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Immigrants Changing Rural America

by Hope Hanson

The demographics of rural America are rapidly changing.

Spanish-speaking immigrants, mainly from Mexico, are moving to rural areas in unprecedented numbers, trickling into the corridors of rural health care facilities for treatment and social services.

While policy debates and demonstrations on immigration persist, and its effects on rural health care are being measured, demographers are trying to sort out why Hispanics are moving all across the country rather than settling in the southwestern United States, as they have for years.

Demographic Details

"Hispanics are now the largest minority group in the United States, surpassing the number of African-Americans in 2003," said William Kandel, a sociologist with the U.S. Department of Agriculture (USDA) Economic Research Service.

According to the USDA, about 14 percent of the U.S. population is Hispanic. By comparison, the majority population is non-Hispanic white at approximately 70 percent.

Kandel said Hispanics also remain the fastest growing minority group—in both metro and nonmetro counties.

"Nonmetro Latinos were always concentrated for the longest time in the Southwest. If you thought about rural Latinos in 1980, you were talking about rural Texas, rural Arizona and rural New Mexico," Kandel said. He said that Hispanics began looking to settle in rural areas of the United States only recently. One reason is that the changes in immigration policies have diverted the flow of traditional entry points for Mexicans and Central and South Americans entering the United States.

Marshalltown Medical (Iowa) serves all patients, regardless of their immigrant status (see "Immigration Integration," Page 7).

"Traditionally, the flow was through the northwestern Mexico-U.S. border. But a number of things happened that made California less attractive to migrants," Kandel said. He cited several reasons including Proposition 187 (passed by California voters on Nov. 8, 1994 to deny public benefits to illegal aliens—Gov. Gray Davis killed the ballot issue in 1999); a sluggish state economy; and tightened security at the border in the early 1990s.

WHO IS HISPANIC/LATINO?

Just like the terms "white" and "Caucasian," or "black" and "African-American," "Hispanic" and "Latino" are often used interchangeably. Hispanic and Latino are generally accepted terms to refer to a person whose ethnic origin is a Spanish-speaking country. The federal government uses "Hispanic," particularly in census data. Some people identify themselves as "Spanish," especially those from European Spanish-speaking countries. Some people identify with all three terms while others may identify with only one. According to the USDA's report "Rural Hispanics At A Glance," Hispanic ethnicity encompasses a wide span of experience, ranging from families having lived many generations in the United States to recently arrived migrants.

Another reason he cited was the national Emigration Reform and Control Act of 1986.

"Between 1986 and 1989, between two and three million undocumented migrants received legal status. Many of them were concentrated in the Southwest. Once they received legal status, they were free to move around and find work. Undocumented migrants can move around and find work too, but when you're legal you do it with a lot more confidence," Kandel said.

The full impact of Hispanic migration to rural America is not yet known. One difficulty in determining the impact is that there are no firm statistics on the number of illegal Hispanic immigrants currently residing in the United States. When the Census Bureau collects information for the decennial census, illegal immigrants often hesitate to mark their foreign-born status for fear of being tracked by a government agency.

However, there is little question that the 40 million people of Hispanic/Latino descent currently in the United States (with an estimated seven to 11 million of them here illegally) will affect health care and social service systems as they move into rural areas.

Immigrant Health and Social Service Issues

As Hispanics push toward rural areas, have families and grow old, it will demand changes in rural health care.

"In general, this will mean an increased demand for some services, and for communities with limited resources—and most communities do have limited resources—it's going to pose a challenge of resource allocation," Kandel said.

He said readjusting services for the young adults will be one necessary change.

"There are many young Latinos moving to rural communities from big cities and they've been in the country for a long time and have legal status and so on. As a result of being younger, being at the age of family formation, and consequently of being ready to have children—they're going to demand services that are different than many rural residents who are older. So imagine if you have a sleepy little community, where it's aging more rapidly than up-and-coming urban areas. Then suddenly someone sets up a meat processing plant or a factory within 20 or 30 miles, and Latinos …move here. Well, that hospital that was providing services to that community is now going to have to increase its services offered to a younger population," Kandel said.

Many would-be immigrants are unable to get very far into the United States, but nevertheless incur health care costs. Hospitals and health centers near the U.S. border must treat those who have suffered injuries while trying to cross into the United States, regardless of their ability to pay. Only if illegal immigrants have been officially taken into custody by the U.S. Immigration and Customs Enforcement (ICE, formerly the INS) will ICE reimburse the hospital for services.

Even though border hospitals are not being overrun by immigrant patients, the costs are substantial.

In testimony before the National Advisory Committee on Rural Health in 2002, George Hooper, M.D., then CEO of Southeast Arizona Medical Center in Douglas, Arizona, said that from August 1995 through February 2002, the hospital had written off more than $9.5 million in charges due to treatment of undocumented aliens and other foreign nationals. The hospital was averaging about 23 to 24 no-payment patients per month in

"There are many young Latinos moving to rural communities from big cities... they're going to demand services that are different than many rural residents who are older."

— *William Kandel, USDA.*

2002. Michael Carter, the center's current CEO, said that the hospital lost $400,000 in 2005 due to treatment given to illegal immigrants.

