

# The RURAL MONITOR

*A Publication of the Rural Assistance Center*

## Support Systems Crucial to Rural Welfare Reform

By Thomas D. Rowley

By most accounts, the welfare reform act passed in 1996 has been a big success. Coupled with a booming economy, the 1996 act has helped get millions of people off the welfare rolls and into jobs, and on to better lives for themselves and their children.

It's a success that has played out in both urban and rural areas.

According to Ron Haskins, a senior fellow at the Brookings Institution and former Senior Advisor to President George W. Bush for Welfare Policy, "the results



*Caller Representative Cynthia Parker of North Carolina's Work Central program assists a customer over the phone.*

ain't bad" for welfare reform in rural America—welfare rolls have declined, poverty has decreased, and employment has increased. But, he adds, the results "could have been better."

One of the key lifelines that emerged from the 1996 Welfare Reform Act was a new program, Temporary Assistance to Needy Families (TANF), which replaced the Aid to Families with Dependent Children (AFDC) program. That assistance, which was funded to the states through a block

### TANF Reauthorization

By Thomas D. Rowley

The 1996 welfare reform act—the Personal Responsibility, Work Opportunity and Reconciliation Act—eliminated the Aid to Families with Dependent Children program and replaced it with Temporary Assistance to Needy Families (TANF) block grants given to states that can be used for cash assistance as well as providing work support systems. Along with the grants came restrictions on eligibility, work requirements, and time limits on assistance.

TANF is now up for reauthorization. And reauthorization, of course, offers Congress a chance to make changes. Some see this as an opportunity to improve TANF. Others fear Congress will only make things worse.

According to Bruce Weber, professor at Oregon State and chair of the Rural Policy Research Institute's Welfare Re-



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form Panel, improvement will come only if Congress recognizes rural America's unique needs.

"There are structural barriers to getting and keeping good jobs in rural areas," says Weber. "TANF reauthorization is a golden opportunity to knock down some of those barriers. But that can only happen if policymakers recognize that rural areas are different, with different resources and different opportunities."

Weber says reauthorization needs to do four things to really help rural welfare recipients.

First, it must fix a distribution formula that sends less money to disproportionately rural states. Second, it must give rural recipients—with fewer job opportunities and support systems—enough time to find a job before cutting off their benefits. (The current law allows a lifetime maximum of five years on assistance.) Third, reauthorization needs to address the nagging lack of licensed child care in rural areas. Finally, says Weber, it ought to extend benefits during recessions, since jobs, particularly in rural areas, are harder to come by when the economy is stumbling.

In February, the House of Representatives passed a reauthorization bill. The Senate version is yet to come. At this

point in the process, Weber's recipe appears in doubt.

In testifying before a Senate committee in March, Brookings Institution fellow Margy Waller said that the House bill reverses much of the flexibility given to states in 1996—a flexibility that many believe led to the success of welfare reform. Waller said that the administration is proposing to increase the number of participants and the number of hours participants must work while narrowing the activities that count towards work activity hours. For instance, education and training would not count towards minimum work hours.

Given state budget crises, Waller said that these changes might cause states to redirect funding away from child care, transportation, literacy training, pregnancy prevention, and a whole host of support services. "Pushing all of the administration's proposed work requirement levers at the same time," said Waller, "would be a recipe for failure—for the states, for low-income workers, and for families on welfare."

One of the key support systems affected by the House bill is child care.

Citing Congressional Budget Office estimates, Jennifer Mezey, Senior Staff Attorney at the Center for Law and Social Policy, a Washington, DC, advocacy

group for low-income families, says that the bill's new work requirements will increase the need for child care by \$3.8 to 4.8 billion over the next five years. Inflation, she says, could tack on another \$4.5 to 5 billion.

To pay for that \$8 to 10 billion increase, the House raises mandatory funding for child care by \$1 billion over the five years, and authorizes a \$3 to 5 billion increase in discretionary funding over the period. Even if the authorized money gets appropriated, there could still be a shortfall of some \$4 billion.

