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High Insurance Premiums Jeopardize Rural OBs

By Thomas D. Rowley

Malpractice insurance rates are on the rise, particularly in high-risk specialties like obstetrics, and that's creating a crisis in some rural communities.

West Virginia faces as difficult a challenge as any state. According to Evan Jenkins, Executive Director of the West Virginia Medical Association, a survey revealed that climbing premiums are prompting 40 percent of West Virginia's doctors to seriously consider leaving the state, changing the nature of their practice, or retiring early.

In a state where 50 of 55 counties are already designated as medically underserved areas or health professional shortage areas, the problem is particularly acute. "We can ill afford, particularly in our rural areas, to lose any more of our physicians," said Jenkins.

While the situation is affecting doctors and hospitals regardless of whether they are rural or not, the problem is reaching a crisis situation in some rural areas.

"Is this only a rural issue? I don't think so," said Alan Morgan, Vice President of Government Affairs and Policy at the National Rural Health Association, "but rural physicians don't have the resources to address it the way urban doctors do."

Dr. Cindy Reese presents baby Chance to his mother after an emergency C-Section.

In rural areas, physicians are less likely to have access to advanced medical facilities such as neo-natal intensive care units or to have colleagues who can help share the workload. In addition, rural doctors typically see a high percentage of Medicare and Medicaid patients, so they often get lower reimbursement levels than their urban counterparts. These factors magnify the malpractice insurance crisis in rural areas.

In West Virginia, Jenkins said, annual premiums are two to three times higher than for doctors in other states. Some doctors, he noted, cannot even get insurance. "West Virginia is experiencing both an availability and affordability insurance crisis," said Jenkins. "The climate continues to deteriorate. Rates continue to climb."

The American College of Obstetricians and Gynecologists (ACOG) concurs with Jenkins's dire assessment. At a May 6 press conference, ACOG named nine "Red Alert" States where the medical liability insurance situation threatens the availability of physicians to deliver babies. West Virginia is one of those states; the others are Florida, Mississippi, Nevada, New Jersey, New York, Pennsylvania, Texas, and Washington.

Citing data from a survey by *Medical Liability Monitor*, ACOG said that nationally, the median insurance premium for OB/GYNs increased

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167 percent from 1982 to 1998. In 2000, it rose seven percent. In 2001, it went up another 12.5 percent. For 2002, the expected increase is 15 percent.

According to *American Medical News,* eight states saw two or more liability insurers raise rates by at least 30 percent in 2001. In more than 12 states, one or more insurers raised rates by 25 percent or more.

"Across the country, liability insurance for obstetrician-gynecologists is becoming unaffordable or even unavailable," said ACOG President Thomas Purdon, MD.

The situation is particularly worrisome for rural areas, where physicians and care are often already in short supply. "Hospitals, public health clinics, and medical facilities in medically underserved areas begin to lose prenatal and delivery care. The impact on rural women and Medicaid patients is most acute," said Dr. Purdon.

In addition to the increases in premiums, some carriers are closing up shop. In December, 2001, The St. Paul Companies, the nation's second-largest medical malpractice underwriter, insuring some 40,000 doctors in 45 states, announced that it would phase out of the business. The reason: it was losing too much money—$1 billion in the last five years, according to CBS News. Other companies have also left the market or become insolvent.

Why OBs?

Obstetrics is considered a high-risk specialty, and, as such, obstetricians pay some of the highest medical liability premiums. Why?

· In obstetrics there are two patients involved—mother and child.
· The outcome—the health of the baby—depends greatly on pre-natal care, which is beyond the control of the obstetrician.
· Claims may be made against obstetricians until the child reaches the age of 18.
· Cases involving infants have some of the highest claims awarded.
· Babies have a much longer life expectancy than adults. That translates into more years of care and greater expenses in the event of a bad outcome.
· In 2000, OB/GYNs were first among 28 medical specialty groups in the number of claims reported against them and highest in the average cost of defending against a claim.

David Mechtenberg, CEO of Ridgecrest Regional Hospital in Ridgecrest, California, put it this way: "A doc will say that OB is 80 percent boredom, 20 percent terror."

In many rural areas, there simply are no obstetricians. As a result, family practitioners like Dr. Cindy Reese provide obstetrical care. And because they do, they get hit with higher rates just like OBs.

