Testimony of

THE NATIONAL RURAL HEALTH ASSOCIATION

Hearing on

Healthy Aging in Rural America

Senate Special Committee on Aging

U.S. Senate

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Good morning. My name is Hilda Heady and I am Executive Director of the West Virginia Rural Health Education Partnerships. I am here today representing the National Rural Health Association (NRHA). I want to thank Chairman Craig, Ranking Member Breaux and the members of the Special Committee on Aging for the opportunity to testify before you on the topic of healthy aging in rural America.

My remarks will focus on access to health care for the elderly in rural communities. I will comment on both success stories, as well as areas in which the Federal government can become partners in our efforts to improve both access and quality for rural elderly.

The NRHA is a national nonprofit membership organization that provides leadership on rural health issues. Through discussion and exploration, the NRHA works to create a clear national understanding of rural health care, its needs, and effective ways to meet them. The association's mission is to improve the health of rural Americans and to provide leadership on rural health issues through advocacy, communications, education and research.

The NRHA membership is made up of a diverse collection of individuals and organizations, all of whom share the common bond of an interest in rural health. Individual members come from all disciplines and include hospital and rural health clinic administrators, physicians, nurses, dentists, non-physician providers, health planners, researchers and educators. Organization and supporting members include hospitals, community and migrant health centers, state health departments, state offices of rural health and university programs.

It has been widely noted that the U.S. population is aging, with 77 million baby-boomers poised to enter the Medicare system in the coming years. The rural population of our nation is aging more rapidly because of elderly people aging in place, younger residents leaving rural areas for metro areas and elderly citizens returning home to rural communities as they age. There are approximately 9.2 million people in rural America aged 65 and older. Rural elderly are less likely to have a high school education and more likely to be poor. Because rural residents tend to have lower lifetime incomes than their metropolitan counterparts, their Social Security benefits are subsequently less in many cases.

As you are well aware, rural areas are unique. They differ from urban areas in their geography, population mix and density, economics, lifestyle, values and social organization. Rural areas are viewed as vulnerable to reduced access to health care for a variety of reasons. These reasons include limited numbers of providers, poorly developed health care systems, high prevalence rates of chronic illness and disability, socioeconomic hardships, and geographic and transportation issues.

Rural areas also differ from urban areas in the way that health care services are delivered to residents. Small, rural hospitals, in addition to being the only source of emergency care, are often a community's only resource for health care services such as long-term care, home health services, and outpatient services. Rural residents tend to have access to a narrower and more costly range of health care services and to be served by fewer health care providers. Rural people and communities require programs appropriate to their individual characteristics and needs and often utilize innovative and creative collaborations to meet their health care needs.

General Needs of the Rural Elderly

The major issues for the rural elderly are access to health and other services, housing, and transportation (not only for health care services but for needs of daily living such as shopping, recreation, etc.) My home state, West Virginia, has become the oldest country in the nation. One of our fastest growing segments of the population is women over the age of 85. These elderly women cannot maintain their homes so housing and a safe household environment become critical. Younger people migrate from rural areas leaving their elderly relatives on their own to try to maintain the homestead.

Telemedicine

One of the recent innovations seen in rural communities is the increased use of telemedicine, or care provided remotely via telecommications equipment from a specialist at an urban center. Last year's Medicare, Medicaid & S-CHIP Benefits Improvement and Protection Act (BIPA) allowed Medicare reimbursement for telemedicine at the same rate that would be reimbursed for in-person provision of services. This change makes telemedicine a more viable option for seniors living in rural areas. However, it remains to be seen how effective telemedicine will be

and how it will impact access in rural areas. Telemedicine should be seen as a part of an access solution, but it does not negate the need for a viable rural health care infrastructure. Telemedicine and telehealth approaches can provide much needed linkages services for rural facilities and providers; however, the training on the use of this technology for health providers and students is essential to ensure the use of this technology in the future.

Medicare

Because the elderly make up a larger proportion of the rural population, Medicare assumes a greater role as a source of financing for health care in rural areas. However, Medicare spends more on urban than rural beneficiaries and in many cases, pays less for the same service provided in a rural as opposed to urban setting. In 1996, Medicare paid an average of $4,400 per beneficiary in rural areas compared to $5,300 in urban areas. Taking into account all of the Medicare rate adjustments, average rural hospital payments are 40% less than urban hospital payments and 30% less for physician payments. Medicare managed care, or Medicare+Choice, has seen slight penetration of rural markets, with 2.45% of rural beneficiaries enrolled in managed care versus 20% of urban beneficiaries enrolled. It is unclear whether Medicare+Choice is a workable solution to the challenge of access to health care in rural areas, as 101 plans pulled out of rural counties last year. Legislation passed during the 106th Congress attempted to solve the problem of Medicare+Choice plan non-renewals by raising payments per beneficiary.

