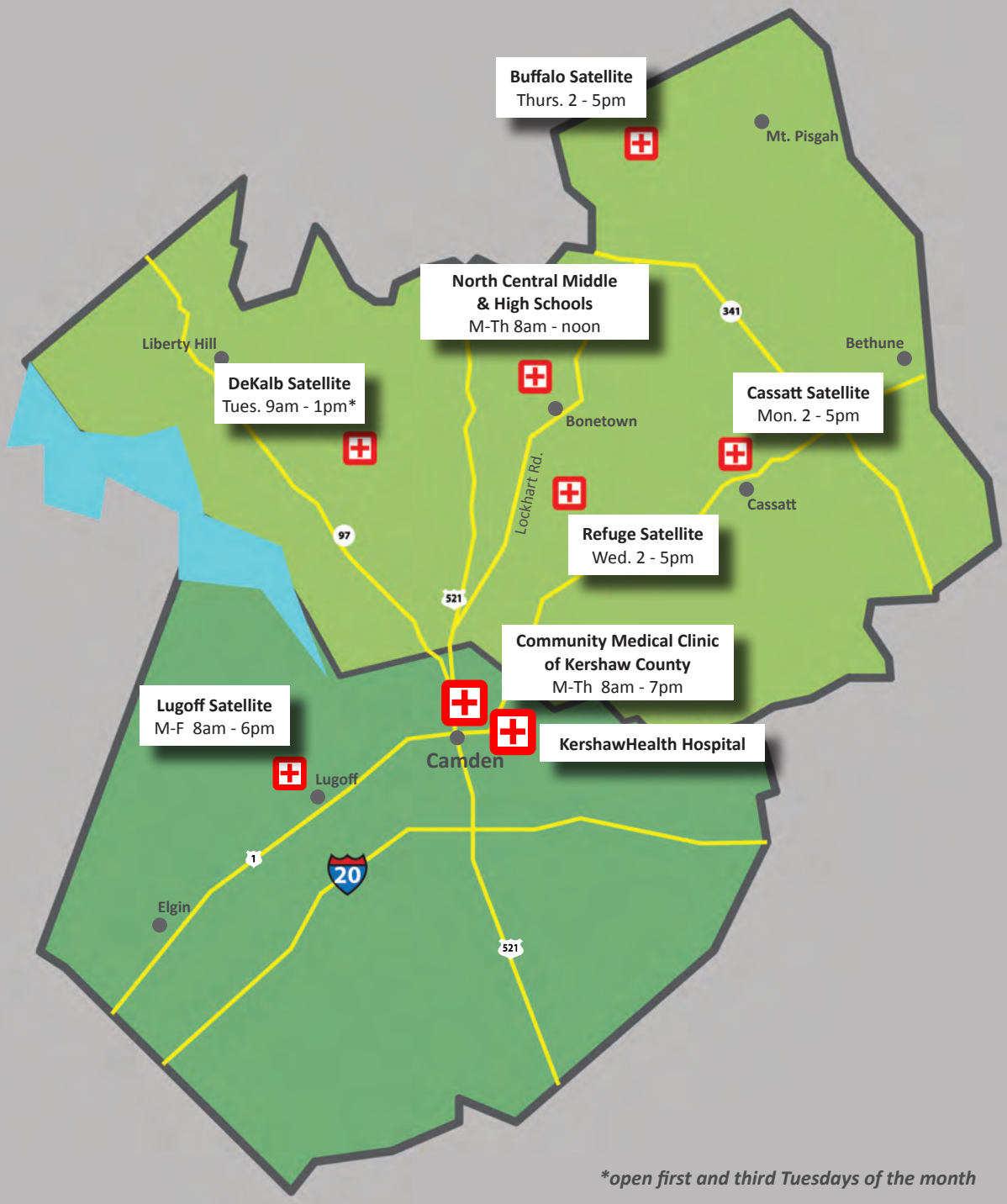
As mentioned on page 12, we are now beginning to transition from tracking outputs to tracking outcomes. We know that all of the Prescription Assistance Program (PAP) and Wellvista applications were approved during this quarter. Due to at least a three to six month delay from the Department of Social Services for approval, we do not know the approval status for the SNAP and Medicaid applications. We will continue to track more outcomes within Fhases, our case management system, and inform the formative evaluation of LiveWell Kershaw.



The Community Medical Clinic of Kershaw County and Satellites

Community Medical Clinic Service Area

= North Central Kershaw County



**open first and third Tuesdays of the month*

Case Study

Patient Perspective - "James"

James is 44-year-old male that has lived in Camden, SC, his entire life. Due to complications with diabetes, James has found himself in the hospital at KershawHealth several times over the past few months. He was admitted once in March of 2016 and again more recently at the end of July, for a 10-day hospital stay for uncontrolled high blood sugar. During his most recent hospital stay, it was discovered that an infection in his knee was the culprit of the elevated blood sugar levels. James' knee infection stems from a work related injury from several years ago that did not heal properly. While in the hospital, James was visited by Sheri Baytes and Jeana Johnson who are Community Care Coordinators with the Transitional Care team. These CCCs began coordinating care for James post discharge. James has benefited greatly from the coordination of transitional care; the team assists him with keeping track of his appointments and making sure he has the medications he needs. Sheri has visited James at home on several occasions to bring him more test strips to check his blood sugar and a walker that now allows him to get around more easily. In addition, Beckie Tompkins, a Community Health Worker, sits in on all of James' medical appointments and is able to keep "everything straight" for him. As a byproduct of this team approach, James feels valued as a person and as a patient. James says that, "Sometimes when people help you, they put too much pressure on you because they are helping you out…but they [transitional care team]are not like that. When they call you they say they want to come check on you, if its not a problem." When asked if he anticipates being hospitalized in the future, James says, "I'm hoping not." His knee is still slightly swollen which is a cause for concern but his doctors believe the swelling will reside after completion of antibiotics. Even so, James feels that his transitional care team has placed him on the right track to stay out of the hospital. He says, "They work with you and let you know that they are concerned with what's going on with you."

Community Care Coordinator Perspective- Sheri

"The good thing about James being with transitional care is that he has someone to guide him…sometimes things can fall through the cracks," says Sheri Baytes, the Community Care Coordinator. It can become overwhelming at times, trying to remember all the medications that need to be taken and appointments that need to be attended. Therefore, patients can be more successful in their recovery efforts by having a

team behind them to provide appointment and medication reminders. "We can help him get focused," says Sheri.

For example, Sheri spoke with James just recently to check on his medications when he informed her that he needed more of one particular medication. James had taken his last dose that morning and would need another dose that evening. Sheri was able to make sure that he would have more medication for that evening.

Additionally, the transitional care team works with the patients to educate them on how to take care of themselves in order to prevent readmission into the hospital. While James was readmitted into the hospital after his admission in March, he was admitted again in late July for a different reason, the infection in his knee. However, since the infection is now controlled, the transitional care team believes that it will be much easier for James to control his blood sugar levels. While transitional care aims to keep patients out of the hospital, Sheri says the team also educates patients on when it is appropriate to go to the hospital. "Some people will hold out on going to the ER and will wait until the last minute, so that's one thing we emphasize…if you need to go, go," says Sheri. Moving forward, the transitional care team is also educating James on signs and symptoms of infection, as well as how to take care of the site where his PICC line was recently removed. By encouraging James to stay on top of his medications, checking for signs of infection, and testing his blood sugar regularly, the transitional care team can lessen the likelihood that James will be readmitted into the hospital.

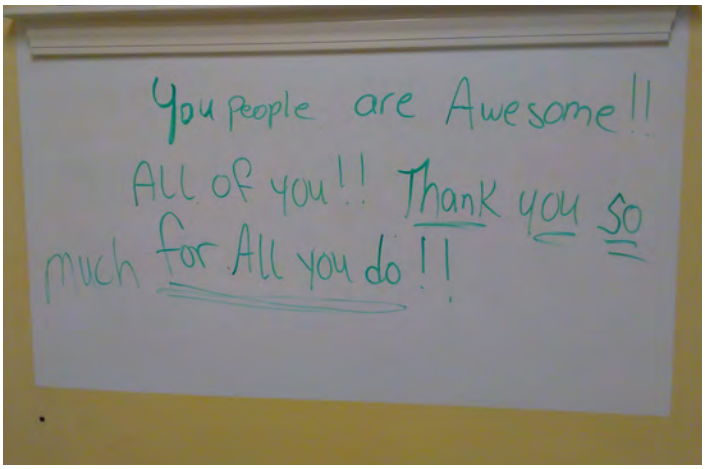
KershawHealth's Hospital Perspective

A close, trusting relationship between the Community Medical Clinic and KershawHealth is vital for the transitional

care piece to run smoothly. A Nurse Practitioner, a case manager, and a care team member at KershawHealth shared their perspectives on working with the transitional care team and the impact this service has had on patients.
"I think it's awesome…the fact that they coordinate the patient's care," says Judy. She then went on to describe how a diabetic patient was recently able to get a glucometer through the help of the transitional care team, so that he can now check his blood sugar levels. Judy believes that if transitional care was not in KershawHealth, there would definitely be more patients readmitted into the hospital. "There is nothing else like this at the hospital," says Cynthia, a Nurse Practitioner. It's been reassuring to patients that they will have medical help after they are discharged from the hospital. The care team at KershawHealth believes that in a perfect world, there would be more access to equipment that patients could use, such as walkers. The equipment that the transitional care team has been able to provide patients has been a blessing.

Transitional Care Team Data

From June 1st, 2016 - August 31st, 2016, **the transitional care team had an active caseload of 14 patients** with the following diagnoses: cellulitis, epiglottis, volume depletion, encephalopathy, bacteremia, hyperglycemia, septic arthritis, bowel obstruction, diabetes, hypertension, diabetic foot disease, hyperthyroidism, chest pain, shortness of breath, and acute kidney injury. For all of these patients, the transitional care team assisted with lab work, medications, home visits and scheduling and attending physician visits. The transitional care team typically has at least weekly contact with each patient in order to make sure all of the patients have sufficient levels of medications, a glucometer, or test strips as needed. For this quarter, eight home visits were completed for four clients. CHWs were scheduled to attend 23 physician appointments but were only able to attend 12 of these due to scheduling conflicts. There was one no-show for a physician appointment at CMC.
Clients are within the transitional care team caseload for a 90-day window unless the Nurse Practitioner recommends that they remain with the team for a longer or shorter period of time. **Only two of the 14 patient were readmitted to the hospital within this window. However, these two patients were admitted for a different reason than their prior admission.** One of the 14 patients did not complete the 90-days because they were able to obtain private insurance and were linked with a Medical Doctor.



A patient at the Camden clinic left this message for the care coordination team.

The Care Coordination team plans to continue seeing established patients from the Community Medical Clinic through the transitional care team model over the next quarter. The team is determining its capacity to handle these complex patients, including what is a manageable case load for the Community Care Coordinator and the Community Health Worker. Evaluation metrics will be tracked for hospital re-admittance and patient outcomes.

Embracing Integrative Medicine

Primary Care and Mental Health Integration in Clinic Setting

The Need for Integration

One out of every five Americans suffers from behavioral health conditions (BHCs) (Klein & Hostetter, 2014). Treatments for these conditions were primarily separate from primary care until around 20 years ago, when the Institute of Medicine declared that treating primary care and behavioral health separately could be labeled as "inferior care" (Klein & Hostetter, 2014). Estimates have shown that 60-70% patients seeking care in primary care settings that have behavioral health conditions will leave those clinics without being treated for their BHCs (Klein & Hostetter, 2014). In addition, 70% of community health patients have a mental health or conduct disorders (Integration of Primary Care). Through the integration of behavioral health and primary care, these numbers would be dramatically reduced. **Evidence has shown that having these two types of care separated worsens health outcomes in patients and especially in those with comorbidities.** In addition, not receiving treatment for mental health conditions makes it more difficult to recover from other primary care medical conditions. The case for integration is clear.

Once the decision to integrate primary care and mental health services has been made, administrators and providers must determine what type of integration model will serve as a guide for care coordination. Most models include a care manager or a behavioral health specialist that follows up with patients regarding their conditions and adherence to treatment (Klein & Hostetter, 2014). However, the top priority amongst integration models is to improve communication between behavioral health specialists and primary care providers in order to improve positive patient outcomes. Other items to take into consideration when choosing an integration model include: capacity of services in the community, workforce availability, organizational support, population targeted, and consumer preferences (Collins, Hewson, Munger, & Wade). These factors will play a role in the success of the integration model chosen.

Published Models in the Literature

Developed at the University of Washington, the TEAMcare model is an approach that promotes simultaneous treatment of mental health conditions and primary care medical issues such as diabetes and/or high blood pressure (Klein & Hostetter, 2014). The purpose of this model is to prevent circumstances in which one poorly controlled chronic condition effects the treatment effectiveness regarding another condition. This model is effective because we know that individuals that are not receiving care for one of their conditions will result in increased medical utilization and may even be more likely to become hospitalized. The TEAMcare Model is delivered in primary care clinics and by telephone. Through this model, nurses provide patient-centered care for both mental health issues and chronic disease. As a result, it has been proven that this model has shown to improve medical disease control and depression outcomes (Klein & Hostetter, 2014).

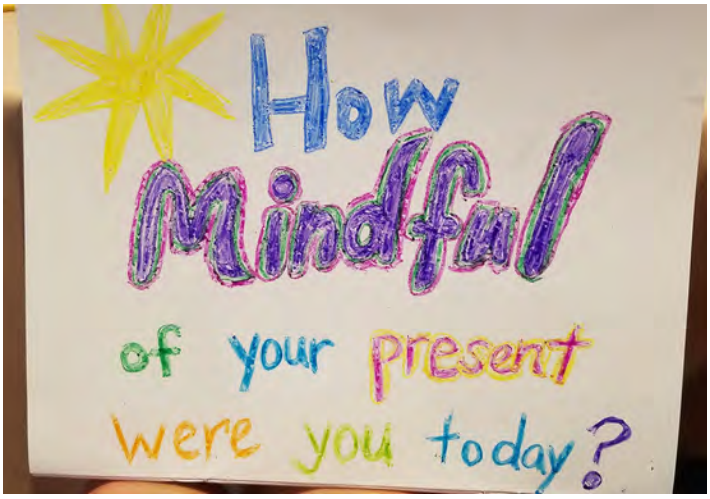
In the Collaborative System of Care model, services can either be partly or fully integrated (Collins, Hewson, Munger, & Wade). When fully integrated, this model can effectively serve patients with high mental health needs and/or those that require access to more specialized mental health services than primary care alone can provide. This model seeks to develop highly individualized plans of care across multiple agencies. The key to this type of service delivery is seamless integration between primary care and mental health services. Some considerations of the Collaborative System of Care model include having the ability to engage multiple partners in the process and securing buy-in from those partners (Collins et al.).

In a case study focused on the work of Cortez Integrated Healthcare, their approach to primary care and behavioral health integration is explained. While no model was specifically indicated as a reference, this case study provides insight into the integration process regarding system of care shifts within their organization. This clinic in Colorado, allows patients to make either an appointment for behavioral health, medical care, or both. About 80% of their patients receive integrative care (Vigram et al., 2015). Patients new to the clinic complete screenings that include questionnaires. Scored electronically, the questionnaires are shown in a “Health Tracker” that is assessed by the provider. At the first appointment, patients are introduced to a therapist that works with the primary care provider. The therapist will join in on this appointment and ask basic questions. Patients that need long-term therapy will be provided with either additional appointments or a referral to another behavioral health specialist within the clinic (Vigram et al., 2015).

Bringing the process of integration into practice has been a learning experience for Cortez Integrated Healthcare. This type of integration required collaboration and cooperation between both the medical care providers and the behavioral health specialists. In fact, there was turnover within the clinic before they found themselves with a full team that was ready to work together. This particular case study highlights the fact that the process of integration is not without its challenges but is instrumental in providing high quality care to those patients needing access to both primary care and behavioral health services.

Primary care and mental health integration has been integral in providing patients with access to much needed

health services. Only 1 in every 4 patients that are referred to a behavioral health specialist actually make it to their first appointment (Integration of Primary Care). By having an integrated care team providing care to the patient, one is increasing the ability for a patient to access needed services. Realizing that integration is key to superior care for patients, policy makers and administrators must determine the best model for integration within their practice. Each model comes with its own set of advantages and challenges. However, all models have the potential to reach the ultimate goal of improved patient outcomes in those with behavioral health needs.



With the help of Christie Derrick, patients and staff are now practicing mindfullness techniques.

Our Approach

CMC has hired Christie Derrick as a part-time Licensed Marriage and Family Therapist and Integrative Health Coach who serves clients 3 days a week. The goal of this initiative is to create an expanded integrated primary care model that includes behavioral health in hopes of improving patient health outcomes and health factors. Activities include: staff and volunteer training, updated policies and procedures, media contact and promotion materials, patient screenings, counseling with patients including co-designing treatment plans, patient support groups and integrative health coaching.

The World Health Report (2001) stated: “Most illnesses (mental and physical) are a combination of biological, psychological and social factors.” According to Healthy People 2010, most chronic diseases are preventable. Behavior accounts for 50 percent of lifestyle choices that adversely affect chronic disease and premature deaths in the United States. (U.S. Department of Health and Human Services)

On June 28, 2016, Christie Derrick introduced staff at the Community Medical Clinic of Kershaw County (CMC) to the Duke Integrative Health model. Unlike conventional medicine, integrative medicine is holistic and focuses on optimizing health in all realms of the patient’s life. Conventional medicine focuses primarily on disease management and is largely directed by a physician or other medical professional. Integrative medicine is a joint endeavor conducted as a partnership between the patient, health professional, and a health coach or mental health professional. (Integrative Health Coach Professional Training Manual, 2011. Later referred to as simply IHCPTM.)

Based on the Duke model, integrative medicine:

- Combines conventional and complementary/alternative approaches
- Provides services across the continuum of care and patient’s life span
- Ranges from preventive and diagnostic exams, surgeries, and medicines to other areas
- May include physical therapy, nutritional therapy, physical exercise, and health psychology
- May encompass acupuncture, botanicals/oils, and supplements, stress reduction and mind-body interventions (IHCPTM)

The Duke Integrative Health Model is illustrated as the Wheel of Health with seven realms of health care (IHCPTM):

Mindful Awareness: Awareness of present moment; paying attention to what you are doing while you are doing it. This also includes time to just "be" instead of "do," to address hectic schedules and lifestyles.

Movement, Exercise & Rest: Activities of daily living, recreation and sleep.

Nutrition: Eating a balanced, healthy diet.

Physical Environment: Spaces where you live/work (including attention to adequate light, acceptable noise level, lack of toxins, soothing color and smells).

Relationships and Communication: Spending time with supportive family, friends and/or coworkers.

Spirituality: Seeing purpose and meaning in something larger than one’s self.

Personal and Professional Development: Growing and developing one's talents and interests; one's personal and professional lives are in balance.
Mind-Body Connection: Paying attention to the interconnectedness of the mind and body, and the effects one has on the other.

Prevention & Intervention, Conventional & Complementary Approaches: Routine screenings and checkups recommended by a conventional medical care provider as well as complementary approaches such as acupuncture, massage, and osteopathy. Health optimization and disease management are accomplished by combining conventional and complementary approaches to health care.

Based on the profiles of CMC patients, the mental health counselor has selected three primary approaches to counseling: cognitive-behavioral, mindfulness-based stress reduction and family systems therapy. Cognitive-behavioral therapy (CBT) has repeatedly proven to be highly effective in treating multiple mental illnesses. It is often described as one of the most rigorously evaluated treatment modalities and is currently identified as one of the most cost effective as well. CBT focuses on a patient's beliefs, thoughts and feelings in response to triggering events.

Mindfulness-based stress reduction (MBSR) has been identified as an efficacious modality for the treatment of depression, anxiety, trauma, and chronic illness (high blood pressure, diabetes regulation, obesity, gastrointestinal problems, various addictions, and sleep disturbance). There is a growing body of neuroscience research that documents the brain's role in stress and relaxation responses. New studies in this field also support the influence of the mind on physical well-being and vice versa.

Family systems therapy addresses the context and narrative of a patient's life including the influence of their family on the individual's health and lifestyle choices. This form of therapy incorporates a patient's belief systems and focuses on family strengths, weaknesses, and their stories of disease, suffering, healing, and resiliency. Also, family systems therapy examines the patient's status within the family's ever-changing developmental stages, which considers gender roles, birth order, relational patterns and more. Finally, for patients who lack a supportive family system, the counselor works with the patient to identify other means of support and encouragement.

Typically, a clinic medical provider will refer a patient to the mental health counselor during a routine physical health care visit. Additionally, patients may self-refer for assessment by the mental health counselor. Regarding the integration of mental health services at CMC, several steps were taken in May-July 2016:

- A letter of introduction publicizing the availability of mental health services at the clinic was mailed to all patients in May 2016.
- A simple brochure on mental health services was developed for the waiting room.
- The Patient Questionnaire was revised to identify key questions that flag patients who should be assessed by the mental health provider. (See Revised V61 Patient Questionnaire.)
- Mental Health/Wellness Policies and Procedures were drafted and incorporated into the clinic's Policies and Procedures Manual.
- Mental Wellness Client Intake Form and Things You Should Know About Counseling were drafted for patients referred for mental health services.
- The counselor joined the Medical Providers team and will attend all monthly meetings.
- The counselor presented two trainings to all staff: Mindfulness and Change: Finding Joy in Transition on May 3, 2016 and Integrative Health Model: Addressing the needs of the whole patient on June 28, 2016.

The counselor is scheduled to present information on trauma-related disorders and health implications to the Medical Director, CEO and all medical providers in August 2016. The title of the training is Riding the Tiger: An overview of trauma-related mental illness. Local yoga instructor, Lisa Riente, will be a co-presenter on information pertaining to the use of yoga in trauma treatment.

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Mental Health Data

Christie Derrick is the mental health counselor at the Community Medical Clinic in Camden, SC. **From June through August, Christie saw 27 counseling clients with a total of 104 visits for the quarter.** Most of these clients are referred from one of the Family Nurse Practitioners at the Community Medical Clinic. However, a few of her clients are self-referrals from receiving letters or handouts publicizing available mental health services. Diagnoses of these clients include the following: Adjustment Disorders, Generalized Anxiety Disorders, Panic Disorder, Dysthymic Disorder, Major Depression, and Post Traumatic Stress Disorder. About half of the 27 clients are receiving medication for psychiatric diagnoses and are also being seen regularly for primary care by a Nurse Practitioner at the clinic. Christie works very closely with the Nurse Practitioners and the rest of the care coordination team to provide quality services to the patients, many who have experienced some type of trauma, and their families.

Case Studies

Sally's Story

Sally is a 38-year-old, African American female who began receiving primary care services at the clinic in November 2015. However, one Friday night in April, she was robbed at gunpoint. Earlier that month, Sally had received a flier in the mail announcing the arrival of a new counselor that would be serving the clinic. The following Monday, Sally came to the clinic so tearful and distraught that the volunteer receptionist had trouble understanding what she was saying. The receptionist knew she was a regular patient and was finally able to determine that Sally was requesting an appointment with the new mental health counselor.

The counselor saw Sally immediately and conducted a thorough assessment. Sally confirmed she was having standard trauma responses: little sleep fraught with nightmares, easily startled, flashbacks of the gun pulled on her with thoughts that she was going to die, increased anxiety and fearfulness, and loss of appetite. During the interview, the counselor learned that Sally had an extensive trauma history from childhood to the present. In the previous year she had been homeless for a period of about eight months.

The counselor asked Sally if she felt safe in her home and had adequate support from family, friends and coworkers. Sally said she was staying with a friend. Her family did not live nearby but her friends and co-workers were being supportive.

Sally did not want any medication to help her deal with the stress and sleep problems. She preferred dealing with problems by talking about them and trying to keep herself busy. The counselor respected Sally's desire to address her distress in a holistic way, and showed Sally how to take deep breaths to calm herself. The counselor explained how her symptoms were common responses to experiencing danger. The counselor reassured Sally that there was hope and scheduled Sally's next appointment in a week.

Over the course of five months, the counselor met with Sally every week. Like most trauma survivors, Sally struggled with frequent triggers which would bring on new symptoms or exacerbate old ones. During her treatment, she was relieved when her assailant was arrested but then relived the event as she watched news of the Orlando and Dallas shootings in summer 2016.

Sally learned more relaxation techniques from her counselor so she didn't need medicine to fall asleep and feel safe in her home. She learned how to monitor the tension in her body as the first line of defense in managing the stress. She also learned to visualize a comforting place in her mind where she could find a break from the onslaught of friends asking details of the robbery, nightly news of other violent crimes in nearby communities, how to handle a new employer who had become verbally abusive, and how to prepare for court where she would have to view video of the robbery.

Her counselor continued to encourage her by acknowledging her progress, normalizing her setbacks, and reminding her that healing is not always linear. Sally made a daily routine of practicing her relaxation exercises. When her stress level

increased, she used these exercises more.

Repeatedly, Sally expressed appreciation to her counselor and amazement at how such simple techniques could have such a profound impact on her stress level. She now reports improved sleep and appetite, and even joy on many days. The counselor is providing updates to the clinic's Nurse Practitioner and is continuing to work with Sally as she moves forward.

Manuel's Story

Manuel is a 28-year-old husband and father of two exuberant children under the age of seven. Several years ago, he was in an accident and suffered a serious head injury. He has never had health insurance and lost his job because he required two years of physical, speech, occupational and psychiatric therapy.

Shortly after losing his job, Manuel and his wife began coming to the Community Medical Clinic of Kershaw County (CMC) for their primary care. For two years, Manuel had to travel to Columbia to receive treatment for Post-Traumatic Stress Disorder (PTSD). Now he and his entire family receive weekly counseling at the clinic. The clinic's Family Nurse Practitioner prescribes medications to help manage his PTSD.

Like most people diagnosed with PTSD, Manuel is bombarded daily with multiple triggers. These triggers can profoundly disrupt his day leaving him feeling bewildered and hopeless. For instance, loud noises trigger flashbacks of him being flown by helicopter from the scene to an area trauma center.

His movement remains restricted on one side. He is often tearful, anxious, withdrawn, and suffers from insomnia. Nevertheless, he tries hard to be a good husband and father by continually putting pressure on himself to continue to be the primary provider for his family – working 40 hours a week at odd jobs.

The accident and his illness didn't just affect Manuel. His whole family fights to cope with the monumental changes they must overcome to remain together. His wife is stoic when discussing the demands of caring for two small children and a husband who suffers from physical and emotional scars.

The children don't understand why their Papa doesn't have the energy to play with them like he did before the accident. They also don't understand why they had to move from their comfortable home where they each had a room, to a much smaller house that has few of their own personal belongings and toys. The oldest child acknowledged worrying about being homeless. Both parents comfort their children with hugs, kisses, and promises that they will never end up on the street but you can see the strain and worry on their own faces.

Manuel and his family will continue to be seen at the Community Medical Clinic for both primary care and mental health services. They feel that the clinic is a very safe place and are encouraged by the small milestones they all are making to improve their quality of life as a family.

Volunteer Elaine Voiles assists with filing at the Lugoff satellite.

Year 3 Quarter 1 Satellite Satisfaction Survey Summary (June 1, 2016 - August 3, 2016)

The purpose of the survey is to determine how receptive patients are to the services, since many do not have means to receive primary care anywhere else. Thirty clients from this quarter completed the survey. Of the 30 survey respondents, we were able to determine that the majority of our clients served were seeking care from the Buffalo location, followed by the Refuge location. Other sites included Cassatt and Sandy Level. The survey results

indicate that 80% of clients only have to travel 5 minutes to reach the clinic of their choice. The remaining respondents indicated that the site they visited took them about 5-10 minutes, 10-20 minutes, or over 20 minutes to reach. 93% of participants indicated that it was extremely easy to schedule their appointment. In regards to appointment wait time, 73% of clients reported no wait, while other clients did experience some wait time. Length of wait time experienced is outlined in the following chart:

How long did you wait to be seen today by the medical provider (medical doctor or nurse practitioner)?		
Answer Options	Response Percent	Response Count
No wait	73.3%	22
Less than 5 minutes	6.67%	2
5-10 minutes	6.67%	2
10-20 minutes	6.67%	2
More than 20 minutes	6.67%	2
answered question		30

Of the responses provided, all clients felt that it was extremely easy to make an appointment and easy to talk with the medical provider. An overwhelming majority of clients felt that they were treated in an excellent manner by the medical provider, that health information was communicated clearly by the provider, and that enough time was spent with them during the appointment. In regards to type of services received, 87% visited the clinic for a Primary Care visit or check-up while 57% visited for a prescription or refill. Other services that were received included sick visits and lab work.

The majority of clients rated the services that they received as excellent, while all indicated that they would recommend LiveWell Kershaw satellite clinic services to family, friends, and co-workers.

It is important to note that no more surveys were collected after August 3, 2016, when it was determined that tracking satisfaction levels was no longer necessary.

Year 3 Quarter 1 Community Health Worker Satisfaction Survey Summary

(June 1, 2016 – August 3, 2016)

A paper-based satisfaction survey was administered to clients from June through August. The purpose of this survey is to determine how receptive clients are to the services provided by the CHWs. After each face to face visit, clients are asked to complete the survey. Thirty-two clients completed the survey. The clients then returned the completed surveys to a sealed container to maintain confidentiality. Kathryn Johnson collects the surveys weekly to analyze the data. The summary of the survey findings are as follows:

Which community health site did you visit today?		
Answer Options	Response Percent	Response Count
Buffalo	18.75%	6
Cassatt	0%	0
DeKalb	37.5%	12
Refuge	31.25%	10
Sandy Level	12.5%	4
Other	6.6%	0
answered question		32
skipped question		0

From the respondents of the survey, we were able to determine that all of our clients found that our health site locations and hours provided were convenient. Our Community Health Workers, Rachel Sladek and Beckie Tompkins, provided excellent service to our clients this quarter. Rachel served 78% of survey respondents while Beckie served around 22% of clients. Of the clients that were served, all felt that they could easily talk with the CHW, that they received kindness and respect during their visit, that health information was clearly communicated by the CHW, and that enough time was spent with them during their visit. All of the respondents felt that the CHWs were very knowledgeable about the reason for their visit.

The most common services received by clients are referrals to Primary Care Physicians (39%) and assistance with applying for SNAP benefits (32%). Other services utilized by clients include: assistance with Medicaid applications, Pharmacy Assistance, Social Security Disability, Medical Bills Assistance, and other services.

From the responses collected, all respondents noted that they were either very satisfied or satisfied with their visit. In addition, all clients indicated that they would recommend LiveWell Kershaw services to family, friends, and co-workers.

It is important to note that no more surveys were collected after August 3, 2016, when it was determined that tracking satisfaction levels was no longer necessary.

Community Health Worker Case Studies

"Pamela"

Moving to a new area can present challenges in many different ways. Pamela, a new Kershaw County resident, is currently experiencing many of those challenges. Now living with her mother, Pamela and her two daughters, along with her boyfriend are struggling to live off of her mother's disability income while searching for employment. In addition, the entire family is in need of medical care. After Pamela visited the LiveWell Kershaw team, she was able to work with Beckie, a CHW, to arrange several different benefits and also get some information on an employment opportunity with Jobworks through Goodwill. After over an hour and a half of coordination, Beckie was able to help Pamela complete applications for Medicaid and SNAP benefits. In total, the estimated amount of benefits for their household of five totals about $1,000. In addition, Pamela is now a patient of the Community Medical Clinic and can received medical care there until she is approved for Medicaid. Pamela was grateful to the LiveWell team for their help and communicated that she did not know of anything like this in her previous home in Pennsylvania. Pamela also noted that in order to have the same amount of services, she would have had to go to several different locations if it had not been for the LiveWell team.

Leigh Reed and Geradline Carter celebrate with SC THRIVE at a monthly admin day.

"Craig"

Craig, a 41-year old native of Cassatt, recently began receiving services through LiveWell Kershaw after becoming unemployed in February and moving in with his retired parents. Because he has Type 2 Diabetes, it is imperative that Craig regularly sees a physician to receive insulin and to check his blood sugar levels. However, without any income, all medical bills have become his parent's responsibility. Therefore, Craig's primary care physician referred him to LiveWell Kershaw in order to alleviate the financial burden that has been placed on his parents. Craig is grateful to LiveWell Kershaw and says, "I would probably go without my medicines if it weren't for y'all helping me out because I don't want that pressure on my parents…I actually might not be alive right now if it weren't for LiveWell or I may have lost a limb by now."

Through LiveWell, Craig was able to have blood work done, get his blood sugar under control, and obtain the medications that he needed. In fact, Craig is glad that he can go to Camden and get his test strips for $5 instead of paying a much higher price at retailers. When asked if there is anything that the LiveWell team should improve on he says, "Nope, everything's been great…they're a God-send." In addition, if Craig could describe the LiveWell team in one word he would choose "lifesaver." Craig looks forward to continuing to receive LiveWell Kershaw services to keep his diabetes under control.

COMMUNITY MEDICAL CLINIC

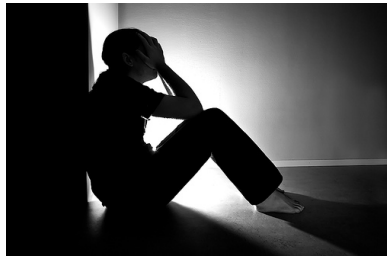
Outreach. Access. Medical Home.

Community Medical Clinic of Kershaw County
110 C East DeKalb Street
Camden, SC 29020
803-713-0806

COMMUNITY MEDICAL CLINIC
Outreach. Access. Medical Home.

Do you need someone to talk to?

Do you feel alone?



Do you need help dealing with problems in your life?

There is someone at the Community Medical Clinic of Kershaw County who can help. Our counselor can help you feel better and address:

- Stress
- Family problems
- Sadness
- Loneliness
- Illness or death of a loved one
- Coping with a serious illness
- Worrying
- Being a caregiver
- Feeling hopeless
- Sleep problems
- Fear
- Pain

Christie Derrick is a licensed marriage and family therapist with more than 15 years of experience helping individuals, couples, and families.

Ms. Derrick works Mondays, Tuesdays and Wednesdays from 8 a.m. to 5 p.m. at the Camden location. You can schedule an appointment with her by calling 803-713-0806.

WHAT YOU DISCUSS IN YOUR COUNSELING APPOINTMENTS IS PRIVATE UNLESS YOU ARE SERIOUSLY THINKING OF HURTING YOURSELF OR SOMEONE ELSE. THEN IT IS OUR RESPONSIBILITY TO BE SURE THAT YOU AND OTHERS ARE SAFE.

Community Medical Clinic of Kershaw County
110 C East DeKalb Street
Camden, SC 29020
803-713-0806
clinick@bellsouth.net

School-Based Health Center

With the success of the SBHC at North Central High School, the School Board approved for the Community Medical Clinic to expand its efforts to North Central Middle School. Students from the middle school will be transported by a staff member to the high school to receive any of the SBHC services. The SBHC is open Monday-Thursday from 8 AM – Noon and staffed by a Nurse Practitioner and a Community Health Worker. The Mental Health team from the University of South Carolina is on-site Monday-Thursday from 8 AM – 3 PM.

North Central High School Demographics

For the 2016-2017 school year, there are currently 483 students enrolled at NCHS. Of this amount, there are 252 males and 231 females. Races included in the school population range from Caucasian (67%), African American (22%), Hispanic (6.2%), two or more races (3.9%), and American Indian (0.62%). Data provided by the South Carolina Department of Education for the 2014-2015 school year also shows that 80% of the students attending this school are receiving either Medicaid, SNAP, or TANF benefits, or are considered homeless, foster, or migrant (South Carolina State Report Card, 2016). Additionally, 13% of the student population is classified as having a disability. Data also indicates that this school has a four-year cohort graduation rate of 84.5% with a drop out rate of 2.5%. In addition to this, the school has an attendance rate of 93.9% (South Carolina State Report Card, 2016).

North Central Middle School Demographics

For the 2016-2017 school year, there are currently 379 students enrolled at NCMS. Of this amount, there are 195 males and 184 females. Races that make up the NCMS population include: Caucasian (70%), African American (18%), Hispanic (7%), two or more races (5%), Asian (0.5%), and American Indian (0.26%). Data from Department of Education for the 2014-2015 school year indicates that 83% of students attending NCMS are receiving either Medicaid, SNAP, or TANF benefits, or are considered homeless, foster, or migrant (South Carolina State Report Card, 2016). In addition, 15% of the student population is classified as having a disability. However, the attendance rate for NCMS is at 95.8% (South Carolina State Report Card, 2016).

The SBHC was recently redecorated to welcome both middle and high school students to the school based health center.

Our Model

The SBHC model that we are using includes both primary care being provided to students by a nurse practitioner and mental health counseling and mentoring provided by doctoral students. The integrated model of primary care and mental health (see pg. 18) is being deployed at the Community Medical Clinic in Camden for adults and for students at the schools. The most recent SBHC whitepaper notes that one in five students show signs of mental health problems that need clinical attention (Price, 2016). Studies also indicate that 50% of adults diagnosed with some type of mental illness expressed their first symptoms at the age of 14 years old (Price, 2016). Cameron Massey, the mental health team lead and wellness coach, works very closely with the Nurse Practitioner, Vicki Craig. All information related to each of the students is documented in the Electronic Health Record, that all medical providers can access remotely.

Primary Care Data

As of September 1, 2016, the primary care provider has seen 33 students from the high school and four students from the middle school and conducted a total of 44 visits. There have been a total of five sick visits conducted with diagnoses including allergies, ear pain, panic attack and one referral made to the Urgent Care. Eight prescriptions were made. The Nurse Practitioner contacted all of the sick students' parents to explain their diagnoses and also directions. All students were sent back to class with excuses, with the exception of one referral to the Urgent Care and one student who drove home. All of the students had a primary care physician with the exception of one student who was uninsured. In addition, 32 sports physicals were conducted by a Nurse Practitioner.

Mental Health Services

The School-Based Health Center, based at North Central High School, is excited to continue offering wellness coaching services for adolescents who are experiencing social, emotional, behavioral, and/or general life stressors for the 2016-17 school year. They provide one-on-one counseling, case consultation, and specialty groups as needed. All services are delivered by doctoral students in the Clinical-Community Psychology program at the University of South Carolina, and are supervised by licensed professionals with extensive background in addressing the various needs of youth. The main aim of wellness coaching services is to help students develop skills to cope with stress in their lives so they can better function in the classroom. For this coming year, they are pleased to report that they are expanding the number of wellness coaches available, increasing their ability to serve students in need. They are proud to announce they are also now offering the same wellness coaching services to students at North Central Middle School. Wellness coaching services are available Mondays and Tuesdays, from 8:00am to 3:00pm. For more information, please contact Cameron Massey at cmassey@email.sc.edu. Due to setting up for the school year, the mental health team did not conduct any counseling or mentoring sessions in the month of August.

Mental Health Counselor Perspective: Felipe's Story

Over the summer, Felipe, a 10th grader at North Central High School, came into CMC to be seen for chest pains and dehydration. Felipe's mother brought him in to the clinic because she was already being seen at CMC for her primary care needs and because the SBHC was closed for the summer. Christie, the mental health counselor at CMC, was able to meet with Felipe and his mother in a joint session to discuss the root cause of the dehydration and chest pains that he was having. Because of a language barrier between Christie and the mother, Mariana, a CNA at both the clinic and the SBHC, was able to interpret during the session. Felipe is young and healthy, Christie noted, so she found it unusual that he was experiencing chest pains. However, through discussion, Christie was able to determine that Felipe was drinking excessive amounts of energy drinks and then later uncovered that he had been drinking alcohol and participating in other risky behaviors. Christie is continuing to work with Felipe, but has referred him to see Cameron for mental health counseling now that the SBHC is open for the new school year.

Vikcy Craig, Susan Witkowski and Cameron Massey discuss the SBHC expansion and how best to coordinate efforts.

Certified Nursing Assistant Perspective

Mariana is a CNA who works at both CMC and the SBHC at NCHS. She was able to interact with Felipe during his visit to CMC over the summer while she served as an interpreter between Felipe's mom and Christie. Because of their interactions and the language commonality, Felipe felt at ease around Mariana and developed a sense of trust in her. Felipe was referred by Christie to see Cameron at the SBHC once school was back in session. Mariana noted that it wasn't long after school started that Felipe stopped by to say that he hadn't heard from Cameron and really wanted to meet with him. That same week, he was able to meet with Cameron for mental health counseling. Mariana could tell that Felipe was hungry for help. The mental health integration works well because "Cameron and Christie are able to collaborate on information and progress regarding this student and how to guide him," says Mariana. While

Mariana notes that Felipe still has some high blood pressure issues, she is encouraged by the work that Christie and Cameron are doing regarding his alcohol use and other high risk behaviors. Felipe is getting the mental help he needs through both the clinic and the SBHC.

School Based Health Center (SBHC) Advisory Meeting Focus Group Summary

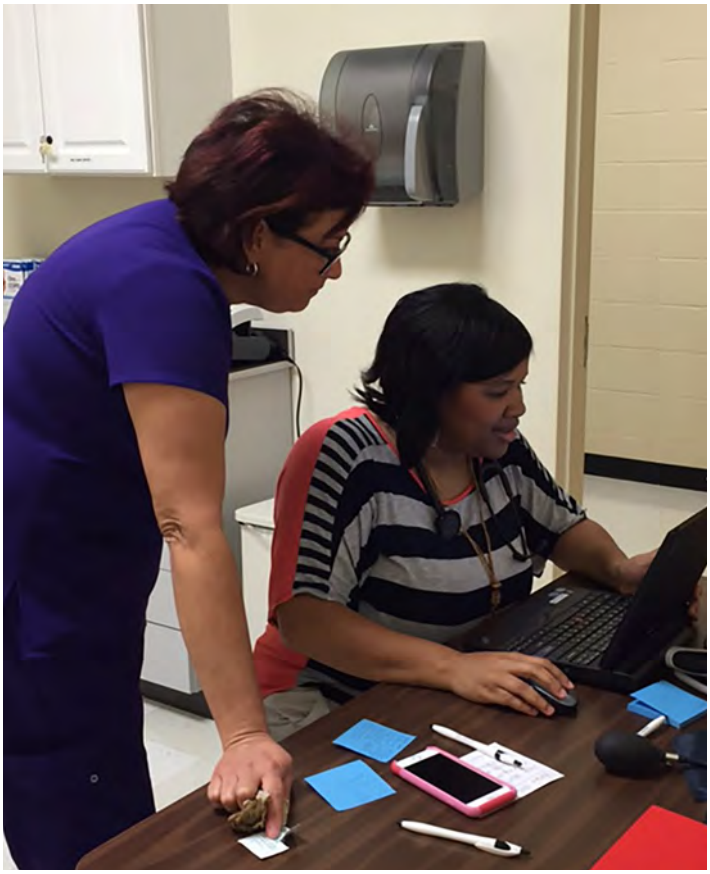
Discussion of North Central High and Middle School

Overview

A SBHC Advisory Board meeting was held on June 29, 2016 with 8 participants. Participants included Assistant Principal, School nurse, CHW, wellness counselor, Community Engagement Manager, CEO and a CNA. A focus group was held to gather feedback regarding challenges, successes, ideas, and recommendations for the SBHC at North Central High School (NCHS). By reflecting on the past year, participants were able to provide their responses to questions asked by Whitney Hinson, the Community Engagement Manager, who led the discussion.

