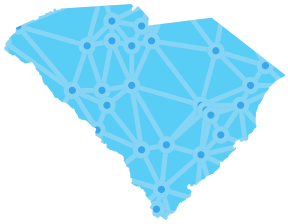

CONNECTIONS FOR
A DIABETES-FREE SC

Table Discussions

2024 DFSC Annual Meeting

November 15, 2024

diabetes*free* SC

Table Discussions Documentation and Summary

2024 Diabetes Free SC Annual Meeting

Diabetes Free SC (DFSC) held its fourth annual meeting Nov. 15, 2024. More than 150 registered attendees represented organizations from all regions of the state with a focus on diabetes prevention, management and/or care. Using this opportunity to collect input related to addressing barriers and potential solutions centered around the topics presented at the meeting, attendees at each of the 20 tables recorded responses to 10 prompts.

DFSC collected and transcribed raw, handwritten responses to each prompt. These responses were then summarized and organized into themes for ease of comprehension.

The resulting executive summary report is intended to share the input of this collective of professionals from diverse areas of the healthcare, public health and community sectors to address the issues of disparity of care and potential solutions to effectively aligning actions and resources in tackling diabetes in South Carolina.

This report is for informational purposes only and includes subjective responses of those who shared their perspectives based on related areas of work and life experiences.

Appendix:

List of represented organizations
Methodology of report creation

Executive Summary

The 2024 DFSC Annual Meeting gathered more than 150 attendees from various organizations across South Carolina to discuss diabetes prevention, management and care. The discussions were organized around 10 key questions, with responses summarized into recurring themes. Cross-cutting key points included trust, communication, community engagement and education.

Question 1: Public Health Workers as Community Conduits

- Building Trust and Relationships
- Effective Communication
- Community Engagement and Outreach
- Structured Support and Resources

Question 2: Enhancing Connections Across Programs

- Building Trust and Empowerment:
- Effective Communication and Collaboration
- Resource Coordination and Mapping
- Community Engagement and Involvement
- Training and Capacity Building
- Unified Goals and Accountability

Question 3: Combating Misinformation

- Trusted Messengers and Community Engagement
- Effective Communication Strategies
- Data-Driven Actions and Resource Coordination
- Training and Development

Question 4: Influence of Spiritual Beliefs on Health and Behavior

- Interconnected Health
- Community and Cultural Impact
- Role of Spiritual Leaders

Question 5: Strategies To Reduce Health Disparities

- Healthy Food and Nutrition Programs
- Physical Activity and Lifestyle Programs
- Community Engagement and Support
- Funding and Resource Allocation
- Data and Disparity Documentation

Question 6: Collaboration to Improve Health Outcomes

- Needs Assessments and Resource Mapping
- Communication and Collaboration
- Utilization of Community Health Workers (CHWs)
- Education and Empowerment
- Infrastructure and Technology
- Policy and Advocacy
- Community Engagement and Support

Question 7: Multidisciplinary Care Teams

- Patient-Centered Approach
- Coordinated Care
- One-Stop Shop Model
- Education and Support

Question 8: Role of Community Health Workers

- Integration and Utilization
- Role and Impact
- Education and Awareness
- Financial Support and Sustainability
- Building Trust and Relationships
- Promoting Health Literacy and Advocacy

Question 9: Maximizing Team Skills

- Role Definition and Efficiency
- Communication and Education
- Empowerment and Autonomy
- Strategic Organization
- Professional Development and Incentives

Question 10: Barriers to Preventing Diabetes Complications

- Access to Care
- Socioeconomic and Education Barriers
- Systemic and Policy Issues
- Community and Environmental Factors
- Trust and Communication
- Organizational and Structural Barriers

DFSC Annual Meeting Table Discussions

Question 1

How can public health workers, or Department of Public Health (DPH) staff, serve as a conduit allowing community members to let us know of their needs, priorities and concerns, while conveying what we can provide or refer people to other resources to meet their needs?

Building Trust and Relationships

- Ensure community members can speak to trusted representatives.
- Establish and build trust and relationships beyond phone calls.
- Identify and engage with unexpected community leaders.

Effective Communication

- Assess and improve communication comprehension.
- Communicate with purpose and clarity.
- Encourage DPH staff to ask relevant questions.

