
ACCESS TO QUALITY HEALTH SERVICES IN RURAL AREAS—PRIMARY CARE

by Larry Gamm, Graciela Castillo, and Stephanie Pittman

SCOPE OF PROBLEM

- There are fewer physicians with the exception of family practitioners and general practitioners, in rural areas in all four regions of the nation.³⁷
- Health manpower shortages, and recruitment and retention of primary care providers are major rural health concerns among state offices of rural health.³⁸ Access to quality health services was the most often nominated rural health priority by state and local rural health leaders across the nation.^{2, 3}
- Fifteen percent of adults in the United States, according to estimates, do not have a preferred doctor's office, clinic, or any other place in which they receive care.¹
- Only about 10 percent of physicians in America practice in rural areas despite the fact that one-fourth of the U.S. population lives in these areas.¹⁰
- As many as 12 percent of all hospitalizations may be avoidable²¹ and are disproportionately frequent among the poor and non-white populations.³³⁻³⁵

GOALS AND OBJECTIVES

In light of these and other challenges, the first listed Healthy People 2010 goal is to improve access to comprehensive, high quality health care service.¹ Many of the access to primary care issues addressed by Healthy People 2010 are problems experienced in many rural areas of the United States.

This review addresses the following HP2010 objectives:

- 1-4. Have a source of ongoing care.
- 1-5. Have a usual primary care provider (PCP).

- 1-8. Increase the proportion of underrepresented ethnic and racial groups among those awarded degrees in the health professions.
- 1-9. Reduce avoidable hospitalizations associated with three ambulatory-care-sensitive conditions—pediatric asthma, uncontrolled diabetes, and immunization-preventable pneumonia and influenza.

Affecting these objectives in many rural areas are shortages of primary care providers, including primary care physicians and non-physician primary care providers (NPPCPs), such as nurse practitioners (NPs) and physician assistants (PAs); and an underrepresentation of female and minority PCPs. Progress on these objectives should contribute to effective utilization of preventive services and primary care by all rural population groups to attain reductions in avoidable hospitalizations and to improve overall health status.

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According to the Rural Healthy People 2010 survey, access to quality health services (which includes access to primary care) was rated as the top ranking rural health priority. Approximately three-quarters of the respondents named access as a priority.² It was the most often selected priority among all four types of state and local rural health respondents in the survey and across all four geographic areas. Nine out of 10 leaders of state health organizations nominated

access as a priority, while about two-thirds of the public health agencies, rural health centers and clinics, or hospitals did the same, a statistically significant difference among the groups.³ No significant differences across regions appeared, as access nominations appeared uniformly high across four geographic regions of the country. Also, in a preliminary survey of state and national rural health experts allowing them to state priorities in an open-ended fashion, three topics related to primary care—access to primary care, access to health workforce, and access to health services—were frequently named as a rural priorities.⁴ One or more of these three primary care topics was named by nearly two-thirds (65 percent) of those who nominated priorities in this preliminary survey.

PREVALENCE

Rural and urban populations are relatively equal in having a source of ongoing care (nearly 90 percent) and in having a usual primary care provider (approximately 77 percent). Rural residents are less likely, however, to have regular access to their usual primary care provider during evening or weekend hours.⁵

Hispanics are much less likely than white and African-American populations to have an ongoing source of care. And, rural Hispanics are less likely than their urban counterparts, 77 percent and 72 percent respectively, to have an ongoing source of care.⁶ Hispanics and African Americans record, respectively, an estimated 20 percent and 33 percent fewer primary care visits per person than white, non-Hispanic persons.⁷

Uninsured people under the age of 65 are 2.6 times less likely to have a usual source of care than people who have public or private insurance.^{1,8} In 1996, 23 percent of rural residents under the age of 65 were uninsured compared to only 18 percent in urban areas.⁶

The maldistribution of physicians in favor of urban areas is a continuing concern affecting rural access to care. The maldistribution is especially pronounced with respect to specialists and is likely to become an

increasing problem with primary health care.⁹ Although 25 percent of the nation's population resides in rural areas, less than 9 percent of active physicians in the United States and 14 percent of practicing primary care physicians provide services in rural areas.^{10,11}

There has been a general increase in the number of physicians in both rural and urban areas over the past decade; however, a closer analysis of both national productivity data and estimates in two states of those

physicians actually practicing suggests little growth in the effective supply of rural physicians and a decline of 9 percent in the supply of family physicians.¹² Moreover, the ratios of physicians per 100,000 population for several other specialties that are frequently classified among primary care physicians—pediatricians, general internists, and obstetrician/gynecologists—are only one-third as large among rural populations as among urban populations.

