Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

ACCESS TO RURAL HEALTH CARE: SUCCESSFUL COMMUNITY INITIATIVES

JULY 1993

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OEI's Atlanta Regional Office staff prepared this report under the direction of Jesse J. Flowers, Regional Inspector General and Christopher Koehler, Deputy Regional Inspector General. Principal OEI staff included:

Atlanta Region

Maureen Wilce, Project Leader
Ron Kalil
Paula Bowker
Ruth Reiser

Headquarters

Cathaleen Ahern

For additional copies of this report, please contact the Atlanta Regional Office at 404-331-4108.

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JULY 1993 OEI-04-92-00730

EXECUTIVE SUMMARY

PURPOSE

To describe successful initiatives for providing access to health care in rural communities that do not have a local hospital.

BACKGROUND

Many changes in the provision of medical care have resulted in an increase in hospital closure. Specialization and advanced technologies have drastically changed the patterns of care at hospitals. Occupancy rates at hospitals have decreased as many procedures are treated with shorter inpatient stays. Further, procedures once requiring inpatient stays can now be performed on an outpatient basis. Likewise, improved mobility of those living in rural areas has contributed to closures of local hospitals. Rural residents can, and often do, bypass local hospitals to obtain more specialized care that is typically available in larger regional or urban hospitals. Nationally, 193 rural hospitals closed during 1987 through 1991. This is 7.1 percent of all rural hospitals that were open in 1987.

The closure of local hospitals had limited effect on access to medical care for most people. Most communities where a hospital closed were within 20 miles of another hospital. However, communities without a nearby hospital and certain populations within the communities, such as the poor and elderly, can have problems accessing health care services. The hospital closures have led to strong interest in providing health care locally without a hospital. This desire of local communities to take responsibility for their own health care needs was recently endorsed by the Secretary of Health and Human Services. She expressed her intent to help rural communities empower themselves to meet their own health care needs.

SCOPE AND METHODOLOGY

We surveyed health professionals in 39 States where one or more rural hospitals had closed to identify communities that had developed a successful initiative for providing health care after their hospital had closed. We selected six initiatives for case study. We visited each selected community and described each of their initiatives and compared and contrasted the services provided.

FINDINGS

Rural communities can empower themselves to create successful health care initiatives

The six initiatives we selected for this study demonstrate commitment, hard work, and creativity to provide access to health care locally. Once communities accepted their inability to sustain a hospital, they created an alternative which reflected individual needs

and resources within a community. Often, traditional community boundaries had to be ignored to create a successful health care initiative. Thereafter, the community must support the initiative or it too will fail as have many small rural hospitals.

Successful initiatives can improve delivery of health care services

Through their initiative, the communities we selected generally improved the supply of health care professionals. They established (1) programs to attract health care professionals to their community, and (2) networks to share health professionals between communities. Likewise, they tailored health care to their community -- eliminating duplication and underused services.

State assistance is critical for successful community initiatives

State governments provided grants and technical assistance. Further, States revised legislation and policies to allow communities to develop and operate their health care initiatives.

Local communities relied on existing Federal programs in developing their initiatives

Virtually all of the initiatives relied on existing Federal programs, such as Medicare and Medicaid, for funding and technical assistance. To illustrate, Newton, Texas, Ekalaka, Montana and Oxford, Nebraska received Medicare and Medicaid reimbursements as part of the existing Rural Health Clinic program. Significantly, no community initiative was funded through new Federal programs.

CONCLUSION

Rural communities where hospitals have closed and those that are trying to save a failing hospital can find other ways to meet their health care needs. Local residents who accept the notion of health care without a hospital can empower themselves to design and implement a strong health care system for their communities. The success of local health care initiatives depends heavily on creative use of all available resources by community leaders. A community must first obtain strong local support and then seek available State and existing Federal support.

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To describe successful initiatives for providing access to health care in rural communities that do not have a local hospital.

BACKGROUND

Changes In The Provision of Medical Care Contribute to Hospital Closures

Significant changes in provision of medical care in recent years have resulted in an increase in hospital closures. The once prevalent general practice of medicine has yielded to increased specialized care. Specialized care requires advanced technologies plus physicians and other medical professionals who are trained to use it. Likewise, the improved mobility of people in rural areas further contributed to hospital closures. The availability of automobiles and interstate highways allows rural citizens easy and fast access to hospitals and other medical services in distant locations. People in rural communities can, and do, bypass a local hospital to obtain more specialized care that is typically available in larger, more urban locations. Advances in emergency ambulance services also allow bypassing a local hospital even in emergency cases.

Our study of hospital closures during 1987 through 1991 showed that 193 rural hospitals closed nationally ("Trends in Rural Hospital Closure: 1987 - 1991" OEI-04-92-00441). This is 7.1 percent of all rural hospitals that were open in 1987. The majority of the hospitals that closed were small and had low occupancy rates.

Hospital Closures Had Limited Effect on Access to Medical Care

The closures of local hospitals had limited effect on access to medical care for most people. In our five years of hospital closure studies, we found that for most communities, hospital care was still available within 20 miles. Further, the Office of Inspector General reported on the effects of hospital closure on access to hospital care in 1990 ("Effects of 1988 Rural Hospital Closures on Access to Medical Care," OEI-04-89-00742). In the 1990 study we found that most residents did not use the local hospital before it closed. Residents chose to bypass the local hospital, and perhaps other small rural hospitals, to travel to newer, larger and more specialized facilities. The study showed that, overall, most residents did not have serious problems accessing health care as a result of hospital closure. Although many residents in communities which lost their hospitals had inpatient and emergency care available nearby, some residents had problems accessing medical care.

Interest In Providing Health Care Without A Hospital

During our evaluations of hospital closures in 1987 through 1991, many Federal, State and local health care providers expressed interest in how communities successfully meet health care needs without a hospital. They wanted to know what communities had done to continue providing health care in their communities when their hospital closed. Further, they wanted to know if the techniques used by these communities could be applied in other communities, including communities facing hospital closure, and communities which have never had a hospital. Finally, Dr. Shalala, Secretary of Health and Human Services, recently expressed her strong intent to help rural communities empower themselves to meet their own health care needs.