The House bill also calls on states to increase the "matching funds" they contribute by some \$785 million over five years in order to get the \$1 billion in federal funds. Faced with crippling budget shortfalls, states may be unable to come up with the money. Indeed, according to a new study by the U.S. General Accounting Office, 23 states have already reduced child care subsidies for poor families by restricting eligibility, closing the program to new families, or increasing the required co-payment.

On top of all that, welfare caseloads have been increasing in many states in the last few months—the result of the faltering economy. That means still more people who will need, and be eligible for, subsidized child care.

*SUPPORT, cont. from page one*

grant, provided support for many of the transition services that helped reduce rolls and move recipients into the workforce. The future of the TANF program is now being debated by Congress as it re-authorizes the program (see accompanying story) and the results of this debate will have significant implications for continuing welfare reform in rural communities.

Experts and advocates alike point out that welfare reform faces obstacles in rural areas that often are more difficult to overcome than obstacles in urban areas.

First and foremost of these obstacles is a lack of suitable jobs. What, after all, is welfare-to-work without work? Yet, rural America, where nearly 20 percent of welfare recipient families live, has higher unemployment, more seasonal employment, and lower wages than urban America. On top of that, seasonal, part-time, and low-wage jobs (the kind so prevalent in rural America) are much less likely to offer benefits like health insurance, retirement, paid vacation and sick leave that families need in order to make ends meet. In short, many rural areas simply may not have enough jobs to lift former welfare recipients out of poverty.

Job opportunities, however, are only half the battle. Even when jobs are available, former welfare recipients typically need help getting and keeping those jobs. They need everything from job

search assistance, training and public transit, to health care and child care. Unfortunately, it can be quite difficult and costly to assemble and maintain these so-called work support systems in rural areas. Much of the basic infrastructure of those services—public transportation systems, licensed day care providers, and the like—is lacking, low population density and long distances raise the per-unit costs of service, and small, resource-strapped local governments are the norm.

The current round of state budget shortfalls, along with the national economic downturn, exacerbates the problem as states are forced to cut back on various services, according to Bruce Weber, who heads the Rural Policy Research Institute's (RUPRI) Welfare Reform Panel.

"One thing happening in a lot of states is that services to low-income working families are being cut and a lot of social services are not getting funded at levels what they were prior to the downturn," Weber said. "Low-income people are getting hit by a political inability to deal with the changed economic situations."

Moving from welfare to work, and staying there, is difficult. Research by the Urban Institute's Pamela Loprest shows that of all U.S. families that left welfare between 1997 and 1999, about 22 percent returned by 1999. The increased obstacles facing rural families mean they have an even tougher row to hoe. According to work by Weber and others on the

RUPRI Welfare Reform Panel, welfare recipients in many rural areas fare as badly, or worse, than anybody—even inner-city recipients—in getting off the dole and onto career ladders.

## **Into the Workforce, With a Fair Bit of Help**

Diana Walters wants to earn a living for herself and her three small children. She just needs some help doing it.

The 21-year-old, single mom lives in Ronco, Pennsylvania—a place she describes as "just a little patch" in the mountainous southwest corner of the state. With no high school diploma, no driver's license, and three kids under the age of three, moving from welfare to work has been no easy feat. In fact, she was not sure she could, but the welfare office, she says, strongly encouraged her to look for jobs and apply.

"They told me I had only so many days left on TANF and that there was no reason why I couldn't go out and get a job," says Walters.

Now she's glad they did.

On TANF, Walters received \$87 cash assistance for each child every two weeks, a total of \$522 a month. "It wasn't enough," she says. She now works at Wal-Mart. It is the first job she has ever had. With it, she gets not only a salary, but also earns income tax credits and other key supports.

"Working is a lot better," she says. In the next sentence, she

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laughingly admits that “It’s a little bit of a pain in the butt. Some of the customers are nasty.”

To land her job, Walters needed help. To keep it, she needs still more.

First, is childcare. Her boyfriend used to take care of the kids, but now he has a part-time job. Others in her circle of family and friends cannot be paid to baby-sit for fear of losing their social security checks. (Many, says Walters, are disabled.) She hopes she will soon have care lined up, and even help paying for it, through the Fayette County Community Action Agency—a non-profit provider of a wide range of services for low-income people and families.

