Appendix G
Field Workshops

During the course of the Rural Health study, the Office of Technology Assessment (OTA) held three field workshops. At these workshops, invited participants presented problems and suggested strategies and discussed them with attending OTA staff, advisory panel members, and observers.

The first workshop, held on January 11, 1989 in Scottsdale, Arizona, addressed issues and strategic options for small, isolated hospitals; larger rural hospitals and those operating in more competitive environments; and rural hospitals in multihospital systems or other affiliations. On February 28,1989, OTA held a workshop on health personnel issues, with a special emphasis on the needs of ''frontier" areas, in Bismarck, North Dakota. Topics included training, recruitment, retention, and practice issues for rural health professionals. The third workshop, held on June 15, 1989 in Meridian, Mississippi, addressed issues related to providing primary care to rural populations, especially those in persistent poverty. Topics included payment and financing, access to care, and practice capacity and organization.

Summary of presentations from invited workshop participants follow.

Scottsdale, Arizona

Small, Isolated Hospitals

James Armstrong, President, Sierra Vista Hospital, Truth or Consequences, NM—Represents a 34-bed Adventist hospital in a community of 7,000. The next hospital is 75 miles away. The community has a large influx of tourists in the summer and semipermanent retirees in the winter. Seventy to eighty percent of the hospital's patients receive Medicare.

Problems—
- lost **$500,000 last** year, low Medicare reimbursement,
- 30 to 40 percent of population is going elsewhere for care,
- expanded need for elderly and emergency medical services (EMS) due to tourism and retirees,
- physician and nurse recruitment and retention,
- community slow to change.

Strategies—
- cut expenses or forego staff expansion,
- improve public image and perceived quality,
- air and ground transport in EMS network
- trained six licensed practical nurses to registered nurses,
- educate physicians to maximize reimbursement.

Elton Summers, Administrator, Gila County General Hospital, Globe, AZ—Represents a 35-bed public(county) hospital in a town of about 7,000 people. There is a competing nonprofit hospital about 6 miles away.

Problems—
- about $1 million in uncompensated care (out of $8 million total),
- seen as social service agency by community and county government,
- low occupancy rates.

Strategies—
- improve business management,
- long-term strategy to try to merge with competing hospital.[2]

Harold Brown, Chief Executive Officer (CEO), Prairie du Chien Memorial Hospital, Prairie du Chien, WI)--Represents a nonprofit hospital with 49 acute beds, swing beds, 4 skilled beds, 2 respite beds, home health, and hospice. The next hospital is 30 miles away and the next large hospital is 65 miles. The hospital was in the black last year. It has 62 percent occupancy in its acute care beds, which generated 57 percent of its revenue. Of the remaining revenue, 24 percent is from outpatient services.

Problems—
- access to capital for modernization and expansion,
- proposed prospective payment for ambulatory services would pay only 70 percent of x-ray costs and 67 percent of lab,
- regulations for many services are not sensitive to rural situation.

Strategies-
- maximized Medicare payments through high base year costs,
- diversifying from inpatient to outpatient services,
- developing local funding via foundation and fundraising,
- report cards for doctors on handling cases and patients.

[1]All three workshop were arranged under contract by the National Rural Health Association. The m@@ in Meridian, Mississippi was arranged by the National Rural Health Association with assistance from the National Association of Community Health Centers, the Mississippi Primary Care Association, and the Alabama Primary Health Care Association.

[2]In 1989, Gila County General Hospital announced plans to merge with the nearby nonprofit hospital, 49-bed Miami Inspiration Hospital.

Bill M. Welch, Administrator, Elko General Hospital, Elko, NV—Represents a 50-bed public hospital with no county subsidy. The service area is growing rapidly and now has 27,000 people, but the county's population density is still 1.6 per square mile. It is about 150 miles to the next hospital.

Problems-
- physician shortage acute,
- increasing accounts receivable,
- competition with urban hospitals outreaching into area,
- facility designed for inpatient services, but about 50 percent are outpatient services.