No More Deliveries

Until last December, family practitioner Dr. Cindy Reese and her nurse mid-wife were the only sources of obstetrical services in Ripley, West Virginia, a town of 3,023 that is 37 miles north of Charleston, and surrounding Jackson County. Then the nurse mid-wife retired, and Dr. Reese quit delivering babies. Soon she will move her family to South Carolina where she will be closer to family, be on call only six days a month, and will not do OB. Now Ripley and Jackson County have no one to deliver babies.

"My office is littered with gifts," Reese said. "Everyone says 'we don't want you to go, but we understand.'"

Reese, the daughter of a small-town doctor in Georgia, moved to Ripley in 1986, fresh from her residency. "I hadn't planned to do OB, but came to West Virginia, fell in love with it, and they needed OB," Reese said. "I went back and got the training."

The doctor figures that she delivered some 50 babies a year. The nurse mid-wife she oversaw delivered twice as many. Multiplied out over 16 years, the two of them delivered a tenth of the county's population.

Then in 1997, she was sued for malpractice. And though she was ultimately dropped from the case, and the hospital "won in an hour," the experience took its toll. "It was just an awful experience. Before, OB had always been a joy and a pleasure."

The suit, combined with the long hours (for much of her tenure, Reese had been on call 26-28 days a month) and the retirement of her nurse mid-wife, prompted Reese to stop delivering babies. As it turned out, she would have had to anyway.

First, the company that provided her with medical liability insurance went bankrupt. Then, the company that took over her policy would not renew her coverage because she was a family practitioner providing obstetrical services. That meant her only option was to get insurance from the state's insurer of last resort program, which charges 10 percent more than the highest private insurer—a prospect Reese described as "an awful thing."

When asked what she would have had to pay for coverage, Reese said, "I have no idea what it would have been…I'm sure it would have been extremely high."

The loss of obstetrical services also means that the hospital where Reese delivered and served on the board will lose about $500,000 a year in Medicaid disproportionate share hospital (DSH) payments. These payments help eligible hospitals offset the costs of providing uncompensated care and serving low-income populations, but only if the hospital provides obstetrical services. No OB; no DSH payments.

Different States, Similar Stories

On April 8, more than a thousand doctors in Texas aired their complaints about the crisis. Around the state, physicians staged a "day of awareness"—what some in the media referred to as a "walk-out"—and held press conferences, rallies on courthouse steps, and other events.

Ben Durr is the Administrator of Uvalde Memorial Hospital in Uvalde, Texas—half-way between San Antonio and the Mexican border at Del Rio. The 66-bed hospital serves five counties with a population of 45,000, in one of the lowest per capita income regions of the state. It is losing two of its four doctors that provided OB at the hospital.

"Now comes the insurance problem," said Durr. "We had two physicians approaching 50 say 'hey it's not worth it.'"

According to Durr, the doctors' insurance went from $20,000 to $70,000 per year. Figuring in the number of deliveries per year, the reimbursement for each, and the overhead on top, Durr said, "You just can't do it. The longer you're in practice you're gonna get claims. As that occurs your rates keep going up. You get run out of business."

Still, he does not blame the insurance companies. "The insurance companies have to do what they have to do. It's not the insurance companies; it's the juries."

Beverly Mahlmann is CEO of Arizona Family Care Association (AFCA), an operator of Rural Health Clinics on the Arizona-Mexico border. "Getting hit with the malpractice crisis was not something we

were planning on," she said.

According to Mahlmann, it had been a buyer's market. Several insurance companies were vying for customers in the state, oftentimes under-pricing their product in order to get customers and increase their market share. Then two things happened. First, the stock market went down, decreasing the returns that insurance companies got on their investments and reducing their reserves. Second, reinsurance companies got hit with catastrophic losses as a result of September 11. As a result, insurance companies were left in a bind, forcing some to raise prices and others to curtail or even stop offering coverage. On top of all that, previous claims in the region and against AFCA prompted insurance companies to see them as high-risk.

AFCA's insurance went from $500,000 per year with no deductible to $897,000 with a $50,000 deductible, and that was available only if they stopped doing OB.

Not surprisingly, AFCA did stop delivering babies. Now, the nearest OB services are an hour away. "I view this as a catastrophic situation," said Mahlmann.

Continued on next page

Contributing Factors: Point

The Texas Medical Association's website explains several contributing factors in detail.

