RURAL HEALTH NEWS

Tracking Changes in Rural Health Care

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Fall, 2000

Disabilities Don't Stop Farmers

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What happens to the older farmer with arthritis who can no longer climb into his tractor? Or to the younger farmer with a hand injury who cannot grip a tool? AgrAbility, a joint project of Pennsylvania State University and Easter Seals Central Pennsylvania offers help. Its staff visits farmers with disabilities at no charge, analyzes their problems, recommends equipment modifications, and helps them find funding for adaptive equipment.

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Richard Maurer, Perry County, Pennsylvania uses a new track system in his dairy operation. It makes it easier for him to move the milking unit between cows, and it is equipped with automatic take-off units.

A Question for Rural Community Leaders: How Good Is Your Health Care Safety Net?

By Pat Taylor, Ph.D.

Last summer, I was one of a small group of researchers who took a first look at the health care safety net in rural towns. I came away from this study fearing that community leaders in many rural towns may know almost nothing about the medically needy or the impact of their dilemma on their town's health care providers.

This is not to suggest that community leaders are indifferent to the needs of people in their communities. The medically needy can be a surprisingly invisible population, including some of the insured as well as the uninsured. And community leaders may subscribe to the commonly held but erroneous assumption that the uninsured can get free or charity care if they need it.

Even if you get answers to the questions I pose below, you are likely to face a tough challenge — finding ways your community can improve health care for the inadequately insured and improve support for the physicians and facilities that care for them.

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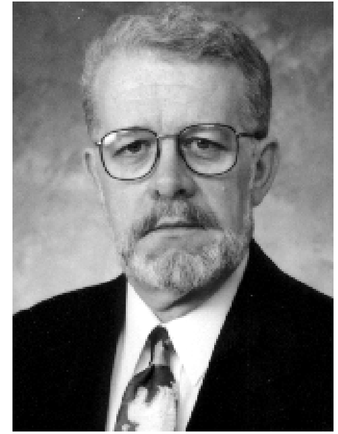
Texas Puts Tobacco Dollars into Rural Health Care

By Sam Tessen

State settlements with tobacco companies have generated widespread interest and discussion across the country. Much of this discussion has centered on how the dollars should be used, with many people contending that they be used for health related purposes. Texas has gone a step further with an innovative approach in our tobacco settlement decisions. We have allocated a significant portion of our settlement dollars to improvements in rural hospitals.



Sam Tessen

Texas was one of the original states that negotiated individual settlements with the tobacco companies. Our settlement established two payment tracks - the bulk of the money going to the State of Texas, and in a later development, an additional settlement going to individual counties.

The part of the settlement (over $4.5 million) that went to the counties was directed to our 115 legislatively authorized county hospital districts - all of which are rural. Elected hospital district board members determine how to use the dollars.

The state portion ($475 million) was the subject of legislation in the 1999 session of the Texas Legislature. The result was HB 1676, a comprehensive approach to health care improvement with a long-term consideration. The bill was passed, signed by the Governor, and went into effect January 2000.

The legislation created five permanent tobacco endowments, each created for specific target populations. It mandates that the interest and earnings from the endowments be spent on programs for the targeted populations.

- The Permanent Fund for Tobacco Education and Enforcement ($200 million).
- The Permanent Fund for Children and Public Health ($100 million)
- The Permanent Fund for Emergency Medical Services and Trauma Care ($100 million).
- The Community Hospital Capital Improvement Fund ($25 million)
- The Permanent Fund for Rural Health Facility Capital Improvement ($50 million)

The Texas Department of Health has developed a series of grant programs for the first four endowments focusing on services for children and adolescents and support for innovative programs and services by local entities, including rural communities.

The Texas Center for Rural Health Initiatives, serving as the Texas State Office of Rural Health, was awarded the Permanent Fund for Rural Health Facility Capital Improvement, targeted to rural public or non-profit hospitals in counties with populations of 150,000 or less.

This program provides funds for rural hospitals with aging physical plants and needs for capital and information services equipment. This year, the program awarded grants to 32 rural hospitals, totaling $2,179,041 for projects such as roof repairs, telemetry systems, ambulance purchases, and mammography units.

This dollar distribution by the legislature results in substantial increases in resources for the targeted programs with both immediate and long term effects. Interest and earnings based on investment for the first year come to approximately $5 million per $100 million endowment. Collectively, these permanent endowments offer new dollars for innovative ideas to serve a wide variety of populations and needs. The beneficiaries will be the citizens of the State of Texas and their health delivery systems.

Sam Tessen is the executive director of the Center for Rural Health Initiatives, the Texas State Office of Rural Health.

A Question for Rural Community Leaders:
How Good Is Your Health Care Safety Net?

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How many people in your community are medically needy?

Based on national and state information, it is very likely that at least ten percent of the people in your town have no health insurance, possibly as many as 20 percent. An equal number may be underinsured, lacking the coverage necessary to both meet medical needs and also pay for food, housing, and other essentials.

In North Carolina, we heard about minimum wage employees with employer insurance that had an annual deductible of $500 for each family member. We met a rural Mainer whose family policy cost $3,360 a year with a deductible of $5,000.

Where do inadequately insured people get health care?

In some rural towns, some or all physicians may see patients regardless of their ability to pay. In other towns, the physicians may see few or no needy patients. Even when physicians see all who come, they can't provide needed tests or prescription drugs except for a few samples. If patients can't afford these, they just don't get them. If your town has a hospital, its emergency room probably provides some care to everyone who comes. But hospital ERs cannot afford to provide primary care, prescription drugs, follow-up tests, specialty consults, or care for chronic conditions for which they will be paid little or nothing. Inpatient care, too, will be limited to that which is most essential, and it depends on physicians' willingness to provide it. In short, when the inadequately insured get care, it may be second-class care. Only 21 percent (496) of the nation's 2,274 rural counties have community clinics which receive federal subsidies for charity care.

Can people with inadequate insurance pay their medical bills?

The medically indigent often delay seeking care until they are really sick because they worry about being able to pay the bills. Most physician practices and hospitals bill all patients at their full fee schedule rate, and some use collection agencies to go after people who haven't paid their bills.