Strategies—
- *intense* community-based physician recruitment,
- using contract collection firm,
- local media campaign to retain market share,
- developing statewide rural hospital consortium,
- use consultants to help identify problems and planning with board.

Larger Rural Hospitals and Those in More Competitive Environments

Patrick Linton, CEO, Yavapai Regional Medical Center, Prescott, AZ—Represents a 129-bed hospital in a town of 25,000. Over 30 percent of the population is over 65 years old. About 54 percent of revenue is from Medicare and 9 percent is from Medicaid.

Problems--
- low rural payments from Medicare and resulting low morale,
- lack of access to capital,
- aging physical facility,
- high proportion of elderly.

Strategies—
- Geriatric Resource Center (foundation funded) to case manage patients and families,
- joined State federation of six hospitals to raise capital.

Steve Ward, Director, Shared Services & Outreach, St. Mary's Hospital, Grand Junction, CO—Represents a 294-bed rural referral center (RRC) in the mountains.

Problems--
- indigent care costs rising,
- competition from urban referral centers.

Strategies—
- favorable payments under RRC designation,
- Considering transportation for physician care and other services,
- strong outreach and marketing program to solidify market.

Douglas Fonnesbeck, Administrator, Logan Regional Hospital, Logan, UT—Represents a 150-bed hospital that is a member of Intermountain Health, Inc. The community is growing and has a diversified economic base.

Problems—
- access to capital,
- deciding ''what you are and what you are not,"
- Medicare reimbursement.

Strategies—
- business-based strategic planning,
- strong guest relations program,
- acute-care case management program.

Virginia Goodrich, Executive Vice President, New Mexico Hospital Association-Represents Rehoboth-McKinley Christian Health Care, Gallup, NM, created by the merger of a 41- and a 81-bed hospital. The current hospital has 74 acute care beds. The area has a multicultural population and a depressed economy.

Problems—
- competing, inefficient hospitals in the same town,
- large indigent population,
- Medicare reimbursement inadequate,
- training costs high due to multilingual requirements,
- red tape in working with Indian Health Service hospital,
- high accounts receivable,
- *community image makes* recruiting difficult.

Strategies—
- merged facilities with agreement to protect jobs for 1 year,
- cut 100 jobs after l-year hiatus,
- easy merger of medical staffs helped bring harmony,
- methodical attention to and elimination of accounts receivable,
- serious planning effort for merged facility.

Rural Hospitals in Systems or Other Affiliations

James R. Beeler, Director of Planning & Marketing/ Regional Operations, Samaritan Health Service, Phoenix, AZ-Represents system of 18 facilities (mostly leased or managed), of which 4 are hospitals ranging from 25 to 84 beds in size.

Problems—
- heavy subsidy of one 22-bed rural hospital,
- manpower recruitment and stabilization,
- physician issues,
- access to capital.

Strategies—
- converted troubled hospital to other uses,
- internal recruiting/locum tenens,
- joint venture With physicians in managed *care* plan,

- prescreening outreaching specialists,
- air transport of specialists to rural areas,
- pooled bond fund provides access to capital,
- local fundraising.

Keith Lundberg, Executive Director, Health Services Consortium, Seattle, WA—Represents a voluntary shared services consortium established in 1973 under the auspices of a large tertiary center. There are 15 rural community hospitals in the consortium.

Problems--
- low utilization,
- recruitment and retention of physicians.

Strategies—
- ***coordinated case*** management,
- focused referral relationships,
- developing physician leadership,
- tangible incentives for patient care relationships.

Carole Guinane, R.N., Asst. Vice President for Medical Staff Services, Parkview Episcopal Medical Center, Pueblo, CO—Parkview joined with Rose Medical Center in Denver to form the Rocky Mountain Health Alliance to provide a link for rural institutions and physicians to the resources at tertiary care facilities and garner referrals for the larger hospitals.

Problems—
- ***urban*** hospitals seen as "black hole" for referrals,
- rurals losing market share due to poor image,
- training and continuing education needs,
- few resources for new equipment and services.

