South Carolina's

RURAL HEALTH ACTION PLAN

a road map to healthy, rural communities

a collaborative endeavor of the South Carolina Rural Health Action Plan Task Force, facilitated and led by the South Carolina Office of Rural Health

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SOUTH CAROLINA OFFICE OF RURAL HEALTH
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Forward

Dear Friends of Rural Health,

As members of the South Carolina Rural Health Action Plan (RHAP) Steering Committee and/or as Workgroup Chairs, we were engaged to provide overall guidance and support for the almost year and half long RHAP development process. As such, we met on a regular basis in addition to the monthly RHAP Task Force meetings. We reviewed material, discussed meeting strategy and structure, and offered feedback on virtually every aspect of the process.

While it has been a challenge to tackle so many big topics in one comprehensive plan, it is rewarding to see connections forming between both topic areas and stakeholders. We also know that while this is a significant accomplishment, producing the report is only a milestone on the journey we are all on. Starting today, the real work begins of changing rural communities for the better.

We, as a group, are committed to continuing in an advisory role, ensuring that the RHAP implementation over the next 3-5 years benefits from continuous feedback and is reflective of changes in the environment. We are hopeful that this plan and the work ahead will bring hope and positive change to our rural communities and all those that call South Carolina home.

In good health,

William Anderson, MD, MHCM
USC School of Medicine

Graham Adams, PhD
SC Office of Rural Health

Mark Jordan
SC Department of Health and Environmental Control Office of Primary Care

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Acknowledgements

The SC Rural Health Action Plan (RHAP) would not have been possible without the hard work and dedication of many individuals.

The Steering Committee charged with guiding the initial development of the process was comprised of: **Graham Adams** (*CEO, South Carolina Office of Rural Health*); **William Anderson** (*Chief Medical Officer, USC Medical Group*); **Virginia Berry-White** (*Director, Family Solutions of the Low Country*); **Susan Bowling** (*Kerr and Associates*); **George Johnson** (*Board Chairman, South Carolina Office of Rural Health and retired Blue Cross Blue Shield of South Carolina executive*); **Mark Jordan** (*Director, South Carolina DHEC Primary Care Office*); **Michelle Mapp** (*CEO, SC Community Loan Fund*); **Carlos Milanes** (*CEO, Edgefield County Hospital*); and **Jan Probst** (*Director, USC, SC Rural Health Research Center*).

The Workgroup Chairs were instrumental in ensuring that recommendations and action steps were targeted and concise. They included **Thornton Kirby** (*President & CEO, SC Hospital Association*) [Access to Care]; **Julie Smithwick** (*Executive Director, PASOs*) [Community Assets Leadership & Engagement (CALE)]; **David Porter** (*Former Abbeville County Administrator*) [Economic Development]; **JR Green** (*Superintendent, Fairfield County Schools*) [Education]; and **Michelle Mapp** (*CEO, SC Community Loan Fund*) [Housing].

The **RHAP Task Force** was comprised of 50+ individuals from around the state who met monthly between August 2016 and April 2017. These individuals offered invaluable advice and perspective to the entire process.

Many **rural community members** gave of their time and energy in contributing their ideas and concerns during the RHAP development through either engaging in dialogue with the Task Force or staff, or by attending a RHAP community event. These contributions were invaluable to this effort.

1000 Feathers was engaged to facilitate all RHAP convenings and communications including layout of printed documents and overall consultation regarding the Plan's development. Thank you to **Forrest Alton**, **Cayci Banks**, and **Isaiah Nelson** for their enthusiasm and ideas. The Plan would not be what it is without them.

Staff members from the SC Office of Rural Health (SCORH) initiated the RHAP effort and provided overall guidance and support throughout the process. **Graham Adams** chaired the Task Force and served as unofficial spokesman. **Melinda Merrell** conducted the community engagement activities and supervised all RHAP activities within SCORH, including the writing and production of this final document. **Andrew Chandler** provided logistical and technical support throughout the entire progress, and also contributed significantly to the final document production. **Stacey Day Halford** and **Michele Stanek** offered support to work group activities. **Christianna Hutchinson** provided event and communications support for the RHAP. The entire staff and Board of Directors of SCORH gave continuous support and feedback as requested throughout the entire process.

Cassie Odahowski, doctoral candidate in epidemiology at the USC Arnold School of Public Health was responsible for all data analyses. **Teresa Brooks**, who received her Master of Public Administration from USC, worked with the SCORH team while she was a graduate student to provide overall assistance to the process as well.

Finally, much appreciation to **The Fullerton Foundation** for their financial support of the RHAP planning process, their belief in the concept, and their positive messaging to their philanthropic peers. Much guidance and support were also received from **Representative Murrell Smith** and **Senator Thomas Alexander** and their staff in the South Carolina General Assembly.

To all the rural champions who contributed to this report in any fashion, your efforts have paved the way for healthier rural communities and an overall improvement in our state's future. Thank you for your dedication to your work and to your communities.

A User Friendly Guide

For quick reference, here are a few places you can flip to for answers to common questions:

How was the Rural Health Action Plan (RHAP) developed?
Go to Chapter 1 (page 16)

How is rural defined?
Go to Chapter 2 (page 26)

How were rural communities engaged?
Go to Chapter 2 (page 26)

What are the overall issues addressed by the RHAP?
- Access to Health Care - Go to Chapter 3 (page 36)
- Community Assets, Leadership, and Engagement - Go to Chapter 4 (page 50)
- Economic Development - Go to Chapter 5 (page 64)
- Education - Go to Chapter 6 (page 78)
- Housing - Go to Chapter 7 (page 92)

What will happen next?
Go to Chapter 9 (page 116)

Where can you find data sources, helpful definitions, and references?
Go to the appendix (page 121)

Who do you contact with further questions? How can you get involved? Send an email to scrhap@scorh.net

Key

Where Is Change Likely to Occur?
Agency – A state agency or statewide organization
Clinician – Individual professionals, including physicians, social workers, etc.
Community – Rural communities at-large
Legislative – The General Assembly OR written policies, rules, and regulations
Philanthropy – State or local funders

Executive Summary

More than one million residents call rural South Carolina home. Preserving access to health care and improving health outcomes in our rural communities are critically important components to South Carolina's vitality. The *America's Health Rankings*, produced by the United Health Foundation, ranks South Carolina 42nd in health among all states (2016). At the county level, the Robert Wood Johnson Foundation's *County Health Rankings* show that our rural counties experience the worst health outcomes and factors in the state. Put simply, the unfortunate reality is if a person lives in a rural community, he or she is more likely to be sicker and die sooner than if he or she lives in an urban community.

More must be done to ensure that rural residents in our state - who often are also living in poverty - have access to the resources and services they need to live healthy, productive lives. This report aims to provide context as to where such resources should be invested by raising awareness of the interconnectedness of existing efforts and issues.

Recently, there has been a heightened interest among policy makers, funders, partners, and most importantly, members of our rural communities in crafting a promising, sustainable, healthy future for rural South Carolina. To help leverage this interest and provide some direction to the conversation, the South Carolina Office of Rural Health, along with partners, stakeholders, friends, and neighbors from all across the state, are pleased to present our collective and comprehensive framework to enhance rural health outcomes: South Carolina's Rural Health Action Plan.

The Plan itself contains 5 areas of focus, 15 recommendations, and 50+ action steps, intended to spur progress over the next 3-5 years. Our timeline is challenging at best, but by working together and holding each other accountable, we can make significant progress in improving health and well being in South Carolina's rural communities.

Introduction

In rural South Carolina, the population is generally older, poorer, and sicker than in urban areas of the state. As the U.S. health care system gradually shifts from providing mostly "sick care" to more preventive care, there is recognition that multiple factors contribute to the ability for an individual to be healthy. The places we live…where we work…our opportunities for recreation…all matter in our quest for personal health. By thinking about these independently from one another, we have created siloed efforts that must be reconnected.

As the state's single point of contact for rural health-related issues, the South Carolina Office of Rural Health (SCORH) has facilitated and led a statewide effort bringing together rural communities and state leaders to create a common vision for healthier rural communities – breaking us out of our siloes so we can address health together as one community and one state.

Like many southern states, rural South Carolina has seen significant changes over the last 50-75 years. The textile mills that were once prominent are now mostly gone; agricultural practices have shifted; and interstate highways have reshaped the once vibrant economies of towns that the interstates bypass. Coupled with decades of underinvestment in infrastructure and the rising costs of health care, many of our rural communities are at a crossroads. How can growth be assured for the future? What are the necessary factors to consider? This discussion is complicated by the existing poor health status of our rural residents and the fragility of our rural health care delivery system itself.

When it comes to health care overall, we can all agree that the United States is a world leader in medical research and medical care. However, the cost we pay for our care does not produce the outcomes that we need, especially on some of the most important measures. We lag behind a number of developed and developing countries on how long we live, and poor outcomes from hospital care are more likely to happen to patients who live in poor or disadvantaged communities. Many of our leaders, in the health care sector as well as others, are beginning to recognize that we must do more to improve our standing.

All residents of South Carolina should have the opportunity to make choices that allow them to live a long, healthy life, regardless of their income, education or ethnic background.

- Rural Health Action Plan Task Force

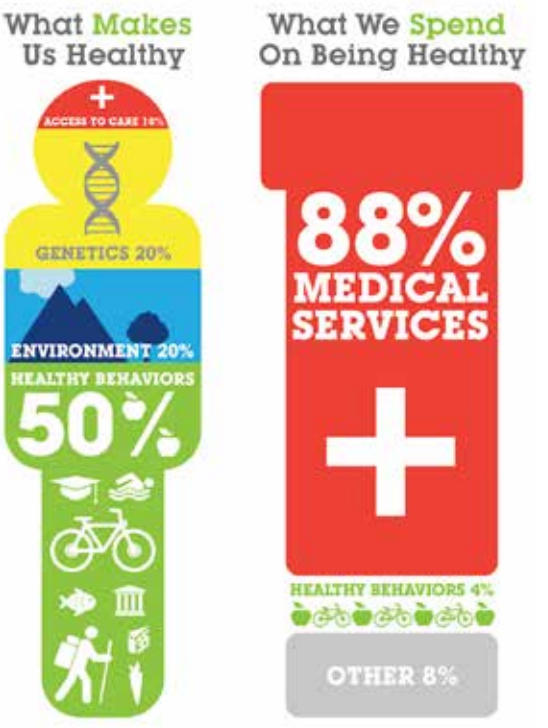
In other words, in order to improve our health, we must get to the root causes of what makes us sick – or more importantly, what keeps us from being healthy. Things such as, do we have a safe and healthy place to live? Can we earn a living wage? Do we have access to healthy food, transportation, and quality schools? Not only are these factors highly correlated to positive health outcomes; they must also be addressed simultaneously in order to see real progress.

As shown in the image below, having access to medical services accounts for only about 10% of our overall health status, despite national estimates that suggest nearly $9.00 out of every $10.00 we spend on our health is allocated to medical services. The other 90% of our health according to this research comes from biology/genetics (20%) and a combination of environment and healthy behaviors (70%).

Consider this call to action from the 2017 Robert Wood Johnson Foundation report, *From Vision to Action: A Framework and Measures to Mobilize a Culture of Health:*

"To achieve lasting change, our nation cannot continue doing more of the same. **We must embrace a more integrated, comprehensive approach to health—one that places well being at the center of every aspect of American life.** This approach must focus largely on what happens outside the health and health care systems, recognizing the importance of the decisions that individuals and families make, as well as the factors found in communities, business and corporate practices, schools, and the many other spheres of everyday life.

Instead of starting from square one, we can and should creatively integrate valuable community resources and existing efforts into the [movement]... Creating a national movement toward better health is not a short-term initiative; it is a cultural shift that will take time, determination, and, above all, the input of many."



Source: Bipartisan Policy Center (http://bipartisanpolicy.org/projects/lots-lose) * Dakotafire Media (www.dakotafire.net)

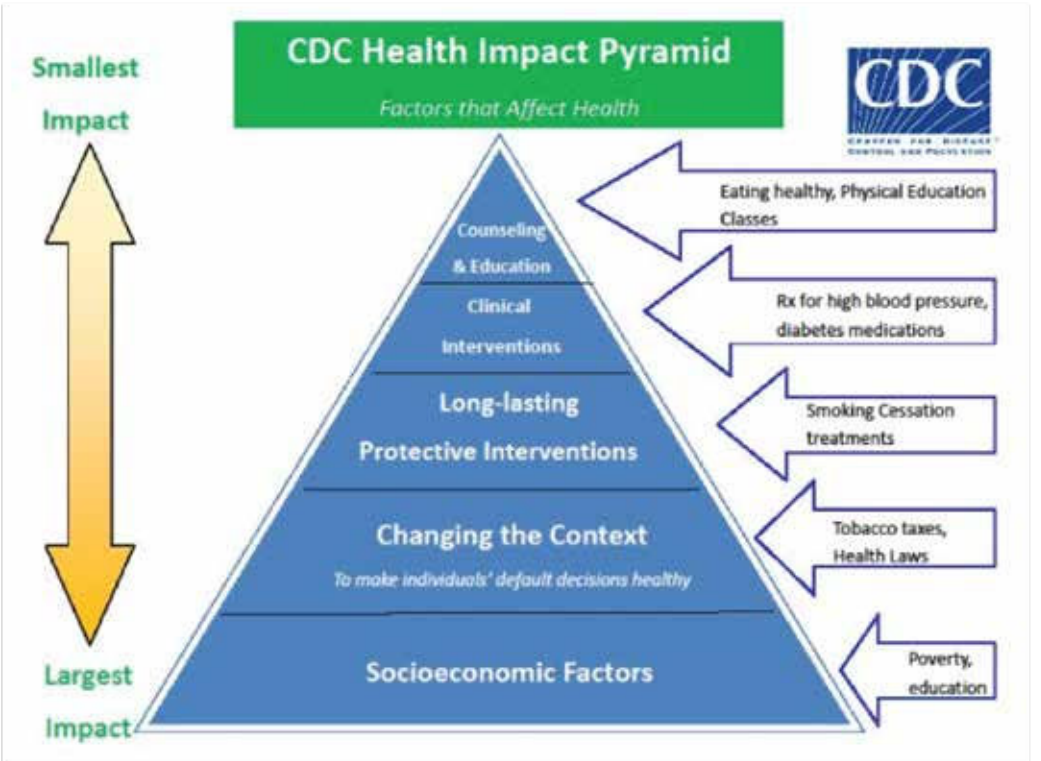
The Centers for Disease Control and Prevention (CDC) also recognizes the impact of these factors. The Health Impact Pyramid visual (see below) represents that the highest impact we can have on improving health is through addressing socio-economic factors. The World Health Organization refers to these collectively as the social determinants of health: "the conditions in which people are born, grow, live, work and age."

In January 2017, the National Advisory Committee on Rural Health and Human Services issued a Policy Brief on the social determinants of health in rural America. While acknowledging that rural communities have overall disadvantage due to their geographic isolation and lack of economies of scale, the Committee emphasized that living in a rural zip code is an important factor to consider for health outcomes as well. That zip code determines what housing and jobs are available locally, what the environment includes that can make eating healthy and exercising an easy choice, and what an individual's perceptions of success are for their life. Some rural areas are even coined as "human service deserts" due to a lack of resources to address these needs along with an inability to compete for new resources.

Overall, the impact of social factors on health in rural communities can be summarized in this way: the same lack of access issues that are evident on the health services side (e.g. few number of health care providers available locally in a community) exist for social and human services in rural communities. These concerns multiply the impact that these social factors have on the ability for rural residents to maintain their health. In the CDC's *Morbidity and Mortality Weekly Report* from January 13, 2017, research on the five leading causes of death in rural America (cancer, chronic lower respiratory disease, heart disease, stroke, and unintentional injury) shows that these may have been prevented with better access to health care and improved public support to address social and environmental issues.

OUR APPROACH

Given the need to include these social factors as part of the overall picture of health in rural communities, the framework on which the South Carolina Rural Health Action Plan (RHAP) was built had to be inclusive of these factors. As such, the Socio-Ecological Model of Health was adapted for use from the North Carolina Rural Health Action Plan (completed in 2014). The North



Source: CDC Office of the Associate Director of Policy, www.cdc.gov/policy/hst/hi5/index.html

Rural Residents Experience Additional Barriers to Health Related to these Social Factors:

- Income, employment, and poverty
- Educational attainment and literacy
- Race/ethnicity
- Sexual orientation/gender identity
- Health literacy
- Adequate community infrastructure, which can ensure public safety, allow access to medical care, and promote wellness
- Environmental health, including water quality, air quality, and pollution
- Access to safe and healthy homes, including issues related to energy costs and weatherization needs, lead-based paint, and other safety issues
- Access to safe and affordable transportation, which can impact both job access and healthcare access. Unsafe transportation, such as vehicles in poor condition, may increase risk of injury
- Access to healthy and affordable food
- Access to health care services

Carolina Institute of Medicine's Task Force on Rural Health selected the socio-ecological model as a guiding theory for focusing on contributors to health in homes, workplaces, and other areas where we spend the majority of our time. The representation of the model (see the column to the right) includes four overarching categories of health factors:

1. Access to and availability of health services
2. Community and environmental factors
3. Genes and biology
4. Health behaviors

These categories were utilized to help drive discussions and data collection throughout our RHAP process, as well as to help set the parameters for what a collective vision for rural health at the state level would look like.

As discussed in the following chapters, our RHAP is unique in that it is the first time that a mix of individuals from across South Carolina, representing rural provider and community interests as well as relevant state-level partners whose activities impact rural communities, have come together to address rural issues as a whole. This multi-sector collaboration is exactly what our state needs to improve rural health outcomes because it brings together the existing projects and programs in place in an effort to align and strengthen individual efforts. Our 15 recommendations resulting from this work are currently the only existing such recommendations that are comprehensive in their approach to solving complex issues for rural communities.

South Carolina's Rural Health Action Plan:
5 topic areas ⇨ 15 recommendations ⇨ 50+ action steps

South Carolina Rural Health Action Plan Recommendations: A Sneak Peek...

Access to Health Care (Chapter 3)

1. Ensure every community member has adequate and appropriate access, locally or via telehealth, to primary care and preventive services, emergency care, oral health services, behavioral health services, robust care coordination, appropriate diagnostic and outpatient therapy, and long-term care.
2. Support and expand innovative efforts to recruit and retain health care professionals needed to deliver health care services in communities.
3. Advocate for every community member to have a mechanism to receive timely health care services so that they do not delay care due to an inability to pay for services.

Community Assets, Leadership and Engagement (Chapter 4)

4. Create and support leadership development and training opportunities for a diverse group of natural leaders, both grassroots and grasstops, who are motivated to engage in locally led, strength-based strategies and initiatives.
5. Promote better state agency and statewide organization engagement, coordination, and communication around the planning and implementation of programs to ensure the needs of communities are being met.
6. Foster the development of sustainable financial models for communities, supplemented by sufficient community training specific to leveraging and aligning funding from income-generation, public support, and private sources to sustain local projects and programming.

Economic Development (Chapter 5)

7. Ensure a diverse and well-trained workforce is actively matched with public, private, and entrepreneurial job opportunities, while removing barriers to employment.
8. Increase technical assistance and training to support teams of community members and key local partners in their efforts to attract and leverage economic development opportunities.
9. Coordinate and establish resource development opportunities and dedicated funding sources that communities can use to address their unique workforce development, growth, and quality of life challenges.

Education (Chapter 6)

10. Provide access to vocational, training, and higher education programs that will provide every student and community member the opportunity to develop skills that match with the jobs that are available to them.
11. Expand access to affordable, full-day 3 and 4-year-old programs to all families.
12. Ensure that every school district has an active Coordinated School Health Advisory Committee as outlined in the Student Health and Fitness Act (2005).

Housing (Chapter 7)

13. Repair and replace substandard housing units to improve the quality, safety, livability, accessibility, and energy efficiency of existing housing stock.
14. Increase the supply of affordable housing through new or existing local, state and federal programs including matching state low-income housing tax credits.
15. Improve access to safe, reliable, and affordable infrastructure and services including clean drinking water, sanitary sewer, and residential broadband access.

Cross-cutting Issues (Chapter 8)

Communications: Access to rural data • Promotion of existing resources • Pro-rural marketing
Rural infrastructure: Broadband • Social Services • Transportation
Socio-economic Factors: Poverty • Racism/Social Justice • Sexism

Chapter 1

RHAP Process

Achieving success in any endeavor requires starting from a strong foundation and strategy. The Rural Health Action Plan (RHAP) Process achieved this through the formation of a Steering Committee, a Task Force, and later naming Workgroup Chairs to guide the overall effort. Our Process was designed to create an inclusive learning community filled with people who are invested in the future of rural South Carolina. Our group heard from content experts, reviewed available data, and wrestled with the issues and concerns of rural communities. We also shared promising practices and "bright spots", which were foundational in planning for the future.

On May 3, 2017, the first major milestone of our Process was achieved with the release of the 15 recommendations. An initial release of the recommendations occurred on the grounds of the South Carolina State House in Columbia. Since that time, our work has continued to create and identify the 50+ action steps that complement the recommendations. Our collective efforts that led to the release of the RHAP cannot be understated.

In the summer of 2016, the South Carolina Office of Rural Health (SCORH) invited a mix of individuals from across the state representing rural provider and community interests, as well as relevant state-level partners whose organizations and programs impact rural communities, to form the South Carolina Rural Health Action Plan Task Force. The charge? To develop a shared vision and comprehensive framework containing actionable strategies to enhance rural health outcomes over the next 3-5 years: a Rural Health Action Plan.

Why did SCORH decide to facilitate this effort? There was historical precedent based on the requirements of SCORH's Medicare Rural Hospital Flexibility Program grant from the Federal Office of Rural Health Policy (refer to Public Law 105-33 (Section 4201 of the Balanced Budget Act of 1997)). Previous Rural Health Plans had been completed in 1999, 2003, and 2008, but they were written primarily to meet this requirement. These previous reports focused on data, were not meant for public distribution, and never included community engagement or input.

SCORH's leadership saw an opportunity to do more to address needs in rural communities. The fact of the matter is that our rural communities have had worse health outcomes than their urban counterparts year after year, decade after decade. The need for a common vision for rural communities became increasingly evident, when as the state recovered from The Great Recession, investments being made in our rural areas lacked coordination across interest groups. Changes in the delivery of rural health care, especially due to the closure of rural hospitals and emergency departments, also began to create a crisis scenario that captured the attention of a variety of people interested in finding solutions. We realized these issues will never improve unless we find ways to work together.

In 2014, the North Carolina Institute of Medicine partnered with the North Carolina Office of Rural Health and Primary Care to produce the North Carolina Rural Health Action plan. This effort, unlike previous Rural Health Plans in either state, engaged stakeholders from a wide variety of rural community perspectives, including economic development and education. In fact, the creation and development of the North Carolina plan served to bring together the rural community interest groups in their state in an efficient and purposeful way. SCORH observed the impact of this effort, and after meeting several times with the North Carolina team that put their plan together, proposed to replicate their design and process for the work to be done in South Carolina. The Task Force agreed and our collective journey began.

OUR JOURNEY

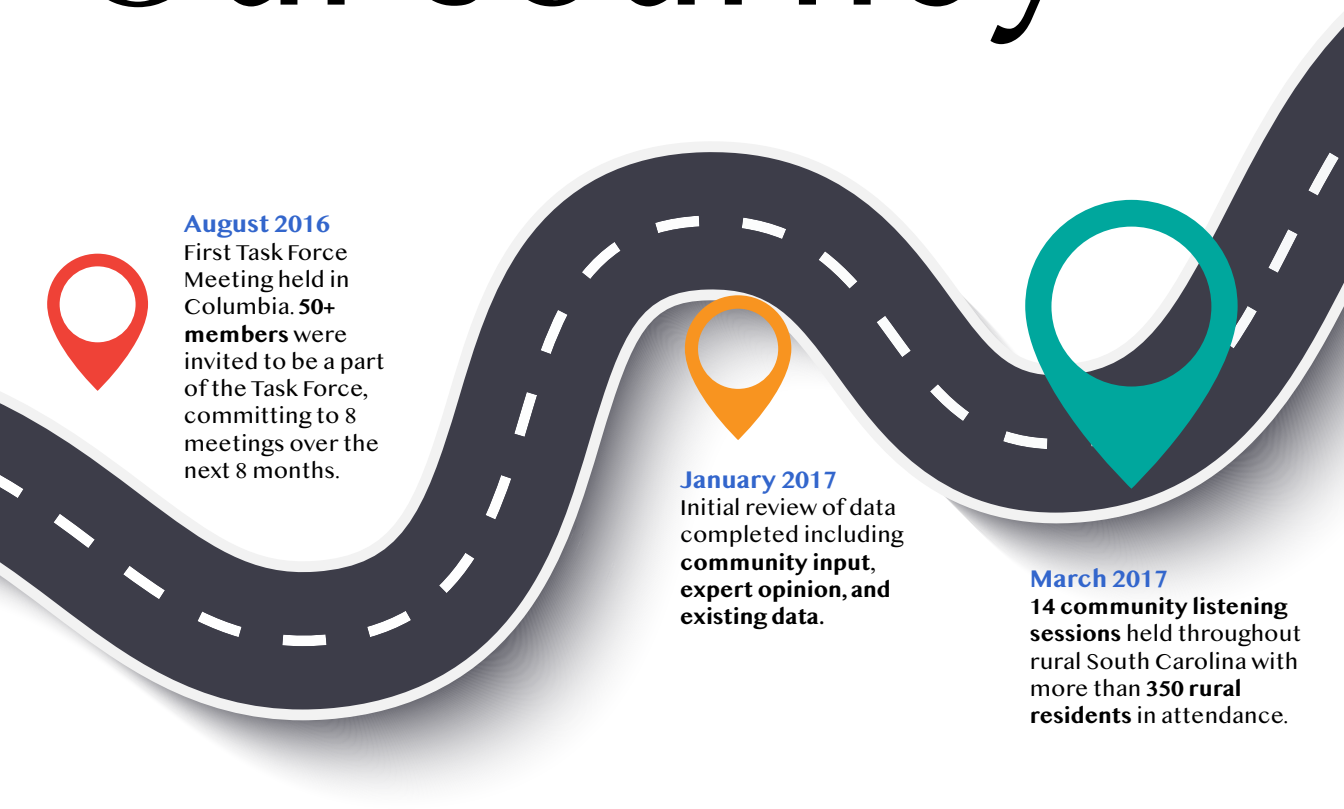
The development of the South Carolina Rural Health Action Plan (RHAP) began in earnest in June 2016 with the formation of our nine-member Steering Committee. The function of our Steering Committee was to provide support and guidance in the development of key areas of the plan, including the theoretical framework, the definition of rural used, and the overall structure and purpose of the process, including the methods for obtaining rural community input. The Committee also provided initial review of and feedback regarding all data collected for review by the Task Force. After two initial planning meetings held on July 14th and August 29th, the Committee met as needed during the RHAP development process.

Members of the Steering Committee also participated on the Task Force. The Task Force was created by inviting both individuals who live and/or work in rural communities and individuals who hold state-level positions whose work impacts rural areas. Task Force members were purposefully selected to include an equal mix of rural and state level partners from every region of the state.

Guiding Principles

- ☑ Develop a comprehensive framework containing actionable strategies to enhance rural health outcomes over the next 3-5 years by creating a shared vision and set of action steps to improve rural health in South Carolina.
- ☑ Provide an avenue for South Carolina's rural communities to have better, more coordinated access to available resources and a better understanding of their needs at the state level.
- ☑ Promote shared accountability between SCORH, its partners, and rural communities for moving the needle in South Carolina's rural communities.

Our Journey



August 2016
First Task Force Meeting held in Columbia. **50+ members** were invited to be a part of the Task Force, committing to 8 meetings over the next 8 months.

January 2017
Initial review of data completed including **community input, expert opinion, and existing data.**

March 2017
14 community listening sessions held throughout rural South Carolina with more than **350 rural residents** in attendance.

In addition, steps were taken to include members from a variety of backgrounds to ensure age, gender, racial, and ethnic diversity at a minimum.

In order to create synergy among members and around conversations, we were asked to not send "representatives" to meetings; instead effort was made to attend via phone when not able to appear in person. Our 50+ person Task Force met almost every month from August 2016 to April 2017 with the following charge:

- Examine available data, especially focused on health equity, that demonstrates the needs of rural populations as well as the assets available in rural communities.
- Propose priority areas for the RHAP.
- Receive feedback from SC rural communities on these priority areas, as well as potential actionable strategies to address priorities.
- Hear testimony and identify evidence-based best practices in priority areas likely to positively impact rural health outcomes.
- Conclusively identify and recommend priorities and strategies for the next 3-5 years to be included in the RHAP. Targeted end users of the RHAP recommendations will be communities, providers, funders, and policy makers.
- Monitor progress of the RHAP on an annual basis (development of a "report card").

Throughout the course of our eight meetings, we culled through a number of issues and concerns, heard from content experts, gathered feedback from community members, and were presented supporting literature and data. The overall design of the RHAP focused on the intersection between the existing content expertise of our Task Force members, quantitative data collected from existing sources, and community input received through

key informant interviews, focus groups and town halls (see figure to the right). We were also given "homework" assignments between meetings of relevant readings or videos that would help to prepare us for discussions at upcoming Task Force meetings.

Further, specific activities were designed for each meeting to increase connectivity among members as well as to engage actively with the material. One constant throughout the eight meetings was a map that we used to tell our individual stories of our connection to rural areas of the state. At almost every meeting the map was updated to reflect where we either live(d), have family, grew up, work, went to school, or otherwise experience(d) life in rural South Carolina. Later meetings included areas where RHAP outreach was conducted (see map on page 23).

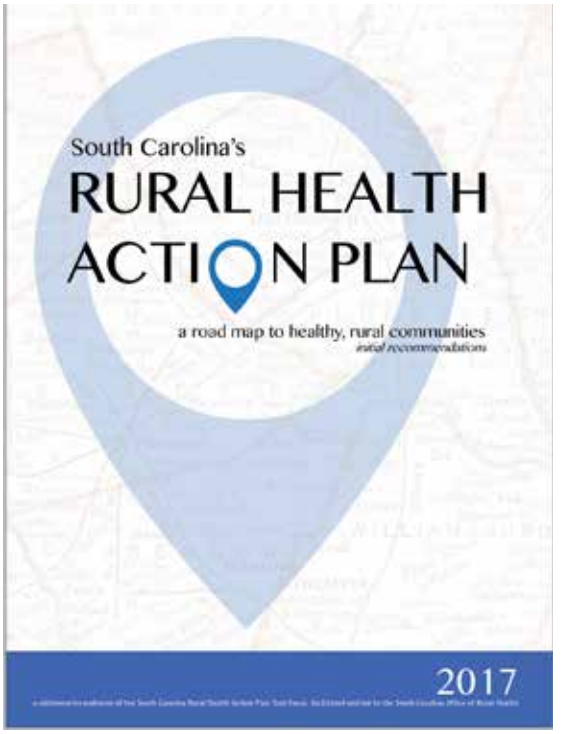
MEETING TOPICS

Each of the eight Task Force meetings was held in a rotating location either in or near the Columbia area to facilitate the travel from various parts of the state. Forrest Alton (1000 Feathers) facilitated all of the meetings. A quick snapshot of each of the meetings held is provided on page 24.

