ROPER ST. FRANCIS HEALTHCARE

2025 Community Health Needs Assessment

Roper St. Francis Healthcare

Charleston Market

2025 Community Health Needs Assessment

Roper St. Francis Healthcare – Charleston Market

Adopted by the Roper St. Francis Healthcare – Charleston Market Board of Directors December 11, 2025

Roper St. Francis Healthcare has been committed to the communities it serves for nearly 200 years. This enduring commitment has evolved intentionally, guided by the most pressing health needs of our communities.

Every three years, Roper St. Francis Healthcare conducts a comprehensive **Community Health Needs Assessment (CHNA)**. This process combines quantitative data with community voices to identify priority health concerns. The findings inform and guide our community investments, benefit programs, and strategic planning. The following document is a detailed CHNA for Roper St. Francis Healthcare.

Our Mission – Healing All People with Compassion, Faith and Excellence, remains central to this work. By listening to the voices of our community, we ensure that resources for outreach, prevention, education, and wellness are directed towards opportunities where they can have the greatest impact.

The following document presents the most recent CHNA for Roper St. Francis Healthcare. We welcome written comments regarding the identified health needs. Please direct feedback to Renee Linyard-Gary, DHA, MBA at Ellen.Linyard-Gary@rsfh.com.

Roper St. Francis Healthcare – Charleston Market

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RSFH CHNA Short Link: Mission Dept

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Executive Summary

Market Summary

For generations, the people of Charleston have turned to Roper Hospital and Bon Secours St. Francis Hospital as trusted pillars of care. These institutions, with histories stretching back nearly two centuries, have stood as anchors in the community, offering healing, comfort, and innovation through times of change.

As the Lowcountry grew, so did its healthcare needs. In the past decade, Roper St. Francis Healthcare expanded its reach, opening Mount Pleasant Hospital and Berkeley Hospital. These additions extended the system's presence into Berkeley, Charleston, and Dorchester counties, ensuring that families across the region could access care close to home.

Today, Roper St. Francis Healthcare is more than a collection of hospitals — it is a comprehensive network. With nearly 700 inpatient beds and more than 115 facilities and physician offices through Roper St. Francis Physician Partners, the system connects patients to a continuum of services that meet diverse health needs.

Collaborating Partners

Roper St. Francis Healthcare extends sincere appreciation to the following organizations for their collaboration in conducting the 2025 Community Health Needs Assessment (CHNA):

- MUSC Health
- Trident Health
- Trident United Way
- Regional partners across the Lowcountry

Hospital members of the CHNA Health Data Work Group joined this collaboration, resulting in a comprehensive portrait of health needs across the region. The final report provides valuable insights into the communities of Berkeley, Charleston, and Dorchester counties.

Overview

Roper St. Francis Healthcare (RSFH) participated in a collaborative Tri-County Community Health Needs Assessment (CHNA) alongside MUSC Health, Trident Health, and Trident United Way. The Healthy Tri-County Coalition, formed in 2016, led the process to understand the needs of Berkeley, Charleston, and Dorchester counties.

The 2025 CHNA process engaged 864 participants through surveys (671 responses), focus groups (86 participants), interviews (13), and community input sessions (84 participants). Priority populations included historically underrepresented groups such as Latino/Hispanic, veterans, and LGBTQIA+ residents. Input was collected in multiple languages (English, Spanish, Brazilian Portuguese, Russian) to ensure equity and inclusiveness.

The 2025 CHNA survey respondents were asked to rank the top 10 health topic areas from Healthy People 2030 that impact the communities where they live and/or work from 1 (most concerning) to 10 (least concerning). The following health topics and needs were identified and ranked by the Tri-County CHNA:

Social Determinant of Health and Social Health Needs

- Mental Health and Stigma
- Healthcare access Barriers in Rural Areas
- Equity Gaps & Cultural Competence in Care
- Preventative Health Gaps
- Community Health Workers as a Vital Connector
- Barriers from Insurance & Income "Gray Zones"
- Basic Needs
- Digital & Language Barriers
- Integrated, Holistic Care

Prioritized Health Needs

1. Access To Care (includes Oral Health)
2. Clinical Preventative Services
3. Behavioral Health (includes Mental Health and Substance Misuse)
4. Obesity, Nutrition, and Physical Activity
5. Maternal, Infant, Child Health (includes Sexual/Reproductive Health)

Our Mission

We live our mission of healing all people with compassion, faith, and excellence.

Our Vision

Our vision of providing convenient, high value, clinically integrated care to all.

Our Values

Human Dignity

We commit to uphold the sacredness of life and being respectful and inclusive of everyone.

Integrity

We commit to act ethically and to model right relationships in all of our individual and organizational encounters.

Compassion

We commit to accompanying those we serve with mercy and tenderness, recognizing that "being with" is important as "doing for".

Stewardship

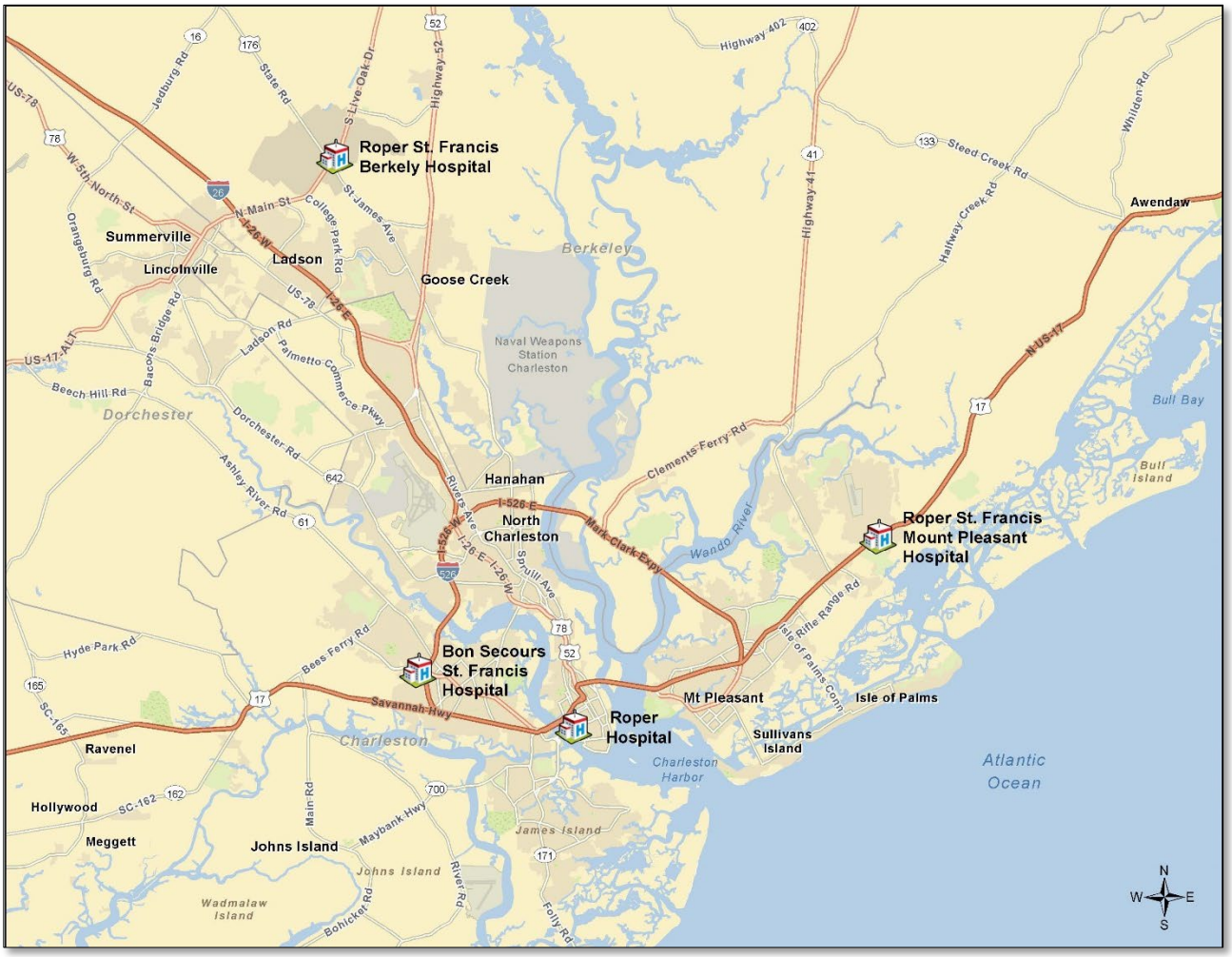
We commit to promote the responsible use of all human and financial resources, including Earth itself.

