

State of Georgia Rural Health Plan

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Introduction

Introduction

The largest state east of the Mississippi River, Georgia is a land of great geographic diversity. Its rural communities are spread across five major geographic regions: the Blue Ridge Mountains in the northeast, the Ridge and Valley Province and the Cumberland Plateau in the northwest, the Piedmont across Georgia's center, and the Coastal Plain in the south.

Georgia's 110 rural counties are those with a population of 35,000 or less and those defined as rural by both state and federal legislation, as used by the State Office of Rural Health. Throughout these regions, the story of rural health has been one of high rates of death and disease, along with persistent poverty, low literacy, and inadequate health care services. Rural communities bear a greater burden of cardiovascular disease, cancer, diabetes, obesity, and infant conditions than their urban counterparts. They also have higher rates of uninsured and fewer physicians per 100,000 residents. These pressing needs, compounded by an ever shrinking pool of financial resources, pose formidable challenges for rural health planning. In response, the State Office of Rural Health embarked on an innovative planning process intended to improve rural health by focusing on community-based transformation.

Need for a New Planning Approach

A multitude of complex factors impact rural health in Georgia, including the broader health system, regulatory changes, the state's public health system, public financing system changes, and the economic health of rural communities. These financial, regulatory and systemic pressures have grown in intensity over the past decade and have created significant dilemmas for health planners. Recent planning processes and their resulting documents primarily focused on specific aspects of rural health care such as hospitals or physicians' services, Federally Qualified Health Centers or Health Information Technology. Typically, they addressed the needs of one community or one region or a selected disease or health problem.

These past efforts have had a significant positive impact on the health of rural Georgians and have established a solid foundation of information and capacity for planning at the community level. In 2005, as staff of the State Office of Rural Health began the task of statewide rural health planning, they became committed to a process of inclusion in the development of the 2007 Georgia Rural Health Plan. They wanted a process that would encourage and enhance collaboration among Georgia's health care stakeholders and produce a plan that all parties could support. Faced with limited financial resources for rural health, they embraced the need for a plan that would provide direction and be a resource for community-based health improvements.

Of utmost importance to the State office of Rural Health was the need for:

- A context in which all of the important conversations could take place. Several health-related planning efforts had been recently completed or were concurrently underway. Some were national population health frameworks such as Healthy People 2010 and the accompanying Rural Healthy People 2010 developed by

the Centers for Disease Control and Prevention and the Institute of Medicine's report on rural health, "Quality through Collaboration." Other initiatives were state focused, such as the Georgia Division of Public Health's seven areas of emphasis

- A process to give voice to the variety of institutions, organizations, and individuals interested in improving the health of rural Georgians, recognizing that the wisdom necessary for success is in all of the people in the system – not just those who represent the top or any one stakeholder group
- A plan that would be supported by all stakeholders. Because rural health planning in Georgia had traditionally been narrowly focused, the expertise of broad groups of community stakeholders had not been fully tapped. By engaging the collective experiences of those closest to the "front line," the plan would reflect invaluable contributions of community stakeholders most knowledgeable about the issues, their implications, and effective strategies
- A strategy that would consider the whole system rather than concentrate on fragmented parts of the system and focus on local solutions with support from the state and national levels

In short, the bottom line was to produce not only a rural health plan, but also to engage those who live in and support rural Georgia in the process of creating the direction for change.

Process of developing the Plan

The State Office of Rural Health is part of the Georgia Department of Community Health. The Georgia Department of Community Health is the state agency which provides health care to more than two million Georgia residents under the Medicaid and PeachCare for Kids™ programs and the State Health Benefit Plan. The Georgia Department of Community Health champions:

- ACCESS to affordable, quality health care in our communities
- RESPONSIBLE health planning and use of health care resources
- HEALTHY behaviors and improved health outcomes

The approach endorsed by the State Office of Rural Health was highly dependent on providing a forum that would allow a variety of stakeholders to be heard and engaged in the plan development process. Consequently, the planning process became one of identifying those individuals, convening them, and facilitating meetings that enabled them to have conversations, share information, and reach decisions.

A broad range of stakeholders including state and local government, public health, hospital administrators, physicians, nurses, mental health, oral health, health-related associations, rural health networks, the Live Healthy Georgia program, the Area Health Education Centers, and academia participated in a series of four meetings over an 18-month process that has resulted in the 2007 Georgia Rural Health Plan. Over 30

individuals provided their insights and guidance in the creation of this plan (see Appendix A).

Two key decisions by these stakeholders set the overall direction of the 2007 Georgia Rural Health Plan. First, recognizing that all change is made at the community level, this group of stakeholders called for a plan that would set the overall vision and establish goals that could be implemented by communities. At the same time, they wanted the plan to serve as a resource or toolkit that would provide data and information that communities could use in implementing change and undertaking new initiatives. Second, they saw the need to narrow the scope of the plan to the areas that would have the most impact on improving the health of rural Georgians. Thus, they chose to focus on five disease areas: cardiovascular disease, cancer, diabetes, obesity, and infant mortality.

The State Office of Rural Health has reaped rich rewards from the process used to develop the 2007 Georgia Rural Health Plan. The stakeholders who participated in the process experienced the power of collaborative planning—and were positively affected by it.

A Vision for the Future of Rural Health in Georgia

The stakeholders' planning process resulted in a succinct vision for rural health in Georgia, which was adopted by the State Office of Rural Health and its partners:

“Communities working collaboratively to improve the health of rural Georgians”

A set of four goals and their related areas of concentration set the vision for rural health within the broader framework of other initiatives addressing health and well-being.

Goal 1: Build a system of care that is unified, clinically relevant, financially viable and responsive to community needs

Priority Action 1. a: Promote the appropriate distribution of health care facilities, workforce and comprehensive services by creating an inventory of existing health care service delivery options for rural communities with periodic reviews and dissemination

Priority Action 1. b: Increase the appropriate utilization of health services by creating and promoting the use of local databases of resources across the continuum of care

Priority Action 1. c: Increase the efficiency of rural health care systems through the development and integration of multi-county health plans that are inclusive across the continuum of care utilizing local collaboratives and provide accompanying external, objective technical support

Goal 2: Promote health and wellness in all aspects of daily living

Priority Action 2. a: Increase healthy behaviors related to nutrition and physical activity among children and adolescents by working with educational systems, other governmental entities, private and grassroots community groups and families to promote healthy lifestyles

Priority Action 2 .b: Promote partnerships among community based groups to create solutions to improve healthy behaviors related to obesity, diabetes, cardiovascular disease, cancer, and infant health through the development of multi-county programs

Priority Action 2. c: Decrease infant mortality and low-birth weight by promoting pre-and post-natal care

Goal 3: Support practical integration of technology to increase the efficiency and effectiveness of health services

Priority Action 3. a: Improve clinical outcomes by encouraging local communities to develop long-term plans based on the Georgia Health Information Technology and Transparency Advisory Board's standards for expanding and maintaining the use of health information technology

Priority Action 3. b: Increase utilization of telemedicine by educating providers and supporting communities in expanding connectivity and other health information technology infrastructure

Goal 4: Engage and enable communities in action

Priority Action 4. a: Facilitate the creation and expansion of multi-county health collaborations in rural communities and provide external, objective technical support to those communities to improve health outcomes

Priority Action 4. b: Improve collaborative, community-based health planning (using relevant health data) that is an integral part of local and/or regional economic development plans

How to Use the Plan

The Georgia Rural Health Plan presents background data and priority actions, best practices, and key resources for achieving the vision and goals. It is intended to be a template for community and state agencies to use in pursuing programs and policies for rural health. Ultimately, it should be used as a toolkit to guide communities in translating well-conceptualized and documented plans into tangible action, building on their expert knowledge of local needs, priorities, and resources.

This plan includes the following sections:

- Demographic, Education, and Economic Data, which includes key health indicators and comparisons of rural and urban Georgia
- Rural Health Resources, which outlines the array of resources to address the health needs of rural Georgians
- Plan for Improvement, which presents the Goals and Priority Actions with state and national examples of best practices and community projects exemplary of successful initiatives that can be adapted to achieve the Goals of the Rural Health Plan
- Appendices, which include Georgia county-by-county data and additional resources for community health improvement

The Plan provides inspiration for making rural health systems stronger and rural lifestyles healthier:

- By creating the will – engaging the community, building enthusiasm around change, getting all parties on the same page, coalescing around common problems
- Facilitating the way – a planning process that actively engages and invests community stakeholders in joint decision making and systems change
- Supporting communities throughout Georgia to produce the what – a vision, goals, and actions for effective programs

Demographic, Education, and Economic Data

Demographic, Education and Economic Data

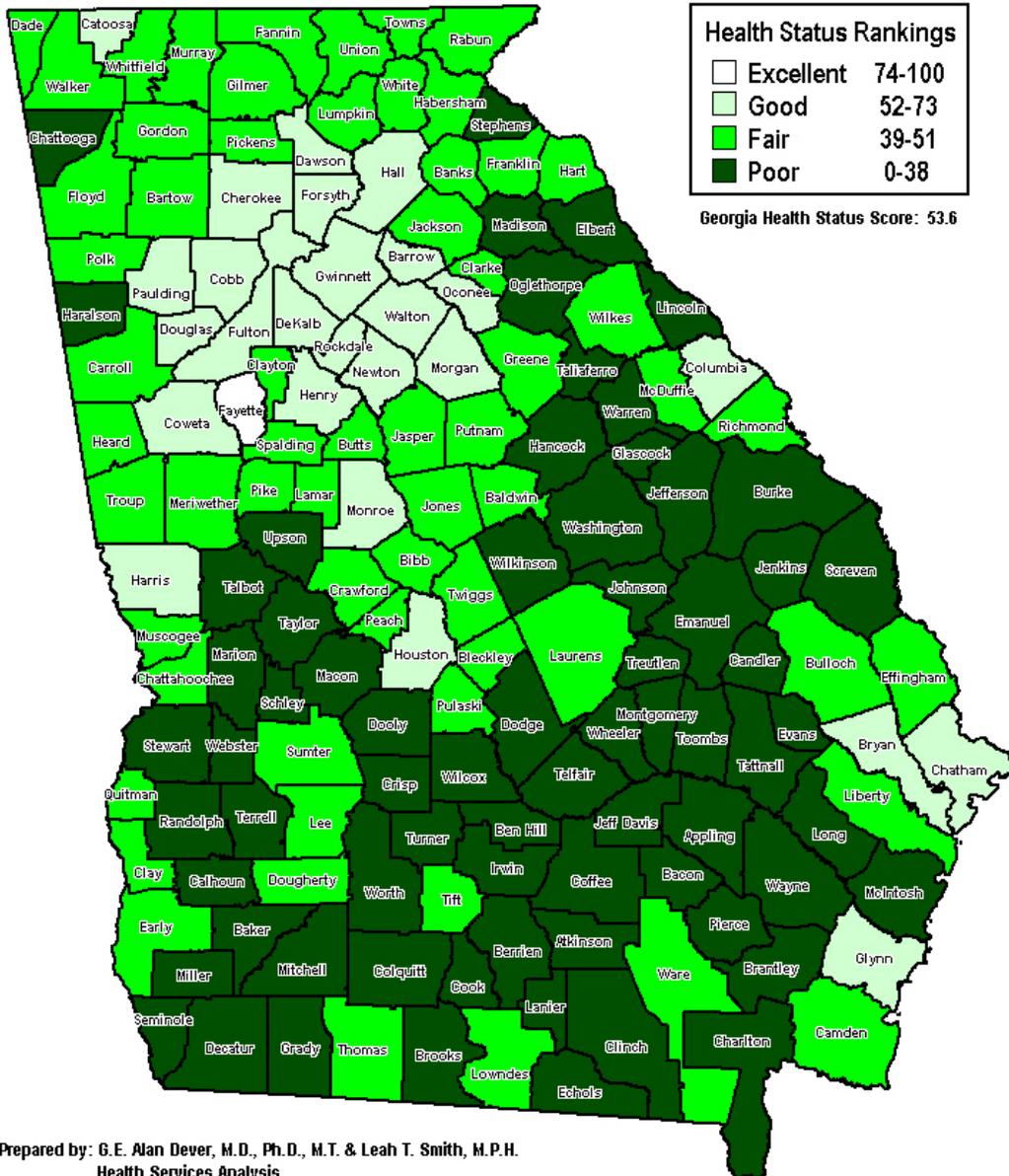
Rural Georgians are older, poorer, and sicker than their urban counterparts, which makes rural health critically important to the state's overall health. Many more Georgians live in urban areas (70 percent) than in rural areas (30 percent). Although the state's smaller rural population masks its social circumstance, the conditions in rural areas significantly affect the state's overall productivity, health, and health care costs.

The health status maps on the following pages depict the relationships among counties along the dimensions of disease prevalence, self-reported health status, and health behaviors.¹ The data underlying the maps are in relation to the rest of the nation, so Georgia's transition to a darker shade of green – or poorer health status – in 2006 may be due to worsening health in Georgia or to greater health status gains made in other states, or both.

As the maps show, residents in rural counties tend to have poorer overall health status than in urban counties. An examination of root causes and demographic differences between Georgia's rural and urban populations may reveal clues to differences in health status.

¹ The Maps represent a composite score of (1) self-reported presence of disease e.g. diabetes, cancer; (2) self-reported perception of health; and (3) self-reported health behaviors e.g. smoking, exercise, and nutrition.

Health Status by County, Georgia 2006



Prepared by: G.E. Alan Dever, M.D., Ph.D., M.T. & Leah T. Smith, M.P.H.
Health Services Analysis

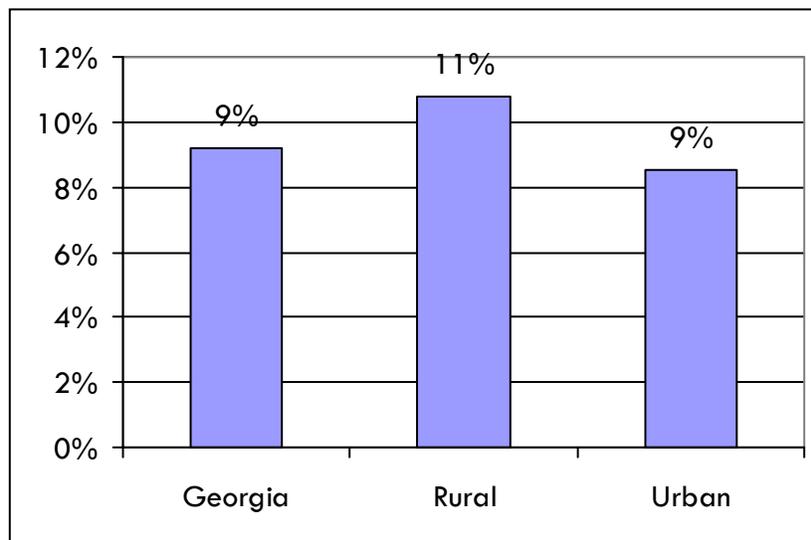
Data Source: Claritas Inc. & Thomson Medstat, 2006

Age

Georgia is aging at a greater rate than the United States as a whole. Currently, Georgia is a “young” state in that its population aged 64 and older is relatively small. According to calculations by the U.S. Census Bureau, the elderly population (i.e. 65 and older) in Georgia will increase by 143 percent between 2000 and 2030 versus a total population increase in Georgia of 46.8 percent.² This compares to a national average elderly population growth of 104.2 percent. In fact, Georgia is among the top ten states expected to have a larger than average growth in elderly population over the forecast period 2000 through 2030. In absolute terms, Georgia will move from ranking 49th in concentration of population aged 65 or older to 47th among all U.S. states by 2030 - still a relatively young state, but older than it is currently.³

Rural Georgians are considerably older than their urban counterparts. Almost 11 percent of rural residents are 65 years or older, while only nine percent of urban residents are elderly.

Georgia Population Age 65 and Older



Source: U.S. Census 2005 American Community Survey

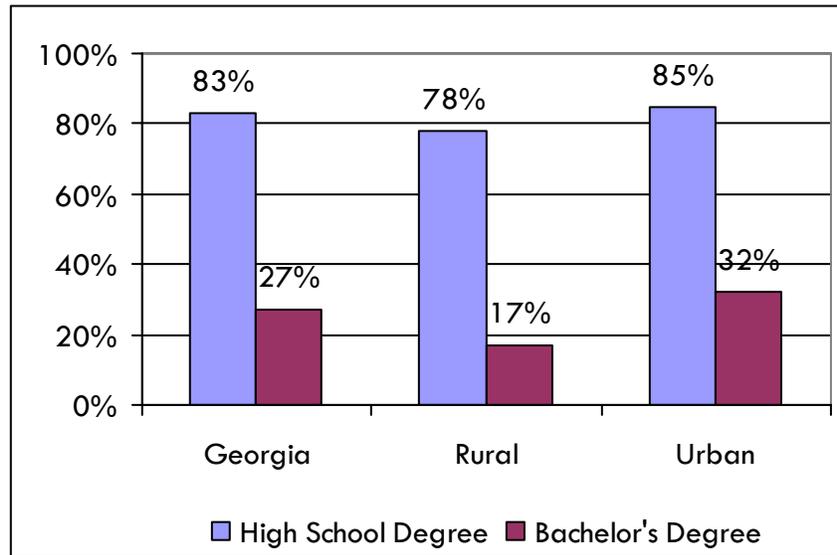
² U.S. Census Bureau, Population Division, Interim State Population Projections, 2005.

³ Georgia Health Policy Center and Fiscal Research Center, “Georgia’s Aging Population – What to Expect and How to Cope”, 2005.

Education

Rural Georgians are less likely than their urban counterparts to complete high school, as seen in the chart below. They are also less likely to have completed a bachelor's degree.

Education Attainment – 2005



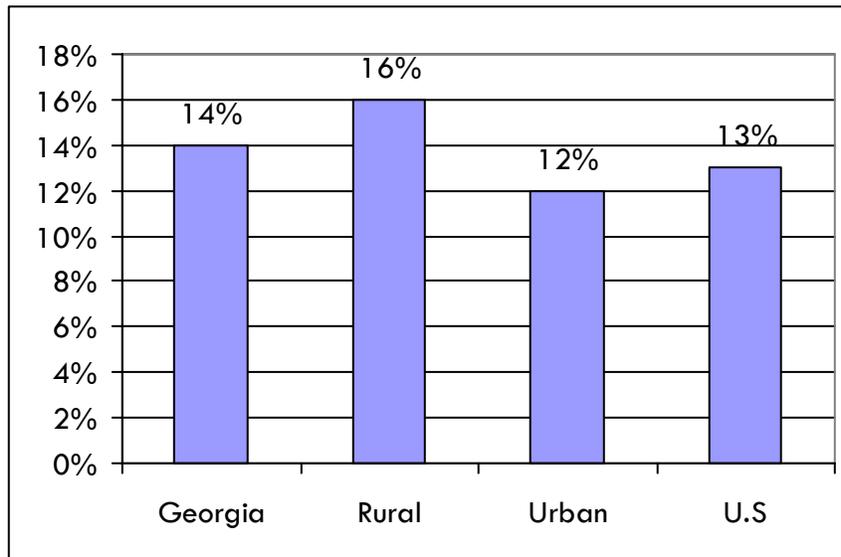
Source: U.S. Census 2005 American Community Survey

The 2006 United Health Foundation State Health Rankings places Georgia at 49th in on-time graduation rates. In fact, according to the U.S. Census Bureau's 2005 American Community Survey, 24 percent of all Georgians and 26 percent of rural Georgians by age 24 do not have a high school diploma.

Poverty and Income

Residents living in poverty encompass 12 percent of Georgia's urban population and 16 percent of Georgia's rural population. This compares with 14 percent statewide and 13 percent nationally.

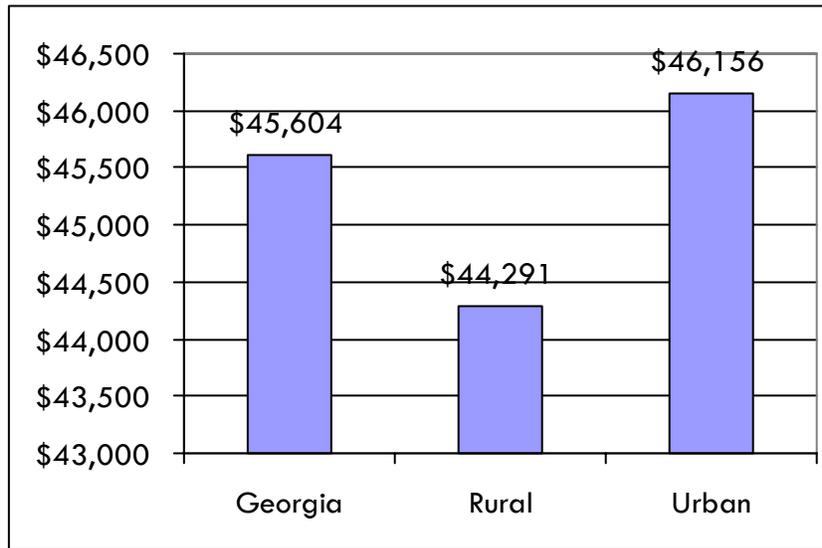
Georgia Residents Living in Poverty – 2004



Source: 2004 U.S. Census Bureau, Data Integration Division, Small Area Estimates Branch

Similar to the poverty levels above, rural Georgians also lag behind in median household income.

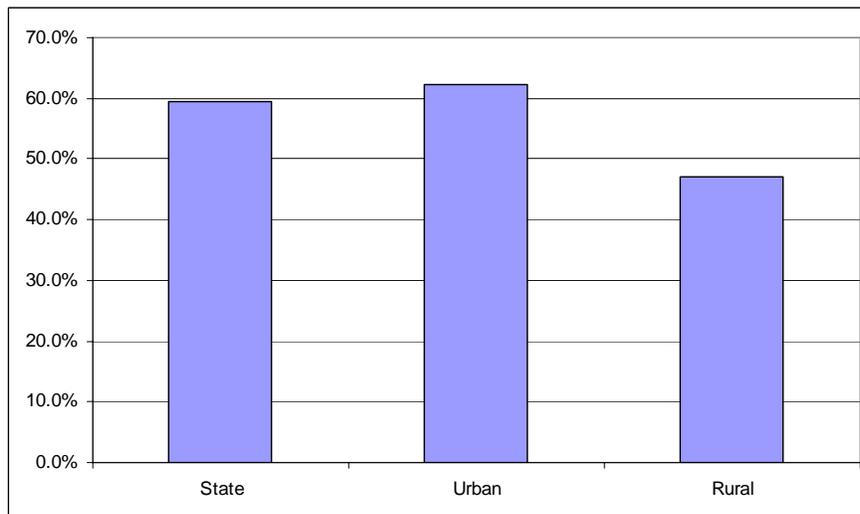
Median Household Income – 2005



Source: U.S. Census 2005 American Community Survey

Those working in white-collar jobs are more likely to have higher incomes and, thus, experience better health than those working in blue-collar jobs. The percentage of those working in white-collar jobs is much lower in rural Georgia, 47 percent, than in urban Georgia, 62 percent.

Percent White-Collar Jobs Georgia, 2000



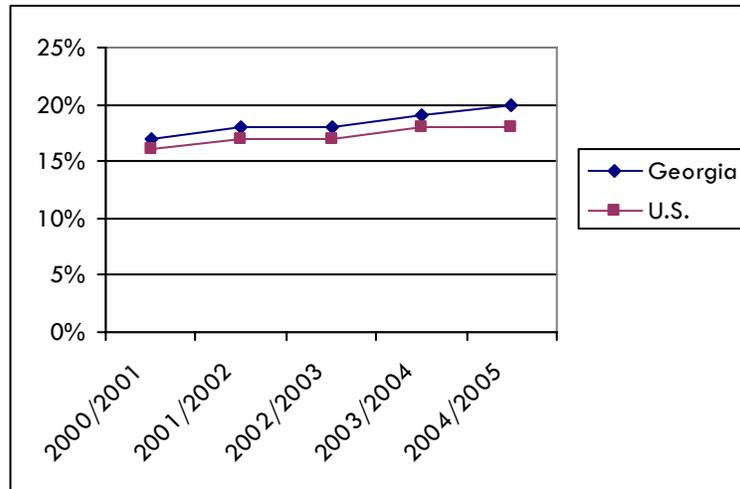
Source: 2005 Area Resource File Data

Health Insurance Status

According to 2006 March Current Population Survey figures, 21 percent, or 1.7 million non-elderly Georgians, lack health insurance. Between 2000 and 2005, Georgia

experienced a 50 percent increase in its uninsured population, up from approximately 1.1 million Georgians.

Change in Georgia Non-elderly Uninsured Rate



Source: Custer and Ketsche, Georgia State University, 2006

Three factors appear to be driving the rapid increase in uninsured Georgians. First, more firms with less than 100 workers are choosing not to offer health insurance because of the escalating cost of providing coverage. According to a 2003 survey by the Georgia Health Policy Center, health insurance status is directly related to income and firm size. The data show that workers in small firms are less likely to be offered employer sponsored health insurance and less likely to participate in a health insurance plan when it is offered due to cost. Small firms dominate rural Georgia, so it follows workers in rural Georgia are more likely to be uninsured.

Second, there has been a three-fold increase in uninsured non-citizens living in Georgia. In fact, 50 percent of non-citizens living in Georgia are uninsured, and non-citizens make up 20 percent of the total uninsured population. Rural Georgia may be disproportionately impacted by the rise in non-citizen uninsured, particularly in counties that experienced rapid growth in immigrant populations in recent years.

Finally, more Georgians between the ages of 18 and 24 are uninsured relative to other age groups. Because rural Georgia is, on average, older than urban Georgia, rural Georgia is not impacted as greatly by the rise in younger uninsured; however, the aging population presents different health care challenges.

Individuals without health insurance lag behind the insured population on many dimensions. They are:

- More likely to report fair or poor health;
- Less likely to receive preventive care;
- More likely to miss school or work;

- Less likely to have a usual source of care;
- Sicker when they are admitted to the hospital; and
- More likely to be readmitted for same illness.

Root Causes of Poor Health

A population's achievement of good health is determined by the degree to which it can access the basic elements for health and the degree to which it is exposed to harmful inputs. If social factors are at the root of observed health disparities, as many researchers have shown, then they might differentially affect a populations' access to the services and other factors that contribute to good health and harmful exposures.

It is established in the research literature that socioeconomic status affects health. Socioeconomic status is usually seen as a function of financial capacity (income and wealth), occupation, education, and social status. It is now widely accepted that the factors that have the greatest effect on people's health are beyond the control of the health sector. Income, housing, education and employment are factors that play a major role in the poor health people experience during their lifetimes.⁴

As one moves up the socioeconomic ladder, health tends to improve. Health disparities across race/ethnicity are also widely examined in the literature, with the general conclusion access to appropriate health care by different racial and ethnic groups affects health outcomes both directly and through its influence on socioeconomic status. Increasing access to health care (often measured by insurance and usual source of care) is held by many to be an important step to reducing health disparities.

Disease Morbidity and Mortality in Rural Georgia

Rural Georgians suffer from the same diseases as other Georgians and the United States as a whole, but those living in rural areas, perhaps due to the root causes of poor health; tend to suffer higher rates of morbidity (illness) and mortality (death) than the rest of the state. This section explores the five conditions targeted by the Rural Health Plan stakeholder group: cardiovascular disease, obesity, diabetes, infant mortality, and cancer.

A review of hospital utilization data highlights rural challenges. A greater proportion of rural Georgians is admitted to the hospital, a greater proportion is admitted for Ambulatory Care Sensitive Conditions (ACSC),⁵ and a higher proportion is admitted to the emergency room – all possible indications of a lack of accessible primary care in rural areas. Alternatively, the statistics could be reflective of a population with more complex conditions due to age or poor health.

⁴ A Guide to Health Impact Assessment: A Policy Tool for New Zealand, 2004.

⁵ ACSC conditions are those that should not have resulted in an inpatient admission if appropriate primary care had been received.

Hospital Utilization by Urban – Rural Status

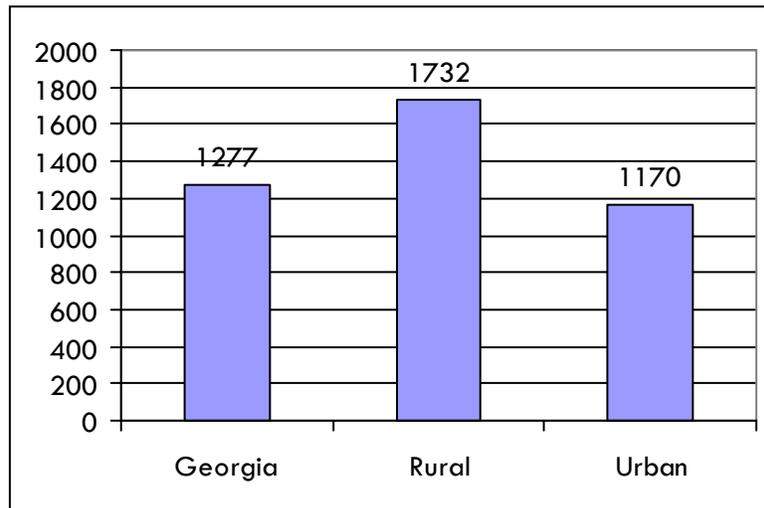
	State	Urban	Rural
Inpatient Admissions per 1,000 Population	117	112	137
Percent ACSC of Total Admissions	14.5%	13.5%	17.7%
Emergency Room Visits per Capita	.33	.32	.39

Source: Georgia Hospital Discharge Data, 2003

Cardiovascular Disease

Rural Georgians suffer significantly more from heart disease than their urban counterparts, and all Georgians experience more heart disease than the United States as a whole.

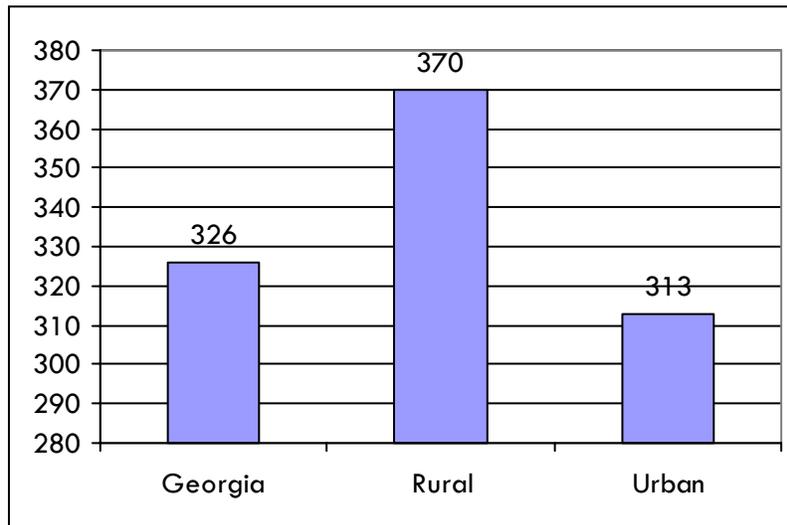
2004 Cardiovascular Disease Morbidity Rates per 100,000



Source: February 2006 Georgia Department of Human Resources, Division of Public Health, Office of Health Information and Policy

Cardiovascular disease ranks first among causes of death in both rural and urban Georgia and in the United States. The U.S. death rate due to cardiovascular disease was 232 cases per 100,000 in 2004. The age adjusted mortality rate for all Georgians was 326, while it was 313 for urban Georgians and 370 for rural Georgians.

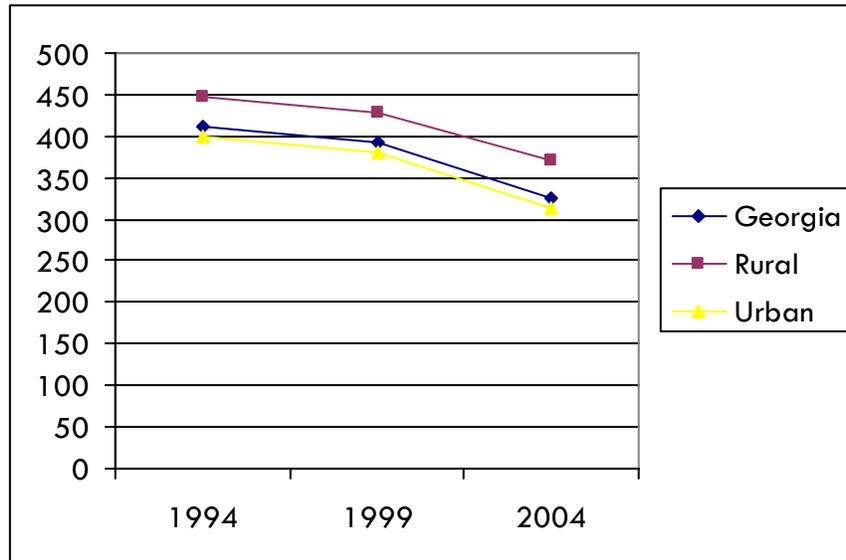
2004 Age-Adjusted Cardiovascular Disease Mortality Rates per 100,000



Source: February 2006 Georgia Department of Human Resources, Division of Public Health, Office of Health Information and Policy

The good news is that cardiovascular disease mortality has trended downward over ten years, but rural Georgia continues to lag behind the rest of the state.

Age-Adjusted Cardiovascular Disease Mortality Rates per 100,000: 1994 – 2004



Source: February 2006 Georgia Department of Human Resources, Division of Public Health, Office of Health Information and Policy

Obesity

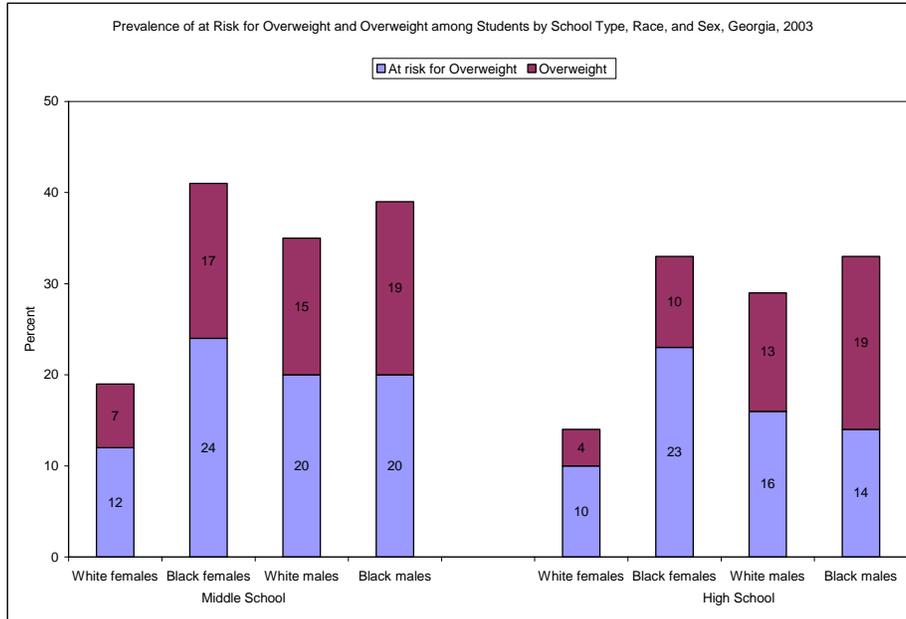
According to Jackson, et al (2005),⁶ more rural Georgians are obese than urban Georgians, and more Black Georgians are obese than are White Georgians. The gap between Black and White is the same in urban and rural areas. Thus, both rural/urban status and race impact obesity. The obesity crisis in Georgia is particularly critical because the state has both one of the highest prevalence rates and the fastest growth rates of obesity in the United States.

According to Georgia's Nutrition and Physical Activity Plan,⁷ overweight among young children ages 2 to <5 years has increased 60 percent over the past decade. The Georgia Pediatric Nutrition Surveillance System¹ (2002) found that 26 percent of children enrolled in the Women, Infants, and Children (WIC) Program were at risk for overweight (14 percent) or were overweight (12 percent). Hispanic WIC children were more likely to be at risk or overweight than any other race or ethnic group. The Georgia Student Health Survey (2003)⁸ indicates that one in three (33 percent) of middle school students aged 11 through 14 years and more than one in four (26 percent) high school students aged 14 through 18 years are overweight or at increased risk for overweight. Middle school males (36 percent) are more likely to be at risk for overweight than middle school females (30 percent). High school males (30 percent) are more likely to be at risk for overweight than high school females (22 percent). Black students are more likely to be at risk or overweight than White students. Notably, the prevalence of at risk or overweight for White females is about half that of other race-, sex- groups.

⁶ Jackson, E., Doescher, M., Ferant, A., and Hart, J., "A National Study of Obesity Trends by Type of Rural County." *The Journal of Rural Health*: 21(2), Spring 2005.

⁷ Georgia Department of Human Resources, Division of Public Health. *Georgia's Nutrition and Physical Activity Plan to Prevent and Control Obesity and Chronic Diseases in Georgia*, July 2005. Publication Number: DPH05/048HW.

⁸ Kanny D, Powell KE. 2003 Georgia Student Health Survey Report. Georgia Department of Human Resources, Division of Public Health, November 2003. Publication Number: DPH03/144.

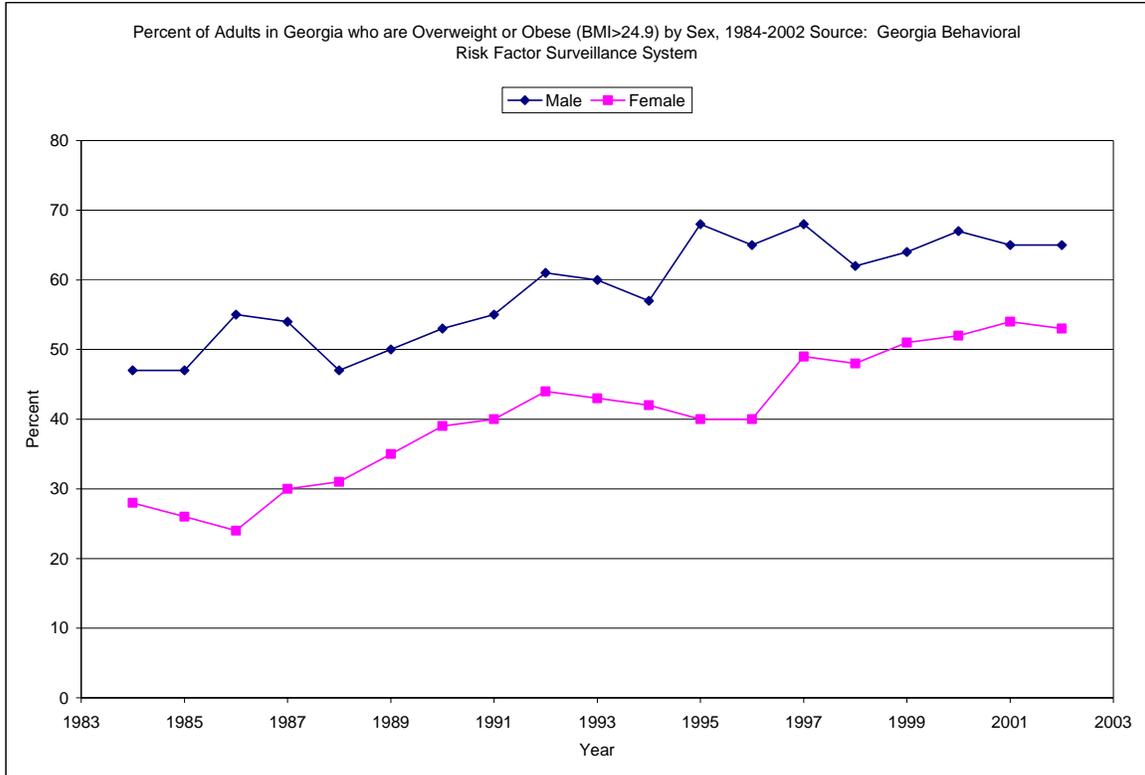


Overweight and obese adults are at increased health risk for cardiovascular disease, diabetes, stroke, hypertension, gallbladder disease, osteoarthritis and certain cancers. In 2002, 59 percent of adults in Georgia were overweight or obese with 35 percent being overweight (having a body mass index (BMI) of 25 to 29.9) and 24 percent obese (having a BMI of 30 or more).⁹ The percent of adults who are overweight or obese has been increasing since the Georgia Behavioral Risk Factor Surveillance System data were first collected in 1984, rising from 37 percent in 1984 to 61 percent in 2003. This represents an average relative increase of three percent per year. In 2002, almost two-thirds of adult men (65 percent) and more than half of adult women (53 percent) were overweight or obese.

White, non-Hispanic adults (21 percent) were less likely than Black, non-Hispanic adults to be obese (31 percent). Hispanic males were more likely to be overweight or obese than males or females of any race or ethnicity. Black non-Hispanic females were more likely to be obese than White females and Black non-Hispanic males were more likely to be obese than males of any race or ethnicity. White non-Hispanic females were least likely than males or females of any race or ethnicity to be overweight or obese. Adults between 45 through 64 years of age were most likely than any other age group to be overweight or obese.

College graduates were less likely than adults with less than a high school education to be overweight or obese. Adults with a higher household income were less likely than adults with a lower income to be overweight or obese.