This report provides information on initiatives developed by selected communities to successfully meet their health care needs. We believe examination of the successful community initiatives will help decisionmakers at the Federal, State and local level design policies and programs to meet local health care needs during a period when the provision of, cost of, and access to health care are changing drastically.

SCOPE AND METHODOLOGY

We interviewed State health and hospital officials and health care advocates in 39 States where one or more rural hospitals had closed. We obtained information on (1) what specific rural communities had done to provide local access to health care following closure of their hospital, and (2) what standards and characteristics indicated successful initiatives in those communities. We then interviewed State health professionals, researchers, and other officials in State and national organizations that have an interest in rural health issues to identify communities they believed had developed successful health care initiatives. They identified 18 rural communities.

To determine the types of health care provided, we interviewed, by phone, community health officials in each of the identified rural communities. We classified each community initiative based on extent and level of health care services provided. We then selected six initiatives which (1) met our standards for a successful initiative, (2) represented different types of initiatives, and (3) gave geographic dispersion among rural communities that had developed initiatives.

We visited each of the selected six communities to (1) document the services actually provided, and (2) obtain information on the development and operation of the initiative. We obtained information by interviewing the administrator, health care professionals, former hospital administrators and staff, board members and community leaders, and by reviewing hospital and community records. Where appropriate, we also interviewed State officials who were involved in the transition from a closed hospital to an alternate method (initiative) of providing health care. Finally, we compared and contrasted the development and operations of the six selected community initiatives (see Appendix A).

We collected and analyzed information during June 1992 through March 1993 to identify successful community initiatives for providing local health care when a hospital closes.

We conducted this inspection in accordance with the *Quality Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

FINDINGS

RURAL COMMUNITIES CAN EMPOWER THEMSELVES TO CREATE SUCCESSFUL HEALTH CARE INITIATIVES

Initiatives Reflect Individual Community Needs And Resources

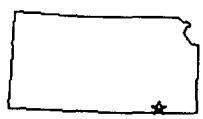
Each of the six initiatives we selected reflected the varied needs and resources within a community. We briefly summarized each of the six selected case examples below.

The Newton County Education Center: This initiative includes a wide mix of (1) public health services, including immunizations and well-child care provided by nurses, (2) a Rural Health Clinic (RHC) where a physician provides basic primary care including lab and x-ray services, (3) vocational educational services provided by county school system employees at the initiative site, and (4) a day care center. The center is located in the former Newton County Memorial Hospital at **Newton, Texas.** It is administered by Jasper Memorial Hospital, located in a neighboring county.

The Rural Health Center: The center is located in **Lewisville, Arkansas.** The initiative is intended to be a "one-stop shopping" center for health care. When completed, it will combine health care and social services. The clinic provides basic primary care, lab, x-ray, and public health services. Four part-time physicians, several nurses, a visiting nurse pediatrician, and a nutritionist staff the clinic. Renovations are underway to include county social services at the center. The clinic also operates a satellite clinic two days a week in another community that is 18 miles away -- Bradley, Arkansas. The center is located in the former Lafayette County Memorial hospital.

The North Pend Oreille Health Services Consortium: The Consortium is located in **Metaline Falls, Washington.** The Consortium of health care providers is centered around a RHC, located in nearby Ione, Washington. The consortium provides primary care, emergency care services, transfer agreements with the nearest hospital, case management and referrals, home health services, psychiatric services through a nurse practitioner, and a van to provide non-emergency transportation for handicapped persons. The clinic is staffed by a full-time physician, one physician assistant, and three part-time health care assistants.

The Oxford Medical Center: The center is located in **Oxford, Nebraska.** Community leaders and board members of the Fritzer [illegible] Health Center in Oxford established an affiliation with a neighboring hospital in Cambridge after the hospital in Oxford closed. The Cambridge hospital already had four satellite clinics. They converted the closed hospital in Oxford into a fifth clinic. The clinic, which is a RHC, is staffed by a full-time physician assistant. Three physicians visit weekly from the affiliated hospital. The clinic offers general, family practice services, lab, x-ray, on-call urgent care after hours, emergency transportation through a volunteer EMT service and helicopter transport, a van service to nearby hospitals, health education, and a pharmacy.



The Jane Phillips Community Health Clinic: The clinic is located in **Caney, Kansas.** Because of serious financial problems, the administrator of the Caney Hospital, an acute care facility, started planning for continuation of health care before the hospital closed. She obtained agreement with the Jane Phillips Episcopal Memorial Hospital in nearby Bartlesville, Oklahoma to provide medical support services. The Caney Clinic provides offices for three physicians (although at present, only two practice at the clinic) and a part-time physician assistant. The initiative provides primary care, lab services, an optician's office, 24-hour urgent care, and emergency transportation to the hospital in Bartlesville. It is also planning to house the town's remaining pharmacy. The Jane Phillips Hospital was already serving as a hub for supporting medical facilities in several other communities. Because of the upfront planning, the Jane Phillips Clinic opened and began providing service on the Monday following closure of the Caney Hospital on Friday.

The Medical Assistance Facilities: The Medical Assistance Facilities are part of a demonstration program in Montana sponsored by the Heath Care Financing Administration, Department of Health and Human Services. Four rural Montana communities, **Circle, Ekalaka, Jordan and Terry,** are participating in the Federal demonstration Medical Assistance Facility program. The Medical Assistance Facilities offer low-intensity inpatient care, 24-hour emergency care and outpatient medical services, including basic laboratory and x-ray services. All MAFs are currently staffed by physician assistants. One community, Circle, also has a physician on site. In addition, all of the MAFs share facilities with nursing homes, and all have transfer protocols established with full-service hospitals. See OIG report number OEI-04-92-00731 for further details on The Medical Assistance Facility demonstration program.