Service

We commit to providing the highest quality in every dimension of our organization.

Facilities Description

Roper St. Francis Healthcare's four full-service member hospitals are the heart of the extensive regional healthcare network. For nearly two centuries, **Roper Hospital** and **Bon Secours St. Francis Hospital** have been medical anchors for the residents of Charleston. In the last decade, the system added **Roper St. Francis Mount Pleasant Hospital** and **Roper St. Francis Berkeley Hospital** to create a vast system that stretches throughout Berkeley, Charleston and Dorchester counties. The near 700 bed system also includes more than 115 facilities and doctor offices (Physician Partners (PP)).



Bon Secours St. Francis Hospital in Charleston, SC

Known for compassionate, quality health care, Bon Secours St. Francis Hospital traces its mission back to 1882, when five Sisters of Charity of Our Lady of Mercy opened St. Francis Infirmary in downtown Charleston — the first Catholic medical center in South Carolina. Today, Bon Secours St. Francis is a 190-bed hospital that combines the latest medical technology with comprehensive acute care, while remaining true to its commitment to caring for the whole person — physically, spiritually, and emotionally.

Bon Secours St. Francis Hospital is proud to be the first hospital in South Carolina to achieve a fourth Magnet designation for nursing excellence. In addition, the hospital has earned numerous honors, including the Outstanding Patient Experience Awards and an "A" rating in patient safety from the Leapfrog Group. These recognitions reflect the hospital's enduring dedication to excellence and compassionate care for the Charleston community.

Roper Hospital in Charleston, SC

Recognized for its leading-edge technology and best practices, Roper Hospital builds a long legacy of excellence. Founded in 1829 as the first community hospital in the Carolinas, Roper Hospital has grown into one of the most trusted names in the Lowcountry of South Carolina. Today, it is a 332-bed facility that includes a comprehensive Intensive Care Unit, offering advanced care across a wide range of specialties.

As the proud recipient of national awards for quality patient care, Roper Hospital enjoys an outstanding reputation for excellent outcomes and personal attention. The hospital has been honored in categories ranging from best physical therapy centers to best overall patient experiences, reflecting its commitment to innovation, compassion, and excellence in healthcare.

Roper St. Francis Berkeley Hospital in Summerville, SC

Roper St. Francis Berkeley Hospital provides quality healthcare closer to home for thousands of our neighbors, family and friends. Whether you are welcoming a new life into the world, need surgery, or require emergency care, we're here for you. We're a full-service hospital with 100 beds and a wide range of services and an expert team dedicated to our mission of healing all people with compassion, faith and excellence.

Roper St. Francis Mount Pleasant Hospital in Mount Pleasant, SC

Roper St. Francis Mount Pleasant Hospital is a true community hospital, providing care with a personal touch. With 85 beds and a 24-hour full-service Emergency Department supported by a helipad, the hospital is equipped to deliver timely and comprehensive care. Whether patients require emergency services, surgery, or physical therapy, Mount Pleasant Hospital is always ready to serve. Nestled among protected woodlands just off Highway 17 North near Wando High School, the hospital was designed with comfort in mind, ensuring that every healthcare experience is as pleasant as possible. Guided by the Roper St. Francis mission of Healing All People with Compassion, Faith, and Excellence, Mount Pleasant Hospital continues to be a trusted resource for the community. St. Francis Mount Pleasant Hospital is a true community hospital, providing care with a personal touch.

Community Served by Hospitals

The Tri-County region consists of Berkeley, Charleston and Dorchester County. According to the American Community Survey, the current estimated Tri-County population for 2024 is 889,940 which is roughly an 11% growth since the 2020 Decennial Census. Roughly 62% of the population is White, 21% Black/African American, 8% Hispanic or Latino, 5% is two or more races and 2% Asian. With 38.5% of Tri-County residents having a bachelor's degree or higher, and a median household income of $88,159 annually. The median age of Tr-County resident is 38.7 years. The population in the Tri-County is roughly 49% male and 51% female, remaining consistent with the 2022 CHNA data.

JOINT CHNA
§1.501(r)-3(b)(6)(i)

This is a "joint CHNA report," within the meaning of Treas. Reg. §1.501(r)-3(b)(6)(v), by and for Charleston Market including Roper Hospital, Bon Secours St. Francis Hospital, Berkeley Hospital, and Mt. Pleasant Hospital. This report reflects the hospitals' collaborative efforts to conduct an assessment of the health needs of the community they serve. Each of the hospitals included in this joint CHNA report define its community to be the same as the other included hospitals. The assessment included is seeking and receiving input from that community.

Process and Methods

Process and Methods to Conduct the Community Health Needs Assessment

Beginning in September of 2024, the Healthy Tri-County Core Partners and Health Data Workgroup began to meet to plan out the timeline and review past CHNA processes. With priority populations and target communities in mind, the Health Data Workgroup began to distribute surveys (available in English, Spanish, Brazilian Portuguese, and Russian) and conduct both focus groups (English and Spanish) and key informant interviews within the Tri-County community. Specific activities included:

- From December 2024 to March 2025, quantitative data includes administering a 27-question online and paper survey to a total of 671 participants.
- To capture a broad range of community perspectives, qualitative data were collected through multiple engagement strategies between February and March 2025. Six focus groups were convened, bringing together more than 100 community members from identified priority populations.
- In addition, 13 in-depth interviews were conducted with both community members and professionals, providing nuanced insights into local needs and experiences.
- Beyond these structured discussions, outreach extended to over 32 community events and communication platforms, including social media and newsletters, ensuring that voices were heard across diverse settings.

Participants were intentionally selected to reflect varied social, economic, and cultural backgrounds, strengthening the representativeness of the findings. This deliberate approach included outreach to Latino and Hispanic residents, community service volunteers, veterans, and individuals working within non-profit organizations. By engaging across these groups, the data collection process ensured that the perspectives gathered were inclusive and reflective of the community's diversity.

Utilizing a combination of human reviewers (i.e., data workgroup, epidemiologists, and students) and online tools (i.e., SurveyMonkey, Google Forms, etc.), the data was coded and analyzed for review. The goal of this analysis was to identify themes and key points of concern as well as understanding the impact of social drivers of health as informed by the community members and leaders. The appearance of each code was tallied in order to quantify and measure the data collected.

External Sources

External data was gathered through existing secondary data sources, including, but not limited to:

- U.S. Department of Health and Human Services
- Health Resources and Services Administration
- Healthy People 2030
- The Post and Courier
- South Carolina Department of Public Health
- Data USA
- U.S. Census Bureau
- Health Resources & Services Administration, National Center for Health Workforce Analysis
- Centers for Disease Control and Prevention
- County Health Rankings: Robert Wood Johson Project
- Other reports on diabetes and chronic disease

Community Input

Every three years, Roper St. Francis Healthcare evaluates health needs through a comprehensive Community Health Needs Assessment (CHNA) process. The most recent assessments, completed by Health Tri-County (a core partnership of MUSC Health, Roper St. Francis Healthcare, Trident Health and Trident United Way) and community leaders, include quantitative and qualitative data that guide both our community benefit and strategic planning.

The Tri-County Health Landscape 2025 Community Health Needs Assessment Report document (see Appendix A) is the detailed CHNA adopted for Roper St. Francis Healthcare, including Roper Hospital, Bon Secours St. Francis Hospital, Roper St. Francis Mount Pleasant Hospital and Roper St. Francis Berkeley Hospital.

Through collaborative efforts such Healthy Tri-County, Roper St. Francis Healthcare remains committed to reassessing the community's priorities every three years, and will continue to promote, design and create programs and services that complement and supplement our partners' efforts.

No written comments were received on the most recently conducted CHNA and Implementation Strategy.

