State Rural Plan for South Carolina

Prepared by the SC Rural Health Research Center

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Table of Contents

Introduction

Description of the State

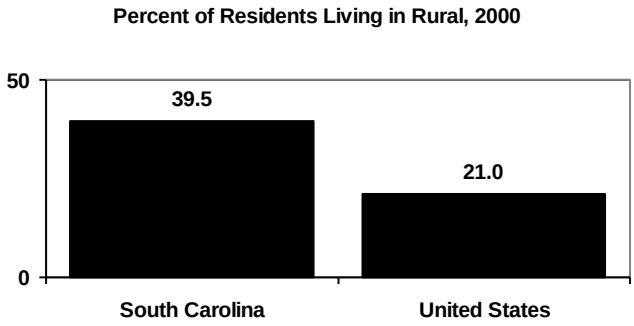
South Carolina is a triangular shaped state in the southeastern region (Deep South) of the United States of America. South Carolina is bordered to the north by North Carolina; to the south and west by Georgia, located across the Savannah River; and to the east by the Atlantic Ocean. South Carolina includes portions of three major natural regions of the eastern United States: the Coastal Plain, the Piedmont Plateau, and the Blue Ridge Mountains[1].

All of the major rivers in South Carolina flow southeastward across the state to the Atlantic Ocean, The three major rivers are the Santee, Great Pee Dee, and Savannah. There are three non-natural lakes in South Carolina created for hydroelectric power purposes: Lake Marion – 110,600 acres; Lake Moultrie – 60,400 acres; and Lake Murray – 50,000 acres[2].

South Carolina is composed of four geographic areas, whose boundaries roughly parallel the northeast/southwest Atlantic coastline. The lower part of the state is the **Coastal Plain**, also know as the ***Lowcountry***, which is nearly flat and composed entirely of recent sediments such as sand, silt, and clay. Just west of the Coastal Plain is the **Sandhills** region, also known as the ***Midlands***. This region of the state is thought to contain remnants of old coastal dunes from a time when the land was sunken or the oceans were higher. The **Piedmont *(Upstate)*** region contains the roots of an ancient, eroded mountain chain. It is generally hilly, with thin, stony clay soils, and contains few areas suitable for farming. The northwest part of the Piedmont is also known as the **Foothills**[3].

Composed of forty-six counties encompassing approximately 30,111 square miles, South Carolina is ranked 40th in the United States in land mass[4].

In 2000, 39.5% of South Carolina's population lived in rural areas. Nationally, only 21% lived in rural areas[5].



[1] South Carolina Department of Parks, Recreation and Tourism – SC Facts and Figures, http://www.scprt.com/programs/statistics/barometer.html retrieved July 9, 2008.

[2] South Carolina Information Highway, Lakes, http://www.sciway.net/tourism/lakes.html retrieved June 20, 2008.

[3] US Geographic Regions, http://www.statemaster.com/state/sc-south-carolina/geo-geography retrieved June 7, 2008.

[4] US Census Bureau, Census, 2006 Statistical Abstract of the United States; Table 17 and 18, http://www.ors2.state.sc.us/abstract/chapter1/staterank1.php retrieved June 9, 2008.

[5] US Census Bureau, Census 2000, SF3, Table P5, SC Office of Research and Statistics, http://www.sccommunityprofiles.org/scpages/sc_urban.asp?COUNTYID=47 retrieved June 9, 2008.

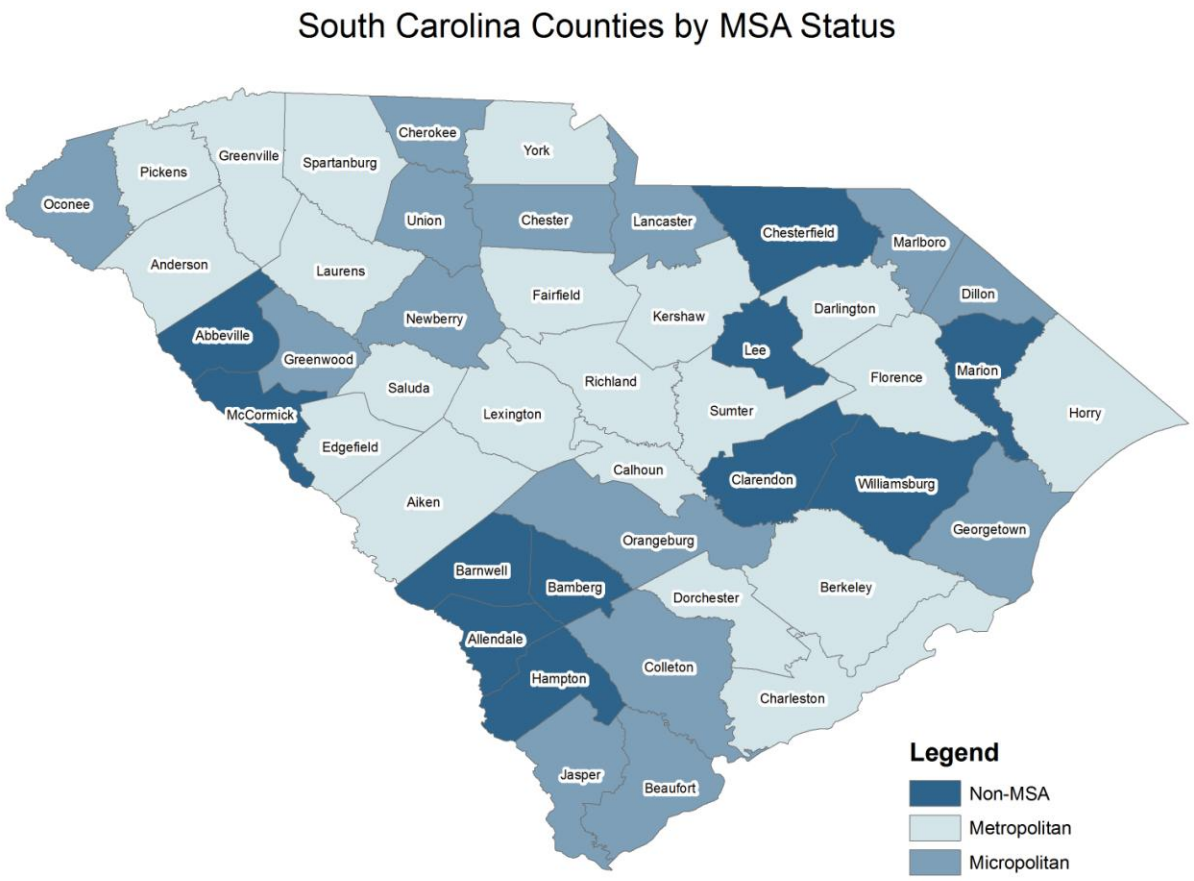
I. Definition of Rural & Related Demographics

The term "rural" has many definitions, depending on the source and purpose. In the SC Rural Health Plan, three definitions are presented with corresponding demographic data: (a) Non-Metropolitan Statistical Area and (b) Urban Influence Codes.

a. Metropolitan Statistical Area (MSA) vs. Non-Metropolitan Statistical Area (Non-MSA)

Metropolitan and micropolitan statistical areas are defined by the US Office of Management and Budget (OMB) for use by Federal statistical agencies in collecting, tabulating, and publishing statistics. A metropolitan statistical area is defined as an area of at least 50,000 people. A micropolitan statistical area contains an urban core of at least 10,000 but less than 50,000 residents. Non-metropolitan statistical areas are defined as a geographic area with less than $10,000 in a core area[6].

The following map shows which counties are rural and urban, based on the OMB definition. The data is current as of June 2008.



[6] US Office of Management and Budget (OMB), http://www.census.gov/population/www/estimates/metrodef.html retrieved June 9, 2006

As of 2000, 18% of the South Carolina population lived in metropolitan statistical areas, compared to 75% in micropolitan and 7% in non-metropolitan statistical areas. Using the OMB definition, the state's demographic profile is presented in the following table:

Table 1: 2000 Demographic Profile by Metropolitan Statistical Area Classification[7]

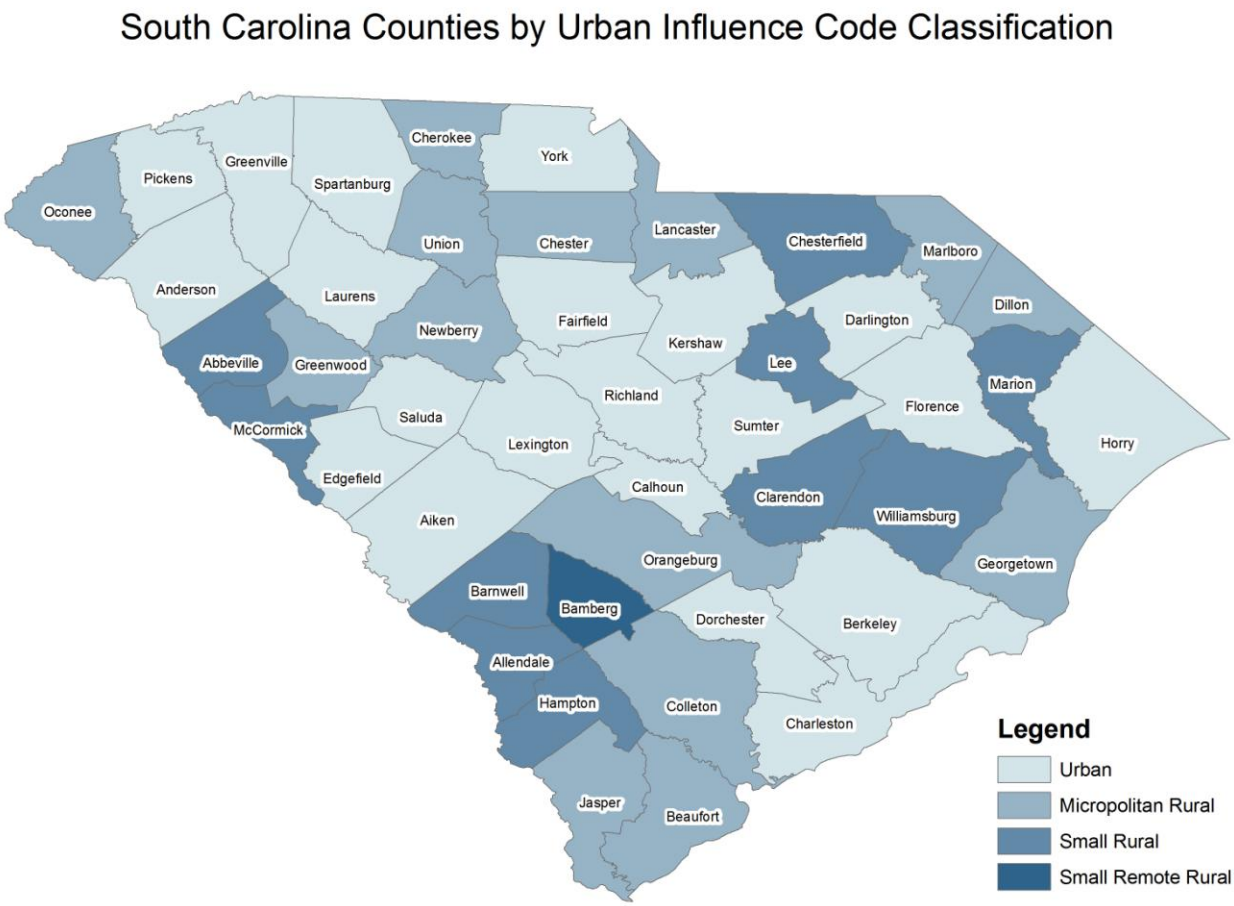
Demographic Category	**Non-MSA** (Total Number) (Categorical Percent)	**Micropolitan** (Total Number) (Categorical Percent)	**MSA** (Total Number) (Categorical Percent)	**Total** (Total Number) (Categorical Percent)
Total	**276,930**	**3,001,853**	**733,229**	**4,012,012**
Gender				
Male	134,211 48.5%	1,459,221 48.6%	355,497 48.5%	1,948,929 48.6%
Female	142,719 51.5%	1,542,632 51.4%	377,732 51.5%	2,063,083 51.4%
Race				
White	129,766 46.9%	2,104,541 70.1%	461,371 62.9%	2,695,678 67.2%
Black	142,696 51.5%	789,873 26.3%	250,158 34.1%	1,182,727 29.5%
Other	4,468 1.6%	107,439 3.6%	21,700 3.0%	133,607 3.3%
Age				
Under 18	73,684 26.6%	751,294 25.0%	184,663 25.2%	1,009,641 25.2%
18 to 64	167,151 60.4%	1,902,438 63.4%	447,449 61.0%	2,517,038 62.7%
65>	36,095 13.0%	348,121 11.6%	101,117 13.8%	485,333 12.1%

[7] US Census Bureau, Census of Population and Housing, http://factfinder.census.gov retrieved July 4, 2008.

b. Urban Influence Code (UIC)

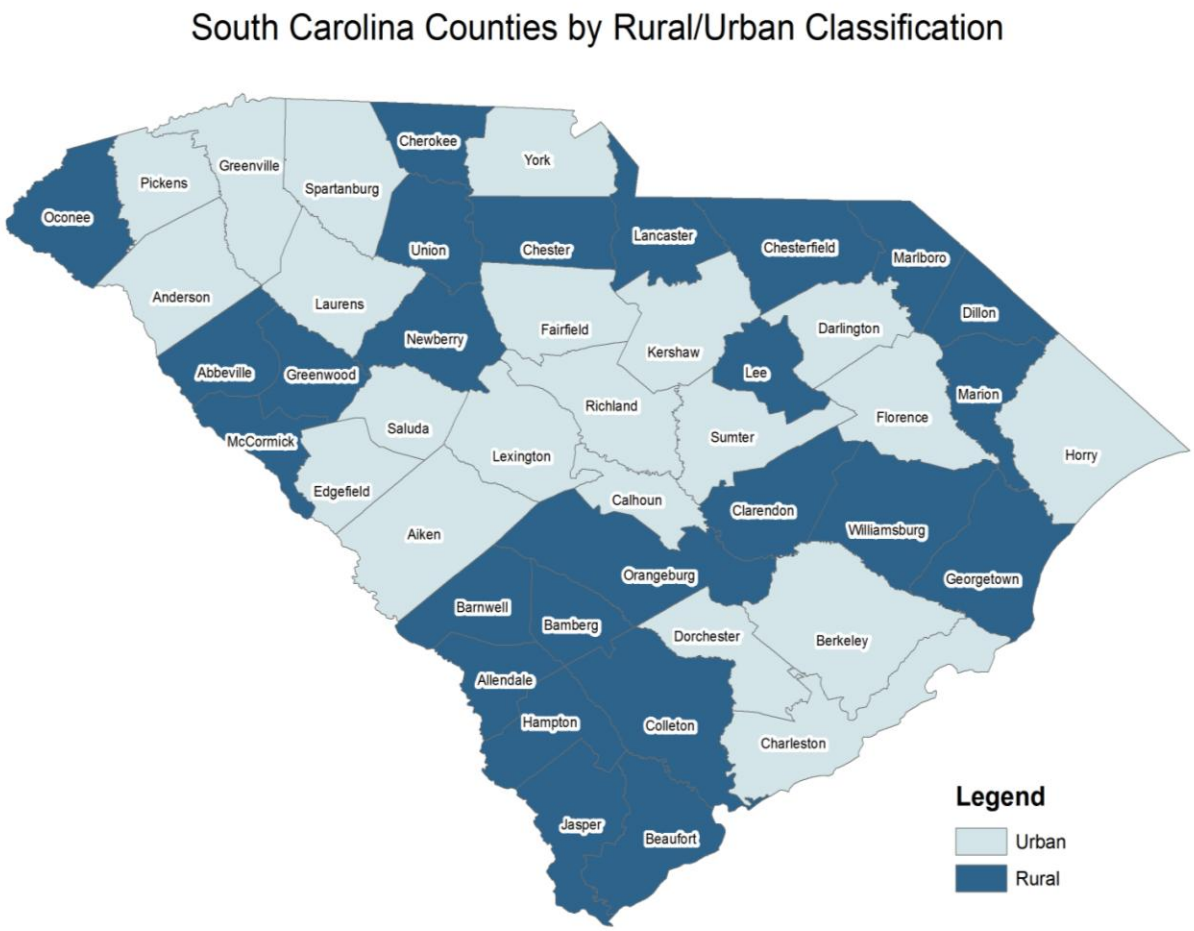
Urban Influence Codes (UICs) classify counties, their equivalents, and independent cities into 12 categories~~,~~ based on population and commuting data from the 2000 Census[8]. UICs are used primarily by researchers to determine the impact levels that rurality has on indicators of interest. UICs 1 and 2 are defined as "Urban~~,~~" while all other UICs are rural. Typical groupings are: "micropolitan" (UICs 3, 5, and 8), "small rural" (UICs 4, 6, and 7), and "small remote rural" (9, 10, 11, and 12).

The following map delinates county classifications using categorical groupings of the UICs (urban, micropolitan, small rural, and small remote rural). The data is current as of June 2008.



[8] US Department of Agriculture Economic Research Service, http://www.ers.usda.gov retrieved June 10, 2008.

When grouping the UICs into two categories (rural and urban), 25 of the 46 counties are defined as rural. The map below delinates these groupings, which are current as of June 2008:



As of 2000, **25.1%** of the population **lived in all rural areas** (small and remote, small, and micropolitan), compared to 74.9% in urban. Using the UIC definition, the state's demographic profile, when examined by rural and urban status, is presented in the following table[9]:

Table 2: 2000 Demographic Profile by Urban Influence Code Categories[10]

Demographic Category	Rural (Total #) (Category %)				Urban (Total #) (Category %)	State Total
	Small & Remote	Small	Micropolitan	**All Rural**		
Total	**16,658**	**260,272**	**733,229**	**1,010,159**	**3,001,853**	**4,012,012**
Gender						
Male	7,831 47.0%	126,380 48.6%	355,497 48.5%	489,708 48.5%	1,459,221 48.6%	1,948,929 48.6%
Female	8,827 53.0%	133,892 51.4%	377,732 51.5%	520,451 51.5%	1,542,632 51.4%	2,063,083 51.4%
Race						
White	6,136 36.8%	123,630 47.5%	461,371 62.9%	591,137 58.5%	2,104,541 70.1%	2,695,678 67.2%
Black	10,384 62.3%	132,312 50.8%	250,158 34.1%	392,854 38.9%	789,873 26.3%	1,182,727 29.5%
Other	138 0.8%	4,330 1.7%	21,700 3.0%	26,168 2.6%	107,439 3.6%	133,607 3.3%
Age						
Under 18	4,235 25.4%	69,449 26.7%	184,663 25.2%	258,347 25.6%	751,294 25.0%	1,009,641 25.2%
18 to 64	10,109 60.7%	157,042 60.3%	447,449 61.0%	614,600 60.8%	1,902,438 63.4%	2,517,038 62.7%
65>	2,314 13.9%	33,781 13.0%	101,117 13.8%	137,212 13.6%	348,121 11.6%	485,333 12.1%

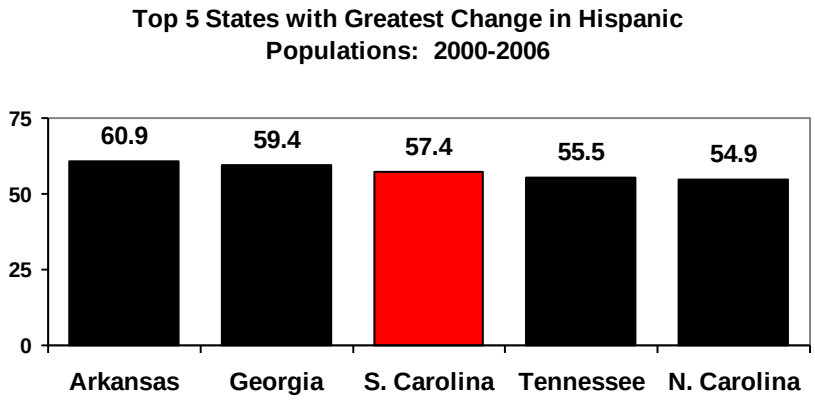
Data presented from this point on in the plan will be categorized using the Urban vs. Rural classification from the UIC.

