



South Carolina Institute of
Medicine & Public Health

June 2019

The Evolving Workforce

Redefining Health Care Delivery in South Carolina



About the South Carolina Institute of Medicine and Public Health Workforce for Health Taskforce

As part of the South Carolina Institute of Medicine and Public Health's (IMPH) mission to collectively inform policy to improve health and health care in South Carolina, we supported a collective process to develop recommendations for state policymakers and other stakeholders regarding the future of the health care workforce for South Carolina.

The South Carolina Institute of Medicine and Public Health convened stakeholders and researched best practices and innovative approaches to care that focused on prevention, community settings and the social-environmental determinants of health and their implications for the workforce. As our country transitions to a health care payment system based on value rather than volume and because many people face significant access barriers, South Carolina needs to consider the evolving needs of the health care workforce within the context of our rapidly changing health care systems.

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South Carolina Institute of Medicine and Public Health is an independent entity serving as a neutral, informed convener around the important health issues in our state. The South Carolina Institute of Medicine and Public Health also serves as a provider of evidence-based information to inform health policy decisions.

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Letter from the Co-Chairs of the Workforce for Health Taskforce

The following report reflects a collaboration between many organizations invested in the development and success of our state's health care workforce. As chairs of the taskforce, our goal was to determine South Carolina-specific policy changes and recommend workforce solutions focused on creating sustainable, person-centered systems of care that will improve population health in the Palmetto state.

This effort is the culmination of what began as conversations among stakeholders about how to best prepare the state's health care workforce in an age of transforming payment models, while also focusing on population health beyond clinical care. In February 2017, the South Carolina Institute of Medicine and Public Health, in collaboration with the South Carolina Hospital Association, sponsored a Health Care Workforce Forum supported through a grant awarded by the National Network of Public Health Institutes with the support of the Robert Wood Johnson Foundation to explore tangible strategies for fostering collaboration between public health and health care. The conversation led to the need for additional research and dialogue.

The Workforce for Health Taskforce convened monthly from April 2018 to February 2019 to evaluate the state of health care and the future of the health care workforce in South Carolina. Each actionable recommendation outlined in the report recognizes the decades of important health system transformation and health workforce initiatives at play in our state while also acknowledging areas that we can all work together to improve. Access to high-quality, cost-effective health care in South Carolina must include a comprehensive assessment and aligned action on how we define, support and empower our health workforce.

It's time to recognize that improved health care in our state must include the expansion of value-based care delivery models, including incentivizing providers to adopt value-based care. Access to clinical care only accounts for 10 percent of what determines health outcomes, while the environment and health behaviors account for a combined 70 percent. Moving beyond clinical walls and integrating the health care workforce with community roles is a necessary evolution to improve South Carolina's health status.

Everyone in our state should have access to the type of care they need, when they need it — regardless of the health issue or their zip code. Improved supports for our health care workforce and value-based care will in turn support a greater movement towards access to quality care that is available to all.

One thing is clear, the landscape of health care is changing, bringing with it new opportunities to adopt value-based systems of care that address all determinants of health. Members of the health and human services workforce in South Carolina need to be empowered to perform as highly adaptive change-agents, able to evolve with the pace of care delivery innovations and demands.

Together, we must re-shape the way we support our health workforce which will in turn drive a community-based, quality health care system in South Carolina. This positions our state to be a national leader in improving health and access to care.

We would like to thank all of the Taskforce members and the advisory committee for the dedication and expertise they gave to this effort. Although this report represents the culmination of the work of the Taskforce, its release marks the beginning of our broader, collective work in transforming South Carolina's health and human services workforce to improve population health.



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Executive Summary

Community-based providers such as direct-care workers, family caregivers and behavioral health workers (among others) have customarily taken a backseat to other health care providers in terms of funding, support, visibility and inclusion in care teams. The traditional acute care centered model of health care has laid the groundwork for a system in which volume-based care is king. However, care delivery innovations have been proliferating throughout the health care system for years now, and value-based care is seeing slow but steady adoption across South Carolina. **The recommendations developed by the Workforce for Health Taskforce aim to follow the trend of patient-centered value-based care upstream, against tradition and traditional reimbursement, to the place where public health, population health, human services and traditional care delivery coalesce.**

Managing the health needs of a community can be a difficult balancing act that requires near-perfect optimization of personnel and resource deployment. Today, finding that balance presents a moving target for providers. The following Workforce for Health Taskforce recommendations are designed to prepare and support health and human service providers as they work to balance the demands of the changing health care landscape in South Carolina.

The recommendations and recommended action steps have been organized across several broad themes:

- A. Embracing the evolution of health and human service roles
- B. Training and educating health and human service providers
- C. Behavioral health workforce needs
- D. Setting the stage for the evolving workforce

In this report, several different phrases are used to describe the health care workforce, including health workforce and health and human service providers/workers.

The phrase “health care workforce” is still widely associated with physicians and nurses operating in traditional care delivery settings. However, we are now seeing that the traditional definition of the health care workforce does not apply to patient-centric, community-focused, value-based care models. In successful examples of such models, the health care workforce includes roles as varied as family caregivers, the local handyman, social workers or educators. A care site may be in a patient’s home, at a local food bank or other locations that are not usually associated with health care delivery. For the purposes of this report, the health care workforce includes both clinicians and any nontraditional roles that can contribute to improving the health of community members.

List of Recommendations

A. Embracing the evolution of health and human service roles

- A-1 Prioritize, promote and support the utilization of emerging and evolving health and human service roles.
- A-2 Create a system to support, educate and train family caregivers.
- A-3 Create a system to support, educate and train direct care workers (DCWs).

B. Training and educating health and human service providers

- B-1 Train health and human service students and existing professionals to define the health of an individual as the integration of behavioral health, primary care, population health, preventative care, social determinants of health, health equity and health disparities.
- B-2 Remove cost as a barrier to the pursuit of a certification or degree in health and human services.
- B-3 Create a public/private partnership to identify and implement policies and programs that overcome the barriers to efficiently placing health and human service students in on-site training positions with qualified mentors.
- B-4 Create a program to help community-based organizations (CBOs) and health care organizations build increased capacity to work together productively.
- B-5 Provide funding to address the state's need for data and information scientists.

C. Behavioral health workforce needs

- C-1 Improve reimbursement for behavioral health services and enable government agencies and CBOs to improve pay for behavioral health professionals.
- C-2 Reduce financial barriers to entry for students interested in behavioral health certifications and degrees.
- C-3 Ensure educational entities, students and employers are aware of the need for more behavioral health professionals in our state.
- C-4 Place special emphasis on creating a positive, supportive work environment with opportunities for growth in behavioral health settings.

D. Setting the stage for the evolving workforce

- D-1 Screen for social determinants of health when interacting with patients and/or clients and integrate that data into electronic health records (EHRs) or other data systems.
- D-2 Participate in bidirectional data sharing at the local level.
- D-3 Implement telehealth policies that will extend the capacity of the workforce to meet the needs of communities at sites such as schools, worksites and prisons.
- D-4 Utilize data derived from improvements to community health needs assessments (CHNAs) and other community assessments to drive priorities for the composition of the workforce at the community level.



Preamble

The Changing Landscape of Care Delivery

The recommendations in this report are written with respect to the existing fee-for-service payment system in use across much of South Carolina, while also anticipating a shift to value-based care. Value-based care and fee-for-service payment systems differ in how they reimburse providers for health care services. The fee-for-service payment model rewards providers based on the volume of services they deliver. Therefore, providers are incentivized to deliver a greater number of higher cost services (such as running tests or performing surgeries) even if the services are unnecessary. Additionally, quality of care is not positively correlated with reimbursement in the fee-for-service model, which leads to unnecessarily high health care costs and inconsistent quality.

Conversely, value-based payment models (also known as pay-for-performance) reward providers based on predetermined publicly-reported quality metrics and the cost of care. According to *Health Affairs*, value-based payment programs have been tested and implemented for years on the federal level, both for physicians and Medicare beneficiaries. Major changes to physician reimbursement have been underway for years; most notably when the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) was signed into law in April 2015.¹ The legislation changed physician reimbursement from the volume-based sustainable growth rate (SGR) to value-based Quality Payment Programs (QPPs). Under the new payment programs, physicians can be reimbursed through the Merit-Based Incentive Program² (MIPS)^a or Alternative Payment Models³ (APMs).^b Both options reward physicians for meeting the Institute for Healthcare Improvement's Triple Aim.

The Institute for Healthcare Improvement (IHI) Triple Aim is a framework that describes an approach to optimizing health system performance. It is IHI's belief that new designs must be developed to simultaneously pursue three dimensions, which we call the 'Triple Aim':

- **Improving the patient experience of care (including quality and satisfaction);**
- **Improving the health of populations; and**
- **Reducing the per capita cost of health care. (The IHI Triple Aim, pg. 1)⁴**

The Centers for Medicare and Medicaid Services' (CMS) Hospital-Acquired Condition Reduction Program⁵ (HACRP) is another example of a value-based payment model. This program penalizes hospitals that perform most poorly on risk-adjusted measures (such as readmission penalties) by reducing their reimbursement by one percent (this penalty amounts to around \$350 million per year, per health system);⁶ thereby creating a financial incentive for providers to deliver high-quality care.

Federal programs such as MACRA and HACRP are shaping the new health care landscape and creating a friendly environment for providers interested in value over volume. This modern approach to care delivery has led to the development of new initiatives in South Carolina. For example, the Healthy Connections Prime program covers those eligible for both Medicaid and Medicare in South Carolina and consolidates payment and care coordination for these beneficiaries via one service that leverages coordinated care delivery and an

^a“Under MIPS, clinicians are included if they are an eligible clinician type and meet the low volume threshold, which is based on allowed charges for covered professional services under the Medicare Physician Fee Schedule (PFS) and the number of Medicare Part B patients who are furnished covered professional services under the Medicare Physician Fee Schedule. Performance is measured through the data clinicians report in four areas - Quality, Improvement Activities, Promoting Interoperability (formerly Advancing Care Information), and Cost.” (MIPS, How Eligibility is Determined, pg. 1)

^b“An Alternative Payment Model (APM) is a payment approach that gives added incentive payments to provide high-quality and cost-efficient care. APMs can apply to a specific clinical condition, a care episode, or a population.” (APMs Overview, pg. 1)

integrated care team. Since its 2015 rollout, Healthy Connections Prime has improved the quality of care, reached more clients and consolidated services and care coordination to a higher extent than was initially anticipated during the planning stages.⁷

To meet the goals of the IHI Triple Aim we must redefine the health workforce to include non-traditional health and human service professionals.⁸ Innovations in care delivery are occurring at a rapid pace and the workforce must adapt to work requirements beyond the confines of acute care delivery.

Social & Environmental Determinants

In the past, health outcomes were considered to be the result of access to, and quality of, care. However, a number of other factors are now understood to greatly impact individuals' health. Figure 1 shows the many factors that influence health outcomes compared to where our health care dollars go.⁹

Although the concept of health determinants extending beyond clinical care is not revolutionary for many people, leveraging this knowledge has only seen widespread adoption in the past few years as Medicaid and Medicare pilot programs use the model to transform care delivery.

Using these factors as a basis for defining the current and future needs of the health workforce, the Workforce for Health Taskforce focused its recommendations on embracing the evolution of health and human service roles, training and educating health and human service providers, behavioral health workforce needs and setting the stage for the evolving workforce.

Implications for the Workforce

South Carolina must rethink how we define, support and empower our health workforce.

The landscape of health care is changing, bringing with it new pressures to adopt value-based systems of care that address social and environmental determinants of health. Members of the health workforce in South Carolina need to be empowered to perform as highly adaptive change-agents to evolve with the pace of care delivery innovations.¹¹

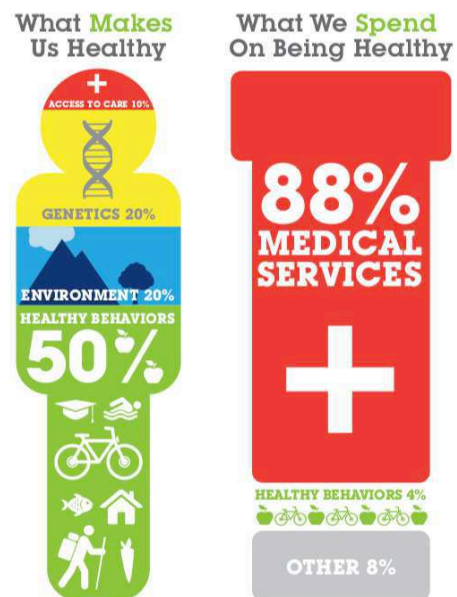
Drivers

South Carolina's population is aging and experiencing an increase in the number of residents with chronic conditions; leading to increasingly¹² costly care.^c Similar trends also exist on a national level. For a number of years, 50 percent of health care expenditures have been attributed to the top 5 percent of costliest patients.¹³

Additionally, the federal government is increasingly shifting more funding to the state level, pushing states to innovate care delivery on their own terms¹⁴ while federal pilot programs continue to proliferate.¹⁵

CMS recently announced a new payment model that expands the reach of the health workforce. The Emergency Triage, Treat and Transport (ET3) Model will provide 5 years of funding for ambulance care teams to receive reimbursement for new care pathways for Medicare beneficiaries. Current regulations only reimburse ambulance services when Medicare beneficiaries are transported by ambulance to hospitals, critical access hospitals (CAHs), skilled nursing facilities (SNFs) and dialysis centers.