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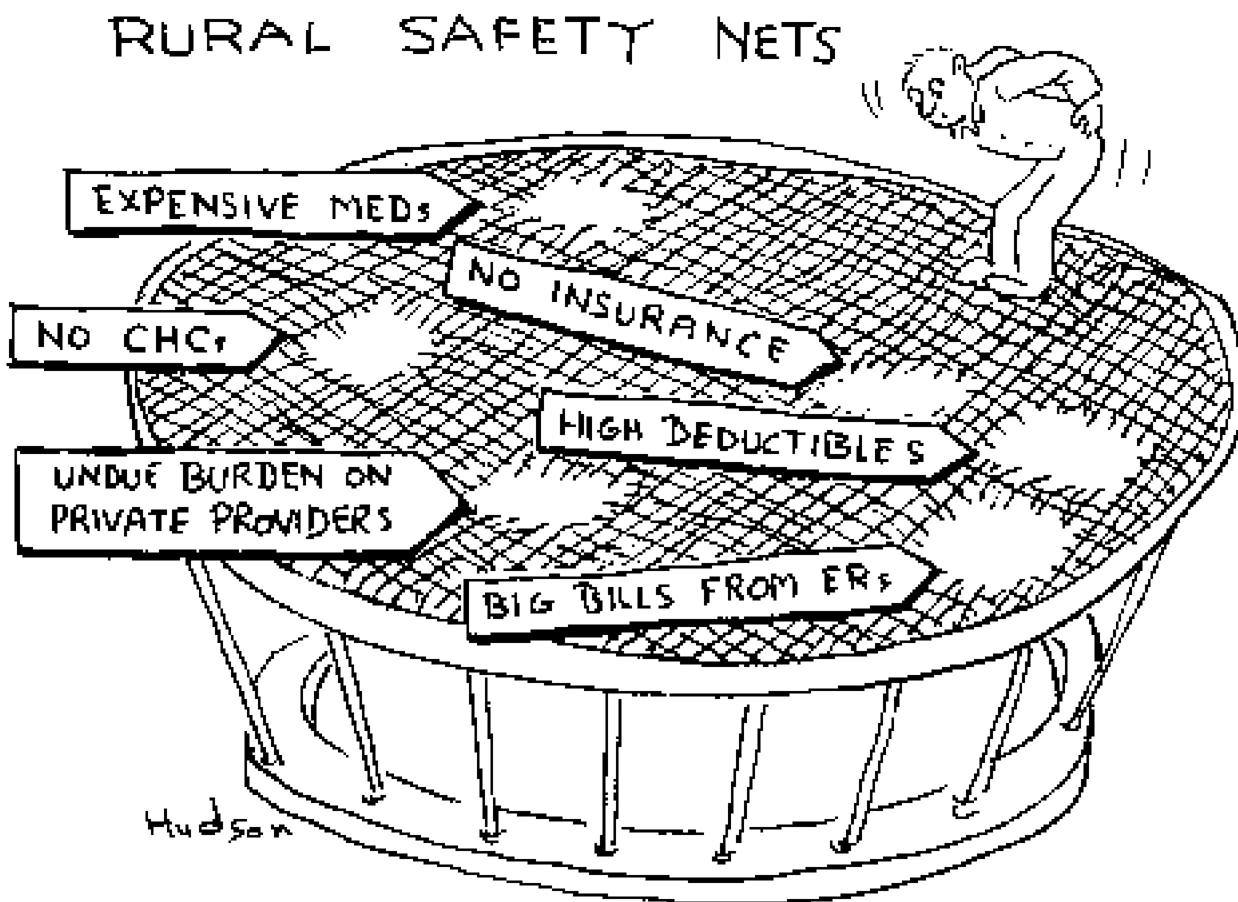

A Question for Rural Community Leaders:
How Good Is Your Health Care Safety Net?

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An uninsured person in a small Idaho town told us, "*Our problem isn't not getting the care we need, it's being unable to pay the bill afterwards.*" In 1995, a Harvard University national survey showed that 60 percent of people without insurance had not been able to pay medical bills and/or had been contacted by a collection agency for medical bills in the past year.

Low income adults who have health insurance have the same problems. A 1999 Commonwealth Fund survey showed that 45 percent of insured individuals earning less than $20,000 a year had problems in paying medical bills and prescription drug and other health care costs in the past year. Thirty-one percent had been contacted by a collection agency about medical bills.

How are your community's physicians and hospitals coping with the financial burden of providing care to those not able to pay for it?

One Idaho physician reported that in the week before we interviewed him 25 percent of his patients were uninsured, some of whom would not be able to pay their bills. The large drain by charity care on practice revenues could be a powerful disincentive to physicians to continue practicing in your town. It may make it extremely difficult to replace retiring physicians. In Texas, where one third of all rural physicians are 55 or older, the state medical association estimates that 10 -15 percent of the care provided by their members is charity care. Large amounts of uncompensated care also endanger the survival of rural hospitals.

How To Examine Your Town's Safety Net

Community leaders in some rural towns take an active role in assuring that uninsured and underinsured people can get needed health care at an affordable cost. Part of this assurance may be community support for a clinic with an income-related sliding fee scale or the distribution of community assistance funds to some medically needy individuals. In other towns, safety net health care is left up to the private practice physicians, community health agencies, and the hospital ER. In these towns only the people who have needed charity care may know how good or bad the safety net is.

The assessment guide on page 12 can give you a start in checking out your town's safety net from both the patient and the provider perspective. In using this guide, be sure to speak with people closest to the problem: inadequately insured people who have needed affordable health care, local physicians and physician practice managers, hospital financial officers and billing managers, and local community leaders. Other good sources are insurance agents, social welfare staff, and public health nurses.

A safety net assessment can be done in lesser or greater depth. Even a less-than-thorough assessment can be illuminating. It is often helpful to partner with a local provider, such as a local hospital or the president of the local medical society. The participation of a respected member of the health care community can open doors that might otherwise remain shut. It is also important to approach this process in a non-judgmental fashion.

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Pilot Study Exposes Lack of Knowledge By Community Leaders And Burden On Physicians

Twenty percent or more of rural people are uninsured or underinsured, and need access to low cost health care. Yet rural community leaders are often ignorant of how many in their communities need charity health care and whether they can get it, according to a recent study of small town health care safety nets.

Case studies of eight small towns scattered across the nation found community leaders in five of the towns were ill-informed about the number of their townspeople in need of charity primary care and about their ability to get it at these communities' private physician practices.

This ground breaking pilot study looked at the primary care safety net in small towns with no publicly subsidized clinics — where the only safety net providers were the private physician practices and the hospital emergency room.

