

The Future of Rural Health: Framing a Community-Policy Focus

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*Presented to the Upper Midwest Rural Health Policy Summit
University of Minnesota—Crookston
Crookston, MN
August 17, 2007*

Introduction:

Thank you. It is an honor to be here and asked to share some thoughts on the future of rural health and rural health policy. The future of rural health – that has a daunting and imposing sound to it. I am a little too much of a rural North Dakota farm boy – even after all these years – to think to myself or to imply to you that I have the answers to what the future will be or even should be. However, I do want this presentation to challenge our thinking including my thinking. I have personally been involved in rural health for over 22 years and after all those years I am still positively challenged by our opportunities. Notice I said opportunities not problems. I was told years and years ago by Dr. Kevin Fickenscher, the first director of the UND Center for Rural Health, that the Chinese use the same symbol for opportunity that is used for crisis. Thus, in that culture crisis and opportunity appear to be synonymous. This is how I have approached rural health over the years. Problems, issues, challenges – yes, certainly. But, opportunity always. Hopefully, you feel the same way. Rural North Dakota, rural Minnesota, rural Montana – this is worth fighting for. Our friends and families in Cando, or Jordan, or Bigfork (I've been to Bigfork by the way) live there and in hundreds of other small, rural communities because they find something they want – safe streets, good schools, spiritual enrichment, clean environment. They also want and seek access to available, quality health services. This is where advocates such as you come into play -- helping and assisting rural citizens to achieve a level of health and a measure of quality along with an assurance that health care is and remains available. This they deserve.

The goal for today is to take an honest look at our environment and to discuss our role, our responsibility, our values toward rural America and rural health. Many of us live in rural areas now or at least many were raised in rural communities. My home-town is Cando, North Dakota in the northeastern part of the state. It is, as we North Dakotans say, a farming town. I am proud of my heritage growing up on a durum wheat farm ten miles from Cando as my parents – products of the Great Depression and World War II -- and their generational peers provided me with the values that I try to apply in my life, my work, and my faith. It is the same for many of you as well. Our rural upbringing and the corresponding values implicitly and explicitly embedded in that experience provide us with a sense of belonging – an active participation in a life held belief that community and togetherness in action can and does produce profound effects.

Presentation Focus:

There are a number of ways to approach the subject of the future of rural health. One approach is to concentrate on large and encompassing environmental issues -- issues that through their mere presence shape and influence the rural health environment. I am referring to demographics, economics, finance, workforce, quality of care, and technology. All of these are critically important to understanding rural health issues and the direction it may take in the future. While I will comment on those briefly, I want to challenge us to contemplate three other fundamental factors that generally do not receive much if any commentary. One of these is **community**, the second is **framing or communicating policy issues**, and the third is **creating a national rural voice**. This is a conference focusing on rural health policy and health reform. Our ability as rural health advocates to shape the policy debate not only in the halls of political power, but also in the cafes, churches, and convenience stores of rural America that eventually lead to those sources of power is fundamental and imperative. Political decisions that affect the rural health delivery system may be made in Washington, DC and St. Paul and Helena and Bismarck but the influence to guide those policy decisions need to be shaped or “framed” if you will, in rural communities. At the same time that we, today, apply our thoughts to the improvement of rural health we need to channel our intellect and our emotions to building the connections between different sectors or spheres within rural America. In other words, forging alliances and partnerships involving rural health and rural housing and rural economic development and rural immigrants and a host of other rural sectors and perspectives to champion the cause for “rural” is on the horizon. This is why I approach the subject of the future of rural health and rural health policy from the model of community and policy framing.

Environmental Factors:

To begin, I do need to make some brief comments on those environmental factors. **Demographic change** is important in discussing the future of rural health because health is population based. Providers need markets. If population shifts lead to a decline in the overall population and/or a growing reliance on a population cohort such as the elderly that has a direct impact on the availability of services, the type of services required by the populations, reimbursement streams, financial and organizational viability and other conditions. In many rural areas, including ND, we see ourselves providing less obstetrics and more geriatric care as we experience a population shift from younger groups to more elderly. The treatment of chronic disease, particularly in the elderly population groups becomes a primary focus of the provider community. Our ND Flex program has funded approximately nine or ten CAH-based cardiac rehab and eight or nine pulmonary rehab programs.