Figure 1



Source: The Bipartisan Policy Center

^c "People with functional limitations and chronic conditions are more than four times more likely than the general population to be among the 5 percent costliest users of health services. And yet, function is rarely addressed in medical visits." (Johns Hopkins CAPABLE program, Pg. 1)

Under the ET3 model, CMS will pay participating ambulance suppliers and providers to 1) transport an individual to a hospital emergency department (ED) or other destination covered under the regulations, 2) transport to an alternative destination (such as a primary care doctor’s office or an urgent care clinic) or 3) provide treatment in place with a qualified health care practitioner, either on the scene or connected using telehealth. (CMS 2019, 1)¹⁶

This pilot program is indicative of new ways the health care workforce can be leveraged to manage population health. As CMS continues to test alternative payment models, the resulting shared learnings create a new frontier for the health care workforce.

Redefining the Workforce

Historically, workforce improvement efforts have focused on physicians, nurses and other clinicians and have addressed clinical issues such as scope of practice, primary care shortages and the need for more nurses and physicians. While these topics still present opportunities for workforce optimization, **this report seeks to explore workforce issues beyond the traditional health care staffing pain points.**

The clinically-centered care delivery model of the past is being replaced by a more efficient, cost-effective system that is person-centered, coordinated and framed by each of the determinants of health. This community-driven approach will serve to empower providers and community-based organizations (CBOs)^d to optimize their efforts to address social determinants of health in their local communities.

Health drivers outside of clinical care have typically been addressed at the community level by human services organizations operating in the social services and nonprofit sectors; work that is not usually coordinated with clinical care. Bringing together health and human service providers from multiple sectors can reduce health care overutilization while improving outcomes.

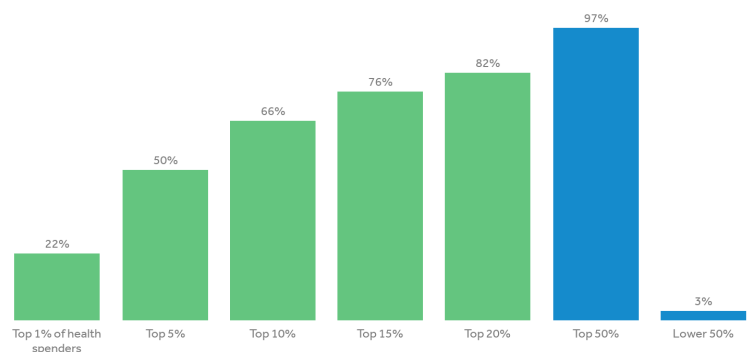
For health care delivery systems and providers who historically receive most of the health care dollars, the movement away from fee-for-service payments toward global payments tied to health outcomes demands that they begin to look for opportunities to achieve cost savings. Often these opportunities for cost savings come by creating conditions for people to be healthy in their homes and communities—work traditionally performed by community social service providers and others outside the health care delivery system.

Many of the existing efforts at the community level focus on patients with the most complex needs, who tend to incur costly services. As

Figure 2 demonstrates, the costliest 5 percent of patients incur 50 percent of total health expenditures.

Figure 2

Contribution to total health expenditures by individuals, 2016



Source: Kaiser Family Foundation analysis of Medical Expenditure Panel Survey, Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services

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Health System Tracker

As the health workforce evolves to meet the new demands of the care delivery system, our State Legislature, health and human service organizations, academic and training institutions and government agencies must also rise to the challenge and adjust effective programs already in place while taking on new initiatives to pave the way for the changing needs of the health workforce.

^d A CBO is a public or private nonprofit organization that is representative of a community or a significant segment of a community and works to meet community needs. Examples of CBOs include schools, housing agencies, food pantries, legal aid, faith communities, social justice organizations, organizations with youth and family-based missions, law enforcement, parks and recreation, Area Agencies on Aging, advocacy organizations, domestic violence shelters and homeless shelters.

Recommendations

Section A. Embracing the Evolution of Health and Human Service Roles



RECOMMENDATION

A-1. Prioritize, promote and support the utilization of emerging and evolving health and human service roles.

Champions:^e *Community-based organizations, health systems, patient advocacy groups, South Carolina Area Health Education Consortium, South Carolina Hospital Association, South Carolina Office of Rural Health*

Timeline: 4-6 years

Currently, our state's health leaders do not have the workforce staffing, capacity and infrastructure in place to fully implement new workforce strategies required to better manage the health of South Carolinians. However, new workforce roles can still be tested on a community level. The School of Nursing at John's Hopkins University has been successful on this level with their CAPABLE (community aging in place) program, which is, "a client-centered home-based intervention to increase mobility, functionality and capacity to 'age in place' for

^eAll lists of champions are in alphabetical order.

low-income older adults.”¹⁷ The program has demonstrated that nontraditional care teams can greatly improve health outcomes while reducing costs. CAPABLE care teams include an occupational therapist, a nurse and a handyman. This “client-centric” approach is working and has achieved more than six times^f return on investment.¹⁸

Recommended Action Steps

1. Community-based organizations should collaborate to track supply and demand data and educational pipelines for emerging and evolving health and human service roles.

With the integration of social services into health care delivery,¹⁹ existing health and human service roles are evolving and new roles are emerging to provide patients with coordinated care at a lower cost than traditional health care services. Information about the emerging and evolving roles will be used to optimize the workforce pipeline, academic and training programs and state funding.

The South Carolina Office of Rural Health (SCORH) plans to “work with the South Carolina Office for Healthcare Workforce to define the existing and future need for emerging health professions (i.e. community health workers, community paramedics) in rural areas to promote recruitment of these professionals.”²⁰

Evolving Health and Human Service Roles

New imperatives for patient and population health management require an adaptive, evolving health care workforce. Increasing the utilization of community-based professionals will allow other providers in the workforce to practice at the top of their licenses. This diffusion of responsibilities will also reduce the cost of care. As demonstrated by the Johns Hopkins School of Nursing CAPABLE program, utilization of more affordable caregivers can prevent the use of costly emergency medicine expenditures.

The list below includes a selection⁹ of new and evolving roles that are likely to see increased utilization and growth as workforce needs adjust to support new care delivery models. Knowledge about their supply numbers or the actual level of demand for their services is currently limited.

- ◆ Care Managers – A care manager is a professional (such as a social worker or nurse) who assists in the planning, coordination, monitoring and evaluation of medical services for a patient, with emphasis on quality of care, continuity of services and cost-effectiveness.²¹ This role has a variety of titles associated with it: care coordinator, discharge planner, case manager and others. In the South Carolina registered nurse (RN) workforce, 5.4 percent of RNs work as care managers. Many more may be providing these services under another title. Because care manager is a role title and not a separate occupation, South Carolina does not currently have data for professionals beyond the RN workforce to indicate the prevalence of care managers in other disciplines.²²
- ◆ Community Health Workers (CHWs) – A community health worker is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community they serve. This trusting relationship enables the worker to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. A community health worker also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy.²³ As a recognized part of the health care team, CHWs are fairly new to South Carolina and have only recently come under the regulatory authority of the state. There are future plans to measure the size of this workforce and learn more about what they do and where they do it.²⁴
- ◆ Dental Therapists – Dental Therapists (DTs) are mid-level practitioners who are members of an oral health care team in several states.²⁵ They provide evaluative, preventive and restorative services within the scope

^f Roughly \$3,000 in program costs yielded more than \$20,000 in savings in medical costs driven by reductions in both inpatient and outpatient expenditures.

⁹ This list is not ranked in order of importance, nor is it comprehensive.

of practice in their state. DTs work under the supervision of a dentist.²⁶ This new occupation is not currently recognized in South Carolina but has been found to create additional access to oral health care, freeing up dentists to concentrate on more complex procedures, and thus extending the capacity of the oral health workforce.²⁷

- ◆ EMTs and Paramedics – Emergency medical technicians (EMTs) and paramedics care for the sick or injured in an emergency. EMTs and paramedics respond to emergency calls, performing medical services and transporting patients to the hospital.²⁸ A recent study by the South Carolina Office for Healthcare Workforce indicated that more than half of all emergency medical services (EMS) agencies surveyed reported that it takes four months or more to fill vacant EMT positions, and to a lesser extent, paramedic positions, suggesting that the demand for EMTs and paramedics is stronger than the available supply.²⁹ Changes to reimbursement policies affecting EMS personnel are currently being developed by Medicare (the ET3 model) that aim to improve quality and lower costs by reducing avoidable transports to the ED and unnecessary hospitalizations following those transports.³⁰
- ◆ Community Paramedics and Mobile Integrated Health Care Providers – These are new roles intended to utilize experienced EMTs and Paramedics to bring preventive and follow-up care to patients in their homes. In 2013 Abbeville County launched a program utilizing these roles with an initial enrollment of 75 patients. In the first two years of the program, 773 home visits were made and the patients in the program had a 58 percent decrease in ED visits, a 60 percent decrease in inpatient stays and the majority had better outcomes for their diabetes and hypertension.³¹ South Carolina does not track supply and demand for these workers.
- ◆ Health Information Technology Specialist – Health information technology specialists support clinicians and staff across many health care settings, including inpatient rehabilitation facilities, acute care hospitals, long-term care facilities, physician offices, mental health facilities and outpatient clinics. Others work for organizations that do not provide direct medical care, such as consulting firms, public health and other government agencies, insurance companies and software vendors.³²
- ◆ Intake Specialists – Intake specialists work in the medical field to help direct people to the services they need. Intake specialists are used in many different areas, such as hospitals, mental health facilities, crisis centers, nursing homes and other care settings. Intake specialists talk directly with patients and their families, determining their needs, their medical history, physical and mental state and special requirements. Understanding these needs helps the intake specialist determine what services are needed and guides patients to the right areas.³³ At this point in time there is no established source of data for these professionals. The South Carolina Office for Healthcare Workforce is investigating how often this job title, and others for emerging roles, are seen in the online job listing database available through the state Department of Employment and Workforce.³⁴
- ◆ Mental Health and Substance Abuse Social Workers – These professionals assess and treat individuals with mental, emotional or substance disorders, including alcohol, tobacco and/or other drugs. Activities may include individual and group therapy, crisis intervention, case management, client advocacy, prevention and education.³⁵ Integrating behavioral health workers into primary care settings, health care teams and other access points for community members is an important component of holistic, coordinated care.
- ◆ Peer Support Specialists – Peer support specialists are professionals who use their experience of recovery from mental health disorders to support others in recovery. Combined with skills often learned in formal training, their experience and institutional knowledge puts them in a unique position to offer support. Although peer supporters have many titles (such as recovery coach), all specialists model recovery, share their knowledge and relate in a way that have made this evidence-based practice a rapidly growing field.³⁶
- ◆ Personal Care Assistant/Direct Care Worker/Home Health Aide – In-home caregivers provide services such as cooking, bathing and other hygiene-related tasks. Home Health Aides have training in skills such as bed, bath and oral care, transferring patients from one location to another and maintaining a safe and healthy environment for their clients. Home health agencies have a large amount of discretion in their training requirements. The demand for both in-home caregivers and home health aides is projected to increase sharply over the next 10 years as our elderly population continues to grow.³⁷ Employees of South Carolina home care agencies can supervise self-administration of medication. Measuring the supply of these important caregivers is currently hampered by the lack of a registry or certification requirements.³⁸

- ◆ Pharmacists – Among other pharmacy care functions, today’s pharmacists can provide immunization services, medication synchronization, patient customized packaging, specialty compounding, medication therapy management^h (MTM), transition of care services and more under collaborative practice agreements. Considerable evidence demonstrates the value of expanded pharmacist involvement in patient care, not only in reducing medication errors and associated hospital stays, but also in terms of patient outcomes and better health.³⁹ South Carolina has basic information about the general supply of pharmacists in the workforce, but very little information about the new settings or the new roles they may be filling in the community to support value-based care and population health.
- ◆ Psychologists – Psychologists are doctoral-level licensed practitioners who engages in the practice of psychology which includes:
 - I. Psychological testing and the evaluation or assessment of personal characteristics, such as intelligence, personality, cognitive, physical and/or emotional abilities, skills, interests, aptitudes and neuropsychological functioning;
 - II. Counseling, psychoanalysis, psychotherapy, hypnosis, biofeedback and behavior analysis and therapy;
 - III. Diagnosis, treatment, and management of mental and emotional disorder or disability, substance use disorders (SUDs), disorders of habit or conduct and the psychological aspects of physical illness, accident, injury or disability;
 - IV. Psychoeducational evaluation, therapy and remediation;
 - V. Consultation with physicians, other health care professionals, and patients regarding all available treatment options; and
 - VI. The supervision of any of the above.⁴⁰
- ◆ Registered Dietitian – Registered dietitians in South Carolina must have a degree from an accredited program, complete a supervised training program, pass a national exam administered by the Commission on Dietetic Registration and maintain required continuing education credits. They maintain continuing education mandated by the Commission on Dietetic Registration and each state. State laws mandate that only licensed dietitians can provide advice related to nutrition and disease (or medical nutrition therapy). The majority of registered dietitians work in the treatment and prevention of disease (administering medical nutrition therapy, as part of a medical team), often in hospitals, Health Maintenance Organizations (HMOs), private practice or other health care facilities.⁴¹ South Carolina maintains a registry of dietitians through the South Carolina Panel for Dietetics at the Department of Labor, Licensing and Regulation. Jobs for registered dietitians are expected to grow about five percent annually in South Carolina over the next seven years.⁴²
- ◆ Social Workers – Social workers have skills that are valuable in all regions of the health care landscape. Many of these professionals are trained specifically for clinical support roles. Social workers with Bachelor’s degrees (BSWs) work with groups, community organizations and policymakers to develop or improve programs, services, policies and social conditions. This focus of work is referred to as macro social work. Licensed clinical social workers (LCSW) provide individual, group, family and couples therapy; they work with clients to develop strategies to change behavior or cope with difficult situations and they refer clients to other resources or services, such as support groups or other mental health professionals. Clinical social workers can develop treatment plans with the client, doctors and other health care professionals.⁴³ In South Carolina approximately 40 percent of all licensed social workers employed in the state are licensed as clinical social workers, based on information gathered from the South Carolina Board of Social Work Examiners and analyzed by the South Carolina Office for Healthcare Workforce. They fill a variety of evolving roles in a value-based health care system. About 20 percent of South Carolina’s social workers are employed in hospitals and another 20 percent in health-related settings such as nursing homes, mental health clinics, hospice and community health centers.