In fact, the safety nets were quite good in most of the study communities. In half of them, however, the primary care practices were controlled by distant owners who might, at any time, decide to limit charity care in these practices which were all fiscally near the edge.

Private practice physicians in one of the eight study towns provided no charity care, while in the other seven towns they provided a great deal of such care. Most of these small town physicians believed that they should care for everyone, and they did - but at a significant cost in their practice revenues which were only adequate, at best.

—Pat Taylor

Health Care Vital to Rural Economies: Getting the Figures to Show It

Health care is more than providing care to ill or injured people. In many rural communities, it is the foundation for the local economy. With assistance provided by Operation Rural Health Works, a project funded by the federal Office of Rural Health Policy and the Rural Policy Research Institute, states now have the opportunity to closely examine the ways health care dollars affect the economies of their communities and the role citizens can play in enhancing that effect.

Consider that about $4,100 is spent annually per capita on health care in the United States, $2,742 on primary care alone. The average rural American county has 22,000 residents. Simple multiplication reveals that these residents generate about $90.2 million in health expenditures. And these dollars multiply in other industries and other jobs. The result is a great deal of money that can be spent either inside or outside the county.

"Can the rural community of today afford not to maximize its health care infrastructure and its retention in the community? The answer is obvious," says Sam Tessen, director of the Center for Rural Health Initiatives, the Texas State Office of Rural Health.

Since September 1999, Operation Rural Health Works has been offering states no-cost training in economic health care data analysis, highlighting the roles of hospitals, physicians, nursing homes, and other providers. The analyses enable states to prepare reports for each of their counties. This information can give local decision makers useful tools in planning and supporting their community health systems.

The county profiles include demographic data; economic indicators, including per capita income, unemployment, and poverty rates; employment distribution, such as: manufacturing, services, government, etc.; and health statistics. Each county's health resources are analyzed through IMPLAN, an economic modeling software which estimates changes in local economic activity caused by a change in any one sector or industry of the local economy.

If a hospital expands its operations to include twenty new jobs, for example, the analysis can estimate the effect of these jobs on spending patterns by the hospital itself, community spending by the new employees, and increased employment in other areas generated by this spending. Depending on county particulars, for every ten people employed by the hospital, there may be five more jobs in other industries in the county. Or, each dollar of health care payroll will generate 50 cents in payroll in other county industries.

"This is the most accurate model available, and it can be used in every county in the United States," says Gerald Doeksen, agricultural economist at Oklahoma State University and one of the initiators of Operation Rural Health Works.

The State Office of Rural Health in Oklahoma has worked with Doeksen to generate reports for each of the state's 77 counties. "We wanted to provide a tool for community health planning and for developing public support for health services, especially in underserved rural areas," says Howard Vincent, former president of the Oklahoma Rural Health Association. For example, he says, Oklahoma allows hospitals to charge a sales tax, a source of revenue especially important to small rural hospitals. But the tax must be approved by a vote of residents in the town or county. "These county profiles," he says, "provide ammunition to rally support for health care. They're outstanding for such campaigns."

Don Darling, the director of the municipal hospital in rural Healdton, Oklahoma used ORHW's data to describe the importance of his hospital to the economic life of Carter County. Citizens responded with a vote to support the hospital through a surcharge on their water meters.

Economic analysis of the health care sector in rural Grant County, Wisconsin has revealed that health care accounts for 10 percent of total county revenue and 12 percent of its personal income and that 34 percent of local residents leave the county to go to a personal

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> *"We use the ORHW as a hook to teach people the value of these hospitals to their communities. We use it as an entree to encourage them to fix their quality problems. They won't listen to us talk about quality until they know it's important to the economy and health of the community."*
>
> —Val Schott, director, Oklahoma State Office of Rural Health

Health Care Vital to Rural Economies:
Getting the Figures to Show It

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or family doctor. "If the health care sector could recapture health dollars leaving the county, and increase volume by only 15 percent, the total revenues from direct and indirect sources would increase by over $17 million in the community. Additionally, 362 jobs would be created, and personal income would increase by $6.5 million," says Catherine Clark, former director of the Southwest Wisconsin Area Health Education (AHEC) and coordinator of the impact study.

The trick is figuring how to act on this knowledge and how to get local people to consider it as they make local decisions. The health plan for county employees in Grant County does not commit patients to local hospitals but encourages them to cross the border into Iowa. "We've met several times with county officials, but their employees are tied into the system. They don't see the whole picture," says Linda Adrian of the Grant County Health Department and member of the Impact Steering Committee.

ORHW was started in 1998 out of concerns about community directed health care. How do you engage communities to take responsibility for their health care? How do you deal with the growing numbers of rural people migrating out of their communities for health care? "We thought an economic message could do it," says Jo Ann Myers, former director of Kentucky's Office of Rural Health. "ORHW is a convergence of community-based decision makers and extension service economists."

This convergence is proving useful as rural communities discuss the possibilities of "critical access hospital" designation. Gerald Doeksen says, "In Oklahoma, we are introducing this health planning process in those communities considering the CAH designation. When community leaders come together and learn about health needs and the economic impact of their health sector, they quickly realize the value of maintaining local health services and become more involved with health care planning."

"ORHW is a great tool," says Paul Moore, director of Atoka Memorial Hospital, a recently designated CAH in rural Atoka, Oklahoma. "We used it to help our local business people understand our strengths and weaknesses. It motivates people to stay home for health care."

> *"For years, we've batted around figures about the economic effects of the health care industry. ORHW gives us hard information to take back to our communities, to make sure that health care is at the table when decisions are being made."*
>
> —Caroline Ford, director, Nevada State Office of Rural Health

Contact:
Gerald Doeksen, (405) 744-6081.

around the country

SOUTH CAROLINA
Resource Mothers Help Rural Pregnant Women

Four “Resource Mothers” are reaching out to pregnant women at risk of inadequate prenatal care and infant death in four rural counties in south central South Carolina. Chosen for their experience as mothers and their ties to the community and trained in pregnancy and infant care issues, these women visit their clients at their homes as teachers, facilitators, role models, and friends.

Although the program is less than a year old, having started in October 1999, some results are already evident. “We’ve not yet seen any repeated pregnancies, common here in adolescents, and we have seen our clients take a more active role in their own health care,” says director Virginia Berry White.

Infant mortality rates in South Carolina are higher than the national average, and some rural counties show more than twice the state rate. The causes are varied and complex, White says. Women can’t get to services because they don’t have transportation or child care. A major problem is that they don’t know what services are available and how they can be eligible.

