

# Rural HEALTH NEWS

*A Publication of the Rural Information Center Health Service*

## Solving the Paramedic Paradox

By Thomas D. Rowley

Rural areas farthest from a hospital have the greatest need for emergency medical services yet have the most trouble maintaining those services.

“It’s the rural paramedic paradox,” says Kevin McGinnis, Director of Ambulance Services at Franklin Memorial Hospital in Farmington, Maine and former Maine State EMS Director. McGinnis is unwilling to leave it at that. “We know there are barriers. What we should all be doing in our little rural EMS labs is experimenting with new ways to provide service.” He says that there are probably a number of models being tested, even if EMS services don’t know they’re testing them. “We should find those and figure out if they work..”

There are a number of models being tested around the United States. Some rural health advocates have called for a centralized database of what rural communities are doing and what they have learned. Such a resource could help communities tap into other ideas.

How well the various models work in solving the paradox will depend in large part on their ability to overcome the barriers McGinnis mentioned. Participants at a recent Capital Area Rural Health



*Rural EMS providers, like this one in Wells, Maine, face severe challenges in training and reimbursement.*

Roundtable identified and discussed the worst of them (*Rural EMS: Financing Preparedness* at <http://rhr.gmu.edu/forums.html>).

### Barriers to Rural EMS

**Low volume; high fixed costs.** The fact that a typical rural ambulance makes far fewer runs over the course of a year than a typical urban one means that the cost per run of the rural service is much higher. Like-

wise, a typical rural hospital emergency room, which sees far fewer patients than an urban hospital, has a higher per-visit cost. Why? It takes a certain amount of money to buy, maintain, and operate an ambulance or build, equip, and operate an emergency room no matter the number of times they are used. Many of the costs are “fixed”.

The problem, of course, is that ambulance services are reimbursed on a per-call, not on a fixed-cost basis. For example, if a rural ambulance provider pays \$100,000 for an ambulance (adding in staff, supplies, gas, oil, and

maintenance can more than double that cost) and sends it out on 100 runs a year over its 10-year life span, it cost the provider \$100 per run. But if the ambulance goes out on 200 runs per year, it only costs the provider \$50 per run. Whether the ambulance service loses money, breaks even, or makes a profit depends on the per run reimbursement rate they receive from Medicare, private insurers, or the patients themselves.

*(continued on next page)*

Not surprisingly, reimbursement rates rarely cover the costs. According to a 1997 paper on rural EMS by the National Rural Health Association, some payers “under-reimburse and actually pay below cost. Payment for EMS by Medicare fluctuates widely across the country, but rural, and especially frontier areas, receive the lowest reimbursement.” As one

America—is on the decline. One reason is the amount of training required each year to maintain certification. Gary Gardner is a paramedic in Eagle Lake, Maine. He, along with four other volunteer paramedics, see to it that Eagle Lake and its surrounding area get 24 hours a day, seven days a week ambulance service. To be able to do that,

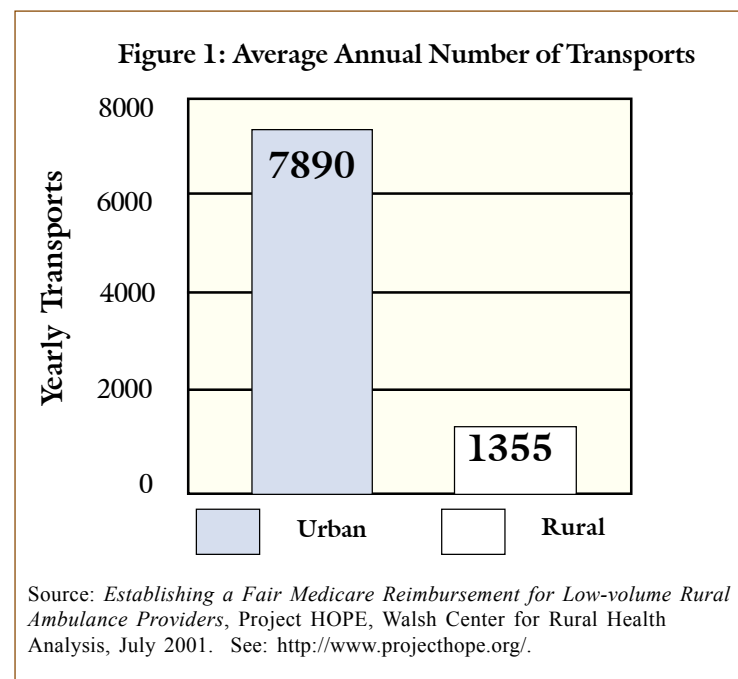
Gardner logs 60 hours per year to keep his training up-to-date. And while nobody denies the benefits of training, putting in the hours for the training plus getting to and from

**Lack of medical oversight.** There are four levels of EMS personnel. Each level requires more training and has more skills than the previous: first responders, emergency medical technicians, intermediate emergency medical technicians, and paramedics. None of the levels, not even paramedics, however, are physicians. Ideally, therefore, an emergency medical service has a doctor granting authority and accepting responsibility for all aspects of the care provided by EMS. Indeed, quality medical direction is essential to providing the best care for EMS patients.

