

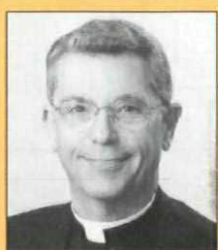
# We Must Make Rural Health Care a High Priority

BY REV. MICHAEL D. PLACE, STD

**I**n early August I had the privilege of visiting two rural Michigan hospitals, Mercy Health Services North-Cadillac and Mercy Health Services North-Grayling, both part of Trinity Health, Novi, MI. Mercy Cadillac has served its community for 93 years; Mercy Grayling has done the same for 90 years. These visits are part of my effort to learn more about the rural Catholic health care ministry. I had previously spent time with the North Dakota Catholic Association, Bismarck, ND; the Southern Region of the Illinois Hospital & HealthSystems Association, Carbondale, IL; and the board of Avera Health, Yankton, SD, all of which are deeply involved in rural health care. In the few next months, I hope to experience other dimensions of this important aspect of Catholic health care in the United States. And it is important: According to our latest figures, about 28 percent of Catholic hospitals are located in rural areas.

In preparation for my recent visits, I reviewed some of the information presented at a recent conference, "Rural Health Care: Current Issues and Future Directions," cosponsored by Southern Illinois Healthcare, a health care system, and the Southern Illinois University School of Law, both based in Carbondale, IL. In this article, I will share some important information about rural health care from that conference and several other sources.

Some readers may ask, "Why should a city boy like Fr. Mike Place be interested in *rural* health care?" My answer is based on our church's preferential concern for the poor and vulnerable—and for those who serve them. In recent years, I have come to appreciate (as I did not before) the fact that rural Catholic health care provides an invaluable service to an often overlooked segment of our population, a segment that suffers significant socioeconomic poverty and is quite vulnerable when it comes to health status. I have also learned that the rural health care ministry is *itself* often economically disadvantaged and that its very future is at risk.



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I therefore offer this column as a beginner's introduction to an important part of our U.S. health care ministry. In the future, I hope that more knowledgeable writers will—perhaps in a special issue of *Health Progress*—provide us with insight into the success and challenges of the rural health care ministry.

## RURAL CHALLENGES

Rural America faces a variety of socioeconomic challenges. For one thing, agriculture no longer supports the rural economy; today only 1.78 percent of the rural population is engaged in farming as a primary occupation.<sup>1</sup> More than 20 percent of total personal income in rural areas is derived from federal transfers. As the federal government continues to reduce such payments, rural communities will have to develop income substitutes. If they fail to do so, they will not remain viable, let alone grow.

In general, the rural economy has strengthened over the past decade, but the economic status of rural Americans has not. Rural employment continues to be dominated by industries in which both wages and health benefits are low. Jobs in rural areas are often seasonal, weather-dependent, and hitched to the economic vagaries of but one or two industries.

Employment among rural Americans has increased somewhat, but wages have not. To increase family income, a worker must often hold more than one job. What is more, rural families are more likely than urban families to be poor *despite* employment. Rural families find it difficult to qualify for Medicaid because, even if they do meet the program's income limits, they do not meet its categorical requirements.

Although rural America's general economy has improved, it continues to have persistent pockets of intractable poverty. In general, poverty rates are higher in rural areas than in urban areas (15.7 percent vs. 12.6 percent, according to 1997 figures.) Child poverty is also higher in rural areas (22.7 percent, as opposed to 19.2 percent in



urban areas). According to the federal government, 23 percent of the nation's 600 "persistent poverty counties" (those in which, from 1960 to 1990, 20 percent or more of the population was impoverished) are rural, being found in the South, Appalachia, the lower Rio Grande Valley, and on Indian reservations.

Along with continuing poverty, rural America is dealing with important demographic changes. Between 1990 and 1999, for example, 61 percent of rural counties experienced a population increase. Nearly 88 percent of that increase was the result of migration from metropolitan areas. When city people move into a rural community, they tend to change its ethnic and racial composition, which, in turn, puts new pressure on the community's traditionally limited governmental infrastructure and small schools.

Rural America's dilemma is complicated by the fact that, despite relative population increases, the historical trend is in the other direction. The United States, once a nation of farmers, changed radically in the 20th century. According to the 2000 census, the population is today 60 percent suburban, 20 percent urban, and 20 percent rural. In 1996 only 76 of 435 congressional districts were in predominantly rural areas. In only 13 states is a majority of the population rural. Those 13 rural states have a total of 59 electoral votes—five more than the number held by California alone.