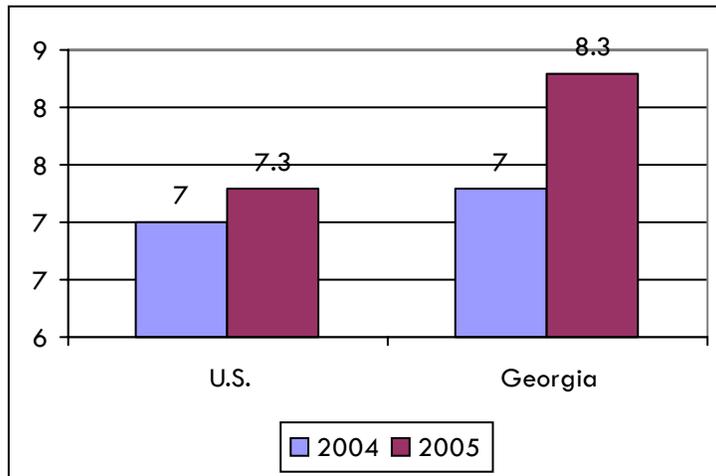
⁹ Behavioral Risk Factor Surveillance System: Atlanta, GA. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention.



Diabetes

Georgia and the rest of the nation have experienced a dramatic rise in rates of diabetes, which may be related to the rise in obesity. According to the Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance Survey, the number of new diagnoses (incidence) of diabetes nationally in the past year increased from seven new cases per 100,000 to 7.3 new cases, while the Georgia rate grew from 7.3 to 8.3 cases. This implies that Georgia is challenged with an accelerated growth of the disease.

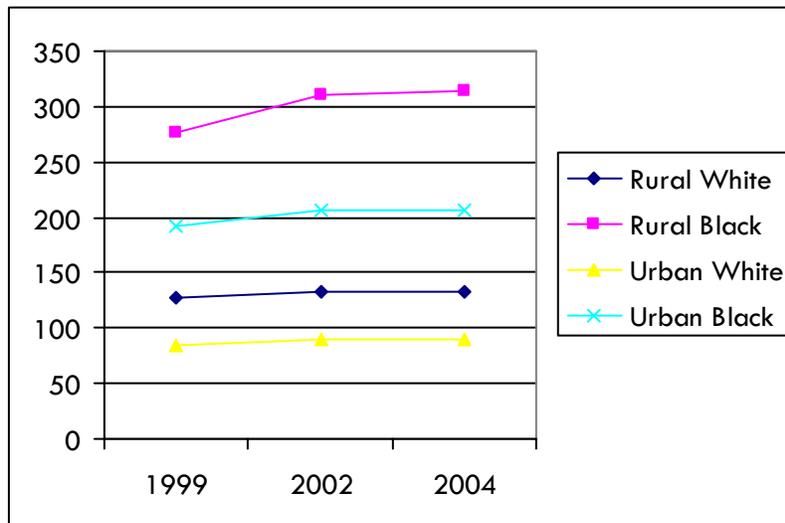
Diabetes Incidence in Georgia: 2004 and 2005



Source: February 2006 Georgia Department of Human Resources, Division of Public Health, Office of Health Information and Policy

A closer examination of diabetes morbidity reveals that, in Georgia, not only do rates vary by rural/urban status, but also by race. Black rural and Black urban rates are both higher than either White rural or urban rates. Black rural diabetes morbidity rates are the highest.

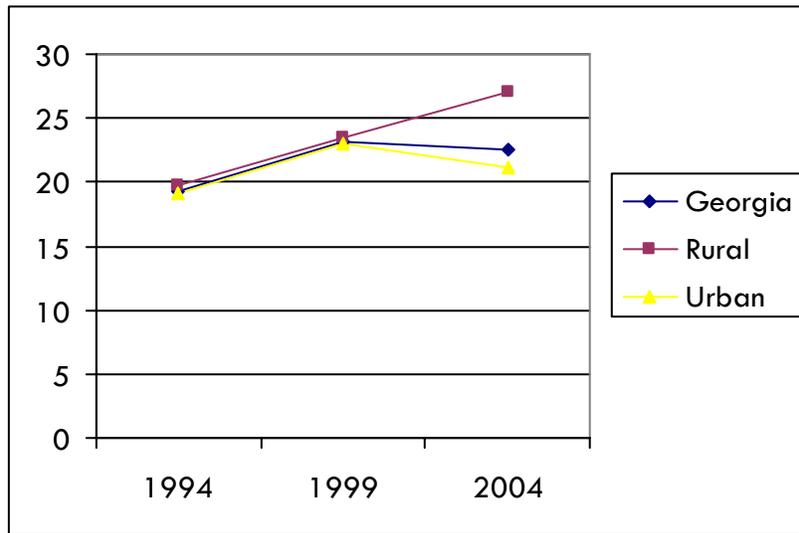
Diabetes Morbidity: Race and Rural/Urban Status



Source: February 2006 Georgia Department of Human Resources, Division of Public Health, Office of Health Information and Policy

Unlike the positive trend observed previously with the reduction of cardiovascular disease deaths, age adjusted deaths from diabetes in rural Georgia have been on the rise since 1994. Because Georgia's urban areas and the state as a whole curbed the rise in 1999, diabetes may be viewed today as a particularly rural challenge.

Age-Adjusted Diabetes Mortality Rates per 100,000: 1994 – 2004

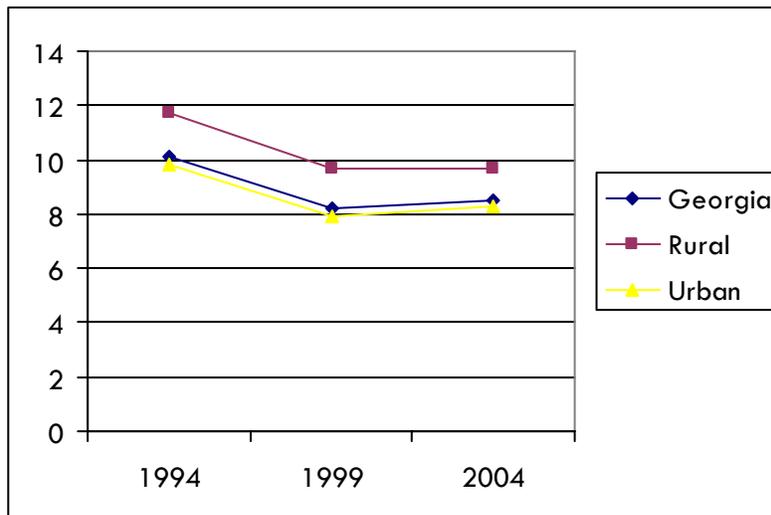


Source: February 2006 Georgia Department of Human Resources, Division of Public Health, Office of Health Information and Policy

Infant Mortality

Infant mortality rates are important indicators of a society's overall health because they reflect basic care and health care infrastructure for one of the state's most vulnerable populations. The national infant mortality rate in 2004 was 6.8 deaths per 1,000 live births. Georgia's rate, at 8.5, is somewhat higher than the national rate, and the rural Georgia infant mortality rate, 9.7, is even higher than the state rate. Infant mortality rates over the past 10 years decreased, but rates that declined to a low point in 1999 increased through 2004.

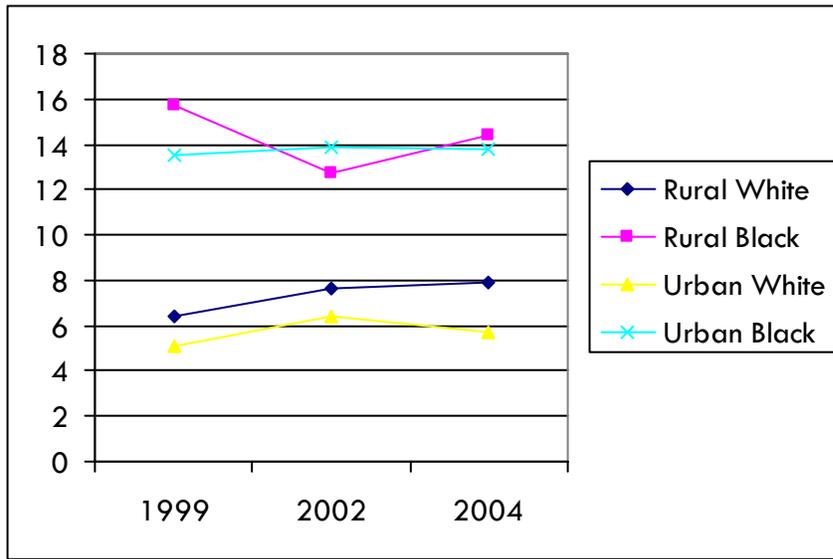
Infant Mortality Rates per 1,000: 1994 – 2004



Source: February 2006 Georgia Department of Human Resources, Division of Public Health, Office of Health Information and Policy

Georgia's progress in infant mortality rates over time and the narrow variation between rural and urban areas masks the disparity that exists between Blacks and Whites, as seen in the chart below. Black infant mortality rates have remained almost double that of whites over 10 years.

Infant Mortality Rates: Race and Rural/Urban Status

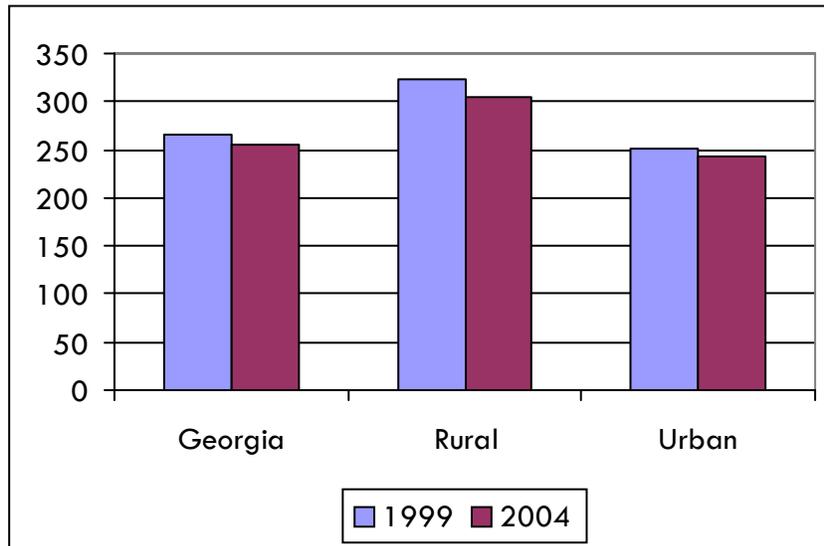


Source: February 2006 Georgia Department of Human Resources, Division of Public Health, Office of Health Information and Policy

Cancer

Cancer morbidity of all types fell from 1999 to 2004. The trend is evident at the state level and in urban and rural regions. Rural Georgia, however, still exceeds the rates of urban areas and the state as a whole.

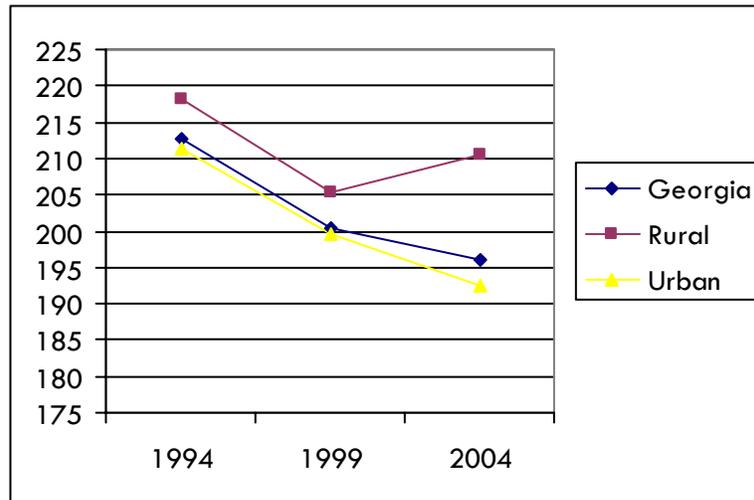
Cancer Morbidity Rates per 100,000: 1999 – 2004



Source: February 2006 Georgia Department of Human Resources, Division of Public Health, Office of Health Information and Policy

Overall, Georgians experience more cancer deaths than the rest of the nation. Georgia's rural age adjusted cancer mortality rate 210.4 exceeds the state's overall rate of 196.1, and they both exceed the national rate of 190.1. As with diabetes, rural mortality rates fell through 1999 and then increased, while urban areas and the state's rate continued to fall.

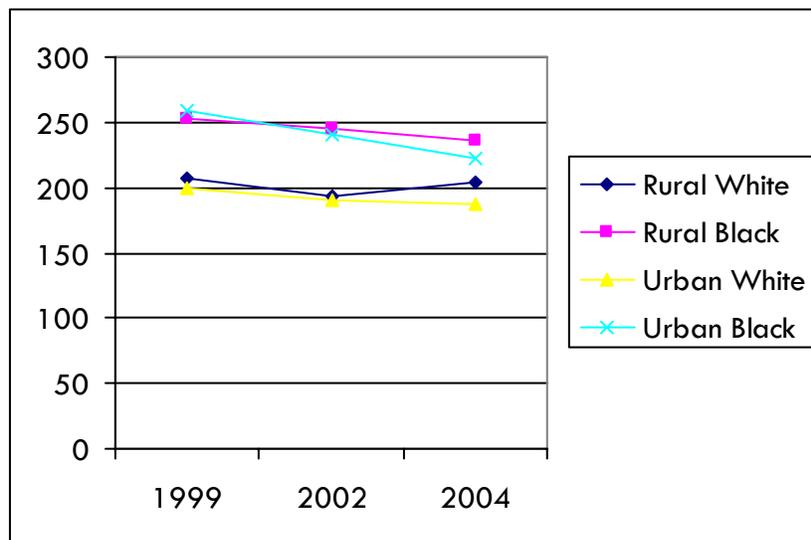
Age-Adjusted Cancer Mortality Rates per 1,000,000: 1994 – 2004



Source: February 2006 Georgia Department of Human Resources, Division of Public Health, Office of Health Information and Policy

As seen in the chart below, Black cancer deaths are disproportionately represented in both rural and urban areas, perhaps serving as a sentinel indicator to community initiatives aimed at reducing cancer mortality.

Age-Adjusted Cancer Mortality: Race and Rural/Urban Status



Source: February 2006 Georgia Department of Human Resources, Division of Public Health, Office of Health Information and Policy

Health Professional Supply

In 2006, Georgia's supply of physicians improved, but its rate of physicians per population remains in the bottom third of states in the United States. The distribution of primary care specialties, especially those other than family practice physicians, remains skewed toward urban areas. In rural Georgia, community-level initiatives to improve health and increase access to care thrive. Rural health partners are making progress through diligence and collaboration, and the continuation of their efforts is essential to further improvement.

Workforce Trends¹⁰

The state appears to have an overall shortage of physicians, nurses, and dentists. Additionally, the distribution of these medical professionals leaves many rural areas with even greater shortages. Georgia's Board for Physicians Workforce is charged with addressing physician supply and has produced several reports documenting the problem and offering solutions.

Georgia's physician supply is not keeping pace with the state's rapidly growing population. A statewide shortage of specialty physicians is becoming evident. Despite the fact the state has four medical schools; Georgia is heavily dependent on other states to train its physicians. About 70 percent of the state's practicing physicians completed their training in another state, and the number of applicants to the state's medical schools has declined over the past five years. Growing concern over rising physician malpractice insurance premiums has raised new fears that many physicians will curtail or close their practices.

The Georgia Board for Physician Workforce reported the following geographic distribution of physicians.

Rural Physician Supply

Designation	2004 Population	Number Of Family Practice Primary Care Physicians	Number Of Internal Medicine Primary Care Physicians	Number Of Pediatrics Primary Care Physicians	Number Of OBGYN Physicians	Number Of General Surgery Physicians	Total Of All Specialty Physicians
Rural	1,722,836	500	268	117	99	79	1,589
Urban	6,961,879	1,793	2,384	1,471	1,072	654	15,924
Georgia	8,684,715	2,293	2,652	1,588	1,171	733	17,513

In 2001, in response to the state's inadequate supply of nurses and other non-physician health professionals, the legislature created a standing policy committee to address the shortages. The Health Care Workforce Policy Advisory Committee was charged with monitoring and addressing ongoing workforce supply and demand issues in four areas:

¹⁰ Source: <http://bhpr.hrsa.gov/healthworkforce/reports/states04/GEORGIA.htm>

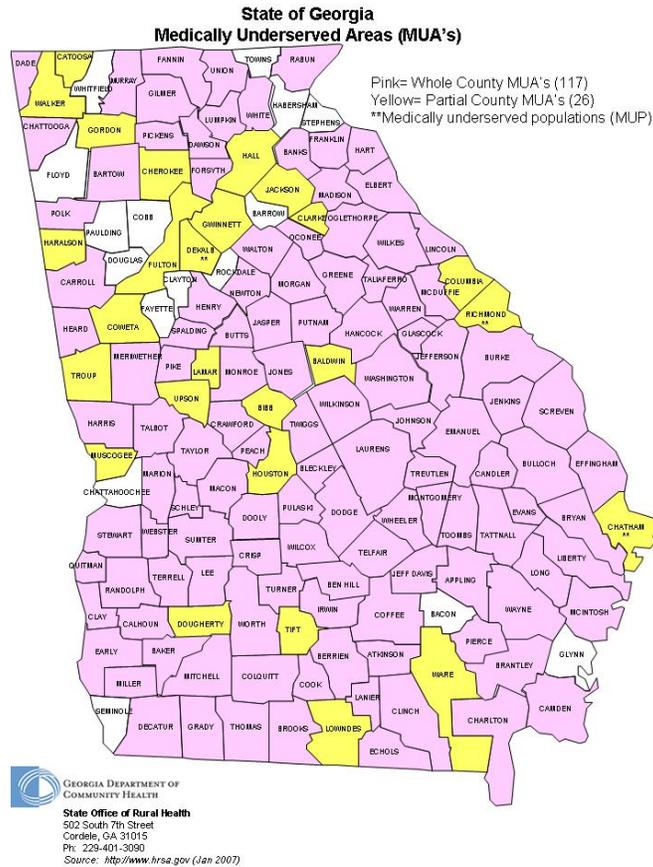
education programming and financing; data and forecasting; work environment and enhanced productivity; and recruitment and marketing.

Shortages of nurses and allied health personnel, particularly in hospitals, have not dissipated. Georgia's nursing shortage is one of the worst in the country. Although the state's changing demand for, and supply of, nurses is becoming better understood, there is a consensus that the nursing shortage in Georgia, like elsewhere, is largely associated with an insufficient capacity of nurse training programs (e.g., shortages of faculty, space and other resources to educate more nurses). Increasing numbers of qualified applicants are turned away from nursing schools. In addition, recent surveys of licensed nurses in the state indicated that almost 45 percent of registered nurses expect to work less than another 10 years.

Although Georgia may face an overall shortage of dentists in the near future, oral health experts agree that the state's current dental workforce shortage is largely a distribution problem, particularly in rural areas. Additionally, according to recent surveys of practicing dentists, more than 45 percent indicate they plan to retire within 10 years.

Medically Underserved Areas

The Shortage Designation Branch in the Health Resources and Services Administration Bureau of Health Professions National Center for Health Workforce Analysis develops shortage designation criteria and uses them to decide whether a geographic area or population group is a Medically Underserved Area, a Medically Underserved Population or a Health Professional Shortage Area.

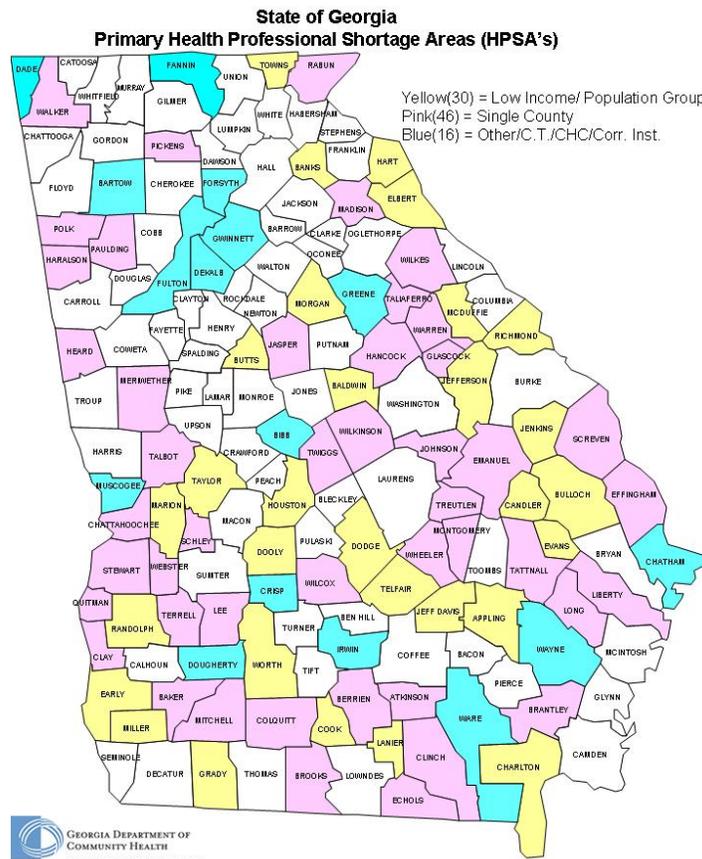


Medically Underserved Areas and Populations have shortages of primary medical care, dental, or mental health providers and may be geographic (a county or service area) or demographic (low income, Medicaid-eligible populations, cultural and/or linguistic access barriers to primary medical care services). They are each assigned an Index of Medical Underservice score, which is used to determine the eligibility of an area or population for Medically Underserved Areas/Populations status.

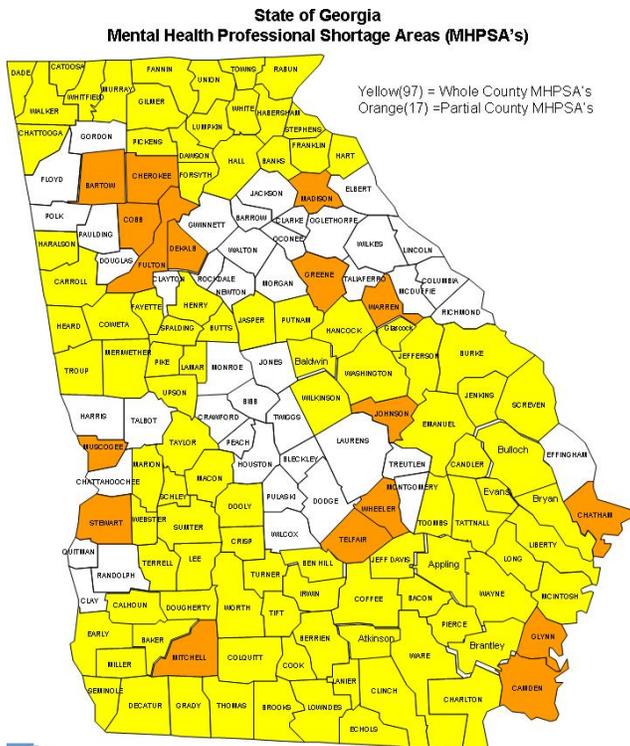
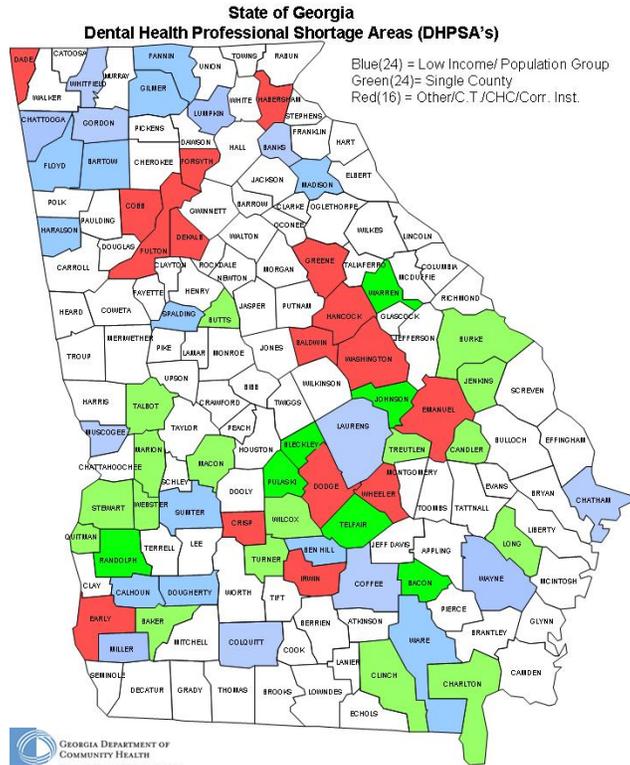
A Health Professional Shortage Area is a federal designation sought by communities that suspect they have a shortage of health professionals. Health Professional Shortage Area designation is a prerequisite for participating in a variety of state and federal funding programs designed to increase access to services, in particular National Health Service Corps placements. These programs represent the federal government's attempt to address the distribution, and to a lesser extent, the diversity, of health professionals.

The first map below shows Georgia's Primary Health Professional Shortage Areas. Of the 85 Health Professional Shortage Areas in Georgia, 66 are located in rural counties. The second map illustrates Dental Health Professional Shortage Areas throughout the state. Of the 63 Dental Health Professional Shortage Areas statewide, 44 are located in rural counties. The third map shows Georgia's shortage of Mental Health professionals.

Of Georgia's 159 counties, 115 are designated Mental Health Professional Shortage Areas and 84 of them are located in rural Georgia.




 GEORGIA DEPARTMENT OF
 COMMUNITY HEALTH
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 502 South 7th Street
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 Ph: 229-401-3090
 Source: <http://www.hrsa.gov> (March 2007)



Rural Health Resources

Rural Health Resources

Georgia is a state of great natural, human, and economic resources. With large rural expanses, Georgia is a rapidly growing state that is becoming more urbanized. The proportion of the population that is minority or ethnic, largely African-American, exceeds the national average. The proportion of the state's population that lacks health insurance exceeds the national average, and Georgia's rural and inner-city population lacks adequate geographical access to basic health care services. The percent of the population residing in primary care and dental federally-designated health professional shortage areas exceeds the national average.

Rural and poor urban areas of the state continue to have difficulty recruiting primary care physicians, despite the fact that the state and federal governments have several programs to spur provider recruitment and retention in these communities. The state's Federally Qualified Health Centers in underserved areas voice growing concerns about their difficulty recruiting and retaining physicians and dentists. State officials rank state programs that now support health professions education in underserved areas (i.e., Georgia's Area Health Education Centers) as having a highly favorable impact on provider recruitment and retention.

The Georgia Department of Community Health is responsible for: insuring more than two million Georgians, 25 percent of Georgia's population); maximizing the state's health care purchasing power; planning for insuring 1.7 million uninsured Georgia citizens; and coordinating health care planning for state agencies.

Within the Georgia Department of Community Health, the State Office of Rural Health works to improve access to health care in rural and underserved areas and to reduce health disparities. The State Office of Rural Health works to empower communities to strengthen and maintain the best possible health care using existing resources, provide up-to-date health systems information and technical assistance, build strong partnerships to meet local and regional needs, provide incentives to local areas to implement integrated service delivery systems, and be the single point of contact for all regional issues related to health care. The State Office of Rural Health also serves as a resource and agent for federal funding and houses the:

- Primary Care Office , which includes the J-1 Visa Waiver Program, National Service Corps, Health Professional Shortage Area and Medically Underserved designations
- Hospital Services Program which includes the Medicare Rural Hospital Flexibility Grant Program and the Small Rural Hospital Improvement Grant Program
- Migrant Health Program
- Health Care for the Homeless Program
- Health Networks

The federal Office of Rural Health Policy promotes better health care service in rural America. Established in August 1987, the Office of Rural Health Policy is located within

Health Resources and Service Administration and is charged with informing and advising the Department of Health and Human Services on matters affecting rural hospitals and health care, coordinating activities within the department that relate to rural health care, and maintaining a national information clearinghouse.

The following provides an overview of resources in terms of recruitment and retention of workforces, primary care delivery, rural hospital sustainability, and additional community and statewide resources, such as public health, that positively impact health and health care delivery in rural Georgia.

Recruitment and Retention Resources

Georgia has many programs that support the recruitment and retention of physicians and other health professionals, including but not limited to:

- Primary Care Office
- J1-Visa Waiver Program
- National Health Service Corps
- Area Health Education Centers
- State Medical Education Board
- Rural Recruitment and Retention Network (3R Net)
- Georgia Board of Physician Workforce
- Public and private institutions of higher learning

Primary Care Office

The Primary Care Office is housed within the State Office of Rural Health and assists communities in improving access to primary health care in Georgia's rural and urban underserved areas. Through a partnership with the Georgia Association for Primary Health Care, Inc., the Primary Care Office helps plan for new and/or expanded Federally Qualified Health Centers assesses primary care needs, shares data and resources, and assists communities in applying for federal designation for assistance with recruiting of health care providers.

The program partners with federal entities to assist underserved communities with recruitment and retention of physicians and other allied-health professionals through programs such as the J-1 Visa Waiver Program and the National Health Services Corps.

Contact: Dave Hartin, director, Primary Care Office
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J-1 Visa Physicians

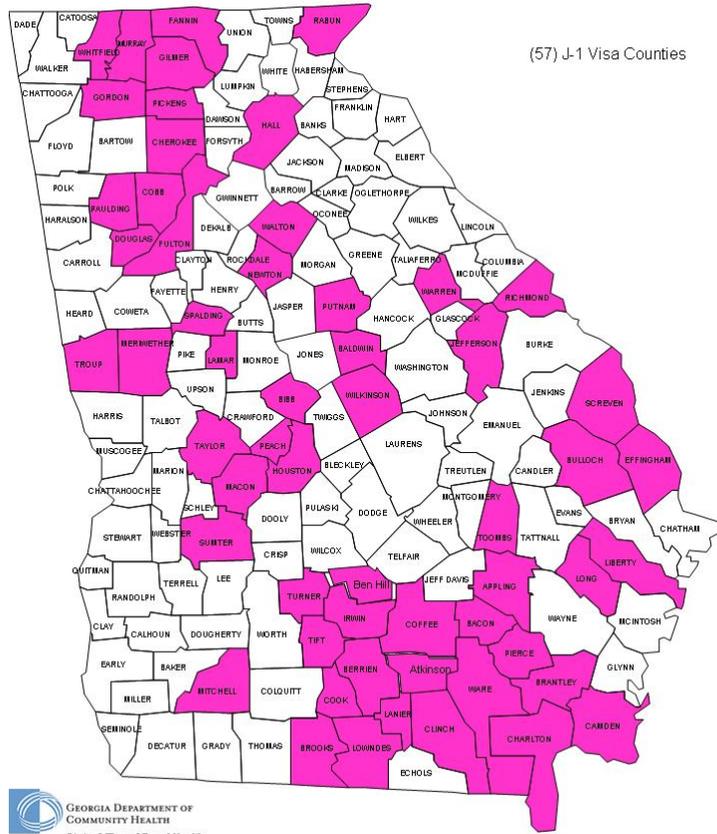
Nearly all foreign medical graduates who come to the United States for residency and training arrive under J-1 exchange program visas. The intent of these visa programs is to provide foreign medical practitioners up-to-date, modern training and to have them, in turn, bring these skills back to their home countries. In order to achieve this objective, all foreign medical graduates J-1 visas carry a two-year home residence requirement. This requirement prevents these visa holders from being granted permanent residence or other types of U.S. work visas until either they have satisfied the two-year requirement, or they have had the requirement waived.

For physicians to obtain a J-1 Visa Waiver, they must practice for three years in a designated Health Care Professional Shortage Area or Medically Underserved Area. In Georgia, an average of 55 J-1 Visa Waiver physicians are serving in medically underserved parts of the state and over 30 J-1 Waiver physicians are serving in rural areas.¹¹

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¹¹ Health Resources and Services Administration

Georgia Counties with J-1 Visa Physicians




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J-1 Visa Waiver Program (Nov. 2006)

National Health Service Corps

The National Health Service Corps was established in 1970 to recruit health professionals for Health Professional Shortage Areas. Health professionals with service obligations under the NHSC Scholarship Program and NHSC Loan Repayment Program and volunteers are sent to communities smaller than 3,500 people with only one primary care physician.

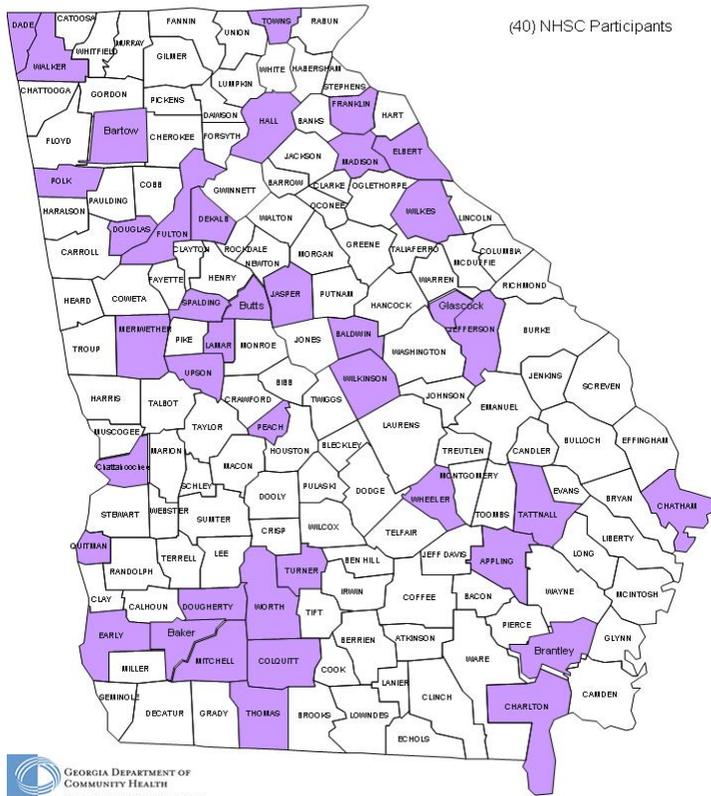
While Georgia has a higher percentage of population living in primary care Health Professional Shortage Areas than the United States as a whole, Georgia has fewer National Health Service Corps professionals per 10,000 population living in Health Professional Shortage Areas than the United States as a whole. In Georgia, approximately 50 National Health Service Corps health professionals provide an important layer of the safety net and provide care in medically-underserved areas, and more than 25 National Health Service Corps professionals serve in rural parts of the state.¹²

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¹² Health Resources and Services Administration/National Health Service Corps

Georgia Counties with NHSC Participants

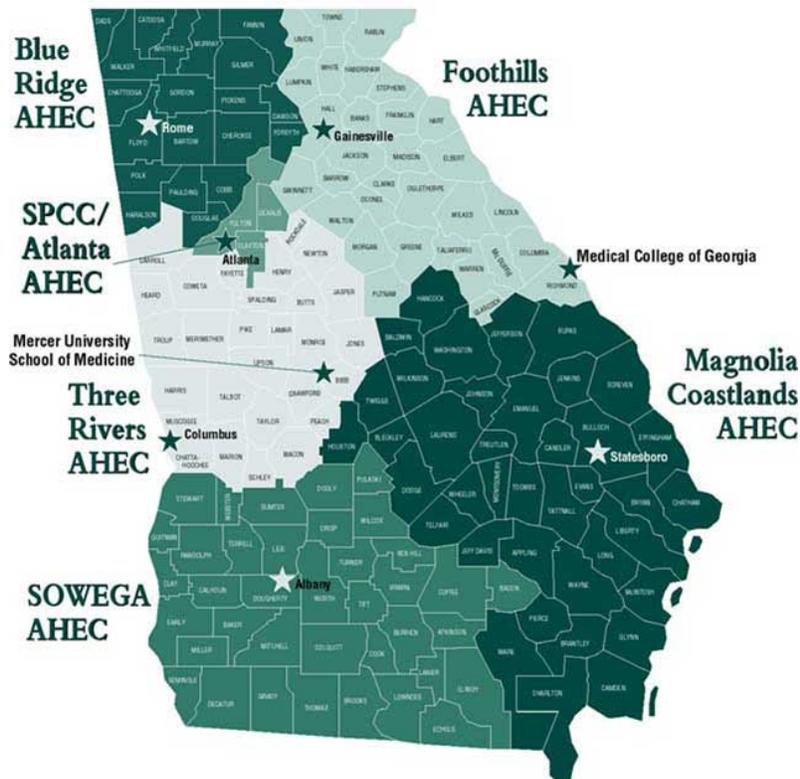
(40) NHSC Participants



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Updated 11/14/06

Area Health Education Centers

Area Health Education Centers were begun by the federal government in the late 1970's as programs designed to address health manpower distribution through community-based initiatives. The federal government, through competitive grants, provides funding to establish Area Health Education Centers programs and centers. The intent is to provide sufficient dollars to build the infrastructure and a case for state support assuming the activities and accomplishments are of value to the communities served by the Area Health Education Centers.



A partnership coordinated between Medical College of Georgia and Mercer University School of Medicine, the Georgia Statewide Area Health Education Centers Network is a complex, multi-disciplinary effort which responds to the problems of health professional supply and distribution in rural and underserved areas of the state.

Since 1984, the Georgia Statewide Area Health Education Centers Network has represented a growing partnership of health providers, health professions students, educators, state agencies, and communities joined together with a commitment to resolve problems through educational support to health professionals in the field, both as students and as practitioners.¹³

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¹³ Georgia AHEC Annual Report, 2006

State Medical Education Board of Georgia

The State Medical Education Board of Georgia was established in 1952 for a two-fold purpose: to provide an adequate supply of physicians in rural areas of the state; and to provide a program of aid to promising medical students who do not have the financial means to attend medical school. The board is instrumental in physician recruitment to rural and underserved Georgia communities. Each year, the board sponsors a medical fair where rural Georgia communities are invited to speak with physicians in training concerning future medical practice opportunities.

Contact: Ben Robinson, State Medical Education Board of Georgia
404-206-5426
brobinson@dch.ga.gov

Georgia Board for Physician Workforce

The Georgia Board for Physician Workforce monitors changes in Georgia's physician workforce with emphasis on the geographic distribution of physicians in the State. Reports available on their Web site help to identify areas of need, monitor the supply and distribution of practicing physicians in Georgia, plan for health services, determine funding for residency programs, and locate facilities.

Contact: Ben Robinson, State Medical Education Board of Georgia
404-206-5426
brobinson@dch.ga.gov

National Rural Recruitment and Retention Network (3R Net)

3R Net is made up of state organizations such as State Offices of Rural Health, Area Health Education Centers, Cooperative Agreement Agencies and State Primary Care Associations. These not-for-profit organizations help health professionals locate practice sites in rural areas throughout the country.

Contact: Nicole Newman, Georgia Department of Community Health
229-401-3090
nnewman@dch.ga.gov
<http://www.3rnet.org>

Public and Private Institutions of Higher Learning

Numerous public and private institutions of higher learning in Georgia provide training for a full array of health professionals. Four such institutions train physicians. They are the Medical College of Georgia, Morehouse School of Medicine, Emory University School of Medicine, and Mercer University School of Medicine.

Delivery of Primary Care

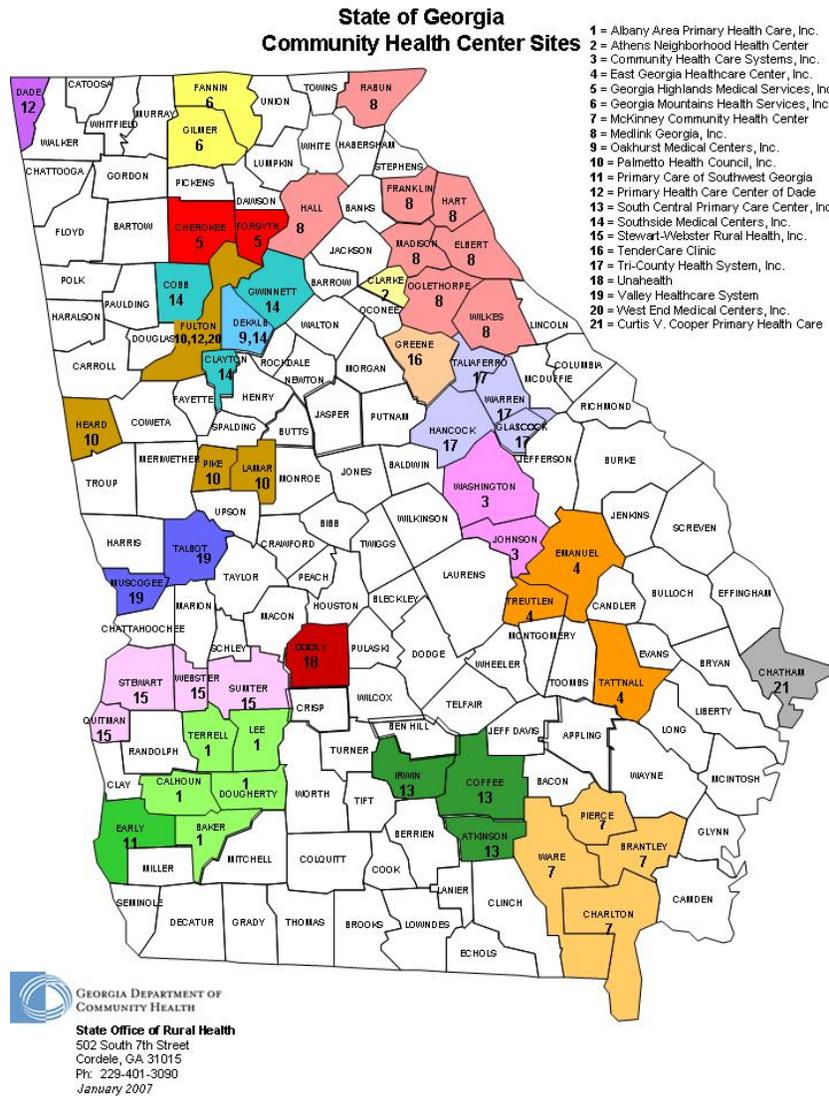
In Georgia, several systems support the delivery of primary care:

- Federally Qualified Health Centers

- Rural Health Clinics
- Volunteer Clinics
- Georgia Farmworker Health Program

Federally Qualified Health Centers

The Federally Qualified Health Center Program is a federal grant program funded under Section 330 of the Public Health Service Act to provide for primary and preventive health care services in medically-underserved areas throughout the U.S. and its territories. This program, administered by Health Resources and Services Administration, provides grant funding for organizations to provide care to underserved populations.