The increasing number of physicians who are women may further restrict the supply of rural physicians. Women account for almost 43 percent of all general physicians among the most recent medical graduates, but they are less likely to practice in rural areas than in urban areas.¹³ Only 13 percent of rural physicians are women compared to 19 percent of physicians in urban locations who are women. The disparities in percentages of female physicians practicing in rural areas are even more pronounced with respect to rural family practitioners/general practitioners (FP/GPs) and obstetrician-gynecologists.¹³

Minority general practitioners are more likely to serve minority populations and larger proportions of the poor and/or uninsured.¹⁴⁻¹⁶ Moreover, there is evidence that minority patients prefer to see physicians who are of the same ethnic/racial group

The maldistribution of physicians in favor of urban areas is a continuing concern affecting rural access to care.

as themselves.¹⁷ African-American and Hispanic-American physicians are much more likely than white physicians to come from a rural or inner city background and to have graduated with a National Health Service Corp service obligation. These minority physicians also report relatively larger proportions of their patients are poor, reliant on Medicaid, and reflect the same racial/ethnic background as their own.¹⁵

Studies reveal that primary care physicians who were raised in rural areas are more likely to practice in rural areas.²⁴

Non-physician primary care professionals, such as physician assistants, nurse practitioners, and certified nurse midwives (CNMs), are becoming more important and more common in rural and

urban areas. In comparison to rural and urban physician-to-population ratios, NPPCP-to-population ratios appear to slightly favor rural settings. NPPCPs are able to provide needed primary care in most cases and, earning less than physicians, are better able to conform to the resource constraints in rural areas than physicians.¹⁸

IMPACT

Even in situations where a local physician is available in a rural community, as many as 30 to 40 percent of rural residents may rely on physicians outside of their locality for care. Reasons given usually are associated with seeking better care, or care that exceeds the skills or technologies available in the rural community.^{19, 20}

The under-representation of female physicians in rural areas may also have an effect on the health of female residents of rural areas. It has been shown that female patients usually prefer female doctors and are more likely to receive pap smears and mammograms if done by a female physician, especially if the physician is an internist or family physician.¹³

One consequence of an undersupply and/or underutilization of primary care providers may be increased hospitalizations that might have been prevented with the timely provision of preventive services and primary care service. As many as 12 percent of all hospitalizations may be avoidable.²¹ Nationally, such hospitalizations have been found to be more prevalent among lower and middle income groups and among African Americans.²¹ A 10-state study finds both African Americans (especially adults), Hispanics (especially children), and the elderly in both minority groups more likely than whites to be hospitalized with preventable conditions.²²

BARRIERS

An Oklahoma statewide study identifies a number of factors associated with a lower likelihood of adult use of primary care-based preventive services. Among those less likely to use such services are residents from rural areas, those lacking access to a usual source of care, those at greater risk for avoidable illness, and the poor lacking health insurance.²³

Studies reveal that primary care physicians who were raised in rural areas are more likely to practice in rural areas.²⁴ One study found that greater than 50 percent of rural female physicians were raised in a town with less than 25,000 people.¹⁰ Several recruitment factors, especially family lifestyle factors, serve to differentiate between female and male physicians in their rural practice location choice. Social issues of interest to female physicians include rural-magnified challenges such as balancing work and family, maternity leave, availability of child care, and job opportunity for the spouse or partner.^{10, 25} Professional issues include such matters as work overload, lack of female colleagues, fewer opportunities for advanced training, and acceptance by the community.¹⁰

The undersupply of minority physicians in rural areas is no doubt related, in part, to the relatively smaller number of underrepresented minorities (URMs) who are enrolled in medical colleges and who are applicants to American medical colleges.

The number of URM students enrolled in American medical colleges peaked in 1994, remained steady in 1995, and decreased by 5 percent in 1996. The enrollment of URM students has declined steadily from 1996 through 2001.^{26, 27} The decline is attributed in large part to reductions occurring at public medical schools and in states directly affected by 1996 court and referenda decisions on affirmative action.²⁶⁻²⁸

Access to non-physician primary care providers is limited in some instances by scope of practice regulations that vary from state to state, some national and state-specific reimbursement constraints, and by competition from urban areas for limited numbers of providers.²⁹ NPPCPs practicing in rural, or in more remote rural settings experience greater autonomy or independence than those in other settings.³⁰⁻³² Although such conditions may be attractive to some NPPCPs, it is possible that it may be offset by greater monetary benefits and professional support found in larger, urban facilities.²⁹

Several state studies examine factors that appear to be associated with ambulatory care sensitive conditions (ACSCs) leading to avoidable hospitalizations, i.e., hospitalization that might have been prevented by proper utilization of primary care. There is unanimity in finding low income to be strongly associated with ACSCs; moderate support for greater prevalence of ACSCs among non-whites; and only mixed support regarding the impact of access to primary care physicians upon ACSCs.³³⁻³⁵

PROPOSED SOLUTIONS

Communities, often working through partnerships among providers, can help to develop programs to improve access to care and/or a regular provider to people who are uninsured or otherwise likely to underutilize health care. A number of solutions to access to primary care are dependent upon support from national and state policies affecting medical education and placement of medical graduates in rural and urban underserved areas. At the same time, medical schools can play an important role in developing, often with grant support, special tracks

that emphasize family practice and rural placements.³⁶

SUMMARY AND CONCLUSIONS

Access to primary care is vital to the achievement of Healthy People 2010's goal of improving access to high quality health services. The objective of maintaining a regular source of care is exceptionally difficult to achieve in rural America given the shortage of not only primary care physicians but also non-physician primary care providers, specialists, female physicians, and minority physicians. Given the higher proportion of elderly and poor in rural areas—two populations often requiring more health care—the consequences of provider shortages are significant.

