

The RURAL MONITOR

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Linking Health and Social Services to Local Economies

By Thomas D. Rowley

The link between health and human services and economic development has long been neglected by both care providers and economic developers.

Yet in many small, rural communities, health care and social services are major economic engines. A local hospital, for example, is often one of the biggest employers in town, just behind the local school district.

“Health care has never pushed it and economic development has never had to think about it,” said Sam Tessen, director of Texas’ Office of Rural Community Affairs (ORCA).

Tessen said that he once told a local economic development official from rural Texas that a major employer in the official’s area was in danger of closing. The official was surprised, especially after Tessen told him that the employer was the local hospital.

“It was news to him,” Tessen said. “He was apoplectic.”



Wright Medical Center helps support the local economy by providing health and social services to the local workforce. Photo by: D. Brent Miller.

But he’s not alone. Many rural business leaders and their health care counterparts have not always seen the symbiotic link between their two worlds.

“People traditionally have the mindset that a hospital is a hospital and not a business,” said Gentry Woodard, director of legislative affairs for St. Joseph Health System in east Texas.

Hospitals, along with other health care and social service providers, are businesses. They employ people, pay wages, and buy supplies. They help keep a community’s workforce healthy and productive. They help attract and retain other businesses by providing services critical to those businesses’ employees and their families.

And they help keep dollars in the community that might otherwise have gone elsewhere—dollars for shopping, lunch, and lodging that people typically spend on a trip to the city for care when it is not available locally, or when local care is thought to be of lesser quality.

All told, health and human services play a huge role in any community’s economy. They play an even larger role in small rural communities, where any sector accounts for a larger share simply due to the small size of the whole.

The flipside is, of course, also true. Bringing or keeping people and income in a community adds to the

(continued on page 3)



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Forging Links: Operation Rural Health Works

Recognizing the need to highlight the economic impact of the health care sector and stress its critical role in rural development, representatives from five states (Kentucky, Missouri, Nevada, Oklahoma and Pennsylvania) met in June 1998 to initiate a pilot project to do just that. Out of that meeting, Operation Rural Health Works was born.

Rural Health Works (RHW) is sponsored by the Federal Office of Rural Health Policy, the U.S. Department of Agriculture's Cooperative State Research, Education, and Extension Service, and the Rural Policy Research Institute. Dr. Gerald Doeksen, professor at Oklahoma State University, directs it.

According to Doeksen, RHW utilizes and has developed several tools for helping local officials understand and improve the linkages between the health sector and the economy. Chief among those tools is an economic model known as IMPLAN (Impact Analysis for Planning), developed by the U.S. Forest Service and adapted by RHW. The model uses data at the county or zip-code level to measure the impacts of changes to one or more sectors on a local economy. In this case, the model measures the impact of hospitals, doctors' offices, nursing homes, pharmacies, and other medical services.

Armed with the data and the IMPLAN model, local planners can determine, among other things, how many jobs in the community depend on the health care sector.

Doeksen said the percentages vary from state to state and community to community, but on average, between 10 and 15 percent of the jobs (and income) in a community of 15,000 people depend on the health care sector—directly and indirectly.

Some people work directly for a hospital or other facility. Some people work at jobs made possible by a hospital purchasing goods and services locally. And still other people work at jobs made possible by hospital employees purchasing goods and services locally. In economic parlance, those effects are known as direct, indirect, and induced. Another way to look at it: every hospital job creates another .10 to one job in the community.

Another tool in RHW's chest is its health care service feasibility study. With that, health care providers can determine whether it makes economic sense to add, say, kidney dialysis or outpatient rehabilitation to the services they offer.

Using such a study, Doeksen said, helped one community in Oklahoma avoid a costly error, when leaders realized that although people wanted adult day service

and the hospital was ready and willing to add it, the numbers simply did not add up. Indeed, adding the service would have meant losing \$20,000 a year. Thus informed, the community and hospital passed.

Another community, Stroud, Oklahoma, found by doing a feasibility study that it could break even providing kidney dialysis. Breaking even, however, was just the starting point. Adding dialysis would mean adding some 10 jobs to operate the service—no small shot in the arm to a small town economy. It also meant that people who had been driving 50 miles to Oklahoma City for treatment and eating and shopping while away, could get treatment, eat, and shop locally—another shot in the arm.

Taking RHW to people around the country has been one of Doeksen's missions for the past five years. He, together with his associate Cheryl St. Clair at OSU, has conducted workshops to train the trainers in 45 states. Local communities in more than 30 of those states have subsequently been introduced to RHW and its tools.