Four different types of health centers are funded through this program including:

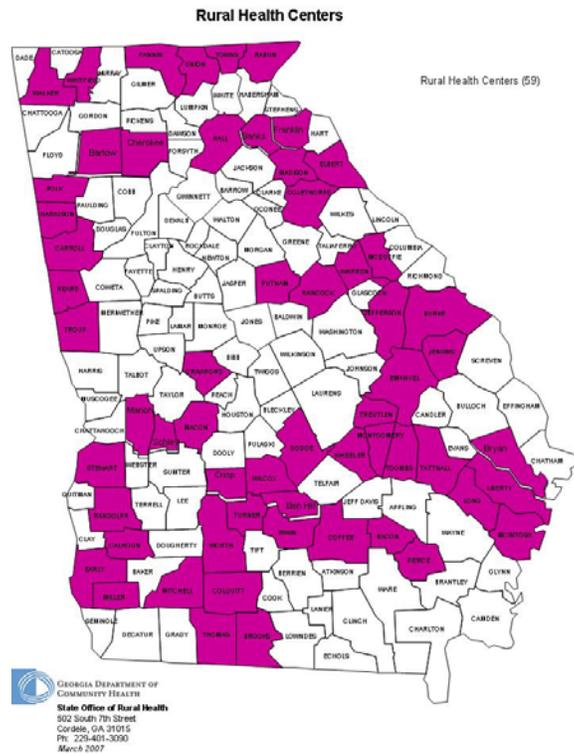
- Federally Qualified Health Center
- Migrant Health Center
- Health Care for the Homeless Program
- Public Housing Primary Care Program

Federally Qualified Health Centers are public or private corporations created through the initiative of local citizens interested in bringing health care to their areas. They are governed by consumer-majority boards of directors, and thus represent the communities they serve. With the help of the community, the board attracts local and outside funding, develops facilities, purchases equipment, hires staff, markets services, and forms linkages with other area health providers such as hospitals and specialty providers. Georgia is home to 21 Federally Qualified Health Centers entities with 93 total service sites in 53 counties. Forty-eight sites are located in rural counties, and 45 sites are located in urban counties.

The Georgia Association for Primary Health Care Inc. supports the development of Federally Qualified Health Centers in Georgia through advocacy to improve access to comprehensive primary health care services for all medically underserved Georgians and to support the continued development and expansion of community-based health center practice systems throughout the state.

Rural Health Clinics

A Rural Health Clinic is a clinic certified to receive special Medicare and Medicaid reimbursement.



The purpose of the Rural Health Clinic program is to improve access to primary care in underserved rural areas. Rural Health Clinics are required to use a team approach of physicians and midlevel practitioners (nurse practitioners, physician assistants, and certified nurse midwives) to provide services.

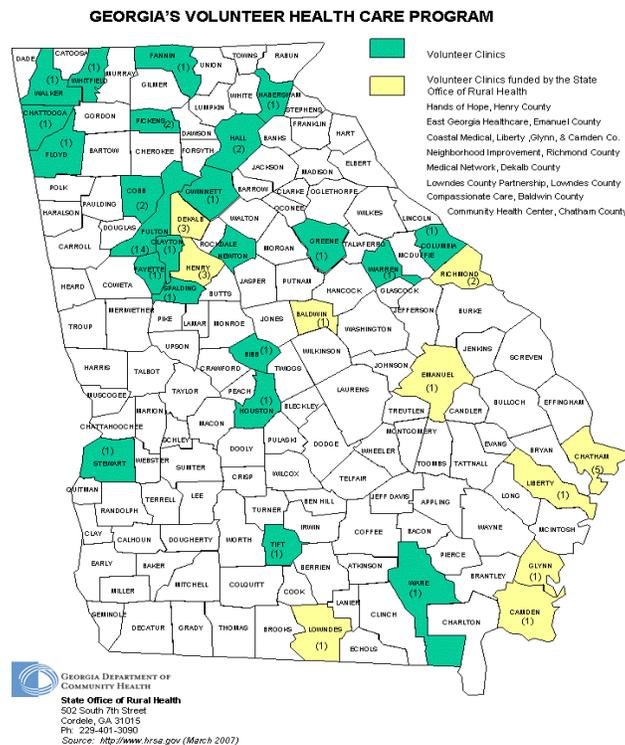
The clinic must be staffed at least 50 percent of the time with a midlevel practitioner. Rural Health Clinics may also provide other health care services, such as mental health or vision services, but reimbursement for those services may not be based on their allowable costs. In Georgia, there are 97 Rural Health Clinics in 59 rural Georgia counties.

- Ellaville Primary Medical Clinic serves Crisp, Macon, Schley, Sumter, and Taylor counties
- Ellenton Clinic serves Brooks, Colquitt, Cook, and Tift counties
- East Georgia Health Care Center serves Candler, Tattnall, and Toombs counties
- Migrant Farmworker Clinic, LLC. serves Echols and Lowndes counties

Georgia Volunteer Health Care Program

The Georgia Volunteer Health Care Program is available to communities to assist volunteer health care professionals with clinic management and projects, including health care provider recruitment, contracting for sovereign immunity protection, administering quality assurance review, and ensuring that providers have the proper licenses.

Contact: Pauline Lindstrom, director, Georgia Volunteer Health Care Program
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 plinstrom@dch.ga.gov



The State Office of Rural Health sponsored grant funds to support the development of volunteer clinics to increase the number of patients receiving medical care through Georgia's Volunteer Health Care Program. In 2006, the State Office of Rural Health provided \$580,000 of state and federal funds to support the development of 11 of the 55 volunteer clinics participating in the Georgia Volunteer Health Care Program.

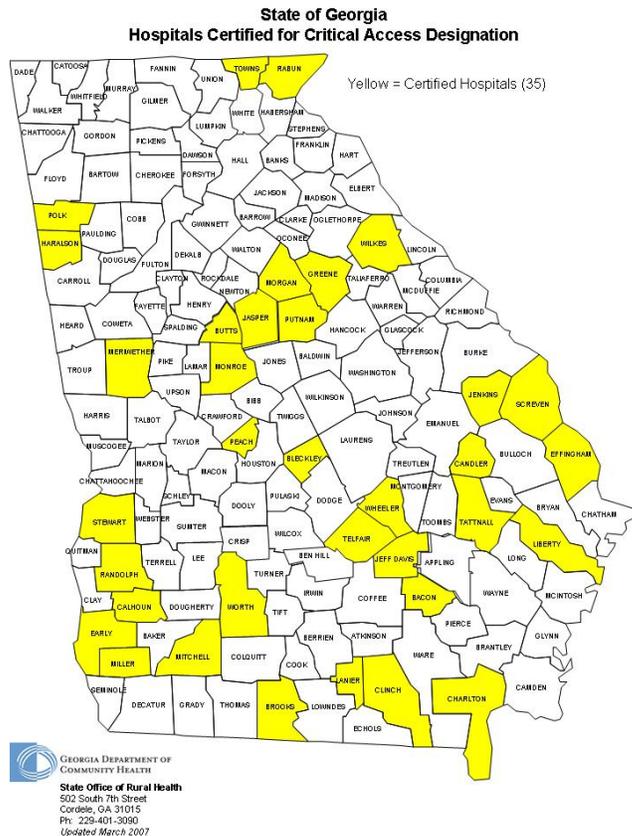
Rural Hospital Resources

Georgia promotes programs that support the sustainability of rural hospitals. Rural hospital utilization patterns reflect the poorer health of rural Georgians and reflect the demand on rural hospitals. Georgia has 67 rural hospitals, 35 of which are designated as critical access.

Critical Access Hospitals

The Critical Access Hospital Program is designed to aid in the continuation of health care services for rural residents. A Critical Access Hospital is a hospital certified to receive cost-based reimbursement from Medicare. The reimbursement that Critical Access Hospitals receive is intended to improve financial performance and reduce hospital closures.

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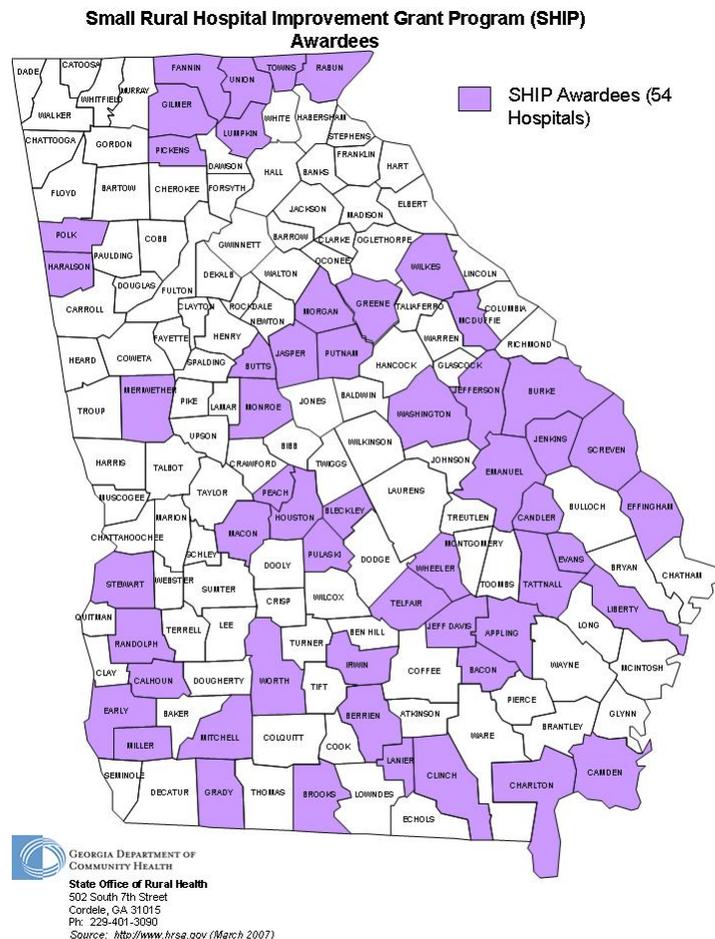


Small Rural Hospital Improvement Program

Of Georgia's 67 rural hospitals, 54 are eligible to receive funding from the Small Rural Hospital Improvement Program grant. To be eligible for Small Rural Hospital Improvement Program grant funding, a hospital must:

- Have 49 or less available beds as reported on the hospital's most recent Medicare Cost Report;
- Be located outside a Metropolitan Statistical Area or located in a rural census tract of a Metropolitan Statistical Area as determined under the Goldsmith Modification or Rural Urban Commuting Areas;
- Be defined as non-federal, short-term, general acute care facility;
- Possess Critical Access Hospital designation; or
- Be located in an area designated by any State law or regulation as a rural area or rural hospital.

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pwhaley@dch.ga.gov



SHIP is designed to assist small rural hospitals in the reduction of medical errors and support quality improvement, obtain products and services to comply with the Health

Information Portability and Accountability Act (HIPAA) regulations and to function effectively within the guidelines of the Perspective Payment System . Each year eligible hospitals in Georgia have the option of pooling financial resources by joining one of two Small Rural Hospital Improvement Program consortiums that provide innovative programs, products and services to address varied quality improvement and HIPAA issues or they may select hospital-specific plans that target their individual needs. Funding for SHIP is made possible by HRSA and is administered by the State Office of Rural Health.

Rural Hospital FLEX Program

The Medicare Rural Hospital Flexibility Program was born out of the Balanced Budget Act of 1997 and focused on the development of Critical Access Hospital designations for hospitals identified as at risk for closure or based on pre-established eligibility criteria for Critical Access Hospital status. Since 1999, Georgia has received over \$4.5 million in Medicare Rural Hospital Flexibility grant funding resulting in the conversion and sustainability of 35 rural Georgia hospitals. The Medicare Rural Hospital Flexibility program helps to sustain the rural health care infrastructure with the Critical Access Hospitals as the hub of an organized system of care (in communities where they exist) through the mechanisms of the Medicare Rural Hospital Flexibility program. These mechanisms include:

- Development of the Rural Health Plan
- Health Care Networks
- Quality Improvement
- Emergency Management Services integration initiatives

Additionally, FLEX must foster the growth of collaborative rural health care delivery systems across the continuum of care at the community level and with appropriate external relationships for referral and support, thus maintaining access to high quality care for rural Medicare beneficiaries. Funding for FLEX is made possible by HRSA and is administered by the State Office of Rural Health.

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Hospital Supply and Utilization

Georgia's rural communities are home to approximately 30 percent of the state's population but only 14 percent of the state's available hospital beds. Rural hospitals serve only 11 percent of the state's hospital admissions. This may be due to the lack of a local hospital, lack of needed specialized services, or a preference for non-local hospitals. Perhaps more importantly, while Georgia's rural hospitals admit 10 percent of the state's total admissions, they admit 15 percent of the state's total Medicare admissions, reflective of the greater share of elderly Georgians living in rural areas and highlighting the need for local access.

Hospitals by Type, Georgia 2004

Source: Department of Community Health, Division of Health Planning

Designation	Type	Number
Rural	General	65
	Psychiatric and Other Specialty Hospitals	2
Urban	General	87
	Psychiatric and Other Specialty Hospitals	25
Total	General	152
	Psychiatric and Other Specialty Hospitals	27

Supply and Utilization of General Hospitals, Georgia 2004

Designation	Number of Hospitals	Capacity Beds	Beds per 1000 Population	Admission	Medicare Admission	Medicaid Admissions	SCHIP Admission	Total Inpatient Days
Rural	65	3,285	1.9	97,242	53,295	20,366	434	388,420
	42.8%	13.6%		10.5%				8.8%
Urban	87	20,814	2.9	831,745	312,855	160,836	4,098	4,032,510
	57.2%	86.4%		89.5%				91.2%
Total	152	24,099	2.7	928,987	366,150	181,202	4,532	4,420,930
	100.0%	100.0%		100.0%				100.0%

Source: Annual Hospital Questionnaire, Georgia Dept. of Community Health/Division of Health Planning, 2004

Network Resources

Collaboration among various stakeholders and across county lines has been identified as tremendously important to health improvement in rural Georgia. The Georgia Department of Community Health has an eight-year history of investment in building rural collaboration through network development. ORHP also supports rural collaboration through its network and outreach grant programs.

Networks for Rural Health

Networks for Rural Health, funded by the Georgia Department of Community Health/State Office of Rural Health, is designed to help rural providers and community leaders build health care systems which:

- Are clinically relevant
- Are financially viable
- Improve health care of rural residents
- Provide access to the uninsured
- Improve overall health status

In 1996, Georgia's rural health crisis came to the forefront. A Medicaid case study confirmed the state's need for improved health care delivery systems in rural Georgia. Since 1996, Georgia government and its partners have invested in an evolving strategy to organize, support, and build capacity for sustainable rural health networks.

Rural health networks play an increasingly important role strengthening rural health care systems to increase access to health and human services and improve health status. More than 64 rural Georgia counties work within rural health networks to fill gaps in access to and availability of health and human services.

Georgia's rural health networks help bridge the health care gap between rural and urban areas and meet the needs of the communities they serve. During tight economies, rural health networks are challenged to meet the health needs of their communities, provide care for more people, and continue their work to improve Georgia's health care safety net, all with less funding.

In 2006, the State Office of Rural Health awarded the East Georgia Health Cooperative a state-funded \$200,000 network revitalization grant. East Georgia Health Cooperative is an eleven county, nonprofit collaborative, comprised of five hospitals, three community health centers, rural health clinics, and affiliated physicians, as well as representation from public health and two community members. The network revitalization grant will support the re-establishment of a strong strategic planning focus with long term sustainability of program and operational structure. Funding for the two-year period includes leadership staffing as well as operational support, sustainability and grant writing consulting assistance.

Rural Outreach Grant Program

Office of Rural Health Planning's Outreach Grant Program is designed to encourage the development of new and innovative health care delivery systems in rural communities that lack essential health care services.

The emphasis of this grant program is on service delivery through creative strategies requiring the grantee to form a network with at least two additional partners. Programs have varied greatly and have brought care that would not otherwise have been available to at least 2 million rural citizens across the country. Through consortia of schools,

churches, emergency medical service providers, local universities, private practitioners and others, rural communities have managed to create hospice care, bring health check-ups to children, and provide prenatal care to women in remote areas. In 2005 and 2006, Outreach Grants were awarded to the following Georgia communities:

- Floyd County Board of Health, Rome
- Turner County Board of Education, Ashburn
- Lincoln County Commission, Lincolnton
- Hospital Authority of Washington County, Sandersville
- Irwin County Board of Health, Ocilla
- Evans County Health Department, Claxton

Rural Network Development Grant Program

Network Development Grants provide funding to help rural communities strengthen their health care systems. Grants for up to three years support rural providers who work together in formal networks, alliances, coalitions, or partnerships to integrate administrative, clinical, financial, and technological functions across their organizations. This integration of functions and services helps to overcome the fragmentation of health care services in rural areas, improves coordination of those services, and achieves economies of scale. This program does not support direct patient care services.

These grants are designed to further ongoing collaborative relationships among health care organizations by funding rural health networks that focus on integrating clinical, information, administrative, and financial systems across members. The goal is to strengthen rural health care systems at the community, regional, and state levels by funding these formal, horizontally or vertically integrated networks.

Grant funds typically are used to acquire staff, contract with technical experts, and purchase other resources to 'build' the network. Grant awards provided by ORHP support up to a three-year implementation process. To be eligible, the applicant organization must be a public or nonprofit entity that is a network or is a member of a network that includes at least three separately owned health care providers or other entities that provide or support the delivery of health care services. Additionally, the applicant's administrative headquarters must be located in a designated rural county or rural ZIP code of an urban county. In 2005, the Turner County Board of Education in Ashburn, Goodwin Community Health Center in Brunswick, and the East Georgia Health Care Center in Swainsboro benefited from Network Development Grants.

Additional Resources

Other important support services for rural Georgians include services for the aging, public health, telemedicine, emergency medical services, and trauma care.

Programs for the Elderly

Because Georgia's older population disproportionately impacts rural areas, rural Georgia needs a greater density of services available to serve an aging population. A 2005 report by the Georgia Health Policy Center and the Fiscal Research Center – "Georgia's Aging Population: What to Expect and How to Cope" examined the state-sponsored programs available to rural and urban Georgians. It found:

- Georgia's supply of rural nursing facility beds (169 facilities; 15,094 beds) is currently adequate. Unfortunately, the availability of institutional beds makes nursing facilities the most convenient option for rural Georgians making long-term care decisions
- The aging of Georgia's population will impact rural areas first; so adequate future staffing remains a concern
- Personal Care Homes¹⁴ are concentrated in urban areas. Because only 25 percent of the Personal Care Home bed supply is in rural areas, the Personal Care Home market under-serves Georgia's rural seniors. With less choice, Georgia's rural seniors are more likely to turn to more expensive nursing facility care
- Georgia's Community Care Services Program¹⁵ provides services in each of Georgia's 159 counties, coordinated by twelve Area Agencies on Aging . Community Care Service Program recipients are distributed fairly evenly among Georgia's urban and rural areas. Unfortunately, the demand for the Community Care Service Program far exceeds available funding. In FY2004, 5,018 Georgians were on a waiting list for Community Care Service Program, up from 3,198 in FY2001¹⁶
- Georgia's SOURCE¹⁷ program primarily serves urban clients, but it is continuing to expand across the state

Public Health

The Division of Public Health, within the Georgia Department of Human Resources, is the lead agency entrusted by the people of the State of Georgia with the ultimate responsibility for the health of communities and the entire population. At the state level, DPH is divided into numerous branches, sections, programs and offices, and at the

¹⁴ Any dwelling that provides or arranges for the provision of housing, food service, and one or more personal services for two or more adults who are not related to the owner or administrator by blood or marriage.

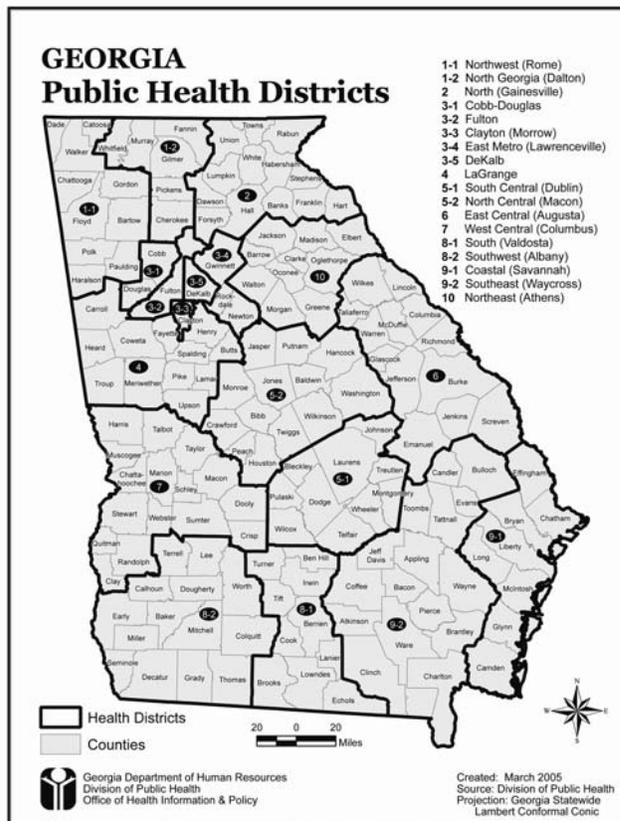
¹⁵ The purpose of CCSP is to help eligible recipients remain in their homes, a caregiver's home, or other community settings for as long as possible. A CCSP recipient must meet the medical, functional, and financial criteria for nursing facility placement and receive physician approval that CCSP can meet the recipient's needs.

¹⁶ "Community Care Services Program Annual Report", State FY 2004, Division of Aging Services, Georgia Department of Human Resources. Counts include non-elderly and elderly CCSP recipients (2004).

¹⁷ Service Options Using Resources in a Community Environment (SOURCE) seeks to serve Georgia's seniors in their homes or communities for as long as possible. SOURCE links primary care with an array of long-term health services in the recipient's home or community to reduce or eliminate the need for institutional care.

local level, Division of Public Health functions via 18 health districts and 159 county health departments.

Each County Board of Health is made up of a county commissioner, mayor of the largest municipality or their designee (who must be an elected official), Superintendent of the county school system or their designee, a licensed physician in active practice appointed by the county governing body, an advocate for consumers of health services, a consumer representing the needy, underprivileged or elderly, and a person interested in promoting public health. The District Health Director functions as the Chief Executive Officer of each county board.



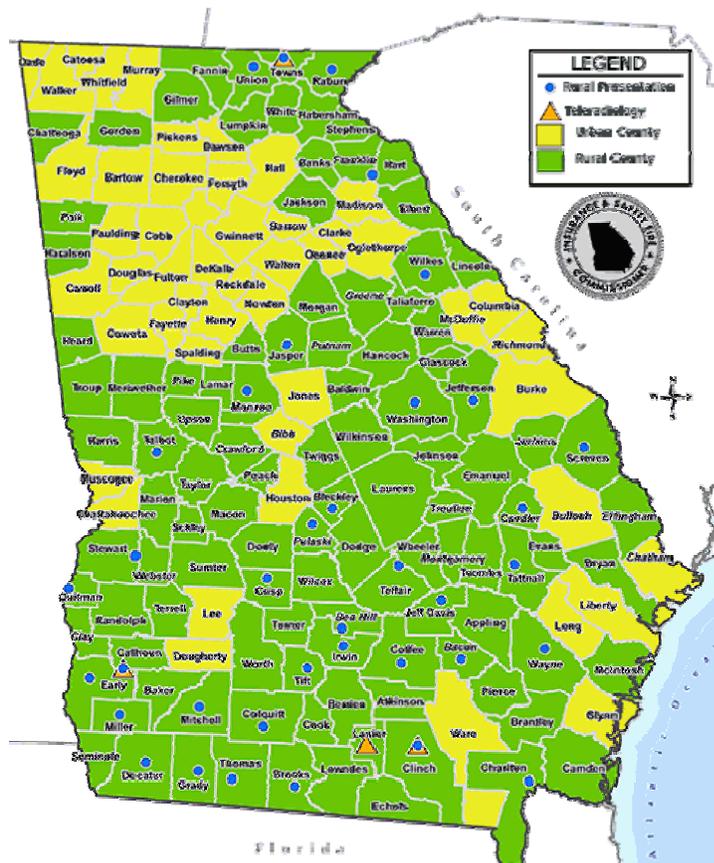
In late 2005, more than 800 Georgians came together for two days at the Summit for a Healthy Georgia to develop a statewide vision for improved health. Convened by the DPH, the summit yielded seven areas of emphasis on which communities throughout the state are focusing to improve the health status of all Georgians. The areas of emphasis are as follows:

- Improve access to health care
- Promote the community culture and conditions necessary for healthy lifestyles, including factors of:
 - Physical activity
 - Sexual behaviors

- Nutrition
- Alcohol and drug abuse
- Tobacco
- Vehicular safety
- Decrease the number of uninsured and underinsured Georgians
- Promote safe communities
- Identify and eliminate inequities in health status
- Address poverty as a root cause of poor health status
- Engage educational partners

Telemedicine

Telemedicine is a health care delivery model that applies high-speed telecommunications systems, computer technology, and specialized medical cameras to examine, diagnose, treat and educate patients from a distance. For example, through a telemedicine encounter, a patient in far southwestern Bainbridge may seek medical treatment from one of Georgia's leading specialty hospitals without spending the time and money required to travel for an in-person appointment.



The program strives to increase access to specialty care throughout Georgia, improve timeliness of diagnosis and treatment, and improve the quality of care for rural patients. The goal is to enable patients anywhere in Georgia to have access to specialty care within a 30-minute drive or less.

The network will provide an open web of access points established throughout the state, connecting rural areas where barriers to specialty care typically exist with advanced tertiary care centers in larger cities. Now developed, the open access network offers unprecedented access to specialty care:

- It connects each presentation site directly to any one of five specialty centers for diagnosis, consultations and reviews, dramatically enhancing access to specialty care for the rural patient
- It enables presentation sites to connect to each other – primary care provider to primary care provider – for peer review, collaboration and educational opportunities
- It enables the addition of new locations as the need or opportunity arises

Emergency Medical Services

Emergency Medical Services in Georgia are centered on providing medical aid and safe transportation to sick and injured people. It requires a collaboration of community organizations, state and local agencies, and private groups to meet the demands and challenges associated with providing pre-hospital care and related health services to citizens. Emergency Medical Services is an umbrella term used to describe the continuum of pre-hospital activities that begin with a rapid response to an initial call for help. Twenty counties in Georgia do not have a 911 system.

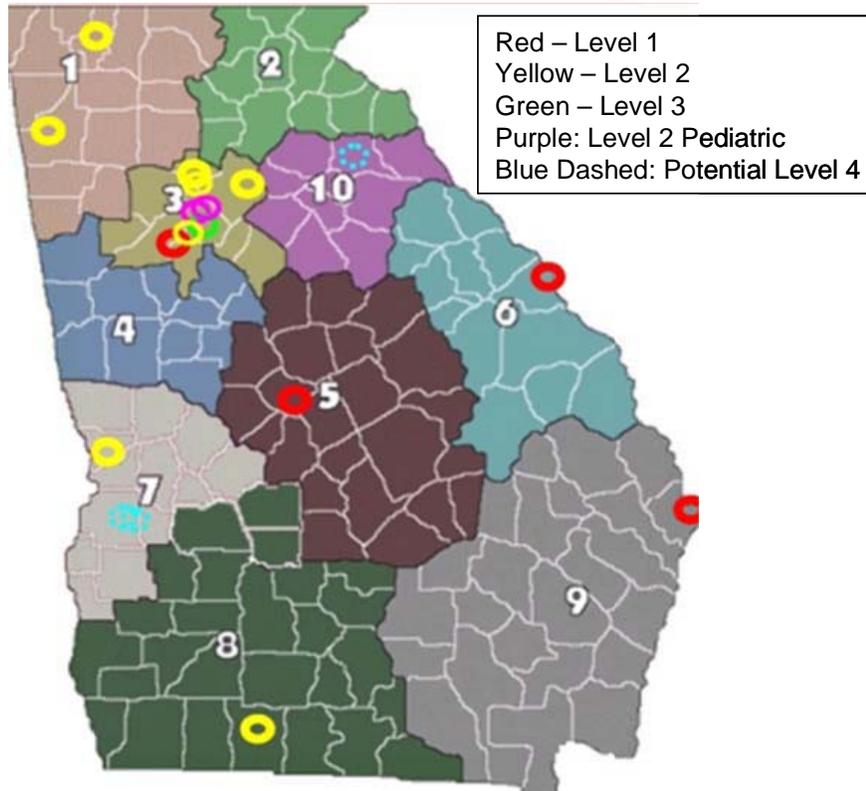
Emergency Medical Services has developed into a medical discipline over the past several decades in Georgia. In the past, funeral homes provided ambulance services, and patient care did not begin until the patient arrived at the hospital. Today, in stark contrast, many of Georgia's Emergency Medical Services personnel are prepared and trained to provide pre-hospital care in emergency situations, which is considered advanced life support.

Georgia has an estimated 1,739 ground ambulances and 282 ambulance service providers. Georgia has five air ambulance services, including: Air Med in Augusta; Life Star One in Savannah; Children's Response Air and Emory Flight/Life Net Georgia; and, Rescue Air in Atlanta. Most of Georgia, especially south of Interstate 16, is not covered by air ambulance. Georgia's 159 counties are grouped into 10 geographical Emergency Medical Services regions. Georgia ranks 24th among the states in size – 59,441 square miles. The smallest region, Region 3, covers 2,343 square miles; however, it serves nearly 3.5 million people because it covers the counties of Fulton, Cobb, Douglas, Clayton, DeKalb, Gwinnett, Rockdale, and Newton.

The largest region in size, Region 9, which covers 12,533 square miles, serves nearly one million people in 24 counties. A look at Region 8 reveals a 27-county area in rural Southwest Georgia. Although there is a Level 2 Trauma Center within this region, Archbold Memorial Hospital in Thomasville, it covers 10,670 square miles and there is no air ambulance service.

Trauma Care

A trauma system is a strategically organized approach to injury prevention, emergency medical services pre-hospital response, hospital-based acute care, and post-hospital rehabilitation that is fully integrated within a state's public health system.



Source: Georgia Department of Human Resources, Division of Public Health, 2004.

The presence of a trauma system means that there is complete coordination between injury prevention, Emergency Medical Services (including air and ground medical transportation) and regional referring hospitals. It also means that there is a systematic integration of the care provided to the very seriously injured at all stages of treatment. The resources required for each component of a trauma system are clearly identified, deployed, and studied to ensure that all injured patients gain access to the appropriate level of care in a timely, coordinated, and cost-effective manner.

The benefits of a trauma system can reduce the preventable death rate by 10 to 30 percent, possibly up to 50 percent. Studies of trauma systems in the U.S. where the most severely injured patients are directed to specialized trauma centers show that the benefit of an organized system of trauma care can reduce the risk of death significantly. Georgia's trauma death rate is 20 percent above the national average. If Georgia could reach the national average, it is likely that 700 lives a year would be saved.

Recent estimates suggest that only 30 percent of major traumatic injuries in Georgia are treated at designated trauma centers. Depending on where the victim is located in the state, the pre-hospital response may require from three to 45 minutes. There may be an additional 10 to 60 minutes before the patient reaches a medical facility, which may not be the appropriate facility. It is easy to continue to increase the passage of crucial time, considering that the patient may have needed on-scene extrication or needed to be transferred from one facility to another. Additional hours, even as many as eight or 10, could possibly lapse before reaching the appropriate level of care. There are still many areas of the state that do not have rapid access to trauma centers. Georgia's hospitals provide quality care to injured patients; however, the standard of care is not uniform.

Additional resources are available in Appendix B.

Plan for Improvement

Plan for Improvement

Along with establishing the vision and goals for the 2007 Georgia Rural Health Plan, the State Office of Rural Health and its partners identified priority actions for each goal. These priority actions represent areas of concentration within each goal and serve as the strategies that are both most likely to contribute to improving health in rural Georgia and to be most feasible for implementation in rural communities. They are focused steps that communities may undertake in their work to address a particular goal or goals. In addition, with input from partners and stakeholders, best practices and community projects were compiled to demonstrate how communities in Georgia and across the nation are addressing the health needs of their rural residents.

The best practices and community projects is not an exhaustive listing, but are examples of initiatives related to each of the four established goals. Georgia communities who want to take action can draw on this collection of success stories to pattern their own efforts. They are included as examples for communities to consider, tailor, and implement in ways that best meet their individual concerns and needs. Georgia's rural communities are encouraged to contact these initiatives for information on replicating their successes.

Goal 1:

Build a system of care that is unified, clinically relevant, financially viable and responsive to community needs

Goal 1: Build a system of care that is unified, clinically relevant, financially viable and responsive to community needs.

Priority Action 1. a: Promote the appropriate distribution of health care facilities, workforce and comprehensive services by creating an inventory of existing health care service delivery options for rural communities with periodic reviews and dissemination

Priority Action 1. b: Increase the appropriate utilization of health services by creating and promoting the use of local databases of resources across the continuum of care

Priority Action 1. c: Increase the efficiency of rural health care systems through the development and integration of multi-county health plans that are inclusive across the continuum of care utilizing local collaboratives and provide accompanying external, objective technical support

The following are community projects and best practices that showcase initiatives in Georgia and across the nation. These examples are resources for communities that strive to move toward a more unified system of care.

GEORGIA

Coastal Medical Access Project

Glynn, Camden and McIntosh counties, Georgia

Coastal Medical Access Project is a 501(c) 3 founded in 2002 and serving the counties of Glynn, Camden and McIntosh. CMAP provides three distinct but interrelated services: primary care services from two free clinics, a pharmaceutical assistance program (MedBank), and Intensive Case Management of chronic conditions. Coastal Medical Access Project is a donated care model with over 100 volunteer physicians and medical professionals and over 125 lay volunteers. It has provided more than 5,000 patient visits to more than 1,300 clients, totaling more than \$850,000 in donated care and \$9 million in free pharmaceutical drugs.

Coastal Medical Access Project
PO Box 1357, 900 Bay St.
Brunswick, GA 31521
Patricia J. Kota RN MSPL, CEO
912-554-3559 ext. 11
pkota@cmapgga.org
www.cmapga.org

**Colquitt Regional Medical Center
Moultrie, Georgia**

Colquitt Regional Medical Center is located in an agricultural community in Southwest Georgia. The hospital operates in an area where it is forced to compete with larger facilities to attract health professionals drawn from a small pool of eligible employees and has struggled to fill key health care positions. In order to address the workforce shortage it was facing, Colquitt Regional Medical Center focused its efforts on both employee recruitment and retention. Its efforts to recruit qualified health professions include partnering with local schools to promote health care professions through job shadowing; expanding the existing scholarship program for hard-to-recruit positions; and implementing Georgia's Intellectual Capital Partnership Program which facilitates hospital/university partnerships to provide health professional training and certification programs for non-traditional students. In addition, Colquitt Regional Medical Center funds a portion of a registered nurse program in a nearby town and receives nursing students doing their clinical rotations.

In addition to their focused efforts on recruitment, the hospital believes that it is equally important to maintain strong job satisfaction and a quality work environment. The hospital focuses on retention in a number of ways, including using bedside computers that allow for electronic charting, the use of wireless telephones, and creating a preceptor program for newly hired nurses.

As a result of their efforts, Colquitt saw a decline in its vacancy rate and has been able to reduce its nurse turnover rate during the first two years of the program.

Colquitt Regional Medical Center
3131 South Main Street
Moultrie, GA 31768
Dawn Johns, Human Resources Director
229-985-3420
djohns@colquittregional.com
www.colquittregional.com

Community Health Works

Bibb, Crawford, Houston, Jones, Monroe, Peach and Twiggs counties in Central Georgia

Community Health Works is a regional collaborative representing physicians, behavioral health organizations, county governments, hospitals, public health and social service providers, pharmacies and others committed to implementing regional solutions to facilitate access to care. Today, Community Health Works is a regional center for health innovation, recognized both statewide and nationally as one of the best of its kind. Community Health Works programs include:

Rx for the Uninsured, Community Health Work's original program, assists adults, 19 to 64 years old, with incomes under 200 percent of Federal Poverty Level, who have one of the targeted disease states: diabetes, hypertension, heart disease, depression and cancer. The program utilizes a case management system that provides advocacy, disease education and disease management, referral services, and access to donated medical services.

The Central Georgia Cancer Coalition, organized in 2002, addresses disparities in access to care for cancer victims and the prevalence of poor outcomes among Central Georgia cancer patients. The Coalition works to promote consumer education and cancer screenings, clinical research, and collaboration among care providers.

Middle Georgia Multi-Share, a program that would bring traditional employer and employee contributions together with non-traditional funding, so that cost is shared among multiple sources. If the program is successful in research and development, it will be of great benefit to one of Central Georgia's hardest working communities, its small businesses.

Community Health Works
105 Patrol Rd.
Forsyth, GA 31029
Greg Dent, CEO
478-994-1914
gdent@chwg.org
www.chwg.org

**Promotores de Salud Program
Murray and Whitfield Counties, Georgia**

The Promotores de Salud program seeks to empower Latinos living in Northwest Georgia to take control of their own health by teaching them how to properly access appropriate health care and community resources by increasing their health care literacy. The program trains bilingual, culturally-competent community health workers to serve as a trusted bridge between Latino community members and the health care system. The health workers, or Promotores, assist their clients in understanding and navigating the health care system, provide health education and case management.

In 2004, its first year of operation, the Promotores de Salud program received over 200 referrals from local schools, medical providers and social services agencies. Promotores reached more than 18,600 individuals at local health fairs and community events, initiated a prescription assistance service, and provided case management for 65 individuals with chronic and acute conditions. The Promotores also conducted extensive community-based health education.

Northwest Georgia Health Care Partnership
PO Box 182
Dalton, GA 30722
Nancy Kennedy, Executive Director
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nkennedy@nhcs.org
www.nwgahealthpartners.org

Service Options Using Resources in a Community Environment (SOURCE) Statewide, Georgia

SOURCE (Service Options Using Resources in a Community Environment) is a Medicaid demonstration waiver program for frail elderly and disabled beneficiaries that seeks to prevent hospital and nursing home care or speed the return to the community from a nursing home or hospital. SOURCE is an enhanced primary care case management program that integrates primary medical care with home and community-based services through case managers who work with the beneficiaries and their primary care physicians. An assessment helps to determine how much care a participant needs. An individual care plan is designed based on the need for medical monitoring and assistance with functional tasks. Family members and other informal caregivers as well as staff from support agencies participate in care plans. In addition to the core services, SOURCE offers home delivered meals, adult day care, personal care home and 24-hour medical access.

SOURCE is a program of the Division of Medical Assistance in the DCH and serves approximately 7,000 frail elderly and disabled Georgians who are eligible for SSI/Medicaid (Supplemental Security Income). People under the age of 65 are eligible if they have a significant disability and are receiving SSI/Medicaid. Eight SOURCE sites administer the program in 120 of the 159 counties in Georgia. The characteristics of the SOURCE administration sites vary significantly, and include nursing facilities, hospitals with outpatient clinics, adult day care centers and area agencies on aging.

St. Joseph's/Candler of Savannah

11705 Mercy Boulevard

Savannah, GA 31419

Hunter Hurst, Executive Director of St. Joseph's/Candler's Georgia Infirmary Inc. and SOURCE program

912-819-1505

HurstH@sjchs.org

www.sjchs.org

Spring Creek Health Cooperative Blakely, Georgia

An innovative multi-county partnership is changing the way Southwest Georgians manage their health, and it is saving taxpayers millions of dollars. The counties of Early, Miller, Calhoun and Clay joined in 2001 as the Spring Creek Health Cooperative to improve access to health care for and health status of the uninsured. Since then, the network's mission has evolved to help those at risk for chronic disease in its service area better utilize the health care system and make healthier lifestyle choices.