On May 3, 2017, 15 recommendations of the RHAP were officially unveiled at a ceremony on the grounds of the South Carolina State House. Task Force members, interested stakeholders, and importantly, community members were on hand to celebrate our milestone accomplishment.

The RHAP Steering Committee, along with the Chairpersons of the five topic workgroups, gathered together again on May 16, 2017 for a discussion on the appropriate direction to be taken to hone in on the actionable strategies that would lead to the accomplishment of the 15 recommendations. Three major steps were developed to be carried out over the summer of 2017: (1) a far-reaching survey of stakeholders to determine existing work in the five topic areas; (2) review of draft action steps by the Steering Committee and Workgroup Chairs to determine additional follow up needed; and (3) a public comment period. By October 2017, over 200 agencies and organizations had been contacted through this part of the process.

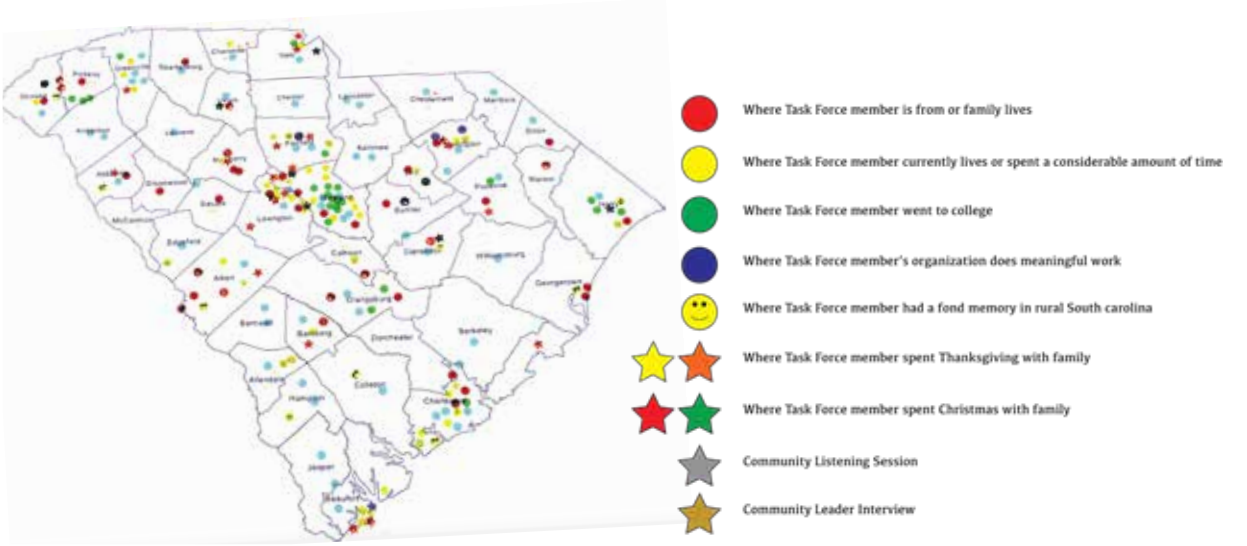
The following pages will provide a snapshot of what we learned over the course of the development of the RHAP. While certainly the culmination of a lot of focused effort and energy, the RHAP is only the beginning in terms of learning more about what works to improve the overall health of rural South Carolina. Certainly there is more exploration and intelligence to be gathered about what is working in our rural communities both in state and nationally, that we can learn from and build upon. This work is a starting point, and in Chapter 9 we will provide more insight about the vision for the future of the Rural Health Action Plan.



"As part of this effort, the Task Force engaged representatives from not only health care but constituents with expertise in education, jobs, housing, and infrastructure in rural communities. We found that the task of improving health in rural communities across the state involved each of these factors, not simply access to care."

- Carlos Milanes, CEO, Edgefield County Hospital
RHAP Steering Committee & Task Force Member

RHAP Task Force Rural Community Connections



RHAP Task Force Meetings

8.17.16
The River Center, Saluda Shoals Park – Columbia, SC
Topics & Speakers:
- Purpose & Process – Dr. Graham Adams
- Data – Cassie Odahowski
- What Does It Mean to Be a Healthy Rural Community – Group

9.20.16
South Carolina Medical Association – Columbia, SC
Topics & Speakers:
- Potential Priority Areas – Group
- NC Rural Health Action Plan – Chris Collins & Maggie Sauer

10.19.16
South Carolina State Museum – Columbia, SC
Topics & Speakers:
- Housing – Loretta Friday (USDA Rural Development), Michelle Mapp (SC Community Loan Fund), Laura Nicholson (SC Housing), Cathy Seawright (USDA Rural Development)
- Jobs – Dr. Ron Bartley (Retired Northeastern Technical College President), Lewis Gossett (SC Manufacturers Alliance), Dr. David Lamie (Clemson University), Jack Swann (SC Vocational Rehabilitation – Chesterfield, Darlington, & Marlboro counties)

11.17.16
Fairfield Career and Technology Center – Winnsboro, SC
Topics & Speakers:
- Education – Director Dinkins & Dr. JR Green (Fairfield County Schools)
- National Rural Health Day – Christian Barnes-Young (Tri-County Community Mental Health Center), Melinda Merrell (SCORH), Dr. Virginia Shaffer (Food Share), Terry Vickers (Fairfield Chamber of Commerce)

1.19.17
South Carolina Hospital Association – Columbia, SC
Topics & Speakers:
- Population Health – Dr. Divya Ahuja (University of South Carolina School of Medicine), Jacqlyn Atkins (SC DHEC), Beth Barry (Alliance for a Healthier Generation), Dr. Rick Foster (South Carolina Hospital Association), Sara Goldsby (SC DAODAS)
- Access to and Availability of Health Services – Dr. Graham Adams (SCORH), Mark Jordan (SC DHEC Primary Care Office), Thornton Kirby (South Carolina Hospital Association), Lathran Woodard (South Carolina Primary Health Care Association)

2.1.17
South Carolina Medical Association – Columbia, SC
Topic: Getting to Action – Five Key Areas of Focus & Work Group Assignments

3.1.17
LRADAC – Columbia, SC
Topic: Creating Draft Recommendations for Community Input

4.5.17
The River Center, Saluda Shoals Park – Columbia, SC
Topic: Finalizing Recommendations

Chapter 2

A Picture of Rural South Carolina

When the word "rural" is said, what is the first thing that comes to mind? Defining "where" rural is, is only the beginning of creating an image of rural South Carolina. The "who" certainly matters, but the "what" and the "why" are also critical to understand the full context of that image.

This chapter provides a broad overview of the current demographic profile of rural South Carolina, including what we considered to be rural for the purposes of the RHAP. Data on the compelling need to address health in rural communities is presented, and the cultural and social context for attending to those needs is highlighted.

One of the first decisions that had to be made by our South Carolina Rural Health Action Plan (RHAP) Steering Committee and Task Force was to decide how the Plan would define rural communities. Federal agencies have at least 88 answers to the question "how do you define rural?" This was no easy task.

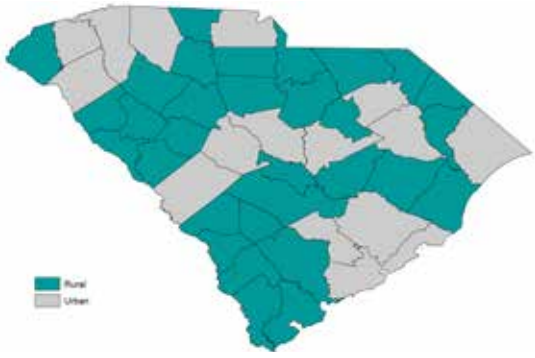
We ultimately landed on the use of the United States Department of Agriculture's 2010 Rural-Urban Commuting Area, or RUCA codes, utilized at both the Census tract and county level depending on the availability of data. RUCA codes utilize the most recent decennial U.S. Census and same-year American Community Survey data to classify population densities, urbanization, and daily commuting patterns.

Throughout this report we refer to rural and urban counties based on our definition unless otherwise noted. All data were compiled on the smallest geographic area available and then aggregated to rural and urban and compared. We ultimately decided that any implementation of strategies from the Plan will be focused on the rural areas as defined at the Census tract level.

IN SOUTH CAROLINA

Before looking at rural outcomes, it is important to start with a baseline understanding of the total rural population in our state. The U.S. Census Bureau estimated the total population of South Carolina in 2015 to be 4,896,146. Rural counties in the state had a total population of 1,317,037 and urban counties 3,579,109.

Rural Definition by County



The population of rural South Carolina is decreasing over time as people move into urbanized areas. Between the years of 2010-2015 there was a trend of out-migration from rural counties into urban counties in South Carolina. Similarly, projections through 2030 show that the trend is expected to continue with as much as a 5% loss of population in some rural counties (see map on page 30).

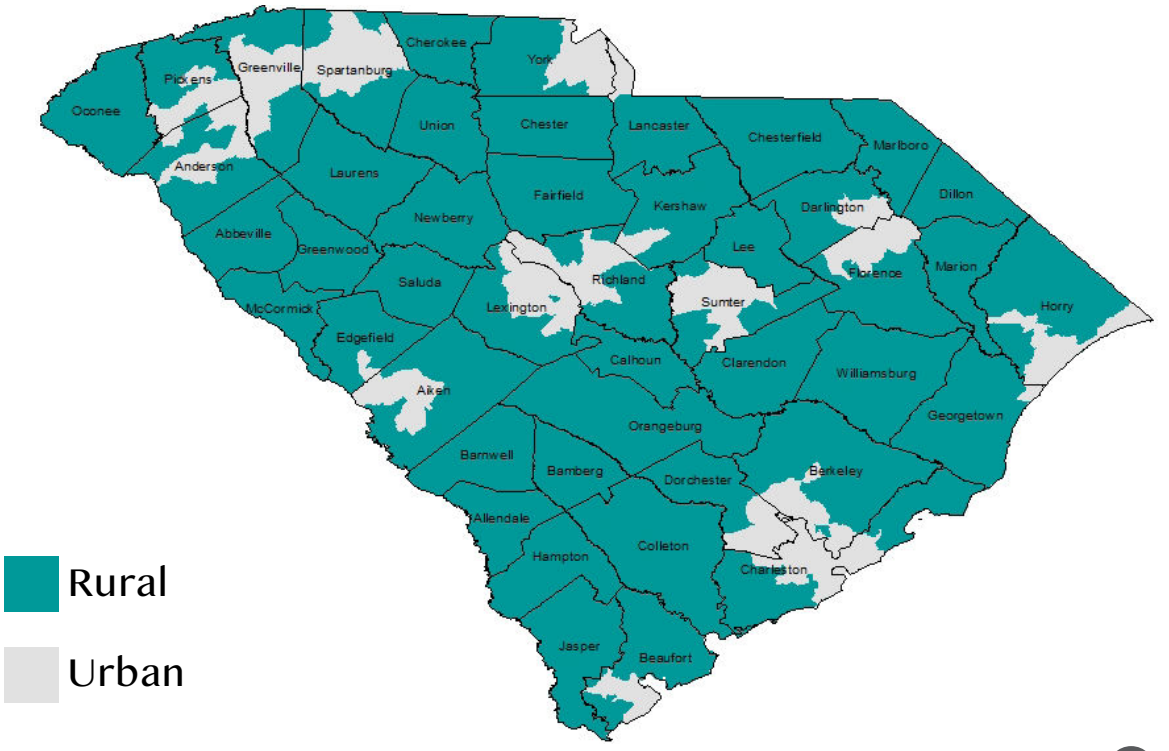
When comparing the age and gender distributions of rural and urban counties, the 65 and over population is higher among rural residents (18%) than urban residents (15%) in South Carolina (see chart on page 30). Gender is very similar across the populations with rural counties being 50.7% female and 49.3% male.

2015 South Carolina U.S. Census

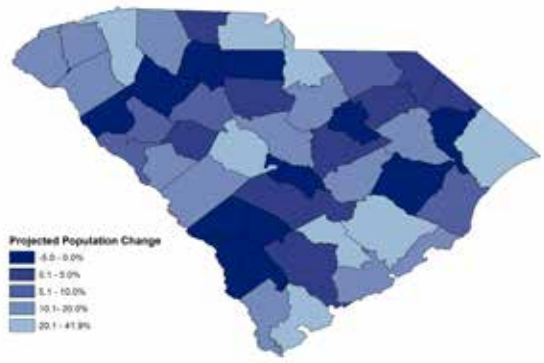
Rural Counties' Population 27%

Urban Counties' Population 73%

Rural Definition by Census Tract



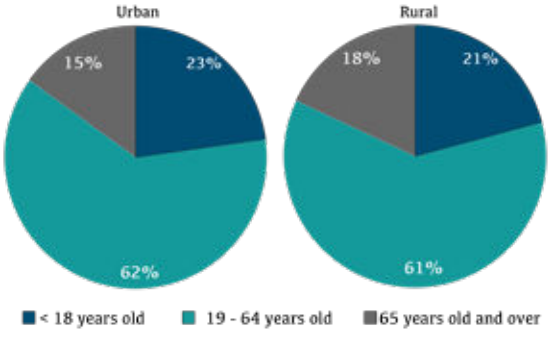
Projected Population Change through 2030



Marlboro County, the location of the Pee Dee Indian Tribe, has the highest percentage of American Indian residents per county with an estimated population size of around 1,300 (4.8% of the county population). There are a total of nine state recognized tribes in South Carolina. York County is home to the only Federally recognized tribe in our state, the Catawba Indian Nation, with a population close to 2,200 (0.9% of the county population). Rural counties in South Carolina have an overall American Indian or Alaskan Native population of 0.7%, compared to 0.5% for urban counties.

The racial composition of rural and urban counties differs as well (see chart on page 31). Fifty-three percent of rural residents are non-Hispanic White versus 66% of urban residents. Also, 40% of rural South Carolina residents are African American while only 26% of urban residents are African American. Saluda, Jasper, and Beaufort counties have the largest Hispanic populations in our state at 14.9%, 13.9%, and 11.4% of their total county populations, respectively. Saluda, Jasper, and Beaufort counties also lead our state in residents with limited English proficiency.

SC Age Distribution, 2015



Deeper Dive: Concerns of South Carolina's Older Adults

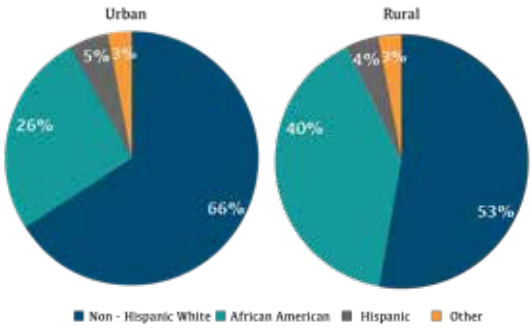
Caregiving: According to AARP, more than 700,000 South Carolinians have been caregivers at one time or another. In a SC AARP poll of 800 registered voters aged 45+, 55% were current or former caregivers. More than 80% of older adults prefer to receive care at home and 50% had needed help with activities of daily living in the previous five years. Almost 70% want services in the community to help them live independently, which could be even more difficult to do in rural areas.

Senior Hunger: SC ranks 3rd lowest in the nation for food security of individuals age 60 and older. According to the "Food Insecurity Among Older Adults" report in 2015 from the AARP Foundation, we rank 2nd lowest for those individuals age 50-59. 20% of those over the age of 60 are food insecure, and 32% of individuals age 50-59 are food insecure. This is compared to the overall national average of 17.3%, which means SC is more than double the national average of food insecurity for those ages 50-59 in the US.

Retirement Savings: Nearly half of Baby Boomers and Gen Xers will lack the income to meet the basic retirement expenses and health care costs. Twenty five percent of households aged 55–64 do not have either a 401(k) or an IRA. SC has the 50th worst rate of 401K savings in the country. The typical working-age household has only $3,000 in retirement assets and retirement households only have $12,000. Further, the average Social Security check in SC is less than $1,200 per month, or about $14,000 per year. Close to 30% of SC Social Security recipients rely on Social Security for 90% or more of their income.

Teresa Arnold, State Director, AARP South Carolina

SC Race/Ethnicity Distribution, 2015

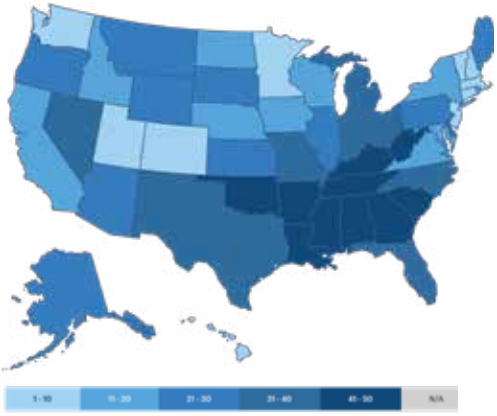


HEALTH IN RURAL SC

In the 2016 edition of *America's Health Rankings*, South Carolina ranked 42nd out of 50 states for health outcomes (see map below). Looking more locally, the annual *County Health Rankings* consistently show that residents in South Carolina's rural counties fare worse than those in urban ones on both health outcomes and health factors. Age-adjusted mortality in rural counties is also worse than in urban counties. That means that even when the overall age of the population is accounted for, people in rural communities are dying at a faster rate each year (see maps on page 32).

To better inform our RHAP Task Force regarding these health outcomes and contributing factors, data and statistics on health behaviors, health outcomes, and social factors were compiled from multiple sources and used to compare the health of rural versus urban South Carolina residents. These data were supplemented by a series of one-on-one interviews with community leaders conducted in nine rural communities.

America's Health Rankings, 2016



Source: United Health Foundation: https://www.americashealthrankings.org/explore/2016-annual-report/state/SC

Deeper Dive: Rural South Carolina's Hispanic Population

The fastest growing segment of many rural communities in South Carolina is the Hispanic population. In fact, there are school districts in some of our rural counties where Hispanic children constitute half of the student population. Unfortunately, Hispanic children and their parents face challenges and barriers in accessing health and social services when they need them.

Issues of trust and immigration-related fears add stress to the already complex interactions in a health care system that is not prepared to effectively meet the language, cultural, or navigation barriers experienced by this population.

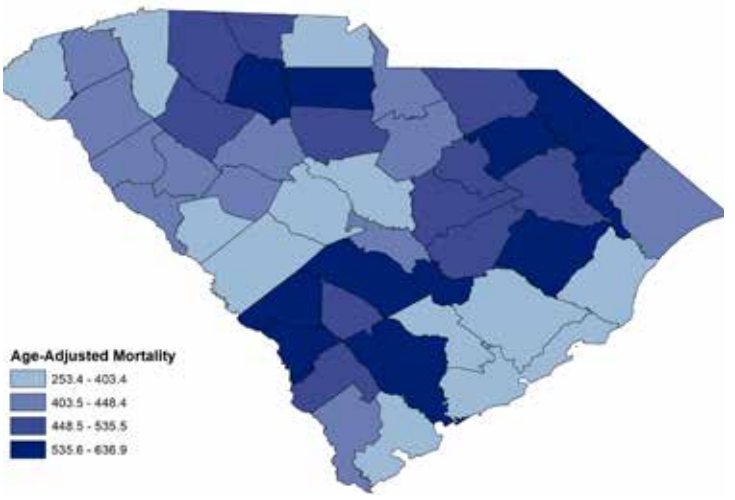
"Having someone they can go to that they feel like understands them and is a safe person to talk to, especially if they are telling really personal things, is huge. One thing I've learned from speaking with people in the rural areas is that it's amazing how few resources they're even aware of because they do not exist in their areas or they are so far away that they've never heard of them.

So things we take for granted in bigger cities as services that people would access, you talk to people in the rural areas and they have never heard of the service because it's so far away, it's not in their language, or no one has done any outreach to them. So there is this huge gap of services for people that I think we may forget about." PASOs Promotora (Community Health Worker), Focus Group, November 2016

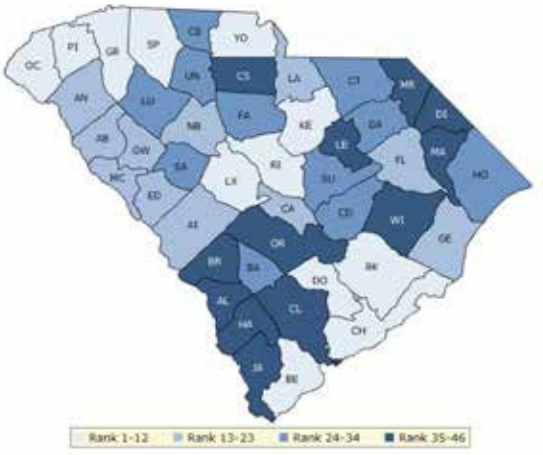
Our communities have the opportunity to do more to facilitate good health outcomes for this expanding population.

Julie Smithwick, LMSW, CHW
Executive Director, PASOs

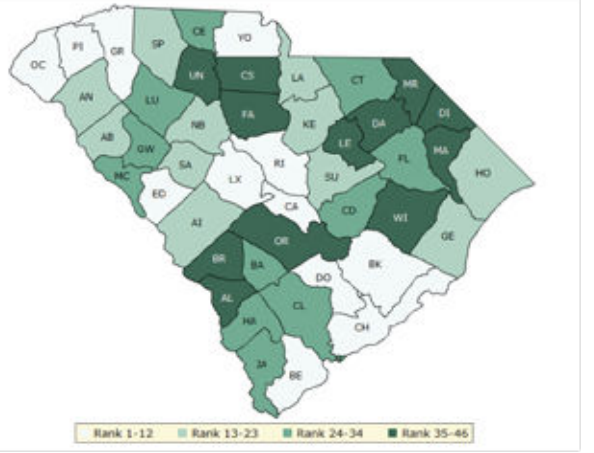
Age-Adjusted Mortality Rate, 2013-2015



County Health Rankings Health Factors, 2017



County Health Rankings Health Outcomes, 2017



Source: County Health Rankings and Roadmaps, http://www.countyhealthrankings.org/app/south-carolina/2017/overview

Best of Rural SC

- ☑ Low Pollution
- ☑ Low Drug Overdose Deaths
- ☑ Low Opioid Use
- ☑ High High School Graduation Rates
- ☑ High Home Ownership
- ☑ High Rate of Social Groups
- ☑ Low Rate of Uninsured Children

Worst of Rural SC

- ☒ High Poverty
- ☒ High Road Fatality Rate
- ☒ Low/Poor Birth Outcomes
- ☒ High STD Rates
- ☒ High Obesity Rate
- ☒ High Rates of Heart Disease
- ☒ High Rates of Cancer
- ☒ Low/Poor Exercise Opportunities

The data review, conducted and presented to our Task Force at both the inaugural meeting in August 2016 as well as in a more fine tuned version in January 2017, informed some conclusions about what is going well in rural South Carolina and where some opportunities may lie in comparison to urban. A summary of the data review is featured in the Best of/Worst of Rural SC table on the opposite page.

Interviews with community leaders were ultimately completed in nine counties, for sixteen interviews among seventeen individuals. Leaders interviewed included library directors, library board and/or staff members, elected officials, faith-based leaders, and local non-profit executives and/or their staff members. Analysis of the interviews and additional information was completed in January 2017 using a thorough, step-by-step process to identify and categorize common ideas.

In addition to the interviews completed with these community leaders, information was gathered from several other sources to provide a broader picture. This information was captured through review of the following sources:

- Publicly available Community Health Needs Assessments;
- Findings from the Healthy Insights community workshops hosted by the South Carolina Association for Community Economic Development in the fall of 2016;
- Findings from the South Carolina Department of Health and Environmental Control's Strategic Priorities development process;
- Findings from a focus group completed with PASOs, an education, support and grassroots leadership organization for the Latino community.

Finally, a series of community listening sessions were held throughout the state in March 2017 to elicit input on our proposed priority areas and recommendations as well as to provide an opportunity for rural communities to propose additional actionable strategies and solutions. Local partners (librarians, faith leaders, hospitals, rural health networks) were asked to co-host the sessions and identify a neutral location to host the meeting. By the end of the month, 14 total events were held around the state: five town hall type meetings in Berkeley, Edgefield, Laurens, Marlboro, and Sumter counties; and nine smaller focus groups with community, civic, or faith organizations held in Anderson, Bamberg, Fairfield, Jasper, Lee, Orangeburg (three separate groups), and Pickens counties.

Rural Needs Identified from Community Listening Sessions

Access to Health Care

- Ability to see providers when needed without payment being a barrier
- Recruitment and retention of health professionals
- Drug treatment access

Community Assets, Leadership, & Engagement

- Rural management/leadership training needed
- Coordinated local leadership
- Access to and help applying for grant funds

Economic Development

- More industry needed in rural areas with high paying, quality jobs
- Active, coordinated, and diverse economic development

Education

- Vocational programs
- 3k and 4k (all day for children)

Housing

- Affordability
- Safety

In addition to these events, an online and hardcopy surveys were available to individuals interested in providing their feedback but not able to attend the meetings. Local South Carolina Department of Health and Environmental Control offices in Abbeville, Barnwell, Chesterfield, Clarendon, Greenwood, Kershaw, and Marion counties alone gathered input from 93 individuals. In total, over 350 rural South Carolinians provided their input for the RHAP.

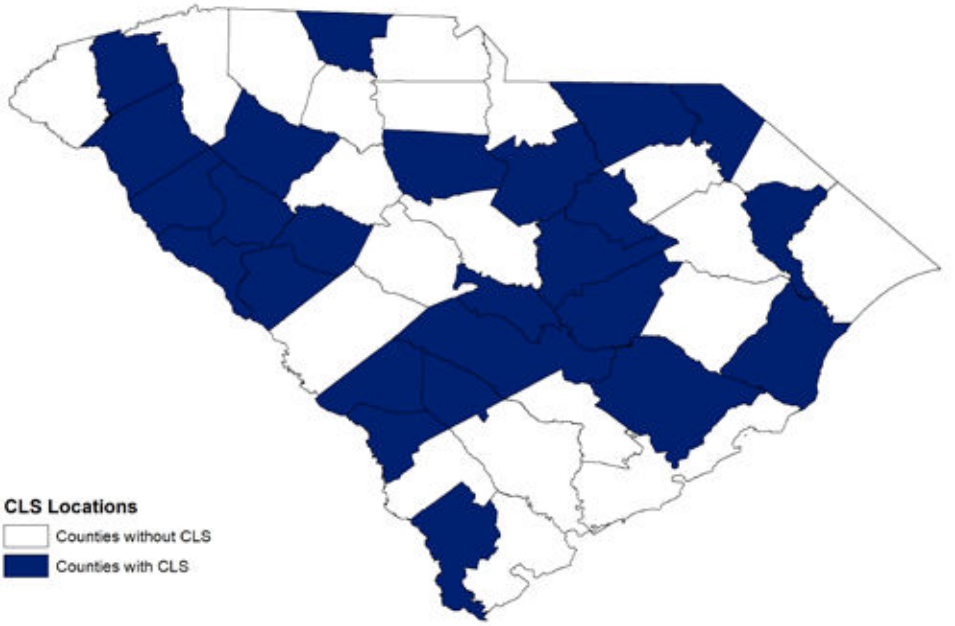
It is worth noting that there were some regional differences observed in the feedback from the community listening sessions. In the Upstate, leaders were very concerned about drug treatment options in their communities. In the Midlands, there was consensus around improving education, including adult education as well as health related education issues. The Pee Dee and Lowcountry both noted concerns around housing for their residents. This may be due in part to the recent flooding and hurricane events that have created a huge strain on resources as well as unsafe living conditions for many residents.

Taken together, this picture of rural South Carolina helped us to create, define, and refine the five priority areas for the SC RHAP and the 15 recommendations that follow.

It is our hope that through this process, greater awareness of not just the needs but also the assets of our rural communities will become evident and together we can work towards common solutions.

350+ individual rural community members provided input for the Rural Health Action Plan

Community Listening Session (CLS) Locations, 2016-2017



Deeper Dive: Addressing Needs Regionally

The RHAP Community Listening Sessions highlighted the fact that rural needs are different in different regions of the state. It is worth noting that there have been other recent efforts in rural South Carolina to better understand and address needs at a regional level, including the South Carolina Promise Zone initiative and the I-95 Corridor study. The Rural Health Action Plan reinforces and builds upon the findings from both of these efforts.

The South Carolina Promise Zone encompasses Allendale, Bamberg, Barnwell, Colleton, Hampton, and Jasper counties. Led by the SouthernCarolina Regional Development Alliance, the Promise Zone's mission is to reduce poverty by aligning organizations and communities to take advantage of Federal grant opportunities. The Promise Zone community has 8 workgroups, each with its own goals: Community Development, Crime Prevention and Law Enforcement, Economic Development, K-12 Education and Early Childhood Development, Health Care, Housing, Private Capital, and Workforce Development.

The I-95 Corridor includes the 17 counties that fall along Interstate-95 stretching from North Carolina down to Georgia. In 2009, Francis Marion University and South Carolina State University worked with RTI International to assess the Corridor's human needs. Six fundamental needs were identified through the study: leadership and local capacity, regional economic development, education, infrastructure, tax and finance, and health care and social service disparities.

Chapter 3

Access to Health Care

Maintaining good health requires us to have more than just access to clinical health care services. However, for our rural communities, sustaining available health care services is critical due to the well-documented, long-standing challenges of health care provider scarcity, rural hospital financial distress and closure, and an inability to adopt new models of care delivery in the absence of adequate reimbursement. There are also increased disease burdens and social challenges in our rural communities, which must be addressed by providing integrated services across clinical, social, and public health sectors.

1. Ensure every community member has adequate and appropriate access, locally or via telehealth, to primary care and preventive services, emergency care, oral health services, behavioral health services, robust care coordination, appropriate diagnostic and outpatient therapy, and long-term care.

2. Support and expand innovative efforts to recruit and retain health care professionals needed to deliver health care services in communities.

3. Advocate for every community member to have a mechanism to receive timely health care services so that they do not delay care due to an inability to pay for services.

