

GRANT
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HEALTH

GIH RURAL HEALTH CARE:

*Innovations in
Policy and Practice*

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BASED ON A
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FOREWORD

As part of its continuing mission to serve trustees and staff of health foundations and corporate giving programs, Grantmakers In Health (GIH) convened a group of grantmakers and rural health experts on November 21, 2008, for a discussion on proven strategies being used to build capacity and improve health care access in rural areas. The Issue Dialogue entitled Rural Health Care: Innovations in Policy and Practice focused on raising the visibility of delivery system improvements that are showing results in rural areas, exploring the interconnectedness between rural and urban areas, and discussing how philanthropic investment can help support and spread the many rural innovations underway. This Issue Brief synthesizes key points from the day's discussion with a background paper previously prepared for Issue Dialogue participants.

Special thanks are due to those who participated in the Issue Dialogue, especially the presenters: Andrew Coburn, Muskie School of Public Service, University of Southern Maine; Mario Gutierrez, The California Endowment; Thomas Irons, The Brody School of Medicine, East Carolina University; Thomas Morris, Health Resources and Services Administration of the U.S. Department of Health and Human Services; Keith Mueller, College of Public Health at the University of Nebraska Medical Center and the Rural Policy Research Institute Center for Rural Health Policy Analysis; Joel Neimeyer, Rasmuson Foundation; Zettie Page, Plains Medical Center; Thomas Ricketts, University of North Carolina (UNC) Gillings School of Global Public Health and the UNC School of Medicine; Mary Wakefield, Center for Rural Health at the School of Medicine and Health Sciences, University of North Dakota; and Wendy Wolf, Maine Health Access Foundation.

Lauren LeRoy, president and CEO of GIH, moderated the Issue Dialogue. Osula Evadne Rushing, program director at GIH, planned the program, wrote the background paper, and synthesized key points from the Issue Dialogue into this report. Faith Mitchell, vice president at GIH, and Leila Polintan, communications manager at GIH, provided editorial assistance.

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EXECUTIVE SUMMARY

RURAL HEALTH CARE:

Innovations in Policy and Practice

All too often discussions of rural health policy concentrate almost exclusively on the challenges in rural areas: high rates of uninsurance, obesity, smoking, and alcohol use; a shortage of medical staff and facilities; economic decline; rapidly changing demographics as the population ages and new immigrants arrive; and physical and social isolation due to geography, population loss, and weather. But while it is true that rural America has not been immune to the effects of major economic and societal trends, rural areas' responses to these challenges demonstrate that they are often ideal incubators for innovative policies and practices.

Rural America

It is estimated that there are 50 million rural Americans who make up 17 percent of the U.S. population and live on 80 percent of the land (Hamilton et al. 2008). Overall in the past decade, the rural population has grown, rural employment and educational attainment have risen, and the rural poverty rate has declined. These aggregated data, however, mask important regional and demographic differences. In fact, rural America is far less homogeneous than most Americans realize, with wide variations in population density; distance from urban districts; and economic, environmental, social, and political traits. Even so, a number of crosscutting topics are under discussion in rural communities of all types.

These include economic and demographic changes, shifting civic institutions and leadership, environmental concerns, and investment in infrastructure.

Access to Care in Rural America

On average, rural Americans are older, more impoverished, and in worse health than their urban counterparts, and the access challenges facing rural America are well documented (Schur and Franco 1999; Eberhardt et al. 2001; Gamm et al. 2003; Ziller et al. 2003). Rural residents, particularly those living in more remote areas, are less likely than their urban counterparts to have health insurance to help cover the costs of

health care and are also more likely to be underinsured. It is also more difficult for rural residents to obtain specialty services, most notably mental health services, than it is for their urban counterparts. The impact of these access barriers is stark. Rural residents are less likely to have a usual source of care for children under the age of six; less likely to have had a health care visit in the past year; more likely to have had an emergency department visit in the past year; less likely to have had a dental visit in the past year; and more likely to report that they did not get medical care, delayed medical care, or did not get prescription drugs due to cost (National Center for Health Statistics 2007).

Rural Health Policy Priorities

There are a number of pressing rural health policy priorities, including establishing and maintaining access to professional health services in rural communities, assuring continuation of essential local services, maintaining adequate payment for rural providers, continuing support for public rural health programs, and continuing to ensure equity in benefits between rural and urban places and people.

Promising Practices

Stakeholders in rural communities have demonstrated that a collaborative culture and a readiness to be creative in the organization and regulation of health systems can result in the capacity and range that are crucial for providing superior and cost-effective services in rural locations.

In many rural areas, local challenges drive innovation. For example, resource scarcity and low volume drive the creation of formal and informal networks that share personnel, expertise, and technology, and workforce shortages drive the creation of new or enhanced roles for health care personnel and team approaches to care. Other innovations grow out of local assets in rural areas. For example, the small scale provides flexibility, enhances the

ability to communicate, and simplifies shared approaches across multiple stakeholders, and the primary care focus drives lower utilization of high-cost services. Taken together, these innovations result in access, efficiency, quality, care coordination, rapid learning, cooperation, and lower spending, and offer ideas and techniques that could usefully be adapted to other rural places and to urban health systems as well.

Rural-Urban Similarities and Interdependencies

In many ways, the problems facing rural America are surprisingly similar to those plaguing urban communities: poverty, underfunded educational systems, insufficient affordable housing, poor population health, limited employment, immigration pressures, racial/ethnic disparities in opportunity, and crumbling infrastructure. In the words of a 2008 Aspen Institute report: “There are...similarities between rural and urban communities around which common cause can be built...the well-being of each place is strongly influenced by what is happening in the other and on finding opportunities to work together to improve their shared fate.”

For philanthropy, the implications of these similarities and interdependencies are twofold. First, serious investment in rural health care access allows health funders the chance to quickly test ideas on a smaller scale and then adapt them in other rural communities and in larger metropolitan areas. And second, “understanding the ways in which rural dynamics are fundamental to urban well-being—and vice versa—could well be the catalyst to develop creative strategies for promoting prosperity and equality for all American communities” (Aspen Institute 2008).

Recent Philanthropic Activities

Over the years, foundations and corporate giving programs have supported a wide range of activities that attempt to improve access to health care in rural

America. These activities include motivating physicians to work in rural areas, enhancing the roles of midlevel practitioners, addressing geographic barriers to health care, improving timely access to specialty care, improving quality and patient safety in rural hospitals, improving the financial viability of rural hospitals, improving health care delivery for agricultural workers, and working to understand the consequences of financial barriers to care in rural America.

Lessons Learned

There are a number of ways for philanthropic investment to help support and spread rural innovations underway. To assist in this effort, the Grantmakers In Health Issue Dialogue brought forth a number of lessons that grantmakers can use: work regionally; collect local data; encourage collaboration; consider flexible approaches and funding strategies; support delivery system reforms; focus on workforce issues; think creatively about technology; build connections between rural and urban areas; work in concert with rural communities, not on their behalf; be prepared to face opposition; and think beyond health care access.

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INTRODUCTION

All too often discussions of rural health policy concentrate almost exclusively on the challenges in rural areas: high rates of uninsurance, obesity, smoking, and alcohol use; a shortage of medical staff and facilities; economic decline; rapidly changing demographics as the population ages and new immigrants arrive; and physical and social isolation due to geography, population loss, and weather. But while it is true that rural America has not been immune to the effects of major economic and societal trends, rural areas' responses to these challenges demonstrate that they are often ideal incubators for innovative policies and practices.

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This Issue Brief focuses on key questions related to rural health access: What is unique about rural America? Which efforts to improve access and redesign the health care delivery system are working in rural areas? Are there specific rural health

policy priorities? What lessons have funders learned from recent foundation initiatives aimed at improving access to health care in rural areas? Are there new ways for philanthropic investment to help support and spread the rural innovations underway?