Collaborating Partners

Roper St. Francis Healthcare thanks the following organizations for their collaboration as part of the process of conducting the needs assessment (January – May 2025):

180Place

AccessHealth Tri-County Network

Alliance for a Healthier SC

BEE Collective

Cane Bay YMCA

Charleston Chamber of Commerce

Charleston Southern University

Cross High School

College of Charleston

County Libraries (Berkeley, Charleston, and Dorchester)

Department of Public Health

Fetter Healthcare Network

First Steps- Berkely, Charleston, and Dorchester counties

Kay Phillips Children's Advocacy Center

Midland Park Primary School

North Charleston Dental Outreach

Nuestro Estado News

Palmetto Goodwill

St. James Health & Wellness

Tri-County Diabetes Prevention Programs Coalition

Universal Latin News

Veterans Suicide Prevention Coalition

Information and Data Considered in Identifying Potential Need

Information and data sources: federal, state or local health or other departments or agencies; community input

Public health departments	Date of data/information
South Carolina Department of Public Health SCDPH (Formerly known as DHEC)	At the Healthy Tri-County Relaunch event on April 26, 2024, special guests from South Carolina's Department of Health and Environmental Control conducted a data walk with members of the health coalition. Epidemiologists from the state and local departments explained the status of 9 health topic areas to participants and conducted a discussion to determine what stood out most to community members.
U. S. Census	On December 5, 2024, at the CHNA Health Data Work Group Meeting, key Census demographic data was reviewed and vetted by the group for inclusion in survey development and for focus group/key informant interview questions.
Healthy People 2030	On November 22, 2024, the CHNA Core Partner Meeting the Health People 2030 Topics and select topical objectives were reviewed by members.

Organization Providing Input	Nature and extent of input	Medically under-served, low-income or minority populations represented by organization
AccessHealth Tri-County Network	Survey collection, focus group, CHNA/CHIP planning meetings	Community/all populations
Alliance for a Healthier SC	CHNA/CHIP planning meetings	Community/all populations
BEE Collective	Survey collection, key informant interview	Community/all populations
Cane Bay YMCA	Survey collection, key informant interview	Community/all populations
Charleston Chamber of Commerce	Survey collection, key informant interview	Community/all populations
Charleston Southern University	Survey collection, CHNA/CHIP planning meetings	Academics/students
Cross High School	Survey collection, focus group	Academics/students
College of Charleston	Survey collection, focus group, CHNA/CHIP planning meetings	Academic/students
County Libraries (Berkeley, Charleston, and Dorchester)	Survey collection, CHNA/CHIP planning meetings	Community/all populations
Department of Public Health	Survey collection, focus group, CHNA/CHIP planning meetings	Community/all populations
Fetter Healthcare Network	Survey collection, key informant interview	Community/all populations
First Steps- Berkeley, Charleston, and Dorchester Counties)	Survey collection, key informant interview	Community/all populations
Kay Phillips Children's Advocacy Center	Survey collection, key informant interview	Community/all populations
Midland Park Primary School	Survey collection, key informant interview	Community/all populations
North Charleston Dental Outreach	Survey collection, key informant interview	Community/all populations
Neuestro Estado News	Survey collection, focus group	All populations/Hispanic/minority health
Palmetto Goodwill	Survey collection, key informant interview	Community/all populations
St. James Health & Wellness	Survey collection, key informant interview	Community/all populations
Tri-County Diabetes Prevention Programs Coalition	Survey collection, focus group, CHNA/CHIP planning meetings	Community/all populations
Universal Latin News	Survey collection, key informant interview	All populations/Hispanic/minority health
Veterans Suicide Prevention Coalition	Survey collection, focus group	Veterans/mental health/substance abuse recovery
180 Place	Survey collection, focus group	Community/all populations

Significant Community Identified Health Needs

Social Determinants of Health Needs – Community Level Needs that Impact Health and Wellbeing

Health Care Access and Quality

Capacity and adequacy of service levels

Health care access and quality was identified in the 2025 CHNA community engagement, data collection, and analysis process as significant health need to address disparities in care within the CHNA Service Area. Since 2016, the CHNA respondents ranked Access to Care as the top priority area of need due to barriers such as lack of providers in rural areas, transportation, insurance limitations, etc.

As outlined in the list of the collaborating partners, Roper St. Francis Healthcare partners or collaborates with organizations across the Berkeley, Charleston and Dorchester counties and surrounding areas to help patients connect to community support outside of the acute or outpatient setting. For a list of community resources, please see the Resources Available section below.

Economic Stability

Capacity and adequacy of service levels

In the 2025 CHNA process, respondents indicated the economic stability barriers related to basic needs such as food insecurity and housing instability as community level drivers. Economic stability is critical to support healthy lifestyle and ability to afford basic needs.

Roper St. Francis Healthcare provides supports for both housing and food assistance in various community health programs for vulnerable populations. Additionally, the system makes significant annual community investments in non-profit partner agencies who address economic instability. This includes some community partners listed in the Resources Available section.

Social Health Needs – Individual Level Non-Clinical Needs

Injury and Violence

Capacity and adequacy of service levels

Between 2022 and 2025, the health topic of Injury and Violence rose from the 8th to the 6th priority health concern in the community, reflecting a growing awareness and increased incidence of related issues. This rise highlights the escalating impact of community violence, domestic abuse, unintentional injuries, and other safety concerns on the well-being of residents.

Injury and violence are closely connected to other social drivers of health, including poverty, housing instability, lack of education, and limited access to mental health and social support services. Communities facing higher levels of socioeconomic disadvantage often experience disproportionate rates of violence and injury, making this issue a public health priority. Under the Resources Available listing, various community partners addressing injury and violence ae listed within Behavioral Health.

Digital and Language Barriers

Capacity and adequacy of service levels

Compared to the 2022 CHNA process, the 2025 CHNA community engagement, data collection, and analysis process identified a need to increase the languages options for the survey tool. In 2022, the survey was offered in two languages; however, in the survey development phase, the CHNA Health Data Work Group identified the need to increase to 5 languages. The additional language options addressed the language barriers assessed by referencing secondary data sources.

Working with the various collaborating partners, the use of paper surveys in all five languages were offered in addition to digital access to the survey. Roper St. Francis Healthcare provides languages services both within the health system and to select community partners. For the 2025 CHNA process, interpretation and translation of documents such as the survey tool was a key activity to address language barriers.

Significant Clinical Health Needs

Capacity and adequacy of service levels

After analyzing the qualitative and quantitative feedback from the community engagement process, the five significant health needs were identified and prioritized as the 2025 clinical health needs. For full detail of capacity and adequacy level, please reference the Tri-County Health Landscape 2025 Community Health Needs Assessment Report document (see Appendix A) under each health topic.

1. Access To Care (Includes Oral Health)
2. Clinical Preventative Services
3. Behavioral Health (Mental Health and Substance Misuse)
4. Obesity, Nutrition, and Physical Activity
5. Maternal, Infant, Child Health (Includes Sexual/Reproductive Health)

Resources Available

Due to the considerable and complex nature of the community identified significant health needs, there are several organizations within the community that may be available to address one or more of the needs identified in this report.

Since the launch of Healthy Tri-County in January 2017, the long-term aspirational goal of our core partners (MUSC Health, Roper St. Francis Healthcare, Trident Health, and Trident United Way) and our member participants has remained the same: to improve the health and well-being of every person and community within the Tri-County region.

The Community Resource Hub is intended to provide support to any individual searching for local, public health resources in Berkeley, Charleston or Dorchester County that advocate, educate or provide healthcare services.

Community Resource Guide

The Community Resource Guide was developed to provide a printable, sample list of recommended health resources from the following health topics and categories prioritized by Healthy Tri-County:

Click on the links below to access the resource website or visit healthytricounty.com.

Access to Care – reducing barriers to receiving comprehensive quality health care and services.

Behavioral Health – treating and preventing substance use, mental health disorder and increasing awareness about behavioral health issues, services and resources.

Clinical Preventive Services – increasing general public's rate of routine disease screening (i.e. cancer and diabetes) and scheduled immunizations.

Maternal, Infant and Child Health – resources for the health of mothers, infants and children.