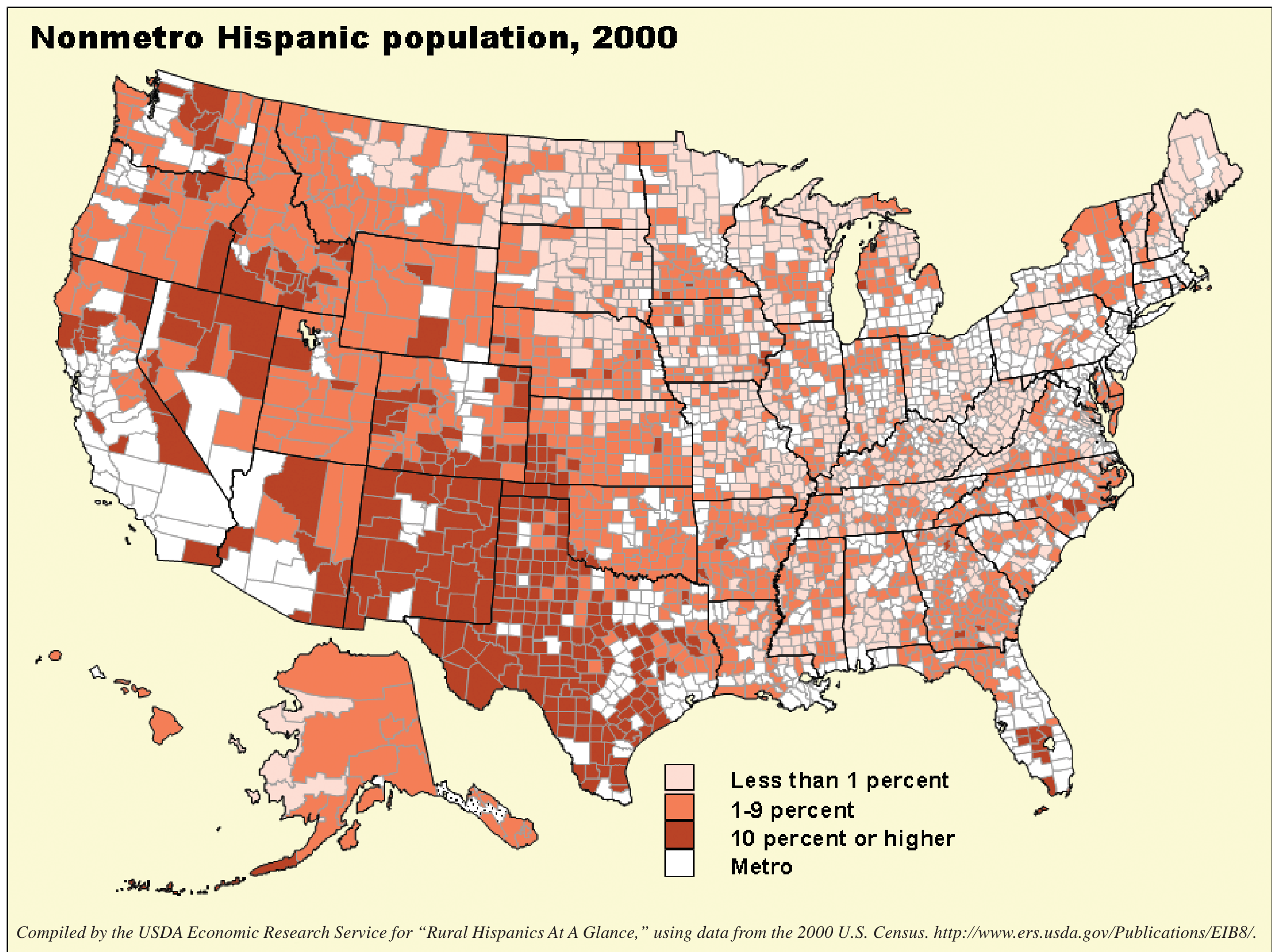
According to the United States/Mexico Border Counties Coalition, in 2000, U.S. border hospitals reported a total loss of $189.6 million in providing uncompensated emergency care to undocumented immigrants; this comprised almost 23 percent of total unpaid care provided.

The Centers for Medicare and Medicaid Services (CMS), through Section 1011 of the Medicare Modernization Act, is currently providing $250 million a year to eligible providers for emergency health services given to undocumented and other specified aliens. The money is allocated to states based on the number of illegal immigrants and apprehensions of illegal immigrants in those states. For 2006, Arizona was allocated $47.6 million, California, $66.6 million and Texas, $46.9 million.

Some say granting immediate amnesty to the immigrant population and making them eligible for federal assistance would help rural health systems financially, but it would hurt the federal budget.

"If we were to legalize the population as is currently being debated, the fiscal burden on the federal government would triple—that's what we estimate—because, they would be eligible for all services. Right now, the burden caused by illegal immigration is about $10.5 billion on the federal government, and that would increase to about $30 billion because they would have more access," said John Walhala, a researcher with the Center for Immigration Studies (CIS). CIS is an independent, non-partisan organization that examines the impact of immigration on the United States.

For now, federally funded health centers are helping lift some of the financial burden off small rural hospitals. These centers, which include community health centers, migrant health centers, homeless health centers and public housing health centers, are able to help uninsured people, both new immigrants and citizens, to get the care



Compiled by the USDA Economic Research Service for "Rural Hispanics At A Glance," using data from the 2000 U.S. Census. http://www.ers.usda.gov/Publications/EIB8/.

HEALTH FACTS ON HISPANIC IMMIGRANTS

- Hispanics have the highest uninsured rates of any racial or ethnic group within the United States.
- Hispanics have higher rates of obesity than non-Hispanic whites.
- Mexican-American adults are two times more likely than non-Hispanic white adults to have been diagnosed with diabetes by a physician.
- In 2001 Hispanic women were 2.2 times as likely as non-Hispanic white women to be diagnosed with cervical cancer.
- Mexican-American mothers were 2.6 times more likely than non-Hispanic white mothers to begin prenatal care late—in the third trimester or not at all.

Source: U.S. Department of Health and Human Services, Office of Minority Health.

they need without draining the hospitals.

"Health centers, by law and by mission, serve everyone regardless of ability to pay—that's the requirement," said Craig Kennedy, director of federal affairs for the National Association of Community Health Centers. "We do not check immigration status or residency status because the mission is to deliver primary care and to keep folks healthy. If they don't come to us, they end up in emergency rooms and drive up health care costs."

Kennedy says studies have shown that a patient using a health center decreases his or her health costs by 30 percent, because of preventive primary care. He says this is especially significant in serving the migrant populations who follow harvest work across the country.

"On documented migrant workers—Hispanic workers who are here legally—when they're on the farm working, they may actually be eligible, in some instances, for Medicaid. However, because they're migrants and they cross state lines, and because Medicaid is state-specific, there've been challenges," Kennedy said. "The sheer act of moving around the country from state to state invalidates the Medicaid portability. And so health centers are forced to serve these Medicaid individuals as uninsured folks and receive no reimbursement for their care. While they should be insured, they oftentimes are not insured, and have a high percentage of uninsured people despite many being eligible for public assistance. So, even on the documented side, there are insurance challenges."

Patient insurance coverage is vital because it can make or break a health center.

"In general, a new health center [federal] grant is $600,000. And we've historically seen health centers serve about 40 percent uninsured. You hope that the rest of your patients are on Medicaid or privately insured or on Medicare or you get state grants or some other payer source comes up. The grant doesn't change even if a large influx of uninsured people show up at your door," Kennedy said.