After childcare, comes transportation. Walters has two vehicles but no driver’s license, and the only public transit in the area is a limited, fixed-route bus service. Nationwide, research shows, nearly 40 percent of rural residents live in areas with no public transportation. Thus, for Walters, and for many others around the country, getting to work, getting her kids to day care, indeed, getting just about anywhere means hitching a ride with family or friends.

Then, comes health care. The state welfare office helps pay for it. In that respect, Walters is fortunate. According to some experts, sickness, of mother or children, presents the biggest problem to former recipients in keeping a job.

To advance her career and improve her family’s life, Walters plans on enrolling in a certified nursing assistant training program, yet another support system service, this one offered by the area’s private industry council. The training will take four hours two to three nights a week for 16 weeks, all on top of working and caring for her children. She admits it will not be easy, and that she will need help.

### Providing That Help

Diana Walters’ story is not unique. Tammy Knouse, Director of Customer Service at Fayette County Community Action Agency (FCCAA), knows countless other families in similar situations. According to Knouse, Fayette County is mountainous, very rural and in “the top 10 in all the things you don’t want to be high on”—poverty, infant mortality, drug abuse, alcoholism, illiteracy, and so on. Eighteen percent of its residents live below the poverty level and 66 percent of its families with children under the age of five live in poverty. Its child poverty rate of 30 percent is the highest in Pennsylvania.

As a result, FCCAA served 38,000 people last year, not including medical and dental clients, in a county of 148,000 people—one quarter of the population. Knouse sees the problems passed from generation to generation.

“The grandparents didn’t graduate, the parents didn’t

graduate, the kids don’t graduate. It’s the same with smoking and other behaviors. The kids don’t see any other options. Those that do move and we’re left with the kids that have the most trouble,” she says. “We have adults that can’t read their mail or a newspaper to look for jobs.”

The root of the county’s troubles (a county that includes tiny Ronco and the “big city” of Uniontown, population some 40,000) is economic. The steel industry closed in the 1940’s and nothing much has replaced it.

The mountainous terrain and isolation of the county also works against it. Knouse reiterated the transportation problems in the county that provide another hurdle for folks like Diana Walters.

According to Knouse, there is no mass transit system and many of the low-income people she deals with have no car.

“Transportation is horrible,” says Knouse.

Against these odds, FCCAA seeks to help the area’s disadvantaged. Much of the work is done in partnership with state and local agencies and other non-profits. Knouse says the groups work well together because they are forced to. “Nobody has enough money [to do it on their own],” she says.

Because the needs are so many, the programs and services FCCAA provides range from education to housing, from employment to transportation. Simply getting a job, as Diana Walters’ story illustrates, is not a magic bullet.

Sometimes a job can work against a person by paying too much for them to get assistance, but too little to meet their needs.

“You can hit a point that makes your life more difficult, where you make enough to not get enough assistance, but not enough to get by,” says Knouse. “We need to be able to supplement for folks who work but don’t make enough. We need to make it worth their while.”

The research bears this out, showing that families who use transitional support services are less likely to return to welfare than those who do not.

Of course, such a long list of programs and services can be overwhelming to a person seeking help. Knouse admits that it can be “hard to negotiate the systems of assistance.” The difficulty is compounded by the hesitancy of those in need, their lack of education, and the time and travel involved in accessing the systems. As a result, participation in work support systems by low-income working families is low.

In recognition of those difficulties and their impact on participation rates, a program in North Carolina is taking an inventive approach.

## Connecting to Help in North Carolina

For 8,600 families in rural northeastern North Carolina’s Work Central program, access to support systems is getting much easier thanks to the telephone.

Jackie Savage, president of Connectinc, the non-profit that



*Caller Representative Nikki Baker (left) and Administrator Dianne Rives of N.C.’s Work Central program discuss transportation strategies for customers.*

runs the program with help from a long list of private industry partners, says the idea came from the fact that families in rural areas had to travel long distances and then wait in long lines to get services. Some simply could not do it; others became discouraged and quit going. Providing services over the phone just made sense.

