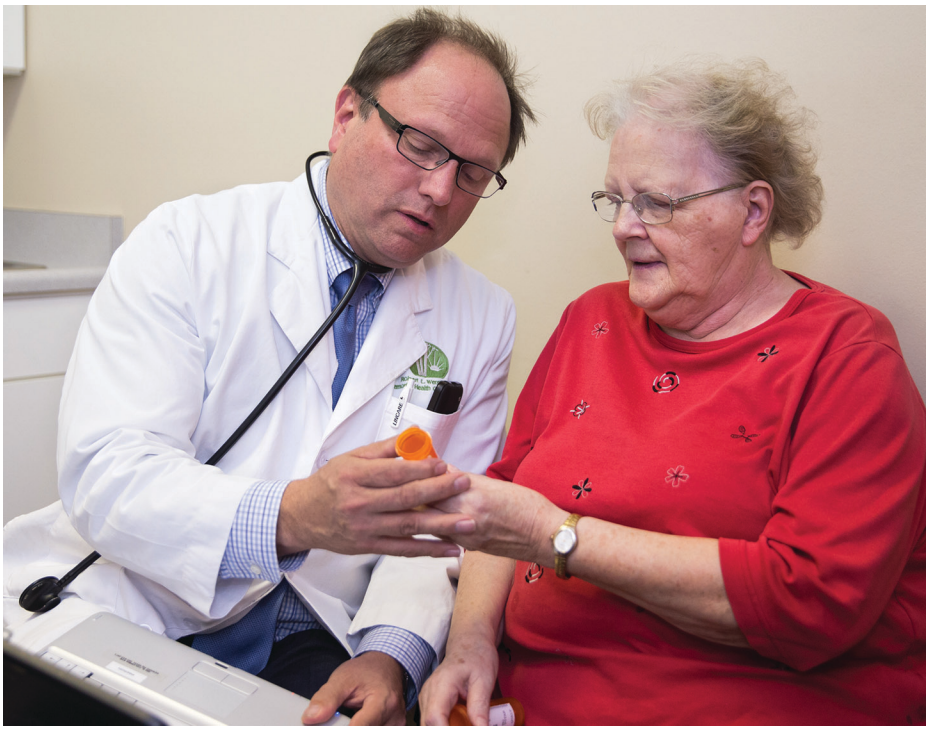

Care in rural America: Dr. Robert Wergin goes over medications with Sharon Stutzman at the Milford Family Medical Center in rural Nebraska. As the number of health care providers working in rural America continues to decline, those such as Wergin who remain often must take extraordinary actions to reach the aging population in their communities.

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AGING & HEALTH

Aging In Rural America

For older Americans, accessing high-quality care can be a challenge. For those in rural communities, it's even harder.

BY SUSAN JAFFE

In the southeastern Nebraska town of Milford, population 2,100, Dr. Robert Wergin understands it's not easy for some of his older patients to get to his office. Some may live on isolated farmsteads several miles out of town, and if they don't drive, their son or daughter—if nearby—may have to take time off from work to bring them to their appointments because there's no public transportation. Massive snowstorms are nothing special but still cause a wave of cancellations.

In addition to these challenges, rural America's elderly tend to be poorer, have higher levels of chronic disease, and have a dwindling supply of health care providers, compared to their peers in urban communities, explains Brad Gibbens, deputy director of the University of North Dakota's Center for Rural Health, in Grand Forks. And their support system is shrinking, as more young adults seeking job opportunities head out to urban areas. "The elderly [rural] population tends to stay put because that's where they've lived all their lives, and there isn't really an economic beacon that's pulling them to another area," he says.

These issues are further complicated by the fact that some of Wergin's longtime patients are not used to going to a doctor, even for minor injuries. "They are pretty fiercely independent," says Wergin, a board-certified family physician and president of the American Academy of Family Physicians.

In northern Maine, Dixie Shaw would agree. "You find that today with many older people, they always think someone is worse off than they are," says Shaw, program director for hunger and relief services for Catholic Services in northern Maine's Aroostook County, on the Canadian border. According to data from the 2010 census, Maine has the nation's largest proportion of residents who live in rural areas (61.34 percent)[1] and the third-largest percentage of residents age sixty-five or older (15.9 percent)[2]

"And pride is one of the biggest challenges," Shaw continues. "They won't ask for help—you have to stumble on to it and understand their needs." Last year Shaw testified as part of the Senate Special Committee on Aging's investigation on poverty and aging.[3]

Wergin and other rural health care providers have found ways in which they can overcome the daunting challenges of providing health care to rural seniors. When Wergin is worried about an elderly patient, he sometimes calls a family member, who may live in another state, and asks that person to call his or her mother or father to check in—not just once, but every day. When necessary, Wergin will also ask the town's ministerial council to help his patients connect to a food pantry or other resources.