Post-Acute Care

Research has shown that the rural elderly make greater use of home health and skilled nursing services, often substituting such services for care that may otherwise be provided in a hospital inpatient setting. Therefore, rural Medicare beneficiaries have experienced a greater impact from reductions in payment rates for home health care in recent years and are more adversely affected by closures of home health agencies and skilled nursing facilities than their metro counterparts.

A lack of rehabilitation options in rural communities has led rural hospitals to diversify and provide a broader range of services to its patients. In 1982, the swing bed program was implemented to allow rural hospitals to receive payments under Medicare Part B to increase the

availability of rehabilitation services in rural areas. Isolation due to geography or distance and a lack of rural home care or assisted living services creates a problem for rural residents with access to rehabilitation care after a hospital stay. Swing beds allow patients to stay in the hospital beyond the end of their acute care stay and receive the nursing and rehabilitation services they need. Sixty percent of rural hospitals participate in the swing bed program, and 47% of patients are discharged directly home after their swing bed stay.

The precarious nature of the rural health care delivery system has the result of creating instability and insecurity for the rural elderly. The lower Medicare reimbursement rates for rural hospitals mean that these providers are constantly at risk and forced to make hard choices about what services they can afford to provide to beneficiaries. A hospital that eliminates health care services may find that it is unable to keep its doors open, and once a hospital closes, other parts of a community's health care infrastructure are endangered as well. The National Rural Health Association continues to advocate for an equalization of payment rates for rural and urban Medicare beneficiaries, thereby expanding access to health care services for the rural elderly and ensuring that the benefits of health care are available to all Americans, regardless of where they live.

Partnerships and Collaboratives

Partnerships, networks, collaboratives, and other cooperative approaches among rural providers can address some of the fragility of the rural health care landscape and can engage rural consumers in health care and policy development. These approaches have been used extensively to create wellness and health promotion programs for the elderly and other rural populations. The strategies of engagement, equanimity, and empowerment makes sense to rural people for these reflect the rural values of working together for the common good in the face of adversity. Any federal approaches which advocate and support the development of partnerships for rural health education, and for wellness and health promotion should be given serious consideration as a viable mechanism to address the health care problems of the rural elderly.

The Aging Rural Veteran and their Families

We know that a significant number of combat veterans live in rural areas and while the Veterans' Administration supports systems of health care for these veterans, we need to give great consideration to the long term care needs that are growing as this population ages. The need for more readjustment outreach centers and their services for the aging Vietnam era baby boomers is increasing. The average age for this vet is now 53. The 1988 National Vietnam Veteran Readjustment Survey found that 15.2% of male and 8.5% of female Vietnam veterans (approximately 486,500) currently have PTSD. Readjustment Centers around the country are experiencing and increase in the number of vets seeking help for acute on set of PTSD related symptoms as they age. I am a member of a women's group in a local Vet Readjustment Center in West Virginia. In that small group over half the women have reported that their husband's acute episodes of PTSD behaviors have occurred after the age of 50 and are increasing as they age. Adding in all the veterans who suffer from partial PTSD, and recognizing that PTSD by definition is a delayed response, the numbers of veterans with full or partial PTSD in need of help and support could be 1.5 million. Knowing that the character of the disease impacts not only the veteran but also his or her loved ones as well, the number of people now suffering with the impact of PTSD from the Vietnam and other wars is staggering. More research is needed to study the needs of the aging veteran and the impact and relationship of PTSD on domestic violence, child abuse, divorce, suicide, and elder and substance abuse.

Examples of Successful Models and Practices for the Rural Elderly

Programs that promote local innovation and development of local resources, engage the elderly in planning, implementing, and dissemination, and build partnerships among resources and citizens are generally the most successful. Among the most important factors in assuring access to services in rural areas are identification and maximization of existing resources. Local volunteers are a valuable potential resource in every community. With specialized training they can provide nearly every population with basic needs and support services. Such an arrangement benefits both the volunteers and the service recipients and can strengthen the community bonds of both parties.