The Resource Mothers work for Low Country Healthy Start, a program of the South Carolina Office of Rural Health, funded through the federal Bureau of Maternal and Child Health to reduce infant mortality and adolescent pregnancies. Each Resource Mother is responsible for 35 to 40 clients at a time who are referred by community health professionals.

The Resource Mothers visit their clients weekly for the first month after contact. Then they visit every two weeks until delivery. After the baby is born they visit weekly for six weeks and then less frequently until the baby is a year old. Each visit is structured around specific teaching goals, such as body changes in pregnancy, breast feeding, colic, infant health, immunizations, feeding problems, and interacting with fathers. The Resource Mothers link their clients with needed community services and encourage better nutrition and reductions in smoking and drug use.

Want to know more?
Contact: Virginia Berry White, 803-793-6000; email: vbwhite@mindspring.com

IOWA
AgriSafe Clinics Offer Health Services Geared To Farmers

“A farmer may visit his physician every winter complaining of bronchitis, and the doctor never suggests reducing dust exposure from the farmer’s grain facility or his hog building,” says Carolyn Sheridan, coordinator of Iowa’s AgriSafe Network. “Health care providers often don’t ask farmers the right questions or make appropriate recommendations, and so they miss opportunities to prevent farm-related illnesses.”

To fill this gap, the AgriSafe Network started with state funding in 1990 and now includes 23 clinics in rural Iowa providing comprehensive occupational health and safety services for agricultural workers. Each clinic, based in a hospital, medical facility, or health department, partners with local organizations, such as the Iowa State University Extension Service, community schools, agribusinesses, and health and human service agencies to develop services specific to the needs of the region’s farmers and their families.

Services include a 90 - 120 minute occupational health screening and assessment focusing on areas of high risk and particular concern to agricultural workers, such as lung function, pesticide exposure, hearing loss, and back safety. Clinic staff offer agricultural health and safety programs to local health care providers and to farm families at community sites, such as grain elevators and churches. They may visit farms for walk-through assessments or consultations about specific hazards, like swine confinement buildings. Clinics offer training in personal protective equipment, which they also sell. Many of the educational and screening programs are free of charge. Farmers can pay for other services through annual membership fees or fees for specific services.

“Serving thousands of people each year, AgriSafe is unique,” Sheridan says. “There are no other effective systems to deliver this type of service to farmers and their families in the United States.” Nebraska and Wisconsin, however, have started to work with AgriSafe to start such networks of their own.

Want to know more?
Contact: Carolyn Sheridan, 712-264-6440; email: csheridan@spenserhospital.org

ARKANSAS
Community Reclaims Its Hospital

Bucking the trend of sales of small community hospitals to distant for-profit corporations, the town of De Queen, Arkansas recently bought its hospital back and is proving that it can be profitable under local management.

In 1984, fearing a financial squeeze because of the new Medicare prospective payment system (DRG's), De Queen sold its community hospital to the Hospital Corporation of America, with eventual control assumed by the Dallas-based Triad Hospitals. In May 1999, Triad announced that it would close the facility if it couldn't find a buyer. De Queen General Hospital, Inc., a newly formed community-owned non-profit organization bought the hospital on November 30.

"The town citizens didn't want to lose their hospital," says Mayor Chad Gallagher. "They do not want to spend that golden hour after an injury traveling 60 miles to Texarkana." Also, he explains, "It's the mayor's duty to recruit industry, and that is impossible if you don't have good schools and a good hospital." The hospital employs 250 people and has an annual $5 million payroll, which has an economic ripple effect throughout the community, Gallagher says.

By the end of its last quarter of operation, Triad had lost $1 million in De Queen, Gallagher says. At the end of the first quarter of local control, "we were $100,000 in the black, and our census is the highest it's ever been," he says. He credits the turn-around to local control which reinvests capital gains and makes more efficient and timely decisions about purchasing and funding procedures.

De Queen, with a population of 8,500 and a hospital service area of 35,000 people in southwestern Arkansas, bought the hospital back for $5 million. The community closed the deal with $3 million in a trust fund set aside from the 1984 sale and a loan from the Christus St. Michael Health System, a Catholic health care system with hospitals and long term care facilities in Texas, Arkansas, Louisiana, and Utah.

"We have a unique situation - local control combined with an affiliation with Christus St. Michaels, a reputable tertiary hospital 60 miles away in Texarkana," Gallagher says. De Queen Regional Hospital is controlled by its community board, but it refers complex cases like open heart surgery and cancer treatment to Christus St. Michaels.

Want to know more?
Contact: Mayor Chad Gallagher, 870-584-3445; Craig Cudworth, De Queen Regional Medical Center CEO, 870-584-4111.

SOUTH DAKOTA
Nursing Homes Offer Career Ladder for Health Aides

If you are a resident in a nursing home, you get help with your daily needs, like dressing, bathing, eating, and exercise from a nursing aide or health aide, usually a state-certified health care worker without a degree in nursing or medicine. Turn-over is high and recruitment is a problem nationally in these important but low-paid positions. To better attract and retain these staff, four nursing homes in rural western South Dakota started a training program and career ladder for them in February 2000.

"It can be difficult to keep nursing aide staff in rural areas," says Carrie LeBrun, director of Support Systems/Human Resources at Banner Health Black Hills. "We just don't have the financial ability to be a leader in terms of money. Instead we look for ways to provide our nursing aides with additional training and recognition."

The three-year program used in the Black Hills facilities was developed by their parent organization, Banner Health System, a not-for-profit health care organization with clinics, hospitals, and nursing homes in western states from Arizona to Alaska.

Nursing aides apply to participate one year at a time. They attend monthly one-hour classes on their own time in their own facilities, and at the end of the year they receive a cash bonus for completion of the coursework. Classes cover a broad range of issues, including the care plan process, dementia, quality assurance, and ethical issues.

"The more they know, the better the care they provide," says Bonnie Renner, in-service educator at Belle Fourche Health Care Center (a 76-bed nursing facility in the small town of that name). "We hope to see these trained nursing aides become leaders on the floor and mentors of new staff."

Want to know more?
Contact: Darlene Steenholt, education director, Banner Health Black Hills, 605-642-2716, ext. 232.

TEXAS
Rural School Offers Full Health Services

Many schools enjoy the services of a school nurse for consultation and attention to minor problems, but few provide the level of health care offered at the Hart Independent School District (ISD) in Hart, Texas.