Rural communities across the nation and in South Carolina have long-standing challenges obtaining equitable access to health care services. Local services are limited due to a variety of factors, including lack of accessibility, lack of providers, and a potential for high cost of care, especially for individuals and families who are uninsured or underinsured. Compounding the limited availability of health care services is the increased burden of disease and social challenges faced by many rural communities.

Research shows that having available health care services, especially in the form of a patient centered medical home, is critical to building healthier communities by way of improving health outcomes and decreasing costs. Primary care, including behavioral health and oral health services, should be the foundation of our health care system in rural communities. Additionally, specialty and hospital services should also be available in a reasonable distance or delivered through telehealth.

> **Timely, high quality, affordable health care services and population-based programs must be available to rural residents.**
>
> *-Access to Health Care workgroup*

Having a usual primary care provider increases the likelihood of appropriate care being delivered to a patient and with higher quality. To this end, 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.

2017, the Centers for Disease Control and Prevention (CDC) began a Rural Health Series of its *Morbidity and Mortality Weekly Report*. A January 13, 2017 report highlighted the current trend of an increasing gap between rural and urban Americans with respect to age-adjusted death rates as well as "potentially excess" deaths among the five leading causes of death.

For South Carolina in 2015, there were approximately 7,400 "potentially excess" deaths among the five leading causes of death: cancer, chronic lower respiratory disease, heart disease, stroke, and unintentional injury. Of these, 49.6% deaths were among rural South Carolina residents.

The lack of access to health care in rural South Carolina is also reflected in our state infant health outcomes. The infant mortality rate in 2015 was seven infant deaths for every 1,000 live births. This rate is always higher in rural areas, and there is a disparity between white and African American populations, with African American babies dying twice as often.

Rural populations will need to be monitored to ensure that vulnerable residents are not left without access to health care services, providers or facilities because of demographic and economic shifts…Interventions targeted at states that chose not to expand Medicaid will be required to meet the health care needs of those residents, particularly as facilities in these states are financially vulnerable and have a higher likelihood of closure.

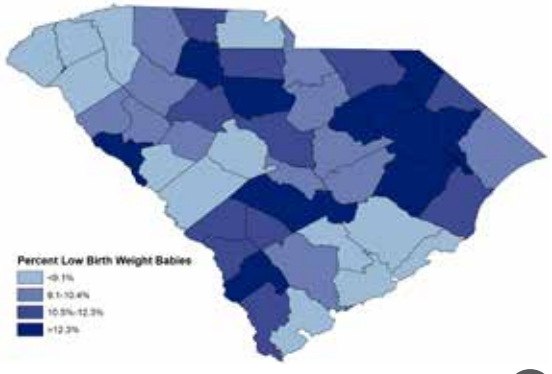
SC Rural Health Research Center, Vulnerable Rural Counties, The Changing Rural Landscape 2000-2010

Another critical factor impacting our rural communities is access to health insurance. Having health insurance in and of itself is linked to improved health status and lower death rates, due in part to individuals receiving recommended preventive health screenings and follow up care on chronic health conditions. Coverage barriers need to be reduced in rural areas to ensure that our residents have the ability to pay for care in the most appropriate setting. There should also be payment equity ("parity") between our rural and urban communities including both behavioral health and oral health services.

The inability of rural South Carolina residents to access health care is demonstrated by poor outcomes on leading health indicators. In

One of the leading causes of infant death is low birth weight. Our state ranks fourth highest in the nation for low birth weight babies, with rural South Carolina having some of the highest percentages, averaging 11% overall.

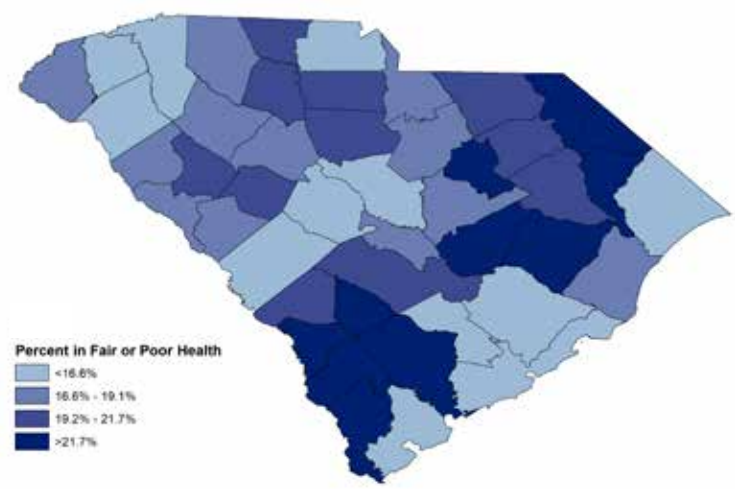
Low Birthweight Babies, 2008-2014



RECOMMENDATION 1

Ensure every community member has adequate and appropriate access, locally or via telehealth, to primary care and preventive services, emergency care, oral health services, behavioral health services, robust care coordination, appropriate diagnostic and outpatient therapy, and long-term care.

Percent of Population with Fair or Poor Health, 2015



Rationale: Rural South Carolina residents are more likely to self-report their health as poor or fair as compared to their urban counterparts. In order to ensure that these individuals and families truly have the care they need to improve their health status, we must focus on building relationships among health and human service providers in order to break down barriers. We must use technology to increase the availability of care and improve the coordination of services in local systems of care. We also must do it now, as changes in health care markets, including purchases and affiliations of and with rural hospitals, are shifting the power of who makes health care decisions for local communities.

ACTION STEP

Appropriate funding, training, equipment and practice support to suitable entities to fund and/or coordinate with partners to accelerate the spread of best practices and programs that improve health and increase the availability of health care services or workers.

Ideas to Consider:

- Establishing Community Health Workers as a recognized and reimbursed health care provider
- Supporting Community Paramedic program development and reimbursement
- Providing for an evaluation of new efforts that show promise for rural communities across the state such as the new pilot program in Greenville County that will utilize Clemson "Health Extension" agents to improve nutrition and health behaviors
- Helping rural communities engage in focused state-level initiatives where communities learn from each other as well as content experts to find ways to address specific needs in their community

State-Level Initiatives that Highlight Evidence-Based Practices

Alliance for a Healthier South Carolina
SCaleDown: South Carolina's Obesity Action Plan
SC Behavioral Health Coalition
SC Birth Outcomes Initiative
SC DHEC's 6 | 18 Initiatives with the CDC
SC Institute of Medicine and Public Health Behavioral Health Task Force Recommendations
SC Institute of Medicine and Public Health Long-Term Care Task Force Recommendations
SC Tobacco-Free Collaborative
Statewide Comprehensive Diabetes Prevention Plan (2016-2021)

ACTION STEP

Adopt policies that provide additional incentives to rural providers to support medical home development in order to integrate and coordinate behavioral health, oral health, and social support services in communities.

Ideas to Consider:

- Working with the South Carolina Patient Centered Medical Home (PCMH) Alliance to determine appropriate incentives for multi-disciplinary integration
- Engaging with the South Carolina Department of Mental Health's Behavioral and Primary Care Integration Initiative to determine feasible incentives for providing primary care for patients with serious and persistent mental illness
- Providing incentives for other disciplines in the "care team" to work in rural practices: social work, clinical pharmacy, Certified Diabetes Educator, Physical Therapy/Occupational Therapy, etc.
- Aligning incentives with participation in SCHIEx, the South Carolina Health Information Exchange, for uniform, statewide data exchange

ACTION STEP

Continue to fund and fast-track efforts of Palmetto Care Connections and the South Carolina Telehealth Alliance to deploy technology and equipment to provide telehealth services in communities as well as train staff to efficiently and effectively utilize these services.
(See text box on page 43)

ACTION STEP

Engage in purposeful, ongoing dialogue with larger, urban-based health care systems as to how they can effectively coordinate with existing rural health and human service providers in their rural service area(s).

Ideas to Consider:

- Engaging in dialogue with groups like the Nonprofit Finance Fund that conduct work to help large health care organizations collaborate with human service providers (e.g. NFF's Healthy Outcomes Initiative)
- Using existing community health needs assessments to drive local service provision
- Building on successes of large and small systems working together for time-sensitive conditions (trauma, STEMI, stroke care) to examine primary care and preventive services

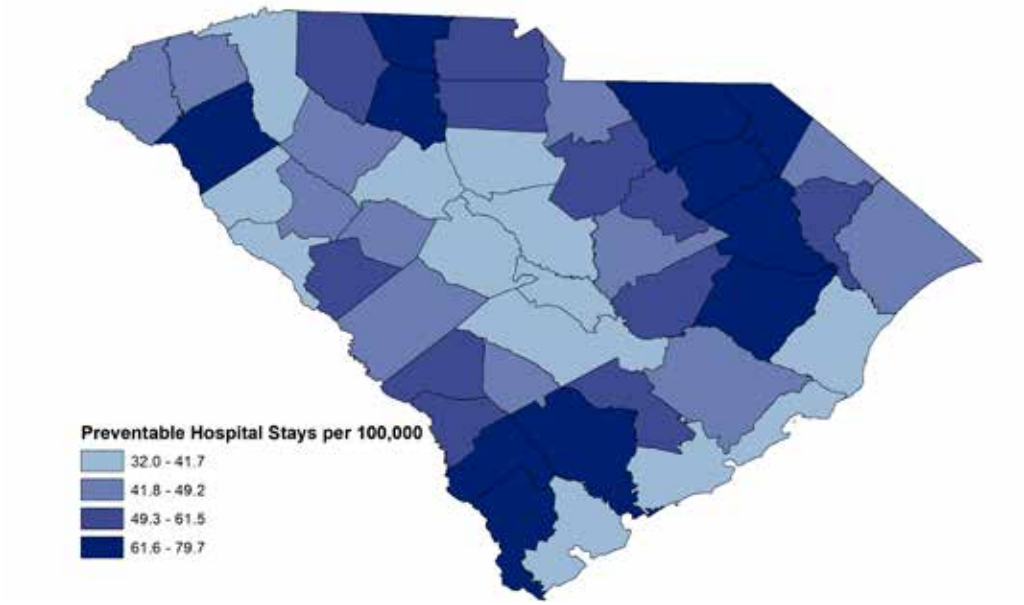
Key Stakeholders

Clemson Extension
Medical University of South Carolina
Palmetto Care Connections
Rural Federally Qualified Health Centers
Rural Free Medical Clinics
Rural Health Clinics
Rural Health Networks and other health service collaboratives
Rural Hospitals
SC Community Health Worker Association
SC Community Paramedic Advisory Committee
SC Department of Health and Environmental Control
SC Department of Health and Human Services
SC Department of Mental Health, including local community mental health centers
SC Hospital Association
SC Office of Rural Health
SC PCMH Alliance
SC Primary Health Care Association
SC Specialty and Allied Health Societies

MEASURE OF SUCCESS

Preventable hospital stays are used as a measure of the functioning primary care system in an area and are defined as the number of hospital stays for ambulatory-care sensitive conditions per 1,000 Medicare enrollees (meaning those conditions that may have been more appropriately treated in a primary care setting). In 2014, rural South Carolina had a higher rate of preventable hospital stays than urban South Carolina. We will review this measure annually.

Rate of Preventable Hospital Stays among Medicare Beneficiaries, 2014



The State of Telehealth in Rural South Carolina

Palmetto Care Connections (PCC), a non-profit telehealth network focusing on improving access to care and the South Carolina Telehealth Alliance (SCTA), a collaboration committed to building a statewide telehealth network, have been working side by side over the last few years to improve the health of all South Carolinians through the use of telehealth.

The PCC and SCTA teams believe that…the physical address of a person should NOT define the quality of life that he/she is able to live. PCC and SCTA are fortunate to have the continued support and commitment from health care leaders across the state to include the four Telehealth Regional Hubs – MUSC, GHS, Palmetto Health and McLeod Health along with our Statewide Specialty Hub, the South Carolina Department of Mental Health. Together we have made tremendous strides in expanding telehealth across our state.

The statewide telehealth network utilizing providers located at MUSC Health, Greenville Health System, Roper Saint Francis and Palmetto Health is projected to complete over 4,000 telestroke consults in 2017 with some of the best door to needle times in the country. 96% of our state's population is within 60 minutes of expert stroke care.

The South Carolina Department of Mental Health (SCDMH) Telepsychiatry Programs are comprised of the Emergency Department Telepsychiatry Consultation Program, the Community Telepsychiatry Program, Inpatient Telepsychiatry and Deaf Services Telepsychiatry. These programs provide approximately 1,550 psychiatric services per month. Since its inception in 2007, more than 70,000 psychiatric services have been provided via telehealth. SCDMH is the largest provider of telehealth services in South Carolina.

Although telestroke and telepsychiatry are our two largest telehealth services available in South Carolina, there are numerous other efforts in the state such as school based telehealth whereby more than 60 rural schools have been equipped with telehealth equipment. The school nurse can facilitate an appointment between the school aged child and a health care provider, which keeps many of the children out of the Emergency Room and allows for the parents to continue with their workday.

The Tele-ICU network in South Carolina has monitored more than 4,900 patients since January 2017 with more than 28,000 video assessments completed and potentially 85 lives saved. MUSC Health's Virtual Telehealth Consultation Program has connected more than 80 health care providers since 2012 and provided almost 1,400 outpatient consultations to rural health care providers. Some of the services provided to the rural providers include Pediatric and Adult Psychiatry, Pediatric and Adult Nutrition, Heart Health and Pediatric Dermatology among others.

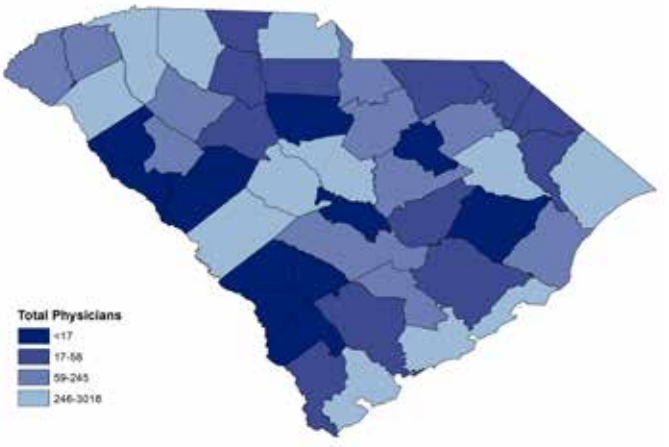
In the years ahead, we will continue our focus on expanding our ability to support the delivery of health care in rural/underserved communities through the use of telehealth.

Kathy Schwarting, MHA, Executive Director, Palmetto Care Connections & Co-Chairman, South Carolina Telehealth Alliance

RECOMMENDATION 2

Support and expand innovative efforts to recruit and retain health care professionals needed to deliver health care services in communities.

Number of Total Physicians by Reported Primary Practice Site per County, 2016



Rationale: South Carolina has several mechanisms in place to assist in the recruitment and retention of primary health care providers. National Health Service Corps (NHSC) federal loan repayment and state Rural Provider Incentive Grants are key to attracting providers to rural and underserved communities, as is the Rural Dental Incentive Grant Program. Yet, primary care physicians (PCPs) are scarcer in rural areas of South Carolina. For example, Saluda County only has six PCPs, while Charleston County has 880 PCPs. This creates a PCP to population ratio per 10,000 population of 3.0 for Saluda County and 22.6 for Charleston County. We must increase state appropriations to allow additional physicians, dentists, advanced practice registered nurses (APRNs) and physician assistants to be funded. We must also continue to support efforts to retain existing providers in rural communities to include technical assistance around quality improvement, Patient Centered Medical Home recognition, practice management, Electronic Medical Records and Information Technology support, access to affordable capital, and further development of the overall care team needed to support population health management.

ACTION STEP

Broaden existing and create new health professions scholarships and/or programs for young, rural students, especially underrepresented minorities, through the enhancement and development of opportunities such as summer internships in an effort to increase the pipeline of rural individuals entering health professions training.

High School for Health Professions

The High School for Health Professions (HSHP) is a public charter school based in Orangeburg Consolidated School District #5. Opened in 2012, the school has seen its number of students jump from 73 to more than 360 in 2017. The HSHP offers grades 9-12 and is geared towards helping students prepare for future careers in the health care industry. College credits may be earned while attending high school as well. Successes of the HSHP to date include 100% graduation and college acceptance rates for the class of 2017; a 100% passage rate of the Calculus AB Advanced Placement exam last year; nationally recognized student organizations; and a brand new facility that opened on August 16, 2017.

ACTION STEP

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.

Ideas to Consider:

- Contributing to the South Carolina Institute of Medicine and Public Health's new Health Care Workforce initiative, a collective process to develop recommendations for state policymakers and others regarding the future of the health care workforce in the state focused on prevention, outpatient/community settings, and the social/environmental determinants of health
- Creating a broad recruitment plan(s) within and between health professional programs, especially those offered through the SC Technical College System and aligning the plan(s) with health care employers through mutual education/training, placement agreements, and job fairs
- Utilizing the work of the South Carolina Graduate Medical Education (GME) Task Force to provide data and information needed for planning

ACTION STEP

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.

Resources:

- National Rural Health Association Community Health Worker Training Network: https://www.ruralhealthweb.org/programs/community-health-workers
- National Community Health Worker Training Center: https://nchwtc.tamhsc.edu
- South Carolina Community Health Worker Association: http://scchwa.org
- communityparamedic.org
- Rural Health Information Hub Community Paramedicine Topic Guide: https://www.ruralhealthinfo.org/topics/community-paramedicine
- South Carolina Community Paramedic Advisory Committee: http://scorh.net/our-services/rural_ems/

Key Stakeholders

Rural Federally Qualified Health Centers
Rural Free Medical Clinics
Rural Health Clinics
Rural Health Networks/other health service collaboratives
Rural Hospitals
Rural Training Programs
SC Alliance of Health Plans
SC Area Health Education Centers
SC Area Health Education Center, Office for Healthcare Workforce
SC Community Health Worker Association
SC Community Paramedic Advisory Committee
SC DHEC Primary Care Office
SC Department of Health and Human Services
SC Department of Insurance
SC GME Task Force
SC Institute of Medicine and Public Health
SC Rural Health Research Center
SC Health Care Payers / Insurance Companies
SC Hospital Association
SC Office of Rural Health
SC Primary Health Care Association
University of South Carolina School of Medicine Rural Healthcare Center for Excellence

MEASURE OF SUCCESS

Every year the South Carolina Office for Healthcare Workforce disseminates its "South Carolina Health Professions Data Book" which includes the latest information on the number of providers located in every county in the state. For this recommendation, we will track the total number of professionals in each of the sections annually.

Number of Rural Healthcare Professionals in SC, 2016

Rural Areas

Physicians

Total Physicians (excludes Federal physicians)	1,116
Family Practice	317
Internal Medicine	150
Obstetrics / Gynecology	62
Pediatrics	92
General Surgery	50
All Other Physicians (Specialists)	445
Physicians Per 10,000 Population	10.4
Primary Care Physicians Per 10,000 Population	5.8
Federal Physicians	7

Nurses

Registered Nurses	4,860
Certified Nurse Midwives	11
Nurse Practitioners	290
Certified Nurse Anesthetists	91
Clinical Nurse Specialists	2
Licensed Practical Nurses	2,091

Dentists and Hygienists

Dentists	261
Dental Hygienists	326
Dental Technicians	13

Other Health Professions

Pharmacists	732
Pharmacy Technicians	1,258
Physical Therapists	281
Physical Therapy Assistants	228
Occupational Therapists	129
Occupational Therapy Assistants	106
Physician Assistants	150
Respiratory Care Practitioners	307
Optometrists	58

Deeper Dive: The Impact of Rural Hospital Closures

The last decade has brought many developments to the world of health care, including new delivery models like telemedicine, therapeutic advances, and a greater emphasis on healthy communities. But the changing environment has been hard on rural hospitals, which typically offer fewer services and struggle to compete with the perception that "bigger is better." Three South Carolina hospitals have closed in the past few years, and our state is not alone. According to the Sheps Center for Health Services Research at the University of North Carolina, 82 rural hospitals have closed across the country since 2010. South Carolina can count ourselves lucky we have not had more closures—North Carolina has lost four, Alabama and Mississippi have lost five, Georgia has lost six, Tennessee has lost eight, and Texas has lost 14 hospitals in the same period.

Why are rural hospitals vulnerable? There are many reasons, which vary in importance according to the community. But common factors include declining populations, greater emphasis on outpatient services (which means less inpatient revenue), aging physical plants, and difficulty recruiting physicians to rural communities. It's also worth noting that most rural hospital closures have occurred in states that chose not to expand Medicaid as permitted by the Affordable Care Act. There's not yet enough evidence to conclude that failure to expand Medicaid caused the rural hospitals to close, but the correlation between non-expansion states and rural hospital closures is strong enough to raise the eyebrows of industry analysts and market investors.

The future is not bleak, however. As hospitals have grown into health systems, many have brought rural hospitals into their folds. This is good news for rural facilities, which otherwise struggle to fund capital improvements, recruit physicians, and negotiate competitive managed care contracts. New models are also emerging for rural communities, and that's the best news yet. As the marketplace better matches health care resources to local community needs, everyone wins.

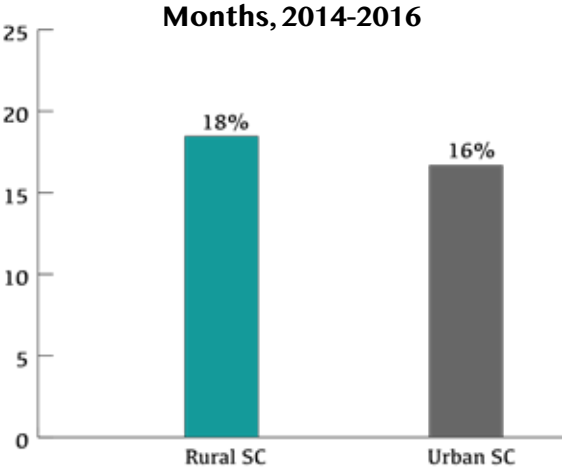
Thornton Kirby, FACHE, President & CEO, South Carolina Hospital Association

RECOMMENDATION 3

Advocate for every community member to have a mechanism to receive timely health care services so that they do not delay care due to an inability to pay for services.

Rationale: Having physical access to care is often not enough to ensure that individuals and families can obtain the care they need. The high cost of health care is a significant barrier that we must address to truly ensure "access", especially for those who are uninsured or underinsured (meaning that even with insurance, medical debt is still acquired). The inability to pay for medical care usually results in patients who do not have a medical home and are forced to seek care in a fragmented way. This may mean more trips to the Emergency Department for routine illnesses, delays in seeking primary care or preventive services such as life-saving screenings, and for women, a lack of pre-natal care if they become pregnant. Some even forgo care altogether to avoid running up a high bill. The number of adults who report delaying care due to cost in the past year is higher in our rural areas (see chart to the right). This percentage does not include adults who lack mental/behavioral health coverage or dental coverage, which varies based on the health benefit plan available to the individual or family.

Percent of SC Residents with Delay of Care Due to Cost in the Past 12 Months, 2014-2016



ACTION STEP

Conduct an environmental scan of available insurance coverage for primary and preventive services, behavioral health, and oral health services in all health insurance benefit packages sold in South Carolina.

Ideas to Consider:

- Researching specific concerns around mental/behavioral and oral health parity rules and enforcement
- Identifying specific financial barriers to care related to insurance coverage that can be addressed through legislative or regulatory action
- Identifying other barriers to care related to coverage such as health literacy, transportation issues, etc.

ACTION STEP

Further bolster private funding source(s) for targeted patient needs that help health care providers offset costs for providing uninsured care to rural patients.

Examples:

- AccessHealth SC – a health care navigation and medical home program for uninsured adults funded by The Duke Endowment
- ChooseWell – an initiative focused on providing contraceptive care, especially for uninsured women funded by the New Morning Foundation

- South Carolina Free Medical Clinics – community-based and primarily volunteer staffed clinics that provide primary and preventive care services for uninsured adults for free
- Mobile Health Clinics – mobile-based (RV/truck) units that travel to different communities to provide primary and preventive care services for uninsured adults at free or reduced cost

Alliance for a Healthier SC Policy & Advocacy Team

The purpose of the Team is to:

- ☑ Identify opportunities to leverage the collective voice of the Alliance to achieve Alliance goals; inclusive of type and level of advocacy needed.
- ☑ Determine the most effective ways to reduce barriers for the achievement of Alliance goals through advocacy.
- ☑ Guide collective advocacy efforts approved by the Alliance.

healthiersc.org

ACTION STEP

Participate in the Alliance for a Healthier South Carolina's Policy & Advocacy Team to forward an agenda for ensuring access to all South Carolinians with particular emphasis on rural and underserved populations.

ACTION STEP

Collaborate with South Carolina health care insurance companies to find workable solutions to ensure rural and underserved adults have access to affordable care.

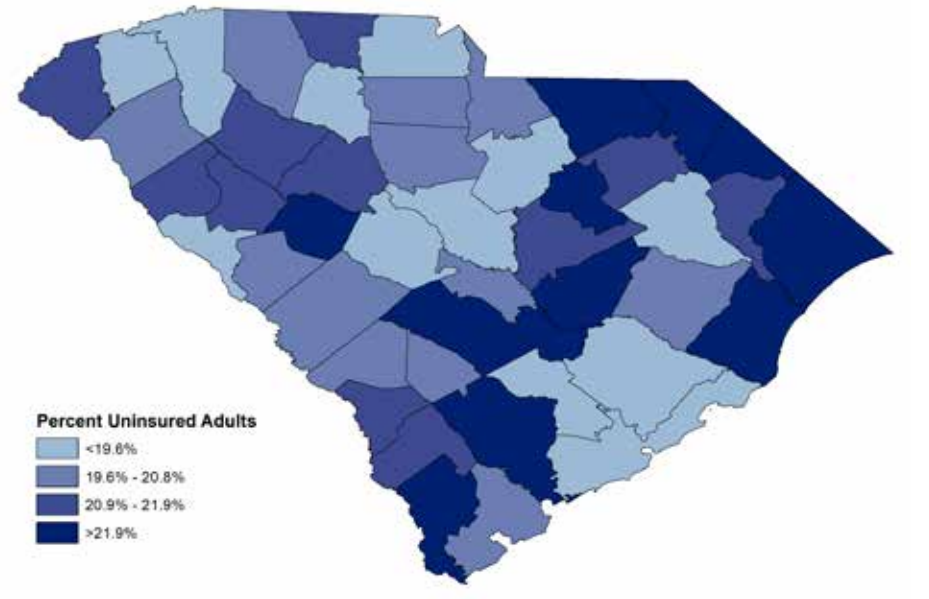
Ideas to Consider:

- Discussing potential public-private models that allow for more adults to be served in rural communities
- Identifying community partners that are willing to work with each other and providers to address financial access issues

MEASURE OF SUCCESS

In 2014, rural and urban South Carolina counties had similar uninsured rates at 22.2% and 19.6% respectively. We will review this metric at least annually as an indicator of financial access to care in rural communities.

Percent of Adults without Health Insurance, 2014



Key Stakeholders

Alliance for a Healthier South Carolina
Blue Cross Blue Shield of South Carolina Foundation
Community Foundations
New Morning Foundation
Rural Dentists
Rural Federally Qualified Health Centers
Rural Free Medical Clinics
Rural Health Clinics
Rural Health Networks and other health service collaboratives
Rural Hospitals
Rural Insurance Agents
Rural United Way Offices
SC Appleseed Legal Justice Center
SC Alliance of Health Plans
SC Department of Alcohol and Other Drug Abuse Services
SC Department of Health and Human Services
SC Department of Insurance
SC Department of Mental Health
SC Health Care Payers / Insurance Companies
SC Hospital Association
SC Office of Rural Health
SC Primary Health Care Association
SC Rural Health Research Center
Sisters of Charity
The Duke Endowment
The Fullerton Foundation

"And you know people... I feel like they're so responsible they don't wanna run up a bill that they can't pay... even when I tell them you need to go to the emergency room, they're so reluctant because they don't feel like they can pay that bill.."

- Rural Community Leader

agency clinician community legislative/policy philanthropy

Chapter 4

Community Assets, Leadership, and Engagement

Effectively using local assets—including financial, social, and human capital—is vital to the development of healthy communities. Too often, our lack of coordination between federal and state agencies and local community members yields rural initiatives that are not integrated, comprehensive, or sustainable. More determination to align our resources as well as utilize community decisions, wisdom, and political will to guide efforts will lead to a better return on investment, ultimately improving the health and well being of communities.

4 Create and support leadership development and training opportunities for a diverse group of natural leaders, both grassroots and grasstops, who are motivated to engage in locally led, strength-based strategies and initiatives.

5 Promote better state agency and statewide organization engagement, coordination, and communication around the planning and implementation of programs to ensure the needs of communities are being met.

6 Foster the development of sustainable financial models for communities, supplemented by sufficient community training specific to leveraging and aligning funding from income-generation, public support, and private sources to sustain local projects and programming.

The National Rural Health Association published a policy brief in 2015 that underscored the need for rural communities themselves to create change:

"Thriving communities embrace change. Local leaders in these communities seek input from residents and create policies that reflect the unique needs and assets of the entire population including new multicultural populations. Stagnant communities reject change and are less likely to welcome new residents and their ideas. Programs that encourage leadership development skill building, conflict resolution training, and asset based community development are essential for rural community sustainability."

Our Rural Health Action Plan (RHAP) Task Force was deliberate in considering how Community Assets, Leadership, and Engagement (CALE) should be included in the RHAP. We believe that by strengthening the people and organizations that reside in our rural communities through leadership development, organizational efficiencies, and sustainable funding streams, better health can be achieved.

We also believe that one of the most underutilized assets of our rural communities are the people that reside there. Developing the capacity and skills of a diverse group of "natural" community leaders can benefit a rural community in several ways. First, any needed change in the community will be directed and implemented through locally led strategies and initiatives. Community leaders can lead conversations about gaps in existing local strategies and initiatives and then identify community assets that can resolve those gaps. Strengthening local leadership also supports better communication throughout the entire community, ensuring greater feedback and direction from the "grassroots" level.

Only by building on strengths and leadership from within rural SC communities will authentic and sustainable change be achieved.

-CALE workgroup

Deeper Dive: CALE at Work

Since 2005, Ten at the Top has operated around its five core values of inclusion, partnerships, regional thinking and discovery, building consensus to improve community, and business partnerships to improve the quality of life across 10 counties in the Upstate. Ten at the Top's efforts have cultivated trust and partnerships among elected officials, business, and community leaders to enhance the Upstate's physical and social infrastructure in order to encourage quality community resources and economic growth. Utilizing a funding opportunity from the Graham Foundation, Ten at the Top also created the Upstate Information Hub, a repository of regional resources for residents to access a comprehensive list of local events, activities, and resources. The organization served as a leader for Our Upstate Vision, a regional collaboration to identify issues and opportunities to improve the quality of life for Upstate residents. Resources for Ten at the Top are provided through businesses, organizations, and local communities who serve as funding partners in improving collaboration, coordination, and cooperation across the Upstate.

