

# Rural HEALTH NEWS

*A Publication of the Rural Information Center Health Service*

## Terrorism Brings Public Health Into Spotlight

By Thomas D. Rowley

The public health infrastructure—composed of local public health departments, state public health agencies, hospitals, clinics, and the people who work there—has long suffered from benign neglect. Indeed, it's a safe bet that most people, and policymakers, have only the vaguest notion of what public health is and does, much less what shape it's in.



Tragically, the atrocities of last autumn, specifically the anthrax incidents and the threat of other bioterrorism attacks, brought public health into our field of vision.

What that spotlight shows—and what public health practitioners have known all along—is that the public health infrastructure in general, and its rural components in particular, are

in dire need of improvement.

“The public health system is overextended and under funded, especially in rural America,” said Mary Wakefield, Director of the Center for Rural Health at the University of North Dakota and member of the National Advisory Committee on Rural Health, at a recent Capital Area Rural Health

Roundtable on rural public health. Others on the dais concurred.

According to Anjum Hajat of the National Association of County and City Health Officials and lead author of the new report

*Local Public Health Agency Infrastructure: A Chartbook*, local public health agencies (LPHAs)—especially rural ones—also suffer from a lack of appropriately trained personnel. “Seventy one percent of rural LPHAs say they cannot hire needed personnel because of budget constraints. Forty seven percent say that they cannot attract qualified applicants.” Both statistics, of course, relate to funding.

Indeed, the report found that 41 percent of rural LPHAs said their biggest challenge was funding. By comparison, only 26 percent of urban LPHAs felt the same way.

In addition to the difficulties in paying for good help, LPHAs have trouble finding it. According to The Public Health Foundation, only 15 percent of the nation's public health workforce has had academic education in public health.

Not surprisingly, these factors undermine the local public health system's ability to “assure conditions in which people can be healthy”—the mission of public health.

In its report on rural public health, the National Advisory Committee (NAC) cited HHS findings that “less than half of the nation's local public health agencies have the capacity to provide the essential public health services.” The committee also cited reports by the National Academy of Science's Institute of Medicine that identified “erosion of the public health infrastructure” as one of the factors contributing to new and reemerging infectious diseases. According to the committee, all of this has “created an increasingly fragile infrastructure during a time of great change.” That

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statement, written in February 2000, is even truer and more ominous today.

## A Time of Great Change

This is a time of great change for the United States and for the whole world. People everywhere realize their vulnerability, perhaps as never before. Stripped of their sense of security, people wonder if their food and water supplies are safe, if there are enough vaccine doses to go around. Whether they know it or not, they are questioning whether the public health system—nationally and in their hometowns—is up to the task. Unfortunately, the answer in many cases is “no.”

The current milieu and its spotlight on public health offer an opportunity to remedy the situation and to see to it that the public health infrastructure is up to the task. Toward that end, the federal government has dramatically increased funding for public health—upping six-fold the \$500 million spent in fiscal year 2001 on bioterrorism to \$2.9 billion in 2002. Of that, \$1.1 billion will go to state and local public health capacity building. Additional funds are called for in pending legislation.

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## The Mission of Public Health

The mission of public health is, according to the 1988 Institute of Medicine report, *The Future of Public Health*, “assuring conditions in which people can be healthy.” Public health personnel pursue that rather broad mandate by assessing health status and needs, investigating hazards, and taking measures to meet the needs and mitigate the hazards. At the local level, the scope of issues that local public health agencies, or LPHAs, deal with run the gamut: from rabies control to restaurant inspection, from botulism to, sadly, bioterrorism.

In addition to these so-called “population services,” LPHAs—especially in rural areas—are also frequently called upon to provide personal health care services to people who either cannot afford to see a private provider or simply have access to no other providers. Thus, for the poor and/or isolated, public health agencies are often the medical provider of first and last resort. They are the safety net.

These dual roles of public health agencies, and the ambiguity which often results, cause problems. In its 2000 report *Rural Public Health: Issues and Considerations*, the

National Advisory Committee on Rural Health said that the perception that public health is primarily a service for poor people “makes it hard to win the support of the middle and upper classes.” Furthermore, the report includes statements from various experts claiming that the public health system has been “undermined...by escalating pressures on state and local governments to provide medical care for the poor and uninsured” and that “support for indigent medical care has exacted a huge toll” on the ability of the system to serve the larger public.