Our three states do not necessarily mirror each other. From 1990-2000, North Dakota had 47 of 53 counties losing population representing 89 percent of all counties. For Montana, 23 of 56 counties or 41 percent lost population in the 1990's and Minnesota had the most success with 25 out of 87 or 29 percent of counties losing population. During the 1990's, Montana's and Minnesota's populations grew by 13 and 12 percent, respectfully while North Dakota's population grew by 0.5 percent (the smallest population growth in the country.) North Dakota is also the only state to have less people living within its borders in 2000 than lived there in 1930

and it was the only state to lose population from 2000 to the 2005 census estimate. We have our issues.

The United States is getting older and certainly rural America reflects that population trend. For our states, by 2030 it is estimated that Minnesota will go from 12 percent of its population being 65 and older as found in 2000 to about 19 percent. Montana is expected to move from 13 percent to 26 percent and North Dakota is comparable going from 15 percent to 25 percent. This will have significant impact on rural health in terms of workforce, health service needs, a growing reliance on Medicare as a payer, and other factors.

At the other end of the age continuum, there are similarities but differences between the three states, as well. By 2030, it is estimated that all three states will see a decline in the percentage of people 18 years of age and younger; however, the decline is greatest for ND. Minnesota will witness a decline of 9 percent, Montana 15 percent and North Dakota 21 percent. The actual number of people 18 and younger will decline by 2030 in both North Dakota and Montana. It is estimated that by 2020, North Dakota will graduate 34 percent fewer high school seniors than today.

Rural health is very important to the **rural economy** and will continue to be part of the engine for rural America. From now through 2012, it is projected that seven of the top ten fastest growing occupations will be in health care. Also, ND statistics indicate that health as a part of the North Dakota economy accounts for nine percent of Gross State Product in comparison to manufacturing, ten percent and agriculture, over seven percent. Health care is an important part of the overall economy.

A rural hospital is typically the second or third largest employer in a rural community. Rural hospitals, nursing homes, physician practices, ambulance squads, public health and other provider and/or service arrangements create an economic impact in employment, product and service purchases, and other conditions. We typically view these as primary or direct and secondary or indirect impacts. A new health job is a direct impact and a job created in another sector due to that direct health job is a secondary impact. The formulas' used for this can be very involved but I have had permission from Dr. Doeksen of Oklahoma State University to use a short-hand version whereby we typically use a multiplier of 1.5 percent to determine secondary impact. Thus, in ND when our Flex program conducted an economic impact estimate of our 32 CAHs we found that in total, the 32 CAHs had a direct financial impact, from wages, of about \$69 million and a secondary impact of another \$35 million. The total wage impact on the rural economy in ND was about \$104 million. The estimated impact of rural physicians and their practices is about \$28 million. Health care is an important part of the rural economy and will continue to grow. A quick example, from North Dakota, is that our office was asked by three rural communities to conduct needs assessments looking at the need for and support for health wellness centers. It is interesting to note that in all three cases the entity contacting and asking for our assistance was not the local hospital or clinic. In all three cases it was local/area economic development commissions or job development authorities. The health care infrastructure was involved and supportive; however, the leadership came from the economic side of the ledger because they saw the linkage between health opportunities and economic development in the form of health and wellness with corresponding jobs creation and the

recruitment and retention of other businesses and families. *The future of rural health is related to our ability to recognize and capture the natural linkages and interdependence of a rural health system with the rural economic system.*

A continuing rural health environmental issue is **health care workforce**. This has obvious implications for the delivery of health services and based on the previous discussion it even has economic implications. Health related jobs in Montana account for about ten percent of that state's total workforce. For Minnesota it is slightly less than ten percent and in ND it stands at close to 12 percent. In ND, eight of the ten largest private businesses or organizations are in the health field. By about 2020, the demand for health workers is expected to outstrip the supply for a number of health occupations as national estimates indicate a shortage of 100,000 physicians and 800,000 nurses. In North Dakota, we recognize these concerns and in the fall of 2006, our office hosted a statewide Health Workforce Policy Summit attended by about 200 people including about 50 state legislators. From this we developed a policy paper discussing options and are currently implementing a series of workgroups to address those themes and options including workgroups on the subjects of K-12 career development programs, higher education training models, higher education and employer partnerships and about four other workgroups. These workgroups will be developing action-oriented plans for addressing health workforce issues in ND. Currently, there are about 50 North Dakotans working together through this workgroup process to fashion constructive solutions. Mary Amundson who directs our Center for Rural Health primary care functions and Patricia Moulton are primary leaders in this effort. From a strategy perspective, our view is North Dakota must take control of the issue and develop options and solutions that meet our needs as opposed to simply relying on national and federal options. *The future of rural health rests on our ability to stake out and develop our own solutions based on our values and needs to not only shape community and policy issues such as health workforce, but also our ability to control and manage the agenda and the options.*