It works like this. One part-time and eight full-time staff members work at a state-of-the-art telecommunications center in Rocky Mount. Over the phone,

they connect former TANF recipients—customers, they call them—from 11 rural counties with a full range of services that include helping them find and apply for a job, obtain health care and day care, clean up bad credit and buy a car or even a house. Then, in a conference call, staff members help customers get through the queue and cut through the red tape to set up appointments, sign up for classes, open an account, or whatever they need to do. At the same time, they model appropriate behavior for customers in the process—teaching them the language of business and showing them how to successfully negotiate what for many can be an intimidating system.

As Savage says, “We champion them through the system—

over the phone.”

The software—a case management database and a geographic information system that shows every business, every job, and every skill set needed in the area—gives staff the ability to instantly pull together everything a customer needs. They can even zap a resume to an employer while they talk.

The service is free to customers and is entirely voluntary.

“They don’t have to work with us if they don’t want to,” says

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Savage. “We can’t take a check away. We can’t take a child away. We have to be results-oriented or the families won’t stay with us.”

As for results, Work Central has helped customers earn \$38 million in wages in its nearly three years of operation. This is all the more remarkable given the demographics of the region. Eastern North Carolina has consistently had the highest poverty rates in the state and many of the counties

in the service area face severe challenges in attracting and maintaining economic development. Last year, only 40 customers went back on TANF—all because of health reasons.

“We consider ourselves economic development, one family at a time,” Savage says.

## GET CONNECTED

For more information on the people and sources described in the previous articles, you can check the following web sites:

- Fayette County Community Action Agency — <http://www.fccaa.org/>
- Connectinc. (the non-profit organization that runs the NC Work Central program) — <http://www.connectinc.org/>
- Brookings Institution fellow Margy Waller’s testimony can be found at: <http://www.brookings.org/views/testimony/mwaller/20030312.htm>
- The GAO report, “Child Care: Recent State Policy Changes Affecting the Availability of Assistance for Low-Income Families” (May 2003), can be found at: <http://www.gao.gov/new.items/d03588.pdf>
- To access reports and commentary on welfare reform by the Urban Institute’s Pamela Loprest, see: <http://www.urban.org/PamelaJLoprest>
- A list of welfare reform studies available through the Welfare Information Network, a partner of the Rural Assistance Center, can be found at: <http://www.financeprojectinfo.org/WIN/welfreformeval.asp>

## Nevada

### Tutors on School Buses Offer Homework Help

Elementary students in rural Douglas County, Nevada, are taking advantage of their long bus ride home in the afternoon to bone up on their studies and get their homework done. Even better, they have a teacher along to help. The Traveling Tutors program, funded by federal Community Service Block Grant money, puts teachers on buses to help at-risk and disadvantaged students from four elementary schools. The students typically come from low-income families and may have no one at home to help them learn.

According to Karen Goode, Supervisor of Social Services for the county, the idea for the program came from teachers who saw both a need and an opportunity. Kids were not learning as well as they should have been and many had an hour bus ride every day. What better way to spend the time than with a tutor? While the teachers are paid for their efforts, Goode notes that they buy the kids treats and things out of their own pockets, to encourage and reward them.

The program is in its third year of operation and is showing impressive results. For the mere sum of \$8,500 last year, Goode says that 157 students received help on the bus or at school after hours, and their grades and the rate at which they turn in homework have both improved.

“I haven’t seen a better program,” says Goode. “I have great faith in it.”

For more information, contact Goode at [kgoode@co.douglas.nv.us](mailto:kgoode@co.douglas.nv.us).

## Wisconsin

### Partnering to Address Health Care Workforce

A partnership between the Lacrosse Medical Health Science Consortium and the Western Wisconsin Workforce Development Board is helping to kill two birds with one stone—lowering unemployment in the region while alleviating its health care worker shortage.

The Consortium is a group of educational institutions and health care facilities that formed 10 years ago to improve health care education and research in the region—23 rural counties in Wisconsin, Minnesota, and Iowa, which Debra Suchla, director of the Consortium, calls “the forgotten corners of those states.” The Workforce Development Board is one of the mechanisms set up under the federal Workforce Investment Act to help develop and find jobs for the region’s workforce. Both the consortium and the board had a similar goal, Suchla says, to help folks in the region who needed jobs prepare for and enter the health care field—a field short on workers.

As Suchla says, it was a “no-brainer to merge efforts.”

