



NATIONAL RURAL HEALTH ASSOCIATION



# rural roads



***In This Issue:***

**21st century  
house calls**

**Mental health care  
for HIV patients**

**The workforce pipeline**

**Gender gap in  
substance abuse  
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*Rural Roads* focuses on model rural health practices and programs, creative use of technology, rural health heroes and human interest stories. Article submission in the range of 250 to 1,500 words is encouraged. The goal of each story should be to motivate, educate or inspire those working to improve health care or living in rural America. *Rural Roads* adheres to standard *AP Style* guidelines. Articles must be submitted electronically to [editor@NRHArural.org](mailto:editor@NRHArural.org). Photos may accompany articles and can be sent electronically as a high-resolution file (at least 300 dpi) in an EPS or Tiff format, a digital photo sent in the largest format available or mailed for scanning and return. The NRHA reserves the right to edit all materials submitted for clarity, consistency and formatting to meet in-house style guidelines. Submission of an article does not guarantee publication. We further reserve the right to publish all letters received.

### Publication schedule

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# ruralroads

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# RURAL ADVOCACY NEEDED NOW

BY ALAN MORGAN, NRHA CEO

**R**ural is not simply a small version of urban. That statement helps explain why so many federal policies and regulations do not work well in rural America. What may work great in downtown Washington, D.C., will not always work well in our rural communities.

In this issue of *Rural Roads*, we explore what makes rural great, and we also highlight some ideas on how to make rural health care even better in the future. It might seem odd that what happens in a small rural town can be so interconnected to what happens miles away in our nation's capitol. However, the federal government regulates every aspect of our nation's system. It also pays for the health care for our nation's elderly and low income citizens. That makes the federal government a necessary partner in our rural health care delivery system.

This partnership between the federal government and our local rural health care systems means that for better or worse, we need to engage in advocacy to ensure this partnership remains strong and vibrant.

Rural is the geographic location where the people most in need of health care services often times have the fewest health care options. As a result, our rural health advocacy efforts often focus on addressing health care disparities and rural workforce shortages to ensure access to care.

Access to health care is a key component of any community. Without access to health care in a rural community, more often than not, that community will disappear over time. This is one of the reasons the health of the community and health care within the community are so closely linked.

A great strength of rural health care is that it often involves small systems of care and small populations engaging in these systems. This allows for these systems to change, react and adapt far better than their larger urban counterparts. Therefore, rural health care is an ideal place to innovate and to begin reforming our nation's health care system. The National Rural Health Association is advocating for this change.

I hope you enjoy this issue of *Rural Roads*, and I hope you will also take the opportunity to become a rural advocate in 2008.



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# IMPROVING PATIENT CARE *together* through national effort

BY PAUL DAVID MOORE, D.PH., NRHA PRESIDENT

“**T**

*wo are better than one; because they have a good reward for their labor... And a threefold cord is not quickly broken.” –Solomon*

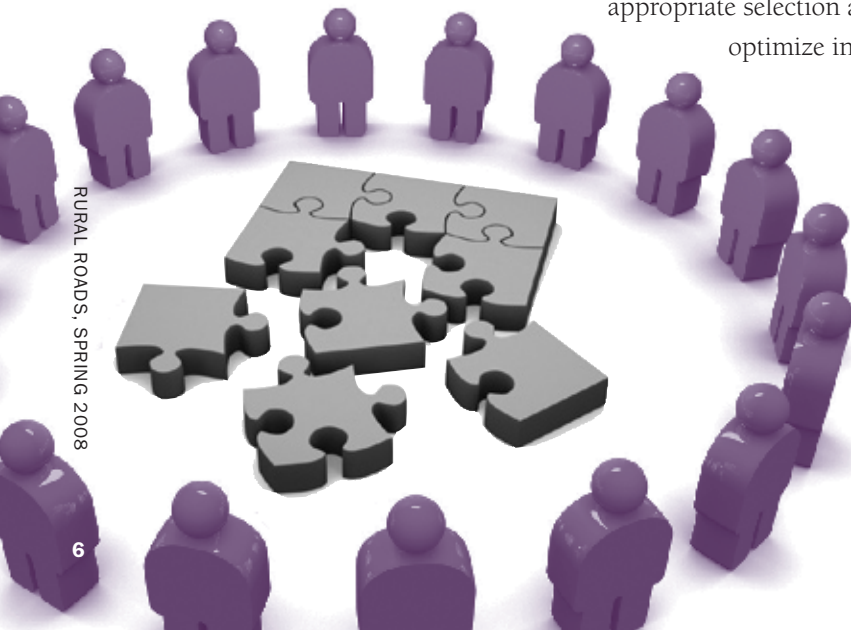
That we can achieve together what we cannot separately is a long-accepted reality. Yet history reveals we tend to wait for an overwhelming challenge to force us to work together. Well, the challenge is here. Adverse health care events continue to be a leading cause of death and injury in the United States even though well-documented methods could prevent their occurrence.

The 1999 Institute of Medicine report *To Err is Human* identified medication errors as a major cause of preventable patient injury, with an estimated 1.5 million people injured annually. It also estimated that for every dollar spent on ambulatory medications, another dollar is spent to treat new health problems caused by the medication. With increased use of medications due to programs such as Medicare Part D, adverse drug events among outpatients will likely increase unless prevention strategies are implemented.

Enter the Health Resources and Services Administration’s (HRSA) Patient Safety and Clinical Pharmacy Services Collaborative. The goal of the collaborative is to ensure patient care delivered by safety net organizations becomes the best in the nation, and a key component is to increase awareness of the benefits of clinical pharmacy services and to promote the role of the pharmacist as an integral part of an interdisciplinary health care team. For the purposes of this collaborative, clinical pharmacy services are defined as patient-centered services that promote the

appropriate selection and utilization of medications to optimize individualized, therapeutic outcomes.

