

THE MOVEMENT NEWSLETTER

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The connection
that keeps us
together



SOUTH CAROLINA
PRIMARY HEALTH CARE
ASSOCIATION



Conferences and Events



 SOUTH CAROLINA
PRIMARY HEALTH CARE
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2026 ANNUAL CONFERENCE *and* BOARD GOVERNANCE RETREAT

 **OCTOBER 23-25**

 **SONESTA RESORT
HILTON HEAD ISLAND**

 **130 Shipyard Drive
Hilton Head Island, SC 29928**

UNIFORM DATA SYSTEM TRAINING 2026

 **VIRTUAL TRAINING SESSION**

 **THURSDAY
NOVEMBER 19TH**  **FRIDAY
NOVEMBER 20TH**

12:30 pm - 4:30 pm  **HOSTED BY**

 SOUTH CAROLINA
PRIMARY HEALTH CARE
ASSOCIATION

 **NCCHCA** NORTH CAROLINA
COMMUNITY HEALTH
CENTER ASSOCIATION



 SOUTH CAROLINA
PRIMARY HEALTH CARE
ASSOCIATION

Save the Date

2027 State Policies & Issues Forum

 **JANUARY 12-13**

 **USC PASTIDES ALUMNI CENTER
900 Senate St., Columbia, SC 29201**

Letter from the Editor



Dear Friends of *The Movement*,

There is something about September that feels like an invitation.

The days may still carry the warmth of summer, but there is a subtle shift in the air. The light begins to change. Mornings feel a little different. The familiar rhythm of a new season starts to take hold. And as fall officially begins this month, we are reminded that change is not something to fear – it is a natural and necessary part of moving forward.

Fall is a season of transition. It asks us to slow down enough to notice what has changed, to appreciate what has grown, and to consider what we are ready to carry with us into the next season. It is also a season of letting go. Trees do not cling to every leaf simply because it has always been there. They release what they no longer need, making room for what comes next.

There is wisdom in that.

As we enter this new season, it is worth asking ourselves: What have we learned? What have we built? What have we outgrown? And, perhaps most importantly, what are we willing to do differently as we continue the work ahead?

At The Movement, we believe progress is rarely a straight line. It is made through seasons—through moments of momentum and moments that require patience, reflection, and recommitment. It is built by people who continue to show up, even when the path forward is uncertain. It grows when we listen to one another, make space for new voices, and turn our shared hopes into meaningful action.

September offers us an opportunity to do just that.

In this edition, we celebrate the people and stories that remind us why this work matters. We look at the progress being made in our communities, the challenges that continue to call for our attention, and the individuals who are helping create change in ways both visible and behind the scenes.

Their stories are reminders that movements are not sustained by a few people doing everything. They are sustained by many people doing what they can, where they are, with what they have.

Sometimes that means leading. Sometimes it means listening. Sometimes it means showing up for someone else. And sometimes it simply means refusing to give up on the possibility of something better.

As the leaves begin to turn and a new season unfolds around us, may we embrace that same spirit of renewal. Let us celebrate how far we have come without losing sight of how far we still have to go. Let us be willing to release old assumptions, make room for new possibilities, and remain open to the lessons each season brings.

Most of all, let us keep moving.

Because change happens when we move from conversation to action, from intention to participation, and from individual concern to collective purpose. Every step matters. Every voice matters. Every person who chooses to engage adds something to the momentum.

So, as you turn the pages of this September edition, I hope you find more than information. I hope you find inspiration. I hope you discover a story that stays with you, an idea that challenges you, or a reminder that your contribution—whatever its size—has a place in this movement.

Fall reminds us that transformation can be gradual and still be profound. A landscape can change one leaf at a time. A community can change one conversation, one act of courage, one person at a time. May this new season bring us clarity about what matters, courage to embrace what is changing, and renewed energy for the work ahead.

Thank you for being part of The Movement—for reading, participating, questioning, encouraging, and continuing to move forward with us.

Here's to a new season, new possibilities, and the continued movement toward a better tomorrow.

With gratitude,

A handwritten signature in black ink that reads "Kenya". The script is fluid and cursive, with a large initial 'K'.

Kenya L. Mingo, MBA, MA, CLSSGB
Editor, The Movement
Director of Corporate Compliance and Communications

A Lesson in Leadership

BEING
A GREAT LEADER
MEANS HIRING
THE BEST PEOPLE
AND THEN
GETTING OUT
OF THEIR WAY.

Victoria Repa. BetterMe

BE PREPARED: A Monthly Emergency Essential



Ready When It Matters - Building a Culture of Emergency Preparedness

Emergencies rarely happen at a convenient time. A severe storm, power outage, fire, medical emergency, workplace incident, or other unexpected events can quickly disrupt normal routines and require people to make important decisions under pressure.

September is National Preparedness Month – a timely reminder that being prepared is not about expecting the worst. It is about taking practical steps today so that we are better equipped to respond when something unexpected happens.

Preparedness Starts Before the Emergency

The first few minutes of an emergency can be critical. Having a plan in place ahead of time helps reduce confusion and allows people to focus on what matters most: protecting themselves and others.

For organizations, preparedness should address more than evacuation routes. A strong emergency plan considers communication, employee safety, continuity of operations, technology and data recovery, and the process for responding to different types of emergencies.

Ask yourself:

- Do I know how I would receive an emergency alert?
- Do I know where I should go during an evacuation or shelter-in-place situation?
- Do I know who to contact if normal communication systems are unavailable?
- Do I know my organization's emergency procedures?
- Have I participated in a drill or reviewed the plan recently?

If the answer to any of these questions is “no,” September is a great time to start.

Make a Plan and Practice It

A plan is only useful if people understand it.

Organizations should regularly review emergency procedures with employees and provide opportunities to practice them. Training and exercises help employees become familiar with what to do before an actual emergency occurs.

Consider reviewing:

- Evacuation routes and designated meeting locations
- Shelter-in-place and lockdown procedures
- Emergency contact information
- Communication procedures and backup methods
- Responsibilities for supervisors, managers, and designated response teams
- Procedures for accounting for employees and visitors
- Business continuity and technology recovery plans

And remember: plans should be updated when circumstances change. A new workspace, staffing change, technology system, or operational process may create new considerations.

Build an Emergency Kit

Preparedness also means having essential supplies available when normal resources are unavailable.

A basic emergency kit may include water, nonperishable food, a flashlight, extra batteries, a first-aid kit, a phone charger or backup battery, a battery-powered or hand-crank radio, sanitation supplies, and other items appropriate to your circumstances. FEMA recommends considering the unique needs of individuals and households when building emergency supplies.

At work, employees may also want to keep a small personal emergency kit available, particularly if they spend significant time at the workplace or commute long distances.

Don't forget the things that can easily be overlooked – important medications, mobility or communication needs, essential documents, pet supplies, and backup power for critical devices.

Stay Connected

During an emergency, reliable information can make a significant difference.

Make sure emergency contact information is current and that you know how your organization communicates urgent information. At home, consider signing up for local emergency alerts and using multiple ways to receive information. FEMA also recommends tools such as Wireless Emergency Alerts and the FEMA App for emergency information.

Most importantly, know where to get information you can trust. During a crisis, rely on official emergency management, public safety, and weather authorities rather than unverified social media posts or rumors.

Preparedness Includes People

No two people experience an emergency in exactly the same way. Effective preparedness considers the needs of the entire community – including individuals who may need additional assistance during an evacuation, communication disruption, or extended power outage.

That means thinking ahead about accessibility, transportation, communication, medical needs, mobility, and other individual circumstances.

Preparedness is stronger when we look out for one another.

Take Five Minutes This September

You don't have to overhaul your entire emergency plan in one day. Start with five minutes.

Check your alerts. Review your emergency contacts. Locate your emergency supplies. Know your evacuation route. Talk with your family or coworkers about what you would do if an emergency happened today.

Small actions taken now can make a meaningful difference later.

Preparedness isn't about predicting exactly what will happen. It's about making sure that when something does happen, we're not starting from scratch.

Be informed. Make a plan. Build a kit. Practice. Stay connected.

Because when an emergency happens, being ready can make all the difference.



September Preparedness Checklist

Take a few minutes this month to make sure you're ready.

☐ Know the plan

Review your workplace emergency procedures, evacuation routes, shelter locations, and emergency contacts.

☐ Update your contacts

Make sure your personal and workplace emergency contact information is current.

☐ Check your alerts

Confirm that you can receive emergency notifications and know where to find reliable information during a crisis.

☐ Build or refresh your emergency kit

Keep essential supplies such as water, food, medications, a flashlight, batteries, a first-aid kit, and phone charging equipment readily available.

☐ Plan for your needs

Consider medications, mobility or accessibility needs, important documents, pets, children, and other individual circumstances that may require additional preparation.

☐ Know where to go

Identify evacuation routes, meeting locations, and safe places to shelter at work and at home.

☐ Practice the plan

Take part in workplace drills and talk with your household about what everyone should do if an emergency occurs.

☐ Stay connected

Know how your organization will communicate during an emergency and identify backup ways to receive important information.

One Small Step Can Make a Big Difference

Preparedness doesn't have to be overwhelming. Start with one item today, then keep building.

Be informed. Make a plan. Build a kit. Practice. Stay connected.



Value-Based Care

VALUE
BASED
CARE



Value-Based Care Strategies for Better Health Outcomes

When we talk about Value-Based Care (VBC), the conversation can quickly become focused on quality measures, data, risk adjustment, attribution, incentives, and reimbursement. While all of these are important, we should not lose sight of the most important question:

What Does Value-Based Care Actually Look Like for the Patient?

At its core, VBC is about providing person-centered, coordinated care that improves health outcomes—not simply providing more services.

For the patient, this may mean having a care coordinator who checks in between visits, receiving help managing a chronic condition, having easier access to care through telehealth or other options, or being connected to community resources that address barriers to good health.

Treating the Whole Person

One of the greatest opportunities for FQHCs is the ability to look beyond the diagnosis and understand the whole person. A patient's ability to achieve better health may be affected by transportation, food insecurity, housing, behavioral health needs, health literacy, or other social factors. VBC encourages care teams to identify these barriers and connect patients with the appropriate resources. Just as importantly, providers should understand the patient's health goals. A successful care plan is not simply something created for the patient, it is something created with the patient.

Data Should Drive the Conversation

VBC also requires us to use the information we already have to identify opportunities to improve care. EHR data, claims information, laboratory results, utilization patterns, and quality data can help health centers identify patients who may be overdue for care, at risk for complications, or experiencing gaps in treatment. This allows the care team to move from reactive care to proactive care. Instead of waiting for a patient to return with a problem, the health center can identify the need and reach out before the problem becomes more serious.