Through its partnerships with Calhoun County Hospital, Early Memorial Hospital, Miller County Hospital, and public health departments, the Spring Creek Health Cooperative works to meet the health needs of this population and provide education to reduce and prevent the costly complications associated with chronic disease.

The Spring Creek Health Cooperative offers case management services for the low-income, indigent and uninsured or underinsured patients with chronic disease. The cooperative manages cases by connecting its targeted patient population with the resources they need to take charge of their health. From regular physician visits and education to helping patients obtain medications at little or no cost, Spring Creek Health Cooperative is producing substantial results in improving the health of its communities.

The cooperative provides case management to more than 250 patient members and pharmaceutical management for an additional 250 or more members. These management services add up to a healthier community and more than \$1.65 million in savings per year for taxpayers. These savings are especially important to hospitals in Miller, Calhoun and Early counties because they are Critical Access Hospitals. Critical Access Hospitals provide essential services to a community and are reimbursed by Medicare on a "reasonable cost basis" to improve their financial performance and thereby reduce hospital closures.

Spring Creek Cooperative
#3 South Jefferson Ave.
Blakely, GA 39823
Sheila P. Freeman, Executive Director
229-723-6061
sfreeman_schc@windstream.net

**NATIONAL
Community Health Access Project
Mansfield, Ohio**

The Community Health Access Project is a not-for-profit organization located in Richland County Ohio. Community Health Access Project employs, trains, and supports Community Health Workers in three Ohio counties. CHAP utilizes a system called Pathways, which allows them to document and better focus on specific outcomes for clients served. Pathways is a standardized methodology for improving health outcomes and was developed and implemented in collaboration with medical, social and community-based providers. In this methodology, critical social services as well as medical services are linked together in a common accountable outcome production tool. Community Health Access Project uses geomapping of outcomes to identify areas with greatest need.

The Community Health Worker model was signed into law as a new profession in the state of Ohio as part of the state's budget bill July 2003. Through this landmark legislation Community Health Workers were credentialed under the Ohio Board of Nursing. The services that Community Health Workers provide through Community Health Access Project are Medicaid reimbursable. Utilizing Pathways and the care coordination services of Community Health Workers, Community Health Access Project has demonstrated an 83 percent reduction in low birth weight for enrolled high risk women identified within the high risk census tracts of Richland County. Community Health Access Project has demonstrated 7,000 positive outcomes related to immunization, lead exposure, truancy, chemical dependency, employment, etc.

Community Health Access Project
Ocie Hill Neighborhood Center
445 Bowman Street
Mansfield, OH 44903
Dr. Mark Redding, Medical Director
419-525-2555
reddingz@att.net
<http://www.chap-ohio.net>

Holy Cross Hospital- CATCH Collaborative Taos, New Mexico

Holy Cross Hospital recognizes the importance of effectively coordinating inpatient treatment and outpatient disease management and support for diabetes patients in order to prevent manageable diabetes-related complications from turning into acute and/or chronic conditions requiring hospitalization. The Community Wellness department at Holy Cross Hospital offers a comprehensive inpatient to outpatient diabetes program including counseling medical nutrition therapy, stress management, weight loss classes and support groups, and the provision of diabetes supplies such as insulin, glucose meters and test strips to those individuals with diabetes who are underinsured or uninsured.

In addition to the education and support that individuals receive from the inpatient and outpatient Holy Cross Hospital diabetes programs, prescription assistance and pharmaceutical care are also provided through Collaborative Action for Taos County Health . Collaborative Action for Taos County Health is an independent, non-profit health care organization that works to improve access to, and coordination of, wellness and disease management in Taos and the surrounding area. Through Collaborative Action for Taos County Health, patients are matched with a patient advocate who assists with intake, referrals and advocacy as well as provision of disease management support. Holy Cross Hospital is a major contributing member of Collaborative Action for Taos County Health.

Holy Cross Hospital
1397 Weimer Road
P.O. Box DD
Taos, NM 87571
Susan Kargula, RN, MSN, CDE, Director of the Community Wellness Department
505-751-5750
skargula@taoshospital.org
www.taoshospital.org

Local Access to Coordinated Health Care Durham, North Carolina

Local Access to Coordinated Health Care was designed as an outreach, primary care and case management system for any Durham resident without health insurance to assist them in better managing their health and securing appropriate health services. Duke (University) Community Health established a consortium to provide services and advocate for improved access to care. Consortium members include local hospitals and health centers, community organizations and faith-based groups and Durham County and City agencies. Initially funded through a grant from the U.S Bureau of Primary Health Care and now funded by Duke University, Local Access to Coordinated Health Care provides support to patients in need of chronic disease management. Since its inception in 2002, Local Access to Coordinated Health Care has enrolled over 6,500 uninsured people into the program, connected patients to a regular source of medical care, decreased the use of emergency rooms as primary health care, and provided patient support and care management to thousands of families in their homes and neighborhoods.

LATCH

A Duke Division of Community Health Program
4321 Medical Park, Suite 102
Durham, NC 27704
Yvette McMiller, Coordinator
919-620-8034 ext 224
yvette.mcmiller@duke.edu
www.communityhealth.mc.duke.edu/clinical/?/latch

Migrant Health Promotion Statewide, Michigan

Community Health Worker programs have been shown to increase health seeking behavior as well as encourage preventive behavior among diverse populations across the United States. Community Health Worker interventions are particularly suited to encourage people to access preventive health care like screenings and prenatal care, and are effective at providing trusted and knowledgeable navigational assistance to people who are otherwise unable or unwilling to engage with the health care system.

Salud Para Todos, Health for All, trains Community Health Workers (called Promotores and Promotoras) to address mental health, substance abuse, stress and violence in their camps and communities. The program provides a model for reaching isolated farmworker and rural communities and breaking down the cultural barriers that prevent community members from seeking care. Promotores (as) have demonstrated the benefits and promise of offering peer support around health issues which are complex, painful and all too often stigmatized.

In collaboration with Migrant and Community Health Centers, the Salud Para Todos program supports Promotores as they provide health education, referrals and advocacy. Sixty percent of farmworkers who participated in Salud Para Todos Programs in Colorado, Michigan and North Carolina reported decreased stress levels as a result of the program.

Migrant Health Promotion
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Saline, MI 48176
Kimberly Kratz, MSW, MPH, Executive Director
734-944-0244
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info@migranthealth.org
www.migranthealth.org

Goal 2:
Promote health and wellness in all
aspects of daily living

Goal 2: Promote health and wellness in all aspects of daily living

Priority Action 2. a: Increase healthy behaviors related to nutrition and physical activity among children and adolescents by working with educational systems, other governmental entities, private and grassroots community groups and families to promote healthy lifestyles

Priority Action 2. b: Promote partnerships among community based groups to create solutions to improve healthy behaviors related to obesity, diabetes, cardiovascular disease, cancer, and infant health through the development of multi-county programs

Priority Action 2. c: Decrease infant mortality and low-birth weight by promoting pre-and post-natal care

The following are community projects and best practices in Georgia and across the nation. These are examples of successful initiatives for communities that want to promote health and wellness.

GEORGIA

Get Healthy Together/Project Triune Village Upson County, Georgia

Get Healthy Together/Project Triune Village began as a program to address childhood obesity and the cardiac health of the youth in the community. It has expanded to be an after school program that helps educate local children about the importance of proper nutrition, fitness and exercise programs. It also includes tutoring programs, classes on life and social skills, and abstinence education. Project Triune Village is centered in a public housing area that has a childhood obesity rate higher than the national average.

Upson Regional Medical Center
801 West Gordon Street
Thomaston, GA 30286
Sue Mangum, Director of Cardiac Services
706-647-8111
suem@urmc.org
www.urmc.org

**Outreach to Migrant Camp Workers
Tattnall, Toombs and Candler counties, Georgia**

To serve the migrant camp workers health needs, staff from the East Georgia Health Care Center visits the camps during the harvest season (eight weeks from April to June). This effort began in 2003. They offer similar but fewer services during the fall planting season, when fewer residents are in the camps. During harvest, each Sunday there are visits from nurse practitioners and physicians who provide primary care services and mobile lab services so test results can be immediate. They also provide quality of life items, including over-the-counter medications, deodorant, soap, socks, sunscreen, and safety goggles. East Georgia Health Care is a participant in a migrant health fair serving approximately 2,000 people; there are bi-lingual providers on site, and items are labeled in Spanish.

East Georgia Health Care Center
316 North Main St., P.O. Box 807
Swainsboro, GA 30401
Jennie Wren Denmark, Executive Director
478-237-6262 x107
JWDenmark@eghc.org,
www.eghc.org

**Perinatal Health Partners
Southeast Georgia: Appling, Atkinson, Bacon, Brantley, Bulloch, Candler,
Charlton, Clinch, Coffee, Evans, Jeff Davis, Pierce, Tattnall, Toombs, Ware and
Wayne counties, Georgia**

Perinatal Health Partners, founded in 2001, is a voluntary association of health and human service providers who commit time, attention, and fiscal resources to improving perinatal health outcomes in its service area. The partnership is a product of collaboration between Savannah's East Health District and Brunswick's Coastal Health District to develop a Southeast Regional Perinatal Health strategic plan. The network combines in-home case management with nursing assessment and care coordination for high-risk pregnant women and their infants. The network currently operates in 10 of the district's 16 counties and collaborates with more than 72 active partners, including public and private providers, such as obstetricians, pediatricians, birthing hospitals, public health and community agencies. From 2003 to 2004, Perinatal Health Partners staff made more than 2,400 home visits to Southeast Georgia women, and the average weight of Perinatal Health Partners infants was more than 35 percent greater than the average birth weight of infants prior to the formation of network.

Southeast Health District 9-2
1115 Church Street, Suite A
Waycross, GA 31501
Greta O'Steen
912-338-5916
gdosteen@gdph.state.ga.us
www.health.state.ga.us/regional/southeast/index.asp

Walk-A-Weigh

Richmond County Extension Service, Richmond County, Georgia

Walk-A-Weigh is an eight-week educational weight-reduction program designed to promote healthy life-styles. The programs include many topics: reducing fats and sugars in recipes, understanding the nutrition label, substituting herbs and spices for salt, and learning that regular physical activity decreases weight and improves the cardiovascular system. Nine participants lost a total of 53 pounds, including one individual losing 21 pounds in the six week period. Previous to these classes they did not exercise at all. All participants indicated an increase of three to five daily servings of fruits, vegetables and grains.

Richmond County Extension Service
602 Greene Street
Augusta, GA 30901
Betty English
706-821-2356
benglish@uga.edu
www.county.ces.uga.edu/richmond/

Washington County Community Wellness Consortium, Taekwondo Program Washington County, Georgia

The Washington County Community Wellness Consortium, a collaboration of agencies and health providers, has developed a small, multidisciplinary weight loss and fitness model program, the cornerstone of which is martial art taekwondo. This model program began July 2005, with a small grant from Georgia Southern University's Intellectual Capital Partnership Program. All program participants receive regular nutrition education and food preparation demonstrations provided by the Washington County Extension Service. Children are required to attend 21 classes in an eight-week cycle (or three classes per week), leading to earning a series of belts. At specific intervals, children's physical and psychosocial progress is assessed. Interval successes and instructor feedback motivates children and families to continue their individual plans.

Washington County Community Wellness Consortium
Hospital Authority of Washington County, Inc.
610 Sparta Road
P.O. Box 636
Sandersville, GA 31082
Tara Broxton
478-240-2391
tbroxton@sandersville.net

**West Georgia Chronic Disease Initiative
Carroll, Haralson and Heard counties, Georgia**

The West Georgia Chronic Disease Initiative is a community-based treatment, management, and prevention program formed in 2001 as a broad partnership with more than 70 local participants. The initiative was prompted in part by the results of two community health assessments which indicated a prevalence of risk factors associated with diabetes and hypertension. The West Georgia Chronic Disease initiative serves individuals who suffer from diabetes, hypertension, asthma or cardio-pulmonary disease, or who are at risk for these diseases. The program places a special emphasis on low-income, uninsured, and underserved individuals, including the community's growing minority populations.

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Carrollton, GA 30117
Kristie Dunson
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kdunson@tanner.org
www.tanner.org

**Wilkes Wild about Wellness
Wilkes County, Georgia**

Wilkes Wild about Wellness is a community-based approach to nutrition intervention through partnerships with community institutions, organizations, and leaders. Five basic steps are followed: assess the community, establish your key contacts, build a network, implement the program, stay connected and evaluate. Wellness First is a nutrition education program for adults and teens developed to improve health and decrease risk of chronic diseases, not necessarily for weight loss. Activities include community, employee, and student walking clubs.

University of Georgia-Medical College of Georgia Collaborative
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NATIONAL

Healthy Communities of Louisiana/The Obesity Project Health Education Research and Prevention Center Grambling, Louisiana

In 2004, the Grambling Health Education Research and Prevention Center developed a comprehensive health education and screening program to increase their primarily African American population's knowledge of health risk factors through an intensive faith-based, family, community and school-based health literacy program. This initiative has resulted in the creation of a variety of culturally-sensitive health education and outreach programs focused on diabetes, cardiovascular disease and obesity.

Health Education Research and Prevention Center
City of Grambling
Grambling, Louisiana
1732 Marsalis St
Arcadia, LA 71001
Calvin R. Young, Program Director
318-247-0011
cry66@hotmail.com

Kentucky River Health Network

Seven rural counties in Kentucky (Lee, Owsley, Jackson, Powell, Wolfe, Estill and Breathitt counties)

The Kentucky River Health Network's mission is to improve access to preventive care services for the underinsured and uninsured people in their area. These services include mammography and prostate screening, development of hepatitis screening services, transportation services, and continuing education for health care providers, and public awareness programs. Long-term goals include expanding to six other counties focusing on the education of children and students throughout the region as well as continuing education for health care providers.

Foothills Community Action Partnership
128 Kentucky Avenue
Irvine, KY 40336
John Esford
606-723-2115 x8210
jjsfort@lourdes-pad.org
www.lourdes-pad.org

**Prenatal Plus Program
Statewide, Colorado**

The Prenatal Plus Program is a Medicaid funded program that provides care coordination, mental health services, and nutrition services to high-risk pregnant women in Colorado. A multidisciplinary Prenatal Plus team consists of a care coordinator, a registered dietitian, and a mental health professional that complement the medical component of prenatal care by addressing the lifestyle and behavioral characteristics that affect birth outcomes. Prenatal Plus services are tailored to the unique risk factors and needs of high-risk pregnant women through a client-centered model of care.

Colorado Department of Public Health and Environment
Prenatal Plus Program
Prevention Services Division
Women's Health Unit - A5
4300 Cherry Creek Drive South
Denver, CO 80246
303-692-2495
www.cdphe.state.co.us/pp/womens/prenatalplus.asp

**Scott County Child Health Initiative
Scott County, Tennessee**

The Scott County Child Health Initiative provides preventive education related to well-child screenings and conducts these screenings in local elementary schools. Complete well-child screenings are provided to students in grades first through third. These screenings are a mandatory component for school attendance in these designated grades. Parents have the choice of receiving the screening through the school-based clinics or with their private physicians. A home visitation/education component of the program targets children listed on TennCare delinquency lists, ages birth to 21 years. Community health workers provide in-home and telephone education related to well-child screenings, EPSDT Health Check Services, immunizations and WIC.

Scott County Health Department
Kerry Byrd-Hamby, Nursing Supervisor
P. O. Box 88
344 Court Street
Huntsville, TN 37756-0088
423-663-2445
Kerri.byrd-hamby@state.tn.us

West Kentucky Dental Health Project
12 counties in rural western Kentucky

The West Kentucky Dental Health Project is a collaborative community-driven project that aims to build an infrastructure in 12 counties in rural western Kentucky to address early childhood dental caries. The project targets children and families of the WIC program, Head Start and first and second graders through educational programming, preventive projects and activities to increase treatment.

Murray State University
Purchase AHEC
225 Wells Hall
Murray, KY 42071
Loretta Maldaner
270-762-4123
Loretta.maldaner@murraystate.edu
www.murraystate.edu

Goal 3:

Support Practical Integration of technology to increase the efficiency and effectiveness of health services

Goal 3: Support practical integration of technology to increase the efficiency and effectiveness of health services.

Priority Action 3. a: Improve clinical outcomes by encouraging local communities to develop long-term plans based on the Georgia Health Information Technology and Transparency Advisory Board's standards for expanding and maintaining the use of health information technology

Priority Action 3. b: Increase utilization of telemedicine by educating providers and supporting communities in expanding connectivity and other health information technology infrastructure

The following are community projects and best practices that showcase initiatives in Georgia and across the nation. These examples can be used as resources for communities that want to integrate technology into their services.

GEORGIA

Georgia Cancer Quality Information Exchange

Pilot projects in progress in Savannah and Rome, Georgia

The Georgia Cancer Coalition created the Georgia Cancer Quality Information Exchange to establish systems, procedures, infrastructure and resources to gather and aggregate all of the data necessary to measure the 52 cancer-related metrics recommended in a 2005 Institute of Medicine study.

Georgia Cancer Coalition
50 Hurt Plaza, Suite 700
Atlanta, GA 30303
Angie Patterson, COO
404-584-7720
apatterson@georgiacancer.org
www.georgiacancer.org

**Georgia Telemedicine Program
Savannah, Georgia and Statewide**

The Georgia Telemedicine Program offers almost 50 sites in Georgia from which patients can access advanced medical care without traveling more than 30 miles. It currently facilitates 150 consultations per month (excluding teleradiology), providing access to 60 specialists in 40 fields.

The program provides a collaborative learning opportunity between the presenting clinician and specialist while allowing patients to maintain their relationship with their local primary care provider. It has proven to expedite care, screening, diagnosis and treatment and has addressed major needs such as diabetes education, nutrition counseling, stress testing, perinatal level 2 ultrasounds, pediatric genetics, and child, adult and geriatric psychiatry.

Using high-speed phone lines, computer equipment, specialized medical cameras and encryption technology, the Telemedicine Program makes it possible to send images, medical records and data rapidly and securely, and facilitates live video encounters between patients and remote specialists. It also can be used to access medical grand rounds, Continuing Medical Education activities and staff training opportunities remotely.

Georgia Telemedicine Program
8001 Chatham Center Drive, Suite 100
Savannah, GA 31405
Paula Guy, Manager
912-550-9025
paula.guy@wellpoint.com

Pathways Community Network Four states including Georgia

Pathways supports human services providers with a variety of tools that encourage collaboration, reduce costs and increase impact so more people find the path to success.

The Pathways Compass Community Information Sharing System features the following components:

- Comprehensive Demographic Information, Services History
- Shelter Bed Reservations, Personal Health Record
- Electronic Medical Referral, Benefits Eligibility Wizard
- Housing and Urban Development-compliant Homeless Management Information System, Residence History
- Income History, Case Management, Veterans Information, Education History

Communities in four states use Pathways Compass to coordinate care for families and individuals in crisis. The state of Georgia uses Pathways Compass for its Homeless Management Information System (HMIS).

Pathways Community Network
2310 Parklake Dr NE Ste 540
Atlanta, GA 30345
William Matson, Executive Director
866-818-1032
william.matson@pcni.org
www.pcni.org

NATIONAL

California Regional Health Information Organization State of California

California Regional Health Information Organization is a statewide collaborative initiative to improve the safety, quality and efficiency of health care through the use of information technology and the secure exchange of health information. It brings together health plans, providers, hospitals, consumers, public agencies, researchers, policy leaders, and others. Working groups include: Clinical and Privacy, Technology, and Regional Efforts.

CalRHIO
526 Second Street
San Francisco, CA 94107
Donald L. Holmquest, MD, PhD, JD
Chief Executive Officer
415-537-6944 or 415-537-6939
dholmquest@calrhio.org
info@calrhio.org
www.calrhio.org

HealthBridge

Greater Cincinnati tri-state area

HealthBridge is a not-for-profit health information exchange serving the Greater Cincinnati tri-state area. Its mission is to improve the quality and efficiency of health care in the community. It serves as a third party working with all participating health care stakeholders to facilitate creation of an integrated and interoperable community health care system, including the adoption of community standard technologies and work processes. HealthBridge provides access to over 60 hospital-based critical care systems including radiology images, fetal heart monitoring, hospital-based electronic medical records and chart completion; and operates a community-based secure clinical messaging system delivering over 1.4 million results (laboratory, radiology, transcription and ADT) to over 4,000 physicians each month.

Healthbridge is managed with a strong business model. It is a subscription-based service and fees are based on the size of the provider organization. The organization does not rely upon grant money to fund its efforts. Resources are tightly managed at the organization, and new projects are only initiated if there is a long term commitment and if the project will help reduce costs, improve efficiency and benefit the community. (Healthbridge has expanded into Kentucky and Indiana with 21 hospitals currently participating across the three states.)

HealthBridge
11300 Cornell Park Drive, Suite 360
Cincinnati, OH 45242
Bob Regan
513-469-7222 ext 19

info@healthbridge.org
www.healthbridge.org

Northern Sierra Rural Health Network Technology Services Center Regional – Northern California

The Northern Sierra Rural Health Network Technology Services Center supports and expands the use of technology by rural health providers in the northeastern corner of California. It provides a technical support program for rural providers with a "help desk" function and field support; a high-speed network that offers internet, data, video and voice services over an IP-based network; and the NSRHN Bridge, which allows many sites to participate in video conferencing from their rural locations. Since ISDN services are not available in all areas, T1 lines are installed from the rural sites to the network so that the bridge can join them with ISDN, IP or other T1 sites. The NSRHN Bridge currently hosts up to 100 video events per month including clinical specialty consults; CME events; support group meetings; technology trainings; staff meetings and supervision; workforce training; board meetings; and community education.

Northern Sierra Rural Health Network
Technology Services Center
1900 Churn Creek Rd., Suite 208
Redding, CA 96002
530-722-1156
info@nsrhn.org
www.nsrhn.org

The Jesse Tree Galveston, Texas

The goal of the Jesse Tree is to help all members of the community locate and utilize available services, to advocate for new or expanded services, and to provide tools, resources, and in-service training to improve existing services. The Jesse Tree maintains an updated computerized directory of hundreds of services available to the community. The Galveston Safety Net is the online, World Wide Web version of this information. Twice a year The Jesse Tree Journal is published and over 40,000 copies are distributed across the county. The Jesse Tree has developed The Jesse Tree WebCare® application that provides agencies in a collaborative environment a way to track the clients and services provided by their own agency while sharing information about referrals with other agencies in the collaborative. It is based on the concept of holistic solutions to client problems. Because of the collaborative nature, where one agency may not have a way to address all the needs of a client, they can share that responsibility with other agencies that do have the capability. The Jesse Tree WebCare® application is being made available to other communities who want to benefit from this low-cost, high-value tool and are interested in helping set its future direction. A demonstration system is available for viewing at <http://demo.web-care.org/>. It is composed of more than 4,000 fictitious clients.

The Jesse Tree

2622 Market Street
Galveston, TX 77550
Ted Hanley, Director
877-621-2455
jessetree@aol.com
www.jessetree.net

Goal 4:
Engage and Enable Communities in Action

Goal 4: Engage and enable communities in action

Priority Action 4. a: Facilitate the creation and expansion of multi-county health collaborations in rural communities and provide external, objective technical support to those communities to improve health outcomes

Priority Action 4. b: Improve collaborative, community-based health planning (using relevant health data) that is an integral part of local and/or regional economic development plans

The following are community projects and best practices that showcase initiatives in Georgia and across the nation. These examples are resources for communities that want to build collaboratives to address health needs.

GEORGIA

East Georgia Health Cooperative, Inc.

Serves an 11 County Area in East Central Georgia

East Georgia Health Cooperative, Inc. is an integrated network of rural providers delivering quality, low-cost primary and specialty care within local communities, and supported where appropriate by links with outside suppliers such as urban tertiary centers. The mission for East Georgia Health Cooperative, Inc. is to enhance the access, scope and viability of health care services in an eleven-county region of East Central Georgia. Membership includes four hospitals, three community health centers, rural health clinics, and affiliated physicians. The Cooperative members pool resources and share opportunities, allowing local delivery of services and specialists. By increasing the availability of services within communities, they broaden the access of those services among an historically underserved population.

East Georgia Health Cooperative, Inc.

543 West Church Street

Swainsboro, GA 30401

Catherine Liemohn

478-289-6110

liemohn@bellsouth.net

www.eghealthcoop.org

Hall County HealthShare Project
Hall County, Georgia

The HealthShare project was initiated by representatives from local health care and social services providers to help the community understand the needs of the uninsured people in Hall County. They seek to improve community health by: researching and telling the story of how community organizations are attempting to meet the health care needs of low-income people who are uninsured; educating the community and business leaders on issues related to indigent care; educating consumers about how to access health care services in the most effective and productive ways possible; securing additional funding from government and philanthropic resources to support indigent health care; and promoting access to insurance and coverage through employers.

The Hall County HealthShare Project
The Longstreet Clinic, P.C.
Corporate Offices
725 Jesse Jewell Parkway
Gainesville, GA 30501
Mimi Collins, Chairperson
770-718-1122 ext. 6590
mimi.collins@longstreetclinic.com
www.longstreetclinic.com

Lowndes County Partnership for Health, Inc.
Lowndes County, Georgia

The Lowndes County Partnership for Health, Inc. represents a grassroots collaborative effort bringing together health providers, educators, public health, community leaders, businesses and the faith community for the purpose of evaluating the health needs of the county and creating cost efficient solutions. Created to help prevent illness, disease and the problems associated with chronic health problems, growth has been rapid for the Partnership. Currently, the Partnership's staff and volunteers are implementing comprehensive wellness programs in 16 local businesses and 20 local churches affecting over 15,000 individuals on a monthly basis.

Lowndes County Partnership for Health, Inc.
100 Jackson St.
Valdosta, GA 31601
John Sparks, Executive Director
229-245-0020
lcph@bellsouth.net
www.lcpfh.org

**Northwest Georgia Health Care Partnership
Whitfield and Murray Counties, Georgia**

The Northwest Georgia Health Care Partnership is a not-for-profit, tax-exempt organization serving Murray and Whitfield Counties since 1992. The Health Care Partnership views itself as going beyond programming and research to include roles of coach, catalyst, convener and facilitator. The partnership's mission is to develop and support cooperation and collaboration among health care providers, business, industry, payers, consumers, social organizations, government, educators and the community for the purpose of improving the health of all through the efficient, effective, and caring use of resources.

Northwest Georgia Health Care Partnership
Post Office Box 182
Dalton, GA 30722
Nancy Kennedy, Executive Director
706-272-6663
nkennedy@hhcs.org
www.hhsc.org

NATIONAL

Access Health for Small Business Muskegon County, Michigan

Access Health, a program developed by Muskegon County Health Project, is an innovative approach to the challenge of providing health coverage to uninsured working families in Muskegon County. More than 400 local small businesses and 1,500 people annually participate in this unique effort aimed at helping people and business get access to affordable coverage. This unique, three-share model distributes the benefit cost equally between employer, employee and the community, enabling small and mid-sized businesses to provide a comprehensive mainstream benefit plan that includes local physician services, inpatient hospitalization, outpatient services, emergency services, behavioral health, prescription drugs (formulary), diagnostic lab and x-rays, home health and hospice care. A shining example of a community-based solution to a national problem, the Health Project, through its Community Health Ventures affiliate, is helping other communities across the nation develop similar programs and is providing information to the U.S. Congress about the role of models of this type in addressing the needs of America's uninsured.

Muskegon Community Health Project
565 W. Western Ave.
Muskegon, MI 49440
Vondie Woodberry, Executive Director
231-728-3201
info@mchp.org
www.mchp.org

CHOICE Rural Health Network Olympia, Washington

CHOICE began as a seven-hospital response to the threat of a hostile takeover by a for-profit hospital and has transformed into a vehicle, which chaperones clients with complex needs through systems of care and coverage they characteristically have trouble navigating. Using a variety of funding sources including membership dues and fees, Medicaid match, federal grant programs and private foundation grant programs, CHOICE has put together programs to serve 17,000 people.

CHOICE Regional Health Network
2409 Pacific Ave SE
Olympia, WA 98501
Kristen West, Executive Director
800-981-2123
info@crhn.org
www.crhn.org

**Coordinated Care Network
Pittsburgh, Pennsylvania**

Coordinated Care Network is a community-based organization founded in 1996 that provides case management and 340-B pharmacy services to underserved populations in 13 counties across southwestern Pennsylvania. Coordinated Care Network's mission is to reduce "system" costs through its case management and prescription discount programs, and in the process, generate sufficient earned income to finance health care for its uninsured population. Coordinated Care Network is comprised of 13 non-profit member agencies that provide medical, social and behavioral health services to vulnerable populations through 194 programs at 79 sites. Creation of CCN was initially funded by 10 local and two national foundations, and subsequently, funded through the federal Community Access Program recently renamed Healthy Communities Access Program. Their services include: preventive case management services, and 340-B physician dispensing and mail order services, 340-B poly-pharmacy member case management services.

Coordinated Care Network
300 Penn Center Boulevard
Suite 505
Pittsburgh, PA 15235
Jeffery S. Palmer, President
412-349-6300
www.jspalmer@coordinatedcarenetwork.org
www.coordinatedcarenetwork.org

**General Assistance Medical Program
Milwaukee, Wisconsin**

A unique partnership of local, state, and federal government, county public health, hospitals, physicians, clinics and more General Assistance Medical Program associates turned a \$15.6 million local tax into \$49.4 million in program funding. Twenty-seven thousand of Milwaukee's uninsured are served each year by a broader, more organized safety net. In this program, participating providers both give and receive; they bear risk for their patients needs when resources run out, but receive a new funding stream to serve program enrollees.

General Assistance Medical Program
1220 West Vliet
Milwaukee, Wisconsin
Chris Collentine, Program Director
414-289-6621
www.county.milwaukee.gov

**Ohio State Health Network
Columbus, Ohio**

Ohio State Health Network is a membership organization that provides cost savings solutions; education and professional networking opportunities to identify and/or develop best practices. Ohio State Health Network is a 501 (c) 3 comprised of one health system, six hospitals and two health care organizations. The members include: Barnesville Hospital, Bucyrus Community Hospital, Madison County Hospital, Mary Rutan Hospital, Mercer County Community Hospital, The Ohio State University Healthsystem, Wyandot Memorial Hospital, and Family Health Care, Inc. Services focus on three main areas: clinical service improvement, operational improvement and community health improvement.

Ohio State Health Network
660 Ackerman Road, Ste. 601
P.O. Box 183110
Columbus, OH 43218-3110
Joanne Ort, Executive Director
614-293-3785
joann.ort@osumc.edu
www.oshn.org

**Project Access
Wichita, Kansas**

Led by one key philanthropically-minded, entrepreneurial physician, local leaders carefully copied a program from a similar community to provide primary and specialty care to low-income uninsured residents. The program uses less than \$180,000 in administrative costs per year to leverage \$5 million in donated services. To date, 5,000 people have been served. Physicians, hospitals, and pharmacies donate care and services, and local government, the United Way and a local foundation support the program financially. Project Access is a community-based, physician-led initiative to expand access to medical services for low-income, uninsured residents of Sedgwick County, Kansas. Project Access is a project of the Central Plains Regional Health Care Foundation in partnership with the Medical Society of Sedgwick County.

Project Access
1102 S. Hillside
Wichita, KS 67211
Anne Nelson, COO
316-688-0600
annenelson@projectaccess.net
www.projectaccess.net

**Rural Wisconsin Health Cooperative
Sauk City, Wisconsin**

The Rural Wisconsin Health Cooperative supports and enhances rural health and quality of care. Rural Wisconsin Health Cooperative is a strong, innovative and mutually supportive network of hospitals with diversified services that combine their strengths to meet local community health needs through advocacy and high value products and services. The Rural Wisconsin Health Cooperative, begun in 1979, supports and enhances rural health and quality of care. The Rural Wisconsin Health Cooperative is owned and operated by 31, rural acute, general medical-surgical hospitals. Rural Wisconsin Health Cooperative has received national recognition as one of the country's earliest and most successful models for networking among rural hospitals. Rural Wisconsin Health Cooperative serves rural Wisconsin hospitals in three basic ways: (1) local and national advocacy for rural health; (2) clinical/management products and services tailored to the needs of individual members; and (3) collaborative managed care contracting. The Rural Wisconsin Health Cooperative also provides technical assistance and training to member and non-members, in and outside of Wisconsin.

Rural Wisconsin Health Cooperative
880 Independence Lane,
P. O. Box 490
Sauk City, WI 53583
Tim Size, Executive Director
608-643-2343
timsiz@rwhc.com
www.rwhc.com

Summary

Through community engagement and facilitation, the State Office of Rural Health developed the 2007 Georgia Rural Health Plan. As a reference document, the plan profiles what currently exists, identifies what can be done to improve rural health in Georgia, and provides resources and information to assist communities in moving forward.

Georgia's rural population suffers disproportionately from the root causes of poor health: lower educational attainment, lower income, and reduced access to a usual source of care. As a consequence, rural Georgia faces challenges in the five disease areas the 2007 Georgia Rural Health Plan stakeholder group chose to focus on: cardiovascular disease, obesity, diabetes, birth outcomes, and cancer. Rural Georgia leads the state in morbidity and mortality rates for all of the selected diseases.

Rural Georgia also faces great challenges in providing resources to address the identified problems. Georgia's physician and specialist workforce is concentrated in urban areas. Nursing shortages are also more pronounced in rural areas. Rural counties are home to many health professional shortage areas. Rural Georgians are disproportionately older than their urban counterparts, and the aging of the population will affect rural Georgia first. Funding for the long-term care of older rural Georgians currently supports more expensive institutional care.

For the past several years, Georgia has been a national leader in addressing rural health issues. The State Office of Rural Health continued this leadership role by embarking on a planning process that brought together stakeholders from around the state to share their collective wisdom about the issues, the implications, and effective strategies for addressing the problems of rural Georgia. The stakeholders' planning process resulted in a vision for rural health in Georgia, which was adopted by State Office of Rural Health and its partners. That vision, "Communities working collaboratively to improve the health of rural Georgians," guided the process and is the lynchpin for this plan. This statewide group adopted four goals and developed priority actions for implementing the goals.

Stakeholders involved in the development of this plan also identified community and national practices and other information resources for communities to use as they work toward implementing their priority actions. As it has in the past, rural Georgia can harness the power of community and community networks to address the problems of disparity, disease prevalence, and workforce. By adapting best practices in use across Georgia and nationally, Georgia's rural communities will continue to serve as national models for community health improvement.

Appendices

Appendix A - Planning Committee

2007 GEORGIA RURAL HEALTH PLAN PLANNING COMMITTEE

Ann Addison

Chief Executive Officer
Primary Care of Southwest Georgia
Blakely

Sonia Alvarez Robinson

Strategic Resource Development
Georgia Division of Public Health
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Wrightsville

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Assistant Director, Nursing and
Clinical Services
Southwest Georgia Public Health
Albany

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Chief Executive Officer
Monroe County Hospital
Forsyth

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State Office of Rural Health
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Valerie Buchanan

Regional Risk Manager/Director of
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ResCare - Southern Region
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H.D Cannington

Health care Consultant
Dublin

Katherine Cummings

Director
Georgia Rural Health Association
Sandersville

Greg Dent

Executive Director
Community Health Works
Forsyth

Kay Floyd

Director of Operation
Community Health Works
Forsyth

Paula Guy

Director
State Telemedicine Program
Waycross

Duane Kavka

Executive Director
Georgia Association for Primary
Health Care
Atlanta

Susan Knox

Health care Consultant
Dublin

Denise Kornegay

Program Director
State AHEC Centers
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Karen Minyard

Executive Director
Georgia Health Policy Center
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Erin Mundy

Medical Clerkship Coordinator
Georgia Statewide AHEC Network
Augusta

Vi Naylor

Executive Vice President
Georgia Hospital Association
Marietta

Gary Nelson

President
Healthcare Georgia Foundation
Atlanta

Charles Owens

Executive Director
State Office of Rural Health
Cordele

Rhett Partin

Executive Director
Center for Rural Health
Georgia Hospital Association
Marietta

Nancy Peed

Administrator and Chief Executive
Officer
Peach Regional Medical Center
Fort Valley

Ben Robinson

Director
Georgia Board for Physician
Workforce
State Medical Education Board
Atlanta

Lisa Marie Shekell

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Atlanta

Janice Sherman

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Georgia Association of Primary
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Blakely

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Rural Health Research Center
Statesboro

Patsy Whaley

Director, Hospital Services
State Office of Rural Health
Cordele

Kathy Whitmire

Managing Director
Hometown Health
Cumming

Stacey Willocks

Research Associate
Georgia Health Policy Center
Atlanta

Appendix B - Resources

GEORGIA

The following Georgia agencies and organizations provide a wide-range of resources on rural health.

Area Health Education Centers

A partnership coordinated between Medical College of Georgia and Mercer University School of Medicine, the Georgia Statewide Area Health Education Centers Network is a complex, multi-disciplinary effort which responds to the problems of health professionals supply and distribution in rural and underserved areas of the state.

<http://www.mcg.edu/AHEC/>

Association of County Commissioners of Georgia

The Association of County Commissioners of Georgia is a nonprofit instrumentality of Georgia's county governments. Association of County Commissioners of Georgia serves as the consensus building, training, and legislative organization for all 159 county governments in the state. It is the mission of the Association of County Commissioners of Georgia to enhance the role, stature and responsiveness of county government in Georgia. With this primary charge, Association of County Commissioners of Georgia works to ensure that the counties can provide the necessary leadership, services and programs to meet the health, safety and welfare needs of their citizens.

<http://www.accg.org/>

Commission on Men's Health, Georgia Department of Community Health, Office of Health Improvement

The Georgia Commission on Men's Health was created to address the ongoing, increasing and predominantly silent crisis in the health and well-being of Georgia men. Due to a lack of awareness, poor health education, and culturally induced behavior patterns in their work and personal lives, men's health and well-being are deteriorating steadily. The commission's goal is to be a catalyst to promote and improve the quality of the physical, social and mental health of men in the state of Georgia.

http://dch.georgia.gov/00/channel_title/0,2094,31446711_40095489,00.html

Division of Aging Services, Georgia Department of Human Resources

The Georgia Division of Aging Services administers a statewide system of services for senior citizens, their families and caregivers. The division works with other agencies focusing on aging and organizations to effectively and efficiently respond to the needs of elderly Georgians. Division of Aging Services meets the challenge of Georgia's growing older population through continued service improvement and innovation.

<http://aging.dhr.georgia.gov/portal/site/DHR-DAS/>

Division of Mental Health, Developmental Disabilities and Addictive Diseases, Georgia Department of Human Resources

The Division of Mental Health, Developmental Disabilities and Addictive Diseases provides treatment and support services to people with mental illnesses and addictive diseases, and support to people with mental retardation and related developmental disabilities. It serves people of all ages with the most severe and likely to be long-term conditions. The division also funds evidenced-based prevention services aimed at reducing substance abuse and related problems.

<http://mhddad.dhr.georgia.gov/portal/site/DHR-MHDDAD/>

Division of Public Health, Georgia Department of Human Resources

The Division of Public Health is the lead agency of the state of Georgia in charge of the ultimate responsibility for the health of communities and the entire population. The division has a commitment to improving health status through community leadership, provide expertise in health information and surveillance, and assure a safer environment. The division is responsive to public health needs, valued for its expertise and innovation, dedicated to excellence, and known for promoting healthy communities through partnerships.

<http://health.state.ga.us/>

Family Connection Partnership

Family Connection Partnership is a public/private partnership created by the State of Georgia and private sector funds. Family Connection Partnership assists communities in addressing the serious challenges facing Georgia's children and families and serves as a resource to state agencies across Georgia that work to improve the conditions of children and families.

<http://www.gafcp.org/>

Georgia Alliance of Community Hospitals

The Georgia Alliance of Community Hospitals works for the interests of more than 60 community not-for-profit hospitals across the state of Georgia. Its main role is to push for the enactment of sound laws, rules and regulations affecting community hospitals. The Alliance conducts and disseminates research on important health care issues, and shares ideas that improve Georgia's health care delivery systems.

<http://www.ciclt.net/gach/>

Georgia Association for Primary Health Care

Georgia Association for Primary Health Care's mission is to improve access to comprehensive primary health care services for all medically underserved Georgians and to support the continued development and expansion of community-based health center practice systems throughout the state.

<http://www.gaphc.org/>

Georgia Board for Physician Workforce

The Georgia Board for Physician Workforce monitors changes in Georgia's physician workforce with emphasis on the geographic distribution of physicians in the state. Reports available on their Web site help to identify areas of need, monitor the supply and distribution of practicing physicians in Georgia, plan for health services, determine funding for residency programs; and locate facilities.

<http://mdworkforce.mercer.edu/>

http://dch.georgia.gov/00/channel_title/0,2094,31446711_32228166,00.html

Georgia Cancer Coalition

The mission of the Georgia Cancer Coalition is to reduce the number of cancer deaths in the state. In so doing, Georgia intends to become a national leader in cancer control by accelerating prevention, early detection, treatment and research. All of the coalition's activities, programs, and budget have been organized around five goals: 1) Prevent cancer and detect existing cancers earlier. 2) Improve access to quality care for all Georgians with cancer. 3) Save more lives in the future. 4) Train future cancer researchers and caregivers. 5) Realize economic benefits from eradicating cancer.