Each of the rural communities above is similar to many other rural communities, where a hospital closed. The hospitals experienced a downward spiral in occupancy, lagging revenues and rising costs. The communities feared that when their hospital closed, the citizens, particularly the poor and elderly, would have unnecessary difficulty obtaining access to health care. Because they realized that their community could not support a full service hospital, the communities found other alternatives for meeting their health care needs.

Community Residents Must First Accept That They Can Not Sustain A Hospital

Many community leaders and residents believe that a hospital is essential for access to health care. Even when a hospital is under-used, a community will often take extreme, costly measures to try and save their hospital. They are proud of their hospital and believe it will keep medical professionals in the community. For example, despite great cost, Metaline Falls, Washington maintained its former hospital building for three years. They hoped that eventually they could reopen the hospital. Trying to keep its hospital open, Oxford, Nebraska passed two bond issues totalling one half million dollars. Both communities are now faced with paying the debt plus interest.

The first step in developing a successful initiative for providing local health care through means other than a hospital is acceptance that the community can not sustain a hospital. In some communities that we visited, this acceptance started with one individual who believed something else could be done. In other communities a group of people, such as the hospital board of directors, saw that closure of their hospital was unavoidable. Thereafter, they provided the leadership in creating an alternative way to provide access to health care in their community.

Community Teamwork And Planning Are Critical For A Successful Initiative

People in each of the communities we selected for study had obtained cooperation and assistance from throughout the community in planning and developing their successful initiative. Although State and Federal financial and advisory support helped several of the communities, local people conceived, designed and led development of their successful initiative.

Each community determined their own health care needs and worked cooperatively in designing and implementing a plan to meet those needs. Some communities adopted a very structured approach. For example, Metaline Falls, Washington followed a formal process developed by the Area Health Education Center. First, the community leaders accepted the closure of their hospital and agreed to start planning for providing health care in the absence of a hospital. Second, they obtained a professional facilitator to lead them through a needs assessment process. Third, the community board designed an alternative (the initiative) for providing health care in the absence of a hospital. Finally, the community leaders worked cooperatively in implementing the initiative. As new health care needs arise and additional resources are generated, the community expects to repeat the process. Other communities used a less structured approach, but teamwork

and planning were very important. For example in Caney, Kansas the hospital administrator worked with the administration of the Jane Phillips Hospital in Bartlesville, Oklahoma directly to develop plans for the initiative.

Ignoring Traditional Community Boundaries May Be Essential For A Successful Initiative

Local people in all of the communities selected for our study had to change the definition of their community in order to successfully provide local access to health care for their citizens. They had to redefine the community boundaries in terms of who would be served by the health care initiative. For example, Lewisville, Arkansas redefined its boundaries for health care to include the southern part of the county near Bradley, Arkansas. Likewise, In Caney, Kansas the local people decided to become a part of a larger community for health care that crossed the State boundary into Oklahoma. In Oxford, Nebraska rivalries which had existed between small neighboring towns were changed into alliances in order to develop a new local health care arrangement. Finally, in defining their community for health care purposes, Newton and Jasper, Texas realized that their football team rivalries did not have to extend to the health care system. One initiative director said "cooperating with other communities is the key" for a successful alternative to hospital care. A State Commissioner of Health said "they put aside their personal and political differences and demonstrated an all-too-rare kind of cooperation."

By deciding to redefine their boundaries, communities were able to establish networks for successfully providing access to quality health care. The networks between communities allowed an individual county to access a wider range of health care services and resources than those that were available through the former small hospitals. To illustrate, the Rural Health Clinic in Metaline Falls, Washington could not provide all the services needed such as home health, psychiatric care, and transportation. By establishing a network with health care providers in neighboring counties, Metaline Falls was able to obtain those services. Likewise, citizens of the neighboring counties can benefit from services offered in Metaline Falls.

Community Support Is Vital To Maintaining A Successful Health Care Initiative

No initiative could be successful if community residents chose not to use the services offered. Although record keeping systems were not comparable, all initiatives appeared to be prospering and growing in the communities we studied. For example, in Metaline Falls, Washington the average number of patients per month at the Rural Health Clinic doubled in the first two months after the physician arrived. In Oxford, Nebraska 1100 new patients have been added since the initiative opened in January of 1990. Also, a new doctor is presently being recruited. A physician assistant at a Medical Assistance Facility in Montana said, "the community has been very supportive. They feel confident in the care we provide. If they feel they'd get second-rate care, they're going to drive those 50 to 80 miles" to another source of care.

The communities also support their initiatives in other ways. For example, some communities support the initiative with local tax dollars. Others had fund-raising events

to support their health care initiative. All communities we studied tried to win back residents who did not use the local hospital before it closed or obtained service of other communities after the hospital closed. They worked hard to communicate a message that the new health care facility was reliable, and that it was a high quality source of health care. They published stories about the new facilities, the physicians, and other health care providers working at the initiatives. The initiative in Metaline Falls, Washington for example, publishes a monthly newsletter to inform the community residents of initiative activities. One registered nurse said, "people aren't going to let it (the initiative) stop. They saw the problem and want to help." Local newspapers also helped support the community initiatives by publishing articles.

SUCCESSFUL INITIATIVES CAN IMPROVE DELIVERY OF HEALTH CARE SERVICES

Initiatives Increased The Supply Of Health Care Professionals

All of the communities that developed a health care initiative had lost physicians and other health care professionals. Such losses clearly contributed to the eventual close of rural community hospitals. Therefore, a major objective of most of the community initiatives we examined was to recruit and retain health care professionals. For example, community leaders in Lewisville, Arkansas worked with the Area Health Education Council to establish a residency program for physicians at the clinic. The work at the clinic served to meet physician residency requirements. The residency program is expected to provide a constant supply of physicians in the community, while allowing medical residents valuable experience in providing rural health care. The Caney, Kansas community was able to recruit a new doctor because of an initiative arrangement which allowed staff privileges for physicians at the Bartlesville, Oklahoma hospital.

