ROPER ST. FRANCIS HEALTHCARE

2026-2028 Community Health Implementation Plan

Roper St. Francis Healthcare

2026-2028 Community Health Needs Assessment – Implementation Plan

Roper St. Francis Healthcare –

Adopted by the Roper St. Francis Healthcare Board of Directors on March 19, 2026.

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.

The following document is a detailed Community Health Implementation Plan 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.

Having identified the greatest needs in our community, the Community Health Implementation Plan ensures our resources for outreach, prevention, education, and wellness are directed towards opportunities where the greatest impact can be realized.

Roper St. Francis Healthcare –

8536 Palmetto Commerce Parkway Ladson, SC 29456

RSFH CHNA Short Link: Mission Dept

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Introduction

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.

The detailed process, participants, and results are available in Roper St. Francis Healthcare's Community Health Needs Assessment, which is available rsfh.com. The CHNA report includes Berkeley Hospital, Bon Secours St. Francis Hospital, Mt. Pleasant Hospital, and Roper Hospital to reflect the hospitals' collaborative efforts to assess the health needs of the community they serve.

This Community Health Needs Assessment Implementation Plan will address the prioritized significant community health needs through the CHNA. The Plan indicates which needs Roper St. Francis Healthcare will address and how, as well as which needs Roper St. Francis Healthcare won't address and why.

Beyond programs and strategies outlined in the plan, Roper St. Francis Healthcare will address the health care needs of the community by continuing to operate in accordance with its mission to extend the healing all people with compassion, faith, and excellence. This includes providing care for all individuals regardless of their ability to pay.

The strategies in this Implementation Plan will provide the foundation for addressing the community's significant needs between 2026 – 2028. However, Roper St. Francis Healthcare anticipates that some strategies, and even the needs identified will evolve over that period. Roper St. Francis Healthcare plans a flexible approach to addressing the significant community needs that will allow for adaption to changes and collaboration with other community agencies.

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.

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.

Executive Summary

Background and Process

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.

Identifying Specific Needs

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)

Implementation Plan

Roper St. Francis Healthcare is committed to addressing the prioritized significant health needs of the community through the strategies described in this Implementation Plan.

Prioritized Significant Health Needs

The table below lists the prioritized significant health needs that were identified through the CHNA and specifies which needs Roper St. Francis Healthcare will address.

Prioritized Significant Health Need	Hospital Addressing Need (Y/N)			
	Berkeley Hospital	Bon Secours St. Francis Hospital	Mt. Pleasant Hospital	Roper Hospital
Access To Care	**Yes**	**Yes**	**Yes**	**Yes**
Behavioral Health	**Yes**	**Yes**	**Yes**	**Yes**
Clinical Preventative Services	**Yes**	**Yes**	**Yes**	**Yes**
Maternal, Infant, and Child Health	**Yes**	**Yes**	**No**	**No**
Obesity, Nutrition, and Physical Activity	**Yes**	**Yes**	**Yes**	**Yes**

Prioritized Significant Social Need	Hospital Addressing Need (Y/N)			
	Berkeley Hospital	Bon Secours St. Francis Hospital	Mt. Pleasant Hospital	Roper Hospital
Injury and Violence	**Yes**	**Yes**	**Yes**	**Yes**
Health Equity	**Yes**	**Yes**	**Yes**	**Yes**

Social Needs:
While the CHNA identified five prioritized health needs, Injury and Violence and Health Equity were included in the Community Health Implementation Plan (CHIP) as cross-cutting focus areas. Both were noted in the CHNA findings as areas of increased concern compared to the previous CHNA cycle. Because these issues influence multiple prioritized needs and contribute to disparities in health outcomes, strategies were included to address their impact across implementation activities.

Roper St. Francis Healthcare will address each need with regional strategies that have various activation dates throughout the three-year implementation life cycle. Some of the strategies will take place in communities that are geographically associated/tagged to a specific hospital.