Practice conditions and personal considerations may lead some physicians away from practice in rural areas. At the same time, there is evidence that those who are from rural areas and/or who have trained in rural areas are more likely than others to pursue rural practice. Although physician assistants and nurse practitioners are somewhat more likely than physicians to pursue positions in rural areas, the opportunities in rural practice, e.g., greater practice autonomy, may be offset by more attractive practice opportunities and salaries in urban settings.

Despite these challenges, viable solutions may exist through training programs with a rural focus for health provider students, loan repayment programs, recruitment of rural students, especially underrepresented minorities for medical school, and continued recruitment and retention efforts directed toward non-physician providers. The desirability of larger numbers of women enrolled in medical schools and in the medical profession needs to be followed by greater efforts to recruit medical students from rural areas and to recruit and retain more female and minority physicians in rural practice.

Finally, increased efforts are needed to reduce avoidable hospitalizations in rural areas, especially among poor and minority groups. Increasing the number of rural providers and their adoption of best

practices in addressing ambulatory care sensitive conditions such as diabetes and asthma are important factors in reducing avoidable hospitalizations and improving the health status of the rural population.

MODELS FOR PRACTICE

The following models for practice are examples of programs utilized to address this rural health issue.

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Chapter Suggested Citation

Gamm, L.; Castillo, G.; and Pittman, S. (2003). Access to Quality Health Services in Rural Areas—Primary Care. Rural Healthy People 2010: A companion document to Healthy People 2010. Volume 1. College Station, TX: The Texas A&M University System Health Science Center, School of Rural Public Health, Southwest Rural Health Research Center.



MODELS FOR PRACTICE

FOCUS AREA: ACCESS (PRIMARY CARE)

Program Name: Community Health Center of West Yavapai County

Location: Prescott, Arizona

Problem Addressed: Access to Primary Care

Healthy People 2010 Objective: 1-4a

Web Address: None

SNAPSHOT

The Community Health Center of West Yavapai County (CHCWYC) began as a free clinic approximately seven years ago. The clinic became a community health center in January 2001 and plans to apply for 330 funding from the Bureau of Primary Health Care in the Health Resources and Services Administration (HRSA). The program has grown from seeing 25 patients per night, two nights a week, with a volunteer staff, to seeing 3,000 patients (uninsured and underinsured) in the first year. CHCWYC has a paid staff of seven and shares an additional four to five staff with the health department. The center is a 501(c)(3) non-profit organization. It was recently awarded a HRSA Community Access Program (CAP) grant allowing it to purchase equipment and software to set up a practice management system and an electronic medical record system. It is one of 16 programs to receive a Robert Wood Johnson Foundation (RWJF) grant to integrate mental health into primary care.

THE MODEL

Blueprint: The CHCWYC service area covers 8,000 square miles. The center is co-located with the Yavapai County Health Department, with which it shares resources, including staff. The center has close working relationships with a variety of partners including the health department, hospital, laboratories, a mental health center, and the United Way. CHCWYC has grown from one location to two and has plans to double the number of sites. The shift from free clinic to community health center was made possible with funding from state tobacco dollars. The uninsured, Medicaid and Medicare recipients, and the underinsured below 200 percent of the federal poverty level receive primary care services at the center based on a sliding fee schedule. These services include clinical preventive services, colposcopy clinics, contracted laboratory and radiology services, and a small pharmacy benefit. The pharmacy benefit is tied to a limited formulary and has a \$10 per prescription co-pay. The community health center, in conjunction with the free clinic, provides mental health services one night per week. A chemical dependency specialist physician and a

clinical pharmacist who specializes in polypharmacy problems staff the clinic on a volunteer basis. Two psychiatrists volunteer their time to provide back up for problems that are more serious.

A HRSA CAP grant awarded in 2001 allows the center to purchase equipment and software to set up systems for sharing of patient data and support patient tracking, demographics, insurance, etc. between their sites and with other provider partners who see the same clientele.

Beginnings: The free clinic began as a class project developed by a nurse in the community who was working on her BSN degree. The clinic almost immediately began seeing 25 patients each night, two nights a week. The success of the free clinic and subsequently of the center was and is attributable, at least in part, to the strong support and commitment of the medical community.

Making a Difference: Evaluation of this grassroots effort up to this point has focused on counting the numbers of people who come through the doors. The program recorded 3,000 uninsured patient visits in the first year plus approximately 400 Medicaid clients. A more sophisticated evaluation is anticipated in response to the CAP grant and RWJF funding; however, these are not yet in place.

Challenges and Solutions: Over the course of seven years, with seeing 25 clients every night, volunteer burnout became an ever-present problem. The move to a community health center daytime operation and the complexity of the computer system resulted in the discontinued use of volunteers. However, the loss of volunteers was offset by state tobacco funding (\$358,000 per year) and revenues from Medicaid, Medicare, and self-pay that enabled the center to hire staff. The center hired its first full-time director, a full-time medical director (provider), a part-time physician, and a part-time nurse practitioner. The new mental health clinic has about 10 volunteers.

Currently, the center has two physical locations and plans to expand to three or four sites. There is a mountain range in between the main site and the other location(s). CAP funding will be used for electronic medical records and patient management systems that will support sharing of patient data, patient tracking, demographics, insurance, etc.

