Improving Patient Outcomes

The Bureau of Community Health and Chronic Disease Prevention developed the following list of programs that are available to support health improvement.

Contact CHIinfo@dhec.sc.gov for more information.

DHEC
PROMOTE PROTECT PROSPER
South Carolina Department of Health and Environmental Control

CR-011607 6/16

Division of Healthy Aging

Michele James, MSW
jamesmd@dhec.sc.gov
(803) 898-0760

The Arthritis Foundation Exercise Program (AFEP):

Community-based group exercise program for people suffering from arthritis. A trained leader chooses from 72 different exercises performed while participants are seated, standing, or lying on the floor—exercises can be modified to fit the abilities of participants. Classes may be time limited or ongoing.

Stanford Chronic Disease Self-Management Program (CDSMP):

CDSMP Better Choices, Better Health helps individuals with chronic diseases gain confidence and skills to better manage their health. Participants attend 2.5-hour sessions held once a week for six weeks in community settings. Workshops are conducted by two trained leaders, one of whom has a chronic health condition.

Walk With Ease (WWE):

Teaches participants how to safely make physical activity a part of their everyday life. WWE is a six-week program that can be done as a group or alone. This program can easily be implemented in a community or work setting and even though it is designed for pain management among arthritis sufferers, people without arthritis can also benefit.

Division of Cancer Prevention and Control

Stephanie Hinton, CPM, MHS, MA
hintonsd@dhec.sc.gov
(803) 898-1602

Best Chance Network (BCN) Breast and Cervical Cancer Early Detection Program:

Provides free breast and cervical cancer screening to women in South Carolina who are 40-64 years old, have no health insurance or have hospitalization coverage only, and have an income at or below 200 percent of the federal poverty level. The screening includes a clinical breast exam, mammogram, pelvic exam, Pap test and HPV test. BCN also provides public and professional education, surveillance, quality assurance and patient navigation for diagnostic follow-up and treatment. If a woman screened through BCN needs treatment for breast or cervical cancer, she may be eligible to apply for Medicaid.

Visit www.scdhec.gov/bcn for more information.

Linda Pekuri, MPH, RD, LD
pekurilm@dhec.sc.gov
(803) 898-1614

South Carolina's WISEWOMAN (Well-Integrated Screening and Evaluation for Women Across the Nation):

A cardiovascular disease prevention program for women participating in the Best Chance Network Breast & Cervical Cancer Early Detection Program, only at health care centers where WISEWOMAN is provided.

Participating women receive:

- Screenings for cardiovascular disease risk (blood pressure, lipids, glucose, body mass index and personal health assessment/medical history)
- Risk-reduction counseling
- Medical evaluation and referral for abnormal findings
- Linkages to free or low-cost medication resources
- Referrals to community resources that support healthy behaviors
- Opportunities to participate in health coaching or lifestyle programs

Office of Minority Health

Jacqlyn Atkins, MPH, CHES
baylisjr@dhec.sc.gov
(803) 898-1597

OMHgeneral@dhec.sc.gov

Cultural Competency Training:

Ideas people have about health, the languages they use, the health literacy skills they have, and the contexts in which they communicate about health reflect their cultures. Organizations can increase communication effectiveness when they recognize and bridge cultural differences that might contribute to miscommunication.

Doctors, nurses and other public health and health care workers belong to professional cultures with their own languages that often aren't the everyday language of the people they serve. When these professionals want to share information, their jargon might be confusing to people with limited literacy and cultural differences. To help improve this situation, the Office of Minority Health will begin offering cultural competency training by request in the spring of 2016. The training contains the following components:

- Increase knowledge of cultural competence principles and applications
- Introduce tools and techniques to assist in the development of basic cultural competence skills
- Demonstrate how basic cultural competence concepts and principles can be used on a daily basis
- Demonstrate the connection between cultural competence and the elimination of health disparities
- Improve the quality of services and health outcomes

Culturally and Linguistically Appropriate Services (CLAS Standards) Implementation:

The Office of Minority Health offers technical assistance on CLAS Standards implementation to external organizations and entities upon request. CLAS Standards improve quality of care and services because they help your staff:

- Become more knowledgeable about how changes in our population (more people from one race or another) can cause changes in your patient population (more patients from different cultural backgrounds).
- Work to lessen the differences among certain groups of people in terms of chronic disease. African Americans are more likely to die from complications from diabetes that other races, for example.
- Improve primary care outcomes.
- Comply with state and federal laws while meeting various regulations and accreditation mandates.