Prioritized Significant Clinical Health Needs Implementation Strategies:

Access To Care

Description
As detailed in the hospital's Community Health Needs Assessment Report:

Access to Care within the Community Health Implementation Plan focuses on reducing barriers that prevent individuals from obtaining timely, appropriate, and affordable healthcare services. While the CHNA identifies gaps, such as provider shortages, insurance coverage limitations, transportation challenges, language barriers, and appointment availability, the Implementation Plan outlines the strategies the health system will deploy to address those gaps.

These strategies include expanding mobile health services, strengthening partnerships with free and charitable clinics, enhancing language access services, improving care coordination and referral pathways, and investing in community health workers.

Goal
The goal is to improve preventive care utilization, reduce avoidable emergency department visits, and advance health equity across the communities served.

Expected impact

For Charleston, Dorchester, and Berkeley Counties, the expected impact of Access to Care strategies is improved timely utilization of primary and preventive services, particularly among uninsured, underinsured, rural, and linguistically diverse populations. Over time, this should reduce avoidable emergency department utilization, improve chronic disease management outcomes, and narrow disparities in access and health outcomes across the Tri-County region.

Targeted populations

- Uninsured and Underinsured Adults – Particularly working adults who fall into coverage gaps or have high deductibles that delay care.
- ALICE Households (Asset Limited, Income Constrained, Employed) – Families earning above the federal poverty level but unable to afford consistent healthcare access.
- Rural Residents (especially in Berkeley and parts of Dorchester County) – Individuals facing transportation barriers, provider shortages, and longer travel times to specialty care.
- Low-Income Families and Medicaid Beneficiaries – Populations with higher rates of chronic disease and greater reliance on emergency departments.
- Racial and Ethnic Minority Populations – Particularly Black/African American communities who experience higher rates of hypertension, diabetes, maternal health disparities, and historical access inequities.
- Hispanic/Latino Communities and Individuals with Limited English Proficiency (LEP) – Residents who face language access barriers and limited health literacy support.
- Older Adults (65+) – Especially those managing multiple chronic conditions and transportation challenges.
- Individuals with Behavioral Health Needs – Including those with limited access to outpatient mental health and substance use services.

Strategies

Strategies	Description	Measures	Goal	Market Hospital Participation
Navigate high users of emergency departments to primary care medical homes	Identify and navigate uninsured and underinsured Emergency Department super utilizers to medical homes through coordinated health system partnerships and team-based care planning.	Number of patients (old and new) for AccessHealth and Greer Transitions Clinic. Percentage reduction in ED visits	Sustain support and participation with Access Health and Greer Transitions Clinic	All Hospitals

Strategies	Description	Measures	Goal	Market Hospital Participation
Connect underinsured and uninsured patients to medical homes.	Refer underinsured and uninsured RSFH patients to AccessHealth and/or the Transitions Clinic.	Number of patients (old and new) for AccessHealth and Greer Transitions Clinic.	Continue to coordinate with AccessHealth and Greer Transitions Clinic.	All Hospitals
Coordinate and collaborate with safety-net partners for delivery of services, including area Federally Qualified Health Centers (FQHC), free clinics, and homeless shelters.	Provide lab and imaging services to partner medical clinics: Barrier Islands Free Medical Clinic, Our Lady of Mercy Outreach, East Cooper Community Outreach, Dream Center, One80 Place, Shifa Clinic & Medical Ministries, Harvest Free Medical Clinic, Edisto Island Free Clinic.	Amount of in-kind lab and diagnostic services provided to free partner clinics.	Continue to provide services to local partners	All Hospitals
Provide in-home care to patients with limited mobility through Home Health and Hospice Care.	Provide high quality care for patients with transportation or mobility issues or those with end-of-life needs through in-home or inpatient Hospice or Home Health services.	Number of home health, in-home hospice, and inpatient patients	Continue providing Home Health and Hospice services.	All Hospitals
Increase community-based access to preventive and primary care services through mobile health outreach.	Deploy mobile services to priority communities on designated days to improve access to preventive and primary care.	Number of events annually, number of persons served.	Expand mobile health outreach to increase weekly community presence and deliver 50–60 targeted screening and engagement events annually.	All Hospitals

