

The RURAL MONITOR

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War Has Big Impact in Rural Areas

by Candi Helseth

The quiet plains of North Dakota are far removed from the Iraq and Afghanistan battlegrounds, but like many other health care facilities across the nation, North Dakota's rural facilities are feeling the pinch of war. Rural health care facilities, many of them already in financial jeopardy, experience added stress when they lose personnel who are deployed to Iraq and Afghanistan.

"These areas are already federally designated health professional shortage areas, and health professionals are being taken out of these facilities to serve overseas," said Alan Morgan, National Rural Health Association CEO. "Based on evidence from both the Washington Post and New York Times on the disproportionate share of call-ups from rural areas and the number of calls our office has had about this concern, I think the issue is well documented."

Bill Finerfrock, executive director of the National Association of Rural Health Clinics (NARHC), said numerous clinics facing staffing issues have also contacted his office for assistance.

Dr. Glenn Faith, who retired from his general medical practice near Rochester, Minn., seven years ago, spends a lot of time covering for missing physicians in small-town North Dakota hospitals. "I just can't say no when they call," said Faith, 72. "It's really hard to get doctors to live and work in these relatively remote areas. Rural medicine is barely surviving. The last hospital I was at was losing 2 percent a year every year. Now with their staff being deployed, these small hospitals face extra hardships."

In Wishek, a North Dakota town of 1,200, Faith doubled as a temporary physician and CEO after the 24-bed



Three generations of a family in Wishek, North Dakota—(left to right) Donald Jr., Donald Sr. and John Kosiak—were deployed overseas at the same time. John, a physical therapist, and Donald Sr., a physician, both had to leave their jobs at Wishek Hospital.

critical access hospital hired him to replace a physician, one of only two on staff. The physician was deployed in 2004 and again in 2006. Faith, who also spent one of his temporary stints at a rural hospital in Carrington, N.D., where two physicians were deployed, said the problem extends beyond primary care providers to other hard-to-recruit staff such as ambulance personnel, pharmacists and therapists.

"It's across the board—there's not been one particular medical profession it's impacting," Morgan said. "And all of these professional positions are very hard to fill in rural areas. When you're talking about rural health care, you're talking about existing workforce shortages already being a major problem."

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Current Wishek Community Hospital and Clinics interim CEO Trina Schilling struggles to fill empty positions with temporary replacements.

“We lost a physical therapist to one tour of duty and he’s back now, but may be deployed again,” Schilling said. “He, his brother, and his father—who was the physician we lost twice—were all deployed at the same time at one point. The husband of a lab technician was deployed, leaving her home with four young children. When she was on-call at night, the dietary manager slept at her house or someone had to take her call duty because there was no one to be with her children. Now she’s moved to Arizona.

“It’s really detrimental to small facilities like ours,” Schilling added. “After his second deployment, the physician didn’t return here. We’re still looking for a doctor. There are 44 openings in the state right now. Other professional areas are really hard to fill, too, in these rural areas.”

Only 10 percent of physicians practice in rural areas despite the fact that one-fourth of the U.S. population lives in these areas, according to Rural Healthy People 2010, Volume 2. To meet rural health clinic requirements, clinics must have a physician, nurse practitioner (NP) and/or physician assistant (PA) available at least 50 percent of the time, Finerfrock said. Under federal law, this staffing requirement can be waived up to one year if the clinics demonstrate they are actively recruiting. Recruiting for temporary positions makes a tough job tougher.

“The expectation is that the person deployed will return to his job, so that creates a conflict on how to resolve the issue,” Finerfrock said. “And if it’s a physician who is called out, the clinic then needs to find some type of appropriate arrangement to provide an alternate supervising physician for the PA or NP until the physician returns.

We’ve asked for clarification or guidance on this issue, but we haven’t received anything as of yet.”

Even without the effects of war, rural communities are already at a disadvantage. In addition to smaller numbers of professionals, rural communities have fewer health care organizations and broad variations in what they are able to offer at their local level.

“Unlike most of urban America, there’s precious little back-up in rural America,” said Dr. Mary Wakefield, director of the Center for Rural Health at the University of North Dakota School of Medicine and Health Sciences in Grand Forks, N.D. “We don’t have a lot of second-tier people or elasticity in the local community in terms of additional physicians or additional nurses or EMT providers. So when you call one person up, it can have a huge

impact and it stretches even more thinly the remaining providers.”

Besides having to find replacements, rural clinics may also encounter reimbursement issues that negatively impact their financial status. Finerfrock said a rural clinic that sought their assistance had arranged coverage by an alternate physician while its primary physician served in Iraq. Medicaid refused to cover the clinic’s Medicaid patients because the new physician wasn’t Medicaid-approved.