Second, public health agencies—who, in the past, had become quite dependent on reimbursements for providing indigent care—are in many cases going through withdrawals as those sources of reimbursement change and, in some cases, disappear. Worse, these reimbursements had often subsidized other, traditional public health services. Now, however, as many states move their Medicaid patients into managed care plans—which often do not contract with public health agencies to provide care—the agencies are seeing an important funding stream dry up.

## 10 Essential Public Health Services

1. Monitor health status to identify community health problems
2. Diagnose and investigate health problems and health hazards in the community.
3. Inform, educate, and empower people about health issues.
4. Mobilize community partnerships to identify and solve health problems.
5. Develop policies and plans that support individual and community health efforts.
6. Enforce laws and regulations that protect health and ensure safety.
7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable.
8. Assure a competent public health and personal health care workforce
9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services.
10. Research for new insights and innovative solutions to health problems.

From *Public Health in America*, Public Health Functions Steering Committee, U.S. Department of Health and Human Services, 1995.

Quoted in *The Washington Post*, Secretary of Health and Human Services Tommy Thompson said, “We recognize that we have not as a country... invested the necessary, scarce resources in our local and state public health systems. We now have an opportunity to build a viable, vibrant, strong ... system that will prepare and protect our citizens for any attack that may come.”

The obvious targets for such attacks are, naturally, big cities—homes to masses of people, centers of business and government, and hubs of communication. Rural areas, however, should not and cannot consider themselves immune. In addition to housing such possible targets as power plants, food and water sources, and defense installations, rural areas are home to 20 percent of the nation’s population and 60 percent of its local public health agencies. Furthermore, as the nation saw with anthrax, an attack on any part of the system puts the whole system at risk. The speed, efficiency, and connectedness of modern life, more than ever, make the public health chain only as strong as its weakest link.

## Paying for Public Health

The same logic applies, of course, to public health concerns beyond those related to terrorism. When it comes to health, what affects rural America affects all of America. Diseases do not respect city limit signs. Public health truly is what economists call a *public good*—a good or service with benefits that people cannot be excluded from enjoying, regardless of who pays for it.

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## 10 Great Public Health Achievements

1. Vaccination
2. Motor vehicle safety
3. Safer workplaces
4. Control of infectious diseases
5. Decline in deaths from coronary heart disease and stroke
6. Safer and healthier foods
7. Healthier mothers and babies
8. Family planning
9. Fluoridation of drinking water
10. Recognition of tobacco use as a health hazard

From: Centers for Disease Control, cited in *Rural Public Health: Issues and Considerations*, National Advisory Committee on Rural Health, 2000.

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Nevertheless, local and state governments (with some pass-through federal money) pay the lion's share of the local public health tab. And therein lie some challenges.

Rural areas—because of their sparse settlement patterns—often find it difficult to raise enough revenue to meet all of their public service needs. Fewer people generally mean lower sales tax and user fee revenues. At the same time, longer distances mean higher per unit costs—a double whammy.

On top of that, state and local governments—more so than the federal government—are at the mercy of the economic cycle. Therefore, when times are bad...

Because most state and local governments are required by law to balance their budgets each year, they cannot rely on deficit spending to get through the downtimes, when sales and income tax revenues trail off, the way the federal government can. To provide for the occasional “rainy day,” states and localities must put away money in advance. Most find that very difficult to do, as is now clear in the red ink spilling from statehouses across the country.

As for the federal share, it too has problems.

Carol Moehrle directs the North Central District Health Department in Idaho. Her agency's mission (“Find the infected, figure out where

they got it, treat them, and protect the rest of us.”) sounds relatively straightforward. Her job does not. The agency's territory stretches over five counties and 13,500 square miles where the Idaho panhandle attaches to the rest of skillet. Yet daunting as that is, it's nothing compared to managing 34 different funding streams or “silos.”