Strategies	Description	Measures	Goal	Market Hospital Participation
Improve equitable access to care by enhancing language access infrastructure and community-based interpretation support.	Enhance access to care for limited English proficiency (LEP) populations through community-based language support partnerships and measurable language access infrastructure.	Number of qualified bilingual staff (QBS)	Establish a baseline of QBS, Continue partnership with local LEP populations	All Hospitals
Maintain community health workers across community and health system settings to improve care navigation and care coordination.	Maintain community health worker integration across community and health system settings to improve care navigation, follow-up, and social needs resolution.	Number of CHW-certified teammates employed	Embed CHW-certified teammates into priority service lines and community settings to strengthen care coordination and reduce avoidable utilization. Add 3 FTW CHW's to the system by 2029.	All Hospitals
Strengthen data collection and reporting processes with Community Investment partners to track and measure the number of individuals served through funded programs and initiatives.	Implement standardized reporting with Community Investment partners to track the number of individuals served through funded programs and measure community health impact aligned with CHNA priorities.	Number of persons served through Community Investment Partnerships	Establish a baseline of persons served through Community Investment partnerships focusing on Access To Care	All Hospitals

Community collaborations

Roper St. Francis Healthcare works closely with a network of community-based clinics and service organizations—including Barrier Islands Free Medical Clinic, Shifa Clinic, Our Lady of Mercy Community Outreach, East Cooper Community Outreach, the Dream Center, One80 Place, Medical Ministries, Harvest Free Medical Clinic, and the Edisto Island Free Clinic; to help ensure that uninsured, underinsured, and vulnerable populations can obtain needed healthcare services.

These partners provide critical safety-net services such as primary care, preventive screenings, chronic disease management, care coordination, and referrals, often at low or no cost for individuals who face financial, transportation, or insurance barriers. For example, free clinics like Barrier Islands Free Medical Clinic provide ongoing medical care and specialty services for low-income, uninsured adults in the Charleston area, helping address gaps in the healthcare system. Through referrals, shared outreach efforts, and coordinated community investment grants, these collaborations strengthen the regional safety-net infrastructure and expand the reach of preventive and primary care services in high-need communities. Together, these partnerships help reduce barriers to care, improve health outcomes, and advance health equity by ensuring that residents, regardless of income or insurance status, can access timely and appropriate healthcare resources.

Community resources available

Additional community resources can be found at:

Charleston County:
https://www.charlestoncounty.org/departments/community-development/files/ResourceDirectory.pdf

Berkeley County: https://berkeleycountysc.gov/dept/coroner/community-outreach-resources/

Dorchester County: https://www.dorchestercountysc.gov/services/homelessness-resources

Prioritized Significant Clinical Health Needs Implementation Strategies:

Behavioral Health

Description
As detailed in the hospital's Community Health Needs Assessment Report:

Behavioral Health within the Community Health Implementation Plan focuses on improving access to mental health and substance use prevention, early intervention, and supportive services across the community. The CHNA identifies ongoing challenges including provider shortages, stigma surrounding mental health care, limited access to treatment services, and gaps in care coordination.

The Implementation Plan outlines strategies to expand community-based behavioral health education, strengthen partnerships with behavioral health providers and community organizations, increase screening and referral opportunities, and integrate behavioral health awareness into outreach and clinical settings.

Goal
The goal is to promote early identification of behavioral health needs, reduce crisis-driven care utilization, and improve overall mental and emotional well-being across the communities served.

Expected impact
Implementation of behavioral health strategies is expected to increase awareness and early identification of mental health and substance use needs, improve access to community-based behavioral health resources, and strengthen coordination between healthcare providers and community partners. These efforts aim to reduce behavioral health crises, decrease avoidable emergency department utilization, and improve overall mental and emotional well-being among residents in Charleston, Dorchester, and Berkeley counties.

Targeted populations

- Uninsured and Underinsured Adults – Particularly working adults who fall into coverage gaps or have high deductibles that delay care.
- ALICE Households (Asset Limited, Income Constrained, Employed) – Families earning above the federal poverty level but unable to afford consistent healthcare access.
- Rural Residents (especially in Berkeley and parts of Dorchester County) – Individuals facing transportation barriers, provider shortages, and longer travel times to specialty care.