“If that decision had remained, it would have prevented the clinic from being able to see Medicaid patients,” he said. “These clinics also risk the loss of productivity, which affects them financially too. A new physician doesn’t know the patients as well, and you may have some in that community,” Finerfrock said. “It got

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STATISTICS ON RURAL SOLDIERS

- More than 44 percent of recent U.S. military recruits have come from rural areas. (Washington Post, Nov. 4, 2005)¹
- Nationwide, one in five veterans enrolled to receive VA health care lives in a rural area. 36 percent of all rural veterans who turn to the VA for their health care have a service-connected disability, for which they receive compensation. (American Journal of Public Health, Oct. 2004)¹
- The proportion of veterans living in rural areas in 18 states is higher than the national average of veterans (which is 12.7 percent). These rates include Montana (16.2%), Nevada (16.1%), Wyoming (16%), and Maine (15.9). (“Veterans: 2000 Census Brief,” p. 5.)²
- Rural areas account for only 19 percent of the adult population in the United States, but have suffered 27 percent of the casualties in the Iraq war.³
- Nearly one-half of the military fatalities in Iraq have been military members from cities with populations of less than 25,000. One in five were from towns of less than 5,000.⁴

Sources:

1. Quoted by the Democratic Staff of the House Veterans Affairs Committee, May 2006.
2. Quoted by Hilda Heady in Written Testimony before the Health Subcommittee of the House Committee on Veterans’ Affairs, June 27, 2006. (See <http://www.census.gov/prod/2003pubs/c2kbr-22.pdf>)
3. Quoted by the Carsey Institute, Fact Sheet No. 3, Fall 2006. (See http://www.carseyinstitute.unh.edu/documents/RuralDead_fact_revised.pdf)
4. According to an Associated Press report released in February 2007. (See <http://www.npr.org/templates/story/story.php?storyId=7492231>).

Rural Vets Return Home to Face New Battles

by Candi Helseth

Jonathan Schulze came back from Iraq a broken man. Schulze had been injured twice in combat in Iraq, but it was his mental anguish that eventually killed him.

A recipient of the Purple Heart, Schulze came from a military-minded family. His father served in Vietnam and an older brother, Travis, served overseas. Schulze was involved in heavy combat in Iraq—35 members of his Marine unit died. Following his discharge in 2005, he returned home to Prior Lake, Minn. But he couldn't put the memories behind him and he couldn't get the professional help he needed, said his mother, Eileen Carlson.

Carlson said she and other family members accompanied Schulze to more than 40 appointments with health care providers and counselors in Minneapolis and St. Cloud after his return home, hours spent on the road getting him to Veterans Administration (VA) facilities. The family says Schulze was diagnosed with posttraumatic stress disorder (PTSD) and was clearly suicidal, but he was put on a waiting list at the VA Hospital in St. Cloud. Soon after Schulze gave up the fight to stay alive—he committed suicide in January.

Recently, the family began "The Jonathan Schulze 'I Can't Hear You' Foundation" (<http://www.jschulzefoundation.org/>) to help other veterans get confidential information about mental health options and "to prevent other veterans from experiencing the same hopeless despair," Carlson said.

Inadequate treatment for PTSD and traumatic brain injury (TBI) were described as major issues in a public hearing held in April by the nine-member President's Commission on Care for America's Wounded Warriors (<http://www.pccww.gov/>). And in a study on veterans' readjustment issues done by the Maine

National Guard and the Community Counseling Center (see <http://www.commcc.org/>), more than three-fourths of Iraq veterans in Maine reported having been exposed to life-threatening experiences. More than one-third reported PTSD reactions after returning home, and one in four had experiences such as flashbacks and nightmares and trouble breathing; about one in four reported depression symptoms. Problems such as marital and financial stress, sleep problems and work-related issues were commonplace. (Almost 90 percent of the Maine Army National Guard has been deployed to Iraq.)

The President's Commission also found that soldiers who need medical care when they return home face unacceptable levels of paperwork and bureaucracy.

Compared to urban counterparts, rural veterans have a lower health-related quality of life. In a recent paper published in the *Journal of Rural Health* ("Rural-Urban Disparities in Health-Related Quality of Life within Disease Categories of Veterans," Summer 2006), Bill Weeks and his co-authors at Dartmouth's VA Outcomes Group Research Enhancement Award Program concluded that the rural veteran population experiences higher disease prevalence and lower physical and mental quality-of-life scores than their urban counterparts.

Because of this, Hilda Heady, an associate vice president of rural health at the West Virginia University Office of Rural Health in Morgantown, said, "There are going to be greater health care demands from rural populations."

Calling TBI the "signature wound" of Iraq, Heady also noted,



Iraq veteran Jonathan Schulze, here holding his infant daughter; asked the VA for help his family says he didn't receive. He killed himself in January, nearly two years after returning home.

"They're not protected enough from the explosive devices over there. The helmet and body armor keep them alive but the concussion is of such great force it creates a brain injury similar to what we know as shaken baby syndrome. One of the best visuals when we talk about it is to put an egg inside a jar and break the egg inside of it. That's roughly what's happening." As a result, she said, "We've created a generation of young people who can live a long life with very difficult disabilities. These individuals will require very specialized care. And as far as PTSD, the military service recognizes that two out of six individuals will acquire some kind of PTSD."

Carlson says both her sons experienced PTSD. "Both boys had sensitivity to loud noises, hyper vigilance, nightmares...Jonny was worse and had flashbacks, mood swings, anger and confusion. We don't believe the right kind of help was available for him. He was seeking help, but he wasn't finding it."

Family members of soldiers can also have PTSD, said Major Grant Wilz with the North Dakota National Guard. "Financial, emotional,

and physical issues can be related to prolonged separation. Add to this the almost daily and constant fear that your loved one is in an environment which is far from safe and the stress of day-to-day activities can at some points almost become unmanageable.”

“Problems derived from combat situations, re-adjustment to civilian life and work, and family and marital issues related to long absences from home often greet veterans as they return home from service,” commented Graham Adams, executive director of the South Carolina Office of Rural Health. “What we are seeing is that there is a scarcity of mental health and family counseling services in rural areas to meet these needs. Mental health resources need to be made available at the local community level. Although Vet Centers provide these services, they are not consistently available at the local levels.”