Unfortunately, due to shortages of physicians in general and physicians trained in emergency medicine in particular, many rural EMS units have no physician acting as the medical director. In fact, in some rural areas EMS personnel are the only healthcare providers.

**Difficulties with skill retention.** Because of the low volume of calls, rural EMS personnel may go long periods without using a particular skill or technique. That lack of practice makes it difficult to retain skills at peak levels. Periodic training can help fill that gap, but for rural (and often volunteer) EMS personnel, training can also be difficult to obtain.

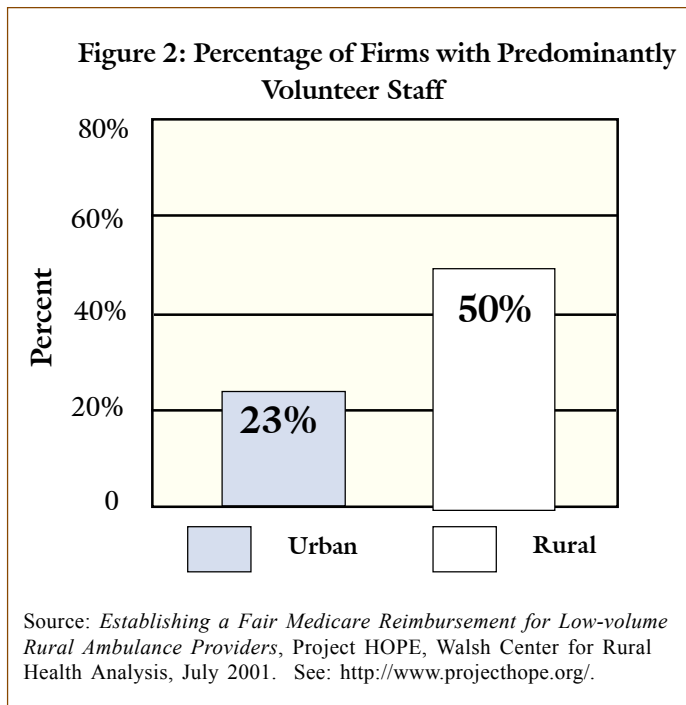
**Fragmented bureaucracy.** At the federal level, the Centers for Medicare and Medicaid Services (the new name for the Health Care Financing



participant in the roundtable put it, “A whole lot of rural EMS units are still supported by bake sales and car washes.”

**Hard to recruit; hard to retain.** Like many rural enterprises, rural ambulance service has historically relied on volunteers. Unfortunately, volunteerism—even in rural

that training (which is often held at some distance from home) can be burdensome on volunteers who hold down full-time jobs. The result: “In the last couple of years, we just can’t get people interested in volunteering,” says Don Therault, Director of Ambulance Service Inc., in Fort Kent, Maine.



Administration) pay for EMS services. The National Highway Traffic Safety Administration (NHTSA) runs some EMS programs. The Health Resources and Services Administration (HRSA) runs others. Consequently, there is no focal point for EMS services—rural or otherwise.

**Policy changes.** As if these barriers were not enough, recent changes in federal policy could well make things worse. Medicare is the leading source of revenue for pre-hospital emergency medical services. Consequently, proposed changes in Medicare reimbursement rates have many rural advocates worried.

ever, required Medicare to establish a national fee schedule for payment of ambulance services furnished under Medicare Part B. And though the negotiated rulemaking process that designed the fee schedule left rural participants feeling like their lot might be improved, the pot of money for ambulance reimbursement is capped at 1998 levels plus inflationary adjustments.

That fact, according to roundtable speaker Dan Manz, Vermont Director of EMS and a participant in the rulemaking, could undermine any improvements gained. Worse, an article in *Hospitals and*

Under the old system, Medicare paid for ambulance services on the basis of customary, prevailing, and reasonable charges. Hospitals that owned or contracted ambulance services were reimbursed on a cost-basis. The Balanced Budget Act of 1997, how-

*Health Networks* quotes NRHA president Charlotte Hardt as saying the lost revenue will force many rural hospitals to decide whether to maintain their ambulance service at all, and even whether to keep their emergency departments open. The Centers for Medicare and Medicaid Services (CMS) estimates that the fee schedule will cut \$19 million from reimbursements to the nation's hospitals—urban and rural.

On the other hand, researchers at the Project HOPE Walsh Center for Rural Health Analysis report that despite concerns that the fee schedule would hurt rural providers, some Critical Access Hospital (CAH) providers whom the researchers interviewed thought that the new system would actually “improve their Medicare receipts.” Specifically, areas served by volunteer squads might benefit because these units traditionally charged very low fees and therefore received very low reimbursement. The researchers therefore conclude, “fears that the new fee schedule will detrimentally affect EMS systems serving CAHs do not appear to be uniformly true, at least under the form currently proposed.”