- Low-Income Families and Medicaid Beneficiaries – Populations with higher rates of chronic disease and greater reliance on emergency departments.
- Racial and Ethnic Minority Populations – Particularly Black/African American communities who experience higher rates of hypertension, diabetes, maternal health disparities, and historical access inequities.
- Hispanic/Latino Communities and Individuals with Limited English Proficiency (LEP) – Residents who face language access barriers and limited health literacy support.
- Older Adults (65+) – Especially those managing multiple chronic conditions and transportation challenges.
- Individuals with Behavioral Health Needs – Including those with limited access to outpatient mental health and substance use services.

Strategies

Strategies	Description	Measures	Goal	Market Hospital Participation
Coordinate services between Emergency Departments and regional mental health agencies.	Participate in the Charleston/Dorchester Mental Health Department's community task force.	Continuing participation and collaboration	Continue participation in regularly scheduled meetings.	All Hospitals
Provide services and education to combat the opioid epidemic.	Partner with local police departments on Drug Take Back events throughout the Tri-County	Number of events held and rural sites identified Engagement with Substance Use Committee	Hold least 4 Take Back events in the area per year.	All Hospitals
Provide mental health screenings at wellness and postpartum OB/GYN visits.	Incorporate depression screenings at primary care wellness visits and postpartum OB/GYN patient visits.	Percentage of patients who received depression screenings during wellness checks and percentage of	Continue tracking and promoting mental health screenings as part of routine primary care and postpartum medical exams.	All Hospitals

Strategies	Description	Measures	Goal	Market Hospital Participation
		patients who received a follow-up post partum visit		
Integrate behavioral health screenings and referral pathways across RSFH primary care, OBGYN, and Mobile Health Services	Continue providing behavioral health screenings for physician partners	Number of behavioral health screenings for physician partners	Continue behavioral health screenings for primary care patients.	All Hospitals
Promote early identification, reduce stigma, and strengthen referral pathways to community-based mental health services.	Strengthen cross-system coordination to improve access, referral pathways, and continuity of care for individuals experiencing behavioral health and developmental disability needs.	Continue partnership with SC Department of Behavioral Health and Developmental Disability	Participate in 3 outreach events annually focusing on mental health.	All Hospitals
Strengthen data collection and reporting processes with Community Investment partners to track and measure the number of individuals served through funded programs and initiatives.	Implement standardized reporting with Community Investment partners to track the number of individuals served through funded programs and measure community health impact aligned with CHNA priorities.	Number of persons served through Community Investment Partnerships	Establish a baseline of persons served through Community Investment partnerships focusing on Behavioral Health	All Hospitals
Combat social isolation and support aging in place by engaging older adults in senior center activities.	The senior centers engage older adults in fitness, wellness, educational, and socialization activities that reduce loneliness, promote independence, and improve overall quality of life.	Total visits to senior center activities (includes activities at off-site locations) Total senior center members	Continue engagement with senior center members	All Hospitals

Community resources available

Additional community resources can be found at:

Charleston County:
https://www.charlestoncounty.org/departments/community-development/files/ResourceDirectory.pdf
Berkeley County: https://berkeleycountysc.gov/dept/coroner/community-outreach-resources/
Dorchester County: https://www.dorchestercountysc.gov/services/homelessness-resources

Prioritized Significant Clinical Health Needs Implementation Strategies:

Clinical Preventative Services

Description
As detailed in the hospital's Community Health Needs Assessment Report:

Clinical Preventive Services within the Community Health Implementation Plan focuses on increasing access to evidence-based screenings, immunizations, and early detection services that prevent disease and improve long-term health outcomes. The CHNA identifies gaps in preventive screening utilization, chronic disease detection, and access to routine preventive care, particularly among uninsured and underserved populations.

Implementation strategies include expanding mobile health outreach, providing community-based screening events, strengthening referral pathways to primary care medical homes, and promoting preventive health education.

Goal
The goal is to increase early identification of health conditions, reduce preventable disease burden, and improve population health outcomes across the communities served.

Expected impact
Implementation of clinical preventive service strategies is expected to increase utilization of evidence-based screenings, immunizations, and early detection services, particularly among underserved and high-risk populations. These efforts aim to improve early identification and management of chronic conditions, reduce preventable disease burden, and decrease avoidable hospitalizations and emergency department utilization across Charleston, Dorchester, and Berkeley counties.