Care Coordination Is Key

Patients often interact with multiple providers and systems. Without coordination, it is easy for care to become fragmented. VBC provides an opportunity for FQHCs to strengthen the connection between primary care, behavioral health, specialty care, care management, and community resources. The goal is simple: The patient should not have to coordinate the health care system by themselves. Integrated teams, individualized care plans, follow-up, patient education, and effective communication can make the health care experience easier for both the patient and the care team.

The Patient Has a Role—And So Does the Health Center

VBC works best when patients are active participants in their care. Patients need to understand their conditions, communicate their concerns, participate in their care plans, and have access to information that helps them make informed decisions. At the same time, health centers have a responsibility to make that participation possible by providing education, improving health literacy, offering convenient access, and meeting patients where they are.

What Does This Mean for FQHCs?

For FQHCs, Value-Based Care is not simply another reimbursement model. It is an opportunity to build on what health centers already do well—providing comprehensive, accessible, patient-centered care.

The financial side of VBC is important. Quality incentives, shared savings, care management payments, and other value-based opportunities can provide resources to support the work. But the ultimate measure of success should be whether those resources help us achieve better outcomes for the people we serve. The goal is not just to capture the data, meet the measure, or earn the incentive. The goal is to use the data, the care team, and the resources available to make a difference in the patient's health.

That is where Value-Based Care becomes valuable.

Clinical Transformation



Childhood Cancer Awareness Month: Advancing Research, Supporting Families, and Strengthening Cancer Prevention

Part One: Advancing Pediatric Oncology Research and Supporting Families

Each September, Childhood Cancer Awareness Month provides an opportunity to recognize children and adolescents affected by cancer, honor survivors, remember those whose lives were lost, and advocate for the families and caregivers who experience the cancer journey alongside them.

Although childhood cancer is considered rare, it remains one of the leading causes of disease-related death among children and adolescents in the United States. Analysis of nearly five decades of Surveillance, Epidemiology, and End Results data demonstrates that childhood cancer survival has improved substantially, with five-year survival increasing from approximately 63% during 1975–1979 to more than 85% during 2010–2019 (Sultan et al., 2025). However, these improvements have not been experienced equally across all cancer types or populations, reinforcing the need for continued research, equitable access to treatment, and targeted interventions.

Advancing Pediatric Oncology Research

Childhood cancers differ biologically from cancers most commonly diagnosed in adults. Because pediatric cancers are comparatively rare, research may be affected by smaller patient populations, limited clinical-trial enrollment, and challenges developing treatments for uncommon cancer subtypes. Continued investment in pediatric oncology research is therefore essential to:

- Develop safer and more effective treatments.
- Expand access to clinical trials and precision medicine.
- Reduce treatment-related toxicity and long-term complications.
- Address disparities in diagnosis, treatment, and survival.
- Improve options for children with rare, relapsed, or treatment-resistant cancers.
- Explore appropriate risk-based surveillance for children with cancer-predisposition syndromes.

Most childhood cancers do not have recommended population-wide screening tests. Unlike breast, cervical, and colorectal cancers, childhood cancers frequently develop rapidly and may not have identifiable precancerous stages. Consequently, broad screening of children at average risk has not demonstrated the same benefits seen with established adult cancer-screening programs (Vasquez et al., 2021). Pediatric cancer strategies must instead emphasize clinical vigilance, recognition of persistent or unusual symptoms, risk-based surveillance, timely diagnostic evaluation, and rapid referral to pediatric oncology specialists.

Supporting Survivors Across the Lifespan

Improved survival has created a growing population of childhood cancer survivors who may require lifelong, risk-based follow-up care. Cancer treatments received during childhood can contribute to cardiovascular disease, endocrine disorders, secondary cancers, cognitive changes, fertility concerns, and other late effects that may emerge years after treatment has ended (Hudson et al., 2021).

Research indicates that approximately two-thirds of childhood cancer survivors will experience at least one late-onset health condition, while many will develop serious or life-threatening complications (Hudson et al., 2021). Survivorship care should therefore include a treatment summary, individualized survivorship care plan, preventive services, behavioral health support, and coordinated monitoring based on the survivor's diagnosis and treatment exposures.

Primary care providers and community health centers can be important partners in this process. Although specialized oncology services may be delivered elsewhere, primary care teams can support routine preventive care, chronic disease management, behavioral health, medication management, and communication with oncology specialists. Integrating primary care into survivorship services can improve continuity and help prevent survivors from becoming disconnected from recommended long-term monitoring (Suh et al., 2022).

Supporting the Entire Family

A childhood cancer diagnosis affects the entire household. Parents may experience significant psychological distress, employment disruption, reduced income, increased travel expenses, and difficulty balancing treatment responsibilities with the needs of other family members. A systematic review found that childhood cancer had substantial socioeconomic consequences for parents, including job loss, reduced working hours, income loss, and increased cancer-related expenses (Roser et al., 2019).

Comprehensive family support should include:

- Patient navigation and care coordination.
- Behavioral health services for children, parents, and siblings.
- Transportation and lodging assistance.
- Financial counseling and connections to community resources.

- School reintegration and educational support.
- Palliative and supportive care when appropriate.
- Clear communication among families, primary care providers, and specialists.
- Survivorship care planning and transition support.

These services are not secondary to clinical treatment. They are essential components of family-centered cancer care. Financial and psychosocial challenges can influence treatment adherence, caregiver well-being, access to follow-up services, and the family's overall quality of life (Roser et al., 2019).

Childhood Cancer Awareness Month should therefore move us beyond simply wearing gold. It should strengthen our collective commitment to research, equitable access to specialty care, practical family resources, and lifelong support for survivors.

Part Two: Connecting Cancer Screening, UDS Performance, and Value-Based Care

Childhood Cancer Awareness Month also presents an opportunity to examine how community health centers approach cancer prevention and early detection across the lifespan.

While routine population-based cancer screening is generally not recommended for children at average risk, screening is an essential component of preventive care for eligible adults. For health centers, cancer-screening performance also reflects the strength of organizational systems for identifying care gaps, engaging patients, coordinating referrals, tracking results, and addressing disparities.

UDS Cancer-Screening Measures

The Uniform Data System includes three primary clinical quality measures related to cancer screening:

- Breast cancer screening.
- Cervical cancer screening.
- Colorectal cancer screening.

For the 2026 Community Health Quality Recognition program, HRSA established performance targets of 80.3% for breast cancer screening, 79.2% for cervical cancer screening, and 72.8% for colorectal cancer screening. Health centers meeting or exceeding at least one of these targets may qualify for National Quality Leader–Cancer Screening recognition (Health Resources and Services Administration [HRSA], 2026).

These measures represent more than annual reporting requirements. They demonstrate whether health centers have dependable systems to identify eligible patients, recommend appropriate screening, support screening completion, communicate results, and coordinate follow-up after abnormal findings.

However, screening disparities remain a significant challenge. A national analysis of 2020 UDS data found that screening utilization among patients served by federally qualified health centers was 45.4% for breast cancer, 51.0% for cervical cancer, and 40.2% for colorectal cancer. These rates were substantially lower than estimates for the broader U.S. population (Amboree et al., 2024).

The study also found that FQHC patients represented a considerable portion of the nation's under screened population, particularly for cervical cancer. These findings underscore the need for targeted outreach, culturally responsive education, stronger referral relationships, and sustainable screening infrastructure (Amboree et al., 2024).

Cancer Screening Through a Value-Based Care Lens

Value-based care shifts the emphasis from the volume of services provided to the quality, outcomes, cost-effectiveness, and experience of care. Within oncology and cancer prevention, value should include clinical outcomes, patient preferences, care coordination, financial burden, and equitable access—not simply the number of tests ordered or visits completed (Tseng & Hicks, 2016).

For cancer screening, this means moving beyond placing an order. A value-based approach should ensure that patients complete the appropriate test and receive timely diagnostic evaluation when results are abnormal.

Health centers can strengthen cancer-screening performance by:

1. Using EHR registries to identify patients with open screening gaps.
2. Incorporating pre-visit planning and standing orders into clinical workflows.
3. Offering screening options that reflect patient eligibility, risk, and preferences.
4. Using patient navigators and community health workers to address transportation, language, cost, and health-literacy barriers.
5. Establishing closed-loop systems for referrals and abnormal results.
6. Stratifying performance data by race, ethnicity, language, insurance status, geography, and other social factors.
7. Partnering with hospitals, specialists, and community organizations to expand access to diagnostic and treatment services.
8. Measuring screening completion, follow-up timeliness, patient experience, equity, and cost.

Community health workers and patient navigators are especially valuable in health-center settings. They can provide education, connect patients with screening and diagnostic services, reinforce adherence, and link patients to financial and community resources. A systematic review found that these roles can improve cancer prevention and screening outcomes among medically underserved patients receiving care through FQHCs (Roland et al., 2017).

Connecting UDS Performance to Better Outcomes

Effective UDS improvement requires more than encouraging clinicians to recommend additional screenings. Sustainable performance improvement depends on standardized workflows, reliable data, team-based accountability, patient engagement, and continuous monitoring.

Health centers should ask:

- Are eligible patients being identified accurately?
- Are screening recommendations documented consistently?
- Are patients able to complete the recommended test?
- Are abnormal results tracked until diagnostic resolution?
- Which populations experience the largest screening gaps?
- Are interventions improving outcomes without creating additional burdens for patients?

These questions reflect the principles of value-based care by connecting clinical quality measures to patient outcomes and experience. Value-based cancer care and patient-centered care are most effective when financial incentives, clinical processes, and patient priorities are aligned (Tseng & Hicks, 2016).

The same infrastructure can support children affected by cancer and childhood cancer survivors. Strong referral networks, interoperable records, care coordination, behavioral health integration, social-needs assessment, and survivorship planning can improve continuity across primary and specialty care.

A Shared Commitment Across the Lifespan

Childhood Cancer Awareness Month reminds us that cancer quality improvement must address the full continuum of care. For children and adolescents, this includes research, clinical vigilance, timely diagnosis, specialty referrals, family support, and lifelong survivorship care. For eligible adults, it includes evidence-based screening and dependable systems for closing care gaps.

Pediatric cancer advocacy, UDS performance improvement, and value-based care ultimately share a common objective: ensuring that every patient and family receives coordinated, equitable, patient-centered, and high-quality care throughout the cancer journey.

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Sickle Cell Disease Awareness Month: Moving from Recognition to Action

Each September, Sickle Cell Disease Awareness Month provides an opportunity to elevate the voices of individuals and families affected by sickle cell disease, confront persistent health inequities, and strengthen support for research, education, and comprehensive care.