Strategies--
- **specialty** physicians contract to return patients to rural physicians,
- training programs for rural doctors, nurses and administrators,
- inventory reduction program; equipment purchase and placement,
- grantswriting assistance,
- marketing and strategic planning assistance.

Gordon Russell, Administrator, Hi-Plains Hospital, Hale Center, TX—Represents the West Texas Independent Affiliated Hospitals, a group of about 30 rural hospitals that are about 40 miles apart covering an area the size of New York. The hospitals average 49 beds in size, and most are public.

Problems—
- not enough money, competitors have too much money,
- low Medicare reimbursement,
- isolation resulting in unsophisticated systems and resistance of change,
- peer Review Organization problems.

Strategies—
- board retreats,
- peer support visits to provide internal review and assistance,
- joint purchasing,
- management information system and cost report sharing.

Cathy Comito, Network Coordinator, Mercy Hospital Consortium, Des Moines, IA—Represents a consortium consisting of 10 rural hospitals within a 100-mile radius of Mercy Hospital in Des Moines. Eight of the hospitals are county; two are nonprofit. Five are managed by Mercy and five are affiliated.

Problems—
- ***isolation,***
- inefficiency.

Strategies-
- local autonomy is key,
- no management fees are charged,
- training programs for all levels of personnel,
- hospitals purchase services from consortium,
- consortium-wide conferences for board and administrative staffs.

Bismarck, North Dakota

Physician Issues

Nelson Tilden, Ph.D., President, Medical Search Consultants, Inc., Overland Park, KS-Operates a small consulting firm that recruits physician, particularly for rural areas.

Problems—
- lifestyle expectations of young physicians often antithetical to rural practice,
- increasing numbers of women physicians whose spouses often have trouble finding positions in rural communities and who tend to have different practice styles and needs (e.g., more time with family, child care, etc.).

Strategies—
- revitalize the National Health Service Corps (NHSC),
- implement the Resource Based Relative Value Scale (RB/RVS) quickly,
- establish a "Peace Corps' '-type program that requires all graduating physicians to serve in a medically underserved area,
- encourage programs to provide "call" coverage, professional interaction, and emotional support for physicians.

Frank Newman, Ph.D., Director, Montana Area Health Education Center (AHEC), Bozeman, MT— Represents interests and concerns of Montana's 45 frontier counties. In 1987,52 percent of the counties in the

State were designated as Health Manpower Shortage Areas. There are 60 hospitals and 45 are rural hospitals of 60 beds or less.

Problems—
- maldistribution of physicians is a problem despite the fact that the State has a physician-to-population ratio of 1:650. Only 33 percent (417 doctors) are serving the rural 70 percent of the population,
- all of the State's small rural hospitals are losing money,
- Indian reservations have a very hard time recruiting doctors and low retention rates,
- a 90 percent occupancy rate exists in the State's nursing homes, but only a 25 percent occupancy in the rural hospitals,
- the two federally funded community health centers (CHCs) are both in urban areas.

Strategies—
- creation of State offices of rural health and State rural health associations,
- Indian health programs have retained a fulltime recruiter which placed 16 doctors last year,
- CHCs should be established in rural areas,
- the WAMI (Washington, Alaska, Montana, Idaho) program of rural rotations,
- the AHEC maintains and publishes practice vacancy lists each month, and helps recruit doctors to the State.

Gerald Sailer, M.D., United Clinics, Hettinger, ND— Represents a 17-doctor practice in a medically remote area. The practice created a health maintenance organization (HMO) that ceased operations in January 1989.

Problems—
- peer support is unavailable unless through group practice or other arrangements,
- time for family must be planned into physician retention plans,
- doctors often are not educated for the demands of rural practice,
- payments for rural doctors and hospitals is very low,
- procedure-oriented physicians are paid much more than cognitive physicians.