Working with HRSA grantees, critical access hospitals and a wide range of other safety net providers, the HRSA Center for Quality and the Office of Pharmacy Affairs are identifying the best practice models in three areas: patient safety, clinical pharmacy services and

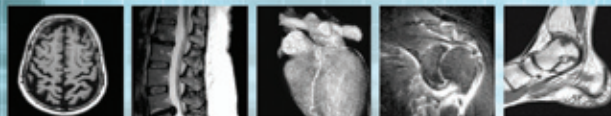


health outcomes. The collaborative is national in scale and intended to generate rapid results. Participation is voluntary but requires teams to commit to ambitious aims, attend learning sessions and conference calls, track progress and results, and share practices and learning in an open and transparent manner. Improvements will be targeted especially in the ambulatory care arena and will emphasize transitions and handoffs of safety net patients, such as between outpatient care and inpatient hospital care settings.

The collaborative brings together federal partners such as CMS, AHRQ, CDC, FDA and VHA, along with leading national partners such as NRHA, national quality organizations, national pharmacy organizations and other stakeholders.

Health care providers and organizations that want to participate in this exciting new national effort should look for information on how to participate in May, and anticipate the first major learning session in Washington, D.C., Aug. 13 through 15. To learn more about this opportunity, please visit [www.hrsa.gov/patientsafety](http://www.hrsa.gov/patientsafety) and sign up for e-mail updates.

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# A home health technology project in rural Kentucky

BY DAVID A. GROSS AND FRAN FELTNER

*With the touch of a button, Henrietta Caskey logged into the hand-sized machine sitting on a table beside her recliner and waited for the screen to activate.*

Seconds later, a message popped up. “I’m so glad you’re back, Henrietta,” the screen read. “Did you check your blood pressure today?”

After clicking “yes” and responding to a series of other health-related questions, Caskey, 77, pressed another key on her Health Buddy, an appliance that plugs directly into a telephone line. Instantly, the information was sent from Caskey’s northeastern Kentucky home to a data center in San Jose, Calif. Using a shared electronic medical record, her local physician and home health nurse can view the results within minutes.

“I never thought I’d be doing anything like this, but I’m glad,” says Caskey, a widowed mother of 10 who has not so much as used a computer in her lifetime. “It gives me something to do.”

More than that, it makes Caskey, who suffers from diabetes and congestive heart failure, an active part of her care team. In fact, prior to her Health Buddy session each morning, Caskey checks not only her blood pressure, but also her weight, pulse rate and blood glucose level.

For the most part, the intense self-monitoring has improved the health outcomes for Caskey and other Morgan County, Ky., residents who are participating in an innovative home health technology project. With support from a state grant, the University of Kentucky (UK) Center for Excellence in Rural Health, Appalachian Regional Healthcare (ARH), Kentucky Homeplace and other partners have implemented telehealth into the homes of approximately 40 patients who face mobility or communication issues.

The in-home units – accompanied by devices such as scales, glucometers and blood-pressure cuffs – enable home health personnel to monitor patient care via a Web-based electronic patient and data management system. Workers at Kentucky Homeplace, a rural-based patient assistance program, train patients to use the technology and assist home health staff members in tracking data. Most importantly,



## “This type of technology is the wave of the future.”

Les Rogers, home health administrator

the project – now in its second year – allows physicians, nurses and pharmacists to have timelier access to outpatient information, resulting in a heightened level of care.

The enhanced response to patient needs already has reduced their rate of hospital re-admissions, says Rhonda Dixon, director of the Morgan County ARH Home Health Agency.

Because of the intriguing prospects, the use of technology in patient self-testing has become increasingly prevalent nationally.

“This type of technology is the wave of the future,” says Les Rogers, corporate home health administrator

for ARH, one of the nation’s largest providers of in-home services. “I can’t have a nurse in the home all the time, but this unit is there all the time.”

### Better for the patient – and the system

That degree of accessibility is particularly important in rural areas, Rogers said, where home health services are all the more vital for a variety of reasons including higher disease rates, older populations, scarce public transportation, and thousands of poor residents living with limited access to other health care and social services.

Yet, the rural-based agencies providing that care face difficulties themselves, including financial pressures that result from lengthy commutes between patients’ homes. During an average year in Kentucky

alone, approximately 115 home health agencies provide services including skilled nursing, therapy, education and personal care for nearly 120,000 patients.

That’s why officials are excited about the home-health technology project – it’s reducing the number of expensive home visits made by nurses while improving patient care.

Part of the reason for participants’ improved health outcomes, Dixon says, is that the Health Buddy assists in patient education by regularly providing useful tips to help patients take better care of themselves.

“The key is reinforcement,” Dixon says. “It’s instilled in them over and over to be cognizant of their health.”

Project officials also realize the importance of producing evidence-based results. Dr. Baretta R. Casey, director of the UK Center for Excellence in Rural Health and



Henrietta Caskey, a patient in the Morgan County, Ky., home health technology project, checks her blood pressure each morning before entering the results into her Health Buddy. Within minutes, the results can be viewed by her physician and home health personnel.



Each day, Henrietta Caskey and nearly 40 other home health patients in Morgan County, Ky., enter health information into a Health Buddy, an appliance that more closely links patients with their home care provider.

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Dr. Baretta R. Casey, director of the University of Kentucky Center for Excellence in Rural Health and principal investigator of the project, talks with West Liberty, Ky., physician James Frederick, who has referred several patients to the home health technology initiative.

herself a former private-practice physician, said plans call for the provision of biannual progress reports to local doctors who refer patients to the project.

to use these devices. It will improve their whole status.”

In the coming months, ARH and UK Center for Excellence in Rural Health officials will analyze project

One of those is Dr. James Frederick, a lifelong resident of Morgan County, Ky.

“These folks are extremely poor, but they’re not dumb,” Frederick says of patients he has referred.

“They’ll learn to use these devices. It will improve their whole status.”

data to determine the potential for future applications, including replication of the project throughout ARH’s operations in eastern Kentucky and southern West Virginia.

“Our ultimate goal is to keep as many patients as possible healthy and out of the hospital,” Casey says, “and in so doing decrease cost to the patients and the health care system. I hope we can spread this throughout Appalachia.”

David A. Gross is the University of Kentucky Center for Excellence in Rural Health’s director of research, marketing and community engagement.

Fran Feltner directs the lay health workers division based at the center.