Federal money for public health comes from a variety of agencies and for a variety of public health activities. Some agencies fund multiple activities. Those funds go to a governor-designated state agency within each state, which then, at its discretion, may contract with local health departments to provide the services specified by those funds. It should be noted: the state does not have to contract with local departments; the money does not have to flow to the local level. When it does, however, the money goes to pay for specific services—immunizations, for example—not for hiring personnel, buying equipment, or building facilities. To the extent that the public health infrastructure does get developed and maintained, it happens primarily on the local dime.

In addition to the fact that the federal money does not support infrastructure, Moehrle sees at least three problems with the current arrangement. First, dealing with 34 funding streams means managing 34

contracts, understanding 34 programs, and meeting 34 reporting requirements. This, she says, leads to situations in many states where more people are managing the contracts than are providing public health services.

Second, the monies are not fungible. Immunization money, for example, cannot be used to hire a nurse to give immunization shots, even when that would be the most effective use of the money.

Third, the arrangement is susceptible to what Moehrle calls the “yo-yo effect”—funding that comes and goes depending on who's in charge of funding and what the hot issue is. One year, heart disease may capture policymakers' attention and get a lot of funding. The next, however, it may be HIV-AIDS. Heart disease funds go down, so do local public health efforts to prevent it. The problem, says Moehrle, is that overall public health funding can stay the same, but when the categories go up and down like a yo-yo it's impossible to maintain a consistent long-term effort.

## Out of the Crisis, Reform?

Horrifying as its *raison d'être* is, the bioterrorism funding holds promise for local—even rural—public health systems. The money is to be

used to develop comprehensive bioterrorism preparedness plans, upgrade infectious disease surveillance and investigation, enhance the readiness of hospital systems to deal with large numbers of casualties, expand public health laboratory and communications capacities, and improve connectivity between hospitals, and city, local and state health departments to enhance disease reporting. In short, the money is to be used to improve the public health infrastructure.

As Moehrle puts it, “A disease—whether its smallpox or hepatitis—is a disease. Anything we can do to deal with bioterrorism will naturally strengthen rural public health.”

And although the money will go to the states, with no requirements that it go to local public health departments, the state applications for the money must include a letter of support from representatives of the local public health sector. Dr. Stephanie Bailey, past president of the National Association of County and City Health Officials and member of the NAC, was in on the drafting of the rules. “We did everything we could to assure that locals got a seat at the table.” As a result, she says, the bioterrorism money “begins to build the foundation.”

The key word is “begins.” Bailey emphasizes that one-time money will not build infrastructure. The effort, she says, must be ongoing. “Public health infrastructure needs to be a line-item in the federal budget—just like our army and navy—that doesn’t go away.”

To help keep public health an ongoing effort, it may be useful for policymakers to review the NAC’s public health report. In it, the NAC made two recommendations. One, create a “Federal Interagency Public Health Coordination Committee” to find ways to integrate the myriad funding streams. Two, establish a dedicated public health system funding stream that would be “equitably distributed among rural and urban health departments.”

Both would make life easier for the Carol Moehrle’s of the world—knocking down silos and moving from paying strictly for services rendered to paying for capacity building. To which, Moehrle says, “Amen! That would help rural public health departments in every corner of every state.”

## **Bioterrorism Funding for Public Health**

The \$1.1 billion from HHS will help states (and localities) strengthen their capacity to respond to bioterrorism and other public health emergencies resulting from terrorism. Specifically, it will be used to develop comprehensive bioterrorism preparedness plans, upgrade infectious disease surveillance and investigation, enhance the readiness of hospital systems to deal with large numbers of casualties, expand public health laboratory and communications capacities, and improve connectivity between hospitals, and city, local and state health departments to enhance disease reporting.

The funding to states and communities is divided into three parts. The first portion will be provided by the Centers for Disease Control and Prevention (CDC) and is targeted to supporting bioterrorism, infectious diseases, and public health emergency preparedness activities statewide. Each state’s allocation will consist of a \$5 million base award, supplemented by an additional amount based on its share of the total U.S. population.

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The Health Resources and Services Administration will provide the second portion of funding, which will be used by states to create regional hospital plans to respond in the event of a bioterrorism attack. Hospitals play a critical role in both identifying and responding to any potential bioterrorism attack or disease outbreak. These funds will be allocated using a formula similar to that used by the CDC. Rural health clinics, federally qualified health centers, community health centers, and rural hospitals are eligible for this latter funding.