Organizational capacity is also a key component of Community Assets, Leadership, and Engagement. Nationally, human service providers are struggling in rural communities due to limited funding and an inability for residents to physically access their services. Although limited resources can make the work of coordination a tough sell, it is imperative that our state and local agencies find ways to communicate better between and among each other. By working together, our clients are better served, and our state agencies and organizations reduce duplication.

Assets in the form of direct capital are also critical to rural community sustainability. Over and over, our rural communities struggle as grant funding ends and new opportunities go unrecognized. The post Great Recession period has been a particularly difficult one in the rural South, as the lack of public funding and services not only diminished support to those in need but also created a vicious cycle such that as services decrease, a large portion of the economy in many rural communities also decreases. The complexity of this scenario for rural Southern communities is highlighted as our large city neighbors have seen extreme rates of growth and prosperity during the same time period. Investing in low-income communities through such mechanisms as Community Development Financial Institutions is one way to address this gap.

In rural South Carolina, Community Assets, Leadership, and Engagement are considered a strength on which each community can build to improve their future. Community leaders provided us with a list of assets that are cornerstones of our rural communities through interviews conducted in January 2017 (see text box on page 54).

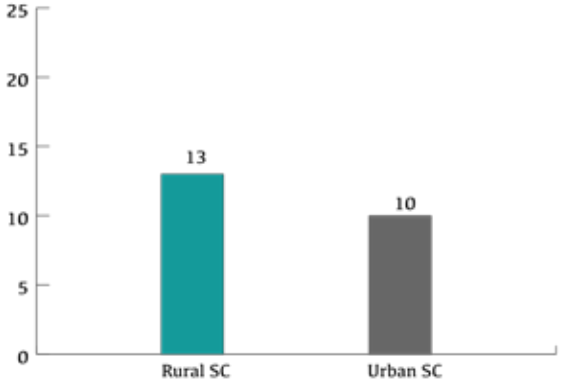
Through these interviews, community leaders also provided us with insight on how leaders support community development and engagement. Leaders work with others to develop their community through use of local data, embracing cultural diversity,

Rural South Carolina Community Assets Identified in Community Interviews, January 2017

Businesses
Charitable Organizations
Civic Organizations
Community Centers
Education Pre-K through 12
Educational Institutions (Higher Learning)
Faith Community
Libraries
Literacy Organizations
Senior Adult Supports

and involving the sense of pride everyone feels about being from a rural area. Another strength highlighted in our rural communities is the ability to "meet them where they are", meaning that leaders can easily get out to the neighborhoods and areas where people live to talk with them. Leaders also promote the use of shared experiences and special events as ways to involve community members. The success of these engagement efforts is likely due in part to the higher number of social associations found in our rural communities, as well as because of the efforts of our faith communities. (For a map/list of churches by county, visit healthyinsight.org.)

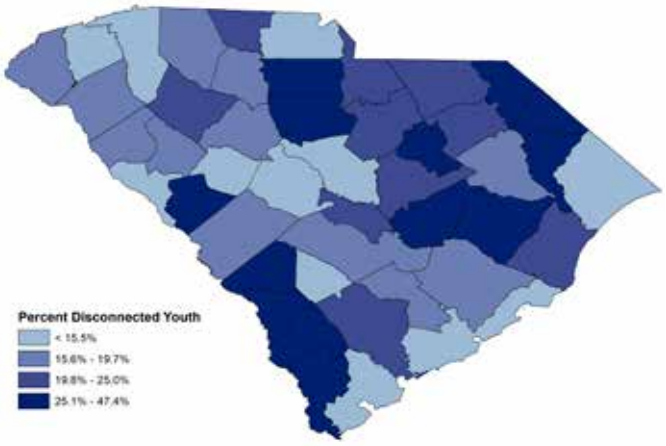
Rate of Social (Membership) Associations in SC Per 100,000, 2014



RECOMMENDATION 4

Create and support leadership development and training opportunities for a diverse group of natural leaders, both grassroots and grasstops, who are motivated to engage in locally led, strength-based strategies and initiatives.

Percent Youth Disconnected from School/Work, 2008-2012



Rationale: Having strong leaders in our rural communities is key to not only improving the community as it stands today, but it is also crucial to secure the future of our communities for our children. In the U.S. today, 30 million children are exposed to "adverse childhood experiences". These individual level factors are compounded if children grow up in areas of high poverty and low resources. However, if resiliency can be created at the community level by developing long-term strategic and collaborative partnerships, there is more opportunity to help children not only move beyond their individual circumstances but enable them to become leaders themselves. This is an important area to address as most of our rural communities have a high population of disconnected youth – that is young adults ages 16-24 who are not in school and/or do not have a job.

ACTION STEP

Recommend that state-sponsored academic programming in the public health and social work disciplines include a community-based component focused on rural areas to foster a higher number of students with an interest in rural practice.

Ideas to Consider:

- Working with rural health and human service providers to establish rural organizations as regular sites for field placements and practicums
- Providing opportunities for engagement with rural communities through school sponsored service-learning opportunities
- Seeking funding 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
- Developing multi-disciplinary translational research programs such as the MUSC Community Engaged Scholars Program that has created an academic-community partnership for community-based research

ACTION STEP 

Allocate funding to new and existing leadership programs that serve and/or have priority criteria for rural leaders for ongoing rural focused leadership development efforts.

Examples:

- The Fred R. Sheheen Non-Profit Leadership Institute at Francis Marion University
- Leadership South Carolina
- Furman University Diversity Leaders Initiative
- SC State 1890 Extension adult leadership program
- County-based efforts led by local Community Foundations or Chambers of Commerce
- Blueprint for Health, a program of the South Carolina Office of Rural Health

ACTION STEP 

Mentor community youth using local leaders and resources that promote and emphasize the value of leadership to nurture the development of young leaders in rural areas.

Resources:

Statewide

- Clemson Extension (including 4-H and Future Farmers of America)
- Eat Smart Move More's Healthy Young People Empowerment (HYPE) Project
- Edventure Youth Summit
- SC Campaign to Prevent Teen Pregnancy
- SC State 1890 Extension (including 4-H)

Local Examples

- Bootstraps Mentoring – Orangeburg County
- Family Solutions of the Lowcountry – Tomorrow's Scholars (Allendale, Bamberg, Barnwell, Hampton & Orangeburg Counties)
- Tea Time with Teens – Marlboro County

Deeper Dive: National Opioid Epidemic

The opioid epidemic – its death toll, impact to families, and fragmentation of communities – continues to capture national attention. In rural communities, opioid users are more likely to have social determinants that predispose them to substance use disorders, to include low socioeconomic status, poor health status, limited job opportunities, and low educational attainment. Nationally, rural communities are harder hit by the opioid epidemic:

- Naloxone use (opioid reversal) is 22% higher in rural communities.
- Drug related deaths are 45% higher in rural areas.
- Rural states are more likely to have higher rates of overdose death, particularly from prescription opiate overdose.
- Men in rural areas are using more opioids than women but more women are dying from opioid overdose.

The availability of drug courts to adjudicate users abusing opioids and other substances, as well as access to treatment options, are less widely available in rural areas. Those seeking treatment in their rural communities, if it is available, may have difficulty obtaining treatment anonymously based on the small communities in which they live. To maintain abstinence from opioids, they may be advised by well-meaning treatment programs to not "go back to their old playgrounds," thus limiting rural residents return to an already declining rural population. A "whole community" response to this crisis is warranted.

Key Stakeholders

Blue Cross Blue Shield of South Carolina Foundation
Clemson Extension
Colleges of Social Work
Eat Smart Move More South Carolina
Edventure
Family Solutions of the Lowcountry
Francis Marion University
Local Governments
Rural Community Coalitions
Rural Health Leaders
Rural Human Service Leaders
Rural School District Staff
Rural Volunteers
Schools of Public Health
SC Arts Commission
SC Campaign to Prevent Teen Pregnancy
SC Community Health Worker Association
SC Department of Health and Environmental Control
SC Department of Mental Health
SC Office of Rural Health
SC State 1890 Extension
The Children's Trust of South Carolina
TogetherSC

MEASURE OF SUCCESS

The AARP Livability Index is an initiative of their Public Policy Institute. The Index seeks to measure the quality of life in American communities across multiple dimensions: housing, transportation, neighborhood characteristics, environment, health, opportunity, and civic and social engagement. The Community Engagement Index includes civic engagement as a measure derived from the U.S. Census that counts the "number of civic, social, religious, political, and business organizations per 10,000 people". For the entire state of South Carolina in 2012, this engagement was measured as 10.9 organizations per 10,000 people. We will review this measure annually in accordance with the Livability Index and/or U.S. Census updates.

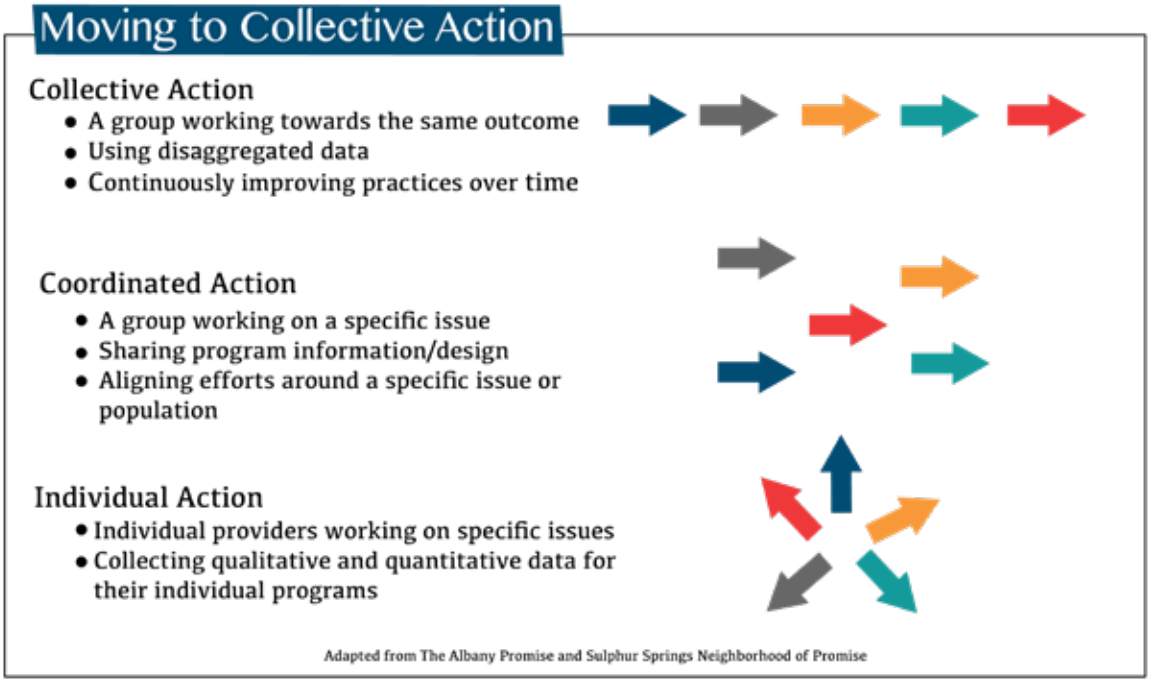
Opportunities for Civic Engagement in SC Per 100,000, 2012

RECOMMENDATION 5

Promote better state agency and statewide organization engagement, coordination, and communication around the planning and implementation of programs to ensure the needs of communities are being met.

Rationale: Research on the impact of community wealth on counties' individual *County Health Rankings* suggests that increasing spending in public health and social services gives a boost to poorer counties. While we need increases in local and state budgets, working to create efficiencies in our existing rural systems may help stretch resources further and take advantage of community connections. Coordinating health and human services also helps us to ensure that rural residents have the full-spectrum of resources needed to be healthy and have a good quality of life. The high level of alignment that is required for fully coordinated services cannot be accomplished, however, without sufficient, timely community input and bi-directional communication. Leaders also need time to build trust with one another and to be held accountable for what they agree to do. By working together and with communities to address specific needs, we can do more in a shorter amount of time to "move the needle."

> **"Convene partners around the population being served, not the issues being addressed."**
>
> *- Fred Leyda, Human Services Alliance, Beaufort County*



ACTION STEP

Encourage members of the South Carolina General Assembly to convene around and coordinate on legislation that impacts rural areas.

Ideas to Consider:

- Establishing bi-partisan committees focused on specific rural concerns
- Publishing rural specific policy updates for constituents
- Holding coordinated meetings between Assembly members and/or local elected officials at the regional level

ACTION STEP

Urge state and local funders to make new grant dollars available only to agencies and organizations who are meaningfully coordinating on behalf of and with the local community.

Ideas to Consider:

- Investing in more projects that incorporate elements of community-based participatory research, so that project leads work more closely with communities to identify problems from the local perspective and work to find appropriate solutions
- Using external evaluators for projects to determine clear demonstrations of success
- Working with and through existing rural community coalitions to coordinate community input

ACTION STEP

Facilitate state agencies and statewide organizations to organize and pool resources, including contracting with each other as needed, for engagement, coordination, and communication at the local/county/regional level to enable these groups to coordinate plans and solve problems together.

Resources:

- The American Public Human Services Association's Creating a Modern and Responsive Health and Human Services System (November 2016): http://www.aphsa.org/content/dam/aphsa/pdfs/What%27s%20New/CreatingModernResponsiveHHSsystem_APHSATransitionDocument_final.pdf
- Rural Health Information Hub's Rural Services Integration Toolkit: https://www.ruralhealthinfo.org/community-health/services-integration
- Family Resource Centers: community sites that combine health and human services such as housing, food and clothing, social services, parent education, preventive health services, etc. as seen in this example: http://www.rupri.org/Forms/HS_Humboldt_Feb2012.pdf

ACTION STEP

Launch a uniform process to effectively receive community input at the local level in order to establish community-focused priorities that inform state agencies and statewide organizations' decision-making processes.

Ideas to Consider:

- Organizing local or regional groups of Community Health Workers to develop a mechanism for community feedback on a regular basis
- Developing a statewide plan for how this input is collected and incorporated on a regular basis
- Using existing rural community coalitions and their individual networks to coordinate the process

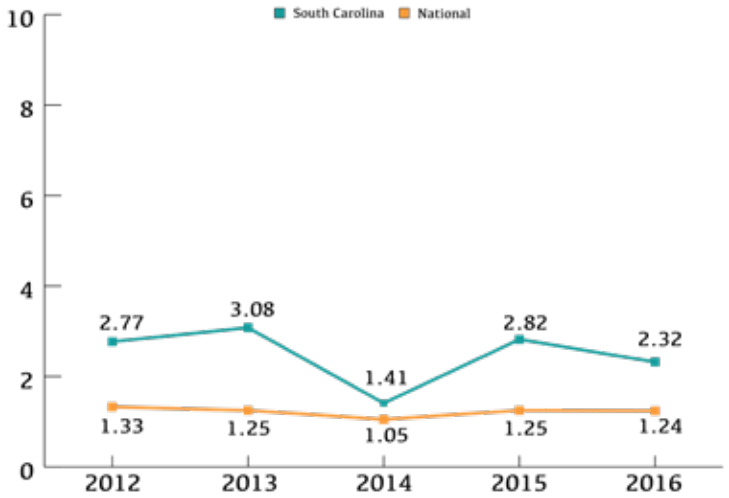
Key Stakeholders

Healthy Start Programs
Local Governments
Members of the General Assembly
PASOs
Rural Community Coalitions
Rural State Agencies
Rural Statewide Organization Offices
Rural United Way Offices
SC Campaign to Prevent Teen Pregnancy
SC Commission on Higher Education
SC Community Health Worker Association
SC Community Loan Fund
SC Department of Agriculture
SC Department of Alcohol and Other Drug Services
SC Department of Commerce
SC Department of Disabilities and Special Needs
SC Department of Education
SC Department of Health and Environmental Control
SC Department of Health and Human Services
SC Department of Juvenile Justice
SC Department of Mental Health
SC Department of Natural Resources
SC Department of Social Services
SC Department of Transportation
SC Emergency Management Division
SC First Steps
SC Grantmakers Network
SC Hospital Association
SC Lieutenant Governor's Office on Aging
SC Office of Rural Health
SC Technical College System
SC Thrive
The Children's Trust of South Carolina
Together SC

MEASURE OF SUCCESS

The Salvation Army Human Needs Index was created to provide a multi-dimensional look at poverty in the U.S. It calculates human need in real-time based on actual services provided in communities: meals and groceries given, housing payments made, clothing and furniture given, medical and energy bills paid. In 2016, the calculated amount of human need for South Carolina was almost twice the national human need. We will assess this measure at least annually, and other metrics including agency / organization customer service will be considered for future tracking.

Human Needs Index Trend in SC, 2012-2016



RECOMMENDATION 6

Foster the development of sustainable financial models for communities, supplemented by sufficient community training specific to leveraging and aligning funding from income-generation, public support, and private sources to sustain local projects and programming.

Persistent Poverty Counties, 2010

Rationale: The Economic Research Service of the USDA has designated 13 counties in South Carolina as Persistent Poverty Counties. All of these counties are rural. As we work to build upon existing Community Assets, Leadership, and Engagement, we must consider that more must be done to bolster the infrastructure of these communities. This requires capital, not only human and social capital, but financial capital as well. While grant funding is an important driver of innovation in rural areas, sustainability of services once the grant funding is over is a continual challenge. Establishing sustainable funding models for needed infrastructure and services is key to long-term strengthening of rural areas. Community Development Financial Institutions (CDFIs) and Community Development Corporations are two important pieces to this complex puzzle that can help drive these conversations locally. By providing financial services to traditionally underserved neighborhoods and communities, more community economic development is spurred. In 2015, there were 22 state-certified Community Development Corporations and CDFIs in South Carolina, and 32 additional non-certified organizations performing similar functions. Fourteen of these organizations were headquartered in a rural county.

ACTION STEP

Incentivize the development and/or enhancement of local lending programs through the South Carolina Community Capital Alliance and its members in support of community development programming in rural South Carolina.

SC Community Capital Alliance

The South Carolina Community Capital Alliance (Alliance) is a 501c4 non-profit statewide intermediary made up of a network of community development stakeholders, lenders, financiers, and investors focused on increasing capital resources for South Carolina's most underserved and undercapitalized communities to support job creation and economic opportunities. The Alliance's primary role is to bring together a network of community development finance organizations and stakeholders to leverage each organization's collective impact through enhanced coverage and capacity, improved communications, and increased access to capital. The purpose of the Alliance is to 1) facilitate community capital, 2) develop the tools necessary to increase capital, and 3) create a landscape which promotes community development investing.

ACTION STEP

Explore community development best practices for South Carolina's rural areas through specific funding for local and regional pilot projects, including consideration of non-traditional forms of investing, such as loan guarantees or other credit enhancements, that make rural projects easier to finance.

Ideas to Consider:

- Convening a rural finance summit that brings together the various lenders who have a specific interest and/or program impact in rural South Carolina
- Creating a South Carolina specific fund that brings together government, philanthropy, and financial stakeholders similar to the Uplift America Fund
- Investing in programs that directly link agricultural products to local communities such as: Farm to School, Farm to Institution, Farm to People, Farm to Summer, Farm to Belly, etc.

ACTION STEP

Ensure community input on local funding priorities is received and addressed in every rural county's municipal and/or county comprehensive planning processes.

Resources:

- South Carolina Association of Counties Planning Information: http://www.sccounties.org/planning-and-zoning
- Municipal Association of South Carolina's 2014 Comprehensive Planning Guide for Local Governments: https://www.masc.sc/SiteCollectionDocuments/Land%20Use%20Planning/Comp%20Planning%20Guide.pdf
- South Carolina Department of Health and Environmental Control's Healthy Comprehensive Planning Project: http://www.scdhec.gov/library/CR-011514.pdf

ACTION STEP

Coordinate locally and regionally between non-profit organizations, including rural community coalitions, and public entities such as Councils of Governments and/or USDA Rural Development, in applying for grant opportunities to ensure investments are sustainable.

Ideas to Consider:

- Developing a local "toolkit" of funding models that includes boilerplate language for grant writing and general fund development as well as a regularly updated calendar of open opportunities
- Leveraging the diversity of partners and identifying the strengths of each group to overcome the biases/gaps between government, non-profit, and for-profit organizations
- Working with and through local community foundations for support and networking (see the Center for Rural Entrepreneurship's Community Development Philanthropy: https://www.energizingentrepreneurs.org/solutions/community-development-philanthropy/)
- Learning from the Sheldon Township Community Support Partnership (Beaufort County) about how they use community volunteers to bring resources to their community

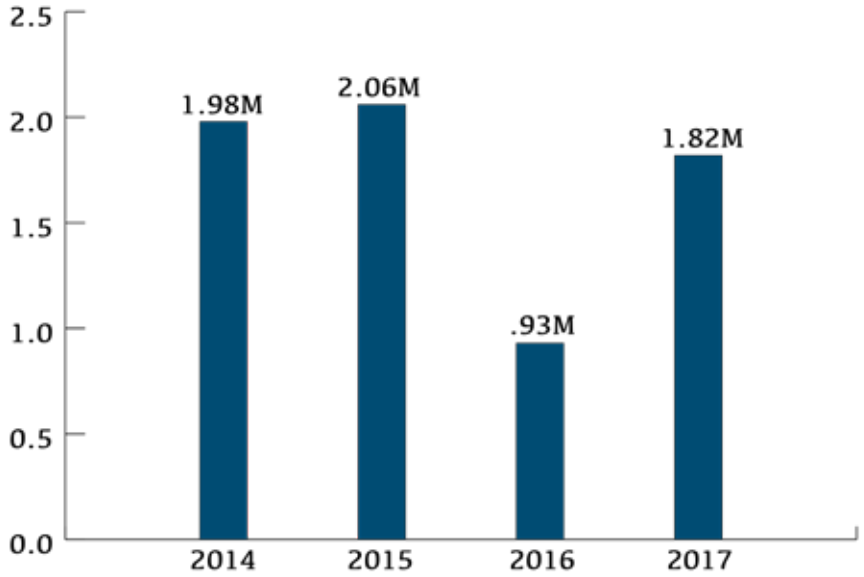
Key Stakeholders

Appalachian Regional Commission
Councils of Governments
Farm Credit Branches
Municipal Association of South Carolina
Rural Community Coalitions
Rural Hospital Foundations
Rural United Way Offices
SC Association of Counties
SC Bankers Association
SC Community Capital Alliance
SC Community Loan Fund
SC Department of Commerce
USDA Rural Development

MEASURE OF SUCCESS

Capturing individual multi-sector investments in each rural community is an area for our future exploration and work. To track success on this recommendation in the interim, we will review investments made in South Carolina on an annual basis through the Community Development Financial Institution's portfolio of programs. Since 1994, over $14 million in investments have been secured.

SC Community Development Financial Institution's Annual Portfolio in Millions of Dollars, 2014-2017



According to an analysis of the Human Needs Index (HNI) by researchers at Indiana University's Lilly Family School of Philanthropy, persistent pockets of poverty in rural America may not be apparent from traditional government measures like unemployment data, SNAP usage and the U.S. Census Bureau's Poverty Report... When the HNI values were tested against conventional measures of poverty, levels of need were higher than government services usage data would suggest.

-The Salvation Army

Chapter 5

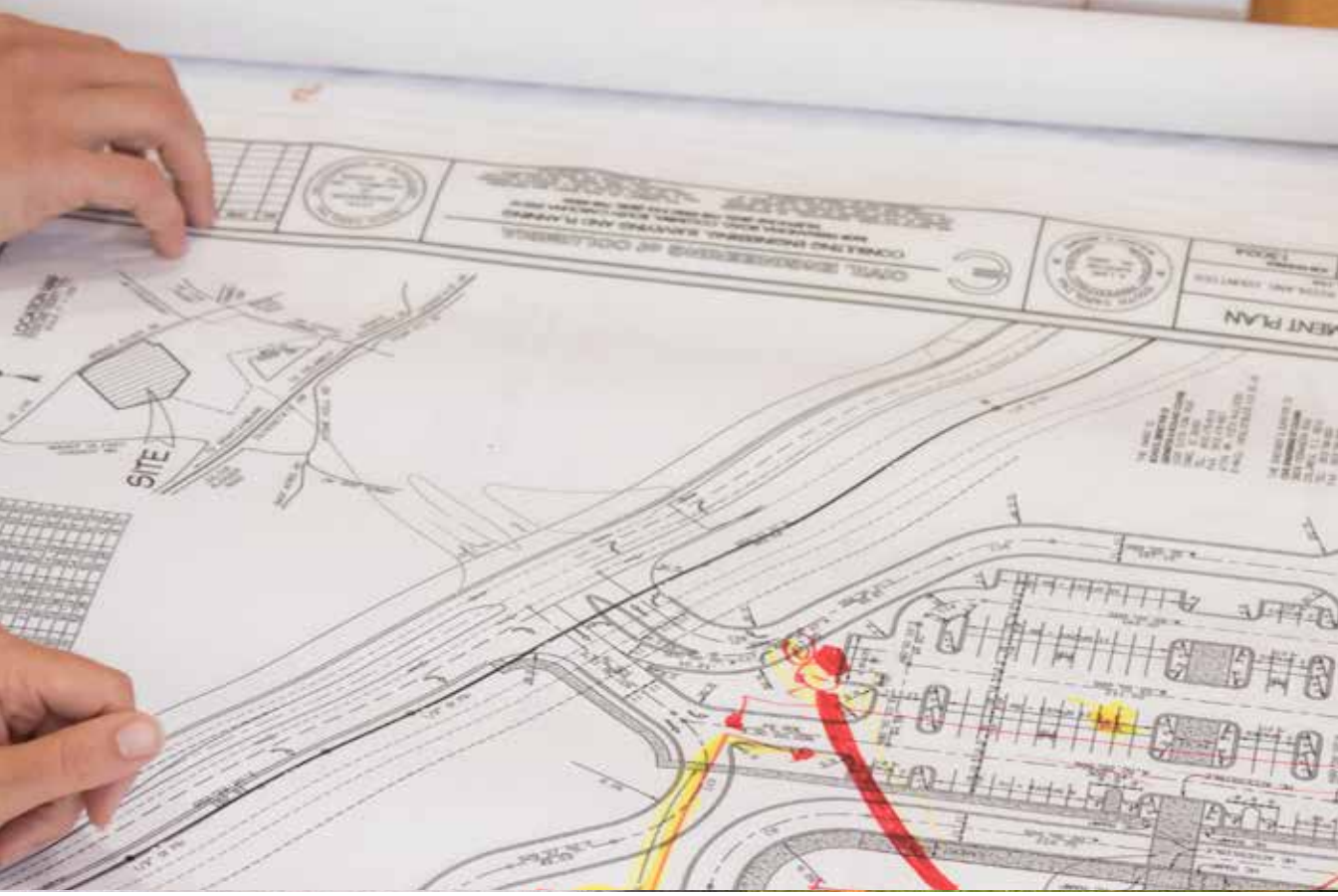
Economic Development

Healthy rural communities often depend, in part, on continued economic development investment. When rural communities lack jobs and basic infrastructure, they lack quality health care options. In order for our communities to grow and provide the resources needed for residents to thrive, we must all become engaged in efforts of expanding the economic base.

7 Ensure a diverse and well-trained workforce is actively matched with public, private, and entrepreneurial job opportunities, while removing barriers to employment.

8 Increase technical assistance and training to support teams of community members and key local partners in their efforts to attract and leverage economic development opportunities.

9 Coordinate and establish resource development opportunities and dedicated funding sources that communities can use to address their unique workforce development, growth, and quality of life challenges.



When income increases, health outcomes improve. The link between higher incomes and healthier babies, fewer chronic diseases for adults, and better mental health results in higher income individuals living on average six years longer than their lower income counterparts. This is due in part to the practical: higher incomes and wealth provide the resources to make healthier decisions and access more resources for healthy living. Higher income neighborhoods tend to be safer, have more services, have access to healthier food and exercise options, and to be more socially engaging.

However in the U.S., our rural communities and residents often struggle to improve incomes and create wealth. An increasingly global economy has shifted business patterns in the U.S., changing the dynamic of the workforce in recent years. Matching the skills and talent of the available workforce with available opportunities for growth is a constant concern for rural areas. In order to be competitive, we must work quickly and efficiently to provide the resources needed to meet industry demands. Likewise, we must work to remove barriers to employment for their workforce.

Related, economies of scale are a challenge for all sectors in rural communities. This challenge has been exacerbated by the outmigration of residents in the past few decades. As industries have closed and downsized, jobs have left communities and the people have followed. In order to stop outmigration and encourage growth, economic development that brings quality jobs into our rural communities is needed. Helping to shore up our existing businesses is also critical (including the local health care system).

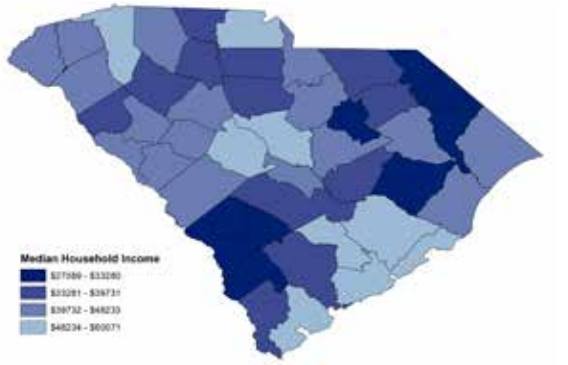
Beyond maintaining the status quo, in order for our rural communities to grow and provide the resources needed for residents to thrive, we must be willing and able to engage in efforts

> **"Bottom line: better economic conditions for American families mean longer lives and better health, and better health means lower health care costs."**
>
> *- From the report "How Are Income and Wealth Linked to Health and Longevity"*

to expand upon and add to available resources. This can be challenging due to the variance in environmental, political, social, and cultural issues from community to community. However, long-term sustainability will not be achieved for our rural communities without tapping into and leveraging multiple resource development opportunities concurrently.

Recovery from The Great Recession has been lagging in many rural communities nationally: between 2010 and 2014, rural employment only grew 1.1% compared to 5% in urban areas in the U.S. While there have been challenges in South Carolina as well, the past year has seen continued positive economic growth for our entire state. In 2016 alone, the South Carolina Department of Commerce reported 132 new

Median Household Income, 2015



economic development projects resulting in a total investment of $3.4 billion along with around 13,000 new jobs (27% of which were in rural South Carolina). Our state's export business, which sends products made here to over 25 different countries worldwide, is rated 15th highest among all states with $31.3 billion in sales in 2016.