Targeted populations

- Uninsured and Underinsured Adults – Particularly working adults who fall into coverage gaps or have high deductibles that delay care.
- ALICE Households (Asset Limited, Income Constrained, Employed) – Families earning above the federal poverty level but unable to afford consistent healthcare access.
- Rural Residents (especially in Berkeley and parts of Dorchester County) – Individuals facing transportation barriers, provider shortages, and longer travel times to

specialty care.

- Low-Income Families and Medicaid Beneficiaries – Populations with higher rates of chronic disease and greater reliance on emergency departments.
- Racial and Ethnic Minority Populations – Particularly Black/African American communities who experience higher rates of hypertension, diabetes, maternal health disparities, and historical access inequities.
- Hispanic/Latino Communities and Individuals with Limited English Proficiency (LEP) – Residents who face language access barriers and limited health literacy support.
- Older Adults (65+) – Especially those managing multiple chronic conditions and transportation challenges.
- Individuals with Behavioral Health Needs – Including those with limited access to outpatient mental health and substance use services.

Strategies

Strategies	Description	Measures	Goal	Market Hospital Participation
Provide routine, primary care for low-income, uninsured adults	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, One80 Place, Shifa Clinic, & Medical Ministries.	Services provided through the year	Continue providing in-kind services to local partners.	All Hospitals
Provide routine, primary care for low-income, uninsured adults	Provide financial support for clinical staff and infrastructure at Our Lady of Mercy Outreach.	Amount of support provided through the year	Continue financial support and promote services of the agency.	All Hospitals

Strategies	Description	Measures	Goal	Market Hospital Participation
Provide early intervention services for patients diagnosed with HIV/AIDS.	Enroll HIV positive patients into Health Services Center White program.	Number of HIV and primary care provided to HIV positive patients	Continue to provide comprehensive HIV care	All Hospitals
Provide early intervention services for patients diagnosed with HIV/AIDS.	Ensure continued health insurance coverage for HIV positive adults using federal and employer insurance programs.	Number of patients the wellness center maintains health coverage for	Continue to enroll patients in federal insurance program and assist with employer-based plans.	All Hospitals
Provide early intervention services for patients diagnosed with HIV/AIDS.	Seek grant funding to expand primary prevention services for high risk HIV negative adults, and prevent the rate of transmission for HIV positive patients.	Number of patients the wellness center provides HIV prevention to	Continue to promote HIV awareness and prevention.	All Hospitals
Provide early intervention services for patients diagnosed with HIV/AIDS.	Provide free HIV testing at community events and in-clinic.	Number of Community Events and clinic tests performed	Continue to promote HIV testing, awareness, and prevention.	All Hospitals
Provide evidence-based outpatient care for diabetic patients.	Track percentage of patients who receive evidence-based outpatient care for diabetes.	Number of patients diagnosis of diabetes receiving A1c testing	Continue assessments via the RSFH Physician Partners.	All Hospitals
Expand access to free annual cancer screenings for priority populations.	Provide free cancer screenings for priority populations including breast, colorectal, lung, and skin.	Number of events and participants	Participate in at least 6 cancer screening events annually.	All Hospitals

Strategies	Description	Measures	Goal	Market Hospital Participation
Increase access to evidence-based preventive screenings through Mobile Health Units and community-based events in high-need zip codes.	Participate in community health events throughout the Tri-County area.	Number of preventative screenings provided	Participate in 50–60 targeted screening and engagement events annually.	All Hospitals
Expand evidence-based diabetes and cardiovascular prevention programs targeting high-risk adults.	Enroll patients into diabetes prevention programs.	Number of individuals enrolled in DPP programs % of individuals completed DPP program.	Establish a baseline of individuals enrolled in DPP programs across the system and the number of individuals who complete the program.	All Hospitals
Increase access to preventative oral health education and screening in underserved populations	Provide oral health care services to underserved populations.	Number of patient visits to the HSC dental clinic	Continue to provide dental services to HSC patients.	All Hospitals
Strengthen data collection and reporting processes with Community Investment partners to track and measure the number of individuals served through funded programs and initiatives.	Implement standardized reporting with Community Investment partners to track the number of individuals served through funded programs and measure community health impact aligned with CHNA priorities.	Number of persons served through Community Investment Partnerships	Establish a baseline of persons served through Community Investment partnerships focusing on Clinical Preventative Services	All Hospitals