^h Drug therapy management is that practice of pharmacy which involves the expertise of the pharmacist in a collaborative effort with the practitioner and other health care providers to ensure the highest quality health care services for patients.

2. SCHA should add relevant emerging roles to the “Be Something Amazing” career profiles website.⁴⁴

Be Something Amazing was created by SCHA to provide individuals with meaningful materials to help them learn more about the abundant career choices available in health care today. Additionally, Be Something Amazing provides video resources and detailed information about the education requirements, job skills and employment outlook for a wide variety of careers in health care, many available with as little as two years of post-high school education.

By helping individuals find a health career that takes advantage of their strengths, SCHA hopes to avoid an impending shortage of health care workers and build a stronger health care workforce in South Carolina. (SCHA 2019, 1)⁴⁵

3. Health systems that utilize emerging roles within at-risk accountable care organizations (ACOs) and other value-based programs⁴⁶ should be incentivized to share data used to assess the ideal utilization for these roles, the return on investment (ROI) of adding them to the care team and any related outcome improvements with payers, providers and government agencies.

The Shared Savings Program is a federal initiative⁴⁷ that creates incentives for ACOs to manage the health of an assigned group of Medicare beneficiaries. According to the National Association of ACOs (NAACOS), “Under a shared risk model, ACOs are eligible to share savings if they meet certain quality standards and other targets, but they also are liable for a portion of increased spending above certain thresholds.”⁴⁸

To achieve success, providers participating in at-risk ACOs and other value-based programs work to optimize care delivery roles and ensure that services are provided in the most cost-efficient way. For example, a peer support specialist may be added to a care team and empowered to counsel and support an individual with mental illness or substance use disorder (SUD).

Health and human service providers in South Carolina would benefit from shared learnings offered by providers in at-risk value-based programs, as initiatives testing population health models reflect the future of care delivery.

4. CBOs, health providers and payers should develop pilot programs through waivers and/or philanthropy to test payment mechanisms for reimbursing emerging and evolving health and human service roles.

As registered dietitians, peer support specialists and other non-clinical professionals become integrated into coordinated care delivery, payment mechanisms must evolve to reflect the utility and cost-savings associated with including these roles in the health care ecosystem.

On a national level, CMS routinely tests the viability of new payment models for Medicare beneficiaries. South Carolina should follow this national trend and consider testing new payment models for Medicaid beneficiaries and the privately insured population.

The South Carolina Rural Health Action Plan recommends that stakeholders “provide sustainable reimbursement for new and innovative health care worker services (i.e. community health workers, community paramedics) and providers (i.e. clinical pharmacists, social workers and care managers), including new population health services, to support a diverse health care workforce in rural areas.”⁴⁹

RECOMMENDATION

A-2. Create a system to support, educate and train family caregivers.^k

Champions: AARP of South Carolina, Alzheimer's Association - South Carolina Chapter, community-based organizations, health and human service training and education programs, patient advocacy groups, South Carolina Department on Aging, South Carolina Department of Health and Human Services, South Carolina Legislature

Timeline: 1-3 years

Family caregivers provide a critical resource for the aging population (in the U.S., approximately 10,000 people turn 65 every day) and other individuals with special needs.⁵⁰ In 2015, about 43.5 million family caregivers reported providing free care to a patient in the previous year in the U.S.⁵¹ Patients were, on average, 69.4 years old, with the average age of caregivers at 49.2.⁵² Fifteen percent of caregivers took care of two adults. A majority, 39.8 million, took care of patients with an illness or disability.⁵³

Providing care to a family member can be intensely difficult work. Many family caregivers experience compassion fatigue, "an extreme state of tension and stress that can result in feelings of hopelessness, indifference, pessimism and overall disinterest in other people's issues."⁵⁴ Family caregivers are more likely to die younger and experience stress, depression and physical and financial problems.⁵⁵ Unlike more formalized health care positions, family caregivers are unlikely to have peer support or the ability to take sick days or vacations away from their loved one.

South Carolina has almost 800,000 family caregivers.⁵⁶ Services provided by family members represent a significant health care expenditure. According to the South Carolina Department on Aging, if these workers were paid \$10.04 per hour, it would cost the state \$7.4 billion per year.⁵⁷

Recommended Action Steps

1. CBOs should partner with government agencies to expand learning and support networks for special needs families.

Providing care to a family member is challenging in the best circumstances, but many families confront additional hurdles in their efforts to provide in-home care. Additional support is needed for families caring for children with cystic fibrosis or other medically fragile conditions, foster children, seniors aging in place, individuals with serious mental illnesses, individuals with special needs who live in group homes and medically fragile children who are transitioning to adulthood.

2. The Taskforce encourages the State Legislature to explore the feasibility of creating and funding a statewide 24-hour hotline for family caregivers.

Many resources exist to support family caregivers on the state and national level, including the South Carolina Department on Aging's Caregiver Support Program,⁵⁸ the Family Caregiver Alliance,⁵⁹ the National Alliance for Caregiving,⁶⁰ the Caregiver Action Network's Family Caregiver Toolbox⁶¹ and others.⁶² However, creating a 24-hour hotline for family caregivers in South Carolina would allow caregivers to access support at any time of the day or night and would be staffed with workers familiar with local resources, processes and procedures.

3. Health and human service providers should identify and connect family caregivers with local resources to ensure caregivers are supported and receive information related to improving self-care and other important issues.

^k A "family caregiver" is anyone who provides any type of physical and/or emotional care for an ill or disabled loved one at home. Loved ones in need of care could be suffering from a physical or mental illness, disability, substance misuse or other conditions.

The first health or human service provider a family caregiver seeks support from should ensure the family caregiver is able to access community resources. The provider may need to contact the organization for the family caregiver. Additionally, caregivers' needs for transportation and any other social or environmental determinants of health should be met. Health and human service providers may include specialists, primary care offices, the South Carolina Department of Social Services and others.

4. South Carolina hospitals and health systems should follow the guidelines of the Caregiver Advise, Record, Enable (CARE) Act during patient discharge.

The CARE Act was developed to provide extra support for the approximately 20 million U.S. caregivers who provide nursing or medical care to their family member. According to the American Association of Retired Persons (AARP), 39 states and DC, Puerto Rico and the U.S. Virgin Islands have signed the CARE Act into law.⁶³

Guidelines of the CARE Act include recording the name of the family caregiver on the medical record, informing the family caregivers when their loved one is to be discharged and providing the family caregiver with education and instruction of the medical tasks he or she will need to perform for the patient at home.

5. Health and human service providers, government agencies and other partners should improve support for family caregivers, especially as it allows people to age in place, through the adoption of recommendations created by the Center for Health Care Strategies' Helping States Support Families Caring for an Aging America initiative.

South Carolina is one of five states selected to improve support for family caregivers through this project. The Center for Health Care Strategies is providing twelve months of technical assistance in examining family caregiver capacity.⁶⁴ There are five areas of opportunity:

1. Support of communities in developing grassroots resources that support family caregivers in those communities with resources right for those communities,
2. Targeted training and direct technical support for family caregivers to provide them with the knowledge, tools and strategies necessary to support an aging relative with complex needs,
3. Targeted incentives to promote family caregiving, including improvements to the availability and support of in-home respite care,
4. Pursuit of Managed Long-Term Services and Support payment reform and
5. Employment policies that support the efforts of family caregivers.

State Partners as of May 2019 include the South Carolina Department of Health and Human Services (SC DHHS), the South Carolina Legislature, AARP South Carolina, the South Carolina Department on Aging and the South Carolina Institute of Medicine and Public Health (IMPH).

It is anticipated that by January 2020, South Carolina will have a plan with measurable objectives and timelines for supporting family caregivers.

RECOMMENDATION

A-3. Create a system to support, educate and train direct care workers (DCWs).¹

Champions: AARP South Carolina, Arnold School of Public Health Community Health Worker Institute, Alzheimer's Association South Carolina Chapter, community-based organizations, health and human services training and education programs, patient advocacy groups, South Carolina Area Health Education Consortium, South Carolina Department of Health and Human Services, South Carolina Office of Rural Health

Timeline: 1-3 years

Historically, non-clinical health care roles, such as CHWs or direct care workers (DCWs), have been underappreciated and underpaid while performing some of the most difficult tasks in health care. As community-based patient-centric care becomes increasingly recognized as essential to reinforcing or preventing clinical care, family caregivers, CHWs, DCWs and other non-clinical human service roles will play a more substantial role in care delivery. As such, these roles should receive status and pay on par with the elevated need for their expertise.

DCWs do not typically have an obvious career trajectory for promotions and higher-paying positions, but these roles can be framed as the first step in a life-long health care career path.

Training standardization for DCWs is essential. Implementation of a statewide training program would ensure that all DCWs in South Carolina are prepared for the new challenges of their roles in the health care ecosystem. Specialized training is also critical. DCWs should be trained to provide person-centered dementia care based on thorough knowledge of the care recipient and their needs. This training will advance optimal functioning and a high quality of life for the patient and will incorporate problem-solving approaches into care practices.

According to the Alzheimer's Association's 2019 Disease Facts and Figures report, 10 percent of Americans age 65 or older have Alzheimer's dementia.⁶⁵ **There are 313,000 Alzheimer's/dementia family caregivers in South Carolina and cases of Alzheimer's disease in our state are projected to increase from 92,000 in 2019 to 120,000 in 2025 – a 30.4 percent increase.**⁶⁶

During 2018, caregivers of people with Alzheimer's disease in South Carolina provided an estimated 357,000,000 hours of informal care, which is valued at over \$4.5 billion.⁶⁷ This significant contribution takes a toll on these dedicated individuals and associated caregiver stress can lead to the unnecessary hospitalization of dementia patients.

Among dementia caregivers in South Carolina:

- More than half have been providing care for at least two years.
- More than one-third provide 20 or more hours of care per week.
- Nearly one-third are in the "sandwich generation" – caring for both someone with dementia and a child or grandchild.⁶⁸

According to the Alzheimer's Association, "the single most important determinant of quality dementia care across all care settings is direct care staff."⁶⁹

¹ The title "direct care worker" represents all unlicensed individuals who are contracted or employed in any setting with public funds or by an agency, hospital or facility that is licensed and/or certified by the SC Department of Health and Environmental Control (DHEC) or SC Department of Disabilities and Special Needs (DDSN) as defined in Section 43-35-10 and who provide hands-on care or services to vulnerable adults.

Recommended Action Steps

1. The South Carolina Institute of Medicine and Public Health Long-Term Care Leadership Council (LC) should oversee a feasibility study to consider the establishment of infrastructure for a comprehensive statewide training program for DCW categories that are not currently subject to any standardized training requirements.
 - a. The Taskforce encourages the State Legislature to consider funding training programs developed as a result of the feasibility study as well as national and state certifications for all current and future DCWs.
 - b. Government agencies and academic and training institutions should consider a tiered approach to training levels for DCWs (ex., level 1, 2, 3).

Training for DCWs in South Carolina is not standardized and requirements vary across care settings, funding sources and occupational categories. Currently, DCWs certified as nursing assistants or home health aides have the most rigorous and defined training, due to federal training standards set by Medicare and Medicaid. There are no such federal training standards for other DCWs, which contributes to inconsistencies in training and variations in quality of care. In its 2008 landmark report, “Retooling for an Aging America,” the Institute of Medicine recommended that states establish minimum training requirements for personal-care aides.⁷⁰ With increasing numbers of individuals being served in home and community-based settings, these workers need adequate training because they may have less supervision in these settings, must work more independently and are increasingly dealing with more complex care needs. Beyond the benefits to the patient and their families, training has been linked positively to higher job satisfaction, improved retention rates and decreases in turnover among DCWs.⁷¹

2. The Taskforce encourages the State Legislature to consider utilizing a neutral convener to study what resources should be deployed to implement low or no-cost ongoing training and career counseling programs to DCWs, offered at no charge to participants.