Weeks said the Dartmouth study also found that “Lack of coordination of health care benefits between the VA and other insurers sometimes results in the most vulnerable veterans—those who are poor, sick and live in rural settings—needing to seek health care that is far from home and family.”

For medical care to be covered, veterans must use VA-approved facilities. Graham said he talked to one vet who drove by 30 physicians’ offices en route to an appointment with a VA-approved physician.

Inadequate professional resources can present another barrier. “Rural areas often don’t have the professional capabilities that are needed,” Heady said. “We know rural America doesn’t have enough physical therapy and rehab services, and there certainly are not enough psychiatric and mental health workers. Some of these debilitating mental health symptoms veterans experience may not crop up for months, sometimes even years.”

NRHA Testimony on Rural Vets

“The disproportionate number of rural Americans serving in the military has created a disproportionate need for veteran’s care in rural areas and yet rural areas are less likely to have VA services available to them... Often access to the most basic primary of care is more difficult in rural America. Combat soldiers who need specialized care to assist with their readjustment to civilian life or adaptation to living with war injuries (both physical and mental) will likely find access to that care extremely limited.”

“There is a national misconception that all veterans have access to comprehensive care because they are served by the Veterans Administration. While this may be true for many veterans, it is not true for many small town veterans, rural veterans or those veterans who choose to be isolated due to the complicated symptoms of Post Traumatic Stress Disorder. The Veterans Hospital Administration (VHA) provided care to 4.5 million of the 7.2 million enrolled veterans in fiscal year 2003. While the quality of VHA care is equivalent to, or better than, care in other systems, it often is not accessible to many rural and frontier veterans.”

“The Defense and Veterans Brain Injury Network of nine VA and one civilian center provides the needed and highly specialized services that these disabled veterans require. However, only three of these network centers are located in two of the 18 states with high rates of rural veterans, Virginia and Florida. Eleven western states with many rural and frontier veterans, and the other southern states with high numbers of rural veterans have very limited access to these centers once discharged from inpatient care.”

-- Excerpts from testimony by Andy Behrman, NRHA Rural Health Policy Board Chair, before the House Committee on Veterans’ Affairs Oversight Hearing on “Access to VA Health Care: How Easy is it for Veterans? Addressing the Gaps,” April 18, 2007. (Full testimony available at: <http://www.nrharural.org/advocacy/pdf/07HouseVATstmny.pdf>).

Rural providers may not recognize symptoms as combat-related, particularly if they occur months later, said David Hartley, a researcher with the Maine Rural Health Research Center at the University of Southern Maine in Portland. Hartley added that many veterans also might not understand their benefits package and what it includes.

All is not doom and gloom, however. These experts say the VA offers high quality care services in areas it serves, and has at least one VA medical center in every state.

“We have only one VA center in Maine, and it has helped that the VA has opened community-based outpatient clinics (CBOC) that

deliver the same high quality care you’d get at a VA center,” Hartley said.

Injured while stationed in Germany, Michael Whyte returned to his hometown of Fort Ashby, W. Va., a town so rural Whyte says it’s “basically a four-way intersection with a stoplight.” Whyte has used several VA medical services: physicians, physical therapy and counseling. “To be very honest, I’ve been treated very well. When I need something, I go in and tell them and they take care of me.”

Rural states are implementing solutions to problems they see. Bob

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RAC's Information Guides – Tools for Learning and Doing

by Kristine Sande

Looking for information and resources on a rural health or human services topic? RAC's information guides could be just what you need. Information guides (http://www.raconline.org/info_guides/) are pages on the RAC web site dedicated to the rural aspects of over 70 specific health, human services, and other important topics. Each information guide is developed by one of RAC's information specialists with the assistance of content experts from organizations such as local-level providers, national membership organizations or federal agencies. Information guides contain information and resources such as:

- Frequently Asked Questions (FAQs)
- Tools, such as web sites and online databases
- Funding opportunities
- Documents, such as publicly available reports, regulations, and government publications
- Organizations with interests in the topic
- News stories and upcoming events
- Terms and acronyms associated with the topic
- Searches and bibliographies
- Maps
- Success stories
- Contact information for experts in the field

Information guides can be used by people with various levels of knowledge about a topic and for a wide range of purposes.

Tools for Learning: RAC's Information Guides are important tools for people who need to learn about new rural health and human service subjects. The overviews and Frequently Asked Questions on each guide help build a basic understanding of the topic, which

can be built upon by accessing any of the other resources listed. For instance, one rural hospital administrator tells us that he uses RAC's Critical Access Hospital Information Guide as a board orientation tool by asking each new board member to review the guide to learn about CAH status. Likewise, one State Office of Rural Health tells us that it uses the information guides to help new staff gain an understanding of numerous rural health issues.

Tools for Doing: Information guides can be very useful documents for people who have a more advanced understanding of the topics, as well. These people often come to the guides looking for specific information that will help them with a task such as writing a grant proposal or figuring out how a regulation will affect their organization. The information guides can help users identify

resources such as maps, statistics, research findings and experts' contact information which will help them to more successfully accomplish their tasks. The information and resources on the information guides have been reviewed and hand-picked by RAC's information specialists to make sure that they are timely and from reliable sources – a definite advantage over using a search engine.