(Associated HRSA Standards: Standards 1, 8, and 18 Associated PCMH Standards: PCMH Standard 2: Team-Based Care, Element C-Culturally and Linguistically Appropriate Services, PCMH Standard 3: Population Health Management Element, A-Patient Information Element C-Comprehensive Health Assessment)

Division of Diabetes, Heart Disease, Obesity and School Health

Rhonda Hill, PhD, MCHES
hillrl@dhec.sc.gov
(803) 898-1643

Diabetes Self-Management Education/Training Program (DSME/T):

DSME/T teaches people with diabetes how to change everyday behaviors and successfully manage the disease and its related conditions on their own. The program is evidence-based and considers the needs, goals and life experiences of the person with diabetes. Seven specific self-care behaviors guide the process of DSME/T and help patients achieve behavior change:

1. Healthy eating
2. Being active
3. Monitoring
4. Taking medication
5. Problem solving
6. Healthy coping
7. Reducing risks

This public health program area is currently working with Federally Qualified Health Centers (FQHCs) and medical practices that have chosen diabetes as a significant chronic condition when seeking Patient Centered Medical Home (PCMH) recognition. The goal is to make it easier for health care staff to access diabetes self-management education and support services and to improve quality outcomes.

(PCMH Quality Improvement Standards: 2D, 3B, 3C, 3D, 3E, 4A, 4B, 4C, 5B, 6A, 6C and 6D.)

Michelle Moody, MPH, CHES
moodyrm@dhec.sc.gov
(803) 898-1636

Measure, Act, and Partner (M.A.P.):

This portion of the Toolkit can improve patient outcomes while working towards achieving Patient Centered Medical Home (PCMH) recognition, as well as help your practice achieve Meaningful Use of your EHR. Meaningful Use sets specific objectives that eligible professionals and hospitals must achieve to qualify for Centers for Medicare & Medicaid Services (CMS) Incentive Programs.

(PCMH Quality Improvement Standard 4: Self-Care Support, B. Provide Referrals to Community Resources.)

National Diabetes Prevention Program (National DPP):

The National DPP emphasizes healthy eating and becoming more physically active, as well as problem solving, stress reduction, and coping skills for people with Type 2 diabetes. The National DPP has been proven to cut the risk of developing Type 2 diabetes by 58 percent.

Participants meet as a group with a trained lifestyle coach:

- 60 minutes once/week for 16 weeks
- Followed by a maintenance routine of 60 minutes once/month for 15 weeks

Prevent Diabetes STAT Screen/Test/Act Today™ Toolkit:

Created by the American Medical Association (AMA) and the Centers for Disease Control and Prevention (CDC) to identify eligible patients with pre-diabetes and refer them to in-person or online National Diabetes Prevention Programs. The Prevent Diabetes STAT Toolkit includes:

- Risk tests to help you explain pre-diabetes and the National DPP
- Patient flow diagrams, algorithms and referral templates to make it easy to identify and counsel patients at risk
- A description of the National DPP to share with other health care providers.

Division of Diabetes, Heart Disease, Obesity and School Health (cont.)

Kay Lowder, MPH, CHES
lowderk@dhec.sc.gov
(803) 898-1644

Hypertension Management Initiative:

Provides support for evidence-based management of hypertension using a team-based care approach. The partnership is available to FQHCs and medical practices that selected hypertension as a chronic condition while working toward achieving Patient Centered Medical Home (PCMH) recognition.

