South Carolina’s Rural Health Safety Net

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SC Office of Rural Health

The South Carolina Office of Rural Health is dedicated to improving access to quality healthcare in rural communities.
What is Rural? That depends on who you ask...
What is Rural? How the people in charge define it...

- Definitions vary by program/agency
  - U.S. Census Bureau
  - OMB
  - RUCAs
  - U.S. Department of Agriculture (USDA) - Economic Research Service
  - Frontier – additional definitions apply

- Estimated SC population (2009) → 4,561,242 people
  - 1,068,193 (23%) live in rural (USDA-ERS definition)
U.S. Census Bureau

- census based
- urbanized areas
- urban places
- rural areas
South Carolina

Three rural definitions based on Census Places

Rural locations are those outside Census Places with a population...

- greater than or equal to 2,500
  - Outside Census Places >= 2,500 people
- greater than or equal to 10,000
  - Outside Census Places >= 2,500 people
  - Census Places: 2,500 - 9,999
- greater than or equal to 50,000
  - Outside Census Places >= 2,500 people
  - Census Places: 2,500 - 9,999
  - Census Places: 10,000 - 49,999

Urban locations under all three definitions:

- Census Places: >= 50,000 people

For more information on definitions, see documentation.
Office of Management and Budget (OMB)

- Metropolitan
- Non-metropolitan
South Carolina

Rural definition based on Office of Management and Budget (OMB) metro counties

For more information on definitions, see documentation
Rural-Urban Commuting Area Codes (RUCAs)

Census tract-based classification scheme that utilizes the standard Bureau of Census Urbanized Area and Urban Cluster definitions in combination with work commuting information to characterize all of the nation's Census tracts regarding their rural and urban status and relationships. In addition, a ZIP Code RUCA approximation was developed.
South Carolina

Rural definition based on Economic Research Service Rural-Urban Commuting Areas (RUCA)

For more information on definitions, see documentation
The Needs of Rural SC Are Many...

- Percent of Residents in Poverty, 2000 = 19%
  - Range → 11% to 35%
- Percent of Residents Uninsured, 2009 = 18%
  - Range → 13% to 26%
- Percent of Residents Receiving Medicaid, 2009 = 29%
  - Range → 19% to 42%
The National Rural Health Movement

- The “Country Doctor”
- Began in the 20th century initially as a workforce issue
- Gained momentum in the 1950s and 1960s with legislation: Hill-Burton, Medicare/Medicaid, National Health Service Corps, AHECs
- Federal Office of Rural Health Policy & National Advisory Committee on Rural Health & Human Services created in 1987
- Further safety net legislation enacted in 1990s and 2000s
SCORH: A Brief History

1991 – Developed through ORHP grant within DHEC (1991-94 = 3 staff)
1994 – Transferred out of DHEC under Rural Physician Board
1995 – Gained 501(c)3 not-for-profit status (1995-97 = 7 staff)
1998 – Secured Healthy Start, Southern Rural Access and Medicare Flex Programs, established Denmark office
2005 – Built new SCORH Headquarters, established RHC services, strategic and business planning
2007 – New board structure, RHC billing
2009 – The Benefit Bank

2011 – 20th Year Anniversary! (37 FTEs)
Why Does SCORH Exist?

- Advocate for rural residents, providers and communities
- Monitor and impact state and federal legislation effecting rural communities
- Serve as a focal point for rural health issues on the state level
- Address problems in our rural healthcare system
SCORH Programs

- Rural Health Clinic Services
- Rural Recruitment Services
- Revolving Loan Funding
- Small Rural Hospital Programs
- EMS Program
- Rural Health Networks
- HIT/HIE/EHR
- Low Country Healthy Start
- The Benefit Bank
Rural Health Clinics
The History of Rural Health Clinics

- Developed out of critical provider shortage in 1960s in rural communities
- Mid-level providers introduced to amelioriate physician shortage
- Mid-level providers at this time were not reimbursed by Medicare and Medicaid (in some states)
- Congress passed Public Law 95-210, the Rural Health Clinic Services Act, in December 1977
The History of Rural Health Clinics

The RHC Services Act authorized Medicare and Medicaid payment to qualified rural health clinics.

- For “physician services” and “physician-directed services” whether provided by a physician, physician assistant or nurse practitioner.