The goal of the workshops is simple. "You demonstrate to the community how important the health sector is," Doeksen said, "get them all fired up, and hope that they expand it to help economic development."

patient base of the community's health sector, thus helping it stay healthy.

Using Taxes in Texas

In Texas, the Office of Rural Community Affairs (ORCA) is itself an attempt to, among other things, better link economic development with health care. As such, the agency encourages communities to not only utilize Rural Health Works (RHW) tools (see text box on page two), but also to utilize other more traditional



By contracting with mobile providers, WMC is able to provide the latest technology and keep patients from taking their dollars elsewhere. Photo by D. Brent Miller.

economic development tools to bolster local health care and thereby enhance economic development efforts.

One such tool is the economic development sales tax created in 1989 to stimulate the Texas economy and provide smaller communities with an optional source of local revenue for economic development. By law, communities may vote to adopt an

economic development sales tax, the revenues from which can finance a variety of economic development projects—from industrial facilities to marketing to training and education. One provision of the law (known as 4B) allows communities to use the revenues to pay for “quality of life enhancements,” including health care facilities.

Upon hearing Sam Tessen at a meeting tout the use of 4B taxes for health care facilities, Gentry Woodard went back to his non-profit hospital system and began looking into the possibilities.

“We were a little creative in what we did,” Woodard said.

What they did was secure some \$47,000 dollars in 4B tax revenues to renovate their Navasota hospital and make room for a CT scanner. How they did it was by showing the Grimes County economic development agency,

which oversees the economic development sales tax in the county, just how important health care is to the local economy.

According to Woodard, a market analysis showed that people from Navasota were leaving town to get nearly 400 CT scans each year. By renovating the hospital, and purchasing and installing a CT scanner, many of those people would stay and

purchase their scans locally—to the tune of about \$1,000 per scan.

Those people would also be spending money locally that would have been spent on trips to get scans. The scanner operation would require additional personnel and therefore create additional jobs. And by contracting with local builders, plumbers, and electricians to do the renovation, even more jobs and money would be generated locally. Finally, the area would become more attractive to prospective firms because of this additional health care resource.

The economic development agency agreed. The funds were made available. The scanner is going in.

“This economic development tax is an example of how the government is putting a carrot in front of the donkey to get businesses to go to rural areas,” Woodard said.

Reaching Out in Iowa

As in Texas, not having the facilities to perform certain procedures meant that patients in tiny Clarion, Iowa, had to go elsewhere, and take their dollars with them. Rather than adding space and purchasing the necessary equipment, however, Wright Medical Center (WMC) has chosen a slightly different route: contracting with mobile providers and circuit-riding specialists.

Steve Simonin, administrator of WMC, said this approach allows the hospital to do three things: avoid huge investments in technology, get their patients access to the best technology available, and keep patients in the community.

“As a small hospital, we’re able to dart and weave to provide services without the huge investments in technology,” he said. “They give us the best quality technology that’s out there. In a larger hospital, they have to use up their resources before they upgrade. Therefore, you’re actually getting better quality in small rural hospitals.”

WMC contracts with mobile providers of a variety of services, including Magnetic Resonance Imaging (MRI), nuclear medicine, and soon, PET CT scans. A trailer truck pulls the self-contained unit, employees and all, into the WMC parking lot once or twice a week depending on the service.

The specialty provider bills for the services, so it’s not a direct source of revenue for the hospital. Still, Simonin said, it keeps patients coming to WMC for other services. For example, a patient with an orthopedic problem is more likely to get treatment locally since he or she can get an MRI locally, rather than driving to Fort Dodge 40 miles away, to help in the diagnosis.

“It’s kind of like milk at the grocery store,” Simonin said. “It’s not exactly a loss-leader, but it brings people in and then they get other things. We’re able to keep them here in the community. That’s huge.”

In addition, the center has a specialty clinic that brings in health care specialists from outside the community on a regular basis to complement the local medical staff. Again, this means patients can stay in Clarion to get their care and support the local economy by doing it. Practitioners in 17 different special-



It would have been expensive to purchase a MRI set-up like this. Contracting for it was a smart business move. Photo by D. Brent Miller.

ties provide care at the clinic.

WMC is also involved in helping provide human or social services to those in need. And that, too, helps economic development, even though that is not the primary goal.

Several years ago, the center began providing space to the Domestic/Sexual Assault Outreach Center (D/SAOC) to run a satellite site in Clarion. Many, though not all, of the people seeking help at the D/SAOC are Hispanic women who work at large industrial hog and chicken operations nearby.