[9] US Census Bureau, Census 2000, Population and Housing , http://www.ors2.state.sc.us/abstract/chapter14/pop14.asp retrieved June 10, 2008

[10] US Census Bureau, Census 2000 Summary File 1, Matrices P13 and PCT12, http://factfinder.census.gov retrieved June 7, 2008

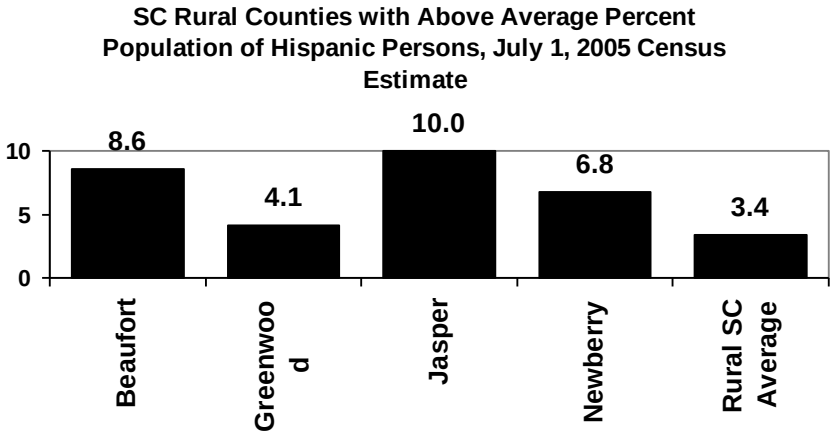
Hispanic and Foreign Born Populations in Rural South Carolina

A noted limitation of the demographic tables presented for the two definitions is the categorization of race to only three groups: White, Black, and Other. It is important to note the similarity of races and ethnicities that comprise the "other" category, although the numbers are too small to adequately represent them in the previous tables.



The growth in the Hispanic population, in particular, deserves attention in this plan. The Hispanic population has tripled in our state during the past decade[11]. South Carolina ranks 3rd nationally in percent change of Hispanic or Latino population growth for the entire state, as presented in the chart on the left[12].

Based on the July 1, 2005 Census Population Estimate, persons with Hispanic ethnicity represented **3.4%** of the state's rural population[13]. Rural counties with above average representation of Hispanic populations in the state are identified in the chart on the right:



[11] US Census Bureau, Census 2000, South Carolina Office of Research and Statistics, http://www.sccommunityprofiles.org/scpages/sc_hispanic_data.asp?COUNTYID=47 retrieved July 30, 2008.

[12] US Census Bureau, Census 2000, Population Estimates, July 1, 2000 to July 1, 2006, http://www.factfinder.census.gov/ retrieved July 30, 2008.

[13] U.S. Census Bureau, http://www.ors2.state.sc.us/abstract/chapter14/pop13.asp retrieved August 6, 2008.

Growth of Foreign-Born Population

The number of foreign-born individuals in the state of South Carolina has more than doubled, increasing by 132.1 percent in the last decade (1990-2000)[14]. Table 3 compares the birth location of persons living in rural South Carolina to their urban peers:

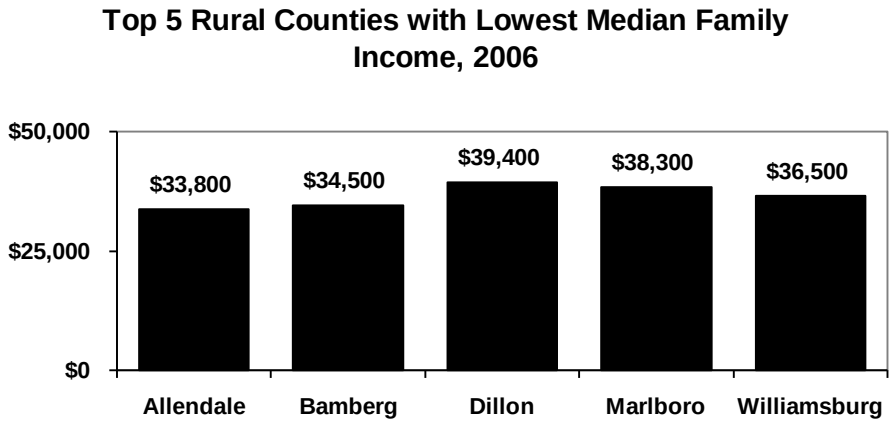
Table 3. Foreign-Born and Native Population, 2000

	Urban (Total number) (Category %)	Rural (Total number) (Category %)	S.C. Total (Total number) (Category %)	U.S. Total (Total number) (Category %)
Total Population	**2,826,610**	**1,185,402**	**4,012,012**	**281,421,906**
Native Population	**2,739,896 97%**	**1,156,138 97.5%**	**3,896,034 97%**	**250,314,017 88.9%**
Born in State	1,777,619 63%	791,335 67%	256,954 64%	168,729,388 60%
Born in Different State	935,842 33%	357,676 30%	1,293,518 32.2%	78,057,078 27.7%
Northeast	198,796 7%	103,964 9%	309,460 7.7%	18,563,204 6.6%
Midwest	150,515 5%	51,804 4%	202,319 5%	21,969,267 7.8%
South	518,714 18%	184,336 15.5%	703,050 17.5%	25,301,191 9%
West	61,117 2%	17,572 1.5%	78,689 2%	12,223,416 4.3%
Born Outside U.S.	26,435 0.9%	7,127 0.6%	33,562 0.8%	3,527,551 1.3%
Puerto Rico	3,846 0.1%	1,026 0.1%	4,872 0.1%	1,439,674 0.5%
U.S. Island Areas	1,108 0	340 0	1,441 0	166,960 0.1%
Born Abroad of American Parents	21,488 0.8%	5,761 0.5%	27,249 0.7%	1,920,917 0.7%
Foreign-Born Population	**86,714 3%**	**29,264 2.5%**	**115,978 2.9%**	**31,107,889 11.1%**
Naturalized Citizen	21,996 0.8%	10,032 0.8%	42,983 1.1%	12,542,626 4.5%
Not a Citizen	53,763 2%	19,232 1.6%	72,995 1.8%	18,565,263 6.6%

[14] US Census Bureau, http://sccommunityprofiles.org/scpages/sc_foreign.asp?COUNTYID=47 retrieved August 1, 2008.

Income and Poverty

In 2006, the **median family income** for South Carolina families was $52,900, a sharp comparison to the median rural family income of **$43,972**. The top 5 rural counties with the lowest median family income are presented in the following chart[15]:



As of 2005, the **personal per capita income** for the 25 rural counties in our state was **$23,344**, which is approximately $5K less than the state average ($28,285) and more than $11K less than the national average ($34,471)[16]. When ranking all South Carolina counties, 22 of the 25 rural counties occupy the lowest rankings for personal per capita income. Table 4 shows the rural counties' personal per capita income and their respective state rankings.

Table 4: Personal Per Capita Income & Rankings for Rural South Carolina Counties, 2005

Rural County	Personal Per Capita Income (State Ranking)	Rural County	Personal Per Capita Income (State Ranking)
Allendale	$18,871 (46)	Cherokee	$22,651 (33)
Williamsburg	$20,005 (45)	Colleton	$22,764 (32)
Marion	$20,299 (44)	Lancaster	$23,560 (30)
Lee	$20,307 (43)	Jasper	$23,696 (29)
Barnwell	$20,409 (42)	Newberry	$23,901 (28)
Marlboro	$20,485 (41)	Orangeburg	$24,002 (26)
McCormick	$20,643 (40)	Union	$24,396 (24)
Dillon	$20,850 (39)	Chester	$24,814 (22)
Bamberg	$20,989 (38)	Greenwood	$25,471 (20)
Clarendon	$21,266 (37)	Oconee	$28,561 (9)
Hampton	$21,566 (36)	Georgetown	$30,399 (6)
Abbeville	$22,111 (35)	Beaufort	$39,308 (1)
Chesterfield	$22,286 (34)		

[15] U.S. Department of Urban Development, Economic and Market Analysis Divisions, http://www.ors2.state.sc.us/abstract/chapter13/income10.asp retrieved August 6, 2008

[16] U.S. Department of Commerce, Bureau of Economic Analysis, 2005, http://www.ors2.state.sc.us/abstract/chapter13/income28.php retrieved August 6, 2008.

Poverty levels in South Carolina are high, especially in rural areas. Unfortunately, the most recent poverty estimates available are dated 1999. Given the economic status in the latter part of the 21st century's first decade, it is reasonable to suggest poverty rates will be higher at the next decennial census. The 1999 poverty data comparing rural and urban South Carolina are presented in Table 5:

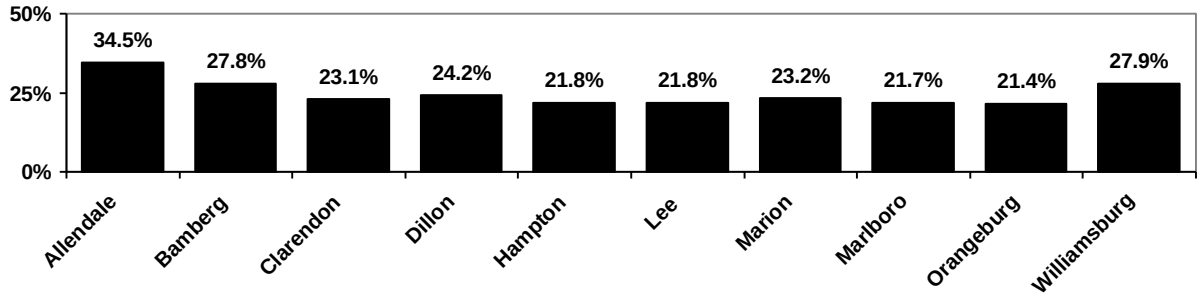
Table 5 South Carolina Persons Living Below Poverty Level by Race and Residence, 1999[17]

Category	Urban (Total Number) (Categorical %)	Rural (Total Number) (Categorical %)	Total (Total Number) (Categorical %)
Total Races	391,682	178,627	570,309
White	168,262 43.0%	56,077 31.4%	224,339 39.3%
Black	188,348 48.1%	110,070 61.6%	298,418 52.3%
Hispanic	15,936 4.1%	6,504 3.6%	22,440 3.9%
Other	19,136 4.9%	5,976 3.3%	25,112 4.4%

As Table 5 demonstrates, proportionately, urban Whites are more likely to live below the poverty level than rural however, rural Blacks are more likely to be poor than their urban counterparts.

The proportion of rural children living in poverty is even more startling. In 1999, **19.5%** of children living in the 25 rural counties were living below poverty, as compared to 14.1% of all children in South Carolina. The 10 rural counties with the highest rates of children living in poverty are identified in the chart below[18]:

Top 10 Rural Counties with Highest Proportions of Children Living Below Poverty, 1999



[17] US Census, 1999, http://www.ors2.state.sc.us/abstract/chapter13/income12.asp retrieved August 1, 2008.

[18] U.S. Census Bureau. 1999 http://www.ors2.state.sc.us/abstract/chapter13/income12.asp retrieved August 6, 2008.

Education

Related to income and employability, the next section is the **educational attainment** of a population. As of 2000, **29.4%** of rural South Carolinians aged 18 years and older lacked a high school diploma, compared to only 22.1% of their urban peers. Additionally, more rural adults than urban stop their education as a high school graduate with more urban continuing on to college. These trends are shows in Table 6 below.

Table 6: Educational Attainment for Persons Aged 18 Years and Older in South Carolina by Residence 2000[19]

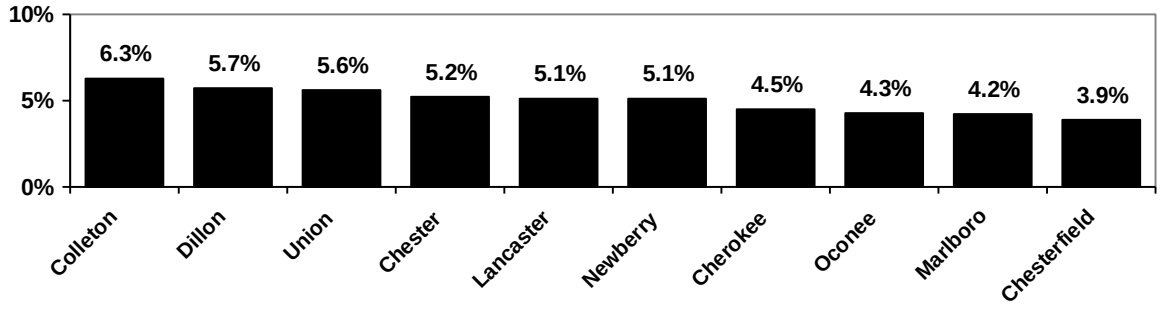
Educational Level	Urban (Total Number) (Categorical %)	Rural (Total Number) (Categorical %)	Total (Total Number) (Categorical %)
Total	2,250,894	752,025	3,002,919
Less than 9th Grade	154,020 6.8%	74,193 9.9%	228,213 7.6%
9th – 12th Grade, No Diploma	344,061 15.3%	146,771 19.5%	490,832 16.3%
No Diploma (sum of above two categories)	498,081 22.1%	220,964 29.4%	719,045 23.9%
High School Graduate	652,907 29.0%	248,920 33.1%	901,827 30.0%
Some College, No Degree	502,690 22.3%	135,148 18.0%	637,838 21.2%
Associate Degree	145,238 6.5%	40,909 5.4%	186,147 6.2%
Bachelor's Degree	307,148 13.6%	70,707 9.4%	377,855 12.6%
Graduate or Professional Degree	144,830 6.4%	35,377 4.7%	180,207 6.0%

High School drop-out rates are also an important indicator of a community's economic viability. During the 2002-2003 school year, 3.4% of rural children enrolled in the 9th through 12th grades dropped out of school, which is not remarkably different from the overall state proportion of 3.2%.[20] Many of the highest drop out rates are found in rural counties. The chart on the next page identifies the 10 rural counties with the highest drop out rates for children enrolled in the 9th through 12th grades during the 2002-2003 school year.

[19] US Census Bureau, 2000, http://www.ors2.state.sc.us/abstract/chapter7/education4.asp retrieved July 26, 2008.

[20] South Carolina Department of Education, Office of Research, Report on Student Dropout and Completion Rates," 2002-03 and "Summary of All 2002-03 S.C. High School Completers Enrolled in 2003-04 College Freshman Classes in S.C. and Other States. Retrieved from http://www.ors2.state.sc.us/abstract/chapter7/education12.asp on August 7, 2008.

Top 10 Rural Counties with Highest Drop Out Rates for Children Enrolled in Grades 9th - 12th, 2002-2003 School Year



During the same school year, two rural school districts received negative recognition from the South Carolina Department of Education. Bamberg District 2 had the largest percent of pupils eligible for the free and reduced price lunch program (93.1%). The Allendale School District had the highest teacher turnover rate from the previous school year (33.3%).[21]

Employment Status

There appear to be fewer rural South Carolinians working in management or professional positions than urban. Conversely, there are more rural adults employed in production, transportation, and material moving occupations than their urban peers. Table 7 shows the differences by occupation types.[22]

Table 7: Employed Civilian Population 16 years & over by Occupation Type and Residence, 2000

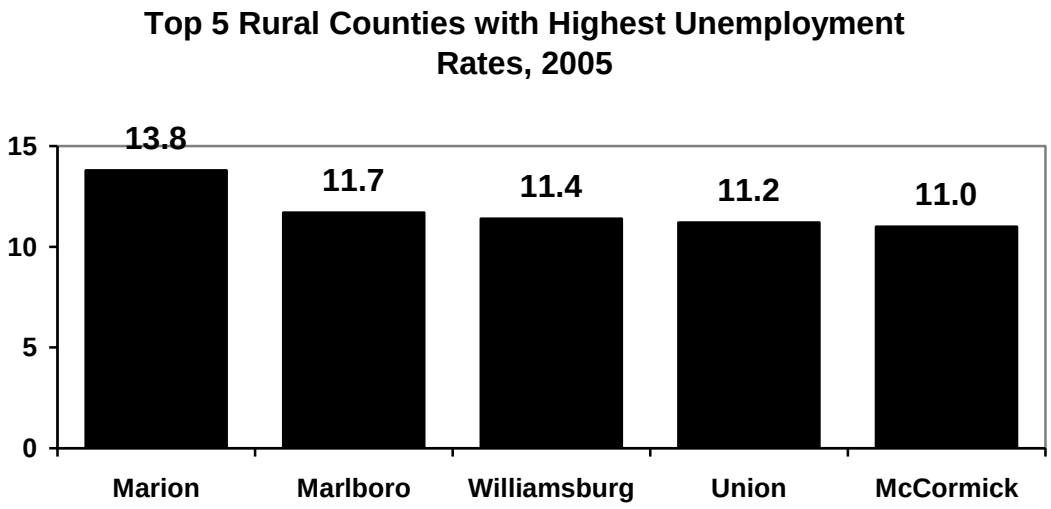
Category	Urban (Total Number) (Categorical %)	Rural (Total Number) (Categorical %)	Total (Total Number) (Categorical %)
Employed Civilian Pop. 16 & Over	1,407,539	417,161	1,824,700
Management, Professional and Related	432,081 30.7%	98,036 23.5%	530,117 29.1%
Service	205,694 14.6%	62,967 15.1%	268,661 14.7%
Sales and Office	365,069 25.9%	94,655 22.7%	459,724 25.2%
Farming, Fishing, and Forestry	6,315 0.4%	4,364 1.0%	10,679 0.6%
Construction, Extraction and Maintenance	155,811 11.1%	53,237 12.8%	209,048 11.5%
Production, Transportation and Material Moving	242,572 17.2%	103,899 24.9%	346,471 19.0%

[21] South Carolina Department of Education, Office of Research, "Rankings of the Counties and School Districts of South Carolina 2002-03," March 2005.

[22] US Census Bureau, http://www.ors2.state.sc.us/abstract/chapter8/employment8.asp retrieved July 24, 2008.

Unemployment

Contrasting with who works is those who are unemployed. For 2005, the state's unemployment rate was 6.8%, comparing sharply with the unemployment rate of the 25 rural counties, which was 9.1%. The rural county with the lowest unemployment rate in 2005 was Jasper (5.0%). The rural county with the highest rate was Marion (13.8%). The five rural counties with the highest unemployment rates in 2005 are presented in the chart below[23]:

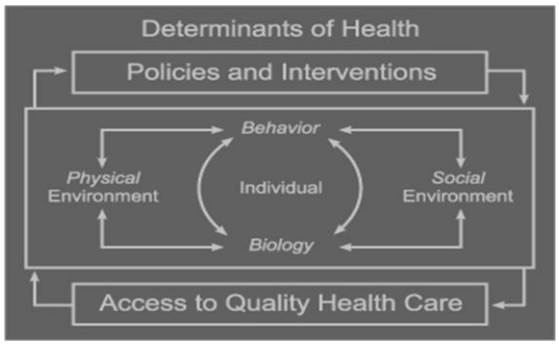


[23] U.S. Department of Labor, Bureau of Labor Statistics. Local Area Unemployment Statistics, Labor Force Data by County, 2004 and 2005 annual averages. http://www.ors2.state.sc.us/abstract/chapter8/employment16.asp retrieved on August 7, 2008.

II. Health Status of Rural South Carolina

To understand the health status of a population, it is very important to monitor and evaluate the outcomes of the determinants of health. The health status of a given population is the description of health for that area. Health status can be measured by birth and death rates, life expectancy, quality of life, morbidity from specific diseases, risk factors, use of ambulatory and inpatient care, accessibility of health personnel and facilities, financing of health care, health insurance coverage, and many other factors.

The leading causes of deaths are usually a result of a variety of factors including behavior influence, environmental factor, and/or the unavailability or inaccessibility of quality health care services, as shown in the Determinants of Health Model to the right[24]. The unavailability and inaccessibility of quality healthcare is a major factor influencing rural health status.