Community Engagement and Outreach

- Provide more opportunities for people to speak freely.
- Develop a deeper understanding of community members.
- Engage directly with the community.
- Form coalitions with public health workers and local partners; develop action plans.

Structured Support and Resources

- Create a community engagement team with CHWs, assigning 1 – 2 counties per person, and market the team to build connections.
- Conduct thorough community and individual assessments; listen beyond the numbers.
- Create and share tailored resource guides in various formats.
- Identify and integrate into safe spaces like clinics.
- Provide funding to community organizations for their work.

Question 2

Some may raise concerns about duplicating efforts, but how do we intentionally overlap to enhance connections across programs and initiatives that touch the same populations?

Building Trust and Empowerment

- Build trust and referrals.
- Empower community members while providing guidance.
- Listen to communities and stakeholders.

Effective Communication and Collaboration

- Foster collaboration and power sharing.
- Enhance communication and data sharing.
- Create a unified voice across the state.
- Share experiences and support each other.
- Communicate effectively about current programs and agencies.

Resource Coordination and Mapping

- Use resource mapping across the state to connect resources.
- Create a required registry of resources to coordinate efforts.
- Rely on DPH as the central point for information coordination.
- Develop a streamlined process for data points along the continuum of care.
- Build interoperability for data sharing with a systematic approach.

Community Engagement and Involvement

- Increase community engagement and set up relationships.
- Align community-based organizations through meetings and conversations.
- Invite outside perspectives and be open to accountability and adjustments.
- Leverage existing networks of stakeholders for multiple resource options.

Training and Capacity Building

- Provide training and empower community members.
- Learn from other programs and share knowledge.
- Invest time and money before program implementation.

Strategic Overlap and Coordination

- Work around turf/territory issues and accommodate capacity.
- Encourage intentional overlap to enhance connections.
- Use existing health coalitions to convene community meetings.
- Tailor information based on income level and access.

Unified Goals and Accountability

- Unify outcomes and develop common goals to maximize resources.
- Focus on results-based accountability.
- Define intended outcomes and priorities for community health.
- Identify community differences and involve community and content experts.

Conferences and Networking

- Participate in conferences such as DFSC Annual Meeting, SC Thrive, Live Healthy SC, Diabetes Initiative of South Carolina Annual Symposium and the Rural Health Conference.
- Meet with different professions to share insights and strategies.

Question 3

Misinformation and disinformation can be very harmful to people's health. How can we best get credible information into the hands of those who need it? How do we connect data, especially about disparities, with feasible actions that address issues and improve health outcomes?

Trusted Messengers and Community Engagement

- **Utilize Trusted Community Members**: Engage barbers, hairstylists, faith-based connections, and other trusted figures to deliver credible information.
- **Recruit and Train CHWs**: Focus on volunteers and CHWs who are already active in the community, ensuring they are well trained to share accurate information.
- **Develop Open Communication Channels**: Allow communities to form their own groups and facilitate open dialogue.
- **Engage Directly With the Community**: Use food box distributions and other direct services to connect with community members.

Effective Communication Strategies

- **Leverage Social Media**: Use platforms to post evidence-based data and correct misinformation.
- **Tailor Messages**: Customize communication to specific audiences, considering literacy levels and cultural relevance.
- **Create Targeted Groups**: Form small groups with specific focuses to ensure messages are relatable and impactful.
- **Use Facts To Correct Misinformation**: Present factual information clearly to dispel myths and falsehoods.

Data-Driven Actions and Resource Coordination

- **Gather and Analyze Data**: Collect data on specific populations to identify disparities and address them effectively.
- **Implement and Adjust Plans**: Develop and modify plans based on ongoing evaluations and community needs.
- **Coordinate Resources**: Use resource mapping and create a registry to streamline efforts and avoid duplication.
- **Target Geographic Areas**: Focus on areas identified through data to improve health outcomes.
- **Develop Value-Based Plans**: Create plans that are measurable and outcome-focused to ensure they meet community needs.

Training and Development

- **Invest in Training**: Provide continuous training for community members and volunteers to ensure they can effectively share health information.
- **Educate Key Community Figures**: Train influential community members to deliver health messages accurately.

Building Relationships and Trust

- **Build Trust With Community Members**: Establish strong relationships with community members and stakeholders.
- **Engage in Community Hearings**: Hold meetings to understand and address the specific needs of different communities.