The supply of health care professional was also increased through community networking for health care services. To illustrate, the network among communities broadened the base of doctors for consultation. It also broadened the base of health professionals for back-up. For example, one physician in a community did not have to be on call 100 percent of the time. The community could spread the on-call duty to all physicians in the network. One initiative director said that "one of the biggest benefits of the consortium is having someone else to call on for help not only with health care, but also with computer problems." This arrangement allowed physicians and other health care professionals some free time to pursue their own interest. Some physicians and health care professionals used that time to upgrade their skills. For example, two directors of the nursing staff told us their staff have upgraded their skills to respond to the wide variety of services needed in rural communities.

Health Care Services Were Tailored To Community Needs

Local people tailored their initiatives to meet their community needs. They chose what services the community could provide and what services would be obtained outside the community. For example, while all communities wanted physicians for general medical

practice, they could not always afford them. Instead, several employed physician assistants. Likewise, all communities wanted to provide emergency care. To do so, some used an emergency room of a former hospital, but other communities established arrangements with nearby community hospitals and referred patients as needed. Further, all communities established agreements for air and road ambulance services to transport patients to appropriate emergency facilities.

One community, Metaline Falls, Washington established a "911" system. Through the 911 system, the community can provide 24-hour-a-day emergency service. The 911 monitoring equipment is located at the clinic during the normal work day, and volunteers take it home with them at night to monitor emergency calls.

Unlike hospital requirements which dictate how resources will be used, community health care initiatives are flexible. They allow any services needed by a community to be added if resources are available, and to be eliminated when the services are no longer needed. For example, the Newton, Texas community initiative included using resources provided by the school system to offer vocational education and day care services. Several communities, including Lewisville, Arkansas, Circle and Ekalaka, Montana, Newton, Texas, Metaline Falls, Washington and Oxford, Nebraska, added non-emergency transportation services to their initiative. The local hospital could not have provided such services as easily as the community added them. Several community initiatives included using the former hospital kitchen to prepare meals for a meals-on-wheels program for senior citizens. Finally, each of the Medical Assistance Facilities in Montana offered a dental clinic one day a week.

Such flexibility enables community initiatives to continue changing as needed to meet community health care needs. Oxford, Nebraska, for example, is currently planning an expansion of its health care services. Likewise, the Lewisville, Arkansas community expects to add another wing to its facility and to add county social services, such as public assistance offices. Also, the Newton, Texas community is planning to include another community, Kirbyville, Texas, into its network initiative for health care. The hospital in Kirbyville, a small rural town, closed in 1988. After observing the effectiveness of Medical Assistance Facilities in four rural Montana communities, Culbertson, Montana recently converted its small hospital to a Medical Assistance Facility. One board chairman of a rural community initiative told us, "we used to talk survival. Now we talk about expanding services and updating equipment."

Successful Initiatives Eliminated Duplicative And Underused Services

By tailoring health care services to meet their needs, the six initiatives we analyzed eliminated services that local people were not using, and those that were available to the community from other sources. All initiatives except MAFs eliminated inpatient care. The MAFs we visited had eliminated surgical care. Residents who need this type of care are transferred from the initiative to a hospital.

The community initiative designers deleted services that were once provided by the former hospital, but not used by the community. For example, in Lewisville, Arkansas the former hospital provided pharmacy services. In developing its initiative for health care after the hospital closed, the community did not include pharmacy services. Instead, the community issued vouchers for patients to use at private pharmacies in town where adequate service was available. Likewise, in Caney, Kansas before the hospital closed, it operated seldom-used and outdated laboratory and x-ray services. Both services were eliminated when Caney developed its initiative for providing access to health care after its hospital closed. They dropped the services because they could get the same services at better quality from the Bartlesville, Oklahoma hospital which was only about 18 miles away.

STATE ASSISTANCE IS CRITICAL FOR SUCCESSFUL COMMUNITY INITIATIVES

Support from State governments has been vital to the development and operations of some community initiatives. For example, State health departments and special task forces in Montana, Washington and Arkansas have supported local community initiatives through technical assistance and grants.

Further, some community initiatives required State legislation. Montana, for example, had to change its State law to expand the role of non-physician health care providers before communities could implement the Medical Assistance Facilities program. The State of Kansas revised its policies on Medicaid reimbursement to allow the partnership between Caney, Kansas and the Bartlesville, Oklahoma hospital. Likewise, as part of its managed care program, Washington State policy would have caused Metaline Falls, Washington Medicaid patients to be sent to health care providers in another community. However, the policy was changed and the patients are served through the Metaline Falls health care initiative.

LOCAL COMMUNITIES RELIED ON EXISTING FEDERAL PROGRAMS TO DEVELOP SUCCESSFUL INITIATIVES

As is true of virtually all health care programs, the six initiatives we examined relied on existing Federal programs to a large extent. Of particular significance, none of the community initiatives were funded through new Federal programs. To illustrate, Newton, Texas, Ekalaka, Montana and Oxford, Nebraska received Medicare and Medicaid reimbursements as part of the existing Rural Health Clinic program. The network of clinics which includes Lewisville, Arkansas, uses existing funds available under the Community Health Center program.

Other Federal health programs were used by several communities to help fund special projects. For example, Ekalaka, Montana used a Rural Transition Grant to design and plan a satellite clinic in the south end of the county. For the Medical Assistance Facilities program in Montana, the Health Care Financing Administration provided funding and approved waivers under a demonstration program.

CONCLUSION

Rural communities concerned about access to health care can find other ways to meet their health care needs without a hospital. Local residents who accept the notion of health care without a hospital can empower themselves to design and implement a strong health care system for their communities. The success of local health care initiatives depends heavily on creative use of all available resources by community leaders. A community must first obtain strong local support and then seek available State and Federal support.

This desire of local communities to take responsibility for their own health care needs was recently endorsed by Secretary Shalala. She expressed her intent to help rural communities empower themselves to meet their own health care needs.

We believe many other rural communities could follow the same processes described in our report to develop an initiative to meet health care needs.