<http://www.georgiacancer.org/>

Georgia Coalition for Physical Activity and Nutrition

Georgia's Nutrition and Physical Activity Initiative, is a joint effort between the Division of Public Health and its partners, to prevent obesity and other chronic diseases through healthy eating and physical activity initiatives across a person's life span. The initiative focuses on the following major behaviors: breastfeeding, healthy eating, physical activity and reduced television/screen time in a variety of settings through education/skill building, policy and environmental approaches.

<http://health.state.ga.us/nutandpa/index.asp>

Georgia Dental Association

The Georgia Dental Association was established in 1859 to promote the highest professional and ethical standards of oral health care. Georgia Dental Association empowers individual dentists to be collectively effective with issues that confront them and serves as an advocate for the advancement of the profession.

<http://www.gadental.org>

Georgia Department of Community Affairs

The Georgia Department of Community Affairs serves as a state-level advocate for local governments. Georgia Department of Community Affairs operates a host of state and federal grant programs; serves as the state's lead agency in housing finance and development; promulgates building codes to be adopted by local governments; provides comprehensive planning, technical and research assistance to local governments; and serves as the lead agency for the state's solid waste reduction efforts.

<http://www.dca.state.ga.us/>

Georgia Free Clinic Network

The purpose of the Georgia Free Clinic Network is to establish a link between individuals, businesses and organizations that are assisting the growing population of people unable to afford health care. Georgia Free Clinic Network provides a central organization for sharing resources and knowledge to advance the movement of free medical services in the State of Georgia.

<http://www.gfcn.org/>

Georgia Health Information Technology and Transparency Board

On October 17, 2006, Governor Sonny Perdue issued an executive order creating the Health Information Technology and Transparency Advisory Board. The board will advise Department of Community Health on the best practices for encouraging the use of electronic health records and establishing a statewide strategy to enable health information to be readily available and transparent. Department of Community Health goals for Health and Information Transparency and Technology in Georgia are to enable the understandable, universal, timely and secure communication of health information across the public and private sectors for the benefit of today's health care consumer. A Web site is being created to provide easy access to a number of health information technology resources. Content on this site is updated based on national, state and local Health and Information Transparency and Technology activities.

http://dch.georgia.gov/00/channel_title/0,2094,31446711_59588545,00.html

Georgia Health Policy Center

The Georgia Health Policy Center provides evidence-based research, program development and policy guidance locally, statewide, and nationally to improve health status at the community level. The center conducts, analyzes and disseminates qualitative and quantitative findings to connect decision makers with the objective research and guidance needed to make informed decisions about health policy and programs.

<http://aysps.gsu.edu/ghpc/>

Georgia Hospital Association, Center for Rural Health

As part of the Georgia Hospital Association, the Center for Rural Health is organized as a not-for-profit association exclusively for charitable, scientific, and educational purposes and to develop policies and positions to benefit rural health in the state of Georgia. The center is organized through the Georgia Hospital Association Research and Education Foundation

<http://www.gha.org/pha/ruralhealth/index.asp>

Georgia Medical Care Foundation

Serving as Georgia's Quality Improvement Organization the Georgia Medical Care Foundation assists physician offices, hospitals, nursing homes and home health agencies in adopting and implementing systems, redesigning processes and developing organizational cultures to accelerate the rate of quality improvement. A key strategy

involves forming partnerships with other professional organizations to extend their reach and broaden their effectiveness.

<http://www.gmcf.org>

Georgia Public Health Association

The Georgia Public Health Association is a non-profit corporation organized for the purpose of promoting the public and personal health of the citizens of Georgia. It provides opportunities for networking with other public health professionals, attending continuing education seminars and advocating for public health issues concerning Georgians.

<http://www.gapha.org/>

Georgia Rural Health Association

The Georgia Rural Health Association, established in 1981, is a non-profit network of individuals and organizations united by a commitment to improve health and health care for rural Georgians. The association:

- 1) Promotes rural health as a distinct concern in Georgia
- 2) Serves as advocates for rural health by promoting improved health status and an improved health care system for rural Georgians
- 3) Encourages the development of appropriate health care resources for

residents of rural Georgia.

<http://www.garuralhealth.org/>

Georgia Volunteer Clinic Program

The Georgia Volunteer Clinic Program is available to communities to assist volunteer health care professionals with clinic management and projects, including health care provider recruitment, contracting for sovereign immunity protection, administering quality assurance review, and ensuring that providers have the proper licenses.

Volunteer clinic grant funding is designated to increase the number of patients receiving medical care through volunteer clinics. In 2006, the State Office of Rural Health provided \$580,000 to support the development of 11 of the 55 volunteer clinics participating in Georgia's Volunteer Clinic Program.

<http://www.dch.ga.gov>

Healthcare Georgia Foundation

Healthcare Georgia Foundation is a statewide, private, independent foundation whose mission is to advance the health of all Georgians and to expand access to affordable, quality health care for underserved individuals and communities. Within this broad, statewide focus, the specific goals of the foundation are to: protect and promote the health of individuals, families and communities; improve the availability, quality, appropriateness and financing of health care services; and integrate and coordinate efforts to improve health and health care services.

<http://healthcaregeorgia.org/>

HomeTown Health, LLC

HomeTown Health, LLC is an organization of rural and small hospitals, located throughout the state of Georgia, who collectively pursue ways to help hospitals survive in this environment of tremendous budget cuts from the state and federal level. HomeTown Health University offers courses that assist practitioners in growing professionally as well as personally in their health care careers.
<http://www.hometownhealthonline.com>

International Capital Partnership Program Health Professionals Initiative

The University System of Georgia administers the Intellectual Capital Partnership Program which is targeted toward non-traditional students seeking a second career in health care as well as, current college students not enrolled in health care courses or degree programs. The Health Professionals Initiative matches private sector health care providers with University System colleges and universities and provides accelerated education to produce graduates in the fields of nursing, medical technology and pharmacy.
<http://www.icapp.org>

Live Healthy Georgia Campaign

In an effort to help the people of Georgia live healthier lives and to reduce the burden of chronic disease and other illnesses, Governor Perdue and the Georgia Department of Human Resources joined forces by launching the Live Healthy Georgia campaign. The Live Healthy Georgia Campaign serves as the umbrella for an outreach initiative that aims to raise awareness about the risk factors associated with chronic diseases and to provide Georgians with information about ways to live healthier, and reduce their risk of developing chronic diseases.
<http://www.livehealthygeorgia.org/>

Medical Association of Georgia

The Medical Association of Georgia is an advocate and a partner in achieving the main goals of the association: to promote the science and art of medicine and the betterment of public health. Its mission is to enhance patient care and the health of the public by advancing the art and science of medicine and by representing physicians and patients in policy-making processes.
<http://www.mag.org>

Office of Women's Health, Georgia Department of Human Resources, Division of Public Health

The mission of the Office of Women's Health is to provide leadership and resources to communities in the development, use and continuous improvement of a continuum of health care that supports and improves the quality of life for women and their families. The office's goals are to increase knowledge of services available and access to appropriate, quality care to women and their families.
<http://health.state.ga.us/programs/women/index.asp>

Office of Minority Health, Georgia Department of Community Health

The Office of Minority Health helps minority communities reach a high level of health and wellness. It works to eliminate the discrepancy in health status between minority and non-minority populations in Georgia. Its activities are organized around four key areas: identify, assess and analyze issues related to the health of minority populations; work with public and private organizations to address specific minority community health needs; monitor state programs, policies and procedures to assure that they are inclusive and responsive to minority community health needs and; facilitate the development and implementation of research enterprises and scientific investigations to produce minority-specific findings.

http://dch.georgia.gov/00/channel_title/0,2094,31446711_40827916,00.html

OneGeorgia Authority

The OneGeorgia Authority utilizes one third of the state's tobacco settlement to assist the state's most economically challenged areas. OneGeorgia's investments are targeted towards rural communities through a rural airport initiative, grants to improve rural broadband access, economic growth of rural businesses, loan guarantees for small businesses and entrepreneurs, an equity fund for rural infrastructure, an E-911 emergency services network, and a strategic industries loan fund.

<http://www.onegeorgia.org/>

State Medical Education Board of Georgia

The State Medical Education Board of Georgia was established in 1952 for a two-fold purpose: to provide an adequate supply of physicians in rural areas of the state; and to provide a program of aid to promising medical students who do not have the financial means to attend medical school. The board is instrumental in physician recruitment to rural and underserved Georgia communities. Each year, the board sponsors a Medical Fair where rural Georgia communities are invited to speak with physicians in training concerning future medical practice opportunities. 2006

<http://smeb.georgia.gov/01/home/0,2197,1408609,00.html>

State Office of Rural Health, Georgia Department of Community Health

The State Office of Rural Health works to improve access to health care in rural and underserved areas and to reduce health status disparities. Its goals are to empower communities to strengthen and maintain the best possible health care using existing resources, provide up-to-date health systems information and technical assistance, build strong partnerships to meet local and regional needs, provide incentives to local areas to implement integrated service delivery systems, and to be the single point of contact for all regional issues related to health care.

http://dch.georgia.gov/00/channel_title/0,2094,31446711_32385451,00.html

Take Charge of Your Health for Older Adults, Georgia Statewide

Take Charge of Your Health for Older Adults is focused on increasing physical activity as well as nutrition. Educational materials focus on correcting risk factors for poor nutrition in older adults and facilitating the voluntary adoption of eating behaviors that promote health and well-being for older adults. Responses to several measures

significantly improved after the intervention. Participants in the intervention knew much more about daily required physical activity than they did before the intervention. Participants also reported an improved feeling of general health.
<http://www.organwiseguys.com/products/4003.asp>

NATIONAL

The following are a sample of national organizations with programs of interest to rural communities.

Agency for Healthcare Research and Quality National Resource Center for Health Information Technology

This Academy Health Web site describes current AHRQ-funded Health Information Transparency and Technology projects in rural communities and lists HIT best practices.

<http://healthit.ahrq.gov/>

American Project Access Network

American Project Access Network is a national, nonprofit organization serving communities that utilize the Project Access system to coordinate physician charity care for low-income, uninsured people. Project Access provides an effective means to enhance access to care and improve the health of this population. American Project Access Network uses the Buncombe County Medical Society Project Access charity health care model developed in Asheville, North Carolina, and others that have been replicated from it, to help guide communities through their own transformational processes. More than 20 communities, with populations ranging in size from 22,000 to over one million have successfully adopted the Project Access model to their unique circumstances. <http://www.apanonline.org/about/about.php>

Bureau of Primary Health Care

The mission of the Health Resources and Services Administration's Bureau of Primary Health Care is to increase access to comprehensive primary and preventive health care and to improve the health status of underserved and vulnerable populations.

<http://bphc.hrsa.gov/>

Communities Joined in Action

Communities Joined in Action is a group of community organizations, individuals and corporations concerned about improving the lives of the uninsured and underinsured in the face of today's health care crisis. This organization:

- (1) Connects communities to affordable, value-added peer-to-peer technical assistance from other community members who have had similar challenges
- (2) Provides learning institutes and "how to" materials from leaders who have been successful
- (3) Supports communities in organizing events that generate political will and dramatic leaps in progress

(4) Facilitates the development and growth of state or regional networks of local communities joined in action towards 100 percent Access and zero Disparities.
www.cjaonline.net

Community Tool Box

The Web site was developed by Kansas University to support work in promoting community health and development. The Tool Box provides over 6,000 pages of practical skill-building information on over 250 different topics. Topic sections include step-by-step instruction, examples, check-lists, and related resources.
<http://ctb.ku.edu/>

E-Health Initiative

The eHealth Initiative and its foundation are independent, non-profit, affiliated organizations whose missions are the same: to drive improvements in the quality, safety and efficiency of health care through information and information technology.
<http://www.ehealthinitiative.org>

Farm Worker Health Services, Inc.

Farm Worker Health Services Inc. offers health services to migrant workers along the eastern seaboard of the United States. Field staff move according to seasonal needs and in their own cars search for camp and individual locations of migrant and seasonal workers to determine direct or referred services.
<http://www.farmworkerhealth.org>

Generation Fit/American Cancer Society

Involves children in community service projects promoting physical activity and healthier eating. The program can be run by coaches, youth groups, or counselors with guidelines and materials provided in the Generation Fit Action Packet from American Cancer Society.
http://www.cancer.org/docroot/PED/content/PED_1_5X_Generation_Fit.asp

Health Level Seven

Health Level Seven is one of several American National Standards Institute -accredited Standards Developing Organizations operating in the health care arena. Most Standards Developing Organizations produce standards (sometimes called specifications or protocols) for a particular health care domain such as pharmacy, medical devices, imaging or insurance (claims processing) transactions. Health Level Seven's domain is clinical and administrative data.
<http://www.HL7.org>

J-1 Visa Waiver Program

The J-1 Visa Program is for foreign medical graduates who wish to pursue graduate medical training in the United States. The visa allows holders to remain in the U.S. until their studies are completed. At the completion of their studies, they are expected to return to their home countries for two years before applying for a permanent visa in the United States. A J-1 Visa Waiver waives the two year home residency requirement

and allows a physician to stay in the country to practice in a federally designated Health Professional Shortage Area or Medically Underserved Area if sponsored by an interested U.S. government agency. State government agencies may also sponsor J-1 physician waiver requests which are called Conrad State 30 programs.
http://www.raconline.org/info_guides/hc_providers/j1visa.php

The Catholic Health Association of the United States published a resource for communities seeking to effectively recruit and retain J-1 Visa Physicians in rural areas:
<http://www.chausa.org/Pub/MainNav/News/HP/Archive/2004/03MarApr/articles/SpecialSection/HP0403m.htm?print=true>

National Association of Community Health Centers

The National Association of Community Health Centers Inc. is a non-profit organization whose mission is to enhance and expand access to quality, community-responsive health care for America's medically underserved and uninsured. In serving its mission, this association represents the nation's network of over 1,000 Federally Qualified Health Centers which serve 16 million people through 5,000 sites located in all of the 50 states, Puerto Rico, the District of Columbia, the U.S. Virgin Islands and Guam.
<http://www.nachc.com>

National Center for Farmworker Health

The National Center for Farmworker Health, established in 1975, is dedicated to improving the health status of farmworker families by providing information services and products to a network of more than 500 migrant health center service sites in the United States as well as other organizations and individuals serving the farmworker population.
<http://www.ncfh.org>

National Cooperative of Health Networks

The National Cooperative of Health Networks is a national association of health network executives and strategic health partners, whose mission is to support and strengthen health alliances through collaborative efforts, networking, and educational opportunities. It is a member-focused organization that assists members in their professional and network development.
<http://www.nchn.org>

National Health Service Corps

The National Health Service Corp is a federal agency located within the U.S. Department Health and Human Services' Health Resources and Services Administration. The group assists medically underserved communities to recruit and retain primary care clinicians, including dental and mental and behavioral health professionals. Since 1972, more than 27,000 health care corps providers have served medically underserved areas across the country. There are currently more than 4,000 professionals placed through the National Health Service Corps.
<http://www.nhsc.bhpr.hrsa.gov/about/>

National Organization of State Offices of Rural Health

National Organization of State Offices of Rural Health was created in 1995 by State Offices of Rural Health to promote a healthy rural America through state and community leadership. Its mission is to foster and promote legislation, information exchange, education, and liaison activities with all State Offices of Rural Health, the Federal Office of Rural Health Policy, the National Rural Health Association, and other organizations.
<http://www.nosorh.org>

National Rural Health Association

The National Rural Health Association is a national nonprofit membership organization with more than 10,000 members that provides leadership on rural health issues. The association's mission is to improve the health and wellbeing of rural Americans and to provide leadership on rural health issues through advocacy, communications, education, research and leadership. The membership is made up of a diverse collection of individuals and organizations, all of whom share a common interest in rural health.

<http://www.nrharural.org>

National Rural Recruitment and Retention Network

The National Rural Recruitment and Retention Network (3R Net) is made up of state organizations such as State Offices of Rural Health, Area Health Education Centers, Cooperative Agreement Agencies and State Primary Care Associations. These not-for-profit organizations help health professionals locate practice sites in rural areas throughout the country.

<http://www.3rnet.org>

Office of Rural Health Policy

The Office of Rural Health Policy promotes better health care service in rural America. Established in August 1987, this office is located within the Health Resources and Services Administration and charged with informing and advising the Department of Health and Human Services on matters affecting rural hospitals, and health care, coordinating activities within the department that relate to rural health care, and maintaining a national information clearinghouse.

<http://ruralhealth.hrsa.gov>

Planned Approach to Community Health

Planned Approach to Community Health is a cooperative program of technical assistance managed and supported by the Centers for Disease Control. The goal of this group is to increase the capacity of communities to plan, implement, and evaluate comprehensive, community-based health promotion programs targeted toward priority health problems.

<http://www.cdc.gov/search.do?action=search&queryText=PATCH>

Racial and Ethnic Approaches to Community Health

Racial and Ethnic Approaches to Community Health is a federal initiative that includes the goal of eliminating racial and ethnic disparities in health by the year 2010. The program was launched in 1999; the Centers for Disease Control and Prevention has a major leadership role in carrying out the goals set forward in this initiative. These approaches focus on the following racial and ethnic minority populations in the United States: African Americans, Alaska Natives, American Indians, Asian Americans, Hispanic Americans, and Pacific Islanders. This initiative supports urban and rural community coalitions in designing, implementing, and evaluating community-driven strategies to eliminate health disparities. While there are no current plans to fund new grantees, the Web site includes examples of community practices.

www.cdc.gov/reach/index.htm

Rural Assistance Center

A product of the U.S. Department of Health and Human Services' Rural Initiative, the Rural Assistance Center is established in December 2002 as a rural health and human services information portal. This organization helps rural communities and other rural stakeholders access the full range of available programs, funding, and research that can enable them to provide quality health and human services to rural residents.

<http://www.raonline.org>

Rural Policy Research Institute

The Rural Policy Research Institute conducts policy-relevant research and facilitates public dialogue to assist policymakers in understanding the rural impacts of public policies and programs. The RUPRI Web site includes publications regarding a wide range of rural health topics.

<http://www.rupri.org/ruralHealth/>

Training in Partnership Television (TiP-TV)

Training in Partnership Television, TiP-TV, provides continuing education and training programs broadcast via satellite as well as online. More than 100 continuing education courses are available yearly for all health care professionals. The programs are available by a subscription purchased either through a GE Service Contract or through a stand-alone subscription.

www.gehealthcare.com

Web Sites of Interest

Diabetes:

Centers for Disease Control and Prevention Community Guide:
<http://www.thecommunityguide.org/diabetes/>

Cardiovascular Disease

- Centers for Disease Control and Prevention:
www.cdc.gov/doc.do/id/0900f3ec802720b8
- American Heart Association: www.americanheart.org

Cancer:

- Centers for Disease Control and Prevention Community Guide:
<http://www.thecommunityguide.org/cancer/idm/default.htm>
- Georgia Cancer Coalition: www.gacancercoalition.com
- National Cancer Institute: www.cancer.gov
- Centers for Disease Control and Prevention: <http://www.cdc.gov/cancer/>
- Cancer Control Planet: <http://cancercontrolplanet.cancer.gov/>

Infant Health:

- Centers for Disease Control and Prevention Reproductive Health:
<http://www.cdc.gov/reproductivehealth/index.htm>
- U.S. Department of Health and Human Services – The National Women’s Health Information Center – Breastfeeding – Best for Baby, Best for Mom:
<http://www.cdc.gov/reproductivehealth/index.htm>
- Zero to Three: <http://www.zerotothree.org/>
- Maternal and Child Health Library:
http://www.mchlibrary.info/KnowledgePaths/kp_infmort.html
- Center for Healthier Children, Families & Communities:
<http://www.healthychild.ucla.edu/NationalCenter/>
- Annie E. Casey Foundation, Kids Count: <http://www.aecf.org/kidscount/>

Nutrition:

- Centers for Disease Control and Prevention Community Guide:
<http://www.thecommunityguide.org/nutrition/>
- University of Arkansas Department of Agriculture- Food Stamp Nutrition Education in Arkansas
Curricula Educational Materials:
http://www.arfamilies.org/health_nutrition/fsne/educational_materials/curricula.htm#Adult
- Georgia’s Nutrition and Physical Activity Initiative (includes Take Charge of Your Health, Georgia): <http://health.state.ga.us/nutandpa/>
- Georgia Coalition for Physical Activity and Nutrition: <http://www.g-pan.org/>

Obesity:

Centers for Disease Control and Prevention Community Guide:
<http://www.thecommunityguide.org/obese/>

Physical Activity:

- Centers for Disease Control and Prevention Community Guide:
<http://www.thecommunityguide.org/pa/default.htm#inter>
- Centers for Disease Control and Prevention – Healthy Youth, Promoting Better Health Strategies:
http://www.cdc.gov/HealthyYouth/physicalactivity/promoting_health/strategies/school.htm
- National Coalition for Promoting Physical Activity:
<http://www.ncppa.org/physactfactsheets.asp>
- The President’s Council on Physical Fitness and Sports:
http://www.fitness.gov/about_overview.htm
- SPARK (Sports, Play and Active Recreation for Kids):
<http://www.schoolsofwellness.org/index.cfm?fuseaction=pages.spark&CFID=4023&CFTOKEN=60372664>
- Georgia’s Nutrition and Physical Activity Initiative (includes Take Charge of Your Health, Georgia): <http://health.state.ga.us/nutandpa/>
- Georgia Coalition for Physical Activity and Nutrition: <http://www.g-pan.org/>

Health Facilities In Georgia's Rural Counties

County	Rural and Critical Access (CAH) Hospitals	Federally Qualified Health Centers	Rural Health Clinics
APPLING	APPLING HOSPITAL <i>Baxley, GA</i>		
ATKINSON		South Central Primary Care Center <i>Pearson, GA</i>	
BACON	BACON COUNTY HOSPITAL (CAH) <i>Alma, GA</i>		BACON COUNTY COMMUNITY CARE CENTER <i>Alma, GA</i>
BAKER		Albany Area Primary Health Care, Inc. <i>Newton, GA</i>	
BANKS			BJC MED CARE - HOMER <i>Homer, GA</i>
BEN HILL	DORMINY MEDICAL CENTER <i>Fitzgerald, GA</i>		DORMINY CARE CLINIC <i>Fitzgerald, GA</i>
BERRIEN	BERRIEN COUNTY HOSPITAL <i>Nashville, GA</i>		
BLECKLEY	BLECKLEY MEMORIAL HOSPITAL. (CAH) <i>Cochran, GA</i>		BLECKLEY MEDICAL CLINIC <i>Cochran, GA</i>
BRANTLEY		McKinney Community Health Center, Inc. <i>Nahunta, GA</i>	
BROOKS	BROOKS COUNTY HOSPITAL (CAH) <i>Quitman, GA</i>		ARCHBOLD PAVO PRIMARY CC <i>Pavo, GA</i> BROOKS MEDICAL ASSOCIATES <i>Quitman, GA</i>
BRYAN			ST. JOSEPH'S/CANDLER MEDICAL GROUP <i>Pembroke, GA</i>
BURKE	BURKE MEDICAL CENTER <i>Waynesboro, GA</i>		B. LAMAR MURRAY, M.D. (RHCS) <i>Waynesboro, GA</i> KEYSVILLE FAMILY HEALTH CENTER <i>Keysville, GA</i> MEDICAL ASSOCIATES <i>Waynesboro, GA</i> MEDICAL ASSOCIATES OF SARDIS <i>Sardis, GA</i>
BUTTS	SYLVAN GROVE HOSPITAL (CAH) <i>Jackson, GA</i>		
CALHOUN	CALHOUN MEMORIAL hOSPITAL (CAH) <i>Arlington, GA</i>	Albany Area Primary Health Care, Inc. <i>Edison, GA</i>	PHOEBE FAMILY MEDICAL CENTER- ARLINGTON <i>Arlington, GA</i> ROBERT E JENNINGS MEDICAL CLINIC <i>Arlington, GA</i>

County	Rural and Critical Access (CAH) Hospitals	Federally Qualified Health Centers	Rural Health Clinics
CAMDEN	SE GA. HEALTH SYSTEM-CAMDEN CAMPUS <i>Saint Marys, GA</i>		
CANDLER	CANDLER COUNTY HOSP. (CAH) <i>Metter, GA</i>		
CHARLTON	CHARLTON MEMORIAL HOSP. (CAH) <i>Folkston, GA</i>	McKinney Community Health Center, Inc. <i>Folkston, GA</i> McKinney Community Health Center, Inc. <i>St. George, GA</i>	
CHATT AHOOCHEE		Southwest Georgia Health Care, Inc. <i>Cusseta, GA</i>	
CLINCH	CLINCH MEMORIAL HOSPITAL (CAH) <i>Homerville, GA</i>		
COOK	MEMORIAL HOSPITAL OF ADEL <i>Adel, GA</i>		
CRISP	CRISP REGIONAL HOSPITAL <i>Cordele, GA</i>		ARABI HEALTH CARE CLINIC <i>Arabi, GA</i> CRISP REGIONAL HEALTH CARE CLINIC <i>Cordele, GA</i>
DADE		Primary Health Care Center of Dade, Inc. <i>Trenton, GA</i>	
DECATUR	MEMORIAL HOSPITAL & MANOR <i>Bainbridge, GA</i>		
DODGE	DODGE COUNTY HOSPITAL <i>Eastman, GA</i>		CENTER FOR COMMUNITY HEALTHCARE SERVICES <i>Eastman, GA</i>
DOOLY		UnaHealth <i>Unadilla, GA</i>	
EARLY	EARLY MEMORIAL HOSPITAL (CAH) <i>Blakely, GA</i>	Primary Care of Southwest Georgia <i>Blakely, GA</i>	BLAKELY IMMEDIATE CARE CENTER <i>Blakely, GA</i> BLAKELY MEDICAL GROUP <i>Blakely, GA</i>
EFFINGHAM	EFFINGHAM HOSPITAL (CAH) <i>Springfield, GA</i>		
ELBERT	ELBERT MEMORIAL HOSPITAL <i>Elberton, GA</i>	MedLink Georgia, Inc. <i>Bowman, GA</i>	MEDICAL CENTER OF ELBERTON, LLP, THE <i>Elberton, GA</i>
EMANUEL	EMANUEL MEDICAL CENTER <i>Swainsboro, GA</i> EMANUEL MEDICAL CENTER <i>Swainsboro, GA</i>	East Georgia Healthcare Center, Inc. <i>Swainsboro, GA</i> East Georgia Healthcare Center, Inc. <i>Swainsboro, GA</i>	SMITH RURAL HEALTH CLINIC <i>Swainsboro, GA</i> TWIN CITY FAMILY HEALTH CENTER <i>Twin City, GA</i>

County	Rural and Critical Access (CAH) Hospitals	Federally Qualified Health Centers	Rural Health Clinics
EVANS	EVANS MEMORIAL HOSPITAL <i>Claxton, GA</i>		
FANNIN	FANNIN REGIONAL HOSPITAL <i>Blue Ridge, GA</i>	Georgia Mountains Health Services <i>Morganton, GA</i> Georgia Mountains Health Services <i>Blue Ridge, GA</i>	MORGANTON FAMILY PRACTICE <i>Morganton, GA</i> MOUNTAIN MEDICAL INC <i>Blue Ridge, GA</i>
FRANKLIN	COBB MEMORIAL HOSPITAL <i>Royston, GA</i>	MedLink Georgia, Inc. <i>Lavonia, GA</i>	TRI-COUNTY MEDICAL CENTER <i>Royston, GA</i>
GILMER	NORTH GA. MED. CENTER <i>Ellijay, GA</i>	Georgia Mountains Health Services <i>Ellijay, GA</i>	
GLASCOCK		Tri-County Health System, Inc. <i>Gibson, GA</i>	
GRADY	GRADY GENERAL HOSPITAL <i>Cairo, GA</i>		SOUTHWEST GEORGIA FAMILY MEDICINE RHC <i>Cairo, GA</i>
GREENE	MINNIE G. BOSWELL MEM. HOSP. (CAH) <i>Greensboro, GA</i>	TenderCare Clinic <i>Greensboro, GA</i>	
HANCOCK		Tri-County Health System, Inc. <i>Sparta, GA</i>	FAMILY PRACTICE & SURGERY CENTER <i>Sparta, GA</i>
HARALSON	HIGGINS GENERAL HOSPITAL (CAH) <i>Bremen, GA</i>		BUCHANAN MEDICAL CLINIC <i>Buchanan, GA</i> HARALSON FAMILY HEALTHCARE <i>Bremen, GA</i> TALLAPOOSA FAMILY HEALTHCARE <i>Tallapoosa, GA</i>
HART	HART COUNTY HOSPITAL <i>Hartwell, GA</i>	MedLink Georgia, Inc. <i>Hartwell, GA</i>	
HEARD		Palmetto Health Council, Inc. <i>Franklin, GA</i>	FRANKLIN PRIMARY HEALTH CARE CLINIC <i>Franklin, GA</i>
IRWIN	IRWIN COUNTY HOSPITAL <i>Ocilla, GA</i>	South Central Primary Care Center <i>Ocilla, GA</i>	IRWIN FAMILY MEDICINE <i>Ocilla, GA</i>
JASPER	JASPER MEMORIAL HOSPITAL (CAH) <i>Monticello, GA</i>		
JEFF DAVIS	JEFF DAVIS HOSPITAL (CAH) <i>Hazlehurst, GA</i>		

County	Rural and Critical Access (CAH) Hospitals	Federally Qualified Health Centers	Rural Health Clinics
JEFFERSON	JEFFERSON HOSPITAL <i>Louisville, GA</i>		FIROZ PATKA, MD <i>Louisville, GA</i> NORTH JEFFERSON MEDICAL CENTER <i>Wrens, GA</i> PHYSICIANS' HEALTH GROUP <i>Louisville, GA</i> PHYSICIANS' HEALTH GROUP- WADLEY <i>Wadley, GA</i> WRENS PHYSICIANS HEALTH GROUP <i>Wrens, GA</i>
JENKINS	JENKINS COUNTY HOSPITAL (CAH) <i>Millen, GA</i>		JENKINS COUNTY FAMILY MEDICINE <i>Millen, GA</i>
JOHNSON		Community Health Care Systems, Inc. <i>Wrightsville, GA</i>	
LAMAR		Palmetto Health Council, Inc. <i>Barnesville, GA</i>	
LANIER	LOUIS SMITH MEM. HOSPITAL (CAH) <i>Lakeland, GA</i>		
LEE		Albany Area Primary Health Care, Inc. <i>Leesburg, GA</i>	
LIBERTY	LIBERTY REGIONAL MED. CTR. (CAH) <i>Hinesville, GA</i>		FAMILY CARE AMERICA HEALTH <i>Hinesville, GA</i>
LUMPKIN	CHESTATEE REGIONAL HOSP <i>Dahlonega, GA</i>		
MACON	FLINT RIVER COMMUNITY HOSP. <i>Montezuma, GA</i>		FLINT RIVER RHC- OGLETHORPE <i>Oglethorpe, GA</i>
MADISON		MedLink Georgia, Inc. <i>Colbert, GA</i>	DANIELSVILLE FAMILY PRACTICE <i>Danielsville, GA</i> TRI COUNTY MEDICAL CENTER RHC <i>Danielsville, GA</i>
MARION			BUENA VISTA FAMILY CLINIC <i>Buena Vista, GA</i>
MCDUFFIE	MCDUFFIE REG. MED. CTR. <i>Thomson, GA</i>		THOMSON PEDIATRICS & INTERNAL MEDICINE <i>Thomson, GA</i>
MCINTOSH			PEDS' R US <i>Darien, GA</i>
MERIWETHER	WARM SPRINGS MED. CTR. (CAH) <i>Warm Springs, GA</i>		

County	Rural and Critical Access (CAH) Hospitals	Federally Qualified Health Centers	Rural Health Clinics
MILLER	MILLER COUNTY HOSPITAL (CAH) <i>Colquitt, GA</i>		INFOMEDIX, PC <i>Colquitt, GA</i> MILLER COUNTY MEDICAL CENTER <i>Colquitt, GA</i>
MITCHELL	MITCHELL COUNTY HOSP. (CAH) <i>Camilla, GA</i>		CAMILLA FAMILY MEDICAL ASSOCIATES RHC <i>Camilla, GA</i> CAMILLA PEDIATRIC CENTER <i>Camilla, GA</i> PHOEBE FAMILY MEDICAL CENTER- CAMILLA <i>Camilla, GA</i>
MONROE	MONROE COUNTY HOSPITAL (CAH) <i>Forsyth, GA</i>		
MONTGOMERY			GLENWOOD FAMILY CLINIC <i>Uvalda, GA</i> HIGGSTON FAMILY CLINIC <i>Ailey, GA</i> MONTGOMERY INTERNAL MEDICINE <i>Mount Vernon, GA</i>
MORGAN	MORGAN MEMORIAL HOSP. (CAH) <i>Madison, GA</i>		
OGLETHORPE		MedLink Georgia, Inc. <i>Lexington, GA</i>	CRAWFORD-LEXINGTON MEDICAL CENTER RHC <i>Lexington, GA</i>
PEACH	PEACH REGIONAL MED. CTR. (CAH) <i>Fort Valley, GA</i>		EARLY FAMILY PRACTICE CENTER <i>Fort Valley, GA</i>
PICKENS	PIEDMONT MOUNTAINSIDE MEDICAL CENTER. <i>Jasper, GA</i>		
PIERCE		McKinney Community Health Center, Inc. <i>Blackshear, GA</i> McKinney Community Health Center, Inc. <i>Offerman, GA</i>	PATTERSON COMMUNITY CARE CENTER <i>Patterson, GA</i>
PIKE		Palmetto Health Council, Inc. <i>Zebulon, GA</i>	
POLK	POLK MEDICAL CENTER (CAH) <i>Cedartown, GA</i>		FLOYD PRIMARY CARE - ROCKMART <i>Rockmart, GA</i>
PULASKI	TAYLOR REGIONAL HOSP. <i>Hawkinsville, GA</i>		

County	Rural and Critical Access (CAH) Hospitals	Federally Qualified Health Centers	Rural Health Clinics
PUTNAM	PUTNAM GENERAL HOSP. (CAH) <i>Eatonton, GA</i>		EATONTON PEDIATRICS <i>Eatonton, GA</i> FAMILY PRACTICE & SURGERY <i>Eatonton, GA</i>
QUITMAN		Southwest Georgia Health Care, Inc. <i>Georgetown, GA</i>	
RABUN	MOUNTAIN LAKES MED. CTR (CAH) <i>Clayton, GA</i>	MedLink Georgia, Inc. <i>Clayton, GA</i>	MOUNTAIN VALLEY MEDICAL CENTER <i>Dillard, GA</i> RIDGECREST MEDICAL GROUP <i>Clayton, GA</i>
RANDOLPH	SW GA. REG. MEDICAL CTR. (CAH) <i>Cuthbert, GA</i>		RANDOLPH MEDICAL ASSOCIATES <i>Cuthbert, GA</i> RANDOLPH MEDICAL ASSOCIATES <i>Shellman, GA</i>
SCHLEY			ELLAVILLE PRIMARY MEDICINE CENTER <i>Ellaville, GA</i> FLINT RIVER- RHC <i>Ellaville, GA</i> SCHLEY COUNTY PRIMARY HLTH CARE CTR <i>Ellaville, GA</i>
SCREVEN	SCREVEN COUNTY HOSP. (CAH) <i>Sylvania, GA</i>		
SEMINOLE	DONALDSONVILLE HOSP. <i>Donalsonville, GA</i>		
STEPHENS	STEPHENS COUNTY HOSPITAL <i>Toccoa, GA</i>		
STEWART	STEWART WEBSTER HOSP. (CAH) <i>Richland, GA</i>	Southwest Georgia Health Care, Inc. <i>Richland, GA</i>	LUMPKIN FAMILY CLINIC <i>Lumpkin, GA</i>
SUMTER	SUMTER REGIONAL HOSP. <i>Americus, GA</i>	Southwest Georgia Health Care, Inc. <i>Plains, GA</i>	
TALBOT		Valley Healthcare System, Inc. <i>Talbotton, GA</i>	
TALIAFERRO		Tri-County Health System, Inc. <i>Crawfordville, GA</i>	

County	Rural and Critical Access (CAH) Hospitals	Federally Qualified Health Centers	Rural Health Clinics
TATTNALL	TATTNALL COMMUNITY HOSP. (CAH) <i>Reidsville, GA</i>	East Georgia Healthcare Center, Inc. <i>Reidsville, GA</i>	TATTNALL COUNTY PRIMARY CARE <i>Glennville, GA</i> TATTNALL MEDICAL GROUP-COBBTOWN <i>Reidsville, GA</i> THOMAS J FERRARI, MD <i>Reidsville, GA</i>
TELFAIR	TELFAIR REGIONAL HOSP. (CAH) <i>Mc Rae, GA</i>		
TERRELL		Albany Area Primary Health Care, Inc. <i>Dawson, GA</i>	
TOOMBS	MEADOWS MEMORIAL HOSP. <i>Vidalia, GA</i>		FAMILY HEALTH CENTER <i>Vidalia, GA</i> RODNEY T. STANLEY SR. HEALTH CENTER <i>Lyons, GA</i>
TOWNS	CHATUGE REGIONAL HOSP. (CAH) <i>Hiawassee, GA</i>		HIAWASSEE FAMILY PRACTICE, PC <i>Hiawassee, GA</i>
TREUTLEN		East Georgia Healthcare Center, Inc. <i>Soperton, GA</i>	MILLION PINES FAMILY HEALTH CENTER <i>Soperton, GA</i>
TURNER			HEALTHPLUS - ASHBURN <i>Ashburn, GA</i> PHOEBE FAMILY MEDICINE - ASHBURN CLINIC <i>Ashburn, GA</i>
UNION	UNION GENERAL HOSPITAL <i>Blairsville, GA</i>		BLUE MOUNTAIN FAMILY PRACTICE <i>Blairsville, GA</i>
UPSON	UPSON REG. MEDICAL CTR. <i>Thomaston, GA</i>		
WARREN		Tri-County Health System, Inc. <i>Warrenton, GA</i>	WARRENTON MEDICAL CENTER <i>Warrenton, GA</i>
WASHINGTON	WASHINGTON CO. REG. MED. CTR. <i>Sandersville, GA</i>	Community Health Care Systems, Inc. <i>Sandersville, GA</i> Community Health Care Systems, Inc. <i>Tennille, GA</i>	
WAYNE	WAYNE MEMORIAL HOSPITAL <i>Jesup, GA</i>		
WHEELER	WHEELER COUNTY HOSPITAL (CAH) <i>Glenwood, GA</i>		ACCORD FAMILY MEDICINE <i>Glenwood, GA</i>
WILCOX			ROCHELLE HEALTHCARE CENTER <i>Rochelle, GA</i>

County	Rural and Critical Access (CAH) Hospitals	Federally Qualified Health Centers	Rural Health Clinics
WILKES	WILLS MEMORIAL HOSPITAL (CAH) <i>Washington, GA</i>	MedLink Georgia, Inc. <i>Washington, GA</i>	
WORTH	PHOEBE WORTH MED. CTR. (CAH) <i>Sylvester, GA</i>		PHOEBE WORTH FAMILY MEDICINE <i>Sylvester, GA</i> WARWICK HEALTH CARE CLINIC <i>Warwick, GA</i>

Appendix C - County Level Health and Demographic Data

2005 Health data¹⁸ By County

Source: May 2007 Georgia Department of Human Resources, Division of Public Health,
Office of Health Information and Policy

Appling				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	305.8	307.7	1,804.60	1,242.70
Infant Mortality	*	8	94.7	31.5
Cancer	217.3	186.6	345.3	247.8
Diabetes	38.7	23	217.2	127.7

Atkinson				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	314.7	307.7	1,481.90	1,242.70
Infant Mortality	*	8	124.5	31.5
Cancer	281.3	186.6	311.3	247.8
Diabetes	*	23	286.4	127.7

¹⁸ Obesity is the fifth indicator. No county level obesity data is available. State level obesity data may be found on page 22.

* Data Not Available.