Conferences and Networking

- **Participate in Conferences**: Attend events to share strategies and insights, enhancing overall communication efforts.
- **Leverage Existing Networks**: Use established networks of stakeholders to strengthen connections across programs.

Unified Goals and Accountability

- **Unify Outcomes**: Develop common goals to maximize resources and ensure all efforts are aligned.
- **Maintain Accountability**: Be open to feedback and adjust plans as necessary to improve effectiveness.

Question 4

How might our spiritual beliefs shape or influence our economic choices and behaviors? In what ways have you seen this play out in personal or community experiences?

Influence of Spiritual Beliefs on Health and Behavior

- **Interconnected Health**: Spiritual, mental and physical health are interwoven and influence each other.
- **Health as a Priority**: Beliefs such as "the body is a temple" can lead to positive health behaviors and outcomes.
- **Faith and Health Status**: There is a correlation between faith and health status.
- **Level of Care**: Spiritual beliefs may influence the levels of care individuals are willing to receive.
- **Expressiveness**: Spiritual beliefs can affect how individuals express themselves in different situations, including their acceptance of certain treatments (e.g., opposing PrEP and condoms for HIV prevention).
- **Humility and Learning:** Humility fosters continuous learning and is necessary to be open to change.

Community and Cultural Impact

- **Community Service**: A high value on health can enhance community.
- **Cultural Priorities**: Culture, influenced by spiritual beliefs, shapes priorities.
- **Environmental Influence**: Poor environments can negatively impact spiritual well-being.

Role of Spiritual Leaders

- **Trust and Empowerment**: Spiritual leaders are trusted figures who can integrate health screenings and interventions into their spiritual guidance.

Question 5

What are some practical strategies we can implement to address and reduce health disparities for those at higher risk of diabetes? What approaches have you seen make a difference in your community?

Healthy Food and Nutrition Programs

- **Healthy Food Programs**: Implement programs that provide access to nutritious foods.
- **Culinary Nutrition Interventions**: Offer cooking classes and healthy recipe guides.
- **Grocery Store Tours**: Educate community members on making healthy choices while shopping.
- **Eating Healthy on a Budget**: Provide tips and programs at neighborhood grocery stores.

Physical Activity and Lifestyle Programs

- **Culturally Tailored Physical Activity Programs**: Develop exercise programs that cater to various cultural preferences.
- **Implementing Health-Promoting Practices in Schools**: Encourage healthy habits from a young age.

Community Engagement and Support

- **Community Health Worker (CHW) Programs**: Use CHWs to provide localized support and education.
  - Establish community-based hubs that can expand outward.
  - Leverage existing resources, like libraries, to house these hubs.
- **Faith-Based Community Engagement**: Leverage faith-based communities to spread health information and support.
- **Tailored Interventions**: Develop strategies based on the specific needs and cultural contexts of the community.
- **Engage Key Community Figures**: Involve trusted community members in spreading health information.

Funding and Resource Allocation

- **Funding Mechanisms**: Secure funding to drive these models and ensure sustainability.
- **Leveraging Existing Resources**: Use existing community resources to support health initiatives.

Data and Disparity Documentation

- **Documenting Disparities**: Start documenting health disparities to identify community needs (e.g., MUSC Health's initiatives).

Education and Empowerment

- **Knowledge and Empowerment**: Provide education to empower patients to take control of their health.
- **Teaching Behavior Change**: Focus on behavior change education to promote long-term health improvements.

Collaboration and Partnerships

- **Closing the Loop**: Partner with other organizations to ensure comprehensive care and support.
- **Upstream Approach**: Focus on preventive measures, especially targeting children and future generations.

Question 6

What ideas do you have for how the healthcare system and community programs could collaborate to improve health outcomes for people with diabetes?

Needs Assessments and Resource Mapping

- **Engage in Needs Assessments**: Healthcare organizations and community-based organizations (CBOs) should conduct needs assessments and resource mapping to create a comprehensive web of services for people with diabetes.
- **Formal Resource Maps**: Develop formal resource maps to help coordinated care teams know what systems they can tie into, such as schools, faith-based organizations and aging populations.