Besides the school nurse, the Hart ISD's 420 students, pre-K to 12th grade, can get services from pediatricians, dentists, a dermatologist, an optometrist, a psychologist, and a social worker - all on the school grounds. The clinic also has a Class D pharmacy license and offers flu vaccines for older residents. The newest school health program, "TeleDoc," links the Hart ISD electronically with Texas Tech University Health Sciences Center in Lubbock (about 70 miles away). This connection allows them to double the amount of physician coverage each week by saving the driving time from Lubbock to Hart, says Don McBeath, director of the Center for Telemedicine at Texas Tech.

Located halfway between the Texas Panhandle towns of Lubbock and Amarillo, Hart (pop. 1200) has no resident health care providers outside of the school clinic. The closest physician's office is 25 miles away. The closest hospital is 15 miles away. The population is predominately low-income and Hispanic. In the early 1990's, Retta Knox, who had been the school nurse at Hart for some 20 years, turned her frustration at the lack of health services into a search for grant funding and partnerships for solutions. With the help of a state health department grant and collaboration with Texas Tech, the Hart ISD was able to start a one-day a week clinic with staff and pediatric residents from Texas Tech. Over the next seven years, the Hart ISD clinic has expanded with additional state funds, federal funds from the Maternal and Child Health Block Grant, increased involvement from Texas Tech, and volunteer nurses and physicians. It serves all enrolled students, their younger siblings, and all Medicaid-eligible children, regardless of enrollment. About 90 percent of the children receive free services, based on income eligibility. The others are charged a small flat fee.

Each child receives a free annual well-child check-up. Students can come into the clinic from class and make an appointment with a health care provider, or appointments can be made by teachers or parents. Parents are asked to sign a permission slip each year to enable their children to make their own appointments. In the last five years, only three families have refused this permission, Knox says. All services require parental notification and consent.

"Since the clinic started, attendance rates have gone up 8 percent and our scores in tests of basic skills have improved," says school district superintendent Martin Early. "The teachers say, 'If children feel well, they are much easier to teach. If you have a tooth ache, you don't care much about reading."

Want to know more?
Contact: Retta Knox, 806-938-2299; rettak@tenet.edu. Also see: **The Hart ISD School-Based Clinic and Telemedicine Program**, *Texas Journal of Rural Health*, 18(2):3-7, 2000.

PENNSYLVANIA
Disabilities Don't Stop Farmers

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"We deal with all disabilities, from arthritis to amputations," says Linda Fetzer of Easter Seals. "Every case is different."

Equipment modifications which allow a farmer with disabilities to continue farming can range from putting a simple sleeve on a handle to improve the grip to providing a tractor with a lift for easier access. George Dills, AgrAbility project assistant at Penn State and a farmer, is part of the team that evaluates the farm operation. "We work with occupational and physical therapists to evaluate the farmer's disability and make sure we avoid secondary injuries with our equipment modifications," he says.

Pennsylvania's is one of 18 current AgrAbility projects in the nation, funded by the United States Department of Agriculture through the 1990 farm bill. States compete on a three - four year funding cycle with joint proposals from a land-grant university and a non-profit disability organization.

Want to know more?
Contact: Linda Fetzer, Easter Seals Central Pennsylvania,
814-238-4434, Voice/TTY;
email:LFETZER@homenursingagency.com

For information about the national program,
go to: www.agrability.org or
call Carol Maus, National AgrAbility Project, National Easter Seals, 1-888-914-4424

around the country

MINNESOTA
Rural Hospital Prospers Through Teamwork

Twenty years ago, the public district hospital in Paynesville, Minnesota was a typical struggling, small rural facility. Today, the Paynesville Area Health Care System, with that public hospital at its core, is a prosperous, multi-part health organization. In June, PAHCS received Minnesota's Rural Health Team Award for the innovation and team work that is a hallmark of its success.

The town of Paynesville (pop. 5,000) and its hospital district area (pop. 24,000), about 80 miles northwest of Minneapolis, enjoys a public health care system that, besides the small acute care hospital, includes four nursing homes, six satellite clinics, a home health agency, a 30-unit assisted living complex, affiliation with several medical and pharmacy student training programs, and an out-patient facility staffed on a weekly or monthly basis by over 50 visiting specialists. "Paynesville people don't want to travel for their health care," says Willie LaCroix, CEO since 1980. "So, we tried to figure out how to keep our patients at home." That means listening to what people want and providing those services, he says.

Paynesville succeeds in recruiting and retaining its ten physicians with a mix of incentives, such as an annual bonus of $10,000 per year for five years to help pay off medical school debts; a team approach to care with leadership roles often assigned to a nurse practitioners, physician assistant, pharmacist, or diabetic educator; on-call duty limited to every ninth weekend; and physician control over the distribution of their salary pool. "Our area cannot compete for private practices," LaCroix says. "Physicians are interested in quality of life issues and a reasonable amount of time off. We can supply that."

LaCroix predicts that the current common migration of rural patients to urban providers is going to reverse itself. "If you can provide good primary care combined with the personal attention and ease of access that is often missing in large urban facilities, people will start to travel 25 miles AWAY from the city to get health care," he says.

Want To Know More?
Contact: Willie LaCroix, CEO, Paynesville Area Health Care System, 320-243-7700; wlacroix@pahcs.com

MISSOURI
Churches Help Students Bring Psychology Into The Ozarks

In the small mountain towns of southwestern Missouri, where drug abuse and other problems abound, there are many barriers to providing mental health services. Perhaps the greatest barrier is the general distrust the residents hold for psychology.

"Down in the hill country, it's not masculine to ask anybody for help or to spill your guts," says Rod Cannedy, director of Clinical Services at the Forest Institute of Professional Psychology based in Springfield, Missouri. "These are people with a very strong fear and lack of trust for 'Godless psychologists.' So we have to make the connections."

With the help of local churches, students from the Forest Institute provide mental health services to some fifty people each week in six small Ozark towns. The Institute program, called Reaching Out to the Rural Ozarks (RORO) uses teams of advanced level psychology trainees, interns, residents, and faculty supervisors to bring affordable testing, assessment, and counseling services to a ten-county area, designated as a Mental Health Professional Shortage Area. The former director of RORO, Don McGehee, a psychologist and a Baptist minister, has organized a network of churches whose pastors allow RORO the use of their buildings for everything from assessments to running a clinic.