Bacon				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	390.6	307.7	1,917.30	1,242.70
Infant Mortality	29.6	8	57.8	31.5
Cancer	180.5	186.6	260.1	247.8
Diabetes	*	23	356.5	127.7

Baker				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	166.4	307.7	1,131.40	1,242.70
Infant Mortality	0	8	0	31.5
Cancer	123.3	186.6	192.6	247.8
Diabetes	*	23	*	127.7

Banks				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	410.3	307.7	1,607.00	1,242.70
Infant Mortality	*	8	*	31.5
Cancer	271.9	186.6	317.7	247.8
Diabetes	50.3	23	193.1	127.7

Ben Hill				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	416.8	307.7	2,027.00	1,242.70
Infant Mortality	20.6	8	144.4	31.5
Cancer	241.2	186.6	294.5	247.8
Diabetes	*	23	196.4	127.7

Berrien				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	333.8	307.7	1,741.70	1,242.70
Infant Mortality	*	8	59.9	31.5
Cancer	190.5	186.6	281.3	247.8
Diabetes	*	23	227.4	127.7

Bleckley				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	293.1	307.7	2,158.00	1,242.70
Infant Mortality	*	8	82.4	31.5
Cancer	231.2	186.6	263.6	247.8
Diabetes	*	23	230.6	127.7

Brantley				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	299.5	307.7	1,342.70	1,242.70
Infant Mortality	*	8	*	31.5
Cancer	240.5	186.6	238.8	247.8
Diabetes	*	23	135.6	127.7

Brooks				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	449.2	307.7	1,659.80	1,242.70
Infant Mortality	*	8	42.9	31.5
Cancer	208.7	186.6	281.7	247.8
Diabetes	0	23	287.9	127.7

Bryan				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	445.9	307.7	1,089.40	1,242.70
Infant Mortality	0	8	52.5	31.5
Cancer	241.1	186.6	255.7	247.8
Diabetes	*	23	98.1	127.7

Burke				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	540.4	307.7	1,832.70	1,242.70
Infant Mortality	11.8	8	68.7	31.5
Cancer	230.6	186.6	283.3	247.8
Diabetes	35.8	23	261.8	127.7

Butts				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	262.1	307.7	1,815.20	1,242.70
Infant Mortality	*	8	47.5	31.5
Cancer	172.3	186.6	299.4	247.8
Diabetes	35.1	23	128.3	127.7

Calhoun				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	352.9	307.7	1,657.70	1,242.70
Infant Mortality	*	8	*	31.5
Cancer	244.7	186.6	318.2	247.8
Diabetes	*	23	368.4	127.7

Candler				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	306.1	307.7	1,773.10	1,242.70
Infant Mortality	*	8	48.4	31.5
Cancer	159	186.6	203.5	247.8
Diabetes	*	23	213.2	127.7

Charlton				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	349.8	307.7	519	1,242.70
Infant Mortality	0	8	0	31.5
Cancer	134.7	186.6	166.8	247.8
Diabetes	*	23	120.5	127.7

Chattahoochee				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	288.2	307.7	292.9	1,242.70
Infant Mortality	*	8	*	31.5
Cancer	199	186.6	74.9	247.8
Diabetes	0	23	68.1	127.7

Chattooga				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	353.9	307.7	1,844.20	1,242.70
Infant Mortality	17.4	8	*	31.5
Cancer	249.3	186.6	319.9	247.8
Diabetes	27.7	23	135.5	127.7

Clay				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	314.2	307.7	431.8	1,242.70
Infant Mortality	*	8	*	31.5
Cancer	209.4	186.6	*	247.8
Diabetes	*	23	0	127.7

Clinch				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	464.6	307.7	1,386.50	1,242.70
Infant Mortality	*	8	*	31.5
Cancer	258.1	186.6	328.8	247.8
Diabetes	*	23	271.6	127.7

Cook				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	393.3	307.7	1,955.30	1,242.70
Infant Mortality	*	8	79.4	31.5
Cancer	205.9	186.6	372.7	247.8
Diabetes	47.6	23	201.6	127.7

Crawford				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	156.2	307.7	1,809.80	1,242.70
Infant Mortality	*	8	*	31.5
Cancer	264.9	186.6	225.3	247.8
Diabetes	*	23	108.7	127.7

Crisp				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	388.3	307.7	2,230.10	1,242.70
Infant Mortality	*	8	54.5	31.5
Cancer	188.1	186.6	331.6	247.8
Diabetes	39.3	23	349.7	127.7

Dade				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	265.1	307.7	280.5	1,242.70
Infant Mortality	*	8	0	31.5
Cancer	224.7	186.6	130.9	247.8
Diabetes	*	23	68.6	127.7

Dawson				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	321.7	307.7	1,368.40	1,242.70
Infant Mortality	*	8	30.4	31.5
Cancer	208.1	186.6	228.1	247.8
Diabetes	*	23	91.2	127.7

Decatur				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	296.9	307.7	1,355.80	1,242.70
Infant Mortality	*	8	52.4	31.5
Cancer	174.3	186.6	269.1	247.8
Diabetes	37.1	23	216.6	127.7

Dodge				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	340	307.7	2,171.20	1,242.70
Infant Mortality	19.2	8	46	31.5
Cancer	197	186.6	296.3	247.8
Diabetes	*	23	260.5	127.7

Dooly				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	459.2	307.7	2,153.40	1,242.70
Infant Mortality	*	8	68.1	31.5
Cancer	198.1	186.6	306.4	247.8
Diabetes	46	23	289.4	127.7

Early				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	418.4	307.7	870.9	1,242.70
Infant Mortality	0	8	*	31.5
Cancer	227.1	186.6	149.3	247.8
Diabetes	*	23	132.7	127.7

Echols				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	257.9	307.7	822.9	1,242.70
Infant Mortality	*	8	117.6	31.5
Cancer	276.3	186.6	258.6	247.8
Diabetes	0	23	*	127.7

Elbert				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	361.5	307.7	2,283.80	1,242.70
Infant Mortality	20.3	8	24	31.5
Cancer	196.4	186.6	264.4	247.8
Diabetes	39.5	23	235.6	127.7

Emanuel				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	398.3	307.7	2,257.10	1,242.70
Infant Mortality	12.8	8	67.8	31.5
Cancer	201.6	186.6	343.8	247.8
Diabetes	22.7	23	239.7	127.7

Evans				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	285	307.7	1,870.10	1,242.70
Infant Mortality	*	8	87.4	31.5
Cancer	141.2	186.6	253.4	247.8
Diabetes	*	23	183.5	127.7

Fannin				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	287.2	307.7	1,813.90	1,242.70
Infant Mortality	*	8	*	31.5
Cancer	198.1	186.6	287.8	247.8
Diabetes	54.4	23	132.5	127.7

Franklin				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	295	307.7	1,778.60	1,242.70
Infant Mortality	*	8	64.8	31.5
Cancer	164.3	186.6	324.2	247.8
Diabetes	50.5	23	152.8	127.7

Gilmer				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	329.9	307.7	1,547.50	1,242.70
Infant Mortality	*	8	65.8	31.5
Cancer	188.2	186.6	267.1	247.8
Diabetes	41	23	80.5	127.7

Glascock				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	334.1	307.7	2,181.10	1,242.70
Infant Mortality	0	8	0	31.5
Cancer	*	186.6	221.8	247.8
Diabetes	*	23	184.8	127.7

Grady				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	396.9	307.7	1,132.20	1,242.70
Infant Mortality	*	8	69.5	31.5
Cancer	271.8	186.6	331.1	247.8
Diabetes	25.5	23	167.6	127.7

Greene				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	366.4	307.7	1,637.70	1,242.70
Infant Mortality	*	8	38.2	31.5
Cancer	172.8	186.6	414.2	247.8
Diabetes	*	23	216.7	127.7

Hancock				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	398.6	307.7	1,783.70	1,242.70
Infant Mortality	*	8	72.6	31.5
Cancer	196.6	186.6	248.9	247.8
Diabetes	53.4	23	217.8	127.7

Haralson				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	404.2	307.7	1,919.70	1,242.70
Infant Mortality	*	8	52.9	31.5
Cancer	176.2	186.6	352.9	247.8
Diabetes	19.8	23	123.5	127.7

Harris				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	284.1	307.7	1,238.30	1,242.70
Infant Mortality	*	8	25.2	31.5
Cancer	207.1	186.6	277.2	247.8
Diabetes	23.5	23	86.4	127.7

Hart				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	377.3	307.7	1,651.70	1,242.70
Infant Mortality	0	8	29.1	31.5
Cancer	165.7	186.6	299.6	247.8
Diabetes	25.6	23	174.7	127.7

Heard				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	293.9	307.7	1,524.80	1,242.70
Infant Mortality	*	8	*	31.5
Cancer	267.6	186.6	299.7	247.8
Diabetes	*	23	158.6	127.7

Irwin				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	330.7	307.7	1,941.90	1,242.70
Infant Mortality	0	8	*	31.5
Cancer	224.2	186.6	257.6	247.8
Diabetes	*	23	208.1	127.7

Jasper				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	357.9	307.7	1,627.70	1,242.70
Infant Mortality	*	8	53.2	31.5
Cancer	196.3	186.6	273.8	247.8
Diabetes	*	23	106.5	127.7

Jeff Davis				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	542.6	307.7	1,918.50	1,242.70
Infant Mortality	*	8	38.2	31.5
Cancer	261.6	186.6	359.2	247.8
Diabetes	44.4	23	221.7	127.7

Jefferson				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	308.9	307.7	2,174.20	1,242.70
Infant Mortality	*	8	35.4	31.5
Cancer	269.9	186.6	277.7	247.8
Diabetes	31.6	23	307.2	127.7

Jenkins				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	354	307.7	1,924.60	1,242.70
Infant Mortality	0	8	0	31.5
Cancer	189.6	186.6	217.7	247.8
Diabetes	*	23	320.8	127.7

Johnson				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	369.9	307.7	2,075.90	1,242.70
Infant Mortality	0	8	*	31.5
Cancer	223.6	186.6	293.6	247.8
Diabetes	*	23	157.3	127.7

Jones				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	356.2	307.7	1,751.40	1,242.70
Infant Mortality	*	8	18.6	31.5
Cancer	192	186.6	234.8	247.8
Diabetes	17.9	23	119.2	127.7

Lamar				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	373.1	307.7	1,990.50	1,242.70
Infant Mortality	0	8	*	31.5
Cancer	242.6	186.6	366.3	247.8
Diabetes	*	23	164.9	127.7

Lanier				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	230.3	307.7	1,707.90	1,242.70
Infant Mortality	*	8	*	31.5
Cancer	219.4	186.6	331	247.8
Diabetes	*	23	238.3	127.7

Lee				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	262.9	307.7	861.8	1,242.70
Infant Mortality	*	8	*	31.5
Cancer	149.5	186.6	192.9	247.8
Diabetes	24	23	96.5	127.7

Liberty				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	293	307.7	745.5	1,242.70
Infant Mortality	10.2	8	71.2	31.5
Cancer	239.8	186.6	192.9	247.8
Diabetes	48.6	23	100.8	127.7

Lincoln				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	353.4	307.7	2,120.10	1,242.70
Infant Mortality	*	8	0	31.5
Cancer	204.5	186.6	341.2	247.8
Diabetes	*	23	207.1	127.7

Long				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	374.3	307.7	739.9	1,242.70
Infant Mortality	*	8	*	31.5
Cancer	315.3	186.6	261.7	247.8
Diabetes	*	23	126.3	127.7

Lumpkin				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	281.2	307.7	1,471.80	1,242.70
Infant Mortality	0	8	28.8	31.5
Cancer	190.8	186.6	308.3	247.8
Diabetes	64.6	23	90.4	127.7

Macon				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	543.9	307.7	2,102.60	1,242.70
Infant Mortality	*	8	*	31.5
Cancer	160.3	186.6	276.5	247.8
Diabetes	66.2	23	320.1	127.7

Madison				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	362.7	307.7	1,601.40	1,242.70
Infant Mortality	0	8	44	31.5
Cancer	183.2	186.6	249.2	247.8
Diabetes	26.3	23	205.2	127.7

Marion				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	496.7	307.7	1,132.00	1,242.70
Infant Mortality	*	8	82.8	31.5
Cancer	240.5	186.6	276.1	247.8
Diabetes	*	23	151.8	127.7

McDuffie				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	360.1	307.7	1,683.30	1,242.70
Infant Mortality	*	8	32.2	31.5
Cancer	219.2	186.6	280.6	247.8
Diabetes	70.1	23	188.6	127.7

McIntosh				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	269.8	307.7	1,508.90	1,242.70
Infant Mortality	*	8	*	31.5
Cancer	234.7	186.6	352.4	247.8
Diabetes	*	23	162.6	127.7

Meriwether				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	508.1	307.7	1,788.90	1,242.70
Infant Mortality	*	8	56.7	31.5
Cancer	205.5	186.6	240	247.8
Diabetes	48.3	23	174.5	127.7

Miller				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	225.7	307.7	1,685.90	1,242.70
Infant Mortality	*	8	*	31.5
Cancer	199.9	186.6	433.5	247.8
Diabetes	*	23	208.7	127.7

Mitchell				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	424.7	307.7	1,492.20	1,242.70
Infant Mortality	18	8	67.3	31.5
Cancer	211.7	186.6	357.3	247.8
Diabetes	*	23	100.9	127.7

Monroe				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	397.8	307.7	1,778.40	1,242.70
Infant Mortality	*	8	*	31.5
Cancer	226.2	186.6	378.4	247.8
Diabetes	37.9	23	176.6	127.7

Montgomery				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	508.2	307.7	1,717.40	1,242.70
Infant Mortality	*	8	*	31.5
Cancer	254.1	186.6	235.7	247.8
Diabetes	*	23	134.7	127.7

Morgan				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	332.1	307.7	1,429.20	1,242.70
Infant Mortality	*	8	40	31.5
Cancer	168.6	186.6	343	247.8
Diabetes	*	23	120.1	127.7

Oconee				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	373.5	307.7	1,116.00	1,242.70
Infant Mortality	*	8	*	31.5
Cancer	188.8	186.6	248.8	247.8
Diabetes	*	23	74	127.7

Oglethorpe				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	462.5	307.7	1,543.10	1,242.70
Infant Mortality	*	8	44.1	31.5
Cancer	152.9	186.6	220.4	247.8
Diabetes	*	23	147	127.7

Peach				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	338.6	307.7	1,710.10	1,242.70
Infant Mortality	*	8	44.4	31.5
Cancer	158.3	186.6	278.3	247.8
Diabetes	29.3	23	104.9	127.7

Pickens				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	388.2	307.7	1,715.80	1,242.70
Infant Mortality	*	8	70.3	31.5
Cancer	171.3	186.6	369.2	247.8
Diabetes	*	23	84.4	127.7

Pierce				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	261.8	307.7	1,606.40	1,242.70
Infant Mortality	0	8	*	31.5
Cancer	188.4	186.6	227.8	247.8
Diabetes	43	23	169.4	127.7

Pike				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	297	307.7	1,506.70	1,242.70
Infant Mortality	*	8	49.6	31.5
Cancer	232.5	186.6	241.8	247.8
Diabetes	*	23	105.4	127.7

Pulaski				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	413.6	307.7	2,434.00	1,242.70
Infant Mortality	0	8	51.4	31.5
Cancer	207	186.6	328.6	247.8
Diabetes	52.2	23	246.5	127.7

Putnam				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	240.7	307.7	1,860.90	1,242.70
Infant Mortality	*	8	45.4	31.5
Cancer	116.8	186.6	327.8	247.8
Diabetes	*	23	176.5	127.7

Quitman				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	236	307.7	324.3	1,242.70
Infant Mortality	*	8	0	31.5
Cancer	360.3	186.6	202.7	247.8
Diabetes	0	23	202.7	127.7

Rabun				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	222.5	307.7	1,591.30	1,242.70
Infant Mortality	0	8	49.7	31.5
Cancer	197.3	186.6	391.6	247.8
Diabetes	25.8	23	149.2	127.7

Randolph				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	393	307.7	1,641.60	1,242.70
Infant Mortality	*	8	68.4	31.5
Cancer	190.5	186.6	383	247.8
Diabetes	*	23	301	127.7

Schley				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	571.8	307.7	1,649.70	1,242.70
Infant Mortality	0	8	0	31.5
Cancer	272.9	186.6	291.1	247.8
Diabetes	*	23	*	127.7

Screven				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	317.6	307.7	1,827.60	1,242.70
Infant Mortality	*	8	32.4	31.5
Cancer	197.9	186.6	343.5	247.8
Diabetes	48.4	23	259.2	127.7

Seminole				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	339	307.7	1,073.10	1,242.70
Infant Mortality	*	8	*	31.5
Cancer	172.1	186.6	249.3	247.8
Diabetes	88.8	23	238.5	127.7

Stephens				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	311.3	307.7	2,198.70	1,242.70
Infant Mortality	*	8	127.7	31.5
Cancer	193.1	186.6	315.2	247.8
Diabetes	*	23	231.4	127.7

Stewart				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	361.5	307.7	1,884.50	1,242.70
Infant Mortality	*	8	*	31.5
Cancer	200.8	186.6	450.6	247.8
Diabetes	*	23	348.2	127.7

Sumter				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	269.8	307.7	1,382.50	1,242.70
Infant Mortality	11.4	8	51.7	31.5
Cancer	202.5	186.6	355.5	247.8
Diabetes	26.9	23	221.8	127.7

Talbot				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	468.4	307.7	1,669.40	1,242.70
Infant Mortality	*	8	0	31.5
Cancer	156	186.6	417.3	247.8
Diabetes	*	23	208.7	127.7

Taliaferro				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	421.1	307.7	2,793.00	1,242.70
Infant Mortality	0	8	*	31.5
Cancer	384.6	186.6	328.6	247.8
Diabetes	*	23	328.6	127.7

Tattnall				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	342.1	307.7	1,663.00	1,242.70
Infant Mortality	*	8	51.7	31.5
Cancer	280.6	186.6	301.6	247.8
Diabetes	*	23	206.8	127.7

Taylor				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	216.3	307.7	2,126.70	1,242.70
Infant Mortality	0	8	*	31.5
Cancer	335.3	186.6	495.1	247.8
Diabetes	65.7	23	135	127.7

Telfair				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	504.9	307.7	2,809.50	1,242.70
Infant Mortality	*	8	*	31.5
Cancer	189.2	186.6	348.4	247.8
Diabetes	0	23	265.1	127.7

Terrell				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	384.9	307.7	1,540.50	1,242.70
Infant Mortality	0	8	84	31.5
Cancer	250.9	186.6	382.8	247.8
Diabetes	*	23	252.1	127.7

Toombs				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	398.9	307.7	1,891.90	1,242.70
Infant Mortality	*	8	80.7	31.5
Cancer	264.9	186.6	363	247.8
Diabetes	*	23	146.7	127.7

Towns				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	202.7	307.7	2,074.60	1,242.70
Infant Mortality	0	8	*	31.5
Cancer	262.4	186.6	368.4	247.8
Diabetes	*	23	155.1	127.7

Trentlen				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	372.4	307.7	2,428.60	1,242.70
Infant Mortality	*	8	*	31.5
Cancer	213.7	186.6	222.1	247.8
Diabetes	*	23	222.1	127.7

Turner				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	407.2	307.7	1,741.60	1,242.70
Infant Mortality	*	8	73.9	31.5
Cancer	168.8	186.6	369.4	247.8
Diabetes	*	23	73.9	127.7

Twiggs				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	419.1	307.7	2,000.20	1,242.70
Infant Mortality	*	8	*	31.5
Cancer	141.6	186.6	378.7	247.8
Diabetes	*	23	155.4	127.7

Union				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	231.6	307.7	1,941.20	1,242.70
Infant Mortality	0	8	30.3	31.5
Cancer	232.8	186.6	460	247.8
Diabetes	*	23	85.9	127.7

Upson				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	495.5	307.7	2,344.70	1,242.70
Infant Mortality	*	8	68.6	31.5
Cancer	196.8	186.6	339.6	247.8
Diabetes	37.6	23	180.6	127.7

Warren				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	427.5	307.7	2,081.60	1,242.70
Infant Mortality	*	8	*	31.5
Cancer	295.5	186.6	278.6	247.8
Diabetes	65.2	23	295	127.7

Washington				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	337.4	307.7	1,700.00	1,242.70
Infant Mortality	*	8	79.5	31.5
Cancer	287.6	186.6	338	247.8
Diabetes	21.9	23	198.8	127.7

Wayne				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	408	307.7	2,078.20	1,242.70
Infant Mortality	19.7	8	45.8	31.5
Cancer	194.3	186.6	348.7	247.8
Diabetes	*	23	221.9	127.7

Webster				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	306.3	307.7	1,266.90	1,242.70
Infant Mortality	0	8	*	31.5
Cancer	*	186.6	218.4	247.8
Diabetes	0	23	*	127.7

Wheeler				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	356.1	307.7	1,774.50	1,242.70
Infant Mortality	*	8	74.6	31.5
Cancer	159.9	186.6	134.2	247.8
Diabetes	*	23	238.6	127.7

White				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	247.1	307.7	1,754.30	1,242.70
Infant Mortality	*	8	29.1	31.5
Cancer	172.8	186.6	282.7	247.8
Diabetes	24.8	23	83.1	127.7

Wilcox				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	373.5	307.7	2,132.80	1,242.70
Infant Mortality	0	8	80.3	31.5
Cancer	177.4	186.6	298.1	247.8
Diabetes	*	23	172	127.7

Wilkes				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	358.3	307.7	2,562.90	1,242.70
Infant Mortality	*	8	*	31.5
Cancer	162	186.6	286.9	247.8
Diabetes	*	23	200.8	127.7

Wilkinson				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	397.9	307.7	2,001.40	1,242.70
Infant Mortality	*	8	49.3	31.5
Cancer	122.5	186.6	285.9	247.8
Diabetes	*	23	167.6	127.7

Worth				
	Number of Deaths for every 100,000 people (county)	Number of Deaths for every 100,000 people (Georgia)	Number of Cases for every 100,000 people (county)	Number of Cases for every 100,000 people (Georgia)
Cardiovascular Disease	294.2	307.7	1,363.90	1,242.70
Infant Mortality	*	8	31.8	31.5
Cancer	207	186.6	304.6	247.8
Diabetes	26.9	23	154.6	127.7

Source:
 May 2007 Georgia Department of Human Resources, Division of Public Health, Office of Health Information and Policy

Demographic Characteristics of Georgia's Rural Counties

DEMOGRAPHIC CHARACTERISTICS OF GEORGIA'S RURAL COUNTIES

Geographic area	Total population	Age distribution				Income in 1999 below poverty level				Education			Employment
		Under 18 years		65 years and over		Percent of population for whom poverty status is determined			Percent of families	Population 1619	Population 25 years and over		Civilian labor force (16 years and older)
		Number	Percent	Number	Percent	All ages	Related children under 18 years	65 years and over		Percent not enrolled in high school and not a high school graduate	Percent with less than a 9th grade education	Percent high school graduate or higher	Percent unemployed
RURAL COUNTIES													
Appling County	17,419	4720.55	27.1	2,062	11.8	18.6	23.9	24.4	14.9	14.1	11.6	67.3	4.8
Atkinson County	7,609	2305.53	30.3	705	9.3	23	27.1	31	18.1	33.3	22.1	56.3	5.2
Bacon County	10,103	2646.99	26.2	1,293	12.8	23.7	31.4	25.7	20.2	8.6	12	67.7	4.5
Baker County	4,074	1112.20	27.3	557	13.7	23.4	32.5	20.1	19.9	5.6	15.7	66	8.3
Banks County	14,422	3778.56	26.2	1,512	10.5	12.5	14	16.3	9.8	16.9	13.2	65.4	3
Ben Hill County	17,484	4808.10	27.5	2,328	13.3	22.3	33.3	17.6	18.7	18.5	12.9	65.8	6.3
Berrien County	16,235	4415.92	27.2	2,027	12.5	17.7	25.4	13	14.6	16.3	11.8	66	4.5
Bleckley County	11,666	3103.16	26.6	1,584	13.6	15.9	24.1	17.8	11.7	5.8	12.9	71.7	6
Brantley County	14,629	4140.01	28.3	1,478	10.1	15.6	19.7	16.9	12.1	13.1	9.6	72.5	4.9
Brooks County	16,450	4425.05	26.9	2,465	15	23.4	32.4	20.1	19.1	17.4	12	67.5	5.3
Bryan County	23,417	7282.69	31.1	1,703	7.3	11.7	14.7	12.6	10.7	14.4	5.8	79	3.1
Burke County	22,243	6962.06	31.3	2,416	10.9	28.7	39	29.8	23.8	14.3	13.3	64.9	9.3
Butts County	19,522	4704.80	24.1	1,994	10.2	11.5	15	16.7	8.6	19.7	10.1	69.8	3.9
Calhoun County	6,320	1396.72	22.1	794	12.6	26.5	39.2	26.5	23.2	8.1	13.4	65.5	5.6
Candler County	9,577	2566.64	26.8	1,453	15.2	26.1	36.9	22	21.4	20.4	17.9	56.9	7.2
Charlton County	10,282	2827.55	27.5	994	9.7	20.9	29.1	20.4	17.8	15.3	10.9	65.1	5.2
Chattahoochee County	14,882	4226.49	28.4	268	1.8	10.6	11.5	18.6	8.9	5.8	2.4	88.8	7.5
Chattooga County	25,470	5832.63	22.9	3,641	14.3	14.3	17.4	14.9	11.3	19.9	16.6	60.4	5.6
Clay County	3,357	862.75	25.7	655	19.5	31.3	43.4	23.9	28.1	7.8	13.6	64.3	6.8

Geographic area	Total population	Age distribution				Income in 1999 below poverty level				Population 1619	Education		Employment
		Under 18 years		65 years and over		Percent of population for whom poverty status is determined			Percent of families		Percent not enrolled in high school and not a high school graduate	Population 25 years and over	
		Number	Percent	Number	Percent	All ages	Related children under 18 years	65 years and over					Percent with less than a 9th grade education
Clinch County	6,878	1918.96	27.9	814	11.8	23.4	26.9	30.9	22.2	8.9	19.3	58.9	4.2
Cook County	15,771	4447.42	28.2	2,046	13	20.7	27.9	24.4	16.5	16.2	12.9	64.6	5.3
Crawford County	12,495	3448.62	27.6	1,150	9.2	15.4	17.2	23.8	12.7	16.6	7.3	67.3	4.6
Crisp County	21,996	6378.84	29	2,853	13	29.3	41.8	24	24.6	20.3	11.5	65.9	7
Dade County	15,154	3606.65	23.8	1,820	12	9.7	7.4	12.5	7.5	12.2	12.6	67	5.4
Dawson County	15,999	4015.75	25.1	1,491	9.3	7.6	8.9	8.6	5.8	20.3	6	79.5	3.4
Decatur County	28,240	8048.40	28.5	3,743	13.3	22.7	33	19.2	19.2	15.6	11.2	69.7	6.5
Dodge County	19,171	4984.46	26	2,539	13.2	17.4	19.4	21.3	13.8	18.8	12.6	66.3	5.4
Dooly County	11,525	2950.40	25.6	1,362	11.8	22.1	29.5	21.2	18	12.6	11.5	68.5	6.4
Early County	12,354	3545.60	28.7	1,945	15.7	25.7	37.2	20.1	22.2	15.5	13.7	68.4	8.1
Echols County	3,754	1099.92	29.3	340	9.1	28.7	33.1	29.8	22.3	26	17.9	60.5	3.7
Elbert County	20,511	5291.84	25.8	3,060	14.9	17.3	23.5	17.2	14.6	15.1	11	67.2	5.8
Emanuel County	21,837	6070.69	27.8	2,909	13.3	27.4	36.7	27.5	21.8	18.9	15	61.4	4.4
Evans County	10,495	2886.13	27.5	1,321	12.6	27	36.2	23.6	23.1	24.3	14.3	65.7	8.1
Fannin County	19,798	4137.78	20.9	3,766	19	12.4	14.1	14.2	10.2	7.1	12.7	70.9	3.9
Franklin County	20,285	4848.12	23.9	3,108	15.3	13.9	16.8	18.5	11	11.9	11.1	67	4.2
Gilmer County	23,456	5699.81	24.3	3,082	13.1	12.5	12.6	16.9	9.3	26.2	14.2	66	4.2
Glascock County	2,556	608.33	23.8	466	18.2	17.2	10.7	38.5	9.4	17.1	15.9	66.1	12.3
Grady County	23,659	6458.91	27.3	3,128	13.2	21.3	29.9	19.8	16.7	16.4	11.3	69.4	7.4
Greene County	14,406	3615.91	25.1	2,073	14.4	22.3	33.8	20.2	16	17.7	10.3	70.1	6.7

Geographic area	Total population	Age distribution				Income in 1999 below poverty level				Education			Employment
		Under 18 years		65 years and over		Percent of population for whom poverty status is determined			Percent of families	Population 1619	Population 25 years and over		Civilian labor force (16 years and older)
		Number	Percent	Number	Percent	All ages	Related children under 18 years	65 years and over		Percent not enrolled in high school and not a high school graduate	Percent with less than a 9th grade education	Percent high school graduate or higher	Percent unemployed
Hancock County	10,076	2428.32	24.1	1,209	12	29.4	45.4	25.3	26.1	9.4	14.5	62.2	13.7
Haralson County	25,690	6705.09	26.1	3,347	13	15.5	18.1	16.1	11.4	21.5	13.7	63	4.1
Harris County	23,695	6065.92	25.6	2,830	11.9	8.2	9.6	13.6	6.5	3.9	7.3	79	3.4
Hart County	22,997	5404.30	23.5	3,797	16.5	14.8	19.1	16.5	12.2	14.5	9.5	71.1	5.3
Heard County	11,012	3160.44	28.7	1,212	11	13.6	14.6	17.4	10.5	25.1	12.5	66	5.7
Irwin County	9,931	2860.13	28.8	1,396	14.1	17.8	23.3	20.8	13.5	9.3	12.6	67.7	6
Jasper County	11,426	3107.87	27.2	1,353	11.8	14.2	19.2	13.5	10.9	7.5	9.1	69.7	4.7
Jeff Davis County	12,684	3450.05	27.2	1,514	11.9	19.4	21.7	22.1	16.8	20.7	13.1	63.3	5.6
Jefferson County	17,266	4903.54	28.4	2,357	13.7	23	28.9	28.8	19.3	12.8	16.7	58.5	11.8
Jenkins County	8,575	2443.88	28.5	1,163	13.6	28.4	39.6	25.5	22.3	14.1	17.2	62	10.7
Johnson County	8,560	2576.56	30.1	1,337	15.6	22.6	29.6	30.9	20.9	26.1	15.8	62.4	5.5
Jones County	23,639	6406.17	27.1	2,441	10.3	10.2	12.3	12.2	7.7	7.6	8.1	77.9	4.5
Lamar County	15,912	3898.44	24.5	2,000	12.6	11.2	14.5	11	8.1	9.6	9.3	71.3	5.5
Lanier County	7,241	1984.03	27.4	771	10.6	18.5	22.9	24.2	15.3	21	10.7	67	6.2
Lee County	24,757	7600.40	30.7	1,570	6.3	8.2	10.5	11.7	6.5	7.9	4.1	81.3	3.4
Lincoln County	8,348	2036.91	24.4	1,218	14.6	15.3	19.6	15.9	12.4	12.7	9.6	71	6
Long County	10,304	3410.62	33.1	594	5.8	19.5	26	19.8	17.6	17.3	10	74.3	8.8
Lumpkin County	21,016	5106.89	24.3	2,040	9.7	13.2	13.5	16.3	9	12.6	11.2	72	4
McDuffie County	21,231	5923.45	27.9	2,528	11.9	18.4	26	20	14.1	11.9	11.3	66.7	7.7
McIntosh County	10,847	3037.16	28	1,280	11.8	18.7	24.1	16.9	15.7	14.8	10	71.2	5.7

Geographic area	Total population	Age distribution				Income in 1999 below poverty level				Education			Employment
		Under 18 years		65 years and over		Percent of population for whom poverty status is determined			Percent of families	Population 1619	Population 25 years and over		Civilian labor force (16 years and older)
		Number	Percent	Number	Percent	All ages	Related children under 18 years	65 years and over		Percent not enrolled in high school and not a high school graduate	Percent with less than a 9th grade education	Percent high school graduate or higher	Percent unemployed
Macon County	14,074	3884.42	27.6	1,791	12.7	25.8	39	22.6	22.1	17	16.2	63.2	9.1
Madison County	25,730	6766.99	26.3	2,827	11	11.6	14	16.5	9.2	17.7	8.5	70.8	2.7
Marion County	7,144	2021.75	28.3	752	10.5	22.4	31.2	25.1	17.8	14.5	11.9	65.4	3.6
Meriwether County	22,534	5994.04	26.6	3,068	13.6	17.8	25.9	16.3	13.6	13	12	65.8	7
Miller County	6,383	1678.73	26.3	1,092	17.1	21.2	28.7	21.1	16.9	8.2	13.6	69	4
Mitchell County	23,932	6533.44	27.3	2,810	11.7	26.4	38.5	20.3	22.3	15.2	12.1	65.3	6.2
Monroe County	21,757	5722.09	26.3	2,251	10.3	9.8	12	13.3	7.3	10.1	7.9	77.7	3.4
Montgomery County	8,270	2067.50	25	877	10.6	19.9	24.7	23.9	15.8	10.8	9.3	71.4	3.9
Morgan County	15,457	4111.56	26.6	1,934	12.5	10.9	14.1	9.6	8.9	14	8.2	74	5.1
Oconee County	26,225	7919.95	30.2	2,238	8.5	6.5	7.4	11.4	4.9	4.6	4.5	86.7	3.7
Oglethorpe County	12,635	3259.83	25.8	1,566	12.4	13.2	15.9	18.4	10	15.8	9.6	72.1	3
Peach County	23,668	6153.68	26	2,331	9.8	20.2	24.5	13.5	15.2	13.6	9.2	73.4	12.9
Pickens County	22,983	5423.99	23.6	3,034	13.2	9.2	13.2	7.4	6.2	26.1	11.7	70.2	2.3
Pierce County	15,636	4174.81	26.7	1,903	12.2	18.4	25.5	22.4	14.4	20.9	12	69.8	4
Pike County	13,688	3777.89	27.6	1,488	10.9	9.6	11.6	11	6.9	20.2	8.4	75.3	3.4
Pulaski County	9,588	2214.83	23.1	1,272	13.3	16.4	19	18.7	12.3	19.8	8.8	73.4	5.5
Putnam County	18,812	4364.38	23.2	2,658	14.1	14.6	20.8	9.8	10.5	16	7.9	75.5	3.8
Quitman County	2,598	623.52	24	516	19.9	21.9	26.6	24.5	16.1	16	16.2	57.8	5.8
Rabun County	15,050	3280.90	21.8	2,730	18.1	11.1	11	13	8.1	11	8.5	75.4	4.9
Randolph County	7,791	2126.94	27.3	1,212	15.6	27.7	36.2	31	22	14.1	16.8	62.4	7.9

Geographic area	Total population	Age distribution				Income in 1999 below poverty level				Education			Employment
		Under 18 years		65 years and over		Percent of population for whom poverty status is determined			Percent of families	Population 1619	Population 25 years and over		Civilian labor force (16 years and older)
		Number	Percent	Number	Percent	All ages	Related children under 18 years	65 years and over		Percent not enrolled in high school and not a high school graduate	Percent with less than a 9th grade education	Percent high school graduate or higher	Percent unemployed
Schley County	3,766	1103.44	29.3	419	11.1	19.9	26	22.7	15.8	18.7	8.4	70	5.7
Screven County	15,374	4289.35	27.9	2,155	14	20.1	22.4	25.5	15.5	3.8	14.2	66.9	9.4
Seminole County	9,369	2454.68	26.2	1,477	15.8	23.2	35.1	18.6	15.8	13	13.4	67.9	7
Stephens County	25,435	5977.23	23.5	3,971	15.6	15.1	17.3	18.6	11.3	16.4	11.4	71.1	4.2
Stewart County	5,252	1307.75	24.9	973	18.5	22.2	30.4	21.9	17.2	18.8	17.3	63.2	10.1
Sumter County	33,200	9229.60	27.8	4,095	12.3	21.4	32.3	16.8	17.6	12.5	10.8	69.9	6.8
Talbot County	6,498	1572.52	24.2	937	14.4	24.2	39.1	19.7	19.9	6.8	13	64.8	8.7
Taliaferro County	2,077	500.56	24.1	393	18.9	23.4	30.3	23.4	22.3	20.2	21.4	56.2	9.8
Tattnall County	22,305	5107.85	22.9	2,506	11.2	23.9	32.9	20.2	18.6	24.9	11.7	66.3	6.8
Taylor County	8,815	2371.24	26.9	1,169	13.3	26	33.9	24.7	20.2	24.3	15	63.6	8
Telfair County	11,794	2653.65	22.5	1,755	14.9	21.2	26.4	23.7	17.3	24.5	10.3	63.6	6.5
Terrell County	10,970	3115.48	28.4	1,425	13	28.6	40.5	22	22.7	18.4	11.8	64.5	8.5
Toombs County	26,067	7455.16	28.6	3,178	12.2	23.9	33.8	18.3	17.8	20.6	11.4	67.3	5.7
Towns County	9,319	1519.00	16.3	2,409	25.9	11.8	13.6	10.4	8.8	3.2	10.2	75.1	3.8
Treutlen County	6,854	1782.04	26	908	13.2	26.3	31.8	33	20.8	23.1	14.9	61.8	9.4
Turner County	9,504	2794.18	29.4	1,230	12.9	26.7	35.8	24.8	20.5	11.6	10.5	67.7	8
Twiggs County	10,590	2859.30	27	1,196	11.3	19.7	25.2	25.8	15.5	19.1	13	63.2	8.3
Union County	17,289	3457.80	20	3,728	21.6	12.5	13.1	15.9	9.3	6.4	9.1	74.2	3.2
Upson County	27,597	7037.24	25.5	4,123	14.9	14.7	21.7	11.7	11.2	13.9	12.4	66.7	7
Warren County	6,336	1672.70	26.4	1,017	16.1	27	36	27.5	24.1	19.2	20	57.1	9.4

Geographic area	Total population	Age distribution				Income in 1999 below poverty level				Education			Employment
		Under 18 years		65 years and over		Percent of population for whom poverty status is determined			Percent of families	Population 1619	Population 25 years and over		Civilian labor force (16 years and older)
		Number	Percent	Number	Percent	All ages	Related children under 18 years	65 years and over		Percent not enrolled in high school and not a high school graduate	Percent with less than a 9th grade education	Percent high school graduate or higher	Percent unemployed
Washington County	21,176	5696.34	26.9	2,671	12.6	22.9	30	23.2	18.7	13.2	11.8	68.3	9.5
Wayne County	26,565	6880.34	25.9	3,017	11.4	16.7	22.7	14.4	13.4	11.8	11.1	70.1	5
Webster County	2,390	602.28	25.2	353	14.8	19.3	26	19.4	17.2	24.5	16.3	61.3	7.5
Wheeler County	6,179	1384.10	22.4	782	12.7	25.3	30.2	26.7	21.6	18	15.4	67.9	5
White County	19,944	4627.01	23.2	2,902	14.6	10.5	12.3	15.4	8.4	10.1	9	76	2.8
Wilcox County	8,577	1955.56	22.8	1,162	13.5	21	29.8	21.3	16.8	8.2	14.3	68.2	4.9
Wilkes County	10,687	2564.88	24	1,832	17.1	17.5	24.2	19.9	13	13.4	12.7	65	4.4
Wilkinson County	10,220	2779.84	27.2	1,334	13.1	17.9	24.9	18	14.6	11.4	9.7	70.4	6.7
Worth County	21,967	6282.56	28.6	2,629	12	18.5	25	20.2	14.7	5.1	10.8	68.3	7.2

Mortality Data

AGE ADJUSTED MORTALITY DATA, ALL RURAL COUNTIES

	Cancer, All Types			Diabetes			Infant Mortality			Cardiovascular Disease		
	1994	1999	2005	1994	1999	2005	1994	1999	2005	1994	1999	2005
Appling	291.6	181.1	217.3	*	*	38.7	21.1	*	*	440.3	439.4	305.8
Atkinson	289.1	146.4	281.3	*	0	*	*	*	*	555.9	476.9	314.7
Bacon	249.1	262.4	180.5	*	*	*	0	*	29.6	610.1	553.6	390.6
Baker	140.5	190.1	123.3	*	*	*	*	0	0	453.5	518.3	166.4
Banks	270.6	202.9	271.9	*	*	50.3	*	0	*	507	383.8	410.3
Ben Hill	247.5	296.9	241.2	51.3	32.5	*	18.5	*	20.6	548.9	518.2	416.8
Berrien	232	258.2	190.5	*	*	*	*	*	*	427.9	502.4	333.8
Bleckley	264.8	294.7	231.2	*	*	*	*	*	*	401.3	460.4	293.1
Brantley	296.6	165	240.5	*	*	*	0	0	*	491.4	407	299.5
Brooks	170.3	186.7	208.7	*	*	0	*	*	*	428.9	393.2	449.2
Bryan	259.4	205.1	241.1	*	*	*	*	*	0	241.4	408.5	445.9
Burke	238.5	204.3	230.6	*	*	35.8	12.3	*	11.8	579.9	431.6	540.4
Butts	299.7	227.4	172.3	*	*	35.1	*	*	*	486.5	426.1	262.1
Calhoun	186	178.1	244.7	*	*	*	0	*	*	550.4	429.2	352.9
Candler	203.3	193.5	159	*	*	*	*	*	*	358.1	425.2	306.1
Charlton	319.3	272.5	134.7	*	*	*	*	*	0	452.7	471.5	349.8
Chattahoochee	321.3	258.8	199	0	0	0	*	0	*	900.3	960.6	288.2
Chattooga	221.9	213	249.3	*	*	27.7	17.2	*	17.4	591.9	449	353.9
Clay	174.2	229.5	209.4	*	*	*	*	*	*	513.6	607.9	314.2
Clinch	270.1	240.3	258.1	*	*	*	*	*	*	464.1	492.4	464.6
Cook	132.1	219.4	205.9	*	*	47.6	*	20.8	*	538.5	489	393.3
Crawford	149.7	129.8	264.9	*	53.5	*	*	0	*	278.3	384.6	156.2
Crisp	258.7	198.8	188.1	*	*	39.3	21.2	*	*	433.4	394	388.3
Dade	91.4	214.7	224.7	*	*	*	*	0	*	412.6	362.5	265.1
Dawson	233.9	238.3	208.1	*	*	*	*	*	*	381.8	324.1	321.7
Decatur	244.6	269.4	174.3	28.5	32.2	37.1	15.4	15.6	*	527.3	508	296.9
Dodge	218.1	205.5	197	*	40.2	*	*	*	19.2	446.8	469.1	340
Dooly	298.6	186.4	198.1	*	*	46	*	*	*	440	337	459.2

*No data available. Rates are per 100,000 population for cancer, diabetes, and cardiovascular disease and per 1,000 for infant conditions.