The third portion of the funds will be provided by the HHS Office of Emergency Preparedness and will support the Metropolitan Medical Response System (MMRS). The MMRS funding will add 25 cities to those funded in the past, and will mean that 80 percent of the U.S. population will be covered by an MMRS plan. MMRS contracts are especially aimed at improving local jurisdictions' ability to respond to the possible release of a chemical or biological disease agent, but also serve to improve local response to any event involving mass casualties.

States will be permitted to begin immediately spending up to 20 percent of their allotments, so as to avoid delay in starting preparedness measures. The remaining 80

percent of the \$1.1 billion in state funds will be released once complete plans have been received and approved.

State plans are due to HHS beginning March 15, 2002, and no later than April 15, 2002. HHS will complete its review of each plan within 30 days of receipt. Each statewide plan is to describe how it will respond to a bioterrorism event and other outbreaks of infectious disease. It will also show how the state will strengthen core public health capacities in all relevant areas. Each statewide plan is to be reviewed and endorsed by the governor prior to submission.

According to Jennifer Riggle in the federal Office of Rural Health Policy, "These programs represent a golden opportunity to strengthen our capacity in public health surveillance, communications, regional hospital planning, and many other areas of preparedness."

For complete, up-to-date information on the HHS effort, see <http://www.hrsa.gov/bioterrorism.htm>, or contact the Office of Public Health Preparedness at (202) 401-4862 or [www.dhhs.gov/ophp](http://www.dhhs.gov/ophp).

For information on the CDC portion, see <http://www.bt.cdc.gov/Planning/CoopAgreementAward/index.asp>.

## Health Alert Network

When completed, the Health Alert Network (HAN) will be a nationwide, integrated information and communication system that allows the Centers for Disease Control and Prevention (CDC) to communicate with state and local health departments regarding possible disease outbreaks or to provide warning if a disease outbreak is known to exist somewhere in the country. Created in 1999, its goal is to cover at least 90 percent of the U.S. population. The network will connect the federal government, state and local public health offices, emergency responders and hospitals via the Internet. "Before HAN, some local health departments didn't even have faxes, let alone the Internet," says Dr. Stephanie Bailey, Director of Health for the Metro Nashville/Davidson County Health Department in Nashville, Tennessee.

Of great significance to local public health departments is the fact that the HAN is the first and only federal public health program to specify that a certain percentage of funds (80 percent) go to the local level. Furthermore, the

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## Federal Government Offers Training on Reimbursement

By Thomas D. Rowley

A recent study funded by Health Resources and Services Administration (HRSA) at the Department of Health and Human Services found that health care organizations receiving HRSA grant funds were not getting all the reimbursement available to them from public and private insurers. These missed opportunities for “third party reimbursement” amount to money left on the table—hurting the organizations as well as their ability to serve people who have no form of health insurance. Such missed opportunities also dilute the impact of existing HRSA grant dollars.

Consequently, HRSA is rolling out a new program to train grantees on maximizing third party reimbursement. The training will help grantees improve and expand the services they provide and help ensure the viability of their mission by improving their reimbursement efforts.

In crafting federal funding programs for health services to vulnerable populations, the Congress and Executive Branch have anticipated that money would come not just from HRSA grant funding, but also from insurance coverage programs. In other words, the federal grant programs were never designed to foot the whole bill.

HRSA began work on its Third Party Reimbursement Training and Technical Assistance Program (TPR training program) in September 2001. Since then, a contractor has been hired, curriculum developed, and a training schedule has been set, with a rollout slated for March 2002. The one and one-half day TPR training sessions will be offered in each state at no cost to participants. Organizations currently receiving grant funds directly from HRSA, as well as organizations currently funded by states and localities using HRSA grant funds, are eligible to participate.

The focus of the TPR training program will be to improve existing operational, business, and billing systems to allow grantees in each state to fully claim allowable reimbursements under the State Medicaid plan, S-CHIP, and other available sources of reimbursement. Following the training, HRSA grantees will have access to individual technical assistance, including written and on-line materials, telephone consultations, and on-site visits by the team of experts.