Because of its shrinking population base, rural America wields little clout in Washington, DC. The result, as Charles W. Fluharty has noted, is that federal programs to aid rural communities "remain very fragmented, across multiple Congressional Committees and Administrative agencies, with no overall responsibility for crafting a more holistic rural policy and program integration."<sup>2</sup>

And the situation is not much better at the state and local levels. In the states, redistricting continues to reduce rural representation in legislatures and give it to suburban areas instead.

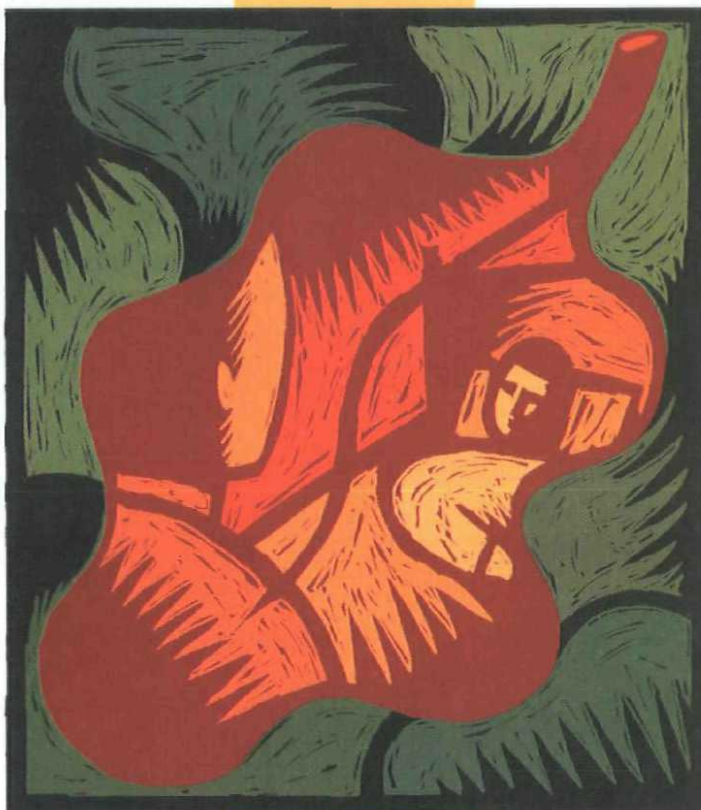
Meanwhile, local governments in rural areas tend to be small and staffed by part-time "citizen servants." Because such governments have less access to technical assistance, research, and grant writing support, they are at a disadvantage when they compete against well-staffed suburban and urban governments for federal and state funds.

### HEALTH CARE CHALLENGES

Today more than 22 million rural residents live in what the federal government calls "Health Profession Shortage Areas" or "Medically Underserved Areas." Compared with those who live in suburban and urban areas, rural residents tend to have less access to both health insurance and health care and little or no access to managed care. (Some of the rural areas I have visited have these characteristics.)

The provision of care in such areas falls increasingly on the small rural hospital. Unfortunately, such facilities often:

- Depend on Medicare and Medicaid reimbursements for 55 percent to 60 percent of the care they deliver; for some rural hospitals, the rate is 80 to 90 percent. The rural patient base tends to be older and poorer as people with private coverage move to urban and suburban areas.
- Lack access to capital necessary to keep pace with physical plant and technology needs. As a result, they lag behind their urban and suburban counterparts in medical and communications technology. For example, rural hospitals suffer a growing "digital divide" between them and more metropolitan institutions.
- Continue to lose their "cost-shift" capability. Rural hospitals have limited bargaining leverage with large, nationwide managed care companies, especially with companies that have a large portion of the area's residents under contract.
- Continue to lose inpatients. Both hospital admissions and average length of stay declined throughout the last decade; they continue on a downward trend.





Despite such limitations, rural hospitals play an increasingly vital role in their communities. Many have developed primary care clinics, including Medicare-certified rural health clinics. In most rural areas, it is the local hospital that takes responsibility for recruiting and retaining physicians. Moreover, such hospitals are often long-term care providers in their communities. In Illinois, for example, 74 percent of all long-term care centers operated by hospitals are run by rural hospitals.<sup>3</sup> And not only are rural hospitals usually the primary local source of health care; they are also frequently the community's dominant economic force (the largest local employer, for example).