Highlights

Participants were able to identify a few moments that came to mind when thinking about the SBHC and its impact on NCHS students and teachers. One impactful moment came from the students who needed to have sports physicals completed in order to participate in afterschool athletics. For example, one student who had never been able to join a sports team due to lack of physical, was so excited to be able to have her physical completed by the Nurse Practitioner at NCHS. “Her self-esteem is going to be so positively impacted by that,” said Susan, the Nurse Practitioner for the SBHC. Some enjoyed watching the School Based Health Center evolve into what it is today. One participant said: “You know, it makes it more realistic, you know, when you say a school-based health center, you know this is an open classroom. No, this, this is a school-based health center. We have everything, just like going to the doctor’s office.” Other highlights from the year included a teacher appreciation day and a student athletic reception where students could be enrolled into the clinic and loved receiving apples. “Everyone’s always so busy when we come here, and it was just nice to see it in a little different way, when they were able to sit down and take a minute or two,” stated a participant in regard to the teacher appreciation day that was held.



Mariana Martinez (l.) and Alicia Pendergrass (r.) connect remotely to the Electronic Medical Record from the SBHC.

Challenges

Enrollment efforts were noted as a challenge for this past school year: “I would say enrollment efforts…(are) not panning out like we thought.” Participants noted past enrollment efforts at a football game and at field day but felt that weather was a barrier to their success. Others felt that it was hard to enroll students because it was near the end of the school year. In addition, mental health services were in high demand resulting in a long wait-list for services. From the mental health perspective, participants felt that the needs of NCHS were underestimated. Other challenges mentioned by participants included the Check and Connect program. Explanations for this challenge included not clarifying what the program was about to teachers and possibly the lack of one-on-one meetings with teachers regarding the program. Group meetings with teachers have happened but the information was not resonating. Also, teachers may not be reading the emails and flyers that were handed out.

Successes

Participants feel that the SBHC is blessed to have the staff that it does. Mental Health Counselors Emily and Cameron

are able to work with students to provide the care that they might otherwise not have received. Additionally, these staff members are able to look at the social situations that may be influencing behavior and influence a more appropriate method of care. This was the case for one particular student; as a result there is more hope for the future of this child. One participant said that: "We don't realize how blessed we are with the stuff that we have...because I was literally amazed when Cameron was able to figure out a more appropriate diagnosis for one particular child…" In another case, the issue of truancy has been addressed through the SBHC. Students that miss a certain amount of class are required to pay for the summer classes to make up that lost time. In one case, the NP was able to work with the mother to enroll the student in the clinic, so that she could determine whether or not he really needed to go home for a medical issue. His enrollment into the SBHC has provided a mechanism to prevent him from using unsubstantiated, medically-related excuses to get out of attending class. A participant noted that: "Now it'll be, 'You're sick, let's send you to the nurse practitioner, let's see what she says.' So you know if it was legitimate, he does need to go home, he's excused, if not, you know, 'you're okay, go back to class.'"

A variety of materials were distributed at school registration days to increase awareness of LiveWell Kershaw services.

Considerations for NCMS

As the SBHC expands to cover students at North Central Middle School (NCMS), there are a few things to consider. One point made during the discussion is that communication between the SBHC and the parents of children seen will need take priority. A parent said the following: "Oh yeah…I have a middle, a middle school daughter and I would want to know, like, everything, you know. What did she, what was her fever, what did she say, what did she, what did you do? Um, middle school parents are going to want a lot of information." However, it is already a part of the NP's routine to contact parents relating to their child's visit to the SBHC. This will continue as NCMS students are seen. Another consideration mentioned was the fact that NCMS runs on a different schedule regarding class times. The NP hopes to have students seen within 20 minutes. However, NCMS classes only last 45-50 minutes each. Even so, it may work to the SBHC's advantage that NCMS students are allowed ten absences for the school year and are counted present for the day upon arriving in the morning. Regardless, the SBHC is looking at the best times to see students, whether that be before school, during lunch, or during class changes.

Recommendations

Enrollment. In order to increase enrollment, participants would like to have SBHC forms available at school registration days. Those that don't register at that time can enroll during open house. In regards to the parents that do not attend any school events, forms could be sent home with the students because these are usually the children that need to be enrolled into the SBHC the most.

Marketing. Most participants feel that in marketing the SBHC, there is a disconnect for the mental health portion of services that are provided. In using the phrase, "Minute Clinic," to describe the SBHC, there is no reference to the fact that mental health services are available to those that need them. However, adding "mental health" to the description may not be wise because of the stigma still attached to those terms. In addition, participants felt that both "behavioral health" and "emotional health" sound weird. In an effort to not stigmatize those that may need the services, some feel that it might be best to promote the service to those that might provide the referrals and to students needing care on a one-on-one basis. Others feel that calling Cameron and Emily, the mental health counselors, "Wellness Counselors," may also be a good idea. On another note, participants also discussed terms that are being used to reference the SBHC. Because the name itself is quite a mouthful, some have begun calling the clinic the "Live Well Room" or Live Well Clinic."

Innovative Ideas. If money was not an object, there are limitless ideas that could be brought to life to better the health of those attending NCHS and NCMS. Participants communicated several different options they might bring to Kershaw County if budget wasn't an issue and approval could be obtained.

Healthy Food Options. Participants felt that it would be great to have healthy food options available in the cafeteria during lunch time. It could be called "Eat Well." This option would have super healthy, very fresh food. However, this may not be feasible because it would be competing with the school lunch since money is being made off of the school lunches that are provided to students. Mr. Branham is currently checking into this with the school district.

Fit Bits. Some feel that a large percentage of adults use these fitness trackers but haven't really seen children with them. Most participants feel that not a large enough percentage of children would really use them correctly or even care about tracking their fitness. However, it might be interesting to offer them to targeted groups of students such as a weight lifting class or a sports rec class.

Sports Rec Class. While this class is going to be offered starting fall 2016, participants had a few ideas on what should be included into the class but might not necessarily be accepted quite yet. The rec class will include a variety of sports in order to give those that aren't necessarily athletic or members of a sports team the opportunity to be active. Ideas offered up included yoga and Zumba. Participants recalled a time when they had an outside person come in and lead the course with great success. As long as the children are supervised while with a non-staff member this type of class is acceptable. This type of option could be a once-a-week class as part of the sports rec course during the semester.

Mindfulness. While this is not an expensive option, approval would be still need to be given in order for this idea to take place. Participants believe that for ten minutes during second block, students could practice mindfulness. This would be on a twice a week basis with reading time being on the other days. The other alternative could be putting on some type of relaxation CD to have the students just "chill." Participants think that this could be beneficial to the students as it is something they are currently using and enjoying at the clinic.

SBHC Enrollment Efforts at School Registration Days

Overview

Various members and volunteers from the LiveWell Kershaw team participated in school registration days in order to enroll more students into the School Based Health Center (SBHC) from both North Central High School (NCHS) and North Central Middle School (NCMS). In addition, information about LiveWell Kershaw services was given out to parents, grandparents, and community members. Schools visited during registration days included: North Central High School, North Central Middle School, Midway Elementary School, Baron DeKalb Elementary School, and Bethune Elementary. Mt. Pisgah Elementary School was not included because there was no volunteer available to visit the school during registration hours. The information below is a collection of both quantitative and qualitative data including the responses given by parents, community members, faculty, and staff regarding their perception of their community. In addition, recommendations for future enrollment efforts during the 2017-2018 school registration events have also been included.

A parent signs her child up for the SBHC with the help of CHW Rachael Sladek.

Quantitative Data

In order to determine our reach and how many students we were able to enroll into the SBHC, the LiveWell team members that were at each school registration event were asked to keep track of of the number of enrollment forms collected for both NCHS and NCMS students. In addition, team members were also asked to track how many individuals visited the LiveWell table and how many individual's contact information was collected in order to be contacted by a Community Health Worker (CHW).

Registration for NCHS was a two-day event. Day one yielded an estimated 150 individuals visiting the table and a total of 50 SBHC enrollment applications collected. Day 2 produced a total of 175 individual visits to the table and a

total of 78 SBHC enrollment applications collected. There were also 2 individuals that gave their contact information in order to be contacted by a CHW to receive other LiveWell services. At NCMS, a total of 90 individual visits to the table occurred and a total of 24 NCMS students were enrolled into the SBHC. For all other schools that had LiveWell team members present, a total of 231 individuals visited the table for information. In addition, there were 6 NCHS students enrolled in the SBHC and 6 NCMS students enrolled. 6 individuals also left their contact information in order to be contacted by a CHW about other LiveWell services.

At final count on August 31, 2016, there were 104 out of 376 students enrolled in the SBHC at NCHS and 210 out of 483 students enrolled at NCMS.

Qualitative Data

A variety of community members such as parents, guardians, and community members were asked two open ended questions regarding what their community needs and what they love about their community. As the day went on, common themes emerged from the responses given. The LiveWell team also gathered feedback from community members on their perception of the SBHC.

Most individuals noted that there should be more activities for the children in their area, as well as afterschool activities for younger students in elementary school. However, others noted that transportation issues and work scheduling are a problem when considering getting children to these activities. In addition, the lack of businesses and grocery stores is also something community members want to change. However, the fact that they live in a small community is what most community members love about living in the small towns surrounding Camden, SC. These same individuals appreciate that their children attend smaller-than-average schools because of the one-on-one attention from teachers. However, community members did note that the lack of mentors and drug issues within the community are cause for concern when it comes to finding role models for the children. In regards to individuals' perceptions of LiveWell or knowing what it was, most had filled out the online application or had seen LiveWell signs but had no idea what it was about. However, after learning about LiveWell at registration day, these individuals were enthusiastic for the services that LiveWell provides both in the community and at the SBHC.

Recommendations for Future Registration Days

Most of the LiveWell team felt that the afternoons were busiest at registration day and that having the LiveWell table set up near the beginning of the registration process worked best for bringing people in. However, another team member felt that it was a struggle to bring in parents because their table did not have a sign identifying what or who they were. In addition, it was noted that tables were not set up close to each other at one school and this made it difficult to reach people because some parents left before getting to the LiveWell table. In the future, the table should be located near other high-traffic tables. Also, the color-changing pencils were a huge hit among the children and are highly recommended for use at next year's registration days.

References

Price, O. A. (2016). School-centered approaches to improve community health: lessons learned from school based health centers. Economic Studies at Brookings, 5, 1-17.

South Carolina State Report Card. (2016, March 30). Retrieved September 15, 2016, from http://ed.sc.gov/data/report-cards/state-report-cards/2015/district/?ID=2801

SBHC Flyer sent to parents.

LiveWell KERSHAW
"Your Bridge to Better Health"

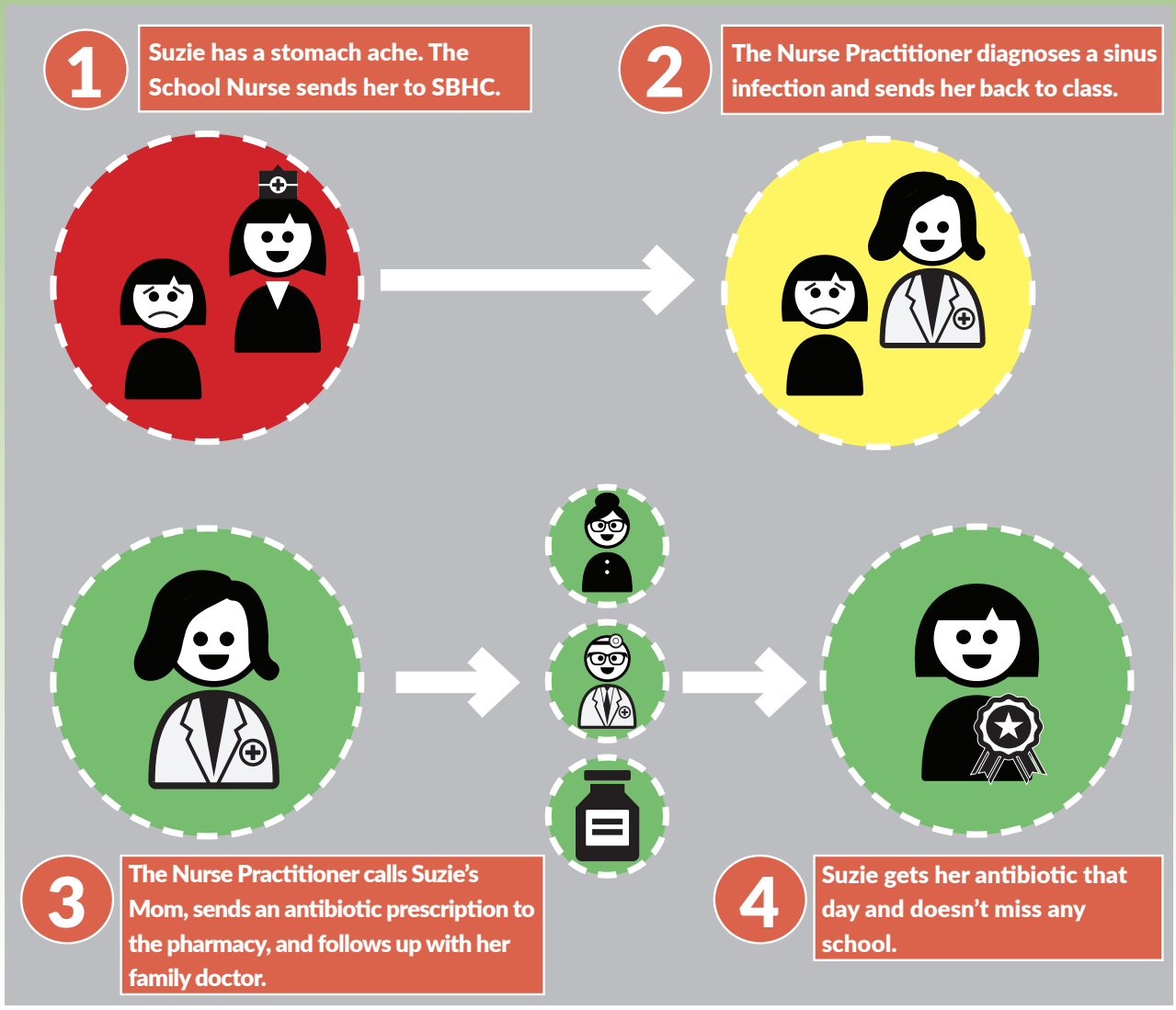
School Based Healthcare Center at North Central Middle & High Schools

110 C East DeKalb Street Camden, SC 29020
803.272.8325

facebook.com/LiveWellKershaw
twitter.com/lwkershaw

North Central now has its own School Based Healthcare Center (SBHC). It's like a minute clinic in the school! The school nurse can refer students to the SBHC where they will see the Nurse Practitioner, who will diagnose and treat common illnesses, care for minor wounds, and write prescriptions. The SBHC also provides sports physicals, vaccinations, and routine lab tests.

The Nurse Practitioner is available **Monday through Thursday from 8:00 am - noon.** We are located in the new gym next to the training room. Most SBHC services are available at no cost to North Central families.



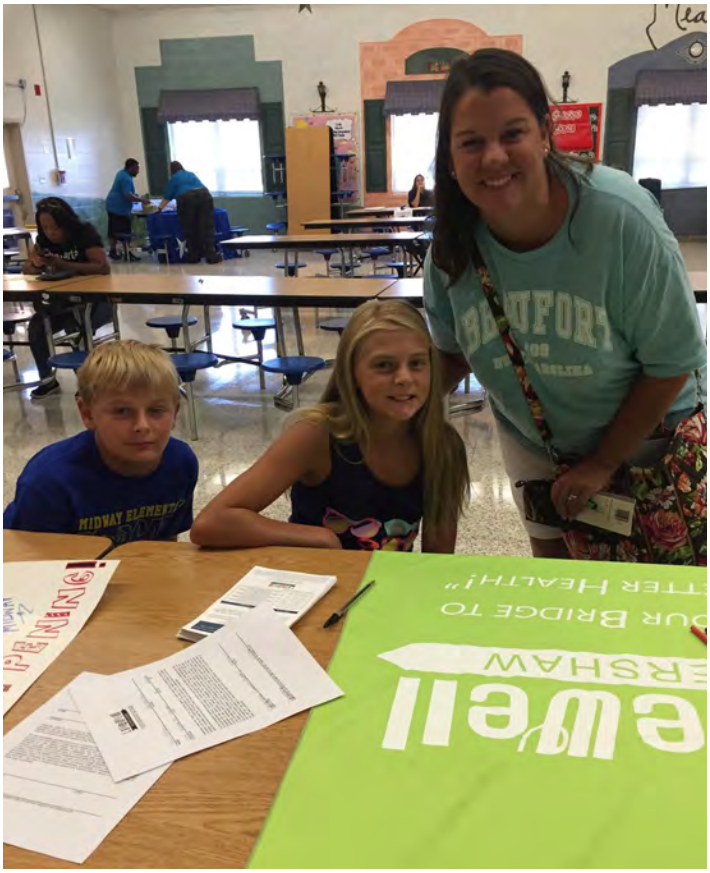
To learn how your student can enroll in the SBHC contact the school nurse (Ms. Bowers) or the office (Ms. Ham).

livewellkershaw.org

Community Outreach

The Community Medical Clinic team participated or presented at 22 community events this quarter. Due to limited capacity, team members are being very intentional in what community events they are participating in. The team is strategizing to target events with large numbers of people and also partner with local groups who aligned missions. See timeline on page 36 of community events.

Five volunteers were recruited during this quarter from Kershaw County. However, none came from the North Central area. There are plans being developed to conduct training for these individuals. Two churches have been contacted regarding a possible visit but no date or time has been set yet. Barriers to volunteer recruitment and church visits included the limited amounts of scheduled events at churches throughout the summer due to low attendance.



Jodi Rogers, our newest CHW, smiles with her children at school registration day.

Cynthia Nelson shares information with community members and recruits new volunteers.

Timeline of Community Events

DATE	STAFF	DESCRIPTION	OUTCOME
6/9/2016	Whitney, Beckie, Karen	Community Council	Mentors provided recommendations for recruitment.
6/14/2016	Susan Witkowski	Presentation to CMC Board	Board requested for a different way to present data.
6/29/2016	Whitney, Susan, Rachael, Marianna, Beckie, Rose Montgomery, Regina Bowers	NCHS SBHC Advisory Council	Insights collected will be used to inform the 2016-2017 school year at SBHC
7/14/2016	Whitney, Beckie, Rachael, Cynthia	Community Council	Cynthia Nelson came to talk about volunteer opportunities for community members.
7/20/2016	Susan Witkowski	Culture of Health RWJ Presentation	Presented information about LiveWell Kershaw to 12 individuals
7/21/2016	Rachael	Bethune Elementary SIC	A flyer will be created to give out to the community in attempt to increase enrollment. Seven individuals in attendance.
7/26/2016	Susan Witkowski	Kershaw County Council	Presented information about LiveWell Kershaw to 50 individuals
7/27/2016	Holly, Cameron, Beckie, Debbie, Rachael	School Registration	Back to school registration in order to increase enrollment into SBHC
7/28/2016	Cameron	School Registration continued	
8/2/2016	Susan Witkowski	Founding Volunteer Luncheon	Will continue to keep this group informed about the latest efforts of LiveWell Kershaw. 29 individuals in attendance.
8/2/2016	Susan Witkowski	KC School Board	Acknowledged that it is important to have a champion on the school board to further our efforts. 35 individuals in attendance.
8/8/2016	Susan Witkowski	Alliance	Will continue to build relationships with key stakeholders because this is key to strategy promotion. 40 individuals in attendance.
8/8/2016	Rachael	Back to school night	About 30 parents came and had three students enrolled into SBHC
8/9/2016	Susan Witkowski	CMC Board	Reports will be generated to reflect the numbers at all satellites to include the dates of Year 2 and Year 3 going forward. Approximately 75 individuals involved.
8/11/2016	Beckie	Back to School Bash	Approximately 400 people reached.
8/11/2016	Rachael	Back to School Night	Around 75 families came. Set up table up front and gave out LWK information and handed out two SBHC forms to be returned
8/13/2016	Rachael, Lawanda, Cynthia	Bethune Community Back to School Bash	About 200 people came. Three applications for NCMS students for SBHC were collected.
8/13/2016	Cynthia, Lawanda, Rachael	Bethune Community Back to School Bash	16 IMPACT cards returned. Was able to connect with a Pastor's wife about coming to visit the church.

DATE	STAFF	DESCRIPTION	OUTCOME
8/13/2016	Susan Witkowski	Happy Feet Rotary Clubs	125 children received a new pair of shoes for school. Families and children were sent a letter from all schools in the district that were eligible to receive a free pair of sneakers or dress shoes. 167 letters were sent. 8 am to 10 am Spoke to several families about the SBHC. One 8th grade female student will be going for a sports physical so she can play baseball. The Dad was thrilled it was free so he could then spend money on cleats at "the Academy".
8/16/2016	Beckie and Lindsay	Camden Kiwanis	Overview provided of CMC, including Access and Outreach/ LWK.
8/23/2016	Susan Witkowski	Camden City Council	Left information at the bill pay window about clinic services. Audience members in attendance were present for school board referendum and were responding to the SBHC information in the presentation. 30 individuals in attendance.
8/25/2016	Susan Witkowski	Golden Club	Group enjoyed discussing systems and process. 31 individuals in attendance.

The PTO has been a major supporter of LiveWell Kershaw efforts.

Direct mail letter sent to county residents.

COMMUNITY MEDICAL CLINIC

Outreach. Access. Medical Home.

Dear _____ :

We have been trying to contact you by phone and have been unable to reach you. Are you uninsured or needing help with getting your medications? Are you or your family members diabetic or dealing with high blood pressure? We can help connect you with a doctor, and help you apply for qualifying programs such as Medicare, Medicaid, Welvista, and SNAP (food stamps).

Many of these services are available at no cost to you. Our Satellite Healthcare Sites are open across the North Central area (see schedule below). We are currently serving Kershaw County residents in the areas of Bethune, Buffalo, DeKalb, Cassatt, Kershaw, Liberty Hill, Mt. Pisgah and Westville.

Satellite Healthcare Site Schedule

Day & Time	Location	Address
Monday 2 pm - 5 pm	Cassatt Baptist Church	2604 Hwy 1 North Cassatt 29032
*Tuesday 9 am - 1 pm	DeKalb Baptist Church	2034 DeKalb School Rd 29020
Wednesday 2 pm - 5 pm	Refuge Baptist Church	2814 Lockhart Rd Kershaw 29067
Thursday 2 pm - 5 pm	Buffalo Baptist Church	6390 Lockhart Rd Kershaw 29067

*Open 1st and 3rd Tuesday of the month

If you would be interested in our services or would like more information please give us a call (803.272.8325) or stop by one of our Satellite Healthcare Sites. Please bring the documents below (if available) to your first appointment:

- Identification (i.e. driver's license)
- Social Security card
- A statement showing any income for the household
- Utility Bill for proof of residence
- Medicaid Denial Letter(this can be obtained from the DSS office)

We look forward to seeing you. Thank you!

Sincerely,

_____

110 C East DeKalb Street Camden, SC 29020
803.272. 8325

You Make a Difference

While walking along a beach, an elderly gentleman saw someone in the distance leaning down, picking something up and throwing it into the ocean.

As he got closer, he noticed that the figure was that of a young man, picking up starfish one by one and tossing each one gently back into the water.

He came closer still and called out, "Good morning! May I ask what it is that you are doing?" The young man paused, looked up, and replied "Throwing starfish into the ocean." The old man smiled, and said, "I must ask, then, why are you throwing starfish into the ocean?"

To this, the young man replied, "The sun is up and the tide is going out. If I don't throw them in, they'll die."

Upon hearing this, the elderly observer commented, "But, young man, do you not realize that there are miles and miles of beach and there are starfish all along every mile? You can't possibly make a difference!"

The young man listened politely. Then he bent down, picked up another starfish, threw it back into the ocean past the breaking waves and said, "It made a difference for that one."

Community Medical Clinic of Kershaw County
110 C East DeKalb Street
Camden, SC 29020
803-713-0806
cmcofkc.org

Volunteer Opportunities

Looking for a place and way to volunteer?
It only takes one person to make a change...
one community to make an impact.
Can we count on you?
Volunteer with the Community Medical Clinic

COMMUNITY MEDICAL CLINIC

Outreach. Access. Medical Home.

cmcofkc.org

About the Clinic

We are a family practice medical clinic. Patient referrals are available to community specialists when necessary. Our partners include AccessKershaw, which connects qualified applicants to free medical and dental care, and LiveWell Kershaw, which serves the North Central area of Kershaw County through a system of satellites.

Chiropractic Services: A local chiropractor treats clinic patients once a week.

Counseling: Patients who have short term needs receive counseling. More advanced problems are referred to Mental Health.

Diabetes Education:
Our Family Nurse Practitioner is also a certified diabetic educator who conducts classes for clinic patients regarding diabetic diet, menu planning and health care instructions.

Physical Therapy: A physical therapist treats patients once a week.

Best Chance Network: Breast Cancer and Cervical Cancer screening program for women between the ages of 30 - 64.

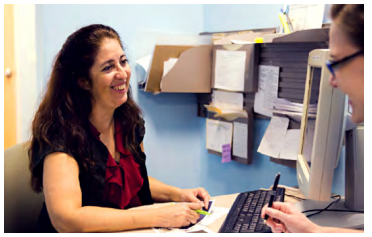
Our Mission

We will lead a collaborative effort to provide the resources for improved health of the underserved, while always respecting the dignity, integrity and diversity of those we serve and those who serve.

Our Vision

A healthier Kershaw county where individuals and communities are empowered to take charge of their own health and well-being.

Volunteer Positions Available



Front Office Assistant: This person is the face of the Community Medical Clinic. Volunteer front office assistants answer phone calls, schedule appointments and welcome patients as they come in. These volunteers often create the first impression to those we serve.

Nurse: Volunteer nurses triage Community Medical Clinic patients. This includes checking vitals such as blood pressure, weight, temperature, blood sugar and other measurements. Nurses also discuss the reason for the patient's visit and escort them to the exam room.

Pharmacy: Volunteer pharmacy technicians help patients receive their medication in a timely manner. These volunteers help patients with the medication application process, call in refills, bag medication, write up prescription labels and follow up with the patients for any additional medication needs.

Patient advocates: Patient advocates have a one-on-one conversation with every person needing services from the Community Medical Clinic. During these conversations, patient advocates gather information and ensure the patient is given the best options of healthcare for their individual situation.

Youth Community Service Opportunities: The Community Medical Clinic offers local young people ways to gain professional experience through job shadowing medical professionals, learning office skills such as organization and communication, and the chance to participate in public speaking opportunities.

If you are interested, please call the Volunteers/Special Events Manager:

803.713.0806 Ext. 408
cnelson@cmcofkc.org

The Community Medical Clinic of Kershaw County is a family practice medical clinic that provides healthcare to the uninsured residents of Kershaw County. To learn more call 803-713-0806 or visit cmcofkc.org

Call to Action Postcard.

The Mission

We will lead a collaborative effort to provide the resources for improved health of the underserved, while always respecting the dignity, integrity and diversity of those we serve and those who serve.

The Vision

A healthier Kershaw where individuals and communities are empowered to take charge of their own health and well-being.

The Soul

Our Clinical and Non-Clinical Volunteers... Our Generous Donors.... People like YOU, who care about Kershaw County

COMMUNITY MEDICAL CLINIC
Serving the uninsured of Kershaw County

CMC VALUE

EVERY $1 = $12.50 OF MEDICAL CARE

*A **$10** donation provides a full one year prescription to a clinic patient.*

*A **$100** donation covers more than 20 visits with a medical provider for clinic patients.*

*A **$500** donation provides diabetes counseling for more than 60 clinic patients.*

Please Help

Community Medical Clinic of Kershaw County
110-C East DeKalb Street, Camden SC 29020
803-713-0806
www.cmcofkc.org

Evaluation

Based on the progression of the initiative, the evaluation team will be transitioning from developmental evaluation to formative evaluation in the next quarter. Detailed logic models will be refined over the next quarter with input from all team members. Detailed tracking systems are now being put into place to track outputs as well as select short-term and intermediate outcomes. In addition, the Evaluator will receive consulting expertise from the Institute of Healthcare Improvement to create meaningful metrics to document the application of the Community Hub and Pathway Model. The evaluation team has full access to the Electronic Health Record, the case management system, and the project management system to access data needed for the evaluation. In addition, the SC Office of Revenue and Fiscal Affairs will be providing data on hospital utilization for Kershaw County residents to supplement the economic evaluation.

In an effort to demonstrate changes in motivation, innovation specific capacity and general capacity at the Community Medical Clinic, a readiness assessment will be administered every six months to track progress and to emphasize areas where additional training and attention may need to be given.

Community Medical Clinic of Kershaw County: Summary of Baseline Readiness Survey Results

Through our recent strategic plan, and revised mission and vision statements, the Community Medical Clinic is committed applying Continuous Quality Improvement principles and processes to improve the health of the underserved in Kershaw County. In order to understand where we need to focus our energies and resources, 16 team members completed a baseline Readiness Assessment (you will need to complete another one in six months to track your progress). This assessment shows what areas the Community Medical Clinic is really strong in and areas that can be enhanced over the next year. For the assessment, the term "innovation" was used to describe applying quality improvement processes and using data to make improvements. Your lowest score was: 4.63 in Inter-Organizational Relationships. Your highest score was 6.33 in Process Capacities. See below for more information about each of these.

Below is a summary of your readiness score findings. Holly Hayes, your data coach, will be going over this with you in much more detail. Overall, the Community Medical Clinic is ready for action.

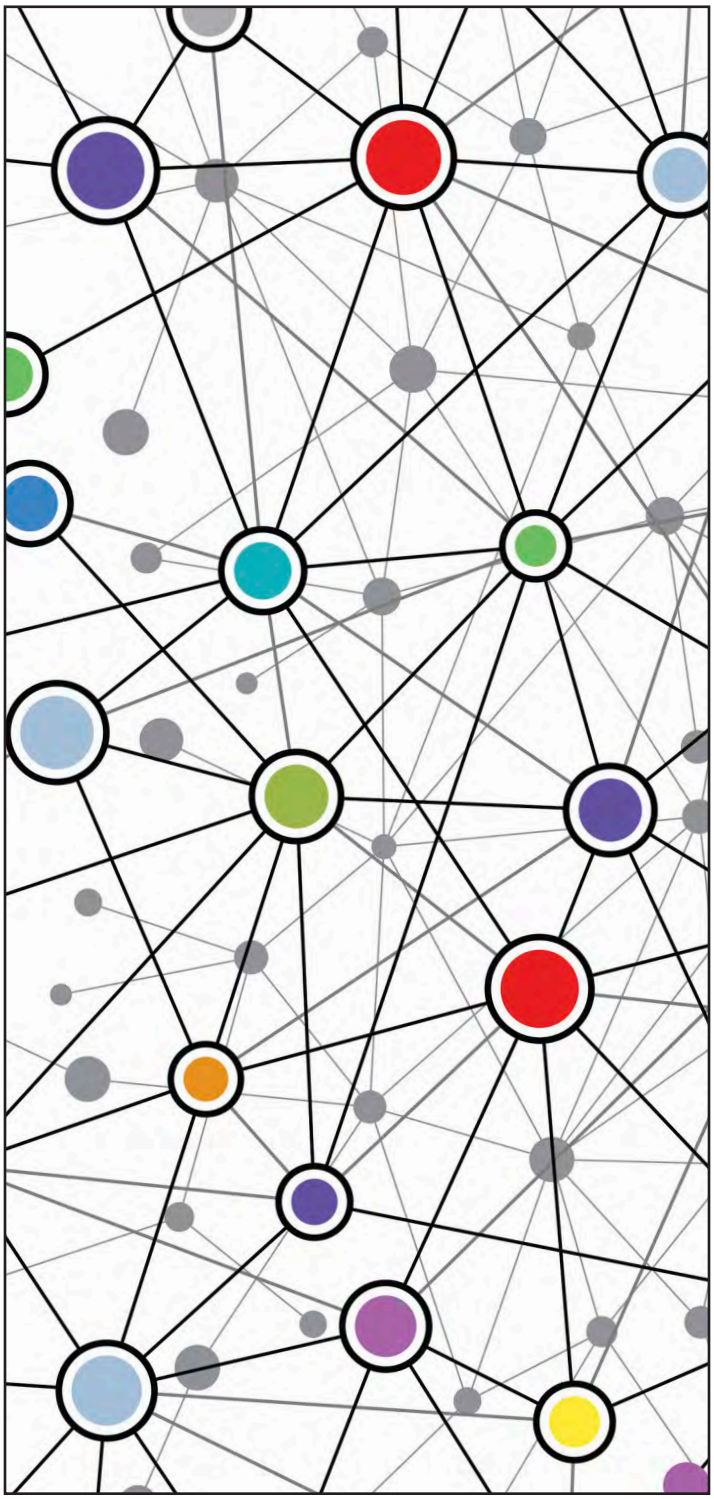
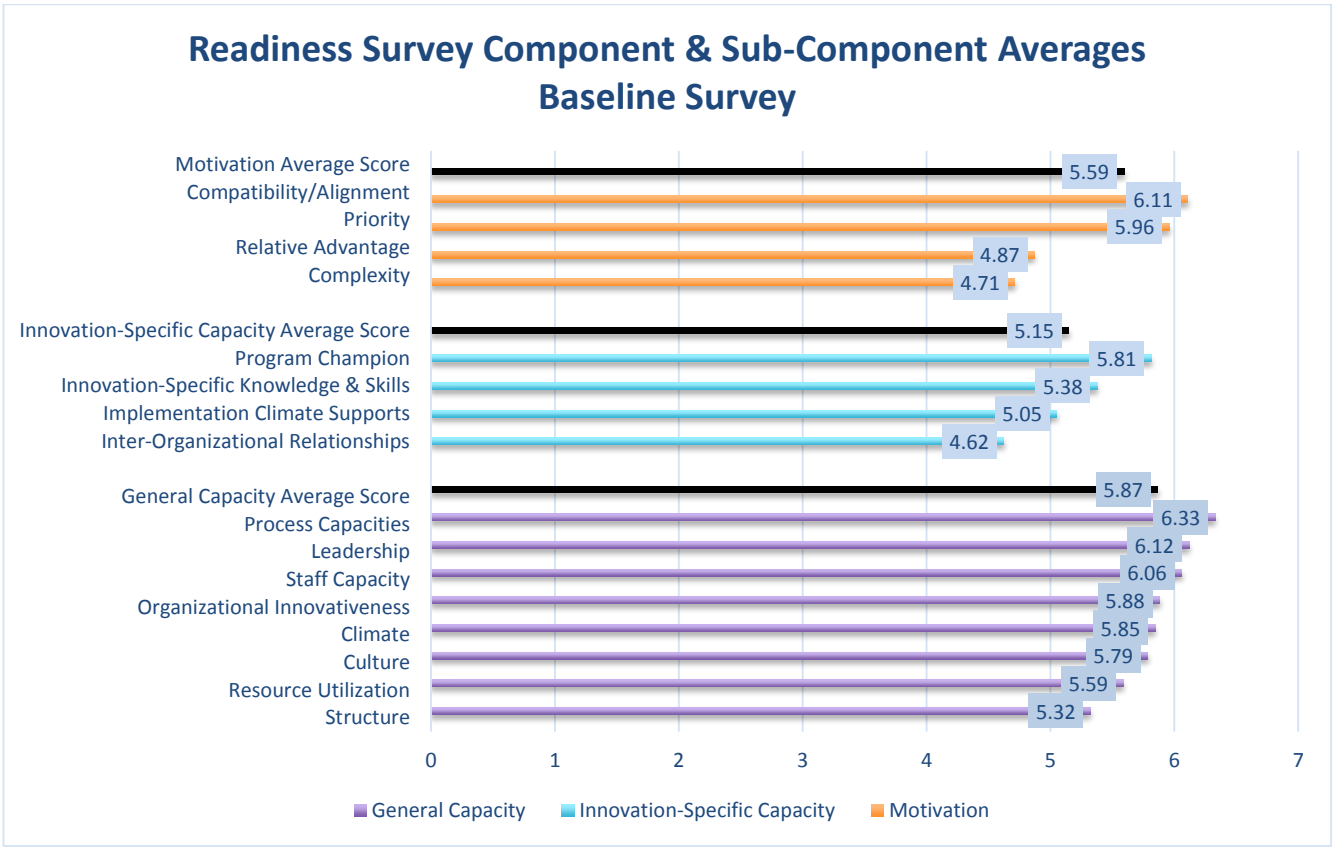


Figure 1.



Scores range from 1-7: Strongly Disagree (1), Disagree (2), Slightly Disagree (3), Neither Agree or Disagree (4), Slightly Agree (5), Agree (6), or Strongly Agree (7)

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[1]Scaccia, J. P., Cook, B. S., Lamont, A., Wandersman, A., Castellow, J. & Katz, J. (2015). A practical implementation science heuristic for organizational readiness: R=MC[2]. *Journal of Community Psychology, 43*(4), 484-501.

Table 1 shows the Community Medical Clinic's average scores on each item from the Readiness Questionnaire. This average score was calculated based on 16 respondents. The sub-component average scores are color-coded to capture trends across the sub-components.

At the organizational level, motivation refers to how motivated you are to begin reviewing data regularly to guide program improvements. If a group is not motivated, despite having capacity, the initiative will not be successful. Table 1 displays the items corresponding to the factors that influence motivation for regularly reviewing data for program improvement and their averages. The data indicates that Motivation is high in some areas (e.g., Priority) and low in others (e.g., Complexity).

Color Coding Key:

Sub-components have been ranked on a color-coded continuum, which indicates each sub-component's score relative to your organization's other sub-component scores.

Weak — Strong

Action recommended: identify strategies for improvement

Consider using as leverage for readiness

Innovation-specific capacities are the human, technical and fiscal conditions that are important for launching a quality improvement initiative. Table 1 also displays the items that correspond to the subcomponents of innovation-specific capacity. These items indicate that there is room for improvement in innovation-specific capacities, particularly in inter-organizational relationships.

General capacities encompass activities related to maintaining a functioning organization (e.g. adequate staffing) and connections with local Fatherhood sites as well as the community. Table 1 highlights climate and staff capacity as strengths within the component of general capacity.

These results can be used as a guide for your site as it seeks to review data for program improvement. Your organization is high in some components of readiness and low in others. The purpose of this assessment is to focus on key areas to increase your strengths. Your data coach will work with you to determine what area your site would like to focus on initially as you being a quality improvement initiative.

Your Data Coach & Evaluator

Holly Hayes
Cell: 803-920-1736

hayeshg@mailbox.sc.edu

Table 1.

Sub-Component	Item	Average Score (N=X)
Relative Advantage	1. Regularly reviewing data for program improvement represents an advance over other methods that are already available for our local Site.	5.31
	2. Regularly reviewing data for program improvement is better than other processes we have considered using at our local Site.	4.56
	3. Regularly reviewing data for program improvement is better than other processes we are currently using at our local Site to monitor and improve our outcomes.	4.75
	SUB-COMPONENT MEAN - RELATIVE ADVANTAGE	**4.87**
Compatibility/ Alignment	4. Regularly reviewing data for program improvement fits well with other initiatives at our local Site.	6.25
	5. Regularly reviewing data for program improvement will help us track the desired outcomes at our local Site.	6.38
	6. Regularly reviewing data for program improvement is timely given the current needs at our local Site.	5.75
	7. Regularly reviewing data for program improvement fits well with the culture and values of our local Site.	6.06
	SUB-COMPONENT MEAN - COMPATABILITY/ALIGNMENT	**6.11**
Complexity	8. At our local Site, regularly reviewing data for program improvement is simple and easy to implement.	4.63
	9. There are so many components to regularly reviewing data for program improvement that it is hard to understand all of the pieces.	5.20
	10. The complexity of regularly reviewing data for program improvement will make it difficult to put it into place.	4.31
	SUB-COMPONENT MEAN - COMPLEXITY	**4.71**

Sub-Component	Item	Average Score (N=X)
Priority	11. Regularly reviewing data for program improvement is a top priority at our local Site.	5.56
	12. Our local Site emphasizes that regularly reviewing data for program improvement is very important to improve the quality of our services.	6.13
	13. We are aware of how important regularly reviewing data for program improvement is at our local Site right now.	6.19
	SUB-COMPONENT MEAN - PRIORITY	**5.96**
Innovation-Specific Knowledge & Skills	14. We have the knowledge we need to regularly review data for program improvement.	5.38
	SUB-COMPONENT MEAN - INNOVATION SPECIFIC KNOWLEDGE & SKILLS	5.38
Program Champion	15. An influential person in our local Site strongly promotes the regular review of data for program improvement.	6.31
	16. At least one person we work with clearly communicates the needs and benefits of regularly reviewing data for program improvement.	5.19
	17. We have designated a person to share our progress in how we regularly review data for program improvement.	5.94
	SUB-COMPONENT MEAN - PROGRAM CHAMPION	**5.81**
Implementation Climate Supports	18. Our local Site actively supports the regular review of data for program improvement.	4.88
	19. We have enough resources at our local Site to regularly review data for program improvement.	5.38
	20. Our local Site dedicates specific resources to regularly review data for program improvement.	5.19
	21. There is a system in place to monitor how well we regularly review data for program improvement.	5.00
	22. We have ways to promote ongoing participation in the regular review of data.	4.81
	SUB-COMPONENT MEAN - IMPLEMENTATION CLIMATE SUPPORTS	**5.05**
Inter-organizational relationships	23. We communicate well with similar fatherhood organizations that focus on regularly reviewing data for program improvement.	4.81
	24. We seek consultation from other organizations to help us regularly review data for program improvement.	4.44
	SUB-COMPONENT MEAN - INTER-ORGANIZATIONAL RELATIONSHIPS	4.63
Culture	25. Our local Site's mission statement is understood by all of us.	6.27
	26. We all know our local Site's vision.	6.00
	27. We have a strong sense of belonging and identification within the local Site.	5.20
	28. Our local Site has a common purpose.	6.19
	29. We have good working relationships within our local Site.	4.81
	30. We know the goals of our local Site.	6.25
	SUB-COMPONENT MEAN - CULTURE	**5.79**

Sub-Component	Item	Average Score (N=X)
Climate	31. Most of the time, people in this local site want to perform to the best of their abilities.	6.44
	32. People are enthusiastic about their work.	6.19
	33. We put in extra effort to make sure our local Site succeeds.	6.13
	34. Our workload is reasonable.	5.50
	35. Morale is positive in our local Site.	5.56
	36. We have a positive attitude toward the work of the local Site.	6.00
	37. Turnover is not a problem in our local Site.	5.50
	38. People who work within our local Site feel valued.	5.44
	SUB-COMPONENT MEAN - CLIMATE	**5.85**
Structure	39. Our local Site can quickly change procedures to meet new conditions and solve problems as they arise.	5.50
	40. Our leadership committees (e.g. board, advisory, or steering) actively contribute to the goals of our local Site.	6.44
	41. We are able to communicate openly within our local Site.	5.56
	42. We understand each other when communicating within our local Site.	5.25
	43. We have a well-defined method to resolve internal problems.	4.81
	44. There is a clear method for sharing information within the local Site.	4.38
	SUB-COMPONENT MEAN - STRUCTURE	**5.32**
Organizational Innovativeness	45. We regularly take time to consider ways to improve how we do things.	5.81
	46. People in our local Site actively try to improve how we do things.	6.25
	47. Our local Site encourages everyone to share their ideas.	5.88
	48. Our local Site listens to people who have new ideas.	5.94
	49. Our local Site learns from its mistakes.	6.25
	50. When we experience a problem in the local Site, we make a serious effort to figure out what's really going on.	6.06
	51. We are deliberate in how we approach change.	5.81
	52. Overall, our local Site adapts to change well.	5.06
	SUB-COMPONENT MEAN - ORGANIZATIONAL INNOVATIVENESS	**5.88**
Resource Utilization	53. We have the ability to access sources of revenue and resources (e.g., multiple grants, public funds, third party private payers, etc.).	5.75
	54. There is a clear financial plan for us to create sustainability.	5.38
	55. There is a clear process by which the local Site prioritizes and distributes resources.	5.63
	SUB-COMPONENT MEAN - RESOURCE UTILIZATION	**5.59**

Sub-Component	Item	Average Score (N=X)
Leadership	56. We have clear leadership in our local Site.	5.88
	57. Our leadership supports ongoing projects.	6.27
	58. Our leadership approaches collaboration by relying heavily on building trust among stakeholders.	6.06
	59. Our leadership expresses confidence in the capabilities of others.	6.13
	60. Our leadership praises/recognizes when someone has done something well.	5.88
	61. Our leadership has a plan to implement our projects.	6.13
	62. Our leadership removes obstacles that prevent our programs from being implemented.	5.94
	63. Our leadership lays out the standards we need to aspire to when putting our programs into practice.	6.25
	64. Our leadership knows what they are talking about when it comes to our projects.	6.13
	65. Our leadership recognizes and appreciates team efforts to help us successfully implement.	6.44
	66. Our leadership supports our efforts to learn more about our projects.	6.19
	67. Our leadership carries on through the challenges of implementing our projects.	6.25
	68. Our leadership reacts to critical issues regarding the implementation of our projects by openly and effectively addressing the problem(s).	6.00
	SUB-COMPONENT MEAN - LEADERSHIP	6.12
Staff Capacity	69. People who work with our local Site have experience working towards program improvement.	6.06
Process Capacities	70. We are able to use strategic planning frameworks to accomplish our goals.	6.50
	71. We know how to conduct a comprehensive needs assessment.	6.31
	72. We are able to develop appropriate goals for our local Site.	6.50
	73. We know how to select an evidence-based strategy that best fits with our local Site and community's needs.	6.31
	74. We know how to identify the capacities needed to put our strategies into place.	6.50
	75. We are able to develop strategic plans.	6.69
	76. We know what it takes to put our innovations into place.	6.19
	77. We know how to evaluate what we do.	6.13
	78. We know how to evaluate if our innovations are reaching our desired outcomes and goals.	6.19
	80. We are able to implement ongoing improvement activities (e.g., PDSA, Six Sigma, Model for Improvement, etc.).	6.00
	SUB-COMPONENT MEAN - PROCESS CAPACITIES	6.33

1. Scores range from 1-7: Strongly Disagree (1), Disagree (2), Slightly Disagree (3), Neither Agree or Disagree (4), Slightly Agree (5), Agree (6), or Strongly Agree (7). 2. Two of the items in the complexity subcomponent have been reverse-coded. A higher complexity score indicates higher levels of readiness and a lower score indicates room for improvement.