DEFINING RURAL

There is no single, unanimously favored definition of the term “rural.” Current federal programs use more than 15 definitions, and the share of the U.S. population deemed rural ranges from 17 to 49 percent depending on the one used.

The most commonly used definitions are based on either the Census Bureau Urbanized Area categorization of census blocks and block groups or the Office of Management and Budget characterization of counties. Even these two classification systems can result in very different sets of places being defined as rural.

Matters are complicated by the fact that rural designations can change with population shifts or altered geographic boundaries. It is important to select a definition with care when designing a rural policy or program, since the choice of definition can result in unintended consequences by making an effort's reach either too narrow or too broad (Coburn et al. 2007; Cromartie and Bucholtz 2008).

RURAL AMERICA

It is estimated that there are 50 million rural Americans who make up 17 percent of the U.S. population and live on 80 percent of the land (Hamilton et al. 2008).

In the words of the landmark Institute of Medicine (IOM) (2005) report *Quality Through Collaboration: The Future of Rural Health Care*:

These rural communities are rich in cultural diversity: from the Native American Indian tribes and Latino communities of the southwest, to the African-American communities of the Mississippi Bayou, to the Amish settlements of Pennsylvania, to the European descendants of the Great Plains, rural communities are home to many of the earliest Americans, as well as more recent immigrants.

Overall in the past decade, the rural population has grown, rural employment and educational attainment have risen, and the rural poverty rate has declined. According to data from the U.S. Department of Agriculture's Economic Research Service, however, these aggregated data mask important regional and demographic differences (Kusmin 2007). The rural population has grown because of domestic migration in western areas that are a draw because of their natural amenities and local economies based on tourism and recreation. And in many parts of the south—like the Florida coast and northern Virginia—these areas are close to urban jobs. But rural areas that do not have booming

service economies—like the poorer rural communities in the Mississippi Delta and Rio Grande Valley and rural communities with few residents in the Great Plains and Corn Belt—are losing population. Rural employment growth has slowed down in the northeast, and rural unemployment rates remain high among African Americans and young people. Rural poverty continues to be higher than urban poverty, with poverty rates in the rural south higher than in any other region.

An Overview of Rural Places

Rural America is far less homogeneous than most Americans realize, with wide variations in population density; distance from urban districts; and economic, environmental, social, and political traits (IOM 2005). Researchers at the University of New Hampshire's Carsey Institute have found it useful to delineate four types of rural places: amenity-rich, declining resource-dependent, chronically poor, and amenity-driven growth combined with resource-based decline (Hamilton et al. 2008).

Overall in the past decade, the rural population has grown, rural employment and educational attainment have risen, and the rural poverty rate has declined. However, these aggregated data mask important regional and demographic differences.

CONCENTRATED RURAL POVERTY AND THE GEOGRAPHY OF EXCLUSION

Poverty debates typically center on the urban poor, particularly those in the inner city. Much less research and policy attention have focused on the rural poor. As a result, the rural poor are often left behind and forgotten in economically distressed small towns in Appalachia, the Mississippi Delta region, *colonias* along the border in Texas and New Mexico, on Indian reservations, and in other pockets of rural poverty throughout the country.

New empirical evidence on concentrated rural poverty shows that one-half of all rural poor are segregated in high-poverty areas. The rates are even more striking for minorities. Three-fourths of rural blacks and two-thirds of rural Hispanics are segregated from America's more affluent, largely white populations.

Clearly, the rural poor, like those in cities, are often physically and socially isolated from most middle-class Americans. These findings call for targeted public policies that address inequalities based on place and the geography of exclusion in America.

Excerpted from Lichter, Daniel T., and Domenico Parisi, *Concentrated Rural Poverty and the Geography of Exclusion* (Durham, NH: University of New Hampshire Carsey Institute, 2008).

Amenity-Rich

Their picturesque settings make amenity-rich rural places—like Chaffee and Park counties in the Rocky Mountains of Colorado—appealing. Baby boomers are tempted by the thought of retirement in charming small towns, the affluent are inspired to buy second homes near scenic vistas and outdoor activities, the middle class enjoys being able to live quiet lives and commute to work in nearby cities, and young professionals are eager to move in to start families out of harm's way. The arrival of these new residents increases property values, necessitates new businesses and services, and often puts the existence of affordable housing and living-wage jobs at risk.

Declining Resource-Dependent

In the past, declining resource-dependent places—like Jewell, Osborne, Republic, and Smith counties in Kansas and other regions of the Midwest—relied almost exclusively on farming, forestry, or mining industries to support a stable working class. These regions have weathered several upswings and downturns, and now that their resources are exhausted and manufacturing is in jeopardy, their economies are weakening. The number of residents is shrinking despite an influx of low-wage immigrants. The previously vigorous working class, so vital to local organizations and customs, feels newly vulnerable.

Chronically Poor

Chronically poor areas—like Kentucky’s Harland and Letcher counties in the center of Appalachia—have a long tradition of adversity and suffering. Over extended periods, both the people and the places have been stripped of resources without equitable compensation, resulting in damaged regions where services are in short supply and infrastructure is weak or crumbling. Underinvestment, failed leadership, and struggling schools have disadvantaged wide swaths of the population, with no end in sight. Unattractive to new residents and noticed only when tragedy—whether it is a hurricane or a mining accident—occurs, these communities are, for the most part, discounted and overlooked.

Amenity-Driven Growth Combined with Resource-Based Decline

Amenity growth/resource decline places—like the Pacific Northwest’s Clatsop county in Oregon and Pacific County in Washington and the Northeast’s Coos County in New Hampshire and Oxford County in Maine—resemble amenity-rich areas in some ways and declining resource-dependent communities in others. In these regions the established economies are diminished, but not gone, and the possibility of expansion exists even though many of the younger residents are leaving.

A Snapshot of Rural Issues

In rural communities of all types, a number of crosscutting topics are under discussion. These include economic and

demographic changes, shifting civic institutions and leadership, environmental concerns, and investment in infrastructure (Hamilton et al. 2008).

Economic Changes

Farming and manufacturing industries are on the wane in rural regions. Between 1997 and 2003, more than 1.5 million rural workers lost their jobs because of transformations in industries that had long been the foundation of the rural economy (Glasmeier and Salant 2006). Agriculture and factory jobs are being replaced by an emerging service industry. These new jobs often call for retraining in areas without well-developed training and education infrastructure.

Demographic Changes

Residents in declining, chronically poor, and amenity growth/resource decline counties are growing older as working adults move away, the elderly stay, and birth rates go down. In contrast, amenity-rich areas are magnets for new residents, young and old. As cities and suburbs spread into rural land, however, rural communities worry about their ability to retain their customs and culture. A number of rural areas outside the historical major immigrant gateways—like the rural Midwest, central North Carolina, and northern Georgia—are also struggling to adapt to new immigrants.

Shifting Civic Institutions and Leadership

Although many of us think of rural regions as close, harmonious communi-

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ties, the reality is more complicated. Unrelentingly poor areas frequently grapple with wide economic, political, religious, and social divides. Residents are not necessarily tied to community resource organizations or to each other. More well-off rural communities often have similar gulfs between established residents and newcomers, particularly in places with an influx of recent immigrants.

Environmental Concerns

Some rural environmental concerns are local. In chronically poor and declining areas, for instance, many rural industries have done harm to the environment and exhausted local resources. In amenity-rich regions,

the sizeable number of people moving in puts an additional strain on the natural and built environment. Other environmental challenges are linked to global concerns. Changes in the weather and seasons linked to climate change, for example, generate new anxieties for rural Americans.