Information guides are living documents that are updated frequently as new information and resources become available. Subscribing to an information guide's RSS feed will allow you to easily see what's changing on the guide in real time. (For more information about RSS feeds, please see, <http://www.raconline.org/rss/>.)

Using RAC's information guide pages can allow you to further your understanding of the topics and issues, in turn helping you to meet the needs of the communities you serve.

The screenshot shows the RAC website interface. At the top is the RAC Rural Assistance Center logo. Below it is a navigation menu with tabs for Funding, Information Guides (selected), News & Events, Experts & Organizations, Publications & Maps, Success Stories, and State Resources. A search bar is located to the right of the navigation menu. Below the navigation menu is a list of other topics: A B C D E F G H I J K L M N O P Q R S T U V W XYZ All Topics. The main content area is titled 'Job Training and Adult Education' and contains an 'On this page' section with links to FAQs, Tools, Funding, Documents, Journals, Organizations, Terms & Acronyms, Success Stories, Contacts, Bibliographies, and News. Below this is an 'Introduction' section with text about job related education and training programs. To the right is a 'News' sidebar with a title 'Learn about RAC's RSS Feeds' and three news items: 'Apr 27, 2007 -- U.S. Department of Labor Announces \$47 Million Competition for YouthBuild Grants', 'Apr 26, 2007 -- Notice of Availability of Funds and Solicitation for Grant Applications (SGA) for YouthBuild Grants', and 'Apr 20, 2007 -- Migrants and Seasonal Farmworkers Program--Solicitation for Grant'.



Rethinking Human Services

by Tom Corbett, Ph.D.

Renewing the Quest to End Poverty in America

According to the ancient axiom... “the poor you shall always have with you.” Perhaps, however, we don’t have to accept that kind of fatalism.

There is evidence that poverty is declining globally. The World Bank estimates that 986 million people lived on less than one dollar per day in 2004, their definition of extreme poverty. That was the first time the figure fell below one billion since their initial estimates in 1990.

Closer to home, geographically at least, we also see progress. The percentage of Mexicans living in extreme poverty, calculated as living on two dollars per day, has fallen by 17 percentage points since 1996. And in Britain, our cultural cousins, we also see progress. Under Prime Minister Tony Blair, child poverty has fallen to 11 percent of the population in 2005, down from about 24 percent in 1998.

But the U.S. track record has been discouraging, with the number of poor as officially measured reaching almost 37 million people by 2005, up from 31.6 million just five years earlier. The number would exceed 41 million if a more accurate measure recommended by the National Academy of Sciences were used. (See *Measuring Poverty: A New Approach*, http://books.nap.edu/catalog.php?record_id=4759). And child poverty, officially measured, rose to 17.8 percent that year.

Why, then, should we feel any optimism on the home front when U.S. poverty increased at the same time that the economy was improving and the wealthy were experiencing dramatic gains? In fact, extreme poverty, calculated as a family having resources equivalent to one-half of the official U.S. poverty threshold, actually jumped 20 percent between 2000 and 2004.

Will official neglect of the U.S. poverty challenge persist or will a new public thrust be undertaken? After all, the costs are not incidental with yearly costs associated with childhood poverty being as high as \$500 billion.

Fortunately, there is some evidence of a renewed interest in the issue. The U.S. House Ways and Means Committee already has held four poverty-related hearings this year. The U.S. Conference of Mayors established a Task Force on Poverty, Work, and Opportunity, and New York’s mayor has created an Economic Opportunity Commission. And getting ahead of national legislation, some 17 states increased their minimum wage levels in 2006.

But real evidence of a potential political shift may lie in changing core beliefs and attitudes among the American public. The Pew Research Center for the People and the Press released a provocative report in late March titled *Trends in Political Values and Core Attitudes: 1987-2007*. As suggested by the title, fundamental public positions were tracked over a two-decade period.

Essentially, the report indicates a substantive increase in support of public efforts to help the disadvantaged between 1994 and 2007. For example, the proportion of respondents agreeing with the statement “government should care for those who can’t care for themselves” jumped 12 percentage points over this period—from 57 percent to 69 percent.

Similarly, the proportion affirming, “government should help the needy even if it means greater debt” increased from 41 percent to 54 percent, with support jumping the most among those identifying themselves as independent voters.

In early 2007, almost 70 percent of respondents believed that food and shelter should be guaranteed to all. And two-thirds of the public

avored a U.S. government guarantee of health insurance for all—even if it meant raising taxes.

Issues that had been controversial now appear to garner overwhelming support. For example, early this year, 93 percent of Democrats, 85 percent of independents and 69 percent of Republicans supported an increase in the national minimum wage to \$7.25 per hour.

What is driving these trends? Who really knows? Concerns about income inequality are on the rise and more people tend to feel that success in life is determined by forces beyond the individual’s control, traditional core feelings associated with liberal positions.

Do these trends presage an imminent wave of social legislation—a contemporary war on poverty? Again, speculation would be foolhardy. The public, after all, is pretty much evenly split on whether they would prefer a smaller or bigger government. Moreover, about 70 percent still believe that the poor are too dependent on public help, though that figure is considerably less than the 87 percent figure measured in 1994.

Perhaps there is one lesson we can take from the past. Historically, people have always favored helping the poor but have consistently disliked providing welfare. That is, the public had strong feelings about how the disadvantaged were helped, favoring strategies that were consistent with conventional American values.

I will look at some emerging strategies to help the poor in my next column, and see how they conform to that public litmus test.