"There's no lack of problems here," says Cannedy, citing high rates of incest, child sexual abuse, alcoholism, and unemployment. "This is the heart of methamphetamine country," he says. "Meth labs have replaced the old moonshine stills."

"We have to work within the confines of local religious values rather than trying to steer clients outside of those limits," McGehee says. Besides testing and evaluation, the Forest students help people manage their depression and anger and teach parenting and social skills.

Want to know more?
Contact: Dr. Rod Cannedy, Director of Clinical Services, Forest Institute of Professional Psychology, 417-865-8943.

ILLINOIS

Outreach Agency Fields Former Farmers and Mine Workers

The best advisor for a troubled farmer or coal miner is someone who's been there. That is the premise behind the Farm Resource Center, a not-for-profit outreach mental health agency whose workers are recruited first for their experience in farming or mining, second for their love of working with people, and third for their education.

"If you're not a farmer, there's no way to easily understand why someone would work so hard for so many years with so little return," says center director Roger Hannan.

The Farm Resource Center fields 22 outreach workers, serving some 1,500 people each year throughout Illinois and parts of West Virginia and Pennsylvania. They work out of their cars and briefcases, responding to telephone referrals and visiting people in their homes. "People are accustomed to making important family decisions at their kitchen tables," Hannan says. "The farmer is in charge there, and the worker's understanding of his situation helps him develop a plan to deal with his personal and emotional issues."

Hannan started the Center in 1986 based on his experience as the director of a community mental health center during the farm crisis of the early eighties. He saw that in spite of the stresses they were experiencing farmers were not coming into community mental health centers because of their pride, their sense of independence, and the stigma associated with mental illness. He brought his outreach idea to the Governor, who had it funded as part of the state's attempt to assist the farm population. In the last nine years, Hannan has expanded the center to cover two other states and to include services to laid-off mine workers and farmers outside Illinois.

The outreach workers are trained in referral sources, confidentiality issues, crisis intervention, and suicide intervention techniques. For the first three months on the job, they are accompanied on their home visits by a senior staff person, and are not allowed to go solo until they are deemed competent. They also recruit "clinical buddies" from mental health providers in their areas to assure prompt access for their clients. "We make sure that our workers know their limits and when to make a referral," Hannan says.

Evaluations from clients and assessments from social service agencies attest to the center's efficacy. "We've demonstrated that we're real and that the program is portable," Hannan says.

Want to know more?
Contact: Roger Hannan, 618-748-9617; email: frc1@midwest.net

MARYLAND

Telemedicine Links Rural Health Care Providers, Schools, and State Offices

Although Maryland is a relatively small state, some rural health care professionals must travel 150 miles each way to attend meetings in the capitol city of Baltimore. With the new Maryland Access to Rural via Telemedicine Initiative (MARTI), staff in five rural health departments, three rural schools, and the state offices of Children's Health and Rural Health are now able to see each other and speak together through their desktop computers.

State funded, MARTI was conceived as a medium for consultation and collaboration, medical education offerings, and easy transmission of health information and data.

"Nurses in rural schools are isolated," says Ebenezer Israel, MD, who worked with state Office of Rural Health director, Marita Novicky, to develop the project. "MARTI will ease their communication with other nurses, with the health department, with emergency services. Parents will be able to talk face to face with the distant Health Department administrator about their child's developmental disability." The first training conference scheduled on the "compressed video" system will deal with child sexual abuse, a problem often seen by the school nurses, Novicky says.

"This kind of system is like a Model T Ford," Israel says. "Telemedicine is getting cheaper, simpler, and better. It won't be long before we will be able to have local hospitals linked to the University for stroke consults, EMS linked to child abuse experts, and police and social workers linked to the pediatric emergency room." For Novicky, the next step is to link up the remaining seven rural health departments in Maryland.

Want to know more?
Contact: Marita Novicky, 410-767-5942

A Question for Rural Community Leaders:
How Good Is Your Health Care Safety Net?

continued from page 4

Community Safety Net Assessment Guide

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Further reading: Uninsured America: A Health Care Crisis, Consumer Reports, September 2000;

Selected Federal Rural Health Programs Meeting the Needs of Rural Americans, by the Capitol Area Rural Health Roundtable, April, 2000. www.gmu.edu/departments/chp/rhr

n **1. Estimate the percent of population under 65 in your community without health insurance and the percent that is underinsured (have high deductibles and co-payments relative to income).**

State level estimates of the uninsured in your county can provide a rough starting point. The percent underinsured will probably require a "best guess" based on conversations with major employers about the types of coverage they provide. Self-employed families of moderate means who have policies purchased in the individual insurance market are likely to be underinsured because of their high deductibles and co-payments.

n **2. List area health care providers. Do any of them receive public subsidies to provide free or low cost care to the medically indigent?**

n **3. To assess safety net access at each local provider, ask them the following questions:**

- Does the practice ask about a patient's insurance status before making an appointment? (This is a common method of screening out uninsured and Medicaid patients.)
- What is the practice policy with respect to seeing patients who have unpaid bills?
- What type of payment arrangements does the practice offer to uninsured and underinsured patients?
- Does the practice/facility offer reduced fees to inadequately insured low income patients, or does it bill these patients at the fee schedule rate?
- Is the practice owned by its practitioners? If not, who owns it? Who makes the charity care policies?

n **4. To assess the financial burden on providers of caring for the uninsured and underinsured, ask the following questions of each practice:**

- What percent of last year's total billings were bad debt and free care?
- What percent of the patient base is insured by Medicaid, CHIP, and other public insurance programs for people with low incomes? What percent of the costs of care do these insurers pay?
- What percent of the patient base is insured by Medicare? What percent of the costs of care does Medicare pay?
- Are uninsured and underinsured patients shared fairly equally among the local physician practices?

n **5. It is important to interview inadequately insured individuals. The conversation should focus on how they negotiate the health care system.**

- Where do they go for care? Why do they go there?
- Are there providers that they wouldn't go to? Why?
- Do they know of local providers who would not see them?
- Do they have difficulty paying their medical bills?
- Have they ever decided to forego needed care for financial reasons?

n **6. Talk with community leaders, and ask them these questions:**

- Is health care access for the medically needy available in the community?
- Have they taken any actions to support the local safety net providers?
- What are the biggest health care needs in the community?

Now What?