Space has been an issue since the free clinic began. Co-location with the local health department, which also enables the sharing of staff resources, has been very successful. A new facility, with 11,000 square feet, is due to open in 2003. The facility represents a pooling of resources—\$500,000 received by the center from the state for a building, \$1.8 million from Yavapai County, and land plus architectural plans donated by the hospital. The new facility will allow the center to expand services to include dental

The success of the free clinic and subsequently of the center was and is attributable, at least in part, to the strong support and commitment of the medical community.

services and provide a separate location for mental health counseling and six exam rooms.

Continued funding is always a problem. The center has been successful applying for funds that support caring for the uninsured, implementation of mental health services, and a computer infrastructure. The need still exists for funds that cover the staff who deliver the services. The center is applying to become a 330 funded Federally Qualified Health Center to help cover indirect service costs.

PROGRAM CONTACT INFORMATION

Peggy Nies, Director
Community Health Center of West Yavapai County
930 Division Street
Prescott, AZ 86301
Phone: (928) 771-3369
Fax: None



MODELS FOR PRACTICE

FOCUS AREA: ACCESS (PRIMARY CARE)

Program Name: Fairview University of Minnesota Telemedicine Network

Location: Wadena, Minnesota

Problem Addressed: Access to Primary Care

Healthy People 2010 Objective: 1

Web Address: <http://www.fairview.org/telemedicine>

SNAPSHOT

The Fairview University of Minnesota Telemedicine Network (FUMTN) is an established means of providing care to rural Minnesota through the use of telemedicine technology. It consists of an urban primary hub site with several spoke sites located in rural areas that are extremely underserved by physicians, especially specialists.

Services encompass the wide span of technologies available, from low-bandwidth video conferencing and Internet access into a patient's home, to high-band live interactive video-conferencing within system sites.

THE MODEL

Blueprint: The Fairview University of Minnesota Telemedicine Network exists to improve access to health care for rural individuals across the lifespan, strengthen linkages with rural practitioners, and foster integrated systems of care. The network currently includes the hub site and seven rural spoke sites. It provides services including cardiology, diabetic management, wound care, dermatology, homecare and hospice, child psychiatry, rheumatology, long-term care, orthopedics, pulmonology, and rural health clinic support by using interactive video-conferencing and store-and-forward telehealth technologies. Services encompass the wide span of technologies available, from low-bandwidth video conferencing and Internet access into a patient's home, to high-band live interactive video-conferencing within system sites.

The hub site at the Fairview University Medical Center in Minneapolis began operation in 1994, and the spoke site at the Tri-County Hospital (TCH) in Wadena began providing services in February 1995. Tri-County Hospital is a private, not-for-profit organization with 49 acute beds. TCH's service area is considered to be 20,000 people within a 25-mile radius, which includes the counties of Todd (the poorest in the state), Otter Tail, and Wadena. This includes 11 additional small, rural communities. These counties are located in north central Minnesota, approximately 170 miles from the St. Paul/Minneapolis metropolitan areas.

Making a Difference: A Minnesota Department of Health statistical report on morbidity shows that deaths from cardiovascular disease in the 11-county

region around Todd, Wadena, and Otter Tail Counties are the highest in the state of Minnesota. Decreased access to cardiology specialists contributes to this problem. Tri-County Hospital has three rural health clinics in designated health professional shortage areas in Todd, Wadena, and Otter Tail Counties that address this and many other health problems. The number of physicians per 10,000 residents in the counties of Todd, Wadena, and Otter Tail are lower than the rest of the state of Minnesota. The state of Minnesota has 22.4 physicians per 10,000 residents overall. The number in Todd County is 4.6 physicians per 10,000 residents; Wadena County is 9.3 physicians/10,000, and Otter Tail County is 10.5 physicians per 10,000 residents. The three rural health clinics help alleviate the health professional shortages in combination with the utilization of telemedicine.

Under its current grant schedule, FUMTN has created additional targeted spoke sites that include one additional primary spoke site and four primary rural spoke sites, one of which will serve a federally recognized Indian community. Additional sites specific to Tri-County Hospital include three rural health clinics and a connection to a long-term care facility. Expansion of TCH's current home care/hospice telehome program is also projected.

Beginnings: The lack of access to primary care was identified through needs assessments that were coordinated by the Fairview-University of Minnesota Telemedicine Planning group. Community needs assessments were completed at many sites, and needs were documented at other sites with extensive input from community members, as well as physician and mid-level providers and public health programs.

The original telemedicine program received three years of funding from the U.S. Office of Rural Health; it then functioned independently of external funds for two years with support from Fairview-University Medical Center. A recent additional grant from the Office for Advancement of Telehealth (OAT) allows FUMTN to expand the sites involved in telemedicine, therefore expanding the access of specialists to rural Minnesota. With ongoing changes in reimbursement and facility fees, the program expects to be sustained after the grant period since FUMTN is an established means of providing care to rural Minnesota.

Challenges and Solutions: The challenges encountered by telemedicine sites that have ultimately failed have involved lack of physician "buy in" of the program. The Fairview University Telemedicine Network believes that each potential site needs a "physician champion" who believes in and can educate the medical staff on the telemedicine process, programs, and advantages. This is especially important since telemedicine sites will not be successful without physician referrals.