Investment in Infrastructure

Infrastructure, including transportation, telecommunications, water, and energy, is crucial for rural growth. Many rural regions, however, are fiscally constrained because of a limited tax base, few economies of scale, and problems adapting to growing or shrinking numbers of residents (Whitener and Parker 2007).

ACCESS TO HEALTH CARE IN RURAL AMERICA

On average, rural Americans are older, more impoverished, and in worse health than their urban counterparts, and the access challenges facing rural America are well documented (Schur and Franco 1999; Eberhardt et al. 2001; Gamm et al. 2003; Ziller et al. 2003).

Rural residents, particularly those living in more remote areas, are less likely to have health insurance to help cover the costs of health care: 33 percent of rural families not living near an urban area have at least one uninsured member, as compared to 28 percent of their urban counterparts (Maine Rural Health Research Center 2007). Rural residents also have less adequate private coverage: 12 percent of privately insured rural residents are underinsured, as compared to 6 percent of urban residents (Ziller et al. 2006).

Although rural areas have far fewer physicians than urban areas (a recent study found that there were 5.3 primary care physicians and 5.4 specialists per 10,000 population in rural areas, compared with 7.8 and 13.4, respectively, in urban areas),

there is some debate about whether the supply of physicians is inadequate (Reschovsky and Staiti 2005). There is general agreement, however, that it is more difficult for rural residents to obtain specialty services, most notably mental health services, than it is for their urban counterparts.

The impact of these access barriers is stark. Rural residents are less likely to have a usual source of care for children under the age of six; less likely to have had a health care visit in the past year; more likely to have had an emergency department visit in the past year; less likely to have had a dental visit in the past year; and more likely to report that they did not get medical care, delayed medical care, or did not get prescription drugs due to cost (National Center for Health Statistics 2007).

Although rural areas have far fewer physicians than urban areas, there is some debate about whether the supply of physicians is inadequate. There is general agreement, however, that it is more difficult for rural residents to obtain specialty services.

RURAL HEALTH POLICY PRIORITIES

There are a number of pressing rural health policy priorities, according to Keith Mueller of the College of Public Health at the University of Nebraska Medical Center and the Rural Policy Research Institute Center for Rural Health Policy Analysis, and each comes with its own obstacles.

How do rural communities scale up to an environment with multiple primary care providers? How do they effectively use family physicians in combination with nurse practitioners and physician's assistants?

First and foremost is establishing and maintaining access to professional health services in rural communities. Policies will need to be far more innovative in considering how to train and use a health care workforce. Often, the perception is that only a primary care physician can meet a rural community's health care needs. That model may not be sustainable, however, especially for a solo practice primary care physician located in a sparsely populated, geographically isolated area (Mueller 2008). But how do rural communities scale up to an environment with multiple primary care providers? How do they effectively use family physicians in combination with nurse practitioners and physician's assistants? Different models will need to be adopted and adapted more widely.

Another priority is to assure continuation of essential local services such as emergency medicine, primary care, and family services that include mental health and oral health (Mueller 2008). This will require rethinking who provides care and how, and involving the community to support these services. There are rural communities where this is a real struggle. Residents have not made the

connection between the necessity of a health care system and other industries that drive their local economy and affect their community.

It will also be important to maintain adequate payment for rural providers, which will be difficult to do in an environment where the government and other payers are looking for ways to reduce expenditures. This may also require creativity and innovation in how rural health systems achieve greater efficiencies, regardless of the scale of practice (Muller 2008).

Other priorities are continuing support for rural health programs like the Rural Hospital Flexibility Grant Program and, as new federal policies are proposed, continuing to ensure equity in benefits between rural and urban places and people (Mueller 2008).

With the support of the W.K. Kellogg Foundation, the Ford Foundation, The Annie E. Casey Foundation, and the National Rural Funders Collaborative, the National Rural Assembly met to identify promising policy opportunities that create positive change for rural communities and to build the voices of rural America. Several of the priorities they identified are related to health care access:

Health Care Workforce

- Support and expand upon programs such as the National Health Services Corps, the U.S. Health Resources and Services Administration’s Health Profession programs, and state-based loan repayment programs.
- Expand and permanently reauthorize the J-1 visa program to encourage international medical graduates in rural areas.
- Support reauthorization of Titles VII and VIII of the Public Health Service Act to train qualified health professionals for rural clinics, practices, and hospitals.
- Encourage collaboration among practitioners to meet regional pharmacy needs. Use technology and targeted training programs to recruit and retain pharmacists in rural areas.
- Allow new workforce initiatives to be applied in creative and flexible ways to address patient care in areas of professional shortages.

Health Care Financing

- Use the change in Administration to prepare for and promote change in health care policy that acknowledges rural-specific challenges in health care delivery.

- Enhance programs that support flexibility in financing and reimbursement schedules for Medicare and Medicaid, for instance Critical Access Hospitals¹.

Health Care Delivery

- Use the call for most Americans to be connected to an electronic health record by 2014 to expand broadband and information technologies to rural America and ensure that policies and financing adequately address post-implementation needs.
- Develop policies that allow the use of the “medical home” as a model to coordinate health care delivery in rural areas.
- Create communitywide partnerships integrated with health care services.
- Design health care policy strategies to increase the likelihood of health outcomes consistent with current professional knowledge.

Family Caregivers and Veterans

- Expand existing caregiver assistance programs to a sufficient level to provide needed support to caregivers.
- Support the Rural Health Initiative introduced in 2008 and similar initiatives that provide services and programs to rural veterans (National Rural Assembly 2008).

¹ A rural hospital designation established by the Medicare Rural Hospital Flexibility Program that was enacted as part of the 1997 Balanced Budget Act. Rural hospitals meeting criteria established by their state may apply for Critical Access Hospital (CAH) status. Designated hospitals are reimbursed based on cost (rather than prospective payment), must comply with federal and state regulation for CAHs, and are exempt from certain hospital staffing requirements (AcademyHealth 2004).

PROMISING PRACTICES

Stakeholders in rural communities have demonstrated that a collaborative culture and a readiness to be creative in the organization and regulation of health systems can result in the capacity and range that are crucial for providing superior and cost-effective services in rural locations (McCarthy et al. 2008).

“We often think about rural areas as being sort of slow. Not at all. You can get a change in a rural hospital in two days that would take you two months to get in a unit of an urban hospital. It’s just a lot easier, simply put, to turn a canoe around than it is to turn around a battleship.”

— Mary Wakefield, Center for Rural Health at the School of Medicine and Health Sciences at the University of North Dakota

A number of states with large rural populations—Iowa, New Hampshire, Vermont, Maine, Wisconsin, South Dakota, Minnesota, Nebraska, and North Dakota—were recently ranked in the top quartile of states in The Commonwealth Fund’s 2007 State Scorecard on Health System Performance (Figure 1). Providers, policymakers, and others in these states have a great deal of information to share about how to improve health care access—and ultimately health care quality and health outcomes—in rural America.

In many rural areas, local challenges drive innovation. For example, resource scarcity and low volume drive the creation of formal and informal networks that share personnel, expertise, and technology, and workforce shortages drive the creation of new or enhanced roles for health care personnel and team approaches to care. Other innovations grow out of local assets in rural areas. For example, the small scale provides flexibility, enhances the ability to communicate, and simplifies shared approaches across multiple stakeholders. The primary care focus drives lower utilization of high-cost services. Taken together, these innovations result in access, efficiency, quality, care coordination, rapid learning, cooperation, and

lower spending, and offer ideas and techniques that could usefully be adapted to other rural places and to urban health systems as well (Wakefield 2008). A few illustrative examples follow.