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

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Look What's Coming

by Wayne Myers, M.D.

Friendly Fire in Mrs. Smith's Hospital Room

Hospital patients here at home are in much more danger of being killed than military personnel serving in Iraq. When I did the arithmetic leading to that conclusion I thought, "This can't be right," so let me walk you through it. At any given time since the invasion there have been around 120,000 American troops in Iraq. They have suffered about 1,000 fatalities per year, or one fatality per 120 person years. In 2004, on an average day, the United States had roughly 660,000 people in acute care hospitals (Statistical Abstracts of the United States: 2007, Table 162).

Thus, in 2004, we had 660,000 person years of hospital inpatient care. The Institute of Medicine endorses estimates that mistakes in U.S. hospitals kill 44,000 to 98,000 inpatients per year. That figures out to one person being killed for every seven to 15 person years of inpatient care, compared to one death per 120 person years of service in Iraq. Conclusion: on any given day a hospital inpatient is eight to 17 times more likely to be killed than an American serving in the armed forces in Iraq.

Hospital administrators and trustees might be startled to estimate the number of accidental deaths taking place in their own facilities in a year. They can simply divide the average number of occupied beds by seven and by 15 to estimate a range.

Note that all these deaths are due to "friendly fire." Hospital patients dying of disease, analogous to "enemy attack," aren't included. All the patients in the preceding calculation were killed by mistakes of the people supposed to be helping them.

This comparison has many shortcomings, and shouldn't be carried very far. I am not trying to minimize the horror of the war or

the danger that our courageous troops face each day. Instead, I am trying to put into context the very real danger that U.S. hospital patients face due to medical errors. My point is the difference between public response to war fatalities and hospital error fatalities. Few Americans are oblivious to the war. What would it take to make hospital "friendly fire" deaths a point of popular concern?

One important difference: hospital accidents are usually concealed or at least unrecognized. "Getting an infection" in the hospital is viewed as reflecting the patient's bad luck rather than the staff's bad technique. Drug dosage miscalculations or administration errors may be hard to spot if they are recorded at all.

"Accountability" is popular these days. It generally means finding someone to blame and punishing them. Our reliance on blaming, and on liability suits to redress wrongs, gives strong incentives for individuals and institutions to conceal accidental deaths. Hospitals are required to report when they treat a person with a gunshot wound, but not when the hospital accidentally kills someone.

Compare this with the simpler case of airline passenger fatalities. When a plane crash kills people, it is noticed and analyzed, and preventive changes instituted. Also, the average airline liability cost for a fatality is well established. Cynical though it may sound, this lets the cost of a proposed safety intervention be compared with the dollar value to the airlines of the lives projected to be saved. We now go through some years with no commercial air crash deaths at all. How could we bring this sort of "analysis and prevention of recurrence" to every hospital accident?

Major efforts are being made by several organizations to help hospitals reduce their chances of killing

people. Programs of the Institute for Healthcare Improvement (<http://www.ihl.org>), the federal Agency for Healthcare Research and Quality and HRSA's Office of Rural Health Policy are impressive and commendable. But are they enough? Can we get control of this major killer without individual case detection and analysis? To go there, though, would require us to grapple with our erratic liability litigation system.

"We need your cooperation to prevent recurrence of this tragedy, and if you tell us what happened you'll get sued out of business."

Perhaps hospital accidents resulting in injury or death should be reportable by any licensed health professional to some sort of hospital safety board, with failure to report carrying significant penalties and good faith reporting bringing appropriate protection. The idea needs considerable refinement, but the goal would be to disrupt the silence surrounding hospital accidents. The norm should shift to getting the facts and factors open to analysis so we can work on preventing recurrence. Present efforts should be strengthened by a public sense of urgency. Concealment should no longer be an option.

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.

Opinions expressed in this column are those of the author and do not necessarily reflect the views of the Rural Assistance Center.

Angel Flight West: A Higher Level of Kindness

by Candi Helseth

When she was just a baby, Taylor Thoman's parents discovered that she had retinoblastoma, a rare form of cancer that affects the retina. The best treatment available was at Children's Hospital in Los Angeles, but the Thomans live in Saratoga Springs, Utah.

Thanks to Angel Flight West, Taylor has been getting to Los Angeles for treatment on a private airplane, without her having to walk through a busy airport and security checkpoints, or on a plane with a large amount of people and germs that could lead to an infection.

Aptly named, Angel Flight West provides free, private air transportation for people with medical and other needs. Angel Flight West has 1,800 volunteer pilots on its roster and provides about 4,000 flights a year, according to Angel Flight West Foundation director Jim Weaver. Angel Flight West is one of six regional organizations that operate as independent entities under Angel Flight America, which spans all 50 states. Because health insurance does not cover the cost of transportation, Angel Flight's free air service is of special benefit to patients in rural areas who live far from major medical centers.

"Our pilots make this free assistance possible," Weaver said. "They use their skills to give back community service. They don't need compensation because they love to help people." Angel Flight transports people who have non-emergency health care problems. "There is no medical service on board so they must be medically stable and ambulatory," Weaver explained.