Rural areas certainly need their hospitals. In Illinois, rural death rates from all causes in the period 1992-1996 were 1,106.7 deaths for every 100,000 people, compared with 853.8 for those in urban areas. Rural deaths from vehicular accidents in the same period were 21.4 per 100,000, compared with only 12.4 for those in urban areas.<sup>4</sup> Michigan residents living in the area served by the Cadillac and Grayling hospitals reveal a level of obesity higher than the state average, which is itself higher than the national average. Deaths in the area from diabetes are higher than the state average—15 percent higher in Grayling, 21 percent higher in Cadillac—which, again, is higher than the national average.<sup>5</sup>

Unfortunately, rural hospitals were hit hard by the Balanced Budget Act (BBA) of 1997. It has been estimated that, of the \$118 billion to be cut over a five-year period, \$16.8 billion was cut from Medicare funds intended for rural areas.<sup>6</sup> Legislation in 1999 restored only some \$1.8 billion of this money, which is certainly not enough. The BBA also established the Medicare Rural Flexibility Program and other enhancements. These enhancements, which include the "Critical Access" designation for some small rural hospitals, along with maintenance of counterpart rural hospital designations (e.g., "Sole Community Provider," "Medicare Dependent," and "Rural Referral") are vital to the preservation of rural health care, a generally low-cost mission.

However, despite these incentives, rural health care continues to bear a significant burden because of the Medicare wage index. This index adjusts Medicare inpatient and outpatient payments to account for the varying wages paid by hospitals in different market areas across the nation. Although the adjustment makes some sense, it disregards the fact that a tightened national market for health care professionals has served to increase labor costs in rural (and smaller urban) communities. The data on which the wage index is based is out of date. It

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counties.*

simply adds to the problems rural hospitals already face in recruiting and retaining highly skilled professionals.

#### NOTES ON THE RURAL CHALLENGE

The following are random observations based on my encounters with caregivers in the rural ministry.

**Rural Hospitals Can Provide a Continuum of Care** Some urban people have an unfortunate bias against rural primary health care: They think it cannot be as good as primary care provided in an urban setting. However, if you believe that periodic accreditation agency scores are an accurate measure of quality, you will find—as I have in my visits to rural areas—that rural facilities score just as high as their urban counterparts. True, they usually do not offer the range of services that urban hospitals do. But they often have unique (and sometimes creative) arrangements with tertiary and specialty care providers, so that even if some services must be delivered away from the "hometown" facility, follow-up care *can* be given at that facility. In this way, rural hospitals do provide the full continuum of care.

**Political Clout Counts** Many rural health ministries are disproportionately vulnerable to economic forces because they lack the political clout enjoyed by urban ministries.

**The Closing of a Rural Hospital Affects the Whole Community** The closing of a rural hospital (or even the scaling back of its services) is not, in rural areas, a "neighborhood" issue. It can affect the health status of the population of an entire county—or counties. Such closings can be especially damaging because rural physicians are more likely than their urban counterparts to be affiliated with (perhaps even employed by) the local hospital. Moreover, primary care clinics and other facilities are more likely in rural areas to be owned by such hospitals.

**The Needs of the Elderly Are Increasing** The growth of the elderly rural population, on top of a general "graying of America," means that the United States must develop rural health care services outside the traditional hospital setting to effectively address rural chronic care needs.

**Small Does Not Necessarily Mean Less** Smaller hospitals, patient populations, and cash flows do not always equal fewer mission challenges. In fact, they may mean *more* mission challenges.

**The Impact Will Be Immediate** Because rural hospitals are often one of an area's larger employers (if not *the* largest), decisions its leaders make to preserve long-term viability will have an immediate impact

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## REFLECTIONS

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# Rural health care bears a significant burden because of the Medicare wage index.

on the community. And that impact can cause the community to become alienated from the hospital.

By the same token, rural people are often more aware than their urban counterparts of the hospital's value to the community. They will be quick to protest any proposal to "downsize" the rural health care mission.

### Staffing Problems Can Affect Everyone

Because rural hospitals are so vital to their communities, staffing shortages that result in either short-term or long-term service reductions are likely to turn into community health status issues.

**CHA Must Pay Attention to Rural Health** Just as we have given a high priority to advocacy efforts on behalf of disproportionate share issues, we must work similarly on equivalent rural issues.