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# Diabetes education program serves high-risk area

*Seven percent of Americans, or 20.8 million people, have diabetes, according to the American Diabetes Association (ADA). Another 6.2 million aren't aware they have the disease.*

In Giles County, Va., the rate of diabetes is nearly double the state and national averages. Faced with these figures, Carilion Giles Memorial Hospital (CGMH) staff and local physicians acknowledged that education would be key in controlling the disease.

Research shows that early diagnosis, treatment and extensive education can delay or prevent complications of type two diabetes. Diabetic education has also been found to delay or prevent progression to type two diabetes in the pre-diabetic patient.

In 2002, an interdisciplinary health care team began developing CGMH's first Diabetes Self-Management Education Program. The program initially provided basic diabetic education to patients, such as what the disease is, its causes, complications, treatment options and how to use a glucose meter.

In the beginning, the program received one or two referrals each month, and those patients were found to have remarkably improved glucose control after

participating in diabetes education. Physicians recognized the value of the program, and referrals increased. To keep up with demand, program directors began researching how to make educational opportunities even better. A structured and more comprehensive program emerged that was aligned with ADA's national standards for diabetes self-management education. Education



Kara Kiemeyer, R.D., educates a patient on portion control and understanding food labels.

## In Giles County, Va., the rate of diabetes is nearly double the state and national averages.

appointments that originally lasted 30 minutes to one hour were extended to one and a half to three hours.

“The process gives us a national standard by which to measure the quality of services we provide,” says Martha Ratcliffe, R.N. and CGMH diabetic nurse educator. “And of course, it assures that our patients will receive high-quality service.”

The enhanced program educates about 300 patients annually on diabetes basics, in addition to nutrition, blood glucose monitoring, medications and exercise. The ADA standards allow instructors to customize teaching plans for each patient. Such flexibility helps diabetic educators meet their students’ unique needs, including learning how to administer insulin, use an insulin pump or monitor glucose. Patients can opt to participate in individual or group classes. The program also provides assistance to obtain diabetic supplies. Many patients are able to receive a glucose meter from CGMH at no cost.

The comprehensive educational program has found success. It

received the American Diabetes Association Education Recognition Certificate for quality diabetes self-management education in August. James E. Tyler, CGMH vice president, points to consistently high patient satisfaction ratings as well as clinical outcomes that prove sustainable levels of blood sugar control.

CGMH’s Diabetes Self-Management Program boasts a staff of two registered nurses and two registered dietitians. Medical nutrition therapy was added offering information on dietary guidelines for diabetics, carbohydrate counting and the effect of food on diabetes. Registered dietitians educate patients on lipid and blood glucose management through a healthy diet. And a

certified personal trainer formulates an activity plan for each patient and provides education on safe exercise in an on-site room with equipment.

The program also features an educational component on foot care, which includes a room for identification and treatment of ulcerations and other foot ailments as well as information on selecting appropriate shoes and socks.

Future plans for the CGMH diabetes education program include increased marketing to physicians, strategies to monitor patients who miss appointments and investigation of diabetes home telemonitoring systems.



Sherry Legard, R.N. and certified personal trainer, instructs a patient on the use of stationary exercise equipment.

# HIV diagnosis requires mental health care

BY SUSAN LAWRENCE

**F**or the thousands of Americans who will find out in 2008 that they are infected, an HIV diagnosis does not carry the “death sentence” it did at the epidemic’s outbreak more than 25 years ago. In the United States, medicines that can help control HIV, health insurance and government assistance that help people afford the care they need, and extensive support networks have increased both life expectancy and quality of life for people living with HIV/AIDS.

Nevertheless, testing positive for HIV still brings individuals to a pivot point upon which their lives will turn, never to be the same again. Even when a client presents no physical symptoms and is otherwise well, a positive HIV test result will likely shake his or her social, economic, emotional and psychological equilibrium. HIV disproportionately affects people with substance abuse, poverty and other HIV/AIDS risk factors, many of which correlate with mental instability. HIV can also bring on depression or anxiety, symptoms such as memory loss and difficulty finding words, and occasionally psychoses or dementia in advanced disease.

“For anyone, learning that you have HIV is a trauma,” says Jayne Stevenson, a consultation liaison psychiatrist in Boise, Idaho, who previously treated patients with HIV/AIDS dementia, delirium and other acute psychiatric problems at San Francisco General Hospital. “For someone living in a rural area it can be far worse. There are fewer supports for people with HIV because the numbers are relatively small, and the stigma associated with HIV is stronger. If you’re living in a big city, people around you are more likely to have some familiarity with HIV. It is very hard for people to know how to talk about their HIV to their families or friends, because HIV is so strongly associated with drug addiction and sexual behaviors.”

Fortunately, even in remote rural areas, Ryan White CARE Act funding requirements and state-mandated HIV testing procedures usually combine to assure that anyone who tests HIV-positive receives an initial mental health consultation or a referral. In Vermont, the four Comprehensive Care Clinics (CCCs) associated with the University of Vermont and Fletcher Allen Health Care provide testing for HIV and other infectious diseases and provide specialized medical care

to 350 HIV clients, a majority of Vermont's HIV-infected population. The CCCs have integrated immediate mental health screening and support into the process they use to deliver a positive HIV test result.

According to Ellen Postlewaite, social worker at the CCC in Burlington, Vt., newly HIV-diagnosed clients meet first with a nurse practitioner and a social worker together.

"We explain what HIV care is, get lab work started and address any barriers to care," she says. "At that very first appointment we talk about how the client will get to the clinic, what their concerns are about stigma, what their relationships are like and who they have to talk with about their diagnosis, and whether they have a mental health history or a reason to worry that the diagnosis may trigger a mental health crisis."

Usually, clients return to the clinic two weeks after their first meeting with the nurse practitioner and social worker.

"Their lab work is done by then, and they will see the HIV/AIDS physician," Postlewaite says. "But we will have them come back the next day if we're concerned about their fragility."