Sickle cell disease (SCD) is a group of inherited blood disorders caused by abnormal hemoglobin. Under conditions such as dehydration, infection, stress, or reduced oxygen, red blood cells can become rigid and sickle shaped. These cells may break down prematurely and obstruct blood flow, contributing to anemia, severe pain, inflammation, tissue injury, and progressive organ damage (Piel et al., 2017; Sundd et al., 2019).

Approximately 100,000 people in the United States live with SCD, while an estimated 300,000 infants are born with the condition globally each year (Kavanagh et al., 2022). Despite its substantial clinical and social burden, SCD has historically received less research investment, public attention, and specialized-care infrastructure than many other serious chronic illnesses.

More Than a Pain Crisis

Pain is one of the most recognizable features of SCD, but it represents only one part of the disease. People with SCD may experience acute chest syndrome, stroke, chronic anemia, kidney disease, pulmonary complications, vision loss, avascular necrosis, infections, leg ulcers, and other life-altering complications (Kavanagh et al., 2022).

The disease can affect nearly every organ system, and its severity varies significantly from one individual to another. Some people experience frequent hospitalizations, while others may have fewer acute episodes but still develop progressive organ damage.

This variability makes consistent, individualized care essential. Comprehensive SCD management may include:

- Routine primary and hematology care.
- Vaccination and infection-prevention services.
- Hydroxyurea and other disease-modifying therapies when appropriate.
- Individualized acute and chronic pain-management plans.
- Screening for kidney, eye, heart, lung, and neurological complications.
- Behavioral health and social support.
- Reproductive and genetic counseling.
- Assistance transitioning from pediatric to adult care.

Hydroxyurea remains a foundational disease-modifying therapy because it increases fetal hemoglobin and can reduce sickling, pain episodes, acute chest syndrome, hospitalization, and transfusion requirements (Kavanagh et al., 2022). However, access to appropriate treatment and specialty expertise remains inconsistent.

The Weight of Inequity

Sickle cell disease disproportionately affects people of African ancestry in the United States, although it also occurs among people of Hispanic, Mediterranean, Middle Eastern, and South Asian ancestry. Its association with historically marginalized populations has contributed to differences in research funding, access to specialty care, pain management, and patient experience.

People seeking emergency care for a vaso-occlusive pain episode may encounter delays, disbelief, or assumptions that they are exaggerating pain or seeking opioids inappropriately. These experiences can damage trust and discourage patients from seeking timely care. Research has documented substantial inequities in SCD services, including shortages of knowledgeable clinicians, inadequate care coordination, limited access to comprehensive treatment centers, and persistent bias surrounding pain treatment (Lee et al., 2019).

Sickle Cell Disease Awareness Month must therefore include an honest discussion about equity. Improving outcomes requires more than clinical innovation. It requires listening to patients, addressing implicit bias, expanding the SCD workforce, strengthening community-based services, and treating pain reports with dignity and urgency.

The Maternal Health Connection: Caring for Two Lives

Sickle cell disease is also an important maternal health issue.

Pregnancy produces physiological changes that can intensify anemia and place additional demands on the heart, lungs, kidneys, and circulatory system. For a pregnant woman living with SCD, these changes may increase the likelihood of pain crises, infection, blood clots, acute chest syndrome, preeclampsia, hospitalization, and other serious complications.

A systematic review and meta-analysis found that pregnant women with the HbSS genotype had increased risks of maternal mortality, preeclampsia, stillbirth, preterm delivery, and delivering an infant who was small for gestational age compared with women without SCD (Oteng-Ntim et al., 2015). Although risk varies by genotype and individual health status, serious complications can occur with any SCD genotype.

These risks do not mean that women with SCD cannot have healthy pregnancies. They mean that pregnancy should be recognized as high risk and supported through early, coordinated, and respectful care.

The Society for Maternal-Fetal Medicine recommends that pregnant patients with SCD receive multidisciplinary care involving maternal-fetal medicine, hematology, genetics, pain management, and social or behavioral health services when appropriate (Sinkey et al., 2024). Preconception counseling is particularly important because it allows the patient and care team to review medications, assess organ function, discuss disease history, evaluate pregnancy-related risks, and develop an individualized care plan.

Maternal care should include:

- Early prenatal care and maternal-fetal medicine consultation.
- Coordination with a hematologist experienced in SCD.
- Genetic counseling and discussion of reproductive options.
- Review of medications before and during pregnancy.
- Assessment for kidney, heart, lung, and other organ complications.
- A personalized plan for managing pain crises during pregnancy.
- Monitoring for preeclampsia, fetal growth restriction, and preterm birth.
- Delivery and postpartum planning, including attention to blood-clot risk.
- Behavioral health, transportation, nutrition, and social-support services.

Care teams should also distinguish SCD from sickle cell trait. A person with sickle cell trait carries one altered hemoglobin gene and generally does not experience the severe manifestations associated with SCD. However, if both biological parents carry sickle cell trait or another clinically significant hemoglobin variant, their child may inherit SCD. Genetic counseling can help families understand these possibilities without pressure or judgment.

For community health centers, maternal health connection is especially important. Primary care, women's health, and prenatal teams may serve as the first point of contact for a patient with SCD who is pregnant or considering pregnancy. Reliable referral pathways, shared care plans, medication reconciliation, social-needs assessment, and communication with hematology and high-risk obstetric specialists can prevent fragmented care.

Maternal health equity requires that women with SCD be believed, informed, and included in decisions about their care. Their diagnosis should never be used to discourage pregnancy automatically. Instead, patients should receive evidence-based counseling and the coordinated clinical support necessary to make informed reproductive decisions.

From Pediatric Care to Adult Health

Newborn screening has transformed early identification of SCD in the United States, allowing preventive care and education to begin during infancy. However, adolescents and young adults may experience disruptions when transitioning from highly coordinated pediatric services to a more fragmented adult healthcare system.

This transition is associated with increased vulnerability, including gaps in treatment, difficulty locating adult specialists, reduced medication adherence, and greater reliance on emergency departments. Although most children with SCD in the United States now survive into adulthood, average life expectancy remains substantially shorter than that of the general population (Kavanagh et al., 2022).

Effective transition planning should begin before adulthood and include disease self-management, medication education, insurance navigation, establishment of an adult medical home, and direct communication between pediatric and adult clinicians.

The Role of Primary Care and Community Health Centers

Primary care practices and community health centers can help close critical gaps in SCD care. Even when hematology services are delivered elsewhere, the primary care team can support vaccinations, preventive screenings, reproductive health, behavioral health, chronic disease management, medication monitoring, and care coordination.

Health centers can strengthen their response by:

1. Identifying patients with SCD accurately within the electronic health record.
2. Developing individualized care plans for routine and emergency treatment.
3. Establishing referral relationships with hematology and maternal-fetal medicine specialists.
4. Training staff on evidence-based pain management and implicit bias.
5. Incorporating reproductive planning and genetic counseling into routine care.
6. Screening for transportation, food, housing, insurance, and medication-access barriers.
7. Supporting adolescents as they transition into adult care.
8. Using patient and family feedback to improve access and experience.

These strategies reflect a broader commitment to patient-centered, equitable, and value-focused care.

Awareness Must Lead to Action

Sickle Cell Disease Awareness Month is about more than knowing the name of a condition. It is about understanding the daily burden carried by patients and families and recognizing the healthcare system's responsibility to respond.

Awareness becomes meaningful when it leads to faster pain treatment, greater investment in research, stronger maternal health services, improved access to hematology, better transitions into adult care, and genuine respect for the voices of people living with SCD.

Patients with sickle cell disease deserve more than resilience as an expectation. They deserve a healthcare system designed to support their health, dignity, reproductive goals, families, and futures.

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HCCN Update



2026 SC State-Level Goals Snapshot

Reporting Period: August 2026 | Total Measures Tracked: 29

✓ Target Achievement Overview

- ✓ Goals Met (at or above target): 6
- ✗ Goals Not Yet Met: 23

⚠ Priority Opportunity Areas

- | | |
|--|-------|
| • Early Entry Into Prenatal Care | 18.6% |
| • Screening for SDOH | 27.0% |
| • Annual Access to LARC | 4.9% |
| • Annual Family Planning Screening | 0.6% |
| • Annual Pregnancy Intention Screening | 2.3% |
| • Engagement of SUD Treatment | 7.2% |
| • Childhood Immunization Status | 14.3% |

🏆 Top Performing Measures (Above 80%)

- | | |
|--------------------------------------|-------|
| • HIV Linkage to Care | 87.5% |
| • Statin Therapy for CVD | 87.6% |
| • Tobacco Use: Screening & Cessation | 88.8% |
| • IVD Aspirin Use | 88.7% |
| • BMI Screening & Follow-Up | 84.6% |

👤 Maternal & Preventive Health Snapshot

- | | |
|--|-------|
| • Early Entry Into Prenatal Care | 18.6% |
| • Low Birth Weight | 0.0% |
| • HIV and Pregnant | 0.0% |
| • Annual Pregnancy Intention Screening | 2.3% |

The data presented herein reflects information and statistics gathered exclusively from participating health centers that are part of the SCHCCN.

HTI-5

What Could It Mean for Community Health Centers?

A simpler, more connected future for health care.

What is HTI-5?

HTI-5 stands for Health Data, Technology, and Interoperability. It is a proposed federal rule from the Office of the National Coordinator for Health Information Technology (ONC). The goal is to make health technology rules simpler while improving how electronic health information is accessed, shared, and used.

Why Does It Matter for Community Health Centers?

Community Health Centers (CHCs) rely on electronic health records (EHRs) and other technology to care for patients, share information, meet reporting requirements, and coordinate with partners. Although HTI-5 is focused on health IT developers, the changes could affect the systems CHCs use and how they work with patients and other organizations.



Potential Benefits for CHCs



Easier Information Sharing

Could make it easier to get and share patient information, helping care teams coordinate care across different settings.



Simpler Technology Requirements

May reduce unnecessary or repetitive certification requirements, which could lead to more efficient EHR tools.



Support for Future Innovation

Paves the way for new technologies, including artificial intelligence (AI) and FHIR-based APIs, which can help systems communicate securely and support better patient care.

Possible Challenges for CHCs



EHR Vendor Updates

Centers may need to work with vendors as they make changes to meet new requirements, which could require time and resources.



Data Sharing and Workflow Changes

Increased data exchange may require workflow adjustments and staff training to use new features effectively.



Costs and Resources

Some updates or new features could come with costs, and centers may need additional staff time to plan, test, and implement changes.



Privacy and Security Considerations

As more information is shared, it remains important to ensure patient data is protected and used safely and appropriately.

COMPLY and Thrive



Compliance in Motion: Staying Ready in a Changing Workplace

As we move into the final stretch of 2026, one thing is clear: compliance is no longer something organizations can address only when a new law takes effect or an issue lands on someone's desk. The pace of regulatory, workplace, and technology changes requires a more proactive approach.