Obesity, Nutrition & Physical Activity – community resources to help with reaching and keeping a healthy body weight, good nutrition and physical activity as part of daily life.

Other Online Resource Hubs – additional, recommended websites with health info and more.

Prioritization of Health Needs

As referenced in the Process and Methods and Community Input sections above, a variety of data and information was collected and analyzed to identify priority health needs of the community. The community health prioritization process included review and analysis of primary data, secondary data and current community health resources.

Additionally, meetings with stakeholders through the CHNA Health Data Work Group and Healthy Tri-County Core Partners were facilitated to review the assessment findings and identify priorities. Both groups will participate in additional sessions to help identify potential implementation strategies.

After examining the range of services currently available, significance, impact ability, relevance to the population served, and needs already being addressed by community partners, Roper St. Francis chose the following priorities to address.

Prioritized Social Determinants of Health Needs and Prioritized Social Health Needs

Health Care Access and Quality + Transportation

With the help of our new Mobile Health Units, Roper St. Francis Healthcare is enhancing patient access to affordable and convenient healthcare.

Funded by donor support, the units provide a variety of services including blood pressure and cancer screenings at health fairs and community events across the tri-county area. Our 38-foot-long customized vehicle is equipped with two exam rooms and a wheelchair ramp for safe and inclusive access. Our Sprinter Van vehicle can go to locations a larger unit wouldn't be able to maneuver through which allows us to reach all communities. Clinical team members and community health workers staff the units to provide various health screenings as well as cancer risk assessments and health education.

Prioritized Clinical Health Needs at Roper St. Francis Healthcare

Access to Care: RSFH's Ryan White Wellness Center was founded in 2000 to care for the region's uninsured patients living with HIV. For two decades, the Ryan White Wellness Center has sustained a legacy of compassionate, state-of-the-art care. The Center empowers patients and the community to take charge of their sexual health while championing overall wellness. It is the only one-stop-shop sexual health center in the Tri-County, offering more than 20 different onsite services.

Clinical Preventive Services: The Diabetes Prevention Project Expansion at RSFH's AccessHealth Tri-County Network began in 2019. Their mission is to meet the community where they are; to empower and equip with the tools that are needed to change the course of their health through education in diabetes prevention. AHTN serves as the HUB of Diabetes Prevention Programs in Berkeley, Charleston and Dorchester counties.

Mental Health (Behavioral Health): RSFH's Greer Transitions Clinic closes this gap for unfunded or underfunded patients who do not have a medical home. The Clinic is helping improve care coordination as a one-stop shop for approximately 2,500 patients annually and on average 43% reduction rate in ED utilization. Patients can visit board-certified physicians, learn preventive care and health literacy, connect with social services and find a primary medical home. The Clinic continues to expand and make a dramatic impact meeting the medical needs and addressing the social determinants of health and wellness which includes behavioral health and counseling services.

Obesity, Nutrition and Physical Activity: The Lowcountry Senior Center and Waring Senior Center are welcoming places for adults 50 and older to learn, exercise and socialize. The Centers promote the whole person's health - spirit, mind and body. The Lowcountry Senior Center and Waring Senior Center are owned by the City of Charleston and managed by Roper St. Francis Healthcare. Both locations offer hundreds of programs a month ranging from strength training and exercise to support groups and painting lessons.

Maternal, Infant and Child Health: Since 2011, Roper St. Francis Maternal Fetal Medicine department has partnered with Our Lady of Mercy Community Outreach to provide free OBGYN Care to the women who lack insurance or the ability to pay. Roper St. Francis Healthcare offers the Centering Pregnancy model of group prenatal care at Bon Secours St. Francis Hospital. The Centering Pregnancy model provides prenatal care to medically underserved women in a group setting of eight to 10 expectant mothers in the same stage of pregnancy.

Significant Health Needs Not Prioritized

For the 2025 CHNA, there were no significant health needs not prioritized after the analysis.

Progress and Impact

Access to Care

Strategies	Progress
Navigate high users of emergency departments to primary care medical homes.	Collaborate with local healthcare systems to identify Emergency Department "super utilizers". The four local hospital systems actively participate in AccessHealth Tri-County Network. Navigate uninsured Emergency Department "super utilizers" to AccessHealth and/or the Transitions Clinic. Sustain support and participation with AccessHealth and Transitions Clinic is ongoing.
Connect underinsured and uninsured patients to medical homes	Refer underinsured and uninsured RSF patients to AccessHealth and/or the Transitions Clinic.
Coordinate and collaborate with safety-net partners for delivery of services, including area Federally Qualified Health Centers (FQHCs), free clinics, and homeless shelters.	Provide lab work, free supplies, and ancillaries to partner medical clinics and supportive service agencies: Barrier Islands Free Medical Clinic, Our Lady of Mercy Outreach, East Cooper Community Outreach, Dream Center, Harvest Free Medical Clinic, One80 Place Medical Ministries Mission with signed contracts to continue partnerships. Continue providing in-kind services. Manage care coordination for eligible patients referred from local partners through the shared care navigation hub managed by AccessHealth.

Clinical Preventive Services

Strategies	Progress
Provide routine, primary care for low-income, uninsured adults that live or work on the sea islands of Charleston County.	Provide financial support for clinical staff and infrastructure at Our Lady of Mercy Outreach. Signed contracts to continue partnerships. Continue financial support and promote services of the agency. Provide lab work, free supplies, and ancillaries to partner medical clinics and supportive service agencies: Barrier Islands Free Medical Clinic, Our Lady of Mercy Outreach, East Cooper Community Outreach, Dream Center, Harvest Free Medical Clinic, One80 Place Medical Ministries Mission with signed contracts to continue partnerships.
Provide early intervention services for patients diagnosed with HIV/AIDS.	Enroll HIV positive patients into federally funded Ryan White program. As of 2025, 1050 enrolled patients. Ensure continued health insurance coverage for HIV positive adults using federal and employer insurance programs. Provide free HIV testing at community events and in-clinic. Seek grant funding to expand primary prevention services for high-risk HIV negative adults and prevent the rate of transmission for HIV positive patients.
Provide evidence-based outpatient care for diabetic patients.	Track percentage of patients who receive evidence-based outpatient care for diabetes. Continue assessments via the RSF Physician Partners.
Expand access to free annual breast health screenings for all women, particularly African American women	Host annual "Family Wellness Night" (formerly Ladies' Night Out) and other screening events for underserved men and women to get breast and colorectal screenings. Host annual skin cancer screening. Continue hosting events and encouraging participation.

Behavioral Health (Mental Health)

Strategies	Progress
Coordinate services between Emergency Departments and regional mental health agencies.	Participate in the Charleston/Dorchester Mental Health Department's community task force. Continue participation in regularly scheduled meetings. Coordinate care of behavioral health patients, using local agencies and resources for support. Continue coordination using community resources. Continue to collaborate with mental health providers to engage community members in highest need areas to direct to appropriate services.
Expand mental health services within central outpatient clinic	Developed and maintain partnerships with local law enforcement to create an alliance for holding Drug Take Back events. Hold at least 4 Take Back events in the area per year. Continue to integrate depression screenings at primary care wellness visits and postpartum OB/GYN patient visits.

Obesity, Nutrition & Physical Activity

Strategies	Progress
Increase opportunities for comprehensive wellness for older adults.	Maintain the promotion of annual primary care screening for each RSF employee. Promote employee participation in disease-specific events to increase health awareness and advocacy with Be Well platform in 2025. Host informative and interactive tables/booths during local community and agency health fairs/screenings. For instance, hosted screening at Coastal Carolina Fair in 2025.
Collaborate with local partners to increase healthy food options in underprivileged communities.	Engage community members in highest need areas to promote wellness and nutrition through Farmacy Project in 2025. Collaborate with the Lowcountry Food Bank and East Cooper Meals on Wheels to provide home-delivered meals in low-income communities. Maintained support through community investment support and program promotion.
Host evidence-based health and wellness community programs for older adults.	Offer physical wellness classes specifically targeting older adults through membership enrollment at Waring and Lowcountry Senior Centers.