Communication and Collaboration

- **Shared Messaging**: Ensure a consistent message across healthcare systems and community programs to reinforce key information.
- **Frequent Meetings**: Increase the frequency of meetings between healthcare systems and community programs to foster collaboration.
- **Community Advisory Boards**: Establish community advisory boards to provide input and guidance on health initiatives.

Utilization of Community Health Workers (CHWs

- **Hire and Train CHWs**: Employ CHWs to lighten the load of providers and connect patients to resources.
- **Integrate CHWs into Clinical Teams**: Bring CHWs into clinical care teams to assist with transportation, patient contact and communication with healthcare teams.
- **Financial Investment in CHWs**: Ensure financial support for CHWs to sustain their roles.

Education and Empowerment

- **Provider Education**: Improve education for providers about available programs and resources to support patients.
- **Community Education**: Educate the community on healthy eating, grocery shopping, nutrition and the impact of diet on medication effectiveness.
- **Diabetes Self-Management**: Empower patients with diabetes self-management education without requiring physical referrals.

Infrastructure and Technology

- **Enhanced EMR Communication**: Improve electronic medical record (EMR) systems to facilitate easy referrals and communication between providers and community programs.

- **Utilize Software Programs**: Use available software programs like HabitNu and patient messaging systems, like CareMessage, to support patient management.
- **Device Management Support**: Provide support for continuous glucose monitors (CGMs) that are affordable and offer professional assessments.

Policy and Advocacy

- **Policy Change**: Advocate for policy changes to improve access to food, health care and other resources.
- **Financial Support for CBOs**: Address the issue of CBOs offering services but not being able to bill by providing financial support from health care systems.

Community Engagement and Support

- **Community Events and Groups**: Organize community events and support groups to build connections and educate people about diabetes management.
- **Family and Faith-Based Models**: Engage family-based and faith-based models for community involvement and support.
- **Collaborative Efforts**: Foster collaborative efforts such as health fairs and learning sessions to share information and resources.

Accessibility and Outreach

- **Meet People Where They Are**: Make clinicians more accessible by having them present in smaller communities and supporting smaller clinics.
- **Bring Services to the Community**: Health care systems should bring services to where the population is, ensuring that care is accessible.

Quality and Follow-Up

- **Focus on Quality**: Ensure follow-up with referrals to close the loop and maintain high-quality care.
- **One-Stop Shopping**: Implement team-based care models to reduce the number of office visits and streamline patient care.

Building Relationships and Trust

- **Relationship Building**: Build relationships with communities to understand their needs and improve trust.
- **Collaborate with Existing Organizations**: Partner with existing organizations that have established relationships within the community to enhance outreach and support.

Question 7

Would you like to be seen by a multidisciplinary care team for your complex health needs? In your mind, what would a team-based care appointment look like?

General Consensus

- **Unanimous Agreement**: All respondents agreed that they would like to be seen by a multidisciplinary care team for complex health needs.

Key Components of an Ideal Team-Based Care Appointment

Multidisciplinary Team

- **Primary Care Provider (PCP)**: Conduct blood tests and general health assessments.
- **Dental Care**: Conduct regular cleanings and procedures.
- **Gynecological Care**: Conduct screenings, especially for conditions such as PCOS.
- **Case Manager for Women's Health**: Coordinate care specific to women's health needs.
- **Providers**: Include doctors, nurses and specialists.
- **CHWs/Social Workers (SWs)**: Provide support and connect patients to resources.
- **Pharmacist**: Manage medications and provide education.
- **Mental Health Provider**: Address psychological aspects of diabetes care.
- **Dietitian**: Offer nutritional guidance.
- **Vision Care**: Conduct regular eye exams.
- **Pediatric Care**: For younger patients.
- **Referral Specialist**: Coordinate external referrals.

Patient-Centered Approach

- Set clear expectations for patients on how to optimize their appointments.
- Offer telehealth or virtual meetings to save time and prioritize in-person care when necessary.
- Conduct onboarding with CHWs or nonclinical providers to review surveys and resource utilization.

Coordinated Care

- Round on patients collectively, including providers, pharmacists, nurses, dietitians, SWs and behavior specialists.
- Ensure all providers have access to comprehensive patient information through health information exchange.
- Conduct warm handoffs to outside referrals to ensure continuity of care.
- Emphasize mental health and social work components.
- Include spiritual care as part of the holistic approach.