In closing, let me offer two images:

At one point during my visit to Mercy Cadillac's newly relocated and renovated obstetrics unit, my hosts and I happened to find ourselves standing just outside the doors of an operating room. The doors opened for a gurney bearing a woman who had just delivered a baby by C-section. Behind the gurney came a man in scrubs carrying the child. I, who was then unaware of OB practice, assumed that the man in scrubs was a staff member. Admiring the care with which he held the newborn, I thought, "What a picture of mission!" Just then, I heard the "staff person" ask a nurse if he could show the baby to "the kids." As we passed by, I saw him showing this new life to its siblings—and heard one of them, a six- or seven-year-old, remark: "The head looks funny." This is Catholic health care: rural, urban, and suburban.

My second image is of a hospital door shattered by the deer that has just crashed through it. I'll bet that few in the urban and suburban health care ministry have problems like that. □

For further information on rural health care, contact the following:

• *The Rural Information Center Health is a joint project of the U.S. Office of Rural Health Policy and the National Agricultural Library. It provides free customized assistance (such as performing database searches on rural health topics and funding resources), refers users to sources for additional information, furnishes selected publications, and posts on the Internet funding resources, conference announcements, bibliographies, directories, and the full texts of documents. See <http://www.nal.usda.gov/ric/richs/>*

• *The National Rural Health Association is a not-for-profit group composed of people who share a common interest in rural health. Headquartered in Kansas City, MO, the association also has an office in Washington, D.C. See <http://www.nrharural.org>*

• *The Rural Policy Research Institute conducts research and facilitates public dialogue to help policy-makers understand the impact of public policies and programs on rural areas. Many policies, though not explicitly "rural," nevertheless have substantial implications for rural areas. The institute is dedicated to comprehending and articulating these implications. See <http://www.rupri.org>.*

## NOTES

1. Unless otherwise noted, the statistics cited in this article are taken from Charles W. Fluharty, "Refrain or Reality: A U.S. Rural Policy? Implications for Rural Health Care," working paper, SIH-SIU Health Policy Institute, Rend Lake, IL.
2. Fluharty, p. 13.
3. Illinois Department of Public Health, "Illinois Rural Health Plan: Rural Health Access and Critical Access Hospitals," March 1998, p. 27.
4. Illinois Department of Public Health, p. 27.
5. "2001 Health Assessment Project," North Central Council, Michigan Health and Hospital Association, Petoskey, MI, June 2001.
6. The Lewin Group, "The Impact of the Medicare Balanced Budget Refinement Act on Medicare Payments to Hospitals," a report prepared for the American Hospital Association, February, 2000. Although Congress intended to cut federal expenditures by \$118 billion, the actual total will turn out to be twice that figure.

## NET GAINS

Continued from page 11

more traditional marketing. For example, the hospital calls its quarterly health information publication *Healthyside*. Reports from focus groups showed that *Healthyside* has strong brand recognition and is well regarded in the community.

Since the new site was launched, overall use has increased by 30 percent. In the future, Simpkins says, the hospital plans to integrate its telephone call-in line with the site and to add other interactive features.

### TIPS ON STARTING A SIMILAR SITE

To those planning a similar, second-generation website, Simpkins offers some advice.

**Develop a Strategic Web Plan** Every great website is based on a plan that spells out, first, what the planners hope to accomplish with the site, and, second, how they intend to develop it. Make sure your plan is linked to the objectives envisioned in your hospital's strategic plan. A good plan will go beyond the site's launch, including recommendations for its maintenance and future use.

**Involve the Right People in the Project** Cast a wide net when forming a team to plan and develop your Web services. Although information services specialists are necessary, recruit nontechnical leaders as well. Select one of your organization's top leaders to make sure that your efforts will be strategic and get the support they need.

**Look for Experience When Selecting Vendors** In both developing the site and providing content, choose vendors who have solid track records—and experience in working with health care organizations. (Simpkins initially considered engaging several vendors who later went out of business.) Ask for references from organizations similar to your own.

**Focus on Building Your Own Brand** Make sure that all your new site's elements—and especially its main design elements—are fashioned to match your organization's branding and identity standards. □

Contact Tom Lawry at [tlawry@verus-tech.com](mailto:tlawry@verus-tech.com), or at 4628 175 Ave., SE, Bellevue, WA 98006; phone 425-643-7117; fax: 206-643-0302.

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