So if health centers are required to treat everybody, including illegal immigrants, how do they stay in business?

"That's the trick," Kennedy said. "It's trying to make sure that your revenue sources meet up with your expenses, and that's very difficult."

CIS has reported that legal and illegal immigrants in 2004 were more than twice as likely to be uninsured as native-born citizens. More than 50 percent of immigrants from Mexico, Guatemala and Honduras were uninsured. CIS attributes the low rates to the immigrants' lower levels of education, which results in their working in low-skill jobs that are less likely to offer insurance. The lack of insurance among illegal Hispanic immigrants is of special concern because many work in hazardous jobs including construction, landscaping, agriculture and meatpacking.

But some say lack of insurance is not much of a problem for new immigrants.

University of California Los Angeles professor Steven P. Wallace, whose research has looked at aging issues and health care equity among minority populations (see "Spotlight on Research," Page 14), says that new immigrants are generally young and in good health when they arrive. He said they don't pick up poor health habits until they've been in the United States a few years.

"It's pretty well documented that immigrants are the healthiest part of the population in the receiving countries. If you look at death and disease rates, recent immigrants are healthier than Americans of the same age," Wallace said.

He says the process of crossing the border is one reason immigrants are healthier.

"With the way the border has clamped down, and you're undocumented, you have to be healthy enough to walk through the desert or survive in somebody's trunk, or go through a very physically demanding ordeal to get across the border. Even if you're a documented immigrant, health problems make it difficult to travel. So on the physical side, along with the psychological component of being an immigrant coming to a new land, you have to

HISPANIC MENTAL HEALTH

Hispanic immigrants can neglect their mental health until conditions spin out of control.

"One problem is that I think they kind of hold to themselves," said Pat Whitmore, a nurse in Marshalltown, Iowa.

Whitmore said the older adults have more trouble because of the language barrier and feel they're too old to learn English. He said younger immigrants tend to know more English.

Homesickness and the ordeal of moving to a new state, much less a new country, can undoubtedly be a traumatic experience for a family. Immigrants who come to the United States, especially from Mexico, often have limited resources to start their new lives. They also face unrelenting stigmas regarding their culture, ethnicity and immigration status. As a result, stress and homesickness may affect Hispanic immigrants much more than they realize.

The American Psychiatric Association (APA) says that Hispanic adolescents have more suicidal ideation and attempts proportionally than non-Hispanic whites and blacks. Studies have found that Latino youth experience proportionately more anxiety-related and delinquency problem behaviors, depression and drug use than do non-Hispanic white youth.

Among Hispanic Americans with a mental disorder, fewer than one in 11 contact mental health specialists, and fewer than one in five contact general health care providers. Among Hispanic immigrants with mental disorders, fewer than one in 20 use services from mental health specialists, and fewer than one in 10 use services from general health care providers.

Of Hispanic adults, 36 percent of men and 53 percent of women reported moderate to severe depressive symptoms.

Several web sites provide more information on Hispanic mental health issues:

- *Surgeon General's Report: Mental Health Fact Sheet, Latinos / Hispanic Americans*. http://www.mentalhealth.samhsa.gov/cre/fact3.asp.

- APA launched the Hispanic Mental Health Initiative in 2005—an effort to make information about mental health treatments and resources available in Spanish. The web site for the Initiative offers links to APA materials and as well as to other relevant web sites. http://www.healthyminds.org/hispanicmh.cfm.

- The U.S. Substance Abuse and Mental Health Services Administration (http://www.samhsa.gov/) provides a list of national mental health helplines in Spanish at http://store.mentalhealth.org/espanol/lineas.aspx.

- In addition, a recent book looks at mental health issues among recent Hispanic immigrants. *Mental Health Care for New Hispanic Immigrants*, published simultaneously as the *Journal of Immigrant & Refugee Services* (Vol. 3, Nos. 1 and 2, 2005), examines psychosocial stressors, psychiatric diagnoses, and use of services among undocumented immigrants. More details are available at http://www.haworthpress.com/store/product.asp?sku=5470.

be a little more aggressive and a little more self-sufficient than the average population," Wallace said. "But, you do see changes over time. The standing joke in the health field is that acculturation is bad for your health. The longer you are in the United States, the unhealthier your habits become."

Once Hispanic immigrants get established, they work on preventive care for their families, but are lax about taking care of themselves.

Pat Whitmore, a nurse in Marshalltown, Iowa (see "Immigration Integration," Page 7), once asked a couple of his fellow Hispanic employees why Hispanic adults never come in and get immunized against the flu. He said, "they're like 'no, no we don't like shots,' but I said 'but yet you make the children come in and the children are fully immunized.' 'Yes, we have to take care of our kids,' was their response. That's their culture—they focus on their families and not themselves."

In fact, the U.S. Department of Health and Human Services reports that in 2002, Hispanic adults ages 65 and older were 30 percent less likely to have received the influenza shot in the past 12 months, compared to non-Hispanic whites of the same age group. And Hispanic adults ages 65 and older were 50 percent less likely to have ever received the pneumonia shot, as compared to non-Hispanic white adults of the same age group. The department confirms that Hispanic children ages 19 to 35 months had comparable rates of immunization for hepatitis, influenza, MMR and

polio compared to non-Hispanic white children.

When adult immigrants focus on finding work and put their health needs on the back burner, they start putting pressure on health care facilities.

"Immigrants come here primarily to find work and they don't come here with the primary intent of taking advantage of our welfare system. But, because they're relegated to jobs that pay very little, and they have low education levels … they require a lot of public services primarily in the form of emergency health care," Walhala said. "Because they're illegal, they don't have access to all of the services that citizens or legal permanent residents would."

CIS also has reported that immigrant households in the United States are more likely to use welfare—Temporary Assistance to Needy Families (TANF), food stamps, Supplemental Security Income (SSI), and Medicaid—than native-born households. In 2001, 14.6 percent of native households used some type of welfare compared to 22.7 percent of all immigrants and 24.3 percent of illegal immigrant households. CIS also found that more than 24 percent of immigrant households are on Medicaid, compared to 14.8 percent of non-immigrant households.

Even though the numbers show that Hispanic immigrants are more likely to use welfare, they often don't have a choice.

