In this issue of “Focus on Rural Health” we have asked Steve Wilhide, MPH, MSW, Executive Director, National Rural Health Association (NRHA) to discuss rural health from a national perspective. Mr. Wilhide assumed his duties as executive director in early 2002. Before this, Mr. Wilhide was an active member of NRHA and most recently served as President and CEO of the Southern Ohio Health Services Network, a rural primary care community health center network serving five Ohio Appalachian counties.

Q. Tell us about the National Rural Health Association. What is the purpose of a national association focused on rural health and why is it important that we have a national focus?

A. For the past 25 years, the National Rural Health Association has served as the national voice of rural health. We are a membership association, representing and advocating for healthy rural communities and the necessary services required to achieve this goal. The common interest that has differentiated NRHA from other national policy and advocacy organizations is a set of unifying beliefs that: Rural people are entitled to a basic level of health and well being equivalent to non-rural people and; healthy rural communities are essential for a strong America and; a strong and appropriate system of health care is an essential component of healthy communities.

The NRHA not only provides a forum for individuals with a shared interest in improving rural health, but NRHA also brings the issues and concerns of rural America to a national stage. This national presence is key, because addressing the health disparities facing rural America will take nothing less than a local/federal partnership.

Q. What does NRHA do for its members? What are some significant accomplishments?

A. Networking, education and advocacy, this is the foundation that makes NRHA relevant to our members. Through national and regional meetings, the NRHA provides its membership with the chance to network with peers, and to learn what is working for other similar rural communities across America.

Our advocacy efforts have resulted in increased funding for rural research, increased federal funding for rural grants and demonstration programs, increased funding for state offices of rural health, and a national recognition that rural is not simply a small version of urban.
NRHA led numerous efforts over the years to develop new ways of improving healthcare for rural Americans. One of the best examples of this was the creation of Critical Access Hospitals (CAHs) and the Medicare Rural Hospital Flexibility (FLEX) program. Although the program is relatively new, most people are not aware of the role NRHA had in its creation. The FLEX program, and CAH designation, not only keeps the doors open for the smallest rural hospitals, but also succeeds in improving the overall health status of rural communities. This goes to the heart of what NRHA represents, and is a great example of why NRHA is important.

NRHA recently developed a new proposal, the Rural Community Hospital Assistance Act. This proposal would strengthen payments to critical access hospitals. In addition, it would also provide a new payment methodology to help those hospitals that are too big for CAH, but too small to generate a positive operating margin under current Medicare rules. We are working with members of Congress to press for the enactment of this new proposal. NRHA has proven over the years to be a national leader in policy development.

Q. From your perspective, what are the primary rural health issues we are facing as a nation?

A. We are rapidly evolving into a two-tiered system of health care in this nation, one for rural Americans and one for urban/suburban Americans. The three primary health issues facing rural America are access, quality, and equity. These three issues must be addressed if we are to succeed in building healthy rural communities.

For rural Americans, health disparities are a real and pressing concern. You have a situation developing in rural America where those most in need of medical attention have the poorest access to care. Issues as divergent as substance abuse, a lack of preventative care, a shortage of health care professionals, and a lack of health insurance coverage all combine to create a national public health crisis in rural America that we must address.

Each year, the NRHA develops a legislative and regulatory agenda, consisting of a multitude of policy issues that need to be addressed in order to build healthy rural communities. Our agenda can be viewed at NRHA rural.org. All of the ideas, developed each year, can fit into the three overriding issues of access, quality, and equity.

Q. When you look to the future, what do you see on the horizon for rural health?

A. I am more optimistic than ever for the future of rural health. U.S. Department of Health and Human Services (DHHS) Secretary Tommy G. Thompson convened a Rural Task Force to examine ways to improve and enhance health care and human services for rural Americans. As a result of this commitment to ensuring healthy rural communities, agencies within DHHS are evaluating their programs and services to identify programmatic and regulatory barriers to serving rural communities. We at NRHA are working closely with the Office of Rural Health Policy of DHHS as well as the Center for Medicare and Medicaid Services (CMS), multiple agencies of the Public Health Service, National Institutes of Health, Substance Abuse and Mental Health Administration, and others to assist them in serving rural communities better and in understanding the unique needs and cultures of rural and frontier areas.