Though scheduled to go into effect on January 1, 2001, the new fee schedule has been indefinitely postponed.

---

The second federal policy of concern is the Health Insurance Portability and Accountability Act (HIPPA), which could cause problems in the coding of emergency medical services and place onerous burdens on emergency medical providers in order to comply with consent and privacy requirements.

Such barriers notwithstanding, rural citizens expect EMS to be ready and able to quickly deliver high-quality care when needed. A 1993 Maine survey found that 87 percent of people asked expected a level of care equal to a paramedic to come through the door in an emergency.

## A Little Help from Title XII

Some help with these barriers comes from the Trauma Care Systems Planning and Development Act of 1990, which created Title XII of the Public Health Service Act. The title provides grants to state EMS offices to improve EMS and trauma care.

In fiscal year 2001, HRSA was appropriated \$3 million for Title XII and grants were awarded to all 50 states. According to Jennifer Riggle in the federal Office of Rural Health

Policy, each grantee will use the funds to convene a meeting of principle stakeholders to complete a standardized trauma needs survey. The survey results will then be used in a national report by HRSA and NHTSA to raise awareness about the status of trauma systems and to establish program priorities for 2002.

On a less cheerful note, Riggle points out that while helpful, Title XII has been funded at far below the \$60 million authorized. Furthermore, although Title XII does have a significant rural focus, the statute allocates only 10 percent of funds to rural areas even though 20 percent of the U.S. population is rural and many of the problems that rural communities face will require additional funding.

## Reinventing the Horizontal Taxicab

Barriers aside, improvements have been and continue to be made. Just look at the past. Forty years ago, ambulances amounted to little more than horizontal taxicabs—a ride to the hospital, sometimes in an off-duty hearse. EMS has come a long way since then, and some places are pushing the concept even further.

And while the models vary from regional EMS systems to mobile training to an idea that McGinnis calls “community paramedics,” they tend to incorporate one or more of the following principles.

***Integrate with the larger healthcare sector.*** Historically, EMS has been primarily connected to the public safety sector (dispatch, law enforcement, and fire service), with nearby EMS units for mutual aid, with the emergency department of nearby hospitals, and, in some areas, with designated trauma centers as part of regional care system. That needs to change. According to NRHA, successful EMS providers will need to integrate more fully with public health and social service agencies, primary care providers, and other providers to ensure that patients are sent to the most appropriate and cost-effective facility. “Care should not occur in isolation; rather it should be part of a seamless system that provides patients with well organized and high-quality care.”

***Utilize paramedics in non-emergency situations.*** “Being a paramedic is not a money thing,” says Kevin McGinnis. That simple statement is true on two levels. First, most paramedics perform the service out of a sense of duty rather than a desire to make money. Second, most rural places cannot afford to pay paramedics much if at all. Therefore,



McGinnis advocates what he calls the “community paramedic” concept. “We have to expand the role of paramedics so that communities will be willing to pay for them to be full-time.” As McGinnis sees it, paramedics could, in addition to their emergency medical responsibilities, act as physician extenders much like physician assistants or nurse practitioners, health advocates helping to educate the community and encourage healthy behaviors, and back-ups to home health nurses doing the things that they cannot or will not do.

***Collaborate with nearby EMS units.*** Rural areas have a long history—both positive and negative—with collaborative efforts. On the positive side, neighbors helped each other raise barns, harvest crops, and round up cattle. On the negative side, school mergers and closures often led to a loss of community identity and distaste for regional efforts. Still, scarce resources, large service areas and, in some cases, difficult terrain point to the need for EMS units in some rural areas to work together in ways that strengthens or stretches their ability to provide service.

***Make training more attractive.*** If, as several rural EMS personnel claim, training to get and maintain skills is often onerous and is a major reason for the decline in volunteers, then training must be made more

attractive. Two ways to do that are paying volunteers to get the training and bringing the training to the volunteers via telecommunications-enabled distance learning or traveling classrooms.

## The Bottom Line

The importance of these principles and the success of models that incorporate them notwithstanding, reimbursement is still the bottom line—figuratively and literally. Because of the low-volume, high fixed-costs faced by rural EMS units, the traditional way of reimbursing for service on a per-ride basis—whether cost-based or fee schedule—does not adequately compensate units for their costs or enable them to maintain preparedness. To remedy this, rural EMS advocates are nearly unanimous in their support of “paying for preparedness, not just the ride.” In other words, EMS must be paid to be ready to act, not just paid when they do. As NRHA puts it, “Compensation for EMS must be based on emergency response, assessment, treatment, triage and disposition that may, or may not, involve traditional transportation.”

### ***Rural EMS Laboratories in New Mexico and Montana***

While McGinnis is still in the early stages of creating community paramedics in Maine, a similar model has proven successful in **Red River, New Mexico**. Begun in 1994 as an experiment, the Red River effort trained paramedics to deliver much-needed primary and preventive care in an area short on healthcare providers. Although Red River is a popular tourist destination, the year-round population is small, too small to support a full-time medical practice. The area did, however, have a full-time EMS unit operated by the Red River Fire Department. Like many rural EMS units though, it was underutilized. The situation was ripe for a “two birds with one stone” solution.