At the end of this process, you will have a good understanding of your community's health care safety net. You will know the percent of the population in need of safety net care and whether inadequately insured people in your town can get needed health care at an affordable cost. You will also know where this population is receiving health care and the economic impact on local providers. Finally, you will be able to assess local community leaders' knowledge about the safety net from both the patient and the provider perspective. With this information, it will be possible to develop strategies to support the safety net in your community.

In Pat Taylor's nine years at the federal Office of Rural Health Policy, she helped to develop federal policy options on many aspects of rural health care and also directed the office's research activities. Since her retirement in 1999, she consults on rural issues in Medicare policy and conducts research on the rural safety net, especially in small towns. For more information about the pilot study mentioned above, contact her at 202-543-2605 or ptaylor@cpcug.org

Managed Care Changes Rural Public Health

Medicaid managed care programs which now operate in over half of the nation's rural counties are drawing Medicaid revenues away from public health departments and affecting their budgets, structures, and programs.

Rebecca Slifkin, Pam Silberman, and Susan Reif of the North Carolina Rural Health Research and Policy Analysis Center have surveyed staff in four rural public health departments in each of five states to ascertain the extent of the changes Medicaid managed care has brought to public health and the effect of these changes on the departments and the communities they serve. The paper summarizing the results of their study, The Effect of Medicaid Managed Care on Rural Public Health Departments, is under review at *The Journal of Rural Health*.

Rural Health News spoke to Dr. Slifkin in August about the study.

How has Medicaid managed care affected the direct patient care services provided by the rural health departments?

Slifkin: Four of the 20 rural health departments we visited had completely stopped providing well-child services. All of these health departments were in states with fully capitated Medicaid managed care programs. Another nine health departments have decreased the number of well-child services they provide. Fourteen of the 20 health departments had decreases in direct service revenue from Medicaid in the mid-nineties. But the financial effects varied according to the organization's ability to generate revenues from other sources and the size of financial reserves from other years.

Why has Medicaid managed care had such an effect?

Slifkin: It's hard to separate out the effect of Medicaid managed care from the effect of increased Medicaid reimbursement or the willingness of private providers to accept Medicaid beneficiaries. Under fee-for-service, Medicaid reimburses any eligible provider, including health departments. Historically, many private providers would not accept Medicaid patients because the reimbursement rates were very low. In the nineties, we believe that some health departments lost Medicaid families because many states raised Medicaid rates, making Medicaid patients more attractive to private providers. At the same time Medicaid managed care requirements such as a designated primary care provider, 24 hour telephone access, and a certain range of services made many health departments ineligible for participation unless children were referred by private providers.

Relationships with local private physicians also affect the ability of health departments to obtain contracts for services covered under Medicaid managed care and to receive referrals for services carved out or covered under direct access provisions. In some areas, the health department and the private providers have strong working relationships; in others, there appeared to be little if any communication.

Ten Essential Public Health Services

1. Monitor health status to identify community health problems.
2. Diagnose and investigate health problems and health hazards in the community.
3. Inform, educate, and empower people about health issues.
4. Mobilize community partnerships to identify and solve health problems.
5. Develop policies and plans that support individual and community health efforts.
6. Enforce laws and regulations that protect health and ensure safety.
7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable.
8. Assure a competent public health and personal health workforce.
9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services.
10. Conduct research for new insights and innovative solutions to health problems.

—Stabilizing the Rural Public Health Infrastructure, *National Advisory Committee on Rural Health, June 1999.*

The health department directors we spoke with attributed their decrease in well-child services to three factors: 1) a state requirement that referral from a primary care provider was necessary in order for health departments to receive reimbursement; 2) increased competition for Medicaid children from private providers; and 3) loss of state funds to pay for these services, particularly for the uninsured.

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Managed Care Changes Rural Public Health

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Where direct patient care services in the health departments have decreased, what happens to the Medicaid population?

Slifkin: It appears that rural Medicaid beneficiaries are receiving more and more of their care from the private sector. These children will probably benefit from having a medical home, and their families may feel less stigmatized going to a private provider rather than receiving services at the public health department.

At the same time, many of the health department directors we talked with are worried about the adequacy of care their former clients are now receiving. They are concerned that private physicians are not able to spend as much time with children as health department staff could, that tests, such as lead screening mandated by federal policy for children with Medicaid, are not being performed, and that private practices are not reminding parents about immunizations nor following up on families that do not bring their children in for services.

How have changes in response to Medicaid managed care affected the rural health department's ability to provide population-based services such as community outreach and education, inspections, and environmental activities?

Slifkin: Population-based services usually do not generate revenue. Some of the directors we spoke with said that they may have to reduce some of the services that were dependent on subsidies from declining clinical revenues. On the other hand, some rural health departments are increasing their population-based services by redirecting staff resources that are no longer needed for clinical work.

Although none of the health departments we visited appeared to be in danger of closing, and some of them were doing quite well, what had changed for most of them was their income security. Fees from Medicaid had provided a steady and reliable source of income, and now revenues and budgets are uncertain. Departments are more vulnerable to changes in political will, the county economy, and shifts in state priorities and funding. The stress level among rural health department directors appears to be high.

Should these market-based changes be viewed as positive or negative?

Slifkin: The answer depends, in large part, on the perspective taken. From a public health perspective, Medicaid managed care may be harmful if its adverse impact on the long-term financial viability of health departments is not somehow balanced by increased financial commitment by government to explicitly support population-based services. The questions raised by the health department directors about the quality of care provided to Medicaid recipients by private providers are also troubling. State Medicaid directors may perceive the changes more positively as recent studies have shown that the move to managed care has helped control Medicaid expenditures and has improved access to private providers. Legislators may have more mixed responses. On one hand, overall health expenditures are lower. On the other hand, if health departments have less ability to cross-subsidize core public health functions or care for the uninsured, they may need a direct appropriation from local, state, or national legislators. From a patient's perspective, whether these changes are perceived as beneficial may depend on whether it is now easier or more difficult to get quality services.

Rebecca T. Slifkin, Ph.D. is the director of the Program on Health Care Economics and Finance at the Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill. She can be reached at (919) 966-4640, fax (919) 966-5764, or becky_slifkin@unc.edu

About 3000 local public health agencies make up the heart of the public health system. Two-thirds of these are in towns with populations of less than 50,000.

— National Association of County and City Health Officials.

If you want to know the latest about rural health services research, don't miss the National Rural Health Services Research Database at http://www.rural-health.org. It describes research projects currently underway or recently completed.

Notes...

