AS A MAJOR ECONOMIC PILLAR IT OFTEN TOLLS THE DEATH KNELL OF A [redacted] COMMUNITY.

BUT DATA ON HOSPITAL CLOSURES ARE LIKE MORTALITY STATISTICS, THEY REFLECT DEATH ONLY, NOT SICKNESS AND SUFFERING.

MANY RURAL HOSPITALS ARE BEING STRANGLED.

THIS MAY RESULT, NOT IN THEIR DEATH, BUT IN THEIR RELATIVE FINANCIAL AND ORGANIZATIONAL SICKNESS.

DHHS SHOULD MOVE ON ~~THEIR~~ ITS PLAN TO ELIMINATE THE URBAN/RURAL DIFFERENTIAL IN STANDARDIZED MEDICARE HOSPITAL PAYMENTS AS SOON AS POSSIBLE. MANY RURAL HOSPITALS WILL NOT MAKE IT UNTIL 1995 WHEN THE CURRENT PLAN IS TO GO INTO EFFECT.

I SEE NO REASON WHY THIS COULD NOT BE ACCOMPLISHED IN FY 91.

CONCURRENTLY DHHS SHOULD REFINE THE AREA WAGE INDEX UNDER MEDICARE TO REFLECT THE REALITY OF A SINGLE NATIONAL MARKET FOR HEALTH PROFESSIONALS.

I CONTINUE TO HEAR STORIES OF AGED VETERANS WHO MUST TRAVEL A HUNDRED MILES TO A VETERANS ADMINISTRATION HOSPITAL AND EVEN THEN MAY NOT BE SEEN THAT DAY.

LETS HELP THE VETERAN, DECREASE THE OVER-CROWDING OF V.A. HOSPITALS, AND INCREASE UTILIZATION OF RURAL HOSPITALS BY ALLOWING OUR RURAL VETERANS TO RECEIVE THE CARE THEY ARE ELIGIBLE FOR AT THEIR LOCAL HOSPITAL.

ONE OF

FARMING IS OUR NATION'S MOST DANGEROUS OCCUPATIONS, AND

ALTHOUGH ARE

FARM ACCIDENTS [redacted] A MAJOR PROBLEM [redacted] UNDER – REPORTED.

GOOD FARM SAFETY PROGRAMS COULD DECREASE NEEDLESS SUFFERING AND THE NEED FOR COSTLY MEDICAL CARE.

THERE ARE MANY NEW INITIATIVES UNDERWAY.

BUT I AM ESPECIALLY EXCITED ABOUT THE UNIVERSITY OF NORTH DAKOTAS' RURAL RESEARCH CENTER.

THERE THEY ARE DEVELOPING GUIDANCE IN ORDERING ROLL BARS FOR TRACTORS AND FOR ADAPTING ROLL BARS FOR DISCONTINUED TRACTOR MODELS.

THIS COULD PROVIDE A SOLUTION TO A MAJOR SOURCE OF FARM ACCIDENTS.

FARM SAFETY IS ALSO AN AREA WHERE THE EXTENSION SERVICE OF USDA COULD BE OF TREMENDOUS ASSISTANCE.

I ENCOURAGE DHHS AND USDA TO WORK CLOSELY TOGETHER IN THE AREA OF FARM SAFETY.

MENTAL HEALTH CARE SERVICES IN THE UNITED STATES ARE IN A SAD STATE OF AFFAIRS.

THE MENTAL HEALTH BLOCK GRANT PROGRAM, WITH ITS UNDER – FUNDING, IS A FAILURE.

MOST STATES HAVE ONLY SUFFICIENT RESOURCES TO TREAT THE CHRONICALLY MENTALLY ILL.

COMMUNITY MENTAL HEALTH CENTERS HAVE ABANDONED OUTREACH AND COMMUNITY ~~EDUC~~ PREVENTION PROGRAMS.

THEY LOOK INSTEAD TO MEDICAID AND PRIVATE INSURANCE TO COVER PATIENTS AND INSURE SURVIVAL.

LET ME REMIND YOU THAT MOST MENTAL DISORDERS ARE TREATED BY FAMILY PHYSICIANS AND THE CLERGY.

WE MUST RECOGNIZE THE INTERDEPENENT RELATIONSHIP BETWEEN PHYSICAL AND MENTAL HEALTH AND FIND WAYS TO BRING THE TWO TOGETHER.