There is also an increased awareness that adequate, affordable and accessible health care is critical for the overall economic and social viability of rural communities. Health care is a critical component of overall rural community and economic development. Without a basic level of health care services a community can not attract and retain industry and therefore provide local jobs.

The NRHA was instrumental in organizing a rural health coalition in the U.S. House of Representatives and rural health caucus in the Senate. These groups are critical in bringing the issues of rural health to the forefront of attention in the Congress. The NRHA government affairs office works closely with these groups to identify issues and develop legislation to improve rural health access, quality, and equity. We are cautiously optimistic that some of the payment inequities for rural health providers will be addressed through legislative and policy changes.

There is a growing realization among policy makers and Congress that a healthy rural America is critical to a strong America. This realization, coupled with a strong commitment to rural health by Secretary Thompson, provides an optimistic future for a healthy rural America.

Congratulations to North Dakota Hospitals

At the recent North Dakota Healthcare Association Convention awards were bestowed upon hospitals, staff, and trustees. The Center for Rural Health would like to congratulate the following:

- AHA PAC Award/2001 Most Valuable Player: Terry Hoff, Trinity Health, Minot and Marlene Krein, Mercy Hospital, Devils Lake
- AHA 25 Year Membership Award: Northwood Deaconess Health Center
- NDHA Leadership Award: Marlene Krein, Mercy Hospital, Devils Lake
- NDHA Trustee Award of Merit: Steve Holm, Pembina County Memorial Hospital, Cavalier
Center for Rural Health faculty and staff recently provided testimony to a Congressional committee concerning Native American aging and health status. The work of the researchers is based on a four year national study and has direct health policy implications.

On July 10, 2002, Richard Ludtke, PhD, Leander “Russ” McDonald, MA, and Allan Allery, MPH, researchers with the National Resource Center on Native American Aging (NRCNAA), a program of the Center for Rural Health, were invited to deliver testimony covering data and research findings to an oversight hearing before the Senate Committee on Indian Affairs on Native American Elder Health Issues in Washington, D.C. Established in 1993, with funding from the Administration on Aging, the NRCNAA has a dual mission of research and training/technical assistance.

Highlights from an elder’s need assessment project, Conducting Local Assessments: Locating the Needs of Elders, were presented. The ongoing project involves conducting a survey on each reservation that voluntarily participates in the project using a standardized survey tool that allows for comparison with national standards. The Center provides training to local personnel who in turn become the data collectors. Training is provided on sampling, interviewing, and basic statistical output. The NRCNAA also provides technical assistance as needed by telephone and provides each tribe with a supply of standardized survey instruments in a scannable format. Each tribe receives a copy of the statistical results along with a copy of their data for local analysis. These surveys are primarily directed at providing local reservation communities with their own data for use in planning, program development, and grant applications. Each tribe collects its own data and authorizes the NRCNAA to append their data to an aggregate file. To date, 83 tribes are in the aggregate file with over 8,560 respondents.

While the project’s results have national implications, the individual tribes derive significant benefit from the collaboration. “Numerous studies have been conducted on reservations but the results are rarely returned to the tribes,” says Russ McDonald, research analyst. “Our research is different. We help the tribes to produce their own data for use in their communities. In this project, the data belongs to the tribe.” McDonald goes on to say that there is an educational benefit to the tribe as well. “Tribal members are trained to conduct and use research to benefit their areas.” Mr. McDonald’s father is from the Spirit Lake Dakota Nation and his mother is Arikara from the Fort Berthold Reservation.

Key findings presented to the committee described disparities between Native American elders and the general population regarding life expectancy and health status. Life expectancy is 71.1 years for Native Americans compared to 76.7 for the U.S. general population. Native elders were 19.5 percent more likely to experience arthritis than the general population; 48.9 percent more likely to suffer from congestive heart failure; 17.7 percent more likely to experience high blood pressure; 17.5 percent more likely to experience a stroke; 44.3 percent more likely to experience asthma; and 173 percent more likely to experience diabetes than the general population.