Maternal, Infant & Child Health

Strategies	Progress
Offer specialized services for high-risk pregnancies.	Continue specialized care teams for high-risk pregnant women to include a board-certified maternal fetal medicine specialist. Support a Maternal Fetal Medicine program that includes medical management, counseling, biophysical profiles, diagnosis and management of birth defects, and other highly specialized services
Provide prenatal care for uninsured patients that are not eligible for Medicaid.	Support prenatal care for eligible uninsured and immigrant patients of Our Lady of Mercy Outreach, a local rural healthcare clinic. Provide routine lab work, radiology services, prenatal education classes, and Maternal Fetal Medicine services for Spanish speaking patients.
Host expectant parent education classes and tours, and Safe Sitter ® classes.	Continue to facilitate regularly scheduled expectant parent education classes and hospital tours as well as Safe Sitter ® classes.

Appendix

Appendix A: TRI-COUNTY HEALTH LANDSCAPE
2025 Community Health Needs Assessment

HEALTHY Tri-County

TRI-COUNTY HEALTH LANDSCAPE

BERKELEY | CHARLESTON | DORCHESTER

2025 Community Health Needs Assessment Report

A Collaborative Effort of MUSC Health, Roper St. Francis Healthcare, Trident Health and Trident United Way

Message to the Community

Since its inception in 2016, the Healthy Tri-County Coalition (HTC) has been a collaborative effort among MUSC Health, Roper St. Francis Healthcare, and Trident United Way, aimed at enhancing the health outcomes of residents in Berkeley, Charleston, and Dorchester counties. In 2023, we were excited to welcome Trident Health as a new Core Partner, further strengthening our commitment to this mission.

The Community Health Needs Assessment (CHNA) has been a cornerstone of our efforts, providing valuable insights into the health challenges faced by our community. As we present the latest CHNA, we are focused on the future and the opportunities it holds for improving community health.

Over the past 6-months, our Core Partners, alongside key community leaders from healthcare, community groups, mental health services, faith-based organizations, educational institutions, nonprofits, and local governments, have worked diligently to conduct comprehensive qualitative and quantitative assessments. These efforts are crucial in identifying the evolving needs of our community and ensuring that we remain responsive and proactive.

The Healthy Tri-County Coalition remains steadfast in its commitment to reassessing community priorities every three years. We continue to gather partners who can help us to design and implement programs and services that are complementary and mutually reinforcing, with the ultimate goal of fostering a healthier future for all residents.

As we reflect on our journey, we are inspired by the progress made and the potential that lies ahead. We are grateful for the unwavering support and collaboration of our partners and community members, whose dedication and spirit drive us forward.

How To Use This Report

This report includes three sections under each of the health topic areas prioritized by the 2025 CHNA respondents:

- **Examining the Issue:** presents national and regional data relevant to the health topic area.
- **Community Spotlights:** showcases organizations within the Tri-County that are addressing the health topic area.
- **Voices from the Community:** provides direct quotes from local community members during 2025 CHNA data collection that address the health topic area.

Healthy Tri-County Core Partners

MUSC Health
Medical University of South Carolina

ROPER ST. FRANCIS HEALTHCARE

TRIDENT HEALTH

Trident UNITED WAY

Want to know more about becoming a partner?
Visit www.healthytricounty.com.

Methodology

Purpose

This report provides insight into the health climate of Berkeley, Charleston, and Dorchester counties through data collected from MUSC Health, Roper St. Francis, Trident Health, and Trident United Way. Designed for a wide range of audiences, the 2025 Community Health Needs Assessment contains actionable data that can be used to inform and aid community health improvement plans.

Health Topics

To guide the data collection, the following top ten health-care topics were utilized for both quantitative and qualitative data collection. They were selected from a 10-year health improvement plan by the US Department of Health and Human Services and are as follows:

- Access to Care
- Clinical Preventive Services
- Injury & Violence
- Maternal, Infant & Child Health
- Mental Health
- Obesity, Nutrition & Physical Activity
- Oral Health
- Reproductive & Sexual Health
- Substance Misuse
- Tobacco Use

CHNA Data Collection Process

Beginning in September of 2024, the Core Partners and Health Data Workgroup began to meet to plan out the timeline and review past CHNA processes. With priority populations and target communities in mind, the Health Data Workgroup began to distribute surveys (available in English, Spanish, Brazilian Portuguese, and Russian) and conduct both focus groups (English and Spanish) and key informant interviews within the Tri-County community. Specific activities included:

- Quantitative data including administering a 27-question online and paper survey to a total of 671 participants (language breakdown)
- Qualitative data including hosting 6 focus groups with over 100 community members from different priority populations, conducting interviews with 13 community members and professionals, and engaging with more than 32 community outreach events and communication outlets (social media, newsletters). To ensure a more comprehensive representation, participants were intentionally selected from diverse social, economic, and cultural backgrounds for focus groups, interviews, and outreach. This includes Latino and Hispanic, community services volunteers, veterans, and non-profit workers.

CHNA Data Analysis

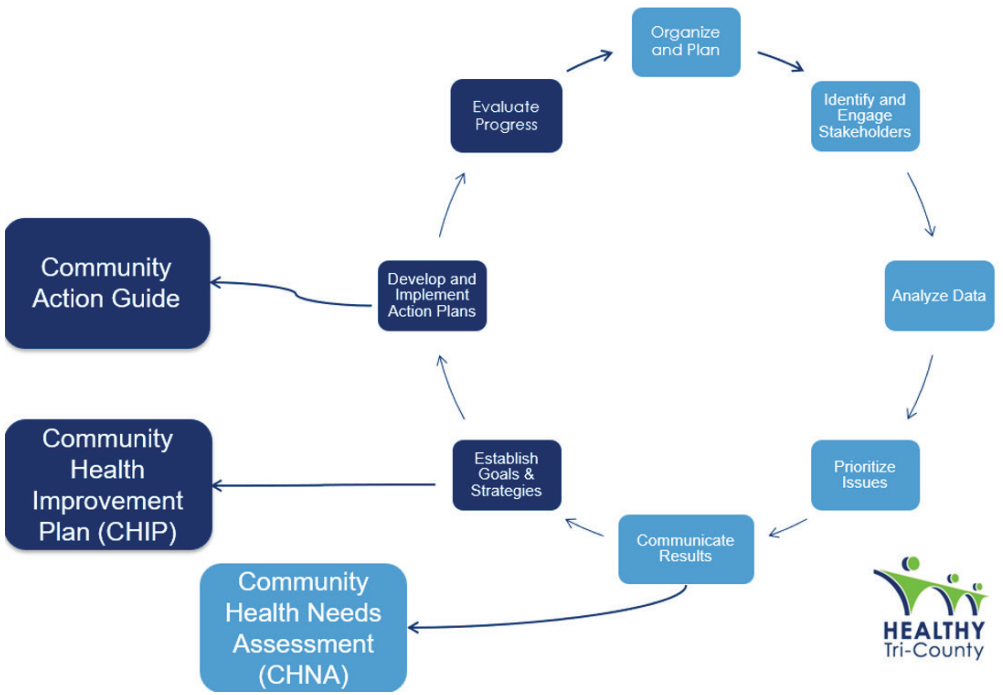
Utilizing a combination of human reviewers and online tools, the data was coded and analyzed for review. The goal of this analysis was to identify themes and key points of concern as well as understanding the impact of social drivers of health as informed by the community members and leaders. The appearance of each code was tallied in order to quantify and measure the data collected.

Challenges and Improvements to Data Collection

Employing insights gained from previous years, the HTC steering committee took intentional steps to reach populations which were underrepresented in previous years, including Latino and Hispanic, LGBTQIA+, and veteran populations. This included working closely with leaders in those communities to ensure equal representation and thorough data collection. We also provided access to our digital survey in 3 languages including English, Spanish and Brazilian Portuguese. As in past years, there was a disproportionate female to male ratio indicating that further intentionality could be applied in future efforts to engage male participants.

Community Health Needs Assessment and Engagement

This process of assessing community needs is cyclical and requires community partnership at every step of the way. Once this report is published, the Core Partners will begin work on the next Tri-County Community Health Improvement Plan (TCHIP) to re-establish goals for our coalition. Following this shared assessment phase, each organization tailors its response based on its unique mission, goals, and regulatory requirements, allowing for strategic prioritization and implementation of health initiatives. Progress is tracked through annual monitoring and evaluation, with HTC Core Partners and collaborating organizations reporting on outcomes and refining strategies to maximize community impact.