Community resources available

Additional community resources can be found at:

Charleston County: https://www.charlestoncounty.org/departments/community-development/files/ResourceDirectory.pdf

Berkeley County: https://berkeleycountysc.gov/dept/coroner/community-outreach-resources/

Dorchester County: https://www.dorchestercountysc.gov/services/homelessness-resources

Prioritized Significant Clinical Health Needs Implementation Strategies:

Maternal Infant and Child Health

Description
As detailed in the hospital's Community Health Needs Assessment Report:

Maternal, Infant, and Child Health within the Community Health Implementation Plan focuses on improving health outcomes for mothers, infants, and children through enhanced access to prenatal care, education, and supportive services. The CHNA highlights disparities in maternal health outcomes, infant mortality, access to prenatal and postpartum care, and social determinants impacting family health.

The Implementation Plan includes strategies to strengthen partnerships with community-based organizations, expand maternal health education and outreach, support care coordination and resource navigation, and increase access to preventive services for mothers and children.

Goal
The goal is to promote healthy pregnancies, improve birth outcomes, support early childhood development, and reduce health disparities among vulnerable populations.

Expected impact
Implementation of maternal, infant, and child health strategies is expected to improve access to prenatal, postpartum, and pediatric preventive services, increase utilization of supportive resources for families, and promote healthy pregnancies and early childhood development. These efforts aim to improve birth outcomes, enhance maternal and infant health, and reduce health disparities among mothers, infants, and children across Charleston, Dorchester, and Berkeley counties.

Targeted populations

- Uninsured and Underinsured Adults – Particularly working adults who fall into coverage gaps or have high deductibles that delay care.

- ALICE Households (Asset Limited, Income Constrained, Employed) – Families earning above the federal poverty level but unable to afford consistent healthcare access.

- Rural Residents (especially in Berkeley and parts of Dorchester County) – Individuals facing transportation barriers, provider shortages, and longer travel times to specialty care.

- Low-Income Families and Medicaid Beneficiaries – Populations with higher rates of

chronic disease and greater reliance on emergency departments.

- Racial and Ethnic Minority Populations – Particularly Black/African American communities who experience higher rates of hypertension, diabetes, maternal health disparities, and historical access inequities.

- Hispanic/Latino Communities and Individuals with Limited English Proficiency (LEP) – Residents who face language access barriers and limited health literacy support.

- Individuals with Behavioral Health Needs – Including those with limited access to outpatient mental health and substance use services.

Strategies

Strategies	Description	Measures	Goal	Market Hospital Participation
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.	Care offered through the year and any other services provided	Continue coordinating care teams.	Berkeley Hospital and Bon Secours St Francis Hospital
Offer specialized services for high risk pregnancies.	Support a Maternal Fetal Medicine program that includes medical management, counseling, biophysical profiles, diagnosis and management of birth defects, and other highly specialized services.	Number of patients visits, and total number of patients served	Continue MFM services.	Berkeley Hospital and Bon Secours St Francis Hospital

Strategies	Description	Measures	Goal	Market Hospital Participation
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.	Number of annual exams, deliveries and GYN patients	Continue support and promote services of the agency.	Berkeley Hospital and Bon Secours St Francis Hospital
Provide prenatal care for uninsured patients that are not eligible for Medicaid.	Provide routine lab work, radiology services, prenatal education classes, and Maternal Fetal Medicine services for Spanish-speaking patients.	Support provided	Continue support and promote services of the agency.	Berkeley Hospital and Bon Secours St Francis Hospital
Host expectant parent education classes and tours, and Safe Sitter ® classes.	Facilitate regularly scheduled expectant parent education classes and hospital tours as well as Safe Sitter ® classes.	Number of classes held and participants	Continue to offer onsite and online options for convenience.	Berkeley Hospital and Bon Secours St Francis Hospital
Expand access to culturally responsive doula and maternal support services to reduce disparities in maternal morbidity and improve birth outcomes across the Tri-County region.	Partner with local doula organizations to provide prenatal education,	Support local agencies providing doula services.	Continue financial support and promote services to local agencies.	Berkeley Hospital and Bon Secours St Francis Hospital