With help from a Rural Health Outreach Grant, the local government and various entities in the healthcare sector formed a coalition and began training “community health specialists.” Now in its seventh year of operation, the program uses a triage system in which the community health specialists transport patients in need of emergency physician care, but treat many others with lesser

---

needs who previously would have to have been transported anyway.

Today, the program supports itself with private insurance and HMO reimbursement and self-pay patients. And just as important, the program has reduced the loss of paramedics to urban units by making the job more challenging and more rewarding.

In **Montana**, rural EMS units have been equipped with multi-media computers to help create a virtual EMS community. TENKIDS (a merger of The Electronic Network for the Coordination of EMS Data and Education and the Emergency Medical Services for Children program) helps EMTs across the state participate in training, discuss crucial issues with colleagues, trade tips on patient care or ambulance operations, and so on. They can even fill out trip reports on the computer, giving ambulance services and the state access to emergency care data.

The effort started in 1995 with grants from the Maternal and Child Health Bureau and the Office of Rural Health Policy. Today, more than 100 services are hooked up. Ultimately, some 200 will be.

According to Nels Sanddal, president and CEO of the Critical Illness and Trauma Foundation in Bozeman, “the most stunning contribution has been a reduction in the sense of isolation among the most rural services.” Its success is attributed to collaboration among the various partners—public, private, individuals, and agencies.

For more information on the Red River project and other innovative EMS programs, see *Working Together Makes Rural and Frontier EMS Work*, National Rural Health Association, 1999. For more information on the Montana effort, see <http://www.citmt.org/tenkids.htm>

---

# Helping Hospitals in the Delta

By Thomas D. Rowley

While small rural hospitals have long struggled to stay afloat and keep their doors open, the problem has been particularly acute for hospitals in the Mississippi Delta Region. But now, thanks to a Federal pilot project, help is on the way.

Earlier this fall, HHS Secretary Tommy G. Thompson announced a one million dollar investment to help small rural hospitals in the Mississippi River Delta area improve their operations and financial performance. The money will fund the first year of a planned three-year Rural Hospital Performance Improvement Project (RHPIP). To date, no funds have been guaranteed for the second and third years.

In announcing the project, the Secretary noted that those hospitals provide critical safety-net services and are often economic engines in their communities.

“This initiative will help stabilize small rural hospitals in the Delta, a region which has some of the nation’s highest rates of preventable disease, disability, and death,” Thompson said in a prepared statement.

The project, which will give the facilities the technical and financial expertise they need to become more viable, is part of a larger initiative to improve health care in rural areas of the Delta and is a direct result of Secretary Thompson’s department-wide effort to improve health care and social services in rural areas across the country.

The million dollars for the RHPIP was awarded competitively to a partnership between the Mountain States Group of Boise, Idaho, and the National Rural Resource Center of Duluth, Minnesota. The funds will be used to accomplish three goals:

- Provide technical assistance to approximately 25 hospitals in the eight-state region in the first year. Assistance, which will aim to improve the financial and operational performance of the hospitals, can be either comprehensive in nature, looking at the whole organization, or targeted, focusing on one issue or problem such as hospital board leadership or marketing. The hospitals will choose the type of assistance they wish.
- Develop tools—evaluation processes, databases, etc.—that will help the hospitals help themselves.
- Build up the capacity of entities within the region—state offices of rural health, university programs and faculty, etc.—to

provide ongoing assistance. Capacity building will entail training, mentoring, and ongoing support.

“The idea,” said project director Terry Hill of the National Rural Resource Center, “is to offer a full array of assistance without creating a dependency relationship. We want to help teach people to fish, not just fish for them.”

In addition to using expert consultants from outside the region, the project will seek to partner with consultants within the Delta.

“We don’t want to turn anybody out,” said Hill. “We want to work with folks that are already there.”

One of those folks that is already there is Bill Jolley, Assistant Vice President of the Tennessee Hospital Association, who said his association is ready and willing to get to work helping rural hospitals evaluate different options and strategies for improvement.

“A lot of times, these hospitals just don’t consider all of the options that are available to them,” he said. “This program will give them the individual attention they need to do that.”

After helping hospitals in the Delta, Jolley hopes to take the lessons learned there and use them in other parts of the state. According to Jerry Coopey, the project officer at the

---

Office of Rural Health Policy, that is exactly the idea.

“This is field testing,” Coopey said. “We hope that other states will be able to take these tools and start using them and improve performance of rural hospitals throughout the country.”

Approximately 80 small rural hospitals across Alabama, Arkansas, Illinois, Kentucky, Louisiana, Mississippi, Missouri, and Tennessee are eligible for assistance under the program. For purposes of the program, small is defined as 50 or fewer staffed beds. Assistance will be offered to the hospitals at no cost.

Many of the eligible hospitals deliver the full range of health care—including inpatient, outpatient, and emergency medical services; skilled nursing care; and home health services—to all residents, including insured consumers as well as underserved populations and Medicare beneficiaries.