In the year 2005, the leading causes of death among South Carolinians were heart disease, cancer, stroke, accidents, chronic lower respiratory disease, Alzheimer's disease, diabetes, nephritic syndrome, nephrosis, pneumonia and influenza and septicemia[25].

Rural citizens experience significant health disparities. The majority of research efforts in rural communities focus on access to health care services. Access to care is an important issue to improving health status throughout rural South Carolina, however, other determinants of health should be of equal importance.

Factors Contributing to Rural Health Disparities[26]

- Limited access to health care services (remote, isolated areas);
- Limited access to health care providers;
- Lower rates of health insurance; less likely to have employer-provided health care coverage and tend to be poorer;
- Rural population is typically more elderly;
- Lack of recognition and priority by legislators for rural health concerns;
- Lower socioeconomic and educational status; and cultural and social differences which leads to cultural divide in health care.

[24] US Department of Health and Human Services, Office of Disease Prevention and Health Promotion, http://www.healthypeople.gov retrieved June12, 2008.

[25] Centers for Disease Control and Prevention, National Center for Health Statistics, http://www.cdc.gov/nchs/FASTATS/lcod.htm retrieved July 24, 2008.

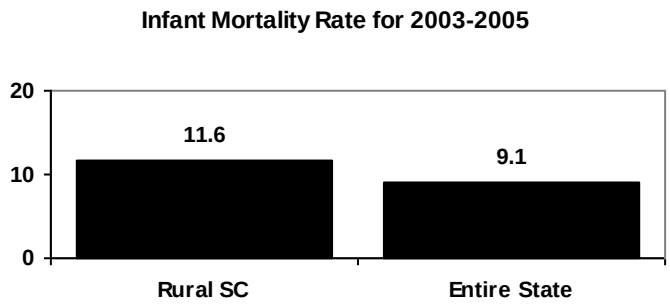
[26] University of Pittsburgh Center for Rural Health Practice, "Bridging the Health Divide, The Rural Public Health Research Agenda, April 2004", http://www.pitt.edu retrieved August 10, 2008.

Maternal and Child Health

Infant Mortality

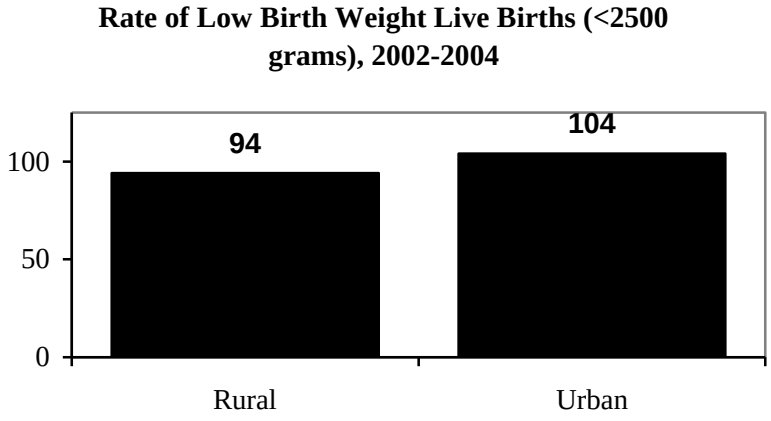
Regarded as a basic quality of life indicator for a community, the infant mortality rate (rate of infant deaths under one year of age per 1,000 live births) reflects the health of both the pregnant woman and the infant. It also reflects the condition in which a child lives during his first year of life and the parenting the child receives[27].

The infant mortality rate is higher among the 25 rural counties than the state as a whole. The rates, presented in the chart on the right, are per 1,000 births[28]. It is important to note than 19 of the 25 rural counties had fewer than 20 infant deaths during 2003-2005. There were a total of 438 infant deaths in the rural counties during the time period, which accounted for 28.5% of all infant deaths in the state.



Low Birth Weight/Very Low Birth Weight

The rate for babies with low birth weights is lower for rural mothers than urban. Data from the vital records is presented in the chart below[29]:



[27] U.S. Department of Health and Human Services, *Healthy People 2010*, 2nd ed. (Washington: U.S. Department of Health and Human Services, 2000), at 16-17, available at: http://www.healthypeople.gov/Publications/ retrieved August 12, 2008.

[28] SC Department of Health and Environmental Control. http://scangis.dhec.sc.gov/scan/mch/infantmortality/input.aspx retrieved August 10, 2008.

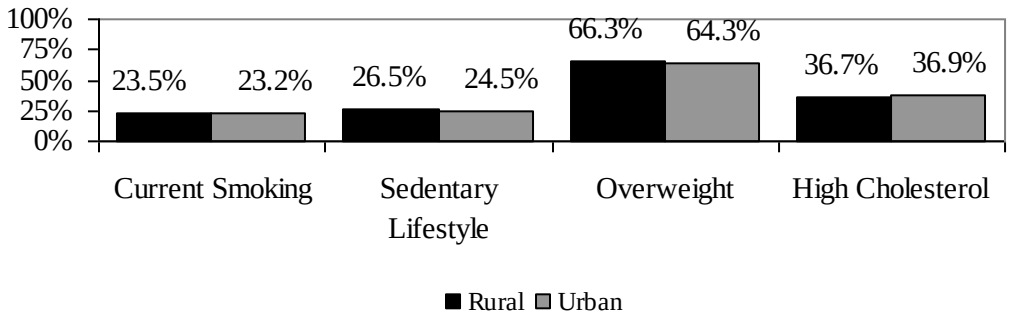
[29] SC DHEC: PHSIS- Division of Biostatistics, Division of Public Health Informatics

Chronic Disease

Chronic conditions continue to affect the health of many South Carolinians. Through primary and secondary prevention, the goal is to reduce the risk factors that contribute to the major chronic diseases and leading causes of death among South Carolinians. Risk factors such as smoking, physical inactivity, obesity, and high cholesterol are related to the major causes of morbidity and mortality among South Carolinians. Some common behavioral risk factors that contribute to the leading causes of death are smoking, sedentary lifestyle, obesity, and high cholesterol[30].

The prevalence of these risk factors from the 2005 South Carolina Behavioral Risk Factor Surveillance System (BRFSS) survey is delineated in the following chart[31].

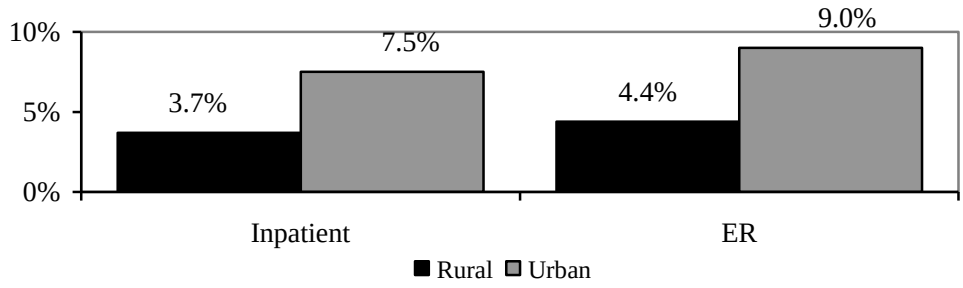
Prevalence of Risk Factors for Chronic Diseases by Residence, 2005



Asthma

Rural residents of South Carolina had fewer hospital encounters (both inpatient and emergency room) than their urban peers in 2006[32]. The chart below delineates the proportion of all inpatient admissions and emergency room encounters due to asthma for rural and urban residents of South Carolina.

Proportion of Hospital Encounters for Asthma by Residence, 2006



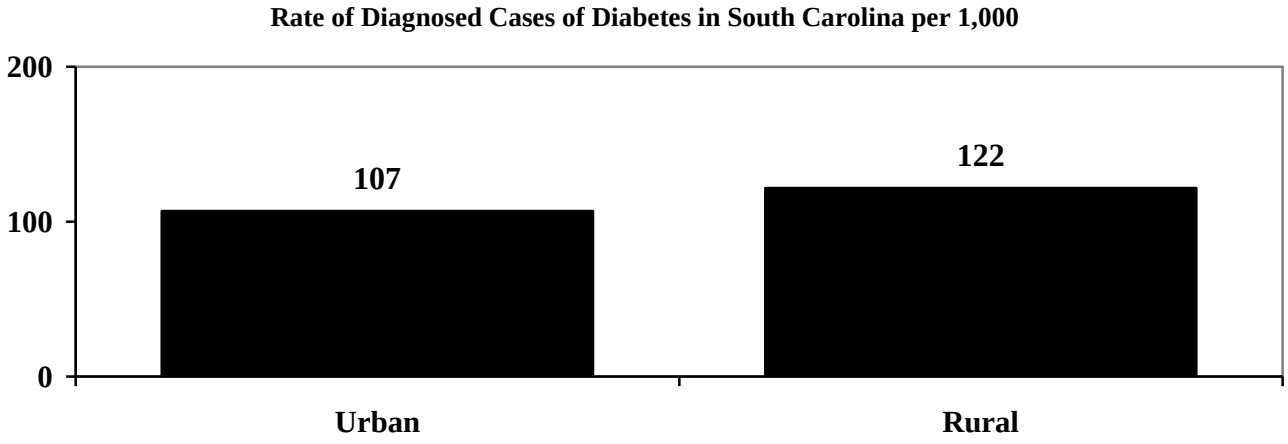
[30] South Carolina Department of Health and Environmental Control, "Impact of Chronic Conditions, 2005" http://www.scdhec.gov/hs/epidata/reports/county_reports retrieved July 1, 2008.

[31] South Carolina Department of Health and Environmental Control, "Impact of Chronic Conditions, 2005" http://www.scdhec.gov/hs/epidata/reports/county_reports retrieved July 1, 2008.

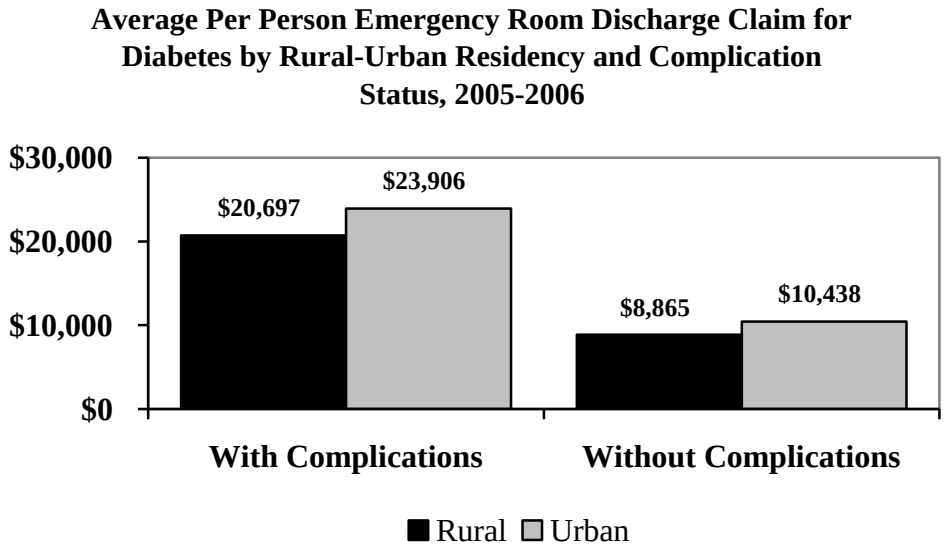
[32] South Carolina Office of Research and Statistics, http://www.ors.state.sc.us/ Retrieved August 10, 2008.

Diabetes

The prevalence rate of persons with diagnosed diabetes in 2005 was greater in rural than urban counties, as depicted in the chart below[33]. The highest rates of diabetes in South Carolina were found in the most rural of counties, 1.7 times greater than in urban counties.



Because more people live in urban than rural South Carolina counties, the actual volume and costs of care for diabetes is greater in urban. For urban counties, there were 5,249 discharges for diabetes with complications and 768 without complications. For rural counties, there were 2,409 and 415 ED discharges for diabetes with and without complications, respectively. The average costs for discharges from South Carolina Emergency Departments are slightly higher in urban than rural, in spite of demonstrable differences in volume[34].

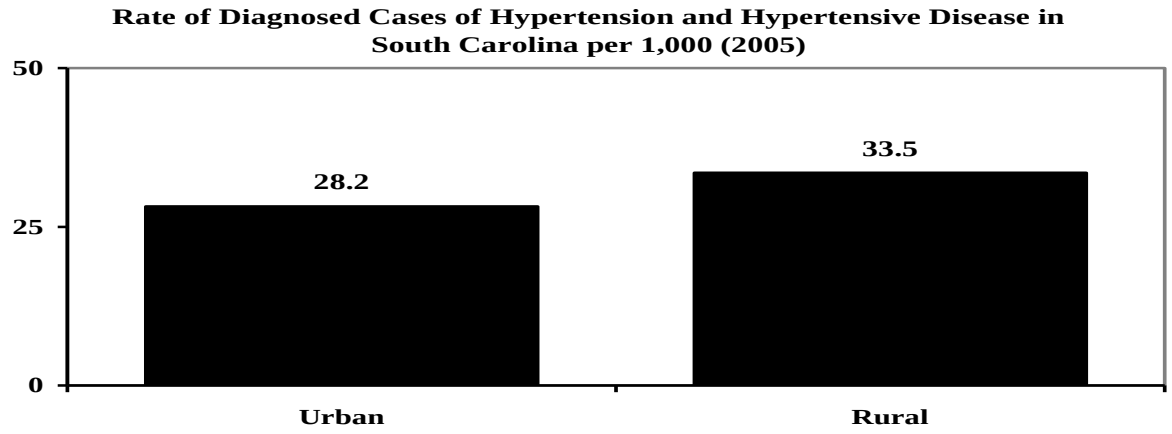


[33] South Carolina Department of Health and Environmental Control, "Impact of Chronic Conditions, 2005" http://www.scdhec.gov/hs/epidata/reports/county_reports retrieved July 1, 2008.

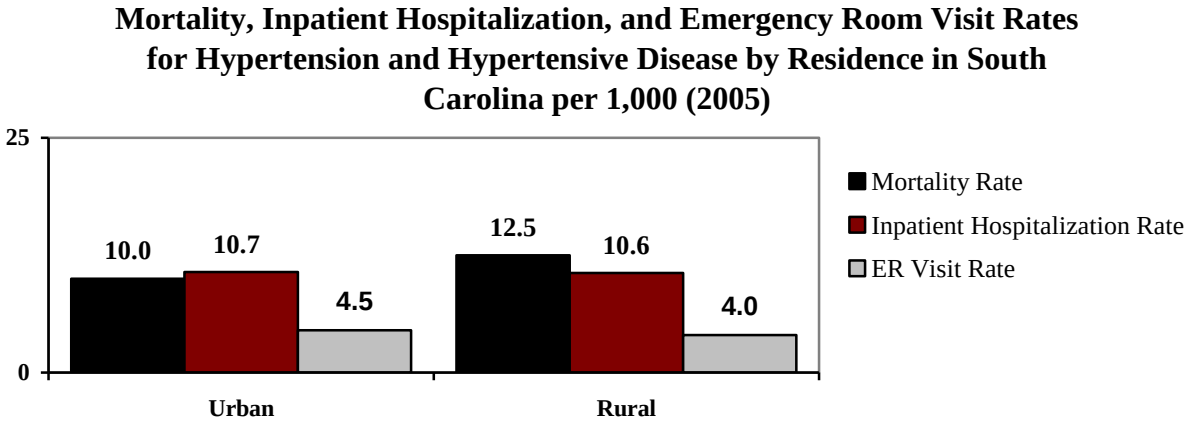
[34] SC Office of Research and Statistics. http://www.ors2.state.sc.us/erquerya.php Retrieved on August 11, 2008.

Hypertension and Stroke

The prevalence of hypertension and hypertensive diseases is much higher in rural South Carolina than in urban. The statewide rate for these conditions is 30 people per 1,000 with higher rates in rural than urban, as presented in the following chart[35].



As with prevalence, mortality rates from these conditions are slightly higher for rural residents with roughly 12.5 out of every 1,000 rural deaths due to these conditions, as compared to 10 for urban[36]. However, hospital service utilizations are slightly lower for rural residents, as presented in the following chart[37].



[35] South Carolina Department of Health and Environmental Control, "Impact of Chronic Conditions, 2005" http://www.scdhec.gov/hs/epidata/reports/county_reports retrieved July 1, 2008. Division of Biostatistics, Office of Public Health Statistics and Information Systems, DHEC using ICD-codes.
[36] ibid
[37] SC Office of Research and Statistics. http://www.ors2.state.sc.us/inpatient.php Retrieved on August 11, 2008.

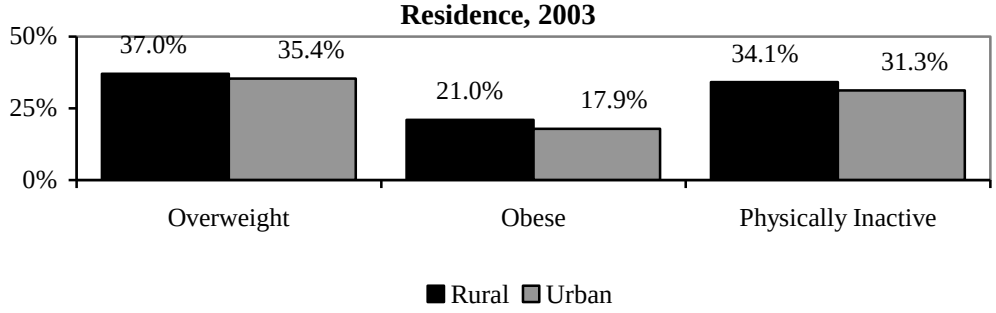
The prevalence of residents who have had a stroke is relatively low (3% urban v. 3.2% rural) due to the high mortality rate that accompanies the event[38]. Statewide, 63% of all deaths are due to stroke. Examined by rural-urban status, rural fairs slightly better than urban with 55% versus 66% of deaths due to stroke[39]. In rural, 24% of hospital admissions are due to stroke, compared to 32% for urban residents[40]. Emergency room visits are markedly lower and have less variability[41].

Obesity

Overweight or obese is defined as having a body mass index (BMI) greater than or equal to 25.0kg/meters squared. Obesity is a contributing factor for asthma and other respiratory problems, hypertension, diabetes, coronary heart disease, depression, gallbladder disease, osteoarthritis, sleep apnea, stroke, and some cancers[42].

The overweight/obesity epidemic disproportionately affects rural children in South Carolina. More than 1 out of 3 rural children in South Carolina aged 10-17 years old were overweight or obese. Data from the 2003 National Survey of Children's Health demonstrate that rural children in our state are more likely to be overweight and physical inactive than their urban peers.

Percent of Children in SC with Select Obesity Indicators by Residence, 2003



Obesity is defined as a body mass index exceeding the 95th percentile for the age and gender[43].
The same data yielded the following facts for rural children and obesity indicators:

- Nearly one-half of all black rural children in South Carolina were overweight or obese (47.8%), as were 22.8% of white children.
- More than one-third of rural children (36.9%) in low income families (<200% FPL) were overweight or obese.

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[38] South Carolina Department of Health and Environmental Control, "Impact of Chronic Conditions, 2005" http://www.scdhec.gov/hs/epidata/reports/county_reports retrieved July 1, 2008. Division of Biostatistics, Office of Public Health Statistics and Information Systems, DHEC using ICD-codes.
[39] ibid
[40] SC Office of Research and Statistics. http://www.ors2.state.sc.us/inpatient.php Retrieved on August 11, 2008.
[41] South Carolina Department of Health and Environmental Control, "Impact of Chronic Conditions, 2005" http://www.scdhec.gov/hs/epidata/reports/county_reports retrieved July 1, 2008.

[42] South Carolina Rural Research Center, Overweight and Physical Inactivity among Rural Children Aged 10-17: A National and State Portrait. Data from the 2003 National Survey of Children's Health. http://rhr.sph.sc.edu/report_by_topic.html Retrieved on August 10, 2008.