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LiveWell KERSHAW

"Your Bridge to Better Health"

Quarterly Report: Year Three Quarter Two

September 1 - November 30, 2016

Our mission:

We will lead a collaborative effort to provide the resources needed for improved health of the underserved, while always respecting the dignity, integrity, and diversity of those we serve and who serve.

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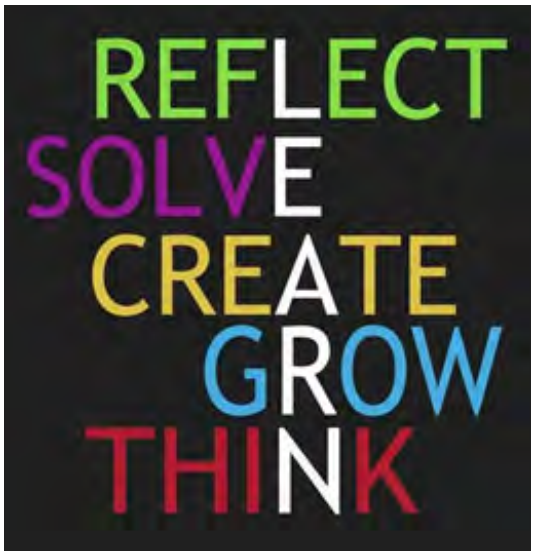
Introduction

December 1st, 2016



We hope you enjoy this quarterly report that highlights our activities and outcomes to date. If we had to summarize this quarter in three words, it would simply be, "hitting our stride." This work began in 2012, when a group of committed community members and organizations sat around the table and envisioned a healthier Kershaw County. From these conversations and the community health needs assessment, LiveWell Kershaw was born.

The community members did not just have the **will** to improve and the **ideas** of ways to transform their communities, they were also committed to **executing** a community health improvement plan. The years that local community members and organizations, state and national partners, volunteers, healthcare providers, and community residents have dedicated themselves to reflecting, solving, creating, growing and thinking have resulted in positive outcomes for the residents of Kershaw County (see figure i).

We encourage you to continue to reflect, think, and learn as you read this quarterly report. The Community Medical Clinic of Kershaw County and LiveWell Kershaw are committed to working together to continue executing the needed strategies for Kershaw County to become the healthiest county in the state.

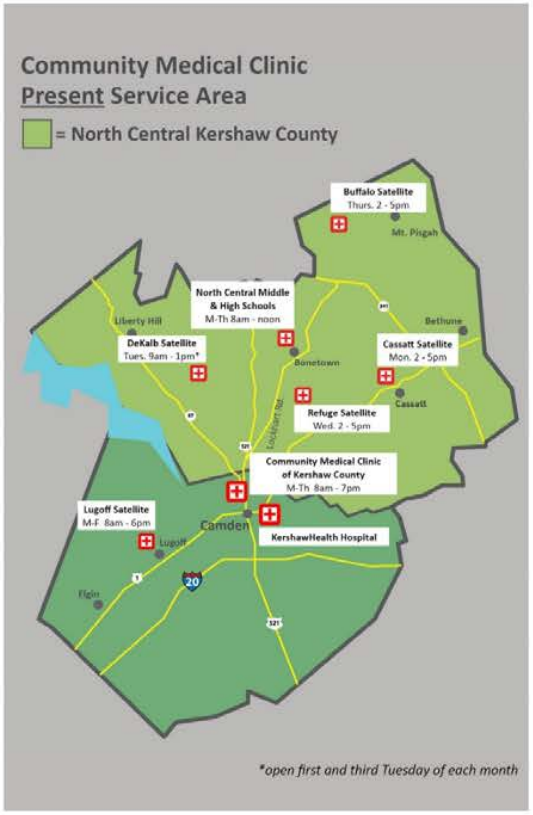
Best in all you do,

Holly Hayes
Evaluator

Susan Witkowski
Chief Executive Officer

Community Medical Clinic of Kershaw County

LiVeWell KERSHAW
"Your Bridge to Better Health"



A **diverse community coalition** in Kershaw County, used the hospital-led Community Health Needs Assessment (FY2013) to create specific actions to address critical issues. The Community Medical Clinic of Kershaw County, a **17-year-old free clinic**, is committed to addressing not only clinical needs but also health behaviors and social and economic factors of patients and their families. **112 patients from the North Central area had a medical home at CMC as of May 1, 2014.**

To date, **over 800 un-duplicated residents from the North Central area have been connected to a medical home with over 3,000 visits.** 76% of these visits are complex and require **case management**. The **School-Based Health Center** currently has 56% of all high school students enrolled and 29% of all middle school students. The Nurse Practitioner and team have conducted 100 **sports physicals, 86 sick visits**, 6 TDAP shots and 10 flu shots. USC doctoral community psychology students have served 85 **unduplicated students for mental health services**, which includes one on one counseling, mentoring, parent sessions, consultations, and support groups. Over 30 teachers have also received mentoring services. The number of disciplinary referrals, tardies and **unexcused absences is decreasing** with **statistically significant results** attributed to the School Based Health Center.

Future plans include **expanding** to all middle and high schools in Kershaw County and expanding to three additional church satellites and one urgent care site in Lugoff and Elgin. **With over 50 signed community letters of commitment,** we are executing our strategic plan to enhance population health and for **Kershaw County to be the healthiest county in the state.** We will be focused on addressing issues **county wide** with specific emphasis on obesity, mental health, teen pregnancy, seniors and rural poverty.

Equity Bus Tour of Kershaw County: October 7, 2016

Equity Bus Tour of Kershaw County
October 7, 2016

The Health Equity Bus Tour of Kershaw County aimed to give all participants a better understanding of population health while recognizing all satellites of LiveWell Kershaw as part of the Community Medical Clinic (CMC). Those invited to participate in the bus tour were either new employees to CMC or influential members of the community, such as mayors or city planners. Other guests included journalists and board members of CMC. In addition, the purpose of the bus tour was to equip participants with a deeper awareness and understanding of health equity and the importance of addressing social determinants of health. Participants were given a detailed bus tour activity booklet with zip code level data on demographics, median income and facts about the towns. It was important for all participants to recognize the great variation in resources, despite being in the same county. Some participants had never toured some of the towns that were part of the rolling classroom experience.

Board chair of CMC, Tim Hudsson, spoke briefly to start off the bus tour.

The bus tour began at the Lugoff satellite known as West Wateree. Participants were able to tour the site with Community Care Coordinators and understand the role of case management. After the tour, participants boarded the bus to begin their three-hour rolling

Bus tour participants pose for a quick photo before beginning their tour of Kershaw County.

classroom experience across Kershaw County. Bus tour guests were asked to view the communities they encountered through lenses of abundance, equity, and risk factors. Through these various lenses, participants have a better understanding of what those living in the community feel or experience in their daily life. In addition, the demographics and median income were given for each community driven through. Stops included in the tour were satellite locations such as Cassatt Baptist Church, Buffalo Baptist Church, and Refuge Baptist Church (refer to map, pg. 7). In addition, the group stopped at North Central High School for a brief presentation on the SBHC by Principal David Branham and toured the school clinic. At each of these stops, participants either toured the location or were able to hear the perspective of the pastor of the church regarding the relationship between the satellite and LiveWell Kershaw. Throughout the tour, Holly Hayes, evaluator of LiveWell Kershaw, and Susan Witkowski, CEO of CMC, discussed population health and explained what it means to focus on equity as opposed to equality. In addition, staff members of CMC and LiveWell shared stories of impact and how LiveWell Kershaw is making a difference in the lives of community members.

At the end of the bus tour, Hayes and Witkowski challenged participants to create an action plan given the information that they were provided with, and to take note of how they now view equity differently. In addition, participants were called upon to give a personal application of what they had learned

Holly Hayes, LiveWell Kershaw evaluator, challenges bus tour participants with a Call to Action.

throughout the tour. Overall, the bus tour was a success. CMC employees hope to have more tours like this in the future.

Evaluation of Event

There were **18 participants in a survey regarding the bus tour** and 25 that participated in the bus tour. However, not all participants answered all questions to this survey.

After participating in the bus tour, the **majority of participants** felt that they fully recognize all sites as being part of the Community Medical Clinic, have an awareness of equity, and have an understanding of population health.

Participants provided insights they gained from the bus tour throughout the survey. Participants noted that they now have a better grasp on the healthcare challenges and disparities throughout the county. "Until this tour, I'd never really grasped just how remote some parts of it are and the challenges that presents. Also, I hadn't thought of healthcare in terms of equity and access rather than simply equality of care. The pieces fit together now - how distance and education and work and disease and access all play off of one another. It's obvious that what works in Camden won't work in Bethune or North Central, and the problem is more nuanced and only an integrated approach has any hope of garnering change. This tour made it blatantly obvious why most approaches to care access fail so completely," said one participant.

Others did not realize how rural Kershaw County truly is until taking the bus tour and driving through communities lacking infrastructure and resources. All participants recognized that there is still a lot to be done but through collaboration, it can be accomplished.

Participants were also asked to provide recommendations for CMC as it moves forward and how to integrate with partners. Some of the comments left by individuals were related to spreading the word about what LiveWell is doing for the community. Others believe that the team should continue to do the bus tour every six months or so among new employees and key individuals to show the needs across the county.

One respondent noted that, "it's important to stress the downstream advantages of this approach, and the funding opportunities. Most organizations are trying to do more with less, and anything that stretches their resources will be welcome. Although it may seem that you're only reaching a few people at a time, that will have a snowball effect moving forward. Also I think it's important to stress that many of those served by this initiative are the "working poor" - not merely the indigent. I truly feel most people do not realize the scope of the gap faced by those who are working, but uninsured or underinsured."

Overall, participants were grateful to have been a part of the bus tour and are impressed with what the LiveWell Kershaw team has accomplished thus far.

Bus tour participants share their insights and experiences along the way.

Community Medical Clinic Service Area

= North Central Kershaw County

**open first and third Tuesdays of the month*

Flip or Flop: Let's Move Kershaw to the Top

Flip or Flop, Let's Move Kershaw County to the Top October 27-28th, 2016

During this quarter, nearly 100 civic, community, education, philanthropic, and healthcare leaders joined with LiveWell Kershaw, the Community Medical Clinic, and internationally-recognized community health experts for Flip-or-Flop, an interactive workshop designed to make Kershaw County the healthiest county in South Carolina. The premise of the event was simple – give a wide variety of community participants the knowledge and tools necessary to create actionable, measurable, cost-effective programs that will have a positive effect on the health of those in Kershaw County.

Flip or Flop was held at the National Steeplechase Museum in Camden.

Place matters, participants learned. Studies show that longevity and health are determined more by ZIP code than genetic code. Whether a person graduates from high school or not is the single largest determinant of future health. Why? Because high school graduation generally leads to higher income. Higher income is associated with better health behaviors, such as not smoking, and better access to health insurance and healthcare. While about 12% of those in the US are uninsured, the number in South Carolina is 15%, and in Kershaw County, it tops 23%. Those are just some of the reasons it's important to move Kershaw County from its current 11th place ranking to number one.

(L to R): Dr. Soma Stout, Susan Witkowski, Holly Hayes, and Tim Hudson at the Flip or Flop event.

But health is more than the absence of disease, they also discovered. It involves mental, physical, social, and spiritual well-being. Health behaviors, clinical care, social determinants, and infrastructure all impact health, and all of these factors are interrelated. Improving health requires a holistic approach involving a wide array of organizations and services and innovative approaches to delivery. Even more important, participants learned, it is possible to design cost-effective initiatives that can deliver positive outcomes quickly.

Not only does place matter, but community is critical, as it forms the starting point for all successful population health initiatives. "People want to be *loved* back to health, not *processed* back to health," noted Holly Hayes, of the USC Arnold School of Public Health, and lead investigator of LiveWell Kershaw (the event sponsor). "That begins with and in their community, with people they know and trust."

Practicality was the driving focus of the event, as those in attendance were in agreement that only thoughtful action effects change. In lively breakout sessions during the day, participants from all disciplines worked together to develop a simple initiative to address one population health challenge – from teen pregnancy to care access. They identified assets currently in place – from Kershaw County's Vision 2030 plan to the school-based health clinics at North Central Middle and High Schools, and how those might be used in the initiative. Finally,

participants committed to “buy into” that initiative over the next few months, helping to implement and evaluate it. They learned how to use the “Aim & Driver” method to assess what might be driving poor outcomes, identify possible solutions, and develop simple steps that could be tested in 30 days. Short-term initiatives like this keep projects moving forward and help develop a portfolio of processes and programs that can be customized for different needs.

Keynote speaker for the event was Dr. Soma Stout, an internationally-recognized expert who has focused her career on improving the health of individuals and communities around the world. She is committed to the idea that “there is great tapped and untapped potential in communities – we have to assume they have what is needed to succeed. My role is to accompany them on that journey.”

Dr. Stout is the Executive External Lead for Health Improvement for the Institute for Healthcare Improvement and serves as Executive Lead of 100 Million Healthier Lives. She also directs the Innovation Fellows Program at the Harvard Medical School Center for Primary Care and is Lead Transformation Adviser at the Cambridge Health Alliance.

The current health delivery system, noted Dr. Stout, is both expensive and fragmented. It leads to health inequities that have a profound impact on chronic disease – one of the costliest and most unsustainable segments of our healthcare system. In addition, the cost of care delivery is forcing tradeoffs in education, infrastructure, and other areas that are becoming increasingly difficult to justify.

Flip or Flop attendees unanimously decided to "flip" the health of Kershaw County.

Dr. Soma Stout, Executive Lead of 100 Million Healthier Lives from the Institute for Healthcare Improvement, discusses equity with the group.

Understanding the systems and policies that create health inequality is critical to effective change. The current healthcare system, for example, is focused on care delivery, not on creating healthier individuals. That focus, notes Dr. Stout, is costly. Currently, healthcare spending consumes 20 percent of the US gross domestic product, and an average family spends nearly 30 percent of its income on healthcare related costs. The cost of treating just a single condition, diabetes, will rise from $322 billion annually today to $520 billion annually in just ten years.

"The cost of health inequality and its impact on chronic disease is simply unsustainable," says Dr. Stout. For example, there is a strong correlation between economic hardship and childhood obesity, and experts also increasingly note the connection between childhood obesity and poor school performance – reinforcing a community of poverty. Effective programs will address each of the factors that make up this community, from schools to healthcare.

Herself the parent of a child with special needs, Dr. Stout noted that current systems are incredibly complex – involving healthcare, schools, transportation, social services, and more. No one person or organization, she personally recognizes, can help individuals navigate such a complex system, which is why she focuses on helping build coordinated systems of care that lead from isolation to interconnectedness. Dr. Stout insists there is tapped and untapped potential in all communities, and most often, her goal is simply to accompany a community as they recognize and employ the resources already in place to create success. Looking upstream from the current problem, she notes, is critical to developing effective change.

Creating a community hub model that helps coordinate care across a complex system is essential to success. Susan Witkowski, Executive Director of the Community Medical Clinic of Kershaw County, noted that is what the clinic provided for its uninsured patients. "We understand that not everyone needs the same amount of care or assistance. Our goal is to help create equity – to build a system that will help raise everyone to an acceptable level of health. Some folks will need more help with that process than others. There are a tremendous number of assets out there, and we try to create a simple process for navigating that system, especially for the uninsured." The clinic has also worked closely with LiveWell Kershaw to expand that model into the community at large, working with a variety of governmental, civic, and philanthropic groups to build a network of care.

Laura Brennan, co-chair of the 100 Million Healthier Lives Leadership Team and director of Pathway to Pacesetter, a program that helps communities across the US accelerate their efforts to promote health, well-being, and equity, enthusiastically urged the group to "fail early, fail often, and fail forward!" Her definition of FAIL – **F**irst **A**ttempt **I**n **L**earning – stresses the idea that effective change is not easy and often not straightforward. Failure, she noted, shouldn't be avoided but embraced. One of her favorite stories, she shared, is of Thomas Edison, who famously noted he didn't *fail* to make the electric light bulb over 900 times – he discovered more than 900 ways *not* to make a light bulb. Perspective, she said, is everything. She challenged participants to avoid getting caught in the "perfect planning trap", but rather to move forward boldly, evaluate constantly, and rethink when necessary. That cycle, she assured everyone, would lead to exceptional success and even bolder thinking in the future.

Participants worked in groups to come up with the ideal model of the healthcare delivery system.

Laura Brennan, Director for Pathway to Pacesetter, encourages the group the adopt a growth mindset.

At the end of the day, participants agreed they had a better perspective on health and had formed important new working relationships with others in the community. In addition, they shared a renewed sense of purpose and vision for Kershaw County and a commitment to turn what is a great place to live for some of its citizens into a great place to live for all its citizens.

Evaluation of Flip or Flop Event

Evaluation Methods

Four distinct, mixed method evaluation strategies were planned to gather process and outcome evaluation data from the Flip or Flop Event. These strategies and corresponding descriptive information, can be found in Table 1.

Participants share written reflections of the event.

Table 1: CHILA 1 evaluation strategies

Technique	Evaluation Category[1]	Type of Data[2]	Who Completed	When Administered
Comprehensive Questionnaire	Inquiry	Process Outcome	All participants	At the end of the final day
Results, Process, and Relationships assessment	Reflection	Process	Implementation team	Two weeks following event
Informal Participant Interviews	Inquiry	Process	Implementation team	Two weeks following event
Team Debrief	Observation	Process	Implementation & evaluation team	End of each session

1.) We used a three pronged strategy of inquiry, observation, and reflection to evaluate the Flip or Flop activities. Inquiry is where we actively seek information about important questions. Observation is where we collect data on the various activities. Reflection is where we employ a structured narrative approach to get stakeholder input on the event and the critical drivers of success.

2.) Process data is information we collect about what happened at CHILA 1. Outcome data is information we collect about whether or not the Flip or Flop event met its goals.

Results

We first discuss the final comprehensive participation evaluation, which captured overall learning and impressions about the Flip or Flop event as a whole. We then review specific comments.

Comprehensive Questionnaire

The final Flip or Flop evaluation was administered via paper form at the end of the day; some participants had already left before the survey was administered. Forty-three unique responses were gathered; a total of 110 attendees participated in at least one portion of the event. Within the comprehensive questionnaire, we used a retrospective pre-post questionnaire to assess knowledge and skills that were gained at Flip or Flop. The retrospective pre-post asks participants to reflect upon their perspective prior to coming to the Flip or Flop event, and then to rate themselves at the conclusion of Flip or Flop. This method helps to correct for initial positive presentation bias, and, in the words of the evaluation PI, "Sometimes people don't know what they don't know." Items were rated on a Likert scale ranging from 1 to 5 (1=Strongly Disagree, 2=Disagree, 3=Neither agree nor disagree, 4=Agree, 5=Strongly Agree). Table 2 below shows that all findings from the comprehensive questionnaire were statistically significant with a p-value less than 0.001.

Table 2. Knowledge and skills gained during Flip or Flop Event

Item	N	Pre-test Mean	Post-test Mean	T-value
I was motivated to be part of the collective effort to enhance population health in Kershaw County.	43	4.19	4.77	-4.355
I felt confident in my ability to lead change efforts in my organization.	43	3.88	4.53	-.4.542
I was highly familiar with RWJ County Health Rankings model and social determinants of health.	43	2.98	4.35	-5.697
I had a good understanding of equity and what it means.	43	3.44	4.51	-5.308
I had a good understanding of ways to enhance population health at the community level.	43	3.3.7	4.65	-6.414
I understood the importance of sharing my community's story of health improvement.	43	3.79	4.77	-5.157

*p<0.001

Participants were also asked to rate their experiences both quantitatively and qualitatively during the Flip or Flop event. Table 3 displays the percentages corresponding with individual responses, along with representative qualitative comments grouped by themes, if applicable. It is important to note that 67.4% of respondents reported that they made a short-term goal related to the content of the event and 60.5% of respondents reported making a long-term goal related to the population health. Further evaluation efforts will examine how participants are applying the content from the event in future quarters.

Table 3: Flip or Flop ratings and comments.

Item		Selected Comments
This conference was a joy to attend.	86%	• Networking and meeting representatives of other organizations. Gaining new knowledge of what organizations offer/have available for community. • Networking with other professionals • Variety of perspectives, community members
The objectives of the conference were clear.	83.7%	• The theme and objectives were very clear. • Everything was valuable • It would have been helpful to understand the goals of the event in advance to allow time for reflection and to prepare for full participation.
The quality of the presenters and facilitators was excellent.	90.7%	• Excellent and knowledgeable speakers. • The speakers and their knowledge were excellent! Including the local gals! • The information and examples given by Dr. Soma Stout in describing the changes that have taken place with improving population health. • Knowing the income disparities and poverty level relevant to income • Learning the data about Kershaw County with uninsured people, food deserts and pediatricians. • The failing forward presentation – maybe because it was after lunch. Presenter was very energetic but I didn't identify with the content.
The pace of the conference fit my learning needs.	81.4%	• Day long event was too long • Please make it shorter duration, maybe 8 am – 2 pm

Item		Selected Comments
The video showcasing Kershaw County leaders was inspiring.	69.8%	• The change that is being made in our county. I could see that there is a large portion of people willing this make this vision come about.
The level of detail presented fit my learning needs.	79.1%	• Too much "fluff" – not enough "nuts and bolts" of how to get started, would have allowed more time to work on goals • Expected to be focused on making North Central to reach its goals
There was the right mix of presentations, discussions, and exercises.	83.7%	• Group activities and discussions. Each member was allowed to participate and engage each other in in-depth conversations. • I felt welcome, regardless of my age. I felt like people cared to hear my opinion.
Instructions for group activities were clear.	88.4%	
The audio/ visual quality was excellent.	74.4%	
The accommodations (venue and food) were excellent.	90.7%	• Food was great
I am excited to share what I have learned from this conference with my organization, family and friends.	88.4%	• Communicate with stakeholders the specific goals and tasks needed to implement change. • I plan to educate those around me! • I will share this information with my organization's board to educate and motivate them on improving population health • Setting work goals in support of making Kershaw County the healthiest county in SC • We must have cultural awareness; you gain more of that by asking questions to those of the community who are affected
The conference met my expectations.	83.7%	• This meeting was more than I expected. • I enjoyed the conference. I learned a lot of information. I met new people.
My overall experience with the conference was excellent.	86%	• One of the best workshops I have attended! • Meeting with people with similar goals

Application

It is important to note that 67.4% of respondents reported that they made a short-term goal related to the content of the event and 60.5% of respondents reported making a long-term goal related to the population health. Additional comments provided by participants focused on follow-up. One participant noted that, "I'm hanging. I needed to leave doing something!" Other participants noted that they need help to network with some of the same key stakeholders again and that for sustainable change to occur the "power players of these organizations and the workers" need to meet regularly. Another participant recommended that an open and honest discussion around real stewardship (time, talent, treasure, influence and desire) needs to occur with key partners.

Further evaluation efforts will examine how participants are applying the content from the event in future quarters.

Some of the responses of specific goals made by participants are listed below.

Short Term Goals Feedback:

- Discuss with FFTS Director what our direction/role will be given new info obtained today.
- To spend more time with patients to encourage exercise and weight loss.
- Be more of an advocate and educator with education for residents of KC
- Follow up with staff as to the flow and efficiency of policies and procedures and overall impact on providing Quality Patient Care
- Work on teen obesity
- Plan of measurement regarding community sense of safety
- To address my Board of Trustees for a commitment on the Drivers in the commitment level
- I want people to realize the seriousness of equity, and my goal is to share my knowledge.
- Nutrition at school, no candy as rewards!
- Will discuss with my church info that I gathered. Indicated that I will volunteer.
- The impact of adult health is profoundly impacted by graduation from high school. This should be the #1 reason as to why people of Kershaw County should vote yes/yes on the upcoming referendum. (It's not about facilities; it's about people)
- To do my part to make our healthier community a reality.
- Use students to educate community on LiveWell progra**m**

Long Term Goals Feedback:

- To try to form policies and procedures to make changes county wide in weight loss, diabetes
- Become more involved in the process and initiatives being generated to reach the 12,000 citizens of the North Central area.
- Improve poverty rates
- Working with youth and seniors to achieve better health
- Pursue my career in medicine, so that I can have a better say when I'm older and important.
- Focus on Hispanic population for access to healthcare
- To work with other agencies to impact charge in my community.
- Make whole child approach to educate children

Holly Hayes shares data related to Kershaw county.

Informal Participant Interviews

Part of the implementation team, the CEO of the Community Medical Clinic and the Development Director interviewed over 10 people following the event. Some of the comments included the participants being surprised of the disparities that exist across the county and the rapid population growth that is occurring in the Lugoff-Elgin area. Additionally, participants were hungry for more data related to the zip codes and understanding what could be done to improve population health in the county. Others noted an appreciation for the diversity of stakeholders that attended the event. At no other time have participants been able to converse with a judge, a high school student, older clinic volunteers, and a principal at the same time while brainstorming solutions. Participants also reiterated that they also really enjoyed networking with these diverse stakeholders and expressed a desire to begin meeting with other organizations regularly to share what they are currently working on and find ways to integrate efforts and not duplicate. Overall, the comments were positive and participants are eager to gain direction and understanding about how they as an organization and an individual can assist in making Kershaw County the healthiest county in the state.

Team Debrief

During the Flip or Flop event, a formative evaluation approach was implemented. The evaluation team, including the speakers, Dr. Soma Stout, Lauren Brennan, and Holly Hayes met after each portion of the agenda to determine what was and not working. It became clear after lunch that participants were eager to take a deeper look at determining the priorities for obesity, elderly, and teen pregnancy. So instead of moving forward with another didactic session, the team decided to break out into four groups to work for over an hour and a half to understand the problem at a deeper level and follow the communities of solution framework to create action items. This group work seemed to reengage participants and those that remained at the event were now energized. We recognize that having the formative evaluation approach is critical, if the agenda had been kept as-is, we may have had a lower attendance at the end of the day. The participants seemed to like the changes made and as a result, four subcommittees were created that are now meeting regularly to carry the communities of solutions forward.

Implementation Team Discussion with Community Medical Clinic team

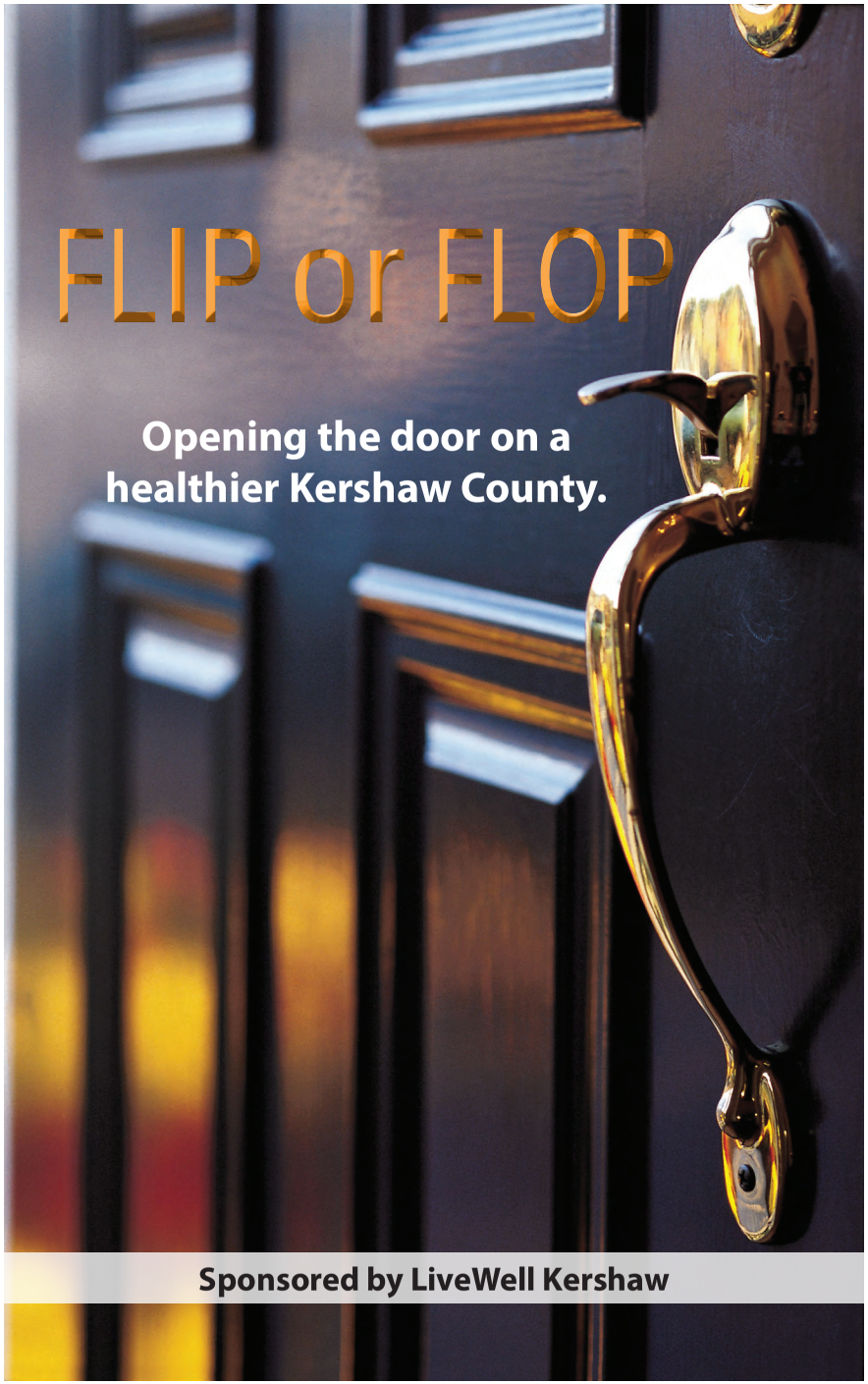
On November 1, 2016, evaluation team members facilitated a group discussion with the implementation team on the Flip or Flop event. Team members gave feedback on areas that worked, and did not work in three dimensions (results, relationships and process).

	 What are the positives (expected or unexpected)?	 What are changes we need to consider based on some "not there yet" moments?
Results *Did you meet your aim? Did we get the rational and experiential aims we were planning for?*	• 46 letters of commitment • 42 evaluation forms • 109 people attended • Soma – most creative PH event	• Took a lot of phone calls at the end to get people to come • People who wrote letter of commitment are responsible the next time • Throwing volunteer story board at last minute • Coffee • Sign up for set-up • Delegate clean up

	 What are the positives (expected or unexpected)?	 What are changes we need to consider based on some "not there yet" moments?
Process *How did all the tasks get done? Review process, how designed, managed, and implemented. Consider the planning, implementation and clean up.*	• Groups were very engaged on conversation • Reception opened up for FR and build on convo • CEUs were great • Displays were awesome • Sign-in table, seating arrangements were well • Twitter • Name tags • Food great – using different caterer	• Consider better time of year • 1 day and no reception • Invitation was too wordy • Registration form could be twittered • Cut shorter and end at 2 PM • Small group at end changed the atmosphere • Physicians need 6 month in advance for CEM • Tables too close and cluttered • Table markers hard to identify • More participation in taking down
Relationships *What was the quality of relationships within the planning team? The CMC team and board? With partners? What was the level of trust, respect, and relationships between you and the target audience?*	• Dr. Adam's church wants a present • Dr. Huntsle – complementary of SBHC • Lugoff School nurse now knows about SBHC • Food for the Soul – Robin understands CHW, didn't know what we do, looking to expand NC • Ed Garrison (ATEC) – student leadership council, brought 3 • Loved for students to be a part of it • Charles McCory – good convo with Vicki, he's all in • DSS – want to come and talk to staff, partner with message • Dr. Penny Baker – convo with Sentinal and Police and staff	• Invite Camden High next time • NCHS on wrong list • More patients participating especially from satellite offices • Representation from Hispanic population (Latino Group) • Need more pastors at event • Not a big representation of minorities • Pastor that did attend to recruit other pastors (peer to peer) • Invite mental health • Community participates in the planning process • 3 big funders could not come because of time of year

Summary

After review of the findings from the four techniques, we conclude that the Flip or Flop event was a huge success. All of the outlined rational and experiential aims for the event were met and all participants had statistically significant changes in knowledge and skill level related to population health, health equity, and understanding the overall definition of health. Given the large amount invested in time and money put forth for the event, it appears that the Flip or Flop event was a wise investment. The evaluation team believes that it is imperative that the implementation team continues to work with all 110 participants to ensure that the execution of the strategies and frameworks discussed at the event move forward. In addition, it would be wise for updates on anything related to the subcommittees and key findings from the 100 Million Healthier Lives campaign to be shared with the group to continue the dialogue.



cover

FLIP or FLOP

Population health. What is it? How does it impact Kershaw County? What does it have to do with me, or my organization?

Those are each excellent questions, and while you may not have much experience with the concept of population health, it is a critical factor in the success of any community, including our own. It affects the well-being of our citizens, our children's education, the strength of local businesses, the appeal of Kershaw County to residents and visitors, and whether industries choose to locate in our county, to name but a few. In myriad ways, it touches us all.

Flip or Flop is an exceptional opportunity for Kershaw County leaders in all fields to connect with nationally-recognized experts in population health from some of the country's leading organizations, including Harvard University, the Institute for Healthcare Improvement, and the Arnold School of Public Health. This project is part of the 100 Million Healthier Lives Campaign, and Kershaw County is honored to be a **Pathway to Pacesetter** community as part of that initiative.

We would like to extend a personal invitation for you to take advantage of this opportunity to make an investment in Kershaw County and its future. I'm certain you'll be both challenged and invigorated by the process.

Best,

Susan Witkowski
Executive Director

Tim Hudson
Board Chairman

Community Medical Clinic of Kershaw County

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ARCHITECTURE

Soma Stout, MD, MS is the Executive External Lead for Health Improvement for the **Institute for Healthcare Improvement** and serves as Executive Lead of **100 Million Healthier Lives**, which brings together hundreds of partners across communities to support 100 million people globally to live healthier lives by 2020. She also directs the Innovation Fellows Program at the **Harvard Medical School Center for Primary Care** and is Lead Transformation Adviser at the **Cambridge Health Alliance** (CHA).

Dr. Stout is deeply committed to improving the health and well-being of underserved people and communities and has worked as a primary care doctor in the safety net for over 15 years. In 2012, she was awarded the Robert Wood Johnson Foundation Young Leader Award for her contributions to improving the health of the nation.

Laura Brennan, MSW has supported communities throughout the United States to create community-based coordinated systems of care that ensure better health for all people at less cost. Laura is committed to meaningful engagement of all stakeholders, and to developing "models that work" to promote health.

Currently, Laura is co-chair of the **100 Million Healthier Lives** Leadership Team. Further, she is the director of **Pathway to Pacesetter**, a program that helps communities across the United States accelerate their efforts to promote health, well-being, and equity.

Holly Hayes, MSPH, PMP, CTF is a Research Associate for the Care of Applied Research Evaluation (CARE) at the University of South Carolina's **Arnold School of Public Health**. She is currently the principal investigator for the evaluation of **LiveWell Kershaw.** a Department of Health and Human Services contract. Holly has extensive experience in evaluation, community-based participatory research, and quality improvement, and specializes in approaches to help both academic and community-based groups maximize their potential. She holds international certifications in professional facilitation and project management, along with Green Belt designation in Six Sigma.

100 Million Healthier Lives

CONVENED BY Institute for Healthcare Improvement

PROJECT

Please join us for Flip or Flop.
Taking Kershaw County to the Top!

Sponsored by LiveWell Kershaw, this exceptional conference will connect business, government, community, education, and healthcare leaders from Kershaw County with nationally-recognized experts in population health and best practices from the Harvard University, the Institute for Healthcare Improvement, and the Arnold School of Public Health.

Our goal?
To share a blueprint for making Kershaw County into one of the healthiest communities in the country and to make it a desirable location for business and industry, residents and visitors alike.

Using this blueprint, we will take what is essentially an outdated house (our current population health model) in a great neighborhood (Kershaw County), and renovate it into a true showplace. By removing barriers, improving flow, updating infrastructure, and beautifying the physical environment, we will create a county that is both healthier and makes the most of its many outstanding assets.

Like any renovation, this one requires a team of participants committed to working together to achieve exceptional results. **That team includes YOU and your organization.** So grab your work gloves and make plans to join us.

FLIP or FLOP

CONSTRUCTION SCHEDULE

GROUNDBREAKING PARTY
Thursday, October 27
6:00 - 8:00 pm
National Steeplechase Museum • Camden
Meet the architects, mingle with other community participants, and learn more about what makes Kershaw County the perfect location for this project at this relaxed get-together.

CONSTRUCTION EVENT
Friday, October 28
National Steeplechase Museum • Camden

Continental Breakfast	8:00 am
Construction Begins	8:30 am
Lunch/Keynote Speaker	Noon
Reveal/Closing	4:30 pm

COST: **$20**
$30 after 10•10•2016
Includes all events.

CEUs are available for FNPs, RNs, and LMSWs.

Sponsored by LiveWell Kershaw

Here's a quick look at our construction plans.

CONSTRUCTION TEAM

YOU AND YOUR ORGANIZATION
As an essential stakeholder, you have a critical part to play in this project. How you and your organization interact with other community team members will affect our overall success and the future of Kershaw County.

FOUNDATION

SOCIAL AND ECONOMIC FACTORS
Education. Employment and income. Family and social support. Safety. These are the underpinnings of a successful community. They must be solidly-built if further construction is to be effective. Many of these factors are already in place in Kershaw County, and we will learn more about how to strengthen and integrate them.

WALLS

HEALTH BEHAVIORS
Diet and exercise. Tobacco and alcohol use. Unsafe sex. These health behaviors have a proven impact on both the length and quality of life. Although these walls can be difficult to move or change, altering their arrangement will transform the look and feel of our house.

DOORS AND WINDOWS

CLINICAL CARE
Access to care and quality of care are two of the barriers to healthcare access. Others can be as varied as language or transportation. Often, these are difficult to identify. Fortunately, the solutions may be simple. As always, sharing best practices elevates the quality of care across all providers.

TRIM AND PAINT

PHYSICAL ENVIRONMENT
Environmental quality. Built environment. These are the natural spaces, parks, playgrounds, roads, and buildings we see around us. They comprise a visual impression of the community, and done well, they will have a far-reaching impact. The physical environment attracts residents and visitors, as well as making a positive impression on prospective businesses and industries.

FLIP or FLOP OCTOBER 28

REGISTRATION

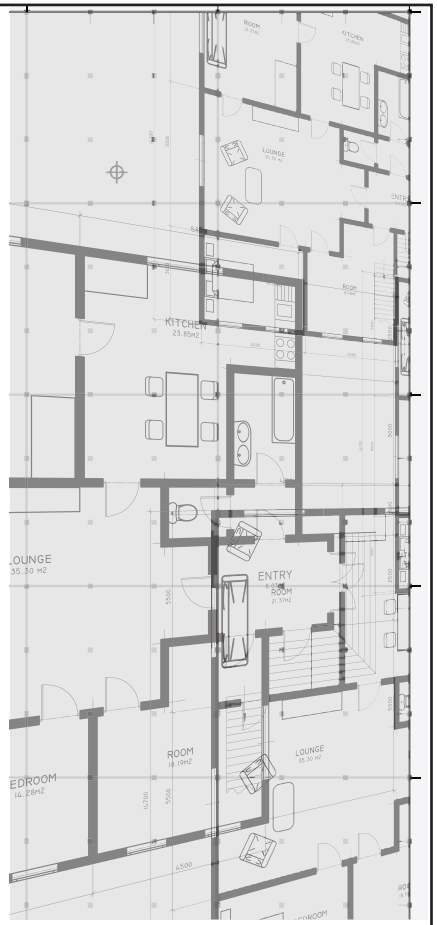
REGISTER TODAY!
Space is limited, and we want to ensure you and your organization are represented, so register now.

COST: **$20**
$30 after 10•10•2016
Includes all events.
Groundbreaking Party 10•27
Construction Event 10•28

ONLINE
It's simple and secure.
www.cmcofkc.org/Flip-or-Flop

BY MAIL
Complete, detach, and mail this form with your payment to the address below.