IN THE LATE 1970'S THERE WAS AN INNOVATIVE PROGRAM BETWEEN COMMUNITY HEALTH CENTERS AND COMMUNITY MENTAL HEALTH CENTERS CALLED "MENTAL HEALTH LINKAGES".

MENTAL HEALTH LINKAGE WORKERS, USUALLY SOCIAL WORKERS, CARRIED A CLIENT CASE LOAD, ACTED AS A LIASON, AND EDUCATED AND SENSITIZED THOSE PROVIDING PHYSICAL HEALTH-CARE.

THE PROGRAM WAS AS SUCCESS, BUT FELL TO THE BUDGET CUTS OF THE EARLY 1980'S. ~~ENCOURAGE~~ ITS REDISCOVERY WOULD BE OF CONSIDERABLE BENEFIT.

ON A MORE POSITIVE NOTE I APPLAUD THE RECENT ESTABLISHMENT OF A RURAL MENTAL HEALTH RESEARCH PROGRAM AT THE NATIONAL INSTITUTE OF MENTAL HEALTH UNDER DR. DELORES PARRONE.

I HOPE THEY WILL FUND RESEARCH AND DEMONSTRATION PROJECTS THAT UTILIZE THE RESOURCES OF PRIMARY CARE PHYSICIANS AND CLERGY TO HELP THOSE WITH MENTAL HEALTH PROBLEMS.

WE NEED MORE RESEARCH, BUT WE ALSO NEED PROGRAMS THAT WILL ADDRESS UNMET LOCAL NEEDS FOR INTEGRATED MENTAL HEALTH SERVICES.

**THERE ARE MAJOR SHORTAGES OF HEALTH PROFESSIONALS IN THE RURAL AREAS.**

**WHILE I ADVOCATE RURAL HEALTH SYSTEMS THAT UTILIZE RELATIVELY SMALL NUMBERS OF PHYSICIANS; THERE MUST BE PHYSICIANS AVAILABLE TO SERVE IN RURAL AMERICA.**

WE MUST MAKE RURAL PRACTICE ATTRACTIVE TO THEM AND TO OTHER HEALTH PROFESSIONALS.

I FAVOR REAUTHORIZATION OF THE NHSC, BUT WITH SOME MAJOR CHANGES. SCHOLARSHIP FUNDING PREFERENCE SHOULD GO TO MEDICAL SCHOOLS, LIKE THE KIRKSVILLE COLLEGE OF OSTEOPATHIC MEDICINE, WITH A LONG TRACK RECORD OF PRODUCING RURAL FAMILY PHYSICIANS.

**WE DON'T NEED MORE EXPENSIVE URBAN ORIENTED PROGRAMS LIKE GEORGETOWN AND GEORGE WASHINGTON UNIVERSITY WITH EXPECTATIONS THAT THEY WILL PROVIDE RURAL PHYSICIANS.**

PAYBACK

**WE SHOULD SUPPORT DEFERMENT FOR PRIMARY CARE PHYSICIAN RESIDENCIES ONLY IN AHEC OR AHEC-TYPE MULTI DISCIPLINARY PROGRAMS PHYSICALLY LOCATED IN RURAL AREAS.**

I SPENT SEVERAL HOURS WITH SEVEN YOUNG MEN AND WOMEN - LEAVING THE FAMILY PRACTICE RESIDENCY TO PRACTICE IN RURAL KENTUCKY. THEY ARE IN A PROGRAM THAT FORGIVES MEDICAL SCHOOL INDEBTEDNESS IN RETURN FOR A RURAL COMMITMENT. THEIR CALIBRE, THEIR DEDICATION WAS MOST ENCOURAGING - SUCH PROGRAMS COULD BE EXPANDED AND REPLICATED.

**RURAL PRACTICE IS DIFFERENT.**

**WE DON'T NEED HUGE NUMBERS OF RURAL FAMILY PHYSICIANS AND WE DON'T NEED TO SPEND A LOT OF MONEY IF WE SPEND IT IN THE RIGHT PLACES.**

**THE N.H.S.C .SHOULD NOT BE A PHYSICIAN – ONLY ACTIVITY.**

WE HAVE JUST AS GREAT A NEED FOR NURSE PRACTITIONERS, PHYSICIANS ASSISTANTS, NURSES, AND ALLIED HEALTH PERSONNEL.