“The work that we do is not optional,” said Joyce DeHaan, executive director of D/SAOC.

Bringing in Human Services

Few look at or understand the economic importance of human or social services. DeHaan, however, does. The help the clinic provides,

she said, enables victims of domestic and sexual abuse to find safety and that enables them to become productive individuals, support their families, and contribute to society.

One reason the value of social services isn’t recognized is due to the absence of numbers. While statistics are available which show the economic impact of certain kinds of social problems, such as alcohol-related illnesses, there is little, if any, data showing the benefit of social services that might address these problems. No models to measure the economic impacts of the social services exist, though Gerald Doeksen wants to move Rural Health Works in that direction and create such models.

Kathleen Belanger will be glad when he does. Belanger is director of child welfare professional development at the School of Social Work at Stephen F. Austin State University in Nacogdoches, Texas. She is also a

leading advocate of rural social services—a long neglected sector, she said.

“If you have the people who are the livelihood of the community and they hit any problem in their life, if they get into alcohol or substance abuse, they’re much less likely to get treatment in a rural community,” Belanger said, “If they can’t get treatment, there is an economic cost. If they can’t get what they need, they can’t work, they can’t get a degree, their business may fold.”

Indeed, social services are part of making a community whole. A thriving Head Start program helps ensure kids start out in school with a leg up academically and assists working parents. A thriving Area Agency on Aging can help the elderly in a rural community live independently longer. Mental health and substance abuse providers also play a key role in helping keep needed services in the community.

“Economic development folks think that social services are a drain on the economy, but they’re wrong,” Belanger said. “Social services are the difference between someone being a productive member of society and a total drain on society.”

Clearly, rural communities benefit when they have both a strong health and human service sector, as the folks at Wright Medical Center have demonstrated.

“We truly believe that the more we can do together, the better off we’ll all be,” Steve Simonin said.

GET CONNECTED

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

Texas Office of Rural Community Affairs
<http://www.orca.state.tx.us/>

Operation Rural Health Works
<http://www.rd.okstate.edu/health/>

Texas Economic Development Council
<http://www.texasedc.org/>

St. Joseph Health System, Texas
<http://www.st-joseph.org/>

Wright Medical Center
<http://www.wrightmed.com/>

Around the Country

by Erica Hauck

Iowa

Addressing the Nursing Shortage in Iowa

A new center is helping facilities throughout Iowa mentor and recruit new nurses and nurses' assistants.

The Iowa Department of Public Health established the Center for Health Workforce Planning in 2002 to address the issues of health workforce supply and demand, and worker recruitment and retention. The Center, which is staffed by two full-time state employees, received \$1.1 million from the U.S. Department of Health and Human Services for its establishment and first year of operations. Congress later authorized an additional \$993,500 for its second fiscal year, ending July 31, 2004.

A large portion of the Center's funding is awarded as grants to health care facilities for recruitment and retention efforts. In its first year, the Center awarded 44 grants, totaling \$838,152, to health care facilities and training institutions for mentoring programs for new nurses, and scholarships for nurses or nursing assistive personnel wishing to advance their careers.

The mentoring programs, which provide intensive orientation and training to new nurses, also have a benefit beyond recruitment and retention of new employees. Because the mentors are nurses already working in the field, mentoring programs "have done a lot for the professional image of the mentors," said Jeneane Moody, a Community Health Consultant with the Center. "It has added a new sense of profes-

sionalism and responsibility" to the role of the existing health care workers, contributing to the overall retention efforts of the Center, Moody said.

In addition, the Center recently partnered with the University of Iowa's Office of Statewide Clinical Education Programs to implement the Regional RN Tracking Pilot Project. The project tracks data on all registered nurses in a 13-county region, including demographics, education, and work settings, and studies the supply and demand of nurses in the area. The Center hopes to eventually expand the RN tracking project to the entire state in order to forecast and respond to shortages in the health care professions.

The Center also engages in research and has published numerous reports, issue briefs and white papers on topics such as health care trends and the supply and demand of health professionals throughout the state. It also works to facilitate communication and the sharing of information among various agencies that collect data on health care professionals, serving as a central point of contact for those seeking information about the health care workforce in Iowa.

For more information, contact Jeneane Moody, Community Health Consultant, Center for Health Workforce Planning, at 515-281-6211, or Eileen Gloor, Executive Officer, Center for Health Workforce Planning at 515-281-8309. Internet: http://www.idph.state.ia.us/ch/health_care_access_content/rhpc/shortage.htm.