PROGRAM CONTACT INFORMATION

Robin Klemek, RN, Telemedicine/Outreach Services Manager
Fairview University of Minnesota Telemedicine Network
Tri-County Hospital
415 North Jefferson
Wadena, MN 56482
Phone: (218) 631-7497
Fax: (218) 631-7596



MODELS FOR PRACTICE

FOCUS AREA: ACCESS (PRIMARY CARE)

Program Name: Rural Health Network of Monroe County, Florida – Lifelines Project

Location: Monroe County, Florida

Problem Addressed: Access to Primary Care

Healthy People 2010 Objective: 1-4, 1-5, 1-6

Web Address: <http://www.ruralhealth-floridakeys.org>

SNAPSHOT

The Lifelines Project is a project of the Rural Health Network of Monroe County (RHNMC) (Florida Keys). This charitable organization provides primary health services to the homeless, uninsured, and others who are underserved. Through the use of two mobile unit medical vans, services such as TB tests and HIV tests, immunizations, and physical exams are provided to populations in need.

Lifelines provides outpatient, primary health care that includes such elements as pharmaceutical assistance, discounted laboratory costs, health education, women's health exams, and referrals.

THE MODEL

Blueprint: Beginning in August 1999, RHNMC, a coalition of 36 agencies and individuals who govern the Lifelines Project and all functions of the network, has provided primary health care to persons in need in the Florida Keys regardless of ability to pay. Lifelines is marketed to the uninsured, underinsured, working poor, and homeless. Income levels of clients usually fall below 200 percent of the federal poverty level (FPL), with a majority of clients with incomes at or below \$15,000 per year. Lifelines provides outpatient, primary health care that includes such elements as pharmaceutical assistance, discounted laboratory costs, health education, women's health exams, and referrals. All clients are asked to pay a \$10 co-pay if they are able. RHNMC has two mobile unit vans, staffed by two teams of medical practitioners that include two paid registered nurses and advanced registered nurse practitioners. The project also employs health educators, a health services director, and a medical director. The vans travel the islands of the Florida Keys and are scheduled to be in the same specific locations each day of the week. In addition to the mobile vans, RHNMC provides outpatient primary health care services five days a week at the Ruth Ivins Center in Marathon.

Monroe County is a unique area in the continental United States with health care access difficulties. It covers 45,000 square miles, but 95 percent of the county is part of the Big Cypress Preserve and the Florida Everglades on the Florida mainland and is uninhabited and non-taxable. The inhabited portion,

known as the Florida Keys, is populated by about 78,000 people and is a group of over 300 islands, of which only 43 are connected by 42 bridges over a two-lane highway. Key West, the county seat and largest population center, is located 150 miles from Miami, the largest proximal city to the Keys. Many residents of Monroe County experience difficulties in accessing housing and medical care since it has had the highest cost of living in the state for 20 years, and many residents are low-income service personnel serving the tourism industry. For this reason, the Lifelines Project is crucial for many inhabitants of the Florida Keys.

Making a Difference: The Lifelines Project provides health care to the uninsured with a level of service that historically was not available in Monroe County before 1999. About 3,200 services are provided each year. Sixty clients were randomly selected from the multiple service sites to complete a service satisfaction survey. All 60 clients responded positively to overall satisfaction with the services. The health services director reports that 100 percent of the time, responses to inquiries for appointments occur within 24 hours. The project has also reduced the number of visits to the local emergency room, therefore reducing emergency room costs for patients and providers. RHNMC has been successful in securing interim funding from the Health Foundation of South Florida and Catholic Charities. It also received sustaining funding for the first time in the project's history from the Monroe County government in August 2001. RHNMC was asked by Catholic Charities to continue making a difference by building a new clinic in Key West to treat the homeless under a Rural Health Outreach Grant from the Health Resources and Services Administration (HRSA). RHNMC also developed a dental program for the uninsured that was projected to begin June 1, 2002.

Beginnings: The Lifelines Project was created as the result of a reduction in health care services offered by the local health department. In 1998, the director of the county health department notified the RHNMC executive director that the residual services provided by the health department in Key West would be reduced and that total elimination of services was anticipated. In response, the RHNMC executive director and the RHNMC board developed a plan of action to provide countywide primary health care services through the use of medically equipped mobile vans. The program was fully implemented on August 31, 1999, and the Ruth Ivins Center began providing services on May 1, 2001. The Monroe County government, University of Miami School of Medicine, and U.S. Department of Housing and Urban Development (HUD) provided start-up funding for the Lifelines Project.

Challenges and Solutions: The University of Miami, one of the original funders, continues to support the project with the placement of third year medical students, but their funding support has come to an end. Monroe County government and HUD continue to financially support the Lifelines

Project. After completion of its first year, the project was awarded a three-year grant from HRSA and a one-year grant-in-aid from Catholic Charities of the Archdiocese of Miami. The Catholic Charities grant-in-aid was renewed in 2001. In May 2001, the project was awarded a one-year grant from the Health Foundation of Southern Florida. The project is currently seeking sustaining funding from the State of Florida to match that of the Monroe County government. Client co-pays only generate about 10 percent of the project's costs, and the Medicare and Medicaid incomes are negligible.