Strategies	Description	Measures	Goal	Market Hospital Participation
	labor support, and postpartum follow-up for high-risk and underserved patients.			
Expand access to pediatric specialty and inpatient services through the development of a dedicated pediatric unit.	Establish and operationalize a pediatric inpatient unit to expand local access to specialized pediatric care and improve continuity of care for children and families within the Tri-County region.	Number of pediatrics admissions to unit	Improve access to high-quality, coordinated pediatric care across Charleston, Dorchester, and Berkeley Counties.	Bon Secours St. Francis Hospital
Strengthen data collection and reporting processes with Community Investment partners to track and measure the number of individuals served through funded programs and initiatives.	Implement standardized reporting with Community Investment partners to track the number of individuals served through funded programs and measure community health impact aligned with CHNA priorities.	Number of persons served through Community Investment Partnerships	Establish a baseline of persons served through Community Investment partnerships focusing on Maternal Infant and Child Health	All Hospitals

Community resources available

Additional community resources can be found at:

Charleston County:
https://www.charlestoncounty.org/departments/community-development/files/ResourceDirectory.pdf
Berkeley County: https://berkeleycountysc.gov/dept/coroner/community-outreach-resources/
Dorchester County: https://www.dorchestercountysc.gov/services/homelessness-resources

Market Hospital Participation

Roper Hospital and Roper St. Francis Mount Pleasant Hospital no longer offer labor and delivery services at its hospital facilities. Roper Hospital and Roper St Francis Mount Pleasant Hospital will not directly address the maternal, infant and child health need. While this need is not a direct focus for the hospitals, Roper Hospital and Roper St Francis Mount Pleasant Hospital will support the strategies of the Roper St. Francis sites and other local organizations specifically designed and better prepared both through resources and experience to respond to this need.

Prioritized Significant Clinical Health Needs Implementation Strategies:

Obesity, Nutrition, and Physical Activity

Description
As detailed in the hospital's Community Health Needs Assessment Report:

Obesity, Nutrition, and Physical Activity within the Community Health Implementation Plan focuses on addressing chronic disease risk factors by promoting healthy eating, active living, and access to wellness resources. The CHNA identifies high rates of obesity and related chronic conditions influenced by limited access to healthy foods, safe spaces for physical activity, and health education opportunities.

The Implementation Plan outlines strategies to provide nutrition education, support community wellness programming, expand partnerships that promote physical activity, and increase access to preventive lifestyle interventions through community outreach efforts.

Goal
The goal is to encourage sustainable healthy behaviors, reduce chronic disease risk, and improve overall quality of life within the communities served.

Expected impact
Implementation of obesity, nutrition, and physical activity strategies is expected to increase access to nutrition education, wellness programming, and opportunities for physical activity that support healthy lifestyle behaviors. These efforts aim to reduce risk factors associated with chronic disease, improve overall physical health outcomes, and promote long-term healthy weight management among residents in Charleston, Dorchester, and Berkeley counties.

Targeted populations

- Uninsured and Underinsured Adults – Particularly working adults who fall into coverage gaps or have high deductibles that delay care.
- ALICE Households (Asset Limited, Income Constrained, Employed) – Families earning above the federal poverty level but unable to afford consistent healthcare access.
- Rural Residents (especially in Berkeley and parts of Dorchester County) – Individuals facing transportation barriers, provider shortages, and longer travel times to specialty care.
- Low-Income Families and Medicaid Beneficiaries – Populations with higher rates of chronic disease and greater reliance on emergency departments.

- Racial and Ethnic Minority Populations – Particularly Black/African American communities who experience higher rates of hypertension, diabetes, maternal health disparities, and historical access inequities.

- Hispanic/Latino Communities and Individuals with Limited English Proficiency (LEP) – Residents who face language access barriers and limited health literacy support.