Awareness of opportunities for career advancement is an important component of job satisfaction. DCWs should have access to these and other incentives. Currently the DCW workforce experiences high rates of turnover due to low pay, difficult working conditions and a lack of opportunities for advancement. Joining the direct care workforce can be a starting point for individuals who want to eventually earn additional certifications and degrees.

3. Employers of DCWs should provide health insurance to their employees.

According to the Bureau of Labor Statistics, the national median salary for home health aides was \$23,210 in May 2017.⁷² Personal care aides made \$110 less in the same year.⁷³ The federal poverty level for a family of four in 2019 is \$25,750.⁷⁴

Most, if not all, DCWs are eligible for health coverage through the federal health insurance exchange and would likely qualify for significant subsidies which will make coverage very affordable and will greatly improve the quality of life for DCWs while reducing sick days through improved access to preventative care.

Section B. Training and Educating Health and Human Service Providers



Most training programs for health care professionals do not include enough focus on coordinated care, population health, social determinants of health, behavioral health, aging in place or community-based care. A 2017 Leavitt Partners poll of physicians reflected that disconnect; of the physicians polled, 69 percent said that physicians and insurers should not be responsible for addressing patients' transportation limitations.⁷⁵ Ninety-one percent conveyed that finding affordable housing for patients should not be in their purview.⁷⁶ These responses speak to a lack of willingness or ability to incorporate the responsibility of non-clinical determinants of health and a lack of experience with population health by physicians. This belief system exists, in part, because the health and human service education system often operates independently of the care delivery system. For some degree programs there are years between when best practices are developed in the professional world and when they are integrated into program curricula.

Our state must ensure a diverse and well-trained workforce is actively matched with public, private and entrepreneurial job opportunities. Community members should have access to vocational training and higher education programs that will prepare them with the skills and competencies to fill roles in our state's health and human service workforce.

The South Carolina AHEC Scholars Program is one example of an innovative approach to health care education and training in our state. The program is a part of a national initiative to prepare tomorrow's health professionals to become leaders in interprofessional, transformative practices that serve populations needing improved access to care. AHEC describes the program as consisting "of didactic and experiential training opportunities with a focus on interprofessional primary care and service to rural and underserved populations."⁷⁷

RECOMMENDATION

B-1. Train health and human service students and existing professionals to understand how the health of an individual is impacted by the integration of behavioral health, primary care, population health, preventative care, social determinants of health, health equity and health disparities.

Champions: Behavioral health providers, community-based organizations, health and human service education programs, health systems, medical practices, National Alliance on Mental Illness South Carolina, patient advocacy groups, public and private academic and training institutions, South Carolina Area Health Education Consortium, South Carolina Commission on Higher Education, South Carolina Department of Health and Human Services, South Carolina Hospital Association, South Carolina Office of Rural Health

Timeline: 4-6 years

Recommended Action Steps

1. The Taskforce encourages the State Legislature to consider increasing funding for AHEC's training modules for current health and human service professionals as well as similar programs as appropriate.

South Carolina AHEC's Continuing Professional Development (CPD) program provides practicing health care professionals with continuing education seminars, workshops, lectures and web-based learning. All four Regional AHEC Centers employ CPD Coordinators from various health disciplines whose principal roles are to assess, develop and present continuing education programs to health professionals in their regions. National, regional and local experts are used as lecturers, faculty and consultants. The South Carolina AHEC CPD Coordinators work closely with hospital education departments, regional health professionals, associations and agencies and educational institutions to deliver easily accessible and affordable educational programs. The life-long learning provided through AHEC follows a set of "Best Practice Standards" designed by the CPD Coordinators to assure quality in programming.⁷⁸

2. Health and human service providers should be trained to assess potential behavioral health conditions when treating patients for any other social determinant of health and address substance use disorders as preventable, treatable, chronic and sometimes deadly diseases.

Historically most primary care providers have not been involved in patients' behavioral health care in a significant way. Today, many people in the health care ecosystem recognize the importance of integrating behavioral health care into primary care treatment so comorbid conditions can be treated by coordinated care teams rather than in health care delivery silos. Those suffering from behavioral health disorders should receive treatment on par with those suffering from other chronic diseases.

3. Health systems and CBOs should work with academic and training institutions to include an integrated perspective of care delivery in continuing education programs and health and human service program curricula.

Integrated care delivery is an essential part of a connected, community-based health care ecosystem. Health and human service academic and training programs should continue to embrace a new set of core competencies and adjust curricula to prepare students for coordinated, integrated care delivery. These programs should align practice and education to ensure experiential application of behavioral health, primary care, population health, preventive care, social determinants of health, health equity and health disparities in CBOs and practice settings.

4. Academic and training institutions should require all health and human service students to participate in a community health needs assessment (CHNA) learning experience, such as a seminar or course.

CHNAs can be an effective tool for designing a community-specific set of health services and programs and for identifying health workforce successes and areas for improvement. As care delivery moves from acute to community settings, student training should adapt to value-based care; emphasizing community-based rotations and outpatient clinical experiences.⁷⁹

RECOMMENDATION

B-2. Remove cost as a barrier to the pursuit of a certification or degree in health and human services.

Champions: *Arnold School of Public Health Community Health Worker Institute, behavioral health providers, community-based organizations, health and human service education programs, health systems, medical practices, National Alliance on Mental Illness South Carolina, patient advocacy groups, public and private academic and training institutions, South Carolina Area Health Education Consortium, South Carolina Commission on Higher Education, South Carolina Department of Health and Human Services, South Carolina Hospital Association, South Carolina legislature, South Carolina Office of Rural Health*

Timeline: 4-6 years

Recommended Action Steps

1. The Taskforce encourages the State Legislature to consider expanding funding for AHEC's Health Careers Programs, the Arnold School of Public Health's Community Health Workers Institute (CHWI) at the University of South Carolina and other programs that support health and human service providers.

AHEC's Health Careers Programs (HCPs) should receive the funding necessary to expand its services to junior high school students and to reach more high school and college students across South Carolina. The South Carolina AHEC HCPs promote academic success, career development and personal growth for young people from under-served populations as they aspire to become health care professionals.⁸⁰

The Arnold School of Public Health Community Health Worker Institute (CHWI) should receive funding to increase the workforce of CHWs through high quality entry level training for Community Health Workers based on national standards, with a strong focus on social determinants and public health.⁸¹ CHWs are able to provide resource navigation, enhance health literacy of vulnerable populations, support care coordination, decrease health care costs and increase the quality of care. The CHWI also provides recruitment and job placement; technical assistance for health systems towards CHW integration, evaluation and payment model design; and return on investment studies (ROI) of the CHW model.⁸²

With increasing recognition of the need to include non-clinical professionals in integrated care, related funding opportunities should keep pace.

2. The Taskforce encourages the State Legislature to consider using lottery funds to provide comprehensive support to underrepresented rural and minority students pursuing high-need, high priority health and human service professions.

Increasing racial and ethnic diversity in health and human service organizations is critical for the health of South Carolinians, but barriers preventing our health workforce from mirroring the state's population persist. For many people in our state, the costs associated with obtaining an education prevent them from entering the career path of their choosing. These costs can extend far beyond the price of a class, textbook or housing. A number of South Carolinians cannot pursue training or an education without covering the costs of childcare, care for a family member, health care, transportation, a computer or even internet service. At the same time, many communities in our state are suffering because they cannot fill positions for the health and human service providers needed to address community health issues. Using lottery funds to provide grants or scholarships to minority and rural students to pursue high priority health professions would help satisfy both of these pain points and will support improved population health at the community level.

The South Carolina Rural Health Action plan emphasizes that "our health care workforce within rural communities should be expanded to include professionals with the skills needed to effectively care for rural populations, and our 'pipeline' to establish this workforce needs to start as early as possible. We must include a diversity of professionals who not only reflect the communities in which they practice, but who also represent

a broad range of provider types.”⁸³ This sentiment is also echoed in the State Health Improvement Plan (SHIP) for South Carolina.⁸⁴

Studies verify the need for diversity in the health care workforce. Patients respond better to treatment when they have access to professionals who share the same racial/ethnic and cultural backgrounds.⁸⁵ A recent study found that “. . . black men seen by black doctors agreed to more and more invasive, preventive services than those seen by nonblack doctors. And this effect seemed to be driven by better communication and more trust.”⁸⁶ Additionally, physicians of color are more likely to treat minority patients in underserved communities, according to a study on the role of African American and Hispanic physicians in providing health care for underserved populations.⁸⁷

African Americans make up 27.4 percent of the population in South Carolina but are significantly underrepresented in well-paid health professions such as dentists, dental hygienists, pharmacists, optometrists, physical therapists, physician assistants, primary care physicians, specialty physicians, registered nurses and nurse practitioners, among others.

3. The Taskforce encourages the South Carolina Department of Education to consider continuing its collaboration with state partners to expand the existing health and human service curriculum used in some high schools in our state to all public high schools and junior high schools in South Carolina.

The Health Sciences Education curriculum

. . . is a secondary program of study that promotes health career opportunities to students in grades 9-12. Integration of health science courses, work-based learning experiences, Health Occupation Students of America (HOSA) - Future Health Professionals activities and academics allow students to make informed decisions regarding an array of careers and educational pursuits. (SCDE 2019, 1)⁸⁸

Currently, some public high school districts in South Carolina offer this health science education program to high school students. Pre-college health training presents an opportunity for high school students to explore health roles and earn credits or certifications towards a number of health professions. This work should expand across the state so students in any high school or junior high school in South Carolina have the opportunity to take part in this specialty course of study.

RECOMMENDATION

B-3. Create a public/private partnership to identify and implement policies and programs that overcome the barriers to efficiently placing health and human service students in on-site training positions with qualified mentors.

Champions: Community-based organizations, Federally Qualified Health Centers, health and human service education programs, health systems, hospitals, medical practices, patient advocacy groups, preceptors and their affiliated universities, public and private academic and training institutions, South Carolina Academy of Family Physicians, South Carolina Area Health Education Consortium, South Carolina Commission on Higher Education, South Carolina Department of Health and Human Services, South Carolina Free Clinic Association, South Carolina Hospital Association, South Carolina Legislature, South Carolina Office of Rural Health, South Carolina Primary Health Care Association, South Carolina Technical College System

Timeline: 4-6 years

In the academic and professional world of health and human services, the process of matching students with on-site training opportunities is sometimes discussed with antipathy and surrender. The process is described in the kindest terms as “impossible to fix.” Using incentives to increase the number of primary care preceptors and training sites for students is a significant step towards addressing this barrier to effective education.

Tax incentives are one way to level the playing field for public institutions trying to compete with private or for-profit entities that can afford to pay preceptors for accepting students. The Taskforce recommended the creation of tax credits to support preceptors, and as this report was written this recommendation was accomplished. State Senator Thomas Alexander introduced S.314 on January 8, 2019, with the bill introduced in the House on February 14. Governor McMaster signed it into law on May 16, 2019. The legislation provides income tax credits for physicians, advanced practice nurses (APRNs) and physician assistants who serve as a preceptor during a clinical rotation. Credits will be provided for four rotations; a deduction equal to the tax credit will be provided for six additional rotations. The tax credits will be provided between 2020 and 2025.⁸⁹

Recommended Action Steps

1. Academic and training institutions should explore new options for funding productivity and time lost at on-site training programs that commit resources to training students.

Participating in on-site training is a critical component of education for health and human service students. Currently, not enough training facilities exist to meet the needs of students. One reason some organizations are unable to bring students on-site is the administrative burden associated with fielding student requests and productivity lost when integrating the student(s) into the processes and culture of the organization. State partners should collaborate to identify and implement funding streams for organizations to offset the extra time and expenses needed to bring students onboard.

2. Training sites should collaborate to develop one set of standards for student placement and a checklist to ensure mentors are qualified.

One stumbling block of matching students with training sites is the variety of standards that exist for student qualification. There is no one platform and/or set of standards for students to use to apply for on-site training; the requirements vary widely. Stakeholders should develop a set of common standards for students and a platform that enables efficient application to care sites.

North Carolina AHEC has implemented Passport to Health Careers (P2HC), a program that offers students the opportunity to receive a certificate of completion for health-focused work and also the ability to “document and collectively report the health science, community service and leadership activities [the student] participates in as early as eighth grade.”⁹⁰ A similar program should be deployed in South Carolina.

Additionally, mentors who oversee students in on-site training programs should be required to meet a standard list of competencies. For example, nursing students should only be mentored by a nurse. Ensuring well-

qualified mentors are participating in on-site training programs will lead to downstream benefits for students and communities.

3. The Taskforce encourages the State Legislature to consider continuation of the funding provided to the South Carolina Center for Rural and Primary Healthcare's forgivable loan program, which is available to advanced practice registered nursing (APRN) students, physician assistant students and medical students who will commit to rural primary care or critical need specialties after graduation.

The South Carolina Center for Rural and Primary Healthcare supports and develops sustainable rural and primary care education and health care delivery in South Carolina through clinical practice, training and research.⁹¹ The forgivable loan program should continue to help incentivize more providers to practice in remote or rural settings and/or in specialties, such as primary care, that need more clinicians.

4. Academic and training institutions should partner with providers to create more opportunities for students to participate in case discussions, simulation centers and other hands-on learning activities as a permanent component of training programs.