One-Stop Shop Model

- Provide all necessary services in one location to reduce transportation and time burdens.
- Coordinate with transportation services to assist patients.
- Include a pharmacy in-house or nearby.
- Offer childcare services to help patients focus on their appointments.
- Incorporate benefits enrollment assistance (e.g., SC Thrive).

Education and Support

- Provide initial education at the time of diabetes diagnosis, involving pharmacists and family members.
- Conduct group education sessions on managing blood sugar, healthy eating and the impact of diet on medication effectiveness.
- Use community events and resources to support ongoing education and engagement.

Streamlined Workflow

- Optimize workflows within provider offices to prevent fragmented care.
- Ensure longer visits are efficient and comprehensive, reducing the need for multiple appointments.
- Improve communication between team members to enhance care coordination.

Community Integration

- Send coordinated teams into the community to address travel and transportation constraints.
- Build relationships with community programs and resources to support patients holistically.

Policy and System Support

- Advocate for policy changes to improve access to care and resources.
- Develop a unified care plan and patient resources platform.
- Ensure EMRs are capable of facilitating easy referrals and communication.

Benefits of Team-Based Care

- Provides comprehensive, patient-centered care that includes physical, mental, and social health aspects
- Improves communication and coordination among health care providers
- Addresses transportation and financial barriers
- Reduces the need for multiple appointments, saving time and resources

Question 8

Do you view CHWs as a potential bridge between the clinical care team and the patients' lived experience (community, faith-based organizations, etc.)?

General Consensus

- **Unanimous Agreement**: All respondents (18) agreed that CHWs are a potential bridge between clinical care teams and patients' lived experiences.

Integration and Utilization

- **Understanding Integration**: Organizations are interested in learning how to integrate CHWs into their systems.
- **Working With CHWs**: There is a need to understand how to collaborate effectively with CHWs.

Role and Impact of CHWs

- **Addressing Social Determinants of Health (SDOH)**: CHWs can tackle the 80% of health determinants that are nonmedical.
- **Translating Community Needs**: CHWs can translate and communicate the needs of the community to health care providers.
- **Connecting to Resources**: CHWs can introduce various programs and connect people to the right resources.
- **Consistency in the Community**: CHWs should be consistently present in the community and understand the specifics of each population type.

Education and Awareness

- **Educating CHWs**: CHWs need to be educated about the resources available from agencies to increase referrals and program connections.
- **Finding and Accessing CHWs**: Organizations need guidance on how to find and access CHWs.

Financial Support and Sustainability

- **Medicare and Medicaid Payments**: Medicare has started to pay for CHWs, but Medicaid payments are relatively low.
- **Expanding the Workforce**: There is a need to pay and expand the CHW workforce to infuse them into various sectors, such as education and faith-based organizations.

Building Trust and Relationships

- **Fostering Trust**: CHWs can build trust for referrals and connections to resources.
- **Removing Barriers**: CHWs help remove barriers to information, follow-up questions, cultural norms and situational stress.

Promoting Health Literacy and Advocacy

- **Health Literacy**: CHWs promote health literacy and facilitate access to nonmedical services.
- **Patient Advocacy**: CHWs advocate for patients, helping them understand and navigate the health care system.

Challenges and Opportunities

- **Confusion About Roles**: There is still some confusion about the roles of CHWs, SWs and other similar positions.
- **Training and Clarity**: Adequate training and clarity on roles are needed to incorporate CHWs effectively.
- **Communities of Non-English Speakers**: CHWs are especially valuable in these communities.

Mainstream Adoption

- **Mainstream Concept**: The concept of CHWs as a bridge needs to become more mainstream.
- **Community-Based Model**: It may be more effective for CHWs to be community-based, allowing them to reach multiple clinical settings rather than being confined to one.

Question 9

How do we ensure that all members of the team work to the top of their skills to effectively prevent diabetes and its complications?

Role Definition and Efficiency

- **Define Roles**: Clearly define roles and write out skill sets.
- **Maximize Scope of Practice**: Ensure team members work to the top of their skill sets for efficiency.
- **Tiered Approach**: Implement a tiered approach to roles.
- **Identify Educators**: Identify diabetes educators in the area and offer education and training to team members (e.g., Certified Diabetes Educators).