While this growth is promising, we must continue to hold steadfast in our efforts to improve incomes for our residents, which are low compared to national standards. In 2014, the median household income for South Carolina was $45,337 compared to $51,759 for the U.S. Breaking this down even further, the median income of rural South Carolina counties was $37,501 compared to $48,537 in urban South Carolina.

More is required of our state to ensure that rural residents have the same opportunities to higher wages as their urban counterparts.

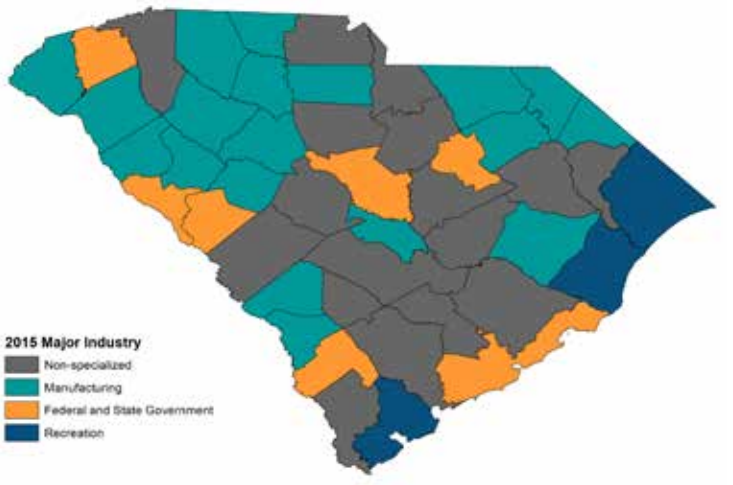
> **Developing healthy and vibrant communities depends on economic investments that build and sustain a rural infrastructure as well as create jobs.**
>
> *- Economic Development workgroup*

RECOMMENDATION 7

Ensure a diverse and well-trained workforce is actively matched with public, private, and entrepreneurial job opportunities, while removing barriers to employment.

Rationale: Helping rural residents access employment means that their training and skills must match the current jobs available in their community and that any barriers to accessing employment, such as child care needs, criminal records, or transportation, are mitigated or removed. Our state as a whole has taken a step in the right direction to match employees and employment in all 46 counties that are all now ACT Work Ready Communities; the first state to become fully certified in the nation. However, this is only one piece of an overall workforce strategy; we must consider the full breadth of industry in our rural counties. The more diverse, educated, healthy, and available our local workforce is, the more attractive our communities are to business investment overall.

Major Economic Driver Per County, 2015



Did You Know? South Carolina Workforce Facts

- ☑ According to the U.S. Bureau of Labor Statistics, for the third quarter of 2016, average weekly wages in 13 counties in SC were $699 or below, 21 counties were from $700-$799, 8 counties were from $800-$899, and 4 counties were above $900
- ☑ The average age of a farmer in South Carolina is 60 years old
- ☑ 15% of parents report job challenges related to child care; the average monthly cost of child care in the state is $1,181 a month

ACTION STEP

Partner with the South Carolina Department of Employment and Workforce to train Community Health Workers to provide proactive, individual outreach and education to rural workers before, during, and after job fairs in order to support individuals in securing employment.

Ideas to Consider:

- Using Community Health Workers to address any access to health care or transportation needs that residents may have
- Working collaboratively at the local level between the South Carolina Department of Employment and Workforce, South Carolina Department of Social Services SNAP2Work,

South Carolina Vocational Rehabilitation and local Technical College staff to ensure a comprehensive approach to residents' needs
- Developing formal partnerships with the South Carolina Child Care Resource & Referral Network and the Division of Early Care and Education at the South Carolina Department of Social Services to address child care needs
- Working with partners like SC Thrive and programs like Increasing HOPE to ensure residents have access to financial resources, including financial management tools
- Encouraging residents with criminal records to attend SC Works Expungement & Pardons Workshops

ACTION STEP

Reward entrepreneurial development in rural areas through the creation and expansion of programs that provide training and mentoring to, among others, food and farm entrepreneurs while helping them to identify startup funding.

Examples:
- Feeding Innovation – partnership between South Carolina Community Loan Fund and Clemson Extension
- Stronger Economies Together – partnership between USDA Rural Development, Clemson Extension, and SC State University
- South Carolina New and Beginning Farmer Program – led by Clemson Extension
- Growing New Farmers Program – led by Lowcountry Local First

ACTION STEP

Support local and regional libraries with the funding and resources needed to allow every branch to provide employment services, including being a South Carolina Department of Employment and Workforce Connection Point, which provides resources to community members seeking unemployment benefits.

Ideas to Consider:
- Creating or broadening job and/or career awareness campaigns with children who utilize the local library: career awareness in elementary school, career exploration in middle school, and career preparation in high school
- Partnering with SC Future Makers and/or local Career and Technology Education Centers to create awareness of jobs in advanced manufacturing that may be available locally
- Expanding the services of the "Connection Point" to provide additional support in navigating the local job market

United Ministries, Greenville

In just two years, the Employment Readiness Program at United Ministries in Greenville has helped 387 individuals complete employability skills classes, 115 individuals complete technical job training, and 192 individuals earn a WorkKeys-based CRC, with 525 jobs obtained by program clients.

Their method? "Following a four-day employability skills class, counselors work one-on-one with participants to build relationships, reinforce employability and financial skills, provide job leads, help with resumes, and remove barriers that negatively impact employment, such as transportation, childcare, criminal background, and substance abuse issues."

Excerpted from: https://united-ministries.org/education-employment/employment-readiness/

ACTION STEP

Prioritize funding for "employment readiness" programs to serve residents in every rural county, helping them to overcome barriers related to job eligibility including workplace culture training, pre-employment drug testing, expungement resources, and child care resources, among others.

Key Stakeholders

Clemson Extension
Councils of Governments
Local Governments
Lowcountry Local First
Rural Business Leaders
Rural Career and Technology Education Centers
Rural Community Action Agencies/ Community Action Partnerships
Rural Farmers
Rural Health Care Leaders
Rural Libraries
Rural Technical Colleges
SC Association of Community Action Partnerships
SC Association of Community Economic Development
SC Child Care Resource & Referral Network
SC Community Health Worker Association
SC Community Loan Fund
SC Department of Commerce
SC Department of Employment and Workforce
SC Department of Health and Human Services
SC Department of Social Services
SC Department of Social Services - Division of Early Care & Education
SC State Library
SC State 1890 Extension Service
SC Thrive
SC Vocational Rehabilitation
SC Works
USDA Rural Development

SC Department of Employment and Workforce Second Chance Program

"Under the direction of [former] Gov. Nikki Haley's office, the South Carolina Department of Corrections and the South Carolina Department of Employment and Workforce (DEW) created the Second Chance initiative to help returning citizens learn a skill and understand how to successfully search for a job. By helping individuals prepare for employment, they gain confidence, purpose, and direction, reducing the recidivism rate. In order to participate in many of these programs, specific requirements must be met by the participant, including a disciplinary-free record and non-violent offenses for incarceration.

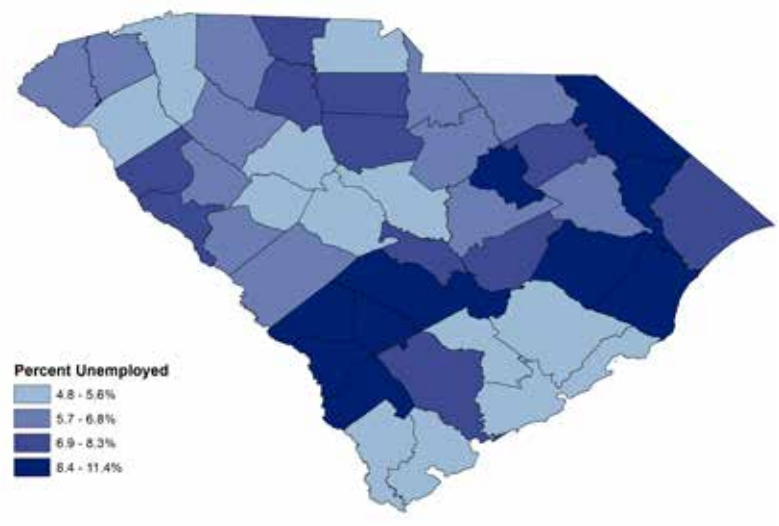
Ninety days prior to release, ex-offenders are taught employment and soft skills in class for one hour each day. During the last 30 days, participants work directly with a DEW counselor to become registered in the SC Works system, craft a resume and apply for jobs online once released. The skills they learn through the Second Chance Initiative help leverage the skills they've acquired through the work programs. Participants in the Second Chance Initiative receive a folder at the time of release that includes a Federal Bonding letter, several copies of their resume, a letter of explanation that outlines their personal situation, information on the SC Works centers across the state and contact information for a case manager in their local SC Works center, and any other information or available resources relevant to that individual."

Excerpted from: https://dew.sc.gov/tools-resources/skill-training-initiatives/second-chance

MEASURE OF SUCCESS

The overall unemployment rate in South Carolina in 2015 was 6.0%. For rural South Carolina counties, the rate was 7.6% compared to 5.8% for urban areas. We will review this measure, provided by the U.S. Bureau of Labor Statistics, annually.

Percent of Population Unemployed, 2015



Deeper Dive: Rural Veterans and the SC Workforce

The Department of Veterans Affairs (VA) estimates there are 21.3 million U.S. veterans living today, and of the current veteran population 5.1 million, or 24% of all veterans, reside in rural or highly rural areas. The state of South Carolina is home to just under 400,000 veterans with almost half enrolled for care from the Johnson VA Medical Center (Charleston) or Dorn VA Medical Center (Columbia). These hospitals serve a 27% and 20% rural veteran population; and Community-based Outpatient Clinics (CBOCs) affiliated with these hospitals provide care to a veteran population that is roughly 45% rural. CBOCs in Beaufort and Orangeburg serve the highest percentage of rural veterans at 75% and 98%, respectively.

For many veterans, factors such as access to transportation, travel distance to a VA facility, and travel costs can be a barrier to obtaining health care. Income and employment also play an important role in the ability to access and obtain health care. Results of the 2015 Survey of Veteran Enrollees' Health and Use of Health Care indicated 45.6% of veterans have a household income of less than $36,000/year; and the U.S. Bureau of Labor Statistics reported the 2016 jobless rate for all veterans was 4.3%.

The U.S. Department of Agriculture Economic Research Service reported elder rural veterans (65+ years old) were more likely to be employed in the agricultural industry while working-age veterans (18 to 64 years) relied on manufacturing for jobs. Though veterans have more education on average than their nonveteran counterparts, and may fare better economically (lower rates of poverty), it is imperative to consider the number of veterans returning to rural communities following active duty when discussing economic development. According to the USDA, "agriculture, forestry, and mining remain important sectors in some rural areas" but most job growth in rural areas of the U.S. has been in the service and retail industries.

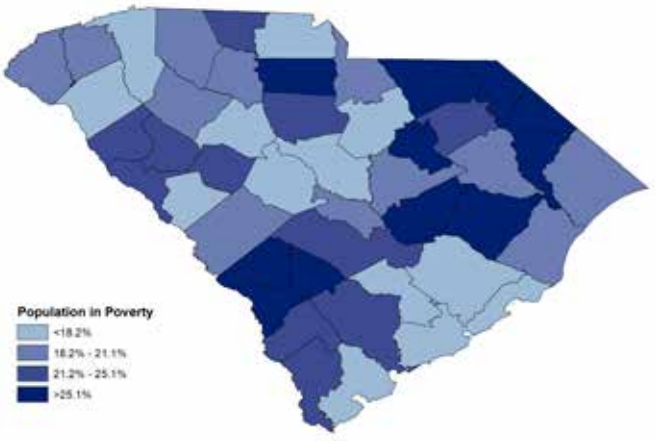
Kristen Wing, MA, Associate Director/Communications Specialist, U.S. Department of Veterans Affairs Office of Rural Health

RECOMMENDATION 8

Increase technical assistance and training to support teams of community members and key local partners in their efforts to attract and leverage economic development opportunities.

Rationale: Healthy communities are bolstered by ongoing investments in economic development and the creation of jobs that provide a livable wage. Thriving communities help attract health and health care resources, and in turn, a strong health system is needed to support communities through recruitment of professionals to the area and maintaining a healthy workforce. Although our state has been successful in recent economic development efforts, we still rank ninth highest in the nation for the total percentage of the population living in poverty. In rural South Carolina, nearly a quarter of our residents live in poverty, and a third of all our African American and Hispanic residents do. More work is needed to make economic development a "team sport" for our rural communities.

Percent of Population Living Below Federal Poverty Line, 2015



A Community Strategy: Piedmont Technical College

Piedmont Technical College (PTC) serves seven rural counties in the Lakelands region of South Carolina: Abbeville, Edgefield, Greenwood, Laurens, McCormick, Newberry, and Saluda. Opened in 1966, PTC operates sites in all seven counties and also serves students through online offerings. The Laurens campus includes PTC's Center for Advanced Manufacturing, which contains classrooms and labs specifically designed to match the technology needs of local manufacturers along/near the I-385 corridor.

Mission-focused, PTC "transforms lives and strengthens communities by providing opportunities for intellectual and economic growth." The College does this by meeting the "academic, training and public service needs of the community." One example of this commitment is its involvement in The Greenwood Promise, which began providing scholarships in 2017 to students graduating from Greenwood Districts 50, 51, or 52. The scholarships pay for nearly all expenses related to obtaining a certificate, diploma, or associate degree from PTC. This allows students to continue their education close to home while also obtaining practical skills for the jobs available in their communities.

PTC also offers a more traditional dual enrollment program for high school students, as well as a Middle College program. Middle College allows students at Ninety Six and McCormick high schools to take college credits starting in their junior year with the option to graduate with an associate degree by the time their high school graduation occurs.

ACTION STEP

Empower communities to engage in purposeful, ongoing dialogue and learning with their health care providers, economic development agencies, utility partners, local governments, and non-profit organizations to strategically work together to meet community-wide economic needs.

ACTION STEP

Build capacity among public and private partners for creating new individual and cooperatively owned business opportunities to meet local community health needs.

Ideas to Consider:

- Supporting the development and sustainability of local food retail, distribution, and value added processing establishments
- Exploring and promoting the resources within our state's Technical Colleges especially the ReadySC and Apprenticeship Carolina programs
- Partnering with local Career and Technology Education Centers, such as those in Edgefield, Fairfield, and Dillon counties to increase the number of potential workers in the "pipeline"
- Considering becoming more bicycle and pedestrian friendly as a way to drive economic and tourism development as cited in a recent report from Eat Smart Move More of South Carolina
- Collaborating with other communities at the South Carolina Annual Rural Summit hosted by the South Carolina Department of Commerce

ACTION STEP

Leverage the existing work of the regional economic development alliances to encourage groups and coalitions within local communities to market the positive attributes of their community, attracting potential new employers and residents.

Ideas to Consider:

- Leveraging the planning and development of the SC Promise Zone for ideas and inspiration in other parts of the state
- Researching the Community Apgar and Recruitable Communities models from the health care sector to increase both recruitment and retention of workers to rural areas
- Building off of the marketing slogans of the six regional economic development alliances to align messaging to potential employers and residents

Regional Economic Development Alliances

- Central SC Alliance
- Economic Development Partnership: Aiken, Edgefield, Saluda
-North Eastern Strategic Alliance
-South Carolina I-77 Alliance
-Southern Carolina Regional Development Alliance
-Upstate Alliance

ACTION STEP

Foster local, thriving food economies by convening and working with community members on local food systems activities such as agritourism, commercial kitchens, farmland access, and expanding market opportunities for local, food-producing farmers.

Ideas to Consider:

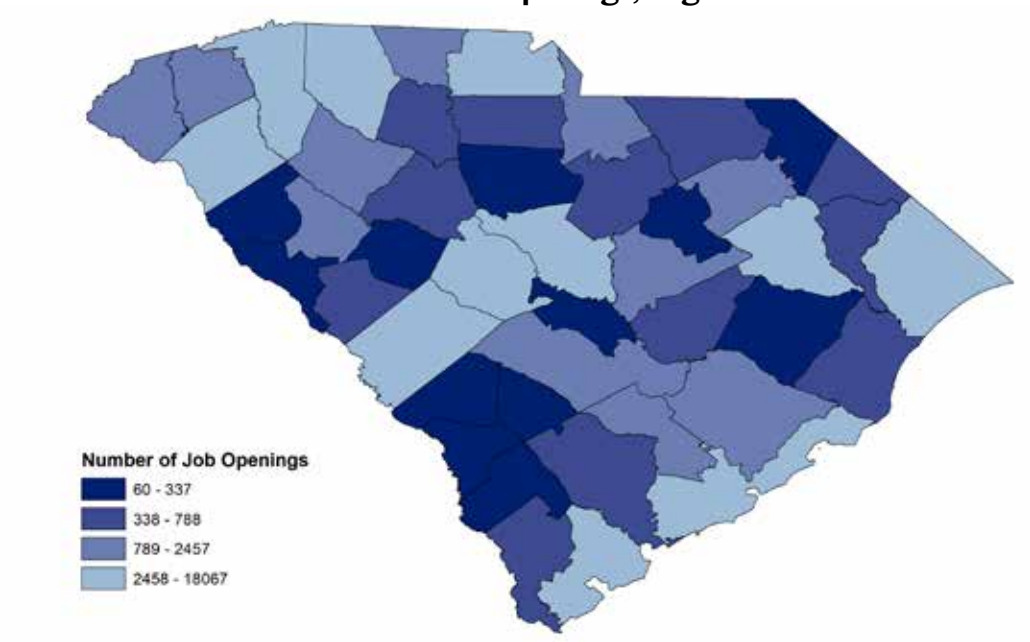
- Expanding Clemson Extension services in each county to enable extension agents to do even more to support local economies
- Exploring ways to increase the number or size of the food hubs in the state
- Developing local food policy councils that work to bring together the full spectrum of stakeholders involved in the food production cycle

- Providing low-cost education for farmers, land owners, and land seekers, especially related to programs such as SC Farm Link and the Good Agricultural Practices (GAP) Counseling and Certification

MEASURE OF SUCCESS

The number of job openings in rural South Carolina in August 2017 was 20,198 according to the SC Works Online Database. While not a perfect indicator for economic development, we will review this measure annually while we continue to consider additional metrics, such as the job openings rate, for future use.

Number of Job Openings, August 2017



Key Stakeholders

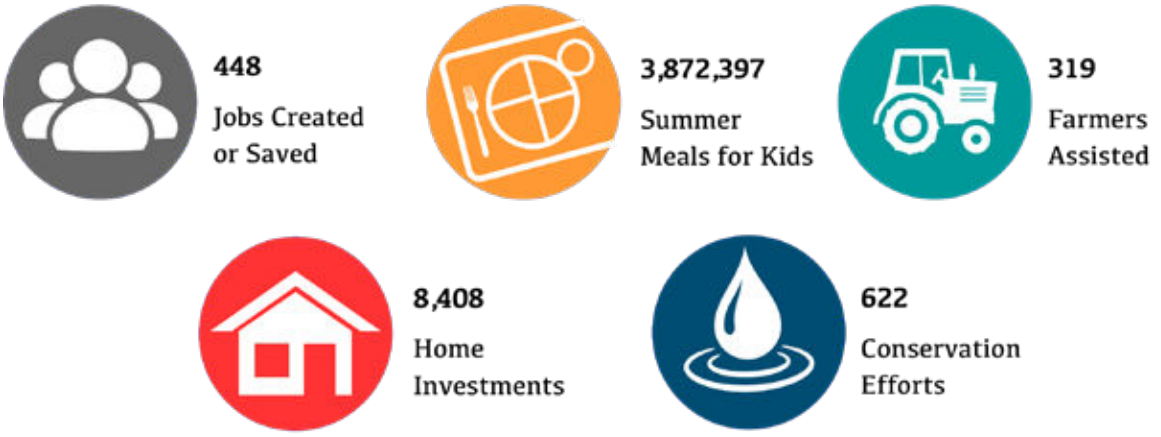
Carolina Farm Stewardship Association
Clemson Extension
Councils of Governments
Eat Smart Move More of South Carolina
Local Governments
Midlands Local Food Collaborative
ReadySC – A Division of the South Carolina Technical College System
Regional Economic Development Alliances
Rural Business Leaders
Rural Career and Technology Education Centers
Rural Chambers of Commerce
Rural County Economic Development Directors
Rural Education Leaders
Rural Health Care Leaders
Rural Land Trusts
Rural Non-Profit Leaders
Rural Utility Company Leaders
SC Association of Community Economic Development
SC Community Loan Fund
SC Department of Agriculture
SC Department of Commerce
SC Food Policy Council
SC Promise Zone
SC State 1890 Extension Service

RECOMMENDATION 9

Coordinate and establish resource development opportunities and dedicated funding sources that communities can use to address their unique workforce development, growth, and quality of life challenges.

Rationale: One of the single most important sources of our overall rural funding in South Carolina is USDA Rural Development. As part of the USDA's StrikeForce Initiative for Rural Growth and Opportunity, in 2015 alone 2,758 projects were completed for a total USDA investment of $436.6 million. The Initiative covers 27 rural South Carolina counties, mostly located in the Lowcountry and Pee Dee areas of the state. While these are significant investments, we must leverage more opportunities to fully address the growth and quality of life challenges faced in our rural areas. Much of the bricks and mortar infrastructure in our rural communities is many decades old, with too few renovations completed in that time. Without quality infrastructure, it is difficult to attract and maintain a healthy workforce, which is key to attracting economic investment; without quality investment, it is difficult to build and sustain communities' needed infrastructure. This is a vicious cycle that we must address.

StrikeForce Initiative for Rural Growth and Opportunity in South Carolina



Source: United States Department of Agriculture, StrikeForce 2015, www.usda.gov/strikeforce

ACTION STEP

Advocate for the assessment, prioritization, and integration of rural health, human service, social and environmental needs into the state Consolidated Plan for Housing and Community Development, which sets HUD funding priorities.

Resources:

- U.S. HUD General Information: https://www.hud.gov/program_offices/comm_planning/about/conplan
- South Carolina General Information: https://www.cdbgsc.com/consolidated-plan/documents
- South Carolina Plan, 2016-2020: https://www.cdbgsc.com/sites/default/files/cdbg/ProgramInformation/Substantially%20Amendeded%202016-2020%20Con%20Plan.pdf
- New South Carolina State Plan Due in 2021

ACTION STEP

Use the United Way Association of South Carolina's Self-Sufficiency Standard and Economic Security Pathways research to determine eligibility criteria and program funding levels for all South Carolina communities to ensure that resources made available are targeted to areas of highest need.

Ideas to Consider:

- Using this research to assess the impact of community grant-making to ensure aligned approaches that result in improved outcomes for rural communities
- Identifying rural communities that are located in higher wage counties that may need targeted support to bolster residents' economic self-sufficiency
- Working with policymakers using this research to determine the impact of proposed rules and regulations
- Providing education and career counseling using this research to individuals in rural communities

ACTION STEP

Promote usage of the USDA's Natural Resource Conservation Service (NRCS) Programs – such as the Environmental Quality Incentives Program (EQIP), Agricultural Conservation Easement Program (ACEP), and Conservation Innovation Grants (CIG) – that provide funding and technical assistance for local farmers as well as support conservation efforts on working lands.

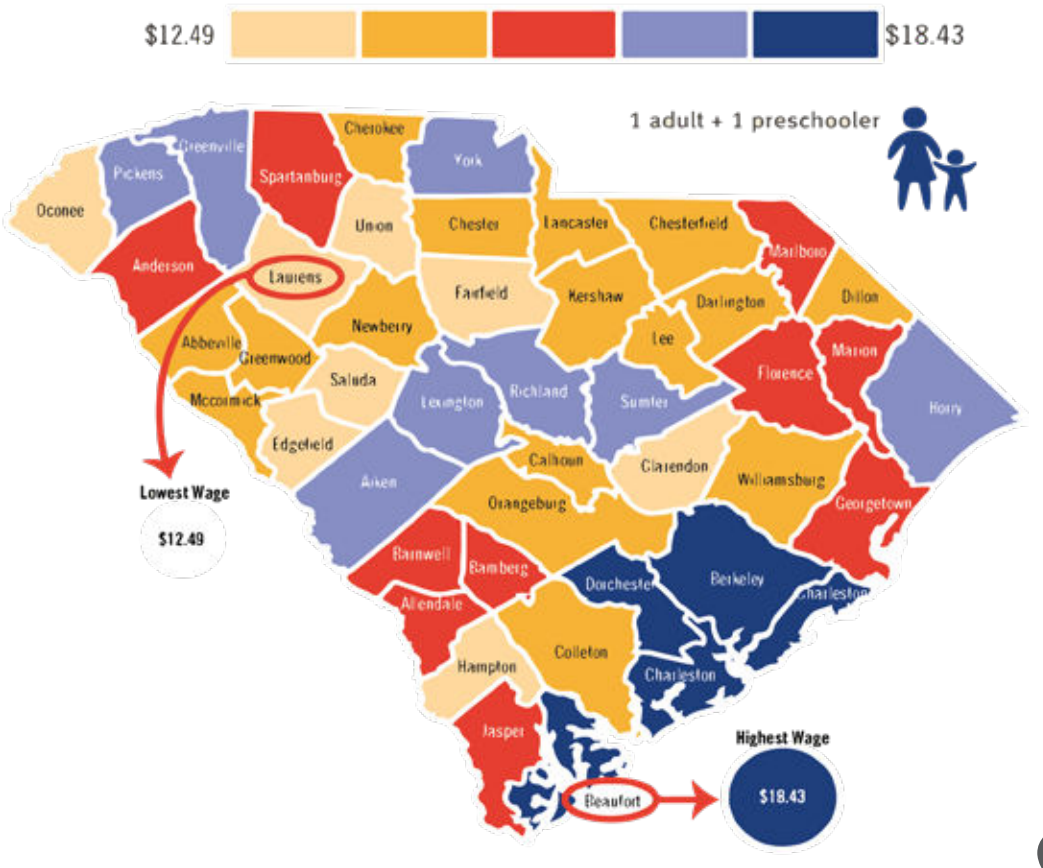
Key Stakeholders

Center for Heirs Property Preservation
Environmental Protection Agency
Minority Landowner Magazine
Rural Business Leaders
Rural Farmers
Rural Health Care Leaders
Rural Land Trusts
Rural Technical Colleges
SC Association of Community Economic Development
SC Community Loan Fund
SC Department of Commerce
SC Department of Employment and Workforce
SC Department of Natural Resources
SC Department of Parks, Recreation, & Tourism
SC Farm Bureau
SC Forestry Commission
SC Rural Resource Coalition
SC Soil and Water Conservation Districts
United Way Association of SC
USDA NRCS Program Office – SC
USDA Rural Development

MEASURE OF SUCCESS

The United Way Association of South Carolina's Self-Sufficiency Standard was calculated for counties most recently in 2016. It is a measure of the average hourly wage an individual or family must make to take care of basic necessities without any public or private assistance. We will review this metric as often as the United Way Association of South Carolina updates this research.

Hourly Wage to Achieve Self-Sufficiency by County, 2016



Chapter 6

Education

Educated communities are healthy communities. There is an extremely strong association between our educational experience and our ability to be financially independent, physically/mentally healthy, and a contributing member of our local community. Rural communities face inordinate challenges with accessing resources that support life-long learning for residents. Given these challenges, education should be defined in a much broader sense than what only happens during the K-12 school years.

10 Provide access to vocational, training, and higher education programs that will provide every student and community member the opportunity to develop skills that match with the jobs that are available to them.

11 Expand access to affordable, full-day 3 and 4-year-old programs to all families.

12 Ensure that every school district has an active Coordinated School Health Advisory Committee as outlined in the Student Health and Fitness Act (2005).

While education is important for ensuring individuals can obtain a well-paying job, there are other impacts directly related to a person's educational attainment: lower risk of disease, a longer life, and overall better health. These positive benefits convey to the children of individuals with higher education as well, and are independent of the influences of individual income.

Many in our rural communities struggle to obtain higher levels of education. Factors, such as poverty and educational attainment of parents, impact students' ability to succeed according to most educational standards, impacting their pursuit of higher education. Students who do perform well in school often leave their rural communities for college. However, there are industries located in our rural areas that need a specialized workforce, with jobs that do not require a 4-year degree. For our educators in rural communities, it becomes critical to expand options for students early in their education to ensure that they are able to pursue the best option available to them post graduation.

The years prior to children starting their formal education are an important period in developing their future opportunities as well. Children who are exposed early to learning opportunities often have better outcomes in many areas over their life course; indeed, early childhood education appears to be a protective factor against the potential for negative events as adults. Many early childhood advocates stress the importance of programs that support children and their families all the way from birth up to five years of age. Rural children

> **"More schooling is linked to higher incomes, better employment options, and increased social supports that, together, support opportunities for healthier choices."**
>
> *- County Health Rankings*

are often at a disadvantage in their ability to simply access these programs due to their resource-limited settings.

Another important issue to address among our rural children is their uptake of healthy behaviors. The ability of rural children to develop good habits including healthy eating and active living is difficult given various environmental and cultural barriers. Schools are a natural intervention site for increasing healthy behaviors early in rural children's lives since they spend a large majority of their time there. Recent efforts to address health and wellness in our schools have been well-received. However, shared accountability is needed between local schools and our communities to truly have a long-term impact on student health.

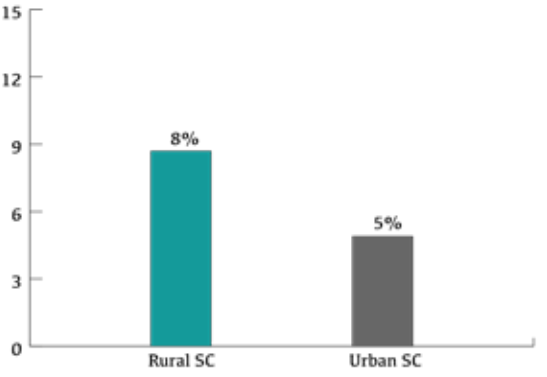
South Carolina's rural schools have had plenty of national attention in the past two decades, primarily for the wrong reasons. While some strides have been made to increase rural school funding in South Carolina, our state still ranks fourth in the nation for urgent rural education needs. The percentage of children in a school system who are eligible for free and reduced lunch is used as a measure of then socioeconomic status of the student population. In rural South Carolina counties, 67% of our children are eligible for free or reduced lunch while in urban counties only 49% of children are eligible. The national percentage is 48.1%.

A comprehensive, life-long educational experience is necessary to improve the community's ability to achieve academic, employment and social progress.