"They don't make a lot of money, yet just like anyone else they require services. Our immigration policy is a 19th-century policy for a 21st-century economy. In many ways, Mexican immigrants are very similar to their 19th- and 20th-century counterparts. Before, native-born Americans were similar in education levels, skill levels and in what jobs they could do compared with incoming immigrants. Now, immigrants are at a much bigger disadvantage and therefore require a lot of services in our advanced welfare system," Walhala said.

GET CONNECTED

For more information on the people and sources described in the previous article, see the following web sites:

- The USDA Economic Research Service maintains a Briefing Room web site on Race and Ethnicity in Rural America at http://www.ers.usda.gov/Briefing/RaceAndEthnic/.
- National Advisory Committee on Rural Health and Human Services (formerly NAC), http://ruralcommittee.hrsa.gov/.
- United States/Mexico Border Counties Coalition. http://www.bordercounties.org/.
- Centers for Medicare and Medicaid Services has a web site on "Service Furnished to Undocumented Aliens," which links to information on Section 1011 regulations. http://www.cms.hhs.gov/UndocAliens/.
- Center for Immigration Studies, http://www.cis.org/.

In addition, these resources are available for learning more about Hispanic/Latino health and human service issues:

- The Rural Assistance Center (RAC) offers these relevant information guides online: Migrant Health, http://www.raconline.org/info_guides/public_health/migrant.php; Minority Health, http://www.raconline.org/info_guides/minority_health/; and Cultural Competence and Limited English Proficiency, http://www.raconline.org/info_guides/culture/. RAC also helped launch a United States-Mexico Border Health web site dealing with issues specifically related to the border area. The site is http://borderhealth.raconline.org/.
- The U.S. Department of Health and Human Services Office of Minority Health web site contains information on funding, data, statistics, cultural competency, health topics and minorities. http://www.omhrc.gov/.
- National Center for Minority Health and Health Disparities is part of the National Institutes of Health. http://www.ncmhd.nih.gov/.

Immigration Integration Working in Two Communities

by Hope Hanson

Many rural communities struggle emotionally, financially and culturally with the influx of new Hispanic residents, but a small Iowa community and a Texas border town are being proactive in making their corners of the world happier, healthier places for all who want to be there.

The traditionally white **Marshalltown, Iowa,** population 26,000, has a Hispanic population of 12 percent. Iowa has an overall 3 percent Hispanic population.

"The newest immigrants to Iowa are here to stay," said city councilman John Cahill. "Without the influx of Hispanic immigrants, our community would have lost population."

He said most new Hispanic residents arrive in Marshalltown to work at the Swift & Company meat processing plant, which employs about 2,100 people. Cahill estimates that 75 to 80 percent of workers on the line are Hispanic. He said he thinks Iowa is attractive because of family-based traditions, education and good housing.

"The increased population works to our advantage. For instance, the school district receives more federal and state funds because they serve a greater number of children. Without the immigrant population, the school numbers would have declined, the base overhead to run the school would have remained the same and less money would have been available to the schools to improve education. The burden would have fallen exclusively on the existing population and property taxes," Cahill said.

In addition to schools, the town's main medical facility, Marshalltown Medical and Surgical Center, is busier.

"I think that there are parts of our hospital that wouldn't be nearly as thriving if we didn't have the Hispanic population," said Marshalltown social worker Susan Hughes. "I would imagine that almost half of our births are from Hispanic mothers—at least a third."

United Medical Centers and other local agencies sponsored a health fair in Eagle Pass, TX on May 9th to help enroll Seniors in Medicare Part-D.

Marshalltown Medical has not had a problem with uninsured immigrants or unpaid bills, mainly because those who make it to this remote Midwest town arrive with purpose—either to take a job or to join family already there.

"Our financial crunch comes from the policy of employers who have a waiting period for health insurance for new workers. That time frame for any young person—and most of the immigrant population is young—can be a problem," said Cahill, who is also the medical center's director of marketing. "While they are waiting to be covered by insurance, they may get injured playing sports or pregnant or ill, so when they get insurance, they have a preexisting condition that's not covered."

Cahill said Marshalltown's federally qualified health center (FQHC) takes some of the burden off the hospital. Primary Health sees 19,000 patients a year through sliding scale fees.

"They have bilingual staff and they get a federal subsidy to treat the uninsured. The clinic was an outgrowth of the hospital's Maternal Health Clinic that we funded ourselves for several years to ensure all women had access to prenatal care," Cahill said.

For emergencies, which can be expensive even for those who are insured, Marshalltown's EMS team doesn't consider a person's insurance status.

"We take care of people. We don't care about insurance. We're the only hospital in this rural community. We treat first, and ask for insurance later," said Pat Whitmore, a registered nurse and director of Marshalltown Medical's emergency services.

While the majority of Marshalltown's Hispanic immigrants are most likely seeking eventual citizenship, it can be many years before that happens. Gaining U.S. citizenship is complicated—like finding the way through a thick forest without a compass. In the meantime, immigrants must fend for themselves, and in some cases, their lives.

"Treating illegal immigrants can be tricky because many of them pass

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Rethinking Human Services

by Tom Corbett, Ph.D.

What is Service Integration?

Earlier articles in this series examined some unique characteristics of rural communities that warranted innovative service delivery strategies; discussed ideas for getting started; and outlined some of the challenges of doing what we call systems integration. The last article examined how institutional culture clashes can be a barrier to successful integration, and I indicated that I would continue this discussion in the future.

Recent work in two states, however, prompts a return instead to a fundamental issue—what is service integration?

In Minnesota, for example, state officials have initiated a number of pilot initiatives to work with long-term welfare families. As project planning and implementation evolved, it became increasingly apparent that confusion existed about what constituted substantive integration, as opposed to merely cooperating better within the existing service environment of discrete and separate programs.

The Wisconsin pilots focus on blending welfare and workforce systems, already integrated to some degree, with more traditional child welfare and human service systems. Again, some local sites were satisfied to hire additional staff to help challenged families navigate the existing systems while other sites struggled to blend separate systems together in more comprehensive and fundamental ways.

State and local officials continue to ponder when they will achieve integration and how they will recognize it when it happens. A key to advancing the service integration agenda, it would appear, involves developing an accepted understanding of what service integration means.