The **financial impact** issue for rural health is and will remain an imperative. We have seen many, many facets to the issue of health care financing. Many of you from rural hospitals have seen the shuffle from a form of cost based reimbursement to prospective payments and, if you are a CAH, back to a form of cost reimbursement. During this period, rural hospitals became experts at controlling costs under PPS only to recognize under CAH that we need to capture a level of cost for reimbursement purposes. Rural hospitals fought for DRG equity and in many respects, that decade or more long fight helped to cement a national rural health movement with corresponding need for rural health research, state rural health offices, state rural health associations, and an overall focus on rural health policy.

Now, we approach newer concepts such a Pay for Performance where we merge our payment stream with our outcomes. Pay for Performance is another example of that Chinese symbol: Challenging to our traditional way of thinking about reimbursement, but also a genuine opportunity to merge goals associated with quality of care, organizational performance, and payment.

In some respects U.S. health care financing, as a whole, represents challenges with opportunities. The challenges are associated with pay equity for providers, financial access for all people, and resources to address emerging issues such as quality improvement and HIT. With

these challenges goes the opportunity to restructure payment and delivery systems in a manner that can come closer to the true concept of managing care as opposed to simply focusing on mechanisms to control costs. The financial consideration is always of paramount concern; however, the improvement of health for the betterment of the individual and the benefit of society is also primary.

The relatively new focus on **quality of care and improving patient safety** in rural health owes much to the work of the Institute of Medicine, including the book “Quality Through Collaboration The Future of Rural Health.” This helps to remind us that while we spend a significant amount of time, energy, and resources on payment policy, workforce policy, financial access policy that we also need to attend to health status, population health, and the quality of care that is provided. I am very proud of the national and state efforts in quality associated with the Rural Hospital Flexibility Programs. In ND, under the leadership of Marlene Miller our state Flex director, located at the Center for Rural Health, we have seen the creation of CAH based quality networks, workshops on quality, formation of a statewide committee on rural hospital quality, and we have furthered our relationship with our QIO. In addition, about 84 percent of our CAHs are reporting some level of data to Hospital Compare and I remind you that CAHs are not required to do this. Thus CAHs are doing this because they think it is a good idea. Kris Juliar, my colleague from Montana commented earlier: “The rural community can be a laboratory for quality.” *For the future of rural health, rural hospitals, clinics, ambulance units, and other providers need to be the champions for quality.*

A final environmental trend is **HIT (health information technology)**. In the 1990’s we had many discussions on tele-medicine and tele-health. What is it? What can technology do for us? What are providers’ attitudes toward the use of technology? And, certainly how do we pay for it and what are the reimbursement streams? As a nation, as states, and as providers we have invested millions of dollars into equipment, wires, and other forms of technology. We can transmit medical images over incredible distances, we can connect patients in a small rural community with a specialist in a tertiary facility, and we can spend more time in our clinics and offices than on the highway. We have accomplished this with tele-health. With President Bush’s State of the Union speech in January of 2004 and his goal for all Americans to have access to an electronic medical record (EMR) in ten years, there has been a major push in the area of HIT. We are seeing how HIT addresses quality, workforce issues, and distance. At the same time we have the challenges associated with cost and our ability to pay for this. We look to the role of federal and state policy and we, particularly SORHs and SRHAs try to identify grant and other funding sources. Like health workforce and quality of care, North Dakotans are taking a proactive approach. In 2006, the Center for Rural Health hosted the first statewide HIT Summit. The North Dakota HIT Steering Committee was developed from the summit (comprised of key statewide stakeholders such as provider groups, associations, payers, state agencies, and others). Their goal is to facilitate the continued exploration of HIT application in North Dakota. Lynette Dickson, Program Director of our State Office of Rural Health, chairs this effort. *The future of rural health is linked to our ability to apply HIT in a productive and cost effective manner. In some respects small, rural health systems are a perfect laboratory for experimenting with HIT application.*