- Education workgroup

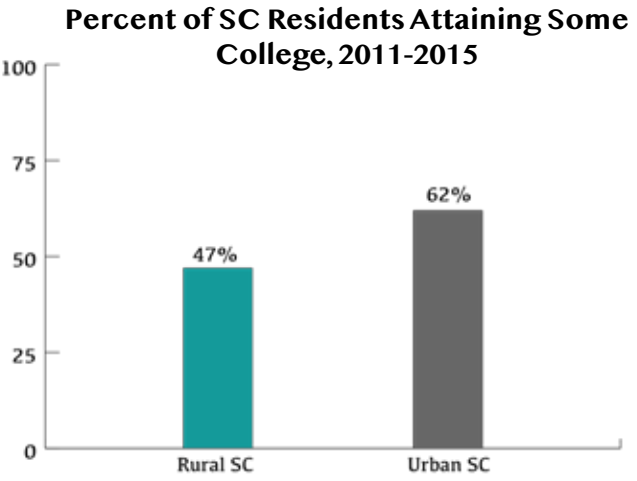
According to the 2015 Kids Count data for South Carolina, 8.3% of students in our rural counties were failing grades 1, 2, or 3. In urban counties, only 4.9% of students were failing grades 1, 2, or 3. (This data only includes public schools, as private schools are not required to release data regarding the benchmarks of their students.) We must do more to help ensure the success of our rural children.

Percent of SC Students Failing Grades 1, 2, or 3, 2015



RECOMMENDATION 10

Provide access to vocational, training, and higher education programs that will provide every student and community member the opportunity to develop skills that match with the jobs that are available to them.



Rationale: Overwhelming poverty, challenging family situations, the overall education of the adults in the community, and even the metrics used to score an educational system, all impact the success of students. Despite these challenges, rural South Carolina students have a public high school graduation rate only 1% lower than urban students. However, enrollment in and completion of college is much lower among our rural residents. One factor causing this may be tuition costs; in the 2012-2013 academic year, South Carolina had the 10th highest in-state tuition for 4-year public universities. Other factors may include family obligations and lack of role models that encourage college. We must address this important issue in the next decade: by 2030, 66.7% of all jobs will require some form of higher education. Our state must ensure the foundation that will prepare South Carolina's residents for the future, no matter their age or stage in life, and no matter where they live in our state.

ACTION STEP

Supplement the South Carolina Educational Lottery System with specific resources to enable all rural students, regardless of age, to access scholarship funding for a broader range of educational programs provided in the state.

Ideas to Consider:

- Establishing eligibility criteria for non-traditional students below age 60 who want to earn a degree
- Funding vocational training programs based on community need that are otherwise not offered in institutions eligible for lottery scholarships (e.g. cosmetology, truck driving, etc.)
- Providing and highlighting opportunities for online courses for rural students

ACTION STEP

Sponsor mentoring programs for all rural youth, especially those programs that utilize the skills of retirees who are interested in giving back to younger generations in the community, to stimulate a culture of life-long learning and teaching in rural areas.

Intergenerational Mentoring: An Idea to Explore

"Intergenerational mentoring is a suggested strategy to increase mentors' sense of self-worth, accomplishment, and well-being. Older adults who participate in intergenerational mentoring programs become part of a network of volunteers and develop meaningful relationships with their mentee(s). Available evidence suggests that intergenerational mentoring can also improve social connectedness, physical and mental health, functioning, and self-esteem for mentors. However, additional evidence is needed to confirm effects.

Intergenerational mentoring can improve participating youth's attitudes toward aging and older adults, increase academic achievement and social development, and decrease substance use and school absences. Overall, mentoring programs increase positive educational outcomes for participants and appear to reduce delinquent behavior for youth at risk of delinquency.

Successful intergenerational mentoring relationships involve matching individual mentor's strengths and resources with the needs of potential mentees, incorporating youths' perspective, and supporting youth-driven interactions. Older adults' life experience and emotional stability prepare them well to advise at-risk youth."

Excerpted from County Health Rankings What Works for Health: http://www.countyhealthrankings.org/policies/intergenerational-mentoring

ACTION STEP

Share educational and training facilities between school districts, Technical Colleges, and employment programs within communities so that different populations may take advantage of the same physical space, to the maximum benefit of the resource.

Ideas to Consider:

- Developing Makerspaces where creative types such as artisans, craftsmen, or others who like to invent or learn new skills can partner with Career and Technology Education Centers or Technical Colleges in rural areas to promote shared learning and innovation across populations
- Providing educational and training programs in industry settings as much as possible to facilitate "on-the-job" learning and to improve efficiency of training resources
- Creating a culture of learning in rural communities, such as the Spartanburg Academic Movement: http://www.learnwithsam.org
- Developing "Community Schools" whereby services beyond education (physical and mental health care, social services, etc.) are provided under one roof and for the entire community beyond the typical school day

Key Stakeholders

Private rural job training programs
Rural Colleges & Universities
Rural School District Boards
Rural School District Staff Members
Rural Technical Colleges
SC Association of School Superintendents
SC Department of Social Services
SC Commission on Higher Education
SC Department of Education
SC Department of Employment and Workforce
SC Department of Social Services
SC Technical College System

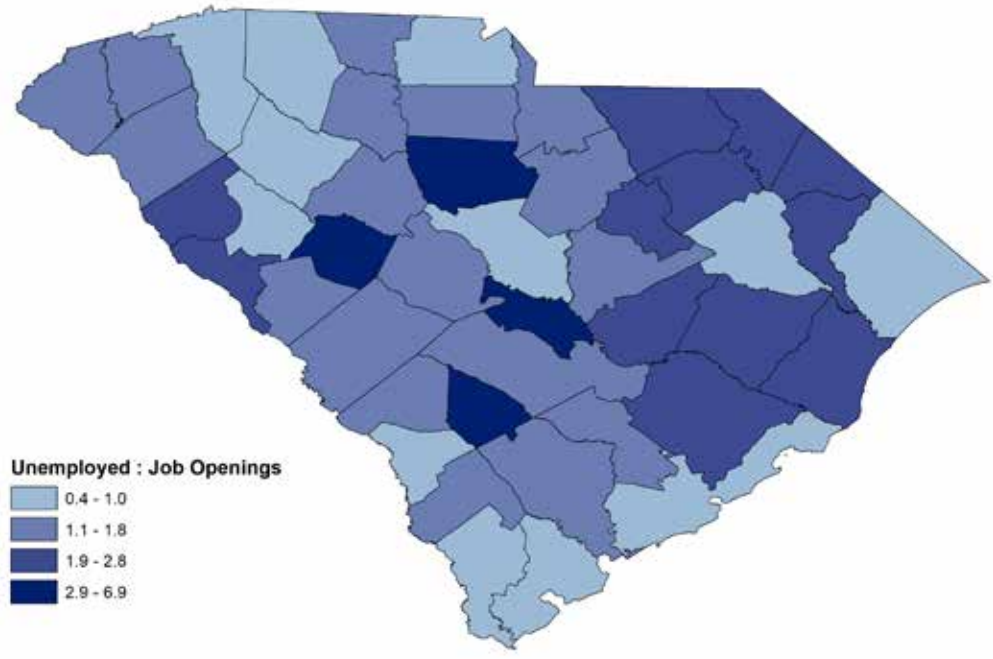
Deeper Dive: Mentoring for Success

The Mentoring for Success program in Greenwood's School District 50 is a mentoring program designed to bridge the gap in academic and social development for under-performing young males in the Greenwood community. Formed by a group of adult male community leaders, program participants are paired with a mentor to learn how to conduct themselves both as students and citizens in the community. Mentors meet monthly in either one-on-one, small group, or large group settings with participants to connect on a deeper level and explore core principles of how to be successful in life. The second Tuesday of each month participating boys and adults wear bow ties to school or work to bring awareness of the program and its impact on the lives of young males in the community. The Mentoring for Success program also takes action to help students who would like to continue their education at a 4-year institution or technical college. Through generous donations, and an annual golf tournament, the program is proud to present an annual scholarship to participants in the program. Over the past four years, the Mentoring for Success program in Greenwood's School District 50 has raised over $28,000 in scholarship funds for the program participants.

MEASURE OF SUCCESS

The SC Works Online Database calculates workforce supply and demand at the county level. For rural South Carolina the ratio of average number of unemployed persons to average job postings in August 2017 was 1.5. We will track this measure at least annually.

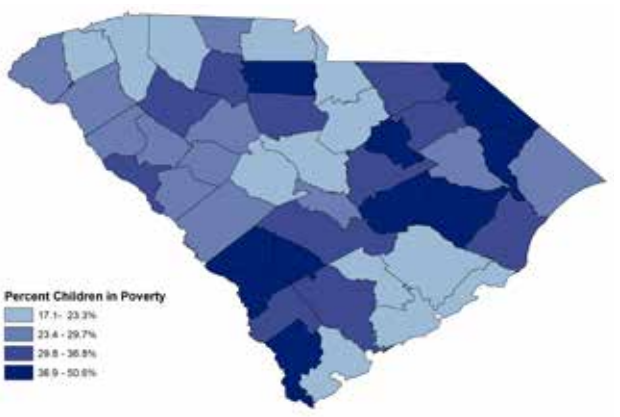
Ratio of Unemployed Persons to Job Openings, August 2017



RECOMMENDATION 11

Expand access to affordable, full-day 3 and 4-year-old programs to all families.

Percent of Children in Poverty, 2015



Rationale: The long-term benefits of early childhood education are well documented. Overall, children who attend preschool programs are more likely as adults to have jobs, to complete high school, and commit fewer crimes than those who did not attend preschool programs. And yet, 56% of 3 and 4 year olds in South Carolina are not enrolled in any type of pre-school. It is imperative that we do more to reach this population due to the high number of rural children in poverty. 35% of our rural children ages 0-17 are living in poverty, and a quarter of our urban children are. If we do not provide support now, their health and economic well-being for their entire life course will be shaped by these conditions. Support for low-income families came from our General Assembly in 2017 in the form of a first-ever State Earned Income Tax Credit; but more must be done to ensure families are able to give their children the best start in life.

ACTION STEP

Develop a pilot program within the South Carolina Education Oversight Committee to study the addition of a full day rural South Carolina Child Early Reading Development and Education Program (CDEP) for 3 year olds to evaluate the feasibility of expansion to this population.

Ideas to Consider:

- Using carry-forward funding from the current CDEP each year to secure pilot funding
- Working with Head Start to target known areas of need for 3-year-old programs
- Conducting a gap analysis of services in targeted rural communities based on the policy work of the Institute for Child Success

SC Child Development Education Program

The South Carolina Department of Education administers the South Carolina Child Development Education Program (CDEP), which provides funding to school districts in impoverished areas to provide full-day 4-year-old kindergarten for eligible children. Eligibility is based on the child's age and a family income of 185% or less of the Federal Poverty Level or Medicaid eligibility. During the 2016-17 school year, CDEP served almost 14,000 South Carolina children; 86% of those children attended 4k in a public school setting (in 246 schools). The remaining were served in a South Carolina First Steps or other private program (in 188 centers). 60% of all South Carolina children (35,183) are at-risk for not being ready for kindergarten; CDEP is able to provide services alongside HeadStart and the ABC Voucher Program to approximately 20,000 of these children. For children in our state's rural communities this is a highly important program due to already limited child care and preschool options. Early program outcomes demonstrate improvement in children's progress over the same course of the school year as well as school readiness targets being met.

ACTION STEP 

Expand funding and eligibility for the existing South Carolina Child Development and Education Program (CDEP) to include all children whose family income is below 400% of the Federal Poverty Level in order to better prepare our state's children for their future.

ACTION STEP 

Invest in public-private partnerships to support the development of additional 3 or 4-year-old programs in local communities where public programs are limited or do not exist.

Ideas to Consider:

- Helping to provide or direct capital to rural school districts who may want to provide or expand their CDEP but do not have adequate space
- Supporting comprehensive early childhood programming for all rural children ages 0-5 in order to fill gaps created by eligibility criteria and waiting lists for Federally-funded programs
- Providing funding for after school child care for private programs that only have half day school
- Facilitating greater awareness of existing programs among families through such efforts as South Carolina First Steps' Countdown to Kindergarten home visitation program
- Promoting early learning and engagement in pediatrician or family medicine practices through programs such as Reach Out and Read Carolinas: http://www.rorcarolinas.org

ACTION STEP 

Consider ways to incentivize providers to make 3 and 4-year-old programs more accessible, including through co-location of programs for early childhood with programs for adults, in order to provide safe, convenient, and affordable options for working families in rural areas.

Ideas to Consider:

- Encouraging new construction and/or rehabilitation of multi-use areas that include retail and service opportunties alongside housing
- Considering Early Childhood Education services and facilities as an economic driver for local communities, to be included in economic development discussions
- Replicating models such as GLEAMNS or Anderson Interfaith Ministries that co-locate multiple support services in one setting

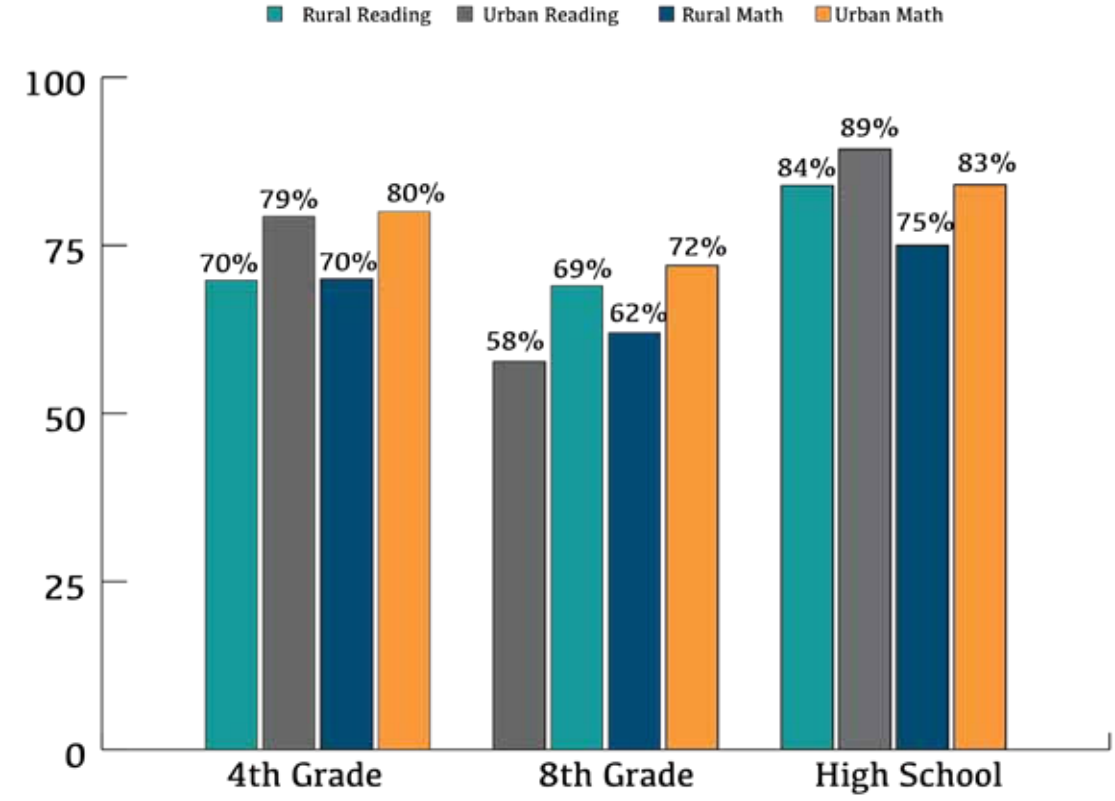
Key Stakeholders

Institute for Child Success
Rural Child Care Providers
Rural Community Action Agencies / Community Action Partnerships
Rural Head Start Programs
Rural School District Boards
Rural School District Staff
SC Association of School Superintendents
SC Community Loan Fund
SC Department of Education
SC Department of Social Services
SC Education Oversight Committee
SC First Steps
SC State Head Start Association
The Children's Trust of South Carolina

MEASURE OF SUCCESS

There is currently not a standard way to measure school readiness in South Carolina. The Kindergarten Readiness Assessment is being introduced in the 2017 school year. For now, we will annually review the math and reading proficiency of rural and urban South Carolina students as reported by the United States Department of Education.

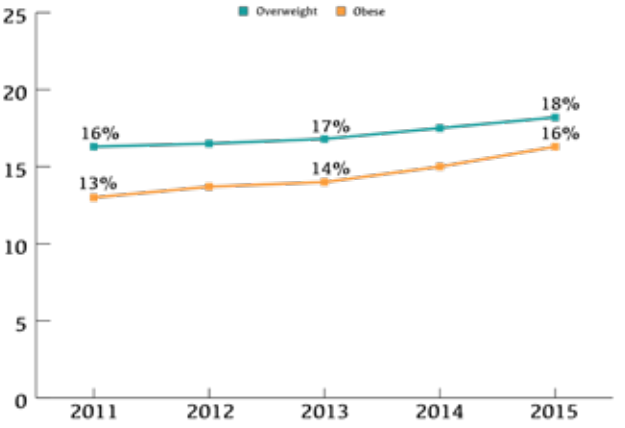
Percent of SC Students Proficient in Reading and Mathematics, 2015



RECOMMENDATION 12

Ensure that every school district has an active Coordinated School Health Advisory Committee as outlined in the Student Health and Fitness Act (2005).

Percent of SC Adolescents who are Overweight/Obese, 2011-2015



Rationale: Schools play an important role in influencing the health of their students and our communities. Likewise, the health of students plays a role in their ability to be academically successful. Simply stated, students that eat nutritious foods and are physically active fair better on cognitive tests and perform better in school overall. The South Carolina Student Health and Fitness Act of 2005 was passed by the General Assembly to address nutrition, physical activity, and access to school nurses, through an overall comprehensive look at school health in our state's public education institutions. One of the many reasons that our state needs to address these concerns is highlighted by the overwhelming statistics regarding childhood obesity. In 2015, according to the Centers for Disease Control and Prevention, 34.5% of adolescents in our state were overweight or obese.

Deeper Dive: Programs for Healthy Meals

There are several programs available through USDA's Food and Nutrition Service which provide nutritious meals and snacks to students including:

School Breakfast Program: Assistance to states to operate breakfast programs in schools and residential childcare programs.

National School Lunch Program: Nutritious low-cost or free lunches to children in schools and residential childcare programs.

Special Milk Program: Reimburses schools for milk they serve to children who do not participate in other federal meal service programs.

Child and Adult Care Food Program: Afterschool Program: Nutritious meals and snacks for afterschool programs served in a group setting to children and teenagers.

Summer Food Service Program: Provides funding to local sponsors who want to combine a meal program with a summer activity program for children 18 years old and younger.

https://www.ruralhealthinfo.org/topics/schools

ACTION STEP

Find ways to collectively fund schools that participate in existing health programs while also providing additional resources for other school initiatives that meet student health needs.

Pee Dee Resiliency Project

"Early adversity in the home can send children down a path to lifelong negative health and social outcomes. That's why Children's Trust of South Carolina is teaming up with the SC Department of Mental Health, University of South Carolina School Behavioral Health Team, and Pee Dee Mental Health Center in a three-year project funded by the BlueCross BlueShield of South Carolina Foundation.

The Pee Dee Resiliency Project (PDRP) is a community-based partnership for students and their families at nine elementary schools in Florence, Darlington and Marion counties. The goal is to help them to prevent and address emotional and behavioral challenges resulting from adverse childhood experiences that interfere with a student's success.

Louise Johnson, the director of children's services at the SC Department of Mental Health's Division of Children, Adolescents and Families said "I've always thought services in elementary schools should be somewhat unique and tailored to meet the specific needs of children and families. The earlier we can get involved, the more impact we can have in the long run when children get to middle and high school."

The idea of supportive schools and connected communities helping build healthy children and resilient families appealed to the BlueCross BlueShield of South Carolina Foundation. Erika Kirby, the senior research analyst and grants manager, said "The work and the opportunity to address adverse childhood experiences in a school-based, coupled with a community-wide, approach hasn't really been done before. In this particular project, we start with a small collection of communities with the mindset to design a model that can be replicated in other communities."

www.scchildren.org/blog/2017/08/02/organizations-partner-with-pee-dee-elementary-schools-in-three-counties-to-promote-resiliency/

ACTION STEP

Offer annual training to members of each Coordinated School Health Advisory Committee (CSHAC) about available resources, best practices, and other relevant health promotion topics to promote coordination with the local health care system.

Resources:

- Alliance for a Healthier Generation
- Eat Smart Move More South Carolina
- LiveWell Kershaw / LiveWell Greenville
- SCaleDown
- SC Campaign to Prevent Teen Pregnancy
- SC DHEC Bureau of Health Improvement & Equity
- SC DHEC Regional Community Health Staff
- School-Based Mental Health Counselors
- South Carolina FitnessGram

ACTION STEP

Include health care providers, retired educators, and other interested parties in each CSHAC in addition to the required members to ensure diversity among volunteers as well as to garner support from a broader set of community members.

Ideas to Consider:

- Incorporating community outreach / marketing departments of local hospitals
- Providing peer encouragement among professionals to support involvement and engagement in CSHACs

- Partnering with local businesses to engage their leadership in school wellness
- Encouraging parent/guardian involvement by helping remove barriers to participating

ACTION STEP

Join with local school district(s) to support, promote, and evaluate the activities of each CSHAC as a sign of the importance of the Committee as well as to highlight positive outcomes achieved by students and schools.

Ideas to Consider:

- Developing community-wide goals for action related to health and wellness with feasible site specific plans
- Connecting to existing community coalitions that can provide leadership, support, and/or expertise
- Utilizing data from annual school health profiles completed for the South Carolina Department of Education to drive decision-making and goal setting

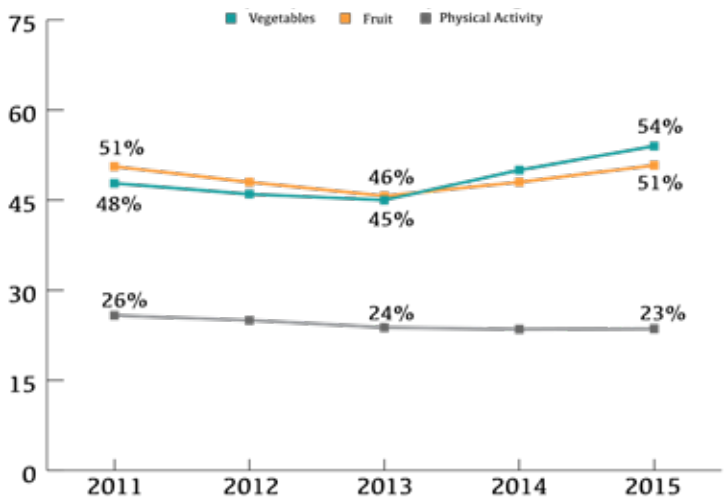
Key Stakeholders

Alliance for a Healthier Generation
Clemson Extension
Eat Smart Move More South Carolina
Rural Businesses
Rural Federally Qualified Health Centers
Rural Health Care Leaders
Rural Health Clinics
Rural Hospitals
Rural Parent Teacher Student Associations
Rural School District Boards
Rural School District Staff
Rural School Nurses
SCaleDown
SC Association of School Superintendents
SC Campaign to Prevent Teen Pregnancy
SC Child Health & Well-Being Coalition
SC Coalition for Healthy Families
SC Department of Education
SC Department of Health and Environmental Control
SC Department of Health and Human Services
SC State 1890 Extension Service

MEASURE OF SUCCESS

23.6% of adolescents in South Carolina were physically active at least 60 minutes per day on all 7 days in the past week (data from 2015). 53.3% of South Carolina adolescents reported consuming vegetables less than one time daily and 50.8% reported consuming fruit less than one time daily. We will monitor these data, from the Centers for Disease Control and Prevention, at least annually.

Percent of Fruit & Vegetable Consumption & 60 Min of Daily Physical Activity Among SC Adolescents, 2011-2015



Chapter 7

Housing

When housing options for families improve, so does their ability to lead healthy and productive lives. Rural residents in our state spend on average twice as much of their income on housing and transportation costs compared to the national standard. A low median income for rural communities adds to the challenges and hard choices our residents must make on where they spend their remaining income for food, health care, and child care, impacting the overall wealth of our rural communities.

13 Repair and replace substandard housing units to improve the quality, safety, livability, accessibility, and energy efficiency of existing housing stock.

14 Increase the supply of affordable housing through new or existing local, state and federal programs including matching state low-income housing tax credits.

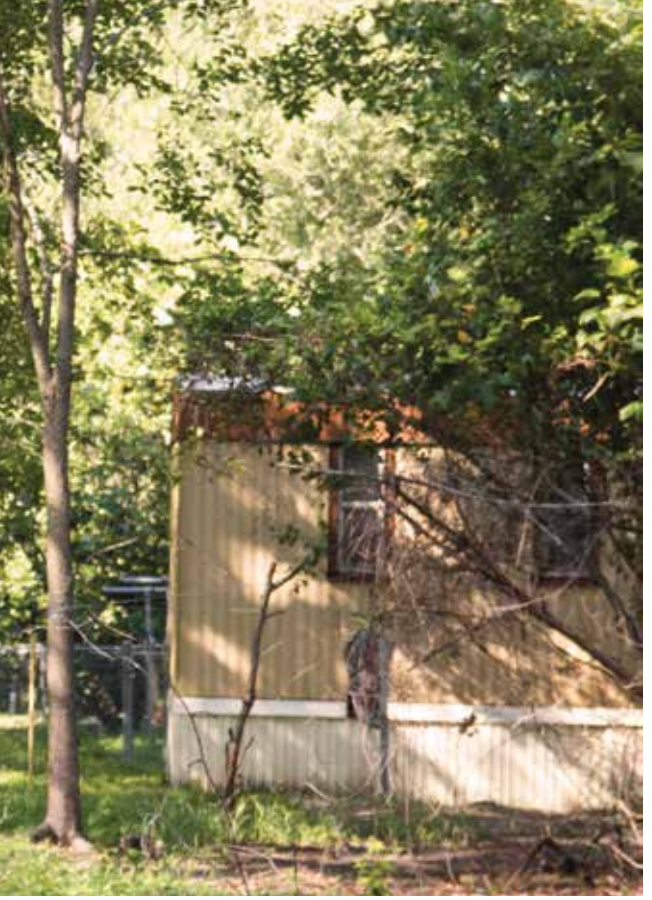
15 Improve access to safe, reliable, and affordable infrastructure and services including clean drinking water, sanitary sewer, and residential broadband access.

Many Americans have come to relate the word "house" with "home" – that is, the place where we find and seek our refuge. Nowhere is this truer than in rural communities. For most Americans, the place where we live is also our single highest expense, and many of us spend a great deal of time in our home. When problems arise with housing, our health may be affected. Homes in need of repair, a lack of affordable housing, and poor community infrastructure have been shown to negatively impact health outcomes.

If the home where we live is not in good repair, this can have a dramatic impact on our physical, mental, or emotional health. Conditions such as cancer, heart disease, asthma, and even infectious diseases may be linked to poor housing. Lead poisoning is a well-known cause of childhood developmental delays. Unsafe conditions in the home may create an opportunity for injury to occur. For low-income individuals and families, this problem is compounded, as they are most likely to experience these conditions and least likely to be able, from a financial standpoint, to fix them.

> **Quality, affordable housing with supporting infrastructure must be available in rural South Carolina.**
> *-Housing workgroup*

A lack of affordable housing in our rural areas is also an issue. Limited housing options often force people into unhealthy living situations or, in some cases, moving homes frequently if they are renting. Also, the more money that is spent on housing, including utility and maintenance costs, the less there is to spend on health maintenance behaviors.



The constant stress of trying to maintain housing and other financial obligations is also a risk factor for poor health.

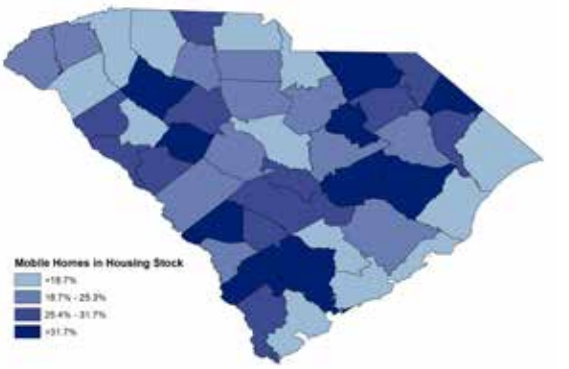
The quality of our environment in rural communities is also a concern due to aging or non-existent infrastructure. From a recent CDC *Morbidity and Mortality Weekly Report*, rural counties in the U.S. were seen to fair better with regards to air quality as compared to urban areas. However, water quality issues were somewhat worse in rural areas. Private wells and septic systems are still in use in many homes in rural South Carolina, adding to potential disease outbreak concerns. As system upgrades and repairs are needed on basic services such as water and sewer, new technologies such as broadband must also be addressed to ensure our rural communities are not limited in their ability to compete.

> **"Internet access in this county is horrible, as far as [broadband] your options are extremely limited."**
>
> *- Rural Community Leader*

A 2016 report from the Urban Institute projected upcoming housing needs in rural America. As rural Americans age and growth occurs in urban areas, the demand for housing in rural areas will actually increase as the housing stock is not refreshed as frequently, and more seniors choose to stay in their homes as they age. Affordability will be a concern for this population, due to needed home repairs to ensure accessibility as health issues arise that require accommodations such as wheelchair ramps. As seniors utilize a higher percentage of the resources available to either repair their homes or find new ones, this may create a disadvantage for families seeking the same resources.

South Carolina's data concur with these national trends. Home ownership is high in rural South Carolina where 72% of our residents own their homes, compared to 68% of residents in urban areas of the state. 47% of rural homeowners also have no mortgage on their home, compared to 34% of urban homeowners. However, our rural areas have a much higher percentage of mobile homes in their housing stock, 25% compared to 14% in urban. A CDC report entitled *Safety and Health in Manufactured Structures* cited multiple health hazards potentially present in mobile homes: lack of structural integrity and building performance, fire hazards, access to safe utilities, moisture and/or mold problems, concerns with pests and pesticide use, and indoor air quality, among others.