The Lifelines Project advertises to prospective clients through advertisements on local access television, newsletters, brochures, and radio public service announcements. Changes in service location are placed in printed media ads, and brochures are distributed in neighborhoods of target populations. Additionally, the Lifelines Project markets to the community at large via the RHNMC website.

PROGRAM CONTACT INFORMATION

Mark Szurek, Ph.D.
Rural Health Network of Monroe County, Florida – Lifelines Project
P.O. Box 4966
Key West, FL 33041
Phone: (305) 293-7570
Fax: (305) 293-7573



MODELS FOR PRACTICE

FOCUS AREA: ACCESS (PRIMARY CARE)

Program Name: A Rural Minority Geriatric Care Management Model

Location: Charleston, South Carolina

Problem Addressed: Access to Primary Care

Healthy People 2010 Objective: 1

Web Address: None

SNAPSHOT

The Rural Minority Geriatric Care Management Model's purpose is to develop an innovative, integrative, and comprehensive service delivery system of care coordination and management for older African Americans in rural areas of South Carolina. The overall aim is to improve the quality of health, medical care, and social services available to older adults. Often, health center clinicians and staff are called upon to spend a large amount of time performing non-clinical tasks, such as helping patients find transportation, accessing indigent drug programs, or applying for public eligibility programs. To relieve the clinician of non-clinical requests, a new type of paraprofessional—a trained, paid geriatric coordinator—serves as a client advocate through case management, health promotion, and linkages with local social service agencies.

THE MODEL

Blueprint: The Rural Minority Geriatric Care Management Model operates in a Federally Qualified Community Health Center (FQHC), its satellite sites, and a rural health clinic in South Carolina. The program targets primarily African-American adults between the ages of 55 and 98, who have low incomes and are underinsured. The geriatric coordinators provide a number of services to the patients of these clinics, each having an expected caseload of 50-100 clients. They are responsible for tracking older clients' needs for primary care health services, assisting clients in making appointments while reminding clients about them as well, arranging transportation to health care, and monitoring their compliance with the medical care they do receive (i.e., medications, diets, lifestyle, appointments). In addition to assisting in health care utilization, the coordinator also facilitates home health care services as needed by the older patients, documents care management activities in a daily log, and attends meetings with the nurse project coordinator and health care providers to discuss client cases and updates. These individuals contribute significantly to the successful implementation of medical treatment in each client's life.

Making a Difference: Outcome measurements find these efforts to have significant success. These successes can be seen in the clients' physical and financial status. For health care, 50 percent of the clients are up-to-date on preventive health services such as mammograms, prostate checks, flu shots, and cholesterol checks; 88 percent have had home environmental safety assessments with referrals, and 42 percent have been diagnosed with diabetes and are receiving ongoing management and education for this condition. Financially, 100 percent of those eligible have been linked with Supplemental Security Income, Medicare Disability, or Medicaid, as opposed to the 54 percent who were eligible but were not receiving benefits prior to the intervention. Fifty-seven percent of the clients receive medications from indigent drug programs; 54 percent receive energy assistance; 30 percent receive food stamps, and 35 percent receive mobile/congregate meals. The impact on the communities in which the program operates has been one of great accomplishment.

Beginnings: In 1997, the South Carolina Department of Health and Human Services provided funds to the Medical University of South Carolina (MUSC) to establish a "Healthy Community Outreach Initiative." MUSC faculty submitted proposals for community programs that were peer reviewed by a panel of MUSC faculty. This community outreach model was chosen for funding for three years. In 2001, the program director submitted a request to the Duke Endowment and received funds to expand and extend the program an additional two years, with the goal of sustainability. The project director believes that a five-year time period is needed to facilitate infrastructure for community programs. The program targets primarily older African-American adults who have low incomes and are underinsured. This group was specifically targeted because of their need for education, advocacy in navigating the health care system, and assistance with linkages to public benefits and social services.

Challenges and Solutions: Maintaining funding for programs such as the Rural Minority Geriatric Care Management Model is challenging; however, the initiative has been successful in this area. A funding award from the Duke Endowment expanded the program to include five additional health center sites and extended the program for an additional two years. Also, the health centers were willing to pay a percentage of the coordinators' salaries over the two-year extension and currently, as the grant funding cycle nears completion, the health centers have committed to retaining the geriatric coordinators as full-time staff. This allows for 100 percent sustainability to be achieved after funding has ceased. Finally, to further ensure future success, the staff publicizes project outcomes, continues to develop ongoing linkages with community agencies and programs to enhance community capacity building, and provides a system of care for older adults.

The program targets primarily older African-American adults who have low incomes and are underinsured.

PROGRAM CONTACT INFORMATION

Esther M. Forti, Ph.D., RN
Associate Professor and Director South Carolina Geriatric Education Center
Department of Health Professions
College of Health Professions
Medical University of South Carolina
P.O. Box 250212
26 Bee St.
Charleston, SC 29425
Phone: (843) 792-5487
Fax: (843) 792-0679



MODELS FOR PRACTICE

FOCUS AREA: ACCESS (PRIMARY CARE)

Program Name: St. Mary's County Health Department Medical Assistance Transportation Program

Location: St. Mary's County, Maryland

Problem Addressed: Access to Primary Care

Healthy People 2010 Objective: 1-4, 1-5, 1-6

Web Address: <http://www.smchd.org>

SNAPSHOT

The primary focus of the Medical Assistance Transportation Program is to get the medical assistance population of St. Mary's County, Maryland, to their medical appointments if they have no other way to get there.