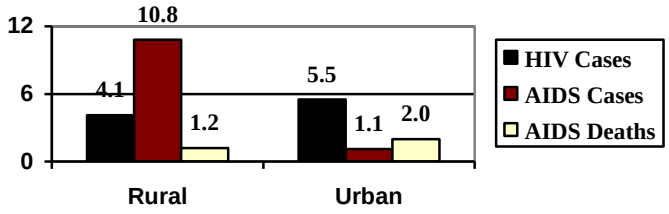
[43] South Carolina Rural Research Center, Overweight and Physical Inactivity among Rural Children Aged 10-17: A National and State Portrait. Data from the 2003 National Survey of Children's Health. http://rhr.sph.sc.edu/report_by_topic.html Retrieved on August 10, 2008.

- More than one-half of rural children (58.0%) did not participate in after school sports, the highest rate in the United States.
- More than one-half of rural South Carolina children (53.6%) spent more than two hours per day using electronic entertainment media.

HIV/AIDS

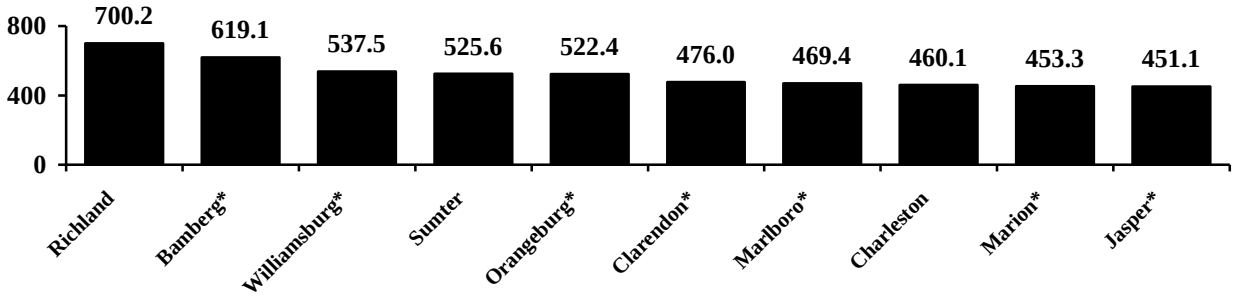
According to the South Carolina Department of Health and Environmental Control (DHEC), more than 16,000 HIV/AIDS cases have been reported in the state since 1986. From July 1999 through June 2000, South Carolina ranked eighth in the nation in reported HIV/AIDS cases. More than seven of every 10 men (73%) and more than eight of every 10 women (83%) diagnosed are African American[44].

Cumulative Rate per 1,000 for HIV and AIDS Cases and Deaths due to AIDS by Residence



Rural counties have demonstrably higher rates of AIDS cases, but lower rates of HIV cases and AIDs deaths, as show in the chart on the right. Six of the 10 counties with the highest rates of AIDS are rural counties. The rankings are cumulative (per 100,000 persons) through 2005.[45] The AIDS population rates for the 10 most prevalent counties are presented in the chart below:

Cumulative Rate through 2005 of AIDS per 100,000 persons for the 10 Most Prevalent Counties



**Rural county*

Cancer

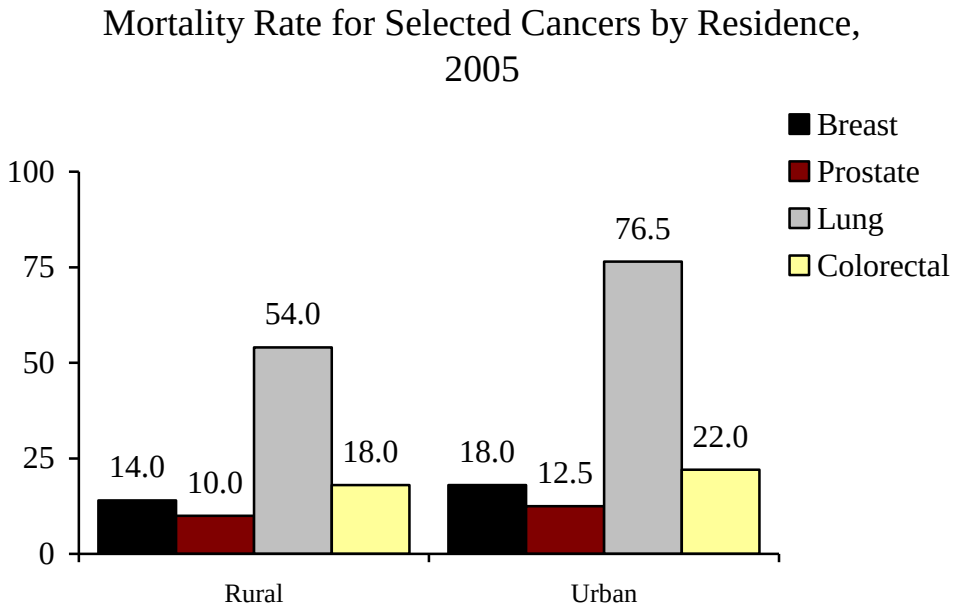
Cancer is the second leading cause of death in South Carolina. South Carolina also has some of the highest rates of cancer deaths in the nation, ranking 2nd in the nation in multiple myeloma, 3rd in the nation in prostate cancer and oral/pharyngeal cancer deaths, and 4th in the nation in pancreatic cancer deaths.[46]

[44] South Carolina Department of Health and Environmental Control, Bureau of Disease Control, http://scdhec.gov/health/disease/stdhiv/surveillance retrieved July8, 2008.
[45] South Carolina Department of Health and Environmental Control, Bureau of Disease Control, http://scdhec.gov/health/disease/stdhiv/surveillance retrieved July8, 2008.

[46] South Carolina Department of Health and Environmental Control, SC Cancer Facts and Figures 2004-2005.

How Does South Carolina Rank in Cancer Mortality?[47]	
Multiple Myeloma	2nd
Oral/Pharynx	3rd
Prostate	3rd
Pancreas	4th
Esophagus	3rd
Cervix	8th
Stomach	11th

Death rates for a variety of cancers are somewhat higher in urban than rural South Carolina[48]. The chart below delineates mortality rates per 1,000 people for breast, prostate, lung, and colorectal cancers:



Breast Cancer is the most commonly diagnosed cancer among women in South Carolina, regardless of race, accounting for 32% of all female cancer cases. There are four counties (Allendale, Beaufort, Dorchester, Richland) that have incidence rates significantly higher than the state average[49].

Prostate Cancer is the most commonly diagnosed cancer among men in South Carolina, regardless of race, accounting for 30% of all male cancer cases. South Carolina has one of the

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[47]South Carolina Department of Health and Environmental Control, SC Cancer Facts and Figures 2004-2005.

[48] Division of Biostatistics, Office of Public Health Statistics and Information Systems, DHEC using ICD-codes.

[49] ibid

highest prostate cancer mortality rates in the nation, currently ranking 3rd in the nation in prostate cancer mortality[50].

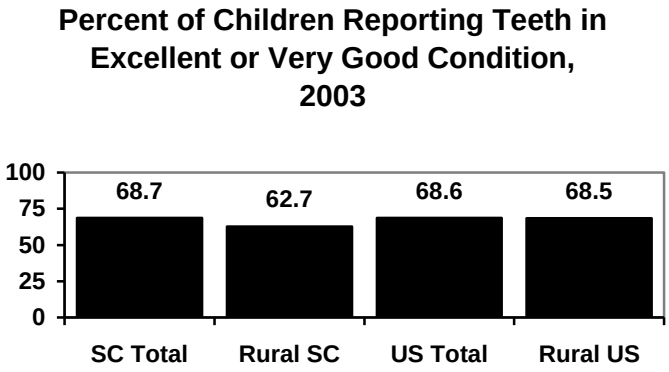
Lung Cancer is the second most common cancer diagnosed in South Carolina, accounting for nearly 16% of all cancer cases. The incidence rate of lung cancer is higher for men than for women; however, rates for men are decreasing, while rates for women are increasing. Seven counties diagnosed (Berkeley, Cherokee, Colleton, Darlington, Horry, Kershaw, Lexington) have incidence rates that are significantly higher than the state average. In 2005, South Carolina was ranked 18th in the nation in lung cancer mortality. An estimated 2,730 South Carolinians were expected to die of lung cancer in 2005[51].

Colorectal Cancer

Colorectal cancer is the fourth most common cancer diagnosed in South Carolina, accounting for nearly 12% of all cancer cases diagnosed. From 1996-2001, a total of 12, 226 colorectal cancers were diagnosed in South Carolina, with 51% of the cases occurring in males and 49% in females. Six counties (Berkeley, Charleston, Chester, Dorchester, Kershaw, Lancaster) have incidence rates significantly higher than the state average[52].

Oral Health

Oral health is a fundamental and critical component of health throughout life. Data from the 2003 National Survey of Children's Health demonstrates children living in rural South Carolina have more oral health challenges. "Dental Health and Access to Care among Rural Children," a chartbook developed by the SC Rural Health Research Center, demonstrated this comparison[53]:



The 2007-2008 Oral Health Needs Assessment conducted by SC Department of Health and Environmental Control revealed that rural children's oral health status is more compromised than

[50] SC DHEC, Office of Public Health Statistics and Information Services, South Carolina Central Registry.

[51] ibid

[52] ibid

[53] SC Rural Health Research Center, University of South Carolina, "Dental Health and Access to Care among Rural Children. http://rhr.sph.sc.edu/index.php Retrieved on August 11, 2008.

their urban peers[54]. Children living in rural areas were more likely than urban to have tooth decay (51% v. 45%), untreated cavities (29% v. 18%), and have treatment urgencies (23% v. 17%).

III. The Organization and Support of Rural Health Systems in South Carolina

The following section describes the types and numbers of rural health facilities in South Carolina that comprise the rural health infrastructure. Programs aimed at improving rural health services are also described in some detail to include recruitment and retention programs aimed at developing and supporting rural health networks.

The Rural Hospital

There are 75 Medicare certified hospitals in South Carolina, of which eight are psychiatric hospitals, two are long-term care hospitals, and three are rehabilitation hospitals. There are a total of 58 hospitals in South Carolina with fewer than 100 licensed beds. Of those, nine are Department of Corrections Infirmaries, six are other State facilities, five are private psychiatric facilities, three are rehabilitation hospitals, and two are educational institution infirmaries; the remaining 29 are general acute care hospitals. In addition, 26 of the 58 are located in cities or towns with fewer than 10,000 residents[55]. Table 8 identifies the states rural hospitals and the years they were established.

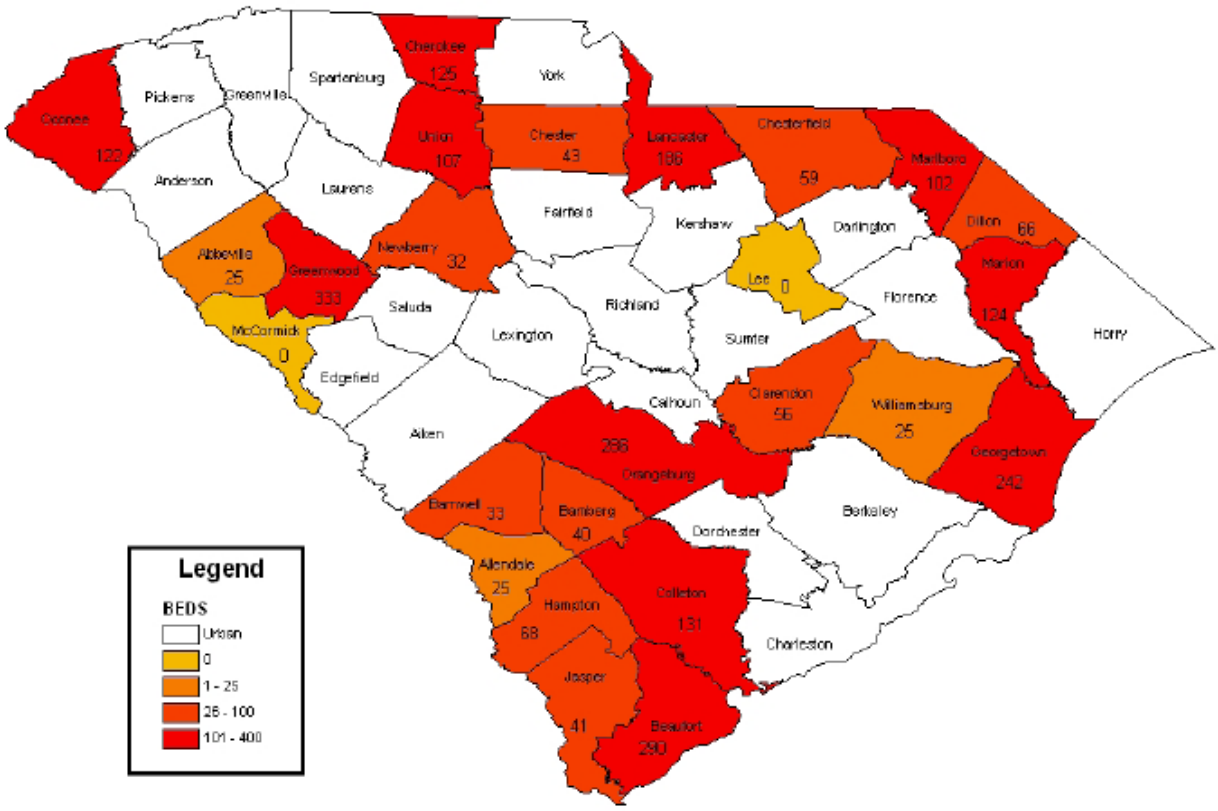
Table 8: Rural Hospitals in South Carolina and Year of Establishment

Hospital	Year Est.	Hospital	Year Est.	Hospital	Year Est.
Abbeville Area Medical Center	1919	Conway Medical Center	1982	Marlboro Park Hospital	No data
Allen Bennett Memorial Hospital	1952	East Cooper Regional Medical Ctr	No data	McLeod Medical Center - Darlington	No data
Allendale County Hospital	No data	Edgefield County Hospital	No data	McLeod Medical Center – Dillon	No data
Bamberg County Memorial Hospital	1952	Fairfield Memorial Hospital	No data	Newberry County Memorial Hospital	1925
Barnwell County Hospital	No data	Georgetown Memorial Hospital	1950	Oconee Memorial Hospital	1939
Beaufort Memorial Hospital	1944	Hampton Regional Medical Center	1950	Palmetto Health Baptist – Easley	1939
Cannon Memorial Hospital	1947	Hilton Head Regional Medical Ctr	1971	Self Regional Healthcare	1951
Carolina Pines Regional Medical Center	1999	Kershaw County Medical Center	1913	Springs Memorial Hospital	No data
Chester Regional Medical Center	No data	Kindred Healthcare-Charleston	No data	Summerville Medical Center	No data
Chesterfield General Hospital	No data	Lake City Community Hospital	No data	Upstate Carolina Medical Center	1988
Clarendon Memorial Hospital	1951	Laurens County Health Care System	1990	Waccamaw Community Hospital	1950
Coastal Carolina Medical Center	No data	Loris Healthcare System	1950	Wallace Thomson Hospital	1921
Colleton Medical Center	No data	Marion County Medical Center	1952	Williamsburg Regional Hospital	1962

[54] SC Department of Health and Environmental Control, Division of Oral Health. Draft results from 2007-2008 Oral Health Needs Assessment (no publication as of August 11, 2008).

[55] South Carolina Hospital Association: www.scha.org & www.myschospital.org

There are a total of 2,561 hospital beds in rural South Carolina. The map below illustrates the number of beds per county:



Top 5 County Inpatient Discharges

Rural hospitals are a major provider of care in the local healthcare systems. The top five discharges for each of the rural counties are identified in Table 9 (next page). The data is based on rural residency, not the location of the hospital. For example, a resident of Bamberg could have delivered in Hampton County, in which case the discharge would have counted in Bamberg County.

Table 9 County Listing of Top 5 Discharges

County	Top 5 Discharges (in order of frequency)
Abbeville	1, 2, 3, 4, 5
Allendale	1, 4, 5, 7, 8
Bamberg	1, 5, 8, 4, 9
Barnwell	5, 1, 4, 7, 6
Beaufort	1, 2, 3, 4, 10
Charleston	1, 6, 2, 4, 3
Cherokee	1, 11, 5, 4, 10
Chester	1, 4, 11, 5, 12
Chesterfield	5, 1, 4, 7, 11
Clarendon	1, 4, 5, 7, 2
Colleton	1, 4, 10, 7, 8
Darlington	4, 1, 5, 10, 7
Dillon	4, 1, 10, 7, 8
Dorchester	1, 2, 10, 3, 4
Edgefield	5, 4, 1, 11, 6
Fairfield	1, 5, 4, 7, 2
Florence	1, 4, 7, 10, 2
Georgetown	1, 4, 3, 10, 13
Greenville	1, 2, 3, 4, 14
Greenwood	1, 3, 4, 2, 6
Hampton	1, 4, 7, 2, 13
Horry	1, 4, 11, 5, 10
Jasper	1, 4, 7, 2, 13
Kershaw	1, 4, 5, 2, 7
Lancaster	13, 1, 7, 4, 15
Laurens	1, 2, 3, 4, 5
Marion	4, 1, 11, 10, 7
Marlboro	4, 5, 1, 7, 16
Newberry	1, 4, 10, 2, 13
Oconee	1, 17, 3, 5, 7
Pickens	1, 3, 5, 2, 4
Union	4, 1, 11, 5, 7
Williamsburg	4, 1, 5, 7, 18

Key:
(1) Vaginal delivery w/o complications
(2) Cesarean
(3) Major joint replacement
(4) Heart failure/shock
(5) Simple pneumonia
(6) Psychoses
(7) Esophagitis, Gastroent & Misc Digest Disorders
(8) Renal failure
(9) Intracranial Hemorrhage or Cerebral Infarction
(10) Chest Pain
(11) Chronic Obstructive Pulmonary Disease
(12) Percutaneous Cardiovascular Procedure
(13) Rehabilitation
(14) Uterine & Adnexa Pro for non-malignancy
(15) Other Antepartum Diagnoses w/medical complications
(16) Septicemia
(17) Pulmonary Edema & Respiratory failure
(18) Red blood cell disorders

Rural residents were more likely to be hospitalized for conditions treatable on an outpatient basis[56]. The consequences of compromised access to care manifest in a variety of ways.

- Overall, rural residents are 26% more likely to be hospitalized for a possibly preventable hospitalization than urban residents
- Rural adults aged 19-44 are 23% more likely to be hospitalized for diabetes than urban.
- Rural blacks are 57% more likely to die from diabetes than are rural whites.
- Very rural blacks are 70% more likely to die from diabetes than are very rural whites.
- 48% of rural residents (and 55% of very rural residents) are hospitalized out of county (versus 19% in urban areas).

Characteristics of Small/Rural Acute Care Hospitals in South Carolina

Critical Access Hospitals (CAH) are part of the Rural Hospital Flexibility Grant Program, a federal initiative that provides funding to states to strengthen rural healthcare. The CAH program was initiated to not only to reduce hospital closures, but to progress rural healthcare. CAH provide the community with fundamental services. For services provided to Medicare patients, the Critical Access Hospitals are reimbursed on a "reasonable cost basis.[57]" Table 10 identifies rural hospitals with critical access designations.[58]

The Social Security Act allows specific small and rural hospitals to enter into a swing-bed agreement; this allows the hospital to use its beds to provide either acute or Skilled Nursing Facility care, as needed. In order to be designated as a swing bed hospital, a hospital or critical access hospital must participate in Medicare, meet certain requirements, and have approval from CMS to provide post-hospital Skilled Nursing Facility care[59]. Table10 identifies rural hospitals with swing beds[60].