Unfortunately, many of them also face financial challenges that could hurt their quality of care. Indeed, half of all small rural hospitals in the Mississippi Delta region—which is characterized by high rates of poverty and unemployment, racial disparities in health, and too few resources to meet current health needs—are losing money.

The Mountain States Group in Boise is a private, non-private organization with extensive experience in community-based development, social services, and hospital improvement tools. The National Rural Resource Center in Duluth is a private, non-profit organization that was developed by a coalition of national health organizations to bring needed technical assistance, information, and process tools to rural communities. In addition to the two partners, Oklahoma State University and its Rural Health Works Program will participate, taking the lead on developing tools that help hospitals evaluate the feasibility of various types of health business ventures.

For more information, contact Terry Hill at [thill@ruralcenter.org](mailto:thill@ruralcenter.org) or call (218) 720-0700.



## ServiceLink Provides Connections

ServiceLink, a New Hampshire statewide network of community-based resources, is dedicated to promoting independence and well being for elders, adults with disabilities, and their families. Among the services it provides are:

- Access to information about available services and opportunities;
- Help with taking the next step in getting service; and
- Public education programs.

Sites for the program are found at 13 community centers throughout the state—one in each county and two in three counties. In addition to the 13 primary sites, there are more than 50 satellite locations throughout the state.

A call to ServiceLink’s toll-free number (866-634-9412, only available to New Hampshire residents) automatically routes people to their nearest site. The call is answered by staff willing and able to help with questions about a variety of needs pertaining to services for these population groups. People are also welcome to visit a ServiceLink site in

person to meet with staff. ServiceLink’s assistance is provided at no cost.

**Want to Know More?** See <http://www.state.nh.us/servicelink>.

## Network Promotes Child Health

Targeting the pre-K through high school youth in its area, the Brooks County Child Health Network in Brooks County, Georgia, has three goals:

- Decrease the percentage of students in the county school system who are absent 10 or more days during a school year;
- Refer 100 percent of the students without a primary care provider to local primary care services; and
- Refer 100 percent of the students with an identified unmet health and/or social service need to necessary services.

To reach those goals, the network—consisting of the county hospital, county health department, county school board, and a grassroots collaborative—has placed nurses in

the school system, sponsored health fairs throughout the county, and provided services and support to the community. As a measure of its success, the network was awarded the Georgia Hospital Association’s Community Leadership Award this year.

**Want to Know More?** Call Glenn Bissett, Executive Director of Brooks County Family Connections, at (229) 263-5805 or David Sanders, Brooks County Hospital, at (229) 263-6309.

## Visiting Nurses Introduce Home ‘Televisits’ to Rural Maine County

Under pressure from insurers concerned about the bottom line, hospitals continue to send patients home as expeditiously as possible. For some patients who haven’t fully recovered, however—especially those who are elderly—an early discharge can mean hardship coping in their home environment.

In rural Maine, the Visiting Nurses of Aroostook (VNA) in the town of Houlton may have a solution to the problem. Working with Regional Medical Center and its affiliate, Sunrise County Home Care

---

Services, in nearby Lubec, VNA in 1999 launched the Northeast Maine Telemedicine NetWork, a high-tech program that allows nurses to monitor a patient's status via a videophone. Ostensibly, this is a telemedicine unit placed in the patient's home. Earlier this year, VNA implemented a round-the-clock triage program linking nurses with homebound patients through telemedicine technology.

The project was started with a three-year, \$450,000 grant made by the Robert Wood Johnson Foundation and is administered by the Center for Health Care Strategies Inc. The project serves Aroostook County, a county in Northern Maine that is "about the size of Connecticut and Rhode Island together," said VNA executive director Sandra Scott-Adams, as well as the northern portions of Penobscot and Washington Counties, "where there is no one else to cover" patients' needs.

The program is saving time and money. From July 1999 through June of this year, the program had conducted an average of 66.3 televisits a month, at an average length of 12.7 minutes. Cumulatively, mileage costs saved are \$15,769 and staff time, \$62,680, for a total of \$78,449, or \$3,269 a month, according to project officials. By cutting down on time

spent driving from house to house, the nurses can actually "see" their patients more often, project directors say.

**Want to Know More?** Call Visiting Nurses of Aroostook at 207-498-2578.

**Source:** *State Health Notes: Forum for State Health Policy Leadership*. National Conference of State Legislatures. Volume 22, Number 360.

## 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).

Health, United States, 2001, with Urban and Rural Health Chartbook.

**National Center for Health Statistics, Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, September 2001**

This 25<sup>th</sup> annual statistical report on the nation's health is the first to look at health status relative to communities' level of urbanization. The report documents differences in a wide range of health characteristics. Among its key findings is that Americans who live in the suburbs fare significantly better in many key health measures than those who live in the most rural and most urban areas. Other findings include:

- The highest death rates for children and young adults were in the most rural counties.
- Residents of rural areas had the highest death rates for unintentional injuries generally and for motor-vehicle injuries specifically.
- Both the most rural and the most urban areas had a similarly high percent of residents without health insurance.