A joint committee formed in March to:

- recruit, educate, employ, and retain an adequate health care workforce;
- build a partnership between health care service and continuing education;
- pursue grants;
- study trends and data on workforce development; and
- address labor force shortages.

According to Suchla, neither group, by itself, could accomplish all that needs to be done, but “when you pull the two together, we really can be pretty powerful in a rural, isolated area.”

For more information, contact Suchla at [Suchla.debr@uwlax.edu](mailto:Suchla.debr@uwlax.edu) or (608) 785-5148.

## Utah

### Innovative Use of GME Dollars Helps Meet Health Care Workforce Needs

The Utah Medical Education Council (UMEC) is breaking new ground in health care workforce training through its use of Medicare and Medicaid graduate medical education (GME) dollars, which are the principal source of support for specialty training of physicians.

According to Gar Elison, Director of UMEC, a waiver obtained from the federal Centers for

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Medicare and Medicaid (CMS) allows UMEC to change the flow of GME dollars in a way that helps the state influence residency programs and thereby better meet its workforce needs. In the past, GME payments had been made directly to hospitals where residents are trained. Under the waiver, direct GME dollars are carved out and flow to UMEC, which then uses them as a “carrot” by passing them on to residency programs that meet the state’s workforce goals. Elison says that the Council does not commit funds to a program until that program has a plan showing how it will meet the workforce objectives. The program then has to live up to its plan or have its funding reduced, giving the effort a “stick” as well.

Historically, residency programs billed hospitals for the salary and benefits of the residents based on their time in the hospital. Under the waiver, programs bill hospitals a lesser amount because the direct GME dollars now flow to the program directors. Program directors—who hire the residents—are held accountable for achieving the state workforce objectives. Directors are also responsible for meeting accreditation requirements and filling the positions in the program. In short, the waiver rationalizes the process and places responsibility with those who have the authority to link training with workforce needs.

Asked if the hospitals object, Elison says that “in many ways, they actually favor it—once they understand it.”

Current goals pursued by the program are to increase the rate at

which Utah-trained health care graduates stay in the state; expand the size of certain residency programs to meet the needs for various specialties; and develop training experiences that meet the state’s workforce needs, in particular, to increase the amount of training in rural areas so graduates will know how to practice there.

“Just because it’s rural,” says Elison, “we don’t want any decrease in skills.” In fact, he says, it’s the other way around. Rural practitioners need to know how to do almost everything.

The Council was created by state law in 1997 as a quasi-governmental entity to help collect health care workforce information from various entities without violating anti-trust regulations. The Council, by statute, was also directed to obtain the CMS waiver for a demonstration project for GME distribution.

Elison knows of no other state that has linked receipt of both Medicare and Medicaid GME to workforce planning, but says that several are looking into it.

For more information, contact Elison at [gtelison@utah.gov](mailto:gtelison@utah.gov) or (801) 526-4552.

## Virginia

### Rural Cancer Outreach

Cancer is the second leading cause of death for rural Americans, partly because of lack of access to care. Oncology—like many medical specialties—can be difficult to access

in rural areas. Patients must often travel, sometimes great distances, to see a cancer specialist. That was the case for residents in several rural Virginia counties until 1993 when the Virginia Commonwealth University/Medical College of Virginia Massey Cancer Center in Richmond created its Rural Cancer Outreach Program (RCOP). Now, five rural outreach sites serve patients in eight counties.

Through the program, patients are diagnosed and treated by a team of cancer specialists from Massey (currently three nurse practitioners and five hematologist/oncologists) working with their own primary care doctors and nurses. Surgical, chemotherapy, radiation, and hospice treatments are all offered at the participating rural hospitals, including Community Memorial Healthcenter in South Hill, Rappahannock General Hospital in Kilmarnock, Southside Community Hospital in Farmville, and Greensville Memorial Hospital in Emporia. A special oncology nursing clinic provides chemotherapy services at Buchanan General Hospital in Grundy.

The hospitals provide space, nurses and support services—lab, radiology, pathology, and pharmacy. Doctors and nurse practitioners manage patient care from Massey and provide consultative services to patients and their local doctors during twice-a-month visits and through 24/7 availability on emergencies. The program also offers a free shuttle service to Massey for patients that need to travel for special treatment.