QUESTIONS?
Call Mary Hill at the
Community Medical Clinic.
803.713.0769



NAME _____

ORGANIZATION _____

ADDRESS _____

CITY _____ **STATE** _____ **ZIP** _____

PHONE _____ **EMAIL** _____

PAYMENT ENCLOSED ☐ **$20** ☐ **$30** (after 10•10•2016)

I will attend the: ☐ Groundbreaking Party ☐ Construction Event

Complete and return this form with your payment to:
Community Medical Clinic of Kershaw County
110C East DeKalb Street • Camden, South Carolina 29020

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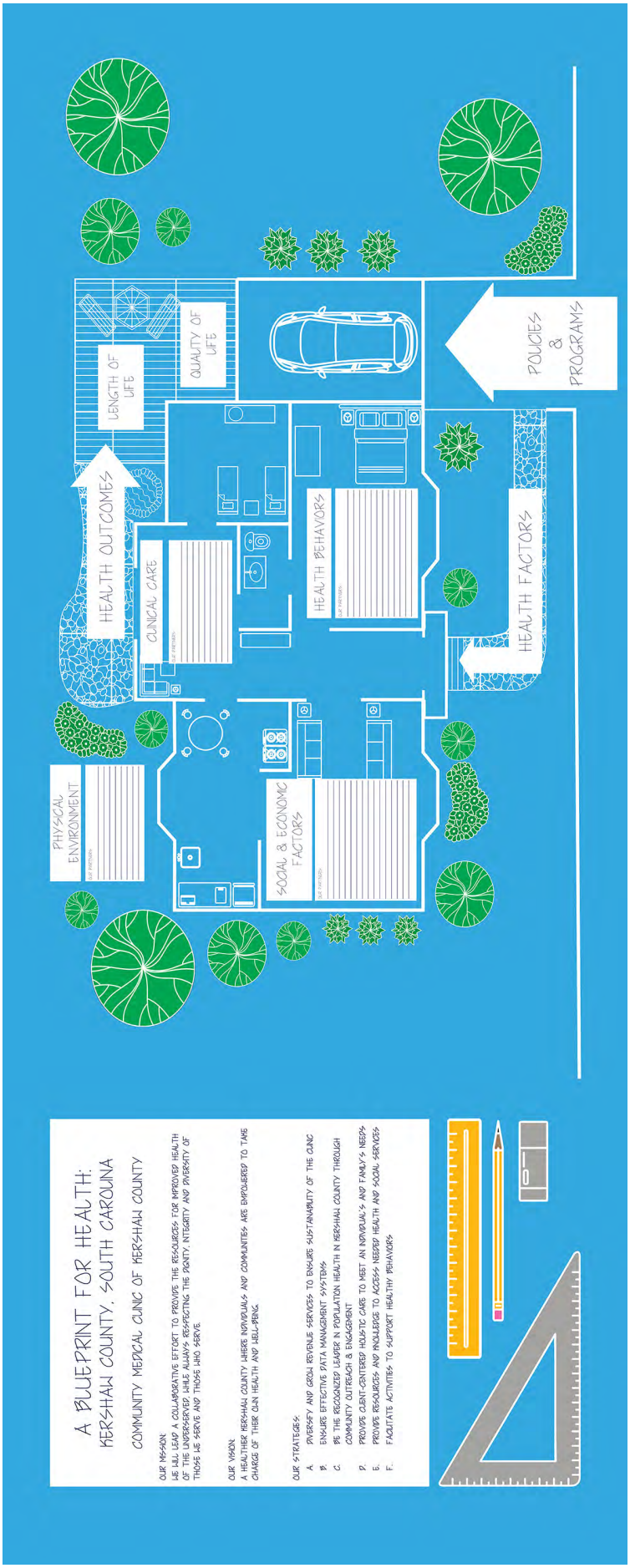
Hosted by Community Medical Clinic of Kershaw County

We will lead a collaborative effort to provide the resources for improved health of the underserved, while always respecting the dignity, integrity and diversity of those we serve and those who serve.

Sponsored by LiveWell Kershaw

back cover

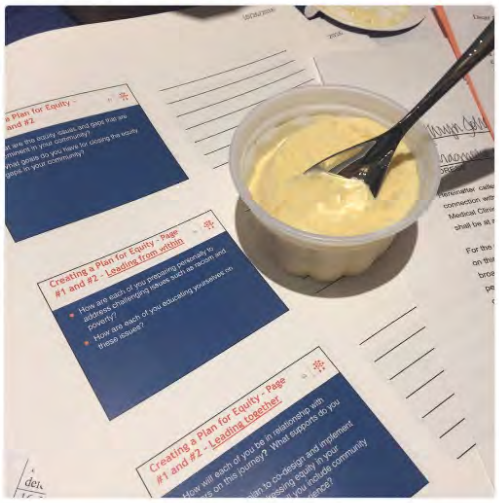
Flip or Flop floorplan graphic.



Flip or Flop event Twitter feed

Flip or Flop event Twitter feed

Kathryn @the_kats_meoww · Oct 28
Afternoon pick me up is 🔥🔥 #fliporflopkershaw



HollyHayes and 1 other liked

Mary Anne Byrd @MaryAnne_Byrd · Oct 28
FAIL = First Attempt In Learning. #fliporflopkershaw

Mayor Tony Scully and 7 others follow

Melissa @melemliz · Oct 28
Groups who believe they can change are able to change it's journey!#fliporflopkershaw

Community Med Clinic @cmcofkc · Oct 28
We are cha cha sliding into the afternoon portion of today's event #fliporflopkershaw

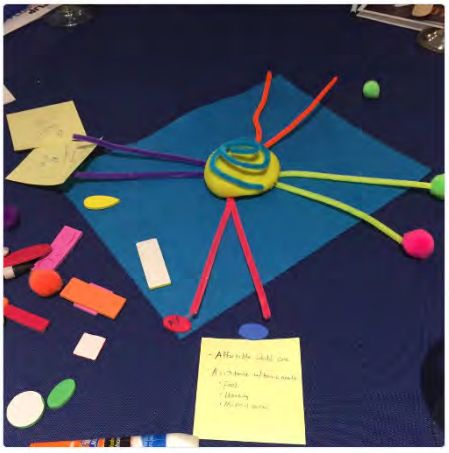
Community Med Clinic @cmcofkc · Oct 28
We spend 322 billion dollars on prediabetes and diabetes in USA...by 2020, we will spend around 520 billion dollars #fliporflopkershaw

Community Med Clinic @cmcofkc · Oct 28
IHI Triple Aim:
1. Population Health
2. Experience of Care
3. Per Capita Cost
#fliporflopkershaw

Melissa @melemliz · Oct 28
The best event I have attended in quite some time-LET'S FLIP KERSHAW COUNTY! #fliporflopkershaw

Community Med Clinic @cmcofkc · Oct 28
"Most of what people need for their health, we cannot provide in just clinics." #fliporflopkershaw

Community Med Clinic @cmcofkc · Oct 28
Creating the ideal health system is hard work! This is an example of some group work happening right now. #fliporflopkershaw



Kathryn Retweeted

100M Healthier Lives @100MLives · Oct 28
Woo! Check out some of our #changeagents in Kewshaw County. Follow #fliporflopKershaw today to see their journey

Soma Stout @somastout
Change agents of @100MLives P2P community, Kershaw County using creativity, data, stories and community to ignite a #COH! #FliporFlopKershaw

Mary Anne Byrd @MaryAnne_Byrd · Oct 28
The single biggest factor affecting a person's health is whether or not he has graduated from high school. -Soma Stout #fliporflopkershaw

Ginger Catoe and 5 others follow

Betsy Long @BeLong8899 · Oct 28
23.4% of Kershaw County residents uninsured. Wow... that's a problem! #fliporflopkershaw

Community Med Clinic @cmcofkc · Oct 28
Having too much fun at #fliporflopkershaw with @somastout

Care Coordination

The LiveWell Kershaw initiative, supported by the Community Medical Clinic of Kershaw County, has been working to support the lives of residents living in the northeastern part of Kershaw County, also known as "North Central." The data below shows outputs from Year 3 Quarter 2 (September 1, 2016-November 31, 2016). This data reflects individuals who received clinical and/or care coordination services and live in the following zip codes: Cassatt (29032), Heath Springs (29058), Jefferson (29718), Kershaw (29067), Liberty Hill (29074), Westville (29175) and Bethune (29009). This data does not reflect the students seen at the School Based Health Center; this is reported separately.

There has been a 6% increase in the number of visits from the North Central area this quarter compared to last quarter with 27% of the residents receiving care at one of the church satellites. This data reflects anyone on the care coordination team that has been provided care in the three-month period. The Care Coordination team consists of a Nurse Practitioner, Community Care Coordinators, the Community Navigator and Community Health Workers. For the care provided by the Nurse Practitioner, 74% of these visits were categorized as a level 3 or 4 CPT code, which demonstrates a complex clinical visit.

The church satellites are now open three times a week and are staffed by a Community Health Worker, and a Nurse Practitioner. One slight variation to this schedule is the DeKalb satellite location. DeKalb is open on the 1st and 3rd Tuesday in the mornings each month.

Community Health Workers (CHWs) are considered an "extender" for the Nurse Practitioner, the patient, and the community. In order to fulfill this role, CHWs fill their day with care coordination, phone calls, transitional care follow ups, and community outreach events. Last quarter, the team came together to decide how heavily weighted each activity should be. As a result, each day for a CHW should consist of 40% care coordination, 30% phone calls, 20% transitional care follow ups, and 10% community outreach events. When asked how their time was split over this quarter, CHW 1 felt that her time was allocated as 40% care coordination, 35% phone calls, 15% transitional care follow ups, and 10% community outreach events. CHW 2 believes that her time was weighted as 50% care coordination, 20% phone calls, 10% transitional care follow ups, and 20% community outreach events. CHWs note that phone calls have become more of a priority over this quarter and that is reflected in their time allocation. Moving forward, we will continue to track how time is allocated in order to continuously monitor and adjust what activities are being prioritized most.

Care Coordination team with Dr. Mark Redding, creator of the Hub and Pathway model.

Case Study

In September, Beckie Tompkins, a Community Health Worker at the time, made a call to an individual from the ER call list to let her know that the LiveWell team could help her with medical care and social determinant issues. That individual was Jenny.

Jenny's story begins three years prior when her husband passed away and she was left without a source of income. Since moving to the North Central area, Jenny had been living off of a small amount of life insurance from her husband's passing but that money was quickly dwindling and she wasn't sure what next steps to take. When Beckie called her, Jenny indicated that she was a patient of CMC and also suffered from some mental health issues. However, Beckie was able to inform her

	Year 3 Quarter 1	Year 3 Quarter 2
Number of patients/clients receiving assistance	252	142
Total number of visits/encounters	469	396
Number of residents connected to a medical home	74	35
Calls made to residents discharged from ER	228	111
Completed and approved Prescription Assistance Program (PAP)	12	3
WellVista applications	33	19
Completed and approved SNAP applications	16	6 (4 approved)
Completed Medicaid applications and recertifications	10	12 (2 approved)
Referrals made to specialists and outcomes	68	2 (1 approved)
Church Satellite Visits (open 2-3 times weekly)	36	47

of the clinic satellites that exist in the community. Jenny was then able to schedule her appointments at Refuge instead of having to drive to Camden to be seen for medical care. This would reduce the amount of travel cost incurred by Jenny so that she could utilize her remaining funds for other necessities.

Through the help of Beckie and Jodi Rogers, another Community Health Worker, Jenny was able to complete applications for both SNAP and Medicaid, as well as charity care for her most recent ER visit that she does not have the funds to cover. That application is pending the Medicaid denial letter. In addition, Jenny has applied for Social Security Disability as a possible source of income. That application is currently pending. While Jenny is now receiving almost $200 a month in SNAP benefits, she is also receiving additional food from the food truck that visits DeKalb once a month.

Even though Jenny's story is just beginning to take shape, both Jodi and Beckie have already witnessed a transformation in her demeanor and her interactions with others. Jenny has developed from her initially withdrawn, depressed nature into a more outgoing and joyful spirit. Over the holidays Jenny delivered baked goods to the Refuge satellite as thanks to the LiveWell team. On another occasion, Beckie ran into Jenny at the grocery store shopping with a friend and she proceeded to give Beckie a hug.

Beckie Tompkins (right) with Holly Hayes (left) and Dr. Mark Redding, creator of the Hub and Pathway model.

While there is still more to come from Jenny's relationship with the LiveWell team, she is already improving emotionally and mentally as she develops relationships in her new community. Beckie and Jodi look forward to continuing to working with her.

Metrics and Outcomes for Year One

Several goals were set for the first year of offering mental health services at the Community Medical Clinic. In order to reach these goals, the LiveWell team brainstormed metrics appropriate to reach the desired goals. The goals, metrics used, and outcomes as a result for this year are listed in the following table.

Outcome Desired	Metric	Results
All Staff/volunteers will demonstrate an understanding of integrative care within three months of training.	Focus groups and continuous quality improvement PDSA model.	90% of the staff and volunteers report an understanding of the integrative care model following the training conducted on June 28, 2016. Staff reported understanding the process to make an appropriate referral to the mental health counselor. Key informant interviews indicate that staff are now asking different questions and being much more mindful of the mind and body connection. Data indicates that 98% of all clients seen in Camden are a result of in-house referrals. Only a few of the clients self-identified as needing mental health services from a letter mailed to all clinic patients. One staff member reported that: "It is great to have counseling available in the same place as primary care to coordinate service better." Some of the newly hired staff members and volunteers reported a lower awareness of the role of the mental health counselor. As a result, an online training for all new employees and volunteers will be made available and the Mental Health Counselor will offer refresher trainings as needed throughout the year.
85% of patients will be engaged in co-designing their care.	Focus groups, surveys, and CQI PDSA model.	100% of patients were engaged in co-designing their care. All 50 clients seen by the Mental Health counselor at the Camden site completed an intake form and identified the areas of their greatest concern. Based on this, the counselor and the client co-designed sessions and even changed the focus of specific sessions based on present circumstances. 18 clients completed an anonymous survey after completing at least three sessions with the mental health counselor. From the survey, 100% of patients either strongly agree or agree that they had a role in determining their treatment goals.
65% of patients participating in at least two health coaching sessions will report improved well being.	Focus groups and surveys and patient current and desired state assessment CQI PDSA model.	Of the 50 clients that the mental health counselor has seen in year one, over 60% of the clients have seen the mental health counselor at least two times. During each individual counseling session, a client conducts a pre and post assessment measuring their level of depression or anxiety on a well-being scale. The mental health counselor reports that the majority of clients show a decrease in their symptoms following the individual counseling. The mental health counselor tailors future sessions based on this well-being assessment to achieve optimal client outcomes. In year one, the mental health counselor conducted 246 sessions during her three days a week at the Camden site. There was an average of four visits per client. The show-rate was 88% with a no-show rate of 12%. The most common diagnoses at the Camden site are depression, anxiety and trauma-related diagnoses. 18 clients completed an anonymous survey after completing at least three sessions with the mental health counselor. Through the survey, 77% of patients reported that they were coping better with their problems; 56% felt that their symptoms were not bothering them as much and 45% felt that they were able to do the things that they want to. These three questions measure the well-being of patients. The mental health counselor is not able to prescribe anti-depressants and anti-anxiety medications; some of the patients are using medications and others have selected to use mindfulness training without medication as their preferred treatment.

Outcome Desired	Metric	Results
25% increase in staff satisfaction within six months of implementation	Baseline survey and focus groups CQI PDSA model	At the end of year one, a survey was sent to all staff members to give input on the integration of the mental health counselor and what could be improved over the next year. Survey results found that of the 16 participants that took the survey, 94% consider Christie Derrick to be an integral part of the care team and are satisfied with the mental health services that patients are receiving. All participants indicated that they understand the importance of mental health integration. Staff members indicate that they are pleased patients have the opportunity to access mental health services and believe that the mental health integration is going well. One staff member "appreciates the support that Christie has been giving to the clinic, especially the younger population as well as the Hispanic patients. It's rewarding to see the smiles on the patients' faces when they leave the clinic after seeing Christie." Survey participants believe that the clinic needs Christie for more hours throughout the week and that more outreach regarding the mental health services that are available should be prioritized. Overall, staff members feel fortunate that a mental health counselor is available to the patients because as one participant stated, "good mental health makes for better physical health." The results from the survey indicate that mental health integration is going well and staff satisfaction has increased. Key informant interviews with staff show that having an extra person on the team has increased staff morale and also job satisfaction. Dealing with complex patients facing physical, mental and social and economic issues can create great fatigue on the care coordination team. Using an integrated approach with the care coordination team has been critical.

Mental Health Service Satisfaction Survey Summary

Patients that are receiving mental health services at the Community Medical Clinic in Camden, SC, through Christie Derrick, are being asked to complete a "Mental Health Satisfaction Survey" to gather information regarding the care that they are receiving. After multiple visits and completion of mental health treatment, patients are asked to complete the survey. Questions on the survey ask patients to rank their level of agreement with certain aspects of the care they have received, as well as what interventions they found to be most helpful. In addition, the final question on the survey allows respondents to the survey to leave qualitative feedback on how services can be improved.

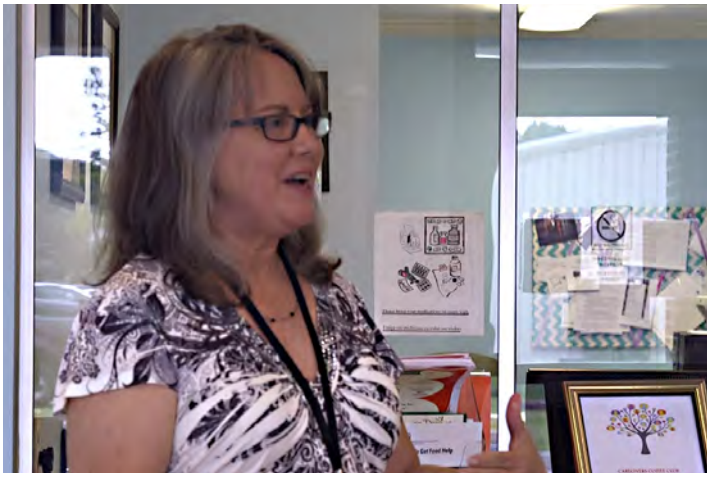
Our goals for mental health included having 85% of patients reporting that they engaged in the co-design of their Plan of Care. From the survey, 100% of patients either strongly agree or agree that they had a role in determining their treatment goals. Another goal was to have 65% of patients report improved well-being as a result of treatment. Through the survey, 77% of patients reported that they were coping better with their problems while 56% felt that their symptoms were not bothering them as much and 45% felt that they were able to do the things that they want to. These three questions measure the well-being of patients. While mental health services are meeting several of the goals set, there are still some areas that could be improved upon.

Mental Health Provider Satisfaction Survey Summary

A survey was sent to all staff members to give input on the integration of the mental health counselor and what could be improved over the next year. Survey results found that of the 16 participants that took the survey, 94% consider Christie Derrick to be an integral part of the care team and are satisfied with the mental health services that patients are receiving. All participants indicated that they understand the importance of mental health integration. Staff members indicate that they are pleased patients have the opportunity to access mental health services and believe that the mental health integration is going well. One staff member "appreciates the support that Christie has been giving to the clinic, especially the younger population as well as the Hispanic patients. Its rewarding to see the smiles on the patients' faces when they leave the clinic after seeing Christie." Survey participants believe that the clinic needs Christie for more hours throughout the week and that more outreach regarding the mental health services that are available should be made a priority. Overall, staff members feel fortunate that a mental health counselor is available to the patients because as one participant stated, "good mental health makes for better physical health." The results from the survey indicate that mental health integration is going well.

Transitional Care

From September 1st, 2016 to November 31st, the transitional care team had 17 active cases. The purpose of the transitional care team is to work with patients of the Community Medical Clinic who are admitted to the hospital and provide coordinated care for them to reduce the likelihood that the patient is readmitted to the hospital. One case is now inactive due to acquiring health insurance and being able to access a private doctor. The patients within this caseload had the following diagnoses: chest pain, epiglottitis, gastro esophageal reflux disease, ventral hernia with small bowel obstruction, heart catheterization, cellulitis of abdominal and chest wall, post-operative anemia, right femoral deep vein thrombosis, non st-segment elevation myocardial infarction, hypoglycemia, septic arthritis, uncontrolled diabetes mellitus, joint effusion, abscess of foot, small bowel obstruction, and appendicitis.



Christie Derrick, mental health counselor for the Community Medical Clinic.

For each of these patients, the transitional care team provided education related to their diagnosis and post-discharge instructions and made sure that the patients had the necessary medical supplies and equipment needed to promote healing and wellness. Some of the materials that Community Care Coordinators (CCCs) have provided patients include: blood glucose testing strips and monitors, blood pressure monitors, and even pillboxes to better manage medications. In addition, the CCCs have at least weekly contact with the patient in order to monitor progress and determine if any additional medications are needed. For this quarter, 48 medical appointments were scheduled and 23 were attended by CHWs. Four of these appointments were not attended by a CHW since the social determinants had already been addressed prior to the provider visit. There was one no-show for an appointment this quarter for which the CHW was still present. In regards to patients readmitted during the 90-day transitional care cycle, two patients were readmitted for the same diagnosis and one patient was readmitted twice, the first time for a different diagnosis and the second time for a related diagnosis. One patient was readmitted for a different diagnosis. The hospital is now providing data on hospital readmission at 90 days for all uninsured patients at KershawHealth, which will help in tracking the outcomes of this improvement initiative. The Transitional Care team has maintained close communication with the hospital administration and the care managers and hospitalists to maintain continuity of care for the patients.

The Transitional Care team meets to discuss their current process.

Success Stories

Tim

Tim has been under the care of the transitional care team since July of 2016, when he underwent knee surgery at Kershaw Health. Tim is currently staying in an older, run-down home that his sister is letting him use. His daughter and two grandchildren live upstairs in this same home and none of the family has access to transportation. Therefore, Tim depends on others to drive him to his doctor appointments. In addition, Tim does not have a telephone but his daughter has agreed to let Debbie Davis, transitional care team member and Community Care Coordinator text her phone weekly to check on Tim's progress. Because KershawHealth's home health only visited three times a week for the first two weeks after Tim's surgery, Tim's daughter has had the responsibility of changing his dressings twice daily and then once daily as time went on. Debbie has visited their home multiple times to provide test strips for his glucometer, as well as gauze and saline for Tim's dressing changes. These materials that Debbie is able to provide have been donated by the Community Medical Clinic (CMC). "Surgical site infection is always a big risk in a home setting, as well as in a hospital, but the daughter is doing a great job with the dressing changes "says Debbie. Debbie then goes on to say that, "…by helping his wounds heal, we decrease the number of specialty surgeon visits, a possible readmission into the hospital, and allows the patient to feel better and able to focus more on controlling his chronic conditions."

Tim is also receiving Ensure, a protein drink, from CMC that he is taking on a daily basis along with a multivitamin. Because of this, Tim has been able to put on some much needed weight and is gaining his color back as a result of the care that he has received since being out of the hospital. Tim has now been out of the hospital for five months.

Jimmy

Jimmy, who suffers from heart disease and diabetes, entered transitional care once he was discharged from KershawHealth in July of 2016. Once working with the transitional care team, Debbie Davis was able to work with Jimmy on getting the medications that he needed. With the help of the Community Care Coordinator, Jimmy was able to apply for a medication program to help cover the cost of the medicines prescribed while at the hospital.

While working with him, Debbie quickly realized that monitoring his elevated blood pressure levels would be a challenge. Debbie educated Jimmy about the effect his diet has on his blood pressure and diabetes. In addition, Jimmy's heart specialist had recommended that he keep a log to record his blood pressure throughout the day. In another instance, Debbie was able to determine the reason behind Jimmy's continued high blood pressure even while being on medication.

After much investigation and information provided by Home Health, Debbie discovered that Jimmy had not told his cardiologist that he had Welvista and once his prescriptions were sent to Walmart, he was not able to afford them. Therefore, Jimmy was going without his blood pressure medication resulting in unchecked elevated blood pressure levels. With help from Mary Lee Addis, the Nurse Practitioner at CMC, Debbie was able to get free medication for Jimmy until his Welvista medications came

Community Care Coordinators with a Case Management client.

in. Debbie fully expects Jimmy's blood pressure to drop to normal levels once he begins taking his medications as prescribed.

At another time, Jimmy's blood pressure monitor broke and he promised to purchase a new one. However, Jimmy did not want to mention that he could not afford one and as a result, his blood pressure went unchecked for some time. Once Debbie realized what was happening, she was able to work with a United Way partner, KARE, to obtain a blood pressure monitor for him. Debbie explained to Jimmy the importance of monitoring his blood pressure as it will help make sure that his medications are working, keep him out of the hospital, prevent him from having a stroke, and keep him around for his wife.

Mary Lee Addis, Nurse Practitioner at the Community Medical Clinic, also recalls working with Jimmy to get his blood pressure and blood sugar levels under control. Once Home Health was able to go into Jimmy's home, they were able to discern whether or not he was taking his blood pressure medication and monitoring his blood sugars. While Jimmy works and tries to maintain an independent lifestyle, Mary Lee noted that it was important to have Home Health available to help him out.

As of today, Jimmy's blood pressure has stabilized to a normal level and his blood sugars are improving but are still a work in progress. Mary Lee is optimistic that with continued guidance from transitional care team and with help from the endocrinologist Jimmy has been referred to, that his conditions will continue to progress to more stabilized levels.

Debbie Davis,
Community Care Coordinator

Jimmy's story is one that showcases the importance of having a team consisting of a Community Care Coordinator and a Nurse Practitioner. Debbie and Mary Lee were able to have frequent contact with Jimmy in order to understand the root causes of the health issues Jimmy was experiencing. Both Debbie and Mary Lee worked to find the real reasons behind why Jimmy was having difficulty controlling his blood pressure. Once they discovered what was really going on, they found a solution to fix the issue and get Jimmy on the right track.

COMMUNITY MEDICAL CLINIC
Outreach. Access. Medical Home.

Dear _____ :

We have been trying to contact you by phone and have been unable to reach you. Do you need help finding a doctor or paying for your medicine? Are you or a family member diabetic or dealing with high blood pressure? We may be able to help you.

When you qualify to become a patient of the Community Medical Clinic of Kershaw County, you do not pay anything for office visits at our locations. We can connect you with a doctor and help you apply for programs such as Medicaid, Welvista and SNAP (Food Stamps).

If you are interested in our services or would like information, please give us a call at 803-408-0500 or stop by one of our locations listed below.

LiveWell Satellite Healthcare Sites	
Day/Time	**Location**
Monday 2 pm - 5 pm	Cassatt Baptist Church 2604 HWY 1 North Cassatt 29032
Tuesday 9 am – 1 pm*	DeKalb Baptist Church 2034 DeKalb School Rd. Camden 29020 **open first and third Tuesday of each month*
Wednesday 2 pm - 5 pm	Refuge Baptist Church 2814 Lockhart Rd Kershaw 29067
Thursday 2 pm - 5 pm	Buffalo Baptist Church 6390 Lockhart Rd Kershaw 29067
Access	
Mon - Fri 8:30 am - 5:00 pm	West Wateree Medical Complex, Suite 300 1165 Highway 1 South Lugoff 29078

Please bring the documents below (if available) to your first appointment:

- Identification (i.e. driver's license)
- Social Security card
- A statement of any income, including pay stubs or Social Security letter
- Utility bill for proof of residence
- Medicaid denial letter (this can be obtained from the DSS office)
- SNAP (Food Stamp) letter, if you receive SNAP benefits

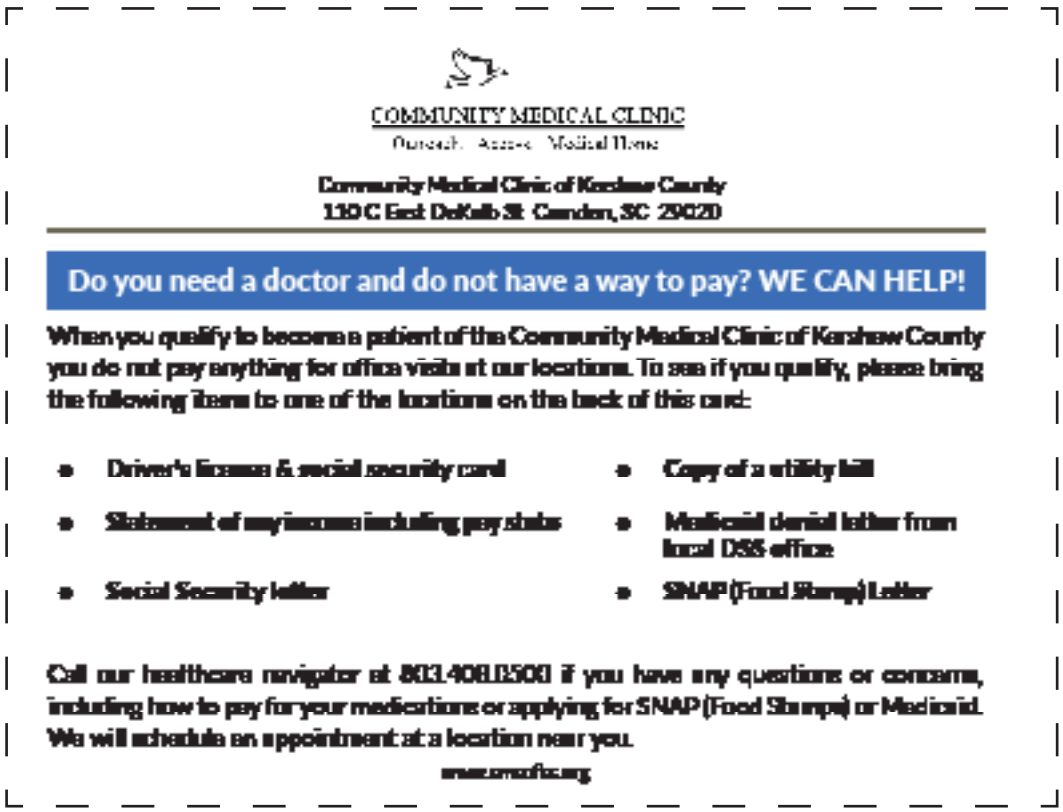
We look forward to seeing you. Thank you!

Sincerely,

_____

110 C East DeKalb Street Camden, SC 29020

Clinic Promo Card front.



COMMUNITY MEDICAL CLINIC

Outreach · Access · Medical Home

Community Medical Clinic of Kershaw County
110 C East DeKalb St Camden, SC 29020

Do you need a doctor and do not have a way to pay? WE CAN HELP!

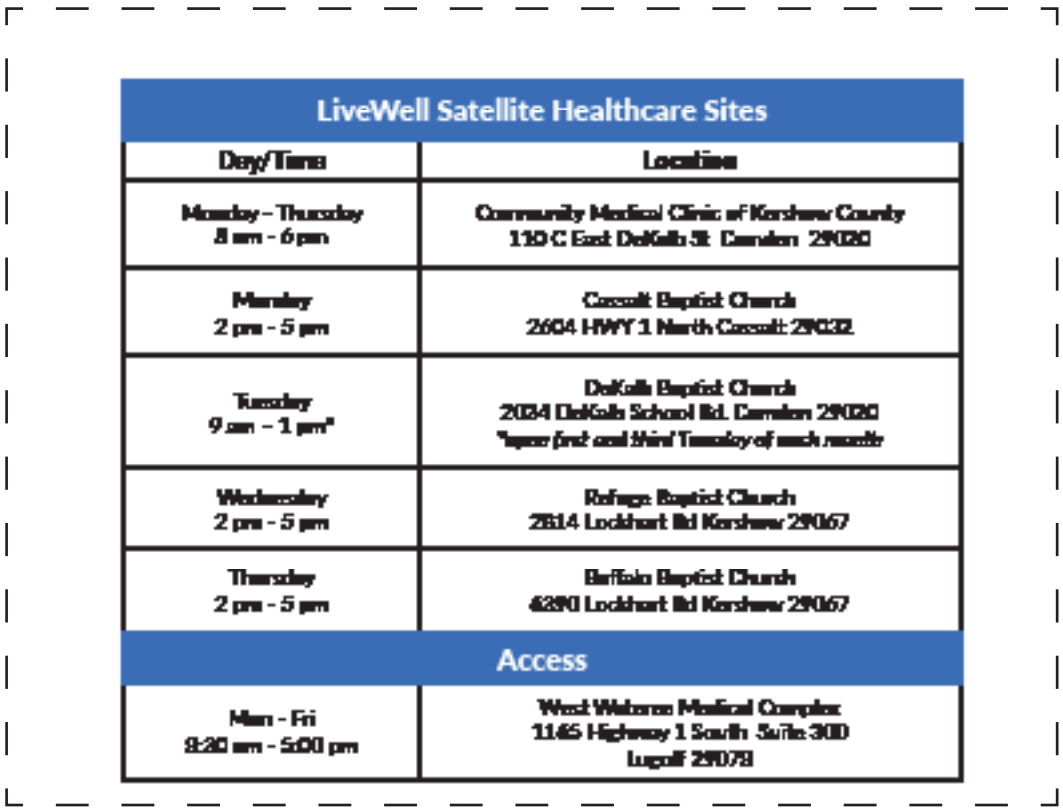
When you qualify to become a patient of the Community Medical Clinic of Kershaw County you do not pay anything for office visits at our locations. To see if you qualify, please bring the following items to one of the locations on the back of this card:

- Driver's license & social security card
- Statement of any income including pay stubs
- Social Security letter
- Copy of a utility bill
- Medicaid denial letter from local DSS office
- SNAP (Food Stamps) Letter

Call our healthcare navigator at 8033408103500 if you have any questions or concerns, including how to pay for your medications or applying for SNAP (Food Stamps) or Medicaid. We will schedule an appointment at a location near you.

www.cmcfc.org

Clinic Promo Card back.



LiveWell Satellite Healthcare Sites

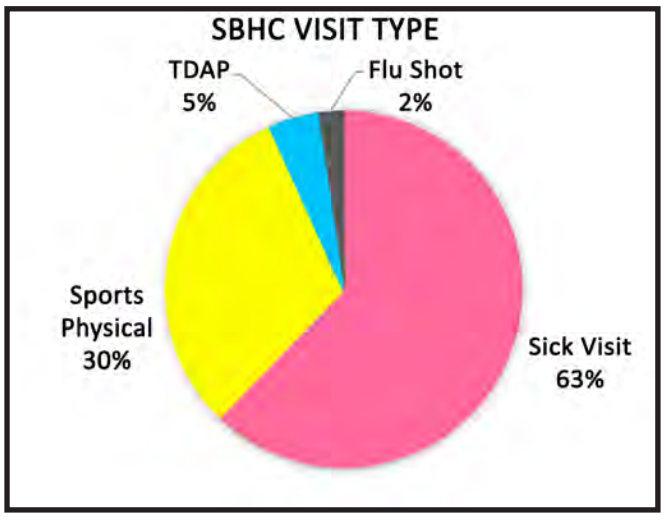
Day/Time	Location
Monday – Thursday 8 am - 6 pm	Community Medical Clinic of Kershaw County 110 C East DeKalb St Camden 29020
Monday 2 pm - 5 pm	Cocoalt Baptist Church 2604 HWY 1 North Cocoalt 29032
Tuesday 9 am – 1 pm*	DeKalb Baptist Church 2034 DeKalb School Rd. Camden 29020 *1pm first and third Tuesday of each month*
Wednesday 2 pm - 5 pm	Refuge Baptist Church 2814 Lockhart Rd Kershaw 29067
Thursday 2 pm - 5 pm	Buffalo Baptist Church 4290 Lockhart Rd Kershaw 29067
Access	
Mon - Fri 8:30 am - 5:00 pm	West Wateree Medical Complex 1145 Highway 1 South Suite 300 Lugoff 29078

Clinic Promo magnet.

School-based Healthcare Center

Data for High and Middle School

From September 1st to November 30th, 2016, the School-Based Health Center had 131 visits with 110 students coming from both North Central High School (NCHS) and North Central Middle School (NCMS). 12 students visited the SBHC three or more times. Four students were seen by both the nurse practitioner and a mental health counselor. During this quarter, 25 high school students and 16 middle school students enrolled in the SBHC for the first time. The enrollment rate goal for the middle school is 50% and the goal for the high school is 80%. As it currently stands, 32% of the middle school and 59% of the high school are currently enrolled in the SBHC. Throughout the next quarter, the LiveWell Kershaw team will focus on improving enrollment rates in order to meet their goals. A breakdown of SBHC visit type can be seen in the figure below.



Satisfaction Survey Results

North Central High School

As it currently stands, there are 283 out of 483 students at North Central High School enrolled in the School Based Health Center (SBHC). For this quarter, 80 students seen completed the satisfaction survey.

When asked to rate their visit with the Nurse Practitioner, 96.25% of students indicated that their visit was great and 3.75% said that their visit was okay. When asked if they would recommend the SBHC to another student or sick friend, 96.25% of respondents indicated that they would while 3.75% said that they didn't know if they would recommend the SBHC.

North Central Middle School

There are currently 120 out of 376 students at North Central Middle School (NCMS) enrolled in the SBHC. For this quarter, 21 students that visited the Nurse Practitioner at the SBHC completed the satisfaction survey.

When asked to rate their visit with the Nurse Practitioner, 100% of students indicated that their visit was great. When asked if they would recommend the SBHC to another student or sick friend, 95.24% of respondents indicated that they would while 4.76% said that they would not recommend the SBHC.

Case Study

Ricky, a 10th grader at North Central High, has dealt with respiratory issues his entire life. So on a normal school day in September when he was experiencing trouble breathing, he thought is was going to be just another day. However, he would soon learn otherwise.

Jodi Rogers, a Community Health Worker, had noticed that her friend Teresa's son Ricky was not enrolled in the School-Based Health Center in August of this year. Concerned, Jodi called Teresa and let her know what the SBHC could offer her son if he were to experience any sickness at school. Teresa immediately enrolled her son, not realizing that he would be in desperate need of medical help.

In September, Ricky was sitting in math class and found it difficult to breathe and quickly notified the teacher. After a visit to the school nurse, Ricky was then referred on to Vicky Craig, the Nurse Practitioner in the

SBHC. Upon arrival, Vicky listened to Ricky's lungs and determined that there was limited airflow and that his oxygen saturation levels were at 72. A normal saturation reading for someone of Ricky's age should be 98. After two breathing treatments from Vicky, Ricky's saturation levels were still only in the low 80s. While airflow was somewhat improved, Ricky was still not doing well and seemed to be worsening. Vicky knew that action should be taken immediately and that he needed a steroid shot from his doctor's office. After learning that Teresa, his mother, was out of town Vicky then contacted Ricky's grandfather to come pick him up and take him to the doctor. As time passed, Vicky continued to monitor his worsening condition. "I was ready to put him in my car and take him because I knew we could not wait until the ambulance got here," said Vicky. Ultimately, the grandfather was able to take Ricky to the doctor for the steroid shot and then went on to the emergency room. Ricky's mother and family credit Vicky and the SBHC team with recognizing Ricky's respiratory distress and saving his life through quick action.

This case study involved a network of caregivers that worked together to create a positive outcome for the student. This story began with a concerned CHW (Jodi) getting the student enrolled into the SBHC, which led to the teacher referral and then the school nurse who involved the Nurse Practitioner (Vicky). In Ricky's case, a hospital visit was unavoidable because it was the treatment that he ultimately needed. Fortunately the acute care services Ricky needed were only a few steps from his classroom.

Vicky Craig, Satellite Operations Director, shares the latest school registration numbers.

North Central High School

Mental Health

In its second year, the mental health counseling component of the LiveWell Kershaw project has grown substantially in its ability to serve North Central High School. Doctoral students Cameron Massey, Chandni Patel, and Alexandrea Golden began the academic year by working to integrate themselves into the culture and climate of the school before starting to see students for individual therapy in September. Early meetings with administration helped to clarify our roles within the school community and provided us with important information about how we can best support students in the academic environment. Also, these initial meetings helped LiveWell personnel establish a strong referral mechanism by which students with mental health needs are identified by teachers, nurses, guidance, and other school personnel, but ultimately are channeled through the assistant principals (Mrs. Rose Montgomery and Mr. Chad Dixon). Referral volume fluctuates throughout the year, with the beginning and ending of each semester seeing more referrals; on average the school refers approximately 1-2 students a week.

From September through November, nineteen students have received treatment for a total of 80 sessions. These sessions are a combination of individual, parent and/or guardian sessions; as well as consultations with school and community personnel focused on improving the students overall functioning within the academic environment. Since the needs of every student vary considerably, clinicians take time to tailor treatment plans that fit the specific presenting issues. The mental health team has worked with students struggling with test anxiety, panic attacks, depression, interpersonal and relationship difficulties, conduct

Cameron Massey, Mental Health Counselor, shares a case study with bus tour participants.

problems, lack of school motivation, and a wide array of other social, emotional and behavioral issues that impair everyday functioning. Outcomes are tracked by first understanding how this impairment manifests itself and then using evidence-based treatments to help ameliorate problem behaviors. For example, if a student presents with panic attacks then a clinician may use a structured, cognitive-behavioral approach to address the environmental and psychological precipitating and perpetuating factors that trigger the student's attacks. While they are working to help the student change maladaptive thoughts and behaviors to more adaptive ones they are additionally teaching the student relaxation and coping strategies to aid in the cognitive restructuring process. Alternatively, if the student were exhibiting school refusal behaviors instead of anxiety or mood problems, treatment outcomes may be measured slightly differently. In this case, while no clinically significant mental health symptoms may be present, increasing student engagement in the academic environment through motivational interviewing and behavioral management would be the most appropriate and beneficial approach to meeting the needs of the student.

The mental health component of the school-based healthcare center always attempts to work directly with the LiveWell nursing staff, in addition to school personnel, with the goal of creating a comprehensive support team around the student in need. Early this year, a referral was made for a student who presented to the school-based healthcare center because of some mild heart-related symptoms. He is an athlete and was concerned about his ability to play football and to wrestle if he actually had a cardiac condition. Upon interviewing this student, the nursing staff identified several problematic behaviors and family concerns that were likely impacting this student's everyday functioning.

Since the mental health team is a part of the school-based healthcare program, the nursing staff was able to immediately consult with clinicians and discuss the appropriateness of a referral for individual counseling services. The LiveWell nursing staff was invaluable in this process since the student's mother does not speak English and required the translation assistance of one of the center's healthcare workers to obtain relevant family information. This student was then assigned to a clinician and the assessment phase of treatment began. While at first only some problematic substance abuse behaviors were identified as potentially being the cause of some of his heart-related symptoms, through a thorough assessment it was found that the student also struggles with significant conduct and familial relationship problems. The initial phase of treatment worked on developing trust and rapport with this student and creating a safe environment in which to express himself.

Ultimately, this student also was able to express that his identity as a minority student impacts him significantly in his daily life, and that he often feels isolated because of this. Sessions have focused on behaviorally-based techniques to improve his overall functioning within the school environment, decrease problematic substance abuse, and increase his regular access to the school-based healthcare center. Interpersonal and communication skills have also been a major focus in therapy, in an effort to help him connect more with his family and prevent conflict from occurring. Treatment is progressing well at this point, with several academic successes being reported in this last quarter and a decrease in discipline referrals.

In the coming months, the mental health team hopes to continue providing support and counseling services to its existing case load, while increasing the number of students being served. The addition of two counselors this year (increasing from one last year to three this year) means that we are able to serve a significantly greater percentage of the student body who may be in need. This increased service capacity at North Central High School has led to discussions about potentially extending the offer to students at North Central Middle School as well. Service provision at the middle school can potentially look similar to what is currently being offered at the high school, though it can also be adapted to meet the specific needs of the middle school. In both schools, clinicians will continue to work with school personnel to help them identify problematic behaviors in students and help them connect with LiveWell Kershaw. In addition to traditional individual service that the mental health team offers, clinicians have discussed with school personnel the possibility of group counseling for students who may benefit from this milieu of treatment. In the past, these groups have centered on grief and bereavement issues, but can be tailored to meet the needs of any group. In the past we have also offered mentoring services to students who need additional academic support and we hope to extend these services to middle school students in the future. These services use educational techniques to help improve study habits, test taking skills, and boost overall academic self-efficacy in an effort to increase a student's academic performance.

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School Based Health Center Enrollment Form

North Central High School 3000 Lockhart Rd Kershaw, SC 29067 803.900.5598

Student Information

Student Name: _____

Street Address: _____ City: _____ ZIP: _____

Date of Birth: _____ Student SSN: _____

Sex: Female Male Race/Ethnicity: _____

School/Grade Level (circle one): NCMS 6 7 8 NCHS 9 10 11 12

Parent/Guardian: _____ Phone: (W) _____ (H) _____

Email Address: _____

1. Please provide any medical information that we should know about your child:
   a. Allergies _____
   b. Medications _____
   c. Chronic illnesses _____
   d. Surgeries _____
   e. Other _____
2. Doctor's name/phone: _____
3. If we need to call in a prescription, which pharmacy would you like us to call?
   Pharmacy name: _____ Phone: _____

Consent for Services and Hipaa Information

Statement of Consent: I, the parent/guardian of said student, give consent for my child to receive services at the NCHS LWK-SBHC. I understand that this consent form will be good until my child leaves/ graduates school or until I provide the Center staff with written directions otherwise.