· **The rising cost of health care.** As technology drives up the cost of health care, the cost of liability insurance also goes up because some of the amount awarded in a successful malpractice claim is partially tied to the cost of ongoing medical care or short-term treatment to reverse physical damage. "This escalation drives the cost of insurance to cover these rates."
· **Inflation.** Inflation causes the value of awards to increase, which then increases the cost of insurance.
· **Underwriting cycles.** Favorable market conditions encourage insurance companies to enter the market and offer policies. Competition among companies can lead to looser guidelines and lower premiums. This results in more risk for less money. When claims mount, companies that priced too low get in trouble and leave the market. Other companies can raise prices because of less competition and need to raise premiums to offset claims.
· **Lower return on investments.** Insurance companies invest their reserves (money that is set aside to cover claims) and count on the investment returns to help cover claims. Last year's downturn in the economy reduced those returns, driving reserves down and premiums up.
· **Lack of reinsurance.** Reinsurance is coverage that insurance companies buy to protect themselves against catastrophic losses. It enables them to assume more risk and make more coverage available. The events of September 11 and other catastrophic losses reduced the availability of reinsurance. That, in turn, reduced the amount of coverage insurers can write and increased premiums for it.
· **The need/desire to limit risk.** In order to reduce their risk of loss, insurance companies tighten their guidelines and refuse to offer some coverage. As a result, certain regions, specialties (OB for example), and providers deemed higher risk find it difficult to get coverage.
· **Claim losses.** The more lawsuits filed, the higher the cost to settle a lawsuit, the more expensive to defend, and the greater the risk of an extremely large award if the case is tried and lost, the higher the premium will be.

For more information, see the Texas Medical Association web site at: http://www.texmed.org/.

Contributing Factors: Counterpoint

The Center for Justice and Democracy cites evidence for the opposing view:

· The average payout for medical malpractice claims is $30,000—about the same as it has been for the last decade.
· There has been no change in the volume of medical malpractice cases in the last five years.
· Eight times as many patients are injured by medical malpractice as ever file a claim. Sixteen times as many are injured as receive any compensation.
· Injured malpractice patients win before juries in only 23 percent of cases—down from 30.5 percent in 1992.
· Only 1.2 percent of medical malpractice plaintiffs who prevail at trial are awarded punitive damages.
· Tort law limits enacted since the mid-1980s have not lowered insurance rates in ensuing years. States with little or no tort law restrictions have experienced about the same changes in premiums as states that have enacted restrictions.

For more on CJD, see: http://www.centerjd.org/.

Wendy Curran, Executive Director of the Wyoming Medical Society, said "We are worried for all our physicians in rural Wyoming." She said she does not know how they will survive what she called the "triple whammy"—cuts in Medicare reimbursement, the rising cost of regulatory compliance, and huge increases in malpractice insurance.

One of the two insurance carriers that provide obstetrical coverage in the state just asked for a 40 percent increase in premiums, she noted. "It's increasingly harder for physicians to maintain the bottom line they need to stay in business. The rising malpractice costs may be the final straw," Curran said.

Reports from rural Mississippi indicate much the same: premiums rising significantly for pregnancy-related care, OBs ceasing to deliver babies because they cannot afford the insurance, and areas left without obstetrical care.

Rates for Mississippi family physicians who provide obstetrical services have risen some 500 percent in the last five years, according to health care consultant Jerry Connolly. Consequently, he said, "few towns under 20,000 people have doctors delivering babies."

Contributing Factors

As Mahlmann pointed out, there are several plausible reasons for the decline of affordability and availability in medical liability insurance. Of all these factors, the one receiving the most attention is claim loss. According to the Texas Medical Association, "It is clear that the basic business of insurance is simultaneously experiencing every imaginable negative influence. While these are all considerations, the primary rate driver is that of loss experience."

Mike Hotra, spokesperson for the American Tort Reform Association—a member association of physicians, trade and professional associations, municipalities, and businesses—agreed that a variety of factors influence the cost of insurance, but you "can't talk about the issue without talking about jury awards."

"Litigation is so out of control that insurers have no way of rationally pricing insurance," he said. "We've seen a sharp up-tick in non-economic damage award amounts and a few outlier jackpot awards."

An Opposing View

The logical conclusion to such statements—and popular consensus—is that tort reform is a big, and necessary, part of the answer. Not everyone, however, agrees.

The Center for Justice and Democracy (CJD) bills itself as a defender of the right to legal redress. The center thinks tort reform is the wrong way to go.