Sometimes Wergin will even resort to subterfuge to see patients such as "John" (not his real name), who is usu-

Photograph by Associated Press/Dan Little/Lincoln Journal Star

ally too busy to come in for a check-up. Last summer Wergin thought that diabetic shoes might relieve John's calluses and peripheral neuropathy. Medicare requires a face-to-face medical visit before it will cover the cost of durable medical equipment such as diabetic shoes, but John had not made an office appointment. So Wergin stopped by his home. As they chatted, Wergin began to ask seemingly innocuous but probing questions. What will he do with his new shoes? John said he wanted to get back in shape by doing more walking. That was great news, Wergin said, but he was suspicious. He'd been trying for years to convince John to get more exercise. Why now? And that's when John finally let slip that he was having chest pains and shortness of breath when he mowed the lawn.

Wergin cajoled John into starting his new exercise routine the next morning by walking on a treadmill for a stress test at Memorial Hospital in Seward. The test revealed a blockage in his left coronary heart artery. Wergin wanted John to see a cardiologist the next day, in Lincoln, about twenty miles away. When John said he was too busy—as usual—Wergin knew just what to say. Wergin threatened to call John's daughter. To avoid such drastic action, John agreed to see the cardiologist, who confirmed that the artery was 95 percent blocked. That afternoon John received a cardiac catheterization and stent.

John's doing fine now, says Wergin. But he acknowledges that the outcome could have been quite different.

"As a rural provider, you have to be innovative," he says.

Confronting Persistent Provider Shortages

Innovation can include reviving past practices such as Wergin's house call to John as well as expanding the traditional role of nurses and licensed practical nurses. The number of physicians per 10,000 people is about 30 percent lower in rural communities than in urban areas, the Center for Rural Health's Gibbens notes. And, making matters worse, seniors nationwide greatly outnumber specialists such as geriatricians. The national mean of geriatricians per 10,000 people age seventy-five or older was 3.8 in 2010. But in most rural states the ratio of geriatricians per 10,000 people of that age was much lower than the national mean, according to the American Geriatrics Society.[4] Among the states above the national mean was New York, with 5.8, and among the lowest was Idaho, with 1.1. That means there are plenty of opportunities for nurses and other medical professionals to fill the gap, as the Institute of Medicine documented in its 2010 *Future of Nursing* report.[5]

"A family care physician who graduates from medical school has an astronomical amount of student loan debt," says Casey Shillam, director of the new bachelor of science in nursing program at Western Washington University, in Bellingham. "How can that doctor practice and pay off that debt? It's not going to happen in a rural area because the pay is lower," says Shillam, who is also a Robert Wood Johnson Foundation Executive Nurse Fellow.

Western's nursing program partners with PeaceHealth Medical System, which serves rural patients who may take ferries from remote islands, ride planes from southern Alaska, or drive down from the Cascades when they need care. In some of these isolated areas without telephones, cellular service, or even electricity, patients may have to go to a local bar to make a phone call.

Nurses who have the training and skills to work at their full scope of practice manage complex patients not only in the hospital but, most important, after they are discharged. This intensive care management can produce a significant decline in emergency department visits and lower health care costs, Shillam says.[6]

Nurses understand the disease process, surgical preparations, and patients' follow-up needs that are essential to successful outcomes, Shillam says. Without access to prescription drugs and good nutrition, for example, "a person isn't going to benefit from a surgery and will wind up costing more to the health care system."

Nurses can also link patients to community-based services and function as a kind of communications "hub" between them. In the small town of Maple Falls, nearly an hour's drive from Bellingham, Shillam says it might be as simple as asking the volunteer fire department to keep an eye on an elderly patient who has just returned home from the hospital.

"If there is a need for specialized care, an intensive case manager or nurse care coordinator can identify much earlier on when the patient is heading down a path of decline," says Shillam. "The nurse care coordinator can intervene sooner to get services in the home or get that person to specialty care and then get them back home where they can function effectively and avoid the really costly readmissions into hospitals over and over again."

Help From The Affordable Care Act

The Affordable Care Act (ACA) has jumpstarted efforts to replenish the rural health care workforce, with provisions that improve government reimbursement, supply training grants for rural physicians, provide new investment in the National Health Service Corps, and reauthorize the Indian Health Service, among other provisions. These measures have won praise from the National Rural Health Association, a nonpartisan organization with more than 21,000 members.[7]

The ACA also lowered seniors' drug costs by shrinking Medicare's prescription drug coverage gap, eliminated cost sharing for recommended preventive health care, and funded pilot projects for in-home care and other senior-oriented programs. But these changes mean little to the rural elderly if they can't find a doctor who will see them or if they can't travel to their appointments.