Table 10 Critical Access Hospitals and Swing Beds

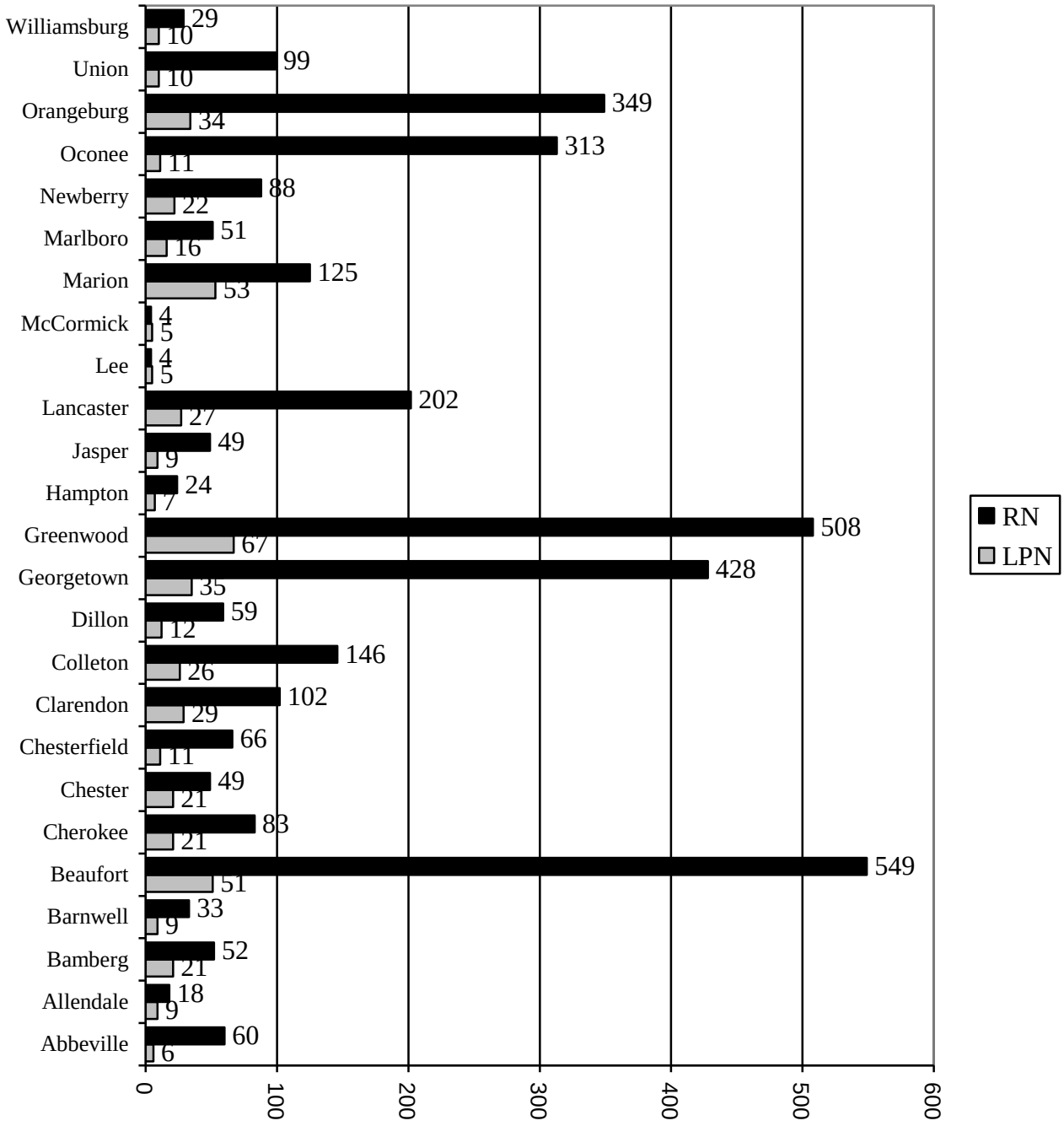
SC Rural Hospitals	Critical Access	Swing Beds
Abbeville Areas Medical Center	Yes	Yes
Allendale County Hospital	Yes	Yes
Bamberg County Memorial Hospital		Yes
Chesterfield General Hospital		Yes
Coastal Carolina Medical Center		Yes
Edgefield County Hospital	Yes	Yes
Fairfield Memorial Hospital	Yes	Yes
Lake City Community Hospital		Yes
Marlboro Park Hospital		Yes
McCleod Medical Center-Darlington		Yes
Wallace Thompson Hospital		Yes
Williamsburg Regional Hospital	Yes	

[56] South Carolina Hospital Association: www.scha.org & www.myschospital.org
[57] South Carolina Hospital Association: www.scha.org & www.myschospital.org
[58] National Rural Health Association (www.nrharural.org)
[59] Department of Health and Environmental Control: http://www.scdhec.net
[60] (2008). Swing bed providers. Retrieved April 20, 2008, from Centers for Medicare& Medicaid Services Web site: http://www.cms.hhs.gov.

Nursing Shortages

The national and state nursing shortages get significant attention. The number of RNs and LPNs employed in hospitals in the 25 rural counties is presented in the chart below:

Active RN's and LPN's Employed in Hospitals in Rural Counties of South Carolina



RN Shortage Facts

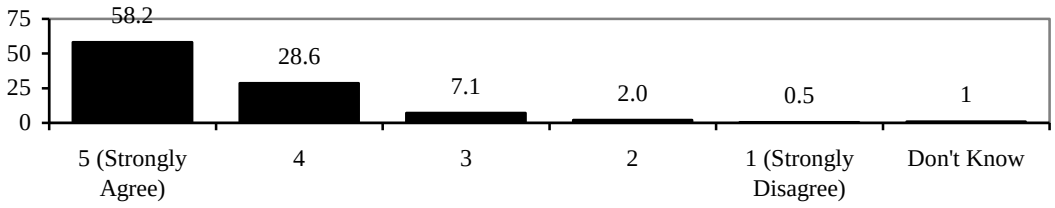
The nursing shortage exists predominantly in rural areas that are not adjacent to cities. One study suggests that this is due indirectly to lower per capita income and higher unemployment rates[61]. Some barriers to rural nursing recruitment and retention include difficulty in spouses finding jobs, long commutes, less opportunities for specialty care, and misperception of what rural nursing really is like.[62]

Hospital Leadership

As a part of a dissertation in 2007, Dr. Royce (Beebe) Adams conducted a survey of boards of directors from rural hospitals in South Carolina. Select findings (shown as percents) are presented below from her survey that asked respondents to indicate their level of agreement[63]:

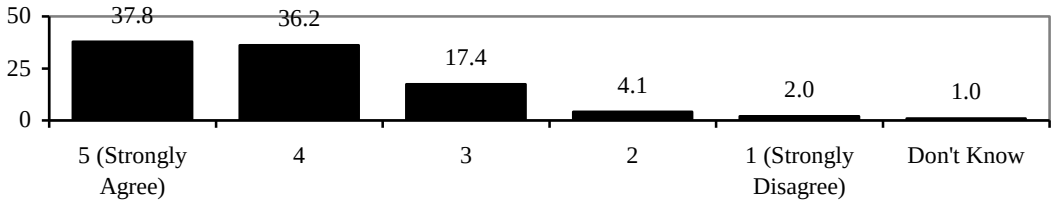
Policies

Strong policies exist for the key areas of finance, personnel, quality, safety, ethics, and all functions unique to our organization's work.

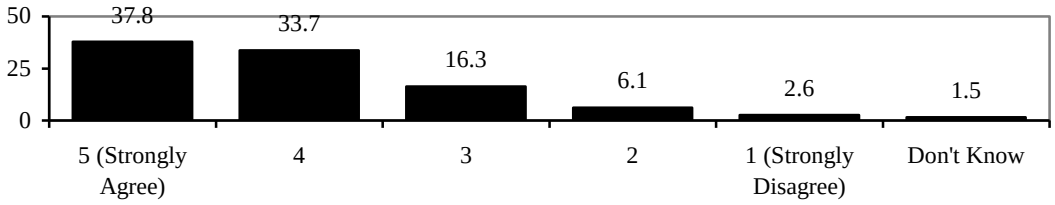


Finance

Financial reports are clearly understood by the Board.



The Board identifies any early warning signals of poor financial performance.



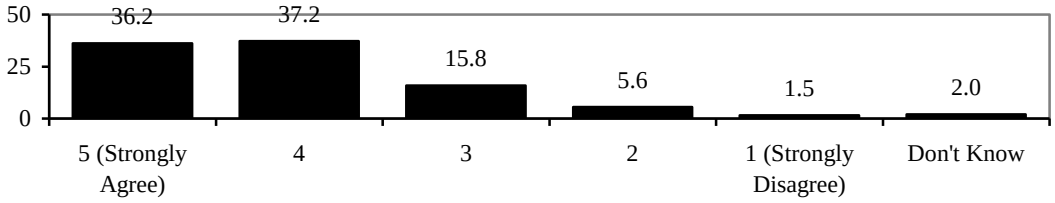
[61] Trossman, S. (2001, July/August). Rural Nursing Anyone? Recruiting nurses is always a challenge. *The American Nurse*, 33(4), 17-19.

[62] Parran, L. (2002, June). Healthcare facilities Take Innovative Approaches to Recruitment and Retention: What's the rural perspective? *ONS News*, 17(6), 5.

[63] Adams, Royce. "Characteristics of Small and Rural Acute Hospital Boards in South Carolina." Dissertation for completion of the Doctor of Philosophy in the Department of Health Services Policy and Management. Norman J. Arnold School of Public Health, University of South Carolina. 2007.

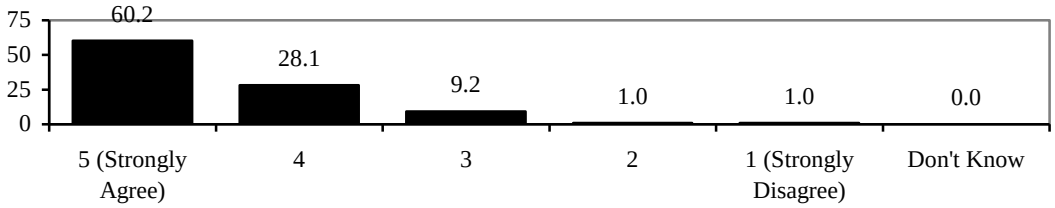
Strategic Plan

The strategic plan is used effectively to guide and evaluate efforts during the year.



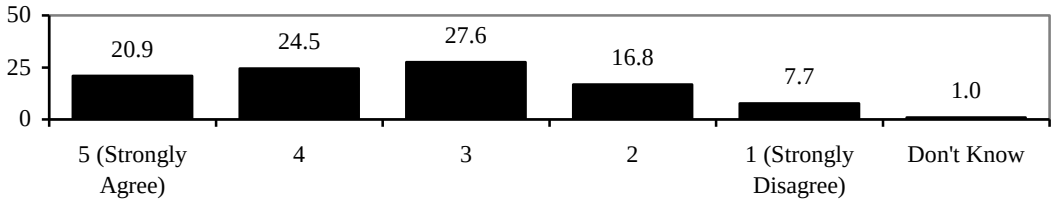
Quality of Care

The Board monitors quality of care, patient safety, and outcomes indicators.



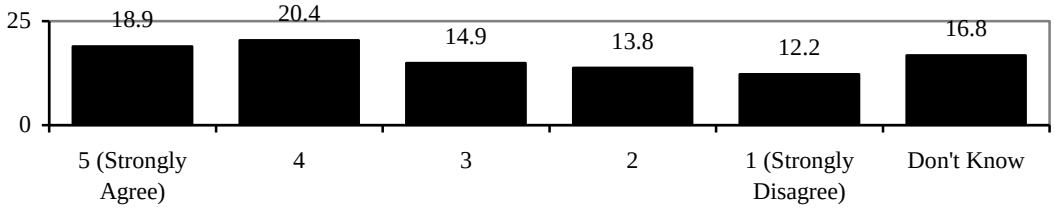
Structure

The Board membership reflects the racial composition of the community.



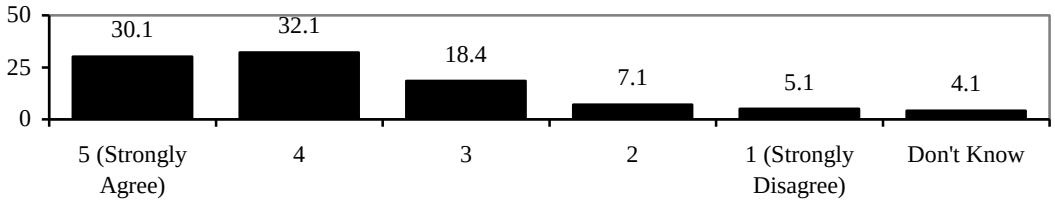
Organization.

The Board has an effective process for removing non-performing Board members.

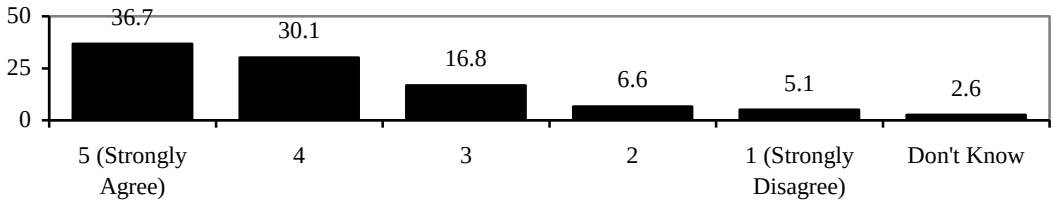


Orientation

Board members get a basic orientation about risk management, EMTALA, HIPAA & medical liability.

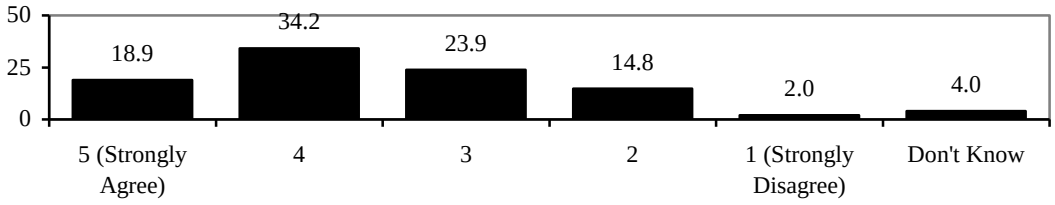


Orientation is reinforced by an ongoing program of education and development.

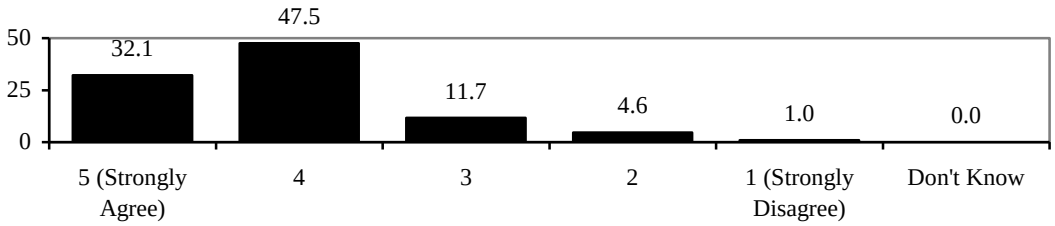


Knowledge

Board members clearly understand the third-party reimbursement system in healthcare.



The expertise/skill levels needed to be an effective board for this organization are adequately represented among current board members.



Long-Term Care (LTC) Facilities/Services

Long-Term Care is a comprehensive range of health, personal, and social services delivered over time to meet the needs of and increase the quality of life of older adults[64]. Researchers, Policy Makers, and care providers are becoming increasingly more aware of the challenges of meeting the complex health and social needs of elderly rural Americans.

As the rural population gets older, the use of healthcare resources continues to rise. Many older Americans living in rural areas remain on waiting lists for essential services or need services that are not available in the area. Changes in policy are reflected in a growing reliance on private funds for services and expansion of residential care alternatives[65]. To delineate the issues and recommended policy for rural LTC, the NHRA has identified the following as priorities[66]:

Long-Term Care Priorities of the National Rural Health Association 2007

- State and Federal reimbursement policies in rural areas
- Home and community-based services in rural long-term care
- Long-term care infrastructure in rural America
- Research Priorities for rural long-term care

Profile of the Rural Older Adults

Despite their growing numbers, the rural elderly are poorer and less healthy than their urban counterparts. Economically, the incomes of older adults in small towns and rural communities tend to be considerably lower than their urban counterparts[67].

The rural elderly also report more chronic illness and physical impairment than their urban elders. Moreover, the availability services, health professionals and other practitioners is typically less in rural areas[68]. Rural older adults represent a larger proportion of the rural population than the urban population[69]. The elderly residents in rural areas have access to fewer long-term care services[70].

Long-Term Care Capacity

As of March 2008, there are 46 long-term care facilities with 4,318 beds with an average occupancy rate of 96% in rural South Carolina.[71] Also, 74% of the facilities are for-profit

[64] National Rural Health Association (www.nrharural.org)
[65] Coburn, AF Bedow, J, & Ladd, R. (2000). Rural long-term care: What we need to know to improve policy and programs. Draft Rural Health Agenda Setting Conference. Washington, D.C.
[66] National Rural Health Association (www.nrharural.org)
[67] Coward, R.T., & Lee, G.R. (1985). The Elderly in Rural Society. New York: Springer.
[68] Dwyer, J.W., Miller, M.D. (1990). Determinants of primary caregiver stress and burden: Area of residence and the caregiving networks of frail elders. The Journal of Rural Health, 6(2), 161-184
[69] U.S. Census Bureau. Age and Sex: 2000.
<http://factfinder.census.gov/servlet/GCTTable?_ts=91533140790>January 7, 2004.
[70] Barnes, N.D. Formal home care services: Examining the long-term care needs of rural older women. Journal of Case Management 6(4):162-165, 1997.
[71] 2008 UCompareHealthCare, LLC

organizations with 17% being not-for-profit and 9% government or county owned. The distribution of long-term care facilities is presented in the map below, which demonstrates the number of facilities per county[72].

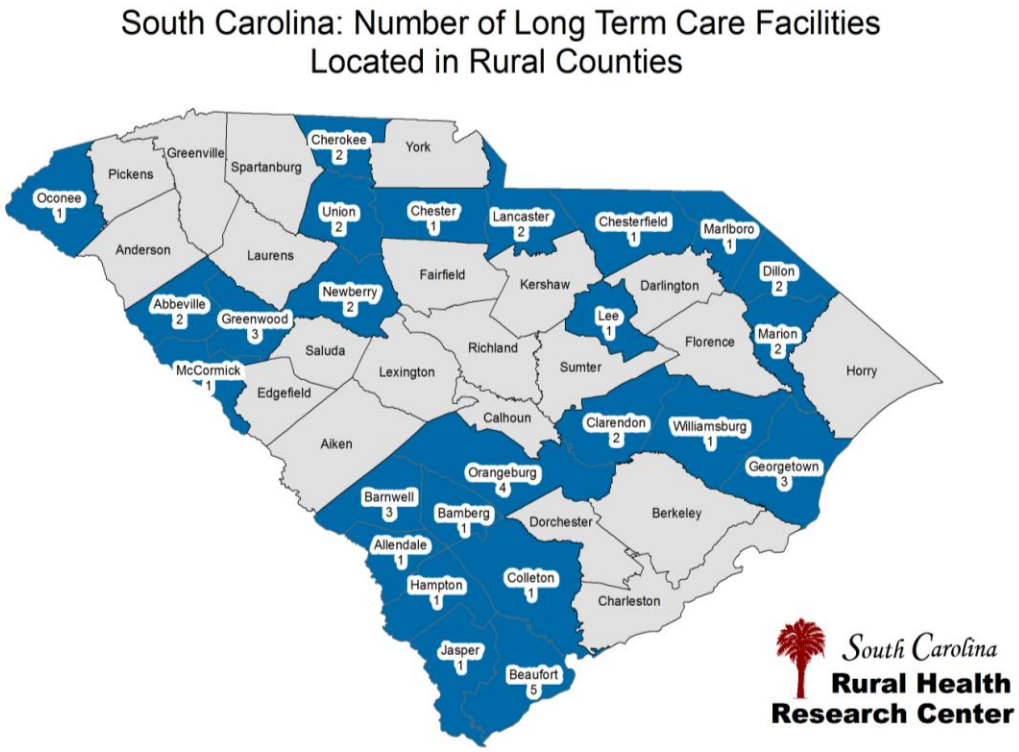


Table 11 delineates the number of long-term care beds in each rural county, which ranges as few as 34 to as many as 410[73].

