

South Carolina

Despite having relatively good *Quality and Patient Safety* and *Medical Liability Environments*, South Carolina needs to address some significant public health concerns and the ability of patients to access the care they need.

Strengths. South Carolina has instituted a number of effective medical liability reforms over the years which contribute to the state’s success in this category. South Carolina is one of only six states that provide additional liability protections for EMTALA-mandated emergency care, and one of only four states that have implemented all three of the following expert witness rules: case certification, requiring witnesses to be of the same specialty as the defendant, and requiring or providing for witnesses to be licensed to practice medicine in the state.

While South Carolina does not excel with regard to *Disaster Preparedness*, the state has made noteworthy strides in this area, despite receiving relatively low levels of federal funding (\$6.91 per capita). The state has written plans for special needs patients, as well as a written plan to supply dialysis for patients during a disaster. In addition, South Carolina has a state-based Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) program and civil liability protections for health care workers during a disaster event.

Challenges. South Carolina scores poorly on a number of public health indicators. The state has the fourth highest infant mortality rate in the nation (9.4 per 1,000 live births), well above the national rate of 6.9 per 1,000 live births, and nearly 30 percent of South Carolina’s adult population is obese. The state also has a rela-

tively high rate of traffic fatalities (24.0 per 100,000 people), 50.0 percent of which are alcohol-related. While South Carolina is successful in immunizing a relatively high percentage of children aged 19–35 months, the state falls well below the national rate with regard to vaccinating older adults. Fewer than 63 percent of adults aged 65 and older receive the influenza vaccine, while only 61.5 percent have ever received the pneumococcal vaccine.

A number of aspects of *Access to Emergency Care* in South Carolina may be negatively affecting the population’s health outcomes. The state, like many others, is facing a workforce shortage in many areas, including primary care, mental health, and specialty medicine. For instance, South Carolina needs an additional 123.0 full-time equivalent primary care providers to serve its population, as well as an additional 33.3 mental health providers. While the state’s Medicaid fee levels for office visits are 111.8 percent of the national average, South Carolina has seen a 21.0 percent decline in reimbursement rates since 2004.

Recommendations. South Carolina should work to address the numerous public health risk factors present, including obesity, the high infant mortality rate, and the low rates of vaccination among older adults. South Carolina might consider tackling these issues through social marketing campaigns, interventions, and improving access to medical care, especially with regard to minorities and the older population, who may face additional barriers to care. As part of the effort to reduce barriers to access, South Carolina should work to reverse the declining trend in Medicaid reimbursement rates for office visits and increase the number of physicians accepting Medicare (2.4 per 100 beneficiaries).

South Carolina should work to address the numerous public health risk factors present in the state.

	RANK	GRADE
ACCESS TO EMERGENCY CARE	45	F
QUALITY & PATIENT SAFETY ENVIRONMENT	16	B+
MEDICAL LIABILITY ENVIRONMENT	5	A
PUBLIC HEALTH & INJURY PREVENTION	50	F
DISASTER PREPAREDNESS	34	C
OVERALL	26	C

South Carolina could improve its *Quality and Patient Safety Environment* further by focusing on its emergency medical systems. A funded state EMS medical director could lend considerable expertise in this area.

While the state continues to have a good *Medical Liability Environment*, South Carolina must be vigilant in maintaining this environment that is critical in helping to provide on-call specialist care. Additional enhancements are possible, including lowering the cap on non-economic damages to \$250,000, completely abolishing joint and several liability, and instituting mandatory pretrial screening panels.

ACCESS TO EMERGENCY CARE F

Board-certified emergency physicians per 100,000 pop.	8.7
Emergency physicians per 100,000 pop.	11.8
Neurosurgeons per 100,000 pop.	1.4
Orthopedists and hand surgeon specialists per 100,000 pop.	8.8
Plastic surgeons per 100,000 pop.	1.8
ENT specialists per 100,000 pop.	3.1
Registered nurses per 100,000 pop.	809.2
Additional primary care FTEs needed	123.0
Additional mental health FTEs needed	33.3
Level I or II trauma centers per 1M pop.	1.1
% of population within 60 minutes of Level I or II trauma center	79.2
Accredited chest pain centers per 1M pop.	1.6
% of population with an unmet need for substance abuse treatment	8.2
Pediatric specialty centers per 1M pop.	2.1
Physicians accepting Medicare per 100 beneficiaries	2.4
Medicaid fee levels for office visits as a % of the national average	111.8
% change in Medicaid fees for office visits (2004-05 to 2007)	-21.0
% of adults with no health insurance	17.6
% of children with no health insurance	10.7
% of adults with Medicaid	8.7
Emergency departments per 1M pop.	13.9
Hospital closures in 2006	0
Staffed inpatient beds per 100,000 pop.	311.8
Hospital occupancy rate per 100 staffed beds	71.1
Psychiatric care beds per 100,000 pop.	25.7
State collects data on diversion	No