Age Adjusted Mortality Rates, General Population												
	Cancer, All Types			Diabetes			Infant Mortality			Cardiovascular Disease		
	1994	1999	2005	1994	1999	2005	1994	1999	2005	1994	1999	2005
Early	222.1	157.9	227.1	43.7	62.2	*	*	*	0	495.8	449.1	418.4
Echols	*	*	276.3	0	*	0	*	*	*	527.1	525.5	257.9
Elbert	253	200.3	196.4	*	24.9	39.5	23.5	*	20.3	346.6	454.5	361.5
Emanuel	206.7	201.8	201.6	*	0	22.7	*	26	12.8	427.6	423.8	398.3
Evans	211.6	215.6	141.2	*	*	*	*	*	*	622.5	405.2	285
Fannin	188.2	172.9	198.1	47.4	33.8	54.4	0	*	*	371.7	279	287.2
Franklin	158.7	178.2	164.3	31.7	*	50.5	*	*	*	445.8	377.2	295
Gilmer	266.3	215.7	188.2	*	*	41	0	0	*	410.2	423.1	329.9
Glascocock	171.3	191.4	*	*	*	*	0	0	0	378.6	357.7	334.1
Grady	201.6	245.4	271.8	*	*	25.5	*	21	*	412.5	386.1	396.9
Greene	255.2	140.4	172.8	*	*	*	33.7	*	*	541.5	462.5	366.4
Hancock	261.5	219.5	196.6	*	*	53.4	*	*	*	515.3	486.9	398.6
Haralson	169.6	213.3	176.2	34.7	22.8	19.8	*	0	*	444.4	463.7	404.2
Harris	214.4	181.3	207.1	38.5	26.2	23.5	*	*	*	430.2	321	284.1
Hart	234.9	183.9	165.7	*	0	25.6	*	*	0	428.2	442.8	377.3
Heard	187.4	201.2	267.6	*	*	*	0	*	*	531.6	383.4	293.9
Irwin	289.9	116.8	224.2	*	*	*	*	0	0	482	307.2	330.7
Jasper	190.5	228.9	196.3	*	*	*	*	*	*	477	500.8	357.9
Jeff Davis	246.4	152.9	261.6	*	43.7	44.4	*	0	*	438.1	565.3	542.6
Jefferson	240	222.1	269.9	30.3	68.1	31.6	*	*	*	562.6	406.8	308.9
Jenkins	270.1	120.6	189.6	*	*	*	*	*	0	652	516.5	354
Johnson	330.1	173.6	223.6	*	0	*	*	*	0	421.6	427.1	369.9
Jones	238.1	256.2	192	34.8	*	17.9	*	15.2	*	407.1	466.8	356.2
Lamar	243.3	224.2	242.6	*	0	*	*	*	0	452.2	394.9	373.1
Lanier	240.7	214.1	219.4	*	*	*	*	*	*	479.1	182.2	230.3
Lee	319.4	217.1	149.5	*	*	24	*	0	*	315.4	257.1	262.9
Liberty	234.5	200.2	239.8	30.7	*	48.6	14.3	11.8	10.2	371.6	583.9	293
Lincoln	180.6	256	204.5	*	55.1	*	*	*	*	411.7	376.6	353.4
Long	204.2	270.5	315.3	0	*	*	*	*	*	509	523	374.3
Lumpkin	176.1	195.8	190.8	*	44.9	64.6	*	*	0	383.3	313.2	281.2

Age Adjusted Mortality Rates, General Population												
	Cancer, All Types			Diabetes			Infant Mortality			Cardiovascular Disease		
	1994	1999	2005	1994	1999	2005	1994	1999	2005	1994	1999	2005
Macon	191.2	204.3	160.3	*	*	66.2	*	*	*	494.7	408.2	543.9
Madison	214.6	197.3	183.2	*	40.9	26.3	*	*	0	457.3	468	362.7
Marion	172.6	158	240.5	*	*	*	*	0	*	436.8	439.3	496.7
McDuffie	196.4	258.6	219.2	*	*	70.1	*	*	*	361.5	475.2	360.1
McIntosh	259.9	206.3	234.7	*	*	*	*	*	*	378.9	427.4	269.8
Meriwether	216.6	194.9	205.5	*	*	48.3	17.9	*	*	517.7	469	508.1
Miller	139.8	172.8	199.9	*	*	*	0	*	*	426.5	463.5	225.7
Mitchell	213.7	255.1	211.7	23.8	26.2	*	*	*	18	454.7	399.1	424.7
Monroe	221.2	190.2	226.2	*	40.2	37.9	*	*	*	463.3	415.2	397.8
Montgomery	300.7	256	254.1	0	*	*	0	*	*	367.6	556.9	508.2
Morgan	208.5	179.7	168.6	*	*	*	0	*	*	489.5	517.8	332.1
Oconee	154.5	201	188.8	*	35.9	*	*	*	*	318.4	387.2	373.5
Oglethorpe	219	141.3	152.9	*	*	*	0	0	*	380.9	459.5	462.5
Peach	217.9	307.3	158.3	30.6	48.1	29.3	25.4	*	*	349.9	504.9	338.6
Pickens	148.7	153.9	171.3	*	*	*	*	16.8	*	460	411.7	388.2
Pierce	247.3	249.4	188.4	*	42.1	43	*	*	0	498.5	575.2	261.8
Pike	167.8	233.6	232.5	0	*	*	*	0	*	534.4	391.3	297
Pulaski	208	247.1	207	*	*	52.2	*	0	0	470.7	432.3	413.6
Putnam	227.4	167.3	116.8	*	*	*	*	*	*	494.1	429.9	240.7
Quitman	477.8	*	360.3	*	0	0	0	*	*	623.8	347.6	236
Rabun	172	175.7	197.3	*	*	25.8	0	*	0	262.8	332	222.5
Randolph	249.7	254.7	190.5	*	*	*	*	39.7	*	469	528.6	393
Schley	351	220.4	272.9	0	0	*	0	*	0	302.6	369.9	571.8
Screven	246.7	198.4	197.9	*	0	48.4	*	*	*	479.1	459.2	317.6
Seminole	169.9	177.8	172.1	62	0	88.8	*	*	*	563.3	426.7	339
Stephens	196.6	184.9	193.1	*	17.3	*	*	*	*	408.6	471.6	311.3
Stewart	168.7	157.9	200.8	*	69.7	*	*	0	*	417.4	323	361.5
Sumter	212.6	210.3	202.5	19.3	31.2	26.9	16.1	*	11.4	376.8	419.4	269.8
Talbot	172.3	220.7	156	*	*	*	0	*	*	503.2	467.6	468.4

Age Adjusted Mortality Rates, General Population												
	Cancer, All Types			Diabetes			Infant Mortality			Cardiovascular Disease		
	1994	1999	2005	1994	1999	2005	1994	1999	2005	1994	1999	2005
Taliaferro	192.8	*	384.6	*	0	*	*	*	0	521.4	362.6	421.1
Tattnall	241.5	218.6	280.6	*	*	*	*	*	*	473.1	450.2	342.1
Taylor	204.8	178.6	335.3	*	*	65.7	0	*	0	602.4	437.1	216.3
Telfair	186.8	255.9	189.2	*	73.6	0	*	*	*	550.8	492.5	504.9
Terrell	218.5	303.7	250.9	*	*	*	*	*	0	364.4	517.8	384.9
Toombs	238.6	250.6	264.9	*	*	*	16.2	11	*	430.5	522.4	398.9
Towns	198.5	163.8	262.4	*	*	*	0	*	0	248.7	352.4	202.7
Treutlen	179.5	171.1	213.7	*	*	*	*	0	*	616.4	529.6	372.4
Turner	126.4	239	168.8	*	62.7	*	0	*	*	485.4	447.3	407.2
Twiggs	158.8	226.1	141.6	*	0	*	*	*	*	353.1	421.4	419.1
Union	263.2	149.1	232.8	*	*	*	*	*	0	389.6	359.3	231.6
Upton	213.5	198.1	196.8	*	25.2	37.6	*	*	*	544.4	482.4	495.5
Warren	222.3	247.8	295.5	*	*	65.2	*	*	*	462	466.6	427.5
Washington	213.5	204	287.6	*	*	21.9	18.1	*	*	451.4	459.4	337.4
Wayne	238.3	193.2	194.3	*	*	*	*	*	19.7	446.8	450.4	408
Webster	340.2	404.8	*	0	*	0	0	0	0	349	537.9	306.3
Wheeler	169.3	147.5	159.9	*	106.3	*	*	0	*	307.2	474	356.1
White	195.9	176.2	172.8	*	24.2	24.8	*	*	*	359.2	391.5	247.1
Wilcox	236	238.4	177.4	*	*	*	*	*	0	354.4	398	373.5
Wilkes	152	237.3	162	44.7	68.7	*	*	*	*	402.3	303.8	358.3
Wilkinson	224	169.9	122.5	*	*	*	*	*	*	508.3	531	397.9
Worth	207.4	157	207	*	26.3	26.9	17.1	*	*	513.3	429.8	294.2
Rural*	218.3	205.3	203.8	19.7	23.5	27.3	11.9	9.8	9.4	447.6	428.9	348
Urban	211.3	199.5	182	19.1	23	21.7	9.8	7.9	7.7	400	380.9	295.8
Georgia	212.7	200.5	186.6	19.2	23.1	23	10.1	8.2	8	411.9	392.1	307.7

Source:

May 2007 Georgia Department of Human Resources, Division of Public Health, Office of Health Information and Policy

*Rural composite rate as calculated by the Georgia Division of Public Health does not include Liberty County

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Morbidity Rates

MORBIDITY RATES, ALL RURAL COUNTIES

	Cancer, all types		Diabetes		Infant conditions		Cardiovascular disease	
	1999	2005	1999	2005	1999	2005	1999	2005
Appling	271.3	345.3	138.5	217.2	28.9	94.7	1,766.40	1,804.60
Atkinson	264	311.3	158.4	286.4	*	124.5	1,161.70	1,481.90
Bacon	417.8	260.1	288.5	356.5	69.6	57.8	1,780.60	1,917.30
Baker	220.1	192.6	*	*	*	0	1,271.70	1,131.40
Banks	249.3	317.7	128.2	193.1	*	*	1,731.10	1,607.00
Ben Hill	411.1	294.5	171.3	196.4	62.8	144.4	1,992.50	2,027.00
Berrien	273.5	281.3	167.8	227.4	68.4	59.9	1,945.80	1,741.70
Bleckley	362.9	263.6	138.3	230.6	51.8	82.4	2,099.70	2,158.00
Brantley	264.5	238.8	76.6	135.6	62.6	*	1,510.20	1,342.70
Brooks	317.5	281.7	152.6	287.9	*	42.9	1,978.10	1,659.80
Bryan	280.8	255.7	133.9	98.1	*	52.5	1,097.20	1,089.40
Burke	347.5	283.3	234.7	261.8	45.1	68.7	1,588.70	1,832.70
Butts	264.2	299.4	121.5	128.3	47.6	47.5	1,611.50	1,815.20
Calhoun	388.6	318.2	259.1	368.4	*	*	1,781.10	1,657.70
Candler	272.8	203.5	251.8	213.2	52.5	48.4	2,088.10	1,773.10
Charlton	195	166.8	87.7	120.5	*	0	818.9	519
Chattahoochee	88	74.9	33.8	68.1	40.6	*	257.1	292.9
Chattooga	298.1	319.9	139.1	135.5	23.8	*	2,233.90	1,844.20
Clay	149.4	*	149.4	0	149.4	*	866.4	431.8
Clinch	362.7	328.8	203.1	271.6	*	*	1,581.50	1,386.50
Cook	334.1	372.7	282.7	201.6	70.7	79.4	2,306.80	1,955.30
Crawford	226.4	225.3	88.9	108.7	*	*	1,342.10	1,809.80
Crisp	328.8	331.6	141.6	349.7	45.7	54.5	2,064.40	2,230.10
Dade	86.5	130.9	53.2	68.6	*	0	385.9	280.5
Dawson	302.6	228.1	78.9	91.2	39.5	30.4	1,374.70	1,368.40
Decatur	288.6	269.1	260.1	216.6	67.7	52.4	1,257.90	1,355.80

*No data available. Rates are per 100,000 population for cancer, diabetes, and cardiovascular disease and per 1,000 for infant conditions.

Morbidity Rates, General Population								
	Cancer, all types		Diabetes		Infant conditions		Cardiovascular disease	
	1999	2005	1999	2005	1999	2005	1999	2005
Dodge	282.1	296.3	240.3	260.5	52.2	46	2,351.20	2,171.20
Dooly	226.9	306.4	314.1	289.4	96	68.1	2,294.70	2,153.40
Early	89.4	149.3	170.6	132.7	89.4	*	755.4	870.9
Echols	253.3	258.6	*	*	0	117.6	956.9	822.9
Elbert	416.2	264.4	176.3	235.6	49	24	1,953.50	2,283.80
Emanuel	303	343.8	243.3	239.7	78	67.8	2,116.20	2,257.10
Evans	262.4	253.4	291.6	183.5	58.3	87.4	2,361.70	1,870.10
Fannin	354.9	287.8	138.9	132.5	25.7	*	2,113.90	1,813.90
Franklin	314.7	324.2	169.8	152.8	69.9	64.8	2,312.60	1,778.60
Gilmer	375.7	267.1	116.3	80.5	53.7	65.8	1,936.80	1,547.50
Glascock	273.2	221.8	*	184.8	0	0	2,029.70	2,181.10
Grady	331	331.1	161.2	167.6	46.7	69.5	1,251.70	1,132.20
Greene	373.3	414.2	309.9	216.7	*	38.2	1,500.10	1,637.70
Hancock	309.4	248.9	319.3	217.8	*	72.6	1,676.50	1,783.70
Haralson	288.5	352.9	166	123.5	83	52.9	1,885.30	1,919.70
Harris	222.4	277.2	115.5	86.4	29.9	25.2	1,137.60	1,238.30
Hart	342.8	299.6	180.2	174.7	35.2	29.1	2,017.20	1,651.70
Heard	353.9	299.7	149	158.6	*	*	1,508.80	1,524.80
Irwin	316.6	257.6	265.5	208.1	*	*	2,052.50	1,941.90
Jasper	357.9	273.8	143.2	106.5	116.3	53.2	1,574.70	1,627.70
Jeff Davis	349	359.2	182.4	221.7	134.8	38.2	1,887.50	1,918.50
Jefferson	403.6	277.7	305.6	307.2	28.8	35.4	1,781.80	2,174.20
Jenkins	246.8	217.7	270.3	320.8	82.3	0	2,173.90	1,924.60
Johnson	315.8	293.6	140.3	157.3	*	*	1,496.90	2,075.90
Jones	320	234.8	128	119.2	34.1	18.6	1,621.40	1,751.40
Lamar	333.5	366.3	128.3	164.9	*	*	1,776.40	1,990.50
Lanier	390.5	331	209.2	238.3	*	*	1,924.70	1,707.90

Morbidity Rates, General Population								
	Cancer, all types		Diabetes		Infant conditions		Cardiovascular disease	
	1999	2005	1999	2005	1999	2005	1999	2005
Lee	152	192.9	82.2	96.5	*	*	875.3	861.8
Liberty	129.1	192.9	71	100.8	67.8	71.2	579.2	745.5
Lincoln	336.8	341.2	144.4	207.1	*	0	2,273.50	2,120.10
Long	59.4	261.7	89	126.3	49.5	*	840.9	739.9
Lumpkin	326.1	308.3	102.2	90.4	*	28.8	1,547.70	1,471.80
Macon	221	276.5	206.7	320.1	42.8	*	1,995.90	2,102.60
Madison	300	249.2	130.3	205.2	39.5	44	1,953.90	1,601.40
Marion	185.2	276.1	114	151.8	99.7	82.8	925.9	1,132.00
McDuffie	339.4	280.6	155.6	188.6	33	32.2	1,734.90	1,683.30
McIntosh	338.8	352.4	131.8	162.6	84.7	*	1,515.30	1,508.90
Meriwether	360	240	208.9	174.5	*	56.7	1,662.10	1,788.90
Miller	296.9	433.5	171.9	208.7	*	*	1,390.80	1,685.90
Mitchell	300.7	357.3	144	100.9	55	67.3	1,274.60	1,492.20
Monroe	420	378.4	177.3	176.6	23.3	*	1,334.60	1,778.40
Montgomery	243.5	235.7	158.2	134.7	73	*	1,448.60	1,717.40
Morgan	366.6	343	150.6	120.1	52.4	40	1,505.80	1,429.20
Oconee	347.2	248.8	109.2	74	27.3	*	1,248.20	1,116.00
Oglethorpe	471.1	220.4	162.4	147	*	44.1	1,705.70	1,543.10
Peach	351.2	278.3	184.2	104.9	21.4	44.4	1,867.40	1,710.10
Pickens	325.1	369.2	132.8	84.4	41.2	70.3	1,401.10	1,715.80
Pierce	363.9	227.8	156	169.4	*	*	1,897.70	1,606.40
Pike	353.1	241.8	97.7	105.4	60.1	49.6	1,547.50	1,506.70
Pulaski	380.6	328.6	296	246.5	*	51.4	2,421.20	2,434.00
Putnam	310.7	327.8	128.6	176.5	48.2	45.4	2,003.50	1,860.90
Quitman	*	202.7	*	202.7	*	0	858.4	324.3
Rabun	385.2	391.6	128.4	149.2	*	49.7	1,831.30	1,591.30
Randolph	345	383	230	301	115	68.4	1,597.00	1,641.60
Schley	485.7	291.1	161.9	*	0	0	1,861.80	1,649.70

Morbidity Rates, General Population								
	Cancer, all types		Diabetes		Infant conditions		Cardiovascular disease	
	1999	2005	1999	2005	1999	2005	1999	2005
Screven	439.2	343.5	177	259.2	124.5	32.4	2,156.50	1,827.60
Seminole	235.5	249.3	267.6	238.5	53.5	*	1,284.40	1,073.10
Stephens	423.4	315.2	158.3	231.4	83.1	127.7	2,188.40	2,198.70
Stewart	474.4	450.6	322.6	348.2	132.8	*	1,840.60	1,884.50
Sumter	297.4	355.5	233.6	221.8	115.3	51.7	1,650.60	1,382.50
Talbot	416.8	417.3	169.8	208.7	*	0	1,837.00	1,669.40
Taliaferro	634.1	328.6	*	328.6	*	*	1,951.20	2,793.00
Tattnall	331.1	301.6	204.1	206.8	68	51.7	1,551.10	1,663.00
Taylor	375.4	495.1	182	135	*	*	2,081.90	2,126.70
Telfair	417.1	348.4	246.9	265.1	76.6	*	3,362.60	2,809.50
Terrell	483.8	382.8	264.7	252.1	45.6	84	1,807.60	1,540.50
Toombs	369	363	196	146.7	57.7	80.7	1,725.90	1,891.90
Towns	558.3	368.4	87.6	155.1	*	*	2,638.20	2,074.60
Treutlen	358.1	222.1	74.6	222.1	*	*	1,805.40	2,428.60
Turner	422.8	369.4	243.1	73.9	*	73.9	1,553.90	1,741.60
Twiggs	237	378.7	142.2	155.4	*	*	1,431.60	2,000.20
Union	474.6	460	189.8	85.9	29.7	30.3	2,355.00	1,941.20
Upson	374.9	339.6	291.2	180.6	29.1	68.6	2,442.40	2,344.70
Warren	345.1	278.6	109.8	295	*	*	2,054.90	2,081.60
Washington	318.7	338	176	198.8	57.1	79.5	1,650.30	1,700.00
Wayne	349.3	348.7	193.6	221.9	79.7	45.8	2,057.70	2,078.20
Webster	337.8	218.4	*	*	*	*	1,478.00	1,266.90
Wheeler	343.6	134.2	163.6	238.6	*	74.6	2,258.20	1,774.50
White	352.3	282.7	124.3	83.1	*	29.1	1,999.70	1,754.30
Wilcox	446.3	298.1	234.9	172	94	80.3	2,137.40	2,132.80
Wilkes	438.9	286.9	242.8	200.8	56	*	2,138.60	2,562.90
Wilkinson	362.3	285.9	186.1	167.6	*	49.3	2,076.00	2,001.40

Morbidity Rates, General Population								
	Cancer, all types		Diabetes		Infant conditions		Cardiovascular disease	
	1999	2005	1999	2005	1999	2005	1999	2005
Worth	262.8	304.6	226.6	154.6	68	31.8	1,486.40	1,363.90
Rural	323.2	298.4	173.3	173.5	48	44.9	1,731.00	1,685.8
Urban	251	236.2	115	117.2	27.7	28.5	1,127.80	1,141.1
Georgia	265.2	247.8	126.5	127.7	31.7	31.5	1,246.40	1242.7

Source:

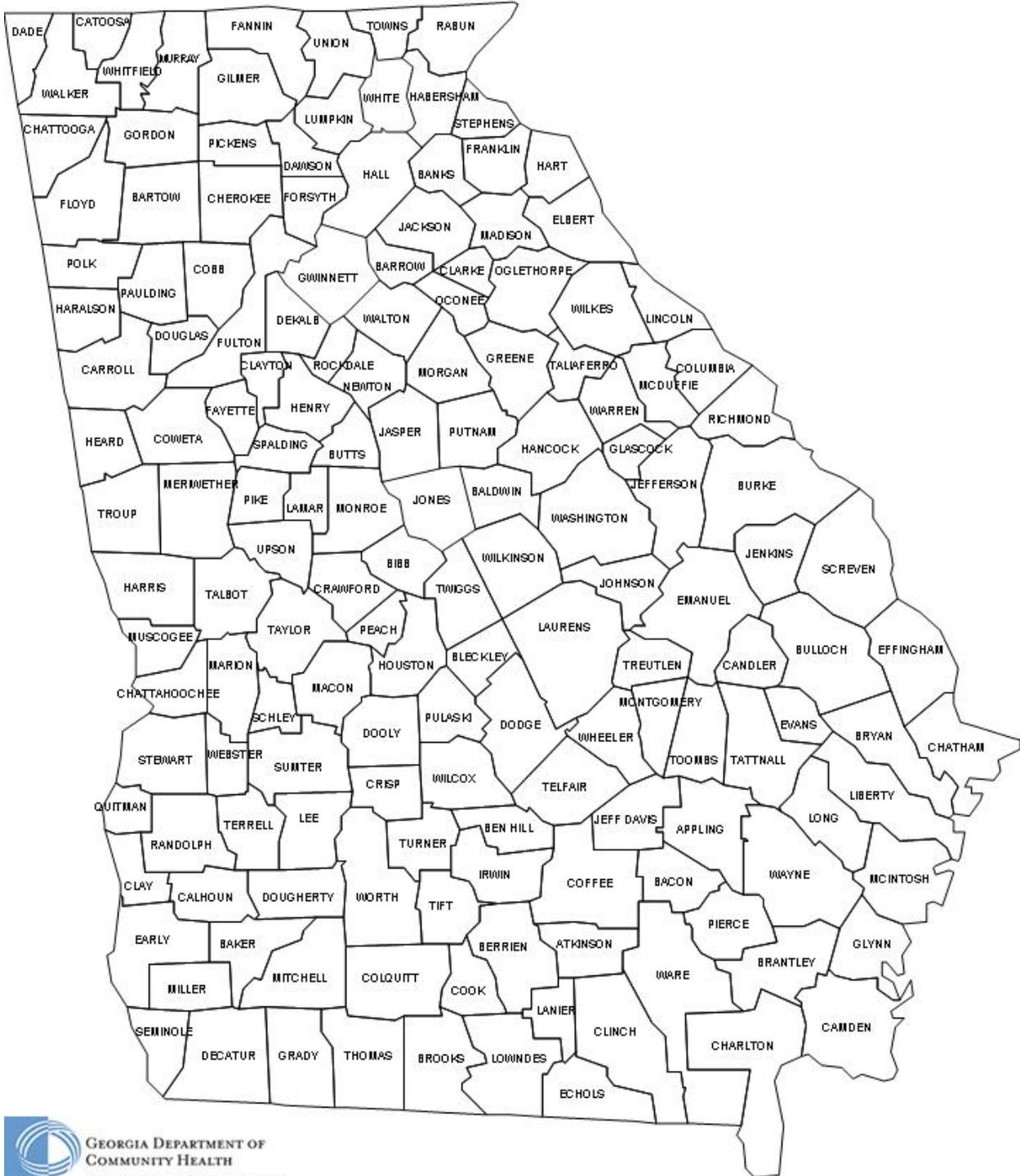
May 2007 Georgia Department of Human Resources, Division of Public Health, Office of Health Information and Policy

*Rural composite rate as calculated by the Georgia Division of Public Health does not include Liberty County.

Appendix D - Maps

Maps provided by the Georgia Department of Community Health are current as of March 2007. Please check the Georgia Department of Community Health Web site (<http://www.dch.Georgia.gov>) for updates.

State of Georgia



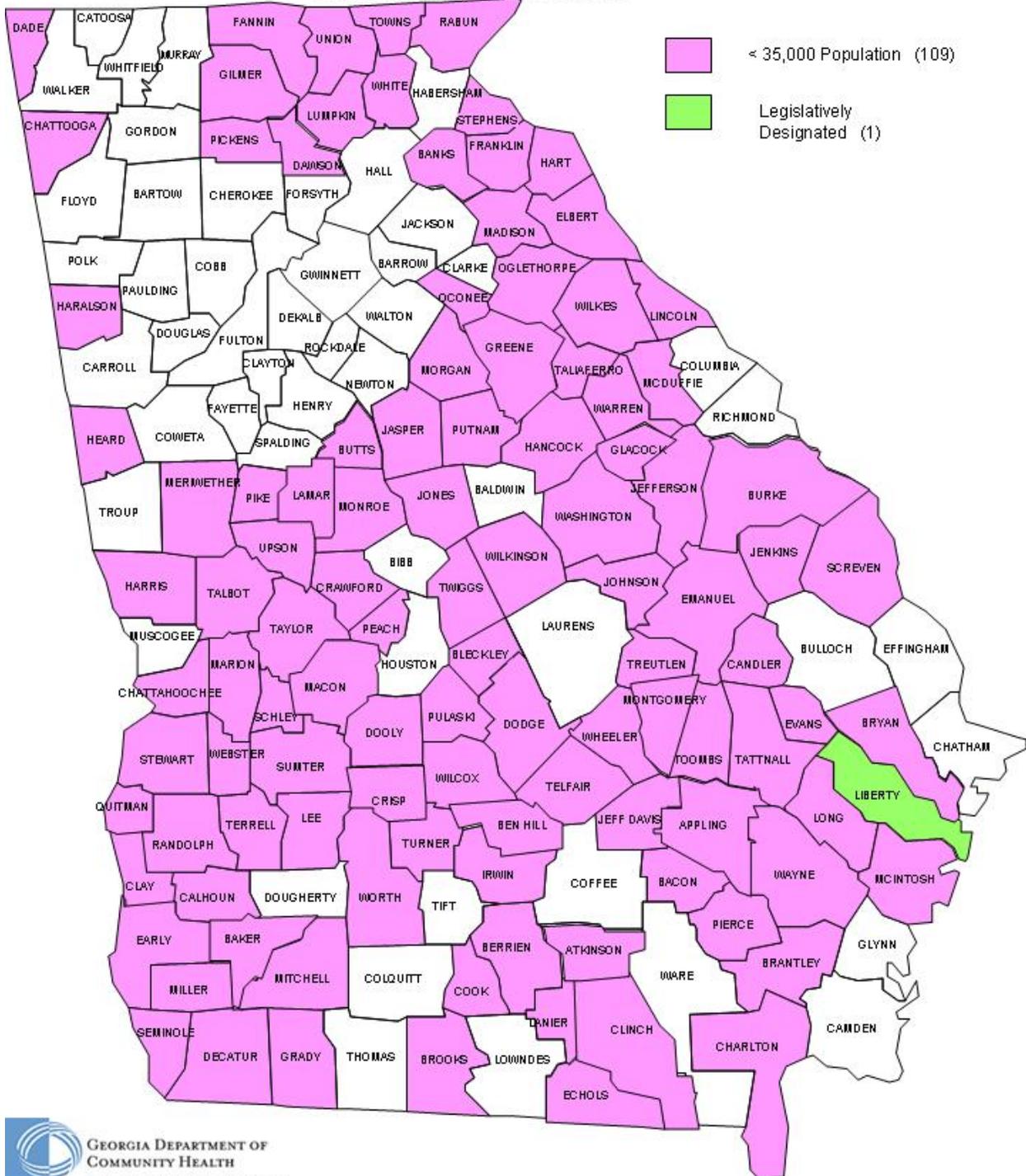
GEORGIA DEPARTMENT OF
COMMUNITY HEALTH

State Office of Rural Health

502 South 7th Street
Cordele, GA 31015
Ph: 229-401-3090

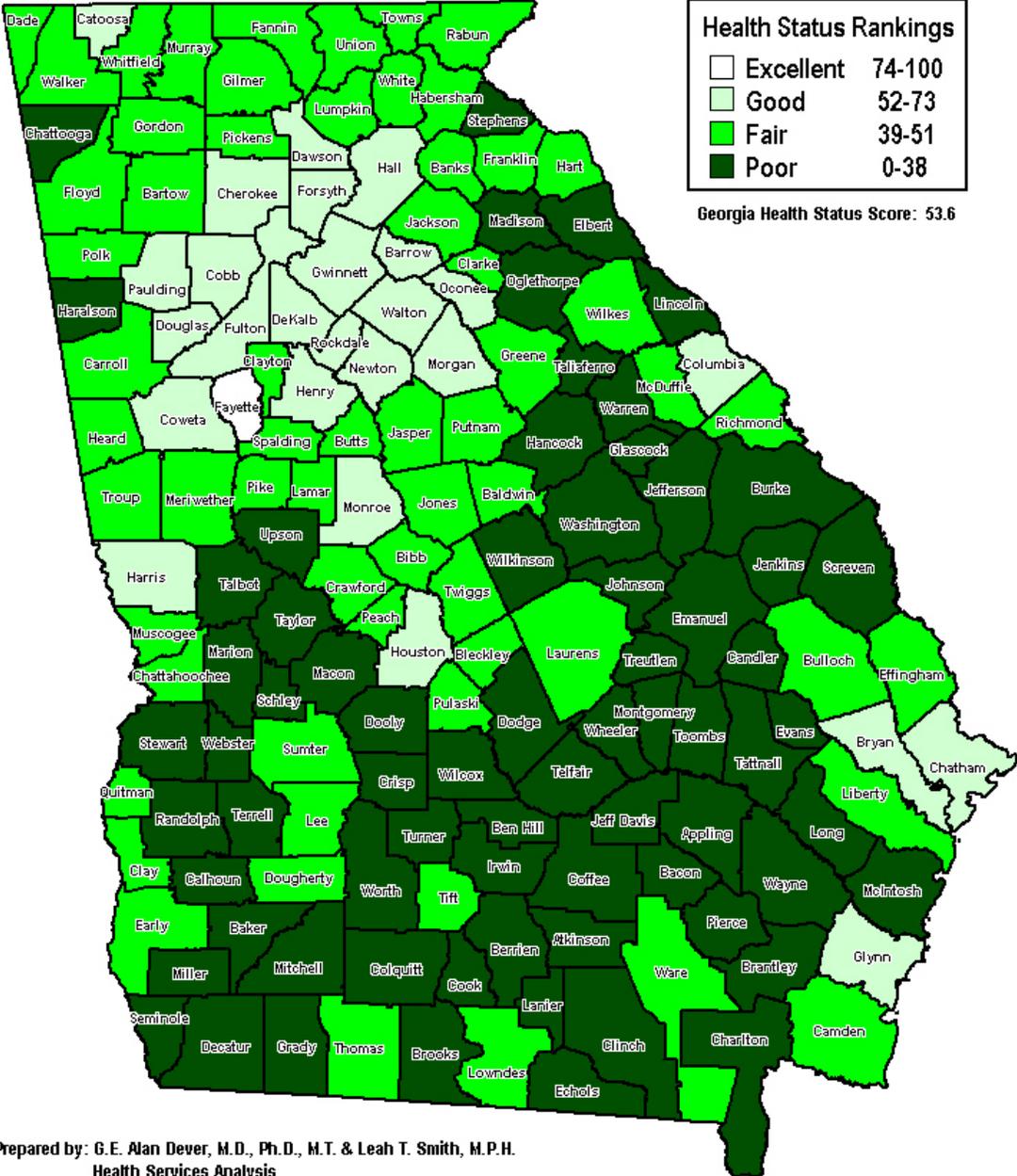
Source: <http://www.hrsa.gov> (Jan 2006)

Georgia Rural Counties = < 35,000 Population and Legislatively Designated



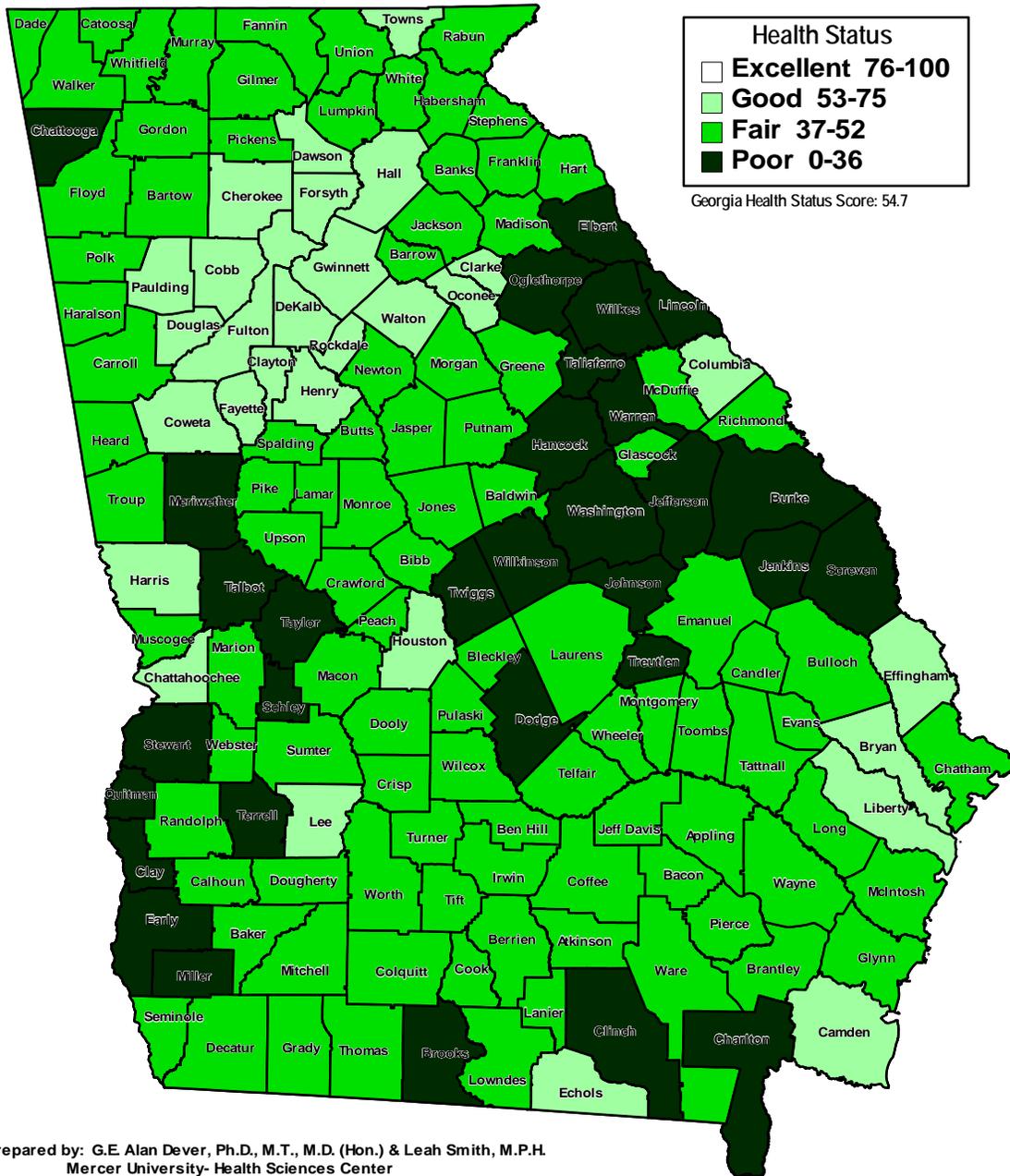
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June 2006

Health Status by County, Georgia 2006



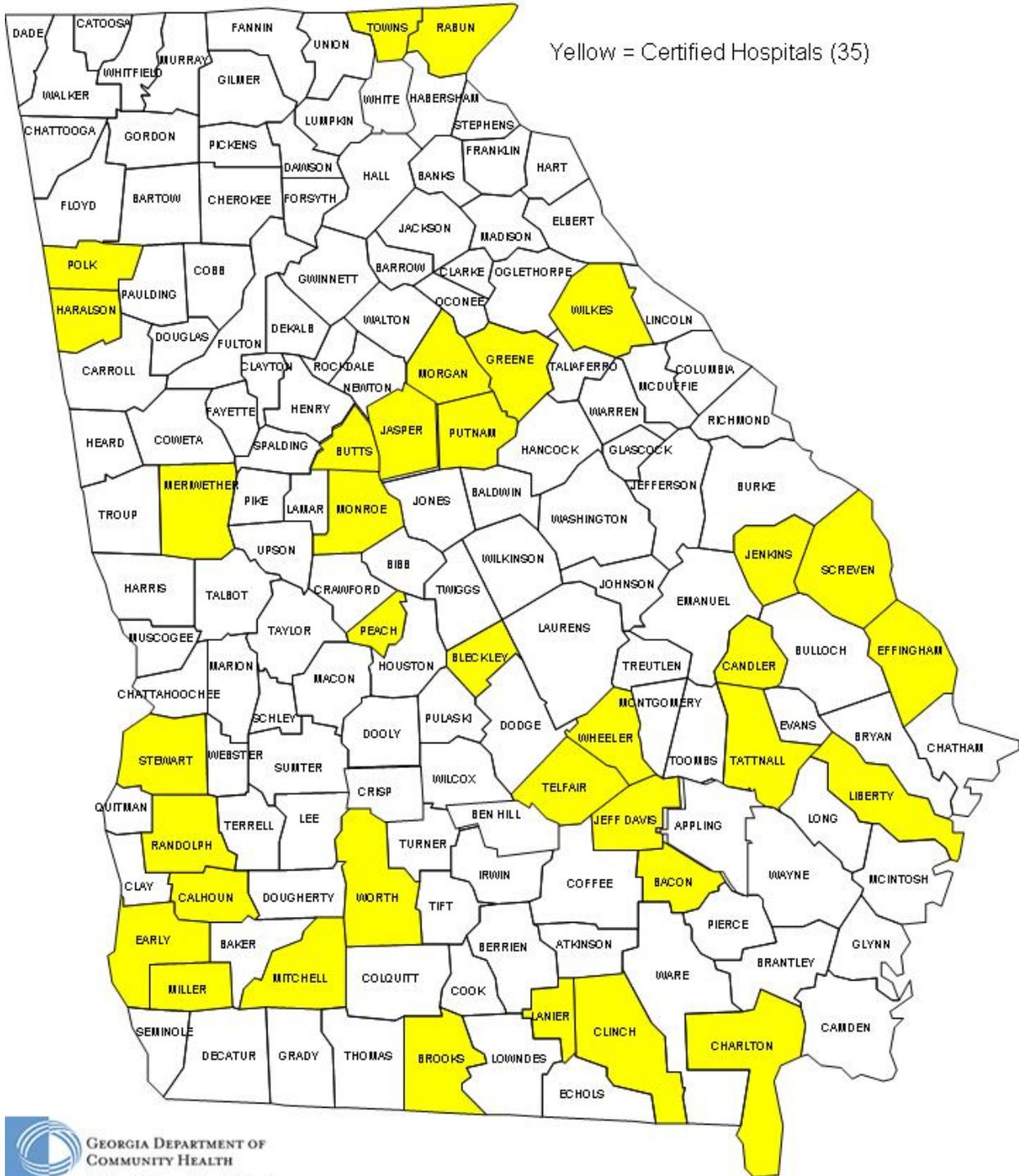
Prepared by: G.E. Alan Dever, M.D., Ph.D., M.T. & Leah T. Smith, M.P.H.
 Health Services Analysis
 Data Source: Claritas Inc. & Thomson Medstat, 2006