Table 11: Total Long-Term Care Beds Per Rural County

County	# of Beds	County	# of Beds	County	# of Beds
Abbeville	116	Allendale	44	Bamberg	85
Barnwell	88	Beaufort	410	Cherokee	229
Chester	34	Chesterfield	204	Clarendon	152
Colleton	132	Dillon	195	Georgetown	256
Greenwood	303	Hampton	104	Jasper	88
Lancaster	274	Lee	120	McCormick	120
Marion	180	Marlboro	110	Newberry	264
Oconee	132	Orangeburg	393	Union	201
Williamsburg	88				

[72] National Rural Health Association (www.nrharural.org)
[73] 2008 UCompareHealthCare, LLC

Table 12 identifies the name of each long-term care facility, the number of licensed beds, the occupancy rate as of 2008, and its ownership status[74].

Table 12: Long-Term Care Facilities and Number of Beds Per Rural County

County	Facility	# Beds	Occupancy Rate	Ownership
Abbeville	Abbeville Nursing Home	94	90%	FP/Corp.
	Due West Retirement Center	22	No data	FP/Private
Allendale	John Edward Harter Nursing Center	44	86%	Gov./County
Bamberg	Laurel Baye Healthcare of Blackville	85	94%	FP/Partnership
Barnwell	Barnwell County Nursing Home	40	100%	Gov./County
	Laurel Baye Healthcare of Blackville	85	94%	FP/Partnership
	Laurel Baye Healthcare of Williston	44	91%	FP
Beaufort	Bayview Manor, L.L.C.	170	95%	FP/Corp.
	Fraser Health Care	33	82%	NFP/Corp.
	Life Care Center of Hilton Head	88	92%	FP/Corp.
	Preston Health Center	44	82%	NFP/Corp.
	Tidepoint by Hyatt Care Center	50		FP/Corp.
Cherokee	Brookview HealthCare Center	132	95%	FP/Corp.
	Cherokee County Long Term Care Facility	97	92%	Gov.
Chester	HealthSouth Rehab. Hospital of Rock Hill	34		FP/Corp.

[74] 2008 UCompareHealthCare, LLC

County	Facility	# Beds	Occupancy Rate	Ownership
Chesterfield	Cheraw Healthcare, Inc.	100	97%	FP/Corp.
	Chesterfield Convalescent Center, Inc.	104	100%	FP/Corp.
Clarendon	Lake Marion Nursing Facility	88	92%	NFP/Other
	Windsor Manor	64	92%	NFP/Corp.
Colleton	Oakwood Health Care	132	98%	FP/Corp.
Dillon	The Pines Healthcare Center, Inc.	84	94%	FP
	Sunny Acres	111	98%	FP
Georgetown	Georgetown Health and Rehab, Inc.	84	85%	FP/Corp.
	Lakes at Litchfield	24	96%	FP/Corp.
	Prince George HealthCare Center	148	93%	FP/Corp.
Greenwood	Magnolia Manor-Greenwood	88	100%	FP
	NHC Healthcare, Greenwood	152	93%	FP/Corp.
	Wesley Commons	63	92%	NFP/Corp.
Hampton	Harper Nursing Center	104	92%	FP
Jasper	Ridgeland Nursing Center, Inc.	88	99%	FP/Corp.
Lancaster	Lancaster Convalescent Center, Inc.	142	97%	FP/Corp.
	White Oak Manor - Lancaster	132	99%	FP/Corp.
Lee	McCoy Memorial Nursing Center	120	95%	FP/Corp.
McCormick	McCormick Health Care Center	120	93%	FP

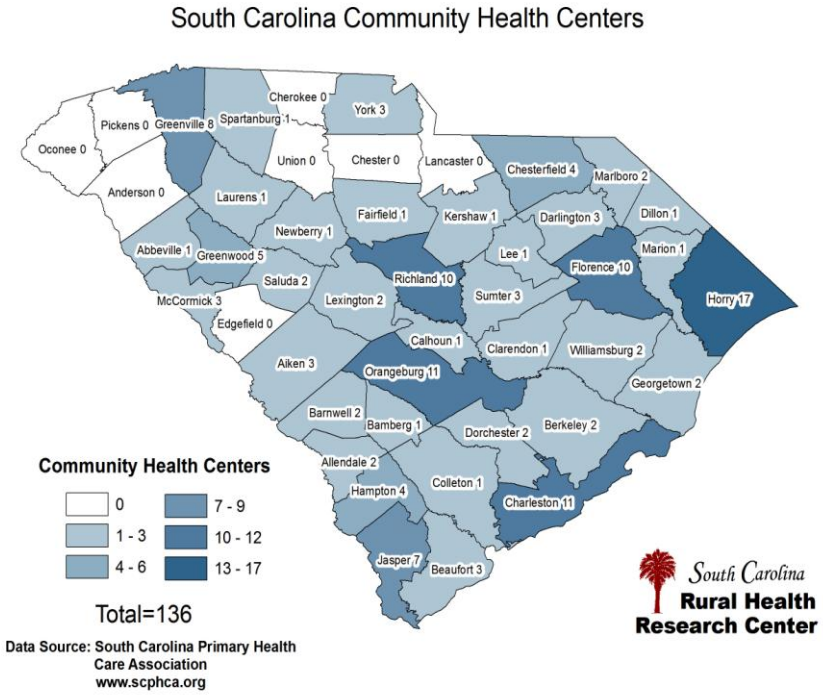
County	Facility	# Beds	Occupancy Rate	Ownership
Marion	Marion Nursing Center	88	99%	FP/Corp.
	Mullins Nursing Center	92	97%	NFP/Other
Marlboro	Dundee Nursing Home	110	97%	FP/Corp.
Newberry	J. F. Hawkins Nursing Home	118	96%	Gov./County
	White Oak Manor - Newberry	146	97%	FP/Corp.
Oconee	Mariner Health Care of Seneca	132	95%	FP
Orangeburg	Jolley Acres HealthCare Center	60	97%	FP/Corp.
	Laurel Baye Healthcare of Orangeburg	113	95%	FP/Corp.
	Methodist Oaks	132	92%	NFP
	Orangeburg Nursing Home	88	97%	FP/Corp.
Union	Ellen Sagar Nursing Home	113	100%	NFP
	Oakmont of Union	88	82%	FP/Corp.
Williamsburg	Kingstree Nursing Facility, Inc.	88	97%	FP/Corp.

Community Health Centers and Rural Health Clinics

Community Health Centers (CHCs) are community-based, non-profit organizations that provide comprehensive health care services. With a focus on primary care, prevention, education, and case management, health centers accept most health insurance plans including Medicare and Medicaid. For those patients without insurance, services are provided on a sliding fee scale based on the patient's income. CHCs receive federal grants through the US Department of Health and Human Services, Bureau of Primary Health Care (BPHC) to partially support the cost of providing health care to the nation's growing uninsured population. In addition, CHCs provide services to help ensure access to care and continuity of care including outreach, transportation, communication assistance (interpreters), case management, and social services. Some Centers may offer additional services such as mental and behavioral counseling and specialty care[75].

CHCs are governed by a community and consumer based Board of Directors and the location, hours of operation, staff and programs of each Center are tailored to meet the specific needs of the community in which it is located. All CHCs must adhere to national, state and local licensure requirements and quality standards, and are held accountable by the BPHC for specific program expectations[76].

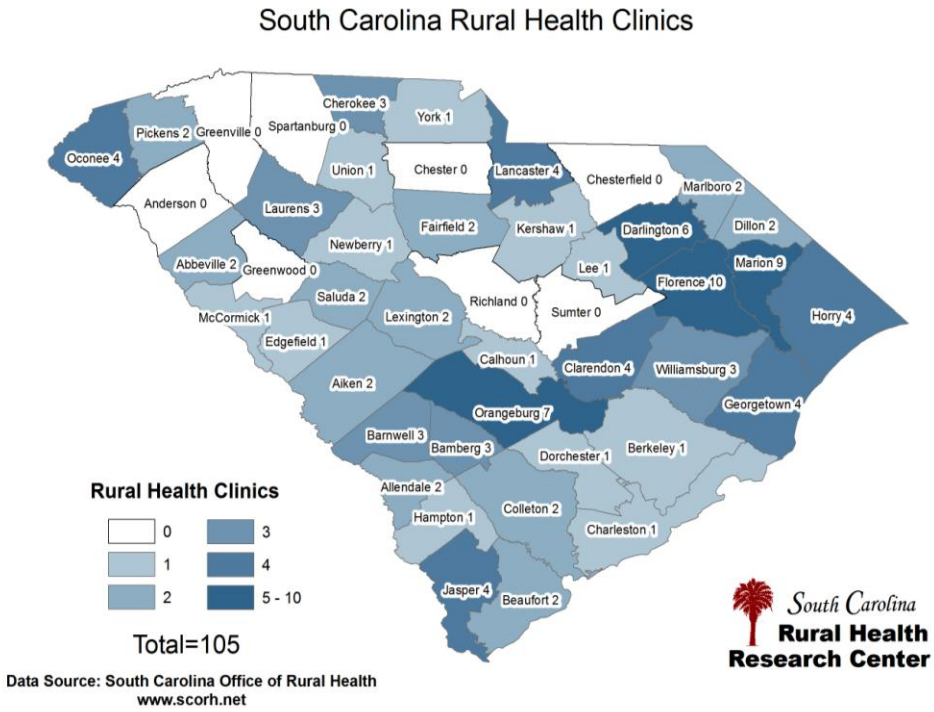
South Carolina has 19 Community Health Centers supporting 136 delivery sites throughout the state. The map below identifies the number of community health center sites in each county.



[75] South Carolina Primary Health Care Association, http://scphca.org/aboutcenter.htm retrieved July 24, 2008.
[76] ibid

A **Rural Health Clinic** (RHC) is a clinic certified to receive special Medicare and Medicaid reimbursement. The purpose of the RHC program is to improve access to primary care in underserved rural areas. RHCs are required to use a team approach of physicians and midlevel practitioners (nurse practitioners, physician assistants, and certified nurse midwives) to provide services. The clinic must be staffed at least 50% of the time with a midlevel practitioner. RHCs may also provide other health care services, such as mental health or vision services, but reimbursement for those services may not be based on their allowable costs[77].

As of April 2008, there were 105 RHCs across the state. The map below identifies the number of RHCs in each county[78].



[77] Rural Assistance Center, http://www.racoline.org/info_guides/clinics/rhcfaq.php#whatis retrieved July 22, 2008.
[78] Personal Interview with Marsha Marze, Rural Health Clinic Coordinator, SC Office of Rural Health, March 2008.

Comparison of Community Health Centers and Rural Health Clinics

Table 13 illustrates how CHCs and RHCs differ with regards to their corporate structure and reimbursement structure.

Table 13: Comparison of Corporate Structure and Reimbursement of Community Health Centers and Rural Health Clinics[79]

Corporate Issue	CHC	RHC
Profit Status	Not-for-profit only	Can be either for-profit or not-for-profit
Initial Application	Required	Required
Federal Grant	Yes	No
Recertification	Written Statement	On-site Survey
Staffing Requirements	Required to have an Executive Director, Financial Director, and Medical Director	Must employ a nurse practitioner, physician assistant or certified nurse midwife at least 50% time
Management & Control Systems	Must Provide Written Description of System	Must Demonstrate Ability.
Sliding Fee Scale	Required	Not Required
Independent Financial Audit	Required	Not Required
Governance	User Majority Board of Directors	No Specific Requirement
Location Requirements	Must be in a Medically Underserved Area (MUA) Can be in either rural or urban	Must be in a MUA or Health Professional Shortage Area reviewed within the last 3 years Must be in a rural area

While both entities are centered around primary health care service delivery, there are differences with regards to their scope of services. Table 14 draws these comparisons.

Table 14: Comparison of Community Health Centers and Rural Health Clinics for Required Scope of Services[80]

Criteria	RHC	FQHC
Primary Health Svs	Required	Required
Primary Care for Lifecycle	Not Required	Required or under arrangement
Basic Lab	6 Specific Tests Required	Required or under arrangement
Emergency Care	First Response Capabilities Required	Required or under arrangement
Radiology	Required on-site or under arrangement	Required or under arrangement
Pharmacy	Not Required	Required or under arrangement
Preventive Dental	Not Required	Required or under arrangement
Transportation	Not Required	Required or under arrangement
Case Managers	Not Required	Required or under arrangement
Dental Screening for Kids	Not Required	Required or under arrangement
After hours care	Not Required	Required
Hospital/Specialty Care	Required Clinic Staff or under arrangement	Required Clinic Staff or under arrangement

[79] Comparison of Rural Health Clinic & Federally Qualified Health Center programs by USDHHS
[80] ibid

Medicare/Medicaid Reimbursement

All Federally Qualified Community Health Centers receive cost-based reimbursement from Medicare based upon the same payment principles as RHCs. Medicaid pays RHCs using a prospective payment system (PPS) methodology based on the historical reasonable costs of the center. This PPS methodology varies by State and the payment rate may be clinic specific. RHCs get reimbursed the same amount regardless of whether the patient is seen by a mid-level practitioner (e.g., nurse practitioner or physician assistant) or a physician. Table 15 demonstrates which services are covered by entity and payor.

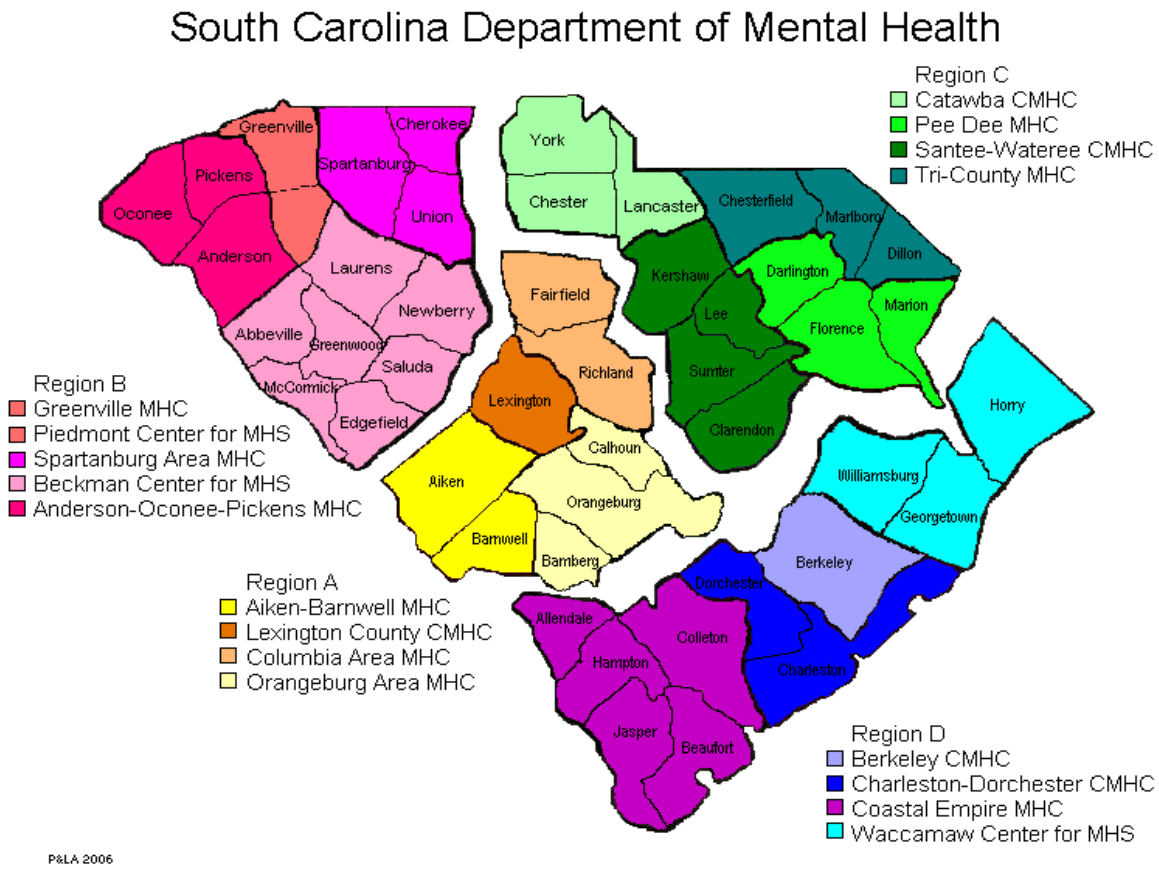
Table 15: Comparison of Community Health Centers and Rural Health Clinics for Covered Services[81]

Service	RHC		FQHC	
	Medicare	**Medicaid**	**Medicare**	**Medicaid**
Physician Service	Yes	Yes	Yes	Yes
MLP Service	Yes	Yes	Yes	Yes
Clinical Psychology	Yes	Yes	Yes	Yes
Clinical Social Worker	Yes	Yes	Yes	Yes
Services/supplies "incident to"	Yes	Yes	Yes	Yes
Visiting Nursing Home Health	Yes	Yes	Yes	Yes
Hospital Care	N/A	If in state plan	N/A	If in state plan
Nursing Home Care	Yes	If in state plan	Yes	If in state plan
Other Ambulatory Svc	N/A	If in state plan	N/A	
DM Self mgmt training & nutritional therapy	N/A	If in state plan	Yes	If in state plan

[81]Comparison of Rural Health Clinic & Federally Qualified Health Center programs by USDHHS

Mental Health Providers

South Carolina is divided into 17 geographical areas, defined by the SC Department of Mental Health, called catchments or service areas, each having its own comprehensive mental health center. South Carolina has been split into four regions, each with several mental health centers, as presented in the graphic below[82]. Community Mental Health Centers, also known as the partial hospital program, were developed to provide mental health services in the community to those patients who might otherwise require hospitalization for mental illness.



Comprehensive mental health centers provide services that usually include the following:

- Screening Services
- Day Treatment
- Alcohol and Drug Services
- Outpatient Services
- Consultation
- Emergency Crisis Intervention
- Case Management Services
- Mental Health Counseling/Psychiatric Services
- Psychosocial Rehabilitation
- School Based Services

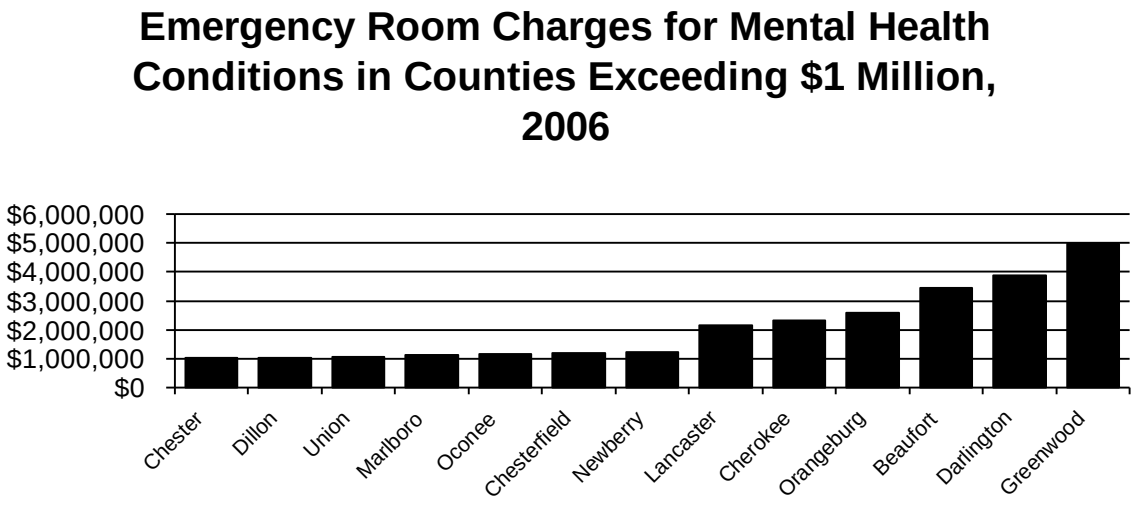
[82] South Carolina Department of Mental Health, (http://www.state.sc.us/dmh/services.htm)

The Department of Mental Health (DMH) understands the challenges of meeting the mental health needs of rural communities. As a part of its strategic planning, (DMH) identified three goals specifically for Child and Adolescent Services.[83]

Rural Strategic Goals of South Carolina Department of Mental Health

1. Increase out-stationed DMH staff by 5 additional DSS offices in rural areas, currently underserved DSS county offices
2. Increase out-stationed DMH staff by 2 additional DJJ officers in underserved DJJ counties
3. Increase the numbers of school-based programs by 10 with focus on rural area schools

Despite the best efforts of (DMH), many rural South Carolinians use hospital emergency rooms for mental health care. In 2006, there were 12,553 ER visits by residents of the 25 rural counties, resulting in $32,377,888 charges. The rural counties whose residents had in excess of $1 million worth of ER visits are presented in the following chart[84]:



Emergency Medical Services

Emergency Medical Services is a part of the Health Regulations Deputyship of the South Carolina Department of Health and Environmental Control (DHEC). Leadership is provided by a division director who relies on a 20 member staff and four regional EMS offices for support. The Director of EMS is advised by the EMS Advisory council, a 25-member board whose membership is described by statute. Subcommittees of the EMS Advisory Council

[83] South Carolina Department of Mental Health, http://www.state.sc.us/dmh/services.htm Retrieved August 8, 2008
[84] SC Office of Research and Statistics. http://www.ors2.state.sc.us/er.php Retrieved August 11, 2008.

include the Training Committee, Medical Control Committee, Equipment and Standards Committee, EMS Children Committee, and the Long Range Planning Committee.