The St. Mary's County Health Department Medical Assistance Transportation Program is a safety net program designed to transport medical assistance patients by a variety of methods to their medical appointments in local and semi-local areas. These individuals have no other means of transportation and would not otherwise be able to attend their appointments and receive care. The program also provides transportation to non-medical assistance individuals for a nominal fee if they have an open seat and are traveling in the same direction.

THE MODEL

Blueprint: The Medical Assistance Transportation Program is grant funded by the Maryland State Department of Health and Mental Hygiene and is managed by the St. Mary's County Health Department. Collaborative efforts and partnerships are relied upon for some areas of service delivery. The primary focus of the Medical Assistance Transportation Program is to get the medical assistance population of St. Mary's County, Maryland, to their medical appointments if they have no other way to get there. The secondary focus of the program is to assist others in the county who need transportation to medical appointments since transportation is a major issue for the county. St. Mary's County is a peninsula at the far southern end of Maryland. At 361 square miles, it lies at the confluence of the Potomac River and the Chesapeake Bay, about 40 miles south of Washington D.C. It is a rural county with a population of just under 90,000. The county has a Medicaid population of about 7,000 and a much larger gray zone population (individuals with incomes too high to qualify for Medicaid but who are unable to afford private health insurance), estimated to be in excess of 12 percent of the population. The non-white population consists of 17 percent black, and the Hispanic population is growing at 2–3 percent. Approximately 30 percent of the population is under the age of 18.

All individuals who participate or are eligible for the state Medical Assistance Transportation Program qualify to receive the services of this program. The program provides transportation to scheduled and urgent same-day trips to local and tri-county medical appointments as well as trips to the Washington D.C. and Baltimore areas. Out-of-state trips are also occasionally made. Five drivers provide the ambulatory trips using a fleet of public service commissioned inspected vehicles, sedans, station wagons, minivans, 15-passenger van, mini bus, and wheelchair-accessible vehicles. This is a door-to-door service provided approximately 80 hours/week. The local public transportation service is used at the expense of the program if an individual lives on the public bus route and is traveling to a destination on the bus route. In extreme circumstances, taxi services are utilized as a last resort at the program's expense. The Medical Assistance Transportation Program also issues gasoline vouchers if the person needing care can get someone to take them to their appointments. In addition, the program contracts with ambulance services for 24/7 access.

The St. Mary's County Health Department Medical Assistance Transportation Program has a reciprocal agreement with a neighboring county (Charles County) transportation system to relay some of the patients to city appointments. They often work in cooperation with each other to schedule appointments for the same day and time if patients from each county must see a physician in the neighboring county. The two county transportation units meet in the middle and then exchange riders to shorten the trip for the drivers and conserve resources.

Making a Difference: The St. Mary's County Health Department Medical Assistance Transportation Program currently runs approximately 1,500 trips per month, totaling 15,000-20,000 miles. These trips are critical to enabling the medical assistance population to access needed medical care.

Beginnings: The program began providing transportation services to the citizens of St. Mary's County in fiscal year 1993, and the program was fully implemented in fiscal year 1994. The problem with transportation was identified by examining the high numbers of missed appointments by this medical assistance population. Non-compliance of patients with medical instructions and poor immunization rates for children within this population were also recognized as problems that could be partially attributed to a lack of transportation. In one instance, a vulnerable individual was lost in Baltimore City for six hours when traveling there for a medical appointment. This event and the knowledge that many of the riders have not traveled in the city alone led to developing a "high visibility" card and ID tag with emergency information on it for riders to carry with them while in the city.

Challenges and Solutions: The program has experienced challenges in persuading the local government to extend/expand bus routes to where the lower income individuals live and to where the medical providers are

located. In addition, the increased costs of ambulance transports threaten the program's ability to continue 24/7 access to this service. Helping the riders develop responsibility skills for keeping appointments, calling to cancel, and being on time continue to be important challenges.

PROGRAM CONTACT INFORMATION

Mary C. Wood
St. Mary's County Health Department Medical Assistance
Transportation Program
21580 Peabody Street
P.O. Box 316
Leonardtown, MD 20650
Phone: (301) 475-4330
Fax: (301) 475-4350



MODELS FOR PRACTICE

FOCUS AREA: ACCESS (PRIMARY CARE)

Program Name: West Virginia Rural Health Education Partnerships

Location: Morgantown, West Virginia

Problem Addressed: Access to Primary Care, and Recruitment and Retention of Rural Health Professionals

Healthy People 2010 Objective: 1

Web Address: <http://wvrhep.org>

SNAPSHOT

The West Virginia Rural Health Education Partnerships (RHEP) was created to train health professionals in rural, underserved communities. State law enables rural, community-based facilities to provide this training in underserved, rural areas of the state. The higher education system requires a three-month rotation and service learning for degree completion for 10 disciplines of health professional students in a state-supported program. Students spend 20 percent of their time in the community on prevention and health education service projects. Local boards, site coordinators, and field faculty help the students choose projects that meet the community needs. The program is state funded and consists of 13 regional partnerships and over 47 rural counties in the largely rural West Virginia.