**"For anyone, learning that you have HIV is a trauma. For someone living in a rural area it can be far worse."**

**Jayne Stevenson, psychiatrist**

The CCCs – in Burlington, Rutland, St. Johnsbury and Brattleboro, Vt., – recently hired a psychiatric nurse practitioner. A combination of specialized psychopharmaceutical knowledge and understanding of HIV/AIDS allows her to prescribe appropriate, effective psychiatric medications that are not contraindicated with a client's HIV/AIDS medications or likely to exacerbate other medical conditions.

Unlike Vermont's CCCs, which offer both HIV testing and HIV/AIDS medical care enhanced by the availability of a social worker, many clinics offer the test only. When an HIV testing clinic does not offer counseling services onsite, staff members who give clients their HIV test results should be prepared to furnish recommendations for mental health services to help them adjust to an HIV diagnosis. In East Texas, Health Horizons provides HIV testing and case management for HIV/AIDS clients in 12 counties from its Nacogdoches Clinic but lacks onsite counseling services. Health Horizons staff immediately refers clients who test positive for HIV to a mental health provider near the client's home. Case man-

agement staff follows up to make sure an initial appointment is made and kept.

"Our clients do go," says Lindsay Albright, database manager and clinical services assistant at the Nacogdoches Clinic. "Most people aren't very educated about HIV, so when they get a diagnosis it's a lot to think about. They're scared to tell their family, they don't want the community to know, they're scared to tell their partners. Most people understand why talking to a counselor is a good idea."

The range of mental health issues that can arise following an HIV diagnosis is quite broad. An individual's temperament and general mental stability will shape the way he or she copes with an HIV diagnosis, along with his or her age, gender, family support or lack thereof, sexual orientation, socioeconomic status and innumerable other factors. Some clients use support groups to keep emotionally and psychologically "on keel" as they adjust to the diagnosis; others need clinical therapy, psycho-pharmaceutical medication, or a combination of these.

Health Horizons has a Consumer Advisory Board (CAB), as mandated by the Ryan White CARE Act. The board's purpose is to give the east Texas HIV/AIDS consumer community a voice in guiding local HIV services. Yet, according to Albright, the CAB functions also as a support

*continued on next page*

group for HIV-positive individuals in Health Horizons' 12-county service area.

Each CAB meeting is planned around a particular topic, and a Health Horizons staff person is always on hand.

"For example, the group will ask for a presentation about the latest antiretroviral medication," Albright says. "Once they get there, the conversation will go into their personal experiences. It's an opportunity to talk and raise issues that they find they share."

Participation in CAB meetings helps to empower those who attend, giving them a safe forum for airing a wide range of HIV/AIDS-related concerns and opportunities to feel more in control of their lives with HIV.

Other support groups aim explicitly at helping clients manage the mental health component of living with HIV. Many people are helped by open discussions with other HIV-positive people about relationships with family members, fears about becoming ill, the anger they may feel related to their infection and other issues. Others benefit from sharing art therapy, journaling or other hands-on experiences with HIV-positive peers.

Research shows that support groups last longest and can have significant impact when they gather HIV-positive people who also share other identity characteristics and concerns, for example, gay men,



African-American single mothers or substance users in recovery. But in rural areas, infected populations are small and not usually clustered together, so creating and sustaining a meaningful, regular support group can be difficult.

Some individuals will need more than a support group to manage their mental health after an HIV diagnosis.

"For people who may have had other traumas in the past, just the shame from the experience might precipitate some kind of collapse in their mental health," says Stevenson. "Depression and risk for suicide are things to watch for. You'll need to explore what meaning the diagnosis has in their lives."

For rural individuals who find out they are HIV-positive, the logistics involved in obtaining care can be daunting enough to lead to clinical depression.

"If someone learns they have HIV, and they don't have insurance, and the specialist doctor is two hours away, that's going to cause some depression, even in someone who has never had a mental health problem before," says Albright.

Health Horizons' HIV/AIDS case managers keep in touch with both the client and the mental health counselor after making an initial referral.

"When they're first diagnosed, and there's no sign of the disease, and they still feel physically good, people may not be motivated to get any counseling help," Albright says. "We cannot force clients to do anything, but we do check to see if they have gone, and we encourage them. We'll ask, 'Do you want me to pick you up and take you? Do you need me to watch your child?' We try to eliminate any barrier possible, so they don't have an excuse to not go."



An HIV diagnosis can intensify existing mental health challenges for individuals who are drug-involved or living in socially or economically marginalized circumstances. Before delivering a positive test result to a patient, a provider should find out what HIV-related mental health supports exist locally or nearby.

“Find out ahead of time where the AIDS services organizations are that help HIV-positive people in your community,” says Postlewaite. “Also find out who is able to provide specialty HIV/AIDS medical care to anyone who is HIV-positive. That provider will be knowledgeable about the multiple issues that can be involved. You may only get that client into specialty care once every six months, but that may be a very important appointment when the individual learns how to access to other services such as substance abuse treatment, psychiatric care or a support group.”

Most people will probably not become psychotic upon diagnosis with HIV, Stevenson says.

“But those with more advanced HIV disease can sometimes present in that way. They may have strange ideas about things; they may present as delusional or in a manic state.”

In fact, she cautions, mental health providers and even general clinicians ought to be alert to the possibility of undiagnosed HIV in clients who exhibit depression or

fluctuations in their mental health stability.

“Although an individual might not even think he or she is at high risk, sometimes an altered mental health status is actually a symptom of HIV,” Stevenson says.

A high “viral load” or particular placements and interactions of HIV in the brain can create symptoms of HIV minor motor cognitive disorder.

“Less severe than HIV dementia, it can still give people significant problems with memory, getting disoriented and lost, fine motor control, or finding words,” she says.

“Once someone tests positive for HIV, antiretroviral drugs may alleviate these symptoms.”

Stevenson has presented about HIV’s mental health symptoms via statewide video conferencing in Idaho, sponsored by the state’s department of public health.

“We’d like to educate providers so

if they have a patient with these symptoms, they will be aware of the possibility of HIV and consider it,” she says. “It’s difficult, but it could prove important to ask the patient if they follow safe sex practices.

Especially in rural areas, most people associate HIV with being gay or having multiple heterosexual partners or drug problems. But like any sexually transmitted disease, it can take only one time of having sex with someone who is HIV-positive to become infected.”