APPENDIX A

DESCRIPTION OF COMMUNITY INITIATIVES

Newton, Texas:	Newton Education Center
Lewisville, Arkansas:	Rural Health Clinic
Metaline Falls, Washington:	North Pend Oreille Health Services Consortium
Oxford, Nebraska:	Oxford Medical Center
Caney, Kansas:	Jane Phillips Community Health Clinic
Circle, Ekalaka, Jordan, and Terry, Montana:	Medical Assistance Facilities

Newton Education Center
Newton, Texas

What is the initiative?

The Newton Education Center offers a variety of services, including a rural health clinic, public health services, educational programs, and community services at the former community hospital.

What was the hospital like before it closed?

The occupancy rates at the Newton County Hospital had been steadily declining before its closure in 1989. The hospital had been built eighteen years earlier, under a Hill-Burton loan. Virtually all physicians in the community had ceased practicing at the hospital and services were seriously reduced. Other doctors in the Newton area did not refer patients to the hospital. Most people traveled to other hospitals in Jasper, 12 miles away, or in Beaumont, 60 miles away. County funds supported the hospital, but could not continue indefinitely. The hospital closed when the last doctor working at the hospital resigned and ceased practicing in the community.

How was the successful initiative developed?

When the hospital closed in 1989 the county was faced with nearly a half million dollar debt and penalties owed for defaulting on the Hill-Burton loan. A new county judge searched for a way for the county to fulfill an indigent care commitment. A vocational teacher, who was also a former hospital board member, was searching for a way for the community to provide a program to help teen mothers stay in school and learn parenting skills. Grant money for a teen parent program was available from the State, but there was no space to operate the program. The teacher obtained a State grant and part of the former hospital was renovated for classrooms and a day care center. As this was happening, the not-for-profit hospital in Jasper hired a new administrator who had run satellite rural health clinics before. The former hospital board in Newton and the former board of another closed hospital in Kirbyville approached the Jasper hospital administrator about opening rural health clinics (RHCs) in their former hospitals. The hospital in Newton was county property, and the county judge obtained agreement to convert part of the former hospital building into a RHC. The RHC opened as part of the Newton Education Center in February 1992. The county health district needed a larger space and also moved into part of the former hospital.

What services does the initiative provide?

The Newton Education Center operates a RHC, public health services, transportation services, and educational services. The RHC provides basic primary care, normal doctor's office services from 8:00 am to 5:00 pm, five days a week. As part of the RHC basic lab and x-ray services are available. A doctor from Jasper Memorial Hospital staffs the clinic. The Newton Education Center provides public health services, such as

immunizations, Women and Infant Care (WIC) services, and well-child care. As part of the health services provided by the RHC and public health offices, people needing hospitalization or more specialized care are referred to Jasper Memorial Hospital or other hospitals in Beaumont, Houston or Galveston.

The Newton Education Center provides limited van service to transport people in need of care to the RHC, and to affiliated community health clinic and referral hospitals.

The county school system funds many educational programs operated at the Newton Education Center. The program for teen mothers opened in August 1990. It provides a place for pregnant students to continue high school, learn parenting skills, and train for careers in child care. A day care center that is open to the public provides a needed community service. Newton Education Center also offers other vocational programs. For example, a food education program is offered in the former hospital kitchen. The food education program provides training for careers in food service. It also provides meals to the elderly that are distributed through a meals-on-wheels program. The Center built a horticultural education center in the field adjacent to the center. It provides training while growing food for meals programs. The horticulture center is partially funded through a contract to provide plant care at county offices. Newton Education Center also provides special education for students with learning disabilities. The Center plans to use former hospital equipment for training material and add health service career programs.

How has the initiative affected community health care needs?

Many people who had to travel to get care in other places are now able to get care locally. Newton residents and patients from a 50-mile radius come to the busy clinic. Since the clinic physician is on staff at a hospital, referral for care is facilitated.

Additional benefits result from offering a range of services in one location like the Newton Education Center. For example, teen mothers get prenatal care, health education, and WIC services while participating in a stay-in-school program. Their children, and other children in a day care center, have access to medical professionals whenever necessary. A food service program provides a nutritional diet directly to the elderly in the community. Secondly it teaches students about the importance of nutritionally balanced diets. The horticulture program supplies some fresh foods for better nutrition, and education on how agriculture processes can affect health.

The Newton Education Center, as part of the health care network with Jasper Memorial Hospital, refers many patients to the hospital. As the patient base expands at Jasper Memorial Hospital, the hospital is able to add staff and state-of-the-art medical equipment. This results in the community of Newton having access to a more sophisticated hospital just 12 miles away.

Contact: James Singletary, Newton Education Center (409/379-2522), or Ernie Domenech, Administrator, Jasper Memorial Hospital (409/384-5461).

Rural Health Clinic
Lewisville, Arkansas

What is the initiative?

The Rural Health Clinic is a community health clinic and the local health department sharing the former hospital building. The clinic serves primarily Lafayette County, an area of about 10,000 people. A satellite clinic is located in the southern part of the county in Bradley. The board for the initiative has plans to include county social services into the building to create a "one-stop shopping center."

What was the hospital like before it closed?

For several years before its closure in 1987, Lafayette Memorial Hospital had lost physicians and was forced to reduce services. The hospital had downsized, but still had an occupancy of only eleven percent. Several larger hospitals that are located about 25 miles away in surrounding counties offered more specialized care. Most people who were able to travel to any of these other hospitals did so, leaving Lafayette Memorial Hospital serving primarily elderly and poor patients. Despite low use, community leaders desired to keep the hospital open. The county levied a one percent sales tax to support the hospital, and the hospital board developed plans to convert part of the hospital into a rehabilitation facility. The plans failed and the hospital closed. After the hospital closed, all but one physician ceased practicing in the county.

How was the initiative developed?

Prior to closure, a group of concerned community leaders formed a board to plan for county health care needs. They sponsored a needs assessment which showed that the county was one of the poorest and most underserved in Arkansas.

At the same time, the State Health Department formed a State Committee on Indigent Health Care to give a rare surplus of Medicaid money as grants to needy communities. The Lewisville board asked State health officials for a grant and technical assistance in planning. Together, they developed a plan to combine a health care center with a social services center to create a one-stop-shopping center to provide care for the poor. The board received a State grant of over $600,000 to renovate and staff a medical clinic in the former hospital facility.