THE MODEL

Blueprint: The program was first developed in 1992 and fully implemented in 1996 with the purpose of addressing three problems: recruitment and retention of the health care workforce in rural, underserved areas; access to primary health care for the underserved population; and rural health leadership and service learning for health professionals. It is a statewide partnership of local rural communities, higher education (19 state and private health professional schools and programs), and state government.

The program consists of 13 regional partnerships, each with its own board, and covers 47 rural, underserved counties in West Virginia. There are 295 rural training sites that include, but are not limited to, community health and primary care centers, small rural hospitals, single specialty clinics, dental offices, pharmacies, home health and hospice agencies, physical therapy services, and substance abuse centers. In addition, there are about 700 local community partners including 498 rural practitioners who serve as preceptors for the students and residents that include physicians, dentists, pharmacists, and a variety of allied health professionals.

The program employs an executive and associate director, administrative secretary, director of research and evaluation, and 17 site coordinators and secretaries. Moreover, the program receives volunteer services from over half of the faculty preceptors and all 200 community member partners. It is funded by appropriations from the state legislature through a direct line item in the higher education budget.

The recruitment/retention program is critical to the state since West Virginia is the second most rural state in the country, with 64 percent of the population living in communities with under 2,500 people and spread over 24,000 square miles. The program covers 47 counties, or 85 percent of all counties in the state. The rural population of these counties represents 1,117,133 of the state's 1.7 million people. Eighteen of these counties are 100 percent rural, and all others are more than 50 percent rural. The state is very mountainous with many secondary two-lane highways and roads. In 1999, West Virginia became the oldest state in the country, with almost 18 percent of the total population over 65 and a median age of 36. The annual median family income is only \$25,602.

Making a Difference: The Rural Health Education Partnerships program primarily focuses on providing prevention and education services to predominantly rural, low-income populations of all ages. In 2001, 216,127 community service contacts were made, and of these 148,593 were prevention and education to the general public; 16,808 were prevention and education for adults, and 50,726 were prevention and education for children. These services are provided by approximately 120 health profession students per month and represent 10 disciplines; 1,402 student rotations were completed in 2001 for a total of 6,822 weeks of training. The program trains and recruits rural physicians in addition to supplying manpower to rural health care facilities through the use of students. An online tracking system called TRACKER® is used to evaluate the program, schedule rotations, and track the practice location following training. This helps the program identify how successful it is in recruiting and retaining health care professionals in rural areas.

Beginnings: In 1990–1991, the West Virginia state legislature examined the issue of the number of rural, underserved areas and the retention rate of state health professional school graduates. They also investigated the expenditures of state dollars to public higher education. This debate sparked community and school interest in developing a statewide system for community-based training as a strategy to improve recruitment and retention of state-trained graduates in the health professions. RHEP was actually created by this legislation and is a program of the higher education system of the state. All health professional students in a state-supported program are required to complete three months of training and service in underserved, rural areas of the state. The partnership began as two programs—the Community Partnership Initiative funded by the W.K. Kellogg Foundation from 1991 to 1996, and the Rural Health Initiative funded by the state's

The recruitment/retention program is critical to the state since West Virginia is the second most rural state in the country, with 64 percent of the population living in communities with under 2,500 people and spread over 24,000 square miles.

Rural Health Act of 1991. These programs were merged into the West Virginia Rural Health Education Partnerships in 1995, and the legislature increased the appropriations from \$6 million to \$7.5 million to cover the Kellogg funding levels. The merger expanded the program into more underserved counties in the state, bringing it to its present level of 47 counties and 13 consortia. Since 1992, the program has been solely funded with state dollars, but many federal and private foundation grants have been received by the partners on the strength of the partnership and the expansiveness of the statewide training network. These have included Health Resources and Services Administration (HRSA) grants for interdisciplinary training in rural areas, research grants, resident training grants, and demonstration and model replication grants.

Challenges and Solutions: Some of the initial challenges included extending the training in rural, underserved communities as a degree requirement; working with lead agencies and some partners in building a partnership that was not a traditional hierarchical organization; devising a decision-making model that was equally shared among all partners; and developing full trust within the partnerships to share resources.

These challenges were overcome by developing a clear, open, and concise system of communication; involving all partners in defining vision, values, mission, strategies, outcomes, and policies regarding operations; and spending time to develop trust. This was facilitated by encouraging partnership interaction and consistently engaging community members and students in the process as the focal point of the partnerships' outcomes. Keeping the focus on the community and the role of the community members as the stewards of the partnership helped to facilitate shared power in decision making.

The program is marketed through local newspapers, websites, and personal advertisements by practitioners. Presentations are also made at civic clubs, churches, social events, and special annual events. The program has been featured in a number of professional publications and is the recipient of numerous awards, including recognition by the U.S. Surgeon General. Examples include receipt of a Community-Campus Partnership, Inc. Award for Leadership, a spotlight in the *New York Times*, and a publication in the *Journal of the American Medical Association*.

PROGRAM CONTACT INFORMATION

Hilda Heady, MSW
West Virginia Rural Health Education Partnerships
Office of Rural Health
West Virginia University Health Science Center
P.O. Box 9003
Morgantown, WV 26506
Phone: (304) 293-6753
Fax: (304) 293-3005