For organizations committed to doing the right thing, compliance is about more than checking a box. It is about creating clear expectations, equipping people with the knowledge to make sound decisions, and building processes that help identify and address risk before it becomes a problem.

Compliance Is a Moving Target

Workplace requirements continue to evolve at the federal, state, and local levels. At the same time, organizations are navigating changes involving artificial intelligence, workplace safety, accommodations, employee data, and employment practices.

This creates a particular challenge for organizations operating across multiple locations. A policy that works in one jurisdiction may need to be adapted elsewhere, and requirements can change faster than handbooks and training materials are updated.

That is why effective compliance requires an ongoing review of three key areas:

- **Policies:** Are our written policies current and consistent with applicable requirements?
- **People:** Do employees and managers understand what is expected of them?
- **Practices:** Are our day-to-day actions actually reflecting our policies?

A gap in any one of these areas can create unnecessary risk.

From Training Completion to Compliance Readiness

One of the most important shifts in compliance is moving beyond simply measuring whether employees completed required training.

Completion matters, but it is only the beginning.

True compliance readiness means employees can recognize a situation, understand their responsibilities, and know what action to take. Current industry discussion increasingly emphasizes whether employees have actually retained compliance information and can apply it when faced with real-world situations.

Consider a workplace harassment policy. It is not enough for an employee to know that the policy exists. Employees should understand what inappropriate conduct can look like, how to report concerns, what protections are available, and why retaliation is prohibited.

The same principle applies to safety, data protection, conflicts of interest, cybersecurity, and other areas of organizational compliance.

Managers Are a Critical Part of the Equation

Managers often serve as the first point of contact when employees raise concerns or encounter difficult situations. That makes manager awareness and consistency particularly important.

A manager may be asked to respond to a workplace complaint, an accommodation request, a safety concern, or a question about appropriate use of technology. Even when the manager is not responsible for resolving the issue, their initial response can influence what happens next.

Organizations should therefore make sure managers know:

- When they can address an issue themselves.
- When they should immediately involve HR, Compliance, Legal, or another designated resource.
- What they should document.
- What they should avoid promising or communicating.
- How to protect confidentiality while still taking appropriate action.

Strong compliance programs do not expect managers to be legal experts. They give managers practical guidance and clear escalation paths.

Technology Adds a New Layer of Responsibility

Artificial intelligence is another area where compliance and organizational responsibility increasingly intersect. Employers are exploring AI for recruiting, communications, productivity, monitoring, decision-making, and other functions, while regulators and lawmakers continue to address questions

surrounding transparency, fairness, privacy, and accountability. The lesson is simple: implementing a new technology should not automatically mean abandoning existing compliance principles.

- Before introducing an AI-enabled tool, organizations should consider:
- What information will the tool collect or process?
- How will that information be protected?
- Could the tool influence employment decisions?
- Who is accountable for reviewing its output?
- What happens when the technology gets something wrong?
- Have employees been given clear expectations for appropriate use?

Technology can improve how organizations work, but responsible implementation still requires human judgment and oversight

Make Compliance Part of the Culture

The strongest compliance programs are not built around fear of enforcement. They are built around clarity, accountability, and trust.

Employees should feel comfortable asking questions and raising concerns. Leaders should model the behaviors they expect from others. Policies should be understandable rather than buried in technical language. Training should connect requirements to situations employees actually encounter.

And when something does go wrong, organizations should focus not only on correcting the immediate issue but also on understanding why it happened and what can be done to prevent it from happening again.

A September Compliance Check-In

As we enter a new season, September is a good time for a compliance reset.

Take a fresh look at your organization's policies, training, reporting channels, and documentation practices. Identify areas where regulations or organizational practices have changed. Confirm that managers know where to turn with questions. And, most importantly, ask whether employees are truly prepared to make the right decision when compliance matters most.

Compliance is always in motion.

The organizations that stay ahead will be those that treat it not as a once-a-year exercise, but as an ongoing commitment to responsible, informed, and accountable decision-making.

The Wellness Way



Outsmart the Sniffles: Your Tips for Reducing Risk of Seasonal Flu



Let's get it out there!

The single best way to reduce the risk of seasonal flu and its potentially serious complications is to get vaccinated each year! There are several options. Speak to your doctor about what's best for you.

But outsmarting the sniffles comes with other preventive actions like avoiding people who are sick, covering your cough and washing your hands.

These steps can help stop the spread of germs and prevent respiratory illnesses like flu.

Now, let's dig a little deeper:

1. When you are sick, keep your distance from others to protect them from getting sick, too.
2. If possible, stay home from work, school, and errands when not feeling well.
3. Cover your mouth and nose when coughing or sneezing. Wearing a mask is an additional prevention strategy that you can choose to do to further protect yourself and others.
4. Washing your hands often will help protect you from germs. If soap and water are not available, use an alcohol-based hand rub.
5. Germs can be spread when a person touches something that is contaminated with germs and then touches his or her eyes, nose, or mouth.
6. You can improve air quality by bringing in fresh outside air, purifying indoor air or gathering outdoors. Cleaner air can reduce the risk of exposure to viruses.
7. Clean frequently touched surfaces, such as countertops, handrails, and doorknobs regularly to help prevent the spread of some illnesses. Also, get plenty of sleep, be physically active, manage your stress, drink plenty of fluids, and eat nutritious food.

Do what it takes to protect yourself and those around you to outsmart the sniffles and have a breath easy ending to the year!

Revenue Review



Getting Back to the Basics for Success with Medicare Billing

In today's healthcare environment, Federally Qualified Health Centers (FQHCs) are balancing increasing patient demand, staffing shortages, evolving regulatory requirements, and new payment models. While many organizations are focused on innovation, artificial intelligence, and value-based care, one of the greatest opportunities to improve financial performance still lies in mastering the fundamentals of Medicare billing.

Every clean claim begins with accurate registration, appropriate documentation, correct coding, and a thorough understanding of Medicare payment rules. Small billing errors can lead to delayed payments, underpayments, overpayments, compliance concerns, and unnecessary administrative work. Taking time to revisit the basics helps ensure your health center receives every dollar it has earned while remaining compliant with CMS requirements.

Start with the Medicare FQHC Encounter

Unlike many commercial insurers, Medicare reimburses FQHCs using the Prospective Payment System (PPS). In most situations, Medicare pays one PPS encounter payment for each medically necessary, face-to-face qualifying visit furnished to a Medicare beneficiary on the same day. The payment is intended to cover the majority of services provided during that encounter.

A qualifying visit must be supported by appropriate documentation and furnished by an eligible FQHC practitioner, such as a physician, nurse practitioner, physician assistant, certified nurse midwife, clinical psychologist, or clinical social worker, among others recognized under Medicare FQHC regulations.

For Medicare billing, the encounter is generally reported using **HCPCS code G0467**, which represents a medically necessary visit at an FQHC. While G0467 identifies the qualifying encounter, the services documented during the visit must still be supported by the appropriate diagnosis codes, medical necessity, and complete clinical documentation.

Remember that coding does not drive payment—documentation does. The medical record should clearly support why the patient was seen, what services were performed, the complexity of medical decision making, and the treatment plan.

Understanding Services That May Be Billed in Addition to the Encounter

One of the most common misconceptions in Medicare billing is believing that every service provided during a patient visit is included in the PPS payment. While many services are bundled into the encounter payment, CMS allows certain services to be billed separately when all Medicare coverage requirements are met.

Examples of services that may be payable outside of the PPS encounter include certain preventive vaccines and their administration, influenza, pneumococcal, hepatitis B, and COVID-19 vaccines when covered by Medicare. Laboratory services that are paid under the Clinical Laboratory Fee Schedule may also be billed separately when appropriate. Certain preventive services provided through outside payment methodologies may also qualify for separate reimbursement depending on CMS billing guidance.

Beginning in 2026, CMS also continues allowing FQHCs to bill individual care management and behavioral health service codes rather than the former all-inclusive care management methodology. Health centers providing qualifying services should understand the documentation, consent, and time requirements for services such as:

- Chronic Care Management (CCM)
- Principal Care Management (PCM)
- Advanced Primary Care Management (APCM)
- Psychiatric Collaborative Care Model (CoCM)
- Behavioral Health Integration (BHI)
- Collaborative Care Model (CoCM)
- Remote Therapeutic Monitoring (RTM)
- Remote Patient Monitoring (RPM)
- Community Health Integration (CHI)
- Principal Illness Navigation (PIN)

These services can create additional reimbursement opportunities while supporting patients with chronic conditions, behavioral health needs, and complex care coordination. However, each service carries specific eligibility, documentation, and billing requirements that must be carefully followed.

Know What Medicare Should Pay

Submitting a clean claim is only one part of successful revenue cycle management. Equally important is verifying that Medicare actually paid the claim correctly.

Finance and billing staff should routinely compare Electronic Remittance Advice (ERA) and Explanation of Benefits (EOB) information against expected reimbursement. Since Medicare annually updates the FQHC PPS payment rate and applies geographic adjustments, health centers should maintain current payment schedules and understand how their local payment rates are calculated.

When reviewing payments, staff should confirm that the encounter was paid at the correct FQHC PPS rate; patient deductibles and coinsurance were calculated appropriately; separately payable services were reimbursed correctly; contractual adjustments were accurate; and any secondary insurance payments coordinated properly.

Routine payment validation helps identify trends before they become significant financial losses.

What To Do When Medicare Underpays a Claim

Even with Medicare's standardized payment methodology, underpayments can occur because of processing errors, incorrect claim edits, coordination of benefits issues, or missing information.

When an underpayment is identified, begin by reviewing the original claim, supporting documentation, remittance advice, and Medicare payment methodology. Determine whether the issue resulted from claim submission, coding, Medicare processing, or beneficiary eligibility.

If the health center determines Medicare processed the claim incorrectly, appropriate follow-up may include requesting claim reopening, submitting a corrected claim when permitted, or filing an appeal within Medicare's required timeframes. Maintaining detailed documentation of payment discrepancies and appeal activity supports both compliance and successful reimbursement recovery.

Organizations should periodically perform payment variance analyses to identify recurring issues affecting multiple claims. Often, one system configuration error can impact hundreds of encounters before it is detected.

What To Do If Medicare Overpays

Overpayments deserve the same attention as underpayments. Federal regulations require providers to report and return identified Medicare overpayments within required timeframes after identification. Failure to do so can expose an organization to significant compliance risk under the False Claims Act.

If an overpayment is discovered, health centers should immediately investigate the cause. Determine whether the issue is isolated or systemic and evaluate whether additional claims may be affected. Once confirmed, follow CMS procedures for reporting and refunding the overpayment while documenting corrective actions taken to prevent recurrence.