Most of us do have a sense of what the existing social welfare system looks like—an array of potentially related programs and systems that deliver distinct benefits or services to narrowly defined target populations. Each program, or system, can be thought of as representing a service silo—a separate and distinct funnel through which money, regulations, and professional norms and expectations flow. As a whole, the "system" of services available to challenged families appears complex, confusing, redundant and incoherent.

Based on continuing work with a number of sites, I would argue that any consensus definition of service integration must focus on the interaction between intended beneficiaries and the new service delivery environment. As a starting point, consider the following as attributes of a fully integrated system.

- Families have:
  - Access to a broad range of services and supports.
  - Ability to engage the system at different levels of intensity.
  - Access to individualized service plans that accommodate multiple issues simultaneously and respond to changing circumstances.

- The focus is on achieving overall goals for individuals and families rather than those of a particular program.

- Public programs are viewed as one part of an overall system designed to support achievement of individual, family and community goals.

Thinking about service integration in this way shifts the perspective from a focus on administrative processes and organizational structure to ways in which target families are impacted. This subtly shifts our view from what we do to bureaucracies to what we do for people—a nuanced yet critical shift.

In achieving the above, seldom do sites go immediately from uncoordinated silos to full integration. Rather, they are likely to go through several iterations through which they achieve *levels* of connectedness.

Reforms at *Level 1* rely heavily on better communications across existing programs and systems. Steps are taken to better acquaint participating programs with each others' rules and services; cross-training may take place; new people may be hired to help families take advantage of existing programs, or new technologies may expand what staff and customers know about each others' domains. But such changes seldom result in formal or widespread transformations in existing protocols or service technologies.

At *Level 2* reform efforts move into more formal, sometimes contractual agreements across participating programs. Sites at this level begin to develop missions and outcomes that cut across traditional program lines. They begin to formally develop service and management protocols that blend important functions such as diagnosing customer needs at the front end, tracking families along appropriate service paths or monitoring progress. Still, participating programs retain much of their individual identities and core management functions (e.g., distinct budgets and program identities).

At *Level 3* the separate programs and systems begin to lose their

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Look What's Coming

by Wayne Myers, M.D.

Rural American Energy

The mother of all questions facing rural communities is: "Why are you here?" The recent jump in the cost of energy is likely to change the answer to that question along with many elements of rural community life.

All our energy except nuclear and geothermal comes from the sun. For the last century we've been using sun energy stored in the form of coal and oil. The sunshine involved fell on the earth long ago, and was used by plants and algae to tie huge amounts of carbon from the atmosphere into long chemical chains that were buried in the ground. We're now using that stored energy and dumping the old carbon back into the air. For most of the past century the costs of getting coal and oil out of the ground were very low, but now oil consumption is outrunning discovery and production. It will be more and more expensive to use old energy out of the earth's oil tank. We will be looking to new energy shipments from the sun to run our society.

The shortage argument applies only to oil. We still have lots of coal, which is the largest energy source of electrical power generation in this country. Pressure to cut coal consumption springs from environmental concerns rather than global shortage. Americans are finally acknowledging the significance of global warming caused by burning coal and oil and putting the carbon dioxide back in the atmosphere. So, for different reasons, we are looking for alternatives to our two largest sources of energy.

This is a very big deal for rural areas. Why? Unlike coal and oil, sunshine and wind are very widely distributed resources. The harvesting of incoming sunshine can take many forms. One or more of these forms are potentially important for much of rural America. Growing corn for fermentation to ethanol, growing sunflower or canola for biodiesel oil, managing banks of silicon solar cells, cutting firewood, maintaining wind-powered electrical generators, getting your home hot water from solar collectors on the roof….all are ways to harvest current solar energy. (Yes, it's the sun that makes the wind blow).

What are the implications for rural communities? New forms of energy harvest mean new, geographically dispersed jobs. Like most jobs in agriculture, forestry and energy extraction, they will be physically demanding, relatively dangerous and appropriate for young workers. If these projects and jobs are well managed, they will be sustained over time. Stable jobs for young workers mean families in self-sustaining communities.

Let's look at some of the other implications of higher cost energy. Telecommuting becomes more attractive. As the demand for broadband telecommunications increases in rural communities so does its availability. At the Myers home in rural Maine we will be able to tie into wireless broadband before cable reaches our country road. Expanded rural demand may finally give rural hospitals and clinics affordable Internet service. It is even possible that high energy and transportation costs will gradually reverse the suburbanization of the country.

Mass transit will become more attractive. Where we live in Maine long-distance bus and train services are being rebuilt. Truck transportation uses more fuel to move a ton of freight than rail or water shipping and will lose some of its advantage. One Maine school district is converting from oil heat to wood chips to save money.

As trucking and energy costs escalate some current farming practices may look a bit strange. Will we continue to grow the corn in Iowa using petroenergy-based fertilizer, truck the corn to North Carolina, feed the hogs and lament the problem of disposing of all that hog manure? In the rest of the world the animals live next to the croplands, and that's where the nutrient–rich animal waste returns. As I write this I'm watching my neighbor prepare his field to sow corn. For the first time since he leased the field six years ago he's spreading manure from his own dairy cattle instead of commercial fertilizer.

In general, as transportation costs rise, some economies of scale disappear. Conversely, local production of fruit, vegetables, lumber and livestock feeds becomes more competitive. The Leopold Center at Iowa State University estimates that it costs eight ounces of fuel, 15 to 20 cents worth, to ship an apple from Washington State to Des Moines. This new cost advantage will help small-scale part time farmers sell their produce locally.

What about rural communities and health care? Transportation for health care is a major problem for the elderly, who use a large proportion of rural care. This problem will get worse. Wages for the least well-paid hospital employees will rise in recognition of their commuting cost increases. But over a period of a few years rural hospitals may be called upon to assume new roles. In many communities they are the largest nongovernmental organizations.

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by Hope Hanson

U.S. Pacific Islands

Helping Hearts

Most people in the U.S. Pacific Islands know as much about automatic external defibrillators (AEDs) as they do about snowblowers.

Bill Rich wants to change that. Rich, a certified emergency medical educator with the International Emergency Planning team at the Centers for Disease Control and Prevention (CDC), is working to inundate the region with a flurry of defibrillator equipment, and educate residents so they can train others and save more lives.

"The islands have limited capacity to respond to emergencies," Rich said. "I have great hopes that these devices will soon be saving lives in the island populations."