"There are problems in some areas, where insurance prices are becoming unaffordable, and we sympathize," said Joanne Doroshow, Executive Director of the CJD. "But the solutions that the medical societies and insurance companies are promoting won't work."

The reason for rising premiums, according to Doroshow, has nothing to do with lawsuits and the legal system, but with a drop in investment income for insurance companies and pricing that is too low.

Rather than caps on jury awards, Doroshow would like to see stronger regulation of the insurance industry, including more detailed disclosure of the reasons for rate increases. She would also like to see premium rates that reflect individual physician's records—something that she says does not happen in most states. Finally, Doroshow believes state disciplinary boards need to do more to hold "bad doctors" accountable.

What Doroshow does not want to see is restrictions on the rights of injured patients. "If you make it harder to sue, it's only going to increase the amount of malpractice out there."

Steven Wallace, an Arizona MD who just took the bar exam, has a similar point of view. "When people attack the tort system, they are attacking the jury system," he said. "It seems to be a reaction against attorneys. There are a lot of reasons to dislike attorneys, but they're cutting their nose off to spite their faces."

"We're not saying that doctors are bad people," said Janice Mulligan, San Diego attorney and member of the American Bar Association's Special Committee on Medical Professional Liability. "But they're human and make mistakes. Someone has to pay for those mistakes. If the justice system isn't there to compensate, then the welfare system will have to. Either way we're going to have to pay."

Seeking Remedies

Despite the counterarguments, tort reform is on everyone's lips and is gaining steam around the country. According to the Health Policy Tracking Service at the National Conference of State Legislatures, 15 states have enacted laws dealing with medical malpractice/tort reform this year.

At the federal level, Congressman James Greenwood (R-PA), along with several co-sponsors, has introduced the HEALTH Act (Help Efficient, Accessible, Low-Cost, Timely Health Care). The Act would

· limit the number of years a plaintiff has to file a healthcare liability action;

· allocate damages in proportion to a party's degree of fault;

· allow patients to recover for economic damages such as future medical expenses and loss of future earnings while establishing a cap on non-economic damages such as pain and suffering of $250,000; and

· place limits on punitive damages to be the greater of two times the amount of economic damages awarded or $250,000.

At a press conference announcing the legislation, Greenwood said "…the system is out of balance. Today, we have OB/GYN practices closing down throughout southeast Pennsylvania and in other areas of the country, doctors changing how they practice medicine, and patients being turned away and forced to find new doctors far away."

Senator John Ensign (R-NV) has introduced a similar bill in the Senate. "We have patients who are hurting, but it's not from the pain of injuries; it's the pain that comes from not knowing whether a doctor will be

there when they need one," he said. "It is my hope that this legislation will provide a long-term solution to a growing nationwide crisis."

In addition to tort reform, other remedies are being proposed and tried.

West Virginia is offering medical liability insurance to physicians through its Board of Risk and Insurance Management. The program acts as an insurer of last resort, providing coverage to providers who cannot find or afford insurance in the private market. The rates for the insurance, however, are mandated to be 10 percent higher than those offered by private insurers.

The West Virginia Medical Association is looking at forming a so-called physician's mutual insurance program, in which doctors form their own company to provide coverage. Doctor-owned companies currently insure about 60 percent of U.S. physicians.

In Pennsylvania, 31 small, community hospitals have banded together to form a group that self-insures its members, with some help from reinsurance companies. The logic of the Community Hospital Alternate Risk Transfer (CHART) is that its members are homogenous, have good claims histories, and present a good and predictable risk profile.

Thomas Norton is Managing Director of the Pittsburgh office of Marsh Inc—the company that helped form the group. According to Norton, these hospitals are a better risk than big, urban hospitals for two reasons. One, the kinds of services they provide are typically lower risk (except for obstetrics). Two, they tend to have better communication and awareness of the issues and potential problems. "They may not have a full-time risk manager," said Norton, "but the CEO's know about individual cases."

The fact that the problem has several contributing causes means that the solution will almost certainly require several complementary efforts. "There aren't any silver bullets. It will be multi-faceted and take time," said Wyoming's Curran.

Time, however, may be in short supply. "If they don't do something," said Doctor Reese, "these rural hospitals are not going to survive."

Jenkins had an even gloomier assessment: "You can't rebuild a health care system overnight. I'm afraid it may be too late for many."

HRSA Grantees Receive World Health Awards

By Thomas D. Rowley

Innovative rural health projects can make a world of difference if a recent Pan American Health Organization awards ceremony is any indication.