Percent Mobile Homes in Housing Stock, 2013

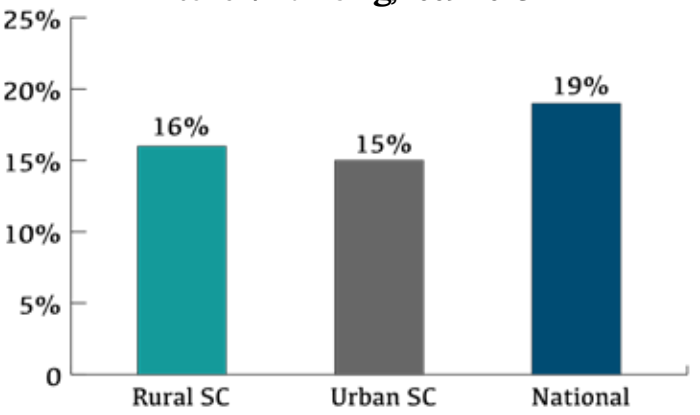


RECOMMENDATION 13

Repair and replace substandard housing units to improve the quality, safety, livability, accessibility, and energy efficiency of existing housing stock.

Rationale: In 2013, rural South Carolina was comprised of 619,756 housing units, of which 492,764 were occupied (75%). One third of these occupied units were considered to be "inadequate" based on issues of overcrowding, high costs, and/or lack of appropriate plumbing or kitchen facilities; a number of these homes were in persistent poverty areas. Overcrowding is an issue in our rural areas since people often want to remain nearby their family members and/or family homes. Even with these concerns, many rural residents are determined to stay in their homes as a matter of family pride as well as independence. To improve health in rural areas, we must alleviate the issue of substandard housing through home repair and rehabilitation services.

Percent of Households in SC with at least 1 of 3 Problems: Overcrowding, High Cost, Lack of Kitchen/Plumbing, 2009-2013



ACTION STEP

Increase funding to the South Carolina Housing Trust Fund in order to provide additional resources targeted to replacing substandard housing in rural communities.

South Carolina HousingTrust Fund

SC Housing provides financial assistance for the development, rehabilitation, and acquisition of affordable housing for low-income and very-low-income households. As Administrator of the Housing Trust Fund, SC Housing strives to maximize federal, state and other housing assistance programs. The Trust Fund delivers funds through established partnerships with other governmental entities, qualified non-profit sponsors, and for-profit sponsors. The Trust Fund does not make funding awards directly to individual citizens, but instead works through a network of partners, including governmental and non-profit entities. These organizations apply for funding for one of the activities listed below, and then use the funds to provide affordable housing to eligible citizens.

- ☑ Emergency Repair
- ☑ Owner-Occupied Rehabilitation
- ☑ Group Homes
- ☑ Supportive Housing

http://www.schousing.com/Housing_Partners/Housing_Trust_Fund

ACTION STEP

Stimulate proactive coordination among privately funded groups, especially faith-based organizations and non-profit organizations, to drive conversations about effective ways to globally meet community needs.

Ideas to Consider:

- Encouraging groups to list their programs and eligibility criteria on statewide and local resource directories, such as those moderated by SC Access (provided by South Carolina Lieutenant Governor's Office on Aging), the South Carolina Assistive Technology Program, or SC 2-1-1
- Supporting organizations to attend trainings held by such organizations as the ReFrame Association
- Promoting partnerships with public entities such as USDA Rural Development to help drive down waiting lists and to leverage enough funds to make a real impact both for individual homeowners and neighborhoods
- Finding common issues to address together: accessibility renovations for seniors, vulnerabilities during natural disasters, addressing health issues, etc.

ACTION STEP

Construct or enhance local and/or regional Affordable Housing Coalitions that serve to inventory current housing stock, coordinate resources, and assist in housing transitions, among other tasks, in support of low-income communities.

Example:

- The Lowcountry Affordable Housing Coalition is a Committee of Together for Beaufort County. The Coalition recently had an Affordable Housing Resolution passed by the Beaufort County Council that gives life to its recommendations for the county including a Housing Coordinator, a county-wide housing inventory, a transition shelter for homeless individuals, permanent supportive housing for the mentally ill and disabled, and re-establishing a fund to help reduce impact fees in low-income situations.

ACTION STEP

Grow the number and capacity of public housing programs in rural areas to provide alternative options for very low-income and/or disabled individuals.

Ideas to Consider:

- Exploring the use of HUD's Rental Assistance Demonstration to leverage capital for rural Public Housing Authorities
- Establishing partnerships, between public housing authorities and entities that provide emergency assistance for rent and utilities, to provide support to individuals and families affected by long waiting lists (up to 5 years in some areas)
- Collaborating with the SC Department of Mental Health and their network of over 40 nonprofit groups statewide that support their Housing and Homeless Programs

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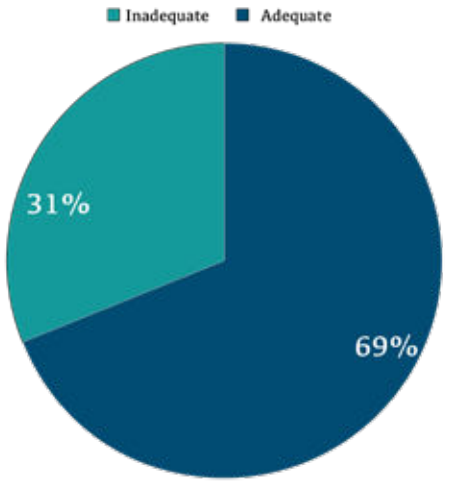
"Less than 5% of our housing stock is public housing. Therefore, only 15% of those eligible for public housing are able to secure housing and the other 85% are competing for housing in the private market."

- Michelle Mapp, MPA, CEO, SC Community Loan Fund

Percent of Inadequate Housing Stock in SC, 2013



MEASURE OF SUCCESS

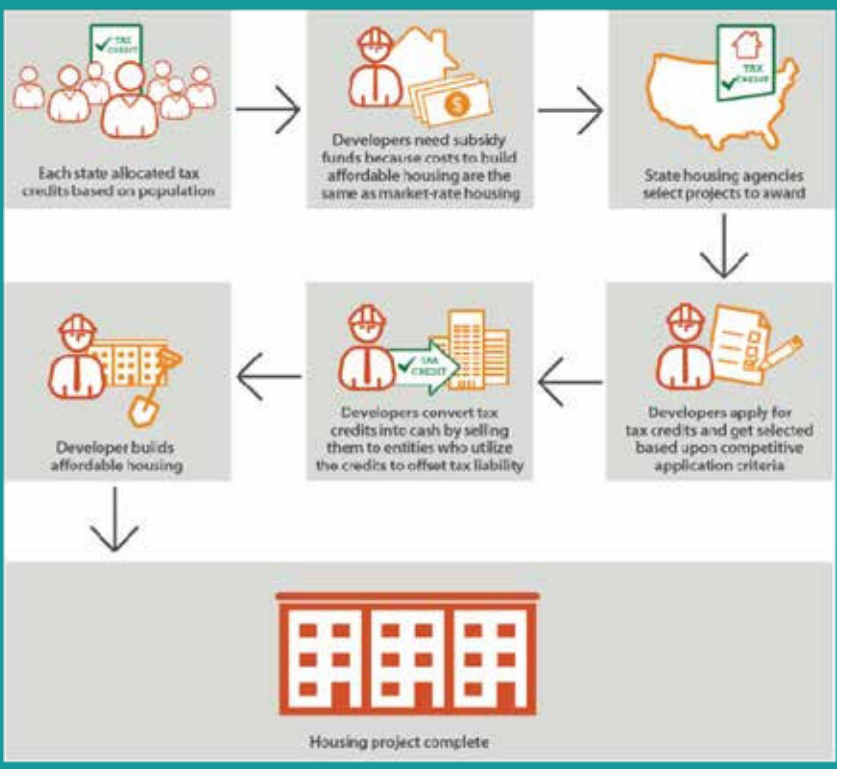
In 2013, 153,131 housing units in rural South Carolina were deemed inadequate. We will review this metric, from U.S. Census data and as tracked by the Housing Assistance Council's Rural Data Portal, annually.

Key Stakeholders

Affordable Housing Coalition of SC
Home Repair and Rehab Focused Non-Profits
Local Governments
Rural Community Action Agencies/ Community Action Partnerships
Rural Public Housing Authorities
SC Association of Habitat Affiliates
SC Community Loan Fund
SC Department of Mental Health
SC Housing
SC Office of Economic Opportunity
USDA Rural Development
US Department of Housing and Urban Development (HUD)

How Low Income Tax Credits (LIHTC) Help Build Affordable Housing

Source: https://www.wellsfargo.com/com/financing/real-estate/affordable-housing/



RECOMMENDATION 14

Increase the supply of affordable housing through new or existing local, state, and federal programs including matching state low-income housing tax credits.

Rationale: Access to affordable housing is associated with improved physical and emotional health. In South Carolina in 2017, the minimum hourly wage a full-time employee would have to make to rent a two-bedroom unit at HUD's Fair Market Rent is $15.83. Federal rental assistance programs help to support nearly 13,000 households in our non-metropolitan areas. Further, in 2015 the average monthly residential electric bill in South Carolina was $144.04, which is third highest in the nation behind Connecticut and Hawaii. Shortages in affordable housing keep individuals from moving into our rural communities, and at worst, create chronic homelessness in communities with limited resources for shelter. Our state must intervene pro-actively to ensure affordable housing for rural South Carolina communities.

ACTION STEP

Address the current shortage of affordable rental housing in rural communities by providing a state match for the HUD Low Income Housing Tax Credit Program that allows communities to design projects that meet individual community needs.

Low Income Housing Tax Credit

The Low Income Housing Tax Credit (LIHTC) is a national program created by the Tax Reform Act of 1986. Nationally, the LIHTC program has assisted in 45,905 projects including 2.97 million housing units since its inception in 1987. The program works through providing budget authority to states and LIHTC-allocating agencies to issue tax credits to real estate developers to support acquisition and rehabilitation or new construction of low-income rental housing units for families and the elderly or disabled. In South Carolina, projects exist in every community in the state. One of the benefits of the program is the ability to create multi-use developments that integrate housing with other needed services in close proximity. One example in South Carolina is the Sustaining Seniors Aging in Place Program out of the Humanities Foundation. This program integrates affordable housing for seniors with food access and telehealth services. In 2015, 36 LIHTC projects were placed in service in South Carolina, 21 of which were rural (869 units). The annual, statewide demand is between 45-80 projects; only about half of those get funded. States like Georgia and Arkansas have enacted legislation and provided funding for a state match to the LIHTC program, which helps leverage additional funds to quickly meet the pressing needs of our communities; South Carolina should follow suit.

- Michelle Mapp, MPA, CEO, SC Community Loan Fund

ACTION STEP

Align with local non-profit organizations in order to educate the public about HUD's Tenant Based Rental Assistance program that allows for eligible individuals to receive a rent subsidy based on household income and local rental market standards.

Resources:

- HOME Tenant-Based Rental Assistance (TBRA) Program Information: https://www.hudexchange.info/home/topics/tenant-based-rental-assistance/#policy-guidance
- HUD Approved Housing Counseling Agencies in Rural South Carolina:
  1. Beaufort County Black Chamber of Commerce: https://bcbcc.org
  2. CCCS of Savannah Area, Inc. (Beaufort, SC): http://www.cccssavannah.org
  3. Southeastern Housing Foundation: http://www.southeasternhcd.org

ACTION STEP

Suggest rural towns and cities include affordable housing in new development or redevelopment efforts.

Ideas to Consider:

- Leveraging New Market Tax Credit and Community Development Block Grant opportunities for development of additional services needed in or near new housing areas
- Replicating North Carolina State Employees' Credit Union Foundation teacher housing model
- Encouraging Main Street South Carolina communities to consider adding or increasing affordable housing options as part of their projects

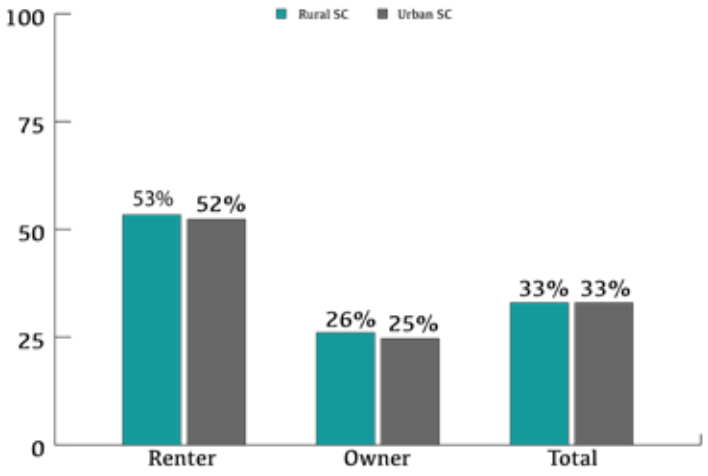
Key Stakeholders

Housing Focused Non-Profits
Local Governments
Municipal Association of SC
Rural Community Action Agencies/ Community Action Partnerships
SC Association for Community Economic Development
SC Community Loan Fund
SC Housing
USDA Rural Development
US Department of Housing and Urban Development (HUD)

MEASURE OF SUCCESS

The percent of Cost Burdened Households, that is, households in which residents spend 30% or more of their income on their housing costs, is slightly higher in rural South Carolina communities. We will review this metric, from U.S. Census data and as tracked by the Housing Assistance Council's Rural Data Portal, annually.

Percent of Cost Burdened Households in SC, 2013



RECOMMENDATION 15

Improve access to safe, reliable, and affordable infrastructure and services including clean drinking water, sanitary sewer, and residential broadband access.

Rationale: The 2017 Infrastructure Report Card by the American Society of Civil Engineers gives the U.S. a poor grade for its efforts to maintain national infrastructure. This includes the drinking water supply, where in South Carolina approximately $1.8 billion in infrastructure needs have been identified to upgrade or replace our aging systems. Thirty-eight percent of our utility systems are concerned about providing services in the future. Additionally, new infrastructure such as broadband capability is necessary for our rural communities to be competitive in the global market. While Palmetto Care Connections and the Palmetto State Providers Network have established a robust broadband network for more than 120 health care entities, rural residents still need access to this service. Cost is an issue for some, but accessibility is a concern as well. For rural South Carolina to thrive, we must meet these infrastructure needs head on.

National Infrastructure Report Card Grade, 2017

Source: American Society of Civil Engineers, www.infrastructurereportcard.org

ACTION STEP

Solicit public-private partnerships among utility companies and non-profit organizations that use innovative techniques to meet individual/family emergency and non-emergency housing related needs in each community.

Ideas to Consider:

- Working with Southeast Rural Community Assistance Project to help increase efficiencies in rural water systems
- Bridging discussions within communities about how to meet both agricultural and community needs for water
- Establishing more "fuel funds" across the state that use private dollars to help low-income households meet their energy needs
- Using population health as a discussion starter among groups

ACTION STEP

Utilize Connect SC to map all broadband capacity throughout the state, including residential and health care points of access, to identify gaps that need to be addressed in rural areas.

Resources:

- Connect SC: www.connectsc.org
- South Carolina Telecommunications and Broadband Association Coverage Map: http://sctba.org/maps.php
- Connect2HealthFCC: https://www.fcc.gov/reports-research/maps/connect2health/background.html
- Universal Service Administrative Company: http://www.universalservice.org/default.aspx

ACTION STEP

Improve public awareness of existing resources for well and septic systems through the South Carolina Department of Health and Environmental Control to promote safe, clean, drinking water.

Resources:

- Well Water Quality Testing Services: http://www.scdhec.gov/Environment/WaterQuality/ResidentialWells/WellWaterTesting/
- Emergency Well Disinfection: https://www.youtube.com/watch?v=N72HqO4jMNY&feature=youtu.be
- Septic Tank Issues: http://www.scdhec.gov/HomeAndEnvironment/

Water Quality

Signs & Effects of Common Drinking Water Problems
From: http://www.scdhec.gov/HomeAndEnvironment/YourHomeEnvironmentalandSafetyConcerns/DrinkingWaterConcerns/CommonProblems/

Contaminant	Signs & Symptoms	Effects
Bacteria	No signs or symptoms	Gastrointestinal illness, which may include nausea, vomiting, abdominal cramps, & diarrhea
Chlorides	Salty Taste	Not generally considered harmful to humans or animals. May contribute to the corrosion of household appliances and plumbing.
Copper	Blue-green stain on plumbing fixtures Very bitter, medicinal taste found when above 1.3 mg/l	Short term exposure can cause stomach cramps and intestinal discomfort. Long term exposure may cause liver and kidney damage
Fluoride	Children exposed to excessive amounts may develop white or brown spots on their teeth.	Excessive fluoride is a concern only when water is used for cooking and drinking.
Hardness	Soaps won't lather. Excessively hard water will cause a hard, chalky scale to form when the water is heated.	Not considered a health hazard. Excessive hard water may cause reduced water heater capacity leading to a burn-out.
Hydrogen Sulfide	Rotten egg odor. Sulfur taste.	Speeds up the corrosion of metal plumbing materials.
Iron & Manganese	Bitter, metallic taste Stains on plumbing fixtures, appliances, and laundry	No evidence to indicate the amount normally found in a well is harmful.
Lead	Corrosion of home plumbing materials containing lead	Damage to brain, nervous system, kidney, and red blood cells. Pregnant women, fetuses, infants and young children are at a **greater risk**. Permanently stunt growth if children are overexposed during growing stage.
Nitrate	In babies: shortness of breath, blueness of skin. In healthy adults: relatively little affect, even when consumed at large quantities.	Infants, pregnant women, individuals with reduced gastric acidity, and individuals with a hereditary lack of methemoglobin reductase. Causes severe oxygen deficiency and can lead to death for those at high risk.
Radium	No signs or symptoms	A lifetime of drinking water with high levels of radium may increase the risk of certain cancers.
Sodium	Salty taste, if sodium & chlorides are present Bitter taste, if sodium & sulfates are present	Increases blood pressure that can eventually lead to hypertension.
Total Dissolved Solids (TDS)	Salty taste when chlorides are present. Bitter taste when sulfates are present. Medicinal taste when bicarbonates are present	Temporary laxative affect may occur after drinking water when sulfates make up most of the TDS. Household plumbing and appliances will deteriorate faster.
Zinc	Bitter, medicinal taste May make water appear milky at concentrations of 30 mg/l When water is heated, elevated levels may produce a greasy film on the top of the water.	At normal levels, zinc is not a health hazard. In high concentrations (675 mg/l and above), zinc can act as an intestinal irritant, causing nausea and vomiting.

ACTION STEP

Highlight the importance of rural infrastructure development as a critical economic tool through a coordinated partnership between rural areas, the Rural Infrastructure Authority, and the South Carolina Chamber of Commerce.

Rural Infrastructure Authority (RIA)

RIA began offering grants in 2013 to underserved communities to assist with infrastructure needs related to water, sewer, and stormwater facilities. In FY2017, RIA provided $23.8 million in 61 grants for construction costs to communities, impacting 50,000 residential customers and 6,500 businesses. The RIA also partners with SC DHEC to administer the State Revolving Fund, which provides low-interest, longer-term loans to communities for Clean and Drinking Water projects. The RIA further provides training and technical assistance to communities to help them address their infrastructure needs and participates in the SC Infrastructure Funders Coordinating Committee to ensure solutions are coordinated across the state. The work of the RIA is foundational to ensuring our rural communities are able to recruit and maintain businesses in their area. Further efforts to ensure a united front on the importance of addressing rural infrastructure needs are critical to the future of rural South Carolina.

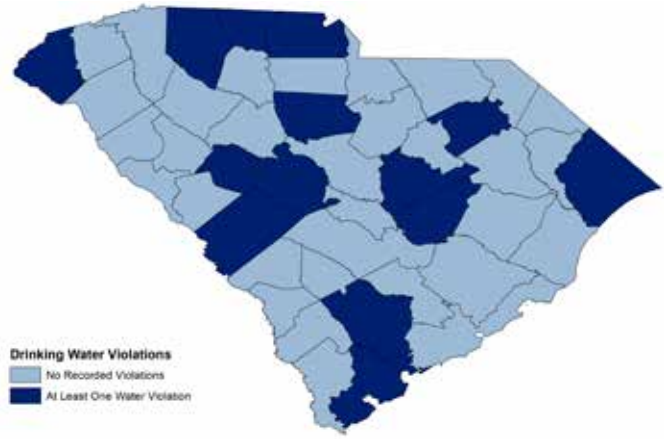
Key Stakeholders

ConnectSC
Councils of Governments
Local Governments
Palmetto Care Connections
Rural Community Action Agencies/ Community Action Partnerships
Rural Electric Cooperatives/Public Utilities
Rural Water & Sewer Authorities
SC Chamber of Commerce
SC Community Loan Fund
SC Department of Agriculture
SC Department of Commerce
SC DHEC
SC Office of Economic Opportunity
SC Rural Infrastructure Authority
SC Rural Resource Coalition
SC Rural Water Association
SC Soil and Water Conservation Districts
SC Telecommunications and Broadband Association
USDA Rural Development

MEASURE OF SUCCESS

The presence of drinking water violations by county from the Safe Drinking Water Information System will be tracked as the data is made available. We will also monitor broadband coverage through regular updates.

Drinking Water Violations, 2013-2014



Deeper Dive: Heirs' Property

The Center for Heirs' Property Preservation of South Carolina defines heirs' property as land, most often rural, that is owned without a written will or was not legally probated within the 10 years required by South Carolina law. Heirs' property is risky because the land can easily be lost, causing future problems, or could be sold for less value. Commonly owned by multiple heirs who own a percentage of the land (not a piece), any heir can force a sale or sell his/her percentage of ownership regardless of whether they are residents on the property, do or do not pay the taxes, or if they have never set foot on the land. Heirs' property also cannot be approved for a mortgage because there is no clear title.

As of January 1, 2017, the State of South Carolina has passed legislation to protect poor families who lack written documentation to their property. In years past where any heir could force a sale on the property, the new law requires family members to attempt buying out those who are interested or other heirs prior to the land being sold. A preliminary hearing to determine whether the land is actually heirs' property is also now required. If the family does decide to sell, it is now a requirement for there to be an independent appraisal on the land to determine fair market value. Still, poor landowners need assistance with helping to ensure that their land transactions are well documented with properly drafting a Last Will and Testament to prevent future issues with heirs' property.

http://www.heirsproperty.org/

Chapter 8

Cross-Cutting Issues

While the South Carolina Rural Health Action Plan process was as inclusive and comprehensive as possible, there are still issues in our rural communities that go beyond the 15 recommendations outlined in this report. These issues will require not only longer than 3-5 years to address but also need a larger coordinated effort focused on each across our state and communities.

This report would not be complete however without at least offering a brief word from a few South Carolina rural health advocates about these nine "cross-cutting" issues, which have been grouped into three areas of focus. These are issues that, while difficult to solve, we must continually recognize wherever possible as part of the solution to improve health outcomes in rural South Carolina.

Communications: Access to rural data • Promotion of existing resources • Pro-rural marketing

Rural infrastructure: Broadband • Social Services • Transportation

Socio-economic Factors: Poverty • Racism/Social Justice • Sexism

COMMUNICATIONS

ACCESS TO RURAL DATA

By: Michele Stanek, MS & Kevin Bennett, PhD

Access to accurate, timely health data on rural communities and populations is critical to understanding rural health needs and rural/urban differences (disparities). A deeper understanding of current trends and data allows more effective communication about the challenges facing rural communities. Data can also be used to inform policy development and strategies related to improving service delivery and the health of rural communities. Despite multiple rural health data sources, additional data and analysis are needed to ensure that the specific needs of rural populations are well understood and that appropriate policies and targeted interventions can be developed and implemented. Rural health data must be available for researchers and policymakers, as well as rural communities themselves. Rural communities must be able to access their own data and it must be understandable and actionable so they can better address their own gaps and opportunities for improvement. Decisions related to improving health must be data driven and there must be rigorous evaluations of new programs' impact on target communities.

Rural-specific data are needed as well as datasets that can be sorted or stratified by rural status. This allows data to be analyzed and rural/urban differences to be identified. It also allows for differences between rural communities to be highlighted. For example data may show differences based on geographic region (i.e., Pee Dee versus Lowcountry). Data that are focused on health care services, workforce, health status, and demographics also exists as well as data that are available that highlight or focus on social determinants or other factors, which impact the health of rural communities, such as employment or income. Despite multiple datasets focused specifically on rural areas, researchers often face difficulty in getting data on smaller rural areas; they either do not have electronic data systems, or there are simply too few encounters to capture reliable estimates.

Investment in both collecting and analyzing rural related data is critical to understanding the health and health care needs of rural populations. Data analyses are also important to developing strategies/policies that reduce rural/urban disparities, improve health care access and improve rural population health.

PROMOTION OF EXISTING RESOURCES

By: Virginia Berry White, LMSW

Families in rural and underserved areas are no different than families in urban, metropolitan and affluent areas when it comes to wanting to meet their basic needs. Individuals in rural communities want to have the ability and resources to take care of their families as well. It's a mistake if people think otherwise.

Abraham Maslow's Hierarchy of Needs continues to be used today (over four decades later) when addressing the needs of human beings. The physiological and security needs are extremely important. Air, food, water, security, health, employment and other resources have to be addressed early on for families to achieve and reach optimum health status. Existing resources are available, though limited, to help families do just that; however, before families in rural communities utilize these services to the fullest, several issues must be addressed:

- **Trust.** Those who are seeking a particular service need to know that whatever is available

through an agency, if they qualify, they will receive. All efforts will need to be made to work through existing barriers that in actuality discourages many from receiving services.

- **Compassion.** Seeking assistance is a major challenge for many, but it becomes even more of an issue when the needed resource is from an office/agency with a perceived lack of compassion for those served. Cultural training needs to be implemented at each agency and organization.
- **Knowing what is available.** Due to questionable reading ability and comprehension, resource directories from agencies and organizations are not the answer. Agencies and organizations need to talk more and share accurate and current resource information.
- **Agencies and entities coming together** to avoid families' having to "jump through hoops".
- **Creation of true "one stop shops."** All partners working together and co-locating services for the betterment of the community would eliminate (some) transportation issues and enable people to access needed services.
- **Existing agencies and organizations need to be reminded how raising families out of poverty helps the community.** What does it mean to "Strengthen Family Resilience"? Workforce Development is important in strengthening families. Eliminating toxic stress is important in strengthening families. Utilizing a trauma-informed approach to care and striving to support the health (physical, mental and behavioral) of families are important to strengthening families.
- **Transportation.** Families experience the lack of public transportation within the rural communities and find it to be a challenge to get to a nearby grocery store, market for fresh fruits and vegetables, continue their education or maintain employment. Families express because they live in rural, it's like a "poverty sentence"; the serious issues around transportation have been identified, but little progress has been made.

Every agency would voice that they provide valuable resources, but all need to have a vision of how bridging resources together is a powerful way to strengthen families and that in turn contributes to having a healthy community. Cultural and social barriers exist and must be addressed to improve the lives of citizens utilizing resources in their community. No one wants to think they will be judged nor that the system will not work for them especially because of their financial status and/or that they are receiving state assistance.

PRO-RURAL MARKETING

By: Sandy Kammerman, MS, EdS

Across the country, there are people leaving rural areas for city or suburban living. However, the converse is also true. Some people find they would prefer country or rural living to that of the city/suburb. In fact there are almost 60 million Americans that live in rural communities. There are advantages to both settings. However the advantages of living in a rural area are often overlooked. Many city folk cannot imagine living in very rural areas.

As a society, we need to acknowledge the advantages of living in a rural area to allow people to make that lifestyle choice. Living in a rural area with lush green foliage, minimal pollution and natural beauty definitely has its advantages:

- **Peace and quiet.** More solitude and the lack of traffic and other city noise.
- **Less crowding.** People live in houses that are further apart than those in the city and there are few apartment buildings.
- **Entertainment options.** People find entertainment close to home through activities with other families and their communities.
- **The Sense of Community.** School, sports, church, local craft fairs, restaurants, bars, libraries, and book clubs are often popular in smaller communities.
- **Volunteer opportunities.** There is a tremendous sense of community when someone needs assistance.
- **Closer contact with nature.** There is more green space and opportunities to garden and choose recreation opportunities in nature.
- **Homesteading.** Living off the land in a wholesome and self-reliant manner.
- **Cost of living is lower.**
- **Ability to focus is much higher.** There are fewer distractions.
- **Day to day life lacks urgency.** There is more time to explore what really matters to you.

The Internet and social media can foster a sense of community and help promote rural living. #PowerofRural, and #RuralisCool are two Twitter campaigns that highlight rural living. The SC Ag + Art Tour promotes art across South Carolina, blending commerce and art. Artists showcase their work through mapped tours hosted at local farms (http://www.agandarttour.com/). The tour is the largest free farm and art tour in the nation with over 20,000 visitors participating since 2012.

People most often hear the disadvantages to living in rural areas. We need to promote or market rural living to attract those who want that lifestyle and help everyone see the advantages. In the end it all comes down to helping a person understand how their lifestyle priorities might suit them best for rural living!

RURAL INFRASTRUCTURE

BROADBAND

By: Jim Stritzinger

In 1829, Boston's Tremont House became the first public building in the United States to feature indoor running water. In the 1920's, only 1% of US households featured both electricity and water; however, nearly 30% had access to telephones. It was not until 1933 that electricity came to rural America due to President Roosevelt's Tennessee Valley Authority.

In 1930, can any of us imagine growing up in a house that featured electricity, running water, and a telephone versus a home that was completely disconnected?

Now, fast forward over eighty years and ask the same questions regarding broadband. Can any of us imagine being 6 years old and growing up in a house that features broadband Internet versus a home that is disconnected? Can we see the opportunity gap of our era?

Connect South Carolina is focused on increasing high-speed Internet access, adoption and use. As a critical part of our mission, we are completing comprehensive maps that detail service capabilities in every county, including broadband service platforms and speeds.

In January 2015, the Federal Communications Commission (FCC) designated the benchmark for broadband Internet service to be 25 Mbps download and 3 Mbps upload speed (25/3). At the time the benchmark was established:

- 17% of all Americans, roughly 55M people, lack access to 25/3.
- Sadly, a disproportionate 55% of rural America, roughly 22M people, lack access to 25/3.

55%
of rural America lacks access to 25/3

Recent survey results from the rural SC Lowcountry Promise Zone (Allendale, Bamberg, Barnwell, Colleton, Hampton, and Jasper Counties) reveal that only 61% of households have access to broadband at 25/3 (June 2016). In addition, competition is very weak in this rural area and costs are high; only 27% have access to Internet connections from two or more providers. As a complement, Mobile Broadband is available to approximately 90% of residents but at much slower 10/1 speeds.

In the Promise Zone, only 42% (vs. 74% nationally) of the residents have chosen to adopt broadband for their household. Interestingly, 70% of the residents report using the Internet on a daily basis.

Finally, it is critical for businesses in South Carolina's rural communities to be online. This connectivity is central to activating entrepreneurship, delivering jobs and creating economic opportunity for small communities across the state.