When AEDs are available and used quickly, most sudden cardiac arrest victims survive. Approximately 163,000 out-of-hospital sudden cardiac arrests occur annually in the United States, according to the American Heart Association.

In response, the CDC developed the Pacific Emergency Health Initiative in 2000. The U.S. Health Resources and Services Administration's (HRSA) Office of Rural Health Policy also has supported the cause through the Rural Access to Emergency Devices Grant Program.

Bill Rich, from the Centers for Disease Control and Prevention, says the success of its AED training program in the Pacific Islands depends on "locals teaching locals."

Training on the use of the AED has been included in Rich's emergency classes, which he has taught in all six of the U.S. Pacific Island jurisdictions of Palau, the Federated States of Micronesia, the Northern Marianas Islands, Guam, the Marshall Islands and American Samoa.

"When HRSA initiated the Rural AED Program grants, a strong concern was that the islanders be able to continue the training of CPR/AED providers after the close of the grant," Rich said. "We worked out a plan to offer instructor training, and in February I taught two-day instructor classes in Palau, Saipan and Pohnpei. Now there are 37 new indigenous instructors who can train and certify CPR/AED providers within their own jurisdictions."

Rich said teaching Pacific islanders to help their fellow citizens will snowball into widespread AED knowledge.

"I feel strongly that, with locals teaching locals, this project will be able to sustain itself in the future," he said.

For more information on the CDC's Pacific Emergency Health Initiative, see http://www.cdc.gov/nceh/ierh/PEHI.htm.

AED Funding Offered

Support is available for those seeking to place AEDs within their communities.

A useful place to start is the Rural Assistance Center's (RAC) Emergency Medical Services information guide at http://www.raconline.org/info_guides/ems/. Several federal funding opportunities are mentioned within the guide.

RAC also suggests checking with state offices of rural health. There is a list at http://ruralhealth.hrsa.gov/funding/50sorh.htm. State offices may know of funding programs for AEDs in their state.

RAC information specialists can also do a comprehensive Foundation Directory search for organizations providing EMS equipment. Call RAC at (800) 270-1898.

Special Series: Technical Assistance Centers

Editor's note: This is the third in a series of articles on rural health technical assistance resources around the country funded by the federal Office of Rural Health Policy (ORHP). The first article (see The Rural Monitor, Fall 2005) gave an overview of what is meant by technical assistance. For a complete list of technical assistance resources available through ORHP, see http://ruralhealth.hrsa.gov/links/TACenters.asp.

National Center for Frontier Communities

Use of the term "frontier" did not disappear with the days of the Wild West— it is alive and well at the National Center for Frontier Communities (NCFC). (The center formerly was called the Frontier Education Center).

"Frontier often generates negative connotations of an untamed America," said Carol Miller, NCFC executive director, "and part of our mission is to dispel that myth and embrace this heritage."

The term "frontier," as opposed to "rural," carries many definitions within the federal and rural health worlds. "Frontier" is most widely known as an area that is home to fewer than six people per square mile. "Rural" is generally considered fewer than 1,000 people per square mile, although classifications vary greatly. Collectively, there are nine million people living in U.S. areas designated as frontier.

"Only about 3 percent of the U.S. population is frontier, but they make a significant contribution to the American society and economy," Miller said.

The NCFC was developed to help policymakers, organizations and frontier communities improve frontier economies and programs, including health care and human services.

NCFC staffers Karen Sweeney (l) and Tess Casados greet visitors to their conference exhibit.

"We do policy research and help people find answers to questions they can't find elsewhere," Miller said. "For example, there are a lot of beliefs out there about seasonal population fluctuations in frontier communities and how they impact the health care system, so we've done two papers on that, including one that's just getting published."

According to Miller, frontier areas tend to be less economically diversified than rural. "They typically have boom-bust economies based on one industry," Miller said, such as oil development or ranching. She said volatile oil prices or a single dry year can devastate a frontier community.

NCFC provides technical assistance through its web site, personal responses to inquiries and referrals.

The center's web site (http://www.frontierus.org) gets 10,000 hits a month. If fact finders cannot obtain answers there, they can call the center directly. Many of the calls Miller and her staff receive revolve around grants.

"Someone will call in and say, 'we're writing a grant and our community's so small we can't meet this particular requirement of the grant program. Do you know anything about this?'" Miller said there are several federal grant programs set up for rural communities that inadvertently exclude frontier communities from consideration through the grant guidelines. She believes this demonstrates the need for the government to be aware of the differences between frontier and rural.

"Even programs that sound good [for frontier] can't be utilized by the smallest communities, so we are always trying to raise awareness on this issue," Miller said.

Another current issue the center is working on is Frontier Extended Stay Clinics.

"In the 1980s, it was reported that the hospital model wasn't appropriate for the smallest communities, which needed to be more like a college health station or an infirmary. We've been working on it ever since," Miller said. "Congress finally passed a demonstration of this model in, of all things, the Medicare Modernization Act. The first demonstration project is under way in Alaska and Washington state."

If Miller and her two staff members cannot help with an issue, they have access to a wide network of resources that can help.

"We can refer them to others and hook them up with other people who know more about their

particular topics," Miller said. "We have a strong network of support."

Sometimes the center doesn't need to do any research but to simply offer support.

"A lot of frontier communities get discouraged. Sometimes we just listen to people—I think that's what a lot of technical assistance is," Miller said. "We are very sympathetic because we live in frontier communities also."

For more information about the NCFC, contact Carol Miller, Executive Director, National Center for Frontier Communities, HCR 65 Box 126, Ojo Sarco NM 87521; phone (505) 820-6732; fax (505) 986-5828; e-mail carol@frontierus.org; or visit http://www.frontierus.org.

National Association of Rural Health Clinics (NARHC)

Because rural health care professionals don't always have the time or resources to travel to educational conferences or technical assistance seminars, the National Association of Rural Health Clinics (NARHC) has set up a series of bimonthly, educational teleconference calls.

The teleconference calls provide technical assistance to the nation's network of Federally Certified Rural Health Clinics. Funded by ORHP, the calls began in December 2004 and have covered such topics as cost reporting, billing, program evaluation, recruitment and retention, electronic medical records and Medicare Advantage.