- Older Adults (65+) – Especially those managing multiple chronic conditions and transportation challenges.

- Individuals with Behavioral Health Needs – Including those with limited access to outpatient mental health and substance use services.

Strategies

Strategies	Description	Measures	Goal	Market Hospital Participation
Increase opportunities for comprehensive wellness for older adults.	Promote annual primary care screening for each RSFH employee.	Number and percentage of teammates who had PCP visits	Continue to implement Wellness Works incentives to increase employee participation.	All Hospitals
Increase opportunities for comprehensive wellness for older adults.	Promote employee participation in disease-specific events to increase health awareness and advocacy.	Hours of staff time supporting initiatives and number of community residents served	Continue to encourage participation in community-based health events.	All Hospitals
Increase opportunities for comprehensive wellness for older adults.	Host informative and interactive tables/booths during local community and agency health fairs/screenings.	Number of events and fairs held or participated in	Expand outreach to increase weekly community presence and deliver 50–60 targeted screening and engagement events annually.	All Hospitals
Host evidence-based health and wellness community programs for older adults.	Offer physical wellness classes specifically targeting older adults.	Total visits to senior center activities (plus off-site locations) Total senior center members	Continue providing programs & classes throughout the Tri-County.	All Hospitals

Strategies	Description	Measures	Goal	Market Hospital Participation
Strengthen data collection and reporting processes with Community Investment partners to track and measure the number of individuals served through funded programs and initiatives.	Implement standardized reporting with Community Investment partners to track the number of individuals served through funded programs and measure community health impact aligned with CHNA priorities.	Number of persons served through Community Investment Partnerships	Establish a baseline of persons served through Community Investment partnerships focusing on Obesity Nutrition and Physical Activity	All Hospitals

Community resources available

Additional community resources can be found at:

Charleston County: https://www.charlestoncounty.org/departments/community-development/files/ResourceDirectory.pdf

Berkeley County: https://berkeleycountysc.gov/dept/coroner/community-outreach-resources/

Dorchester County: https://www.dorchestercountysc.gov/services/homelessness-resources

Prioritized Significant Social Health and Social Determinants of Health Needs Implementation Strategies:

Injury & Violence and Health Equity

Injury & Violence

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.

Strategies

Strategies	Description	Measures	Goal	Market Hospital Participation
Enhance coordination between RSFH Emergency Departments and community-based violence prevention and victim support agencies to reduce repeat injury and improve long-term safety outcomes.	Refer patients presenting with violence-related injuries, including domestic violence, assault, and unintentional injury to community resources	Number of violence-related ED cases referred to community partners	Continue to provide support services to patients presenting with violence-related injuries	All Hospitals

Strategies	Description	Measures	Goal	Market Hospital Participation
Expand community-based infant injury prevention education	Facilitate regularly scheduled expectant parent education classes and hospital tours as well as Safe Sitter ® classes.	Number of classes held and participants	Continue to offer onsite and online options for convenience.	Berkeley Hospital and Bon Secour St. Francis Hospital

Health Equity

The 2025 CHNA survey respondents were asked to identify most concerning social health and social determinants topics. In summary, the identified topics were related to with health inequities and disparities in care such as equity gaps, cultural competence in care, preventative health gaps, community health workers as a vital connector, digital & language barriers, etc. Thus, we strive to improve health equity within our health system and community.

Strategies

Strategies	Description	Measures	Goal	Market Hospital Participation
Improve culturally competent engagement	Increase Health Literacy in priority populations	Number of health education projects translated to Spanish	Translate10 projects into Spanish annually	All Hospitals

Board Approval

The Roper St. Francis Healthcare 2026-2028 Community Health Implementation Plan was approved by the Roper St. Francis Healthcare Board on March 19, 2026

ROPER ST. FRANCIS BOARD OF DIRECTORS

By: Michael Pazzo
Michael P. Pazzo
Secretary to the Roper St. Francis Healthcare Board

Date: March 19, 2026

For further information or to obtain a hard copy of the CHIP please contact: Ellen.Linyard-Gary@rsfh.com

RSFH CHIP Website: https://www.rsfh.com/about/mission-department/