(PCMH Quality Improvement Standards: 2D, 3B, 3E, 4A, 4B, 4E and 5B.)

The Hypertension Management Initiative improves outcomes for patients through:

- Adoption of evidence-based hypertension management guidelines
- Team-based care approach
- Patient blood pressure self-monitoring
- EHR Modification

Tina Marie Devlin, MPH, CHES
devlintm@dhec.sc.gov
(803) 898-7867

South Carolina Prevention and Health Across Systems and Environments (SC PHASE):

Provides health system interventions and community-clinical linkage strategies to support heart disease, stroke and diabetes prevention efforts. This partnership is available to medical practices that selected hypertension and pre-diabetes as chronic conditions; those seeking PCMH designation.

SC PHASE improves outcomes for patients through:

- EHR adoption and enhancements
- Engagement of non-physician team members in hypertension management
- Patient blood pressure self-monitoring
- Engagement of community health workers (CHW's) for adults with high blood pressure, pre-diabetes and those at high risk of Type 2 diabetes
- Implementing systems to facilitate bi-directional referrals between health systems and community resources

Office of Professional and Community Nutrition Services

Ashley Nitzkorski, RD, LD
raasch@dhec.sc.gov
(803) 898-1629

Cooking Matters:

Community partners serving low-income families offer six-week Cooking Matters courses taught by a volunteer chef and nutrition educator. The course covers meal preparation, grocery shopping, food budgeting and nutrition. Adult and teen participants take home a bag of groceries at the end of each class. **Cooking Matters is offered in Bamberg, Calhoun, Florence, Lexington, Orangeburg, Richland and Sumter counties with plans for expansion.**

- *Cooking Matters for Parents* teaches low-income adults with children how to prepare and shop sensibly for healthy meals on a limited budget.
- *Cooking Matters for Families* teaches school-age children (ages 0 to 5) and their parents about healthy eating as a family and the importance of working together to plan and prepare healthy meals on a budget.
- *Cooking Matters for Kids* engages children ages 8 to 12 in learning about healthy eating and provides simple nutritious recipes that children can prepare themselves.
- *Cooking Matters for Adults* teaches low-income adults how to shop sensibly for and prepare healthy meals on a limited budget.

Brooke Brittian, MS, RD, LD, CHES
brittaba@dhec.sc.gov
(803) 898-0918

SNAP-Ed Program:

Improves the likelihood families will make healthy food choices within a limited budget and choose physically active lifestyles consistent with the current USDA Dietary Guidelines for Americans and MyPlate Food Guidance System. The target populations are SNAP recipients or income-eligible potential SNAP recipients.

It's Your Health . . . Take Charge:

Nutrition and healthy lifestyles education are customized to the audience and delivered in community-based settings such as elementary schools, Head Start Programs, faith-based organizations, parks and recreation programs, after-school programs and senior centers. SNAP-Ed programs are provided in Bamberg, Calhoun, Darlington, Dorchester, Fairfield, Florence, Kershaw, Lexington, Lee, Marion, Orangeburg, Richland and Sumter counties.

Division of Tobacco Prevention and Control

Katy L. Wynne, EdD, MSW
wynnekl@dhec.sc.gov
(803) 545-4464

Tobacco Cessation/SC Tobacco Quitline:

- Free CME provider training at www.helppatientsquitsc.org
- Provider tools/free materials order form at www.scdhec.gov/quitforkeeps/helpyourpatientsquit

SC Tobacco Quitline Prenatal Program:

- Free technical assistance on helping pregnant/postpartum patients quit smoking and improve birth outcomes in South Carolina

  (PCMH Quality Improvement Standards 3 & 4)

SC Tobacco Quitline eReferral Program:

- Free technical assistance on making electronic referrals (e-Referrals) to the Quitline
- Provider training at www.scquitline.org
- CME Meaningful Use training explains how to use certified electronic health record (EHR) technology to improve the quality, safety and efficiency of clinical practice and reduce health disparities