"Each call is generally about a 45-minute presentation with a speaker, and then the last 15 minutes are for questions and answers," said NARHC Executive Director Bill Finerfrock. "It's just as if callers were in a conference room together anywhere in America," he said. "And it's obviously a heck of a lot cheaper than traveling."

Finerfrock said the speakers post their presentation materials on the ORHP web site in advance so callers can have the visuals in front of them during the conference. He said videoconferencing was considered, but limited technological capabilities in many rural areas eliminated that option.

Each call has had more than 50 people participate and/or listen in, with as many as 495 in on one call.

"Additionally, many people go in and view the transcript [on the web] afterward if they are unable to be in on the call," Finerfrock said.

Mary Peterson, director of compliance and billing at Mile Bluff Clinic in Mauston, Wisconsin, is a regular participant in the billing-related conference calls.

"I think as we're confronted with problems in various parts of the country they're everybody's problems eventually. Everybody's viewpoint in the solution is really needed," Peterson said. "These calls are a place to share and to take out what you need to know about particular problems or new billing programs or new regulations or whatever it is."

In addition to hosting the federally funded teleconference calls, NARHC serves as a national advocacy organization dedicated to improving the delivery of health care in rural underserved areas through the Rural Health Clinics (RHC) Program. It hosts the "NARHC Listserve," which is available to both NARHC members and nonmembers. Currently, more than 1,100 people are subscribers to the listserv.

"It's a forum for exchanges and questions," Finerfrock said. "For example, one individual had a patient who was a 20-year-old woman and a foster child. Her [former] foster mother wanted access to her medical records and the clinic was uncomfortable with that and they put out an inquiry out on the listserv. Several people were able to comment and said that at 20, this is an individual whose mother should not have access to the medical records. It would be a HIPPA [Health Insurance Portability and Accountability Act] violation. Here they were able to put something out, get quick feedback from some people who had similar experiences, and get it resolved."

Finerfrock said the listserv covers a range of topics—whatever is on the minds of rural health care professionals.

"Yesterday there was a discussion and dialogue on the value of outsourcing. Do people use outside companies to do their billing and cost reporting, or do they try to do it in-house with existing staff? It [the listserv] is an opportunity to do networking and discuss things—practical issues that you're dealing with on a day-to-day basis," Finerfrock said.

Those wishing to join the teleconference calls may sign up to receive call-in dates and times at http://www.narhc.org/members/orhp_series.php. Transcripts of past calls are available at http://ruralhealth.hrsa.gov/RHC/.

To sign up for the "NARHC Listserve," visit http://www.narhc.org/members/members_listserve.php. (Sign up for "NARHC News").

For more information about NARHC, contact Bill Finerfrock, Executive Director, National Association of Rural Health Clinics, 426 C Street NE, Washington DC 20002; phone (202) 543-3048; fax (202) 543-2565; e-mail info@narhc.org; or visit http://www.narhc.org/.

For more information on rural health clinics, see the RAC's "Rural Health Clinics Information Guide" at http://www.raconline.org/info_guides/clinics/rhc.php.

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their green card around to friends and family who don't have one," Whitmore said. "I've told them that from my perspective, that's very dangerous because if the person who really owns the card has an allergy say, to penicillin, and then he gives the card to a friend, and he comes here [to the emergency room], we could kill him with the wrong medication. But they say it's such a tedious job to get the paperwork to become a legal U.S. citizen that it's the risk that they have to take."

While immigrants aren't draining the rural health care system in Marshalltown, there is one expense directly related to recent immigrants: language interpreter services.

"The hospital has several [Spanish] interpreters, one of whom is on call 24/7, plus we have several employees in the building who are bilingual," Whitmore said.

Hughes, who supervises the interpreters, said they are tested and screened before being hired.

"There's no certification in Iowa at this point as far as interpreters so they have to pass our [own] written and verbal tests," she said.

Unlike Marshalltown, the border town of **Eagle Pass, Texas,** doesn't have this problem.

"I would say 95 percent of our staff are fluent in Spanish," said George Kypuros, administrator of United Medical Centers, an FQHC and migrant health center. "Most of our staff are Hispanic."

United Medical Centers (UMC) provides health services to the people of Maverick, Val Verde and Kinney counties—designated Medically Underserved Areas and Health Professional Shortage Areas. UMC employs about 235 people, including 26 medical providers. Fortunately, Eagle Pass has not had to care for many people injured trying to cross the border from Mexico into the United States.

"A lot of people have now established themselves. They're formerly from Mexico and they have relatives here and have established a residence here [meaning they have an address and utility bills]," Kypuros said.

UMC treats undocumented people, but does have some stipulations.

"Our criteria for the sliding scale discounts is that they must be residents of our counties. But we will treat everyone who walks in the door. Everyone. I don't care if they're from New York, Africa, Egypt or California," Kypuros said.

He said health care facilities are not responsible for monitoring people who are in the country illegally. Their priority is helping people.

"We don't consider ourselves having a responsibility of checking their immigration status," he said.

Kypuros says helping everyone is not placing UMC in a financial crunch.

"I don't know how many illegal immigrants we have, because when we apply the discounts, it's because we have proof that they are residents of our counties, and that they're low-income. If someone's not telling us the entire truth, it's hard for us to tell. But, for those people who cannot prove that they're low-income or residents of this county, we simply don't give them a discount, but we do serve them and charge the regular fees," he said.

Like Marshalltown, Eagle Pass is a small, close-knit community seeing past the national immigration debates and into the eyes of friends and neighbors.

"In our border community, many of us have friends and relatives that are coming in from Mexico, and we are very sympathetic to them for the most part. I would say that in our border communities we feel strongly that they're part of the family. I know some of these Hispanic members go to areas where there are a lot of non-Hispanics, and they're viewed differently, but I would say that here, for the most part, it's people that we know or they're somehow related, or they're friends or compadres or whatever," said Kypuros, who has his own friends and family in Mexico.

In Marshalltown, the stigma against Hispanics and immigrants is fading.

"There is a difference between talking with people about immigration and talking with them about their neighbors. They hate the thought of illegal immigration, dual language signage, and so forth, but they love that nice family who moved in next door to them—the people they interact with and who help them with neighborhood projects or who have the cute kids," Cahill said.

Whitmore said Marshalltown is beginning to understand that helping the new population is only going to help their community in the long run.