What You Can Do
to Support Community Health

- **Share the Data** – Help raise awareness by sharing findings from the 2025 Community Health Needs Assessment (CHNA) with elected officials, community leaders, and your personal and professional networks.
- **Take Informed Action** – Use insights from the Examining the Issue sections to guide meaningful actions within your organization or community.
- **Request the Data File** – Email HTCsupport@tuw.org to request the full 2025 CHNA data file for deeper analysis and to inform your health strategies and programming.
- **Engage the Community** – Seek feedback from community members and involve them in co-creating culturally relevant programs and materials.
- **Become an Organizational Member** – Join Healthy Tri-County as an organization by submitting a commitment pledge from your company or institution's senior leadership.
- **Join as an Individual** – Support the coalition by becoming an individual member. Visit healthytri-county.com/become-member to learn more and complete the member interest form.

Community Engagement in Action

Similar to the 2022 CHNA, we continued to build upon previous assessment efforts to engage with all populations in our Tri-County. In collaboration with our Health Data Workgroup, we identified target populations including who have been historically underrepresented in our surveys. With the help of undergraduate students Kiran Sharma (CSU) and Jocelyn Nguyen (CofC), the Core Partners took a multi-sector approach to ensure community stakeholder engagement to advance our goal of hearing from all populations in the Tri-County.

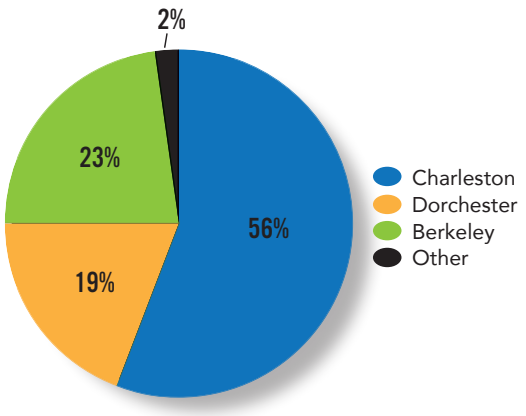
Health Interns, Jocelyn & Kiran, with Health Program Manager Madison James (not pictured) attended the Charleston Hispanic Association's Consulate Day where they encouraged attendees to take the CHNA, celebrated World Water Day, and provided connection to health resources in Spanish & English.

The Healthy Tri-County Core Partner team was excited to share about our work and resources at the 2025 Charleston Black Expo.

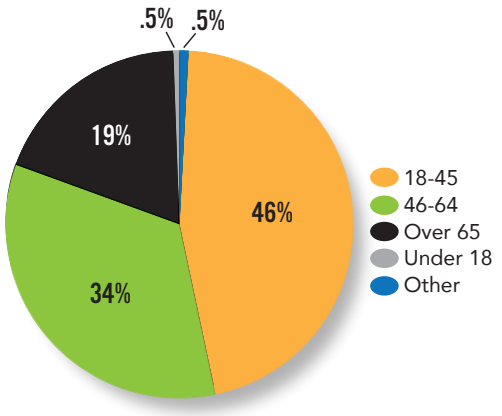
What We Found: Common Barriers and Challenges Identified in Focus Groups and Interviews

- **Mental Health and Stigma**
  - Barriers: Anxiety, depression, untreated trauma, stigma, and lack of providers
- **Healthcare access Barriers in Rural Areas**
  - Barriers: Few providers, transportation, insurance limitations, lack of mobile units
- **Equity Gaps & Cultural Competence in Care**
  - Barriers: Black Maternal Mortality, Unequal Bedside Manner, Culturally Irrelevant Nutrition Advice
- **Preventative Health Gaps**
  - Barriers: Missed lung cancer screenings, diabetes prevention, dental decay due to lack of earlier care
- **Community Health Workers as a Vital Connector**
  - Benefits: Bridge gaps in trust, cultural alignment, communication.
- **Barriers from Insurance & Income "Gray Zones"**
  - Barriers: Working people who make too much for assistance but not enough to thrive
- **Basic Needs First**
  - Barriers: If survival needs aren't met, health takes a back seat
- **Digital & Language Barriers**
  - Barriers: Tech literacy, informed consent, accessing telehealth appointment systems
- **Desire for Integrated, Holistic Care**

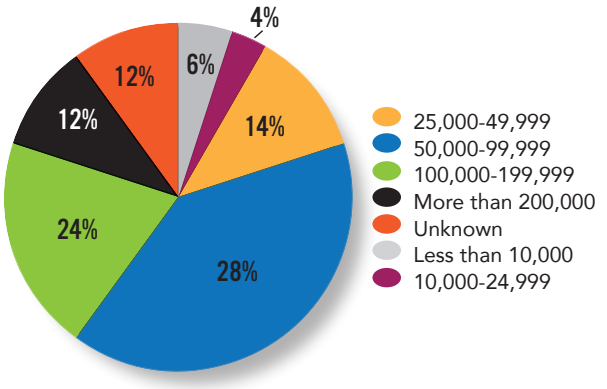
CHNA Data and Demographics



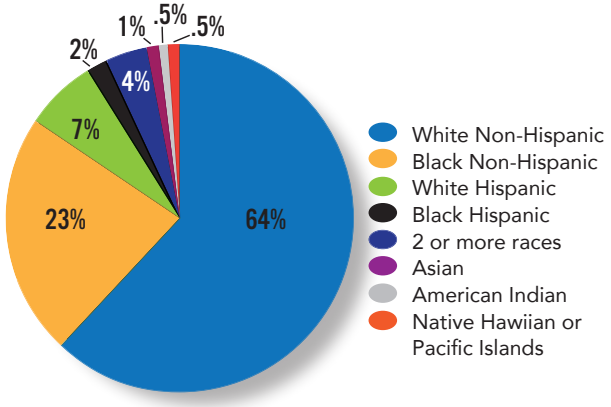
Respondents by County



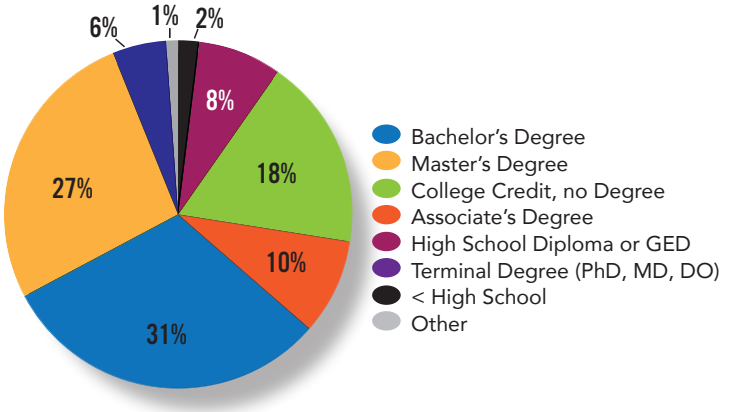
Respondents by Age



Respondents by Income



Respondents by Race/Ethnicity



Respondents by Education

864
Total Participants

671
Total Surveys

13
Interviews

86
Focus Group Participants

84
Community Input Session Participants

10
Focus Groups

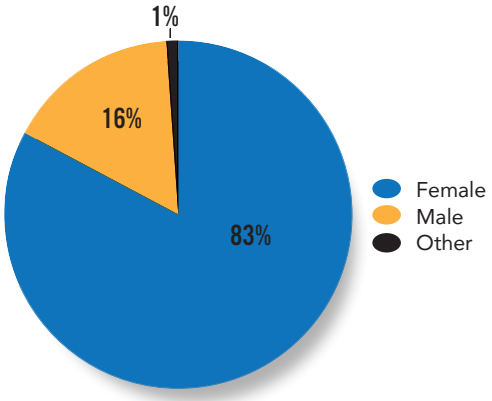
Community At a Glance

What We Found: Common Barriers and Challenges Identified in Focus Groups and Interviews