- Reimbursement under the Rural Health Clinic Services Act became available to midlevel provider practices, even when services were delivered at a clinic in the absence of a physician, as long as the practice of the physician assistant or nurse practitioner was within the scope of state law and regulations.
What is a Certified Rural Health Clinic?

- A RHC is a primary health care clinic located in a non-urbanized area that has been shown to have a shortage of health care services or health care providers and has been certified as a Rural Health Clinic under Medicare.

- **Two types**
  - *Provider Based*
    - Owned and operated by a Medicare participating provider [hospital, skilled nursing facility, home health agency]
  - *Free Standing*
    - Owned and operated by a physician, nurse practitioner, physician assistant or certified midwife.
What is a Certified Rural Health Clinic?

- A certified Rural Health Clinic must:
  - Be located in a non-urbanized area;
  - Be located in a Medically Underserved Area (MUA) or Health Professional Shortage Area (HPSA);
  - Provide outpatient primary care services;
  - Use the services of at least one mid-level practitioner (PA, Nurse Midwife, Clinical Social Worker, Nurse Practitioner) at least 50% of the time the clinic is open;
  - Meet health and safety requirements set by Medicare and Medicaid.
South Carolina Rural Health Clinics

Total RHCS=110
Total RHCS Pending Application=7

*NO RHCS Present in County
Some counties have RHCS with pending applications.

Counties with 1 application pending include:
Bamberg, Fairfield, Jasper

Counties with 2 applications pending
included: Union, Dillon
How Do RHCs Impact the Safety Net in South Carolina?

What Role Does SCORH Play in the Work of RHCs?
Rural Hospitals
The History of Rural Hospitals

- Early 1900s – Majority of hospitals were located in cities
- 1946 – Hill-Burton Act led to rural health care construction
- 1983 – Change to IPPS resulted in the closure of 304 hospitals between 1983 and 1991
- 1983 to now – Series of “fixes” to Medicare program to enhance rural payments
- 1990s to now – The number of rural hospitals has continued to decrease reflecting national trends
What Makes a Hospital Rural?

- Dependent on location and bed size
  - Typically small in size with aging physical structure
  - Usually serve many Medicare beneficiaries
  - 31 (28 + 3) rural hospitals in SC
  - 61% have less than 100 beds; 23% less than 50 beds

- Typical Services
  - Emergency Room
  - Outpatient Services (especially diagnostics and physician offices)
CMS Rural Hospital Classifications

- Critical Access Hospital
- Medicare DSH Hospital
- Sole Community Hospital
- Medicare Dependent Hospital
- Rural Referral Center
How Do Rural Hospitals Impact the Safety Net in South Carolina?

What Role Does SCORH Play in the Work of Rural Hospitals?
Other Rural Safety Net Providers

- **Community Health Centers/FQHCs**
  - 7 out of 19 main CHC sites total are in rural SC

- **Free Medical Clinics**
  - 16 out of 40 sites total are in rural SC

- **EMS**
  - 86 out of 258 agencies total are in rural SC
SC Rural Health Safety Net Programs

- SORH, FLEX, SHIP
- Network Development, Planning, Outreach, IT
- Rural Access to Emergency Devices
- Rural Health Research Center
- HPSAs/MUAs
Critical Rural Safety Net Partners

- County or Regional
  - Healthy Start programs
  - Community Mental Health, Drug and Alcohol
  - Social Services, Disabilities and Special Needs
  - Public Health Department
The Economics of Rural Health

- Health care usually largest employer in rural counties.
- An average estimate is that for every two jobs created or lost in rural health care, jobs in other local businesses will increase or decrease by one job.
- There is a vital connection between rural health and rural economic development, period.
SCORH’s Impact CY2010

- Supported 18 small, rural hospitals including 5 Critical Access Hospitals and 11 Small Rural Hospital Improvement Program Grantees
- Provided services available to 110 certified Rural Health Clinics
- Assisted 5 rural health networks
- Developed 355 The Benefit Bank sites
- Placed 12 health providers students in rural or underserved rotations
- Recruited 20 health professions providers to rural or underserved communities
- Completed Economic Impact Studies in 16 counties
- Secured over $6 million in loan funds for rural providers
- Provided over $17,500 in EMT-I training scholarships
- Provided over $20,000 in paramedic training scholarships
- Served the community through Low Country Healthy Start