Examples of Angel Flight's medical missions include transporting patients for chemotherapy, surgery, dialysis, diagnosis, treatments and follow-ups. Angel Flight



Chuck and Diana Thomans hold their daughter, Taylor, just before her trip with Angel Flight West. Accompanying her on the flight were actor Lorenzo Lamas (L), who was mission assistant, and Glenn Prestwich (R), a professor at the University of Utah in Salt Lake City, who was pilot on the flight.

also flies missions of compassion, including transporting children to and from special needs camps such as those for burn survivors or children with life-threatening diseases. Other non-medical needs cover a wide range, Weaver said, from moving battered women out of shelters and into other safe locations to responding to emergency situations such as moving evacuees out and reuniting families during Hurricane Katrina. Angel Flight pilots also transport corneas, blood, tissues and technicians needed for organ donations.

"The high majority of people we transport are going from rural areas to university hospitals or major medical centers," Weaver said. "Many times there is no easy access for them. We get requests for assistance from a variety of areas, but it's primarily social service agencies, hospitals, rural community organizations and physicians' offices."

When transportation requires flying beyond Angel Flight West's territory, he added, they link with other regional Angel Flight chapters to relay flights to the person's destination. Because small aircraft are used, he said the maximum

length of their missions is 1,000 miles. They also occasionally use some commercial carriers that discount fares. In those cases, the patient lives in a remote, rural location not served by public transportation or a major airport. The flights are coordinated under Angel Flight's Mercy Medical Airlift organization.

Taylor, now two, is doing well, according to her parents. Her most recent flight to Los Angeles was in March of this year. In a thank you letter to Angel Flight West, Taylor's parents wrote, "Thank you for being there to get our daughter life-saving treatment, when we could barely get out of bed and put one foot in front of the other. You may think you are doing such a small act, simply providing the service of transportation. But you have done so much more. You have given us the life of our daughter.

Knowing how they have helped people fuels their commitment, said Weaver, who recently moved from a position as Angel Flight West executive director to Foundation director.

On a larger scale Angel Flight America, a tax-exempt, nonprofit

corporation, oversaw more than 18,000 flights arranged through its regional organizations and Mercy Medical Airlift program in 2005. More than 7,200 volunteer pilots and outreach volunteers from all 50 states are on its roster. A grant from Pioneer Services has added a new dimension to the corporate mission. Angel Flight America and Pioneer Services reunites families of wounded soldiers returning from active duty in Iraq. When Angel Flight volunteer pilot resources aren't available, a special fund has been established to purchase commercial airline tickets for service members and families in times of bereavement or humanitarian emergency.

To learn more about Angel Flight America, call 877-621-7177 or visit <http://www.angelflightamerica.org>. For information on Angel Flight West, see <http://www.angelflight.org> or call 888-426-2643.

MEDLearn: Fake Patient Teaches Real Medicine

"Stan" is the perfect patient. While first responders and health care providers all over Montana prod, inject, medicate and repeatedly resuscitate him, Stan never complains or runs away.

Stan is the nickname for a human patient simulator offered for hands-on practice by Montana Health Network's Montana Mobile Education Delivery and Learning (MEDLearn) Program. Under the direction of a masters-prepared clinical educator, MEDLearn students participate in an interactive learning situation that includes performing emergency interventions on the full-size, computer-driven mannequin. Stan travels in a mobile unit to deliver onsite training to facilities in rural Montana and is also used in classroom practice, both in person and via telemedicine.

The MEDLearn Program was started after an expert panel commissioned by the State of Montana found that the death rate from accidents and injuries in rural Montana is 31 percent higher than the national norm. The goal of the project is to give emergency providers in first contact with accident victims a higher level of clinical proficiency so that deaths will be prevented.

"We have critical access hospitals that may only see one or two patients a day in their ERs, or may have long periods of time between seeing the same types of situations," said Janet Bastian, Montana Health Network (MHN) CEO. "Emergency medical technicians and first responders are volunteers in these areas, and they're usually the first point of contact for the patient."

Bastian said feedback has been overwhelmingly positive. The simulator looks like a real person, and instructors can program it to have a wide variety of reactions such as seizures, bleeding, deflated lungs, etc. "We set up a scenario where certain interactions occur and students handle the situation," Bastian explained. "They don't know what pieces we will bring into this situation, and the patient gets better or worse depending on their treatment."

Non-existent educational budgets due to financial constraints and long distances between facilities were compromising patient outcomes. Bastian said MEDLearn classes initially focused on emergent-type situations such as trauma, stroke and heart attack, and taught patient stabilization and preparation of patients for transfer to larger facilities.

That focus has since broadened. Some facilities had acquired new equipment, but staff lacked



Stan, a human patient simulator, is giving health care workers in Montana hands-on experience with trauma and emergency care.

experience operating it. "We've used the simulator to give hands-on experience before the equipment is used on patients," Bastian said. "For instance, we did training at one place on using their new ventilator."

The original cost of Stan and his trailer was around \$120,000.00, purchased with the help of a grant from the VHA Health Foundation. To help pay for Stan's continued upkeep and travel costs, MHN members pay a fee for each class and MHN currently subsidizes the rest.

MHN is a collaborative effort of 17 nonprofit health care providers, 15 of them rural, that benefit from mutual networking. It provides services to 46 health care providers that include physician offices, nursing homes and acute care facilities. The majority of those are critical access hospitals. While MHN does offer classes statewide, its primary efforts are targeted at the eastern half of the state. When MHN applied for the VHA grant, Bastian said, "Helping staff maintain clinical proficiency was the most urgent currently unmet need identified by rural and frontier providers." MEDLearn was implemented in January 2005.

For more information, visit <http://www.montanahealthnetwork.com/medLearn.php> or contact Janet Bastian at (406) 234-1420.