Available at [www.cdc.gov/nchs/products/pubs/pubd/hus/hus.htm](http://www.cdc.gov/nchs/products/pubs/pubd/hus/hus.htm)

Comments on "Medicare in Rural America"

**RUPRI Rural Health Panel, September 2001**

This policy paper comments on and critiques the findings in the June 2001 MedPAC report, *Medicare in Rural America*. In general, the panel believes that while MedPAC's report "helps set a framework for analysis and provides some specifics" it should not be viewed as "a definitive treatise on Medicare's role in rural health." The report goes on to say that most of MedPAC's recommendations would have positive impacts on health care for rural beneficiaries, other recommendations would do no harm, still others could be strengthened, and a few—particularly those relating to access to services—"suffer from disparities and weaknesses."

Available at [www.rupri.org](http://www.rupri.org)

**Establishing a Fair Medicare Reimbursement for Low-volume Rural Ambulance Providers**

**Project HOPE, Walsh Center for Rural Health Analysis, July 2001**

This national study of ambulance transport costs looks at the advantages and disadvantages of several options for Medicare to compensate low-volume (defined as less than three transports per day) rural ambulance providers. Among the findings

- Two-thirds of rural EMS firms meet the definition of low-volume provider.
- Low-volume rural firms average less than one transport per day.
- Low-volume rural firms depend heavily on volunteer staff.
- While per-transport costs for full-cost, low-volume providers are more than double the industry average, costs for volunteer firms are substantially below the industry average.

Based on their findings, the researchers conclude that

- Many low-volume rural volunteer EMS providers will benefit from the new Medicare fee schedule.
- A volume-based premium offers a disincentive for small providers to grow and take advantage of economies of scale.
- Cost-based reimbursement for a select class of rural providers would not over- or under-pay vulnerable providers.

Available at [www.projhope.org](http://www.projhope.org)

---

## Medicaid Managed Behavioral Health Programs in Rural Areas

### Maine Rural Health Research Center, Institute for Health Policy, August 2001

Using a national survey and inventory of states implementing Medicaid managed behavioral health (MMBH) programs in rural areas, this study looks at how MMBH programs work in rural areas, where the challenge is often to enhance service delivery rather than to reduce it.

The study's goals: 1) determine which states have implemented programs in rural areas; 2) describe the programs in terms of Medicaid populations served, program design, and implementation model; and 3) describe the programs' experience regarding access to and coordination of services.

Its conclusions include

- Implementation of MMBH in rural areas has leveled off. This reflects the usual diffusion pattern of a new approach or innovation as well as the issues in extending managed care to special-needs populations.
- MMBH programs continually contend with limited rural infrastructure. Developing programs in rural areas requires assessment of existing

infrastructure and realistic ways of dealing with the limitations.

- Whether to carve in or carve out behavioral care from other services (as well as other major design decisions) reflect prevailing political and state program concerns. Policymakers need to carefully assess how MMBH programs would help or hurt the capacity of rural systems to serve.

Available at  
[www.muskie.usm.maine.edu/mrhr](http://www.muskie.usm.maine.edu/mrhr)

## Local Public Health Agency Infrastructure: A Chartbook

### National Association of County and City Health Officials, October 2001

This publication provides an extensive look at the infrastructure of the nation's local public health agencies (LPHAs), including a look at metropolitan versus nonmetropolitan LPHAs. Topics include: Programs and Services; Workforce; Partnerships and Collaboration; Community Health Assessment; General Characteristics of LPHAs.

Among the report's findings are:

- With the ever-changing health services environment, LPHAs are reassessing and redefining their roles. In general, they are moving away from providing comprehensive primary care services.

- Forty-one percent of nonmetro LPHAs, compared with 26 percent of metro LPHAs, cited funding as their biggest challenge.

- Not surprising, metro LPHAs tend to have larger and more diverse staffs than their nonmetro counterparts. For example, mental health occupations are much more frequent in metro LPHAs.

- Communicable disease control, environmental health, and child health were consistently chosen as top priorities by LPHAs regardless of their nonmetropolitan versus metropolitan status. Some differences among nonmetro versus metro LPHAs did, however, show up. For example, metro LPHAs list inspections more frequently as a priority, while nonmetro LPHAs list family planning and home health services more frequently.

Available free of charge at [www.naccho.org](http://www.naccho.org). Hard copies are available for \$30 by contacting Anjum Hajat at (202) 783-5550 x253 or [ahajat@naccho.org](mailto:ahajat@naccho.org).



## ORHP in 2001

by Marcia Brand, Director,  
Federal Office of Rural Health  
Policy

The past year has been one of increasing interest in rural health and associated issues in Washington, DC and an exciting time for the Office of Rural Health Policy. Our current President, Congress and Secretary of Health and Human Services share a commitment to rural issues that provides a foundation for unprecedented attention to rural America. While ORHP has played a central role in helping formulate the Departmental agenda for rural policy and programming, we have also reorganized some of our own programming and expanded the scope of our Office's work.