"There are still a lot of stigmas in this community, but I think if they [Hispanics] want to live here and work here and help support our community, that's great," Whitmore said.

Spotlight on Rural Research

by Hope Hanson

Mexican Immigrants Vulnerable to Health Disparities

Two heads are better than one—or, in the case of a recent university research project—two countries.

University of California, Los Angeles (UCLA) researcher Steven P. Wallace and his team released a collaborative report with Mexico, titled *Mexico-United States Migration Health Issues,* in October 2005.

"This document brings to light how vulnerable Mexican immigrants are when it comes to health care, especially regarding health insurance coverage," said Wallace, associate director of the UCLA School of Public Health's Center for Health Policy Research.

The idea for the report originated when Wallace and his team were in Mexico a few years ago for California's Binational Health Week, which is held simultaneously with Mexico's National Health Week. Events take place annually in selected regions of the United States and Mexico.

"A few months later the team was in Mexico at another conference and we had stopped and talked with Elena Zúñiga, who is the director of CONAPO [Consejo Nacional de Población, Mexico's demography bureau], simply as an exploratory 'would you be interested in doing some binational work.' So, that led to this collaboration," Wallace said.

The report finds that the naturalized Mexican immigrant population health insurance coverage rate of 70 percent is only slightly lower than that of Mexican-Americans at 73 percent. Coverage for both groups is far behind that of the U.S.-born white population at 87 percent.

Most people's health insurance in the United States is private and based on employment. Mexican immigrants work primarily in low-skill and low-paid jobs when they first arrive, where health insurance is often not offered as an employee benefit. "Because a large proportion of Mexican immigrants in rural areas work in agriculture, the health insurance gap will be even larger," according to Wallace.

"There are a lot of health issues common on both sides of the border, so it makes sense to try to highlight some of the health issues and to establish the health programs binationally," Wallace said.

He said that through this work, Mexico is paying more attention to the access to health care of its citizens who migrate north. It has helped fuel the strong interest on both sides of the border in establishing and promoting low-cost health insurance that can be used by Mexican immigrants and their families, with most of the high-cost services being provided in Mexico. It has also provided additional support for other health efforts aimed at immigrants.

"In Mexico, there's now an entire office [set up] for Mexicans living abroad. They have a health program called 'Go Healthy, Return Healthy.' In Mexico, they don't call people who go to the United States 'Mexican immigrants' like people who've left the country. They call them 'Mexicans in the U.S.' So there's still a feeling that people who emigrate to the U.S. are still Mexicans—still belong to Mexico," Wallace said.

The report is printed in both English and Spanish and is available at http://www.healthpolicy.ucla.edu/pubs/publication.asp?pubID=155.

Other Studies

• A study published in the April issue of the *Journal of Immigrant and Minority Health* found that many Hispanic farmworker families in North Carolina live in inadequate housing, placing them at higher risk of exposure to disease, toxins and overcrowding. The research, led by Thomas Arcury of the Wake Forest University School of Medicine, indicated that among farmworkers in the study, 36 percent to 46 percent lived in crowded conditions, compared to an estimated 3 percent of the rural population. An abstract

Additional Resources on Minority Health

- The University of Pittsburgh's Center for Minority Health of the Graduate School of Public Health and the University of Pittsburgh Library System have joined to develop the Minority Health Archive as an online repository for minority health documents. The archive is at http://minority-health.pitt.edu/.
- The U.S. Department of Health and Human Services Agency for Healthcare Research and Quality has a search engine for finding numerous research references on minority health at http://www.ahrq.gov.
- Minority Health Project, http://www.minority.unc.edu.
- The Center for Research on Minority Health http://www.mdanderson.org/departments/crmh/.
- Midwest Latino Health, Research, Training, and Policy Center http://www.uic.edu/jaddams/mlhrc/mlhrc.html

of the study, which was funded by the National Institute of Environmental Health Sciences and the National Institute of Occupational Safety and Health, is available at http://springerlink.metapress.com/link.asp?ID=70J3768157G4H032.

• *Beyond Gateway Cities: Economic Restructuring and Poverty Among Mexican Immigrant Families and Children.* Zhenchao Qian, Martha L. Crowley and Daniel T. Lichter. June 2005.

This study from the Rural Poverty Research Center finds that Mexican workers, especially new immigrants, had much lower rates of poverty in the new destination regions and rural areas than their counterparts that remained in traditional areas of population concentration—the Southwest.

http://www.rprconline.org/WorkingPapers/WP0507.pdf.

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distinct identities. Core functions such as budgeting, personnel decisions, determining and monitoring success, and so forth, become increasingly blended. Most importantly, customers and the public are less able to determine who is helping them and to which systems the helping agents belong.

Substantive integration is most likely when customer needs, and not the way bureaucracies are organized, become the driving force that shapes what the service system looks like and how it functions.

Tom Corbett has emeritus status at the University of Wisconsin-Madison and is an active affiliate with the Institute for Research on Poverty where he served as Associate Director. He has worked on welfare reform issues at all levels of government and continues to work with a number of states on issues of program and systems integration.

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They may be called upon to join, or lead, in developing new local capacity in areas such as transportation and even utilities. The hospital may find itself selling heat to neighboring homes and businesses from its large new alternative fuel heating plant.

A rural hospital or clinical practice is rarely stronger than its hometown. If young working families are staying in rural America will more seniors choose to age in place? Perhaps rural communities will be able to hold both young families and senior citizens, reverse the demographic dwindles, and stabilize rural communities and services.

There will certainly be stresses and hardship. In some respects we'll look a bit more like Europe where most countries keep fuel prices high for domestic policy reasons. Trucking families, interstate towns and families engaged in high input agriculture will suffer while new ethanol plants—and jobs—are springing up in small towns. As my old mother used to say, "It's an ill wind that blows no one good."

Wayne Myers, a pediatrician, founded the University of Kentucky Center for Rural Health and served as its director. He also served as director of the Office of Rural Health Policy in the Department of Health and Human Services' Health Resources and Services Administration. He is a past president of the National Rural Health Association and currently serves on its Board of Trustees.

Rural Assistance Center

www.raconline.org

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Call for Input

Something newsworthy going on in your part of rural America? Send a one-paragraph summary to the editor at: editor@raconline.org

Rural Assistance Center

Current Information Guides, May 2006

http://www.raconline.org/info_guides/

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