Strategies—
- adopt RB/RVS without geographic differences,
- equalize urban and rural payments for similar services for both hospitals and physicians,
- pay for nurse-anesthetist services at cost in hospitals eligible for Sole Community Hospital (SCH) designation,
- develop payment rates for rural HMOs that are not based on usual and customary rates, which perpetuates payment inequities,
- refine the definition of and payments to assure that necessary hospitals survive.

Carol Miller, President, Mountain Management, Ojo Sarco, NM—Represents concerns of "frontier" areas.

Problems—
- ***cutbacks in Federal*** funding,
- physician maldistribution,
- reductions in funding have crippled rural and frontier communities' ability to recruit health professionals,
- medical indigency is a primary barrier to access.

Strategies—
- restore and improve the NHSC,
- expand Medicaid to assure the same coverage in all States,
- provide tax credits and incentives for rural practice,
- provide locum tenens coverage for doctors' vacations and continuing medical education (CME),
- make Federal CHC and NHSC programs more available for small sites in rural and frontier areas.

Nursing Issues

Lois Merrill, Dean, College of Nursing University of North Dakota, Grand Forks, ND—Represents concerns of nurses and their employees.

Problems—
- rural nurses and facilities can't afford additional training required by modern practice,
- reimbursement for rural hospitals makes them unable to compete with urban hospitals for nurses,
- urban hospitals are raiding rural areas for nurses,
- direct reimbursement for advanced degree nurses is unavailable.

Strategies—
- support outreach education,
- financial aid should recognize the needs of adults,
- reimburse rural hospitals equitably, recognizingg the increased demand and pay scales for nurses,
- provide indirect payments for nurse training as is available for physician training,
- direct reimbursement for nurse practitioners, nurse midwives and certified registered nurse anesthetists.

Sue Ebertowski, R.N., Director of Nursing, Mercy Hospital, Williston, ND—Represents a 125-bed rural hospital, 200 miles from the nearest tertiary hospital. It is paid rural rates and has an occupancy rate of 35 to 40 percent. The nursing staff has a 21 percent turnover rate and currently has no vacancies.

Problems—
- obsolete job and work structures,
- insufficient job feedback,
- lack of participation in decision-making,
- first line manager deficiencies,
- ineffective nurse-to-nurse relationships,
- ineffective nurse-to-physician relationships,

- nonproductive nurse-to-ancillary department relationships,
- high stress among nurses,
- lack of innovative environment,
- deficient internal and external image of nursing,
- untargeted and ineffective recruitment marketing,
- inadequate wage systems,
- nursing technology lag,
- underdeveloped strategic plans for the nursing organization.

Karen Pederson-Halle, R.N., Luke Regional District Health Unit, Devils Lake, ND—Represents a health department unit that serves five counties, an area of 5,835 square miles. There are 6.6 full-time equivalent nurses, and the Unit should have four more nurses to meet standard staffing ratios. The Unit provides community health nursing, WIC, family planning, health screening and environmental health services to a population of over 38,000.

Problems—
- salaries are considerably lower than in local hospitals and even lower compared to city hospitals in the State,
- the area is not considered attractive to many nurses with the largest town having a population of only 750,
- little chance for advancement,
- declining funding for public health programs,
- difficult to identify results from preventive care,
- need to be better versed in politics and public ***speaking.***

Strategies—
- **increase funding** for public health programs,
- train nurses for community and rural practice,
- develop career ladders within region.

Hurdis Griffith, R. N., Ph.D., University of Texas, Austin, TX—Represents concerns of rural nurse practitioners (NPs).

Problems—
- low pay for NPs **(rural NPs** average $13.36/hr),
- lack of recognition of capabilities of NPs to function independently,
- State laws and their interpretation are sometimes real barriers to implementation of Rural Health Clinics Act (RHCs),
- many third-party payers do not reimburse for NPs' services.

Strategies—
- simplify RHC reporting, which is currently not feasible in small sites,
- establish NP traineeships to help train local nurses to become NPs,
- provide direct reimbursement for NPs' services.