Tom Morris in the Office of Rural Health Policy believes that the TPR training program will help organizations funded through the Rural Health Outreach and Network Development Grant programs—both demonstration programs—sustain their efforts once federal funding ends. “We urge grantees to identify

sources of funding beyond additional grants that will allow the projects to continue,” Morris says. “In particular, we encourage them to enroll eligible individuals in any public insurance programs such as Medicaid and S-CHIP or other private and state-based insurance programs that might be available.”

Morris also believes the TPR training will help rural hospitals and providers. Rural hospitals and providers, he says, are often the focal point of the rural health care delivery system and the primary source of inpatient and emergency care. Both, however, are facing tough times. Typically, they are more dependent on Medicare and Medicaid reimbursement than their urban counterparts yet often have significantly lower operating margins. This makes it hard to shift costs to third-party payers. At the same time, these facilities see a growing number of uninsured patients.

All of this puts rural hospitals and providers in a situation in which every dollar counts. “It is our hope that rural hospitals and providers might also benefit from the lessons learned through this project,” Morris says.

For more information on the program, a curriculum outline, and a schedule of upcoming training sessions, see [www.hrsa.gov/tptr](http://www.hrsa.gov/tptr) or call George P. Smith, TPR Project Officer, at 301-443-1516.

## Kansas Setting Public Health Standards

In 1999, the Kansas Association of Local Health Departments, with support from the state Office of Local and Rural Health and the Kansas Health Foundation, began developing a set of local health standards to help see to it that all Kansans have access to public health services. The philosophy behind the effort: you only get that which you measure.

Although national standards exist, public health leaders in Kansas believed that the process of developing and implementing their own standards would be more helpful than adopting someone else's. First, the national standards centered on the "10 essential public health services." The folks in Kansas thought standards centered on programs (which is what local health departments are familiar with and also how the money flows) would be less abstract and more appropriate. Second, designing their own meant involving local health practitioners in a grassroots efforts that made it easier to understand, accept, and implement the standards.

Although not yet complete, the effort has been successful. Because Kansas had developed standards with respect to communicable diseases and

had conducted an assessment of local health department efforts, the state has "a leg up" on using the recently announced bioterrorism funds. Kansas is ready to, as Edie Snethen, Executive Director of the Kansas Association of Local Health Departments, puts it, "close the gaps, rather than study them."

That said, Kansas is considering converting to the national standards in order to help ensure compatibility with future funding initiatives and out of recognition of the benefits of everyone have comparable standards. Richard Morrissey, Director of Kansas' Office of Local and Rural Health, points out that conversion will not mean throwing away the work done on the Kansas standards. Rather, it will inform and help with the conversion, resulting in a better outcome.

For more information, contact Edie Snethen at [snethenel@earthlink.net](mailto:snethenel@earthlink.net).

## South Carolina Center to Focus on Rural and Minority Health

The new Center of Excellence for Rural and Minority Health in Denmark, South Carolina, is the first of its kind in the nation to combine

education, research, and clinical services focused on the health of rural minorities. It evolved from the premise that to make a difference in the lives of rural and minority populations, the center must 1) be located in a rural community, 2) be linked to historically black colleges and universities, and 3) integrate clinical services, health education, behavioral health, and research.

The center is the brainchild of Dr. Monnie Singleton, a family practitioner and the center's director. "The center will help eliminate racial and ethnic disparities in health in rural South Carolina," says Singleton.

Clinical services at the center will include primary and preventive clinical care, podiatry, dentistry, pediatrics, and pharmacy. Educational services will include interdisciplinary rural health care training, an exchange program for students and faculty, and health seminars. Research efforts will include data collection and analysis for policy makers and will focus on health care access, racial and ethnic health disparities, and the effects of behavior and lifestyle on health.

Located on the campus of Voorhees College, the center is currently in temporary quarters, but will ultimately be housed in a new \$3 million facility on campus. Realiza-

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tion of that goal was helped in December by a \$1.5 million award from the federal Health Resources and Services Administration in the Department of Health and Human Services. Partners in the center include Vorhees College, the Medical University of South Carolina, the South Carolina State Office of Rural Health, South Carolina State University, the University of South Carolina School of Public Health, and Clemson University.

For more information, contact (803) 703-7007.