An Integrated Health System Model

Geisinger Health System is an integrated delivery system in central and northeastern Pennsylvania with almost 700 doctors in 55 primary and specialty care sites, three acute care hospitals, specialty hospitals and ambulatory surgery campuses, a 215,000-member health plan, and various other services from prenatal outreach to community-based care for the frail elderly. Geisinger provides health care to 2.5 million Pennsylvania residents who are less wealthy, young, and healthy than the national population and are spread over nearly 50 rural counties. By implementing delivery system improvements such as patient-oriented medical homes, chronic disease management, and bundled payment of acute-care episodes, Geisinger has upgraded its quality of care and realized improved outcomes for patients, while simultaneously cutting costs and boosting value. Early

results from the medical home model show a 20 percent decrease in hospital admissions and a 7 percent drop in total medical costs (Paulus et al. 2008). Preliminary evidence from the chronic disease management model used with more than 20,000 diabetic patients shows statistically significant progress in measures like glucose

control, blood pressure, and vaccination rates. Four months after putting into practice the bundled payment model for acute-care episodes, the share of patients getting coronary artery bypass graft surgery according to guidelines rose from 59 percent to 100 percent (Paulus et al. 2008).

Figure 1

State Scorecard Summary of Health System Performance Across Dimensions

State Rank



Rank	State	Access	Quality	Avoidable Hospital Use & Costs	Equity	Healthy Lives
1	Hawaii					
2	Iowa					
3	New Hampshire					
4	Vermont					
5	Maine					
6	Rhode Island					
7	Connecticut					
8	Massachusetts					
9	Wisconsin					
10	South Dakota					
11	Minnesota					
12	Nebraska					
13	North Dakota					

Rank	State	Access	Quality	Avoidable Hospital Use & Costs	Equity	Healthy Lives
26	Alaska					
26	Arizona					
26	New Jersey					
29	Virginia					
30	Idaho					
30	North Carolina					
32	District of Columbia					
33	South Carolina					
34	Oregon					
35	New Mexico					
36	Illinois					
37	Missouri					
38	Indiana					

Rank	State	Access	Quality	Avoidable Hospital Use & Costs	Equity	Healthy Lives
14	Delaware					
15	Pennsylvania					
16	Michigan					
17	Montana					
17	Washington					
19	Maryland					
20	Kansas					
21	Wyoming					
22	Colorado					
22	New York					
24	Ohio					
24	Utah					

Rank	State	Access	Quality	Avoidable Hospital Use & Costs	Equity	Healthy Lives
39	California					
40	Tennessee					
41	Alabama					
42	Georgia					
43	Florida					
44	West Virginia					
45	Kentucky					
46	Louisiana					
46	Nevada					
48	Arkansas					
49	Texas					
50	Mississippi					
50	Oklahoma					

Source: adapted from The Commonwealth Fund State Scorecard on Health System Performance 2007

A Community Health Center Model

The year after Hurricane Floyd struck the eastern counties of North Carolina in 1999, causing rivers and streams to flood and some communities to be underwater for weeks, a nonprofit organization called Access East was awarded U.S. Health Resources and Services Administration (HRSA) funds to implement an uninsured care program in the area. Access East had already developed the Community Care Plan of Pitt County, a program that enabled the organization to engage in a public-private partnership with the North Carolina Office of Rural Health and the Division of Medical Assistance to design and implement a locally driven program to manage the care of the Medicaid population. The new initiative, HealthAssist, provided primary care in the form of a medical home for uninsured residents of Pitt County using volunteer and paid physicians. The program, spearheaded by Dr. Thomas Irons, sponsored initiatives to assure access to preventive health services and primary, specialty, and hospital care. In addition, enrollees received care coordination; access to affordable therapeutic drugs; links to social services; mental health care; and life skills enhancements, such as computer skills courses and GED classes. As proud as they were of the program's design and accomplishments, Dr. Irons and his colleagues worried about the program's long-term financial sustainability and the fact that, from their point of view,

there were pieces missing since the local rural populations in several of the communities in which they worked were too thin to support the presence of even a midlevel health care practitioner (Irons 2008).

They began to reach out to other community entities and form more extensive partnerships, building a consortium of nontraditional partners and unlikely allies. In the fall of 2003, the consortium sketched out a plan to build a major comprehensive community health center in the northern part of the county, an underserved community with the lowest indicators in the area. The result is the 15,000-square-foot, \$2.8 million James D. Bernstein Community Health Center, which houses comprehensive primary health care and dental services, plus a pharmacy, an education center, and related operations tailored to the needs of low-income residents of eastern North Carolina, particularly the uninsured. The Bernstein Center is a partnership among several organizations with strong commitments to regional health. Access East, Inc. owns the building. The facility is operated by Eastern Carolina Community Health Centers of Snow Hill, a component of Greene County Health Care. The East Carolina University Division of Health Sciences handles pharmacy operations, and Pitt Community College coordinates all educational efforts. Major contributors to the center have included E.R. Lewis Construction, which donated both land and site development; the North Carolina Office of Rural Health and

Community Care; the Golden Leaf Foundation; The Kate B. Reynolds Charitable Trust; the Blue Cross and Blue Shield of North Carolina Foundation; the Pitt Memorial Hospital Foundation; The Duke Endowment; the North Carolina Rural Economic Development Center, Inc.; HRSA; and private donors (University Health Systems 2008; Irons 2008).

Cooperation through Rural Networks

Northland Healthcare Alliance (NHA) is a 10-year-old group of 25 rural and urban, Catholic and non-Catholic hospitals and long-term care facilities that work together to purchase and maintain capital equipment, handle accounts receivable and collections, manage employee benefits and group contracting, and conduct grant development and marketing. The network helps its members by allowing them to swap skills and knowledge, capture the attention of funding organizations, improve their ability to negotiate joint contracts, and lessen their remoteness and seclusion. An illustration of a beneficial NHA program is a mobile magnetic resonance imaging (MRI) service that makes it possible for patients to access care locally at a lesser price than if they were referred out of the community. This joint endeavor makes sure that revenue stays in local areas and eases patients' travel time and costs. In another example of rural networking, the Northwestern North Dakota Information Technology Network is collaborating to build the hardware and software infrastructure

for electronic medical records that can be shared by 10 Critical Access Hospitals (CAHs) and a tertiary-care hospital in North Dakota. This venture extends an effective partnership between two CAHs that have improved their efficiency by sharing a computer server and clinical information software applications (McCarthy et al. 2008).

Cooperation to Promote Telepharmacy and Telemedicine

The North Dakota Telepharmacy Project is a partnership among the North Dakota State University (NDSU) College of Pharmacy, the North Dakota State Board of Pharmacy, and the North Dakota Pharmacists Association to “restore, retain, or establish pharmacy services in medically underserved rural communities” (McCarthy et al. 2008). The project makes a licensed pharmacist at a central pharmacy available to oversee the dispensation of prescriptions by a registered pharmacy technician at a remote “telepharmacy” site. The project was designed to counter a considerable decline in accessible pharmacies in rural North Dakota, with the backing of the North Dakota Pharmacists Association. In 2002 Congress established a federal matching grant program within HRSA's Office for the Advancement of Telehealth, which has awarded \$2.5 million to the NDSU College of Pharmacy to help support early expenses of the telepharmacy network.

As of January 2007, 57 North Dakota sites were involved in the telepharmacy project, including 21

central pharmacies and 36 remote telepharmacy sites. The remote sites are typically around 60 miles from central sites and fill nearly 70 prescriptions per day in communities with an average of 800 residents. Over 40,000 rural residents in 55 percent of North Dakota counties now have access to pharmacy services in their community (McCarthy et al. 2008). The rate of dispensing errors was under 1 percent at telepharmacy sites, compared to a national average of about 2 percent. The profits of participating rural pharmacies have doubled. Each remote telepharmacy site makes about \$500,000 per year for the local community, producing 40 to 50 new jobs and adding an estimated \$12.5 million to the state's rural economy (McCarthy et al. 2008).