## Internal Medicine or Family Practice Physicians

### St. Helens, Oregon

Legacy Health System is actively recruiting for Internal Medicine/Family Practice physicians who are Board Certified/Board Eligible to provide services in the rural community of St Helens, Oregon, just 30 miles northwest of the Portland Metropolitan area.

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AA/EOE

# THE WORKFORCE PIPELINE

## *UND's Center for Rural Health works to gain interest in health careers*

BY AMANDA SCURRY

**Y**outh are often asked what they want to be when they grow up.

The Center for Rural Health at the University of North Dakota (UND) School of Medicine and Health Sciences hopes their answers will be health-care related.

Workforce shortages are a challenge for the health care system nationwide with projected physician shortages between 85,000 and 96,000 by 2020, according to the Federal Council on Graduate Medical Education.

“These shortages can negatively affect health care quality and access to health care services,” says Mary Amundson, Center for Rural Health assistant professor. “Shortages can increase stress on available providers and contribute to higher health care costs by increasing the use of overtime pay and expensive temporary personnel.”

A year ago, the Center for Rural Health, in partnership with the Dakota Medical Foundation and others, hosted a Health Care Workforce Summit to examine health care workforce issues in North Dakota. The purpose of the summit was to share current practices to feed the state's health care workforce pipeline, to explore current and emerging challenges associated with the supply and demand of health care workers in the state, and to begin to develop an action plan to address these challenges. Participants included state legislators, statewide organizations, economic development commissions, health care employers, educators and providers.

### **The pipeline**

Staff at the Center for Rural Health uses the idea of a workforce pipeline to explain that interest in health careers starts at a young age and must continue through several steps.

“Each step of the pipeline offers opportunities to target specific strategies from workforce training to retention,” explains Patricia Moulton, Center for Rural Health assistant professor.

During the summit, participants identified goals and key issues within each step, barriers to achieving the goals, elements needing change and action steps.

## K-12 students

Summit attendees indicated a need to increase student exposure to health care professions through education and business partnerships. They wanted to provide more students with age-appropriate experiences in health care facilities including tours, presentations and related activities to introduce students to health care professions.

The North Dakota Medicare Rural Hospital Flexibility Program at the Center for Rural Health has funded several such endeavors throughout the state. The Fostering Opportunities in Rural Health Occupations program funds community partnerships to expose children to health occupations with the intent of increasing their awareness, interest and understanding of health careers.

One of these programs in Park River, N.D., made strides in educating the community's fifth-graders about health careers. First Care Health Center in Park River partnered with Park River School to do a five-week program they called Inspector Well Ness and the Care of the Many Medical Careers.

Medical professionals visited fifth-grade classrooms each week to discuss their careers and provide a hands-on activity relating to their chosen field. Students heard from

physician assistants and nurse practitioners, paramedics, laboratory and imaging technicians, physical therapists, nurses and dietitians. The students viewed X-rays, tried on

a cast, had their blood pressure monitored and took a ride in an ambulance, among other activities. They also visited the health center to see the equipment and meet more health professionals.

"Introducing students to a variety of careers when they are young is very important," says Ruth Jelinek,

**"Introducing students to a variety of careers when they are young is very important."**

**Ruth Jelinek, First Care Health Center**

who led the project for First Care Health Center. "Most of the students didn't know what these medical careers were."

The students were tested on their knowledge of health careers before and after the program. Before the five-week program, only a few students correctly matched health careers with a description of that



Lois Mathiason of First Care Health Center in Park River, N.D., shares the Inspector Well Ness and the Care of the Many Medical Careers program with fifth-graders.

career. However, when they were tested after the program, there was marked improvement.

## Higher education students

Summit attendees acknowledged a need to engage community and education programs to educate undergraduate students about health care programs.

MeritCare Health System and the UND medical school's internal medicine residency program in Fargo have been working with Concordia College in neighboring Moorhead, Minn., for a number of years to provide pre-med students with a real-life picture of what health careers are like.

The cooperative education class gives students credit for observing physicians and volunteering in hospitals and nursing homes. Students spend a half a day a week in the internal medicine residency clinic. They spend an additional 35 hours a semester with mentoring physicians, either job shadowing or conversing about medical careers.

*continued on next page*

The class also visits the UND medical school for a day and participates in its Patient-Centered Learning curriculum.

“They observe how care is delivered and visit with residents on what it is like to go through medical school and residency,” says Dr. Julie Blehm, UND School of Medicine and Health Sciences Southeast Campus associate dean. “They get realistic impressions of what medicine is.”

### Higher education programs

Summit attendees also discussed designing rural interdisciplinary education programs for all health care disciplines and increasing the number of rural training programs statewide. They suggested an assessment of current programs and the potential for establishing other programs and collaborations along with further development of a rural curriculum.

In recent years, the Fargo-based Dakota Medical Foundation has supported efforts to increase health care training in the state, especially in rural areas. The foundation has contributed hundreds of thousands of dollars to higher education institutions throughout the state to support efforts to make their programs more accessible to rural residents and to make health students more interested in careers in the rural areas. These projects include increasing the number of seats in nursing programs,

establishing distance education programs in rural areas, and providing scholarships to health profession students who intend to remain in the area.

### Employer recruitment and retention

Recruitment and retention of health care providers is the most immediate section of the pipeline. With fewer and fewer medical students choosing family medicine and other primary care fields, it is especially difficult for small rural communities to find physicians.

One North Dakota community, Cando, recently had success in recruiting a physician by involving the entire community and his entire family. Dr. Robert Hamilton is currently a third-year physician-resident at UND’s Minot Center for Family Medicine. He was first introduced to the community by Cando physician Dr. Greg Culver, who precepts at the Minot program. Culver convinced Hamilton to spend his one-month rural rotation in Cando, which started a series of regular visits between Cando residents and the Hamiltons.



Dr. Julie Blehm advises Katrina Enderle, a senior pre-med student from Concordia College who shadows residents at the clinic.