In the past, some on-site training programs have leaned heavily on students to fulfill administrative duties, rather than allowing hands-on career training. This approach puts the student, their academic program and future patients at a disadvantage. Statewide standards could be developed to inform the percentage of time students spend on a variety of on-site tasks, dictated by their program of study.

5. Clinical science programs should emulate other health and human service programs to promote opportunities for interprofessional training for their students.

Historically, providers educated in clinical science have been at the center of the health care ecosystem. As this ecosystem changes to meet the need for interdisciplinary, integrated, value-based care delivery, clinical students and professionals should embrace and advocate for interprofessional training. An introduction to collaborative care delivery will better prepare future providers to work with coordinated care teams when it becomes standard practice.

Additionally, South Carolina's public and private academic and training institutions should work together to align health and human service student calendars. This will better facilitate identification of opportunities for shared training.

An example of an organization created to address the realities of changing care models, the National Center for Interprofessional Practice and Education (NCIPE) is a public/private partnership developed to "provide the leadership, evidence and resources needed to guide the nation on the use of interprofessional education and collaborative practice as a way to enhance the experience of health care, improve population health and reduce the overall cost of care."⁹² This work is facilitated by focusing on collaborative practice and interprofessional education. NCIPE also provides training resources to address the gap between health education and health care delivery.

RECOMMENDATION

B-4. Create a program to help CBOs and health care organizations build increased capacity to work together productively.

Champions: *Arnold School of Public Health Community Health Workers Institute, community-based organizations, health systems, patient advocacy groups, South Carolina Academy of Family Physicians, South Carolina Department of Health and Human Services, South Carolina Hospital Association, South Carolina Office of Rural Health, South Carolina Primary Health Care Association*

Timeline: 1-3 years

Recommended Action Steps

1. A neutral convener should explore the establishment of a learning academy for the workforce of CBOs and health care organizations.
 - a. Leadership of CBOs should be trained to work effectively in collaboration with health system partners around topics including data collection and sharing, understanding health care funding mechanisms and development of a shared language for the CBOs to be active, effective, efficient partners with health systems.
 - b. Health system leaders should be trained to work effectively and in collaboration with communities and CBOs around topics such as community realities, social determinants, best practices in community-driven work, functional data-sharing, shared language and cultural competencies.

As health care delivery evolves, CBOs and health care organizations will be required to work together in increasingly substantial ways.⁹³ In most cases, these organizations speak different languages when it comes to caregiving and may have different perspectives on their community's most significant health needs. Both CBO and health system leadership need to increase their capacity to work collaboratively in partnerships. The proposed training system will prepare them to collaborate as equal partners.

RECOMMENDATION

B-5. Provide funding to address the state's need for data and information scientists.

Champions: *Health and human service education programs, public and private academic and training institutions, South Carolina Commission on Higher Education, South Carolina Department of Health and Human Services*

Timeline: 1-3 years

Recommended Action Steps

1. The Taskforce encourages the State Legislature to consider funding the expansion of degree programs for data scientists, statisticians, data analysts, health economists, epidemiologists and other data experts.

In recent years, data analysis has dramatically changed the way we live and work. Understanding how to collect and analyze health and economic data has the power to transform our health care ecosystem for the better. Data experts can use predictive analytics to provide clinical decision support, reduce readmissions, avoid adverse events and manage the care of the chronically ill.⁹⁴ Harnessing health data is also critical to precision medicine — a trend towards hyper-individualized patient treatment.⁹⁵

2. CBOs, state associations and other state partners will create and distribute continuing education modules for data and information scientists interested in advancing their health information technology acumen, free of charge to participants.

Health Information Technology (HIT) professionals should have access to opportunities to enhance their base knowledge and expand their skill sets to keep up with rapid innovations in health data analysis. Continuing education may include topics such as artificial intelligence, interoperability, cybersecurity and others. Health and human service providers can work with state partners to track HIT curriculum weaknesses and build out continuing education to meet those needs.

Section C. Behavioral Health Workforce Needs

On an annual basis, substance use disorders (SUDs) cost our society an estimated \$740 billion⁹⁶ and ‘...serious mental illness—defined as a mental, behavioral or emotional disorders that causes significant functional impairment that substantially interferes with or limits one or more major life activities—costs the country about \$200 billion a year in lost earnings.’⁹⁷ Additionally, behavioral health^m disorders are expected to be the leading cause of disability in the U.S. by 2020.⁹⁸

In our nation’s hospitals, 12.8 percent of mental disorder discharges and 9.9 percent of substance abuse-related discharges are readmitted for the same diagnosis within 30 days.⁹⁹ However, visiting a community mental health center after hospitalization led to a reduced readmission rate for these patients.¹⁰⁰

South Carolina also struggles to manage the cost of behavioral health. In an effort to direct funds to high-need areas of behavioral health, South Carolina lawmakers approved a state budget in March 2019 that included \$2.2 million to hire mental health counselors for South Carolina school districts. The budget also provide \$10 million for school resource officers.¹⁰¹ A national American Civil Liberties Union (ACLU) report examining 2015-2016 data found that during those years, 14 million students attended schools with police officers but no counselor, nurse, psychologist or social worker.¹⁰²

Behavioral health providers are in high demand. According to the Live Healthy South Carolina 2018 State Health Assessment, 20.5 percent of adults had been diagnosed with depression as of 2016. The national average during that time was 17.4 percent.¹⁰³

Creating a behavioral health system in South Carolina that fully meets the needs of residents and the behavioral health workforce is much more complex than balancing a budget. South Carolina has experienced substantial behavioral health transitions and challenges in recent years, including changes to how services are funded and the way providers are regulated, licensed and operated. This includes transition to a recovery-oriented system of care and the growth of peer-related support services, new state legislation that establishes licensure for addiction counselors, an increased focus on integrated service delivery models and perceived pressure to consolidate services at the regional level.

Additionally, anticipated turnover expected in the behavioral health workforce is likely to destabilize behavioral health policies and programs in South Carolina. Recently, **the Behavioral Health Services Association (BHSA) of South Carolina’s 2018 workforce survey projected a 35 percent turnover¹⁰⁴ in 301 administrators in the next 2 years.**ⁿ The survey also showed that 25 percent of the overall SUD workforce expect to “leave the field” in the next 5 years. The existing pool of program administrators with the experience to effectively manage service delivery during times of significant systemic change is shrinking and filling vacancies for program administrators, treatment counselors, peer specialists and medical staff will become an even greater challenge in the coming years.



^m Behavioral health includes both mental health illnesses and substance use disorders (SUDs) and is defined as “a state of mental/emotional being and/or choices and actions that effect wellness” by the Substance Abuse and Mental Health Services Administration (SAMHSA).

ⁿ This information is from a private survey conducted by the Behavioral Health Services Association of South Carolina in 2018.

Ultimately, behavioral health illnesses are diseases of the brain and must be treated as an important component of integrated, holistic care delivery. According to a 2017 Health Affairs Study, “across all three insurance types [Medicaid, Medicare, Dual Medicaid-Medicare], more than half of adults treated for a behavioral disorder had four or more comorbid physical conditions.”¹⁰⁵ An increase in comorbid conditions results in substantially higher treatment costs.

The Health Affairs study also shows the disparity in health care spending on comorbidities. When a patient had both physical and behavioral health conditions, “the vast majority (85 percent) of spending was attributed to treatment of the physical comorbidities. Only 15 percent was attributed to treatments of the behavioral disorders.”¹⁰⁶

Figure 3

Average annual health care spending, by payer and number of comorbid conditions, among people treated for depression only and for all behavioral health disorders, 2010 –13

Number of comorbid conditions	All adults age 18+ (N = 36,867,323)		Medicaid (n = 2,834,459)		Medicare (n = 8,102,949)		Dual Medicaid-Medicare (n = 1,792,808)	
	Depression only	All BH disorders	Depression only	All BH disorders	Depression only	All BH disorders	Depression only	All BH disorders
Spending in billions of US dollars								
No additional conditions	\$ 5.49	\$ 12.13	\$ 0.51	\$ 1.92	\$ 0.15	\$ 0.67	\$ 0.35	\$ 0.95
+1 condition	13.79	27.44	1.20	2.15	0.96	2.66	0.46	0.80
+2 conditions	18.85	39.56	1.42	2.57	1.96	3.37	0.44	2.18
+3 conditions	34.31	52.61	2.26	3.08	5.85	8.32	1.16	2.62
+4 or more conditions	354.02	540.62	32.21	41.51	112.27	183.1	37.07	57.43
Per capita spending in US dollars								
No additional conditions	\$ 3,967	\$ 4,121	\$ 4,740	\$ 7,383	\$ 6,188	\$ 9,075	\$ 9,144	\$ 14,735
+1 condition	6,438	6,389	6,008	6,465	9,294	9,348	9,825	11,764
+2 conditions	8,808	8,780	7,948	8,354	9,668	8,717	8,843	17,762
+3 conditions	13,129	11,541	10,915	10,419	16,040	13,043	18,176	22,296
+4 or more conditions	27,743	26,286	27,183	25,327	29,127	27,247	39,777	40,441

Source: Thorpe, Jain and Joski analysis of pooled 2010–2013 Medical Expenditure Panel Survey Data.

The provider community also struggles with internal conflicts about how to best treat those with a substance use disorder. Many providers in the field approach addiction treatment solely from a 12-step philosophy, rebuking medical treatment for addiction.

Many behavioral health concerns can be attributed to a lack of access to coordinated care, education or cost. Medication adherence is critical in many cases and accessibility to prescribers and counseling is maldistributed between urban and rural areas of the state.

With a greater understanding of patients’ needs beyond a clinical, inpatient experience, many new workforce roles are developing to meet the demand for new skill sets, such as care managers, addiction counselors, community health workers and peer support specialists. The shift toward integrated care delivery has challenged traditional staffing patterns, resulting in an increased need to nurture mental health and SUD competence among health care professionals who lack exposure to, or experience with, treating addiction and mental health illnesses.

Despite the development of these new roles, behavioral health staffing shortages in South Carolina persist.

RECOMMENDATION

C-1. Improve reimbursement for behavioral health services and enable government agencies and CBOs to improve compensation for behavioral health professionals.

Champions: Behavioral health providers, patient advocacy groups, National Alliance on Mental Illness South Carolina, South Carolina Department of Alcohol and Other Drug Abuse Services, South Carolina Department of Health and Human Services, South Carolina Healthy Connections, South Carolina Department of Mental Health, South Carolina Hospital Association, South Carolina Legislature

Timeline: 4-6 years

Recommended Action Steps

1. The Taskforce encourages the Governor, the Department of Administration and the State Legislature to consider collaborating to adjust public sector pay bands to be more competitive and reflect the level of education required for behavioral health workers.

Adjusting public sector pay bands to provide more competitive pay for behavioral health workers would help create a more positive work life for these providers and encourage more young people to pursue a career in behavioral health. Many positions in this field require a master's degree and hands-on experience; pay bands should reflect this reality.

Mental health professionals employed by the state fall into two pay bands. The majority of those in GA50 make between \$35,000 and \$45,000 per year.¹⁰⁷ These professionals are required to have a master's degree and observation hours before they are licensed. The average turnover rate for this group was 22 percent in 2018. The average tenure for GA50s in South Carolina is 5.1 years.¹⁰⁸

Figure 4: Mental Health Professional Pay Bands for State Employees

Classification and Band	Minimum Salary	Midpoint Salary	Maximum Agency Delegated Salary
GA50 Band 5	\$32,838	\$46,799	\$60,760
GA60 Band 6	\$39,960	\$56,947	\$73,939

Source: South Carolina Department of Mental Health Community Mental Health Services Presentation¹⁰⁹

Budget constraints and lack of career advancement opportunities in state agencies drives experienced clinicians to private practice or other settings providing better compensation. State agencies in South Carolina struggle to staff SUD counselors (among other positions) as those who are educated in the state seek higher paying positions¹¹⁰ after 6-7 years of education or more and concurrent budgetary challenges (such as assuming student loan debt).

RECOMMENDATION

C-2. Reduce financial barriers to entry for students interested in behavioral health certifications and degrees.

Champions: *National Alliance on Mental Illness South Carolina, South Carolina Area Health Education Consortium, South Carolina Commission on Higher Education, South Carolina Department of Alcohol and Other Drug Abuse Services, South Carolina Department of Health and Human Services, South Carolina Department of Mental Health, South Carolina Legislature*

Timeline: 1-3 years

Recommended Action Step

1. Educational entities and other state partners should provide behavioral health students with additional tuition reimbursement opportunities, loan repayment programs and incentives funded by local, state and/or federal investments.

Students interested in pursuing a behavioral health degree may be discouraged by the stigma and notoriously low pay in the sector. Offsetting much of the cost of obtaining a degree will protect students from the significant loans they may incur and help them view a career in behavioral health as a financially sound investment.

RECOMMENDATION

C-3. Ensure educational entities, students and employers are aware of the need for behavioral health professionals in our state.

Champions: *Payers, patient advocacy groups, South Carolina Area Health Education Consortium, South Carolina Commission on Higher Education, South Carolina Department of Alcohol and Other Drug Abuse Services, South Carolina Department of Education, South Carolina Department of Health and Human Services, South Carolina Hospital Association*

Timeline: 1-3 years

1. Relevant government agencies and academic and training institutions should partner with health and human service providers to market roles within the behavioral health workforce to middle school, high school and college students.