The Rural Health Clinic needed a constant supply of operating funds. Several nearby counties belonged to a network of community health clinics, called Cabun. The Cabun network participates in the Federal Community Health Clinic (CHC) program. To obtain CHC funds the clinic at Lewisville joined the network. Cabun handles the administration, quality assurance and supervisory work involved in running the clinic.

The State-run health department which had offices located in Lewisville had outgrown its old offices and needed a larger facility. The State Health Department area administrator, working with the community, obtained a State grant to renovate part of the hospital building for use as State Health Department offices.

What services does the initiative provide?

The Rural Health Clinic provides basic primary care, normal doctor's office services from 8:00 am to 5:00 pm for five days a week. Basic lab and x-ray services are available. Public health nurses at the Clinic also provide services such as immunizations and well-child care. A visiting pediatric nurse and nutritionist supplement care. The Clinic coordinates home health services that are provided through the State health department. The Clinic provides van service to bring people without transportation to the Clinic or transfer them to their choice of hospitals. The Clinic will include county social services when a new wing is built onto the former hospital building.

The Rural Health Clinic also staffs and administers a satellite clinic, which is located in the southern part of the county in Bradley, Arkansas. Several years ago, a large hospital in Louisiana donated an equipped trailer to be used as a clinic in the very underserved Bradley area. Now all services provided in Lewisville are also provided on a part-time basis in Bradley. The high volume of patients has outgrown the trailer, and needs to be expanded. The Lewisville board is applying for a State grant to build a permanent facility.

Currently, four doctors, including one pediatrician, work part-time at the Clinic. The doctors are employees of Cabun, and all travel into the community to provide care. The Clinic board in coordination with Area Health Education Council is planning to employ a full-time physician-educator from the University of Arkansas medical school to staff the clinic. The physician would then train residents in rural health care.

How has the initiative affected community health care needs?

For the very poor, the Rural Health Clinic offered them an opportunity to receive needed non-emergency health care locally. The Clinic provides reduced cost health care, enabling access to poor people who would otherwise not be able to pay for private health care. Since care is locally provided, children, elderly and people without transportation no longer have to travel or rely on emergency ambulance services to obtain care.

Once the one-stop shopping center is complete, people in Lewisville will have access to a full-range of social and health services. One short application form will make services available to patients with fewer hassles to clients and enable providers to better coordinate services.

Contact: Charles McGrew, Director, Section of Health Facility Services and Systems, Arkansas Department of Health (501/661-2194).

North Pend Oreille Health Services Consortium
Metaline Falls, Washington

What is the initiative?

North Pend Oreille Health Services Consortium is a network of volunteer and professional primary health care providers from in and around North Pend Oreille county.

What was the hospital like before it closed?

Mt. Linton hospital in Metaline Falls, Washington closed in 1988 when the only physician moved out of town. It had 23 beds with an occupancy rate of 9.25 percent. Most residents received hospital care either by driving 100 miles to Spokane, or 50 miles to Newport. Upon closing, the hospital district became liable for unemployment insurance for the former employees and ran up a debt of $77,000, which still exists.

The hospital was run by three locally elected Hospital Board commissioners. The Board receives a portion of the property taxes -- approximately $9,000 per year in this poor rural area. The Commissioners used tax revenue and donations from local companies to pay for insurance and heat to keep the building in good enough condition to reopen. In 1992, four years after closure, the Hospital Board acknowledged that the hospital will not reopen. They surplused the building and are accepting bids from potential buyers.

How was the successful initiative developed?

Community members formed a Committee after the hospital closed. Two Committee members attended a rural health conference and learned of a State grant program (Rural Health Care Systems Development) and the "community encourager" program. The pastor of a local church completed the grant application and the community subsequently received $57,000 from the State. The local Hospital Association paid for one Committee member to be trained to become a community encourager, which is basically a community organizer. The Hospital Association used some of the grant money to follow a planning process developed by Eastern Washington Office of Rural Health, Area Health Education Center (AHEC), and Washington State University. The planning process entails several steps. First, AHEC surveyed residents and analyzed community needs and resources. Then, the community convened a meeting to arrive at consensus on what health services they wanted and would support. The community decided its main goals were to get a physician and to obtain 24 hour emergency care. AHEC told them about a Federal Office of Rural Health Policy Outreach grant. The same pastor completed an application and the community subsequently received $267,000 for the first year of a 3-year grant. By following the planning process, developed by AHEC, the community established the basic structure of linkages among providers that enabled them to meet the requirements to obtain the Federal grant. The Hospital Association, after years of efforts, successfully recruited a physician in July 1992.

What services does the initiative provide?

The Consortium provides primary care to the community through a clinic, staffed with a physician, one physician assistant, and three part-time health care assistants who are licensed by the State. The clinic is open 5 days a week and the physician provides after hours coverage for life threatening emergencies. The clinic has a referral agreement with a group of physicians 50 miles away for specialty services. The Consortium also employs a community health worker who assesses client health and human service needs and makes referrals using the Consortium's health resource inventory and an 800 line. A nearby rural health clinic provider is helping the clinic set up a pharmacy.

The Consortium also supports emergency care. They have a volunteer 911 system, staffed by the clinic during the work day and five volunteer households on rotating 16-hour shifts at all other times. The community also has an all volunteer first response unit with EMTs, Advanced Life Support (ALS) and High Angle Rescue and Dive Team. In addition, they have an all volunteer ambulance service staffed with EMT and ALS personnel. The Consortium paid for EMT training and upgrading ambulance equipment.

The Consortium has an agreement with the nearest hospital in Newport to provide telephone consultation for (1) 911 operators, (2) emergency room care, and (3) inpatient care. A nearby health care provider has agreed to expand home health services to serve the Metaline Falls community. The county mental health department will hire two psychiatric nurse practitioners to serve four counties in the area. A third organization, Rural Resources, used Consortium funds to help buy and operate a handicapped van to provide transportation. The Consortium has a continuing relationship with AHEC for planning and evaluation.