ALSO

WE SHOULD ENCOURAGE STATES TO LICENSE MORE INDEPENDENT NURSE PRACTITIONERS FOR RURAL

AREAS. I WOULD ALSO ENCOURAGE MORE FLEXIBILITY IN NHSC ASSIGNMENTS TO ALLOW FOR EXPERIMENTATION IN NEW MODELS OF CARE. (E.G. ALLOW COMMUTING, ALLOW COMBINATION CHC HEALTH DEPT./ PRIVATE COMBINATIONS.

I WOULD LIKE TO SEE STRONGER STATE ROLES IN ESTABLISHING HEALTH MANPOWER SHORTAGE AREAS THAT ARE MEDICAL SERVICE AREA BASED RATHER THAN COUNTY BASED.

STATES SHOULD BE GIVEN AN OPPORTUNITY TO SET THEIR OWN PRIORITIES, WITH APPROPRIATE SAFEGUARDS FOR COMMUNITY HEALTH CENTER'S / COMMUNITY MENTAL HEALTH CENTER'S.

WOULDN'T IT BE GOOD

~~I WOULD LIKE~~ TO SEE STATE OFFICES OF RURAL HEALTH AS A MECHANISM FOR THIS AND ~~HOPE THEY WILL~~ EXPECT THEM TO TAKE THE BROAD APPROACH OF WORKING WITH PRIVATE AND PUBLIC PROVIDERS SUCH AS ~~LIKE~~ JIM BERNSTEIN HAS PIONEERED IN NORTH CAROLINA FOR ALMOST 20 YEARS.

I REFERRED EARLIER TO THE "RURAL CHRISTMAS TREE" IN THE SENATE APPROPRIATIONS REPORT.

IT CONTAINED SOME VERY ENCOURAGING THINGS : EQUITABLE FUNDING ALLOCATION TO RURAL / URBAN COMMUNITY HEALTH CENTERS, RURAL MENTAL HEALTH RESEARCH, INCLUDING RESEARCH & DEVELOPMENT AREA CENTERS, TWO ADDITIONAL RURAL HEALTH RESEARCH CENTERS ( ONE MINORITY ), ACADEMIC / PRACTITIONER LINKAGE GRANTS, AND A COMPREHENSIVE RURAL POLICY RESEARCH STUDY.

I CONTINUE TO WORRY ABOUT "SPECIAL POPULATIONS" : BLACK, HISPANIC, ELDERLY, ETC. AS COMMUNITY HEALTH CENTER'S / COMMUNITY MENTAL HEALTH CENTER'S, HEALTH DEPARTMENTS HAVE CUT BACK OUTREACH, THESE ARE FORGOTTEN PEOPLE,

I HOPE THERE ARE RESEARCHERS IN THIS AUDIENCE WHO WILL GO OUT AND SURVEY THESE POPULATIONS,

SO WE CAN RE - INVENT OUTREACH WORKERS AND COMMUNITY CASE WORKERS.

THESE SPECIAL POPULATIONS ARE DIVERSE AND WILL REQUIRE NEW APPROACHES SUCH AS WORKING THROUGH THE BLACK OLDER CHURCHES, AS WELL AS METHODS TRIED AND TRUE.

ALSO IN THAT REPORT WAS THE REQUIREMENT FOR SOME PILOT PLANNING GRANTS TO COALITIONS OF STATE HEALTH DEPARTMENTS, STATE PRIMARY CARE ORGANIZATIONS, AND UNIVERSITIES TO DEVELOPE STATE MIGRANT HEALTH AND SOCIAL SERVICES PLANS.

THE MIGRANTS ARE TRULY "THE WORKING POOR".

THEY DO SO MUCH; THEY ASK FOR SO LITTLE,

JUST A SHOT AT THAT AMERICAN DREAM I MENTIONED EARLIER.

MIGRANTS HAVE NO POLITICAL POWER.

THEY CAN'T TAKE PART IN OUR " INTEREST GROUP" STYLE OF POLITICS.

AT THE MOMENT THEY HAVE ONLY A FEW STRONG ADVOCATES LIKE SONIA REIG, DIRECTOR OF THE FEDERAL MIGRANT HEALTH PROGRAM, AND THERE MUST BE MORE.

HUMAN COMPASSION ASIDE, WE MUST REALIZE THAT WE ARE BECOMING PART OF A WORLD ECONOMY AND FOR MODERN AGRICULTURE TO SURVIVE AND COMPETE WE NEED A HEALTHY AND PRODUCTIVE MIGRANT AGRICULTURAL WORK FORCE.