All healthcare information is confidential. By signing the consent form you are giving NCHS LWK-SBHC, school nurse and your child's regular doctor (if applicable) permission to communicate and share medical information regarding your child's medical condition on an as needed basis with the understanding that this information will continue to be treated in a confidential manner. No student will be denied access to health care services due to inability to pay. As in any health center, there may be a charge depending on the service provided. When available, insurance or Medicaid will be billed. The health center may release information regarding treatment to third party payors for billing purposes. You also give SBHC staff permission to transport your child from North Central Middle School to the SBHC at NCHS.

Confidentiality between the student, parents and the health center is assured. In accordance to state and federal law, some information requires the student's signed consent prior to disclosure to anyone, including parents/guardians. The staff will encourage every student to involve his/her parent/guardian in health care decisions.

I am the legal guardian of the above named child. I understand that if guardianship changes a new consent must be signed by the legal guardian. I also understand that by providing an alternative contact, if I cannot be reached, medical information regarding the above named child will be shared between the medical provider and the alternative contact.

Release of Information: I authorize my child's school and/or healthcare providers to discuss, disclose, and/or release the contents of my child's complete health record to **NCHS LWK-SBHC**, including records relating to mental healthcare and communicable diseases for the purpose of providing continuity of care. This medical information may be used by **NCHS LWK-SBHC** for medical treatment or consultation, billing or claims payment, or other purposes as needed to appropriately attend to my child's healthcare needs.

I understand that I have the right to revoke this authorization, in writing, at any time. This Release of Information will remain in effect until terminated by me in writing.

HIPAA Release: The Health Insurance Portability and Accountability Act, also known as HIPAA, was created in 1996 by the US Congress to protect the privacy of your health information. The act prohibits your health care providers from releasing or discussing any aspect of your health and medical information with anyone who is not directly involved in your care. The NCHS LWK-SBHC staff is committed to ensuring that your child receives appropriate care and his/her information is protected.

_____ _____

Signature of Parent / Legal Guardian Date

110 C East DeKalb St Camden, SC 29020
803.272.8325

LiveWell KERSHAW
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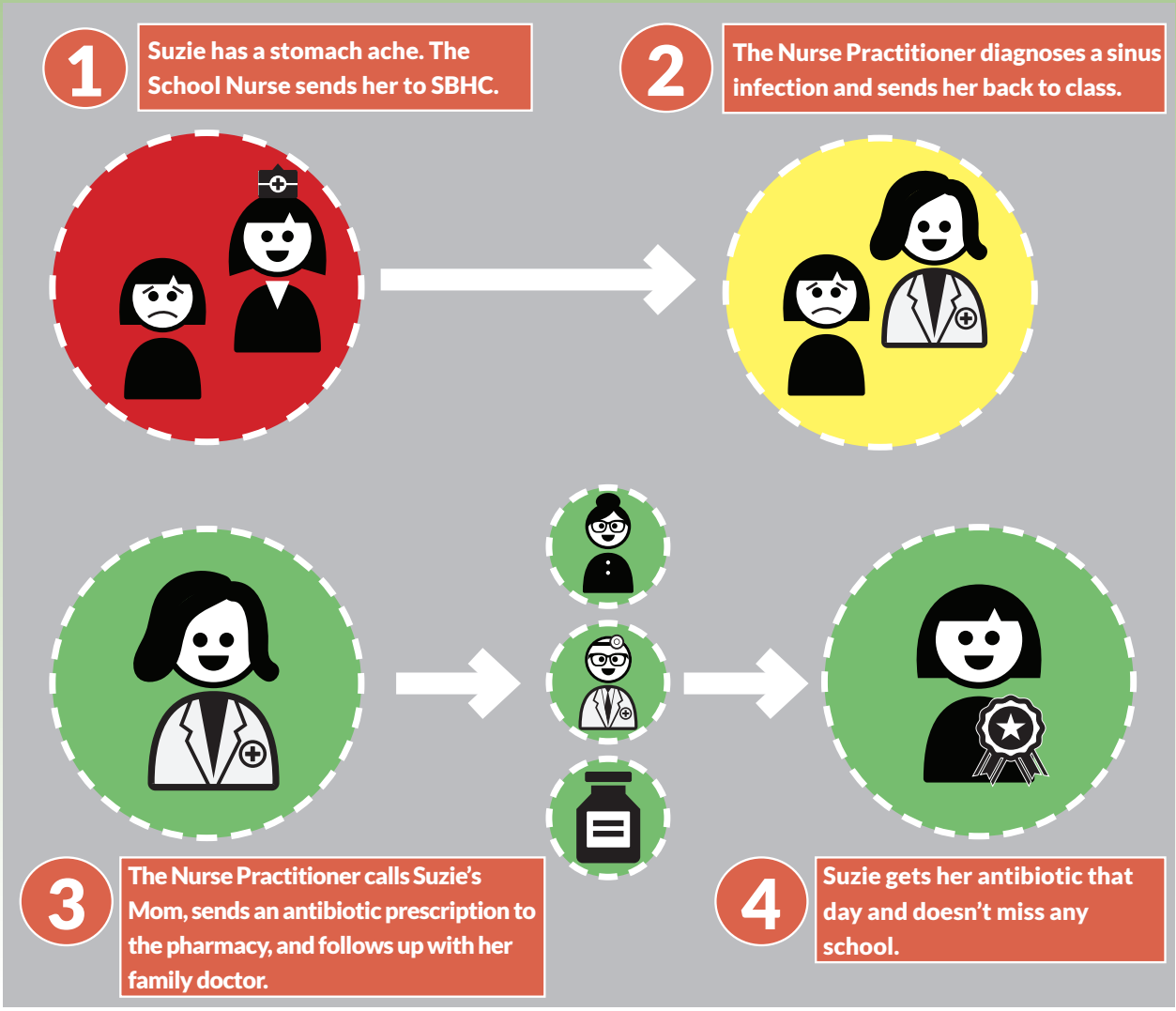
School Based Healthcare Center at North Central High School

110 C East DeKalb Street Camden, SC 29020
803.272.8325

facebook.com/LiveWellKershaw
twitter.com/lwkershaw

North Central now has its own School Based Healthcare Center (SBHC). It's like a minute clinic in the school! The school nurse can refer students to the SBHC where they will see the Nurse Practitioner, who will diagnose and treat common illnesses, care for minor wounds, and write prescriptions. The SBHC also provides sports physicals, vaccinations, and routine lab tests.

The Nurse Practitioner is available **Monday through Thursday from 8:00 am - noon.** We are located in the new gym next to the training room. Most SBHC services are available at no cost to North Central families.



To learn how your student can enroll in the SBHC contact the school nurse (Ms. Bowers) or the office (Ms. Ham).

livewellkershaw.org

Community Outreach

Community Efforts

The Community Medical Clinic team participated or presented at 18 community events this quarter. The types of events included a variety of settings and audiences in order to engage as many individuals as possible (see timeline, pg 43). The Community Medical Clinic and the LiveWell Kershaw Initiative were on the front page of the *Chronicle Independent* three times this quarter documenting the successful equity bus tour and also the Flip or Flop event.

Six volunteers were recruited and trained during this quarter from Kershaw County. However, none came from the North Central area.

Community Outreach Success

On October 25th, 2016, Beckie Tompkins and Sheri Baytes attended and presented at a Vocational Rehabilitation meeting to a group of about 28 individuals. After presenting information to the group about all the different services offered through LiveWell Kershaw and the Community Medical Clinic, Beckie and Sheri were able to hand out informational materials and answer any questions. While responding to questions from the group, they were able to make a connection with a mother and her son. The next day, they received a call from the mother, Mary. From this conversation, the team was able to determine that the family had no income or access to medical care. Soon after, Mary came into the clinic and received help from Sheri, a Community Care Coordinator and Rachael, a Community Health Worker. Through a social needs assessment, it was determined that the highest priority was restoring electricity to the home. Due to having no income, there was no way for the family to pay their electricity bills. The team worked to connect the family with local resources to restore power and were successful.

Jodi Rogers and Vicky Craig attend a NCHS football game and enroll eight students into the SBHC.

Following the assessment, the Community Care Coordinator assisted the mother and son with completing the needed paperwork to become eligible for patient status at the Community Medical Clinic. During the son's first visit to a Nurse Practitioner he was diagnosed with high blood pressure. The clinic team is working to stabilize the son's blood pressure while also connecting the family with community resources. For example, a Community Health Worker is assisting the family with obtaining food stamps.

Based on the high quality care that the family has received, Mary's husband is also planning to complete the necessary paperwork to become a patient of the Community Medical Clinic.

Beckie believes that this story is a great example of how community outreach can bring new patients into the clinic family, while also showcasing how effectively the team can work together to address both the clinical and social needs of patients and their families.

Food for Thought

This quarter, The LiveWell team began hosting Food for Thought events on a rotating basis among the satellite church locations. The purpose of these events were to bring in community members and provide them with a hot meal while showcasing the School-Based Health Center's role with students attending North Central High and Middle Schools, providing opportunities to enroll more students, and explaining LiveWell services throughout the satellites. The events were also valuable for collecting feedback from community members about what is working and not working, and to determine the best means to deliver the recruitment message to those residents not currently seeking our services. This "testing period" replaced the quarterly Community Council meetings which on average had six to eight residence in attendance.

During this quarter, Food for Thought meetings have been held at DeKalb and Cassatt Baptist Churches - two of our satellites. An average of 50 - 75 individuals have attended at each location, which is much higher than anticipated. Each of these meetings were considered successful.

At the first meeting at DeKalb, the assistant principal for North Central High School, Rose Montgomery, spoke about the positive impact that the School Based Health Center (SBHC) has had on the students and the strong relationship between the school and LiveWell Kershaw. Additionally, several of the LiveWell team members spoke briefly about the primary care and care coordination services available at the church sites.

Principal of North Central High School David Branham and Nurse Practitioner Vicky Craig.

Kathryn Johnson, Jodi Rogers and children, Rachael Sladek, Susan Didato and Vicky Craig serve dinner at Food for Thought.

For the second Food for Thought meeting, the principal of North Central High School, David Branham, spoke at Cassatt Baptist Church. After hearing Mr. Branham speak highly of LiveWell Kershaw, one individual in attendance was moved to give a $100 donation to the LiveWell Kershaw team.

Food for Thought meetings have not only been successful in increasing awareness in the community, but have also connected individuals with needed services. At least three students were enrolled in the SBHC at these meetings and one has already seen the Nurse Practitioner (Vicky Craig). In addition, members of the community were able to identify people that could benefit from LiveWell services and took flyers to distribute to their neighbors, friends, and individuals in need.

We expect continued success from the Food for Thought Meetings and will focus on increasing attendance to these events next quarter.

Timeline of Community Events

DATE	STAFF	DESCRIPTION	OUTCOME
9/7-9/9/2016	Beckie, Rachael, Jodi	SC Thrive Annual Training in Charleston, SC	Multiple sessions were offered including: It takes a village, Enhancing efforts in the Hispanic and Latino population, Grant writing, etc.
9/16/2016	Jodi and Beckie	Football game at NCHS	Tent set up with promo information. CHWs interacted with attendees providing information on CMC with a focus on the SBHC. Eight new students were enrolled
9/20/2016	Jodi and Beckie	DeKalb Food Truck at Dekalb Baptist Church	Assisted with food distribution, while also interacting with volunteers and clients that came to pick up food.
9/24/2016	Jodi and Rachael	Firefest at Rhame Arena	CHWs set up a table and spoke with approximately 100 people regarding services.
9/28/2016	Vicky, Jodi, Rachael, Beckie, Sheri, Susan, Cynthia, Holly	Food for Thought at Refuge Baptist Church	Approximately 28 people were in attendance with a meal of spaghetti and salad being served. Assistant Principal Rose Montgomery gave a presentation regarding the SBHC.
10/11/2016	Jodi, Debi and Brandi	SC Thrive Training in Columbia, SC	Staff were given initial training on using the Benefit Bank to assist with SNAP, Medicaid and Family Independence applications.
10/15/2016	Jodi	Family Farm Day in Camden, SC	Booth set up and van taken. Spent the full day interacting with attendees discussing the services available.
10/19/2016	Jodi, Rachael, Sheri, Debbie, Brandi, Susan, Vicky, Holly and Beckie	SC HOP meeting at SCHA in Columbia, SC	Met with Dr. Rick Foster and Dr. Mark Redding prior to the HOP meeting to discuss our program and implementation of his Hub and Pathway model. HOP meeting afterwards, including group activities using the Hub and Pathway model.
10/19/2016	Rachael, Jodi, Sheri, Susan D and Beckie	Food for Thought at DeKalb Baptist Church	Approximately 75 adult attendees. Dinner was served and Principal David Branham talked about the NCHS SBHC.
10/20/2016	Jodi and Beckie	Midway Fall Festival at Midway Elementary School	Booth set up with LWK information, including Food for Thought and SBHC applications. Over 400 people were in attendance. Spoke with approximately 75 individuals about services offered.
10/25/2016	Beckie and Sheri	Vocational Rehabilitation in Camden, SC	Presentation given regarding the services available through CMC programs. The group of 26 was very engaged and asked a lot of really good questions. Robbie Truesdale will plan on asking us to come back whenever they have such a group.
11/5/2016	Beckie	Belk Charity Day in Camden, SC	A table was set up at the event that showcased the services that we offer.
11/14/2016	Beckie	Hispanic/Latino Support Group at Community Medical Clinic in Camden, SC	Met with five individuals reviewing LWK/Access community offerings, including the SBHC via translator.
11/15/2016	Vicky and Cameron	NCHS Student Team leaders at NCHS	Discussed SBHC and LWK community efforts. Approximately 35 in attendance.
11/16/2016	Rachael, Jodi, Debbie, Susan D, Beckie, Cameron, Vicky, Cynthia, Carol, Brandi	Food for Thought at Cassatt Baptist Church	Beckie did a brief introduction and Vicky and Cameron spoke about the SBHC. Approximately 50 people attended the event. Info was also available about our other services.

DATE	STAFF	DESCRIPTION	OUTCOME
11/22/2016	Rachael and Jodi	Gifts for all staff in NC area	Insulated type drink tumblers were distributed to each of the six schools in the LWK area (one for each staff person) as a thank you for their support of our program. Beckie and Rachael were able to schedule two follow up events with BDK Elementary, one in December and one in March 2017.
11/23/2016	CMC Access and Outreach Team	Food Lion Food Event	Brandi and Beckie picked up approximately 150 boxes of food and distributed them between West Wateree, the Clinic, and Refuge (only site open that day). Some of the boxes will go on to Cassatt and Buffalo next week.
11/29/2016	Sheri, Geraldine and Beckie	Welvista Open House in Columbia, SC	Attended the ribbon cutting and interacted with key Welvista staff.

LiveWell KERSHAW
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Newsletter

September 2016

110 C East DeKalb St Camden, SC 29020
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An initiative led by the Community Medical Clinic of Kershaw County

NEW SITE HOURS FOR FALL

Starting in September, our Satellite Sites located throughout North Central will be operating on a new schedule. The sites will be open 2 - 5 p.m. with the exception of the DeKalb site (see schedule right). We hope that these new, later hours will allow more North Central residents to make full use of LiveWell's services.

The Nurse Practitioner will be available during all afternoon Satellite Site hours. This means that scheduling visits for primary care services, such as diagnostics and prescriptions, should be that much easier. Many services provided by the Nurse Practitioner are available at no cost.

We invite you to join us for our Food for Thought meetings this fall. This group rotates monthly among the four Satellite Sites. Dinner will be served, and guest speakers will present healthy living and healthcare topics each month. There is no charge to attend. The first meeting will be at Refuge Baptist Church (2814 Lockhart Rd.) on September 28 at 5:30 p.m. The speaker will be Rose Montgomery, Assistant Principal for North Central High School. She will discuss the new School Based Health Center at NCHS, which serves high and middle school students.

Fall Satellite Site Hours	
Monday 2 - 5pm	Cassatt Baptist Church 2601 Hwy 1 North, Cassatt
*Tuesday 9am - 1pm	DeKalb Baptist Church 2034 DeKalb School Rd, Camden
Wednesday 2 - 5pm	Refuge Baptist Church 2814 Lockhart Rd, Kershaw
Thursday 2 - 5pm	Buffalo Baptist Church 6390 Lockhart Rd, Kershaw

** Open first and third Tuesday of each month*

WELCOME NEW STAFF

This fall two new staff members join LiveWell Kershaw: Vicky Craig and Jodi Rodgers.

Vicky Craig, FNP, joined the CMC team in September as the Satellite Operations Director, overseeing clinical operations for the School Based Health Center and satellite clinics as well as treating patients. She has previously worked at the Healthcare Place in Bethune, where her husband and son live She attended USC and the University of Massachusetts-Boston.

Vicky Craig, FNP

Jodi Rodgers is our newest Community Healthcare Worker. She holds a counseling degree from Marshall University and has been an area sales manager for Belk's, connecting nonprofits in the community with the company. She has also worked with DSS in the SNAP/food stamp division. She will be working with other CMC staff to provide resources to the North Central area. Rodgers is married to NCHS coach Jamie Rodgers and has two children who attend Midway Elementary.

Jodi Rodgers

SBHC UPDATE

The School Based Healthcare Center opened its doors for the new school year on Monday, August 15. The SBHC is open to NCHS and NCMS students and thus far has enrolled over 200 new students for this year.

The SBHC is like a minute clinic in the school. Students see the Nurse Practitioner, who diagnoses and treats common illnesses, cares for minor wounds, and write prescriptions. The SBHC also provides sports physicals, vaccinations, and routine lab tests. We are located in the new gym next to the training room at NCHS. Most SBHC services are available at no cost to North Central families. **SBHC hours are 8 a.m. - noon, Monday - Thursday. Parents can enroll their students by picking up an enrollment form from either the NCHS or NCMS front office, or by downloading the form at our website:** *http://livewellkershaw.org/school-based-healthcare-sites*
Forms can also be requested by phone: 803.272.8325

Rachael Sladek, CHW (right), registers students for the SBHC at NCHS registration day.

MINDFULNESS PROVIDES A MULTITUDE OF BENEFITS

Recently I was privileged to participate in a three-day workshop, "Yoga, Meditation and Neuroscience," at the Asheville Yoga Center. The workshop reminded me that no matter how hard it can be to maintain a daily practice of meditation and mindfulness in the midst of chaos, the benefits far outweigh the inconveniences. So I encourage all to establish and protect 10 minutes in the morning and at night to return to your breath, and to the holiness that exists in each of us.

For those unfamiliar with the term, mindfulness is "moment-to-moment . It is cultivated by purposefully paying attention to things we ordinarily never give a moment's thought to [such as feelings, thoughts and bodily sensations]. It is a systematic approach to developing new kinds of control and wisdom in our lives, based on our inner capacities for relaxation, paying attention, awareness, and insight." (Kabat-Zinn, 2009)

The workshop provided 76 Benefits of Meditation, which are now supported by decades of rigorous research and meta-analyses (for many prayer and daily devotions offer similar benefits). Mindfulness can contribute to a multitude of health benefits and an overall sense of well-being. These benefits include:

Healthier Bodies
- Improves immune system and energy level
- Improves breathing and heart rate
- Reduces blood pressure
- Contributes to longevity
- Lessens heart and brain problems
- Lessens inflammatory disorders and asthma
- Lessens premenstrual and menopausal syndrome
- Helps with pain management attributed to arthritis, fibromyalgia and other chronic diseases

Emotional Well-being
- Lessens worry, anxiety and impulsivity
- Lessens stress, fear, loneliness and depression
- Enhances self-esteem and self-acceptance
- Improves resilience against pain and adversity
- Increases optimism, relaxation and awareness
- Helps prevent emotional eating and smoking
- Helps develop positive social connections
- Improves mood and emotional intelligence

Cognitive Functioning
- Increases mental strength and focus
- Increases memory retention and recall
- Improves cognitive skills and creative thinking
- Improves decision making and problem solving
- Helps with information processing
- Lessens effects of distractions
- Helps manage ADHD

Christie Derrick is a licensed marriage and family therapist with nearly 20 years experience in mindfulness practice, family systems therapy, and cognitive behavioral therapy. She specializes in treating anxiety, depression and trauma, and has presented at international, national, regional and local conferences and trainings.

Christie Derrick is available at the Community Medical Clinic of Kershaw County on Mon., Tues. & Wed. from 8 a.m. - 5 p.m. To make an appointment call: 803-713-0806.

FOOD FOR THOUGHT

This fall we invite all Kershaw county residents to join us for our Food for Thought meetings. Dinner will be served, and guest speakers will present healthy living and healthcare topics each month. There is NO CHARGE to attend.

Our first guest speaker will be Rose Montgomery, Assistant Principal for North Central High School. She will discuss the new School Based Health Center at NCHS, which serves high and middle school students.

Food for Thought meetings rotate monthly among the four Satellite Sites. The first meeting will be at Refuge Baptist Church (2814 Lockhart Rd.) on September 28 at 6:00 p.m.

LiVeWell KERSHAW

"Your Bridge to Better Health"

110 C East DeKalb St Camden, SC 29020
803.272.8325

Food for Thought flyer #2

FOOD FOR THOUGHT

We invite you to join us for our monthly Food for Thought meetings this fall. Dinner will be served, and guest speakers will present various topics.

Please come by and learn more about healthy living and the healthcare services available from LiveWell Kershaw.

Food for Thought meetings rotate between the four North Central satellites. There is NO CHARGE to attend.

Fall 2016 Food for Thought Meeting Schedule	
October 19th 6:00 pm	DeKalb Baptist Church 2034 DeKalb School Rd, Camden
November 16th 6:00 pm	Cassatt Baptist Church 2604 Hwy 1, Cassatt
December 14th 5:15 pm	Buffalo Baptist Church 6390 Lockhart Rd, Kershaw

Food for Thought events are hosted by the Community Medical Clinic of Kershaw County

LiveWell KERSHAW
"Your Bridge to Better Health"

Community Medical Clinic of Kershaw County
110 C East DeKalb St Camden, SC 29020 803.272.8325

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LiveWell KERSHAW

"Your Bridge to Better Health"

An initiative of the Community Medical Clinic of Kershaw County

Quarterly Report: Year Three Quarter Three
December 1, 2016 - February 28, 2017

Maintaining Our Momentum

Our vision:

A healthier Kershaw county where individuals and communities are empowered to take charge of their own health and well-being.

Table of Contents

INTRODUCTION

March 1, 2017

We hope you enjoy this quarterly report, which captures major activities and our progress to date. We are pleased to report that LiveWell Kershaw is continuing to make great strides in increasing access to health services to the residents of the North Central area in Kershaw County. The theme for this quarterly report is "Maintaining Our Momentum."

We recognize and understand that random acts of improvement will not create community change or enhance population health. We continue to be intentional in our approach and only go as fast as the "speed of trust" within our community. The LiveWell Kershaw team continues to move ideas into action and make improvements along the way, using the Model for Improvement as our framework.

Some examples of how we are maintaining our momentum can be found on the the following page.

Best in all you do,

Holly Hayes
Evaluator

Susan Witkowski
Chief Executive Officer

Maintaining Our Momentum

Expanding mission and vision statement	Made substantial progress on three year strategic plan (see pg. 5)
Recognizing that the Clinic, AccessKershaw were operating independently	Implemented quarterly team meetings, data sharing, and creation of care coordination teams
Getting input from a few residents quarterly at community advisory meetings	Launched monthly "Food for Thought" meetings ranging from 25 to 100 residents to share success stories and also preventative health information
Making a commitment to "flip" Kershaw County	Active subcommittees meeting monthly to address issues that emerged from the event, a service gap analysis is being conducted to answer questions from residents about the most recent data scan of area, and organizations sharing information from the event with their partners to begin moving commitments into actions
Digging deeper into how more residents of North Central can be impacted by the LiveWell Kershaw initiative	Team has expanded hours of the satellites with increased time with Nurse Practitioner and moving forward to adding a new site in Bethune and adding a transitional care pilot to reduce 30 day hospital readmissions
Implementing a School-Based Health Center at North Central High School and provide acute care and mental health services	Expanding to the Middle School with Nurse Practitioner and nurse available four days a week
Wisely using funds from the DHHS initiative	Leveraging resources by applying for funding to support LiveWell Kershaw collation with the Healthy People, Healthy Carolinas initiative, requesting a one year renewal through the SC Legislature, and launching a donor campaign to support comprehensive care coordination efforts

Events

16 Number of tours given at the Sponsors Appreciation Drop-in Feb. 2

41 Number of participants in the KershawHealth 5K Training group in preparation for the Clinic Classic McDonalds 5K on April 29.

Sponsorships

27

Number of sponsorships committed since we introduced our 2017 Sponsorship Opportunities packet

Digital Media

Our corporate sponsors are now listed in a scrolling footer at the bottom of all pages on the clinic's website, cmcofkc.org

3k Number of people we have reached through Facebook in the last month.

680 Number of people we have on our emailing list.

Sign up for our email list at cmcofkc.org.

Wellness Wednesdays

CMC has partnered with Cool 102.7 WPUB to produce a radio spot every Wednesday featuring a local expert offering tips to live a healthier life. Tune in at 12:45pm every Wednesday to hear it!

Together, we are creating a healthier Kershaw County.

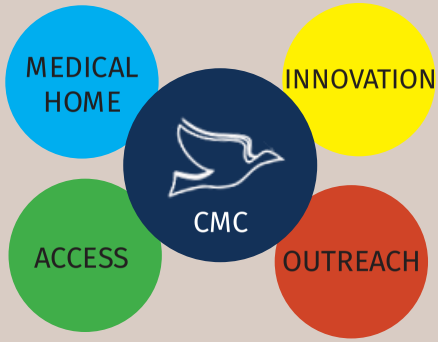
Encouraging our friends and neighbors to thrive, not just survive.

Vision

A healthier Kershaw County where individuals and communities are empowered to take charge of their own health and well-being.

Mission

We will lead a collaborative effort to provide the resources for improved health of the underserved, while always respecting the dignity, integrity and diversity of those we serve and those who serve.



Market Penetration for 6 zip codes in North Central

23% Percentage of people living in North Central who are uninsured, estimated to be 3236 people.

39.6% Percentage of the uninsured population in North Central who have received services from CMC. Since June 2014, CMC has served 1280 patients from North Central.

The greatest number of patients receiving care are from the Cassatt zip code.

LiveWell Kershaw

9899 Total number of clinical visits between June 2014 and Jan. 2017 (Patient was seen by NP or mental health counselors)

7194 Total number of non-clinical visits between June 2014 and Jan. 2017 (Patient was seen by CHW or other CMC staff to assist with social or economic factors)

Closing the gap between cost and quality

CMC has adopted a shared model for care coordination. This allows the Clinic to build a sustainable model to provide high quality services to vulnerable populations. Taking a systems-level approach and re-designing a free clinic model to serve as the backbone for population health in the county has taken an enormous amount of time and resources. However, this system change will impact the delivery of healthcare for the entire county and will be able to more efficiently track and report outcomes for medical, social, and economic determinants. CMC's Hub and Pathway database went live March 13, 2017. CMC is the first free clinic in the country to use this model.

Strategic Plan Update 2016-2018

- 80 — Objective A : Diversify and grow revenue services to ensure sustainability of the clinic
- 85 — Objective B : Ensure effective data management systems
- 90 — Objective C : Be the recognized leader in population health in Kershaw County through Community Outreach & Engagement
- 90 — Objective D : Provide client-centered holistic care to meet an individual's and family's needs
- 30 — Objective E : Provide resources and knowledge to access needed health and social services
- 10 — Objective F : Facilitate activities to support healthy behaviors

COMMUNITY MEDICAL CLINIC

Outreach. Access. Medical Home.

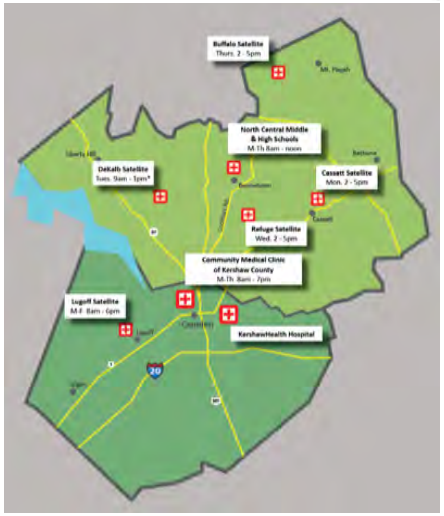
Community Medical Clinic of Kershaw County
MAIL: PO Box 217
LOCATION: 110C East DeKalb Street
Camden, SC 29020
803.713.0806
www.cmcofkc.org

LiveWell Satellite Healthcare Sites	
Day/Time	**Location**
Monday - Thursday 8 am - 6 pm	Community Medical Clinic of Kershaw County 110 C East DeKalb St Camden 29020
Monday 1:30 pm - 5:30 pm	Cassatt Baptist Church 2604 HWY 1 North Cassatt 29032
1st Tuesdays 9 am – noon* 3rd Tuesdays 1:30 - 5:30 pm **Community health worker only*	DeKalb Baptist Church 2034 DeKalb School Rd. Camden 29020
2nd & 4th Tuesdays 1:30 pm - 5:30 pm	Bethune City Hall 101 Elm St. Bethune 29009
Wednesday 1:30 pm - 5:30 pm	Refuge Baptist Church 2814 Lockhart Rd Kershaw 29067
Thursday 1:30 pm - 5:30 pm	Buffalo Baptist Church 6390 Lockhart Rd Kershaw 29067
Access	
Mon - Fri 8:30 am - 5:00 pm	West Wateree Medical Complex 1165 Highway 1 South Suite 300 Lugoff 29078

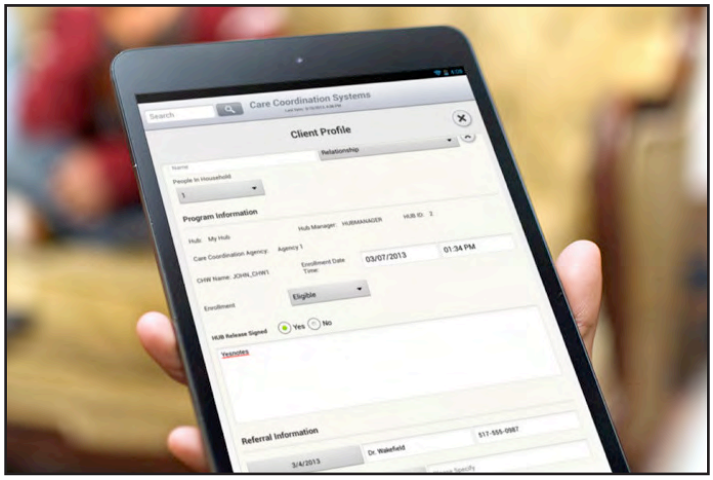
NEW

The Community Medical Clinic has a new mailing address:

PO Box 217
Camden, SC 29021



The LiveWell Kershaw team is continuing to maintain its momentum through IT advances and also active community subcommittees.



Hub and Pathway Software Implementation

During this quarter, a contract was signed with Care Coordination Systems to purchase a five-year software license agreement. this software will allow us to track the outcomes for the whole person and not just a list of symptoms. The Pathways Community HUB model that we are now using originated out of Ohio and was developed by Drs. Sarah and Mark Redding.

Traditionally, healthcare has relied on a reactionary system that delivers treatment in response to urgent needs and reimbursement based on service volume rather than value. The Pathways Community HUB Model helps reverse this trend by shifting the treatment emphasis to preventative care that contains costs rather than increasing expenditures.

The Community Medical Clinic's Hub and Pathway database will go live on March 13, 2017 after the LiveWell team goes through three and a half day training led by Pathways Community HUB trainers. This new model will allow the LiveWell team to continue to provide high-quality services to those in our community who need it the most, as well as efficiently track and report outcomes for medical, social, and economic determinants. The team looks forward to utilizing this new care coordination system to effectively identify and track the impact of our services.

Flip or Flop Follow-Up Update

In October 2016, Kershaw County hosted the inaugural "Flip or Flop, Let's Move Kershaw County to the Top," event featuring Dr. Soma Stout, from Harvard Medical School Center for Primary Care, the Lead Transformation Advisor at the Cambridge Health Alliance. Sponsored by LiveWell Kershaw, this conference connected business, government, community, education and healthcare leaders from across the county with nationally-recognized experts from the Institute for Healthcare Improvement, Harvard University's School of Public Health.

During the event, Dr. Soma Stout led a keynote address entitled, "We Need a New Model," in reference to our current healthcare system. This keynote address is available on YouTube. The Flip or Flop event is currently being aired on on TruVista, Channel 39. Since February, residents have been able to view the keynote address and reach out to LiveWell Kershaw to become involved.

North Central Subcommittee Action

During the Flip or Flop event, several subcommittees were formed to address various issues seen within the Kershaw community. One particular group, known as the North Central subcommittee, has been meeting on a monthly basis with a targeted focus on the lack of nutritional foods and transportation services in the North Central area. In order to make an impact, the group has brainstormed feasible ways to combat these issues through use of the United Way's Mobile Nutrition Center and the possibility of piloting a van transportation service to a LiveWell Kershaw satellite location. The Mobile Nutrition Center will visit one of LiveWell Kershaw's satellite sites located in the North Central area, Cassatt Baptist Church during its typical food truck day on the 3rd Monday of every month to bring fresh fruits and vegetables to residents.

Care Coordination

The LiveWell Kershaw initiative supported by the Community Medical Clinic of Kershaw County has been working to support the lives of residents living in the northeastern part of Kershaw County, also known as "North Central." **The data below shows outputs from Year 3 Quarter 3-- December 1, 2016-February 28, 2017. This data reflects individuals who received clinical and/or care coordination services and live in the following zip codes: Cassatt (29032), Heath springs (29058), Jefferson (29718), Kershaw (29067), Liberty Hill (29074), Westville (29175) and Bethune (29009).** The data below does not reflect the students seen at the School Based Health Center; this is reported separately.

The Care Coordination team consists of a Nurse Practitioner, Community Care Coordinators, the Community Navigator and Community Health Workers. Community Health Workers (CHWs) are considered an "extender" for the Nurse Practitioner, the patient, and the community. This team actively collaborates in order to provide for both the medical and social needs of each individual.

The data below shows key process metrics tracked quarterly for all locations. This data includes clients being seen at church satellites, at West Wateree in Lugoff and the Community Medical Clinic in Camden. For the past three quarters, 149 North Central residents have been connected to a medical home. The majority of these clients are now patients at the free clinic or the local Federally Qualified Health Center. Over 50% of all residents using LiveWell Kershaw Services are from the Cassatt zipcode of 29032. This includes services offered at the church sattelites as well as the Camden and Lugoff locations.

Process Metrics for Care Coordination Table

	Year 3 Quarter 1	Year 3 Quarter 2	Year 3 Quarter 3
Number of patients/clients receiving assistance	252	142	151
Total number of visits/encounters	469	396	342
Number of residents connected to a medical home	74	35	40
Calls made to residents discharged from ER	228	111	176
Completed and approved Prescription Assistance Program (PAP)	12	3	1
WellVista applications	33	19	17
Completed and approved SNAP applications	16	6 (4 approved)	12
Completed Medicaid applications and recertifications	10	12 (2 approved)	25
Referrals made to specialists and outcomes	68	2 (1 approved)	6
Church Satellite Visits (open 2-3 times weekly)	36	47	71

Year 3 Quarter 2 Church Satellite Productivity by Community Health Workers				
Satellite	**December**	**January**	**February**	**Total**
Refuge Baptist Church (open 1 time weekly)	5	11	4	**20**
Cassatt Baptist Church (open 1 time weekly)	4	10	11	**25**
Buffalo Baptist Church (open 1 time weekly)	6	6	8	**20**
DeKalb Baptist Church (open 2 times monthly)	4	2	0	**6**

Updates

This quarter, the team has worked to expand satellite operations into the Bethune area. The Healthcare Place at Bethune offers limited hours and primarily serves the Medicare population. The group decided to test a location that was not located in a Baptist church to see if a more diverse group of residents would enroll. Beginning in March, clients can be seen at the old police department beside Town Hall in Bethune from 1:30pm-5:30pm every 2nd and 4th Tuesday of the month. The Rural Health Clinic does not offer services on Tuesdays. Vicky Craig, LiveWell Kershaw's Nurse Practitioner, was instrumental in securing this location with the help of the Bethune Town Mayor, Charles McCoy. "The community is excited about having us there and everyone has been very helpful in getting the building cleaned out and ready for us to move in," says Vicky. The team is excited to begin offering LiveWell services to the Bethune area and will provide updates on this new location in the coming months.

As we maintain momentum, all of the existing church satellites continued seeing clients. Clients report increased satisfaction with being able to see a Nurse Practitioner and Community Health Worker close to where they live. LiveWell Kershaw is conducting a service gap analysis to determine where new satellites are needed as we continue to expand our care coordination efforts.

The care coordination team took time this quarter to celebrate a patient's three year anniversary of being alcohol free! Care Coordination team (L to R): Brandi Thompson, Jodi Rogers, Yolanda Roary, Becki Tompkins, Rachael Sladek, Sheri Bayes, and Debbie Davis.

Case Study

One day, Linda, a 54-year-old from Cassatt, received a call from Rachael Sladek, a Community Health Worker with LiveWell Kershaw. Unsure of why she was being contacted, Rachael explained that she knew Linda had been in the Emergency Room of KershawHealth earlier that week and wanted to know how she was doing and if she needed medical help. In addition, Rachael explained her role in helping individuals obtain medical attention and other social services if they are needed and the individual qualifies. Linda stated that she normally goes to the ER whenever she is hurting and does not have insurance or a primary care provider. Rachael informed her that she could be seen by a Nurse Practitioner at Cassatt Baptist Church on Mondays at no charge. Linda now has a medical home with the Community Medical Clinic.

The next Monday, Linda came in to see Rachael and completed all the necessary paperwork to be seen, as well as an application to obtain Medicaid and SNAP benefits. Linda explained to Rachael that she is constantly in pain and always has difficulty walking. The following Monday, Linda came back to be seen by Vicky Craig, the Nurse Practitioner. Upon examination and the results of lab work ordered by Vicky, it was determined that Linda was suffering from Rheumatoid Arthritis. According to Vicky, her Rheumatoid factor levels were off the charts. Linda knew that she was in pain, but didn't really realize that anything was seriously wrong. Vicky was able to give her validation for the pain that she was having. Linda was then sent to the hospital for a steroid shot to help with the pain and inflammation.

Since this first encounter, Linda has been approved for SNAP benefits and Medicaid Healthy Checkup. The LiveWell team was also able to find Linda a Rheumatologist that would accept Christian Community Ministries vouchers. As a result, Linda is currently receiving follow-up care from this Rheumatologist.

The LiveWell satellite team worked together to coordinate not only the social services that Linda needed but also the medical care that she so desperately required. Linda is the perfect example of an emergency room list "cold call" that resulted in an individual who previously utilized emergency services regularly that now has a primary care provider and a specialist for her arthritis.

Patient Navigator, Yolanda Roary, greets each individual into the West Wateree office location with warm welcome and a smile.

On Valentine's Day, a patient stopped by to thank the Care Coordination team (L to R: Brandi Thompson, Debbie Davis, Sheri Baytes) and Patient Navigator, Yolanda Roary, for all that they do.

Case Management Case Study—Joseph

Brandi Thompson, a Community Care Coordinator, has been working with Joseph, a gentleman suffering from type II diabetes since late September 2016, but has met with his many times throughout this quarter. Joseph was referred to LiveWell through his Primary Care Physician after receiving his type II diagnosis a few months ago. When he first met with Brandi, Joseph's A1C level measured at 16 and a glucose level that maxed out at 555. Immediately, Brandi began working with Joseph on bringing his levels to a more manageable state.

In order to do so, Brandi worked with him on reviewing his medications, discussing portion control, and making healthy choices when dining out. In addition, they went over the benefits of exercising and increasing physical activity levels.

"She helped me look at menus and came up with an eating plan for me," says Joseph. One area that Brandi focused on was helping Joseph learn how to read product labels when purchasing items from the store. In order to keep track of this Joseph kept logs and used the glucometer that Brandi provided him with. In his logs, he wrote down his blood sugar levels and what he was consuming throughout each day.

Brandi meets with Joseph every couple of weeks and calls him weekly to check in and see how he is progressing. At last measure, his A1C levels had gone from 16 to 5.2. While Joseph has not reported much weight loss yet, he says, "I feel much better and my clothes are fitting better." Brandi will continue

to work with Joseph on his self-management and ensure sustainability of his new lifestyle. We look forward to seeing the additional strides that Joseph will make in the coming months.

Integrative Medicine Spotlight

In addition, North Central residents are able to see a mental health counselor at the Camden site. Chrisite Derrick works closely with Vicky Craig, the Nurse Practitioner, who refers potential patients. The two were able to co-host a stress reduction workshop on December 12th at Cassatt Baptist Church. From this, one patient (See Phillip's case study) began counseling sessions. Unfortunately, Christie is not able to see patients at the church satellites, so transportation has been a barrier.

Community Health Worker, Jodi Rogers, poses for a quick picture with two LiveWell Kershaw volunteers and Pastor Keith Coates of the Dekalb Baptist Church satellite location.

Case Study

Philip is a 40 year old, single, Caucasian male who lives with and cares for his 78 year old mother in Cassatt, SC. They live in a modest home in rural Kershaw County. Philip's two sisters work and live with their families elsewhere in the county. Philip never finished school but was able to work odd jobs for many years. Like many men, Philip felt best when he could contribute to the household income and had a place to go each day where he felt valued as a worker.

Philip came to the Community Medical Clinic for his first appointment in July, 2016. It was his first physical in 22 years. Like many residents of SC, Philip grew up on a diet rich in saturated fat and salt. He subsequently developed high blood pressure and high cholesterol. Philip began smoking when he was 12 years old.

In October, 2016 Philip suffered a heart attack. As a result of LiveWell Kershaw, Philip does not have to drive to Camden anymore and began have his primary care visits at Cassatt Baptist Church. The Nurse Practitioner and Community Health Care Worker were able to get him enrolled in a cardiac rehabilitation program. While he was recuperating from his heart attack Philip lost his job in November, 2016. He started smoking a pack of cigarettes a day. He began feeling depressed and useless as a man and as part of his family.

In December, 2016 Philip was encouraged to attend a stress reduction workshop held at Cassatt Baptist Church. During the workshop, Philip disclosed he was having regular thoughts of suicide. The counselor then met privately with Philip and talked with him about how difficult the past year has been. She reminded him of how important he was to his mother and her being able to stay in her own home instead of going into a nursing facility.