## Montana Combines Faith and Health

In the spring of 2001, the Montana Office of Rural Health and the Montana Association of Churches formed the Montana Faith-Health Cooperative “to foster and promote productive faith-health partnerships across Montana designed to improve holistic health and social well-being of Montanans and their communities.” The impetus came from a Rural Crisis Outreach Grant from the Evangelical Lutheran Church of America, which supported a series of day-long forums in rural towns across the state. The forums were convened by local faith-based organizations to

bring together community members in seeking solutions to the farm and ranch crisis. Results of the forums showed that faith-based organizations can play a significant role in improving the health and well-being of rural communities.

As its guiding philosophy, the cooperative believes in whole-person health care, which recognizes the interdependence of a person’s physical, mental, emotional and spiritual capacities. Furthermore, it believes that faith/spirituality-based groups need to reclaim their role in the health care delivery system.

For more information, see <http://healthinfo.montana.edu/ruralhealth/mtfhc/mtfhc.html> or call the Montana Office of Rural Health at (406) 994-5553.

## Colorado Effort Helps Meet Equipment Needs

Used Supplies With a Purpose (USWAP) was created by the Colorado Rural Health Center to help meet the need for health care equipment and supplies in rural areas. The program does this by playing matchmaker, linking organizations with used equipment and/or unneeded supplies with rural health care providers that need equipment and supplies.

Information at <http://www.coruralhealth.org/> or by calling the Colorado Rural Health Center at (303) 832-7493.

## Moving Beyond Enrollment in Massachusetts

Health insurance enrollment does not always translate into care. The reasons for this include poor client understanding of the health care system and their role in getting care; complex and confusing insurance coverage; bureaucratic errors and delays; billing and payment errors; and difficulties in transportation, child care, and language interpretation.

To overcome these challenges, Massachusetts’ AHEC/Community Partners, with funding from a Rural Health Outreach Grant, developed the Moving Beyond Enrollment program. Begun in 1999, the program funds outreach workers—who were already enrolling people in Medicaid programs—to give them the extra hours they needed to “move beyond enrollment” and make sure their clients: 1) understand how to make the system work, 2) know what they are entitled to, and 3) have a

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relationship with an appropriate provider.

Two aspects of the program stand out. Clients are educated about and encouraged to get *preventive* services for themselves and their children. Outreach workers are working with providers' offices to solve access problems for patients and billing and bureaucratic problems of providers.

Outreach workers are the lynchpin in the effort. Because they develop expertise in dealing with systems that should complement each other but often do not (state agencies, health plans, medical providers), they are in a unique position to solve problems that otherwise go unattended.

Since the program's inception three rural sites have helped over 2000 individuals to move beyond enrollment.

Information available at [www.ahecpartners.org](http://www.ahecpartners.org) or by calling AHEC/Community Partners at (413) 253-4283.

## Minnesota Training Nurses On-Line

Using a grant from the Health Resources and Services Administration, the University of Minnesota's School of Nursing is offering all of its courses in its nurse midwifery, women's health care nurse practitioner, and public health nursing tracks online in web-based format. By offering online courses, the school will be able to offer students from Minnesota, Wisconsin, Iowa, North Dakota, or South Dakota the opportunity to complete the M.S. program from the convenience of their own homes. In addition, the grant will enable the school to link graduate students with K-12 educational institutions to expose young students to roles and career opportunities in nursing.

For information, see <http://www.nursing.umn.edu/telign.html>, or call (888) 240-8636.

## 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](mailto:t-mrowley@juno.com).

*Medicare Payment Disparities That Adversely Affect Rural Areas.*

**D. Minge, The Blandin Foundation, 2002.**

The author of this study is former Minnesota Congressman David Minge, who writes that, Medicare "... is complex and is riddled with payment disparities." Those disparities, he argues, negatively affect rural Minnesota health care and communities. "When all the dollars are netted out, it appears that rural hospitals and providers in Minnesota are losing at least \$300 million per year in Fee for Services disparities." By taking into account damage to the rural economy, he estimates the total economic impact on rural Minnesota at \$525 million per year.

As for remedies, Minge says that, "although visionary reform is needed, the reality is that modest changes are the most that can be expected in a tight budget era..."