Health Topic Rankings and Writeup

1) Access To Care
2) Clinical Preventative Services
3) Mental Health
4) Obesity, Nutrition, and Physical Activity
5) Oral health
6) Injury and Violence
7) Maternal, Infant, Child Health
8) Sexual Health
9) Substance Misuse
10) Tobacco Use

Data Infographics



Respondents by Sex

Between 2022 and 2025, the health topic of Injury and Violence rose from the 8th to the 6th priority health concern in the community, *reflecting a growing awareness and increased incidence of related issues. This rise highlights the escalating impact of community violence, domestic abuse, unintentional injuries, and other safety concerns on the well-being of residents. Injury and violence are closely connected to other social drivers of health, including poverty, housing instability, lack of education, and limited access to mental health and social support services. Communities facing higher levels of socioeconomic disadvantage often experience disproportionate rates of violence and injury, making this issue both a public health priority and a social justice concern.*

Access to Care

Examining the Issue

Achieving the best possible health outcomes requires timely and equitable access to health care. However, many residents across the Tri-County region face persistent barriers that prevent them from receiving the care they need. These challenges range from a lack of awareness about available services and limited transportation options to difficulty forming trusted relationships with providers. Many of these barriers are rooted in broader social drivers of health, which continue to impact individuals and communities in complex ways. While not all populations face the same challenges, the data suggests that all are affected by access issues in some form.

Charleston County:
Approximately **10.6%** of residents under age 65 are without health insurance, slightly below the national average of **11.5%**.

Berkeley County:
The uninsured rate for those under 65 stands at **10.7%**, also below the national average.

Dorchester County:
11.5% of residents under 65 lack health insurance, aligning with the national average.

COMMUNITY SPOTLIGHT

The Medi Community Resource Center, located in North Charleston, South Carolina, is a nonprofit organization committed to promoting health equity through patient-centered approaches. A key aspect of their mission is enhancing access to care by connecting communities with existing healthcare and social services. Utilizing technology, The Medi facilitates efficient and person-centered information exchange to ensure individuals can easily find resources such as food, health services, housing, and job training programs. Their initiatives include "Red Dress Sundays," which educates women in faith-based communities about heart disease risk factors, and "Medi Mondays," a weekly broadcast on WJNI 106.3 FM focused on community education.

Did You Know

In some Hispanic and Latin communities, the meanings of urgent care and emergency room don't always align with how those terms are understood in the U.S. healthcare system. In fact, in certain countries, the term "urgent care" may be more closely associated with the level of seriousness we attribute to emergency departments—leading individuals to seek out urgent care centers for severe symptoms like chest pain or difficulty breathing. On the other hand, some may view emergency departments as places for less pressing issues simply because of how those services were structured or labeled in their home countries. These differences in interpretation, combined with language barriers and unfamiliarity with the U.S. healthcare landscape, can create confusion and result in delays or inappropriate care. That's why culturally tailored health education and patient navigation services are essential in ensuring all communities can access the right care at the right time.

Voices From The Community

"We may have some of the best healthcare resources in the world you just can't get them"
- Community Organization

"If you don't speak English, it's harder to get care. There's a lot of reasons, part of it being liability reasons and some providers don't feel comfortable getting informed consent if it's not in the same language, and don't feel well positioned or supported to find a way to get informed care."
- Community Leader

Clinical Preventive Services

Examining the Issue

Preventive care significantly reduces the risk of disease, disability, and premature death — yet millions of people across the United States still do not receive the recommended services. Clinical preventive services include routine health screenings, dental check-ups, immunizations, and counseling for healthy behaviors. These services are designed to catch health issues early—such as high blood pressure, diabetes, or certain cancers—before they become more serious and costly to treat. They also include interventions that help prevent illness altogether, like flu shots and smoking cessation support.

Despite their importance, many individuals face barriers that keep them from accessing this care. These barriers include cost, lack of a primary care provider, geographic distance from clinics or providers, language and cultural challenges, and limited awareness about which preventive services are recommended for their age or risk factors. Expanding access to clinical preventive services, especially in underserved communities, is essential for improving health outcomes and reducing health disparities across the Lowcountry.

COMMUNITY SPOTLIGHT

North Charleston Dental Outreach (NCDO) is a faith-based nonprofit dental clinic dedicated to providing essential dental care to underinsured individuals facing financial constraints. Among its array of services, NCDO emphasizes preventative care to promote long-term oral health. In collaboration with Trident Technical College, the clinic offers basic hygiene services, including deep cleanings, to established patients. These services are designed to prevent dental issues before they escalate, ensuring patients maintain optimal oral health. Eligible patients can access these preventative care services for a nominal fee on a sliding scale. By focusing on preventive measures, NCDO aims to reduce the incidence of severe dental problems in the community, aligning with its mission to serve those in need through compassionate and accessible dental care.

Did You Know

South Carolina is part of the "Stroke Belt," a region in the southeastern United States with a notably higher incidence of stroke and cardiovascular diseases compared to the national average. This area includes 11 states, among them South Carolina, where factors such as higher rates of hypertension, diabetes, and obesity contribute to the increased risk. Regular clinical preventive services, including blood pressure screenings, cholesterol checks, and lifestyle counseling, are essential in mitigating these risks and reducing the prevalence of stroke in the region.

Voices From The Community

"When people are focused on their basic needs, then they're not going to be as concerned about other things that they may see as optional"
- Community Organization

"My mom's 84 and I still see people in her generation, her age range that don't have access to consistent, reliable health care. Health care is defined by an event and not a lifestyle, so if something happens, they'll go to a doctor. But just as a routine maintenance type. It's a reactionary. It's very reactionary."
- Community Leader

Behavorial Health

Examining The Issue

According to data from the federal Health Resources and Services Administration, about 122 million people, or about 35% of the U.S. population, live in an area with a mental health care professional shortage. In SC, the factors impacting mental health, such as increased pressures from social media; population disparities; and lingering impacts of the global pandemic are amplified by the lack of access to mental health care. These pressures are especially impacting youth, who, are also pressured by academic demands and societal expectations. Therefore, prioritizing youth will be essential in strengthening our future generations.

COMMUNITY SPOTLIGHT

Landmarks for Families, formerly known as the Carolina Youth Development Center, is a Charleston-based nonprofit organization dedicated to supporting the behavioral health and overall well-being of children and families in South Carolina. Recognizing behavioral health as a critical need, the organization offers a continuum of care that includes parent education, family preservation, residential services, and community-based programs. Utilizing evidence-based models like the Teaching-Family Model® and Trust-Based Relational Intervention, Landmarks for Families provides trauma-informed, individualized care aimed at healing and empowering individuals. Their services address the impacts of trauma, abuse, and neglect, fostering resilience and promoting mental health through supportive environments and skill-building initiatives. By focusing on prevention, safety, and continuous support, Landmarks for Families plays a pivotal role in nurturing the mental and emotional health of the communities they serve.

Did You Know

In Charleston County, the Tri-County Crisis Stabilization Center (serving Charleston, Dorchester, and Berkeley) saw a 57% increase in admissions and a 35% increase in referrals since 2023—a sign of both rising demand for mental health crisis care and the growing utilization of dedicated crisis services. This surge highlights an urgent need for accessible, specialized behavioral health support across the tri-county region.

Voices From The Community

"I would love to see our community take more steps in preventative care and be more open to talk about mental health and how those things can also lead to other things. I think about our immigrant population who has issues with substance abuse - they go to work, they come home, and repeat six days a week, seven days a week. I have noticed just from being in this community that that takes a total on their mental health. Their way of dealing with it is through alcohol predominantly. They're hard workers, but it pains me to see them not enjoy a healthy lifestyle, because that can lead to aggressive behavior, domestic violence, or things of that nature."

- Community Leader

Obesity, Nutrition, Physical Activity

Examining the Issue

Healthy Tri-County's approach to Obesity, Nutrition, and Physical Activity focuses on ensuring that individuals have access to the fresh fruits and vegetables and safe spaces for physical recreation to reduce the prevalence of chronic diseases and thus improve quality of life. We know that maintaining a healthy diet and an active lifestyle are among the recommendations for maintaining a healthy weight which can decrease the risk for a number of other conditions. All of our counties have pockets of food desserts, an area without access to healthy food options. Creating more access points to fresh produce has been one of our focuses since the last CHNA through funding provided by Healthy People, Healthy Carolinas.