“The patients love it,” says Haidee Waters, one of the nurse practitioners at Massey. “The people caring for them in these clinics—the nurses—know these people and are very supportive.” Being in the community, says Waters, also allows family members to stay with patients during treatment to offer support. In addition, patients can get treatment during their lunch hour or after work—avoiding taking time off from jobs.

The program also benefits the rural hospitals by generating new revenue for them, and, according to a 1999 study, generates enough revenue for Massey to cover its costs.

For more information, see <http://www.vcu.edu/mcc/mcc/RCOP.htm> or contact Dr. Mary Helen Hackney, MD, RCOP Director at 804 628-1933.

## Call for Input

Something news-worthy going on in your part of rural America?

Send a one-paragraph summary to the editor at: [info@raconline.org](mailto:info@raconline.org)  
Attn: **Tom Rowley**



The Rural Assistance Center (RAC) was established in December 2002 as a rural health and human services "information portal." RAC helps its users access the full range of available programs, funding, and research that can enable them to provide quality health and human services to rural residents. RAC is a collaboration of the University of North Dakota Center for Rural Health, the Rural Policy Research Institute (RUPRI), and the Welfare Information Network (WIN); and is funded through HRSA's Office of Rural Health Policy.

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## *Best Practices in Revolving Loan Funds for Rural Affordable Housing*

**A. Rose and C. Holden. Housing Assistance Council, April, 2003.**

This case study analysis of four rural revolving loan funds looks for best practices that are the most salient in different rural contexts. The funds examined include the Kentucky Mountain Housing Development Corporation, the Federation of Appalachian Housing Enterprises, the Vermont Community Loan Fund, and the Northwest Farmworker Housing Loan Fund.

It finds that different community lending structures are appropriate to different rural contexts. It then outlines best practices that are common to the four case studies. For example, in founding a loan fund, a clearly focused mission, good technical assistance, and solid initial capitalization are key. In structuring loan fund policies and procedures, successful funds start with simple, user-friendly procedures, and then diversify their lending products and practices as their funds encounter competition from other community lending groups. In the area of risk management, all types of funds must ensure that the collateral for each loan will cover the costs of a possible default, and delinquencies should be monitored as closely and as soon as possible. Familiarity with borrowers through in-house technical assistance (for development groups) and homebuyer education and counseling

(for individuals) also helps to prevent delinquencies. Finally, the longevity of a fund can be promoted through investment in information technology and staff capacity, so that the fund is able to handle increasingly complex financing deals and reporting requirements as it grows.

The benefits and drawbacks of obtaining certification and funds from the Community Development Financial Institutions (CDFI) Fund are also analyzed, with the conclusion that CDFI status has been very important to the continued growth of three of the loan funds studied. However, CDFI award recipients also caution that any organization thinking of pursuing CDFI certification should examine its own capacity very carefully to determine if it will be able to handle the application and reporting requirements.

Available at:

<http://www.ruralhome.org/pubs/credit/revolvingloansfunds.pdf>.

*Rural Healthy People 2010: A Companion Document to Healthy People 2010. Volumes 1 and 2.*

**L. Gamm, L. Hutchison, B. Dabney, and A. Dorsey, eds. Southwest Rural Health Research Center, Texas A&M University System Health Science Center, 2003.**

Volume One of this two-volume report provides 1) overviews of the top rural health concerns and objec-

tives associated with the focus areas outlined in *Healthy People 2010*; 2) references to key literature about these concerns; and 3) descriptions of models for practice that rural communities can draw upon to achieve key *Healthy People 2010* objectives. Volume Two is an appendix that presents more detailed literature reviews and associated references for the top rural health concerns.

*Healthy People 2010* identified 467 objectives within 28 focus areas intended to stimulate and support action to improve the nation's health. These objectives were intended to guide actions by national, state, and local governments and by numerous health provider and community-based organizations across the country. This report extends that analysis by identifying a number of those focus areas and objectives of importance to rural communities and by providing illustrations of approaches taken by rural areas to address their needs.

Available at:

<http://www.srph.tamushsc.edu/rhp2010> or (979)458-0653.