A state medical control Physician serves as medical advisor to the Director and as chairman of the Medical Control Committee.

The Regional EMS offices were organized based on population and geographic patterns within the state. These geographical patterns were based on four regions with patient referral patterns principally used to resource hospitals within each of the areas. The four regional EMS offices provide planning, training, and technical assistance services to the state's 46 counties with funds provided under contract with the state EMS. Each regional EMS office is guided by its own Board of Directors. The regions are:

The **Upstate Regional EMS Office** serves a 12-county area, which includes Anderson, Cherokee, Greenville, Oconee, Pickens, Spartanburg and Union counties.

The **Midlands Regional EMS Office** serves a 15-county area, which includes Abbeville, Aiken, Chester, Edgefield, Fairfield, Greenwood, Kershaw, Lancaster, Laurens, Lexington, McCormick, Newberry, Richland, Saluda, and York.

The **Pee Dee Regional EMS Office** serves a12-county area, which includes Chesterfield, Clarendon, Darlington, Dillon, Florence, Georgetown, Horry, Lee, Marion, Marlboro, Sumter, and Williamsburg.

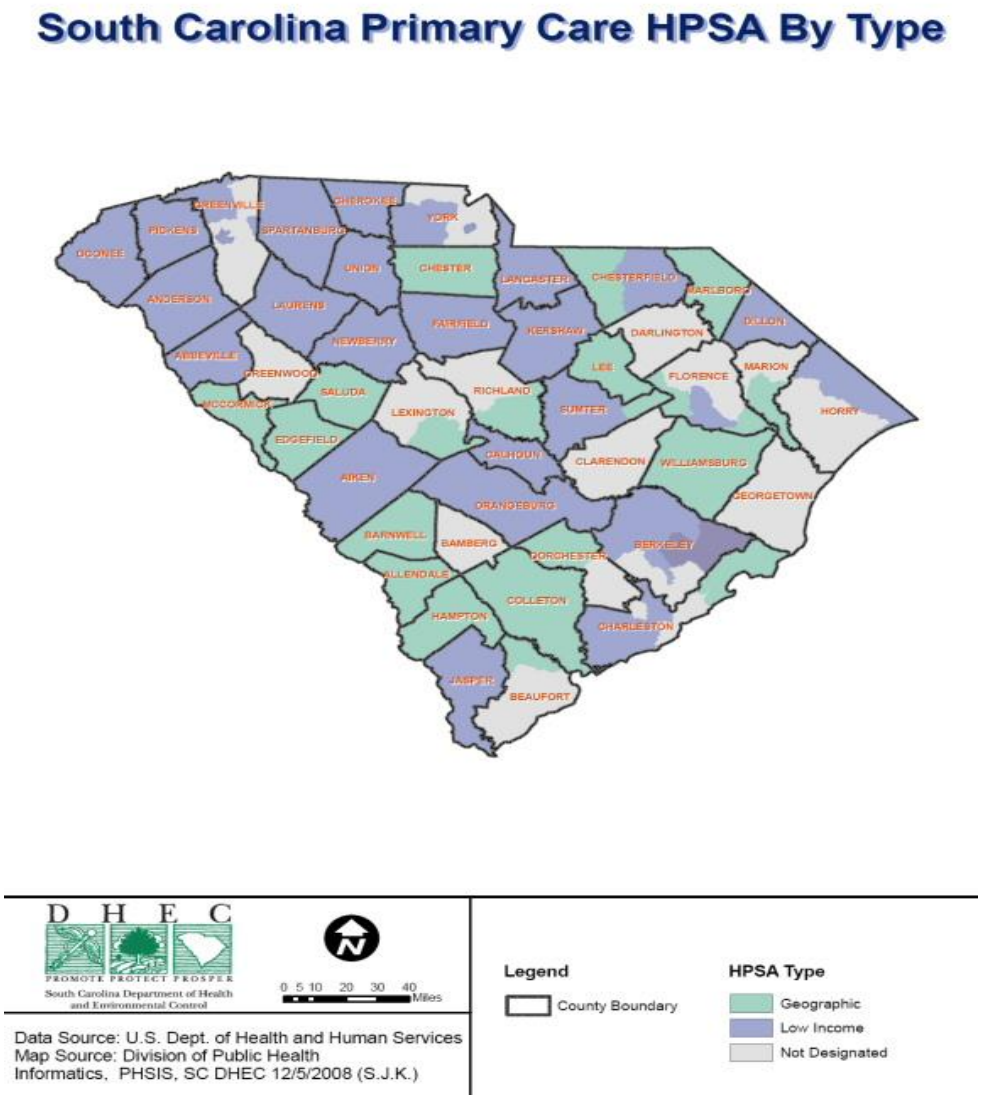
The **Low Country Regional EMS Office** serves a12-county area, which includes Allendale, Bamberg, Barnwell, Beaufort, Berkeley, Calhoun, Charleston, Colleton, Dorchester, Hampton, Jasper, and Orangeburg[85].

[85] South Carolina Department of Health and Environmental Control, http://www.scdhec.gov/health/ems/ Retrieved August 9, 2008

Healthcare Workforce and Profession

Primary Care Workforce

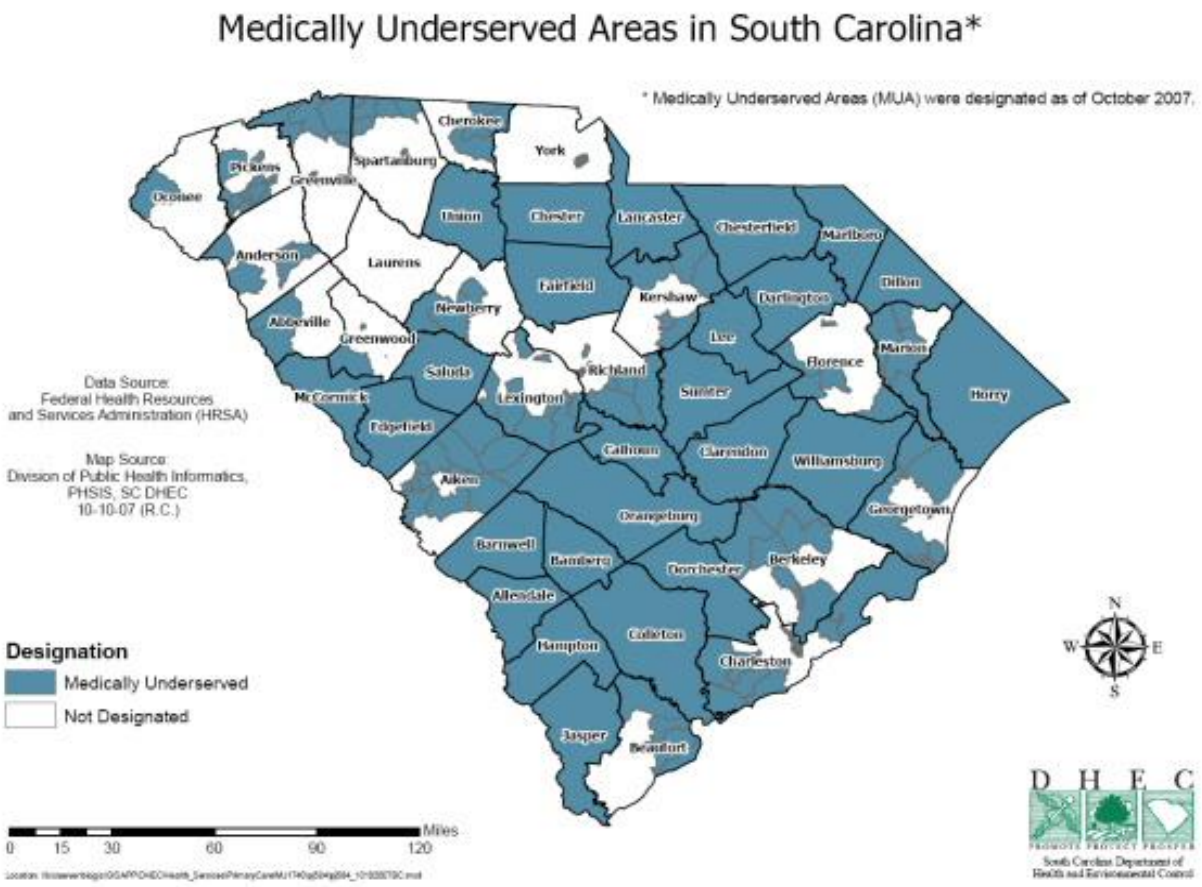
Most counties, rural and urban, in our state have some Health Professional Shortage Area (HPSA) designation. The Federal Division of Shortage Designation (DSD), Bureau of Primary Health Care, Health Resources and Services Administration, Department of Health and Environmental Control, designates areas as HPSAs. The designation is usually a geographic area consisting of a county or sub-county area and is based on the ratio of primary care physician providers to the population[86]. The Office of Primary Care (OPC) compiles the information and forwards it to the DSD. Additionally, 25 of the 46 counties in South Carolina are designated as a Medically Underserved Area (MUA) and another 19 counties are designated as partial MUAs. The map below, from the SC Office Primary Care, shows the 2008 designations[87].



[86]US Department of Health and Human Services, Health Resources and Services Administration, http://www.bhpr.hrsa.gov/shortage Retrieved August 15, 2008.

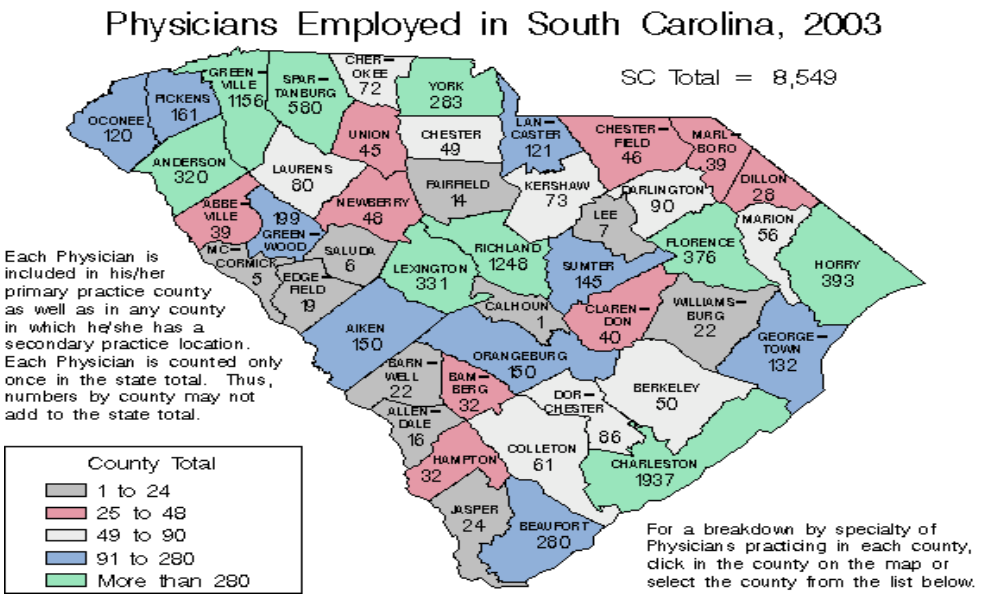
[87] SC Office of Primary Care. http://www.scdhec.gov/health/opc/hpsa.htm Retrieved on August 11, 2008.

Medically Underserved designations are comparable to HPSAs, but have stricter definitions. However, in South Carolina, the two designations reflect comparable areas. The following map demonstrates the state experiences with access to care[88]:

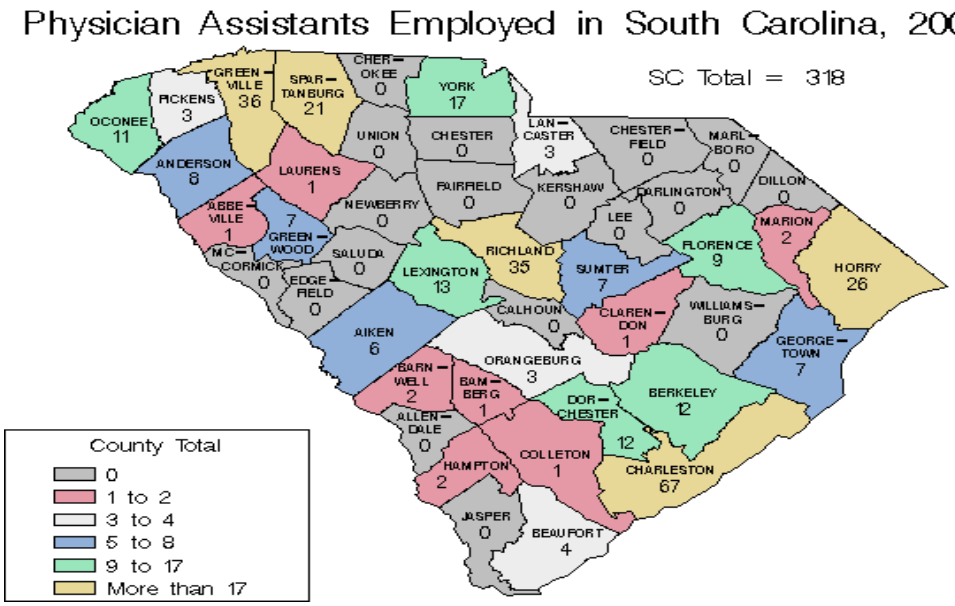


Unfortunately, workforce numbers are not published for the same time period as the HPSA designations. For physicians, the most recent data is 2003, available through the Office of Research and Statistics. County specific numbers of practicing physicians are presented in the map on the following page[89]:

[88] SC Office of Primary Care http://www.scdhec.gov/health/opc/hpsa.htm Retrieved August 11, 2008.
[89] SC Office of Research and Statistics. http://www.ors2.state.sc.us/manpower1.php Retrieved August 11, 2008.



Contributing to primary care access, especially in rural areas, is the use of physician assistants (PA) and advanced practice nurses. The map (below) of PAs employed in South Carolina shows that most of the rural counties in South Carolina do not have a PA employed in that county, despite the volume of rural health clinics in the state[90].

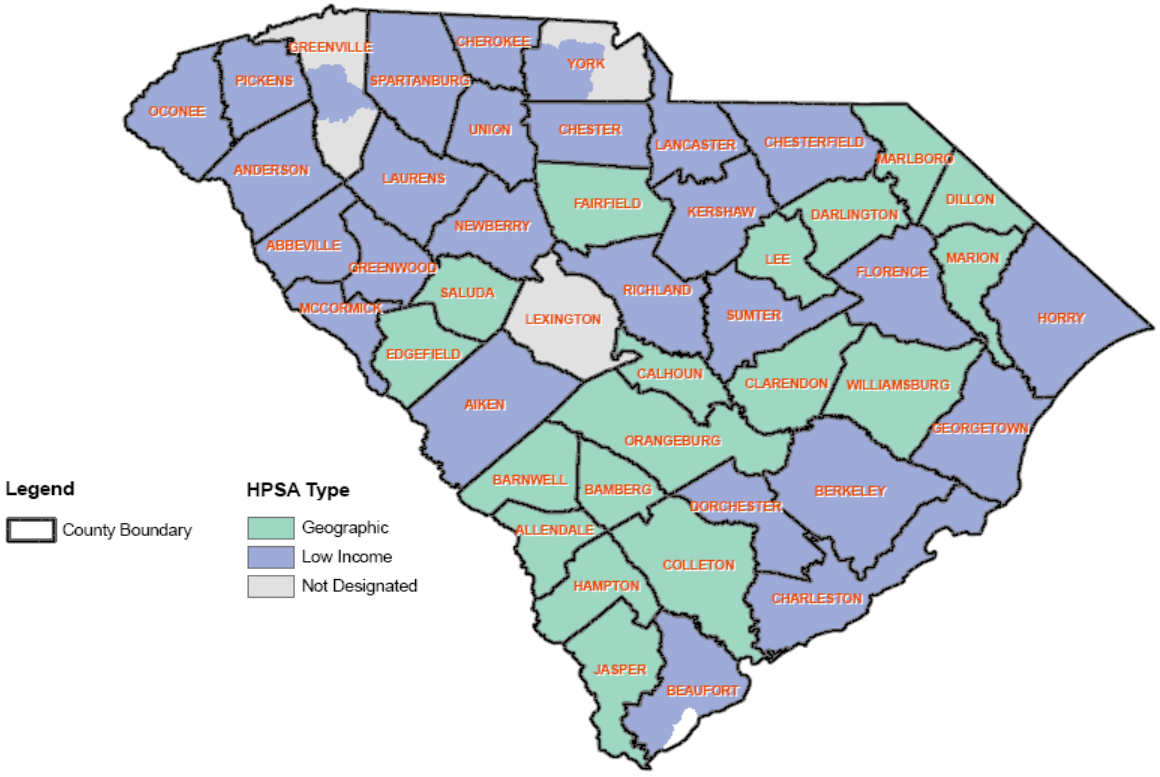


[90] South Carolina Office of Research & Statistics, http://www.ors2.state.sc.us/manpower2.php Retrieved August 11, 2008.

As November 2005, there were 302 nurse practitioners employed in the 25 rural counties. The five counties with the highest employment of nurse practitioners were: Beaufort (51), Greenwood (37), Orangeburg (35), Oconee (33), and Darlington (26)[91].