The Concept and Importance of Community

These environmental issues are significant contributors to what is and what will be rural health. However, I want to discuss another factor: the idea of community as not only a physical presence, but also as a unifying conception. Rural health is community. Community is why you do what you do. Community is a tangible place and yet it is a philosophical concept and belief to produce progress, to build societal relationships for the good of all, and to fashion a sense of togetherness – we are **all** in this together. The concept of community is intertwined with the concept of rural health because the condition of health – simply being healthy – implies a positive physical, emotional, and spiritual focus and being. A healthy community, like a healthy person, connotes similar attributes. Community and rural health intersect in other ways. The focus and processes associated with health care implies working with others – a patient, client, resident, providers – to stabilize or improve their health. Providing health care, like building and sustaining a community, requires team-work, collaboration, cooperation, and a common goal. It also entails common values and shared beliefs. As was established in the previous discussion on environmental issues, rural health organizations are part of a complex and unpredictable environment. Health organizations cannot survive on their own – they are part of the community, they contribute to the community, and the community, in turn, makes significant contributions to the health organization. The community is a source of ideas, inspiration, vitality, wants and needs, workforce, material and social resources, funding, volunteers, patients or clients, and other resources. Rural health organizations give back not only in the form of direct health services to the population, but also in the form of direct and indirect economic inputs; an educated and committed workforce available for other community functions such as serving on the school board, church committees, and civic organizations; and overall community leadership. I've always been impressed by the number of rural health professionals I have met who are actively involved in their town's leadership. I think of Doris Vigen, DON, at Union Hospital in Mayville who serves on the school board or Dale Aman who is the former hospital administrator in Linton, ND who served on the city council and many more. This is a significant part of that rural health – rural community bond.

In our office, when we discuss rural health/rural community connections we have a history of thinking of the traditional pillars that comprise a rural community. I am referring to sectors such as these: 1) health care sector, 2) education sector, 3) business, 4) church or faith, and 5) public sector. I would add a sixth sector being cultural. Each of these is important. One is not more important than another as we need all of them to be pulling together in the same direction to fashion the community.

Community development experts will point out that common weaknesses for rural communities relative to urban areas, are rural communities tend to have fluctuating economies, skewed population demographics, lack of or limited resources, shortage of professionals, and an orientation that can be characterized as out-and-out resistant to change. With regard to these sectors that means we have a more precarious set of conditions and resources to avail ourselves of in making sure these sectors can and do work in tandem. At the same time, rural areas have numerous strengths that benefit this endeavor such as having strong informal support networks, fundraising, a cohesive orientation, an established sense of interdependence, and a tendency for collaboration. In a way, our more limited resources like skewed population and shortages of

professionals, drives us to a culture of collaboration. ***The future of rural health is linked to our ability to continue to weave together community sectors in a collective manner recognizing both the natural boundaries of each sector, but also building on the natural integration of those sectors. This endeavor reminds me of that Chinese character of challenge and opportunity.***

In an audience like this – and I am thinking specifically about those of you who are members of the Minnesota Rural Health Association – I would assume that membership is probably weighted on the side of people who work directly in rural health. However, there are members in the association who represent the business and economic development sector, education sector, public sector, faith sector, and cultural interests. A rural health association will likely have a strong affinity with the rural community for all the reasons I have presented. If rural health does exist to improve the health status of individuals and the overall community, then rural health and community are intrinsically linked, marshalling their collective resources to advance the cause for not only stronger and more stable rural health delivery systems, but also stronger and more stable rural communities. The two goals are not mutually exclusive. The two goals are and can be essentially the same. Thus, a state based rural health association should be broad in its composition to import the skills, perspectives, and values represented in other sectors. While improving health status and organizational viability may be the stated purpose of an association, the improvement of those health factors, in turn, improves the community. The improvement, the strengthening, the fulfillment of the community, in turn, improves the health sector. ***The future of rural health is connected to our ability to forge multi-organizational alliances compelled to build stronger, more dynamic voices for rural Minnesotans, rural Montanans, and rural North Dakotans. Challenge and opportunity.***