The findings serve as the basis for framing a health policy discussion. “Our national data set contains new data which can inform policymaking at the federal, state, and local levels,” says Mary Wakefield, PhD, director, Center for Rural Health. “It will drive important changes in health care policy regarding Native American elderly and allow the government to target policies differently based on varying needs of tribal entities.” The Center’s staff made several recommendations to the committee which included: 1) an initiative to develop intervention and health promotion models leading to improved outcomes for Native American and Alaskan Natives as they enter their elder years; 2) the need for the development of long-term care requires solutions that are tailored in terms of the types of care that work best and the means by which local communities can realistically produce the care required; and 3) increase the support for targeted research on Native American aging and related educational and capacity building programs is essential to help fill gaps in information.

For additional information on the research findings or to read the complete testimony presented to the committee, please contact Mr. McDonald at (800) 896-7628 or by email, rmcdonal@medicine.nodak.edu or the following website: http://medicine.nodak.edu/crh.
Center for Rural Health staff and faculty are involved in a number of activities and projects to improve rural health care in North Dakota, the region, and the nation. We want this staff report to be educational and useful to our readers. If you read of a project, meeting, conference, or other information source that you believe can help your community, practice, and/or facility then please contact the appropriate party by calling (701) 777-3848.

Mary Wakefield, PhD, RN, Professor and Director, was a speaker at the annual research meeting of the Academy for Health Services Research and Health Policy, Washington D.C. The topic was “Paying and Organizing for Quality: A Plan for Crossing the Quality Chasm.” Dr. Wakefield also gave a presentation on Medicare equity for rural beneficiaries to the U.S. Senate health legislative assistants in Washington D.C. Dr. Wakefield was a keynote speaker at the 2002 North Dakota Nurses Convention, September 15-17, in Fargo, ND. The title of her presentation was “Aligning Healthcare for the Future.” Dr. Wakefield was also a keynote speaker at the 2002 North Dakota Healthcare Association Annual Convention, September 25-27, in Fargo, ND. Her topic was “MedPAC Workforce Issues.”

Brad Gibbens, MPA, Assistant Professor and Associate Director, recently attended the National Organization of State Offices of Rural Health (NOSORH) Annual Conference, Charlotte, North Carolina in September. The conference provides continuing education to SORH directors and staff on current rural health trends, issues, and policy. Mr. Gibbens serves on two NOSORH committees: Rural Hospital Flexibility and Legislation. Mr. Gibbens also spoke at the North Dakota Healthcare Association Annual Convention on rural hospital grants and community development options.

Mary Amundson, MA, Assistant Professor, attended the annual Primary Care Office/Primary Care Association and State Loan Repayment Symposium in Bethesda, MD.

Patricia Moulton, PhD, Assistant Professor and Research Analyst, gave a presentation, along with Connie Kalanek, PhD, RN, Executive Director of the State Board of Nursing, on the North Dakota Nursing Needs Study to the North Dakota Legislative Interim Budget Committee which met in Bismarck, ND.

Kyle Muus, PhD, Assistant Professor and Director of Research, on September 12-14, 2002, attended the Heartland Emergency Medical Services for Children (EMSC) Coalition Regional Conference in Minneapolis, MN.

Richard Ludtke, PhD, Professor, attended the Rural PACE Summit hosted by the National Rural Health Association (NRHA) and the National Pace Association in Roanoke, VA. PACE (Programs for All-inclusive Care for the Elderly) seeks to provide and coordinate a comprehensive range of preventive, primary, acute and long-term care services needed for the frail, older individuals to continue living in their communities. PACE programs recently made the transition from demonstration projects conducted under federal waivers to permanent Medicare and Medicaid provider status. This allows the program to expand its delivery, which has been largely limited to urban areas during the period of demonstration. The meeting focused on developing plans for expanding opportunities to adapt and employ the PACE model to meeting the long term care needs of people in rural areas.