Rural projects from Wisconsin and West Virginia were among the winners at an April 5th event sponsored by the Pan American Health Organization (PAHO) and the U.S. Department of Health and Human Services that was part of the national celebration of World Health Day. The international theme for this year's World Health Day was "Move for Health". It focused on the importance of physical activity and ways to get people moving.

"Unfortunately, many Americans are not aware of the importance of physical activity," said Richard L. Wittenberg, President and CEO of the American Association for World Health. "Many people believe physical activity involves a gym membership or expensive equipment. This initiative is about dispelling those myths and educating individuals that any type of movement, whether it is walking the dog, washing the car, or taking the stairs, is physical activity."

The two rural award winners were the Ho-Chunk Nation Youth Fitness Program in rural Jackson County, Wisconsin and the Eastern Panhandle Integrated Delivery System (EPIDS) of Petersburg, West Virginia. Both projects are funded by the Office of Rural Health Policy in the Health Resources and Services Administration (HRSA). They focused on rural populations that are at risk of health problems that can be mitigated by physical activity.

The Wisconsin project received an award for its "leadership in creating a successful and innovative physical activity promotion program for an at-risk population." The project focuses on the tribe's at-risk youth, ages 6-18—a population that reports problems with obesity at five times the national average. Many members of the Ho-Chunk Nation are affected by Type 2 Diabetes; obesity is a major risk factor for the disease.

The project provides the youth with nutrition counseling and exercise training. Potential participants are identified by school nurses. Participation is also encouraged by awareness raising efforts in the local newspapers.

The exercise portion of the program includes games, weight training, and cardiovascular exercise for older children, and balance, coordination, agility and strength work for younger children. Exercise classes also teach about the effects of exercise on the body.

On the nutritional front, a pediatric nutritionist performs in-home family assessments and teaches meal-planning skills. Low-fat cooking tips, food substitutes, and advice on eating out are among the topics covered.

To help overcome transportation obstacles, the program bought one bus and had another donated. Now, the program can come to the children when they cannot come to it.

To help overcome motivational obstacles, participants receive incentives in the form of t-shirts, water bottles, and field trips.

The program is the product of collaboration between the Ho-Chunk Nation Department of Health, the Ho-Chunk Nation Youth Services Program, the University of Wisconsin-Madison Pediatric Fitness Clinic and three rural school districts.

Helping Seniors Stay Healthy

In West Virginia, the target group is seniors. The Eastern Panhandle Integrated Delivery System (EPIDS) of Petersburg, West Virginia, received its award for "implementing a physical activity promotion project that increases awareness of and access to physical activity services for the elderly." The program works to improve access to services for people 55 and older in six rural, medically underserved counties in the state's mountainous eastern region. Four of these counties rank among West Virginia's highest for the number of elderly living below the federal poverty level.

Among the program's efforts are "Lunch and Learn" programs that provide nutrition education and programs that focus on energy, balance, and weight loss. An exercise physiologist has also developed nine fitness programs for the seniors, focusing on cardiovascular health, stress reduction, and exercise education.

A resource directory containing information about health and social service providers is being distributed. And monthly support groups for diabetes, multiple sclerosis, heart disease, and cancer patients and their families are being held at the local hospital. In addition, an "End of Life" group has begun meeting.

Finally, help in connecting uninsured and underinsured seniors to medical and social services, including discounted prescription drugs, is being offered, as are low-cost medical screenings.

EPIDS is the result of collaboration between several rural health and human services agencies, including Grant Memorial Hospital, E.A. Hawse Health Center (a federally qualified community health center), Potomac Highlands Guild (a nonprofit mental health center), the Potomac Highlands Health Departments, the Hardy County Committee on Aging, and EastRidge Health Services (a mental health center).

"We have a tendency to underestimate the good that we're doing in rural areas," said Fran Welton, EPIDS Rural Outreach Grant Coordinator. "The World Health Award is similar to putting a Good Housekeeping seal of approval on our efforts."

The challenge, according to Welton, will be to make the programs self-sustaining after the grant funds run out.

The Ho-Chunk project has been a HRSA grantee since 1999, EPIDS since 2000. The emphasis of the Rural Health Outreach Grant Program is on service delivery through creative strategies. Grantees are required to form a network with at least two additional partners. Grantees must also have their headquarters in a public or nonprofit private entity and be located in a designated rural county, or exclusively provide services to migrant and seasonal farmworkers in rural areas, or be a Native American Tribal or quasi-tribal entity.