How has the initiative affected community health care needs?

Residents are very happy to finally have a physician. Part of the Consortium grant of $267,000 pays the physician's salary for now since the clinic's income is not yet sufficient to support him. In addition, the consortium provides for more and different types of care beyond what the physician provides. The Consortium has enabled better emergency care and more primary care, and it provides some types of care that were previously unavailable, such as home health care and mental health care. Although many residents still would like a place where people could stay overnight for medical observation, such as a Medical Assistance Facility, many feel the Consortium is a satisfactory adaptation to not having a hospital. The Consortium anticipates that by the time the grant funds are exhausted, the clinic will have regained enough patients to be self-supporting.

Contact: Kathy Grass, Director, North Pend Oreille Health Services Consortium, Ione, Washington (509/442-3514).

Oxford Medical Center
Oxford, Nebraska

What is the initiative?

The initiative is a primary care clinic staffed by a physician assistant and owned by a general acute care hospital in Cambridge, Nebraska, 30 miles away. The clinic is housed in part of the closed hospital building. It is one of five satellite clinics operated by the Cambridge hospital. The Oxford clinic hours are 9:00 am to noon and 1:00 to 5:00 pm Monday through Friday, except Wednesday afternoons, when it is closed. It is a licensed independently certified provider-based rural health clinic.

What was the hospital like before it closed?

The closed hospital, Fritzer Memorial Hospital and Health Center, was built in the 1920's. In 1987 the Fritzer Foundation gave the hospital to the city of Oxford. During the 1980's the financial condition of the hospital deteriorated due to problems of physician availability and a declining occupancy.

During approximately the last decade the hospital was open, it was staffed by one medical doctor (MD), except for very brief periods when a second MD was employed. One physician assistant was also employed the last two years, 1988 and 1989. The sole MD had gradually narrowed her practice to geriatrics, so younger patients seeking OB/GYN and/or pediatric services had to go elsewhere. Some community members assert that people had begun to migrate to Holdrege several decades earlier. Holdrege is 21 miles away, and it offered a wider variety of both shopping facilities and medical services.

In 1988 the one MD at the hospital was sanctioned by the Peer Review Organization (PRO), and could no longer serve Medicare and Medicaid patients. Since this sanction eliminated most of her patients, the physician tendered her resignation, effective January 1, 1990. A temporary physician, who was recruited after the long-term physician left, and the physician assistant staffed the hospital until December 8, 1989 when inpatient services were terminated.

People in the community exerted extraordinary efforts to save the hospital. They passed two bond issues totaling over a half million dollars, developed a system of "Keno" (a legal form of gambling), and held auctions and bake sales to raise funds. The unabated decline in occupancy, however, made it impossible to keep the hospital open.

How was the successful initiative developed?

Several years prior to the hospital closure the CEO from the hospital in Cambridge had begun to foster relationships with people in Oxford. He knew the Oxford hospital was having a difficult time, and wanted the people in Oxford to know that the Cambridge hospital was willing to try to help, if they wanted them to do so. Late in 1989 when the

Board at Oxford saw that closure was unavoidable, they approached several nearby hospitals to ask what each could do to help maintain health care. Only the hospital in Cambridge responded with an offer to open a clinic, initially on a 90-day trial basis. Three physicians from the Cambridge hospital provided health care from the time the hospital closed, until the clinic opened on January 3, 1990, and until a full-time physician assistant was hired in July 1990. Those three physicians each still work at the clinic one afternoon a week.

The newspaper in Oxford supported the transition of the former hospital to a primary care clinic by publishing articles about the new clinic. Medical and non-medical staff from the Cambridge hospital spoke to groups at meetings in Oxford to express their commitment to the clinic. Influential citizens in Oxford openly supported the clinic and encouraged people to use it.

What services does the initiative provide?

The clinic offers general family practice services. Specifically it offers prenatal care, physician assistant care, laboratory and x-ray services, urgent care during business hours and on an on-call basis after hours, emergency transportation services through a volunteer EMT service and helicopter transport to nearby hospitals, well-child services, family planning services, vision and hearing screening for school and employment, nutrition education, EKG, health education services, and a pharmacy.

How has the initiative affected community health care needs?

When the hospital closed the community was generally in a state of despair. Now the community in general is happy and appreciative of what they have. Many believe the clinic health care is far more reliable and varied than that previously offered by the former hospital. The clinic has preserved a system of primary care and emergency care in the community, made Medicare- and Medicaid-reimbursed services available again, brought people back to the business section of town, preserved professional and technical level jobs, saved the only pharmacy in town from closing, and made access to care better. The addition of a "handibus" which runs between Oxford and Cambridge on Tuesdays has improved access to hospital services -- particularly for the elderly and the poor. The initiative has helped to erode a strong sense of rivalry between the two towns and enlarged the concept of what a "community" is.

The Cambridge hospital continues efforts to recruit a full-time medical doctor to staff the Oxford clinic and hopes to broaden their services further with the addition of specialists.

Contact: Jim Naeve, CEO, Cambridge Memorial Hospital and Medical Center, Cambridge, Nebraska (308/697-3329).

Jane Phillips Community Health Clinic
Caney, Kansas

What is the initiative?

In Caney, Kansas (population 2,300) the former acute care hospital is now a doctors' clinic and a 10 bed long-term care facility. The clinic is a satellite of a large regional health center, Jane Phillips Episcopal Memorial Medical Center in Bartlesville, Oklahoma, just 18 miles away.

What was the hospital like before it closed?

The hospital was staffed to provide 24-bed in-patient acute care, 24-hour emergency care, x-ray and clinical lab services.

Caney hospital served a community with a large number of elderly people. In the years preceding closure, the Medicare use rate ranged between 40 and 60 percent, once going as high as 78 percent.

Few people were using the hospital. It had an occupancy rate of about 25 percent prior to closing. From 1981 to 1988 annual patient admissions declined from 521 to 217.