Leander R. McDonald, MA, Research Analyst, was awarded the 2002 Annual TRIO Achievement Award during the Annual Association of Special Programs in Region eight (ASPIRE) Conference held in Fargo on October 6-10. The award is given to high achievers who have overcome disability, minority, or socioeconomic status barriers.
Cando Expands Services to Include Chemical Dependency Treatment

Brad Gibbens, MPA

In this issue of Focus on Rural Health we initiate a new feature called Community News. The purpose of this feature is to identify and discuss rural community health programs, events, and activities from around the state of North Dakota. We have two goals. One goal is to present another educational opportunity to our readers. By focusing on rural community efforts we hope that community health providers can learn from each other. “Best practices” and “new models” typically originate at the community level. The second goal is to offer communities the opportunity to gain statewide exposure on their efforts and accomplishments. We ask our readers to consider their own activities for future stories. If you have a program or project that can benefit others, an award or honor bestowed upon your facility or staff, a new community or multi-community initiative then please contact Brad Gibbens, bgibbens@medicine.nodak.edu or (701) 777-3848. We inaugurate this feature with an innovative effort being developed by the Towner County Medical Center, Cando, North Dakota.

Service diversification has been the rallying cry of many rural health systems over the years. Rural health providers struggle to maintain economic viability and to meet the service needs of their constituents. The rural hospital has proven to be a primary source of innovation developing new programming that meets the economic, social, and health obligations of the facility. Towner County Medical Center (TCMC) exemplifies this philosophy in its new chemical dependency treatment program.

Following more of a social model than a medical model, Cando will open the doors of a new treatment facility this fall. The Solutions Based Program (SBP) will be implemented by TCMC in a 12-bed unit located just outside of the city on a farmstead. SBP is an innovative approach to treatment that relies more on personal respect and self-esteem than on punishment and shame. “We don’t drag the client through the hurt and shame, and we don’t dwell on the reasons for the addiction. Instead, we look for solutions – for ways to become sober – and we keep focused on positive behavior that will allow the client to stay there,” says Glenda Larson, licensed addiction counselor and co-director (as quoted in the Towner County Record Herald). Larson elaborates that SBP clients are “several times more likely to stay sober” than those found in more traditional treatment methods.

The Cando facility will be the only SBP in the state. The project is an outgrowth of a Minot effort. The two co-directors (the other director is licensed addiction counselor Brad Skari) have worked with TCMC to move the program to a more rural setting. Trinity Medical Center, Minot, also supports the project. It is the very ruralness of the location that makes the program attractive to all the partners. Tim Tracy, CEO, TCMC, explains that for many clients the anonymity factor is a key motivator. Thus, a rural location in the country offers a level of anonymity found in few places but still offers the complete professionalism found in more urban settings. The hospital has purchased a homestead and converted it into a 12-bed unit, but has maintained the homely atmosphere. While the treatment program focuses on the complexities associated with chemical addiction, the setting conveys more of a “bed and breakfast” atmosphere. It will reinforce the rigors of the treatment method with the pastoral serenity found in rural Towner County. This also has a bearing on the client’s family. Tracy points out that while the location may seem remote to some, it can actually facilitate the healing process for the family with the resident. What may be seen as a typical “urban amenity” such as “the mall” can actually be a distraction for a family involved in the treatment process; thus, the countryside of rural Towner County can be more conducive for family bonding. “In a rural setting like this there is time for reflection,” says Tracy.

While the health and social components of the initiative are paramount, there is also a recognition of the economic impact of the program in the area. Tracy states that the marketing of the program will be extensive, covering not only North Dakota, but also Minnesota, South Dakota, Montana, Wyoming, and other states. This will present the opportunity for new revenue to accrue to the community. “This looks outside of North Dakota. We can build a new market and add wealth to the county that comes from outside of the area. We see other states gaining wealth from North Dakotans such as people going elsewhere to winter. Now we have a chance for some new wealth to come back to the state,” says Tracy.

The health services expansion will include three licensed addiction counselors, one occupational therapist (who will also work with the nursing home residents of TCMC), and five residential technicians. This means TCMC is responsible for bringing eight new jobs to the Cando economy. Tracy states that so far there are four new families in town, due to this program, and that the impact will be felt by the business community along with the school and churches.