Michigan

Community Leadership Training

A new program in Michigan is providing rural residents with the tools to make decisions based on consensus and the unique needs of their communities.

The Michigan Center for Rural Health is offering training in the Community Leadership Development Process (CLDP), a collaborative process that brings together stakeholders from multiple sectors in the community. The training is supported by funding from the Robert Wood Johnson foundation.

The CLDP programs teach volunteers how to garner participants and support in the community, and how to hold focus groups or meetings with multiple stakeholders that can reach consensus on a particular issue. All viewpoints are considered in the CLDP decision-making process, including those from the health care, faith-based, law enforcement and business sectors. It is an approach that can be used to address a multitude of different community issues.

The state- and federally-funded center, located in East Lansing, Michigan, had its first experience with CLDP during a demonstration project it conducted last spring. Using funding from the National Rural Health Association and the National Highway Traffic Safety Administration, the Center helped communities with Critical Access Hospitals develop educational campaigns for seat belt use. As part

of the project, community members participated in a one-day training session on CLDP in order to learn effective strategies for implementing campaigns that were tailored to their communities.

After their success with the training for the seat belt campaigns, the Center's Critical Access Hospital Program Administrator, Angie Dietlein said, "We realized this process could be applied to anything."

Employees of the Center began going into rural communities in October to train volunteers on how to apply the process to an awareness campaign for MICHild (the state's S-CHIP program). They hope to reach more working poor families that are not eligible for Medicaid. So far, they have completed training in two communities, and based on their success, they plan to reach many more communities in the future.

For more information, contact Angie Dietlein, Critical Access Hospital Program Administrator, Michigan Center for Rural Health, at 517-355-7757, or Marolee Neuberger, Rural Health Initiative Program Coordinator, Michigan Center for Rural Health, at 517-355-8250.

New Hampshire

Public Health and Bioterrorism

The public health infrastructure in twelve communities in central New Hampshire is getting a boost thanks to the efforts of a regional coalition

and a bioterrorism grant it recently received.

The Caring Communities Network of the Twin Rivers (CCNTR) received the \$48,000 bioterrorism grant through the state from the Centers for Disease Control and Prevention (CDC). The CCNTR is a broad-based network of area agencies and organizations that works with the region's twelve communities to identify regional problems and needs, and mobilizes local resources to plan and implement solutions to those needs.

The CCNTR, comprising such organizations as the regional hospital, local school districts and other service providers, was created six and a half years ago to integrate services and planning and improve the regional public health infrastructure. The network also works in partnership with area municipalities, which have no official health departments, to address the clinical and public health care needs of the communities and to foster economic and social capital development.

CCNTR is one of twelve regional groups that applied for and was awarded funding from New Hampshire after the state received \$8 million from the CDC to implement emergency preparedness programs aimed at bioterrorism. The network is using the money to "beef up" its public health infrastructure by taking a public health systems development and all hazards approach, a rationale that assumes the same infrastructure and system needed to respond to a bioterrorism threat can be used for all types of public health emergencies.

The grant has enabled the

network to expand its partners to include the first responder community, and to conduct emergency training sessions that bring together representatives from civic organizations like schools, fire departments, local businesses, and area health and human service agencies. The groups collaborate on planning responses to hypothetical disaster scenarios, such as tornadoes, earthquakes and disease outbreaks. These sessions achieve several important goals for strengthening the public health infrastructure: they help integrate individual towns' emergency plans; identify areas that need improvement; discover ways to engage civic and business groups; and increase collaboration among all providers of health and human services in the area.

According to Richard Silverberg, Managing Director of the CCNTR, the network is working on the region's public health infrastructure at a very grass-roots level, through the collaboration and expertise of members of the local community. "You've got to start somewhere, and we're starting at a very basic level," Silverberg said.

The network's success has been recognized by other communities in the state. It was recently asked by a neighboring region to provide consultation and technical assistance on the creation of a public health network similar to CCNTR so that it can apply for a bioterrorism grant from the CDC as well.

For more information, contact Richard Silverberg, Managing Director, Caring Communities Network of the Twin Rivers, at 603-934-0177.

Oklahoma

Getting More Out of EMT's in Oklahoma

Emergency medical technicians (EMTs) in Stroud, Oklahoma, are putting their “down time” to good use by working in the emergency room and other patient care areas of Stroud Hospital while they are not on emergency or transport calls.