Behavioral health stakeholders should ensure students have a clear line of sight to behavioral health careers, job opportunities and information about educational requirements. This could include an online tool and interactions with high school students and freshman and sophomore college students.

RECOMMENDATION

C-4. Place special emphasis on creating a positive, supportive work environment with opportunities for growth in behavioral health settings.

Champions: Behavioral health providers, community-based organizations, health and human service providers, patient advocacy groups, National Alliance on Mental Illness South Carolina, South Carolina Area Health Education Consortium, South Carolina Department of Alcohol and Other Drug Abuse Services, South Carolina Department of Health and Environmental Control, South Carolina Department of Health and Human Services, South Carolina Department of Mental Health, South Carolina Office of Rural Health

Timeline: 1-3 years

Recommended Action Steps

Organizations providing behavioral health services or employing behavioral health professionals should:

1. Guarantee time for motivational activities and bonding among co-workers.
2. Utilize coaching and consultation during field clinical supervision.
3. Identify and utilize career ladder models for advancement and provide continuing education at no cost to employed behavioral health professionals.

Behavioral health providers have some of the most challenging jobs in the health care industry. These professionals spend an intense amount of time re-living trauma with patients and working through life or death situations.¹¹¹ These circumstances can lead to high rates of compassion fatigue and burnout. Given the sensitivity of the material they work through with patients, employers of behavioral health providers should prioritize the creation of a positive and supportive work environment for employees.

Additionally, the absence of a formal or even informal career ladder framework will continue to work against recruitment and retention efforts and limit people's interest in this field.

Section D. Setting the Stage for the Evolving Workforce



RECOMMENDATION

D-1. Screen for social determinants of health when interacting with patients and/or clients and integrate that data into EHRs or other data systems.

Champions: Community-based organizations, health and human service providers, program accreditation bodies, public and private academic and training institutions, South Carolina Area Health Education Consortium, South Carolina Commission on Higher Education, South Carolina Department of Alcohol and Other Drug Abuse Services, South Carolina Department of Education, South Carolina Department of Health and Environmental Control, South Carolina Department of Health and Human Services, South Carolina Department of Mental Health, South Carolina Healthy Connections, South Carolina Hospital Association, South Carolina Office of Rural Health, South Carolina Primary Health Care Association

Timeline: 4-6 years

Increasing health care costs and worsening life expectancy are the results of a frayed social safety net, economic and housing instability, racism and other forms of discrimination, educational disparities, inadequate nutrition and risks within the physical environment. These factors affect our health long before the health care system ever gets involved. (Castrucci and Auerbach 2019, 1)¹¹²

As more knowledge is gained through programs that test whole-person, team-based, integrated care, the importance of social determinants of health are consistently identified as highly significant factors in determining health outcomes. Screening for social determinants of health and analyzing that information can provide

predictive analytics that identify patients who need resources outside of clinical care before that need translates to ED overuse or avoidable admissions and readmissions.

Montefiore Health System presents one example of the significant upside possible through harnessing social determinants of health data. Over time, the health system recognized that some patients suffering from chronic conditions and other serious illnesses were losing their homes because they could not maintain employment due to their poor health and medical needs.¹¹³ Patients discharged to a homeless shelter were more likely to become overutilizers of the ED and were continuously readmitted to the hospital.¹¹⁴ Given these circumstances, Montefiore began flagging patients who were at risk for homelessness; an effort made easier due to the existing coordinated care infrastructure used by their accountable care organization.¹¹⁵ In addition to other outpatient beds, New York invested Medicaid funds into securing 20 “housing units” for the health system to house the chronically ill homeless.¹¹⁶ This initiative provides housing for select patients at a cost of \$140 per night, per bed; less than the expense of an overnight hospital stay.¹¹⁷ This initiative has resulted in a 300 percent return on investment for Montefiore.¹¹⁸

Recommended Action Steps

1. Government agencies and payers should require adoption of a nationally accepted standard definition of social determinants of health for all providers in South Carolina.

Sharing data is an important part of managing the health of individuals and communities. Developing a defined data set of social determinants measures will minimize confusion when organizations across the state share data.

2. The Taskforce encourages the State Legislature to consider funding training and incentives for government agencies, CBOs and appropriate personnel in health and human service organizations to screen for social determinants of health.

The health of an individual is determined by much more than their clinical status. Screening for social determinants of health will help health and human service professionals prevent poor health outcomes and address all components of health when treating a patient. See figure 1 on page 10 for components of health.

3. Select government agencies should track the NC 1115 waiver rollout for learning opportunities related to sharing and screening for determinants of health data.

North Carolina has received CMS approval for an 1115 waiver. The waiver will provide the state with a five-year demonstration period for two to four pilots in which Medicaid funds can be used to address social determinants of health related to food insecurity, transportation and housing. This work aims to adjust the current fee-for-service payment model to a managed care model. State and federal Medicaid funding of up to \$650 million has been authorized to support the pilot programs.¹¹⁹

To prepare for the upcoming pilots, the North Carolina Department of Health and Human Services is partnering with NCCARE360 to screen for social determinants of health and link health care entities with CBOs through the North Carolina Resource Platform. The platform has been developed through a public-private partnership between health insurers, associations and nonprofits and is available to all North Carolinians at no cost.^o

[The North Carolina Resource Platform] will be a robust, integrated resource database, website, call center and care coordination platform for clinicians, social workers, care coordinators, families and others to connect people to the community resources they need. Additionally, the platform will connect community-based organizations to each other across the state so they can collaborate, while allowing for the tracking of system-wide outcomes and supporting system improvement. (The NC Resource Platform 2018, 1)¹²⁰

^o NCCARE360 is a joint-venture of United Way of North Carolina and its NC 2-1-1 information and referral system; Unite Us, the nation’s leading care coordination platform integrating health care and social services; Expound Decision Systems, a leader in business intelligence, system integrations and data repositories and Benefits Data Trust, a national nonprofit that provides streamlined benefits enrollment assistance.

4. Government agencies and CBOs should educate providers and the public on the uses of social determinants of health data, such as improving care delivery and health outcomes while addressing Health Insurance Portability and Accountability Act of 1996 (HIPAA) fears.

Social determinants of health, EHRs and HIT are unfamiliar concepts to the majority of South Carolinians. With data breaches now a common occurrence, the public is understandably fearful of their personal information being accessed unlawfully. Providing education on the utility of sharing data to improve health care presents an opportunity to assuage public fears about private health data exchanges. Health entities in this state should educate patients about the positive outcomes associated with the collection and analysis of shared data and ensure privacy concerns are addressed through robust security measures.

Health systems, hospitals, Federally Qualified Health Centers (FQHCs) and CBOs should create more formal and informal partnerships to enhance the use of their workforce in communities across the state and to fill gaps in the health care and public health workforce. This work will be driven by social determinants of health data in addition to clinical data.

RECOMMENDATION

D-2. Participate in bidirectional data sharing at the local level.

Champions: AARP of South Carolina, community-based organizations, health and human service providers, health systems, patient advocacy groups, South Carolina Academy of Family Physicians, South Carolina Department of Administration's Office of Revenue and Fiscal Affairs, South Carolina Department of Alcohol and Other Drug Abuse Services, South Carolina Department of Health and Environmental Control, South Carolina Department of Health and Human Services, South Carolina Department of Mental Health, South Carolina Free Clinic Association, South Carolina Healthy Connections, South Carolina Hospital Association, South Carolina Legislature, South Carolina Office of Rural Health

Timeline: 7-10 years

Health systems, medical providers, CBOs and agencies working with the same population often do not share data and information that would improve the quality of care, allow for targeted interventions, save resources and improve health outcomes. Health care providers participating in a health data exchange pilot program found that sharing health data resulted in “faster treatment decisions, reduced readmission and test duplication, better care coordination, cost savings and seamless sharing of health data.”¹²¹

In 2017, New York's health information exchange (HIE), Healthix, began using the InterSystems Healthshare information exchange platform to improve bidirectional data sharing between the HIE and health providers (including home health, inpatient and outpatient settings). This data included encounter details, lab results, allergies, documents, immunizations and more. Organizations submitting patient data include two additional HIEs^p, hospitals, health insurance plans, physician practices, behavioral health facilities, long-term care facilities, Medicaid health homes, New York City correctional facilities, independent labs and radiology centers, independent pharmacies, community-based care organizations and data available from other qualified entities in the Statewide Health Information Network for New York.¹²² This ongoing project has allowed Healthix to develop composite profiles of over 16 million patients.¹²³

^p Northwell Health and Mount Sinai Health System HIEs

Recommended Action Steps

1. South Carolina should develop a uniform platform to screen and track social determinants of health data that will be utilized by health and human service providers.

Once the platform is established, health systems and CBOs should receive training on the platform operations and uses.

2. Relevant state agencies and health and human service providers should develop data sharing agreements that address HIPAA fears.

It is crucial that health data are not accessible to any individuals and organizations not expressly granted access. Data sharing agreements should include standards and guidelines for data protection.

3. Relevant state agencies should create a database that lists health systems and CBOs that have received training on and participate in, bidirectional data sharing.

To encourage the adoption of data sharing agreements, the public should have access to information detailing health and human service providers' participation in bidirectional data sharing.

4. Payers should offer an incentive for CBOs and health care providers to encourage as many South Carolina organizations as possible to adopt a common set of standards to track health and human service referrals and social and health outcome data.

Tracking referrals and health outcomes is an important part of enabling coordinated, integrated care delivery. A New York program launched recently is using new technology to this end. In October 2018 a group of community, social service and health care providers in Glen Falls, New York launched ADK Wellness Connections in the Adirondack region to help residents in nine neighboring counties access health and human services more easily.¹²⁴ Services accessible through this partnership include food, housing, transportation, education, employment, health insurance and other social supports. ADK Wellness Connections uses the "Unite Us" software platform, which offers a shared social determinants of health dashboard and provides real-time electronic referrals, in-app messaging and notifications. By February 2019, the wellness connections initiative included 63 partner organizations with 91 service sites across nine counties.¹²⁵

5. Once bi-directional data sharing has been adopted, payers, providers and government organizations should fund a program to collect and evaluate data on its impact.

Researchers should identify data that demonstrates changes to health outcomes, cost savings associated with bidirectional data sharing and the impact of having additional data about patients and/or clients on hand during provider interactions. This information will allow stakeholders to evaluate the return on investment of bidirectional data sharing and will provide opportunities to adjust the initiative to optimize its utility if needed.

RECOMMENDATION

D-3. Implement telehealth policies to extend the capacity of the workforce to meet the needs of communities at sites such as schools, worksites and prisons.

Champions: Patient advocacy groups, public and private academic and training institutions, South Carolina Area Health Education Consortium, South Carolina Community Health Worker Association, South Carolina Department of Alcohol and Other Drug Abuse Services, South Carolina Department of Corrections, South Carolina Department of Health and Environmental Control, South Carolina Department of Health and Human Services, South Carolina Department of Mental Health, South Carolina Department of Veteran Affairs, South Carolina Hospital Association, South Carolina Legislature, South Carolina Office of Rural Health, South Carolina Primary Health Care Association, South Carolina Rural Infrastructure Authority, South Carolina Telecommunications and Broadband Association, South Carolina Telehealth Alliance

Timeline: 4-6 years

The Health Resources Services Administration defines telehealth as the use of electronic information and telecommunications technologies to support long-distance clinical health care, patient and professional health-related education, public health and health administration. Technologies include videoconferencing, the internet, store-and-forward imaging, streaming media and terrestrial and wireless communications.

Telehealth is different from telemedicine because it refers to a broader scope of remote health care services than telemedicine. While telemedicine refers specifically to remote clinical services, telehealth can refer to remote non-clinical services, such as provider training, administrative meetings and continuing medical education, in addition to clinical services. (HealthIT.gov 2017, 1)¹²⁶

Examples of telehealth clinical services include consultation with a patient at a distant clinical site or their home, consultation between two clinicians, remote monitoring of a patient and secure asynchronous electronic transfer of patient data (such as lab results) from one provider to another. Telehealth extends the capacity of the current health care workforce in many ways, including increasing access to expert care, reaching rural populations and decreasing unnecessary referrals.¹²⁷

As the health and human service workforce changes to reflect the new realities of care delivery, the tools available to the workforce will also change to optimize efforts to provide quality care at a lower cost. In the past five years our state government has spent \$68 million on telemedicine initiatives.¹²⁸ These funds have led to positive outcomes for state residents. For example, every resident of the state is now within one hour of travel to a virtual appointment with a stroke expert.¹²⁹ Despite the advances our state has seen in telemedicine, 11 percent of South Carolina residents do not have an internet connection reliable enough to access telehealth.¹³⁰ This disparity is even more pronounced in rural communities, where 26 percent of residents lack access to a reliable internet connection.¹³¹

Recommended Action Steps

1. Government agencies, CBOs and health systems should partner with the South Carolina Telehealth Alliance (SCTA) to assist in reaching the goals and objectives of the annually-updated Statewide Telehealth Strategic Plan.⁹

To support and build from SCTA's current strategies, state partners should consider creating a digital literacy certificate for relevant personnel who will assist patients with telehealth sessions in their homes and collaborate

⁹ SCTA strategies include open access, service development, collaboration, rural focus, education and training, SCTA collaboration, mental health, outcomes, promotions and sustainability.

to develop a telehealth curriculum for health and human service students and providers. Academic institutions that train health and human service providers should test the best models for interprofessional training with the use of telehealth as part of their academic programs.