Communication and Education

- **Stay Updated**: Ensure team members stay current with new information.
- **Clear Communication**: Maintain clear and effective communication.
- **Advocacy**: Advocate for patients and connect them to proper care resources.
- **Continuing Education**: Promote ongoing education and training for all team members.

Empowerment and Autonomy

- **Empower Team Members**: Allow team members to operate within the full scope of their positions.
- **Mindset**: Foster a mindset that preventing diabetes is everyone's job.
- **Autonomy**: Encourage autonomy and ability to offer nontraditional help, such as providing rides or addressing indirect health needs (e.g., refrigeration for medications, car tires).

Strategic Organization

- **Right Team Members**: Ensure the right people are on the team.
- **Shared Vision**: Develop a shared work plan and vision to ensure everyone follows the same road map.
- **Regular Meetings**: Hold regular, recurring meetings to maintain alignment and address issues.

Patient-Centered Approach

- **Check-Ins**: Have team leads regularly check in with team members and patients.
- **Group Formation**: Allow time for forming cohesive groups, both personally and professionally.
- **Patient Comfort**: Consider patients' comfort levels, especially when multiple providers are involved in one clinic room.

Professional Development and Incentives

- **Encourage Development**: Promote professional development opportunities.
- **Team-Based Incentives**: Offer incentives for team-based approaches and team awards to recognize leaders.
- **Supportive Environment**: Create an environment where individuals feel supported, work well together, and have fun.

Recognition and Support

- **Recognize Good Work**: Acknowledge and encourage good work.
- **Share Responsibilities**: Break up responsibilities to share the load and prevent burnout.
- **Cross-Training**: Implement cross-training to enhance team flexibility.
- **Fair Compensation**: Ensure fair compensation and living wages for all staff, not just providers.
- **Fair Work Distribution**: Distribute work fairly among team members.
- **Culture of Respect**: Facilitate a culture of respect and listening among all parties.

Additional Strategies

- **Address Indirect Needs**: Find ways to help with needs that indirectly impact health.
- **Resource Utilization**: Ensure team members are aware of and use available resources.
- **Incentives for Teamwork**: Provide incentives for effective teamwork and collaboration.
- **Family-Centered Activities**: Organize family-centered get-togethers to build team cohesion.

Question 10

What barriers exist in our current health care and or community environments that make it difficult to prevent chronic complications from diabetes?

Access to Care

- **Health Care Access**: Limited access to health care services, especially in rural areas
- **Insurance Coverage**: Lack of insurance or underinsurance, and issues with Medicaid expansion
- **Transportation**: Lack of transportation options to attend appointments and follow-up visits
- **Internet Access**: Limited internet access preventing telehealth use

Socioeconomic Barriers

- **Low Income and Basic Needs**: Financial strain, expensive health care, food, and housing
- **Working Poor**: Time constraints and inability to care for additional health needs due to work commitments
- **Food Insecurity**: Limited access to whole foods and nutritious options, especially in rural areas

Education and Awareness

- **Physician Awareness**: Lack of physician awareness and education about available resources
- **Health Literacy**: Low health literacy among patients
- **Cultural Barriers**: Language barriers and cultural differences affecting health behaviors and acceptance of chronic disease management

Systemic and Policy Issues

- **Fragmented Care**: Lack of coordinated, team-based care
- **Fee-Based vs. Value-Based Care**: Current fee-based care models versus value-based care approaches
- **Policy and Funding**: Inadequate funding and policy support for preventive care and chronic disease management

Community and Environmental Factors

- **Community Environment**: Issues such as food swamps, processed foods and lack of supportive environments
- **Rurality**: Challenges specific to rural areas, including lack of providers and educators
- **Social Determinants of Health**: Broader social factors affecting health, such as education, employment and housing

Medication and Treatment Barriers

- **Medication Costs**: High costs of medications and medical supplies
- **Insurance Reimbursement**: Issues with insurance reimbursement for certain treatments and medications
- **Lack of Education on Medications**: Insufficient patient education on medication use and nutrition

Trust and Communication

- **Lack of Trust**: Distrust in the health care system
- **Communication Issues**: Difficulties in communication with patients, especially regarding lab work and follow-up care

Organizational and Structural Barriers

- **Lack of Staff**: Health care facilities being short-staffed, leading to delays and inefficiencies
- **Siloed Work**: Working in silos and not aligning with available resources
- **Medical Records Integration**: Lack of integrated medical records