The eight EMS employees are included in the hospital's regular staffing schedule, and work their shifts at the hospital until an emergency or transport call comes in. They do not require any extra training for the work they do in the hospital. Anything they are trained to do in the field they can perform in the hospital — this includes checking patients into the emergency room (ER), administering IV's, drawing blood, and providing basic emergency care.

According to the hospital's EMS manager, Scott Devers, the EMTs participate in almost all forms of patient care within the hospital. “If it happens in the hospital, we're involved in it,” Devers said.

Sharing the EMT's time and skills with the hospital allows for greater efficiency and cost-effectiveness. The EMS department, which serves a rural area in central Oklahoma with a population of roughly 3,500, had only about 450 calls last year. This would have resulted in significant amounts of “down time” if the EMT's had not also worked in the hospital. The plan also saves the EMS department a great deal of money, because for the time they spend working in the ER,

the EMT's salaries are charged to the ER budget. In general, about 45% of the funding for the EMT's salaries comes from the ER budget.

Since its inception in March 2001, when the hospital reopened after a tornado destroyed it in 1999, the EMT staffing plan has been very successful. In fact, in 2002, the EMS department turned a profit, which according to Devers, is rather unusual for emergency services departments. “It is getting harder and harder for [emergency] services to earn a profit,” he said, “especially nowadays with Medicare cuts.”

For more information, contact Scott Devers, Stroud Hospital EMS Manager, at 918-968-3571.

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.

Research Roundup

by Thomas D. Rowley

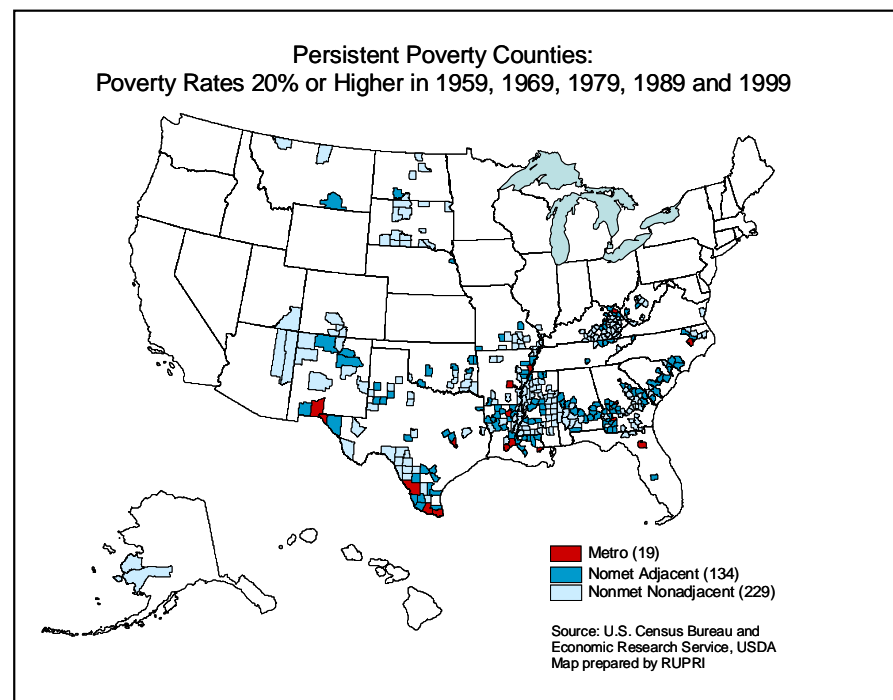
Rural Poverty: New Looks at an Old Phenomenon

Three recent studies in rural poverty expand the understanding of that arena beyond the widely-known “poor folks live in the country, too.” They do that by illustrating the variation of poverty across space and place, the variation of the depth and severity of poverty among the poor, and the unvarying toll it takes on the most vulnerable among us: our children.

In *How Do Persistent Poverty Dynamics and Demographic Vary Across the Rural-Urban Continuum?*, Kathleen Miller of the Rural Policy Research Institute and Bruce Weber of Oregon State University show that poverty rates vary across the rural-urban continuum: the smaller and more remote the place, the more poverty you find. And in some of the smallest and most remote places there are pockets of high and long-standing poverty.

High poverty counties—those with 20 percent or more of their population living below the federal poverty level—are geographically concentrated in the South, Appalachia, the lower Rio Grande Valley, and on Indian Reservations of the Southwest and Great Plains.