In another example, a University of North Dakota School of Medicine telemedicine pilot in psychiatry provided cognitive behavioral therapy to patients with bulimia by

telemedicine and through face-to-face encounters with therapists traveling to remote communities. The results of the pilot, which included reductions in binge eating, eating disorder severity, and depression, were “roughly equivalent” among patients who were randomly assigned to receive treatment via telemedicine or through face-to-face encounters (McCarthy et al. 2008). The average cost of therapy was only \$73 per case for telemedicine compared to \$230 per case for face-to-face care, which usually forces providers to travel lengthy distances for each appointment. In patient satisfaction surveys, patients rated both methods equally well. The chief obstacle to the telemedicine program was professional licensure issues across state lines which, for example, required patients in South Dakota to drive to North Dakota for treatment. Insurance reimbursement for telemedicine also remains erratic (McCarthy et al. 2008).

RURAL-URBAN SIMILARITIES AND INTERDEPENDENCIES

In many ways, the problems facing rural America are surprisingly similar to those plaguing urban communities: poverty, underfunded educational systems, insufficient affordable housing, poor population health, limited employment, immigration pressures, racial/ethnic disparities in opportunity, and crumbling infrastructure (Reed 2008).

In the words of a 2008 Aspen Institute report: “There are... similarities between rural and urban communities around which common cause can be built...the well-being of each place is strongly influenced by what is happening in the other and on finding opportunities to work together to improve their shared fate.”

For philanthropy, the implications of these similarities and interdependencies are twofold. First, serious

investment in rural health care access allows health funders the chance to quickly test ideas on a smaller scale and then adapt them in other rural communities and in larger metropolitan areas. And second, “understanding the ways in which rural dynamics are fundamental to urban well-being—and vice versa—could well be the catalyst to develop creative strategies for promoting prosperity and equality for all American communities” (Aspen Institute 2008).

EXAMPLES OF RURAL-URBAN CONNECTIONS

People

Isolated rural and poor urban communities both have limited access to high-quality health care; rural-urban collaborations could work on system-level interventions in health care.

Public education works least well in rural areas and inner cities. If they join together, they could have the power to initiate state-level reforms in school financing that could benefit both.

New immigrants move primarily to poor urban, rural, and suburban areas. Strategies for addressing immigration dynamics and immigrant needs could be more powerful if they were tested in all types of locations and shared.

Place

National and state-level protections for clean water, air, and green space could be strengthened by finding collaborative strategies that balance urban, suburban, and rural needs.

Increasingly, political power resides in the suburbs, and some state legislatures have more than 50 percent representation from suburbs. Rural and urban alliances around common interests could counterbalance suburban dominance.

Prosperity

Urban and rural coalitions could work toward federal action to mitigate the effects of deindustrialization on workers and their communities.

Recognition that people in rural, suburban, and urban areas live far from their jobs could strengthen commitment to improved investments in regional transportation and communications infrastructure.

Sharing experiences around equitable economic development strategies, such as using tax incentives to attract businesses to weak market communities or successes around community benefits agreements, could help both rural and urban economic plans.

Excerpted from Aspen Institute, *Our Shared Fate: Bridging the Rural-Urban Divide Creates New Opportunities for Prosperity and Equity* (New York, NY: 2008).

RECENT PHILANTHROPIC ACTIVITIES

Over the years, foundations and corporate giving programs have supported a wide range of activities that attempt to improve access to health care in rural America. These activities include motivating physicians to work in rural areas, enhancing the roles of midlevel practitioners, addressing geographic barriers to health care, improving timely access to specialty care, improving quality and patient safety in rural hospitals, improving the financial viability of rural hospitals, improving health care delivery for agricultural workers, and working to understand the consequences of financial barriers to care in rural America. Illustrative examples of this type of work follow.

Motivating Physicians to Work in Rural Areas

Colorado faces a severe dearth of primary care doctors in rural and urban clinics that supply health care to uninsured and underinsured residents. At present, there are over 85 vacant positions in these clinics, and the state's Federally Qualified Health Centers (FQHCs) anticipate 96 by 2010. It is not easy for these nonprofit clinics to hire providers because they offer less competitive salaries than other employers do. With a new \$6-million grant, The Colorado Health Foundation expects to aid recruitment efforts by helping to pay back doctors' medical school debt, which averages approximately \$120,000 – \$150,000 (The Colorado Health Foundation 2008).

The foundation, the Colorado Rural Health Center, and the Colorado Community Health Network have joined forces to develop an initiative that tackles loan debt by repaying the loans of up to 12 doctors each year if they work in an underserved rural or

urban area. The foundation will pay \$50,000 a year for three years toward the doctor's loans with an upper limit of \$150,000. It will be available to doctors at all safety net clinics in the state, including FQHCs, Rural Health Clinics, and freestanding clinics, which will not be obligated to make a financial match. The program will make Colorado's attempts to hire primary care providers for underserved communities among the most aggressive in the country (The Colorado Health Foundation 2008).

This work builds upon the work of the Robert Wood Johnson Foundation (RWJF), which has employed a number of approaches to improve health services for people living in rural areas. The Practice Sights program, for example, reinforced states' attempts to recruit health care providers to rural areas. The Reach Out program aimed to persuade doctors to donate care to people living in underserved areas, many of which were rural. A range of projects offered training and support to nurses, nurse practitioners, and physician

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assistants practicing in rural areas. The foundation has supplied scholarships to medical students from rural areas (testing the hypothesis that they were prone to return to work in rural areas), supported rural hospitals, and created rural perinatal care networks and rural physician group practices (Diehl 2006).

The foundation's Southern Rural Access Program (SRAP) (1997-2006) worked to enhance access in nine underserved states in the South: Georgia, South Carolina, North Carolina, Virginia, West Virginia, Alabama, Mississippi, Louisiana, and Arkansas. SRAP was a nine-year, \$35-million national program that incorporated several of the approaches from prior RWJF efforts in rural areas: employment and retention of health care staff in rural areas, revolving loan funds to support health care services in rural areas, rural health networks to provide joint services and economy of scale, and the cultivation of rural health leaders who work to advance their communities (Diehl 2006).

The foundation learned a number of lessons from this work with health care professionals:

- **Revolving Loan Funds:** These are an essential and effective component of SRAP for most of the states and produced 100 loans totaling approximately \$131 million, which is more than an 18:1 ratio to the RWJF investment of \$7 million in grants. This achievement would not have been possible without a blend of state, federal, and philanthropic resources to provide seed capital.

- **Regional Health Networks:** Banding together made physicians better organized and increased their capacity, and joint office management strategies increased revenues. Linking patients to several accessible health care services was more successful than abandoning them to navigate the health care system. Networks produced collaborations between regions and states.
- **Recruitment and Retention:** SRAP enlarged the number of primary care physicians in the program states. In Mississippi alone, 114 new physicians were recruited. The technical assistance offered to physician offices proved to be one of the best strategies for physician retention (RWJF 2008).

Enhancing the Roles of Midlevel Practitioners

In rural Alaska, the rate of dental caries among the Alaska Native population is 2.5 times higher than the national average (Kaplan 2008). With the encouragement of numerous rural Native health organizations, the Rasmuson Foundation, along with RWJF, the Ford Foundation, the National Rural Funders Collaborative, and others, assisted in the design of a new category of dental providers under a long-term, successful Community Health Aide Program². The motivation for the Dental Health Aide Therapist program was straightforward: if midlevel dental care providers were available to provide regular dental care more frequently,

oral health care would improve in communities without local dentists (Kaplan 2008).