MEDICAL LIABILITY ENVIRONMENT A

Lawyers per 10,000 pop.	11.9
Lawyers per physician	0.5
Lawyers per emergency physician	9.9
ATRA judicial hellholes (range 0 to -7)	0
Malpractice award payments/100,000 pop.	1.2
Average malpractice award payments	\$218,482
Databank reports per 1,000 physicians	23.6
Patient compensation fund	Yes
Health court pilot project grant	No
Number of insurers writing medical liability policies per 1,000 physicians	5.0
Average medical liability insurance premium for primary care physicians	\$9,788
Average medical liability insurance premiums for specialists	\$40,936
Pretrial screening panels	No
Are pretrial screening panels' findings admissible as evidence?	N/A
Periodic payments	No
Medical liability cap on non-economic damages	\$350,001-500,000
Additional liability protection for EMTALA-mandated emergency care	Yes
Joint and several liability abolished	Partially
State provides for case certification	Yes
Expert witness required to be of the same specialty as the defendant	Yes
Expert witness must be licensed to practice medicine in the state	Yes

QUALITY & PATIENT SAFETY ENVIRONMENT B+

Funding for quality improvement within the EMS system	Yes
Funded state EMS medical director	No
Emergency medicine residents per 1M pop.	6.6
Adverse event reporting required	Yes
Hospital-based infections reporting required	Yes
Mandatory quality reporting requirement	Yes
% of counties with E-911 capability	100.0
Uniform system for providing pre-arrival instructions	No
State has or is working on a stroke system of care	Yes
State has or is working on a PCI network or a STEMI system of care	Yes
Statewide trauma registry	Yes
% of hospitals with computerized practitioner order entry	21.9
% of hospitals with electronic medical records	63.5
% of patients with acute myocardial infarction given PCI within 90 minutes of arrival	55
Number of Joint Commission reviewed sentinel events per 1M pop. (1995-2006)	15

PUBLIC HEALTH & INJURY PREVENTION F

Traffic fatalities per 100,000 pop.	24.0
% of traffic fatalities alcohol related	50.0
Front occupant restraint use (%)	74.5
Helmet use required for all motorcycle riders	No
Child safety seat/seat belt legislation (10 points possible)	6
% of children immunized, aged 19-35 months	83.2
% of adults aged 65+ who received flu vaccine in the last 12 months	62.9
% of adults aged 65+ who ever received pneumococcal vaccine	61.5
Fatal occupational injuries per 1M workers	58.9
Homicides and suicides (non-motor vehicle) per 100,000 pop.	19.9
Unintentional fall-related fatal injuries per 100,000 pop.	4.9
Unintentional fire/burn-related fatal injuries per 100,000 pop.	2.2
Unintentional firearm-related fatal injuries per 100,000 pop.	0.6
Gun-purchasing legislation (8 points possible)	1
% of tobacco settlement funds spent on health-related services and programs	100.0
Total injury prevention funds per 1,000 pop.	\$186.97
Unintentional injury prevention funds per 1,000 pop.	\$63.38
Intentional injury prevention funds per 1,000 pop.	\$0.00
Fall injury prevention funds per 1,000 pop.	\$0.00
Infant mortality rate per 1,000 live births	9.4
% of adults with BMI > 30	29.4
Current smokers, % of adults	22.3
Binge alcohol drinkers, % of adults	13.5

DISASTER PREPAREDNESS C

Per capita federal disaster preparedness funds	\$6.91
Disaster preparedness funds used specifically for health care-related preparedness are tracked	Yes
All-hazards medical response plan or ESF-8 plan?	Yes
Plan shared with all EMS and essential hospital personnel?	Yes
Public health and emergency physician input into the state planning process	Yes, No
Public health and emergency physician input into the daily operations of the SEOC	Yes, No
Written plan for the coordination of the SEOC or local EMAs to provide security to hospitals in case of emergency events	No
Number of drills and exercises conducted involving hospital personnel, equipment, or facilities	47
Accredited by the Emergency Management Accreditation Program	Conditionally
Written plan specifically for special needs patients	Yes
Written plan to supply medications for chronic conditions	No
Written plan to supply dialysis for patients	Yes
Real-time notification system in place to notify identified health care providers of an event	Yes
"Just-in-time" training systems in place	Statewide
Statewide medical communication system with one layer of redundancy	No
Statewide patient tracking system	Yes
Statewide victim tracking system	No
Statewide real-time or near real-time syndromic surveillance system	Yes
Real-time surveillance system in place for common ED presentations	Yes
Bed surge capacity per 1M pop.	791.6
Burn unit beds per 1M pop.	1.6
ICU beds per 1M pop.	316.2
Verified burn centers per 1M pop.	0.0
State able to verify credentials and assign volunteer health professionals to four ESAR-VHP levels	Yes
Nurses registered in ESAR-VHP per 1M pop.	73.3
Physicians registered in ESAR-VHP per 1M pop.	12.9
Training required in disaster management and response to bio- and chem terrorism for essential hospital personnel, EMS personnel	Yes, Yes
State or regional strike teams or medical assistance teams	Yes
Additional liability protections for health care workers during a disaster	Yes, civil
% of RNs that received any emergency training	38.2
State requires EMS and essential ED personnel to be NIMS compliant	Yes

	Improved since 2006
	Worsened since 2006
	No change since 2006
NR	Not reported
N/A	Not applicable
See Summary Statistics for State Comparisons	