The Hamiltons were welcomed by the hospital CEO and staff, and the community reached out to them, including hospital board members, real estate agents, patients and other community members. While in Cando, citizens treated the Hamiltons to the best the community has to offer, including trail rides, trap shooting and Devils Lake. The result was a successful bid for Hamilton start his practice in Cando.

### Next steps

To continue the work begun at the summit, the State Office of Rural Health program at the Center for Rural Health is funding a statewide Health Care Workforce Committee that includes individuals representing state boards, state associations, medical facilities (urban, rural and Veterans Administration), long-term care, health and human services and academic and economic development.

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# Substance abuse treatment for women in Indiana:

## *A costly gender gap*

BY MARTHA C. LEVEY AND RUTH M. CASE

**A**ffiliated Service Providers of Indiana Inc. (ASPIN) is a network of community mental health centers and substance abuse treatment facilities. ASPIN's rural providers are familiar with the barriers and obstacles to health care for rural citizens as a result of experience in providing services to the majority of designated rural counties in Indiana.

Rural Indiana citizens can be separated from mid-sized cities and mental health providers by a 45-minute drive. Thirteen of ASPIN's counties are designated mental health professional shortage areas, and 13 are health professional shortage areas.

An analysis of ASPIN's treatment data provided documentation of a long-held suspicion that the women of Indiana are significantly underrepresented in substance abuse treatment. The following analysis brings to light not only disparity, differences in referral and differences in use, but also barriers to access which must be addressed.

### **Current substance abuse treatment: A gender comparison**

During the 2007 fiscal year, ASPIN providers served 7,587 chronically addicted people with incomes at or below 200 percent of the federal poverty level. Women comprised only 31 percent of these patients. These women, on average, had an annual household income approximately 60 percent of that of males served (\$8,342 compared to \$14,222), but with more dependent children.

The women in the study cited their primary source of referral to treatment as court (51 percent) and individuals, self, family and friends (30 percent). Men had similar sources of referral; however, the court had even greater influence at 64 percent, with individuals at 25 percent.

Consistent with income information, women in treatment had greater unemployment/under-employment levels than men. Forty-eight percent of the women served were unemployed compared to 41 percent of the men. Only 19 percent of the women served were employed full time, while 35 percent of the men worked full time.

In addition to demographic and financial differences between men and women in treatment, differences in addiction patterns also exist. At the time of enrollment, about half of the men served identified alcohol as their primary drug of choice,

whereas only 39 percent of women selected alcohol. Women were more likely to use crack, cocaine or methamphetamines than men in the population.

PRIMARY SUBSTANCE USED	FEMALES	MALES
Alcohol	39%	49%
Marijuana/hashish	22%	27%
Cocaine/crack	17%	11%
Methamphetamine	11%	7%
Other drugs	11%	7%

Despite women comprising only 31 percent of the chronically addicted clients served, the total cost of serving women was 38 percent of the total cost for substance abuse services. A total of \$5,181,710 was spent serving 2,383 women, while \$8,451,131 was spent serving almost twice as many men. On average, women received 25 encounters compared to 20 encounters per man served. The average cost per woman served was \$2,241 compared to \$1,677 for men.

Women received almost double the case management services compared to men, as well as a greater number of services with physicians, psychiatrists and intensive outpatient treatment. The need for a wider service array, coupled

with the higher costs for those services, adds a substantial financial burden to women in treatment who are already less financially secure, and who are more likely to be unemployed, underinsured and supervising more dependents.

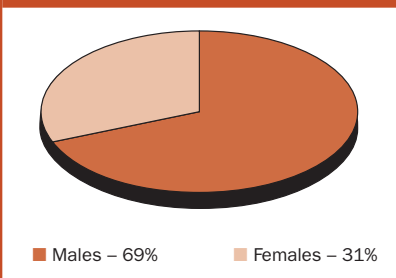
According to the Indiana Penetration Rate Report by County, in fiscal year 2005, only 12.2 percent of the eligible population of chronically addicted women with children or who were pregnant received services in Indiana. This comprised the most significantly underserved population cited by the Division of Mental Health and Addiction. ASPIN data, a subset of the state data, shows a similar lack of service provision. The maximum percentage of chronically addicted women served by ASPIN in any one county is 15 percent.

### Barriers to treatment

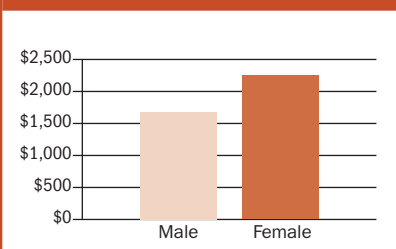
Rural Indiana women encounter additional barriers which affect treatment engagement. These include financial, legal and cultural issues, as well as the lack of available child care and partner support.

The economic barriers to treatment are overwhelming for women seeking substance abuse treatment. In addition to fewer financial resources and a greater number of dependents, these women are also more likely to be unemployed and uninsured. A

### ASPIN FY 2007 PERSONS SERVED WITH CHRONIC ADDICTIONS



### AVERAGE COST OF SUBSTANCE ABUSE SERVICES PER PERSON



secondary effect of poverty for women is a lack of available transportation to treatment sites.

The majority of people seeking substance abuse treatment are referred to treatment through the judicial system. However, only 27 percent of the court referrals are women. Further review of data indicates that women are less likely to be court-ordered into treatment and more likely to be sent to jail, possibly due to additional charges related to endangering children in their care.

Women seeking substance abuse treatment face greater cultural stigma. And women with children who are in need of substance abuse treatment often fear losing custody

*continued on next page*



of children, criminal/child endangerment charges or other sanctions if they are identified as substance users with children. Only one of ASPIN's treatment centers has on-site child care available. Other facilities provide child care through referral agreements. Many treatment centers are unable to offer child care onsite due to costs, liability and space.

In addition to the cultural stigma, women also lack necessary support. For many men in treatment, their partner or spouse is responsible for encouraging them to enter treatment; this is often not the case for women.

### Effective evidence-based treatment for women

The Substance Abuse and Mental Health Services Administration Office of Applied Sciences has been conducting research on the most effective treatment for substance-abusing women. Study outcomes indicate availability of child care services has increased treatment retention, reduced depressive symptoms and increased self-esteem. Higher rates of retention have also been noted when women in residential treatment are allowed to live with their children.