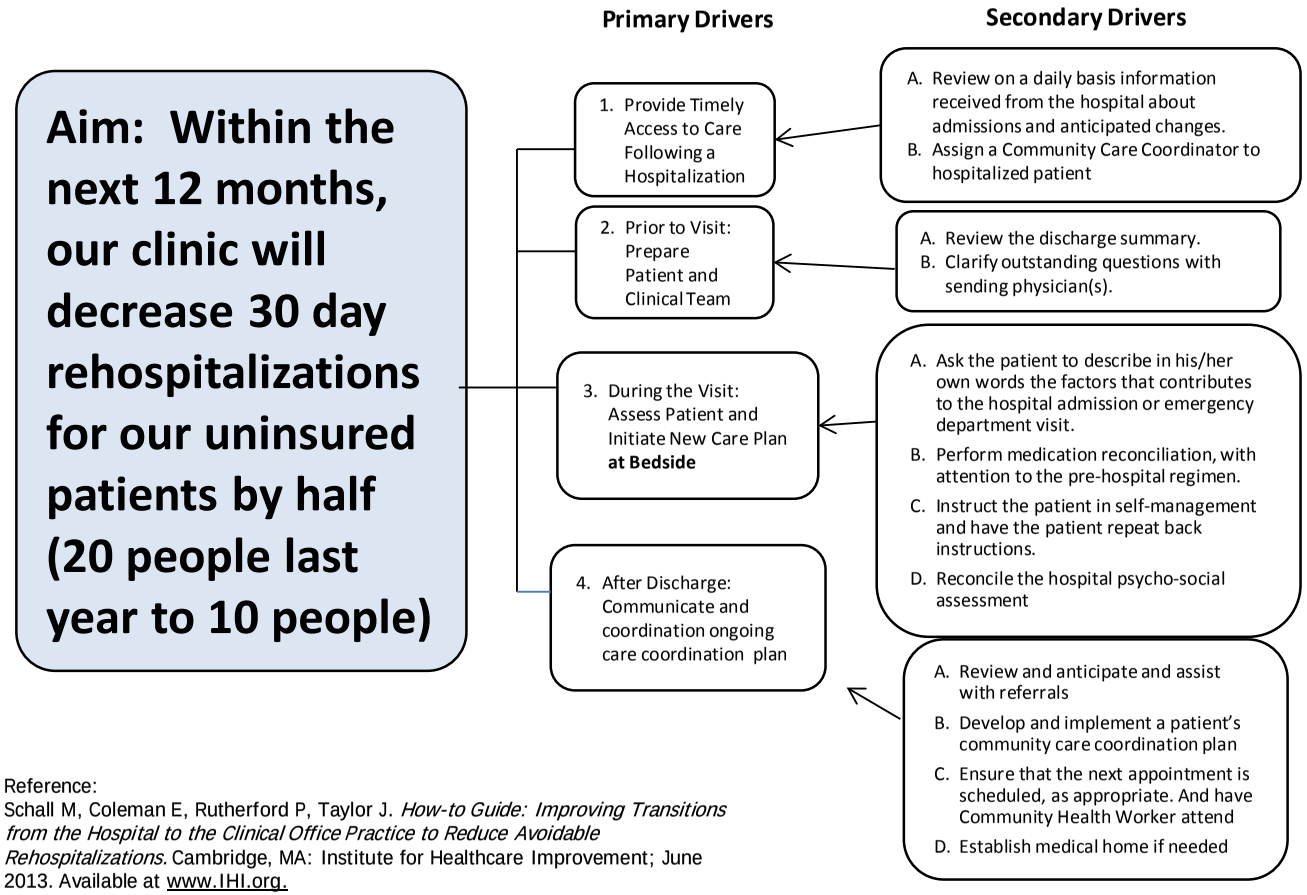
The counselor explained how depression often accompanies heart attacks and encouraged Philip to begin counseling. Philip responded that two of his doctors had told him counseling could help him get healthier. He agreed to start therapy.

That same day, the counselor and Nurse Practitioner discussed an expanded care plan that included counseling and anti-depressant medication. Philip is scheduled for his first therapy appointment next week.

Transitional Care

LiveWell Kershaw is part of the 41st cohort for the Institute for Healthcare Improvement's Quality Improvement Advisor program based in Cambridge, Massachusetts. The LiveWell Kershaw's care coordination team is focusing on how to reduce the number of uninsured patients readmitted to the hospital within 30 days. See the driver diagram on page 13 to understand our "theory of change." Detailed results to date will be shared in the final quarterly report.

Transitional Care Driver Diagram



Reference:
Schall M, Coleman E, Rutherford P, Taylor J. *How-to Guide: Improving Transitions from the Hospital to the Clinical Office Practice to Reduce Avoidable Rehospitalizations.* Cambridge, MA: Institute for Healthcare Improvement; June 2013. Available at www.IHI.org.

Case Study

Margie is a 51-year-old female that lives with her mother and her disabled adult son. Margie's journey with transitional care began when she was admitted to the hospital in August 2016 with Diverticulitis. Over the past 12 months, Margie reports going to the emergency room over ten times. She eventually came off of transitional care but was recently placed back in the program when she was admitted again in January for Epiglottitis.

Epiglottitis is a serious medical condition that can result in death if not treated quickly. This flap of tissue keeps food from going into the trachea and windpipe during swallowing. When this flap becomes infected, it can close off the windpipe, which can be fatal. This condition can occur as a result of environmental factors, trauma, or respiratory infection.

Margie is a smoker and also lives in a home with no working air conditioning; both contributors to her health condition.

Margie was referred to transitional care for the second time by the discharge nurse at KershawHealth. Since then, Debbie Davis, Community Care Coordinator, has been working with her to keep her out of the emergency room. In order to do this, Margie would need to undergo a Tracheostomy. Prior to hospital admission for the surgery, Debbie worked with her to complete a Medically Indigent Assistance Program Application to cover costs. In addition, she was able to help Margie obtain Medicaid Healthy Checkup coverage.

After Margie's surgery, Debbie did a home visit to check on her and make sure that she had enough supplies for her trach, as well as provide education about tracheostomy care. Education on care reduces the likelihood of infection and additional hospital admissions for Margie. Debbie also provided education and encouragement to Margie regarding smoking cessation.

Since the surgery, Margie had not smoked any cigarettes. Behind the scenes, Debbie knew that Margie would be low on supplies so she worked to secure additional materials. Home Health was able to bring these additional supplies on their courtesy visit.

Since then, Debbie has made several follow-up calls to Margie to see how she is doing. While Margie has since began smoking again because she believes that it helps with her coughing, she is smoking much less than her previous daily intake. Debbie educated Margie on replacing her trach and on how to sterilize them, as they can be reused.

Appropriate and consistent follow up with patients is key to transitional care success. In this case, Debbie is continuing to provide ongoing education and support to Margie to ensure that her tracheostomy is a success and that she does not return to the emergency room for issues related to the chronic epiglottis that she is having. Thus far, Margie is doing well and is scheduled for an appointment at the Medical University of South Carolina in April to further evaluate her chronic epiglottis. The LiveWell Kershaw team attributes Margie not being re-admitted to the hospital to the transitional care program. Margie has a support system and a medical home at the Community Medical Clinic.

School Based Healthcare Center

School Based Health Center Updates

This quarter, the School Based Health Center (SBHC) located at North Central High School (NCHS) has seen a variety of students for a multitude of reasons from bone fractures to the flu. The SBHC serves students at both North Central High school and middle school. Vicky Craig, the Nurse Practitioner, and her Certified Medical Assistant, Carol Baker, have been busy this school semester. While 69% of student visits to the SBHC from December 1 – February 28 were sick visits, the team has seen an increase in sports physicals now that the spring sports season is underway. During these sports physicals, Vicky was able to diagnose three students with heart murmurs and then refer them to a local cardiologist. One student in particular, John, came into the SBHC with chest pains that worsened with exercise. Vicky was able to determine that he also had a heart murmur. None of the three students had previously been diagnosed. Carol Baker commented that Vicky is very good at treating the entire student and taking time to understand what the student may or may not be saying related to their overall health. Without the SBHC, these students' heart health issues could have continued to go undiagnosed.

Carol also notes occasions when students may not actually be sick but just want to come speak with Vicky regarding a health issue that they do not feel comfortable talking about with their family members. This is another example of the trust that Vicky has built with the students. One student that has been seen by the Nurse Practitioner four times during this quarter. The parents have stated that they would rather have their child seen at school in the SBHC by Vicky than visiting the urgent care over the weekend. Carol attributes this to the trust that the parents have in the quality of care their child will receive when they come to the SBHC. The clinical team emphasizes that the "SBHC" is a minute clinic in the school and always follows up with a student's primary care provider.

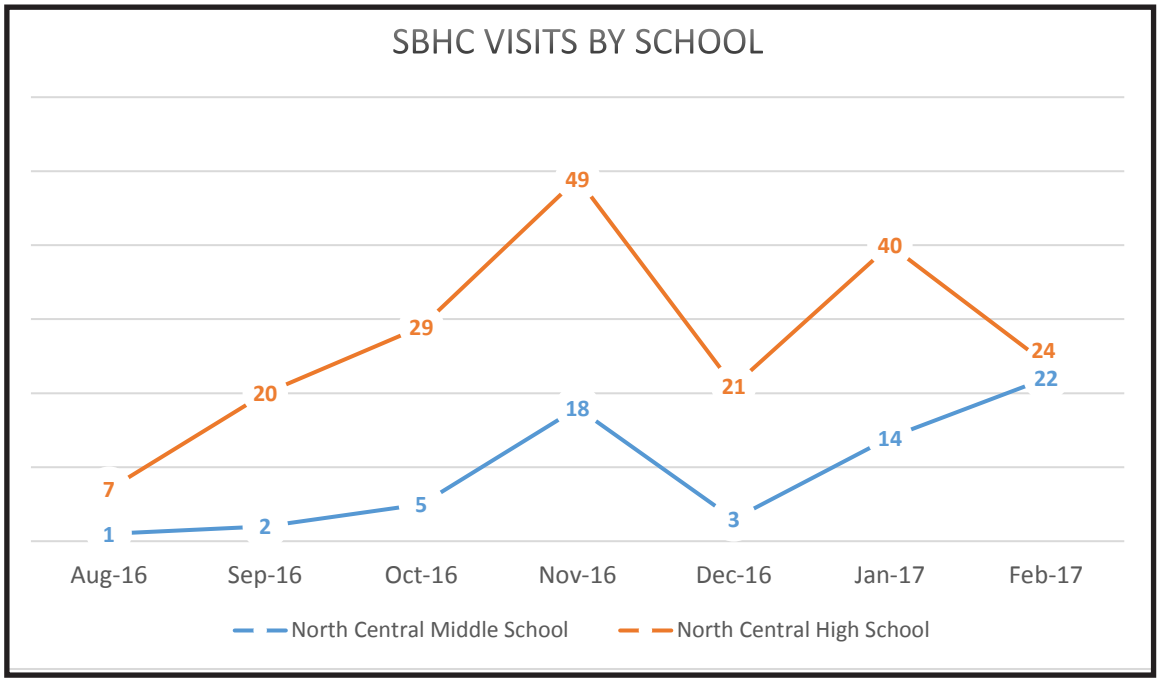
Vicky Craig has seen many middle schoolers since opening up services to North Central Middle School.

The School Based Health Center, located at North Central High School (NCHS), serves high school students and North Central Middle School students.

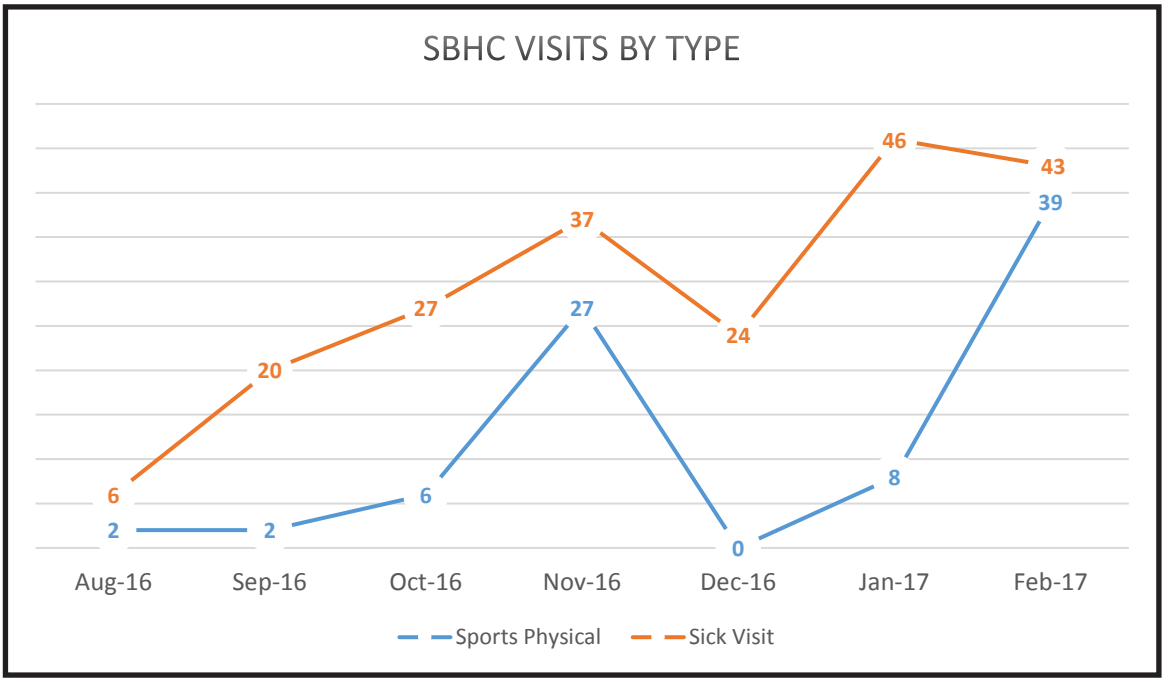
Not only have these students been able to gain access to sports physicals, but also treatment at sick visits. When a student needs to come over to the SBHC, Carol Baker, the Certified Medical Assistant drives over in the driver's education car to pick up students and brings them back to be seen by Vicky. The hand off of any middle school student in need of SBHC services occurs in the front office of North Central Middle School.

Christina Hunt, the Health Assistant at NCMS commented on this process. "We initially had some issues working out communication between the SBHC and our health room regarding whether students were being sent home or going back to class. The communication has since been much improved and we are now all on the same page as to if students are being sent home after their visit or coming back to class at NCMS. The SBHC has been great for us." On a recent ride over to NCMS to pick up a student for a sick visit, Carol was exiting the car when a student stopped to thank her for helping him receive a sports physical. This type of comment is a testament to the impact that the SBHC has had on both the middle and high school students.

School Based Health Center Data



For Year 3 Quarter 3 (December through February), the SBHC saw 124 students total. Low numbers for the month of December are attributed to the two weeks that the school was closed for Christmas break. The trend in higher student volume from NCHS compared to NCMS is attributed to the higher level of enrollment for NCHS which currently stands at 60.5% compared to NCMS at 39.2%.

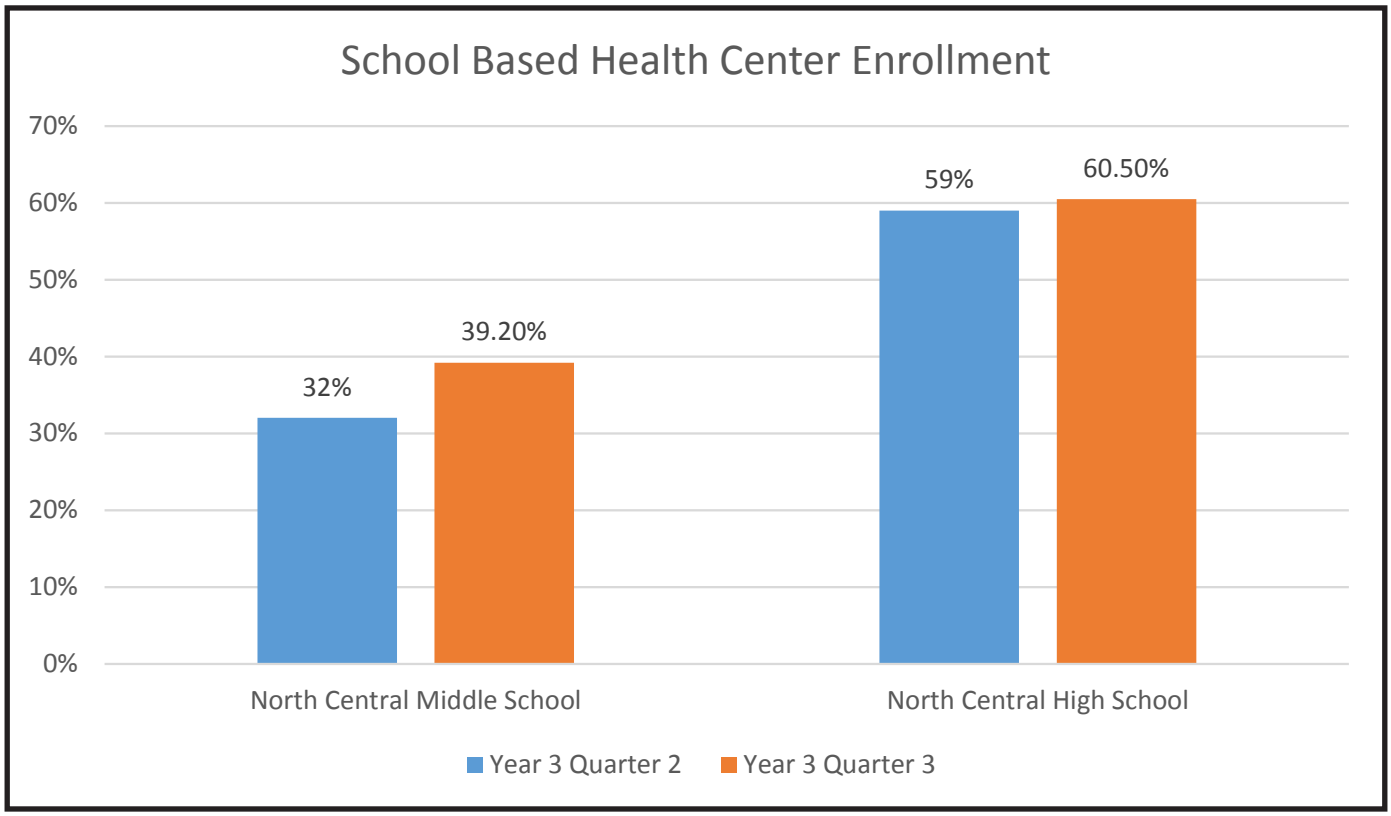


The graph above displays the number of sick visits and sports physicals for the months August through February as a comparison overtime. For Year 3 Quarter 3 (December 1, 2016- February 28, 2017), there were a total of 47 sports physicals completed and a total of 113 sick visits for a combined total of 160 visits. The low amount of all visits in the month of December is attributed to school being closed for two weeks

for Christmas break. There were no sports physicals conducted in the month of December due to there not being any sports practices. A steady increase in sick visits began in October and lasted through January during the peak of cold and flu season. There is also a noticeable uptake in sports physicals during both November and February.

SBHC Enrollment

From Year 3 Quarter 2 to now, in Year 3 Quarter 3, enrollment in the SBHC for both NCHS and NCMS has increased. Currently, 60.5% of NCHS is enrolled and 39.2% of the NCMS is enrolled in the SBHC. The graph below displays the increase over the past two quarters. The enrollment rate goal for the middle school is 50% and the goal for the high school is 80%.



Satisfaction Survey Results

North Central High School. For this quarter, 102 students seen at the SBHC completed the satisfaction survey. When asked to rate their visit with the Nurse Practitioner, 94.12% of students indicated that their visit was great and 5.88% said that their visit was okay. When asked if they would recommend the SBHC to another student or sick friend, 97.06% of respondents indicated that they would while 0.98% said they would not and 3.75% said that they didn't know if they would recommend the SBHC.

North Central Middle School. For this quarter, 51 students that visited the Nurse Practitioner at the SBHC completed the satisfaction survey. When asked to rate their visit with the Nurse Practitioner, 88.24% of students indicated that their visit was great and 11.76% of students said that their visit was okay. When asked if they would recommend the SBHC to another student or sick friend, 88.24% of respondents indicated that they would while 1.96% said they would not and 9.80% said that they do not know if they would recommend the SBHC.

Administration Perspective

In a recent interview with North Central High School's Rose Montgomery, the Assistant Principal for 9th graders credited the SBHC with the seemingly lessened impact of strep and flu season on North Central High School students and staff members. "Because students are able to see the Nurse Practitioner first thing in the morning before class, Mrs. Craig is able to determine whether or not they are sick and send them home from there. They aren't staying in school and getting everyone else sick," says Rose. She went on to say that she can tell a different in the impact that cold and flu season has had in surrounding areas within South Carolina and while there have been flu cases reported at North Central High School, it has not impacted the school as dramatically as other schools. Rose attributes this to the presence of the SBHC.

Case Study

In January, Eli, a senior at North Central High School, had been playing baseball when he injured his finger. Knowing something was wrong with it by the amount of swelling, bruising, and pain, Eli showed his father. His father said, "There isn't anything wrong with your finger." Still concerned and hoping to get a second opinion, Eli decided to go to the SBHC the following morning at school just to be sure. Because he was already enrolled in the clinic, Eli was able to be seen by Vicky Craig, the Nurse Practitioner. Upon examination, Vicky determined that the finger was most likely broken from the impact of jamming the finger at baseball practice. After this discovery, Vicky coordinated for Eli's mom to take him to Elgin Urgent Care to be seen. Until then, Vicky advised Eli to take Ibuprofen and ice the finger. Eli confirmed later that day that the finger was fractured.

About a week later, Eli was back in the SBHC for the same issue. Another broken finger as a result of injury at baseball practice and in the same situation with a parent denying that anything is wrong with the finger. Again, Vicky was able to assess the injury and determine that it was indeed broken again. This case is an example of the benefit of having a Nurse Practitioner within the school that is qualified to determine the extent of an injury from participating in sports. Not only can the School Based Health Center provide sports physicals and see children for sick visits, but also assess injuries and provide treatment options for injuries sustained from participating in sports.

Mental Health Updates

Over the past quarter, the mental health team at the School Based Health Center has provided 17 students with 63 clinical hours of mental health services. The team hopes to start back up with Check and Connect mentoring services at both NCMS and NCHS in the spring, depending on level of interest and needs identified by administration.

l. to r: Vicky Craig, Organ Andy, and Carol Baker

Health Education

Vicky Craig and Carol Baker have moved beyond just treating students and into health education within both North Central Middle and North Central High School. When Vicky sees patients for either sick visits or for a sports physical, she will use "Organ Andy" to highlight the different organs of the body and demonstrate what happens to those organs when students that play sports do not stay hydrated. This visual learning tool is an excellent way to reach students in a way that they may find comical but also memorable.

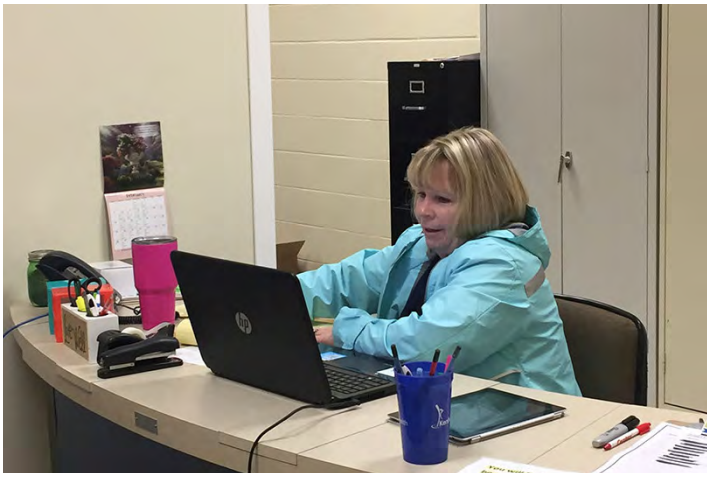
Case Study

John is a 16 year-old, white male who lives at home with both his mother and father. He was referred to LiveWell mental health services due to low motivation in school, which resulted in him repeating the 9th grade for a second time. John reported having support from friends in the school environment and also having a strong relationship with both his nuclear and extended family.

When initially meeting with Alexandra Golden, a doctoral student in Psychology at the University of South Carolina, John told her that he while he is interested in obtaining his high school diploma, but that he was not concerned with doing so within the typical four years. Over the course of this initial session, he also informed the therapist that he was interested in installing speaker systems as a job option after high school. This discussion with the therapist validated reports from the Vice Principal pertaining to John's lack of motivation towards school.

After the completion of four sessions, the therapist noted that John's motivation had improved significantly. John expressed interest to both Alexandra, the therapist, and school officials that he would like to enroll in a course that would allow him to make up missed credits. John stated that after a conversation with his father, he realized that receiving his high school diploma was critical for his ability to gain employment following high school. In this same session, John also expressed that due to his parent's limited education he would need a mentor to help him attain the skills that would aid in pursuing his diploma.

During treatment, Alexandra worked effectively with both John and his teacher to identify John's progress in his coursework. Additionally, through working on communication skills and relaxation techniques, John's relationship with his teacher has improved. John's teacher has also noted significant improvement in John's progress and has expressed that he is impressed with John's behavior. Therapist will continue working with John and his teacher to improve their communication and empower John to pursue information on his course performance and trajectory from both his teacher and his counselor.



Carol Baker, Medical Assistant, works hard to ensure that the workflow of the SBHC runs smoothly for students, administration, and Vicky Craig, the Nurse Practitioner.

Case Study

Deshawn is a sophomore at North Central High school who was referred to the School Based Health Care Center initially due to issues controlling his anger at home and in the classroom. Deshawn would often get into yelling matches with his parents to the point where he would threaten to harm himself and others. This behavior would also occur at school, where he would often make vague threats of harm to students who he felt were disrespectful to him. Complicating matters, Deshawn is also identified as intellectually disabled, with very low cognitive abilities. Part of what was initially discovered during the early assessments with the LiveWell mental health team, specifically Cameron Massey, a doctoral student in Psychology at the University of South Carolina is that he is unable to understand how comments made in anger have lasting effects and consequences. Deshawn's family struggles to make ends meet and does not have access to reliable transportation in the community, therefore receiving services at the SBHC is truly and ideal situation.

Initial treatment focused on helping Deshawn how his words were interpreted by others and how they often got him in trouble. Clinicians at the SBHC used concrete examples and strategies to help Deshawn associate his threatening language with the negative consequences of getting in-school suspensions and detentions, as well as alienating him from many of his peers. While Deshawn was learning to understand how his actions affected those

around him, the clinician working with him began to introduce anger management strategies tailored to meet his special circumstances. **To date, Deshawn has gone 9 months without a discipline referral at the school, has engaged in no disruptive behaviors in the classroom setting, has passed all of his classes this academic year, and recently received an award through the school for his respectful and positive attitude.**

While Deshawn has experienced some positive changes in the academic environment, he does continue to struggle with his home life. Over the recent semester break, Deshawn's arguments with his parents escalated to the point of Deshawn needing to be hospitalized for three days. While this represented a setback in terms of treatment, the SBCH clinician was able to adjust their role from a direct provider of mental health services to more of a care coordinator, facilitating and supporting the treatment Deshawn is now obtaining through enhanced services through the Department of Mental Health. The LiveWell Kershaw clinician is still able to help Deshawn in school, which he is still maintaining his positive behavioral and academic gains, while at the same time helping to coordinate his family care through additional community resources.

Thinking about practical solutions

With the start of the new General Assembly session here in South Carolina and the beginning of a new administration in Washington, public education will, as usual, be a subject of debate for our state and national leaders. These debates tend to both amuse and irritate me because they end up being more oriented to sound bites, tweets, political posturing and quick fixes than to actual solutions.

Public schools are educating more students with more challenges more effectively than ever before. Folks tend to wax nostalgic about the "good old days" when things were supposedly better. The reality is that they weren't. In those days, dropout rates were incredibly high, starting in elementary school, although no one got too worked up because kids could leave school and find relatively gainful employment in mills and factories that no longer exist. Special needs children weren't even part of the equation, and "separate but equal" schools were only separate. The bygone era wasn't nirvana by any stretch of the imagination.

Regrettably, our political leaders keep going back to the same dry well for educational solutions. During my 42 years in education, I have seen time and again that more high stakes testing doesn't raise achievement, that charter schools and vouchers aren't panaceas, and that money without clear purpose isn't the answer.

The solutions required to increase student achievement need to be practical ones that focus on both academic and non-academic needs.

Physical and Emotional Needs

A student who is hungry, sick, or under significant emotional stress is not going to learn effectively. This isn't rocket science. The physical and emotional needs of students have to be met if they are going to be successful academically.

Childhood hunger is real, and it hinders learning. The federal breakfast and lunch program is a critical service when school is in session. The problem is when school is out. During weekends, breaks, and the summer, a larger number of students than we want to acknowledge do not have adequate food. Local efforts here in Kershaw County, including "Sacks of Love," the United Way Summer Feeding Program and Mobile Food Pantry do much to fill the void, but it's a huge void. A legitimate educational reform package must address the reality of hunger that exists for countless students across our country.

Access to health care is also a tremendous barrier to academic achievement, especially in rural areas. Without access to health care, these students are absent a lot. Older students end up missing school for both for personal illness and to care for younger siblings who are sick because parents have to work. Our district's pilot with LiveWell Kershaw, which provides nurse practitioner services in the North Central area and a school-based health clinic at North Central High School, has had an immediate positive impact on reducing absenteeism and increasing achievement. Expanding access to health care, especially in rural areas, is essential to improving academic outcomes.

Students experiencing emotional problems are often disruptive and are not successful academically. For these students to succeed in school, more intensive counseling services than can be provided by a guidance counselor are needed. (A couple of years ago, our own principals identified more intensive counseling services as a priority need.) The LiveWell Kershaw pilot and our district's partnership with the Alpha Center have been very successful in helping these students to be more successful in school.

By the way, these areas are all strongly related to poverty. Schools reflect the communities they serve. Many politicians seem to believe that more testing will alleviate poverty.

Quality Teachers

Research has shown over and over that the key factor in student achievement is a quality teacher. Unfortunately, the main approach to improving teacher quality in our state and across the country has been to increase high stakes testing and sanction or reward teachers based on the results of this testing. It hasn't worked. It's actually backfired in terms of driving many good people out of the profession.

Any approach to improving teacher quality needs to start with compensation. We're not going to attract the people we want in the numbers we need with starting salaries in the mid $30,000s that barely increase with inflation over the course of a career. Making matters worse is the fact that one of the attractions to teaching has always been a predictable pension. In South Carolina and many other places, this has been or very possibly be replaced by a less stable pension system.

A strategy to begin to improve teacher compensation would be to actually pay professionals for the days they work to take courses, develop curriculum, and pursue other training outside of contractual time. I can guarantee you that the work teachers have to do does not get done within the confines of a 190-day contract. This fact has long gone unnoticed by our political leaders, who have gotten accustomed to getting this work for free.

I suspect the idea of paying teachers based on test scores will again be floated. Dragging this old saw out again will not improve achievement and will not attract and retain good teachers

Funding

These areas might be funded at least in part by taking a percentage of the almost $2 billion that our country spends every year on standardized testing, a figure which does not include the massive soft costs for administration and bureaucracy tied to this testing. Some of this money might be better spent in our classrooms and our communities rather than on testing contractors and their entourage.

Here's an interesting factoid...American public school students take about 112 standardized tests between kindergarten and 12th grade.

What has this accomplished?

I'm always pleased to talk with folks about our schools. My direct dial phone number is 425-8916 and my email is frank.morgan@kcsdschools.net. Citizens can also contact me through the "Ask the Super" link on the homepage of the district website. I also invite community members to read my "blog," which can also be reached through a link on the homepage of the district website. In addition, I do a podcast after each School Board meeting summarizing the meeting. This podcast can also be accessed through a link on the district homepage.

(Dr. Frank Morgan is the Superintendent of the Kershaw County School District.)

Morgan, F. (January 17, 2017). Thinking About Practical Solutions. *Chronicle-Independent.*

Community Outreach

Community Outreach Efforts

The Community Medical Clinic team participated or presented at 18 community events this quarter. The types of events included a variety of settings and audiences in order to engage as many individuals as possible. See timeline on page 41 of community events. Through these outreach efforts, LiveWell Kershaw has become a recognizable name throughout the northeastern part of the county.

In an effort to maintain momentum, the team is working to expand its community outreach efforts. The care coordination team has revisited and updated their outreach plan, which includes fostering new relationships and maintaining existing relationships with community members, partners, churches and organizations. Community Health Workers are not designating Friday afternoons to focus on community outreach. This typically includes visiting popular restaurants and businesses in the area and sharing information to residents while they are shopping. The CHWs also maintain a strong relationship with the local schools and local government leaders. The Care Coordination Team Manager, Beckie Tompkins, is monitoring the impact of these efforts on an updated tracking tool.

In an effort to make these relationships more fruitful, the Care Coordination team participated in a Public Speaking Boocamp on February 17th. During this bootcamp, the team was provided with tips and advice on public speaking best practices. LiveWell Kershaw leadership will continue to work with the care coordination team to increase capacity and comfort level with public speaking. In the next quarter, we will reassess community outreach efforts and also the capacity of individual team members.

Church members and volunteers pitch in to bring in food from the food truck that delivers on the 2nd Tuesday of each month to Dekalb Baptist Church. The truck currently feeds 56 families. The LiveWell team is also at the church on food truck days.

Outreach at Russell's Smoking Good Barbeque

On Friday, February 24th, Community Health Workers, Jodi Rogers and Rachael Sladek took the LiveWell Kershaw van to Russell's Smoking Good Barbeque and met with about twenty people. Jodi Rogers (pictured) is an excellent advocate for LiveWell Kershaw's services.

Food for Thought Monthly meetings

The LiveWell team continues to maintain the monthly Food For Thought meetings that began in the previous quarter. Food for Thought meetings originated from the members of the Community Advisory Meetings and the care coordination team after recognizing that quarterly meetings for their entire north central area were not being as effective as they could be. From December, January and February, meetings were held at Buffalo Baptist Church (40 in attendance), Refuge Baptist Church (20 in attendance), and DeKalb Baptist Church (100 in attendance); rotating location on a monthly basis. A healthy warm meal is provided to all community members along with a speaker and time for discussion on community issues. Speakers for this quarter's meetings featured the Assistant Principal for North Central Middle School, Chad Dixon, and Summer Rigby from Vocational Rehabilitation. At each meeting, the speakers have had a chance to highlight the benefits of working with the LiveWell team and the services that they are able to provide community members and students. In addition, the speakers have also had a chance to explain the services that their programs offer to the public as well.

Individuals in attendance at the Food for Thought meetings are not only exposed to what LiveWell can offer, but also other critical services in the community. This quarter, the team focused on growing attendance for the Food for Thought meetings by distributing flyers for the event and announcing it at the churches for several weeks prior. As a result, the attendance of these meetings grew in all locations.

Community Outreach Director Beckie Tompkins and Volunteer Coordinator Cynthia Nelson presented information about the Community Medical Clinic and LiveWell Kershaw to Shiloh United Methodist Church.

Jodi Rogers, Community Health Worker, chats with church members and volunteers at Dekalb Baptist Church about healthy living in rural Kershaw County.

For Assistant Principal Chad Dixon, his students at North Central Middle School are able to enroll and have direct access to the School Based Health Center located at North Central High School. At Buffalo Baptist Church, he was able to describe the impact that this has had on his students. For example, Dixon recounted a story of a student that was now able to participate in sports as a result of having his sports physical completed by Vicky Craig, the Nurse Practitioner at the SBHC. The link between athletic involvement and academics is critical to student success.

For Summer Rigby at Vocational Rehabilitation, having the opportunity to share the services that her organization is able to provide to the community is paramount. Her participation in Food for Thought at Refuge Baptist Church gave her the platform to share her services, as well as praise the LiveWell Kershaw team on their ability to refer patients to Vocational Rehabilitation. Advancing the community health, is dependent on trusting relationships with community partners. Summer also participated in the Food for Thought that was held at Dekalb Baptist Church which had just over 100 individuals in attendance.

Donor Drop-In

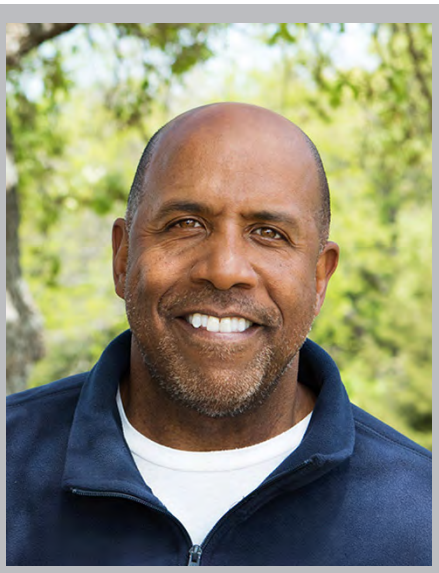
During this quarter, the Community Medical Clinic had its first annual Appreciation Drop-in for all 2016 event sponsors. It was a special evening and a great opportunity for our staff to thank our many supporters. Clinic tours were provided so the guests could understand how their involvement with our medical home is impacting and saving lives in Kershaw County. Many of participants had not visited the clinic previously and were amazed at the services that we offered, including outreach in the North Central schools, rural parts of Kershaw County, as well in the hospital. Participants were very interested in mental health services, equity, church satellites, and free prescription services. This event helped highlight how our staff and their support is helping our patients strive not just survive.

Volunteers look over their packet of materials for their annual training.

Volunteer Efforts

Five volunteers and four student volunteers were recruited during this quarter from Kershaw County.

During this quarter, the volunteers of the Community Medical Clinic underwent their annual training on January 20, 2017 to update their knowledge on the Emergency Plan for the clinic, OSHA, HIPAA, and



Outreach Success

As a result of the Stress Reduction workshop held at Cassatt Baptist Church in December with mental health counselor, Christie Derrick, and Nurse Practitioner, Vicky Craig, one participant was identified as having suicidal ideations. Vicky was able to evaluate the patient that day, start him on anti-depressants, and refer him to mental health.

Since then, the patient is doing much better with decreased thoughts of harming himself. In Christie's last visit with him, the patient reported that he has had no suicidal ideations. While he continues to be followed by mental health, both his cognitive and psychological well-being has already improved. The collaboration and integration between the clinical side and mental health are evidenced in this case. Vicky Craig and Christie Derrick worked together in order to achieve the best outcomes for this patient identified through a community outreach event.

fire safety precautions. Prior to this training, all volunteers of the clinic were given the opportunity to complete an online or paper version of a survey that asked questions regarding the success of the current volunteer program. The results from the survey were organized into a SWOT (strengths, weaknesses, opportunities, and threats) analysis and presented to the group as a means to improve the coordination of the volunteer program and to increase the awareness level of volunteers regarding the satellite locations of LiveWell Kershaw. From these findings which included input from 15 volunteers, the LiveWell Kershaw Director is making a more concerted effort to inform the volunteers about LiveWell Kershaw satellites and activities. The updated maps and photos of all team members are now posted at all locations to assist with this.

Volunteer Program Evaluation Feedback — January 20, 2017

Strengths	Weaknesses
• Reduces costs to CMC, increase the donated dollar, and increases funds that can be used to help the patient	• Each shift has a new person that may not know of new policies and procedures.
• Variety of personalities and backgrounds	• Unsure of staff responsibilities and how to direct phone calls because of this
• Voice in the community to tell of the good CMC does	• Even small changes made are not communicated effectively with volunteers. Ex. Pharmacy changes
• CMC does a great job showing appreciation to volunteers	• Unsure who should be let into the back office for meetings with staff
• People—willing to help in any way and believe that they are making a difference in the community. • Doubtful that the clinic would be possible without use of volunteers • The community involvement helps build better relationships. • Volunteers are people that care for others and make patients "feel the love." • I enjoy volunteering at this clinic because everyone is so friendly and always ready to help. • CMC would not exist without the volunteers.	• Equipment • Down time—when there is nothing to do. If schedule only requires one person, call and let someone stay home. • More working lunches • Most people I talk to have never heard of the clinic or what it does • Continual changes without input from those that will be required to carry out changes. • Allow volunteers to determine what they are capable of and do not make them feel guilty if they cannot put in as much time as others.
Opportunities	**Areas for Improvement**
• Announce at churches the need for volunteers at CMC. Seniors at these churches have time and the inclination to volunteer. • Partnerships with churches and institutions.	• Have once a month meeting w/ volunteers to discuss problems or changes
• Use volunteers strengths and provide them with challenging opportunities	• Have phone numbers to satellite locations handy for quick reference
• Use social media to advertise • Better marketing strategies	• Introduce volunteers to staff members

	• Share phone numbers, email addresses, and Facebook post to communicate more easily. • Email could be used to inform volunteers of policy changes. • Use a volunteer in the lobby

Wellness Wednesdays Radio Spots

In an effort to provide education on health topics to the community, LiveWell Kershaw has begun sponsoring radio spots on local station WPUB Cool 102.7 FM. "Wellness Wednesdays" can be heard every Wednesday at 12:25pm. This outreach effort began on February 15, 2017 and being broadcast in Kershaw County and a small portion of Richland county. During these time slots, the Community Medical Clinic interviews local health experts on various health and community topics. February focused on heart health with an interview from the KershawHealth Emergency Room Director and Jessica Wilkes, nurse practitioner at the Community Medical Clinic. Not only does this increase community awareness of health issues, it also educates the area about lifestyle's influence on health.

Wellness Wednesday spots are also archived on the clinic's YouTube channel, which can be found here:

https://www.youtube.com/channel/UC1hUhKa209ZXb1rNdfuIX6g

Timeline of Community Events

DATE	STAFF	DESCRIPTION	OUTCOME
12/12/2016	Beckie	Baron DeKalb Elementary PTO	Brief review of services to be presented during the Christmas PTO program at Baron DeKalb Elementary. Approximately 140 adults were in attendance for the presentation. Also, spent one on one time with two teachers discussing options for services
12/14/2016	Beckie, Jodi, Rachael, Kathryn Susan, Susan D, and Vicky	Food for Thought- Buffalo Baptist Church	Approximately 35-40 adults in attendance. Assistant Principal Chad Dixon spoke about the SBHC.
12/17/2016	Jodi, Rachael, Susan, Mary, Vicky and Sheri	Bethune Christmas Parade	LWK van in Christmas parade and provide magnets with CMC/Access/Satellite information being handed out.
12/12/2016	Christie and Vicky	Cassatt Baptist Church Stress Reduction	4 participants. 1 participant identified with suicidal ideations and was referred to our FNP. The FNP evaluated patient that same day, started client on anti-depressants and mental health referral was made.
1/18/2017	Rachael, Jodi, Vicky, Kathryn, Carol, and Beckie	Food for Thought- Refuge Baptist Church	Summer Rigby from Vocational Rehab spoke to the group of 20, including staff, regarding services available through Vocational Rehab. Written information packets were available. CMC new promotional cards were also distributed along with date of upcoming Food for Thought. Summer will also come to the next FFT @ DeKalb Baptist.