Prompt identification and repayment demonstrate a strong compliance program and reduce regulatory risk.

Strong Revenue Cycle Performance Begins with Strong Fundamentals

High-performing FQHC revenue cycle programs consistently focus on the basics. Registration staff verify Medicare eligibility before every visit. Clinical teams document complete, medically necessary services. Coders accurately translate documentation into billable services. Billing staff submit clean claims promptly, while finance teams verify payments and monitor denials and adjustments.

Rather than viewing these functions independently, successful organizations recognize that every department contributes to the financial health of the organization. One missing signature, one inaccurate diagnosis code, or one overlooked remittance adjustment can affect reimbursement.

Routine internal audits, payment reconciliation, staff education, and policy reviews help ensure billing processes remain accurate as CMS guidance evolves. Organizations should also monitor annual Medicare updates, including changes to PPS rates, covered services, HCPCS codes, and billing instructions.

Back to the Basics: A Recipe for Long-Term Success

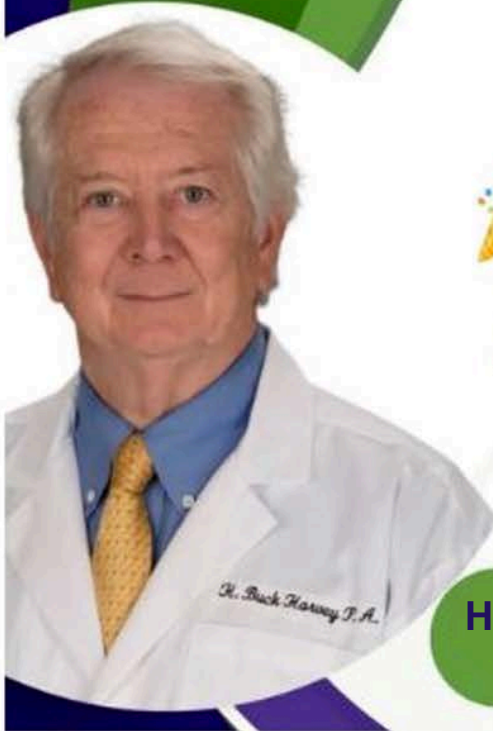
Technology will continue to transform healthcare, but the foundation of successful Medicare billing remains unchanged. Accurate documentation, compliant coding, complete claims, and diligent payment review are the building blocks of a healthy revenue cycle.

Health centers that invest in ongoing education, routinely validate payments, monitor billing trends, and promptly resolve discrepancies position themselves for stronger financial performance while maintaining compliance with Medicare requirements.

Sometimes the best strategy for moving forward is simply getting back to the basics. When every member of the revenue cycle team understands their role and consistently applies Medicare billing fundamentals, the result is improved cash flow, fewer denials, stronger compliance, and more resources available to support the mission of providing high-quality care to the communities that need it most.

Health Center News

Beaufort Jasper Hampton
Comprehensive Health
Services, Inc.



RETIREMENT ANNOUNCEMENT

Harold "Buck" Harvey, PA-C
Primary Care



RETIREMENT ANNOUNCEMENT

HONORING 48 YEARS OF SERVICE



After 48 wonderful years as a Physician Assistant, I have made the decision to retire from a career that has been one of the greatest honors of my life.

It has been a privilege to care for so many patients and families throughout the years. I am deeply grateful for the trust you placed in me and for the relationships and memories we shared. Being your healthcare provider has been much more than a job. It has been an honor and a privilege.

I am also thankful to the wonderful community of Hampton County and the surrounding areas for the kindness, encouragement, friendship, and support shown to me throughout my career. You made this journey meaningful and rewarding.

I extend my heartfelt gratitude to my family, Phyllis, Renee, Chaney, Chase, and William, for their love, patience, and unwavering support. I could not have made it through 48 years without you.

I am especially grateful to my mentors, Dr. Harrison Peebles and Dr. Neal Shealy, whose knowledge, wisdom, and example helped shape the healthcare provider I became. I also extend special thanks to the old guard, Drs. Hayne, Young, Pulaski, Causey, and Deloach, for the knowledge I gained from them many years ago, as well as the new guard, Drs. Welcker and Vega, who have been instrumental in my life.

Thank you to my colleagues, Vickie Reynolds, NP, Pam Moore, NP, Sharon Shealy, NP, and Rebecca Swofford, PA. I also offer my sincere appreciation to the staff of Beaufort-Jasper-Hampton Comprehensive Health Services, Harrison Peebles Health Care Center, and Hampton Regional Medical Center for being part of my journey.

Above all, I thank God for leading me throughout my career, giving me strength, wisdom, and guidance, and placing so many wonderful people in my path. To borrow from a country song, I was a PA when PAS were not cool.

As I begin this next chapter, I leave my career with a grateful heart and countless wonderful memories. I will always carry with me the people who touched my life throughout these 48 years.

Thank you for allowing me to be part of your lives and for ALLOWING ME to serve you and your families. It has truly

With heartfelt gratitude and warmest wishes



CareSouth Carolina Receives Community Health Catalyst Award from South Carolina Cancer Alliance

CareSouth Carolina has been recognized with the Community Health Catalyst Award by the South Carolina Cancer Alliance for its ongoing work to expand access to cancer screenings, improve health outcomes, and advance health equity throughout the communities it serves.

The award was presented during the South Carolina Cancer Alliance 2026 Annual Meeting, “The Next Chapter Starts Together,” which brought together healthcare professionals, community leaders, and partners working to strengthen cancer prevention and control efforts across South Carolina. The Community Health Catalyst Award recognizes Federally Qualified Health Centers that are making a meaningful difference at the community level through cancer prevention, early detection, and screening efforts.

“Receiving the Community Health Catalyst Award is a tremendous honor for CareSouth Carolina and a reflection of the work our teams are doing every day to improve access to cancer education, prevention, and screening in the communities we serve,” said Marek Calhoun, Director of Social and Community Services for CareSouth Carolina. “We understand that improving health outcomes means reaching people where they are, removing barriers to care, and making sure rural and underserved communities have access to opportunities for early detection and prevention. This recognition reinforces our commitment to advancing health equity and continuing to build stronger, healthier communities.”

In addition to accepting the recognition on behalf of CareSouth Carolina, Calhoun participated in a panel discussion during the annual meeting focused on the importance of partnership and collaboration in cancer prevention and screening.

The discussion provided an opportunity to share CareSouth Carolina’s experience working within local communities and collaborating with organizations and partners to connect more people with education, preventive services and screenings.

Those partnerships are especially important in rural communities, where transportation, financial concerns, access to providers and other challenges can prevent individuals from receiving preventive care.

CareSouth Carolina works to help reduce those barriers by connecting patients and community members with resources and opportunities that can support earlier detection and better long-term health outcomes.

CareSouth Carolina is a private, non-profit community health center delivering patient-centered health and life services in the Pee Dee region of South Carolina. CareSouth Carolina operates centers in Bennettsville, Bishopville, Cheraw, Chesterfield, Dillon, Hartsville, Lake View, Latta, McColl and Society Hill.

Services provided by CareSouth Carolina include family medicine, internal medicine, pediatrics, women's services, OB/GYN, HIV/AIDS primary care, infectious disease primary care, IV therapy, substance abuse prevention, dental, chiropractic services, pharmacy, senior support services, family support services, clinical counseling, laboratory, ultrasound, x-ray, agricultural worker health services, podiatry, and veterans' choice provider.





CareSouth Carolina Now Offering Flu Vaccines Throughout the Pee Dee

CareSouth Carolina is now administering seasonal flu vaccines at its offices throughout the Pee Dee, giving patients and families a convenient way to prepare for the upcoming flu season.

Appointments are now available. Patients can call 843-309-8301 to schedule their flu vaccine at a CareSouth Carolina location.

Flu season can bring increased illness, missed days from work and school, doctor visits and, in more serious cases, hospitalization. Getting vaccinated each year remains one of the most important steps people can take to reduce their risk of influenza and its potentially serious complications.

“Getting your flu vaccine is a simple step that can make a real difference for you, your family and our entire community,” said Jeri Andrews, Chief Medical Officer at CareSouth Carolina. “We want to make it as convenient as possible for people throughout the Pee Dee to get vaccinated and head into flu season with an added layer of protection.”

Why Getting a Flu Vaccine Matters

According to the Centers for Disease Control and Prevention, annual flu vaccination is recommended for everyone 6 months of age and older, with rare exceptions.

September and October are generally considered good times for most people to receive their flu vaccine. Because it takes approximately two weeks after vaccination for the body to develop antibodies that help protect against influenza, getting vaccinated before flu activity increases can give the body time to build protection.

The flu vaccine cannot guarantee that someone will avoid influenza completely, but vaccination can reduce the risk of becoming sick. It can also reduce the severity of illness and lower the risk of flu-related hospitalization and death.

The CDC estimates that the 2024–2025 flu season resulted in approximately 51 million illnesses, 23 million medical visits, 710,000 hospitalizations and 45,000 deaths nationwide. The CDC classified it as the first high-severity flu season in the United States since 2017–2018.

Flu vaccination can be especially important for people who face a higher risk of serious complications, including young children, adults 65 and older, pregnant women and people with certain chronic medical conditions.

South Carolina public health officials also identify influenza vaccination as one of the best ways to help prevent hospitalization and death associated with the flu.

Protecting More Than Yourself

Getting vaccinated can also help protect the people around you. That can be particularly important for family members, friends and neighbors who may be more vulnerable to serious illness.

Flu viruses change over time, which is one reason a flu vaccine is recommended every year. Vaccine formulations are reviewed and updated to provide protection against influenza viruses expected to circulate during the upcoming season.

CareSouth Carolina encourages residents not to wait until flu activity increases to begin thinking about vaccination.

Schedule Your Flu Vaccine Today

To schedule an appointment, call **843-309-8301**.

Patients with questions about whether a flu vaccine is appropriate for them should speak with their healthcare provider.

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CareSouth Carolina's Latta Office Puts Fun Twist on Fight Against Hunger

LATTA, S.C. — A friendly competition at CareSouth Carolina's Latta office ended with a pie to the face, plenty of laughs and, most importantly, more support for families across the Pee Dee.

Latta Site Administrator Tara Stubbs recently earned the opportunity to pie Dr. Johnathan Davis, who provides chiropractic care at the Latta office, after the two went head-to-head in a fundraising competition supporting CareSouth Carolina's annual "Hunger Games."

The Hunger Games is CareSouth Carolina's internal friendly competition for 2026 with a simple goal: collect as many canned goods as possible to support the organization's food pantries. CareSouth Carolina sites across the Pee Dee participate each year, collecting food to help patients and community members facing food insecurity.