At the program's beginning, there was enormous resistance from dentists. The Alaska Dental Society, along with the American Dental Association (ADA), lobbied against the program in Congress, expressing alarm about patient safety and standards of care, despite the program's thorough training and management of aides by practicing dentists. Until 2008 the program carried out its training in New Zealand because no American dental school would house the program, even though the dental health aide therapist model has been enthusiastically practiced in 50 countries across the world (Kaplan 2008).

Five years since its start, the Dental Health Aide Therapist program, run by the Alaska Native Tribal Health Consortium, is gaining ground. There are now more than 10 therapists practicing in rural communities in Alaska. After a great deal of legal work by the Alaska Native Tribal Health Consortium, the ADA and the Alaska Dental Society dropped a lawsuit against the program in June 2008 and decided to support the initiative, though only in the state of Alaska. The University of Washington has developed a curriculum for the program, although only for

the first year of a two-year program. (Fortunately there are enough dentists within Alaska for students to train with during their second year, and an in-state training program has been established.) The W.K. Kellogg Foundation has made a sizeable grant to the program, and several rural communities around the country are interested in adapting it (Kaplan 2008).

Addressing Geographic Barriers to Health Care

In New Hampshire, the Endowment for Health has made progress on the issue of geographic barriers to health care by looking for better ways of getting patients to services and by moving services to where users can more easily access them. The foundation has pursued two main strategies in this area: transportation to services and activities that support telehealth, and technology strategies to connect people and health care.

In the transportation arena, the endowment has supported planning and pilot efforts to test approaches to the range of transportation needs in rural, urban, and suburban areas, including demonstration projects to create community-based transportation brokerages, which

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² The Community Health Aide Program was developed in the 1950s in response to a number of health concerns, including the tuberculosis epidemic, high infant mortality, and the high rate of injuries in rural Alaska. In 1968 the program received formal recognition and congressional funding. The long history of cooperation and coordination between the federal and state governments and Native tribal health organizations has facilitated improved health status in rural Alaska. The program now consists of a network of approximately 550 community health aides/practitioners (CHA/Ps) in over 170 rural Alaska villages. CHA/Ps work within the guidelines of the 2006 *Alaska Community Health Aide/Practitioner Manual*, which outlines assessment and treatment protocols. There is an established referral relationship, which includes midlevel providers, physicians, regional hospitals, and the Alaska Native Medical Center. In addition, providers, such as public health nurses, physicians, and dentists, make visits to villages to see clients in collaboration with CHA/Ps (Alaska Community Health Aide Program 2008).

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increase resources by coordinating transportation across agencies and transit providers. In addition, the endowment has backed projects intended to collect information about need, call together stakeholders, and build coordinated plans to address transportation barriers in rural areas such as Mascoma Valley, Sullivan County, Souhegan Valley, and the eastern Monadnock region. It has also funded grants to bring experts on community-based brokerages to New Hampshire and supported applied research in the field, including a study on demand and perceived need for public transportation. Knowing that public systems cannot replace fully private ones, the endowment recently funded planning for expansion of Bonnie Car Loans and Counseling, which helps lower-income individuals purchase reliable, efficient cars (Endowment for Health 2008).

The endowment's work on telehealth is at an early stage in its development. Statewide convening and planning efforts supported by the endowment included the state's first telehealth conference, the development of a white paper to guide implementation of the New Hampshire Telehealth Program, and a wide-ranging needs assessment. A multidisciplinary planning committee has been created to ensure the development of a collaborative program that meets the needs of all stakeholders and, most importantly, the needs of the state's rural communities. The planning committee is working to complete a strategic business plan, secure reimbursement, and continue to

provide technical assistance to organizations interested in using telehealth to increase access and improve the quality of care. The endowment has funded planning for a home care pilot project to better manage chronic disease through telehealth. It has also supported technical assistance to design a cost-efficient videoconferencing network linking each of New Hampshire's 10 community mental health centers and the state hospital with experts in child/adolescent trauma treatment (Endowment for Health 2008).

Improving Timely Access to Specialty Care

While public hospitals and community clinics throughout California work to meet the demand for specialists, circumstances are most difficult in rural parts of the state where there are a much lower number of physicians per capita and wait times for appointments can be three months or more. In an effort to tackle this problem, the California HealthCare Foundation (CHCF) has awarded a total of \$350,000 in planning grants to seven provider coalitions operating in 16 rural counties, including the far north counties, the Lake Tahoe and Sierra regions, and Merced County. The grants are intended to aid health care professionals in their efforts to discover ways to improve timely access to specialty care, including establishing formalized referral relationships between primary care physicians and specialists and using telemedicine to link patients with doctors in other cities (CHCF 2008).

Over 40 provider organizations, including community health centers, hospitals, medical groups, and county health departments, have agreed to participate in the projects. The seven coalitions, each awarded \$50,000, will be qualified to receive supplementary funding from CHCF to execute their plans. The grants are similar to an initiative backed by the Kaiser Permanente Community Benefit program. Together, the 21 grants awarded by CHCF and Kaiser will support work in 32 of California's 58 counties. The project is part of a broader CHCF effort to identify pioneering regional and local efforts that reinforce quality, efficiency, and access in California's safety net clinics and hospitals (CHCF 2008).

Improving Quality and Patient Safety in Rural Hospitals

In a new initiative, Maine Health Access Foundation (MeHAF) has given \$670,000 in grants to 14 small, rural Critical Access Hospitals in the state. The grants support the execution of newly created plans and procedures to improve medication safety. The hospitals have worked together through a six-month planning process that MeHAF also supported in order to swap strategies and knowledge. Strengthening Maine's health care safety net—the network of providers and organizations that serve Maine people with limited resources or access—is one of MeHAF's three program priorities.

While the grantee hospitals are small, they serve as the chief health care site for a large share of Maine's rural residents (MeHAF 2008).

Through a guided process managed by the Muskie School of Public Service at the University of Southern Maine, each hospital shares its best practices and solutions for staffing, discharge procedures, and internal record reconciliation. Each hospital has planned a specific way to meet its distinctive challenges and has arranged to keep taking part in a larger project overseen by the Maine Quality Forum, in partnership with the Maine Hospital Association and the Maine Center for Disease Control and Prevention Office of Rural Health and Primary Care, to improve overall patient safety. Some of the hospital project plans include establishing standardized discharge plans that contain simple written medication instructions with post-discharge support, increased and regular pharmacist consults combined with computerized recordkeeping and standard communication with community health agencies used by patients, and automated medication dispensing (MeHAF 2008).

Improving the Financial Viability of Rural Hospitals

In 2008 The Duke Endowment commissioned the study *The State of Small and Rural Hospitals in the Carolinas* to assess the health care delivery system across North and South Carolina. The foundation's

In a new initiative, Maine Health Access Foundation has given grants to 14 small, rural Critical Access Hospitals to improve medication safety.

principal goal was to detail the role of small and rural hospital providers within the health care delivery system and to discover the needs of these providers and the communities they serve.

The study's key findings and conclusions were:

- Success, as measured by profitability, depends chiefly on inpatient volume and size, followed by physician mix and commercial payer mix.
- On average, Medicaid, bad debt, and charity mix do not explain the difference in the financial viability of hospitals.
- Aside from the lower performers, system affiliation (being owned by or closely affiliated with a multihospital system) seems to explain financial performance overall. For the lower performers, system affiliation may be the cause of their current survival.
- Regional referral centers—hospitals with an average daily census greater than 190 and/or offering open-heart services—are fairly well spread throughout North and South Carolina. Only 30 hospitals are more than one hour's drive time from a regional referral center.
- Communities with limited access to regional referral centers are largely rural, lightly populated, and geographically remote.
- Smaller, less successful hospitals are found in more rural, geographically remote areas. Most of these

hospitals, however, are considered vital for preserving access to health care in their communities (The Duke Endowment 2008).