According to the HRSA website, programs funded have varied greatly, and have brought care that would not otherwise have been available to at least two million rural citizens across the country.

Dr. Elizabeth Duke, Administrator of HRSA, was on hand at the ceremony. "HRSA programs touch the lives of millions of people each year," she said. "By promoting healthy behaviors, we build the foundation for healthy communities and a healthy nation."

CMS Open Its Doors to the Rural Community

By Thomas D. Rowley

The Centers for Medicare and Medicaid Services (CMS) in the U.S. Department of Health and Human Services has opened its doors to rural providers, and providers have taken advantage of the opportunity.

Each month, the agency holds a meeting and conference call with physicians, hospital administrators and other interested parties to raise issues and ask questions about Medicare and Medicaid policy issues. More than 80 people participated in the rural session in May.

Brent Miller, Director of Federal Government Relations at the Marshfield Clinic has also made it to most of the sessions, either in person or by phone.

"They've done a really good thing. It's not an easy thing to do—open your door and let people in to complain," Miller said. Consequently, he said, "There have been some sessions that have been relatively dramatic."

The sessions are part of a new CMS (formerly known as the Health Care Financing Administration or HCFA) effort to improve relations with the provider community. The Rural Open Door sessions are one of a number of focus areas for the forums. There are also monthly meetings for hospitals, physicians, home health care providers and other segments of the health care world.

Each Open Door session is chaired by a senior CMS official, although the rural sessions have the added advantage of being chaired by CMS Administrator Tom Scully, along with his special assistant, Tim Trysla. The next Rural Open Door Forum is scheduled for June 18th. (see the schedule at http://cms.hhs.gov/opendoor/schedule.asp).

Rural providers are already seeing the benefits.

"I'm very pleased with them," said Stephen Noble, president of Accord Healthcare Corporation, which operates hospitals and nursing homes in rural Georgia. "I don't miss any.

Continued on next page

Open Door Results

CMS lists several accomplishments of its rural open door sessions:

- **Amending** regulations to permit payments to clinical practices owned by physicians assistants;
- **Implementing** the critical access hospital all-inclusive payment option provisions of the Benefits Improvement and Protection Act of 2000, and waiving the 60-day notification requirement for critical access hospitals that wanted to elect the option;
- **Eliminating** the requirement that critical access hospitals complete the Minimum Data Set for swing bed patients.
- **Permitting** more critical access hospitals to qualify for Certified Nurse Anesthetists pass-through payments;
- **Allowing** a sole community hospital to retain its status when another facility opens within 35 miles, provided that there is no significant overlap of services; and
- **Clarifying** the on-call requirements of the Medicare program and limiting the scope of Emergency Treatment and Labor Act (EMTALA) to provider-based entities that actually provide emergency services.

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Rural providers of all flavors need to tune in."

As an example of the results, Noble related how CMS agreed to change its requirements on a particularly onerous administrative task that required small rural hospitals to collect a great deal of clinical information on nursing home residents under the Minimum Data Set. After raising the issue in one of the hour-long calls, Noble and others had relief 60 days later in the form of a rule change that exempted some small facilities from the requirement.

To date, the forums have been held in Washington, DC, with provisions for people to participate via conference call. However, Thomas Barker, Forum Coordinator, said that CMS would like to hold some rural sessions out in rural areas. He invited parties interested in hosting a session to contact CMS.

For more information, see http://cms.hhs.gov/opendoor/.

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University of Pittsburgh creates Rural Center in Bradford

Rural issues are getting a new focus within the University of Pittsburgh thanks to the establishment of the Center for Rural Health Practice at the school's campus in Bradford.

"The University of Pittsburgh is home to many of the nation's top health researchers," said center director Michael Meit. "Our goal is to get these folks out of the city so they can apply their knowledge and expertise to addressing rural health concerns."

The University of Pittsburgh created the center in conjunction with the University of Pittsburgh's Schools for the Health Sciences, the University of Pittsburgh Medical Center Health System, and area hospitals and health providers. The idea is to provide the opportunity to engage University researchers and practitioners in rural health issues in a rural setting. Bradford is located in Northwestern Pennsylvania near the New York-Pennsylvania border.

