Briefing

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Obtaining access to care is a major concern for persons living in the United States, especially in rural areas. Proposals such as President Bush's (see p. 12) and the Catholic Health Association's (CHA's) offer an array of systemic reforms to improve access. Rev. James J. McCartney urges Catholic providers to participate as new delivery models evolve and specifies their particular responsibilities (p. 32).

Articles such as Fr. McCartney's and the myriad proposals for reform that are currently on the table underscore what is already clear when one looks at the fragile state of the Medicare hospital trust fund (projected to run out in 10 years): We must find new ways to provide healthcare. To accomplish this, providers in rural areas have had to be creative—perhaps more so than their urban counterparts.

In sparsely populated Montana, flexibility and innovation are paying off. The state's Medical Assistance Facility Demonstration Project relaxes licensure requirements to allow rural hospitals to continue to provide needed acute care services (p. 42). In Billings, Saint Vincent Hospital and Health Center operates five clinics—two staffed by certified physician assistants (PAs). Practicing under physician supervision, the PAs enable the clinics to maintain rural residents' access to primary care services (p. 46).

Urban hospitals can also play a role in increasing rural access. Homer H. Schmitz describes how they can work with physicians to bring care to rural areas (p. 38).

This issue reports on three surveys to help hospitals plan their future strategies. One study asked rural nurses what retention efforts would influence them to stay in their jobs (p. 60). Authors Shirley F. Olson and F. Theodore Helmer found interesting regional variations in nurses' responses. In the Southeast, for example, nurses were interested in advancement, while those in the Southwest and Midwest stressed higher salaries. The authors suggest a variety of ways rural hospitals can address their nurses' unique needs.

A CHA study of rural hospitals' performance identified financial and other factors characteristic of "consistently sound" and "adversely affected" hospitals (p. 54). Commonalities among hospitals within each group included system affiliation, bed size, and service mix.

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Shifts in the strategic orientations (categorized as the defender, analyzer, prospector, or reactor) of many rural hospitals over a two-year period were revealed in a national study of Catholic and non-Catholic hospitals (p. 49). The study also found that hospitals whose viability increased in that period made changes in their administrative structure more often than other hospitals.

CHA Assembly

In June the Catholic Health Assembly convenes experts in healthcare reform, genetic technology, cultural diversity, community-based AIDS care, labor relations, and many other issues healthcare managers face. See pp. 65-68 for registration information. The deadline is May 21. Don't miss this opportunity to prepare for the future.