The Latta office has already collected more than 5,000 pounds of food during this year's effort. The pie competition started after Stubbs agreed to take a pie to the face if the office raised \$500. Davis jokingly volunteered to be the person to throw it, but the Latta team had another idea. A staff member challenged Davis to compete against Stubbs instead. Whoever raised the most money would get to pie the other.

"Team Tara" ultimately came out on top, raising \$425.75 compared to \$107 raised by "Team Dr. Davis."

That meant Stubbs got the final laugh — and Davis got the pie. While the competition gave staff members a chance to have some fun, Stubbs said the purpose behind the Hunger Games means much more.

"Our patients, I want them to be taken care of totally," Stubbs said. "The whole person. That means not just their medical needs, but also their physical, emotional and mental needs. If they don't have food, they're not going to be healthy. We're able to have fun while also taking care of our patients' needs."

That commitment to caring for the whole person is also at the center of what Stubbs believes makes CareSouth Carolina's Latta office special.

"Latta is home," Stubbs said. "It's a good place with good people, and we treat you like family. We know you by name, and that is important. It's personal."

CareSouth Carolina's Latta office is located at 122 Latimer Street and offers comprehensive family care, an on-site pharmacy, chiropractic care, IRIS services, behavioral health, and much more.

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CareSouth Carolina Welcomes Dr. Michael Chandler to Bishopville Office

BISHOPVILLE, S.C. — CareSouth Carolina is pleased to announce that Michael Chandler, M.D., has moved to the organization's Bishopville office, where he will continue providing family medicine services to patients in Lee County and the surrounding communities.

Dr. Chandler joined CareSouth Carolina in late 2025, initially serving patients at the Society Hill office. With more than 25 years of experience in Family Medicine, he brings decades of knowledge and a strong commitment to building relationships with the patients and families he serves.

Dr. Chandler's career has included emergency care, urgent care and family practice settings throughout South Carolina. He has been board-certified in Family Medicine since 1998 and was re-certified in 2020. Over the years, he has served communities throughout the Pee Dee region while focusing on compassionate, accessible and patient-centered care.

For Dr. Chandler, the most rewarding part of practicing medicine comes down to the people he has the opportunity to serve.

"Making a difference. That's the Bottom line," Dr. Chandler said. "I enjoy getting to know the patients and be a part of making a difference in their lives."

As he settles into the Bishopville office, Dr. Chandler looks forward to getting to know even more patients and families in the community while helping them manage their health through every stage of life.

Outside of work, Dr. Chandler enjoys spending time outdoors. While he is not a hunter, he enjoys shooting, boating and fishing. He appreciates opportunities to get outside and enjoy what he describes as "the beautiful world that our good Lord gave us."

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Services provided by CareSouth Carolina include family medicine, internal medicine, pediatrics, women's services, OB/GYN, HIV/AIDS primary care, infectious disease primary care, IV therapy, substance abuse prevention, dental, chiropractic services, pharmacy, senior support services, family support services, clinical counseling, laboratory, ultrasound, x-ray, agricultural worker health services, podiatry, and veterans' choice provider.





Carolina Health Centers Awarded More Than \$700,000 Through South Carolina Rural Health Transformation Program

GREENWOOD, S.C. – Carolina Health Centers, Inc. (CHC) is proud to announce that it has been awarded a total of \$703,660 through the South Carolina Department of Health and Human Services (SCDHHS) Rural Health Transformation Program (RHTP). These awards support strategic investments through the ‘Connections to Care’ and ‘Shoring Up to Sustainability’ initiatives, helping strengthen healthcare infrastructure and improve access to care for the rural communities CHC serves.

The funding includes:

- \$260,451 through the Connections to Care initiative to support health information technology infrastructure modernization.
- \$112,018 through the Shoring Up to Sustainability initiative for facility enhancement investments.
- \$151,181 through the Shoring Up to Sustainability initiative for healthcare infrastructure improvements.
- \$180,010 through the Shoring Up to Sustainability initiative for critical infrastructure modernization.

“These investments are about ensuring that patients across all of our communities continue to have access to high-quality, compassionate healthcare close to home,” said Miriam Ferguson, President and CEO of Carolina Health Centers. “The Rural Health Transformation Program recognizes the importance of strengthening rural healthcare systems through thoughtful, sustainable improvements. We are grateful for this support and committed to being responsible stewards of every dollar entrusted to us.”

The awards are part of South Carolina’s broader Rural Health Transformation Program, which focuses on creating sustainable improvements in rural healthcare through strategic investments in technology, infrastructure, workforce, and access to care. RHTP was designed to strengthen healthcare delivery systems and improve health outcomes in rural communities throughout the state.

While specific project details are not being released at this time, the funded initiatives will support CHC's ongoing efforts to enhance patient access, strengthen operational efficiency, modernize healthcare infrastructure, and ensure long-term sustainability across its network of locations serving the Lakelands region. These investments will help create a stronger healthcare system capable of meeting the needs of patients today and well into the future.

For nearly 50 years, Carolina Health Centers has remained committed to its mission of improving the health, well-being, and quality of life of the communities it serves. As a Federally Qualified Health Center, CHC provides comprehensive primary care, behavioral health, dental, pharmacy, and supportive services regardless of a patient's ability to pay. The organization serves residents across Greenwood, Abbeville, Edgefield, Laurens, McCormick, Newberry, and Saluda counties.

"These awards are not simply investments in buildings, equipment, or technology," Ferguson added. "They are investments in people. They will help us continue removing barriers to care, expanding opportunity for healthier lives, and delivering on our promise to provide patient-centered care with dignity, compassion, and excellence throughout the communities we serve."





Carolina Health Centers Earns Two National HRSA Awards for Excellence in Patient Care and Health Technology



GREENWOOD, S.C. – Carolina Health Centers, Inc. (CHC) is proud to announce that it has received two national recognitions from the Health Resources and Services Administration (HRSA) for 2026: the Silver Health Center Quality Leader Badge and the Advancing Health Information Technology (Health IT) Badge.

These awards recognize health centers that demonstrate exceptional performance in delivering high-quality patient care while strategically leveraging technology to improve health outcomes, patient access, and operational efficiency.

The Silver Health Center Quality Leader Badge places Carolina Health Centers among a select group of federally qualified health centers recognized nationally for achieving strong clinical quality outcomes. The distinction reflects CHC's ongoing commitment to evidence-based care, quality improvement, and health equity throughout the communities it serves.

"Earning the Silver Quality Leader badge is a direct reflection of our staff's dedication to delivering equitable, top-tier care," said Zille Elahi, Director of Quality and Population Health. "By leveraging data-driven strategies and evidence-based workflows, our teams proactively improve community health outcomes. This relentless focus on quality ensures we provide exceptional care today while innovating to meet the future needs of the patients we serve."

CHC was also recognized with the Advancing Health IT Badge, which honors health centers that effectively utilize health information technology to support quality improvement, care coordination, and enhanced patient engagement.

"Receiving the HRSA Advancing Health IT badge is a meaningful recognition of Carolina Health Centers' commitment to using technology to improve the care we provide," said Tim Anderson, Chief Information Officer. "Technology touches nearly every part of the patient experience today, from our electronic health record and patient-facing tools to improved clinical workflows, care coordination, and the use of data to support better decisions across our health centers."

Anderson emphasized that continued investment in technology is essential to supporting CHC's mission. "Health information technology allows us to grow and innovate while helping our providers and staff work more efficiently, protect patient information, and remain focused on what matters most: providing high-quality care to the communities we serve."

Together, these recognitions underscore Carolina Health Centers' commitment to advancing patient care through a combination of clinical excellence, innovation, and continuous improvement.





Carolina Health Centers Achieves Advanced PCMH Recognition and Maintains NCQA Patient-Centered Medical Home Certification Across All Sites



GREENWOOD, S.C. – Carolina Health Centers (CHC) is proud to announce that the organization has successfully achieved Advanced Patient-Centered Medical Home (Advanced PCMH) recognition for Saluda Family Practice while maintaining National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home (PCMH) certification across all CHC clinical sites. This accomplishment reflects CHC's ongoing commitment to delivering high-quality, coordinated, and patient-focused care to the communities it serves throughout the Lakelands region of South Carolina.

According to NCQA, the Patient-Centered Medical Home model places patients at the center of their healthcare experience by fostering stronger relationships between patients and their care teams, emphasizing coordinated care, quality improvement, better health outcomes, and enhanced patient experiences. Practices that earn NCQA recognition demonstrate a commitment to continuous quality improvement and evidence-based care delivery.

Achieving and maintaining NCQA PCMH recognition is a rigorous, year-round process that requires healthcare organizations to demonstrate excellence in key areas such as patient access, care coordination, population health management, quality measurement, performance improvement, and team-based care. Advanced PCMH recognition requires organizations to go even further by demonstrating sophisticated population health strategies, enhanced care management capabilities, data-driven quality initiatives, and measurable improvements in patient outcomes.

"At Carolina Health Centers, quality is not a one-time achievement. It is embedded into every patient interaction, every workflow, and every improvement initiative we undertake," said Derek Bannister, Director of Operations at Carolina Health Centers. "This recognition validates the extraordinary work of our providers, nurses, support staff, quality team, and leadership who are committed every day to ensuring our patients receive comprehensive, coordinated, and compassionate care."

CHC's Quality Improvement program continuously evaluates clinical performance, patient outcomes, population health metrics, and operational processes to identify opportunities for improvement and ensure patients receive the highest standard of care. Recent quality initiatives have included enhanced care coordination, proactive outreach to patients with chronic conditions, expanded preventive health screenings, improved risk stratification processes, and strengthened quality measurement capabilities. These efforts support CHC's broader commitment to improving health outcomes while addressing the unique healthcare needs of rural communities throughout its service area.

As part of its 2026 quality initiatives, CHC successfully completed the submission of evidence required for NCQA PCMH certification for multiple sites and completed Advanced PCMH certification review activities, demonstrating the organization's dedication to continuous improvement and practice transformation.

For patients, NCQA Patient-Centered Medical Home recognition means they can expect:

- Better coordination between providers, specialists, hospitals, and community resources
- Increased focus on preventive care and chronic disease management
- Greater access to care and patient engagement opportunities
- Enhanced use of data and technology to support clinical decision-making
- A healthcare team that works collaboratively to address the whole person, not just individual medical conditions
- Ongoing measurement and improvement of quality, safety, and patient experience

"While all our facilities received PCMH certification, SFP was the only practice that applied for and received the Advanced PCMH. To qualify, a facility needs to already meet regular PCMH requirements. It then needs to scale up those workflows to be able to manage total cost of care, clinical quality outcomes, and enhanced care coordination through data interoperability," said Zille Elahi, Director of Quality & Population Health at Carolina Health Centers. "SFP was able to demonstrate that it dedicated resources to actively coordinate care for our highest-risk patients, address complex social determinants of health, and execute rapid interventions to keep our community healthy. It also means that SFP leveraged advanced population health analytics (incorporating payer data and care transitions data from other providers) allowing for dynamic risk stratification and proactive care management."