From this assessment, the endowment plans to create new initiatives that will improve the health care delivery system and guarantee the long-term success of critical health care services in rural communities.

Working to Understand the Consequences of Financial Barriers to Care in Rural America

In 2006, with funding from the United Methodist Health Ministry Fund, The Access Project collaborated with the Kansas Farmers Union to conduct a small survey examining medical debt among Kansas farmers. The results were disquieting: although 95 percent of the survey respondents reported that all members of their households had health insurance continuously over the previous 12 months, nearly a third (29 percent) of the nonelderly respondents said they had medical debt, which raised the question of whether their health insurance coverage adequately protected them from financial risk (Lottero et al. 2006). More than one-third (36 percent) of larger households—those with three or more members—reported having medical debt, compared with 10 percent of smaller households, which suggests that medical debt may be more of a concern for families with children or other dependents than

it is for single people or childless couples. Doctors and hospitals were most often cited as the source of the medical debt, with 91 percent of respondents with medical debt saying they owed money to doctors. Nearly as many (84 percent) owed hospitals, nearly two-thirds (64 percent) had outstanding prescription costs, half (51 percent) owed dentists, and 13 percent had debts from ambulance services (Lottero et al. 2006).

Many of those with medical debt reported delaying needed primary care, either because they did not want to add to the money they owed for medical bills (47 percent) or because they felt uncomfortable about the debt (20 percent) (Lottero et al. 2006). Medical debt contributed to reduced savings and increased credit card debt—more than a third of respondents with debt (36 percent) said they had used a large part of their savings to pay medical bills, and a third (33 percent) said they incurred or increased their credit card debt. Twenty percent of those with medical debt reported having been contacted by a collection agency (Lottero et al. 2006). With the support of the W. K. Kellogg Foundation, the Mid-Iowa Health Foundation, the Missouri Foundation for Health, The California Endowment, and RWJF, The Access Project has since conducted more detailed surveys of farm and ranch families in California, Iowa, Minnesota, Missouri, Montana, Nebraska, North Dakota, and South Dakota, urging policymakers to consider proposals that will ease the

burden of health care costs for rural residents and small business operators.

Improving Health Care Delivery for Agricultural Workers

Agriculture is one of the most essential components of the California economy, providing more than \$27 billion in crop revenue to the state. California ranks first in the nation in food production and is responsible for over 50 percent of U.S. fruit, nut, and vegetable production. Incongruously, the agricultural workers who produce this healthy food are often at serious risk for life-threatening chronic diseases caused by poor nutrition and little or no access to health care or services, while often living and working in unsafe and unsanitary conditions. In 2001 The California Endowment announced a five-year, \$50-million commitment for programs and strategies to improve the health and living conditions of California's estimated 1 million agricultural workers and their families. The endowment has taken an active leadership role to address the needs of this vastly underserved population since 1997. Work to date includes:

- **Direct Services:** The endowment awarded \$10.5 million to 30 community-based nonprofit organizations across California to strengthen and support health-related services. In the first year alone, more than 118,000 agricultural workers/family members received primary care and dental health services.

Incongruously, the agricultural workers who produce healthy food are often at serious risk for life-threatening chronic diseases caused by poor nutrition and little or no access to health care or services.

- **Research:** The endowment sponsored the nation's first statewide health survey of hired agricultural workers, the California Agricultural Worker Health Survey, which found that the large majority of this population is at risk for life-threatening chronic diseases such as diabetes and hypertension. Nearly 70 percent of those surveyed lacked any form of health insurance, 50 percent had multiple health problems, and 40 percent had never seen a physician.
- **Advocacy:** The endowment provided funding to statewide organizations dedicated to advocating for the health and human rights of agricultural workers such as California Rural Legal Assistance and the United Farm Workers Movement. The endowment's approach is to increase the organizations' capacity so that they can provide needed leadership in the public policy arena and more effectively advocate for health-related policy and action.
- **Coalition Building:** The endowment built partnerships with public policy, agri-business, health, government, advocacy, and elected leaders in a joint effort to advance the health status of agricultural workers. In fall 2000 the endowment brought together a Blue Ribbon Task Force to help develop program and public policy priorities. The task force shaped a series of recommendations that called for an enduring and inclusive approach to improve access, health education, housing conditions, and insurance coverage (The California Endowment 2008).

BEYOND ACCESS TO CARE

The Institute of Medicine (IOM) report *Quality Through Collaboration: The Future of Rural Health Care* encourages rural communities to build a population health focus into decisionmaking within the health care sector, as well as in other key areas that influence population health. This recommendation has a direct effect on decisions about which investments are made in rural communities. For example, efforts to reduce diabetes would include public policies that support making more healthy food available in schools and restaurants, in addition to more traditional medical interventions (IOM 2005). Shifting resources in this way, however, will mean making tough choices about how public and private funds are spent. Tackling the social determinants of health will also require cross-sectoral partnerships that bring together medical care, human services, and public health agencies and funding streams (Coburn 2008).

LESSONS LEARNED

There are a number of ways for philanthropic investment to help support and spread rural innovations underway. To assist in this effort, the Grantmakers In Health Issue Dialogue brought forth a number of lessons that grantmakers can use, as outlined below.

Work Regionally

- Many rural health problems are problems not of location alone, but of problems related to race/ethnicity and regional poverty. This suggests that the “community of the solution” might be broader than a specific community in need and points to regional solutions.

one dependable source of operating funding; inclusiveness and flattening of hierarchies; and flexibility.

- Incentives are needed to encourage collaboration and shared resources that bring together public health; ambulatory care; acute care; and other unlikely allies such as law enforcement, education, and others.
- Many of the innovations in rural health care depend on regulatory changes. Foundations can assist rural innovators by helping get representatives of regulatory agencies to the table at the beginning of conversations about new policies and programs.

Collect Local Data

- One of the things that a regional strategy needs to include is collaboration around the development of data that help increase the understanding of problems at the community level; national data sets may not accomplish this.

Consider Flexible Approaches and Funding Strategies

Encourage Collaboration

- As important as collaboration is, there are still community stakeholders who refuse to reach out to the people with whom they have traditionally been unable to communicate with or who hold something back at the table. The key elements of a successful collaboration are committed leadership; a clear, simple, and continually reinforced value statement; at least

- Flexibility, rather than a one-size-fits-all approach, should be a guiding principle in rural health work. Rural areas look very different from one another.
- Demonstrations in rural areas should pool funding sources and de-emphasize categorical funding and site-specific financing. Foundations can be important catalysts in driving this orientation.

“In contrast to the stereotype that’s held by some, rural areas are not always backwaters. Sometimes they are actually headwaters of innovation. They provide wonderful laboratories and incubators that [funders] can capitalize on to drive newer and even better innovation.”

— Mary Wakefield, Center for Rural Health at the School of Medicine and Health Sciences at the University of North Dakota

Support Delivery System Reforms

- It is important to focus on policies and programs that strengthen network development and service coordination in rural communities.

Focus on Workforce Issues

- Foundations have a role to play in preparing the next generation of health care providers to harness and deploy new technologies, function in interdisciplinary teams, and bring nontraditional providers into the health care workforce.
- In addition to focusing on the recruitment of physicians and dentists and the training of midlevel practitioners, rural areas are struggling to find lab technicians, radiologists, pharmacists, and other staff. Pipeline programs in rural areas need to be improved so that young people looking for work can receive the training they need to fill those positions.
- The changing racial and ethnic demographics in a number of rural areas suggest the need for training and including *promotoras* and other health care navigators into rural health systems.

Think Creatively About Technology

- Telehealth applications that link providers and patients hold a great deal of promise, but it is often

difficult for foundations to figure out how to support telehealth services in a way that is rational and cost effective. It would be useful for foundations to have and support conversations about how telehealth can be used most effectively.