One opportunity may be how we define community. In rural health we have become experts at forging collaborations, informal and formal provider networks, sharing resources, establishing linkages while by-in-large maintaining an appropriate level of autonomy and independence. My point is this: if 20 or so rural hospitals from 20 or so rural communities in North Dakota and Minnesota can work together in the North Region Health Alliance (and that is just one example) finding common ground yet remaining independent – can we take that same quest and apply to actual communities? Can we broaden our definition of community to take on a regional perspective? Can we stop fighting over who won a basketball game in 1957? Can we accept that a town stole the county seat in 1907 and it isn't giving it back? If we can deal with the difficult emotions associated with rural school consolidation – can we then move on to discussing between two, three, five, or more communities in a common area how we can work together to simultaneously maintain our own historical identity, but to also build a shared identity for the future. ***Can we create a regional focus?***

A final thought on community is a somber one. I have been to and worked with many communities over the years. I worry that we are losing and in some cases have already lost momentum and confidence for our future. That may be more of a ND issue. Again, for 20 straight years, 47 of 53 counties have experienced population loss. Some as high as 30 percent or more. With a declining population, we witness the impact on the local schools, church attendance, the number of businesses, the types of services, and our ability to reinvest in ourselves in terms of leadership and simply having enough people to serve on committees.

People in small towns call it “wearing out” or “wearing down”. Rural citizens reference the same people time after time being asked to serve on this committee, to attend this meeting, to do this thing one more time for the community or the organization. People wear down. There is also a concern that in some cases people are holding on, hoping that their job or business can last another ten years or so and then they can retire and move either to a larger city in state or even out of state. The focus is to “just survive” to protect what we have, to maintain the status quo; it is not to invest, take a risk, sacrifice. If this attitude exists or becomes pervasive then it is difficult to see the town surviving. Over the last two or three years when I have been asked to make community presentations I bring up these concerns. I don’t do it to dwell on a negative and I don’t do it to create a conflict. But yes, I do say it to force some dialogue in a community. I do say it to encourage, even force community members to face some difficult issues, subjects we may prefer to ignore. If we ignore these conditions and issues we, once again, risk our future. ***The future of rural health is related to our ability to face difficult issues both for the community and for rural health. It rests on the ability of rural residents to have a vision for the future. It rests on their willingness to invest in their future by believing in their community. It is possible that some people and maybe even some towns have abandoned the quest for a viable future. I personally find that latter point distressing; however, I concede it is possible and maybe, in some cases, a rational choice. In ND 51 percent of our organized communities have 200 or less people. I am expressing my concern for towns at around 1,000 or even 2,000 with rural health systems that are seemingly struggling with their identify and ability to craft a future. If we lose towns at about 1,000 then we have truly significant issues. Challenge and opportunity.***

Framing and Communicating Policy Messages.

The future of rural health is closely linked to policy formation. Typically when we think of rural health policy we immediately turn to specific issues and ideas on how to address those problems. We seek policy that reimburses CAHs at 101 percent of cost; we adjust the area wage index, we change the formula for providing Medicare bonus payments to physicians, we create a federal grant program for rural HIT. This is policy and it is important. It represents the rural health community working with advocacy groups and policy makers to create the change we feel will have a positive impact on our environment.

However, if rural policy, including rural health policy is to advance we need to think specifically about how we communicate our message to not only policy makers but also potential allies. For the last year or so I have had the good fortune to be part of a W.K. Kellogg Initiative called Rural People Rural Policy which is essentially the creation of a series of rural regional networks around the country. My colleague Dr. Alana Knudson and I are part of the Great Plains Region. There are ten organizations from North and South Dakota, Montana, and Nebraska that comprise this region representing a variety of rural perspectives such as health, economic development, legal services, poverty, housing, immigrants/New Americans, tribal, and human rights. A significant focus is on learning how to frame or communicate rural issues in a policy arena.