A Potpourris of Related Issues

Dwayne Ollerich, Ph.D., Academic & Research Affairs, University of North Dakota School of Medicine, Grand Forks, ND—Represents general economic concerns of rural North Dakota, where agricultural economy has been poor, retail sales have dropped, and population and jobs have declined.

Problems-
- underemployment of rural residents,
- lack of outreach training available that will allow **rural,** residents to train while employed or in their own communities.

Strategies—
- ***need assistance*** grants for transition ***from*** farming to other employment,
- programs to develop leadership within local resources,
- need support for students for travel, tuition and child care,
- should use new communications technology for local training.

Tom Robertson, Director, Southeast Montana Rural Health Initiative, Glendive, MT—Represents a county health department that serves a geographically large five-county area with a population of 85,000. He is also part-time director of the SE Montana Rural Health Initiative, a primary care program that no longer has funding from the CHC program. Most of the people in the area consider themselves lucky to live within 50 miles of a physician or a physician's assistant (PA).

Problems—
- recruitment and retention of all health personnel, especially emergency medical technicians (EMTs),
- very long drives for training and services with no one picking up the costs of that travel,
- EMT testing is often provided 200 to 300 miles away,
- low pay rates for health professionals is a disincentive for retention.

Strategies—
- training throughout rural and frontier areas funded by the Public Health Service,
- payment for more services not covered by current home health programs for frontier areas,
- allow more flexibility in productivity and other standard in the CHC Program,
- allow more multiple-county CHC projects.

Pam Locken, Administrator, Isabel Community Clinic, Isabel, SD—Represents a CHC staffed by a solo PA whose backup physician supervisor is 104 miles away by air transport. The clinic is between two Indian reserva-

tions. It is 60 miles to the nearest hospital. The average age in the three-county service area is 19 years old.

Problems—

- ***poor counties with*** low tax base,
- . no backup for PA when he is on vacation or CME travel,
- . bad weather limits ability to transport,
- nearest pharmacy is 55 miles away,
- . Indian Health Service will not acknowledge PA's prescription.

Strategies—

- certification as RHC allows payments to cover relatively high per unit cost,
- all staff are cross-trained to do others' jobs,
- use starter doses for prescriptions until mail truck can deliver medications.

Denise Denton, Rural Health Field Coordinator, Utah Department of Health, Salt Luke City, UT—Utah is ***83*** percent frontier and about 90 percent rural. The State's rural health effort was begun with a NHSC contract in 1982. At that time the State had 12 to 15 new Corps assignees per year, and a total of 25 to 33 assignees in the State. In 1986 the number of new assignees was four, and in 1988 there were no new assignees.

Problems—

- . family physician supply is too small to meet the need in both urban and rural areas,
- need better training for communities on how to recruit and retain,
- . professional liability is driving doctors out of rural practice,
- . grantwriting abilities of many rural communities is weak,
- . inequitable reimbursement for physicians provides a disincentive for rural practice.

Strategies—

- provide ***locum tenens coverage*** for doctors, PAs and NPs,
- tie midlevel providers in with teaching hospitals,
- provide financial incentives for medical schools to do rural programs,
- develop a more relevant rural curriculum for training health professionals.

Meridian, Mississippi

Payment and Financing

Alan Strange, Ph.D., Consultant, National Association of Community Health Centers, Washington, DC— Represents the concerns of the Nation's federally funded 536 CHCs, of which 329 (63 percent) are rural.

Problems—

- ***. rural*** areas receive 42 percent fewer Federal dollars per capita for health care than urban areas,
- rural people are disproportionately poor and often ineligible for Medicaid,
- rural CHCs serve 50 percent of all CHC users, but receive only 41 percent of Federal CHC funding,
- rural CHCs are required to provide the same scope of services, but lack the economies of scale of larger practices.

Strategies—

- compulsory service for providers completing training,
- improve reimbursement under the Rural Health Clinics and the federally Funded Health Centers Programs,
- expand the Hospital Transition Grant Program to include CHCs,
- increase funding for the NHSC,
- allocate funds targeted for special populations (AIDS, homeless, infant mortality, etc.) on the same basis as basic appropriations.