2. Once reimbursement is established in traditional care sites, the Taskforce encourages the State Legislature to consider expanding the South Carolina Telemedicine Act to include telehealth reimbursement for community health workers, peer support specialists, pharmacists and other health and human service providers not currently covered.

The lack of reimbursement for some health and human service providers now seen as critically important players in lowering health care costs and providing quality care has had a negative impact on their ability to participate fully in some coordinated care models. Other clinicians cannot practice to the top of their licenses if they are not supported by a more substantial community-based workforce.

South Carolina's Medicaid program currently reimburses telemedicine practiced by physicians, nurse practitioners and physician assistants.¹³² No policy currently exists that requires private payers to provide the same coverage. Medicare provides reimbursement for telemedicine appointments administered by physicians, nurse practitioners, physician assistants, nurse midwives, clinical nurse specialists, clinical psychologists, social workers and registered dietitians or nutrition professionals.¹³³

RECOMMENDATION

D-4. Utilize data derived from improvements to community health needs assessments (CHNAs) and other community assessments to drive priorities for the composition of the workforce at the community level.

Champions: Health systems, patient advocacy groups, South Carolina Area Health Education Consortium, South Carolina Commission on Higher Education, South Carolina Department of Administration's Office of Revenue and Fiscal Affairs, South Carolina Department of Alcohol and Other Drug Abuse Services, South Carolina Department of Education, South Carolina Department of Health and Environmental Control, South Carolina Department of Health and Human Services, South Carolina Department of Mental Health, South Carolina Free Clinic Association, South Carolina Healthy Connections, South Carolina Hospital Association, South Carolina Legislature, South Carolina Office of Rural Health, South Carolina Primary Health Care Association, South Carolina Technical College System, South Carolina Telehealth Alliance

Timeline: 1-3 years

A community health needs assessment (CHNA), refers to a state, tribal, local or territorial health assessment that identifies key health needs and issues through systematic, comprehensive data collection and analysis. Community health assessments use such principles as

- **Multisector collaborations that support shared ownership of all phases of community health improvement, including assessment, planning, investment, implementation and evaluation**
- **Proactive, broad and diverse community engagement to improve results**
- **A definition of community that encompasses both a significant enough area to allow for population-wide interventions and measurable results and includes a targeted focus to address disparities among subpopulations**
- **Maximum transparency to improve community engagement and accountability**

- **Use of evidence-based interventions and encouragement of innovative practices with thorough evaluation**
- **Evaluation to inform a continuous improvement process**
- **Use of the highest quality data pooled from and shared among, diverse public and private sources (CDC)¹³⁴**

Based on a provision of the Affordable Care Act (ACA), The Internal Revenue Service (IRS) requires that every non-profit hospital conduct a CHNA every three years.

Recommended Action Steps

1. The Taskforce encourages SC DHEC to consider defining standardized statewide CHNA methodologies to include validity, cultural competence and representative participant groups.

This process would be conducted on a continuous basis as determined by participating stakeholders, to ensure CHNAs are yielding the most informative, actionable data.

CHNAs can be a reliable resource for evaluating important community health data. However, the quality of the resulting report is only as relevant and actionable as the assessment itself. When CHNAs misrepresent the demographics of the communities they are meant to serve it creates a barrier to drawing actionable data. In some cases, surveys used in assessments have a higher response rate from middle class individuals, potentially weakening the validity of the data. This potential outcome demonstrates the necessity of designing CHNAs in a culturally competent way.

2. Health systems should continue, or begin to, use a portion of their community benefit, charity care or other resources to invest in workforce needs identified by CHNAs.

Optimizing the workforce is a continuous process. As the needs of a community change, the health and human service workforce demands will also change. Funding these changing priorities is a worthwhile investment for providers.

South Carolina Office of Rural Health suggests that “funding [could be] sought to create programs to address specific needs, such as the recent Federal grant awarded to the University of South Carolina College of Social Work to help expand the behavioral health workforce in rural areas of the state.”¹³⁵

3. CBOs and other partners should utilize existing community-led health improvement efforts such as Healthy People, Healthy Carolinas; Blueprint for Health; and Eat Smart Move More South Carolina coalitions to support workforce priority setting.

The concept of optimizing the health workforce in South Carolina is not new. Many state organizations have been working on this topic for years. It is critical that new efforts to address the health workforce take into account previous efforts and work to build from them.

Programs working directly with people in communities are well situated to understand the complexities of social and environmental determinants of health and workforce needs.

Conclusion

Building a health care workforce that can meet the needs of South Carolinians and adapt and evolve on pace with the changing care delivery landscape is critical to improving the cost and quality of health care in South Carolina. The definition of health care provider is expanding to include more community-based professionals who can support population health management and allow more specialized clinicians to practice at the top of their degrees. These factors require that changes are made to how the workforce is educated and trained. Ensuring all students have an on-site training placement is a challenging, complex problem; but it is also a solvable one. When health care workers are exposed to new ideas, best practices or other new approaches to care delivery that are successful, those learnings should be translated to the classroom and continuing education curricula in months, not years.

Health and human service providers can no longer operate in silos. Our workforce needs to be ready to deliver care in a format that is community-based, coordinated and constantly evolving. This change is perhaps most evident in what science has revealed about the connection between behavioral and physical health. Patients' conditions must be treated holistically and providers must be connected with other care team members to ensure holistic treatment is taking place.

Our state demands a great deal of our health care providers; following the momentum away from fee-for-service health care will demand even more. The Palmetto State should ensure that our health and human service workforce is less indebted, better supported, better compensated and better enabled to improve access to, and quality of, care. Additionally, **South Carolinians should have access to health and human service providers who represent the diversity of the populations they serve.**



South Carolina Health Care Workforce – Emerging Best Practices

South Carolina Area Health Education Consortium (SC AHEC)

SC AHEC builds and supports the health care workforce through a focus on recruiting, retaining and educating health care professionals across the state in all health care settings. They offer a variety of programs, starting with students in high school and progressing through college and health professions training programs and life-long learning for community-based professionals throughout their careers.

SC AHEC's Health Careers Programs encourage and support underrepresented minority youth in the pursuit of health careers to build a future health care workforce that is more diverse and representative of patient populations in the counties served. Health Professions Student Programs provide community-based training experiences exposing students to the realities of living and working in rural and underserved areas of our state. Recruitment and Retention Programs financially incentivize providers to practice in rural areas and AHEC's Continuing Professional Development Programs support health professionals in maintaining current knowledge to support their certifications and licensure at a price they can afford.

The South Carolina Office for Healthcare Workforce (SCOHW) is a division of SC AHEC that supports effective health care workforce planning in the state by studying the forces affecting the supply of health care professionals and the demand for their services. This small research center measures changes in the supply of licensed health care occupations using data gathered by regulatory boards and certifying agencies. SCOHW monitors the number and size of education programs in the state that produce new health care professionals in order to understand the health care workforce pipeline. SCOHW also conducts periodic studies at the individual occupation level to measure the balance of supply and demand for specific professionals. The team at SCOHW is working to understand how a move toward value-based care and bundled payment may be changing the demand for traditional provider groups, creating demand for new types of providers and/or shifting the ways in which traditional providers are being utilized to reduce cost, improve patient outcomes and improve the health of South Carolinians.

South Carolina Hospital Association (SCHA)

Be Something Amazing

With funding from the Career Cluster Partnership Grant in partnership with the South Carolina Department of Education (SCDE) and HOSA Future Health Professionals, SCHA is aggressively marketing health care careers to middle and high-school students to attract the next generation of health care employees. Be Something Amazing, a campaign developed more than a decade ago with the SCDE, continues to market a broad spectrum of health care positions as attractive, practical careers.

Be Something Amazing is a mobile-friendly, online resource for teachers, students and prospective employers. Online tools provide accurate, updated information about a variety of occupations that helps students find ones that are a good fit. An interactive career finder provides job descriptions, employment outlook, median income and educational requirements for a dozen career paths ranging from case manager to physician, along with links to websites of state college programs and federal labor information. Teachers, guidance counselors, college recruiters and hospital human resource officers can access a media toolkit of photos, presentations and testimonials for use at career fairs or open house events.

Compensation, Benefits, Vacancy and Turnover Surveys

In partnership with Compdata, SCHA conducts an annual compensation and benefits survey. By participating, hospitals provide their human resources departments with detailed data on compensation and benefits – their

own and their peers – for more than 300 position types. The survey can help hospitals establish competitive policies and practices by benchmarking against hospitals of similar size and type in the state or region. Data is aggregated into overall averages and 25th, 50th and 75th percentiles. SCHA also conducted an initial survey of vacancy and turnover rates in 2018, with the goal of establishing and testing parameters and standards to be used later in a statewide survey to help hospitals better understand and address their specific vacancy and turnover issues. This survey currently targets 7 – 10 specific positions.

HospitalCareers.com

HospitalCareers.com is a national recruiting network utilized by 27 state hospital associations to help members recruit and evaluate prospective employees for a wide variety of health care positions. The website allows health care professionals to research and apply for job openings at the hospital that best fits their experience, specialty and interest. For an annual fee, hospitals can post an unlimited number of positions on the website, which SCHA promotes to in-state colleges and universities. Jobs can also be automatically populated to the website.

Benefits of HospitalCareers.com include:

- A direct link to qualified health care professionals, physicians and graduates seeking hospital employment;
- A cost-effective and less time-consuming method of recruitment and advertising for hospitals;
- Promotion by SCHA to the state’s premier universities, colleges and residency programs; and
- Analytics tracking the number of visitors, job views, profile views and application clicks.

Indigo Enrichment Scholarship

SCHA created the Indigo Enrichment Scholarship to help build the pipeline for health care positions that require advanced education. SCHA committed an initial award of \$25,000 to Clemson’s School of Nursing for its partnership with the Greenville Health System and \$25,000 to the Department of Health Services Policy & Management in the University of South Carolina’s (USC) Arnold School of Public Health. Subsequent funding in year two and beyond will be determined based on an annual review. Clemson will use the funds to help create interprofessional opportunities within the clinical learning environment and USC will use the funds to support students in the Master of Health Administration program. The program is supported through funds generated by Solvent Networks, the SCHA division that partners with endorsed companies to offer workforce and operational services to state hospitals and health systems at negotiated prices.

Just Culture

As part of its strategic priority to foster high reliability in health care, SCHA partners with the Dallas-based systems engineering firm Outcome Engenuity to offer training and certification in “Just Culture,” a model used by high-consequence industries to improve institutional safety and staff accountability. Creating a more positive workplace starts with accountability, fairness and reliability. A just culture is one where employees feel safe and empowered to report mistakes and near misses, knowing that they will be fairly evaluated and addressed. The South Carolina Board of Nursing has incorporated Just Culture principles into their certification.

Just Culture training is research-based and designed to help organizations achieve better outcomes, effect positive culture changes through learning and justice and reduce adverse events. Just Culture certification requires a significant time commitment. The course consists of online, self-paced optional trainings to build a foundation prior to the certification course, a two-day, facilitator-led classroom component with presentations, group activities, coursework and homework, an online certification exam and post-course reading. Participants will receive a one-year subscription to the Just Culture assessment tool.

Path to Provide

A partnership currently involving 10 state technical colleges and 13 volunteer hospitals, Path to Provide (www.scpathtoprovide.com) combines scholarships and hands-on training by allowing students to attend classes full-time and work part-time in a clinical setting. The program allows students pursuing an associate degree in nursing to graduate with relevant experience, no debt and an entry-level job after they complete all academic

and licensing requirements. Piloted in the 2018-2019 academic year, the program awarded scholarships valued at \$70,000 to 14 South Carolina students.

Personal Membership Groups

The opportunity to network with and learn from peers is one of the most effective tools to help staff develop professionally. SCHA's personal membership groups (PMGs) for clinical and non-clinical staff offer this opportunity. PMGs allow people in similar positions to gather regularly to share best practices, learn from industry experts, participate in conferences or workshops focusing on topical health care issues and earn continuing educational credits to mastering new skills or keeping existing credentials current. Often, PMGs meet with colleagues at similar groups in other states for access to a broader range of knowledge and expertise. Currently, there are more than a dozen formally organized PMGs:

- SC Society for Hospital Fund Development (SCSHFD)
- SC Association for Healthcare Quality (SHAHQ)
- SC Chapter of the American Society of Healthcare Risk Management (ASHRM)
- SC Society of Chaplains (SCSC)
- SC Healthcare Human Resources Association (SCHHRA)
- SC Organization of Nurse Leaders (SCONL)
- SC Healthcare Recruiters Network (SCHRN)
- SC Society for Hospital Engineers (SCSHE)
- SC Society of Hospital Materials Management (SCSHMM)
- SC Society of Healthcare Directors of Volunteer Services (SCSHDVS)
- SC Society for Healthcare Emergency Management (SCSHEM)
- SC Executive Assistants in Healthcare (SCEAH)
- SC Association of Hospital Auxiliaries (SCAHA)

Working Well

Staff who are at optimal health can have a positive impact on the employer's bottom line through lower health care costs, less absenteeism, higher productivity and improved morale. Working Well is an SCHA program that helps employers develop a strategic plan to impact employee health by focusing on policy, systems and environmental changes, which are often low or no cost. Working Well aims to help employers create a sustainable culture of well-being by using effective, evidence-based best practices to create worksites where the healthy choice is the easy choice.