Have you seen the Center’s new look?
Check it out at http://medicine.nodak.edu/crh
Recruitment and Retention Issues Among North Dakota EMS Personnel

Kyle Muus, PhD

Rural EMS is highly dependent upon volunteer personnel. Few small communities have a paid, professionally staffed EMS service. Most of the state’s volunteer personnel work full-time in non-health related positions within the community. Some employers are not supportive of employees taking time from work to be involved in emergency care provision or training. Volunteer EMS providers donate their personal time to pre-hospital care provision and are usually expected to be available 24 hours a day, and on weekends and holidays. Some of the main reasons why local residents agree to participate in local EMS include the crucial medical need within the community and the town pride in their autonomy and independence.

Previous studies have documented problems pertaining to EMS personnel issues. In 1996, the Center for Rural Health conducted a survey of EMS personnel attending a state EMS conference in Grand Forks, North Dakota. Results indicated respondents felt the most pressing problems for North Dakota EMS were retention of personnel (61% of respondents), recruitment of new personnel (58%), getting time off from one’s non-EMS job (26%), lack of community acknowledgment/recognition (24%), and inadequate medical direction (15%).

A 1994 national study was conducted on rural EMS. It involved a survey of state EMS office directors. Respondents were asked to identify rural EMS problems, solutions and policy options in their respective state. Findings indicated that the three most commonly-cited problems were staffing, training, and finance. In rural North Dakota, the study revealed that staffing and training were the most prominent EMS problems (Center for Rural Health, 1994).

The recruitment and retention of health professionals, regardless of the type, to rural areas are particular problems. Numerous studies have documented the nature of these problems among various health providers, including physicians, nurses, physician assistants, nurse practitioners, psychologists, social workers, lab technicians, physical therapists and occupational therapists. The literature indicates a number of contributing factors to these recruitment/retention problems, including lower pay/benefits, outdated facilities/equipment, long hours, lack of collegial interaction/support, unfavorable scope of practice, poor access to specialty care, and poor access to social amenities.

To learn more about EMS recruitment and retention problems, questionnaires were mailed to 5,870 EMS personnel in North Dakota. The group consisted of all persons who are North Dakota-registered as a first responder, ambulance attendant, driver, emergency care technician, EMT-Basic, EMT-Intermediate or EMT-Paramedic. Of the 5,870 sent, 2,003 (38.9%) returned a completed survey. Surveys were not received for 12.2% of the individuals due to inactive EMS status or incorrect address.

Figure 1. Seriousness of Your Squad’s Recruitment/Retention Problems

EMS Personnel Recruitment

Seriousness of Recruitment Problem

Close to two-thirds (63.2%) of respondents said that recruiting individuals to EMS was a serious problem in their local area (Figure 1). When results were broken down by geographic location, it was not surprising to find that rural-based EMS personnel (69.7%) felt the problem was much worse than those in urban areas (39.1%). Respondents indicated that the most substantial barriers to recruitment (Figure 2) were the time commitment (77.2%), training requirements (71.8%), lack of interest in EMS (40.4%), stress (38.7%), and inadequate pay (38.7%).

Reasons for Joining EMS

EMS personnel were asked for the main reasons why they joined local EMS. The most significant factors were satisfaction in helping others (86.9%), community need (78.0%), interest in EMS (72.6%), interest in trauma care (59.9%), and challenge of providing EMS care (52.2%).

Figure 2. Main Barriers to Recruit Local People Into EMS
**Getting Time Off**

Previous studies have indicated that obtaining time off from work is a problem for some EMS providers. It has been found to be a barrier to both recruitment and retention. Through this survey, we sought to determine the extent of this problem among North Dakota EMS personnel. Results indicated that of those that said EMS was not their primary occupation, 72.7% said that getting or taking time off from their main job for EMS duties was at least somewhat of a problem. One-quarter (25.6%) indicated it was a serious problem. Respondents felt the main reasons for this problem stemmed from schedule/shift work (31.6%), loss of personal income (16.6%), lack of support from employer (7.4%), lack of support from employees (3%) and other reasons (20.7%).