- Supporting efforts around broadband Internet access in rural areas is a promising way to assure both economic viability for rural communities and a better health care system for rural communities.

Build Connections Between Rural and Urban Areas

- Foundations can educate their urban grantees about the similarities and interdependencies between urban and rural areas, and encourage urban facilities to partner with their rural counterparts.

Work in Concert with Rural Communities, Not on Their Behalf

- It is very important to engage local leadership in thinking about the health care delivery system and shaping it to meet local needs. One of the ways to raise community awareness is by discussing the economic impact of the delivery system in communities. Making a strong connection between the health system and a community’s quality of life will help sustain that system in the long term.

- Business and civic leaders in rural communities should be heavily involved in the recruitment and retention of the health care workforce. It means a great deal when a prospective provider coming from an urban area can meet with representatives of the local chamber of commerce; school system; real estate company; and, if relevant, minority communities.
- Rural innovation should be developed with the community, not for the community.

Be Prepared to Face Opposition

- Even when a foundation is supporting a rural innovation that is locally driven and locally responsive, it may face organized opposition. It is important to

think through in advance who likely opponents to a policy change might be.

- It can be extremely effective to bring representatives of the opposition to innovative rural programs to see the work firsthand. It helps them get a better sense of community needs and of the program details, and helps the program's proponents make valuable new allies.

Think Beyond Health Care Access

- Working in rural areas lends itself to place-based strategies and provides the opportunity to partner with community foundations and other funders who do not give in health, but who are concerned about the economic vitality and sustainability of rural areas.

STRENGTHENING RURAL GRANTMAKING

In a recent report funded by the W.K. Kellogg Foundation, the National Committee for Responsive Philanthropy developed a set of recommendations to strengthen and promote more effective grantmaking to rural America:

- Grantmakers should fund organizations whose missions include changing attitudes about rural America, advocating on behalf of rural interests, or conducting and disseminating research on timely rural issues so that grantmaking and policymaking reflect rural realities rather than outdated or incorrect perceptions.
- Seasoned rural grantmakers should take seriously their roles as sponsors of rural interests by funding and promoting site visits and events at which urban foundations and rural nonprofits can discuss rural needs and funding opportunities.
- Foundations should develop impact measurements appropriate to rural areas with less dense populations rather than applying metrics that are more appropriate to urban areas. Rural nonprofit leaders must take the lead in deciding what impact measurements are appropriate for their communities.
- Organizational capacity deficits should not exclude rural applicants that serve disadvantaged populations from foundation funding. To build organizational capacity, funders should provide sufficient long-term core operating support to nonprofits with appropriate technical assistance funding to build the capacities of under-resourced rural nonprofits. Foundation grantmaking should reflect a willingness to fund organizational slack, as well as reserves for surviving crises and turbulence.

- Seasoned rural grantmakers should actively scan the field for effective rural organizations and develop ways to promote them effectively.
- Regional and national foundations should identify infrastructure gaps in rural regions and capitalize and help sustain organizations that will support and promote rural nonprofit and community interests.
- Foundations should use intermediary organizations when they have neither the staff nor the expertise to meet nonprofit funding and capacity-building needs. Foundations funding through intermediary organizations need to develop strong one-on-one relationships with rural grantees. Seasoned rural grantmakers and intermediary organizations should develop strategies jointly to effectively expose and promote intermediary organizations to foundations that cannot give to rural populations without them.
- Funders should consider forming new collaboratives when their purpose is to grant new and more money for rural populations. Rural funding collaboratives should elect a funder “champion”—a foundation that can visibly and actively promote and campaign for new, flexible foundation dollars.
- Endowment building should be promoted by urban foundations when they are willing to jointly fund local endowments and support current funding needs. Local endowment building is not a substitute strategy for nonlocal rural grantmaking, nor should it be a diversion for redistributing more foundation dollars to rural populations.

Excerpted from Swierzewski, Rachael, *Rural Philanthropy: Building Dialogue from Within* (Washington, DC: National Committee for Responsive Philanthropy, 2007).

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ABOUT GIH

With a mission to help grantmakers improve the health of all people, Grantmakers In Health (GIH) seeks to build the knowledge and skills of health funders, strengthen organizational effectiveness, and connect grantmakers with peers and potential partners. We help funders learn about contemporary health issues, the implications of changes in the health sector and health policy, and how grantmakers can make a difference. We generate and disseminate information through meetings, publications, and on-line; provide training and technical assistance; offer strategic advice on programmatic and operational issues; and conduct studies of the field. As the professional home for health grantmakers, GIH looks at health issues through a philanthropic lens and takes on operational issues in ways that are meaningful to those in the health field.

Expertise on Health Issues

GIH's Resource Center on Health Philanthropy maintains descriptive data about foundations and corporate giving programs that fund in health and information on their grants and initiatives. Drawing on their expertise

in health and philanthropy, GIH staff advise grantmakers on key health issues and synthesizes lessons learned from their work. The Resource Center database, which contains information on thousands of grants and initiatives, is available on-line on a password-protected basis to GIH Funding Partners (health grantmaking organizations that provide annual financial support to the organization).

Advice on Foundation Operations

GIH focuses on operational issues confronting both new and established foundations through the work of its Support Center for Health Foundations. The Support Center offers an annual two-day meeting, The Art & Science of Health Grantmaking, with introductory and advanced courses on board development, grantmaking, evaluation, communications, and finance and investments. It also provides sessions focusing on operational issues at the GIH annual meeting, individualized technical assistance, and a frequently asked questions (FAQ) feature on the GIH Web site.

Connecting Health Funders

GIH creates opportunities to connect colleagues, experts, and practitioners to one another through its Annual Meeting on Health Philanthropy, the Fall Forum (which focuses on policy issues), and day-long Issue Dialogues, as well as several audioconference series for grantmakers working on issues such as access to care, obesity, public policy, racial and ethnic health disparities, and health care quality.

Fostering Partnerships

Grantmakers recognize both the value of collaboration and the challenges of working effectively with colleagues. Although successful collaborations cannot be forced, GIH works to facilitate those relationships where we see mutual interest. We bring together national funders with those working at the state and local levels, link with other affinity groups within philanthropy, and connect grantmakers to organizations that can help further their goals.

To bridge the worlds of health philanthropy and health policy, we help grantmakers understand the

importance of public policy to their work and the roles they can play in informing and shaping policy. We also work to help policymakers become more aware of the contributions made by health philanthropy. When there is synergy, we work to strengthen collaborative relationships between philanthropy and government.

Educating and Informing the Field

GIH publications inform funders through both in-depth reports and quick reads. Issue Briefs delve into a single health topic, providing the most recent data and sketching out roles funders can and do play. The GIH Bulletin, published 22 times each year, keeps funders up to date on new grants, studies, and people. GIH's Web site, www.gih.org, is a one-stop information resource for health grantmakers and those interested in the field. The site includes all of GIH's publications, the Resource Center database (available only to GIH Funding Partners), and the Support Center's FAQs. Key health issue pages provide grantmakers with quick access to new studies, GIH publications, information on audioconferences, and the work of their peers.

DIVERSITY STATEMENT

GIH is committed to promoting diversity and cultural competency in its programming, personnel and employment practices, and governance. It views diversity as a fundamental element of social justice and integral to its mission of helping grantmakers improve the health of all people. Diverse voices and viewpoints deepen our understanding of differences in health outcomes and health care

delivery, and strengthen our ability to fashion just solutions. GIH uses the term, diversity, broadly to encompass differences in the attributes of both individuals (such as race, ethnicity, age, gender, sexual orientation, physical ability, religion, and socioeconomic status) and organizations (foundations and giving programs of differing sizes, missions, geographic locations, and approaches to grantmaking).



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