Penella M. Washington, Health Resources Development Section, North Carolina Department of Human Resources, Raleigh, NC—Represents the State of North Carolina's concerns regarding helping providers become certified as RHCs.

Problems—

- timeframe for certification (from date of application to date eligible for claim reimbursement) is too long (6-9 months),
- centers awaiting certification must discontinue Medicare/Medicaid billing during the approval process, causing cash-flow problems,
- midlevel providers are required to be onsite at least 60 percent of the time the clinic operates, which limits staffing flexibility,
- annual recertification surveys are conducted without prior notification of the clinic, hence appropriate personnel may be absent. Current methodology for calculating productivity screens contains disincentives for exceeding productivity standards,
- documentation required for reimbursement for bad debt is often difficult for small clinics to produce,
- HCFA regions and intermediaries interpret program regulations inconsistently.

Strategies—

- make federally funded CHCs automatically eligible for RHC certification, and streamline process to no longer than 3 months,
- lower midlevel provider requirement to 50 percent of time the clinic is open based on a 12-month fiscal year,
- advise clinics of recertification surveys in advance,
- develop a "team approach" to computing productivity,

- simplify the bad debt recovery process by paying 90 percent of estimated bad debt.

William A. Curry, M.D., F.A.C.P., Carrollton, AL- Represents a private medical group practice that consists of four internists. The local hospital has a medical staff of 10. Local citizens recently passed by a 3 to 1 margin a 3 percent sales tax to support the local hospital.

Problems—
- problems of rural hospitals, doctors, etc. are interconnected,
- structural changes imposed from above won't work; we need to look for "free market" approaches,
- inequitable reimbursement is the major problem for both rural hospitals and doctors,
- alternative model that would turn rural hospitals into simple triage and transport facilities will not be efficient or effective.

Strategies—
- reform the payment system for Medicare and Medicaid to provide equitable payments for rural doctors and hospitals,
- adopt the RB/RVS with adjustments for cost of practice, not cost of living,
- reform Medicaid.

Clinton Smith, M.D., Director, Division of Medicaid, Office of the Governor, Jackson, MS—Represents the Mississippi Medicaid Program.

Problems—
- shortages of doctors, nurses and other health professionals to practice in rural areas,
- rising rates of uncompensated care in hospitals,
- hospitals and doctors dropping obstetrical service,
- transportation, even though it is reimbursable under Medicaid,
- categorical eligibility for Medicaid unfairly restricts coverage.

Strategies-
- provide focused incentives for people to enter health professions and practice in rural areas,
- provide fair reimbursement under Medicaid and Medicare; equal for both urban and rural providers,
- allow States to selectively increase payments for obstetrical care,
- develop public transportation in rural areas,
- dissociate Medicaid eligibility from Aid to Families With Dependent Children, and use more universal standard such as Federal poverty level,
- expand Medicaid coverage for persons between 21 and 65 years.

Access to Care

Rims Barber, Director, Mississippi Human Services Agenda, Jackson, MS—Represents the concerns of the rural poor.

Problems—
- slow Medicaid application processing,
- transportation for the rural poor is difficult to find and expensive,
- home environments often lack basic amenities,
- high rates of teenage pregnancy.

Strategies—
- develop a program of ''community facilitators' within CHCs or other entities,
- simplify eligibility and expand coverage under Medicaid,
- mandatory Medicaid participation for doctors to assure that the poor have services available.

Mickey Goodson, Executive Director, Georgia Association for Primary Health Care, Atlanta, GA— Represents primary care providers in Georgia, which has 159 counties (120 with hospitals, 150 with physicians). Nineteen percent of the rural population is poor.

Problems—
- economic status is still a major obstacle to access,
- indigent care burden falls heavily on rural providers,
- maldistribution of doctors and other health professionals.

Strategies—
- more emphasis on comprehensive primary care models of delivery,
- provide universal access to basic services.