A subset of those high poverty counties are the 382 counties that have had poverty rates of 20 percent or more in every decennial census from 1960 on. These persistent poverty counties are the hardest of the hardest hit. They are also overwhelmingly rural (95 percent of persistent poverty counties are nonmetro). Again, persistent poverty



increases where county population centers are smaller and where places are more remote from urban centers.

As one would expect, persistent poverty counties not only have lower incomes, they have higher unemployment rates. They also tend to have higher proportions of minority population and higher proportions of people without high school diplomas than do non-persistent poverty counties.

The good news in Miller and Weber’s report is that the 2000 Census shows a dramatic decline in the number of persistent poverty counties, down from 571 in 1990 to 382 in 2000. Not surprisingly, the 189 counties that left the persistent poverty designation were those counties that hovered near the threshold—that is, for example, a county with 21 percent poverty was

more likely to leave than one with, say, 30 percent. The “leavers” also tended to be metro, or, if nonmetro, at least adjacent to metro; on the geographic edge of the poverty pockets; and have significantly lower shares of minority populations.

The bad news and the conclusion of the report is that persistent poverty—already a predominantly rural problem—is becoming ever-more so, hitting remote rural areas the hardest.

From that, one might conclude that poverty is worse in rural America. That conclusion, however, is a bit oversimplified. It depends upon one’s definition of “worse.”

In *Comparisons of Metropolitan-Nonmetropolitan Poverty During the 1990s*, Dean Jolliffe of USDA’s Economic Research Service uses

measures that go beyond the widely used rate-of-incidence method to look at the depth and severity of poverty. Jolliffe measures depth by using a poverty-gap index to show how far below the poverty line, on average, a population is and measures severity by calculating the square of that index to get at the extreme cases or unequal distribution of people below the poverty line. By doing so, he goes beyond mere headcounts of the poor to answer the question “just *how* poor are the poor?”

According to Jolliffe, the usefulness of these measures is illustrated by looking at a transfer of money from a rich person to a poor person. If the transfer is insufficient to lift the poor person out of poverty, it has no effect on the headcount index. It has, however, raised the income of the poor person, and this improvement in well-being is reflected in a reduction of both the poverty gap (depth) and the squared poverty gap (severity) indexes. Similarly, a transfer of income from a poor person to a poorer person does not change either the headcount or the poverty gap index, but it does improve the distribution of income among the poor and reduces the squared poverty gap index.

Using the measures, Jolliffe finds that while rural America clearly has a greater incidence of poverty, depth and severity of poverty are only slightly greater in rural than urban America. Indeed, the depth of poverty in nonmetro was statistically higher at the five percent level in only six of the ten years in the 1990s. The severity of poverty was statistically higher in only three of the 10 years.

As for the causes of these differences, Jolliffe offers several contributing factors: on average, the nonmetro poor are older and less likely to work because of illness, disability, or retirement. The metro poor are more likely to be in school. He does not find evidence to support the common assertions that higher nonmetro poverty is a result of working less or working at lower wage jobs.

All of which has implications for policy. The bottom line is that the best approach to addressing poverty depends upon how you measure that poverty. Metro poverty could best be helped by focusing on job training, while nonmetro poor might benefit more from focusing on supplemental income assistance for the elderly and disabled.

All these variations aside, what does not vary is the consistent impact of poverty on children. In *Dimensions of Child Poverty in Rural Areas*, Carolyn Rodgers of ERS finds that child poverty rates—urban and rural—continue to be much higher than those of the general population. The share of rural children in poverty did decline from 22 percent in 1990 down to 19 percent in 2000, but the fact remains that nearly one-fifth of rural children are still mired in poverty. A slightly lower number—15 percent—of urban children are in those straits. In all, some 11.3 million U.S. children under 18 were poor in 2000.

As Rodgers points out, child poverty is closely linked to poorer health, difficulty in school and low educational attainment, behavioral and emotional problems, and delin-

quency. Poor children are also more likely to need public assistance and, as adults, to earn less and be unemployed more frequently.

Chilling as that is, Rodgers concludes on an even colder note: “...child poverty rates could climb higher in the future unless more targeted efforts are made by Federal, State, and local agencies to reach these groups [minority children and mother-only families], especially in more remote and very poor rural areas.”

Reports available at:

http://srdc.msstate.edu/measuring/series/miller_weber.pdf

<http://www.ers.usda.gov/publications/rdr96/>

<http://www.ers.usda.gov/Briefing/IncomePovertyWelfare/ChildPoverty/>

For more information on rural poverty, please see the Rural Poverty Research Center at: <http://www.rprconline.org>.



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