*Meeting the Challenge of Social Service Delivery in Rural Areas*

**P. Friedman, Welfare Information Network, *Issue Notes*, vol. 7, no. 2, March, 2003**

This report provides an overview of the challenges social service agencies face in delivering services to

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rural residents. It draws upon previous research and several innovative programs from around the country. It also poses and addresses several key questions:

- Why should states consider development social service policies that target rural areas and what should those policies do?
- What role can state agencies play in service rural families transitioning from welfare to work?
- How can service providers do a better job?
- What resources can states use to support the effort?

Available at:

<http://www.financeprojectinfo.org/WIN/meetingthechallengeIN.htm>.

*Design of Enhanced Primary Care Case Management Programs Operating in Rural Communities: Lessons Learned from Three States*

**S. Poley, P. Silberman, and R. Slifken. North Carolina Rural Health Research and Policy Analysis Center, University of North Carolina, March, 2003.**

This findings brief focuses on the use of enhanced primary care case management to provide benefits to Medicaid beneficiaries in rural areas.

It highlights lessons learned from Florida, North Carolina, and Oklahoma. Among the findings, are that:

- Recipients in more isolated communities seem to benefit greatly from the additional clinicians and individualized care associated with case and disease management programs.
- Face-to-face care management is more difficult to implement and maintain in rural areas because of the geographic dispersion of enrollees and the limited number of recipients in a given service area.
- Disease management programs that rely on telephone case management are problematic, as some Medicaid recipients do not have consistent access to telephones.
- Rural care managers may have more responsibilities due to the lack of other available community resources to provide patient education or address psychosocial problems.
- Partially capitated systems can ensure the viability of rural primary care providers by guaranteeing a stream of revenue with minimal financial risk.

Available at:

[http://www.shepscenter.unc.edu/research\\_programs/rural\\_program/fb\\_77.pdf](http://www.shepscenter.unc.edu/research_programs/rural_program/fb_77.pdf).

*The Impact of Interim and Prospective Payment Systems on Home Health Providers and Medicare Beneficiaries in Rural Pennsylvania*

**C. Jeng Lin, M. Meit, M. Schwartz, L. Davis, J. Leon, J. Davitt, and J. Marainen. University of Pittsburgh Center for Rural Health Practice, May, 2003.**

This report examines the effects of interim payment systems (IPS) and prospective payment systems (PPS) on home health agencies in rural areas. As the nation shifts health care away from traditional and more expensive modes of delivery, home health care rises in importance.

The report finds that:

- Medicare home health agencies are operating under more financially challenging circumstances now than before the implementation of IPS and PPS.
- The number of consumers of Medicare home health services has decreased since the implementation of IPS and PPS. In addition, Medicare home health visits dropped 42 percent after the implementation of the new payment systems.

- The majority of agencies experienced an improvement in financial conditions under PPS as compared to IPS. Agencies, on average, were able to realize gains. However, the average gain per episode will drop significantly after accounting for payment cuts in October 2002 and the elimination of the 10 percent rural add-on effective April 1, 2003. Projections demonstrate that agencies will begin losing money for episodes receiving a low-utilization payment adjustment after this additional payment reduction. Furthermore, the financial position of agencies may worsen given the additional administrative burden placed on agencies.

- Medicare margins will decrease dramatically after taking into account payment reductions effective October 1, 2002, and removal of the 10 percent rural add-on.
- Home health agencies are delivering a different mix of home health services, increasing the use of physical therapy services and decreasing the use of skilled nursing and home health aide services.
- Agencies and beneficiaries have faced increased service utilization restrictions for Medicare home health services since IPS and PPS were implemented. The result has been an increase in patient use of private-pay nursing and aide services, as well as an increase in the need for patient self-care and help from informal caregivers.

Based on these findings, the report recommends extending the 10 percent rural add-on, providing technical assistance to small rural agencies, and educating health care providers on the role of home health.

Available at [http://www.upb.pitt.edu/crhp/home\\_health.pdf](http://www.upb.pitt.edu/crhp/home_health.pdf) or by calling (814) 362-8656.

*Note: If you experience any problems downloading these files, please contact the researcher(s).*



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