The research on framing has been done by The Frameworks Institute in Washington D.C. Formed in 1999, The Frameworks Institute works to advance the non-profit’s sector communications capacity for framing the public discourse about social problems. Within the RPRP process we have participated in workshops and we have another workshop scheduled for October to continue to learn and hone our skills in policy framing. For the Center for Rural

Health, Dr. Knudson and I are attempting to learn and understand this new nomenclature to help us craft appropriate rural health policy messages in our documents. In essence, a frame is an organizing principle that is shared and persistent overtime. It is as Walt Lippmann said, “the pictures in our heads.” When we hear certain ideas and concentrate on the words, we form a mental image. For example, when some people hear the phrase universal access to health care, they hear “socialized medicine.” People use mental shortcuts to make sense of the world, to facilitate understanding, and to speed up communication. These mental shortcuts rely on “frames” or a small set of our internalized concepts and bits of information including our values and belief structures that we use to form meaning to what we are hearing.

This is an example of why it is important to influence or control your frames. Universal access does not necessarily mean a government-run health system so for the message sender “socialized medicine” is the wrong frame, or at least not the frame they intended. However, for some message receivers, that is the understanding. Frames are both conveyed and interpreted.

For the future of rural health, framing policy issues will become more and more important. We account for only about 20 percent of the U.S. population and national policy makers have an urban bias now, and this will become more pronounced. We have to get the right message and convey it in a manner that has meaning and resonance to non-rural people. Urban citizens and policy makers need to understand rural policy messages because there are not enough rural people or rural advocates to adequately carry the message. We need understanding and alliances with urban people, policymakers, and organizations.

What message frames work for rural America? According to the research done by the Frameworks Institute, two effective frames are the “fairness frame” and the “interdependence frame”. The former refers to framing arguments that appeal to a basic sense of fairness and equity. A rural policy framed on a fairness argument says that rural American is the same as urban America deserving the same or similar treatment. Maybe without being aware of the concept of framing, rural health advocates used a fairness frame when we argued for Medicare equity in DRG payments. Why should the same condition be reimbursed at a significantly higher rate in an urban hospital than a rural hospital? At some level, this is intuitive. The “interdependence frame” is based on the assumption that there isn’t an “us” and “them.” There is, instead, a “we” – urban needs rural and rural needs urban. Structuring policy and policy discussions that seek to find the interconnection and a sense of interdependence between regions and areas, be they rural and urban lends itself to constructive policy formulation.

In the discussion on community, I mentioned the need for creating a regional focus or dialogue. Community is more than just a standard political subdivision and can have, instead, a broader, regional flavor. This idea of regional thinking also fits with policy framing because in approaching that issue we need to frame the need and the potential benefit carefully just as we need to conceptualize the overall nature of community health in coherent, positive frames for state and national policy makers. In a similar vein, we must recognize that while rural is unique, so is urban. ***If we are to move forward – rural America, urban America, all of us --we have to think in terms of fairness and the interdependence that unites and connects us together.***

Creating a National Rural Voice:

Some final thoughts on the future of rural health and rural policy relate to the idea of creating a national rural voice. Earlier, I mentioned the Rural People Rural Policy initiative. As an outgrowth of that effort, the Kellogg Foundation and another large national foundation, the Ford Foundation are collaborating in an effort to try to build a national rural movement to give

“voice” for not only the challenges, but also the opportunities found in rural America. Currently, it is called the National Rural Assembly. At this stage, it is somewhat nebulous and even to some of us abstract. I am serving on the national steering committee that is engaged in developing a process that can lead to the realization of this goal – creating a unified national voice for rural America. At a meeting such as today’s we are discussing rural health; however, we need to continue to find ways to discuss the broader concept of rural -- including voices from rural health, rural economic development, rural education, rural housing, and a number of other perspectives.

In our future discussions on a national rural process, we will no doubt be focusing on processing and articulating a rural based policy: policy that meets our needs for rural health or rural poverty or rural economic development. We must also begin to think of rural policy in a broader context, one based on how all these focal areas link together to shape rural America. This can foster a new rural agenda and set of actions. It is possible too, that this new agenda will find allies with new urban partners. Framing our policy messages based on values associated with fairness and interdependence may set this stage.

Conclusion:

As I have stressed this morning, the future for rural health is bound together with our concept of community, our respect for community, along with our ability to frame our messages for appropriate policy action. Rural health, as is the case with rural America, simultaneously contemplates inherent challenges that lend themselves to our best ability to isolate the opportunity. As my Montana colleague, Kris Juliar, stated in her presentation, in rural American “there are a lot of good people doing a lot of good work.” Thank you.