Available at: Blandin Foundation, 100 North Pokegama Avenue, Grand Rapids, MN 55744. Telephone: (Toll Free) 1-877-882-2257. Internet: [www.blandinfoundation.org](http://www.blandinfoundation.org)

*Rural Hospitals' Ability to Finance Inpatient, Skilled Nursing and Home Health Care.*

**J. Stensland and I. Moscovice. Working Paper #37. Minnesota Rural Health Research Center. October 2001.**

The Balanced Budget Act of 1997 (BBA) hurt rural hospitals by reducing Medicare payments for inpatient, outpatient, skilled nursing care, and home health services. This report surveyed 448 rural hospitals to investigate how they are restructuring in light of the BBA. Its findings include

- The most popular strategy for small rural hospitals is to convert to Critical Access Hospital status. Thirty-five percent of the hospitals surveyed have converted or are considering doing so.

- Thirteen percent of the hospitals that operated a home health agency in 1997 closed it by October 2000. Fourteen percent of the hospitals that operated a skilled nursing facility in October 1997 closed that facility by October 2000.

- The vast majority of rural patients appear to still have access to one or more skilled nursing facilities and one or more home health agencies.

- Policy makers should consider paying a portion of the bad debt and charity care expenses that Critical Access Hospitals incur when treating non-Medicare patients. Doing so will help preserve access to basic inpatient and emergency care in even the poorest areas.

Available from: Rural Health Research Center, Division of Health Services Research & Policy, School of Public Health, University of Minnesota, Box 729 Mayo, 420 Delaware Street S.E., Minneapolis, MN 55455-0392. Form for publications requests available on the Internet at: [http://www.hsr.umn.edu/rhrc/wkp\\_monographs.html](http://www.hsr.umn.edu/rhrc/wkp_monographs.html).

*Patterns of Health Insurance Coverage Among Rural and Urban Children.*

**A. Coburn, T. McBride, and E. Ziller. Working Paper #26. Maine Rural Health Research Center. November 2001.**

Implementation of the S-CHIP in rural areas may be hampered by a lack of understanding about the patterns of insurance coverage that rural children experience. Differences in the frequency and length of uninsured spells, for example, can affect whether, how, and the degree

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to which rural children enroll in the program.

This report assesses differences in the patterns of insurance coverage and uninsured spells among rural and urban children in 20 states and examines the implications of those differences for the design and implementation of public insurance programs such as S-CHIP. Among the findings

- Rural children were more likely than urban to lack health insurance at a point in time (15.5 vs. 13.8 percent in December 1993 and 14.3 vs. 12.7 percent in December 1994).

- Rural children were more likely than urban to have had at least one spell of uninsurance during the 36-month period (36.3 vs. 31.1 percent).

- Rural children who lost coverage during the survey were slightly more likely than urban children to have uninsured spells that lasted four months or less (50 vs. 47.7 percent), and were more likely to have uninsured spells that lasted 17 months or more (9.2 vs. 8.3 percent).

- Rural children had slightly lower rates of private insurance than urban children (63.5 vs. 65.3 percent). The percentage of each with Medicaid coverage was nearly identical.

- The characteristics of rural children differed significantly from those of their urban counterparts. Several of those characteristics likely contributed to differences in insurance coverage, some—such as higher proportion of children living in poverty—contributed negatively, others—such as higher proportion living in two-parent families—contributed positively.

Available from: Maine Rural Health Research Center, Muskie School, USM, 96 Falmouth Street, P.O. Box 9300, Portland, Maine 04104-9300. Telephone: (207) 780-4846 (Contact: Donna Reed).

Available soon on the Internet at: <http://www.muskie.usm.maine.edu/mrhc>.

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money is specifically for purchasing and installing electronic computing and communications equipment, training local public health workers in the use of information technology, and developing local health department performance standards—that is, building and maintaining the public health infrastructure. Those two provisions are critical and should be written in to other federal public health programs, says Carol Moehrle, Director of Idaho's North Central District Health Department.

To date, some \$90 million in grants have gone to states, Guam, and 7 large cities. In addition to funding, CDC provides consultation and technical assistance to grantees.

Information at  
[www.phppo.cdc.gov/han](http://www.phppo.cdc.gov/han)

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