Focus on Funding

A guide to rural funding opportunities and how to access them

Capital Improvements

by Beth Blevins

This guide offers a brief overview of capital funding for health care facilities and then presents case studies of recent capital funding projects. For a more comprehensive list of grants available for capital funding, as well as a list of Frequently Asked Questions regarding the funding process, see the RAC's Capital Funding Information Guide, http://www.raconline.org/info_guides/funding/capital.php.

Overview

Sooner or later, most health care facilities will need to make capital improvements. Small-scale capital improvements—that is, improvements that cost a few hundred thousand dollars or less—may find partial or complete funding through targeted grants. For example, a hospital that seeks funding to establish or improve its telehealth program can pursue a grant from USDA's Rural Development Telecommunications Program (see <http://www.usda.gov/rus/telecom/>).

For larger scale improvements that may run several million dollars—such as expanding, updating or constructing buildings—most organizations will have to rely, at least in part, on loans from public and private entities in addition to any funding gathered from local fundraising efforts, private donations, grants from foundations or local agencies, or other sources.

There are three types of capital loan sources available to hospitals or health care facilities: federal, state and non-governmental.

Federal

- **Housing and Urban Development (HUD)** - HUD 242 (FHA Section 242) (see [\[raconline.org/funding/funding_details.php?funding_id=95\]\(http://www.raconline.org/funding/funding_details.php?funding_id=95\)\); In addition, HUD offers funding to states for their community projects through its State Community Development Block Grant \(CDBG\) Program \(see \[http://www.raconline.org/funding/funding_details.php?funding_id=93\]\(http://www.raconline.org/funding/funding_details.php?funding_id=93\)\);](http://www.</div><div data-bbox=)

- **United States Department of Agriculture** - USDA Community Facilities Guaranteed Loan Program and Community Facilities Direct Loan Program (see http://www.raconline.org/funding/funding_details.php?funding_id=91); and,

- **Small Business Administration** - Small Business Investment Companies (SBIC) and other SBA loans are available to for-profit hospitals with a limited amount of revenue (see http://www.raconline.org/funding/funding_details.php?funding_id=1591).

State

- **State Health Facilities Finance Authorities** - These can issue revenue bonds for non-profit hospitals. A state-by-state listing is available at <http://www.nchffa.com/members.htm>. (For more information, see the FAQ at http://www.raconline.org/info_guides/funding/capitalfaq.php#state).

Non-Governmental

These are private loan sources that include local bank loans. In addition, there are investment firms that offer both tax-exempt and taxable capital to rural and critical access hospitals and other health care facilities. Contact your state office of rural health for more information (see <http://ruralhealth.hrsa.gov/funding/50sorh.htm> for a list of state offices).

For more information on available funding for rural hospitals, see the Office of Rural Health Policy publication, Financing Rural Hospital Capital Improvements, http://www.raconline.org/pdf/capital_brochure.pdf.

Funding Examples

The following health care facilities used these public loan sources for recent building projects.

HUD 242

Name: Bucyrus Community Hospital

Location: Bucyrus, OH

Facility description: Bucyrus Community Hospital is a 75-year-old, 25-bed Critical Access Hospital (CAH) that offers general medical and surgical care. The hospital has a staff of more than 200 and provides care for a service area population of 25,000. On an annual basis, over 750 patients are admitted to Bucyrus. There are approximately 25,000 outpatient visits and over 14,000 visits to the emergency room.

Project objective: To fund renovations and three major additions including a new main entry, a new emergency room and a new operating room.

Projected cost of project: \$26 million

Major source of funding: \$24.9 million in HUD 242 loans.

“Bucyrus Community Hospital was the first, and still the only, hospital in Ohio to receive this funding. It allows our facility to modernize and provides small Ohio hospitals with a local model for using federal programs to access otherwise scarce funding and help change the face of health care in communities such as

ours.”—Gerard D. Klein, Bucyrus President & CEO

Additional sources of funding: \$2.3 million is being raised through a capital campaign.

Date(s) of project: Construction commenced on July 29, 2005 with completion projected for August 30, 2007.

For more information: Visit <http://www.bchonline.org/> or contact Gerard D. Klein by mail: 629 N Sandusky Ave., Bucyrus, Ohio 44820; or email: gdklein@bchonline.org. A case study of this project is available at: http://www.lancasterpollard.com/assets_LPC/CS/Bucyrus-FHA-Section-242CAH.pdf.

USDA Community Facilities loans

Name: Yuma District Hospital

Location: Yuma, CO

Facility description: Yuma District Hospital consists of a 15-acute-care bed and seven-swing-bed Critical Access Hospital, medical clinic, a home health care agency, and an outreach clinic in Akron and Joes, Colorado, serving a combined population of approximately 7,000 people.

Project objective: To construct a replacement facility. “We believe that this facility and the services provided within will raise the standard of care available to rural communities.”—John Gardner, Yuma CEO.

Cost of project: \$26,308,247.

Major source of funding: \$17.5 million in USDA Guaranteed loans, \$7 million USDA Direct loans.

Additional sources of funding: State of Colorado Energy Impact Grant, \$975,000; community contributions, \$400,000; and interest earned on construction loan, \$433,247.

Date(s) of project: Project was funded fiscal year 2005. Groundbreaking for the new facility took place May 31, 2006. The

facility is still under construction spring 2007 with the planned grand opening on May 30, 2007, 364 days after groundbreaking.