An important highlight of ORHP's year was the reorganization of the State Office of Rural Health program. Recognizing that States have unique and myriad opportunities to address rural health issues, five ORHP staff have become liaisons to states organized by region. In addition, a new position, Coordinator of State-Based Efforts, was established. This reorganization facilitates a more direct exchange of information between ORHP and States and enhances ORHP's responsiveness to SORH's and other State-based constituents.



*Marcia Brand, Director, ORHP*

The ORHP staff has continued to administer the Outreach, Network, Flex and SORH grant programs and has developed and administered a new grant program. This program, the Mississippi Delta Project, gives us a chance to address health problems on a regional basis in eight states in the Mississippi Delta region, an area with long-standing and intractable problems with health services. While this grant program specifically focuses on the Delta region, solutions for the Delta that emerge from this program will be helpful for other underserved regions. ORHP has also become engaged in rural EMS and trauma, rural AED (Automatic External Defibrillator) provision and bioterrorism prepared-

ness. ORHP jointly administers trauma and EMS system development with the Maternal and Child Health Bureau and has conducted several rural AED demonstration projects in 2001.

In the past year, we've also been working hard on several policy issues. Our bi-monthly meetings with Tom Hoyer and Linda Ruiz, the Senior staff rural liaisons at the Centers for Medicare and Medicaid Services, continue to pay dividends. In the past year, we've worked with CMS on a range of regulatory issues. In 2001, CMS made several regulatory changes that have helped Critical Access Hospitals and other rural providers. For example, certified



---

registered nurse anesthetists' are now able to do the pre- and post-operative evaluations of surgical patients in CAHs thanks to a change announced by CMS earlier this year. CMS officials also made adjustments to how it calculates payments for rural hospitals under the "hold harmless" protections for the new Medicare Outpatient Prospective Payment System that have helped improve cash flow for small rural hospitals.

The past year also saw the release of the much-anticipated rural Medicare report for the Congress produced by the Medicare Payment Advisory Commission (MedPAC). Our staff had the opportunity to work with MedPAC staff on this report and while we may not have agreed with all of the conclusions, we do believe it highlighted some very important issues about the challenges rural hospitals are facing in serving Medicare beneficiaries.

ORHP was also fundamental in drawing the Secretary and Department's attention to rural issues. After a visit to ORHP, the Secretary called for a Department-wide Rural Initiative in which all agencies would evaluate how they work with rural America. ORHP helped manage the initiative and learned a great deal about how our Office and our Department serve rural America. Response to our

Federal Register Notice soliciting public comment about the Department's rural programs was phenomenal; we received over 450 comments, with respondees ranging from professional associations to rural health care providers. This Initiative and response to it have provided a tremendous opportunity to improve the way that our Department works with rural partners. We are excited to continue this work in the coming year.

In all of our efforts this year, partnerships have been essential. As we encourage our grantees and other constituents to connect with one another, we are striving to better connect with our partners. Our federal partners have included the Maternal and Child Health Bureau as we work on rural EMS issues and the Bureau of Primary Health Care as we develop a primary care agenda for HRSA and work on Community Health Center issues. We have begun a dialogue with the Substance Abuse and Mental Health Services Administration about rural mental health and substance abuse services. The Secretary's Rural Task Force included all HRSA agencies and other Departments expressed interest in similar Initiatives.

Non-federal partners have included the National Rural Health Association Office of Legislative and Government Affairs and the Capitol Area Rural Health Roundtable, both

of which have been very effective in keeping Congress informed about rural health. The National Organization of State Offices of Rural Health has been helpful in obtaining and disseminating information, especially because of their accessibility to States and State legislatures. The Rural Policy Research Institute's research has provided a framework for where we might go next in terms of rural policy and programs. Relationships with the American Psychological Association and the National Association of Rural Mental Health are also getting stronger and the National Conference of State Legislatures has become an important partner in our work on EMS and Critical Access Hospital issues.

Throughout all of our work this year, I have been extremely proud of the creativity and responsiveness of the ORHP staff. The entire staff is committed to responding to all of our constituents and to learning about and addressing more issues. What is most remarkable to me is that some of the activities of our relatively small office have national resonance for many people. The hard work of the ORHP staff makes this possible. I look forward to the coming year with excitement as we continue our work and improve our Office's and our Department's response to rural America.