COMMUNITY SPOTLIGHT

FoodShare SC is a state-wide initiative to increase access to fresh produce across the state of South Carolina. In 2023, FoodShare of Berkeley County began in Moncks Corner, at the Berkely County Resource Connection center. Moncks Corner is both an urban center for the county and a food desert which makes it an ideal location for the first distribution site. As of April 2025, the program has expanded to FoodShare Tri-County including 6 partner sites, serving an average of 250 unique customers and approximately 1000 boxes of food per quarter thanks to funding by Healthy Tri-County and other community partners.

Voices of The Community

"Diabetes does so much damage, it affects your vision and your limbs. If we can prevent that just by healthy eating and education, we would really be able to reduce so many other issues that come from diabetes".

- Community Organization

"I've been in some classes where they teach people how to eat healthier and talk about portions, but it's all relevant to an American based diet,so people can't relate, can't connect. Changing that perspective in those programs to also be culturally competent is really important, because obesity is heavy in our community, the sugar intake from sodas is very high."

- Community Leader

Maternal Infant Child Health

Examining the Issue

Maternal and child health in the Charleston, Berkeley, and Dorchester counties of South Carolina focuses on improving health outcomes for women, infants, and children. Key initiatives aim to enhance reproductive health, reduce maternal mortality and morbidity, and ensure early identification and treatment of developmental delays in young children. Despite advancements in medical care, persistent inequities in maternal and infant health continue to affect communities of color throughout these regions. One of the worst health outcomes for women and infant health in the United States remains maternal mortality, which remains significantly higher than in other high-income countries. Black women face the highest rates of maternal deaths, with many of these deaths being preventable, underscoring the urgent need for better healthcare and policy changes. Severe maternal morbidity, including complications during pregnancy and childbirth, is also a critical issue.

COMMUNITY SPOTLIGHT

BEE Collective (Beloved Early Education and Care Collective) is a community-focused organization dedicated to birthing and healing justice in South Carolina. Founded in 2017, the Collective aims to improve children's social-emotional development from birth to age six, particularly in Berkeley County. They address issues like exclusion and expulsion in early learning settings, which disproportionately affect children of color and children with disabilities.

The BEE Collective's work is not just about providing services; it's about inspiring change. They support family resilience through various services, including doula support, reproductive health information, and parent groups. They aim to ensure all families can access quality maternal, child, and family health care. By tackling biases in the birthing and early education systems, the Collective is inspiring the community to lead the way toward solutions, showing that change is possible and within reach.

Did You Know

As of 2021, 14 counties in South Carolina had no practicing OB-GYNs, and five counties had only one OB-GYN provider. This shortage is also evident in the Tri-County region.

According to The Post and Courier, the number of OB-GYNs whose primary practice location is in each county is as follows:

- Berkeley County: 1
- Dorchester County: 12
- Charleston County: 124

This stark disparity highlights a critical gap in access to maternal healthcare, particularly in rural and underserved areas.

Voices of The Community

"The TriCounty continues to lead the state and country with the highest rates of maternal mortality at 47.2/100,000 live births, significant racial disparities with black women 4 times more likely to die than white women, infant mortality rate 6.8/1,000 live births, and rural hospitals at continued risk of closing its doors annually. It's time SC health care is overhauled and resources are provided to allow providers to be proactive rather than reactive. This can be done in the form of improved access to care, doula services, enhanced provider education and cultural competency training."

- Community Leader

Acknowledgement

CHNA Advisory Group

This report is based on the collaboration of numerous organizations. The Core Partners are pleased to extend a special thanks to all staff and community partners who actively served on the Community Health Needs Assessment Advisory Workgroup.

South Carolina Department of Public Health
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Dr. DaQuarta Wright, Organizational Excellence

Trident United Way
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Angela Johnson*, Community Impact
Kiran Sharma, Health Intern (Charleston Southern University)
Jocelyn Nguyen, Health Intern (College of Charleston)

Supporting Community Partners
AccessHealth Tri-County Network
Alliance for a Healthier SC
BEE Collective
Cane Bay YMCA
Charleston Chamber of Commerce
Charleston Southern University
Cross High School
College of Charleston
County Libraries (Berkeley, Charleston, and Dorchester)
Department of Public Health
Fetter Healthcare
First Steps- Berkely, Charleston, and Dorchester counties
Kay Phillips Children's Advocacy Center
Midland Park Primary School
North Charleston Dental Outreach
Nuestro Estado News
Palmetto Goodwill
St. James Health & Wellness
Tri-County Diabetes Prevention Programs Coalition
Universal Latin News
Veterans Suicide Prevention Coalition
180Place

Healthy Tri-County Health Data Workgroup
Several staff and organizations dedicated additional time and resources to gather qualitative and quantitative data throughout the data collection process.
Lydia Ford
Rita Aidoo
Renee Dykstra
Elijah Melendez
Paul Wieters
Sydney Conrad
David Powell
Crystal Davis
Krystal Scott
Braw Dewalt
Denika Richardson
Simone Davis
Hyacinthi Mwangu

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Community at a Glance

// United States / South Carolina / Berkeley County, South Carolina

Populations and People
Total Population
229,861

Employment
Employment Rate
62.2%

Business and Economy
Total Employer Establishments
4,230

Income and Poverty
Median Household Income
$86,658

Housing
Total Housing Units
106,977

Families and Living Arrangements
Total Households
100,299

Education
Bachelor's Degree or Higher
33.8%

Health
Without Health Care Coverage
8.5%

Race and Ethnicity
Hispanic or Latino (of any race)
20,328

// United States / South Carolina / Charleston County, South Carolina

Populations and People
Total Population
408,235

Employment
Employment Rate
63.5%

Business and Economy
Total Employer Establishments
15,801

Income and Poverty
Median Household Income
$93,911

Housing
Total Housing Units
216,974

Families and Living Arrangements
Total Households
186,235

Education
Bachelor's Degree or Higher
51.6%

Health
Without Health Care Coverage
7.3%

Race and Ethnicity
Hispanic or Latino (of any race)
29,280

// United States / South Carolina / Dorchester County, South Carolina

Populations and People
Total Population
161,540

Employment
Employment Rate
63.1%

Business and Economy
Total Employer Establishments
2,861

Income and Poverty
Median Household Income
$83,907

Housing
Total Housing Units
71,069

Families and Living Arrangements
Total Households
67,113

Education
Bachelor's Degree or Higher
30.0%

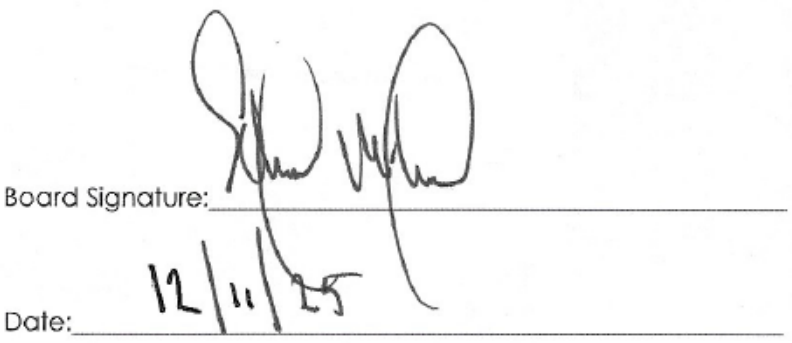
Health
Without Health Care Coverage
7.5%

Race and Ethnicity
Hispanic or Latino (of any race)
10,861

Source: U.S. Census Bureau

Board Approval

The Roper St. Francis Healthcare – Charleston Market 2025 Community Health Needs Assessment was approved by the Roper St. Francis Healthcare– Charleston Market Board of Directors on December 11, 2025.



For further information or to obtain a hard copy of this Community Health Needs Assessment (CHNA) please contact Renee Linyard-Gary, DHA, MBA at Ellen.Linyard-Gary@rsfh.com.

Roper St. Francis Healthcare CHNA Website:
https://www.rsfh.com/about/mission-department/


ROPER ST. FRANCIS
HEALTHCARE
Mobile Health Unit