During the last two years of its existence as an acute care facility, the Caney hospital was dependent on fundraisers and private donations to continue operations. As one board member of the former hospital said, "You can't tax enough to keep a rural hospital in business."

How was the successful initiative developed?

The vision and initial groundwork for the initiative was provided by the administrator of the former hospital. Many communities undertake ill-advised yet understandable refinancing measures in order to ensure their hospitals stay open. However, Caney, having struggled to keep their hospital afloat, was primed to accept another means of care. The administrator responded to evidence of impending financial insolvency by identifying options, which included recognizing health care system support being provided by the Jane Phillips Episcopal Memorial Medical Center in Bartlesville, Oklahoma.

In fact, the Jane Phillips story is the real story here. It was already providing a variety of support services as a hub for several other formerly independent community health care facilities. Included in these are hospitals in Pawhuska, Oklahoma and Sedan, Kansas. A third hospital in Nowata, Oklahoma presently serves as a drug and alcohol rehabilitation facility. In addition, two other satellite physician clinics in Barnsdahl and Ramona, Oklahoma complete the regional picture. In each case the facility facing closure approached Phillips Hospital for support ranging from management services to direct financial aid. In each case, Phillips responded by providing the appropriate level of support to maintain the health care service or some altered type of service.

While this is not a formal EACH/RPCH demonstration, the model which Jane Phillips pioneered in the region is very similar. The major hospital at the hub is surrounded by a number of other limited health programs. One important difference is that in the Caney instance the health community served crosses State lines which EACH/RPCH prohibits. Foresight and careful planning allowed the Caney Hospital to close as an acute care facility one Friday and open on the following Monday as a Jane Phillips 24-hour doctors' health clinic and long-term care facility.

What services does the initiative provide?

The Caney facility provides offices for three physicians, lab services, and an optician's office. At the time of our site visit, September 1992, Caney was preparing to house its remaining pharmacy in the same complex with the clinic. The clinic also serves the community of Caney and the immediately surrounding rural area with 24-hour urgent care and emergency transportation services to Jane Phillips Hospital in Bartlesville, Oklahoma.

At the time of our visit, Caney had two practicing physicians. Negotiation to obtain a third practicing physician for the community was almost completed. The former hospital also employed the services of a physician assistant on a part-time basis. With lab services on site and access to more advanced diagnostics at the Phillips hospital, the arrangement meets community needs. Physicians shared a waiting room and reception services. Each had a private office and several patient treatment rooms. Each also had privileges at Phillips hospital.

The clinic was in the process of becoming a focal point in town for all health services except dentistry. An optician had recently moved offices into the facility and a pharmacy was also preparing to do so. The clinic also has the ability to transport patients with both a helipad and an ambulance available for cases requiring stabilization and transport.

How has the initiative affected community health care needs?

The implications for one-stop health care are obvious. With the convenience offered here, buoyed by the capability of Phillips to provide more sophisticated medical services, the initiative is meeting Caney health care needs better than the original hospital. In fact, the transition to the clinic concept was so smooth that most citizens we contacted expressed a belief that it is still a hospital with more services. While the former hospital was underused, the clinic now has a waiting list of patients wanting health care service.

Contact: Catherine H. Abrams, Vice President for Regional Development, Jane Phillips Episcopal Memorial Medical Center, Bartlesville, Oklahoma (918/333-7200 Ext. 748).

Medical Assistance Facilities
Circle, Ekalaka, Jordan, and Terry, Montana

What is the initiative?

A Medical Assistance Facility (MAF) offers low intensity inpatient care, 24-hour emergency care, and basic outpatient medical services. As designed under Montana law, a MAF must be in a county with a population density of no more than six residents per square mile. Further, it must be located more than 35 miles from the nearest hospital. MAFs operate without meeting the same licensing requirements as hospitals. In MAFs, care may be provided by physician assistants or nurse practitioners, with a supervising physician visiting the MAF once every 30 days. The MAF does not need to be staffed 24-hours a day unless a patient is in the facility. Only one MAF staff member must be on duty or on call at all times. Patients may receive up to four days of inpatient care in a MAF. However, patients with serious illnesses or injuries are stabilized at the MAF and transported to a full-service hospital.

What was the hospital like before it closed?

At the time of our review, four Montana communities had MAFs. They are Circle, Ekalaka, Jordan, and Terry. All four of the community hospitals had low occupancy rates. Most of the hospitals had scaled back services. None of the four hospitals provided specialty care. Finally, most surgeries and obstetrical services were discontinued.

How was the successful initiative developed?

Unlike other communities with successful initiatives, the four Montana communities were invited to participate in the MAF project. Early in the 1980's, the governor of Montana created a task force to study the future of rural hospitals. The task force determined many rural communities could not continue to support a full-service hospital, yet communities needed access to primary and emergency care. In 1987, the Montana State legislature authorized the MAF program. This program was designed to provide continued access to health care by converting a full-service hospital into a low-intensity, short-stay health care service center.

In 1988, the Montana MAF program received planning and development funding through a Health Care Financing Administration (HCFA) demonstration grant. Also, HCFA waived numerous hospital requirements so that MAFs could receive Medicare reimbursement. In 1990, HCFA authorized a cost-based reimbursement system for MAFs. HCFA also established quality assurance, utilization review and certification, and life safety standards for MAFs.

What services does the initiative provide?

MAFs provide up to 96 hours of inpatient acute care, 24-hour emergency services, stabilization and transfer services for severe cases, basic lab services and basic x-ray services. All MAFs also offer outpatient medical service, and are collocated with nursing homes. Each MAF may offer other services based on the needs and resources of the community.

How has the initiative affected community health care needs?

MAFs meet most of the health care needs of a community. With the combination of 24-hour emergency care and limited inpatient care, MAFs are providing basically the same care as that provided by the former hospital. Providers at the MAF are performing only limited and clearly defined services which they are fully equipped and trained to handle. When patients need care that is not available at a MAF, the MAFs transfer them to a facility that can provide the needed care.

Contact: Keith McCarty, Director, Montana Hospital Research and Education Foundation (406/442-8802).