This achievement reinforces Carolina Health Centers' mission of improving the health and well-being of the communities it serves while continuing to advance innovative care models that place patients at the center of everything it does.



Carolina Health Centers Achieves Advanced PCMH Recognition and Maintains NCQA



This month, Carolina Health Centers held our very first Recovery Month Celebration event on 9/12. This event included live music, food vendors, games, art, as well as community and state resources. Our community gathered together to celebrate, remember, and spread awareness on how recovery is possible.

Steven Gause, our Greenwood County Peer Support Specialist, said, "I was blown away to see so many people from different walks of life and recovery come together in the same space. It was a true celebration of the spirit of recovery and Greenwood definitely showed out! I can attest how difficult it is to escape substance use. Anyone who can break those chains deserves to be celebrated. Recovery is simply a process of progress, growth, and improvement, but to me it means everything. I know that my life without my recovery does not exist. As a community, we cannot do it alone. We will always need a solid foundation. We can't keep what we have without giving it away but also remember that you can't transmit something that you haven't got."

We are very proud of our Peer Support Specialists and our entire Behavioral Health Department who continue to show that recovery is possible through their services and actions.



Carolina Health Centers Supports Greenwood Abbeville Coalition: Sharing Stories of Hope at the Candlelight Vigils



Carolina Health Centers supports Greenwood Abbeville Coalition throughout the year in many events. Two of these events are the Candlelight Vigil that takes place in both Greenwood and Abbeville. Members of our staff showed up and shared their testimonies at these vigils, specifically Greenwood's.

Alyssa Birch, Behavioral Health Coordinator, states, "I am the Vice Chair for Greenwood Abbeville Coalition (GAC) who hosts the candlelight vigils every year. GAC's mission is to have a

drug-free community and is open for any member of the community to join. I have been to both Abbeville and Greenwood vigils over the years and have to say, it is always a combination of touching and gut-wrenching. We come together to remember those we love who have passed away due to overdose and bring hope to those who face addiction. We had 13 overdose deaths in Greenwood since the 2025 vigil, and 7 in Abbeville." Steven Gause shared his testimony and says, "It is always difficult to talk about the ones that we have lost from the epidemic of overdose. Overdose is real, and 13 chairs were set up in remembrance that can attest to that. On the other hand, it is always reassuring to be able to look around and see the faces of so many examples that recovery is alive and well." Infectious Disease Outreach Navigator, Madelynne Barker, states, "The vigils left me speechless with gratitude. Seeing the community come together in memory of those we've lost to overdose was beautiful. It helps let people who may be struggling to know they deserve safety, compassion and another chance! The best way to fight overdose is to show up for people while they are still here!"

Recovery is possible and we are here for those facing addictions and recovery. As Alyssa said, "I want anyone who reads this to know that in the face of hopelessness, we are here for you. We see you, we want to help you, and we will continue to strive for a mission of a drug-free community despite any challenges we face."



Investing in Tomorrow: Carolina Health Centers Welcomes Seven Interns

Carolina Health Centers is excited to have seven interns join us from Piedmont Technical College and Lander University this semester! These interns are completing their internships in the Quality Improvement Department, Behavioral Health Department, and the Marketing/Development Department. The interns have specific projects that they work on in their departments that help advance our services in our communities. We are thankful for each of our interns. Thank you to Cadence Milton, Ella Howard, Elizabeth Ledbetter, Morgan Axiotis, Jaedien Irizarry, Samantha Carnell, and Declan Dunn for choosing Carolina Health Centers for your internships!



Foothills Community Health Care Expands Access to Dental, Psychiatry, Pharmacy, and Primary Care Services Across the Upstate



Foothills Community Health Care is pleased to expand services across the Upstate of South Carolina. In Anderson, Foothills will welcome Dr. Stephen Hobby as our general dentist, with dental services expected to open in September of this year. The new dental suite will open with three fully equipped treatment rooms, with space designed to accommodate future expansion as the needs of our community grow. **Building Bright Smiles** is Foothills Community Health Care's **\$1 million fundraising campaign** to bring comprehensive dental services to our health center and expand access to essential oral health care in the communities we serve. We invite you to learn more about the Building Bright Smiles campaign, our vision for expanding dental care, and how you can be part of this important effort by visiting www.myfchc.org.

Psychiatry services will also expand in October 2026. Dr. Dana Wiley, who has more than 30 years of psychiatry experience, will serve patients at the Anderson location. In Easley and Clemson, Daina Foyet, PMHNP, will provide psychiatric services. In addition, Foothills Community Health Care will open a new site in Iva, South Carolina, as part of our continued mission to be a comprehensive and compassionate medical home to the communities we serve.



Foothills Community Health Care will also launch its first standalone pharmacy location in Easley, South Carolina, in October of this year.



From the Parade Route to Town Hall: Expanding Access to Care in Yemassee



This month, Genesis Healthcare served as the platinum sponsor of the annual Yemassee Shrimp Festival, a cherished Lowcountry tradition that brings together residents, families, businesses, and visitors in celebration of community, culture, and local heritage.

As platinum sponsor, Genesis Healthcare was honored to support an event that reflects the values of connection, service, and community engagement. Throughout the festival, our team enjoyed meeting attendees, sharing information about our healthcare services, and strengthening relationships with the communities we serve.

One of the highlights of the weekend was participating in the festival parade, where Genesis Healthcare proudly drove its mobile healthcare unit through the parade route. The mobile unit serves as an important resource for expanding access to healthcare throughout the region, and the parade provided a unique opportunity to showcase this service while celebrating alongside community members.

Our commitment to the Yemassee community extends beyond the festival. Starting in October, Genesis Healthcare will have its mobile unit stationed at Yemassee Town Hall, providing residents with greater access to healthcare services close to home. By bringing care directly into the community, we continue to advance our mission of improving access to quality healthcare and meeting patients where they are.



Genesis Healthcare, Inc. Expands Rural Care with First-Ever Lydia Clinical Bus Event



Genesis Healthcare, Inc. (GHC) rolled its mobile medical unit out to the Lydia community on Thursday, Sept. 17, hosting its inaugural Lydia Clinical Bus Event at Luke Arthur Ballfield, 5213 Indian Branch Road, from 9 a.m. to 1 p.m.

The mobile clinic offered sick visits, new patient visits, and follow-up appointments to rural residents who might otherwise face long drives to reach a doctor's office.

GHC operates mobile medical units throughout the region with a mission to close gaps in healthcare access. The units are designed to reach remote areas, serve underserved populations — including low-income residents and rural farm workers — and provide support at community festivals, health fairs and public gatherings. Services available on board include basic health checkups and screenings, wellness and disease-prevention education, and on-site assistance during local events.

Howard Nettles, GHC's Director of Development, and Kaylen Snapp, Specialty Pharmacy Marketing Manager, joined other GHC staff members on site to serve the Lydia community. Darlington County Sheriff Michael August and Sgt. Jacob Heatherly also attended to show their support.

The event marked a new step in GHC's ongoing effort to bring quality healthcare directly to the doorsteps of South Carolina's rural communities.



WFHS Band Booster Club Check Presentation



Last month, Genesis Healthcare presented funds to the West Florence High School Band Booster Club in support of its talented student musicians, and the important role music education plays in our community.

The donation will help provide water, snacks, and other essential supplies to keep band members energized, prepared, and supported throughout practices, performances, competitions, and travel. By helping meet these everyday needs, the Band Booster Club can continue focusing on creating meaningful opportunities and experiences for its students.

At Genesis Healthcare, we believe investing in local youth is an investment in the future of our communities. We are proud to support the West Florence High School Band and the dedication, hard work, and teamwork its members demonstrate both on and off the field.



Sardis Timmonsville Fire Dept. ClinicalBus Event



Genesis Healthcare was proud to host a Clinical Bus Event in Timmonsville in partnership with the Sardis-Timmonsville Fire Department. The event provided community members with convenient access to essential healthcare services close to home, helping to reduce barriers to care and improve health outcomes throughout the region.

During the event, our clinical team provided sick visits, new patient visits, follow-up appointments, and vision, hearing, and blood pressure screenings. These services allow residents to receive timely medical attention and preventive care in a familiar and accessible setting.

Our team enjoyed connecting with community members and sharing information about available healthcare resources. Events like this reflect Genesis Healthcare's ongoing commitment to expanding access to quality care and supporting the health and well-being of the communities we serve.

HOPEHEALTH ACQUIRES EASTERN CAROLINA PEDIATRIC ASSOCIATES, EXPANDING PEDIATRIC CARE ACROSS THE PEE DEE

FLORENCE, S.C. (September 14, 2026) – HopeHealth is pleased to announce the acquisition of Eastern Carolina Pediatric Associates (ECPA), a respected pediatric practice that has served children and families throughout the Pee Dee for more than 40 years. The acquisition expands access to trusted pediatric care in Florence and Darlington Counties while preserving the relationships families have established with their providers for decades.

Dr. Richard Davis and Dr. John Keith have built a pediatric practice that takes care of the whole child; providing a specialized, heartfelt service for families of the Pee Dee for many years. This transition brings the experienced providers, nurses and staff of ECPA into the HopeHealth family, strengthening pediatric services while maintaining the patient-centered approach that has made the practice a trusted name in children's health care. Patients will continue receiving care from their familiar providers with minimal disruption as the practice is integrated into HopeHealth's growing network.

"We are honored to welcome Eastern Carolina Pediatric Associates to HopeHealth," said Carl Humphries, Chief Executive Officer of HopeHealth. "For decades, their providers have earned the trust of families throughout our community by delivering exceptional pediatric care. Our top priority is to preserve the outstanding care families expect while expanding access to comprehensive, coordinated health services that help children thrive."

"Joining HopeHealth allows us to continue the legacy of care our patients have trusted for 42 years while providing access to additional resources and services that will benefit children and families throughout the region," said Dr. Richard Davis, ECPA President and co-founder. "We share the same commitment to delivering compassionate, high-quality care, and we are excited about what this partnership means for the future of pediatric health care in our community."

"Eastern Carolina Pediatric Associates has been privileged to care for generations of children and families in Florence, Darlington and the surrounding communities," said Dr. John Keith. "We see this partnership with HopeHealth as an opportunity to build on that history and create an even stronger future for pediatric care in the Pee Dee. HopeHealth shares our commitment to putting patients first, and together we will have greater resources to serve children and their families."