New rules proposed for EMS Medicare reimbursement affect rural providers. Comments accepted until November 13, 2000. See the proposal in *The Federal Register*, 65(177), September 12, 2000; http://www.access.gpo.gov/su_docs/fedreg/a000912c.html (scroll down to Health Care Financing Administration, Medicare). For background information, see: Rural Ambulances: Medicare Fee Schedule Payments Could Be Better Targeted, United States General Accounting Office, July, 2000; http://www.gao.gov/new.items/he00115.pdf

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There is a future for managed care in rural America, says Keith Mueller, director of the Nebraska Center for Rural Health Research. He presents his thesis in *Managed Care in Rural Areas: 2010*, published in the fourth edition of The Managed Health Care Handbook, Peter R. Kongsvedt, ed. (Aspen Publishers, 2000).

New members are welcome to join the Health Care Systemic Change Initiative (SCI), a national network of rural health care leaders and advocates, which works with state Rural Development Councils and other rural constituents to identify issues, collect data, and communicate the health care concerns of rural communities to national, state, and local policy makers.

In the past year, SCI focused on the Children's Health Insurance Program (CHIP). They produced a briefing packet for Rural Development Councils and discussed rural obstacles in CHIP outreach and implementation with federal officials. Monthly teleconferences feature presentations on issues of interest to members, such as emergency medical services and problems with dental care in rural areas.

Information: Helen Huarca, National Rural Development Council, 202-205-3505; hhuarca@os.dhh.gov

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Recent withdrawals of managed care plans from the Medicare+Choice program disproportionately impact rural elderly, according to analysts from the Rural Policy Research Institute (RUPRI). RUPRI has been tracking the rural impacts of Medicare+Choice since its inception.

Information: Chuck Fluharty, RUPRI director, 573-882-0500; www.rupri.org

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The National Health Service Corps has information packets to aid in state and community health care professional recruitment. They describe NHSC scholarship and loan repayment programs and include state specific maps showing current NHSC field strength and indicators of underservice. Contact: Michael Berry, 301-594-4200, mberry@hrsa.gov

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Smoking, drinking, and drug use among young teens is higher in rural communities than in the nation's urban centers, according to No Place To Hide: Substance Abuse In Mid-Size Cities And Rural America, a January 2000 report from the National Center on Addiction and Substance Abuse at Columbia University. The report cites staggering comparisons: rural eighth-graders are 104 percent likelier to use amphetamines than their urban counterparts, 50 percent likelier to use cocaine, 83 percent likelier to use crack cocaine; 70 percent likelier to ever have been drunk, etc. Information: http://www.casacolumbia.org

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Besides being a known carcinogen, chewing tobacco is linked to tooth decay, say Scott L. Toner and Deborah Winn in Chewing Tobacco Use and Dental Caries Among U.S. Men, *Journal of the American Dental Association*, 130(11):1601, November 1999.

The Hesperian Foundation distributes health education materials in English, Spanish, Portuguese, and French, focusing on ethnic and immigrant communities. Information: 510-845-1447; www.hesperian.org

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Developing affordable housing with services in rural areas requires creative strategies for design, finance, construction, marketing, and operating, as well as flexible state regulations, according to E.J. Bolda, S.T. Salley, R.G. Keith, M.F. Richards, R.M. Turyn, and P. Dempsey in Creating Affordable Rural Housing With Services: Options and Strategies, Working Paper #19, April 2000, Maine Rural Health Research Center. For copies: Go to: http://www.muskie.usm.maine.edu/research/ruralheal/index.html or call Donna Reed, 207-780-4846.

The experience of five rural health networks in Washington, Kansas, West Virginia, Florida, and California in approaching issues of organization and development may help rural decision makers think through their network issues and arrive at their own solutions. See: Building Rural Health Networks: Examples From The Rural Network Development Grant Program, September 1999, a report of the federal Office of Rural Health Policy, prepared by Anthony Wellever. For copies: www.nal.usda.gov/orhp/BuildingNets.htm

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Rural residents reveal gaps in knowledge about lead poisoning prevention, and educational efforts should focus on decreasing these gaps, writes Barbara J. Polivka of the Ohio State University College of Nursing in Rural Residents' Knowledge of Lead Poisoning, *Journal of Community Health*, 24(5):393-408, October 1999.

In urban areas, 30.1 percent of seniors have no prescription drug coverage. In rural communities, the number soars to 46.1 percent. The Maine Rural Health Research Center and the Rural Policy Research Institute describe a framework for assessing the effects of new proposals for Medicare drug benefits on rural beneficiaries. See: Improving Prescription Drug Coverage for Rural Medicare Beneficiaries: Key Rural Considerations and Objectives for Legislative Proposals, RUPRI, P2000-8, June 30, 2000; http://www.rupri.org/pubs/archive/reports/p2000-8/index.html.

Subscribe...

Sign Up for New Rural Health News

Since its inception in 1992, *Rural Health News* has been through a number of incarnations. Along the way, it has built up a steady readership and loyal support. Beginning with the next issue, the publication will go through another evolution. We at the federal Office of Rural Health Policy hope you'll be along for the ride as we transform *Rural Health News* into an e-newsletter.

The change is motivated by several factors. First, we wanted to consolidate some of our activities so we decided to move *Rural Health News* to the Rural Information Center for Health Services, or RICHS. As many of you know, RICHS is a national clearinghouse for rural health information both electronically and through a 1-800 dial-up request line. Second, we wanted to take advantage of technologies such as the World Wide Web and electronic mail that make it infinitely easier to get information out quickly. RICHS has the capability to make this happen.

We will make sure that we continue the best features of *Rural Health News* - its feature stories, its round-up of stories from around the country, and its updates on key research. Barbara Leitenberg, the current editor, and Andy Coburn and company at the University of Southern Maine's Rural Health Research Center have helped make this publication eminently readable, interesting, and chock full of information.

The new version of *Rural Health News* will be sent to subscribers via e-mail and will also be available on the RICHS web site. We should also note that we're fully aware that not all of rural America is connected to the Internet. So, for those subscribers who do not have Internet access, we will make a selected number of copies available for mailing.

To make this happen, however, we're going to need help from you. If you want to receive *Rural Health News* electronically, please send a fax or an e-mail to RICHS staff (see box for mailing information) with your e-mail address. (Please make sure to use the tag line "Rural Health News" in the subject line to alert staff). If you want to receive a printed copy, please send your mailing address to RICHS staff.

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