Susan Jones, M.D., West Alabama Health Services, Eutaw, AL-Represents a primary care center that sponsors a three-county program to reduce teen pregnancies and improve pregnancy outcomes.

Problems—
- shortage of physicians for rural practice,
- high infant mortality rates in rural areas that are twice as high for black infants.

Strategies—
- ***funding*** for programs targeted for specific problems and population segments,
- develop comprehensive systems which include transportation, tracking systems and home visiting,
- revitalize the NHSC.

Pamela Hammock, State Health Office, Tallahassee, FL-Represents the State of Florida, which passed a law in 1984 to create the Public Medical Assistance Trust Fund, funded by a combination of taxes on hospital revenues and general revenue from the State. The Fund

has supported primary care projects in all 67 counties and permitted the State to expand Medicaid coverage.

Problems—
- ***rising*** and maldistributed indigent care costs,
- poor access to primary health care,
- restricted Medicaid eligibility.

Strategies—
- State funds similar to the Florida model can work to provide additional access for the poor and provide funds for other developmental purposes.

Practice Capacity and Organization

Steven Shattls, Executive Director, Valley Health Systems, Huntington, WV-Represents a primary care health system with a wide array of services, including a perinatal program (which serves 70 percent of the eligible women in a 10,000 square mile area) and to the homeless. The system is located in West Virginia, which is dependent on coal mining in a deep economic depression, and nearly bankrupt.

Problems—
- high reliance on the NHSC for physician manpower and low retention,
- categorical funding restricts ability to use funds to meet the needs of the community,
- limited funding and reimbursement,
- transportation,
- coordinated care important but difficult in rural areas.

Strategies—
- ***joint*** approaches to retention with hospitals and public and private providers,
- more flexibility and creativity in using categorical funding,
- more aggressively seek categorical funding,
- more money for case management programs.

Al Fox, Executive Director, Health Development Corp., Tuscaloosa, AL-Represents a system that provides primary health care for six counties. Its initial mission was to recruit and place health professionals in practices that would become stable private practices. Over an n-year period, it placed 16 physicians and 3 dentists in independent practices. In 1987, it changed its program to conform with the CHC Program to operate comprehensive health centers rather than setting up private practices.

Problems—
- **hospital closures hurt recruitment and retention efforts,**
- **need for** stronger working **relationships with public health,**
- **need for standardization in small clinics,**
- **low per capita incomes and high indigent care load.**

Strategies--
- more NHSC physicians for rural practice,
- regionalized training for **small** clinics to help with efficiency and quality,
- establish linkages with community agencies and programs,
- more CHC funding to cover increasing indigent care load.

Bernard Simmons, Executive Director, Southwest Health Agency for Rural People, Tylertown, MS— Represents a primary health care center in a rural area with no shortage of health manpower but with a high rate of poverty.

Problems—
- financial barriers prevent access to care for many residents,
- teen pregnancy rate is 25.4 percent,
- initial perception of program as a "Federal clinic" with low participation from White population.

Strategies—
- expand Medicaid to include more of population,
- interact with local private providers to give "team approach" to health care,
- funding for midlevel providers to help clinics become certified as RHCs,
- funding for social workers or others to act as case managers.

Shirley Parker, Executive Director, Laurel Forklear Fork Health Centers, Clairfield, TN—Represents a network of four small clinics located in Eastern Tennessee and Kentucky in areas where organized health care was first provided by "camp doctors" hired by the mining companies. Fifty-five percent of the people in the service have incomes below the poverty level.

Problems—
- **high** proportion of indigent care,
- recruitment and retention,
- ***need*** **for automation** of billing and bookkeeping functions,
- high cost for medical liability insurance,
- increasing facility repair and maintenance costs.

Strategies—
- increases in grant funds should be tagged to increasing patient load and indigent care load,
- excess program income should be retained by centers to use or to save as they see fit,
- tort reform needed on malpractice,
- provide tax credits or deductions for rural doctors,
- better reimbursement for mid-level providers,
- more rural-based training programs for physicians,
- renovation money should be made available.