**EMS Personnel Retention**

**Seriousness of Retention Problem**

When respondents were asked about retention of local EMS personnel, they indicated it was less of a problem than recruitment of new individuals (Figure 1). About one-third (32.2%) said retention was a significant problem in their area. Again, a larger percentage of rural-based personnel rated the problem as serious, compared to urban-based EMS providers (35.7% vs. 29.2%). Respondents were asked for their opinion regarding the reasons why squad members have quit their EMS duties in the past 2-3 years. Their most common responses regarding major factors toward quitting (Figure 3) were time commitment (64.5%), training requirements (55.4%), personality conflict with EMS personnel (30.5%), loss of interest (30.2%), and shortage of backup EMS personnel (29.3%).

**Future Plans for Their EMS Role**

EMS personnel were asked how long they plan to remain involved in local EMS (Figure 4). About two-thirds (66%) said they would likely stay five years or more. Approximately 15% indicated they would stay another 3-4 years, 14% said they would remain 1-2 more years, and 6% stated they would likely leave EMS within a year.

**Figure 3. Significant Factors Behind Persons Quitting EMS Squads**

**Figure 4. How Long Do You Plan to Remain in EMS?**

**Figure 5. Main Forces Behind Decision to Stay in EMS**

This study was conducted by the Rural EMS Initiative (REMSI) staff and funded by the Otto Bremer Foundation and Dakota Medical Foundation. REMSI is a program of the Center for Rural Health. For more information contact Kyle Muus, Center for Rural Health, (701) 777-3848, or by e-mail at klmuus@medicine.nodak.edu

Additional information on the REMSI project can be found on the web at: http://medicine.nodak.edu/crh/ems/remsi.html
The Community HealthCare Association of the Dakotas (CHAD) is a 501 (C)(3) corporation whose mission is to provide a network for advocacy and support services to member organizations that provide primary health care to the medically underserved residents of North Dakota and South Dakota. CHAD members include the 29 community, migrant, and homeless health centers in North and South Dakota, several Rural Health Clinics, and other primary care facilities.

CHAD has been serving the needs of North and South Dakota for over 16 years by working to maintain both an adequate supply of qualified primary health care professionals and accessible, affordable health care facilities. CHAD started with a single office at the University of South Dakota School of Medicine, Department of Family Medicine under the name, Dakota Association of Community Health Centers, Inc. As CHAD grew in both staff size and responsibility, in 1995, the agency entered into a contract with the North Dakota Medical Association to provide part-time legislative and other staffing needs. In January 2000, the agency received supplemental funding and established an office independent of the Medical Association in Bismarck. Jenny Witham became the first director of the North Dakota office in Bismarck. In 2001, Janelle Johnson became the director of the North Dakota office, which now has a staff of four. Scot Graff, the Association’s Chief Executive Officer, has been with the agency since its beginning and now supervises a staff of 13 between both states.

CHAD works to create an understanding of primary health care, its needs, and effective ways to meet those needs for both North and South Dakota. By working with its members and other organizations, CHAD builds coalitions of concerned people to address primary health care issues and to develop and promote effective solutions applicable at national, state, and local levels.

CHAD administers several federal grants on behalf of the states, including the Health Resources and Services Administration’s (HRSA), Bureau of Primary Health Care’s State Primary Care Association grant and the National Health Services Corps grant in South Dakota. In addition, CHAD has served in a leadership capacity for both North and South Dakota’s Covering Kids initiatives.

CHAD staff members provide technical assistance, training and support for participants in the Federally Qualified Health Center program and the Rural Health Clinics program. The organization relies on funding from public and private sources, membership fees, and generated revenues. For more information about CHAD, please contact Janelle Johnson at (701) 221-9824.

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**CALENDAR OF EVENTS**

**2003 Nurses Day at the Legislature.** Best Western Ramkota Inn and State Capital, Bismarck, ND, January 9-10. For more information call Sharon Moos, ND Nurses Association, (701) 223-1385.

“Medicare/Medicaid Conditions of Participation.” Roger Unger & staff from ND Department of Health, Doublewood Inn, Bismarck, ND, January 6. For more information call Linda Simmons, ND Healthcare Association, (701) 224-9732.


**14th Annual Rural Health Policy Institute.** Grand Hyatt Washington, Washington, DC, March 3-5. For more information contact NRHA, (816) 756-3140.

**26th Annual NRHA Rural Health Conference.** Grand America Hotel, Salt Lake City, Utah, May 14-17. For more information contact NRHA, (816) 756-3140.