---

## ORHP Staff

**Marcia Brand, PhD, Director**  
Government relations, operations oversight, legislation, policy and administration issues, National Advisory Committee Exec Sec  
301-443-4619  
mbrand@hrsa.gov

**Sahira Rafiullah, MPA, Acting Deputy Director**  
Operations, annual budget process, rural health clinics, human resources coordinator, RICHS, third party, GPRA, NAC staff  
301-443-0835  
srafiullah@hrsa.gov

**Forrest Calico, MD, MPH, Health Systems Advisor**  
Physician fee schedule, workforce, Rural Hospital Flexibility Grant Program (lead), HIPPA, quality  
301-443-0614  
fcalico@hrsa.gov

**Tina Cheatham, Special Assistant**  
Secretary's Rural Initiative (lead); Communications, SCHIP, Medicaid, Special initiatives  
301-443-0649  
tcheatham@hrsa.gov

**Jerry Coopey, MPH, Strategic Planning**  
Rural economic development, program planning, capital grant and loan program, community health workers, SE regional liaison  
301-443-7306  
jcoopey@hrsa.gov

**Blanca Fuertes, MPA, Public Health Analyst**  
Minority health, mental health, border health, migrant health, cultural competency, Midwest regional liaison, Medicare home health, HPSAs/MUAs backup, Medicare preventive health benefits  
301-443-0612  
bfuertes@hrsa.gov

**Kathy Hayes, DMD, MPH, Commander, USPHS**  
Public health, oral health, workforce issues, homeless, western regional liaison, Medicare physician fee schedule  
301-443-7444  
khayes@hrsa.gov

**Steve Hirsch, MSLS, Program Analyst**  
NE Regional Liaison, technology (website, database, listserv), Rural Hospital Flexibility Grant Program (Coordination), Geographic designations (HPSA/MUAs, RUCAs, definitions of rural)  
301-443-7322  
shirsch@hrsa.gov

**Eileen Holloran, Grant Programs Coordinator**  
Rural Health Outreach Grant Program (Lead), Grants Management Liaison, Office grant coordinator, Mobile Health, Congressional Earmarks  
301-443-7529  
eholloran@hrsa.gov

**Sandi Lyles, Administrative Programs Coordinator**  
Office budget, Outreach and Network grants, minority health, Delta grants (support)

301-443-7321  
slyles@hrsa.gov

**Evan Mayfield, MS, Public Health Analyst**  
Emergency medical services, Medicare ambulance fee schedule, automatic external defibrillators (AEDs), bioterrorism and emergency preparedness  
301-443-7440  
emayfield@hrsa.gov

**Tom Morris, MPA, Policy Coordinator**  
Legislative liaison, CMS Medicare & Medicaid regulations (lead on Medicare inpatient and outpatient PPS), National Advisory Committee staff, program re-authorizations, Capital Area Rural Health Roundtable  
301-443-4269  
tmorris@hrsa.gov

**Suzanne Powell, Truman Fellow**  
National Rural Development Partnership, Rural Health Research Center Grant Program (support), Secretary's Rural Initiative (support)  
301-443-0837  
spowell@hrsa.gov

**Michelle Pray, MPH, Program Analyst**  
West-Central regional liaison, Secretary's Rural Initiative (support) Faith-based initiative, National Advisory Committee support, Medicare skilled nursing PPS, Medicare Swing Beds  
301-443-7320  
mpray@hrsa.gov

---

**Jennifer Riggle, JD, Coordinator of  
State-Based Activities**

State Office of Rural Health Grant  
Program (lead), NRHA Cooperative  
Agreement, State-based activities,  
Medicare prescription drugs  
301-443-7530  
jriggle@hrsa.gov

**Lilly Smetana, Grant Programs**

*Assistant*  
Outreach and Network Development  
Grant Programs support and technical  
assistance  
301-443-6884  
lsmetana@hrsa.gov

**Karen Stewart, Presidential Manage-  
ment Intern**

Secretary's Rural Initiative (support),  
Evaluation, public health (support),  
health education

**Jessamy R. Taylor, MPAff, Network  
Development Coordinator**

(lead), Delta Grants (lead) women's  
health  
301-443-0513  
jtaylor1@hrsa.gov

**Joan Van Nostrand, DPA, Research  
Director**

Rural Health Research Center Grant  
Program Director, rural health policy,  
palliative care, elderly  
301-443-0613  
jvan\_nostrand@hrsa.gov

**Support Staff**

**Katherine Bolus, HRSA Scholar**

301-443-3712  
kbolus@hrsa.gov

**Chris Phillips, HRSA Scholar**

301-443-0736  
cphills@hrsa.gov

**Sheila Fenner, Lead Secretary**

301-443-0246  
sfenner@hrsa.gov

**Mary Collier, Support Staff Member**

301-443-0836  
mcollier@hrsa.gov

**John Pino, Support Staff Member**

301-443-7650  
jpino@hrsa.gov

Office of Rural Health Policy  
5600 Fishers Lane, Room 9-A-55  
Rockville, MD 20857  
Phone: 301-443-0835/Fax: 301-443-2803  
[www.ruralhealth.hrsa.gov](http://www.ruralhealth.hrsa.gov)

**Rural Health News** is a publica-  
tion of the Rural Information  
Center Health Service (RICHS).  
For additional copies, please see:  
<http://www.nal.usda.gov/ric/richs/>  
or call 1-800-633-7701.

**RICHS**  
**National Agricultural Library,**  
**Room 304**  
**Beltsville, MD 20705-2351**  
**E-mail: [ric@nal.usda.gov](mailto:ric@nal.usda.gov)**