Volunteers in Calhoun County, West Virginia, prior to providing transportation to services for older people in remote areas, requested education and training in coping with sudden health problems that might occur in the course of a journey. After such education and training they provide the volunteer service on a daily basis. Last week while engaged in a service-learning experience with health professions students in our state, I was fortunate to attend the morning session of the Adult Day Care program of the Integrated Health and Services Council in Ritchie County, West Virginia. One hundred and one year old Nellie was there for the morning and for lunch and shared with me stories about her life in a comfortable trailer on her 55-year-old grandson's buffalo farm. This extended family uses the services of the Adult Day Care program for respite and for social activities for this dear woman.

Many kinds of health-care providers can also be a valuable resource in rural communities but as yet are underutilized. For instance, as patient loads increase and fewer physicians venture into rural practice, pharmacists can serve as a vital link for health information and for education and support of patients. The West Virginia Rural Health Education Partnerships is a collaboration of over 670 individuals across the state. This program trains 10 disciplines of health profession students in rural underserved areas of the state. Our state higher education system requires these students to complete three months of their training in these areas and to engage in service-learning, interdisciplinary case management and community based research while in these rural communities. Last year students completed 1,339 rotations for 6,145 weeks of training and served 185,000 rural residents, many of them elderly, in health promotion and disease prevention activities. This is a state funded program and the other West Virginia programs cited are funded both with local, state, and federal funds

The Federal Office of Rural Health Policy through its Rural Health Outreach Grants has fostered innovation in the use of local resources for services to the elderly. Three such programs, in Idaho, Iowa, and Georgia are also examples of best practices in the use of local resources. In Moscow, Idaho the Adult Day Health Program provides a continuum of appropriate health and therapeutic services, recreational activities, nutritional services, psychosocial support, and educational activities in a safe, caring, stimulating environment. The primary target populations for this program are African American (1%), American Indian (3%), Caucasian (90%), and

Hispanic (5%). A collaboration of regional health and human services agencies provides additional support, expertise, and ancillary services. The program's targeted population is the frail elderly, the developmentally disabled, and severely impaired adults of the service area. The overall goals of the center are to maintain and improve the physical health status and activity level, improve the psychosocial health status and activity level, and improve participants' ability to perform activities of daily living and remain in the home community with an optimum level of independence. To achieve these goals the center extends services to geographically and socially isolated residents; coordinates services with other providers; provides transportation and well-trained staff escorts to allow participants to attend appointments for other services; and provides assistance, education, and psychosocial support to family members and caregivers of the targeted population.

The North Iowa Mercy Health Center in Mason City provides expanded health care services to seniors in 15 counties in northern Iowa. The project recycles and repairs assistive technology equipment to clients who are unable to afford new durable medical equipment or the repair costs of their existing equipment. The project also develops a multiprovider clinic to ensure local access to physician, therapy, and dental services. This site also provides the focal point for the equipment outreach that is done both at the clinic and in the homes of needy seniors. The project is also developing an education initiative to promote the project and the equipment and health care services available to local residents.

The Partnership for Rural Elderly in Dahlonega, Georgia is a collaborative interdisciplinary effort committed to providing direct rehabilitation, consultative, and educational services to rural, low-income elderly citizens in the North Georgia region who do not otherwise have access to such care. This community is primarily Caucasian (96%). This program provides services within this underserved community to bridge the gap between medical care and quality of life. County Senior Center, Programs Assisting Community Elderly, Dahonega Habitat for Humanity, Gainesville Aid Project, Georgia AHEC, and the Lumpkin County Commissioner.

The federal government can be helpful in the following ways:

- Provide a prescription drug benefit under Medicare

- Improve reimbursement to home health and other community-based services that seek to keep the elderly healthy and at home.
- Develop funding partnerships with state governments to encourage state to train health professional students in rural communities and engage in service-learning with the elderly while they train.
- Fund a national study on the rural aging veteran and their families with a focus to improve the outreach and readjustment center services in rural areas.
- Improve funding to local communities who engage local resources to renovate the homes for the rural elderly.
- Provide increased funding for transportation programs that serve the rural elderly.

On behalf of the NRHA, I wish to thank Chairman Craig and members of the Committee again for the opportunity to testify here today. As my testimony to you today indicates, good things are happening in our rural communities to help seniors obtain quality health care. I want you to know that the NRHA stands ready to work with your Committee and the Congress to ensure improved access to essential health care services for the elderly in rural and frontier communities. I would be happy to take any questions you may have.