Some women participating in women-only treatment models have

shown reduced substance use and increased social adjustment compared to women receiving mixed-gender treatment. And women in female-only treatment were more than twice as likely to complete treatment as women in mixed-gender care.

Women receiving mental health services in addition to

substance abuse services have had better outcomes over time than women in substance-only treatment. It is hypothesized that the success of combined treatment is due to treatment of underlying problems that contribute to the etiology of women's addictions – grief, trauma, abuse and depression.

### A call for action

ASPIN is committed to enhancing and expanding services for women in need of substance abuse treatment. Additional funding is essential to eliminate or reduce barriers and to implement recommended practice treatment models.

The hidden costs of not treating women effectively are great. The financial burden of a woman serving time in prison combined with foster care for her children far exceeds the cost of providing quality substance abuse and mental health treatment and supplemental education for that same woman, and with much improved outcomes. Community leaders, the judicial system, social service organizations, government agencies and treatment providers must creatively partner to break down barriers and provide needed comprehensive services for substance-abusing women.

Martha Levey is the business development coordinator for Affiliated Service Providers of Indiana.

Ruth Case is a performance improvement consultant monitoring data sets for ASPIN.



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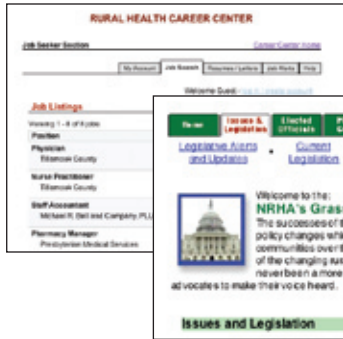
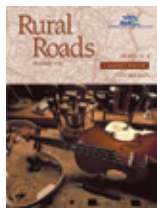
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# HOUSING MARKET SLUMP

## *impacts health care collections*

BY MITCH PATRIDGE

The housing market is in the midst of significant crisis, and it's having a ripple effect throughout the U.S. economy.

Many health care providers are wondering how the mortgage meltdown will impact the business of collecting debt. There are several clear trends.

In the housing bubble of the last five to seven years, consumers were able to pay out-of-pocket health care costs in a number of ways. Many patients paid these bills by tapping into their newfound home equity or by refinancing their homes.

And, in order to compete with the home mortgage market, underwriting standards for unsecured debt were loosened, providing many consumers with the ability to use credit cards to pay health care debt. But, this is no longer the case. The meltdown in the housing market has caused a general tightening throughout the consumer lending market. Today, underwriting standards for mortgages have significantly tightened, and many credit card issuers have followed suit, cutting back offers to less creditworthy customers and lowering credit limits.

A 2005 health care cost survey revealed startling statistics. Fifty-two percent of all respondents had depleted their nest eggs to pay health care costs, and 15 percent had declared bankruptcy. In today's financial climate it is difficult, and often impossible, for consumers to tap into home equity or obtain consumer credit lines to pay hospital bills. Often, those consumers are using credit cards to meet daily needs and are already at their credit limit.

When you combine the credit crunch and housing crisis with escalating health care costs, the results are bound to be disastrous. Most people have less discretionary income to spend, yet out-of-pocket health care costs are skyrocketing.

### **Preparing for the worst**

The trends are clear. Out-of-pocket health care costs will continue to rise, and patients will have increasing difficulty paying their debt. So how do health care providers prepare for this? Here are some suggestions from hospitals already addressing these challenges.

**1. Provide your patient finance department with additional tools enabling them to increase efficiencies, automate work processes and improve customer service.**



A strong loan program will enable your patient finance department to meet cash goals and reduce the number of patients referred to collections.

**2. Stay competitive with other hospital programs. You've provided your patients with excellent health care services; now follow through with superior patient financing options.**

Ensure the lender you partner with utilizes a customer service department trained in patient-centered counseling approaches and compassionate collection practices.

**3. Develop clear-cut charity guidelines and make sure hospital staff adheres to those guidelines.**

Don't substitute a loan program for a well thought-out charity program. Instead, utilize credit scoring or similar programs to identify patients who may be eligible for charity.

**4. Develop and mandate adherence to an internal collection policy.**

By partnering with a lender that offers easy-to-qualify-for patient loans and low monthly payments, you can offer patients a needed benefit while decreasing the

workload associated with billing, collecting and posting cash on payment plans.

**5. Consider partnering with a lender instead of offering internal patient payment plans.**

With the right financial partner, hospitals can improve cash flow and reduce the administrative costs related to monthly billing, tracking, posting, skip tracing and other collections activity.

**6. If you partner with a lender, make sure to optimize your results by choosing a vendor with direct experience in patient finance.**

Hospitals will achieve better results by partnering with a lender that specializes in patient lending.

Meet the challenges of the new economic situation with innovative solutions. Doing so will improve your hospital's bottom line as well as the overall patient experience.

Mitch Patridge is CEO of Varisol and CSI Financial Services, which provides patient financing for hospitals.

## RURAL RALLY



East Tennessee State University (ETSU) celebrated receiving the NRHA's Outstanding Rural Health Program Award.

NRHA President Paul Moore visited ETSU in February to present the university's Community Partnerships Rural Interdisciplinary Track Program with the award.

The program prepares graduates to work in rural communities by placing students in experiential courses in rural areas, where they provide primary prevention services to communities that otherwise would not have access to care.

The Outstanding Rural Health Program Award recognizes ETSU's work to promote the delivery of health care in rural areas and secure the future rural health workforce through this innovative program.



# NOW DO SOMETHING:

## *The do-call list*

BY TIM FRY, GOVERNMENT AFFAIRS MANAGER

**T**he NRHA mission is to improve the health of rural Americans by providing leadership on rural health issues through advocacy, communications, education and research. In the last few Rural Roads issues, the NRHA Government Affairs staff has detailed why advocacy is essential for the future of rural health and explained ways you can effectively advocate, including writing to and meeting with your elected representatives on issues that are important to you. This is the fourth part in the series.