Health Status by County, Georgia, 2003



Prepared by: G.E. Alan Dever, Ph.D., M.T., M.D. (Hon.) & Leah Smith, M.P.H.
 Mercer University- Health Sciences Center
 Data Source: Inforum, 2004

State of Georgia Hospitals Certified for Critical Access Designation

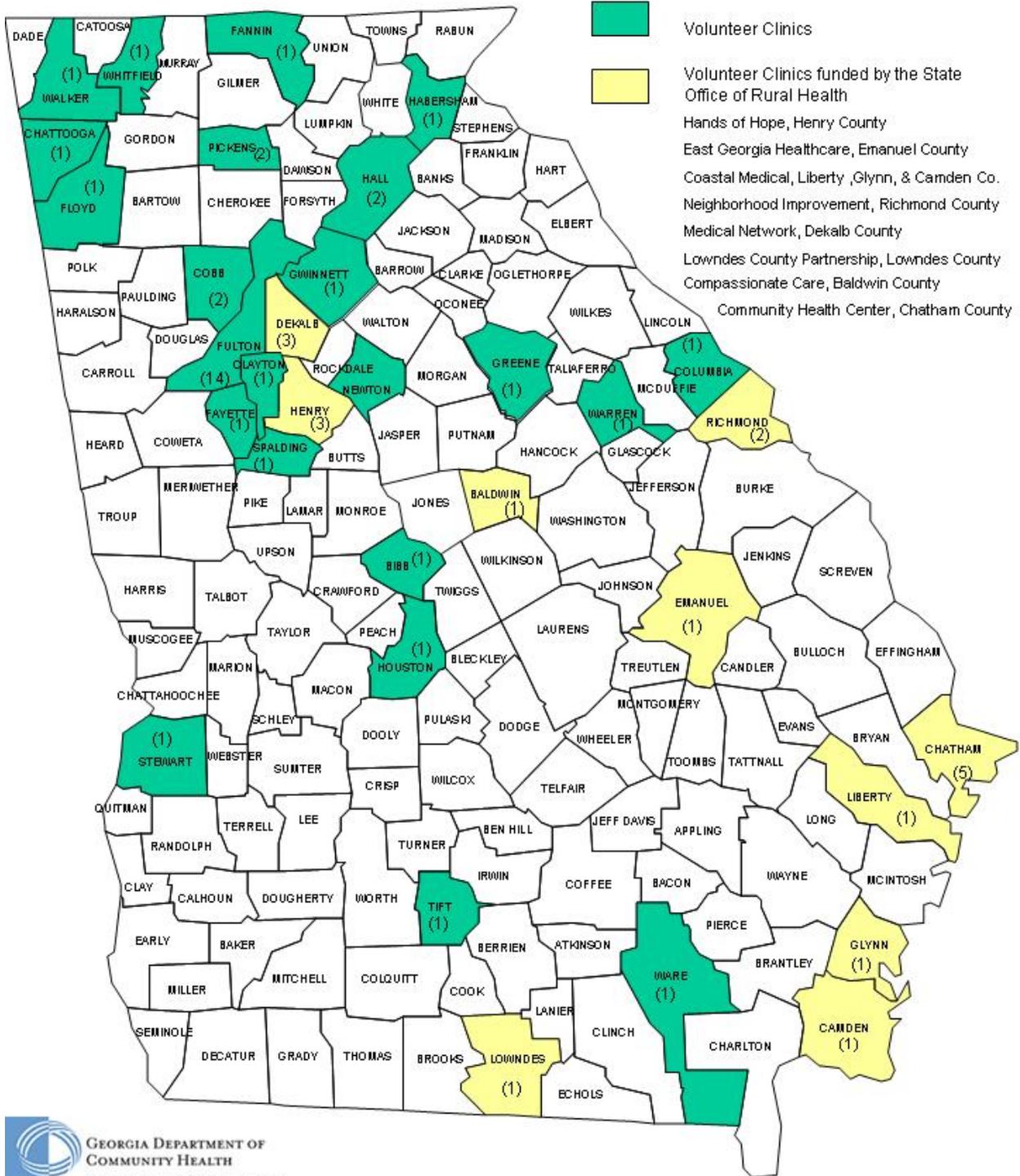


**GEORGIA DEPARTMENT OF
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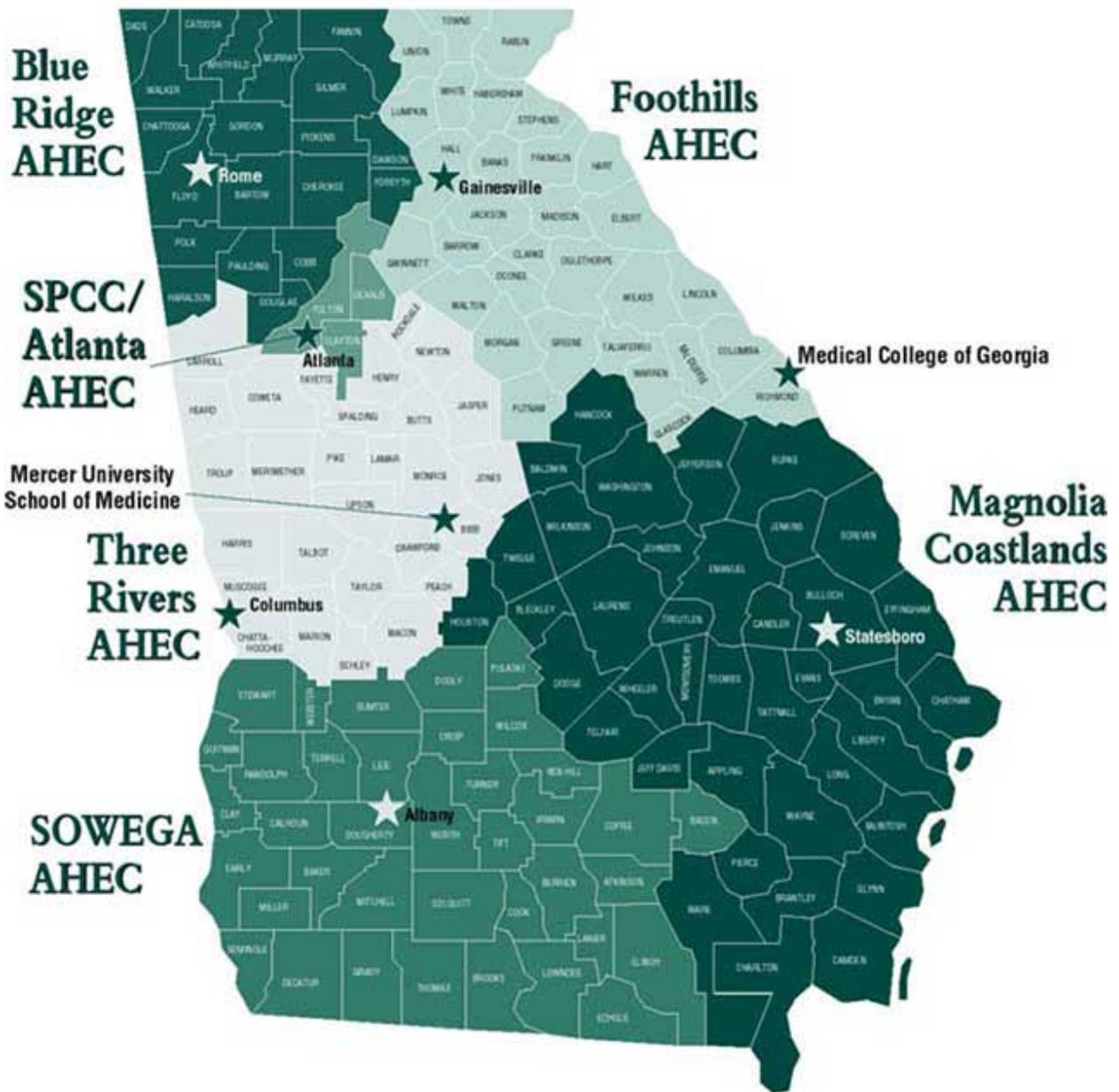
State Office of Rural Health

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Updated March 2007

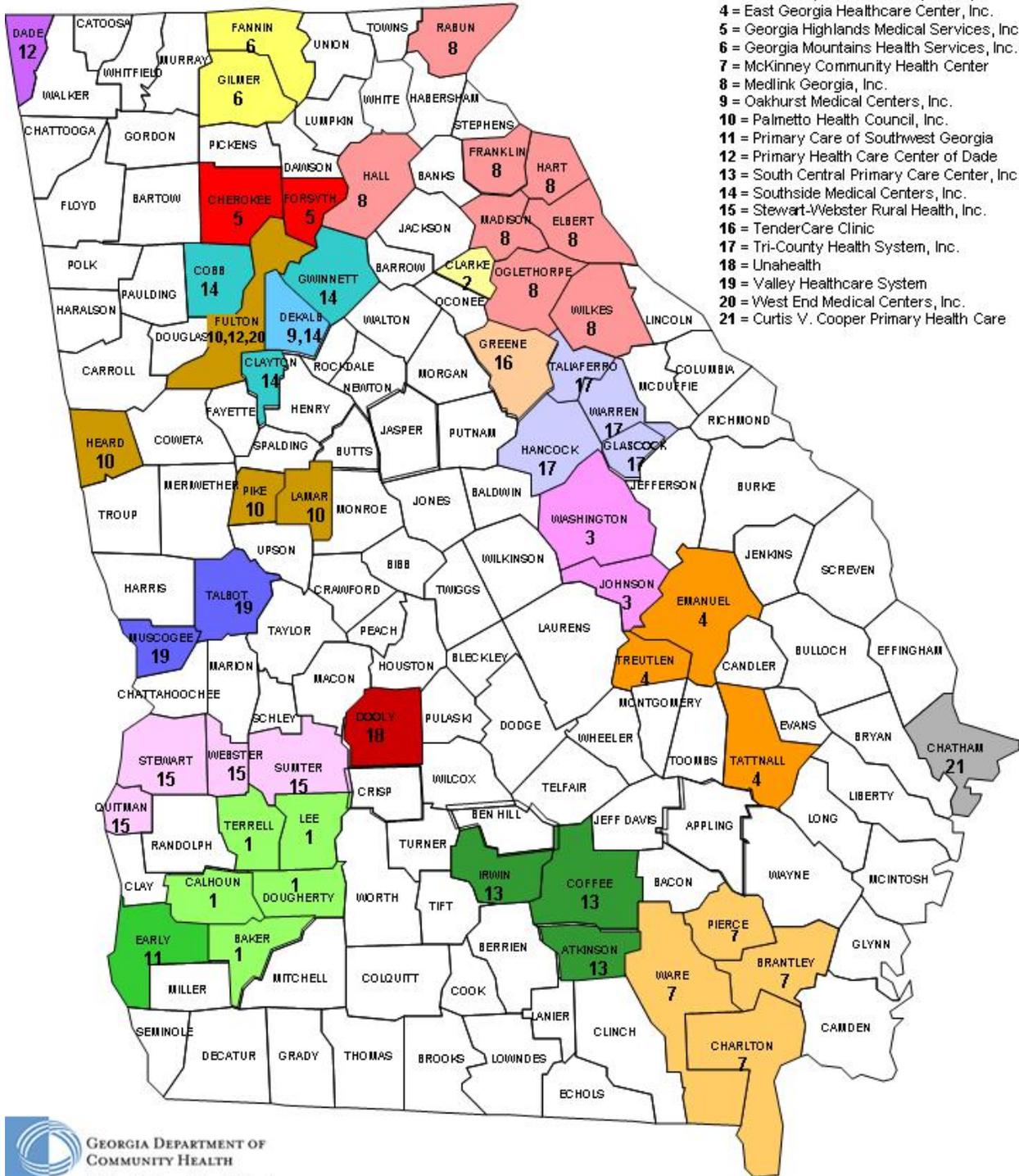
GEORGIA'S VOLUNTEER CLINICS



 **GEORGIA DEPARTMENT OF COMMUNITY HEALTH**
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 Ph: 229-401-3090
 Source: <http://www.hrsa.gov> (March 2007)



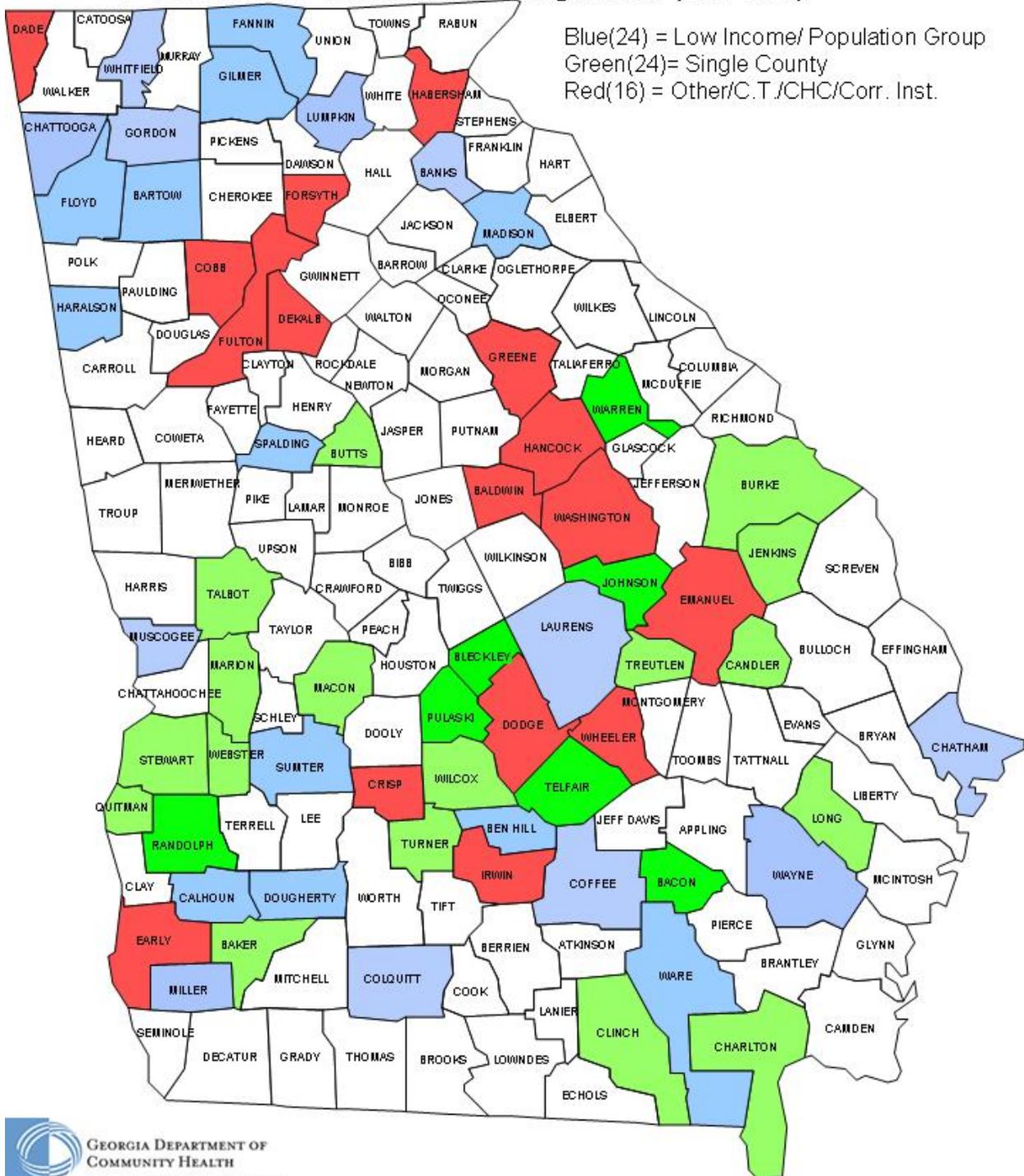
State of Georgia Community Health Center Sites



- 1 = Albany Area Primary Health Care, Inc.
- 2 = Athens Neighborhood Health Center
- 3 = Community Health Care Systems, Inc.
- 4 = East Georgia Healthcare Center, Inc.
- 5 = Georgia Highlands Medical Services, Inc.
- 6 = Georgia Mountains Health Services, Inc.
- 7 = McKinney Community Health Center
- 8 = Medlink Georgia, Inc.
- 9 = Oakhurst Medical Centers, Inc.
- 10 = Palmetto Health Council, Inc.
- 11 = Primary Care of Southwest Georgia
- 12 = Primary Health Care Center of Dade
- 13 = South Central Primary Care Center, Inc.
- 14 = Southside Medical Centers, Inc.
- 15 = Stewart-Webster Rural Health, Inc.
- 16 = TenderCare Clinic
- 17 = Tri-County Health System, Inc.
- 18 = Unahealth
- 19 = Valley Healthcare System
- 20 = West End Medical Centers, Inc.
- 21 = Curtis V. Cooper Primary Health Care

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January 2007

State of Georgia Dental Health Professional Shortage Areas (DHPSA's)



Blue(24) = Low Income/ Population Group
 Green(24)= Single County
 Red(16) = Other/C.T./CHC/Corr. Inst.



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State Office of Rural Health

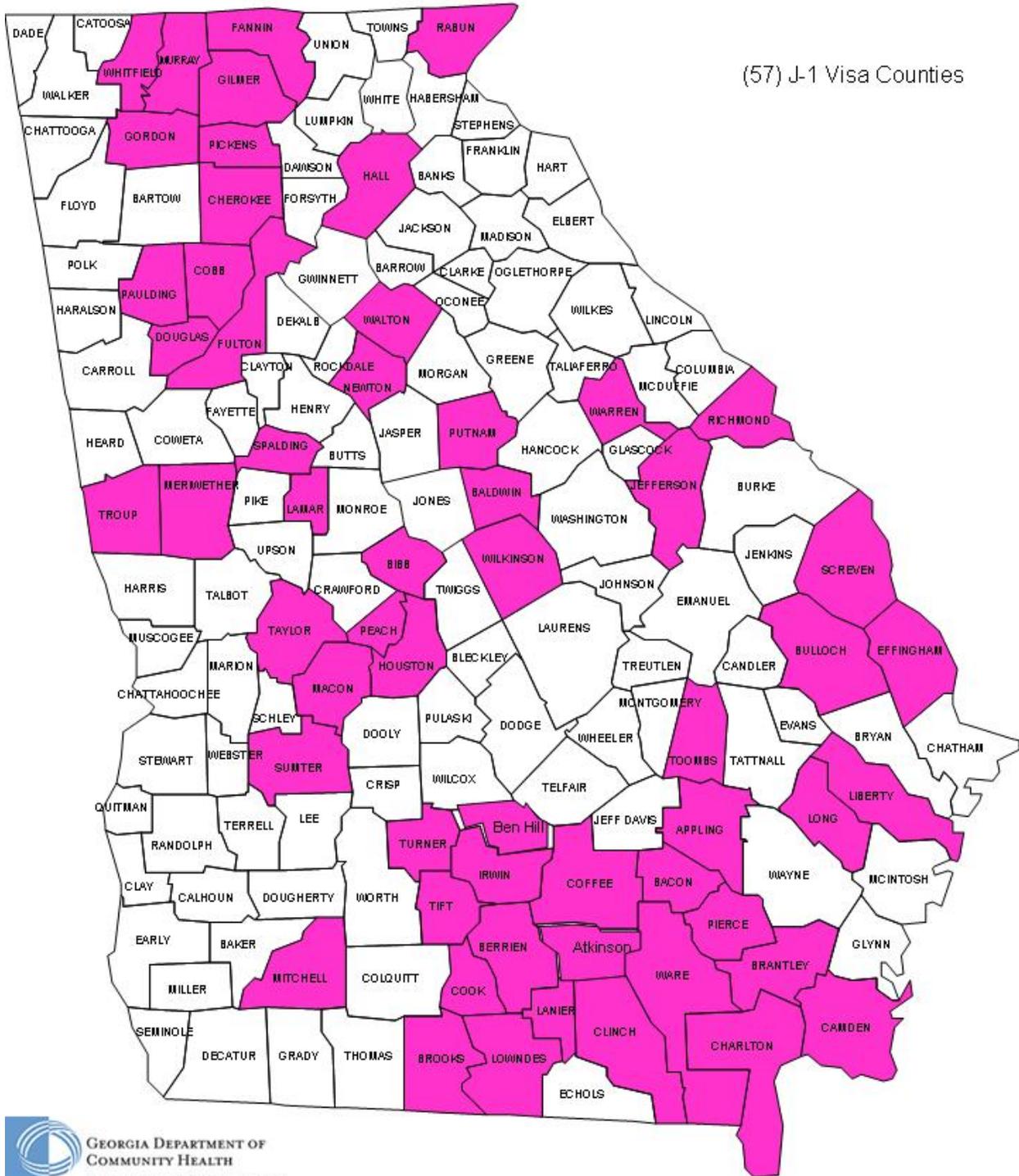
502 South 7th Street

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Ph: 229-401-3090

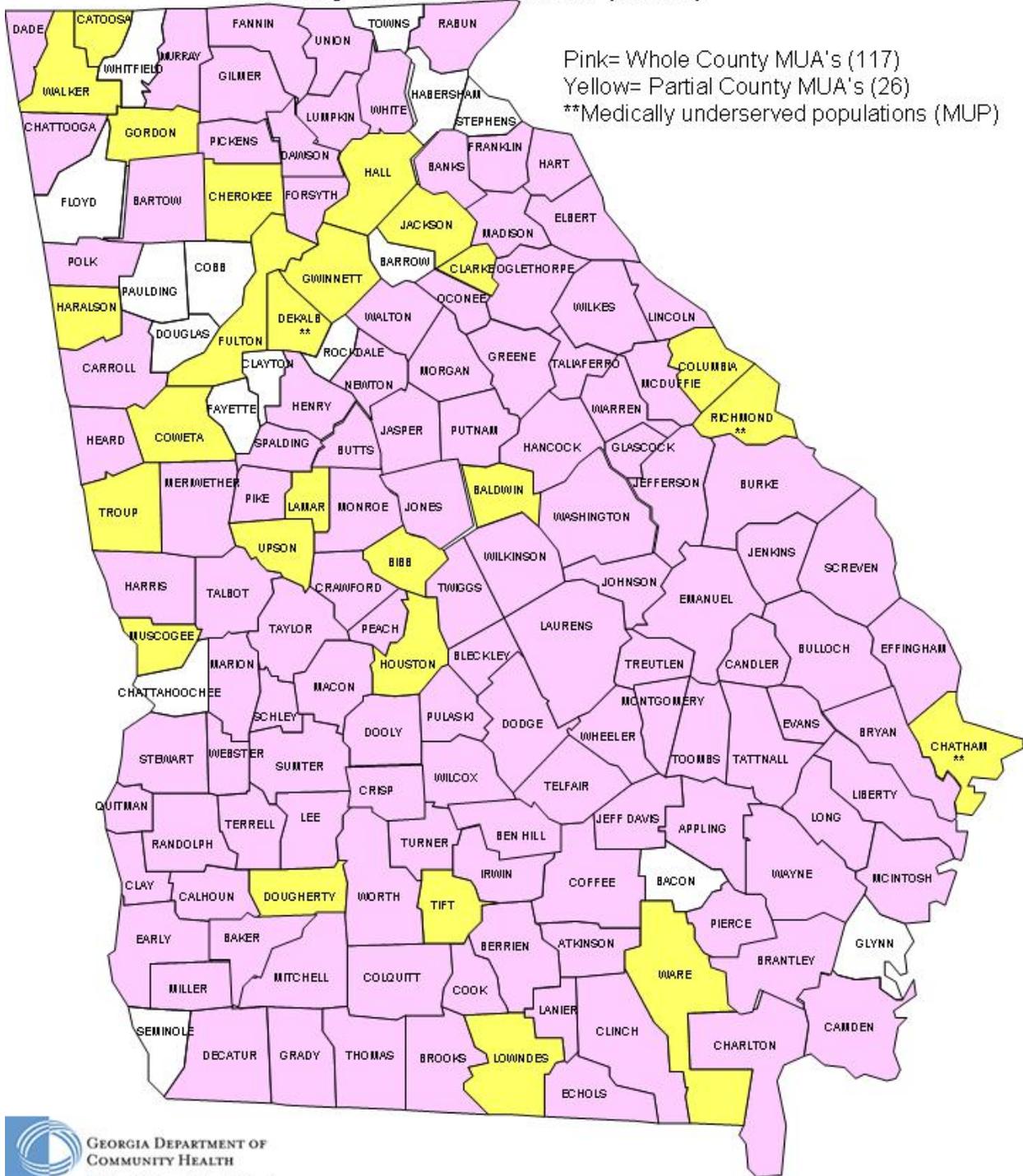
Source: <http://www.hrsa.gov> (March 2007)

Georgia Counties with J-1 Visa Physicians



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J-1 Visa Waiver Program (Nov. 2006)

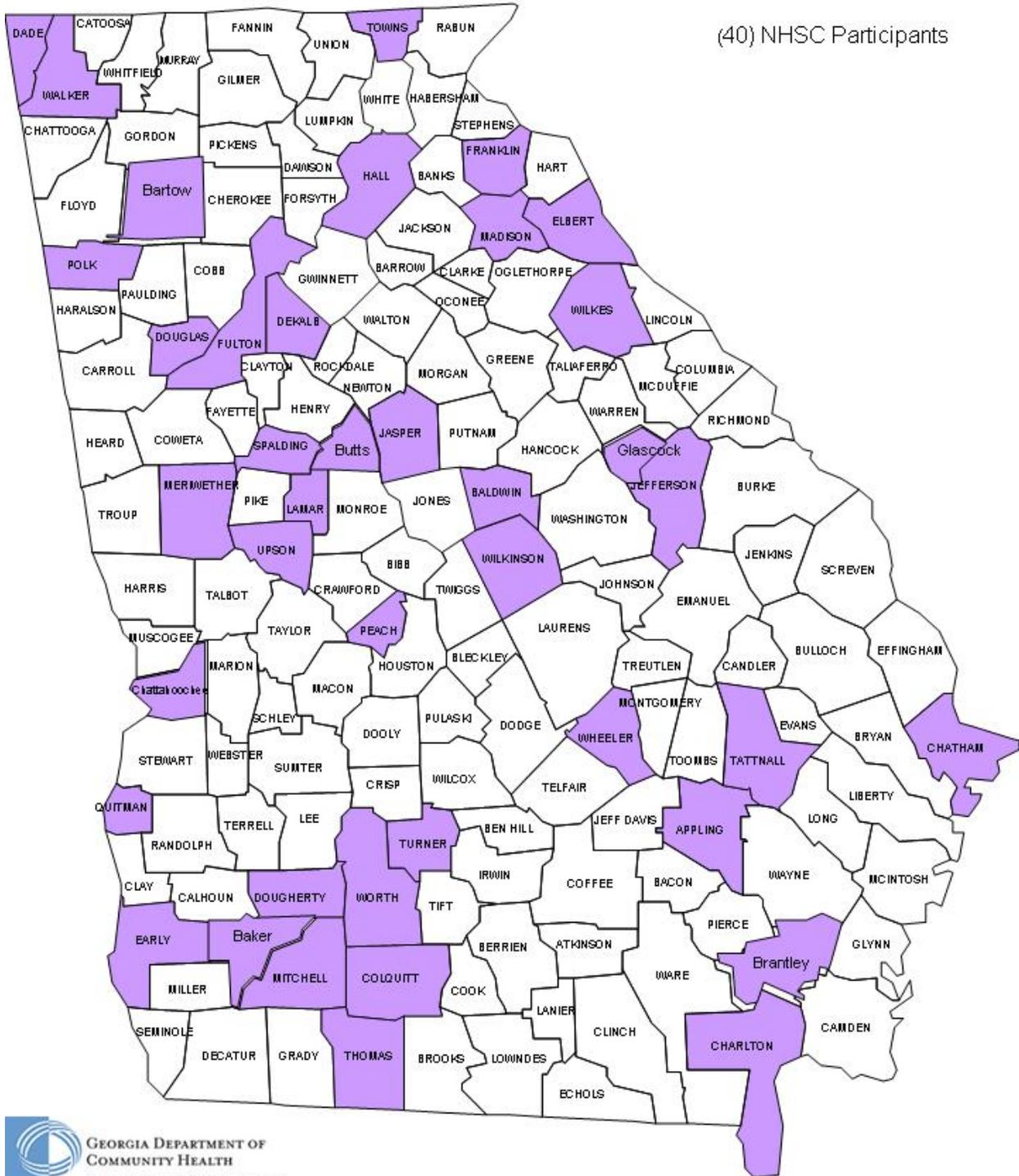
State of Georgia Medically Underserved Areas (MUA's)



Pink= Whole County MUA's (117)
 Yellow= Partial County MUA's (26)
 **Medically underserved populations (MUP)

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 Source: <http://www.hrsa.gov> (Jan 2007)

Georgia Counties with NHSC Participants



GEORGIA DEPARTMENT OF
COMMUNITY HEALTH

State Office of Rural Health

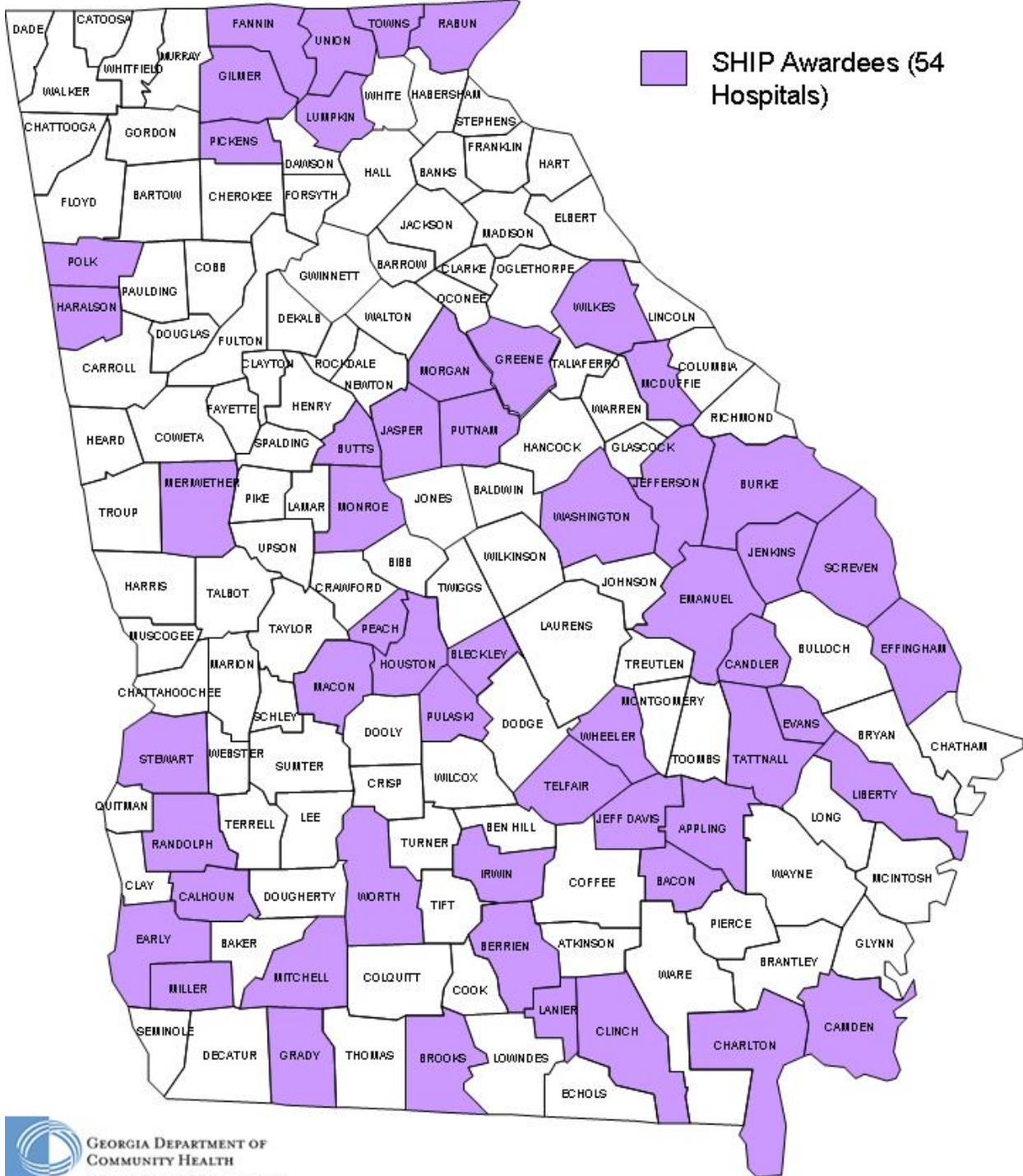
502 South 7th Street

Cordele, GA 31015

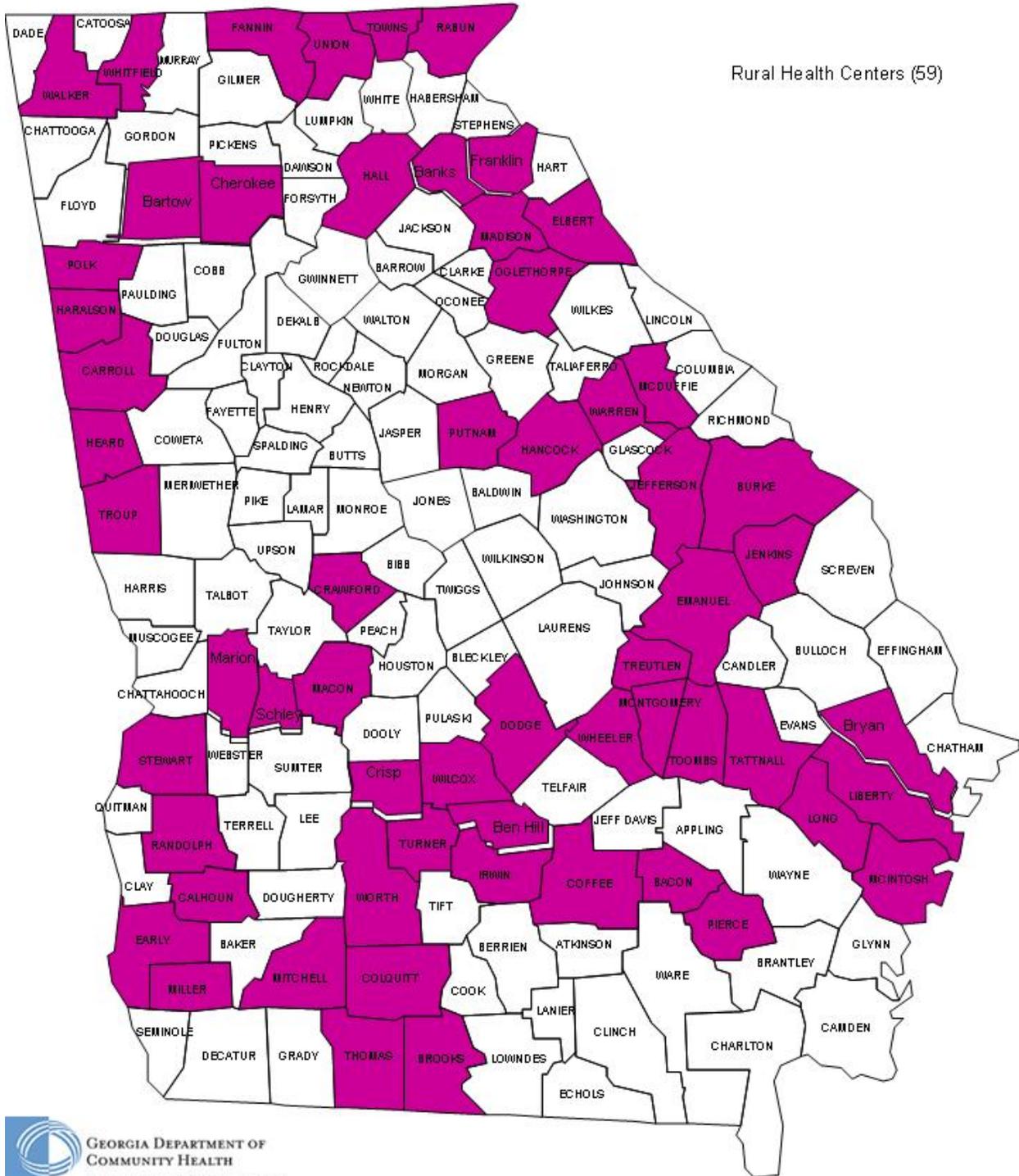
Ph: 229-401-3090

Updated 11/14/06

Small Rural Hospital Improvement Grant Program (SHIP) Awardees



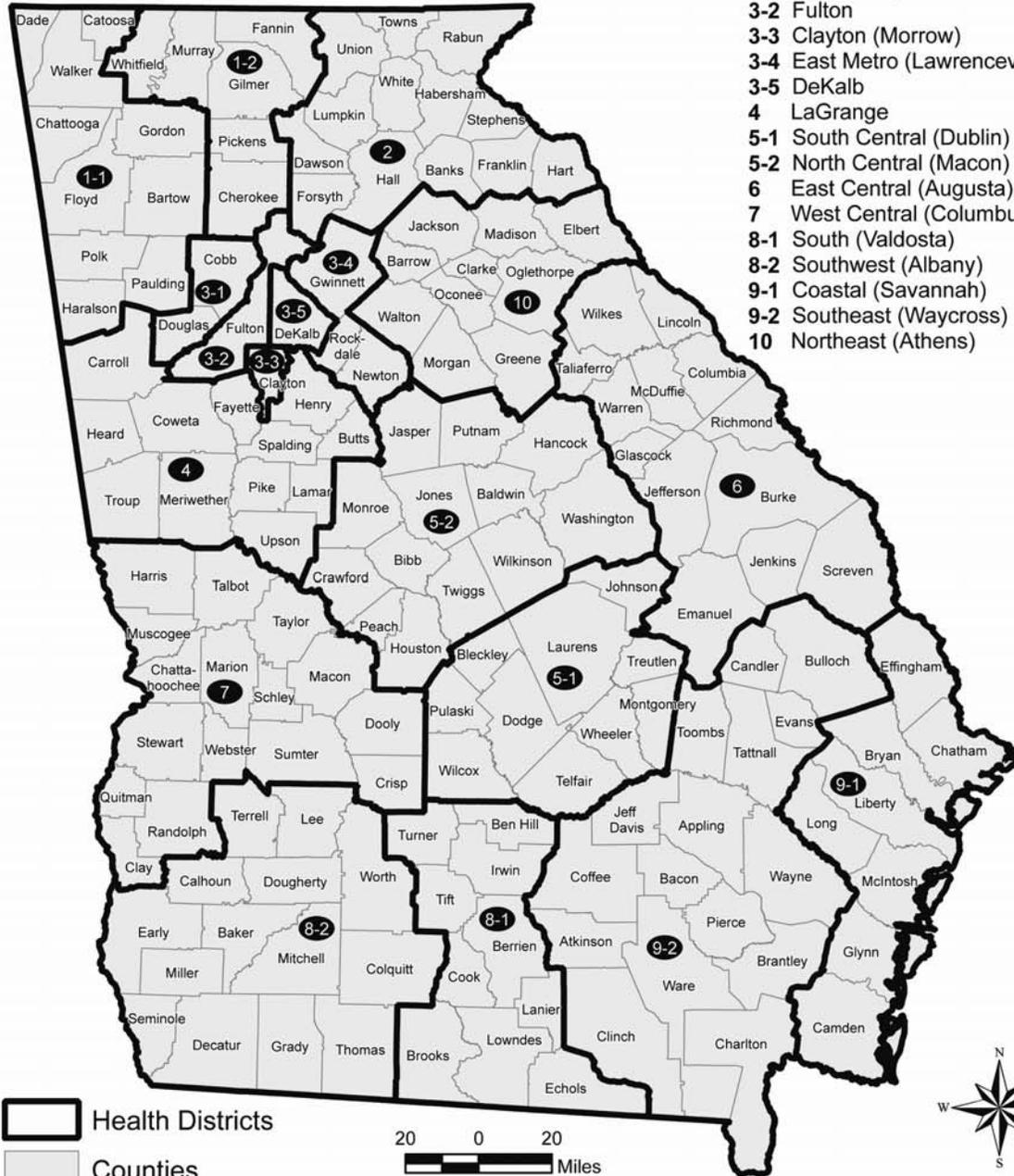
Rural Health Centers



 **GEORGIA DEPARTMENT OF
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March 2007

GEORGIA Public Health Districts

- 1-1 Northwest (Rome)
- 1-2 North Georgia (Dalton)
- 2 North (Gainesville)
- 3-1 Cobb-Douglas
- 3-2 Fulton
- 3-3 Clayton (Morrow)
- 3-4 East Metro (Lawrenceville)
- 3-5 DeKalb
- 4 LaGrange
- 5-1 South Central (Dublin)
- 5-2 North Central (Macon)
- 6 East Central (Augusta)
- 7 West Central (Columbus)
- 8-1 South (Valdosta)
- 8-2 Southwest (Albany)
- 9-1 Coastal (Savannah)
- 9-2 Southeast (Waycross)
- 10 Northeast (Athens)




 Georgia Department of Human Resources
 Division of Public Health
 Office of Health Information & Policy

Created: March 2005
 Source: Division of Public Health
 Projection: Georgia Statewide
 Lambert Conformal Conic