Sociopolitical Factors

- **Sociopolitical Will**: Need for enhanced primary care and improved access through sociopolitical support
- **Limited Clinic Time**: Insufficient time allocated for clinic appointments

Recommendations for Improvement

- **Statewide Coordination**: Need for a coordinated statewide effort to address these barriers
- **Prevention Networks**: Identifying and using state-level prevention networks and health promotion opportunities
- **Data Utilization**: Using data to connect statistics with relevant outcomes and improve health promotion efforts

APPENDIX

Contributing Organizations

Affinity Health Center
Alliance for a Healthier Generation
Arnold School of Public Health, University of South Carolina
Beaufort Jasper Hampton Comprehensive Health Services
BlueCross® BlueShield® of South Carolina
BlueCross® BlueShield® of South Carolina Foundation
BlueCross® BlueShield® of South Carolina Medicaid TPL
Brookland-Lakeview Empowerment Center
Burton Center
CareSouth Carolina
Clemson Extension School & Community Garden Team
Clemson Extension TEACH Center
Clemson Rural Health
Department of Public Health — Diabetes and Heart Disease Management Section
Diabetes Free SC (BlueCross® BlueShield® of South Carolina)
Ehrhardt Pharmacy
Fairfield Forward
Family Solutions
Fetter Healthcare Network
FoodShare South Carolina
GrowFood Carolina
HabitNu
Health E Strategies
Health Sciences South Carolina
HopeHealth
James E. Clyburn Scholarship and Research Foundation
Kids in Parks
Lexington Medical Center
Lowcountry Street Grocery
MUSC (Medical University of South Carolina)
MUSC Boeing Center for Children's Wellness
MUSC Department of Medicine
MUSC Division of Endocrinology
MUSC Health Orangeburg
Novo Nordisk
NuEmpowerment Health
Nutrition I.A.M.
Path of Life Nutrition
Prisma Health
Prisma Health Midlands Healthy Start Program
Prisma Health MOMs in Control — Columbia, SC

Prisma Health OB-GYN Center
Prisma Health OB-GYN
Prisma Health OB-GYN Midlands
Prisma Health Tuomey
Prisma Health Upstate
Richland One School District
Rural Health Services Inc.
South Carolina Cancer Alliance
South Carolina Center for Rural and Primary Healthcare
South Carolina Community Health Workers Association
South Carolina Department of Health and Human Services
South Carolina Department of Public Health
South Carolina Department of Public Health and South Carolina Oral Health Action Network
South Carolina Department of Transportation
South Carolina Department on Aging
South Carolina District Alpha Phi Alpha Fraternity
South Carolina Empowerment Centre
South Carolina Empowerment Centre/FoodShare Laurens
South Carolina Hospital Association (SCHA)
South Carolina Institute of Medicine and Public Health
South Carolina Office of Rural Health
South Carolina Office of Rural Health Family Solutions
South Carolina State University Health Equity Research and Training Center
South Carolina Surgical Quality Collaborative
Tandem Health
Tapestry Wellness Institute
The MEETING Place
USC (University of South Carolina)
USC School of Medicine
Welfare Baptist Church
Wholespire

Methodology for Creation of DFSC 2024 Annual Meeting Table Discussion Report

1. Documented responses from table discussions were handwritten by a scribe at each table on the question packet. (Original source)
2. Transcribed handwritten responses by question using iOS camera text recognition, then saved as Microsoft Word documents. (Format exchange by technology)
3. Reviewed and corrected the transcribed responses for accuracy against handwritten notes. (Human verification)
4. Defined report goals, specified structure and developed prompts to organize each set of responses into consistent summaries and categorizations. (Human expertise)
5. Input transcribed documents into company approved Microsoft Copilot AI assistant to format and categorize content. (Productivity enhancement by technology/AI)
6. Reviewed accuracy of resulting content against the original responses and edited when needed. (Human verification)
7. Developed executive summary of the report extracting main topics and applying prioritization. (Human expertise)
8. Entire report reviewed by DFSC leadership along with raw transcription of compiled responses. Feedback provided to communications specialist. (Human verification)
9. Entire report reviewed, edited, refined for accuracy and impact against transcribed responses. (Human expertise)

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