For more information: Visit <http://www.yumahospital.org/> or contact John Gardner by mail: Yuma District Hospital, 910 South Main, Yuma, CO 80759; or phone: 970-848-4601.

Revenue Bonds

Name: Thundermist Health Center

Location: Woonsocket, Wakefield, and West Warwick, RI

Facility description: A private, non-profit community health center that serves three communities with primary medical, dental and mental health care, plus a full, in-house pharmacy.

Project objective: To acquire and renovate a facility. “We realized that we needed a larger facility since every corner of our space—including the closet—had been converted into office space.”—Sam Limiadi, Thundermist CFO

Cost of project: \$7.4 million.

Major source of funding: \$6.4 million in tax-exempt bonds.

Additional sources of funding: Federal grant, fundraising and equity.

Date(s) of project: The decision to build a new facility began in 2001. In 2002, the clinic received a \$750,000 appropriation grant from Congress. In August 2003, they purchased a 40,000 sq. ft. warehouse building using a bank short-term mortgage. The tax-exempt bond was issued February 2004. The groundbreaking was in the August 2004 and the building was occupied in August 2005.

For more information: Visit <http://www.thundermisthealth.org/> or contact Sam Limiadi, by mail: 191 Social Street, Woonsocket, RI 02895; phone: 401-767-4163, ext.

3015; or email:

SamL@thundermisthealth.org. A longer profile of the project is available at: <http://www.caplink.org/Project%20Profiles/Thundermist.pdf>

Additional Case Studies and Examples

Capital Link, a national nonprofit consulting organization that assists health centers in accessing capital, offers grant funding profiles, which include graphs on amounts financed and sources of funding. See http://www.caplink.org/Capital_Link_Project_Profiles_Grants.htm.

GENERAL FUNDING INFORMATION

For general information on all kinds of funding sources, see RAC's Funding Guide: <http://www.raconline.org/funding>.

You may also call the information specialists at the RAC, who can assist you in your search for information on SCHIP Outreach or other kinds of funding. Contact them at (800) 270-1898 or by email at info@raconline.org. Please include the following information in your request: your name and organization; the type of project you are interested in funding; and the location for your project: city, county and state.

Special thanks to Jerry Coopey of the Office of Rural Health Policy, who provided information on the types of capital loan sources, and Mary Reinertson-Sand of the Rural Assistance Center, who provided editing assistance.

Note: Links to outside companies and organizations are provided for information only. The Rural Assistance Center does not endorse any service providers.

Continued from *War Has Big Impact in Rural Areas*, Page 2

worked out so that he didn't have to go. We haven't heard of any clinics that have actually been forced to close due to deployments." Communities, employers and health care workers can appeal call-ups to the Department of Defense through their Congressional leaders, Finerfrock said.

Health care providers are not the only rural businesses likely to be hard hit by the rural exodus of young workers. National Guard and Reserve units are heavily represented in rural areas and these military

members must leave their rural place of employment when they are deployed. Forty-six percent of Army forces in Iraq, in 2005, were composed of Guard and Reserve units.

Faith, a 23-year National Guard member himself, said what's happening now in rural communities is no different from what happened during other wars. An enthusiastic historian, Faith said entire hospital units were shipped overseas during both world wars. "This isn't something new. Many major medical centers sent a whole 1,000-bed

hospital unit to Europe. It's unfortunate, but that's the way it is and that's the way it's always been during a war.

"Remember, small town hospitals are already a very endangered species," Faith continued. "The rural population is heavily elderly, and the government payment structure is withering these small rural hospitals. It's heavily skewed toward bigger centers.

"Don't try to blame the Guard for killing rural medicine."

Continued from *Rural Vets Return Home to Face New Battles*, Page 3

Hanson, administrator at the North Dakota Veterans Affairs Office in Fargo, said the state has placed service officers in every county to help veterans with access needs. With only one VA hospital in Fargo, primary care centers have been opened in several cities throughout the state. Family assistance centers have been put in place since the war began. Hanson said vans in six locations around the state are available to transport vets to Fargo to the VA center; the van drivers are retired military members who have driven more than 487,000 miles in the last two years.

The North Dakota National Guard is trying to organize the families left at home into family readiness groups, so that they can provide one another with mutual support and understanding. The Guard has also added licensed social workers for counseling and referral to its family program staff, and opened regional family assistance centers in five cities.

But Heady, Adams and Hartley say more action needs to be taken on the federal level. They testified before Congress in favor of increasing rural access and services, and the National Rural Health Association (see text box, page 4) went on record recommending, among other things, that Congress: pass legislation to increase the numbers of outreach centers and CBOCs; have the VA collaborate with non-VA rural facilities such as Critical Access Hospitals and Rural Health Clinics, and; increase the availability of TBI services, which can be difficult for rural veterans to access.

Senate Bill 3421 approved establishing a VA Office of Rural Health charged with several functions, including a directive to develop a plan by September to improve access and quality of care. Administrator Kara Hawthorne said they are in the early stages of development.

"Even for me, it's taken awhile to get used to being a civilian again," Whyte said.

"As soon as the fireworks are over, we have a tendency in this country to forget. I'm hoping people will see what military people go through and we won't try to pretend this didn't happen, but we'll keep on seeing that people get the help they need."

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

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Continued from *Rethinking Human Services*, page 6

welfare reform issues at all levels of government and continues to work with a number of states on issues of program and systems integration.

Opinions expressed in this column are those of the author and do not necessarily reflect the views of the Rural Assistance Center.