The center will identify priority rural health issues, develop collaborative efforts to address identified issues, secure necessary resources, and engage University personnel and external consultants in research and programs. In addition, rural Pennsylvania communities will serve as the testing grounds for national program models and for the development of rural health policy. Finally, the center will serve as a clearinghouse for University of Pittsburgh programs on rural health.

The center's current initiatives are in the areas of rural home health and rural health information systems. Future priority areas include workforce development, aging, rural health disparities, and rural public health infrastructure.

For more information, contact Michael Meit at meit@pitt.edu or (814) 362-8656.

On-Line Nursing Courses in South Dakota

The people behind a new project in South Dakota hope that home-grown nurses will allay an ongoing nursing shortage in the some of the state's rural areas.

The SEED Program (Skills Enhancement and Education through Distance Learning) uses distance-learning technology to train nurses where they live in the hope that they will stay and practice in their rural communities. The program offers courses toward RN, BSN, and RN-BSN degrees via closed-circuit television to students in hospitals and clinics in eight rural communities. The facilities are affiliated with Avera St. Luke's, a nonprofit system of hospitals and health care facilities in South Dakota. Presentation College in Aberdeen, South Dakota, provides the curriculum and faculty and televises the courses. It also has senior personnel at the satellite facilities to act as adjunct professors.

Funding for the effort came from the U.S. Department of Labor, to train needed technical workers, including nurses and other allied health professionals. To date, $2.7 million has been received. The possibility for more exists.

Tami Lichtenberg, Director of Rural Health Programming at Avera, wrote the grant. She said the program has been so well received, that they are considering ways to take it statewide.

"The beauty of this program is that we're taking place-committed people and we're providing them an opportunity," said Lichtenberg. "We're eliminating the two greatest barriers—distance and finance. This is going to keep our rural communities alive."

The advantages of distance-learning make it easier for full-time workers, parents, and others who could not easily travel to Aberdeen to take the classes. In most cases, students are even able to take their clinical exams at the satellite facilities. On top of all that, tuition is free. The students only have to pay for their textbooks.

The program's beauty was recognized by the National Rural Health Association, which named the SEED Program its Outstanding Rural Health Program of 2002. The award recognizes a community, regional or statewide program that promotes the development of rural health delivery systems. Criteria include collaboration of services, networking, innovation, and lasting impact.

"We're pleased by the honor," said Max Morse, Director of the SEED program. "We hope it will help open doors for expanding the program and using it as a model in other parts of rural America."

The program currently has 165 students, with 200-300 more on the waiting list. For more information, contact Max Morse at (605) 622-5774.

Call for Input

Something newsworthy going on in your part of rural America? Send a one-paragraph summary to the editor at t-mrowley@juno.com.

Hawaii Association Structured to Deal with Challenges

Rural health in Hawaii has its own unique set of challenges, among them the fact that the state consists of islands—making meetings, collaboration, and service delivery more difficult even than in most rural areas. On top of that, the situation and conditions vary from island to island.

To help deal with these challenges, the Hawaiian Rural Health Association (HRHA) has a somewhat different structure than rural health associations in most states. The 501c3 (nonprofit) organization consists of four county rural health associations, each a 501c3, representing a total of seven islands. The president and another representative from each county association comprise the state association board.

The arrangement started on the island of Hawaii after several people attended a Community Development Block Grant meeting and came away excited about the possibility of communities being able to have more of a say in their own health futures. From there, other islands followed, then the state. The State Office of Rural Health played an important role in helping the organization get up and running.

Daryl Mukai is the HRHA's Rural Health Coordinator and its first paid staff member. According to Mukai, building communications between the county associations, as well as communities within the counties, is a key priority. "Being an island state," he said, "we have to meet over the phone or it's a day lost flying plus $150 round trip."

According to Mukai, there is also a possibility of creating community-level associations within the counties. Health needs even on the same island, he said, can be very different.

Current activities of the HRHA include working with 22 communities to create a comprehensive rural health plan; helping train those communities to meet the needs identified in the plan; and participating in a state-wide dental care coalition to get dental services to rural areas.

Maya Yonting-Dornes, President of HRHA, would also like to see the organization help create a rural voice. "Eighty percent of the state is rural, but 90 percent of the population is on the island of Oahu, where Honolulu is," she said. "Rural voices get kind of lost."

For more information contact Daryl Mukai at (808) 224-5146.

Hard to Reach: Rural Homelessness & Health Care

P. Post, National Center for the Homeless Council, January 2002.

This report examines obstacles to health care faced by the homeless in small communities and remote rural areas of the nation. It contrasts the experience of the rural homeless with that of their urban counterparts.