We must continue to invest throughout the state to ensure that all residents have opportunities to connect, compete, and grow in the connected global economy.

Can any of us imagine being 6 years old and growing up in a house that features broadband Internet versus a home that is disconnected? Can we see the opportunity gap of our era?

SOCIAL SERVICES

By: Sarah Craig, MHA

Health care, in its simplest form, can be defined as utilizing medical treatment for preventive or acute care needs to improve the well-being of a person. Similarly, social services address the social well-being of a person; such as, the basic needs of life which are work, housing, etc. When such essential needs are not met, maintaining good health is often an unattainable goal.

In rural communities especially, social services, community partners, and the health care system are continually bound together, intertwined by the needs of an adult or child. Often vulnerable adults have co-occurring conditions with mental illness, substance abuse, and/or physical health problems; additional resources to meet and maintain whole-person (mind and body) health are undeniably needed. Enhancing the ease and availability of social services will ultimately improve the health of a population.

Emergency Medical Services (EMS) personnel often see first-hand the impact of a lack of access to social services. A director of a South Carolina EMS agency who has experience serving vulnerable adults who do not have the necessary resources to manage and maintain their well being stated the following:

"Often, we encounter patients that do not have the mental capacity to manage their household, yet alone their health and often live without necessities such as food, medicine, and utilities. Occasionally, we will also encounter someone who doesn't have the ability to manage their finances and their benefit checks are distributed to their family; there are incidents where family members won't pay the bills or buy groceries, leaving them without necessities for days or worse, weeks.

Patients often rely on the local hospital as their medical home, or a means of escaping their inadequate living environment. In the incidence of negligence, social services can assist the vulnerable adult with local resources until the occurrence has been investigated, often by law enforcement."

Having an adequate social services workforce is an important part of a healthy rural community. Giving that workforce the tools and resources that are critical for meeting the local need is a job for all of us.

TRANSPORTATION

By: Darlene Lynch

Transportation is an important social determinant of health in rural communities. The availability of reliable transportation impacts a person's ability to access appropriate and well-coordinated health care, purchase nutritious food, and otherwise care for him or herself. Negative health effects related to the transportation system can fall hardest on vulnerable members of the rural population, such as low-income residents, minorities, children, persons with disabilities and older adults.

Public transit is currently available to residents in 40 counties in South Carolina. In rural areas, just 32 percent of counties have full access to public transportation services with another 28 percent having only partial access. A lack of transportation options presents particular challenges in rural areas where distances to social and health services are often greater than in urban areas. Compelling statistics regarding the need for senior transportation include the fact that on average, women outlive their ability to drive by ten years and men by seven years – that is a large

number of years for possible medical and social isolation. Also, after giving up driving, seniors report 15% fewer trips to the doctor; 59% fewer shopping trips; and 65% fewer trips to be with family and friends, go to church and other life enhancing purposes.

States can support some transportation costs for getting to medical visits within the Medicaid program, and certain Community Health Centers may be able to include transportation as part of their services. Similarly, Head Start programs can provide transportation to and from child care centers, and Medicaid's Program of All-Inclusive Care for the Elderly (or PACE) includes transportation. While these program options can help address rural transportation challenges, there are still many gaps for rural residents.

There is a need to expand public transportation services to all 46 counties to meet the mobility needs of all South Carolina's citizens. Expanding transit service and greater awareness of available services in rural areas could benefit those who cannot drive.

Rural South Carolina has the highest rural road fatality rate in the nation... revealing that issues around transportation in rural areas are more than just about access.

- Data from TRIP Report, June 2017

SOCIO-ECONOMIC FACTORS

POVERTY

By: South Carolina Commission on Minority Affairs

With a new administration and changes being made in our government, it is important that we ensure South Carolina has policies in place that promote sustainability and economic development where all of our residents have access to opportunities to prosper. It will be imperative that we address and eliminate laws and policies that may create barriers to accessing resources and promoting equity and economic development.

Currently there are 1,212,645 people living in poverty in SC. Unfortunately, public policy has had a significant impact on low-income families and specifically communities of color. With 13.5% of our state's population living in poverty, low-income families and communities of color can have a significant impact on changing public policy. It will be important to lay the foundation for creating a policy agenda that addresses poverty and deprivation in the state to ensure that all residents of South Carolina have access to resources that promote economic prosperity.

The desired outcome for this focus area is to develop a strategic approach to assess and evaluate current policies and laws that may create barriers to addressing and reducing poverty in South Carolina. Another outcome is to identify potential opportunities to create a public policy agenda that will help guide decisions and policymaking in order to strengthen efforts to address and reduce poverty. Achieving this outcome will require forging relationships and partnerships with stakeholders who can provide direction and leadership for navigating the policymaking and legislative processes in South Carolina.

> **"South Carolina's rural communities, and for that matter the majority of rural communities nationwide, have experienced decades of neglect and underinvestment that have led them to where they are today. Poverty is the common element underlying the dismal statistics and shuttered main streets and poverty experienced over numerous generations breeds hopelessness and despair. Many urban communities struggle with poverty as well and this plan is not meant to diminish those struggles. However, rural poverty is exacerbated by lack of infrastructure, remote distances and greater isolation between racial and ethnic groups."**
>
> *- Graham L. Adams, PhD, CEO, SC Office of Rural Health*

RACISM AND RURAL HEALTH

By: The Rural Health Information Hub

Many rural minorities face discrimination and racism that can result in stress, negatively impacting their health. Unfair treatment may impact rural minorities' ability to fully access services to support health, including healthcare services.

A 2009 *Journal of Behavioral Medicine* review article, *Discrimination and Racial Disparities in Health: Evidence and Needed Research,* looked at a wide range of studies of the health effects of perceived discrimination in different minority populations. While these studies were not specific to rural areas, rural minorities face the same impacts. Discrimination can result in:

- Mental health impacts, including stress, anxiety, and depression
- Violence, including intimate partner violence
- Raised blood pressure
- Poorer self-rated health
- Chronic health conditions
- Delay or failure to seek treatment, including preventive care
- Substance abuse

To learn more, see the American Public Health Association webinar series, The Impact of Racism on the Health and Well-Being of the Nation, www.apha.org/events-and-meetings/webinars/racism-and-health.

Cultural beliefs can also act as a social determinant for minority groups. A belief might undermine health. For example, not expecting a long lifespan may result in life choices that don't support health. Cultural beliefs may also serve as barriers to connecting with healthcare providers.

Culture as a Social Determinant of Health: Examples from Native Communities, a 2012 paper commissioned by the Institute of Medicine's Roundtable on the Promotion of Health Equity and the Elimination of Health Disparities, discusses how a healthcare system that doesn't respect the beliefs and culture of Native American patients may result in patient experiences that include:

- Patients not following healthcare providers' advice and instructions
- Reluctance to use the healthcare system
- An experience of alienation, fear, and disrespect

Healthcare providers, in turn, may misunderstand their patients, assuming they are not interested in their own health or not able to follow instructions. The development of cultural competence is a key method for healthcare providers to help better address the needs of minority populations.

For a comprehensive, though not rural-specific, look at the impact of the social determinants of health on racial and ethnic minorities, see the March 2016 National Academy of Medicine discussion paper, *Building a Culture of Health Equity at the Federal Level*.

A RURAL SOCIAL JUSTICE ISSUE: FOOD INSECURITY

By: Carrie Draper, MSW

Food insecurity, or the inability to afford enough of the right kinds of foods to maintain a healthy and active life, is well recognized as a social determinant of health. Even the mildest forms of food insecurity when experienced by children are associated with long-term negative health impacts including developmental, physical, and mental. Among adults, food insecurity is associated with chronic diseases including hypertension and diabetes. Approximately, 13% of households in South Carolina reported experiencing food insecurity in 2016. Single mothers, people who are African American or Hispanic, and households in rural locations were disproportionately affected.

An array of public nutrition assistance programs and emergency food assistance organizations exist to address the issue of food insecurity. However, many of these are underutilized, inadequate, stigmatized, demoralizing to access, and, at times, all together absent especially in rural locations. In addition to these programmatic challenges, deficits within South Carolina's transportation infrastructure, a decline of farms and farmers who produce food for human consumption, and an overabundance of low paying unstable job opportunities also contribute to the problem.

Recommendations from the South Carolina Food Access Task Force, with the endorsement of the South Carolina Food Policy Council can provide guidance on how to alleviate food insecurity in rural locations. These include: 1) continual state funding for Healthy Food Financing Initiatives; 2) ensuring healthy foods are affordable to low-income individuals; 3) supporting existing and creating new initiatives to recruit, train, and steward food-producing farmers; 4) encouraging local governments to integrate planning and zoning regulations into comprehensive plans that promote healthy food production, processing, distribution, and access; and 5) building collaborative relationships between healthy food advocates, community planners, and transportation agencies to identify and support policies and projects that increase food security in communities with limited access to transportation. (Full report found here: http://sccommunityloanfund.org/blog/2016/08/24/sc-food-access-task-force-releases-update-to-2014-food-access-report/)

AVOIDING SEXISM: APPLYING A GENDER LENS ON RURAL HEALTH

By: Ann Warner, MIA, MPH

Sex and gender are biological and social determinants of health status. Biologically, males and females have different health needs, including, but not limited to, their reproductive characteristics. Socially constructed characteristics of gender also influence health in multiple ways, including: differences between males and females in access to health information; differences in health-seeking behavior; and differences in exposure to health risks. These sex and gender-related biological and social variables contribute to different health outcomes for women and men.

Gender also interacts with other social determinants of health, particularly socioeconomic status. Statewide, more women live below the poverty line than men in South Carolina (19.6%, of women, compared to 16.1% of men). Women's lower socioeconomic status creates barriers to health care. Women are also more likely to bear responsibility for the health of dependents in their household, and this burden is even more pronounced when they are the sole or primary breadwinners for their families. For example, more than 47% of households with children under 18 in Dillon County are female- headed, and more than 55% of households with children under 18 in Marion County are female-headed.

Enhancing women's health has intergenerational benefits: when women are healthier and more economically secure, their children will also be healthier, more educated, and more economically secure. Women are the gatekeepers for health care in their families, so ensuring that they are being reached with health services is essential to maximizing the benefits of health interventions.

For these reasons and more, applying a "gender lens" on rural health will improve programs and policies. Examples of recommendations to use a gender lens should include:

- Disaggregate and analyze data by gender (in addition to race, age, and other socio-economic characteristics that affect health status and access to resources) to improve targeting of resources.
- Design and evaluate programs and policies with a gender lens to ensure that they address the different biological and social characteristics, needs and responsibilities that women and men have.


FORWARD TOGETH
THE SPIRIT OF LANCASTER

Chapter 9

Plan for the Future

Full implementation of our South Carolina Rural Health Action Plan will not solve all of the challenges that face our rural communities. It will not totally fix inadequate housing, underperforming and/or underfunded schools, create jobs for everyone that needs one, or eliminate access to health care issues. What we have aimed to do is to raise awareness of the interconnectedness between these issues and to create a collective road map for lifting up rural communities throughout South Carolina. We strive to help people understand that a leaky roof and inability to pay the light bill does indeed have a direct impact on how healthy a person is and how long he or she lives.

The other important thing that the RHAP does is point out a few areas of success within our state's rural communities. There are available assets on which to build, and we must all do more to recognize those and do all that we can to strengthen them. The biggest assets in our rural communities is the people that call rural home. They are the champions for their hometowns and they are the ones putting in the hours to make things better for their family, friends, and neighbors.

These recommendations and action steps clearly have more than one intended audience. State agencies and organizations, philanthropy, the legislature, and rural communities will all be asked to do their part to implement this broad plan. While this plan was not designed exclusively for the state's General Assembly, there are numerous action items that require legislative fixes. Solving these complex, vexing issues is not the responsibility of any one entity or body, but rather will take cooperation and negotiation among us to marshal the resources and political will that is needed to see improvement.

From an economic perspective, in order to make our state a better, more competitive player in the global marketplace, whether we are recruiting a Fortune 100 company, a technology start-up or the best academic talent, we still must lift up those who struggle the most. South Carolina will never significantly improve beyond 42nd in health outcomes until we address the health of the counties that have the most need. We can significantly invest in our metropolitan areas, but neglecting underperforming rural counties will always hurt our ranking and competitiveness.

Our Rural Health Action Plan (RHAP) and its recommendations are designed to be achieved by 2023. Progress towards accomplishing the recommendations and action steps will be monitored according to the measures of success, and progress reports will be offered on a periodic basis. Our RHAP Steering Committee will guide the implementation phase, monitoring progress and offering modifications as needed. We will convene on a regular basis, fostering accountability among partners. If amendments are necessary, we will make them in real-time so momentum is not lost. The RHAP risks succumbing to the fate of other well-intentioned planning efforts: atrophy through lack of consistent attention. The potential for success of the RHAP dictates that we do not let this happen.

In addition to the work of the RHAP Steering Committee, the South Carolina Department of Health and Environmental Control (SC DHEC) is currently in the process of conducting a State Health Needs Assessment and accompanying State Health Improvement Plan as part of their application for Public Health Accreditation Board recognition (a collective effort known as Live Healthy SC). The RHAP is complementary and additive to this work of SC DHEC, and as such there are plans for us to coordinate on all aspects of the state assessment and plan. We will bring together partners from not only the RHAP process but also SC DHEC and its supporting organization the Alliance for a Healthier South Carolina.

As we move forward, the South Carolina Office of Rural Health (SCORH) is committed to providing staff support to the RHAP Steering Committee. SCORH staff members will be charged with evaluating progress and serving as a catalyst, encouraging movement within each of the priority areas. However, for our RHAP to be truly impactful, a broad group of community and statewide partners must engage and do their part. Leaders from economic development, education, housing, health care and other key areas must think about how their work impacts other sectors and purposely build bridges.

The good news is we have a plan… a road map… and a new collection of partners that are tired of working in silos and are committed to seeing progress. Not just progress for the coast or the upstate, but for the whole state.

Our rural communities abound with talented, energetic folks who strive to make life better for themselves and those around them. Connecting with the resources needed to make improvement will yield great things for our rural communities. With rural champions in the General Assembly, philanthropic community, and state government, our RHAP will serve as a spark for innovation and change.

> **"If you could get all these people to the table and get them thinking and working together, ah, what could we accomplish? "**
>
> *- Rural Community Leader*

The official release of our RHAP coincides with National Rural Health Day, a national day of celebration where communities and providers across the country take time to honor the good work happening all around us and spotlight promising practices in rural health. What better way to launch the next phase of this important work and sync our collective efforts!


RUF

	Measure	Data Source	Year(s)
Chapter 2	Rural Definition	USDA Rural-Urban Commuting Area (RUCA)	2010
	Rural Population	US Census Population Estimates	2015
	Projected Population Change Through 2030	US Census Bureau & SC DHEC Vital Records; Projections by SC Revenue and Fiscal Affairs Office	2000, 2010
	SC Age Distribution	US Census Population Estimates	2015
	SC Race/Ethnicity Distribution	US Census Population Estimates	2015
	Age-Adjusted Mortality Rate	CDC WONDER Mortality Data	2013-2015
Chapter 3	Low Birthweight Babies	National Center for Health Statistics – Natality Files	2008-2014
	Percent of Population with Fair or Poor Health	Behavioral Risk Factor Surveillance System	2015
	Rate of Preventable Hospital Stays among Medicare Beneficiaries	Dartmouth Atlas of Health Care	2014
	Number of Total Physicians by Reported Primary Practice Site per County	South Carolina Office for Healthcare Workforce	2016
	Number of Rural Health Care Professionals in SC	South Carolina Office for Healthcare Workforce	2016
	Percent of SC Residents with Delay of Care Due to Cost in the Past 12 Months	Behavioral Risk Factor Surveillance System	2014-2016
	Percent of Adults without Health Insurance	US Census Small Area Health Insurance Estimates	2014
Chapter 4	Rate of Social (Membership) Associations in SC per 100,000	US Census County Business Patterns	2014
	Percent Youth Disconnected from School/Work	Measure of America	2008-2012
	Opportunities for Civic Engagement in SC per 100,000	AARP Livability Index	2012
	Human Needs Index Trend in SC	The Salvation Army	2012-2016
	Persistent Poverty Counties	US Department of the Treasury, CDFI Fund	2010
	SC Community Development Financial Institution's Annual Portfolio in Millions of Dollars	CDFI Fund Awards Database	2014-2017
Chapter 5	Median Household Income	US Census Small Area Income and Poverty Estimates	2015
	Major Economic Driver per County	USDA Economic Research Service	2015
	Percent of Population Unemployed	Bureau of Labor Statistics	2015
	Percent of Population Living Below Federal Poverty Line	US Census Small Area Income and Poverty Estimates	2015
	Number of Job Openings	SC Works Online System	2017
	Hourly Wage to Achieve Self-Sufficiency by County	United Way Association of South Carolina	2016
Chapter 6	Percent of SC Students Failing Grades 1, 2, or 3	National Kids Count	2015
	Percent of SC Residents Attaining Some College	US Census American Community Survey	2011-2015
	Ratio of Unemployed Persons to Job Openings	SC Works Online System	2017
	Percent of Children in Poverty	US Census Small Area Income and Poverty Estimates	2015
	Percent of SC Students Proficient in Reading and Mathematics	US Census Small Area Income and Poverty Estimates	2015
	Percent of SC Adolescents who are Overweight/Obese	Youth Risk Behavior Surveillance System/CDC	2011-2015
	Percent of Fruit & Vegetable Consumption & 60 Minutes of Daily Physical Activity Among SC Adolescents	Youth Risk Behavior Surveillance System/CDC	2011-2015
Chapter 7	Percent Mobile Homes in Housing Stock	Behavioral Risk Factor Surveillance System	2013
	Percent of Households in SC with at least 1 of 3 Problems: Overcrowding, High Cost, Lack of Kitchen/Plumbing	Comprehensive Housing Affordability Strategy (CHAS)	2009-2013
	Percent of Inadequate Housing Stock in SC	Housing Assistance Council Rural Data Portal	2013
	Percent of Cost Burdened Households in SC	Housing Assistance Council Rural Data Portal	2013
	Drinking Water Violations	Safe Drinking Water Information System	2013-2014

Appendix: Helpful Definitions

ABC Vouchers – Financial assistance from the SC Department of Social Services to help low-income families make payments to child care providers

Access – A patient's ability to obtain appropriate health care services. The ease of access is determined by components such as availability of insurance, the location of health care facilities, transportation, hours of operation, affordability and cost of care.

Ag + Art Tour - A free, self-guided tour of designated farms in South Carolina featuring local artisans and farmer's markets.

Alliance for a Healthier Generation – A national advocate for children's health. Alliance for a Healthier Generation works with schools, companies, community organizations, healthcare professionals and families to transform the conditions and systems that lead to healthier kids.

Alliance for a Healthier South Carolina – A collaborative effort to coordinate action on shared goals to improve the health of all people in South Carolina.

America's Health Rankings – An annual assessment of the nation's health on a state-by-state basis.
American Infrastructure Report Card – An annual report provided by the American Society of Civil Engineers to assess infrastructure problems within the US

Behavioral Risk Factor Surveillance System (BRFSS) – Health-related telephone surveys that collect data in all 50 states as well as the District of Columbia and three US territories about adult US residents regarding their health-related risk behaviors, chronic health conditions and use of preventive services.

Birth Outcomes Initiative (BOI) – A collaborative effort by the South Carolina Department of Health and Human Services (SCDHHS), South Carolina Hospital Association, March of Dimes, Blue Cross Blue Shield of South Carolina and over 100 stakeholders to improve the health outcomes for newborns not only in the Medicaid program but throughout the state's population.

Centers for Disease Control and Prevention (CDC) – A federal agency (based in Atlanta) within the US Department of Health and Human Services that serves as the central point for consolidation of disease control data, health promotion and public health programs.

Chronic Diseases – Diseases which have one or more of the following characteristics: permanent, leave residual disability, require special training of the patient for rehabilitation or may be expected to require a long period of supervision, observation or care.

Community Development Corporations – Nonprofit community based organizations focused on enhancing community conditions, typically in low income and underserved neighborhoods, by providing capital for housing and other critical community health needs.

Community Development Financial Institutions – A subsidiary program of the US Department of the Treasury dedicated to expanding economic opportunity for underserved people and communities.

Community Health Center (CHC) – An ambulatory health care program usually serving a geographic area which has scarce or nonexistent health services or a population with special health needs. CHCs attempt to coordinate federal, state and local resources into a single organization capable of delivering both health and related social services to a defined population. While such a center may not directly provide all types of health care, it usually takes responsibility to arrange all medical services needed by its patient population.

Community Health Worker – Trained health workers who come from the communities they serve which aids in building trust and vital relationships with the residents of the community. This peer-to-peer relationship enables the CHWs to be effective links between their own communities and systems of care.

Appendix: Helpful Definitions

Community Paramedic Program - Community paramedicine is an emerging healthcare profession. It allows paramedics to operate in expanded roles to provide routine healthcare services to underserved populations, and helps to improve rural emergency medical services (EMS)

Connect SC – A non profit organization serving the State of South Carolina to assess the current state of broadband adoption

Coordinated School Health Advisory Council (CSHAC) - Coordinated School Health Advisory Councils are responsible for "assessing, planning, implementing, and monitoring district and school health policies and programs". CSHACs must be composed of members of the community, school representatives, students, parents, district food service employees, and school board members.

County Health Rankings - Annual county level rankings funded by the Robert Wood Johnson Foundation to provide an assessment of a state's health and how health is influenced by the surrounding environment.

Data Warehouse – A specific database (or set of databases) containing information from many sources that are linked by a common subject (e.g., a health plan member).

Emergency Medical Services (EMS) – A system of health care professionals, facilities and equipment providing emergency care.

Federal Poverty Level (FPL) – The amount of income determined by the federal Department of Health and Human Services to provide a bare minimum for food, clothing, transportation, shelter and other necessities. The level varies according to family size. In 2014, the FPL for an individual was $11,670, and for a family of four was $23,850.

Federally Qualified Health Center (FQHC) – A health center in a medically underserved area that is eligible to receive cost-based Medicare and Medicaid reimbursement and allows for the direct reimbursement of nurse practitioners, physician assistants and certified nurse midwives.

Fee-For-Service (FFS) – Method of billing for health services under which a physician or other practitioner charges separately for each patient encounter or service rendered.

Food Share Program – A non-profit organization that provides access to affordable fresh produce in the Midlands Region of South Carolina.

Head Start Program – Federal programs that promote the school readiness of children from birth to age five from low-income families

Healthy Insights - A data tool provided by the South Carolina Association for Community Economic Development to identify healthy lifestyle resources in South Carolina communities.

Low Income Housing Tax Credit – A dollar for dollar tax credit that can be used for affordable housing investments.

Medicaid – A health insurance program, funded jointly by federal and state governments and managed by the states, that provides medical coverage to qualified low-income individuals in need of health and medical care. The program is subject to broad federal guidelines, with states determining the benefits covered and methods of administration.

Medicare Rural Hospital Flexibility Program - created by Congress in 1997. It allows small hospitals to be certified as Critical Access Hospitals (CAHs) and offers grants to States to help implement initiatives to strengthen the rural health care infrastructure. The grant program is administered by the Health Resources Service Administration's Federal Office of Rural Health Policy. HRSA is a division of the U.S. Department of Health and Human Services.

Appendix: Helpful Definitions

Medicare – A federal health insurance program for older adults and people with disabilities regardless of financial status. It consists of two separate but coordinated programs: hospital insurance (Part A) and supplementary medical insurance (Part B). It also includes a separate drug coverage program administered by the private sector (Part D).

Morbidity – The extent of illness, injury or disability in a defined population. It is usually expressed in general or specific rates of incidence (new cases) or prevalence (total cases).

Palmetto Care Connections - The telehealth network for South Carolina that offers telehealth support services and membership opportunities to healthcare providers.

Patient Centered Medical Home (PCMH) – A health care delivery model whereby patient treatment is coordinated through their primary care physician to ensure they receive the necessary care when and where they need it, in a manner they can understand. The core functions of primary health care include comprehensive, patient-centered, coordinated care with accessible services and ongoing quality and safety improvements.

Population Health – The health outcomes of a group of individuals, including the distribution of such outcomes within the group, that are influenced by multiple determinants of health, including medical care, public health, genetics, behaviors, social and environmental factors.

Prevention – Actions taken to reduce susceptibility or exposure to health problems (primary prevention), detect and treat disease in early stages (secondary prevention) or alleviate
the effects of disease and injury (tertiary prevention).

Primary Care – A basic level of health care provided by a licensed health care professional with whom an individual has an ongoing relationship and who knows the patient's medical history. Primary care services emphasize a patient's general health needs such as preventive services, treatment of minor illnesses and injuries or identification of problems that require referral to specialists.

Provider – Individual or organization that provides health care or long-term care services (e.g., doctor, nurse, hospital, physical therapist, home health aide and more). A health care provider may also be a public/community health professional.

Public Health – A broad array of programmatic and policy-related activities that society performs collectively, often in partnership with federal, state and local government entities, to assure the conditions in which people can be healthy. This includes organized community efforts to prevent, identify, preempt and counter threats to the public's health.

Rural Urban Commuting Area Codes (RUCA) - The rural-urban commuting area (RUCA) codes classify U.S. census tracts using measures of population density, urbanization, and daily commuting. The classification contains two levels. Whole numbers (1-10) delineate metropolitan, micropolitan, small town, and rural commuting areas based on the size and direction of the primary (largest) commuting flows.

Rural Health Clinic (RHC) – A public or private hospital, clinic or physician practice designated by the federal government and in compliance with the Rural Health Clinics Act. The practice must be located in a medically underserved area or a Health Professional Shortage Area (HPSA) and use physician assistants and/or nurse practitioners to deliver services.

Rural Health Network – Refers to any variety of organizational arrangements to link rural health care providers in a common purpose.

Safety Net – Providers and institutions that provide low cost or free medical care to medically needy, low income or uninsured populations. They include community and migrant health centers, free medical clinics and public hospitals.

Appendix: Helpful Definitions

Social Determinants of Health – The circumstances, in which people are born, grow up, live, work and age and the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, education and politics.

South Carolina Area Health Education Center (SC AHEC) – A South Carolina program that is part of a national effort to improve access to health services through changes in the education and training of health professionals

South Carolina Department of Alcohol and Other Drug Abuse Services (SC DAODAS) – State agency charged with ensuring the provision of quality services to prevent or reduce the negative consequences of substance use and addictions.

South Carolina Department of Education – State agency charged with providing leadership and support to the public education system in South Carolina

South Carolina Department of Health and Environmental Control (SC DHEC) – State agency charged with protecting public health, coastal resources and the state's land, air and water quality.

South Carolina Department of Health and Human Services (SC DHHS) – State agency that manages the Medicaid program.

South Carolina Department of Mental Health (SC DMH) – State agency that provides mental health services to South Carolinians.

South Carolina Education Oversight Committee (EOC) – An independent , non partisan group made up of educators, business people, and elected officials who have been appointed by legislature and the government to improve the state's K-12 educational system

South Carolina Grantmakers Network - A philanthropic network committed to education, rural development and environment, healthcare and connecting funders across South Carolina.

South Carolina Health Information Exchange (SCHIEx) – Statewide information highway that allows participating health care providers to view a patient's medical history, including medications, diagnoses and procedures. It is not a data warehouse, but a secure network, where providers use certified technology to share the information they need for better outcomes.

South Carolina Hospital Association – A private, not-for-profit organization made up of some 100 member hospitals and health systems and about 900 personal members associated with our institutional members. The South Carolina Hospital Association was created in 1921 to serve as the collective voice of the state's hospital community.

South Carolina Manufacturers Association (SCMA) - The state's preeminent industrial trade association. Provides a vehicle for all manufacturers to advocate their interests at the legislative, regulatory, and executive levels in South Carolina.

South Carolina Primary Health Care Association - The unifying organization for Community Health Centers (CHCs) in South Carolina.

South Carolina Telehealth Alliance – A statewide collaboration dedicated to ensure South Carolinians have access to quality healthcare services via telemedicine.

South Carolina Vocational Rehabilitation - The South Carolina Vocational Rehabilitation Department prepares and assists eligible South Carolinians with disabilities to achieve and maintain competitive employment.
State Earned Income Tax Credit – A refundable tax benefit provided by the state to help low-income to moderate-income, working people

Appendix: Helpful Definitions

Students Health and Fitness Act of 2005 – State law to provide every elementary school with access to at least 30 minutes of physical activity, improve nutrition standards, and to establish Coordinated School Health Advisory Councils.

Telemedicine – Specifically defined form of video conferencing that can provide medical consultation (e.g., psychiatry) to patients living in remote locations or otherwise underserved areas.
The Great Recession – period of economic decline observed in world markets during the late 2000s and early 2010s

Underinsured – People with public or private insurance policies that do not cover all necessary health services, resulting in out-of-pocket expenses that often exceed their ability to pay.

Uninsured – People who lack public or private health insurance.

United States Department of Agriculture (USDA) - The US government's principal agency for leadership on food, agriculture, natural resources, nutrition, and related issues based on public policy, the best available science, and effective management.

United States Department of Agriculture Rural Development - A subsidiary of the Department of Agriculture, UDSA Rural Development is committed to helping improve the economy and quality of life in rural America. Rural Development offers loans, grants, and loan guarantees to support economic development and essential services. Their agency also provides technical assistance to agricultural producers.

United States Department of Health and Human Services (US DHHS) – The US government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves. Many DHHS-funded services, including Medicaid, are provided at the local level by state or county agencies or through private-sector grantees.

Thank you to the South Carolina Institute of Medicine and Public Health and their "Pocket Guide to Health Care Terms", a resource published by their office to help understand the numerous terms and acronyms that a part of ongoing health discussions. The definitions provided are a combination of terms from the "Pocket Guide for Health Care Terms" and the SC Rural Health Action Plan.

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SOUTH CAROLINA OFFICE OF
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The South Carolina Office of Rural Health (SCORH), a 501(c)3 non-profit statewide organization, is dedicated to improving the health of rural and underserved communities throughout the state. Since 1991, SCORH has worked with local, statewide and national partners to leverage opportunities for improving rural quality of life. As the only federally-designated statewide organization solely focused on the health needs of rural communities, SCORH strives to connect available assets with community need.

With 27% of the state's population living in rural communities, improving quality health care and positive health outcomes is paramount. Through a family of programs and resources, SCORH offers training, education and technical assistance to rural providers, advocates and communities. Encouraging rural-friendly policy, robust asset allocation and pro-rural messaging are cornerstones of SCORH's work.

The South Carolina Office of Rural Health's Staff and Board are committed to closing the gap in health status and life expectancy between rural and urban communities. Through strong collaboration with state and national partners, and most importantly, rural communities themselves, we aim to do just that!

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