Timeline of Community Events			
DATE	**STAFF**	**DESCRIPTION**	**OUTCOME**
1/23/2017	Vicky, Jodi, Cameron, Carol, and Beckie	9th (Rising) Grade Open House at NCHS	Vicky coordinated blood sugar and blood pressure screening with the Northeastern Technical College nursing students. Cameron, Jodi and Carol were available to answer questions and provide SBHC applications to attendees. Beckie did a brief presentation to the group (approximately 100) regarding the SBHC (both counseling and health related) and other services available through LWK efforts. Mrs. Montgomery, Assistant Principal, was very complementary of the LWK efforts. Six new students were enrolled in the SBHC that pm and additional applications were given to others.
1/31/2017	Vicky and Jodi	Bethune Outreach	Drove van to Meat Market in Bethune and handed out LiveWell Kershaw information to shoppers.
2/3/2017	Jodi	Bethune Outreach	Van driven to Meat Market in Bethune to continued giving out LiveWell Kershaw information. Completed one CMC intake.
2/10/2017	Rachael and Jodi	Kershaw Outreach	Van driven to Rabbits near NCHS, talked to customers and handed out LiveWell information.
2/7/2017	Jodi	DeKalb Senior meeting	Talked to the Senior group at DeKalb. Six people were in attendance and shared with them information about CMC and the LiveWell Kershaw program and satellite sites, places and times. Left green cards with them for hand out and Food for Thought flyers.
2/15/2017	Jodi, Rachael, Sheri, Beckie	Dekalb Food for Thought	Community event with approximately 100+ people. Brief review of LWK services. Summer Rigby of Voc Rehab provided a program on VR services
2/16/2017	Jodi	Midway Kindergarten Round up	Set up a table for the Kindergarten Round up. Handed out green cards with CMC and LiveWell Kershaw Sites and times. Talked to seven parents during my time (3-5pm) about services. Left additional cards for the school nurse and at the school for other parents that would be coming in.
2/16/2017	Rachael	Bethune Elementary School	Spoke with Susan Carmichael (Secretary) and Estelle Benson (Principal). Dropped off Green Cards with our information and asked if there were any events coming up. Stated she would put our cards at the counter where parents sign in and out their children and would also be giving them out to the parents who come to kindergarten registration.
2/16/2017	Rachael	Mt. Pisgah Elementary School	Spoke with Jaquette Baker (Secretary) about LiveWell again and gave her cards to give out and put at the office. Checked with her again about the Community Caring Fair that they will be having and confirmed the date and time and let her know I would be attending that day. It's on March 7th from 6pm-7pm.
2/16/2017	Rachael	Buffalo Mt. Pisgah Fire Dept./ Rescue Squad	Stopped by on the way to Buffalo. There was not anyone on site at either building. Upon getting to Buffalo there was a lady that came in needing help for her son.

Timeline of Community Events			
DATE	**STAFF**	**DESCRIPTION**	**OUTCOME**
2/24/2017	Rachael and Jodi	Russell's BBQ Westville	Livewell Van activity, 11am-2pm spoke to about 20 customers about services and program. Also gave out Green cards with locations and times.
2/24/2017	Jodi	NCHS Green and Gold Pageant	Livewell Outreach from 5:30-7:30. Set-up a table with Livewell Green Cards and also had SBHC applications and information on hand. Spoke to approximately 25 people during the time. Most knew of the SBHC and a few took Green cards.
2/25/2017	Beckie, Cynthia, and Susan D.	Shiloh United Methodist Church Lugoff	Presentation related to all CMC programs.

LiveWell KERSHAW
"Your Bridge to Better Health"

December 2016

Newsletter

110 C East DeKalb St Camden, SC 29020
803.272.8325

facebook.com/LiveWellKershaw
twitter.com/lwkershaw

An initiative led by the Community Medical Clinic of Kershaw County

HAPPY HOLIDAYS FROM LIVEWELL

Just before Thanksgiving, the Community Medical Clinic (CMC) staff, volunteers and patients came together for a fellowship dinner, hosted by Food for the Soul.

"Look around the room. This is our Clinic family. All of us are together in this mission of helping each other in the community," said CMC Director Susan Witkowski. Witkowski also emphasized that while many members of the Clinic family struggled during the past year, this was the perfect time to come together and support one another: "The biggest part of being a family is that we help each other thrive, not just survive."

Camden based Food for the Soul serves free, home-cooked lunches four days a week to anyone in need, and also operates a winter shelter. It also provides warmth, showers and clothes washing for the homeless whenever night time temps are predicted to be 36° F or lower.

Clinic patients, staff, volunteers and board members celebrated the Thanksgiving season at Food for the Soul in Camden on November 21.

After dining together, all attendees had the opportunity to tour Food for the Soul's facilities and learn more about the services they provide.

FOOD FOR THOUGHT

This fall, our Food For Thought meetings have seen sizable crowds coming out to learn more about our services, including the School Based Healthcare Center (SBHC), and to enjoy a complimentary meal.

Speakers have included principal David Branham and assistant principal Rose Montgomery from North Central High School. Both spoke highly of the impact of having a SBHC that meets the needs of students. Additionally, several LiveWell staff members spoke about the services available at the satellite sites (Buffalo, Cassatt, DeKalb, and Refuge Baptist Churches).

Reception from Kershaw county residents has been very positive. At least three students were enrolled in the SBHC at these meetings and one has already seen the nurse practitioner. After listening to Mr. Branham tout the benefits of the SBHC, one attendee offered a $100 donation. Community members also agreed to spread information about LiveWell to individuals in need.

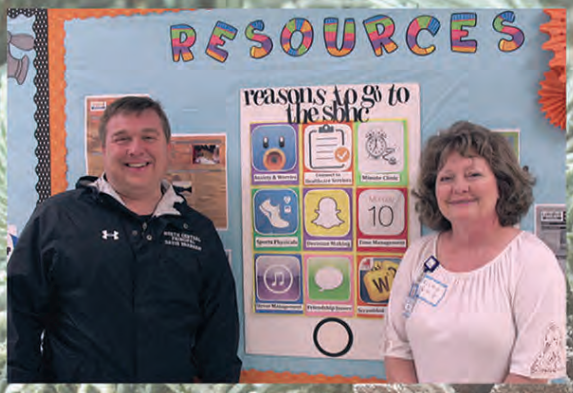
The next Food for Thought meeting is scheduled for January 18 at 5:30 pm at Refuge Baptist Church (2814 Lockhart Rd). As always these meetings are free to attend and dinner will be provided free of charge.

SCHOOL BASED HEALTHCARE GROWING

At the start of the 2016 school year, LiveWell Kershaw increased the number of days per week that the School Based Health Center (SBHC) and satellites in the North Central area are staffed by the nurse practioner. Also, SBHC services are now offered to students from North Central Middle School.

Vicky Craig, MSN-Ed, FNP-C, FAANP, was hired to work with residents in the North Central area of Kershaw County. She lives in the North Central area and is very passionate about the services that she provides at both the school and the satellites. At the SBHC, Craig now sees students four days per week (Monday through Thursday from 7:30 a.m. to 12:00 noon) and patients at various satellites three times per week. By increasing the availability of the nurse practioner at these locations, the number of individuals seen at both the SBHC and the satellites has steadily increased.

For the first three months of the school year, 276 NCHS students were enrolled and 113 NCMS students were enrolled in the SBHC. New enrollments continue to come in every week. There have been a total of 152 visits to the SBHC, including 69 sports physicals, 77 sick visits and 6 TDAPP immunizations. In many cases, interaction with a student has resulted in additional services being provided to their family members at the satellites. With these additional services provided by Vicky Craig and the support staff, we are providing holistic care to entire families.



NCHS principal David Branham and Vicky Craig

TRANSITIONAL CARE

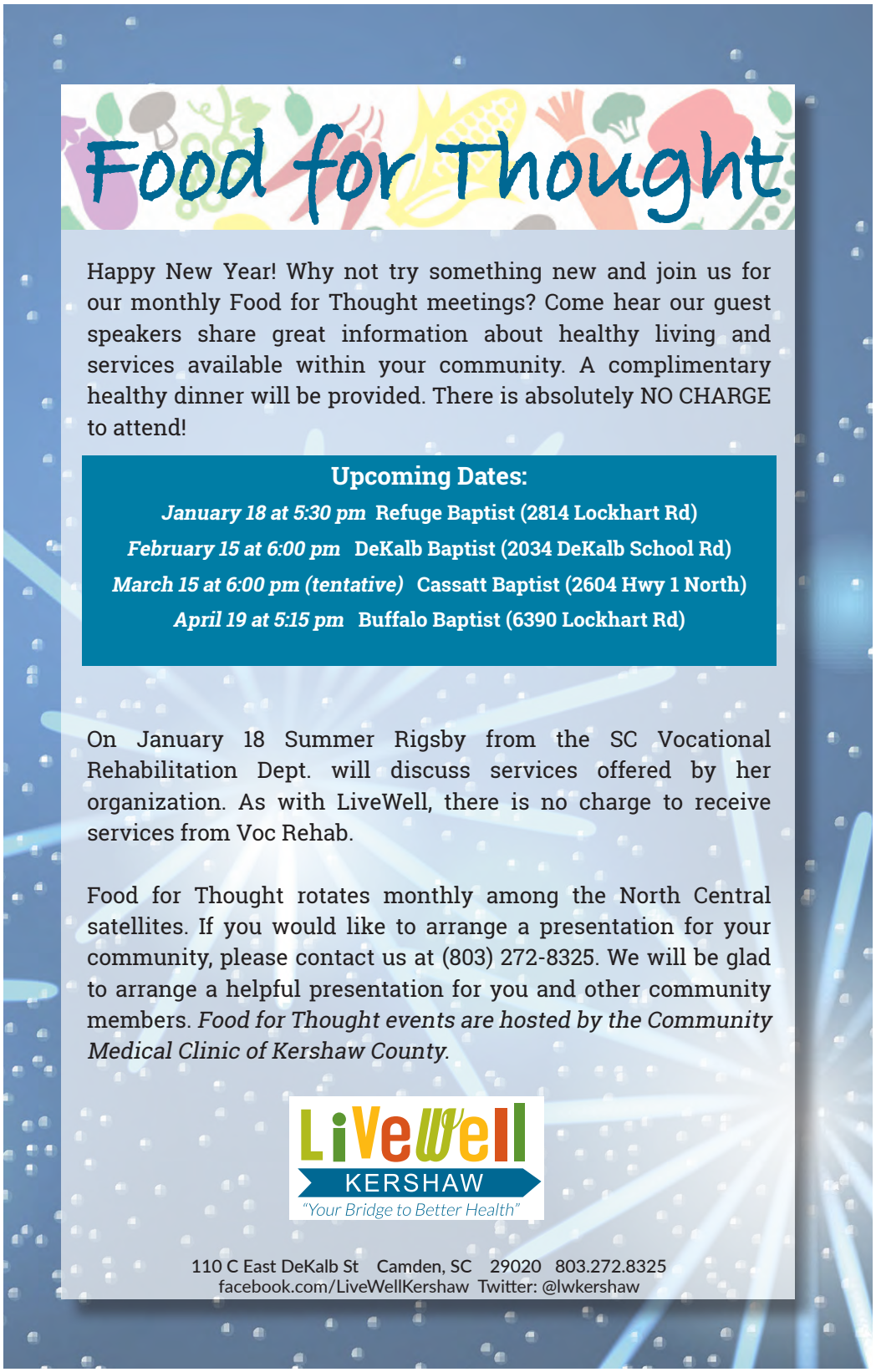
The Community Medical Clinic Transitional Care team has been hard at work helping patients not only while they are admitted to the hospital but also after they are discharged. Community Care Coordinators (CCCs) Brandi Thompson, Sheri Baytes, and Debbie Davis are striving for success for all transitional care patients - through education and by ensuring that each patient has the necessary medical supplies to avoid hospital readmission. Some of the supplies that CCCs have provided to patients include blood glucose testing strips and monitors, blood pressure monitors, and even pillboxes to better manage medications.

The transitional care team provides supplies for at-home monitoring of blood pressure and diabetes.

While each CCC has an active caseload of patients, they also continue to work with patients that have reached the end of the 90-day cycle without requiring hospital readmission. CCCs periodically check on patients to see how they are managing self care. Initially, the Transitional Care team worked with only current CMC patients admitted to the hospital. Just recently the team has begun reaching out to those that are not currently CMC patients but still need transitional care to be successful.

The work of the Transitional Care team continues to make a difference to population health, by impacting both the lives of CMC patients and now non-CMC patients as well.

Food for Thought flyer



Flyer with updated hours and locations

COMMUNITY MEDICAL CLINIC
Outreach. Access. Medical Home.

Community Medical Clinic of Kershaw County
110 C East DeKalb St Camden, SC 29020

Do you need a doctor and do not have a way to pay? We can help!

When you qualify to become a patient of the Community Medical Clinic of Kershaw County you do not pay anything for office visits at our locations. To see if you qualify, please bring the following items to one of our Satellite Healthcare Sites:

- **Driver's license & social security card**
- **Statement of any income including pay stubs**
- **Social Security letter**
- **Copy of a utility bill**
- **Medicaid denial letter from local DSS office**
- **SNAP (Food Stamp) Letter**

Satellite Healthcare Sites	
Day/Time	**Location**
Monday - Thursday 8 am - 6 pm	Community Medical Clinic of Kershaw County 110 C East DeKalb St Camden 29020
Monday 2 pm - 5 pm	Cassatt Baptist Church 2604 HWY 1 North Cassatt 29032
Tuesday 9 am – 1 pm*	DeKalb Baptist Church 2034 DeKalb School Rd. Camden 29020 **open first and third Tuesday of each month*
Wednesday 2 pm - 5 pm	Refuge Baptist Church 2814 Lockhart Rd Kershaw 29067
Thursday 2 pm - 5 pm	Buffalo Baptist Church 6390 Lockhart Rd Kershaw 29067
Access	
Mon - Fri 8:30 am - 5:00 pm	West Wateree Medical Complex 1165 Highway 1 South Suite 300 Lugoff 29078

Call our healthcare navigator at 803.408.0500 if you have any questions or concerns, including how to pay for your medications or applying for SNAP (Food Stamps) or Medicaid. We will schedule an appointment at a location near you.

www.cmcofkc.org

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LiVeWell KERSHAW

"Your Bridge to Better Health"

An initiative of the Community Medical Clinic of Kershaw County

Quarterly Report: Year Three Quarter Four
March 1 - May 31, 2017

Our vision:

A healthier Kershaw county where individuals and communities are empowered to take charge of their own health and well-being.

Table of Contents

INTRODUCTION

June 1, 2017

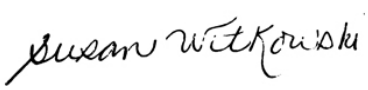
In your hands is our 12th quarterly report documenting LiveWell Kershaw's efforts over the past three years. The journey with the Department of Health and Human Services' contract to focus on a chronic-disease hotspot in the northeastern part of Kershaw County began on June 1, 2014. Working closely with our partners and listening to our patients and residents, we have learned a great deal about innovation, rural health, population health, relationships, and evaluation.

One key lesson from our journey is that numbers are important, AND outcomes are even more important. After adopting the Hub and Pathway Model in year two of the contract, we are now utilizing a software that is able to not only track all of our care coordination outputs but also the outcomes of each of the pathways a patient is assigned. Customized reports are reviewed weekly by the Hub Manager to ensure that pathways are being closed in a timely manner and patient outcomes are being maximized. Accountability matters. Hospital readmission reports are being sent monthly to our team to create run charts on how many patients enrolled in the transitional care program are being readmitted to the hospital within 30 days. Outcomes matter. Attendance clerks, guidance counselors, and school staff at North Central High School are reviewing key metrics on students enrolled in the School Based Health Center to determine the impact of having a Nurse Practitioner and a Medical Assistant serve their student population four days each week. Graduation rates matter. Expanding the primary care model into five churches and a town hall in the North Central area allows the patient to reduce travel time for some from 50 minutes to 5 minutes. Proximity matters. Nurse Practitioners, Community Health Workers, volunteers, medical assistants, pharmacy assistant and a mental health counselor discuss complex cases and how they can best serve the patient and their family. Personalized and integrative medicine matters.

We encourage you to read the case studies in this report from Jennifer, Rhonda, and Stephanie. Reaching out to local businesses and community partners on a consistent basis is paramount. Our strategies continue to evolve as we determine the best ways to engage local residents, as our Community Health workers continue to test a weekly visit to businesses in four of the zip codes. Relationships matter.

We encourage you to read this quarterly report to not only see our progress, but also to inspire you to join us as we continue to maintain our momentum. Our final evaluation report (coming July 2017) will highlight what impact we have made in six zip codes of Kershaw County. We believe the model we have refined over the past three years with the School-Based Health Center, using Community Health Workers within our care coordination teams, leveraging the assets of community members and partners, and practicing continuous quality improvement is a promising practice for the rest of our county, and our state. Together, we will achieve a "healthier Kershaw County where individuals and communities are empowered to take charge of their own health and well-being."

Best in all you do,



Holly Hayes
Evaluator

Susan Witkowski
Chief Executive Officer

Care Coordination

The LiveWell Kershaw initiative, supported by the Community Medical Clinic of Kershaw County, has been working to support the lives of residents living in the northeastern part of Kershaw County, also known as "North Central." The data below shows outputs from Year 3 Quarter (March 1 - May 31, 2017). This data reflects individuals who received clinical and/or care coordination services and live in the following zip codes: Cassatt (29032), Heath Springs (29058), Jefferson (29718), Kershaw (29067), Liberty Hill (29074), Westville (29175) and Bethune (29009). The data below does not reflect the students seen at the School Based Health Center (see page 18).

The Care Coordination team consists of a Nurse Practitioner, Community Care Coordinators, Medical Assistant, the Community Navigator and Community Health Workers. Community Health Workers (CHWs) are considered an "extender" for the Nurse Practitioner, the patient, and the community. This team actively collaborates in order to provide for both the medical and social needs of each individual.

Care Coordination Table				
	Year 3 Quarter 1	Year 3 Quarter 2	Year 3 Quarter 3	Year 3 Quarter 4
Number of patients/clients receiving assistance	252	142	151	300
Total number of visits/encounters	469	396	342	503
Number of residents connected to a medical home	74	35	40	43
Calls made to residents discharged from ER	228	111	176	289
Completed and approved Prescription Assistance Program (PAP)	12	3	1	2
WellVista applications	33	19	17	16
Completed and approved SNAP applications	16	6 (4 approved)	12	4
Completed Medicaid applications and recertifications	10	12 (2 approved)	25	2
Referrals made to specialists and outcomes	68	2 (1 approved)	6	4
Church Satellite Visits (open 1-2 times weekly)	36	47	71	48

(L to R) Vicky Craig, Nurse Practitioner, Jodi Rogers, Community Health Worker, and Carol Baker, Medical Assistant are excited to offer LiveWell Kershaw services to the residents of Bethune

Updates

During this quarter, the team has looked into the productivity levels of all satellite sites and spoken with community members regarding levels of awareness of LiveWell Kershaw services within the community. In order to gather information to inform decision making, two focus groups were conducted and eight individuals from the North Central area were interviewed. In addition, the pastor of each satellite location completed a survey to provide feedback regarding the impact of LiveWell Kershaw within their community. After all information was collected, the team reviewed the data in order to make a determination regarding satellite location hours and availability.

As a result of these efforts, Buffalo Baptist Church satellite location will alter its hours to be open on the second Thursday of each month instead of twice monthly. The team has seen less than two residents per visit, and believe that consolidating the visits will increase the team's productivity. Care Coordination Team Manager Beckie Tompkins and Satellite Operations Director Vicky Craig will continue to monitor this site to determine if productivity is improving. For this quarter, the Nurse Practitioner saw 29 patients with 35 visits at the church satellites.

As a result of feedback from pastors and residents in the area, the LiveWell Kershaw team has renewed five Memoranda of Understanding with all of the participating churches for another year. The team will continue to operate satellites at the following churches: Refuge, Cassatt, Buffalo, Dekalb and Bethune Baptist churches. Additionally, the team will continue operating a satellite at an old fire station in Bethune; the team is testing a non-church location and it appears to be accepted by the community.

Satellite Site Focus Groups Results Summary

Two focus groups were conducted at two LiveWell Kershaw satellite sites - Cassatt Baptist Church and Refuge Baptist Church in May.

Overview

The objective of the focus groups was to allow for exploration of how services received through satellite sites are impacting individuals, as well as gain feedback on signage for LiveWell Kershaw and awareness of services within the community. A total of two focus groups were conducted during the week of May 15, 2017. Focus group participants were asked questions to help answer the evaluation question: "What changes need to be made in order to increase community awareness of availability of LiveWell Kershaw services?"

Focus groups were conducted by an experienced facilitator and lasted 30-40 minutes, with a total of four participants and were held at either Cassatt Baptist Church or Refuge Baptist Church (both LiveWell Kershaw satellite sites). Because

(L to R) Beckie Tompkins, Care Coordination Team Manager, and Vicky Craig, Satellite Operations Director, meet weekly to coordinate efforts.

availability of transportation has been a consistent barrier for individuals in these communities, recruitment was a challenge. Out of 23 individuals that were contacted regarding attending the focus groups, four attended either focus group. Even so, the focus group attendees provided rich conversation concentrated around the topics initiated by the facilitator.

Demographics

Those that attended the focus groups are active users of LiveWell Kershaw satellite sites and have utilized sites at Cassatt, Refuge, and Buffalo. All participants are uninsured. Focus group attendees either resided in Kershaw (50%) or Cassatt (50%). Additionally, 75% of attendees were female and 25% were male. 100% of participants were Caucasian. Three participants fell into the 50-59 age range, and one participant indicated that they fell into the 30-39 age range.

Summary

Several themes arose from the focus groups. These themes included: 1) lack of awareness in community and 2) appreciation of services provided.

1) Lack of Awareness in Community

"Some people know about it, but I don't know why they are scared to come or what."

"I don't hear nobody talking about it."

Participants indicated that seeing "LiveWell Kershaw" on a sign by a church doesn't really explain to an outsider what LiveWell Kershaw is. Others pointed out that most of the time when driving by churches that they do not attend, it is easy to "zone out" and not see the signs or if seen, assume that the program is only available to members of that particular church. A couple of participants noted that while some may know services exist they choose not to participate for different reasons. One participant mentioned that she found out about the Cassatt site through her mother, who goes to the LiveWell Kershaw site at Refuge Baptist Church. While some news about LiveWell Kershaw travels

Integrative medicine is this team's priority. (L to R) Carol Baker, Jodi Rogers, and Vicky Craig work together to make sure they address both medical and social needs of each individual to provide holistic care.

by word of mouth, most participants haven't heard anything circulating in the larger community.

Others found out about it through receiving a call from a Community Health Worker after having been in the Emergency Room. "They literally called me... and I'm glad they did, I didn't know a thing about it," said the participant. Another participant explained that when she spoke to friends about LiveWell, they did not know what she was talking about because they had not heard of it. The evaluation team also visited a gas station near one of the churches, and the employee did not know about LiveWell Kershaw or the services that were being offered next door to the gas station.

Satisfaction with Satellite Locations

Question: "So, can you tell me, what is it like receiving care from a nurse practitioner, like in a church?"

Answer: "It's wonderful, I mean, I don't care where it's at."

All participants indicated that they are very satisfied with the services that they receive at LiveWell satellite locations. When beginning services at the church satellites, none of the residents were attending the local churches. As a result of the satellites, one of the couples is now attending church where they also receive primary care from the LiveWell Kershaw team. One participant stated that she would rather come to the church instead

of a doctor's office because there is less wait time and she is able to spend more time with Vicky Craig, the Nurse Practitioner, without feeling rushed. In addition, the same participant noted that she doesn't like being in doctor's offices where she is more likely to pick up additional viruses due to her weakened immune system caused by a chronic condition.

While participants note that some in the community may not be comfortable coming to a church, participants themselves do not have any issues with the location of satellites or the hours of availability. The locations of the satellites were also mentioned as a positive. "I'm like five minutes away," said one participant. The participants appreciated not having to drive all the way to Camden to receive quality clinical care and care coordination services.

2) Appreciation of Services Provided

"They helped me so much… all of them, Doctor Vickie and everybody, is just as sweet and as good as they can be."

"(Vicky) spends a lot of time with you. Any other doctors, they don't spend much time on me."

All focus group participants feel that their futures are brighter now that they are receiving medical care and assistance with social needs. Previously, none of the participants were able to be seen by a medical provider unless they went to the Emergency Room or to Elgin Urgent Care because none have health insurance. All of the participants have at least one chronic condition. Participants also indicated appreciation for the help that Community Health Workers, Jodi Rogers and Rachael Sladek, have been able to provide in completing various applications and connecting them to much-needed resources. One participant discussed how available Rachael Sladek is when it comes to any questions she has, and how Rachael worked with her via email when she was without a phone for an extended period of time.

Recommendations from Participants

The focus groups were able to provide useful feedback. Participants believe that a lot of people in the community need the services but are simply unaware that LiveWell Kershaw exists. Many members in the community cannot afford to buy health insurance through the Marketplace and could benefit from using LiveWell Kershaw services. Ideas to increase awareness among community members included radio spots, flyers, the gas station in Cassatt, and a weekly newspaper. In addition, participants feel that using verbiage such as, "Have no insurance? Come here," on signs would be clearer than "LiveWell Kershaw." Participants recommended placing these signs throughout the community, and not near the churches. Another idea participants had was to target the parents of children who use the School Based Health Center to let them know that free health services exist for those that are uninsured.

Summary

The verbatim transcript and focus group summary was shared with the Care Coordination team. The team and leadership of LiveWell Kershaw will revisit the branding of LiveWell Kershaw and ways to optimize messaging.

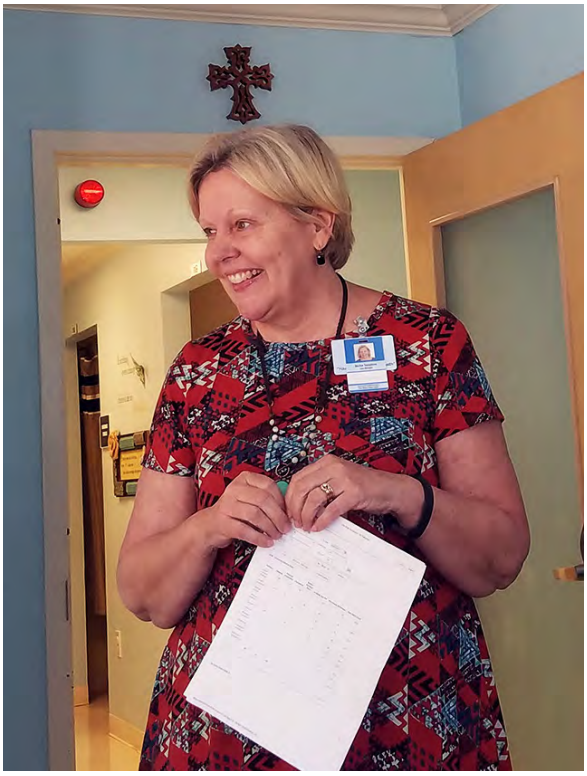
Hub and Pathway Training

Last quarter, the CMC made the decision to adopt a new care coordination software known as Community HUB and Pathway, produced by Care Coordination Systems, to help the LiveWell team capture, effectively treat and track the outcomes for the whole person and not just a list of symptoms. Traditionally, healthcare has relied on a reactionary system that delivers treatment in response to urgent needs and reimbursement based on service volume rather than value. The Pathways Community HUB Model helps reverse this trend by shifting the treatment emphasis to preventative care that contains costs rather than increasing expenditures.

After receiving three and a half days of training on HUB and Pathway from two experienced users from Ohio, the software went live on March 13th, 2017. Training on the software included a review of best practices for software utilization and covering the processes associated with using the software on a daily basis. This new case management software has

allowed the LiveWell team to continue to provide high-quality services to those in our community who need it the most, as well as efficiently track and report outcomes for medical, social, and economic determinants.

Phase one of the implementation included inserting patients into the system that had been seen by a team member in the last 3 years. As of today, there are active patients in the system and each of the patients have been assigned a care coordination team member. For a patient to be considered "complete," 80% or more of the patient's client profiles and clinical checklists needs to be completed. The team is focused on completing an initial adult checklist list and adult checklist for each patient, and will begin to complete other checklists in the coming months. The team has worked out a process and has determined that the adoption of the software has already proven to be a good investment. Rachael Sladek, Community Health Worker, noted that it "doesn't feel like it all has to be in my head anymore." Beckie Tompkins is finding the report features very helpful and tracking how many pathways are open and closed and determining ways to increase efficiencies. Yolanda Roary has found the initial checklist to be very helpful, and is now asking questions to patients that she had never asked before. The initial checklist includes the following categories: Client Information, General Health, and Safety and Emotional Health. She shared that for example, a diabetic may answer that their refrigerator is broken which then helps determine their root cause of uncontrolled diabetes and not being able to refrigerate their insulin. The team is also enjoying have having multiple charts for an individual person, but all of the information is one place, that various members of the care coordination team can access. The team's favorite feature is the "contacts" which allows care coordination members to set reminders and prompts with patients and themselves.



Care Coordination Team Manager Beckie Tompkins, is optimistic that the Community HUB software will allow for better tracking of patient outcomes.

Patient Navigator Yolanda Roary provides an overview of the Community HUB software to the Community Medical Clinic.

This is the first quarter that we have been able to systematically look at both outputs and outcomes for care coordination. During this quarter, there were 602 pathways open and 294 pathways closed. All other pathways are currently in progress.

In the follow-up since the initial training and go-live of the software, the Care Coordination Team Manager and the LiveWell Kershaw evaluation team have participated in several webinars hosted by the President of Care Coordination Systems, Bob Harnack. These webinars have been key to

identifying the needs of the group as well as how reporting information will be pulled out of the system in the future. Currently, the team has been able to use reporting features to determine what pathways are being opened and which ones have already been completed by the Care Coordination team.

The Community HUB software has already allowed LiveWell Kershaw to target patient outcomes in a meaningful way. The Community Medical Clinic is leading South Carolina in this software implementation - it is the first free clinic to adopt the software and the first organization in South Carolina to implement Community HUB and Pathways. Beckie Tompkins and Susan Witkowski spoke at a HOP webinar in May sharing their experiences with the software and encouraged other HOP partners to adopt the outcome-centered tool. Beckie and Susan plan to continue this dialogue and have agreed to assist with a state-wide adoption of the Hub and Pathway Model.

Cassatt Baptist Church, site of one of LiveWell's satellite sites.

Case Study

Stephanie is a 38-year-old mother of two who lives in Cassatt. Stephanie's journey with LiveWell Kershaw began in May 2016 with a visit to the Community Medical Clinic to see Community Health Worker, Rachael Sladek. Stephanie came in because she did not have a Primary Care Provider and usually visited Elgin Urgent Care for any medical issues, which is over 40 minutes from her home. Stephanie has several chronic conditions including Lupus. However, her main concern at this time was a lump in her breast.

"KershawHealth said that they would not do the mammogram because I have no income or health insurance," said Stephanie. Rachael was able to screen Stephanie that same day to determine if she was eligible to become a patient of the Community Medical Clinic.

Since then, Stephanie has been a part of the Best Chance program and is now eligible for a mammogram at no cost. To Stephanie's relief, it was determined that the lump in her breast was not cancerous. Other services utilized by Stephanie included visits with CMC's mental health counselor, Christie Derrick, and help completing social service applications for Welvista, SNAP, Medicaid, and KershawHealth Financial Assistance. Additionally, Stephanie was connected to the Mobile Food Pantry, through United Way, that visits Cassatt Baptist Church every third Tuesday each month.

Beginning in March 2017, Stephanie no longer had transportation to her appointments at CMC in Camden but realized that she could receive the same medical care and social service assistance at the Cassatt Baptist Church satellite location. "I love having a mobile clinic nearby. Cassatt Baptist Church is only about three miles from my home," says Stephanie. The only issue that Stephanie has had is that Christie, the counselor, is unable to see patients at satellite locations. Stephanie hopes that will change soon; she attributes her decreased anxiety levels to the biweekly appointments with Christie. "She really helped my anxiety issues because I had a person to help me talk through any issues I had," says Stephanie.

Community Health Worker Rachael Sladek has continually worked with Stephanie's paperwork and obtaining approvals for various benefits. In March 2017, Stephanie was denied SNAP benefits because she lives in her ex-husband's home with her two children and had to report his income although she receives none of it. Through collaboration with the rest of the LiveWell Kershaw team, Rachael was able to enlist the help of Jodi Rogers, another CHW for LiveWell Kershaw. Jodi reached out to a contact she has at SNAP to determine the protocol for obtaining a Fair Hearing for Stephanie to appeal her SNAP denial. This hearing is now pending as a result of Jodi's efforts.

Stephanie appreciates Rachael's efforts to think outside the box when it comes to removing barriers.

"If she [Community Health Worker] doesn't have the answer, she will find it. If I need help with something and she can't, she leads me in the right direction and helps me get in contact with someone who can," says Stephanie.

Before receiving help from LiveWell Kershaw, Stephanie had gone years without medical attention for her chronic conditions because she had no insurance and could not qualify for disability. Stephanie is now able to manage her Lupus through the medications she receives from Welvista and regular medical appointments with Vicky Craig, LiveWell's Nurse Practitioner.

Not only has Stephanie received the benefits of working with LiveWell Kershaw team members, her fiancé now receives medical care for his high cholesterol and triglycerides at Cassatt Baptist Church as well. Because of the care that both she and her fiancé have received, Stephanie believes that her future is much brighter.

Integrative Medicine Case Study

This case study highlights the integration between all parts of the LiveWell Kershaw team within the Community Medical Clinic, and how collaboration is used to care for the whole patient - not simply one component of their health. Involved in the care of Dottie, a 57 year old female, we find a Nurse Practitioner (Mary Lee Addis), a mental health counselor (Christie Derrick), and Patient Navigator (Yolanda Roary). Each team member plays a role in helping Dottie to restore her health to its status prior to a heart attack. While one team member addresses her physical health, another takes an in-depth look at her mental health, discovers that Dottie needs financial assistance, and refers her to another team member whom addresses that issue. The LiveWell team will continue to work with Dottie to help address any and all issues that impact her health.

Dottie is a 57-year-old, African American female who lives in Camden and has been a patient at the Community Medical Clinic of Kershaw County since 2012. This past January, Dottie suffered a heart attack and was hospitalized for four days.

When she met with Family Nurse Practitioner Mary Lee Addis on March 28, 2017, she was agitated and expressed anxiety over the medical bills she incurred from her heart attack and hospitalization. She also expressed sadness and worry over lost independence and a slow recovery. Mary Lee referred her immediately to the mental health counselor, Christie Derrick, who was able to see her right away.

Dottie talked to Christie about riding in the helicopter that transported her, recalling the noises of the hospital, and not being fully aware of what was happening to her during that time. Dottie spoke of her fears of having another heart attack, noting that her own mother had died of cardiac arrest six years prior.

Dottie also recalled the times she awoke in the middle
of the night to find her heart racing, feeling both alone and afraid. She also expressed concern about how she would be able to pay off medical bills incurred from this hospital visit while also taking care of her regular monthly expenses. Her cardiologist has not approved her to return to work at this time.

Christie explained to Dottie that she might benefit from weekly counseling sessions to learn relaxation exercises and work on a plan to help her recover from her heart attack. At this point, Christie explained that there was someone else who could help address her concerns about her bills. Christie asked if Dottie would allow her to call someone on the CMC team who could help with these medical expenses. Dottie didn't realize that this type of assistance was available. Before Dottie left the clinic Christie offered a prayer for Dottie's health and healing.

While Dottie was driven home by a friend Christie talked with Yolanda Roary, the Patient Navigator located at Access, and explained the situation. Once Dottie had made it back home, Yolanda gave her call and made her aware of how she could help alleviate the financial stress.

When Dottie experienced her heart attack, she was initially taken to KershawHealth and then later transferred to Providence Hospital in Columbia, SC. Yolanda contacted Providence to find out what assistance they could offer Dottie through patient assistance programs that cover hospital stays for low income patients. Upon investigation, Yolanda discovered that the billing department had been trying to contact Dottie and had been unsuccessful. Yolanda was able to provide the billing department with updated demographics for Dottie and requested that they make contact again, including mailing her an application for their patient assistance program.

When Yolanda spoke with Dottie, she was made aware that she would be receiving a call as well as the packet in the mail. Yolanda instructed her to complete the application and return it to Providence Hospital as soon as possible, to which Dottie agreed and was extremely appreciative. Yolanda also mailed Dottie a KershawHealth Charity application to complete in order to have her stay there covered as well.

When Dottie returned to the clinic the next week for her counseling session with mental health counselor Christie Derrick, she said, "a huge weight was lifted from my shoulders when I learned I could get help with my medical bills." Her tears were replaced with smiles. "I feel someone is in my corner," she explained. The team will continue to work with Dottie as long as she feels that needs assistance. However, Christie Derrick notes that Dottie may be close to discharge from mental health counseling because the stress of the financial burden is being alleviated. Each member of the team fully understands how stress can impact the mental health status of an individual. Moving forward, the team will continue to work with Dottie for as long as she needs assistance.

This transitional care patient is happy to have Community Health Worker, Jodi Rogers, sit in on her follow-up appointment at the Community Medical Clinic after being discharged from the hospital.

Transitional Care Updates

Since its implementation in June 2016, the Transitional Care program has cared for 48 individuals. The team has agreed that the transitional care program is meeting a need for the uninsured residents of Kershaw County and are transitioning from the testing phase to the implementation phase. The team has demonstrated that their model (see driver diagram from the past quarterly report) does in fact reduce the likelihood of patients being readmitted to the hospital. Implementation has included the following: creating a brochure to give to patients (see page 17), written policies and procedures and the development of a checklist to monitor the adherence to the policies and procedures every month. The team continues to have a close relationship with KershawHealth and is excited about making this program a permanent fixture at CMC.

Transitional Care Policies and Procedures

Brief Summary: Transitional care refers to the coordination and continuity of health care from one setting to another. The goal of this program is provide holistic care to result in reduced inappropriate Emergency Room visits and the avoidance of hospital readmissions, primarily within 30 days post-discharge from hospital.

A. **Eligibility for the Transitional Care Program**

1. Uninsured
2. Kershaw County resident
3. In-patient and outpatient observation at KershawHealth
4. Priority can be given to those individually referred with face sheet and cover sheet.
5. Patients who are re-admitted to the hospital are considered a new patient.
6. If the number of potential transitional care patients exceed capacity, priority will be given to the following conductions:

B. **Role of the Transitional Care Lead Community Care Coordinator (CCC)**

1. The Lead CCC rotates weekly and is posted on a calendar at the Wateree office.
2. If the Lead is on Paid Time Off (PTO), the Care Coordination Team Manager will assign a CCC to cover their position.
3. The Lead will review the admissions registrar twice daily (morning and afternoon) and also review the Emergency Room and Elgin Urgent Care list daily.
4. The Lead will visit the hospital daily if there are patients who meet the eligibility criteria are there. If there are no eligible patients, the lead will visit the hospital twice a week and communi cate with hospital case management staff.

At Bedside

a. The Lead will verify that the patient meets all eligibility requirements (with specific attention given to proof of residence).

b. The Lead will speak to the respective case managers at the hospital.

c. The Lead will introduce the Transitional Care Program to the patient and supply a Community Medical Clinic business card and brochure (See Appendix).

d. The main talking points include:

i. The transitional care program is designed for any resident in Kershaw County without insurance and is at absolutely no charge to you. This is a service provided by the Community Medical Clinic of Kershaw County.

ii. This program would allow you to have a personal coach to help coordinate your care, to keep you out of the hospital, once you are discharged.

iii. Based on your individualized needs, this may be a phone call or a face-to-face visit. We really personalize the care you receive based on your needs.

iv. We can help you with getting a primary care doctor, help manage all of your medicines, and help enroll you into any programs that may help you and your family as you recover.

v. If you are interested in participating, we need consent forms signed that will allow us to have access to your health records, so that we can provide the best quality care to you.

e. The Lead will determine the patient's willingness to participate.

i. The Lead will get the Release of Medical Records. The lead will also get phone numbers of key contacts (i.e. next of kin), if the patient cannot be reached.

ii.If no, the patient will be provided contact information, in the event that they need services in the future. Current promotional materials will be provided to the patient.

f. Once the patient signs consent forms, the CCC assesses and prioritizes the patient's needs and appropriate pathways.

At Wateree Office

a. The lead CCC will document the bedside visit within 48 business hours into the Pathways Care Coordination database.

b. The assigned CCC will follow-up with patient as soon as possible post discharge, but no later than two business days post discharge.

c. The assigned CCC will contact the patient by phone within two business days.

C. **Post-Discharge Care**

a. The patient enrolled into the program will receive services for 30 days from discharge. These services will occur by phone and/or face to face based on patient's individualized needs. The assigned CCC and the CMC Nurse Practitioner will determine if services are needed beyond the 30-day period.

b. The assigned CCC will contact the patient by phone within two business days post-discharge.

c. The CCC has the following consent forms signed: Authorization to use and disclose protected health information, Authorization for release of confidential information, USC form *(get name and copy),* and the Pathways Authorization to Use or Disclose Protected Health Information (see Appendix).

d. The assigned CCC will continue to monitor and assess for additional pathways (pathways are initiated by the lead CCC beginning at time of initial contact).

    i. The assigned CCC gives priority to the Medical Home pathway, and reviews primary care options with the patient, such as the Community Medical Clinic, Sandhills, or other options based on the patient's Federal Poverty Level.

    ii. Within seven days of post discharge, the assigned CCC meets with the patients and conducts a medication reconciliation.

    iii. Home visits will be based on the individualized need of the patient and will be executed at the discretion of the assigned CCC and Nurse Practitioner.

e. If the patient does not have a medical home and chooses CMC, the CCC will initiate that paperwork during the hospitalization, if possible. The CCC coordinates post hospital visit with the CHW who follows up to ensure the completion of the necessary paperwork, assists with scheduling the clinic appointment for the patient and attends the first post hospital clinic visit.

f. The CHW will attend all CMC patients' first appointment. The CHW is responsible for this on days where they are not at a satellite. The CHW prioritizes follow up visits with transitional care patients on non-satellite days. The attendance at all other appointments are determined at the discretion of the assigned CCC.

g. Once the patient is discharged, the assigned CCC will assess the patient for other appropriate programs to enroll for continuity of care. These programs can include but not be limited to: Healthy Outcomes Plan (HOP), Medicaid, case management, etc.

D. **Communication with the Care Coordination Team**

a. Discharge communication between the provider and the CCC is sent by secure Community Medical Clinic email.

b. The care coordination team will communicate regularly to ensure continuity of care and compliance with the plan of care.

c. Huddles occur with the entire team every other Tuesday of every month to discuss the status of active transitional care patients.

d. Appropriate documentation will be in the Pathways Care Coordination database. The lead CCC, assigned CCC, and CHW are all responsible for documenting all encounters, and pathway progress within 48 hours of patient encounter.

e. Documentation will follow the CCAT model.

    i. Confidential – signed consent, respectful of privacy

    ii. Complete – understood clearly, correct grammar

    iii. Accurate – never exaggerated, false or made-up, brief and concise, avoid run-on sentences

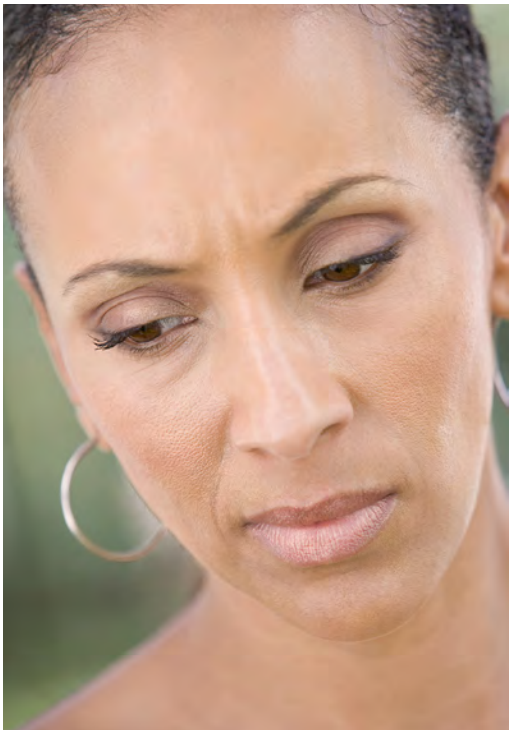
    iv. Timely – with 48 hours of contact

Transitional Care Case Study: Rhonda

Rhonda, a 46-year-old resident of Camden, has experienced several hardships over the past couple months. She has been dealing with the deaths of two of her close friends, which has taken a toll on her mental health and interpersonal relationships. In addition, she has recently become unemployed after an argument with a significant other that resulted in imprisonment. On top of this, her physical health has been impacted as well. Over the course of one week, Rhonda's world was turned upside down. One Friday morning in the shower, Rhonda noticed a cyst that had developed almost overnight. Because she was a member of the Community Medical Clinic, Rhonda scheduled an appointment to be seen the following Monday.