Dentists

The majority of South Carolina counties are designated as Dental Health Professional Shortage Areas. HPSAs are designated as geographic, low-income populations or facility designations. The map below, produced by the SC Office of Primary Care, shows the type of Dental HPSA by county.[92]



There were 1,839 dentists, 1,883 dental hygienists, and 2,970 dental assistants practicing in South Carolina in 2005. In 2000, there were 43.2 dentists per 100,000 population in South Carolina, which is well below the national rate of 63.6. The per capita ration of dental hygienists was also substantially lower then the national rate, which is at 44.2 per 100,000 population[93]. A map of practicing dentists from 2003 is presented on the next page.[94]

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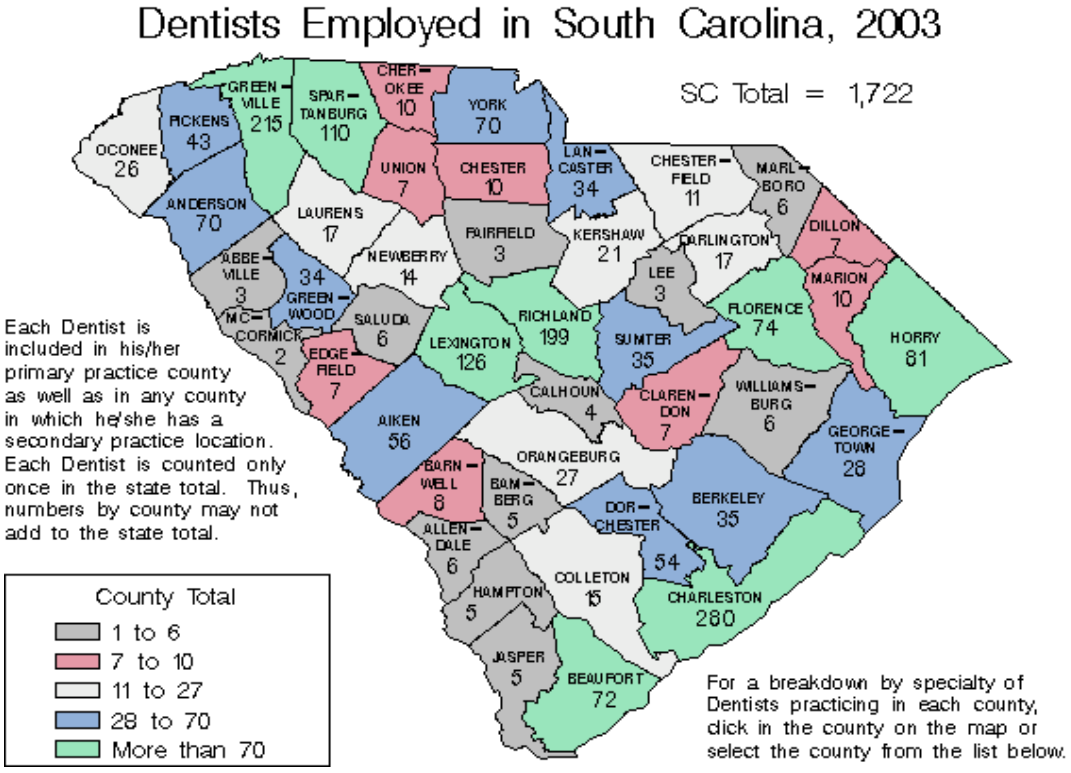
[91] SC Office of Research and Statistics. http://www.ors2.state.sc.us/manpower/RN06Table13.pdf Retrieved August 11, 2008.
[92] SC Office of Primary Care. http://www.scdhec.gov/health/opc/hpsa.htm Retrieved August 11, 2008.
[93] Division of Public Health Informatics, PHSIS, SC SCDHEC (2008) www.scdhec.net/health/opc/docs/HPSA_Dental08.pdf
[94] SC Office of Research and Statistics http://www.ors2.state.sc.us/manpower1.php Retrieved August 11, 2008.

Between 1991 and 2000, the number of dentists in South Carolina increased by 71 percent while the state's population grew by 13 percent. The result was a 52 percent increase in dentists per capita compared to a 16 percent increase nationwide. However, this was offset by the 25 percent decrease in the number of dentists between 2000 and 2005, despite the state's continued population growth[95].

Only two counties, Lexington and Newberry, are not designated as Dental Professional Shortage Areas (DPSA). Of the other counties, 19 are designated as geographic DPSA, and 25 are designated as income DPSA.

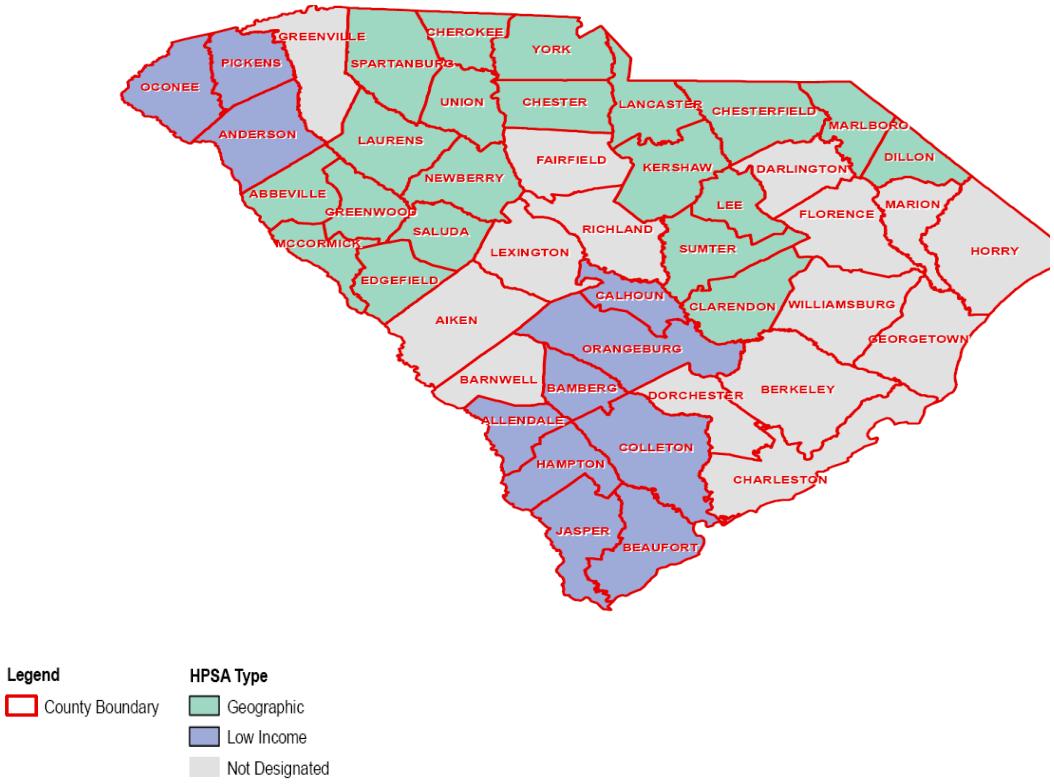


[95] South Carolina Office of Research and Statistics. Health and Demographics. (2003) http://www.ors2.state.sc.us/manpower/dent/dent1a.gif Retrieved August 15, 2008.

Mental Health Providers

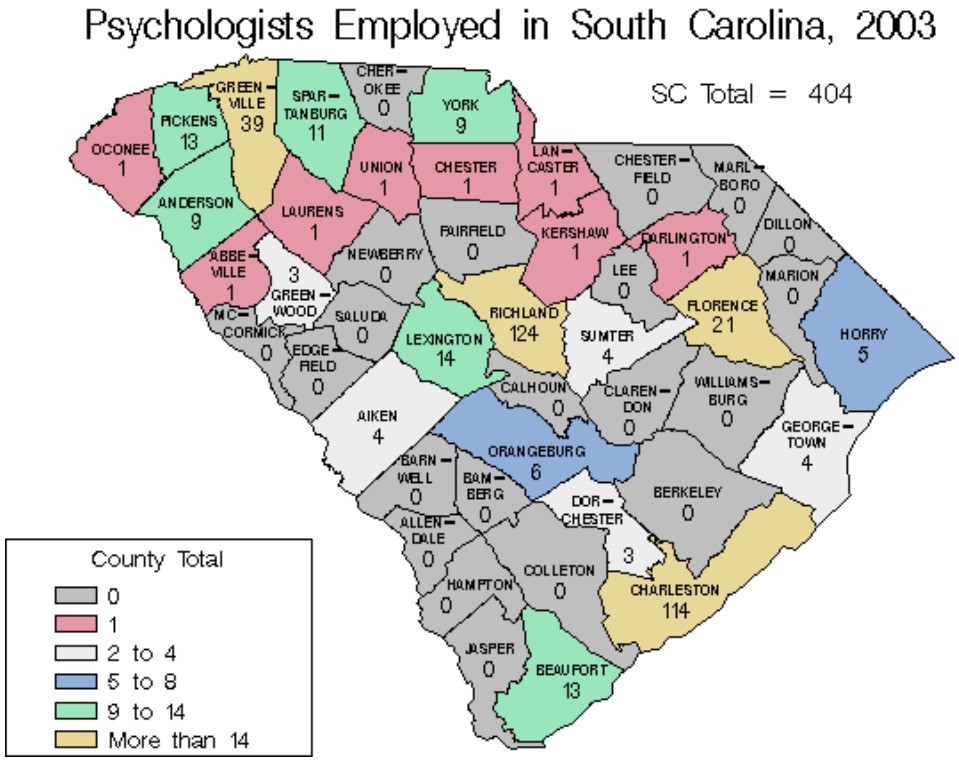
The capacity of mental health treatment was described in a previous section. As with primary care and dental, there are HPSA designations for mental health. The map below identifies which counties have mental health HPSA designations.[96]

South Carolina Mental Health HPSA



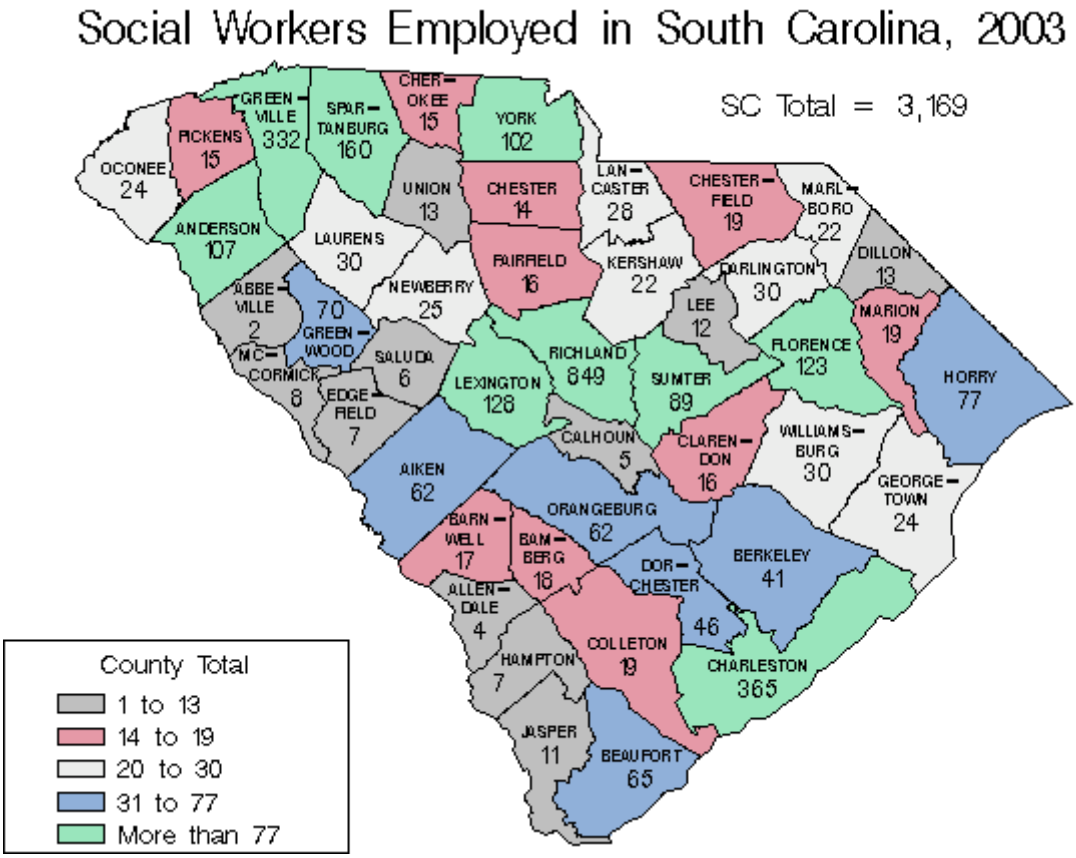
[96] SC Office of Primary Care. http://www.scdhec.gov/health/opc/hpsa.htm Retrieved August 11, 2008.

Corroborating the HPSA data is manpower data from the SC Office of Research and Statistics. There is a lack of practicing psychologists in the 25 rural counties, as delineated in the following map[97]:



[97] SC Office of Research and Statistics. http://www.ors2.state.sc.us/manpower2.php Retrieved August 11, 2008

Social workers, especially in rural areas, serve as principle providers of mental health services, as they are more available than psychologists. The number of practicing social workers by county is presented in the map below[98]:



Incentive Programs

National Health Service Corps (NHSC)

The National Health Service Corps offers loan repayment and scholarship incentives in exchange for a service commitment to a primary health care facility that meets federal guidelines and is located in a health professional shortage area. The Emergency Health Personnel Act passed in 1970 created the NHSC to meet the most critical needs of rural America's health care problems. In 1982, the NHSC began forming partnerships with states to assist in the placement of providers into shortage areas. Currently, 27 states have joined the NHSC State Loan Repayment Program, a federal-state partnership to obtain the services of providers by repaying their educational loans. In addition, a Community Scholarship Program

[98] SC Office of Research and Statistics http://www.ors2.state.sc.us/manpower2.php Retrieved August 11, 2008.

was started as a federal-state and local partnership to support students committed to serve in their underserved community upon completion of their primary care training[99].

More than 20,000 health professionals have served in the Corps since its inception in 1970. Of these, over 13,500 received NHSC scholarship or loan repayment support[100].

South Carolina is one of the states in partnership with the NHSC in both the State Loan Repayment Program and the Community Scholarship Program. Since 1991, 185 providers have been placed in South Carolina. Currently, 67 providers are on site and 41 providers are serving.[101]

J-1 Visa Waiver Program Facts[102]

- This program has placed 150 physicians in South Carolina over the past 9 years
- Physicians must work full-time in an MUA or HPSA, have a three year contract with an approved employer, and must be sponsored by an Interested Government Agency
- As of 2007, there were 13 new J-1 placements in South Carolina
- This program places Mental Health and Primary Care Physicians in HPSAs

The Nurse Loan Repayment Program

HRSA allocates money each fiscal year for rural health and clinician recruitment and service, which includes the Nurse Loan Repayment and Scholarship Programs.

The Nurse Loan Repayment and Scholarship Program is a program that offers nursing education loan repayment of 60 percent of principal and interest to Registered Nurses (RNs) who contract to work full-time for two years in a critical shortage health care facility. For an additional year of full-time service, these RNs may be eligible to receive an extra 25 percent deduction of the original loan balance. Preference is given to those of greatest financial need[103]. In 2005, 663 of the 803 awarded recipients worked in a disproportionate share hospital, which is a hospital that receives supplemental payments through Medicare and Medicaid programs to subsidize the costs associated with providing care to a high proportion of low-income patients. However, only 11.2% of theses awardees worked in a facility that was in a rural region[104].

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[99] Health Resources and Services Administrations. (n.d.) *Fiscal Year 2009: Justification of Estimates for Appropriations Committees.* Retrieved April 10, 2008, from ftp://ftp.hrsa.gov/about/budgetjustification09.pdf.

[100] Rural Policy Research Institute. (2006, October). *Demographic and Economic Profile South Carolina.* Retrieved April 11, 2008, from http://www.rupri.org/Forms/SouthCarolina.pdf.

[101] Personal interview with Mark Jordan, Director of the SC Office of Primary Care, March 2008.

[102] Mark Jordan, Director, SC Office of Primary Care, Dr. Amy Martin, DrPH, Deputy Director SC Rural Health Research Center

[103] Health Resources and Services Administrations. (n.d.) *Fiscal Year 2009: Justification of Estimates for Appropriations Committees.* Retrieved April 10, 2008, from ftp://ftp.hrsa.gov/about/budgetjustification09.pdf.

[104] United States Government Accountability Office. (2007, April). *Nursing Workforce: HHS Needs Methodology to Identify Facilities with a Critical Shortage of Nurses.* Retrieved on April 15, 2008, at http://www.gao.gov/new.items/d07492r.pdf.

Nurse Scholarship Program

The Nurse Scholarship Program offers scholarships to individuals enrolled in accredited nursing programs in exchange for two years of service in a critical shortage health facility after graduation. Preference is given to full-time undergraduate students who are not receiving financial support from their families. In 2006, 45 percent committed to working one year beyond their two-year contract[105].

South Carolina Office of Rural Health[106]

The **South Carolina Office of Rural Health (SCORH)** was established in 1991 pursuant to Section 3385 of the Public Health Service Act. The general purpose of this legislation is to improve the health infrastructure in rural areas through the operation of the SCORH. In South Carolina, as a 501(c)3 organization, the SCORH operates under the direction and oversight of the SCORH Board of Directors, in partnership with the South Carolina Healthcare Recruitment and Retention Center and the South Carolina AHEC Recruitment and Retention Program. In addition, a close relationship exists with the SC Department of Health and Environmental Control's (DHEC) Office of Primary Care, the SC Primary Health Care Association, the SC Health Alliance (formerly the South Carolina Hospital Association), the SC Medical Association, and the SC Rural Health Association.

The mission of the SCORH is to improve and enhance the health status of rural and underserved people through advocacy, education and assistance to providers, communities and policy makers. The SCORH will continue to emphasize the development of a full continuum of care for the community---including primary, emergency, acute transitional care, and long-term care services, and the importance of coordinated community-based systems care. In order to accomplish this mission, the SCORH provides rural communities and health care providers with a number of programs, activities and services. These include:

- Health Care Infrastructure Development - The SCORH offers expertise in community infrastructure development. This infrastructure is vital if rural communities are going to recruit and retain health care providers. Through Community forums, site visits, community development processes, and other initiatives, the SCORH helps enable rural communities to compete with larger communities for health resources.

- Rural Health Revolving Loan Program - This revolving loan fund provides low interest, long-term loans to rural communities and health care facilities for renovation, construction, and expansion of services.

- Rural Health Grant Initiatives - The SCORH provides technical assistance to individuals and organizations in preparing grant applications for the Rural Health services Outreach and Network Grant Programs as well as the rural Health

[105] Health Resources and Services Administrations. (2007, November). *List of Rural Counties and Designated Eligible Census Tracts In Metropolitan Counties.* Retrieved April 4, 2008, from ftp://ftp.hrsa.gov/ruralhealth/Eligibility2005.pdf.

[106] The South Carolina Office of Rural Health, http://www.scorh.net Retrieved August 15, 2008.

telemedicine Grant Program. Assistance is also provided in reference to initiatives directed to foundations (Duke Endowment, RWJ, etc.) or other funding sources.

- South Carolina Rural Health Association - the SCORH provides leadership and administrative support for all activities of the Association.

- "Focus on Rural Health" newsletter - This newsletter is published quarterly and highlights current rural health issues and concerns.

Special Projects of the South Carolina Office of Rural Health

- Low Country Healthy Start - This program is centered in Hampton, Allendale, Bamberg, and lower Orangeburg counties and is focused on reducing infant mortality and improving birth outcomes.

- South Carolina Rural Health Access Program - This program receives funding from the Robert Wood Johnson Foundation and is aimed at improving the health of rural South Carolinians through improving access to health care.

The South Carolina Rural Health Research Center (SCRHRC)[107]
Since its inception, the **South Carolina Rural Health Research Center (SCRHRC)** has focused on one principal goal: to illuminate the problems experienced by poor and minority rural populations in order to guide research, policy, advocacy and legislation. Reflecting this goal, our **specific aims** are to:

- Develop the methods and conduct the research necessary to provide a clear picture of health status, health care needs, health services use and health outcomes among poor and minority rural populations;

- Investigate the effectiveness of policies aimed at improving health and reducing barriers to care among rural poor and minority residents;

- Assess the resources available to and barriers experienced by rural healthcare providers as they work with poor and minority rural residents;

- Promote the development of minority researchers examining rural health issues;

- Provide expert advice to national, state and local government and to rural and minority constituency groups to empower policy development and advocacy; and

- Develop a repository of knowledge regarding health issues among poor and minority populations.

[107] SC Rural Health Research Center http://rhr.sph.sc.edu/index.php Retrieved August 11, 2008.

The Center builds on and expands ongoing cooperative research partnerships with other key organizations – government, academia, health services delivery and the rural community who can join our quest to improve the health of rural Americans.

The Center includes in its focus rural institutions, such as hospitals, community health centers, and rural health clinics, essential to the health of low-income and minority rural populations. The Center is based in the Department of Health Services Management and Policy, Arnold School of Public Health, University of South Carolina. Current and past research studies are available on the SCRHRC website, which also contains links to other sources of information about rural health.