The NRHA is unique in that we have members from every segment of the national health care landscape (multiple provider categories, researchers, training professionals and patients) with one thing in common: a deep desire to improve the health of rural Americans. In my time at NRHA, I've learned we have at least one other thing in common: we are incredibly busy.

I have had numerous phone calls interrupted so the NRHA member I was talking to could deliver a baby or provide care in a medical emergency.

Administrators in this association often have smaller staffs than urban peers, requiring them to wear more hats and deal with a variety of responsibilities. Interactions with our researchers and university and state employees have shown that NRHA members are incredibly passionate about rural America and will answer my e-mails well after they should have gone to bed.

I know you, as a member of the NRHA, care about moving rural health forward through advocacy, and any extra time you have is valuable. More than 400 of you came to our 19th Annual Policy Institute in



January for this purpose. How can you continue to make an impact throughout the year and interact with your representatives without it being your fifth full-time job? One simple and quick way is to pick up the phone.

The idea of a phone call can be a lot scarier than sending an e-mail or a letter. Put on the spot discussing an issue we only know peripherally, we can be tripped up without time to look up an answer. But a phone call can have a tremendous, timely impact in getting the attention of a congressional staffer, who will often remember your verbal pitch while an e-mail can be lost in the deluge. Also, talking directly to hill staffers allows them to hear your concerns and ask follow-up questions on the issues.

Not only is a phone call effective, it should take only a small investment of time. Two issues ago, we discussed how to write a letter or e-mail to a congressional staffer. We asked you to do a number of things to make a significant impact: personalize the message; explain your facility; discuss issues relevant to your community with statistics or stories; and proofread. A good letter, even with a template from NRHA staff, could take nearly 30 minutes. A phone call should take no longer than a couple of minutes; you just need to follow a few simple rules.

First, make sure to ask directly for the health staff member in an office.

When you call your representative's or senator's office, a low-level staffer will answer the phone. This person is important as a gatekeeper, so treat them well, but they are not who you need to speak with. I have sat in many congressional offices where I have heard staffers answer the phone in the midst of other tasks and say, "Thank you for your message, I will make sure to let the senator know your thoughts." With hundreds of calls a day and little contact with the member of Congress, they are not likely to get your message where it needs to go. When you call the office, ask for the health staffer, by name if you know it. Do not leave a message at the front desk.

If the staffer at the front desk offers to let you leave a message on the voice mail of the health staffer, do it. This is normal and to be expected until you develop a relationship with the staffer. They will listen to your concern, and they will have your contact information if they want to follow up. Most staffers listen to their messages multiple times each day, so your message will be timely.

Keep your message or verbal pitch short and simple. Start by saying who you are and how you serve the constituents of the member's district or state. Explain your

*continued on next page*

## SUMMARY

**To make a call that has impact on congressional action, remember these key points:**

- 1. Speak or leave a message directly with the health staffer.**
- 2. Introduce yourself and your facility.**
- 3. Keep it simple. Ask for one thing and give brief information why it is important.**
- 4. Leave a short message.**
- 5. Provide your key contact information.**
- 6. Follow up by e-mail with additional information. This can be a powerful way to get both your e-mail and phone call attention.**

**You can look up the contact information for your elected officials directly on the NRHA Web site. Go to <http://capwiz.com/nrha/dbq/officials/> and follow the instructions to contact your member of Congress.**

reason for calling, and ask for their support of a bill or higher funding. Mention one or two of the talking points supplied by NRHA, and/or give an anecdote or local fact about the program and how it will help your community. Finish by thanking the staffer for their support of rural health, and give all of your key contact information so they can follow up. This message should take no longer than two minutes.

Go longer and the machine may cut you off, or they may hit delete.

Finally, if you have supporting material or evidence you want to pass along to the staffer, let them know you will be following up by e-mail. Make sure to follow through on this promise, and if the staffer promised you anything on the call, a follow-up e-mail a couple weeks later is perfectly appropriate and a good reminder.

Through a quick phone call, you can make sure a hill staffer addresses an issue in a quick and timely manner. Mail can be lost in the shuffle for weeks, and you likely do not have the time or the money to make a trip to Washington, D.C., every time an issue that impacts your facility is before Congress. Making a quick and easy call can ensure Congress is working to improve the health of rural Americans.

## The family caregiver dilemma:

# Helping beneficiaries get the most out of their Medicare

More than 44.4 million Americans, more than one in five adults, provide unpaid care to a loved one valued at a staggering \$306 billion each year. The new 28-minute edition of the *My Health. My Medicare.* television program features a panel of experts discussing the family caregiver dilemma in the United States, in addition to explaining resources that are available from the Department of Health and Human Services to support family caregivers.

Medicare partners are invited to take advantage of this resource to help family caregivers and beneficiaries get the most out of their Medicare.

In this episode viewers will:

- Meet a family caregiving expert from the National Alliance for Caregiving and develop a comprehensive understanding of family caregiving issues.

- Get advice from representatives from the Administration on Aging as they explain the services offered by the National Family Caregiver Support Program.
- Learn about the home and community-based Medicaid waiver program and its impact on family caregivers.
- Hear about Medicare prescription drug coverage, preventive services, Medicare Advantage and new developments.

*My Health. My Medicare.* is produced by the Centers for Medicare and Medicaid Services, as a public service. To request a VHS or DVD free copy of this program, contact Julie Brookhart in the Kansas City Regional Office of the Centers for Medicare and Medicaid Services at 816-426-6312. Quantities are limited.

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May 7-10, 2008  
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Early bird rate deadline: April 7, 2008

**Clinical and Quality Conference**

July 15-17, 2008  
San Diego, California  
Early bird rate deadline: June 14, 2008

**Rural Health Clinic Conference**

October 14-15, 2008  
Savannah, Georgia  
Early bird rate deadline: September 20, 2008

**Critical Access Hospital Conference**

October 15-17, 2008  
Savannah, Georgia  
Early bird rate deadline: September 20, 2008

**Minority and Multicultural  
Health Conference**

December 11-12, 2008  
Albuquerque, New Mexico  
Early bird rate deadline: November 7, 2008



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