Rhonda was seen by Mary Lee Addis, a Nurse Practitioner at CMC who immediately referred her to Dr. Christenberry at KershawHealth Surgical Associates to assess the cyst, which was becoming an abscess. The abscess on her abdomen was determined to be staphylococcus aureus. These types of infections can turn deadly if the bacteria spreads deeper into the body and enters the bloodstream. Therefore, timeliness of treatment is very important. Because of the severity of the infection, Dr. Christenberry was unable to drain the abscess in his office and scheduled a surgery at KershawHealth. Rhonda has no health insurance so the thought of incurring additional medical debt was another stressor that affected her. However, this procedure was necessary for her health.

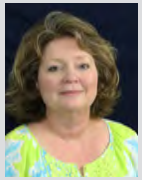
After surgery and in recovery, Rhonda was greeted by Community Care Coordinator Debbie Davis, who took time to explain the Transitional Care program and how she could benefit from its services. Rhonda described Debbie's presentation and interaction as "comfortable" and said that she felt at ease throughout the conversation. Rhonda was elated to have the opportunity to participate in this program and interact with individuals that could coordinate her medical care and assist with social determinant needs such as the medical bills that she would incur as a result of the surgical procedure and subsequent hospitalization.



"I was able to focus on the medical side of this," says Rhonda, "even a distant thought that there might be some help out there with the financial side…I was able to relax and be more at ease and focus in on feeling secure." Rhonda also saw Christie Derrick, the mental health counselor, for four sessions to process her thoughts and feelings and learn appropriate coping techniques.

Thus far, Rhonda has been able to receive help with completing KershawHealth Financial Assistance applications, medical education on the healing process of a wound, and assistance with receiving medications. At her follow-up appointment at the Community Medical Clinic, Rhonda met with Community Health Worker Jodi Rogers who sat in on her appointment with Mary Lee. Rhonda was happy to have another person on her care team to see her through this challenging time and assist her with recalling details from appointments. Dealing with personal, medical, and financial issues can be overwhelming for anyone. However, these issues in conjunction with loss of employment can hinder proper healing. The goal of transitional care is to provide the proper support and resources to lessen the stress associated with hospitalization. The team will continue to work with Rhonda as she recovers from surgery and regain control of her personal life and employment status.

Meet the Team



Vicky Craig,
MSN-Ed, FNP-C, FAANP

Mary Lee Addis,
FNP-BC

Jessica Wilkes,
FNP

Sheri Baytes,
RN

Debbie Davis,
RN, BSN

Brandi Thompson,
RN

Rachael Sladek,
Community Health Worker

Jodi Rodgers,
Community Health Worker

Yolanda Roary,
Patient Navigator

Beckie Tompkins,
Care Coordination Team Manager

Mission

We will lead a collaborative effort to provide the resources needed for improved health of the underserved, while always respecting the dignity, integrity, and the diversity of those we serve and who serve.

COMMUNITY MEDICAL CLINIC

Outreach. Access. Medical Home.

Transitional Care Program for the Uninsured of Kershaw County

COMMUNITY MEDICAL CLINIC

Outreach. Access. Medical Home.

What is Transitional Care?

Transitional Care is the coordination of your healthcare once you leave the hospital. The goal of our program is to provide complete care that may prevent you from being readmitted to the hospital.

You are eligible to participate in this program **at no cost** if…

- you are a Kershaw County resident
- you have no health insurance

AND

- you are hospitalized or placed under outpatient observation at KershawHealth.

What can I expect from the Transitional Care Team?

- A personal coach to help coordinate your medical care after you are discharged from the hospital
- Prevention of unnecessary hospital readmission through patient education
- Help with finding a Primary Care Provider
- Assistance in managing medications
- Possible enrollment in other assistance programs
- Regular contact with your assigned Community Care Coordinator

What do I need to enroll today?

A signed consent form allowing our team to access your health records.

Contact Information:

West Wateree Medical Complex
1165 Highway 1 South #300
Lugoff, SC 29078
Phone: (803) 408-0500

COMMUNITY MEDICAL CLINIC

Outreach. Access. Medical Home.

www.cmcofkc.org

School Based Healthcare Center

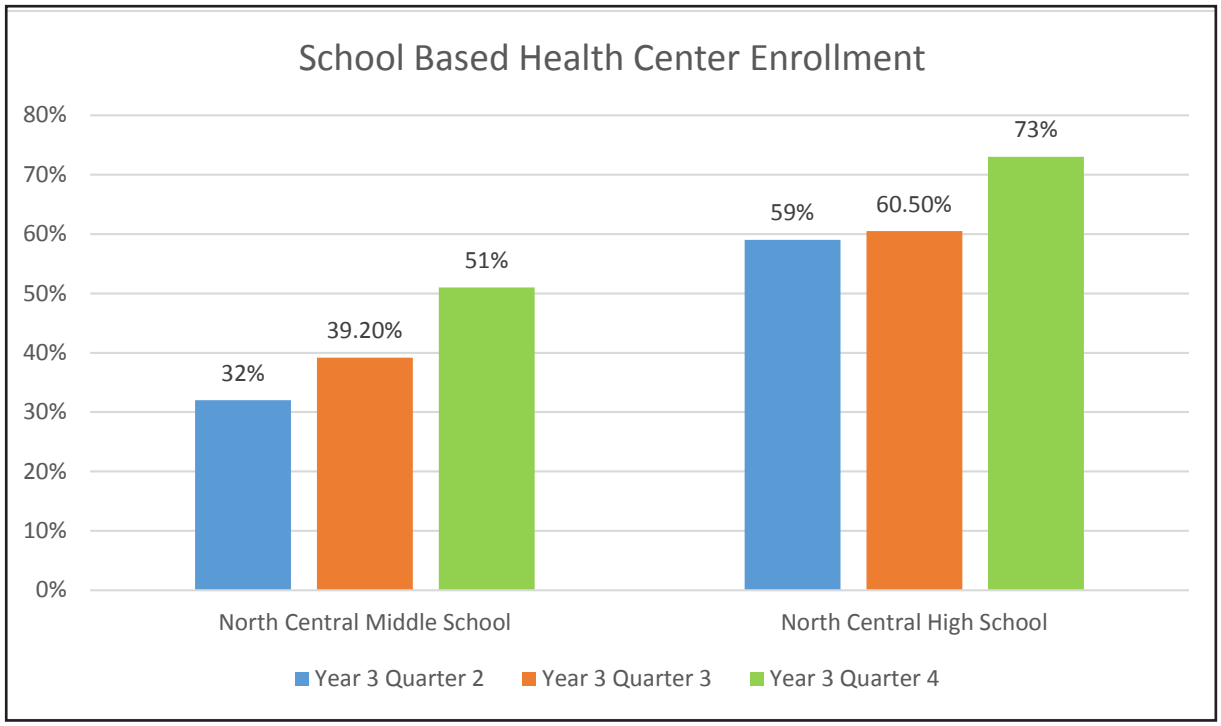
Enrollment Increases

Since its inception, the School Based Health Center (SBHC) has set goals for enrollment levels for North Central High School (NCHS) and North Central Middle School (NCMS). It was the LiveWell Kershaw team's desire to have 80% of NCHS and 50% of NCMS enrolled in SBHC services.

This quarter, the team reached their goal for NCMS with enrollment levels with 190 of 372 students (51% of the student population enrolled). The team is also quickly approaching their goal enrollment level for NCHS students with 311 out of 427 students (73% of the student population enrolled). Based on the school based health center advisory committee recommendation, the LiveWell Kershaw team attended the graduations of 5th graders at area elementary schools and other end-of-school-year awards ceremonies. Schools attended included: Mt. Pisgah Elementary, Bethune Elementary, Midway Elementary, and Baron Dekalb Elementary. The team is hoping to enroll as many soon to be 6th graders during this academic year.

(L to R) Chandi Patel, Alexandra Golden, and Cameron Massey provide mental health services to students enrolled in the School Based Health Center.

In addition, the school nurse, guidance counselors, administration and staff have been major players in encouraging students in the spring semester for the school based health services. Once a student is enrolled, they are eligible throughout their time at North Central Middle and High Schools.



Survey of NCMS and NCHS Staff

During the final two weeks of school, the LiveWell Kershaw evaluation team provided the staff of both NCMS and NCHS an opportunity to complete a survey to provide feedback that will guide the efforts and focus of the School Based Health Center in the upcoming 2017-2018 school year. Teachers and staff participated in the survey with 15 participants from NCHS and 22 from NCMS. Over 73% of participants from both schools identified as being a teacher, followed by coach (11%), counselor (8%), support staff (8%), and administrator (3%). Other respondents included a librarian, health room assistant, and an instructional assistant.

Participants were asked to rank their level of awareness regarding School Based Health Center services. The majority of respondents (49%) indicated that they were very aware of the services provided, followed by somewhat aware (38%), somewhat unaware (8%), and very unaware (5%). When asked if aware that the School Based Health Center is available to all students regardless of insurance status, an overwhelming majority (86%) of participants indicated that they knew this information, while 14% did not know that all students could use the SBHC at no cost.

Jodi Rogers, Community Health Worker, is thrilled to be a part of a program that is beneficial to students, parents, and school administration.

The survey also gathered staff perceptions related to why they believe parents may not be enrolling their children into the SBHC. The majority of respondents feel that parent apathy (41%) and not realizing that SBHC is for all students (41%) are the primary reasons why parents are not enrolling their children. Other reasons included: parents saying they already have a primary care provider, students failing to return paperwork, belief that services are not needed, and students having no guardian to complete the paperwork.

The SBHC currently operates from 8:00 am to 12:00 noon, Monday through Thursday. When asked whether or not the current hours of operation should be changed, 67% of respondents said no and 33% said yes. Survey participants were allowed an opportunity to provide additional comments to their answer. Comments recorded included adding Friday to the schedule, being available for additional hours, such as 8am-2pm or 7am-4pm. One teacher indicated that hours should be more accommodating for students' schedules as one student has missed 2-3 days of one class due to visiting the clinic, which has negatively impacted the student's class grade.

Staff were allowed to provide any specific examples of students that have benefitted from utilizing the SBHC. The following responses were recorded:

- The medical notes for absences are huge!! We often have students who lose credit when they were actually sick but guardians fail to take them to the doctor.
- I've had students come to my class feeling sick, and LiveWell was able to help right away. I've also had multiple students with issues at home who speak highly of the counselling services available.
- One of my students greatly benefits from mental health services. Her entire attitude is improved after service.
- Students are able to go during the school day to complete a free physical.
- When parents don't have the time or take the time to attend to health issues that students maybe having or complaining about.

(l. to r.) Carol Baker, RN; Vicky Craig, FNP; Mary Foster Cox, FNP; Teresa Alderson, MD; and Stephanie Burgess, PhD, APRN, BC, FAANP, pose for a photo inside the School Based Health Center and enjoy discussing the many beneficial aspects of providing medical services to students at school.

- I have two students that receive mental health service. It is a great service for them.
- They miss less school than normal doctor visits.
- I have students who would not have access to medical care without LiveWell! Even those who have Medicaid don't always have reliable transportation.
- Students who were sick and otherwise would not get to the doctor in a timely fashion were able to go to the doctor quickly. That decreased the time that they were out sick and decreased the amount of makeup work and missed classes.
- Been allowed to take a sports physical and be available to participate in try outs without having to schedule an appointment with a doctor and the scheduled appointment is after the tryouts deadline.
- Illness the nurse can't diagnose or test
- A number of sick students have used the service.
- Quick assistance and health service provider spoke with parent about physical concerns taking the burden off the school official.
- When the students are diagnosed and treated and not found to be contagious, they are able to stay in school vs. missing school for non-contagious illnesses and doctor appointments.
- Several students have had MRSA or staph infections that have been treated by LiveWell (antibiotics called in).
- Vaccinations, physicals, flu issues that could be addressed

Looking ahead to the next school year, the LiveWell Kershaw team is hoping to provide additional support to teachers and staff. If the SBHC mental health counselors were to conduct educational workshops with teachers, the majority of respondents would be interested in Addressing Student Apathy and Motivation (63%). Other workshops included Addressing Substance Abuse in Teens (49%), Addressing Student Depression (46%), Addressing Teacher Burnout (37%), Recognizing Signs of Suicidal Thoughts (37%), and Mental Health First Aid (37%).

When asked what additional services the SBHC should be providing to students, one respondent noted that there should be some sort of support or informational guidance for students who become parents during high school, as this was the case for multiple students this school year. Another idea was to have foster parents be automatically connected to this service when enrolling their foster child in school. Other ideas included the following:

- Help with hygiene issues
- Seeing teachers within the SBHC
- Promotion of healthy eating habits
- In-service with teachers

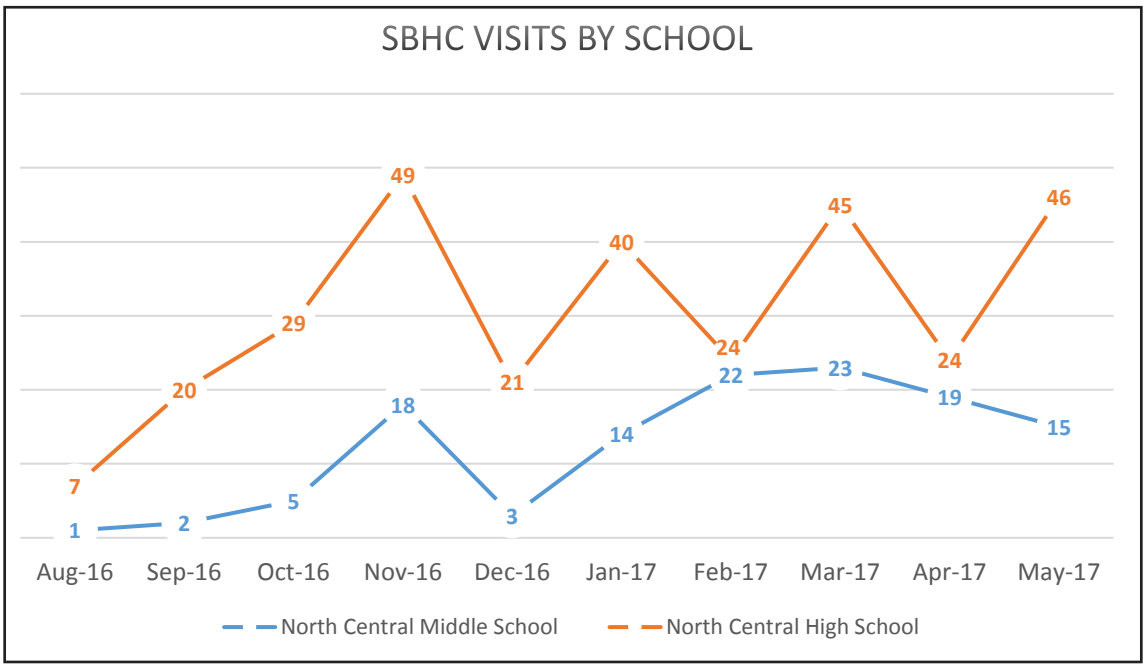
When asked for additional comments or ideas regarding the SBHC, the following responses were collected:

- I think the live well program if fabulous! All schools should have something like this available.
- Thank you for all you do for our kids!
- Your services have been such a wonderful addition!
- Students have been very positive regarding LiveWell.
- So happy to have them here!

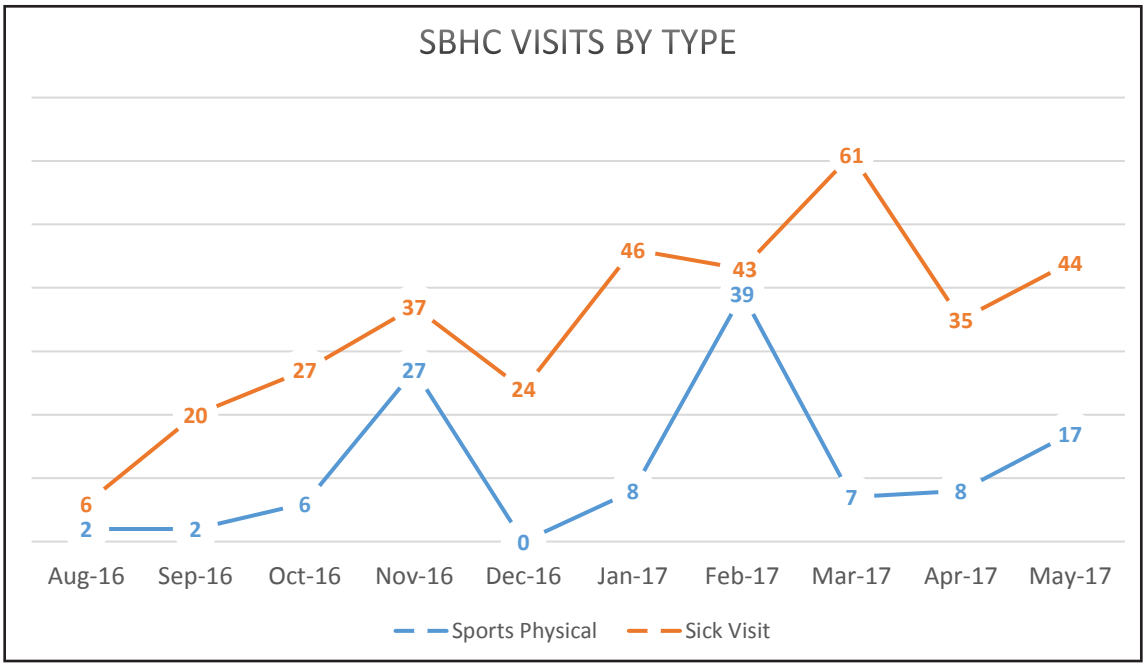
School Based Health Center Data

North Central Middle and High School continue to offer acute care services Monday – Thursday from 8:00 a.m. to noon. The mental team provides counseling services daily.

For Year 3 Quarter 4 (March through May), the SBHC saw 120 students total. The trend in higher student volume from NCHS compared to NCMS is attributed to the higher level of enrollment for NCHS which currently stands at 73% compared to NCMS at 51%.



The graph below displays the number of sick visits and sports physicals for the months August through February as a comparison over time. For Year 3 Quarter 4 (March 1, 2017- May 31, 2017), there were a total of 47 sports physicals completed and a total of 140 sick visits for a combined total of 172 visits.



Satisfaction Survey Results

North Central High School

For this quarter, 107 students seen at the SBHC completed the satisfaction survey. When asked to rate their visit with the Nurse Practitioner, 96.3% of students indicated that their visit was great and 3.74% said that their visit was okay. When asked if they would recommend the SBHC to another student or sick friend, 98.1% of respondents indicated that they would while 0.98% said they would not and 1.87% said that they didn't know if they would recommend the SBHC.

North Central High School

North Central Middle School

For this quarter, 53 students that visited the Nurse Practitioner at the SBHC completed the satisfaction survey. When asked to rate their visit with the Nurse Practitioner, 92.5% of students indicated that their visit was great and 7.6% of students said that their visit was okay. When asked if they would recommend the SBHC to another student or sick friend, 98.1% of respondents indicated that they would while 2.0% said that they do not know if they would recommend the SBHC.

Case Study: Katie

Katie, a junior at North Central High School, recently utilized the School Based Health Center after suffering a panic attack while taking a test at school. Common panic attack symptoms can include rapid breathing, irregular heartbeat, dizziness, sweating, and chills. Panic attacks can be very frightening; especially when you are not sure what exactly is happening to your body but knowing that you are not in control.

North Central Middle School

When Katie presented at the SBHC to be seen by Nurse Practitioner Vicky Craig, her blood pressure was 198/120 (normal blood pressure is considered to be 120/80). Vicky knew that next steps would include calling EMS to take Katie to the Emergency Room. When EMS arrived, Katie's blood pressure had already climbed to 240/120. It was under the care of Emergency Room providers that Katie was diagnosed as having a panic attack and released from the hospital. She was then referred to Cardiology, who after further assessment, diagnosed Katie with hypertension and cardiac issues. Katie is now being treated for these medical conditions.

When a seemingly healthy and active student has medical issues, such as a panic attack, it can be confusing for the student, their parents, and school administration. Katie, a cheerleader and active member of the student body at North Central High School, suffered a panic attack during the administration of a test. This incident demonstrates how stress can affect the body and also bring underlying health conditions to light. The SBHC and the quick reacting Vicky Craig were well equipped to deal with this situation. As a result, Katie is now being treated for her underlying health conditions, hypertension and cardiac problems. She is extremely grateful that her school has a school based health center.

School-Based Health Center Advisory Committee Meeting

Vicky Craig led the SBHC advisory council meeting on April 18th. Five representatives from the middle and high school participated including a high school senior.

SBHC Update – NCHS and NCMS

Vicky Craig, Satellite Operations Director and Nurse Practitioner for the SBHC, gave a powerpoint presentation on the progress the SBHC has made over the past academic year at both the middle and high schools. Ms. Craig shared data from August 2016 to present including number of SBHC visits by school and by type, registration numbers and also the results of the satisfaction surveys and reasons for school absences. Cameron Massey, Wellness Coach, shared that the capacity for mental health has doubled this academic year compared to last year, with the USC team able to serve 40-45 students.

Discussion and Feedback from Advisory Members about Presentation

Lori Pate shared that she was very pleased with the 88% satisfaction among middle schoolers that have used the SBHC. According to Pate, the middle school population tends to be more pessimistic. Pate noted that "I'm super happy about everything and the services being provided at the middle school."

Rose Montgomery noted that the number of flu cases has been significantly lower this year and attributes this to the SBHC. Thanks to the SBHC, students who do come to school sick are being sent straight there and not to class, exposing other students. She said it's been wonderful that students can get care for sore throats without their parents having to drive them all the way to Camden and take a day off of work.

Advisory members discussed how they were surprised that the number of excused absences were not higher among those who used the SBHC. Some of the advisory members recommended that the LiveWell Kershaw team examine the demographics, and socio-economic factors between those who are

Vicky Craig shares data with the LWK leadership team at a joint Board & Staff meeting.

registered and not registered for the SBHC. The team also believes that some of the students who are now engaged in the SBHC are also staying engaged with a primary care provider, possibly compared to a year ago when they may have not.

Student Hannah Sal shared that she did not think she qualified for the SBHC, and that it was only for those who did not have insurance or were on Medicaid. Her father, who is an employee of the school, assured both her and her mother that the SBHC was for all students. Hannah has since used the SBHC services and has been very pleased. Angie Bowers mentioned that there is still confusion about who is eligible to receive SBHC services. As a member of the advisory committee and the PTO, she was under the impression that the SBHC was only for the uninsured. She believes that there may be confusion since the church satellites, also known as LiveWell Kershaw, only see adults without insurance and limited income. She also thought that parents would have to make a claim and file information.

The Advisory group recommends more marketing and advertising. Ms. Pate believes that targeting the 5th graders, who will attend NCMS next year, at the four elementary schools would be very beneficial. She emphasized that an individual letter that was not part of the middle school packet, which can be overwhelming to some, would be best. The team also recommended that the teachers need a reminder of LiveWell Kershaw's services, re-emphasizing that it is for all students. Jill White was overjoyed that the SBHC is able to provide physicals to students at no charge. She said: "Y'all are priceless. Physicals are a nightmare if you can't get to the doctor or have

to wait for your mother to get paid and you have an eligibility deadline to meet." She described that participation in sports has increased at both the middle and high schools.

Rose Montgomery would like LiveWell Kershaw to incorporate teachers and staff for both acute care and mental health services. There is a shortage of substitute teachers and often teachers remain in school even when they are sick. Rose shared that she believed teachers would be fine to bill their private insurance for these services.

Hannah Sal shared that she believes that brochures are not helpful. She wonders if an assembly with all of the students, teachers, and administrators would be helpful. She noted that it would be great to share a presentation similar to the presentation to the Advisory group today with real data and stories. The team also shared that there is a new athletic director and the four home games will be probably be very well attended. The 5th quarter event is usually only attended by students, and not a place to target parents. The fall festivals at the elementary school are also well attended.

Vicky Craig adjourned the meeting and will be sharing any data with the team via email over the summer months.

Mental Health Updates

Over the past quarter, the mental health team at the School Based Health Center has provided 20 students, 16 high schoolers and 4 middle schoolers, with a total of 83 clinical hours of mental health services, including two hours of crisis response and a mix of individual and parent contact hours.

Case Study: Tim's Story

Tim is a 14-year-old freshman at North Central High School (NCHS) referred to the LiveWell School-Based Health Center (SBHC) towards the end of the academic year. His referral to the mental health services of the SBHC came following a district hearing Tim had regarding threatening comments made towards other students. The assistant principal at NCHS was notified about several journal entries that included violent and angry content, written by Tim earlier in the school year. Another student

had found these journal entries, which led to a confrontation between Tim and the student.

The assistant principal was required to bring Tim before a disciplinary board; however, she suspected that Tim was experiencing some emotional disturbances beyond just anger and believed the mental health team could help assess what was going on. Upon assessment, it was revealed that Tim's home life was chaotic and stressful, fueling his negative mood and angry feelings. Adding to his emotional turmoil, Tim had recently experienced some unhealthy interpersonal relationships which exacerbated his depression and hostility. The journal entries were a method for Tim to cope with some of these feelings and never intended for others to see, so when another student found them Tim was obviously upset and confronted the student, leading to the district's disciplinary action.

The SBHC counselor was able use the information obtained during the initial assessment to work with school personnel to help everyone understand that Tim's anger was a result of extreme negative events at home rather than a result of maliciousness on his part. Counseling sessions began immediately to help Tim find short-term behavioral solutions that he can use to help keep himself safe while in the school setting, such as avoiding students who might serve as triggers for his anger, identifying "safe" authority figures such as teachers and principals he can go to when he is feeling upset, and choosing actions that will de-escalate situations rather than escalate them. Since the referral came so late in the year, the SBHC counselor also helped Tim identify other community resources that might be of service during the summer, with the expectation that services would continue through the LiveWell SBHC in the fall.

Community Outreach

The Community Medical Clinic team participated or presented at 23 community events this quarter. Types of events included a variety of settings and audiences in order to engage as many individuals as possible (see timeline on page 29 of community events). Through these outreach efforts, LiveWell Kershaw has become a recognizable name for some in the northeastern part of the county.

This quarter, the Care Coordination Team tested a new model for care coordination. The team's goal is to visit at least one business near each of the church satellites once a month in an effort to increase awareness of the LiveWell Kershaw program. This should help achieve the desired result of increasing the number of satellite site visits from residents of the area.

The CHWs were able to visit businesses and set up a table at lunch time in Bethune (1st Friday), Westville (2nd Friday), Cassatt (3rd Friday) and Boonetown (4th Friday) this month. The team believed that the first round of visits were successful and recognized that a lot of residents in the area had not heard of LiveWell Kershaw before, and wanted to know, 1) Who are you? and 2.) Do you take donations? So far no participants have visited the church satellites as a result of the local business outreach. The team is planning to conduct another round of visiting a business each Friday in the month of June.

Community Health Worker Rachael Sladek hits the town of Behtune to speak with community members about the services that LiveWell Kershaw can provide.

Jodi Rogers, Community Health Worker, is hitting the road in the LiveWell Kershaw van to do outreach in the North Central area.

Volunteer Appreciation Event & Restructuring of the Volunteer Program

On April 20th, 2017, the Community Medical Clinic took time to acknowledge the hard work and dedication of the volunteers that keep the clinic and other locations operating on a day-to-day basis. This year's Annual Volunteer Appreciation event started off with a time for about 50 volunteers and staff to mingle and take part in light refreshments while reminiscing on years past. The program began with board chair Tim Hudson opening with a prayer. Susan Witkowski then led those in attendance through a poem dedicated to the volunteers that have passed away during the year and presented their family members with a single white rose. The ceremony ended with an invitation to visit CMC's volunteer memorial garden. Volunteers enjoyed musical selections provided by We Three and discussed the changes that CMC has seen throughout the years. Staff took advantage of this time to show their appreciation for all that volunteers provide to the clinic, such as their time and dedication to serving the uninsured and underserved of Kershaw County.

Gloria Watts (c.) poses for a photo with Beckie Tompkins (l.) and Kitty Beard (r.). She has volunteered at the front desk for three years but has also worked as a patient screener. "Everyone is very appreciative of the work we do," says Watts, "but a lot of people still don't know about the clinic. I was able to connect a person to the clinic the other day through conversation out in the community."

Staff and members of CMC's Board fully recognize that fulfilling the mission of the Community Medical Clinic would be impossible without the support of volunteers.

As a result of volunteer surveys on the strengths, weaknesses, opportunities and threats (completed on January 20, 2017) and discussions with several of the volunteers, the CEO determined that the volunteer program needed to be restructured. Cultivating relationships with volunteers is critical to growing a volunteer program that experiences rapid change. The CMC is still undergoing changes based on the expansion of church satellites and services, which creates a lot of activity with new partners, individuals and schedules.

During this quarter, three volunteers were recruited and are expected to be scheduled to work in triage within the next month. In an effort to better serve the volunteers and to strengthen the program, Susan Didato now serves as a volunteer recruiter and an administrative assistant helps with scheduling and clerical duties. In the next two months, CMC leadership will create a list of one year

Kitty Beard is the 2nd oldest volunteer at the clinic and has been a nurse volunteer for CMC for 19 years.

Dr. Larry Parrott

Dr. Larry Parrott has been a volunteer at the clinic for 15 years. "It is very satisfying to help people that cannot get help anywhere else," he says. Dr. Parrott worked with the state-sponsored Best Chance program that provides much needed Cervical and Breast Cancer screening to women ages 30-64.

Dr. Parrott believes that CMC should continue getting the word out about services to the community through events such as the Annual Clinic Classic race that will bring out lots of individuals. While Dr. Parrott does not do clinical work anymore, he still has an active teaching role at CMC as he presents a case study for Nurse Practitioner students once a year.

accomplishments for the volunteer program that will meet the needs of an expanding organization.

Teacher Appreciation Events for North Central High School and North Central Middle School

On Monday, May 1st, and Wednesday, May 3rd, the LiveWell Kershaw team hosted a Teacher Appreciation event at both North Central Middle School and North Central High School. On these days, the team provided a catered lunch for the teachers of both schools to show their appreciation for all that teachers do, as well as increase teacher awareness of the School Based Health Center and services that it offers students.

At both schools, the LiveWell Kershaw Team provided lunch to 65-75 teachers. Teachers commented that LiveWell Kershaw "has been a big help" and they didn't want any of the services to end. Administrators commented that the "team does a great job and couldn't imagine what they would do without them in the schools." It was evident from both appreciation events that Vicky Craig, Nurse Practitioner, and Carol Baker, Medical Assistant, along with Cameron Massey, Alex Golden and Chandi Patel (USC Department of Community Psychology) are very well respected within the school, and have become integrated with administration, teachers, staff and students.

Both events were considered a success as teachers and school staff were able to mingle with members of the LiveWell Kershaw team, who provided information on the services available to all students at no cost. The team is committed to expanding school-based health center registration at both schools.

Staff at North Central High School take part in Teacher Appreciation Day hosted by the LiveWell Kershaw team.

Principal of North Central Middle School, Lori Pate shows her thanks for the "fiesta-themed" meal provided by the LiveWell Kershaw team.

L to R)- Jodi Rogers, Gail Horton, and Rachael Sladek are thankful for the partnership between North Central Middle School and LiveWell Kershaw

Students and staff of West Wateree enjoy the last day of the experience together.

Doctors Without Borders Visit

For two weeks, college students from New York were hosted by the staff of the Community Medical Clinic in an effort to expose the students to various areas of the medical field. The students were also able to see first-hand what it is like to practice medicine within the rural areas of Kershaw County. Not only were the students able to help out around the clinic, but they were able to shadow Nurse Practitioner Vicky Craig, the Community Health Workers, and the Community Care Coordinators.

The students described their time in Kershaw County as, "impactful," and appreciated the kindness and generosity of the community. The students also noted the close, personal relationships that the staff are able to create with patients and also "go above and beyond" in treating the whole person, not just medical needs.

As a result of this experience, the students have committed to treating patients as people and not simply a customer, as well as considering the social and economic aspects of patient's lives, instead of simply looking at medical issues as a separate piece. These future medical students described a free clinic as "hope" and "a second chance" for those that have been failed by a system.

Timeline of Community Events			
DATE	**STAFF**	**DESCRIPTION**	**OUTCOME**
3/7/2017	Rachael	Mt. Pisgah Community Caring Fair	125 attended including children approximately and at least 50 people took information about services
3/15/2017	Jodi, Sheri, Debbie, Susan W, Mary, Vicky, Carol	Cassatt Food for Thought	55 people attended and Dr. Neinhaus conducted diabetes education and had informational hand-outs for those interested.
3/21/2017	Susan W	Kershaw Health Transition Care Team	15 KH employees to discuss the process for transitional care patients
3/23/2017	Susan W	SCFCA Legislative Breakfast	200 Legislatures and staff. Awareness of free clinics in SC
3/24/2017	Rachael and Jodi	North Central Outreach	Meeting with New Athletic director and Head Football Coach Drakeford, continued on to Hwy 1 Cafe in Cassatt and interacted with about 30 people in regards to the Livewell Kershaw program. Left informational materials at register. Interacted and took photo with Staff of Bethune Discount store and the Meat Market and some Bethune Residents and left green informational cards at register.
4/18/2017	Susan W and Susan D	KC Chamber of Commerce	Presented to 35 Board of Visitors. Awareness of CMC and improving population health
4/19/2017	Rachael, Jodi, Beckie	Buffalo Food for Thought	Approximately 40 people attended the program. Dinner was provided and Summer Rigby, Vocational Rehabilitation Supervisor spoke about the services available through that agency.
4/20/2017	Yolanda, Rachael, Beckie, Vicky, Carol, Sheri, Debbie, Brandi,	Volunteer Appreciation	Event at Community Medical Clinic with approximately 50 people in attendance.
4/21/2017	Rachael and Jodi	Buffalo Outreach-903 Grill	Spoke with approximately 15-20 people. Some not from area and only passing through for work.
4/29/2017	Susan W	Clinic Classic 5K run/walk	400 participants
5/1/2017	Jodi, Rachael, Beckie, Vicky, Carol	NCMS Teacher Appreciation Lunch	Recognition of teachers and other staff at NCMS. Lunch was prepared for 65 staff.
5/3/2017	Jodi, Rachael, Beckie, Vicky, Carol, Cameron, and Chandi	NCHS Teacher Appreciation Lunch	Recognition of teachers and other staff at NCHS. Lunch was prepared for 75 staff.
5/5/2017	Rachael and Jodi	Bethune Outreach-Winner's Circle	Talked with 53 People who took informational materials. Six declined materials.
5/5/2017	Rachael and Jodi	Bethune Outreach-Dollar General	Spoke with 14 people. Seven took information and seven declined.
5/12/2017	Rachael and Jodi	Westville Outreach-Russell's BBQ	Spoke with about 15 people and handed out materials to eight.
5/12/2017	Rachael and Jodi	Westville Outreach-Solo's Gas Station	Spoke with 27 people who all took information except one.
5/19/2017	Rachael	Cassatt Outreach-Hw 1 Cafe	Spoke to about ten people and gave out informational materials to six.
5/22/2017	Rachael	Mt. Pisgah Elementary Awards/Graduation	Enrolled 13 Students in the SBHC gave applications to three parents who said they would return. Handed out LiveWell Kershaw info to ten people.

Timeline of Community Events			
DATE	**STAFF**	**DESCRIPTION**	**OUTCOME**
5/23/2017	Rachael	BethuneElementary Awards/ Graduation	There were about 75 people in attendance. Got 5 completed applications out of 10 students had 4 parents who stated they had it at home from NCMS Folder and would fill it out and return to NCMS. Had 1 parent who will return application to me and also the 2 older siblings' applications.
5/24/2017	Beckie	Midway Elementary 5th grade graduation	LWK table set up. Approximately 350 people in attendance. Attempt to enroll rising 6th graders @ SBHC. Enrolled 10 new students for next school year
5/25/2017	Rachael and Jodi	Baron Dekalb Elementary Graduation	2 Applications completed. Table set up location was not good. Parents were focused on the students and pictures and leaving. Did not have refreshments afterward like other schools, finished graduation and they left.
5/25/2017	Susan W and Beckie	Webinar Hub and Pathway	100 participants. Presented lessons learned from Hub and Pathway
5/26/2017	Rachael and Jodi	North Central/Refuge Outreach-Rabbits/ Jimmy's Store	Spoke with about 30 people; 25 took information

Community Health Workers, Jodi Rogers and Rachael Sladek, pose for a quick selfie before passing out LiveWell Keshaw materials to those stopping by Rabbitt's gas station.

LiveWell KERSHAW
"Your Bridge to Better Health"

Newsletter

March 2017

PO Box 217 Camden, SC 29021
803.272.8325

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An initiative led by the Community Medical Clinic of Kershaw County

NEW SATELLITE HOURS AND LOCATIONS

This month we are adding a new satellite healthcare location in Bethune and new hours to our existing locations (see info below). Most satellites will be open 1:30 pm - 5:30 pm.

Our nurse practitioner provides many primary care services available in a doctor's office such as diagnostics, treatment and prescriptions -many at no cost. Community Health Workers (CHWs) are also available to assist with insurance applications, Medicare, Medicaid, and SNAP benefits; they also help with managing diabetes, high blood pressure, and overall health. Call 803.408.0500 to make an appointment at a location near you.

Be on the lookout for LiveWell on the road! Every other Friday our van will be out in the community sharing information about our services and sites. Check Facebook and Twitter for dates and times.

LiveWell Satellite Healthcare Sites	
Day/Time	**Location**
Monday - Thursday 8 am - 6 pm	Community Medical Clinic of Kershaw County 110 C East DeKalb St Camden 29020
Monday 1:30 pm - 5:30 pm	Cassatt Baptist Church 2604 HWY 1 North Cassatt 29032
1st Tuesdays 9 am – noon* 3rd Tuesdays 1:30 - 5:30 pm *Community health worker only	DeKalb Baptist Church 2034 DeKalb School Rd. Camden 29020
2nd & 4th Tuesdays 1:30 pm - 5:30 pm	Bethune City Hall 101 Elm St. Bethune 29009
Wednesday 1:30 pm - 5:30 pm	Refuge Baptist Church 2814 Lockhart Rd Kershaw 29067
Thursday 1:30 pm - 5:30 pm	Buffalo Baptist Church 6390 Lockhart Rd Kershaw 29067
Access	
Mon - Fri 8:30 am - 5:00 pm	West Wateree Medical Complex 1165 Highway 1 South Suite 300 Lugoff 29078

FOOD FOR THOUGHT UPCOMING DATES

April 19 at 5:15 pm
Buffalo Baptist (6390 Lockhart Rd)

Are you looking for new ideas for healthy living? Then join us for our monthly Food for Thought meetings. Come hear our guest speakers share great information about healthy living and the services available in your community. A complimentary, healthy dinner will be provided. There is absolutely NO CHARGE to attend!

Food for Thought rotates monthly among the North Central satellites. If you would like to arrange a presentation for your community, please contact us at (803) 272-8325. We will be glad to arrange a helpful presentation for you and other community members. *Food for Thought events are hosted by the Community Medical Clinic of Kershaw County.*

SCHOOL BASED HEALTHCARE CENTER

The School Based Health Center (SBHC) continues to be a beacon in the North Central area with increasing enrollment numbers weekly. Currently at North Central High School, 60.5% of all students are enrolled in the SBHC as well as 39.2% of North Central Middle School students.

Historically, the SBHC has mainly seen students for sports physicals and acute injuries. However, a trend toward serving sick patients is growing. School administrators, faculty, students and parents all have embraced this hybrid form of care. Through consistent education, parents will often bring their children to the SBHC to prevent sending them into the classroom and possibly infecting others.

The SBHC team believes the faculty played a vital role in managing and preventing an outbreak of influenza as well by following the protocols that address such contagious illnesses.

HOW TO IMPROVE YOUR SLEEP

Try these tips for getting to bed easier and sleeping through the night:

Routine. Go to bed and wake up at the same time everyday including weekends, days off and holidays.

Bright light. Get outside and soak up the sunlight. Bright, natural light will help you sleep better. Bright light also helps tell the brain when to stay awake.

Darkness. Darkness tells the brain when to go to sleep. If your bedroom is not completely dark then use black-out curtains or a thick blanket over the windows to completely darken the room. Turn your bright digital clock so it faces away from your bed.

Tired. It is important for your body and mind to be tired and relaxed in order to get good sleep. Avoid major exercise at least three hours before bedtime because it overstimulates your body and makes it harder to sleep.

Relaxation. Ease your mind and body into sleep by spending some time relaxing for about two hours before bedtime. Taking a warm shower or bath, reading something pleasant, praying or some other quiet activity are all good ways to relax before turning off the lights.

Unplug. Scientists have found the light from computers, cell phones and TV screens affect our sleep cycle. Avoid using any electronics at least two hours before bedtime.

Naps. Try to avoid naps during the day. If you must nap do it for no longer than 30 minutes.

Temperature. Most people sleep best when the room temperature is between 65-67 degrees. Wear socks if your feet get cold. Warm feet and hands help you drift off to sleep.

Light snack. Graham crackers, a small glass of milk, pudding, yogurt or a slice of toast will prevent you from waking up hungry. Avoid foods that are heavy, greasy, spicy or hard to digest.

Liquids. Limit your intake of any liquids like water, herbal tea or juice at least two hours prior to going to bed.

Caffeine. Avoid caffeine about six hours before bedtime, alcohol for about four hours, and never smoke.

White noise. Some people cannot go to sleep when it's too quiet. If you are one of those people use a fan, a water fountain or soft, relaxing music. Do not sleep with a television on!

Counseling. If you continue to sleep poorly consider seeing a nurse practitioner or counselor to talk about what's keeping you awake.

Bethune satellite promo flyer

LiveWell KERSHAW

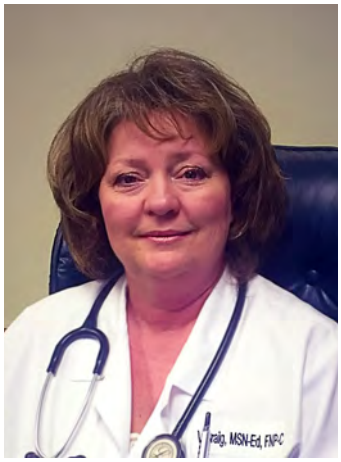
"Your Bridge to Better Health"

Our newest Satellite Healthcare Site is now open in Bethune.

Are you uninsured? Need help with medications? Are you diabetic or have high blood pressure? Do you need to connect with a healthcare provider?

Our newest Satellite Healthcare Site is now open in Bethune (101 Elm St.). **Hours are 1:30 - 5:30 pm on the second and fourth Tuesday of the month.**

Vicky Craig, our nurse practitioner, provides many of the same primary care services available in a doctor's office or clinic, such as diagnosing and treating illnesses and writing prescriptions. **Many are available at little or no cost.**



Vicky Craig, Family Nurse Practitioner

When you qualify to become a patient you do not pay anything for office visits at our locations. We can connect you with a doctor and help you apply for programs such as Medicaid, Welvista and SNAP (Food Stamps).

Call our healthcare navigator at 803.408.0500 if you have any questions or concerns, including how to pay for your medications or applying for SNAP (Food Stamps) or Medicaid.

This program is limited to Kershaw County residents only. Please see the back of this flyer for information about additional locations.

An initiative led by the Community Medical Clinic of Kershaw County

P.O. Box 217 Camden, SC 29021 ph. 803.272.8325

www.livewellkershaw.org

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