To help rural elderly patients gain access to health care, the Department of Agriculture's Distance Learning and Telemedicine program awarded $20.5 million in grants last November to health care providers and educational institutions to "provide rural Americans access to medical services, improve educational opportunities, and support Native American communities."[8]

Although Wergin and other rural health care providers value improvements in technology that connect them to other providers, they say patients' use of telemedicine is still limited, especially in remote areas.

"There are big pockets in rural Amer-

ica where there is still either no cell phone service or it's limited or sporadic, or there is limited access to the Internet," says Gibbens.

Despite the ACA's improvements and the promise of telemedicine, rural health advocates argue that more needs to be done. "Since the beginning of 2013, 24 rural hospitals have closed; this is double the pace of the previous 20 months," Sen. Tammy Baldwin (D-WI) and twenty-six other senators from both parties wrote in a November 2014 letter to President Barack Obama urging him to protect rural hospitals from proposed cuts in Medicare reimbursements.[9]

Since January 2010 forty-four rural hospitals have closed, including four in Georgia, six in Texas, five in Alabama, and five in Georgia, according to an analysis by the Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill.[10]

"Individuals living in rural communities, particularly the elderly and those with low incomes, will be significantly impacted by these changes," the senators wrote. "Requiring patients to travel long distances for care may result in life-threatening emergency care delays and barriers to essential preventive care."

An Aging Workforce

In rural states such as North Dakota, employees at nursing home and assisted living facilities are growing older, aging along with the people they care for.

At one small nursing home in Glen Ullin, North Dakota, most of the employees are in their seventies and eighties, the owner recently told Shelly Peterson, president of the North Dakota Long Term Care Association, which represents 200 nursing home, assisted living, and other long-term care providers. The owner is "not sure what he'll do if they retire," Peterson says. That's because the state has an extreme shortage of nurses, licensed practical nurses, and even housekeeping staff, the association reports.[11]

Late last year North Dakota's oldest employee, a cook at another nursing home, retired because of poor health, nine months after her one hundredth birthday, says Peterson.

Despite the ACA's improvements and the promise of telemedicine, rural health advocates argue that more needs to be done.

North Dakota may be a preview of the problems other states could face if, as predicted, their long-term care workforce shortages persist while their populations grow older. Although North Dakota's staffing shortage is driven in part by its low unemployment rate, which has intensified the competition for workers—a problem many states might envy—the shortages' impact could look similar in other states, regardless of the cause.

Nearly two-thirds of North Dakota's nursing homes employ temporary contract registered nurses and licensed practical nurses because it's so difficult to hire permanent employees, says Peterson. The state has provided facilities with scholarships of up to $52,000 per person to help employees become registered or licensed practical nurses. Those who have completed their education may be eligible for $15,000 to pay off their student loans. Some facilities offer $10,000 signing bonuses (over four years) for nurses, dietary aides, and housekeeping staff.

And to help low-income seniors stay at home for as long as possible, the state has a program to train and pay an elderly person's spouse, son, daughter, grandchild, or friend to care for him or her. Seniors must meet income and asset limits to receive assistance, and, Peterson says "it works really well." And it's separate from other home care services for people with very low incomes who qualify for Medicaid.

Nearly half of North Dakota's nursing home residents are discharged back to their own homes or to a lower level of care when their health improves. Those who stay are among the oldest nursing home residents in the country. According to the Centers for Medicare and Medicare Services, North Dakota has the nation's largest percentage of nursing home residents age eighty-five or older (58.4 percent). That includes 13.8 percent of residents age ninety-five or older—nearly double the national average.[12]

Rural health advocates concede that some of the problems confronting older adults in sparsely populated areas might be solved if they moved to where more assistance is: larger towns and even cities.

"If you are seventy-five or eighty and you're frail, you have less resources to rely on than you would in an urban area," says Gibbens, a life-long North Dakotan.

"There may be an attitude that it's their problem, they chose to live there," he continues. "And if you choose to live in rural America and if you're eighty years old, that basically means you should accept that there will be less for you.

"But the point of view those of us who are advocates for rural America have is, yes, it is a choice," he says. "But do we want to live in a country where there is inequity based on geography?"

The vast majority of older Americans say they want to stay in their own homes for as long as possible, whether that's a New York City apartment or a Montana ranch, polls have shown.[13]

"My job is to support people in their homes, in their environment, and keep them as safe and healthy as they can be," says Shillam, who grew up on her family's eighty acres in Oregon. And that also means "knowing where that boundary is," when it's time for a change. ■

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