While there are fewer homeless people in rural areas than in urban, the proportionate incidences of homelessness in some rural areas are similar to or greater than those in major metropolitan areas. The report says that, "Homelessness is a serious and growing problem in rural areas throughout the United States."

The rural homeless differ from the urban in several ways: they are less educated, are more likely to be employed (although in temporary jobs with no benefits), have higher average monthly incomes, are more likely to get cash assistance from friends and are less likely to get it from the government. As for health, problems seen in both rural and urban homeless people "tend to be more advanced in rural patients, who present with more untreated, chronic health problems."

Access to health care for rural homeless people is seriously limited by three primary obstacles: lack of transportation, lack of health insurance, and unavailable or inaccessible health services—especially secondary and tertiary care, and behavioral health care.

The report makes recommendations that fall into seven categories:

· Provide transportation assistance;
· Expand health coverage and facilitate access to covered services;
· Stimulate development of a comprehensive service delivery infrastructure in rural communities that responds to the needs of homeless people;
· Coordinate rural service delivery systems;
· Increase outreach to "hidden" homeless people in remote rural areas;
· Promote cultural competence among homeless assistance providers; and
· Focus on homelessness prevention.

Available at www.nhchc.org or by calling (615) 226-2292.

Access to Emergency Medical Services in Rural Areas: The Supporting Role of State EMS Agencies

A. Knott, Rural Health Research Center, University of Minnesota, Working Paper # 38, February 2002.

This study's purpose is to improve knowledge about rural EMS and its support by state EMS agencies. It is based upon a survey of state EMS directors.

Among its findings:

· State EMS agencies are largely state-funded and have mainly regulatory and policymaking obligations.
· A variety of state agencies are responsible for EMS issues, which illustrates substantial state-to-state variation in their approaches.
· EMS system development has not been a priority in state efforts (less than one-third of those surveyed have a statewide EMS plan).
· Only 29 percent of state EMS agencies provide services and/or programs that specifically address the needs of rural EMS providers.
· Medical direction in rural EMS is a major issue for a majority of states; however, few states place a high

priority on it.

· While integration among EMS providers occurs, more innovative approaches—such as integration between EMS and public health—are not common.

The report concludes with a recommendation for "a new national initiative to address EMS issues and to stimulate the development of EMS as a system, beyond its current fragmented state."

Available at www.hsr.umn.edu/rhrc/wkp_monographs.html.

The Immediate and Future Role of the J-1 Visa Waiver Program for Physicians: The Consequences of Change for Rural Health Care Service Delivery

Special J-1 Visa Waiver Program Task Force and K. Mueller (Principal Author). RUPRI Center for Rural Health Policy Analysis, *Policy Paper* P2002-3, April 2002.

The longstanding and well-documented problem of maldistribution of physicians resulting in areas of shortage continues to plague much of rural America. The supply of physicians to those shortage areas currently includes physicians from nations other than the United States—international medical graduates—who obtain waivers on visa requirements (J-1 visas), allowing them to remain in this country after their residency training. This Policy Paper addresses the question: *What are the consequences for the delivery of health care services in rural underserved areas if current policies governing the granting of J-1 visa waivers are changed (resulting in increases or decreases in the numbers of physicians affected)?*

The paper provides available information and analysis to help frame and examine policy options for placing physicians in rural underserved areas.

Available at http://www.rupri.org/healthpolicy or by calling (402) 559-5260.

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http://www.nal.usda.gov/ric/richs/ or call 1-800-633-7701.

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Medicare Minus Choice: How HMO Withdrawals Affect Rural Beneficiaries

M. Casey, A. Knott, and I. Moscovice, The University of Minnesota Rural Health Research Center, October 2001

Rural Managed Care: Expansion or Evolution?

M. Casey, I. Moscovice, and J. Klingner, The University of Minnesota Rural Health Research Center, April 2002

These two chartbooks focus on rural managed care issues. The first assesses the short and long term impact of Medicare HMO withdrawals and service reductions on rural Medicare beneficiaries. The second examines trends in rural managed care enrollment over time and discusses the implications of changes in the commercial HMO market, state Medicaid programs, and the Medicare + Choice program for managed care in rural areas. The chartbooks were completed with support from the Robert Wood Johnson Foundation.

Available by contacting raasc001@tc.umn.edu or by calling (612) 625-0955.