Patients can expect continuity of care throughout the transition. Existing appointments will continue as scheduled, providers and staff will remain in place, and practice locations in Florence and Darlington will continue serving patients under HopeHealth's management. Medical records will transition seamlessly, and existing insurance plans will continue to be accepted, subject to individual plan participation. The organizations are working closely together to ensure a smooth experience for patients, families and employees.

The acquisition also helps address the growing need for pediatric providers across the Pee Dee by expanding access to preventive care, well-child visits, immunizations, developmental screenings, same-day sick visits and chronic disease management for children. As HopeHealth continues to grow, the organization remains focused on strengthening local health care, improving patient outcomes and ensuring families have access to comprehensive care regardless of their ability to pay.

HopeHealth is a nonprofit leader in providing affordable, expert primary and specialty health care services for all ages in Florence, Aiken (Infectious Diseases), Clarendon, Orangeburg, and Williamsburg Counties. Our federally qualified health centers are the health care home of choice for nearly 85,000 patients. To become a patient, call 843-667-9414 or visit hope-health.org.



My Family. My Doctor. My Choice.

ReGenesis Health Care Awarded More Than \$2.4 Million in Grants to Expand Access to Care



SPARTANBURG, S.C. — ReGenesis Health Care has been awarded more than \$2.4 million in grant funding to expand access to care, strengthen health care infrastructure, enhance community-based services and increase treatment opportunities for individuals with Opioid Use Disorder (OUD).

The funding includes \$1,198,316 through South Carolina's Rural Health Transformation Program (RHTP) and \$1,224,500 through the South Carolina Opioid Recovery Fund.

The Rural Health Transformation Program is a federal initiative led by the Centers for Medicare & Medicaid Services (CMS) to strengthen rural health systems through investments in access, infrastructure, technology, workforce development and innovative models of care. South Carolina's RHTP includes initiatives focused on modernizing rural health care and bringing services closer to the communities that need them.

Through the Rural Health Transformation Program, ReGenesis Health Care received funding for three projects: Leveling Up to Expand Remote Patient Monitoring — \$425,000

This funding will help ReGenesis expand its Remote Patient Monitoring capabilities, allowing more patients to benefit from ongoing monitoring and support as part of their chronic care management. The investment will help extend care beyond the traditional clinical setting and support improved health management for patients.

Connections to Care to Modernize Health IT Infrastructure — \$333,316

This grant will support improvements to ReGenesis Health Care's health information technology infrastructure. The investment will help strengthen the systems that connect patients, providers and health care services, supporting more coordinated, efficient and accessible care.

Wellness Within Reach to Expand Community Care Sites — \$440,000

Through this grant, ReGenesis will upfit one of its Mobile Medical Centers to provide dental services. Expanding the capabilities of the mobile unit will allow ReGenesis to bring essential oral health services directly into the communities it serves and further reduce barriers to accessing dental care.

In addition to the Rural Health Transformation funding, ReGenesis Health Care has been awarded \$1,224,500 through the South Carolina Opioid Recovery Fund.

The funding will be used to expand the availability of and enhance treatment for Opioid Use Disorder, supporting ReGenesis' efforts to increase access to treatment and related services for individuals affected by opioid use. The South Carolina Opioid Recovery Fund identifies expanding treatment for OUD as an approved use of recovery funds.

Together, the \$2,422,816 in grant funding will support ReGenesis Health Care's continued efforts to expand access, strengthen its health care infrastructure, bring care into the community and improve health outcomes for the patients and families it serves.

About ReGenesis Health Care

ReGenesis Health Care is a non-profit organization that provides comprehensive health services in ten locations to residents in Spartanburg, Cherokee and Union counties. ReGenesis Health Care is one of 19 federally qualified community health centers in South Carolina and the only center of its kind in Spartanburg, Cherokee and Union counties. Mission: We increase community access to comprehensive healthcare.

For more information about ReGenesis Health Care, visit www.myrhc.org.

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Tandem Health Earns Seven 2026 HRSA Quality Badges



Tandem Health has earned seven 2026 Community Health Quality Recognition (CHQR) badges from the Health Resources and Services Administration (HRSA).

The national recognitions, based on Tandem Health’s 2025 performance, were announced during National Health Center Week and reflect achievement across clinical quality, access to care, health information technology, patient engagement, operational value, and improved health outcomes.

“To receive seven national quality recognitions is an extraordinary honor for Tandem Health and our entire community,” said Annie Brown, Chief Executive Officer of Tandem Health. “These badges represent far more than recognition. They reflect the exceptional care our patients receive, the outcomes our patients achieve and the commitment our team demonstrates every day.”

Tandem Health’s quality trajectory has accelerated significantly over the past three years, advancing from one CHQR badge in 2024 to five in 2025 and seven in 2026. Tandem Health accounted for seven of the 72 badges earned statewide in 2026.

The organization also improved 14 clinical quality measures from the prior reporting year. Its recognitions highlight success in preventive health, diabetes, and heart health, while also acknowledging Tandem’s work to expand access, use technology to strengthen care, engage patients, and deliver high-value services.

Tandem Health Welcomes New Family Medicine Resident



Tandem Health welcomes Jana Dhillon, MD, one of the new Family Medicine Residents, to the team.

Jana Dhillon, MD, is a Family Medicine Resident Physician who is passionate about building meaningful relationships with her patients and making healthcare easier to understand and access. Born and raised in Vancouver, Canada, Dr. Dhillon has trained in a variety of healthcare settings and communities, including Chicago, Kentucky, Hawaii, and Texas. She is one of the family medicine residents with the Family Medicine Residency program, a collaborative partnership between Prisma Health Tuomey Hospital, the USC School of Medicine and Tandem Health.

Dr. Dhillon's interest in medicine began at a young age after seeing members of her own family experience challenges with language barriers and access to healthcare. Helping her family communicate with their physicians showed her the importance of making patients feel heard, informed, and supported—values that continue to shape her approach to care today.

She chose Family Medicine because she enjoys the opportunity to develop lasting relationships with patients and families. She is particularly interested in Vein & Lymphatics Medicine after seeing how targeted care could help a patient regain mobility, confidence, and quality of life. She is also interested in the potential for Artificial Intelligence to improve healthcare.

Outside of medicine, Dr. Dhillon enjoys boxing, Brazilian Jiu-Jitsu, gaming—especially World of Warcraft—and exploring Sumter. She looks forward to becoming an active part of the community and getting to know the patients and families she serves.

Tandem Health Welcomes New Family Medicine Resident



Tandem Health welcomes Shreeya Thapa, MD, one of the new Family Medicine Residents, to the team.

Shreeya Thapa, MD is a Family Medicine physician at Tandem Health with a focus on primary care. She earned her medical degree from North East Medical College and Hospital in Sylhet, Bangladesh, graduating in 2019. She began her career as a medical officer in Nepal before practicing for nearly a year in New York, bringing broad, cross-cultural clinical experience to her primary care practice. She is one of the family medicine residents with the Family Medicine Residency program, a collaborative partnership between Prisma Health Tuomey Hospital, the USC School of Medicine and Tandem Health.

Dr. Thapa is dedicated to providing accessible, whole-person primary care and building lasting relationships with her patients. Though new to the Sumter community, she is eager to get involved in local community programs and looks forward to becoming an active part of the area she now calls home.

Outside of medicine, Dr. Thapa considers herself a collector of moments rather than things and enjoys discovering new places and creating memories with the people she cares about. She hopes her legacy reflects the values of empathy, dedication, and the ability to bring comfort to others.

Changing Healthcare, Enriching Lives

Tandem Health Welcomes New Dentist



Tandem Health Dental welcomes Ishita Kapoor, DMD, a new Dentist, to the team.

Ishita Kapoor, DMD, provides comprehensive general dentistry with a focus on creating a comfortable, welcoming experience for every patient. A lifelong South Carolina resident, she earned her Doctor of Dental Medicine degree from the Medical University of South Carolina. She provides preventive services, fillings, extractions, crowns, bridges, dentures, partial dentures, and root canal therapy.

Her passion for dentistry started early. Getting braces could have been an intimidating experience, but thanks to a caring dentist and orthodontist, it became a turning point. That experience stayed with her and continues to shape how she cares for her own patients today: with patience, warmth, and a genuine desire to understand their needs.

Dr. Kapoor believes that great care begins with listening. She takes the time to understand her patients' concerns, answer their questions, and help them stay informed throughout their visits. She is particularly passionate about helping patients who experience dental anxiety, creating a calming environment where they can receive care at their own pace.

Outside the office, you will find her trying out a new recipe, staying active, or spending time with friends and family. She looks forward to building lasting relationships with her patients and becoming part of the Sumter community, one smile at a time.

Changing Healthcare, Enriching Lives

Coffee and Communication



Communication That Moves Us Forward

As we move into September, it is a good time to reflect on the role communication plays in building stronger communities, organizations, and relationships. At its best, communication does more than share information—it creates connection, builds understanding, and inspires action.

In the work of The Movement, our words matter. Whether we are communicating with members, partners, community leaders, volunteers, or the broader public, every message is an opportunity to reinforce who we are, what we value, and the change we are working to create.

Clarity Is a Form of Leadership

Effective communication begins with clarity. People should not have to guess what we mean, what we are asking of them, or why a particular message matters.

Clear communication is especially important when the information being shared does not require a response. Not every email, announcement, or update requires action. Sometimes the purpose is simply to keep people informed and ensure everyone has the same information.

Being intentional about that distinction can reduce unnecessary back-and-forth, prevent misunderstandings, and allow everyone to focus their time and energy where it is needed most.

Communication Should Build, Not Divide

Strong communication also requires respect. We will not always agree, and we will not always interpret a situation in the same way. That is normal. What matters is how we navigate those differences.

Before responding, it is worth asking:

- Is a response actually needed?
- Am I responding to what was said, or to how I interpreted it?
- Is my message helping to solve the issue?
- Am I applying the same standard that I expect from others?
- Does my communication reflect the values of the organization?

These simple questions can change the tone and outcome of difficult conversations.

Consistency Matters

Trust is built through consistency. The standards we establish for communication should apply regardless of who is sending the message.

When we expect professionalism, courtesy, and thoughtful communication from others, we must demonstrate those same qualities ourselves. Consistency creates credibility, and credibility is essential to effective leadership.

As we continue the work of The Movement, let us be mindful not only of **what** we communicate, but **how** we communicate it. Our communication should reflect the culture we want to create: one grounded in respect, accountability, transparency, and a shared commitment to progress.

Moving Forward Together

September brings a renewed sense of momentum. As schedules become busier and our collective work continues, let's make communication a strength rather than a source of unnecessary friction.

Let's communicate with purpose.

Let's listen before responding.

Let's be clear about what we need and what we expect.

And, most importantly, let's remember that every interaction is an opportunity to move the work forward.

When we communicate better, we work better—and when we work better together, we create greater impact.

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