The program helps organizations:

- Assess their current wellness culture,
- Identify and implement best practices in employee well-being,
- Focus on policy, environmental and systems change,

- Enhance, align and sustain current wellness initiatives,
- Create a culture of well-being; and
- Invest in human capital by taking care of the organization’s most valuable asset – its employees.

For online resources, visit the Working Well website at <https://www.scha.org/working-well>.

South Carolina Office of Rural Health (SCORH)

The SCORH Workforce Program aims to find the right fit between potential candidates and employers. SCORH works with South Carolina’s Rural Health Clinics (RHCs), Federally Qualified Health Centers (FQHCs), look-a-like community health centers (CHCs), Critical Access Hospitals (CAHs) and other rural health care employers in all 46 counties in South Carolina. SCORH works not only with employers, but also current and future candidates for roles in those settings.

SCORH has relationships with all primary care residency programs in South Carolina. Each year SCORH is invited to present to current residents on topics such as working and living in rural South Carolina, available loan repayment, incentive programs and how to qualify and how SCORH can assist once they are ready to begin their career.

For South Carolina health care providers and students, SCORH offers information and technical assistance for all available loan repayment and incentive programs as well as a streamlined process to connect potential candidates with appropriate employment opportunities. In addition, SCORH is the state member for 3RNET (Rural Recruitment and Retention). This is an online database offering a platform for candidates to upload a CV, create a profile and search for open employment opportunities in South Carolina.

As an organization, SCORH strives to support all rural communities in the state and their specific workforce needs.

South Carolina Health Care Workforce – Program Highlights

The chart below catalogs additional workforce programs and initiatives in South Carolina in an effort to provide a comprehensive overview of work in this area.

ENTITY	PROGRAM	FOCUS
Arnold School of Public Health— South Carolina Rural and Minority Health Research Center (SCRHRC), University of South Carolina	Rural Nursing Workforce: Current Education Characteristics and Options for Improvement	This project examined the current distribution of nurses across the rural US and identified the proportion of programs offering rural content or facilitating rural placement.
Arnold School of Public Health— South Carolina Rural and Minority Health Research Center (SCRMHRC), University of South Carolina	Identification of High- Need Rural Counties Lacking Federally Qualified Health Center (FQHC) Presence	FQHCs have been key safety net providers since the program was initiated. However, many rural communities lack this resource. Expanding on the index of relative rural deprivation developed by the SCRMHRC, researchers identified high-need rural counties that are not served by an FQHC or similar provider.

ENTITY	PROGRAM	FOCUS
Arnold School of Public Health, University of South Carolina	Arnold School of Public Health Community Health Worker Institute (CHWI)	CHWI will provide CHW training and curriculum development; recruitment and job placement; technical assistance for health systems towards CHW integration, evaluation and payment model design; and return on investment studies (ROI). The Institute is developing high quality entry-level training to CHWs based on national standards, with a strong focus on social determinants and public health.
Arnold School of Public Health— Office on the Study of Aging, University of South Carolina	Home Care Specialist Training	The Home Care Specialist course provides training on chronic disease management and is intended for Personal Care Aide (PCA) workers caring for people in their own homes. This course provides PCAs with an extra level of training about chronic disease conditions affecting their clients. PCAs learn about warning signs and symptoms of nearing health crisis and receive practical information about what to do and who to call to help prevent or better manage their clients' health crisis.
Arnold School of Public Health— South Carolina Rural Health Research Center, University of South Carolina	Perceived Facilitators and Barriers to Rural Ambulatory Care Practice Among Registered Nurses	This study surveys rural and urban nurses to ascertain perceived facilitators and barriers to remaining in rural practice.
Health Resources and Services Administration (HRSA)	Advanced Nursing Education Workforce (ANEW) Program	The purpose of this project is to increase the longitudinal clinical immersive training experiences with rural and/or underserved population for selected primary care APRN students, develop a clinical preceptor education and support program and facilitate post-graduate employment in rural and health professional shortage areas (HPSA) and/or medically underserved areas (MUA) in three nurse practitioner roles: adult-gerontology nurse practitioner (AGNP), family nurse practitioner (FNP) and psychiatric nurse practitioner (PNP). The ANEW project will provide traineeships to 14-16 students who commit to at least two years of primary care work in a rural and HPSA and/or MUA after graduation. The project period is 07/01/2017- 06/30/2019.

ENTITY	PROGRAM	FOCUS
Medical University of South Carolina (MUSC), College of Nursing	Building the Healthcare Workforce to Serve the Underserved	The goal of this project is to develop a model of integrated clinical experiences for interprofessional teams of students within the safety net delivery systems to establish a network of teaching community health centers. This proposal builds on the momentum established by the AHEC Institute for Primary Care, a collaboration between the Medical University of South Carolina (MUSC) and East Cooper Community Outreach (ECCO) to provide care to the uninsured and an interest by Fetter Health Care Network (FHCN), a Federally Qualified Health Center, to build a pipeline of primary care providers to serve the underserved. The project period is 12/01/2016 – 06/30/2019.
Medical University of South Carolina, College of Nursing	Behavioral Health Workforce Education and Training Program	This project supports innovative interdisciplinary academic-practice partnerships to prepare psychiatric mental health nurse practitioner (PMHNP) students in the Master of Science in Nursing (MSN) and Doctorate of Nursing Practice (DNP) program at MUSC College of Nursing for the professional track. The purpose of this project is to expand lifespan behavioral health workforce through increased longitudinal placements and provide interprofessional training in collaborative practice for students, faculty and preceptors (field placement supervisors). The project period is 09/30/2017- 08/31/2021.
Medical University of South Carolina	Statewide program combining palliative care and telehealth	In September 2018, the Duke Endowment awarded MUSC a \$1.27 million grant to create a statewide program combining two popular trends in the health care industry — palliative care and telehealth. The primary objectives of the program are to offer palliative care to South Carolina’s population and increase the knowledge of what palliative care is across the state.
Medical University of South Carolina	Community Engagement	The Community Engagement Program is dedicated to engaging community members and academic partners in all aspects of the research process to promote health, reduce the risk of illness and disease and build community resilience to help transform health care and eliminate health disparities. These objectives are supported through a portfolio of consultative services and a robust community-engaged research training program that incorporates pilot grant opportunities and is guided by a diverse group of stakeholders who are part of the Translational Research Community Advisory board.

ENTITY	PROGRAM	FOCUS
National Alliance on Mental Illness South Carolina (NAMI)	Ending the Silence	<p>NAMI Ending the Silence for Students: 50-minute presentation designed for middle and high school students that includes warning signs, facts and statistics and how to get help for themselves or a friend.</p> <p>NAMI Ending the Silence for School Staff: 1-hour presentation for school staff members that includes information about warning signs, facts and statistics, how to approach students and how to work with families.</p> <p>NAMI Ending the Silence for Families: 1-hour presentation for adults with middle or high school aged youth that includes warning signs, facts and statistics, how to talk with your child and how to work with school staff.</p>
National Alliance on Mental Illness South Carolina (NAMI)	NAMI Provider	<p>NAMI Provider introduces mental health professionals to the unique perspectives of people with mental health conditions and their families. Participants will develop enhanced empathy for their daily challenges and recognize the importance of including them in all aspects of the treatment process.</p> <p>NAMI Provider is a free, 15-hour program of in-service training taught by a team consisting of an adult with a mental health condition, a family member and a mental health professional who is also a family member or has a mental health condition themselves.</p>
Orangeburg County Technical College	Orangeburg High School for Health Professions	<p>The mission of the High School for Health Professions is to improve student achievement by using rigorous academic instruction supplemented by innovative teaching, interactive learning and professional mentoring to give students a competitive edge throughout their high school, college and professional careers.</p>
PASOs	Community Health Workers	<p>PASOs provides culturally responsive education on family health, early childhood and positive parenting skills; individual guidance for participants in need of resources; and partnership with health care and social service providers to help them provide more effective services. Founded in 2005, PASOs helps the Latino community and service providers work together for strong and healthy families.</p>

ENTITY	PROGRAM	FOCUS
Prisma Health	MedEx Academy	MedEx Academy is making health professions accessible to students from diverse cultural and socio-economic backgrounds. After the conclusion of the 2019 summer, MedEx Academy celebrated its ninth year. MedEx has offered summer experiences to more than 570 students from 48 high schools within the region and 48 colleges and universities from across the country. Annually, MedEx Academy hosts well over 175 students for a summer experience.
South Carolina Department on Aging	Evidence Based Disease Prevention and Health Promotion	Title III-D of the Older Americans Act provides funds to South Carolina based on the share of the population age 60 and over for programs that support healthy lifestyles and promote healthy behaviors. These funds can only be used for evidence-based disease prevention and health promotion programs which are designed to help older adults prevent and/or manage chronic diseases, adopt healthier lifestyles, improve their health status and reduce their use of hospital services and ED visits.
South Carolina AHEC	Rural Dentist Loan Repayment Program	This program offers loan repayment for Dentists who work in identified Dental Health Professions Shortage Areas (HPSAs).
South Carolina Community Health Worker Association	Building a Statewide Community Health Worker Organization	The South Carolina Community Health Worker Association (SCCHWA) is made up of professionals and supporters who are building a healthier South Carolina through the promotion of education, networking and advocacy for the community health worker profession. The association provides a forum for networking, sharing of strategies and resources and provides a foundation for education of CHWs and the organizations and systems that support them.
South Carolina Hospital Association	In-System certified nursing assistant (CAN) Training to Fulfill Workforce Needs	Carolinas Health System in Marion developed a training program to assist recruitment and retention of certified nursing assistants (CNAs). This program includes state requirements and additional skills like more lab time, more hospital rounds and 40 hours of soft skill training to prepare CNA students for work in hospitals. CNA students involved in the program experienced a 100% pass rate for state certification boards.
South Carolina Hospital Association	Bringing Just Culture into the Classroom	A comprehensive framework for teaching students to respond when adverse events occurred and a best practice approach for improving the human systems of hospitals.

ENTITY	PROGRAM	FOCUS
South Carolina Hospital Association	Be Something Amazing	Be Something Amazing is an initiative of the SCHA designed to encourage students to consider the wide range of health professions available and provide guidance to students seeking information about health careers. The site provides video resources (filmed in South Carolina health care settings) and detailed information about the education requirements, job skills and employment outlook for a wide variety of careers in health care. Link: www.besomethingamazing.com
Spartanburg Regional Health System	Workforce Development and Community Improvement	Spartanburg Regional and the Northside Development Group (NDG) have collaborated to revitalize the Northside mill neighborhood of Spartanburg through the creation of community walkways, community gardens, new schools and cleared lots. Residents of the Northside neighborhood were interested in working at the hospital, so an apprenticeship program was implemented to train residents in collaboration with the local community college. As a result, unemployment has dropped in the Northside community as the hospital continues to hire residents and leads to additional employment opportunities. Link: https://www.scha.org/collaborating-on-workforce-development-and-community-improvement
South Carolina Office for Healthcare Workforce at SC AHEC	South Carolina Health Professions Data Book	This resource profiles each county in the state in terms of the number and distribution of 19 licensed health care provider groups. Published every two years, it also includes population age and race, health status indicators such as infant mortality, number of cancer deaths, diabetes prevalence, etc, and socio-economic indicators related to health. Each provider group is mapped to show their statewide distribution and concentration relative to the county population size.
South Carolina Office for Healthcare Workforce at SC AHEC	Defining Primary Care Service Areas in South Carolina	Ninety-five primary care service areas were identified in South Carolina, based on the commuting patterns between where people live (zipcode level) and where the plurality of their primary care services were received (provider zipcode) in 2013.
South Carolina Office for Healthcare Workforce at SC AHEC	Forecasting Healthcare Provider Needs in South Carolina	This project estimates the types and levels of health care utilization needed in South Carolina over the next 20 years. It will aid in dictating the demand for different health care providers.

ENTITY	PROGRAM	FOCUS
South Carolina Office of Rural Health (SCORH)	Rural Provider Recruitment and Retention	SCORH's Rural Provider Recruitment and Retention program services health care professionals wishing to be a part of the rural health care workforce. Services include access to loan repayment, incentive programs and matching candidates to best fit jobs.
University of South Carolina School of Nursing	Amy V. Cockcroft Leadership Development Program	The goal of this program is to prepare nurse executive leaders to meet the urgent demands of today's health care environment.

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The mission of the South Carolina Institute of Medicine and Public Health (IMPH) is to collectively inform policy to improve health and health care. IMPH seeks to achieve this mission by convening academic, governmental, organizational and community-based stakeholders around issues important to the health and well-being of all South Carolinians. In conducting this work, IMPH takes a comprehensive approach to advancing health issues through data analysis and translation and collaborative engagement. The work of IMPH is supported by a diverse array of public and private sources. The Workforce for Health Taskforce was supported by The Duke Endowment, the South Carolina Hospital Association, Prisma Health and Tideland Health.